Kitsap County Mental Health, Chemical Dependency & Therapeutic Court Programs

Fourth Quarter Report

October 1, 2022 – December 31, 2022

Progress on Implementation and Program Activities:

Agency: Agape Unlimited **Program Name: AIMS/Construction**

Reflecting on evaluation results and overall program efforts, describe what has been achieved this Quarter. If objectives went unmet, why? Are there any needed changes in evaluation or scope of work?
The AIMS program did meet the measure of 98% of all SUD intakes will complete an AIMS questionnaire to determine need for services and further screening. The AIMS program is only staffed two days per week due to statewide LMHC staff shortages. Our LMHC is only staffed two days per week (Monday and Tuesday) at present time which has impacted some of our objectives. During this quarter several Mondays fell on observed Holidays. All individuals served received 1 or more services per month. We averaged serving 8 unduplicated individuals per month.

Briefly describe collaborative efforts and outreach activities employing collective impact strategies.
We have strong partnerships and a robust referral system with other behavioral health organizations which assists the referral process. Agape started the Recovery, Empowerment, Advocacy and Linkage (REAL) program in October 2021 in response to the Blake decision (State vs Blake) which meets the definition of the recovery navigator program. The REAL team in Kitsap County has been a great referral source. Our screening and eligibility requirements are very minimal with few disqualifying factors to ensure that eligible participants have quick access to services (contact within 24 hours by the LMHC or Patient Care Coordinator). Many staff are crossed trained to screen for program eligibility as well as for disseminating accurate information in appropriate forums to our target population.

Please describe your sustainability planning – new collaborations, other sources of funding, etc.
Agape Unlimited continuously searched for other funding streams to support the patient care coordinator position.
We have been unsuccessful at finding funding for non-Medicaid billable services for support staff.

Success Stories:
I have been coming a while now and it is nice having someone to share with that is not connected in my life. I have gotten some skills I use at home and have been able to be living in the same house with other women and stay off drugs.

Agency: Agape Unlimited **Program Name: Treatment Navigator SUD**

Reflecting on evaluation results and overall program efforts, describe what has been achieved this Quarter. If objectives went unmet, why? Are there any needed changes in evaluation or scope of work?
The Treatment Navigator program was very successful serving clients during this quarter. We are meeting all of our objectives, and do not believe there are any changes needed in the scope of work. We are seeing some data issues in how services are tracked in regard to duplicated and unduplicated services/ clients. Some clients have changes in medical coverage, zip code, so it would be the same clients so tracking could change for the client even in the same quarter.

Briefly describe collaborative efforts and outreach activities employing collective impact strategies.
Agape's treatment navigator has recognized other critical needs that clients have, and we have been able to meet those additional needs. We have partnered with multiple agencies such as District Court, Healthcare Authority, Cell phone companies, and other social service agencies to meet the need of our clients and minimal expense to the grant and provide a greater impact to the client.

Please describe your sustainability planning – new collaborations, other sources of funding, etc.

Agape Unlimited continuously searched for other funding streams to support the patient care coordinator position.

We have been unsuccessful at finding funding for non-Medicaid billable services for support staff. Agape is in the process of getting out Navigator to become a Certified Peer. Agape's goal is to have the Navigator certified as a peer counselor and be able to provide a portion of the treatment navigators expenses paid as a Medicaid.

Success Stories:
She helped me to get my stuff I needed for my first time and in at an Oxford and I got a job. I am still in groups here and she has helped get me food and to my court.

Agency: Kitsap County Aging and Long-Term Care Program Name: Partners in Memory Care

Reflecting on evaluation results and overall program efforts, describe what has been achieved this Quarter. If objectives went unmet, why? Are there any needed changes in evaluation or scope of work?
All objectives were met. Due to high cold, RSV, flu, and COVID numbers this past quarter, a couple consultation services were postponed until the following month (same quarter).

Briefly describe collaborative efforts and outreach activities employing collective impact strategies.
Outreach to the following agencies throughout the year to increase collective impact for mutually served individuals: Poulsbo CARES team, Adult Protective Services, adult family homes, transitional and supportive housing programs, skilled nursing and assisted living facilities, local hospitals, legal advisors, primary care physicians, counselors, University of Washington Brain Wellness Center, ECHO project, caregiver support groups, and long-term care case managers.

Please describe your sustainability planning – new collaborations, other sources of funding, etc.

Kitsap Aging will be using American Rescue Plan stimulus funds to continue the project. There is a 2023 legislative ask to expand the Dementia Catalyst pilots sites from 2 to 4 (statewide) in the biennium budget. If this is funded, Kitsap Aging will be submitting a proposal to be awarded these competitive funds.

Success Stories:
Completed satisfaction survey results: 18 in 4th quarter; 25 for YTD.
YTD, overall experience with the Consultant scored 4.8 (out of 5).

Comments for 4th quarter included:
“Denise was most helpful and very sensitive to our situation.”
“Denise was extremely skilled in listening to my concerns and furnished a range and depth of information and support. She could not have been more helpful. Thank you.”
“Denise is a good listener and stays focused on our individual needs. Not your typical canned presenter. Qualified and caring.”
“Denise was prompt in returning my calls and very engaged and interested in my personal challenges in caring for my mother.”

Added comments: Very busy with referrals from the community and the hospital.
Thank you for the opportunity to launch an innovative project beginning in 2018. Today, Kitsap Aging has sustainable funding through stimulus funding to continue the services. Over the years, Kitsap Aging has provided this service to support individuals and their families through a difficult and stressful episode time in their lives. Caregivers have felt supported, and families have been connected to vital services/ information for advanced care and legal planning.

Agency: Bremerton Police Department
Program Name: Bremerton Behavioral Health Outreach Program 2022

Reflecting on evaluation results and overall program efforts, describe what has been achieved this Quarter. If objectives went unmet, why? Are there any needed changes in evaluation or scope of work?

Briefly describe collaborative efforts and outreach activities employing collective impact strategies.

Please describe your sustainability planning – new collaborations, other sources of funding, etc.

Success Stories:

Agency: City of Poulsbo Program Name: CARES

Reflecting on evaluation results and overall program efforts, describe what has been achieved this Quarter. If objectives went unmet, why? Are there any needed changes in evaluation or scope of work?
Our program changed data collection systems in October 2022. We migrated from an excel based collection system to a much more sophisticated system with Julota. I can see, when looking at our year end and Q4 numbers, that they do not accurately capture our activity. We also lost insurance information for some participants. This is frustrating, but I know our data will be more accurate and comprehensive in 2023.

In 2023, I'd like to report out on number of referrals the team receives and number of outreach visits. Re the latter-the team did upwards of 850 in person visits in 2022, and this is not captured in our report. We are also not capturing the kinds of referrals we are making to services - just the connections to services made (we often do not know about connections).

Very low survey response rate this year which is unusual for our program. Survey was sent to over 80 people: response of 34.

Briefly describe collaborative efforts and outreach activities employing collective impact strategies. As always-the team works collaboratively with providers in the medical, behavioral health, and social services field to improve care coordination. We've had some great successes partnering with the AMFM mental health counselors at Fishline this quarter and working with their case managers.

Please describe your sustainability planning – new collaborations, other sources of funding, etc.
We have successfully applied for grants with Salish Behavioral Health ASO and our regional Accountable Communities of Health.

Success Stories:
In late December, CARES had the pleasure of closing a referral for an elderly program participant who required considerable support following a significant injury. CARES successfully assisted the participant in navigating the medical system, medical insurance, and transportation to/from medical appointments by completing a connection to the Kitsap Transit Access program. The participant's injury caused isolation and subsequent depression and anxiety about their future including some passive suicidal ideation. CARES utilized the contracted AMFM mental health provider housed at Fishline to intervene on mental health symptoms quickly and effectively, provided a ride to the first appointment, and ensured the participant could continue to access weekly therapeutic appointments remotely.

CARES completed a referral to Kitsap County Aging and Long-Term Care to activate other resources that may be of use. CARES also provided referrals to mobile animal care providers to ensure the participant's animal's needs were met during their period of recovery and limited mobility. Finally, CARES conducted weekly telephone contact to provide ongoing support and continue to assess the participant's needs. They are now recovered enough to be mobile both inside and outside of their home and no longer require CARES intervention, however, they have disclosed that during their time of need, they relied on CARES when no other sources of support were available.

In November the CARES Team was referred to an 11 yo child with escalating mental health symptoms and occasionally aggressive behaviors who had both law enforcement and EMS responses to the home as a result. The CARES Team successfully engaged the family following one such incident and was able to assure proper connection to area resources providing specialized services to adolescent populations as well as supports for the entire family. A delay between service intake and service initiation is typical and can be a considerably stressful time for a family trying to cope with little support or skills while waiting for help. CARES social workers have been able to bridge the gap and respond to the home to provide crisis stabilization and support as needed. In addition, the CARES social workers have been able to effectively facilitate the child's agreement to voluntary transport by the parents to Seattle Children's for intensive evaluations and real-time support. CARES Team expertise and availability has resulted in the avoidance of EMS response to the home.

Additional Comments:
As always--appreciate the County's support and assistance. Looking forward to a great new program year.

Agency: The Coffee Oasis — Program Name: Homeless Youth Intervention

Reflecting on evaluation results and overall program efforts, describe what has been achieved this Quarter. If objectives went unmet, why? Are there any needed changes in evaluation or scope of work?
The fourth quarter of 2022 saw a greater reach for our program as we built on relationships with school districts working closer with support staff, counselors, and social workers. We also made an intentional priority to reconnect with educational services that had fallen off our radar; some of those include an increased presence at Renaissance, Discovery, Marcus Whitman, Bremerton, and Olympic High Schools.

The fourth quarter also saw a significant increase in crisis connections over our text line. We switched to a new platform allowing more excellent usability and support. The platform also provides more ability to track metrics, support volunteers, and add additional information to help provide youth with better service.

With a heavy heart, we lost a youth who had been in service with us in the past. We had worked with this youth and her family extensively and learned that they had run away from home over the holidays. A month later, this youth was located during a 911 call after they had overdosed. We want to share this because it was not an outcome anyone wanted; however, the pain shows the need for the services our county offers and why we as a community need to do better in strengthening our weaknesses and building upon our strengths. It is a story that has opened and will continue to open dialogue about improving our efforts and increasing collaborative care as a community. Some additional outcomes we believe we could track in 2023 are referrals to Behavioral health in the community and track the health care insurance that we have established through case management.

Briefly describe collaborative efforts and outreach activities employing collective impact strategies.

We continue to build strong relationships with law enforcement agencies across the county. In quarter four, we supported the Bremerton Police Department in several situations, including the placement of youth into our shelter, assistance locating an endangered youth, and collaborative efforts with their community support navigators.

We continue to collaborate with the South Kitsap School district social worker in connecting with students who need additional support outside the classroom. Our specialist has been building solid relationships with students, and the feedback we have received has been positive, with students showing improvement in the classroom. One student who had begun living on her own was struggling with not knowing how to do basic skills such as grocery shopping, cooking, etc. Our specialist was able to come alongside this youth and help teach her how to purchase groceries and cook on her own. We also provided necessities such as pots and pans, utensils, etc.

Please describe your sustainability planning – new collaborations, other sources of funding, etc.

Since the COVID pandemic, we are thankful that general giving has been up, helping to fund all of our programs, including Crisis Services. We pursued and were awarded additional OHY funding to help support this programming. This is a primary focus for at least one quarterly fundraising campaign in 2023. Crisis Services remains a priority and we look forward to serving many more youth in Kitsap County.

Success Stories:

I first discovered Coffee Oasis when I was a sophomore in 2019, and by then I had pretty big issues with bottling up my feelings. Having dealt with stress from an abusive, dysfunctional family and loneliness at school, I never had anyone to talk to, and I felt pretty lonely and sad but otherwise tried to repress those feelings. But with Coffee Oasis, I finally had someone to talk to and get my biggest emotional burdens off my chest, like my abusive brother who mocked me for being autistic as well as an abusive counselor who constantly criticized and shamed me. I also didn't really have friends at school, so the hotline provided one of my only outlets for being able to enjoy talking about myself as well as my autistic identity without being judged. While I do admit in recent months, it has been difficult to talk to certain people on the hotline, and there was some advice I didn't like, I did find the support of caring people. One of the people who operate the hotline is my own personal case manager, and she helps me with my personal goals such as finding a job and enjoying life.

Agency: Eagles' Wings **Program Name: Coordinated Care**

Reflecting on evaluation results and overall program efforts, describe what has been achieved this Quarter. If objectives went unmet, why? Are there any needed changes in evaluation or scope of work?

We are especially proud that more than 95% of participants feel safe, stable, and satisfied with EWCC services. At the end of 2022, 56 of the 1/10th participants are still housed. We served 121 unique individuals through this program, which was well over our goal of 50 clients for the year. We were unable to meet some of our goals, however, the goal of keeping 75% of participants housed 6+ months and connecting 75% of participants with income or housing support was likely too optimistic. Given the dearth of consistent, long-term funding and that many of the participants we have served represent the hardest to serve in our community, we are still immensely proud to have outcomes upwards of 60% in these measures. More than 1/3 of the people we serve(d) are in a therapeutic court, drug diversion, or on probation. Relapse is often part of recovery, but a positive UA can lead to a jail sanction. Seven of our drug court participants (5.7% of all participants) accounted for two-thirds(66.7%) of all arrests this year. Despite not meeting our arrest reduction goal, we helped to divert 23 of 30 therapeutic court participants from further criminal justice involvement this past year. Lastly, we are proud of our ability to serve 47 people who identify as a Person of Color (POC), making our program more diverse than the general Kitsap population. This statistic does not include that at least eight EWCC participants identify as LGBTQ+ individuals nor does it consider the 10+ participants who are Registered Sex Offenders. In addition to justice-involved participants, the two latter mentioned groups are persistently marginalized, underserved, and denied housing and support services.

A large part of our success is driven by the collective EWCC team comprised of nurses, master-level health professionals, social workers, and case managers. This team works closely with the live-in Resident Aides to coordinate everything from medication management (40% of clients) to crisis de-escalation and relapse prevention, often while also providing transportation to multiple agencies to gather documentation needed for rental assistance requests--a process that often must be repeated monthly.

Briefly describe collaborative efforts and outreach activities employing collective impact strategies.

We have continued to work very closely with a lot of different agencies, many of which are also 1/10th recipients. Of the 121 participants served through the 1/10th program in 2022, 10% have exited after being accepted into more stable housing such as Pendleton Place, Milan Apartments, the Drug Court Alumni House, or reuniting with family and moving in with them. We continue to work closely with Crisis Triage/Pacific Hope and Recovery Center, Kitsap County Jail, Kitsap Rescue Mission, Salvation Army, Community Correctional Officers, and Catholic Community Services Housing Essential Needs program. We continue to receive referrals for the hardest to place individuals, including those with dual diagnoses, Registered Sex Offenders, and recently incarcerated individuals, who have been denied or failed out of other housing options. Our partnerships with the therapeutic courts have remained strong, as evidenced by the high proportion of participants (24.7%) who are enrolled with both EWCC and a therapeutic court or jail diversion such as Trueblood. We have recently partnered with the Bremerton Municipal Court who is starting their own diversion program and have taken two referrals at the time of this report. Further efforts to increase therapeutic court support is addressed in the next section.

Please describe your sustainability planning – new collaborations, other sources of funding, etc.

We have applied for a Department of Commerce grant for capital funds to buy a Bed and Breakfast to increase our housing stock and help cover operations.

We are also applying for Project Based Vouchers through Bremerton Housing Authority and submitted a Letter of Intent to the Medina Foundation to help with operations costs. We are currently working on a large, multi-year federal funding opportunity that would support increased therapeutic court care coordination and housing. We have outreached to city and county officials to see how we might be able to work together to support those displaced when one of two Kitsap shelters closes in April, and we continue to prioritize Foundational Community Support reimbursement for our eligible participants. Our partnership with HEN's Pilot program to house stable individuals in single rooms through our Next Steps homes continues to be strong as well. Lastly, with 12 of 13 houses being WAQRR accredited, we are now able to request some back rent reimbursement for individuals who were unable to obtain rental assistance through coordinated entry before the monthly funding allocation ran out.

Success Stories:

We are so proud of the life, love, and sense of community that flows through all our houses. We especially feel this at our Clubhouse, where we hold meetings, celebrations, game nights, and Process Groups most nights of the week. This is a place where participants can come together with other community members, social service workers, retirees, landlords, and EWCC staff in a relaxed community setting. We reduce stigma around homelessness, mental health, and substance use through communal meals and engaging in communal activities. We are in the finishing stages of a recording studio in the basement of the Clubhouse where an EWCC participant wishes to volunteer this skills and time to teach other participants how to DJ and records music as a form of self-care. As previously mentioned, we have 56 1/10th participants still housed, accounting for 50% of all EWCC participants housed at the end of 2022. Many of these individuals have graduated into Resident Aide positions, regained their licenses, gained employment, enrolled in school, reconnected with family and children and/or well on their way to drug court graduation. These are individuals many people had given up on and there is nothing that feels more successful then when we get to witness them thrive and give back to the community, they live in.

Agency: Family Behavioral Health CCS

Program Name: Intensive Therapeutic Wraparound

Reflecting on evaluation results and overall program efforts, describe what has been achieved this Quarter. If objectives went unmet, why? Are there any needed changes in evaluation or scope of work?

Our efforts this quarter and year have been viewed as successful overall - based on both client and staff feedback. This program continues to provide needed services to a higher-acuity population that does not otherwise have access to this level of intensive services.

Our most telling outcome measurements show that we have met our goal of reducing the number of Juvenile Justice/Law Enforcement encounters and Emergency Department visits/Inpatient Mental Health stays for the clients we serve, from 33 during the year prior to our services down to only 6 during our services. In addition to meeting our goal, this equates to substantial savings for costly emergency services.

We have had four graduations from services this year with lengths of service of 7.5, 10.5, 4, and 2.3 months long. We have another planned graduation in January. One of these graduations took place this 4th quarter with no clients dropping out of services.

We have made some minor changes to our scope of work and evaluation which is reflected in our proposal for 2023 and should improve the experience of our clients and the clarity of our measures.

Briefly describe collaborative efforts and outreach activities employing collective impact strategies.

Here are some current collaborations noted by Bryan Collins, the supervisor of this program, in addition to the many other collaborations we have reported on throughout the year in previous reports: "Clients have been able to work with The Coffee Oasis, a local outreach program.

Clients have been able to get additional support through free case management in that program. Clients have utilized different psychiatric services for medications and the teams have been able to collaborate with those systems as well."

Haley, our Clinical Access Specialist, is reaching out monthly to youth and families on the Identified for Services list (essentially our waitlist) to check-in with them and obtain up-to-date information on the youth and families current needs and youth's behaviors. She is also able to provide additional resources and information as needed for each family.

Please describe your sustainability planning – new collaborations, other sources of funding, etc.

We continue to try and bill insurance companies for services. We have also requested information on, and are looking into, other funding opportunities such as the Mental Health Block Grant via the Salish BH-ASO.

Success Stories:

"The team has been really great, and we have seen a lot of progress with [the client]. We are excited to graduate."
"We have really appreciated what the team has been able to accomplish and teach us."
"We have seen some good progress and happy to continue."
"Skye has been really wonderful, and she has connected well with our family" (Skye is our Clinical Care Coordinator, or "CCC")

Skye shared this success story: One of our clients began services because they were assaulting kids at school, hitting, and kicking parents and being physically aggressive towards the animals in the home.

Parents reported that youth had a hard time listening and managing inappropriate behaviors. After being in services for seven months youth has not been physical with parents, peers, or pets in the home for a majority of that time. Youth is also able to advocate for the services they would like and express feelings regarding parental relationships. Family has chosen to graduate from WISe due to a lack of need for intensive services but will develop a relationship with a long-term therapist in order to maintain the achievements and emotional stability that they have developed over the last seven months.

Additional Comments:

We are very thankful for the opportunity to provide these much-needed intensive services to families who do not have Medicaid Coverage and thus face a gap in the continuum of care otherwise unavailable to them.

Our team has done great work with those in services with us to improve their quality of life as well as reduce the need for costly emergency services. As shown in our outcome measures, our services have had a substantial impact on the utilization of legal and emergent mental health resources for those we serve. While we are not able to serve a large number of clients due to the intensive wraparound nature of our services and the high acuity of our clients, we are making substantial impacts in those we are able to serve and hope to someday be able to expand our services to reach more who need them.

We are especially thankful we have been given funding to continue this important work. Your support is improving the lives of struggling families who haven't been able to find the level of services they needed before this program was available. We are looking forward to an impactful next year.

Thank you from all of us at CCS FBH!

Agency: Fishline Program Name: Counseling Services

Reflecting on evaluation results and overall program efforts, describe what has been achieved this Quarter. If objectives went unmet, why? Are there any needed changes in evaluation or scope of work?

Goal 1: Receive 5 referrals a month or 15 referrals per quarter from partner agencies. We surpassed this goal with 27 referrals to counseling services.

The Poulsbo Fire Cares team and Police Navigator teams reported referring 10 people to our counselors in quarter four.

Fishline case managers referred 9 clients to our counselors.

Eight clients self-reported hearing about our free counseling services from market staff, volunteers, and friends and 2 unknown referral sources.

Goal 2: Complete 5 Intakes per month or 15 Intakes per quarter/See clients within 3 business days/75% will be satisfied and have experience improvement upon exit. We met this goal.

We completed 191 intakes this quarter. Our new relationship with AMFM started has been exceptionally collaborative and has reduced barriers to care. We were approved to hire another provider to offer services part time.

100% of new clients were contacted and scheduled within 3 business days. More than 80% were seen within 3 business days. The primary contributing factor to why clients did not see the counselor within 3 business days was client preference.

Goal 3: 75% of those seen by the counselor will be referred to a Fishline case manager/Schedule and attend quarterly meetings with other providers.

10 clients had already seen a case manager and were enrolled in services. Of the 10 clients who came from outside Fishline, 9 were referred to other providers. We met this goal.

Briefly describe collaborative efforts and outreach activities employing collective impact strategies.

In the 4th quarter, Fishline provided updates about our free counseling services at our monthly and quarterly community meetings. The case managers and Social Services Manager met with providers from other agencies, such as Suquamish Wellness Center, Scarlet Road, and local churches.

Please describe your sustainability planning – new collaborations, other sources of funding, etc.

We are pleased to report that we have been awarded $11,800 from the Bainbridge Community Foundation for 2023. The city of Poulsbo has allowed us to carry over $26,300 of funds from the 2022 calendar year to 2023. Fishline also plans to allocate revenue from our thrift store, Second Season, and direct donations towards funding this program.

Success Stories:

A client who was seeing our one therapist at first. He was working on CBT and solution focused therapy. He was referred to our Case Managers for further support with gas, living situation, and overall to get his basic needs met. He was unemployed when he began our services. He was then referred by the first therapist to the other one who specializes in EMDR to process past trauma. Within the time with him, he continued to consistently work with our case managers, complete a target memory in EMDR to install a positive cognition around a trauma memory. He applied for jobs and got a job in Alaska for 6 months. He was discharged to Alaska with resources in his area, reported feeling stable, has resources for when he returns, and felt excited. He specifically stated, "having good coping skills", the ability to adapt to build a new routine, and felt in a positive, adaptive space in his trauma.

A client was working with case management for resources and support and was referred to our mental health therapist. At the beginning of working with the client she struggled with self-worth and esteem issues, increasing depression and anxiety symptoms. Since providing CBT therapy in sessions this has helped the client enact change in thinking patterns and behaviors. She has now begun to work with a job coach here at Fishline and has completed a resume and engaged in job searching. She has also begun to ask for help and attends therapy routinely.

Additional Comments:

Although we started off with a few challenges, we were able to successfully sign on AMFM Healthcare. This has proven to be an extremely solid, fortunate teaming. The therapists and staff at Fishline have proven to have established a relationship of respect, trust and are collaborating well. This has demonstrated to be immensely beneficial for our clients because we have been able to offer wrap around services, resources and reduce barriers to care.

Agency: Kitsap Community Resources Program Name: ROAST 2022

Reflecting on evaluation results and overall program efforts, describe what has been achieved this Quarter. If objectives went unmet, why? Are there any needed changes in evaluation or scope of work?

We had many successful placements in permanent housing during this quarter. During November and December over half of the ROAST clients living in temporary shelter in motels moved into apartments. Most of these clients came from encampments, but a few were clients who have been on our caseload for 2+ years. We continue to have slow but steady progress with our contracted therapist from MCS Counseling meeting with clients. Many are resistant, but she is slowly meeting with more and more people, and she has helped the clients deal with a few traumatic incidents that affected everyone, such as the death of a client.

Briefly describe collaborative efforts and outreach activities employing collective impact strategies.

The housing team and the Housing Solutions Center, particularly the HEART outreach team, have worked increasingly closer together as a collaborative team. The case managers often will go out in teams to work with clients, and when there's one case manager a client responds to best, often staff will collaborate to make sure the person the clients are most comfortable with are available. Oftentimes it takes a while for a new client to become comfortable with their case manager, when most of their contact up until that point has been with the outreach workers, so having this crossover has been a game changer as far as client engagement in services.

Please describe your sustainability planning – new collaborations, other sources of funding, etc.
We are currently relying heavily on CHG to fund both ROAST case managers and provide long term rental assistance for ROAST clients who are case managed. We have continued to increase the number of clients who are qualified for Foundational Community Supports (FCS), and we use that to supplement case manager salaries as well. Both of these will continue to be funding sources we will have access to.

Success Stories:
Martin and his son Gary have been working with the ROAST program since 2018 and had been homeless for many years prior. When we started working them originally, they were living in a van. Both have physical disabilities and are in wheelchairs. Over the past few years, they have at various times lived in a vehicle, Martin has been in and out of the hospital and rehab centers, both lived in motels with KCR assistance, and, at times, Gary has lived in the woods in a small encampment due to motels not allowing him to stay there due to some of his behaviors. This household's main barrier to housing has been in getting proper documentation together (social security cards, income letters) in order to apply for rentals and qualify for other programs. Their case manager truly went above and beyond this last year, working directly with the hospital, the rehab center employees, and transporting this household himself to offices in order to get IDs, social security letters, and social security cards. They are finally qualified for the CHG Permanent Supportive Housing for Chronically Homeless Families program, and are housed, as of December 2022. They are settling in nicely, and the ROAST case manager will continue to work with them as long as necessary to support in stabilization of mental and physical health, substance use, and to make sure they stay housed. This is a long time coming and we are thrilled to finally see this family permanently housed!

Agency: Kitsap County District Court
Program Name: Behavioral Health Court 2022

Reflecting on evaluation results and overall program efforts, describe what has been achieved this Quarter. If objectives went unmet, why? Are there any needed changes in evaluation or scope of work?
Behavioral Health Court has fully returned to standard pre-COVID operational practices while using virtual appearance for certain circumstances and as a reward in later phases for compliance meeting attendance. Participant enrollment and program referrals decreased slightly from 2021 levels.

Briefly describe collaborative efforts and outreach activities employing collective impact strategies.
We continue to work closely with the Kitsap County Jail staff for in-custody assessments, court viewing and attendance, exit interviews, and urinalysis collection. Kitsap Mental Health Services and Kitsap Recovery Center remain strong partners in helping program participants through treatment and the recovery process, each agency dedicating staff time to attend staffing and program meetings. Kitsap Support, Advocacy, and Counseling (KSAC) remains committed to helping provide more specialized trauma treatment modalities to those in need.

Please describe your sustainability planning – new collaborations, other sources of funding, etc.
This year, District Court and the Office of Public Defense both prepared budgets that included their respective funded positions in their budget for consideration by the Board of County Commissioners (BOCC).

Neither position was assumed within the General Fund and remain grant-funded positions through 2023.

Success Stories:

- Steve* experienced a significant loss during his final phase of the program. Having a history of depression and addiction, he would have responded to this situation very differently in the past. He credits his ability to manage in healthy ways to his time spent in BHC, gaining skills for coping, and his robust sober community supports. Steve managed one of the most stressful life events without any setbacks; it was evident by his response how far he had come in the program.

Additional Comments:

Zip Codes: Missing 98367 Port Orchard as an available option; we have 2 participants with this zip code.

Agency: Kitsap Community Foundation (Kitsap Strong)
Program Name: Relational Mentor Training

Reflecting on evaluation results and overall program efforts, describe what has been achieved this Quarter. If objectives went unmet, why? Are there any needed changes in evaluation or scope of work?

All objectives were met during this quarter. A survey was completed at the end of the COP sessions (ending in December). No changes are needed to evaluation or scope of work.

Briefly describe collaborative efforts and outreach activities employing collective impact strategies.

Kitsap Strong utilized its existing partnerships to conduct outreach for recruitment of training participants. We used direct emails, broad email distribution, social media and had partners share

information through their communication channels. XParenting used existing relationships/partnerships to recruit additional presenters to present during our COP sessions so that participants were able to hear additional perspectives, methods, and resources. Kitsap Strong utilized its existing partnerships to conduct outreach for recruitment of training participants. We used direct emails, broad email distribution, social media and had partners share information through their communication channels. XParenting used existing relationships/partnerships to recruit additional presenters to present during our COP sessions so that participants were able to hear additional perspectives, methods, and resources.

Please describe your sustainability planning – new collaborations, other sources of funding, etc.

XParenting has been approached by several community organizations, i.e., foster care agencies, tribal communities, and local colleges about partnering to provide additional RISE trainings.

Success Stories:

Our data from the initial training show the success of an increase of knowledge and a perspective shift. Each COP session we are able to hear how they are able to put the knowledge and skills into action and gain confidence. Each new session gives them a new tool to use. It's exciting to watch them grow and support the children in our community! This report we highlight the overall experience. Since participating in the RISE Community of Practice, respondents reported changing how they interact with youth/children. Changes mentioned were understanding and implementing regulation strategies, more empathy and reflection, and confidence in their ability to navigate events of emotional dysregulation, i.e.

Additional Comments:
Participants were asked how much the community of practice has increased their depth of knowledge since the initial relational mentor training regarding:
- regulation/de-escalation strategies, 73% reported substantially, 13% reported moderately, and 13% reported a little.
- the generational impact of trauma, 33% reported substantially, 53% reported moderately, and 13% reported a little.
- the importance of self-care, 40% reported substantially, 40% reported moderately, 13% reported a little, and 7% reported no change.
- the role of a safe adult in helping children overcome adversity, 33% reported substantially, 53% reported moderately, and 13% reported a little.
- trauma's effect on the brain and body, 60% reported substantially, 27% reported moderately, and 13% reported a little.

Participants were asked how confident they would feel having a conversation with a peer on the following topics:
- regulation/de-escalation strategies, 29% reported very confident, 65% reported confident, and 6% reported not unconfident or confident.
- the generational impact of trauma, 35% reported very confident, 53% reported confident, and 12% reported not unconfident or confident.
- the importance of self-care, 47% reported very confident, and 53% reported confident.
- the role of a safe adult in helping children overcome adversity, 53% reported very confident, and 47% reported confident.
- trauma's effect on the brain and body, 35% reported very confident, 53% reported confident, and 12% reported not unconfident or confident.

Regarding if youth discuss their concerns, fears, or things that may negatively impact them, 33% reported substantial increase, 13% reported moderate increase, 20% reported a little increase, 7% reported moderate decrease, and 27% reported no change.
Respondents reported they had witnessed an increase in how much the youth/child they have a relational connection with discusses either their interests, goals, and future (87%) or their concerns, fears, and things that may negatively impact them (66%); see Figure 6 and 7. According to the article "Understanding Healing Relationships in Primary Care", some of the relational outcomes of a healing relationship are trust, hope, and the sense of being known. Essentially, this encompasses a person's willingness to be vulnerable, feeling cared for, believing a positive future is possible, and feeling acknowledged as a person. These relational outcomes were concluded to apply to any healing relationships (Scott et al., 2008, p. 320). Hence, increased changes in youth/children discussing their goals, future, concerns, or fears may signify that they are engaging in a healing relationship, considering they feel comfortable discussing such personal information.

Agency: Kitsap County Juvenile Services
Program Name: Juvenile Therapeutic Courts 2022

Reflecting on evaluation results and overall program efforts, describe what has been achieved this Quarter. If objectives went unmet, why? Are there any needed changes in evaluation or scope of work?

In our Satisfaction Survey all questions were answered Agree/Strongly Agree at least 83% with a high of 97%. Recidivism rates are one of the most important measures for any agency working with youth involved in the juvenile justice system. Our recidivism rates continue to be extremely low for youth that complete our Therapeutic Courts. 91% of youth remain conviction-free 12 months after successfully completing the programs. 87% of youth remain conviction-free 18 months after successfully completing the programs. Both numbers exceed our goals of 80% for 12 months and 70% for 18 months.

Briefly describe collaborative efforts and outreach activities employing collective impact strategies.

While we did terminate our collaboration with MCS in September, we did add Olive Crest to our therapeutic court teams in 2022. We also partnered regularly with Kitsap Strong, The Dispute Resolution Center, Agape' Unlimited, and Kitsap Mental Health, who is providing HSYNC (housing services for court involved youth) and STAY services (a type of family counselling).

Please describe your sustainability planning – new collaborations, other sources of funding, etc.

In mid-2022 we started working towards hiring a fulltime BHS and eliminating that cost from future asks. By September we had secured the funding and hired a fulltime BHS. Also, during 2022 we continued to contract with DCYF to pay for a Court Services Officer to supervise the youth in our JDC and ITC Therapeutic Courts.

Success Stories:

A youth entered our treatment courts a little over a year ago. At the time their home and school life were both in complete disarray. She was in physical altercations with her parents weekly, she was failing all her classes, rarely attending school, and her mental health issues were going untreated.

After struggling early in the program and being sanctioned often she started to make life changes in the spring of 2022. She started setting goals with her treatment court team and seeing the BHS on a regular basis. While the change that was happening was slow and, at times, hard to see, it was happening, and she started to build on her success. When she graduated, she was enrolled at Olympic College to get her GED. She had not been in a physical altercation with her parents in months and she had developed a trusting relationship with her therapist and was in med. compliance for the first time in years.

Agency: Kitsap County Prosecuting Attorney
Program Name: Alternative to Prosecution

Reflecting on evaluation results and overall program efforts, describe what has been achieved this Quarter. If objectives went unmet, why? Are there any needed changes in evaluation or scope of work?

This quarter showed a great increase in the number of applications we received—nearly double what we received last quarter! It is too early to assign this to a trend of any kind, but it does foster hope that we are starting to emerge from the COVID / Blake reduction in new applicants.

You will see in our statistics this quarter an enormous increase in the average number of days from review to entry as well as the average number of days from application to entry. Unfortunate as it is to our statistics, it is directly caused by one case which is an anomaly but whose history skewed the rest of our numbers. We had one case which had been on warrant status for twenty years. The defendant now lives out of state. Her attorney reached out to us to seek to quash the warrant and resolve the case.

Due to a variety of circumstances, we agreed to allow the case to enter the felony diversion program, upon certain specific conditions, including a form of restitution to the victim of the crime. We wanted to make sure the victim was made whole prior to allowing the defendant to enter the program, and we required her to attend court in person when she did finally enter the program. In all, it took fourteen months from the time of her application until she had met our pre-entry requirements and was able to travel here to make the court date. So that one case did hugely affect our statistics. Removing that case from consideration, our numbers for the quarter would have been only 33 days for time from review to entry and only 37 days from application to entry, which actually reflect the best times of the entire year!

Briefly describe collaborative efforts and outreach activities employing collective impact strategies.
This quarter, we sent out an evaluation request to our partners in the Superior Court treatment teams asking for feedback on the performance of the prosecutor's office as a team member. All but one partner responded with resoundingly positive comments, indicating their belief that the prosecutor was a valued member of the therapeutic team who contributed a breadth of knowledge and experience not otherwise present on the existing team. The one partner identified above indicated mostly "neutral" responses (when given the choices of "strongly disagree", "disagree", "neutral", "agree" or "strongly agree"). As the evaluation was anonymous, we don't know for sure from whom the neutral responses came, but it does show us there is always room to improve and helps us know that work can be done to make sure ALL of our partners are satisfied with the services we provide overall.

Please describe your sustainability planning – new collaborations, other sources of funding, etc.
As we always do, we request that the general fund cover the costs of our Therapeutic Court Unit. As we have seen in the past, however, we have consistently been denied that request.

There really are not a lot of other options for a program such as ours, since the majority of the federal grants or other funding sources are focused on providing dollars to treatment agencies or case management organizations that directly work with the population. We do subscribe to the state-wide treatment court publications and the state-wide CJTA committee often sends out grant information that may apply to some of our partners. We review those emails closely to see if any of the grant requirements could be something worth applying for that we would qualify for, and we will continue to do so.

Success Stories:
As is standard protocol, drug court conducts quarterly graduation ceremonies. At the most recent (January 27th, 2023), one of the graduates' bears mentioning. The individual was facing 60+ to 120 months on charges in Kitsap County, but also had several charges pending in another county as well. After much discussion, that county agreed to send their charges to Kitsap to allow for the person to enter drug court on all of the counts. In total, due to the fact that some of the charges were misdemeanors and some felonies, the person would have faced a total possible sentence of thirteen years in prison.

It was a struggle to get him to meet with his attorney, show up to court, and complete the necessary paperwork to enter the program since he was out-of-custody. He had excuse after excuse and multiple failures to appear. After one missed court appearance, his attorney reached out to inform us he was in the hospital with a severe blood infection due to a heart issue. The team thought it was just another excuse. However, the following week, he appeared for court (this was during the time all court appearances were via zoom due to COVID) from his hospital bed! He did indeed have a serious infection and was required to spend several weeks in the hospital receiving IV antibiotics in order to save his life.

He attended court and treatment sessions faithfully, from his hospital bed, until he was discharged from the hospital almost three months later. He jumped right into the swing of things and didn't miss a beat with the program requirements. He has become a beacon for newer participants and a strong advocate of the Narcotics Anonymous fellowship. At his graduation, he joined the very, very small group of drug court graduates with bragging rights to claim they completed the program without a single sanction (program violation) throughout their whole participation!! We expect great things of him as he seamlessly joins the league of drug court alumni who offer their help and wisdom to the new participants in early phases of the program.

In the words of one of our recent graduates, "I have no words of wisdom, no homily for posterity. Instead, I have a rekindled spark…no, a FLAME of life that was all but gone 3 years ago. This program opened up the world to me again – I'd been drowning in a sea of drugs, alcohol, and misery. I waited patiently in jail for a bed date in treatment and embraced everything BHC, KRC, and KMHS had to offer me. This program means many things to many people. For me it meant my freedom – free to find out who I am and what I want for myself. I'm a firm believer in you get back what you put out in life, and I was more than ready to put out some good juju for a change. BHC gave me confidence in myself, the ability to make boundaries, recognize red flags and act accordingly, and the knowledge that I am ENOUGH. When I first viewed court to see if I like what I saw – I observed a woman in Phase 4, dressed nicely, smiling with poise and confidence. I thought to myself I would NEVER be able to achieve that…and today I AM that woman. I am a walking miracle… thank you BHC for all the support and guidance – I am ready to fly!!"

Agency: Kitsap County Sheriff's Office
Program Name: Crisis Intervention Coordinator

Reflecting on evaluation results and overall program efforts, describe what has been achieved this Quarter. If objectives went unmet, why? Are there any needed changes in evaluation or scope of work?

As the CIC, I'm presently documenting my behavioral health responses using three separate sources; ILEADS, Julota, and internal spreadsheet. Quarterly reporting for 1/10th asks for measures that carry some ambiguity and require tedious review of my internal spreadsheet for me to provide accurate statistics. These calculations take up a substantial amount of time when ideally, I'd prefer to pull statistics directly from Julota which automatically generates figures. As much as I wanted to discard the spreadsheet due the extra time it requires to accurately maintain when I'm already making data entry into Julota, I had to keep utilizing it solely for the purpose of being able to answer 1/10th reporting measures. I do believe the measures I'm referring to are worthy of reporting and carry valuable information for the Salish BSO and WASPC, but my dilemma is they aren't tracked in Julota which requires I track them elsewhere (ever growing spreadsheet). Examples of measures listed in 1/10th reporting that Julota doesn't calculate are, # of CIC contacts where individual is no longer in crisis at CIC encounter (year-to-date), # of CIC contacts where individuals require court order to go to hospital (year-to-date), # of CIC contacts where individuals refuse transport (year-to-date), # of CIC contacts where individuals are not in crisis and are provided with mental health resources (year-to-date), # Of unduplicated applicable clients connected to a DCR (year-to-date), # of CIC contacts where individuals are provided referral to West Sound Treatment/REAL Team (year-to-date), # of interactions with clients that have a safe result without incidents (year-to-date).

I hope and will be suggesting that Julota modify their database to configure the same statistics being requested through the 1/10th quarterly reporting for the primary purpose of saving time that could be utilized making outreach in the community. Currently I can use Julota's "Admin Dashboard" to pull the following measures/statistics: total encounters, average encounter per participant, average length of encounter, encounter type, encounter outcome (only shows whether successful, unsuccessful, left voicemail, left card, other, unknown, etc.), encounter method (in person, phone, email, unknown, other), ages, gender, race and ethnicity (I haven't' tracked these, but could in Julota), services provided, patients with multiple services, patients served, reason for referral, and zip codes (much easier than tracking via spreadsheet). If I were asked what measures should be listed in the 1/10th reporting that I'd like to see Julota configured to calculate, I'd suggest the following: total use of force encounters beyond handcuffing (this can be documented in Julota via selecting "yes or no", but doesn't capture stats when viewing Admin Dashboard), total emergent detentions pursuant to RCW 71.05, total court orders served for detention/apprehension for involuntary treatment, total REAL Team referrals, total arrests made of clients while conducting behavioral health outreach (tracked via spreadsheet currently), DCR involvement (only tracked via spreadsheet currently), and voluntary transport to hospital when client did not meet emergent detention criteria. However, I'm continuing to maintain the internal spreadsheet until either Julota is reconfigured and/or until the 1/10th reporting measures are modified to where I can pull requested measures/statistics from Julota as the database is designed to do.

Briefly describe collaborative efforts and outreach activities employing collective impact strategies.

*Since I was without an embedded MHP for the last quarter of 2022, I communicated regularly with the CRT (DCR's @ KMH) to discuss clients needing intervention. With there being a shortage of DCR's, often (not always, but often) law enforcement is unsuccessful with getting DCR's to respond to a scene on request.

I could typically coordinate with the Crisis line (LE number) to schedule a time to have a DCR accompany me to an outreach, but immediate response by DCR's isn't always possible due to their staffing levels and their own call volume. When I'm on duty, DCR's contact me regularly and they know I will accompany them during any outreach assuming I'm available. On few occasions I've been preoccupied with another Crisis event where I must refer DCR's to Patrol for assistance during outreach. When I review case reports and note someone who's still in the community (not arrested or already detained pursuant to RCW 71.05 or 71.34) and said report articulates a presentation that could result in the client meeting emergent or non-emergent detention criteria, I will request a DCR accompany me to assess. On the occasions where DCR's aren't available to respond immediately, I still conduct the outreach and detain if the client meets emergent detention criteria; if I don't see imminence, but the client presents "likelihood" of serious harm or is gravely disabled meaning I have no legal authority to compel/force them to be admitted to the nearest triage facility, then I'll document my observations in a new ILEADS report or supplement an existing case and forward the report to the CRT (DCR's) requesting follow up evaluation while highlighting why I feel they client meets non-emergent detention criteria which my report would/can support a petition for initial detention. I will also contact the CRT (DCR's) by phone to discuss my report and requests. During this process, I educate the involved family members, if any, in cases where they feel their loved one requires inpatient treatment. I encourage family, even though I may have requested evaluation through forwarding a report to the CRT (DCR's), to call the Crisis line and formally request a DCR investigation of their loved one while explaining that after 48-hours if DCR's didn't intervene and/or chose not to detain the client, the family member would still have the option to petition the court through Joel's law to get their loved one court ordered treatment.

*With the Poulsbo CARES team expanding to Central Kitsap, I had the opportunity to take their Social Worker (K.T.) on multiple ride-alongs where she got to attend several Crisis events and allowed for collaboration with how CARES would be implemented in Central Kitsap in conjunction with agencies/entities or programs such as the CIC/KCSO, CRT/DCR's, St Michael's Medical Center, Kitsap Mental Health AIU/YIU/MCOT/CTC, REAL Team's, etc.

Please describe your sustainability planning – new collaborations, other sources of funding, etc.
N/A; I have never been asked or directed to seek other sustainable income sources.

Success Stories:
*CIC was contacted by the mother of a 36-year-old transient male who's lived on the streets in Silverdale for 10+ years. The mother has been victim to many criminal acts by her son who suffers from severe substance abuse and mental illness. This male has been booked into KCSO Jail 18 times since 2017. The mother expressed feelings of hopelessness with her son ever accepting treatment or bettering his quality of life in any fashion. CIC was familiar with the male from many prior contacts including arrests both felonious and misdemeanor. CIC's last contact with this male was when a local bank called 911 reporting an unwanted person sleeping in front of their entrance. As a result of the contact, CIC referred this male to the West Sound REAL Team who outreached the male, but he declined to accept any services for substance abuse or his behavioral health. Upon being contacted by the mom, I learned the male was presently in custody for destroying property of his mother's and I knew the male was not due to be released for at least another 10 days. The mother and CIC agreed her son would benefit from immediate treatment. I believed proper coordination would allow for the male to be transferred from the Jail for treatment. CIC coordinated with the Jail to ensure the male was placed on a DCR hold while I forwarded a new updated report to DCR's documenting this male's steady decompensation as well as I requested an evaluation occur.

While arranging this, CIC educated the mother with Joel's law and connected her with DCR's so that if after 48 hours the male was not detained pursuant to RCW 71.05, then legally the mother could petition the courts to have her son detained for involuntary treatment since he clearly has continued decompensating in the community. The good news outcome occurred when the mother contacted me to say thank you after she was notified by DCR's that her son had been evaluated and he'd finally agreed to participate in a substance abuse program called New Start who will provide him with housing upon when he's released from jail.

*CIC attended recent training. Verbal Craft/De-Escalation Training Trainer: Andy Prisco, Jumpstart Mastery. CIC was referred to this class by Kimberly Hendrickson (Housing, Health and Human Services Director) with the City of Poulsbo. The KCSO Community Resource Officer attended alongside me and CARES Team members from Poulsbo and Central Kitsap. In my role as CIC with often interacting with community members in "primitive brain states" i.e., fight, flight, heightened anxiety, etc. with limited diversity of thought and expression. I can say this training was well received by all attendees to include I genuinely felt more confident with interacting with community members experiencing a behavioral health crisis.

*In the final quarter of 2022, CIC received an email tip from County Code Enforcement stating Kitsap1 received complaint of a public nuisance property and possible situation involving self-neglect of a vulnerable adult at Northlake Mobile Home Park. A neighbor submitted a report to Kitsap1 wanting her neighbor removed from the park due to nuisance; furthermore, it was reported the occupant had mental health issues, delusional, paranoid, leg amputation, etc.

Also reported the male was believing he was being spied on through a top hole of his camper/trailer. CIC responded immediately upon receiving this report; upon arrival, I/CIC could hear what sounded like someone yelling for help coming from inside the camper. I noted smelling the extreme odor of feces coming from within the camper; I opened the door after noting "help" was being yelled from inside this camper. I located an elderly male on the floor amongst piles of trash, old food, buckets of urine, etc. I could see where the male had been defecating on himself, his feet/toes/toenails were abnormally large and discolored indicating fungal infection; the interior was utterly uninhabitable to include the bathroom and kitchen were not accessible or functional. I noted the living conditions were some of the worst I've encountered while with KCSO. I immediately summoned for Fire/Aid for hospital transport. The male required numerous first responders to extract him from the camper; the male was stuck on the floor and was incapable of caring for himself much less ambulate on his own. I later learned from a neighbor that they suspected it had been weeks since this male had been outside his trailer meaning, he likely wouldn't have survived long if not for another neighbor making the initial complaint with Kitsap1. I/CIC would immediately notify DCR's, hospital social worker, and APS of the situation to ensure this male did not get released from this hospital back to this camper/trailer where initially encountered. I learned the male was a Navy Veteran from the Vietnam era who likely wasn't enrolled with the VA nor was he receiving VA medical or compensation. CIC contacted VA representatives with Kitsap Community Resources (KRC) to relay this male's information and synopsis of events to ensure the male receives appropriate VA resources and/or housing before being allowed to return to the community. Due to HIPPA, I have not been informed or learned of any updates involving this male's inpatient/hospital stay and/or nor I have I learned whether he was discharged. However, I did receive acknowledgement from APS and KRC that my referrals were received and that they would intervene.

**During the final quarter of 2022, CIC was contacted by DCR's reference a 45-year-old female whose family had called the Crisis line reporting extreme mental decompensation (likely due to methamphetamine use); family reported she was threatening to kill everyone living in the home, threatened to stab her aunt, threatened to burn down the home with everyone inside, reported she'd broken the dishwasher, and finally reporting she'd been leaving the stove on.

CIC was familiar with this female from other arrests, detentions, and from August 2022 after she'd been detained via court order after her previous home burned/condemned by the Fire Marshal. CIC got a team of Deputies together and met DCR's in the area of the residence. Based off the information provided by family and DCR's combined with known behavioral health history, CIC believed there was reasonable cause to conduct an emergent detention before we attempted contact; CIC briefed assisting Deputies that this female shall be placed in handcuffs if she offers any resistance to the detention; our initial plan was to simply restrict her pathways, explain to her that DCR's needed to speak with her, and ultimately allow for a safe ITA assessment by the DCR; however, CIC made it known to all Deputies on scene that the likelihood this female flees or resists was high, so she should be detained in handcuffs if it seemed like a peaceful assessment was not going to occur. The family had reported the female should be hiding in the backyard somewhere; after a check of the area and not locating her, family pointed out she was hiding in a vehicle and/or asleep in a vehicle on the property. CIC contacted the female who instantly became argumentative, threatening, and clearly presented as suffering from behavioral/substance issues. The female, despite warnings to keep her hands in her lap, kept reaching into the passenger's seat where there were many sharp objects/weapons of opportunity. When the female did not follow commands and began fumbling through the passenger's floorboard, CIC and assisting Deputy quickly secured her wrists/arms, extracted her from the vehicle, applied handcuffs in the standing position, and held her in this safe position until Medics could arrive for transport.

CIC along with assisting Deputies, assisted the female onto a gurney where four-point restraints were applied. After the female was transported/admitted for treatment at SMMC, CIC and DCR's remained at the residence interviewing family. This family was very gracious as to how the matter was handled; the family later emailed the Kitsap Mental Health and praised the DCR's, CIC, and Patrol Deputies for the overall professionalism, courtesy, and compassion with how their family member was treated.

Additional Comments:

In August of 2022, the DCR who was teamed with me/CIC for behavioral health co-response, resigned from KMH. When I was partnered with an MHP, I found my administrative tasks could be accomplished easier since I had someone to share interactions with clients, families, or partner agencies I.e., at times I could type ILEADS reports and update Julota referrals while documenting each service encounter; I also maintained a mass spreadsheet simply to track each contact I made primarily to make 1/10th quarterly reporting calculable. The quarterly reports have measures wanting feedback that Julota doesn't track which is really the only reason I've continued maintaining this spreadsheet. I hope to transition to only making documentation in ILEADS and Julota which will ultimately save me valuable time which will allow for more proactive behavioral health outreach and more follow up contacts from ILEADS reports generated by KCSO Patrol and/or other agencies. The role of CIC requires many interactions in person, phone, and by email with clients, families, DCR's, and other involved agencies such as APS, CPS, CCS, CARES, REAL TEAM, etc. I admit that finding rhythm or sticking to a set schedule is an ongoing struggle since Crisis events can't be predicted. As the CIC, I review dozens of reports weekly as well as I receive referrals from other agencies where I try identifying clients in need of immediate intervention as a priority. When I lost my embedded DCR from KMH, the amount of outreach I could conduct did decline since operating solo meant I had no one to share the many interactions needed to coordinate behavioral health response which causes required documentation to stack quickly. Presently KCSO is hiring a mental health professional internally to co-respond with me where we'll be able to share overall administrative requirements such as Julota primarily which if inputting metrics accurately with solid input, takes up valuable time.

I look forward to making more impactful outreaches in the community alongside a licensed MHP and anticipate since I can share data entry with the MHP, our production (number of contacts/outreaches/emergency responses) will certainly increase meaning more cliental receive intervention and/or resources that can better their quality of life or potentially divert certain cases from the criminal justice system to behavioral health or substance abuse programs.

Agency: Kitsap County Sheriff's Office
Program Name: Crisis Intervention Training (CIT)

Reflecting on evaluation results and overall program efforts, describe what has been achieved this Quarter. If objectives went unmet, why? Are there any needed changes in evaluation or scope of work?

This year we were rebuilding the course, making the class more desirable, relatable, and modern in what should be taught. Because of that, we did not conduct evaluations, because we wanted to make sure the questions are related to the content being taught. We only heled one class this year, because agencies are still faced with staffing challenges and did not have the ability to send people. For 2023, we plan on 2-3 40-hour classes and 1 advanced course.

Briefly describe collaborative efforts and outreach activities employing collective impact strategies.
This year we collaborated with many organizations to help develop a high level of training. We included the HART Program, Welcome Home Program, the local co-responder programs, St. Michael's, Catholic Community Resources, and local community members to sit on a panel and explain their experiences with law enforcement as a person with Behavioral health, or a family member. We of course invited some of the best instructors to teach us how to identify someone in crisis, how to respond, suicide prevention, and understanding of the NEAR Sciences. The 40 hir training received positive feedback,

Please describe your sustainability planning – new collaborations, other sources of funding, etc.
We continue to try and use CJTC funds to pay for the classes and avoid using these funds. We will continue to do so and focus on spending the funds on advanced training.

Success Stories:
During the 40-hour class, we had a few attend from Olympia PD and they were really impressed with the local resources we have in our community, for example the co-responder teams, and HART. Olympia has a high homeless population and they do not offer the services like we do. It was nice to validate that we have a great county that is supportive of their community members

Agency: Kitsap County Sheriff's Office
Program: Re Entry Program

Reflecting on evaluation results and overall program efforts, describe what has been achieved this Quarter. If objectives went unmet, why? Are there any needed changes in evaluation or scope of work?
We are happy to say we surpassed our numbers, despite only having one reentry coordinator. We spent the latter half of last year recruiting and hiring the newest reentry coordinator that started working at the end of December.

Briefly describe collaborative efforts and outreach activities employing collective impact strategies.
New Start-: coordination for assessments, appointments, transportation, and housing
Mat
KMH-Trueblood
KMH-Jail Services
Welcome Home
Coffee Oasis
Veteran Services
P-Cap
KRC
Agape
DSHS
Housing Solutions:
Scarlett Road
REAL Program
Early Head Start
YMCA

All Managed Care Coordinator (MCO)

Please describe your sustainability planning – new collaborations, other sources of funding, etc.
We continue to inform the Commissioners that including these positions into our regular budget.

Success Stories:
Male completed his intake at PCHS on September 29th, 2022, for MAT after being released from Kitsap County Jail. In conjunction with weekly appointments, he attended Kitsap Recovery Center for detox. The male currently returned from Olalla after being gone for a month being successful on our program. He has been consistent in his progress with weekly follow-ups, graduated to bi-weekly appointments and continues to be successful in the MAT program. He has regained visitation with is son, reconnected with his parents and has a full-time job.

Female completed her intake at PCHS on October 7th, 2022, for MAT after being released from Kitsap County Jail. She has been consistent in her progress with weekly follow-ups and is now on bi-weekly appointments. She continues to show success after release by attending her scheduled MAT appointments.

Patient that has been arrested nine times in the last three years, for various crimes including DUI, felony elude, and property crimes. She has also been a victim of domestic violence and would continually return to the person who abused her, because they had something in common, drug use. In August of this year, we inducted her into our MAT Program and a few weeks later, she was released from our jail. She had been on our program before, without success in her follow-ups, but we were hoping this time might be the time, and it was. She had been attending her appointments and has graduated to weekly ones. She has also been attending substance abuse counseling with one of our jail's reentry programs. She has been successful in removing two hurtful elements in her life, drugs and the male that was abusing her.

Agency: Kitsap County Superior Court
Program Name: Adult Drug Court

Reflecting on evaluation results and overall program efforts, describe what has been achieved this Quarter. If objectives went unmet, why? Are there any needed changes in evaluation or scope of work?
Our Quarterly Objectives:
- We served 108 unduplicated participants this quarter.
- Our Educational/Vocational Navigator met with 103 participants within 90 days of admission into the ADC.
- Five (5) Participants were terminated this quarter, or 4.6%.
- The ADC had 7 participants graduate this quarter, 100% of whom were either employed or in school.
- The ADC had 44 participants or 40% utilizing MAT services.
- The ADC has 35, or 32% of program participants utilizing mental health services through KMHS.

Briefly describe collaborative efforts and outreach activities employing collective impact strategies.
The Adult Drug Court continues to build our relationship with the Public Works Department in developing a "Litter Crew" similar to the old Jail work crew, which would create a meaningful sanction for participants who are non-compliant.

Please describe your sustainability planning – new collaborations, other sources of funding, etc.

The Adult Drug Court will apply for HIDTA funding (cap of $50,000), July 1, 2023. This funding would pay for some DV counseling, anger management classes, a percentage of one of our Compliance Specialists, and assist the Sheriff's office in obtaining Narcan.

Success Stories:

We graduated our first participant with a sex crime that would have precluded him from participating in our program a few years ago. He graduated our program sanction-free and is gainfully employed and has opened the door for the Prosecutor to take more serious charges than Federal Grant Guidelines typically limit.

Agency: Kitsap County Superior Court
Program Name: Veterans Therapeutic Court

Reflecting on evaluation results and overall program efforts, describe what has been achieved this Quarter. If objectives went unmet, why? Are there any needed changes in evaluation or scope of work?

Objectives for the quarter:

-We served 19 participants this quarter
- 1 Veteran was admitted during the quarter
- 1 veterans graduated this quarter
- 0 veterans were terminated this quarter
- 3 of 19 veterans, or 15% are utilizing Medication Assisted Treatment
- 1 participant was screened using ASAM criteria within one week of admission into the VTC
- 1 participant screened positive for substance use disorder and mental health issues was placed into treatment services within 30 days of the assessments.

Briefly describe collaborative efforts and outreach activities employing collective impact strategies.

The Veteran's Treatment Court continues to build our relationship with the Public Works Department in developing a "Litter Crew" similar to the old Jail work crew, which would create a meaningful sanction for participants who are non-compliant.

Please describe your sustainability planning – new collaborations, other sources of funding, etc.

The Veteran's Treatment Court will apply for HIDTA funding (cap of $50,000), July 1, 2023. This funding would pay for some DV counseling, anger management classes, a percentage of one of our Compliance Specialists, and assist the Sheriff's office in obtaining Narcan.

Success Stories:

Our Veteran's Justice Outreach Social Worker has started a Combat Veteran's group at Retsil after court on Friday afternoons. The group was started because we have a high percentage of combat veterans in our court and the feedback from the group members has been excellent. It's a fantastic enhancement to our program.

Agency: Kitsap Public Health District
Program Name: Nurse Family Partnership

Reflecting on evaluation results and overall program efforts, describe what has been achieved this Quarter. If objectives went unmet, why? Are there any needed changes in evaluation or scope of work?

Our Community Health Worker (CHW)/ Health Educator has transitioned to a new role during this quarter and has worked to onboard a new bilingual CHW; our new CHW comes from the local area and has been working closely with our immigrant communities for many years. In addition, she has worked with the YWCA and KSAC (Kitsap Support, Advocacy & Counseling) and those who may be involved with the justice system; we look forward to how this experience will support her as she continues building relationships with community partners. We hope to increase the number of Mental Health & Health Habits assessments completed; barriers this period includes language & culture, client declined screen or already connected with a mental health provider, lack of privacy during virtual visits & newly enrolled. We are also on-boarding a new bilingual Spanish speaking nurse who will strengthen our ability to serve our community.

Briefly describe collaborative efforts and outreach activities employing collective impact strategies.

Mama Moves Kitsap has allowed us increased ability to collaborate with other community partners working with postpartum families. This list includes a representative of Kaiser Permanente, Northwest Family Practice, Navy New Parent Support, and Kitsap Mental Health Services as we spread the word about options for all postpartum families and held sessions with parents. We are actively seeking and on-boarding new CAB members with recent additions including a representative from a local chemical dependency support program and our regional PECC (Peninsula Early Childhood Coalition) lead. We are excited to have a long-time member and local sheriff as the newest CAB chair.

Please describe your sustainability planning – new collaborations, other sources of funding, etc.

We continue to receive funding from Department of Children, Youth and Families; Maternal Child Health Block Grant; Healthy Start Kitsap; & the Kitsap County Division of Behavioral Health and Recovery. We also have one additional year of ARPA (American Rescue Plan Act) funding through Kitsap County. Much advocacy for increased federal home visiting funding happened this year with a resulting continuation and increase in the federal Maternal & Infant Early Childhood Home Visiting program (MIECHV); Kitsap NFP has not qualified for this funding in the past but may in future DCYF expansions.

Success Stories:

I’ve been meeting with an NFP client regularly since she since she was pregnant. Our visits initially focused on her job, finances, and housing, and at the beginning, her biggest risk was unstable housing. Phone visits always took place while she was in her car, and I found out she was living in a temporary shelter during her pregnancy. She never disclosed feeling depressed or anxious, and her screening scores were always low. Right before her birth, she was able to move into a studio apartment using local housing resources. She shared how excited she was to set up her baby’s bassinet and have a place to put the baby supplies. After her birth, the focus of our visits slowly shifted to her thoughts and feelings related to her own childhood and how becoming a parent changed how she thought of her experience. Themes of substance abuse and occasional physical abuse within her family as a child surfaced. She shared that she felt depressed and alone and didn’t know who to talk to. I offered screening for depression and anxiety which she accepted, and my heart sank as I counted her score and found that it indicated moderate depression.

When I shared her score with her, I continued listening to her and made sure to give her the space to be heard and for her to fully share her feelings. As much as I wanted to offer advice and take her pain away, I knew there wasn't a simple solution. Together, we talked about how her past has shaped who she is now, and how she is in control of how she wants to show up for her child. When she was ready, we talked about available resources and support groups. Over time, she began taking steps toward getting support. Over many NFP visits where I continued to highlight her strengths, and sessions with a counselor in the community, I began to see a change. She is now more engaged with her baby during visits. She looks her baby in the eyes and talks to him. I hear mutual laughter during our visits and highlight the strong attachment she is creating through shared positive experiences. She uses her kitchen in her apartment to make homemade baby food and we talk about food she enjoys cooking and what mealtimes look like. While I don't know what the future looks like for this client, I know that she will continue to show up for her child in a way that looks different to how she was raised, and I am filled with hope.

Agency: Kitsap Homes of Compassion
Program Name: Permanent Supportive Housing

Reflecting on evaluation results and overall program efforts, describe what has been achieved this Quarter. If objectives went unmet, why? Are there any needed changes in evaluation or scope of work?

We are slowly meeting the goals of our internship program. As noted in our last report, the internship and practicum cycles don't perfectly match the timelines of the grant. We have students ready, and contracts signed to start in the fall. We have no scope of work or changes needed in our reporting.

Briefly describe collaborative efforts and outreach activities employing collective impact strategies.

We have been working with Helpline House and more recently a coalition to develop a micro shelter in Bremerton.

Please describe your sustainability planning – new collaborations, other sources of funding, etc.

Hired a part time grants person to research and write grants, manage social media and donor management program. We were awarded our Mental Health license and will be working to set up a counseling program.

Success Stories:

1. Obtained our Mental Health License
2. Moved into stable office, 245 4th Street, Bremerton
3. Added two homes- the Sarai house is the location of our biggest success.

Due to our creating this house, two formerly homeless individuals were able to have permanent housing that enabled one to re-start their own business of house cleaning. The second was a young man(20) that had no rental history and had been couch surfing and going back and forth to parents was able to have stable housing and get a full-time job at Les Schwab.

4. Added part time staff to assist with grants, social media, and donor development

Agency: Kitsap Mental Health Services
Program Name: Pendleton Place

Reflecting on evaluation results and overall program efforts, describe what has been achieved this Quarter. If objectives went unmet, why? Are there any needed changes in evaluation or scope of work?

There has been an increase in accessing mental health care by our residents. We have added layers of staff to support residents making progress on goals and working with people one on one. With the added layers of staff, I do not think we will need changes to the scope of our work.

Briefly describe collaborative efforts and outreach activities employing collective impact strategies.

We have provided classes that encourage group participation, life skills, budgeting. We have connected with Goodwill and WorkSource to provide employment and job readiness classes. We have collaborated with Agape Unlimited Real team to assist our residents in accessing treatment services. We continue to engage with Housing Solution Center to identify new tenants from the priority pool. PCHS is onsite 2 days per week to encourage engagement and ease of access for primary care. KMHS has a care coordinator that comes 1 day per week to help residents engage in mental health care. We will have continued meetings with providers in the area to come in and explain services that are available.

Please describe your sustainability planning – new collaborations, other sources of funding, etc.

We are working on getting residents approved to be billed through Amerigroup Foundational Community Supports.
For residents we are connecting them with DSHS for ABD or our SOARS worker for SSI. We will continue to look for any grants that may help pay for services of this housing type.

Success Stories:

This quarter we have been working with one of our residents to manage chronic pain issues by seeking primary care at our PCHS onsite office. He has also been trying to stabilize his mental health and substance use. He is currently trying to go to detox so that he can "reboot" and "get back on track" The housing support staff has been instrumental in helping this individual identify the need for change and make plans to stop using substances.

Additional Comments:

This quarter we had some residents that were unable to maintain housing due to violent behavior onsite. We continue to have classes aimed at helping residents with healthier living, nutrition, financial management, and maintaining their housing. Residents continue to come to staff with excitement on the goals they are working on and what they have achieved thus far. We are still in the process of building community partnerships with outside agencies to bring classes and groups in the facility for the residents.

The resident's community meetings continue to grow, and they seem to be more interactive and involved in the housing process and wanting to live in a safe community. We will be meeting with an internal resident advisory committee to work collaboratively with our residents about issues in the community or programs they would like to see us implement. One of our residents has come forward to lead an NA self-help support recovery meeting.

Residents have been engaging with each other to help with grocery shopping, household upkeep and other outings that are a part of forming healthy relationships and community. This year has been a wonderful experience while continuing to build this program.

Agency: Kitsap Mental Health Services
Program Name: Unfunded BHS-Crisis Triage

Reflecting on evaluation results and overall program efforts, describe what has been achieved this Quarter. If objectives went unmet, why? Are there any needed changes in evaluation or scope of work?

The client satisfaction surveys for CTC and PHRC over this last quarter average 97% satisfaction. Clients reported 98% success rate in their ability to access care when they needed and feeling safe. 99% of the clients stated that they were connected to necessary community resources and were able to safety plan for the future.

Briefly describe collaborative efforts and outreach activities employing collective impact strategies.

Crisis Triage and Pacific Hope and Recovery have regular community meetings where successes and challenges are discussed, and problem solved. We hold short check-in with law enforcement, which includes the Suquamish Tribal officers, and another weekly call with St. Michaels were real time issues are discussed and solutions are sought so that we can all work better together.

Please describe your sustainability planning – new collaborations, other sources of funding, etc.

We continue to explore financial opportunities in the area to sustain operations. One key area where we are investing a large amount of agency resources is towards becoming a Certified Behavioral Health Center which will provide more funding opportunities for the agency and continued resources for the community.

Success Stories:

Because of the 1/10th funding we were able to accept individuals seeking crisis stabilization and/or substance use treatment regardless of their ability to pay. Two clients wrote: "I was treated with kindness and compassion while at CTC. The staff was helpful in all aspects. Thank you for taking good care of me." "You are so good. I have a very hard time asking and excepting help. This is the first time I have even asked or been to a place of recovery. This place has changed the way I feel about help. Need places like this one. Every employee no matter what the role, was a pleasure and had a heart to give power to those seeking help for whatever issues. This place produces magic for our community. When the time comes for me to be in a place to support the needs of others, this is the place I will give my efforts first. Good People, good help."

Additional Comments:

Thank you for this opportunity to support our community!

Agency: Kitsap Rescue Mission
Program Name: Coordinated Care 2022

Reflecting on evaluation results and overall program efforts, describe what has been achieved this Quarter. If objectives went unmet, why? Are there any needed changes in evaluation or scope of work?

We provided 26,000 emergency shelter bed nights, more than 40,000 meals, Housing Stability Planning, and 267 SUDP interventions (1:1 sessions) to KRM shelter guests in 2022. Guest Satisfaction Surveys are in process for the year 2022. We very much look forward to the addition of a full-time LMHC position via a partnership with MCS Counseling who is currently in the process of recruitment. We anticipate the improved success of our shelter guests who suffer from co-occurring behavioral health disorders which can make recovery from mind-altering chemicals challenging.

Briefly describe collaborative efforts and outreach activities employing collective impact strategies.

We continue to collaborate closely with HSC, PCHS, Kitsap WorkSource, and other community partnerships to ensure positive outcomes for those in KRM emergency shelter. Most recently we are working more closely with the new KCR/HSC full-time case manager located at the Quality Inn in buildings A & B and are in process of implementing the shared use of our SUDP. Once the MCS LMHC is hired, we will also share that position with KCR/HSC for those located in buildings A & B.

Please describe your sustainability planning – new collaborations, other sources of funding, etc.

KRM has ramped up its fund development plan to include a part-time development position. This role will provide the cultivating and stewardship of KRM donors. We have also increased our seeking of private and foundation grants and most recently received $6,500 from the Kitsap Community Foundation for our "KRM Hope Fund" which provides funds for exiting shelter guests' first and last month's rent and moving expenses.

Success Stories:

We have recently said goodbye to a shelter guest who was featured on a recent BKAT video during a "Commissioner's Corner" episode on homelessness. He originally came into shelter struggling with substance use and mental health conditions and was unemployed. With ongoing support from the SUDP and KRM case manager, this guest was able to find sobriety and recovery, engaged with mental health services in the community, and was eventually able to go back to work. He recently found a 1-bedroom apartment and was exited successfully into the community. He continues to work full time, and to access recovery and mental health support in the community.

Additional comments:

The Kitsap Rescue Mission staff and leadership continue to receive training re: trauma informed care and best practices for non-profits. We anticipate the addition of the full-time LMHC in the coming weeks and know that this will be a valuable addition to the services provided to our shelter guests. Staffing capacity has been an ongoing concern as we ramp up shelter operations to serve up to 120 (from 80) unduplicated shelter guests. We are currently recruiting a full-time case manager; a shelter support staffs member and an assistant food services director.

It appears that while several of our shelter guests enjoy attending recovery support groups in house which are facilitated by a volunteer "Peer Recovery Specialist", the majority of our shelter guests prefer meeting with our SUDP for 1:1 recovery support.

Agency: Olympic Educational Service District 114
Program Name: Behavioral Health Counseling 2022

Reflecting on evaluation results and overall program efforts, describe what has been achieved this Quarter. If objectives went unmet, why? Are there any needed changes in evaluation or scope of work?

The OESD achieved program goals:
The projected number of elementary, middle, and high school students served is 376 for the grant cycle; to date 431 students (198 elementary, 124 middle school and 109 high school) have been served. In addition to the 431 students served, staff reported 513 drops in visits by students in need of crisis intervention, brief support and/or information.

Briefly describe collaborative efforts and outreach activities employing collective impact strategies.

The OESD offered two staff trainings this quarter descried below. Funding for these trainings came from several federal grants the OESD receives for school improvement, COVID-Recovery Support, and Community Prevention and Wellness Initiative funding.

- True Colors – personality understanding explained as - Each of us having a different and unique personality; however, there are commonalities that we share. True Colors is an attempt to identify various personality styles and label them with colors. This model of categorizing personality styles is based on many years of work by other researchers and psychologists. Essentially it draws heavily on the work of Isabel Briggs-Myers, Katherine Briggs, and David Keirsey. The purpose was to strengthen the teams understating of one another as well as applicability to the diversity in students we serve and recognizing we do not all act and respond the same.

- Ethics training. The description for this training was “Participants will develop an ethical decision-making framework for analyzing and resolving ethical issues through the application of American School Counselor Association Ethical Standards, case and statutory law, school board rules and community standards. Through small-group and large-group discussion of 40 case studies, participants will be given the opportunity to increase their understanding of the complexities of respecting a minor’s right to confidentiality, to develop a sensitivity to the need to consider their actions in context of each situation for each individual student and to understand the rights of parents. Discussion topics will include areas such as confidentiality and duty to warn, minors’ rights to privacy, counselors’ responsibilities toward suicidal children, civil and criminal liability, sexually active minor clients, birth control, abortion counseling, defamation, child abuse, HIV-positive students, case notes and educational records, malpractice in academic advising, sexual harassment, the Hatch Amendment and guidance curriculum and personal conduct.”

Professional Development for Schools:
The OESD is offering a learning series for K-12 educators from October through May. The COVID-19 pandemic has disrupted the education system and the costs have been tremendous in terms of learning losses, health, and well-being and drop-out. Navigating the emotional and behavioral responses of students while trying to achieve academic objectives is challenging. In this series, educators learn about the science of trauma and build skills in social and emotional learning (SEL) and trauma-informed teaching practices. The first session began in October, participants engaged in learning about trauma and the impact of COVID-19 pandemic on student behavioral and mental health. The second session (November) provided an overview of the neurological response to trauma and recovery.

The third session (December) provided participants an opportunity to explore school-wide universal strategies related to supporting recovery and resilience in the classroom.

This above PD opportunity was supported through grant funds through OSPI for COVID-Recovery Support. The funds support 1.0 FTE Behavioral Health COVID Response Advocate. The primary focus of this position is to provide mental and behavioral health prevention and wellness education to students and educators that support universal tier one behavior supports.

In partnership with Kitsap Strong the OESD continues to provide training on Trauma Informed Schools (TIS) framework. A TIS Framework is a mental health prevention school-wide area of focus assisting schools in implementing social, emotional behavioral skills curriculum, establish policy and procedures that are trauma informed and training of all staff in trauma awareness and classroom supports; and an intervention strategy for identification and referral to counseling supports for students be impacted by behavioral health issues. The current Cohort (5) consists of 8 schools, 1 school-based organization, and 1 skills center. Session 3 objectives were to learn about trauma informed values, trauma informed classroom strategies, and integration of key areas to MTSS. Session 4 objectives were to explore Hope's impact on academics, well-being, and relationships, to learn about pathways and agency thinking as well as Hope's applicability to TIS Framework, and to consider ideas for building/fostering hope with students and staff.

Committee Work:
The OESD staff continued participation on Kitsap County Suicide Awareness and Prevention Group, North Kitsap and Bremerton Community Prevention Wellness Coalition meetings and the regional Youth Marijuana Prevention Education Program.

Please describe your sustainability planning – new collaborations, other sources of funding, etc.
OESD was a partner in a state grant submitted by OSPI to Department of Education. This was a collaboration with the Association of Educational Service Districts for the purpose of developing a systematic infrastructure that creates pathways to support people at multiple levels of education to work in a school-based behavioral health program. This was the school-Based Mental Health Services Grant Program (SBMH) The SBMH grant program provides competitive grants to State educational agencies (SEAs), Local educational agencies (LEAs), and consortia of LEAs to increase the number of credentialed school-based mental health service providers delivering school-based mental health services to students in LEAs with demonstrated need. Recently, we learned that the grant was not awarded.
In addition to grant possibilities/opportunities, we are continuing to have conversations with school districts about increasing their contributions for funding positions.

Success Stories:
Secondary Program:
1. Last school year, the SAP was referred a student after violating the school drug and alcohol policy. The student was struggling socially and academically frequently and would often turn to high-risk behaviors such as self-harm and substance abuse. From the start, the student very open to working on their mental health and substance use issues with the SAP. The student participated in the Insight group and relied on the SAP's services throughout most of the school year. The student set many goals and stayed focused on developing healthy coping skills and making good choices. Although there were a few setbacks, the student persevered and kept moving forward.

This school year the student is now attending West Sound Tech for half of the day, passing all of their classes, and was nominated for a student of the month award.

2. The SAP is working with a student who has significant anxiety who stopped coming to school. The student was able to come to school for a 4 out of 5 days last week.

3. The SAP has been working with a student who does not feel comfortable talking with adults about her mental health and the student finally agreed to sign up for E-therapy.

Elementary Program:

1. The Mental Health Therapist (MHT) began providing services to second grader in the fall due to low self-esteem and lack of coping skills for anger. The MHT worked with the student to challenge negative thoughts with positive self-talk, identify strengths, understand that learning new things takes time and practice, and learning coping skills to use when angry and frustrated like squeezing and relaxing his muscles. The students' teacher reports that the student is starting to handle transitions in school better and is more engaged with staff and other students. The students' mom has reported a boost in self-confidence at home and although the student still struggles with things, he doesn't quit.

2. The MHT was referred a third-grade student who was suffering from separation anxiety, abandonment issues and trauma, which impacted her emotions and behaviors at school. The student has spent most of her life in foster care but recently returned to mom's care. When the MHT started working with the student, she was not able to sit in her classroom most of the day nor participate positively with her peers or complete her work. She displayed behaviors such as pushing other kids, storming out of class, ripping up her work, refusing to go to class, crying, yelling, etc. The MHT focused on emotional regulation strategies, coping skills, CBT for anxiety, mindfulness and behavioral activation. The student is now able to talk about her feelings, use her coping skills, her emotional regulation skills, and other tools to help her throughout the day. She is getting along better with her peers and her relationship with her mom has improved.

3. The student was referred to the Mental Health Therapist (MHT) because they struggled with anxiety and separating from mother during transition to school. Previously, the student would cling to the mother, become visibly distressed, and refuse to transition to class. After intake, building rapport and trust, the MHT utilized CBT for anxiety to manage anxiety. The student learned and effectively utilized relaxation response strategies and learned to "Boss back their worries." The MHT aided in disputing and restructuring unhelpful thinking and set up a reinforcement system. The student showed significant progression per teacher, mother, and self-reporting in a short period of time. The student no longer struggles with transition and scales anxiety at a zero comparative to a ten on a fear ladder. "I am much better than before and feeling like a zero every day." The student appears confident, manages worries, and consistently demonstrates the ability to distinguish between useful and spinning worries. The student shows up happy and is excited about school.

Agency: Peninsula Community Health Services Program Name: Too Cruel for School

Reflecting on evaluation results and overall program efforts, describe what has been achieved this Quarter. If objectives went unmet, why? Are there any needed changes in evaluation or scope of work?

The original goal of the project was to serve at least 125 youth with 1,000 visits. While the project did not reach this goal, it served 107 youth with 330 visits. Part of the reason for not meeting the original target was a delay in opening the intended school-based health care clinic. Besides simply opening, it also takes time for utilization of services to be known and trusted by the student population. When comparing 3rd quarter and 4th quarter visits and people served, there is more than double the number of mental health visits, substance use disorder visits, and the number of youths served. These are all positive indicators that by the end of the project not only are the services available to youth, but utilization is increasing, and trust is building between the school, students, and project staff.

Another annual target for this project was for 60% of the youth served to have completed at least one physical health visit during the year. The project exceeded this goal at 65%. This speaks to the strength of an integrated school-based program where both medical and behavioral health services are readily available.

To measure the level of engagement, this project sought for at least 70% of patients complete three or more behavioral health visits. Unfortunately, the project only reached 40% of the students having three or more visits. Given the slower start and increase in utilization, if there was another 6 months of time at the rate of utilization seen in the fourth quarter, it is realistic that the project would have reached a 70% engagement rate.

One of the most exciting aspects of this project is the fact that 94% of youth served were screened for depression and/or anxiety using the PHQ2/9 and/or GAD-7. Out of the 56 students who screened positive for either depression or anxiety, there were 77% who saw improvement in their scores over time. While analyzing the data it is also worth noting that students with more visits experienced more significant improvements in their PHQ-9 and GAD-7 scores. Clearly school-based health care is making a positive impact in student health and well-being.

Briefly describe collaborative efforts and outreach activities employing collective impact strategies.

Collaboration and outreach activities continue with school administration and counselors. This quarter we were welcomed into the Olympic High School to give presentations on behavioral health. They have asked for us to do this on a semester basis. Kingston High School has asked us to be a part of their suicide prevention planning for the year and to also give behavioral health presentations in their health classes as well. Being welcomed into classrooms help students know about services and gives the PCHS staff an opportunity to meet and engage youth who might be anxious about accessing care.

Please describe your sustainability planning – new collaborations, other sources of funding, etc.

The most significant aspect impacting sustainability is having a volume of utilization high enough to allow for billing for services that support the FTE present at the school-based health center. Having financial support at the beginning helps tremendously while visit volume is lower and the program is ramping up. As utilization continues to increase it keeps the program sustainable.

Success Stories:

Story 1: Student who the clinician started seeing sometime last school year was referred by their PCP, and after completing the intake, the clinician referred this student to Psychiatry for medication. The student was hesitant at first, but they are now prescribed medication and is taking them even though initially they were opposed to them. By working together with the Psychiatric provider regarding this patient it has been helpful because the medication treated some of the issues the patient was experiencing.

Story 2: PCHS received a referral from school staff regarding a patient who has been struggling in school, both with their grades and home environment. School staff also shared with the PCHS BH provider that the student struggled with suicidal ideation and has been having difficulty with the family disruption related to changes and a transition that was occurring in their life. The BH provider saw the student the same day of the referral to complete a formal intake. It was apparent that the student has been struggling with suicidal ideation since they relocated to Kitsap County and did not have many peers within their school. The student engaged with PCHS staff weekly until their suicidal ideation became manageable and diminished. They transitioned to bi-weekly appointments and currently monthly to ensure safety and collaborative care. The student and BH staff continued to meet to identifying symptoms, maintain their stability in their emotional and mental well-being, and learn new coping skills to decrease their thoughts. The collaboration between both parents, school staff, and the PCHS BH provider, the student now has a peer support group within their school, grades have improved, and they continue to make noticeable progress.

Agency: Scarlet Road
Program Name: Specialized Rental Assistance

Reflecting on evaluation results and overall program efforts, describe what has been achieved this Quarter. If objectives went unmet, why? Are there any needed changes in evaluation or scope of work?

In the fourth quarter, we assisted eight individuals with rental assistance. Six of those clients were able to sustain their current housing. One of our clients we assisted by alleviating rental debt in order to prevent future denial of housing access. We connected our final participant with a local landlord and provided a deposit, first and last months of rent, and utilities as we continue to work toward a Section 8 voucher.
Our 1 FTE case management team has been able to serve a total of 14 people this quarter with recovery support services including access to mobile advocacy, life skills, and budgeting support. Even after experiencing hiring difficulties through the majority of the year, we were very close to hitting our goal of 15 people. The staff continue to participate in conferences and webinars on trauma informed care, addiction, serving marginalized communities, and more.

Briefly describe collaborative efforts and outreach activities employing collective impact strategies.

This quarter, we have had the privilege of working with some old and new landlords that want to specifically support our clients and work creatively with us. This has been extremely helpful in the current housing shortage. We continue to provide training to our community specifically to those in the medical community as well as to 6 schools totaling 792 students this quarter. We have also collaborated robustly with the REAL team as we serve those populations with higher substance abuse and mental health needs. Recently, we were invited into discussions with both Mission Creek and Purdy Prison to have our teams come in with our services to the only two women’s prisons in the state.

Please describe your sustainability planning – new collaborations, other sources of funding, etc.
In quarter 4, the Aftercare program was awarded the MultiCare Community Partnership grant for $5000 and the First Fed Foundation Grant for $25,000. Scarlet Road received the BECU Glide Path grant for $2500, and the Archarios Foundation grant for $5000 toward our general operating budget. Additionally, we received the Bainbridge Community Foundation grant for $1500 for capacity building.
We have also been completing final interviews for our open Director of Philanthropy position which would encourage our financial growth into 2023.

Success Stories:
*Fern had struggled for years with substances that she had used to cover up the pain of her trauma and abuse. Her husband had sold her to support his addiction and eventually she lost everything. She had been unhoused for nearly a decade when she connected with Scarlet Road.

Agency: West Sound Treatment Center
Program Name: New Start

Reflecting on evaluation results and overall program efforts, describe what has been achieved this Quarter. If objectives went unmet, why? Are there any needed changes in evaluation or scope of work?
*We are finding difficulty engaging inmates upon their release. We believe this is due to lacking a dedicated New Start Peer Support staff member to track and offer engagement/outreach.
*We hope this will improve in the coming year when we can offer SUD outpatient in conjunction with assessments in the jail.
*We need funding to offer indigent supplies to people coming out of jail.
*Thank you for your continued support.
*Thank you for your work.

Briefly describe collaborative efforts and outreach activities employing collective impact strategies.
We actively collaborate with all community partners who are involved in SUD treatment in Kitsap.

Please describe your sustainability planning – new collaborations, other sources of funding, etc.
We seek all funding sources to maximize sustainability at WSTC

Success Stories:
We have witnessed a success in “J” who is a member of the New Start men’s house. J came to WSTC in the summer of 2021. J quickly realized he needed to change his living environment if he was going to be successful in his program. “J” applied for housing in July of 2021 and was accepted which he expressed renewed his faith in the program. At that time, the available house was in Washington Ave. We noted very quickly that “J” was eager to jump in and get things done in the house. He became a strong core member within a short time and often offered to do things to improve the house from small repairs, to yard work. He remarked that it was a way he felt he give back. J had a background working construction and he said it made he feel good to get back in to swing of working with his hands to create things, and to establish a routine more in line with a 9-5 job during the day. “J” always kept things real with staff, communicating the needs of the house and challenges that arose as well.

Agency: West Sound Treatment Center
Program Name: Mental Health Wrap Around

Reflecting on evaluation results and overall program efforts, describe what has been achieved this Quarter. If objectives went unmet, why? Are there any needed changes in evaluation or scope of work?

Objectives are unmet as this project is only being staffed by CEO on a limited-time basis. We have been unable to find a MH professional to lead the project full time, and this is a region-wide issue at this time. The changes in scope of work for future contracts will focus on peer support staff with CEO as LMHCA & outside referrals in order to overcome the lack of MH professionals in our region.

Briefly describe collaborative efforts and outreach activities employing collective impact strategies.

CEO's two summaries of client assessments indicate CEO is cognizant of community partners and can/will make adequate referrals as needed. Both clients' files indicate adequate use of outside partners for additional/pertinent services. Both files indicate adequate services/documentation from within WSTC to provide a quality experience.

Please describe your sustainability planning – new collaborations, other sources of funding, etc.

We will most likely be concluding this project at the end of quarter 4, as we have been unable to find a full-time MH to lead this project. We are simply doing what can be done in the time that is left to help who we can. CEO will continue working one on one with engaged clients at end of contract, however.

Success Stories:

The program is too fresh to have any long-term outcomes at this time. Our success is the ability to serve at least one+ individuals with their MH at this fragile time in our society. Our patients are high-risk and high-needs, and even the ability to launch near end-contract, we thank the county & 1/10th for this opportunity.

Comments:

We thank the 1/10th of 1% board for funding this underserved need. We are sad to announce that we have not been able to fill this position and find it to be a Peninsula-wide deficiency. We have chosen to re-write/re- structure the program to be peer support focused hopefully for the 2023 year, with a very small percent of people receiving MH evals for referrals, based on need. The MH exams will be fulfilled by Ken Wilson LMHCA. We look forward to continuing our work here and making a difference in Kitsap's recovery community.

Added comments:

Overall, launching at the end of quarter 3 for a short duration, this project is off to a good start. Both clients that CEO has worked with have expressed desire to do one-on-one work to counsel/work through MH issues in great detail. Both clients agreed to journal series. One client, although engaged with WSTC was placed back into custody albeit the probation/parole officer suggested that participation in MH at WSTC would suffice the violation. This is an opportunity to see first-hand the barriers to SUD recovery, as well as what we can do to provide best-care treatment. We appreciate the ability to serve the small few we can during this time. We look forward to increasing out peer support staff + CEO/LMHCA, in lieu of 100% FTE MH staff in the future.

Agency: YWCA

Program Name: Survivor Therapy Program

Reflecting on evaluation results and overall program efforts, describe what has been achieved this Quarter. If objectives went unmet, why? Are there any needed changes in evaluation or scope of work?

We have met with the therapists; we have developed our team and we have gone over contracts/agreements with therapists. The contracts took a while to develop and then the therapists reviewed, some had lawyers review them and then we had several conversations about them. In addition, there was conversations back and forth about insurance. This is a new project, so this took time.

Briefly describe collaborative efforts and outreach activities employing collective impact strategies.

We have a great collaboration with our therapists. We will reach out to health care and mental health agencies if we need expertise and referrals. At this time, we feel we will receive several referrals for survivors seeking therapy from our YWCA Programs.

Please describe your sustainability planning – new collaborations, other sources of funding, etc.

We have a part time grant writer at this time, so we are researching and reviewing several grant options to enhance this project and sustain it as well as other YWCA Programs.

Success Stories:

A mom has had a hard time finding therapy for herself and her children. Either the therapists do not take her insurance, or they have 6 month waitlists. We are excited to offer her this opportunity as she continues to find a therapist. We will refer her to one of our therapists and then she can transition to her own.

Additional Comments:

We appreciate the opportunity to offer this program to survivors. It will do exactly what we hoped, allow survivors to quickly get into therapy when they are read and not have to wait or be turned away.

Kitsap County Mental Health, Chemical Dependency and Therapeutic Court Programs Quarterly Fiscal Report January 1, 2022 - December 31, 2022

Fourth Quarter: October 1, 2022 - December 31, 2022

2022 Revenue: $ 5,828,647.62

Agency	2022 Award	First QT	%	Second QT	%	Third Qt	%	Fourth Qt	%	2022 Total	2022 Balance
Agape	$ 209,392.00	$ 34,765.67	16.60%	$ 81,756.81	39.00%	$ 102,421.25	49.00%	$ 27,991.73	62.28%	$ 130,412.98	$ 78,979.02
Aging and Long-Term Care	$ 90,000.00	$ 7,789.15	8.65%	$ 36,798.69	40.88%	$ 58,333.38	65.00%	$ 31,666.62	100.00%	$ 90,000.00	$ 0
City of Bremerton	$ 50,000.00	$ -	0.00%	$ 0	0.00%	$ 0	0.00%	$ 50,000.00	100.00%	$ 50,000.00	$ 0
City of Poulsbo	$ 85,457.00	$ 6,577.53	7.70%	$ 41,670	48.76%	$ 67,464.79	80.00%	$ 16,523.53	98.28%	$ 83,988.32	$ 1,468.68
The Coffee Oasis	$ 289,626.00	$ 63,769.38	22.02%	$ 178,414.06	61.60%	$ 239,966.79	83.00%	$ 49,659.21	100.00%	$ 289,626.00	$ 0
Eagles Wings	$ 196,478.00	$ 20,745.98	10.56%	$ 81,512.52	41.48%	$ 138,325.57	70.00%	$ 52,618.62	97.18%	$ 190,944.19	$ 5,533.81
Family Behavioral Health CCS	$ 287,694.00	$ 34,818.71	12.10%	$ 167,880.71	58.35%	$ 268,633.71	93.00%	$ 39,720.96	100.00%	$ 309,354.67	$ 0
Fishline NK	$ 136,000.00	$ -	0.00%	$ 59,301.05	43.60%	$ 59,301.05	44.00%	$ 0	62.13%	$ 84,501.05	$ 51,498.95
Kitsap Community Resources	$ 684,055.00	$ 184,975.73	27.04%	$ 399,925.15	58.46%	$ 499,808.91	73.00%	$ 131,914.05	92.34%	$ 631,722.96	$ 52,332.04
Kitsap Community Foundation	$ 45,529.00	$ 15,179.98	33.34%	$ 29,162.96	64.05%	$ 34,909.14	77.00%	$ 6,786.92	100.00%	$ 41,696.06	$ 0
Kitsap County District Court	$ 341,035.00	$ 87,987.85	25.80%	$ 169,399.14	49.65%	$ 256,198.34	74.00%	$ 54,753.46	91.17%	$ 310,951.80	$ 30,083.20
Juvenile Therapeutic Courts	$ 195,238.00	$ 46,209.20	23.67%	$ 98,248.71	50.32%	$ 149,483.39	77.00%	$ 21,511.09	87.58%	$ 170,994.48	$ 24,243.52
Kitsap County Prosecutors	$ 297,696.00	$ 50,690.10	17.03%	$ 122,465.44	41.13%	$ 207,837.49	70.00%	$ 69,371.92	93.11%	$ 277,209.41	$ 20,486.59
Kitsap County Sheriff's Office CIO	$ 134,367.00	$ 7,414.15	5.52%	$ 96,991.99	72.18%	$ 108,189.22	81.00%	$ 22,394.46	97.18%	$ 130,583.68	$ 3,783.32
Kitsap County Sheriff's Office CIT	$ 22,500.00	$ -	0.00%	$ 0	0.00%	$ 0	0.00%	$ 0	0.00%	$ 0	$ 22,500.00
Kitsap County Sheriff's Office Reentry	$ 336,547.00	$ 26,028.22	7.73%	$ 56,677.13	16.84%	$ 75,619.77	22.00%	$ 19,684.36	28.31%	$ 95,304.13	$ 241,242.87
Kitsap Superior Court (Adult Drug Court)	$ 488,567.00	$ 102,409.95	20.96%	$ 205,599.94	42.08%	$ 305,499.83	63.00%	$ 88,912.19	80.72%	$ 394,412.02	$ 94,154.98
Kitsap Superior Court (Veterans)	$ 90,023.00	$ 23,251.65	25.83%	$ 40,879.23	45.40%	$ 58,980.16	66.00%	$ 12,218.67	79.08%	$ 71,198.83	$ 18,824.17
KPHD NFP and Evaluation Epidem	$ 285,353.00	$ -	0.00%	$ 93,339.37	32.70%	$ 141,572.93	50.00%	$ 45,555.76	77.26%	$ 220,481.65	$ 64,872.35
Kitsap Homes of Compassion	$ 345,000.00	$ 57,000.00	16.52%	$ 171,000.00	49.56%	$ 256,500.00	74.00%	$ 57,000.00	90.86%	$ 313,500.00	$ 31,500.00
Kitsap Rescue Mission	$ 99,925.00	$ 1,803.48	1.80%	$ 27,162.73	27.18%	$ 44,318.80	44.00%	$ 21,074.77	65.44%	$ 65,393.57	$ 34,531.43
Olympic ESD 114	$ 699,193.00	$ 51,127.86	7.31%	$ 196,077.26	28.04%	$ 311,472.70	45.00%	$ 265,620.68	82.53%	$ 577,093.38	$ 122,099.62
One Heart Wild	$ 132,600.00	$ 32,339.75	24.39%	$ 69,655.50	52.53%	$ 107,522.20	81.00%	$ 25,022.80	100.00%	$ 132,545.00	$ 0
Kitsap Mental Health Services	$ 430,607.00	$ 56,096.50	13.03%	$ 151,026.89	35.07%	$ 179,258.92	42.00%	$ 118,854.60	69.23%	$ 298,113.52	$ 132,493.48
Peninsula Community Health	$ 294,517.00	$ -	0.00%	$ 11,053.14	3.75%	$ 26,242.93	9.00%	$ 8,928.45	5.91%	$ 35,171.38	$ 259,345.62
Scarlet Road	$ 75,000.00	$ 1,151.89	1.54%	$ 18,058.65	24.07%	$ 31,736.99	42.00%	$ 43,263.01	100.00%	$ 75,000.00	$ 0
Suquamish Tribe	$ 0	$ -	0.00%	$ 0	0.00%	$ 0	0.00%	$ 0	0.00%	$ 0	$ 0
West Sound Treatment Center	$ 450,951.00	$ 27,562.74	6.11%	$ 178,034.88	39.47%	$ 237,831.86	53.00%	$ 132,481.55	82.11%	$ 370,313.41	$ 80,637.59
YWCA	$ 176,456.00	$ -	0.00%	$ 0	0.00%	$ 0	0.00%	$ 0	0.00%	$ 0	$ 176,456.00
Total	$ 7,087,585.00	$ 939,695.47	13.26%	$ 2,782,091.95	41.63%	$ 3,967,430.12	56.00%	$ 1,413,529.41	0.00%	$ 5,828,647.62	$ 1,003,404.34

County Mental Health, Chemical Dependency & Therapeutic Court Programs Quarterly Summary Outputs and Outcomes Report

October 1, 2022 – December 31, 2022

Agency	Fourth QT Outputs	Fourth QT Outcomes
Agape Unlimited- AIMS Co-occurring Disorder Services Baseline: Unduplicated number of individuals served during the quarter	*AIMS:* • 10 assessments(Q3) 7 (Q2) 3 (Q1) 2 • 17 total clients (Q3) 12 (Q2) 28 (Q1) 29 • 0 graduates (Q3) 0(Q2) 0 (Q1) 4 *Treatment Navigator:* • 140 assessments (Q3) 183 (Q2) 67 (Q1) 33	*AIMS:* • 297 SUD intakes Y-T-D AIMS questionnaire (Q3) 215 (Q2) 134(Q1) 57 • 56 clients referred to AIMS services Y-T-D • 56 eligible to attend first apt. (Q3) 7 (Q2) 5 (Q1) 2 • 17 enrolled participants attended at least 1 appointment per month *Treatment Navigator:* • 222 total clients qtd • 0 clients gained insurance (Q3) 3 (Q2) 6(Q1) 5 • 2 clients gained photo ID's(Q3) 5 (Q2) 3 (Q1) 4 • 2 clients filled out housing applications (Q3) 0(Q2) 2 (Q1) 3 • 14 transports provided by navigator(Q3)15 (Q2) 20 (Q1) • 651 unduplicated clients YTD
Aging and Long-Term Care- Kitsap County Baseline: Unduplicated number of individuals served during the quarter	• 29 individual consultations(Q3) 51 (Q2)40 (Q1) 26 • 0 staff consultation(Q3) 1 (Q2) 0 (Q1) 1 • 1 workshops(Q3) 0 (Q2) 0 (Q1) 1 • 25 individuals of focus(Q3) 45 (Q2) 24 • 0 staff served(Q3) 1 (Q2) 14	• 15 PCP referrals(Q3) 18 (Q2) 21 (Q1) 16 • 5 legal services referrals(Q3) 13 (Q2) 7 (Q1) 6 • 1 counseling support referral(Q3) 0 (Q2) 3 (Q1) 1 No referrals to counseling because Kitsap Aging behavioral health provider is not accepting referrals
Bremerton Police Department Baseline: Unduplicated number of individuals served during the quarter	• 701 behavioral health calls, (Q3) 701 (Q2) 831 (Q1) 680 • 152 referrals provided, (Q3) 152 (Q2) 119 (Q1) 107 • 152 outreaches to individuals, (Q3) 152 (Q2) 72 (Q1) 106 • 152 individuals served, (Q3) 152 (Q2) 72 (Q1) 90 (99 people accepted services the others refused or did not need services) ** No Q4 report, submitted blank	• 3 diversion plan navigators involved in(Q3) 3 (Q2) 1 • 10 high utilizers who have shown reduction in negative law enforcement contact, (Q3) 10 (Q2) 4 (Q1) 2 • 261 follow ups made about connections to services with connections to services, (Q3) 261 (Q2) 226 (Q1) 90 • 162 interested in receiving those services (Q3) 162 (Q2) 162 • 52 post-suicidal call outreach/not detained (Q3) 52 (Q2) 39

City of Poulsbo Baseline: Unduplicated number of individuals served during the quarter	• 185 home visits, (Q3) 262 (Q2) 101(Q1) 120 • 0 community visits(Q3) 98 (Q2) 32 • 39 visits with family or caregivers, (Q3) 86 (Q2) 46(Q1) 37 • 10 transportation services, (Q3) 11 (Q2) 30 (Q1) 5 • 41 individuals provided case management, (Q3) 8 (Q2)12 (Q1) 10 • 136 unique individuals served(Q3) 143 (Q2) 50	• 2 homeless and sheltered, (Q3) 5 (Q2) 7 (Q1) 8 • 1 homeless and unsheltered, (Q3) 8 (Q2) 4 (Q1) 9 • 18 suicide attempts or ideation, (Q3) 18 (Q2) 2 (Q1) 5 • 3 Veteran or Active military (Current qtr.) • 1 overdose, (Q3) 1 (Q2) 1 (Q1) 0 • 13 youth (under18), (Q3) 10 (Q2) 2 (Q1) 2 • 66 seniors (over 65), (Q3) 51 (Q2) 23 (Q1) 2 • 49 self-reported mental health issues, (Q3) 40 (Q2) 13 (Q1) 8 • 24 self-reported substance use issues, (Q3) 26 (Q2) 6 (Q1) 8
Coffee Oasis Baseline: unduplicated number of individuals served during the quarter	• 50 texts responded to on crisis line, (Q3) 456 (Q2) 44 (Q1) 675 • 186-person crisis intervention outreach contacts, (Q3) 57 (Q2) 69 (Q1) 95 • 0unduplicated BH therapy sessions, (Q3) 16 (Q2) 3 (Q1) 12 • 33 unduplicated BH SUD specific therapy sessions, (Q3) 7 (Q2) 12 (Q1) 9 • 37 intensive case management sessions, unduplicated, (Q3) 18 (Q2) 14 and 42 (Q1) 91 and 11 • 223 total clients served, (Q3) 49 (Q2) 42 (Q1) 168 • 186 crisis intervention outreaches(Q3) 49 (Q2) 142 (Q1) 71	• 177 youth in crisis who engaged in at least two contacts; call or text, (Q3) 456 (Q2) 140 (Q1) 44 • 882 youth in crisis contacted Y-T-D, (Q3) 659 (Q2) 237 (Q1) 95 • 4565 texters in crisis, (Q3) 2784 (Q2) 86 (Q1) 675 • 174 crisis texts that are resolved over the phone or with community resources, (Q3) 127 (Q2) 85 (Q1) 28 • 112 youth served by SUD professional by appointments, (Q3) 96 (Q2) 56 (Q1) 12 • 43 in case management services who completed a housing stability plan including educational/employment goals, (Q3) 16 (Q2) 15 (Q1) 11 • 23 homeless youth served by Coffee Oasis within management, (Q3) 16 (Q2) 20 (Q1) 9
Eagles Wings Baseline: unduplicated number of individuals served during the quarter	• 18 psychiatric intakes, (Q3) 39 (Q2) 18 (Q1) 22 • 119 housing meetings (weekly meetings at 7 different houses) (Q3) 169 (Q2) 119 (Q1) 91 • 1836 case management encounters, (Q3) 2145 (Q2) 1836 (Q1) 936	• 48 unduplicated individuals served with 55 still active at end of quarter, (Q3) 76 (Q2) 48 (Q1) 24 • 20 individuals served with medication management, (Q3) 51 (Q2) 20 (Q1) 21 • 10 individuals served in therapeutic court program, (Q3) 20 (Q2)10 (Q1) 2

Family Behavioral Health CCS Baseline: Unduplicated number of individuals served during the quarter	• 272 services, (Q3) 273 (Q2) 261 (Q1) 120 • 13 clients, (Q3) 14 (Q2) 12 (Q1) 8	• 224.58 service hours, (Q3) 215.32 (Q2) 252 (Q1) 145 • 11 clients served, (Q3) 7 (Q2) 12 (Q1) 8 • 2 total referrals, (Q3) 2 (Q2) 18 (Q1) 26 • 8 referrals entered services, (Q3) 6 (Q2) 5 (Q1) 8 • 3 clients with PCOMS treatment response score, (Q3) 5 (Q2) 2 (Q1) 2
Fishline NK Baseline: Unduplicated number of individuals served during the quarter	• 62 outreaches to the community about counseling services, (Q3) 28 (Q2) 76 (Q1) 20 • 12 referrals from Fishline to counseling services, (Q3) 13 (Q2) 10 (Q1) 21 • 6 referrals from counselor to Fishline, (Q3) 3 (Q2) 18 (Q1) 17 • 209 counseling sessions, (Q3) 162 (Q2) 162 (Q1) 72 • 18 clients served, (Q3) 17 (Q2) 30 (Q1) 17	• 27 referrals, (Q3) 17 (Q2) (Q1) 9 • 49 individuals assessed and seen within 3 days by Fishline therapist, (Q3) 44 (Q2) 31 (Q1) • 49 individuals assessed and enrolled in Fishline Counseling Services YTD • 49 served with therapeutic counseling services, (Q3) 17 (Q2) 30 (Q1) 17 • 6 clients referred to a case manager, (Q3) 3 (Q2) 31 (Q1) 17
Kitsap Community Resources Baseline: Unduplicated number of individuals served during the quarter	• 57 referrals to mental health, (Q3) 48 (Q2) 15 (Q1) 23 • 62 referrals to SUD services, (Q3) 56 (Q2) 8 (Q1) 11 • 67 referrals to primary care, (Q3) 45 (Q2) 14 (Q1) 16 • 36 referrals to employment and training services, (Q3) 9 (Q2) 2, (Q1) 7 • 83 referrals to housing, (Q3) 49 (Q2) 28 (Q1) 44	• 49 average households on a caseload, (Q3) 47 (Q2) 38 (Q1) 24 • 238 unduplicated individuals, (Q3) 237 (Q2) 170 (Q1) 154 • 173 households, (Q3) 169 (Q2) 116 (Q1) 105 • 162 households that have received rental assistance and maintained housing 1 month (Q3) 160 (Q2) 85 (Q1) 87 • 179 households that have maintained housing for 6 months
Kitsap County District Court Behavioral Health Court Baseline: Unduplicated number of individuals served during the quarter	• 17 service referrals provided, (Q3) 20 (Q2) 14 (Q1) 16 • 3 individuals housed, (Q3) 4 (Q2) 1 (Q1) 2 • 19 program participants, (Q3)19 (Q2) 20 (Q1) 25 • 5 program referrals, (Q3) 6 (Q2) 7 (Q1) 5 • 0 participant terminated, (Q3) 1 (Q2) 2 (Q1) 2	• 0 reoffenders in last quarter, (Q3) 0 (Q1) 0 • 0 graduates from last 18 months who reoffended, (Q3) 0 (Q1) 0 • 5 graduates last 6 months with 3 this quarter who completed a diversion program, (Q3) 5 (Q1) 5 • 10 participants reported feeling favorable overall life satisfaction, (Q3) 50% (Q1) 40% • 1 remain homeless or became homeless again in the last quarter, (Q3) (Q1) 29% • 6 are trying to re-engage in vocational activities were successful, (Q3) 35% (Q1) 66% • 12 participants trying to reobtain a driver's license were successful, (Q3) 7
Kitsap County Juvenile Services Baseline: Unduplicated number of individuals served during the quarter	• 0 BHS sessions with ITC participants, (Q3) 23 (Q2) 8 (Q1) 23 • 0 BHS sessions with DC participants, (Q3) 1 (Q2) 5 (Q1) 9 • 0 BSH sessions with post-graduates, (Q3)3 (Q2) 23(Q1) 14 • 5 UA tests for designer drugs, (Q3)6 (Q1) 22 • 0 ITC served by BHS (Q3) 5 (Q2) 6 • 0 drug court participants served by BHS(Q3) 1 (Q2) 2	• 12 unduplicated youth in ITC who receive services from dedicated BHS, Y-T-D • 0 unduplicated youth in ITC who didn't already have a therapist at entry, Y-T-D • 7 juvenile drug court who receives MHTS by BHS, • 0 juvenile drug court who didn't have a therapist at entry, • 53 youth screened for use of designer drugs who test negative, YTD • 54 youth screened for use of designer drugs

Kitsap County Prosecuting Attorney's Office Baseline: Unduplicated number of individuals served during the quarter	• 28 treatment court entries, (Q3) 23(Q2) 23 (Q1) 18 • 4 BH court entries, (Q3) 2(Q2) 0 (Q1) 2 • 15 drug court entries, (Q3) 17(Q2) 13 (Q1) 11 • 8 felony diversion, (Q3) 1(Q2) 6 (Q1) 4 • 0 entry to veteran's court, (Q3) 2 (Q2) 1 (Q1) 1 • 1 entry to THRIVE Human Trafficking Court(Q3) 2 (Q2) 1	• 76 applications, (Q3) 44 (Q2) 60 (Q1) 48 • 29 entries, (Q3) 20 (Q2) 22 (Q1) 22 • 3 opted out, (Q3) 3 (Q2) 4 (Q1) 3 • 28 court entries, (Q3) 23 (Q2) 23 (Q1) 18 • 36 denied entry, (Q3) 20 (Q2) 29 (Q1) 17 • 5 DOSA participants, (Q3) 3 (Q2) 3 (Q1) 2
Kitsap County Sheriff's Office Crisis Intervention Coordinator (CIC) Baseline: Unduplicated number of individuals served during the quarter	• 100 proactive contacts, (Q3) 116 (Q2) 83 (Q1) 92 • 56 calls received requesting services from Crisis Intervention Coordinator, (Q3)57 (Q2) 44 (Q1) 86 • 13 meetings held to collaborate with KMHS and other organizations on crisis intervention, (Q3)9 (Q2) 5 (Q1) 11	• 58 unduplicated client proactive contacts made based on generated reports, (Q3) 78 (Q2) 211 (Q1) 64 • 137 reactive contacts to Crisis calls by CIC, (Q3) 103 (Q2) 17 (Q1) 17 • 242 unduplicated applicable clients connected to a DCR, (Q3) 214 (Q2) 71 (Q1) 88 • 214 unduplicated applicable clients, (Q3)214 (Q2) 212 (Q1) 174 • 75 contacts with clients no longer in crisis, (Q3) 75 (Q2) 19 (Q1) 32 • 10 contacts were client voluntarily goes to hospital, (Q3) 10 (Q2) 7 (Q1) 5 • 46 contacts where client refused transport, (Q3) 46 (Q2) 13 (Q1) 15 • 14 clients required court order to go to hospital, (Q3) 14 (Q2) 5 (Q1) 6 • 51 contacts where individuals not in crisis but provided mental health resources, (Q3) 51 (Q2) 16 (Q1) 16 • 35 contacts where individuals provided referral to West Sound Treatment REAL Team, (Q3) 35 (Q2) 10 (Q1) 7
Kitsap County Sheriff's Office Crisis Intervention Training (CIT) Baseline: Unduplicated number of individuals served during the quarter	• 0 CIT trainings (8 hour) • 1 CIT training (40 hour) YTD • 0 CIT training (enhanced 24 hour) • 1 individual served – Bainbridge YTD • 1 individual served – Bremerton YTD • 2 individuals served – Kitsap County Sheriff • 0 individual served – Port Orchard YTD YTD • 2 individuals served – Poulsbo YTD • 0 individuals served – Port Gamble YTD • 0 individuals served – Suquamish YTD • 7 individuals served – Other YTD	• 1 40-hour classes to 30 different Kitsap County Deputies YTD • 0 sum of test scores at conclusion of course • 0 sum of test scores at baseline of course • 0 class participants who increased their knowledge, attitude and skills scores by at least 25%

Kitsap County Sheriff's Office Reentry Officer and Coordinator Program 2022 Baseline: Unduplicated number of individuals served during the quarter	• 22 substance use disorder services, (Q3) 22 (Q2) 23 (Q1) 50 • 7 mental health services, (Q3) 6 (Q2) 4 (Q1) 6 • 89 co-occurring substance use disorder and mental health services, (Q3) 72 (Q2) 98 (Q1) 128 • 118 participants, (Q3) 120 (Q2) 118 (Q1) 184 • 75 participants receiving MAT, (Q3) 71 (Q2) 62 (Q1) 47	• 448 prisoners receiving services, (Q3) 336 (Q2) 214 (Q1) 184 ********* • 6424 jail bed days for participants post-program enrollment, (Q3) 3531 (Q2) 937 (Q1) 106 • 30,422 jail bed days for participants pre-program enrollment, (Q3) 23,554 (Q2) 16,267 (Q1) 6346 • 81 clients, (Q3) 82 (Q2) 44 (Q1) 8 • 118 total clients served current quarter • $10,637,497 monies saved based on jail bed day reductions, (Q3) $3,342,171 (Q2) 2,406,810.00 (Q1) 980,616
Kitsap County Superior Court Baseline: Unduplicated number of individuals served during the quarter	*Adult Drug Court:* • 10 attending college, (Q3) 8 (Q2) 3 (Q1) 11 • 5 received OC GED, (Q3) 4 (Q2) 5 (Q1) 3 • 12 created resumes, (Q3) 13 (Q2) 8 (Q1) 11 • 21 obtained employment, (Q3) 8 (Q2) 10 (Q1) 11 • 3 BEST business support training, (Q3) 2 (Q2) 5 (Q1) 3 • 37 housing assistance, (Q3) 41 (Q2) 14 (Q1) 6 • 33 licensing and education, (Q3) 18(Q2) 12 (Q1) 8 • 103 received job services, (Q3) 70(Q2) 81 (Q1) 90 • 13 new participants, (Q3) 12 (Q2) 11 (Q1) 10 • 5 graduates seen, (Q3) 9 (Q2) 6 (Q1) 5 • 13 legal financial obligations, (Q3) 6 (Q2) 8 (Q1) 5 • 21 budget services, (Q3) 18 (Q2) 17 (Q1) 19 *Veterans Treatment Court:* • 1 military trauma screening, (Q3) 1 (Q2) 5 (Q1) 1 • 1 new participant added, (Q3) 1 (Q2) 5 (Q1) 1 • 1 mental health referrals, (Q3) 1 (Q2) 3 (Q1) 1 • 1 substance use disorder screening, (Q3) 1 (Q2) 5 (Q1) 1 • 1 referrals for substance use disorder treatment, (Q3) 1 (Q2) 5 (Q1) 1 • 19 active participants, (Q3) 21 (Q2) 23 (Q1) 20 • 0 participant discharged, (Q3) 0 (Q2) 0 (Q1) 1 • 1 graduates, (Q3) 3 (Q2) 3 (Q1) 1 • 3 active participants receiving MAT services, (Q3) 3 (Q2) 3 (Q1) 3	*Adult Drug Court:* • 108 active participants, (Q3) 106(Q2) 99 (Q1) 95 • 35 receiving COD services, (Q3) 36(Q2) 39 (Q1) 38 • 5 discharged, (Q3) 4(Q2) 5(Q1) 4 • 7 graduates, (Q3) 8 (Q2) 5 (Q1) 4 44 receiving MAT services, (Q3) 41(Q1) 37 *Veteran's Treatment Court:* • 27 participants screened using ASAM criteria within one week o admission to VTC, (Q3) 26 (Q2) 25 (Q1) 20 • 22 participants screened positive for needing substance use treatment and placed at either American Lake or KRC within two weeks of that determination, (Q3) 21 (Q2) 20 (Q1) 17 • 27 participant treatment plans reviewed/revised, if necessary, every 90 days by VA clinical provider recommendation, (Q3) 26 (Q2) 23 (Q1) 20 • 1 participant screened positive for needing mental health services were placed in treatment at VAMC or KMHS within 30 days of assessment, (Q3) 1 (Q2) 3 (Q1) 3

Kitsap Homes of Compassion Baseline: Unduplicated number of individuals served during the quarter	• 136 supportive housing residents served, (Q3) 107(Q2)120 (Q1) 117 • 79 residents living in sober living homes, (Q3)21 (Q2)21 (Q1) 14 • 22 residents in low-barrier housing, (Q3) 89(Q2)99 (Q1) 103	• 1 full-time navigators and 1 therapist hired • 4 school connections for student recruitment, • 2 master level interns recruited, • 0 bachelor level BA interns recruited, • 14 volunteer house managers who are attending training, • 2 trainings conducted • 65 residents receiving KHOC case management • 140 residents receiving case management • 150 residents receiving housing supports, • 150 wellness intake screenings, • 42 mental health clients, • 42 mental health clients have a completed treatment plan, • 3 crisis calls with response time within 1 hour, • 4 crisis calls resulted in activation of emergency services,
Kitsap Mental Health Services Baseline: Unduplicated number of individuals served during the quarter	*Pendleton Place:* • 46 classes held for clients(Q3) 35 (Q2) 13 (Q1-N/A) • 730 client meetings with housing supports (Q3) 774 (Q2) 608 (Q1-N/A) • 130 meetings with peer support(Q3) 183 (Q2) 173 (Q1-N/A)	*Pendleton Place:* • 72 individuals served (Q3) 72(Q2) 66 (Q1-N/A) • 49 mental health(Q3) 53(Q2) 39 (Q1-N/A) • 12 substance use disorder (Q3) 14 (Q2) 13 (Q1-N/A) • 26 dual diagnosis(Q3) 13 (Q2) 20 (Q1-N/A) • 1 individuals received permanent housing(Q3) 5 (Q2) 66 (Q1-N/A) • 37 engaged in MH/SUD care prior to placement(Q3) (Q2) 47 of 66 (Q1-N/A) • 49engaged in MH/SUD care since placement(Q3) (Q2) 52 of 66 (Q1-N/A) • 52 engaged in primary care prior to placement (Q3)53 (Q2) 51 of 66 (Q1-N/A) • 55 engaged in primary care since placement(Q3) 61(Q2) 54 of 66 (Q1- N/A)

Kitsap Mental Health Services Baseline: Unduplicated number of individuals served during the quarter	*Unfunded Behavioral Health – Crisis Triage* • 135 individuals served in 550 days for crisis stabilization services(Q3) 135 (Q2) 307 individuals served in 1221 days for crisis stabilization services (Q1)172 individuals served in 692 days for crisis stabilization services • 62 individuals served in 1264 days of residential substance use treatment services (Q3) 68 (Q2) 135 individuals served in 2261 days of residential substance use treatment services (Q1) 66 individuals served in 1088 days of residential substance use treatment services	*Unfunded behavioral Health – Crisis Triage* • 420 individuals stayed for up to 5 days • 276 individuals are clients of KMHS or accepted services for MH services at discharge • 62 crisis triage clients who chose SUS and have 1st appt scheduled at completion of treatment/planned discharge • 107 PHRC clients who are current KMHS clients or chose to accept KMHS and have 1st appt scheduled • 49 PHRC clients who chose SUS and have 1st appt scheduled • 158 crisis triage clients who are KMHS clients with successful f/u post discharge within 7 days
Kitsap Public Health District Baseline: Unduplicated number of individuals served during the quarter	• 120 NFP nursing visits (Q3) 134(Q2)103 • 85 outreaches, presentations, referrals(Q3)130 (Q2) 63 • 41 mothers served(Q3) 43 (Q2) 32 • 30 infants served(Q3) 35(Q2) 31 • 15 Mothers with CHW or Public Health Educator outreach/case management	• 490 CHW or Public Health Educator Outreach and case management encounters (Q3) 390 (Q2) 72 • 11 postpartum support group sessions(Q3) (Q2)5 • 89% retention rate for NFP clients • 33% unduplicated clients who have PHQ-9 and GAD 7 screen(Q3) (Q2) 39 • 35% of graduated clients show improvement with identified substance use disorder(Q3) (Q2) 83% • 48% of unduplicated clients show improvement in Omaha System at graduation in past five years (Q3) (Q2)93% • 48% of graduated clients with mental health problems identified-show improvement in KBS at graduation in past five years(Q3) (Q2) 95%
Kitsap Rescue Mission Baseline: Unduplicated number of individuals served during the quarter	• 1 assessments, (Q3) 0 (Q2) 2 (Q1) • 0 detox admits, (Q3) 0(Q2) 5 (Q1) • 0 inpatient treatment admit, (Q3)0 (Q2) 1 (Q1) • 1 outpatient admit, (Q3) 0(Q2) 1 (Q1) • 0 sober living placements, (Q3) 2(Q2) 1 (Q1) • 252678 1:1 session, (Q3) 258 (Q2) 27 (Q1) • 0 1:1 session with a CMHP or MH provider, (Q3)0 (Q2) 8 (Q1) • 17 911 calls, (Q3)25 (Q2) 31 (Q1) • 6 emergency room engagements, (Q3) 8 (Q2) 2 (Q1)	• 71 individuals served, • 26 individuals served with SUDP services, • 0 individuals served with MH services • 27 individuals utilizing housing navigator services

Kitsap Strong Baseline: Unduplicated number of individuals served during the quarter	• 0 RISE trainings conducted(Q3) 2 (Q2) 1 (Q1) 2 • 3 Community of Practice sessions (1 per month) • 48 mentors • 6132 youth served by mentors (per mentors) • 35 unduplicated mentors who attended at least one of the three community practice sessions	• 48 individuals admitted into the RISE training YTD • 48 individuals who applied for RISE training YTD • 48 individuals register for Caring Adult Cohort YTD • 48 individuals who register for training YTD • 48 Individuals who completed RISE training YTD
Olympic Educational District 114 Baseline: Unduplicated number of individuals served during the quarter	• 882 elementary contacts with clients, (Q3) 148 (Q2) 808 (Q1) 808 • 400 middle school contacts with clients, (Q3) 58 (Q2)87 (Q1) 220 • 33964 high school contacts with clients, (Q3) 34 (Q2)107 (Q1) 111 • 54 elementary drop-ins, (Q3) 9 (Q2) 25 (Q1) 19 • 67 middle school drop-ins, (Q3) 31 (Q2)12 (Q1) 83 • 113 high school drop-ins, (Q3) 74 (Q2) 9 (Q1) 17 • 282 elementary parent interactions, (Q3) 106 (Q2) 355 (Q1) 289 • 23 middle school parent interactions, (Q3) 3 (Q2) 4 (Q1) 39 • 24 high school parent interactions, (Q3)5 (Q2) 1 (Q1) 3 • 429 elementary staff contacts, (Q3) 145 (Q2) 421 (Q1) 437 • 62 middle school staff contacts, (Q3) 22 (Q2) 0 (Q1) 48 • 76 high school staff contacts, (Q3) 23 (Q2) 0 (Q1) 18	• 286 students have received services at targeted elementary, middle, and high schools (year to date), • 198 unduplicated elementary students served, YTD • 124 unduplicated middle school students served, YTD • 109 unduplicated high school students served YTD
One Heart Wild Baseline: Unduplicated number of individuals served during the quarter	• 25 family coordination sessions • 131 telehealth sessions • 27 mental health treatment/BHS • 174 animal -assisted mht/bh services • 79 Total clients • 43 Elementary YTD • 49 Middle school YTD • 54 High School YTD	• 213 clients complete an intake • 8 clients established care coordination plans with OHW • 1 – hire a new staff counselor? (1 yes, 2-no) • 213 clients established care with OHW • 875.5 hours of BHS provided at low or NO cost • 126 clients who improved score from initial survey to most recent survey

Peninsula Community Health Services Baseline: Unduplicated number of individuals served during the quarter	• 128 mental health visits(Q3) 53 (Q2) 97 (Q1) 42 • 21 substance use disorder visit (Q3) 8 (Q2) 25 (Q1) 1 • 65 youth clients (Q3) 27 (Q2) 43 (Q1) 21	• 1 Staff hired and oriented by end of(Q3) 1 (Q2) N/A (Q1) 1 • 42 behavioral health patients who have completed 3 or more behavioral health visits (year to date) (Q3)32 (Q2) 28 (Q1) 5 • 107 of behavioral health patients (year to date) (Q3) 74 (Q2) 58 (Q1) 21 • 107 youth served (year to date) (Q3) 74 (Q2) 58 (Q1) 21 • 330 visits by youth (year to date) (Q3) 219 (Q2) 158 (Q1) 43 • 70 unduplicated patients who completed at least one physical health visit (year to date) (Q3) 40 (Q2) 24 (Q1) 2 • 107 unduplicated patients who completed at least one behavioral health visit (year to date) (Q3) 74 (Q2) 58 (Q1) 21
Scarlet Road Baseline: Unduplicated number of individuals served during the quarter	• 20 times rental assistance provided(Q3) 8 (Q2) 3 (Q1) 4 • $14,844.26 for rental assistance(Q3) $2,232.78 (Q2) $5,528.34 (Q1) $2,189 • 14 adult victims (Q3) 15 (Q2) 3 (Q1) 3 • 2 dependents(Q3) 5 (Q2) 2 (Q1) 2 • 10 adult victims connected to LMH (Q3) 10 (Q2) 1 (Q1) 3	• 12 adults receiving rental assistance (Q3)7 (Q2) 4 (Q1) 3 • 12 adult received employment services (Q3)7 (Q2) 4 (Q1) 1 • 8 needed employment services (Q3) 7(Q2) 4 (Q1) 2 • 14 unduplicated victims provided with recovery support services by additional case manager • 9 case management individuals who participated in self-help groups YTD • 18 case management individuals YTD • $25,000 spent on rental assistance YTD
Suquamish Tribe Baseline: Unduplicated number of individuals served during the quarter	• 150 outreach contacts with Individuals(Q3) (Q2) 25 (Q1) 7 • 10 contacts/outreach with impacted family members • 100 naloxone kits distributed	• 2 community event participation (Q3) (Q2) 2 (Q1) 1 • 1 long distance transport(Q3) (Q2) 1(Q1) 1 • 20 individuals served by peer support specialist(Q3) (Q2) 15 (Q1) 4 • 1 was peer support specialist hired? (1 yes, 0 no) • 30 individual contacts YTD • 150 contacts completed Q3

West Sound Treatment Center Baseline: Unduplicated number of individuals served during the quarter	Mental Health Wrap Around Services: • N/A (Q2) (Q1) In a competitive hiring process hoping to secure a MH Professional employee • 5 individual sessions (Q3) 3 • 0 group sessions New Start Program: • 57 assessments (Q3) 64(Q2) 71 (Q1) 82 • 32 intakes (Q3) 20 (Q2) 38 (Q1) 29 • 233 transports to New Start/reentry clients(Q3) 478 (Q2) 144 (Q1) 32 • 420 New Start Client(Q3) 109 (Q2 123) (Q1) 132 • 204 housing applicants(Q3)51 (Q2) 90 (Q1) 12 • 92 eligible housing applicants (Q3) 35 (Q2) 21 (Q1) 6 • 81 housed participants(Q3) 18 (Q2) 21 (Q1) 21 (*29 people were housed over the course of q3 in total)	Wrap Around Services: • N/A (Q2) (Q1) In a competitive hiring process hoping to secure a MH Professional employee • 2 clients received mental health services from West Sound (Q3) • 2 clients who completed a needs and barrier assessment • 2 clients • 2 clients who completed a CAAPE 5 assessment • 2 clients YTD New Start Program: • 18 sober living house units filled (Q3)18 (Q2) 13 (Q1) 12 • 77 in need of supportive housing(Q3) 62 (Q2) 33 (Q1) 12 • 152 participants answered transportation questionnaire with 48% not needing transportation supports (Q3) 130 (Q2) 106 (Q1) 72 and 36% • 81 housed clients (year to date) (Q3) 64 (Q2) 42 (Q1) 21 • 79 have visited a primary care physician within 30 days of entering sober living(Q3) 58(Q2) 36 (Q1) 19 • 169 clients need MH services with 84 connected to SIH(Q3) 142 (Q2) 108 (Q1) 55 and 42 • 106 clients enrolled in Health care 7 days after release from incarceration(Q3) 87 (Q2) 54 (Q1) 29 215 totals released from incarceration (year to date) (Q3) 188 (Q2) 134 (Q1) 53
YWCA Baseline: Unduplicated number of individuals served during the quarter	• 11 referrals: 12 adults, 4 children (Q3) 16 (Q2) 18 referrals, 12 adults, 6 children (Q1) 11 referrals: 4 adults, 7 children • 0 Individual therapy sessions held	• 1 avg hours of therapy provided each week • 19 DV survivors served each week (Q3)24 (Q2)19 (Q1) 0 • 4 signed up for health insurance(Q3) 20 (Q2) 4 (Q1) 0 2 eligible to sign up for health insurance