Kitsap County Mental Health, Chemical Dependency & Therapeutic Court Programs

Fourth Quarter Report

October 1, 2024 – December 31, 2024

Kitsap County Mental Health, Chemical Dependency & Therapeutic Courts Program Quarterly Narrative Summary

Progress on Implementation and Program Activities:

Agency: Agape Unlimited

Program Name: AIMS

$40,955

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 goal was to serve 15 clients, and we were able to serve 14 clients. Our LMHP works on Mondays only until census and utilization increase. During this quarter there were 3 holidays on Monday which impacted our goals. For the year 2025 we have found have created an alternative for the patient care coordinator and will no longer be utilizing this grant funding.

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. We have been monitoring census and utilization within our own agency and other behavioral health agencies to track trends to help us project any future changes. 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). Many staff are trained to screen for program eligibility as well as to disseminate accurate information in appropriate forums to our target population. We are excited to be able to attend and host in-person meetings again which helps educate our partners on our programs more effectively than in prior online platforms. We will be attending large community events this summer to disseminate material to the community and other agencies in attendance.

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

We have found alternatives to filling the patient care coordinator position. We will no longer be utilizing the 1/10th grant to fund this position. Agape is very thankful for the opportunity to get this much-needed program started and running.

Success Stories:

I just started with AIMS and already I can see a difference in how I feel. I have to set boundaries with my still-using girlfriend and having this service has helped me protect my recovery and sanity.

Agency: Agape Unlimited

Program Name: Treatment Navigator SUD

$83,618

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 continues to be efficient and necessary for our organization. We have again exceeded our goals and objectives by decreasing the no-show rate and engaging many people in our services. We have also connected clients to ancillary services, such as Skookum, food banks, benefits, medical and mental health care, etc. This promotes overall good health, stability, and effective treatment response. The treatment navigator finds new and innovative ways to help participants reduce barriers and get their needs met. Our treatment navigator has been instrumental in getting household items for our housing participants on the day of their move into our program.

Moreover, Agape's Treatment Navigator has recognized other critical needs that clients have, and we have been able to fulfill those additional requirements.

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

We have partnered with multiple social service agencies to meet the needs of our clients and minimize expenses while providing a greater impact to the client. We work with DSHS, Abrahams house, therapeutic courts, KCR, KRC, Pacific Hope and Recovery, PCAP, Skookum, Scarlet Road and many more.

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

The Agape treatment navigator has finished the requirements for their peer certification. However, we are waiting for the state exam to be offered before she can complete the peer process. We aim to have the Navigator certified as a peer counselor, which will allow us to offer a portion of the treatment navigator's expenses as a Medicaid billable service. We have established partnerships with local resources that have aided meet our client's needs.

Success Stories:

The treatment navigator has been a tremendous help since my first day at Agape. I completed an assessment in August 2023 and started treatment in October of that year. She has assisted me in securing housing, obtaining food, getting a phone, and accessing many other resources. Every week, she transports myself and my peers to drug court, ensuring we arrive on time. I have completed IOP and am almost done with my outpatient treatment. I truly appreciate her support.

Agency: Bainbridge Youth Services
Program Name: Year Round Youth Counseling
$105,000

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?

BYS was able to achieve our goals for our free mental health therapy program in quarter 4:

*109 Kitsap County youth attended 1208 hours of BYS mental health therapy in quarter 4:

- 100% of BYS youth participants reported that they believed participating in BYS programs helped improve their mental health or overall well-being.
- 100% of BYS youth participants reported that they believed they have gained new skills or a better understanding of themselves by participating in BYS programs.

*18 Kitsap County parents/caregivers participated in BYS counseling services and/or parent peer support groups in quarter 4. This included 91 hours of one-on-one counseling for Kitsap County parents/caregivers.

- 100% of parents/caregivers reported feeling BYS services helped improve their abilities in their parenting.
- 100% of parents reported gaining new skills or a better understanding of themselves through BYS services.

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

BYS employs collaborative outreach strategies to support youth mental health by partnering with public and private schools in Kitsap County. We provide resources, mental health flyers, and classroom presentations by therapists and community representatives, addressing high-risk behaviors. Collaborating with professionals such as doctors, social workers, and housing organizations ensures coordinated care for at-risk youth, including those experiencing homelessness. Partnerships with Kitsap Mental Health, Peninsula Community Health, the Salish Youth Network Collaborative, and the Suquamish and Port Gamble communities, expand access to trauma-informed services, especially in underserved rural areas, enhancing collective efforts for impactful youth support.

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

BYS was awarded grant funding from the following funders in Quarter 4:

-City of Bainbridge Island: 2-year grant of $57,000 per year

-First Fed Foundation: $7,000

-Suquamish Tribe/Port Madison Enterprises: $5,000

-Bainbridge Community Foundation – Capacity Building Grant: $2,500
-Kitsap Bank: $2,500
-Bainbridge Island Parks & Trails Foundation: $1,000
We also held our annual Trivia Night fundraiser on October 19.

Success Stories:

*Youth Success Stories -
When BYS Youth were asked how BYS services have made a difference in their life, comments included:
-"It is helpful to be able to talk about stuff that I don't want to talk to my friends about"
-"[Therapy] has given me clarity about my situation. And has provided a safe space for me to cope and move forward."
-"I have gained breathing techniques and tools to use while I'm in high-stressed and anxiety increasing situations."
*Parent/Caregiver Success Stories:
When asked how the parent peer support program has made a difference for them, parents/caregivers reported:
-"Helped to normalize the seemingly incomprehensible stuff I deal with."
-"One of the most valuable aspects was realizing how common all these parenting struggles are, and tools to help deal with them."
-"I loved the guided 'grounding' sessions at the beginning of our meetings. You offered plenty of strategies in how to calm oneself."
-"I don't feel alone – I gained perspective that helps me better love myself and my teen. Our relationship has gotten stronger because of what I integrated from this support group."

Agency: City of Bremerton
Program Name: Therapeutic Court
$100,000

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 continuing to increase our numbers of participants. The treatment programs are making a big difference in these participants.

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

We will be holding our next resource fair in March. This resource fair helps those get connected with resources they may not have known about, ie. housing, medical, phones etc...

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

There is a huge need for post-conviction cases in our court where participants need help with resources. The participants are indigent and can't afford treatment, having a treatment provider come into TCC and provide these services is a huge benefit.

Success Stories:

One participant is a veteran, we got him into inpatient treatment and then into long term veteran housing at a local facility. He is continuing to do really well and is continuing to do counseling as well as take care of his PTSD that he has from serving.

Agency: Central Kitsap Fire Department
Program Name: CARES
$375,000

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?

During Quarter 4 of 2025, Kitsap Fire CARES teams received 443 referrals from fire departments, law enforcement, schools, and various community agencies. These referrals led to successful engagement with 409 unique individuals, resulting in over 1,000 contacts across multiple channels, including in-home visits, field outreach, phone calls, and interactions with support systems and providers. In addition, 131 individuals were referred to 211 services and resources, and 80 people were confirmed to have connected with 146 different services. CARES delivered a total of 1,329 direct services, which included follow-up contacts, care coordination, case management, the provision of concrete goods such as harm reduction supplies (e.g., naloxone), hygiene items, assistive devices, and transportation, as well as conducting safety and risk assessments for both behavioral health and medical needs. Interventions were tailored based on these assessments. Preliminary data for the quarter shows a 33% decrease in 911 calls and a 15% reduction in emergency department visits for individuals receiving CARES interventions. Complete three-month post-intervention data will be available by April 1, 2025. However, similar data from Quarter 4 of 2023 indicated an 81% reduction in both 911 and ED utilization for program participants, and Quarter 4 2024 is expected to show comparable outcomes. To further strengthen the program, Kitsap Fire CARES has introduced a new CARES Administrator role, responsible for ensuring program fidelity through the implementation of standardized operating procedures aligned with behavioral health industry best practices. This role also supports consistent data tracking and reporting. Kitsap Fire CARES continues to meet its established metrics and objectives, demonstrating both strong outputs and positive outcomes for the community.

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

In addition to critical partnerships with Kitsap County and the Salish BH ASO, Kitsap Fire CARES collaborates with several key partners to enhance community impact and improve crisis intervention efforts. Through formal contracts with the University of Washington and the Co-Response Outreach Alliance, Kitsap Fire CARES supports shared training, resources, and educational opportunities. These initiatives strengthen crisis intervention skills for both EMS crews and behavioral health co-response teams, fostering a more coordinated and effective response to community needs. Additionally, Kitsap Fire CARES is contracted with Kitsap County and Saint Michael's Hospital to provide an advanced medical provider who will serve a range of vulnerable populations. This includes individuals who are unhoused or unsheltered, those with high behavioral health needs, and others who face barriers to accessing medical care and resources. This partnership ensures that individuals in need receive timely, compassionate care both in the field and within the EMS and emergency department systems. Kitsap Fire CARES also maintains a strong partnership with the Kitsap Recovery Center, which provides a Substance Use Disorder (SUD) Professional to work alongside CARES teams. This collaboration allows for field-based assessments and seamless navigation to SUD services and supports, ensuring individuals receive the help they need in real time. Moreover, Kitsap Fire CARES and local fire departments are actively exploring opportunities to expand early intervention strategies, including the use of buprenorphine in the field. This initiative aims to bridge gaps in access to Medication-Assisted Treatment (MAT) and Medications for Opioid Use Disorder (MOUD), helping to address the ongoing opioid crisis in the region. Through these collaborative efforts, Kitsap Fire CARES is playing a critical role in building a more integrated and responsive system for individuals facing medical, behavioral health, and substance use challenges.

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

Kitsap Fire CARES continues to pursue germane funding opportunities related to co-response alongside fire departments as well as field based behavioral health and crisis intervention services in the field. In addition to grants, Kitsap Fire CARES remains actively engaged in a feasibility study, alongside the University of Washington, to determine the potential benefits of becoming a licensed behavioral health agency that may allow for billing

and/or contracting for crisis intervention services through the Health Care Authority for both community based response teams and street medicine teams, the Salish Behavioral Health Administrative Services Organization for crisis services rendered, through the Managed Care Organizations on a capitated payment contract, and other future funding opportunities. Fire departments deploying CARES programs in Kitsap County routinely bridge funding gaps to ensure continuity of service to the community.

Success Stories:

In November, an 81-year-old woman visited the SK fire station several times asking for directions and presenting as anxious and confused, raising concerns with staff who completed a referral to CARES 31 (C31). During contacts, she revealed serious issues at home involving an adult child residing on her property who was demonstrating concerning behaviors potentially associated with elder abuse. C31 made contact with the individual and she was determined to be anxious, and sleep-deprived, though no physical abuse was evident. C31 filed an Adult Protective Services (APS) report and, after several follow-up contacts with the woman, ongoing safety assessments and escalating concerns, and her expressed desire for support, C31 facilitated a connection to legal intervention at Kitsap County Superior where she was granted a vulnerable adult protection order. C31 also connected her with follow-up legal support and confirmed that her adult child had left the property. The intervention was determined to be successful evidenced by the women no longer seeking intensive support from C31

CK CARES was referred to an individual who was experiencing symptoms of a mental health crisis, including delusions, paranoia, and behavioral disruptions. CARES engaged the individual during a 911 response and quickly assessed the situation for immediate needs. We were able to relieve crews from scene and avoid an unnecessary ED visit. Instead, we felt a more appropriate response was to coordinate with the client's PCP for medication management. We coordinated with the client's PCP to communicate the emergent need for an appt to avoid an unnecessary utilization of a higher level of care, like an ED, and were able to secure an appt that day to address the immediate, non-medical mental health crisis. We took the client to their PCP appt, advocated for the client by communicating the presenting symptoms, helped the client fill their prescriptions at the pharmacy, and drove them to a shelter. We worked very closely with the client for the following weeks to reduce unnecessary 911 calls and ED visits. We engaged the client in case management to ensure they had adequate access to food, clothing, and shelter, coordinated with their PCP to communicate new or worsening symptoms, and engaged the client is crisis de-escalation. We worked with the client until the crisis was stabilized and then connected her to KMHS and YWCA for ongoing services.

Since 2023, Poulsbo Fire CARES has been actively supporting a 73 year-old-male with a history of chronic alcohol use and a high risk of falls. In the fourth quarter of 2024 alone, EMS responded to and referred over 30 calls involving this individual. Through established relationships with his daughters and other family members, the CARES team maintains regular communication to provide support and coordinate care. Interventions include hospital transports, provision of fall prevention tools and mobility aids, collaboration with substance use disorder specialist, hospital check-in's, communication with hospital staff, detox coordination, and access to recovery resources. These efforts reflect CARES program commitment to addressing complex needs and improving the well-being of both the individual and his family. CARES will continue to provide crisis intervention resources, ongoing support, and tailored care as this individual works toward greater stability and safety.

Agency: The Coffee Oasis

Program Name: Homeless Youth Intervention

$289,000

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 seen a drop in clients served through our 24/7 crisis text line. We have struggled to keep this functioning, and in addition, a number of additional lines have been established throughout Kitsap.

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

The Coffee Oasis is part of the Kitsap Human Services and Suicide Prevention Workgroup. The department's mission for Human Services is "to provide essential services that address individual and community needs, preserve the rights and dignity of those they serve, and promote the health and well-being of all Kitsap residents." One of our strongest partnerships has been with the South Kitsap School District - specifically, the district's social workers and School Resources Officer, with whom we have built close relationships and continue to work in continuity to support the best youth struggling with mental health concerns. One youth in therapeutic mentorship was escaping from domestic violence.

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

Describe your agency's plan for financial sustainability for this program. Describe how the project used federal, state, local, or private funds and/or in-kind resources during the last budget period, especially Federal Medicaid funds. Describe a preliminary plan for how the project will continue after the next funding period (i.e., sustainability). This program has a huge impact on the community we serve, and it is a priority to continue its success. TCO has multiple revenue streams for programming, including business sales from our cafes, grants, and donations. Our case management staff helps youth who may not have insurance become insured.

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

$300,000

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?

For this annual report, the online reporting system only asked for current quarter (Q4) data. In past years, we have reported both current quarter and YTD data at the end of the calendar year to showcase how the program performed over the total year. If you'd like Year to Date outcomes, please contact Kelsey Stedman at kelsey@eagleswingscc.net and Ariana Miller at ariana@eagleswingscc.net. There is also no place to enter insurance status however, 113/128 of clients served in Q4 had Apple Health (Medicaid), 4/128 had Medicare, 9/128 were dual eligible for Medicaid (Apple Health) and Medicare, and 2/128 were uninsured. The two biggest challenges we continually face are 1) lack of affordable housing options to transition participants into, and 2)

access to stable, long-term rental assistance sources for funding our transitional housing participants. We are extremely grateful for our partnership with BHA through which we have acquired 4 Project Based Vouchers and over 30 Housing Choice Vouchers however, it has taken an average of 9 months or more to go through the voucher process and finding sustainable funding to support participants in our transitional housing during this time continues to be an issue.

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

We continue to collaborate with many community partners through bidirectional referrals and care coordination including HSC, HEN, Trueblood, Kitsap County therapeutic courts, Bremerton Municipal Therapeutic Court, PCHS, KMHS, Bremerton Housing Authority, WAQRR, etc. We are also strengthening our partnerships with state partners such as Department of Commerce and Health Care Authority and are contracted with three of the Managed Care Agencies who provide Apple Health (Medicaid) coverage.

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

This quarter we executed our $1.2 million contract with WA Department of Commerce Housing Trust Fund and Apple Health and Homes for acquisition of two sites. One is a 4-unit building that will be used for supportive housing with four Project Based Vouchers in partnership with BHA and the other is a 9-bedroom home used for transitional housing. We also contracted out our billing services for Apple Health (Medicaid) billing and have seem more stability in our monthly reimbursement for Foundational Community Supports (FCS) as a result. We are also pursuing billable Peer Navigation services and have begun receiving reimbursement for our Medical Respite services.

Success Stories:

We are very proud that 86.5% of the participants served in Q4 were still in services at the end of the year. Even more exciting is that, of the 77 participants who had intakes at least 6 months ago, 88% (n=68) of them are still in services with us. We also find success in the outcome that we have consistently served a population of participants that is more diverse than the general population of Kitsap County. Throughout 2024, approximately 70% of participants identify as White, Non-Hispanic/Latino, while 30% of participants served by EWCC identified as Black, Indigenous, Person of color (BIPOC), more than one race, and/or Hispanic/Latino. In comparison, approximately 78% of Kitsap County residents identify as White per Office of Financial Management (OFM) 2020-2024 data.

Agency: Fishline
Program Name: Counseling Services
$95,000

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: Aim to receive 5 referrals monthly or 15 referrals quarterly from partner agencies.
We achieved this goal with 16 referrals. During the holidays, many people seek out mental health professionals to help manage the increased stress and emotional challenges that often accompany this time of year.
Goal 2: Strive to complete 5 intakes monthly or 15 intakes quarterly, see clients within 3 business days, and ensure 75% client satisfaction and improvement upon exit. We did not fully achieve this goal, primarily because therapists had full schedules and could not safely discharge current clients who needed additional support.
This quarter, we completed 12 intakes. Our partnership with AMFM has been highly collaborative and beneficial for clients, reducing care barriers. We have also started offering virtual appointments, which have been well-received by clients. All new clients were contacted and scheduled within 3 business days, with over 80% seen within this timeframe. The main reason for delays beyond 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. We have not achieved this goal and are considering setting new benchmarks, since the existing one has become difficult to reach because many of our clients are already involved with Fishline case managers or other service providers.

Briefly describe collaborative efforts and outreach activities employing collective impact strategies.
During the fourth quarter, Fishline provided updates on our free counseling services at our monthly and quarterly community meetings. Our case managers and the Director of Programs and Services interacted with representatives from various agencies and participated in resource fairs. This quarter, we organized 52 Fishline tours for community members and different organizations. During these tours, we shared details about our services and consistently received positive feedback. We also gave a presentation to the Olympic College BSN students, highlighting our free mental health therapy program. Additionally, we shared information about this service with our donors, volunteers, and clients via our e-newsletter, and with the wider community through our social media channels.

Please describe your sustainability planning – new collaborations, other sources of funding, etc.
We are actively pursuing additional grants and have launched various fundraising initiatives to increase year-round donations. Additionally, Fishline is excited to announce the opening of a new Thrift Store, which complements our existing store, Second Season. Fishline Thrift opened to the public on June 26, 2024, and has already seen an increase in revenue that supports Fishline's programs and services.

Success Stories:
Sarah, a mother of two, had been struggling with anxiety and depression for years. Feeling overwhelmed, she sought help through our free mental health therapy program. From the first session, Sarah felt relief as her therapist provided a safe space to discuss her feelings. Over time, she learned coping strategies and noticed significant improvements in her mental well-being, regaining confidence and strengthening her relationships. "The support I received was life-changing. I finally felt understood and not alone," Sarah shared. Today, Sarah is thriving and continues to use the tools she learned in therapy to maintain her mental health. She is an active member of our community, often sharing her story to inspire others. Sarah's journey is a testament to the positive impact of free mental health therapy and the support it provides.

Agency: Flying Bagel
Program Name: Attachment Biobehavioral Catch-up Parent Coaching
$200,000

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?
While we did not quite meet our goal for clients served, we were able to nearly meet the goal, and we have developed relationships and referral pathways that have increased our referrals. We have also developed and refined our policies and procedures and will continue to do so in a way that improves and enhances our ability to provide ABC services to Kitsap families.

Briefly describe collaborative efforts and outreach activities employing collective impact strategies.
This quarter, we completed parent outreach sessions, partnering with other community organizations and sharing information on infant mental health and parent coaching. Mary Rose Dewald presented as part of a panel with the WA State Health Care Authority on assessment and evaluation in Infant and Early Childhood Mental Health. Mary Rose and Laura Daley both met with therapists in the community to share about services, and to identify additional referral sources.

Please describe your sustainability planning – new collaborations, other sources of funding, etc.
We have completed our BHA application and are waiting for this to be approved with minor changes. Once this application is complete, we will be able to provide non-clinical ABC staff with an Agency Affiliated Counselor license from the DOH and will be able to bill for additional services that will support the agency. We have also sought connections with funders and have identified additional grants that could be pursued and will continue to do so.

Success Stories:
One of our parent coaches, Erika Brende, worked with a family who initially began with very low parental sensitivity (scoring 2/5 on the initial assessment) and, after 10 ABC sessions, showed the highest score possible on the post assessment (5/5).

Agency: Kitsap Brain Injury
Program Name: Support Groups and Classes
$14,387

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?
At a high level, we accomplished the largest yet unspoken goal of providing an example of successful brain injury recovery. At the marginal improvement level, I think we underestimated our efficacy. Our survivors recovered better than anticipated, and about 95% do not drink alcohol or use illegal substances.
Briefly describe collaborative efforts and outreach activities employing collective impact strategies.
We began a wellness partnership with Project Access Northwest to provide our member-free pro-bono counseling services to our members. We are in the process of developing a collective outreach campaign for funding from Virginia Mason. Our in-house outreach and awareness campaign was a homerun.
Please describe your sustainability planning – new collaborations, other sources of funding, etc.
We have been working with DSHS to begin funding Washinton State Brain Injury support groups again and believe we are on the precipice. We designed a patient advocate program for the county and Olympic Community Health, but it seems the cost was too much.
Success Stories:
We had two members open businesses, which was a large-scale success. However, we noted the overall improvement across our survivors for beginning to take ownership of their realities.

Agency: Kitsap Community Resources
Program Name: ROAST
$557,800

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?
For Q4, we hired another case manager to assist with maintaining and expanding our current ROAST caseload. We expect our numbers, specifically for services in current quarter, to increase in the coming months. In Q4, KCR was able to assist 276 individuals throughout 200 unique households. 191 of these households were able to maintain their housing for at least one month after receiving rental assistance.
Briefly describe collaborative efforts and outreach activities employing collective impact strategies.
We have two ROAST Recovery Outreach Coordinators who regularly visit inpatient treatments centers in Kitsap County. We also have continued to work with partners, such as REAL Team, West Sound Housing Navigator Team, and the Salvation Army to ensure that all clients are properly assisted.
Please describe your sustainability planning – new collaborations, other sources of funding, etc.
Since hiring an additional case manager, we have greatly increased our capacity with FCS, and we are now billing at a much higher rate than in the previous quarter. We will be able to use the revenue we get from FCS to help maintain our employees and services.
Success Stories:
Client initially got kicked out of motel and returned to street homelessness. The client later went to jail for a period of time. After exiting the jail system, the client entered treatment and is now housed in West Sound housing. They have the opportunity to get a job through the wrap-around services provided to them. The client is making a lot of

progress and gaining a lot of tools for success.

Agency: Kitsap County District Court
Program Name: Behavioral Health Court
$433,762

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 Behavioral Health Court (BHC) program demonstrated significant progress during the current quarter exceeding all but one goal. It provided services to 37 program participants, and including the 4 graduates. 112 service referrals were made, ensuring participants had access to resources and support. The 34 active participants maintained stable housing, highlighting the team's dedication to addressing housing stability for participants. All participants who entered the program without housing found stable housing.

The program's efforts to meet its objectives are reflected in the recidivism outcomes. Among the 34 current program participants, there were no instances of reoffending this quarter. Additionally, none of the four participants who graduated within the past six months reoffended; only one graduate from the past 12 months reoffended this quarter.

Incentive use remains key to participant motivation. This quarter, 696 incentives were issued compared to 43 sanctions, achieving a ratio of over 16:1. This ratio far exceeds the All Rise therapeutic court best practice standards of 4:1, reflecting the program's emphasis on positive reinforcement and evidence-based practices.

The program continues to serve a high-risk/high-needs population, with all 15 participants who entered the program since January 1, 2024, scoring as high-risk/high-needs on the RANT assessment. This alignment with best practice standards ensures that the program targets individuals who can benefit most from intensive therapeutic intervention.

Participants continue to work towards reaching their vocational and personal goals. Of the six individuals striving to re-engage in vocational activities, four (67%) successfully met their objectives. Progress in other areas, such as re-obtaining driver's licenses, has been slower this quarter, with one of four participants achieving this milestone below the target rate of 60%. Notably, 20 out of 34 (.588) participants currently have their driver's licenses. The program continues to address barriers to success through individualized support and referrals.

Participant feedback suggests strong satisfaction with the program. Of the 10 participants who completed the exit survey year-to-date, nine (90%) reported favorable outcomes. Additionally, 60 out of 95 survey respondents (63%) reported favorable outcomes for their quality of life, reflecting the program's positive impact on participant well-being.

This quarter, the program saw no terminations or participant exits, further demonstrating stability and engagement. Four participants graduated from the program this quarter, bringing the total number of graduates since January 2024 to 10. These accomplishments demonstrate the BHC program's ability to support participants through completion while achieving strong retention rates.

The Behavioral Health Court continues to progress toward its goals, improving participants' outcomes and maintaining alignment with therapeutic court best practices.

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

Collaborative efforts to develop and maintain relationships with local community partners and agencies have been ongoing, focusing on strengthening partnerships and enhancing resources available to participants.

•Quarterly Retreat: On October 18th, the team attended a half-day quarterly retreat to discuss policies and program improvements. This retreat followed the WSADCP Conference, allowing the team to integrate insights gained from the event. The next quarterly meeting is scheduled for January 31st.

•Scarlet Road Partnership: A meeting was held with Scarlet Road to discuss bringing in additional resources for the THRIVE program, specifically addressing the needs of participants who have experienced exploitation.

•Kitsap County Drug Court Alumni-:Active participant at the Kitsap County Drug Court alumni business meeting to understand resource opportunities that participants have in the. We discussed how we would include BHC

into the existing Drug Court Alumni Projects like housing and events.
•Meeting with DVR: Ongoing efforts include scheduled discussions with the Division of Vocational Rehabilitation (DVR) to explore further collaboration and learn about vocational assessments and resources available for participants.
•Peninsula Community Health Services: reached out to PCHS to collaborate on how best to ensure participants can connect with a health care navigator to get insurance and primary care provider.
•Salish BHASO: Discussed getting a naloxone cabinet put into the courthouse to remove barriers to access of Naloxone and improve harm reduction practices. We also discussed crisis intervention services available in the community.
•Workforce Innovation and Opportunity Act Division: We collaborated with WIOA to learn about their programs and any opportunities they may have for Treatment court participants. The Act is designed to help job seekers access employment, education, training, and support services to succeed in the labor market and to match employers with the skilled workers they need to compete in the global economy.
•Engagement with other MH coordinators: Misty Griffith (Spokane District) visited to observe staffing and court proceedings, gaining insight into how the team utilizes staffing reports and conveys information to the judge. I also hosted a meeting with Rebecca Marriott from Jefferson County to discuss strategies for CJTA for participant incentives and information sharing about our SBHO
•Criminal Justice Training Commission Presentation: The treatment court team shared information about the Kitsap County District Court Behavioral Health Court and THRIVE program was shared during the 40-hour Crisis Intervention Training (CIT). This presentation highlighted collaboration with law enforcement and emphasized their role as a vital referral source.
•Partnership with Kitsap Mental Health Services (KMHS) and KITSAP Recovery Center (KRC): The leadership of the partner agencies met to strengthen collaboration, discuss program goals, and address shared participant needs. The goal is to have quarterly meetings. Both managers were invited to view staffing and court, and the scheduling is forthcoming.
•KMHS PACT/FACT Team; Pacific Hope Recovery; CTC; AIU; Trueblood – The KMH BHS have access to the mental health records and staff at KMH. They are present at the staffing table with updates and schedules. CTC and AIU have communicated with the BHS about participants. FACT and now PACT are active in emails, communicating schedules and appointments with BHC. Trueblood has been actively helping a new participant and collaborating with BHC to support the participants needs.
•Collaboration with MCS: The director of MCS, an agency that provides trauma therapy services, and I met to discuss program updates, address participant needs, and ensure alignment with program goals.
These ongoing meetings and collaborations reflect a strategic effort to build and maintain strong partnerships, increase awareness in our community about the Behavioral Health Court and THRIVE programs, and ensure participants have access to comprehensive resources and support systems.

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

We continue to take step to find sustainable income. This quarter, we contacted the Administrative Office of the Courts District and Municipal Courts Judges associations, contracted grant writers, and CPIN to identify funding that aligns with the courts' mission and is a sustainable income source. Additionally, we requested that the court's positions be added to the general budget.

Success Stories:

A behavioral health court participant who got out of inpatient treatment prematurely due to behavioral issues had some struggles to start this quarter, though he turned it around. Through getting accepted into Oxford housing, outpatient treatment, and getting a job, he managed well and flourished by the end of 2024. This participant was able to grow and reunite with his daughter. The daughter is 5 years old, and he had never been around her while sober before. Her mother moved back from California just before the holidays, supporting the father's and daughter's relationship. The participant was surprised and happy and could spend the holidays with his daughter and family. He was able to do all the family activities he previously missed out on in his active addiction. The court heard about and witnessed so much of it. Seeing such a new and previously troubled

participant do so well and reconnect with his daughter and family was truly inspiring.
A BHC participant joined us after recently serving 12 years of prison and getting a new charge. When he started BHC, he was released from jail with the team's support for stable housing and resources. He restarted his Medicaid and was working on his Medicare. He has Trueblood support in addition to KRC and BHC. He restarted his food stamps and monthly benefits. He got household goods and groceries along with medications. He completed his KRC intake appointment to start chemical dependency treatment. He started KMHS services and completed his intake. He has regained his bus pass and knows the routes to get to and from appointments. He started a paper and electronic calendar to organize his time and appointments. He got a phone that was new to him after his prison time. He learned the basic skills so he could call the liaison and staff. He restarted his housing payments with DOC for the remainder of his 6 months with them. Reentry is challenging, and he was overwhelmed at the start but stated, "This is why I was scared of time out. This is a lot and too much, and it's scary and nerve-racking. It's too much, just too much. I can't do this alone, and I realized after a few weeks that I'm not alone, and I have you (BHC Team member) and Casey(Trueblood). It's a lot, and I'm grateful for this and you."

Agency: Kitsap County Juvenile Court
Program Name: Enhanced Juvenile Therapeutic Court
$143,192

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?
Looking back on our evaluation results we met or exceeded our goals in all objectives. For the year 88% of participants completed or continued on in their programs, exceeding our goal of 75%. Our goal of a 4-1 incentive to sanction ratio is again far higher than expected at 14-1. This number is skewed a bit due to our Safe Babies and Family Treatment Courts not giving out sanctions like our other Therapeutic Courts. We may look to adjust this in the future. There were zero positive tests for designer drugs. With our Participant Satisfaction Surveys 82% or higher agree or strongly agree in all domains. At this time, we don't see a need to change our scope of work or evaluation.
Briefly describe collaborative efforts and outreach activities employing collective impact strategies.
We continue to collaborate with Peninsula Community Health Services so our clients and their families can receive free medical services. We also partner with Agape' Unlimited, Olive Crest, the OESD, Soroptimists of Bremerton, Kitsap Mental Health, and Catholic Community Services. All of which will provide services not only when the youth is on supervision, but long after they have left our jurisdiction.
Please describe your sustainability planning – new collaborations, other sources of funding, etc.
As we write about every year, we will not be looking to find a other "sustainable income sources". We will always raise and lower our ask based on the needs of our programs and the youth we serve.
Success Stories:
1. We were able to supply the 44 families associated with our therapeutic courts with Thanksgiving dinners.
2. We had a youth who recently graduated from one of our therapeutic courts who truly struggled when they first started the program. Problems at home with their family and at school with their grades and attendance, coupled with a substance abuse issue. He quickly adjusted to the courts and treatments expectations and finished the program in less than a year. Since completing the program, he spoke to his old treatment group and spoke to them about how he had turned things around. This has inspired two others to double their efforts in the therapeutic court.

Agency: Kitsap County Prosecuting Attorney
Program Name: Alternative to Prosecution
$395,862

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 Q4, we saw a large decrease in applications over both Q3 and Q4 from 2023. This did not affect the overall number of applications we received in 2024 vs. 2023, however. In terms of people applying, we screened a total of 239 people with 318 cases in 2024 vs. 249 people with 365 cases in 2023. Q4 does cover the holiday period where many are on leave, and we see a decrease in activity at the courthouse overall. The office of public defense also had a transition during this time frame in which they were in the process of splitting into multiple divisions. The acceptance numbers from year to year remained consistent from 2023 to 2024, varying by only a couple of people. I predict there will be an influx of new applicants with the new year though, as the number typically rises in Q1 and Q2.

In Q4, we were able to decrease the time from review to entry and application to entry by two days this quarter. While the time from application to review average went back to four days, we are still within our target. In reviewing the stats compared to 2023, we were able to significantly reduce the time from review to entry and application to entry by nearly 30 days overall. We did have a transition of attorneys in the TCU in 2024 and we made it a goal to try and have potential participants screened and entered as quickly as practicable given the data learned at conference about making a quicker process from application to entry.

Finally, Q4 did see a decrease in graduations from our programs, which can be attributed to varying entry dates of participants and completion dates. We also saw a decrease in terminations from our programs, only terminating five participants in Q4. Overall, the graduation numbers in 2024 vs. 2023 showed a significant increase from 58 to 72 in 2024. The biggest increase was in people completing our felony diversion program and in our BHC program, which saw a total of 12 graduates in 2024 compared to 2 in 2023! We are hoping to continue this success rate in 2025.

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

For Q4, while I often focus on outside organizations, I wanted to highlight the collaborative efforts of our individual teams that make everything within these courts work, especially during times of transition. Q4 saw the absence of a key team member in drug court, requiring several members of the team, including the prosecutor, step in to make sure everything continued to move smoothly. The drug court team also saw new treatment counselors replace outgoing treatment counselors from West Sound and KRC. The entire team worked together to welcome these new members and ensure a smooth and easy transition for the participants.

An additional collaboration to highlight is BHC working with a company to potentially implement a medication locking device program to ensure participants are taking their prescribed medications appropriately. This is helpful to the program as it avoids participants abusing their medications and allows for better monitoring to ensure that the participants are stable.

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

We continue to make efforts to find other ways for income to support the TCU, but given budget cuts across the State and County, this will continue to prove difficult. Additionally, the recent federal grant funding freeze has affected our Veteran's Treatment Court. Finding grant funding, especially for a prosecutor's office, will continue to prove difficult.

Success Stories:

Q4 saw four graduates in BHC. One in particular highlights the importance of these programs.

One particular graduate of BHC in Q4 had a recent history of criminal activity and struggles with competency issues. By admitting him into BHC, maintaining proper use of prescribed medications, he was able to stabilize and successfully graduate the program. Another graduate is someone who struggled with the rules and boundaries set by the court at the outset, but by the end of the program, he had become a mentor to others in the program. He is continuing to assist those in the program become successful as well.

We also had four graduates from drug court in Q4. A common theme across the graduates was that participating and completing the program has led to a reunification of their family. Whether it was reconnecting with estranged parents or getting custody of their children back, this group of four was able to achieve the goals of reconnecting with a family. Prior to drug court, they previously ignored or drifted away from them due to their addiction and have been able to show them they can be successful and productive members of society.

Agency: Kitsap County Sheriff's Office
Program Name: Crisis Intervention Officer
$158,635

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 expected, I noted fewer overall contacts/interventions during final quarter 2024. I was unavailable for Crisis response and/or planned intervention/s during this final reporting period due to vacation, sick leave for several unexpected family medical event/s, hosting CIT 40-hour (weeklong training), CJTC (Academy) training/s, etc. Factoring my absences, I don't feel objective/s were unmet.

I'm satisfied presently with current method/s of tracking/documenting progress on objectives. At the beginning of 2024's reporting, I linked with Hannah to review/modify my (CIC) evaluation to rid identified redundancies i.e., tracking irrelevant information. This modification allowed for more simplistic day-to-day tracking of CIC progress/objectives.

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

Recently I met with KCSO leadership during strategic planning for 2025 which also includes forecasting 1-, 2-, and five-year program goals. One important adjustment to CIC's responsibilities is case review and assignment; as CIC, I voiced concern with having any/all report/s with behavioral health nexus being routed to me (CIC) for review for purpose of identifying cliental i.e., citizens presenting with behavioral health dx/s and who are identified as higher utilizers of 911/Jail/Hospital/Fire-Aid/etc. This has been changed to system where CIC is notified by leadership (Patrol) who's highest utilizers warranting CIC's attention and dedicated time for follow-up alongside behavioral health partners.

*The primary behavioral health partner is the Crisis Response Team aboard Kitsap Mental Health. I've been fortunate to have great partnership with crisis-responder (Designated Crisis Responder/DCR) Kathy Mobilia whose experience, and consultation always proves valuable during evolutions of Crisis intervention.

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

As CIC, my position presently is funded through 1/10th sales tax. I've yet to be tasked with identifying other income sources. Presently, I'm the sole Crisis Intervention Coordinator (CIC/Deputy) with KCSO, while strategic planning forecast's five-year goal of adding another CIC Deputy. Currently, as sole CIC, I work four days a week (Mon-Thurs; 10-hour shifts). KCSO's Patrol Division has two teams (green/gold) which by adding a second CIC position, would provide better continuity, coverage, and/or awareness of clients/circumstances warranting co-response i.e., behavioral health resolutions pursuant RCW 71.05, RCW 71.34, RCW 10.31.110, etc.

Success Stories:

*67-year-old male, Military Veteran, Naval Shipyard retiree, lived in Navy Yard City alone after wife died several years prior, known to have co-occurring behavioral health dx/s; as CIC, I contacted this citizen countless times since 2021 - Nov 2024, as he was one the counties highest utilizers of emergency services not limited to Kitsap/911, St. Michael's and St. Anthony's Medical Center/s, South Kitsap Fire/Rescue (CARES Team/s), Kitsap Mental Health (MCOT/DCR's), Salish Regional Crisis line (VOA), Veteran's Crisis Line, KCSO, etc. As CIC, I along with Crisis Responder K. Mobilia, have spent countless hours with this citizen in his home both for 911/Crisis response and follow-up investigation/s for numerous incident/s involving suicidal and homicidal threat/s with weapon/s involved/mentioned. With assistance from South Kitsap Fire/Rescue CARES Team (J. Goss, J. Moran), after this citizen's exhausted local resources with 911 event/s increasing, exhaustive effort/s led to the citizen

receiving ambulance ride/s to Seattle Veteran's Hospital where case management and care coordination would initiate. This citizen would leave against medical advice on several occasions after such great efforts were taken to transport him to Seattle VA as non-critical patient. This citizen has since been reunited with family and has relocated away from an environment that proved toxic for him i.e., 911 events involving neighbor with weapon/s, arrest/s, detention/s, home-neighbor-landlord disputes, landlord-tenant legal matter/s, local criminal case, etc. Many messages had been left for various family members in Washington State and California over past couple years; his daughter reunited and relocated to another county in Northern Washington where her father has new housing within close proximity to VA Center/s where he's more committed to substance abuse and PTSD treatment/s.

*12/18/2024 911/Assist for Bremerton Police with 57-year-old male who'd eloped from St. Michael's Medical Center. Bremerton Police had just transported/hospitalized after DCR evaluation resulted in revocation/detention pursuant RCW 71.05. I was in immediate vicinity of the hospital when CenCom dispatched the males last location nearby Lowe's. Alongside a familiar patrol sergeant, quick rapport was established allowing for seamless transport back to the hospital while ultimately avoiding harm to the citizen, responder/s and avoiding unnecessary use of force application/s.

*During Q4 (11/19/2024), as KCSO CIC and CNT (Crisis Negotiator Team) member, I responded with numerous KCSO Patrol Deputies to area of Madrona Day School (3733 W Loxie Eagans Blvd) after Kitsap/911 was alerted by reporting party, Child Protective Services worker, of a suicidal 14-year-old male student who'd just fled from the day school. Details provided by reporting party: "Almost jumped off bridge", "Family issues is the cause", "Now standing in middle of street wanting to get hit", "Now walking towards bus stop", "Family not aware of 911 call", "He's been staying on the streets", "I'm going to chase after (law enforcement) them with a knife and get myself shot and killed", "He will not cooperate with law enforcement", etc. I (CIC) linked with the on-scene supervising Patrol Sergeant while other Deputies began containment of perimeter area; it was decided I, as CIC and CNT member, would communicate/negotiate initial contact with the juvenile male. Immediately upon arrival, the juvenile fled i.e., he sprinted across the busy roadway into residential area penetrating containment. Deputies pursued him on foot for several minutes and successfully prevented him from reaching Highway 3 overpass/bridge. After roughly five minutes of maneuvering and redirecting his direction of travel, we corralled the young male within busy intersection of Loxie Eagans/National Ave. Although outnumbered/outweighed, the juvenile insisted on fighting/resisting detention. We'd already coordinated medical aid (ambulance) response to stage for hospital transport. Once we had safe control of the juvenile, medics were summoned, and he was safely transferred from handcuffs to hospital bed/gurney where soft restraints were applied. Despite his high level of aggression and emotional disturbance, once on the ambulance, he settled enough to allow some dialogue with law enforcement which mentioned, "He made it clear he didn't want his mother or father contacted because they are not actively a part of his life". This statement along with other learned information, was immediately shared with CPS on-scene as well as hospital social worker/s (in-person and via written documentation). This incident listed as good news without factoring post-detention outcome/s i.e., HIPPA often prevents information sharing after citizen's admitted to a triage facility (SMMC). This incident is an example of Deputies utilizing patrol tactics to increase overall likelihood of safe outcome/s. Furthermore, once the juvenile was safely in KCSO's custody, responder/s seamlessly switched to compassionate caretaking role/s alongside medical personnel with SKFR.

Agency: Kitsap County Sheriff's Office
Program Name: Crisis Intervention Training (CIT)
$22,500

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 only held /40 hour CIT that CJTC wanted us to out on. We have been having them fund that course, since they have the funds at this point to do so. We did hold an advanced de-escalation, two of them, and were able to get approximately 75 people through. The class was well received and taught a lot.
Briefly describe collaborative efforts and outreach activities employing collective impact strategies.
We continue to collaborate with all of the agencies in the county to make sure their training needs are met as far as CIT classes. We also collaborate with CJTC working on getting classes set up and also paid for by them. Finally, when we do schedule these classes locally, we make sure that all of our local treatment providers are part of the training session so they can educate the class attendees on the services they provide.
Please describe your sustainability planning – new collaborations, other sources of funding, etc.
We try and lessen the amount of money we spend by using the funds from CJTC. With budgets at "status quo" the money allocated towards training has not increased, despite the need for this mandated training.
Success Stories:
Just one of many examples of the good work patrol does healing individuals that are in crisis. Central units were dispatched to missing 12-year-old female with suicidal ideations. The child was last seen on video surveillance leaving the campus of Ridgetop Jr High after school counselor contacted her regarding self-harm cuts all over her arms. The school told her they would be notifying her mother. The child was upset over this and left the campus at approximately 1235 (today was a half day) Several Search and Rescue deputies were consulted and as patrol was arriving at the child's residence she was located hiding in the woods. She was transported to St. Michaels as she reported she wanted to hurt herself.

Agency: Kitsap County Sheriff's Office
Program: Reentry Program
$221,094

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 surpassed the numbers expected and we continue to see the success of the people we are helping. Approximately 40%, 163, people we connected to reentry services, 413, returned to jail.
Briefly describe collaborative efforts and outreach activities employing collective impact strategies.
Below is all the collaboration we do.
New Start (Referrals and coordination)
Mat Screens/Referrals/coordination
KMH-Trueblood (Referrals and/or coordination)
KMH-Jail Services Referrals only until Nov 6th then only coordination)
KMH-Peer Pathfinder Referrals
KMH-Forensic Programs (OCRP, FPATH, FHARPS) Referrals and other coordination
Road To New Beginnings (formerly Welcome Home) Referrals (coordination for those already on their program will also be counted)
Coffee Oasis (Referrals and Coordination)
Veteran Services (Referrals, phone calls, resources and coordination for the veteran)
P-Cap (Referrals and/or coordination)
KRC (Referrals and/or coordination)
Agape (Referrals and/or coordination)

DSHS in jail paperwork done with them and faxed for food/cash/HEN benefits
Housing Solutions: Paperwork done with them and faxed to prepare for housing assistance upon Release and/or helped with placement at shelter (facilitation of phone interviews for housing with benedict. St Vinnies, Georges House, Rescue mission Eagles Wings etc.)
Scarlett Road (Referrals Only as there is weekly visits and/or coordination)
REAL Program (Referrals and/or coordination)
West Sound-Supportive Housing & Behavioral Health Liaison Services
Tribal Wellness (PGST & Suquamish for assessments and other assistance)
Coordination with MCO's (United Health, Molina, Coordinated Care, CHPW, WLP) & HCA
Peninsula Community Health Services (Referrals)
North Kitsap Recovery Resource Center (gave info/business card per their request or if a person we screen lives in NK)-As of Sept they are visiting
YMCA (Referrals and/or coordination)
WorkSource Referrals/coordination/visits
Common Street (coordination)
Pre-releases/Release Planning food/shelter/work/education/COVID-19/Transportation/insurance/phone/appointments (discussed how to access the resources).

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

Our general fund budget for 2025 did not include adding any new additional positions, so we do not have the funds to keep these positions unless they are funded through the 1/10th. That is why it is important to track the data and show the success of these positions that support the reentry providers that come into our facility.

Success Stories:

Male – Age 36
He was first booked at Kitsap County Jail at the age of 19 during 2006. Since then, he has been booked at KCJ 24 times. His crimes range from Malicious Mischief, FTA's, Failure to Comply, Indecent Exposure, Escape from Community Custody, Assault 4, Use of Drug Paraphernalia, Criminal Trespass 2, and Protection Order Violations. Kitsap County Jail Reentry has met with him numerous times. The first connection was in October 2020, then early 2021 and mid-2023.
During his last incarceration he was here for 3.5 months and KCJ Reentry met with him in March of 2024. He wanted to switch treatment providers and was referred to Agape. He is in Drug Court and still actively enrolled at KMH.
Pre-Release Reentry Services: We provided resources for food, cash, work, school, housing, and agape real team. His paperwork was completed and faxed to Housing Solutions.
Post Release: He released from Kitsap County Jail mid-April for a local in-patient treatment facility. His United Health Care Jail Transition Coordinator got him some clothing and a backpack for treatment. She coordinated with the compliance office and dropped off the bag for him
Update from Agape Unlimited – Treatment
He has been living at Agape Housing, enrolled in IOP, doing well in Drug Court, and in compliance with everything required of him.

Agency: Kitsap County Sheriff's Office
Program: POD
$350,000

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 reported prior, we decided not to open the pod because of the difficulty of open positions, and the continual challenge of filling the positions. Our reentry team still did a great job. This year we surpassed the numbers

expected and we continue to see the success of the people we are helping. Approximately 40%, 163, people we connected to reentry services, 413, returned to jail.

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

New Start (Referrals and coordination)
Mat Screens/Referrals/coordination
KMH-Trueblood (Referrals and/or coordination)
KMH-Jail Services Referrals only until Nov 6th then only coordination)
KMH-Peer Pathfinder Referrals
KMH-Forensic Programs (OCRP, FPATH, FHARPS) Referrals and other coordination
Road To New Beginnings (formerly Welcome Home) Referrals (coordination for those already on their program will also be counted)
Coffee Oasis (Referrals and Coordination)
Veteran Services (Referrals, phone calls, resources and coordination for the veteran)
P-Cap (Referrals and/or coordination)
KRC (Referrals and/or coordination)
Agape (Referrals and/or coordination)
DSHS in jail paperwork done with them and faxed for food/cash/HEN benefits
Housing Solutions: Paperwork done with them and faxed to prepare for housing assistance upon Release and/or helped with placement at shelter (facilitation of phone interviews for housing with benedict. St Vinnies, Georges House, Rescue mission Eagles Wings etc.)
Scarlett Road (Referrals Only as there is weekly visits and/or coordination)
REAL Program (Referrals and/or coordination)
West Sound-Supportive Housing & Behavioral Health Liaison Services
Tribal Wellness (PGST & Suquamish for assessments and other assistance)
Coordination with MCO's (United Health, Molina, Coordinated Care, CHPW, WLP) & HCA
Peninsula Community Health Services (Referrals)
North Kitsap Recovery Resource Center (gave info/business card per their request or if a person we screen lives in NK)-As of Sept they are visiting
YMCA (Referrals and/or coordination)
WorkSource Referrals/coordination/visits
Common Street (coordination)
Pre-releases/Release Planning food/shelter/work/education/COVID-19/Transportation/insurance/phone/appointments (discussed how to access the resources).

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

Our general fund budget for 2025 did not include adding any new additional positions, so we do not have the funds to keep these positions unless they are funded through the 1/10th

Success Stories:

Male – Age 36

He was first booked at Kitsap County Jail at the age of 19 during 2006. Since then, he has been booked at KCJ 24 times. His crimes range from Malicious Mischief, FTA's, Failure to Comply, Indecent Exposure, Escape from Community Custody, Assault 4, Use of Drug Paraphernalia, Criminal Trespass 2, and Protection Order Violations. Kitsap County Jail Reentry has met with him numerous times. The first connection was in October 2020, then early 2021 and mid-2023.

During his last incarceration he was here for 3.5 months and KCJ Reentry met with him in March of 2024. He wanted to switch treatment providers and was referred to Agape. He is in Drug Court and still actively enrolled at KMH.

Pre-Release Reentry Services: We provided resources for food, cash, work, school, housing, and agape real team. His paperwork was completed and faxed to Housing Solutions.

Post Release: He released from Kitsap County Jail mid-April for a local in-patient treatment facility. His United Health Care Jail Transition Coordinator got him some clothing and a backpack for treatment. She coordinated with the compliance office and dropped off the bag for him
Update from Agape Unlimited – Treatment
He has been living at Agape Housing, enrolled in IOP, doing well in Drug Court, and in compliance with everything required of him.

Agency: Kitsap County Superior Court
Program Name: Adult Drug Court
$636,409

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 worked with 135 participants this quarter.
-39% or 53 participants have received Mental Health treatment this quarter.
-3% or 4 participants were graduated this quarter.
-4.4% or 6 participants were discharged this quarter.
-45% or 61 participants have received MAT this quarter.
-100% of all program participants have met with our Ed/Voc Navigator within 90 days of admission into the program.
Briefly describe collaborative efforts and outreach activities employing collective impact strategies.
The Treatment Court Manager met with HIDTA staff to discuss drug trends in Kitsap County and will continue to collaborate to learn about the latest drug trends effecting our community.
The Adult Drug Court will be partnering with West Sound Treatment Centers and Agape to deliver DV MRT. DV treatment is scarce in Kitsap County, so this is extremely helpful to all County residents who require DV treatment.
Please describe your sustainability planning – new collaborations, other sources of funding, etc.
No funding opportunities have presented themselves this quarter.
Success Stories:
Upon graduation, a participant received employment at the Bremerton Food Line as the Food Bank Manager. Our Alumni Association just opened a sober home for men and children.

Agency: Kitsap County Superior Court
Program Name: Veterans Therapeutic Court
$85,775

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 13 participants enrolled this quarter, and 2 new admissions.
-We had 0 discharge this quarter.
-We had 1 person graduate this quarter.
-100% of program participant are screened using ASAM criteria.
-100% of all participants who screened as needing SUD treatment and were placed in treatment within 14 days of admission.
-100% of program participants' treatment plans are updated every 90 days.
Briefly describe collaborative efforts and outreach activities employing collective impact strategies.
An MOU was signed between the Court and the VAMC American Lake and VAMC Seattle. This document clearly outlines and defines expectations around our collaboration.

Please describe your sustainability planning – new collaborations, other sources of funding, etc.
No funding opportunities have presented themselves this quarter.
Success Stories:
Our Veterans are now welcome to join our alumni association. They came to the drug court Holiday party and will participate in sober sporting events our Alumni group sponsors. Our Vets now also attend Adult Drug Court graduations.

Agency: Kitsap Homes of Compassion
Program Name: Housing Supports
$300,000

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?
It has taken most of the year to recruit a full time counselor, but we were successful in hiring a licensed professional counselor. Our outreach work at the North Kitsap Recovery Center has been going well. We have become a significant and viable resource for the Center. We are well on the way with stabilizing our counseling services and anticipate groups starting in early February 2025.
Briefly describe collaborative efforts and outreach activities employing collective impact strategies.
I mentioned above the work we have been doing with NKRRC. We have continued our work with the KRC, KCR, KMH and Peninsula Health.
Please describe your sustainability planning – new collaborations, other sources of funding, etc.
Now that we have our team, we have all of our licensing information and will begin concrete efforts to become credentialed and contracted for services. We hope to be able to provide billable services in March 2025.
Success Stories:
We have multiple success stories. One such story is related to an African American gentleman, 55 years old that is confined to a wheelchair. We have been able to assist him with obtaining long term housing and maintain his mental health services through our team.

Agency: Kitsap Mental Health Services
Program Name: Pendleton Place
$200,000

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 continue to provide supportive services to residents at Pendleton Place. We have 45 of 69 residents engaged in MH care, 5 of 69 engaged with SUD Tx, and 61 of 72 engaged with PCP. We have met all objectives this quarter.
Briefly describe collaborative efforts and outreach activities employing collective impact strategies.
We have worked with Bremerton Foodline to get senior commodities delivered, PCHS provides PCP services in our building, Kitsap Harvest is a community partner, but their donations have reduced significantly due availability. We continue to work with Bremerton Housing Authority as our property manager and to assist residents to move into an outside rental with housing choice vouchers after they move on from Pendleton Place. We also partner with MPSS Security to ensure safety on our property. We are working with Kitsap County Extension SNAP-Ed Program to coordinate a safe food handling and cooking class.
Please describe your sustainability planning – new collaborations, other sources of funding, etc.
We continue to seek funding by applying for all grants we qualify for. We also continue to obtain reimbursement through Foundational Community Supports for providing housing support services to qualified individuals. We have sought and gained CIAH funds for Pendleton for 2024 calendar year. We had applied for Balance of State,

we were recommended to receive it, but they did not have enough funding for all projects they wanted to fund for the year. We are waiting to hear the results of the Housing Trust Fund-Permanent Supportive Housing and Operations Maintenance Supports funding application that has been submitted.

Success Stories:

We had a resident who had been experiencing homelessness for 25 years and had been a part of the Kitsap Connect Program which provided case management services to the most vulnerable population which were high utilizers of medical services. He had been housed in other housing programs but had not been successful due to behaviors that were exacerbated by a traumatic head injury. He came to live at Pendleton Place when we first opened. During his stay here he began seeking medical attention for many conditions including his heart. Staff was able to provide support by providing reminders about his medical appointments, help him pick up medication and for transportation to appts. He did struggle while he was here with behaviors that violated the lease, was not paying rent and had faced an eviction. He was able to advocate for himself with a lawyer from Kitsap Legal and get reasonable accommodations for reminders to put his belongings away so that he was not constantly getting lease violations. He attended SUD treatment while he lived here as well. He was able to get back into compliance with his lease and requested a Section 8 Housing Choice Voucher so that he could move on from Pendleton and find a private rental. He was able to secure the rental and has moved out on his own. He still visits some of the residents here at Pendleton Place. He had reported wanting to become a peer support professional to help others who had been in his situation.

Agency: Kitsap Public Health District
Program Name: Nurse Family Partnership
$190,000

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 team has had a bumpy transition over the past few months within the administrative framework. The long-term manager retired. A nurse internal to the team was mentored into the management role and a new NFP nurse was hired as her replacement. The new manager needed to take an unanticipated 2 month leave of absence and then found that she would not be able to commit to the program and so resigned. The program is currently co-managed by the Director and the District Administrator and the supervisor (returned from maternity leave). The NFP team continues to function meeting all of its fidelity requirements. The newest full time NFP nurse has progressed to a caseload of 12 and continues to be an incredible asset to the clients that she serves as do the other two NFP nurses.

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

1) We have partnered with the county libraries in order to provide our Mama Moves support group throughout the rainy winter months. We have further partnered with individuals who have provided programming around Baby Yoga and Baby Massage.

2) We have facilitated the Perinatal Clinical Leadership Collaborative in collaboration with the Family Center Director at our local hospital, St. Michaels. A group of selected obstetricians, nurse practitioners, midwives, doulas, primary care providers, mental health specialists, social workers, and our U.S. Naval partners now meet quarterly to work through issues within our community that are current and/or to address issues presented in our most recent Community Health Assessment.

3) We have contracted with the Suquamish Tribal Nation such that beginning in March, they will have an NFP nurse who will be supervised by the KPHD NFP supervisor. We are all thrilled with this partnership.

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

We have diversified the sources of our income. We are currently developing a plan to propose/establish a Child First (or similar) tax that may serve to provide sustainable long-term funding.

Success Stories:

Nurse Story (Names Changed)

Story1: Used for 1/10th January 2025

"He's so clingy to me", said Suzy at a Nurse-Family Partnership visit, in reference to her toddler son. "He sees you meet his needs with love and patience and knows he can turn to you", said Nurse J.

"I'm such a bad mother; I don't know what to do when he's fussy", said Suzy. Nurse J then shared how 10 minutes ago she observed Suzy provide distraction to her child in a moment of fussiness, with books and toys. "I did that" reflected Suzy"; "you did that" reflected Nurse J.

These snapshots in parenting come after an almost 2 year partnership with Suzy and her nurse, where they have navigated challenges related to her social anxiety, substance use, mental health, and relationships.

In partnership, Nurse J and Suzy explored Suzy's many strengths, allowing those to become a larger and larger part of her story, rather than her early experiences of abuse and trauma, which had led to her use of substances from her teenage years, and presented in mental health challenges.

Together, pulling in PCAP and behavioral health services along the way, they've met regularly to address the goals and dreams she has for herself and for her child.

Now, supported by a medication regimen that meets her needs, and continued conversation with her nurse about how she talks to herself, Suzy notes that she's being kinder to herself in her thought life. Step by step she has built up her capacity to go from fearing walks around her neighborhood, to adding titles of driver and employee in the behavioral health system.

Suzy reflects on how her "all day every day" vaping and regularly marijuana use has been reduced to 1 time each night after her child has gone to bed. Keeping in mind a conversation they'd had about how parents are not able to see their baby's needs if they're using substances, rather from a lack of love, she notes, "I don't want it to get in the way of taking care of my baby".

Agency: Kitsap Recovery Center
Program: Person in Need ~ PIN
$242,335

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 "one-two punch" of having 2 people work on these things has been very useful. With one doing all of the legwork and another doing admin and resource collection, we were able to better serve some of our most fragile community in more dynamic ways.

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

The tactic we have adopted of not offering services up front has been working well. We establish a relationship with people and allow them to come to us for services on their own terms. this is how we are getting some of the hardest to reach clients out there.

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

We continue to search for more funding opportunities and collaborations. There was a great meeting with a clean and sober house in Pierce County that wants to work with our people who want to relocate and they have internal and established funding sources of their own. This just happened, so we haven't had a chance to work with them yet, but we look forward to trying them out to make sure that they are who they claim to be. Our clients deserve the best we can get them.

Success Stories:

We've been fortunate to have a wonderful alliance with St. Michael Medical Center this year. Quite often we receive a call from their social workers, letting us know that they have a patient interested in going to substance use treatment, and we immediately go to work to secure a door to door facility transfer whenever possible. What's extraordinary about our November success story is not only the outcome for this gentleman, but also the beautiful teamwork between St. Michael and KRC inpatient staff. After completing a bedside assessment on a

Tuesday, our clinical team and medical director reviewed this request for admission, the hospital sent their records, and we were able to confirm an admission to our inpatient treatment program for Wednesday morning. Even better than our wonderful agency teamwork here, was this patient, and his commitment and dedication to making a big change in his life at this time. He was so responsive to our offer of help and support, and we regularly heard updates from his counselor about how well he participated in treatment. He moved directly into sober housing and immediately started going to outpatient treatment and is continuing to do well now.

Agency: Kitsap Rescue Mission
Program Name: On site Mental Health Services
$260,694

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 we prepared for our move to our new shelter location in Port Orchard, we discontinued taking new intakes into shelter as folks transitioned out into permanent housing in the 4th quarter because the Quality Inn allowed us to serve 110 folks however, the new building accommodates 75. We wanted to ensure that no one was returned to homelessness during our transition. As a result, the direct service hours of our SUDP and LMHC went down in the 4th quarter as anticipated. We have successfully moved our entire shelter operations to our new location and anticipate ramping up our intakes into shelter and the direct services provided by our SUDP and LMHC again during this first quarter of 2025.
Briefly describe collaborative efforts and outreach activities employing collective impact strategies.
Our collaborative efforts are ongoing. We continue to utilize and expand our community partner organizations to leverage critical services to our shelter guests. At our new location, Kitsap County, PCHS, KPHD, KARE (Kitsap Animal Rescue and Education), MCS Counseling, Agape' Unlimited, KHOC, Eagle's Wings, Bremerton Housing Authority, Skookum, and many others are engaged at the facility and are contributing to the care, stabilization, well-being, and self-sufficiency of our shelter guests.
Please describe your sustainability planning – new collaborations, other sources of funding, etc.
We continue to analyze funding trends and have a comprehensive fund development plan in place. We rely on diverse resources including community donations, grants, and calls to action to help support the organization and its operations. We provide ongoing communications, volunteer opportunities, and donor cultivation and stewardship to continue growing our resources.
Success Stories:
Rachel, a single mother with 2 small children was struggling to get and stay sober and was thrown out of a family members home due to her addiction. The KRM SUDP was able to build rapport with her, completed an assessment and got her engaged in outpatient treatment. Meanwhile, the guest was able to meet in real time for 1:1 sessions with the SUDP for additional recovery support while in shelter. The guest and her children became stabilized and with additional support from the KRM Housing Navigator, the guest was able to secure a Housing Choice Voucher and 2 bedroom apartment which she and her children transitioned into successfully. She continues to connect with the SUDP and her KRM Case Manager and reports she is still sober, and she and her children are doing well.

Agency: Olympic Educational School District 114
Program Name: In Schools Mental Health Project
$600,000

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 projected number of elementary, middle, and high school students served is 407 for the grant cycle; to date, 702 students (252 elementary, 237 middle school, and 213 high school) have been served. In addition to the 702

students served, staff reported 661 drop-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.

Professional Development for Schools:

OESD provided CARE Suicide Prevention Training. Compassionate Assessment and Response in Education was developed to meet the requirements for certificate renewal for school counselors, school psychologists, school nurses, and school social workers in Washington State and is offered 2-3 times throughout the school year. The training provides an overview of the prevalence of suicide, warning signs, risk and protective factors, prevention education, and intervention, including screening and safety planning, and postvention supports. Nine school staff attended.

Crisis Counseling Response:

The OESD coordinates and responds to tragic incidences that impact a school (i.e. car accident resulting in death of a student/students, suicide, drug overdose, death by violence). For this quarter, the OESD provided support to two days at a local high school following the death/homicide of a student.

Committee Work:

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

In addition, the Student Services and Support Department worked with Kitsap County Substance Abuse Prevention and Youth Services to obtain opioid prevention materials which were distributed all secondary schools in the county.

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

The OESD and KMHS continue to work collaboratively to look for and write, when eligible, for other grants that support this work; and are working collaboratively with other ESD's to seek other funding through state prevention and intervention funding.

We continue to leverage funds through:

- School district match; and Medicaid match
- Funding received from the HCA-DBHR (KHS, BREM HS for 2024-25 school year).

Unfortunately, we were not awarded the Department of Education Federal grant that was submitted in partnership with the nine ESD's across the State.

Success Stories:

Secondary Program:

1. The Student Assistance Professional (SAP) is working with a student who has experienced many ACEs in their life. Over the summer, the student gravitated towards unhealthy coping strategies. During the most recent meeting, the student shared they had followed up on a mental health counseling referral made by the SAP. The student is now participating in mental health counseling services and has decreased their nicotine use and feels more stable with their moods.

2. The Student Assistance Professional (SAP) was referred a student for possible substance use whom they had worked with the year prior. During their first meeting, the student shared that he was ready to learn more strategies on how to cope with stressful situations, identify goals, and ways to decrease his use. The SAP is now teaching him skills to support his decision to remain substance-free and different coping skills to manage stressful situations.

3. The Student Assistance Professional (SAP) is working with a student who was referred for substance use. The SAP recommended the student seek outpatient mental health counseling, complete a chemical dependency assessment, and join their intervention group. The student expressed that he wasn't ready for counseling or to decrease/quit using but agreed to join the SAP's intervention group. During the most recent meeting, the student was able to make small attainable goals, has been engaged in the group, and shared that he's ready to quit using marijuana. The student still has a lot of work to do but expressed that he's hopeful that he can quit using it with the support of the SAP.

Elementary Program:
1. The Mental Health Therapist (MHT) was referred a student for being disruptive in class and unable to sit still, having lots of fights with peers at school, and escalating quickly when angry, often cussing and throwing things. The MHT worked with the students' family to get him assessed for ADHD and worked with school staff to implement interventions that would support his focus and emotional regulation in class, like planned movement breaks regularly throughout the day, the use of fidgets, and a kick band for his chair at his desk. The student also had experienced domestic violence between his parents and often expressed negative self-talk saying things like "I'm the worst" or "I'm so stupid". The MHT helped the student process his trauma and express his feelings about what he had experienced in his past. The MHT also worked with the students' teacher to provide lots of praise and positive reinforcement for any positive behaviors displayed in class. Since the beginning of the year, the student's teacher reports he is now staying at his desk and engaging in schoolwork much more often, with decreased angry escalations and conflicts with his peers. The student often reports he's having great days and is now regularly able to identify positive affirmations he can practice about himself, often says things like "I am smart".
2. The MHT referred a 6-year-old student who was in kindergarten and was having trouble transitioning, demonstrating poor impulse control and following directions in the classroom consistently. The student's mother has mentioned that he doesn't do well when he loses games and has often been labeled a "bad kid." From observation, the student appeared to have low self-esteem, poor decision-making, and unexpected behaviors in the school setting. The MHT worked on improving confidence, self-esteem overall, and control over oneself/actions. The MHT sent out resources to the family, including ways to practice controlling his body at home, and worked closely with the teacher to help with various incentives and classroom jobs to increase the confidence and role he has in the classroom setting. Per parent and teacher reports, classroom jobs, playing games at home, and earning stars have increased expected behaviors and raised overall self-esteem.

Agency: One Heart Wild
Program Name: Animal Assisted Therapy
$62,224

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 exceeded our goals with the number of clients and sessions offered through scholarship funding provided by this grant. We are very grateful to have this support available for our community members who need it to access care.
Briefly describe collaborative efforts and outreach activities employing collective impact strategies.
We have increased our connections with medical providers, especially pediatricians and psychiatrists who can offer a higher level of care for evaluating complex youth needs and managing medication. We have also established warm hand off relationships with two inpatient programs for youth who need that level of care.
Please describe your sustainability planning – new collaborations, other sources of funding, etc.
Our primary efforts have been the continuation of getting therapists paneled with insurance companies in our area. We have made great progress this year towards this goal. Unfortunately, it just takes a lot of time, red tape, and waiting due to backlogs on their end.
Success Stories:
I would be happy provide a client story with pictures as needed.

Agency: Scarlet Road
Program Name: Specialized Rental Assistance
$100,000

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 Quarter 4, Scarlet Road served 26 survivors of sexual exploitation through robust, wraparound case management, totaling 35 survivors served in 2024. Through this grant funding in quarter 4, one survivor was able to maintain safe housing and two survivors were able to receive life-saving and empowering emergency housing support. One survivor, in particular, was able to leave a life of sexual exploitation because of this financial assistance.

In 2024, 91% of Scarlet Road participants engaged in therapeutic services and 71% accessed employment services. Seven male participants worked through the aftercare program, and one of these men graduated in the Spring. Scarlet Road offered 4 groups in Q4 and saw 74% of participants engage in facilitated groups and group programming in 2024. This winter, Scarlet Road hosted the largest peer event of the year which facilitated community connection, provided gifts for survivors and their families during Christmas, and fed about 70 people. Mobile advocacy, connection with community resources, and assistance in navigating complex systems were offered to each client.

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

Due to the success, we have seen identifying and serving victims in incarceration spaces and the trust built with leadership and administration, in Quarter 4, Scarlet Road assisted in implementing another layer of identification and support in the Kitsap County Jail through the use of an additional screening tool. This tool is being used in the Classifications unit which screens ALL people coming into the jail. It is a self-administered tool that, once completed, can render support from Scarlet Road advocates.

Through the screening tool in the jail, we continue to receive referrals and connect with all survivors including many male survivors. When appropriate we are continuing to offer referrals for the LOCOS men's support group for those coming out of incarceration settings as well.

From a behavioral health perspective, in Quarter 4, we provided two group facilitation sessions to those in a local Substance Use Disorder Providers (SUDP) facility that serves many marginalized individuals. We were also invited to sit on the Advisory Committee for Common Spirit and the Northwest Family Medical Residency to advise the medical enterprise on how to better serve those marginalized in our community. Scarlet Road hopes to equip them with information to identify survivors of trafficking that so often are missed by our medical systems through the implementation of a screening tool.

Lastly, Scarlet Road was contacted by a representative from the U.S. Committee for Refugees and Immigrants (USCRI) and we have developed a partnership serving foreign nationals referred to our program. In the process, we have been able to utilize the language VOYCE app at our local CACWA to better serve the Guatemalan population and are building partnerships with our local immigrant assistance center.

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

In October, Scarlet Road hosted a fundraiser at Eleven Winery focused on engaging major donors in North Kitsap and Bainbridge Island. We had the opportunity to engage with new donors and exceeded our event goal, raising over $13,000. In addition, we welcomed supporters at an open house at our Bremerton drop-in center and conducted a successful year-end individual donor campaign.

In Quarter 4, Scarlet Road was awarded two general operating grants: a multi-year $50,000 grant from the Norcliffe Foundation and a $5,000 grant from the Archarios Foundation.

Scarlet Road recognized the importance of regular income from diversified sources, so this quarter we built a monthly donor campaign. Imago Consulting has provided valuable support through this process, and Scarlet Road received a $2,500 capacity building grant from the Bainbridge Community Foundation to continue consultation services into 2025.

Success Stories:
What once felt like an empowering choice to Fern*, became a trap and her worst nightmare. Though this online platform was a legal form of the sex industry and therefore culturally accepted, Fern began to see all the deception, lies, and exploitation of people's vulnerabilities and previous abuse stories. She connected with a therapist to work through the emotional toll the sex industry had taken on her life and was referred to Scarlet Road. An advocate was able to connect with her and together they identified that her main goal was to get out of sex work and away from her abusers which meant she would need new housing. The Scarlet Road team worked with a few local landlords to find her safe, temporary housing so that she could leave the home she was being sexually exploited in and settle enough to begin to look for a new job. Once out, she messaged her advocate saying, "...Today was the first day no longer doing sex work. I quit and it felt amazing, and I am completely out of the old house. Thank you"
*Name and details altered to protect confidentiality.

Agency: Westsound Treatment Center
Program Name: New Start
$387,741

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 actively evaluating whether age, sex, and race should inform more specialized, demographically focused care for our participants. As a team, we are assessing the potential clinical benefits of tailoring services to these specific groups. This decision is still under review.

We are scheduled to meet at the end of February to refine our metrics collection process, ensuring it aligns with best practices and adheres to public health and epidemiological standards.
Additionally, our team will convene this month to strategize engagement efforts for 2025. Our goal is to enhance data capture beyond previous limitations, which were impacted by COVID-19, political factors, jail protocols, and other systemic barriers. We are exploring comprehensive approaches, including strengthening intake processes within the jail to build early rapport and reduce attrition. Simultaneously, we are assessing strategies to support inmates upon release, ensuring we effectively identify and address their needs to foster continuity of care. Potential solutions under consideration include a mobile outreach unit and/or a satellite office to extend our reach.
Given the current political landscape, economic instability, and rising needs within justice-involved populations, the urgency for accessible services has never been greater. Today, fentanyl is more readily available than treatment, a reality we refuse to accept. We are committed to deploying every possible resource and strategy to stay ahead of addiction and provide life-saving interventions where they are needed most.
Briefly describe collaborative efforts and outreach activities employing collective impact strategies.
Navigator's Notes:
Summary of Outside Entities WSTC Has Connected Patients With:
WSTC has connected patients with a wide range of substance use disorder (SUD), mental health, housing, legal, and community support services. The most frequently utilized entities include:
Primary Healthcare & MAT Services:
PCHS (Peninsula Community Health Services) – Frequently referred for MAT (Medication-Assisted Treatment) and primary healthcare.
KMHS (Kitsap Mental Health Services) – A key referral for mental health and co-occurring disorders treatment.
BAART, SeaMar, Consejo Counseling – Additional behavioral health and MAT providers.
Substance Use Treatment & Recovery Programs:
NA (Narcotics Anonymous), AA (Alcoholics Anonymous) – Peer recovery and 12-step meetings.

ABHS (American Behavioral Health Systems), Triumph, Prosperity Wellness, Olalla Recovery, Key Recovery, Isabella House – Detox, inpatient, and outpatient treatment options.
Pathways, PHRC (Puget Health & Rehab), NSBH (North Sound Behavioral Health), JOTC (Judicial Opportunity for Treatment Court), Sundown M Ranch – Residential and outpatient SUD services.
Legal & Justice System Referrals:
DOC (Department of Corrections), Drug Court, DSHS (Department of Social & Health Services) – Support for justice-involved individuals.
Agape TR via KCJ (Kitsap County Jail), Seeking IIP Services – Transitional reentry services.
Housing & Shelter Services:
Supportive Housing, Housing Solutions, Benedict House, Olive Branch Housing, Working Wardrobe – Assistance with stable housing and job readiness.
Kitsap Transit, Orca Card, Verizon Programs – Transportation support for accessibility to services.
Veteran & Specialty Services:
VA Programs, Seattle Indian Board, Suquamish Wellness Center – Culturally and population-specific resources.
HCA 4 Insurance – Support with insurance navigation.
WSTC's extensive network of referrals ensures that clients receive comprehensive, wraparound care addressing addiction, mental health, housing, legal challenges, and reentry needs.

Summary of Personal Success Elements for Clients:
Clients have demonstrated various personal successes in their recovery and reentry journeys. Key achievements include:
Treatment & Recovery Engagement:
Many clients have engaged in treatment services (Tx), including outpatient (OP), residential, and medication-assisted treatment (MAT) programs.
Several individuals are now actively participating in NA (Narcotics Anonymous), AA (Alcoholics Anonymous), and Drug Court treatment services.
Clients have accessed Spanish-speaking services to ensure culturally competent care.
Housing Stability & Safety:
Some clients secured housing (HSG), providing a sense of stability and safety while engaging in recovery programs.
Legal & Reentry Progress:
Clients have secured release dates and successfully transitioned to IIP (Intensive Inpatient Programs) or DOSA (Drug Offender Sentencing Alternative) placements.
A notable success includes a vacated substance abuse charge, supporting a fresh start post-incarceration.
Mental Health & Additional Support:
Clients have begun engaging in mental health (MH) counseling and outpatient appointments.
Program Enrollment & Placement:
Several individuals have scheduled intakes, received bed dates, or secured placements in inpatient facilities.
Overall, WSTC has successfully facilitated treatment engagement, housing stability, legal progress, and mental health support—ensuring that clients are connected with resources that promote long-term success.
---
47 times, participants have either partnered with or been referred to another provider for SUD care. This demonstrates our capacity to track participant pathways and ensure continuity of care. By maintaining these connections, we position ourselves as a long-term support system, ready to facilitate treatment whenever it is needed in the future.

New business:
1. CARES Partnership – CARES has requested our assistance with assessments, and we have committed to conducting them three times per week.

2. 12-Step Yoga in Poulsbo – Our WSTC Outreach Center in Poulsbo is now offering 12-step Yoga as part of our holistic recovery support.
3. New NA Group in Bremerton – WSTC has leased space at our Bremerton office for a new NA group at a symbolic rate of $1. This group, independently run and fully confidential, is being organized by Michelle Lamb, WSTC's Lead Liaison, while remaining separate from WSTC's treatment services.
4. Community NA Group in Poulsbo – To further support the community, WSTC is facilitating the addition of an NA group in Poulsbo. Like the Bremerton group, it will operate independently of our treatment services, organized by Michelle Lamb, and serve as a community resource.
5. Development & Outreach Expansion – Beth Wilson is leading social media efforts, advertising, resource coordination, event planning, and fundraising initiatives. Her role has addressed a critical gap in Development, ensuring WSTC's outreach and engagement strategies are fully operational and impactful as we move into 2024. As WSTC's Chief of Development, I am truly grateful for Beth Wilson's trauma-informed care approach and her sincere dedication to serving marginalized populations with a "non-ego first" mindset. I also deeply appreciate the support in this area, as it has historically been an unmet need—one that, when effectively executed, significantly strengthens grant development efforts.

Our previously discussed collaborative efforts and outreach initiatives include the New Start Navigator, WSTC's liaisons, and the WSTC REAL Team. These person-centered roles allow us to take a multi-pronged approach in meeting clients where they are. While not everyone immediately enrolls in treatment, we remain steadfast in our commitment to reducing barriers and providing consistent support. Even if WSTC does not directly provide treatment, we ensure individuals have access to care—whether through transportation to inpatient facilities, referrals, or wraparound services via New Start Navigator. For us, success is not measured by immediate enrollment or program completion, but by our ability to guide individuals toward the help they need, however long that process may take.

As a low-barrier center, we serve all populations, including individuals with criminal backgrounds and those from diverse income brackets. Whether through direct care or strategic referrals, we ensure that no one seeking help is turned away.

We actively collaborate with all industry partners within our local community, maintaining an open-door policy for partnerships that enhance service accessibility. We apply for all Requests for Proposals (RFPs) within our licensure and scope, prioritizing opportunities that align with the needs of our population, regardless of funding outcomes. Additionally, we continue to seek financial support from OCH and SBH-ASO to sustain and expand our impact.

While we pursue federal and state grants, we remain mindful of mission alignment, ensuring that funding opportunities do not divert resources from our core population. Our experience with pilot programs has shown that ventures outside our primary scope can strain administrative capacity and detract from our local service commitments. Therefore, we carefully evaluate each opportunity to maintain focus on our community's most pressing needs.

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

To establish long-term financial stability, we have pursued a comprehensive funding approach that integrates multiple income sources aligned with our mission and strategic objectives. Our team actively identifies, evaluates, and applies for all viable funding opportunities at private, corporate, local, state, and federal levels. This includes competitive grants, programmatic funding, and general operating support.

We have developed a structured pipeline to track grant deadlines, prioritize high-impact opportunities, and maintain steady funding applications. Simultaneously, we foster relationships with philanthropic organizations, corporate sponsors, and individual donors to secure recurring contributions. We are also exploring earned revenue models, such as fee-for-service programming, to generate unrestricted funds.

To strengthen financial resilience, we invest in research tools, attend industry events, and collaborate with peer organizations to increase eligibility for joint funding. Additionally, we implement long-term sustainability strategies, such as multi-year grant applications, legacy giving initiatives, and capital campaigns. By diversifying

revenue streams and proactively engaging with funders, we ensure that our programs remain financially sound and scalable.

We have not been able to replace or supplant funding but rather supplement it. While shifting our mission, vision, or program scope could open new funding opportunities, we remain fully committed to serving Kitsap County residents involved in the justice system. For over a decade, West Sound has played a critical role in providing services to incarcerated individuals, touching countless lives through jail-based programs and wraparound services offered by New Start. When larger entities, such as tribes or institutional partners, have adapted their programming or withdrawn, New Start and West Sound have remained steadfast in their commitment.

Currently, Medicaid does not cover treatment services during incarceration, making county funding essential for providing substance use disorder (SUD) care inside correctional facilities. These funds allow us to build relationships with incarcerated individuals, ensuring continuity of care post-release. Given the uncertainty in today's political climate, withdrawing support from justice-involved and marginalized populations would be a devastating setback. West Sound remains dedicated to serving those facing incarceration, homelessness, employment barriers, and behavioral health challenges. If funding were discontinued, we would be forced to reconsider our scope, but until that moment, we will continue to be the foundation of reentry services that our community members deserve.

Success Stories:

As a professional in substance use treatment, I have had the privilege of witnessing remarkable transformations. One client, in particular, stands out—a person who initially resisted treatment, reluctant to engage and determined to isolate. Like many entering recovery, they planned to keep to themselves, go through the motions, and leave as soon as possible.

However, their journey took an unexpected and inspiring turn. At first, they attended meetings merely to comply with the program. But as they listened, they began to hear their own story reflected in the experiences of others. Without speaking a word, they felt understood—perhaps for the first time. This connection was what they had been missing.

Treatment required them to dive deeper: writing down the pros and cons of their addiction, identifying personal boundaries, and reflecting on both internal and external motivators. Through this process, they began to see their addiction for what it was—a symptom of a deeper struggle.

Developing coping skills became critical. They learned that avoidance is sometimes necessary—not everything that presents itself deserves space in one's life. Open communication became a priority, allowing them to process challenges rather than suppress them. Self-care also played a vital role; they discovered that rewarding themselves wasn't indulgent but essential for maintaining sobriety.

A testament to their growth came when they took a trip to Las Vegas, fully engaging in everything the city had to offer while remaining completely sober. What stood out most was the unexpected support from vendors and promoters—one of whom was in recovery himself. Beyond personal coping strategies, they found strength in their support system and embraced the core philosophy of recovery: service to others.

Understanding that meetings provide guidance, but the real challenge lies in navigating the other 23 hours of the day, they took a proactive role in their recovery community. Nearly eight months ago, they began facilitating support groups—initially to help their goddaughter stay sober until she found a sponsor. What started as an act of support blossomed into an ongoing commitment, with both of them meeting regularly and holding each other accountable.

Reflecting on their journey, the client shared a powerful realization: "Sobriety is not just about avoiding substances; it's about taking control of one's life." A year after their initial trip, they returned to Las Vegas and once again experienced the city—this time without a single temptation to drink. They had come to understand that while addiction has deep roots, lasting change begins with personal responsibility.

Their story serves as a reminder that recovery is possible for anyone willing to do the work. They proved to themselves—and to others—that transformation isn't just about abstaining; it's about rebuilding a life worth living. Their journey stands as an inspiration to those still struggling, demonstrating that with commitment, support, and

self-awareness, long-term sobriety is achievable.

Agency: Westsound Treatment Center
Program Name: Resource Liaison
$387,741

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, the program has successfully met its primary objective of providing a low-barrier, universally accessible service for Kitsap's most vulnerable populations. The liaisons (2 FTE) have both qualitatively and quantitatively served individuals suffering from unmet mental health (MH) and substance use disorder (SUD) needs. The program has demonstrated its unique capacity to build long-term relationships with participants, offering continued support regardless of engagement in other programming, without imposing time limits or barriers.
Key Achievements:
Accessibility and Reach: The liaisons have provided contact and data access to individuals who might otherwise fall through the cracks due to barriers such as homelessness or lack of technological connectivity.
Flexibility in Service Delivery: The program's open-ended nature allows participants to continue receiving support indefinitely, fostering trust and engagement over time.
Impact on High-Barrier Groups: Despite significant challenges (46% homelessness, 25% without email, 30% without phones), the liaisons have maintained robust outreach and service delivery efforts.
Challenges:
A major barrier to engagement and retention lies in the lack of "larger-ticket" supports, such as housing, which can be critical for participants' willingness and ability to engage.
The absence of adequate resources for immediate needs can discourage ongoing participation.
Needed Changes:
Evaluation Enhancements: To better understand and address barriers to engagement, additional research and data collection are planned for Q1 2025. This will include surveying participants to gain insights into factors influencing their engagement and continuity.
Scope of Work Adjustments: Consideration should be given to partnerships or funding opportunities that can provide critical resources, such as housing solutions or technological support, to address key gaps.
Focused Interventions: Efforts should be directed toward increasing access to basic necessities that directly impact participants' ability to engage, such as phones, internet access, and transitional housing.
In summary, while significant progress has been made, the unmet need for essential supports highlights the importance of refining both evaluation methods and the program scope to ensure the program's ongoing success and growth.
Briefly describe collaborative efforts and outreach activities employing collective impact strategies.
We are keeping track of when participants are being referred and/or reaching out for services:
2024 October: 39 new participants
2024 November: 27 new participants
2024 December: 24 new participants
Age ranges:
18-30: 15
31-40: 33
41-50: 20
51-60: 16
61-70: 5
71-80: 1
81-90: 0

WSTC's liaisons are serving folks who are actively engaged in the following agencies:
Agape
Agape REAL
Bremerton Municipal Court
Bremerton Therapeutic Court
CARES
CPS
CTC
Doc Bremerton
Doc Port Orchard
Drug Court
Homes of Compassion
KCR
KMH
PCAP
Salvation Army
Participants were referred to the following places this quarter:
ABHS
Access
Benedict
BUPE Line
Catholic Community HEN
CPS Walk-In
Department of Corrections
DOL - Financial Assistance for IID
DOL
Drug Court
Eagle's Wings
Fishline
Georgia's House
HOC
Hotpads.com
Housing Kitsap
Housing Solutions Center
Housingkitsap.org
Fishline Poulsbo
KCR
Kitsap Legal Services
KMH
KRC Detox
KRC
Lifeline
NW Hospitality
NW Justice Project
Olalla
Oxford Houses
Paratransit Access
PCHS
Prosperity Inpatient

Salvation Army
Scarlet Road
Sound Integrated Health
SoundWorks at Fishline
SSI
St. Vincent Shelter
Tacoma Section 8
The Recovery Village
Village Fair
Women's Shelter
Worksource
WSTC Assessment
WSTC Housing
WSTC Outpatient
We received referrals from the following places:
Cares 1
Drug Court 3
Heart 1
KMH 1
Real Agape 1
*These are noteworthy sources for liaisons due to the quantity of referrals received, and where we will target our programming:
Self-Referred (Continue marketing and awareness)= 6
Kitsap Jail = 27
WSTC Outpatient = 27
WSTC Outreach = 23

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

For this program, we have concentrated on building a foundation rooted in data. By focusing on data collection and analysis, we aim to demonstrate the program's utility, ensure its longevity, and attract community support and additional funders. As a new initiative, we are still refining our understanding of outputs and outcomes, identifying the most evidence-based care for participants, and determining the most effective methods for serving this population.

To sustain and expand the program, we have actively sought funding through all possible opportunities, including pursuing several grants in 2024. Additionally, we are committed to maintaining fidelity to the liaison model, which is a cornerstone of our approach. This ensures that the program continues to address the critical and often unmet needs of Kitsap community members during their most vulnerable times. Our efforts are directed toward securing long-term support that will enable us to provide impactful, evidence-based solutions for the community.

Success Stories:

Summary: Participant 1 can benefit from peer support to provide consistent follow-up and encouragement to access services. PT is in need of housing. He was excited from our new start house.

Summary: Participant 2 can benefit from peer support to assist in navigating housing resources and maintaining stable living arrangements.

Kitsap jail referral. PT states he needs MH but has no SA issues. He can stay with a friend in Poulsbo. He would like help going to the DOL to see if he can get a license.

Summary: Participant 3 can benefit from peer support to facilitate access to mental health resources and transportation to the DOL.

Kitsap Jail referral. PT is from Seattle. He states he would like to go back as they have more resources for homelessness. He also states he needs an assessment as he has been using alcohol since age 3-4 and using meth blues and crack for most of his life. He is also deaf and needs housing.
Summary: Participant 4 can benefit from peer support to coordinate housing options and provide advocacy for accessible services for his disabilities.
Kitsap Jail referral. PT states she might need housing as where she lives isn't a safe environment for her and her 14-year-old. She also needs ignition interlock, preferably not Intoxalock, as it caused violations before. She was assessed yesterday.
Summary: Participant 5 can benefit from peer support to guide housing transitions and assist with ignition interlock system coordination.
Kitsap Jail referral. PT is going to prison for a year and a day. He states his biggest obstacle is housing upon release. He is going to write me while in prison so I can send him resources for housing.
Summary: Participant 6 can benefit from peer support to maintain communication and provide housing resources for post-release planning. I transported PT to DOC Port Orchard a month ago to go to ABHS in Spokane. He is getting released, and I was able to get him into our homeless housing. He will be out Thursday and do housing intake and treatment intake on Friday, Oct 10th and 11th.
Summary: Participant 7 can benefit from peer support to encourage engagement with housing and treatment programs post-release.
PT needs housing, help with transportation, and clothing.
Summary: Participant 8 can benefit from peer support to assist in meeting immediate basic needs and connecting with resource networks.
PT would like to get her driver's license.
Summary: Participant 9 can benefit from peer support to facilitate access to DMV services and support the licensing process.
PT graduated Northpoint and needed transport back home to his Oxford house.
Summary: Participant 10 can benefit from peer support to help with transportation and reintegration into recovery housing.
In need of housing for her and her newborn.
Summary: Participant 11 can benefit from peer support to provide housing resources and emotional support for maternal care.
PT is in need of housing, mental health treatment, recovery support, and transportation.
Summary: Participant 12 can benefit from peer support to connect them with comprehensive recovery and transportation resources to promote stability.
PT needs assistance with transportation, employment, substance use, and mental health. PT is also at risk of being homeless.
Summary: Participant 13 can benefit from peer support to assist in accessing mental health services and stabilizing their housing and employment.
PT needs assistance with transportation, housing, substance use, mental health, and harm reduction. PT is at risk of domestic violence.
Summary: Participant 14 can benefit from peer support to help establish safety and access critical resources for harm reduction and mental health.
PT needs help with transportation and employment.
Summary: Participant 15 can benefit from peer support to facilitate transportation solutions and job readiness assistance.
PT needs help with getting his license, interlock system, and transportation.
Summary: Participant 16 can benefit from peer support to guide them through the licensing process and securing interlock systems.

Kitsap Jail referral. PT states she was assessed yesterday 10-8-24 for IOP. She states she can stay with her daughter in Bainbridge upon release. She also states she is on methadone for MAT.
Summary: Participant 17 can benefit from peer support to coordinate post-release housing and MAT continuity.
Kitsap Jail referral. PT states he badly needs an assessment for all of the courts in Kitsap. He also states he needs a MH assessment due to years of drug use. His house is being foreclosed on the 11th of Oct. He states he wants Vivitrol before leaving the jail.
Summary: Participant 18 can benefit from peer support to connect to mental health evaluations and support systems for housing and addiction recovery.
I transported PT to KCR in Poulsbo to get help with rental assistance. We also set up an assessment and intake for Wed 10-16-24 @ noon with a counselor.
Summary: Participant 19 can benefit from peer support to ensure access to rental assistance and complete necessary intakes for stability.
PT was referred by Kelley, her WSTC counselor. As a part of her treatment plan, she would like to seek MH treatment. I called PT and left a message as I got no answer.
Summary: Participant 20 can benefit from peer support to assist in consistently accessing mental health services and treatment adherence.
PT is in need of peer support, housing, and transportation.
Summary: Participant 21 can benefit from peer support to connect with housing and reliable transportation options. PT would like to live in supportive housing after inpatient.
Summary: Participant 22 can benefit from peer support to transition into stable and supportive housing post-treatment. PT lives in a toxic environment and needs housing.
Summary: Participant 23 can benefit from peer support to relocate to a safer and more stable living environment. PT just started drug court and is feeling overwhelmed. We met with him and worked on his insurance, spoke about meetings in his area, took him to pick up his meds, and offered peer support. We made an appointment for next week to work on his CPS case.
Summary: Participant 24 can benefit from peer support to manage stress related to drug court and navigate resources like insurance and CPS. PT is seeking support to help her gain independence. Mental health and substance use. Not focusing on substance use at this time but harm reduction resources are requested. Transportation is needed for DSHS or mental health appointments.
Summary: Participant 25 can benefit from peer support to access harm reduction resources and reliable transportation to appointments. PT came in and did initial paperwork. We spoke about barriers. He had his toe amputated three weeks ago and has been living in his truck. We went to KCR and completed a Benedict House shelter referral and background check. We also went to Wilco and got DIY shots for his dog so he would be allowed in the shelter.
Summary: Participant 26 can benefit from peer support to address housing needs and ensure shelter access for both PT and his pet. PT was a Kitsap jail referral. His barriers are housing and needing a support system of people that don't use. I was able to get him into our housing. He will be released Saturday, and WSTC will transport him.
Summary: Participant 27 can benefit from peer support to maintain sobriety and access housing. PT is a Kitsap jail referral. His barriers include housing, treatment, and MAT.
Summary: Participant 28 can benefit from peer support to coordinate addiction treatment, MAT, and housing services. PT is a Kitsap jail referral. She stays at Salvation Army. She states her needs are assessment, SUD treatment, and MH services.
Summary: Participant 29 can benefit from peer support to complete assessments and access SUD and MH services. PT states the judge ordered her to go to inpatient as a condition and term of her sentence. I spoke with WSTC and let her know as she was just assessed for IOP. She will need housing upon release as well.
Summary: Participant 30 can benefit from peer support to navigate inpatient treatment and housing arrangements. PT needs resources for a phone for drug court and treatment services.
Summary: Participant 31 can benefit from peer support to access communication tools to meet drug court requirements.

PT is in need of housing, transportation, and a phone.
Summary: Participant 32 can benefit from peer support to coordinate basic resources for housing, communication, and mobility. PT would like other harm reduction tools besides Suboxone.
Summary: Participant 33 can benefit from peer support to explore and access alternative harm reduction strategies. PT needs housing and MAT services.
Summary: Participant 34 can benefit from peer support to connect with stable housing and medication-assisted treatment services. PT is in need of a phone. PT needs help with transportation and groceries.
Summary: Participant 35 can benefit from peer support to address communication, mobility, and food security needs. PT needs MAT options, detox, and inpatient treatment.
Summary: Participant 36 can benefit from peer support to access addiction recovery services, including MAT and detox. PT needs transportation support.
Summary: Participant 37 can benefit from peer support to arrange reliable transportation to access services. PT is interested in employment and housing.
Summary: Participant 38 can benefit from peer support to navigate job placement and housing resources. PT is currently homeless, has limited funding, and is in need of housing.
Summary: Participant 39 can benefit from peer support to secure financial assistance and stable housing. Needs healthy housing and transportation for outpatient treatment.
Summary: Participant 40 can benefit from peer support to find suitable housing and access transportation for treatment. Needs support in recovery and help getting his ID and SSC.
Summary: Participant 41 can benefit from peer support to obtain essential identification documents and recovery resources. PT needs MAT services.
Summary: Participant 42 can benefit from peer support to access and maintain MAT for substance use recovery. Needs housing and support while in drug court.
Summary: Participant 43 can benefit from peer support to access housing and navigate drug court services. Needs help overcoming barriers to getting housing.
Summary: Participant 44 can benefit from peer support to address and resolve housing access challenges. Met in jail and discussed needs and barriers. Wants to get into drug court, was assessed for inpatient, and needs housing.
Summary: Participant 45 can benefit from peer support to transition into drug court and secure stable housing. Met in jail and spoke about barriers and needs. Needs inpatient and housing.
Summary: Participant 46 can benefit from peer support to navigate inpatient treatment and secure safe housing. Met in jail and discussed barriers and needs. Has transportation needs and requires housing.
Summary: Participant 47 can benefit from peer support to address mobility challenges and housing instability. Met in jail and discussed needs and barriers. Needs a license and wants to get into drug court.
Summary: Participant 48 can benefit from peer support to regain a driver's license and transition into drug court. Met in jail and discussed needs and barriers. Needs shelter, prefers Benedict House, and needs an assessment for BMC.
Summary: Participant 49 can benefit from peer support to access shelter and complete necessary assessments. Met in jail and discussed barriers and needs. Wants to get into vet court, needs housing, and wants to stop drinking.
Summary: Participant 50 can benefit from peer support to transition into veteran-specific services and recovery housing. Met in jail and discussed barriers and needs. Wants treatment; already assessed; needs housing; wants to get the NCO on his boyfriend lifted.
Summary: Participant 51 can benefit from peer support to coordinate housing and legal advocacy to address relationship barriers. PT was in need of a winter coat.
Summary: Participant 52 can benefit from peer support to access basic necessities, including seasonal clothing. PT is homeless with his three children. PT has no income at this time due to lack of childcare. PT would like stable housing for him and his family.

Summary: Participant 53 can benefit from peer support to secure family housing and connect to childcare resources. PT wants MAT services and to find new housing.
Summary: Participant 54 can benefit from peer support to access MAT and transition into stable housing. PT needs assistance with getting her van fixed or finding another vehicle. She currently lives in the woods. She also is working with CPS to get her child back. She is seeking housing.
Summary: Participant 55 can benefit from peer support to address transportation challenges and family reunification needs. PT is a referral from Kitsap Sheriffs Reentry. He states he came from Oregon where he was ordered to do a 90-day adapt program which he never completed. He would like to continue MAT upon release and possibly has housing and a job through a friend.
Summary: Participant 56 can benefit from peer support to maintain MAT and secure post-release housing and employment opportunities. PT is a Kitsap jail referral. We spoke about barriers. He is likely releasing tomorrow. He would like a MH evaluation. He was assessed yesterday. He lives in Olalla and has no transportation. He would like help getting into Oxford and getting Medicaid. He has several DUIs he is seeking treatment for.
Summary: Participant 57 can benefit from peer support to connect to mental health services and coordinate housing and Medicaid access. PT is a Kitsap jail reentry referral. He states he would like to get on MAT and is required to do treatment. He states he has housing at this time. He will be released on Nov 28th.
Summary: Participant 58 can benefit from peer support to access MAT and transition into stable treatment services. I met PT in the Kitsap Jail. He was accepted into drug court. He has a 5-month-old baby and really wants to get his life on track. He needs housing and sober supports.
Summary: Participant 59 can benefit from peer support to maintain sobriety and connect to family-oriented housing and recovery services. PT is a Kitsap jail referral. She was extradited from California for DOC warrant and a warrant for NCO violation. She is taking her case to trial. She is working on getting into Thrive court.
Summary: Participant 60 can benefit from peer support to navigate legal challenges and transition into recovery-focused court programs. PT needed transportation from inpatient to compliance. PT will likely need support as he enters drug court.
Summary: Participant 61 can benefit from peer support to access transportation and navigate the transition into drug court. PT needs support with transportation so she can attend outpatient.
Summary: Participant 62 can benefit from peer support to ensure consistent transportation to outpatient services. PT called from Olalla and needed a ride back upon completion. He also needed housing. I was able to secure him a spot in our housing and pick him up on 11-25-25. I gave him a warm handoff to Wendy, our housing case manager. We will reconnect after his intake and make an appointment to work on his goals. We also went to BAART clinic and got his MAT.
Summary: Participant 63 can benefit from peer support to maintain housing stability and access MAT services. I met PT in jail; he was a referral from reentry. He would like to be assessed and states he has housing with his mom. He states he and his girlfriend currently live there. He also states he is a master mechanic and will work with WorkSource upon release. He might be getting bailed.
Summary: Participant 64 can benefit from peer support to connect with employment resources and secure stable housing. I met with PT in the jail. She is in need of SUD services. She states she has trial on Monday and is very concerned about it. We spoke about barriers and plans to do things differently.
Summary: Participant 65 can benefit from peer support to address substance use disorder needs and navigate trial preparations. PT is needing housing that is wheelchair accessible.
Summary: Participant 66 can benefit from peer support to secure ADA-compliant housing. PT just moved back to Washington. She needs insurance, shelter, transportation, and income.
Summary: Participant 67 can benefit from peer support to navigate basic resource coordination for housing, income, and insurance. PT would like to apply for subsidized housing.
Summary: Participant 68 can benefit from peer support to navigate the application process for affordable housing programs. PT has recently been a victim of DV. PT's spouse took her car and phone. PT is asking for support.
Summary: Participant 69 can benefit from peer support to access DV survivor services and basic resources. PT is homeless and in need of housing. PT wants to work and "get her son back."

Summary: Participant 70 can benefit from peer support to connect with housing and family reunification services. PT needs a coat and phone card.
Summary: Participant 71 can benefit from peer support to access basic necessities, including clothing and communication tools. PT needs MAT services.
Summary: Participant 72 can benefit from peer support to maintain medication-assisted treatment for recovery. PT is dealing with traumatic events.
Summary: Participant 73 can benefit from peer support to connect with trauma-informed care and emotional support resources. PT would like to move to Kitsap. He has a felony as a barrier.
Summary: Participant 74 can benefit from peer support to navigate housing and employment opportunities while addressing legal barriers. PT is in need of a winter coat.
Summary: Participant 75 can benefit from peer support to obtain essential seasonal clothing. PT needs peer support.
Summary: Participant 76 can benefit from ongoing peer support to assist with emotional and recovery challenges. PT needs a winter coat and will soon like support finding employment.
Summary: Participant 77 can benefit from peer support to secure seasonal clothing and job placement services. PT came in and was in need of help figuring out his insurance. He is on Medicare, so he doesn't qualify for Medicaid. We set up a meeting to go to SSI on Monday and discussed some goals for PT to sign up for housing in Kitsap and Tacoma housing section 8. We also did paperwork for his ignition interlock financial assistance through the DOL.
Summary: Participant 78 can benefit from peer support to navigate insurance, housing applications, and financial assistance processes. PT would like support in getting his driver’s license.
Summary: Participant 79 can benefit from peer support to access DMV services and regain independence through licensing. PT needs shelter and support finding employment.
Summary: Participant 80 can benefit from peer support to secure housing and employment resources. PT wants support in recovery and needs housing.
Summary: Participant 81 can benefit from peer support to access recovery-focused housing and services. PT was a Kitsap Jail referral. We spoke about his barriers. He is interested in getting into drug court and states his attorney is requesting the prosecutor to ask for his assessment. He also states he is already approved for drug court. He will need housing as he has a DV charge and isn’t allowed to go back to his house. He seems to have high hopes that the charge will be dismissed.
Summary: Participant 82 can benefit from peer support to navigate legal challenges and secure stable housing during drug court. PT was a referral from Kitsap jail re-entry. He states he needs an assessment which I have put in for. He also needs housing and an ID. His last one was from Idaho. He also states he needs help with DSHS, SSI, ABD, and a birth certificate.
Summary: Participant 83 can benefit from peer support to access identification services and coordinate essential resources. PT was a referral from Kitsap Jail reentry. We spoke about his barriers, and he states he has been using for 4 years since age 16. He is in need of housing and sober support. I have put in to have him assessed. He is considering drug court for the accountability.
Summary: Participant 84 can benefit from peer support to transition into sober living and engage in drug court for structured accountability. PT needs housing. PT is currently living in a car with a girl despite having a protection order.
Summary: Participant 85 can benefit from peer support to secure safe housing and navigate legal challenges. PT is in need of access to paratransit services. He recently got out of a wheelchair and is having mobility issues. I called and made an appointment to meet with him after court on Thursday, 12/26.
Summary: Participant 86 can benefit from peer support to coordinate accessible transportation and mobility assistance. PT is in need of sober housing. Drug court wants him to move from his current situation. I was able to get him into an Eagles Wings house on 12th Street. PT is very excited about having a home for Christmas.
Summary: Participant 87 can benefit from peer support to maintain sobriety and access supportive housing. PT needs support with transportation.

Summary: Participant 88 can benefit from peer support to secure reliable transportation for accessing services. PT needs support in recovery and transportation.
Summary: Participant 89 can benefit from peer support to ensure consistent recovery-focused transportation services. PT is in need of housing and help with a mental health referral. She is currently living in a hotel that is being paid for by her in-laws and her significant other, who is incarcerated at Walla Walla. She states she is bipolar 2 and 15 months clean from fentanyl, meth, and alcohol. She would like to find more permanent housing, so her daughter won't move back to Clallam County. She is currently requesting to do so, which is not a good place for PT to stay sober. I have called and left a general message.
Summary: Participant 90 can benefit from peer support to secure stable housing, ensure mental health care continuity, and maintain long-term sobriety.

										2024 Revenue	$7,811,208.00
Agency	**2024 Award**	**First QT**	**%**	**Second QT**	**%**	**Third QT**	**%**	**Fourth QT**	**%**	**2024 Total**	**2024 Balance**
Agape AIMS	$ 40,955.00	$ 8,094.59	19.76%	$ 4,129.93	29.85%	$ 7,657.66	48.55%	$ 16,328.33	88.42%	$ 36,210.51	$ 4,744.49
Agape Navigator	$ 83,618.00	$ 19,013.01	22.74%	$ 20,138.03	46.82%	$ 19,061.43	69.62%	$ 21,682.21	95.55%	$ 79,894.68	$ 3,723.32
Bainbridge Youth Services	$ 105,000.00	$ 30,000.00	28.57%	$ 30,000.00	57.14%	$ 30,000.00	85.71%	$ 15,000.00	100.00%	$ 105,000.00	$ -
Central Kitsap Fire (CARES)	$ 375,000.00	$ 8,442.49	2.25%	$ 31,860.09	10.75%	$ 57,603.66	26.11%	$ 110,462.09	55.56%	$ 208,368.33	$ 166,631.67
City of Bremerton Courts	$ 100,000.00	$ 16,451.24	16.45%	$ 27,718.45	44.17%	$ 29,566.36	73.74%	$ -	73.74%	$ 73,736.05	$ 26,263.95
The Coffee Oasis	$ 289,000.00	$ 43,787.06	15.15%	$ 38,811.71	28.58%	$ 36,159.58	41.09%	$ 15,618.37	46.50%	$ 134,376.72	$ 154,623.28
Eagles Wings	$ 300,000.00	$ 77,193.76	25.73%	$ 78,060.06	51.75%	$ 77,806.54	77.69%	$ 66,839.64	99.97%	$ 299,900.00	$ 100.00
Fishline NK	$ 95,000.00	$ 50,960.00	53.64%	$ 28,760.00	83.92%	$ 15,280.00	100.00%	$ -	100.00%	$ 95,000.00	$ -
Flying Bagel	$ 200,000.00	$ 81,279.33	40.64%	$ 39,865.26	60.57%	$ 39,547.00	80.35%	$ 39,308.41	100.00%	$ 200,000.00	$ -
Kitsap Brain Injury	$ 14,387.00	$ 3,438.51	23.90%	$ 4,768.44	57.04%	$ 1,539.04	67.74%	$ 4,421.51	98.47%	$ 14,167.50	$ 219.50
Kitsap Community Resources	$ 557,800.00	$ 204,662.25	36.69%	$ 197,260.07	72.05%	$ 111,077.68	91.97%	$ 44,800.00	100.00%	$ 557,800.00	$ -
Kitsap District Court	$ 433,762.00	$ 96,587.02	22.27%	$ 113,840.99	48.51%	$ 100,818.49	71.76%	$ 117,159.14	98.77%	$ 428,405.64	$ 5,356.36
Juvenile Therapeutic Courts	$ 143,192.00	$ 31,703.04	22.14%	$ 32,941.72	45.15%	$ 32,610.91	67.92%	$ 30,995.38	89.57%	$ 128,251.05	$ 14,940.95
Kitsap County Prosecutors	$ 395,862.00	$ 101,829.45	25.72%	$ 108,238.56	53.07%	$ 90,034.99	75.81%	$ 61,866.01	91.44%	$ 361,969.01	$ 33,892.99
Kitsap Sheriff CIO	$ 158,635.00	$ 39,658.77	25.00%	$ 39,658.77	50.00%	$ 39,658.77	75.00%	$ 39,658.77	100.00%	$ 158,635.08	$ (0.08)
Kitsap Sheriff CIT	$ 22,500.00	$ -	0.00%	$ 7,157.00	31.81%	$ -	31.81%	$ -	31.81%	$ 7,157.00	$ 15,343.00
Kitsap Sheriff POD	$ 350,000.00	$ 16,749.11	4.79%	$ 31,983.95	13.92%	$ -	13.92%	$ -	13.92%	$ 48,733.06	$ 301,266.94
Kitsap Sheriff Reentry	$ 221,094.00	$ 46,278.93	20.93%	$ 63,941.10	49.85%	$ 46,160.49	70.73%	$ 45,426.81	91.28%	$ 201,807.33	$ 19,286.67
Kitsap Superior Court AD CT	$ 636,409.00	$ 129,681.18	20.38%	$ 138,488.53	42.14%	$ 134,524.65	63.28%	$ 134,839.10	84.46%	$ 537,533.46	$ 98,875.54
Kitsap Superior Court VET CT	$ 85,775.00	$ 19,364.70	22.58%	$ 21,466.65	47.60%	$ 24,349.99	75.99%	$ 18,954.79	98.09%	$ 84,136.13	$ 1,638.87
Kitsap Public Health District NFP	$ 190,000.00	$ 48,715.50	25.64%	$ 48,249.12	51.03%	$ 46,964.23	75.75%	$ 41,481.15	97.58%	$ 185,410.00	$ 4,590.00
Kitsap Homes of Compassion	$ 300,000.00	$ 75,000.00	25.00%	$ 75,000.00	50.00%	$ 75,000.00	75.00%	$ 75,000.00	100.00%	$ 300,000.00	$ -
Kitsap Recovery Center (PIN)	$ 242,335.00	$ 57,840.22	23.87%	$ 56,706.02	47.27%	$ 60,767.62	72.34%	$ 44,391.11	90.66%	$ 219,704.97	$ 22,630.03
Kitsap Rescue Mission	$ 260,694.00	$ 59,618.64	22.87%	$ 56,844.97	44.67%	$ 64,852.86	69.55%	$ 69,503.19	96.21%	$ 250,819.66	$ 9,874.34
Olympic ESD 114	$ 600,000.00	$ 95,000.65	15.83%	$ 85,925.62	30.15%	$ 127,244.23	51.36%	$ 250,856.69	93.17%	$ 559,027.19	$ 40,972.81
One Heart Wild	$ 62,224.00	$ 15,555.99	25.00%	$ 15,555.99	50.00%	$ 15,555.99	75.00%	$ 15,555.99	100.00%	$ 62,223.96	$ 0.04
Kitsap Mental Health Services	$ 200,000.00	$ -	0.00%	$ -	0.00%	$ 66,115.88	33.06%	$ 133,884.12	100.00%	$ 200,000.00	$ -
Scarlet Road	$ 100,000.00	$ 30,999.42	31.00%	$ 22,998.26	54.00%	$ 23,508.02	77.51%	$ 22,494.30	100.00%	$ 100,000.00	$ -
West Sound Treatment Center NS	$ 387,741.00	$ 93,908.11	24.22%	$ 95,823.76	48.93%	$ 87,688.10	71.55%	$ 110,351.03	100.01%	$ 387,771.00	$
Westsound Treatment Center RL	$ 250,000.00	$ 81,714.23	32.69%	$ 44,804.80	50.61%	$ 50,057.05	70.63%	$ 69,595.45	98.47%	$ 246,171.53	$ 3,798.47
TOTAL	**$ 7,200,983.00**	**$ 1,583,527.20**		**$ 1,560,997.85**		**$ 1,511,211.22**		**$ 1,616,473.59**		**$ 6,272,209.86**	**$ 928,773.14**

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

Fourth Quarter: October 1, 2024 – December 31, 2024

Agency	Fourth QT Outputs	Fourth QT Outcomes
Agape Unlimited - AIMS Co-occurring Disorder Services Baseline: Unduplicated number of individuals served during the quarter	AIMS: • 1 assessment, 47 Q1, 4 Q2, 4 Q3 • 14 total clients, 17 Q1, 19 Q2, 18 Q3 • 0 graduates, 0 Q1, 0 Q2, 0 Q3 Treatment Navigator: • 142 assessments, 222 Q1, 129 Q2, 194 Q3 • 1 client gained insurance, 6 Q1, 3 Q2, 3 Q3 • 1 client gained photo ID's, 0 Q1, 0 Q2, 0 Q3 • 2 clients filled out housing applications, 1 Q1, 5 Q2, 2 Q3 • 61 transports provided by navigator, 35 Q1, 42 Q2, 75 Q3	AIMS: • 123 SUD intakes AIMS questionnaire, 67 Q1, 139 Q2, 72 Q3 • 10 participants per month, 8.3 Q1, 10.6 Q2, 6 Q3 • 44 clients referred to AIMS services, 17 Q1, 19 Q2, 7 Q3 • 3 enrolled participants attended at least 1 appointment per month, 14 Q1, 5 Q2, 4 Q3 Treatment Navigator: • 222 total clients, 321 Q1, 203 Q2, 308 Q3 • 142 assessment appointments, 222 Q1, 129 Q2, 194 Q3
Agape Unlimited – Navigator Baseline: Unduplicated number of individuals served during the quarter	• 142 assessments conducted, 222 Q1, 129 Q2, 194 Q3 • 61 transports, 35 Q1, 42 Q2, 75 Q3 • 0 obtain Narcan, 3 Q1, 0 Q2, 0 Q3	• 138 individuals who no-showed but later successfully attended an appointment, 11 Q1, 67 Q2, 102 Q3 • 222 total clients served, 321 Q1, 203 Q2, 308 Q3
Bainbridge Youth Services Baseline: Unduplicated number of individuals served during the quarter	• 1208 total youth counseling hours, 1368 Q1, 1434.5 Q2, 1175.5 Q3 • 91 total adult counseling hours, 122 Q1, 115 Q2, 78 Q3 • 8 parents attending support groups, 8 Q1, 7 Q2, 8 Q3 • 0 Spanish-Language support groups, 0 Q1, 0 Q2, 0 Q3 • 109 active youth clients, 139 Q1, 127 Q2, 104 Q3 • 32 clients discharged, 31 Q1, 62 Q2, 55 Q3 • 18 active adult clients, 18 Q1, 18 Q2, 20 Q3	• 10 clients on waitlist, 9 Q1, 15 Q2, 6 Q3 • 151 intakes or screenings, 42 Q1, 81 Q2, 116 Q3 • 151 total intakes, 42 Q1, 81 Q2, 116 Q3 • 89 average number of program participants per month last QT, 99 Q1, 108 Q2, 77 Q3 • 127 clients enrolled in BYS who attended at least one appointment per month last QT, 157 Q1, 145 Q2, 124 Q3 • 127 total clients enrolled in AIMS, 157 Q1, 145 Q2, 124 Q3
City of Bremerton – Therapeutic Court Baseline: Unduplicated number of individuals served during the quarter	• 8 transports to treatment, 4 Q1, 4 Q2, 4 Q3 • 11 case management services, 6 Q1, 10 Q2, 10 Q3 • 0 attendees for Resource Fair, 0 Q1, 148 Q2, 167 Q3 • 8 referrals to treatment programs, 4 Q1, 4 Q2, 5 Q3	• 10 individuals served with MH diagnosis, 4 Q1, 7 Q2, 4 Q3 • 11 individuals served with SUD diagnosis, 4 Q1, 9 Q2, 5 Q3 • 4 individuals served with co-occurring diagnosis, 4 Q1, 6 Q2, 8 Q3 • 11 applicants to Bremerton Therapeutic Court, 42 Q1, 3 Q2, 2 Q3 • 7 participants enrolled in 2024, 9 Q1, 10 Q2, 7 Q3

Agency	Fourth QT Outputs	Fourth QT Outcomes
Central Kitsap Fire – CARES Baseline: Unduplicated number of individuals served during the quarter	• 1014 total contacts, 809 Q1, 1038 Q2, 1536 Q3 • 269 over the phone, 332 Q1, 453 Q2, 415 Q3 • 418 in person, 324 Q1, 411 Q2, 470 Q3 • 27 crisis response, 11 Q1, 27 Q2, 39 Q3 • 327 referral or follow-up, 202 Q1, 353 Q2, 475 Q3 • 163 work with family or caregiver, 110 Q1, 199 Q2, 185 Q3 • 3 dropped off to Crisis Triage Center, 0 Q1, 2 Q2, 2 Q3	• 409 individuals served, 288 Q1, 315 Q2, 433 Q3 • 131 individuals referred to services, 209 Q1, 252 Q2, 165 Q3 • 80 individuals connected to services, 158 Q1, 166 Q2, 74 Q3 • 21 individuals receiving case management, 3 Q1, 49 Q2, 18 Q3 • 0 preventions 911, 0 Q1, 0 Q2, 0 Q3 • 9 hospital diversions – alternate destination, 1 Q1, 6 Q2, 7 Q3 • 21 hospital diversions -home, 1 Q1, 6 Q2, 19 Q3 • 17 relieved fire crew, 15 Q1, 11 Q2, 21 Q3
The Coffee Oasis Baseline: unduplicated number of individuals served during the quarter	• 93 texts responded to on crisis line, 41 Q1, 67 Q2, 18 Q3 • 64 in-person crisis intervention outreach contacts, 481 Q1, 494 Q2, 58 Q3 • 0 unduplicated BH therapy sessions, 6 Q1, 4 Q2, 13 Q3 • 11 unduplicated BH SUD specific therapy sessions, 3 Q1, 14 Q2, 13 Q3 • 9 intensive case management sessions, 4 Q1, 7 Q2, 4 Q3 • 57 total clients served, 949 Q1, 535 Q2, 88 Q3 • 64 unduplicated crisis intervention outreaches, 481 Q1, 129 Q2, 58 Q3	• 67 youth in crisis who engaged in at least two contacts; call or text, 481 Q1, 1355 Q2, 22 Q3 • 1996 youth in crisis contacted, 481 Q1, 969 Q2, 64 Q3 • 93 texters in crisis, 43 Q1, 67 Q2, 67 Q3 • 67 crisis texts that are resolved over the phone or with community resources, 43 Q1, 43 Q2, 52 Q3 • 23 youth served by SUD professional by appointments, 3 Q1, 7 Q2, 8 Q3 • 13 in case management services who completed a housing stability plan including educational/employment goals, 4 Q1, 6 Q2, 4 Q3 • 18 homeless youth served by Coffee Oasis within management, 3 Q1, 16 Q2, 24 Q3
Eagles Wings – Coordinated Care Baseline: unduplicated number of individuals served during the quarter	• 0 psychiatric intakes, 2 Q1, 0 Q2, 24 Q3 • 0 housing meetings, 196 Q1, 0 Q2, 195 Q3 • 0 case management encounters, 1400 Q1, 0 Q2, 1400 Q3 • 58 services provided, 1600 Q1, 0 Q2, 1600 Q3 • 128 unduplicated individuals served, 131 Q1, 122 Q2, 120 Q3	• 45 unduplicated individuals served with medication management, 46 Q1, 41 Q2, 33 Q3 • 25 unduplicated individuals served in a therapeutic court program, 27 Q1, 15 Q2, 20 Q3 • 68 participants stably housed for 6 months, 84 Q1, 82 Q2, 0 Q3 • 82 participants EWCC has been able to engage or re-engage in mental health services, 60 Q1, 57 Q2, 65 Q3 • 54 participants who have transitioned from simple participation to community involved positions, 30 Q1, 28 Q2, 40 Q3
Fishline NK Baseline: Unduplicated number of individuals served during the quarter	• 52 outreaches to the community about counseling services, 85 Q1, 30 Q2, 27 Q3 • 11 referrals from Fishline to counseling services, 26 Q1, 26 Q2, 24 Q3 • 5 referrals from counselor to Fishline, 6 Q1, 4 Q2, 5 Q3 • 304 counseling sessions, 336 Q1, 341 Q2, 429 Q3 • 304 clients served, 20 Q1, 14 Q2, 23 Q3	• 16 referrals to Fishline received, 6 Q1, 4 Q2, 5 Q3 • 66 individuals assessed and seen within 3 days by Fishline therapist, 20 Q1, 14 Q2, 23 Q3 • 1228 served with therapeutic counseling services, 336 Q1, 677 Q2, 1106 Q3 • 14 clients referred to a case manager, 6 Q1, 10 Q2, 15 Q3 • 4 meetings held with referral agency North Kitsap Services, 1 Q1, 2 Q2, 3 Q3

Agency	Fourth QT Outputs	Fourth QT Outcomes
Flying Bagel Baseline: unduplicated number of individuals served during the quarter	• 16 outreaches to the community about services, 25 Q1, 27 Q2, 18 Q3 • 81 referrals to Flying Bagel from agencies, 3 Q1, 2 Q2, 24 Q3 • 20 referrals to Flying Bagel for the community, 12 Q1, 9 Q2, 68 Q3 • 41 referrals to outside organizations, 3 Q1, 2 Q2, 20 Q3 • 10 intake sessions, 7 Q1, 3 Q2, 6 Q3 • 30 counseling sessions, 23 Q1, 36 Q2, 14 Q3 • 0 trainings, 2 Q1, 0 Q2, 1 Q3 • 13 clients served, 7 Q1, 8 Q2, 7 Q3 • 10 families engaged in services, 6 Q1, 8 Q2, 8 Q3	• 10 pre-assessments completed, 7 Q1, 2 Q2, 4 Q3 • 1 post assessment completed, 0 Q1, 1 Q2, 2 Q3 • 4 children served ages 0-2, 2 Q1, 3 Q2, 3 Q3 • 6 children served ages 2-4, 5 Q1, 5 Q2, 5 Q3 • 52 referrals to Flying Bagel received, 15 Q1, 25 Q2, 44 Q3 • 66 referrals to outside agencies, 3 Q1, 5 Q2, 25 Q3 • 29 individuals receiving services, 7 Q1, 13 Q2, 19 Q3 • 6 individuals trained, 6 Q1, 6 Q2, 6 Q3 • 1 individual who became certified, 0 Q1, 1 Q2, 1 Q3
Kitsap Brain Injury Baseline: unduplicated number of individuals served during the quarter	• 3 monthly educational groups, 3 Q1, 3 Q2, 3 Q3 • 45 total participants who attended monthly educational groups, 80 Q1, 75 Q2, 75 Q3 • 13 weekly support groups, 13 Q1, 13 Q2, 307 Q3 • 324 total participants who attended weekly support groups, 217 Q1, 307 Q2, 382 Q3	• 162 total active participants, 297 Q1, 382 Q2, 382 Q3 • 4 participants who are there as supportive individuals, family seeking support etc., 3 Q1, 382 Q2, 21 Q3 • 28 QOLIBRI surveys completed, 29 Q1, 25 Q2, 25 Q3 • 28 who self-reported, 29 Q1, 25 Q2, 25 Q3 • 10 participants report an increase in positive mental health and well-being, 29 Q1, 21 Q2, 21 Q3
Kitsap Community Resources - ROAST Baseline: Unduplicated number of individuals served during the quarter	• 8 referrals to mental health, 22 Q1, 9 Q2, 5 Q3 • 36 referrals to SUD services, 19 Q1, 4 Q2, 36 Q3 • 6 referrals to primary care, 27 Q1, 10 Q2, 6 Q3 • 0 referrals to employment and training services, 6 Q1, 4 Q2, 0 Q3 • 43 referrals to housing, 62 Q1, 20 Q2, 16 Q3	• 0 average households on a caseload, 0 Q1, 0 Q2, 0 Q3 • 276 unduplicated individuals, 413 Q1, 480 Q2, 124 Q3 • 200 households, 255 Q1, 298 Q2, 103 Q3 • 191 households that have received rental assistance and maintained housing 1 month, 243 Q1, 296 Q2, 98 Q3
Kitsap County District Court - Behavioral Health Court Baseline: Unduplicated number of individuals served during the quarter	• 112 service referrals provided, 53 Q1, 13 Q2, 148 Q3 • 34 individuals housed, 2 Q1, 5 Q2, 8 Q3 • 37 program participants, 32 Q1, 36 Q2, 34 Q3 • 6 program referrals, 9 Q1, 10 Q2, 10 Q3 • 0 participants terminated, 1 Q1, 0 Q2, 2 Q3 • 0 new participants, 0 Q1, 0 Q2, 0 Q3 • 696 incentives, 723 Q1, 634 Q2, 655 Q3 • 43 sanctions, 44 Q1, 32 Q2, 32 Q3	• 0 reoffenders in last quarter, 0 Q1, 1 Q2, 1 Q3 • 1 graduate from the past 18 months who reoffended, 0 Q1, 0 Q2, 3 Q3 • 4 graduates in past 6 months who completed a diversion program, 2 Q1, 3 Q2, 0 Q3 • 9 participants reported feeling favorable overall life satisfaction, 14 Q1, 32 Q2, 5 Q3 • 0 remain homeless or became homeless again in the last quarter, 5 Q1, 4 Q2, 0 Q3 • 4 participants who were trying to re-engage in vocational activities were successful, 14 Q1, 13 Q2, 2 Q3 • 1 participant trying to reobtain a driver's license were successful, 17 Q1, 5 Q2, 3 Q3

Agency	Fourth QT Outputs	Fourth QT Outcomes
Kitsap County Juvenile Court Baseline: Unduplicated number of individuals served during the quarter	• 10 BHS sessions with ITC participants, 16 Q1, 14 Q2, 11 Q3 • 8 BHS sessions with JDC participants, 5 Q1, 7 Q2, 7 Q3 • 0 BHS sessions with post-graduates, 588 Q1, 0 Q2, 0 Q3 • 8 UA tests for designer drugs, 150 Q1, 45 Q2, 6 Q3 • 2275 incentives given, 588 Q1, 509 Q2, 544 Q3 • 159 sanctions given, 46 Q1, 83 Q2, 119 Q3	• 7 BHS sessions with KPAC participants, 13 Q1, 11 Q2, 9 Q3 • 8 BHS sessions with Girls Court, 3 Q1, 7 Q2, 11 Q3 • 4 BHS sessions with Family Treatment Court, 7 Q1, 2 Q2, 4 Q3 • 7 BHS session with Safe Babies Court, 1 Q1, 7 Q2, 7 Q3 • 215 youth screened for use of designer drugs who test negative, 150 Q1, 198 Q2, 204 Q3 • 215 youth screened for use of designer drugs, 150 Q1, 45 Q2, 204 Q3
Kitsap County Prosecutor's Office Baseline: Unduplicated number of individuals served during the quarter	• 25 treatment court entries, 24 Q1, 34 Q2, 39 Q3 • 3 BH court entries, 3 Q1, 4 Q2, 7 Q3 • 16 drug court entries, 17 Q1, 20 Q2, 12 Q3 • 4 felony diversion, 4 Q1, 6 Q2, 17 Q3 • 2 entries to veteran's court, 0 Q1, 3 Q2, 2 Q3	• 38 applications, 52 Q1, 80 Q2, 69 Q3 • 48 pending entries, 21 Q1, 44 Q2, 39 Q3 • 0 opted out, 4 Q1, 12 Q2, 6 Q3 • 25 treatment court entries, 24 Q1, 34 Q2, 39 Q3 • 13 denied entry: 3 for criminal history, 6 for current charges, 0 for open warrants, 4 for other, 21 Q1, 26 Q2, 31 Q3 • 0 DOSA participants, 2 Q1, 4 Q2, 2 Q3
Kitsap County Sheriff's Office Crisis Intervention Officer (CIO) Baseline: Unduplicated number of individuals served during the quarter	• 9 detentions, 11 Q1, 5 Q2, 10 Q3 • 10 diversions, 9 Q1, 11 Q2, 18 Q3 • 3 planned apprehensions, 4 Q1, 3 Q2, 7 Q3 • 84 911 Behavioral Health total contacts, 100 Q1, 121 Q2, 169 Q3	• 64 CIC contacts where individual is transported to the Hospital, 23 Q1, 34 Q2, 54 Q3 • 202 contacts referred to REAL, VAB, CPS, etc., 27 Q1, 66 Q2, 145 Q3 • 11 CIC contacts where individual is arrested, 2 Q1, 5 Q2, 9 Q3
Kitsap County Sheriff's Office Crisis Intervention Training (CIT) Baseline: Unduplicated number of individuals served during the quarter	• 0 CIT training, 0 Q1, 0 Q2, 1 Q3 • 0 total individuals served in Bainbridge Island, 0 Q1, 0 Q2, 90 Q3 • 0 total individuals served in Bremerton, 0 Q1, 0 Q2, 0 Q3 • 75 total individuals served Kitsap County Sheriff, 0 Q1, 0 Q2, 75 Q3 • 0 total individual served in Poulsbo, 0 Q1, 0 Q2, 0 Q3 • 0 total individual served in Port Gamble, 0 Q1, 0 Q2, 0 Q3 • 0 total individuals served in other, 0 Q1, 0 Q2, 15 Q3	• 1 40-hour class to 30 different Kitsap County Deputies, 0 Q1, 0 Q2, 30 Q3 • 30 participants who successfully completed end-of-course mock scenes test, 0 Q1, 0 Q2, 30 Q3 • 3 total class participants, 0 Q1, 0 Q2, 30 Q3

Agency	Fourth QT Outputs	Fourth QT Outcomes
Kitsap County Sheriff's Office Reentry Program Baseline: Unduplicated number of individuals served during the quarter	• 29 substance use disorder services, 25 Q1, 16 Q2, 15 Q3 • 0 mental health service, 1 Q1, 2 Q2, 2 Q3 • 53 co-occurring substance use disorder and mental health services, 123 Q1, 115 Q2, 102 Q3 • 82 participants, 123 Q1, 133 Q2, 119 Q3 • 49 participants receiving MAT, 73 Q1, 81 Q2, 77 Q3	• 82 prisoners receiving services, 0 Q1, 133 Q2, 0 Q3 • 2839 jail bed days for participants post-program enrollment, 172 Q1, 1383 Q2, 3238 Q3 • 7242 jail bed days for participants pre-program enrollment, 4,256 Q1, 6799 Q2, 5912 Q3 • 86 return clients, 15 Q1, 49 Q2, 75 Q3 • $687,088.15 monies saved based on jail bed day reductions, $641,392.20 Q1, $1,492,917.30 Q2, $2,034,669 Q3
Kitsap County Sheriff's Office POD Program Baseline: Unduplicated number of individuals served during the quarter	• 29 substance use disorder services, 25 Q1, 16 Q2, 15 Q3 • 0 mental health service, 1 Q1, 2 Q2, 2 Q3 • 53 co-occurring both substance use and mental health services, 123 Q1, 115 Q2, 102 Q3 • 35 referrals to Westsound, 114 Q1, 59 Q2, 92 Q3 • 6 referrals to Agape, 10 Q1, 17 Q2, 8 Q3 • 21 referrals to Scarlet Road, 27 Q1, 26 Q2, 23 Q3	• 82 total participants, 149 Q1, 133 Q2, 119 Q3 • 49 participants receiving MAT medicated Assisted Treatment, 73 Q1, 81 Q2, 92 Q3 • 24,209 jail bed days for participants pre-program enrollment, 4,256 Q1, 6,799 Q2, 5,912 Q3 • 7,626 jail bed days for participants post-program enrollment, 172 Q1, 1383 Q2, 3238 Q3 • $687,088.15 amount saved based on jail bed day reduction, $641, 392.20 Q1, $1,492,917.30 Q2, $2,034,669 Q3 • 86 return clients, 15 Q1, 55 Q2, 75 Q3 • 0 classes provided to participants in West POD, 0 Q1, 0 Q2, 0 Q3 • 0 POD weeks of operation, 0 Q1, 0 Q2, 0 Q3
Kitsap County Superior Court Baseline: Unduplicated number of individuals served during the quarter	Adult Drug Court: • 25 attending college, 20 Q1, 25 Q2, 25 Q3 • 0 received OC GED, 3 Q1, 6 Q2, 4 Q3 • 3 created resumes, 5 Q1, 10 Q2, 6 Q3 • 37 obtained employment, 14 Q1, 20 Q2, 20 Q3 • 1 BEST business support training, 0 Q1, 0 Q2, 1 Q3 • 7 housing assistance, 46 Q1, 35 Q2, 2 Q3 • 21 licensing and education, 17 Q1, 14 Q2, 20 Q3 • 144 received job services, 201 Q1, 210 Q2, 188 Q3 Veterans Treatment Court: • 2 military trauma screening, 0 Q1, 3 Q2, 2 Q3 • 2 new participant added, 0 Q1, 3 Q2, 2 Q3 • 1 mental health referral, 0 Q1, 1 Q2, 2 Q3 • 2 substance use disorder screening, 0 Q1, 3 Q2, 2 Q3 • 2 referral for substance use disorder treatment, 0 Q1, 3 Q2, 1 Q3 • 13 active participants, 15 Q1, 16 Q2, 16 Q3 • 0 participants discharged, 2 Q1, 1 Q2, 0 Q3	Adult Drug Court: • 135 active participants, 128 Q1, 136 Q2, 138 Q3 • 53 receiving COD services, 85 Q1, 55 Q2, 57 Q3 • 6 discharged, 5 Q1, 4 Q2, 7 Q3 • 4 graduates, 7 Q1, 6 Q2, 12 Q3 • 61 receiving MAT services, 75 Q1, 72 Q2, 68 Q3 Veteran's Treatment Court: • 22 participants screened using ASAM criteria within one week of admission to VTC, 15 Q1, 16 Q2, 16 Q3 • 21 participants screened positive for needing substance use treatment and placed at either American Lake or KRC within two weeks of that determination, 14 Q1, 14 Q2, 14 Q3 • 22 participant treatment plans reviewed/revised, if necessary, every 90 days by VA clinical provider recommendation, 15 Q1, 16 Q2, 16 Q3 • 20 participants screened positive for needing mental health services were placed in treatment at VAMC or KMHS within 30 days of assessment, 15 Q1, 12 Q2, 13 Q3

	• 1 graduate, 0 Q1, 1 Q2, 5 Q3 • 3 active participants receiving MAT services, 3 Q1, 3 Q2, 2 Q3	

Agency	Fourth QT Outputs	Fourth QT Outcomes
Kitsap Homes of Compassion – Housing Supports Baseline: unduplicated number of individuals served during the quarter	• 95 unduplicated permanent supportive housing residents served, 103 Q1, 98 Q2, 95 Q3 • 47 unduplicated residents served who are in a sober home, 45 Q1, 46 Q2, 42 Q3 • 58 unduplicated residents served who are living in a low-barrier home, 58 Q1, 52 Q2, 53 Q3 • 15 total clients receiving psychiatric assessments, 4 Q1, 7 Q2, 10 Q3 • 53 total clients receiving case management, 7 Q1, 23 Q2, 48 Q3 • 72 total clients engaged in counseling services, 19 Q1, 30 Q2, 35 Q3 • 213 total clients engaged in mental health programming, 310 Q1, 321 Q2, 291 Q3	• 2.9 months average duration of clients who stay housed, either in KHOC program or community housing, 2.9 Q1, 2.9 Q2, 2.9 Q3 • 2 months is what it takes clients engaged in supportive services such as counseling, to become housed, 2 Q1, 2 Q2, 1.5 Q3 • 0 reductions in emergency psychiatric services or hospitalizations, 2 Q1, 0 Q2, 43 Q3 • 0 self-reported data from clients on reducing psychiatric services or hospitalization, 19 Q1, 0 Q2, 0 Q3 • 27 self-reported data from clients on reducing law enforcement activities, 19 Q1, 6 Q2, 19 Q3
Kitsap Mental Health Services Baseline: Unduplicated number of individuals served during the quarter	Pendleton Place: • 73 classes held for clients, 73 Q1, 89 Q2, 69 Q3 • 332 meetings with housing supports, 551 Q1, 586 Q2, 431 Q3 • 128 client meetings with Peer Support, 0 Q1, 0 Q2, 44 Q3 • 73 individuals housed, 73 Q1, 73 Q2, 72 Q3 • 69 individuals with mental health, 72 Q1, 69 Q2, 69 Q3 • 30 individuals with substance use disorder, 30 Q1, 30 Q2, 30 Q3 • 30 individuals with dual diagnosis, 30 Q1, 30 Q2, 30 Q3 • 3 individuals who terminated lease, 2 Q1, 4 Q2, 2 Q3	Pendleton Place: • 61 residents who accessed primary care, 63 Q1, 62 Q2, 62 Q3
Kitsap Public Health District Nurse Family Partnership Baseline: Unduplicated number of individuals served during the quarter	• 175 NFP nursing visits, 203 Q1, 178 Q2, 184 Q3 • 67 CHW or Public Health referrals, 46 Q1, 45 Q2, 60 Q3 • 40 mothers served in NFP, 45 Q1, 44 Q2, 39 Q3 • 34 infants served in NFP, 36 Q1, 36 Q2, 32 Q3	• 538 CHW or Public Health management encounters, 58 Q1, 110 Q2, 140 Q3 • 20 postpartum group sessions held, 0 Q1, 8 Q2, 19 Q3 • 75 total mothers participating in support group sessions, 0 Q1, 31 Q2, 58 Q3

Agency	Fourth QT Outputs	Fourth QT Outcomes
Kitsap Recovery Center Person in Need (PIN) Baseline: Unduplicated number of individuals served during the quarter	• 17 referrals to higher level of inpatient services, 12 Q1, 46 Q2, 26 Q3 • 17 individuals who request substance use disorder services, 14 Q1, 20 Q2, 26 Q3 • 12 individuals who start detox, 10 Q1, 20 Q2, 24 Q3 • 3 individuals who started outpatient services, 1 Q1, 4 Q2, 4 Q3 • 1 individual transferred to supportive housing, 1 Q1, 8 Q2, 9 Q3	• 14 individuals who accepted housing after completing inpatient treatment, 1 Q1, 9 Q2, 10 Q3 • 65 individuals who were offered housing after inpatient treatment, 2 Q1, 14 Q2, 15 Q3 • 5 clients screened who entered services same day, 8 Q1, 19 Q2, 45 Q3 • 42 clients screened who entered treatment, 9 Q1, 35 Q2, 58 Q3 • 18 clients who left treatment not complete, 2 Q1, 10 Q2, 18 Q3 • 49 total who have exited treatment (complete and not complete), 8 Q1, 31 Q2, 49 Q3
Kitsap Rescue Mission Baseline: Unduplicated number of individuals served during the quarter	• 1 assessment, 8 Q1, 4 Q2, 3 Q3 • 0 detox admits, 1 Q1, 1 Q2, 1 Q3 • 0 inpatient treatment admit, 0 Q1, 1 Q2, 1 Q3 • 0 outpatient admits, 5 Q1, 1 Q2, 2 Q3 • 6 sober living housing placements, 2 Q1, 0 Q2, 0 Q3 • 200 1:1 session, 239 Q1, 37 Q2, 176 Q3 • 104 1:1 session with MH provider, 208 Q1, 228 Q2, 165 Q3 • 6 911 calls, 0 Q1, 2 Q2, 4 Q3 • 3 emergency room engagements, 4 Q1, 7 Q2, 3 Q3	• 70 individuals served, 0 Q1, 21 Q2, 0 Q3 • 54 individuals served with SUDP services, 47 Q1, 15 Q2, 46 Q3 • 22 individuals served with MH services, 0 Q1, 6 Q2, 58 Q3 • 0 individuals utilizing housing navigator services, 0 Q1, 0 Q2, 0 Q3
Olympic Educational District 114 Baseline: Unduplicated number of individuals served during the quarter	• 57 elementary contacts with clients, 997 Q1, 1054 Q2, 378 Q3 • 67 middle school contacts with clients, 408 Q1, 625 Q2, 125 Q3 • 231 high school contacts with clients, 523 Q1, 286 Q2, 79 Q3 • 54 elementary drop-ins, 31 Q1, 34 Q2, 7 Q3 • 127 middle school drop-ins, 36 Q1, 47 Q2, 12 Q3 • 189 high school drop-ins, 26 Q1, 12 Q2, 47 Q3 • 399 elementary parent interactions, 252 Q1, 314 Q2, 150 Q3 • 81 middle school parent interactions, 30 Q1, 45 Q2, 12 Q3 • 50 high school parent interactions, 10 Q1, 30 Q2, 25 Q3 • 312 elementary staff contacts, 385 Q1, 441 Q2, 106 Q3 • 47 middle school staff contacts, 25 Q1, 14 Q2, 15 Q3 • 100 high school staff contacts, 41 Q1, 14 Q2, 32 Q3	• 702 students have received services at targeted elementary, middle, and high schools (year to date), 321 Q1, 410 Q2, 515 Q3

	• 39 unduplicated elementary students served, 138 Q1, 154 Q2, 164 Q3 • 82 unduplicated middle school students served, 98 Q1, Q2, 59 Q3 • 66 unduplicated high school students served, 41 Q1, 85 Q2, 55 Q3	

Agency	Fourth QT Outputs	Fourth QT Outcomes
One Heart Wild Baseline: unduplicated number of individuals served during the quarter	• 8 family coordinated sessions, 5 Q1, 12 Q2, 3 Q3 • 8 telehealth sessions, 61 Q1, 78 Q2, 31 Q3 • 4 mental health / behavioral health sessions, 4 Q1, 4 Q2, 8 Q3 • 125 animal assisted mental health treatment / behavioral health services, 179 Q1, 146 Q2, 120 Q3 • 110 youth clients, 105 Q1, 84 Q2, 97 Q3 • 15 adults served with a child, 7 Q1, 7 Q2, 10 Q3 • 200 youth reached through school, 354 Q1, 361 Q2, 220 Q3	• 301 clients completed an intake, 76 Q1, 96 Q2, 105 Q3 • 8 clients have established care coordination plans with OHW, 11 Q1, 12 Q2, 10 Q3
Scarlet Road Baseline: Unduplicated number of individuals served during the quarter	• 3 times flexible rental assistance provided, 12 Q1, 2 Q2, 5 Q3 • $3,140.88 spent for rental assistance, $12,532.39 Q1, $2510.89 Q2, $3,815.84 Q3 • 21 adult victims, 17 Q1, 17 Q2, 22 Q3 • 5 youth victims, 2 Q1, 2 Q2, 6 Q3 • 20 adult victims connected to LMH, 14 Q1, 16 Q2, 0 Q3	• 3 adults receiving rental assistance, 8 Q1, 9 Q2, 34 Q3 • 25 adults received employment services, 5 Q1, 15 Q2, 23 Q3 • 22 needed employment services, 3 Q1, 10 Q2, 15 Q3
West Sound Treatment Center – New Start Baseline: Unduplicated number of individuals served during the quarter	New Start Program: • 99 applications for New Start and Re-Entry, 116 Q1, 119 Q2, 127 Q3 • 54 assessments performed, 70 Q1, 49 Q2, 61 Q3 • 12 intakes performed, 35 Q1, 21 Q2, 12 Q3 • 80 transports to New Start/reentry clients, 58 Q1, 90 Q2, 35 Q3 • 79 referrals to the REAL team, 61 Q1, 96 Q2, 96 Q3 • 79 referrals to SABG for vocational need, 61 Q1, 96 Q2, 96 Q3 • 54 New Start/Re-Entry Clients, 167 Q1, 119 Q2, 96 Q3 • 21 housed participants, 26 Q1, 22 Q2, 22 Q3	New Start Program: • 297 clients with a housing barrier who received sufficient referrals to housing (year to date), 26 Q1, 122 Q2, 218 Q3 • 224 clients with a housing barrier (year to date), 26 Q1, 49 Q2, 145 Q3 • 90 have visited a primary care physician within 30 days of entering sober living (year to date), 25 Q1, 47 Q2, 69 Q3 • 91 housed participants (year to date), 26 Q1, 48 Q2, 70 Q3 • 332 clients who need MH services connected to SIH (year to date), 61 Q1, 157 Q2, 253 Q3 • 266 clients who need mental health services (year to date), 61 Q1, 91 Q2, 187 Q3

		• 26 clients who need mental health medication who report receiving mental health medication management (year to date), 4 Q1, 9 Q2, 18 Q3 • 26 clients who need mental health medication (year to date), 4 Q1, 9 Q2, 18 Q3
West Sound Treatment Center – Resource Liaison Baseline: Unduplicated number of individuals served during the quarter	Resource Liaison Program: • 196 transportation supports received, 48 Q1, 54 Q2, 170 Q3 • 89 housing supports received, 64 Q1, 38 Q2, 73 Q3 • 89 behavioral Health supports received, 129 Q1, 159 Q2, 93 Q3 • 90 harm Reduction supports received, 65 Q1, 108 Q2, 93 Q3 • 10 units received (cell phone or similar supports), 4 Q1, 4 Q2, 10 Q3 • 4 units received (ID or similar supports), 3 Q1, 5 Q2, 1 Q3	Resource Liaison Program: • 89 clients completed a needs assessment, 128 Q1, 107 Q2, 84 Q3 • 137 clients successfully connected to resources of needs, 73 Q1, 20 Q2, 88 Q3 • 137 total individuals who have been supported with successful connections to services, 107 Q1, 107 Q2, 52 Q3 • 103 other supports received, 76 Q1, 97 Q2, 503 Q3