Mental Health Services Act

AN ANNUAL UPDATE TO THE THREE-YEAR PROGRAM AND EXPENDITURE PLAN

JUNE 2021

INCLUDES DATA FROM FISCAL YEAR 2019-20, ALONG WITH THE ANNUAL INNOVATIONS AND PREVENTION AND EARLY INTERVENTION REPORTS

Shasta County Health & Human Services Agency

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A Vision of Recovery

Recovery is a process of change through which people improve their health and wellness, live a self-directed life and strive to reach their full potential. There are many different pathways to recovery, and each individual determines his or her own way.

Supporting a Life in Recovery

Health: Overcoming or managing one's disease(s) or symptoms and for everyone in recovery, making informed, healthy choices that support physical and emotional wellbeing.

Home: A stable and safe place to live.

Purpose: Meaningful daily activities, such as a job, school, volunteerism, family caretaking or creative endeavors, and the independence, income and resources to participate in society.

Community: Relationships and social networks that provide support, friendship, love, and hope.

Guiding Principles of Recovery

Recovery emerges from hope.

Recovery is person-driven.

Recovery occurs via many pathways.

Recovery is holistic.

Recovery is supported by peers and allies.

Recovery is supported through relationship and social networks.

Recovery is culturally-based and influenced.

Recovery is supported by addressing trauma.

Recovery involves individual, family, and community strengths and responsibility.

Recovery is based on respect.

Message from the Director

The COVID-19 pandemic has forced all of us to change the way we deliver mental health services in Shasta County. We had to think quickly and creatively to continue providing critical services while protecting the community from the physical and mental health threats posed by this deadly pandemic. Our staff, our community partners, our clients and their families all stepped up to provide people with the tools they need to make progress in their recovery from mental illness, and to address the long-lasting emotional impacts of COVID-19.

The Mental Health Services Act was designed to create a system that promotes recovery and wellness for adults with serious mental illness and resiliency for children with severe emotional disturbance and their families. With the help of community partners, the Shasta County Health and Human Services Agency continues to provide Mental Health Services Act-funded programs that serve children, transitional age youth, adults and older adults.

We continue to fine-tune our programs based on feedback from our community, and we measure the results of these programs so we know what needs to be adjusted to make them work better.

Thank you for reviewing this report and providing the feedback that continues to help us meet the needs of all Shasta County residents.

Sincerely,

Donnell Ewert, MPH

Shasta County Health and Human Services Agency Director

Mental Health Services Act Overview

Proposition 63, known as the Mental Health Services Act, was approved by California voters in November 2004 and became law in January 2005. The Mental Health Services Act is an additional 1 percent tax on individual taxable income in excess of $1 million, and that money funds a comprehensive approach to developing a system of community-based mental health services and supports. It addresses a broad continuum of prevention, early intervention and service needs, and the necessary infrastructure, technology and training elements that effectively support this system.

The purpose and intent of the Mental Health Services Act is:

To define serious mental illness among children, adults and seniors as a condition deserving priority attention, including prevention and early intervention services, and medical and supportive care.

To reduce the long-term adverse impact on individuals, families, and state and local budgets resulting from untreated serious mental illness.

To expand the kinds of successful, innovative service programs begun in California, including culturally and linguistically competent approaches for underserved populations. These programs have already demonstrated their effectiveness in providing outreach and integrated services, including medically necessary psychiatric services, and other services, to individuals most severely affected by or at risk of serious mental illness.

To provide state and local funds to adequately meet the needs of all children and adults who can be identified and enrolled in programs under this measure. State funds shall be available to provide services that are not already covered by federally sponsored programs or by individuals' or families' insurance programs.

To ensure that all funds are expended in the most cost-effective manner and services are provided in accordance with recommended best practices subject to local and state oversight to ensure accountability to taxpayers and to the public.

The Mental Health Services Act is divided into five components: Community Services and Supports (CSS), Prevention and Early Intervention (PEI), Workforce Education and Training (WET), Capital Facilities and Technological Needs (CF/TN), and Innovation (INN). Through the community planning process, the projects and programs under each of these components are planned, developed, approved, implemented, monitored and updated.

Shasta County Health and Human Services Agency spearheads the community planning process and is responsible for outreach, providing opportunities to participate, involving consumers and/or family members and providing training when necessary. The community planning process involves many stakeholders, both individuals and agencies with an interest in mental health services in Shasta County.

Community Program Planning

The Mental Health Services Act community stakeholder process is a collaboration that adheres to California Code of Regulations § 3320 to plan, implement and evaluate Shasta County's Mental Health Services Act programs. We take care to ensure that we reach out to people of all ages, ethnicities and socioeconomic backgrounds, mental health clients and family members, people who provide services to people with mental health challenges and substance use disorders, and people from all corners of our county. The goal is to work together to gather diverse opinions to ensure that our wellness-, recovery- and resilience-focused programs will be successful.

Community program planning for the Mental Health Services Act in Shasta County happens throughout the year, at locations all over the county. Several standing committees and workgroups actively involve a wide array of people and agencies, and their input helps guide the Health and Human Services Agency as it administers the Mental Health Services Act in Shasta County. These groups provide ideas and feedback for plans and updates, mental health policies, programs, budgets, and outreach and engagement efforts.

The stakeholder process also uses e-mail, websites, newsletters, social media, trainings and webinars to communicate with stakeholders.

Underserved cultural populations	
Good News Rescue Mission	Pit River Health Services
Hispanic Latino Coalition	Redding Rancheria
Local Indians for Education	Shasta County Citizens Against Racism
NorCal OUTReach	Victor Youth Services (LGBT)
Consumer-based organizations	
Circle of Friends Wellness Center	Olberg Wellness Center
Consumer and/or family member	
Adult/Youth Consumers & Family Members	Public Health Advisory Board
Mental Health, Alcohol and Drug Advisory Board	Rowell Family Empowerment
NAMI Shasta County	
Health and Human Services Agency	
Law Enforcement	
Redding Police Department	Shasta County Sheriff's Department
Shasta County Probation Department	Anderson Police Department
Education	
All Shasta County Schools	Shasta Community College
Chico State University	Shasta County Office of Education
National University	Simpson University
Community-based organizations	
Area Agency on Aging	Tri-Counties Community Network
Shasta County Chemical People	Youth Violence Prevention Council
Health care	
Hill Country Health and Wellness Center	Shasta Community Health Center
Mountain Valleys Health Center	Shingletown Medical Center

Community Program Planning

Regular stakeholder committees:

MHSA Stakeholder Workgroup: The MHSA Stakeholder Workgroup meets quarterly and as needed, depending upon the needs of the Health and Human Services Agency in administering the Mental Health Services Act. The workgroup provides input for the planning, implementation and oversight of the Mental Health Services Act.

Meeting dates: July 16, 2019; October 15, 2019; January 14, 2020 (these meetings were put on hold after March 2020 due to the pandemic)

Stand Against Stigma Committee: This committee works to promote mental wellness, increase community awareness of mental health and end the stigma surrounding mental illness and substance abuse. The community-based committee supported by the Health and Human Services Agency meets monthly and is open to all interested members of the public.

Meeting dates: July 9, 2019; September 10, 2019; October 8, 2019; November 12, 2019; December 10, 2019; January 14, 2020; February 11, 2020; March 10, 2020; May 12, 2020; June 9, 2020 (during the pandemic, meetings have been moved online)

Suicide Prevention Workgroup: The Suicide Prevention Workgroup is a local collaboration of community members and public and private agencies who focus on reducing suicide in Shasta County. This active workgroup discusses the progress being made in suicide prevention, as well as action planning, implementation and evaluation.

Meeting dates: August 20, 2019; September 17, 2019; October 15, 2019; November 19, 2019; January 21, 2020; March 17, 2020 (during the pandemic, meetings have been moved online)

The **Mental Health, Alcohol and Drug Advisory Board** also provides opportunities for discussion, education and input at its meetings. A Mental Health Services Act update report is given at its regular bi-monthly meeting, and they hear periodic presentations on Mental Health Services Act programs.

Meeting dates: July 10, 2019; September 4, 2019; November 6, 2019; January 8, 2020; February 5, 2020; March 4, 2020 (these meetings were put on hold after March 2020 due to the pandemic)

Community Stakeholder Meetings

Three in-person general community stakeholder meetings were held in Fiscal Year 2019-20 to provide guidance on MHSA programs. Each meeting included updates on projects outlined in the Three-Year Program and Expenditure Plan, along with robust discussion about ideas for upcoming Innovations projects. Meetings included representatives from the following groups:

- People who have severe mental illness
- Families of children, adults, and seniors who have severe mental illness
- People who provide mental health services
- Law enforcement agencies
- Educators
- Social services agencies
- Veterans
- Providers of alcohol and drug services
- Health care organizations

Stakeholder meetings in Fiscal Year 2019-20 continued to focus on selecting Shasta County's next Innovations project.

Stakeholders also shared feedback about successes and gaps in the existing mental health system. Veterans and people hospitalized for mental illness are some of the groups of concern to stakeholders, and expanding Wellness Recovery Action Planning (WRAP) and suicide awareness trainign were both of high interest. Respite care for families, effective discharge planning and more outreach to the homeless were other concerns brought forward from the group. At stakeholders' request, HHSA began offering two different times for each stakeholder meeting, to make them more accessible to those who might be unable to attend a morning meeting.

All stakeholder meetings were advertised in press releases and on social media, and we encouraged our partners and committee members to also share them in their circles. Stakeholders suggested recording the meetings to share online for those who were unable to attend in person.

Because Shasta County does not have any threshold languages, all meetings were conducted in English. However, the county has interpreters who were available to translate verbally and a translation service that could translate the survey into other languages if we were to receive such a request. The Stakeholder Survey Results Report can be found in Appendix A.

We also receive feedback on our services through a Client Satisfaction Survey, which is in Appendix B.

Program Evaluation

In the mental health treatment field, outcomes are used to understand and measure how a person responds to programs. They are important because they help answer the question:

Are we offering effective services that are helping individuals have more meaningful lives?

Shasta County Health and Human Services Agency is dedicated to measuring mental health outcomes for the purpose of guiding treatment practices at both the individual and service level. Our youth mental health services use Child and Adolescent Needs and Strengths (CANS), while our adult mental health services are measured in part by the Milestones of Recovery Scale (MORS).

CANS: Child and Adolescent Needs and Strengths

CANS is a multipurpose tool for use in children's programs to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to monitor outcomes of services. It was developed to help link the assessment process with the design of individualized service plans. The CANS is well liked by parents, providers and other partners because it is easy to understand and does not necessarily require scoring to be meaningful to an individual child and family.

This tool addresses the mental health of youth and their families. It is a comprehensive assessment of psychological and social factors, as well as the strengths of the family/caregiver and child/youth, for use in treatment planning. It was developed with the objectives of permanency, safety and improved quality of life.

MORS: Milestones of Recovery Scale

The MORS is an effective evaluation tool for tracking the process of recovery for adults with persistent, serious mental illness. It is rooted in the principles of psychiatric rehabilitation and defines recovery as a process beyond symptom reduction, client compliance and use of services. It operates from a perspective that meaningful roles and relationships are the driving forces behind achieving recovery and leading a fuller life.

The MORS provides a snapshot of an individual's progress toward recovery. It uses milestones that include level of risk, level of engagement and level of skills and supports. The MORS helps staff tailor services to fit each individual's needs, assign individuals to the right level of care and assist with treatment plan design. By administering the MORS on a regular basis, an individual's process of recovery can be monitored and treatment adjusted with the goal of achieving positive outcomes for the individual.

Client satisfaction

The Health and Human Services Agency uses feedback from clients, family members and the general public to help ensure a positive experience for people using our services. The Performance Outcomes Quality Improvement (POQI) is conducted twice a year. The California Department of Health Care Services requires all California counties to make the survey available, but client participation is voluntary.

Looking forward: Health and Human Services Agency staff will continue to look at ways to deliver excellent, timely and sensitive customer service to all people who walk through our doors. We will also work to increase participation in our surveys, so we can effectively respond to client feedback.

Mental Health Services Act Programs

Community Services and Supports	
Client and Family Operated Services	
• NAMI	• Wellness centers
STAR (Shasta Triumph and Recovery)	
Rural Health Initiative	
Older adult services	
Crisis services	
Housing continuum	
Co-occurring disorders	
Outreach	
Prevention and Early Intervention (PEI)	
Client and Family Operated Services	
• Triple P • Trauma-Focused Treatment • Community programs for At-Risk Middle School Students	• 0-5 • Adverse Childhood Experiences • Launch • IMPACT
Older adult	
Individuals experiencing the onset of serious psychiatric illness	
Stigma and discrimination reduction	
Suicide prevention	

Workforce Education and Training (WET)
Volunteer program
Comprehensive training program – MHSA Academy
Internship/residency program

Innovation (INN)
CARE Center
Pending: Hope Park Project
Capital Facilities/Technological Needs (CF/TN)
None during this reporting period

Community Services and Supports (CSS)

Community Services and Supports (CSS) programs aim to change the public mental health system by providing for system improvement, service expansion and new systems of delivery. CSS programs are designed with a comprehensive and inclusive approach for individuals with serious mental illness or serious emotional disturbance.

The nine CSS projects, along with the number of unique individuals served by HHSA staff in Fiscal Year 2019-20, are:

CSS Projects	No. Individuals Served
1. Client- and family-operated systems	(unduplicated number can't be determined)
2. Shasta Triumph and Recovery (STAR)	
3. Rural health initiative	
4. Older adult	
5. Crisis services	
6. Crisis Residential and Recovery Center	
7. Housing continuum	
8. Co-occurring disorders integration	
9. Outreach/Access	

1. Client- and Family-Operated Systems

Shasta County has two consumer-run wellness centers: the Sunrise Mountain Wellness Center in Redding, and Circle of Friends in Burney. Both wellness centers are funded through contracts with community providers. Circle of Friends is operated by Hill Country Health and Wellness Center. The Sunrise Mountain Wellness Center is run by Kings View, and was formerly the Olberg Wellness Center operated by Northern Valley Catholic Social Service. Unfortunately, due to the pandemic, these centers had to close most of their in-person operations and offer services online only. Under normal circumstances, these multi-service mental health programs provide ethnically and culturally diverse opportunities in a healthy, inclusive manner with a wide spectrum of activities. Both centers provide services and activities for people with mental illness and/or their family members. In Fiscal Year 2019-20, the centers offered 2,074 individual workshops, groups, activities and 12-step recovery meetings.

Some of the goals for wellness center participants include an increased ability to spend time in meaningful activities, increased community involvement, a reduction in the consequences of untreated or under-treated mental illness, and increased linkages to services. The contracts for both wellness centers require participant involvement in the planning and direction of services and activities provided there. Staffing for the centers, including the use of volunteers, must meet requirements for consumer and/or family member employment. Services and activities support consumers in reaching and maintaining their wellness and recovery goals; foster recovery and resiliency; and are therapeutic, social and educational in nature.

The Wellness Centers Summary Report can be found in Appendix D.

Also through Client- and Family-Operated Systems, the Health and Human Services Agency contracts with the Shasta County National Alliance on Mental Illness (NAMI) to provide education programs in the community, including NAMI Basics, NAMI Family-to-Family, NAMI Peer-to-Peer, Family Support Group and NAMI On Campus, along with numerous community activities. They operate out of the Hill Country CARE Center, where they facilitate peer support groups and offer one-on-one mentoring in person and over the phone. The NAMI Summary Report can be found in Appendix E. For more information on NAMI educational programs, please visit www.nami.org/find-support/nami-programs.

2. Shasta Triumph and Recovery (STAR)

Requirements and guidelines for Full Service Partnership programs are in Title 9 of the California Code of Regulations. Each county provides a Full Service Partnership program through the Mental Health Services Act. Shasta Triumph and Recovery (STAR) is the Full Service Partnership program in the urbanized I-5 corridor that includes Redding, Anderson, and the City of Shasta Lake. This program serves all age groups, is enrollee-based, and can serve up to 60 members. The STAR program through Adult Services serves 21 years old or older, and STAR program through Children's Services serves ages up to 21 years old.

The Health and Human Services Agency also contracts with Hill Country Health and Wellness Center to provide a Full Service Partnership program, which has the capacity to serve up to 15 individuals in the Intermountain area, plus another five in North Redding.

Full Service Partnership programs are wellness-, recovery-, and resiliency-based and practice the 24/7 "whatever it takes" model to provide access to services. People eligible for partnership include those with severe and persistent mental illness or children with severe emotional disturbance, who are homeless or at risk of homelessness and/or incarceration, have an increased risk of hospitalization or multiple hospitalizations and/or emergency department contacts, at risk of being conserved or on LPS conservatorship, difficult to engage or not in treatment, multiple functional impairments and struggles to complete activities of daily living tasks without support or prompts from intensive case management, and who may also have a substance use disorder. The individuals who meet this criteria are provided with outreach until they either become a Full Service Partner or are transferred to other appropriate programs. Services include individual and group therapy, rehabilitation activities, case management, medication support, transportation, supports for housing, employment or employment preparation, peer relations, social activities and education. This program also has very strong links to the wellness centers, which provide additional support and services.

The Woodlands permanent supportive housing complex has been increased by 20 units, 10 of which are be for Full Service Partner-eligible tenants.

Three-Year Goal: More Full Service Partners (FSP) will be able to access supportive housing through Woodlands' Phase II Housing. STAR Team will continue to provide extensive social and supportive services with the goal of maintaining permanent housing. The STAR Team will continue its efforts to reach out to the hardest-to-reach populations, including people who are homeless and suffer from severe and persistent mental illness, which was identified as an underserved group by stakeholders. The goal is to increase supportive independent housing for our FSP and expanding STAR services to provide comprehensive intensive services to decrease placing clients in out of county higher level of care placements while also increasing and adding Assisted Outpatient Treatment services. Adult STAR Team would also like to increase the number of FSP served by the team to 80 partners.

Year One Progress: More FSP clients have been connected with the newly added apartments at The Woodlands. Multiple mental health group services and support is being offered throughout the week, with an emphasis of helping FSPs increase coping skills and life skills to enjoy and maintain their independence.

3. Rural Health Initiative

The focus of the Rural Health Initiative is to engage people of all ages who are living with severe and persistent mental illness, are unserved or underserved, and have previously not been able to access mental health services in the rural areas. The Rural Mental Health Committee meets monthly and is a forum for service providers to discuss barriers and service options for the rural population.

Because people of all ages and ethnicities were unserved and underserved in Shasta County's rural areas, the Health and Human Services Agency has contracts with four Federally Qualified Health Centers, which provide integrated primary and mental health care to these populations. These are Hill Country Health and Wellness Center in Round Mountain, Shingletown Medical Center, Mountain Valleys Health Centers in Burney, and Shasta Community Health Center in Redding. Services include telepsychiatry, intensive case management, medication management, crisis services and support, and integration with primary care physicians.

The Federally Qualified Health Center Annual Summary Report can be found in Appendix G.

Three-Year Goal: Our Federally Qualified Health Centers are in the unique position of being able to attend to patients' physical and mental health in rural areas, and this dovetails with stakeholders' interest in treating "the whole person." We will work to ensure that programs and services offered in the larger cities are as accessible as possible to those in rural areas, potentially increasing the use of technology that helps to bridge geographical gaps, such as telepsychiatry.

Year One Progress: The number of people who received mental health services at a Federally Qualified Health Center dropped by 4 percent this fiscal year, with most people seeking services for substance-related disorders, anxiety, depressive, bipolar and adjustment disorders. The Health and Human Services Agency continues to work closely with administrators to ensure that programs meet community needs.

4. Older Adult

This program focuses on older adults with severe and persistent mental illness who are transitioning from acute care medical hospitals, psychiatric hospitals, board and care homes or jail. Outreach and engagement activities in the community are age appropriate, culturally competent and accessible, and they support recovery or rehabilitation as deemed appropriate by the client and his/her natural support system of family and community. Services also include access to increased housing options, depending upon the level of care the person needs.

The Health and Human Services Agency serves on the Shasta County Older Adult Policy Council, which meets monthly. It is also involved with the Area Agency on Aging. This collaboration among government and community-based agencies aims to enhance the well-being of Shasta County adults aged 50 and older. It develops policies to increase resources and the effectiveness of services available to seniors. These services address co-occurring substance use disorders, including prescription drug abuse, homelessness, physical disabilities, chronic serious medical illness and risk of loss of independence.

Three-Year Goal: We will continue to ensure that outreach and stakeholder groups include older adults.

Year One Progress: Older adults continue to participate in stakeholder meetings at a rate that's proportional to the Shasta County overall population. The Area Agency on Aging is an active participant in stakeholder meetings.

5. Crisis Services

The Crisis Services work plan serves people experiencing a mental health emergency. Participants include people who come to local emergency rooms on an involuntary mental health hold, people with a psychiatric diagnosis who visit emergency rooms frequently, people who may need acute psychiatric hospitalization, and people who require specialized services to maintain a lower level of care and stability. Services include discharge planning to coordinate and ease transition of care, emergency services and 24/7 telephone crisis services. Clinical staff are co-located in Redding's two emergency rooms, which allows for more rapid assessment and shortens the time people spend in the emergency room. For people who don't need inpatient psychiatric hospitalization, the time from evaluation to discharge is shorter. One local hospital now has an inpatient psychiatric wing.

A care coordination program helps facilitate successful discharge of clients from both the emergency department and inpatient facilities. This case manager coordinates with emergency department crisis staff, HHSA outpatient services and community providers for successful linkage to ongoing services, reducing the need for continued use of emergency/crisis services.

A mobile crisis team is now provided in Shasta County through a contract with Hill Country Health and Wellness Center.

Three-Year Goal: Stakeholders have identified that providing services for people in crisis continues to be a relevant concern. HHSA's new discharge planner is a case manager who will continue to coordinate with co-located emergency department crisis staff, HHSA outpatient services and community providers to help facilitate discharges from emergency departments and psychiatric hospitalizations and link clients with ongoing services. We will identify and address challenges in the inpatient admissions and discharge processes. Ongoing evaluation of the program will identify additional needs, which may include additional clinical support to better meet the needs of client especially in the area of engaging and supporting high utilizers.

Year One Progress: A Care Coordination program was started in HHSA which consisted of a case manager dedicated to facilitating successful discharge of clients from both the emergency department and inpatient facilities. This case manager coordinated with co-located emergency department and crisis staff, HHSA outpatient services, and community providers for successful linkage to ongoing services, thus reducing the need for continued access of emergency/crisis services.

6. Crisis Residential and Recovery Center

The Crisis Residential and Recovery Center provides services for up to 30 days to people 18 years of age and older. The center provides support to people following a mental health crisis, and aims to prevent the need for the person to be hospitalized. Stays are voluntary and include such services as daily groups focused on wellness and recovery, coping skills, medication support, education, daily living activities, peer support, and short-term respite care.

The center is designed for adults with mental illness who have become suicidal, critically depressed or otherwise psychiatrically incapacitated. These services help people move from crisis into short-term transitional housing and stabilization and Full Service Partnership enrollment, Whole Person Care enrollment, or to outpatient intensive case management and support, as needed. For some, the Crisis Residential and Recovery Center is the initial access point into the public mental health system.

The center's Program Activity Report can be viewed in Appendix H.

Three-Year Goal: To develop systems that accurately standardize practice and approach in service delivery so that we may adjust our current model in order to assist clients in connecting to appropriate level of care. We will focus on increasing the level of clinical intervention and documentation within the center and linkage to outside clinical resources in an effort to prevent / reduce the need for future psychiatric hospital stays in Shasta County.

Year One Progress: The Crisis Residential and Recovery Center continues to fill a gap, particularly for people who need temporary, less-intensive services after experiencing a mental health crisis. While at the CRRC, people can be connectedto community mental health resources such as Shasta County Mental Health and NVCSS's Olberg Wellness Center, medication monitoring, groups designed to improve the client's quality of life, a safe environment to recover from trauma and caring staff that assist clients on their road to recovery.

7. Housing Continuum

Housing remains a challenge for many consumers, and we have maintained our focus on addressing the need for housing for people with serious mental illness. The primary goal is to help people who have serious mental illness and their families who are homeless or at risk of homelessness by providing access to housing options, both transitional and permanent supportive, in the least restrictive setting possible.

Permanent Supportive Housing

The Woodlands was expanded to include 75 units, with 29 MHSA funded and designated for people who are eligible for Full Service Partnership services. A Health and Human Services Agency case manager and peer support specialist provide case management, links to community resources and more for people in the MHSA-funded apartments. The Woodlands Permanent Supportive Housing Report can be viewed in Appendix I.

Northern Valley Catholic Social Service is responsible for providing various life skills classes to help clients maintain permanent housing. Classes offered to Woodlands residents included Wellness Recovery Action Planning (WRAP), life skills, nutrition education, after-school homework help, suicide prevention, seeking safety and peer support. Alcoholics Anonymous classes are offered weekly. A residents' council gives residents an avenue to address concerns and voice their opinions about decisions that affect them.

Permanent supportive housing in the Burney area is still needed. Finding appropriate land and funding has proven quite challenging, and a local developer continues to troubleshoot this problem.

Another housing project is in the works next to Hill Country Community Clinic's new 40,000-square-foot medical facility. Spearheaded by ADK Properties and The McConnell Foundation, the Center for Hope Apartments is funded by No Place Like Home and it will be a 49-unit complex with up to 15 units reserved for people who need permanent supportive housing services delivered by Hill Country Community Clinic.

Transitional Housing

For individuals with severe mental illness, accessing and maintaining housing can be very difficult and housing can be lost very quickly if that individual suffers a mental health crisis, has a loss of income, or experiences a loss of their support system. The Health and Human Services Agency aims to house people in the least restrictive setting possible and help move them toward permanent independent living situations. The Transitional Housing program helps people find affordable, accessible housing near their support systems with adequate access to transportation to services. Activities that support this goal include:

- Evaluate all placement options locally and in neighboring counties
- Expand local placement options with existing providers
- Develop new placement options with existing providers
- Review existing Board and Care contracts for the purposes of:
    - Expanding current capacity
    - Developing levels of care for varying client needs
- Evaluate financial leveraging opportunities

Board and care facilities in Shasta County are privately owned and receive their funding from residents. Most individuals receive Social Security Income, which pays for their board and care. Some residents require additional supports due to their mental illness, and in those instances, the Health and Human Services Agency will provide "patch" funding to cover the costs of the increased care.

Three-Year Goal: Despite improvements in recent years, housing is always identified by stakeholders as a significant barrier to wellness. Whole Person Care, No Place Like Home and other programs provide opportunities for collaboration, and we will continue working collaboratively to identify ways to secure funding for housing in our county.

Year One Progress: The Woodlands 2 is complete and occupied, partners continue to work on solutions for permanent supportive housing in Burney, and the Center of Hope Apartments continues to move forward.

8. Co-occurring/Primary Care Integration

The Co-occurring/Primary Care Integration program serves people who have both mental illness and substance use problems, as well as people who have a mental illness and another physical illness. The mind and body are intrinsically connected, and what happens to one profoundly impacts the other. This program coordinates needed care for easier access, greater consumer satisfaction and better outcomes.

People with serious mental health conditions die an average of 25 years earlier than the general population. For those with a physical illness, the goal is to connect them to primary care to provide coordinated care to treat the whole person, and to provide services that focus on both their mental and physical illnesses and how the two can interact. Providers coordinate the detection, treatment and follow-up of mental and physical conditions. Services include outreach, education, case management, treatment, medication support, and clinical and nursing services. This program looks at the following diagnoses:

- Diabetes
- Hypertension
- Chronic Obstructive Pulmonary Disease
- Hepatitis B or C
- Metabolic Syndrome (could include anything that leads to obesity)
- Chronic Heart Failure

Three-Year Goal: The Health and Human Services Agency, along with community providers, will continue to work together to improve the integrated treatment of co-occurring disorders in order to improve the quality of life for people who have both co-occurring severe mental illness and substance use disorders.

Year One Progress: Clinical staff continue to identify ways to effectively identify whether a client's symptoms are due to a mental health disorder or substance use, and treatment programs look at clients holistically. Whole Person Care has made significant progress in this work.

9. Outreach

Outreach services help people who are unserved and underserved using a “whatever it takes” approach. Case management, nursing and clinical staff reach out to bring people in need into the behavioral health system. Access services are provided in the main mental health services building and out in the field. The Access Team evaluates and assesses everyone who is referred to (or is seeking) mental health services. During this process, the person’s level of need is determined and they are referred to a service provider, which can include county mental health outpatient programs, contract service providers, primary care physicians, wellness centers and other community behavioral health providers.

Three-Year Goal: We will reinstate our field-based nursing services to help people remain as stable and independent as possible by working collaboratively with clients, health care providers, and community partners.

Year One Progress: Due to limited nursing staff, we were unable to meet our field-based nursing goal.

Prevention and Early Intervention (PEI)

Shasta County's Prevention and Early Intervention Plan is designed to bring mental health awareness to the entire community. Reducing stigma and discrimination against people with mental health problems helps encourage people to seek the help they need. Early intervention programs provide help at the earliest possible signs of concern.

Prevention includes promoting wellness, fostering health and preventing suffering that can result from untreated mental illness. Early intervention involves identifying mental health problems early, so they can be addressed quickly, ideally avoiding the need for more extensive treatment.

The five projects in Prevention and Early Intervention are:

1. Children and Youth in Stressed Families
2. Older Adult Gatekeeper Program
3. Individuals Experiencing Onset of Serious Psychiatric Illness
4. Stigma and Discrimination
5. Suicide Prevention

Unlike programs in Community Services and Supports, it is difficult to measure the number of people served by these programs during a specific time period. Therefore, we have done our best to quantify their impact in ways that make the most sense for each unique program. People reached by PEI programs has been captured in Appendix ZZZZZZZZZZZZ.

1. Children and Youth in Stressed Families

The goal of this project is to help parents become positive change agents for their children and enhance the community's capacity to support at-risk children and their families. This project includes Triple P - Positive Parenting Program, Trauma Focused Treatment, At Risk Middle School Students, and Adverse Childhood Experiences.

In school year 2019/20, a community stakeholder group developed a new County Student Attendance Review Board model for supporting school attendance. The new model, consisting of a three-tier system, was implemented at the beginning of the school year 2020/21. On December 15, 2020, the Board of Supervisors approved a nine-month agreement with the Shasta County Office of Education to fund a case manager for the new model. The new model, which includes Community Connect, has been successful and the need for attendance and family support has continued to increase. More than 40 schools have provided referrals to Community Connect and, from August 2020 to January 2021, 380 students from pre-kindergarten to high school were referred. Community Connect has been able to make contact with 174 students' families and more than 100 of them have agreed to engage in care coordination services. For families needing specialized services, the engagement rate is high, with a reach rate double than the standard good reach rate of 15%. Due to the steady increase in referrals, the care coordination caseload has exceeded the staff currently assigned. MHSA funding supported two additional case managers and two college interns for the remainder of the school year. In addition to providing services to additional students and their families, one of the new case managers was assigned to families that require more intensive help due to mental health issues in the family and homelessness.

Launch was provided in partnership with First 5 Shasta through parent partners at Pathways to Hope for Children to serve the families of kindergarten-age youth with attendance issues in kindergarten. Services have included Parent Cafés, case management to connect to additional resources/supports, parenting education, and collaboration with local school sites to identify families that can be referred to this program for additional supports.

Prevention and Early Intervention (PEI)

Triple P – Positive Parenting Program®

Triple P is an evidence-based, multi-level parenting and family support strategy that aims to prevent severe behavioral, emotional and developmental problems in children by enhancing parents' knowledge, skills and confidence. This program is done in partnership with First 5 Shasta.

The Triple P Sustainability Committee continues to meet quarterly to discuss program barriers, successes and training needs.

The Triple P Shasta County Evaluation Report can be found in Appendix J.

Three-Year Goal: Going forward, the Health and Human Services Agency will study how the program is being used, what barriers prevent the use of the program and its tools, how to address the barriers and how organizations can fund Triple P in the future. The Agency is also exploring a new version of the Triple P Scoring Application that Triple P Australia has built, specifically looking at ease of use for practitioners and the availability of data reports and their content.

Year One Progress: Triple P continues to provide services through Wright Education, Northern Valley Catholic Social Service and the Shasta County Office of Education. A variety of Triple P parenting levels are offered in individual and group settings, with services offered in person and virtually. We continue to do outreach to the community to ensure that all parents are aware of Triple P resources in the community.

Prevention and Early Intervention (PEI)

Trauma Focused Treatment

Trauma focused treatment is a necessity for serving youth and families today. Trauma-informed treatment addresses the unique needs of children with difficulties related to traumatic life experiences. This is imperative to helping those affected by Adverse Childhood Experiences move through their trauma and increase resiliency for the future. In the past, the Health and Human Services Agency has used Trauma Focused-Cognitive Behavioral Therapy, a psychotherapy model, to address these children's needs.

Another area of training includes the Trust-Based Relational Intervention (TBRI), an attachment-based, trauma-informed intervention that is designed to meet the complex needs of vulnerable children. TBRI is designed for children from "hard places" such as abuse, neglect and/or trauma. Because of their histories, it is often difficult for these children to trust the loving adults in their lives, which often results in perplexing behaviors. TBRI offers practical tools for parents, caregivers, teachers or anyone who works with children to see the "whole child" in their care and help that child reach his highest potential.

Three-Year Goal: The agency will be evaluating both evidence-based practices and promising practices to best meet the needs of the youth and families in our community.

Year One Progress: HHSA continues provide the evidence-based Trauma-Focused Cognitive Behavioral Therapy and Trust-Based Relational Intervention. Community providers and resource families serving foster youth received TBRI training throughout the last year from the HHSA TBRI certified staff.

Community Implemented Programs for At-Risk Middle School Students

During the transition from middle school to high school, adolescents frequently establish patterns of behavior and make lifestyle choices that affect their current and future mental well-being. This is especially true for children and youth in stressed families or in underserved populations. Evidence supports the idea that a prevention or early intervention approach which targets mental health during the adolescent years is appropriate and effective, with both short-term and lifespan benefits. The target population for this strategy is at-risk middle school students from stressed families who either live in an underserved geographic location or are a member of an underserved cultural population.

The Botvin LifeSkills Training for Middle School is provided by teachers trained in the evidence-based curriculum. The Botvin LifeSkills program is flexible in that it can be delivered by multiple different types of trained staff. Dunamis Counseling provides the training at Anderson Middle School, and it was expanded in Spring 2020 to include Turtle Bay, Pacheco and Happy Valley schools. Each school selected has committed to providing the curriculum for a three-year period to build upon student exposure and increase individual student outcomes in reduced harmful substance use, increased coping skills, and improved school attendance.

The INVO/IMPACT program was launched in October 2020 to serve youth identified through Shasta County Office of Education, Child Welfare and Mental Health as benefiting from early intervention services.

The Botvin LifeSkills Evaluation Report can be found in Appendix K.

Three-Year Goal: HHSA will evaluate the pilot programs to determine program outcomes and potentially expand the program to other schools in the future.

Year One Progress: Botvin LifeSkills was expanded to Turtle Bay, Pacheco and Happy Valley schools, and the INVO/IMPACT program kicked off. HHSA will evaluate the two pilots to determine program outcomes and possible expansion to other schools in the future.

<u>0-5 Program</u>

The 0-5 program addresses concerns about toddlers who have significant emotional and behavioral challenges, and how these challenges keep them from being successful in preschool and unprepared for kindergarten. These early challenges and failures, if extreme enough, can set the stage for continuing school challenges, as behavior struggles increase with age and become more entrenched and difficult to manage. HHSA has partnered with Shasta County Office of Education (SCOE) and its Bridges Program to provide support to children and their families. Increasing prevention efforts and responding to early signs of emotional and behavioral health problems among children aged 0-5 years old can reset the trajectory toward better health and success of children and young people.

The 0-5 clinician uses Triple P with parents of young children to get them focused on positive parenting, and uses Trauma-Focused Cognitive Behavioral Therapy with the little ones to address any traumatic events that may be driving the behavioral issues the children are exhibiting.

Prevention and Early Intervention (PEI)

Adverse Childhood Experiences (ACEs)

The experiences of childhood impact our health, behavior and overall well-being in adulthood - for better or worse. Adverse Childhood Experiences (ACEs) are traumatic experiences in the first 18 years of a person's life and include abuse, neglect and household dysfunction, which produce toxic stress. Toxic stress harms the brains and bodies of children, increasing their likelihood of chronic disease, cancer, mental health issues, drug addiction, homelessness, incarceration, decreased work productivity and even early death.

The Strengthening Families Collaborative was founded in 2011 to begin addressing the abnormally high numbers of Adverse Childhood Experiences in Shasta County and to build resiliency in those who have experienced ACEs. Laura Porter provided a. It focused on identifying better ways for family-serving agencies and medical providers to work as one. This collaborative, along with the HHSA and ACE Interface Trainers, have partnered with the community to work toward building resilience and transformational change.

More about this work is available at www.shastastrongfamilies.org.

Three-Year Goal: The Strengthening Families Collaborative and ACE Interface Trainers will work on ways to reduce Adverse Childhood Experiences and build resilience in Shasta County. They will also encourage other community partners to invest in creating innovating and impactful programs that will reduce the prevalence of ACEs in Shasta County.

Year One Progress: (need update).

2. Older Adult Gatekeeper Program

This was completed, as reflected in a prior Three-Year Plan, and is therefore not included in this report.

3. Individuals Experiencing Onset of Serious Psychiatric Illness

Early Onset

Serious psychiatric illnesses such as schizophrenia and bipolar often emerge in late adolescence or early adulthood. This project targets individuals between ages 15 and 25 who have symptoms that might indicate the start of a serious and persistent mental illness. The priority components of the Early Onset Program are early detection, engagement and prompt assessment, referral, treatment, and family support. In addition to the treatment interventions, outreach and education helps the community understand that this program has the expertise and resources to address the first signs of serious mental illness.

Treatment objectives of the program are psychoeducation for client and family on serious mental illness, individual therapy, individual rehabilitation services, family therapy, cognitive behavioral group therapy and parent support groups for families on the Early Onset caseload.

Challenges to the program continue to be providing the best client care for engaged people, while also being engaged in consistent outreach to community stakeholders.

New Three-Year Goal: The Early Onset clinician and peer support specialist will continue working with other Shasta County intensive programs and supportive staff, such as parent partners, to increase service breadth and depth to clients.

Year One Progress: The Early Onset clinician and peer support specialist continue to meet with the Children's Access Team, providing information regarding early signs and symptoms of serious mental illness and when to refer to the program for further evaluations. The Early Onset clinician and other children's mental health staff provided presentations and information at fairs, local colleges, high schools, continuation and independent study schools, and has met with local school counselors who provide services to multiple school districts.

4. Stigma and Discrimination Reduction

Shasta County's Stand Against Stigma campaign works to promote mental wellness, increase community awareness of mental health and end the stigma surrounding mental illness and substance abuse. The stakeholder-developed messages used in this project are strength-based and focused on recovery:

- Mental health problems affect almost every family in America.
- People with mental health problems make important contributions to our families and communities.
- People with mental health problems recover, often by working with mental health professionals and by using medication, self-help strategies, and community supports.
- Stigma and fear of discrimination keep many people from seeking help.
- You can make a difference in the way people view individuals' mental health problems if you:
    - Learn and share the facts about mental health and about people with mental health problems, especially if you hear or read something that isn't true;
    - Treat people with mental health problems with respect and dignity; and
    - Support the development of community resources for people with mental health problems and their friends and family.

Stand Against Stigma includes the following strategies:

- Media campaign
- Community education and open-to-the-public forums as part of the "Stand Against Stigma: Changing Minds About Mental Illness" and "Get Better Together" awareness campaigns
- Promoting and rewarding positive portrayals of people with mental health problems
- Brave Faces Portrait Gallery and Speakers Bureau featuring more than 25 local residents who share their experiences with mental illness, substance abuse disorders and suicide loss
- Annual Minds Matter Mental Health Resource Fair and Music Festival
- The mental health-themed "Hope Is Alive!" Open Mic series
- Becoming Brave trainings (based on the Honest, Open and Proud curriculum) that provide guidance on how and when to disclose
- Recovery Happens events to celebrate recovery from substance use disorders
- Social media campaigns/awareness
- Multimedia and short documentaries

Stand Against Stigma activities are directed by input and guidance from the Stand Against Stigma Committee, which includes people with lived experience, family members, representatives from community-based organizations and members of the Shasta County Mental Health, Alcohol and Drug Advisory Board. Thousands of people have witnessed or taken part in Stand Against Stigma activities in person, and social media campaigns have reached tens of thousands more.

Shasta County's Stand Against Stigma: Changing Minds About Mental Illness campaign has been in place since 2012. Its strength-based messages promote mental wellness, and counter the discrimination and stigma associated with mental health problems. The Get Better Together campaign aims to connect 16- to 25-year-olds with peers who are dealing with heavy issues, educating them about the normalcy of struggles with mental illness, asking them to help themselves, help others, and share what they live and know. Plans are under way to partner with the youth-focused programs and revitalize the Get Better Together website.

In addition, the Stand Against Stigma Committee has collaborated with local musicians and performers to hold 22 Hope Is Alive! Open Mic nights over the past five years, which encourage any local performer to show up and present

music, dance or art that connects with overcoming difficult times or promoting awareness of misunderstood issues. This theme has led to many performers sharing creative works that are mental health related. More than 1,000 people have attended the open mic nights, and more than 110 performers have participated.

The Brave Faces Portrait Gallery and Speakers Bureau use true stories of hope and recovery to fight stigma by improving our understanding of mental illness and suicide. About one in four people will struggle with a mental illness every year, and about 45 people in Shasta County die by suicide every year. Because of shame and discrimination associated with mental health problems, many people don't seek the help they need. Brave Faces are people with lived experience of mental illness, suicide and substance abuse. They go into the community and talk about their lives and their experiences, using their stories to offer hope and recovery, provide education, promote seeking help and end stigma. Audiences include faith-based organizations, media organizations, local businesses, community-based organizations, cultural groups, county and state government agencies, junior high and high schools, local colleges and more. More than 250 Brave Faces presentations have been done within our community, and more than 7,000 people have been reached through these presentations. Our growing number of speakers (about 30 active participants in total) allows us to effectively tailor our messages to the audiences we serve.

The Stand Against Stigma Committee also produces short documentaries and promotes them on social media as a way to reach more people online. See Appendix K for more information.

Three-Year Goal: In addition to all of the activities outlined above, we will continue producing short films and social media content to expand our reach. We are pursuing a Minds Matter podcast and television show in partnership with a local nonprofit. We will also actively participate in local Recovery Happens activities to focus more heavily on addiction related issues. We will continue to evaluate our cadre of Brave Faces speakers to ensure that they are a diverse and dynamic mix.

Year One Progress: (need update)

5. Suicide Prevention

From 2017 to 2019, an average of 48 Shasta County residents died by suicide each year. Hundreds more are left to cope with the aftermath. This does not include the many more who struggle to cope with or recover from attempted suicide or self-injury. Suicide prevention project activities are implemented by the Health and Human Services Agency in partnership with the Shasta Suicide Prevention Workgroup, a collaborative of local public and private agencies and concerned community members working to decrease suicide attempts and deaths in Shasta County.

Prevention activities must meet five fundamental concepts of the MHSA: cultural competence; wellness, recovery, resilience; community collaboration; client- and family-driven mental health system; and integrated service experience. A suicide prevention website promotes these ideas and keeps the community up to date on local meetings, trainings and events. The page also promotes local and national resources, such as the National Suicide Prevention Lifeline, the Institute on Aging Friendship Line for older adults, and the Alex Project Crisis Text Line.

Captain Awesome, a men's mental health campaign launched in 2017, continues to combat the societal pressures for men to repress emotions and not show weakness. Captain Awesome demystifies mental health and depression while giving men the tools to maintain their mental and emotional health. "More than Sad", an evidence-based educational program developed by the American Foundation for Suicide Prevention, teaches teens to recognize signs of depression in themselves and others, challenges the stigma surrounding depression, and demystifies the treatment process. Question, Persuade, Refer (QPR) trainings teaches people the warning signs of suicide and provide them with tools to respond to a person in suicide crisis. These trainings are given to groups or organizations in the county upon request. Since 2015, 1,355 people have received Question, Persuade, Refer (QPR) Suicide Prevention Training.

Additional suicide prevention activities include:

- Continued collaboration with local law enforcement, firearms vendors and concealed weapon training instructors about decreasing the access to lethal means for suicide attempts.
- Participation at community outreach events (health fairs), especially those concerning mental health, support services and suicide prevention, such as Running Brave, the American Foundation for Suicide Prevention's Out of the Darkness Walk and Suicide Loss Survivor Day.
- Promotion of the Directing Change Program and Student Film Contest to local high schools.
- Annual Suicide Prevention and Mental Health Symposium.
- Educating local media and news outlets regarding the importance of appropriate and responsible reporting of suicide.
- Providing suicide prevention resources to local medical professionals.
- Utilize techniques from The Center for Mind-Body Medicine (CMBM) to provide mind-body skills small groups and workshops to high-risk populations to help reduce stress.
- Promotion of Hill Country's Mobile Crisis Outreach Team (MCOT) – Mobile Health Van.

See Appendix M for the complete Suicide Prevention Report.

Three-Year Goal: Continue to grow and evaluate the Captain Awesome campaign with ongoing input from the Men's Advisory Group. Explore postvention and lethal means safety approaches, and pursue opportunities for collaboration with agency partners, including but not limited to law enforcement and community organizations.

Year One Progress: The Captain Awesome campaign was updated and rolled out, after receiving feedback from the Men's Advisory Group. Mind-body skills groups continue throughout the community, and community-wide Mental Health First Aid courses have been offered.

Prevention and Early Intervention (PEI)

5. CalMHSA Statewide Projects

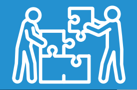
CalMHSA provides California counties, including Shasta, with a flexible, efficient and effective administrative and fiscal structure. It helps counties collaborate and pool their efforts in:

- Development and implementation of common strategies and programs
- Fiscal integrity, protections and management of collective risk
- Accountability at state, regional and local levels

CalMHSA administers three MHSA Prevention and Early Intervention statewide initiatives on behalf of California counties:

- Suicide Prevention
- Stigma and Discrimination Reduction
- Student Mental Health Initiative

Workforce Education and Training (WET)



Workforce Education and Training (WET) programs are designed to create a public mental health workforce which includes clients and family members; is sufficient in size; has the diversity, skills, and resources to deliver compassionate, safe, timely and effective mental health services to all individuals who are in need; and contributes to increased prevention, wellness, recovery, and resiliency. The intent of WET is to provide programs to address identified shortages in occupations, skill sets, and individuals with unique cultural and linguistic competence in public mental health programs. These projects are included in the Health and Human Services Agency's WET plan:

1. Comprehensive Training
2. Consumer and Family Member Volunteer Program
3. Internship Program
4. Superior Region WET Partnership
5. Office of Statewide Health Planning and Development

1. Comprehensive Training

The Comprehensive Training project provides trainings on specific strategies and skills to help people working in the public mental health field learn more about providing services that meet the community's needs. Trainings provide opportunities to increase competencies of the community workforce and are available to HHSA staff, contract providers, private practice professionals, community-based organizations, consumers, family members, and students.

The HHSA's De-Escalation Training teaches employees how to identify behaviors that could lead to a crisis, effectively respond to prevent the situation from escalating, use verbal and nonverbal techniques to defuse hostile behavior and resolve a crisis before it becomes violent, cope with one's own fear and anxiety, and avoid injury if behavior does become physical. This program has been incorporated into HHSA's human resources unit and is no longer funded by MHSA.

2. Volunteer Program

The Mental Health Services Act Volunteer Program addresses the WET goals of increasing mental health career development opportunities and promoting employment of consumers and family members. This program is open to anyone over age 18 who desires an introduction to the public mental health system and the opportunity to explore their interest in and suitability for this type of work. Prior to volunteering, each participant completes the Shasta MHSA Academy training program. These projects have been put on hold during the pandemic.

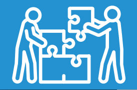
Wellness Recovery Action Planning (WRAP)

Shasta County has several certified Advanced Level WRAP facilitators (ALFs), which has increased capacity to provide WRAP trainings in the community. Anyone can use this evidence-based prevention and wellness process to get well, stay well and make their life the way they want it to be. It is used by health care and mental health systems all over the world to address physical, mental health and life issues. The majority of WRAP courses are now being provided by a community partner, Sunrise Mountain Wellness Center.

3. Internship Program

This program gives people working toward a degree or licensure the opportunity to gain required internship supervision hours. Internships and residencies are available for Marriage and Family Therapists, Masters of Social Work, and Psychiatric Mental Health Nurse Practitioners. Supervision is provided by Health and Human Services Agency staff, including the Chief Psychiatrist and a Marriage and Family Therapist.

Students (employees and non-employees) are provided internship hours required by their educational programs as they work toward a master's degree. Once an employee has graduated and starts working toward licensure, clinical supervision hours are provided to meet licensure requirements.



4. Superior Region WET Partnership

WET funds from the state are paying for regional county partnerships throughout California that focus on increasing the education and training resources dedicated to the public mental health system workforce. These regional partnerships are supported by staff from participating counties. Shasta County is part of the Superior Region WET Partnership, which has been revitalized in the past year. Led by Butte County's Mental Health Services Act coordinator, the Superior Region WET Partnership looks to increase offerings in months to come.

Shasta County has also expanded its peer support program, and continues to integrate these valuable employees into its programs.

Three-Year Goal: We plan to expand peer mentoring support and volunteer support throughout the community, and we continue to monitor California peer certificaiton efforts. We will continue working with California State University Chico, California State University Humboldt, Simpson University and National University to provide internship opportunities to students in their master's programs.The Health and Human Services Agency will continue to participate in the Superior WET Regional Partnership to bring statewide projects to Shasta County.

Year One Update: All HHSA employees received De-Escalation training. WRAP Level 1 training has been provided throughout the community. Peer support specialists continue to provide critical support to clients at HHSA facilities and through community partners.

Innovation

Innovation projects are novel, creative and/or ingenious mental health practices or approaches that contribute to learning. In 2019, MHSA staff sought feedback from community stakeholders for a new Innovation project. The process focused on reviewing the current mental health continuum of care, identifying weaknesses or absences in services, and brainstorming ideas for a new project that would fill the identified gaps and better meet community needs. The idea that bubbled to the top was an intergenerational project that addressed two things – the high number of Adverse Childhood Experiences in Shasta County, and isolation and the resulting depression that can occur in older adults.

After receiving direction from stakeholders and going through the Request for Proposals process, Pathways to Hope for Children was selected to create a teen center staffed by older adults that builds hope and resiliency among youth, while also reinforcing a sense of purpose for older adults. This project will be presented to the Mental Health Services Oversight and Accountability Commission later this year.

This is also the final year for the Counseling and Recovery Engagement (CARE) Center to receive Innovations funding. Stakeholders supported continuing this program using Community Services and Supports funding starting in early 2021, as it has met its objectives:

1. Improve access to services, particularly for people unserved or underserved by the existing mental health system.
2. Reduce mental health crises, including trips to the hospital emergency room, in both human and economic benefits.
3. Bridge service gaps, facilitate access to community-based resources and better meet individual and family needs.
4. Help families by partnering with other agencies and community-based organizations, including family-focused services, to increase access to mental health services and supports for families with competing daytime responsibilities.
5. Identify services that are most associated with successful individual and family outcomes, with a particular focus on effective collaborative approaches.

In addition, Shasta County has been participating in the planning process for a multi-county Innovations project regarding Psychiatric Advance Directives,and the planning process for another Innovations project will begin in Fall 2021.

The CARE Center Activity Report and the Innovation Project Outcome Tracking Report can be found in Appendices N and O.

Mental Health Services Act Budgets

FY 2019/20 Mental Health Services Act Annual Update Funding Summary

	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
Estimated FY 2019/20 Funding						
Estimated Unspent Funds from Prior Fiscal Years	5,533,207	2,760,712	2,163,462	0	0	
Estimated New FY2019/20 Funding	6,423,207	1,605,802	422,579			
Transfer in FY2019/20a/	0					
Access Local Prudent Reserve in FY2019/20						0
Estimated Available Funding for FY2019/20	11,956,414	4,366,514	2,586,041	0	0	
Estimated FY 2019/20 MHSA Expenditures	7,457,618	1,674,356	749,000	0	0	
Estimated FY2021/22 Funding						
Estimated Unspent Funds from Prior Fiscal Years	4,740,710	2,204,802	960,663		0	
Estimated New FY2021/22 Funding	8,307,812	2,076,953	546,566			
Transfer in FY2021/22a/	0					
Access Local Prudent Reserve in FY2021/22						0
Estimated Available Funding for FY2021/22	13,048,522	4,281,755	1,507,229	0	0	
Estimated FY2019/20 Unspent Fund Balance	4,498,796	2,692,158	1,837,041	0	0	

Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2019	
2. Contributions to the Local Prudent Reserve in FY 2019/20	0
3. Distributions from the Local Prudent Reserve in FY 2019/20	0
4. Estimated Local Prudent Reserve Balance on June 30, 2020	0

a/ Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

Mental Health Services Act Budgets

Community Services and Supports (CSS) Component Worksheet

Fiscal Year 2019/20	Total Mental Health Expenditures	CSS Funding	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other Funding
FSP Programs						
1. Client Family Operating Services	505,098	505,070				28
2. Shasta Triumph and Recovery	2,098,758	1,605,539	465,935			27,284
3. Crisis Residential and Recovery	896,177	0	893,560			2,617
4. Crisis Response	1,295,543	895,825	332,483			67,235
5. Outreach-Access	1,440,656	1,102,909	322,690			15,057
6. Housing	1,034,780	962,647	18,036			54,097
Non-FSP Programs						
1. Rural Health Initiative	905,799	457,890	99,541			348,368
2. Older Adult Services	46,423	24,876	19,357			2,190
3. Co-Occurring/Primary Care Integration	252,261	48,123	167,817			36,321
4. Laura's Law	401,115	382,979	18,136			
5.				0	0	
CSS Administration	1,477,490	1,471,760				5,730
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	10,354,100	7,457,618	2,337,555	0	0	558,927
FSP Programs as Percent of Total	97.5%					

Mental Health Services Act Budgets

Prevention and Early Intervention (PEI) Component Worksheet

Fiscal Year 2019/20	Total Mental Health Expenditures	PEI Funding	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other Funding
Prevention Programs						
1. Stigma and Discrimination	210,848	210,808				
2. Suicide Prevention	228,913	228,913				
3.						
4.						
5.						
6.						
Early Intervention Programs						
7. Children and Youth in Stressed Families:	0					
a. Triple P	568,658	521,854	46,545			259
b. TFCBT	342,464	314,394	28,031			39
c. ACE	61,155	56,144	5,006			5
e. Positive Action Program	114	105	9			
8. Individuals Experiencing Early Onset of Serious Psychiatric Illness	106,302	75,201	30,869			232
						0
				0	0	
PEI Administration	267,024	266,937				87
PEI Assigned Funds						
Total PEI Program Estimated Expenditures	1,785,478	1,674,356	110,460	0	0	662

Mental Health Services Act Budgets

Innovations (INN) Component Worksheet

Fiscal Year 2019/20	Total Mental Health Expenditures	PEI Funding	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other Funding
Prevention Programs						
1. Counseling and Recovery Engagement Center	755,399	742,880	12,519			
INN Administration	6,120	6,120				
Total INN Program Estimated Expenditures	761,519	749,000	12,519			

State of California
Health and Human Services Agency

Department of Health Care Services

ANNUAL MHSA REVENUE AND EXPENDITURE REPORT and ADJUSTMENT WORKSHEET COUNTY CERTIFICATION

County/City: Shasta

Local Mental Health Director

Name: Donnell Ewert

Telephone: 530-225-5900

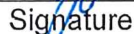
Email: dewert@co.shasta.ca.us

Document for Certification:

Prudent Reserve Assessment FY: 2020-2021

I hereby certify[1] under penalty of perjury under the laws of the State of California that the attached Annual MHSA Revenue and Expenditure Report or Adjustments to Revenue or Expenditure Summary Worksheet is complete and accurate to the best of my knowledge.

Donnell Ewert
Local Mental Health Director (PRINT)



Signature

5/3/2021
Date

[1] Welfare and Institutions Code section 5899(a)

DHCS 1820 (02/19)

Fiscal Years: 2015-16 thru 2019-20 (five total)
Cost Center: 40400
Account: 536402
Account Description: State Prop 63 MH Svs Act
Purpose: to establish a state required Prudent Reserve fund using the ***minimum*** *allowable amount*
1 *Sources: California Code of Regulations (CCR) - 9 CCR 3420 Local MHSF: Allocation and Expenditure Requirements*
2 *Sources: DHCS Information Notice 19-037*
3 *Sources: California Code of Regulations (CCR) - 9 CCR 3420.30 Prudent Reserve Funding Levels - (a) thru (b)*

	FY Fiscal Year	MHSA Mental Health Services Act	CSS Community Services and Supports CCR 3420 (b)(3)	PEI Prevention and Early Intervention CCR 3420 (b)(2)	INN Innovations CCR 3420 (b)(1)
		40499 Roll-up	76%	19%	5%
4.a	2015-2016	$ 6,944,791.58	$ 5,278,041.60	$ 1,319,510.40	$ 347,239.58
4.b	2016-2017	$ 8,760,996.69	$ 6,658,357.48	$ 1,664,589.37	$ 438,049.83
4.c	2017-2018	$ 9,592,724.73	$ 7,290,470.79	$ 1,822,617.70	$ 479,636.24
4.d	2018-2019	$ 9,319,939.54	$ 7,083,154.05	$ 1,770,788.51	$ 465,996.98
4.e	2019-2020	$ 8,178,862.46	$ 6,215,935.47	$ 1,553,983.87	$ 408,943.12
4	Total GL Balance	$ 42,797,315.00	$ 32,525,959.40	$ 8,131,489.85	$ 2,139,865.75
5	MHSA Prop 63 Total:	$ 42,797,315.00	$ 32,525,959.40	$ 8,131,489.85	$ 2,139,865.75
	Difference	-	-	-	-

3 *DHCS Methodology:*

3.a	Total CSS Revenue over previous five full fiscal years:	$ 32,525,959.40	see CCR 3420 (b)(1)
3.b	Divide total CSS revenue by five fiscal years:	$ 6,505,191.88	see CCR 3420 (b)(2)
3.c	Multiply by 5% to calculate MINUMUM:	$ 325,259.59	see CCR 3420 (b)(3)
3.d	Multiply by 33% to calculate MAXIMUM:	$ 2,146,713.32	see CCR 3420 (b)(3)

3

§ 3420.30. Prudent Reserve Funding Levels.
9 CA ADC § 3420.30
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
Title 9. Rehabilitative and Developmental Services
Division 1. Department of Mental Health
Chapter 14. Mental Health Services Act
Article 4. Funding Provisions

9 CCR § 3420.30

§ 3420.30. Prudent Reserve Funding Levels.

(a) A County shall fund its Prudent Reserve only with funds transferred from its CSS Account pursuant to section 3420.10.

(b) A County shall fund its Prudent Reserve at a minimum level of five (5) percent and a maximum level of thirty-three (33) percent of the average amount the County allocated to its CSS Account, pursuant to section 3420, over the previous five (5) fiscal years. The calculation for the minimum and maximum funding levels percentage shall be as follows:

(1) Add the total funds allocated to the County's CSS Account over the previous five (5) fiscal years.

(2) Divide the amount in subsection (b)(1) by five (5); and,

(3) Multiply the amount in subsection (b)(2) by five (5) percent to determine the minimum level, and multiply the amount in subsection (b)(2) by thirty-three (33) percent to determine the maximum level.

(c) A County shall assess its Prudent Reserve funding level as of July 1, 2019 and include the assessment in the County's Three-Year Program and Expenditure Plan or annual update for the 2019-20 Fiscal Year pursuant to sections 3310 and 3315. The assessment shall include the maximum funding level and the actual funding level of the County's Prudent Reserve as of July 1, 2019.

(d) A County shall reassess its Prudent Reserve funding levels as of July 1, 2024, and as of July 1 every five (5) fiscal years thereafter and include the reassessment in the applicable County Three-Year Program and Expenditure Plan pursuant to sections 3310 and 3315. The reassessment shall include the minimum and maximum funding levels and the actual funding level of the County's Prudent Reserve. A County may reassess its Prudent Reserve funding levels more frequently.

(e) A County shall submit a complete Mental Health Services Act Prudent Reserve Assessment/Reassessment form DHCS 1819 (02/19), hereby incorporated by reference, to the Department by email at MHSA@dhcs.ca.gov when submitting a County's Three Year Program and Expenditure Plan or annual update, beginning in fiscal year 2019-2020 and every five (5) fiscal years thereafter and during any other fiscal year a County assesses its Prudent Reserve levels.

(f) A County shall maintain a Prudent Reserve balance that does not exceed the maximum funding level as the County determined in its most recent assessment or reassessment, pursuant to subsections (c) and (d).

(g) A County shall transfer funds in excess of the County's maximum funding level into its CSS Account during fiscal year 2019-2020 and during each subsequent fiscal year in which the County reassesses its Prudent Reserve funding level pursuant to subsection (d). A County may transfer funds from its CSS Account to its CFTN Account, WET Account, PEI Account or JPA, pursuant to sections 3420.10, 3420.15 and 3420.20 during the same fiscal year in which the County transfers funds from its Prudent Reserve to its CSS Account pursuant to this subsection.

(h) A County that transferred funds from its PEI Account to its Prudent Reserve in fiscal year 2007-08 may transfer funds in excess of the County's maximum funding level into its PEI Account during fiscal year 2019-20, and during each subsequent fiscal year in which the County reassesses its Prudent Reserve funding level pursuant to subsection (d). A County may transfer funds from its Prudent Reserve to its PEI Account until the amount transferred equals the amount the County transferred from its PEI Account to its Prudent Reserve in fiscal year 2007-08.

(i) Funds a County transfers into its CSS Account pursuant to subsection (g) shall be subject to reversion, as specified in sections 3420.50 and 3420.55, 3420.60, and the applicable Reversion Period for those funds shall begin the fiscal year the County transferred the funds from the Prudent Reserve to the CSS Account.

Note: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5847(b)(7), 5892(b) and 5892(h), Welfare and Institutions Code.

Enclosure 1

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

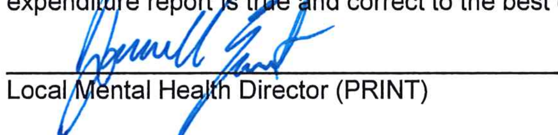
County/City: Shasta

☐ Three-Year Program and Expenditure Plan
☑ Annual Update
☐ Annual Revenue and Expenditure Report

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Donnell Ewert, MPH	Name: Brian Muir
Telephone Number: (530) 245-6269	Telephone Number: (530) 225-5541
E-mail: dewert@co.shasta.ca.us	E-mail: bmuir@co.shasta.ca.us
Local Mental Health Mailing Address: 2615 Breslauer Way Redding, CA 96001	

I hereby certify that the Three-Year Program and Expenditure Plan, Annual Update or Annual Revenue and Expenditure Report is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for counties in future years.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached update/revenue and expenditure report is true and correct to the best of my knowledge.

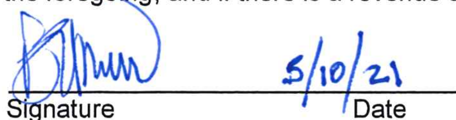


Local Mental Health Director (PRINT) | Signature 5/3/2021 | Date

I hereby certify that for the fiscal year ended June 30, 2020, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated December 16, 2020 for the fiscal year ended June 30, 2020. I further certify that for the fiscal year ended June 30, 2020, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

I declare under penalty of perjury under the laws of this state that the foregoing, and if there is a revenue and expenditure report attached, is true and correct to the best of my knowledge.

Brian Muir AUDITOR-CONTROLLER



County Auditor Controller / City Financial Officer (PRINT) | Signature | 5/10/21 Date

[1] Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)

Three-Year Program and Expenditure Plan, Annual Update, and RER Certification (07/22/2013)

FY 2019/20 Mental Health Services Act Annual Update
Funding Summary

County: Shasta

Date: 5/10/21

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2019/20 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	5,531,883	2,760,712	2,163,462	0	0	
2. Estimated New FY 2019/20 Funding	6,423,207	1,605,802	422,579			
3. Transfer in FY 2019/20a/	0					
4. Access Local Prudent Reserve in FY 2019/20						0
5. Estimated Available Funding for FY 2019/20	11,955,090	4,366,514	2,586,041	0	0	
B. Estimated FY 2019/20 MHSA Expenditures	7,457,618	1,674,356	749,000	0	0	
G. Estimated FY 2019/20 Unspent Fund Balance	4,497,472	2,692,158	1,837,041	0	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2019	
2. Contributions to the Local Prudent Reserve in FY 2019/20	0
3. Distributions from the Local Prudent Reserve in FY 2019/20	0
4. Estimated Local Prudent Reserve Balance on June 30, 2020	0

a/ Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

FY 2019/20 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding

County: Shasta

Date: 5/10/21

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Client Family Operating Services	505,098	505,070				28
2. Shasta Triumph and Recovery	2,098,758	1,605,539	465,935			27,284
3. Crisis Residential and Recovery	896,177	0	893,560			2,617
4. Crisis Response	1,295,543	895,825	332,483			67,235
5. Outreach-Access	1,440,656	1,102,909	322,690			15,057
6. Housing Continuum	1,034,780	962,647	18,036			54,097
7.	0					
8.	0					
9.	0					
Non-FSP Programs						
1. Rural Health Initiative	905,799	457,890	99,541			348,368
2. Older Adult Services	46,423	24,876	19,357			2,190
3. Co-occurring Integration	252,261	48,123	167,817			36,321
4. Laura's Law	401,115	382,979	18,136			
5.	0					
6.	0					
7.	0					
CSS Administration	1,477,490	1,471,760				5,730
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	10,354,100	7,457,618	2,337,555	0	0	558,927
FSP Programs as Percent of Total	97.5%					

FY 2019/20 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: Shasta

Date: 5/10/21

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Stigma and Discrimination	210,848	210,808				40
2. Suicide Prevention	228,913	228,913				
3.	0					
4.	0					
PEI Programs - Early Intervention						
11. Children and Youth in Stressed Families:	0					
Triple P	568,658	521,854	46,545			259
ACE	342,464	314,394	28,031			39
Middle School Youth at Risk	61,155	56,144	5,006			5
TFCBT	114	105	9			
16. Individuals Experiencing Onset of	106,302	75,201	30,869			232
Serious Psychiatric Illness	0					
17.	0					
PEI Administration	267,024	266,937				87
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	1,785,478	1,674,356	110,460	0	0	662

FY 2019/20 Mental Health Services Act Annual Update
Innovations (INN) Funding

County: Shasta   Date: 5/10/21

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Counseling and Recovery Engagement Center	755,399	742,880	12,519			
2.	0					
3.	0					
INN Administration	6,120	6,120				
Total INN Program Estimated Expenditures	761,519	749,000	12,519	0	0	0

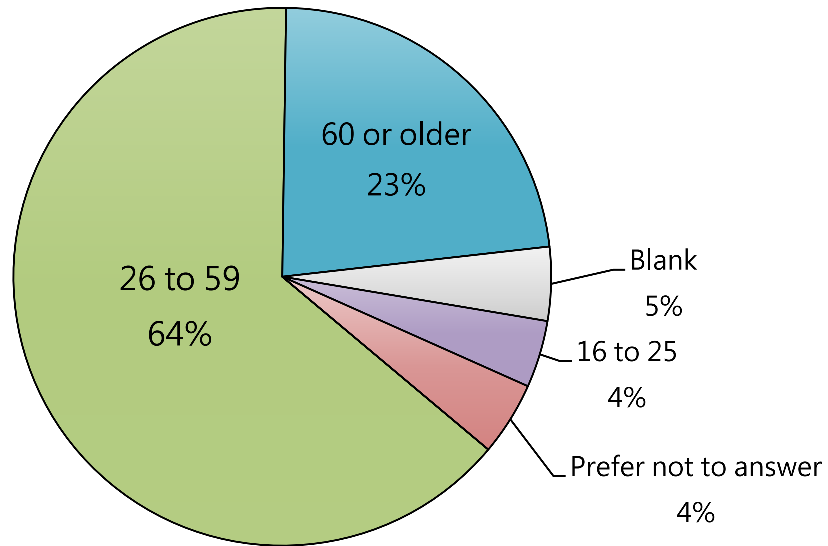
Community Stakeholder Survey Results (2019/2020) Mental Health Services Act (MHSA)

Electronic and paper versions of the Community Stakeholder Survey were consolidated in this report. A total of 248 surveys were collected. Please note that some surveys may have been completed by the same people at different meetings, or completed multiple times online, so this is not an unduplicated count.

DEMOGRAPHICS

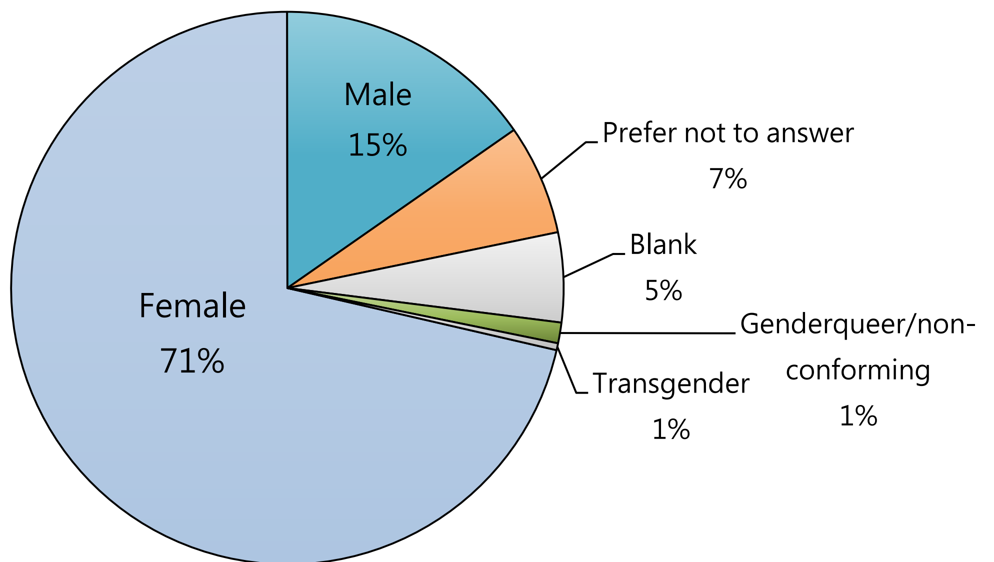
Age Groups Represented by Community Stakeholder Surveys

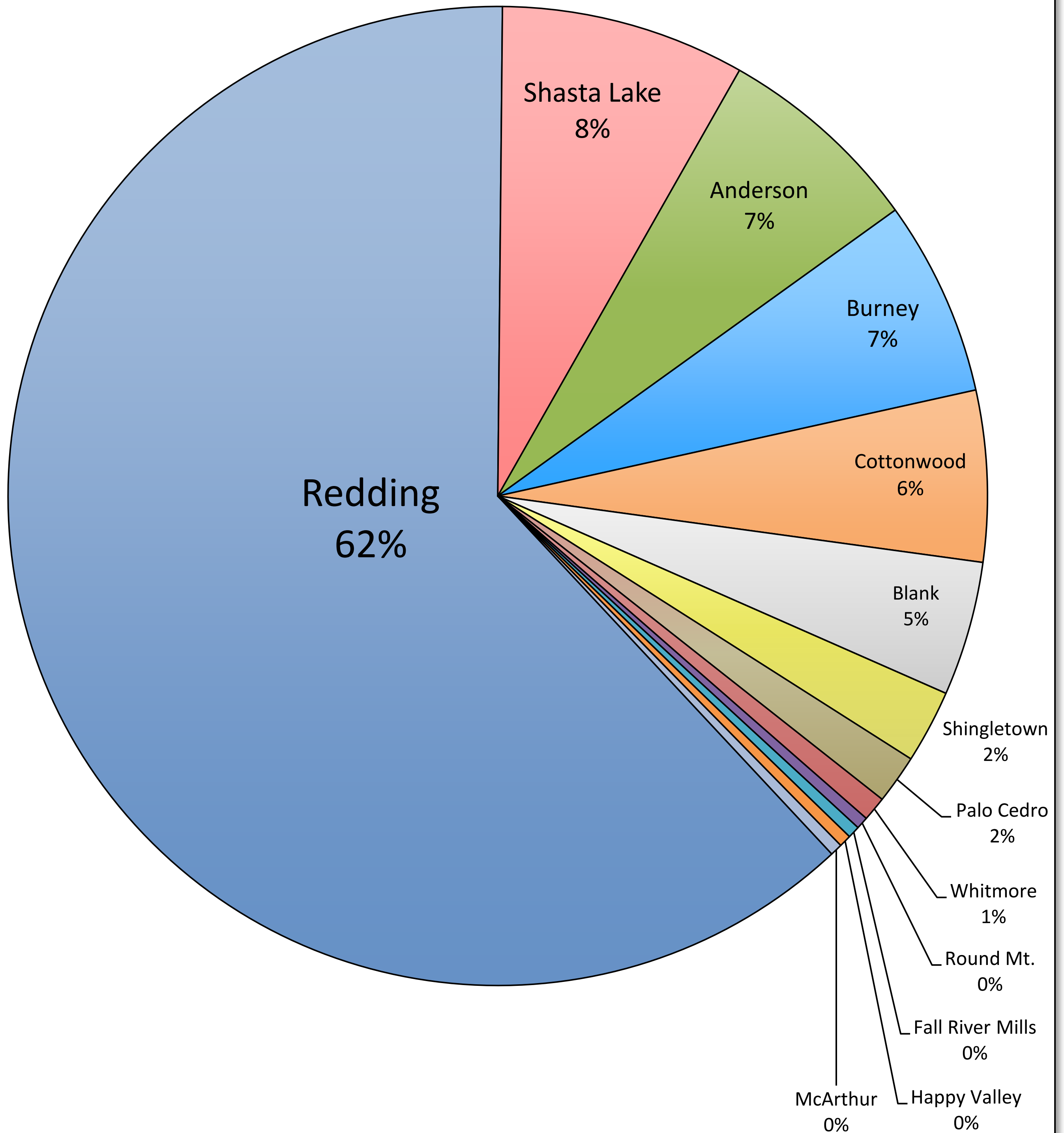
N = 248

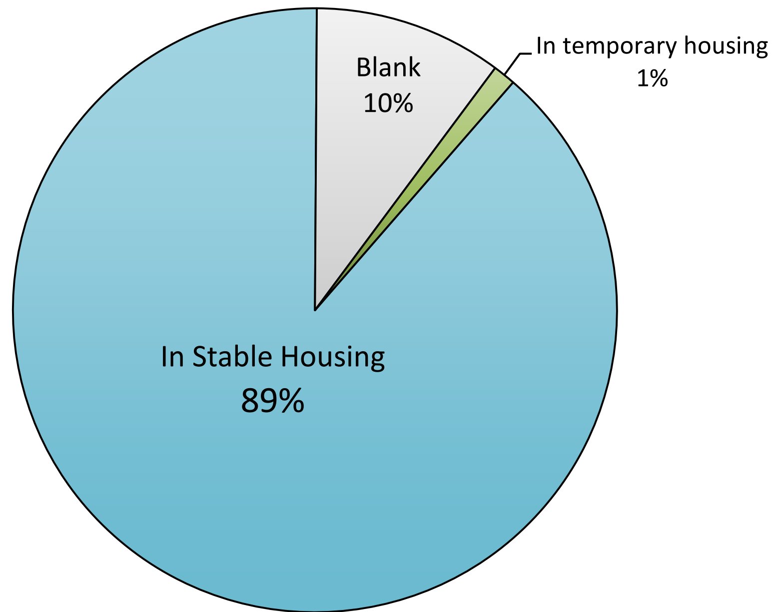


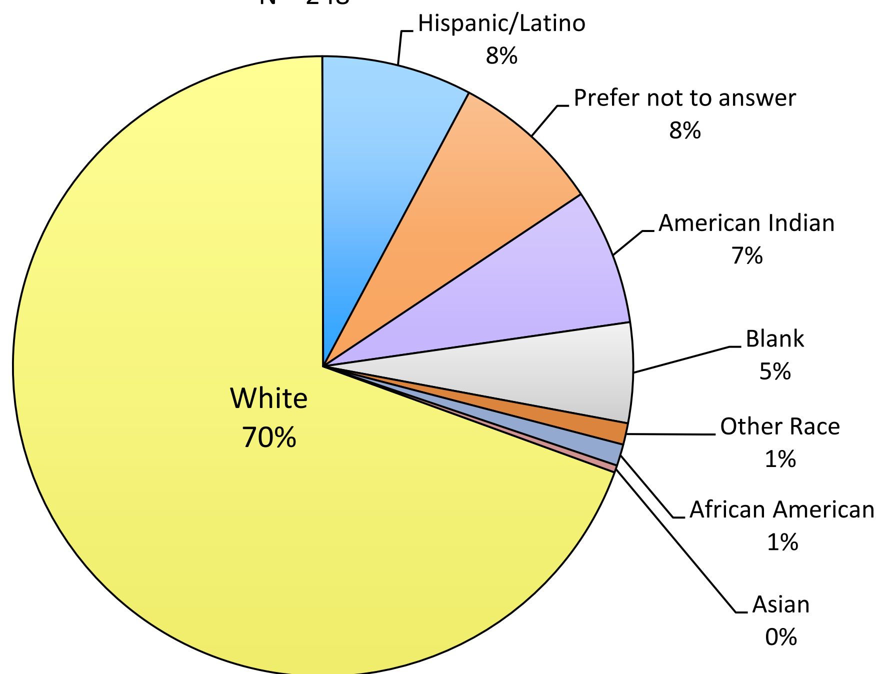
Genders Represented by Community Stakeholder Surveys

N = 248



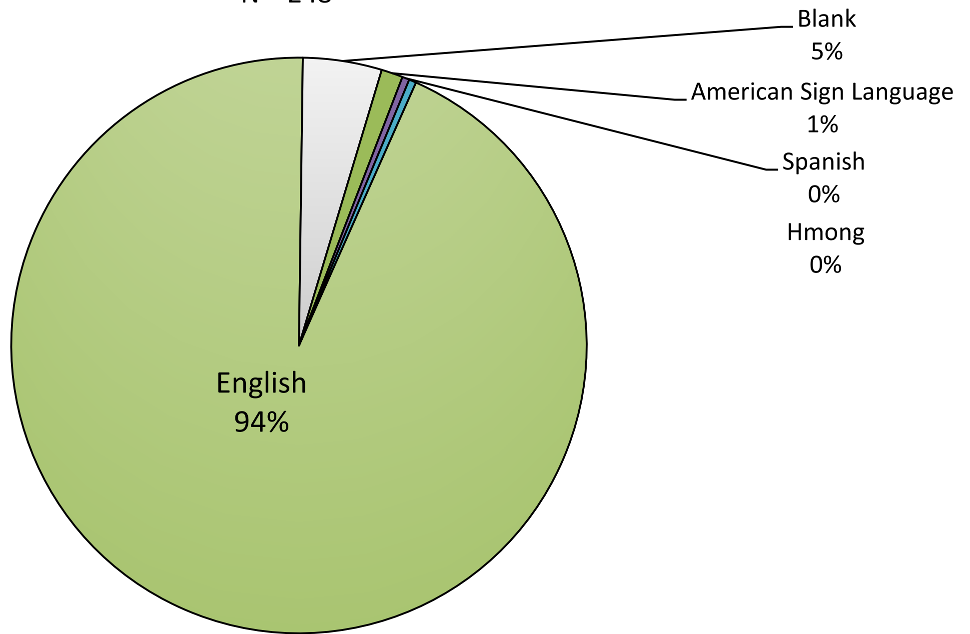

Towns/Communities Represented by Community Stakeholder Surveys
N = 248
(Percentages are rounded and may not add up to 100%)
Redding
62%
Shasta Lake
8%
Anderson
7%
Burney
7%
Cottonwood
6%
Blank
5%
Shingletown
2%
Palo Cedro
2%
Whitmore
1%
Round Mt.
0%
Fall River Mills
0%
Happy Valley
0%
McArthur
0%


Homeless Represented by Community Stakeholder Survey
N = 248
Blank
10%
In temporary housing
1%
In Stable Housing
89%


Race/Ethnicity Groups Represented by Community Stakeholder Surveys
N = 248
Hispanic/Latino
8%
Prefer not to answer
8%
American Indian
7%
Blank
5%
Other Race
1%
African American
1%
Asian
0%
White
70%

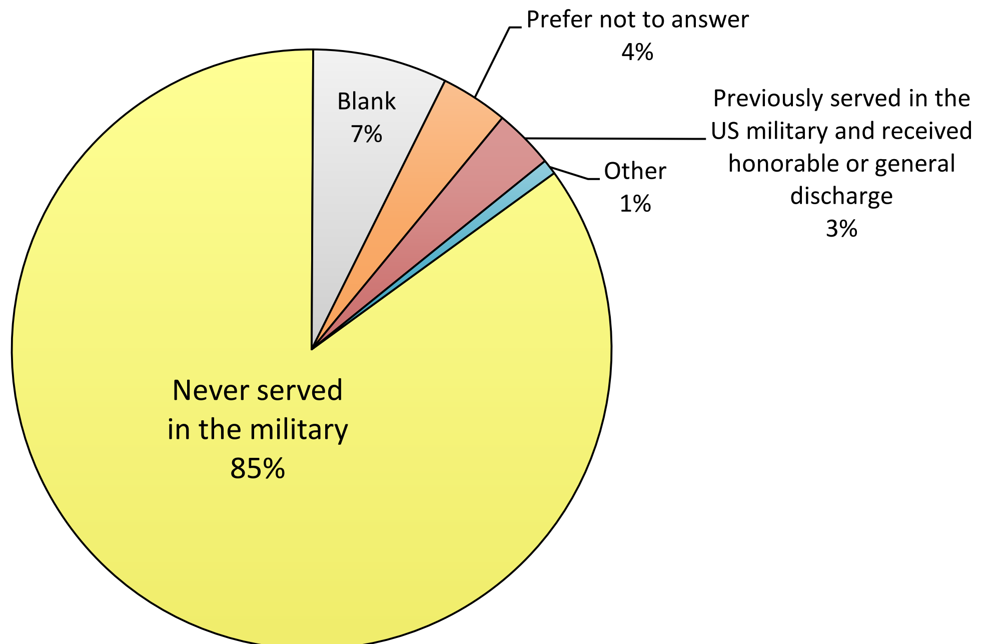
Primary Language Groups Represented by Community Stakeholder Surveys

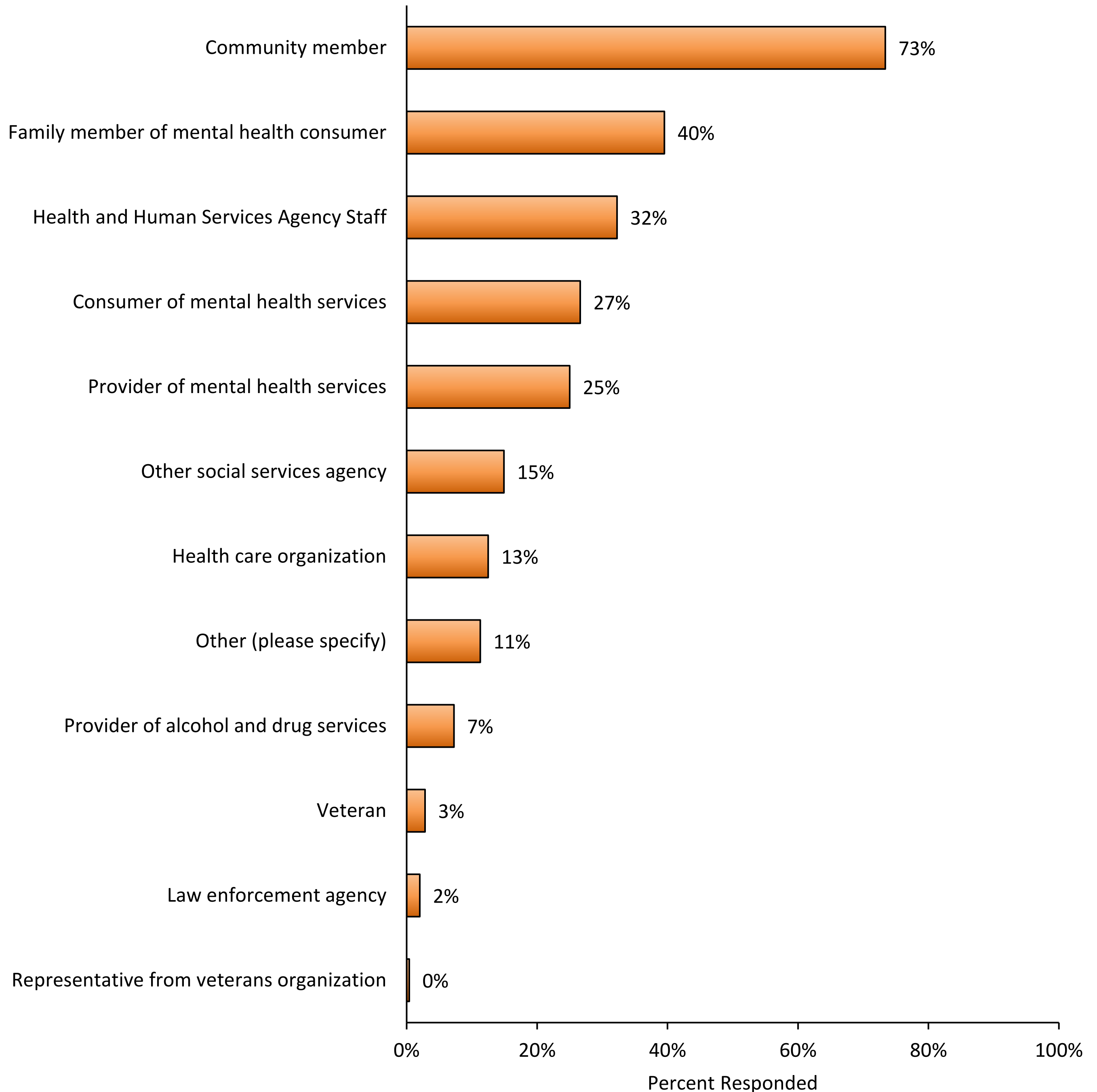
N = 248



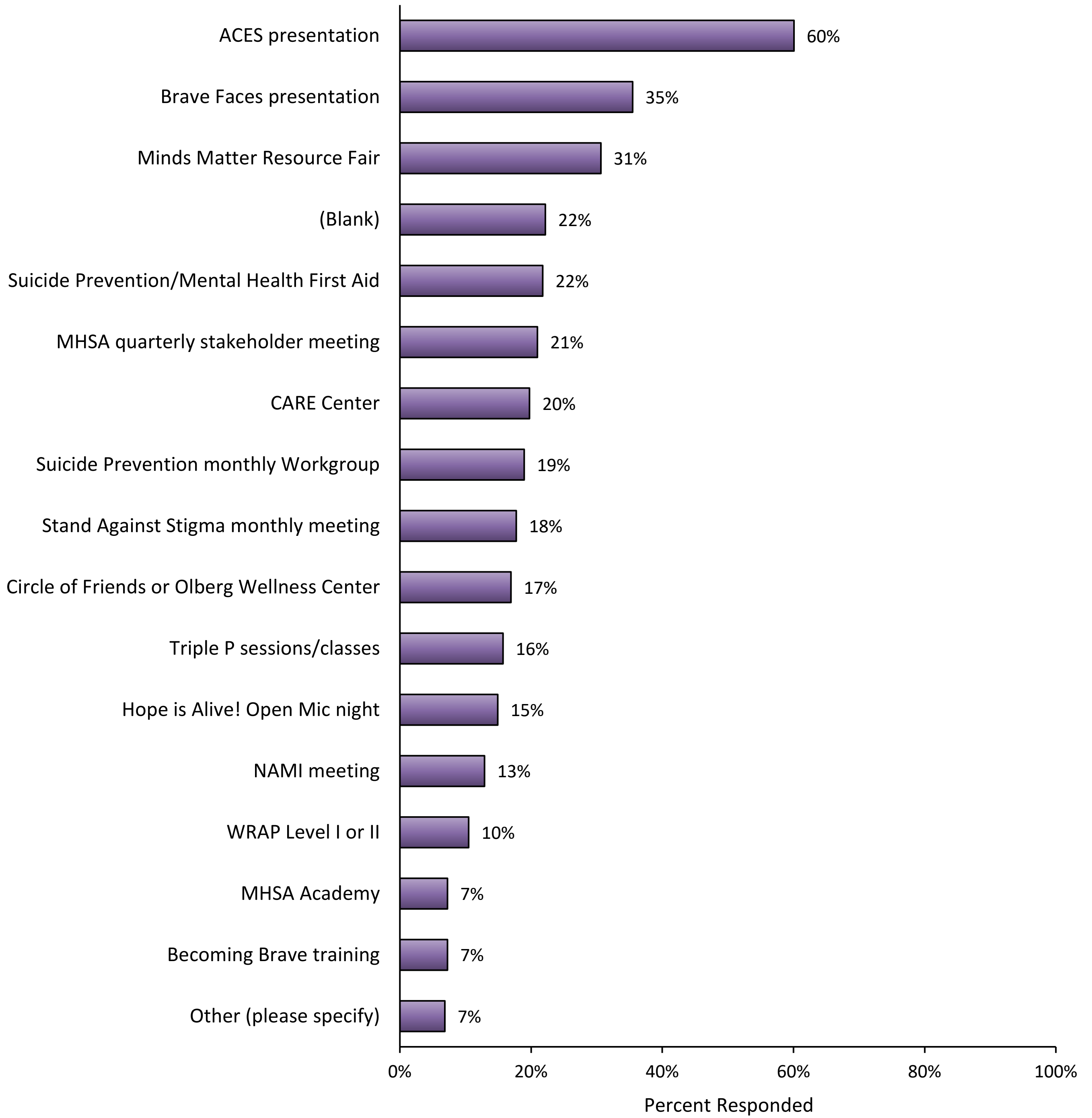
Military Status

N = 248




Groups Stakeholders Have Identified With
N = 248
(stakeholders were asked to mark all that apply, so the total may exceed 100%)
Community member
73%
Family member of mental health consumer
40%
Health and Human Services Agency Staff
32%
Consumer of mental health services
27%
Provider of mental health services
25%
Other social services agency
15%
Health care organization
13%
Other (please specify)
11%
Provider of alcohol and drug services
7%
Veteran
3%
Law enforcement agency
2%
Representative from veterans organization
0%
0%
20%
40%
60%
80%
100%
Percent Responded

PERSONAL INVOLVEMENT / PUBLIC PRESENCE



MHSA EXISTING PROGRAM IMPORTANCE RANKINGS

People were asked to rank the importance of 5 existing programs within the Community Service and Supports category of MHSA services, and 5 existing programs within the Prevention & Early Intervention category of MHSA services. The ranking scale ranged from 1 being the most important to 5 being the least important. This ranking scale means that the lower the average rating number, the more important the program was rated by people. Results have been color coded to shade as follows:

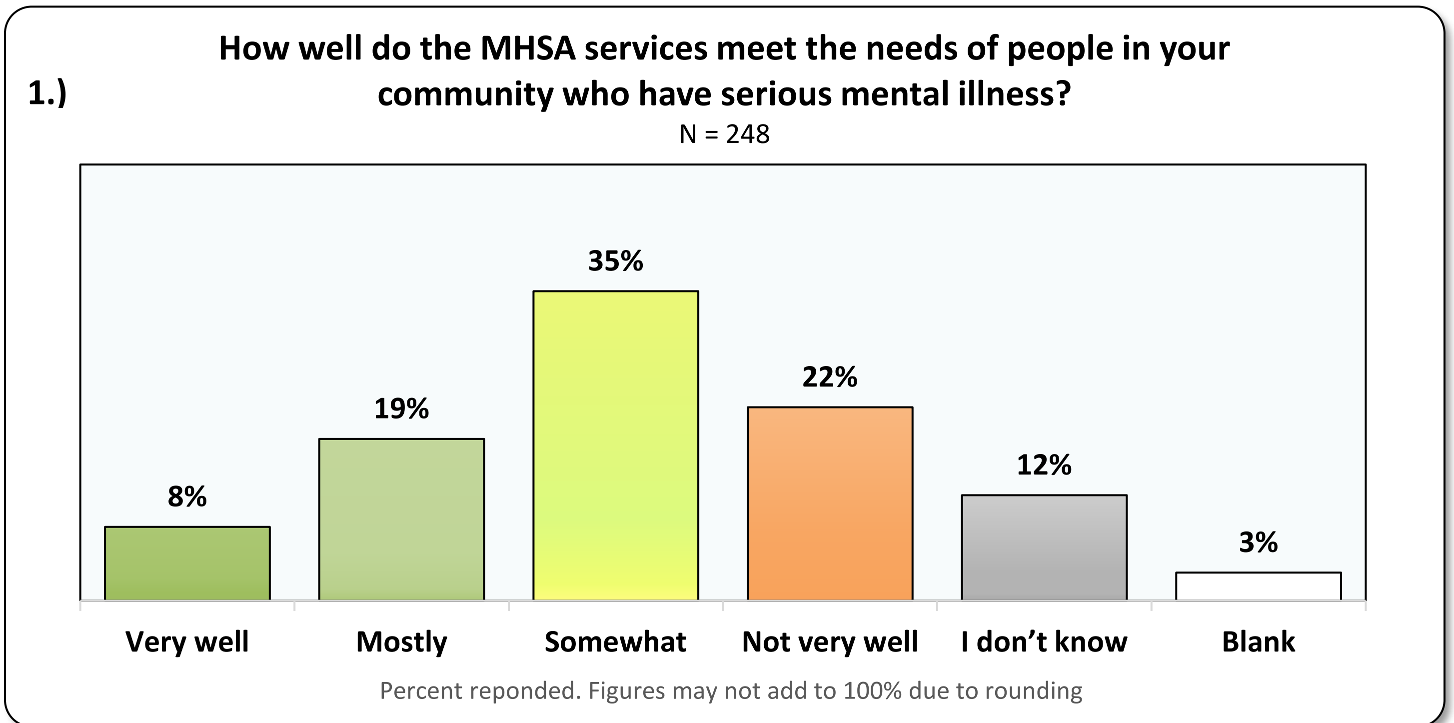
Most Important / Most Responses				Least Important / Least Responses

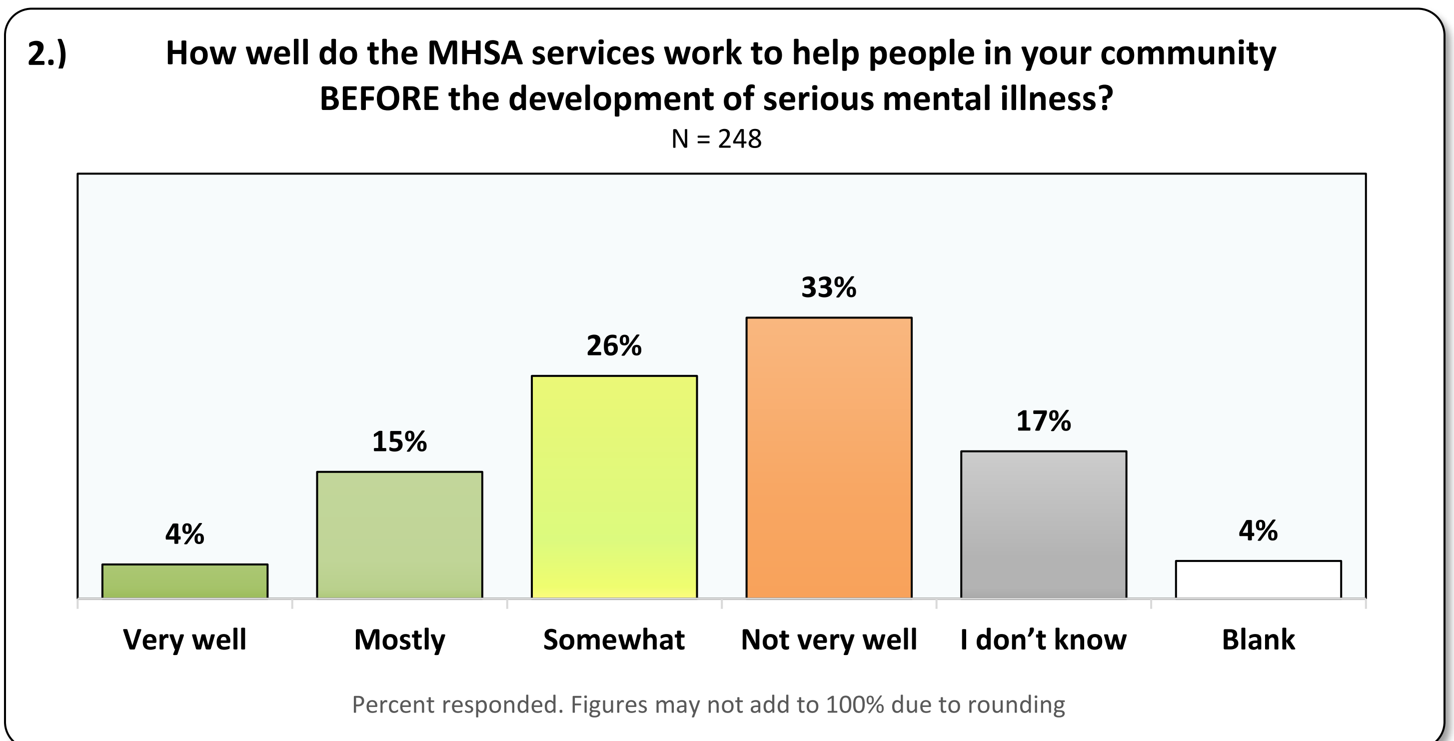
Community Services and Supports (CSS) Programs N = 232	Rating Average	1 Most Important	2 Very Important	3 Important	4 A Little Important	5 Least Important
Crisis Services	2.17	36%	27%	25%	9%	3%
Programs for people with both substance abuse & mental illness	2.51	25%	30%	22%	13%	9%
Housing Programs	3.11	19%	18%	18%	23%	22%
Education & Training Programs	3.45	13%	11%	20%	30%	26%
Wellness Centers (Olberg, Circle of Friends) & NAMI Programs	3.76	7%	13%	15%	25%	40%

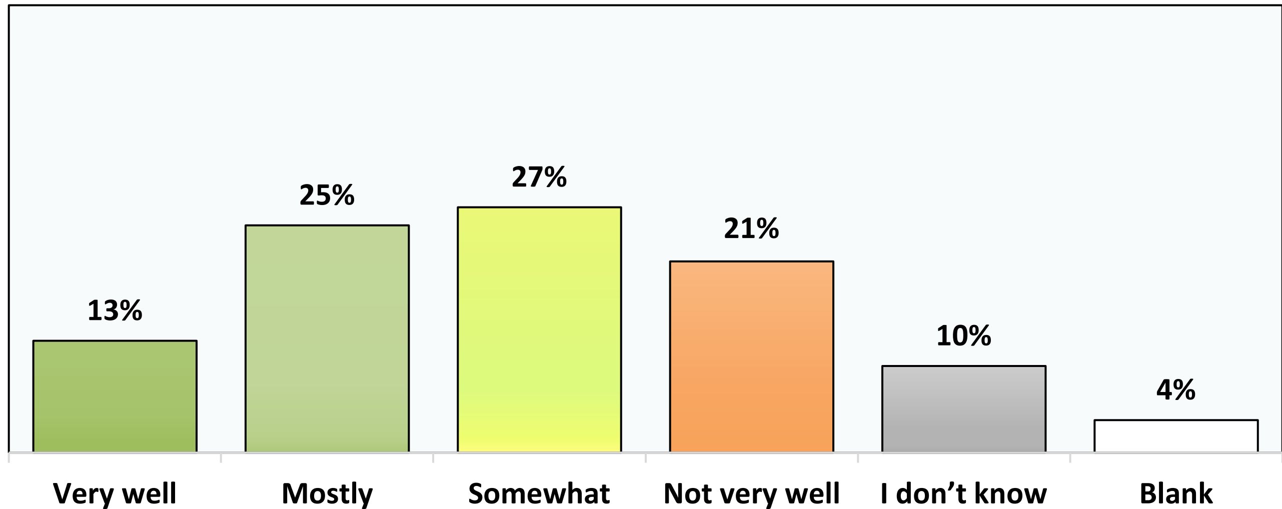
Prevention and Early Intervention (PEI) Programs N = 223	Rating Average	1 Most Important	2 Very Important	3 Important	4 A Little Important	5 Least Important
Parenting skill programs	2.65	31%	17%	21%	19%	13%
Suicide Prevention	2.72	23%	21%	27%	21%	9%
Programs Educating middle school students about mental health issues	3.08	14%	25%	20%	20%	21%
Reducing Stigma about mental illness	3.23	18%	18%	15%	19%	30%
Preventing mental illness relapses	3.32	13%	19%	17%	22%	28%

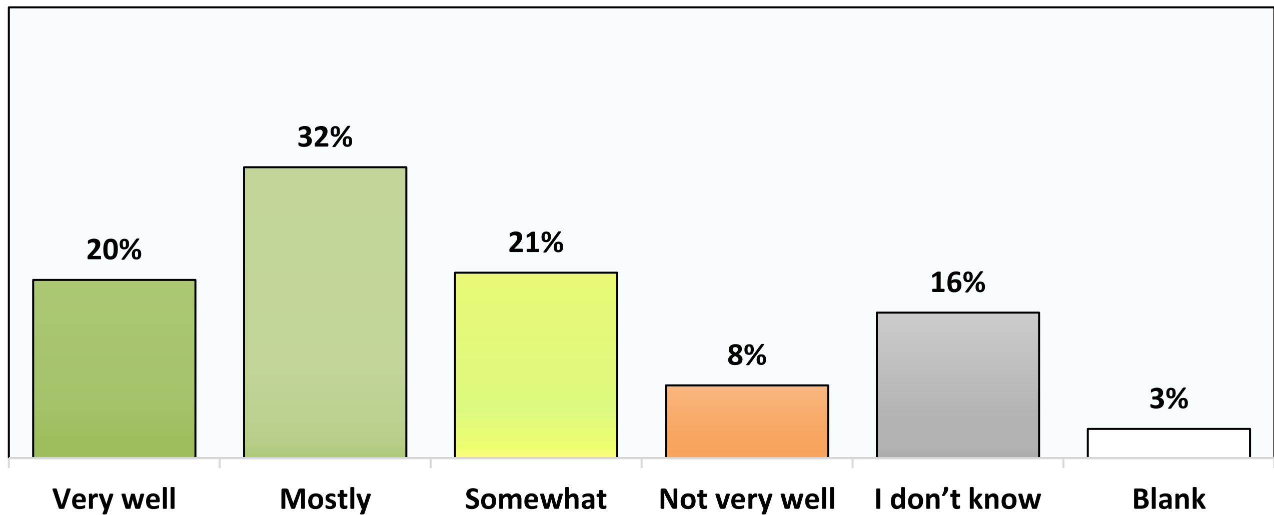
MHSA SERVICE FEEDBACK

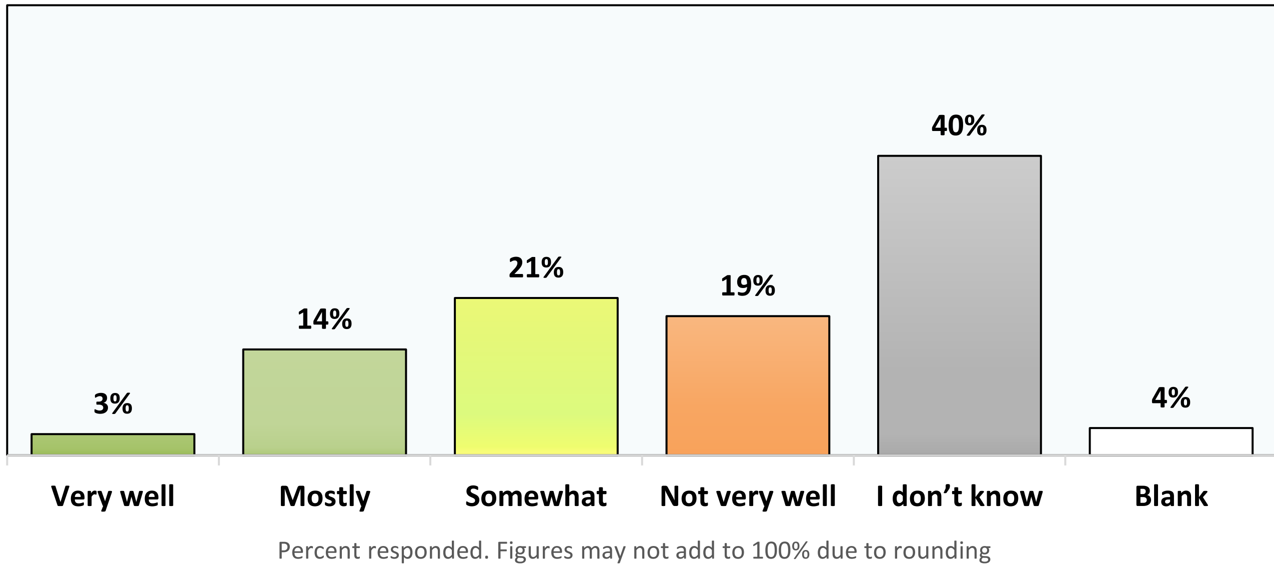
Stakeholders were asked a series of questions about how well MHSA services are working. Bar graphs representing MHSA Service feedback are shown below:

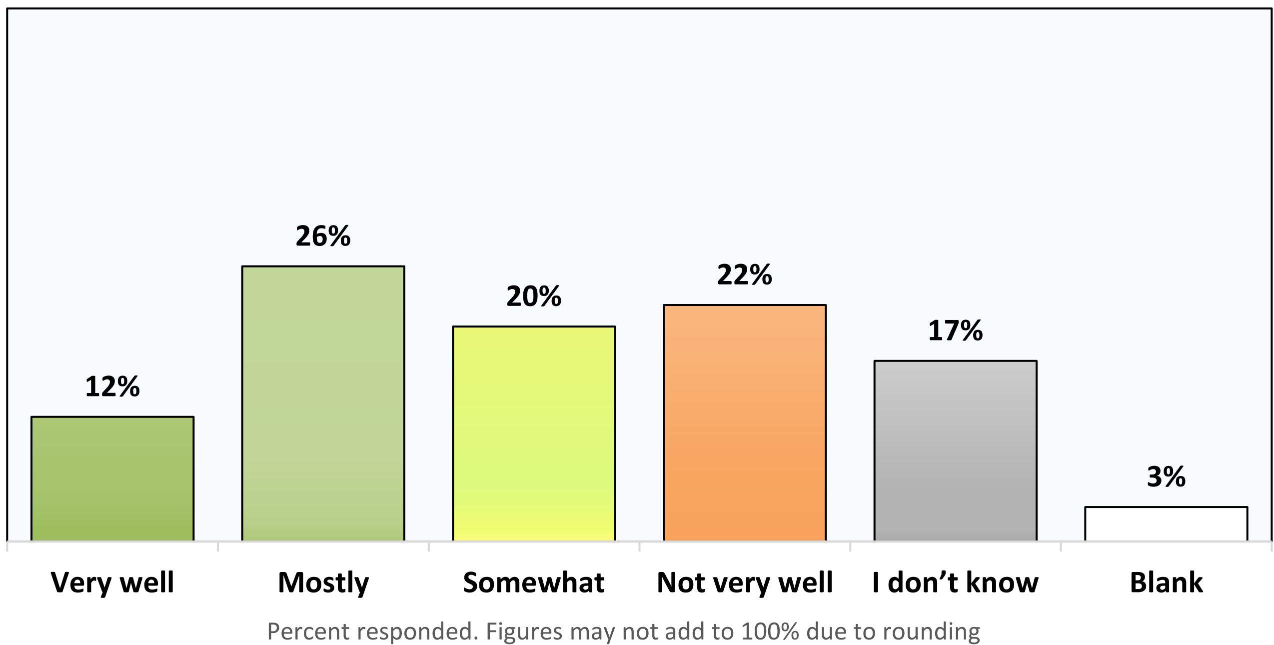


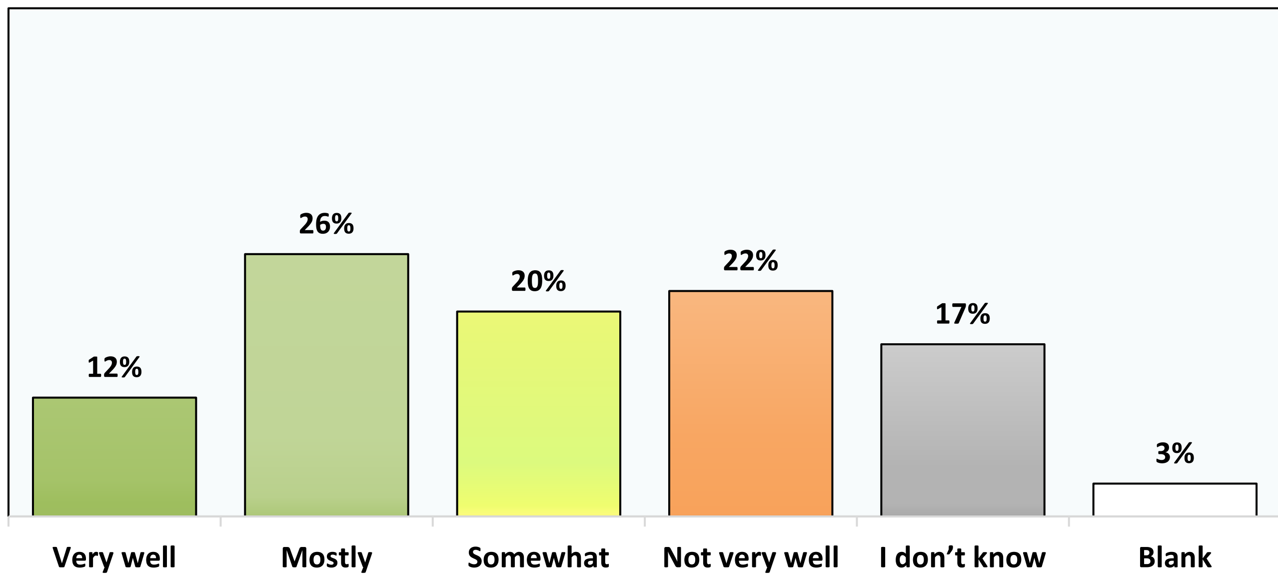


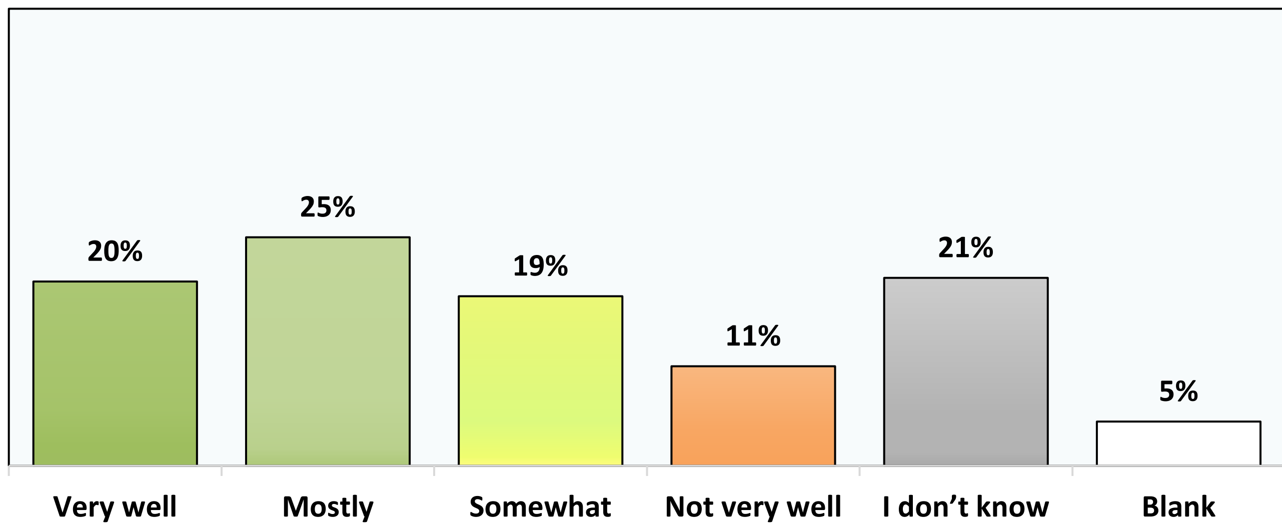

3.)
How well do the MHSA services meet the needs of people in your community who are experiencing a mental health crisis?
N = 248
13%
25%
27%
21%
10%
4%
Very well
Mostly
Somewhat
Not very well
I don't know
Blank
Percent responded. Figures may not add to 100% due to rounding

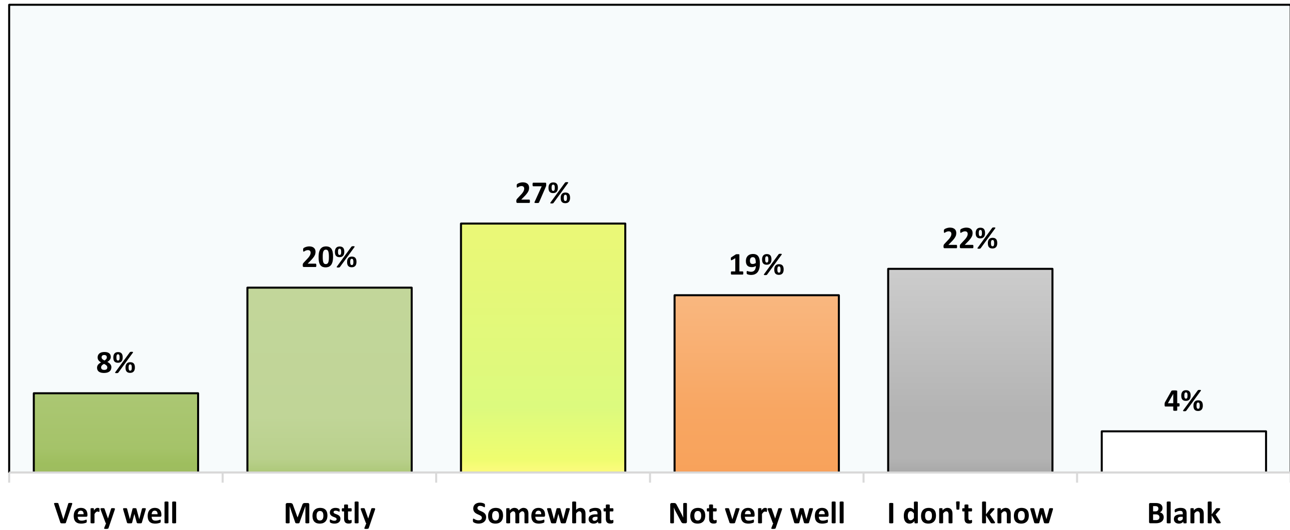

4.)
How well trained are mental health providers in meeting the needs of consumers?
N = 248
20%
32%
21%
8%
16%
3%
Very well
Mostly
Somewhat
Not very well
I don't know
Blank
Percent responded. Figures may not add to 100% due to rounding

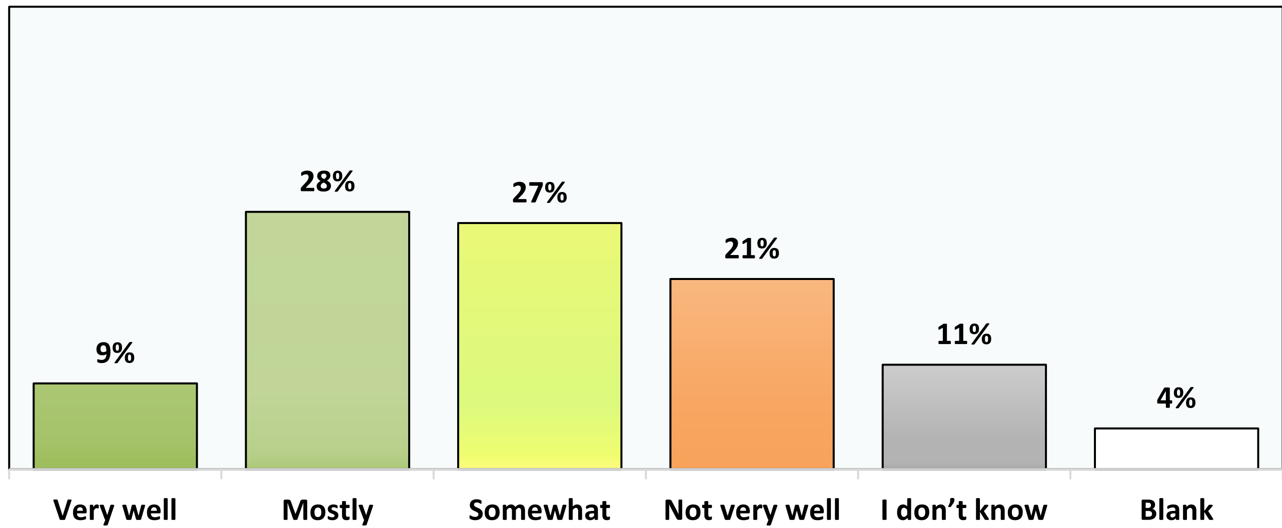

5.) How well are job opportunities for clients and family members included in MHSA services?
N = 248
3%
14%
21%
19%
40%
4%
Very well
Mostly
Somewhat
Not very well
I don't know
Blank
Percent responded. Figures may not add to 100% due to rounding


6.) How well do agencies coordinate referrals for mental health services?
N = 248
12%
26%
20%
22%
17%
3%
Very well
Mostly
Somewhat
Not very well
I don't know
Blank
Percent responded. Figures may not add to 100% due to rounding


7.)
Services are focused on wellness, recovery, and resilience
N = 248
12%
26%
20%
22%
17%
3%
Very well
Mostly
Somewhat
Not very well
I don't know
Blank
Percent responded. Figures may not add to 100% due to rounding

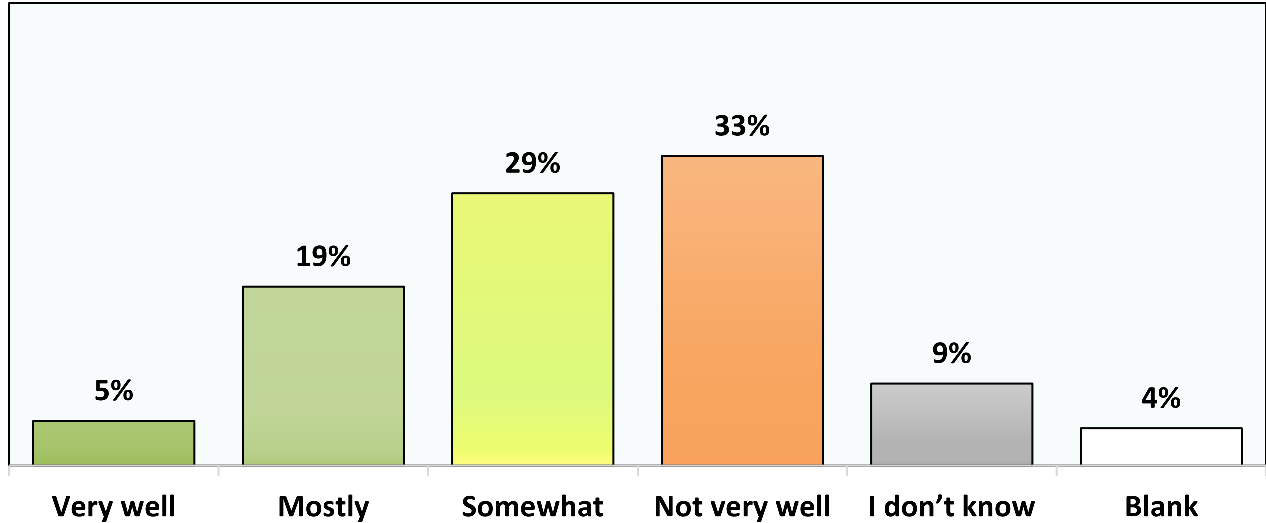

8.)
Services respect the culture and language of consumers and their families
N = 248
20%
25%
19%
11%
21%
5%
Very well
Mostly
Somewhat
Not very well
I don't know
Blank
Percent responded. Figures may not add to 100% due to rounding


9.)
Consumers and families are involved in the design of mental health services
N = 248
8%
20%
27%
19%
22%
4%
Very well
Mostly
Somewhat
Not very well
I don't know
Blank
Percent responded. Figures may not add to 100% due to rounding


10.)
Agencies work together to coordinate mental health services for consumers
N = 248
9%
28%
27%
21%
11%
4%
Very well
Mostly
Somewhat
Not very well
I don't know
Blank
Percent responded. Figures may not add to 100% due to rounding

11.) It is easy for consumers and family members to access mental health services

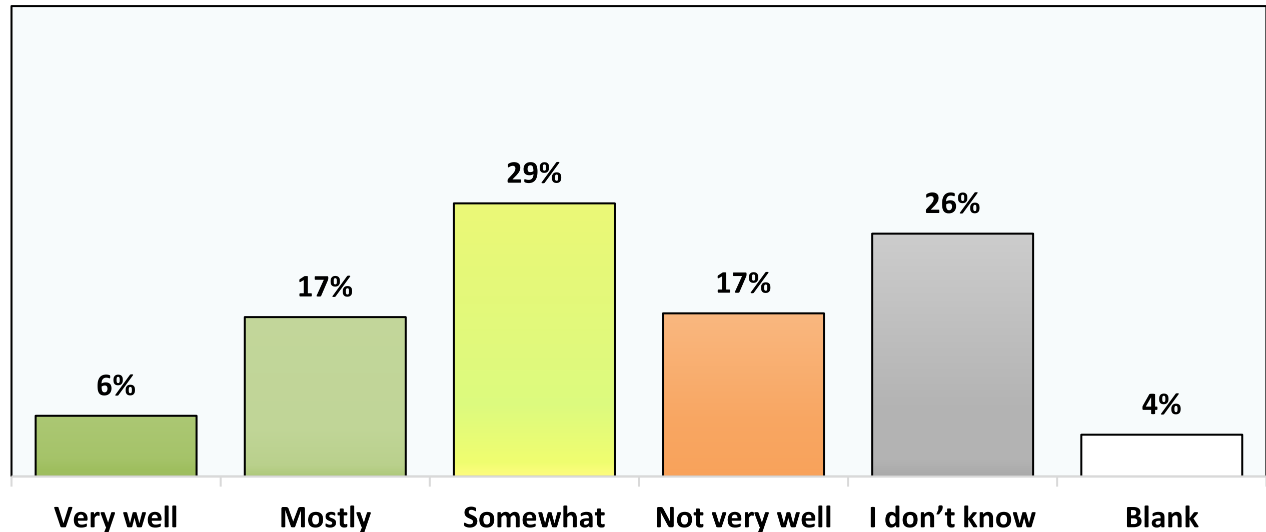
N = 248



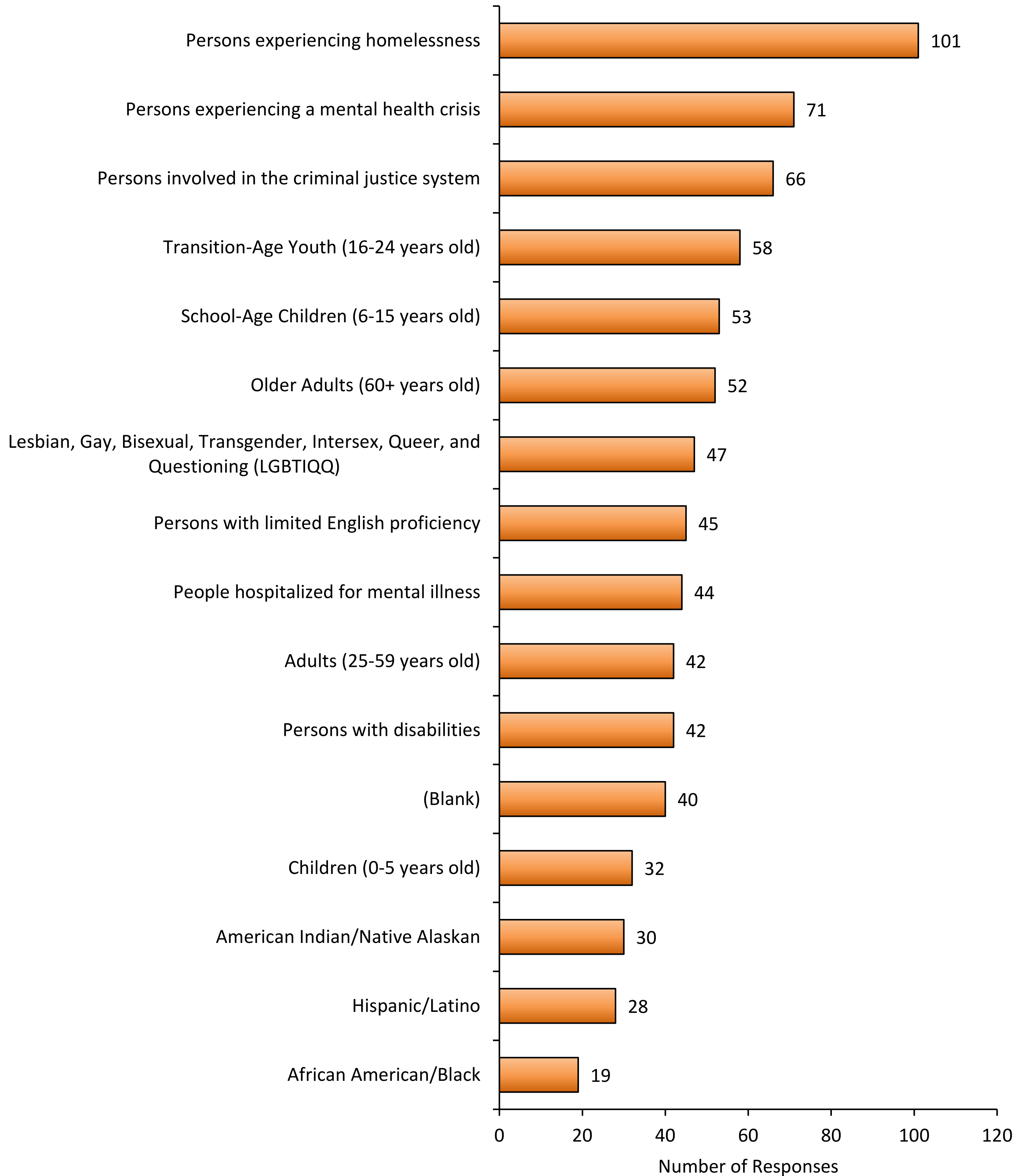
Percent responded. Figures may not add to 100% due to rounding

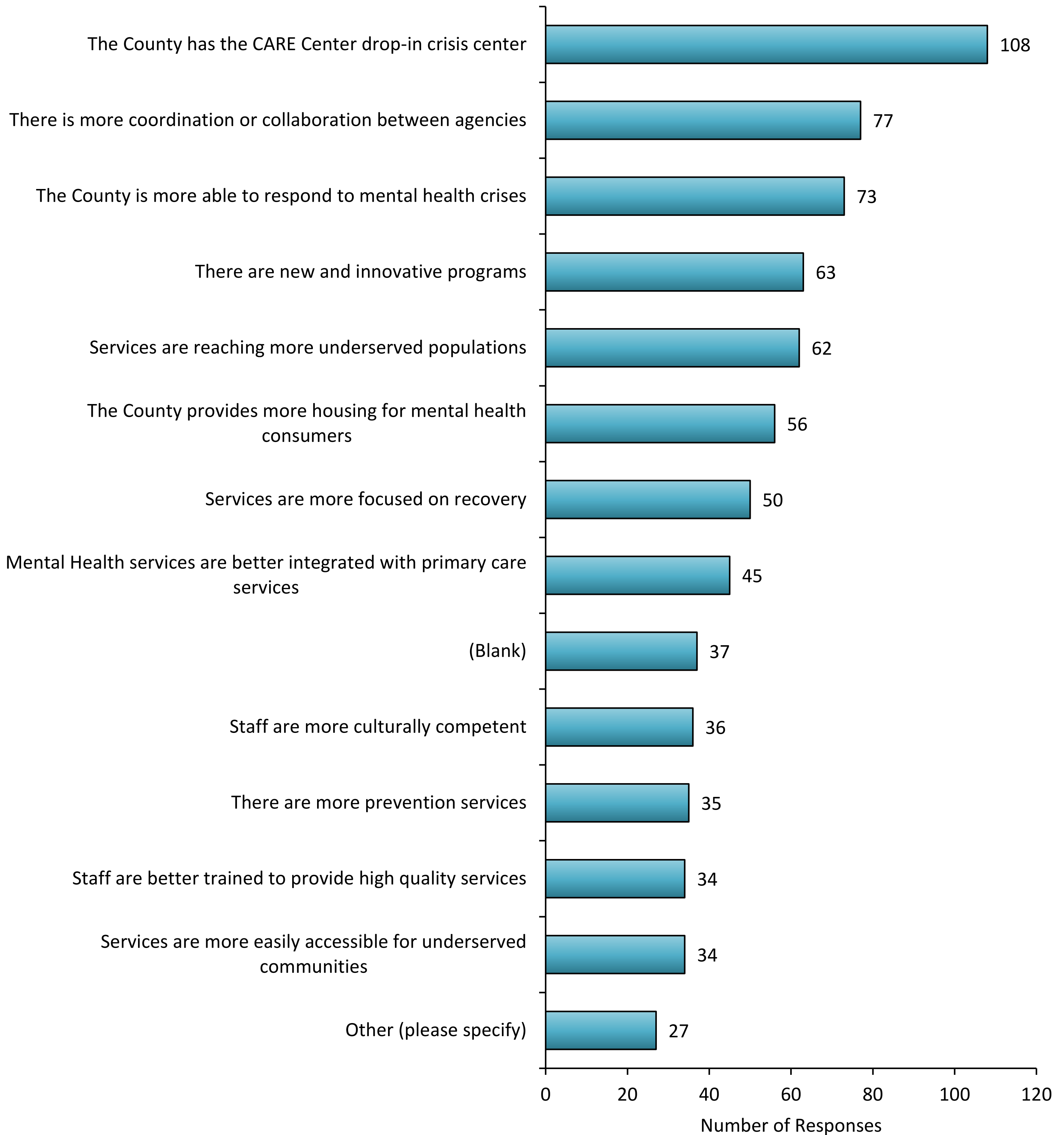
12.) Members of the community are involved in the planning process for MHSA services

N = 248



Percent responded. Figures may not add to 100% due to rounding


Are there any populations or groups of people who are not being adequately served by the current MHSA services?
(responders were asked to mark all that apply)
N = 248
Persons experiencing homelessness
101
Persons experiencing a mental health crisis
71
Persons involved in the criminal justice system
66
Transition-Age Youth (16-24 years old)
58
School-Age Children (6-15 years old)
53
Older Adults (60+ years old)
52
Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, and Questioning (LGBTIQQ)
47
Persons with limited English proficiency
45
People hospitalized for mental illness
44
Adults (25-59 years old)
42
Persons with disabilities
42
(Blank)
40
Children (0-5 years old)
32
American Indian/Native Alaskan
30
Hispanic/Latino
28
African American/Black
19
0
20
40
60
80
100
120
Number of Responses


Over the past five years, what have been the most helpful changes in the County's mental health services?
(responders were asked to mark all that apply)
N = 248
The County has the CARE Center drop-in crisis center
108
There is more coordination or collaboration between agencies
77
The County is more able to respond to mental health crises
73
There are new and innovative programs
63
Services are reaching more underserved populations
62
The County provides more housing for mental health consumers
56
Services are more focused on recovery
50
Mental Health services are better integrated with primary care services
45
(Blank)
37
Staff are more culturally competent
36
There are more prevention services
35
Staff are better trained to provide high quality services
34
Services are more easily accessible for underserved communities
34
Other (please specify)
27
0
20
40
60
80
100
120
Number of Responses

SERVICE SATISFACTION SURVEY

The Service Satisfaction Survey is provided to all individuals who visit the HHSA Adult Services Branch on Breslauer Way. The surveys are placed at the main entrance to the building and at the desk in the Crisis Recovery and Residential Center, where they are easily accessible to everyone. Surveys are anonymous and are collected from drop boxes in the building.

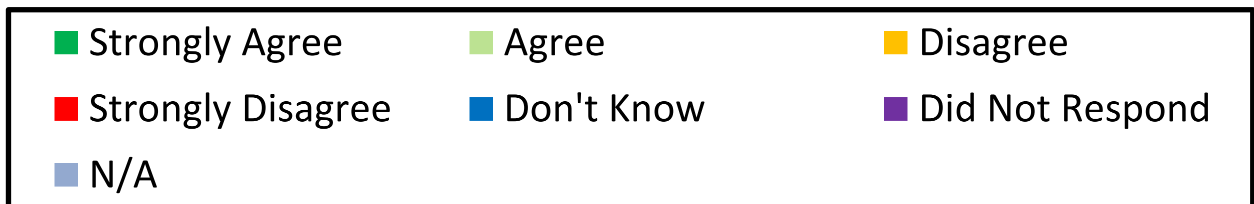
The overall survey results include data from people accessing the following service areas: adult mental health, adult alcohol and drug, in-home supportive services, public authority, and public guardian.

Customer Satisfaction Survey Results
July 2019 through June 2020)
Total surveys collected = 5

0% 20% 40% 60% 80% 100%

Are staff welcoming and engaging?
My calls are returned within 24 hours.
Services are available at times that are good for me.
I am encouraged to use peer support programs.
I help determine my wellness and recovery goals.
Staff encourage me to get involved in community related activities.
Staff here believe that I can grow, change, and recover.
Staff are sensitive to my cultural experiences, interests, and concerns.
I feel free to complain.
I like the services that I receive here.

0% 20% 40% 60% 80% 100%



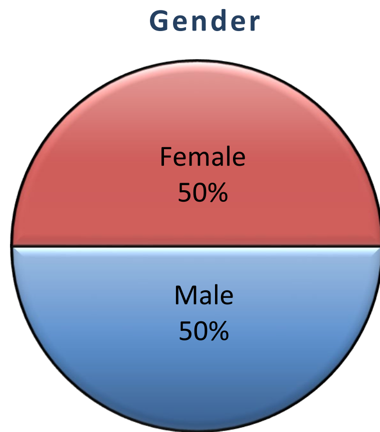
Wellness Center Summary Report

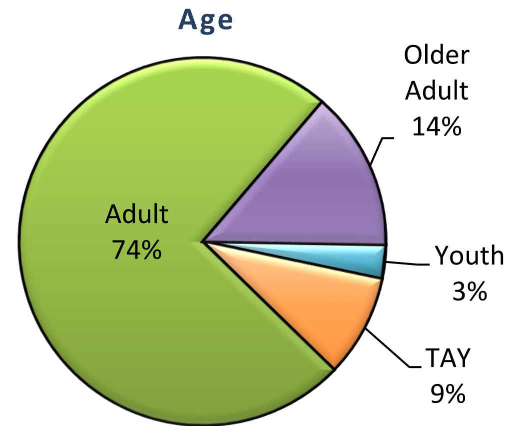
July 2019 – June 2020

Shasta County had two wellness centers in operation during the twelve-month period of July 2019 through June 2020: Olberg Wellness Center in Redding and Circle of Friends in Burney. Olberg Wellness Center is on a monthly reporting cycle, while Circle of Friends in on a quarterly reporting cycle. Because of this, some averaging was necessary for their data to be comparable, so all combined data is an approximation.

Demographics

Approximately 50% of wellness center attendees were male and 50% female. None reported as transgender or other.

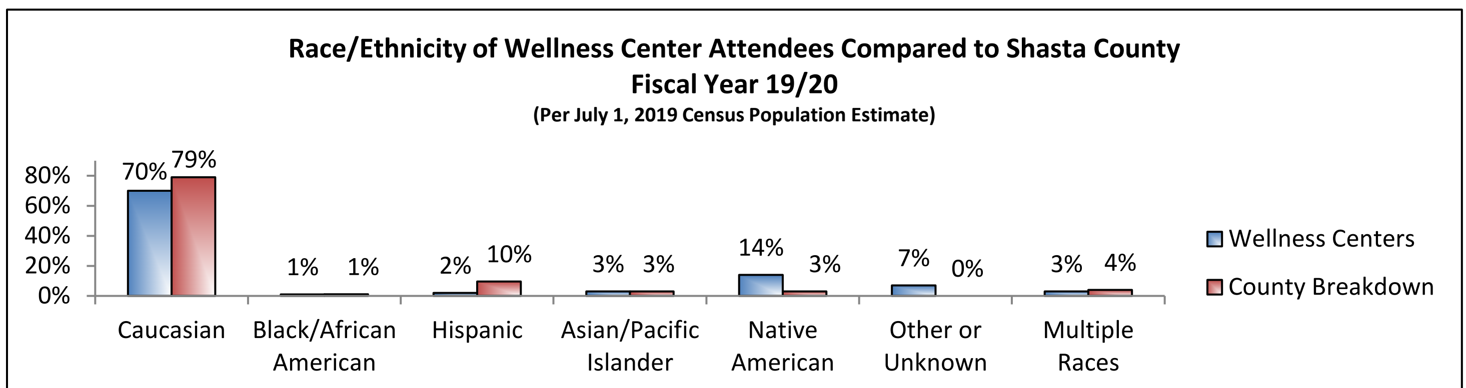




Approximately 3% of wellness center attendees were Youths (0-15 years of age), 9% were Transitional Age Youths (16-25 years of age), 74% were Adults (26-59 years of age), 14% were Older Adults (60+ years of age), and none were of unknown age.

Approximately 94% of wellness center attendees were consumers, 5% were family members of consumers, and 1% were unknown or declined to state.

Caucasians, Hispanics, and Multiple Races were under-represented while Native Americans and Other or Unknown were over-represented.



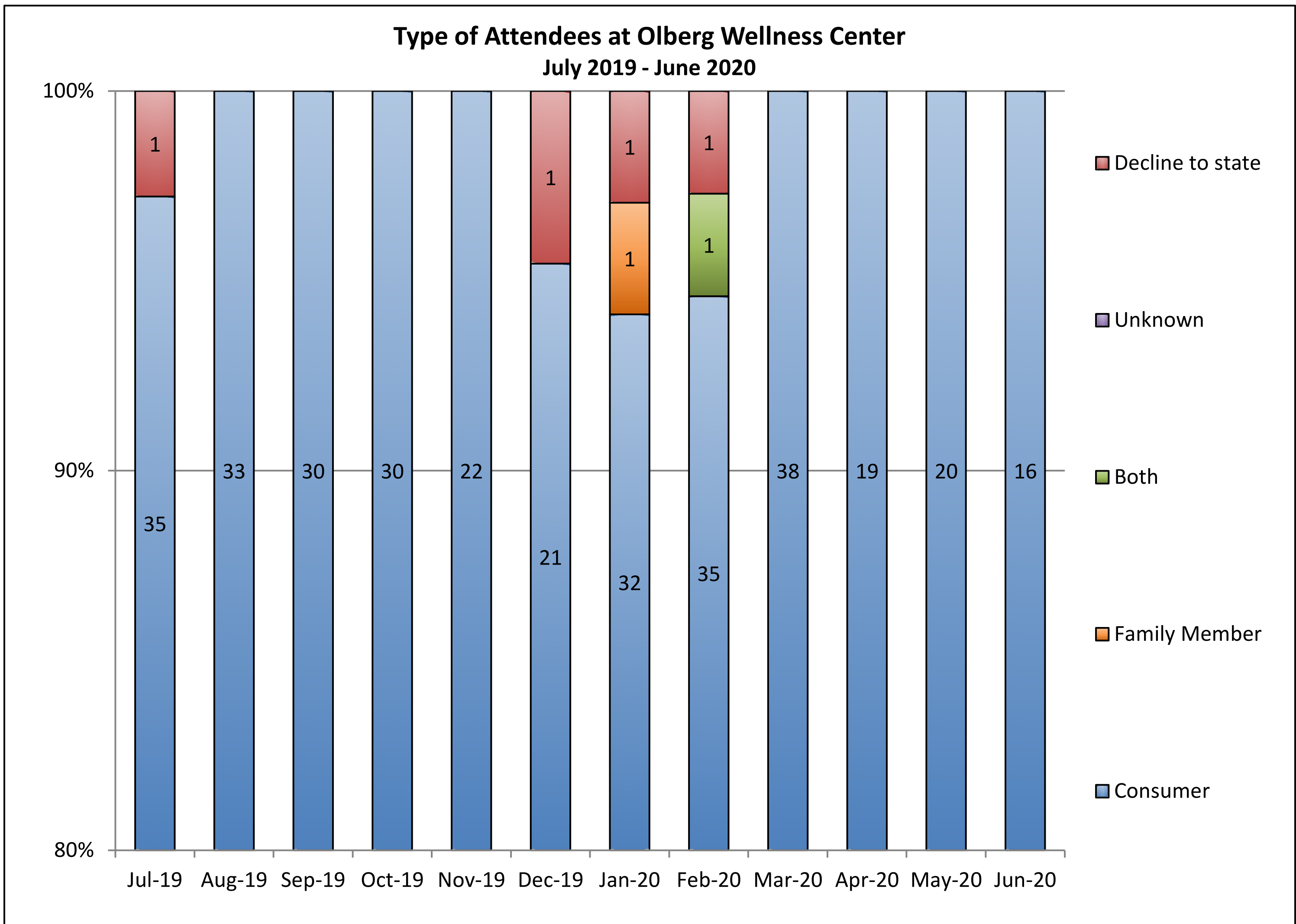
Services Provided

Overall, a total of 2,074 individual workshops, groups, activities, and 12-step recovery meetings were held during this twelve-month period.

Olberg Wellness Center

Attendance

Attendance decreased 20% from the previous twelve-month period, with an average of 28 unduplicated participants each month.



Demographics

On average, 99% of attendees were consumers. Less than 1% were the following: family members, both family members and consumers, participants of unknown type, and declined to state. On average, 90% of staff members (including volunteers) were consumers and/or family members. In order to maintain confidentiality, age, gender and race/ethnicity is not broken down by individual wellness center.

Services Provided

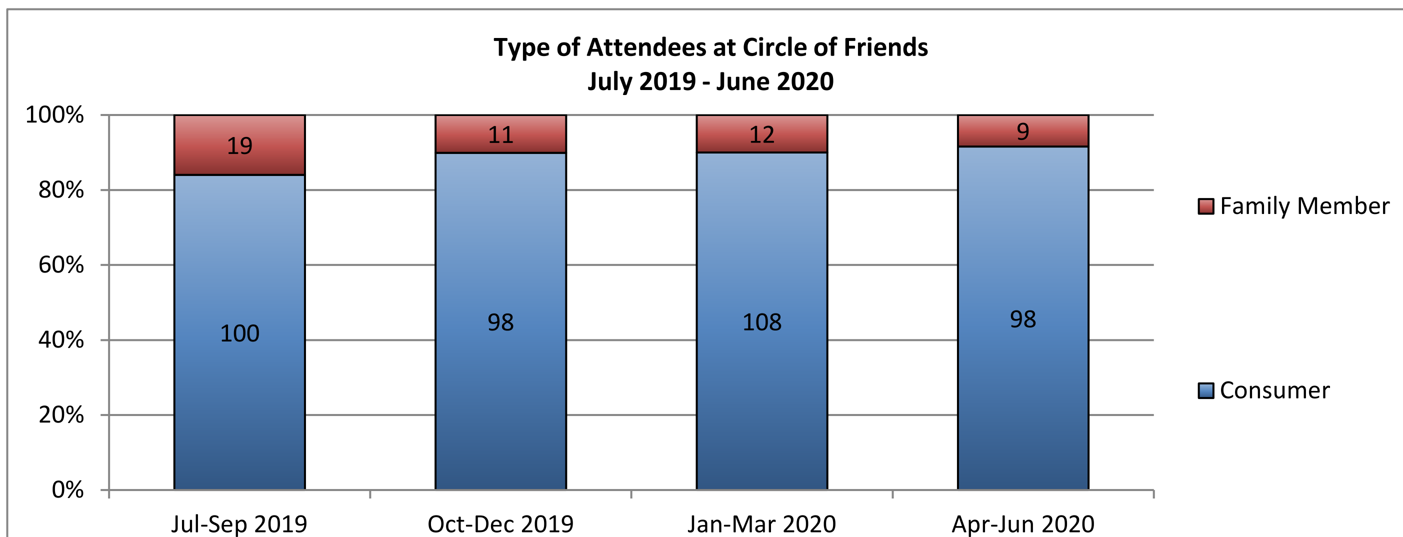
Olberg Wellness Center is open Monday through Friday 10 am to 3 pm. During this twelve-month period 1,362 individual activities and groups were available for participants, with the average being 6 groups or activities offered per day. On the average, there were approximately 5 participants per activity.

Attendee Direction

Olberg Wellness Center has weekly Members' Meetings and monthly Steering Committee Meetings, open to consumers and family members. During this twelve-month period, they had an average of 10 participants per meeting.

Circle of Friends

Attendance
Attendance decreased 8% from the previous twelve-month period, with an average of 114 unduplicated people attending Circle of Friends each quarter.

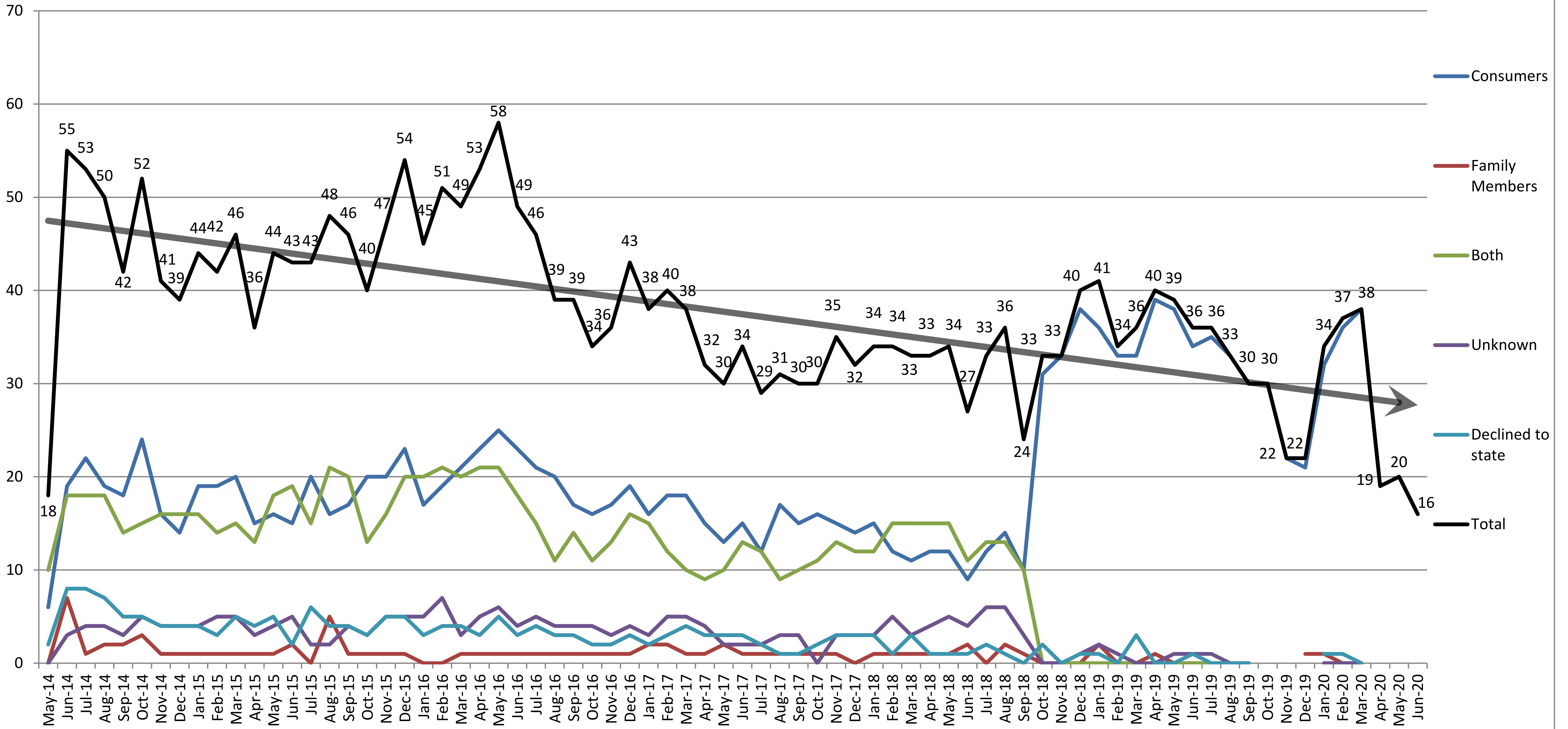


Demographics
Eighty-nine percent of attendees were consumers and 11% were family members. Eighty-two percent of staff and 99% of volunteers were consumers and/or family members. In order to maintain confidentiality, age, gender and race/ethnicity is not broken down by individual wellness center.

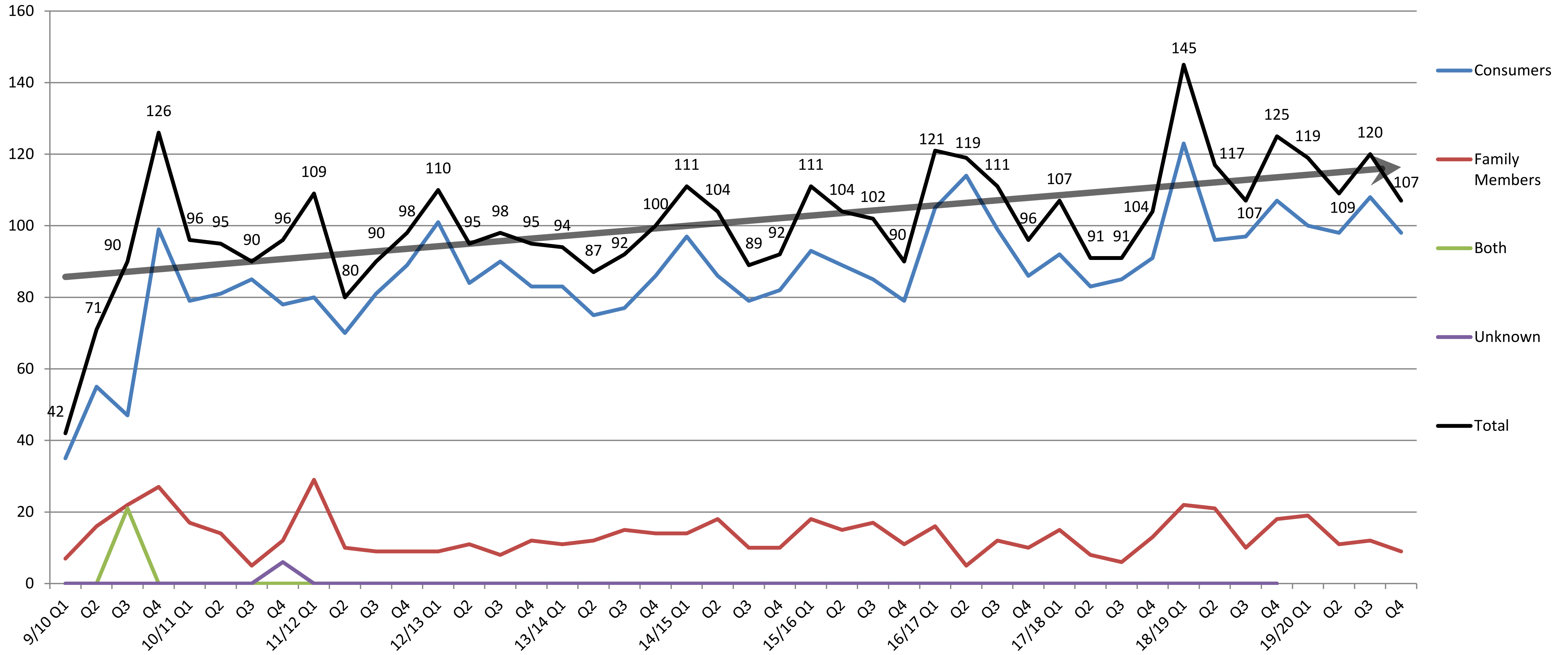
Services Provided
Virtual hours of operation are scheduled for Monday, Wednesday and Friday, 12:30-2:00 via Zoom. Outdoor gatherings are held every Wednesday from 10:00-11:00 at varying locations. Although the building is not open for activities during this time, they remain open for food and clothing distribution Monday through Friday from 8:00 to 4:30.

Five workshops, 208 different activities, and 12 step recovery meetings provided 712 individual activities/groups for participants during this twelve-month period.

Attendee Direction
An average of 26 attendees (23%) contributed to the planning and direction of the program each quarter. All decisions relating to the center were based on participant input through Stand Against Stigma Committee meetings; their Outdoor Gatherings; “My Favorite Things from the Weekly Packet Are…”; “Planning for Our Future”; “Something I Would Like to Do on Zoom”; “What are We Learning? Discussion – What Can We Take with Us Moving Forward?”; Zoom Planning; Quarantine Buster Packet Mailings and Deliveries, Check-In Time, the Steering Committee, Calendar and Newsletter Planning Meetings, Creating a Walk Bingo, Go to Meeting Planning, the Steinburg Institute visit, check-in time, Think Pink Week Planning, Fundraising Planning Meeting, MHSA Three-Year Plan Update, MHSA Stakeholders Meeting, Good Medicine Health Fair, and other activity-specific planning meetings. Activities offered are based on participant preferences.



Attendance Over Time - Olberg Wellness Center
Consumers
Family Members
Both
Unknown
Declined to state
Total


Attendance Over Time - Circle of Friends
160
140
120
100
80
60
40
20
0
Consumers
Family Members
Both
Unknown
Total
9/10 Q1
Q2
Q3
Q4
10/11 Q1
11/12 Q1
12/13 Q1
13/14 Q1
14/15 Q1
15/16 Q1
16/17 Q1
17/18 Q1
18/19 Q1
19/20 Q1
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Shasta County Health & Human Services Agency

NAMI Summary Report

July 2019 through June 2020

Program Offerings

NAMI Shasta County offered Family to Family Support Group sessions and one-on-one mentoring sessions during Fiscal Year 19/20. The Family Support Group met every two weeks. Local NAMI president Susan Power, along with several volunteers, assisted with the one-on-one mentoring sessions. NAMI volunteers ran the family support group sessions. The average total number of hours volunteers spent on mentoring sessions each week was 7.5.

Location of Family Support Group Session	Date of Session	Length	Number of Attendees
Hill Country CARE Center	07/02/2019	2 hours	9
Hill Country CARE Center	07/16/2019	2 hours	5
Hill Country CARE Center	08/06/2019	2 hours	7
Hill Country CARE Center	08/20/2019	2 hours	10
Hill Country CARE Center	09/04/2019	2 hours	9
Hill Country CARE Center	09/18/2019	2 hours	6
Hill Country CARE Center	10/01/2019	2 hours	9
Hill Country CARE Center	10/15/2019	2 hours	10
Hill Country CARE Center	11/05/2019	2 hours	7
Hill Country CARE Center	11/19/2019	2 hours	5
Hill Country CARE Center	12/03/2019	2 hours	6
Hill Country CARE Center	12/17/2019	2 hours	7
Hill Country CARE Center	01/07/2020	2 hours	6
Hill Country CARE Center	01/21/2020	2 hours	7
Hill Country CARE Center	02/04/2020	2 hours	10
Hill Country CARE Center	02/18/2020	2 hours	5
Hill Country CARE Center	03/03/2020	2 hours	7
Hill Country CARE Center	03/17/2020	cancelled	cancelled
Hill Country CARE Center	06/16/2020	2 hours	6

There were no facilitated peer support sessions, Peer-to-Peer, Family-to-Family, or NAMI Basics programs offered during this reporting period.

The NAMI On Campus program was not implemented during Fiscal Year 19/20. In March, schools began closing.

Successes included having phone calls returned and holding family support group meetings every two weeks (until March).

Barriers included volunteers dealing with crises with their own families and challenges because of COVID-19.

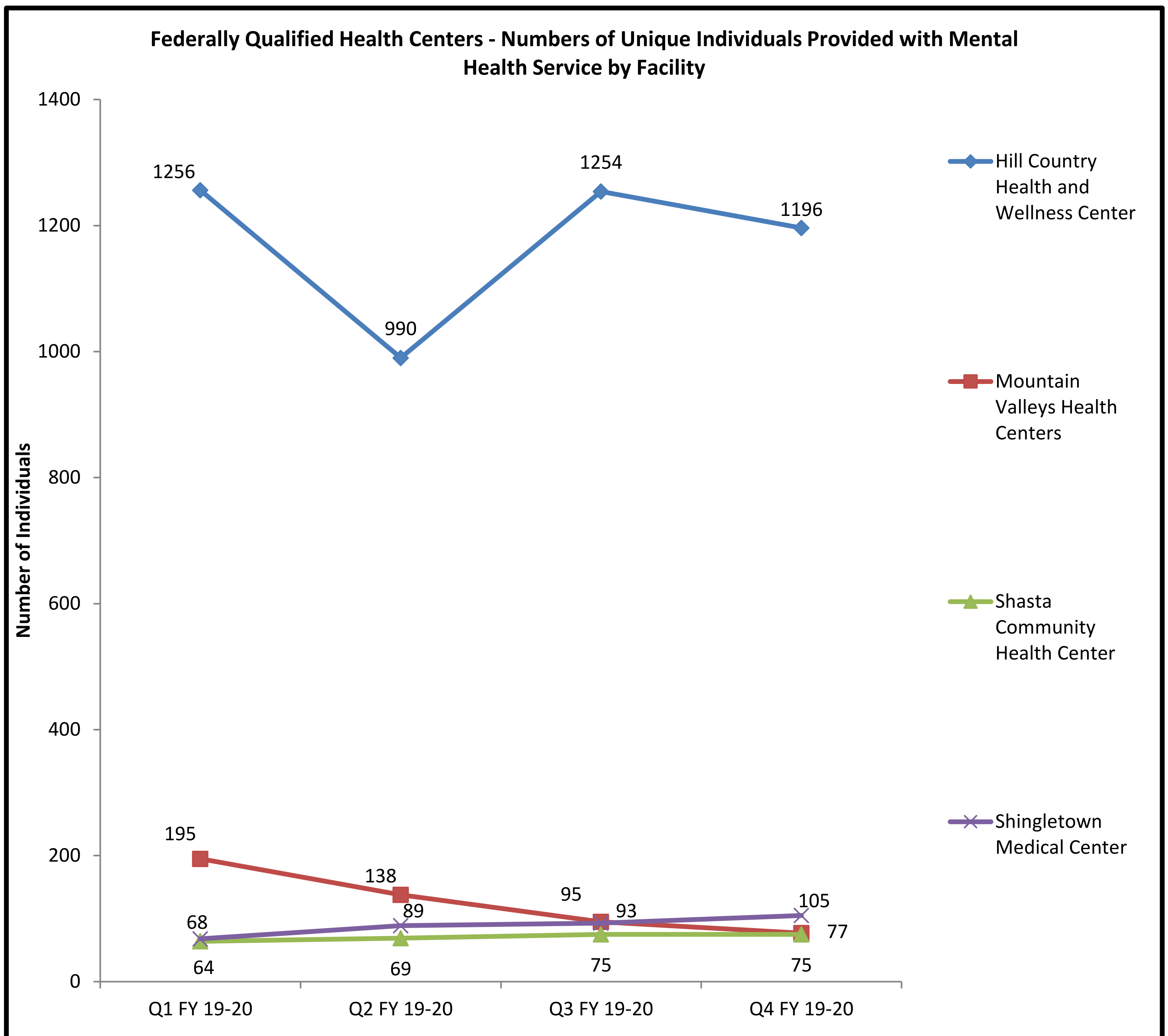
Federally Qualified Health Centers Annual Summary Report

July 2019 through June 2020

To better provide access to mental health services in Shasta County, the Shasta County Health and Human Services Agency has contracted with four different Federally Qualified Health Centers (FQHCs) to provide new or expanded mental health services, integrate mental health services with existing mental health and medical services provided by the FQHCs, and strengthen the relationship between the FQHCs and the County's public mental health system. Funding is provided through the Mental Health Services Act (MHSA). Shasta County had four federally qualified health centers in operation during the 2019-2020 fiscal year: Hill Country Health and Wellness Center in Round Mountain; Mountain Valleys Health Centers in Burney; Shasta Community Health Center in Redding; and, Shingletown Medical Center in Shingletown.

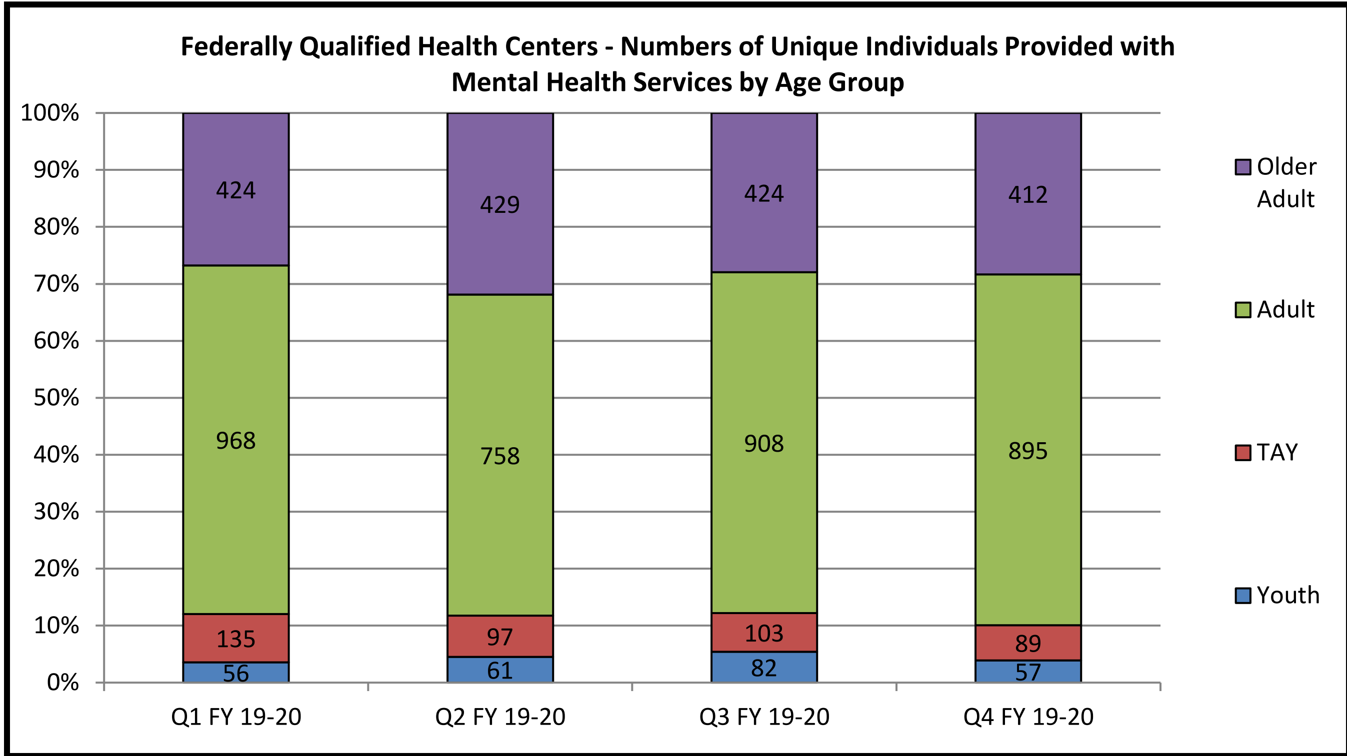
Attendance

An average of 1460 people visited a federally qualified health center in each quarter of fiscal year 2019-2020. This is a 4.39% decrease compared to the previous fiscal year.

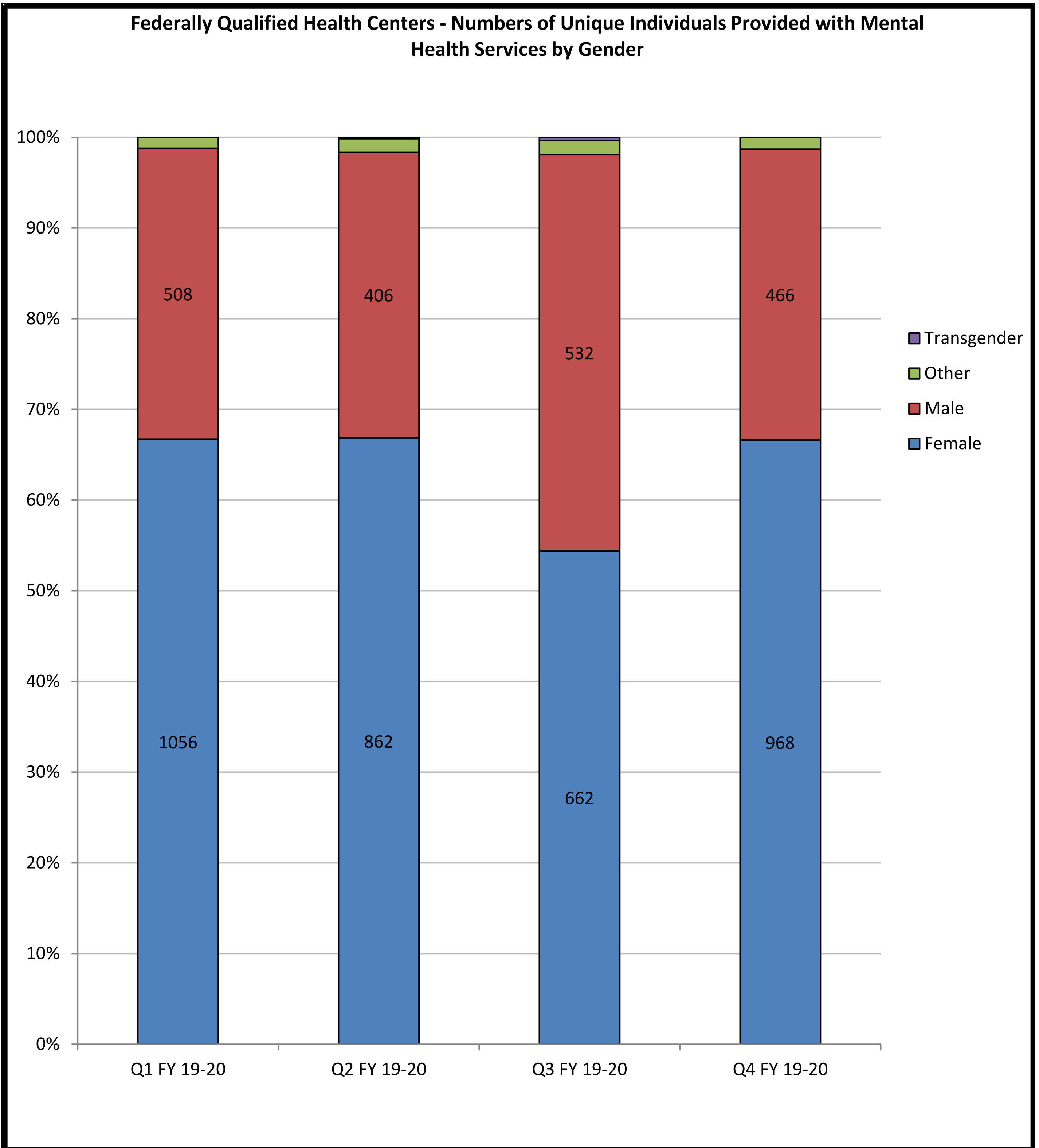


Demographics

Age - The MHSA uses four age categories: Youth – ages 0 to 15, Transitional Aged Youth (TAY) – ages 16 to 25, Adult – ages 26 to 59, and Older Adult – ages 60 and up.



Gender - The MHSA uses four gender categories: Male, Female, Transgender, and Other. Counts of less than 20 individuals are not labeled to help maintain consumer confidentiality, but are included in the chart.



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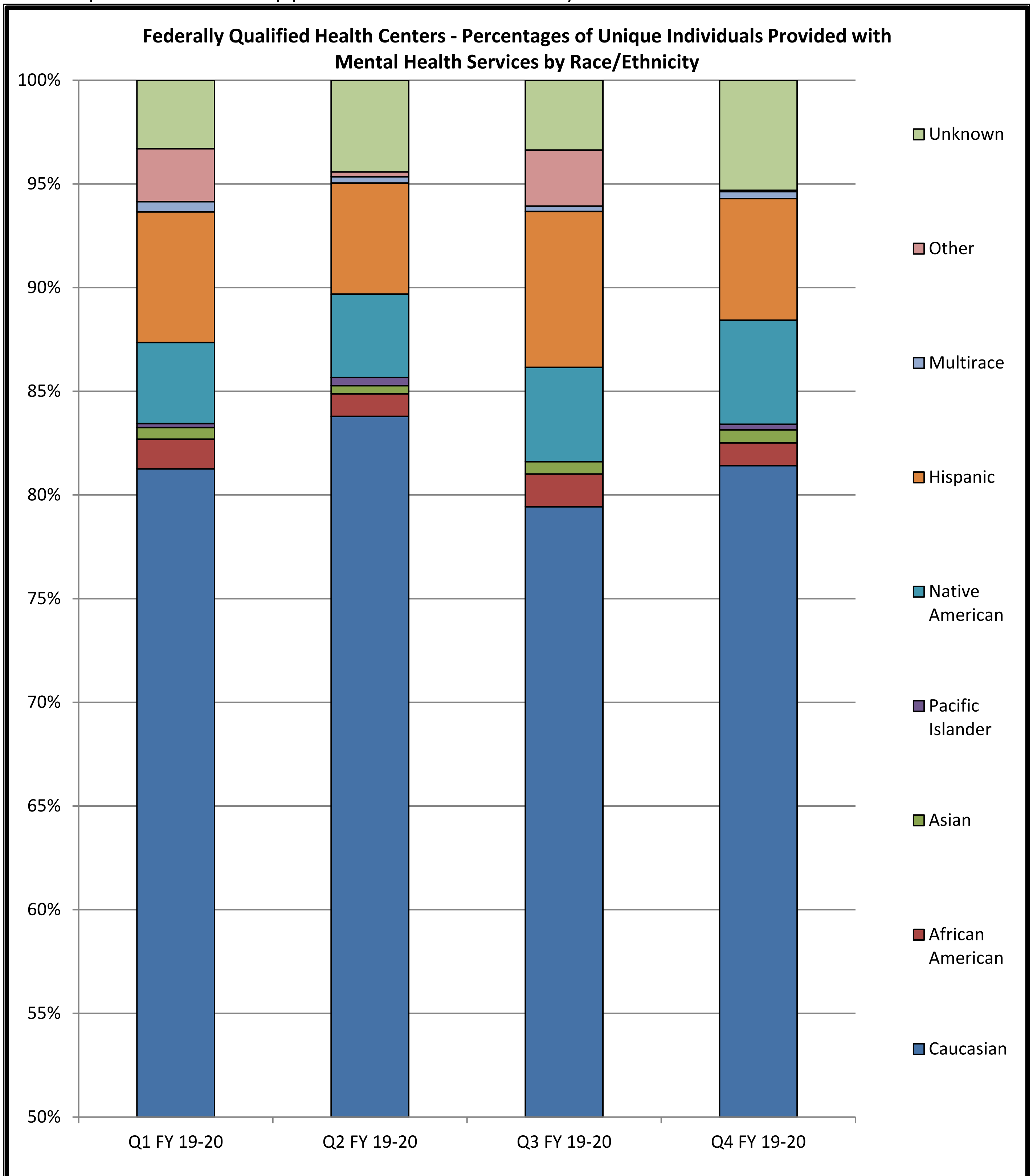
Race/Ethnicity - Because of the low gross numbers for some of these ethnicities within small communities, actual counts are not reported in order to help protect consumer confidentiality.



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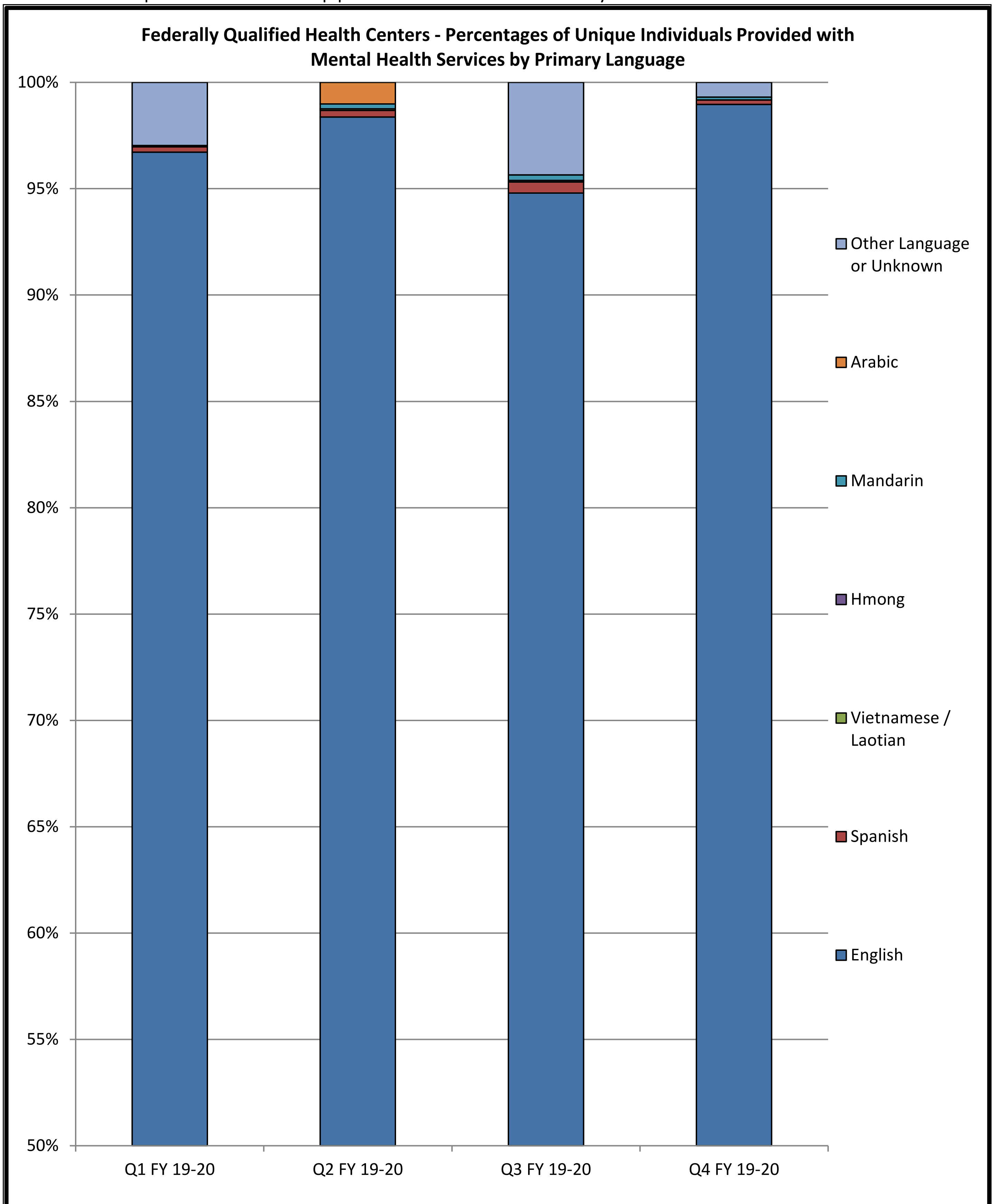
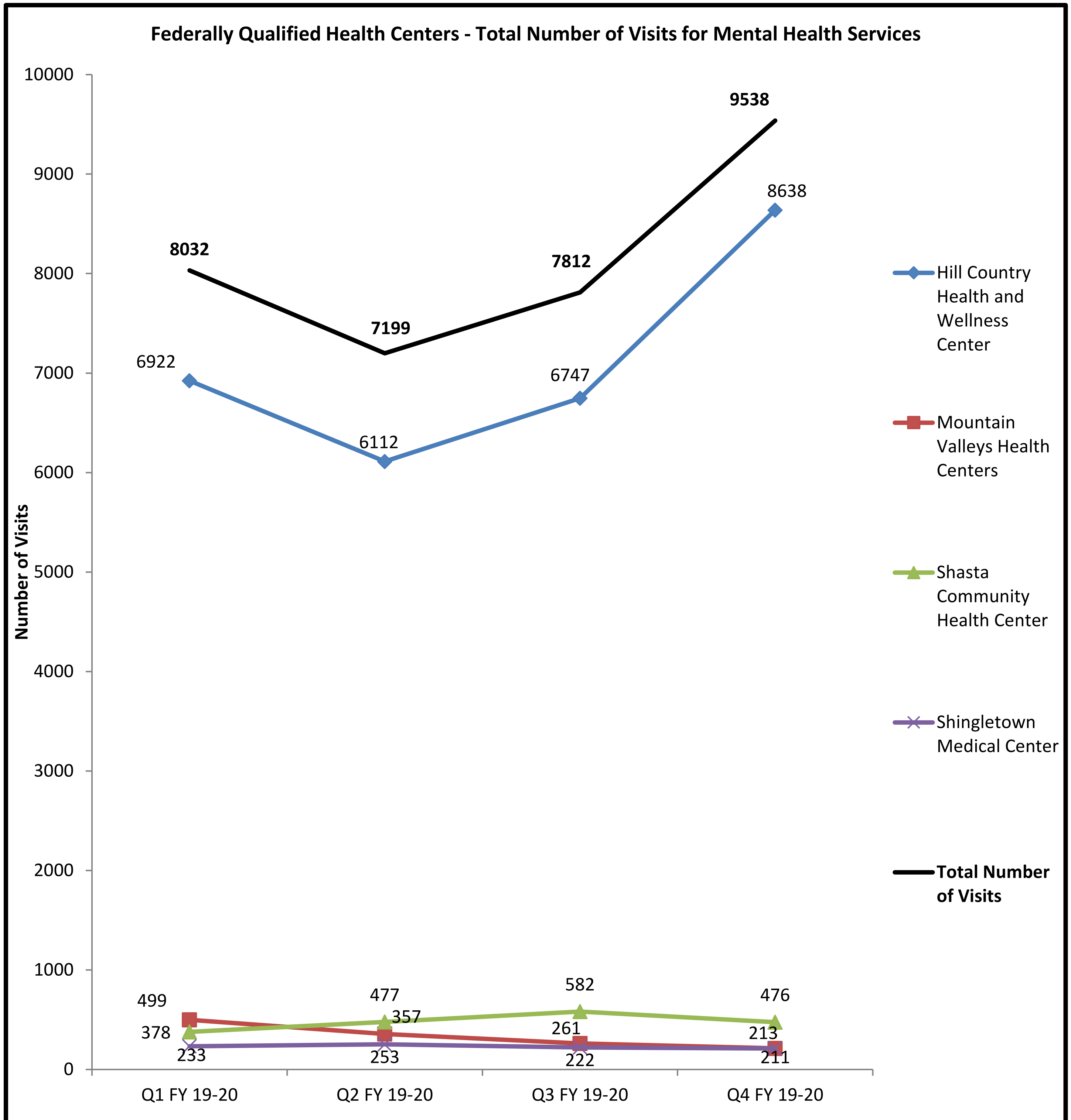
Primary Language - Because of the low gross numbers for some of these languages within small communities, actual counts are not reported in order to help protect consumer confidentiality.



Services Provided

Most people will have multiple visits to the FQHC each quarter, and different types of service may be offered at different times in order to provide everyone with comprehensive and integrated age appropriate mental health services. Services provided may include such things as screenings, assessments, medication management, and individual or group psychotherapy sessions. For fiscal year 2018-2019, there were a total of 29,258 visits to a federally qualified health center for some type of mental health service. This is a 25.43% increase compared to the previous fiscal year.



Primary Mental Health Diagnosis
All FQHCs are asked to report on the primary mental health diagnosis for each consumer. However, due to some health recordkeeping systems in use, not all facilities are able to isolate primary mental health diagnosis, and so all mental health diagnoses made by them are reported. Because of this, comparisons are made by percentage of each diagnosis.

Regarding the categories used for reporting mental health diagnoses, "Other Conditions" is a state diagnosis category (as are all the others) which still refers to a mental health diagnosis and not a physical health ailment. This diagnosis is generally a mental health issue not readily fitting into the other main groupings (for example, conditions such as Anorexia Nervosa, Sleep Terror Disorder, Impulse-Control Disorder, Bereavement, etc.). If there is no mental health diagnosis, it would be reported under the category "Deferred Mental Health Diagnosis."

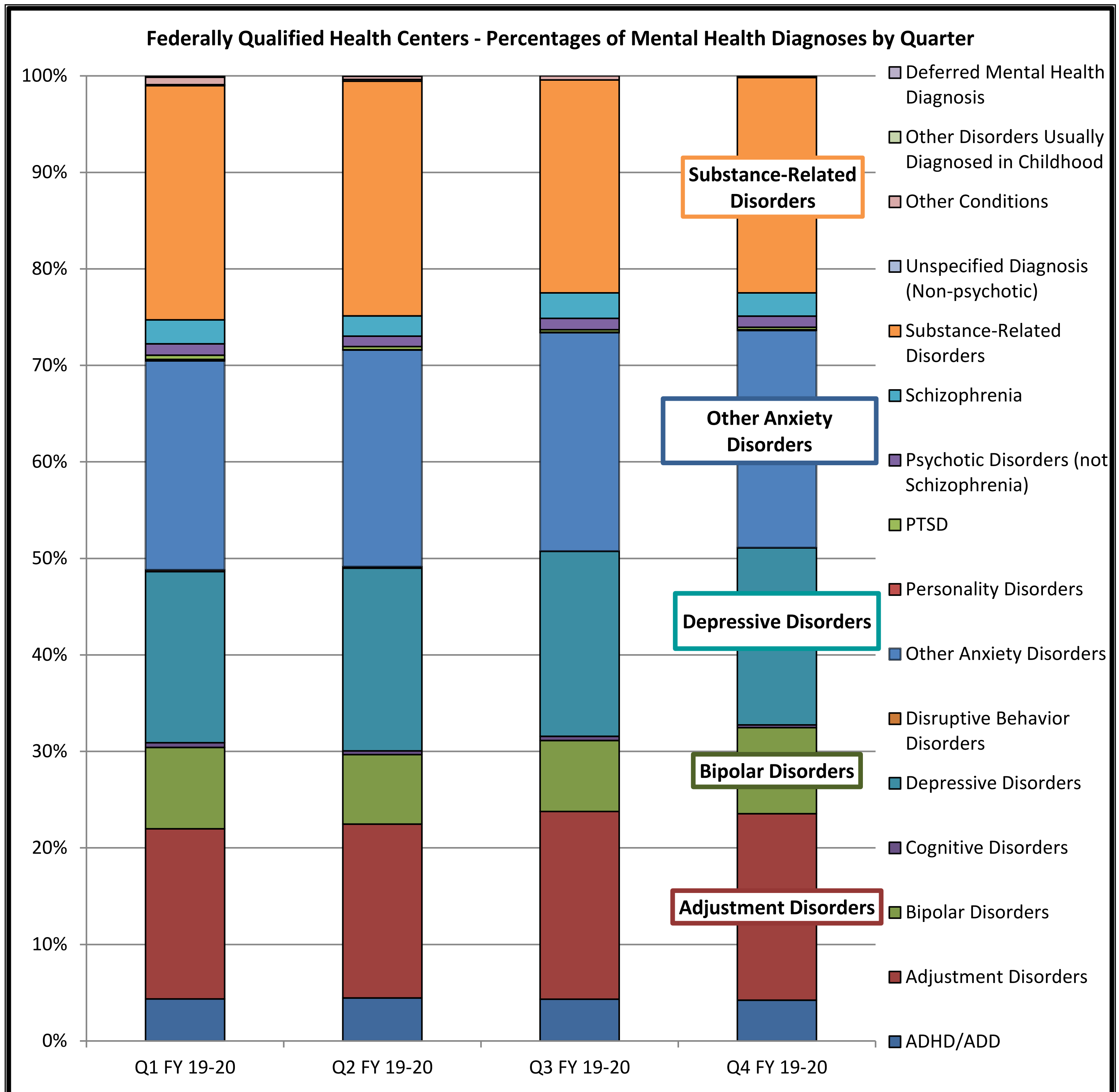


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Table 3: Bolded and underlined numbers represent the highest number during the fiscal year. In June, the number of CRRC admits at 14 was a decrease of -13% compared to May and was the same as from the same month of last year. There were 241 CRRC bed days for June, -22% less than May, and a -37% decrease from the same month of the prior year. The average length of stay for June was 17 days, which was -2 less than May and -10 less than June of the previous year.

CRRC/*Elpida* Admits (chart on page 5)

Fiscal Year	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY Total	FY Change +/-**
YTD Change +/-*	18%	-14%	-6%	-15%	-17%	-16%	-15%	-9%	-8%	-11%	-8%	-8%		
2019-20	**20**	12	17	14	13	13	17	19	15	10	16	14	**180**	-8%
2018-19	17	20	15	**22**	18	14	18	13	15	16	13	14	**195**	13%
2017-18	17	13	12	12	13	14	19	11	10	16	16	**20**	**173**	13%
2016-17	16	17	5	16	14	5	16	8	**22**	11	10	13	**153**	-13%
2015-16	18	9	15	20	14	11	12	15	10	**21**	11	19	**175**	-5%
2014-15	17	**23**	17	14	15	12	17	13	14	10	14	19	**185**	-1%
2013-14	17	17	19	19	12	15	**21**	6	19	15	10	16	**186**	-27%
2012-13	26	**28**	21	25	24	19	17	22	18	17	19	20	**256**	-3%
2011-12	24	23	27	20	11	23	21	22	**29**	18	22	25	**265**	-2%
2010-11	20	26	23	23	21	23	22	19	23	19	**30**	21	**270**	-6%

CRRC/*Elpida* Days (chart on page 5)

Fiscal Year	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY Total	FY Change +/-**
YTD Change +/-*	-3%	-16%	-20%	-20%	-23%	-21%	-21%	-19%	-18%	-18%	-19%	-21%		
2019-20	**366**	291	**247**	314	235	260	294	317	360	313	309	241	**3,547**	-21%
2018-19	376	404	348	403	357	*285*	367	320	394	407	**437**	381	**4,479**	50%
2017-18	204	165	**187**	204	260	329	288	264	191	201	**353**	339	**2,985**	13%
2016-17	295	280	201	185	291	*120*	242	199	167	228	130	**313**	**2,651**	-7%
2015-16	236	224	244	**342**	301	266	194	217	178	215	193	229	**2,839**	-5%
2014-15	**345**	268	280	235	235	186	284	239	174	246	192	304	**2,988**	-3%
2013-14	274	231	255	295	136	207	333	311	212	**335**	242	243	**3,074**	-14%
2012-13	315	341	321	310	344	**361**	248	259	296	308	213	274	**3,590**	20%
2011-12	216	202	296	**329**	209	196	247	191	279	291	267	268	**2,991**	2%
2010-11	193	254	250	290	278	231	**307**	192	203	165	302	280	**2,945**	-10%

CRRC/*Elpida* Average Length of Stay (Bed Days/Discharge Count) - (chart on page 5)

Fiscal Year	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY Avg. LOS	Change +/- **
2019-20	18	24	10	22	18	20	17	17	24	**31**	19	17	**20**	-13%
2018-19	22	20	23	18	20	20	20	25	26	25	34	27	**23**	35%
2017-18	12	13	16	17	20	24	15	24	19	13	22	17	**17**	0%
2016-17	18	16	**40**	12	21	24	15	25	8	21	13	24	**17**	6%
2015-16	13	**25**	16	17	22	24	16	14	18	10	18	12	**16**	-6%
2014-15	20	12	16	17	16	16	17	18	12	**25**	14	16	**17**	-11%
2013-14	16	14	13	16	11	14	16	**52**	11	22	24	15	**19**	36%
2012-13	12	12	15	12	14	**19**	15	12	16	18	11	14	**14**	17%
2011-12	9	9	11	16	**19**	9	12	9	10	16	12	11	**12**	9%
2010-11	10	10	11	13	13	10	**14**	10	9	9	10	13	**11**	-8%
2009-10	**15**	10	13	12	11	13	10	11	9	12	11	11	**12**	0%
2010-11	7	9	12	12	12	12	**18**	9	11	10	16	14	**12**	-8%

* YTD Change +/- is calculated to show month to month comparison of the prior Fiscal Year to Current Fiscal Year.

** FY Change +/- is calculated based on the prior Fiscal Year comparison to Current Fiscal Year.

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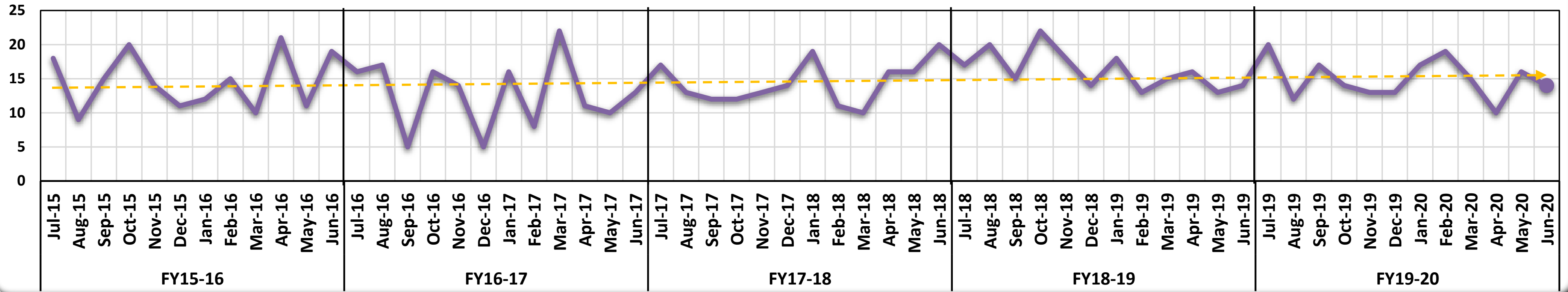
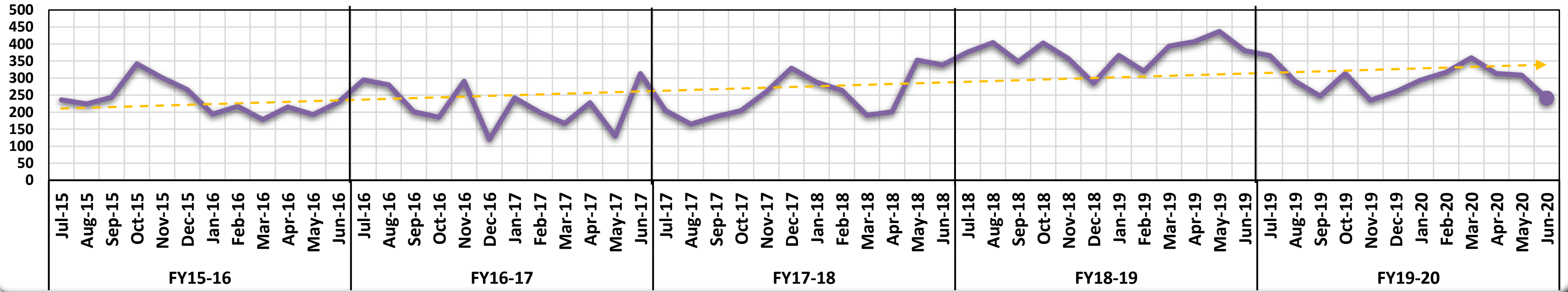
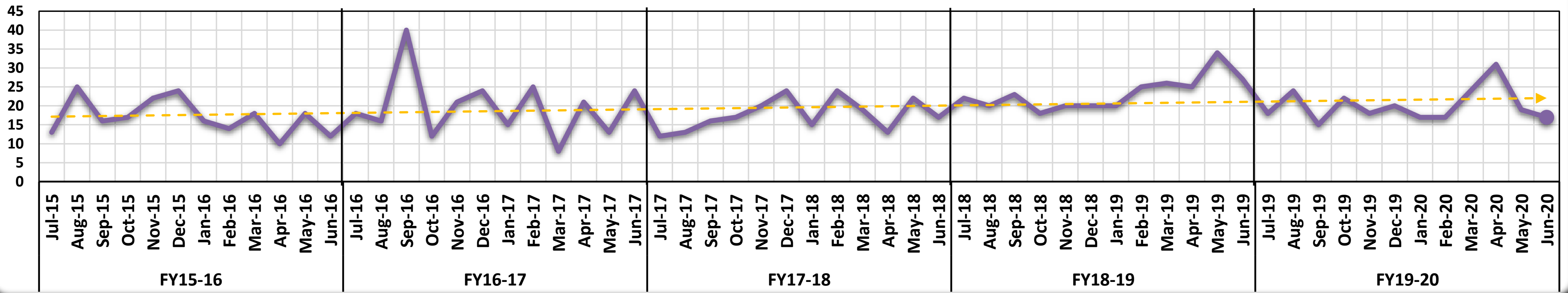
Chart 3: Crisis Residential







Shasta County Health & Human Services Agency

The Woodlands Permanent Supportive Housing

Fiscal Year 2019/2020

The Woodlands is an affordable housing complex that has twenty-four of its seventy-five units reserved for applicants with serious mental illness who are also homeless or at risk of being homeless. Applicants who have met the criteria for eligibility are referred to as clients. Of the twenty-four units that are reserved for clients, nineteen are one-bedroom units and five are two-bedroom units. Clients have access to an on-site community center that has a computer room, game room, activity room, laundry facilities, County staff office, and manager's unit. Other areas include a pool, social plaza, BBQ area, exercise circuit, children's play areas, and community garden along with other landscaped areas.

The County partners with Northern Valley Catholic Social Services (NVCSS) to provide clients with social services such as:

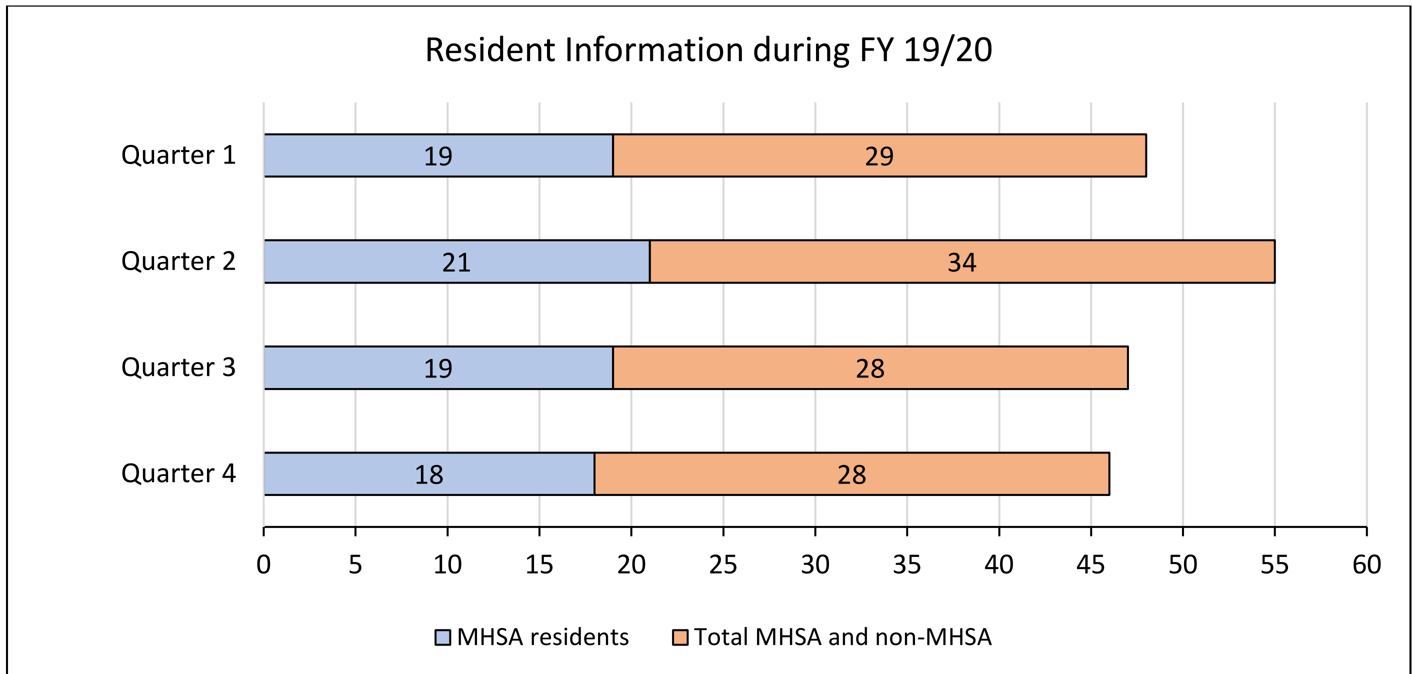
- Finance/Budgeting Classes
- Personal Income Tax Preparation
- Adult Education Classes
- Benefit/Entitlement Assistance
- After-School Activities
- Health and Wellness Classes.

The County also provides clients with supportive services such as:

- Case Management
- Clinical Support
- Crisis Management
- Medication Support
- Co-Occurring Treatment
- In-Home Support Services
- Wellness & Recovery Action Planning ("WRAP")
- Life Skills Training
- Peer Support
- Family Support
- Benefits Counseling
- Public Guardian
- Employment Readiness and Resources
- Adult Protect Services
- Representative Payee Support
- Vocational Services
- After-Hours Crisis Support

Ongoing social and supportive services are available to help clients maintain housing stability to prevent homelessness and substance abuse among other challenges. A caseworker and peer support specialist are stationed at the Woodlands to assist with these services.

Data on the Woodlands residents, classes, and activities are shown below. To maintain confidentiality, demographic information on residents is not reported on. A bar chart representing the number of tenants in MHSA units each quarter is shown below.



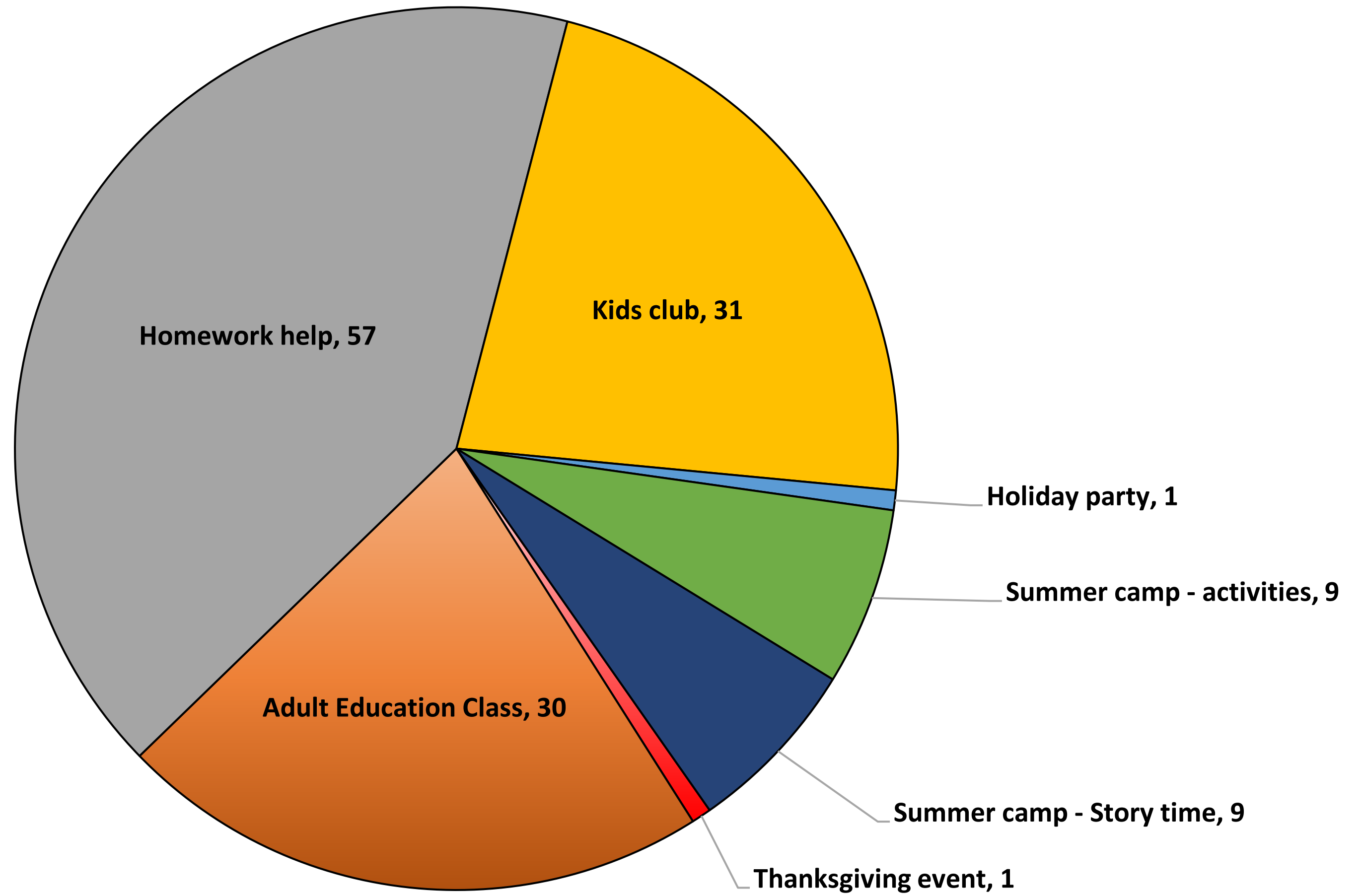
When tenants leave MHSA units, vacancies are quickly filled by those who are on the MHSA Permanent Supportive Housing Project waitlist. The total number of MHSA residents who left their units permanently during Fiscal Year 19/20 was 4.

During Fiscal Year 19/20, clients engaged in different activities, community education programs, and classes to learn skills. During April-June 2020, activities were cancelled due to COVID-19. The services provided, and the number of times those services have been provided, is summarized on the pie chart on the next page.

The Woodlands

Frequency of each social service provided

Fiscal Year 19/20



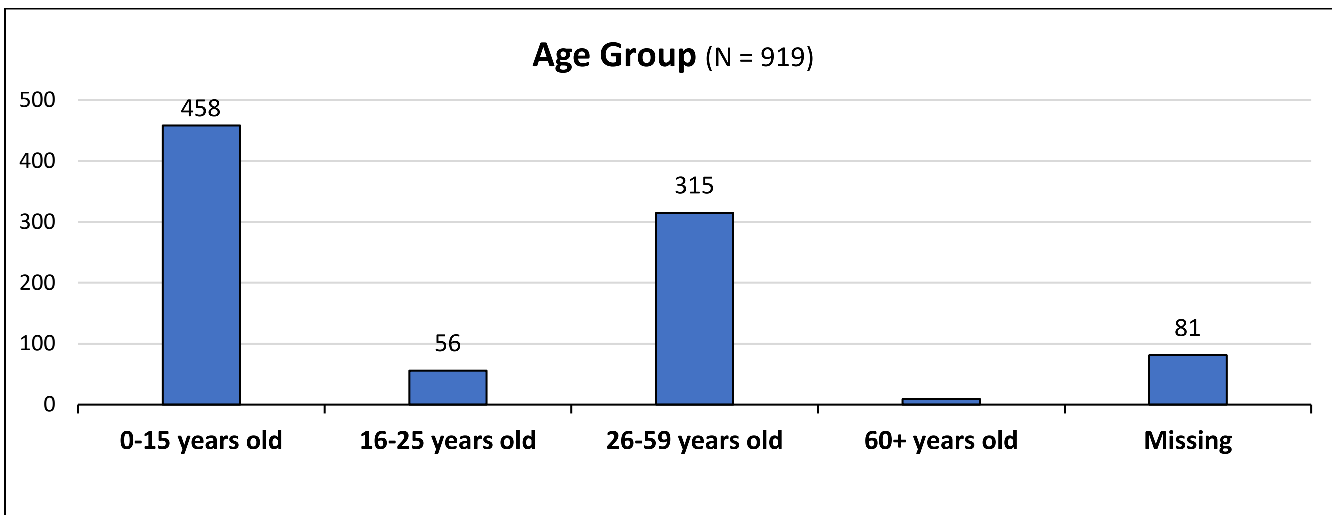
Does not include supportive services.

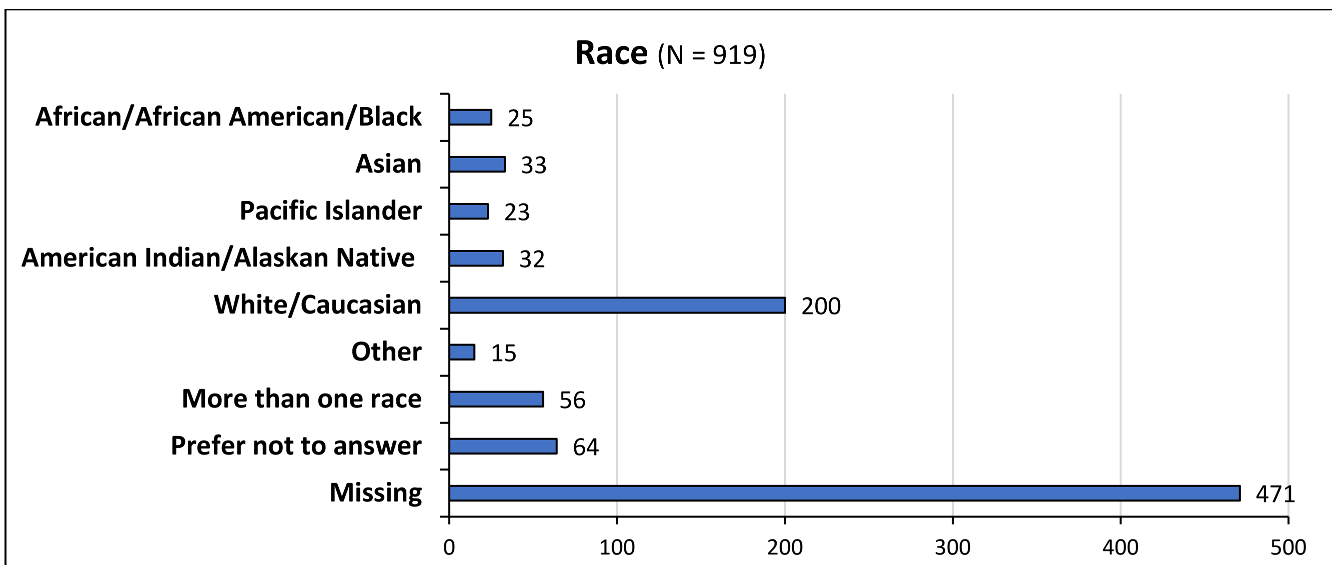
MHSA Prevention and Early Intervention Fiscal Year 19/20 Demographics Report

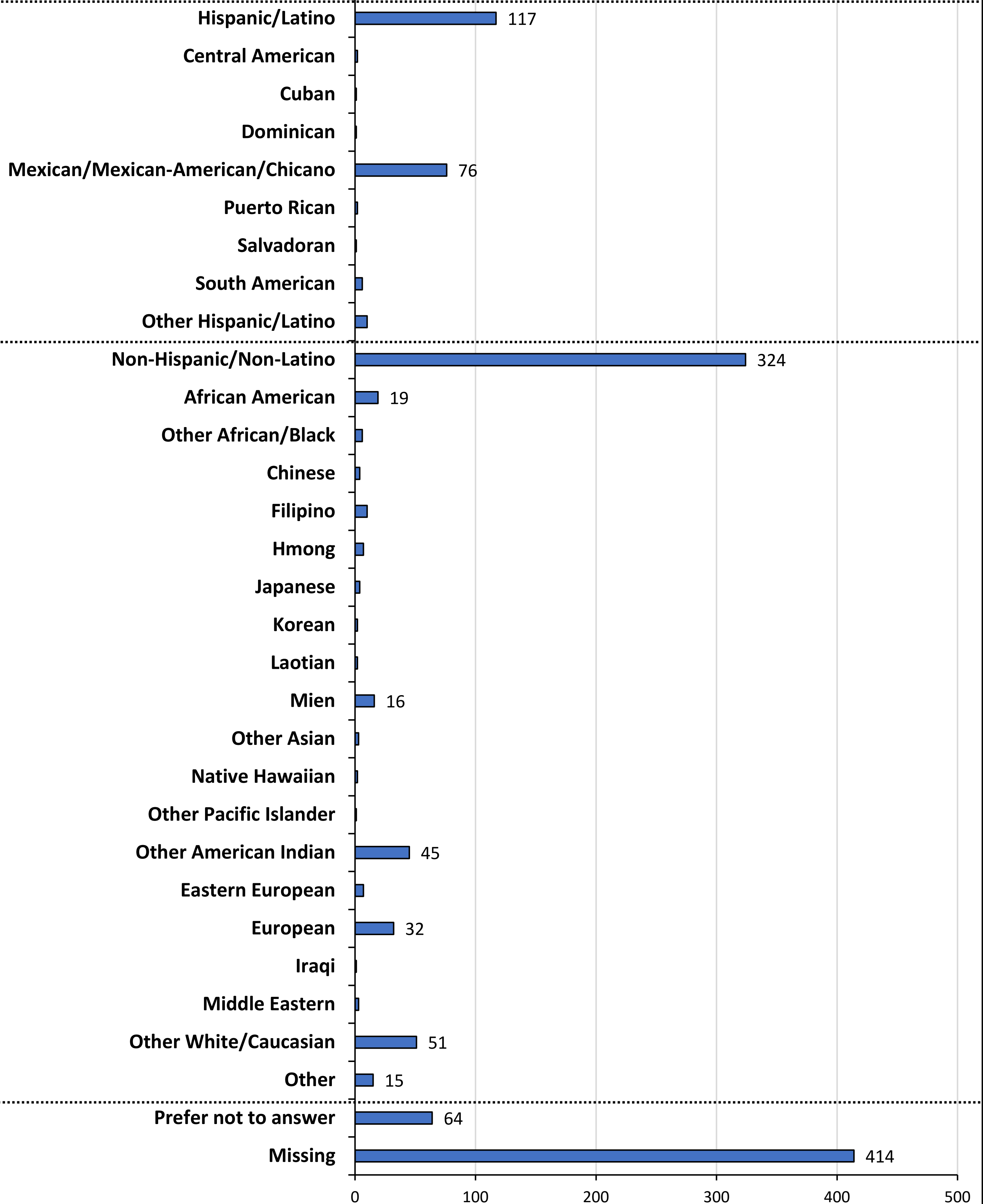
I. Prevention and Early Intervention Program Demographics

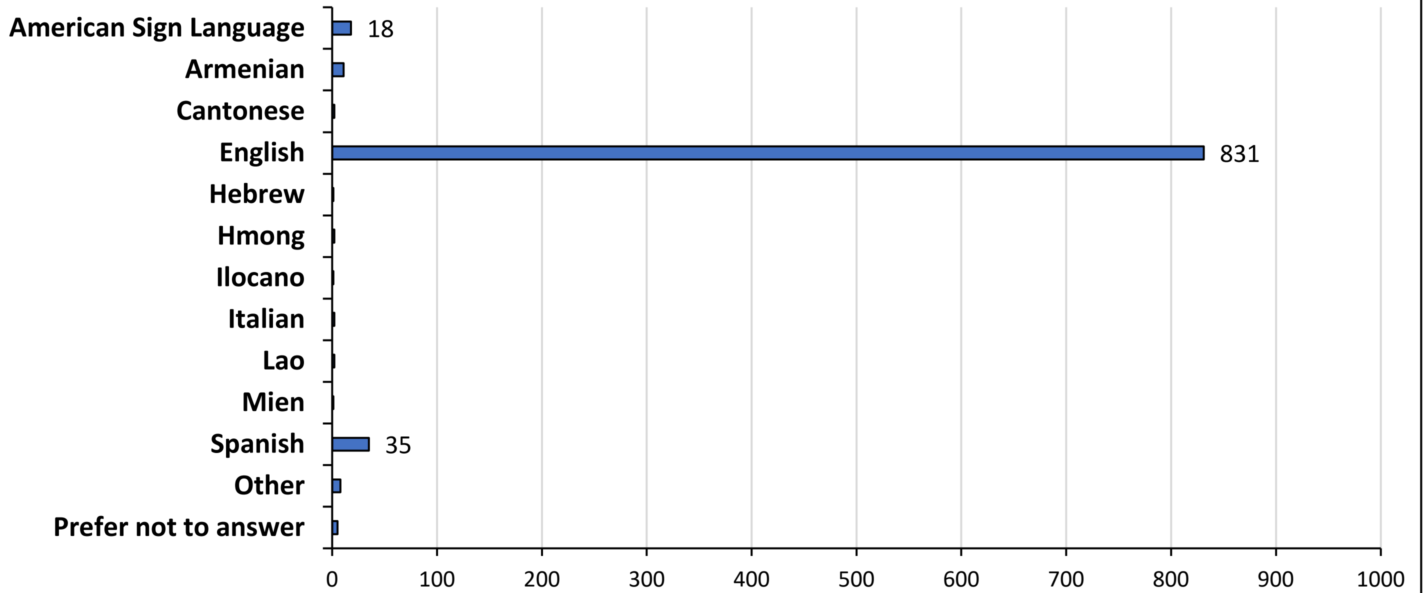
- Triple P (414 individuals submitted data)
- Botvin Lifeskills (505 individuals submitted data)

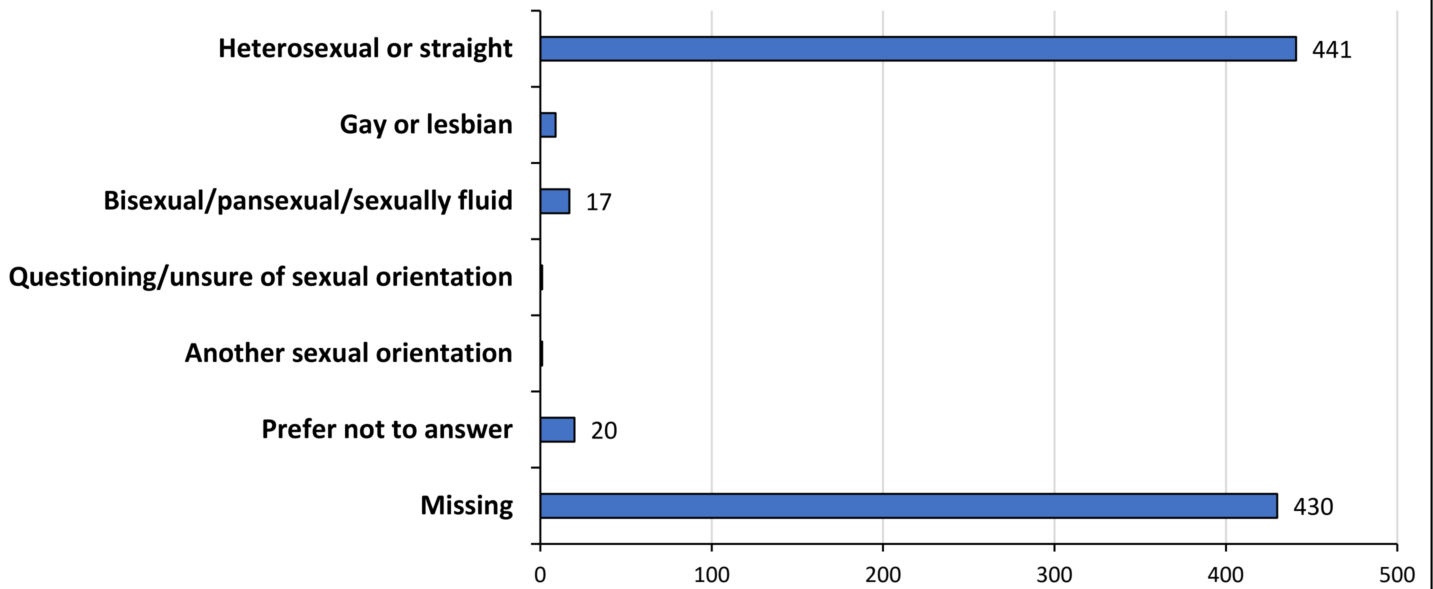
919 total individuals submitted data. Categories that received 11 or less responses are not labelled to help protect client confidentiality. Categories that received zero responses are not shown.

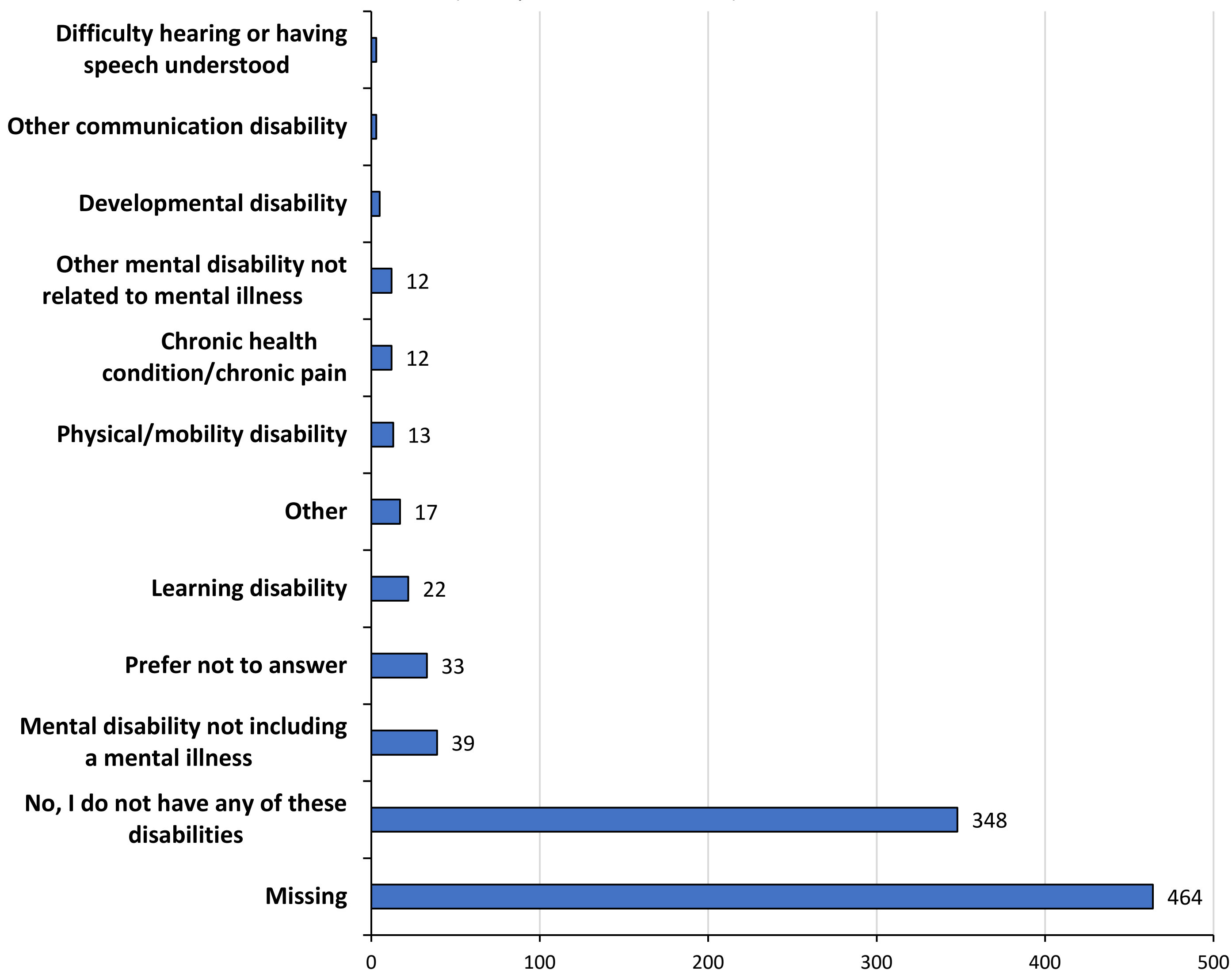


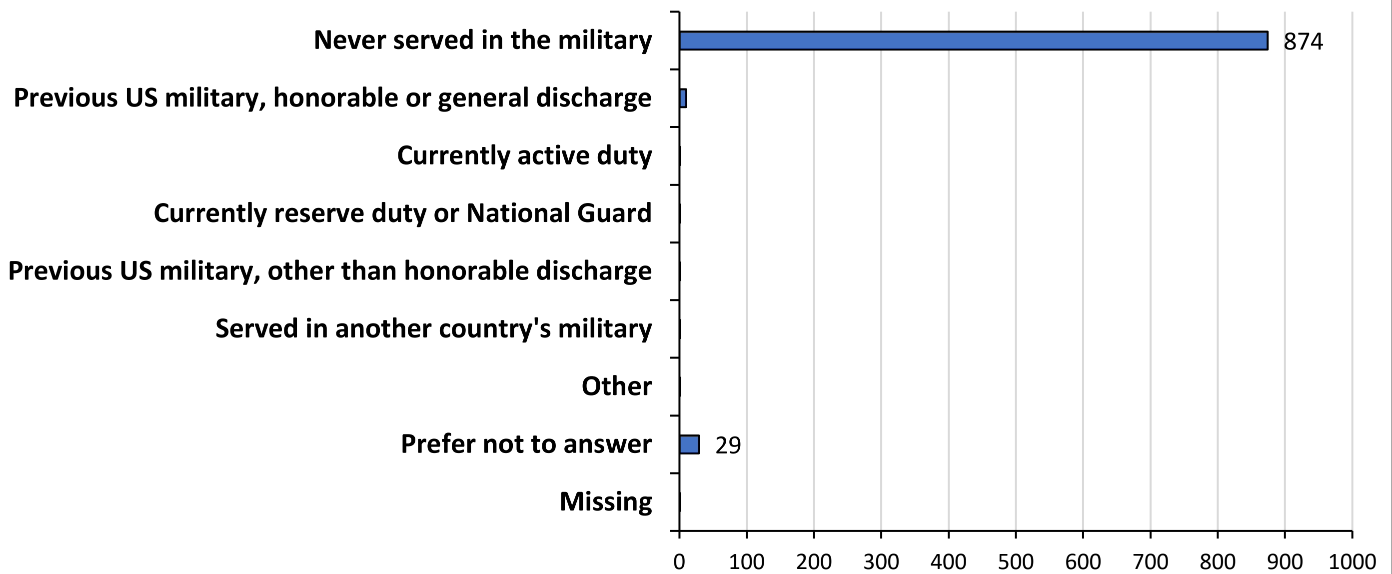


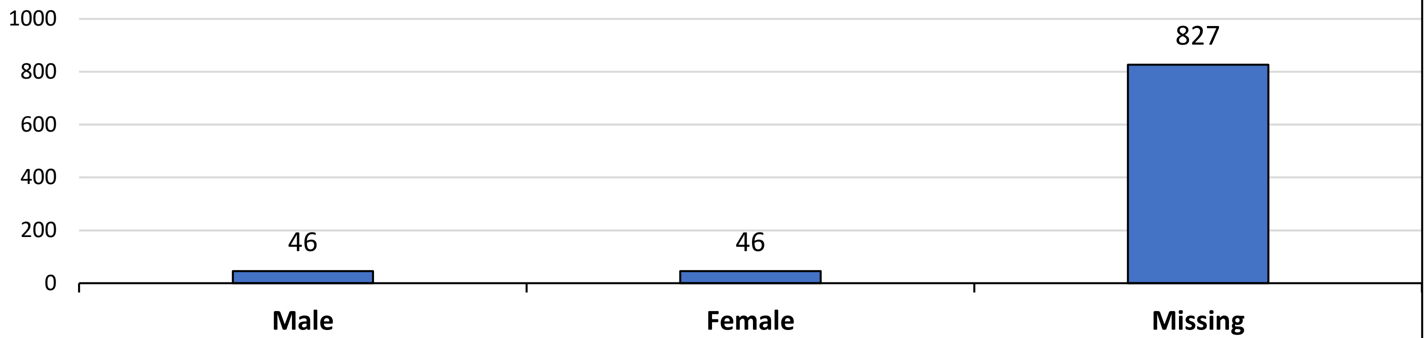

Ethnicity (N = 919)
(Multiple answers allowed)
Hispanic/Latino
117
Central American
Cuban
Dominican
Mexican/Mexican-American/Chicano
76
Puerto Rican
Salvadoran
South American
Other Hispanic/Latino
Non-Hispanic/Non-Latino
324
African American
19
Other African/Black
Chinese
Filipino
Hmong
Japanese
Korean
Laotian
Mien
16
Other Asian
Native Hawaiian
Other Pacific Islander
Other American Indian
45
Eastern European
European
32
Iraqi
Middle Eastern
Other White/Caucasian
51
Other
15
Prefer not to answer
64
Missing
414
0
100
200
300
400
500

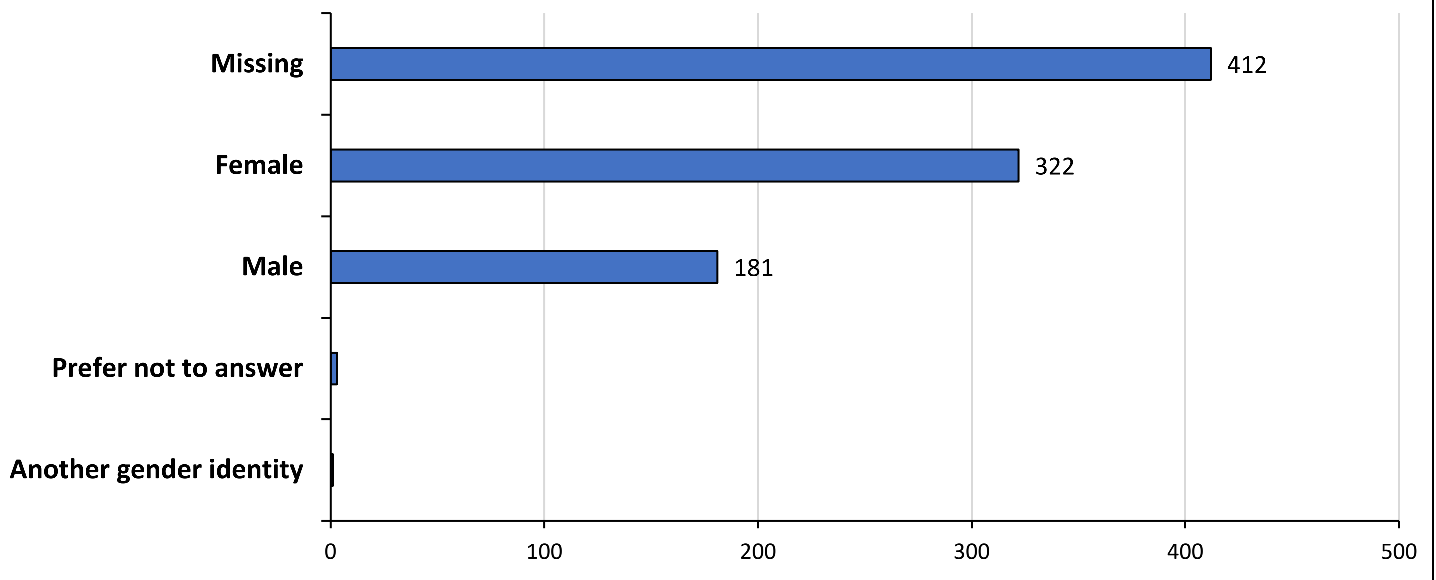

Primary Language (N = 919)
American Sign Language
Armenian
Cantonese
English
Hebrew
Hmong
Ilocano
Italian
Lao
Mien
Spanish
Other
Prefer not to answer
18
831
35
0
100
200
300
400
500
600
700
800
900
1000


Sexual Orientation (N = 919)
Heterosexual or straight
Gay or lesbian
Bisexual/pansexual/sexually fluid
Questioning/unsure of sexual orientation
Another sexual orientation
Prefer not to answer
Missing
441
17
20
430
0
100
200
300
400
500


Disabilites (N = 919)
(Multiple answers allowed)
Difficulty hearing or having speech understood
Other communication disability
Developmental disability
Other mental disability not related to mental illness
12
Chronic health condition/chronic pain
12
Physical/mobility disability
13
Other
17
Learning disability
22
Prefer not to answer
33
Mental disability not including a mental illness
39
No, I do not have any of these disabilities
348
Missing
464
0
100
200
300
400
500


Military Status (N = 919)
(Can be multiple choice)
Never served in the military
Previous US military, honorable or general discharge
Currently active duty
Currently reserve duty or National Guard
Previous US military, other than honorable discharge
Served in another country's military
Other
Prefer not to answer
Missing
874
29
0
100
200
300
400
500
600
700
800
900
1000

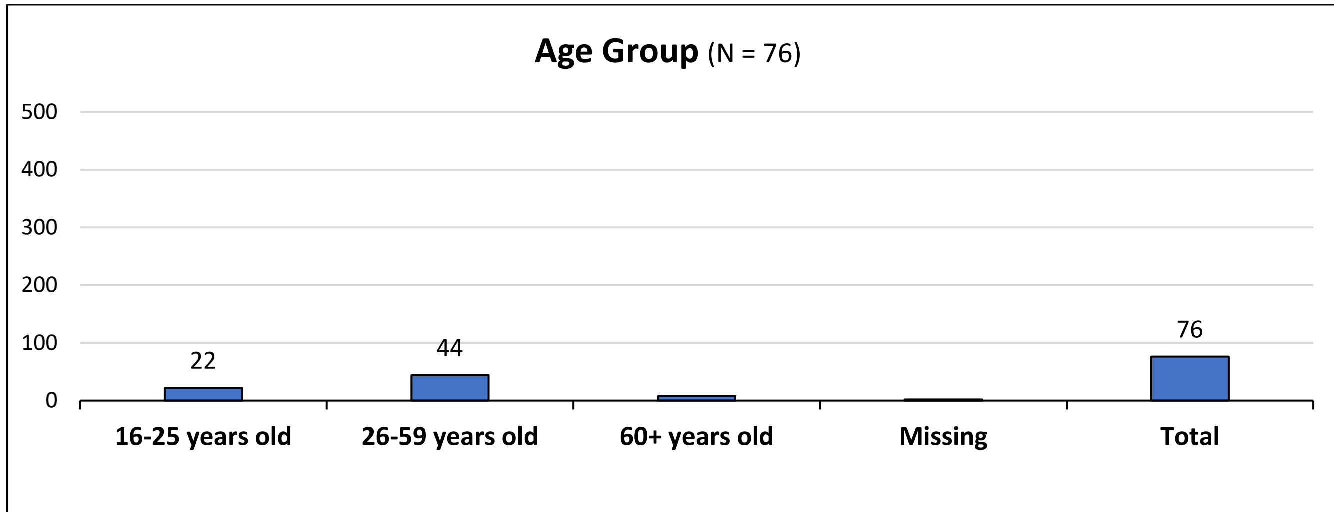

Sex on Birth Certificate (N = 919)
1000
800
600
400
200
0
46
46
827
Male
Female
Missing

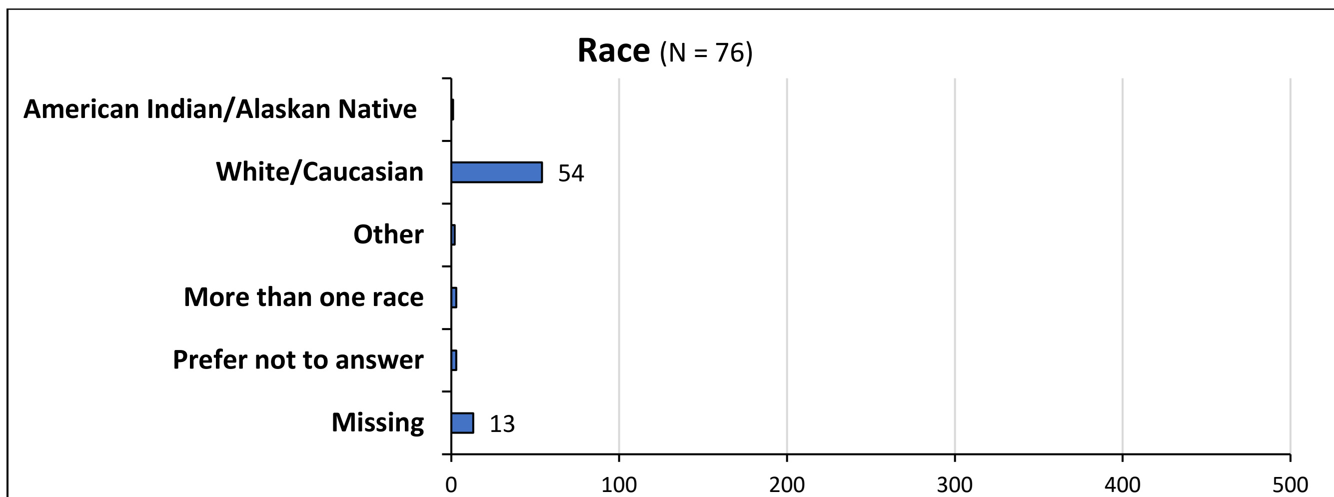

Gender Identity (N = 919)
Missing
Female
Male
Prefer not to answer
Another gender identity
412
322
181
0
100
200
300
400
500

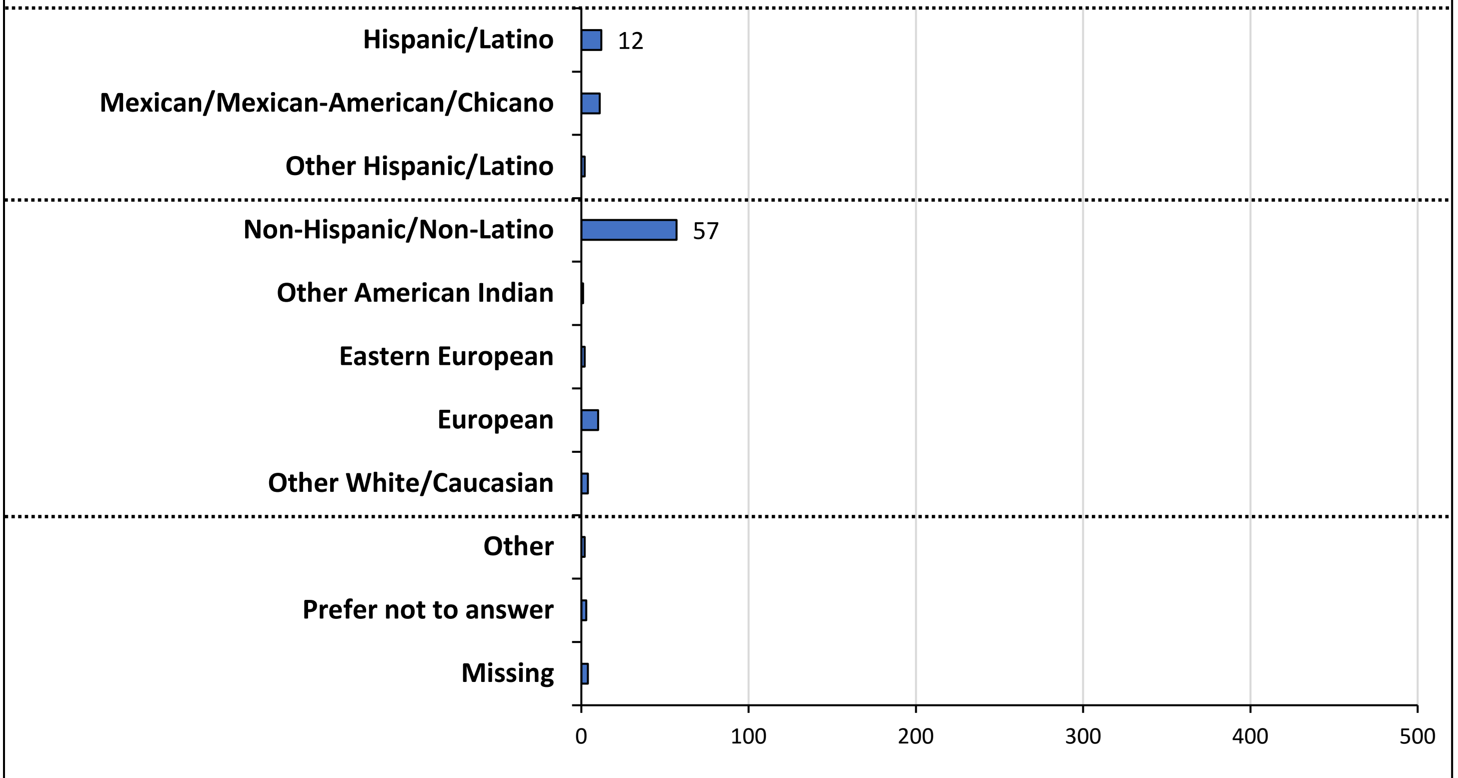
II. Outreach for Increasing Recognition of Early Signs of Mental Illness Program Demographics

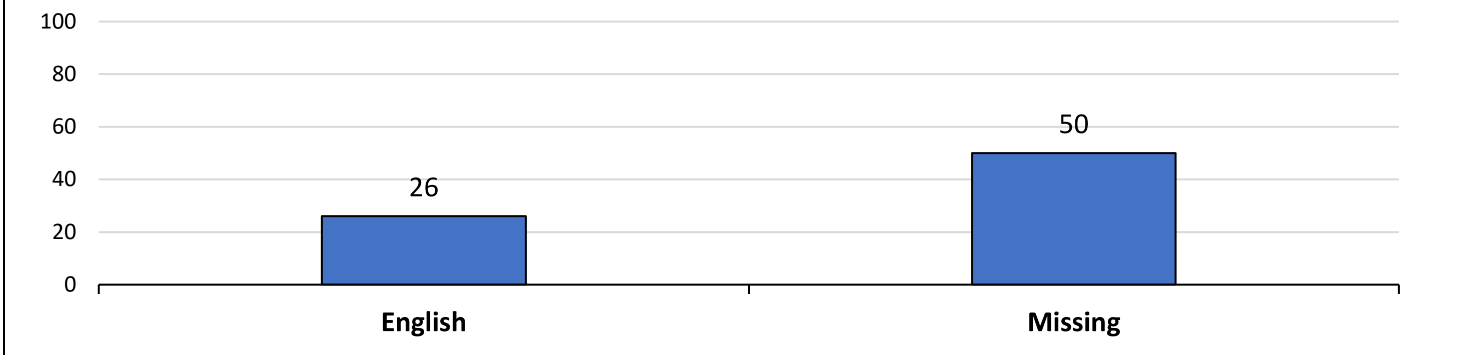
- Stand Against Stigma (48 individuals submitted data)
- ACES (28 individuals submitted data)

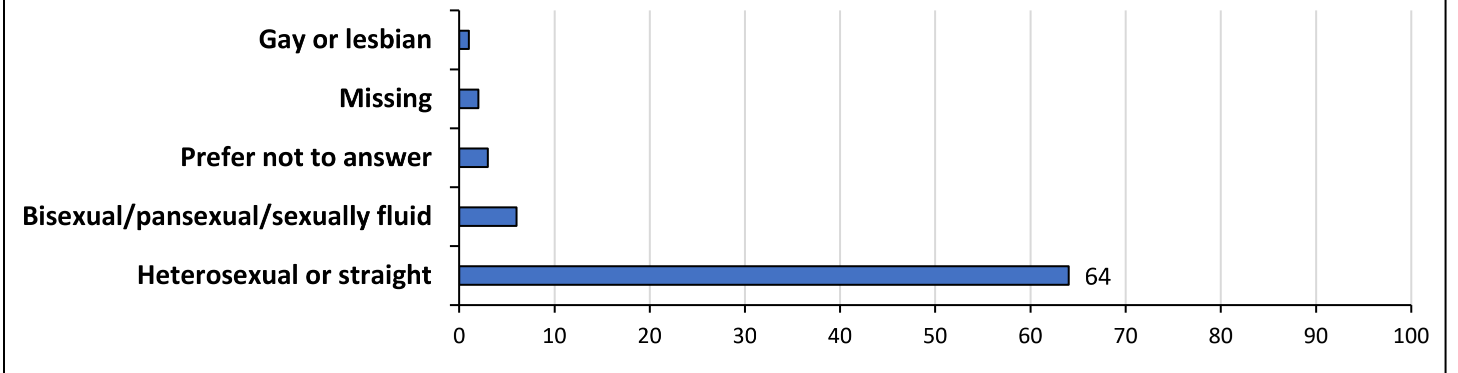
76 total individuals submitted data. Categories that received zero responses are not shown.






Ethnicity (N = 76)
(Multiple answers allowed)
Hispanic/Latino
12
Mexican/Mexican-American/Chicano
Other Hispanic/Latino
Non-Hispanic/Non-Latino
57
Other American Indian
Eastern European
European
Other White/Caucasian
Other
Prefer not to answer
Missing
0
100
200
300
400
500

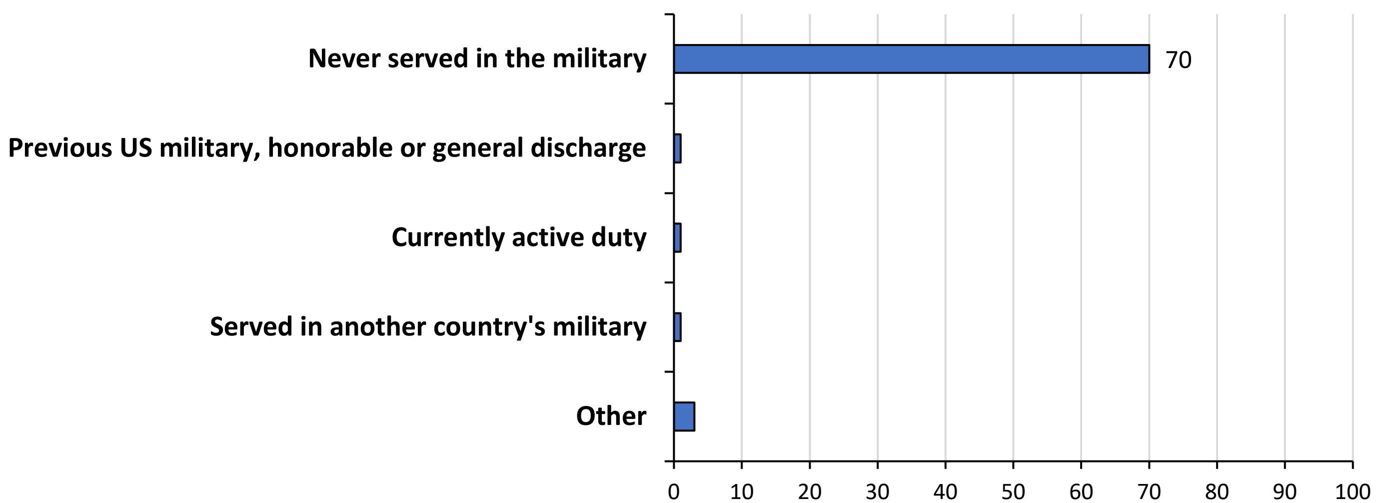

Primary Language (N = 76)
100
80
60
40
20
0
26
50
English
Missing

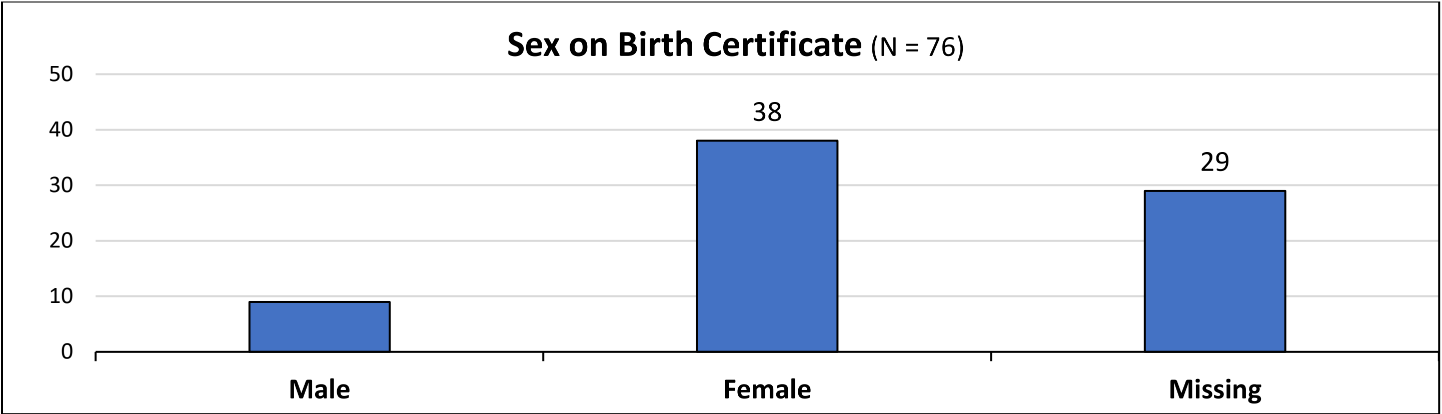

Sexual Orientation (N = 76)
Gay or lesbian
Missing
Prefer not to answer
Bisexual/pansexual/sexually fluid
Heterosexual or straight
64
0
10
20
30
40
50
60
70
80
90
100

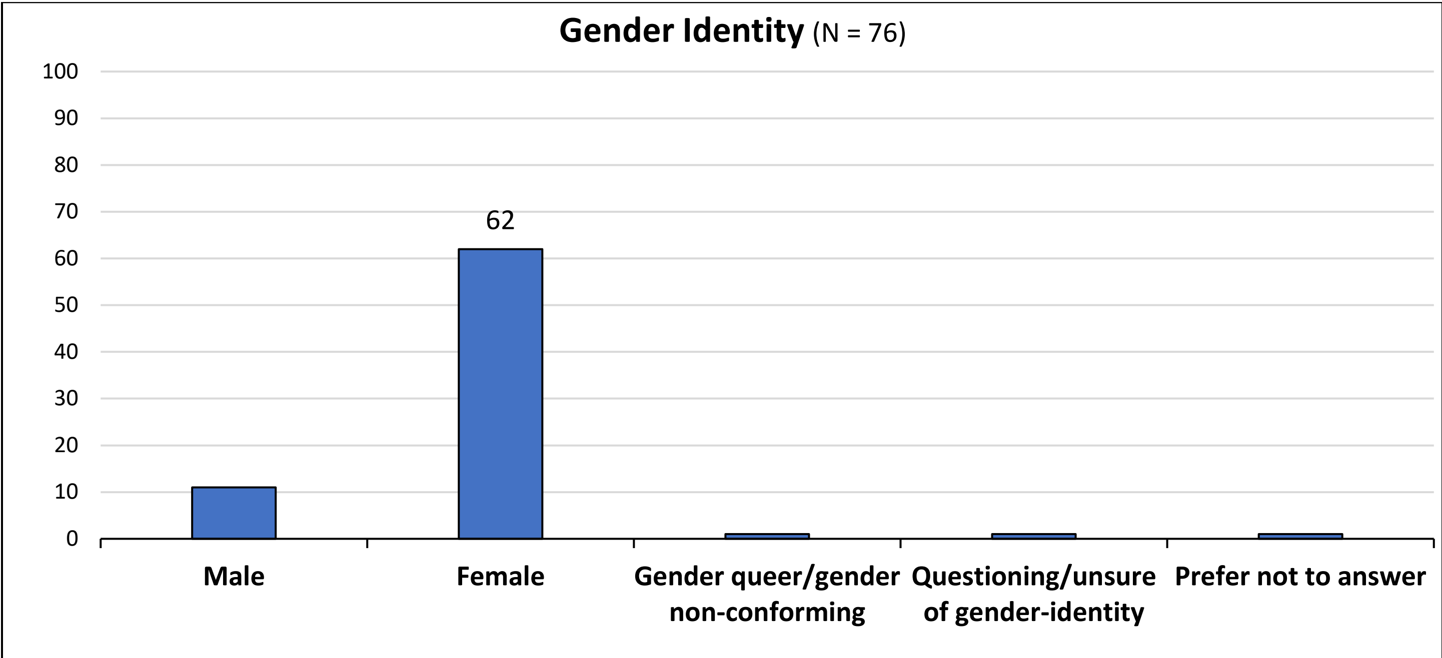
Disabilites (N = 76)
(Multiple answers allowed)

Developmental disability
Physical/mobility disability
Prefer not to answer
Difficulty hearing or having speech understood
Learning disability
Other mental disability not related to mental illness
Other
Chronic health condition/chronic pain
Difficulty seeing
Mental disability not including a mental illness
Missing
No, I do not have any of these disabilities 45

0 10 20 30 40 50




Sex on Birth Certificate (N = 76)
50
40
30
20
10
0
38
29
Male
Female
Missing


Gender Identity (N = 76)
100
90
80
70
60
50
40
30
20
10
0
62
Male
Female
Gender queer/gender non-conforming
Questioning/unsure of gender-identity
Prefer not to answer

III. Access and Linkage to Treatment Strategy or Program Demographics

- Early Onset

Demographic and referral data on this program is not made public due to a sample size too small to protect patient confidentiality.

Triple P Outcome Evaluation

Fiscal Year 19/20

Prepared by Shasta County Health and Human Services Agency

Shasta County Health & Human Services Agency

Introduction

The Positive Parenting Program ("Triple P") teaches parents the skills, knowledge, and confidence they need to improve behavioral problems in children or teens. Triple P is an international and evidence-based program. This report analyzes data collected from our local Triple P partners to get a clearer picture of the program's local scope and impact. Triple P is funded by the Mental Health Services Act (MHSA) to help children and youth in stressed families.

Program overview

"Kids don't come with an instruction manual so when it comes to parenting, how do you know what's best and what works? That's where the Positive Parenting Program (Triple P) comes in. Triple P is one of the world's most effective parenting programs because it's one of the few that has been scientifically proven to work."[1]

The Triple P program isn't just for parents, it is for any caregiver. A caregiver is someone who regularly looks after the child or teen. The program aims to increase the knowledge, skills, and confidence of parents and other caregivers using five foundational principles:

- ensure a safe and engaging environment
- keep a positive learning environment
- use assertive (rule-based) discipline
- have realistic expectations
- take care of yourself as a parent or caregiver

The Triple P program is divided into levels 1 through 5. Level 1 is least intensive while level 5 is most intensive:

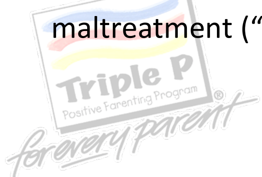
Level 1: using media to raise public awareness of Triple P.

Level 2: a seminar or brief one-on-one consultation with a Triple P practitioner.

Level 3: approximately four individual consultations with a Triple P practitioner lasting fifteen to thirty minutes each.

Level 4: ten one-hour individual counseling sessions or small group sessions with a Triple P practitioner.

Level 5: becomes available once a level 4 program has been completed (or is being taken concurrently) and pinpoints other complicating factors such as partner dysfunction, parents with mental health concerns, and situations that are causing a stressful environment ("Enhanced Triple P") or parents at risk of child maltreatment ("Pathways Triple P").



Versions of each level of Triple P

Different versions of levels 3-5 are available to address unique concerns:

Version Name	Description	Level(s)
Primary Care	one-on-one sessions for caregivers of a child up to 12 years old	3
Group	minimum of 4 participants at a time	3, 4
Teen	for caregivers of an adolescent up to 16 years old	3, 4
Standard	one-on-one sessions for caregivers of a child up to 12 years old	4
Stepping Stones	for caregivers of a child up to 12 years old who has a disability	4
Family Transitions	for parents experiencing distress from separation or divorce which is negatively impacting their parenting	5
Enhanced	for parents who have family issues such as stress, poor coping skills, and/or partner conflict	5
Pathways	for parents at risk of child maltreatment	5

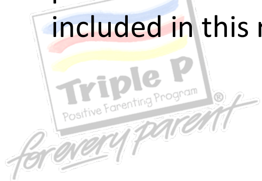
The program is available in different versions so that caregivers and parents can take the version that best meets their needs.

How the data in this report was collected

Practitioners teach the Triple P program from their local organization and have participants fill out parenting surveys before and after completing the program (parenting surveys that were taken before starting the program are referred to as "pre" surveys while surveys taken after completing the program are referred to as "post" surveys).

Practitioners enter participants' pre- and post- parenting surveys into a web-based Scoring Application. The Scoring Application "scores" the participant's survey responses ('scoring' means that the pre- and post-survey responses are converted into number values and then compared with each other for differences). Participants' pre-survey responses establish their baseline knowledge and attitudes towards parenting which is compared with their post-survey responses to see how going through the program affected their results (if at all). Additionally, within the scoring application, practitioners can add or track existing participants, create reports, and export session data. The Scoring Application that was used is called ASRA (Automatic Scoring and Reporting Application),

The source data for this report does not include data received from other sources. There may be other providers in Shasta County who provide Triple P, but if they did not enter information into ASRA, they are not included in this report.



(ASRA) Automatic Scoring and Reporting Application data

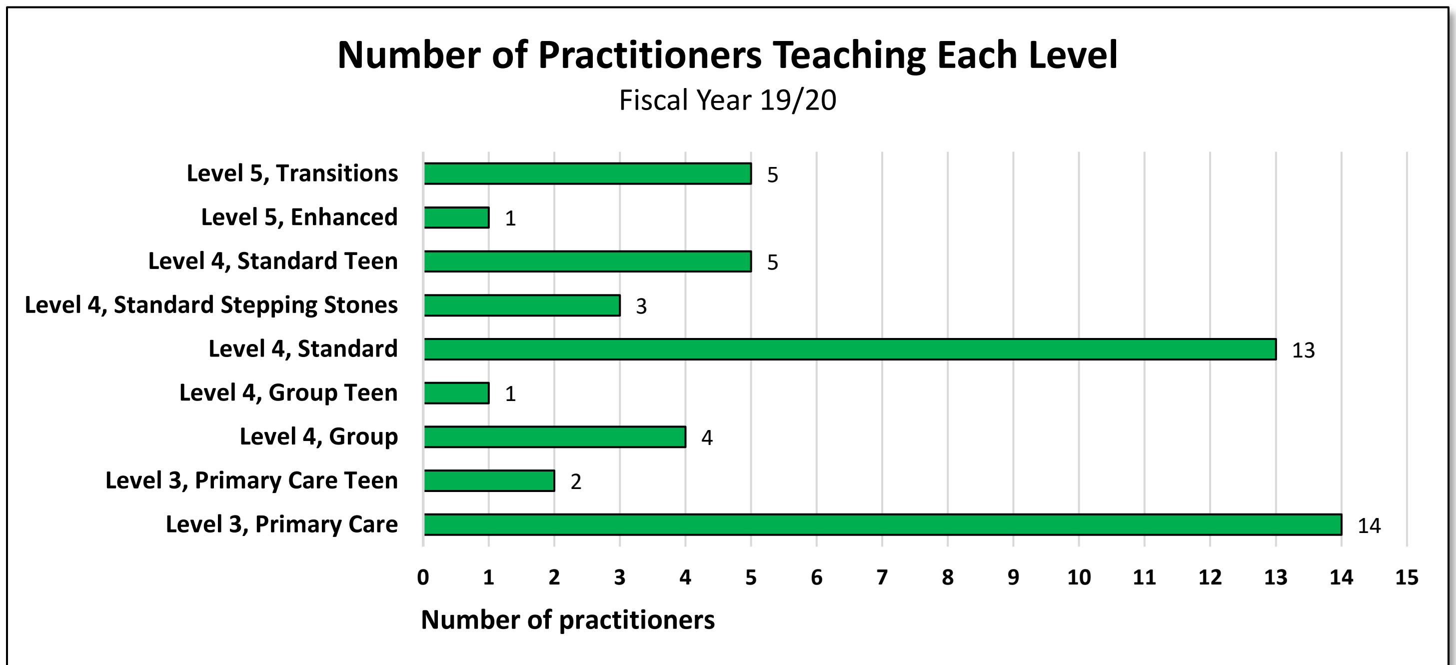
Overview

The table below shows the total number of Triple practitioners who entered data into the ASRA Scoring application during Fiscal Year 19/20, along with the organization they were with, and the total number of caregivers and families they served:

Partnered Organizations Providing Triple P Fiscal Year 19/20			
Organization	**Practitioners**	**Caregivers**	**Families**
Bridges to Success/ Shasta County Office of Education	5	110	92
Child Abuse Prevention Coordinating Council of Shasta County (CAPCC)	6	18	17
FaithWorks	1	2	2
Family Dynamics	4	66	66
Northern Valley Catholic Social Services	2	62	60
Shasta County Health & Human Services Agency: Children's Services	2	21	16
Wright Education Services	4	75	69
Youth and Family Programs	1	61	50
Totals:	**25**	**415**	**372**

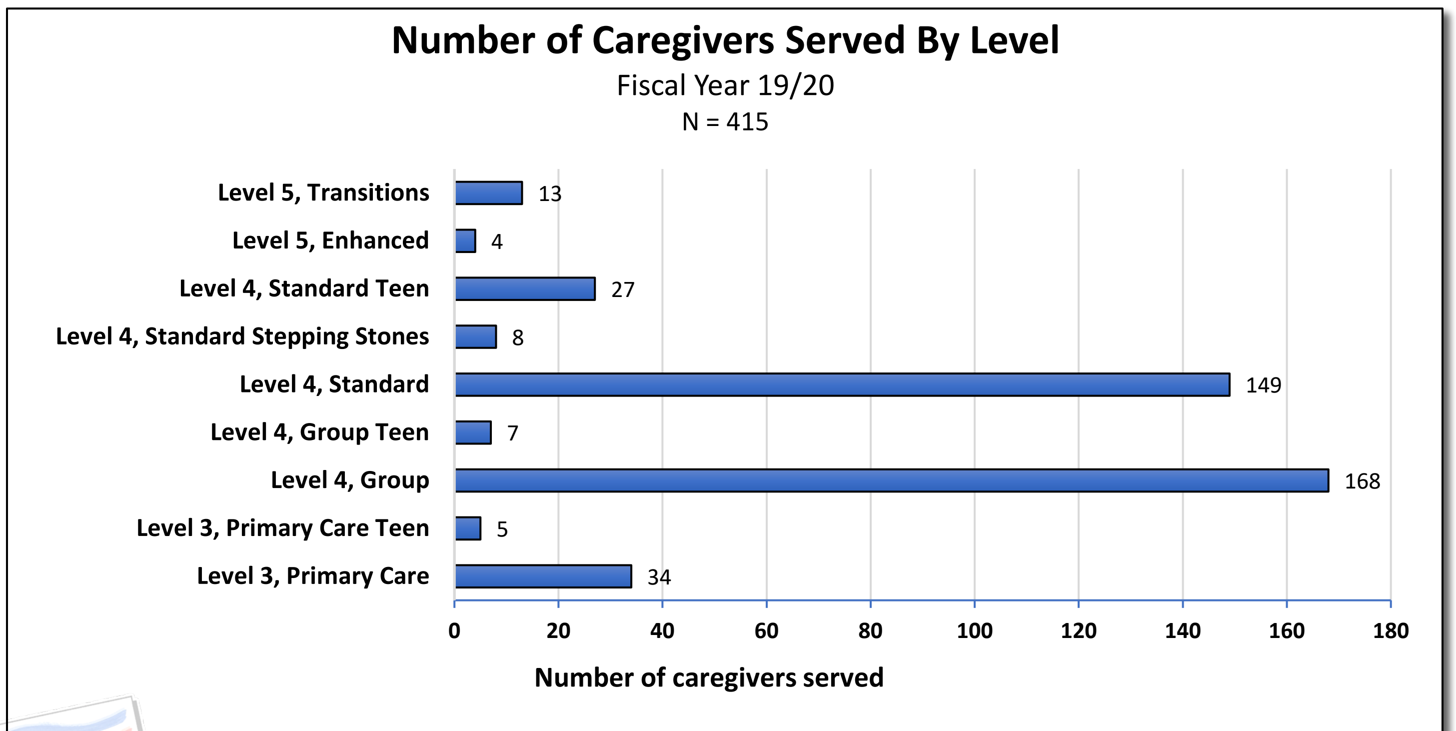
Some families may have received services in more than one organization, level, or version of Triple P. The information stored in the scoring application is anonymous (names were not collected). For this reason, the total number of unique caregivers and children/teens served between all levels couldn't be determined. In addition, if a practitioner was still submitting data in the Scoring application after transitioning to a new organization during Fiscal Year 19/20, they would be counted as a practitioner in each organization they were a part of.

There were 25 practitioners who provided Triple P services over this time period. In the graph below, you can see the number of practitioners who provided the various Triple P levels (some practitioners are counted more than once as some practitioners are trained to teach more than one level):

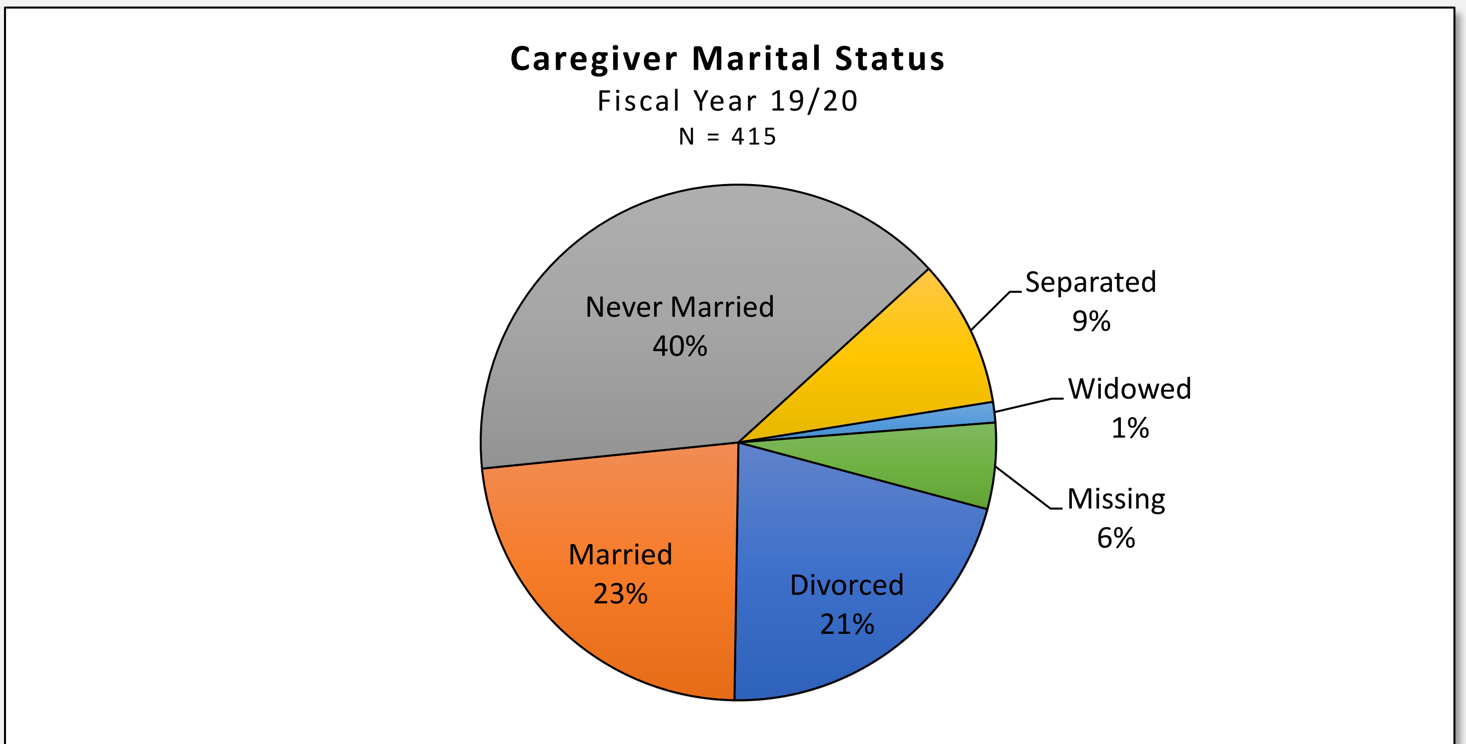


Data on the caregivers and their families

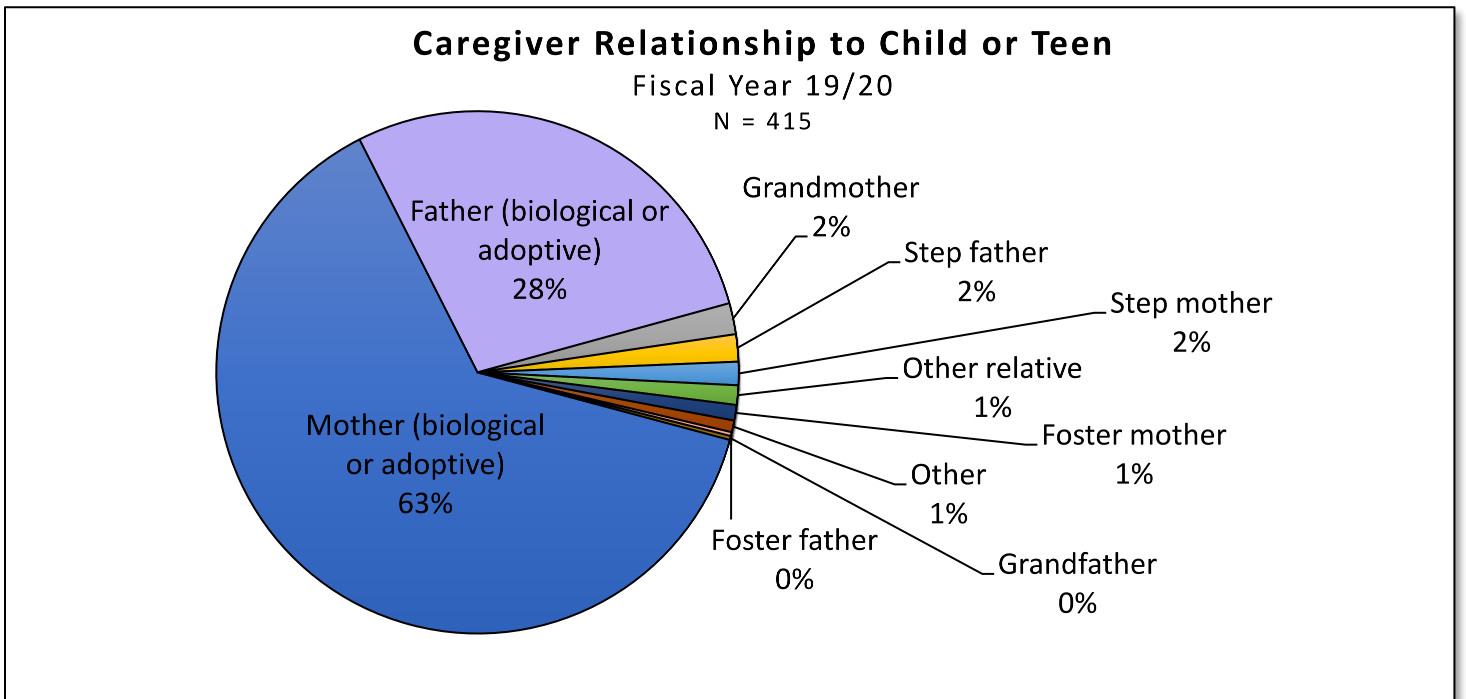
A total of 415 caregivers attended Triple P sessions. The number of caregivers in each level of Triple P is shown below:



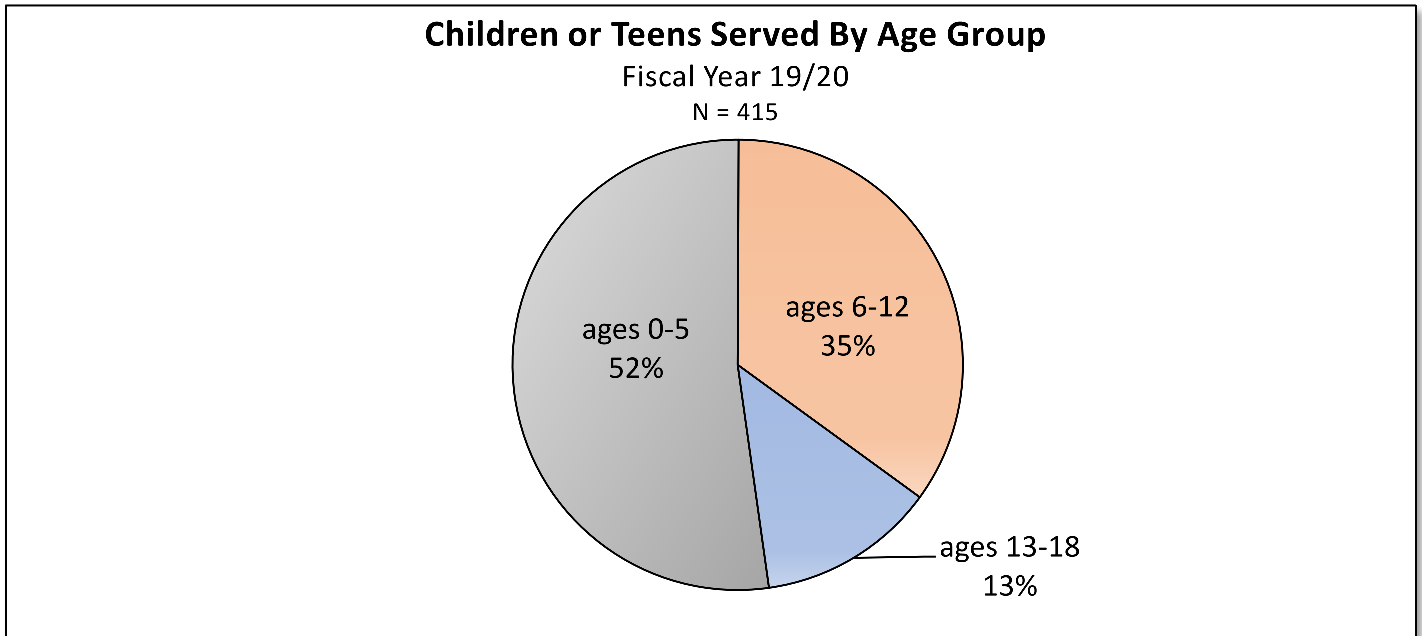
The marital status of the caregivers is pictured below:



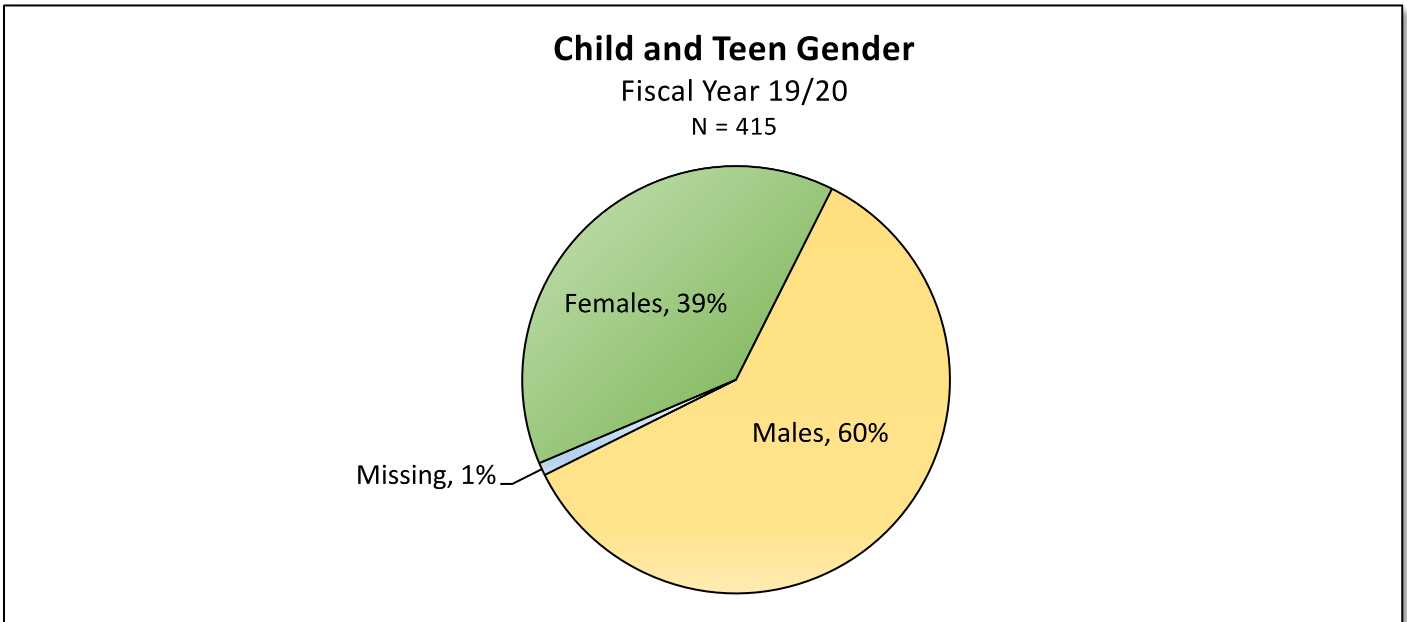
The pie chart below shows how the caregiver relates to the child or teen:



A pie chart showing the percentage of children or teens served by age group is shown below. The age of the child or teen was recorded at the beginning of the session. 217 children were aged 5 or younger out of the total 415 and the average age was 6.



There were 250 males, 161 females, and 4 records missing for child and teen gender data:



Outcomes and Measures

"Outcomes" are results that show how well a program accomplished its goals. Outcomes for Triple P are measured as changes in an individuals' parenting skills, knowledge, and confidence of its participants. The "measures" used in Triple P are various self-assessments on parenting that were given to participants before and after attending the program. Each answer on the self-assessments corresponded with a score that represented higher or lower parenting effectiveness. The results will be analyzed to see how participants' pre-assessment scores compare to their post-assessment scores. The required self-assessments are selected based off advances in the scientific literature on parenting and will be described in more detail below.

The Parenting and Family Adjustment Scale (PAFAS) Self-assessment:

This 30-item questionnaire provides a scored evaluation on seven different aspects of parenting:

- Parental Consistency score (lower scores mean parents more frequently follow through and do as they say they will).
- Coercive parenting score (lower scores mean parents don't persuade their children through force, threats, or emotional distress).
- Positive Encouragement score (lower scores mean parents more frequently give words of support and actions that express approval).
- Parent-Child relationship score (lower scores represent stronger bonds between the parent and child).
- Parental Adjustment score (lower scores mean that parents have a healthier outlook on life and have a better time coping with the emotional demands of parenting).
- Family Relationships score (lower scores mean that family members are more emotionally supportive of one another).
- Parental teamwork score (lower scores mean that parents more strongly agree on how to parent).

On the PAFAS survey, the respondent was instructed to indicate, on a scale from 0-3, how true each statement on the survey was for them (over the past 4 weeks). Selecting "0" meant that the statement was not true at all while "3" meant that the statement was very much true or true most of the time.[2]

A blank example of the PAFAS survey is shown on page 8, a scoring illustration of the PAFAS is shown on page 9, and the actual pre-/post-average scores from the PAFAS survey during Fiscal Year 19/20 is shown on page 10.

PAFAS Blank Assessment (example)

	How true is this of you?			
1. If my child doesn't do what they're told to do, I give in and do it myself	0	1	2	3
2. I give my child a treat, reward or fun activity for behaving well	0	1	2	3
3. I follow through with a consequence (e.g. take away a toy) when my child misbehaves	0	1	2	3
4. I threaten something (e.g. to turn off TV) when my child misbehaves but I don't follow through	0	1	2	3
5. I shout or get angry with my child when they misbehave	0	1	2	3
6. I praise my child when they behave well	0	1	2	3
7. I try to make my child feel bad (e.g. guilt or shame) for misbehaving to teach them a lesson	0	1	2	3
8. I give my child attention (e.g. a hug, wink, smile or kiss) when they behave well	0	1	2	3
9. I spank (smack) my child when they misbehave	0	1	2	3
10. I argue with my child about their behaviour/attitude	0	1	2	3
11. I deal with my child's misbehaviour the same way all the time	0	1	2	3
12. I give my child what they want when they get angry or upset	0	1	2	3
13. I get annoyed with my child	0	1	2	3
14. I chat/talk with my child	0	1	2	3
15. I enjoy giving my child hugs, kisses and cuddles	0	1	2	3
16. I am proud of my child	0	1	2	3
17. I enjoy spending time with my child	0	1	2	3
18. I have a good relationship with my child	0	1	2	3
19. I feel stressed or worried	0	1	2	3
20. I feel happy	0	1	2	3
21. I feel sad or depressed	0	1	2	3
22. I feel satisfied with my life	0	1	2	3
23. I cope with the emotional demands of being a parent	0	1	2	3
24. Our family members help or support each other	0	1	2	3
25. Our family members get on well with each other	0	1	2	3
26. Our family members fight or argue	0	1	2	3
27. Our family members criticize or put each other down	0	1	2	3

If you are in a relationship please answer the following 3 questions

28. I work as a team with my partner in parenting	0	1	2	3
29. I disagree with my partner about parenting	0	1	2	3
30. I have a good relationship with my partner	0	1	2	3

PAFAS Scoring Illustration

Parental Consistency scores are calculated by adding scores for questions 1, 4, and 12, with the reverse-score for questions 3 and 11 (reverse-scoring means that a selection of 0 = a score of 3, 1 = 2, 2 = 1, and 3 = 0):

Question	How true is this of you? Not at all	little	often	very		
1. If my child doesn't do what they're told to do, I give in and do it myself	0	1	2	3		(Range) 0 – 15
4. I threaten something (e.g. to turn off TV) when my child misbehaves but I don't follow through	0	1	2	3		
12. I give my child what they want when they get angry or upset	0	1	2	3		
3. I follow through with a consequence (e.g. take away a toy) when my child misbehaves	0	1	2	3	(Reverse-scored)	
11. I deal with my child's misbehaviour the same way all the time	0	1	2	3	(Reverse-scored)	

Coercive parenting scores are calculated by adding scores for questions 5, 7, 9, 10, and 13:

Question					
5. I shout or get angry with my child when they misbehave	0	1	2	3	(Range) 0 – 15
7. I try to make my child feel bad (e.g. guilt or shame) for misbehaving to teach them a lesson	0	1	2	3	
9. I spank (smack) my child when they misbehave	0	1	2	3	
10. I argue with my child about their behaviour/attitude	0	1	2	3	
13. I get annoyed with my child	0	1	2	3	

Positive Encouragement scores are calculated by reverse-scoring questions 2, 6, and 8:

Question						
2. I give my child a treat, reward or fun activity for behaving well	0	1	2	3	(Reverse-scored)	(Range) 0 – 9
6. I praise my child when they behave well	0	1	2	3	(Reverse-scored)	
8. I give my child attention (e.g. a hug, wink, smile or kiss) when they behave well	0	1	2	3	(Reverse-scored)	

Parent-Child relationship scores are calculated by reverse-scoring questions 14, 15, 16, 17, and 18:

Question						
14. I chat/talk with my child	0	1	2	3	(Reverse-scored)	(Range) 0 – 15
15. I enjoy giving my child hugs, kisses and cuddles	0	1	2	3	(Reverse-scored)	
16. I am proud of my child	0	1	2	3	(Reverse-scored)	
17. I enjoy spending time with my child	0	1	2	3	(Reverse-scored)	
18. I have a good relationship with my child	0	1	2	3	(Reverse-scored)	

Parental Adjustment scores are calculated by adding scores for questions 19 and 21 with the reverse-scores for 20, 22, and 23:

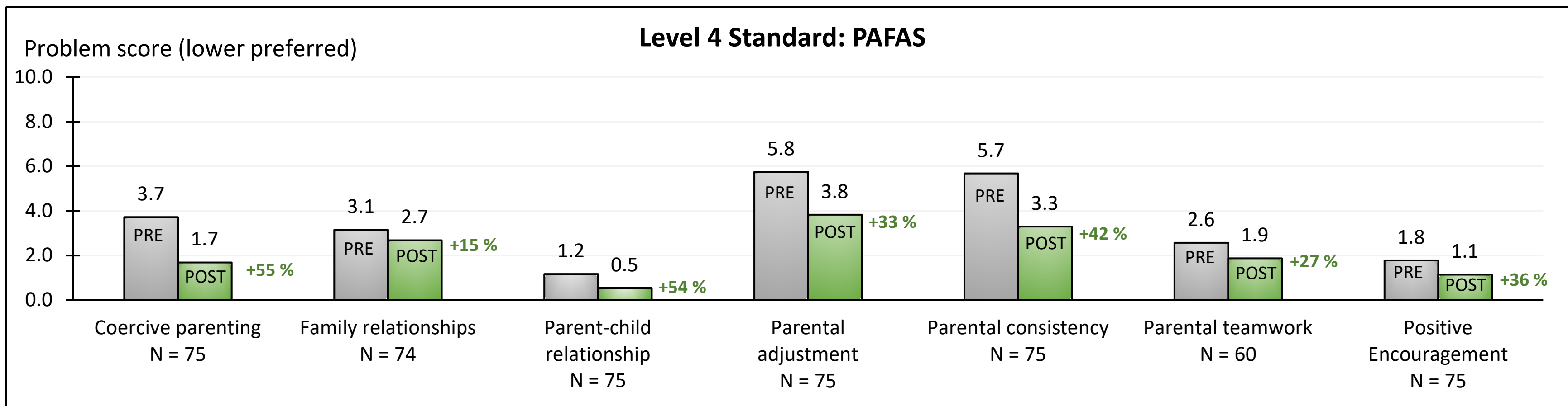
Question						
19. I feel stressed or worried	0	1	2	3		(Range) 0 – 15
21. I feel sad or depressed	0	1	2	3		
20. I feel happy	0	1	2	3	(Reverse-scored)	
22. I feel satisfied with my life	0	1	2	3	(Reverse-scored)	
23. I cope with the emotional demands of being a parent	0	1	2	3	(Reverse-scored)	

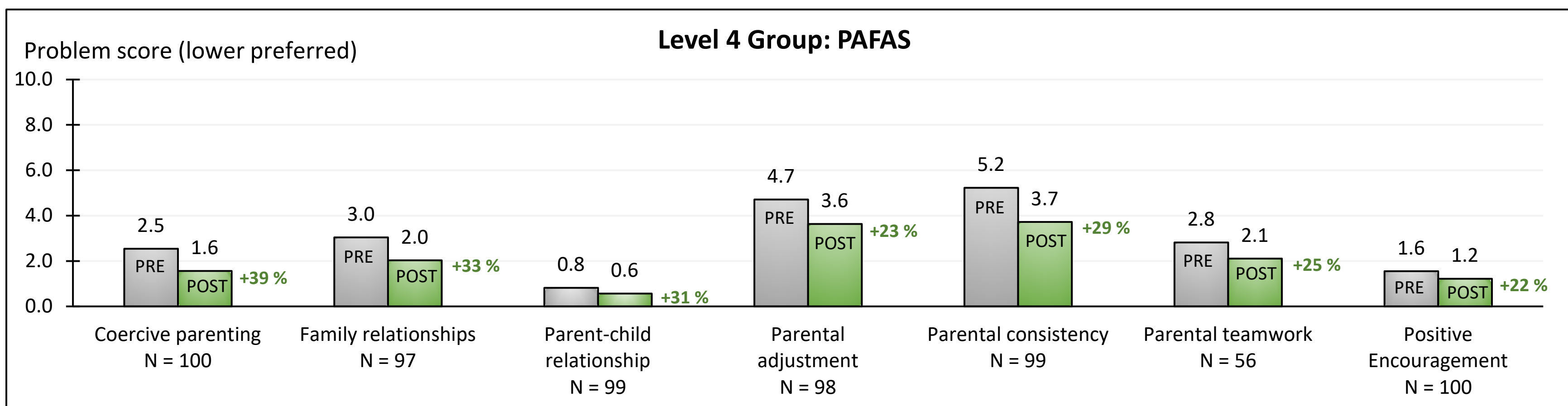
Family Relationships scores are calculated by adding scores for 26 and 27 with the reverse-scores for 24 & 25:

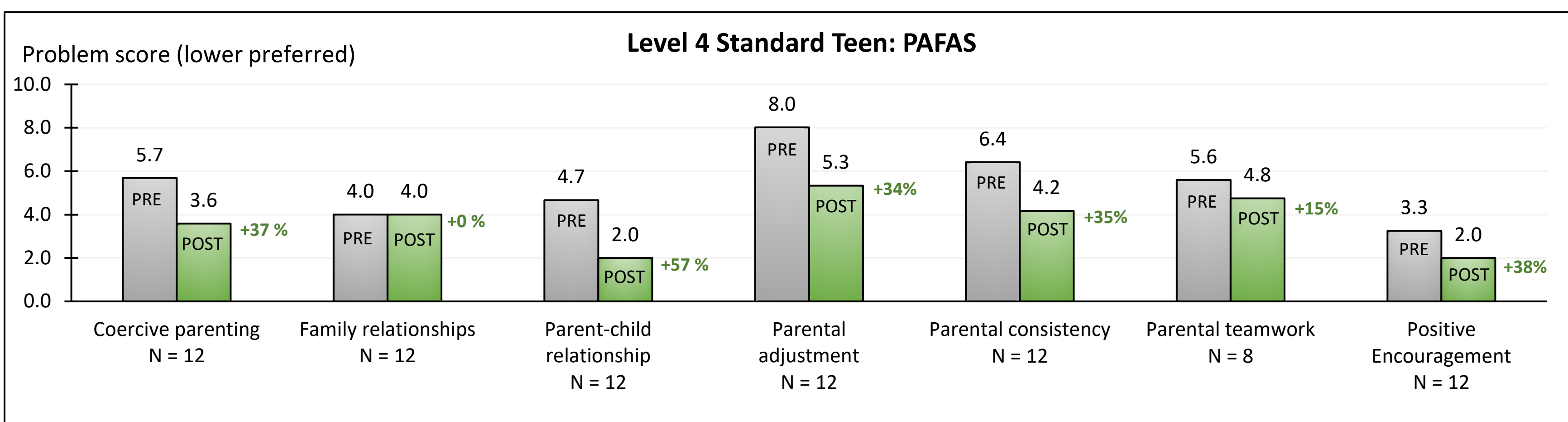
Question						
26. Our family members fight or argue	0	1	2	3		(Range) 0 – 12
27. Our family members criticize or put each other down	0	1	2	3		
24. Our family members help or support each other	0	1	2	3	(Reverse-scored)	
25. Our family members get on well with each other	0	1	2	3	(Reverse-scored)	

Parental Teamwork scores are calculated by adding the score for 29 with the reverse-scores for 28 and 30:

Question						
29. I disagree with my partner about parenting	0	1	2	3		(Range) 0 – 9
28. I work as a team with my partner in parenting	0	1	2	3	(Reverse-scored)	
30. I have a good relationship with my partner	0	1	2	3	(Reverse-scored)	


Level 4 Standard: PAFAS
Problem score (lower preferred)
10.0
8.0
6.0
4.0
2.0
0.0
3.7
PRE
1.7
POST
+55 %
3.1
PRE
2.7
POST
+15 %
1.2
0.5
+54 %
5.8
PRE
3.8
POST
+33 %
5.7
PRE
3.3
POST
+42 %
2.6
PRE
1.9
POST
+27 %
1.8
PRE
1.1
POST
+36 %
Coercive parenting N = 75
Family relationships N = 74
Parent-child relationship N = 75
Parental adjustment N = 75
Parental consistency N = 75
Parental teamwork N = 60
Positive Encouragement N = 75


Level 4 Group: PAFAS
Problem score (lower preferred)
10.0
8.0
6.0
4.0
2.0
0.0
2.5
PRE
1.6
POST
+39 %
3.0
PRE
2.0
POST
+33 %
0.8
0.6
+31 %
4.7
PRE
3.6
POST
+23 %
5.2
PRE
3.7
POST
+29 %
2.8
PRE
2.1
POST
+25 %
1.6
PRE
1.2
POST
+22 %
Coercive parenting N = 100
Family relationships N = 97
Parent-child relationship N = 99
Parental adjustment N = 98
Parental consistency N = 99
Parental teamwork N = 56
Positive Encouragement N = 100


Level 4 Standard Teen: PAFAS
Problem score (lower preferred)
10.0
8.0
6.0
4.0
2.0
0.0
5.7
PRE
3.6
POST
+37 %
4.0
PRE
4.0
POST
+0 %
4.7
PRE
2.0
POST
+57 %
8.0
PRE
5.3
POST
+34%
6.4
PRE
4.2
POST
+35%
5.6
PRE
4.8
POST
+15%
3.3
PRE
2.0
POST
+38%
Coercive parenting N = 12
Family relationships N = 12
Parent-child relationship N = 12
Parental adjustment N = 12
Parental consistency N = 12
Parental teamwork N = 8
Positive Encouragement N = 12

The Child Adjustment and Parent Efficacy Scale (CAPES) Self-assessment:

This 27-item questionnaire assesses a child's level of emotional and behavioral problems and how confident the parent is in their ability to handle these problems when they arise.[3]

There are three scored measures on the CAPES scale:

- Emotional Maladjustment score
- Behavioral Problems subscale score
- Total Intensity score

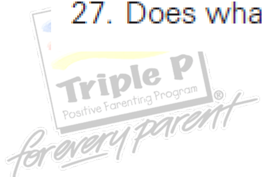
Parents were asked to rate the intensity of their child's behavior on a scale ranging from 0 (not at all) to 3 (very much or most of the time). Parents were also asked to rate their level of confidence or self-efficacy in managing their child's behavioral problems on a scale ranging from 1 (certain I cannot manage it) to 10 (certain I can manage it).

On the CAPES assessment, LOWER scores represent more desirable outcomes.

A blank example of the CAPES survey is shown on page 12, a scoring illustration of the CAPES survey is shown on page 13, and the actual pre-/post-average scores from the CAPES survey during Fiscal Year 19/20 is shown on page 14.

CAPES self-assessment (blank example)

My child:	How true is this of your child?				Rate your confidence (from 1–10)
1. Gets upset or angry when they don't get their own way	0	1	2	3	☐
2. Refuses to do jobs around the house when asked	0	1	2	3	☐
3. Worries	0	1	2	3	☐
4. Loses their temper	0	1	2	3	☐
5. Misbehaves at mealtimes	0	1	2	3	☐
6. Argues or fights with other children, brothers or sisters	0	1	2	3	☐
7. Refuses to eat food made for them	0	1	2	3	☐
8. Takes too long getting dressed	0	1	2	3	☐
9. Hurts me or others (e.g., hits, pushes, scratches, bites)	0	1	2	3	☐
10. Interrupts when I am speaking to others	0	1	2	3	☐
11. Seems fearful and scared	0	1	2	3	☐
12. Has trouble keeping busy without adult attention	0	1	2	3	☐
13. Yells, shouts or screams	0	1	2	3	☐
14. Whines or complains (whinges)	0	1	2	3	☐
15. Acts defiant when asked to do something	0	1	2	3	☐
16. Cries more than other children their age	0	1	2	3	☐
17. Rudely answers back to me	0	1	2	3	☐
18. Seems unhappy or sad	0	1	2	3	☐
19. Has trouble organising tasks and activities	0	1	2	3	☐
20. Can keep busy without constant adult attention	0	1	2	3	
21. Cooperates at bedtime	0	1	2	3	
22. Can do age appropriate tasks by themselves	0	1	2	3	
23. Follows rules and limits	0	1	2	3	
24. Gets on well with family members	0	1	2	3	
25. Is kind and helpful to others	0	1	2	3	
26. Talks about their views, ideas and needs appropriately	0	1	2	3	
27. Does what they are told to do by adults	0	1	2	3	



CAPES self-assessment (scoring illustration)

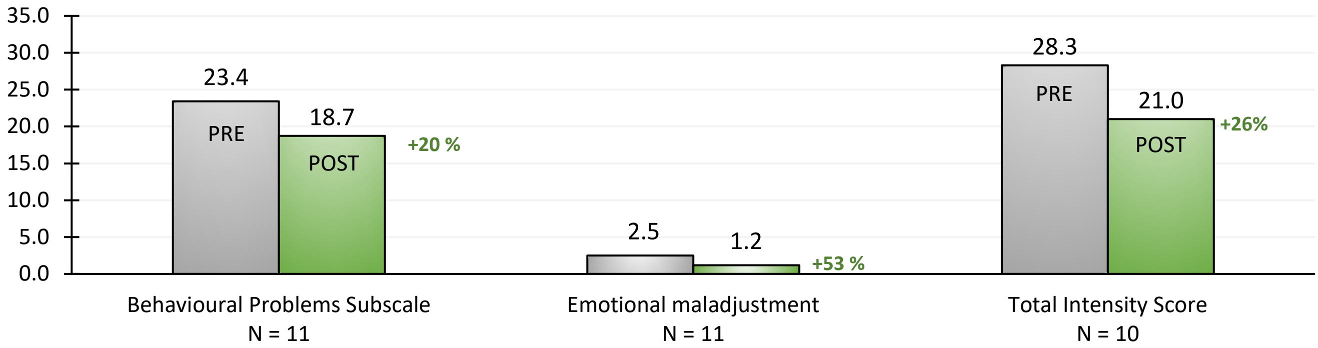
Emotional Maladjustment scores are calculated by summing the scores for questions 3, 11, and 18:

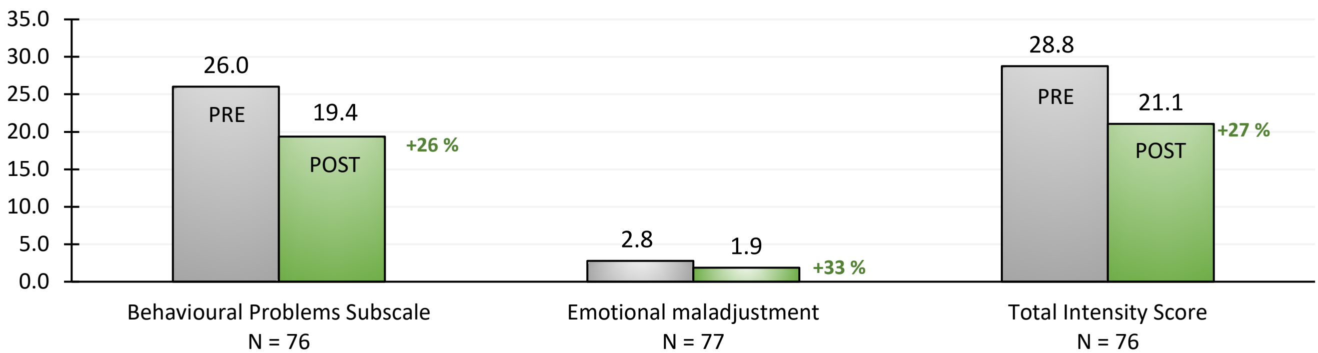
My child:	How true is this of your child? Not at all	little	often	very	(Range)
3. Worries	0	1	2	3	0 – 9
11. Seems fearful and scared	0	1	2	3	
18. Seems unhappy or sad	0	1	2	3	

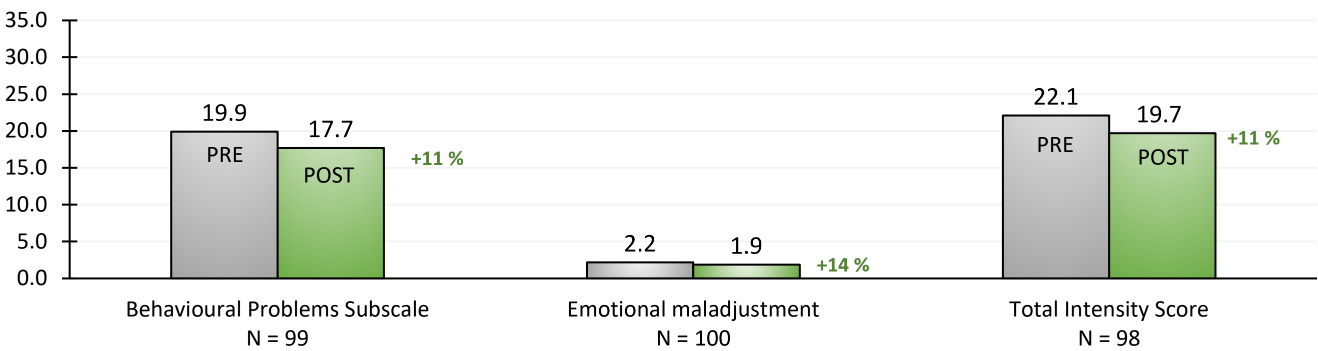
Behavioral Problems subscale scores are calculated by summing the scores for all remaining questions on the assessment:

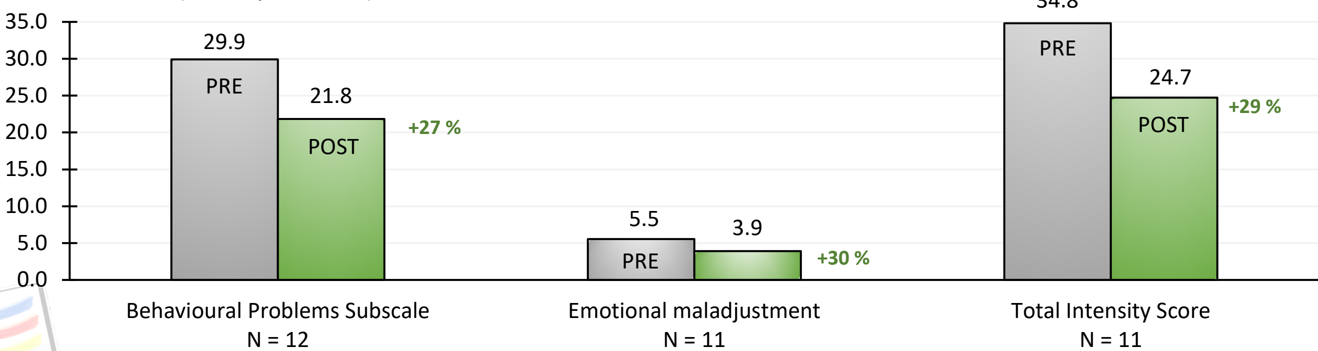
Item					(Range)
1. Gets upset or angry when they don't get their own way	0	1	2	3	0 – 72
2. Refuses to do jobs around the house when asked	0	1	2	3	
4. Loses their temper	0	1	2	3	
5. Misbehaves at mealtimes	0	1	2	3	
6. Argues or fights with other children, brothers or sisters	0	1	2	3	
7. Refuses to eat food made for them	0	1	2	3	
8. Takes too long getting dressed	0	1	2	3	
9. Hurts me or others (e.g., hits, pushes, scratches, bites)	0	1	2	3	
10. Interrupts when I am speaking to others	0	1	2	3	
12. Has trouble keeping busy without adult attention	0	1	2	3	
13. Yells, shouts or screams	0	1	2	3	
14. Whines or complains (whinges)	0	1	2	3	
15. Acts defiant when asked to do something	0	1	2	3	
16. Cries more than other children their age	0	1	2	3	
17. Rudely answers back to me	0	1	2	3	
18. Seems unhappy or sad	0	1	2	3	
19. Has trouble organising tasks and activities	0	1	2	3	
20. Can keep busy without constant adult attention	0	1	2	3	
21. Cooperates at bedtime	0	1	2	3	
22. Can do age appropriate tasks by themselves	0	1	2	3	
23. Follows rules and limits	0	1	2	3	
24. Gets on well with family members	0	1	2	3	
25. Is kind and helpful to others	0	1	2	3	
26. Talks about their views, ideas and needs appropriately	0	1	2	3	
27. Does what they are told to do by adults	0	1	2	3	

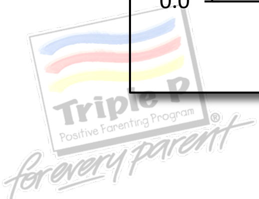
Total Intensity scores are calculated by adding the Emotional Maladjustment and Behavioral problems subscale scores together (range is 0 – 81).


Level 3 Primary: CAPES
Problem score (lower preferred)
35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0
23.4
PRE
18.7
POST
+20 %
2.5
1.2
+53 %
28.3
PRE
21.0
POST
+26%
Behavioural Problems Subscale
N = 11
Emotional maladjustment
N = 11
Total Intensity Score
N = 10


Level 4 Standard: CAPES
Problem score (lower preferred)
35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0
26.0
PRE
19.4
POST
+26 %
2.8
1.9
+33 %
28.8
PRE
21.1
POST
+27 %
Behavioural Problems Subscale
N = 76
Emotional maladjustment
N = 77
Total Intensity Score
N = 76


Level 4 Group: CAPES
Problem score (lower preferred)
35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0
19.9
PRE
17.7
POST
+11 %
2.2
1.9
+14 %
22.1
PRE
19.7
POST
+11 %
Behavioural Problems Subscale
N = 99
Emotional maladjustment
N = 100
Total Intensity Score
N = 98


Level 4 Standard Teen: CAPES
Problem score (lower preferred)
35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0
29.9
PRE
21.8
POST
+27 %
5.5
PRE
3.9
+30 %
34.8
PRE
24.7
POST
+29 %
Behavioural Problems Subscale
N = 12
Emotional maladjustment
N = 11
Total Intensity Score
N = 11


Triple P
Positive Parenting Program
forevery parent

In addition to the required CAPES and PAFAS assessments**,** the Client Satisfaction Questionnaire (CSQ) was also given to participants to voice how satisfied they were with the program (pictured below):

(Page 1 of 2)

Client Satisfaction Questionnaire *(example)*

This questionnaire will help us to evaluate and continually improve the program we offer. We are interested in your *honest opinions* about the services you have received, whether they are positive or negative. Please answer all the questions.

Please circle the response that best describes how you honestly feel.

1. How would you rate the quality of the service you and your child received?

7	6	5	4	3	2	1
Excellent		Good		Fair		Poor

2. Did you receive the type of help you wanted from the program?

1	2	3	4	5	6	7
No, definitely not		No, not really		Yes, generally		Yes, definitely

3. To what extent has the program met *your child's* needs?

7	6	5	4	3	2	1
Almost all needs have been met		Most needs have been met		Only a few needs have been met		No needs have been met

4. To what extent has the program met *your* needs?

7	6	5	4	3	2	1
Almost all needs have been met		Most needs have been met		Only a few needs have been met		No needs have been met

5. How satisfied were you with the *amount* of help you and your child received?

1	2	3	4	5	6	7
Quite dissatisfied		Dissatisfied		Satisfied		Very satisfied

6. Has the program helped you to deal more effectively with your child's behaviour?

7	6	5	4	3	2	1
Yes, it has helped a great deal		Yes, it has helped somewhat		No, it hasn't helped much		No, it made things worse

7. Has the program helped you to deal more effectively with problems that arise in your family?

7	6	5	4	3	2	1
Yes, it has helped a great deal		Yes, it has helped somewhat		No, it hasn't helped much		No, it made things worse

8. Do you think your relationship with your partner has been improved by the program?

1	2	3	4	5	6	7
No, definitely not		No, not really		Yes, generally		Yes, definitely

9. In an overall sense, how satisfied are you with the program you and your child received?

7	6	5	4	3	2	1
Very satisfied		Satisfied		Dissatisfied		Very dissatisfied

(Page 2 of 2)

10. If you were to seek help again, would you come back to Triple P?

1	2	3	4	5	6	7
No, definitely not		No, I don't think so		Yes, I think so		Yes, definitely

11. Has the program helped you to develop skills that can be applied to other family members?

1	2	3	4	5	6	7
No, definitely not		No, I don't think so		Yes, I think so		Yes, definitely

12. In your opinion, how is your child's behaviour at this point?

1	2	3	4	5	6	7
Considerably worse	Worse	Slightly worse	The same	Slightly improved	Improved	Greatly improved

13. How would you describe your feelings at this point about your child's progress?

7	6	5	4	3	2	1
Very satisfied	Satisfied	Slightly satisfied	Neutral	Slightly dissatisfied	Dissatisfied	Very dissatisfied

14. Since the beginning of this program, have you sought further assistance for your child's behaviour or for your family from any other source? If so, please describe.

....

....

....

....

15. Have you had any other problems with your child which you feel may be related to the original difficulty?

....

....

....

....

16. Do you have any other comments about this program?

....

....

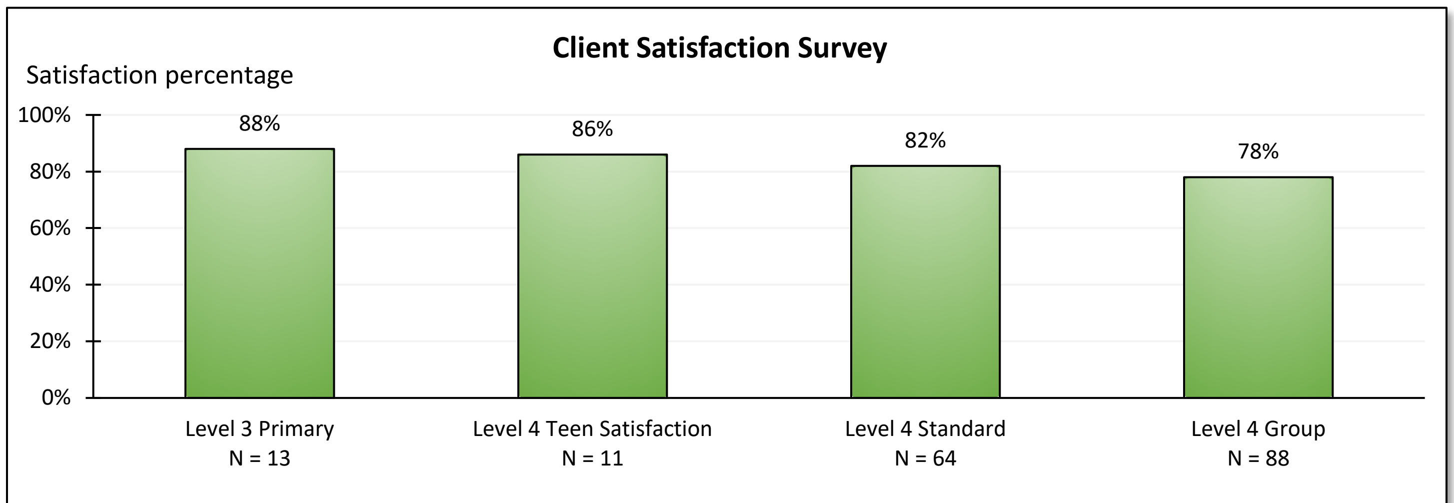
....

....

Thank you

Client Satisfaction Questionnaire:

Client Satisfaction in each level was as follows:



Conclusion:

Outcomes showed decreased problem scores on both the PAFAS and CAPES assessments during Fiscal Year 19/20. In some levels, there was minimal participant data (N = < 5) and the results were not considered reliable enough to report on.

CAPES findings:

Participants showed an average decrease in problem scores in the following levels:

- 33% in Level 3 Primary
- 29% in Level 4 Teen
- 28% in Level 4 Standard
- 12% in Level 4 Group

PAFAS findings:

Participants showed an average decrease in problem scores in the following levels:

- 38% in Level 4 Standard
- 31% in Level 4 Teen
- 29% in Level 4 Group

These results indicate that the program had an appreciable impact on improving participants' skills, knowledge, and confidence in their parenting.

References

[1] Shasta.com. "Welcome to Triple P." *Positive Parenting Program | Triple P Shasta*, www.triplepshasta.com/.

[2] Evaluation Tools for Triple P | EPISCenter. Episcenter.psu.edu. Retrieved from http://episcenter.psu.edu/newvpp/triplep/evaluation-tools. Published 2019.

[3] Measures Library. Pfsc.psychology.uq.edu.au. Retrieved from https://pfsc.psychology.uq.edu.au/research/measures-library. Published 2019.

Botvin LifeSkills

Outcome Evaluation

Fiscal Year 19/20

(July 1st, 2019 – June 30th, 2020)

Shasta Lake and Anderson Middle School

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Introduction

The Botvin LifeSkills program is an evidence-based substance use and violence prevention program for adolescents and young teens. LifeSkills Training is funded by the Mental Health Service Act (MHSA) as outlined in Shasta County's strategic plan as a prevention and early intervention program to address at-risk middle school students. The program can be taught in a variety of environments (often in schools) and has been proven effective in reducing tobacco, alcohol, opioid, and illicit drug use. Other benefits include reductions in delinquency, fighting, and verbal aggression as students learn valuable social and coping skills.

The program was administered to 6th-8th grade students attending Shasta Lake and Anderson Middle School during Fiscal Year 19/20. The program promotes healthy alternatives to risky behavior through activities that help students resist peer pressure to smoke or use drugs and alcohol, develop greater self-esteem and social skills, learn about relaxation techniques to cope with anxiety, and learn about the effects of substance abuse and healthier lifestyle choices.

This is the third year of delivering Botvin Lifeskills in 6th-8th grades at Shasta Lake and the second year at Anderson Middle School. Shasta Lake had teachers trained to deliver the Botvin Lifeskills program. Anderson Middle School has a collaboration between trained teachers and a contracted counseling provider (Dunamis Wellness) delivering the Botvin Lifeskills program.

Method

National Health Promotion Associates, Inc. (NHPA) designed a survey to gauge how much students know about illicit drug use, how they feel about it, and determine what kind of social and coping skills they have (an individual's knowledge and attitudes towards drug use, as well as knowing what kind of social/coping skills they have, is indicative of their propensity to stay away from drugs).[1] The survey was given to students before and after participating in the program and consisted of 7 questions about the students' background and 53 questions that related to one of three categories of substance abuse prevention: *knowledge*, *attitudes*, or *life skills.* All three categories were broken down into related subgroups and each subgroup was scored according to the instructions on the Botvin Lifeskills website.[2] The name of each category and subgroup is listed below:

Knowledge category

- Anti-drug knowledge (13 questions)
- Life skills knowledge (19 questions)
- Overall knowledge (anti-drug/life skills knowledge combined - 32 questions)

Attitudes category

- Anti-smoking attitudes (4 questions)
- Anti-drinking attitudes (4 questions)
- Anti-drug attitudes (anti-smoking/anti-drinking attitudes combined - 8 questions)

Life Skills category

- Drug refusal skills (6 questions)
- Assertiveness skills (3 questions)
- Relaxation skills (2 questions)
- Self-control skills (2 questions)

Each subgroup is a measure that is scored once the survey is completed. Measures in the *Knowledge* category were scored as a percentage (with 100% being the maximum score) while measures in the *Attitudes* and *Life Skills* categories

were each scored out of five possible points (with 5/5 being the maximum score). Under the "Data Analysis" section of this report, details of how the scores were generated for these measures are provided.

Results

The results of each scored measure for 6th – 8th grade students from Shasta Lake school is shown in the matrix below. Higher post-survey scores in every measure are preferred. Higher post-survey scores are represented by green arrows while lower scores are shown as red arrows.

		Shasta Lake School								
		6th grade			7th grade			8th grade		
	Measure	**Pre-Survey** (N = 7)	**Post-Survey** (N = 7)	**Change**	**Pre-Survey** (N = 21)	**Post-Survey** (N = 21)	**Change**	**Pre-Survey** (N = 84)	**Post-Survey** (N = 84)	**Change**
Knowledge	Anti-drug	56.04%	64.10%	+8.06% ↑	63.74%	68.86%	+5.12% ↑	67.58%	65.52%	-2.06% ↓
	Life skills	60.15%	72.81%	+12.66% ↑	65.66%	71.93%	+6.27% ↑	79.39%	82.56%	+3.17% ↑
	Overall (combined)	58.10%	68.46%	+10.36% ↑	64.70%	70.40%	+5.70% ↑	73.49%	74.04%	+0.55% ↑
Attitudes	Anti-smoking	4.18	4.79	+0.61 ↑	4.63	4.55	-0.08 ↓	4.48	4.33	-0.15 ↓
	Anti-drinking	4.14	4.71	+0.57 ↑	4.43	4.42	-0.01 ↓	4.37	4.18	-0.19 ↓
	Anti-drug (combined)	4.16	4.75	+0.59 ↑	4.53	4.48	-0.05 ↓	4.43	4.26	-0.17 ↓
Life Skills	Drug refusal	1.76	3.17	+1.41 ↑	3.68	3.05	-0.63 ↓	3.60	3.72	+0.12 ↑
	Assertiveness	3.62	3.11	-0.51 ↓	3.33	3.54	+0.21 ↑	3.46	3.44	-0.02 ↓
	Relaxation	3.64	3.67	+0.03 ↑	3.68	3.93	+0.25 ↑	4.01	4.07	+0.06 ↑
	Self-control	3.29	3.67	+0.38 ↑	3.70	3.81	+0.11 ↑	3.69	3.80	+ 0.11 ↑

Note: Numbers may not add due to rounding.

The results of each scored measure for 6th – 8th grade students from Anderson School is shown in the matrix below. Higher post-survey scores in every measure are preferred. Higher post-survey scores are represented by green arrows while lower scores are shown as red arrows.

		Anderson Middle School								
		6th grade			**7th grade**			**8th grade**		
	Measure	**Pre-Survey** (N = 23)	**Post-Survey** (N = 23)	**Change**	**Pre-Survey** (N = 13)	**Post-Survey** (N = 13)	**Change**	**Pre-Survey** (N = 20)	**Post-Survey** (N = 20)	**Change**
Knowledge	Anti-drug	54.52%	66.08%	+11.57%	71.79%	67.83%	-3.96%	57.31%	69.68%	+12.38%
	Life skills	63.39%	74.16%	+10.78%	69.30%	76.56%	+7.26%	70.53%	82.04%	+11.52%
	Overall (combined)	58.96%	70.12%	+11.18%	70.55%	72.20%	+1.65%	63.92%	75.86%	+11.95%
Attitudes	Anti-smoking	4.86	4.84	-0.02	3.90	4.41	+0.51	4.40	4.56	+0.16
	Anti-drinking	4.80	4.82	+0.02	4.10	4.39	+0.29	4.40	4.49	+0.09
	Anti-drug (combined)	4.83	4.83	No Change	4.00	4.40	+0.40	4.40	4.52	+0.12
Life Skills	Drug refusal	1.76	3.17	+1.41	2.7	4.02	+1.32	3.38	3.80	+0.42
	Assertiveness	3.20	3.73	+0.53	3.27	3.33	+0.06	3.60	3.78	+0.18
	Relaxation	3.61	3.76	+0.15	3.85	3.95	+0.10	4.21	3.85	-0.36
	Self-control	3.35	3.12	-0.23	3.38	2.95	-0.43	3.61	3.82	+0.21

Note: Numbers may not add due to rounding.

Before analyzing these results, consideration should be given to some data collection limitations.

Limitations

School Closures from COVID-19

When schools switched to distance learning due to the California Governor's stay-at-home order in March (from the Covid-19 pandemic), both schools had challenges with delivering the program and collecting surveys. School closures that began in March significantly lowered the number of Botvin Lifeskills lessons delivered, the Botvin Lifeskills post-survey participation rate, and program fidelity.

Survey Design

The "Drug refusal" score might have been adversely affected by the transition from survey Section C.) to Section D.). Section C.) had a series of statements representing attitudes towards drug use (i.e. "Smoking cigarettes makes you look cool") where students indicated where they agreed or disagreed with the statement in question. "Disagree" represented an anti-drug response across the entire section. The next section on the survey, Section D.), had a series of statements such as "Smoke a cigarette", "Use cocaine or other drugs" where, again, students indicated their agreement or disagreement, but, unlike the preceding section, "Agree" was the anti-drug response for this section due to a lead-in statement that read: "I would say NO if someone tried to get me to [Smoke a cigarette], [Use cocaine or other drugs], [etc.,]." In the preceding section C.), there was no lead-in statement. Students could have misinterpreted section D.) if they did not see the lead-in statement.

Conclusion

For both schools, the results indicate that the program was successful at improving students' overall (combined) anti-drug knowledge and life skills knowledge in each grade. For Anderson, overall anti-drug attitudes among the sixth graders did not change but overall anti-drug attitudes for seventh and eighth graders improved. For Shasta Lake, overall anti-drug attitudes among the sixth graders improved, but slightly worsened among the seventh and eighth graders. According to NHPA, caution should be exercised when interpreting findings without a control group because drug use and risk factors tend to worsen during early adolescence, even during a prevention program. The best way to evaluate program effects is to compare the changes over time with those who received the program and a control group that did not. Measures in the Life Skills category had mixed success for both schools, but most measures in this category showed improved post-survey scores.

Recommendations

Efforts should be made to continue improving the program. This would consist of addressing barriers to learning, changing attitudes, and implementing life skills. If it is feasible, program staff should consider adjusting the curriculum to better influence anti-drug attitudes and improve implementation of life skills learned by students. Ideally, program fidelity would not be impacted by external factors (like school closures). Also, perhaps tweaking the survey design between sections C.) and D.) would be ways to improve.

Data Analysis

In this section, information on the students' background (including demographic information) and how the scored measures were calculated will be explored in greater detail. Missing responses were ignored when calculating the scored measures, and missing responses were also not individually tracked in the student background section. Only students who took both pre- and post-surveys were counted (linked by their student ID number). If multiple surveys were taken by the same student, only the survey they completed first was used. Survey questions, shown further on in this report, are formatted differently for illustrative purposes. The structure of this section is as follows:

Shasta Lake

Section A: Student Background .... Pages 8-9

Section B: Knowledge Measures .... Pages 10-11

Section C: Attitude Measures .... Page 12

Section D: Life Skills Measures .... Page 13

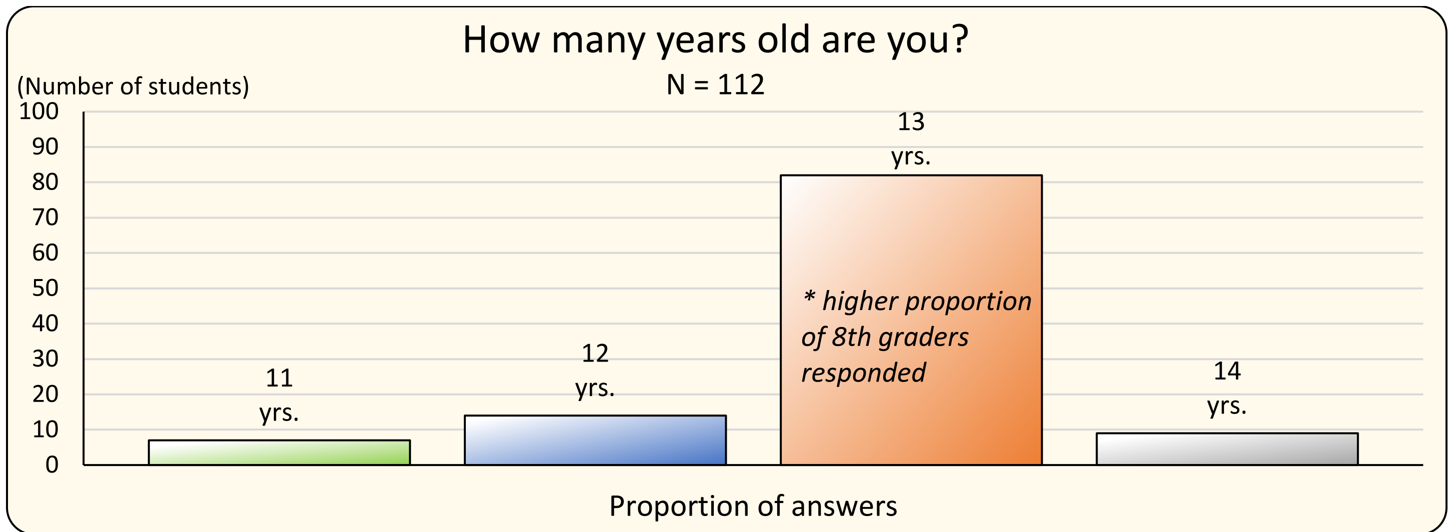
Anderson

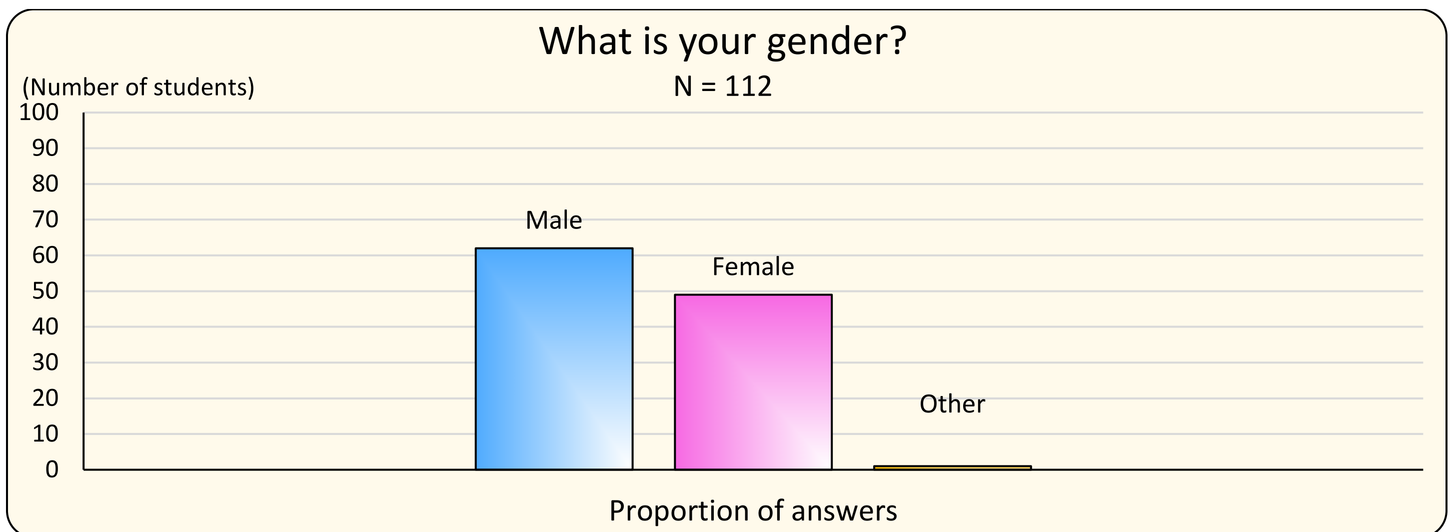
Section A: Student Background .... Pages 14-15

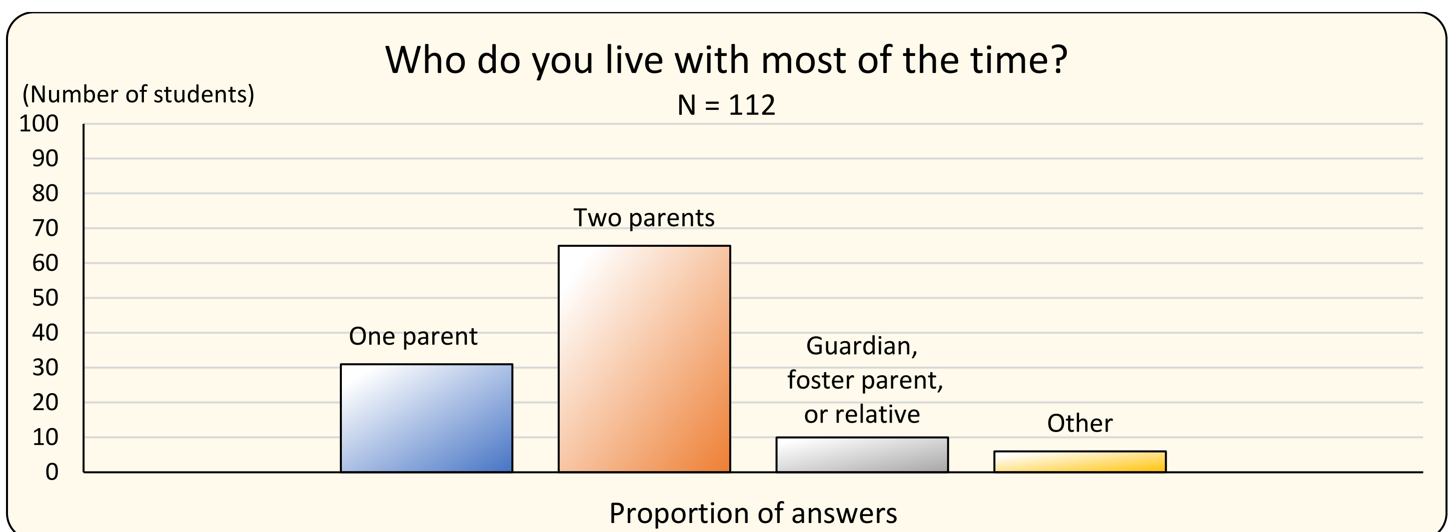
Section B: Knowledge Measures .... Pages 16-17

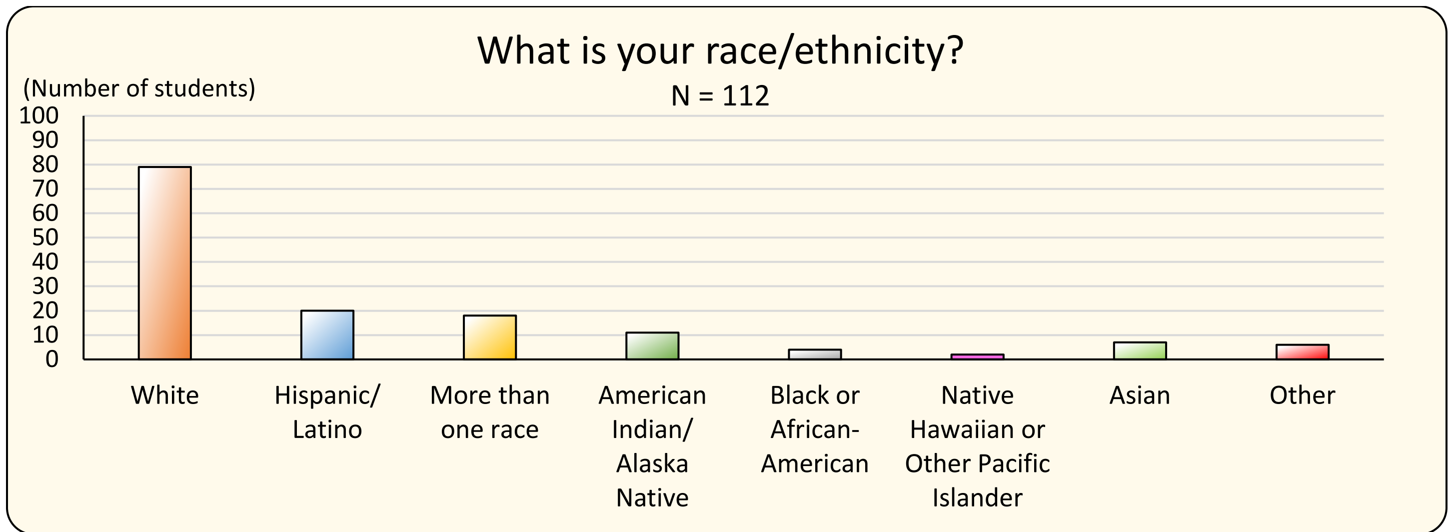
Section C: Attitude Measures .... Page 18

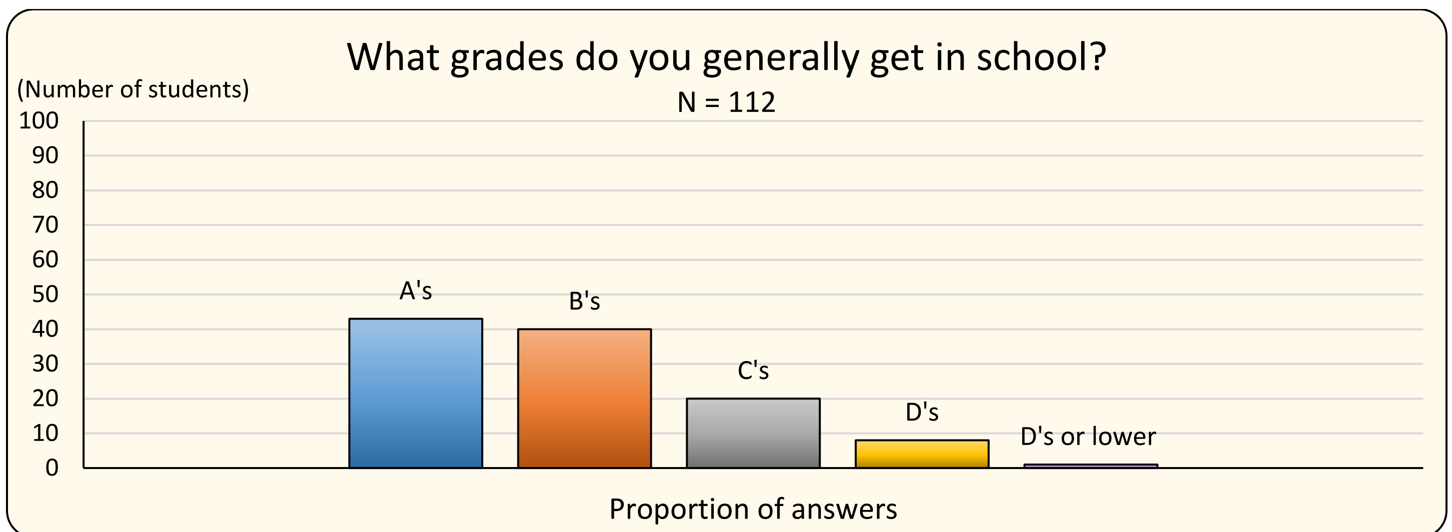
Section D: Life Skills Measures .... Page 19

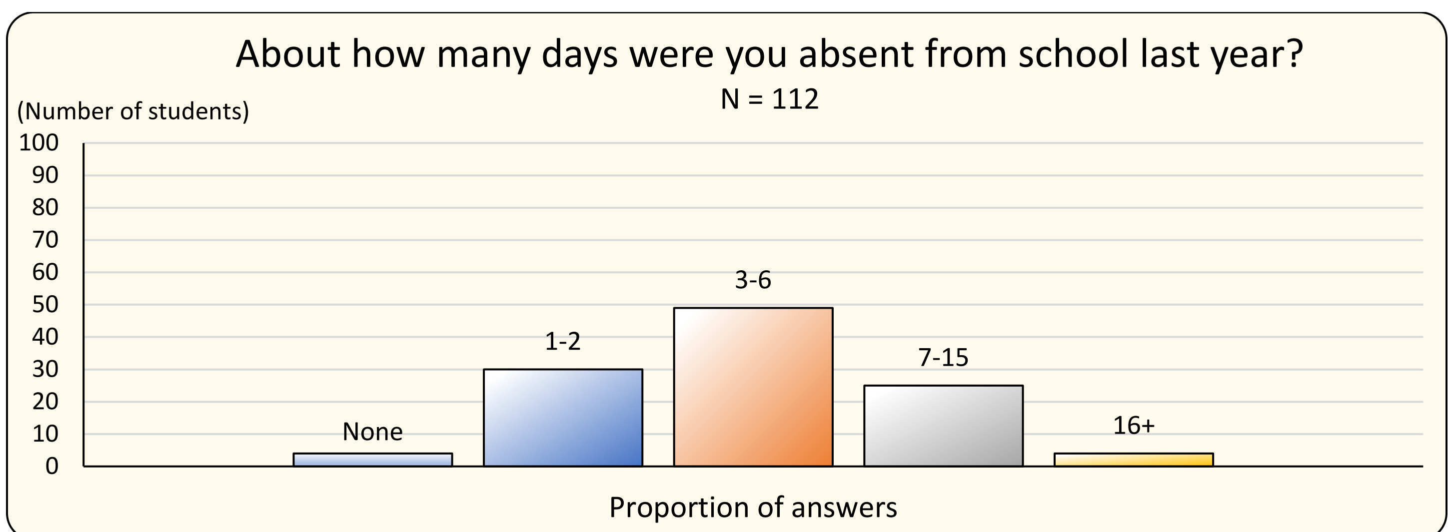

How many years old are you?
N = 112
(Number of students)
100
90
80
70
60
50
40
30
20
10
0
11 yrs.
12 yrs.
13 yrs.
* higher proportion of 8th graders responded
14 yrs.
Proportion of answers


What is your gender?
N = 112
(Number of students)
100
90
80
70
60
50
40
30
20
10
0
Male
Female
Other
Proportion of answers


Who do you live with most of the time?
N = 112
(Number of students)
100
90
80
70
60
50
40
30
20
10
0
One parent
Two parents
Guardian, foster parent, or relative
Other
Proportion of answers


What is your race/ethnicity?
N = 112
(Number of students)
100
90
80
70
60
50
40
30
20
10
0
White
Hispanic/ Latino
More than one race
American Indian/ Alaska Native
Black or African-American
Native Hawaiian or Other Pacific Islander
Asian
Other


What grades do you generally get in school?
N = 112
(Number of students)
100
90
80
70
60
50
40
30
20
10
0
A's
B's
C's
D's
D's or lower
Proportion of answers


About how many days were you absent from school last year?
N = 112
(Number of students)
100
90
80
70
60
50
40
30
20
10
0
None
1-2
3-6
7-15
16+
Proportion of answers

Section B: Knowledge measures (Anti-drug)

"To create an **anti-drug knowledge summary score**, add up the number of items (out of items 1 – 7, 12 – 17) that are answered correctly and divide by 13 (the total number of drug knowledge items). This number gives you the proportion of drug knowledge items answered correctly." [2]

Anti-Drug knowledge items (Shasta Lake)		6th grade (% correct)			7th grade (% correct)			8th grade (% correct)		
		PRE (N = 7)	POST (N = 7)	Change	PRE (N = 21)	POST (N = 21)	Change	PRE (N = 84)	POST (N = 84)	Change
1.	Most adults smoke cigarettes. (F)	14.29%	50.00%	35.71%	42.86%	28.57%	-14.29%	57.14%	53.01%	-4.13%
2.	Smoking a cigarette causes your heart to beat slower. (F)	14.29%	50.00%	35.71%	42.86%	76.19%	33.33%	59.52%	63.86%	4.33%
3.	Few adults drink wine, beer, or liquor every day. (T)	57.14%	50.00%	-7.14%	42.86%	66.67%	23.81%	48.81%	45.78%	-3.03%
4.	Most people my age smoke marijuana. (F)	71.43%	50.00%	-21.43%	76.19%	57.14%	-19.05%	55.95%	55.42%	-0.53%
5.	Smoking marijuana causes your heart to beat faster. (T)	28.57%	83.33%	54.76%	76.19%	80.95%	4.76%	69.05%	66.27%	-2.78%
6.	Most adults use cocaine or other hard drugs. (F)	57.14%	66.67%	9.53%	61.90%	61.90%	0.00%	78.57%	78.31%	-0.26%
7.	Cocaine and other hard drugs always make you feel good. (F)	71.43%	83.33%	11.90%	80.95%	80.95%	0.00%	89.29%	90.36%	1.08%
12.	Smoking can affect the steadiness of your hands. (T)	85.71%	100%	14.29%	85.71%	100.00%	14.29%	94.05%	91.57%	-2.48%
13.	A stimulant is a chemical that calms down the body. (F)	71.43%	66.67%	-4.76%	66.67%	61.90%	-4.76%	54.76%	51.81%	-2.95%
14.	Smoking reduces a person's endurance for physical activity. (T)	85.71%	83.33%	-2.38%	80.95%	85.71%	4.76%	89.29%	87.95%	-1.33%
15.	A serving of beer or wine contains less alcohol than a serving of "hard liquor" such as whiskey. (F)	28.57%	16.67%	-11.90%	19.05%	33.33%	14.29%	29.76%	24.10%	-5.67%
16.	Alcohol is a depressant. (T)	71.43%	33.33%	-38.10%	57.14%	71.43%	14.29%	57.14%	50.60%	-6.54%
17.	Marijuana smoking can improve your eyesight. (F)	71.43%	100%	28.57%	95.24%	90.48%	-4.76%	95.24%	92.77%	-2.47%
Anti-drug knowledge summary score (higher % is preferred):		**56.04%**	**64.10%**	**+8.06%**	**63.74%**	**68.86%**	**+5.12%**	**67.58%**	**65.52%**	**-2.06%**

Legend
Post-improvement increased by more than 5% (Section B)
Post-improvement decreased by more than 5% (Section B)

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Section B: Knowledge measures (Life skills)

"To create a **life skills knowledge summary score**, add up the number of items (out of items 8 – 11, 18 – 32) that are answered correctly and divide by 19 (the total number of life skills knowledge items). This number gives you the proportion of life skills knowledge items answered correctly." [2]

	Life skills knowledge items (Shasta Lake)	6th grade (% correct)			7th grade (% correct)			8th grade (% correct)		
		PRE (N = 7)	POST (N = 7)	Change	PRE (N = 21)	POST (N = 21)	Change	PRE (N = 84)	POST (N = 84)	Change
8.	What we believe about ourselves affects the way we act or behave. (T)	71.43%	83.33%	11.90%	95.24%	80.95%	-14.29%	91.67%	90.36%	-1.31%
9.	It is almost impossible to develop a more positive self-image. (F)	85.71%	100.00%	14.29%	76.19%	80.95%	4.76%	78.57%	80.72%	2.15%
10.	It is important to measure how far you have come toward reaching your goal. (T)	85.71%	100.00%	14.29%	85.71%	95.24%	9.52%	95.24%	92.77%	-2.47%
11.	It's a good idea to make a decision and then think about the consequences later. (F)	28.57%	50.00%	21.43%	71.43%	80.95%	9.52%	90.48%	93.98%	3.50%
18.	Some advertisers are deliberately deceptive. (T)	42.86%	66.67%	23.81%	80.95%	71.43%	-9.52%	71.43%	81.93%	10.50%
19.	Companies advertise only because they want you to have all the facts about their products. (F)	42.86%	66.67%	23.81%	52.38%	38.10%	-14.29%	64.29%	78.31%	14.03%
20.	It's a good idea to get all information about a product from its ads. (F)	42.86%	33.33%	-9.52%	61.90%	76.19%	14.29%	65.48%	71.08%	5.61%
21.	Most people do not experience anxiety. (F)	42.86%	83.33%	40.48%	61.90%	71.43%	9.52%	73.81%	81.93%	8.12%
22.	There is very little you can do when you feel anxious. (F)	57.14%	83.33%	26.19%	38.10%	57.14%	19.05%	70.24%	71.08%	0.85%
23.	Deep breathing is one way to lessen anxiety. (T)	85.71%	100.00%	14.29%	76.19%	95.24%	19.05%	92.86%	96.39%	3.53%
24.	Mental rehearsal is a poor relaxation technique. (F)	71.43%	66.67%	-4.76%	47.62%	71.43%	23.81%	72.62%	74.70%	2.08%
25.	You can avoid misunderstandings by assuming the other person knows what you mean. (F)	71.43%	66.67%	-4.76%	57.14%	71.43%	14.29%	75.00%	77.11%	2.11%
26.	Effective communication is when both sender and receiver interpret a message in the same way. (T)	57.14%	83.33%	26.19%	61.90%	66.67%	4.76%	85.71%	89.16%	3.44%
27.	Relaxation techniques are of no use when meeting people. (F)	85.71%	100.00%	14.29%	66.67%	80.95%	14.29%	80.95%	79.52%	-1.43%
28.	A compliment is more effective when it is said sincerely. (T)	85.71%	83.33%	-2.38%	85.71%	85.71%	0.00%	96.43%	93.98%	-2.45%
29.	A nice way of ending a conversation is to tell the person you enjoyed talking with him or her. (T)	71.43%	83.33%	11.90%	90.48%	80.95%	-9.52%	97.62%	96.39%	-1.23%
30.	Sense of humor is an example of a non-physical attribute. (T)	42.86%	50.00%	7.14%	52.38%	33.33%	-19.05%	66.67%	67.47%	0.80%
31.	It's better to be polite and lead someone on, even if you don't want to go out with them. (F)	28.57%	16.67%	--11.90%	28.57%	52.38%	23.81%	58.33%	71.08%	12.75%
32.	Almost all people who are assertive are either rude or hostile. (F)	42.86%	66.67%	23.81%	57.14%	76.19%	19.05%	80.95%	80.72%	-0.23%
	Life skills knowledge summary score (higher % is preferred):	**60.15%**	**72.81%**	**+12.66%**	**65.66%**	**71.93%**	**+6.27%**	**79.39%**	**82.56%**	**+3.18%**

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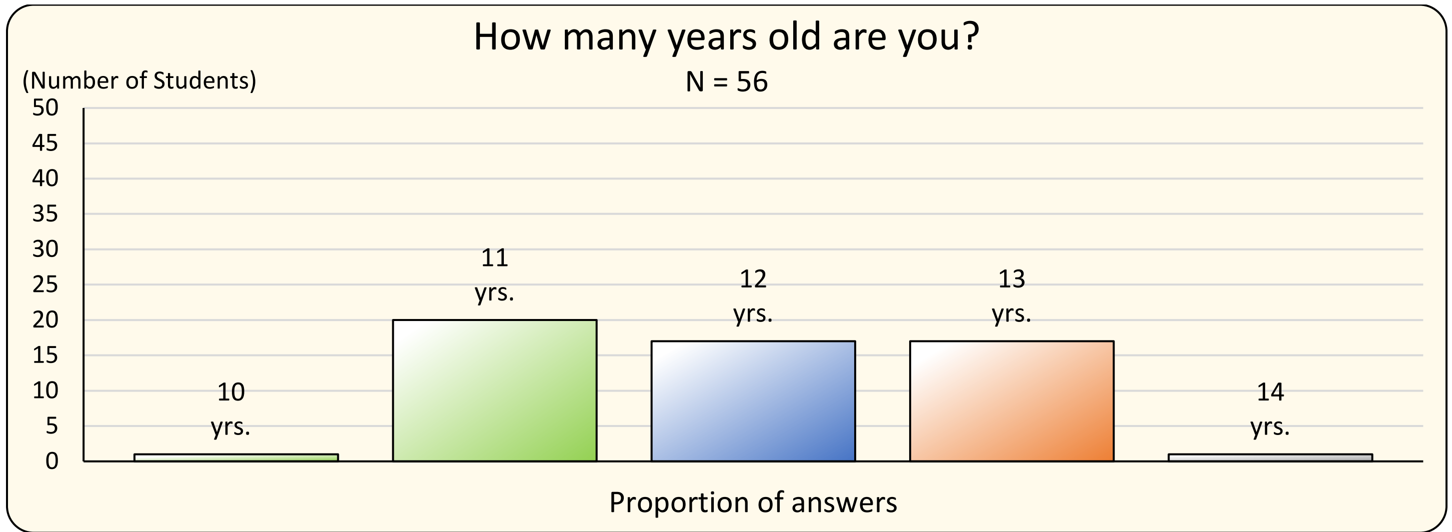
Section C: Attitude measures (Anti-drug)

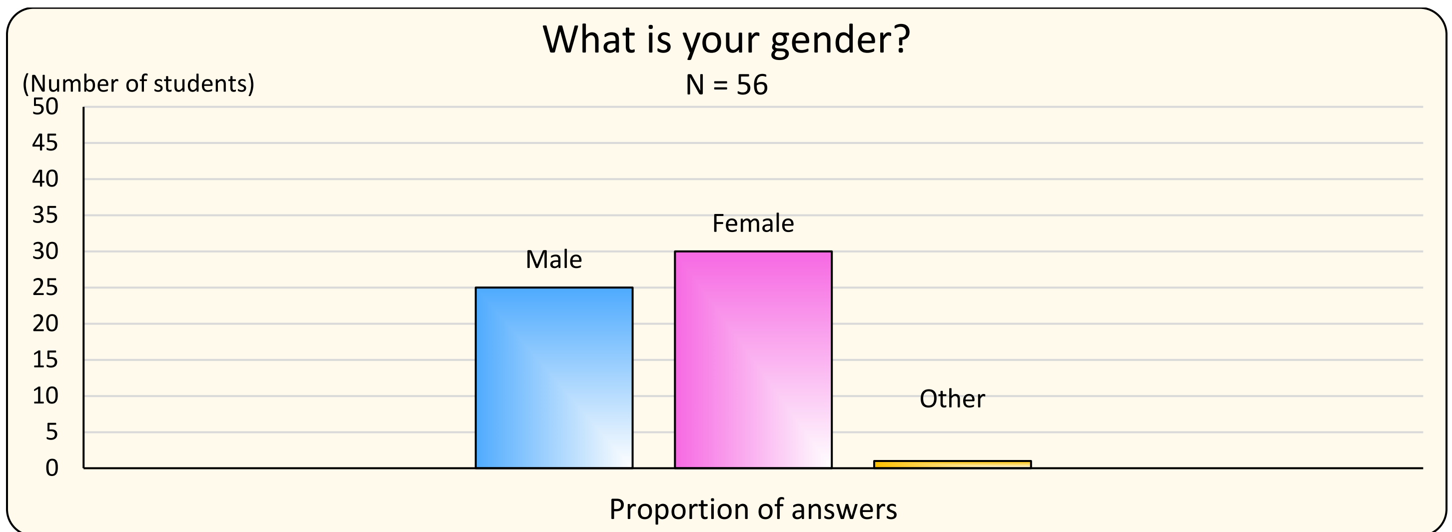
"To create an **anti-drug attitudes summary score**, calculate the mean of all 8 items (C1 to C8). To create an anti-smoking attitudes summary score, calculate the mean of items C2, C4, C6, and C7. To create an anti-drinking attitudes summary score, calculate the mean of items C1, C3, C5, and C8. Higher scores indicate stronger attitudes against smoking and drinking." [2]

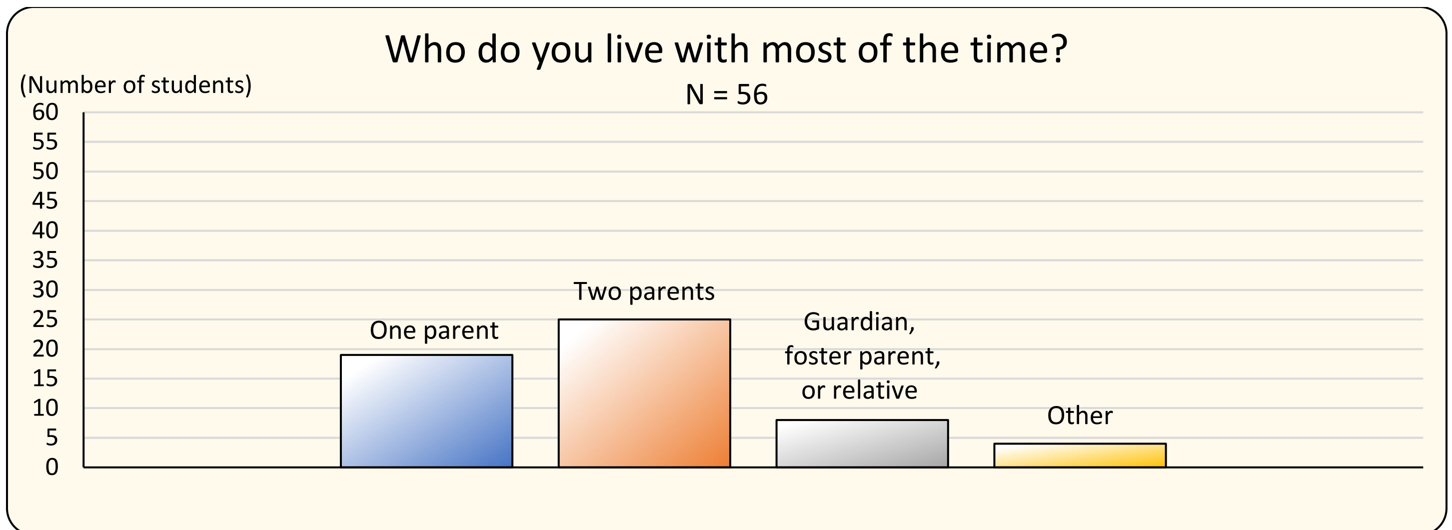
	Anti-drug attitudes (Shasta Lake)	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	6th grade		7th grade		8th grade	
							PRE (N = 7)	POST (N = 7)	PRE (N = 21)	POST (N = 21)	PRE (N = 84)	POST (N = 84)
1.	Kids who drink alcohol are more grown-up.	①	②	③	④	⑤	4.43	5.00	4.45	4.33	4.50	4.29
2.	Smoking cigarettes makes you look cool.	①	②	③	④	⑤	4.43	5.00	4.80	4.76	4.75	4.48
3.	Kids who drink alcohol have more friends.	①	②	③	④	⑤	3.43	4.50	4.15	4.14	4.08	3.93
4.	Kids who smoke have more friends.	①	②	③	④	⑤	3.43	4.50	4.30	4.29	4.00	3.83
5.	Drinking alcohol makes you look cool.	①	②	③	④	⑤	4.43	4.50	4.60	4.62	4.55	4.37
6.	Smoking cigarettes lets you have more fun.	①	②	③	④	⑤	4.14	4.67	4.85	4.67	4.58	4.51
7.	Kids who smoke cigarettes are more grown-up.	①	②	③	④	⑤	4.71	5.00	4.55	4.48	4.60	4.49
8.	Drinking alcohol lets you have more fun.	①	②	③	④	⑤	4.29	4.83	4.50	4.57	4.35	4.14
	Anti-drinking attitudes score (scores range from 1 to 5, scores closest to 5 are preferred):						**4.14**	**4.71**	**4.43**	**4.42**	**4.37**	**4.18**
	Anti-smoking attitudes score (scores range from 1 to 5, scores closest to 5 are preferred):						**4.18**	**4.79**	**4.63**	**4.55**	**4.48**	**4.33**
	Anti-drug attitudes summary score (scores range from 1 to 5, scores closest to 5 are preferred):						**4.16**	**4.75**	**4.53**	**4.48**	**4.43**	**4.26**

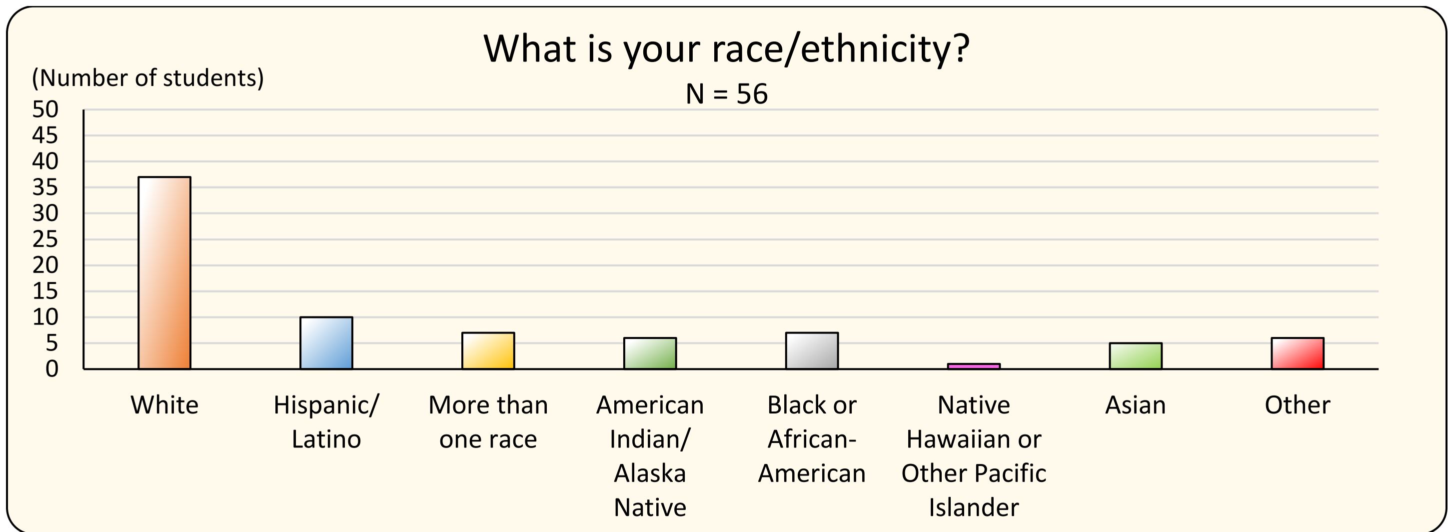
Legend
This question factors into the Anti-drinking attitudes score (Section C)
This question factors into the Anti-smoking attitudes score (Section C)
Post-improvement increased by more than 5% (Sections C & D)
Post-improvement decreased by more than 5% (Section C & D)

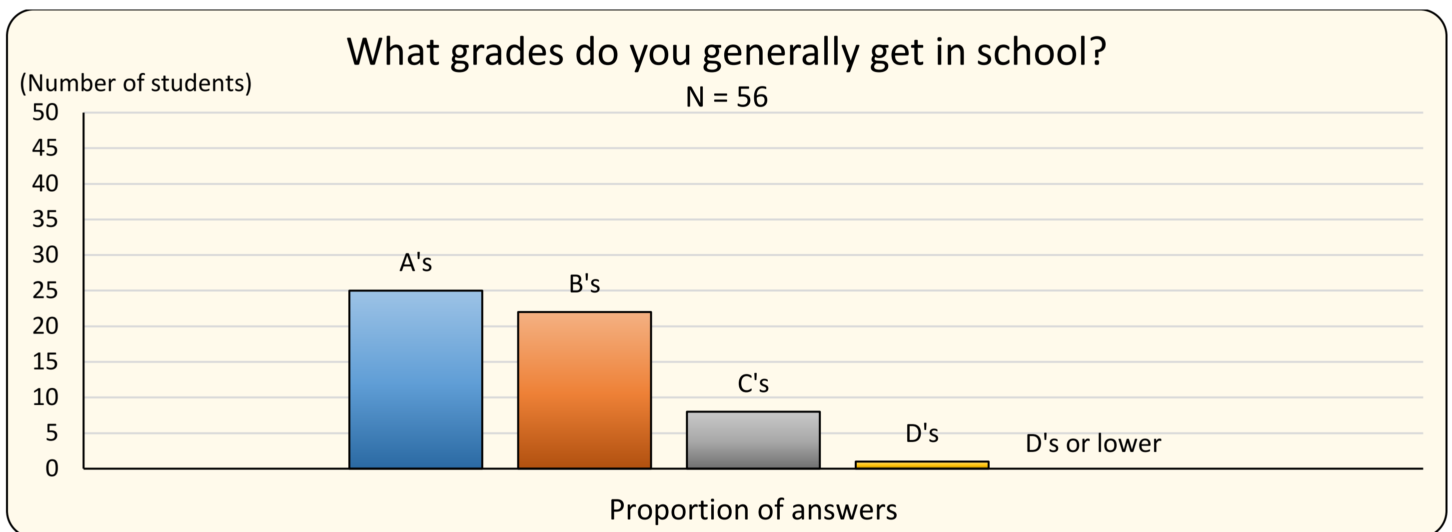
	Life skills (Shasta Lake)	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	6th grade		7th grade		8th grade	
							PRE (N = 7)	POST (N = 7)	PRE (N = 21)	POST (N = 21)	PRE (N = 84)	POST (N = 84)
I would say NO if someone tried to get me to:												
1.	Smoke a cigarette. ***[Lower scores preferred]***	①	②	③	④	⑤	4.29	2.83	2.40	2.86	2.25	2.18
2.	Drink beer, wine, or liquor. ***[Lower scores preferred]***	①	②	③	④	⑤	4.00	2.83	2.35	3.00	2.45	2.37
3.	Smoke marijuana or hashish. ***[Lower scores preferred]***	①	②	③	④	⑤	4.29	2.83	2.15	3.14	2.45	2.40
4.	Use cocaine or other drugs. ***[Lower scores preferred]***	①	②	③	④	⑤	4.29	2.83	2.30	2.81	2.29	2.18
5.	Use a prescription drug that was prescribed for someone else. ***[Lower scores preferred]***	①	②	③	④	⑤	4.29	2.83	2.25	2.76	2.40	2.25
6.	Vape or smoke an e-cigarette ***[Lower scores preferred]***	①	②	③	④	⑤	4.29	2.83	2.50	3.14	2.54	2.28
	Drug refusal skill [2]*(Scores for Q's. 1-6 are averaged then subtracted from 6 to invert them - **higher scores are preferred**):*						**1.76**	**3.17**	**3.68**	**3.05**	**3.60**	**3.72**
I would:												
7.	Tell someone if they gave me less change(money) than I was supposed to get back after paying for something. ***[Lower scores preferred]***	①	②	③	④	⑤	2.71	2.67	2.20	2.29	2.11	2.17
8.	Say "no" to someone who asks to borrow money from me. ***[Lower scores preferred]***	①	②	③	④	⑤	2.29	2.83	2.95	2.57	2.71	2.60
9.	Tell someone to go to the end of the line if they try to cut ahead of me. ***[Lower scores preferred]***	①	②	③	④	⑤	2.14	3.17	2.85	2.52	2.81	2.92
	Assertiveness skills [2]*(Scores for Q's. 7-9 are averaged then subtracted from 6 to invert them - **higher scores are preferred**):*						**3.62**	**3.11**	**3.33**	**3.54**	**3.46**	**3.44**
In order to cope with stress or anxiety, I would:												
10.	Relax all the muscles in my body, starting with my feet and legs. ***[Lower scores preferred]***	①	②	③	④	⑤	2.71	2.33	2.35	2.05	2.14	2.00
11.	Breathe in slowly for a count of four, then hold my breath in for a count of four, and slowly exhale for a count of four. ***[Lower scores preferred]***	①	②	③	④	⑤	2.00	2.33	2.30	2.10	1.83	1.87
	Relaxation skills [2]*(Scores Q.10 & Q.11 are averaged then subtracted from 6 to invert them - **higher scores are preferred**):*						**3.64**	**3.67**	**3.68**	**3.93**	**4.01**	**4.07**
In general:												
12.	If I find that something is really difficult, I get frustrated and quit. ***[Higher scores preferred]***	①	②	③	④	⑤	3.14	3.67	3.5	3.62	3.48	3.63
13.	I stick to what I'm doing until I'm finished with it. ***[Lower scores preferred]***	①	②	③	④	⑤	2.57	2.33	2.1	2.00	2.10	2.04
	Self-Control Skills [2]*(Score for Q. 13 is subtracted from 6 to invert it then averaged with Q. 12 – **higher scores are preferred**):*						**3.29**	**3.67**	**3.70**	**3.81**	**3.69**	**3.80**

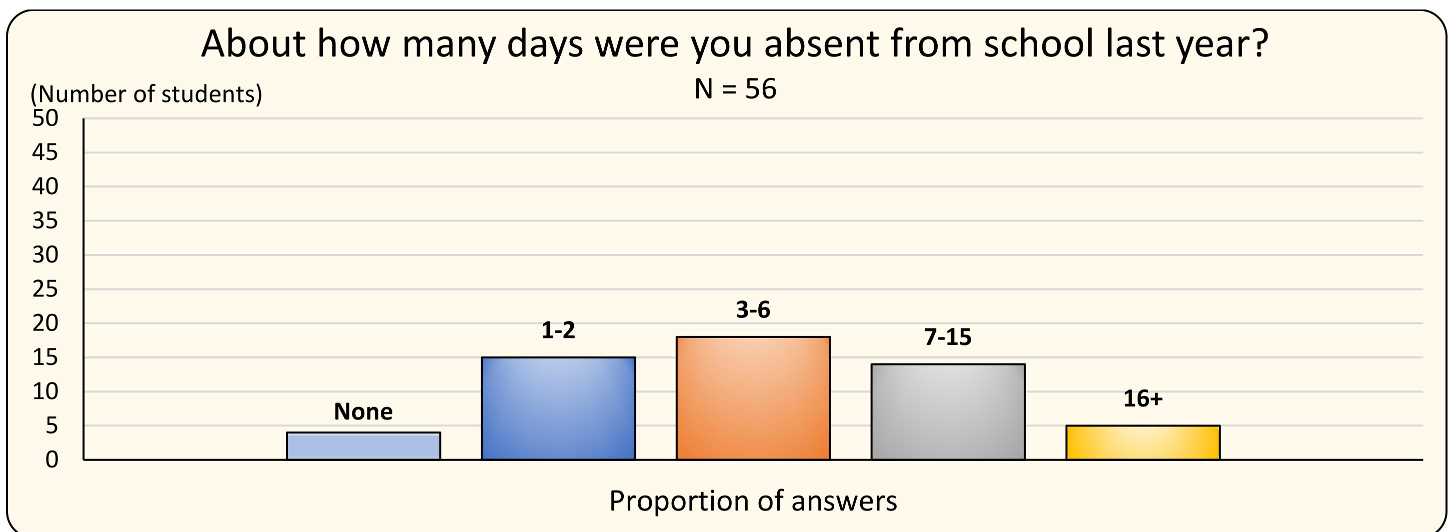

How many years old are you?
N = 56
(Number of Students)
50
45
40
35
30
25
20
15
10
5
0
10 yrs.
11 yrs.
12 yrs.
13 yrs.
14 yrs.
Proportion of answers


What is your gender?
N = 56
(Number of students)
50
45
40
35
30
25
20
15
10
5
0
Male
Female
Other
Proportion of answers


Who do you live with most of the time?
N = 56
(Number of students)
60
55
50
45
40
35
30
25
20
15
10
5
0
One parent
Two parents
Guardian, foster parent, or relative
Other


What is your race/ethnicity?
N = 56
(Number of students)
50
45
40
35
30
25
20
15
10
5
0
White
Hispanic/ Latino
More than one race
American Indian/ Alaska Native
Black or African-American
Native Hawaiian or Other Pacific Islander
Asian
Other


What grades do you generally get in school?
N = 56
(Number of students)
50
45
40
35
30
25
20
15
10
5
0
A's
B's
C's
D's
D's or lower
Proportion of answers


About how many days were you absent from school last year?
N = 56
(Number of students)
50
45
40
35
30
25
20
15
10
5
0
None
1-2
3-6
7-15
16+
Proportion of answers

Section B: Knowledge measures (Anti-drug)

"To create an **anti-drug knowledge summary score**, add up the number of items (out of items 1 – 7, 12 – 17) that are answered correctly and divide by 13 (the total number of drug knowledge items). This number gives you the proportion of drug knowledge items answered correctly." [2]

	Anti-Drug knowledge items (Anderson)	6th grade (% correct)			7th grade (% correct)			8th grade (% correct)		
		PRE (N = 23)	POST (N = 23)	Change	PRE (N = 13)	POST (N = 13)	Change	PRE (N = 20)	POST (N = 20)	Change
1.	Most adults smoke cigarettes. (F)	30.43%	45.45%	15.02%	83.33%	54.55%	-28.79%	40.00%	70.59%	30.59%
2.	Smoking a cigarette causes your heart to beat slower. (F)	13.04%	27.27%	14.23%	66.67%	45.45%	-21.21%	45.00%	52.94%	7.94%
3.	Few adults drink wine, beer, or liquor every day. (T)	43.48%	45.45%	1.98%	33.33%	63.64%	30.30%	50.00%	47.06%	-2.94%
4.	Most people my age smoke marijuana. (F)	78.26%	77.27%	-0.99%	50.00%	45.45%	-4.55%	40.00%	35.29%	-4.71%
5.	Smoking marijuana causes your heart to beat faster. (T)	39.13%	50.00%	10.87%	83.33%	81.82%	-1.52%	45.00%	70.59%	25.59%
6.	Most adults use cocaine or other hard drugs. (F)	69.57%	81.82%	12.25%	83.33%	81.82%	-1.52%	65.00%	94.12%	29.12%
7.	Cocaine and other hard drugs always make you feel good. (F)	60.87%	100.00%	39.13%	66.67%	63.64%	-3.03%	60.00%	82.35%	22.35%
12.	Smoking can affect the steadiness of your hands. (T)	60.87%	86.36%	25.49%	83.33%	81.82%	-1.52%	90.00%	88.24%	-1.76%
13.	A stimulant is a chemical that calms down the body. (F)	56.52%	72.73%	16.21%	66.67%	63.64%	-3.03%	65.00%	58.82%	-6.18%
14.	Smoking reduces a person's endurance for physical activity. (T)	69.57%	77.27%	7.71%	100.00%	100.00%	0.00%	90.00%	94.12%	4.12%
15.	A serving of beer or wine contains less alcohol than a serving of "hard liquor" such as whiskey. (F)	39.13%	27.27%	-11.86%	83.33%	36.36%	-46.97%	20.00%	29.41%	9.41%
16.	Alcohol is a depressant. (T)	60.87%	68.18%	7.31%	66.67%	81.82%	15.15%	50.00%	88.24%	38.24%
17.	Marijuana smoking can improve your eyesight. (F)	86.96%	100.00%	13.04%	66.67%	81.82%	15.15%	85.00%	94.12%	9.12%

Anti-drug knowledge summary score (higher % is preferred):	**54.52%**	**66.08%**	**+11.57%**	**71.79%**	**67.83%**	**-3.96%**	**57.31%**	**69.68%**	**+12.38%**

Section B: Knowledge measures (Life skills)

"To create a **life skills knowledge summary score**, add up the number of items (out of items 8 – 11, 18 – 32) that are answered correctly and divide by 19 (the total number of life skills knowledge items). This number gives you the proportion of life skills knowledge items answered correctly." [2]

	Life skills knowledge items (Anderson)	6th grade (% correct)			7th grade (% correct)			8th grade (% correct)		
		PRE (N = 23)	POST (N = 23)	Change	PRE (N = 13)	POST (N = 13)	Change	PRE (N = 20)	POST (N = 20)	Change
8.	What we believe about ourselves affects the way we act or behave. (T)	82.61%	77.27%	-5.34%	100%	100%	0.00%	85.00%	88.24%	3.24%
9.	It is almost impossible to develop a more positive self-image. (F)	52.17%	68.18%	16.01%	50.00%	54.55%	4.55%	70.00%	70.59%	0.59%
10.	It is important to measure how far you have come toward reaching your goal. (T)	86.96%	95.45%	8.50%	83.33%	100%	16.67%	90.00%	94.12%	4.12%
11.	It's a good idea to make a decision and then think about the consequences later. (F)	69.57%	72.73%	3.16%	66.67%	72.73%	6.06%	70.00%	82.35%	12.35%
18.	Some advertisers are deliberately deceptive. (T)	56.52%	77.27%	20.75%	66.67%	81.82%	15.15%	70.00%	70.59%	0.59%
19.	Companies advertise only because they want you to have all the facts about their products. (F)	56.52%	77.27%	20.75%	50.00%	45.45%	-4.55%	65.00%	70.59%	5.59%
20.	It's a good idea to get all information about a product from its ads. (F)	60.87%	59.09%	-1.78%	66.67%	72.73%	6.06%	35.00%	47.06%	12.06%
21.	Most people do not experience anxiety. (F)	56.52%	77.27%	20.75%	83.33%	81.82%	-1.52%	80.00%	88.24%	8.24%
22.	There is very little you can do when you feel anxious. (F)	30.43%	50.00%	19.57%	66.67%	54.55%	-12.12%	55.00%	76.47%	21.47%
23.	Deep breathing is one way to lessen anxiety. (T)	73.91%	81.82%	7.91%	66.67%	100%	33.33%	95.00%	100%	5.00%
24.	Mental rehearsal is a poor relaxation technique. (F)	73.91%	77.27%	3.36%	66.67%	72.73%	6.06%	85.00%	88.24%	3.24%
25.	You can avoid misunderstandings by assuming the other person knows what you mean. (F)	65.22%	72.73%	7.51%	66.67%	81.82%	15.15%	75.00%	76.47%	1.47%
26.	Effective communication is when both sender and receiver interpret a message in the same way. (T)	73.91%	68.18%	-5.73%	100%	63.64%	-36.36%	65.00%	94.12%	29.12%
27.	Relaxation techniques are of no use when meeting people. (F)	52.17%	77.27%	25.10%	66.67%	72.73%	6.06%	65.00%	94.12%	29.12%
28.	A compliment is more effective when it is said sincerely. (T)	78.26%	81.82%	3.56%	83.33%	100%	16.67%	85.00%	94.12%	9.12%
29.	A nice way of ending a conversation is to tell the person you enjoyed talking with him or her. (T)	78.26%	90.91%	12.65%	66.67%	100%	33.33%	95.00%	94.12%	-0.88%
30.	Sense of humor is an example of a non-physical attribute. (T)	52.17%	72.73%	20.55%	66.67%	63.64%	-3.03%	40.00%	58.82%	18.82%
31.	It's better to be polite and lead someone on, even if you don't want to go out with them. (F)	39.13%	59.09%	19.96%	50.00%	63.64%	13.64%	45.00%	88.24%	43.24%
32.	Almost all people who are assertive are either rude or hostile. (F)	65.22%	72.73%	7.51%	50.00%	72.73%	22.73%	70.00%	82.35%	12.35%
	Life skills knowledge summary score (higher % is preferred):	**63.39%**	**74.16%**	**+10.78%**	**69.30%**	**76.56%**	**+7.26%**	**70.53%**	**82.04%**	**+11.52%**

"To create an **anti-drug attitudes summary score**, calculate the mean of all 8 items (C1 to C8). To create an anti-smoking attitudes summary score, calculate the mean of items C2, C4, C6, and C7. To create an anti-drinking attitudes summary score, calculate the mean of items C1, C3, C5, and C8. Higher scores indicate stronger attitudes against smoking and drinking." [2]

	Anti-drug attitudes (Anderson)	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	6th grade		7th grade		8th grade	
							PRE (N = 23)	POST (N = 23)	PRE (N = 13)	POST (N = 13)	PRE (N = 20)	POST (N = 20)
1.	Kids who drink alcohol are more grown-up.	①	②	③	④	⑤	4.87	4.91	4.00	4.73	4.55	4.71
2.	Smoking cigarettes makes you look cool.	①	②	③	④	⑤	4.91	4.95	4.20	4.64	4.85	4.82
3.	Kids who drink alcohol have more friends.	①	②	③	④	⑤	4.83	4.68	4.00	4.09	3.85	4.00
4.	Kids who smoke have more friends.	①	②	③	④	⑤	4.74	4.68	3.60	3.73	3.80	4.00
5.	Drinking alcohol makes you look cool.	①	②	③	④	⑤	4.83	4.95	4.80	4.64	4.80	4.76
6.	Smoking cigarettes lets you have more fun.	①	②	③	④	⑤	4.91	4.77	3.80	4.64	4.45	4.71
7.	Kids who smoke cigarettes are more grown-up.	①	②	③	④	⑤	4.87	4.95	4.00	4.64	4.50	4.71
8.	Drinking alcohol lets you have more fun.	①	②	③	④	⑤	4.70	4.73	3.60	4.09	4.40	4.47
	Anti-drinking attitudes score (scores range from 1 to 5, scores closest to 5 are preferred):						**4.80**	**4.82**	**4.10**	**4.39**	**4.40**	**4.49**
	Anti-smoking attitudes score (scores range from 1 to 5, scores closest to 5 are preferred):						**4.86**	**4.84**	**3.90**	**4.41**	**4.40**	**4.56**
	Anti-drug attitudes summary score (scores range from 1 to 5, scores closest to 5 are preferred):						**4.83**	**4.83**	**4.00**	**4.40**	**4.40**	**4.52**

Life skills (Anderson)		Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	6th grade		7th grade		8th grade	
							PRE (N = 23)	POST (N = 23)	PRE (N = 13)	POST (N = 13)	PRE (N = 20)	POST (N = 20)
I would say NO if someone tried to get me to:												
1.	Smoke a cigarette. ***[Lower scores preferred]***	①	②	③	④	⑤	3.22	2.38	3.20	2.00	2.58	2.24
2.	Drink beer, wine, or liquor. ***[Lower scores preferred]***	①	②	③	④	⑤	3.22	2.38	2.80	1.91	2.68	2.06
3.	Smoke marijuana or hashish. ***[Lower scores preferred]***	①	②	③	④	⑤	3.17	2.38	3.40	1.91	2.68	2.18
4.	Use cocaine or other drugs. ***[Lower scores preferred]***	①	②	③	④	⑤	3.09	2.33	3.60	2.00	2.63	2.24
5.	Use a prescription drug that was prescribed for someone else. ***[Lower scores preferred]***	①	②	③	④	⑤	3.17	2.38	3.80	2.09	2.68	2.18
6.	Vape or smoke an e-cigarette ***[Lower scores preferred]***	①	②	③	④	⑤	3.17	2.38	3.00	2.00	2.47	2.29
Drug refusal skill [2]*(Scores for Q's. 1-6 are averaged then subtracted from 6 to invert them - **higher scores are preferred**):*							**2.83**	**3.63**	**2.7**	**4.02**	**3.38**	**3.80**
I would:												
7.	Tell someone if they gave me less change (money) than I was supposed to get back after paying for something. ***[Lower scores preferred]***	①	②	③	④	⑤	2.70	2.24	2.40	2.55	2.42	1.76
8.	Say "no" to someone who asks to borrow money from me. ***[Lower scores preferred]***	①	②	③	④	⑤	3.13	2.29	3.00	2.82	2.53	2.71
9.	Tell someone to go to the end of the line if they try to cut ahead of me. ***[Lower scores preferred]***	①	②	③	④	⑤	2.57	2.29	2.80	2.64	2.26	2.18
Assertiveness skills [2]*(Scores for Q's. 7-9 are averaged then subtracted from 6 to invert them - **higher scores are preferred**):*							**3.20**	**3.73**	**3.27**	**3.33**	**3.60**	**3.78**
In order to cope with stress or anxiety, I would:												
10.	Relax all the muscles in my body, starting with my feet and legs. ***[Lower scores preferred]***	①	②	③	④	⑤	2.48	2.38	3.00	2.18	1.89	2.18
11.	Breathe in slowly for a count of four, then hold my breath in for a count of four, and slowly exhale for a count of four. ***[Lower scores preferred]***	①	②	③	④	⑤	2.30	2.10	2.00	1.91	1.68	2.12
Relaxation skills [2]*(Scores for Q's 10 & 11 are averaged then subtracted from 6 to invert them - **higher scores are preferred**):*							**3.61**	**3.76**	**3.85**	**3.95**	**4.21**	**3.85**
In general:												
12.	If I find that something is really difficult, I get frustrated and quit. **[Higher scores preferred]**	①	②	③	④	⑤	2.91	2.76	3	2.73	3.37	3.65
13.	I stick to what I'm doing until I'm finished with it. ***[Lower scores preferred]***	①	②	③	④	⑤	2.22	2.52	2.25	2.82	2.16	2.00
Self-Control Skills [2]*(Score for Q. 13 is subtracted from 6 to invert it then averaged with Q. 12 – **higher scores are preferred**):*							**3.35**	**3.12**	**3.38**	**2.95**	**3.61**	**3.82**

Botvin LifeSkills Training
Evidence-Based Prevention Programs for Schools, Families, and Communities

References

(1.) "MHSA Docs | Shasta MHSA". *Shastamhsa.com*, 2020, http://shastamhsa.com/site/assets/files/1151/brief-lst-ms-survey-september_2018.pdf.

(2.) "MHSA Docs | Shasta MHSA". *Shastamhsa.com*, 2020, http://shastamhsa.com/site/assets/files/1151/lifeskills-training-middle-school-survey-instructions-revised-9-7-18.pdf.

Shasta County
Health & Human
Services Agency

Stigma & Discrimination Reduction activities

Fiscal Year 2019-2020

Stigma and Discrimination Reduction activities are performed by the Stand Against Stigma workgroup and as well as other volunteers. The goal of the various activities is to reduce the negative perceptions surrounding mental illness through trainings, social media campaigns, speaking engagements, outreach exhibits, events, and more. In each quarter, from July 2019 to June 2020, the Stigma and Discrimination Reduction activities were as follows:

Quarter 1 (July – September 2019)

Speaking Engagements:

Date	Brave Faces Advocate(s)	Presentation Type	Organizer	Location	Reach
07/23/2019	Aiden Mares, Emalee Mims and David Wharton	Formal	Simpson College Human Sexuality Class	Simpson College Library	8
07/26/2019	Denise Green and Jullie Calkins	Destig Intro and Discussion	Adult Services Outpatient Staff	Adult Services	20
08/21/2019	Denise Green	Destig Intro and Discussion	One Safe Place Staff	One Safe Place	15
08/24/2019	Mike Skondin and Cherish Padro	Speaking Engagment at Event	Lotus Educational Services, Stand Against Stigma and Suicide Prevention	Old City Hall`	37
08/26/2019	Denise Green	Destig Intro and Discussion	Olberg Wellness Center	Olberg Wellness Center	15
09/23/2019	Josie Englin	Formal	One Safe Place DV/SA Class	One Safe Place	11

Events:

Date	Brave Faces Advocate(s)	Event	Organizer	Location	Attendance
08/24/2019	Mike Skondin and Cherish Padro	S Word Screening & Hope Is Alive! Open Mic	Lotus Educational Services, Stand Against Stigma and Suicide Prevention	Old City Hall`	37
09/29/2019	Mike Skondin, Jullie Calkins and Crystal Johnson	Recovery Happens	Community Collaboration	Lake Redding Park Gazebo	500

Trainings:

Date	Facilitator	Event	Location	Attendees	Graduates
08/17/2019	Emalee Mims and Jullie Calkins	Becoming Brave Training	Stand Against Stigma	Boggs	10

Gallery:

Date	Portraits	Install or Publish	Location	Approx Reach
08/06/2019	David Wharton	Website and Facebook	Online	591

Outreach exhibits:

Date	HHSA Staff / Volunteer(s)	Event	Organizer	Location	Attendees Engaged
07/12/2019	Carrie Jo Diamond	Good Medicine Health Fair	Pitt River Tribe	Burney	200
07/27/2019	Carrie Jo Diamond	Plugging In and Powering Up Wildfire Survivior Resource Fair	Cal HOPE Shasta	City Hall Community Room	100
08/07/2019	Carrie Jo Diamond	Redding Rancheria Health Fair	Redding Rancheria	Win River	100
08/28/2019	Carrie Jo Diamond	Shasta College Welcome Day	Shasta College	Shasta College Quad	200
09/05/2019	Carrie Jo Diamond	Shasta College Health and Safety Fair	Shasta College	Shasta College Quad	50
09/12/2019	Carrie Jo Diamond	Written Off	Dignity Health	Casade Theatre	100

Quarter 2 (October – December 2019)

Speaking Engagements:

Date	Brave Faces Advocate(s)	Presentation Type	Organizer	Location	Reach
10/11/2019	Mike Skondin and Jullie Calkins	Formal	ACEs Learning Community	First 5 Shasta	8
10/16/2019	David Wharton and Aiden Mares	Speaking Engagment at Event	All Things [Not] Being Equal	Shasta College	30
11/13/2019	David Martinez and Mike Skondin	Formal	Institute of Techonology	IOT	Not recorded

11/15/2019	Aiden Mares	Formal	MHSA Academy	Shasta Lake Regional Services Office	Not recorded
12/10/2019	Jullie Calkins, Cherish Padro, David Matinez, Matt Sprenger	Formal	National University Case Management Class	National University	Not recorded

Events:

Date	Brave Faces Advocate(s)	Event	Organizer	Location	Attendance
11/01/2019	Jullie Calkins	Hope Is Alive! Open Mic (AFTA)	Stand Against Stigma/ART from the ashes	Old City Hall	Not recorded

Trainings:

Date	Facilitator	Event	Location	Attendees	Graduates
11/16/2019	Josie Englin and Aiden Mares	Becoming Brave	Boggs	Not recorded	12

Quarter 3 (January – March 2020)

Speaking Engagements:

Date	Brave Faces Advocate(s)	Presentation Type	Organization	Location	Reach
01/14/2020	Josie Englin*	Destig Intro and Discussion	Stand Against Stigma	CARE Center	Not recorded
02/27/2020	Mike Skondin, Jullie Calkins, David Wharton	Formal	Dignity Health Connected Living	Dignity Health Connected Living	Not recorded

Outreach exhibits:

Date	HHSA Staff / Volunteer(s)	Event	Organizer	Location	Attendees Engaged
01/04/2020	Christopher Diamond	Redding Health Expo	Redding Health Expo	Redding Civic Center	500
Not recorded	Christopher Diamond	Dr. Lake Anti-bullying Presentation	Beloved Community	Shasta College	75

Quarter 4 (April – June 2020)

Speaking engagements:

Date	Brave Faces Advocate(s)	Presentation Type	Organization	Location	Reach
04/30/2020	Jullie Calkins	Informal	One Safe Place	Zoom Meeting	Not recorded

Events and outreach activities for April-June were cancelled due to COVID-19.

Shasta County
Health & Human
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Brave Faces: Pre/Post Survey Analysis

Results for Fiscal Year 2019/2020

Brave Faces is a part of Shasta County's Stigma and Discrimination Reduction project

Introduction

"Brave Faces" is an event where a person who has experienced a serious mental illness shares their story with others to promote recovery, hope, and wellness. At the event, viewers are given surveys to assess their attitudes towards mental illness before and after listening to the Brave Faces speaker. The purpose of this analysis is to explore any changes in the attitudes participants had towards mental illness before and after viewing the presentation using their pre-/post-surveys.

Survey Tool

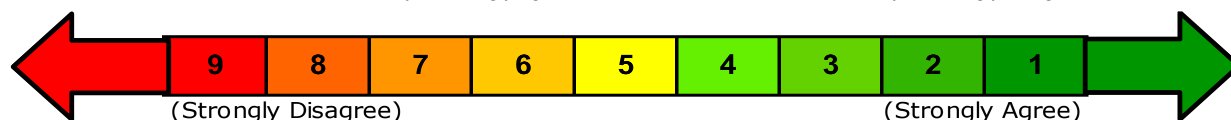
The survey listed 18 statements about mental illness and the participant was instructed to indicate how strongly they agreed or disagreed with each statement using a Likert Scale from 1-9 where selecting "1" meant "strongly agree" and selecting "9" meant "strongly disagree."

Statements on the survey were divided into four subjects: Attitudes towards a character with a serious mental illness (7 statements), their overall opinion about people with mental illness (2 statements), their overall perspective on the value of people with mental illness (3 statements), and their willingness to seek help if they themselves became mentally ill (6 statements). The survey also collected demographic information on the respondent such as their age, gender, level of education, race, sexual orientation, and employment status. Their completed pre/post-surveys were collected to assess any changes in attitudes. This analysis looks at the change in pre-/post-survey scores during Fiscal Year 2019/2020.

Analysis

Statistically significant differences between the pre-and post-score averages for each survey statement were assessed using a paired t-test at a 95% confidence interval. This analysis excluded participants who were missing either a pre- or post-survey. If post-survey scores moved closer to the "1" side of the Likert Scale, this means that participants, on average, agreed more strongly than before. Stronger agreement represents an increasingly positive attitude towards those who have mental illnesses. Results for Fiscal Year 2019/2020 are shown on the next page.

On a scale from 1-9, select "1" if you strongly agree with the statement and select "9" if you strongly disagree with the statement



Fiscal Year 19/20

Harry's story	Average Score PRE	Average Score POST	Change	Statistically significant change? (95% confidence)	P Value	N
I would be friends with Harry.	3.9	3.1	0.80	✓	0.0004	40
Harry would be successful at his job.	4.4	3.2	1.23	✓	0.0000	40
If I had a problem, I'd ask for Harry's opinion.	4.8	3.4	1.33	✓	0.0000	40
If Harry said he needed someone to talk to, I would listen.	2.5	2.0	0.55	✓	0.0001	40
I would think Harry is a part of my community.	2.5	2.1	0.38	✓	0.0101	40
Harry's hospitalizations are going to help him get better.	3.5	3.0	0.53	✓	0.0054	40
It's encouraging that Harry is taking his medications.	2.4	2.1	0.33	✓	0.0397	40

Overall Opinion about people with mental illness	Average Score PRE	Average Score POST	Change	Statistically significant change? (95% confidence)	P Value	N
People with mental illness have goals in life they want to reach.	1.7	1.7	-0.03	⃠	0.5941	40
Coping with mental illness is not the main focus of the lives of people with mental illness.	4.2	3.3	0.93	✓	0.0074	40

Overall Perspective on the Value of People with Mental Illness	Average Score PRE	Average Score POST	Change	Statistically significant change? (95% confidence)	P Value	N
I feel people with mental illness are persons of worth.	1.6	1.7	-0.08	⃠	0.7939	40
I see people with mental illness as capable people.	1.9	1.8	0.10	⃠	0.2559	40
People with mental illness are able to do things as well as most other people.	2.2	2.3	-0.10	⃠	0.6573	40

Willingness to seek help	Average Score PRE	Average Score POST	Change	Statistically significant change? (95% confidence)	P Value	N
I would speak to a primary care doctor if I were significantly anxious or depressed.	3.0	2.5	0.46	✓	0.0101	39
I would speak to a psychiatrist if I were significantly anxious or depressed.	3.4	2.7	0.72	✓	0.0017	39
I would speak to a counselor if I were significantly anxious or depressed.	2.1	1.9	0.23	✓	0.0053	39
I would speak to a minister or other clergy member if I were significantly anxious or depressed.	4.3	3.7	0.54	✓	0.0155	39
I would speak to a friend or family member if I were significantly anxious or depressed.	2.3	2.4	-0.11	⃠	0.7715	38
I would seek help from a peer support or self-help program if I were significantly anxious or depressed.	3.2	2.9	0.21	⃠	0.2416	39

Results and Conclusion

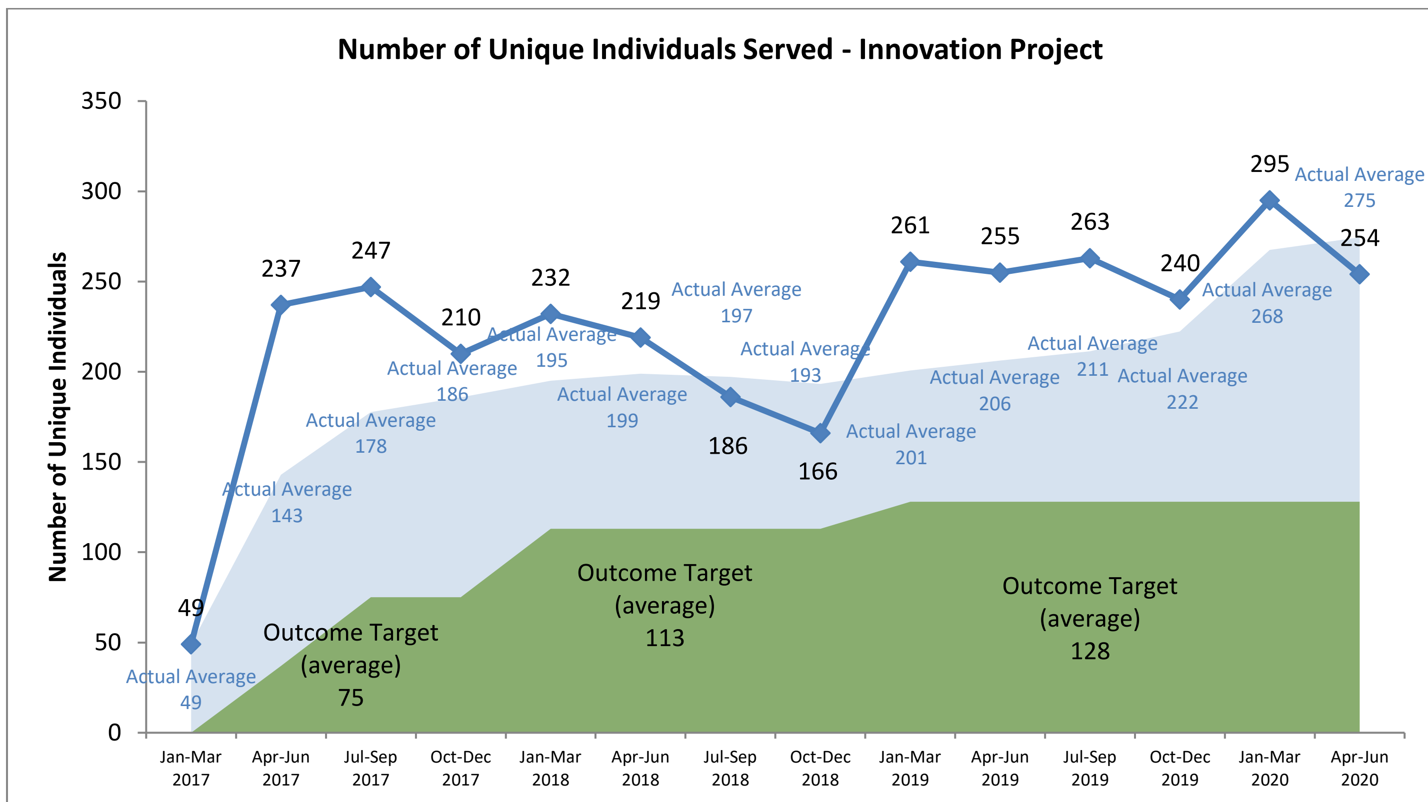
Participants' average pre-survey scores indicated agreement on all 18 statements. There were 12 statements that had statistically significant differences in average post-survey scores. The direction of those 12 differences all represented stronger agreement than before. The minimum number of responses received was 38. The number of responses received was lower compared to previous years due to the COVID-19 pandemic limiting gatherings and events.

These results indicate Brave Faces presentations during Fiscal Year 19/20 had a positive impact on their audience's attitudes towards mental illness. This presentation format seems effective and beneficial for stigma and discrimination reduction efforts and has been successful in changing people's attitudes towards mental illness.

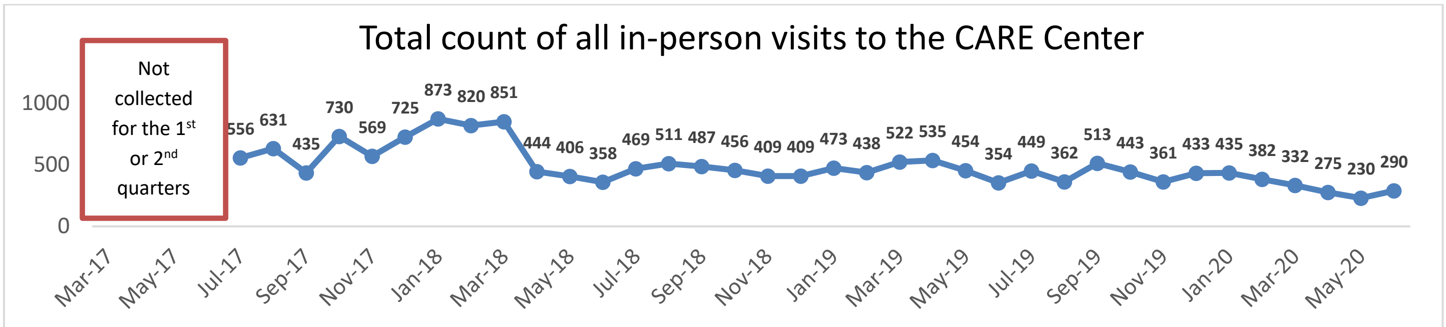
CARE Center Activity Report – Innovation Project
January 2017 through June 2020

To determine if providing access to mental health services after traditional office hours will improve access to services, reduce mental health crisis (including trips to the hospital emergency departments) and bridge service gaps, the Shasta County Health and Human Services Agency has contracted with Hill County Health and Wellness Center to provide new and expanded mental health services at the Counseling and Recovery Engagement (CARE) Center. Funding is provided through the Mental Health Services Act (MHSA) for the Innovation Project portion of this center. The CARE Center contract was approved as of January 2017, and they officially opened for business on March 12, 2017. For this report, data was gathered using the CARE Center Quarterly Progress Reports for January 2017 through June 2019. Please note that due to the CARE Center not actually opening for business until early March 2017, the first quarter reflects less than one month of data. Additionally, there are several measures where their data systems and/or electronic health record were in process, or where methodology changed, so they could not be tracked. As of the Oct-Dec 2017 quarter, all measures are now tracked and reported on, although further refinement of the data collection is still underway for some measures.

The outcome target numbers are for the CARE Center to serve an average of 75 unique individuals per quarter by the end of year one (12/31/17), 113 per quarter by the end of year two (12/31/18), and 128 per quarter by the middle of year three (6/30/19).



Due to much higher utilization of the Care Center than anticipated, the number of in-person visits per month are being tracked as of July 2017. Please note that most clients visit more than once - this is not an unduplicated person count. Refinement of the counting process occurred in the Apr-Jun 2018 quarter, with individuals visiting for meetings or standing workgroups being excluded, and all phone calls being tallied separately.



All demographics questions are optional, so each includes the category “Declined to State”.

AGE

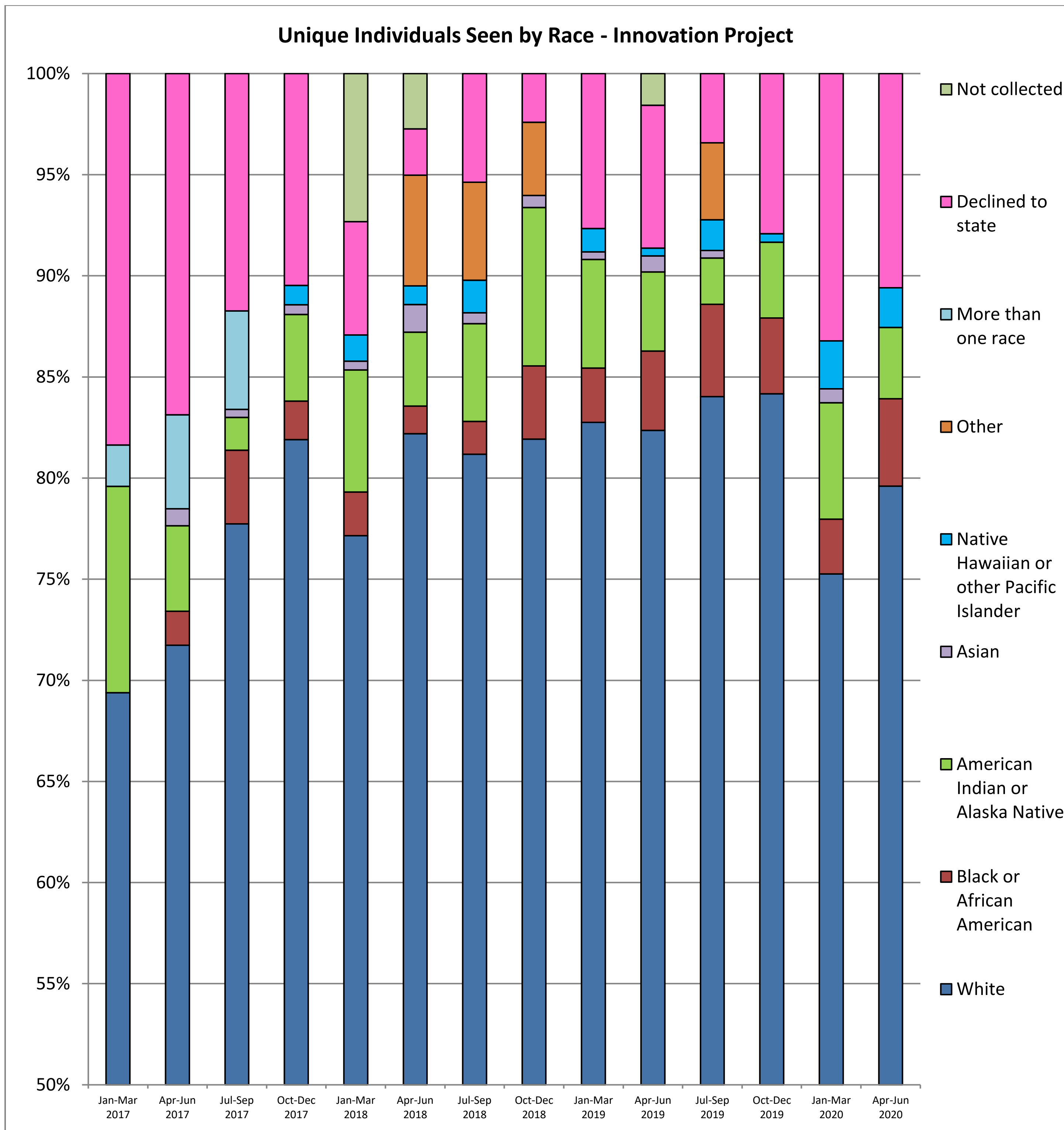
The MHSA uses four age categories: Youth – ages 0-15, Transition Age Youth – ages 16-25, Adult – ages 26-59, and Older Adult – ages 60 and up.

Unique Individuals Seen by MHSA Age Group - Innovation Project

Number of Unique Individuals	Jan-Mar 2017	Apr-Jun 2017	Jul-Sep 2017	Oct-Dec 2017	Jan-Mar 2018	Apr-Jun 2018	Jul-Sep 2018	Oct-Dec 2018	Jan-Mar 2019	Apr-Jun 2019	Jul-Sep 2019	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020
Youth	1	9	9	4	15	7	5	2	15	7	7	14	24	5
TAY	6	37	39	36	35	39	25	22	29	40	40	43	49	34
Adult	38	169	175	148	150	151	134	125	174	175	177	153	187	182
Older Adult	4	22	24	22	32	22	22	17	43	33	39	30	35	34
Declined to state														

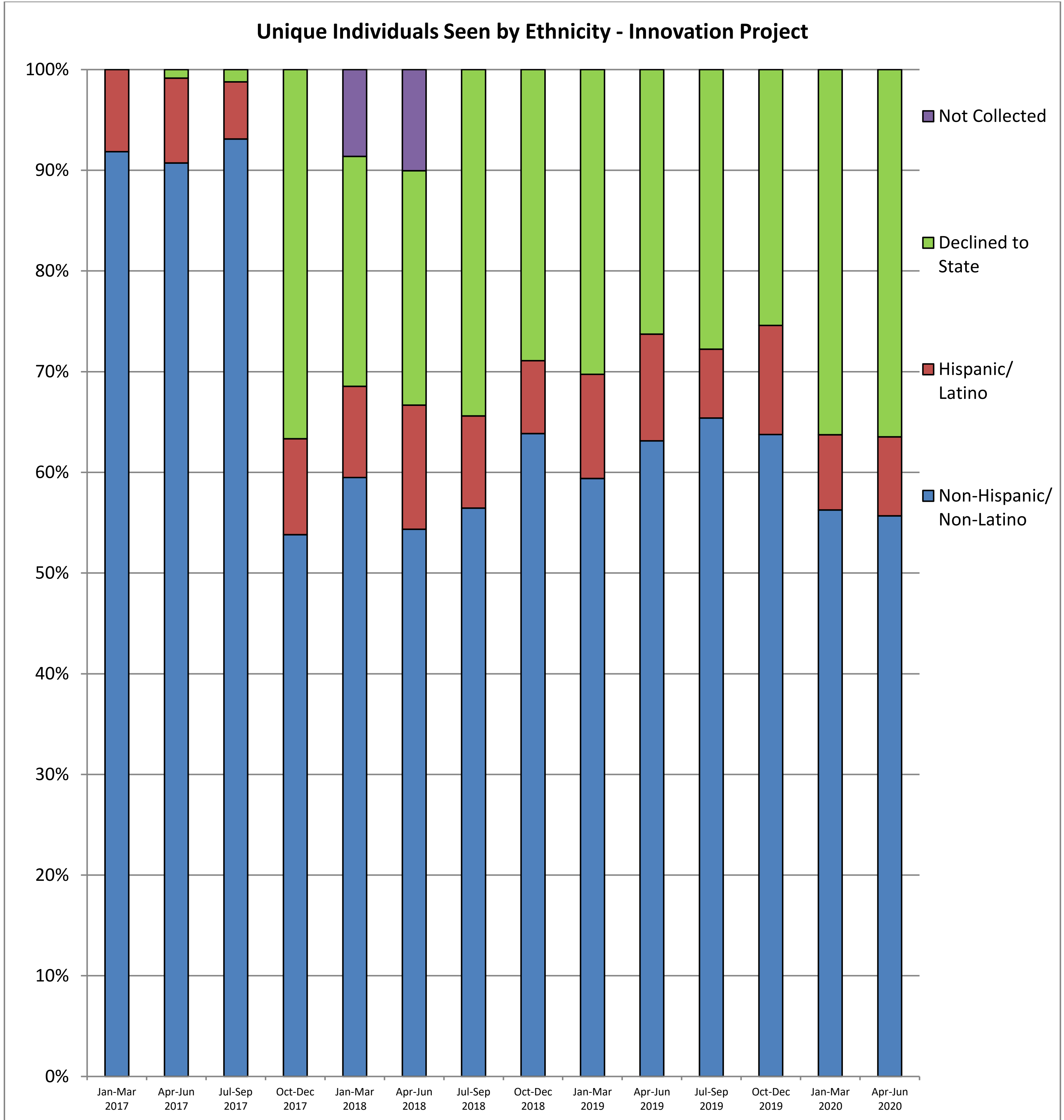
RACE

Because of the low gross numbers for some of these races, actual counts are not reported to help protect consumer confidentiality.



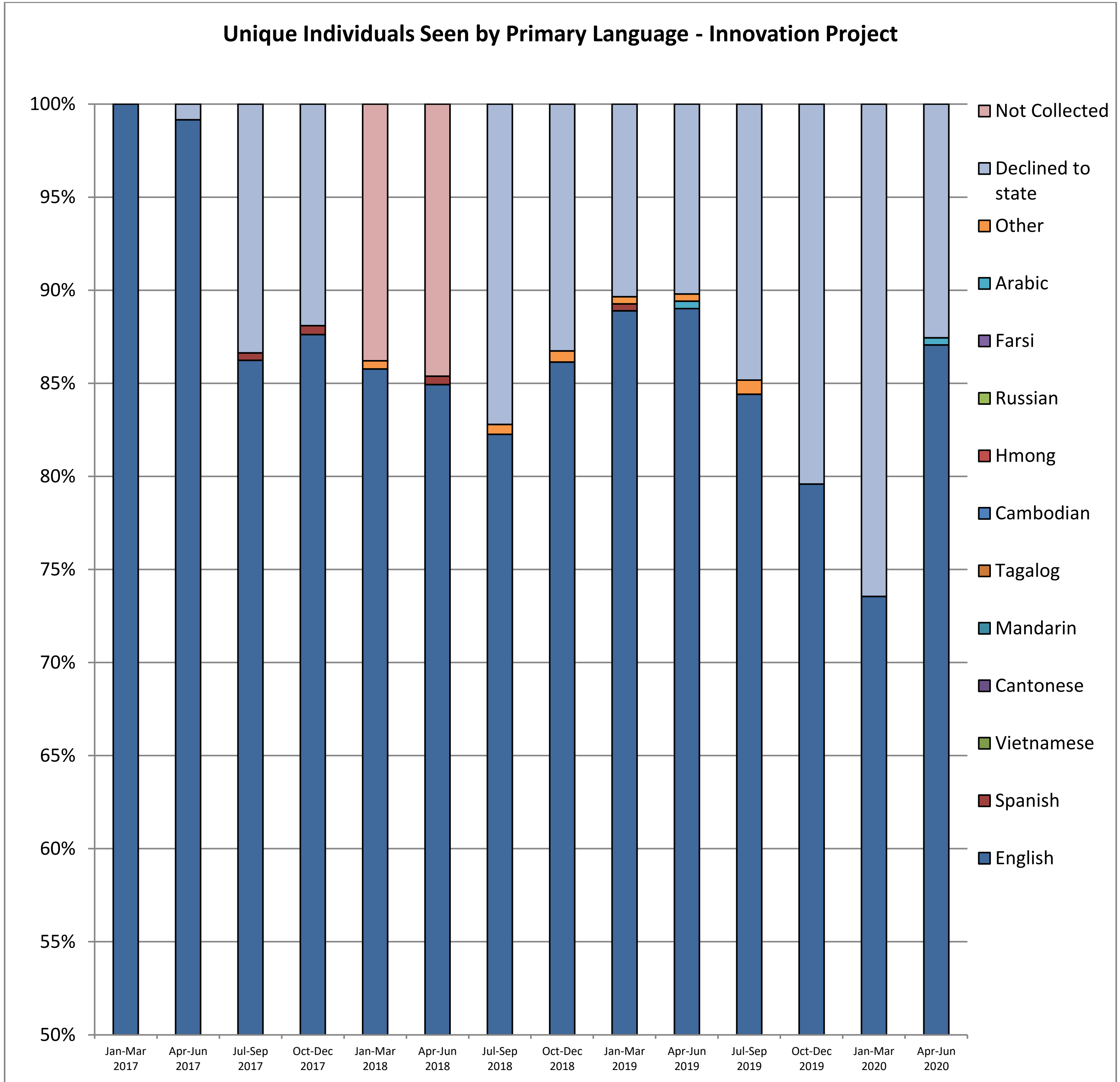
ETHNICITY

Because of the low gross numbers for some of these ethnicities, actual counts are not reported to help protect consumer confidentiality.

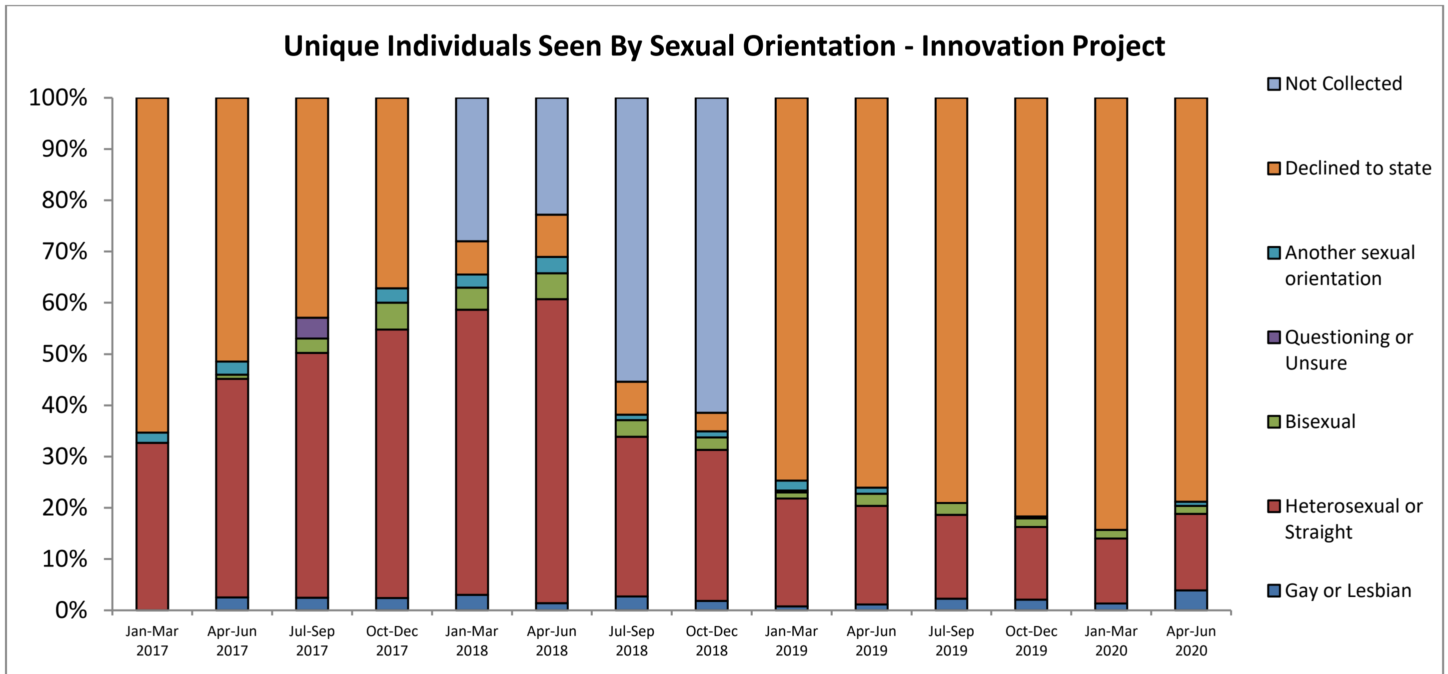


PRIMARY LANGUAGE

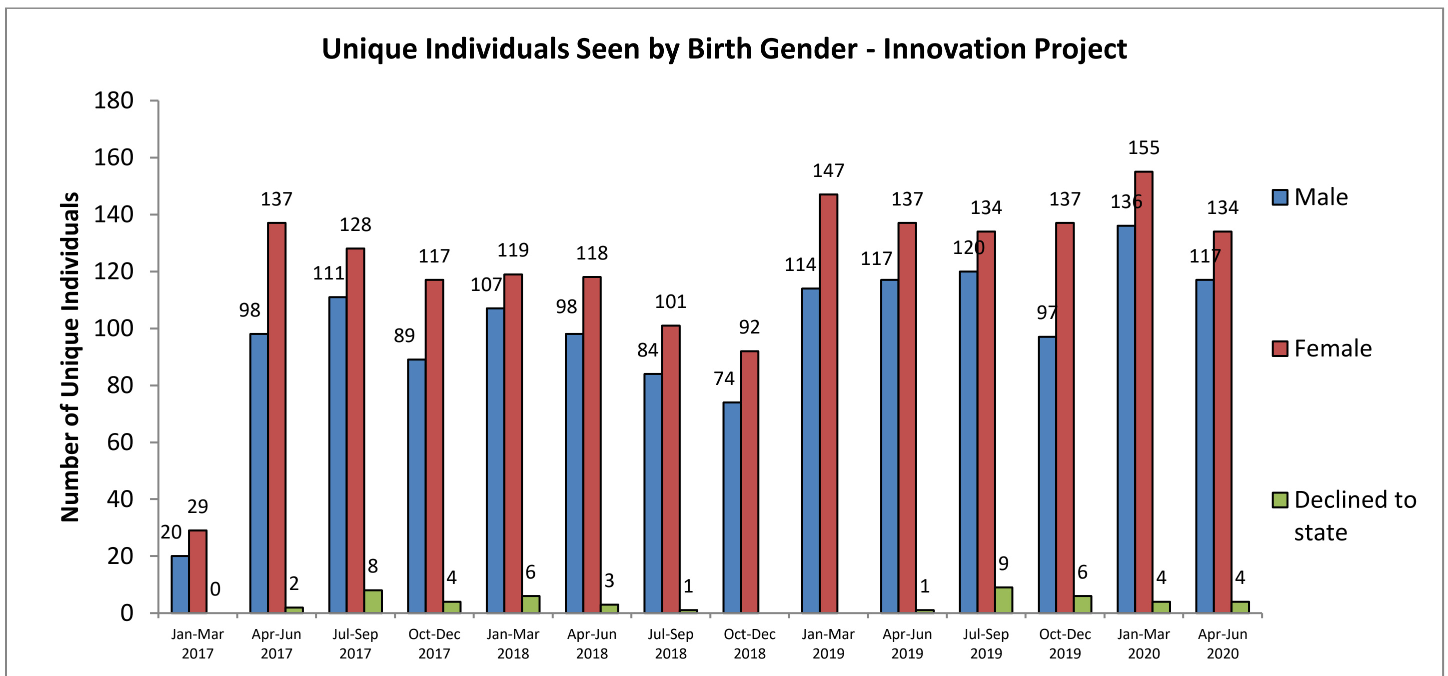
The primary language of consumers served by the CARE Center is English for nearly 100% of the people. Because of the low gross numbers for some reported languages, actual counts are not reported to help protect consumer confidentiality.



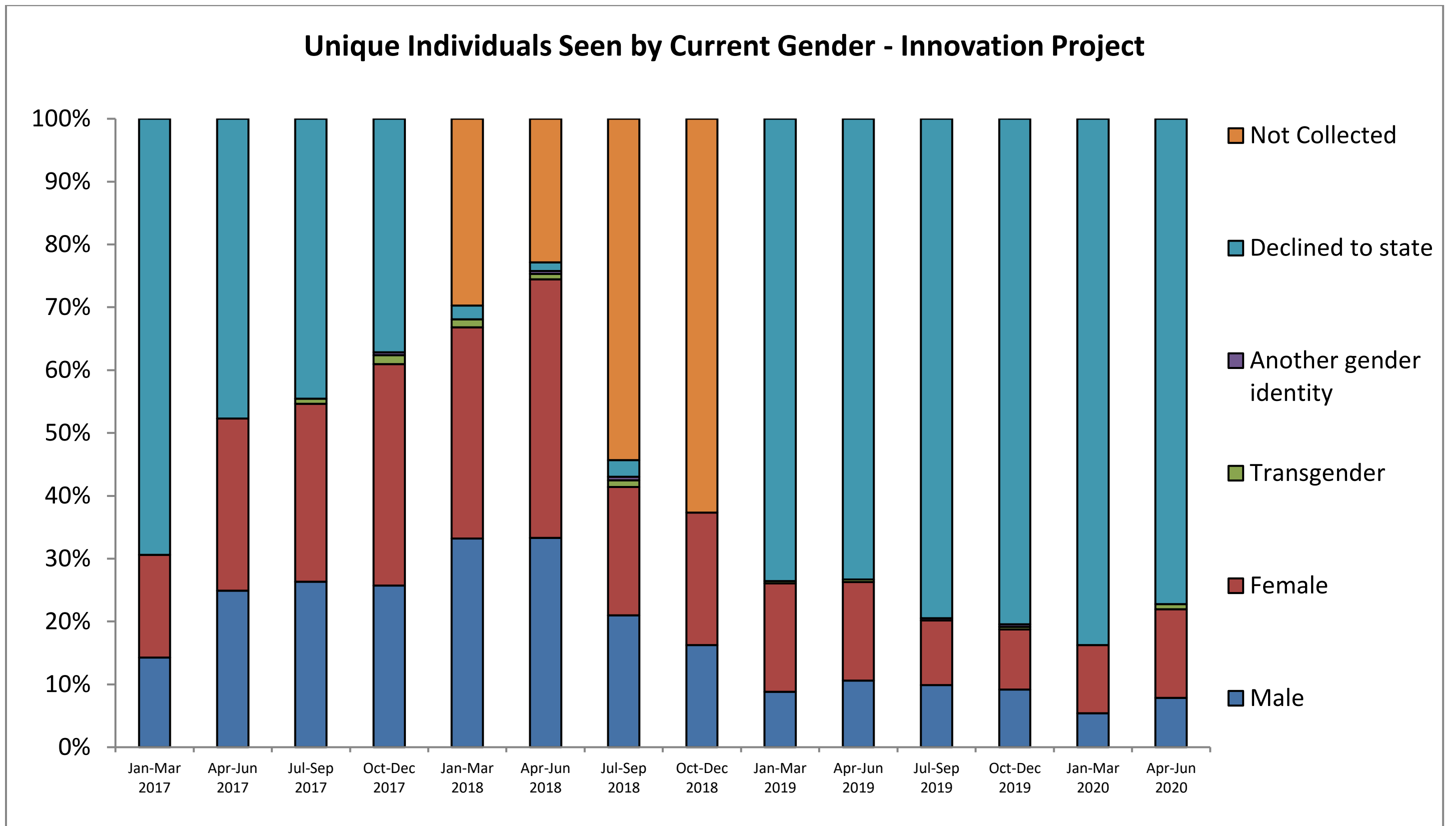
SEXUAL ORIENTATION



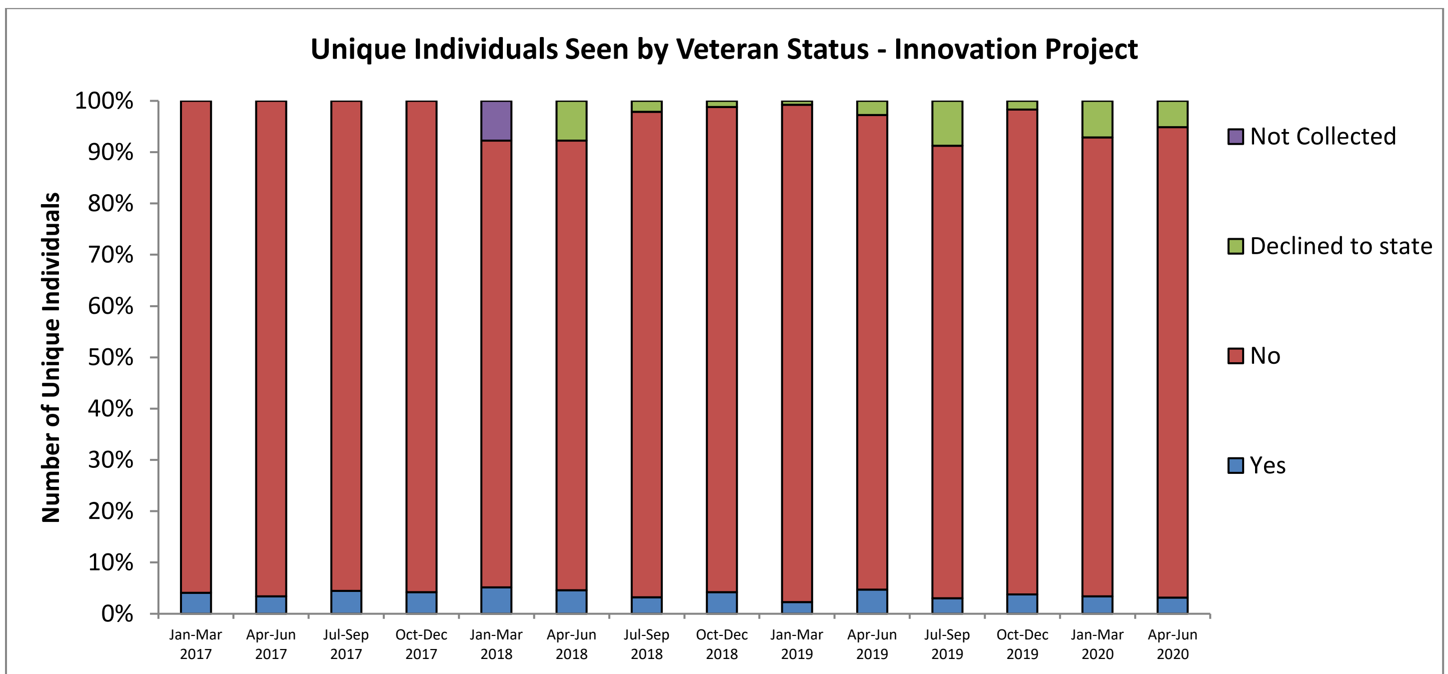
BIRTH GENDER



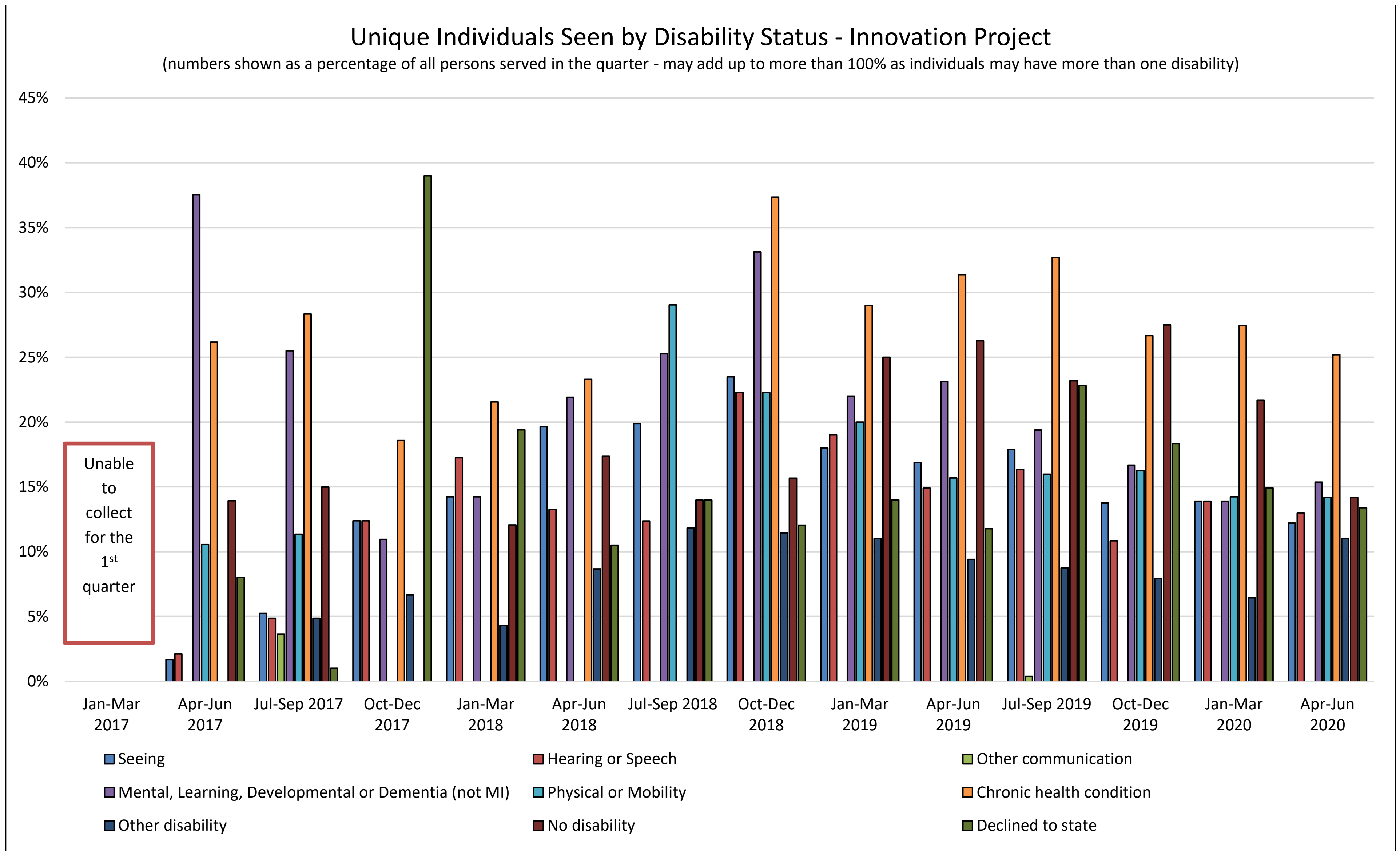
CURRENT GENDER



VETERAN STATUS



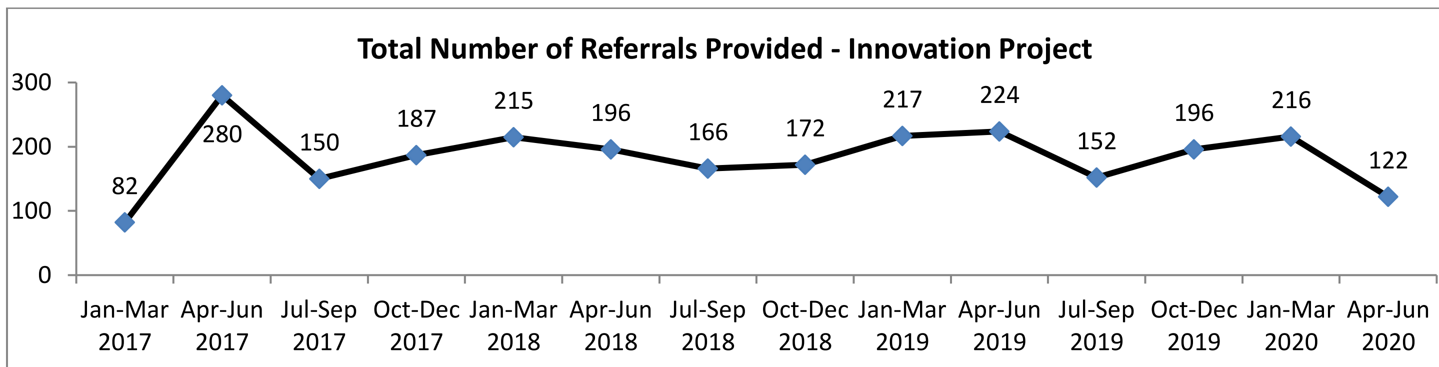
DISABILITY STATUS

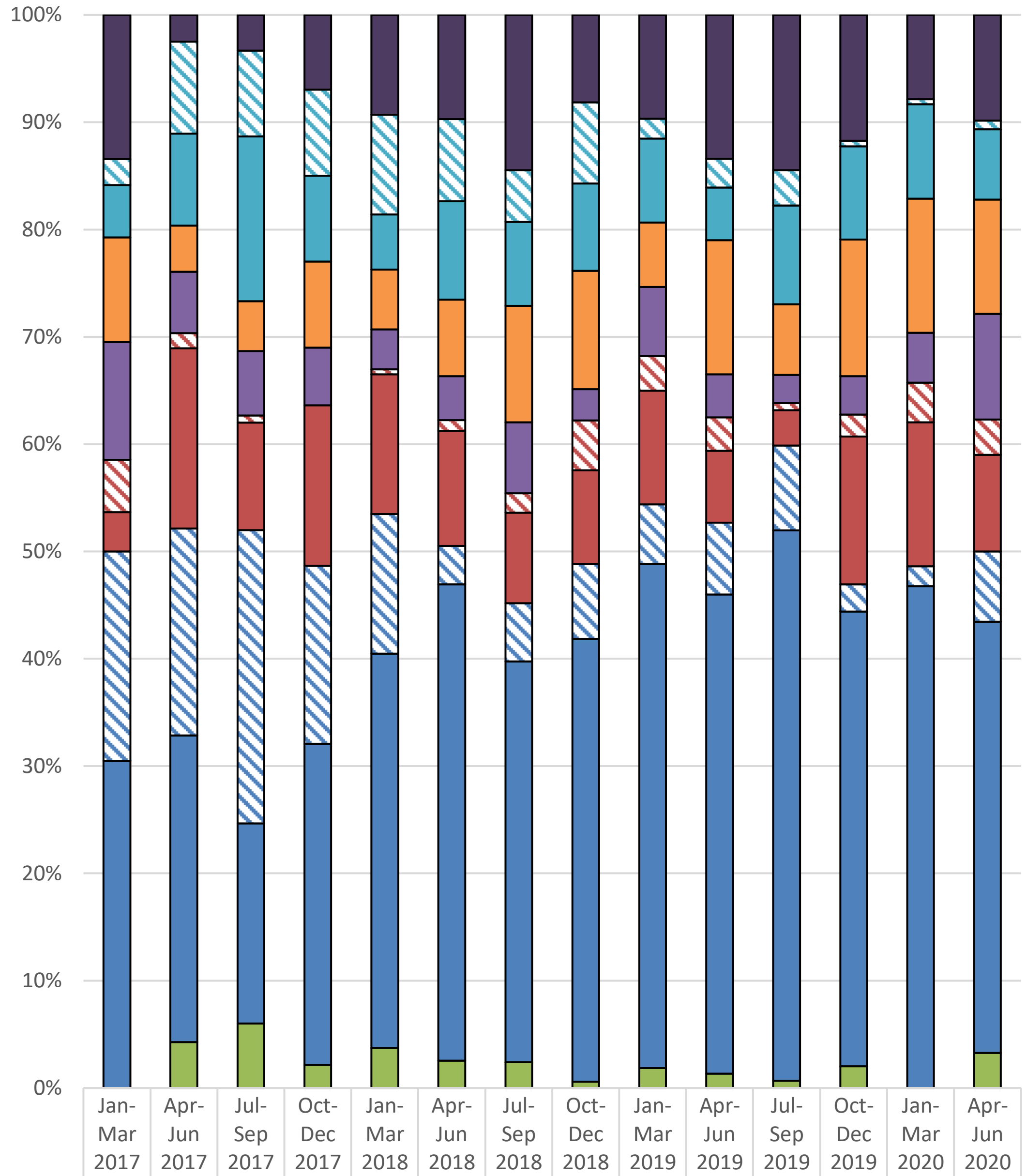


NUMBER OF OUTSIDE REFERRALS PROVIDED AND SUCCESSFULLY ACCESSED

There are many other departments and agencies to which individuals can be referred for items or services not directly provided by the CARE Center Innovation Project, and these are all reported to Shasta County in specific granular detail. For the purposes of this report, referrals have been categorized into 8 main types, and the reported numbers consolidated into these categories by external referrals and internal Hill Country referrals where applicable. The referral type categories are:

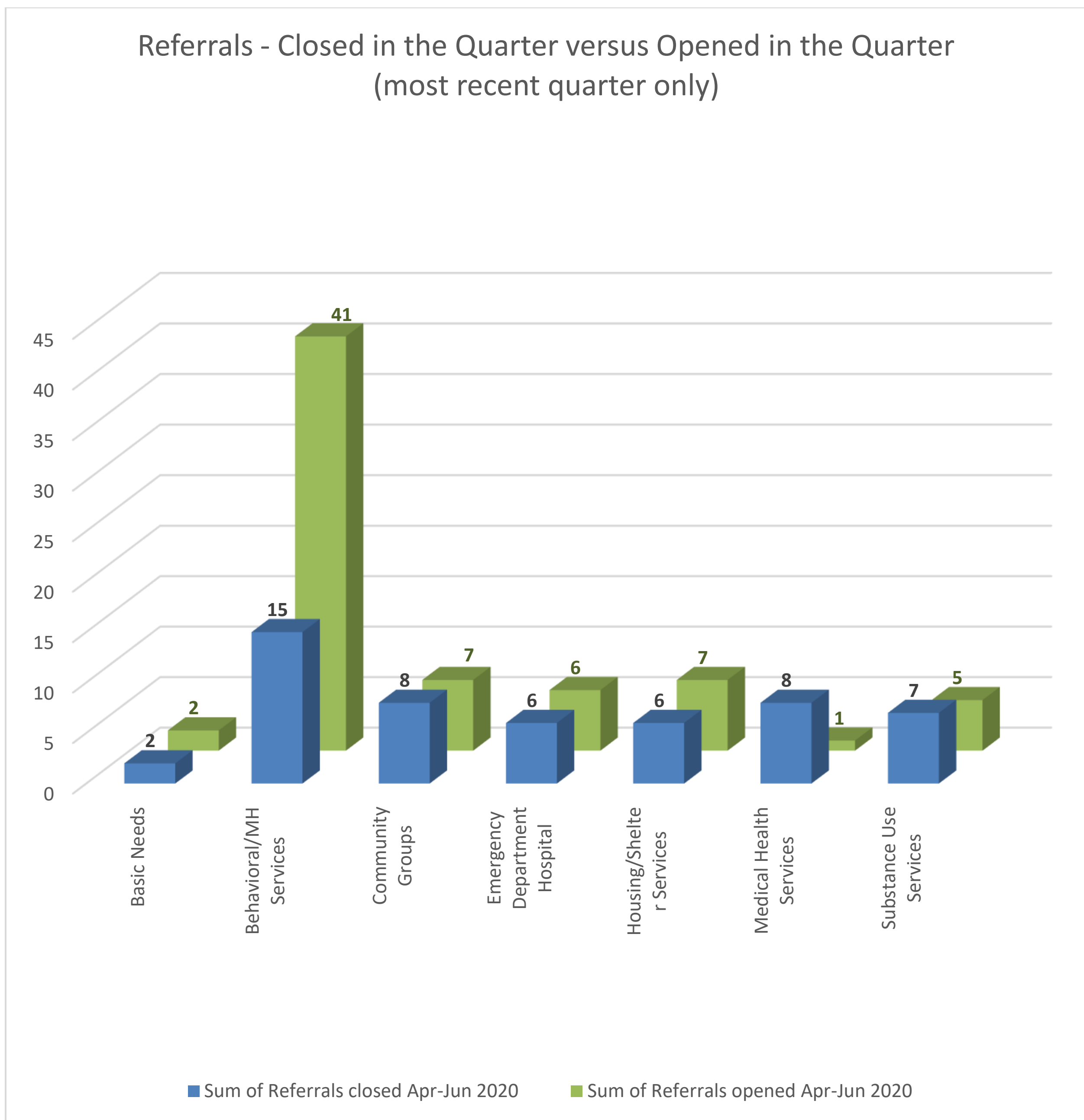
- “Basic Needs” which include referrals to:
  - Emergency clothing resources
  - Emergency food resources
  - Financial benefit application assistance
  - Health insurance application assistance (Medicare/Medi-Cal/etc.)
  - Transportation assistance
- “Behavioral/MH Services” which include referrals to:
  - Assisted Outpatient Treatment (AOT) program by Hill Country
  - Hill Country behavioral health services at various clinic locations
  - Mental health community services
  - Mental health county services
  - Specialty/psych health care services
  - Support group
  - Wellness and recovery
- “Community Groups” which include referrals to:
  - Community groups
  - Other external referrals
  - Other Hill Country referrals
- “Emergency Department Hospital”
- “Housing/Shelter Services”
- “Medical Health Services” which include referrals to:
  - Hill Country medical services at various clinic locations
  - Primary health care services
- “Substance Use Services” which include referrals to:
  - Medication-Assisted Treatment (MAT)
  - Substance Use Disorder (SUD) treatment





	Jan-Mar 2017	Apr-Jun 2017	Jul-Sep 2017	Oct-Dec 2017	Jan-Mar 2018	Apr-Jun 2018	Jul-Sep 2018	Oct-Dec 2018	Jan-Mar 2019	Apr-Jun 2019	Jul-Sep 2019	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020
Substance Use Services	11	7	5	13	20	19	24	14	21	30	22	23	17	12
Medical Health Services Hill Country	2	24	12	15	20	15	8	13	4	6	5	1	1	1
Medical Health Services External	4	24	23	15	11	18	13	14	17	11	14	17	19	8
Housing/Shelter Services	8	12	7	15	12	14	18	19	13	28	10	25	27	13
ED Hospital	9	16	9	10	8	8	11	5	14	9	4	7	10	12
Community Groups Hill Country	4	4	1	0	1	2	3	8	7	7	1	4	8	4
Community Groups External	3	47	15	28	28	21	14	15	23	15	5	27	29	11
Behavioral/MH Services Hill Country	16	54	41	31	28	7	9	12	12	15	12	5	4	8
Behavioral/MH Servivces External	25	80	28	56	79	87	62	71	102	100	78	83	101	49
Basic Needs	0	12	9	4	8	5	4	1	4	3	1	4	0	4

Referrals are also tracked to see if the individuals who are referred to services provided by entities other than the CARE Center are successful in completing the referral. Success is measured by the person being provided a warm hand-off, and getting connected to the new service provider. The CARE Center is not being held accountable for whether the person was granted the benefits or items they were referred for, as that is outside the CARE Center staff's control. To track this measure, the CARE Center is reporting on numbers of referrals closed in each quarter, compared to referrals opened. Please note that due to the timing of some referrals, they will not show as closed until a later quarter. Some referral categories may also reflect closed referrals that had been opened in a prior quarter.

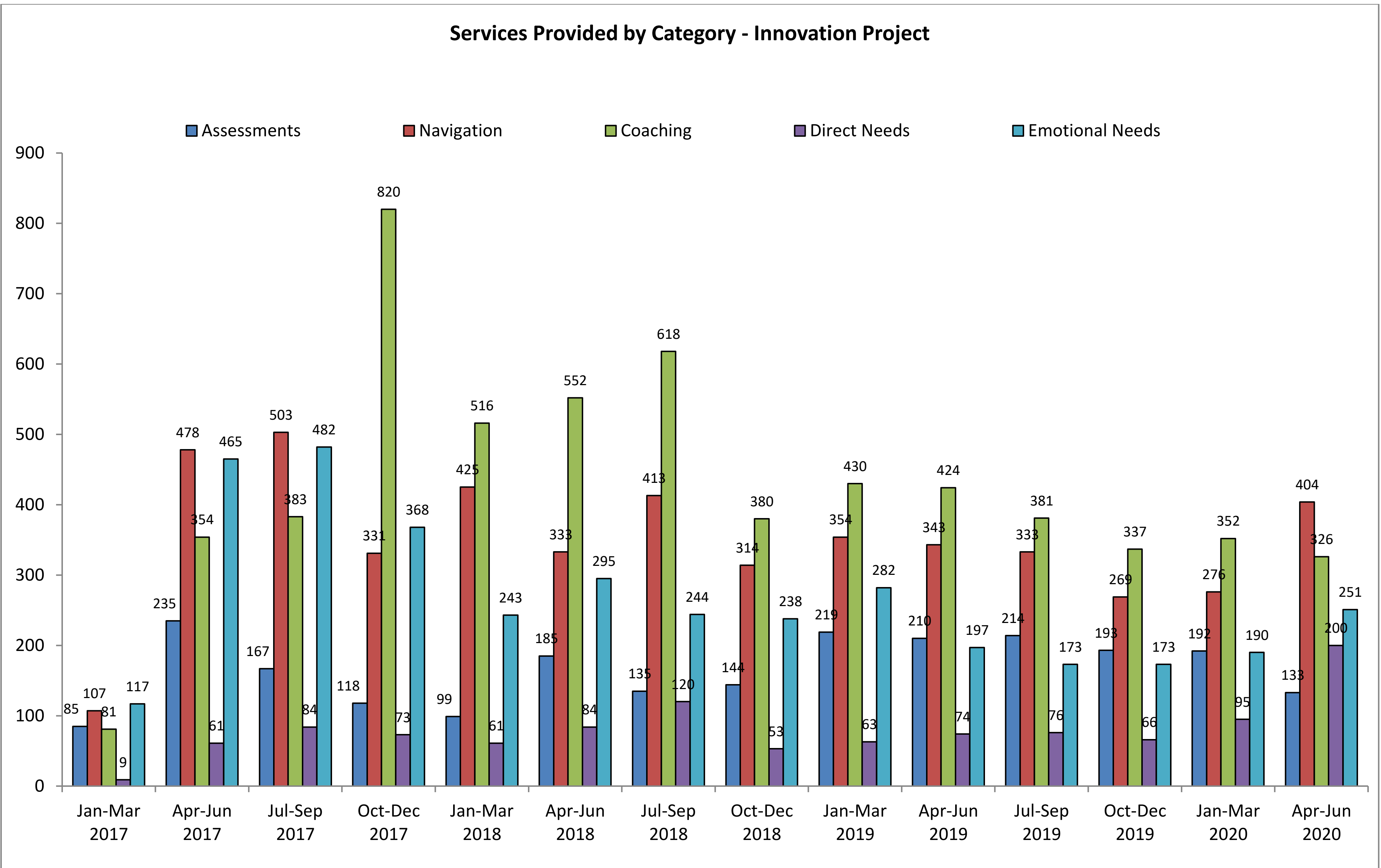


NUMBER OF SERVICES PROVIDED AND SUCCESSFULLY COMPLETED

Individuals can access a large number of services directly through the CARE Center Innovation Project, and these are all reported to Shasta County in specific granular detail. These services are provided directly by CARE Center staff members (including clinical staff, case managers, and peer volunteers). For the purposes of this report, services have been categorized into 5 main types, and the reported numbers consolidated. These service type categories are:

- "Assessments" which include
  - Mental health assessments
  - Needs assessments
  - Wellness and recovery assessments
- "Navigation" which includes
  - Advocacy
  - Navigation
  - Referral linkage and follow up
- "Coaching" which includes
  - Development of support systems
  - Goal and action planning
  - Skill building
  - Wellness coaching
- "Direct Needs" which include
  - Basic needs
  - Food/clothing
  - Medical care
  - Transportation
- "Emotional Needs" which include
  - Crisis intervention/emotional support
  - Mental health follow up
  - Social services

Services are also tracked to see if the individuals who are needing the service(s) provided by the CARE Center are successful in accessing the services, and either completing the activities or receiving any tangible items involved with each service. To date, all services have been reported as successful at 100%.


Services Provided by Category - Innovation Project
Assessments
Navigation
Coaching
Direct Needs
Emotional Needs
0
100
200
300
400
500
600
700
800
900
Jan-Mar 2017
Apr-Jun 2017
Jul-Sep 2017
Oct-Dec 2017
Jan-Mar 2018
Apr-Jun 2018
Jul-Sep 2018
Oct-Dec 2018
Jan-Mar 2019
Apr-Jun 2019
Jul-Sep 2019
Oct-Dec 2019
Jan-Mar 2020
Apr-Jun 2020
85 107 81 9 117
235 478 354 61 465
167 503 383 84 482
118 331 820 73 368
99 425 516 61 243
185 333 552 84 295
135 413 618 120 244
144 314 380 53 238
219 354 430 63 282
210 343 424 74 197
214 333 381 76 173
193 269 337 66 173
192 276 352 95 190
133 404 326 200 251

HOUSING STATUS

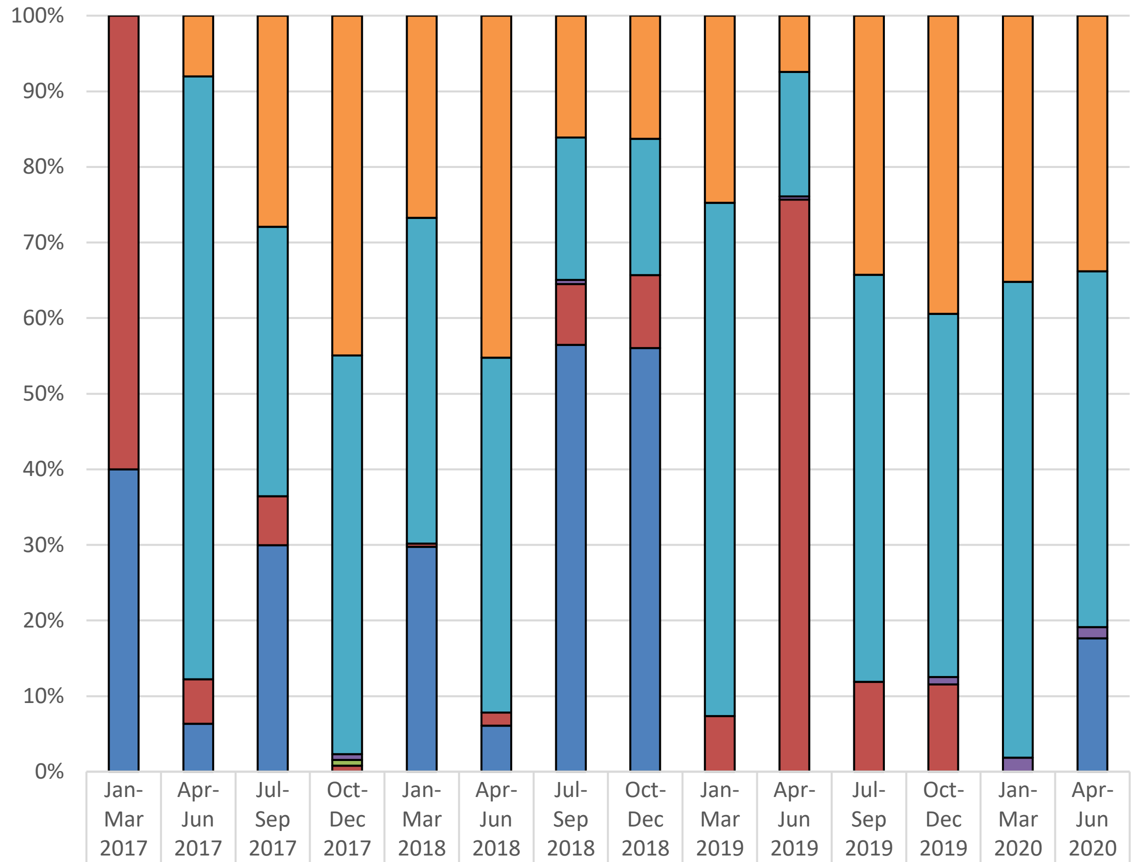
To help track the impact and effectiveness of services, the CARE Center has been asked to track the housing status of individuals accessing the Innovation Project services at the time they first start services, and then at the 3-month point after that first service. The target outcome numbers are to see a 15% increase in housing stability/permanence at the 3-month mark.

Housing status has been divided up into the following categories:

- Homeless/emergency shelter
- General living, which includes the following:
  - Apartment or house, alone or with family/roommates
  - Foster home
  - Single room occupancy
- Residential program, which includes the following:
  - Community treatment program
  - Group home (any level)
  - Long term care facility
  - Residential treatment program
  - Skilled nursing facility (any type)
- Supervised placement, which includes the following:
  - Assisted living facility
  - Community care facility, such as a Board and Care
  - Congregate placement
- Inpatient psychiatric hospitalization, which includes the following:
  - Psychiatric Health Facility (PHF)
  - Institute of Mental Disease (IMD)
- Incarcerated/justice placement, which includes the following:
  - Jail
  - Prison
  - Juvenile hall
  - Juvenile justice placement
- Other
- Unknown

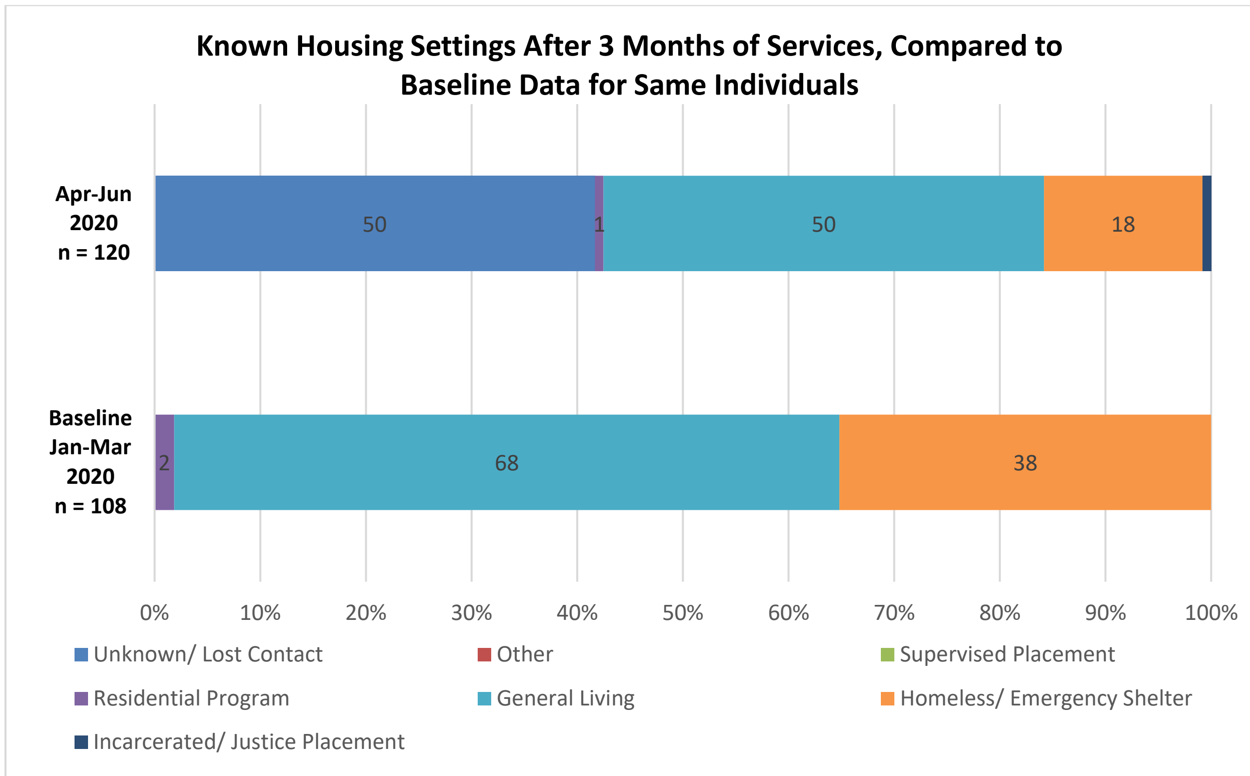
HOUSING STATUS AT START OF SERVICES

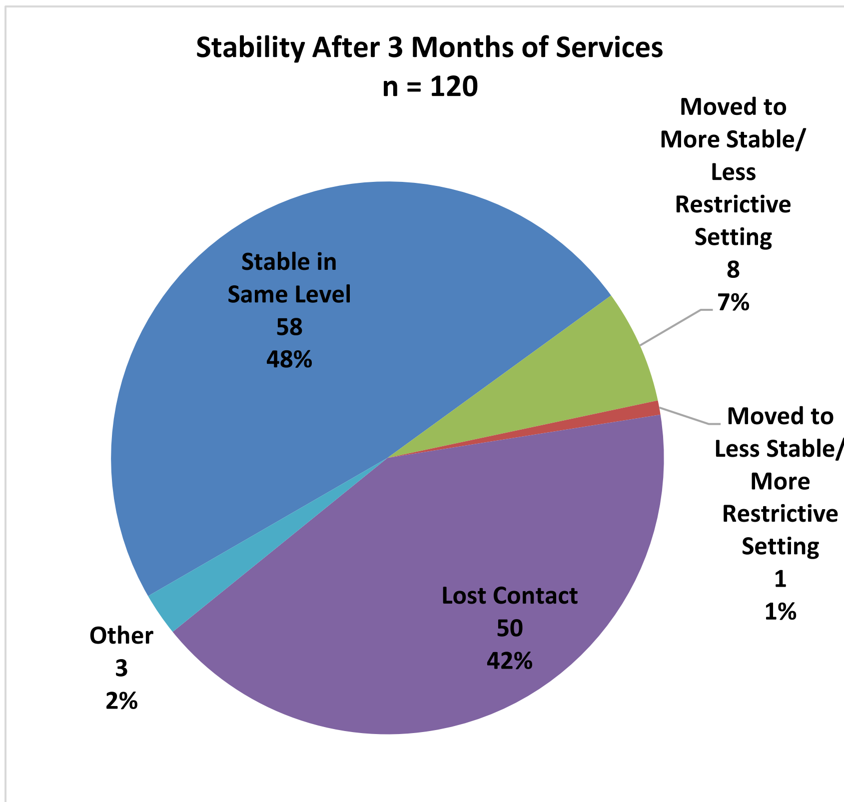
New Participant Housing Status at Intake - Innovation Project



	Jan-Mar 2017	Apr-Jun 2017	Jul-Sep 2017	Oct-Dec 2017	Jan-Mar 2018	Apr-Jun 2018	Jul-Sep 2018	Oct-Dec 2018	Jan-Mar 2019	Apr-Jun 2019	Jul-Sep 2019	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020
Homeless/ Emergency Shelter	0	19	69	58	62	52	30	27	27	19	49	41	38	23
General Living	0	189	88	68	100	54	35	30	74	42	77	50	68	32
Residential Program	0	0	0	1	0	0	1	0	0	1	0	1	2	1
Supervised Placement	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Other	3	14	16	1	1	2	15	16	8	193	17	12	0	0
Unknown	2	15	74	0	69	7	105	93	0	0	0	0	0	12

HOUSING STABILITY 3 MONTHS AFTER SERVICES AT THE CARE CENTER- Most Recent Quarter





For the 8 people who moved to more stable/less restrictive settings in this quarter 6 transitioned from Homeless/E.S. to General Living, and 2 transitioned from a Residential Program to General Living.

For the 1 person who moved to a less stable/more restrictive setting, they were incarcerated.

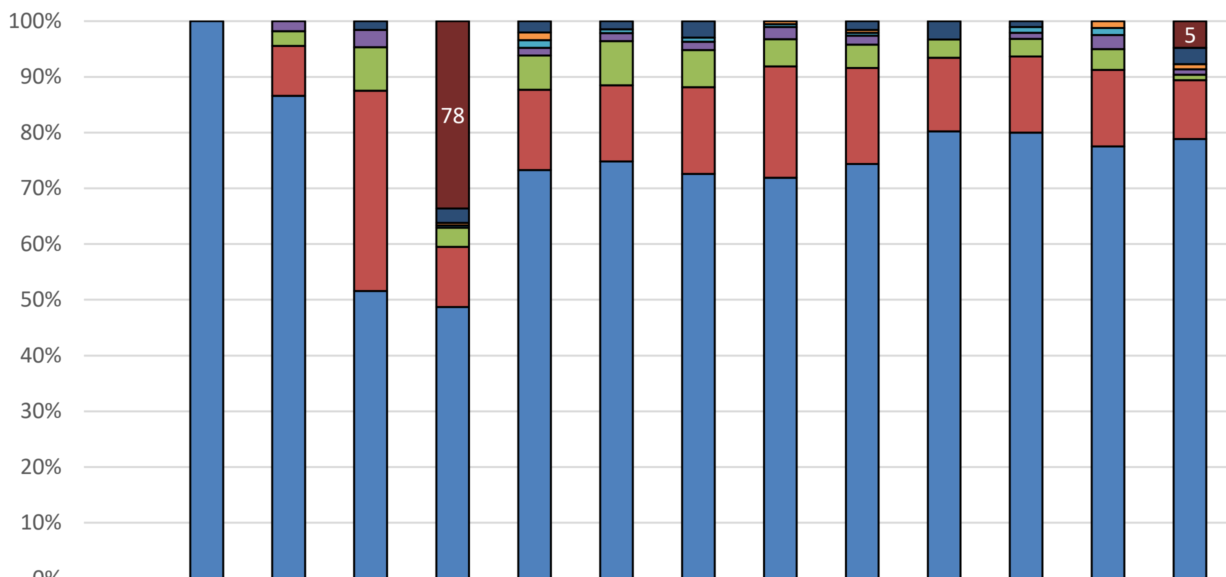
The 3 “Others” did not list their original setting, so it is unclear if the move was positive or negative. One entered sober living, one a hotel, and one moved out of state.

EMERGENCY DEPARTMENT VISITS

One of the goals of the Innovation Project is to reduce the number of emergency department visits for psychiatric reasons. Statistics are being tracked directly from the hospitals, but to measure the impact and effectiveness for individuals, the CARE Center has been asked to track the number of ER visits individuals report having made in the 6 months prior to the time they first start services at the CARE Center, and then at the 3-month point after that first service. The target outcome numbers are to see a 15% decrease in ER visits at the 3-month mark.

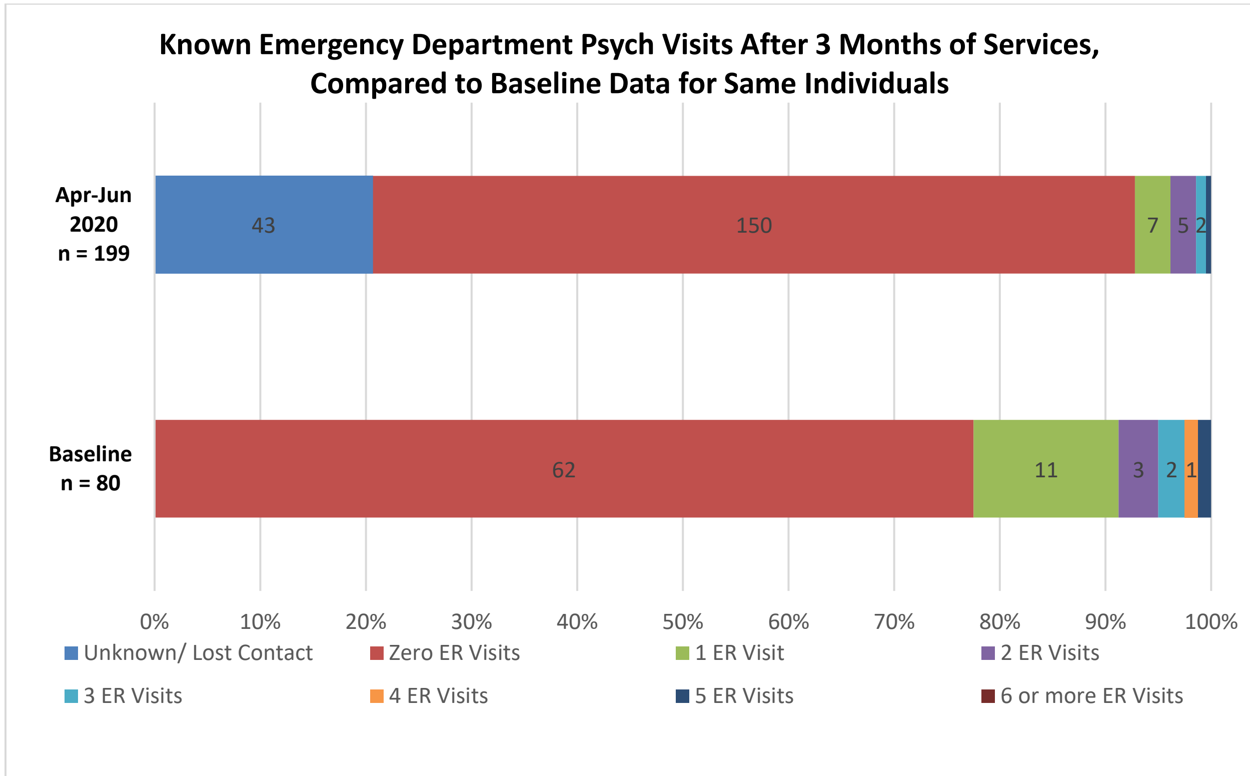
BASELINE EMERGENCY DEPARTMENT PSYCHIATRIC VISITS – PRIOR TO CARE CENTER SERVICES

Unique Individuals by Number of ER Visits in 6 Months Prior to CARE Center Services - Innovation Project

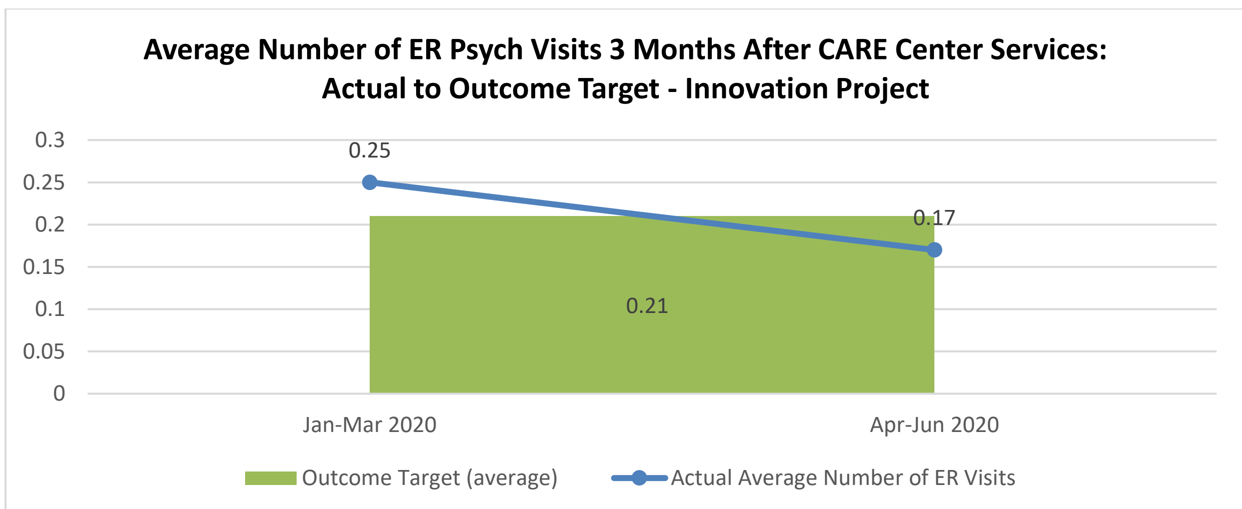


	Jan-Mar 2017	Apr-Jun 2017	Jul-Sep 2017	Oct-Dec 2017	Jan-Mar 2018	Apr-Jun 2018	Jul-Sep 2018	Oct-Dec 2018	Jan-Mar 2019	Apr-Jun 2019	Jul-Sep 2019	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020
Not Collected	Unable to collect for the 1st quarter	0	0	0	78	0	0	0	0	0	0	0	0	5
6 or more ER Visits		0	0	1	6	3	2	4	0	3	3	1	0	3
5 ER Visits		0	0	0	1	2	0	0	1	1	0	0	1	1
4 ER Visits		0	0	0	1	2	1	1	1	1	0	1	1	0
3 ER Visits		0	2	2	0	2	2	2	4	3	0	1	2	1
2 ER Visits		0	3	5	8	9	11	9	9	8	3	3	3	1
1 ER Visit		0	10	23	25	21	19	21	37	33	12	13	11	11
Zero ER Visits		14	97	33	113	107	104	98	133	142	73	76	62	82

EMERGENCY DEPARTMENT PSYCH VISITS 3 MONTHS AFTER SERVICES AT THE CARE CENTER – Most Recent Quarter



The average number of ER visits in the prior 6 months for the Jan-Mar 2020 baseline quarter was 0.25 per individual who had visit data reported (excluding all in the Unknown/Lost Contact category). This makes the target number for the 3-month mark in the Apr-Jun 2020 quarter 0.21 or fewer ER visits on average.

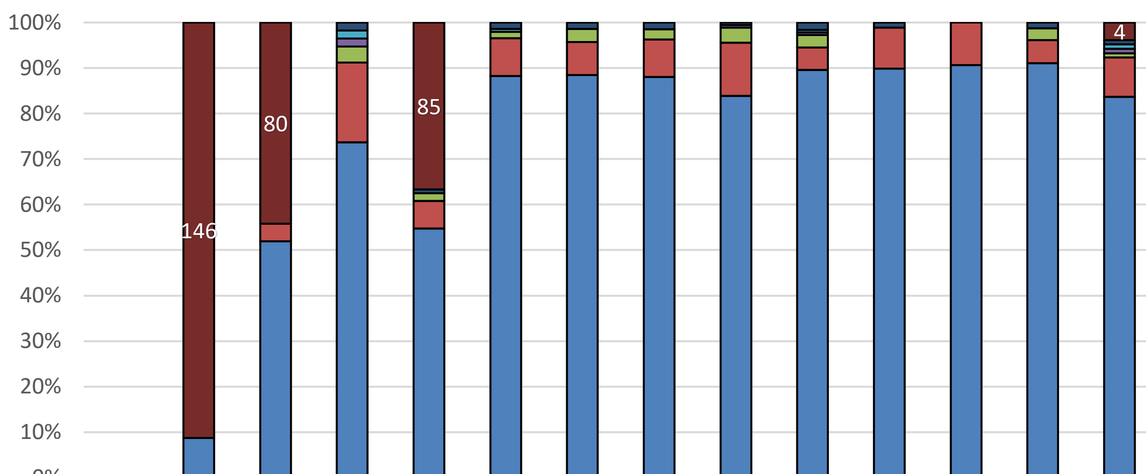


PSYCHIATRIC INPATIENT HOSPITALIZATIONS

Another goal of the Innovation Project is to reduce the number of psychiatric inpatient hospitalizations, and the number of days spent in the hospital during those hospitalizations. The CARE Center has been asked to track the number of psychiatric inpatient hospitalizations and number of days spent in the hospital that individuals report having made in the 6 months prior to the time they first start services at the CARE Center, and then at the 3-month point after that first service. While the number of hospitalizations can be tracked, getting an accurate count for number of days has proven to be extremely problematic, given both the mental status of the people being served, and the short, intensive time-limited duration of the services being provided. Due to this, only the numbers of hospitalizations will be tracked. The target outcome number is to see a 15% decrease in hospitalizations at the 3-month mark.

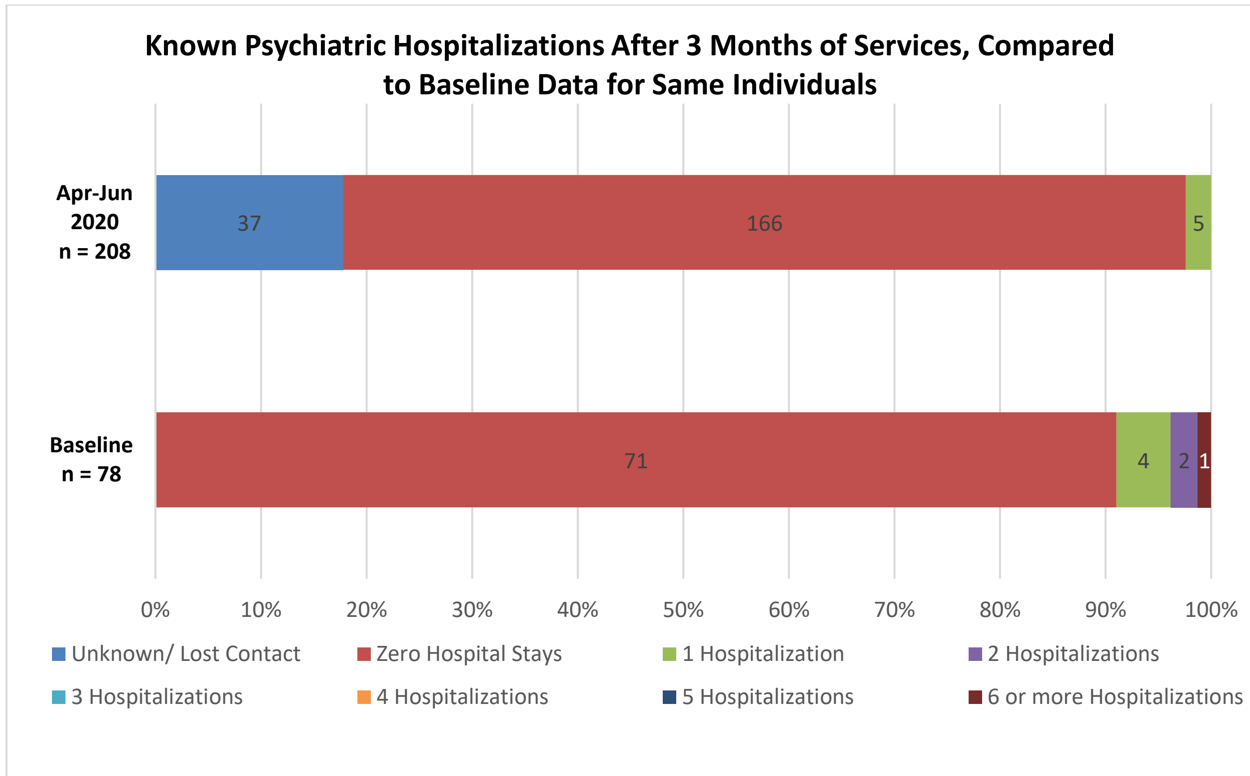
BASELINE PSYCHIATRIC HOSPITALIZATIONS – PRIOR TO CARE CENTER SERVICES

Unique Individuals by Number of Psychiatric Hospitalizations in 6 Months Prior to CARE Center Services - Innovation Project

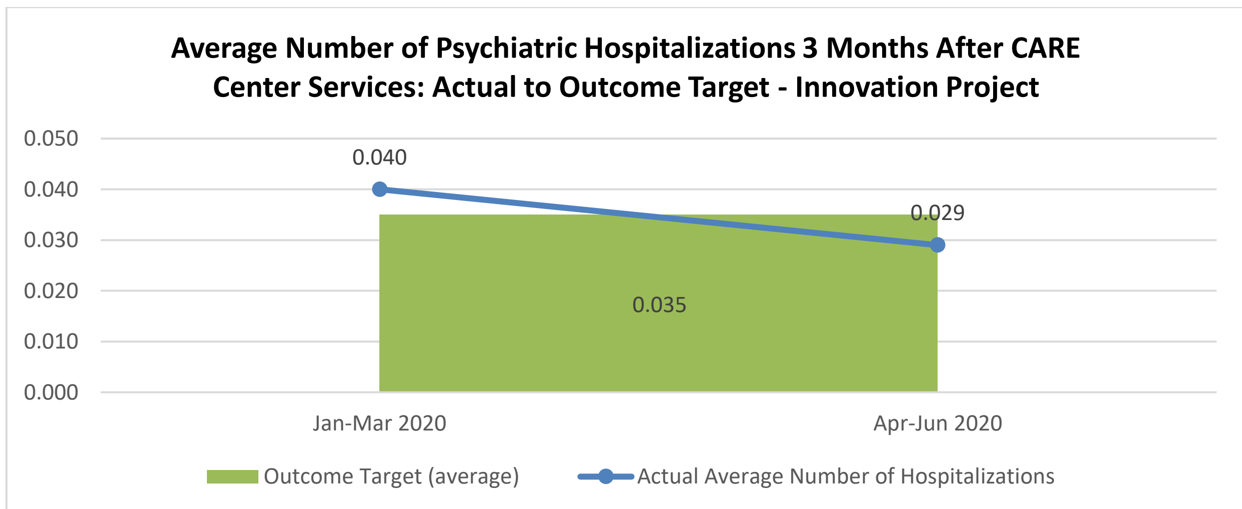


	Jan-Mar 2017	Apr-Jun 2017	Jul-Sep 2017	Oct-Dec 2017	Jan-Mar 2018	Apr-Jun 2018	Jul-Sep 2018	Oct-Dec 2018	Jan-Mar 2019	Apr-Jun 2019	Jul-Sep 2019	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020
Unknown	Unable to collect for the 1st quarter	146	80	0	85	0	0	0	0	0	0	0	0	4
6 or more Hospitalizations		0	0	1	2	2	2	2	1	3	1	0	1	1
5 Hospitalizations		0	0	0	0	0	0	0	0	0	0	0	0	0
4 Hospitalizations		0	0	1	0	1	0	0	0	1	0	0	0	1
3 Hospitalizations		0	0	1	0	0	0	0	1	1	0	0	0	1
2 Hospitalizations		0	0	2	4	2	4	3	6	5	0	0	2	1
1 Hospitalization		0	7	10	14	12	10	11	21	9	8	9	4	9
Zero Hospital Stays		14	94	42	127	128	123	118	151	163	80	87	71	87

PSYCHIATRIC HOSPITALIZATIONS 3 MONTHS AFTER SERVICES AT THE CARE CENTER – Most Recent Quarter



The average number of psychiatric hospitalizations in the prior 6 months for the Jan-Mar 2020 baseline quarter was 0.040 per individual who had any hospitalizations. This makes the target number for the 3-month mark in the Apr-Jun 2020 quarter 0.035 or fewer hospitalizations on average.

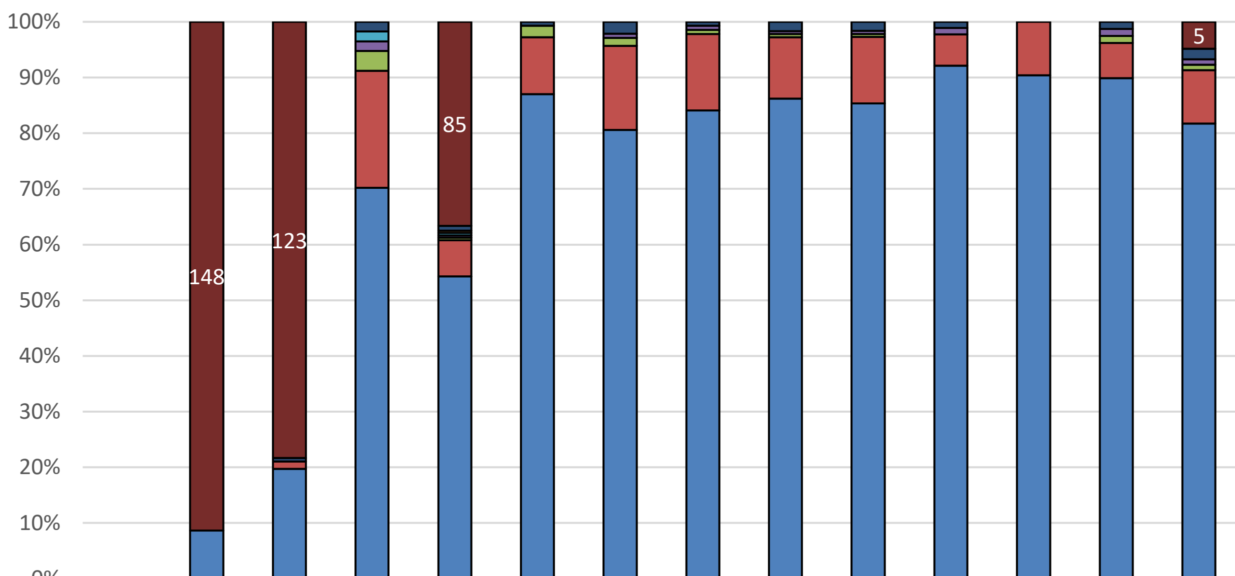


ARRESTS

Another goal of the Innovation Project is to reduce the number of arrests, and the number of days spent incarcerated. The CARE Center has been asked to track the number of arrests and number of days spent incarcerated that individuals report having made in the 6 months prior to the time they first start services at the CARE Center, and then at the 3-month point after that first service. However, as mentioned in the above section, while the raw number of times arrested is generally available, getting an accurate count of the number of days incarcerated at each arrest has proven problematic. Due to this, only the number of arrests will be tracked. The target outcome numbers are to see a 15% decrease in arrests at the 3-month mark.

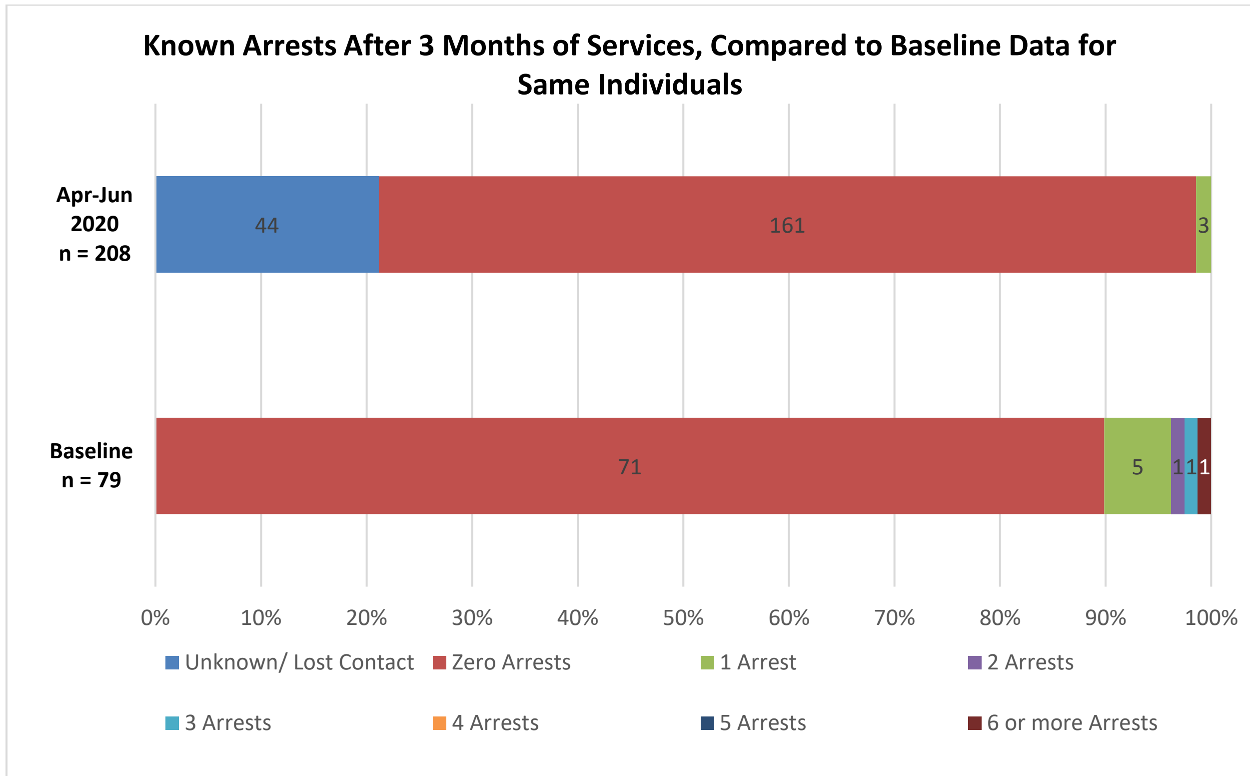
BASELINE ARRESTS – PRIOR TO CARE CENTER SERVICES

Unique Individuals by Number of Arrests in 6 Months Prior to CARE Center Services - Innovation Project

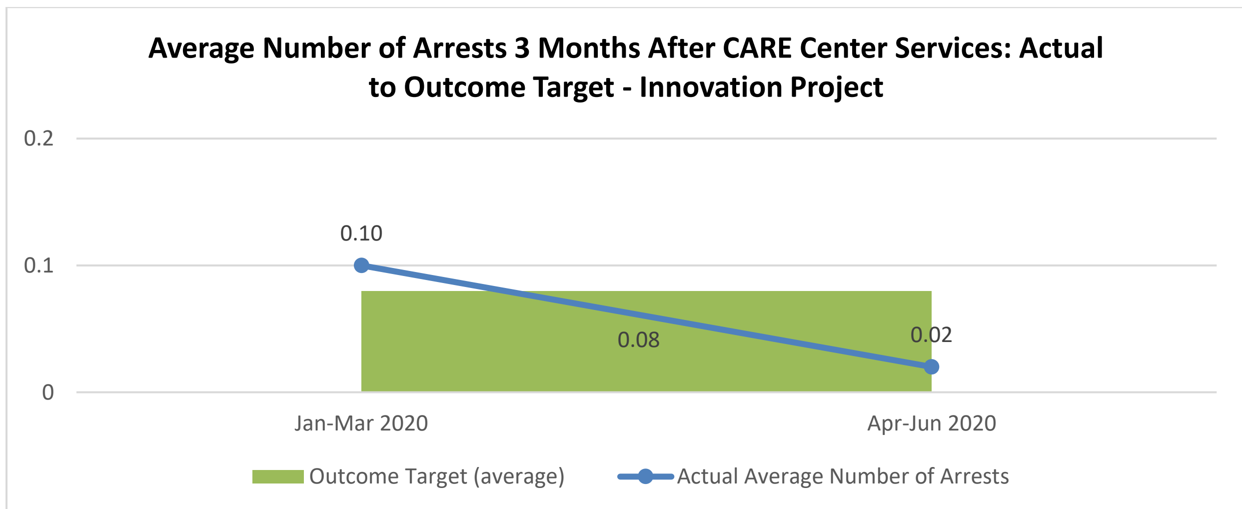


	Jan-Mar 2017	Apr-Jun 2017	Jul-Sep 2017	Oct-Dec 2017	Jan-Mar 2018	Apr-Jun 2018	Jul-Sep 2018	Oct-Dec 2018	Jan-Mar 2019	Apr-Jun 2019	Jul-Sep 2019	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020
Unknown	Unable to collect for the 1st quarter	148	123	0	85	0	0	0	0	0	0	0	0	5
6 or more Arrests		0	1	1	2	1	3	1	3	3	1	0	1	2
5 Arrests		0	0	0	1	0	0	0	0	0	0	0	0	0
4 Arrests		0	0	1	1	0	0	0	0	0	0	0	0	0
3 Arrests		0	0	1	1	0	1	1	1	1	1	0	1	1
2 Arrests		0	0	2	1	3	2	1	1	1	0	0	1	1
1 Arrest		0	2	12	15	15	21	19	20	22	5	9	5	10
Zero Arrests		14	31	40	126	127	112	116	156	157	82	85	71	85

ARRESTS 3 MONTHS AFTER SERVICES AT THE CARE CENTER – Most Current Quarter

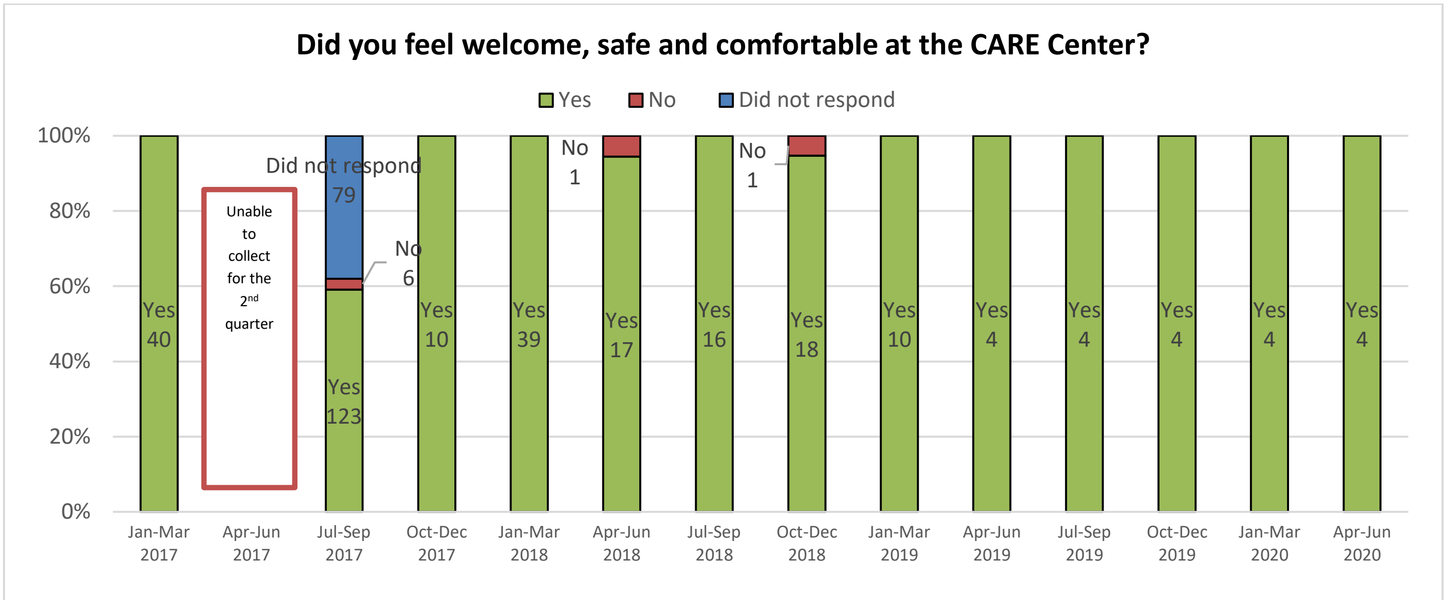


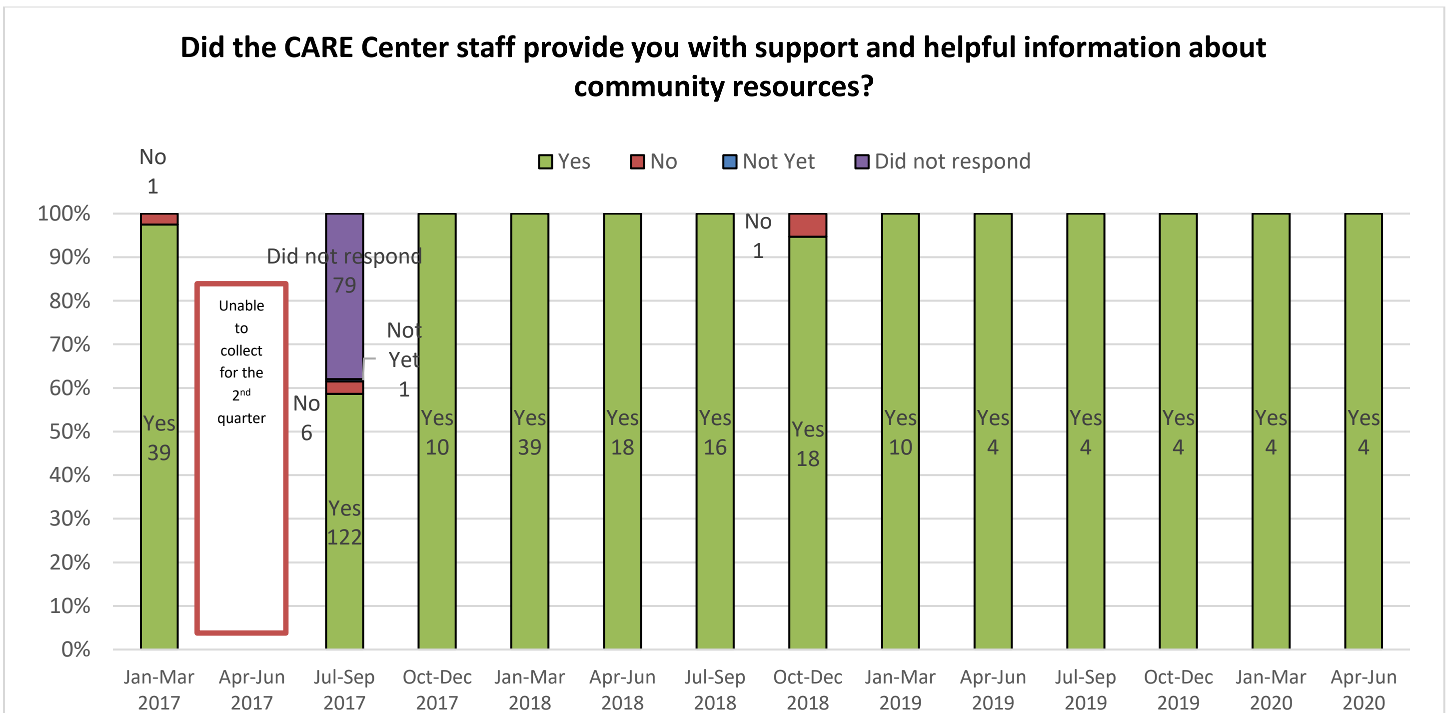
The average number of arrests in the prior 6 months for the Jan-Mar 2020 baseline quarter was 0.10 per individual who had arrest data reported (excluding all in the Unknown/Lost Contact category). This makes the target number for the 3-month mark in the Apr-Jun 2020 quarter 0.08 or fewer arrests on average.



CUSTOMER SURVEYS

In the first quarter, each person served was offered the chance to complete a simple 4-question survey. Survey changes were made in the second quarter, and not all data points are available. Full survey results were again available in Jul-Sep 2017 quarter and moving forward.





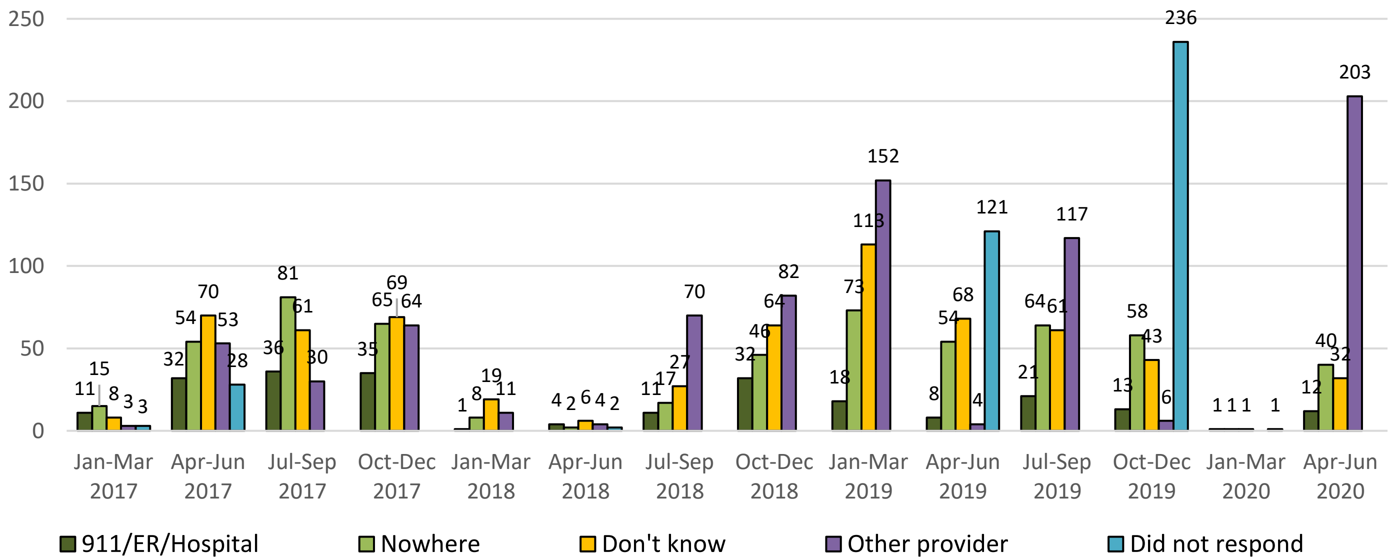
If you did not go to the CARE Center for help today, where would you have gone?

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

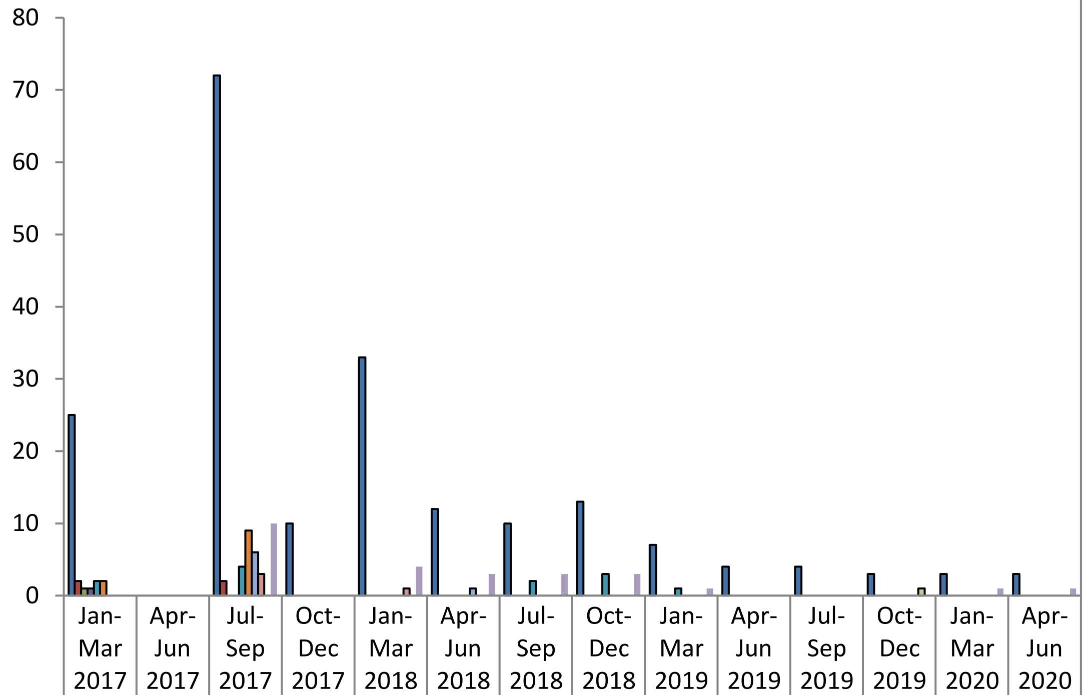
Outcome target for "ER/ Hospital" responses= 50%

Jan-… Apr-… Jul-Sep… Oct-… Jan-… Apr-… Jul-Sep… Oct-… Jan-… Apr-… Jul-Sep… Oct-… Jan-… Apr-…

Did not respond
Other provider
Don't know
Nowhere
911/ER/ Hospital



Was there something you were hoping for from the CARE Center that you did not receive, or what can we do better?

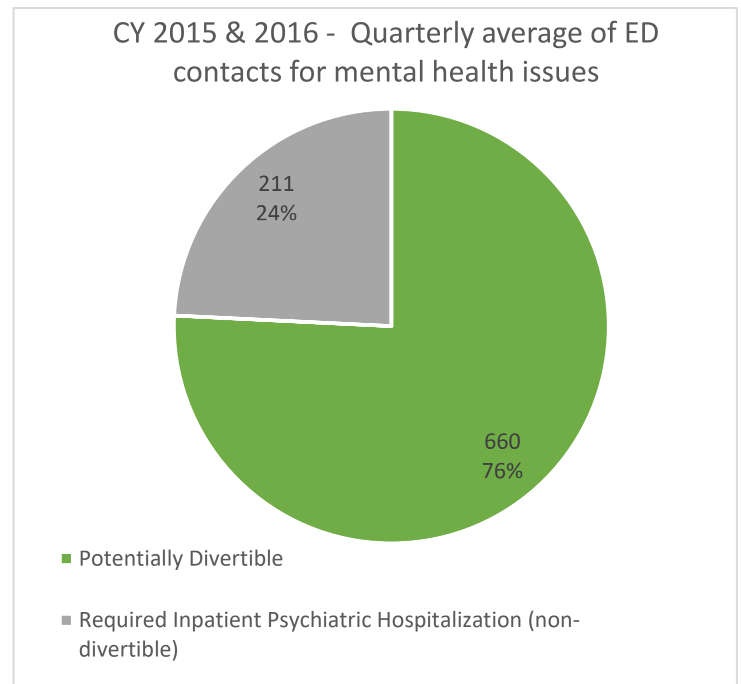


	Jan-Mar 2017	Apr-Jun 2017	Jul-Sep 2017	Oct-Dec 2017	Jan-Mar 2018	Apr-Jun 2018	Jul-Sep 2018	Oct-Dec 2018	Jan-Mar 2019	Apr-Jun 2019	Jul-Sep 2019	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020
Happy with experience/ services	25		72	10	33	12	10	13	7	4	4	3	3	3
Medication	2	Unable to collect for the 2nd quarter	2	0	0	0	0	0	0	0	0	0	0	0
Dental Care	1		0	0	0	0	0	0	0	0	0	0	0	0
Services for alcoholics in crisis	1		0	0	0	0	0	0	0	0	0	0	0	0
More and/or different groups	2		4	0	0	0	2	3	1	0	0	0	0	0
Other facility amenities (music, TV, coffee, snacks etc.)	2		9	0	0	0	0	0	0	0	0	0	0	0
More staff/ better trained staff	0		6	0	0	1	0	0	0	0	0	0	0	0
Food & clothing	0		3	0	1	0	0	0	0	0	0	0	0	0
Immediate Shelter	0		0	0	0	0	0	0	0	0	0	1	0	0
Other	0		10	0	4	3	3	3	1	0	0	0	1	1

Innovation Project Outcome Tracking – Shasta County Emergency Department Contacts over Time

There will be many factors behind these numbers and their change over time, and it is not the intent to presume that the Innovation Project will be solely responsible for those changes. However, emerging trends could indicate potential project success or failure.

One additional consideration which was not identified in the original plan is the impact of community-wide catastrophes and pervasive trauma to everyone in Shasta county and the surrounding areas. Thousands of people were displaced by the Carr, Delta, Hirz, Camp and other fires in summer 2018, with historic numbers of homes destroyed and lives lost. Winter 2018/19 was also difficult on the community with record snowfall, pervasive power outages, and widespread property damage. The COVID-19 pandemic struck the entire world the end of 2019 and continues to current date. All of this has had a huge impact on the emotional and mental well-being of everyone living in the greater North State area, and it remains to be seen how much data trends could change over time, based on these possible additional needs for support and assistance.



Some emergency department visits for mental health issues are necessary, appropriate and unavoidable, particularly in cases when medical clearance is needed prior to an inpatient psychiatric hospitalization. Other visits (although not all) may be better served at a lower level of care in a less stressful setting. Using this philosophy, emergency department visits for mental health issues have been divided up into two categories: non-divertible (those ending with psychiatric inpatient hospitalization where the level of care is obviously appropriate) and potentially divertible (those which could possibly have been seen elsewhere and had their mental health needs met in a lower level of care).

Looking at numbers from the Shasta County hospitals with emergency departments for calendar year 2015 and 2016, the average is 660 potentially divertible contacts for mental health issues (76%), and 211 non-divertible (24%) each quarter.

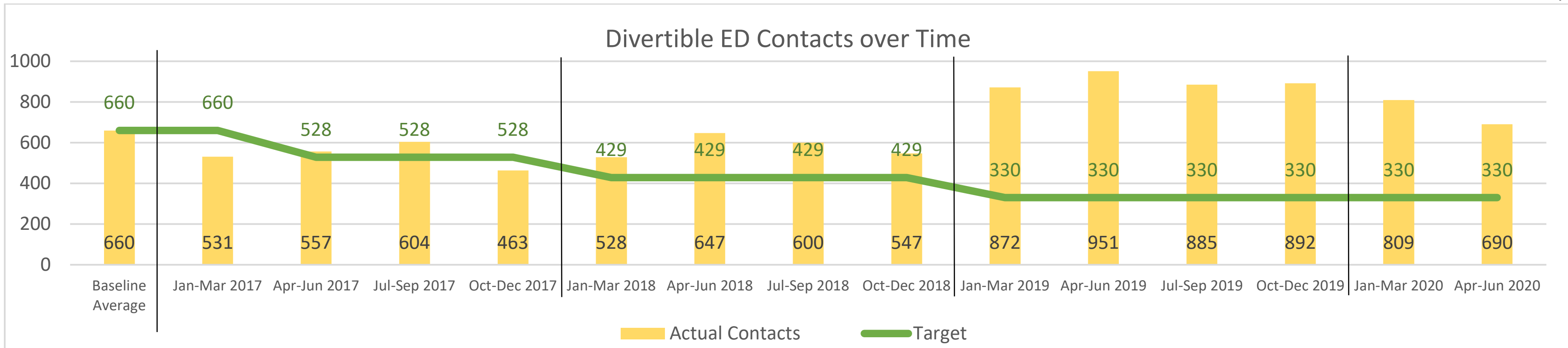
One of the goals for the Innovation Project, as approved by the state MHSOAC office and the Shasta County Board of Supervisors, is to reduce emergency department visits for mental health issues over time by the following amounts:

- At the end of year one – reduced by 20%
- At the end of year two – reduced by 35%
- By the mid-point of year three – reduced by 50%

Using the historical data, and applying these percentages, the goals for the emergency department contacts calculate out to the following:

- For the quarter ending 12/31/17 – potentially divertible ED contacts should equal 528 or fewer
- For the quarter ending 12/31/18 – potentially divertible ED contacts should equal 429 or fewer
- For the quarter ending 6/30/19 – potentially divertible ED contacts should equal 330 or fewer

Data as of: 8/28/2020



There may be additional factors to overall emergency department contact numbers which will make tracking just the hard number of contacts misleading (for example, if overall numbers of all ED contacts increase greatly, it may appear as if very few or none are being diverted). Tracking the percentage of divertible versus non-divertible mental health contacts could potentially be more revealing.

Assuming the average number of non-divertible contacts is constant, and applying the calculated number of divertible contacts for each time period that are the goal, the percentages of non-divertible versus divertible should change as follows:

- For the quarter ending 12/31/17 – 29% non-divertible to 71% divertible (211 vs. 528)
- For the quarter ending 12/31/18 – 33% non-divertible to 67% divertible (211 vs. 429)
- For the quarter ending 6/30/19 – 39% non-divertible to 61% divertible (211 vs. 330)