Mental Health Services Act

THREE-YEAR PROGRAM AND EXPENDITURE PLAN

FISCAL YEAR 2020-21 - 2022-23

Shasta County
Health & Human Services Agency

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.

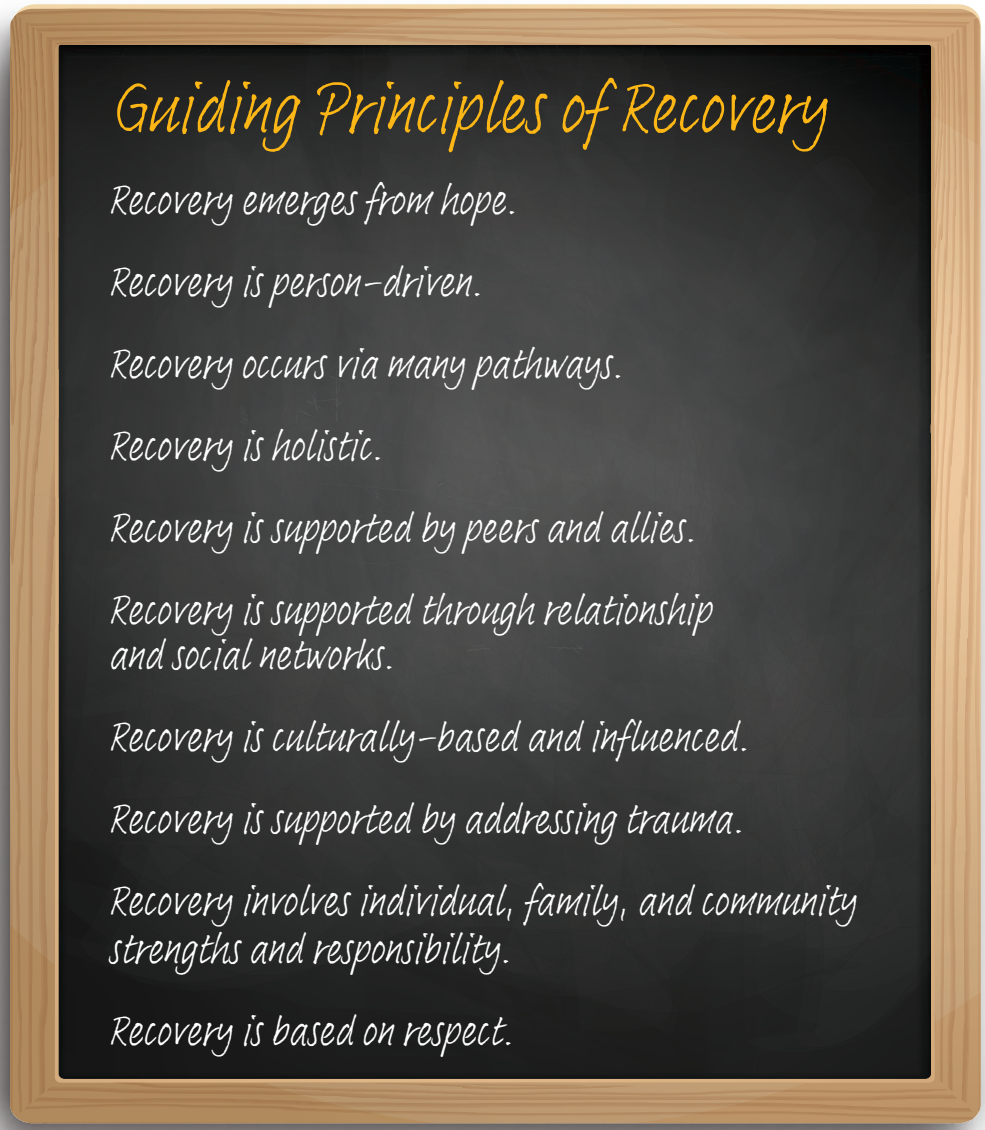
Supporting a Life in Recovery

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.



Message from the Director

Our Mental Health Services Act programs have grown and diversified in Shasta County over the past few years, but the COVID-19 pandemic has already created new challenges. Our community is gripped by trauma, budgets are suddenly uncertain, and we have had to look at most things we do in new ways.

One thing that has not and will not change is our commitment to fulfilling the purpose of the Mental Health Services Act, which 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. Thanks to collaboration among our clients, loved ones, service providers and many others, we continue to work diligently to provide people with the tools they need to make progress in their recovery from mental illness.

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. These programs align with our Agency's mission: "Engaging individuals, families and communities to protect and improve health and wellbeing."

We continue to fine-tune our programs based on feedback from our community, as you will see in this report, and we measure the results of these programs to ensure that they are effective. My deepest thanks to our many stakeholders who contributed their ideas to this plan, which is our roadmap for the next three years.

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: October 2, 2018; January 9, 2019; April 9, 2019; July 6, 2019; October 15, 2019

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 10, 2018; August 15, 2018; September 11, 2018; October 9, 2018; November 13, 2018; December 11, 2018; January 8, 2019; February 12, 2019; March 12, 2019; April 9, 2019; May 21, 2019; June 11, 2019

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: July 17, 2018; August 21, 2018; September 18, 2018; October 16, 2018; November 27, 2018; December 18, 2018; January 15, 2019; February 19, 2019; March 19, 2019; April 16, 2019; June 18, 2019

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 11, 2018; September 5, 2018; October 8, 2018; November 7, 2018; January 2, 2019; March 6, 2019; May 1, 2019; June 5, 2019

Community Stakeholder Meetings

Three in-person general community stakeholder meetings were held in Fiscal Year 2018-19 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

A primary focus of stakeholder meetings in Fiscal Year 2018-19 was to solicit input for Shasta County's next Innovations project. The gaps identified in the prior Three-Year Program and Expenditure Plan are all being actively addressed, including wraparound crisis services, a mobile crisis team (deployed in early 2019), and mental wellbeing in the community (being addressed by a new Public Health team). The ideas brought forth by stakeholders during these meetings is addressed in the Innovations section of this report.

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.

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
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
Psychosocial rehabilitation program (discontinued)

Innovation (INN)
CARE Center
Community intervention pre-crisis team (completed)
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)	99
3. Rural health initiative	119
4. Older adult	67
5. Crisis services	1,217
6. Crisis Residential and Recovery Center	158
7. Housing continuum	174
8. Co-occurring disorders integration	158
9. Outreach/Access	1,754

1. Client- and Family-Operated Systems

Shasta County has two consumer-run wellness centers: the Olberg 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, and the Olberg Wellness Center has been operated by Northern Valley Catholic Social Service. A request for proposals was conducted in Spring 2020, and beginning in July, this wellness center will be run by Kings View.

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 2018-19, the centers offered nearly more than 2,200 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.

Community Services and Supports (CSS)

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.

The report on Full Service Partnerships can be found in Appendix ZZZZZ.

Year Three Progress: Adult Services STAR Team, on-site case manager, and peer support specialist continue to provide mental health services and support to assist FSP to successfully get off of LPS conservatorship and for the first time are able to live and maintain independent living at our Woodland's Supportive Housing. Multiple mental health group services and support is being offered throughout the week with an emphasis of helping our FSP develop coping skills and life skills to enjoy and maintain their independence. A second clinician was added to the Adult STAR Program which allow the program to add Assisted Outpatient Treatment Services to the Program.

New 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.

Community Services and Supports (CSS)

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.

Year Three Progress: The number of people who received mental health services at a Federally Qualified Health Center increased by 12.9 percent this fiscal year, with most people seeking services for adjustment disorders, depression, anxiety, substance use or bipolar disorder. Mayers Memorial Hospital provided Crisis Intervention Training to staff. The Health and Human Services Agency continues to work closely with administrators to ensure that programs meet community needs.

New 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.

Community Services and Supports (CSS)

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.

Year Three 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.

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

Community Services and Supports (CSS)

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.

A new 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. We are now also providing mobile crisis services through a contract with Hill Country Health and Wellness Center, which had been identified as a significant need during our last Three-Year Program and Expenditure Plan stakeholder process.

Year Three 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.

New 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..

Community Services and Supports (CSS)

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.

Year Three Progress: The Crisis Residential and Recovery Center continues to grow its census as a result of the awareness campaign launched in 2018 and the continuous outreach conducted throughout the year. A record 4,500 bed days were recorded for this past fiscal year, which is 800 more bed days than any year since 2008. The CRRC's client base primarily consists of clients being discharged from SRMC's Center for Behavioral Health, Mercy Medical Center Emergency Room, the two Restpadd's in Redding and Red Bluff and community partners such as Hill Country Community Health Center and the Redding Rancheria. Services provided to clients by the CRRC consist of; connecting clients to 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.

New 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.

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 original Woodlands permanent supportive housing complex includes 55 units, with another 20 units nearing completion. Of those, 29 are MHSA funded and designated for people 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 also moving forward; NVCSS purchased a six-acre site off Main Street, where they plan to build a 20-unit complex called Burney Commons. The land and infrastructure will be funded by Partnership HealthPlan and Community Development Block Grant dollars, and NVCSS will apply for HOME funds and tax credits to cover construction.

On January 8, 2020, ADK Properties and The McConnell Foundation submitted a state competitive application, No Place Like Home, with Shasta County to propose a 49-unit apartment complex with up to 15 units reserved for permanent supportive housing services delivered by Hill Country Community Clinic. This proposed project, Center of Hope Apartments, will include retail space and will be adjacent to Hill Country's 40,000 square foot medical facility.

Community Services and Supports (CSS)

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

The Ridgeview Board and Care supportive transitional apartment complex in Shasta Lake City has increased housing options for MHSA clients. 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.

Year Three Progress: The Woodlands 2 is nearing completion, partners continue to work on solutions for permanent supportive housing in Burney, and the Center of Hope Apartments are moving forward.

New 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.

Community Services and Supports (CSS)

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

Year Three 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 is making significant progress in this work.

New 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.

Community Stakeholder Meetings

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.

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

New 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.

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.

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.

HHSA partnered with Shasta County Office of Education (SCOE) Bridges to Success Program to use Triple P with families of children age 0-5 as a helpful intervention for the most vulnerable populations. HHSA completed a competitive procurement process in spring of 2019 to award contracts to SCOE, Wright Education Services, Family Dynamics and Northern Valley Catholic Social Service (NVCSS) to provide free or low-cost Triple P services to families in Shasta County. These contracts will be in effect until the June 30, 2022 and will support providing Triple P levels 3, 4, 5, Transitions, Stepping Stones and Group levels.

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.

Year Three Progress: Efforts to meet program goals have been vast and successful in working to streamline and monitor program deliverables, update marketing materials and target training needs based on community input and support. The Automated Scoring and Reporting Application (ASRA) was successfully implemented in March 2019 and trainings were provided to over 10 organizations and a dozen more individual practitioners. ASRA has received positive feedback as a way to minimize previous reporting barriers. Shasta County partnered with First 5 in January 2020 to provide local training at a reduced cost for Level 3, Contract monitoring of those providers delivering Triple P has been extensive to ensure program fidelity and outcomes are being achieved. Marketing and outreach activities are planned for spring/summer of 2020.

New 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.

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.

Year Three Progress: HHSA continues to have clinicians trained in the evidence-based Trauma-Focused Cognitive Behavioral Therapy, and three staff were trained as trainers in Trust-Based Relational Intervention. HHSA purchased 30-minute Bruce Perry videos that were used in conjunction with Probation and other community partners to train staff on trauma, brain development, and trauma interventions. Community providers and resource families serving foster youth received TBRI training throughout the last year from the HHSA TBRI certified staff.

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.

Prevention and Early Intervention (PEI)

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.

Through community feedback, the Botvin LifeSkills Training for Middle School was selected, and training 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. Counselors are providing the training at Anderson Middle School and Parent Partners are using it at the Anderson Teen Center. 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 Botvin LifeSkills Evaluation Report can be found in Appendix K.

Year Three Progress: October 2019 marked the beginning of Shasta Lake Elementary's third year and Anderson Middle School's second year of participating in the Botvin LifeSkills Training Middle School program pilot. Shasta Lake has 90 sixth graders, 83 seventh graders, and 92 eighth graders (totaling 265 students) and Anderson Middle School has 90 sixth graders, 105 seventh graders, and 83 eighth graders (totaling 278 students) that started the LifeSkills Training program in October. Students from both schools are expected to complete the program by June 2020.

The most recent program report for the 2018/2019 school year shows that students across all 6th, 7th, and 8th grades increased their anti-drug and life skills knowledge. Both delivery models of having teachers provide the curriculum as well as having outside counselors have shown to be positive depending on the needs of the school. Although the Anderson Teen Center was unable to deliver lessons directly to students, trained staff are able to reinforce lessons learned with youth that visit the center.

HHSA will evaluate the two pilots to determine program outcomes and possible expansion to other schools in the future.

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

Prevention and Early Intervention (PEI)

0-5 Program

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. This has included two well-attended town hall meetings. Nationally recognized ACE experts Dr. Robert Anda and Laura Porter came to Shasta County to share the science behind ACE research and provide guidance to community leaders, then returned to train dozens of ACE Interface trainers who have since presented the Neuroscience, Epigenetics, Adverse Childhood Experiences and Resiliency (NEAR) Science evidence-informed curriculum to thousands of people. Three community partners received Public Health Advisory Board awards for their work.

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

Year Three Progress: Laura Porter provided a two-day leadership training in December 2018 to build skills and empower community leaders to build resilience and reduce ACEs in their spheres of influence. A pediatric symposium explored ways to implement ACEs into medical practices. The HHSA also partnered with First 5 Shasta to bring the "Launch: Young Futures Start" now program with local schools and parent partners to expand direct services to those families with young children who have been absent 10 percent or more from school. The Strengthening Families Collaborative created an Action Plan for 2020, and the ACE Data Dashboard highlights Shasta County's 11 ACE indicators. ACE Luncheons continued quarterly, highlighting topics including leadership, self-care, and the Strengthening Families 5 Protective Factors. Monthly Learning Community meetings support ACE Interface Trainers, who delivered nearly 50 presentations to more than 1,200 Shasta County residents in the business, education, faith, family, health, and justice spheres. Twenty showings of Resilience reached nearly 750 Shasta County residents. In Shasta County, more than 10 organizations and agencies use ACE screenings for their clients. Community partners hosted Parent Cafés, trauma-informed trainings, protective factors trainings, and 40 Developmental Assets trainings. In September, Shasta County received the Merit Award from 2019 California State Association of Counties (CSAC) Challenge for its ACE prevention efforts. HHSA also invested in the ACEs Resilience and Hope Fund, partnering with Shasta Regional Community Foundation to invest in projects that prevent and mitigate the impact of ACEs.

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.

Prevention and Early Intervention (PEI)

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. In 2018, the Early Onset Program expanded to include a Peer Support Specialist, who is providing support to the Early Onset clients.

Year Three Progress: The Early Onset clinician and peer support specialist consistently met 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.

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.

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.

Year Three Progress: In 2019, we collaborated with the Shasta Suicide Prevention Workgroup and a local Mental Health First Aid trainer to organize a screening of The S Word, which included a display of the Brave Faces Portrait Gallery and a Hope Is Alive! Open Mic. The program also collaborated with the local Art From The Ashes exhibition, an art display comprised of artwork created from salvaged materials from the 2018 Carr Fire, to put on an open mic night for members of the community who worked through their disaster trauma using poetry and song. The 12th Annual Minds Matter Mental Health Fair was held at the Sundial Bridge and featured a packed Hope Is Alive! Open Mic line up of performances, about 35 exhibitors and approximately 600 attendees. Intermountain Mental Health Week featured a free Mental Health First Aid training in Burney area attended by 22 people, a screening of Resilience: The Biology of Stress and the Science of Hope, a Mind-Body skills workshop and a Hope Is Alive! Open Mic. The Recovery Happens Committee doubled in size this year, increasing capacity to raise awareness about substance use issues in our community. A Recovery Happens Passport featured "open houses" at 15 different recovery programs and sober living homes. The Recovery Happens barbecue celebration also had attendance that doubled in size, with more than 20 exhibitors and attendance of approximately 600. Each year we tally the time attendees have been in recovery, and almost 800 years of sobriety were represented at this event. We coordinated more than 30 Brave Faces presentations with local organizations and schools, onboarded five new speakers and are in the process of creating four new Brave Faces galleries.

New 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.

Prevention and Early Intervention (PEI)

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.

Three Year Progress: The third media flight for Captain Awesome was released, featuring six local men sharing their tips for resilience and strength during challenging times. This strategic ad campaign was directed at men through their web browsing patterns. Initial reports indicated that during the initial launch week, the campaign served more than 56,000 impressions, 91 clicks to the ads, and 0.16% click through rate (more than three times the industry average). Two Captain Awesome promotional banners were also created and displayed at Big League Dreams, Redding's baseball and softball stadium, for the 2019 baseball season collegiate summer league. In December 2019, the Men's Advisory Group held its first meeting to discuss and evaluate Captain Awesome materials and proposed ad campaigns. Male attendees provided valuable insight and feedback on the future direction of the project. The Firearms Safety Brochure was revised to include updated statistics and state regulations. Through a continued partnership with local businesses, 200 brochures are provided each month to residents receiving firearms instruction and training. Two eight-week mind-body skills groups and four workshops with HHSA employees and teaching staff from one local 6th–12th grade school were provided. Participants discussed and practiced several mindfulness techniques to help reduce stress. Organized by members of the Shasta Suicide Prevention Workgroup, the newly created attempt survivors support group Hang on Pain Ends (HOPE) was started in conjunction with the Good Grief loss survivors support group. Both groups provide those with similar experiences the opportunity to connect and support one another, and promote continued healing.

New 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.

Prevention and Early Intervention (PEI)

In 2018, Shasta County was honored to host the second Mental Health Services Oversight and Accountability Commission Suicide Prevention Subcommittee meeting, which was supported by HHSA, Redding Rancheria Tribal Health Center, the California Rural Indian Health Board and The McConnell Foundation. More than 50 people participated and helped the committee better understand the challenges of suicide prevention in a rural community.

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.

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.

Shasta Mental Health Services Act Academy

This free 65-hour training program helps people prepare for careers in the public mental health field or to become peer mentors. Participants learn new information, strengthen skills and network with mental health professionals. The Academy includes 45 hours of interactive classroom-based learning and 20 hours of hands-on learning. Classroom learning is based on curriculum from the International Association of Peer Specialists and reflects the national ethical guidelines and practice standards for peer supporters. Hands-on learning covers training in group dynamics, meeting facilitation, stakeholder engagement, peer interaction and center-based program delivery. Participants volunteer in local wellness centers and our main mental health facility, participate in advisory groups and/or stakeholder meetings, and shadow staff. Several Academy graduates have had the opportunity to pursue careers with HHSA and other local organizations.

Shasta College Student Volunteer Internship Program

HHSA partners with Shasta College to provide students who are interested in the mental health field with hands-on learning and volunteer experience. Each student receives one unit of college credit for spending at least 60 hours volunteering and job shadowing mental health staff. Many who graduated have gone on to become employed in the public mental health field.

Workforce Education and Training (WET)

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.

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 sponsors a variety of programs to meet WET goals:

- Working Well Together – A technical assistance center whose primary goal is to help counties ensure they are prepared to recruit, hire, train, support and retain consumers, family members and parents/caregivers as employees of the public mental health system.
- Distance learning – A partnership with several University of California systems within the Superior Region to provide online education for those wishing to further their education and already are, or would like to become, employed in the public mental health field.

Year Three Update: All HHSA employees received De-Escalation training. Volunteers helped at the Hill Country Care Center, the Olberg Wellness Center, the Crisis Residential and Recovery Center (CRRC) and the Whole Person Care Program, and dozens of people completed the MHSA Academy. WRAP Level 1 training was provided at the Woodlands, Circle of Friends, Hill Country Counseling Center, Hill Country CARE Center, the Olberg Wellness Center and on the HHSA campus. Level 2 trainings were also provided. Interns continue to shadow staff to learn more about public mental health work.

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.

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.

Shasta County also continues to use Innovations funding for the Counseling and Recovery Engagement (CARE) Center, which opened in March 2017 and is operated by Hill Country Health and Wellness. The center is open 7 days a week, 365 days a year, in the afternoons and evenings. Services include:

- After-hours pre-crisis clinical assessment and treatment
- Case management and linkage
- Treatment groups
- Warm line
- Community outreach
- Buddy/mentor system for youth and adults
- Transportation
- Connection to respite care and transitional housing
- A peer-staffed resource center which provides resources and information, assistance with linkage to benefits, resource materials, referrals, education and support groups

The CARE Center Innovation project has five 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.

The program evaluation is built around these objectives.

Shasta County planned on a four-year overall timeframe for this Innovation project: six months of start-up activities (complete); three years of project implementation; and a final six months of wrap-up activities. Stakeholders, the Mental Health, Alcohol and Drug Advisory Board and the Shasta County Board of Supervisors approved requesting a one-year extension of the pilot project, which was approved by the Mental Health Services Oversight and Accountability Commission in May 2019.

Innovation

The CARE Center continues to perform above expectations. Hundreds of people who likely would have gone to the emergency department if the CARE Center didn't exist have been referred to lower-level, more appropriate and less expensive services. The vast majority of visitors reported in a survey that they felt welcome, safe and comfortable at the CARE Center, and said staff provided them with support and helpful information about community resources.

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 2020/21 through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan

	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
Estimated FY 2020/21 Funding						
Estimated Unspent Funds from Prior Fiscal Years	8,542,049	3,567,962	1,850,016	0	0	
Estimated New FY2020/21 Funding	8,065,837	2,016,459	530,647			
Transfer in FY2020/21a/	(61,117)					
Access Local Prudent Reserve in FY2020/21						0
Estimated Available Funding for FY2020/21	16,546,769	5,584,421	2,380,663	0	0	
Estimated FY 2020/21 MHSA Expenditures	11,806,059	3,379,619	1,420,000	61,117	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 FY2021/22 Expenditures	10,909,747	3,184,338	1,034,896	0	0	0
Estimated FY2022/23 Funding						
Estimated Unspent Funds from Prior Fiscal Years	2,138,775	1,097,418	472,333	0	0	
Estimated New FY2022/23 Funding	8,557,046	2,139,261	562,963			
Transfer in FY2022/23a/	0					
Access Local Prudent Reserve in FY2022/23						0
Estimated Available Funding for FY2022/23	10,695,822	3,236,679	1,035,297	0	0	
Estimated FY2022/23 Expenditures	10,263,125	3,073,389	1,034,896	0	0	
Estimated FY2022/23 Unspent Fund Balance	432,697	163,290	401	0	0	

Mental Health Services Act Budgets

Community Services and Supports (CSS) Component Worksheet

Fiscal Year 2020/21 Estimates	Total Mental Health Expenditures	CSS Funding	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other Funding
FSP Programs						
1. Client Family Operating Services	717,080	717,080				
2. Shasta Triumph and Recovery	2,961,282	2,449,698	505,312			6,272
3. Crisis Residential and Recovery	1,281,080	123,036	1,158,044			0
4. Crisis Response	1,391,697	923,492	361,615			106,590
5. Outreach-Access	2,649,644	2,261,959	380,115			7,570
6. Housing	2,102,333	2,074,118	28,215			
Non-FSP Programs						
1. Rural Health Initiative	965,278	410,239	135,516			419,523
2. Older Adult Services	97,261	76,245	19,221			1,795
3. Co-Occurring/Primary Care Integration	255,907	22,041	210,616			23,250
4. Laura's Law	500,000	500,000				
5.				0	0	
CSS Administration	2,248,151	2,248,151		0	0	
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	15,169,713	11,806,059	2,798,654	0	0	565,000
FSP Programs as Percent of Total	73.2%					

Mental Health Services Act Budgets

Community Services and Supports (CSS) Component Worksheet

Fiscal Year 2021/22 Estimates	Total Mental Health Expenditures	CSS Funding	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other Funding
FSP Programs						
1. Client Family Operating Services	681,226	681,226	0			0
2. Shasta Triumph and Recovery	2,813,218	2,276,368	530,578			6,272
3. Crisis Residential and Recovery	1,217,026	1,080	1,215,946			0
4. Crisis Response	1,322,112	835,826	379,696			106,590
5. Outreach-Access	2,517,162	2,110,471	399,121			7,570
6. Housing	1,997,216	1,967,591	29,626			0
	0					
						0
					0	
Non-FSP Programs						
1. Rural Health Initiative	917,014	355,199	142,292			419,523
2. Older Adult Services	92,398	70,421	20,182			1,795
3. Co-Occurring/Primary Care Integration	243,112	821	219,041			23,250
4. Laura's Law	475,000	475,000	0			0
5.				0	0	
CSS Administration	2,135,743	2,135,743		0	0	
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	14,411,227	10,909,747	2,936,481	0	0	565,000
FSP Programs as Percent of Total	73.2%					

Mental Health Services Act Budgets

Community Services and Supports (CSS) Component Worksheet

Fiscal Year 2022/23 Estimates	Total Mental Health Expenditures	CSS Funding	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other Funding
FSP Programs						
1. Client Family Operating Services	647,165	647,165	0			0
2. Shasta Triumph and Recovery	2,672,557	2,135,707	530,578			6,272
3. Crisis Residential and Recovery	1,156,175	1,026	1,155,149			0
4. Crisis Response	1,256,007	769,721	379,696			106,590
5. Outreach-Access	2,391,304	1,984,613	399,121			7,570
6. Housing	1,897,356	1,867,730	29,626			0
	0					
						0
					0	
Non-FSP Programs						
1. Rural Health Initiative	871,163	309,349	142,292			419,523
2. Older Adult Services	87,778	65,801	20,182			1,795
3. Co-Occurring/Primary Care Integration	230,956	1,808	205,898			23,250
4. Laura's Law	451,250	451,250	0			0
5.				0	0	
CSS Administration	2,028,956	2,028,956		0	0	
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	13,690,666	10,263,125	2,862,541	0	0	565,000
FSP Programs as Percent of Total	73.2%					

Mental Health Services Act Budgets

Prevention and Early Intervention (PEI) Component Worksheet

Fiscal Year 2020/21 Estimates	Total Mental Health Expenditures	PEI Funding	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other Funding
Prevention Programs						
1. Stigma and Discrimination	646,871	646,871				
2. Suicide Prevention	339,475	339,475				
3.						
4.						
5.						
6.						
Early Intervention Programs						
7. Children and Youth in Stressed	0					
a. Triple P	893,234	692,959	197,775			2,500
b. TFCBT	75,000	75,000				
c. ACE	1,051,749	1,051,749				
e. Positive Action Program	331,038	331,038				
8. Individuals Experiencing Early Onset of Serious Psychiatric Illness	125,821	9,452	113,869			2,500
9.						0
				0	0	
PEI Administration	233,075	233,075		0	0	
PEI Assigned Funds						
Total PEI Program Estimated Expenditures	3,696,263	3,379,619	311,644	0	0	5,000
PEI Programs as Percent of Total	%					

Mental Health Services Act Budgets

Prevention and Early Intervention (PEI) Component Worksheet

Fiscal Year 2021/22 Estimates	Total Mental Health Expenditures	PEI Funding	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other Funding
Prevention Programs						
1. Stigma and Discrimination	614,527	614,527				
2. Suicide Prevention	322,501	322,501				
3.						
4.						
5.						
6.						
Early Intervention Programs						
7. Children and Youth in Stressed	0			0	0	
a. Triple P	848,572	640,909	207,664			
b. TFCBT	71,250	71,250				
c. ACE	999,162	999,162				
e. Positive Action Program	314,486	314,486				
8. Individuals Experiencing Early Onset of Serious Psychiatric Illness	119,530	81	119,449			
9.						0
				0	0	
PEI Administration	221,421	221,421		0	0	
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	3,511,450	3,184,338	327,112			
PEI Programs as Percent of Total	%					

Mental Health Services Act Budgets

Prevention and Early Intervention (PEI) Component Worksheet

Fiscal Year 2022/23 Estimates	Total Mental Health Expenditures	PEI Funding	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other Funding
Prevention Programs						
1. Stigma and Discrimination	596,092	596,092				
2. Suicide Prevention	312,826	312,826				
3.						
4.						
5.						
6.						
Early Intervention Programs						
7. Children and Youth in Stressed	0			0	0	
a. Triple P	823,115	605,068	218,047			
b. TFCBT	69,113	69,113				
c. ACE	969,187	969,187				
e. Positive Action Program	305,052	305,052				
8. Individuals Experiencing Early Onset of Serious Psychiatric Illness	115,944	1,273	114,671			
9.						0
				0	0	
PEI Administration	214,779	214,779		0	0	
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	3,406,106	3,073,389	332,718			
PEI Programs as Percent of Total	%					

Mental Health Services Act Budgets

Innovations (INN) Component Worksheet

Fiscal Year 2020/21 Estimates	Total Mental Health Expenditures	INN Funding	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other Funding
INN Programs						
1. Program Implementation	1,420,000	1,420,000				
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						0
				0	0	
INN Administration				0	0	
INN Assigned Funds						
Total INN Program Estimated Expenditures	1,420,000	1,420,000				
INN Programs as Percent of Total	%					

Mental Health Services Act Budgets

Innovations (INN) Component Worksheet

Fiscal Year 2021/22 Estimates	Total Mental Health Expenditures	INN Funding	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other Funding
INN Programs						
1. Program Implementation	1,034,896	1,034,896				
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						0
				0	0	
INN Administration				0	0	
INN Assigned Funds						
Total INN Program Estimated Expenditures	1,034,896	1,034,896				
INN Programs as Percent of Total	%					

Mental Health Services Act Budgets

Innovations (INN) Component Worksheet

Fiscal Year 2022/23 Estimates	Total Mental Health Expenditures	INN Funding	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other Funding
INN Programs						
1. Program Implementation	1,034,896	1,034,896				
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						0
				0	0	
INN Administration				0	0	
INN Assigned Funds						
Total INN Program Estimated Expenditures	1,034,896	1,034,896				
INN Programs as Percent of Total	%					

Mental Health Services Act Budgets

Workforce, Education and Training (WET) Component Worksheet

Fiscal Year 2020/21 Estimates	Total Mental Health Expenditures	WET Funding	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other Funding
WET Programs						
1. Statewide Programs	61,117	61,117				
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						0
				0	0	
WET Administration				0	0	
WET Assigned Funds						
Total WET Program Estimated Expenditures	61,117	61,117				
WET Programs as Percent of Total	%					

Mental Health Services Act Budgets

Workforce, Education and Training (WET) Component Worksheet

Fiscal Year 2021/22 Estimates	Total Mental Health Expenditures	WET Funding	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other Funding
WET Programs						
1. Statewide Programs						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						0
				0	0	
WET Administration				0	0	
WET Assigned Funds						
Total WET Program Estimated Expenditures						
WET Programs as Percent of Total	%					

Mental Health Services Act Budgets

Workforce, Education and Training (WET) Component Worksheet

Fiscal Year 2022/23 Estimates	Total Mental Health Expenditures	WET Funding	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other Funding
WET Programs						
1. Statewide Programs						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						0
				0	0	
WET Administration				0	0	
WET Assigned Funds						
Total WET Program Estimated Expenditures						
WET Programs as Percent of Total	%					

Mental Health Services Act Budgets

The public comment period for the Fiscal Year 2020/2021 through Fiscal Year 2022/2023 Three-YearProgram and Expenditure Plan opened on May 24, 2021, and will close on June 23, 2021. A Public Hearing will be conducted by the Shasta County Mental Health, Alcohol and Drug Advisory Board during their June 23, 2021, special meeting.

Public notice regarding the public comment period and public hearing was published on www.ShastaMHSA.net and the Shasta County Health and Human Services Agency's Facebook, Instagram and Twitter pages during the 30-day public comment period of May 24, 2021, to June 23, 2021. Public notice and copy of the draft document was posted in several public locations throughout the community. A link to the draft document was e-mailed to stakeholders, advisory board members and stakeholder workgroup members, and copies were available upon request.

(Comments received will be listed here:)

For information regarding this document, please contact:

Kerri Schuette, Mental Health Services Act Coordinator

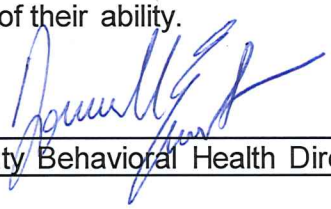
Shasta County Health and Human Services Agency

(530) 245-6951

kschuette@co.shasta.ca.us

DHCS Form 5510

MHSA Three-Year Program and Expenditure Plan or Update Extension FY 2020-21

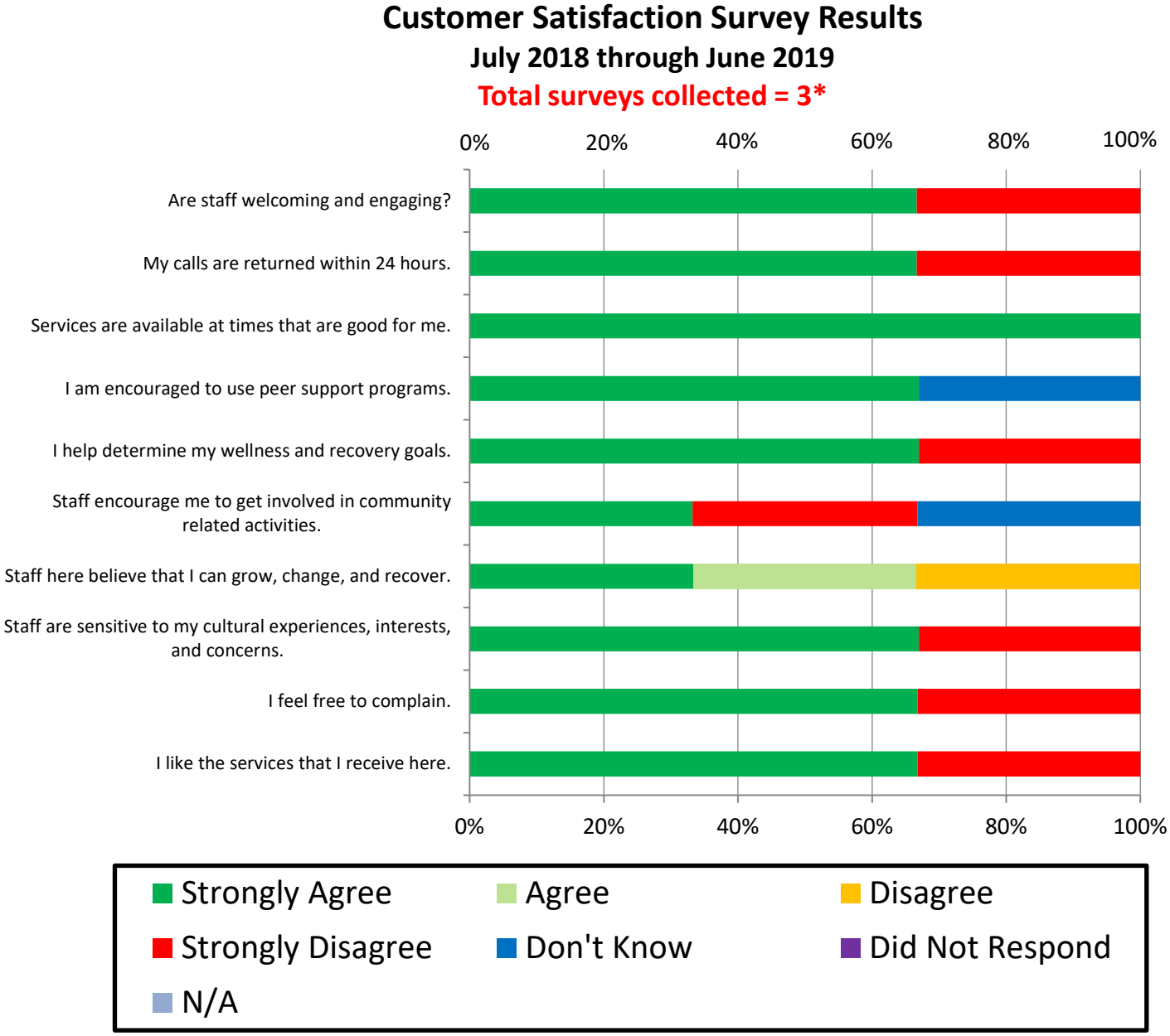
Background and Instructions
Welfare and Institutions (W&I) Code section 5847(h), allows a county that is unable to complete and submit a Three-Year Program Expenditure Plan (Plan) or annual update (update) for fiscal year (FY) 2020-21 due to the COVID-19 Public Health Emergency to extend the effective time frame of its currently approved Plan or update to include FY 2020-21, and submit the subsequent Plan or Update on July 1, 2021. This document provides notification to DHCS that the County is extending the effective time frame of its currently approved Plan or Update to include FY 2020-21, per W&I Code section 5847(h). Please enter the requested information in the fields below and submit a completed form electronically to DHCS at MHSA@DHCS.ca.gov.
Section I: County Information
a. Type of Plan or Update: Update
b. Date current Plan/Update was approved: June 5, 2019
Section II: Stakeholder Notification
Stakeholders have been notified that the County is extending the effective time frame of its currently approved Plan or update to include FY 2020-21 as of: Fall 2020 (website: shastam
Section III: Extension Justification
Provide a brief summary describing how the COVID-19 Public Health Emergency inhibited the County's ability to complete and submit its Three-year Plan or annual update for FY 2020-21. Because Shasta is a smaller county where many employees wear several hats, most of the staff assigned to MHSA administration have been working full-time on response to the COVID-19 pandemic. Shasta's MHSA coordinator is the public information officer for the COVID-19 response, and all of our data analysts have been reassigned for the past year to provide either full- or part-time support for COVID's required epidemiological work. Our Mental Health, Alcohol and Drug Advisory Board was unable to meet for most of 2020, and many stakeholders do not have the technology needed for online meetings. We had nearly finished the 2020-2023 Three-Year Plan, including having held several stakeholder meetings, when the statewide shutdowns occurred, but we will need to hold at least one more before we can submit this report. This is scheduled for March 30, 2021.
Section IV: Certification
The undersigned certifies that the information included in this form is complete and accurate to the best of their ability. County Behavioral Health Director Signature:  Printed Name: Donnell Ewert Date: 3/1/21

Shasta County Health & Human Services Agency

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.



*This sample size is very small, which increases the amount of error in the sample.

Shasta County Health & Human Services Agency

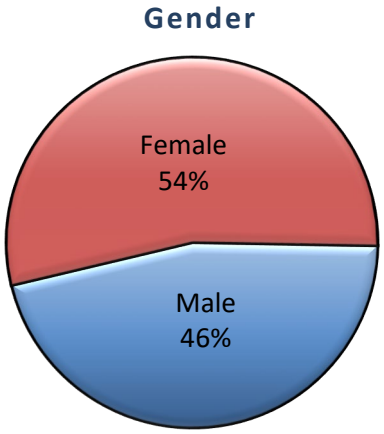
Wellness Center Summary Report

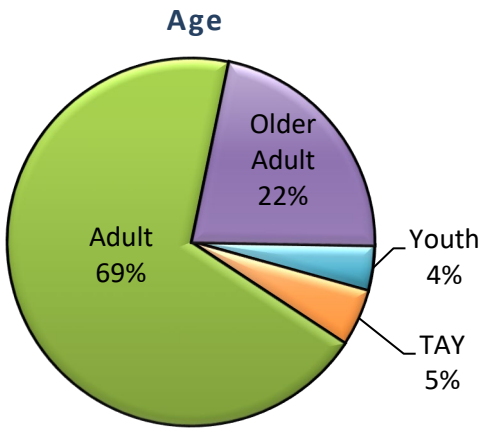
July 2018 through June 2019

Shasta County had two wellness centers in operation during the twelve-month period of July 2018 through June 2019: 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 46% of wellness center attendees were male, 54% female, and 0% reported as transgender or other.

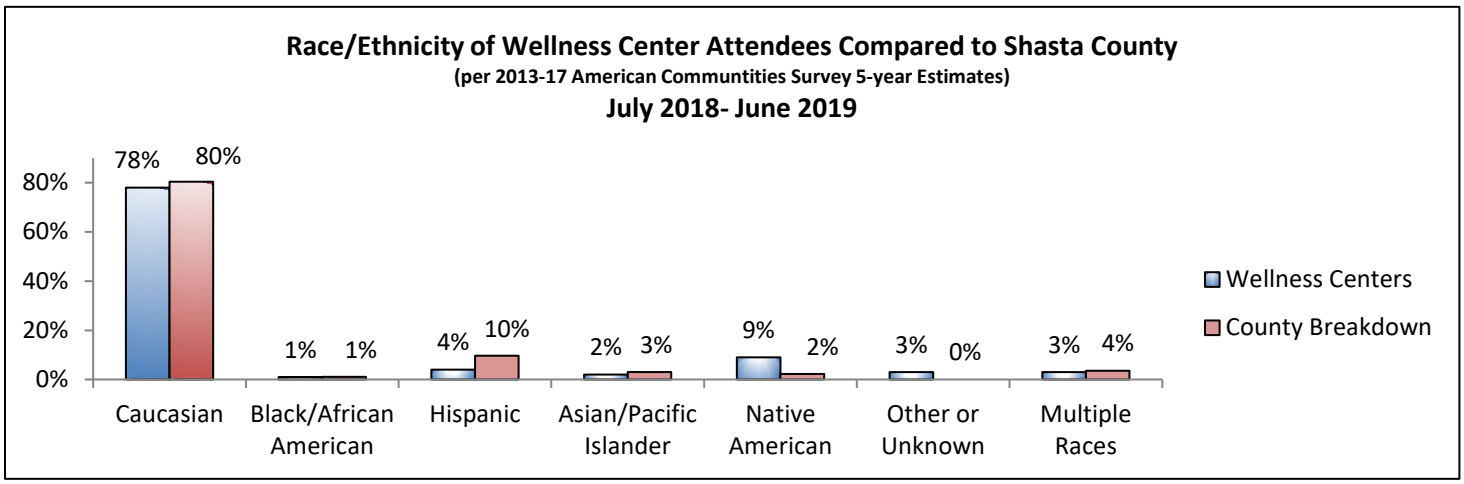




Approximately 4% of wellness center attendees were Youths (0-15 years of age), 5% were Transitional Age Youths (16-25 years of age), 69% were Adults (26-59 years of age), 22% were Older Adults (60+ years of age), and 0% were of unknown age.

Approximately 84% of wellness center attendees were consumers, 9% were family members of consumers, and 4% identified as both consumers and family members, with 3% unknown or declining to state.

Caucasians, Hispanics, Asian/Pacific Islanders, and Multiple Races were slightly under represented. Native Americans and Other or Unknown were slightly over represented.



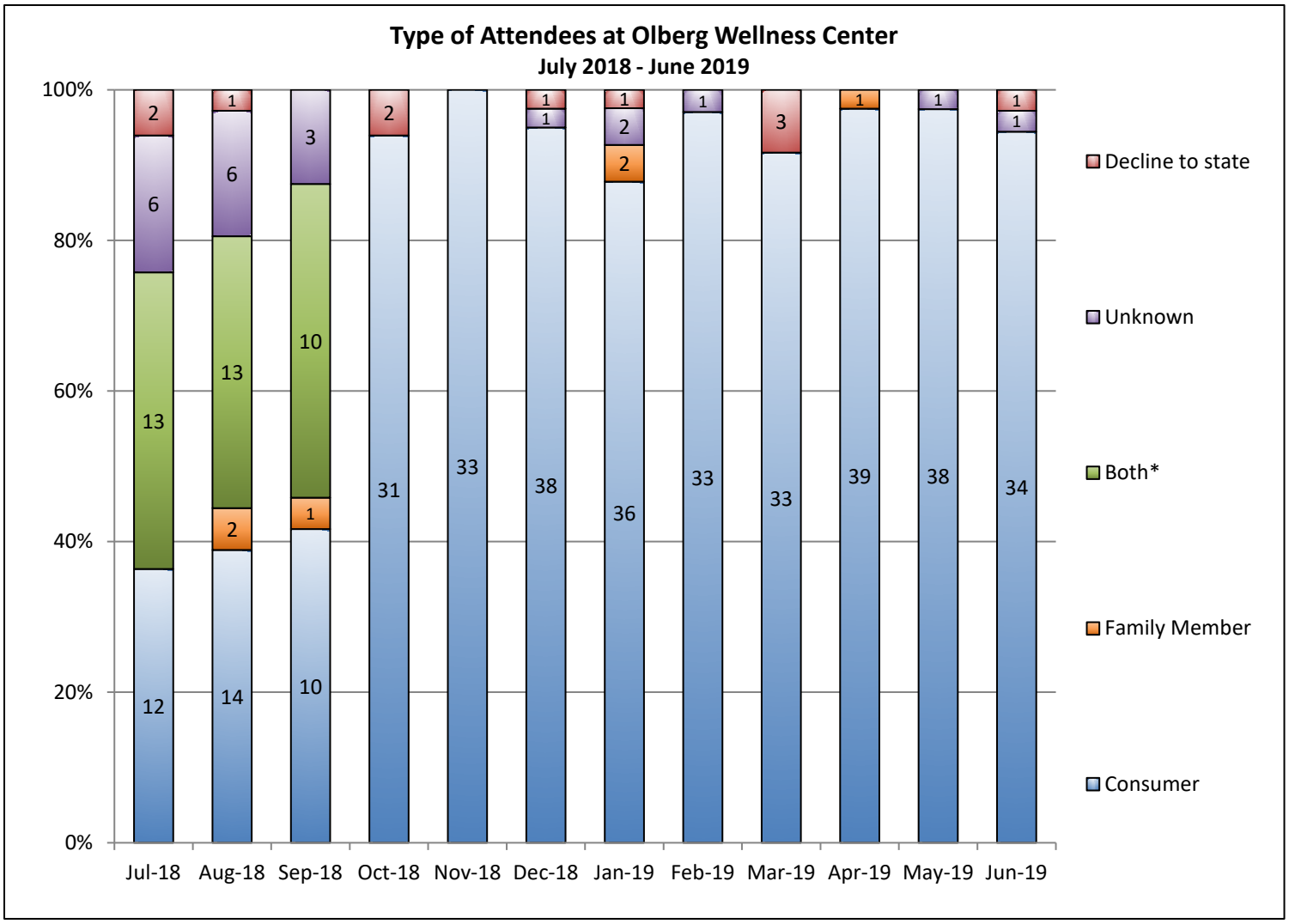
Services Provided

Overall, a total of 2,186 individual workshops, groups, activities, and 12-step recovery meetings were held during this twelve-month period.

Olberg Wellness Center

Attendance

Attendance increased 11% from the previous twelve-month period, with an average of 35 unduplicated participants each month.



*The category for identifying as "both" a family member and consumer was discontinued in October 2018.

Demographics

On average, 80% of attendees were consumers, 2% were family members, and 10% identified as both family members and consumers. On average, 5% of the participants were of unknown type, and 3% declined to state. On average, 91% 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 1,445 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.

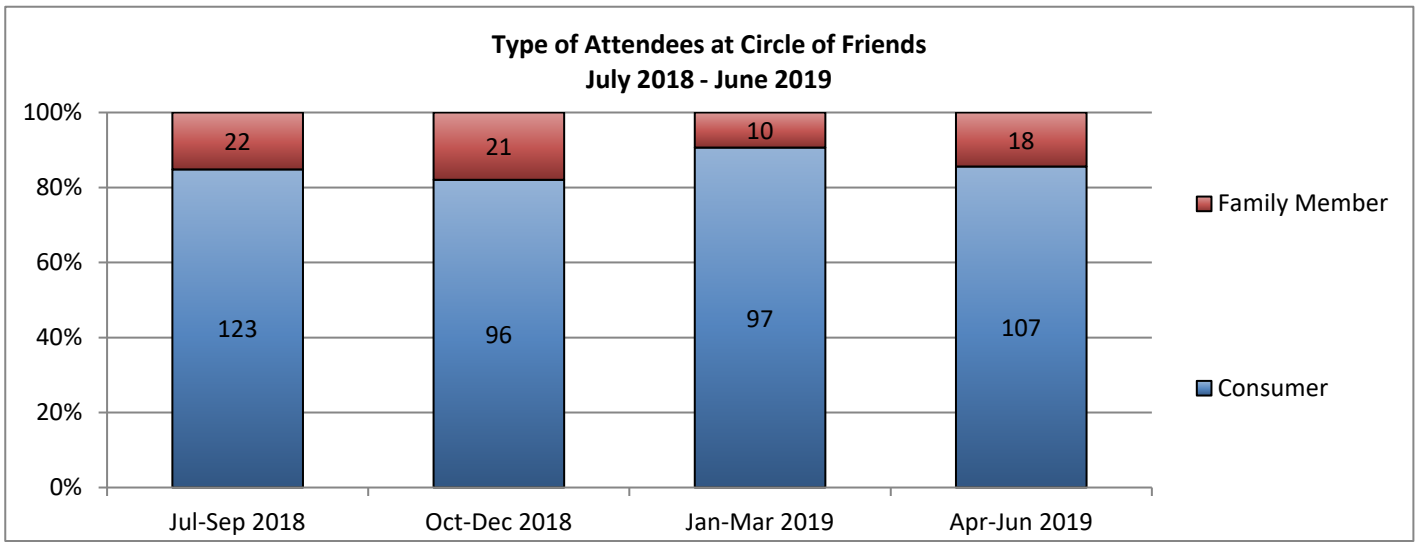
Attendee Direction

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 11 participants per meeting.

Circle of Friends

Attendance

Attendance increased 26% from the previous twelve-month period, with an average of 124 unduplicated people attending Circle of Friends each quarter.



Demographics

Eighty-six percent of attendees were consumers and 14% were family members. Eighty-eight percent of staff and 95% 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.

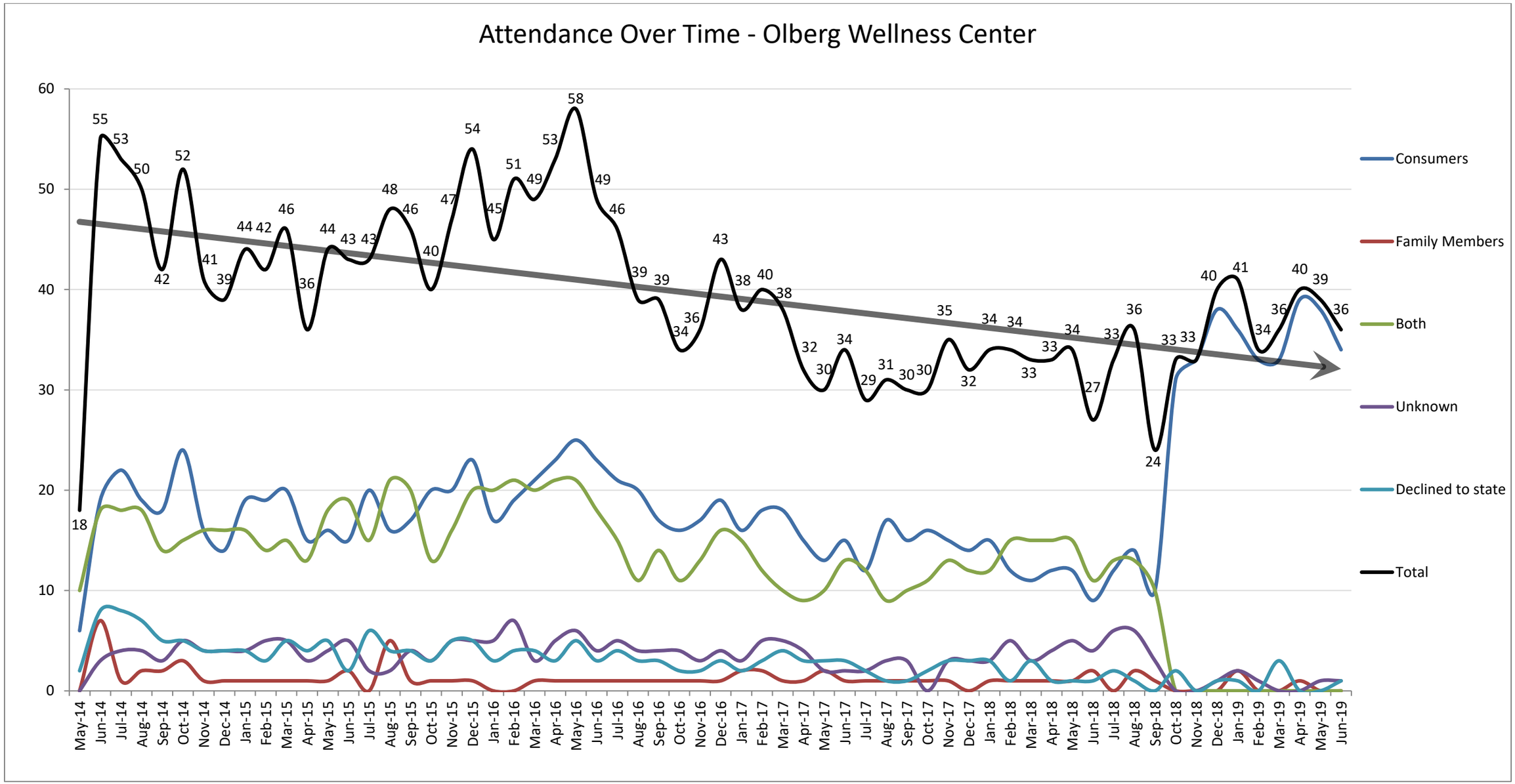
Services Provided

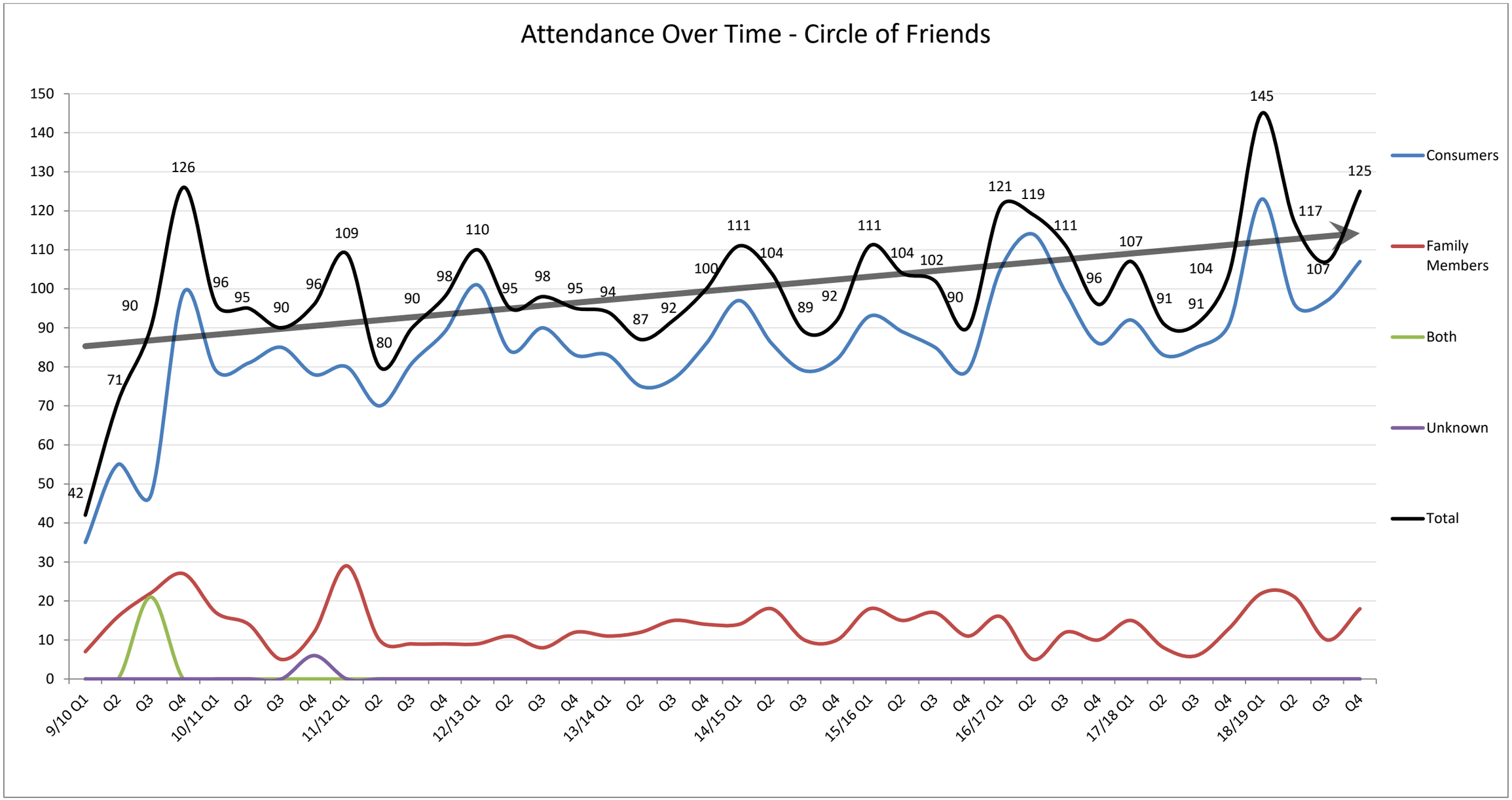
In Burney, the standard hours are 12:30 PM to 3:30 PM Monday, Wednesday, and Friday; and varying hours on Tuesdays and Thursday afternoons depending on the scheduled activity. In Round Mountain, activities are occasionally scheduled on Tuesdays or Thursdays. In addition, many scheduled activities and outings, chosen by participants, take place on other days, including evenings and weekends.

Ten workshops, 229 different activities, and 16 different weekly/biweekly 12 step recovery meetings were held on a regular basis, which provided 741 individual activities/groups for participants during this twelve-month period.

Attendee Direction

An average of 21 attendees (17%) contributed to the planning and direction of the program each quarter. All decisions relating to the Center are based on participant input through the Steering Committee, Stand Against Stigma Committee, Calendar and Newsletter Planning Meetings, daily check-in time, 10th Anniversary Planning Meetings, Becoming Brave Training, Coach Advocate Hiring Interviews, Mayers Memorial Community Health Fair, and other activity-specific planning meetings. Activities offered at the Center 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
150
140
130
120
110
100
90
80
70
60
50
40
30
20
10
0
42
71
90
126
96
95
90
96
109
80
90
98
110
95
98
95
94
87
92
100
111
104
89
92
111
104
102
90
121
119
111
96
107
91
91
104
145
107
117
125
9/10 Q1
Q2
Q3
Q4
10/11 Q1
Q2
Q3
Q4
11/12 Q1
Q2
Q3
Q4
12/13 Q1
Q2
Q3
Q4
13/14 Q1
Q2
Q3
Q4
14/15 Q1
Q2
Q3
Q4
15/16 Q1
Q2
Q3
Q4
16/17 Q1
Q2
Q3
Q4
17/18 Q1
Q2
Q3
Q4
18/19 Q1
Q2
Q3
Q4
Consumers
Family Members
Both
Unknown
Total

NAMI Summary Report

July 2018 through June 2019

Program Offerings

NAMI Shasta County offered Family to Family Support Group sessions and one-on-one mentoring sessions during Fiscal Year 18/19. 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. One of the NAMI volunteers ran the family support group sessions during Susan's absence. The average total number of hours volunteers spent on mentoring sessions each week was 23.5.

Special events and trainings that NAMI Shasta County arranged (or participated in) during the Fiscal Year are listed below:

- Fire Recovery Groups weekly from August to October
- Acupuncturists without borders weekly from August to October
- Holiday Celebration for clients on 12/7/2018 (125 attendees)
- Book signing for First Break (a book about dealing with mental illness) on 12/17/18 (20 attendees)
- Family Support Group North State Training from 11/2/18-11/4/18 (10 attendees)
- Stand Against Stigma meetings monthly from January through March
- "Minds Matter" on 5/10/19 from 3-9:30pm at Turtle Bay (50+ attendees)
- "Resources for resilience" presentation on 5/23/19 from 6:30-9:30pm at the library (45 attendees)
- "Solstice Jazz Festival" on 6/21/19 from 3-10pm at the Sun Dial bridge (75 attendees)

There were no facilitated peer support sessions, Peer-to-Peer, Family-to-Family, or NAMI Basics programs offered within the last year.

NAMI On Campus program

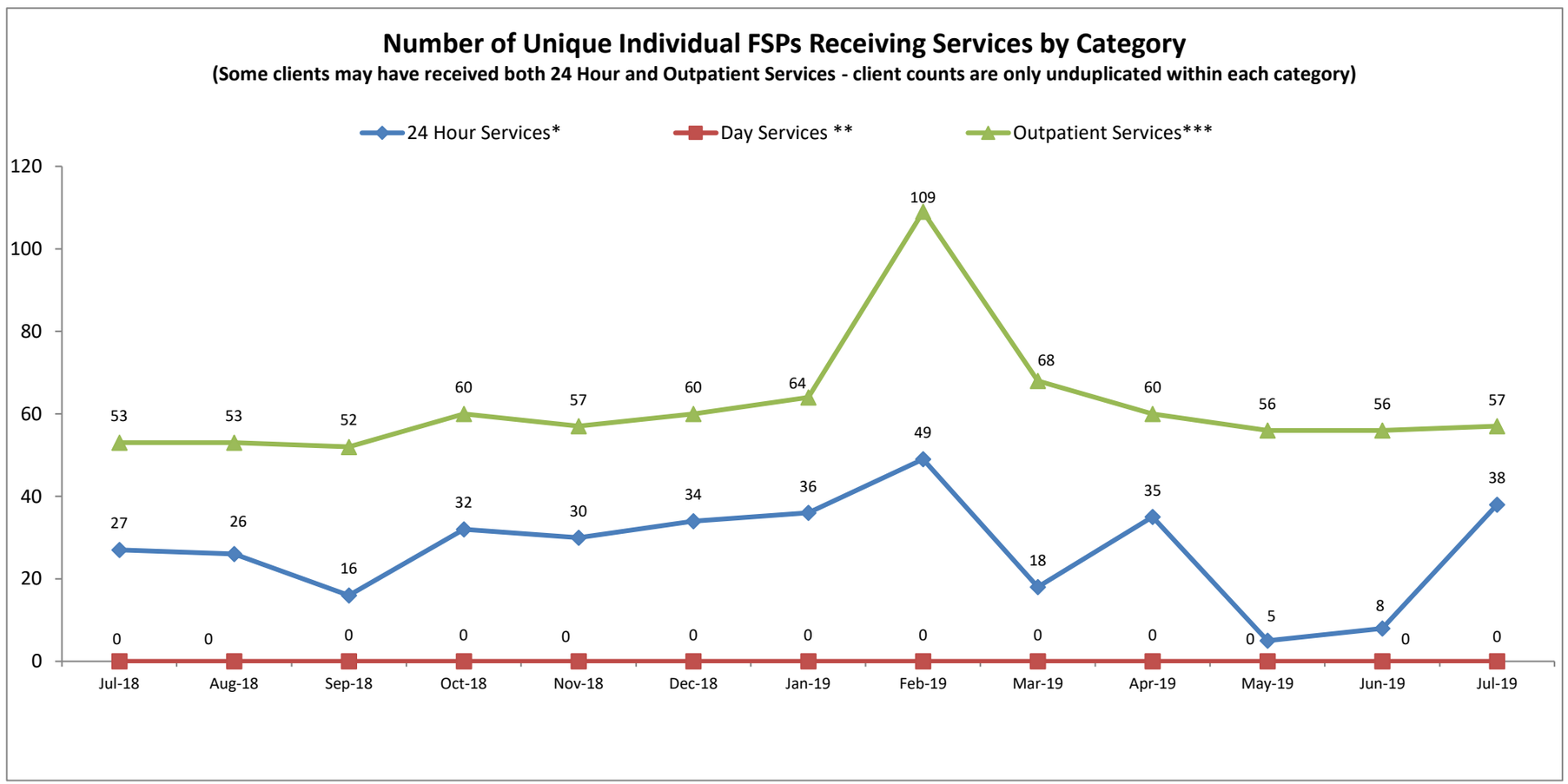
The NAMI On Campus program was planned for two schools: California Heritage Youthbuild Academy (CHYBA) and Shasta College. The NAMI On Campus program was not been implemented during Fiscal Year 18/19. Susan reported working with NAMI California to get a NAMI On Campus trainer to give her and her volunteers the tools to begin.

Successes included having phone calls returned and holding family support group meetings every two weeks, receiving NAMI reaffiliation at the state and national level (which happens every 10 years and must include the submission of a checklist of nearly 100 items to NAMI State for approval and revision), lots of diversity and consistency with the family support groups, and great feedback about NAMI's presence at the Summer Solstice Jazz Festival.

Barriers included limited help during certain weeks with office duties, not enough facilitators for Peer Support Group, NAMI participants facing challenges as a result of the fires, health issues, and needing more time with their families.

CSI AND FSP LINKED DATA – FY 2018-19

As part of the MediCal billing process in the State of California, information from the electronic health records on patient data and treatment is uploaded monthly from the county to the state. This is called Client and Service Information, or CSI. Within the MHSA Full Service Partnership (FSP) program, data is also collected in the state Data Collection and Reporting (DCR) system. Beginning in May 2015, the State of California Mental Health Services Oversight and Accountability Commission started sponsoring regional training (provided by Mental Health Data Alliance, LLC) on a newly available tool which can combine information from both these data sources. This information helps describe what treatments and services Full Service Partners are receiving in Shasta County, and how those services compare with other Shasta County consumers who are not part of the Full Service Partnership program. Data from the CSI file is based on input file date, and NOT on date of service, so information on this report may not match data from other sources due to late service reporting/billing by outside providers. This data includes Shasta County FSPs of all ages.



Mental Health Services are divided into three main categories: 24 Hour Services; Day Services; and, Outpatient Services.

24 Hour Services include various types of residential services, such as Skilled Nursing Facilities, Mental Health Rehab Centers and Psychiatric Health Facilities. These services are billed for by the day.

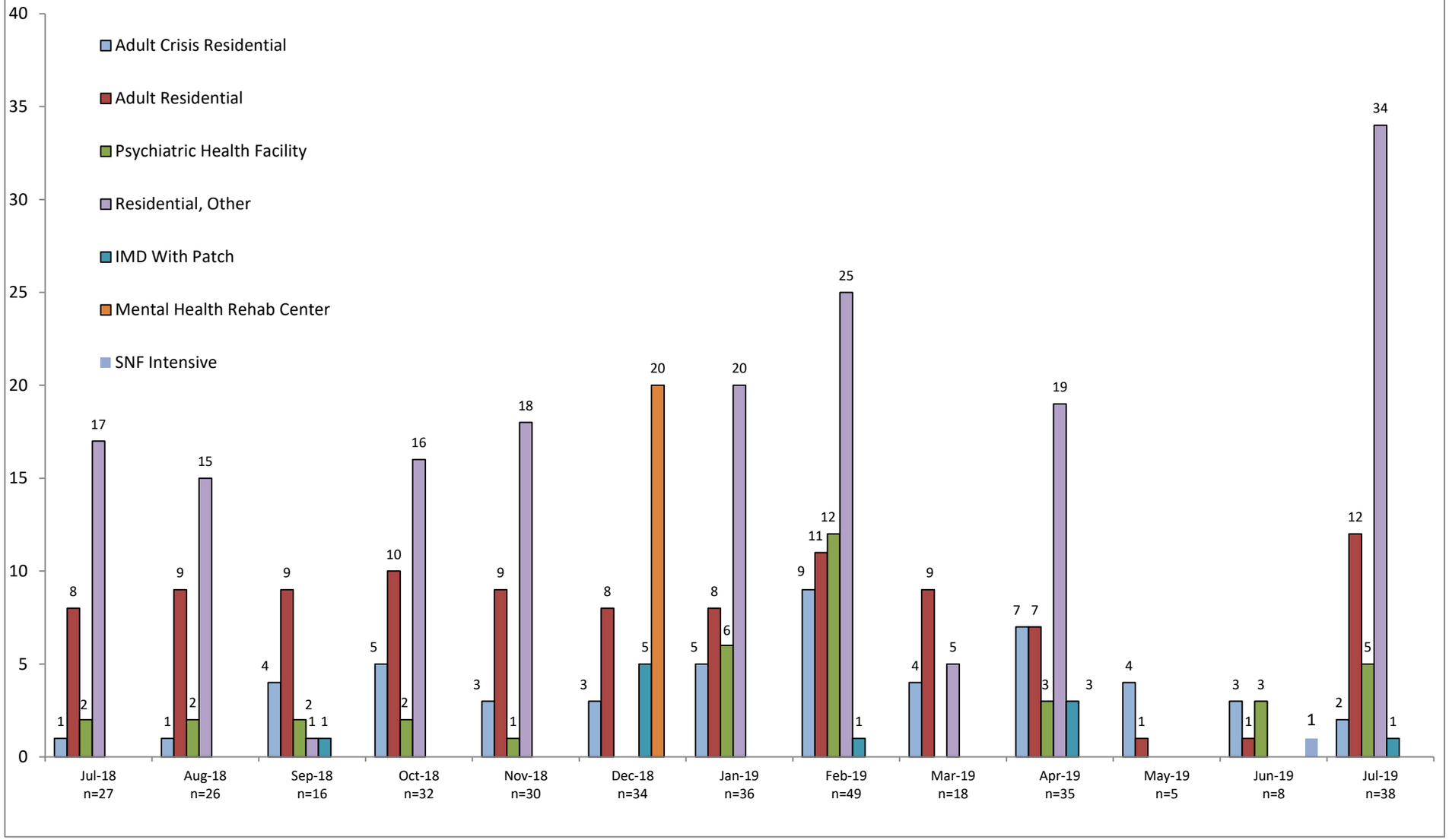
Day Services include such things as Day Treatment or Day Rehabilitation. These services are also billed for by the day, but differ from 24 Hour Services in that they do not provide over-night care.

Outpatient Services include things such as Crisis Intervention, Linkage/ Brokerage and Medication Support. These services are billed for by the minute.

*24 Hour Services are broken down by providers on pages 8 (SCMH) and 9-10 (vendors)
**Day Services are broken down by providers on page 12
***Outpatient Services are broken down by providers on pages 6 & 7 (SCMH) and 11 (vendors)

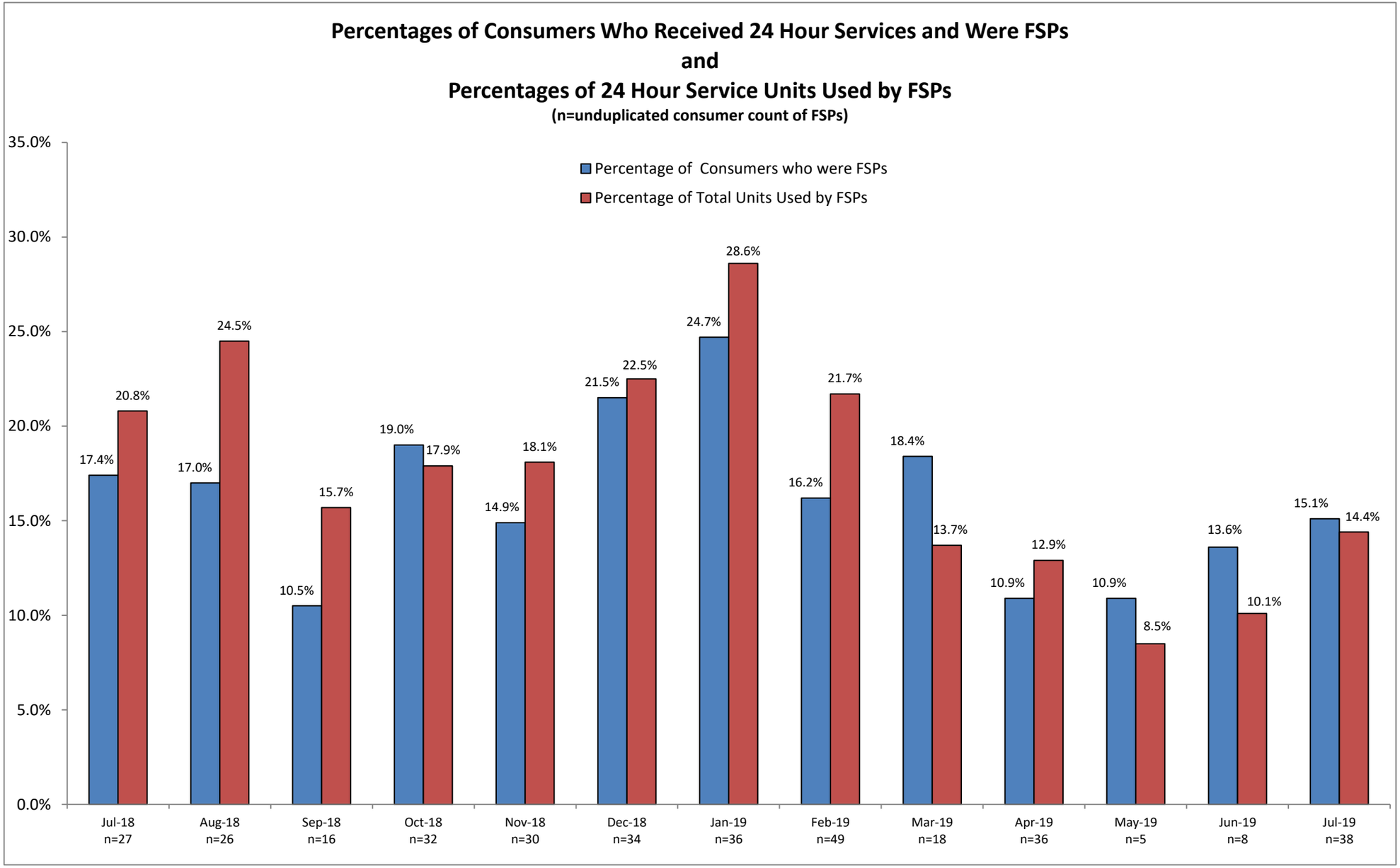
Number of Unique Individual FSPs Receiving 24 Hour Services by Type

(n=unduplicated consumer count of FSPs; should match blue line in chart on page 1)
(24 Hour Services are broken down by individual providers on pages 8-10)



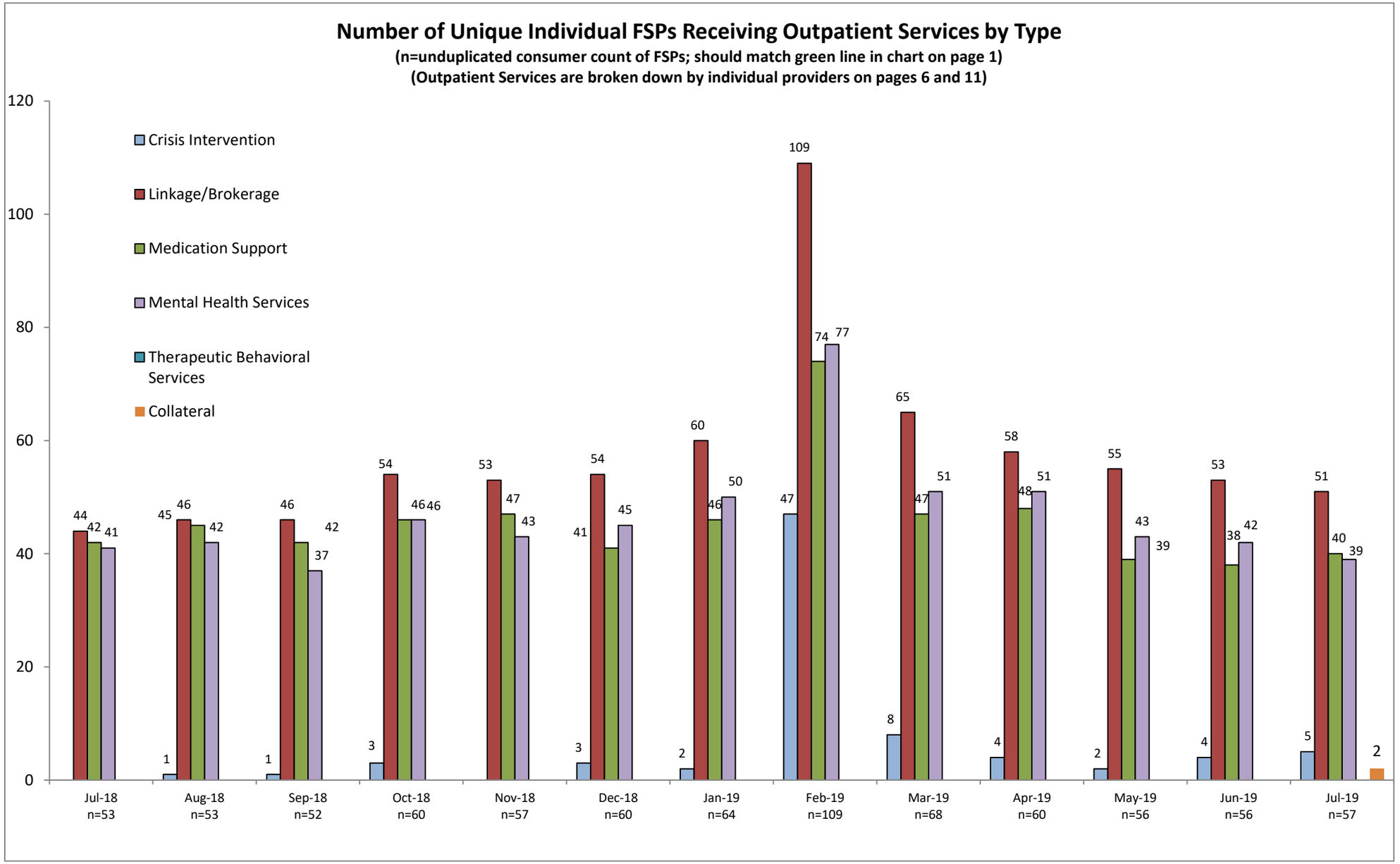
In this chart, the number of unduplicated Full Service Partners who received any type of 24 Hour Services is noted under the month as “n”.

The bars above each month show how many of those unduplicated Full Service Partners received each type of 24 Hour Service. Because consumers can, and often do, received more than one kind of service in any given month, the numbers for the services types each month may add up to more than the number listed as “n”.



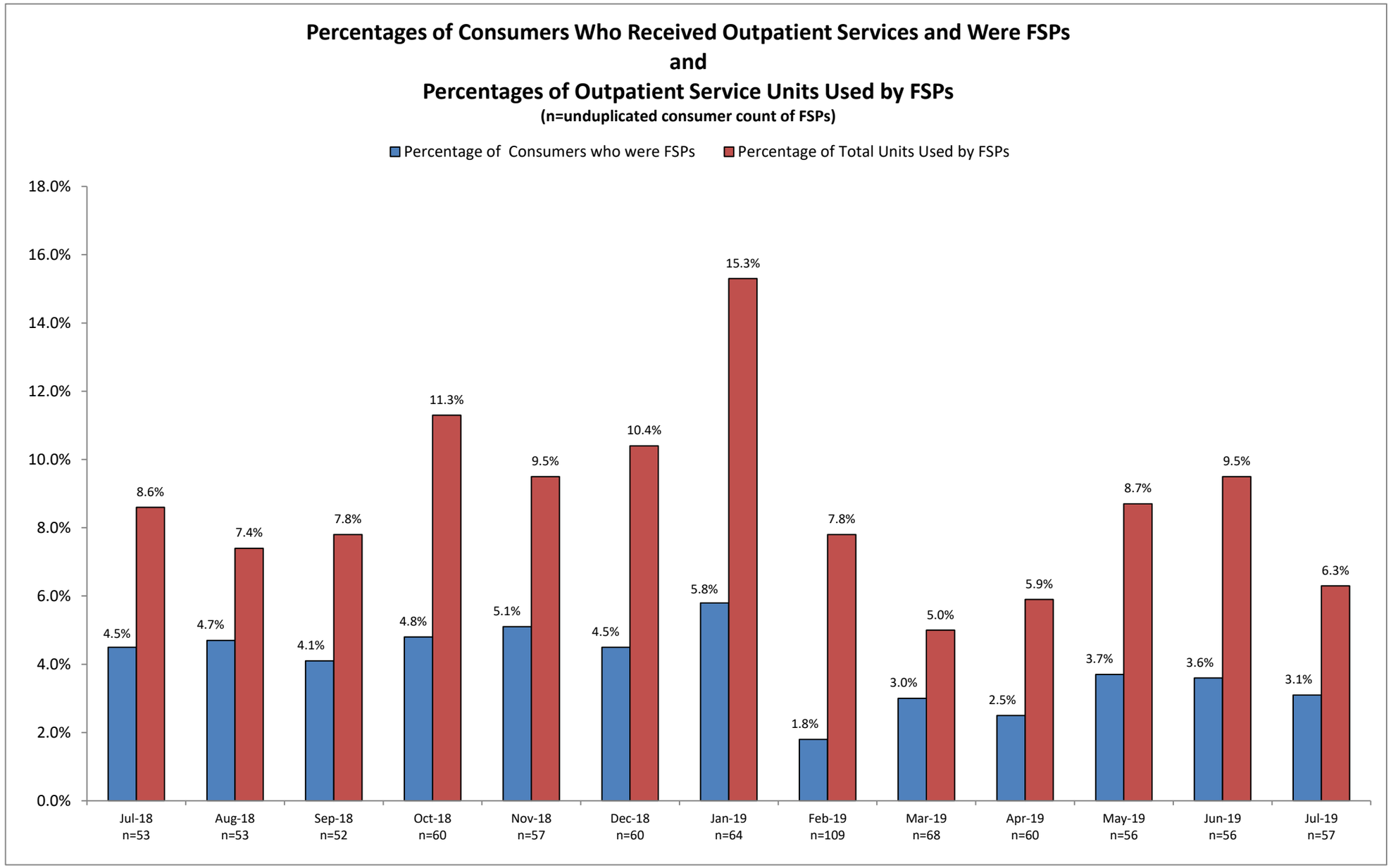
As mentioned before, 24 Hour Services are billed for by the day. This chart compares, by percentage, how many of the consumers who utilized 24 Hour Services were Full Service Partners, and how many of the days billed for were used by Full Service Partners.

Because the Full Service Partnership program is designed to provide intensive services, it is expected that partners may utilize disproportionately more of the services than non-partner consumers.



In this chart, the number of unduplicated Full Service Partners who received any type of Outpatient Services is noted under the month as “n”.

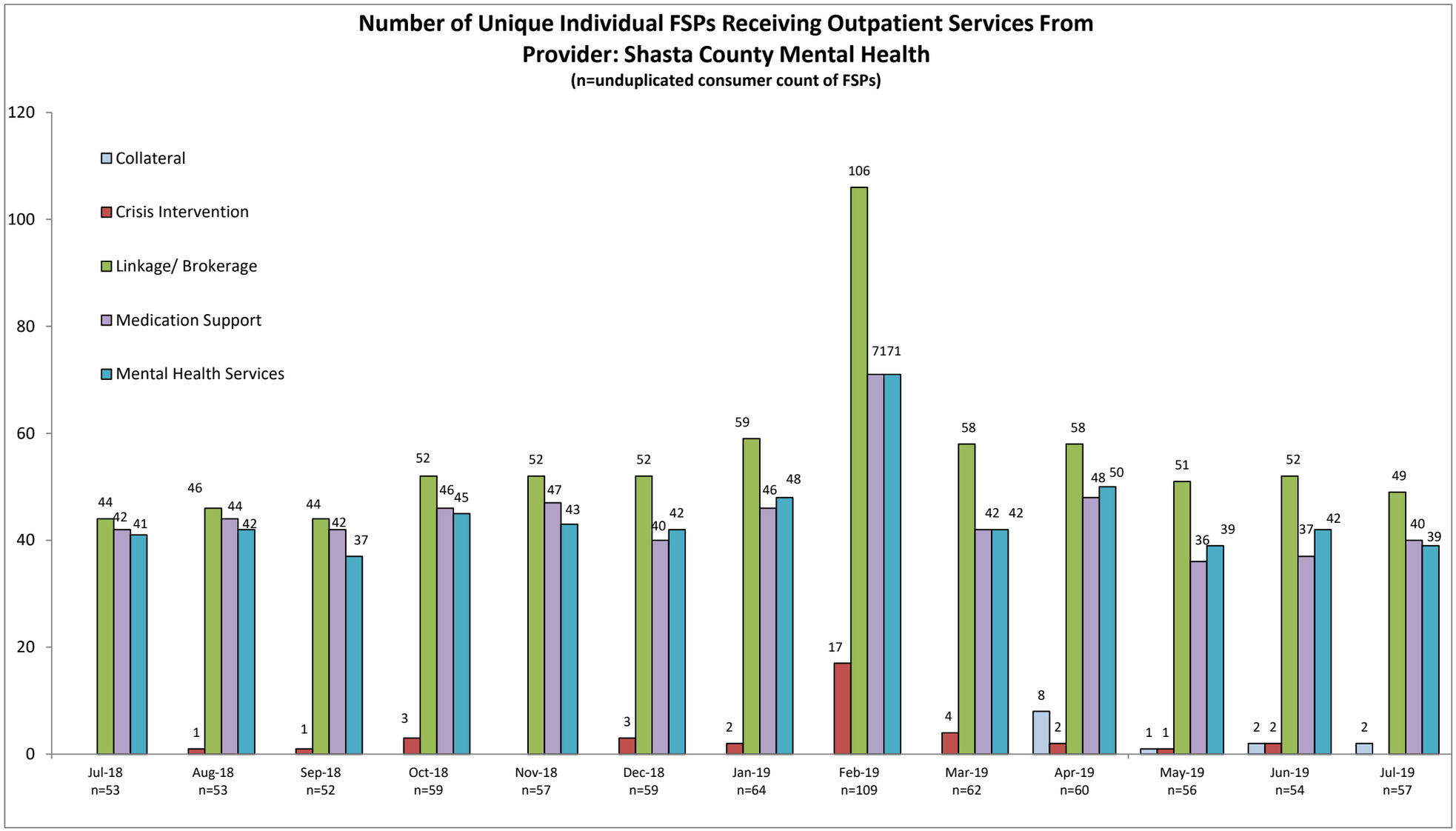
The bars above each month show how many of those unduplicated Full Service Partners received each type of Outpatient Service. Because consumers can, and often do, received more than one kind of service in any given month, the numbers for the services types each month may add up to more than the number listed as “n”.



As mentioned before, Outpatient Services are billed for by the minute. This chart compares, by percentage, how many of the consumers who utilized Outpatient Services were Full Service Partners, and how many of the minutes billed for were used by Full Service Partners.

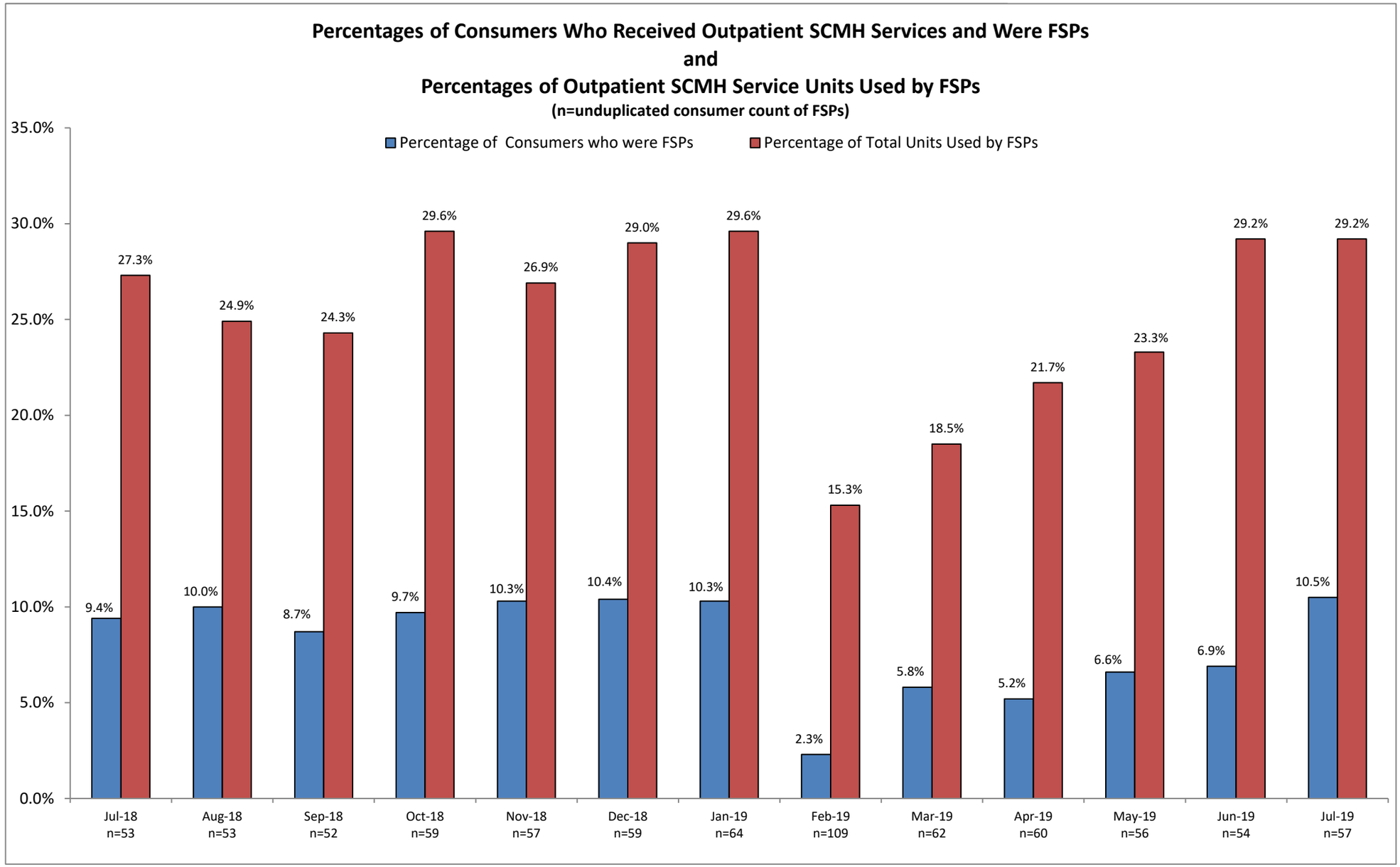
Because the Full Service Partnership program is designed to provide intensive services, it is expected that partners may utilize disproportionately more of the services than non-partner consumers.

Data can be further narrowed down into specifics regarding who provided the services. Based on this, the following charts split out both Outpatient and 24 Hour Services into those provided by Shasta County Mental Health (SCMH) and those provided by outside vendors.



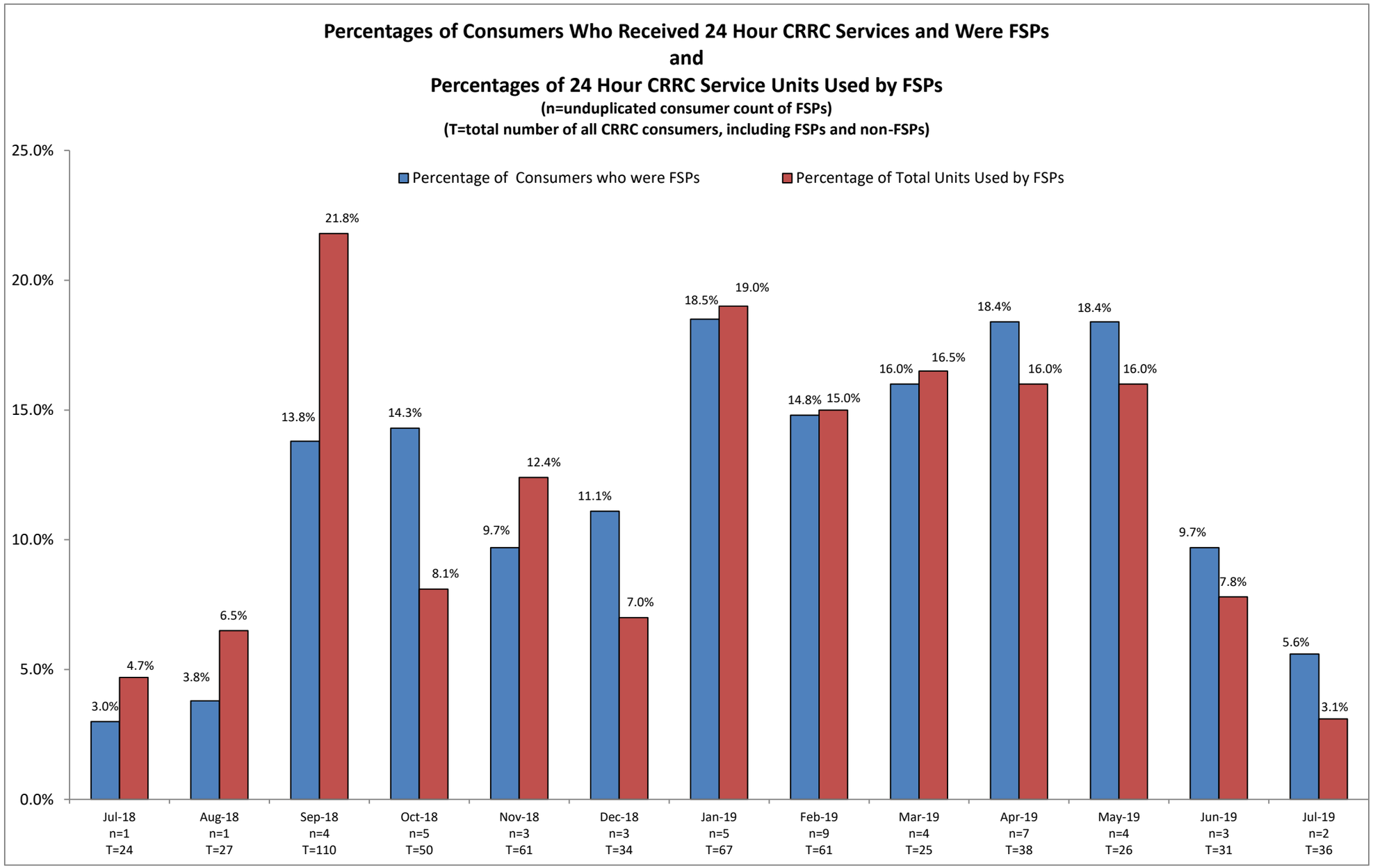
In this chart, the number of unduplicated Full Service Partners who received any type of Outpatient Services from SCMH is noted under the month as "n".

Again, the bars above each month show how many unduplicated Full Service Partners received each type of Outpatient Service. Because consumers can, and often do, received more than one kind of service in any given month, the numbers for the services types each month may add up to more than the number listed as "n".



This chart compares, by percentage, how many of the consumers who utilized Outpatient Services were Full Service Partners, and how many of the minutes billed for were used by Full Service Partners.

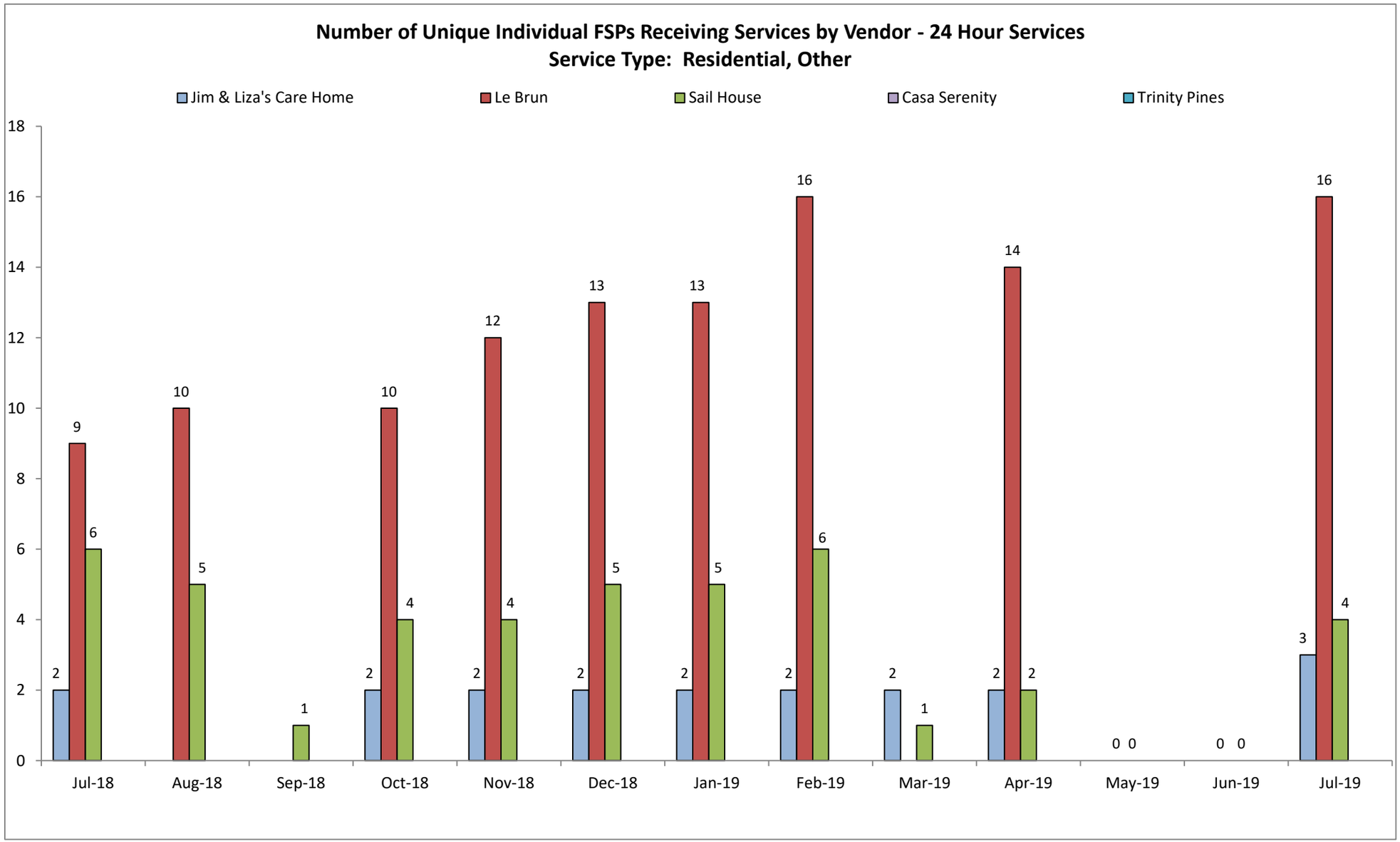
Because the Full Service Partnership program is designed to provide intensive services, and particularly because case management of FSPs is handled by SCMH staff, it is expected that partners may utilize disproportionately more of the services than non-partner consumers.



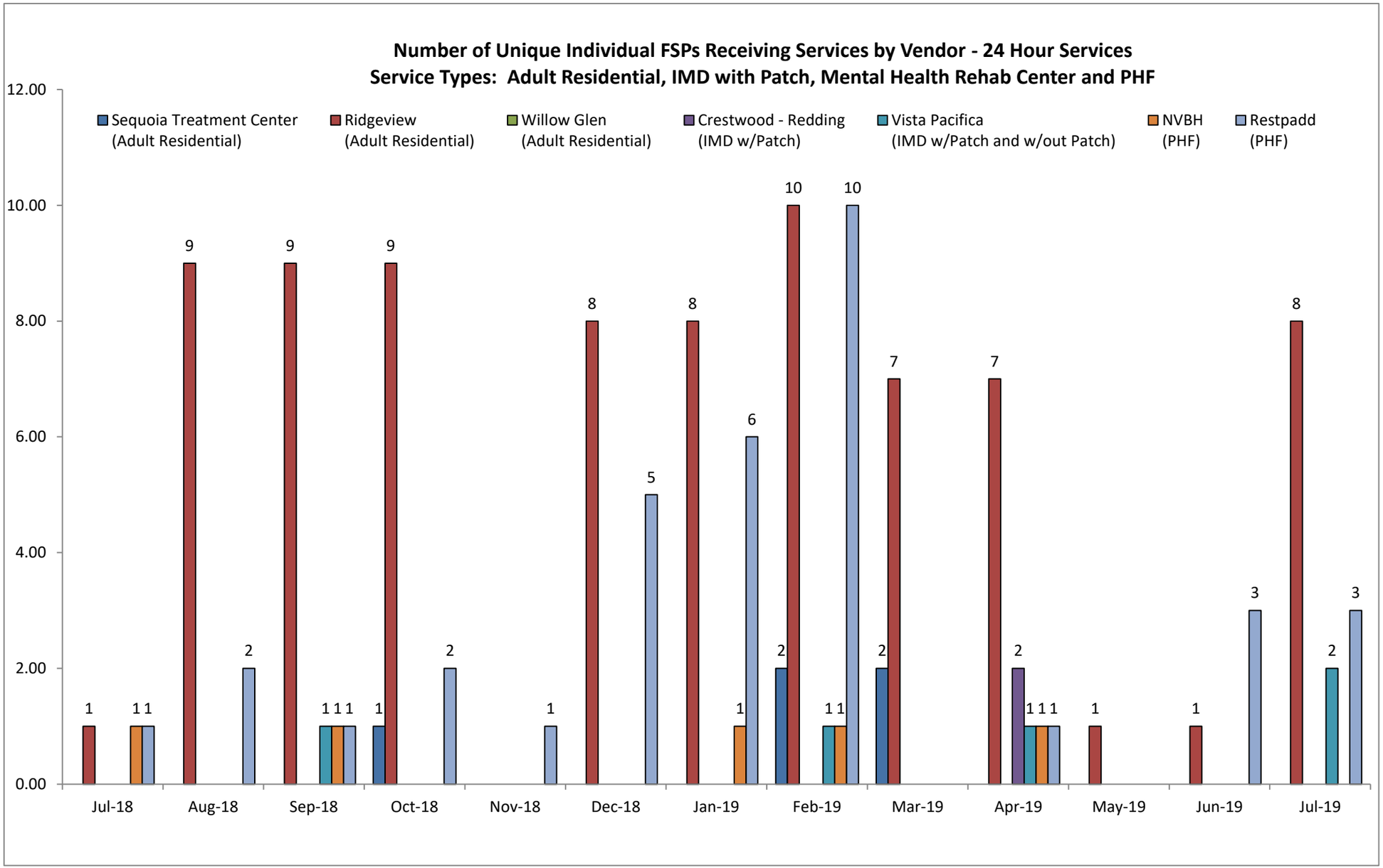
The only 24 Hour Service provided directly by Shasta County Mental Health is the Crisis Residential and Recovery Center (CRRC).

This chart compares, by percentage, how many of the consumers who utilized the CRRC were Full Service Partners (FSP), and how many of the days billed for were used by FSPs.

In this chart, the number of unduplicated FSPs who received CRRC services is noted under the month as “n”. The total number of all persons served by CRRC (including FSPs) is noted under the month as “T”.



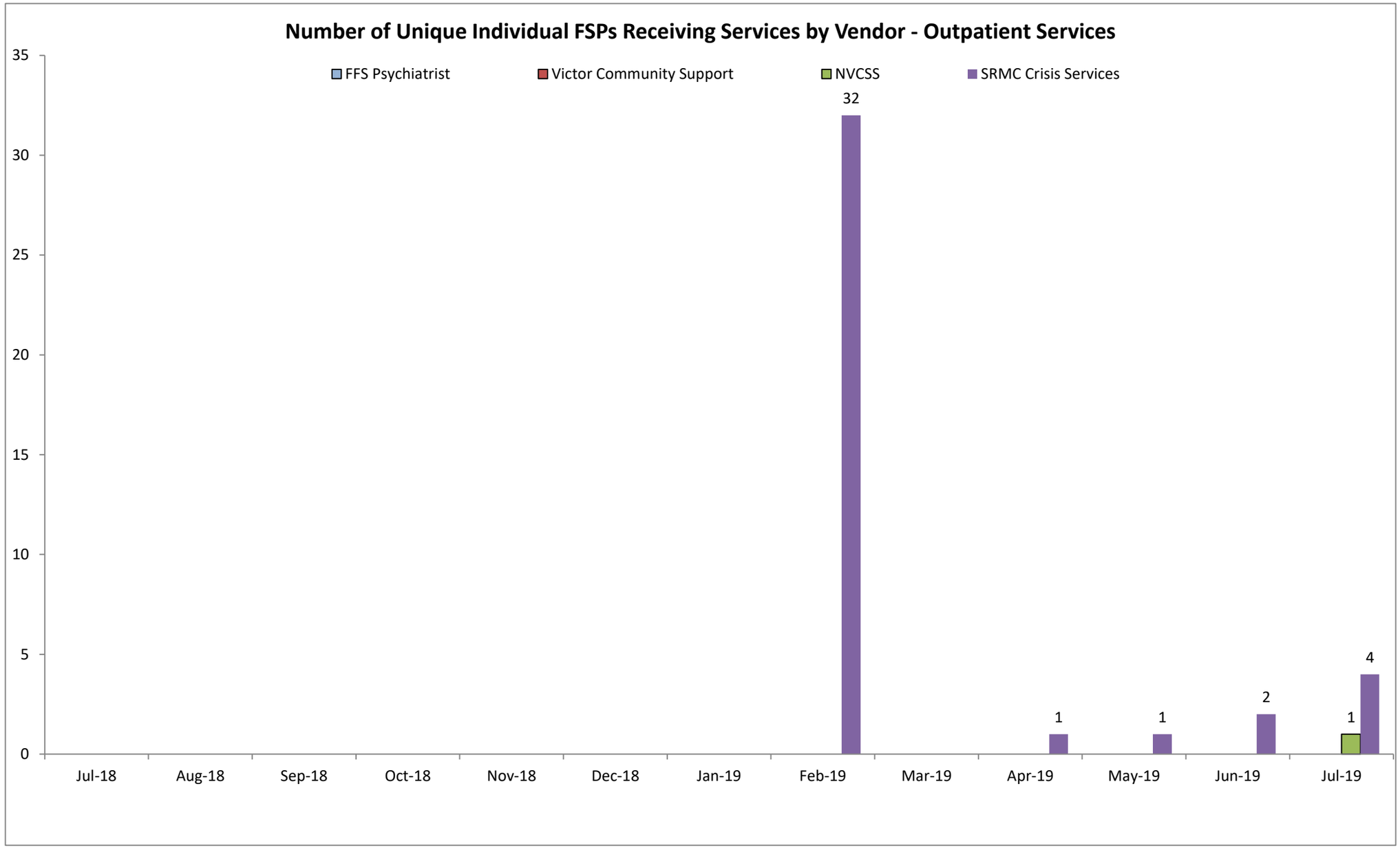
This chart shows the number of unduplicated Full Service Partners each individual vendor providing 24 Hour "Residential-Other" Services reported serving. Vendors appear to be some level of Board and Care setting. Because partners may have moved from one Board and Care to another in the same month, numbers of partners are only unduplicated by individual vendor. Due to the relatively large number of vendors, but small number of partners, no further breakdown of the data was performed.



This chart shows the number of unduplicated Full Service Partners each individual vendor providing all other 24 Hour Services reported serving. These vendors appear to be providing services at a higher level of care than a standard Board and Care facility.

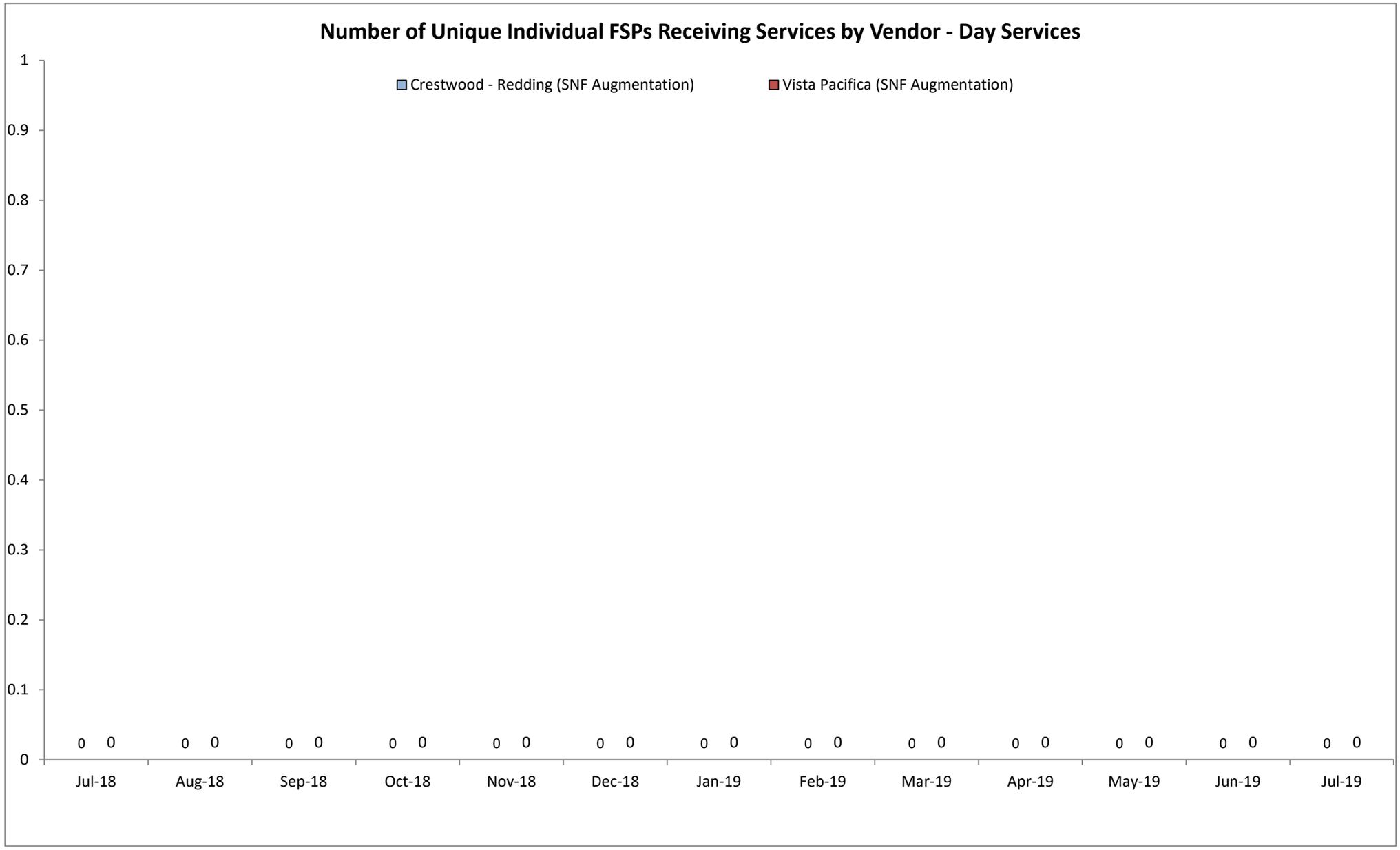
Because partners may have moved from one facility to another in the same month, numbers of partners are only unduplicated by individual vendor.

Due to the relatively large number of vendors, but small number of partners, no further breakdown of the data was performed.



This Chart shows the number of unduplicated Full Service Partners each individual vendor providing Outpatient Services reported serving.

Due to the small number of partners, no further breakdown of the data was performed.



This chart shows the number of unduplicated Full Service Partners each individual vendor providing Day Services reported serving.

Due to the small number of partners, no further breakdown of the data was performed.

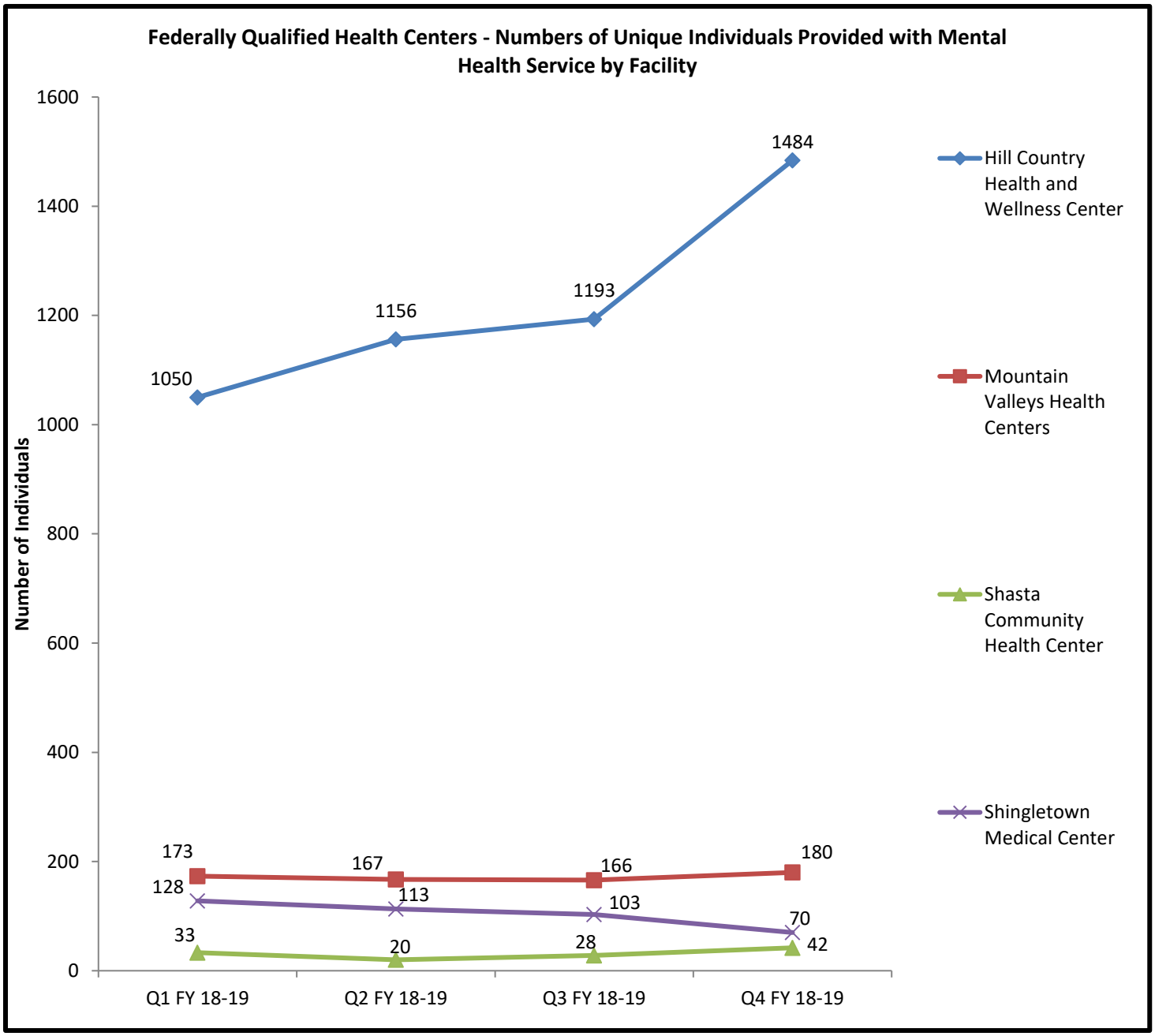
Federally Qualified Health Centers Annual Summary Report

July 2018 through June 2019

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 2018-2019 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.

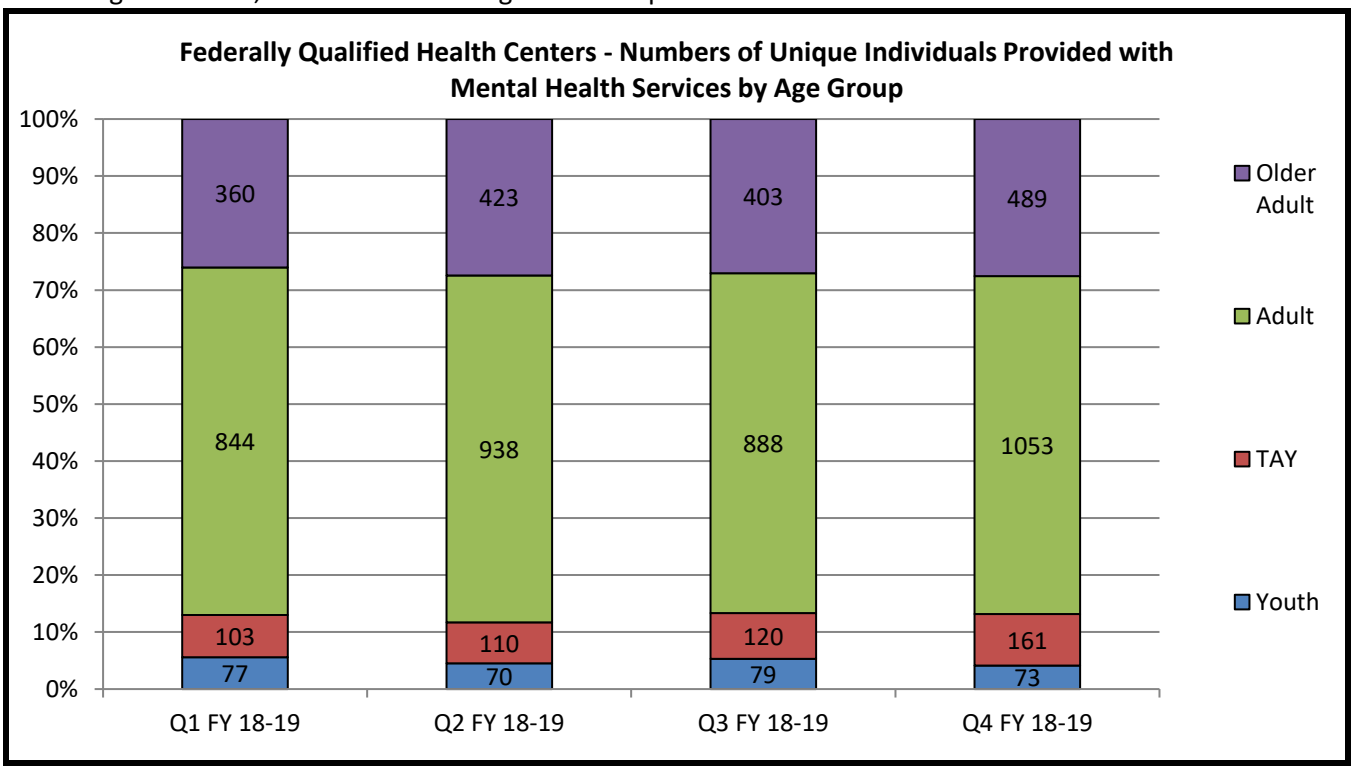
Attendance

An average of 1527 people visited a federally qualified health center in each quarter of fiscal year 2018-2019. This is a 12.94% increase compared to the previous fiscal year.

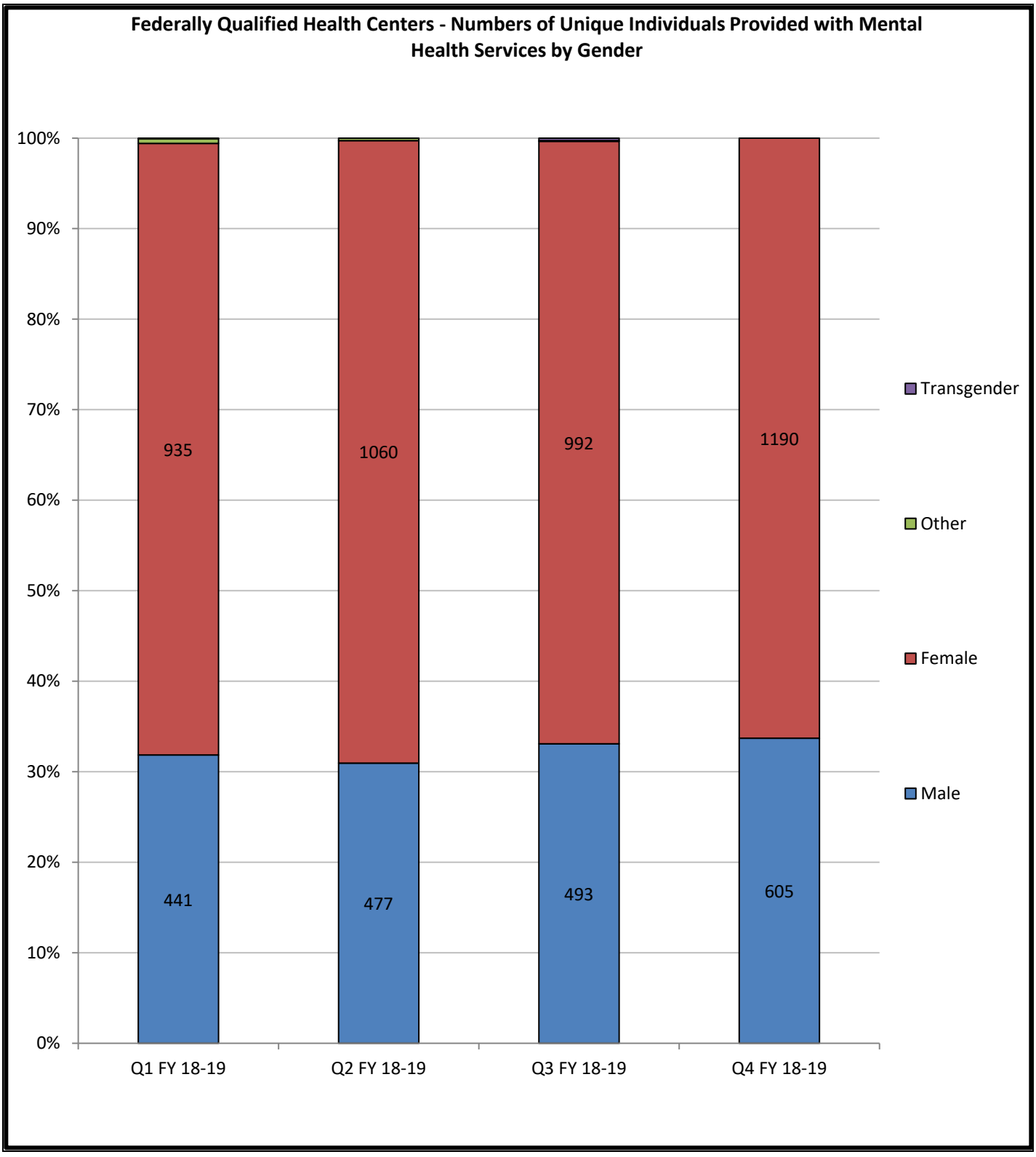


Demographics

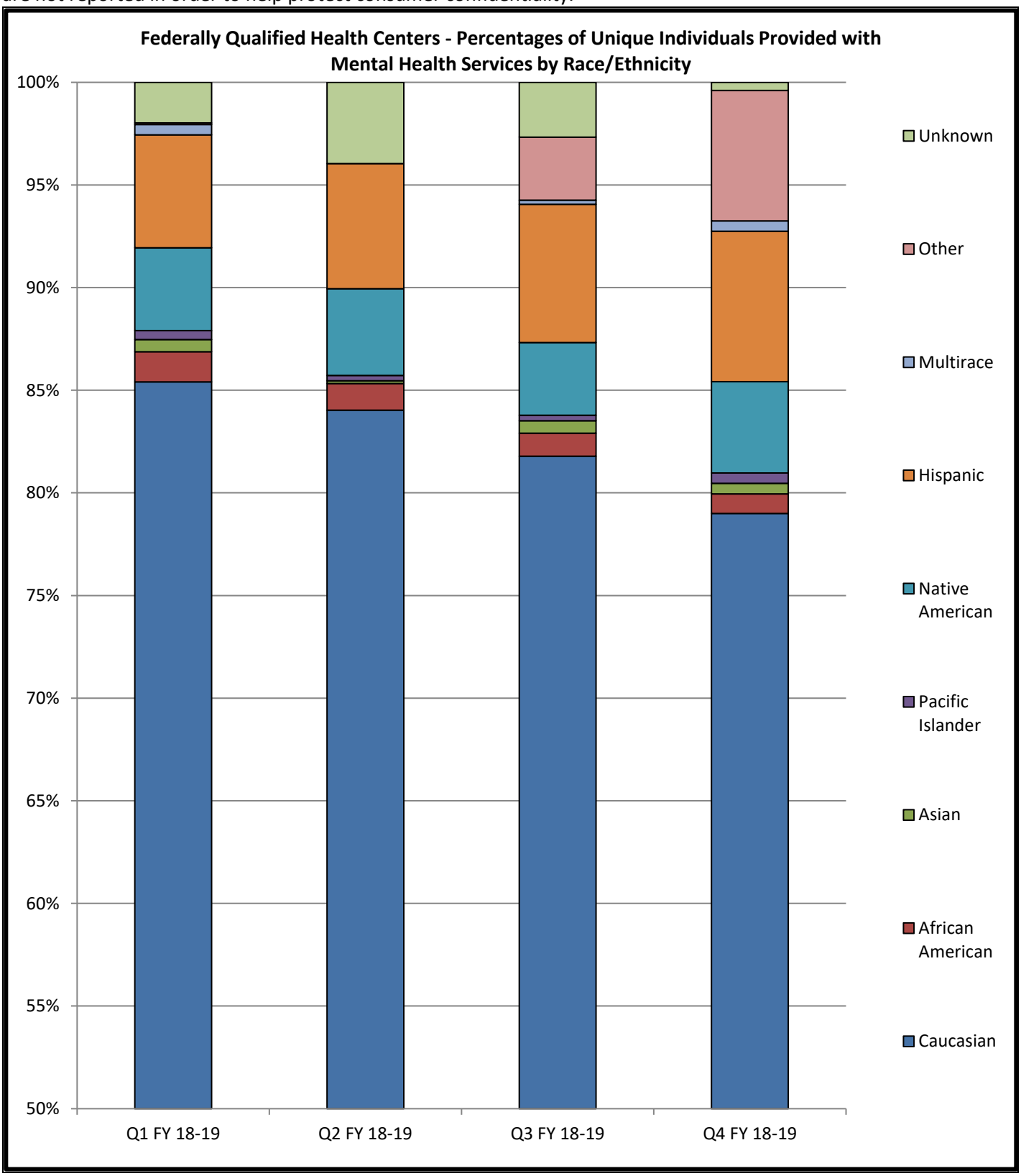
Age - The MHSA uses four age categories: Youth – ages 0 to 15, Transitional Aged Youth (TAY) – ages 16 to 25, Adult – ages 26 to 59, and Older Adult – ages 60 and up.



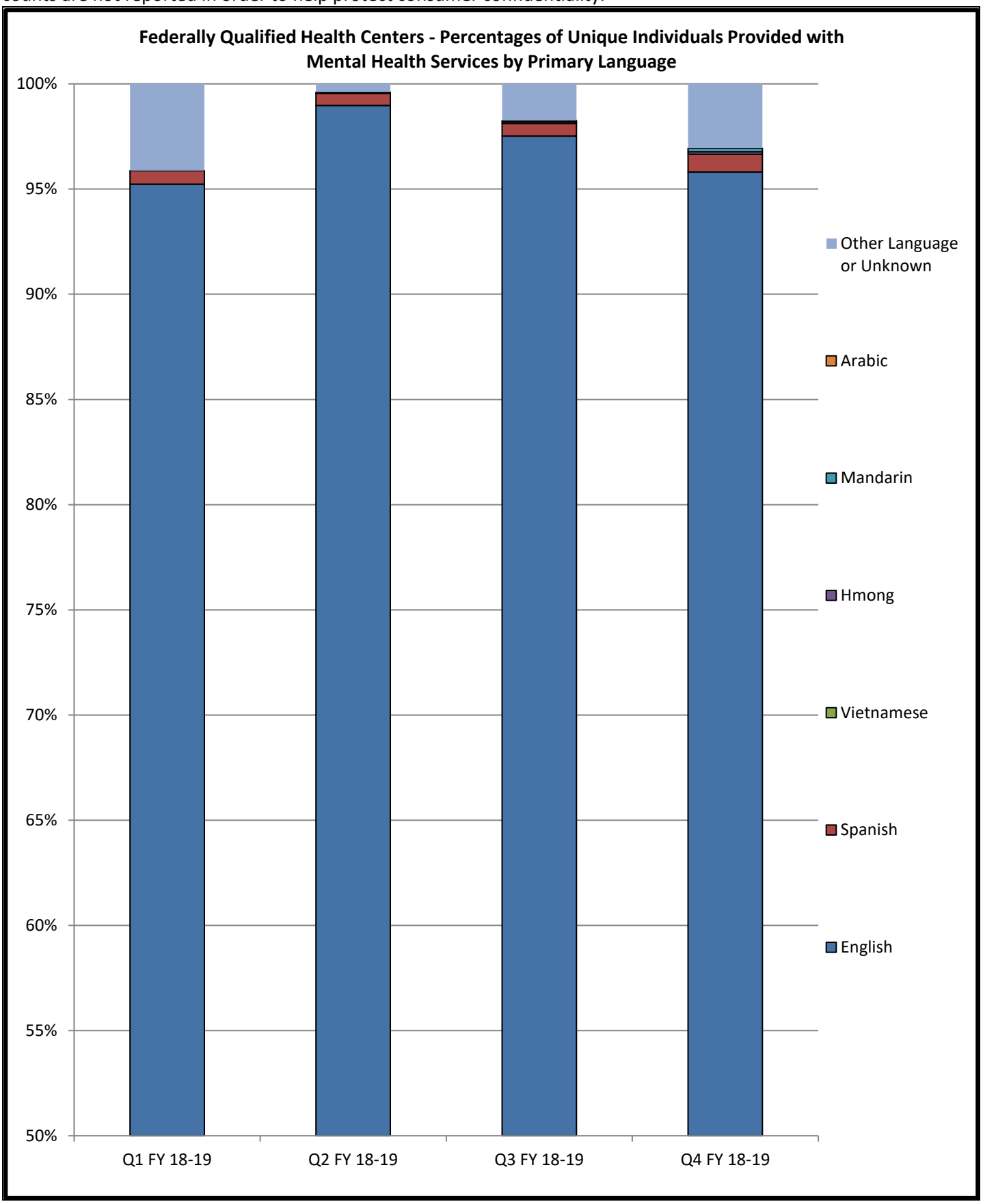
Gender - The MHSA uses four gender categories: Male, Female, Transgender, and Other. Counts of less than 20 individuals are not labeled to help maintain consumer confidentiality, but are included in the chart.



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.

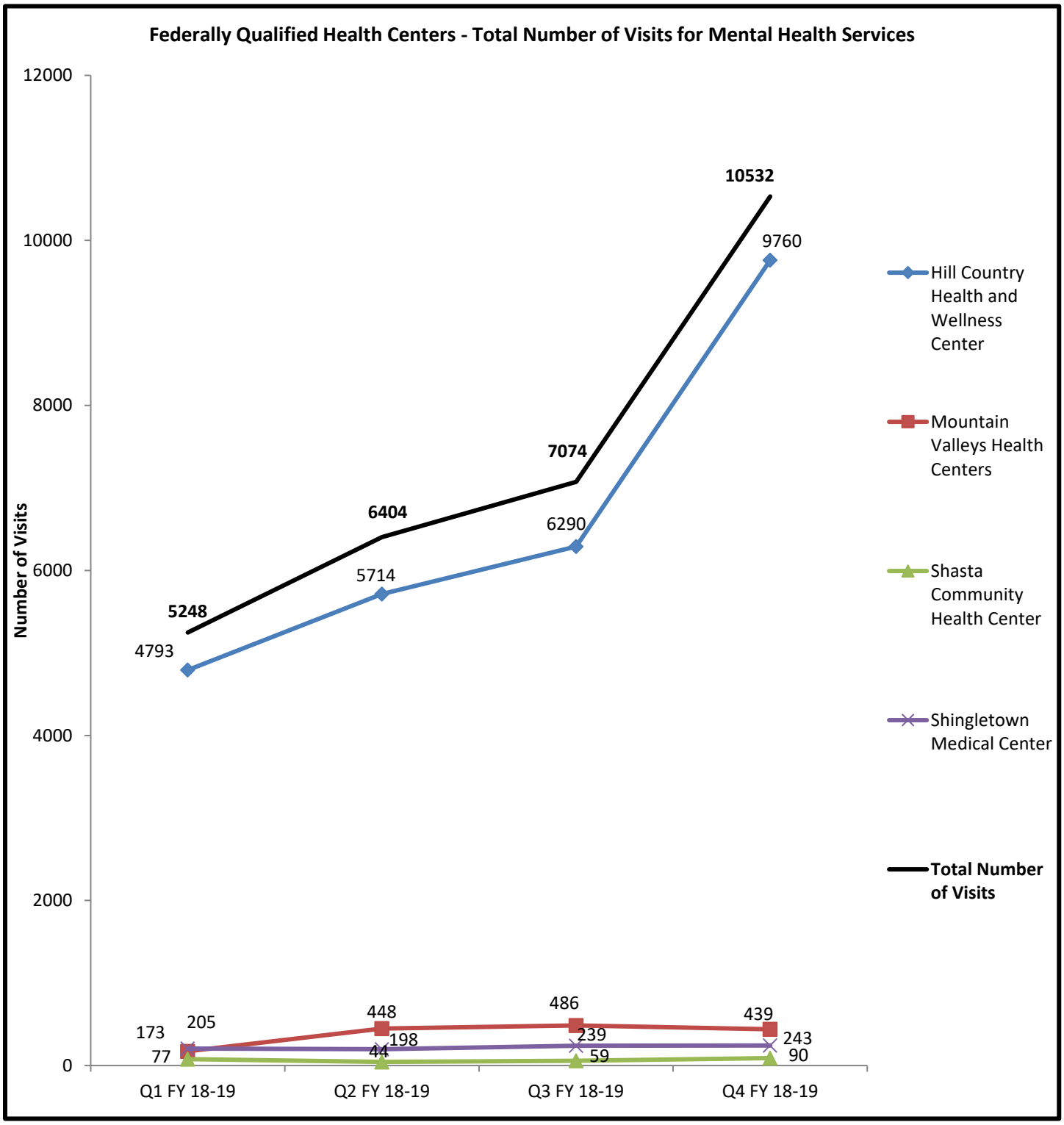


Primary Language - Because of the low gross numbers for some of these languages within small communities, actual counts are not reported in order to help protect consumer confidentiality.



Services Provided

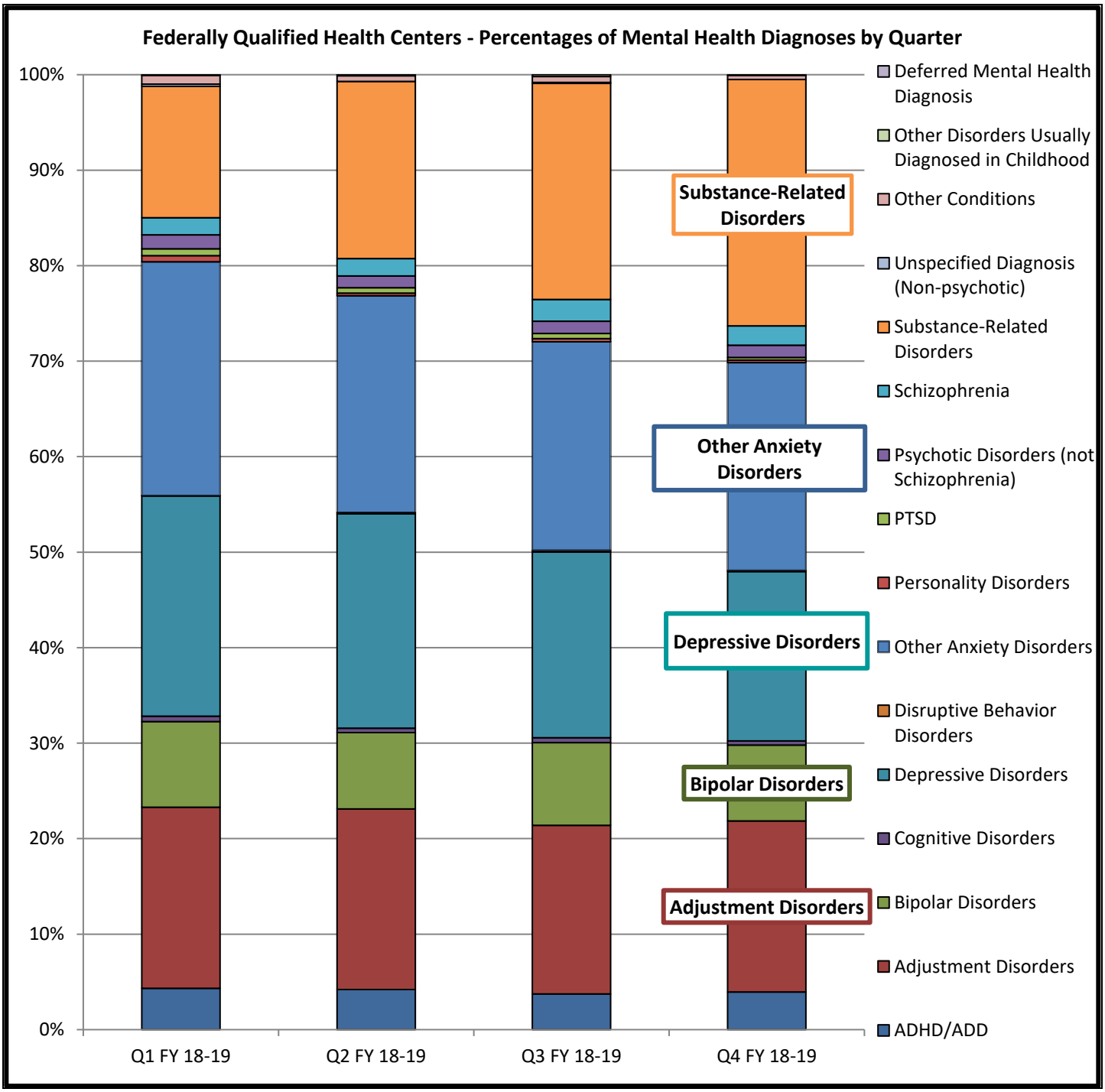
Most people will have multiple visits to the FQHC each quarter, and different types of service may be offered at different times in order to provide everyone with comprehensive and integrated age appropriate mental health services. Services provided may include such things as screenings, assessments, 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."



Crisis Residential and Recovery Center (CRRC) Program Activity

Bolded and underlined numbers represent the highest number during the fiscal year. There were 13 CRRC admits in June, which was the same as May (13), and a 35% decrease from the same month of the prior fiscal year. The CRRC bed days of 379 for June was a 13% decrease from May, and a 12% increase from June of last year. The average length of stay during June was 29 days, a 15% decrease from May, and a 71% increase from June in the previous year.

CRRC/*Elpida* Admits (chart on page 4)

FY	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY Total	FY Change +/-**
YTD Change +/-*	-6%	20%	21%	35%	36%	30%	23%	23%	25%	22%	18%	12%		
2018-19	16	20	15	***22***	18	14	18	13	15	16	13	13	**193**	12%
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%
2009-10	24	26	25	27	***29***	15	23	24	27	20	22	24	**286**	-24%
2008-09	31	35	34	34	31	26	27	29	37	24	28	***39***	**375**	1%

CRRC/*Elpida* Days (chart on page 4)

FY	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY Total	FY Change +/-**
YTD Change +/-*	84%	111%	103%	101%	85%	61%	55%	50%	55%	60%	55%	50%		
2018-19	375	404	348	403	357	285	367	320	394	407	***437***	379	**4476**	**50%**
2017-18	204	165	187	204	260	329	288	264	191	201	***353***	339	**2985**	**13%**
2016-17	295	280	201	185	291	120	242	199	167	228	130	***313***	**2651**	-7%
2015-16	236	224	244	***342***	301	266	194	217	178	215	193	229	**2839**	-5%
2014-15	***345***	268	280	235	235	186	284	239	174	246	192	304	**2988**	-3%
2013-14	274	231	255	295	136	207	333	311	212	***335***	242	243	**3074**	-14%
2012-13	315	341	321	310	344	***361***	248	259	296	308	213	274	**3590**	20%
2011-12	216	202	296	***329***	209	196	247	191	279	291	267	268	**2991**	2%
2010-11	193	254	250	290	278	231	***307***	192	203	165	302	280	**2945**	-10%
2009-10	***356***	272	323	319	311	199	231	266	245	241	238	267	**3268**	-12%
2008-09	330	300	301	248	270	276	318	319	***366***	310	312	350	**3700**	50%

CRRC/*Elpida* Average Length of Stay (Bed Days/Discharge Count) - (chart on page 4)

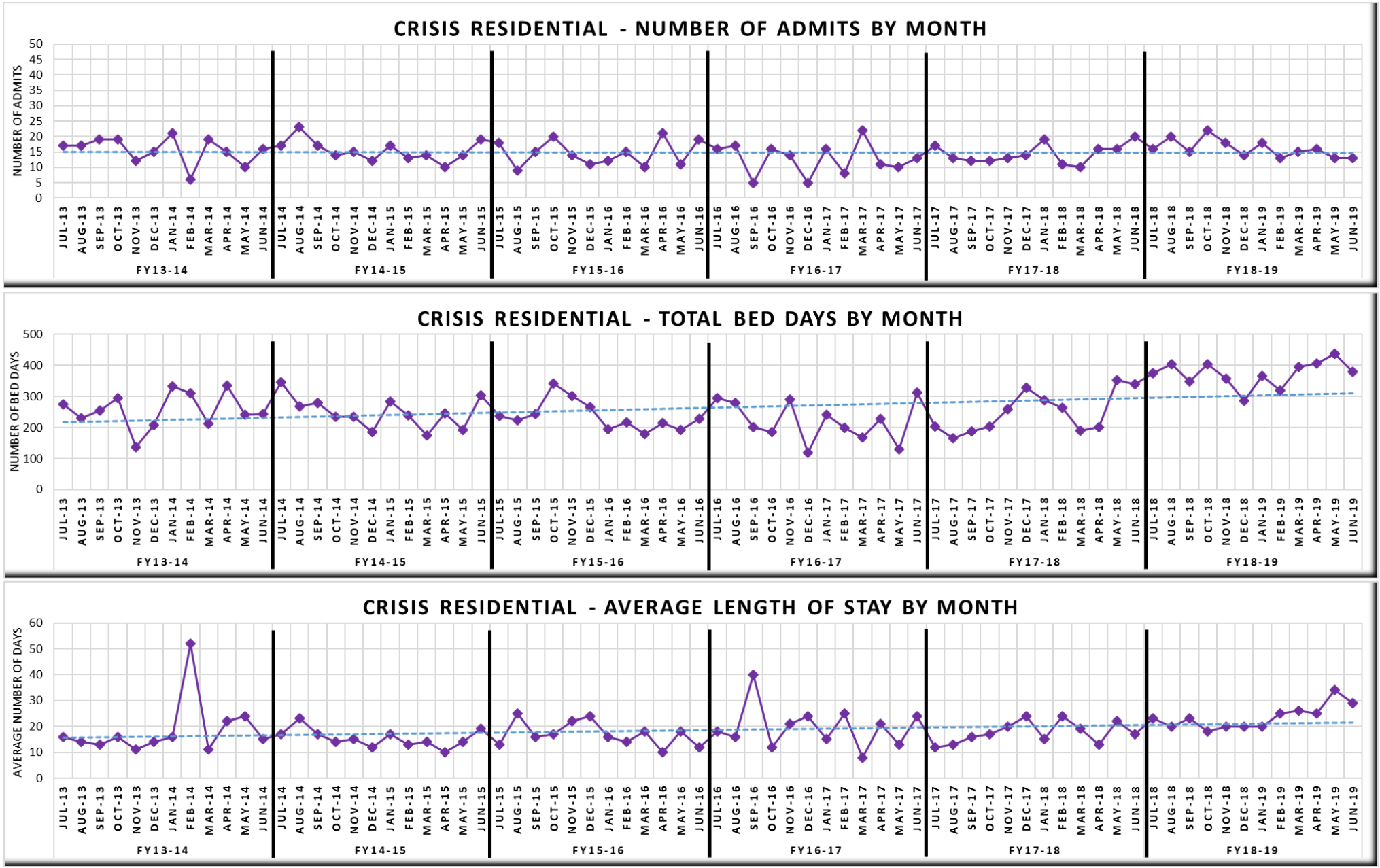
FY	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY Avg. LOS	Change +/-**
2018-19	23	20	23	18	20	20	20	25	26	25	***34***	29	**24**	33%
2017-18	12	13	16	17	20	24	15	24	19	13	22	17	**18**	-11%
2016-17	18	16	***40***	12	21	24	15	25	8	21	13	24	***20***	16%
2015-16	13	***25***	16	17	22	24	16	14	18	10	18	12	**17**	7%
2014-15	20	12	16	17	16	16	17	11	12	***25***	14	16	**16**	-14%
2013-14	16	14	13	16	11	14	16	***52***	11	22	24	15	**19**	32%
2012-13	12	12	15	12	14	***19***	15	12	16	18	11	14	**14**	19%
2011-12	9	9	11	16	***19***	9	12	9	10	16	12	11	**12**	8%
2010-11	10	10	11	13	13	10	***14***	10	9	9	10	13	**11**	-4%
2009-10	***15***	10	13	12	11	13	10	11	9	12	11	11	**12**	13%
2008-09	11	9	9	7	9	11	12	11	10	***13***	11	9	**10**	61%

* 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.

Data as of: 7/10/19 OPE JC

Chart: Crisis Residential



Length of stays are rounded numbers.

Data as of: 7/10/19 OPE JC

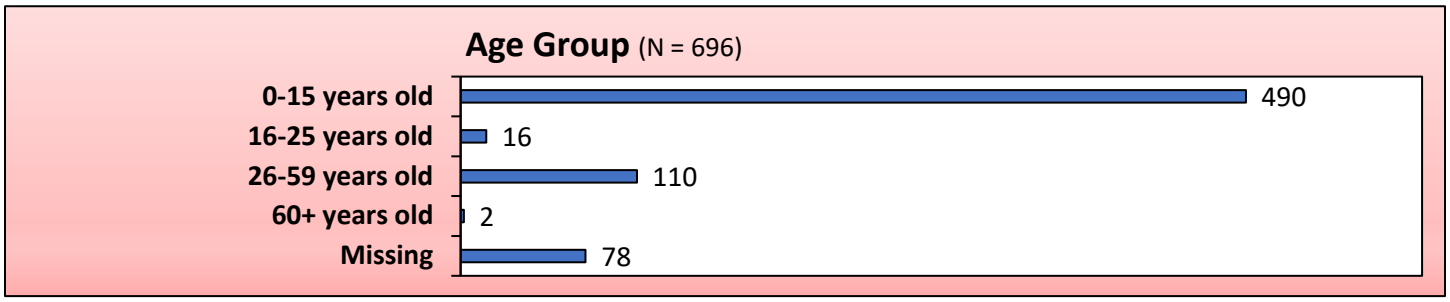
Shasta County Health & Human Services Agency

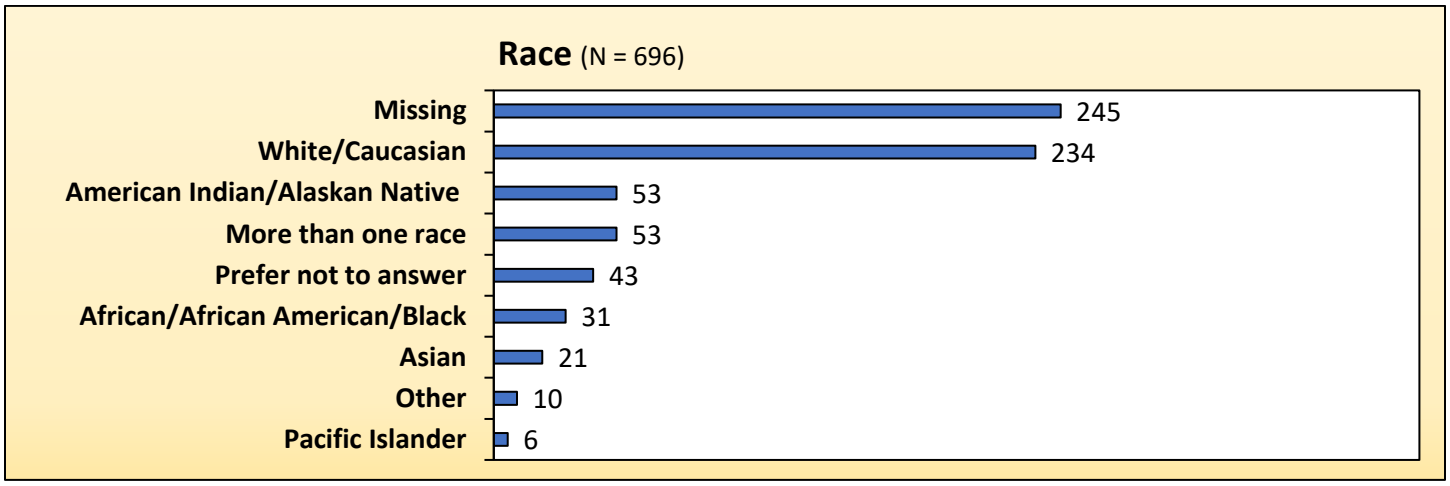
MHSA Prevention and Early Intervention Fiscal Year 18/19 Demographics Report

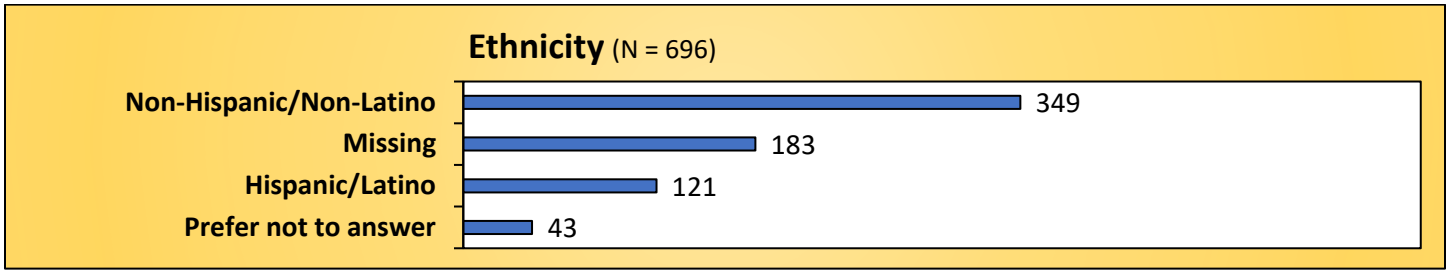
I. Prevention and Early Intervention Program Demographics

- Triple P (151 individuals submitted data)
- Botvin Lifeskills (534 individuals submitted data)
- Early Onset (11 individuals submitted data)

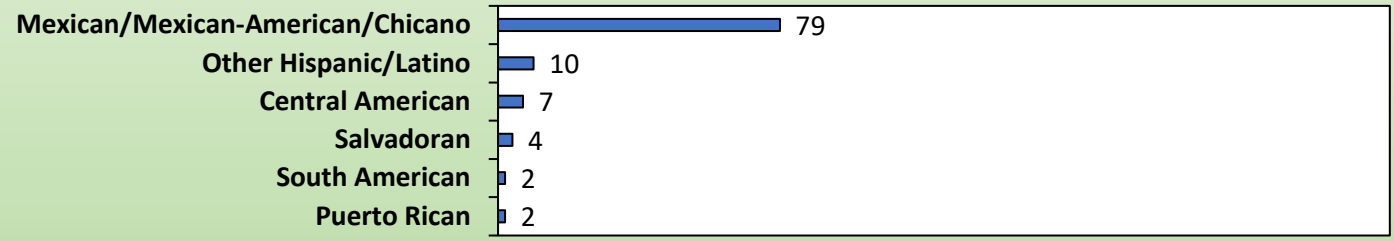
696 total individuals submitted data



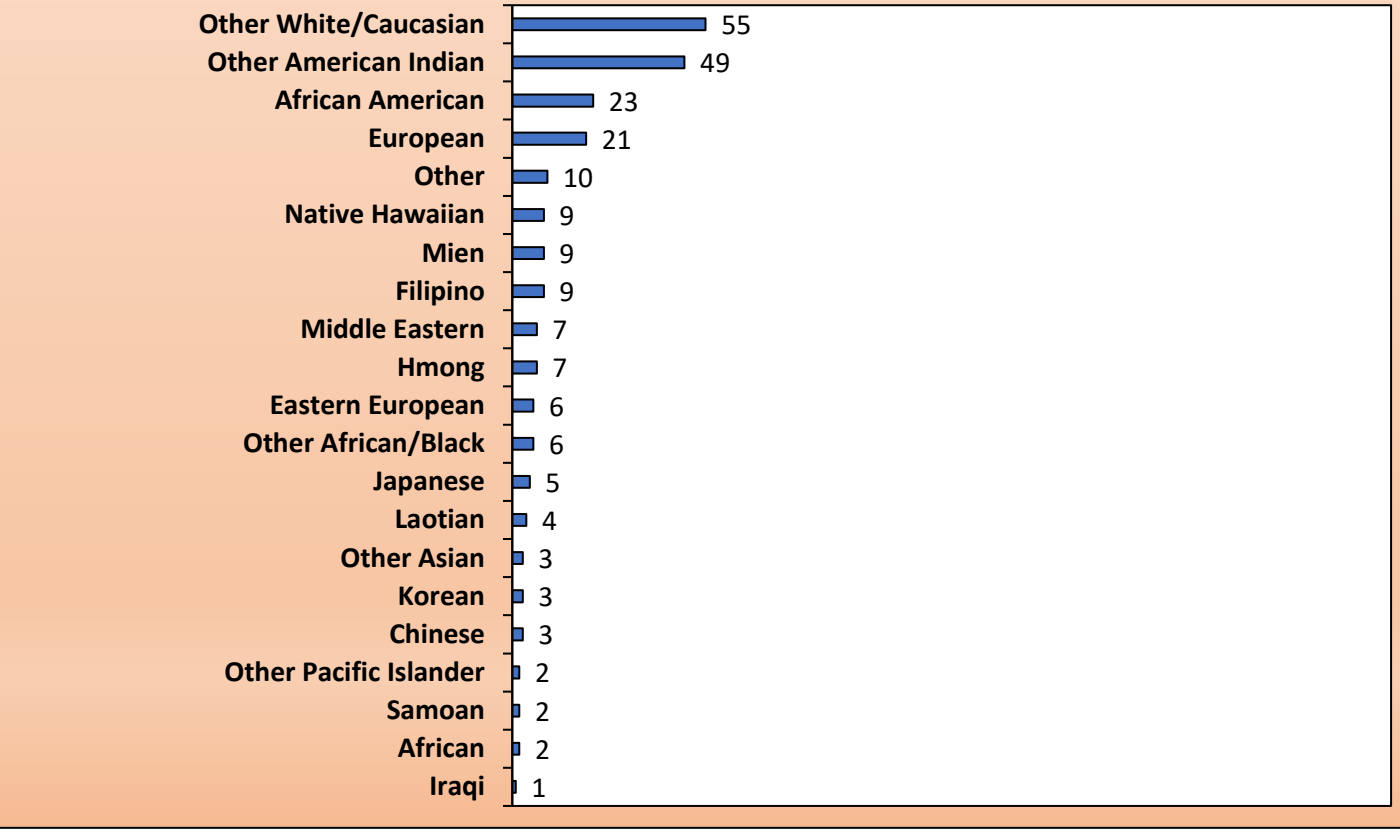




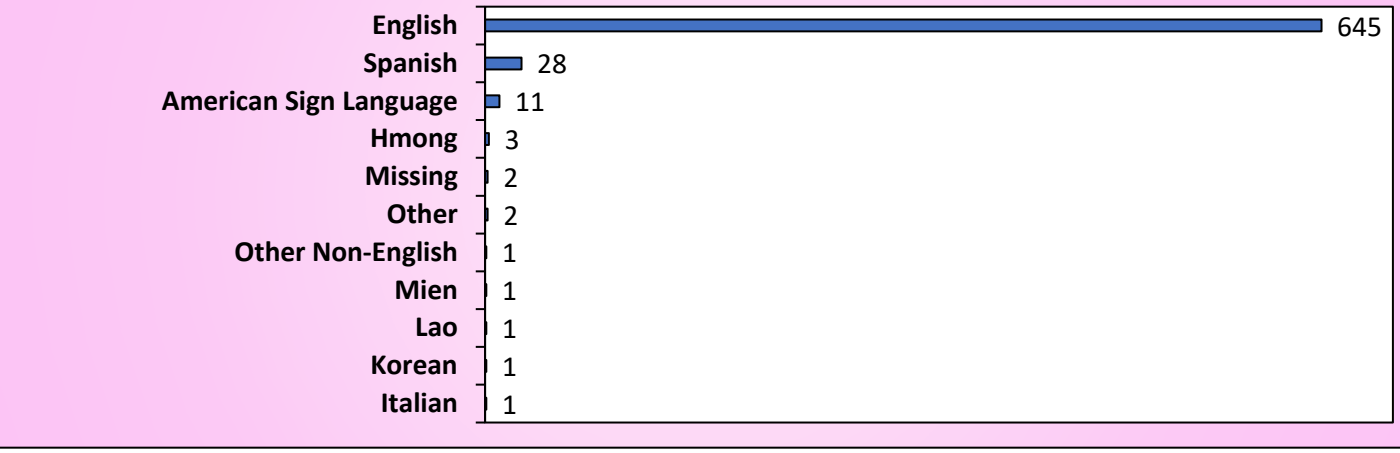
Ethnicity (Hispanic/Latino) N = 121

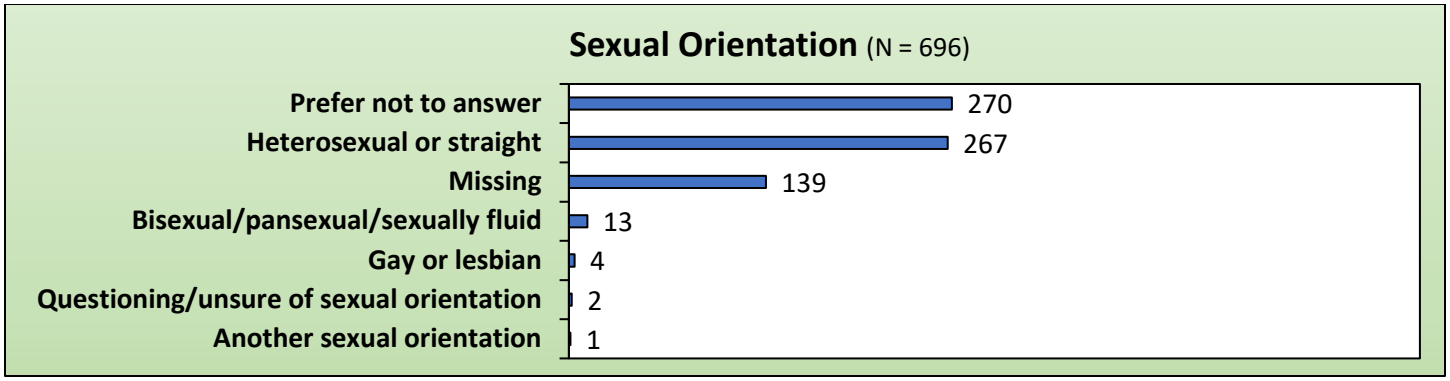


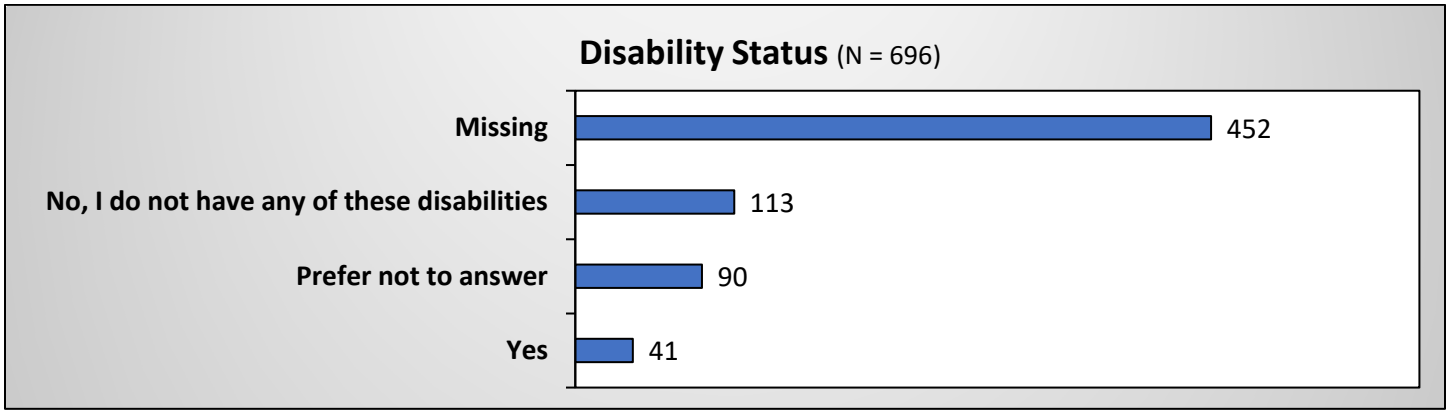
Ethnicity (Non-Hispanic/Non-Latino) N = 349

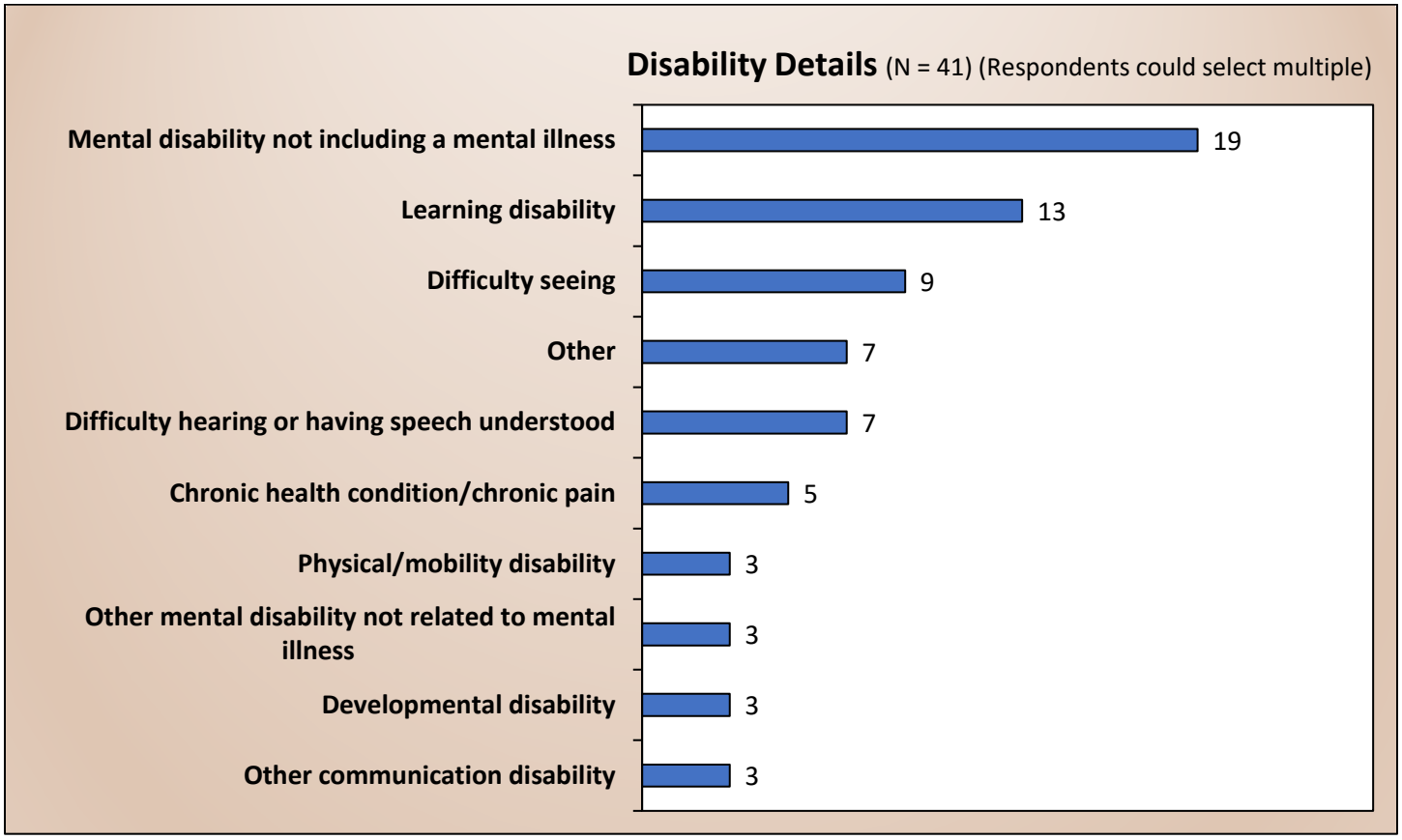


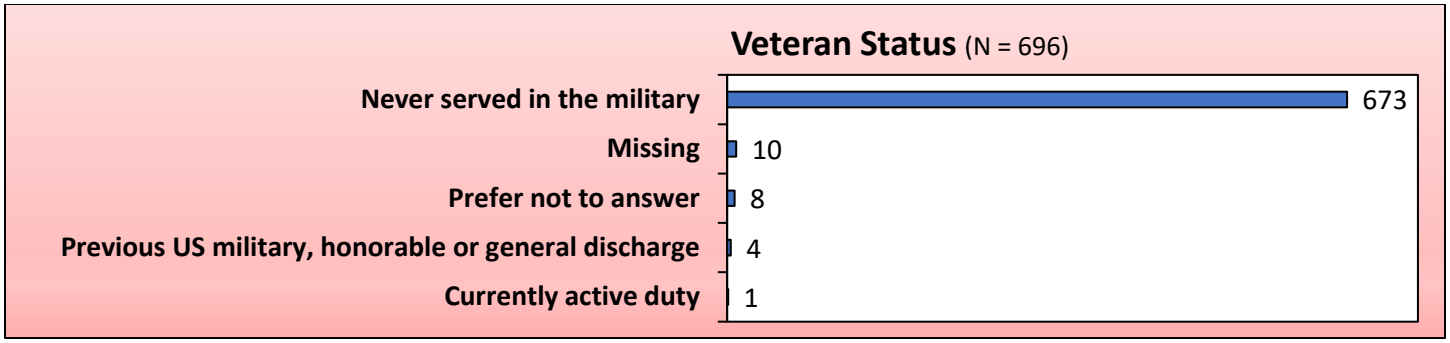
Primary Language (N = 696)

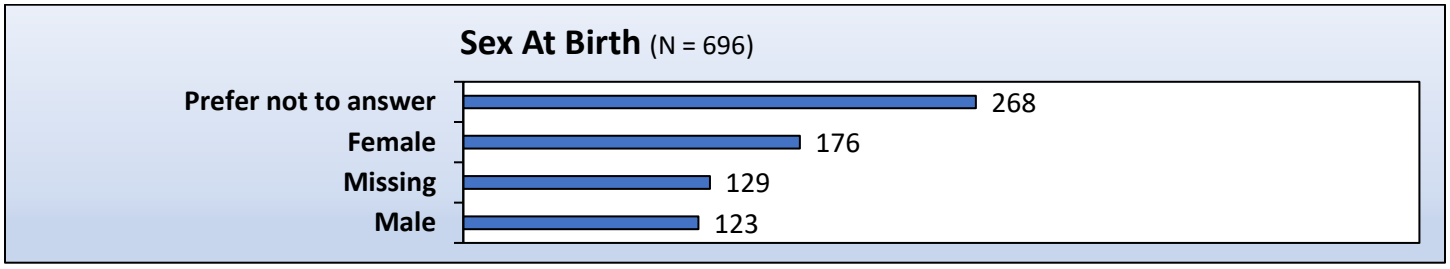


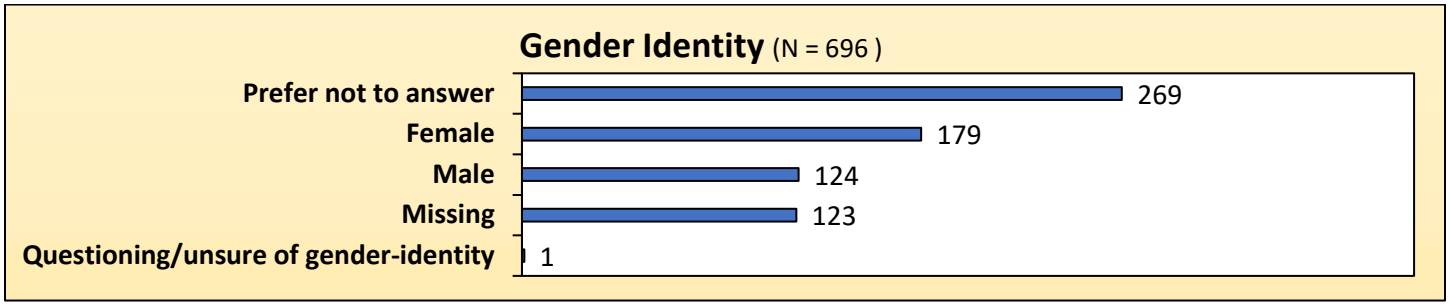

Sexual Orientation (N = 696)
Prefer not to answer
270
Heterosexual or straight
267
Missing
139
Bisexual/pansexual/sexually fluid
13
Gay or lesbian
4
Questioning/unsure of sexual orientation
2
Another sexual orientation
1


Disability Status (N = 696)
Missing
452
No, I do not have any of these disabilities
113
Prefer not to answer
90
Yes
41


Disability Details (N = 41) (Respondents could select multiple)
Mental disability not including a mental illness
19
Learning disability
13
Difficulty seeing
9
Other
7
Difficulty hearing or having speech understood
7
Chronic health condition/chronic pain
5
Physical/mobility disability
3
Other mental disability not related to mental illness
3
Developmental disability
3
Other communication disability
3


Veteran Status (N = 696)
Never served in the military
673
Missing
10
Prefer not to answer
8
Previous US military, honorable or general discharge
4
Currently active duty
1

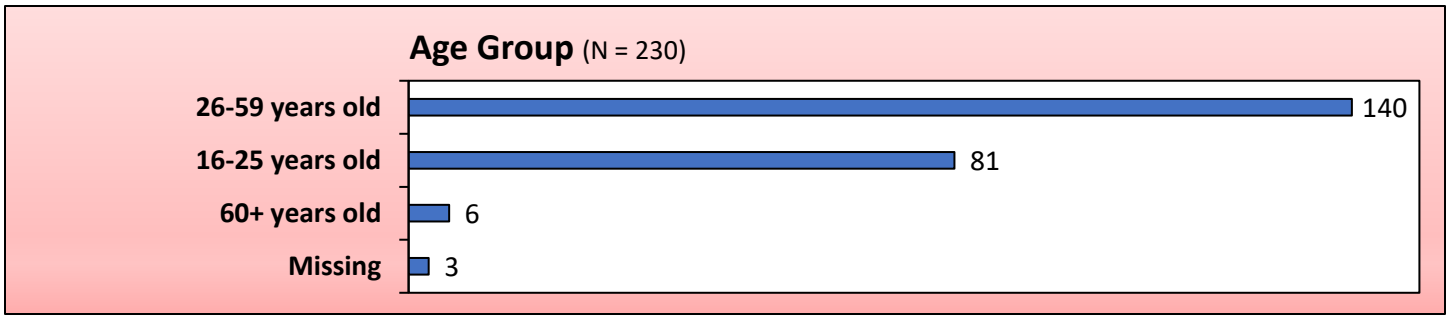

Sex At Birth (N = 696)
Prefer not to answer
268
Female
176
Missing
129
Male
123

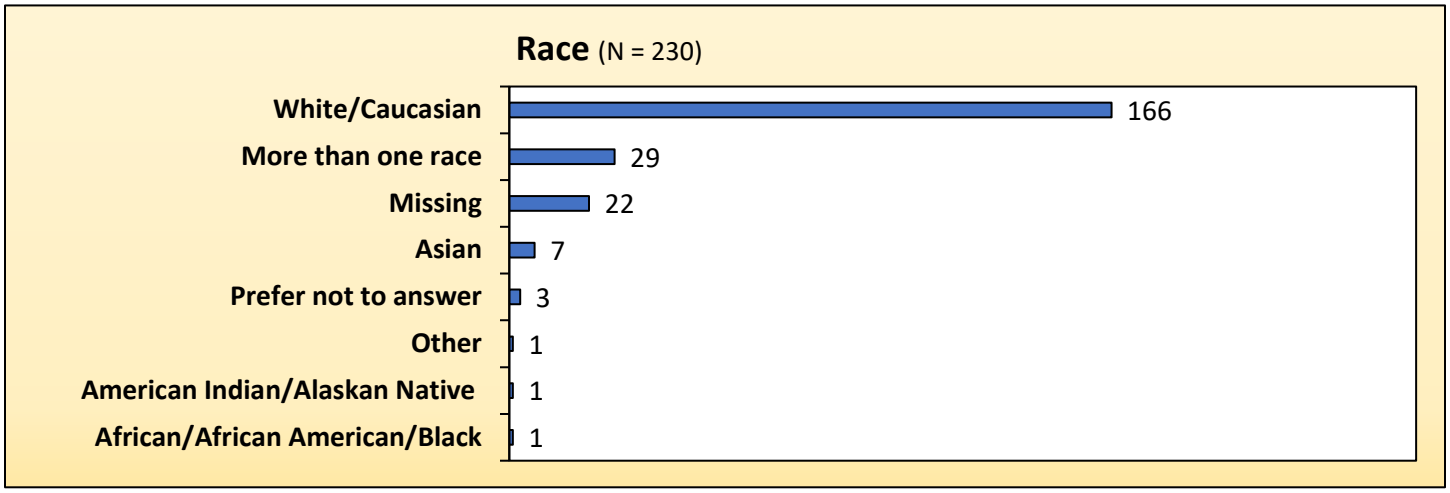

Gender Identity (N = 696)
Prefer not to answer
269
Female
179
Male
124
Missing
123
Questioning/unsure of gender-identity
1

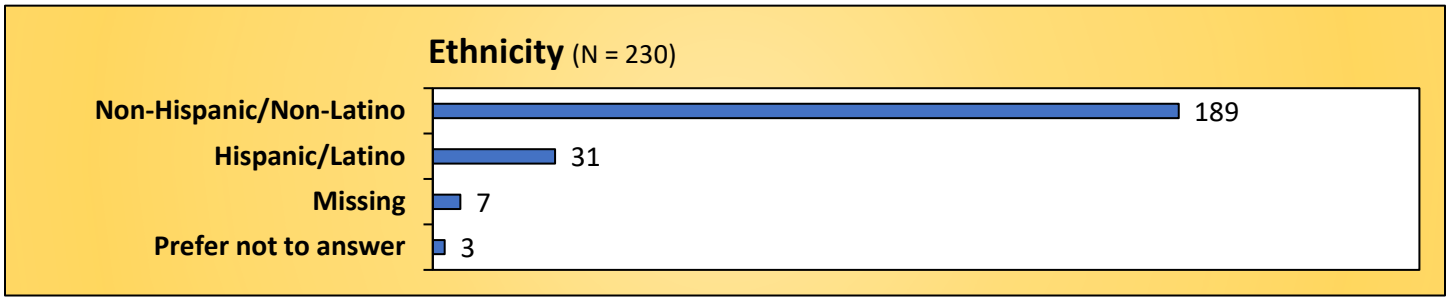
II. Outreach for Increasing Recognition of Early Signs of Mental Illness Program Demographics

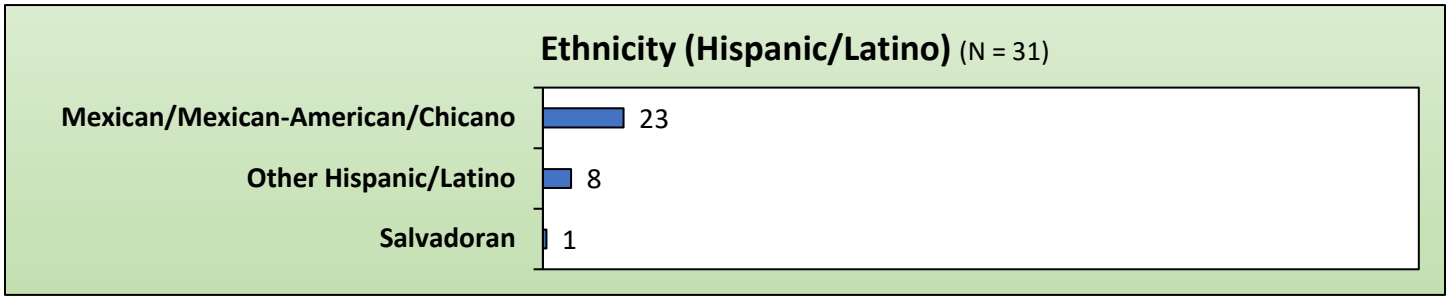
- Stand Against Stigma (230 individuals submitted data)
- ACES (no individuals submitted data)

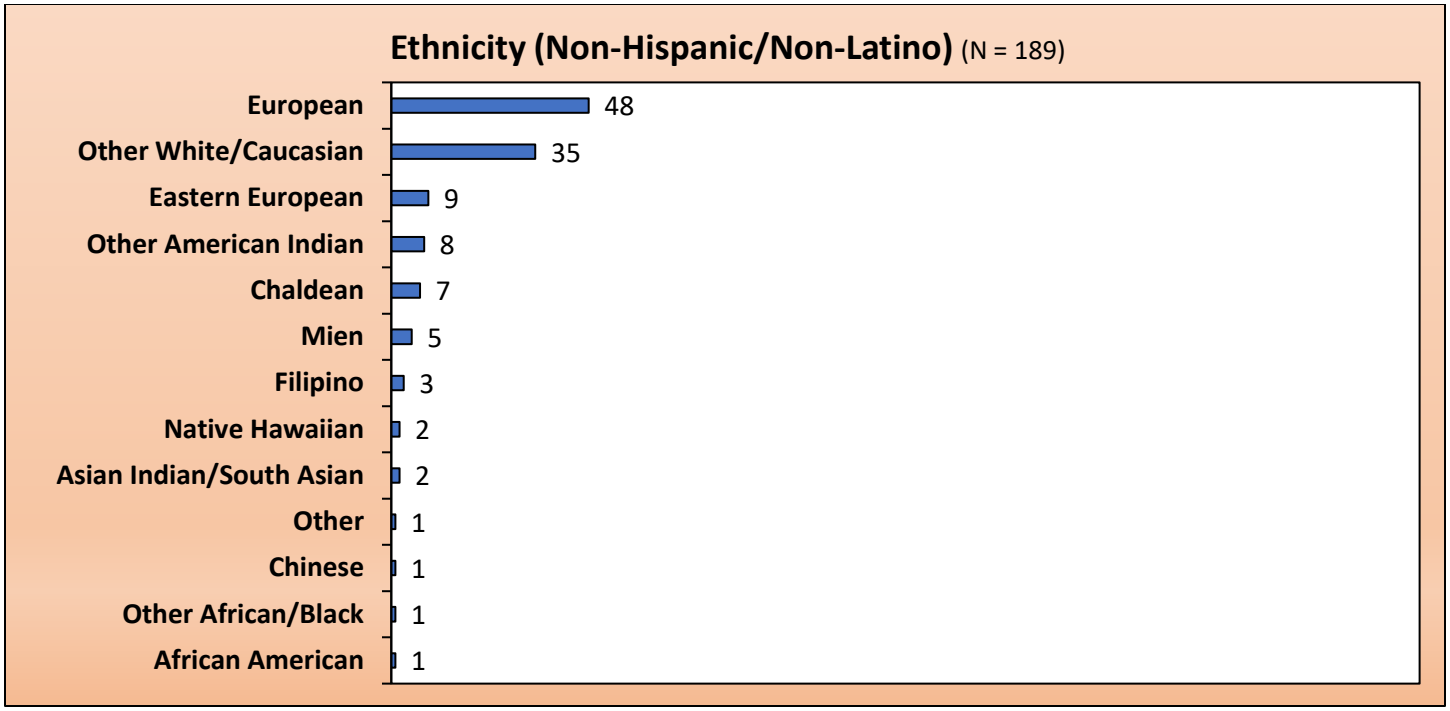
230 total individuals submitted data

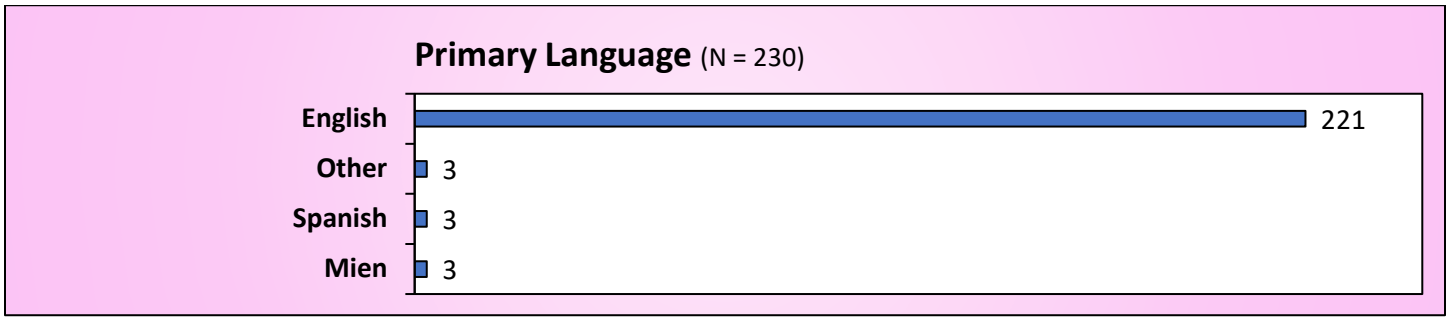


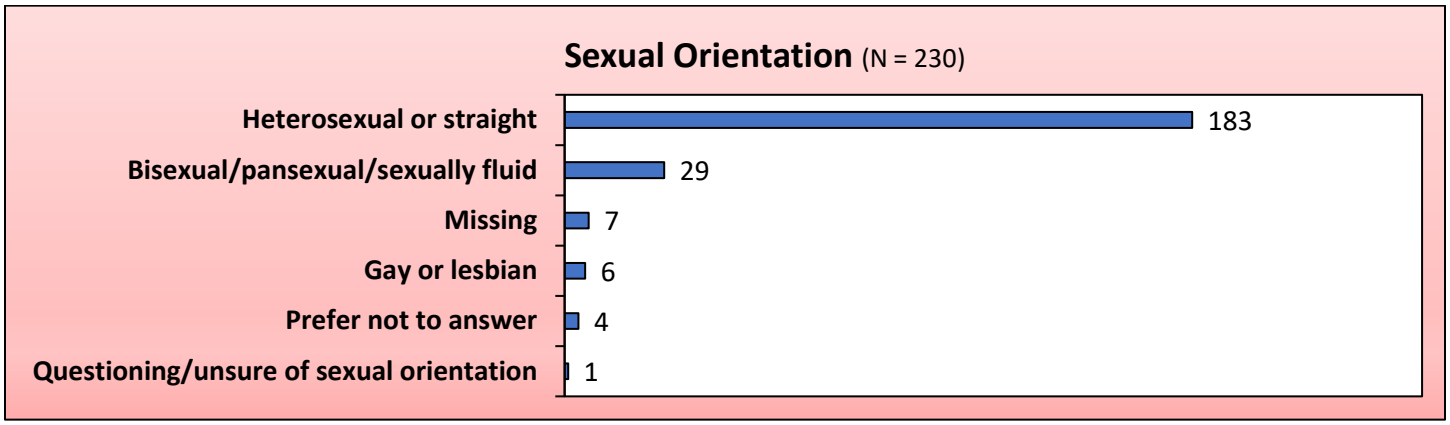


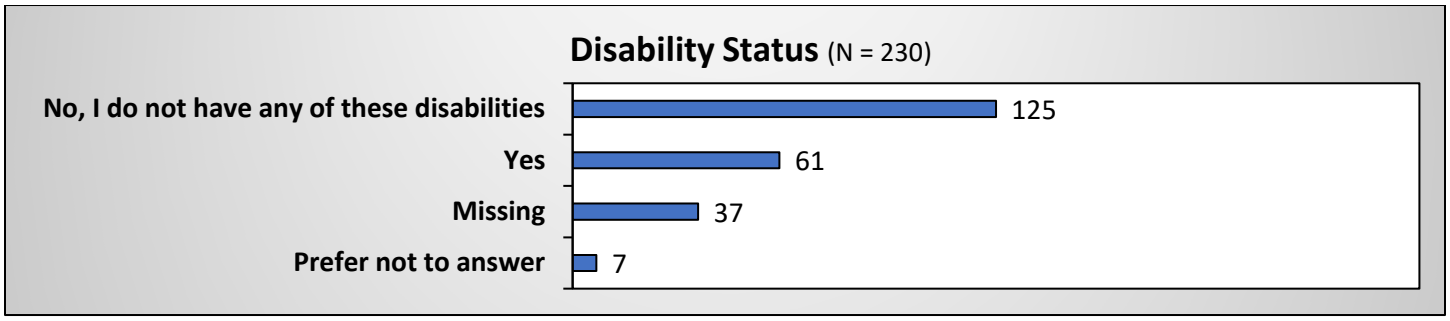


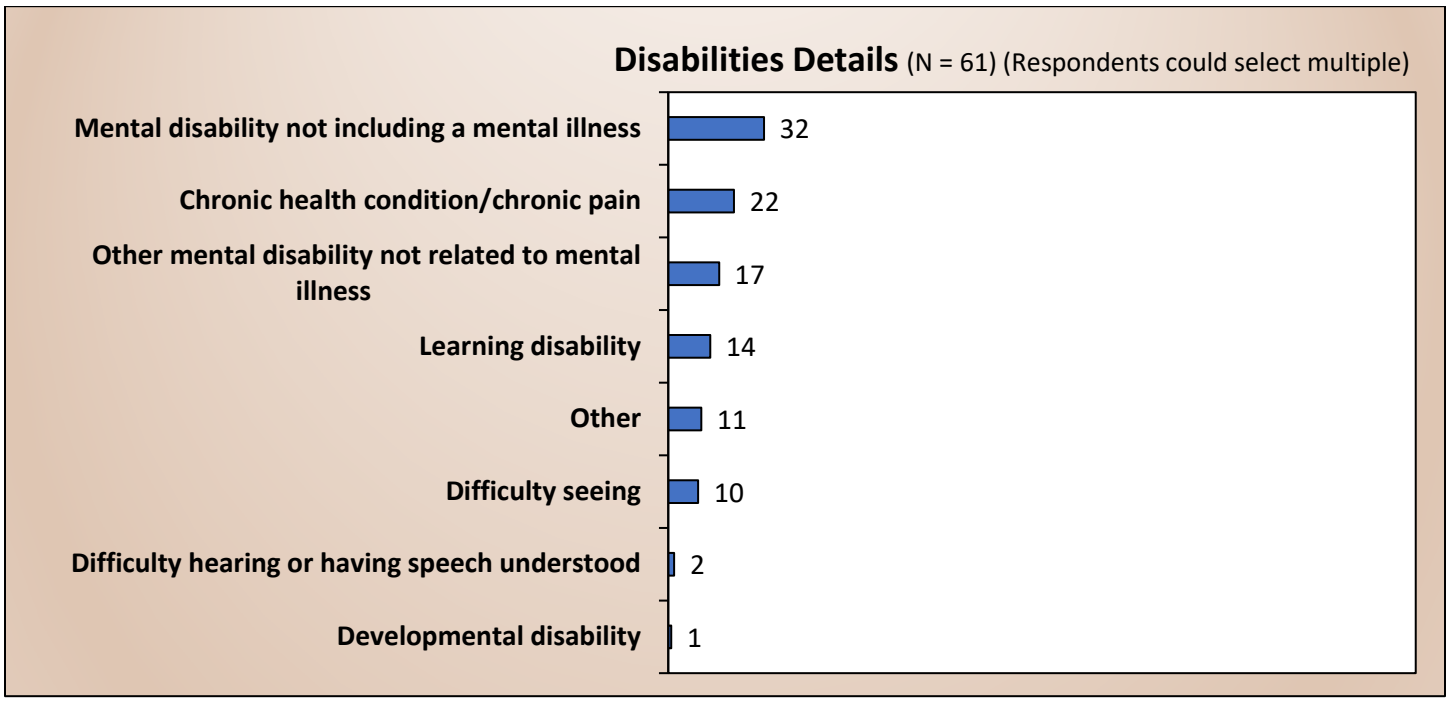


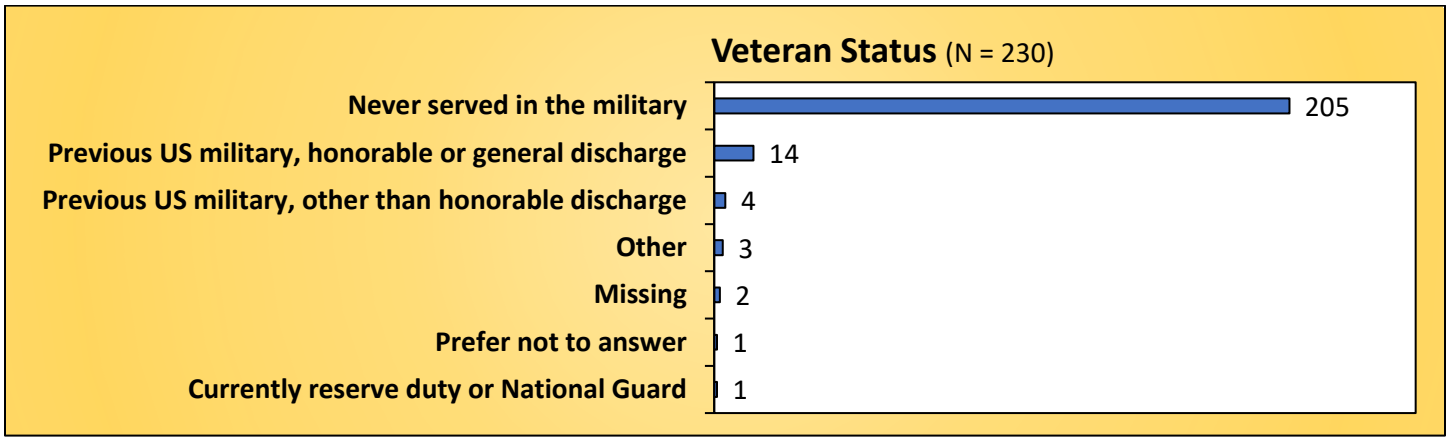

Ethnicity (Non-Hispanic/Non-Latino) (N = 189)
European 48
Other White/Caucasian 35
Eastern European 9
Other American Indian 8
Chaldean 7
Mien 5
Filipino 3
Native Hawaiian 2
Asian Indian/South Asian 2
Other 1
Chinese 1
Other African/Black 1
African American 1

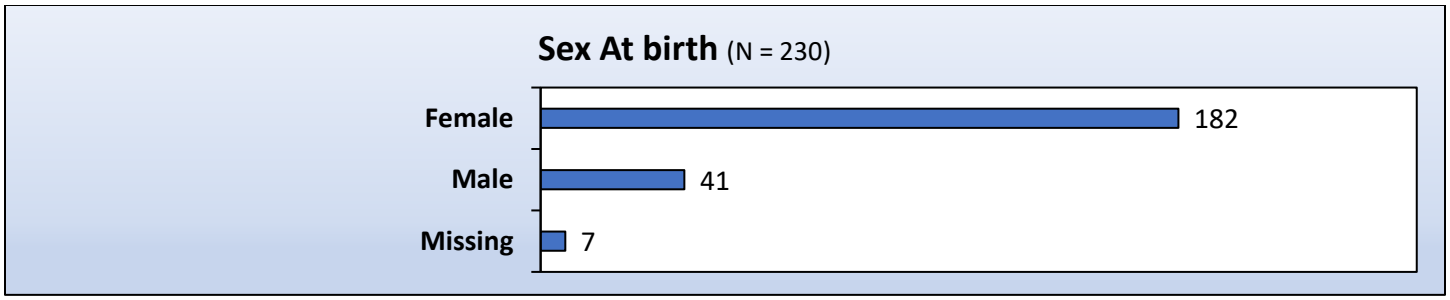

Primary Language (N = 230)
English 221
Other 3
Spanish 3
Mien 3

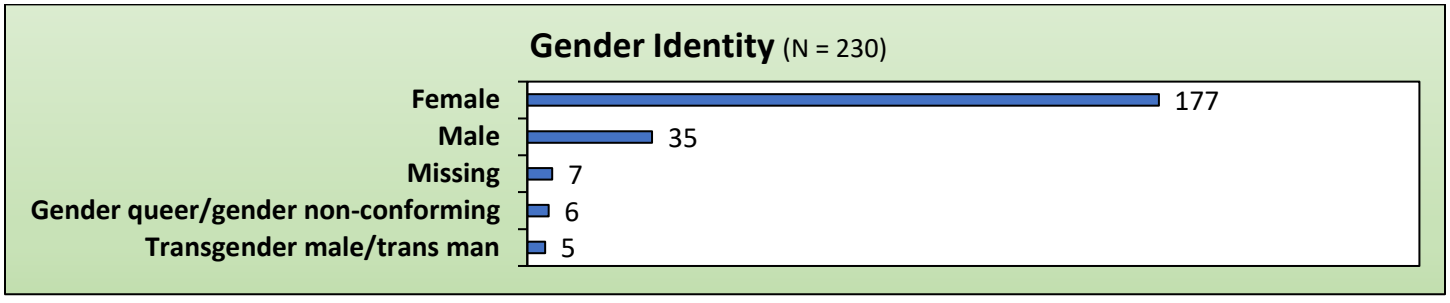

Sexual Orientation (N = 230)
Heterosexual or straight 183
Bisexual/pansexual/sexually fluid 29
Missing 7
Gay or lesbian 6
Prefer not to answer 4
Questioning/unsure of sexual orientation 1


Disability Status (N = 230)
No, I do not have any of these disabilities 125
Yes 61
Missing 37
Prefer not to answer 7


Disabilities Details (N = 61) (Respondents could select multiple)
Mental disability not including a mental illness
32
Chronic health condition/chronic pain
22
Other mental disability not related to mental illness
17
Learning disability
14
Other
11
Difficulty seeing
10
Difficulty hearing or having speech understood
2
Developmental disability
1


Veteran Status (N = 230)
Never served in the military
205
Previous US military, honorable or general discharge
14
Previous US military, other than honorable discharge
4
Other
3
Missing
2
Prefer not to answer
1
Currently reserve duty or National Guard
1


Sex At birth (N = 230)
Female
182
Male
41
Missing
7


Gender Identity (N = 230)
Female
177
Male
35
Missing
7
Gender queer/gender non-conforming
6
Transgender male/trans man
5

III. Access and Linkage to Treatment Strategy or Program Demographics

- Early Onset (11 individuals submitted data)

To protect client confidentiality, demographic and referral data on this program is not made public.

Triple P Outcome Evaluation

Fiscal Year 18/19

Prepared by Shasta County Health and Human Services Agency

Shasta County Health & Human Services Agency

Introduction

The Positive Parenting Program ("Triple P") is an international evidence-based program that teaches parents (or caregivers) best practices for correcting misbehaviors in children and teenagers and also teaches them how to create and maintain a positive family environment. 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 all caregivers. 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 to see if going through the program affected their knowledge and attitudes. Additionally, within the scoring application, practitioners can add or track existing participants, create reports, and export session data.

Triple P practitioners began transitioning from the Legacy Scoring Application to the ASRA scoring application during Fiscal Year 18/19. Consequently, some data in this report is from the Legacy Scoring Application while some data is from the ASRA Scoring Application. In this report, the data between both scoring applications is kept separate. Data was not able to be unduplicated between both scoring applications. As of July 2019 and onward, data will only be stored in the ASRA scoring application.

This report contains data collected from all providers of Triple P who entered data into either Scoring Application from July 1st, 2018 through June 30th, 2019 (Fiscal Year 18/19). The source data for this report is from the Legacy and ASRA Scoring Applications only and 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 either of these two Scoring Applications, they are not included in this report.

Legacy Scoring Application data

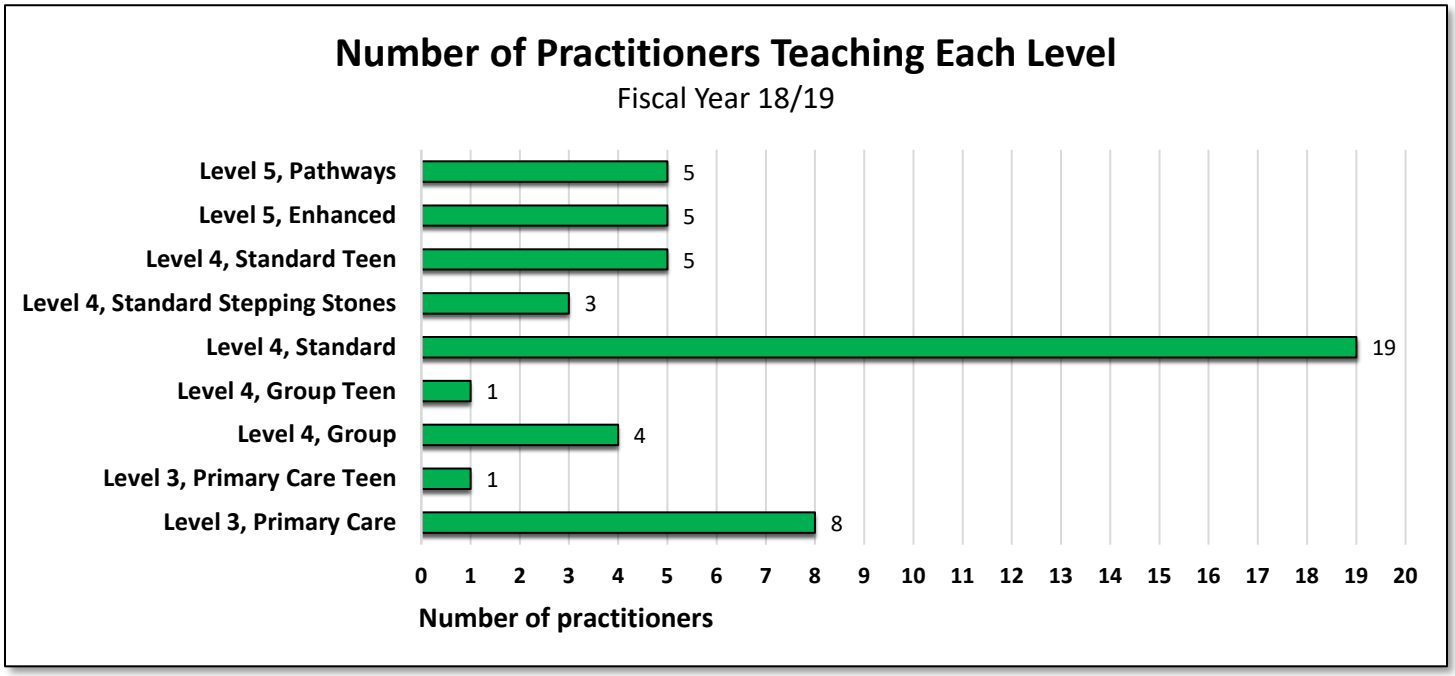
Overview

The table below shows the total number of Triple practitioners who entered data into Shasta County's Legacy Triple P Scoring application during Fiscal Year 18/19, along with the organization they were with, and the total number of caregivers and children/teens they served:

Shasta County Triple P Fiscal Year 18/19			
Organization	**Practitioners**	**Caregivers**	**Children/Teens**
Bridges to Success/ Shasta County Office of Education	7	83	64
Child Abuse Prevention Coordinating Council of Shasta County (CAPCC)	2	8	7
Family Dynamics	4	82	74
Northern Valley Catholic Social Service	6	26	21
Shasta County Health & Human Services Agency: Children's Services	3	14	11
Tara Tate – Private Practice	1	3	2
Victor Community Support Services	1	4	3
Wright Education Services	3	45	33
Youth and Family Programs	1	21	18

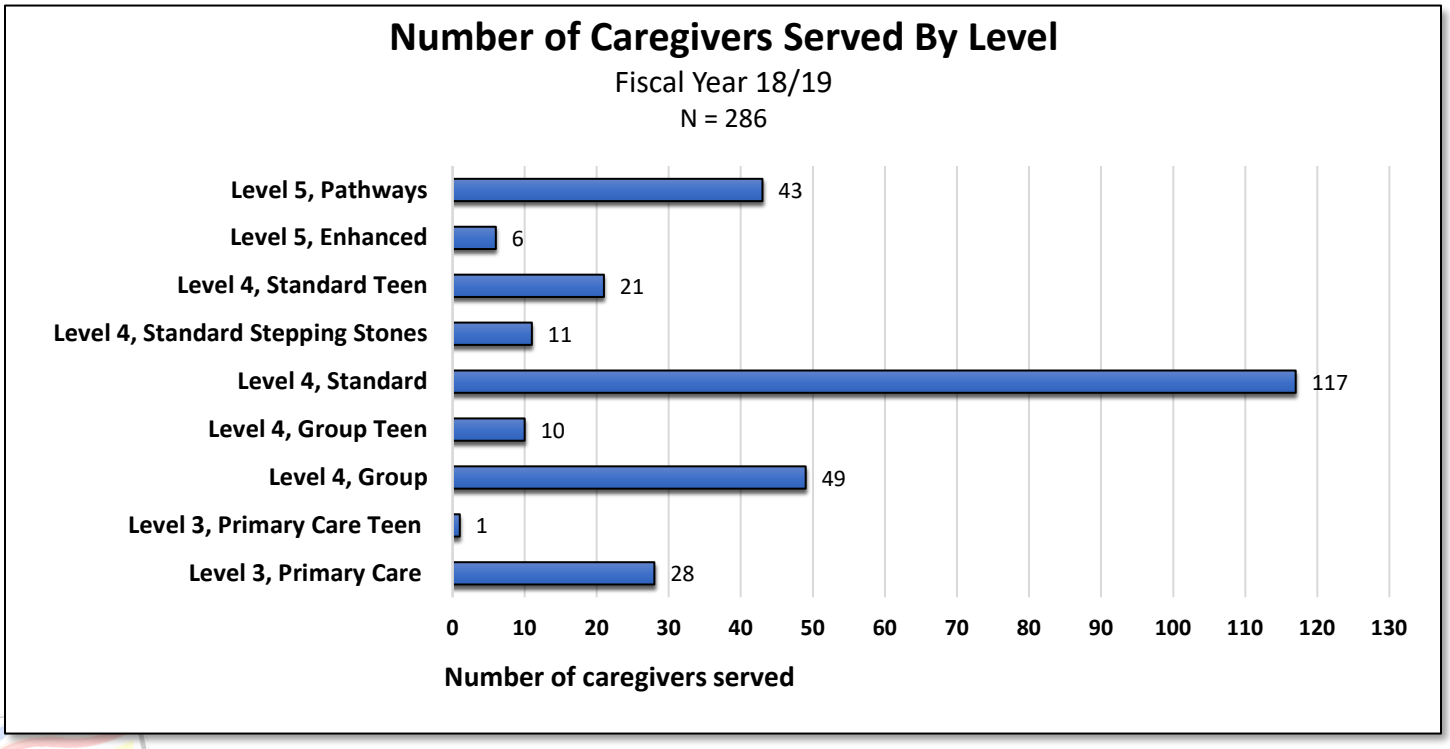
Some families may have received services in more than one organization, level, or version of Triple P. The information stored in the scoring application is anonymous (names were not collected). For this reason, the total number of unduplicated caregivers and children/teens served between all levels couldn't be determined. In addition, if a practitioner was still submitting data in the Scoring application after transitioning to a new organization during Fiscal Year 18/19, they would be counted as a practitioner in each organization they were a part of.

There were 27 unduplicated practitioners who provided Triple P services during Fiscal Year 18/19. 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):

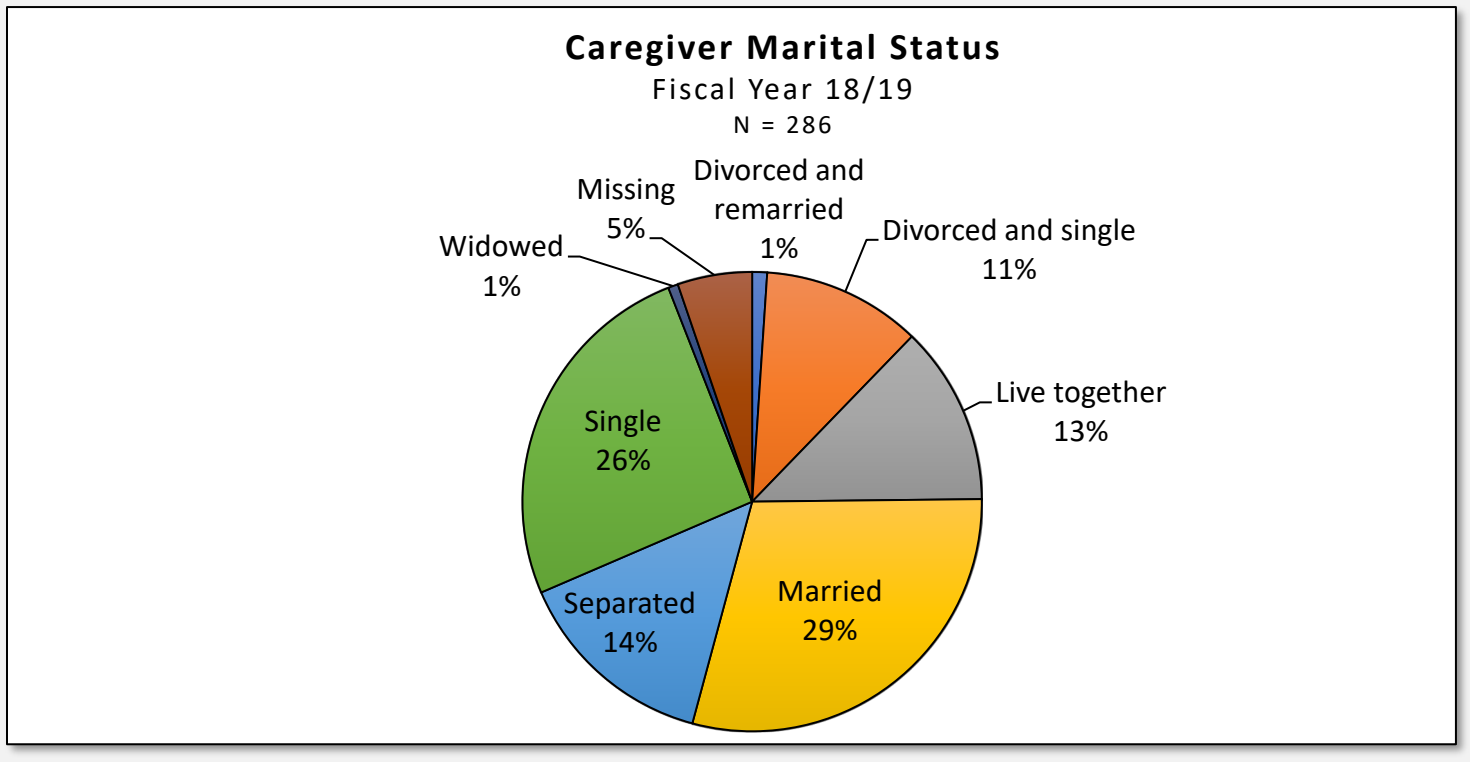


Data on the caregivers and their families

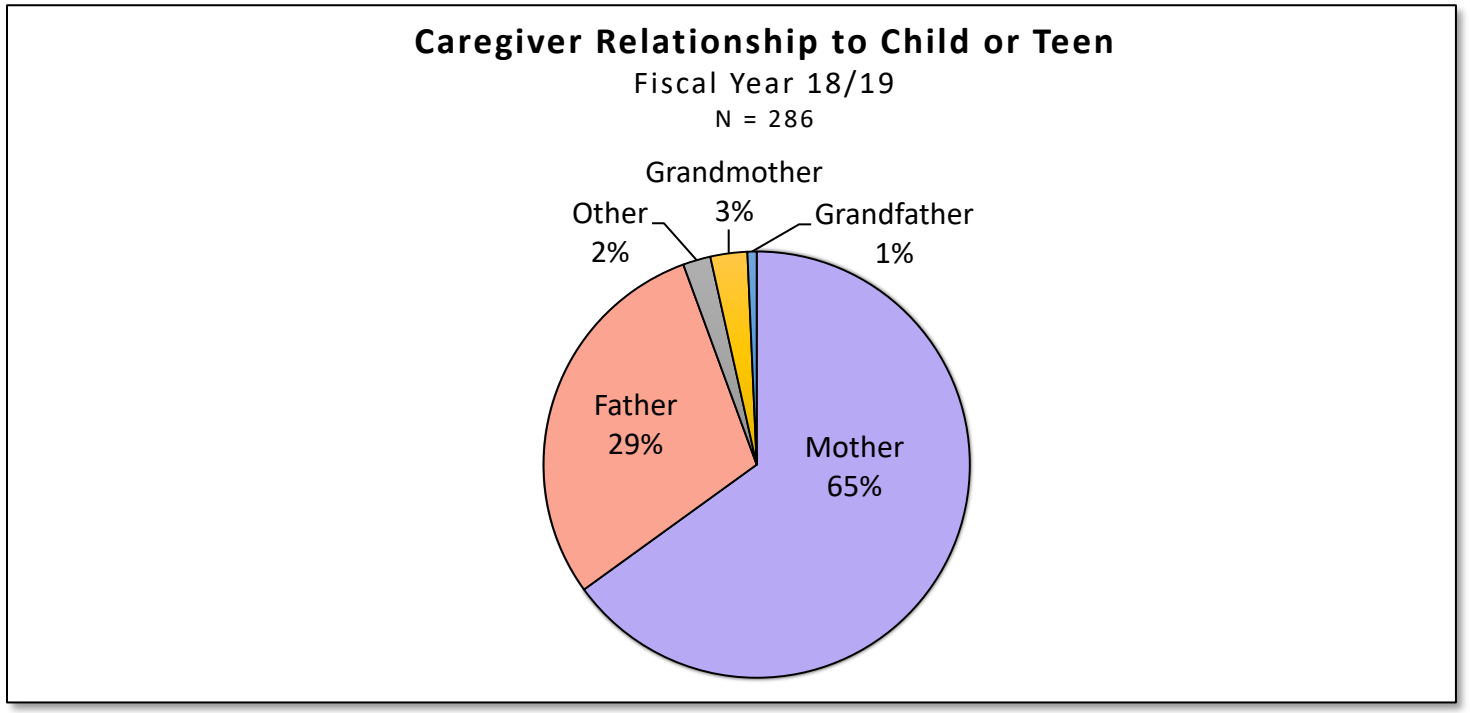
Data in the Legacy scoring application shows that 286 caregivers were served during Fiscal Year 18/19. A breakdown of the number of caregivers served by each Triple P level is shown below:



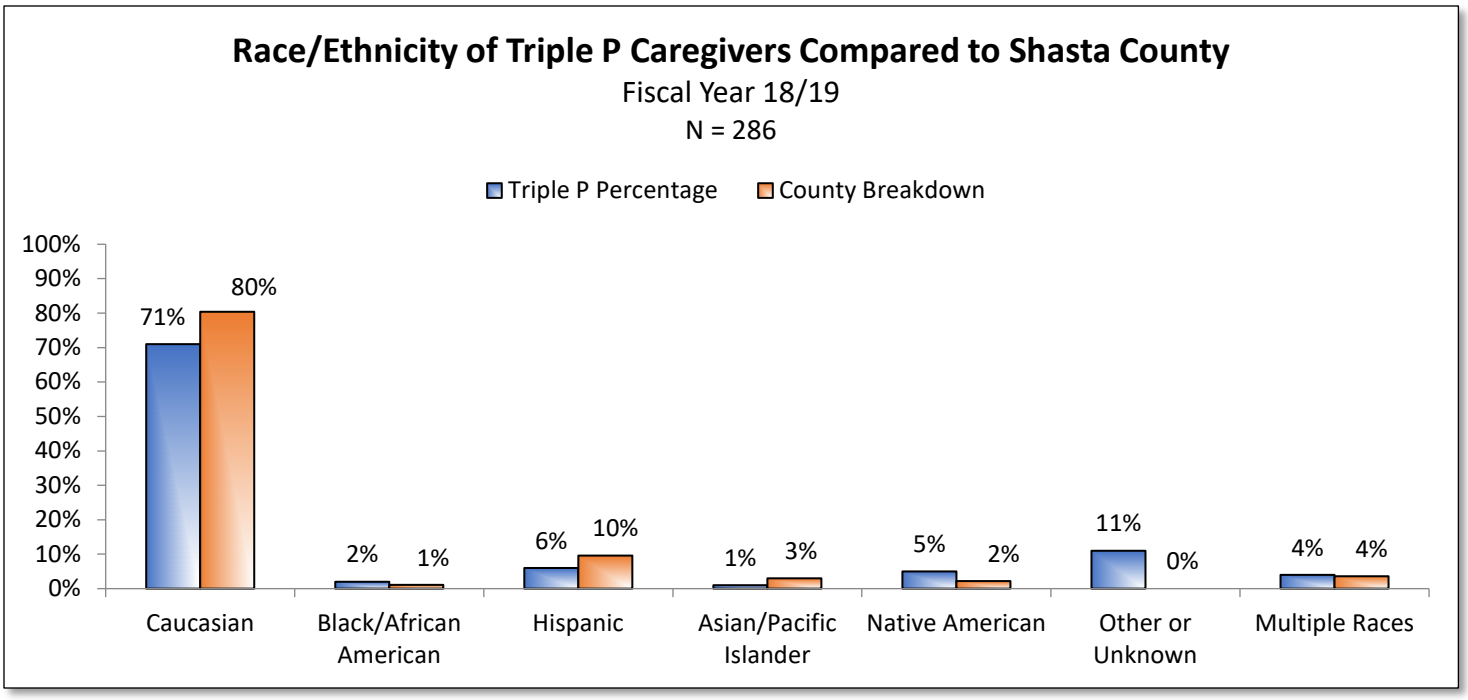
The marital status of the caregivers is pictured below:



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



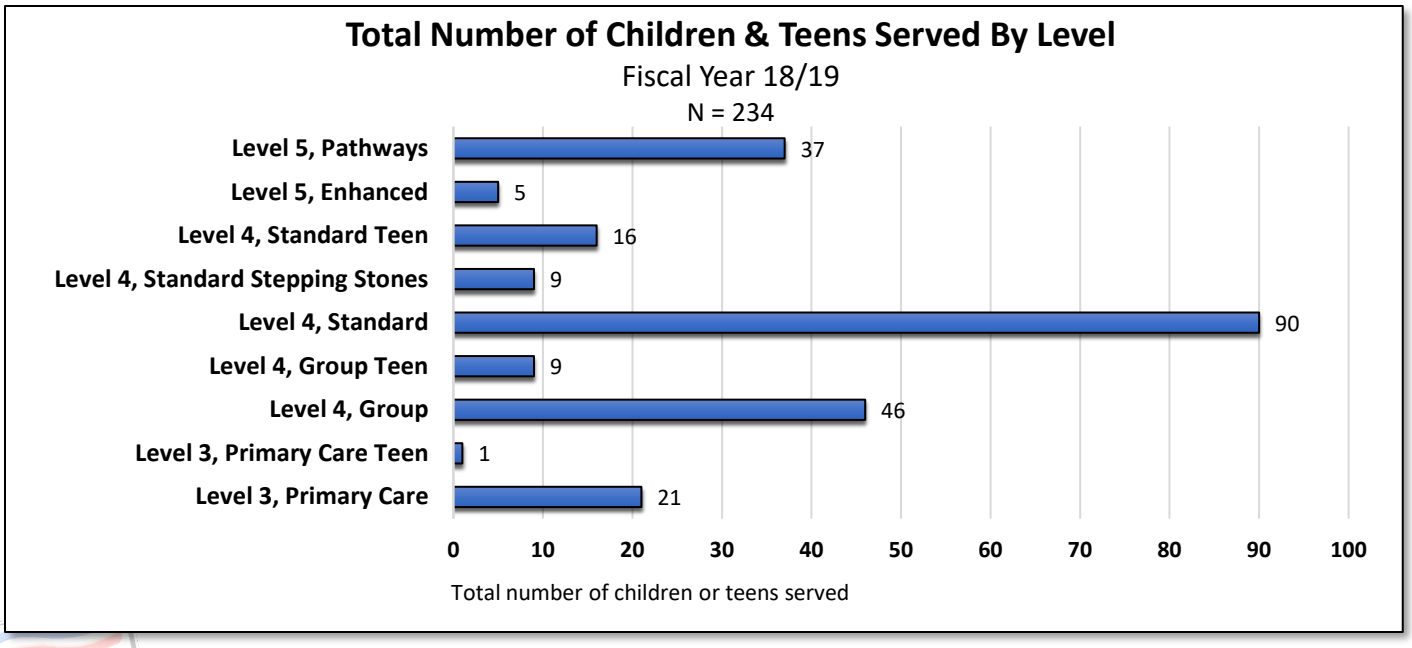
The bar graph below illustrates the breakdown of the caregivers' ethnicities compared to Shasta County:



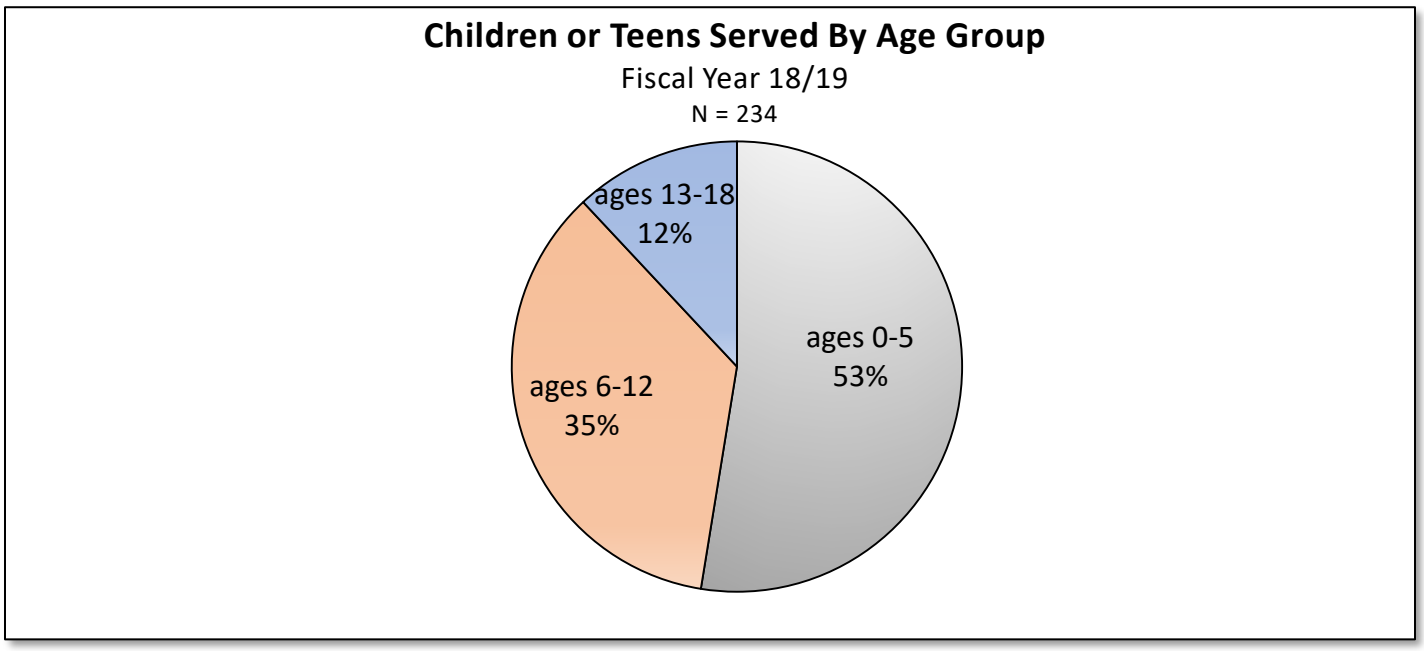
County breakdown per 2013-2017 American Communities Survey 5-year Estimates.

The Caregiver's ID number connects to a unique "Client ID number." The Client ID number represents the child or teen. The Client ID number is created before the caregiver enrolls in Triple P and this Client ID number is different for every level or version they participate in. For this reason, a total number of unduplicated children or teenagers served across all levels couldn't be determined.

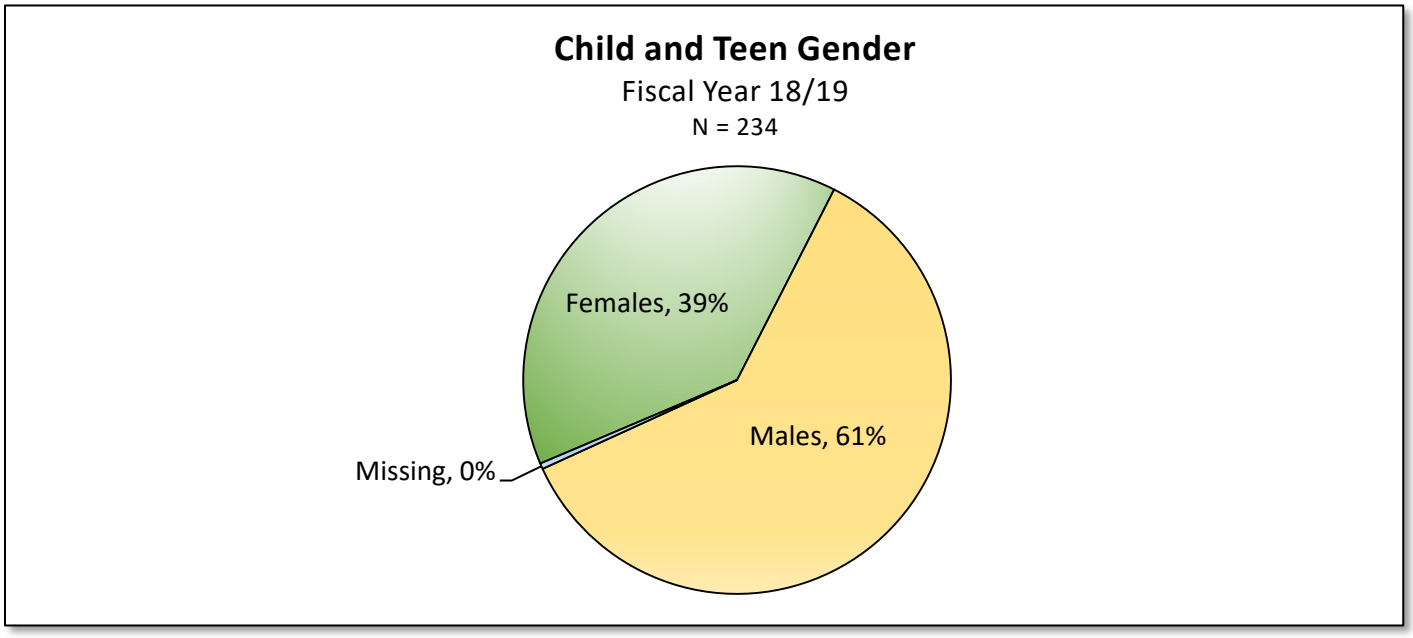
The total number of children and teenagers represented by caregivers during Fiscal Year 18/19 was 234 as shown below:



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. 123 children were aged 5 or younger out of the total 234 and the average age was 6.



There were 142 males, 91 females, and 1 record missing for child and teen gender data:



Outcome Measures

"Outcome measures" help determine whether a program was effective in reaching its intended goals. They are devices that provide results pertaining to some core objective of the program. These results, collected over the course of the program, are compared with the program's original goals to evaluate whether it was effective in reaching them (and to what extent). Various self-assessments related to parenting were given to Triple P participants before starting the program ("pre") and at the end of the program ("post") to benchmark their results on different measures of parenting effectiveness with a focus on whether the program improved their post–assessment results relative to their pre-assessment results. The self-assessments are the "measures" while the "outcomes" result from the difference between their pre-assessment scores and post-assessment scores.

Outcomes in this section are shown for data that was entered into the Legacy scoring application during Fiscal Year 18/19. Practitioners transitioned to a new scoring application during the third quarter of Fiscal year 18/19 so the data collected isn't representative of the entire fiscal year. Outcomes were determined using various self-assessments. In this next section, each self-assessment and their corresponding outcome measures will be examined.

Self-assessments (Legacy data only)

Self-assessment (#1): The Strengths and Difficulties Questionnaire (SDQ)

Caregivers use this questionnaire to identify strengths and problems with their child or teen's behavior. On the questionnaire, participants were instructed to indicate whether a series of statements relating to their child or teen's emotional symptoms, conduct problems, hyperactivity, problems with peers, or prosocial behavior was "Not true", "Somewhat true", or "Certainly true."

A response of "Not true", "Somewhat true", or "Certainly true" is assigned a value of "0", "1", or "2" respectively, and in turn, this is used to generate scores for each category of the child or teen's behavior (categories such as emotional symptoms, conduct problems, hyperactivity, peer problems, and prosocial behavior).

An example of the Strengths and Difficulties Questionnaire is shown on the next page: [2]

Strengths and Difficulties Questionnaire

For each item, please mark the box for Not true, Somewhat true or Certainly true. Please answer all items as best you can, even if you are not absolutely certain. Give your answers on the basis of your child's behaviour over the last 6 months.

	Not true	Somewhat true	Certainly true
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other children (treats, toys, pencils etc.)	☐	☐	☐
Often has temper tantrums or hot tempers	☐	☐	☐
Rather solitary, tends to play alone	☐	☐	☐
Generally obedient, usually does what adults request	☐	☐	☐
Many worries, often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other children or bullies them	☐	☐	☐
Often unhappy, down-hearted or tearful	☐	☐	☐
Generally liked by other children	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous or clingy in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often lies or cheats	☐	☐	☐
Picked on or bullied by other children	☐	☐	☐
Often volunteers to help others (parents, teachers, other children)	☐	☐	☐
Thinks things out before acting	☐	☐	☐
Steals from home, school or elsewhere	☐	☐	☐
Gets on better with adults than with other children	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Sees tasks through to the end, good attention span	☐	☐	☐

This version of the Strengths and Difficulties Questionnaire also included an "impact supplement." An example of the impact supplement is shown on the next page: [2]

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No	Yes, minor difficulties	Yes, definite difficulties	Yes, severe difficulties
☐	☐	☐	☐

If you have answered 'Yes', please answer the following questions about these difficulties:

• How long have these difficulties been present?

Less than a month	1–5 months	6–12 months	Over a year
☐	☐	☐	☐

• Do the difficulties upset or distress your child?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

• Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
Home life	☐	☐	☐	☐
Friendships	☐	☐	☐	☐
Classroom learning	☐	☐	☐	☐
Leisure activities	☐	☐	☐	☐

• Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

A "Total Impact Score" can be calculated by adding up the numeric values that correspond with the caretaker's level of agreement on how strongly difficulties with emotions, concentration, behavior, or being able to get along with other people that the child or teen encounters interferes with their everyday life. [2] An example of how the Total Impact Score works is shown below:

Generating and interpreting Impact Scores

When using a version of the SDQ that includes an 'Impact Supplement', the items on overall distress and social impairment can be summed to generate a Total Impact score that ranges from 0 to 10.

	Not at all	Only a little	Quite a lot	A great deal
Difficulties:				
Upset or distress child	0	0	1	2
Interfere with home life	0	0	1	2
Interfere with friendships	0	0	1	2
Interfere with classroom learning	0	0	1	2
Interfere with leisure activities	0	0	1	2

Results for the Strengths and Difficulties Questionnaire (SDQ) are shown below:

(SDQ) Strengths and Difficulties Questionnaire results

Lower "Post" scores represent improved outcomes except 'Prosocial' (higher Post scores on this measure are better)

	Level 3 Standard (N = 25)			**Level 4 Standard** (N = 25)			**Level 4 Group** **(N = 8)**			**Level 4 Teen** **(N = 8)**			**Level 5 Pathways** (N = 20)		
	Pre	Post	Change	Pre	Post	Change	Pre	Post	Change	Pre	Post	Change	Pre	Post	Change
Prosocial	6.9	7.6	+11.46%	7.1	7.9	+11.17%	7.3	8.6	+18.75%	8.6	8.4	-1.67%	8.0	8.0	0.00%
Hyperactivity	6.9	6.6	-3.12%	5.9	4.2	-28.24%	5.5	4.7	-13.33%	6.0	5.1	-14.29%	3.8	4.1	7.89%
Emotional	3.1	2.6	-16.28%	3.5	2.9	-18.63%	2.2	1.9	-12.50%	4.7	3.9	-18.18%	1.9	1.2	-36.84%
Conduct	3.6	3.3	-8.00%	4.0	2.8	-29.31%	1.9	1.5	-19.05%	3.4	1.7	-50.00%	1.9	1.2	-36.84%
Peer Problems	2.7	2.8	2.63%	3.1	2.7	-11.24%	2.0	1.5	-22.73%	3.9	3.7	-3.70%	2.0	1.8	-10.00%
Impact Score	4.9	3.9	-19.12%	4.3	2.0	-53.17%	2.2	3.3	50.00%	8.6	5.6	-35.00%	3.1	0.6	-80.65%
Total Score	16.2	15.3	-5.73%	16.4	12.6	-23.27%	11.5	9.7	-15.75%	18.0	14.4	-19.84%	9.6	8.3	-13.54%

Improved outcomes are indicated with a green background while worsened outcomes are indicated with a red background. Sample sizes ("N") of 10 or less are bolded in red to bring attention to the fact that the margin of error is greater with having fewer samples collected.

Self-assessment (#2): The Depression Anxiety Stress Scale-42 (DASS42)

This is a 42-item self-assessment that measures symptoms of depression, anxiety, and stress (see below): [3]

DASS

Name: *Date:*

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

1	I found myself getting upset by quite trivial things	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I just couldn't seem to get going	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I had a feeling of shakiness (eg, legs going to give way)	0	1	2	3
8	I found it difficult to relax	0	1	2	3
9	I found myself in situations that made me so anxious I was most relieved when they ended	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting upset rather easily	0	1	2	3
12	I felt that I was using a lot of nervous energy	0	1	2	3
13	I felt sad and depressed	0	1	2	3
14	I found myself getting impatient when I was delayed in any way (eg, elevators, traffic lights, being kept waiting)	0	1	2	3
15	I had a feeling of faintness	0	1	2	3
16	I felt that I had lost interest in just about everything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I perspired noticeably (eg, hands sweaty) in the absence of high temperatures or physical exertion	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life wasn't worthwhile	0	1	2	3
22	I found it hard to wind down	0	1	2	3
23	I had difficulty in swallowing	0	1	2	3
24	I couldn't seem to get any enjoyment out of the things I did	0	1	2	3
25	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
26	I felt down-hearted and blue	0	1	2	3
27	I found that I was very irritable	0	1	2	3
28	I felt I was close to panic	0	1	2	3
29	I found it hard to calm down after something upset me	0	1	2	3
30	I feared that I would be "thrown" by some trivial but unfamiliar task	0	1	2	3
31	I was unable to become enthusiastic about anything	0	1	2	3
32	I found it difficult to tolerate interruptions to what I was doing	0	1	2	3
33	I was in a state of nervous tension	0	1	2	3
34	I felt I was pretty worthless	0	1	2	3
35	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
36	I felt terrified	0	1	2	3
37	I could see nothing in the future to be hopeful about	0	1	2	3
38	I felt that life was meaningless	0	1	2	3
39	I found myself getting agitated	0	1	2	3
40	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
41	I experienced trembling (eg, in the hands)	0	1	2	3
42	I found it difficult to work up the initiative to do things	0	1	2	3

Results for the Depression Anxiety Stress Scale (DASS) are shown below:

(DASS) Depression, Anxiety, and Stress Scale results

Lower "Post" scores represent improved outcomes

	Level 4 Standard (N = 49)			**Level 4 Teen** **(N = 3)**			**Level 4 Group** (N = 26)			**Level 5 Enhanced** **(N = 2)**			**Level 5 Pathways** (N = 22)		
	Pre	Post	Change	Pre	Post	Change	Pre	Post	Change	Pre	Post	Change	Pre	Post	Change
Stress	14.7	8.7	-40.39%	23.3	11.3	-51.43%	7.3	6.8	-7.85%	31.0	3.5	-88.71%	6.2	5.5	-10.95%
Anxiety	8.4	4.6	-45.65%	14.7	2.0	-86.36%	4.8	4.7	-3.97%	17.5	0.5	-97.14%	4.3	3.1	-28.42%
Depression	9.7	4.2	-56.24%	22.7	6.7	-70.59%	5.8	4.9	-15.23%	22	0	-100.00%	2.8	3.0	+6.56%

Improved outcomes are indicated with a green background while worsened outcomes are indicated with a red background. Sample sizes ("N") of 10 or less are bolded in red to bring attention to the fact that the margin of error is greater with having fewer samples collected.

Self-assessment (#3): The Parenting Scale

The Parenting Scale is a 30-item self-assessment to determine whether the participant has a parenting or disciplinary style that is associated with behavioral problems in children. It is completed by parents/caregivers of children ages 1-12.

The Parenting Scale measures the degree of "Laxness", "Overreactivity", and "Verbosity" in parenting styles. Laxness describes a parenting style that is permissive and inconsistent when it comes to disciplining. It includes a lack of consistency and ineffective limit-setting. Overreactivity is characterized by threats and physical punishment. Verbosity describes a parenting style of giving lengthy verbal reprimands instead of taking direct action.[4]

Lower scores are better. Possible scores on all measures range from 1-7. An example of the parenting scale is shown on the next page: [5]

1. When my child misbehaves... *I do something right away*	○	○	○	○	○	○	○	*I do something later*
2. Before I do something about a problem... *I give my child several reminders and warnings*	○	○	○	○	○	○	○	*I use only one reminder or warning*
3. When I'm upset or under stress... *I am picky and on my child's back*	○	○	○	○	○	○	○	*I am not more picky than usual*
4. When I tell my child NOT to do something... *I say very little*	○	○	○	○	○	○	○	*I say a lot*
5. When my child pesters me... *I can ignore the pestering*	○	○	○	○	○	○	○	*I can't ignore the pestering*
6. When my child misbehaves... *I usually get into a long argument with my child*	○	○	○	○	○	○	○	*I don't get into an argument*
7. I threaten to do things that... *I'm sure I can carry out*	○	○	○	○	○	○	○	*I know I won't actually do*
8. I am the kind of parent that... *Sets limits on what my child is allowed to do*	○	○	○	○	○	○	○	*Lets my child do whatever he/she wants*
9. When my child misbehaves... *I give my child a long lecture*	○	○	○	○	○	○	○	*I keep my talks short and to the point*
10. When my child misbehaves... *I raise my voice or yell*	○	○	○	○	○	○	○	*I speak to my child calmly*
11. If saying no doesn't work right away... *I take some other kind of action*	○	○	○	○	○	○	○	*I keep talking and try to get through to my child*
12. When I want my child to stop doing something... *I firmly tell my child to stop*	○	○	○	○	○	○	○	*I coax or beg my child to stop*
13. When my child is out of sight... *I often don't know what my child is doing*	○	○	○	○	○	○	○	*I always have a good idea of what my child is doing*
14. After there's been a problem with my child... *I often hold a grudge*	○	○	○	○	○	○	○	*Things get back to normal quickly*
15. When we're not at home... *I handle my child the way I do at home*	○	○	○	○	○	○	○	*I let my child get away with a lot more*
16. When my child does something I don't like... *I do something about it every time it happens*	○	○	○	○	○	○	○	*I often let it go*
17. When there is a problem with my child... *Things build up and I do things I don't mean to do*	○	○	○	○	○	○	○	*Things don't get out of hand*
18. When my child misbehaves I spank, slap, grab, or hit my child... *Never or rarely*	○	○	○	○	○	○	○	*Most of the time*
19. When my child doesn't do what I ask... *I often let it go or end up doing it myself*	○	○	○	○	○	○	○	*I take some other action*
20. When I give a fair threat or warning... *I often don't carry it out*	○	○	○	○	○	○	○	*I always do what I said*
21. If saying "no" doesn't work... *I take some other kind of action*	○	○	○	○	○	○	○	*I offer my child something nice so he/she will behave*
22. When my child misbehaves... *I handle it without getting upset*	○	○	○	○	○	○	○	*I get so frustrated or angry that my child can see I'm upset*
23. When my child misbehaves... *I make my child tell me why he/she did it*	○	○	○	○	○	○	○	*I say "no" or take some other action*
24. If my child misbehaves and then acts sorry... *I handle the problem like I usually would*	○	○	○	○	○	○	○	*I let it go that time*
25. When my child misbehaves... *I rarely use bad language or curse*	○	○	○	○	○	○	○	*I almost always use bad language*
26. When I say my child can't do something... *I let my child do it anyway*	○	○	○	○	○	○	○	*I stick to what I said*
27. When I have to handle a problem... *I tell my child I'm sorry about it*	○	○	○	○	○	○	○	*I don't say I'm sorry*
28. When my child does something I don't like, I insult my child, say mean things, or call my child names *Never or rarely*	○	○	○	○	○	○	○	*Most of the time*
29. If my child talks back or complains when I handle a problem... *I ignore the complaining and stick to what I said*	○	○	○	○	○	○	○	*I give my child a talk about not complaining*
30. If my child gets upset when I say "no"... *I back down and give in to my child*	○	○	○	○	○	○	○	*I stick to what I said*

Results for the Parenting Scale are shown below:

Parenting Scale results

Lower "Post" scores represent improved outcomes

	Level 4 Standard (N = 25)			**Level 4 Teen** **(N = 8)**			**Level 4 Group Teen** **(N = 8)**			**Level 4 Stepping S.** **(N = 4)**			**Level 5 Pathways** (N = 20)		
	Pre	Post	Change	Pre	Post	Change	Pre	Post	Change	Pre	Post	Change	Pre	Post	Change
Laxness	3.1	2.2	-27.90%	4.1	2.5	-39.46%	3.7	3.6	-3.35%	2.2	2.6	17.64%	2.8	2.4	-13.75%
Overreactivity	3.3	2.2	-31.66%	3.6	2.3	-38.29%	4.0	4.0	0.00%	1.4	1.2	-14.04%	2.5	2.0	-20.92%
Verbosity	3.9	3.1	-20.17%	N/A	N/A	N/A	N/A	N/A	N/A	3.3	3.4	3.12%	3.9	2.9	-26.28%
Total	3.4	2.5	-26.26%	3.7	2.3	-38.12%	3.8	3.7	-2.01%	2.3	2.4	4.38%	3.0	2.5	-16.18%

Improved outcomes are indicated with a green background while worsened outcomes are indicated with a red background. Sample sizes ("N") of 10 or less are bolded in red to bring to attention to the fact that the margin of error is greater with having fewer samples collected.

A modified version of the Parenting Scale was designed for teenagers which did not include a Verbosity score (if no score was available it is marked with N/A).

Self-assessment (#4): The Being a Parent Scale

The Being a Parent Scale (PSOC) is a 16-item assessment that measures parenting self-esteem, or efficacy, and satisfaction with the parenting role. Parents indicate their satisfaction with their parenting role and their confidence in parenting on a 6-point Likert scale (1 = strongly agree, 6 = strongly disagree). Possible scores for Efficacy range from 7-42 and scores for Satisfaction range from 9-54. Higher scores represent greater levels of parenting self-efficacy and parental satisfaction. The "Being a Parent Scale" is a strength-based assessment.

An example of the Being a Parent Scale is shown below:[6]

BEING A PARENT SCALE

On this questionnaire are 16 items relating to your feelings about being a parent. Please read each item carefully and rate whether you feel it applies to you, by circling a number from 1 (strongly agree) to 6 (strongly disagree) on the scale.

The rating scale is as follows:

1 Strongly agree
2 Agree
3 Mildly agree
4 Mildly disagree
5 Disagree
6 Strongly disagree

1. The problems of taking care of a child are easy to solve once you know how your actions affect your child, an understanding I have acquired.	1	2	3	4	5	6
2. Even though being a parent could be rewarding, I am frustrated now while my child is at his/her present age.	1	2	3	4	5	6
3. I go to bed the same way I wake up in the morning, feeling I have not accomplished a whole lot.	1	2	3	4	5	6
4. I do not know why it is, but sometimes when I'm supposed to be in control, I feel more like the one being manipulated.	1	2	3	4	5	6
5. My mother/father was better prepared to be a good mother/father than I am.	1	2	3	4	5	6
6. I would make a fine model for a new mother/father to follow in order to learn what she/he would need to know in order to be a good parent.	1	2	3	4	5	6
7. Being a parent is manageable and any problems are easily solved.	1	2	3	4	5	6
8. A difficult problem in being a parent is not knowing whether you're doing a good job or a bad one.	1	2	3	4	5	6
9. Sometimes I feel like I'm not getting anything done.	1	2	3	4	5	6
10. I meet my own personal expectations for expertise in caring for my child.	1	2	3	4	5	6
11. If anyone can find the answer to what is troubling my child, I am the one.	1	2	3	4	5	6
12. My talents and interests are in other areas, not in being a parent.	1	2	3	4	5	6
13. Considering how long I've been a mother/father, I feel thoroughly familiar with this role.	1	2	3	4	5	6
14. If being a mother/father were only more interesting, I would be motivated to do a better job as a parent.	1	2	3	4	5	6
15. I honestly believe that I have all the skills necessary to be a good mother/father to my child.	1	2	3	4	5	6
16. Being a parent makes me tense and anxious.	1	2	3	4	5	6

Results for the Being a Parent Scale are shown below:

Being A Parent Scale results

Higher "Post" scores represent improved outcomes

	Level 4 Standard (N = 44)			Level 4 Group (N = 22)		
	Pre	Post	Change	Pre	Post	Change
Efficacy	28.3	32.8	16.00%	30.0	33.5	11.84%
Satisfaction	35.5	41.7	17.49%	43.7	44.6	1.98%
Total	63.8	74.5	16.83%	73.7	78.1	5.98%

Improved outcomes are indicated with a green background while worsened outcomes are indicated with a red background. Sample sizes ("N") of 10 or less are bolded in red to bring attention to the fact that the margin of error is greater with having fewer samples collected.

In addition to the self-assessments, the Client Satisfaction Questionnaire (CSQ) was given to participants to indicate their satisfaction with the program after completing a particular level of Triple P. An example of the Client Satisfaction Questionnaire is shown below and on the next page:

(Page 1 of 2)

Client Satisfaction Questionnaire

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

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

Results for the Client Satisfaction Questionnaire are shown below:

Satisfaction Survey results

	Level 3 Standard (N = 17)	**Level 4 Standard** (N = 50)	**Level 4 Teen** **(N = 8)**	**Level 4 Group** (N = 25)	**Level 4 Group Teen** **(N = 9)**	**Level 4 Stepping Stones** **(N = 3)**	**Level 5 Pathways** (N = 20)	**Level 5 Enhanced** **(N = 2)**
Score	(83.2% of total) 75.65 / 91.00	(88.2% of total) 80.34 / 91.00	(91.1% of total) 82.88 / 91.00	(87.5% of total) 79.60 / 91.00	(72.5% of total) 66.00 / 91.00	(77.3% of total) 70.33 / 91.00	(86.8% of total) 79.00 / 91.00	(90.1% of total) 82.00 / 91.00

The maximum score for the Client Satisfaction Questionnaire is 91. Each score was divided by 91 to show how each score equates to a percentage out of 100%.

(ASRA) Automatic Scoring and Reporting Application data

Outcomes in this section are only shown for data that was entered into the ASRA scoring application. New assessments were required during Fiscal Year 18/19 that were available in ASRA but not the Legacy scoring application. The required assessments are selected based off advances in the scientific literature on parenting.

Bar graphs representing pre- and post-assessment comparisons, shown further in the report, were generated by ASRA automatically. Pre- and post- comparisons are based on the data available.

Self-assessments (ASRA)

For Fiscal Year 18/19, the required self-assessments were as follows:

Self-assessment (#1) The Parenting and Family Adjustment Scale (P.A.F.A.S.)

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.[7]

Details of how each of these seven scored measures were calculated is shown on the next page. Questions that factor into each measure's score are grouped into sections. Questions on the next page are not sorted by sequential order. The questions shown on the next page are formatted differently for illustrative purposes.

On the PAFAS assessment, LOWER scores/points ("pts") represent more positive outcomes.

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 = 3pts, 1 = 2pts, 2 = 1pt, and 3 = 0pts):

P.A.F.A.S Scoring Illustration	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:

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:

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:

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:

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:

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:

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)	

P.A.F.A.S. 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

Self-assessment (#2) The Child Adjustment and Parent Efficacy Scale (C.A.P.E.S.)

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.[8]

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 or points ("pts") represent more positive outcomes.

Details of how each of these three scored measures were calculated is shown on the next page. Questions that factor into each measure's score will be grouped into sections. Questions on the next page are not sorted by sequential order. The questions shown on the next page are formatted differently for illustrative purposes.

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

C.A.P.E.S Scoring Illustration

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

(Range) 0 – 9

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

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
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

(Range) 0 – 72

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

C.A.P.E.S. Blank Assessment (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	

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

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

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

Outcomes by level (ASRA data only)

In this next section, details about the number of families served, average child's age, child's gender distribution, and number of individual family members served will be reported on for each version of levels 3, 4, and 5 under the "Overview" section.

After the "Overview" section, assessment results for the CAPES and PAFAS will be reported on for each version of levels 3, 4, and 5 under the "CAPES" and "PAFAS" sections (if data was available).

After the "CAPES" and PAFAS" sections, the client satisfaction scores will be reported on for each version of levels 3, 4, and 5.

The last section will summarize these results into tables followed by a "Conclusion" section to highlight the key takeaways.

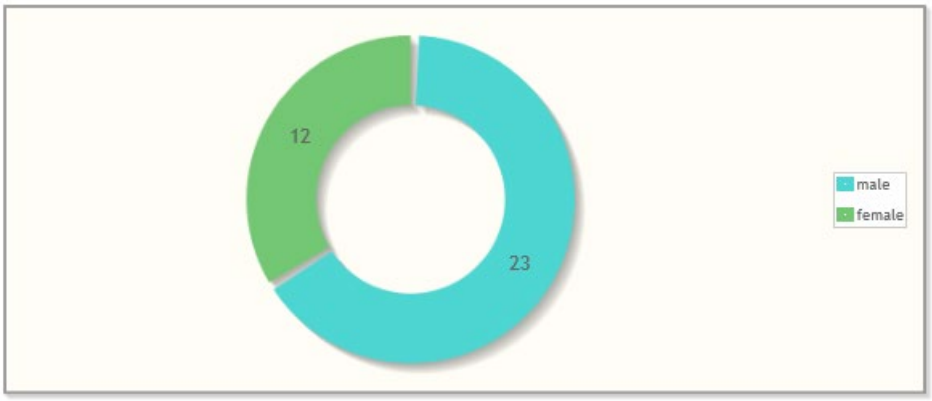
Overview: Level 3 Primary Care

Number of families
32

Child average age
5.5

Number of family members
34

Child Genders



Children's age distribution

Ages of the children ranged from 2 to 11 years old.

Due to the limited sample size, the Children's age distribution, which showed the number of children at each age, is not shown to protect client privacy.

Overview: Level 3 Primary Care TEEN

Number of families
5

Child average age
14.0

Number of family members
5

Child Genders

The majority of children in this version of level 3 were male.

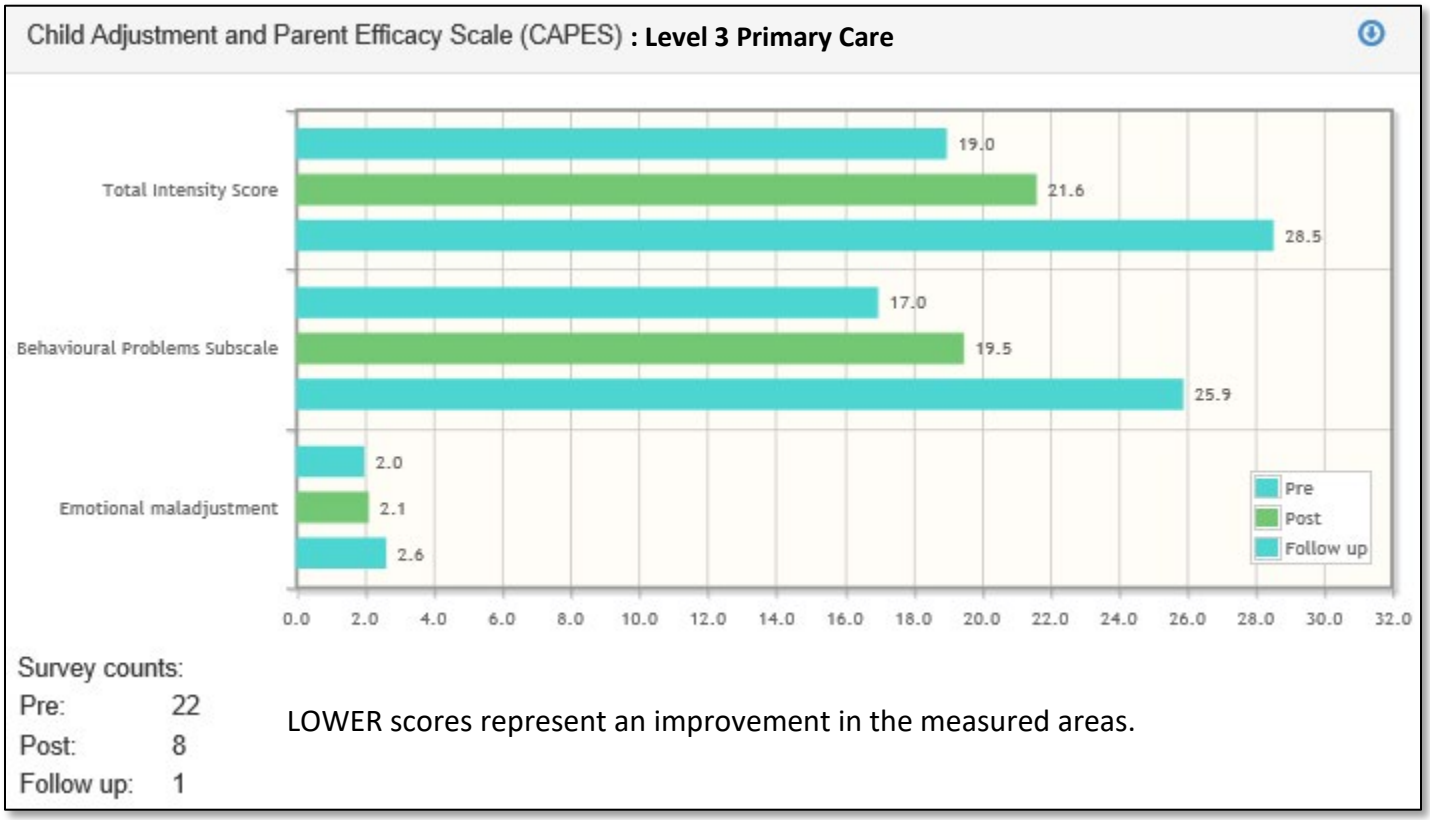
Due to the limited sample size, a count of the children's gender is not shown to protect client privacy.

Children's age distribution

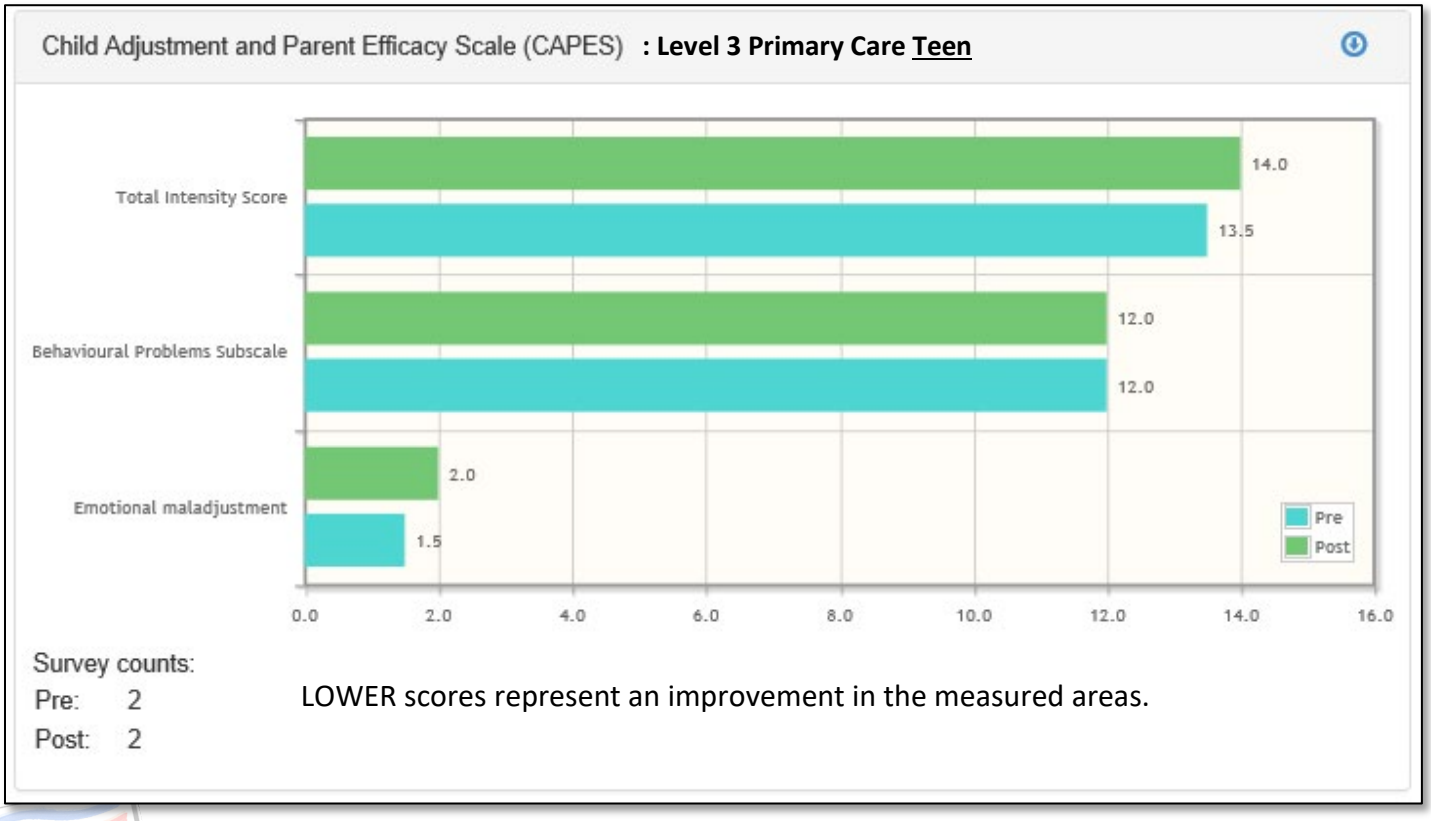
Ages of the teenagers ranged from 14 to 17 years old.

Due to the limited sample size, the Children's age distribution, which showed the number of children at each age, is not shown to protect client privacy.

Level 3: CAPES Assessments



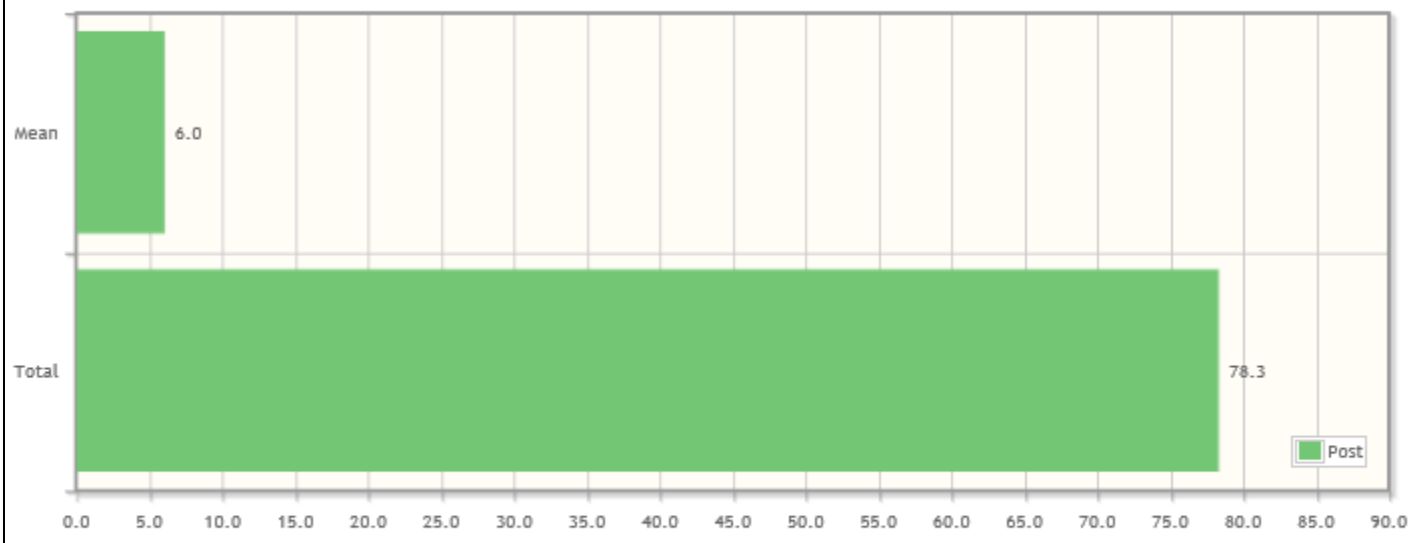
LOWER scores represent an improvement in the measured areas.



LOWER scores represent an improvement in the measured areas.

Level 3: Client Satisfaction Questionnaire

Client Satisfaction Questionnaire (Post Only) : **Level 3 Primary Care**



A maximum total score of 91 and a minimum total score of 13 are possible, with higher scores indicating greater program satisfaction. The mean item score can range from 1 to 7.

Survey counts:

Post: 14

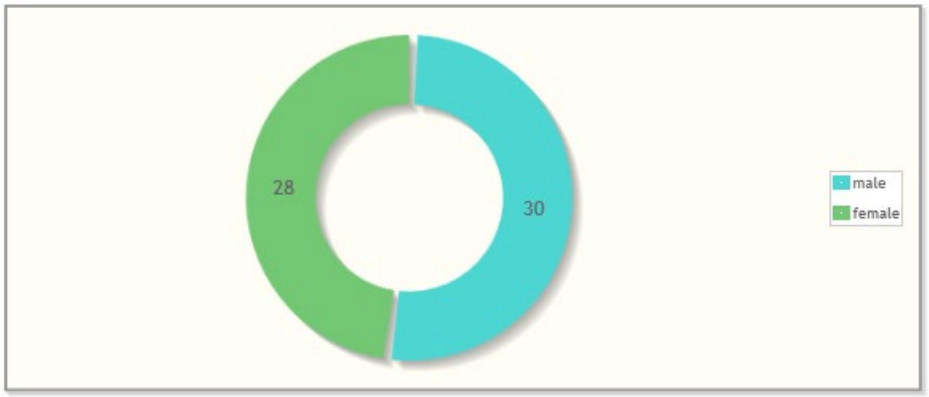
Overview: Level 4 Standard

Number of families
57

Child average age
5.4

Number of family members
73

Child Genders



Children's age distribution

Ages of the children ranged from 2 to 13 years old.

Due to the limited sample size, the Children's age distribution, which showed the number of children at each age, is not shown to protect client privacy.

Overview: Level 4 Standard Teen

Number of families
16

Child average age
14.7

Number of family members
19

Child Genders

The majority of children in this version of level 4 were male.

Due to the limited sample size, a count of the children's gender is not shown to protect client privacy.

Children's age distribution

Ages of the teenagers ranged from 13 to 18 years old.

Due to the limited sample size, the Children's age distribution, which showed the number of children at each age, is not shown to protect client privacy.

Overview: Level 4 Stepping Stones

Number of families
1

Child average age
Due to the limited sample size, this is not shown.

Number of family members
1

Child Genders

Due to the limited sample size, a count of the children's gender is not shown to protect client privacy.

Children's age distribution

Due to the limited sample size, the Children's age distribution, which showed the number of children at each age, is not shown to protect client privacy.

Overview: Level 4 Group

Number of families
21

Child average age
6.5

Number of family members
26

Child Genders

The majority of children in this version of level 4 were male.

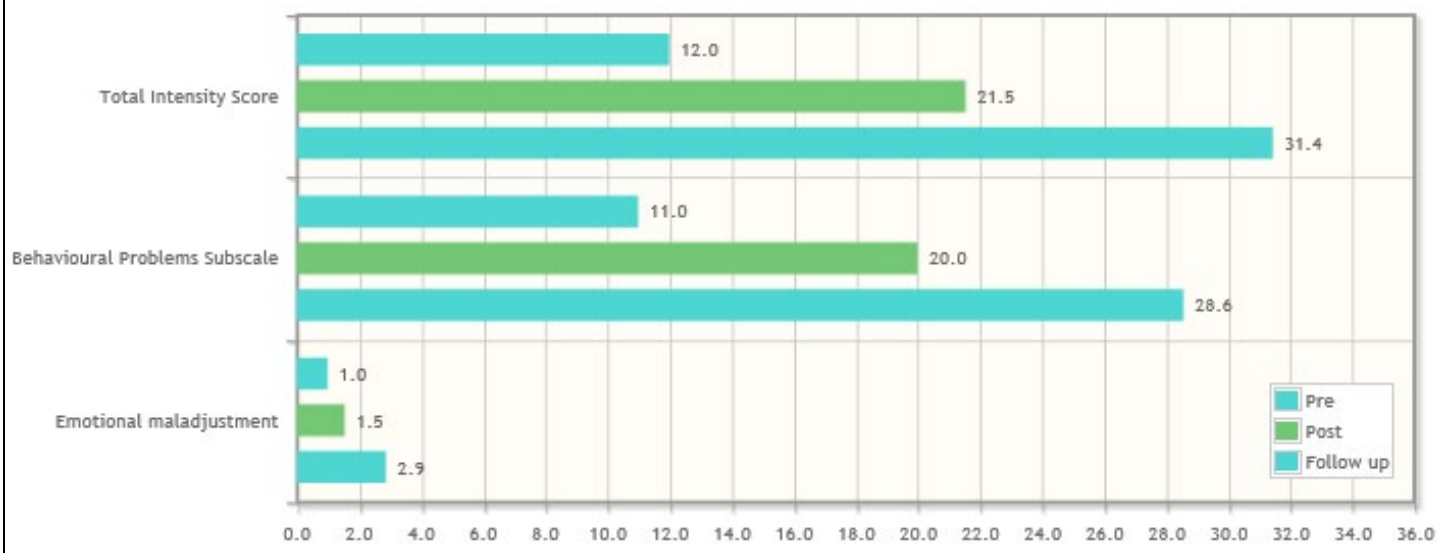
Due to the limited sample size, a count of the children's gender is not shown to protect client privacy.

Children's age distribution

Due to the limited sample size, the Children's age distribution, which showed the number of children at each age, is not shown to protect client privacy.

Level 4: CAPES Assessments

Child Adjustment and Parent Efficacy Scale (CAPES) : **Level 4 Standard**

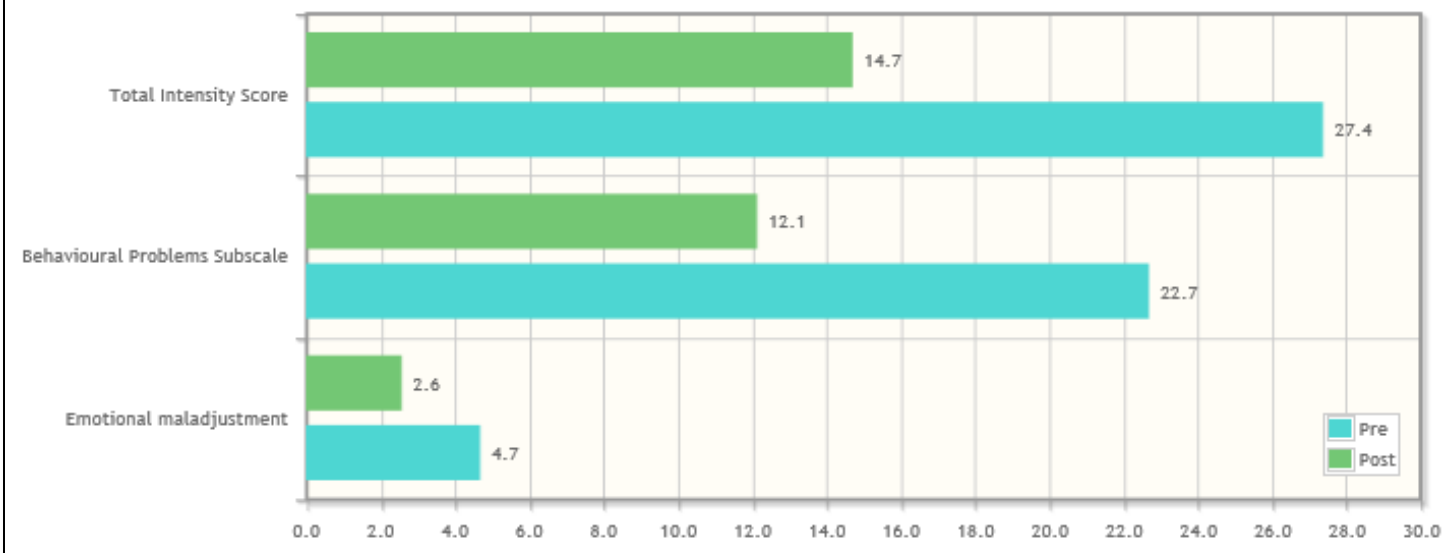


Survey counts:

Pre:	41
Post:	11
Follow up:	1

LOWER scores represent an improvement in the measured areas.

Child Adjustment and Parent Efficacy Scale (CAPES) : **Level 4 Standard Teen**

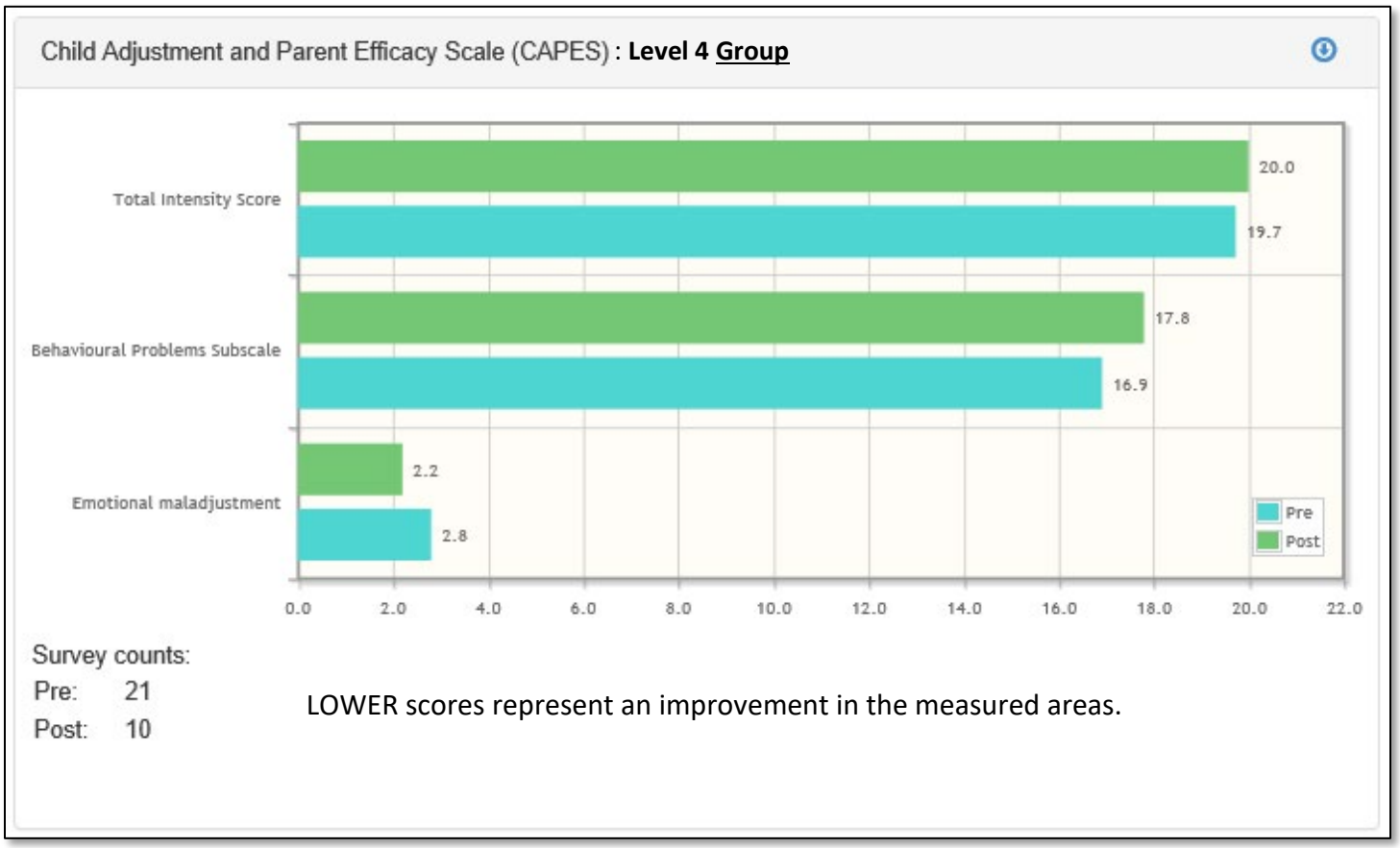


Survey counts:

Pre:	16
Post:	7

LOWER scores represent an improvement in the measured areas.

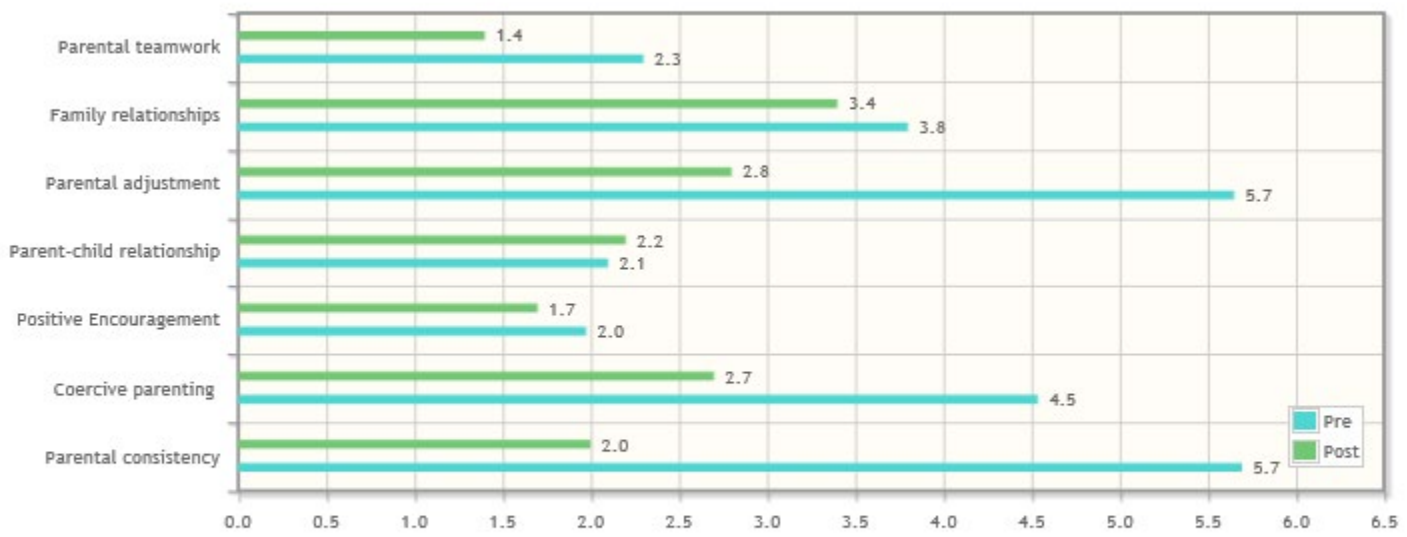
Level 4: CAPES Assessments (continued)



LOWER scores represent an improvement in the measured areas.

Level 4: PAFAS Assessments

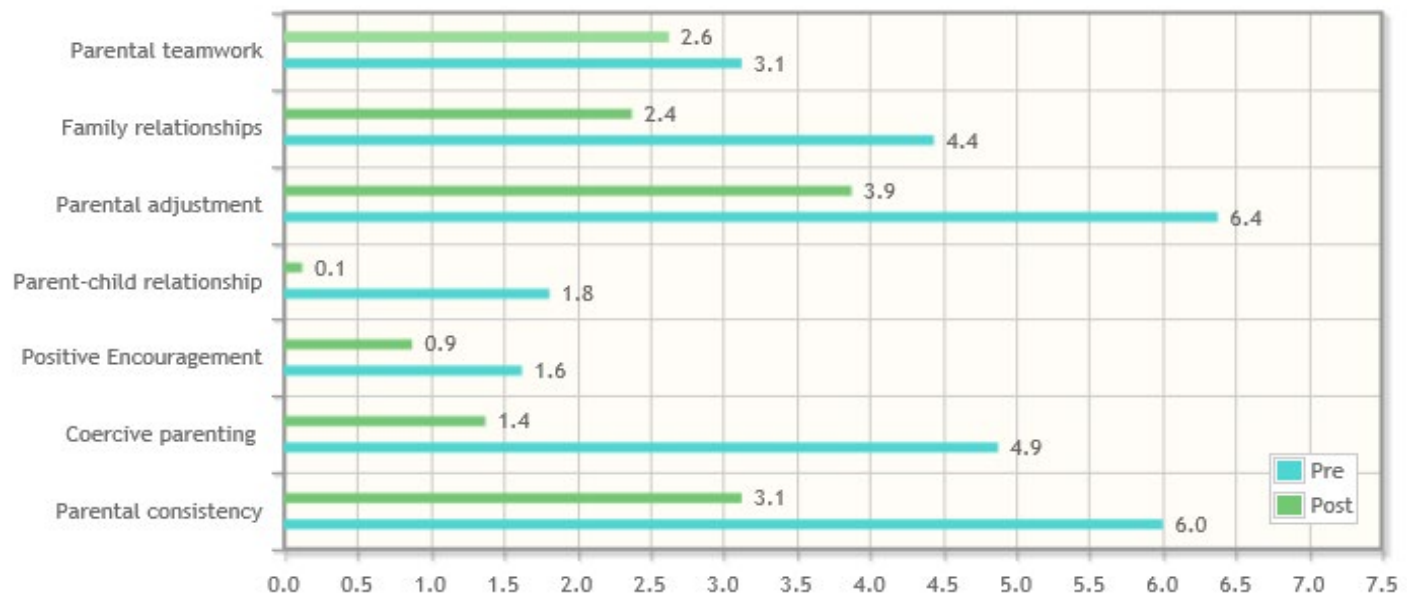
Parenting and Family Adjustment Scale (PAFAS): **Level 4 Standard**



Survey counts:
Pre: 40
Post: 10

LOWER scores represent an improvement in the measured areas.

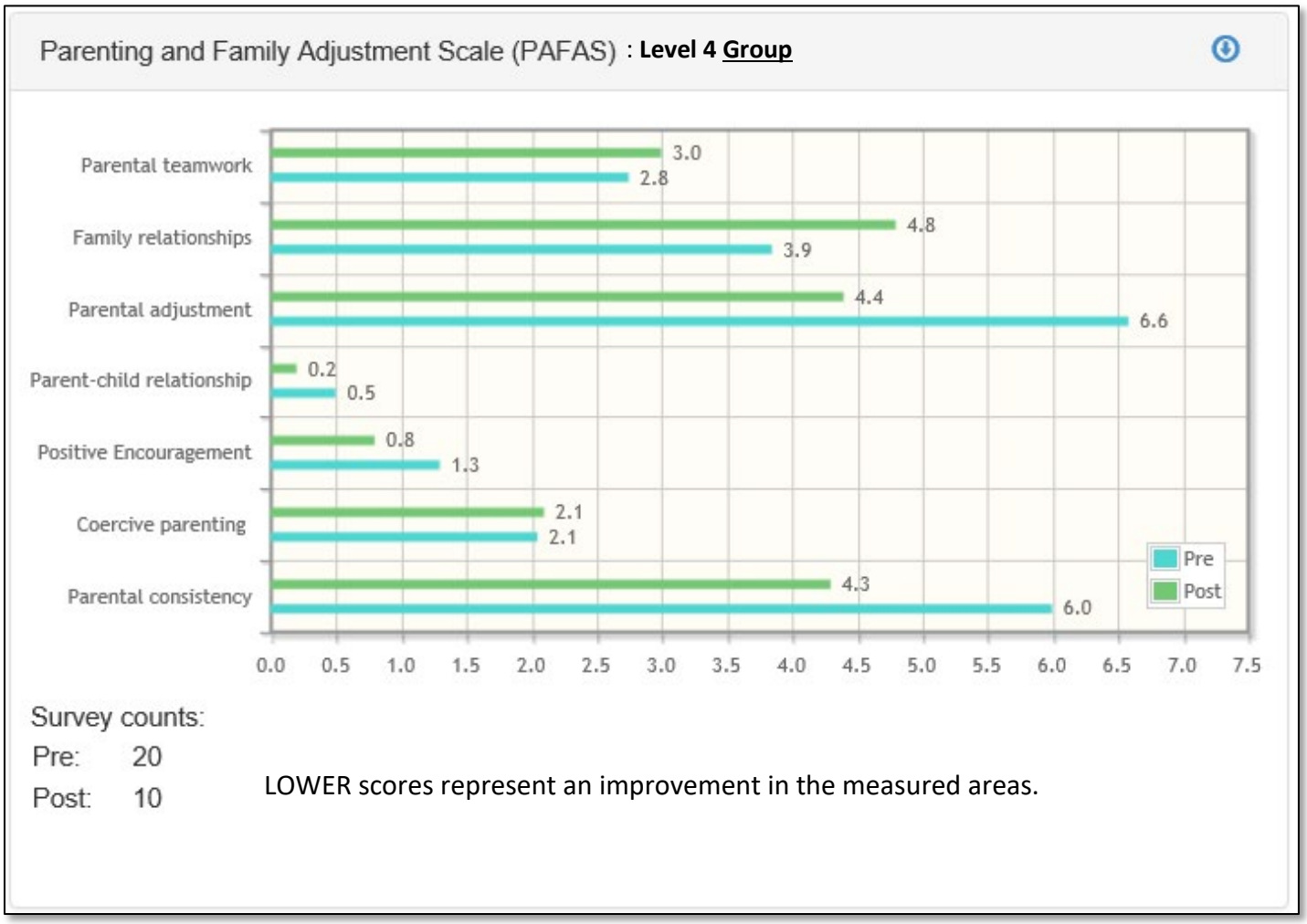
Parenting and Family Adjustment Scale (PAFAS): **Level 4 Standard Teen**



Survey counts:
Pre: 16
Post: 8

LOWER scores represent an improvement in the measured areas.

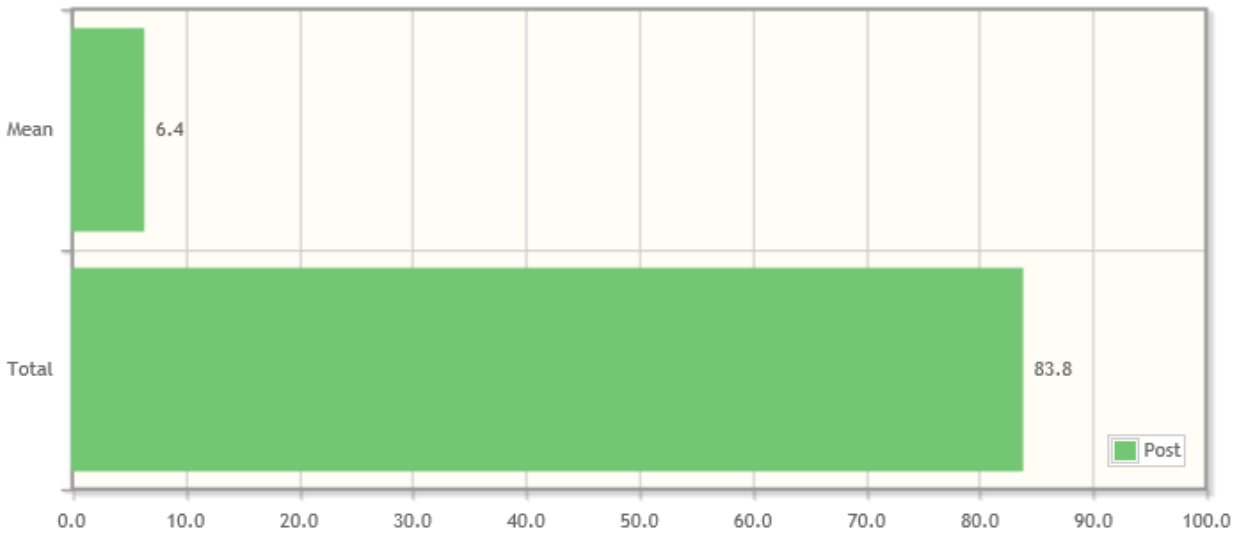
Level 4: PAFAS Assessments (continued)



LOWER scores represent an improvement in the measured areas.

Level 4: Client Satisfaction Questionnaire

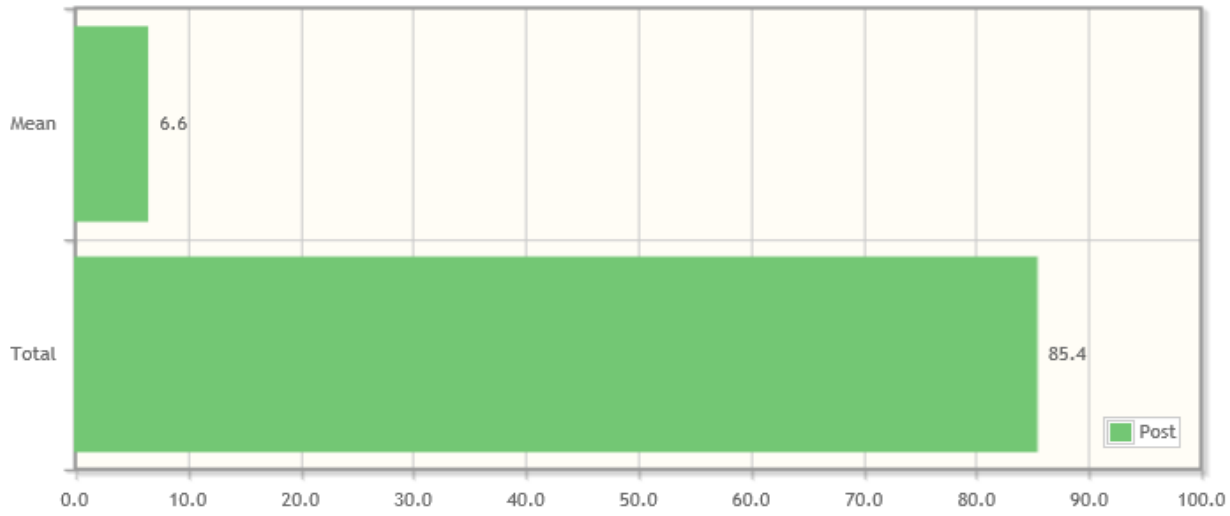
Client Satisfaction Questionnaire (Post Only) : **Level 4 Standard**



A maximum total score of 91 and a minimum total score of 13 are possible, with higher scores indicating greater program satisfaction. The mean item score can range from 1 to 7.

Survey counts:
Post: 19

Client Satisfaction Questionnaire (Post Only): **Level 4 Standard Teen**

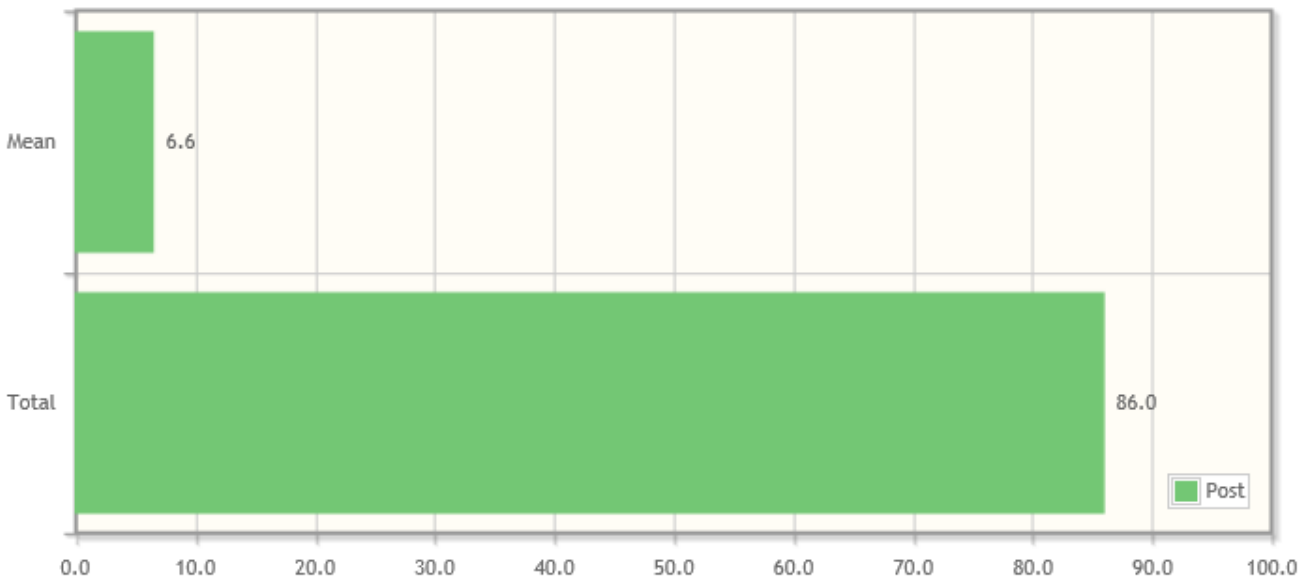


A maximum total score of 91 and a minimum total score of 13 are possible, with higher scores indicating greater program satisfaction. The mean item score can range from 1 to 7.

Survey counts:
Post: 7

Level 4: Client Satisfaction Questionnaire (continued)

Client Satisfaction Questionnaire (Post Only) : **Level 4 Group**



A maximum total score of 91 and a minimum total score of 13 are possible, with higher scores indicating greater program satisfaction. The mean item score can range from 1 to 7.

Survey counts:
Post: 2

Overview: Level 5 Family Transitions

Number of families
4

Child average age
10.3

Number of family members
6

Child Genders

The majority of children in this version of level 5 were male.

Due to the limited sample size, a count of the children's gender is not shown to protect client privacy.

Children's age distribution

Due to the limited sample size, the Children's age distribution, which showed the number of children at each age, is not shown to protect client privacy.

Overview: Level 5 Pathways

Number of families
1

Child average age
Due to the limited sample size, this is not shown.

Number of family members
1

Child Genders

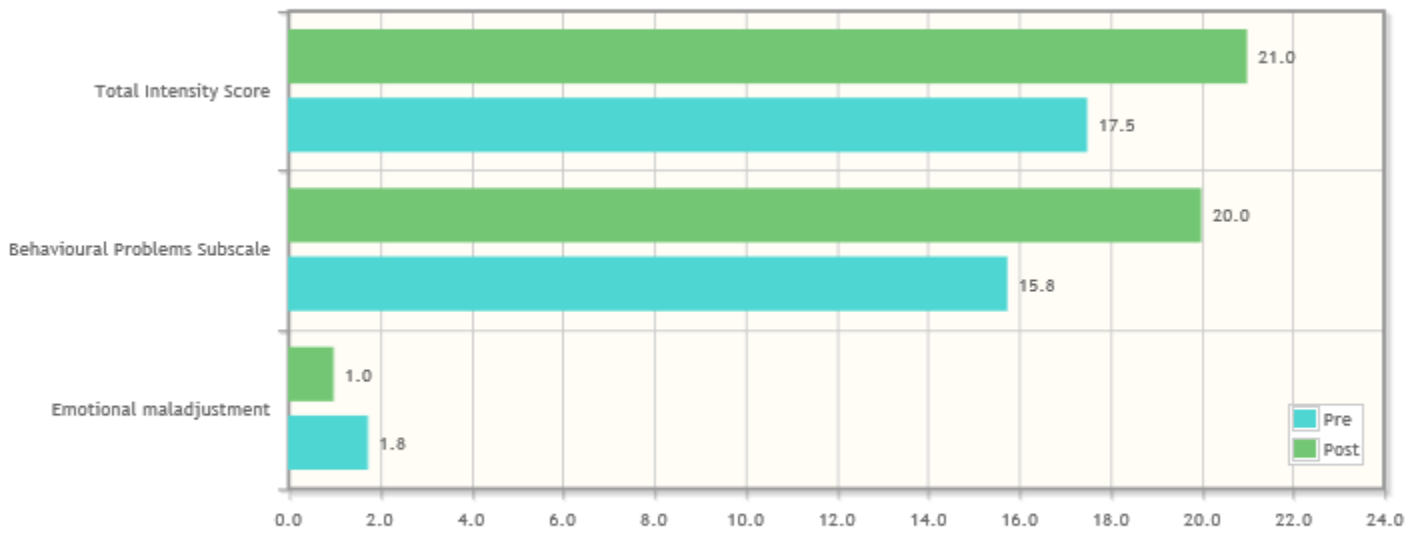
Due to the limited sample size, a count of the children's gender is not shown to protect client privacy.

Children's age distribution

Due to the limited sample size, the Children's age distribution, which showed the number of children at each age, is not shown to protect client privacy.

Level 5: CAPES Assessments

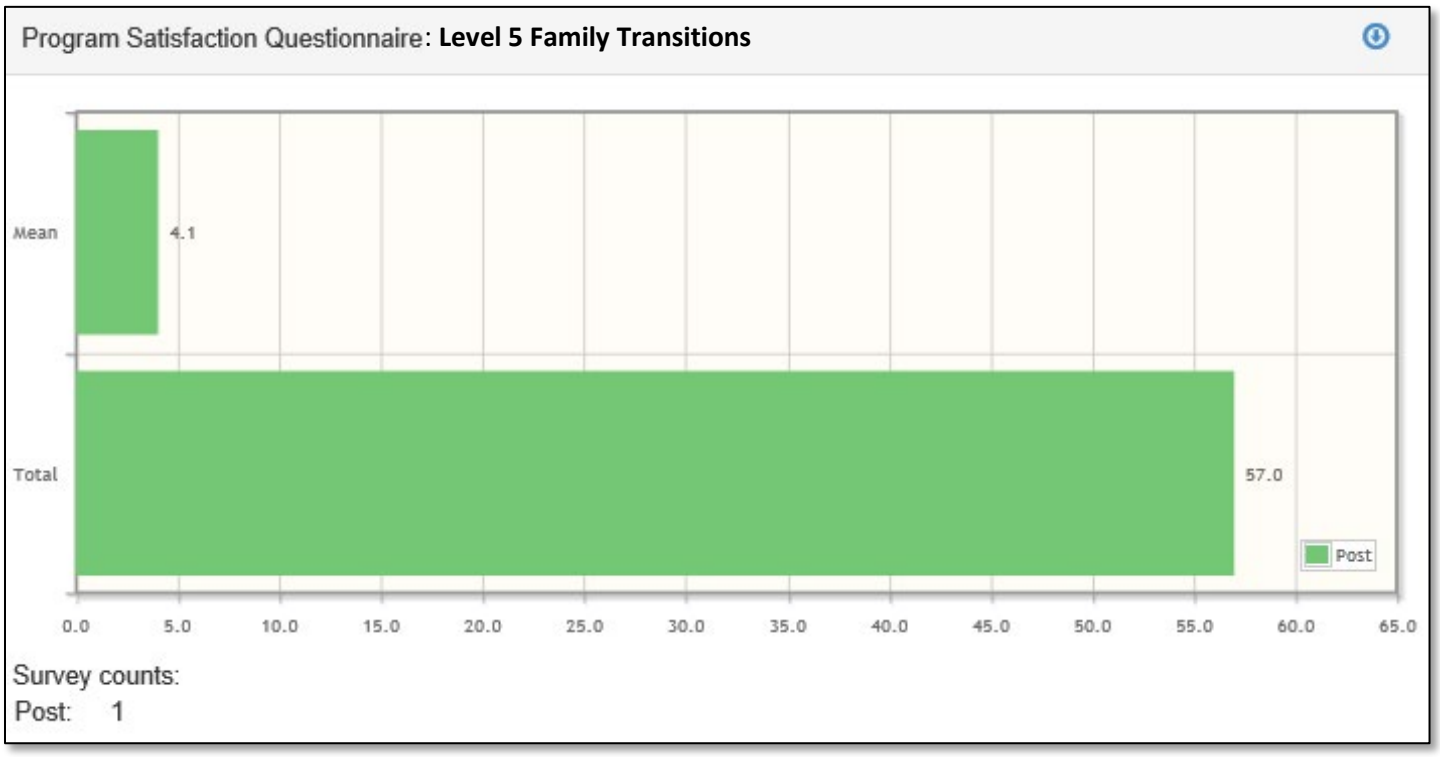
Child Adjustment and Parent Efficacy Scale (CAPES) : **Level 5 Family Transitions**



Survey counts:
Pre: 4
Post: 1

LOWER scores represent an improvement in the measured areas.

Level 5: Client Satisfaction Questionnaire



CAPES Summary Tables

Level 3 Primary			
# of Assessments	Pre	Post	Complete %
	22	8	36%
Measure	Pre	Post	Change
Total Intensity	28.5	21.6	24%
Behavioral Problems	25.9	19.5	25%
Emotional Maladjust.	2.6	2.1	19%

Level 3 Primary Teen			
# of Assessments	Pre	Post	Complete %
	2	2	100%
Measure	Pre	Post	Change
Total Intensity	13.5	14.0	-4%
Behavioral Problems	12.0	12.0	0%
Emotional Maladjust.	1.5	2.0	-33%

Level 4 Standard			
# of Assessments	Pre	Post	Complete %
	41	11	27%
Measure	Pre	Post	Change
Total Intensity	31.4	21.5	32%
Behavioral Problems	28.6	20.0	30%
Emotional Maladjust.	2.9	1.5	48%

Level 4 Standard Teen			
# of Assessments	Pre	Post	Complete %
	16	7	44%
Measure	Pre	Post	Change
Total Intensity	27.4	14.7	46%
Behavioral Problems	22.7	12.1	47%
Emotional Maladjust.	4.7	2.6	45%

Level 4 Group			
# of Assessments	Pre	Post	Complete %
	21	10	48%
Measure	Pre	Post	Change
Total Intensity	19.7	20.0	-2%
Behavioral Problems	16.9	17.8	-5%
Emotional Maladjust.	2.8	2.2	21%

Level 5 Family Transitions			
# of Assessments	Pre	Post	Complete %
	4	1	25%
Measure	Pre	Post	Change
Total Intensity	17.5	21.0	-20%
Behavioral Problems	15.8	20	-27%
Emotional Maladjust.	1.8	1.0	44%

Improved outcomes are indicated with a green background while worsened outcomes are indicated with a red background. Sample sizes ("N") of 10 or less are bolded in red to bring to attention to the fact that the margin of error is greater with having fewer samples collected.

Client Satisfaction Questionnaires Summary Table

Level / Version	# of assessments	Average Score
Level 3 Primary	14	78.3
Level 4 Standard	19	83.8
Level 4 Standard Teen	**7**	85.4
Level 4 Group	**2**	86
Level 5 Family Transitions	**1**	57

Improved outcomes are indicated with a green background while worsened outcomes are indicated with a red background. Sample sizes ("N") of 10 or less are bolded in red to bring to attention to the fact that the margin of error is greater with having fewer samples collected.

PAFAS Summary Tables

Level 4 Standard			
# of Assessments	Pre	Post	Complete %
	40	**10**	25%
Measure	Pre	Post	Change
Parental Teamwork	2.3	1.4	39%
Family Relationships	3.8	3.4	11%
Parental Adjustment	5.7	2.8	51%
Parent-Child Bond	2.1	2.2	-5%
Positive Encouragement	2	1.7	15%
Coercive Parenting	4.5	2.7	40%
Parental Consistency	5.7	2	65%

Level 4 Standard Teen			
# of Assessments	Pre	Post	Complete %
	16	**8**	50%
Measure	Pre	Post	Change
Parental Teamwork	3.1	2.6	16%
Family Relationships	4.4	2.4	45%
Parental Adjustment	6.4	3.9	39%
Parent-Child Bond	1.8	0.1	94%
Positive Encouragement	1.6	0.9	44%
Coercive Parenting	4.9	1.4	71%
Parental Consistency	6	3.1	48%

Level 4 Group			
# of Assessments	Pre	Post	Complete %
	20	**10**	50%
Measure	Pre	Post	Change
Parental Teamwork	2.8	3	-7%
Family Relationships	3.9	4.8	-23%
Parental Adjustment	6.6	4.4	33%
Parent-Child Bond	0.5	0.2	60%
Positive Encouragement	1.3	0.8	38%
Coercive Parenting	2.1	2.1	0%
Parental Consistency	6	4.3	28%

Conclusion:

Outcomes showed positive improvements, overall, on both the PAFAS and CAPES assessments during Fiscal Year 18/19. In some levels, there was minimal participant data and lower than normal pre-/post-survey completion percentages due to the transition to the ASRA scoring application during Fiscal Year 18/19 (regular use of the ASRA scoring application began during Q3).

CAPES findings:

Improvements were highest among caregivers who completed Teen versions of Triple P. Among the three parenting measures on the CAPES survey, participants showed an overall average improvement of 46% in Level 4 Teen, 37% in Level 4 Standard, and 5% in Level 4 Group.

This assessment was also given in Level 3 and Level 5 (averaging negative results), but only had two or less post-surveys completed. For level 3 Primary, which had 8 post-assessments completed, the overall average improvement was 23%.

PAFAS findings:

Again, improvements were highest among caregivers who completed Teen versions of Triple P. Among the seven aspects of parenting that the PAFAS measures, participants had an overall average improvement of 51% in Level 4 Teen, 31% in Level 4 Standard, and 18% in Level 4 Group.

Client Satisfaction Questionnaire:

Out of 13-91 possible points, Level 4 Teen Satisfaction was 85.4 (94% of total), Level 4 Standard was 83.8 (92% of total), and Level 3 Primary was 78.3 (86% of total). In levels that had two or less post-surveys completed, Level 4 Group was 86 (95% of total) and Level 5 Family Transitions was 57 (63% of total).

References

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[4] Irvine, A., Biglan, A., Smolkowski, K., & Ary, D. V. (1999). The value of the Parenting Scale for measuring the discipline practices of parents of middle school children. Behaviour Research and Therapy, 37(2), 127-142. doi:10.1016/s0005-7967(98)00114-4

[5] Children of Parents with a Mental Illness: Mental health information and resources for Australian parents, children, families, carers and health professionals. Retrieved from http://www.copmi.net.au/images/pdf/Research/Parenting-Scale-Feb2015.pdf

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[8] 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 18/19

(July 1st, 2018 – June 30th, 2019)

Shasta Lake and Anderson School

Table of Contents

Introduction

The Botvin LifeSkills program is an evidence-based substance use and violence prevention program for adolescents and young teens. 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 School during Fiscal Year 18/19. 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.

Methods

Survey Tool

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 to 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 demographics questions and 52 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 (5 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.

Limitations

Lack of survey data collection software

Data quality was decreased without the availability of survey software due to susceptibility to:

- Illegible handwriting (of student ID numbers or indiscernible answer bubble markings).
- Invalid selections (marking more than one bubble, or in-between bubbles for which only one selection was allowed). Invalid selections were treated as a missing response.
- Students who didn't write their student ID number on both their pre-and post-survey. Without having a student ID number on both the pre-survey and post-surveys, there was no way of linking them together, so pre-surveys that have no corresponding post-survey, or vice-versa, are included in the results (increasing the amount of error).
- Possible data entry errors. Students' written survey responses were typed into a database, introducing the risk of typos or any other type of inaccurate transfer of information.

Program implementation

An implementation error occurred where the pre-survey tear-off sheet was printed double-sided with the page that collected the student ID number (to link students' pre- and post-surveys).

Another implementation error occurred where Anderson students were given an earlier version of the post-survey that did not include one of the questions that was on the pre-survey (no post-score on this question was calculated).

Survey Design

The "Drug refusal" score might have been adversely affected by the transition from Section C.) to Section D.) on the survey. 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 would have misinterpreted section D.) if they did not see the lead-in statement.

Results

The results of each scored measure for 6th – 8th grade students from Shasta Lake school is shown in the matrix below.

		Shasta Lake School								
		6th grade			7th grade			8th grade		
	Measure	Pre-Survey (N = 92)	Post-Survey (N = 89)	Change	Pre-Survey (N = 86)	Post-Survey (N = 87)	Change	Pre-Survey (N = 101)	Post-Survey (N = 93)	Change
Knowledge	Anti-drug	57.16%	70.33%	+13.17% ↑	62.80%	69.06%	+6.26% ↑	60.54%	60.87%	+0.34% ↑
	Life skills	65.28%	70.42%	+5.13% ↑	71.57%	75.62%	+4.05% ↑	72.87%	76.69%	+3.83% ↑
	Overall (combined)	61.99%	70.38%	+8.40% ↑	68.01%	72.96%	+4.94% ↑	67.86%	70.27%	+2.41% ↑
Attitudes	Anti-smoking	4.53	4.55	+ .02 ↑	4.46	4.42	- .04 ↓	4.45	4.40	- .05 ↓
	Anti-drinking	4.42	4.53	+ .11 ↑	4.34	4.33	- .01 ↓	4.27	4.30	+ .03 ↑
	Anti-drug (combined)	4.48	4.54	+ .06 ↑	4.40	4.38	- .02 ↓	4.36	4.35	- .01 ↓
Life Skills	Drug refusal	3.99	4.03	+ .04 ↑	3.99	4.07	+ .08 ↑	3.99	3.90	- .09 ↓
	Assertiveness	3.58	3.60	+ .02 ↑	3.62	3.55	- .07 ↓	3.66	3.62	- .04 ↓
	Relaxation	3.89	4.13	+ .24 ↑	3.85	3.97	+ .12 ↑	3.90	3.90	No change
	Self-control	3.79	3.83	+ .04 ↑	3.69	3.54	- .15 ↓	3.55	3.73	+ .18 ↑

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.

		Anderson School								
		6th grade			7th grade			8th grade		
	Measure	Pre-Survey (N = 97)	Post-Survey (N = 96)	Change	Pre-Survey (N = 99)	Post-Survey (N = 91)	Change	Pre-Survey (N = 110)	Post-Survey (N = 94)	Change
Knowledge	Anti-drug	55.15%	61.84%	+6.69% ↑	52.87%	62.16%	+9.29% ↑	55.91%	61.50%	+5.59% ↑
	Life skills	63.37%	68.41%	+5.04% ↑	66.54%	69.97%	+3.43% ↑	69.25%	69.92%	+0.68% ↑
	Overall (combined)	60.03%	65.74%	+5.71% ↑	60.98%	66.80%	+5.81% ↑	63.83%	66.50%	+2.67% ↑
Attitudes	Anti-smoking	4.33	4.39	+ .06 ↑	4.32	4.25	- .07 ↓	4.18	4.01	- .17 ↓
	Anti-drinking	4.22	4.32	+ .10 ↑	4.25	4.08	- .17 ↓	3.99	3.79	- .20 ↓
	Anti-drug (combined)	4.27	4.36	+ .09 ↑	4.29	4.17	- .12 ↓	4.08	3.90	- .18 ↓
Life Skills	Drug refusal	4.07	3.76	-0.31 ↓	3.93	3.91	- .02 ↓	4.02	4.04	+ .02 ↑
	Assertiveness	3.66	3.54	- .12 ↓	3.51	3.59	+ .08 ↑	3.49	3.58	+ .09 ↑
	Relaxation	3.95	4.07	+ .12 ↑	3.60	3.68	+ .08 ↑	3.43	3.60	+ .17 ↑
	Self-control	3.49	3.63	+ .14 ↑	3.46	3.51	- .05 ↓	3.37	3.33	- .04 ↓

Note: Numbers may not add due to rounding.

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

Conclusion

The results indicate that the program was successful at improving students' anti-drug knowledge and life skills knowledge. Anti-drug attitudes strengthened among the sixth graders but weakened among the seventh and eighth graders overall. 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. The measures in the Life Skills category had mixed success, but with most measures in this category showing improved post-survey scores.

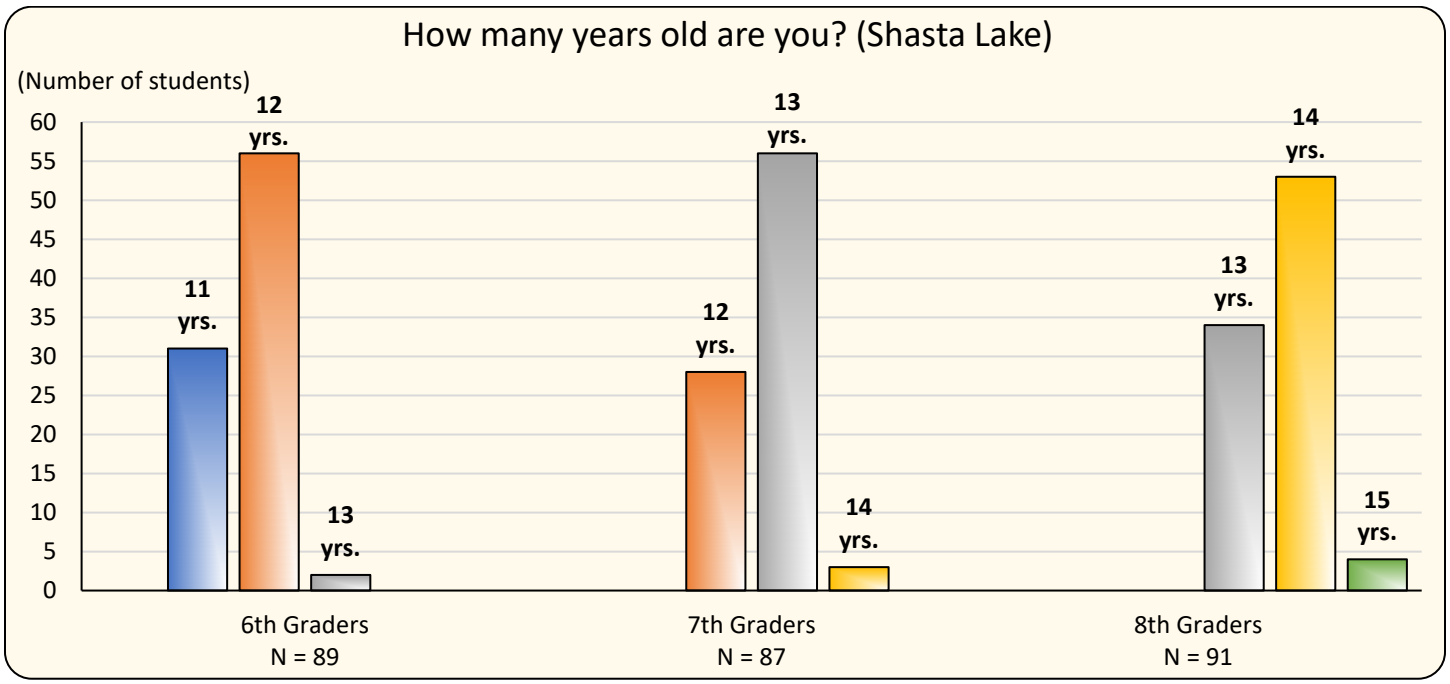
Recommendations

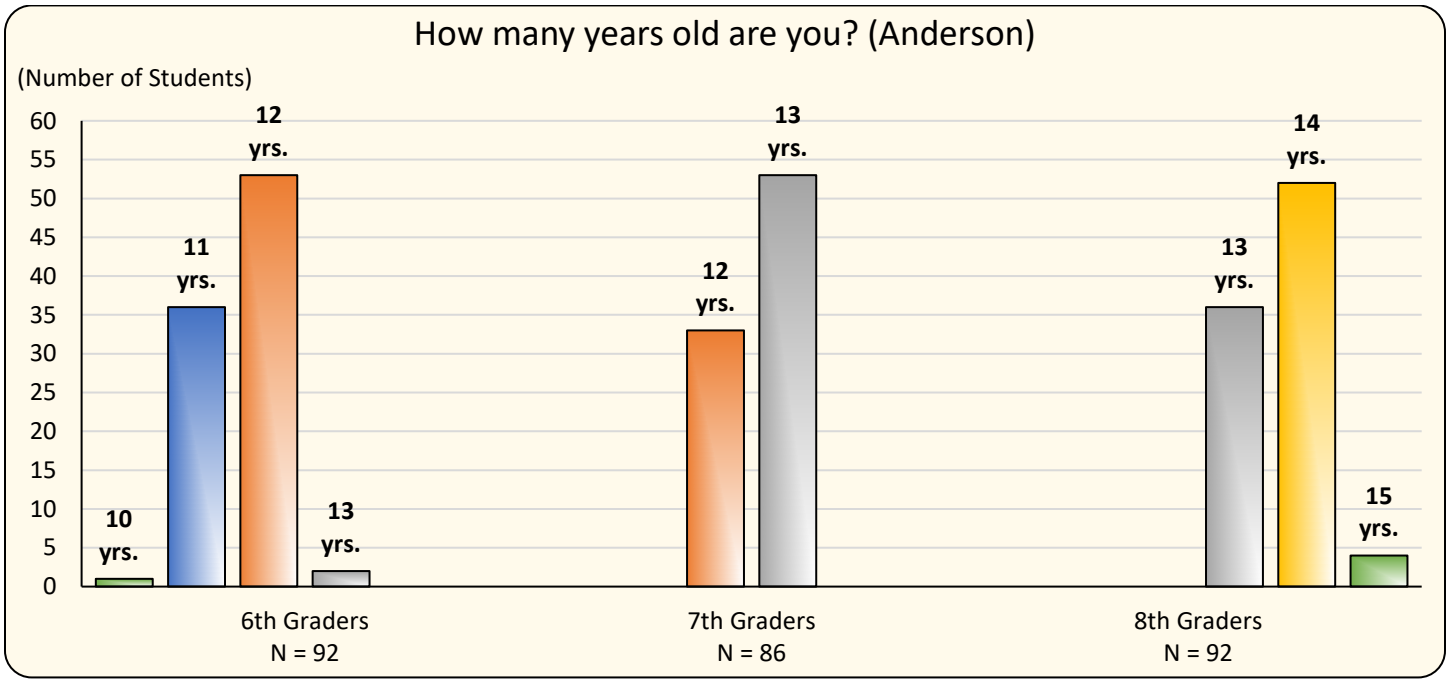
Efforts should be made to continue improving the program. This would consist of addressing barriers to learning, changing attitudes, and implementing life skills. If it is feasible, program staff should consider adjusting the curriculum to better influence anti-drug attitudes and improve implementation of life skills learned by students. The addition of survey software to enhance data collection quality, correcting program implementation mistakes, and perhaps tweaking the design between sections C.) and D.) would be ways to improve.

Data Analysis

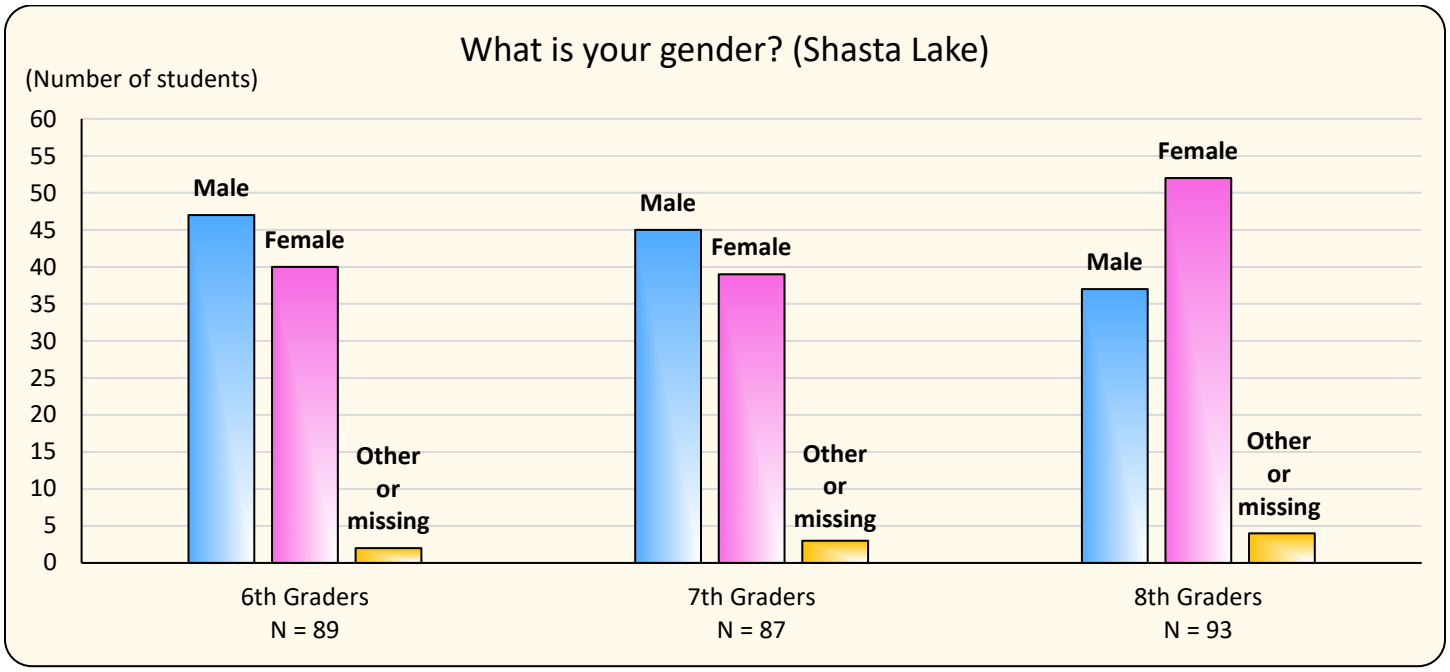
In this section, information on the students' background (including demographic information) and how the scored measures were calculated will be explored in greater detail. Missing responses were ignored when calculating the scored measures, and missing responses were also not individually tracked in the student background section. Survey questions, shown further on, are formatted differently for illustrative purposes. The structure of this section is as follows:

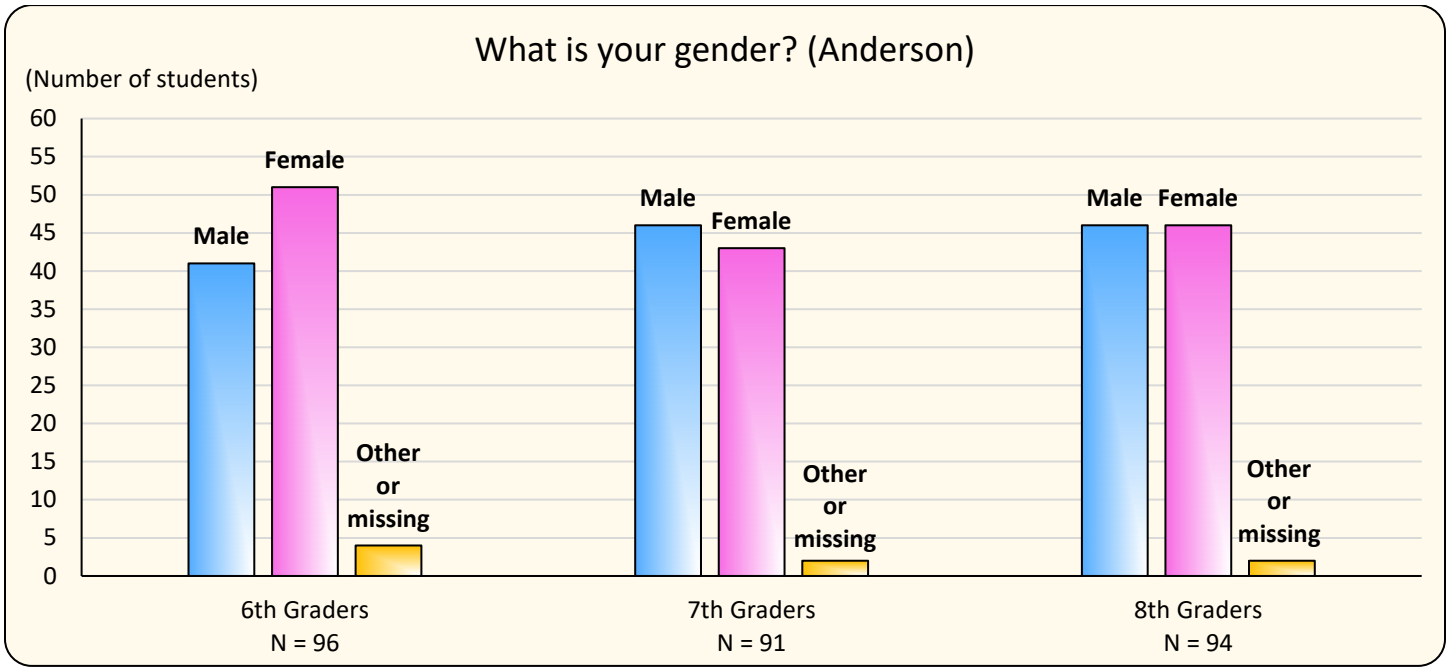
Age


How many years old are you? (Shasta Lake)
(Number of students)
60
55
50
45
40
35
30
25
20
15
10
5
0
11 yrs.
12 yrs.
13 yrs.
12 yrs.
13 yrs.
14 yrs.
13 yrs.
14 yrs.
15 yrs.
6th Graders
N = 89
7th Graders
N = 87
8th Graders
N = 91

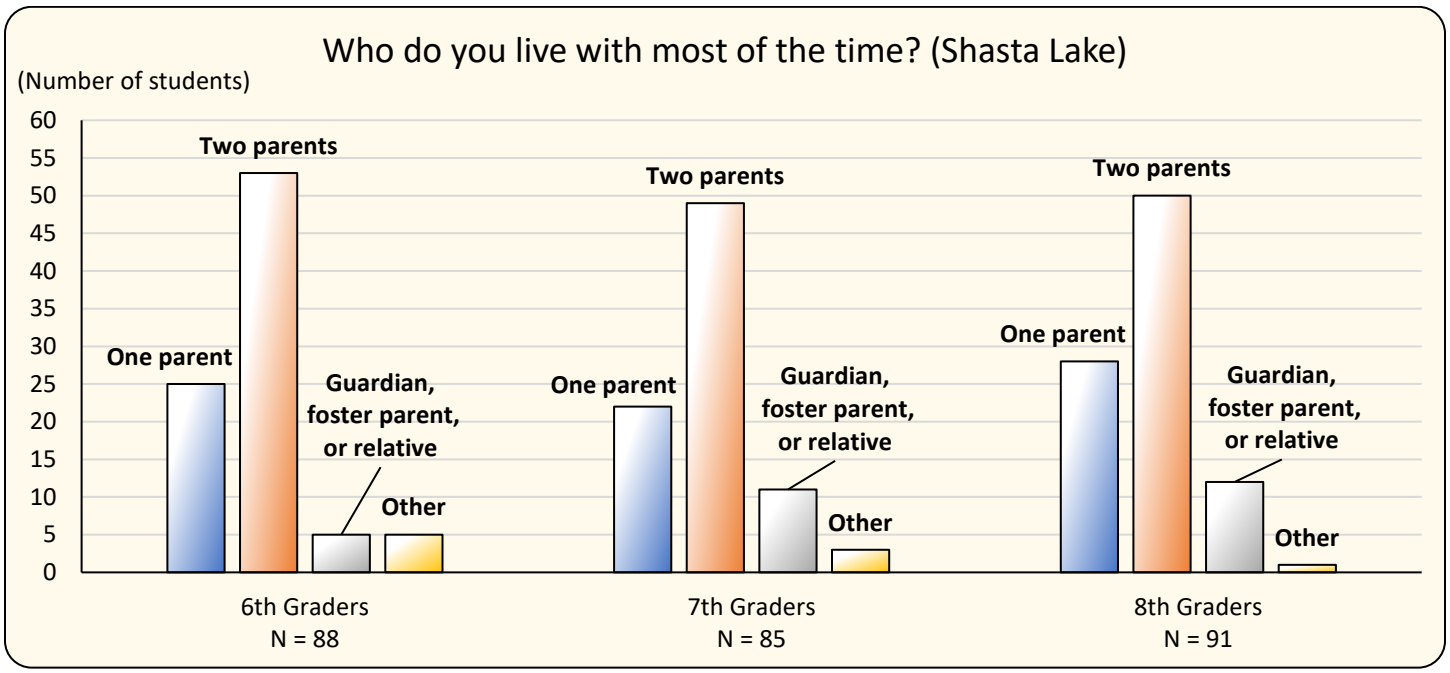

How many years old are you? (Anderson)
(Number of Students)
60
55
50
45
40
35
30
25
20
15
10
5
0
10 yrs.
11 yrs.
12 yrs.
13 yrs.
12 yrs.
13 yrs.
13 yrs.
14 yrs.
15 yrs.
6th Graders
N = 92
7th Graders
N = 86
8th Graders
N = 92

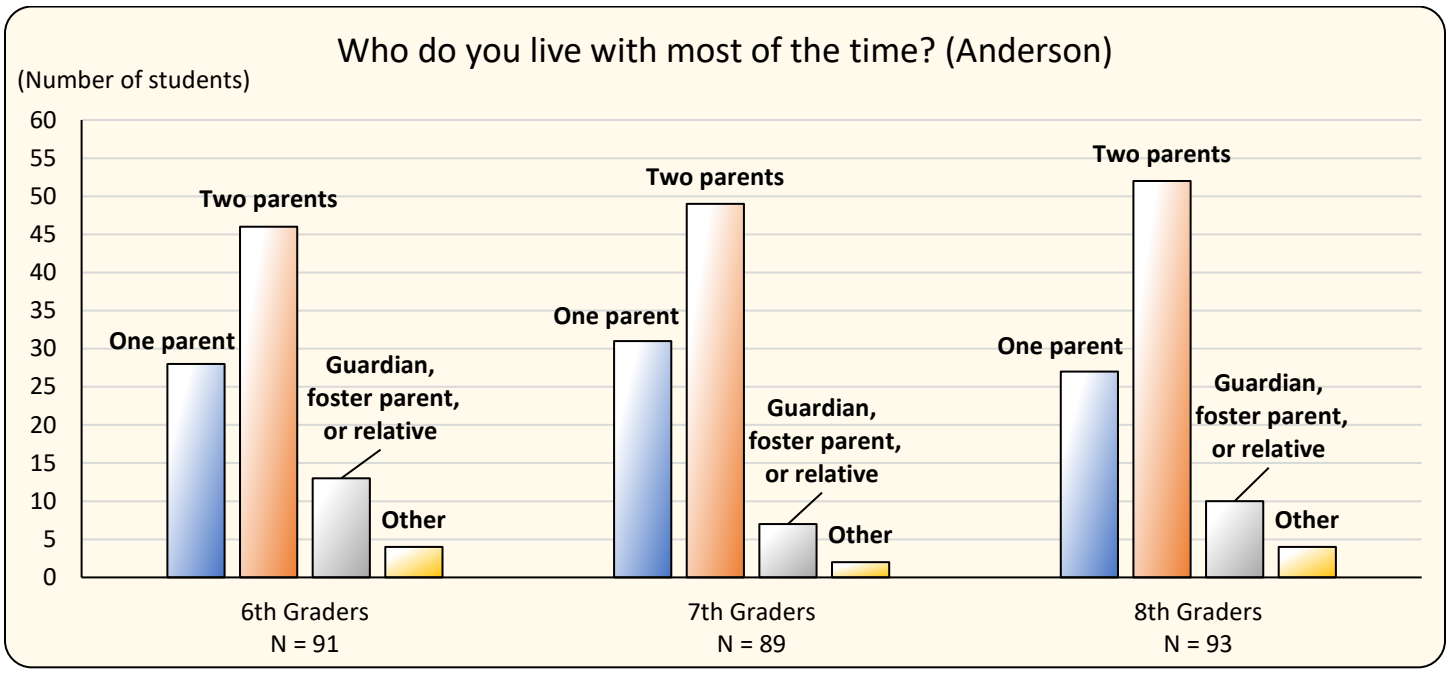
Gender


What is your gender? (Shasta Lake)
(Number of students)
60
55
50
45
40
35
30
25
20
15
10
5
0
Male
Female
Other or missing
6th Graders
N = 89
Male
Female
Other or missing
7th Graders
N = 87
Male
Female
Other or missing
8th Graders
N = 93

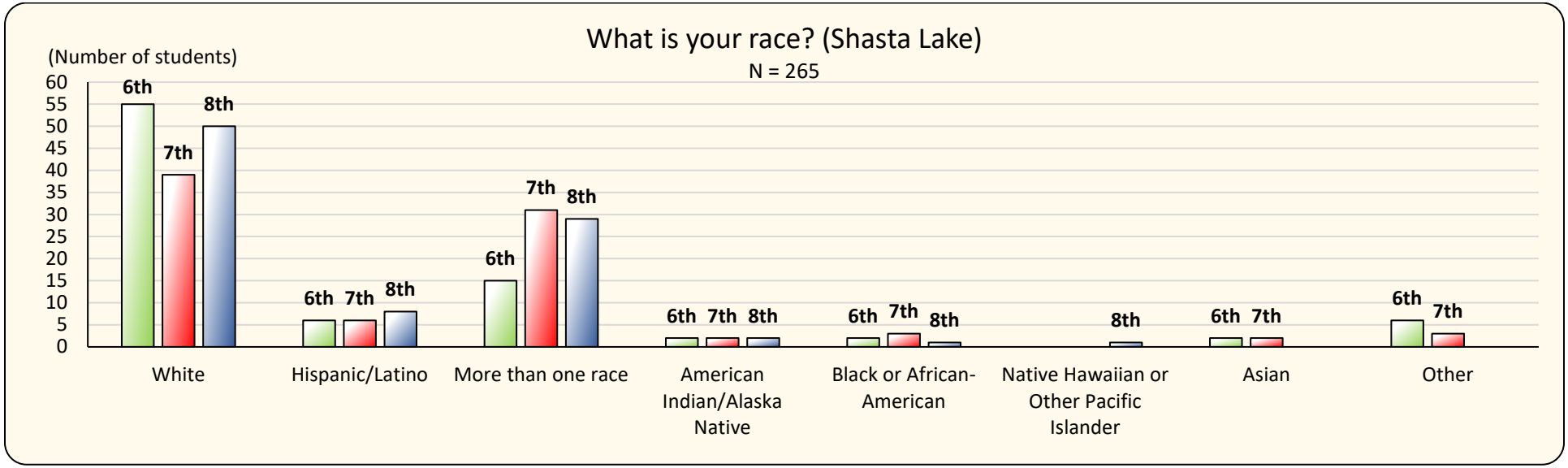

What is your gender? (Anderson)
(Number of students)
60
55
50
45
40
35
30
25
20
15
10
5
0
Male
Female
Other or missing
6th Graders
N = 96
Male
Female
Other or missing
7th Graders
N = 91
Male
Female
Other or missing
8th Graders
N = 94

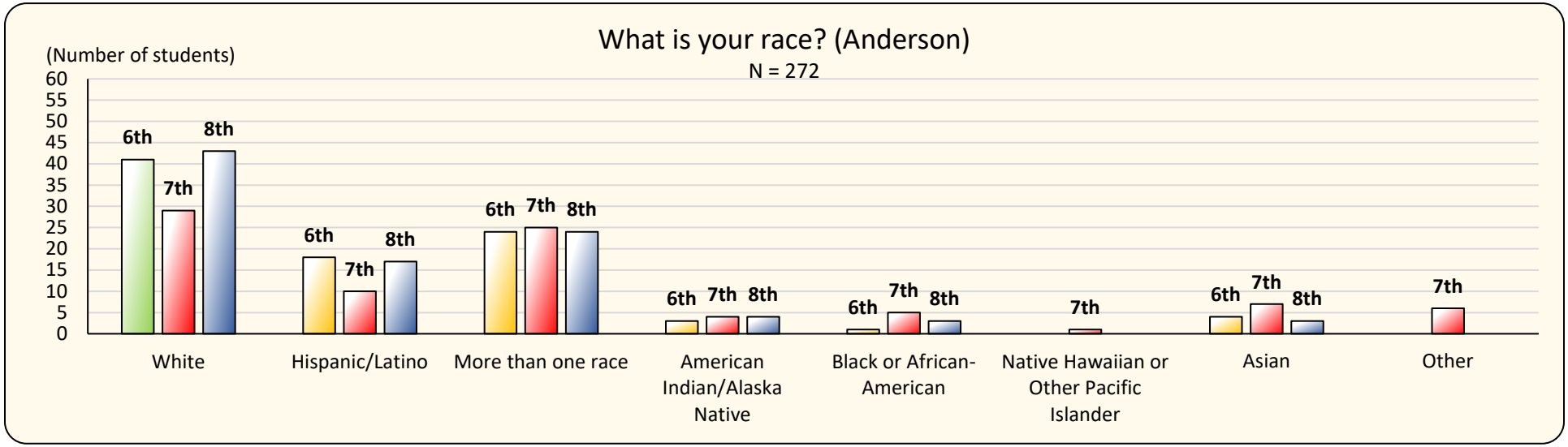
Living Situation



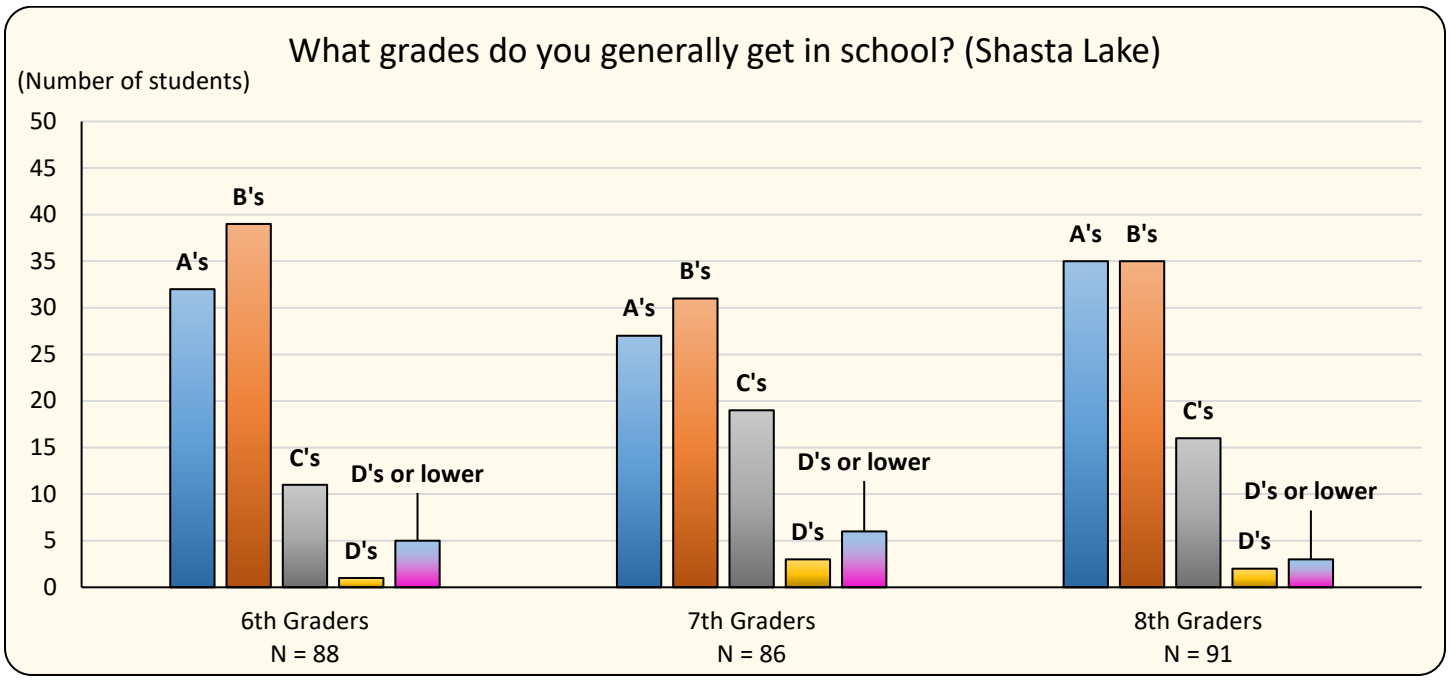


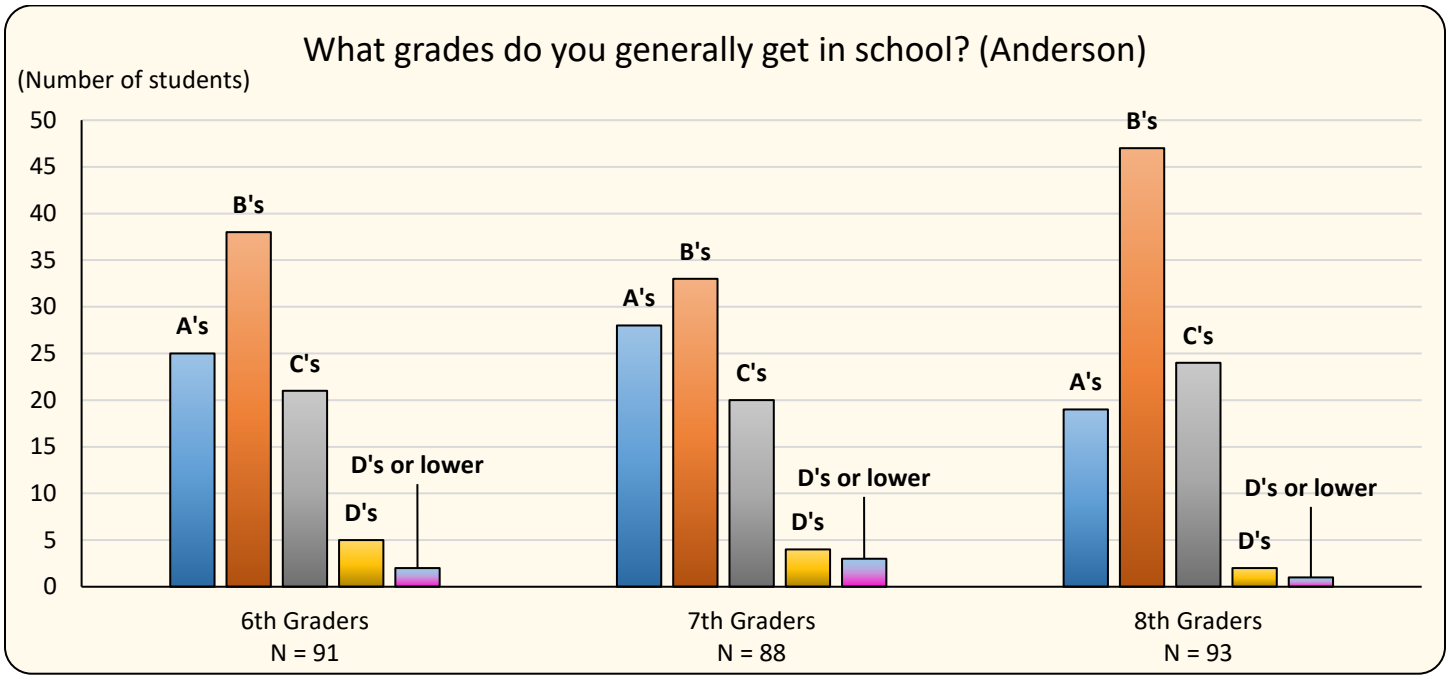
Race


What is your race? (Shasta Lake)
N = 265
(Number of students)
60
55
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

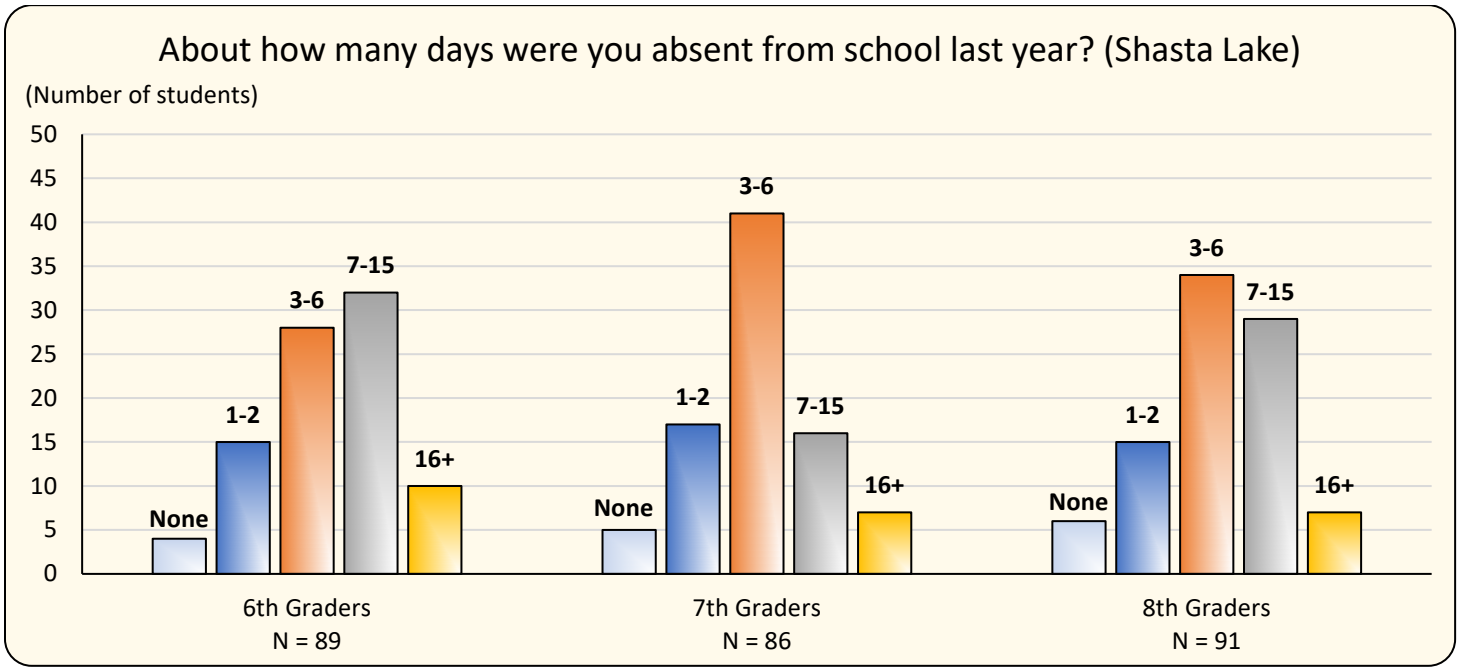

What is your race? (Anderson)
N = 272
(Number of students)
60
55
50
45
40
35
30
25
20
15
10
5
0
White
Hispanic/Latino
More than one race
American Indian/Alaska Native
Black or African-American
Native Hawaiian or Other Pacific Islander
Asian
Other

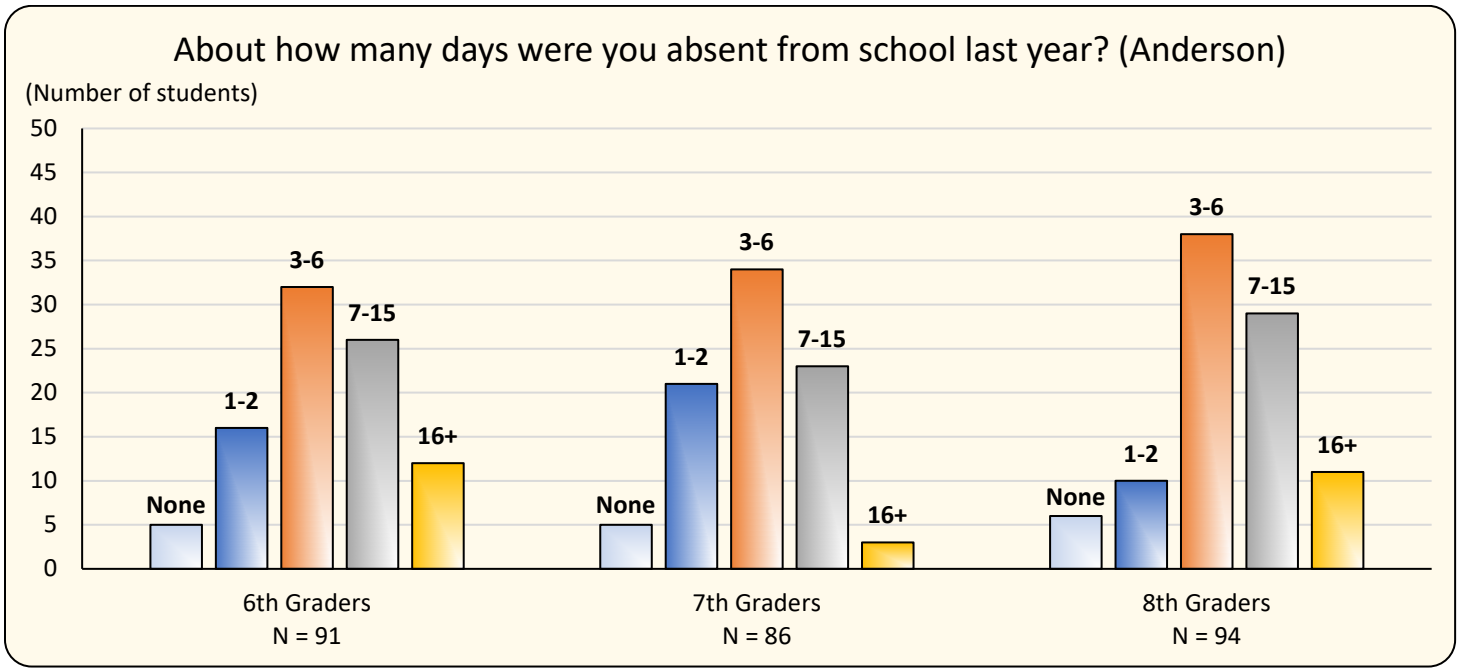
General Grades





Days Absent


About how many days were you absent from school last year? (Shasta Lake)
(Number of students)
50
45
40
35
30
25
20
15
10
5
0
None
1-2
3-6
7-15
16+
6th Graders
N = 89
7th Graders
N = 86
8th Graders
N = 91


About how many days were you absent from school last year? (Anderson)
(Number of students)
50
45
40
35
30
25
20
15
10
5
0
None
1-2
3-6
7-15
16+
6th Graders
N = 91
7th Graders
N = 86
8th Graders
N = 94

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 = 92)	POST (N = 89)	Change	PRE (N = 86)	POST (N = 87)	Change	PRE (N = 101)	POST (N = 93)	Change
1.	Most adults smoke cigarettes. (F)	39.56%	35.96%	-3.61%	44.19%	47.06%	2.87%	51.49%	50.54%	-0.95%
2.	Smoking a cigarette causes your heart to beat slower. (F)	36.26%	61.80%	25.53%	45.88%	69.41%	23.53%	49.49%	51.61%	2.12%
3.	Few adults drink wine, beer, or liquor every day. (T)	38.20%	49.44%	11.24%	50.59%	60.00%	9.41%	56.44%	47.83%	-8.61%
4.	Most people my age smoke marijuana. (F)	84.44%	84.27%	-0.17%	68.24%	64.29%	-3.95%	47.52%	43.48%	-4.05%
5.	Smoking marijuana causes your heart to beat faster. (T)	44.71%	85.39%	40.69%	53.66%	75.90%	22.25%	48.48%	54.95%	6.46%
6.	Most adults use cocaine or other hard drugs. (F)	70.79%	74.16%	3.37%	74.42%	80.95%	6.53%	79.21%	78.26%	-0.95%
7.	Cocaine and other hard drugs always make you feel good. (F)	87.36%	84.09%	-3.27%	79.01%	93.10%	14.09%	84.00%	78.02%	-5.98%
12.	Smoking can affect the steadiness of your hands. (T)	50.56%	96.63%	46.07%	83.53%	89.41%	5.88%	79.00%	81.52%	2.52%
13.	A stimulant is a chemical that calms down the body. (F)	63.95%	77.65%	13.69%	59.52%	60.98%	1.45%	56.12%	49.40%	-6.72%
14.	Smoking reduces a person's endurance for physical activity. (T)	73.86%	72.29%	-1.57%	81.71%	76.47%	-5.24%	72.00%	80.68%	8.68%
15.	A serving of beer or wine contains less alcohol than a serving of "hard liquor" such as whiskey. (F)	17.24%	30.23%	12.99%	30.59%	38.10%	7.51%	31.31%	29.67%	-1.64%
16.	Alcohol is a depressant. (T)	44.05%	64.71%	20.66%	54.43%	50.59%	-3.84%	46.94%	57.78%	10.84%
17.	Marijuana smoking can improve your eyesight. (F)	92.13%	97.73%	5.59%	90.70%	91.57%	0.87%	85.00%	87.64%	2.64%
	Anti-drug knowledge summary score (higher % is preferred):	**57.16%**	**70.33%**	**+13.17%**	**62.80%**	**69.06%**	**+6.26%**	**60.54%**	**60.87%**	**+0.34%**

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

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 = 97)	POST (N = 96)	Change	PRE (N = 99)	POST (N = 91)	Change	PRE (N = 110)	POST (N = 94)	Change
1.	Most adults smoke cigarettes. (F)	37.89%	35.87%	-2.03%	30.61%	42.70%	12.08%	34.55%	47.87%	13.33%
2.	Smoking a cigarette causes your heart to beat slower. (F)	35.79%	39.56%	3.77%	31.63%	55.17%	23.54%	43.64%	64.13%	20.49%
3.	Few adults drink wine, beer, or liquor every day. (T)	45.26%	45.74%	0.48%	52.08%	45.56%	-6.53%	46.79%	41.30%	-5.48%
4.	Most people my age smoke marijuana. (F)	75.53%	70.97%	-4.56%	60.82%	46.67%	-14.16%	44.95%	41.94%	-3.02%
5.	Smoking marijuana causes your heart to beat faster. (T)	41.30%	73.63%	32.32%	51.58%	68.18%	16.60%	42.59%	64.52%	21.92%
6.	Most adults use cocaine or other hard drugs. (F)	58.70%	63.74%	5.04%	50.00%	69.32%	19.32%	72.48%	77.17%	4.70%
7.	Cocaine and other hard drugs always make you feel good. (F)	74.44%	73.03%	-1.41%	64.29%	72.29%	8.00%	72.73%	72.83%	0.10%
12.	Smoking can affect the steadiness of your hands. (T)	52.69%	86.81%	34.13%	70.10%	86.52%	16.41%	65.74%	85.71%	19.97%
13.	A stimulant is a chemical that calms down the body. (F)	55.06%	66.67%	11.61%	47.87%	63.86%	15.98%	66.04%	56.32%	-9.72%
14.	Smoking reduces a person's endurance for physical activity. (T)	67.02%	69.23%	2.21%	71.13%	68.54%	-2.59%	75.70%	64.04%	-11.66%
15.	A serving of beer or wine contains less alcohol than a serving of "hard liquor" such as whiskey. (F)	23.66%	37.63%	13.98%	31.25%	35.96%	4.71%	30.56%	32.22%	1.67%
16.	Alcohol is a depressant. (T)	66.67%	67.39%	0.72%	44.68%	71.26%	26.58%	50.47%	72.53%	22.06%
17.	Marijuana smoking can improve your eyesight. (F)	82.98%	73.63%	-9.35%	81.25%	82.02%	0.77%	80.56%	78.89%	-1.67%
	Anti-drug knowledge summary score (higher % is preferred):	**55.15%**	**61.84%**	**+6.69%**	**52.87%**	**62.16%**	**+9.29%**	**55.91%**	**61.50%**	**+5.59%**

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 = 92)	POST (N = 89)	Change	PRE (N = 86)	POST (N = 87)	Change	PRE (N = 101)	POST (N = 93)	Change
8.	What we believe about ourselves affects the way we act or behave. (T)	82.02%	79.78%	-2.25%	87.21%	88.51%	1.30%	84.16%	94.62%	10.47%
9.	It is almost impossible to develop a more positive self-image. (F)	63.64%	79.55%	15.91%	76.47%	71.76%	-4.71%	68.32%	73.63%	5.31%
10.	It is important to measure how far you have come toward reaching your goal. (T)	93.33%	93.26%	-0.07%	88.24%	88.37%	0.14%	85.15%	90.32%	5.17%
11.	It's a good idea to make a decision and then think about the consequences later. (F)	76.67%	71.59%	-5.08%	84.71%	90.80%	6.10%	74.00%	76.92%	2.92%
18.	Some advertisers are deliberately deceptive. (T)	63.95%	57.50%	-6.45%	73.17%	62.50%	-10.67%	67.35%	69.88%	2.53%
19.	Companies advertise only because they want you to have all the facts about their products. (F)	50.57%	53.41%	2.83%	53.57%	72.94%	19.37%	71.00%	59.34%	-11.66%
20.	It's a good idea to get all information about a product from its ads. (F)	52.81%	62.50%	9.69%	51.16%	57.65%	6.48%	66.00%	72.83%	6.83%
21.	Most people do not experience anxiety. (F)	59.77%	71.59%	11.82%	76.19%	73.26%	-2.93%	70.41%	78.49%	8.09%
22.	There is very little you can do when you feel anxious. (F)	40.91%	62.92%	22.01%	55.81%	65.12%	9.30%	58.59%	63.04%	4.46%
23.	Deep breathing is one way to lessen anxiety. (T)	78.65%	89.66%	11.00%	80.95%	91.67%	10.71%	82.47%	89.13%	6.66%
24.	Mental rehearsal is a poor relaxation technique. (F)	55.29%	73.03%	17.74%	73.49%	74.39%	0.90%	72.92%	71.43%	-1.49%
25.	You can avoid misunderstandings by assuming the other person knows what you mean. (F)	72.41%	69.77%	-2.65%	63.41%	67.82%	4.40%	71.72%	72.22%	0.51%
26.	Effective communication is when both sender and receiver interpret a message in the same way. (T)	71.43%	73.86%	2.44%	81.18%	78.82%	-2.35%	80.41%	80.43%	0.02%
27.	Relaxation techniques are of no use when meeting people. (F)	56.82%	75.86%	19.04%	65.88%	75.29%	9.41%	67.35%	68.13%	0.78%
28.	A compliment is more effective when it is said sincerely. (T)	71.26%	71.91%	0.65%	81.18%	87.36%	6.18%	73.47%	86.67%	13.20%
29.	A nice way of ending a conversation is to tell the person you enjoyed talking with him or her. (T)	92.05%	89.89%	-2.16%	94.19%	86.21%	-7.98%	93.88%	95.65%	1.77%
30.	Sense of humor is an example of a non-physical attribute. (T)	50.00%	45.88%	-4.12%	64.20%	71.08%	6.89%	61.86%	66.29%	4.44%
31.	It's better to be polite and lead someone on, even if you don't want to go out with them. (F)	41.38%	44.19%	2.81%	44.58%	55.81%	11.24%	61.22%	68.13%	6.91%
32.	Almost all people who are assertive are either rude or hostile. (F)	67.44%	71.76%	4.32%	64.29%	77.38%	13.10%	74.23%	80.00%	5.77%
	Life skills knowledge summary score (higher % is preferred):	**65.28%**	**70.42%**	**+5.13%**	**71.57%**	**75.62%**	**+4.05%**	**72.87%**	**76.69%**	**+3.83%**

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 = 97)	POST (N = 96)	Change	PRE (N = 99)	POST (N = 91)	Change	PRE (N = 110)	POST (N = 94)	Change
8.	What we believe about ourselves affects the way we act or behave. (T)	85.71%	86.96%	1.24%	86.73%	88.64%	1.90%	89.72%	84.95%	-4.77%
9.	It is almost impossible to develop a more positive self-image. (F)	65.96%	68.89%	2.93%	74.49%	67.78%	-6.71%	63.21%	64.52%	1.31%
10.	It is important to measure how far you have come toward reaching your goal. (T)	90.43%	90.43%	0.00%	79.38%	83.15%	3.76%	81.13%	80.65%	-0.49%
11.	It's a good idea to make a decision and then think about the consequences later. (F)	62.37%	61.70%	-0.66%	64.29%	70.00%	5.71%	80.37%	79.35%	-1.03%
18.	Some advertisers are deliberately deceptive. (T)	67.82%	77.17%	9.36%	62.37%	67.06%	4.69%	67.62%	73.03%	5.41%
19.	Companies advertise only because they want you to have all the facts about their products. (F)	57.45%	58.06%	0.62%	61.86%	67.42%	5.56%	61.90%	64.04%	2.14%
20.	It's a good idea to get all information about a product from its ads. (F)	53.68%	59.78%	6.10%	54.08%	56.18%	2.10%	58.33%	59.55%	1.22%
21.	Most people do not experience anxiety. (F)	56.04%	63.33%	7.29%	66.67%	77.01%	10.34%	67.29%	68.89%	1.60%
22.	There is very little you can do when you feel anxious. (F)	51.69%	42.22%	-9.46%	43.88%	42.05%	-1.83%	58.88%	57.30%	-1.58%
23.	Deep breathing is one way to lessen anxiety. (T)	77.17%	87.50%	10.33%	86.87%	80.90%	-5.97%	83.02%	89.01%	5.99%
24.	Mental rehearsal is a poor relaxation technique. (F)	58.89%	63.64%	4.75%	62.50%	63.95%	1.45%	66.67%	65.56%	-1.11%
25.	You can avoid misunderstandings by assuming the other person knows what you mean. (F)	55.43%	57.78%	2.34%	59.60%	65.17%	5.57%	63.81%	65.52%	1.71%
26.	Effective communication is when both sender and receiver interpret a message in the same way. (T)	60.87%	74.42%	13.55%	71.72%	80.90%	9.18%	73.08%	70.79%	-2.29%
27.	Relaxation techniques are of no use when meeting people. (F)	54.95%	66.29%	11.35%	61.86%	71.26%	9.41%	57.41%	60.67%	3.27%
28.	A compliment is more effective when it is said sincerely. (T)	69.23%	83.15%	13.92%	82.47%	88.76%	6.29%	80.77%	74.71%	-6.06%
29.	A nice way of ending a conversation is to tell the person you enjoyed talking with him or her. (T)	83.52%	91.01%	7.49%	85.86%	79.55%	-6.31%	80.73%	80.22%	-0.51%
30.	Sense of humor is an example of a non-physical attribute. (T)	58.24%	56.18%	-2.06%	51.55%	64.37%	12.82%	54.21%	65.52%	11.31%
31.	It's better to be polite and lead someone on, even if you don't want to go out with them. (F)	40.66%	51.69%	11.03%	48.45%	44.83%	-3.63%	62.39%	60.23%	-2.16%
32.	Almost all people who are assertive are either rude or hostile. (F)	53.93%	59.55%	5.62%	59.57%	70.45%	10.88%	65.14%	64.04%	-1.09%
	Life skills knowledge summary score (higher % is preferred)**:**	**63.37%**	**68.41%**	**+5.04%**	**66.54%**	**69.97%**	**+3.43%**	**69.25%**	**69.92%**	**+0.68%**

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 = 92)	POST (N = 89)	PRE (N = 86)	POST (N = 87)	PRE (N = 101)	POST (N = 93)
1.	Kids who drink alcohol are more grown-up.	①	②	③	④	⑤	4.26	4.51	4.52	4.53	4.47	4.45
2.	Smoking cigarettes makes you look cool.	①	②	③	④	⑤	4.72	4.73	4.59	4.61	4.66	4.61
3.	Kids who drink alcohol have more friends.	①	②	③	④	⑤	4.34	4.43	4.17	3.98	3.95	4.10
4.	Kids who smoke have more friends.	①	②	③	④	⑤	4.34	4.39	4.09	4.02	3.89	3.90
5.	Drinking alcohol makes you look cool.	①	②	③	④	⑤	4.61	4.64	4.53	4.51	4.55	4.50
6.	Smoking cigarettes lets you have more fun.	①	②	③	④	⑤	4.63	4.58	4.55	4.51	4.62	4.52
7.	Kids who smoke cigarettes are more grown-up.	①	②	③	④	⑤	4.45	4.48	4.61	4.53	4.63	4.56
8.	Drinking alcohol lets you have more fun.	①	②	③	④	⑤	4.46	4.53	4.13	4.32	4.11	4.14
	Anti-drinking attitudes score (scores range from 1 to 5, scores closest to 5 are preferred):						**4.42**	**4.53**	**4.34**	**4.33**	**4.27**	**4.30**
	Anti-smoking attitudes score (scores range from 1 to 5, scores closest to 5 are preferred):						**4.53**	**4.55**	**4.46**	**4.42**	**4.45**	**4.40**
	Anti-drug attitudes summary score (scores range from 1 to 5, scores closest to 5 are preferred):						**4.48**	**4.54**	**4.40**	**4.38**	**4.36**	**4.35**

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)

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 (Anderson)	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree
1.	Kids who drink alcohol are more grown-up.	①	②	③	④	⑤
2.	Smoking cigarettes makes you look cool.	①	②	③	④	⑤
3.	Kids who drink alcohol have more friends.	①	②	③	④	⑤
4.	Kids who smoke have more friends.	①	②	③	④	⑤
5.	Drinking alcohol makes you look cool.	①	②	③	④	⑤
6.	Smoking cigarettes lets you have more fun.	①	②	③	④	⑤
7.	Kids who smoke cigarettes are more grown-up.	①	②	③	④	⑤
8.	Drinking alcohol lets you have more fun.	①	②	③	④	⑤

6th grade		7th grade		8th grade	
PRE (N = 97)	POST (N = 96)	PRE (N = 99)	POST (N = 91)	PRE (N = 110)	POST (N = 94)
4.26	4.19	4.20	4.18	4.23	4.01
4.48	4.55	4.52	4.45	4.37	4.23
4.02	4.16	4.03	3.79	3.70	3.53
3.99	4.27	3.96	3.70	3.70	3.54
4.34	4.52	4.48	4.34	4.24	4.02
4.39	4.45	4.39	4.36	4.28	4.08
4.44	4.30	4.41	4.47	4.36	4.17
4.25	4.41	4.28	4.02	3.78	3.61
4.22	**4.32**	**4.25**	**4.08**	**3.99**	**3.79**
4.33	**4.39**	**4.32**	**4.25**	**4.18**	**4.01**
4.27	**4.36**	**4.29**	**4.17**	**4.08**	**3.90**

Anti-drinking attitudes score (scores range from 1 to 5, scores closest to 5 are preferred):

Anti-smoking attitudes score (scores range from 1 to 5, scores closest to 5 are preferred):

Anti-drug attitudes summary score (scores range from 1 to 5, scores closest to 5 are preferred):

Section D: Life skills measures (Drug refusal, assertiveness, relaxation, and self-control)

Shasta Lake

Life skills (Shasta Lake)		Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	6th grade		7th grade		8th grade	
							PRE (N = 92)	POST (N = 89)	PRE (N = 86)	POST (N = 87)	PRE (N = 101)	POST (N = 93)
I would say NO if someone tried to get me to:												
1.	Smoke a cigarette. *[Lower scores preferred]*	①	②	③	④	⑤	2.03	2.01	1.94	1.86	1.96	2.07
2.	Drink beer, wine, or liquor. *[Lower scores preferred]*	①	②	③	④	⑤	2.02	1.92	2.20	2.00	2.13	2.19
3.	Smoke marijuana or hashish. *[Lower scores preferred]*	①	②	③	④	⑤	1.99	1.93	2.06	2.01	2.28	2.35
4.	Use cocaine or other drugs. *[Lower scores preferred]*	①	②	③	④	⑤	2.03	1.98	1.92	1.85	1.82	1.97
5.	Use a prescription drug that was prescribed for someone else. *[Lower scores preferred]*	①	②	③	④	⑤	1.98	2.03	1.93	1.92	1.85	1.94
Drug refusal skill [2] *(Scores for Q's. 1-5 are averaged then subtracted from 6 to invert them - higher scores are preferred):*							**3.99**	**4.03**	**3.99**	**4.07**	**3.99**	**3.90**
I would:												
6.	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	2.17	2.16	1.92	2.12	1.98	2.11
7.	Say "no" to someone who asks to borrow money from me. *[Lower scores preferred]*	①	②	③	④	⑤	2.66	2.72	2.64	2.71	2.47	2.46
8.	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	2.43	2.31	2.58	2.51	2.57	2.57
Assertiveness skills [2] *(Scores for Q's. 6-8 are averaged then subtracted from 6 to invert them - higher scores are preferred):*							**3.58**	**3.60**	**3.62**	**3.55**	**3.66**	**3.62**
In order to cope with stress or anxiety, I would:												
9.	Relax all the muscles in my body, starting with my feet and legs. *[Lower scores preferred]*	①	②	③	④	⑤	2.19	2.03	2.27	2.04	2.07	2.18
10.	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	2.02	1.70	2.04	2.02	2.13	2.02
Relaxation skills [2] *(Scores Q.9 & Q.10 are averaged then subtracted from 6 to invert them - higher scores are preferred):*							**3.89**	**4.13**	**3.85**	**3.97**	**3.90**	**3.90**
In general:												
11.	If I find that something is really difficult, I get frustrated and quit. *[Higher scores preferred]*	①	②	③	④	⑤	3.70	3.60	3.51	3.44	3.25	3.61
12.	I stick to what I'm doing until I'm finished with it. *[Lower scores preferred]*	①	②	③	④	⑤	2.11	1.94	2.13	2.36	2.16	2.14
Self-Control Skills [2] *(Score for Q. 12 is subtracted from 6 to invert it then averaged with Q. 11 – higher scores are preferred):*							**3.79**	**3.83**	**3.69**	**3.54**	**3.55**	**3.73**

Section D: Life skills measures (Drug refusal, assertiveness, relaxation, and self-control)

Anderson

	Life skills (Anderson)	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	6th grade		7th grade		8th grade	
							PRE (N = 92)	POST (N = 89)	PRE (N = 86)	POST (N = 87)	PRE (N = 101)	POST (N = 93)
I would say NO if someone tried to get me to:												
1.	Smoke a cigarette. *[Lower scores preferred]*	①	②	③	④	⑤	1.97	2.23	2.00	2.04	1.96	1.82
2.	Drink beer, wine, or liquor. *[Lower scores preferred]*	①	②	③	④	⑤	2.08	2.23	2.14	2.14	2.19	2.10
3.	Smoke marijuana or hashish. *[Lower scores preferred]*	①	②	③	④	⑤	1.88	2.28	2.14	2.23	2.08	2.11
4.	Use cocaine or other drugs. *[Lower scores preferred]*	①	②	③	④	⑤	1.87	2.20	1.99	1.94	1.85	1.82
5.	Use a prescription drug that was prescribed for someone else. *[Lower scores preferred]*	①	②	③	④	⑤	1.88	N/A	2.11	N/A	1.83	N/A
	Drug refusal skill [2] *(Scores for Q's. 1-5 are averaged then subtracted from 6 to invert them - higher scores are preferred):*						**4.07**	**3.76**	**3.93**	**3.91**	**4.02**	**4.04**
I would:												
6.	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	1.93	2.35	2.28	2.19	2.32	2.30
7.	Say "no" to someone who asks to borrow money from me. *[Lower scores preferred]*	①	②	③	④	⑤	2.86	2.63	2.66	2.52	2.64	2.49
8.	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	2.24	2.40	2.53	2.52	2.58	2.46
	Assertiveness skills [2] *(Scores for Q's. 6-8 are averaged then subtracted from 6 to invert them - higher scores are preferred):*						**3.66**	**3.54**	**3.51**	**3.59**	**3.49**	**3.58**
In order to cope with stress or anxiety, I would:												
9.	Relax all the muscles in my body, starting with my feet and legs. *[Lower scores preferred]*	①	②	③	④	⑤	1.99	1.88	2.46	2.43	2.65	2.40
10.	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	2.11	1.98	2.33	2.21	2.49	2.39
	Relaxation skills [2] *(Scores Q.9 & Q.10 are averaged then subtracted from 6 to invert them - higher scores are preferred):*						**3.95**	**4.07**	**3.60**	**3.68**	**3.43**	**3.60**
In general:												
11.	If I find that something is really difficult, I get frustrated and quit. *[Higher scores preferred]*	①	②	③	④	⑤	3.26	3.33	3.09	3.36	3.15	2.98
12.	I stick to what I'm doing until I'm finished with it. *[Lower scores preferred]*	①	②	③	④	⑤	2.28	2.08	2.17	2.34	2.41	2.33
	Self-Control Skills [2] *(Score for Q. 12 is subtracted from 6 to invert it then averaged with Q. 11 – higher scores are preferred):*						**3.49**	**3.63**	**3.46**	**3.51**	**3.37**	**3.33**

References

(1.) "MHSA Docs | Shasta MHSA". *Shastamhsa.com*, 2019, http://shastamhsa.com/site/assets/files/1151/brief-lst-ms-survey-september_2018.pdf.

(2.) "MHSA Docs | Shasta MHSA". *Shastamhsa.com*, 2019, 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 2018-19

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 2018 to June 2019, the Stigma and Discrimination Reduction activities were as follows:

Quarter 1 (July – September 2018)

Speaking Engagements:

Date	Brave Faces Advocate(s)	Presentation Type	Organizer	Location	Reach
07/11/2018	David Wharton	Formal Presentation & Discussion	Social Security Administration	SSA Office	35
07/17/2018	David Wharton and Aiden Mares	Destig Intro & Brave Faces Talk	Simpson College Counseling Masters Program	Simpson College	10
09/11/2018	Chris Paradis & Sherry Morgan	Destig Intro & Brave Faces Talk	HHSA TOP Unit	Not recorded	Not recorded
09/27/2018	Aiden Mares	Formal Presentation & Discussion	Shasta College Sociology of Minorities Class	Shasta College Main Campus	Not recorded
09/28/2018	Crystal Johnson & Mike Skondin	Formal Presentation & Discussion	DA's Office - Victim Advocates	DA's Office	Not recorded

Events:

Date	Brave Faces Advocate(s)	Event	Organizer	Location	Attendance
07/13/2018	Brandon Leake	Hope Is Alive! Open Mic	Stand Against Stigma	Old City Hall / SCAC	13 Performers / 50 Attendees
09/29/2018	N/A	Recovery Happens	Community Partners & Stand Against Stigma	Lake Redding Park Gazebo	300 Attendees

Trainings: *(Training this quarter was Cancelled due to the Carr Fire)*

Gallery:

Date	Portraits	Install or Publish	Location	Approx Reach
10/12/2018	Kay Hicks & Mary Graham	Install	Circle of Friends	75

Outreach exhibits:

Date	HHSA Staff / Volunteer(s)	Event	Organizer	Location	Attendees Engaged
07/13/2018	Carrie Jo Diamond	Good Medicine Health Fair	Pit River Health Service	Burney	50
08/01/2018	*Turned into a Carr Fire Info Table*	*Discover Health*	*Redding Rancheria*	*Win River*	*100*
08/29/2018	Carrie Jo Diamond	Shasta College Welcome Day	Shasta College	Main Campus	50
09/12/2018	Courtney Parker	CalTrans Employee Resource Fair	CalTrans	CalTrans	25
09/22/2018	Courtney Parker	Redding Pride Festival	NorCal OUTreach Project	Redding City Hall	100
09/29/2018	Carrie Jo Diamond	Recovery Happens	Stand Against Stigma Community Collaboration	Lake Redding Park Gazebo	300

Quarter 2 (October – December 2018)

Speaking Engagements:

Date	Brave Faces Advocate(s)	Presentation Type	Organizer	Location	Reach
10/04/2018	Alex Tara	Destig Intro & Brave Faces Talk	HHSA Clerical All Staff	Boggs	35
10/06/2018	Matt Sprenger	Formal Presentation & Discussion	Shasta CAPCC AmeriCorps Orientation	Anderson Teen Center	10
10/09/2018	Cherish Padro	Destig Intro & Brave Faces Talk	Stand Against Stigma Committee	CARE Center	8
10/29/2018	Brave Faces Documentary & MHSA anti-Stigma unit	Educational Presentation	CHYBA	CHYBA	6
11/16/2018	Matt Sprenger and Aiden Mares	Destig Intro & Brave Faces Talk	MHSA Academy	CARE Center	12
11/21/2018	David Wharton	Formal Presentation & Discussion	Healthy Shasta	Lab Conference Room	6

11/28/2018	Aiden Mares and David Wharton	Formal Presentation & Discussion	One Safe Place	One Safe Place	3
11/29/2018	Crystal Johnson	Destig Intro & Brave Faces Talk	MAT Collaborative	Boggs	40
12/05/2018	Matt Sprenger, Cherish Padro and Aiden Mares	Formal Presentation & Discussion	National University Social Work Class	National University	6
12/11/2018	Emalee Mims	Destig Intro & Brave Faces Talk	Stand Against Stigma Committee	CARE Center	10
12/14/2018	Chris Paradis & Mike Skondin	Destig Intro & Brave Faces Talk	Anderson Alt. Education	North Valley High School	50

Events:

Date	Brave Faces Advocate(s)	Event	Organizer	Location	Attendance
11/09/2018	David Martinez	Hope Is Alive! Open Mic	Stand Against Stigma	Billy's Café Montgomery Creek	8 Performers / 50 Attendees

Trainings:

Date	Facilitator	Event	Location	Attendees	Graduates
11/03/2018	David Wharton and Carrie Jo Diamond	Becoming Brave	Boggs	75	5

Outreach exhibits:

Date	HHSA Staff / Volunteer(s)	Event	Organizer	Location	Attendees Engaged
10/14/2018	Carrie Jo Diamond	Out of the Darkness Walk	American Foundation for Suicide Prevention	Caldwell Park	50
12/08/2018	Carrie Jo Diamond	Promotores Hmong/Mein Community Festival	NVCSS	Anderson Community Center	20

Quarter 3 (January – March 2019)

Speaking Engagements:

Date	Brave Faces Advocate(s)	Presentation Type	Organization	Location	Reach
02/05/2019	Denise Green	Destig Intro & Brave Faces Talk	Stand Against Stigma	CARE Center	35
02/27/2019	Emalee Mims	Formal Presentation & Discussion	UPrep AP Psychology Class	Uprep High School	10
03/18/2019	Aiden Mares, Matt Sprenger, Mike Skondin	Formal Presentation & Discussion	Institute of Technology	Institute of Technology	7

Events:

Date	Brave Faces Advocate(s)	Event	Organizer	Location	Attendance
02/22/2019	Brandon Leake	Hope Is Alive! Open Mic	Stand Against Stigma	Old City Hall	18 Performers/100 attendees

Trainings:

Date	Facilitator	Event	Organizer	Location	Attendees	Graduates
01/12/2019	Chris Paradis & Emalee Mims	Becoming Brave Training	Stand Against Stigma	Boggs	12	Not recorded

Gallery:

Date	Portraits	Install or Published to Website	Requester	Location	Approximate Reach
01/15/2019	Cherish Padro and Shellisa & Cree	Install	Stand Against Stigma	Shasta County Admin Building	300
03/23/2019	Denise Green and Crystal Johnson	Meeting with Photographer	Stand Against Stigma	Cottonwood	Not recorded
03/26/2019	David Wharton	Oral History Recording	Stand Against Stigma	Office of the Director	Not recorded

Outreach exhibits:

Date	HHSA Staff / Volunteer(s)	Event	Organizer	Location	Attendees Engaged
1/5-1/6/2019	Carrie Jo Diamond	Redding Health Expo	Redding Health Expo	Redding Convention Center	100
01/12/2019	Courtney Parker	Promotores Community Health Fair	NVCSS	NVCSS	50
03/08/2019	Carrie Jo Diamond	Compass Health and Wellness Fair	Anderson Fronteir Senior Center	Anderson Fronteir Senior Center	100
03/09/2019	Carrie Jo Diamond	International Women's Day	Women's Health Specialists	Women's Health Specialists	50

Quarter 4 (April – June 2019)

Speaking engagements:

Date	Brave Faces Advocate(s)	Presentation Type	Organization	Location	Reach
04/08/2019	Mike Skondin and Cherish Padro	Formal Presentation & Discussion	One Safe Place ADJU Class	Shasta College	35
04/11/2019	Aiden Mares and Denise Green	Formal Presentation & Discussion	IOT Nursing	Institute of Technology	10
04/19/2019	David Wharton and Emalee Mims	Formal Presentation & Discussion	One Safe Place Volunteer Training	One Safe Place	15
04/29/2019	Cherish Padro and David Wharton	Formal Presentation & Discussion	Heather Wylie's Sociology Class	Shasta College	30
05/02/2019	Greg Burgin Jr. and Aiden Mares	Destig Intro & Brave Faces Talk	Tehama County Behavioral Health	Tehama County Behavioral Health	30
05/10/2019	Cherish Padro	Destig Intro & Brave Faces Talk	Minds Matter Open Mic	Stand Against Stigma	150
05/14/2019	Jullie Calkins*	Destig Intro & Brave Faces Talk	Burney Circle of Friends	Burney Circle of Friends	6
05/15/2019	Denise Green	Destig Intro & Brave Faces Talk	CIT Training for Law Enforcement	Boggs	40
05/21/2019	Emalee Mims	Destig Intro & Brave Faces Talk	Shasta High School HOSA Club	Shasta High School	30
06/11/2019	Joel Covert*	Destig Intro & Brave Faces Talk	Stand Against Stigma Meeting	CARE Center	20
06/18/2019	Jullie Calkins, Matt Sprenger and Joel Covert*	Destig Intro & Brave Faces Talk	Suicide Prevention Meeting	CARE Center	15
06/20/2019	Mike Skondin, Denise Green and Jullie Calkins	Destig Intro & Brave Faces Talk	RPD Mental Health Awareness Training	City Hall Community Room	35

Events:

Date	Brave Faces Advocate(s)	Event	Organizer	Location	Attendance
04/01/2019	N/A	Restoration Healing Through Art at Shasta College	Stand Against Stigma	Shasta College Theater	18
04/02/2019	N/A	Restoration Healing Through Art at Anderson Teen Center	Stand Against Stigma	Anderson Teen Center	4
04/03/2019	N/A	Restoration Healing Through Art at Shasta College	Stand Against Stigma		8
04/05/2019	N/A	Youth Hope Is Alive! Open Mic Night	Stand Against Stigma	Old City Hall	3
04/30/2019	N/A	Mental Health Rocks!	Stand Against Stigma	CARE Center	15
05/08/2019	Cherish Padro and Brandon Leake	Minds Matter Mental Health Fair & Hope Is Alive! Open Mic	Stand Against Stigma	Sundial Bridge	500
05/15/2019	N/A	Resilence Documentary Screening	Stand Against Stigma/Shasta Strengthening Families	Burney Circle of Friends	12
05/17/2019	N/A	Hope Is Alive! Open Mic Night	Stand Against Stigma	Burney Lions Club	30

Trainings:

Date	Facilitator	Event	Organizer	Location	Attendees	Graduates
05/04/2019	Courtney Parker and David Wharton	Becoming Brave Training	Stand Against Stigma	Boggs	14	Not recorded
05/13/2019	Marcia Ramstrom	Mental Health First Aid	Stand Against Stigma/The Lotus Center	Burney Presbyterian Church	22	Not recorded
05/16/2019	Lindsay Tibbetts	Mind-Body Skills Class	Stand Against Stigma/Suicide Prevention Workgroup	Burney Circle of Friends	8	Not recorded

Outreach exhibits:

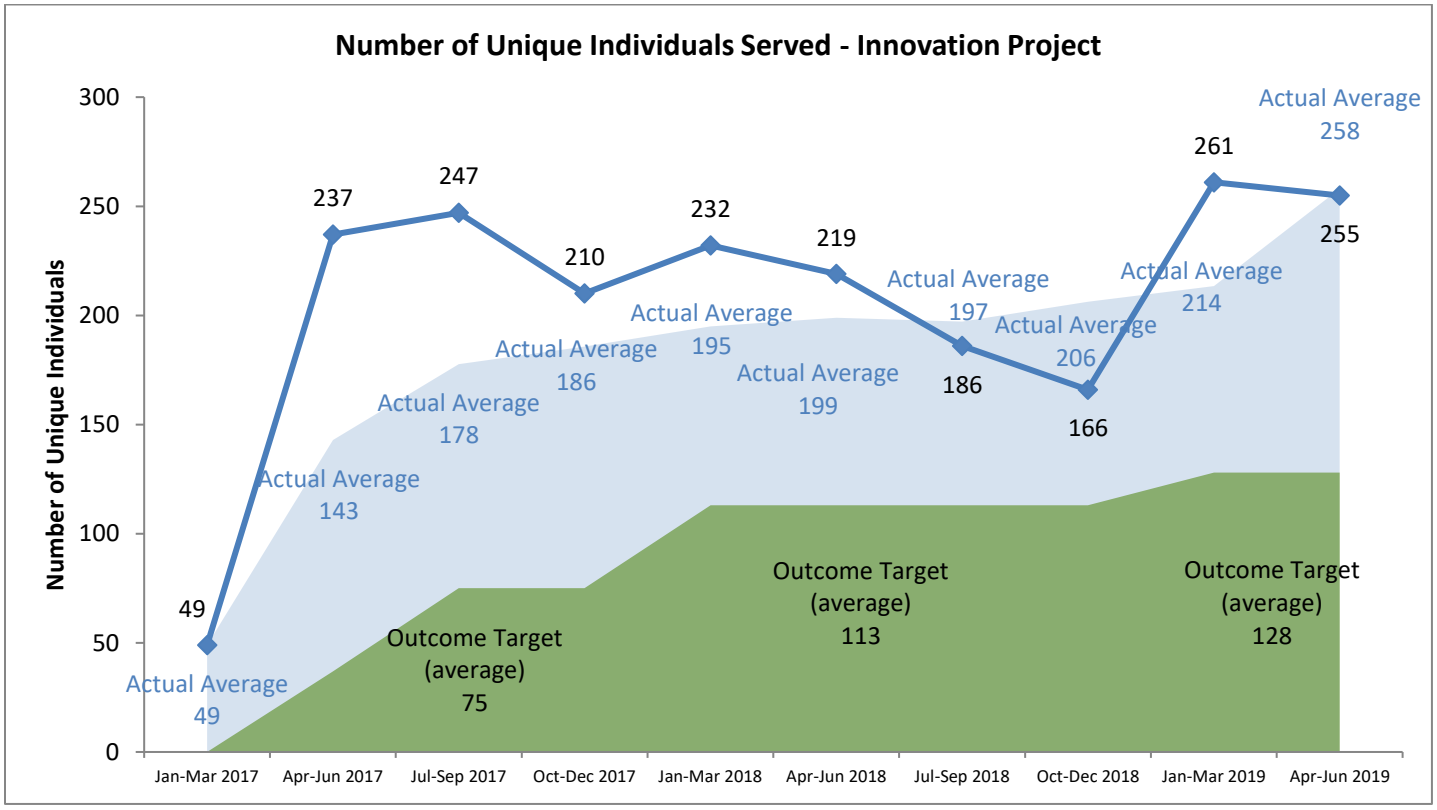
Date	HHSA Staff / Volunteer(s)	Event	Organizer	Location	Attendees Engaged
04/03/2019	Carrie Jo Diamond	Take Back The Night	Shasta College CARES	Shast College	50
04/06/2019	Burney Circle of Friends	Mayer's Health Fair	Mayer's Memorial Hospital	Fall River Mills	50
04/06-04/07/2019	Carrie Jo Diamond	Sportsman's Expo	Dustin Janc	Redding Civic Center	300

04/10/2019	Carrie Jo Diamond	CAPCC WOTYC Event	Shasta CAPCC	Mt. Shasta Mall	50
04/20/2019	Carrie Jo Diamond	Whole Earth and Watershed Festival	Whole Earth and Watershed Festival	Redding City Hall	200
05/10/2019	Carrie Jo Diamond	Minds Matter Mental Health Fair	Stand Against Stigma	Sundial Bridge	500
05/23/2019	Carrie Jo Diamond	Shasta High School Mental Health Awareness Day	SHS HOSA Club	Shasta High School	100
06/12/2019	Carrie Jo Diamond	Shasta County Employee Appreciation Day	Shasta County	Holiday Inn	100
06/21/2019	Carrie Jo Diamond & Lindsay Tibbetts	Colt 45s Game	Stand Against Stigma/SPW	Tiger Field	50

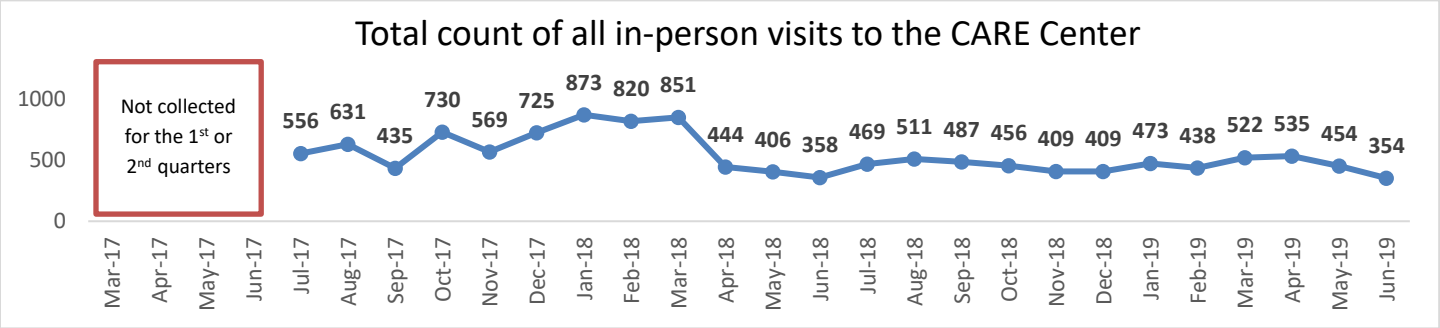
CARE Center Activity Report – Innovation Project
January 2017 through June 2019

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).



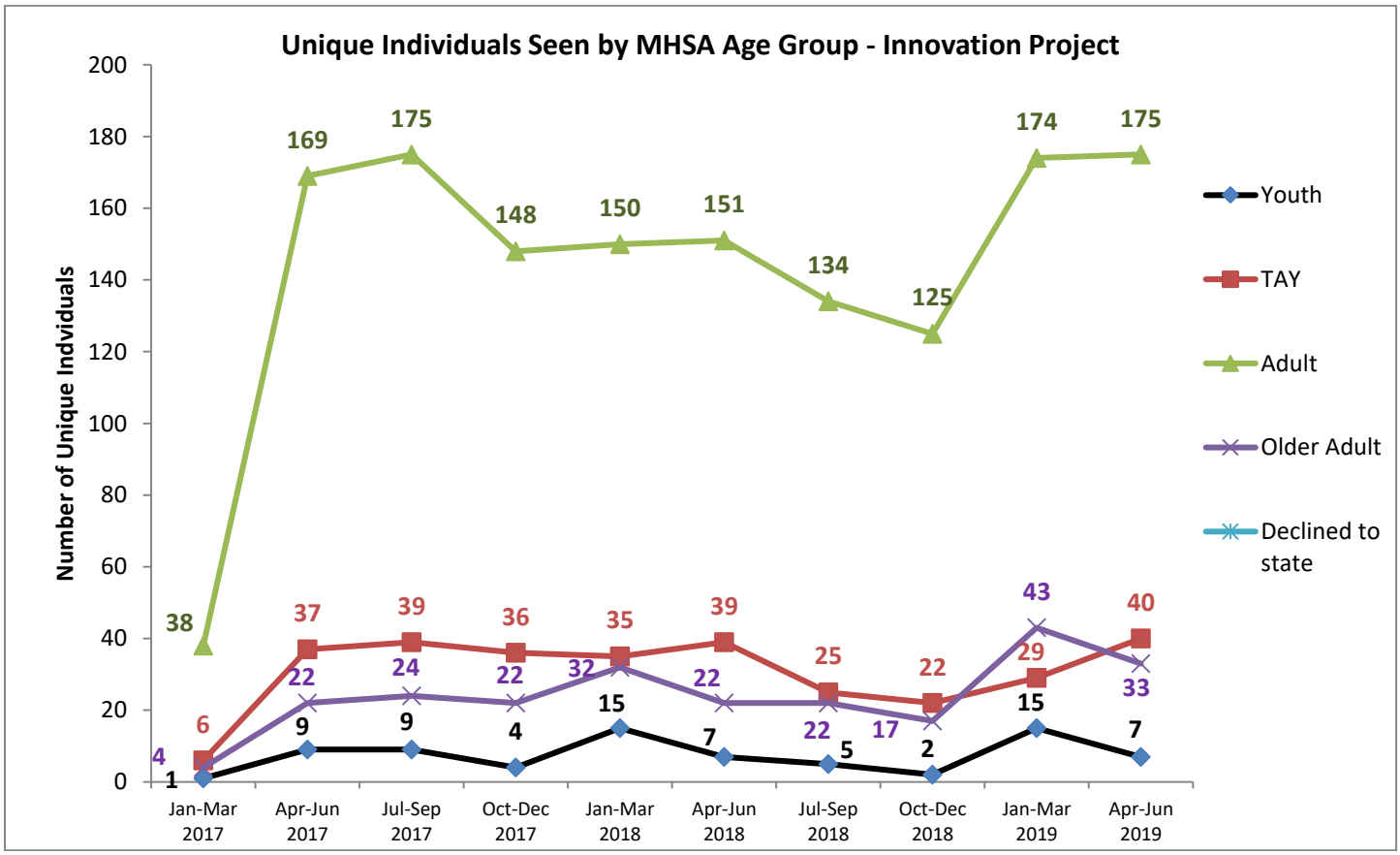
Due to much higher utilization of the Care Center than anticipated, the number of in-person visits per month are being tracked as of July 2017. Please note that most clients visit more than once - this is not an unduplicated person count. Refinement of the counting process occurred in the Apr-Jun 2018 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".

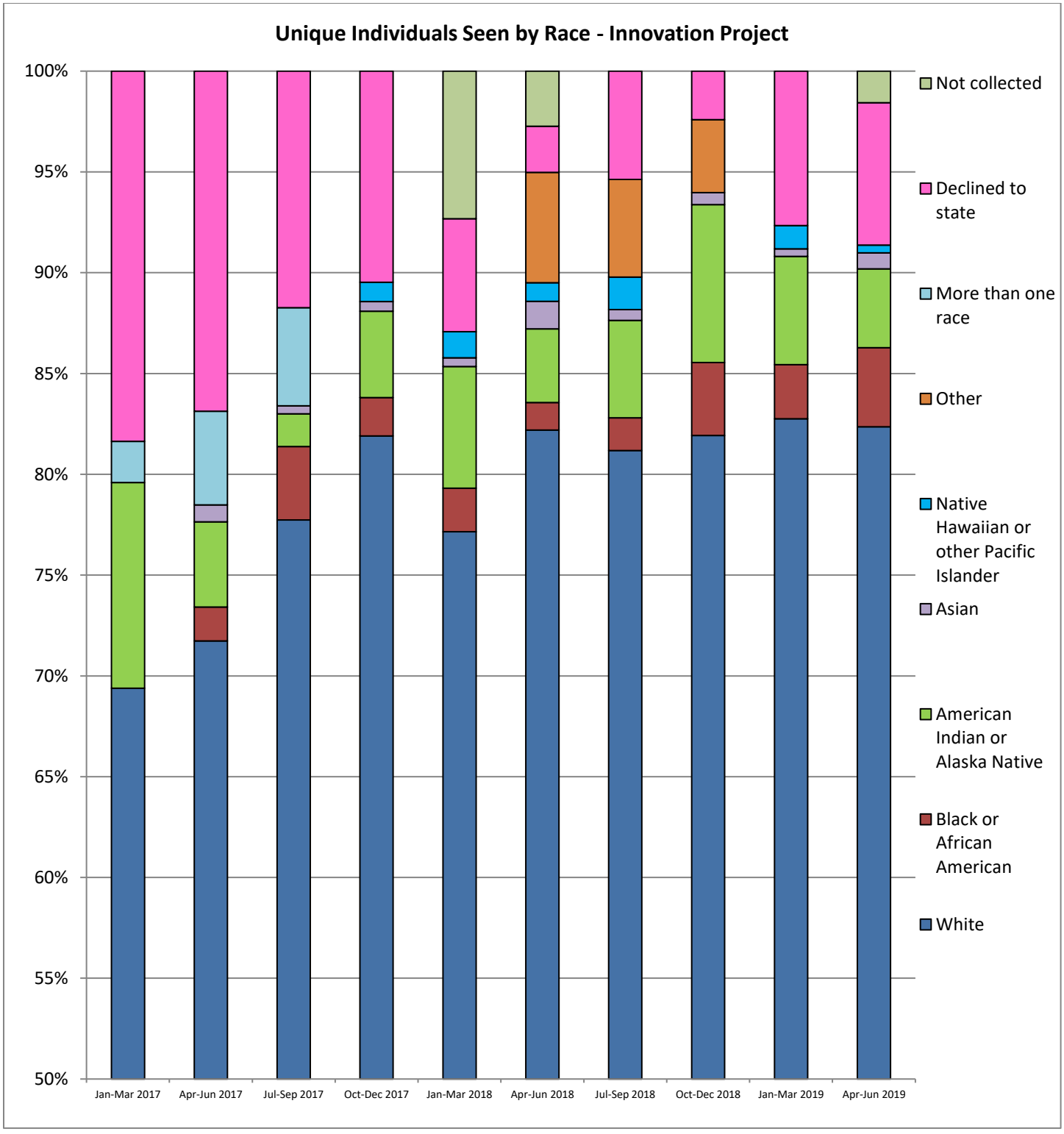
AGE

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.



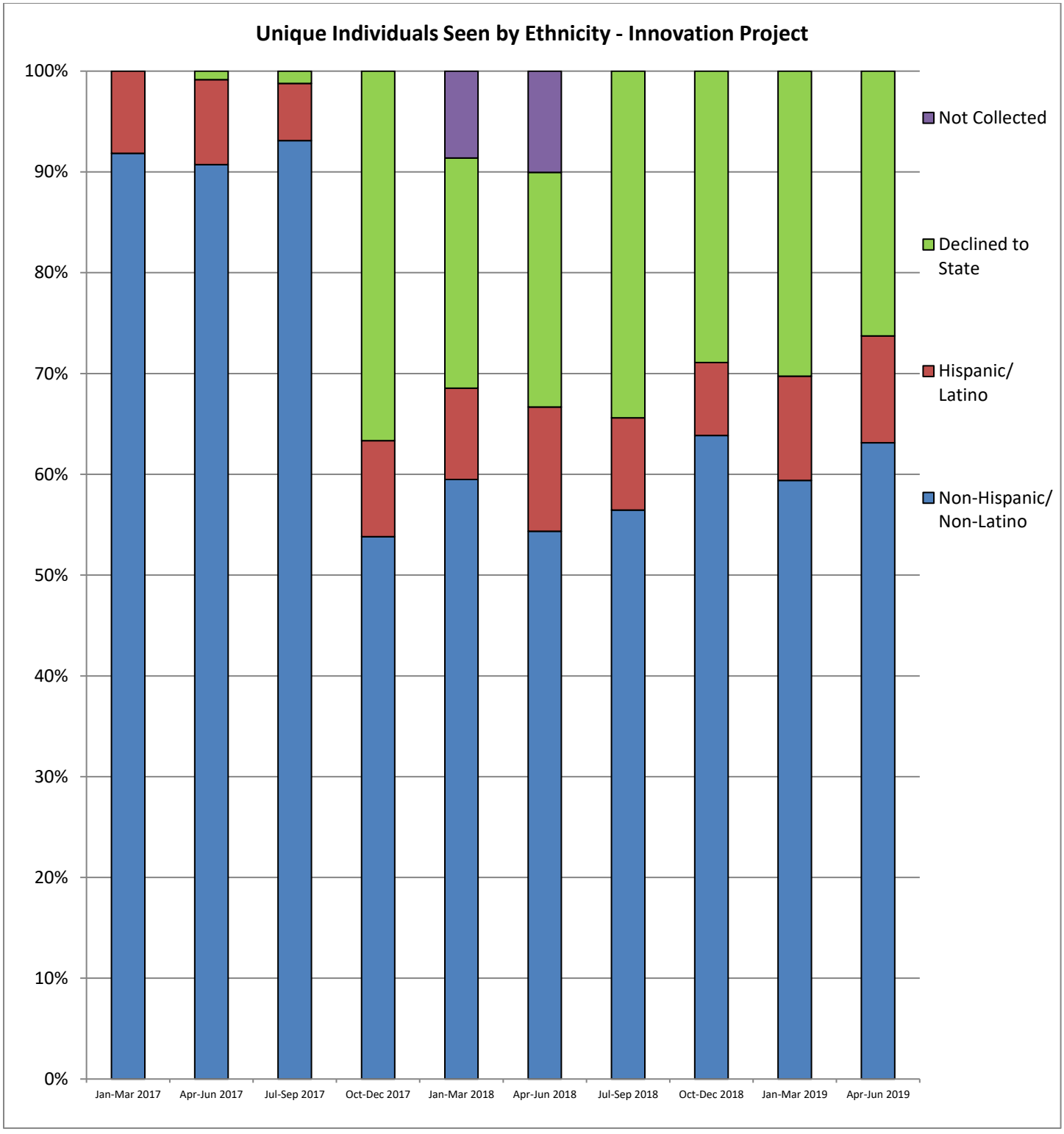
RACE

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



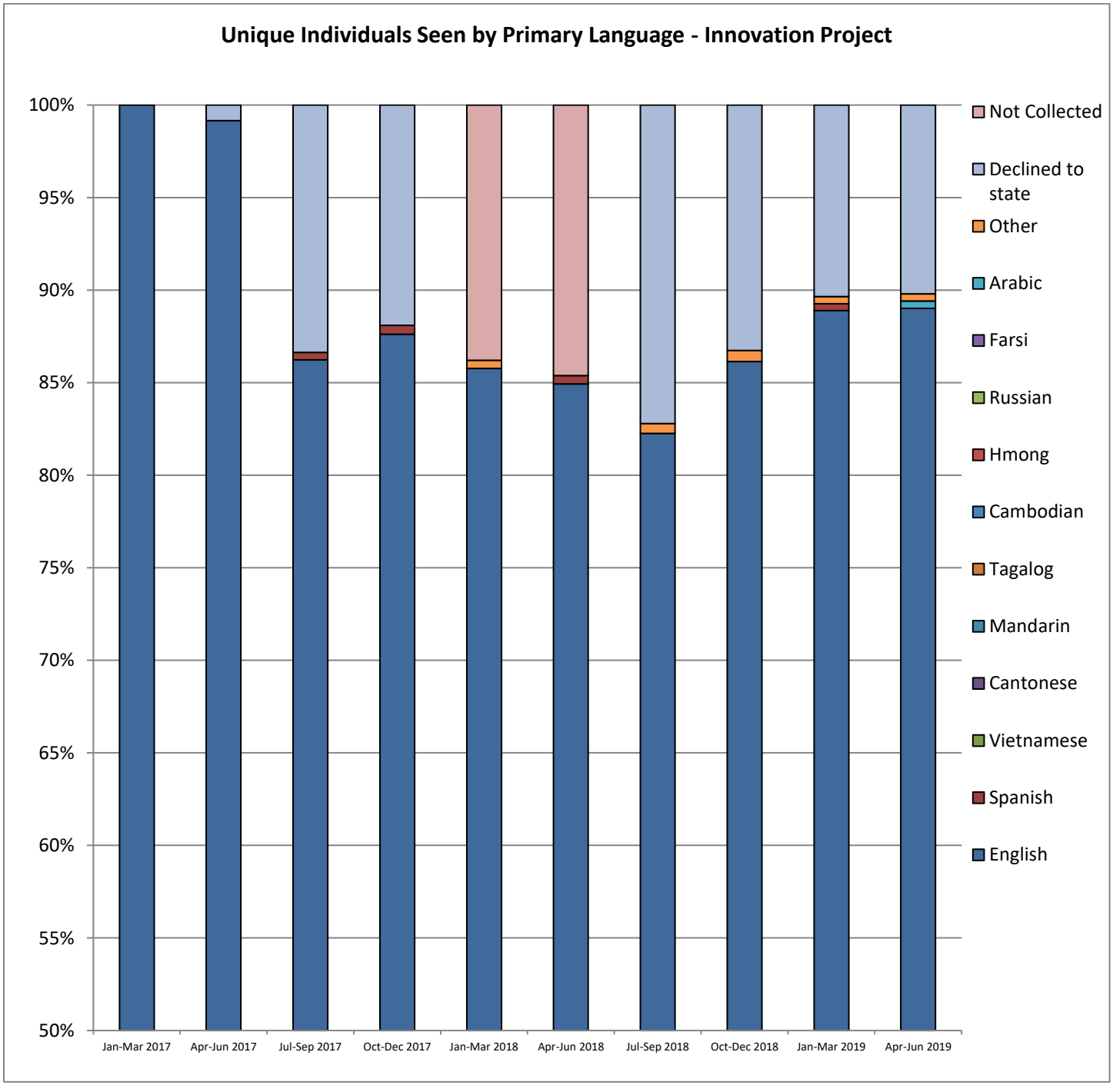
ETHNICITY

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

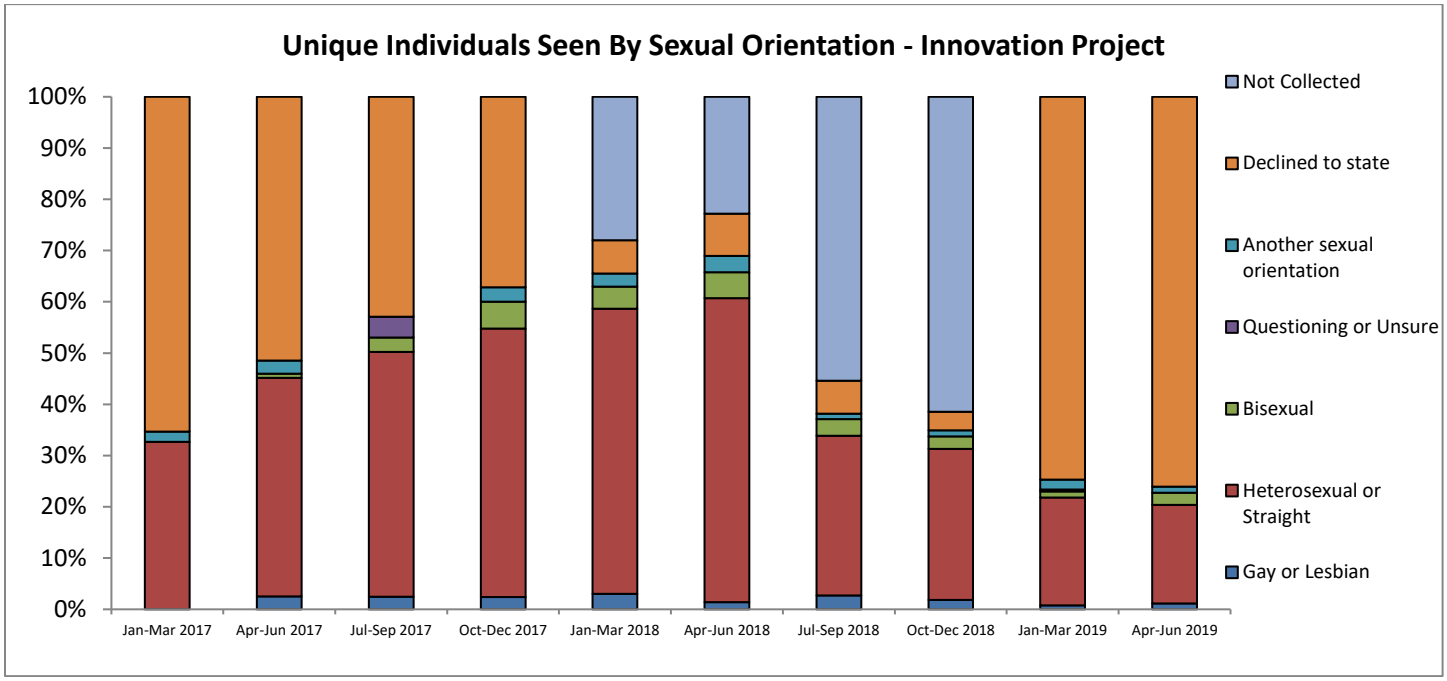


PRIMARY LANGUAGE

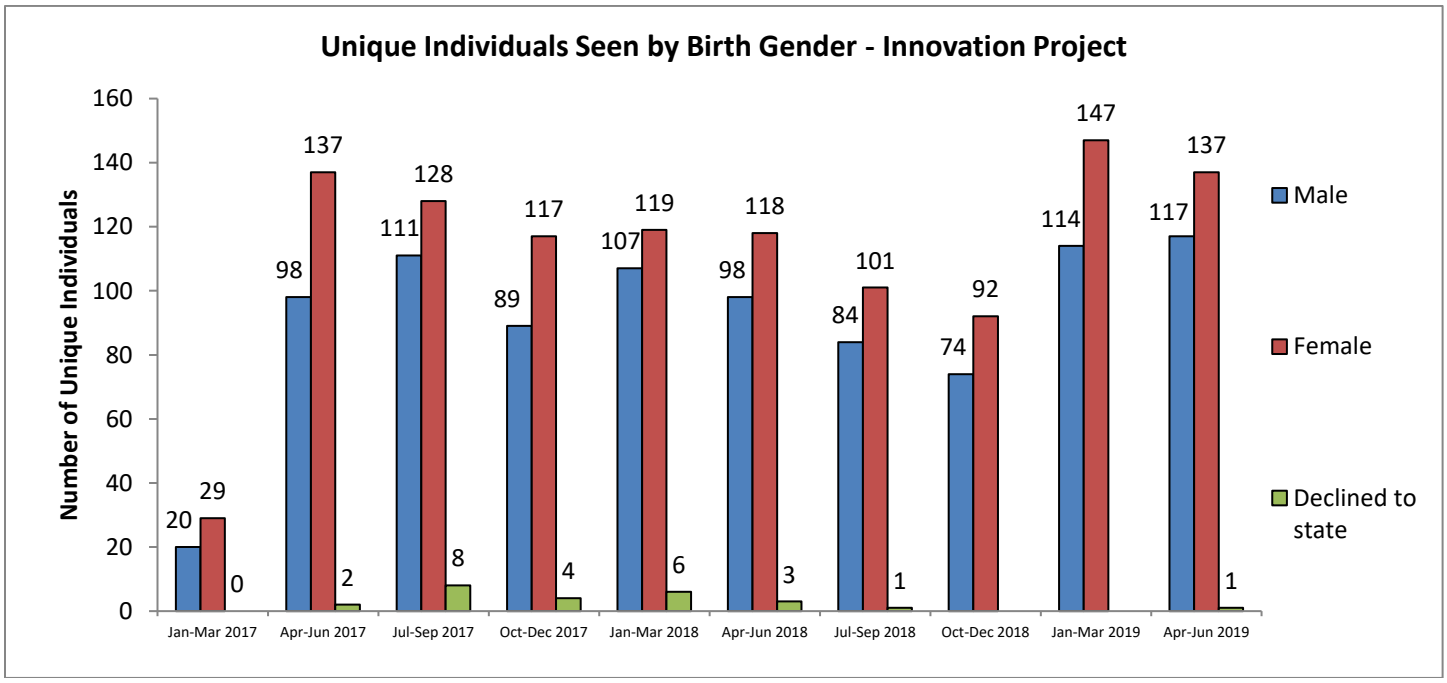
The primary language of consumers served by the CARE Center is English for nearly 100% of the people. Because of the low gross numbers for some reported languages, actual counts are not reported to help protect consumer confidentiality.



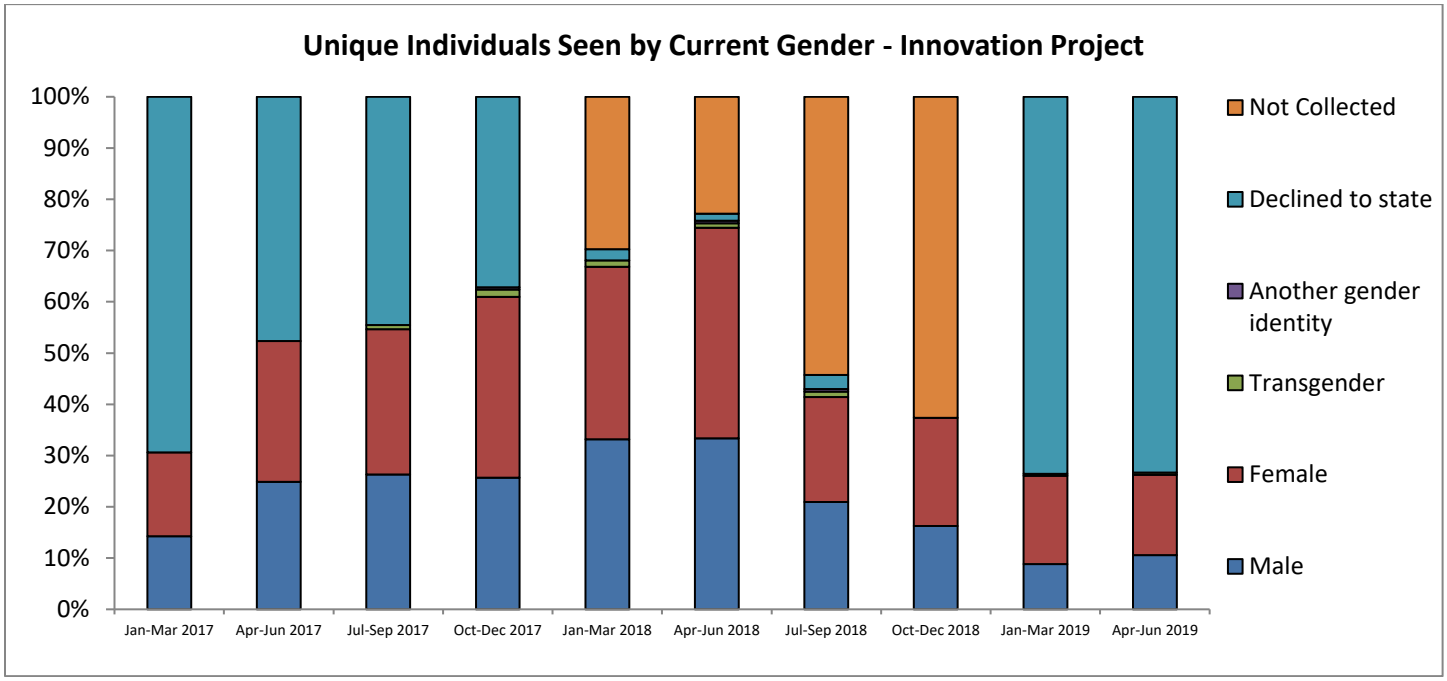
SEXUAL ORIENTATION



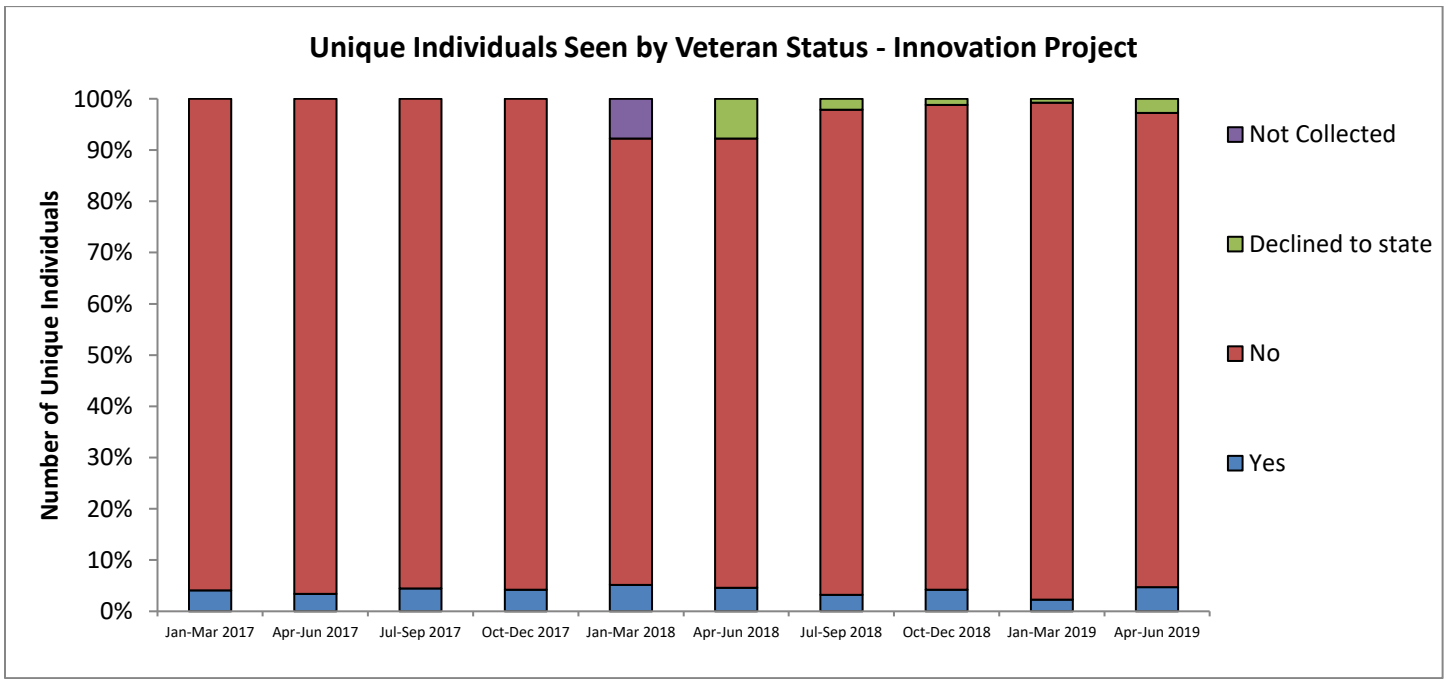
BIRTH GENDER



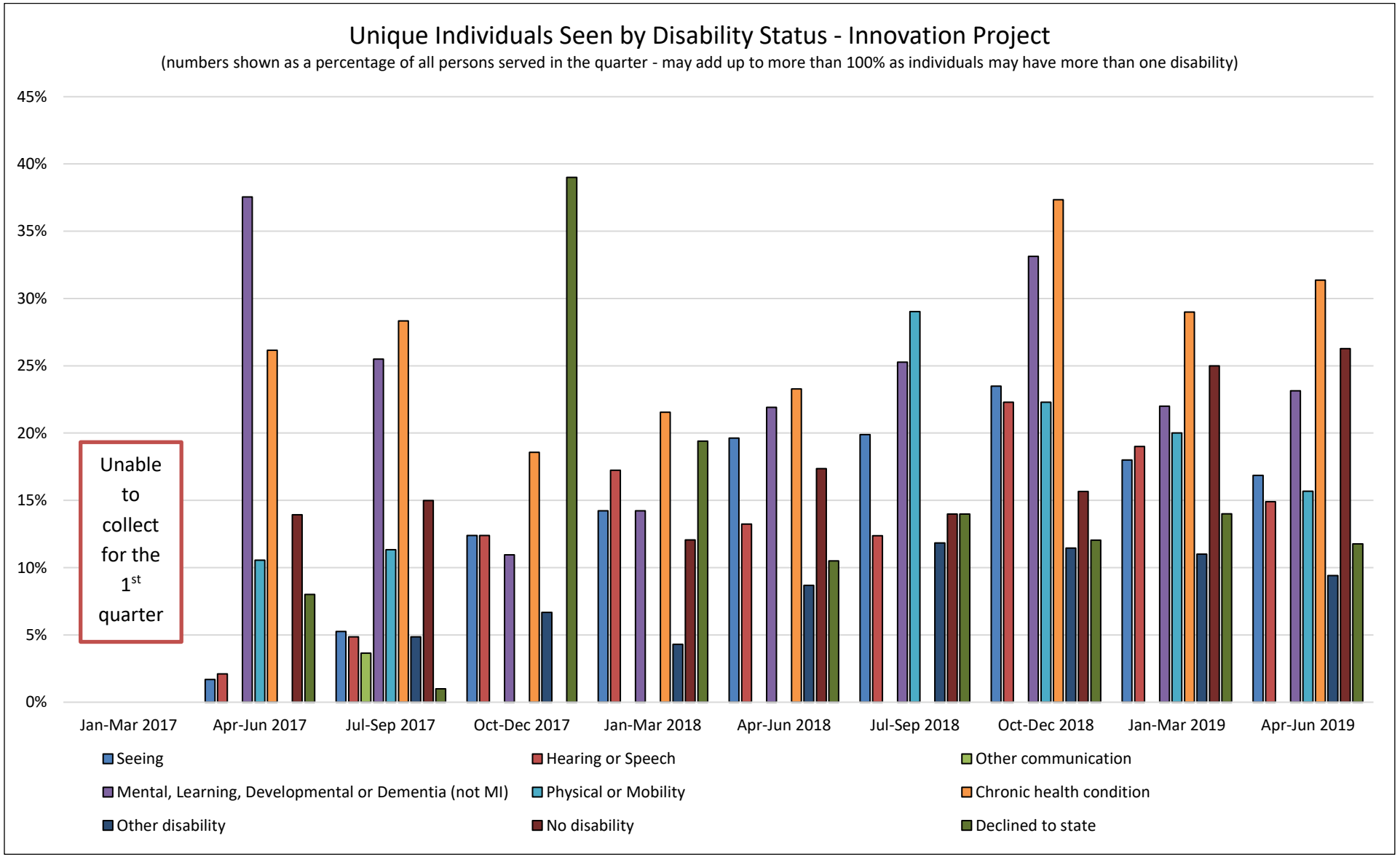
CURRENT GENDER



VETERAN STATUS



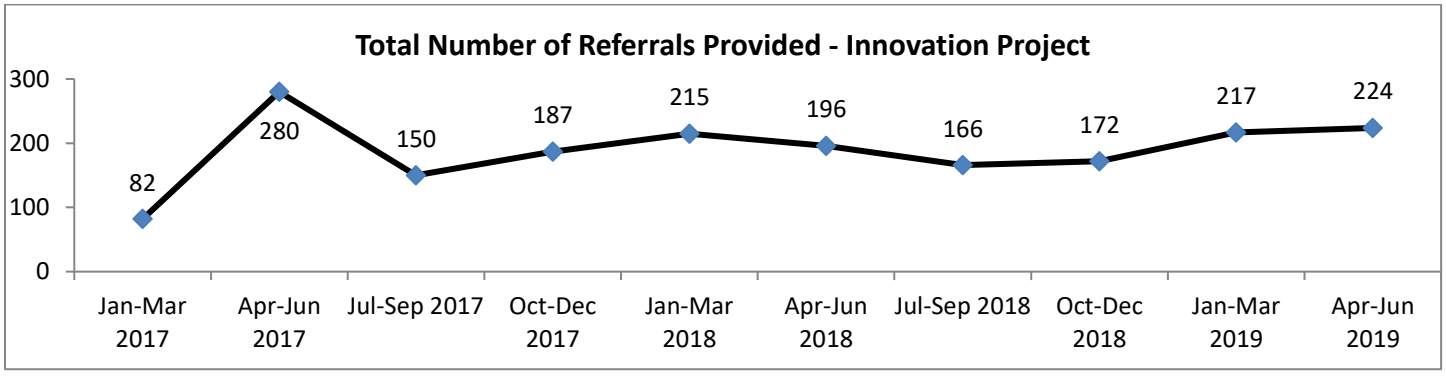
DISABILITY STATUS



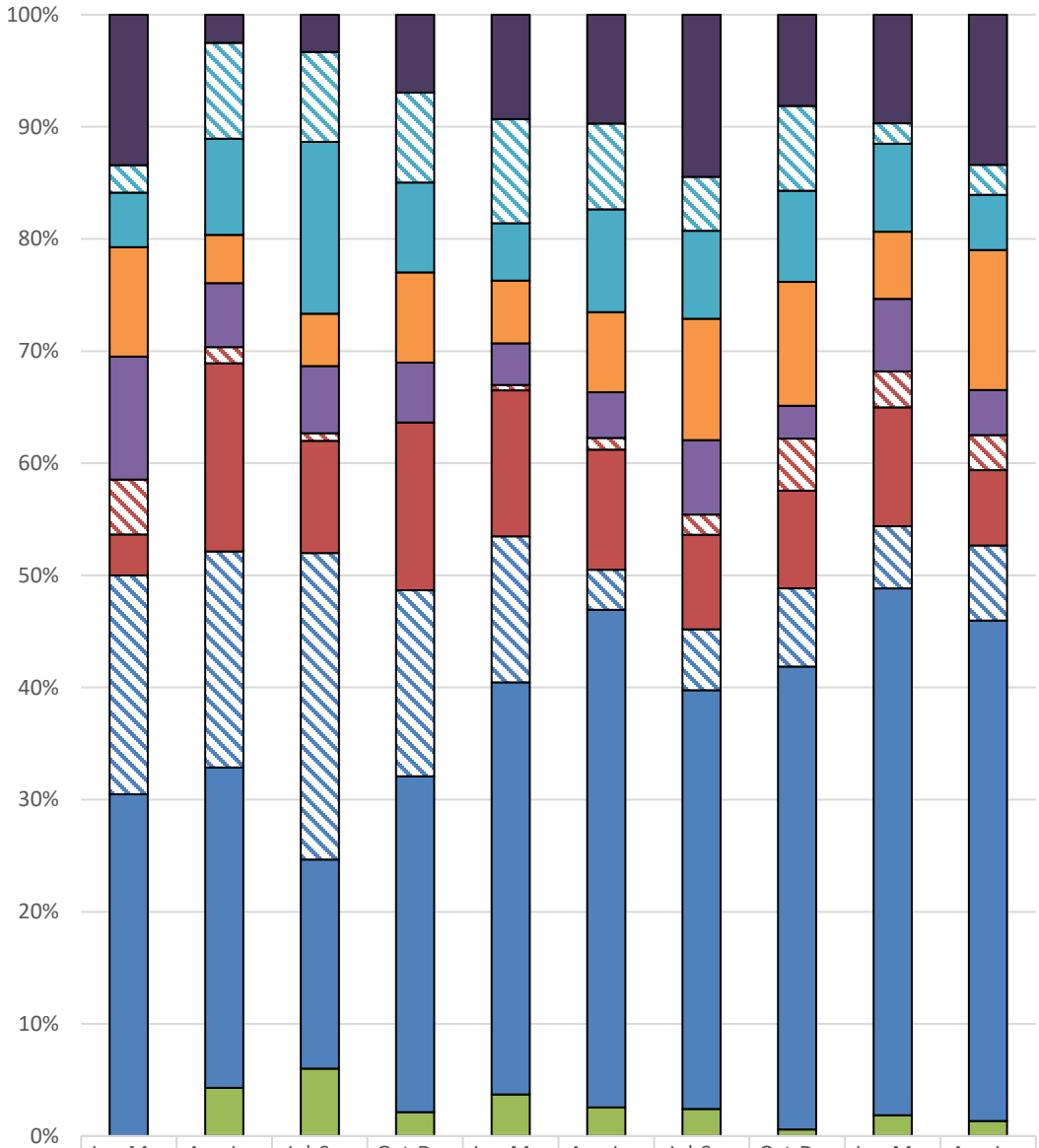
NUMBER OF OUTSIDE REFERRALS PROVIDED AND SUCCESSFULLY ACCESSED

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

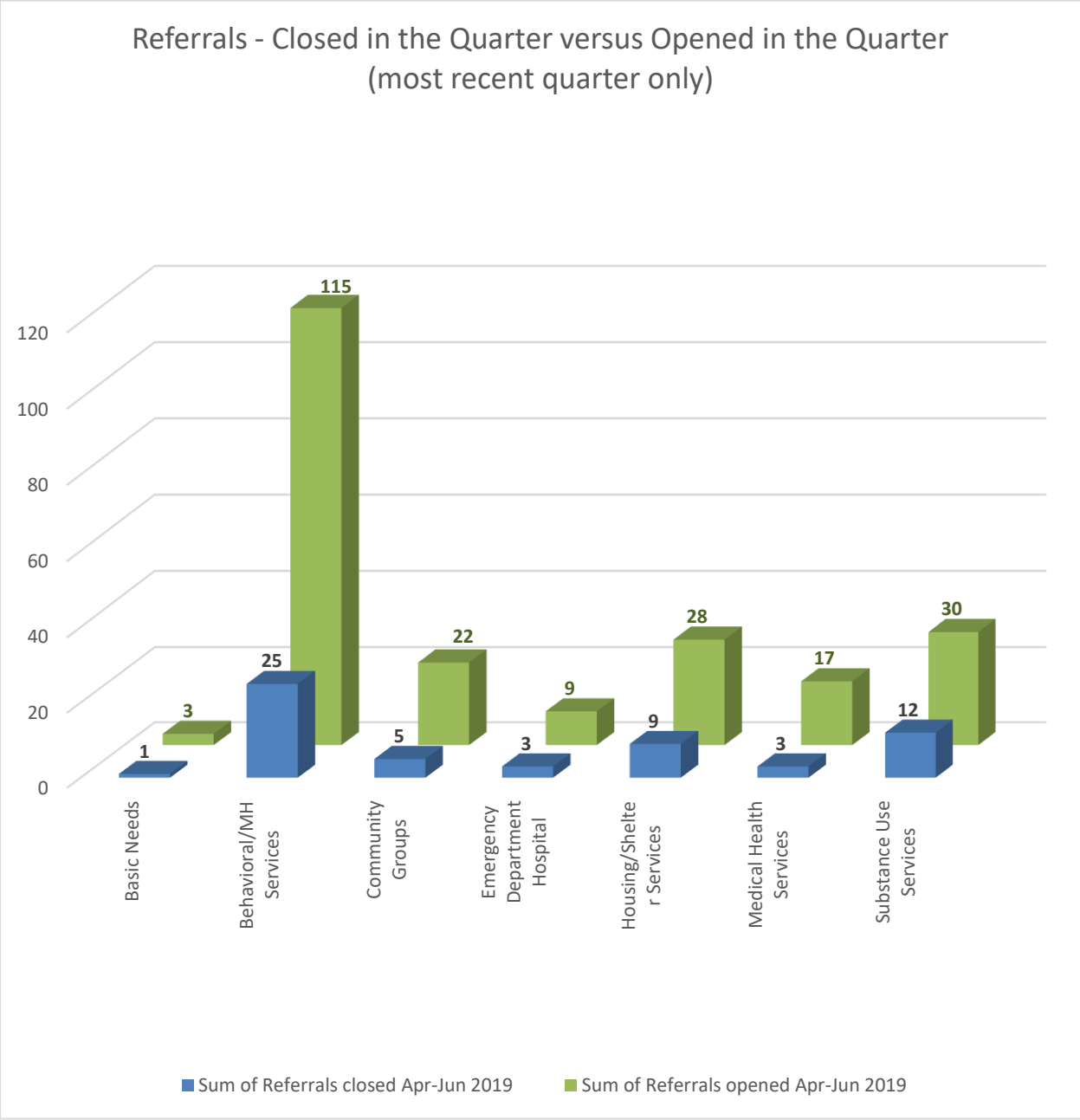


Referrals Provided by Category - Innovation Project



	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
Substance Use Services	11	7	5	13	20	19	24	14	21	30
Medical Health Services Hill Country	2	24	12	15	20	15	8	13	4	6
Medical Health Services External	4	24	23	15	11	18	13	14	17	11
Housing/Shelter Services	8	12	7	15	12	14	18	19	13	28
ED Hospital	9	16	9	10	8	8	11	5	14	9
Community Groups Hill Country	4	4	1	0	1	2	3	8	7	7
Community Groups External	3	47	15	28	28	21	14	15	23	15
Behavioral/MH Services Hill Country	16	54	41	31	28	7	9	12	12	15
Behavioral/MH Servivces External	25	80	28	56	79	87	62	71	102	100
Basic Needs	0	12	9	4	8	5	4	1	4	3

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.

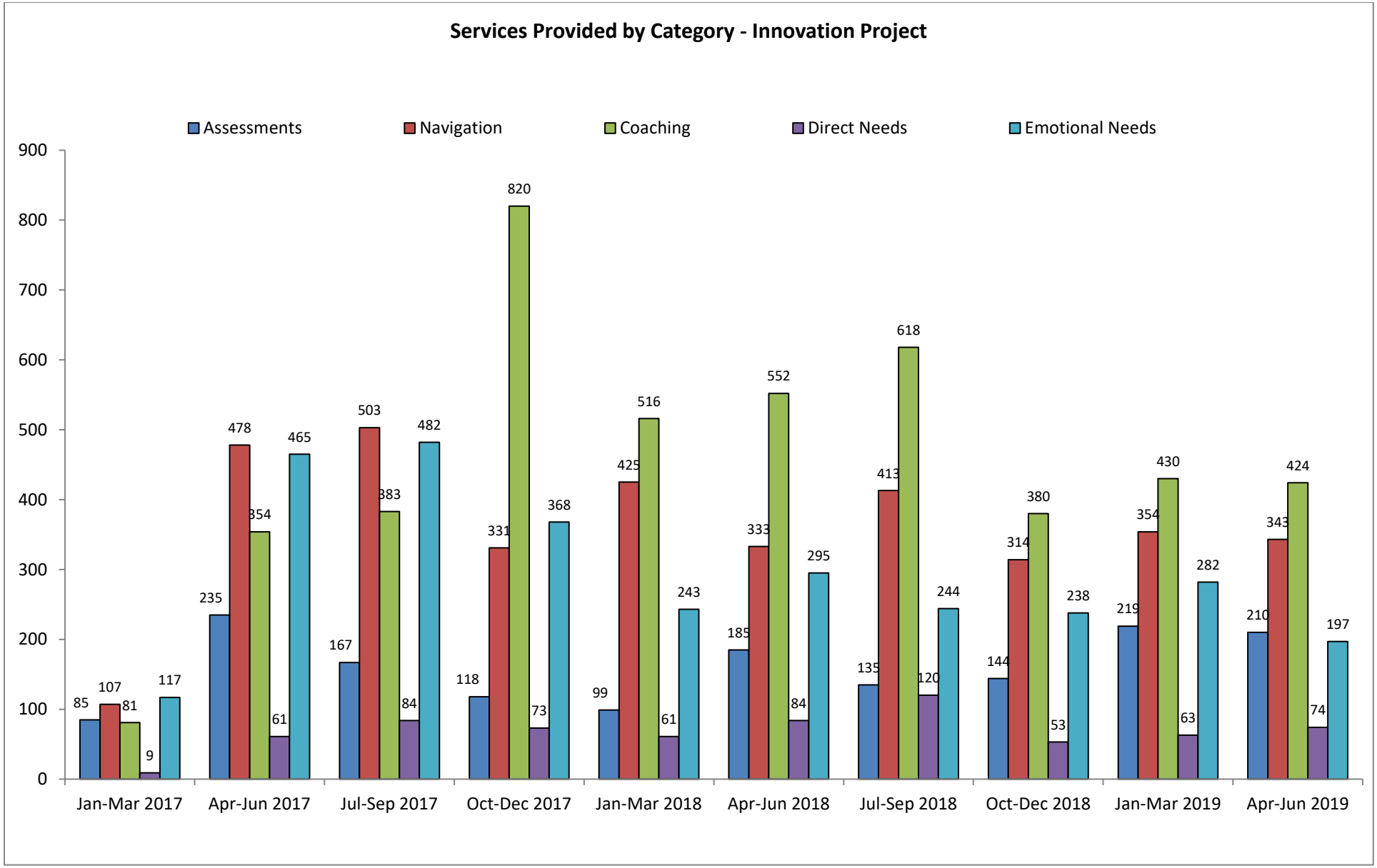


NUMBER OF SERVICES PROVIDED AND SUCCESSFULLY COMPLETED

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
900
800
700
600
500
400
300
200
100
0
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
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

HOUSING STATUS

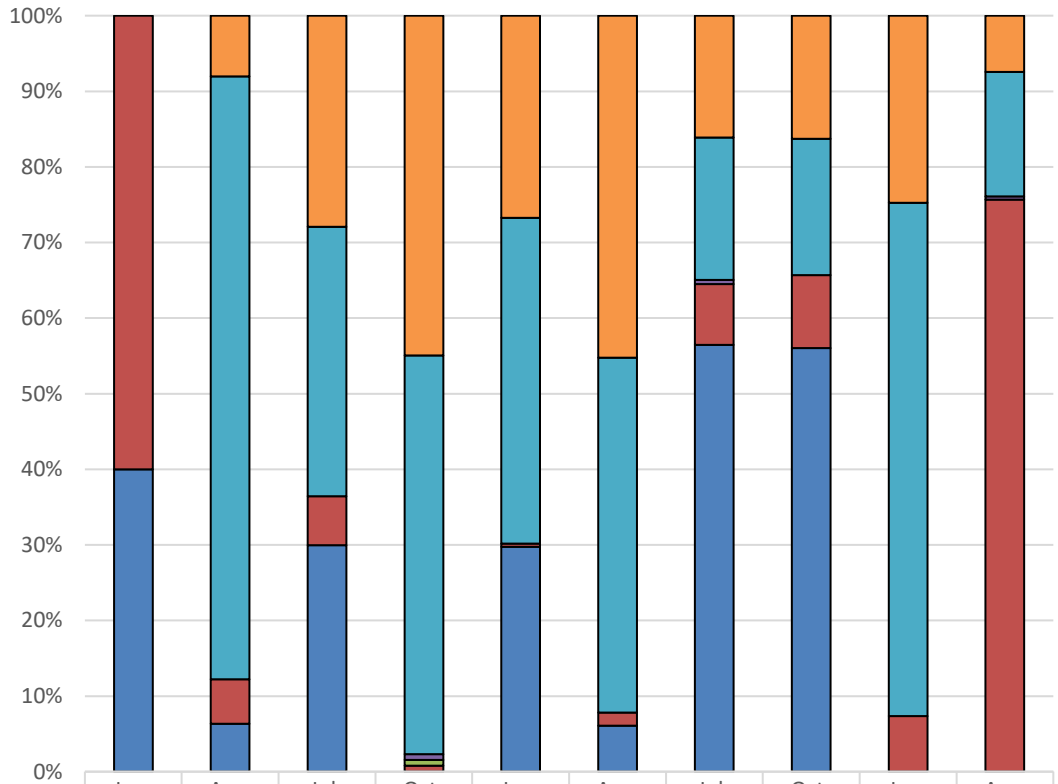
To help track the impact and effectiveness of services, the CARE Center has been asked to track the housing status of individuals accessing the Innovation Project services at the time they first start services, and then at the 3-month point after that first service. The target outcome numbers are to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

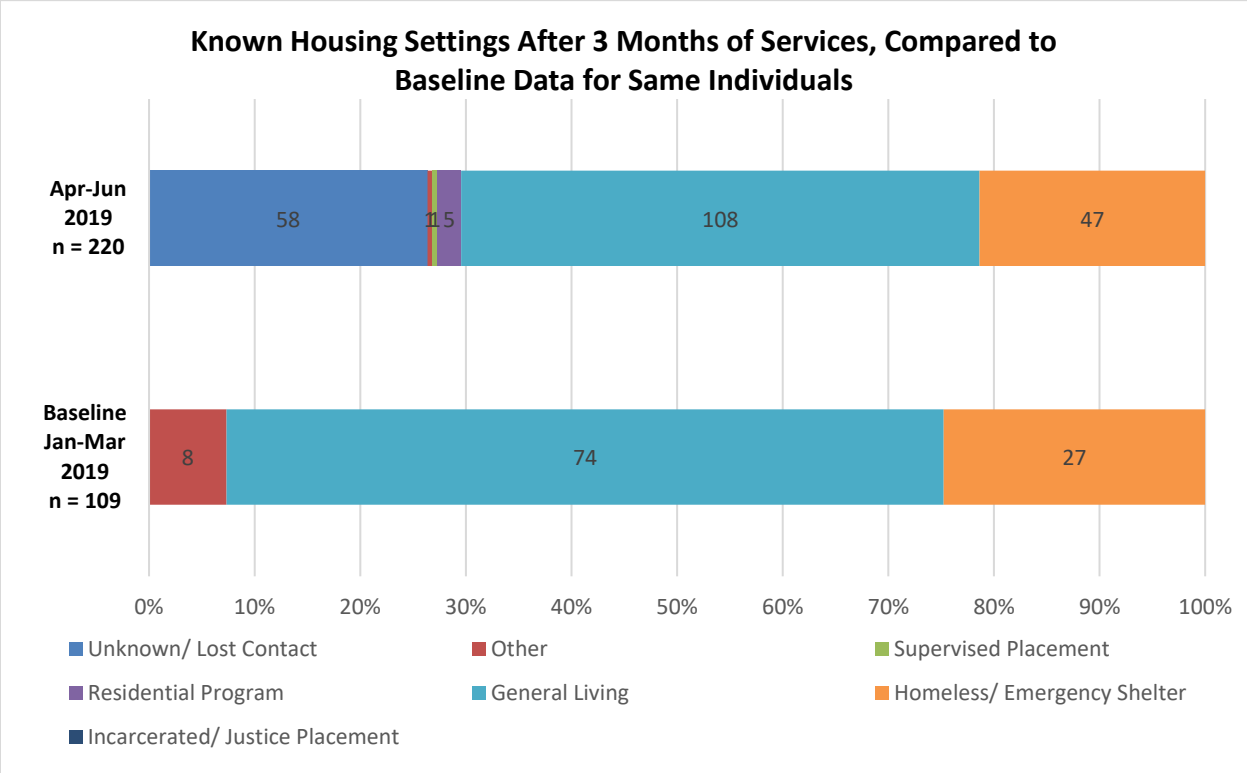
HOUSING STATUS AT START OF SERVICES

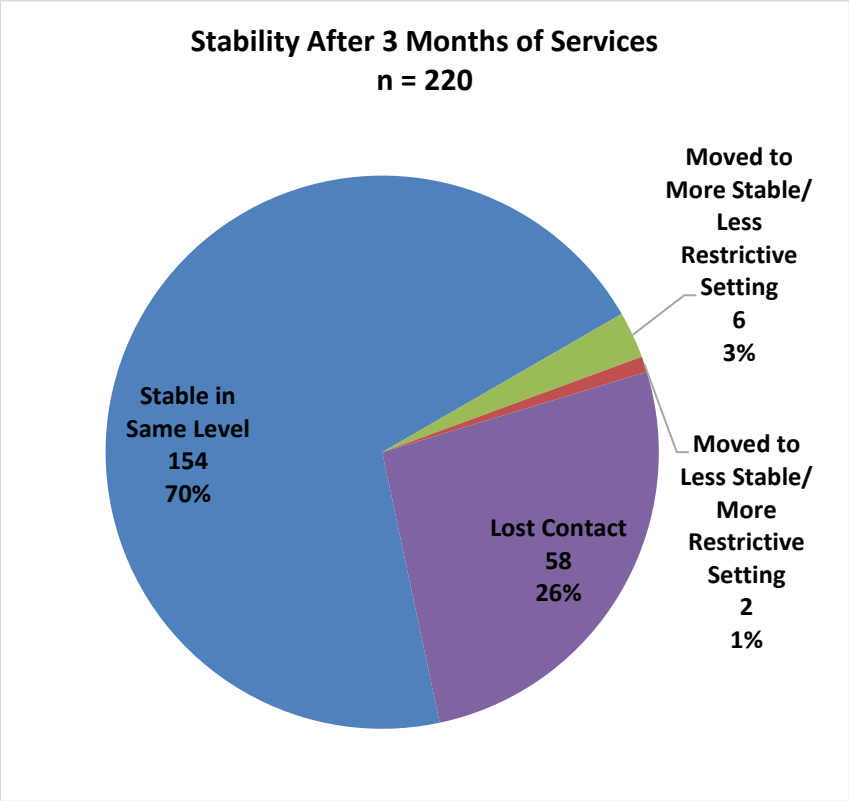
New Participant Housing Status at Intake - Innovation Project



	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
Homeless/ Emergency Shelter	0	19	69	58	62	52	30	27	27	19
General Living	0	189	88	68	100	54	35	30	74	42
Residential Program	0	0	0	1	0	0	1	0	0	1
Supervised Placement	0	0	0	1	0	0	0	0	0	0
Other	3	14	16	1	1	2	15	16	8	193
Unknown	2	15	74	0	69	7	105	93	0	0

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





For those 6 people who moved to more stable/less restrictive settings, 4 transitioned from Homeless/E.S. to General Living and 2 from Homeless/E.S. to Residential Program.

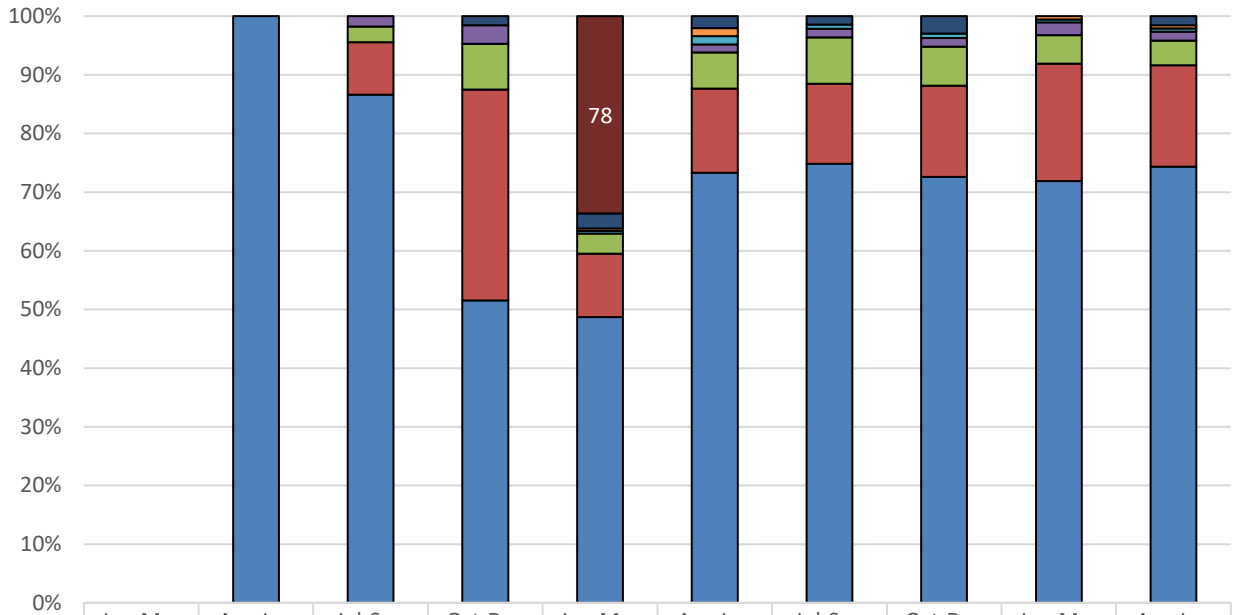
For the 2 people who moved to a less stable/more restrictive setting, 1 transitioned from General Living to Residential Program and 1 from General Living to Homeless/E.S.

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.

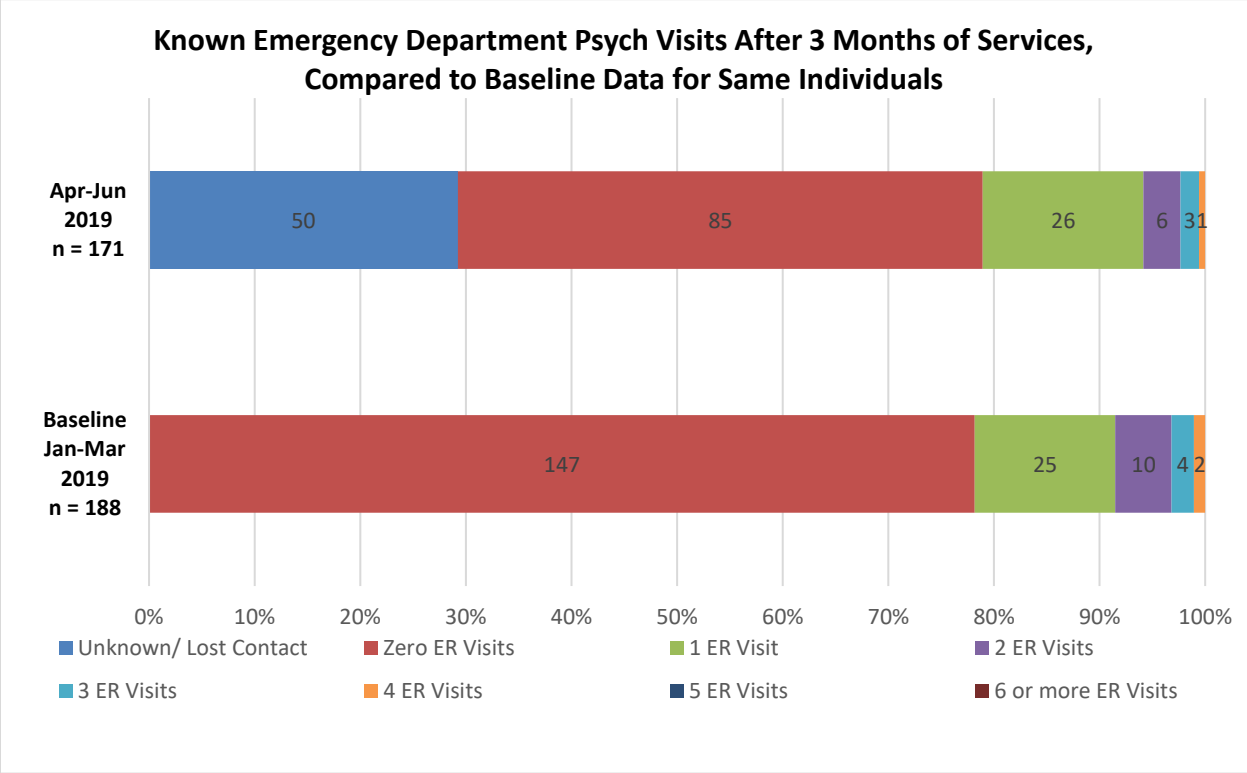
BASELINE EMERGENCY DEPARTMENT PSYCHIATRIC VISITS – PRIOR TO CARE CENTER SERVICES

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

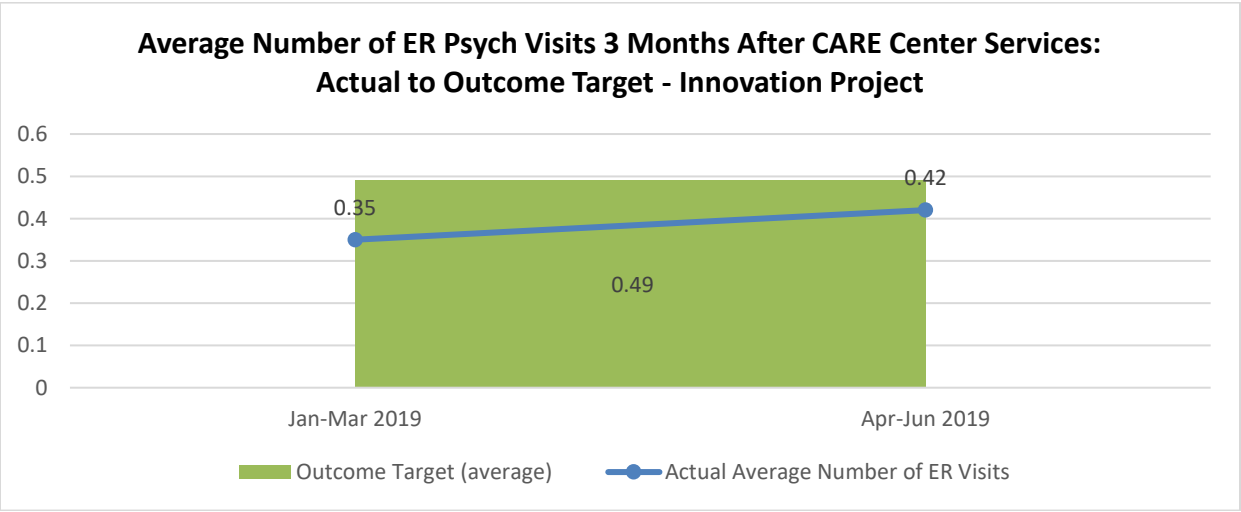


	Jan-Mar 2017	Apr-Jun 2017	Jul-Sep 2017	Oct-Dec 2017	Jan-Mar 2018	Apr-Jun 2018	Jul-Sep 2018	Oct-Dec 2018	Jan-Mar 2019	Apr-Jun 2019
Not Collected	Unable to collect for the 1st quarter	0	0	0	78	0	0	0	0	0
6 or more ER Visits		0	0	1	6	3	2	4	0	3
5 ER Visits		0	0	0	1	2	0	0	1	1
4 ER Visits		0	0	0	1	2	1	1	1	1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

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 2019 baseline quarter was 0.58 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 2019 quarter 0.48 or fewer ER visits on average.

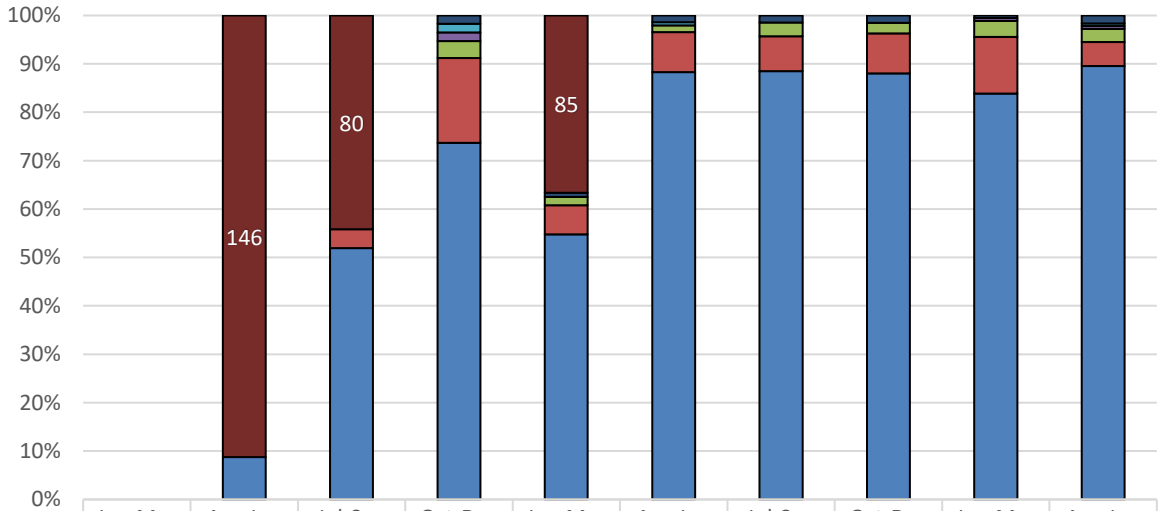


PSYCHIATRIC INPATIENT HOSPITALIZATIONS

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.

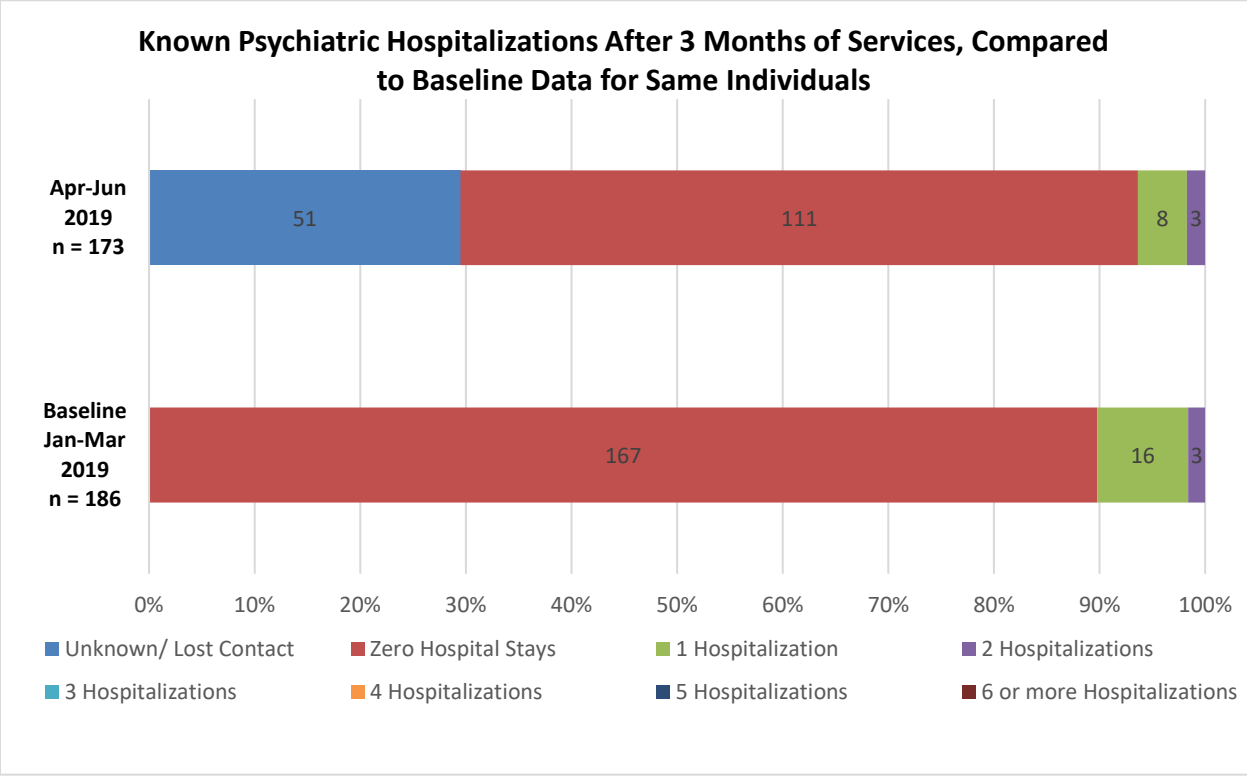
BASELINE PSYCHIATRIC HOSPITALIZATIONS – PRIOR TO CARE CENTER SERVICES

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

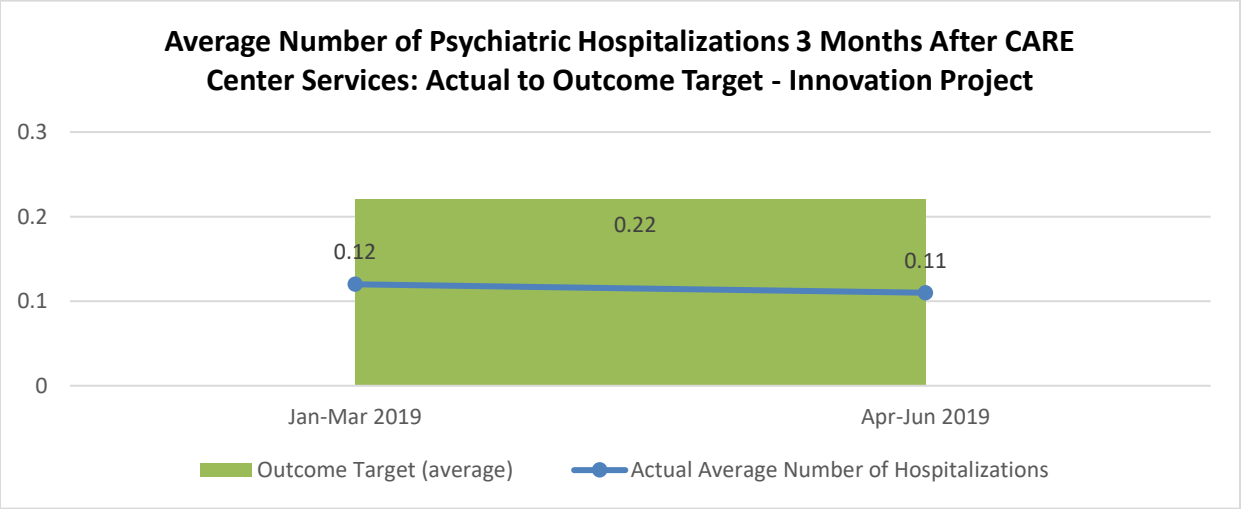


	Jan-Mar 2017	Apr-Jun 2017	Jul-Sep 2017	Oct-Dec 2017	Jan-Mar 2018	Apr-Jun 2018	Jul-Sep 2018	Oct-Dec 2018	Jan-Mar 2019	Apr-Jun 2019
Unknown	Unable to collect for the 1st quarter	146	80	0	85	0	0	0	0	0
6 or more Hospitalizations		0	0	1	2	2	2	2	1	3
5 Hospitalizations		0	0	0	0	0	0	0	0	0
4 Hospitalizations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

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 2019 baseline quarter was 0.26 per individual who had any hospitalizations. This makes the target number for the 3-month mark in the Apr-Jun 2019 quarter 0.22 or fewer hospitalizations on average.

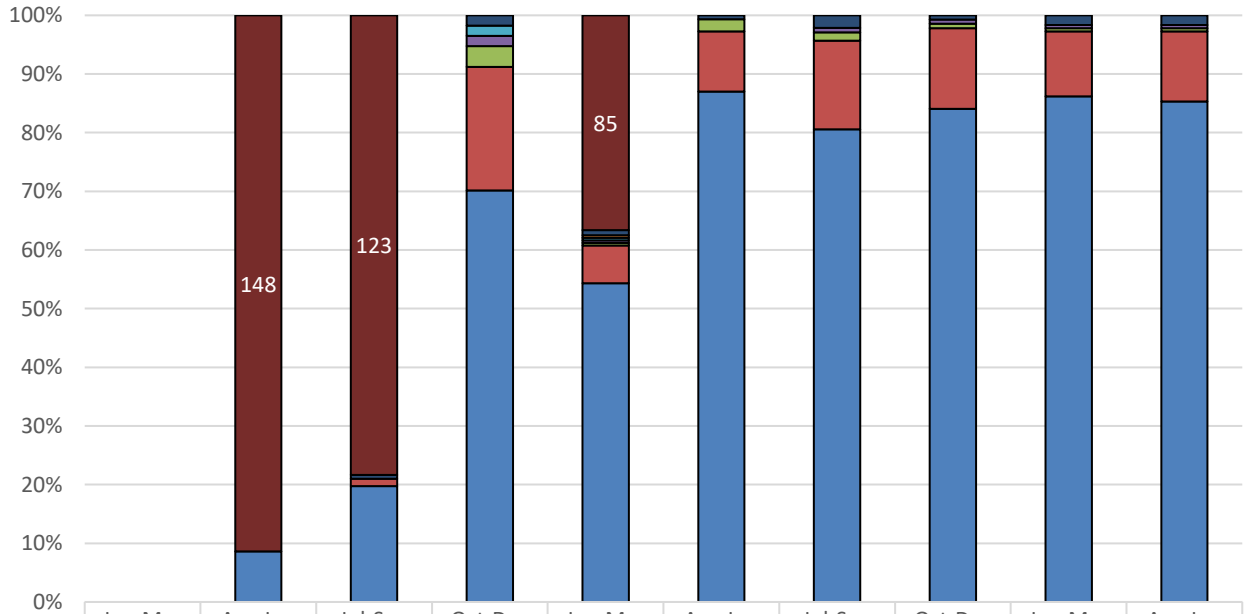


ARRESTS

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.

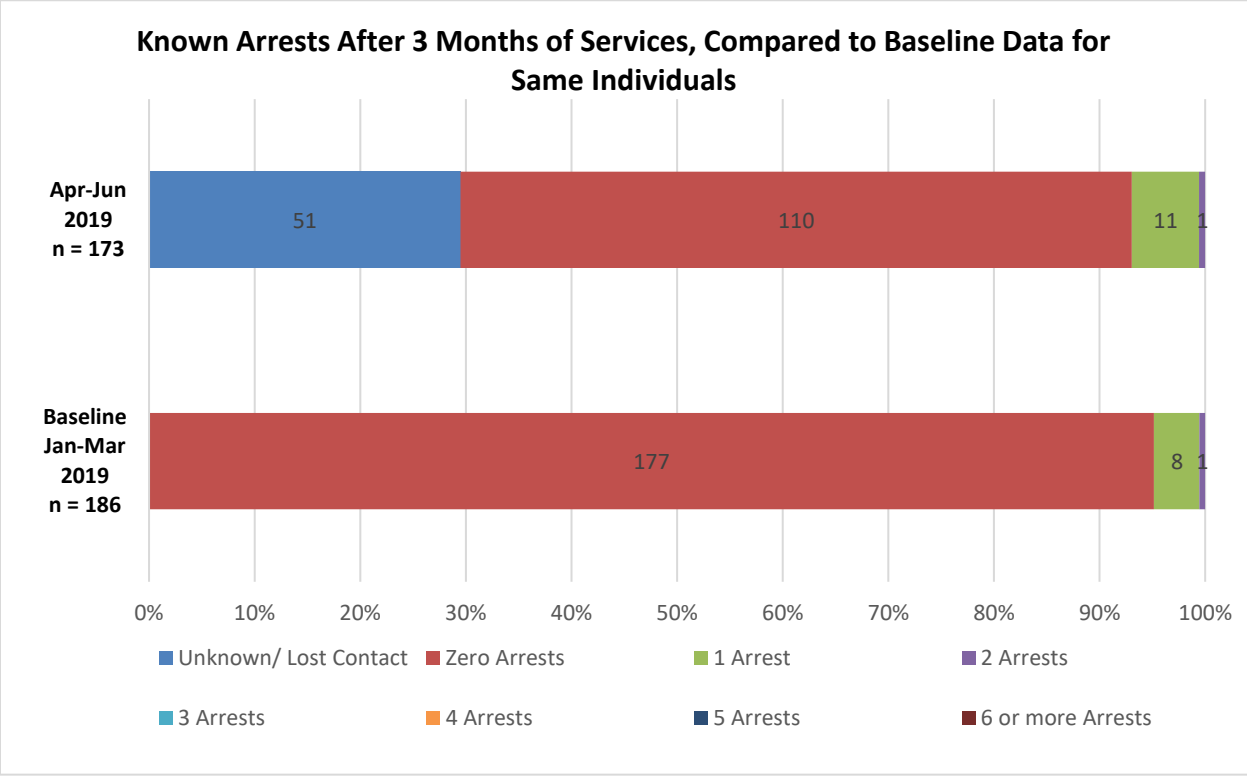
BASELINE ARRESTS – PRIOR TO CARE CENTER SERVICES

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

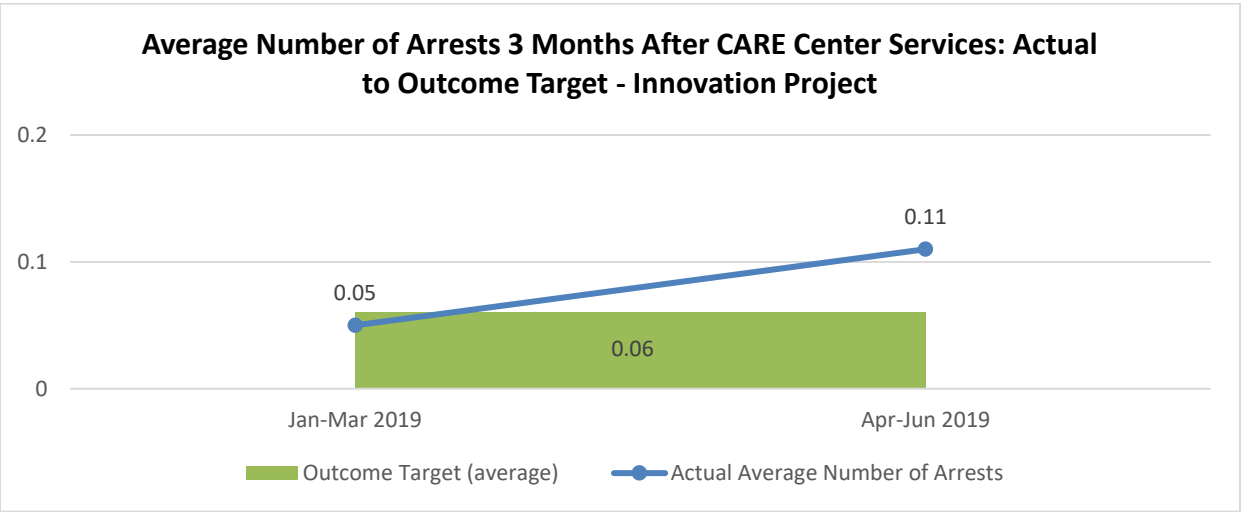


	Jan-Mar 2017	Apr-Jun 2017	Jul-Sep 2017	Oct-Dec 2017	Jan-Mar 2018	Apr-Jun 2018	Jul-Sep 2018	Oct-Dec 2018	Jan-Mar 2019	Apr-Jun 2019
Unknown	Unable to collect for the 1st quarter	148	123	0	85	0	0	0	0	0
6 or more Arrests		0	1	1	2	1	3	1	3	3
5 Arrests		0	0	0	1	0	0	0	0	0
4 Arrests		0	0	1	1	0	0	0	0	0
3 Arrests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

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

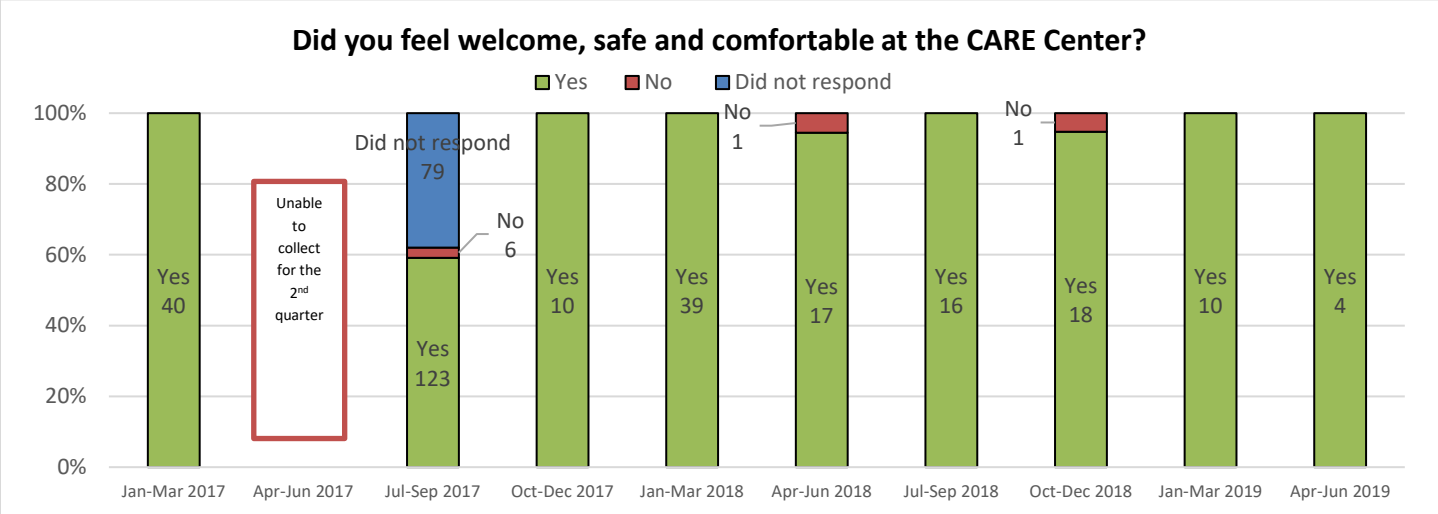


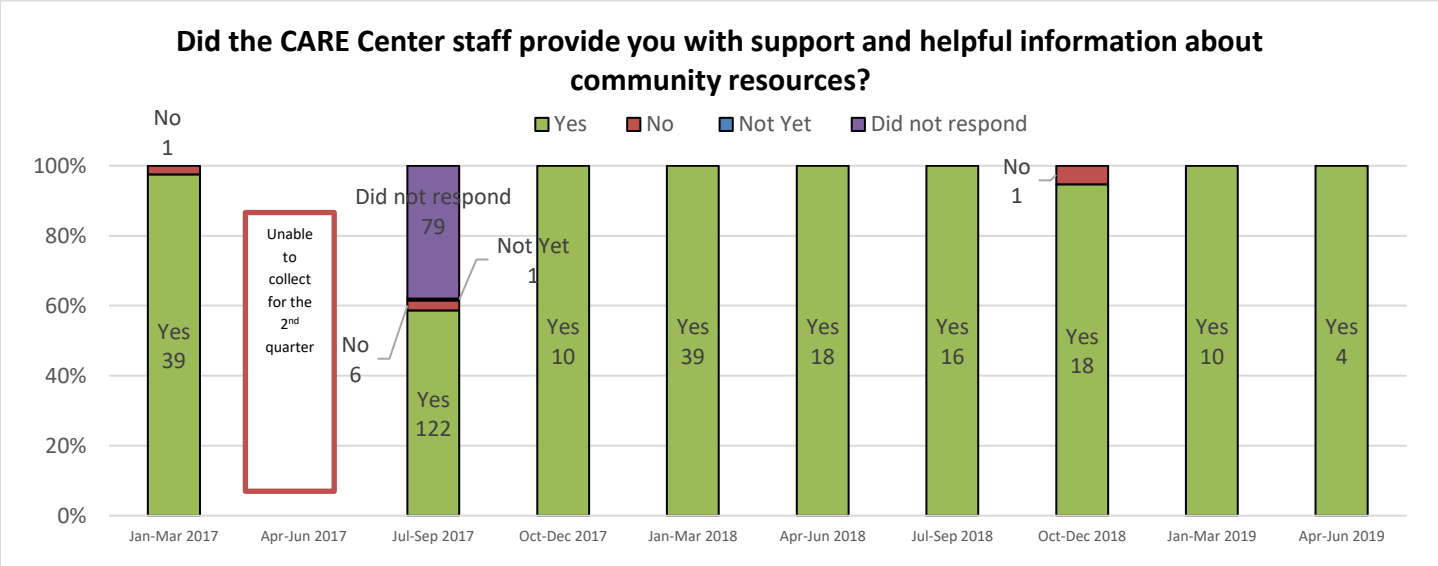
The average number of arrests in the prior 6 months for the Jan-Mar 2019 baseline quarter was 0.08 per individual who had arrest data reported (excluding all in the Unknown/Lost Contact category). This makes the target number for the 3-month mark in the Apr-Jun 2019 quarter 0.06 or fewer arrests on average.

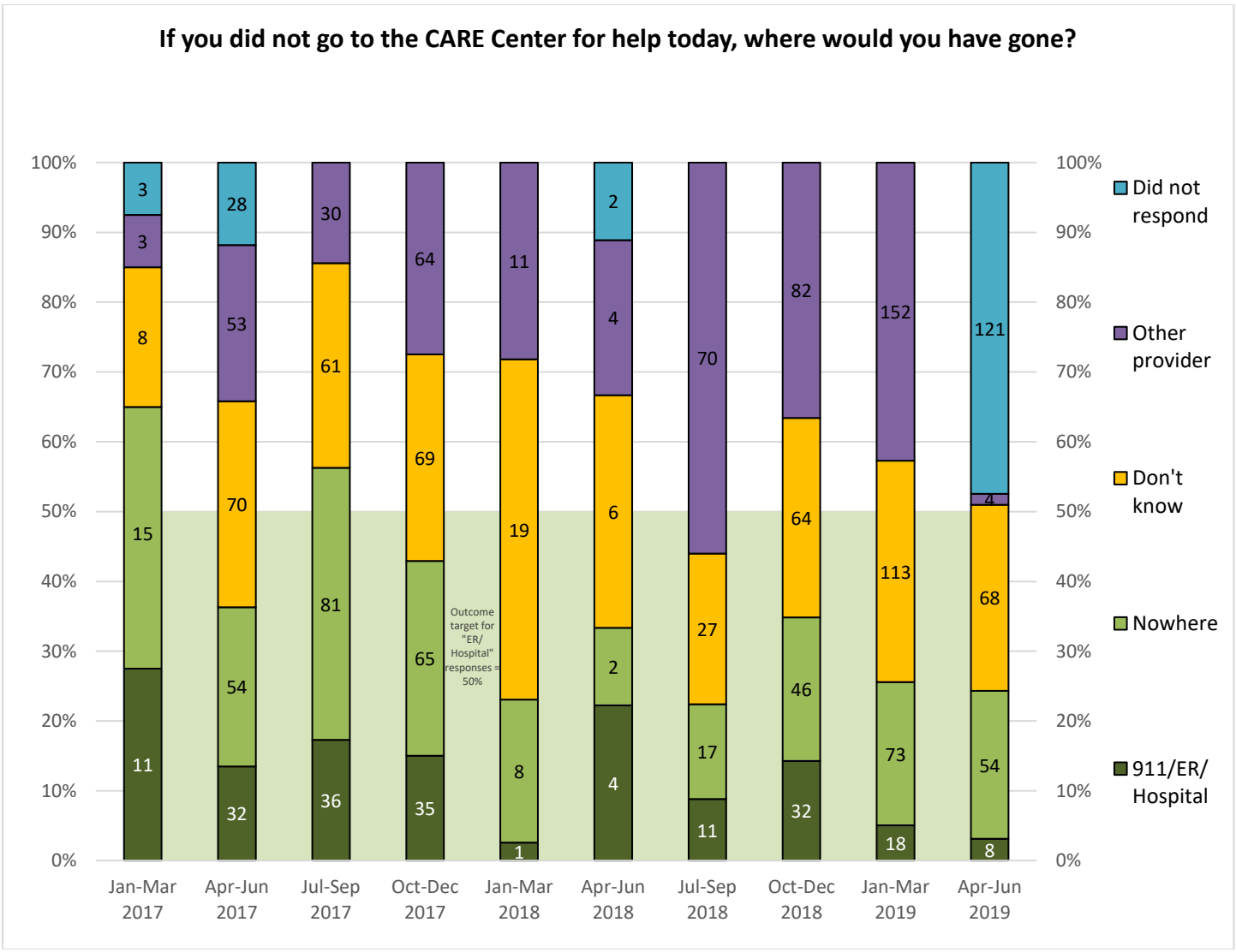


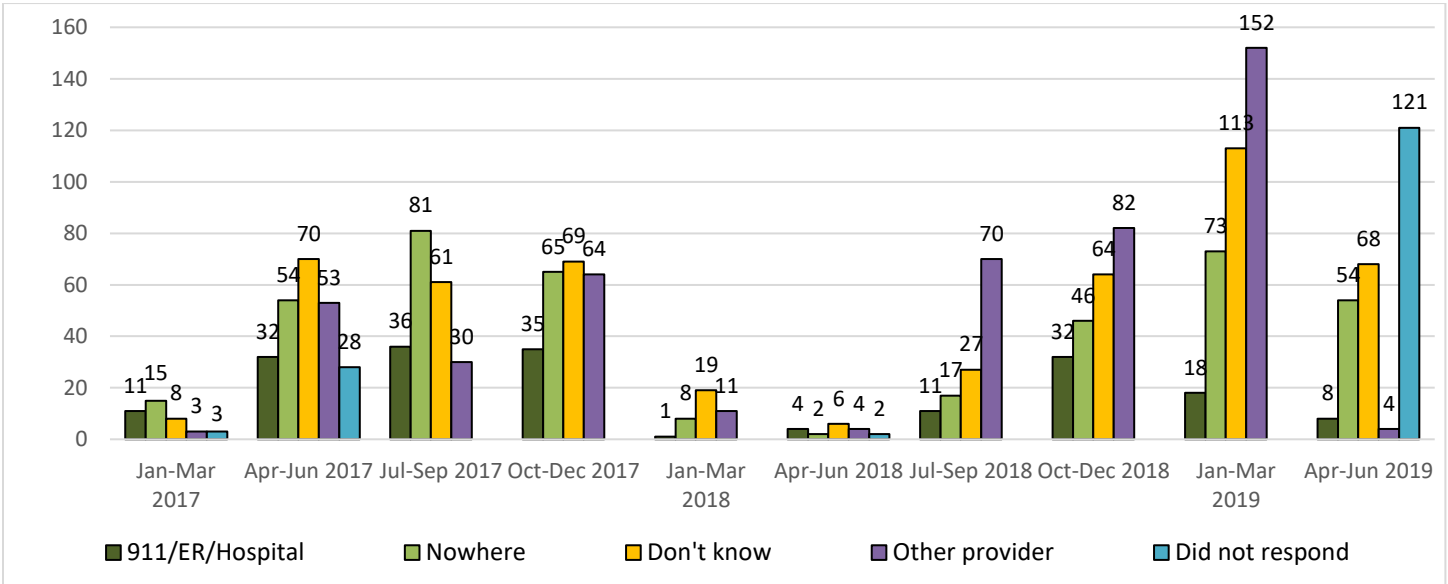
CUSTOMER SURVEYS

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.

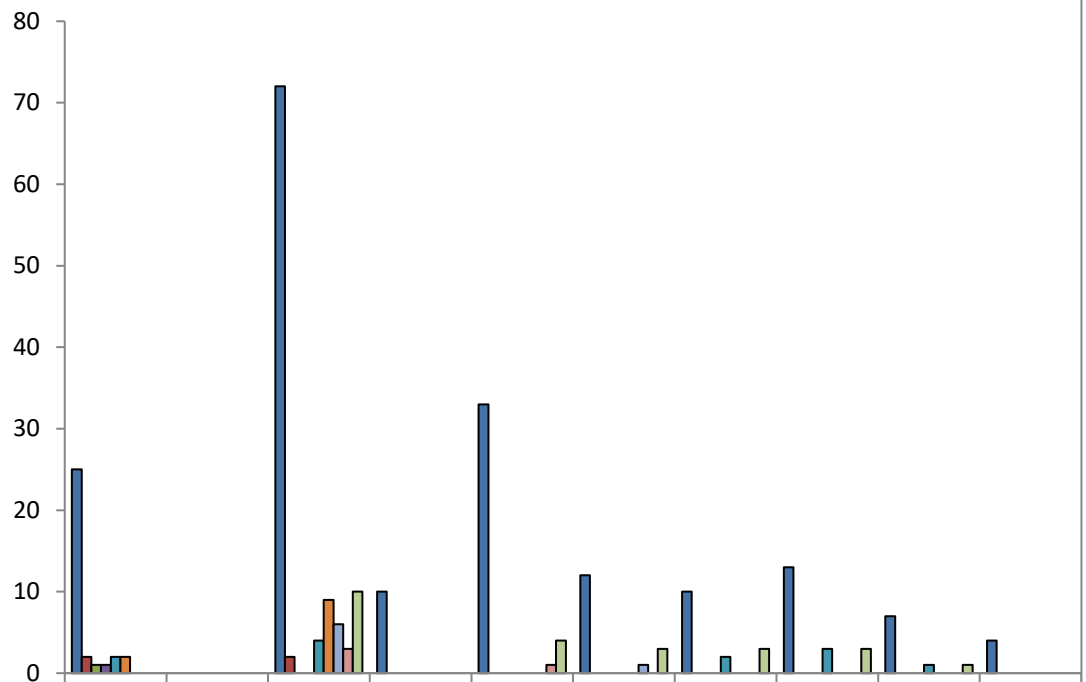





If you did not go to the CARE Center for help today, where would you have gone?
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Jan-Mar 2017
Apr-Jun 2017
Jul-Sep 2017
Oct-Dec 2017
Jan-Mar 2018
Apr-Jun 2018
Jul-Sep 2018
Oct-Dec 2018
Jan-Mar 2019
Apr-Jun 2019
Outcome target for "ER/ Hospital" responses = 50%
Did not respond
Other provider
Don't know
Nowhere
911/ER/ Hospital
11 15 8 3 3
32 54 70 53 28
36 81 61 30
35 65 69 64
1 8 19 11
4 2 6 4 2
11 17 27 70
32 46 64 82
18 73 113 152
8 54 68 4 121


160
140
120
100
80
60
40
20
0
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
911/ER/Hospital
Nowhere
Don't know
Other provider
Did not respond

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
Happy with experience/ services	25		72	10	33	12	10	13	7	4
Medication	2	Unable to collect for the 2nd quarter	2	0	0	0	0	0	0	0
Dental Care	1		0	0	0	0	0	0	0	0
Services for alcoholics in crisis	1		0	0	0	0	0	0	0	0
More and/or different groups	2		4	0	0	0	2	3	1	0
Other facility amenities (music, TV, coffee, snacks etc.)	2		9	0	0	0	0	0	0	0
More staff/ better trained staff	0		6	0	0	1	0	0	0	0
Food & clothing	0		3	0	1	0	0	0	0	0
Other	0		10	0	4	3	3	3	1	0

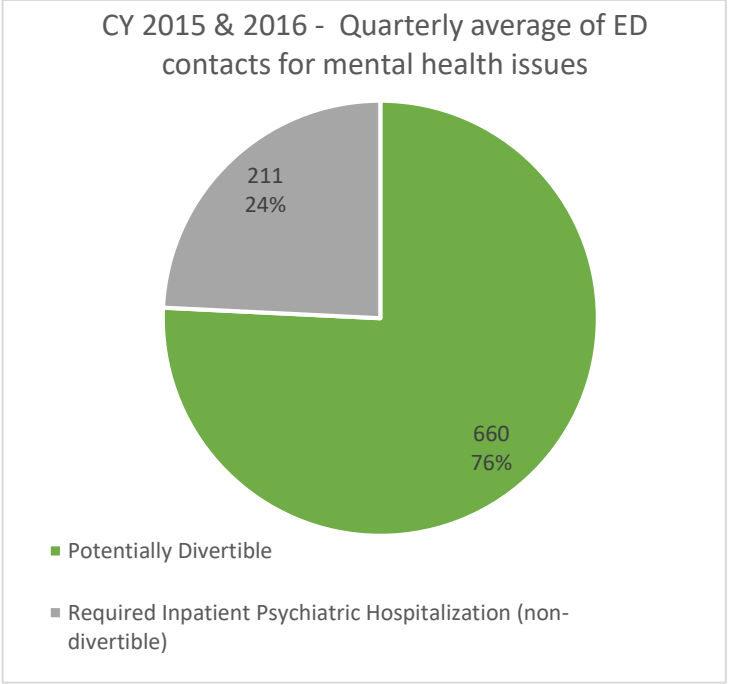
Innovation Project Outcome Tracking – Shasta County Emergency Department Contacts over Time

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. All of this could potentially have 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. Due to this and other factors, the Innovations pilot project has been extended for an additional year.

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.

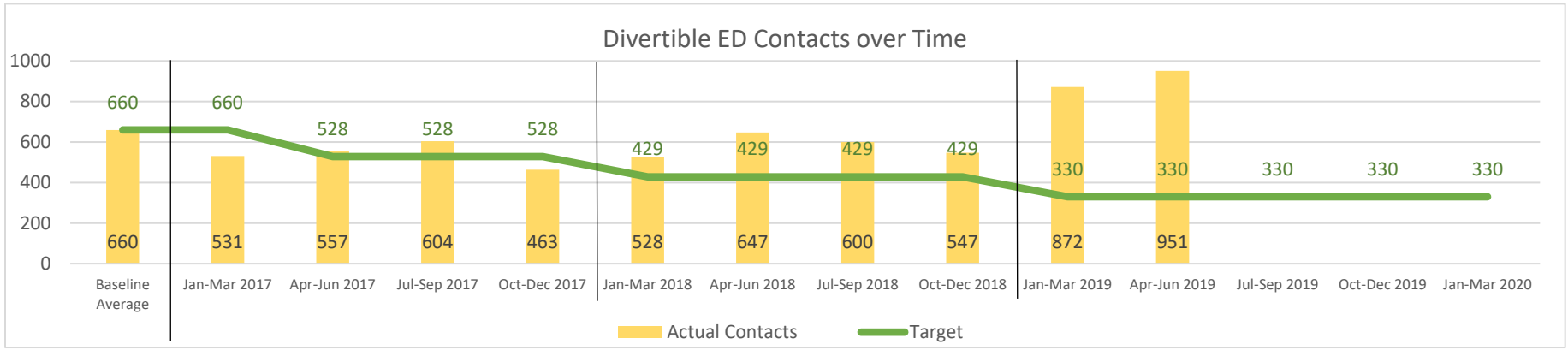


One of the goals for the Innovation Project, as approved by the state MHSOAC office and the Shasta County Board of Supervisors, is to reduce emergency department visits for mental health issues over time by the following amounts:

- 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



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)