Public Notice
County of Shasta

Mental Health, Alcohol and Drug Advisory Board (MHADAB)

Regular Meeting Agenda

Wednesday, June 7, 2023, 5:30 pm
Boggs Building
2420 Breslauer Way, Redding, CA 96001

I. Call to Order & Welcome

II. Public Comment

Members of the public will have the opportunity to address the Board on any issue within the jurisdiction of the Board. Speakers will be limited to three minutes.

III. Announcements and Staff Updates

A. Staff will address Public Comment follow up from the previous meeting.

B. Clinical Program Coordinator Leah Shuffleton will provide a QI Update.

IV. Consent Calendar

The following Consent Calendar items are expected to be routine and non-controversial. They may be acted upon by the Board at one time without discussion. Any Board member or staff member may request that an item be removed from the Consent Calendar for discussion and consideration. Members of the public may comment on any item on the Consent Calendar before the Board's consideration of the Consent Calendar. Each speaker is allocated three minutes to speak.

A. **Approval of Meeting Minutes**
Board members will review and approve minutes from the May 3, 2023 Meeting.

V. Presentations

A. A presentation of Public Comments on the Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan will be provided by Nicole Carroll, Interim MHSA Coordinator.

VI. Regular Calendar

A. Open public hearing to receive comments on the “Mental Health Services Act Three-Year Program and Expenditure Plan, which covers Fiscal Years 2022-23-2025-26”; close public comment period; and close public hearing (as required by California Code of Regulations, Title 9, section 3315A).

B. Consider approval of the “Mental Health Services Act Three-Year Program and Expenditure Plan, which covers Fiscal Years 2022-23-2025-26”; and consider recommending that the Shasta County Board of Supervisors

approve the "Mental Health Services Act Three-Year Program and Expenditure Plan, which covers Fiscal Years 2022-23-2025-26."

VII. Discussion Items

A. Board members may ask questions about the Director's Report.

B. Board members may make suggestions for future agenda item consideration.

VIII. Board Member Reports

Board members will report committee meeting updates.

IX. Adjourn

Regular MHADAB Meeting

July 12, 2023, 5:30 pm
Boggs Building
2420 Breslauer Way
Redding, CA 96001

Executive Committee Meeting

June 12, 2023, 11:00 am
HHSA Adult Services Branch, Admin Conference Room
2640 Breslauer Way, Redding, CA 96001

Committees

Shasta Substance Use Coalition
Virtual via Zoom
July 11, 2023, 10:30
jill@shastatraining.org

ADP Provider Meeting
Cancelled this quarter
2420 Breslauer Way
Redding, CA 96001
kcassidy@co.shasta.ca.us

Stand Against Stigma
2420 Breslauer Way
Redding, CA 96001
June 13, 2023, 1:30
cdiamond@co.shasta.ca.us

Shasta Suicide Prevention Collaborative
July 11, 2023, 2:30
Contact for Meeting Location
stinger@co.shasta.ca.us

Continuum of Care (CoC), Executive Meeting
Contact for meeting location.
June 15, 2023, 3:00
HCAP@co.shasta.ca.us

MHSA Stakeholder Workgroup
TBD
mhsa@co.shasta.ca.us

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Public records which relate to any of the matters on this agenda (except Closed Session items), and which have been distributed to the members of the Advisory Board, are available for public inspection at Shasta County Health and Human Services Agency, 2640 Breslauer Way, Redding, CA 96001. This meeting will be recorded. If there are any questions regarding this agenda, please contact Rachel Renier at 530-229-8306, or via e-mail at rrenier@co.shasta.ca.us.

SHASTA COUNTY MENTAL HEALTH, ALCOHOL AND DRUG ADVISORY BOARD (MHADAB)
REGULAR MEETING
Minutes
May 3, 2023

Members: Ron Henninger, David Kehoe, Kayln Jones, Heather Jones, Cindy Greene, Mary Rickert, Dale Marlar, Jo-Ann Medina, Angel Rocke, Christine Stewart, Anne Prielipp, Allan Mullikin.
Virtual Member attendance: Sam Major
Absent Members: Charlie Menoher, Connie Webber.
Shasta County Staff: Rachel Renier, Miquel Rodriguez, Christopher Diamond, Josie Englin, Marie Marks.

Agenda Item	Discussion	Action	Individual Responsible
I. Call to Order & Welcome	➢ The meeting was called to order and all present parties were welcomed.		➢ Ron Henninger, MHADAB Chair
II. Open Public Comment Period	➢ Nancy commented that she stands with all the employees on strike and supports the wage increase.		➢ Nancy DeNayer
III. Staff and Board Member Reports	▪ Staff addressed Public Comments from the previous meeting. ▪ Miguel Rodriquez provided an update on the Release of Information and Woodlands Housing staff availability. Managed Care is creating a new survey to gather client information, and it will be presented to the Board when completed. ▪ MHSA Stakeholder Update presented on behalf of Nicole Carroll. ▪ STAR Program Criteria was discussed at the previous meeting and there may be a future presentation. ▪ There will be a new Sub-Committee Workgroup to detail specific program data, contracts, and any other details the Board would like to receive. Volunteers for the work group are Heather Jones, Ron Henninger, Christine Stewart, and Kayln Jones. ▪ Miguel Rodriguez discussed client treatment in the Emergency Room at Mercy Hospital, and he is working with Ron to compose a letter to Mercy with specific details. Please send any specific details to him by email.	➢ A future agenda item on the STAR Team Criteria was requested during previous Public Comment Period.	➢ Miguel Rodriquez, Director of Mental Health ➢ Rachel Renier, Board Secretary ➢ Miguel Rodriquez, Director of Mental Health

IV. Consent Calendar	A. <u>Approval of Meeting Minutes</u> Board members reviewed minutes from the April 5, 2023, Regular Meeting.	➢ The Consent Calendar was passed unanimously with twelve (12) ayes, and zero (0) nays, and zero (0) abstentions.	➢ Motion: Jo-Ann Medina Second: Heather Jones
V. Presentations	➢ Christopher Diamond, Community Education Specialist, presented an Overview of Stand Against Stigma (SAS) and Mental Health Month. SAS has two special projects: working on training for medical professionals and community education on the science of addiction. The Wellness Recovery Action Plan is an 8-week training course for staff, and the Men's Advisory Group as a culture of wellness for men. He also said the Brave Faces Program is ten years old and they are developing a new podcast.		➢ Christopher Diamond, Community Education Specialist
VI. Regular Calendar			
VII. Discussion Items	A. Miguel Rodriguez, Director of Mental Health, reviewed topics in relation to the Director's Report and presented a review of the Hope Park Innovation. He reviewed the project goals and provided feedback on goals which have not been met. Hope Park Innovation project met seven goals and did not meet thirteen. B. Board members were invited to participate in meeting planning by attending Executive Committee meetings.		➢ Miguel Rodriguez, Director of Mental Health ➢ Ron Henninger, MHADAB Chair
VII. Adjournment		➢ Adjournment (6:48 p.m.)	

_____
Ron Henninger, Chair

_____
Rachel Renier, Administrative Secretary II

Shasta County Health & Human Services Agency

MHSA Stakeholder Demographics

Due to the virtual MHSA Stakeholder meeting format, the number of people in attendance and the number of demographics forms received were lower compared to previous years.

The number of responses varied by question. The number of responses received were 38, but not every survey was answered fully. To protect participant confidentiality, only summary statistics are provided below.

Q1) How many years old are you?

- Mean Age = 55
- Median Age = 57
- Age Range = 24 - 81

Q2) What is your military status?

- >80% of respondents had never served in the military

Q3) What is your primary language?

- >90% identified English as their primary language

Q4) Do you have any disabilities?

- >60% identified as having a disability. Difficulty hearing or having speech understood, chronic health condition/chronic pain, and learning disability were the most reported.

Q5) What is your race/ethnicity?

- 50% identified as being white and 50% identified as a race/ethnicity other than white.

Q6) What is your gender identity?

- >65% identified as female

Q7) What is your sexual orientation?

- >80% identified as heterosexual

Consumer Perception Survey Results (Youth Only)

FY 21/22

N = 56

The Consumer Perception Survey measures clients' satisfaction with the services they received from Shasta County HHSA. The survey is a tool to gather feedback from Youth (under age 18) who received services within the last 6 months (or based on the services they have received so far). The survey is voluntary. The aggregated responses for FY 21/22 are shown below along with the corresponding survey questions and categories to indicate overall client satisfaction. *Total figures may not add up to 100% due to rounding. Colors indicate highest percentages.

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Not Applicable
1. Overall, I am satisfied with the services I received.	2%	0%	4%	49%	44%	0%
2. I helped to choose my services.	2%	2%	12%	51%	30%	2%
3. I helped to choose my treatment goals.	6%	2%	2%	62%	28%	0%
4. The people helping me stuck with me no matter what.	2%	0%	5%	48%	45%	0%
5. I felt I had someone to talk to when I was troubled.	4%	4%	7%	40%	42%	2%
6. I participated in my own treatment.	0%	2%	16%	44%	37%	0%
7. I received services that were right for me.	2%	0%	11%	56%	31%	0%
8. The location of services was convenient for me.	0%	4%	11%	40%	42%	2%
9. Services were available at times that were convenient for me.	0%	2%	14%	47%	37%	0%
10. I got the help I wanted.	0%	2%	12%	45%	40%	0%
11. I got as much help as I needed.	0%	2%	24%	44%	29%	0%
12. Staff treated me with respect.	2%	0%	5%	36%	55%	2%
13. Staff respected my religious / spiritual beliefs.	2%	0%	7%	35%	44%	12%
14. Staff spoke with me in a way that I understood.	2%	0%	2%	55%	41%	0%
15. Staff were sensitive to my cultural / ethnic background.	0%	0%	11%	39%	41%	9%
As a result of the services I received:	**Strongly Disagree**	**Disagree**	**Undecided**	**Agree**	**Strongly Agree**	**Not Applicable**
16. I am better at handling daily life.	0%	7%	30%	44%	19%	0%
17. I get along better with family members.	5%	9%	34%	27%	25%	0%
18. I get along better with friends and other people.	5%	5%	17%	44%	29%	0%
19. I am doing better in school and / or work.	5%	12%	30%	26%	26%	2%
20. I am better able to cope when things go wrong.	2%	5%	21%	44%	28%	0%
21. I am satisfied with my family life right now.	5%	15%	34%	22%	24%	0%
22. I am better able to do things I want to do.	5%	7%	19%	47%	23%	0%

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For Questions #23-26, please answer for relationships with persons other than your mental health provider(s).

As a result of the services I received:	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Not Applicable
23. I know people who will listen and understand me when I need to talk.	0%	2%	11%	42%	40%	4%
24. I have people that I am comfortable talking with about my problem(s).	0%	5%	7%	50%	39%	0%
25. In a crisis, I would have the support I need from family or friends.	4%	4%	22%	31%	36%	2%
26. I have people with whom I can do enjoyable things.	2%	0%	10%	39%	49%	0%

Consumer Perception Survey Results (Families Only)

FY 21/22

N = 41

The Consumer Perception Survey measures clients' satisfaction with the services they received from Shasta County HHSA. The survey is a tool to gather feedback from anyone who received services within the last 6 months (or based on the services they have received so far). The survey is voluntary. The aggregated responses for FY 21/22 are shown below along with the corresponding survey questions and categories to indicate overall client satisfaction.

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Not Applicable
1. Overall, I am satisfied with the services my child received.	0%	6%	9%	31%	54%	0%
2. I helped to choose my child's services.	3%	9%	6%	41%	32%	9%
3. I helped to choose my child's treatment goals.	0%	9%	3%	49%	34%	6%
4. The people helping my child stuck with us no matter what.	3%	9%	6%	34%	49%	0%
5. I felt my child had someone to talk to when he / she was troubled.	3%	3%	3%	32%	56%	3%
6. I participated in my child's treatment.	3%	3%	3%	39%	50%	3%
7. The services my child and / or family received were right for us.	0%	3%	20%	29%	49%	0%
8. The location of services was convenient for us.	3%	6%	3%	26%	63%	0%
9. Services were available at times that were convenient for us.	0%	11%	3%	31%	54%	0%
10. My family got the help we wanted for my child.	0%	6%	17%	28%	50%	0%
11. My family got as much help as we needed for my child.	0%	15%	12%	38%	35%	0%
12. Staff treated me with respect.	0%	6%	0%	28%	67%	0%
13. Staff respected my family's religious / spiritual beliefs.	3%	0%	6%	17%	46%	29%
14. Staff spoke with me in a way that I understood.	0%	3%	0%	29%	66%	3%
15. Staff were sensitive to my cultural / ethnic background.	3%	0%	3%	20%	43%	31%

As a result of the services my child and / or family received:	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Not Applicable
16. My child is better at handling daily life.	3%	6%	26%	37%	26%	3%
17. My child gets along better with family members.	3%	12%	18%	50%	18%	0%
18. My child gets along better with friends and other people.	3%	9%	14%	57%	17%	0%
19. My child is doing better in school and / or work.	3%	12%	15%	45%	24%	0%
20. My child is better able to cope when things go wrong.	3%	12%	29%	38%	18%	0%
21. I am satisfied with our family life right now.	0%	17%	26%	43%	11%	3%
22. My child is better able to do things he or she wants to do.	0%	6%	26%	50%	15%	3%

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For Questions #23-26, please answer for relationships with persons other than your mental health provider(s).

As a result of the services my child and / or family received:	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Not Applicable
23. I know people who will listen and understand me when I need to talk.	0%	9%	6%	37%	49%	0%
24. I have people that I am comfortable talking with about my child's problem(s).	0%	3%	11%	37%	49%	0%
25. In a crisis, I would have the support I need from family or friends.	0%	8%	8%	39%	42%	3%
26. I have people with whom I can do enjoyable things	0%	6%	3%	53%	28%	11%

Consumer Perception Survey Results (Adults Only)

FY 21/22

N = 11

The Consumer Perception Survey measures clients' satisfaction with the services they received from Shasta County HHSA. The survey is a tool to gather feedback from anyone who received services within the last 6 months (or based on the services they have received so far). The survey is voluntary and has a low response rate. The aggregated responses for FY 21/22 are shown below along with the corresponding survey questions and categories to indicate overall client satisfaction.

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
1. I like the services that I received here.	45%	36%	9%	0%	0%	9%
2. If I had other choices, I would still get services from this agency.	36%	27%	18%	0%	9%	9%
3. I would recommend this agency to a friend or family member.	45%	18%	18%	0%	9%	9%
4. The location of services was convenient (parking, public transportation, distance, etc.).	45%	27%	18%	0%	0%	9%
5. Staff were willing to see me as often as I felt it was necessary.	64%	9%	9%	18%	0%	0%
6. Staff returned my calls within 24 hours.	73%	18%	0%	0%	0%	9%
7. Services were available at times that were good for me.	55%	27%	18%	0%	0%	0%
8. I was able to get all the services I thought I needed.	27%	45%	27%	0%	0%	0%
9. I was able to see a psychiatrist when I wanted to.	27%	45%	27%	0%	0%	0%
10. Staff here believe that I can grow, change and recover.	73%	9%	18%	0%	0%	0%
11. I felt comfortable asking questions about my treatment and medication.	50%	30%	20%	0%	0%	0%
12. I felt free to complain.	36%	36%	9%	18%	0%	0%
13. I was given information about my rights.	50%	20%	20%	0%	10%	0%
14. Staff encouraged me to take responsibility for how I live my life.	36%	45%	9%	0%	9%	0%
15. Staff told me what side effects to watch out for.	36%	45%	18%	0%	0%	0%
16. Staff respected my wishes about who is, and who is not to be given information about my treatment.	45%	27%	18%	0%	0%	9%
17. I, not staff, decided my treatment goals.	55%	9%	27%	0%	0%	9%
18. Staff were sensitive to my cultural background (race, religion, language, etc.).	45%	27%	18%	0%	0%	9%
19. Staff helped me obtain the information I needed so that I could take charge of managing my illness.	36%	36%	9%	9%	0%	9%
20. I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	27%	55%	9%	0%	0%	9%
As a direct result of the services I received:	**Strongly Agree**	**Agree**	**I am Neutral**	**Disagree**	**Strongly Disagree**	**Not Applicable**
21. I deal more effectively with daily problems.	27%	45%	18%	0%	0%	9%
22. I am better able to control my life.	45%	27%	9%	0%	9%	9%

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As a direct result of the services I received:	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
23. I am better able to deal with crisis.	36%	45%	9%	0%	0%	9%
24. I am getting along better with my family.	45%	18%	9%	18%	0%	9%
25. I do better in social situations.	36%	36%	18%	0%	0%	9%
26. I do better in school and /or work.	30%	30%	20%	10%	0%	10%
27. My housing situation has improved.	40%	10%	40%	0%	0%	10%
28. My symptoms are not bothering me as much.	27%	36%	18%	0%	9%	9%
29. I do things that are more meaningful to me.	27%	27%	36%	0%	0%	9%
30. I am better able to take care of my needs.	27%	36%	18%	0%	9%	9%
31. I am better able to handle things when they go wrong.	36%	27%	27%	0%	0%	9%
32. I am better able to do things that I want to do.	36%	36%	9%	9%	0%	9%

For Questions #33-36, please answer for relationships with persons other than your mental health provider(s).

As a direct result of the services I received:	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
33. I am happy with the friendships I have.	36%	18%	36%	0%	0%	9%
34. I have people with whom I can do enjoyable things.	27%	55%	9%	0%	0%	9%
35. I feel I belong in my community.	36%	18%	36%	0%	0%	9%
36. In a crisis, I would have the support I need from family or friends.	27%	45%	18%	0%	0%	9%

Shasta County Health & Human Services Agency

Wellness Center Summary Report

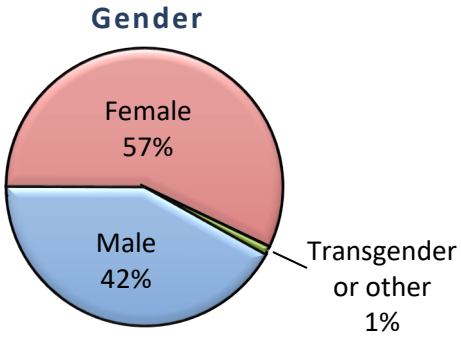
July 2021 – June 2022

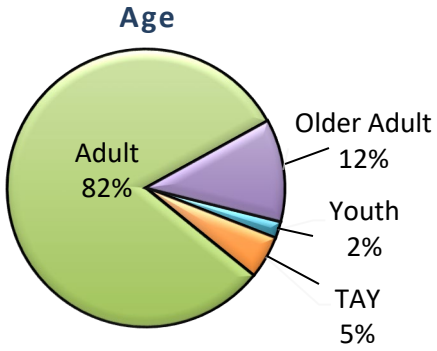
This report provides quarterly data collected from two wellness centers in Shasta County: Sunrise Mountain Wellness Center in Redding and Circle of Friends in Burney. Wellness centers provide support to anyone with mental health challenges through facilitated discussions and activities, transportation to community events, workshops, education, referrals to resources, and fellowship. Wellness center operations are funded by the Mental Health Services Act (Proposition 63).

Sunrise Mountain Wellness Center and Circle of Friends are both on a quarterly reporting cycle. Data from both Wellness Centers will be combined for the first section of this report. In the next section, both wellness centers will be reported on individually.

Combined wellness center demographics

Approximately 42% of wellness center attendees were male and 57% female. 1% reported as transgender or other.

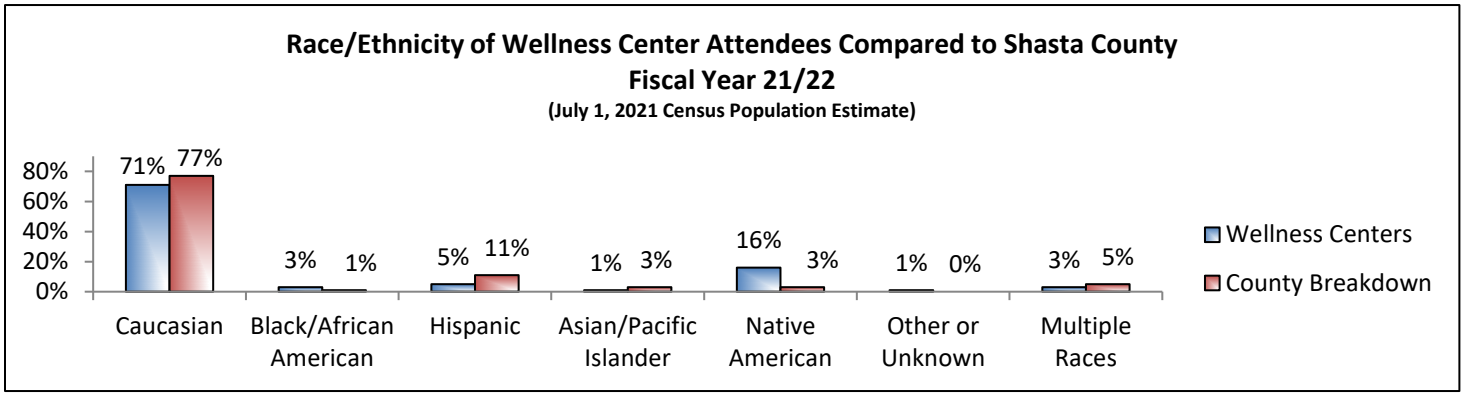




Approximately 2% of wellness center attendees were Youths (0-15 years of age), 5% were Transitional Age Youths (16-25 years of age), 82% were Adults (26-59 years of age), 12% were Older Adults (60+ years of age), and none were of unknown age.

Approximately 95% of wellness center attendees were consumers and 5% were family members of consumers.

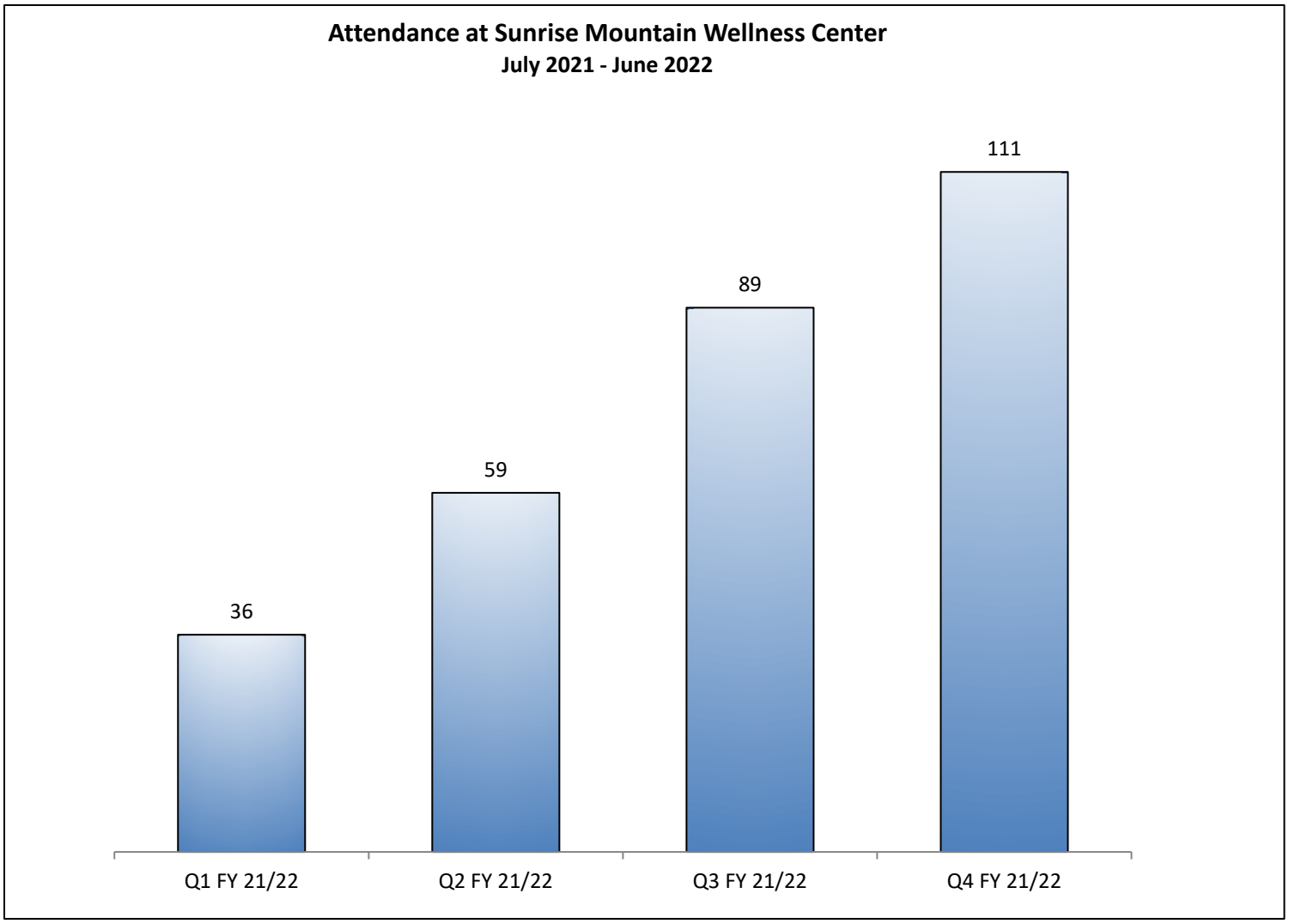
Caucasian, Hispanic, Asian/Pacific Islander, and Multiple Races were under-represented while Native American, Black/African American, and Other or Unknown were over-represented.



Overall, a total of 2,144 individual workshops, groups, activities, and 12-step recovery meetings were held during this twelve-month period.

Sunrise Mountain Wellness Center

Attendance
An average of 74 unduplicated participants attended Sunrise Mountain Wellness Center each quarter.



Demographics
On average, 100% of attendees were consumers. On average, 76% 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.

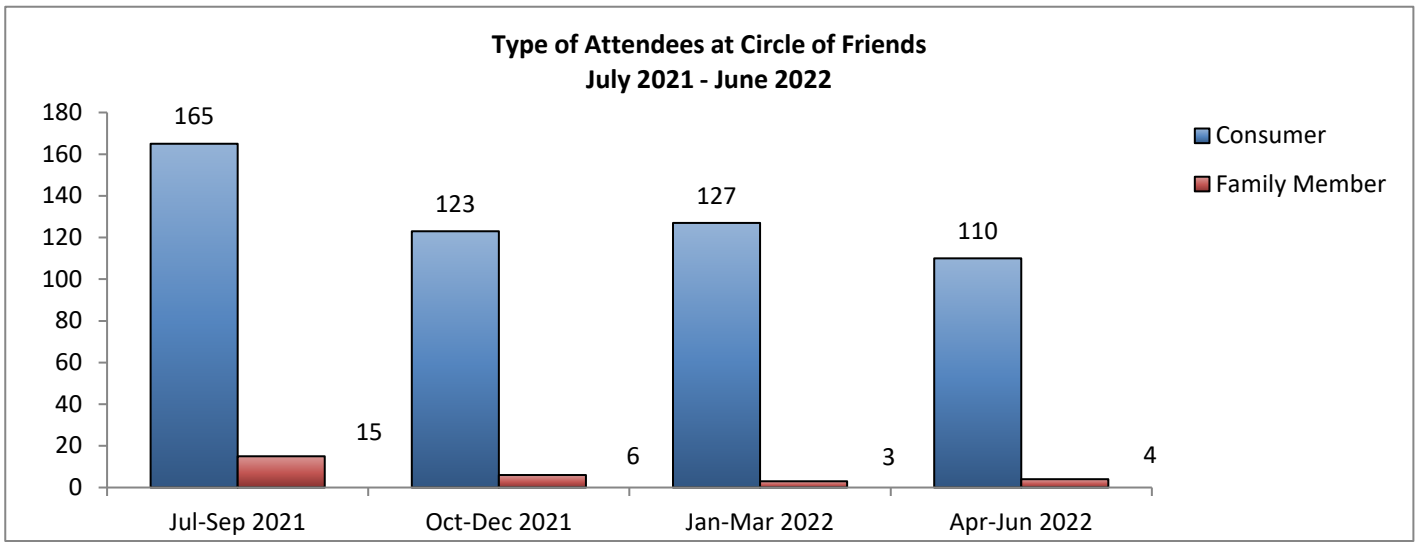
Services Provided
Sunrise Mountain Wellness Center's operating hours are 8:00am to 4:30pm Monday - Friday. From Q1 through Q4, there were 1,547 individual activities and groups available for participants.

Attendee Direction
Sunrise Mountain Wellness Center had weekly center advisory meetings (open to consumers and family members) to contribute to the direction and planning of the program. From Q1 through Q4, they had an average of 15 participants per meeting.

Circle of Friends

Attendance

Attendance decreased 6% from the previous twelve-month period, with an average of 138 unduplicated people attending Circle of Friends each quarter.



Demographics

Ninety-five percent of attendees were consumers and 5% were family members. Seventy-five percent of staff and 100% 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.

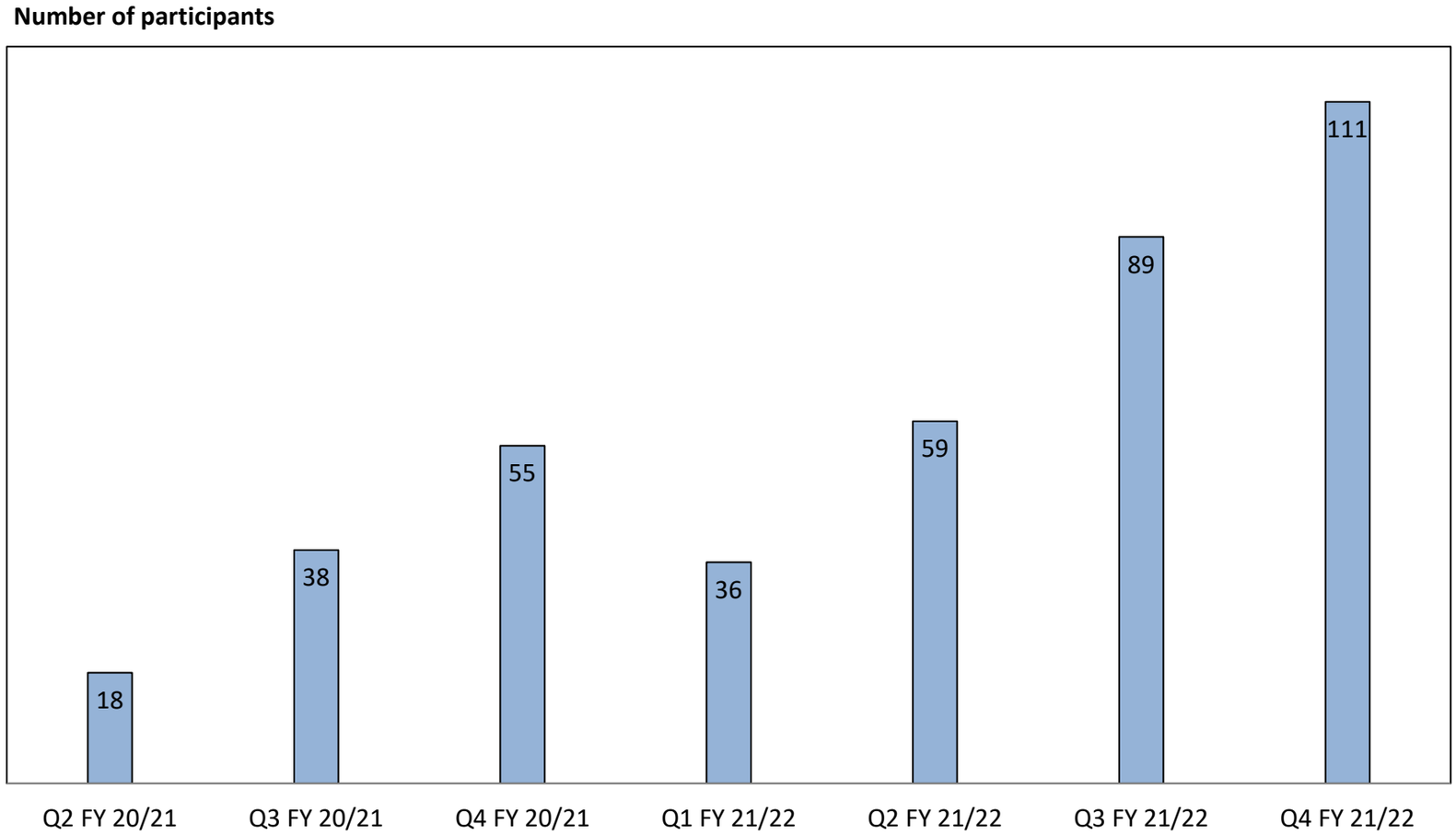
Services Provided

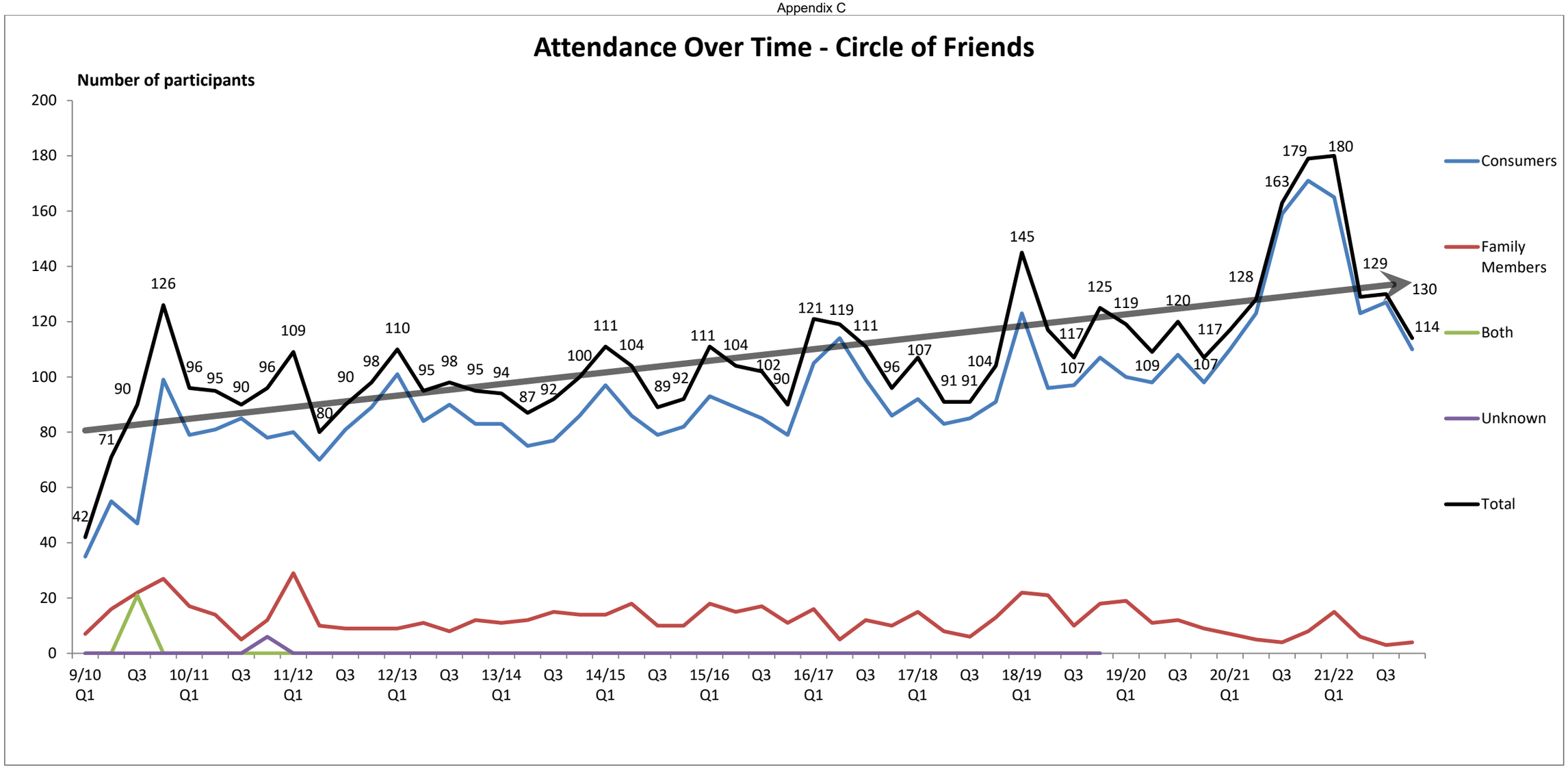
Circle of Friends Wellness Center was open for participant activities Monday, Wednesday, and Friday from 12:30 to 3:30. They are open for food and clothing distribution Monday through Friday from 8:00 to 4:30. During those hours they were available to address most concerns and requests that came their way; everything from using the phone or Wi-Fi, to managing homelessness. Showers were available Tuesdays and Thursdays as staffing was available. 225 different activities provided 597 individual activities/groups for participants during this twelve-month period.

Attendee Direction

An average of 20 attendees (15%) contributed to the planning and direction of the program each quarter. All decisions relating to the center were based on participant input through activity-specific planning meetings.

Attendance Over Time - Sunrise Mountain Wellness Center




Attendance Over Time - Circle of Friends
Number of participants
200
180
160
140
120
100
80
60
40
20
0
9/10 Q1
Q3
10/11 Q1
Q3
11/12 Q1
Q3
12/13 Q1
Q3
13/14 Q1
Q3
14/15 Q1
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20/21 Q1
Q3
21/22 Q1
Q3
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 91 104 145 107 117 125 119 109 120 107 117 128 163 179 180 129 130 114
Consumers
Family Members
Both
Unknown
Total

Shasta County Health & Human Services Agency

NAMI Summary Report

July 2021 through June 2022

Program Offerings

NAMI Shasta County offered Family to Family Support Group sessions and one-on-one mentoring sessions during Fiscal Year 21/22. The Family Support Group met every two weeks. Local NAMI president Susan Power, along with several volunteers, assisted with the one-on-one mentoring sessions. NAMI volunteers ran the family support group sessions. The average number of hours volunteers spent on mentoring sessions at the NAMI Office and/or by telephone each week was 2.75.

Location of Family Support Group Session	Date of Session	Length	Number of Attendees
CARE Center/Online hybrid	07/06/2021	2 hours	10
CARE Center/Online hybrid	07/20/2021	2 hours	8
CARE Center/Online hybrid	08/03/2021	2 hours	9
CARE Center/Online hybrid	08/17/2021	2 hours	9
CARE Center/Online hybrid	09/07/2021	2 hours	7
CARE Center/Online hybrid	09/21/2021	2 hours	10
CARE Center/Online hybrid	10/05/2021	2 hours	5
CARE Center/Online hybrid	10/19/2021	2 hours	8
CARE Center/Online hybrid	11/02/2021	2 hours	12
CARE Center/Online hybrid	11/19/2021	2 hours	12
CARE Center/Online hybrid	12/07/2021	2 hours	9
CARE Center/Online hybrid	12/21/2021	2 hours	8
CARE Center/Online hybrid	01/04/2022	2 hours	6
CARE Center/Online hybrid	01/18/2022	2 hours	4
CARE Center/Online hybrid	02/15/2022	2 hours	13
CARE Center/Online hybrid	03/01/2022	2 hours	12
CARE Center/Online hybrid	03/15/2022	2 hours	11
CARE Center/Online hybrid	04/05/2022	2 hours	10
CARE Center/Online hybrid	04/19/2022	2 hours	8
CARE Center/Online hybrid	05/03/2022	2 hours	7
CARE Center/Online hybrid	05/17/2022	2 hours	9
CARE Center/Online hybrid	06/07/2022	2 hours	9
CARE Center/Online hybrid	06/21/2022	2 hours	5

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

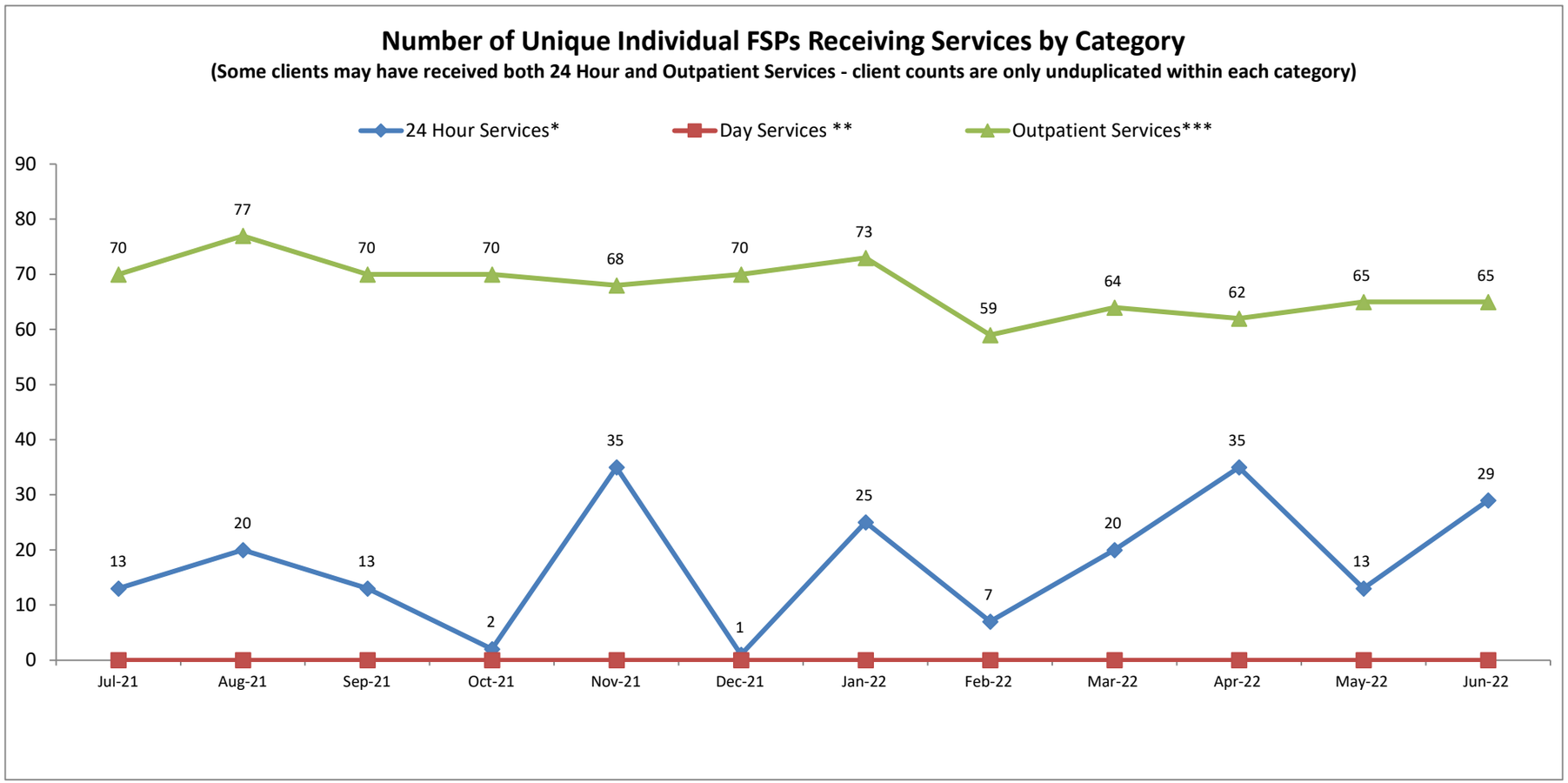
Successes: Family Support Group meetings were held online and in-person. NAMI's annual Christmas Party included gift bag giveaways to local supported housing facilities in lieu of an actual party due to Covid concerns. About 150 bags were distributed. NAMI members were active attendees at meetings for Stand Against Stigma, MHADAB, and The Woodlands (assisted housing).

Barriers: The NAMI office is still being used on a limited basis. NAMI reported that members do not feel comfortable enough using the office regularly since it is shared with Hill Country Community Engagement Program's staff and their occasional clients. The office phone's outgoing message still requests the person to call and leave a message on the

home landline of Susan Power. Few people are calling the alternate number as instructed. Many NAMI members, including Susan Power, are in a Covid-19 At-Risk group and stay home to avoid any gatherings. Individual call logs were often not completed. Some NAMI class instructors voiced concerns about having in person trainings due to Covid-19. NAMI Leadership had ongoing challenges with family members in crisis and medical issues.

CSI AND FSP LINKED DATA – FISCAL YEAR 2021/2022

As part of the Medi-Cal billing process in the State of California, information from 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 Mental Health Services Act (MHSA) Full Service Partnership (FSP) program, data is collected in the state Data Collection and Reporting (DCR) system. Beginning May 2015, the State of California Mental Health Services Oversight and Accountability Commission (MHSOAC) 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.

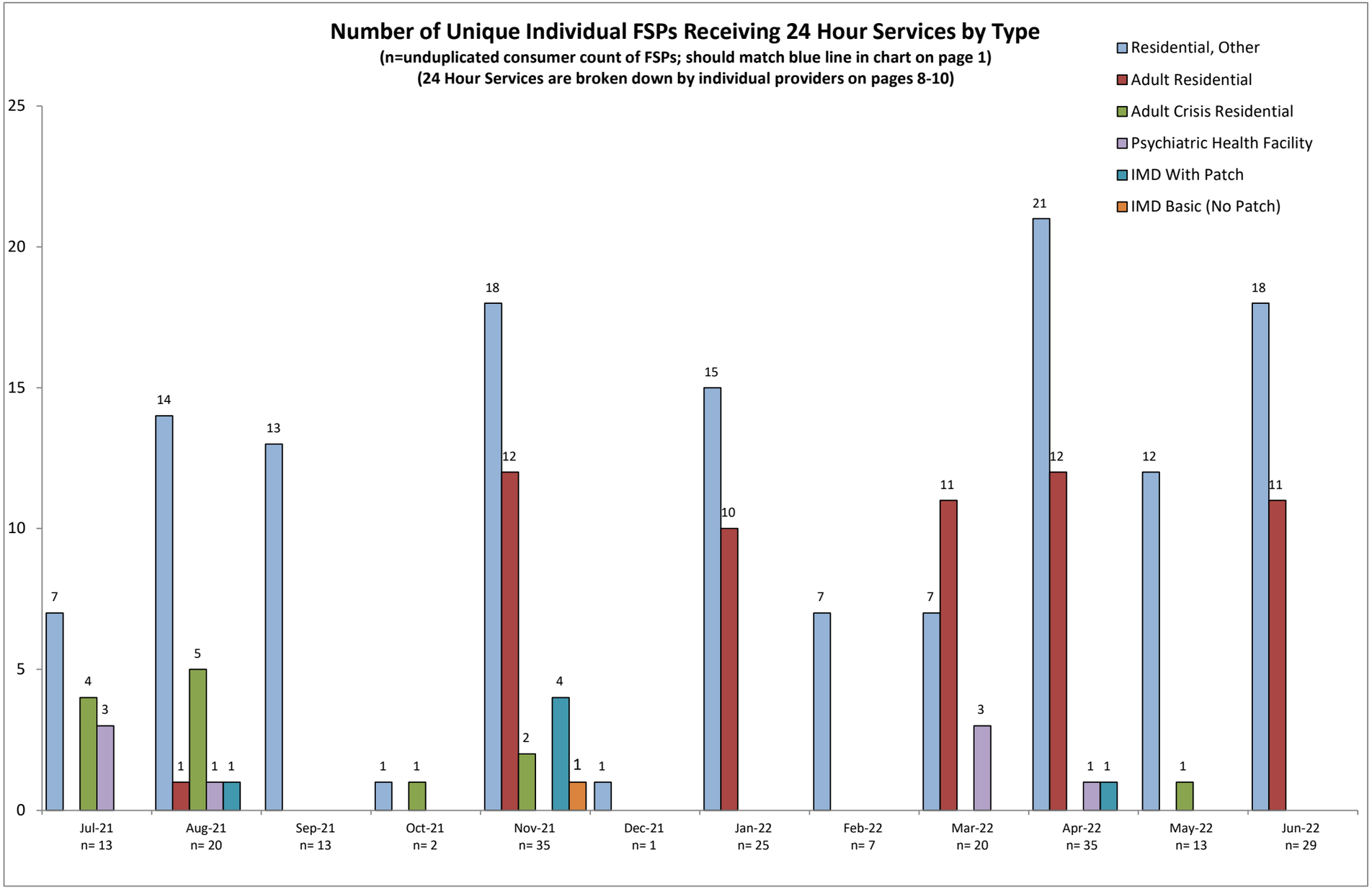


Mental Health Services are divided into three main categories: 24 Hour Services; Day Services; and, Outpatient Services.

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

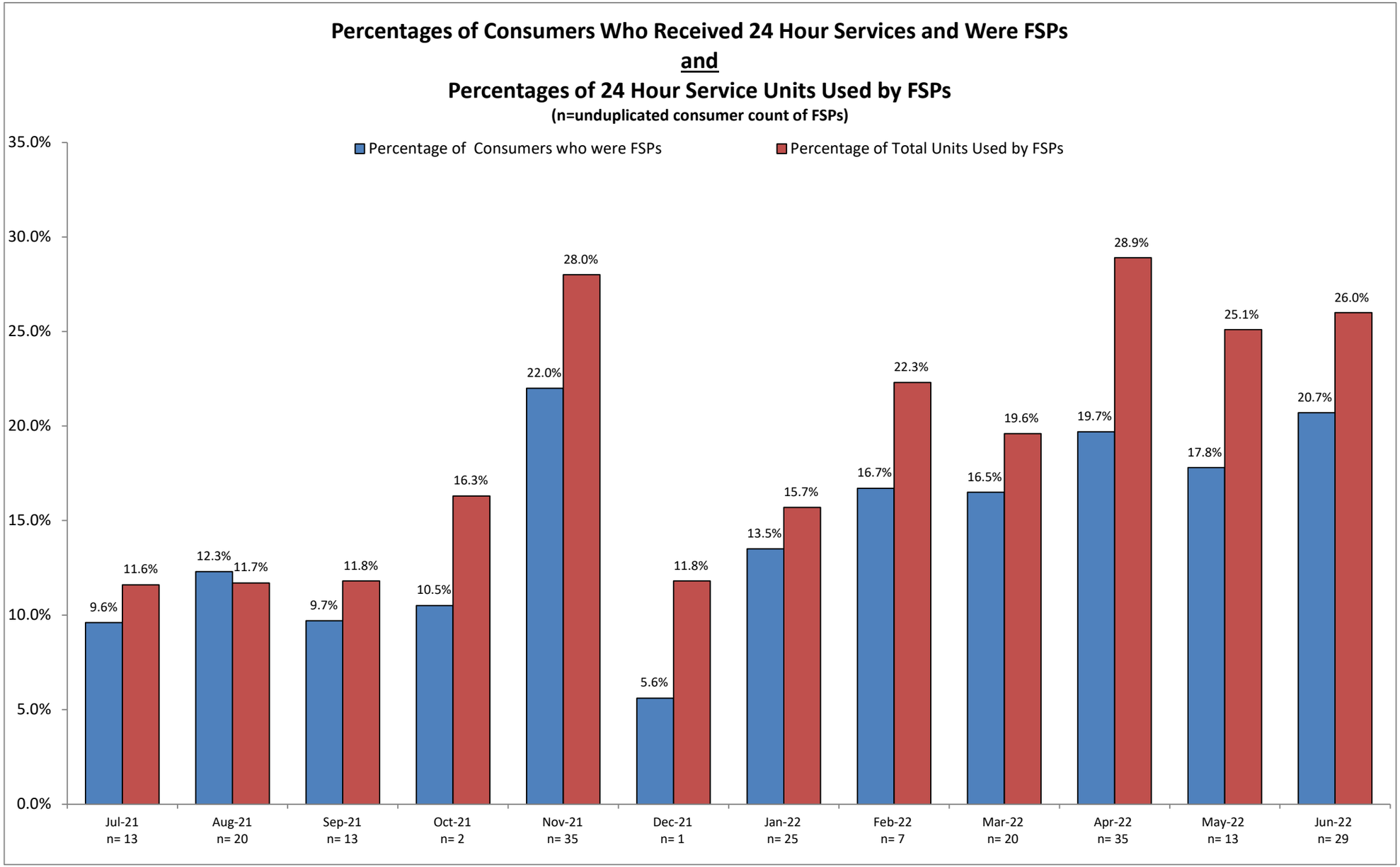
Day Services include things such as Day Treatment or Day Rehabilitation. These services are also billed for by the day, but differ from 24 Hour Services in that they do not provide over-night care.

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



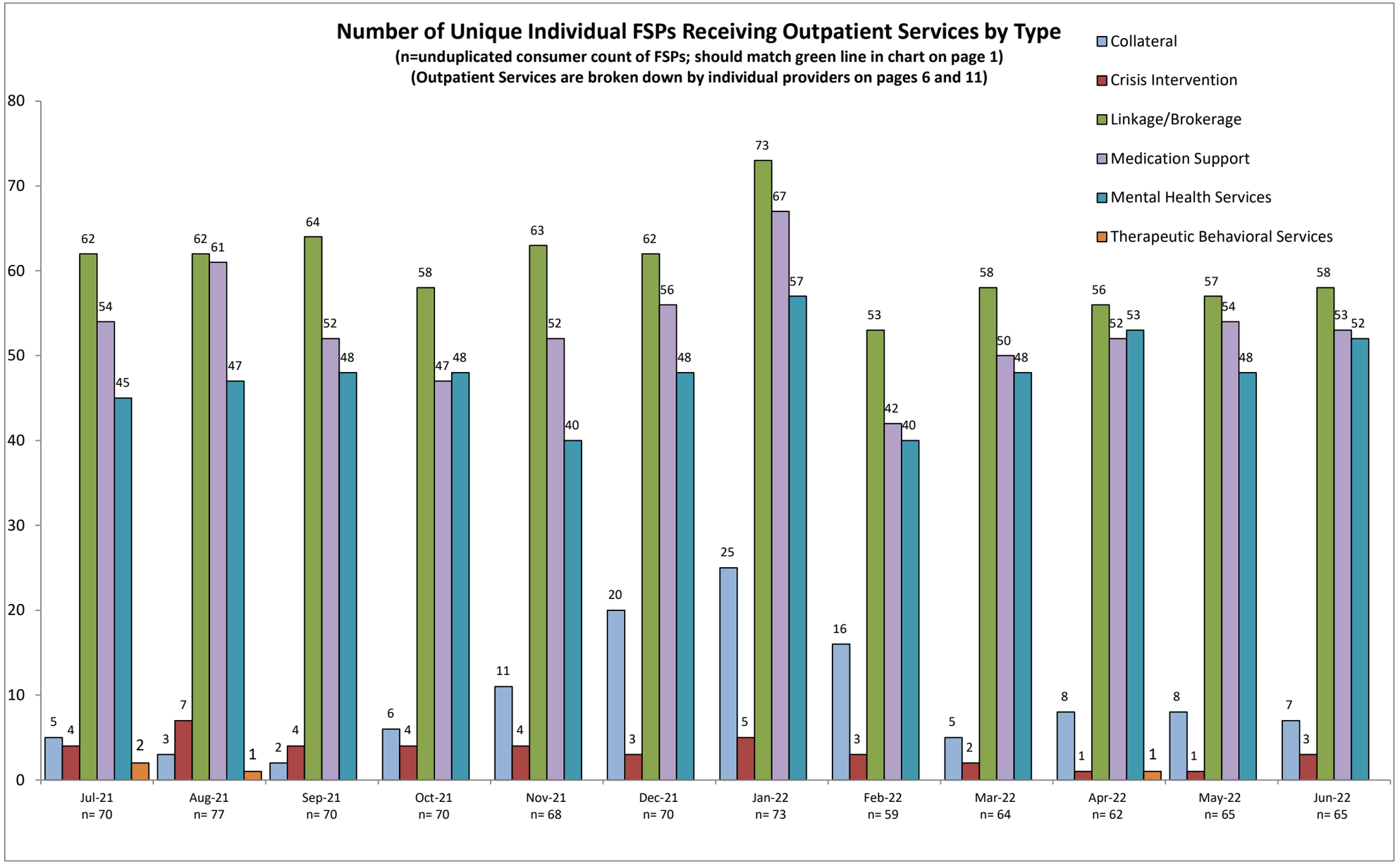
In this chart, the number of unduplicated Full Service Partners that received any type of 24 Hour Service is noted under the month as “n”.

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, receive more than one kind of service in any given month, the combined number for the service types each month may add up to more than the number listed as “n”.



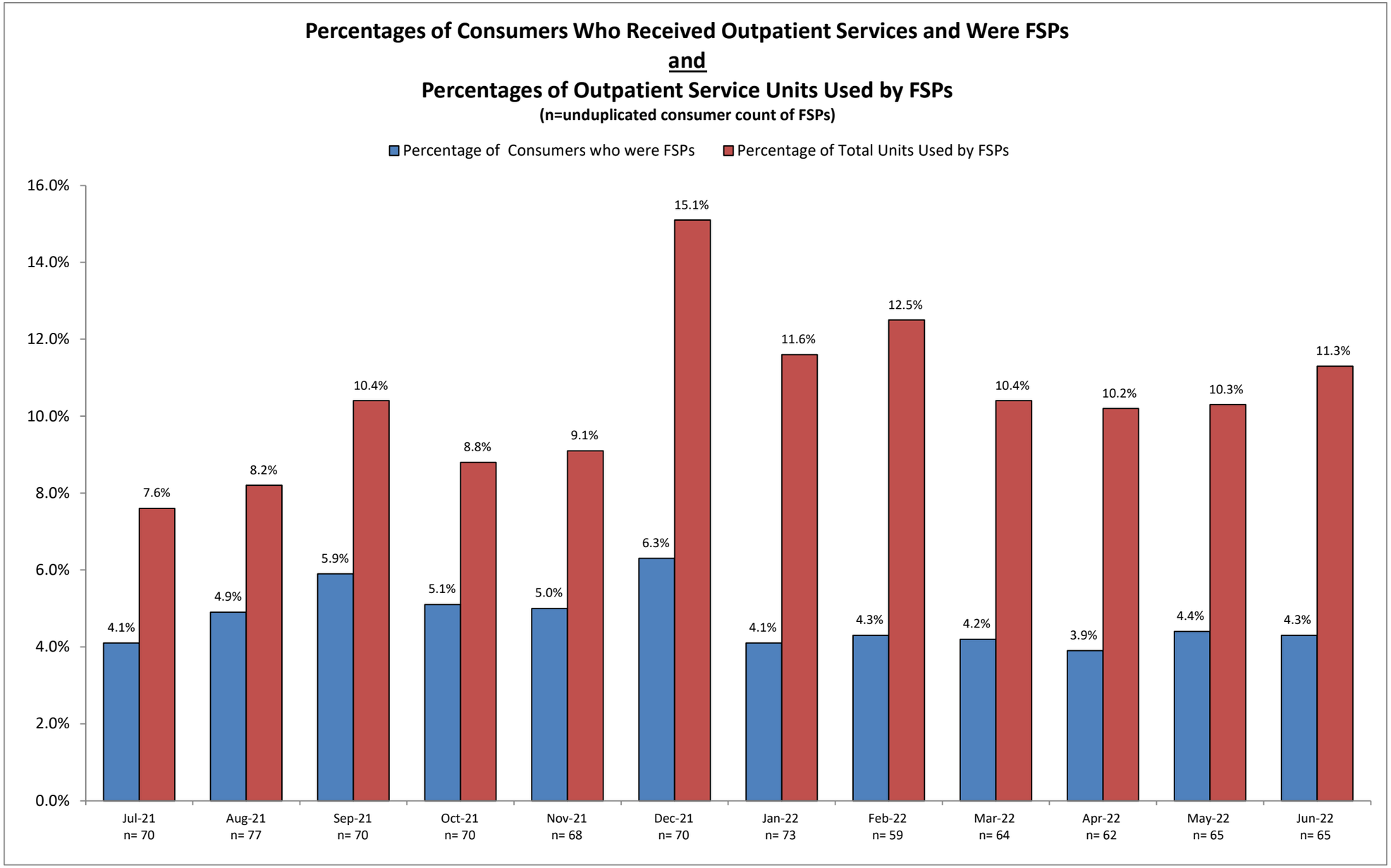
24 Hour Services are billed for by the day. This chart compares, by percentage, how many of the consumers that utilized 24 Hour Services were Full Service Partners, and how many of the days billed for were used by Full Service Partners.

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.



The number of unduplicated Full Service Partners that received any type of Outpatient Service is noted under the month as “n” on this chart.

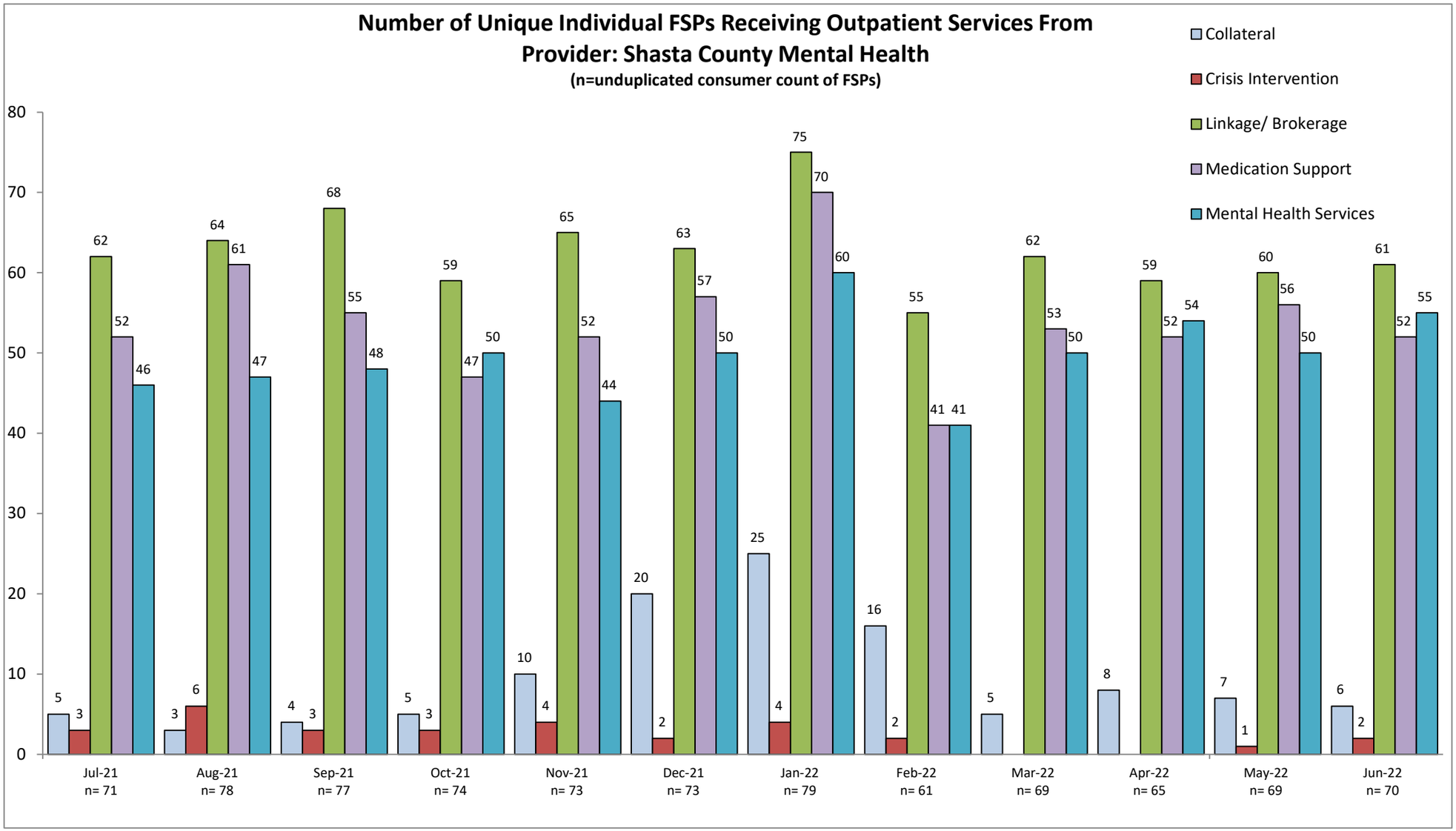
The bars above each month show how many of those unduplicated Full Service Partners received each type of Outpatient Service. Because consumers can, and often do, receive more than one kind of service in any given month, the combined number for the service types each month may add up to more than the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



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

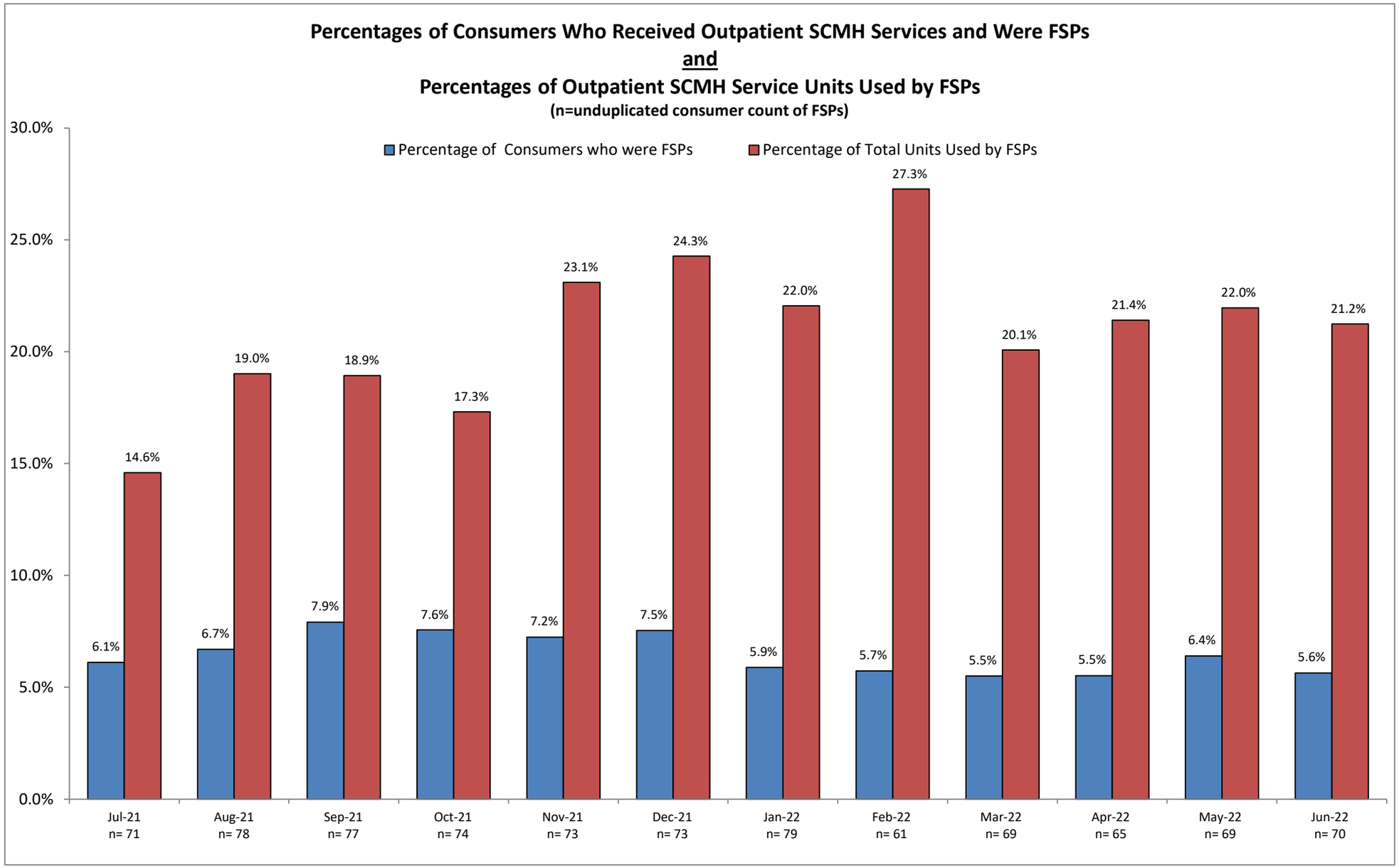
Because the Full Service Partnership program is designed to provide intensive services, it is expected that partners may utilize disproportionately more of the services than non-partner consumers.

***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.**



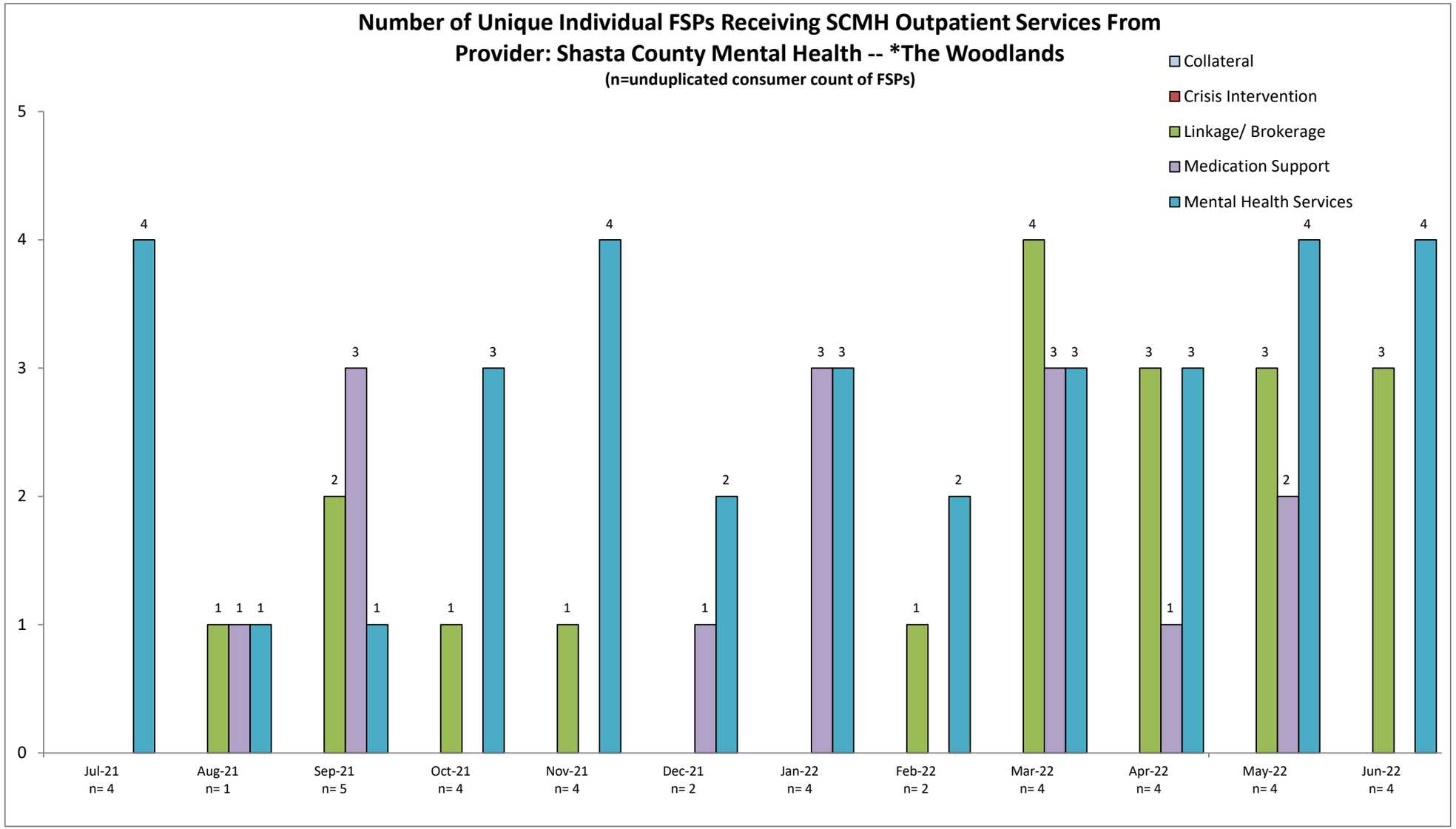
In this chart, the number of unduplicated Full Service Partners who received any type of Outpatient Service from SCMH is noted under the month as “n”.

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



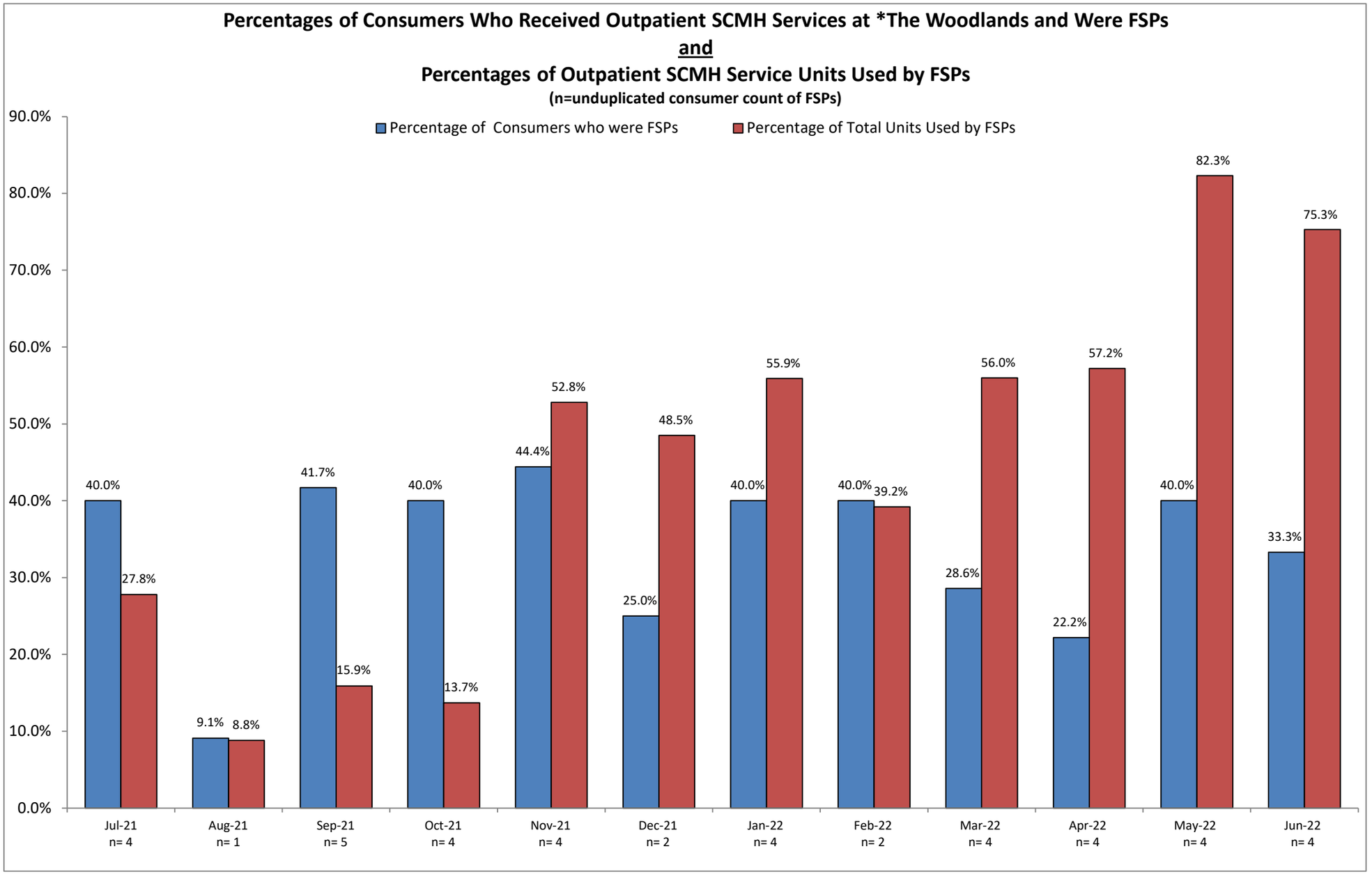
This chart compares, by percentage, how many of the consumers that utilized Outpatient Services were Full Service Partners, and how many of the minutes billed for were used by Full Service Partners.

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



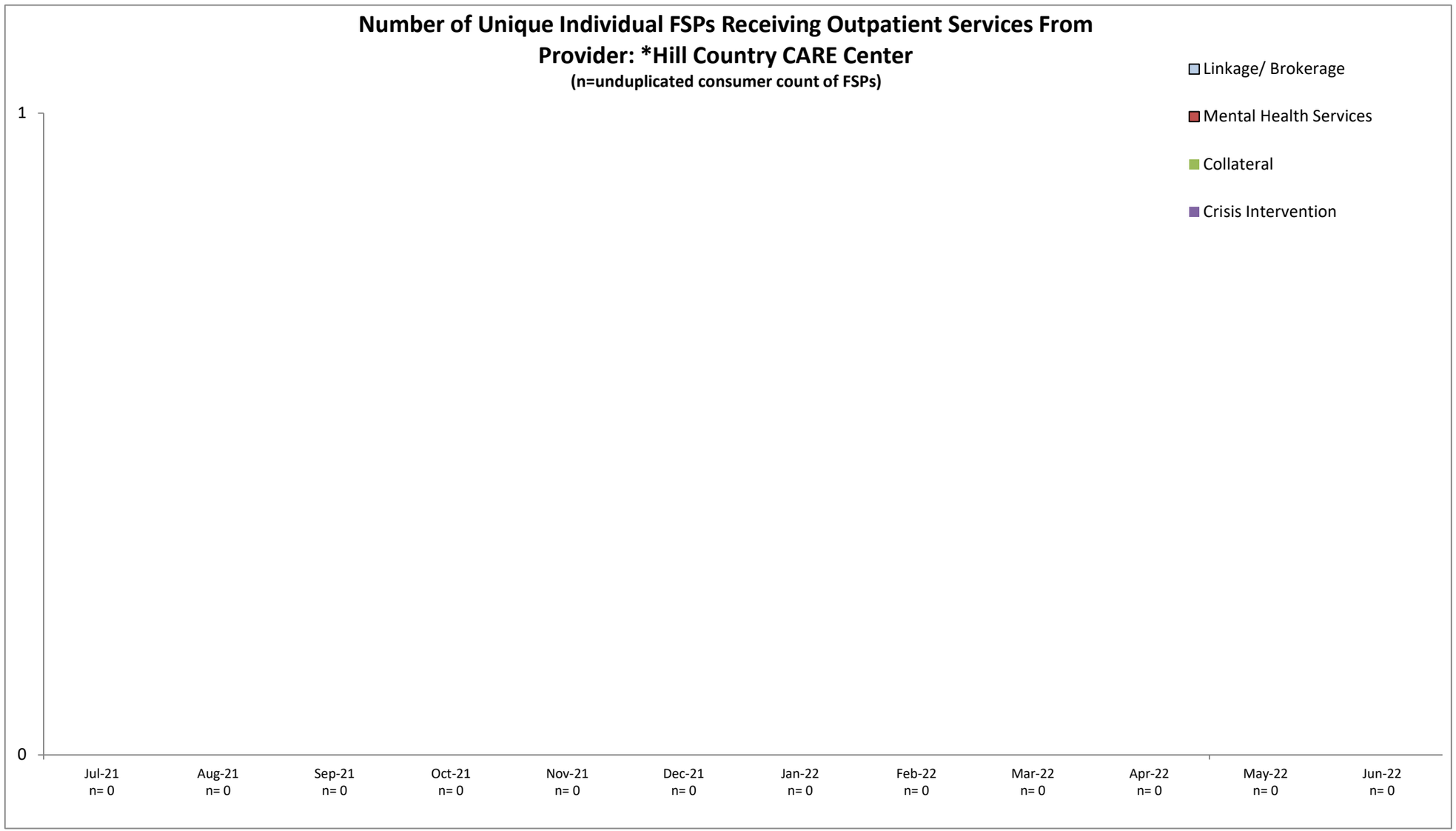
In this chart, the number of unduplicated Full Service Partners that received any type of Outpatient Service at The Woodlands Housing Project from SCMH is noted under the month as “n”.

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



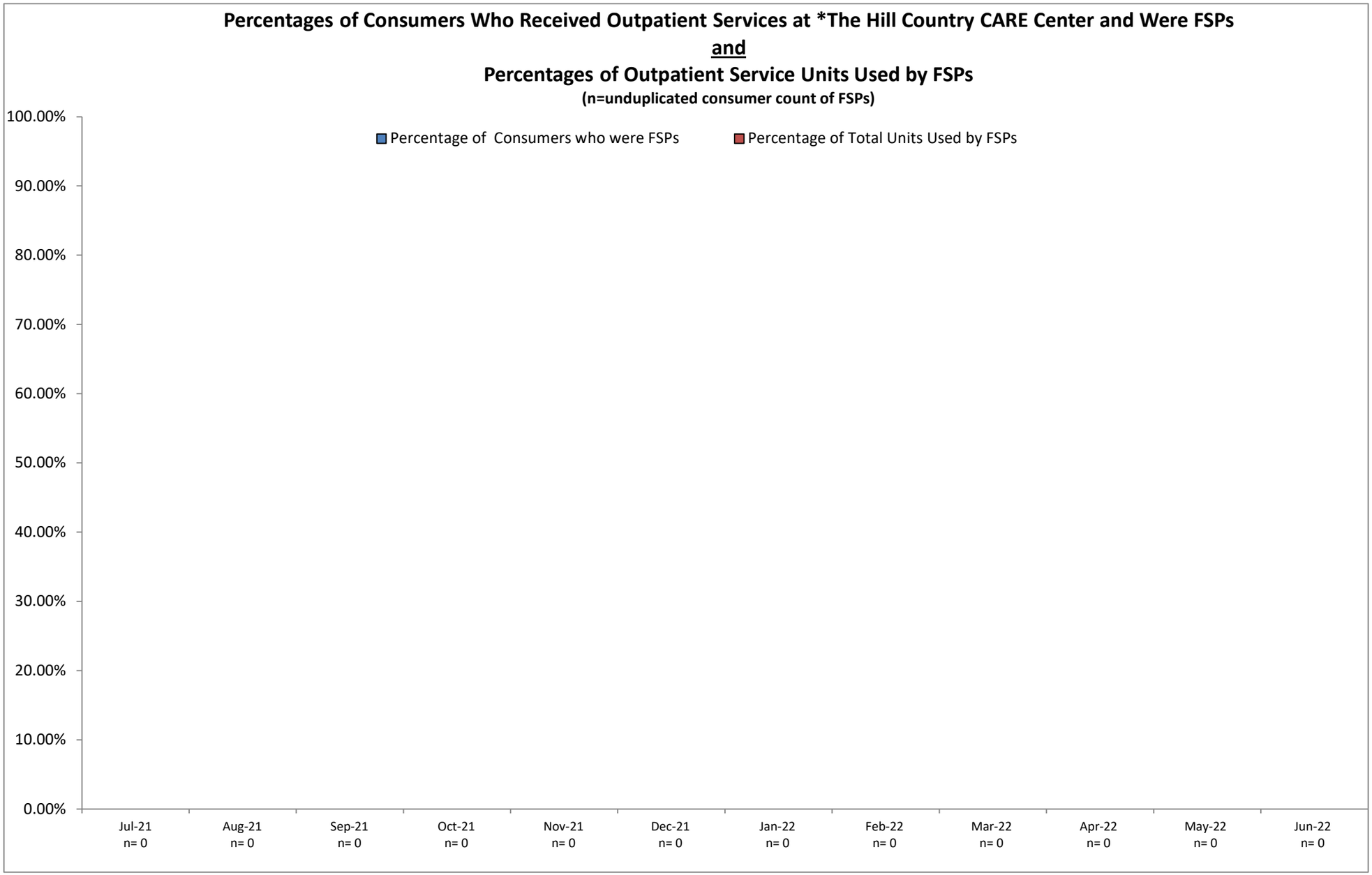
This chart compares, by percentage, how many of the consumers that utilized Outpatient Services at The Woodlands Housing Project were Full Service Partners, and how many of the minutes billed for were used by Full Service Partners.

Because the Full Service Partnership program is designed to provide intensive services, and 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.



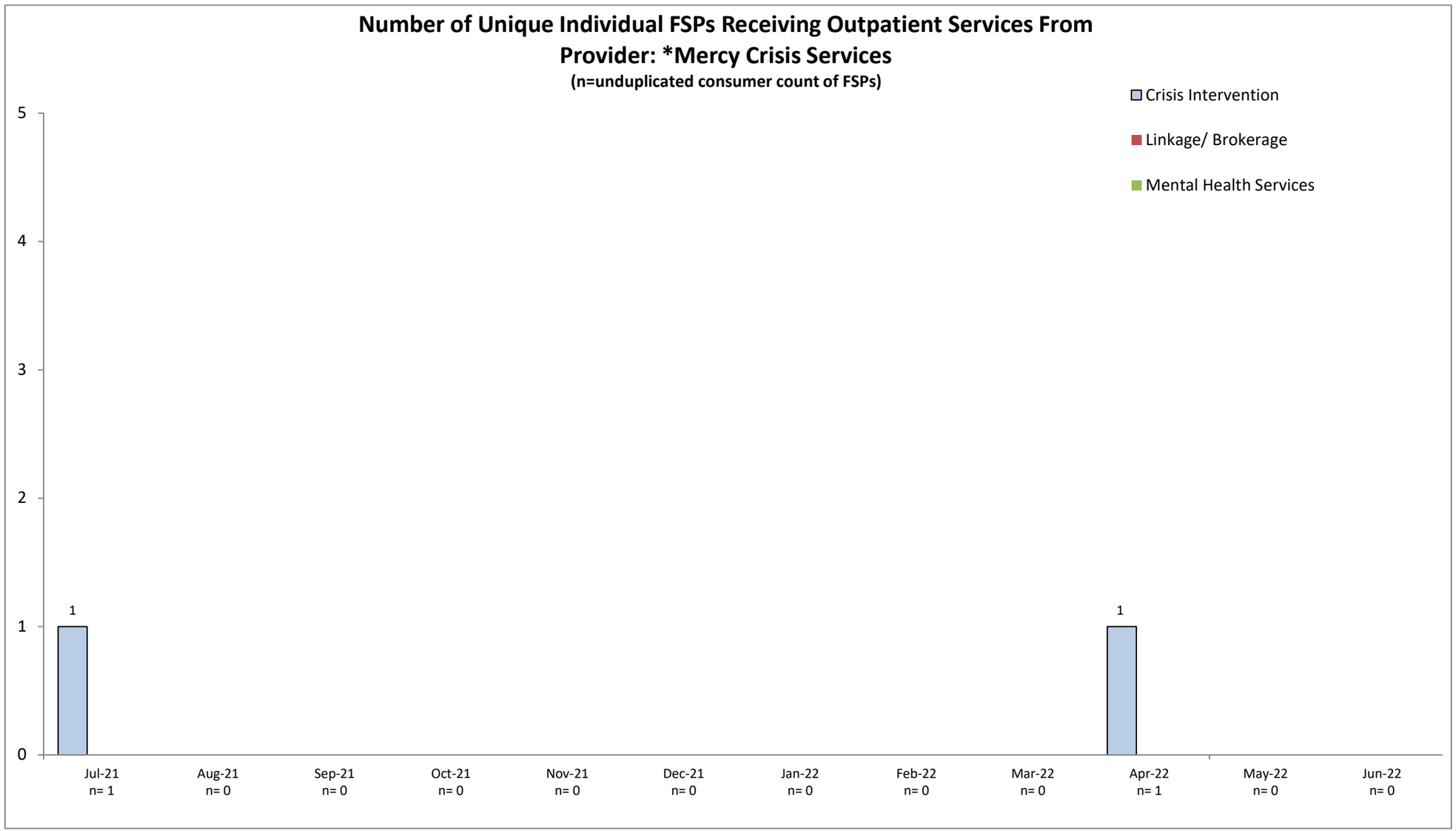
In this chart, the number of unduplicated Full Service Partners that received any type of Outpatient Services at the Hill Country CARE Center is noted under the month as "n".

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



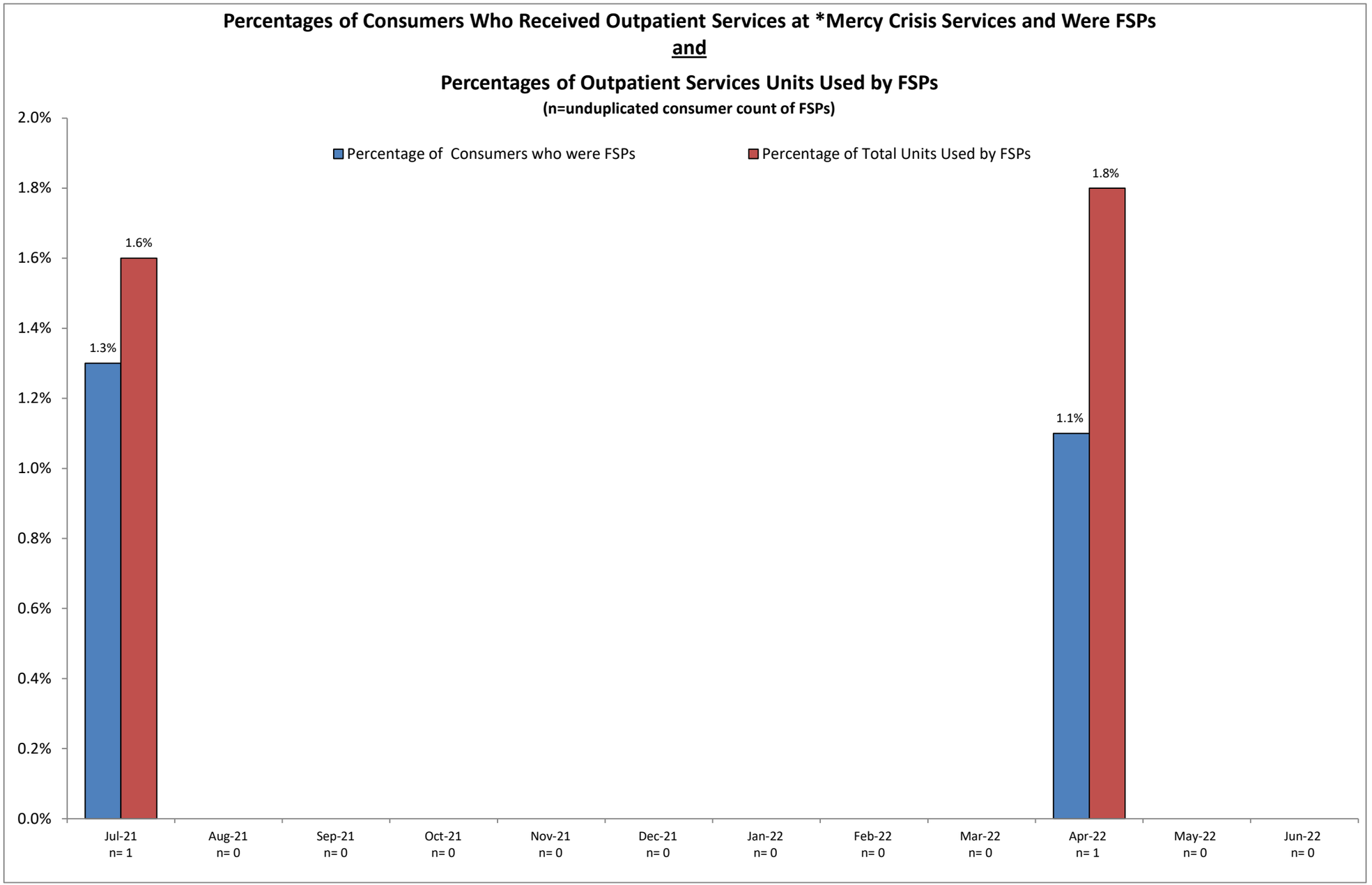
This chart compares, by percentage, how many of the consumers that utilized Outpatient Services at the Hill Country CARE Center were Full Service Partners, and how many of the minutes billed for were used by Full Service Partners.

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



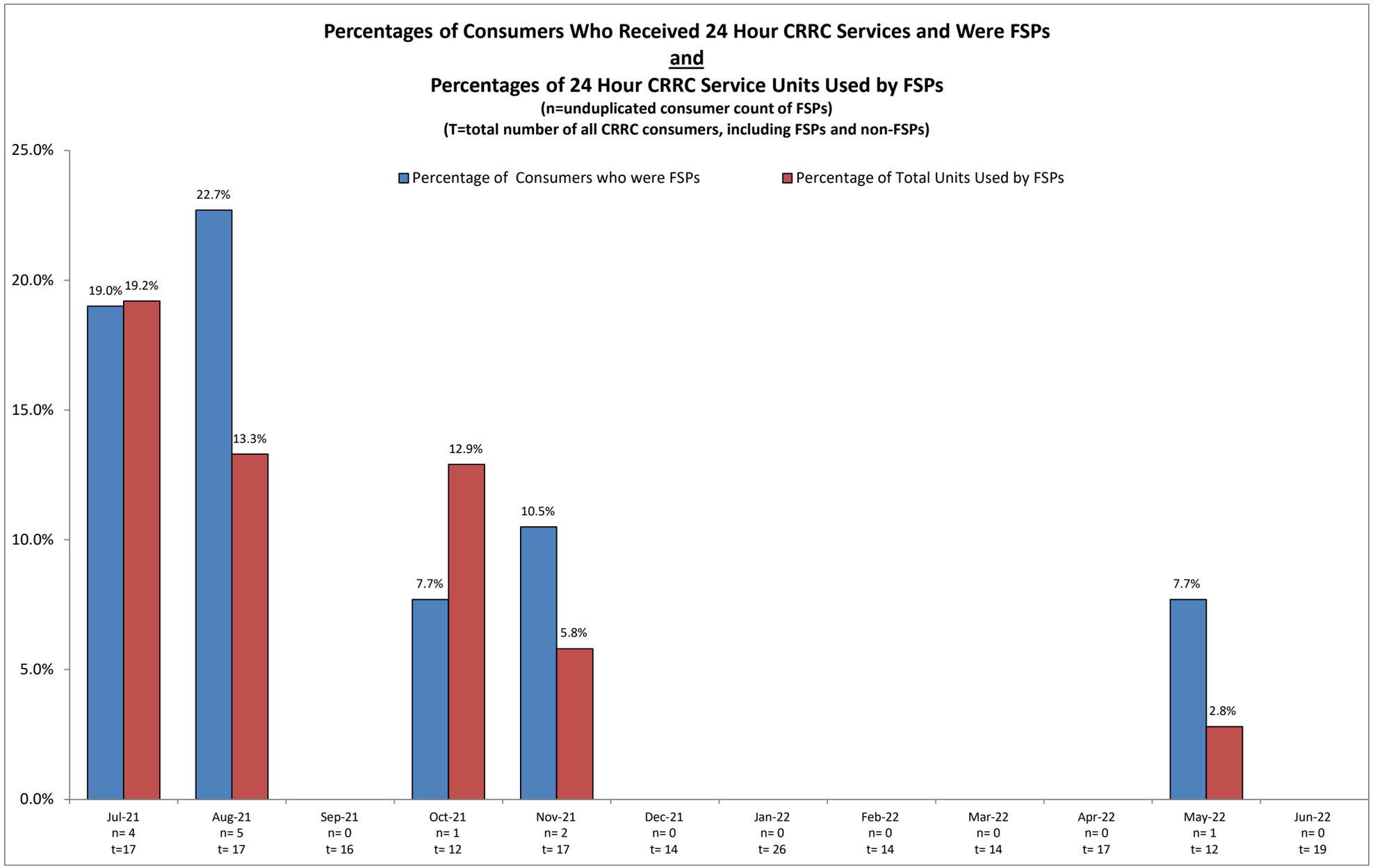
In this chart, the number of unduplicated Full Service Partners that received any type of Outpatient Service at Mercy Crisis Services is noted under the month as “n”.

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



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

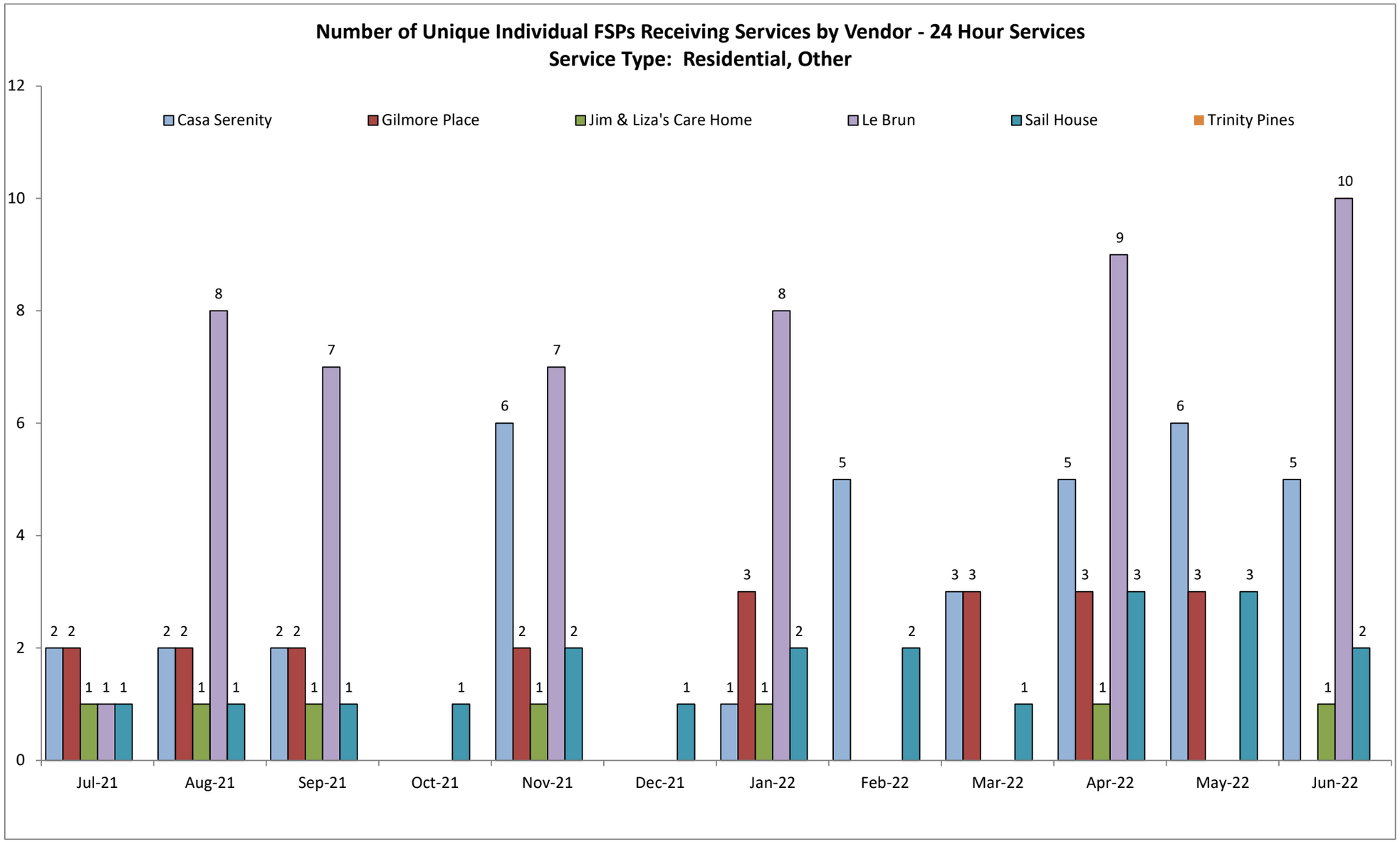
Because the Full Service Partnership program is designed to provide intensive services, and because case management of FSPs is handled by Mercy Crisis Services staff, it is expected that partners may utilize disproportionately more of the services than non-partner consumers.



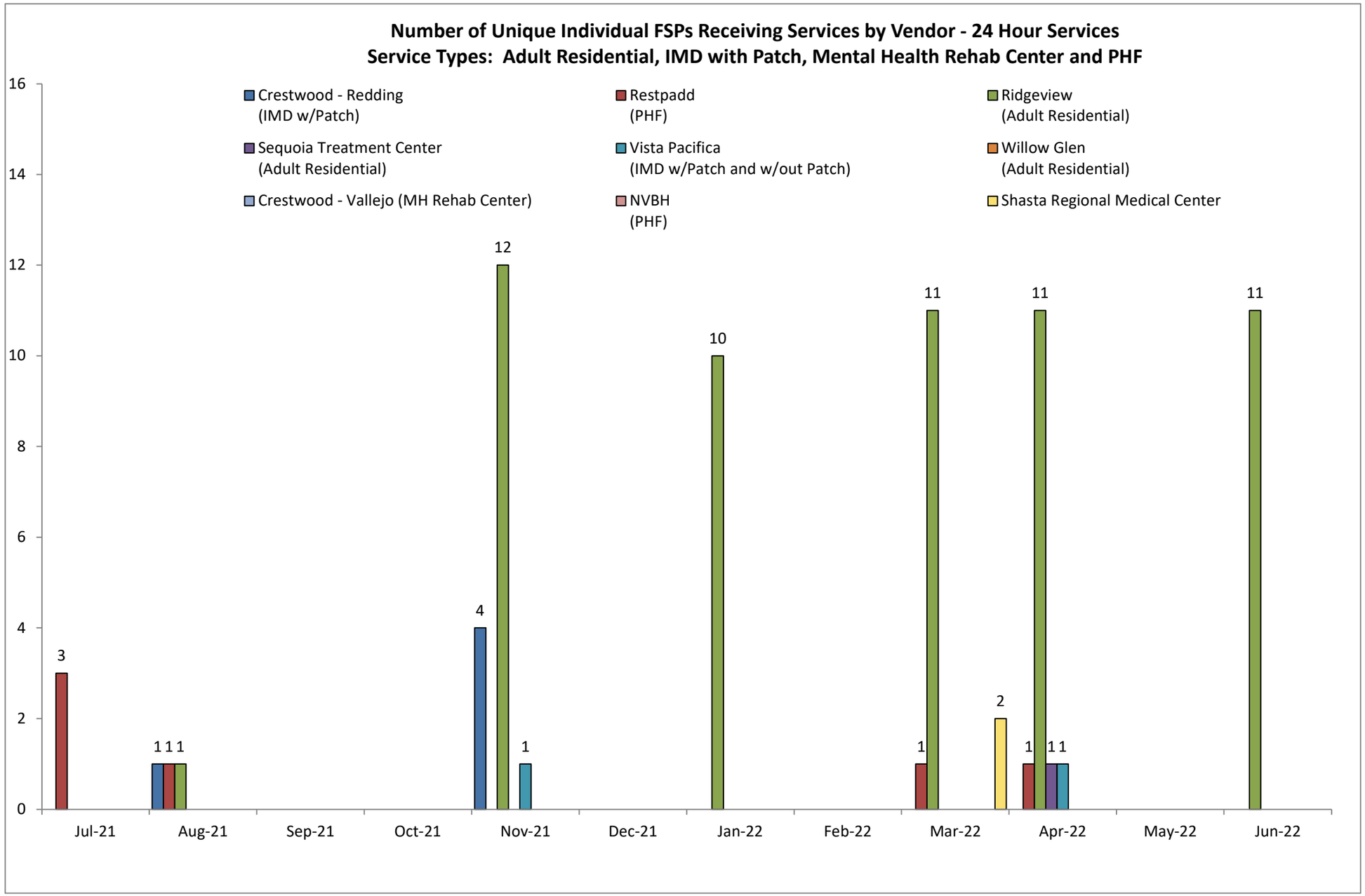
The only 24 Hour Service provided directly by Shasta County Mental Health is the Crisis Residential and Recovery Center (CRRC).

This chart compares, by percentage, how many of the consumers that 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 that 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”.



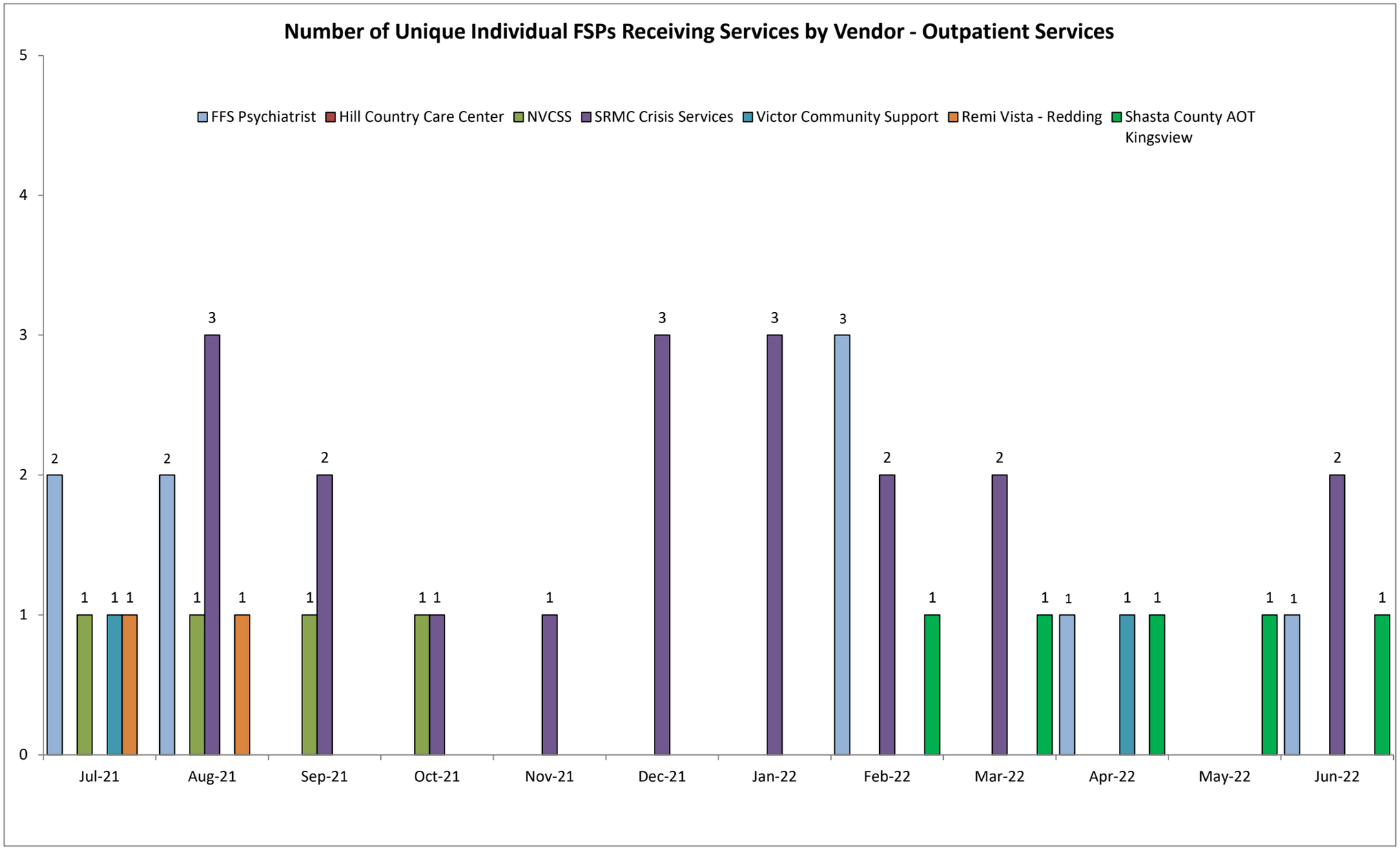
This chart shows the number of unduplicated Full Service Partners each individual vendor providing 24 Hour "Residential-Other" Services reported serving. Vendors provide some level of Board and Care setting. Because partners may have moved from one Board and Care to another in the same month, numbers 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 provide services at a higher level of care than a standard Board and Care facility.

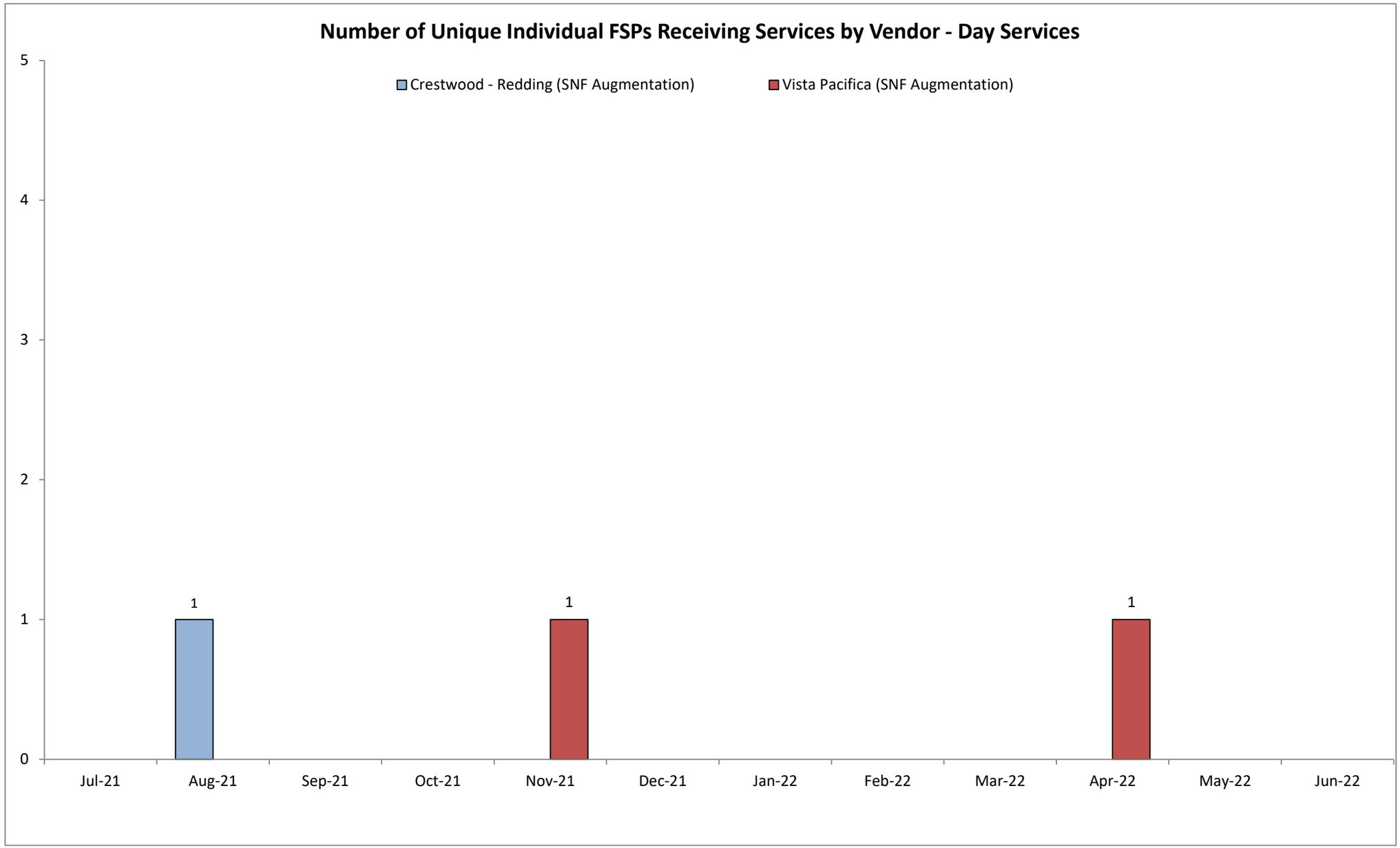
Because partners may have moved from one facility to another in the same month, numbers of partners are only unduplicated by individual vendor.

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.

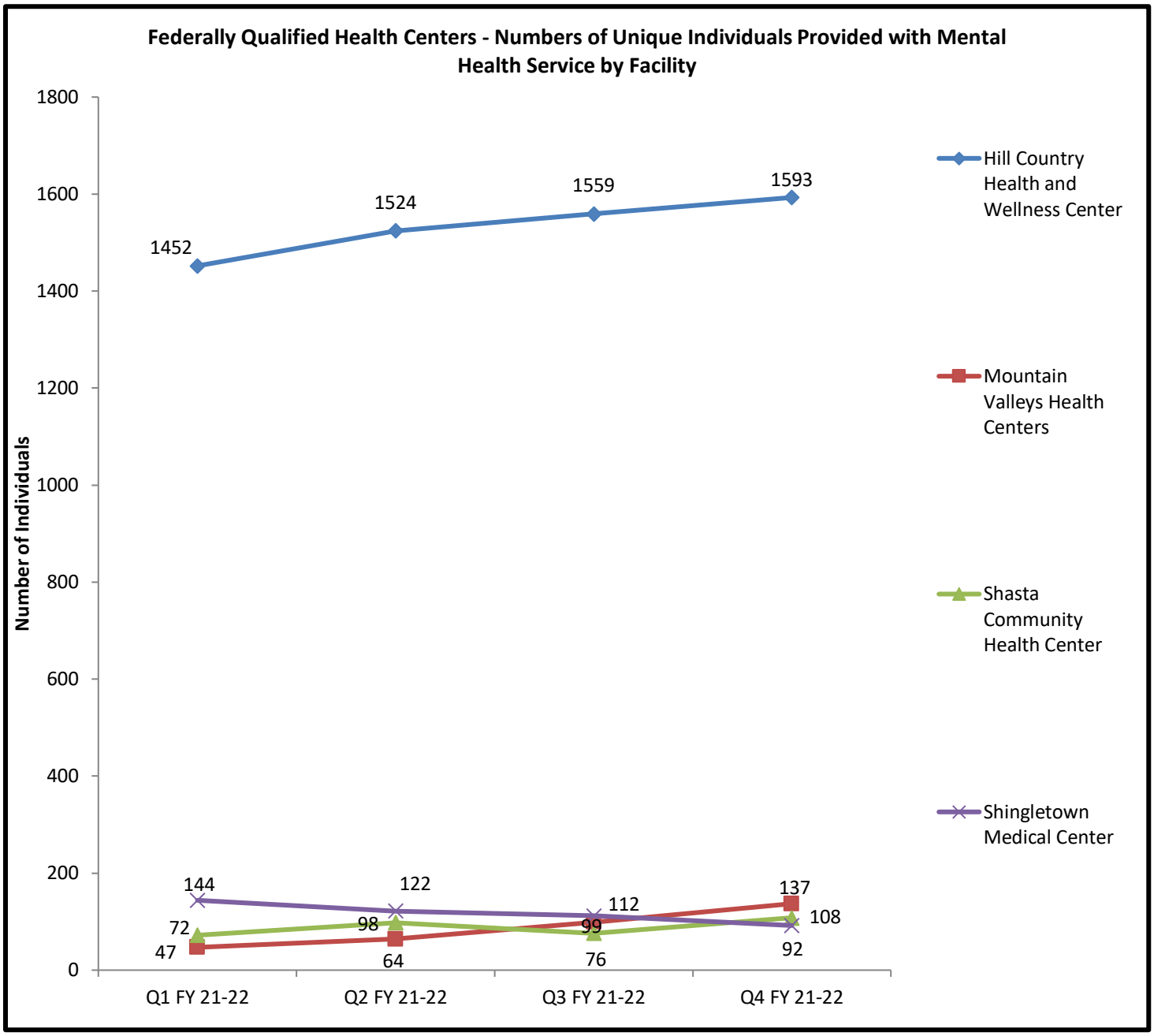
Federally Qualified Health Centers Annual Summary Report

July 2021 through June 2022

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 FQHCs in operation during the 2021-2022 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.

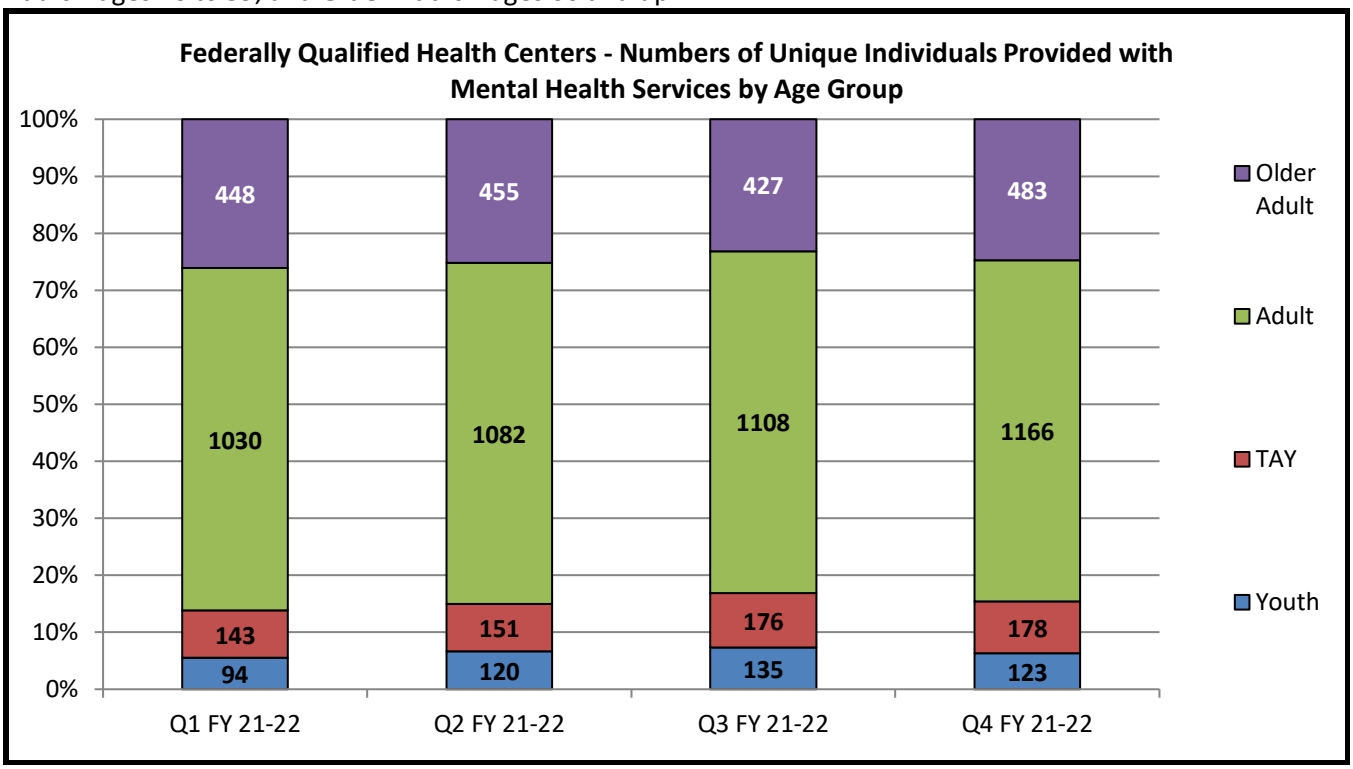
Attendance

An average of 1,825 unique individuals visited a FQHC in each quarter of fiscal year 2021-2022. This is a 15.3% increase compared to the previous fiscal year (1,583 people).

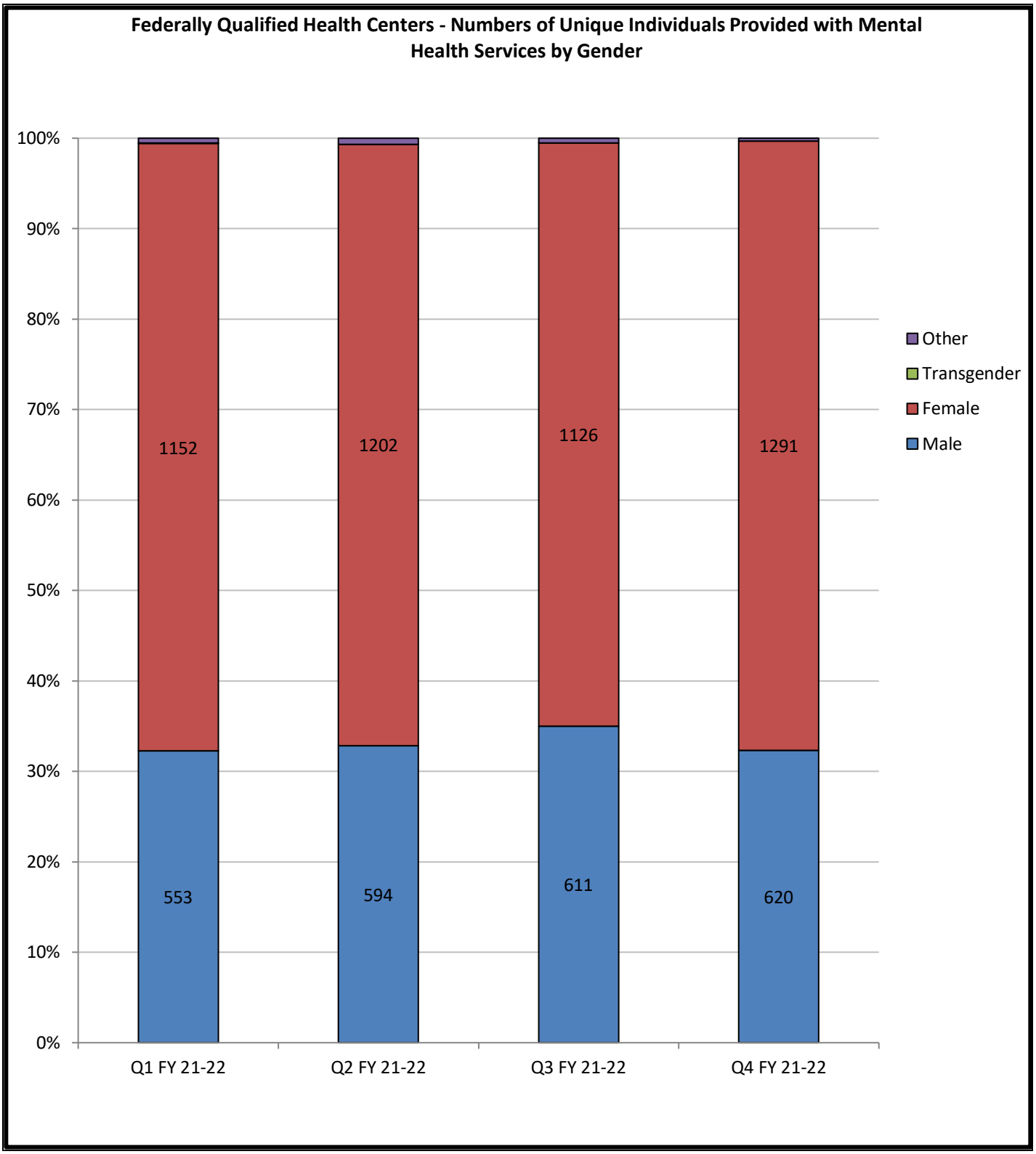


Demographics

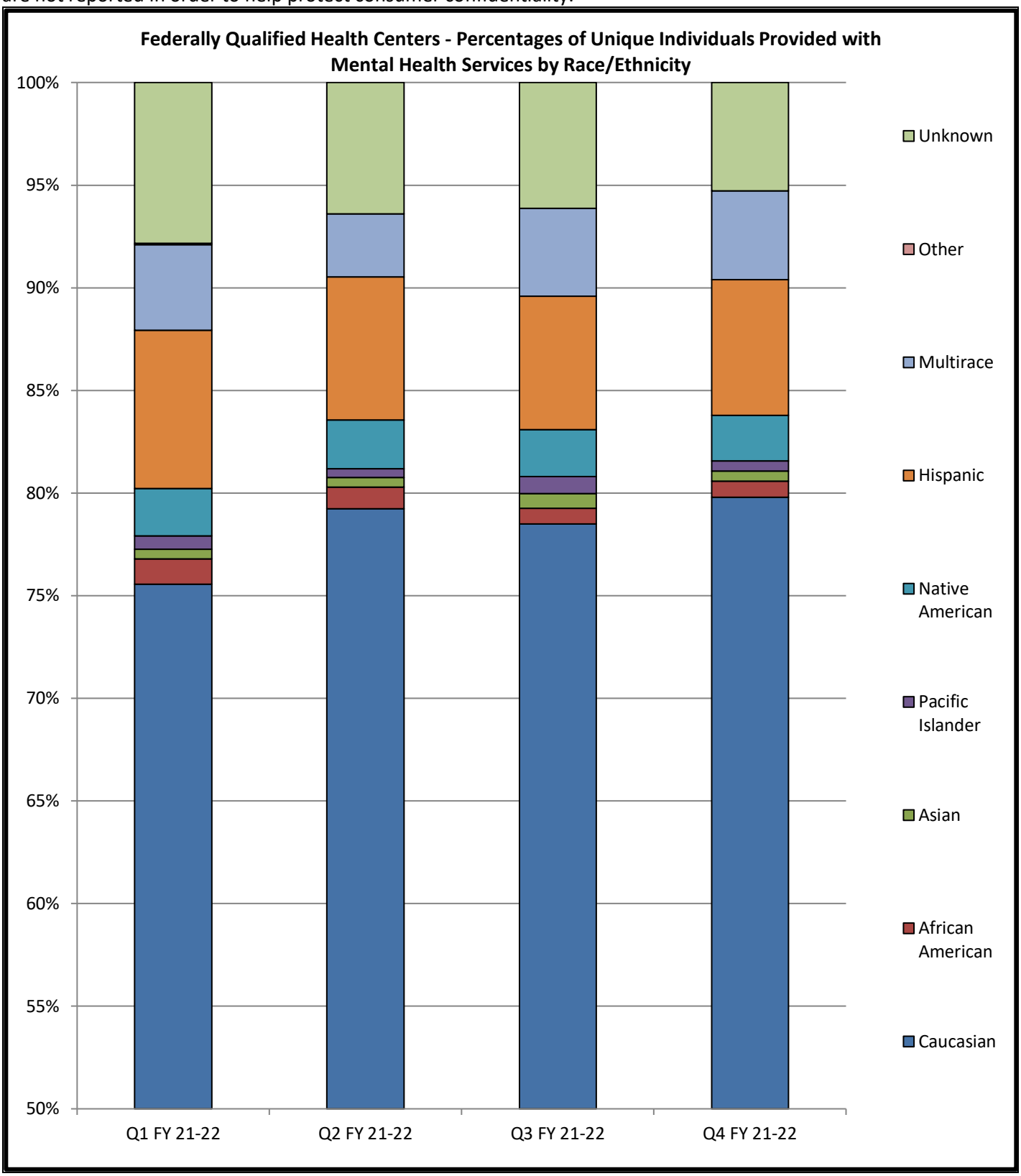
Age - The MHSA uses four age categories: **Youth** – ages 0 to 15, **Transition Aged Youth** (TAY) – ages 16 to 25, **Adult** – ages 26 to 59, and **Older Adult** – ages 60 and up.



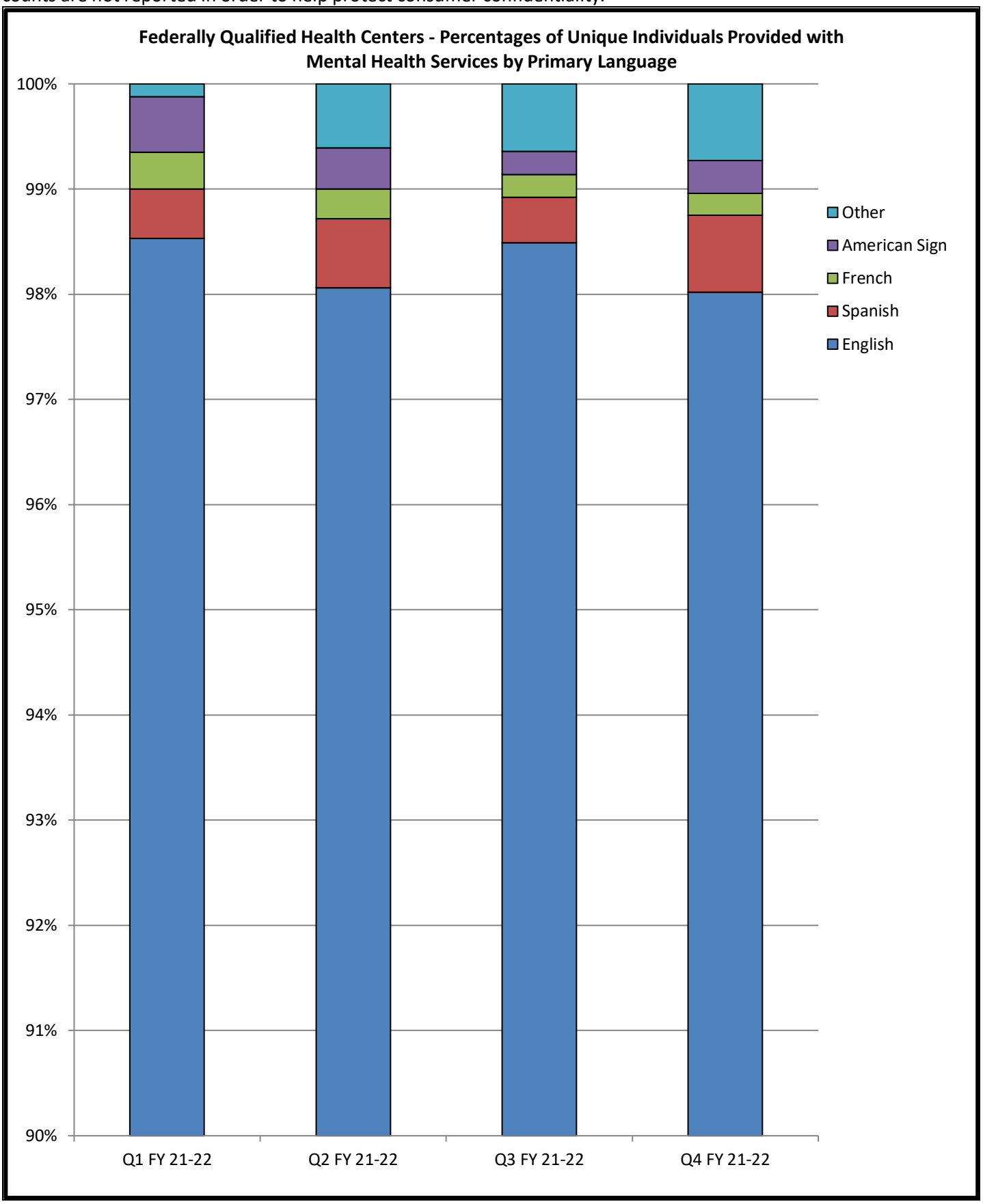
Gender - The MHSA uses four gender categories: **Male**, **Female**, **Transgender**, and **Other**. Counts of less than 20 individuals are not labeled to help maintain consumer confidentiality but are included in the chart.



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.

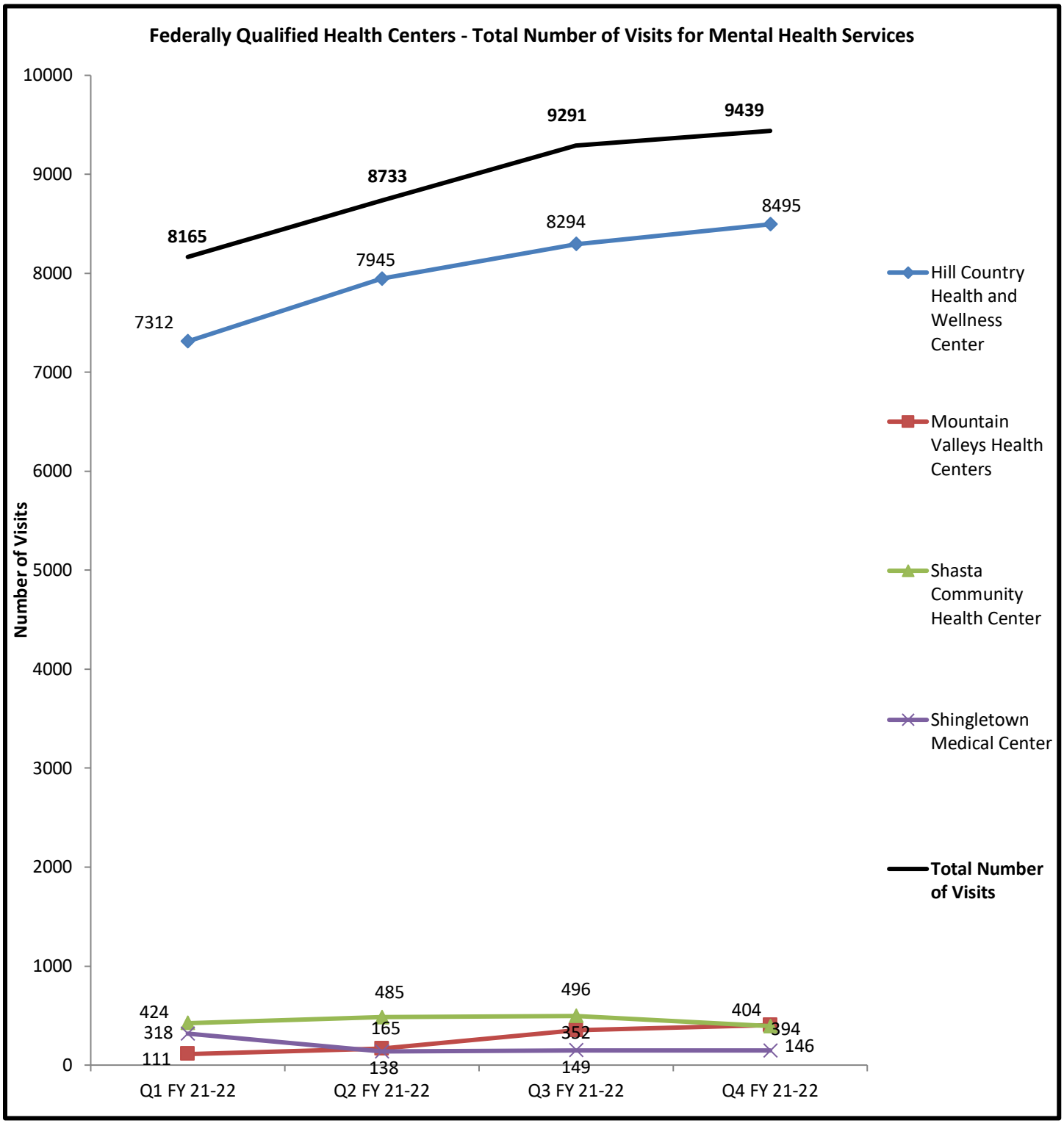


Primary Language - Because of the low gross numbers for some of these languages within small communities, actual counts are not reported in order to help protect consumer confidentiality.



Services Provided

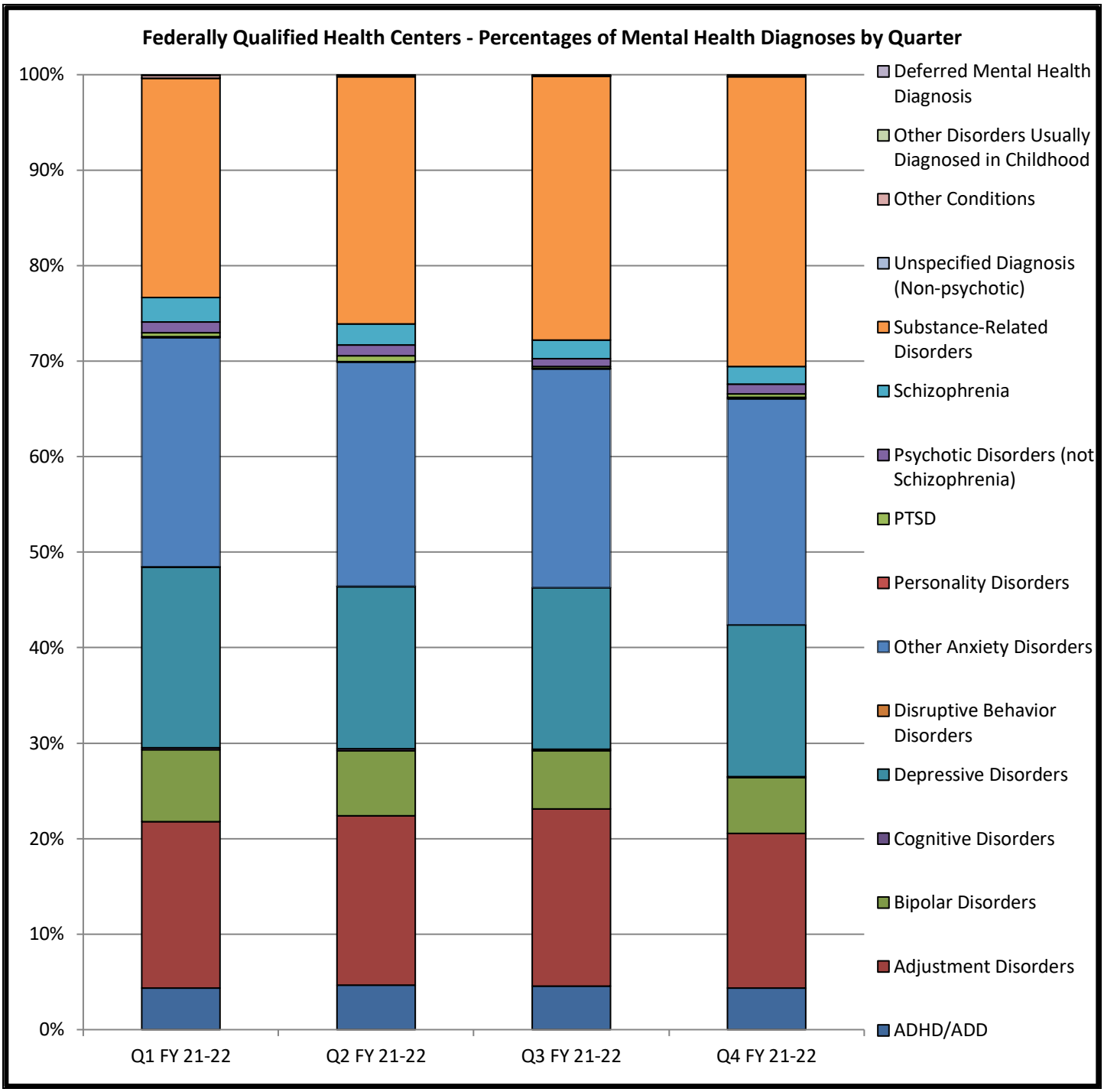
Most people will have multiple visits to the FQHC each quarter, and different types of service may be offered at different times in order to provide everyone with comprehensive and integrated age appropriate mental health services. Services provided may include such things as screenings, assessments, medication management, and individual or group psychotherapy sessions. For fiscal year 2021-2022, there were a total of 35,628 visits to a FQHC for some type of mental health service. This is a 11.6% increase compared to the previous fiscal year (31,913 visits).



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."

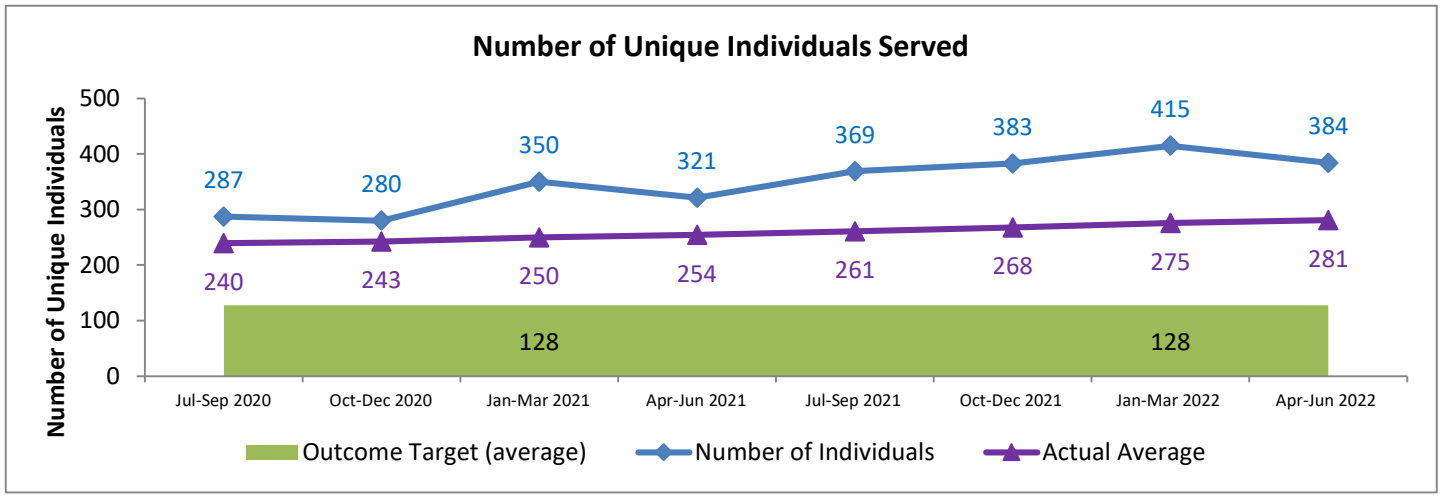


CARE Center Activity Report
July 2020 through June 2022

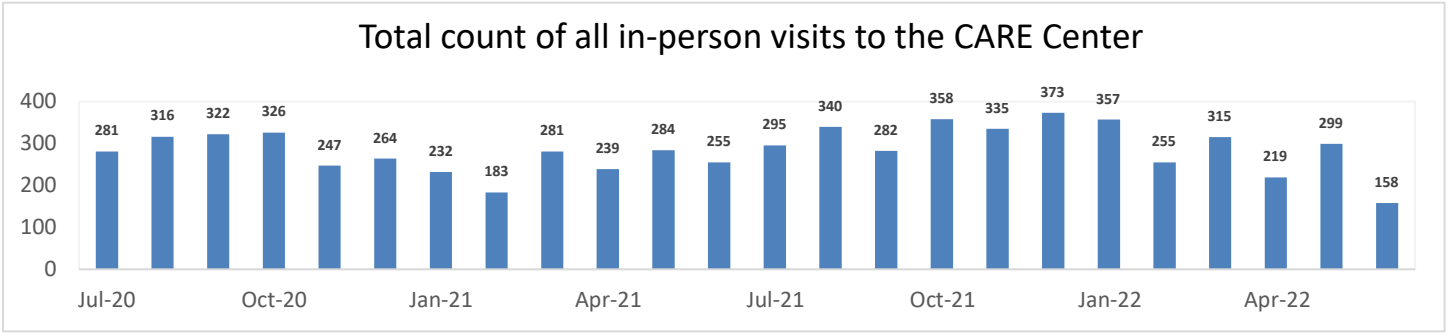
To determine if providing access to mental health services after traditional office hours will improve access to services, reduce mental health crisis (including trips to the hospital emergency departments) and bridge service gaps, the Shasta County Health and Human Services Agency has contracted with 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 Community Services and Support 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 July 2020 through June 2022. Please note that further refinement of the data collection is still underway for some measures.

INDIVIDUALS SERVED

The outcome target number is for the CARE Center to serve an average of 128 unique individuals per quarter.



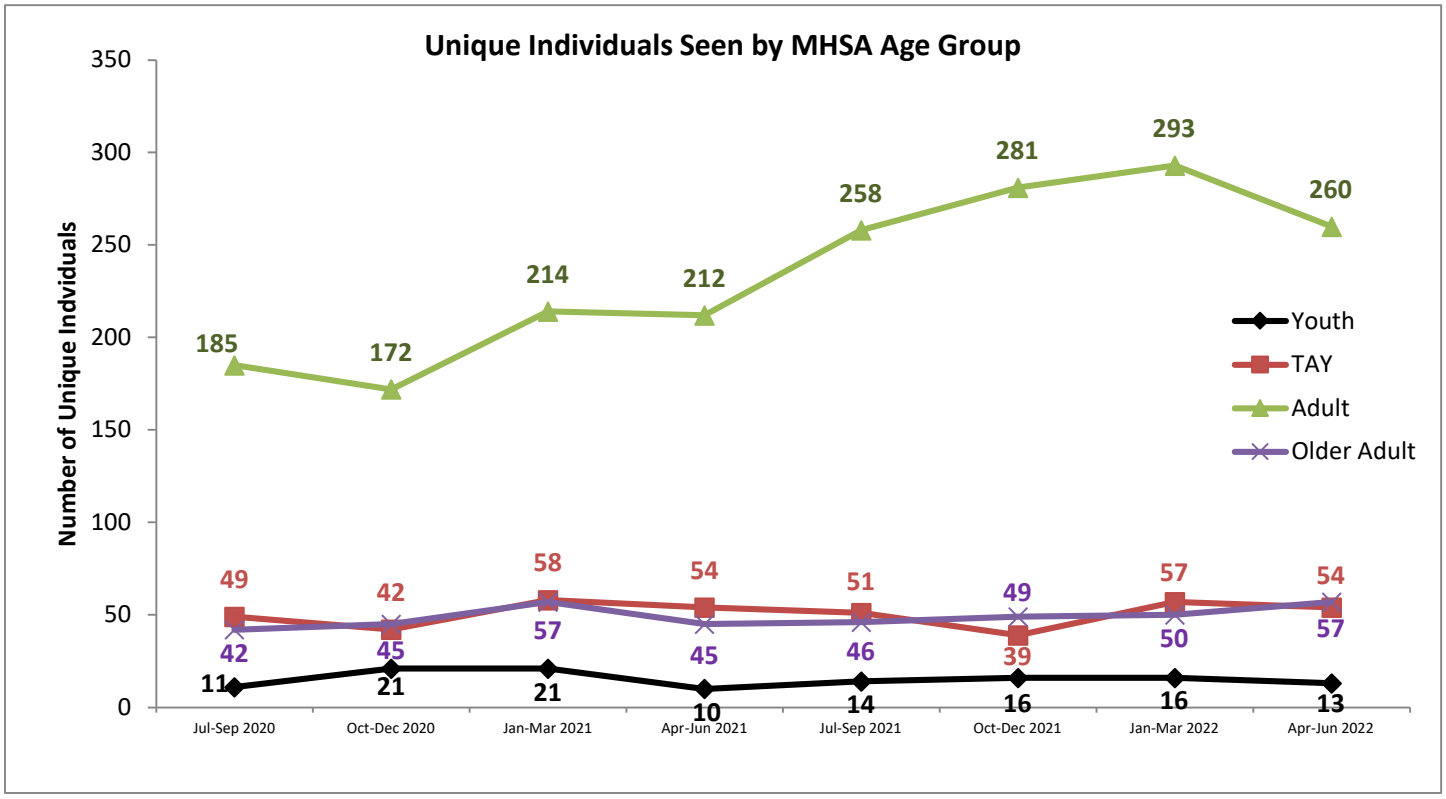
Please note that most clients visit more than once – the graph below is not an unduplicated person count.



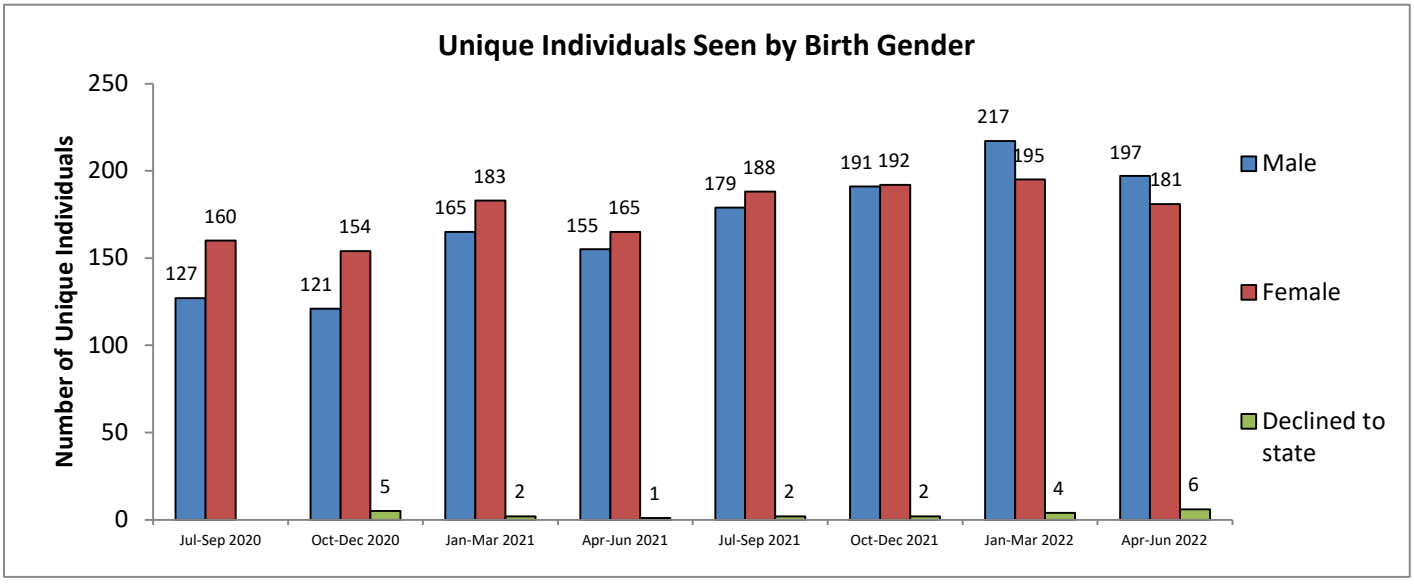
***All demographics questions are optional, so each includes the category "Declined to State".**

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.

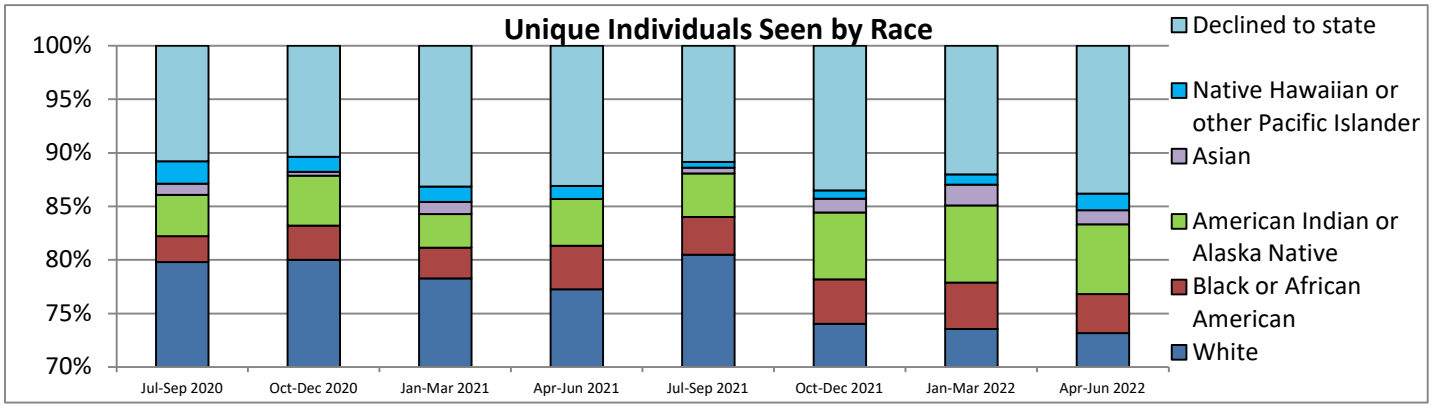


BIRTH GENDER



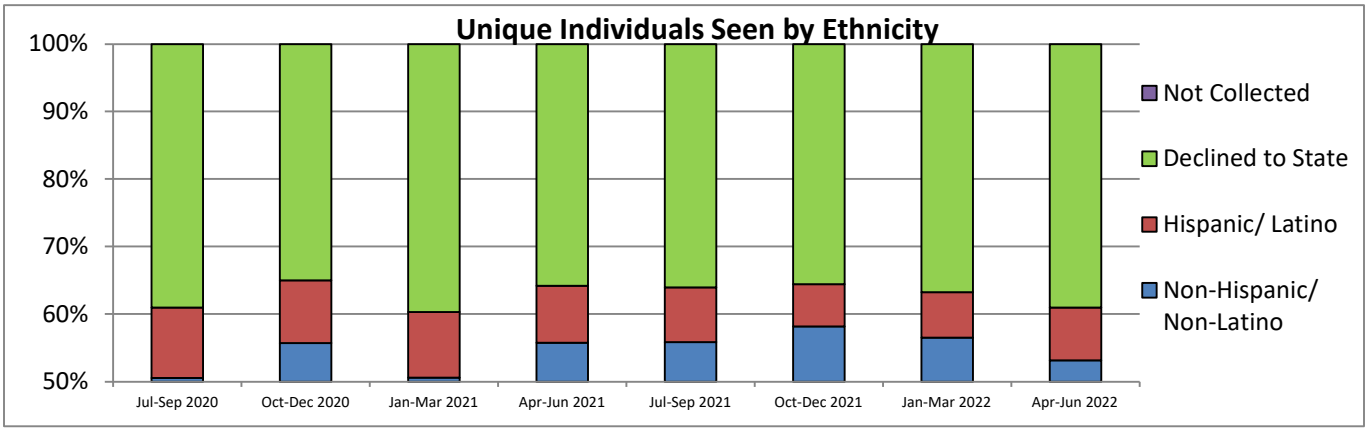
RACE

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



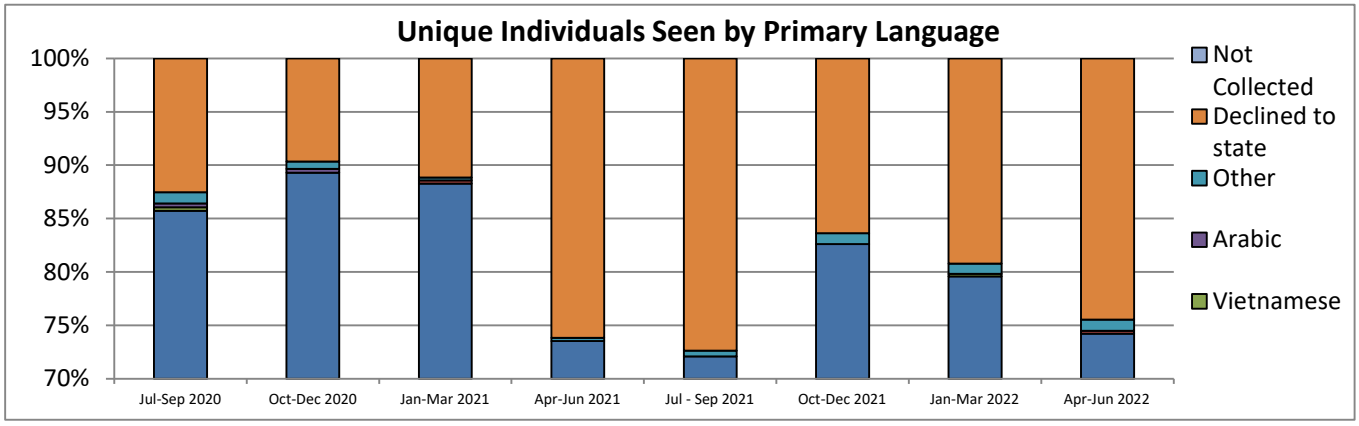
ETHNICITY

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

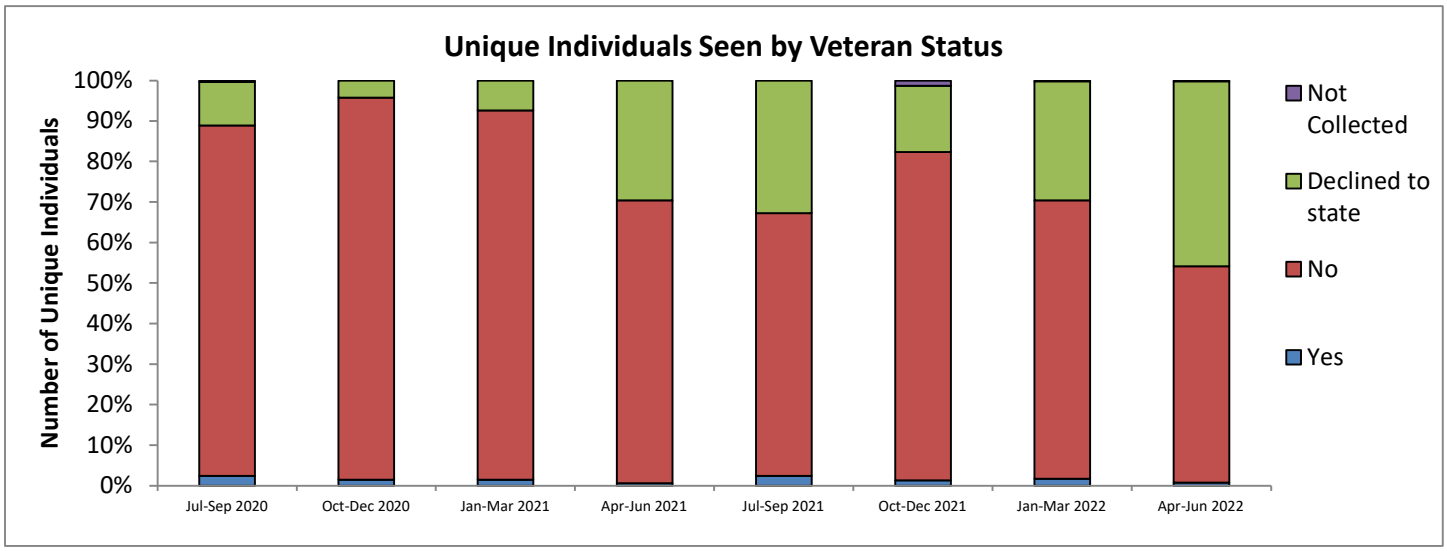


PRIMARY LANGUAGE

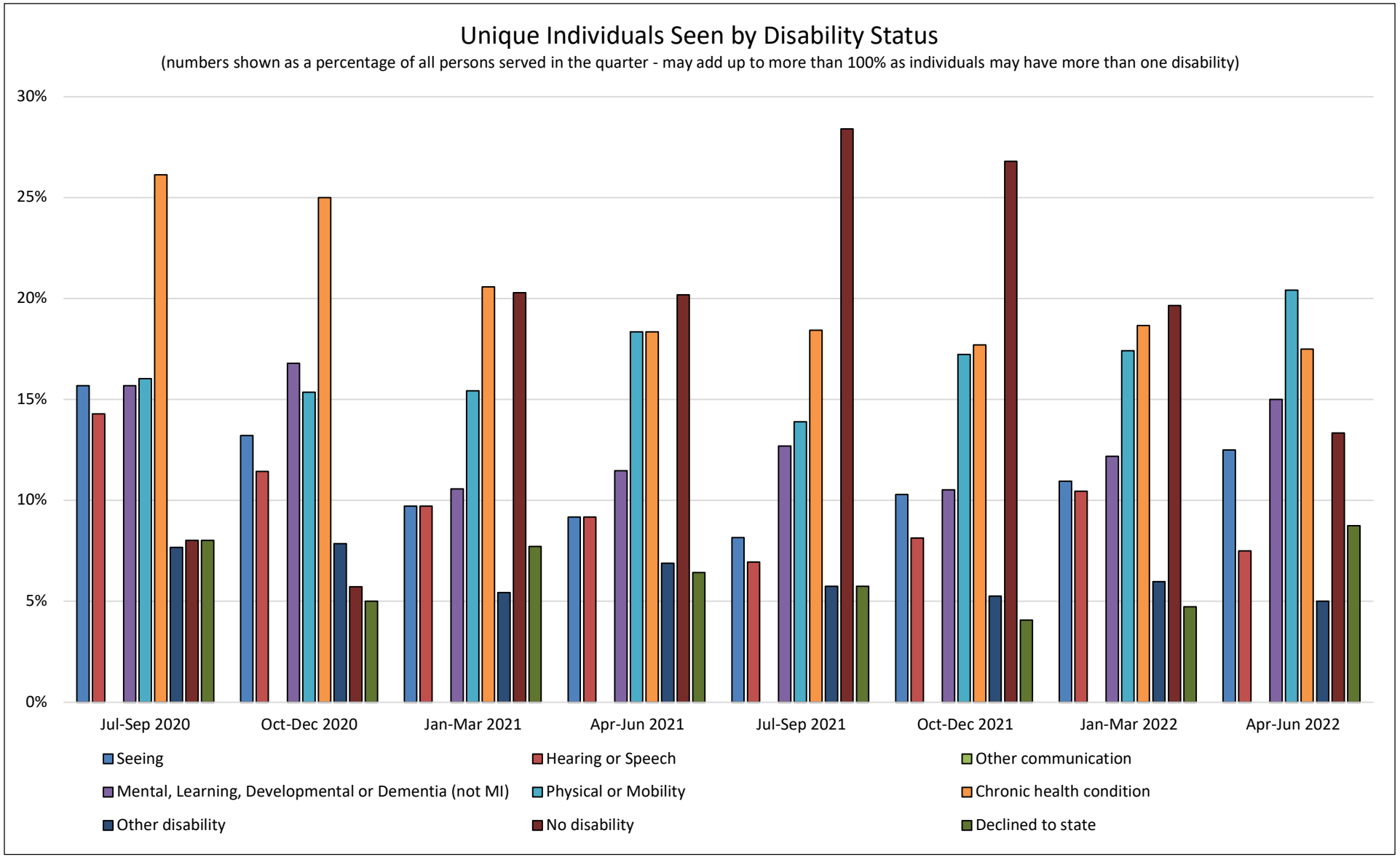
The primary language of consumers served by the CARE Center is English for nearly 100% of the people who chose to answer this question. Because of the low gross numbers for some reported languages, actual counts are not reported to help protect consumer confidentiality.



VETERAN STATUS



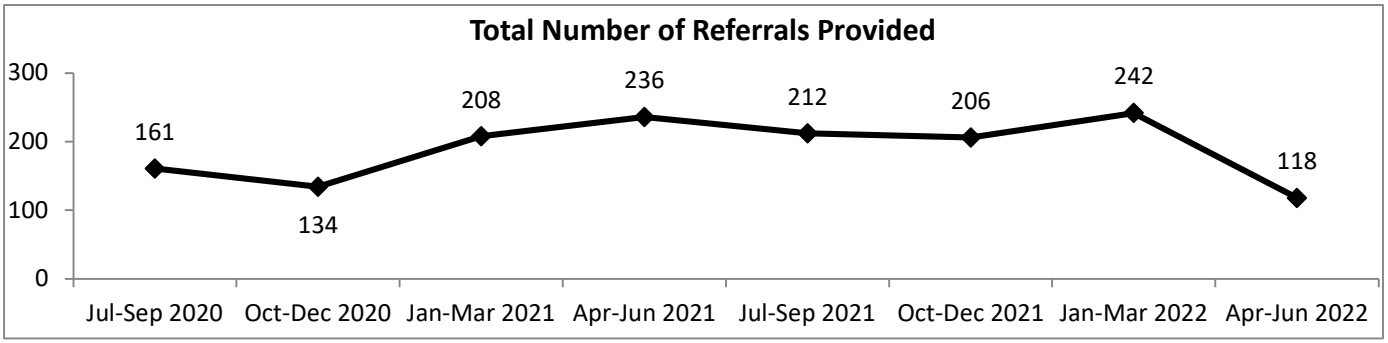
DISABILITY STATUS



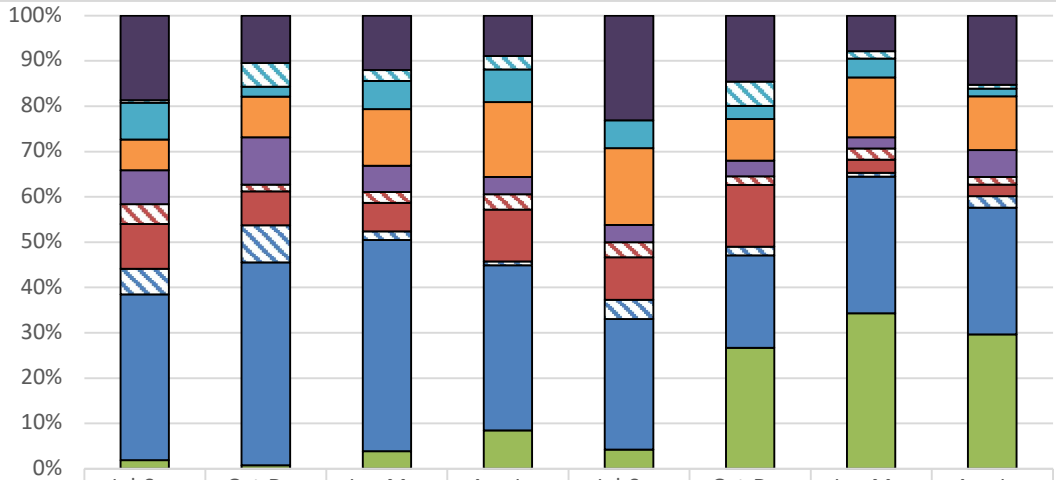
NUMBER OF OUTSIDE REFERRALS PROVIDED AND SUCCESSFULLY ACCESSED

There are many other departments and agencies to which individuals can be referred for items or services not directly provided by the CARE Center 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
- "**Emergency Department Hospital**"
- "**Housing/Shelter Services**"
- "**Community Groups**" which include referrals to:
  - Community groups
  - Other external referrals
  - Other Hill Country referrals
- "**Medical Health Services**" which include referrals to:
  - Hill Country medical services at various clinic locations
  - Primary health care services
- "**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
- "**Substance Use Services**" which include referrals to:
  - Medication-Assisted Treatment (MAT)
  - Substance Use Disorder (SUD) treatment

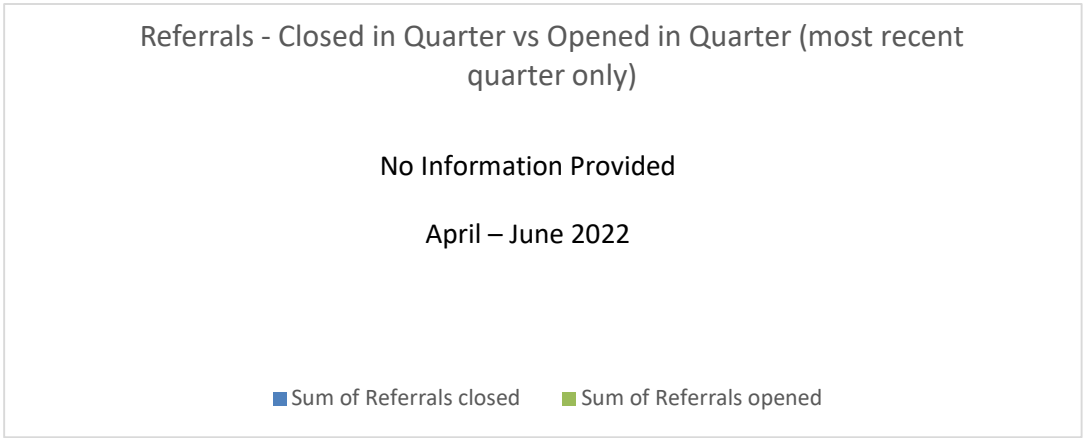


Referrals Provided by Category



	Jul-Sep 2020	Oct-Dec 2020	Jan-Mar 2021	Apr-Jun 2021	Jul-Sep 2021	Oct-Dec 2021	Jan-Mar 2022	Apr-Jun 2022
Substance Use Services	30	14	25	21	49	30	19	18
Medical Health Services Hill Country	1	7	5	7	0	11	4	1
Medical Health Services External	13	3	13	17	13	6	10	2
Housing/Shelter Services	11	12	26	39	36	19	32	14
ED Hospital	12	14	12	9	8	7	6	7
Community Groups Hill Country	7	2	5	8	7	4	6	2
Community Groups External	16	10	13	27	20	28	7	3
Behavioral/MH Services Hill Country	9	11	4	2	9	4	2	3
Behavioral/MH Services External	59	60	97	86	61	42	73	33
Basic Needs	3	1	8	20	9	55	83	35

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.

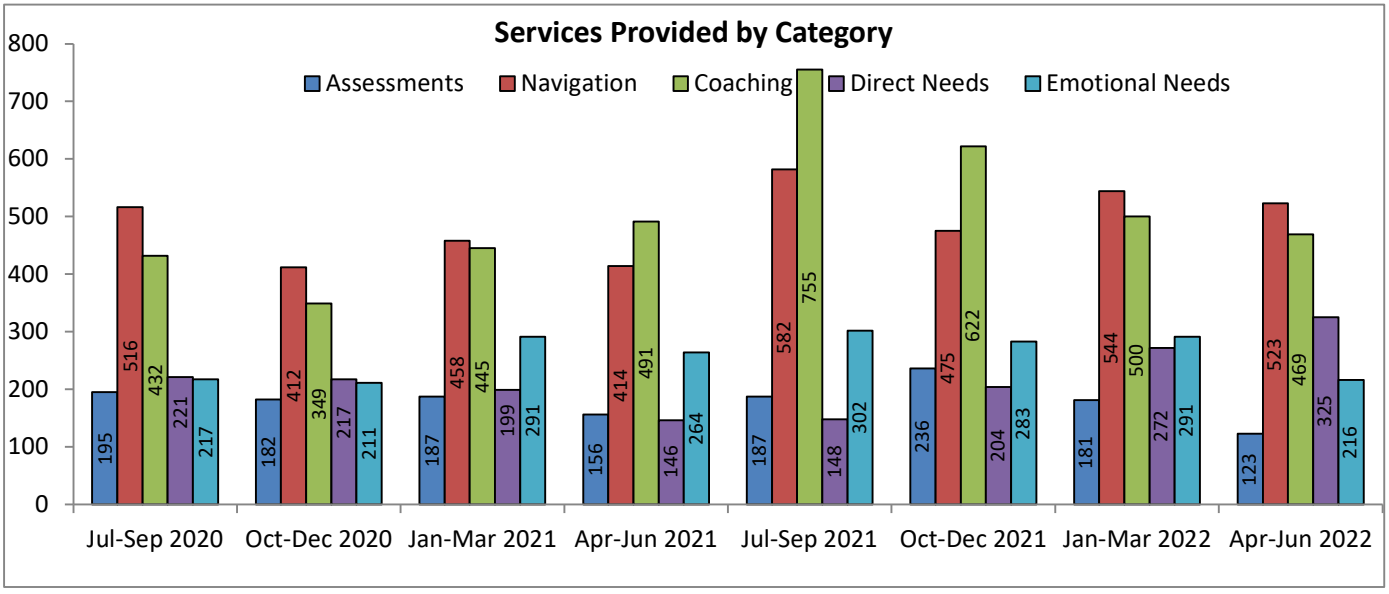


NUMBER OF SERVICES PROVIDED AND SUCCESSFULLY COMPLETED

Individuals can access a large number of services directly through the CARE Center 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
- "**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
- "**Coaching**" which includes
  - Development of support systems
  - Goal and action planning
  - Skill building
  - Wellness coaching

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%.



HOUSING STATUS

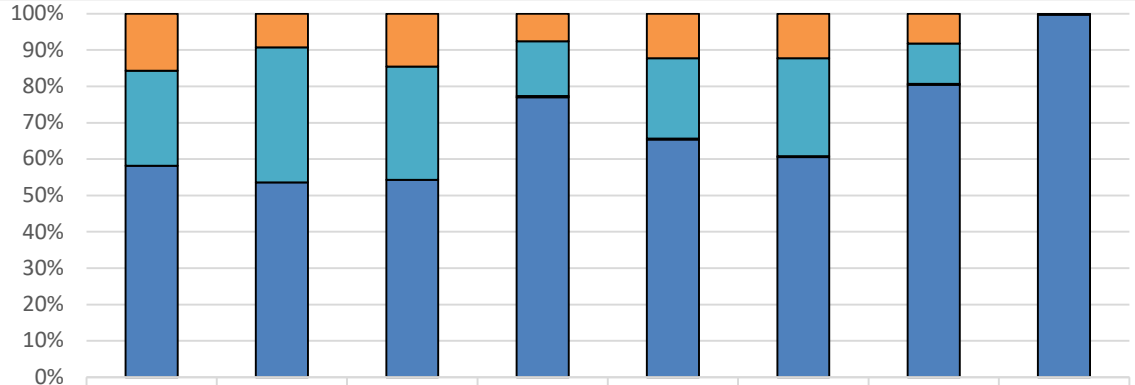
To help track the impact and effectiveness of services, the CARE Center has been asked to track the housing status of individuals accessing the project services at the time they first start services, and then at the 3-month point after that first service. The target outcome numbers are to see a 15% increase 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
  - Apartment or house, alone or with family/roommates
  - Foster home
  - Single room occupancy
- "**Supervised Placement**" which includes
  - Assisted living facility
  - Community care facility, such as a Board and Care
  - Congregate placement
- "**Inpatient Psychiatric Hospitalization**" which includes
  - Psychiatric Health Facility (PHF)
  - Institute of Mental Disease (IMD
- "**Residential Program**" which includes
  - Community treatment program
  - Group home (any level)
  - Long term care facility
  - Residential treatment program
  - Skilled nursing facility (any type)
- "**Incarcerated/Justice Placement**" which includes
  - Jail
  - Prison
  - Juvenile hall
  - Juvenile justice placement
- "**Other**"
- "**Unknown**"

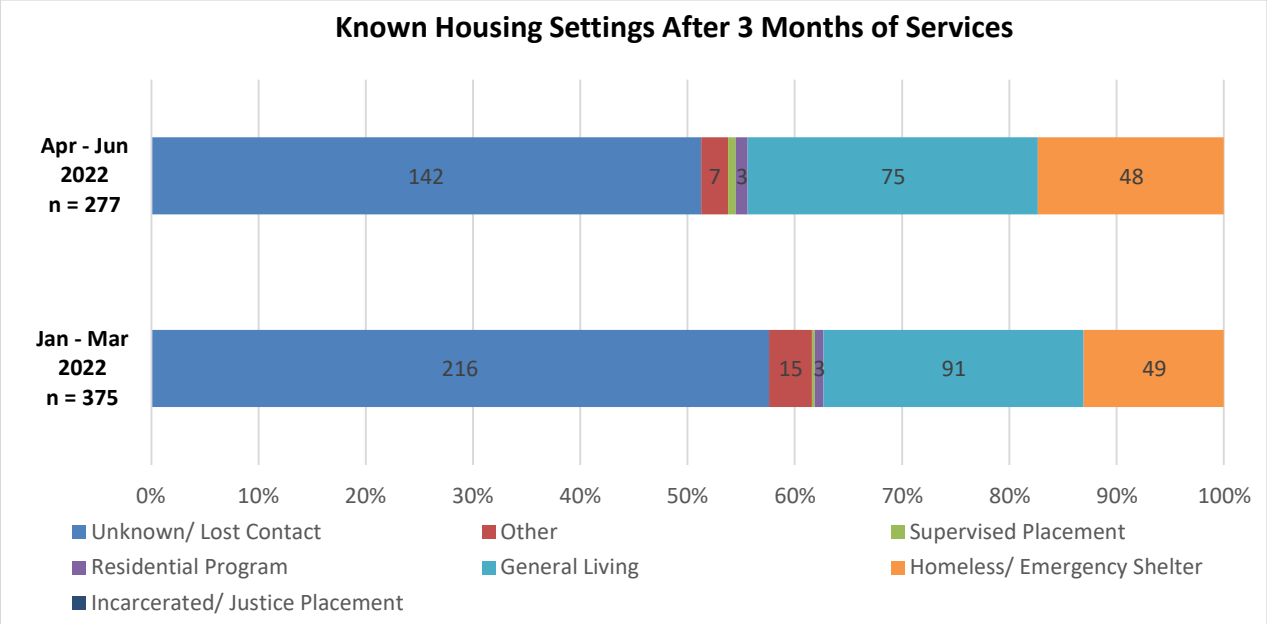
HOUSING STATUS AT START OF SERVICES

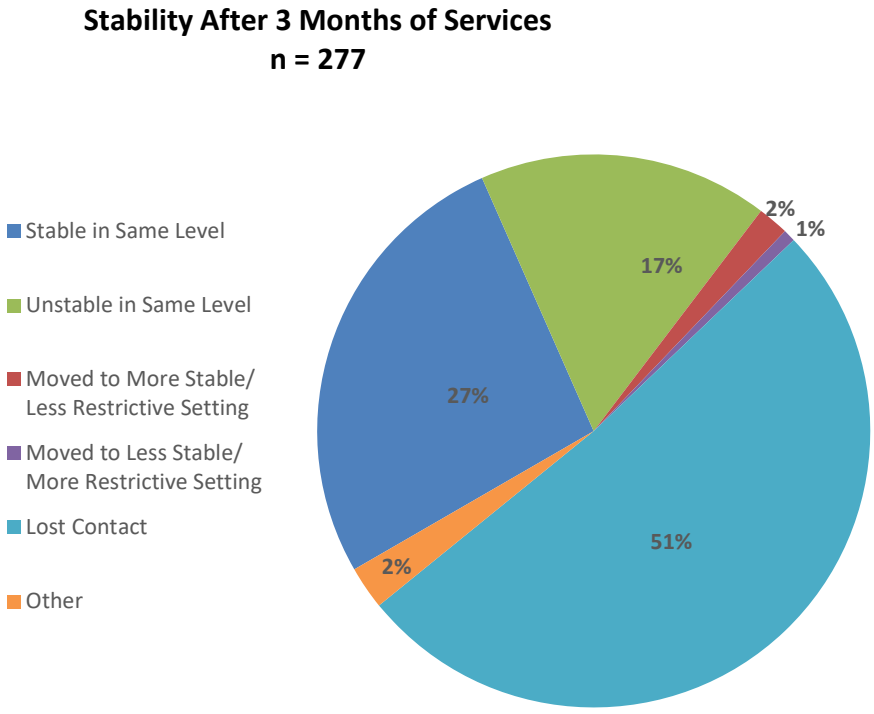
New Participant Housing Status at Intake



	Jul-Sep 2020	Oct-Dec 2020	Jan-Mar 2021	Apr-Jun 2021	Jul-Sep 2021	Oct-Dec 2021	Jan-Mar 2022	Apr-Jun 2022
Homeless/ Emergency Shelter	45	26	51	24	45	47	34	0
General Living	75	104	109	48	81	103	46	1
Residential Program	0	0	0	0	1	0	0	0
Supervised Placement	0	0	0	0	0	0	0	0
Other	0	0	0	1	0	1	1	0
Unknown	167	150	190	245	240	232	334	382

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





Changes for April-June 2022

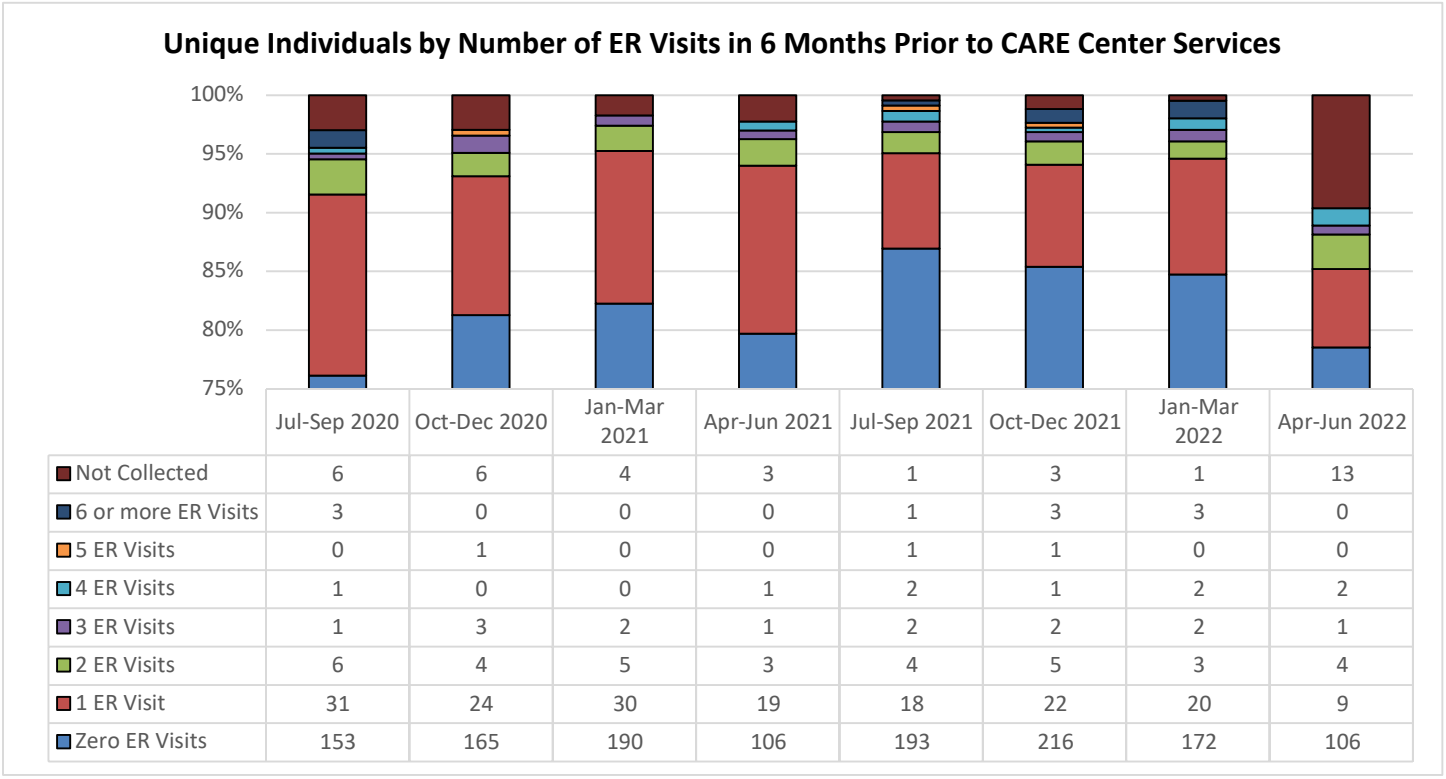
For the 5 people that moved to more stable/less restrictive settings, 2 transitioned from Homeless/E.S to General Living, 1 to a Motel Room through CEP, 1 moved back to family property and 1 moved from Supervised Placement to a Residential Program.

For the 2 people that moved to less stable/more restrictive settings, 1 transitioned from General Living to a Residential Program and 1 moved from Homeless or E.S to Inpatient Psychiatric Hospitalization.

EMERGENCY DEPARTMENT VISITS

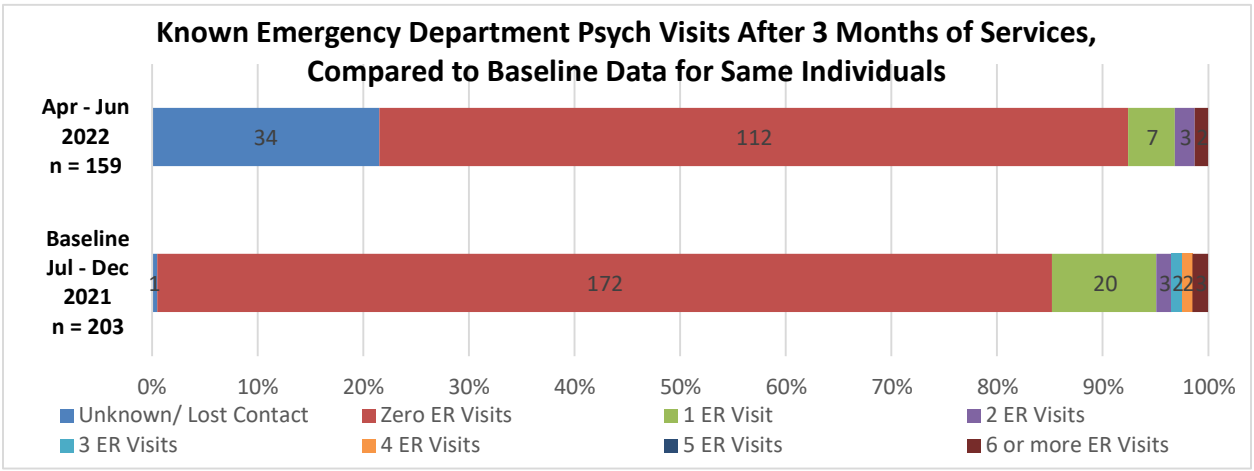
One of the goals of the project is to reduce the number of emergency department visits for psychiatric reasons. Statistics are being tracked directly from the hospitals, but to measure the impact and effectiveness for individuals, the CARE Center has been asked to track the number of ER visits individuals 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

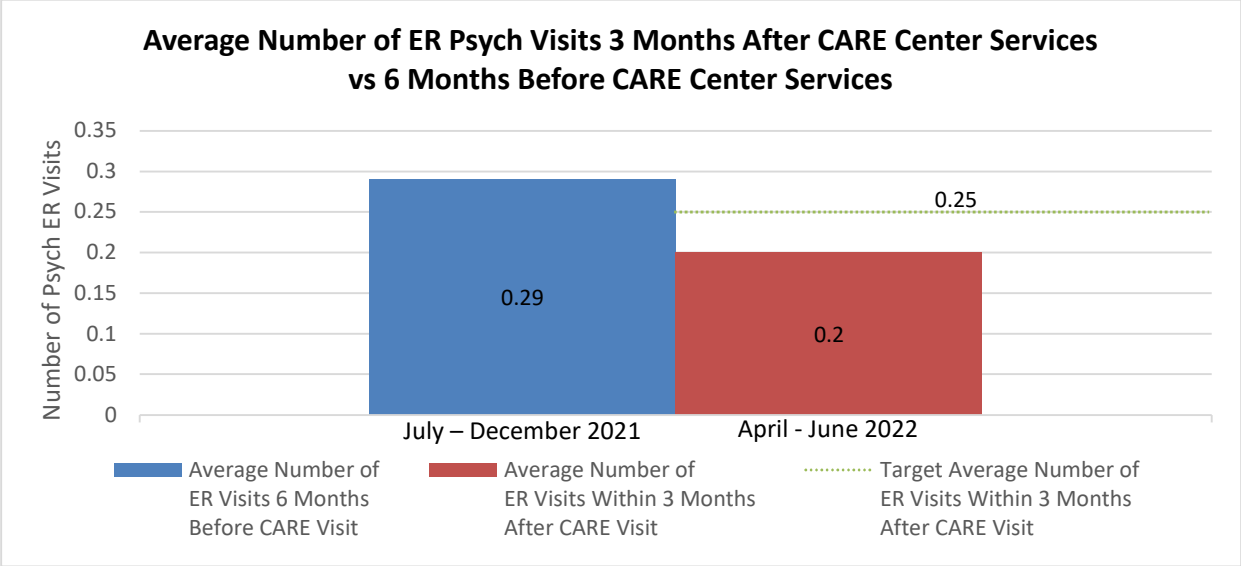


	Jul-Sep 2020	Oct-Dec 2020	Jan-Mar 2021	Apr-Jun 2021	Jul-Sep 2021	Oct-Dec 2021	Jan-Mar 2022	Apr-Jun 2022
Not Collected	6	6	4	3	1	3	1	13
6 or more ER Visits	3	0	0	0	1	3	3	0
5 ER Visits	0	1	0	0	1	1	0	0
4 ER Visits	1	0	0	1	2	1	2	2
3 ER Visits	1	3	2	1	2	2	2	1
2 ER Visits	6	4	5	3	4	5	3	4
1 ER Visit	31	24	30	19	18	22	20	9
Zero ER Visits	153	165	190	106	193	216	172	106

EMERGENCY DEPARTMENT PSYCH VISITS 3 MONTHS AFTER SERVICES – Most Recent Quarter



The average number of ER visits in the 6 months prior to care, July - December 2021, was 0.29 ER Psych Visits per individual who had visit data reported (excluding all in the Unknown/Lost Contact category). This makes the target number for the 3-months after care was received, April - June 2022, 0.25 or fewer ER visits on average, this was met with an average of 0.2 ER Psych Visits per individual who had visit data reported and had received care at the CARE Center in the prior 3 months.

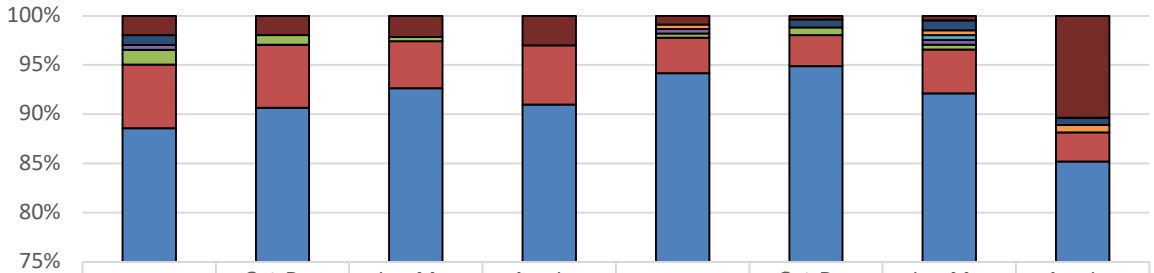


PSYCHIATRIC INPATIENT HOSPITALIZATIONS

Another goal of the 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.

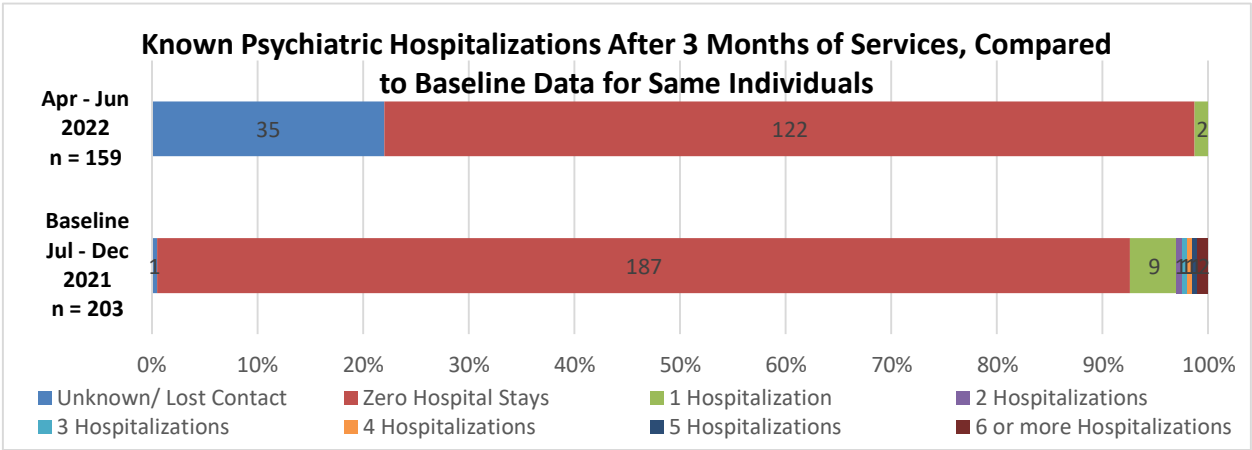
BASELINE PSYCHIATRIC HOSPITALIZATIONS – PRIOR TO CARE CENTER SERVICES

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

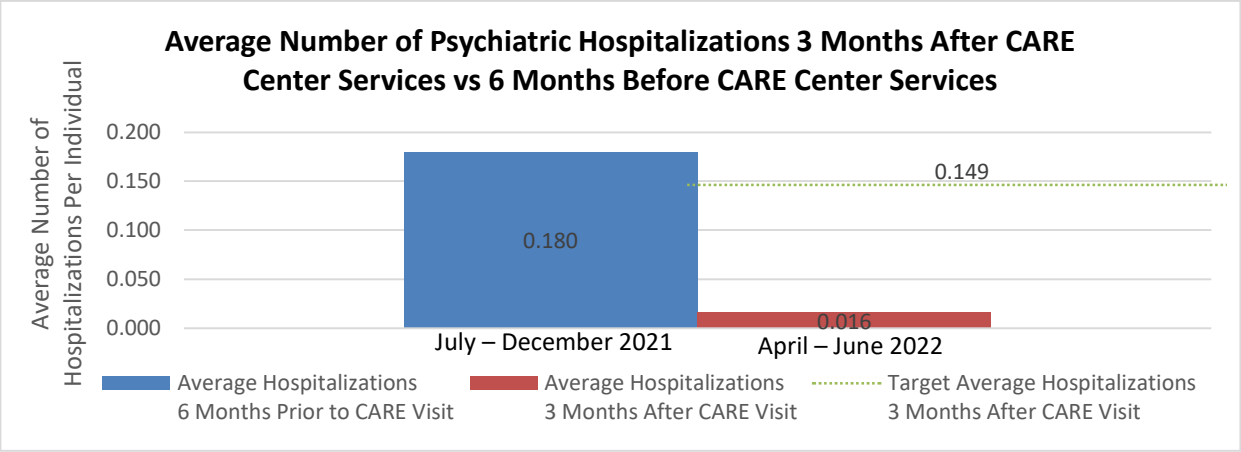


	Jul-Sep 2020	Oct-Dec 2020	Jan-Mar 2021	Apr-Jun 2021	Jul-Sep 2021	Oct-Dec 2021	Jan-Mar 2022	Apr-Jun 2022
Unknown	4	4	5	4	2	1	1	14
6 or more Hospitalizations	2	0	0	0	0	2	2	1
5 Hospitalizations	0	0	0	0	1	0	1	1
4 Hospitalizations	0	0	0	0	0	0	1	0
3 Hospitalizations	1	0	0	0	1	0	1	0
2 Hospitalizations	3	2	1	0	1	2	1	0
1 Hospitalization	13	13	11	8	8	8	9	4
Zero Hospital Stays	178	184	214	121	209	240	187	115

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



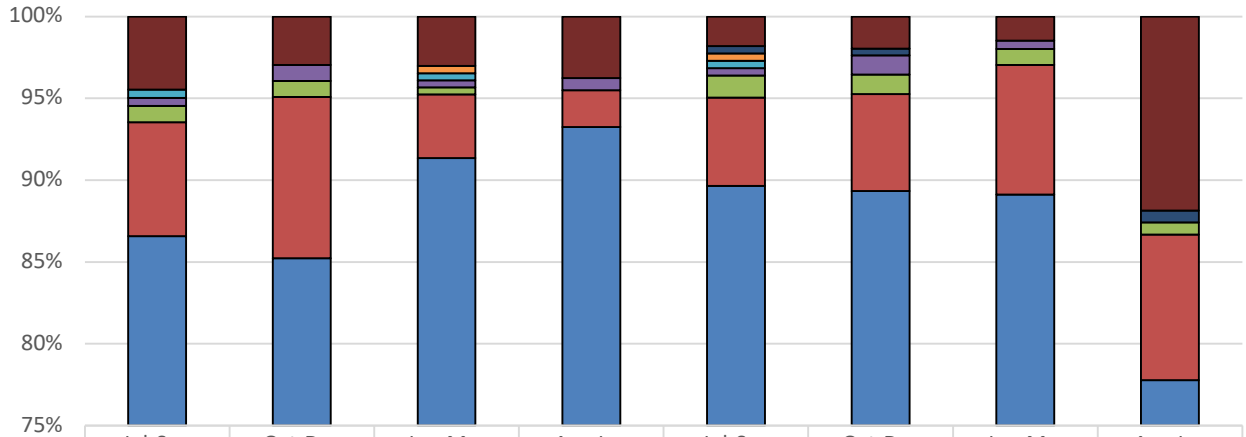
The average number of Psychiatric Hospitalizations in the 6 months prior to care, July - December 2021, was 0.180 Psychiatric Hospitalizations per individual who had visit data reported (excluding all in the Unknown/Lost Contact category). This makes the target number for the 3-months after care was received, April - June 2022, 0.149 or fewer Psychiatric Hospitalizations on average, this was met with an average of 0.016 Psychiatric Hospitalizations per individual who had visit data reported and had received care at the CARE Center in the prior 3 months.



ARRESTS

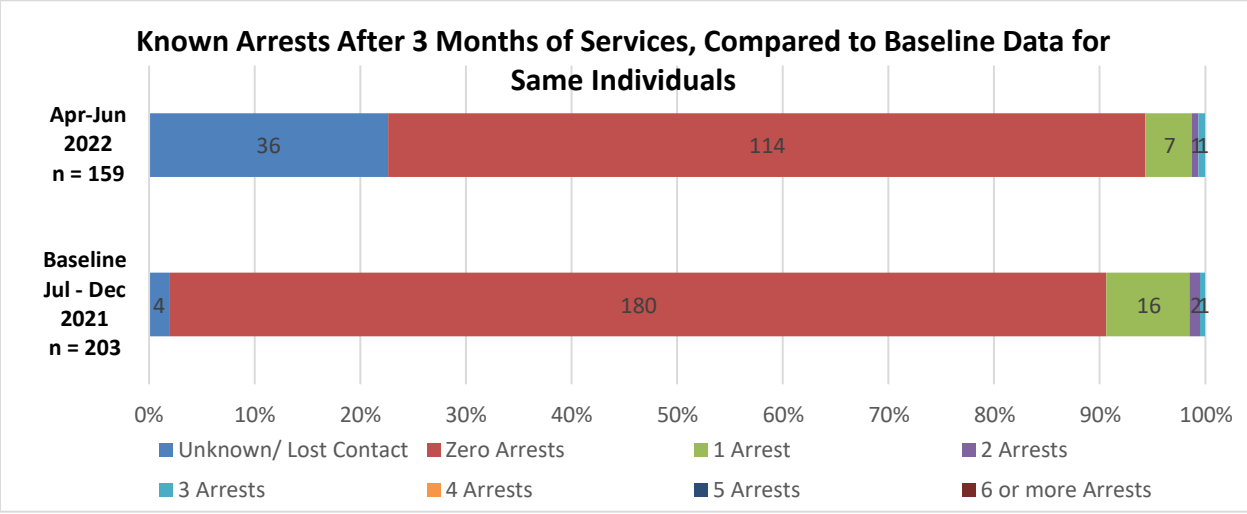
Another goal of the project is to reduce the number of arrests, and the number of days spent incarcerated. The CARE Center has been asked to track the number of arrests and number of days spent incarcerated that individuals report having made in the 6 months prior to the time they first start services 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

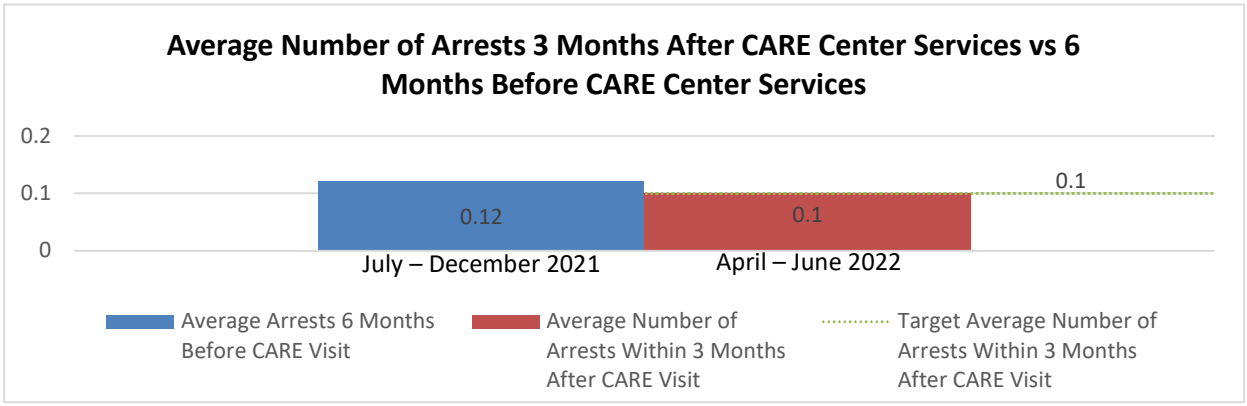


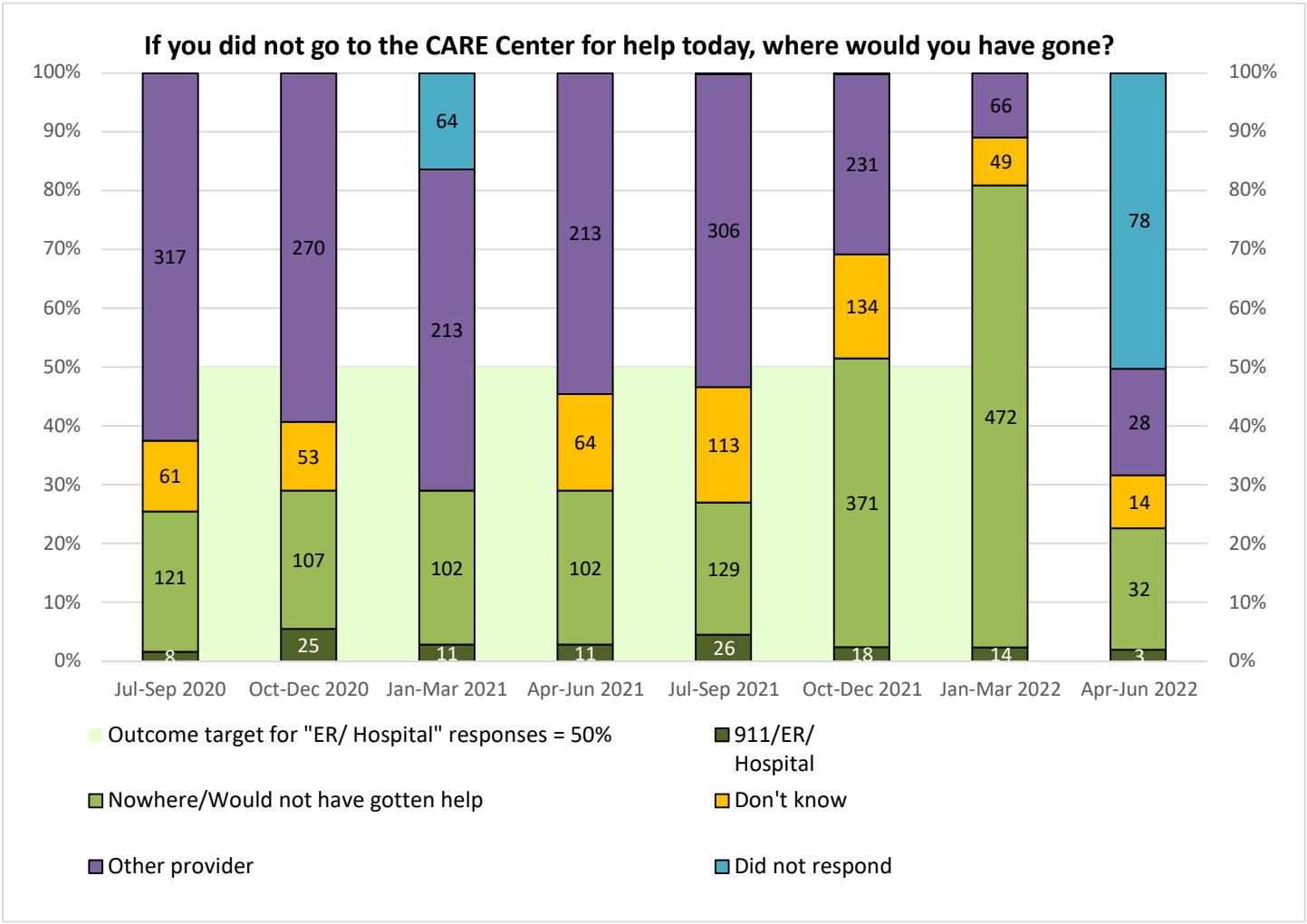
	Jul-Sep 2020	Oct-Dec 2020	Jan-Mar 2021	Apr-Jun 2021	Jul-Sep 2021	Oct-Dec 2021	Jan-Mar 2022	Apr-Jun 2022
Unknown	9	6	7	5	4	5	3	16
6 or more Arrests	0	0	0	0	1	1	0	1
5 Arrests	0	0	1	0	1	0	0	0
4 Arrests	1	0	1	0	1	0	0	0
3 Arrests	1	2	1	1	1	3	1	0
2 Arrests	2	2	1	0	3	3	2	1
1 Arrest	14	20	9	3	12	15	16	12
Zero Arrests	174	173	211	124	199	226	180	105

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



The average number of Arrests in the 6 months prior to care, July - December 2021, was 0.12 Arrests per individual who had visit data reported (excluding all in the Unknown/Lost Contact category). This makes the target number for the 3-months after care was received, April - June 2022, 0.1 or fewer Arrests on average, this was met with an average of 0.1 Arrests per individual who had visit data reported and had received care at the CARE Center in the prior 3 months.





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FY21-22 CRRC Report (Prior month and year information is updated to current information)

Table 3: Bolded and underlined numbers represent the highest number during the fiscal year. In February, the number of CRRC admits at 10 was an increase of 67% from January and increased 100% from the same month of last year. There were 166 CRRC bed days for February, 18% more than January, and a 20% increase from the same month of the prior year. The average length of stay for February was 17 days, which was -7 less than January and -11 less than February of the previous year.

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

Fiscal Year	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY Total	FY Change +/-**
2021-22	15	10	10	9	9	6	12	5	13	11	7	**18**	**125**	-31%
2020-21	15	17	19	17	**20**	11	10	15	14	18	12	14	**182**	1%
2019-20	**20**	12	17	14	13	13	17	19	15	10	16	15	**181**	-7%
2018-19	17	20	15	**22**	18	14	18	13	15	16	13	14	**195**	12%
2017-18	17	13	12	12	13	14	19	11	11	16	16	**20**	**174**	14%
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%

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

Fiscal Year	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY Total	FY Change +/-**
2021-22	**343**	268	**257**	282	289	300	211	138	211	209	149	234	**2,891**	-9%
2020-21	306	276	276	278	203	*235*	165	251	323	**360**	288	215	**3,176**	-11%
2019-20	**366**	291	**247**	314	235	260	294	317	360	313	309	270	**3,576**	-20%
2018-19	376	404	348	403	357	*285*	367	320	394	407	**437**	381	**4,479**	50%
2017-18	204	165	**187**	204	260	329	288	264	194	201	**353**	339	**2,988**	13%
2016-17	295	280	201	185	291	*120*	242	199	167	228	130	**313**	**2,651**	-7%
2015-16	236	224	244	**342**	301	266	194	220	178	215	193	229	**2,842**	-5%
2014-15	**345**	268	280	235	235	186	284	239	174	246	192	304	**2,988**	-3%
2013-14	274	231	255	295	136	207	333	311	212	**335**	242	243	**3,074**	-14%
2012-13	315	341	321	310	344	**361**	248	259	296	308	213	274	**3,590**	20%

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

Fiscal Year	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY Avg. LOS	Change +/- **
2021-22	23	27	26	31	32	**50**	18	28	16	19	21	13	**23**	35%
2020-21	20	16	15	16	10	21	17	17	23	20	**24**	15	**17**	-15%
2019-20	18	24	10	22	18	20	17	17	24	**31**	19	18	**20**	-13%
2018-19	22	20	23	18	20	20	20	25	26	25	34	27	**23**	35%
2017-18	12	13	16	17	20	24	15	24	18	13	22	17	**17**	0%
2016-17	18	16	**40**	12	21	24	15	25	8	21	13	24	**17**	6%
2015-16	13	**25**	16	17	22	24	16	15	18	10	18	12	**16**	-6%
2014-15	20	12	16	17	16	16	17	18	12	**25**	14	16	**17**	-11%
2013-14	16	14	13	16	11	14	16	**52**	11	22	24	15	**19**	36%
2012-13	12	12	15	12	14	**19**	15	12	16	18	11	14	**14**	17%

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

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

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Shasta County Health & Human Services Agency

The Woodlands Permanent Supportive Housing

Fiscal Year 2021/2022

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

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

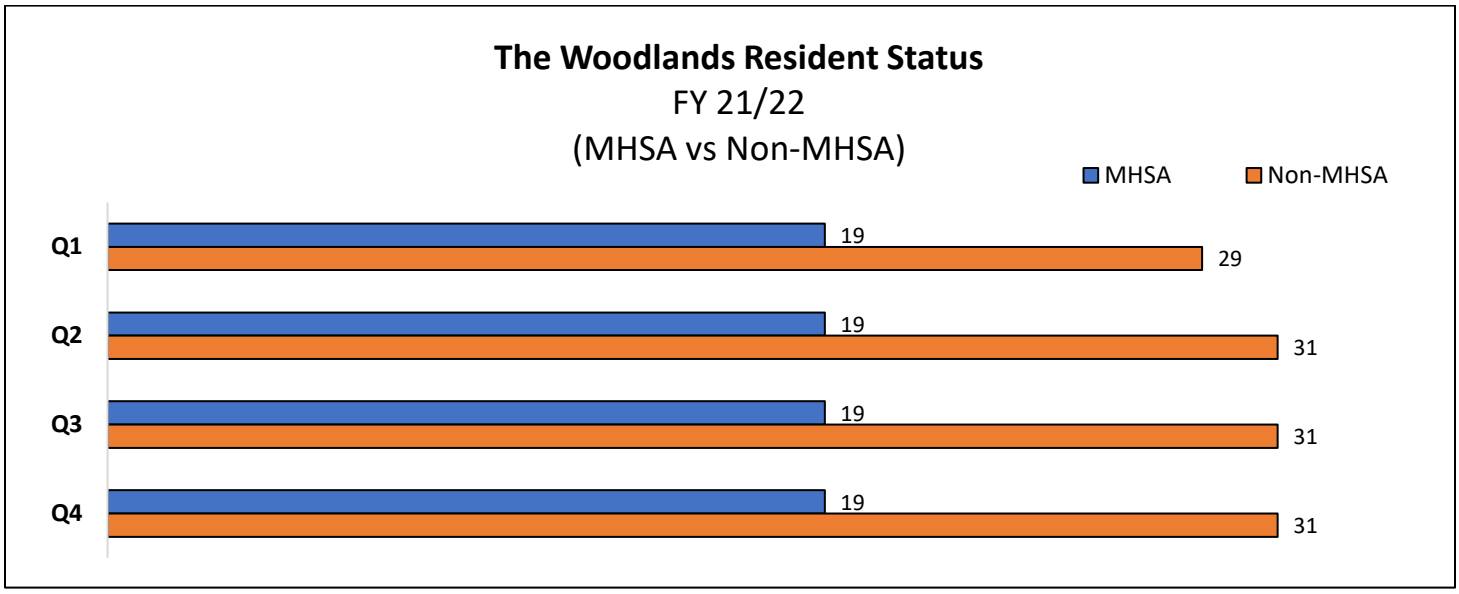
- Finance/Budgeting Classes
- Personal Income Tax Preparation
- Adult Education Classes
- Benefit/Entitlement Assistance
- After-School Activities
- Health and Wellness Classes.

The County also provides clients with supportive services such as:

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

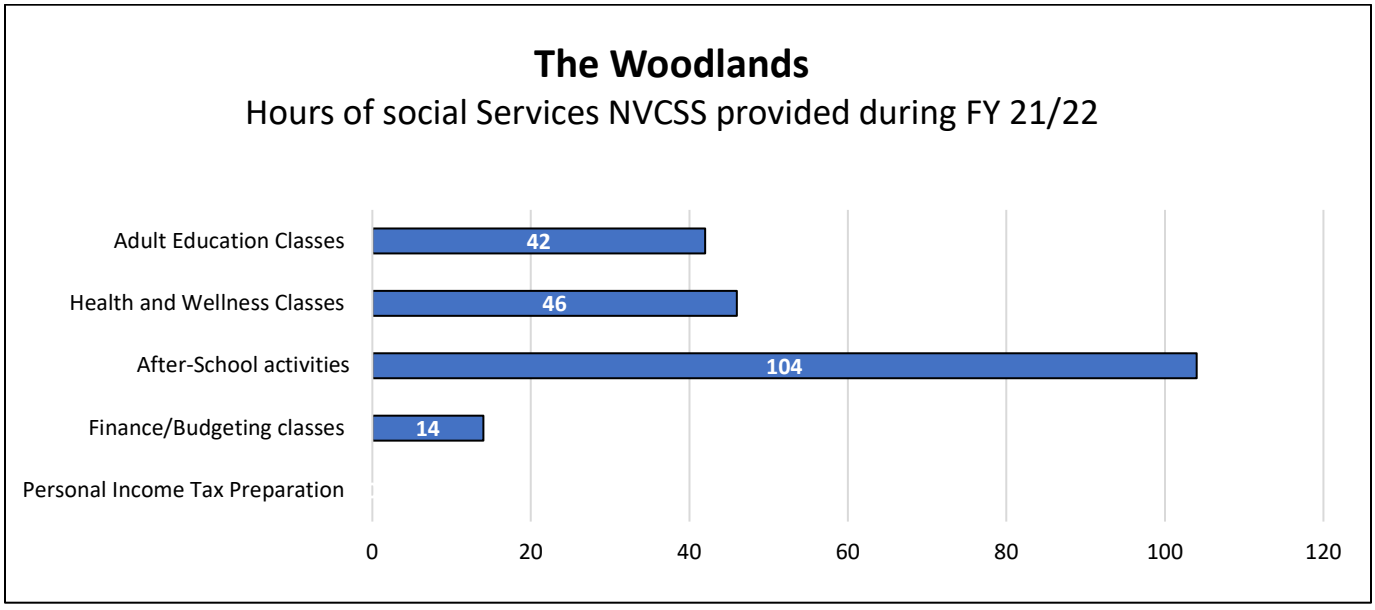
Ongoing social and supportive services are available to help clients maintain housing stability to prevent homelessness and substance abuse among other challenges. A caseworker and peer support specialist are stationed at the Woodlands to assist with these services.

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



When tenants leave MHSA units, vacancies are quickly filled by those who are on the MHSA Permanent Supportive Housing Project waitlist. There was 1 permanent departure from a MHSA-designated unit.

During Fiscal Year 21/22, clients engaged in many different activities, community education programs, and classes to learn skills. The types of social services provided, and the number of times those services have been provided, is summarized on the bar chart below.



Triple P Outcome Evaluation

Fiscal Year 21/22

Prepared by Shasta County Health and Human Services Agency

Shasta County Health & Human Services Agency

Introduction

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

Program overview

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

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

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

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

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

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

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

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

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

Versions of each level of Triple P

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

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

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

How the data in this report was collected

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

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

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

(ASRA) Automatic Scoring and Reporting Application data

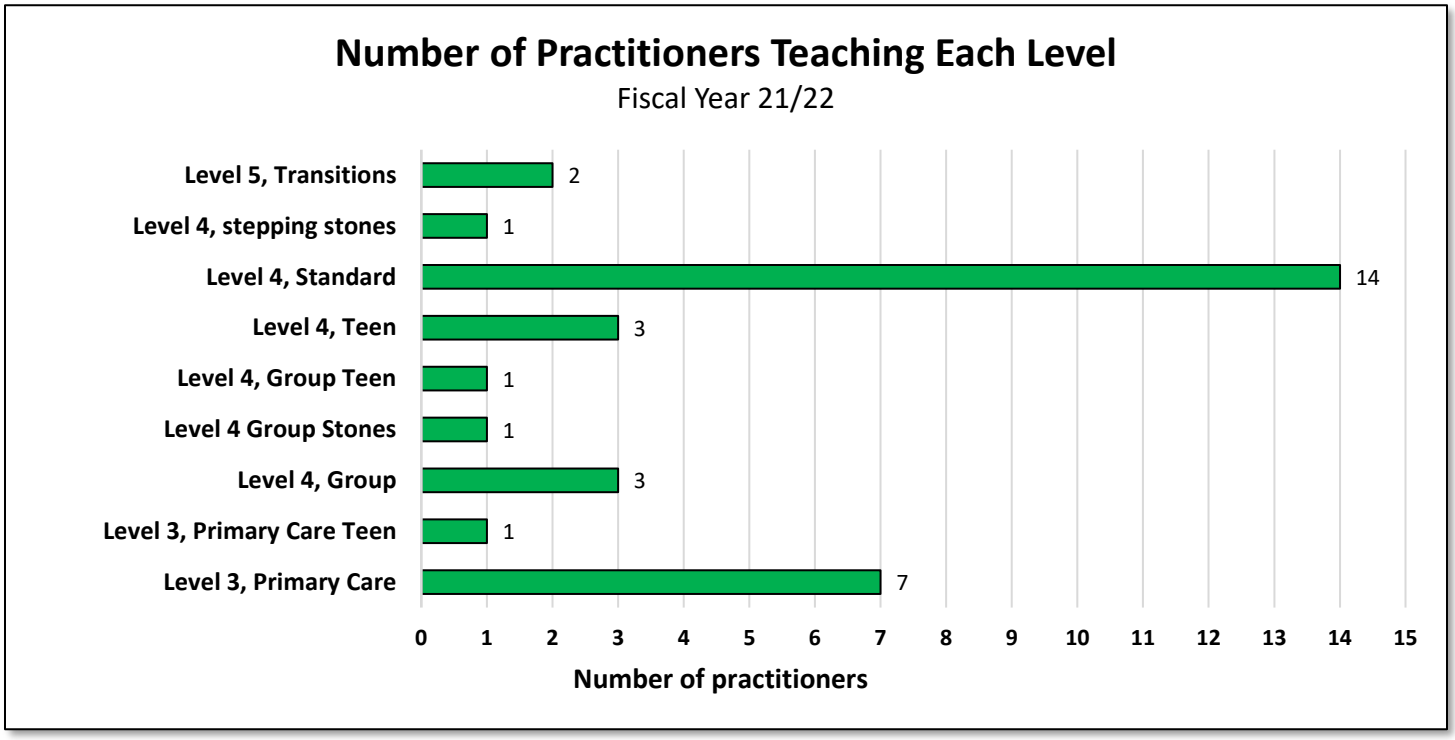
Overview

The table below shows the total number of Triple practitioners who entered data into the ASRA Scoring application during Fiscal Year 21/22, along with the organization they were with, and the total number of caregivers and families they served:

Partnered Organizations Providing Triple P Fiscal Year 21/22			
Organization	**Practitioners**	**Caregivers**	**Children**
Bridges to Success/ Shasta County Office of Education	7	91	73
Child Abuse Prevention Coordinating Council of Shasta County (CAPCC)	4	24	23
FaithWorks	4	7	6
Northern Valley Catholic Social Services	1	3	2
Shasta County Health & Human Services Agency: Children's Services	3	12	6
Wright Education Services	4	66	54
Youth and Family Programs	1	24	18
Totals:	**24**	**227**	**182**

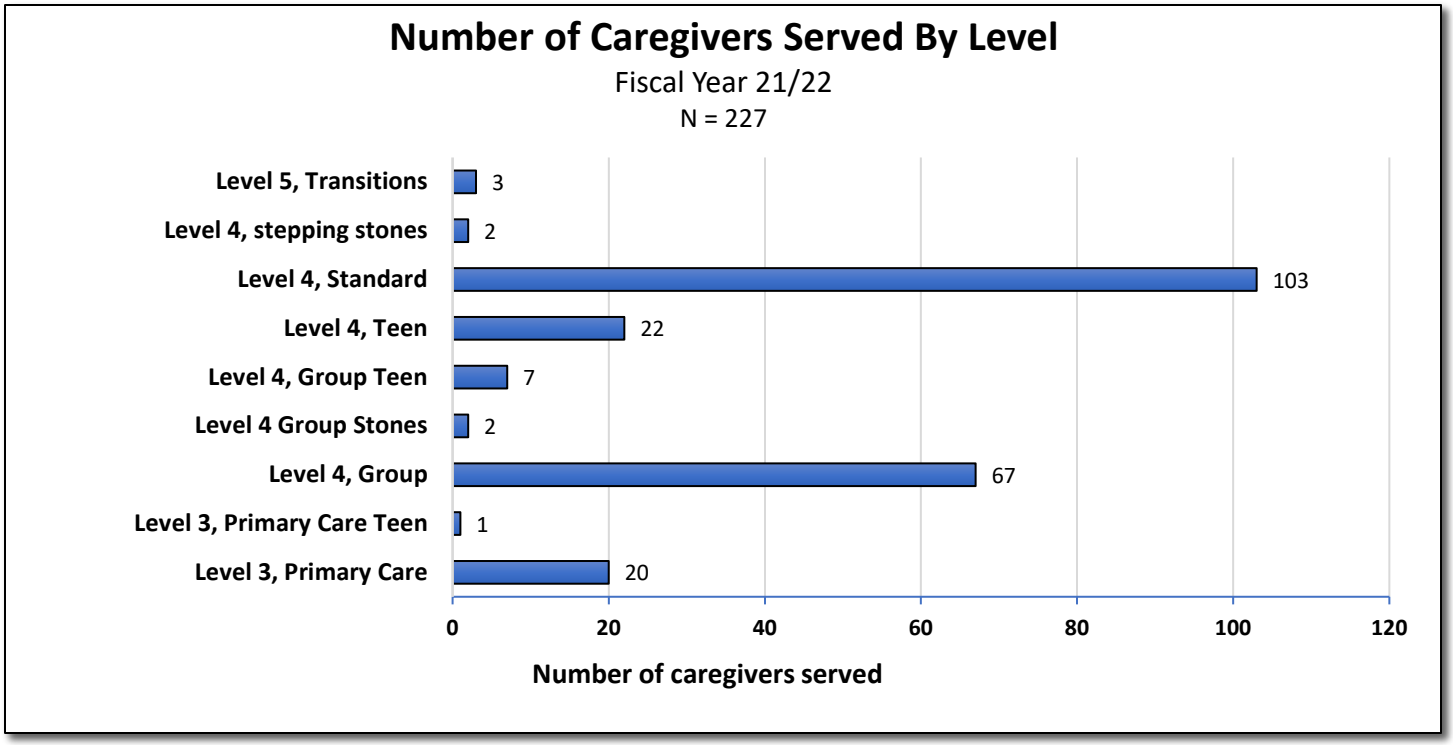
Some families may have received services in more than one organization, level, or version of Triple P. The information stored in the scoring application is anonymous (names were not collected). For this reason, the total number of unique caregivers and children/teens served between all levels couldn't be determined. In addition, if a practitioner was still submitting data in the Scoring application after transitioning to a new organization during Fiscal Year 21/22, they would be counted as a practitioner in each organization they were a part of.

There were 16 practitioners who provided Triple P services over this time period. In the graph below, you can see the number of practitioners who provided the various Triple P levels (some practitioners are counted more than once as some practitioners are trained to teach more than one level):

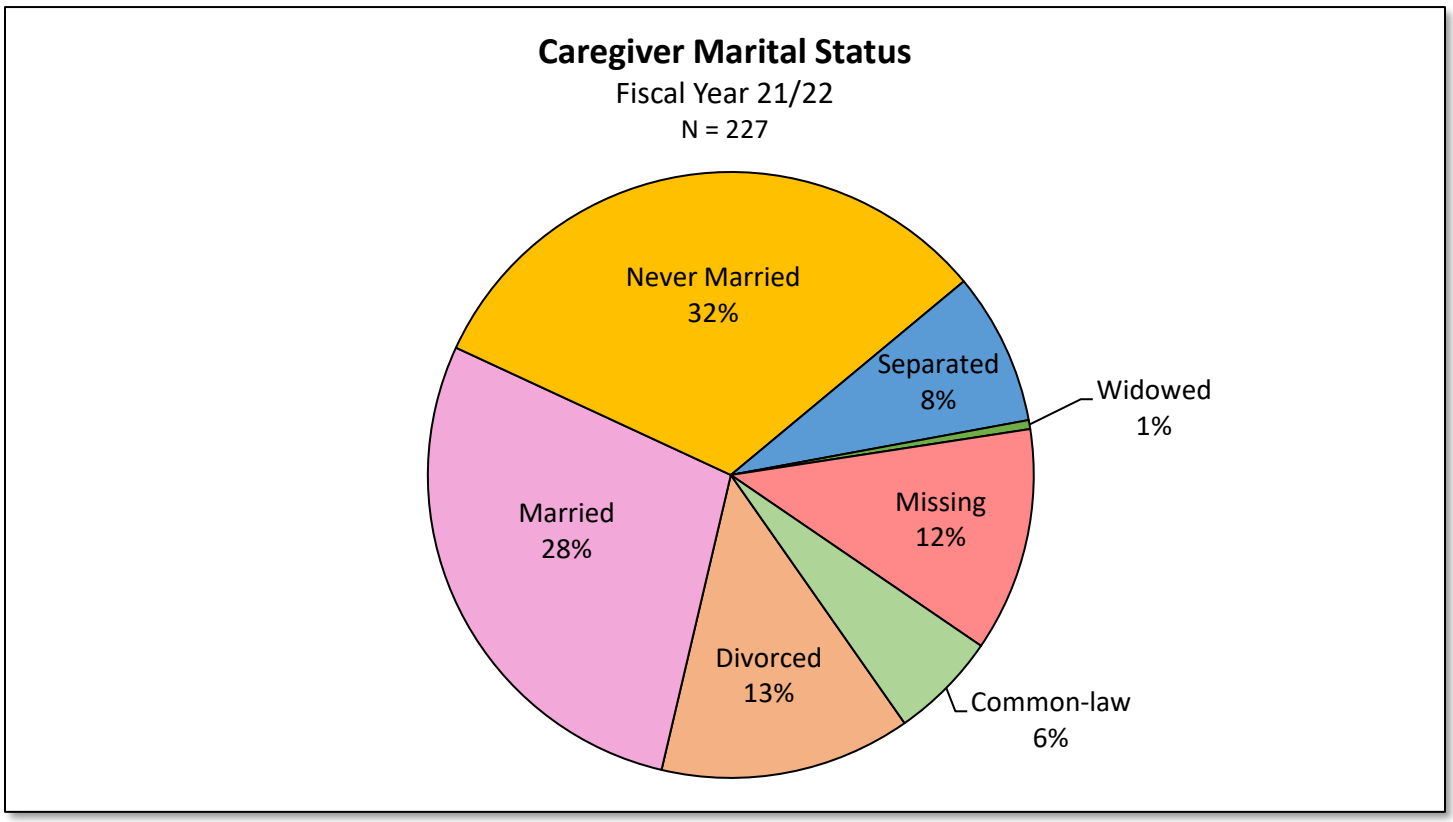


Data on the caregivers and their families

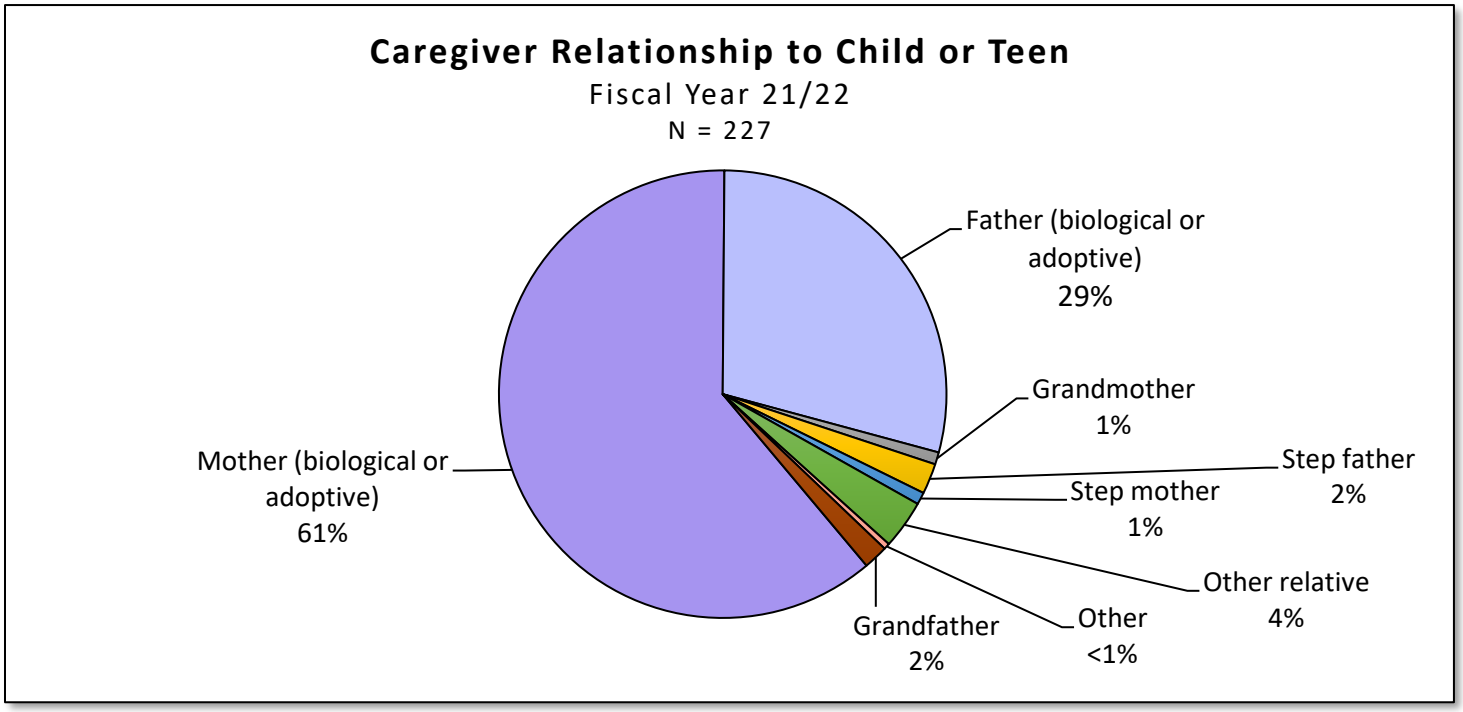
A total of 227 caregivers attended Triple P sessions. The number of caregivers in each level of Triple P is shown below:



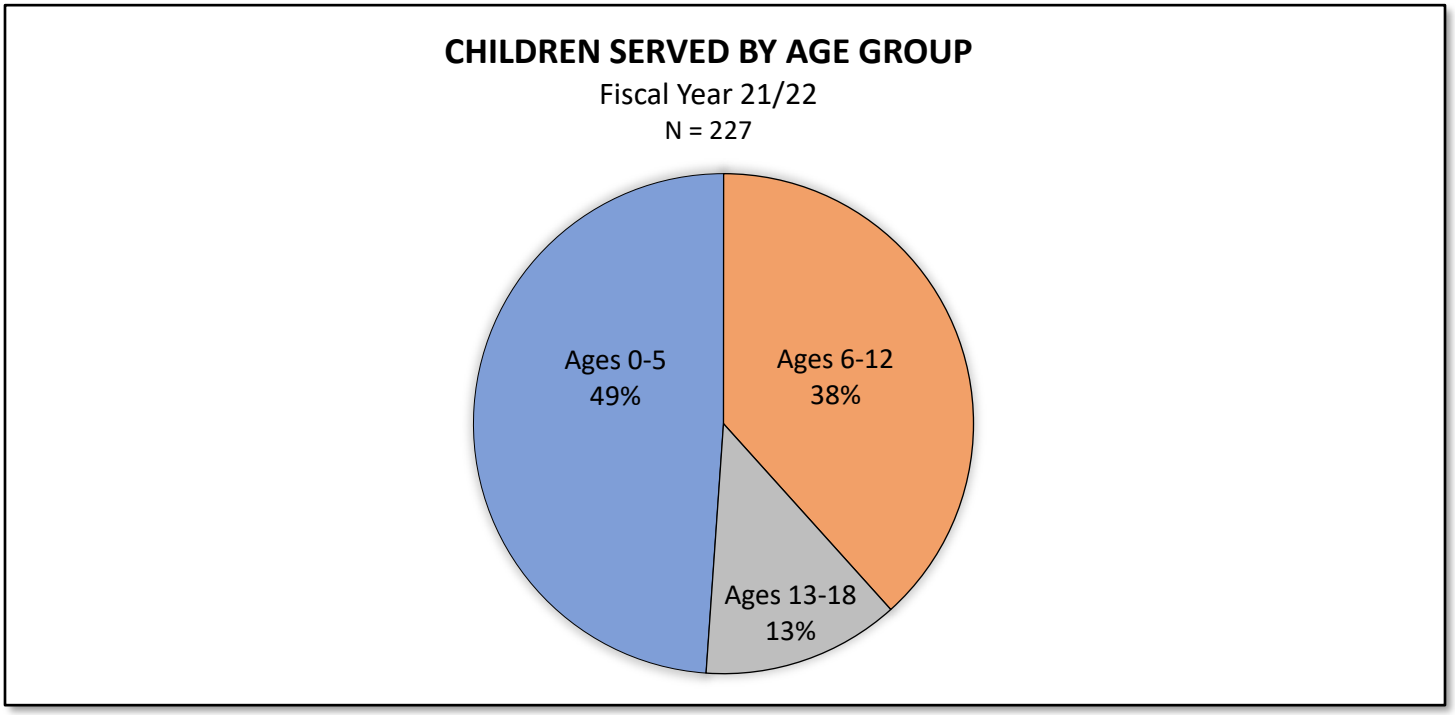
The marital status of the caregivers is pictured below:



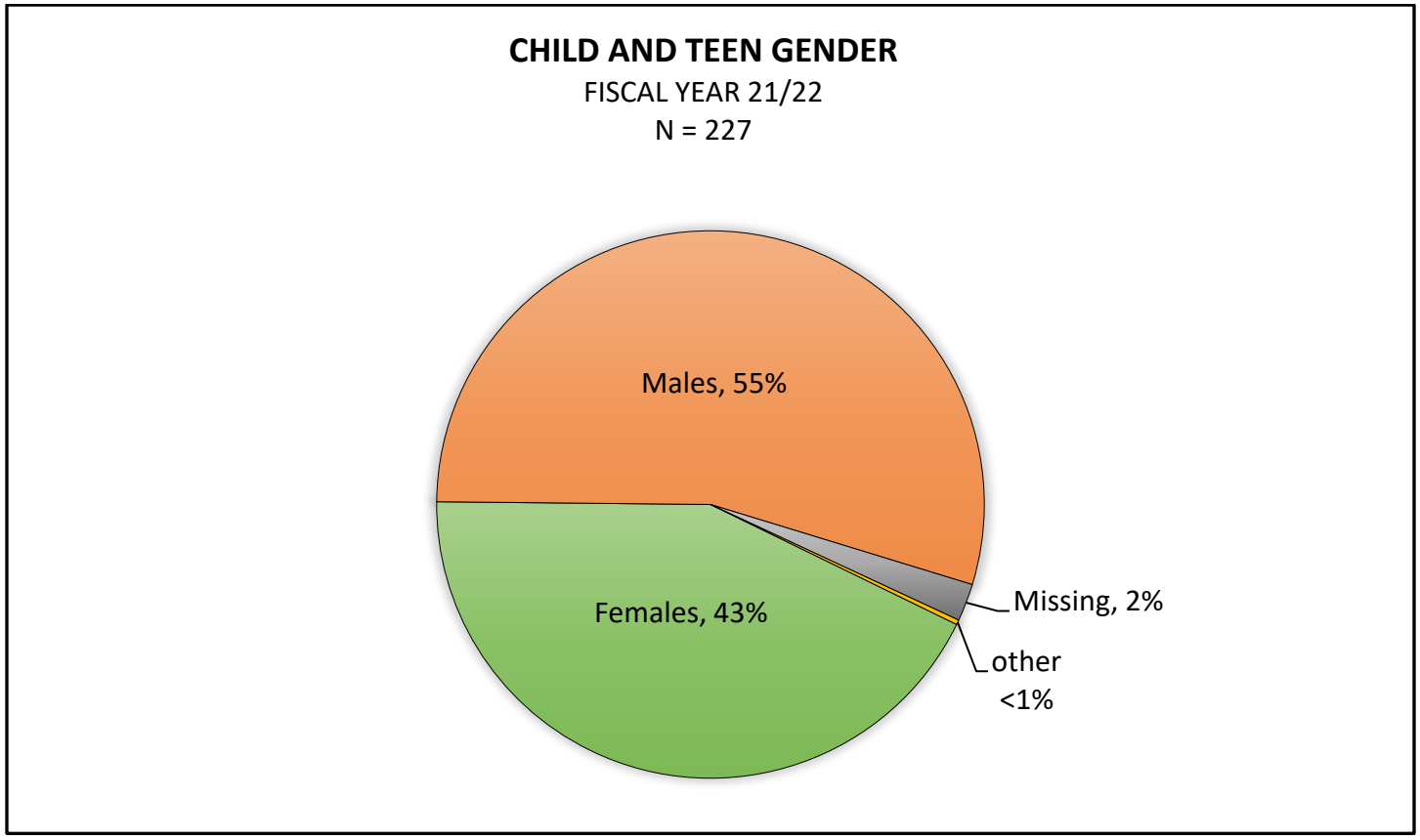
The pie chart below shows how the caregiver relates to the child or teen:



A pie chart showing the percentage of children or teens served by age group is shown below. The age of the child or teen was recorded at the beginning of the session. 111 children were aged 5 or younger out of the total 227 and the average age was 6.59.



There were 127 males, 96 females, 1 other, and 3 records missing for child and teen gender data:



Outcomes and Measures

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

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

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

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

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

A blank example of the PAFAS survey is shown on page 9, a scoring illustration of the PAFAS is shown on page 10, and the actual pre-/post-average scores from the PAFAS survey during Fiscal Year 21/22 is shown on page 11.

PAFAS Blank Assessment (example)

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

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

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

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

	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:

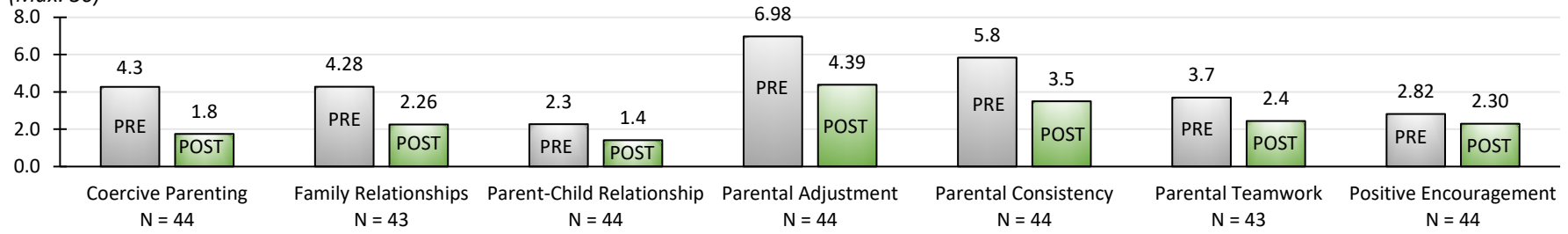
26. Our family members fight or argue	0	1	2	3		(Range) 0 – 12
27. Our family members criticize or put each other down	0	1	2	3		
24. Our family members help or support each other	0	1	2	3	(Reverse-scored)	
25. Our family members get on well with each other	0	1	2	3	(Reverse-scored)	

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)	

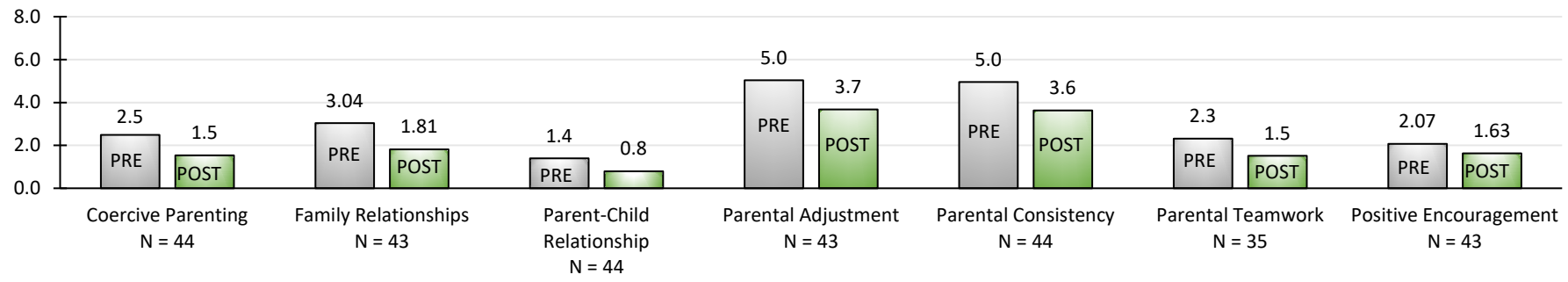
(PAFAS) Level 4 Standard

Problem score (lower preferred)
(Max: 30)



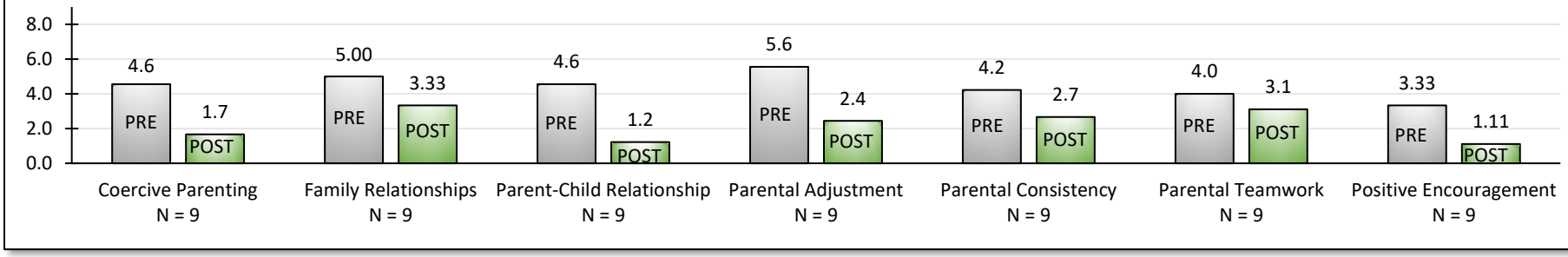
(PAFAS) Level 4 Group

Problem score (lower preferred)
(Max: 30)



(PAFAS) Level 4 Teen

Problem score (lower preferred)
(Max: 30)



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

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

There are three scored measures on the CAPES scale:

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

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

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

A blank example of the CAPES survey is shown on page 13, a scoring illustration of the CAPES survey is shown on page 14, and the actual pre-/post-average scores from the CAPES survey during Fiscal Year 20/21 is shown on page 15.

CAPES self-assessment (blank example)

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

CAPES self-assessment (scoring illustration)

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

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

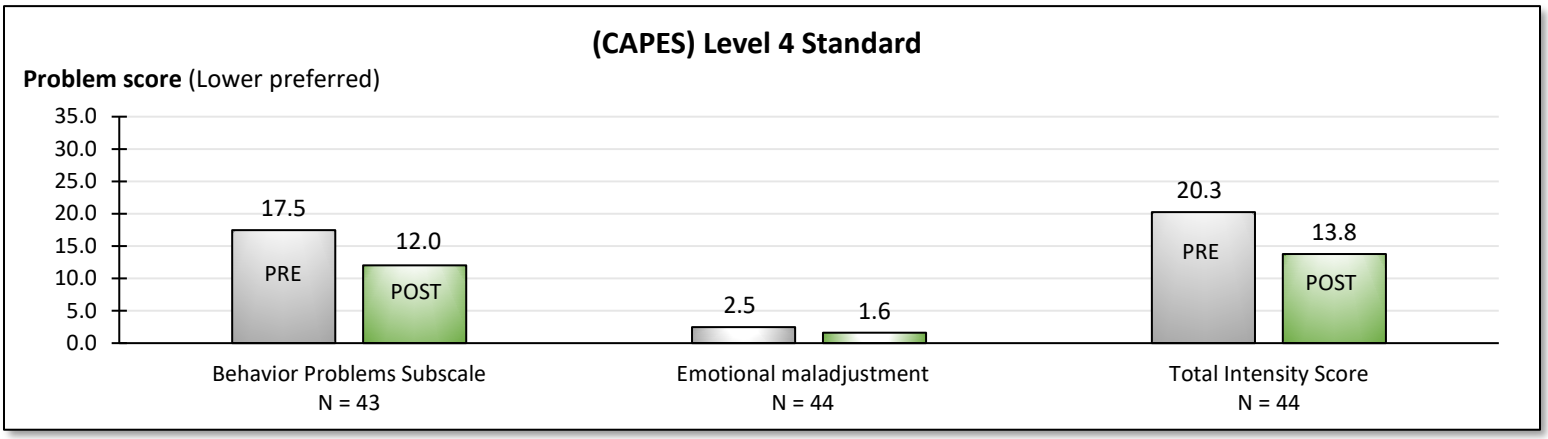
(Range) 0 – 9

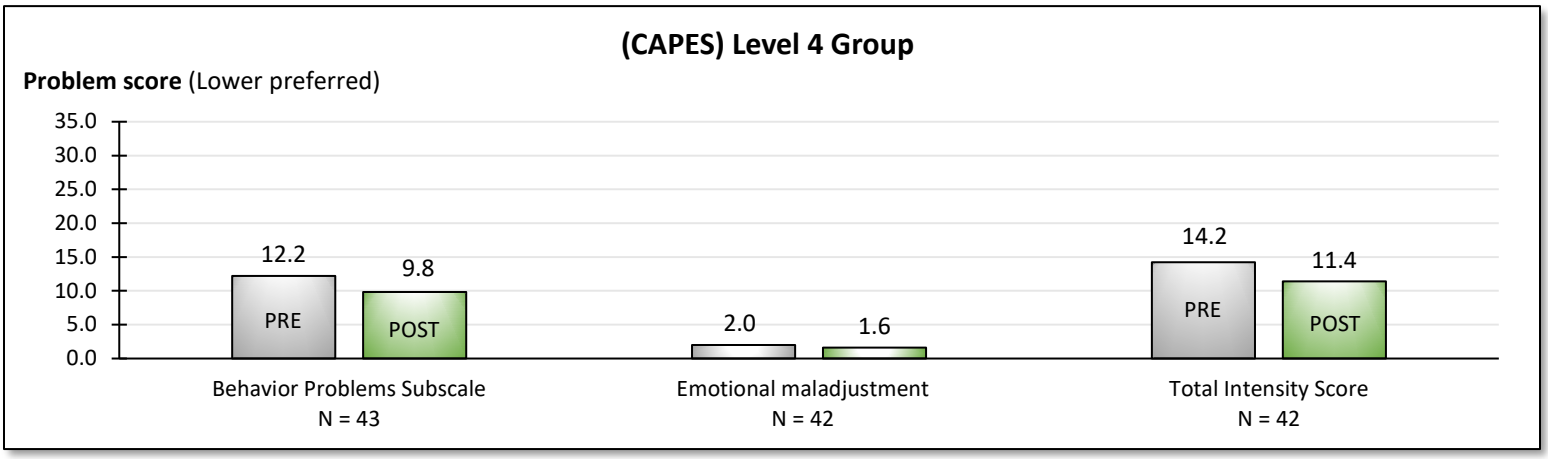
Behavioral Problems subscale scores are calculated by summing the scores for all remaining questions on the assessment:

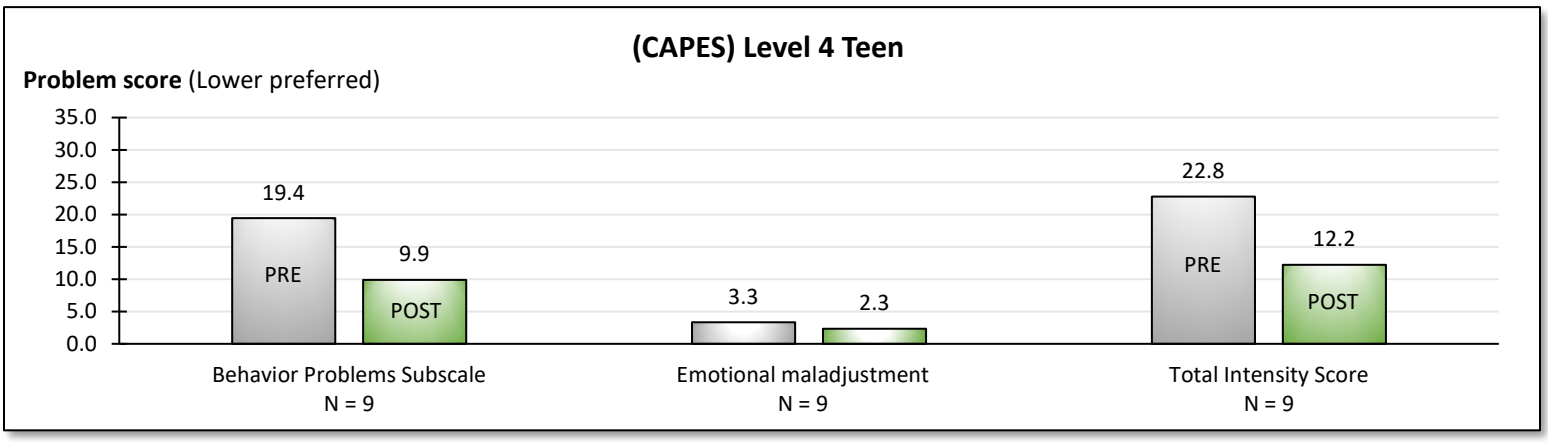
1. Gets upset or angry when they don't get their own way	0	1	2	3
2. Refuses to do jobs around the house when asked	0	1	2	3
4. Loses their temper	0	1	2	3
5. Misbehaves at mealtimes	0	1	2	3
6. Argues or fights with other children, brothers or sisters	0	1	2	3
7. Refuses to eat food made for them	0	1	2	3
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


(CAPES) Level 4 Standard
Problem score (Lower preferred)
35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0
17.5
PRE
12.0
POST
2.5
1.6
20.3
PRE
13.8
POST
Behavior Problems Subscale
N = 43
Emotional maladjustment
N = 44
Total Intensity Score
N = 44


(CAPES) Level 4 Group
Problem score (Lower preferred)
35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0
12.2
PRE
9.8
POST
2.0
1.6
14.2
PRE
11.4
POST
Behavior Problems Subscale
N = 43
Emotional maladjustment
N = 42
Total Intensity Score
N = 42


(CAPES) Level 4 Teen
Problem score (Lower preferred)
35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0
19.4
PRE
9.9
POST
3.3
2.3
22.8
PRE
12.2
POST
Behavior Problems Subscale
N = 9
Emotional maladjustment
N = 9
Total Intensity Score
N = 9

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

(Page 1 of 2)

Client Satisfaction Questionnaire *(example)*

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

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

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

7	6	5	4	3	2	1
Excellent		Good		Fair		Poor

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(Page 2 of 2)

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

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

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

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

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

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

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

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

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

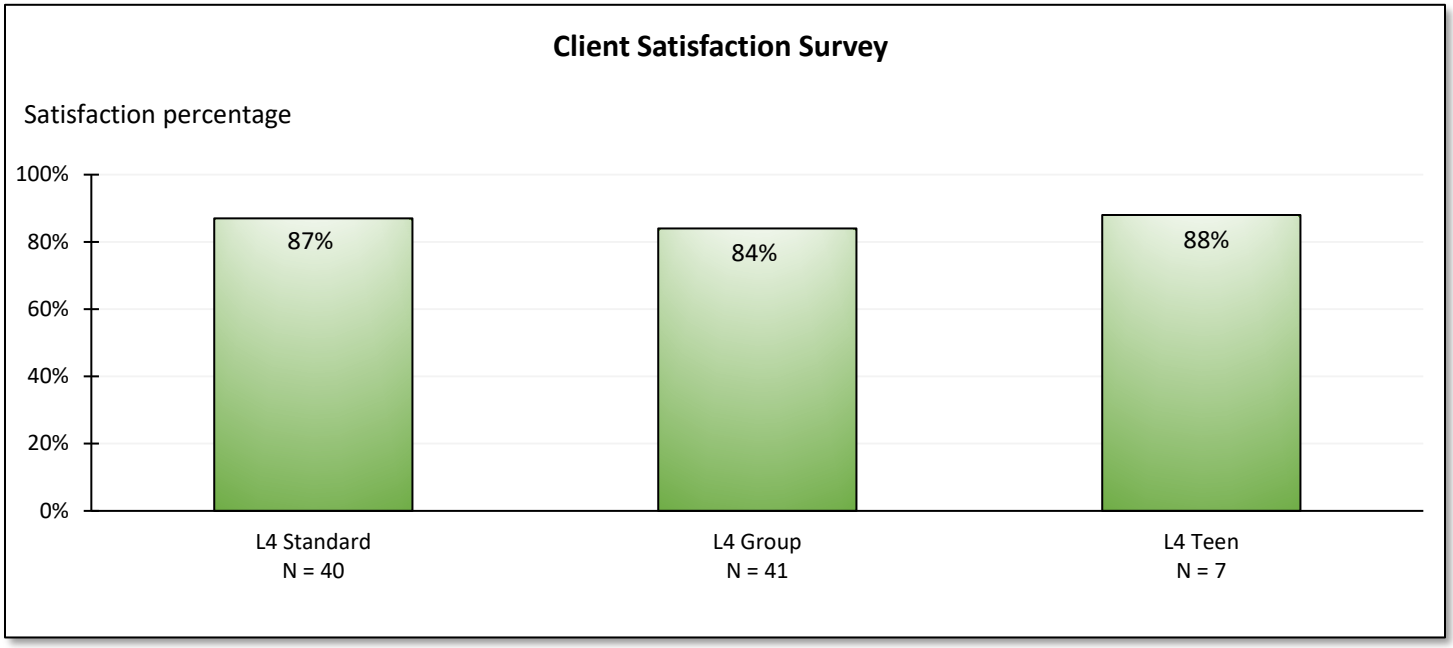
15. Have you had any other problems with your child which you feel may be related to the original difficulty?

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

Thank you

Client Satisfaction Questionnaire:

Client Satisfaction in each level was as follows:



Conclusion:

Outcomes showed decreased problem scores on both the PAFAS and CAPES assessments during Fiscal Year 21/22. In some levels, there was minimal participant data and the results were not considered reliable enough to report on.

CAPES findings:

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

- 42% in Level 4 Teen
- 33% in Level 4 Standard
- 20% in Level 4 Group

PAFAS findings:

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

- 39% in Level 4 Standard
- 50% in Level 4 Teen
- 33% in Level 4 Group

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

References

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

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

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

Shasta County
Health & Human
Services Agency

Botvin LifeSkills
Outcome Evaluation

Fiscal Year 21/22

(July 1st, 2021 – June 30th, 2022)

Table of Contents

Introduction

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

The program was administered to 6th-8th grade students attending Turtle Bay, Bella Vista, and Happy Valley during Fiscal Year 21/22. 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.

Method

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

Knowledge category

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

Attitudes category

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

Life Skills category

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

Each subgroup is a measure that is scored once the survey is completed. Measures in the *Knowledge* category were scored as a percentage (with 100% being the maximum score) while measures in the *Attitudes* and *Life Skills* categories were each scored out of five possible points (with 5/5 being the maximum score). Under the "Data Analysis" section of this report, details of how the scores were generated for these measures are provided.

Results

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

		Turtle Bay								
		6th grade			7th grade			8th grade		
	Measure	Pre-Survey (N =59)	Post-Survey (N =59)	Change	Pre-Survey (N = 42)	Post-Survey (N = 42)	Change	Pre-Survey (N = 56)	Post-Survey (N = 56)	Change
Knowledge	Anti-drug	62.7%	65.6%	2.9%	63.7%	68.5%	4.8%	63.3%	63.4%	0.1%
	Life skills	67.5%	76.5%	9.0%	75.4%	79.1%	3.6%	76.6%	82.4%	5.8%
	Overall (combined)	65.5%	72.1%	6.5%	70.7%	74.8%	4.1%	71.2%	74.7%	3.5%
Attitudes	Anti-smoking	4.63	4.53	-0.10	4.52	4.42	-0.10	4.45	4.34	-0.11
	Anti-drinking	4.50	4.44	-0.06	4.46	4.36	-0.10	4.37	4.24	-0.13
	Anti-drug (combined)	4.56	4.49	-0.07	4.49	4.39	-0.10	4.41	4.29	-0.12
Life Skills	Drug refusal	2.83	3.56	0.73	2.78	3.19	0.41	3.86	3.96	0.10
	Assertiveness	3.37	3.42	0.05	3.55	3.56	0.01	3.37	3.44	0.07
	Relaxation	3.98	3.94	-0.04	3.87	3.87	0.00	3.69	3.90	0.21
	Self-control	3.74	3.75	0.01	3.74	3.52	-0.21	3.18	3.52	0.34

Note: Numbers may not add due to rounding.

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

		Bella Vista								
		6th grade			7th grade			8th grade		
	Measure	Pre-Survey (N = 22)	Post-Survey (N = 22)	Change	Pre-Survey (N = 23)	Post-Survey (N = 23)	Change	Pre-Survey (N = 29)	Post-Survey (N = 29)	Change
Knowledge	Anti-drug	57.7%	65.7%	8.0%	58.8%	64.2%	5.4%	57.3%	64.5%	7.2%
	Life skills	71.8%	79.7%	7.9%	71.2%	70.9%	-0.2%	76.4%	78.4%	2.0%
	Overall (combined)	66.1%	74.0%	8.0%	66.1%	68.2%	2.1%	68.6%	72.7%	4.1%
Attitudes	Anti-smoking	4.33	4.42	0.09	4.66	4.41	-0.25	4.22	3.98	-0.23
	Anti-drinking	4.11	4.27	0.16	4.61	4.23	-0.38	4.09	3.91	-0.18
	Anti-drug (combined)	4.22	4.35	0.12	4.64	4.32	-0.32	4.16	3.95	-0.21
Life Skills	Drug refusal	3.86	3.04	-0.73	3.80	3.50	-0.30	3.47	3.55	0.08
	Assertiveness	3.32	3.70	0.38	3.32	3.46	0.14	3.33	3.37	0.03
	Relaxation	3.43	3.57	0.14	3.35	3.67	0.33	3.66	3.86	0.20
	Self-control	3.68	3.48	-0.20	3.61	3.50	-0.11	3.33	3.29	-0.03

Note: Numbers may not add due to rounding.

The results of each scored measure for students from Happy Valley are shown in the matrix below (8th grade post-surveys were not completed and were excluded from the evaluation). Higher post-survey scores are represented in green while lower scores are shown in red. Higher survey scores in every measure are preferred.

		Happy Valley								
		6th grade			7th grade			8th grade		
	Measure	Pre-Survey (N = 17)	Post-Survey (N = 17)	Change	Pre-Survey (N = 21)	Post-Survey (N = 21)	Change	Pre-Survey	Post-Survey	Change
Knowledge	Anti-drug	61.5%	66.1%	4.5%	63.7%	61.9%	-1.8%			
	Life skills	65.3%	67.2%	1.9%	72.2%	69.7%	-2.5%			
	Overall (combined)	63.8%	66.7%	2.9%	68.8%	66.5%	-2.3%			
Attitudes	Anti-smoking	4.54	4.5	-0.04	4.52	4.08	-0.44			
	Anti-drinking	4.47	4.25	-0.22	4.44	4.04	-0.40			
	Anti-drug (combined)	4.51	4.38	-0.13	4.47	4.07	-0.40			
Life Skills	Drug refusal	3.04	3.52	0.48	2.81	3.37	0.56			
	Assertiveness	3.16	3.98	0.82	3.40	3.32	-0.08			
	Relaxation	4.15	3.91	-0.24	3.95	3.33	-0.63			
	Self-control	3.5	3.28	-0.22	3.57	2.97	-0.60			

Note: Numbers may not add due to rounding.

Conclusion

The results show that the program was successful at improving anti-drug and life skills knowledge in each grade at Bella Vista and Turtle Bay. Happy Valley 6th graders also improved their anti-drug and life skills knowledge, but 7th graders showed a small decline. Happy Valley 8th graders did not complete the post-surveys.

Overall Life Skills (consisting of Drug Refusal, Assertiveness, Relaxation, and Self-control) and anti-drug attitudes (consisting of Anti-smoking and Anti-drinking) showed mixed results with some grades showing improvements while others worsened.

Efforts should be made to improve implementation of the program. Some grades were not available for post-survey follow-up. Some students received the program in a virtual format due to the pandemic which may have contributed to lower post-survey participation. Other improvements would consist of addressing barriers to learning, changing attitudes, and implementing life skills. Program staff should consider adjusting the curriculum to better influence anti-drug attitudes and improve implementation of life skills learned by students.

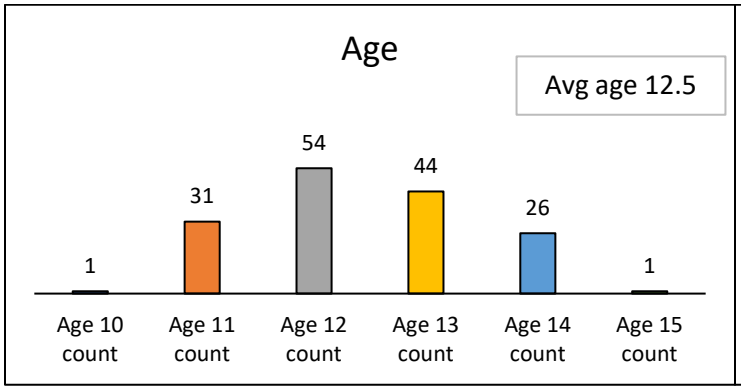
Data Analysis

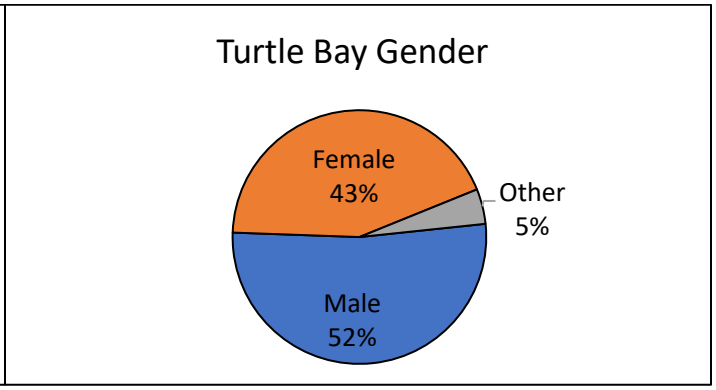
In the following section, information on the students' background (including demographic information) and how the scored measures were calculated will be explored in greater detail. Missing responses were ignored when calculating the scored measures, and missing responses were also not individually tracked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

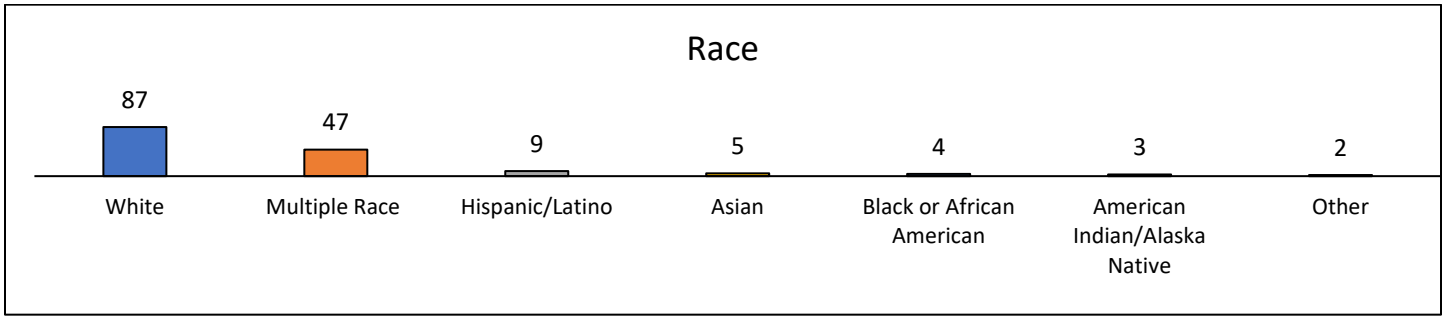
Section A: Student Background

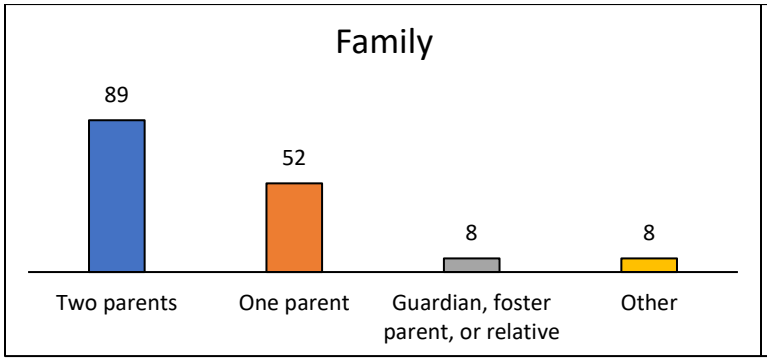
Turtle Bay Demographics

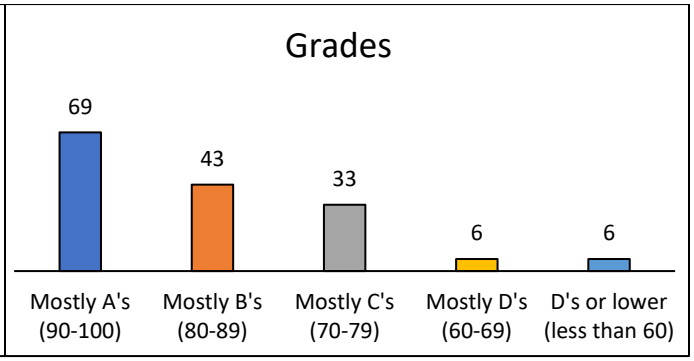
(6th-8th graders, N = up to 157)

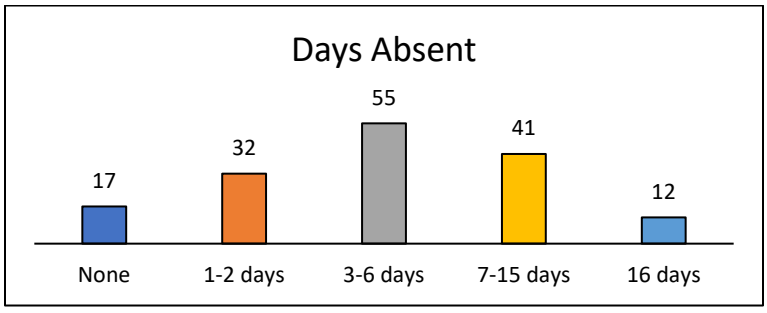












Section B: Knowledge measures (Anti-drug)

"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 (Turtle Bay)	6th grade (% correct)			7th grade (% correct)			8th grade (% correct)		
		PRE (N = 59)	POST (N = 59)	Change	PRE (N = 42)	POST (N = 42)	Change	PRE (N = 56)	POST (N = 56)	Change
1.	Most adults smoke cigarettes. (F)	42.37%	45.61%	3.24%	42.86%	45.24%	2.38%	53.70%	54.55%	0.85%
2.	Smoking a cigarette causes your heart to beat slower. (F)	16.95%	31.58%	14.63%	26.19%	40.48%	14.29%	31.48%	50.91%	19.43%
3.	Few adults drink wine, beer, or liquor every day. (T)	45.76%	29.82%	-15.94%	47.62%	38.10%	-9.52%	19.51%	27.27%	7.76%
4.	Most people my age smoke marijuana. (F)	91.53%	80.70%	-10.83%	80.95%	88.10%	7.15%	66.67%	45.45%	-21.22%
5.	Smoking marijuana causes your heart to beat faster. (T)	44.07%	73.68%	29.61%	66.67%	61.90%	-4.77%	78.05%	65.45%	-12.60%
6.	Most adults use cocaine or other hard drugs. (F)	69.49%	64.91%	-4.58%	76.19%	80.95%	4.76%	83.33%	74.55%	-8.78%
7.	Cocaine and other hard drugs always make you feel good. (F)	96.61%	80.70%	-15.91%	80.95%	88.10%	7.15%	88.89%	87.27%	-1.62%
12.	Smoking can affect the steadiness of your hands. (T)	66.10%	82.46%	16.36%	80.95%	88.10%	7.15%	78.05%	85.45%	7.41%
13.	A stimulant is a chemical that calms down the body. (F)	79.66%	71.93%	-7.73%	73.81%	76.19%	2.38%	57.41%	54.55%	-2.86%
14.	Smoking reduces a person's endurance for physical activity. (T)	72.88%	68.42%	-4.46%	88.10%	90.48%	2.38%	87.80%	85.45%	-2.35%
15.	A serving of beer or wine contains less alcohol than a serving of "hard liquor" such as whiskey. (F)	37.29%	50.88%	13.59%	21.43%	30.95%	9.52%	40.74%	32.73%	-8.01%
16.	Alcohol is a depressant. (T)	61.02%	73.68%	12.66%	50.00%	69.05%	19.05%	48.78%	74.55%	25.76%
17.	Marijuana smoking can improve your eyesight. (F)	91.53%	98.25%	6.72%	92.86%	92.86%	0.00%	88.89%	85.45%	-3.43%
	Anti-drug knowledge summary score (higher % is preferred):	**62.71%**	**65.59%**	2.88%	**63.74%**	**68.50%**	4.76%	**63.33%**	**63.36%**	0.03%

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

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 (Turtle Bay)		6th grade (% correct)			7th grade (% correct)			8th grade (% correct)		
		PRE (N = 59)	POST (N = 59)	Change	PRE (N = 42)	POST (N = 42)	Change	PRE (N = 56)	POST (N = 56)	Change
8.	What we believe about ourselves affects the way we act or behave. (T)	86.44%	89.47%	3.03%	97.62%	92.86%	-4.76%	90.24%	94.55%	4.31%
9.	It is almost impossible to develop a more positive self-image. (F)	64.41%	71.93%	7.52%	66.67%	71.43%	4.76%	74.07%	72.73%	-1.34%
10.	It is important to measure how far you have come toward reaching your goal. (T)	89.83%	84.21%	-5.62%	92.86%	92.86%	0.00%	75.61%	90.91%	15.30%
11.	It's a good idea to make a decision and then think about the consequences later. (F)	67.80%	75.44%	7.64%	71.43%	78.57%	7.14%	83.33%	76.36%	-6.97%
18.	Some advertisers are deliberately deceptive. (T)	64.41%	80.70%	16.29%	76.19%	85.71%	9.52%	78.05%	89.09%	11.04%
19.	Companies advertise only because they want you to have all the facts about their products. (F)	40.68%	68.42%	27.74%	66.67%	76.19%	9.52%	75.93%	76.36%	0.43%
20.	It's a good idea to get all information about a product from its ads. (F)	62.71%	64.91%	2.20%	69.05%	69.05%	0.00%	62.96%	78.18%	15.22%
21.	Most people do not experience anxiety. (F)	71.19%	80.70%	9.51%	71.43%	85.71%	14.28%	83.33%	81.82%	-1.51%
22.	There is very little you can do when you feel anxious. (F)	40.68%	59.65%	18.97%	52.38%	57.14%	4.76%	48.15%	70.91%	22.76%
23.	Deep breathing is one way to lessen anxiety. (T)	84.75%	89.47%	4.72%	78.57%	85.71%	7.14%	92.68%	87.27%	-5.41%
24.	Mental rehearsal is a poor relaxation technique. (F)	66.10%	82.46%	16.36%	80.95%	71.43%	-9.52%	77.78%	89.09%	11.31%
25.	You can avoid misunderstandings by assuming the other person knows what you mean. (F)	76.27%	75.44%	-0.83%	73.81%	85.71%	11.90%	75.93%	78.18%	2.25%
26.	Effective communication is when both sender and receiver interpret a message in the same way. (T)	74.58%	73.68%	-0.90%	92.86%	73.81%	-19.05%	78.05%	89.09%	11.04%
27.	Relaxation techniques are of no use when meeting people. (F)	64.41%	85.96%	21.55%	71.43%	78.57%	7.14%	77.78%	83.64%	5.86%
28.	A compliment is more effective when it is said sincerely. (T)	72.88%	78.95%	6.07%	83.33%	88.10%	4.77%	87.80%	89.09%	1.29%
29.	A nice way of ending a conversation is to tell the person you enjoyed talking with him or her. (T)	88.14%	96.49%	8.35%	90.48%	95.24%	4.76%	87.80%	96.36%	8.56%
30.	Sense of humor is an example of a non-physical attribute. (T)	50.85%	64.91%	14.06%	69.05%	78.57%	9.52%	75.61%	85.45%	9.84%
31.	It's better to be polite and lead someone on, even if you don't want to go out with them. (F)	44.07%	52.63%	8.56%	52.38%	54.76%	2.38%	62.96%	61.82%	-1.14%
32.	Almost all people who are assertive are either rude or hostile. (F)	72.88%	78.95%	6.07%	76.19%	80.95%	4.76%	66.67%	74.55%	7.88%
	Life skills knowledge summary score (higher % is preferred):	**67.53%**	**76.55%**	9.02%	**75.44%**	**79.07%**	3.63%	**76.57%**	**82.39%**	5.82%

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 (Turtle Bay)	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 = 59)	POST (N = 59)	PRE (N = 42)	POST (N = 42)	PRE (N = 56)	POST (N = 56)
4.39	4.60	4.40	4.43	4.41	4.25
4.85	4.68	4.71	4.57	4.72	4.60
4.31	4.28	4.21	4.26	3.96	3.82
4.41	4.25	4.19	4.19	3.81	3.75
4.76	4.54	4.79	4.55	4.69	4.53
4.83	4.58	4.67	4.52	4.63	4.49
4.42	4.61	4.52	4.40	4.63	4.53
4.53	4.35	4.45	4.19	4.41	4.36
4.50	4.44	4.46	4.36	4.37	4.24
4.63	4.53	4.52	4.42	4.45	4.34
4.56	4.49	4.49	4.39	4.41	4.29

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):

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)

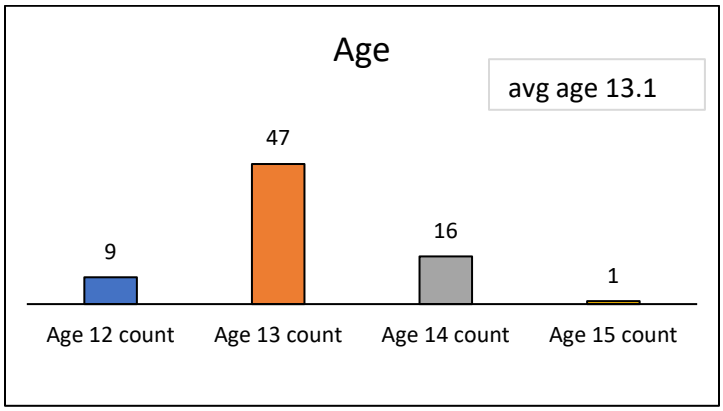
Section D: Life skills measures (Drug refusal, assertiveness, relaxation, and self-control)

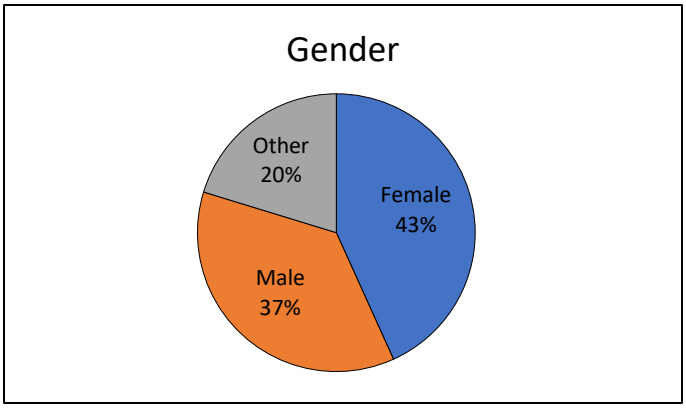
	Life skills (Turtle Bay)	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	6th grade PRE (N = 59)	6th grade POST (N = 59)	7th grade PRE (N = 42)	7th grade POST (N = 42)	8th grade PRE (N = 56)	8th grade POST (N = 56)
I would say NO if someone tried to get me to:												
1.	Smoke a cigarette. ***[Lower scores preferred]***	①	②	③	④	⑤	3.15	2.39	3.17	2.79	2.13	2.00
2.	Drink beer, wine, or liquor. ***[Lower scores preferred]***	①	②	③	④	⑤	3.20	2.51	3.29	2.86	2.17	1.98
3.	Smoke marijuana or hashish. ***[Lower scores preferred]***	①	②	③	④	⑤	3.17	2.44	3.26	2.71	2.24	2.17
4.	Use cocaine or other drugs. ***[Lower scores preferred]***	①	②	③	④	⑤	3.22	2.39	3.24	2.83	2.06	1.93
5.	Use a prescription drug that was prescribed for someone else. ***[Lower scores preferred]***	①	②	③	④	⑤	3.12	2.46	3.26	2.88	2.06	2.02
6.	Vape or smoke an e-cigarette ***[Lower scores preferred]***	①	②	③	④	⑤	3.17	2.46	3.12	2.81	2.19	2.13
	Drug refusal skill [2]*(Scores for Q's. 1-6 are averaged then subtracted from 6 to invert them - **higher scores are preferred**):*						2.83	3.56	2.78	3.19	3.86	3.96
I would:												
7.	Tell someone if they gave me less change(money) than I was supposed to get back after paying for something. ***[Lower scores preferred]***	①	②	③	④	⑤	2.34	2.49	2.29	2.26	2.44	2.19
8.	Say "no" to someone who asks to borrow money from me. ***[Lower scores preferred]***	①	②	③	④	⑤	2.81	2.58	2.67	2.57	2.69	2.63
9.	Tell someone to go to the end of the line if they try to cut ahead of me. ***[Lower scores preferred]***	①	②	③	④	⑤	2.73	2.67	2.40	2.48	2.76	2.85
	Assertiveness skills [2]*(Scores for Q's. 7-9 are averaged then subtracted from 6 to invert them - **higher scores are preferred**):*						3.37	3.42	3.55	3.56	3.37	3.44
In order to cope with stress or anxiety, I would:												
10.	Relax all the muscles in my body, starting with my feet and legs. ***[Lower scores preferred]***	①	②	③	④	⑤	2.05	2.23	2.24	2.21	2.44	2.19
11.	Breathe in slowly for a count of four, then hold my breath in for a count of four, and slowly exhale for a count of four. ***[Lower scores preferred]***	①	②	③	④	⑤	1.98	1.89	2.02	2.05	2.19	2.02
	Relaxation skills [2]*(Scores Q.10 & Q.11 are averaged then subtracted from 6 to invert them - **higher scores are preferred**):*						3.98	3.94	3.87	3.87	3.69	3.90
In general:												
12.	If I find that something is really difficult, I get frustrated and quit. ***[Higher scores preferred]***	①	②	③	④	⑤	3.58	3.67	3.50	3.50	3.04	3.31
13.	I stick to what I'm doing until I'm finished with it. ***[Lower scores preferred]***	①	②	③	④	⑤	2.10	2.18	2.02	2.45	2.69	2.28
	Self-Control Skills [2]*(Score for Q. 13 is subtracted from 6 to invert it then averaged with Q. 12 – **higher scores are preferred**):*						3.74	3.75	3.74	3.52	3.18	3.52

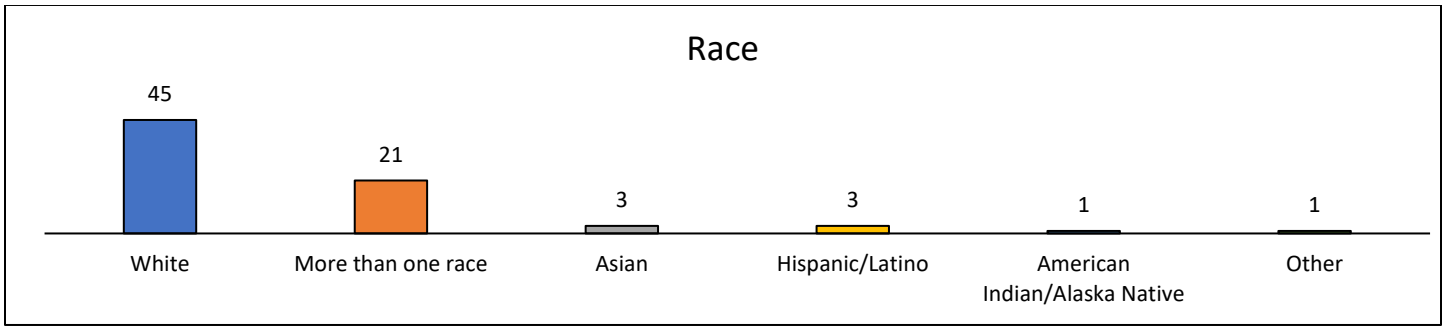
Section A: Student Background

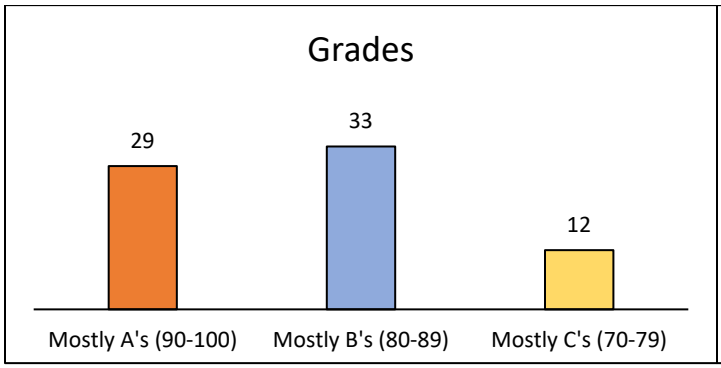
Bella Vista Demographics

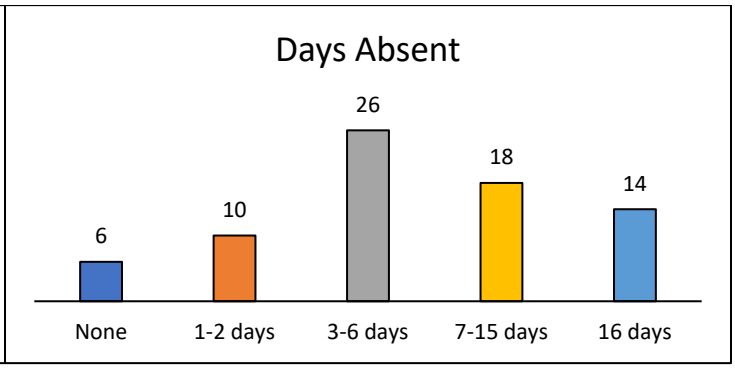
(6th-8th graders, N = up to 74)

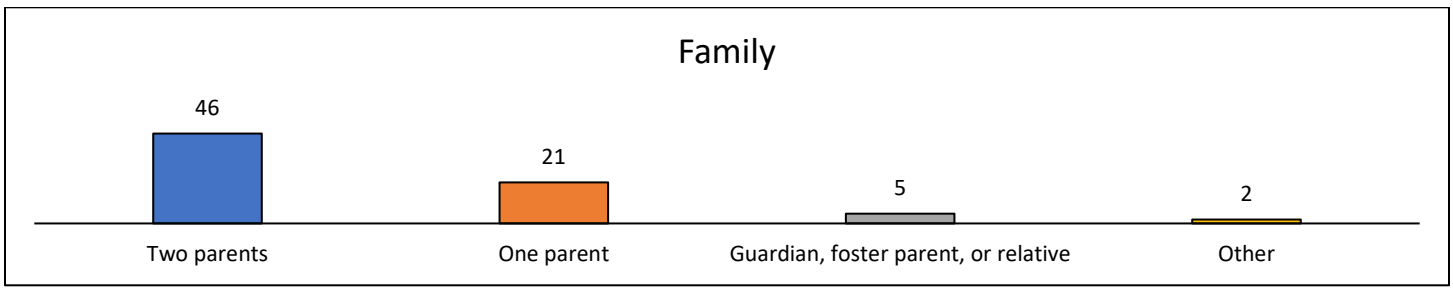












Section B: Knowledge measures (Anti-drug)

Bella Vista

"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 (Bella Vista)	6th grade (% correct)			7th grade (% correct)			8th grade (% correct)		
		PRE (N = 22)	POST (N = 22)	Change	PRE (N = 23)	POST (N = 23)	Change	PRE (N = 29)	POST (N = 29)	Change
1.	Most adults smoke cigarettes. (F)	36%	36%	0%	30%	52%	22%	34%	28%	-6%
2.	Smoking a cigarette causes your heart to beat slower. (F)	32%	23%	-9%	17%	17%	0%	24%	38%	14%
3.	Few adults drink wine, beer, or liquor every day. (T)	32%	32%	0%	43%	17%	-26%	31%	41%	10%
4.	Most people my age smoke marijuana. (F)	73%	68%	-5%	78%	87%	9%	59%	59%	0%
5.	Smoking marijuana causes your heart to beat faster. (T)	64%	82%	18%	65%	91%	26%	79%	83%	4%
6.	Most adults use cocaine or other hard drugs. (F)	45%	64%	19%	52%	65%	13%	86%	79%	-7%
7.	Cocaine and other hard drugs always make you feel good. (F)	68%	82%	14%	91%	91%	0%	66%	76%	10%
12.	Smoking can affect the steadiness of your hands. (T)	73%	91%	18%	73%	91%	18%	79%	86%	7%
13.	A stimulant is a chemical that calms down the body. (F)	55%	73%	18%	65%	48%	-17%	38%	38%	0%
14.	Smoking reduces a person's endurance for physical activity. (T)	77%	86%	9%	74%	87%	13%	90%	90%	0%
15.	A serving of beer or wine contains less alcohol than a serving of "hard liquor" such as whiskey. (F)	27%	36%	9%	26%	30%	4%	10%	45%	35%
16.	Alcohol is a depressant. (T)	68%	82%	14%	61%	65%	4%	66%	90%	24%
17.	Marijuana smoking can improve your eyesight. (F)	100%	100%	0%	87%	91%	4%	83%	86%	3%
	Anti-drug knowledge summary score (higher % is preferred):	58%	66%	8%	59%	64%	5%	57%	65%	7%

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

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 (Bella Vista)		6th grade (% correct)			7th grade (% correct)			8th grade (% correct)		
		PRE (N = 22)	POST (N = 22)	Change	PRE (N = 23)	POST (N = 23)	Change	PRE (N = 29)	POST (N = 29)	Change
8.	What we believe about ourselves affects the way we act or behave. (T)	82%	95%	13%	83%	87%	4%	90%	83%	-7%
9.	It is almost impossible to develop a more positive self-image. (F)	73%	86%	13%	61%	65%	4%	62%	62%	0%
10.	It is important to measure how far you have come toward reaching your goal. (T)	82%	91%	9%	96%	91%	-5%	93%	93%	0%
11.	It's a good idea to make a decision and then think about the consequences later. (F)	50%	91%	41%	74%	74%	0%	72%	69%	-3%
18.	Some advertisers are deliberately deceptive. (T)	82%	95%	13%	70%	70%	0%	79%	86%	7%
19.	Companies advertise only because they want you to have all the facts about their products. (F)	59%	64%	5%	65%	65%	0%	66%	72%	6%
20.	It's a good idea to get all information about a product from its ads. (F)	55%	59%	4%	70%	65%	-5%	76%	86%	10%
21.	Most people do not experience anxiety. (F)	86%	95%	9%	70%	57%	-13%	83%	86%	3%
22.	There is very little you can do when you feel anxious. (F)	50%	64%	14%	65%	61%	-4%	48%	62%	14%
23.	Deep breathing is one way to lessen anxiety. (T)	77%	86%	9%	78%	83%	5%	97%	76%	-21%
24.	Mental rehearsal is a poor relaxation technique. (F)	77%	82%	5%	48%	65%	17%	66%	66%	0%
25.	You can avoid misunderstandings by assuming the other person knows what you mean. (F)	82%	77%	-5%	70%	61%	-9%	72%	83%	11%
26.	Effective communication is when both sender and receiver interpret a message in the same way. (T)	64%	73%	9%	74%	74%	0%	79%	86%	7%
27.	Relaxation techniques are of no use when meeting people. (F)	86%	91%	5%	57%	57%	0%	79%	76%	-3%
28.	A compliment is more effective when it is said sincerely. (T)	73%	95%	22%	74%	87%	13%	79%	90%	11%
29.	A nice way of ending a conversation is to tell the person you enjoyed talking with him or her. (T)	91%	91%	0%	91%	83%	-8%	93%	93%	0%
30.	Sense of humor is an example of a non-physical attribute. (T)	64%	64%	0%	78%	70%	-8%	69%	90%	21%
31.	It's better to be polite and lead someone on, even if you don't want to go out with them. (F)	45%	41%	-4%	57%	65%	8%	72%	72%	0%
32.	Almost all people who are assertive are either rude or hostile. (F)	86%	73%	-13%	74%	70%	-4%	76%	59%	-17%
	Life skills knowledge summary score (higher % is preferred):	72%	80%	8%	71%	71%	0%	76%	78%	2%

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 (Bella Vista)	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 = 22)	POST (N = 22)	PRE (N = 23)	POST (N = 23)	PRE (N = 29)	POST (N = 29)
3.91	4.55	4.52	4.39	4.14	3.97
4.64	4.73	4.87	4.48	4.45	4.03
4.05	3.64	4.35	3.91	4.14	3.79
3.95	3.91	4.35	4.30	4.07	3.76
4.41	4.41	4.91	4.35	4.28	4.00
4.41	4.59	4.78	4.48	4.21	4.14
4.32	4.45	4.65	4.39	4.14	4.00
4.09	4.50	4.65	4.26	3.83	3.90
4.11	**4.27**	**4.61**	**4.23**	**4.09**	**3.91**
4.33	**4.42**	**4.66**	**4.41**	**4.22**	**3.98**
4.22	**4.35**	**4.64**	**4.32**	**4.16**	**3.95**

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):

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)

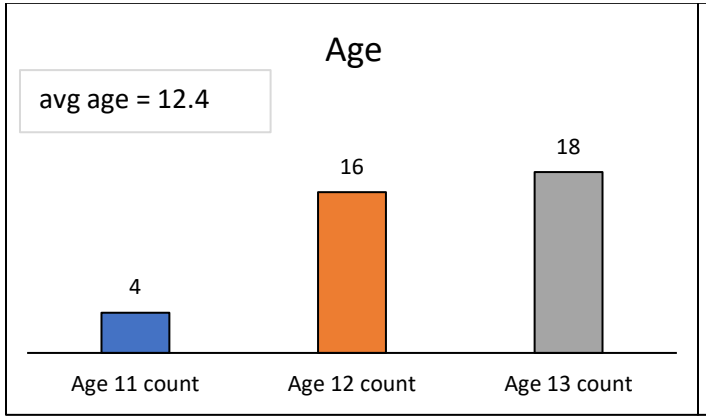
Section D: Life skills measures (Drug refusal, assertiveness, relaxation, and self-control)

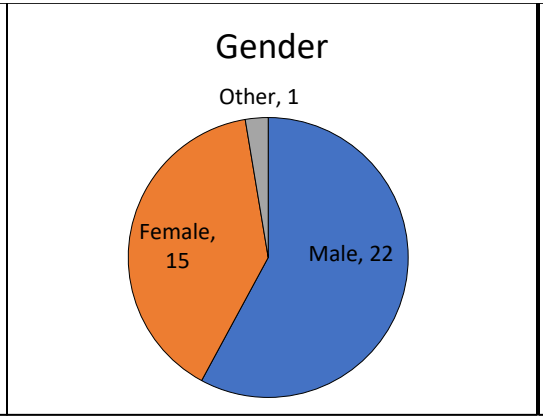
	Life skills (Bella Vista)	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	6th grade PRE (N = 22)	6th grade POST (N = 22)	7th grade PRE (N = 23)	7th grade POST (N = 23)	8th grade PRE (N = 29)	8th grade POST (N = 29)
I would say NO if someone tried to get me to:												
1.	Smoke a cigarette. ***[Lower scores preferred]***	①	②	③	④	⑤	2.18	2.95	2.17	2.43	2.41	2.31
2.	Drink beer, wine, or liquor. ***[Lower scores preferred]***	①	②	③	④	⑤	2.27	2.95	2.30	2.83	2.72	2.45
3.	Smoke marijuana or hashish. ***[Lower scores preferred]***	①	②	③	④	⑤	2.18	2.95	2.13	2.48	2.55	2.59
4.	Use cocaine or other drugs. ***[Lower scores preferred]***	①	②	③	④	⑤	1.95	3.00	2.17	2.39	2.48	2.48
5.	Use a prescription drug that was prescribed for someone else. ***[Lower scores preferred]***	①	②	③	④	⑤	2.00	3.09	2.17	2.43	2.45	2.48
6.	Vape or smoke an e-cigarette ***[Lower scores preferred]***	①	②	③	④	⑤	2.23	2.82	2.22	2.43	2.55	2.38
	Drug refusal skill [2]*(Scores for Q's. 1-6 are averaged then subtracted from 6 to invert them -* ***higher scores are preferred****):*						**3.86**	**3.04**	**3.80**	**3.5**	**3.47**	**3.55**
I would:												
7.	Tell someone if they gave me less change (money) than I was supposed to get back after paying for something. ***[Lower scores preferred]***	①	②	③	④	⑤	2.59	2.27	2.70	2.61	2.45	2.41
8.	Say "no" to someone who asks to borrow money from me. ***[Lower scores preferred]***	①	②	③	④	⑤	2.91	2.64	2.70	2.57	2.83	2.69
9.	Tell someone to go to the end of the line if they try to cut ahead of me. ***[Lower scores preferred]***	①	②	③	④	⑤	2.55	2.00	2.65	2.43	2.72	2.79
	Assertiveness skills [2]*(Scores for Q's. 7-9 are averaged then subtracted from 6 to invert them -* ***higher scores are preferred****):*						**3.32**	**3.70**	**3.32**	**3.46**	**3.33**	**3.37**
In order to cope with stress or anxiety, I would:												
10.	Relax all the muscles in my body, starting with my feet and legs. ***[Lower scores preferred]***	①	②	③	④	⑤	2.64	2.45	2.65	2.39	2.52	2.10
11.	Breathe in slowly for a count of four, then hold my breath in for a count of four, and slowly exhale for a count of four. ***[Lower scores preferred]***	①	②	③	④	⑤	2.50	2.41	2.65	2.26	2.17	2.17
	Relaxation skills [2]*(Scores for Q's 10 & 11 are averaged then subtracted from 6 to invert them -* ***higher scores are preferred****):*						**3.43**	**3.57**	**3.35**	**3.67**	**3.66**	**3.86**
In general:												
12.	If I find that something is really difficult, I get frustrated and quit. **[Higher scores preferred]**	①	②	③	④	⑤	3.36	2.86	3.30	3.13	3.21	3.00
13.	I stick to what I'm doing until I'm finished with it. ***[Lower scores preferred]***	①	②	③	④	⑤	2.00	1.91	2.09	2.13	2.55	2.41
	Self-Control Skills [2]*(Score for Q. 13 is subtracted from 6 to invert it then averaged with Q. 12 –* ***higher scores are preferred****):*						**3.68**	**3.48**	**3.61**	**3.50**	**3.33**	**3.29**

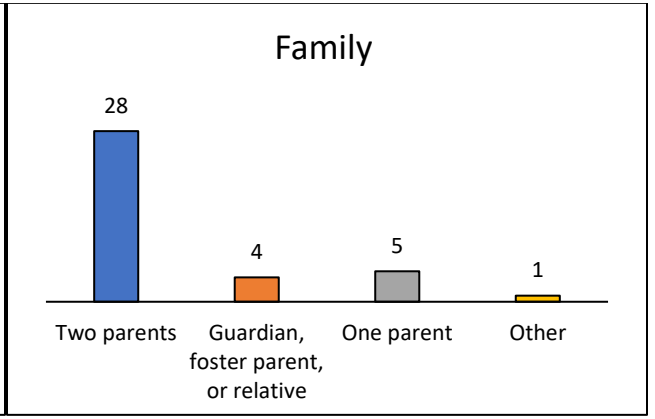
Section A: Student Background

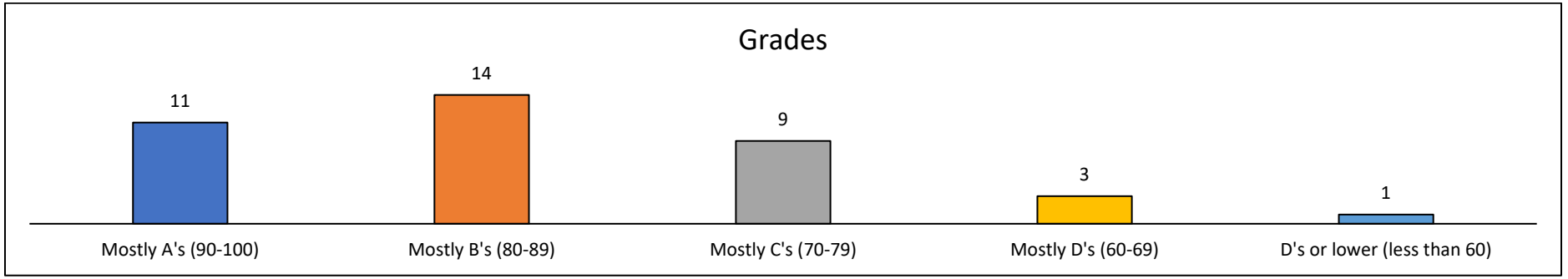
Happy Valley Demographics

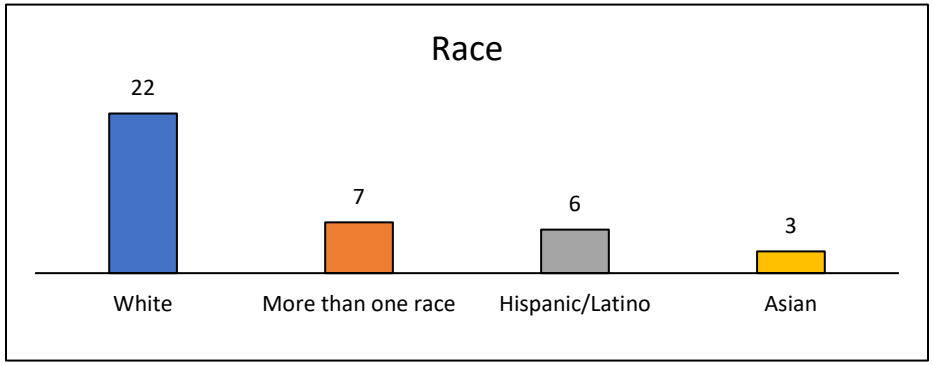
(6th-8th graders, N = up to 38)

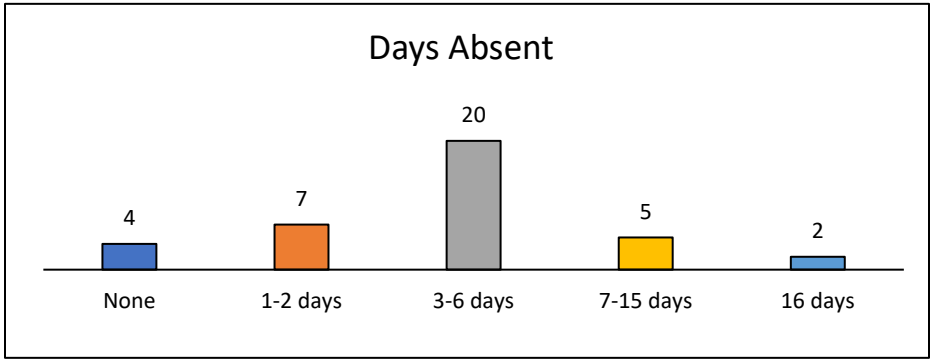












Section B: Knowledge measures (Anti-drug)

Happy Valley

"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 (Happy Valley)	6th grade (% correct)			7th grade (% correct)			8th grade (% correct)		
		PRE (N = 17)	POST (N = 17)	Change	PRE (N = 21)	POST (N = 21)	Change	PRE	POST	Change
1.	Most adults smoke cigarettes. (F)	35%	47%	12%	48%	57%	9%			
2.	Smoking a cigarette causes your heart to beat slower. (F)	24%	29%	5%	38%	52%	14%			
3.	Few adults drink wine, beer, or liquor every day. (T)	41%	18%	-23%	43%	10%	-33%			
4.	Most people my age smoke marijuana. (F)	94%	94%	0%	90%	71%	-19%			
5.	Smoking marijuana causes your heart to beat faster. (T)	29%	82%	53%	62%	67%	5%			
6.	Most adults use cocaine or other hard drugs. (F)	76%	76%	0%	62%	76%	14%			
7.	Cocaine and other hard drugs always make you feel good. (F)	100%	88%	-12%	86%	81%	-5%			
12.	Smoking can affect the steadiness of your hands. (T)	53%	100%	47%	81%	71%	-10%			
13.	A stimulant is a chemical that calms down the body. (F)	88%	71%	-17%	67%	71%	4%			
14.	Smoking reduces a person's endurance for physical activity. (T)	71%	82%	11%	86%	67%	-19%			
15.	A serving of beer or wine contains less alcohol than a serving of "hard liquor" such as whiskey. (F)	35%	47%	12%	33%	43%	10%			
16.	Alcohol is a depressant. (T)	53%	53%	0%	48%	57%	9%			
17.	Marijuana smoking can improve your eyesight. (F)	100%	71%	-29%	86%	81%	-5%			
	Anti-drug knowledge summary score (higher % is preferred):	61%	66%	5%	64%	62%	-2%			

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

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 (Happy Valley)		6th grade (% correct)			7th grade (% correct)			8th grade (% correct)		
		PRE (N = 17)	POST (N = 17)	Change	PRE (N = 21)	POST (N = 21)	Change	PRE	POST	Change
8.	What we believe about ourselves affects the way we act or behave. (T)	88%	82%	-6%	90%	86%	-4%			
9.	It is almost impossible to develop a more positive self-image. (F)	76%	41%	-35%	71%	76%	5%			
10.	It is important to measure how far you have come toward reaching your goal. (T)	88%	88%	0%	95%	81%	-14%			
11.	It's a good idea to make a decision and then think about the consequences later. (F)	82%	65%	-17%	67%	71%	4%			
18.	Some advertisers are deliberately deceptive. (T)	59%	53%	-6%	67%	43%	-24%			
19.	Companies advertise only because they want you to have all the facts about their products. (F)	53%	59%	6%	71%	71%	0%			
20.	It's a good idea to get all information about a product from its ads. (F)	59%	59%	0%	57%	81%	24%			
21.	Most people do not experience anxiety. (F)	82%	76%	-6%	76%	71%	-5%			
22.	There is very little you can do when you feel anxious. (F)	47%	65%	18%	57%	76%	19%			
23.	Deep breathing is one way to lessen anxiety. (T)	82%	76%	-6%	95%	76%	-19%			
24.	Mental rehearsal is a poor relaxation technique. (F)	65%	53%	-12%	62%	67%	5%			
25.	You can avoid misunderstandings by assuming the other person knows what you mean. (F)	71%	59%	-12%	67%	71%	4%			
26.	Effective communication is when both sender and receiver interpret a message in the same way. (T)	53%	88%	35%	76%	67%	-9%			
27.	Relaxation techniques are of no use when meeting people. (F)	47%	76%	29%	71%	71%	0%			
28.	A compliment is more effective when it is said sincerely. (T)	71%	71%	0%	76%	67%	-9%			
29.	A nice way of ending a conversation is to tell the person you enjoyed talking with him or her. (T)	65%	82%	17%	95%	62%	-33%			
30.	Sense of humor is an example of a non-physical attribute. (T)	35%	65%	30%	67%	43%	-24%			
31.	It's better to be polite and lead someone on, even if you don't want to go out with them. (F)	47%	41%	-6%	43%	67%	24%			
32.	Almost all people who are assertive are either rude or hostile. (F)	71%	76%	5%	67%	76%	9%			
	Life skills knowledge summary score (higher % is preferred):	65%	67%	2%	72%	70%	-2%			

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 (Happy Valley)	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

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):

6th grade		7th grade		8th grade	
PRE (N = 17)	POST (N = 17)	PRE (N = 21)	POST (N = 21)	PRE	POST
4.12	4.00	4.52	3.76		
4.76	4.38	4.52	4.05		
4.65	4.50	4.48	4.00		
4.59	4.44	4.48	4.05		
4.59	4.50	4.62	4.33		
4.65	4.69	4.43	4.14		
4.18	4.50	4.57	4.14		
4.53	4.00	4.14	4.05		
4.47	**4.25**	**4.44**	**4.04**		
4.54	**4.5**	**4.50**	**4.10**		
4.51	**4.38**	**4.47**	**4.07**		

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

	Life skills (Happy Valley)	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	6th grade PRE (N = 17)	6th grade POST (N = 17)	7th grade PRE (N = 21)	7th grade POST (N = 21)	8th grade PRE	8th grade POST
I would say NO if someone tried to get me to:												
1.	Smoke a cigarette. ***[Lower scores preferred]***	①	②	③	④	⑤	2.88	2.38	3.19	2.52		
2.	Drink beer, wine, or liquor. ***[Lower scores preferred]***	①	②	③	④	⑤	2.82	2.75	3.10	2.52		
3.	Smoke marijuana or hashish. ***[Lower scores preferred]***	①	②	③	④	⑤	2.94	2.56	3.29	2.62		
4.	Use cocaine or other drugs. ***[Lower scores preferred]***	①	②	③	④	⑤	2.94	2.44	3.14	2.62		
5.	Use a prescription drug that was prescribed for someone else. ***[Lower scores preferred]***	①	②	③	④	⑤	3.06	2.31	3.29	2.76		
6.	Vape or smoke an e-cigarette ***[Lower scores preferred]***	①	②	③	④	⑤	3.12	2.44	3.14	2.71		
	Drug refusal skill [2]*(Scores for Q's. 1-6 are averaged then subtracted from 6 to invert them - **higher scores are preferred**):*						**3.04**	**3.52**	**2.81**	**3.37**		
I would:												
7.	Tell someone if they gave me less change (money) than I was supposed to get back after paying for something. ***[Lower scores preferred]***	①	②	③	④	⑤	2.71	1.75	2.52	2.52		
8.	Say "no" to someone who asks to borrow money from me. ***[Lower scores preferred]***	①	②	③	④	⑤	3.06	2.38	2.62	2.81		
9.	Tell someone to go to the end of the line if they try to cut ahead of me. ***[Lower scores preferred]***	①	②	③	④	⑤	2.76	1.94	2.67	2.71		
	Assertiveness skills [2]*(Scores for Q's. 7-9 are averaged then subtracted from 6 to invert them - **higher scores are preferred**):*						**3.16**	**3.98**	**3.40**	**3.32**		
In order to cope with stress or anxiety, I would:												
10.	Relax all the muscles in my body, starting with my feet and legs. ***[Lower scores preferred]***	①	②	③	④	⑤	1.94	2.13	2.19	2.80		
11.	Breathe in slowly for a count of four, then hold my breath in for a count of four, and slowly exhale for a count of four. ***[Lower scores preferred]***	①	②	③	④	⑤	1.76	2.06	1.90	2.55		
	Relaxation skills [2]*(Scores for Q's 10 & 11 are averaged then subtracted from 6 to invert them - **higher scores are preferred**):*						**4.15**	**3.91**	**3.95**	**3.33**		
In general:												
12.	If I find that something is really difficult, I get frustrated and quit. **[Higher scores preferred]**	①	②	③	④	⑤	3.35	2.56	3.67	2.95		
13.	I stick to what I'm doing until I'm finished with it. ***[Lower scores preferred]***	①	②	③	④	⑤	2.35	2.00	2.52	3.00		
	Self-Control Skills [2]*(Score for Q. 13 is subtracted from 6 to invert it then averaged with Q. 12 – **higher scores are preferred**):*						**3.5**	**3.28**	**3.48**	**2.97**		

References

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

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

Shasta County Health & Human Services Agency

Adverse Childhood Experiences FY: 2021 -2022

Protective Factors

Parent Café's

During this reporting period, Tri County Community Network hosted three Parent Café's that served 57 attendees, and Pathways to Hope for Children hosted 20 Parent Café's that served 321 attendees in Shasta County.

Table Host Trainings

In FY 21-22, Pathways to Hope for Children trained 19 attendees at five events to become Parent Café table hosts.

Trauma-Informed Practices Trainings

Organization	Number of Trainings Provided	Number of Attendees
Rocky Point Staff	1	15
Montgomery Creek Staff	1	14
CHYBA Staff	1	22
Pathways to Hope for Children	1	20
Shasta County Office of Education	4	84
First 5 Shasta	5	269
	Total Trainings: 13	**Total Attendees:** 424

Protective Factors Trainings

During this reporting period, Pathways to Hope for Children provided two trainings on Protective Factors to 21 attendees.

Hope Navigators | Pathways to Hope for Children

In FY 21-22, Pathways to Hope for Children hosted two meetings and 83 trained Hope Navigators attended. During this same reporting period, four trainings were offered serving 418 attendees.

Community Engagement

Strengthening Families Collaborative (SFC)

SFC membership includes: Far Northern Regional Center, First 5 Shasta, Northern Valley Catholic Social Service, One Safe Place, Pathway's to Hope for Children, Shasta County Health & Human Services Agency, Shasta College, Shasta County Office of Education, Shasta County Probation, Shasta Head Start, and Youth Options Shasta

In 2021 the SFC Chair was Michael Burke from Pathways to Hope for Children, and the Chair Elect was Tracie Neal from Shasta County Probation. In 2022, the SFC voted to keep the same Leadership Team for another term through December 2022.

Meeting agendas during this reporting period included discussion relating to: Vital Art Murals in Shasta County, Developmental Relationships Presentation by Susan Wilson, Hope Navigator Trainings and Hope Theory in Shasta County, SFC Data Dashboard, support for families going "Back to School" post-Covid, ACE Master Trainers, ACE Public Service Announcements, Redding Teen Center, SFC Website Development, and Conducting a Local ACE Survey.

SFC Data Committee (sub-committee)

The SFC Data Committee includes members from the following organizations: First 5 Shasta, One Safe Place, Shasta County Health and Human Services Agency, Shasta County Probation, and Youth Options Shasta

Meetings held during the reporting period focused on:

- Discussion regarding how the Data Dashboard relates to ACEs, and how to define the work we are doing to be easily understood by the public.
- Reviewing the 11 ACE Indicators and identifying those responsible for reporting.
- Launching the live Data Dashboard. Data updates will be provided annually.
- Ensuring the Data Dashboard link will be included on the new Shasta Strengthening Families website once completed.

ACE Learning Community/ACE Interface Trainers

ACE Trainers include staff from the following Shasta County organizations: Branches Faith, Children's Legacy Center, Shasta County District Attorney, Evergreen Middle School, First 5 Shasta, Shasta County Health and Human Services Agency, HOPE City Redding, I am Brave International Inc., Northern Valley Catholic Social Service, One Safe Place, Shasta College, Shasta County Office of Education, Shasta County Juvenile Probation, Shasta Head Start, Turtle Bay School, and Youth Options Shasta.

During this reporting period, Learning Community activities included:

- Discussion on recruiting new ACE Presenters to expand network to additional spheres of influence (housing, business, judicial system, etc.)
- Updating the ACE Presentations including slides, scripts, activities, and handouts
- 5 Master Trainers were trained by Laura Porter. Master Trainers will have the ability to train new ACE Presenters in Shasta County and provide support to presenters during Learning Community Meetings.

ACE Master Trainers represent the following organizations: Northern Valley Catholic Social Service, Shasta County Office of Education, Children's Legacy Center, First 5 Shasta, and Youth Options Shasta.

ACE Master Trainers met monthly during the FY 21-22 reporting period and accomplished:

- Develop Action Plan to formally outline Master Trainer meetings, training ACE Presenters, Community ACE Presentations, and supporting Learning Community meeting needs.
- Planning Quarterly ACE Presentations, in addition to a specific ACE Presentation series for Law Enforcement.
- Reengagement with ACE Presenters who were less active due to the pandemic.
- Review and update the ACE Presentation Evaluation.

ACE Events

ACE Luncheons

Two Luncheons were held during this reporting period:

- From ACEs to Hope: Building Resilience in Our Families held on January 26th and included 58 attendees; held virtually.
- From ACEs to Hope: Wellbeing in the Workplace held on April 20th and included 31 attendees; held in-person.

ACE Presentations & Movie Showings

Appendix L

ACE Presentations

Quarter	Number of ACE Presentations	Number of Attendees
July - September	11	234
October – December	7	92
January – March	4	81
April - June	8	110
	Total Presentations: 30	**Total Attendees:** 517

Due to COVID-19 restrictions, many ACE events were limited and virtual during this reporting period. To improve and enhance ACE Presentations, the ACE Coordinator worked in collaboration with the ACE Master Trainers to create a new electronic survey platform to assist ACE Presenters with collecting ACE scores and evaluations during training events.

Movie Showings *(Resilience, Paper Tigers, and Broken Places)*
Due to the COVID-19 restrictions, there were no movie showings that occurred during this reporting period. The ACE Coordinator initiated contact with RoCo Films to discuss purchasing licensing for virtual movie screenings.

Shasta Strengthening Families Marketing

Social Media Engagement

During this reporting period, Instagram followers increased from 470 to 908 people. During this same time, Facebook followers increased from 485 to 558 people.

Social media account administration was changed from First 5 Shasta to Shasta County HHSA. Posts included information on upcoming events, protective factors, developmental assets, and other information to supporting parents and families in preventing and mitigating toxic stress.

The ACE Coordinator created a media plan to promote the new website, revamped ACE events, and positive parenting tips related to the impact of the pandemic.

Website

During this time the SFC/ACE website update was in development to create a sample mockup to share with the Strengthening Families Collaborative for review and feedback. Web content was then submitted through the HHSA internal editing process for approval.

The ACE Coordinator worked with the contracted vendor, Pacific Sky, to complete the website layout design and content development. In addition to the website, Pacific Sky was also contracted to create four short videos to be included on the website that featured information on toxic stress, protective factors, and ACEs in Shasta County. Video scripts and storyboards were developed and shared with the SFC for feedback and approval.

Public Service Announcements/Videos

During this reporting period, the ACE Coordinator discussed new Public Service Announcement (PSA) videos to feature updated information relating to the impacts of toxic stress and featuring local programs that prevent or mitigate ACEs in Shasta County. Shasta County HHSA initiated the contract process with Faires Wheel Films. Pathways to Hope for Children and Youth Options Shasta will also develop ACE related PSAs for their organizations.

Materials

New education outreach materials were designed to promote ACE/SFC efforts such as ChapSticks, youth sunglasses, food storage containers, magnets, stickers, books for families, and stress balls.

Materials:	Number of Items Distributed:
SFC ChapStick	750
Sunglasses	160
Food Storage Containers	65
Magnets	220
Stickers	560
"Help That Helps" Book	600
Stress Ball	135

Additionally, the ACEs program purchased a canopy and tablecloth to increase visibility at local outreach events.

Other

During this reporting period the ACE Coordinator/Strengthening Families Collaborative Coordinator returned to program duties in July after demobilizing from the COVID-19 response.

The ACE Coordinator, in collaboration with the SFC, partnered with Vital Art to create 15 murals around Shasta County to promote preventing ACEs and positive parenting. A branding guide was developed to assist with SFC members sharing and promoting various events with the standard logo including the approved colors and fonts.

An article was featured in North State Parent Magazine titled "Adverse Childhood Experiences: One Caring Adult Can Make a Difference".

The ACE Program collaborated with additional Public Health programs to develop a new local Mental Wellness Survey to Shasta County Residents that included questions regarding ACEs. 600 Shasta County residents completed the local telephone survey, and the results were evaluated in the following fiscal year.

The Northern ACEs Collaborative hosted the Rural ACEs Summit virtually in September 2021. The theme was innovation and best practices for implementing Trauma-Informed and ACEs practices in rural communities and tribal lands across the nation. Charlene Ramont, Shasta County HHSA Public Health Branch Deputy Director presented on the Shasta County HHSA's ACEs Hope & Resilience Fund which provides funding support to local community organizations implementing evidence-based programs.

Shasta County Health & Human Services Agency

Stigma & Discrimination Reduction activities

Fiscal Year 2021-2022

The goal of the Stand Against Stigma campaign is to reduce stigma and discrimination associated with mental illness. Stigma and Discrimination Reduction activities include trainings, social media campaigns, speaking engagements, outreach exhibits, events, and more.

In 2021-2022, Stand Against Stigma adapted its activities due to the pandemic.

Community Outreach and Education:

- The Stand Against Stigma Committee continued to meet every other month.
- Provided a training to United Way staff on stigma, its impacts and what to do to reduce stigma in our community.
- Brave Faces presentations were given in a virtual format. Brave Faces shared their stories with One Safe Place volunteers and staff, as well as law enforcement officers attending a Crisis Intervention Team training.
- To celebrate the Brave Faces Speaker's Gallery and Speakers Bureau 10-year anniversary, a permanent gallery was installed at Circle of Friends in Burney. Circle of Friends members were some of the first to share their recovery stories through the program. Five galleries of the members are on display.
- In place of the Minds Matter Mental Health Fair, a smaller "Minds Matter Mental Health Resource Meet 'n Greet" was held at Sunrise Mountain Wellness Center. Local mental health providers were invited to have conversations with attendees about their services and/or provide materials for resource bags. About 30 people participated. Volunteers filled 100 bags to give out at the event. Left over bags were given to new members of the wellness center throughout the year.
- A Hope Is Alive! Open Mic was held at Sunrise Mountain Wellness Center during mental health month. It was the first open mic since the pandemic started.
- The Stand Against Stigma website was updated to include detailed information about the basics of navigating the mental health system: Where to Start, Community Support, Crisis Support, Quick Resource List.

- Conducted table outreach at the Redding Rancheria Discover Health Fair, Redding LGBTQ+ Pride, Project Homeless Connect, and the Redding Health Expo. In total, approximately 300 people engaged with the exhibit.
- The Recovery Happens committee resumed meetings to plan an event for September 10, 2022.

SUICIDE PREVENTION FISCAL YEAR JULY 21/JUNE 22 REPORT

STRATEGY: CREATE A SYSTEM OF SUICIDE PREVENTION

Activities the Shasta County Suicide Prevention Program has undertaken during this reporting period are:

With the creation of Shasta County's Suicide Prevention Strategic Plan, the Shasta Suicide Prevention Workgroup (SPW) voted to rename the group to the Shasta Suicide Prevention Collaborative (SPC) during the January 2022 meeting to demonstrate the focused efforts of the group to reduce suicide attempts and deaths in Shasta County through collective planning and action. An asset mapping survey was conducted in January 2022 to inform the goals and objectives of the Strategic Plan. The Shasta Suicide Prevention Collaborative continued to encourage seniors to use the Institute on Aging Friendship Line. There were **214** calls from Shasta County to the warmline during this fiscal year. Please note, call volume data was not provided for October-December 2021. The Warmline allows callers to remain anonymous, so the actual number of callers from Shasta County could be higher because they may not have identified their county of residence.

Members of the Shasta Suicide Prevention Collaborative continued to promote and distribute the National Suicide Prevention Lifeline and Crisis Text Line cards in order to increase community members' access to crisis resources. Cards were generously distributed during trainings, health fairs, directly to schools, and other points of contact during outreach efforts. During this reporting period, prevention resources were directly distributed to Shasta County Office of Education, Simpson University, Shasta College, Nice Shot, Redding Rancheria, Shasta Community Health Center, Lotus Educational Services, Inc., One Safe Place, and HHSA's Economic Mobility and Adult & Children's Services Branches.

The Suicide Prevention Program, with support from Stand Against Stigma, continued to promote the Captain Awesome mental health/suicide prevention campaign which focuses on men in their middle and later years, a cohort at higher risk for suicide. The Captain Awesome campaign was developed to help reduce stigma associated with mental health, increase understanding of mental health and suicide, encourage help-seeking, and promote crisis resources among men in Shasta County. The campaign included print, social media, and online advertising materials promoting the men's mental health suicide prevention website: www.captain-awesome.org. Media flights featured local men who elected to participate in the campaign. The Suicide Prevention Coordinator shared information about the Captain Awesome program with Marin County in April 2022 and during the CDPH Community of Practice meetings in May and June 2022 due to the request from counties having shared interest in creating similar campaigns throughout the state. The Men's Advisory Group (MAG), a group of local men, met on August 20, 2021, to provide input and feedback on past and future campaign efforts to ensure Captain Awesome effectively resonates with male community members. A website redesign was delayed due to staff reassignment to the pandemic response and remained in progress during this reporting period.

The Suicide Prevention Coordinator initiated conversations with Dr. Kimberly Repp in February 2022 after being selected as one of four California counties to develop a Suicide Fatality Review (SFR) team. The primary purpose of an SFR team is to review suicide death cases to identify trends in potential risk factors and develop prevention activities to mitigate those risks while also promoting protective factors (e.g., connectedness, knowledge of resources, access to resources, etc.). Tentative SFR plans were discussed with the Coroner's Office in March 2022. On June 2, 2023, Dr. Repp traveled to Shasta County to present the purpose and structure of an SFR and facilitated a mock Shasta SFR team meeting. Additional SFR preparations will be conducted in the 22-23 reporting period.

The Suicide Prevention Coordinator, in addition to 6 community partners, were previously certified to deliver the Question, Persuade, Refer (QPR) training. QPR teaches participants how to recognize the warning signs of a suicide crisis and how to question, persuade, and refer someone to help. Due to the pandemic, many community partners were unable to provide QPR trainings with the exception of the Suicide Prevention Coordinator who conducted five QPR trainings during the reporting period. All QPR trainings are listed in the table under Strategy 2. The Suicide Prevention Program contracted suicide prevention training services from Lotus Education Services, Inc. to provide SafeTALK and Applied Suicide Intervention Skills Training (ASIST) to community members. SafeTALK trains participants to recognize and engage with persons having thoughts of suicide and connect at-risk individuals to an intervention provider/resource. ASIST teaches attendees to recognize when someone may be at-risk for suicide, conduct a suicide intervention, and create a plan to support their immediate safety. Under this contact, three SafeTALK and two ASIST trainings were provided at no cost to community members during this reporting period.

The Suicide Prevention Coordinator enhanced links and integration among Shasta County systems and programs, including health, mental health, aging, social services, first responders, and hotlines, as well as increased their capacity to provide effective crisis intervention and suicide prevention during this reporting period in the following ways:

The website ShastaSuicidePrevention.com remained live for the community. Additional resources were added to the website, including information on national and local resources for suicide prevention, counseling and medical care, and supportive programs for specific needs and groups.

The Suicide Prevention program continued to promote the suicide loss and attempt support group "Speaking of Suicide" (SOS). The group met several times during the reporting period at Hill Country CARE Center in Redding in accordance with safety guidelines. When pandemic mandates increased, group meetings were held virtually.

HHSA's behavioral health staff, including the ACCESS teams, provided Suicide Prevention resources to the community as needed. Representatives from the Adult Services and Children's Services Branches remained connected to Suicide Prevention Program updates via virtual Collaborative meetings and email.

An SPC member serves on the Mental Health Alcohol and Drug Advisory Board (MHADAB) and provided updates and announcements from the SPC at the MHADAB.

The Suicide Prevention Coordinator maintained contact with elder care service providers, including the PSA2 Area Agency on Aging. A representative from PSA2 remained connected to Suicide Prevention Program updates via virtual Collaborative meetings and email.

The Suicide Prevention Coordinator also maintained ongoing communication with community partners including NorCal OUTreach, Shasta College, Simpson University, Dignity Health, local licensed clinical social workers (LCSW), and others to encourage opportunities to discuss collaboration and support.

Volunteer opportunities at community events and trainings were promoted through the Suicide Prevention Collaborative monthly newsletter to encourage connection among community members, the sharing of important resources, and raise awareness of the impact and need of these events. The "Get Involved" page on the Shasta Suicide Prevention website also promoted volunteer opportunities through the American Foundation for Suicide Prevention (AFSP) and PSA 2.

The Suicide Prevention Collaborative met bi-monthly during this reporting period to discuss current suicide prevention activities and develop implementation plans for additional strategies to reduce suicide attempts and deaths in Shasta County. All meetings were held virtually due to COVID-19 pandemic safety mandates. Collaborative members also stayed connected through e-mail, the Collaborative Facebook page, and the monthly newsletter.

The use of local, state, and national hotline services were promoted during this reporting period were as follows:

National Suicide Prevention Lifeline data was previously provided by Vibrant Emotional Health. With the development of the 988 Suicide and Crisis Lifeline, Vibrant suspended providing quarterly data. The Suicide Prevention Program made preparations for the 988 transition and provided updates to the community as needed.

Suicide Prevention of Yolo County (SPYC) provides lifeline services to Shasta County residents. During the reporting period, SPYC, in partnership with North Valley Suicide Prevention Hotline, provided crisis support for Shasta County callers routed from the National Suicide Prevention Lifeline.

July 1, 2021-June 30, 2022

Callers Identified as Shasta County Residents	441
Moderate/ High Lethality Calls	59
Active Rescue Calls	7
Callers Requiring Follow Up	57

Note: this information/report solely reflects services delivered through SPYC and does not include Shasta County residents routed to a different crisis line.

The National Suicide Prevention Lifeline, Know the Signs, Crisis Text Line, and Trevor Project wallet cards were distributed to schools, non-profit organizations, and community groups via outreach events, through various Shasta County service programs, and social media. Crisis line information was included on HHSA Public Health and Suicide Prevention Collaborative websites.

STRATEGY 2: IMPLEMENT TRAINING AND WORKFORCE ENHANCEMENTS TO PREVENT SUICIDE

QPR

QPR Trainer Certification: August 2020

Shasta County QPR Trainers:

Lindsay Heuer – Shasta County HHSA, Public Health	**Jennifer Ely** – Pathways to Hope for Children
Lisa Stout – Northern Valley Catholic Social Service	**Eric Friend** – Pathways to Hope for Children
Nora Smith – Shasta County Veteran Services Office	**Angie Cravens** – Shasta County Probation
Lorie Ratliff – Redding Rancheria	

QPR Trainings Provided (7/2021 – 6/2022):

Training Date	Organization	Number of Participants
7/23/2021	Containment Branch – COVID-19 DOC	30
8/19/2021	One Safe Place Staff	22
9/1/2021	Residents of Woodlands Apartments	6
9/23/2021	Children's Mental Health – Parent Group	3
11/18/2021	Suicide Prevention Collaborative	17

Contracted Trainings – Lotus Educational Services, Inc.; Marcia Ramstrom

SafeTALK (4-hour training)		
Date	**Morning Session # of Attendees**	**Afternoon Session # of Attendees**
9/16/2021	23	CANCELED
3/3/2022	30	30

ASIST (2-days; 16 hours)	
Date	**Number of Participants**
8/12-12/2021	28
6/9-10/2022	25

STRATEGY 3: EDUCATE COMMUNITIES TO TAKE ACTION TO PREVENT SUICIDE

Date of Event	Event	# of Materials
9/2021	Redding Pride Festival 2021 (Drive-Thru)	250
11/2/21	Northern Valley Catholic Social Services – Materials Delivery	150
12/3/21	Simpson University	200
3/30/22	The Woodlands Apartments	50
4/18/22	HHSA Economic Mobility Branch	200
4/2022	Critical Incident Stress Management; Peer Support Training	30
5/17/22	Shasta College	500
5/2022	The Woodlands Apartments	50
5/2022	Mental Health Month Display Boards (e.g., Public Health Lobby, Mental Health Clinic Waiting Room, Economic Mobility)	100+
5/2022	Project Homeless Connect	300+
5/2022	Public Health Advisory Board Meeting	15

The peer support programs that address suicide prevention and intervention services as well as services provided after a suicide or suicide attempt that offer follow-up care for survivors and their families have been fostered during this reporting period were as follows:

The Speaking of Suicide (SOS) support group met in-person on Wednesdays from 5:30PM – 7PM at the Hill Country CARE Center. When COVID-19 mandates increased, group meetings were held virtually. SOS support group meetings were promoted through the Shasta Suicide Prevention Collaborative monthly newsletter, Facebook page, and Collaborative meetings.

During the previous reporting period, Facebook "Likes" were at 675, and at the end of this reporting period there were 683 likes on the page. Engagement on posts rose with the regular posting schedule of two times per week. The content shared on this page ranged from resources for those who have attempted suicide, friends and family of those that experience suicidal thoughts, and those who have lost someone to suicide. The page often shared ways to cope with loss, stress, loneliness, etc. and/or local and national events and resources surrounding suicide prevention.

Performance data indicates that 573 people accessed the Shasta Suicide Prevention Collaborative monthly newsletter from July 2021 to June 2022. Similar to the suicide prevention Facebook page, the newsletter also shared information about resources, training opportunities, and upcoming events with the community to increase awareness of suicide in Shasta County, promote connectedness, and improve linkage to crisis and mental health services.

The community has been educated about how to safely handle potentially lethal materials such as firearms and medications during this reporting period in the following ways:

The Firearm Safety brochures, which stress the need for increased awareness and prevention efforts when it is suspected that an individual is in crisis or suicidal, were distributed to law enforcement and CCW/firearm vendor contacts along with other suicide prevention resource materials. The Firearm Safety brochures and safe medication disposal cards were also distributed during outreach events as resources for the community. In addition to print materials, the Suicide Prevention Program offers firearm safety cable locks to gun owners in the community to help support securing firearms safely.

STRATEGY 4: EDUCATE COMMUNITIES TO TAKE ACTION TO PREVENT SUICIDE

Local capacity for suicide attempt and suicide data collection, reporting, surveillance, and dissemination has increased during this reporting period in the following ways:

The Suicide Prevention Program maintained direct contact with epidemiologists reporting data for Shasta County Health and Human Services Agency and referenced reliable and recognized sources for county, state, national and international suicide reporting data.

The Suicide Prevention Coordinator invited the HHSA Epidemiologist to regularly attend the Shasta Suicide Prevention Collaborative meetings and discuss data with members.

Throughout the Fiscal Year, Shasta County Suicide Prevention Resources were disseminated as shown in the table below:

Resource Dissemination Shasta County Suicide Prevention Program	Trevor Project	Know the Signs		Suicide Prev. Hotline			Access Brochures	QPR Flyer	Directing Change	211 Materials	Website Flyer	Mobile Crisis Outreach	Estimated Reach
	Flyers	English	Spanish	Cards	Pens	Crisis Text Line							
Redding Pride Festival 2021 (Drive Thru)	X	X	X	X		X	X	X		X	X	X	250
Simpson University	X	X	X	X		X	X	X	X	X	X	X	200
Shasta College	X	X	X	X		X	X	X	X	X	X	X	500
Lotus Educational Services, Inc.	X	X	X	X	X	X	X	X		X	X	X	300
One Safe Place	X	X	X	X		X	X	X		X	X	X	200
Northern Valley Catholic Social Services	X	X	X	X		X	X	X		X	X	X	150
HHSA Economic Mobility Branch	X	X	X	X	X	X	X	X		X	X	X	200
Critical Incident Stress Management; Peer Support Training		X		X	X	X	X	X		X	X	X	30
The Woodlands Apartments	X	X	X	X	X	X	X			X	X	X	100
Mental Health Month Display Boards	X	X		X		X	X		X	X	X	X	100+
Project Homeless Connect	X	X	X	X	X	X	X	X		X		X	300+
Public Health Advisory Board Meeting		X		X	X	X	X	X	X	X	X	X	15

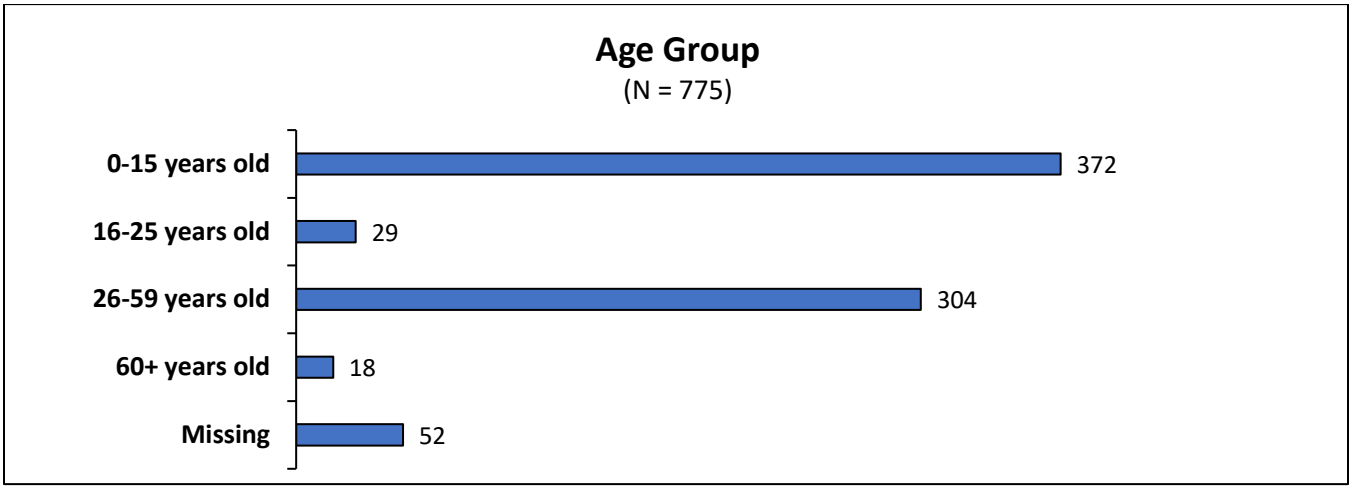
Shasta County Health & Human Services Agency

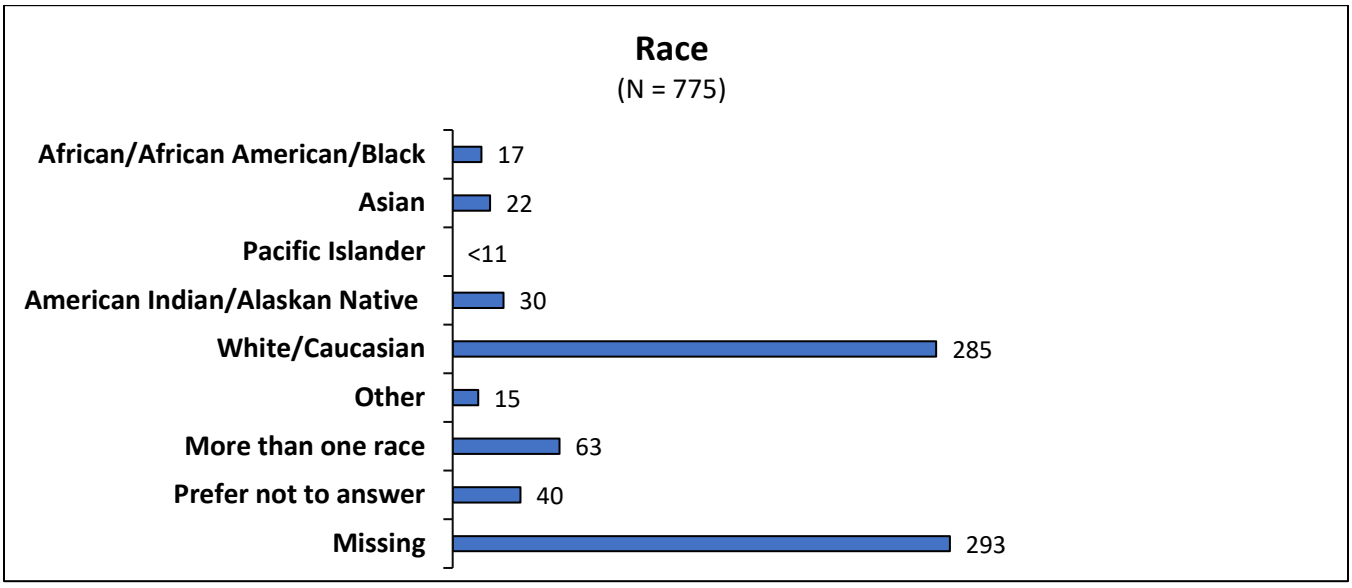
MHSA Prevention and Early Intervention Fiscal Year 21/22 Demographics Report

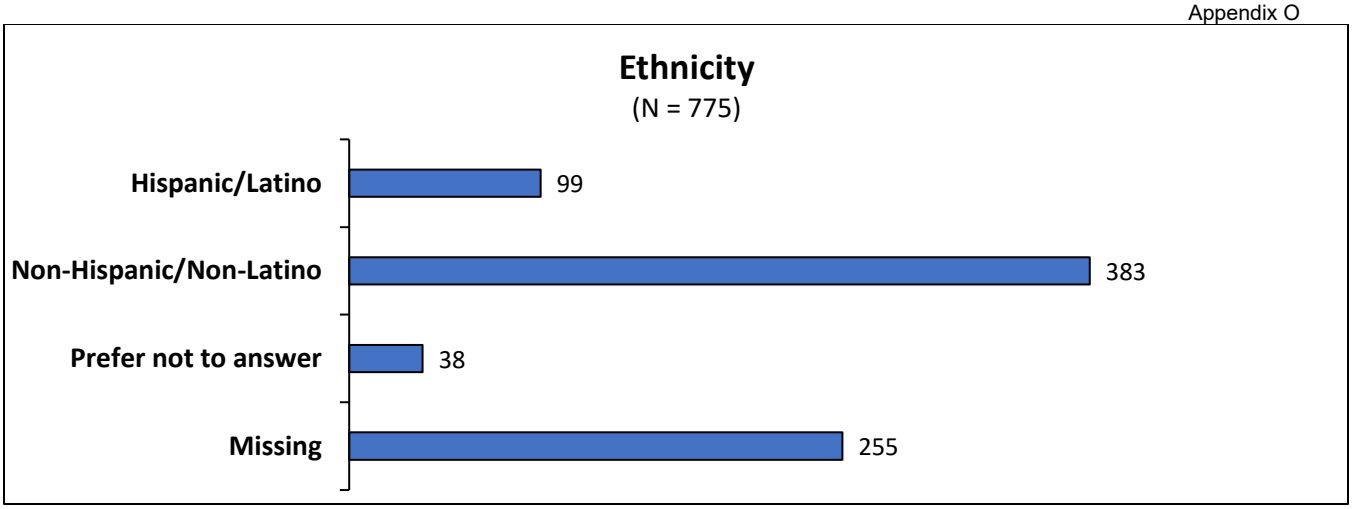
I. Prevention and Early Intervention Program Demographics

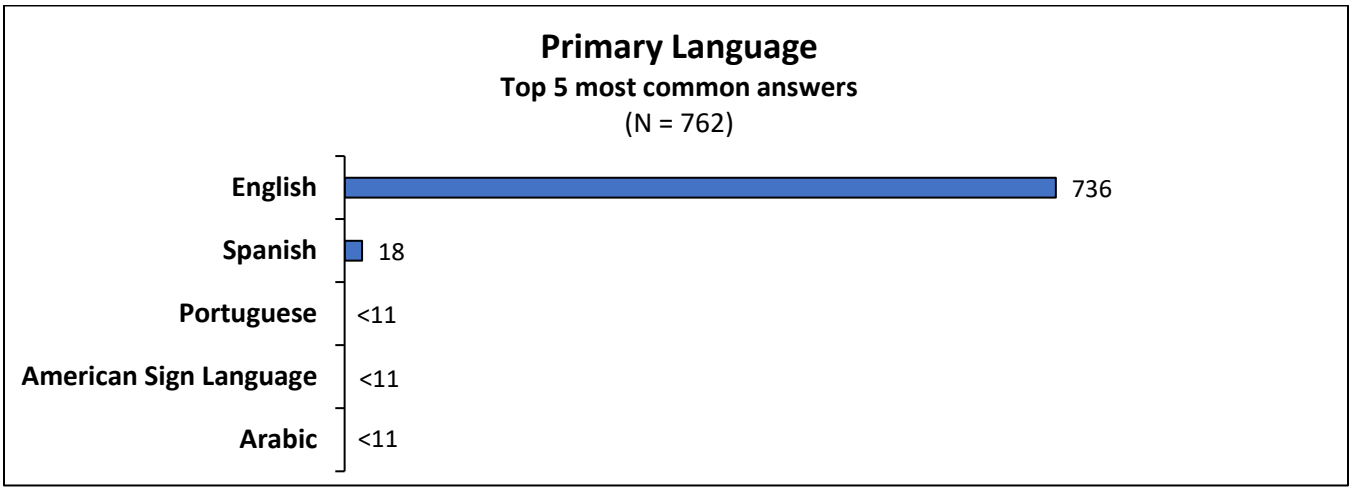
- Triple P (226)
- Botvin Lifeskills (364)
- Mental Health First Aid (69)
- Hope Navigator (62)
- LAUNCH (14)
- IMPACT (40)

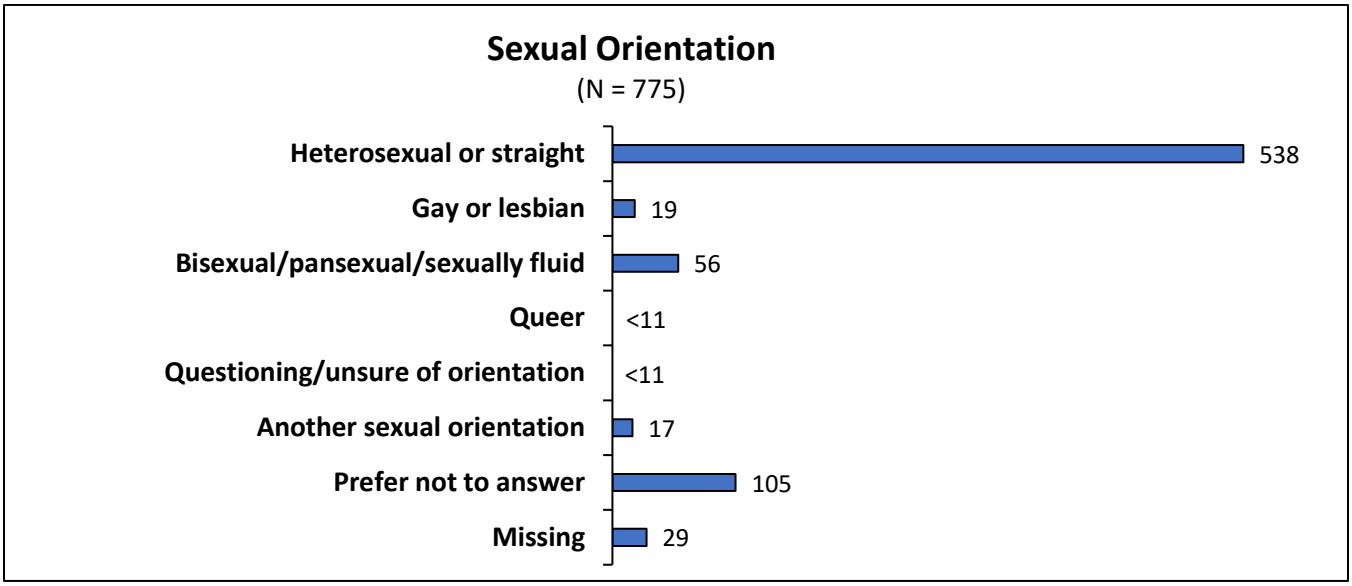
775 total individuals submitted data. Categories that received 11 or less responses are not labelled to help protect client confidentiality. Categories that received zero responses are not shown.

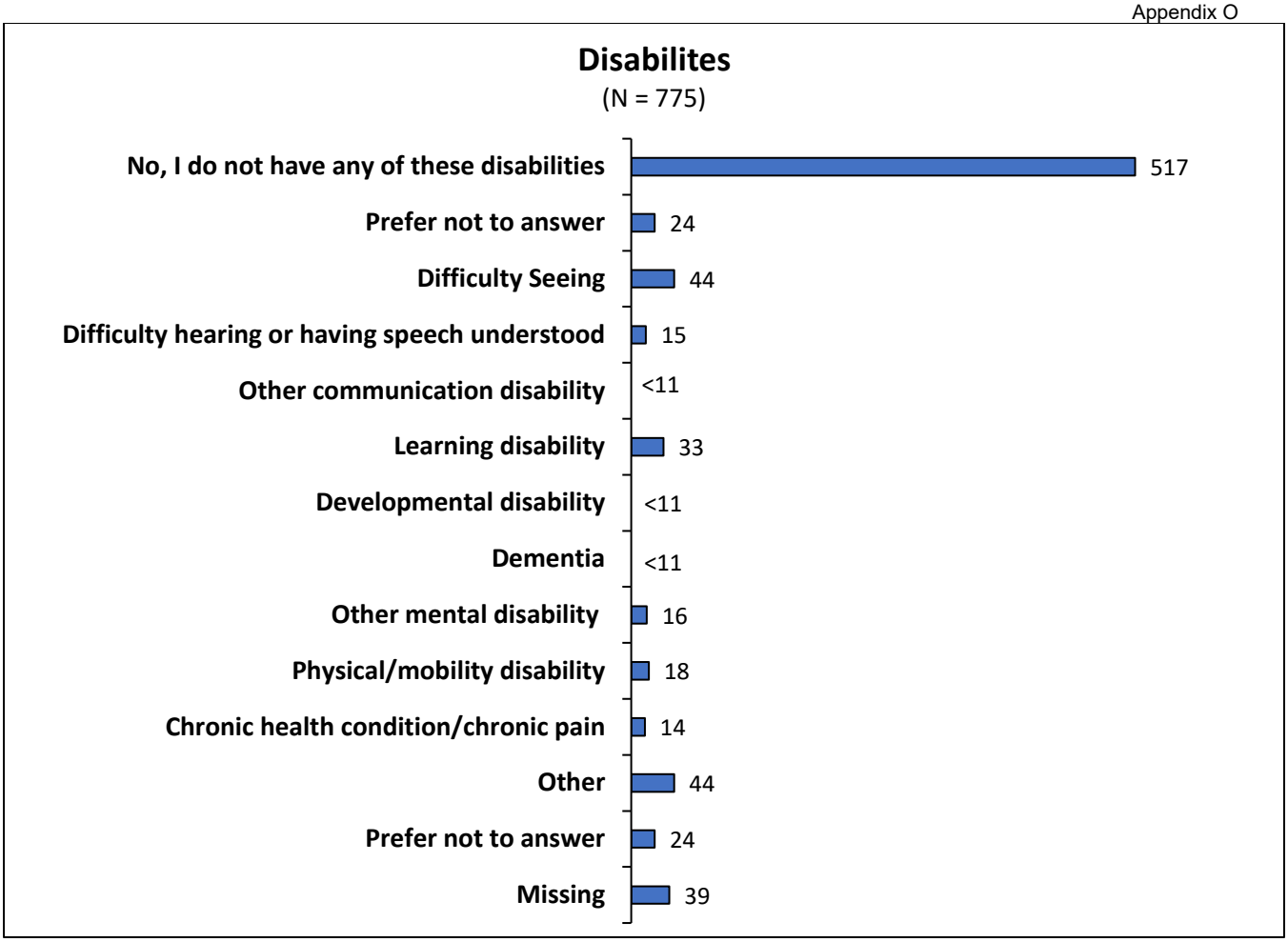


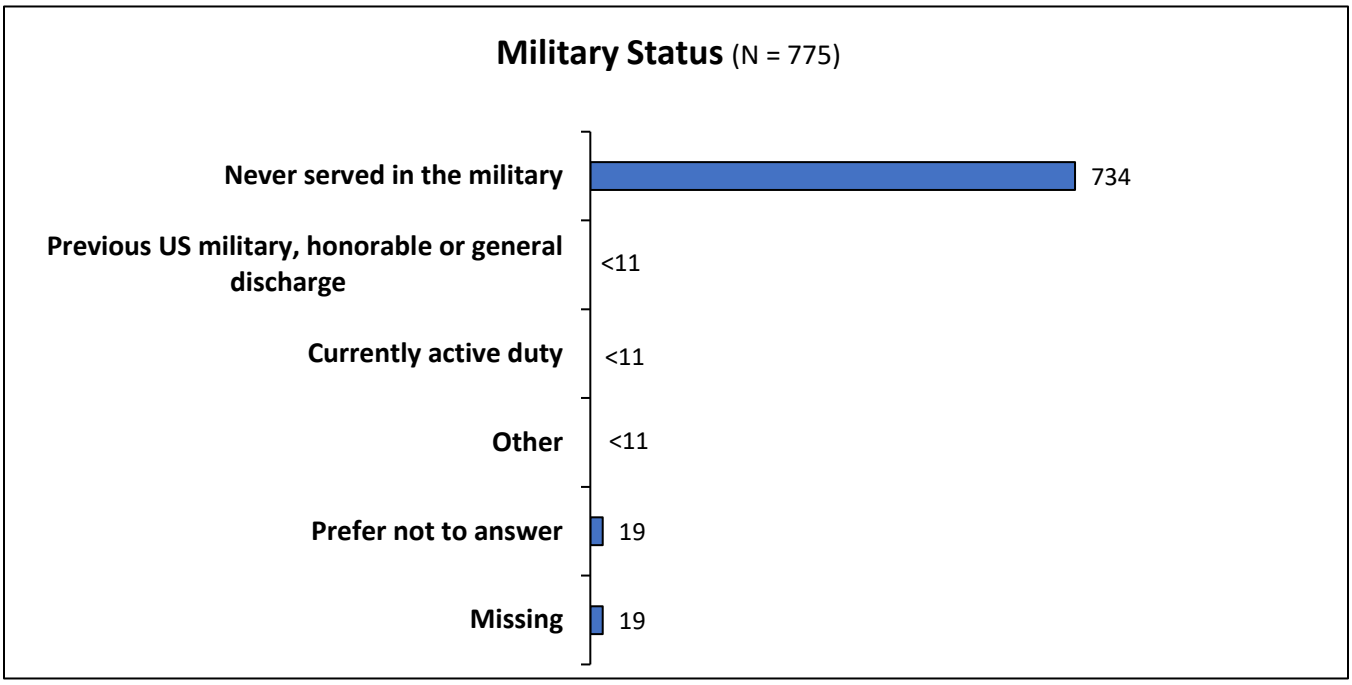


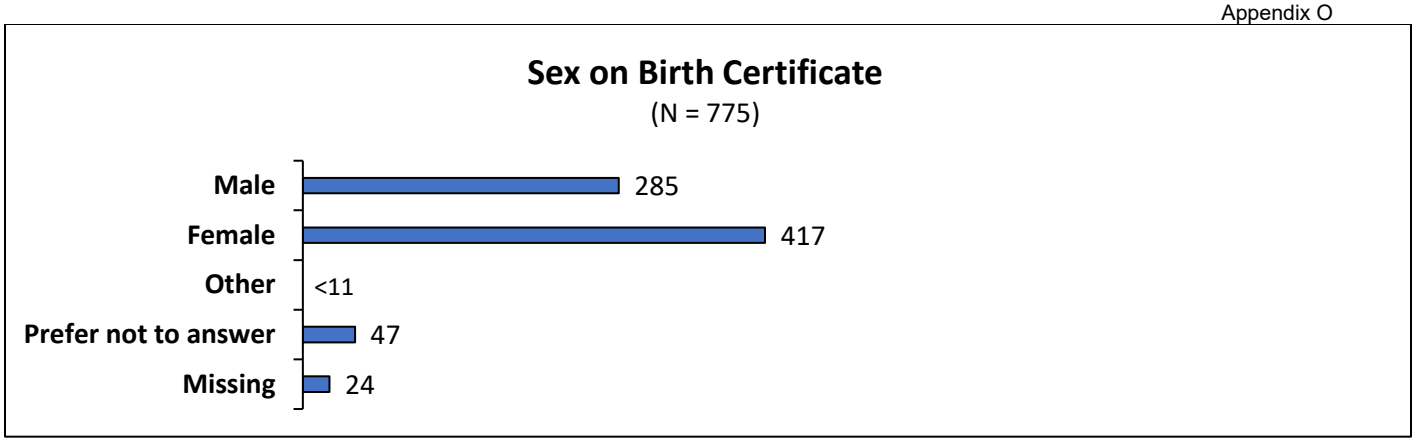

Ethnicity
(N = 775)
Hispanic/Latino
99
Non-Hispanic/Non-Latino
383
Prefer not to answer
38
Missing
255

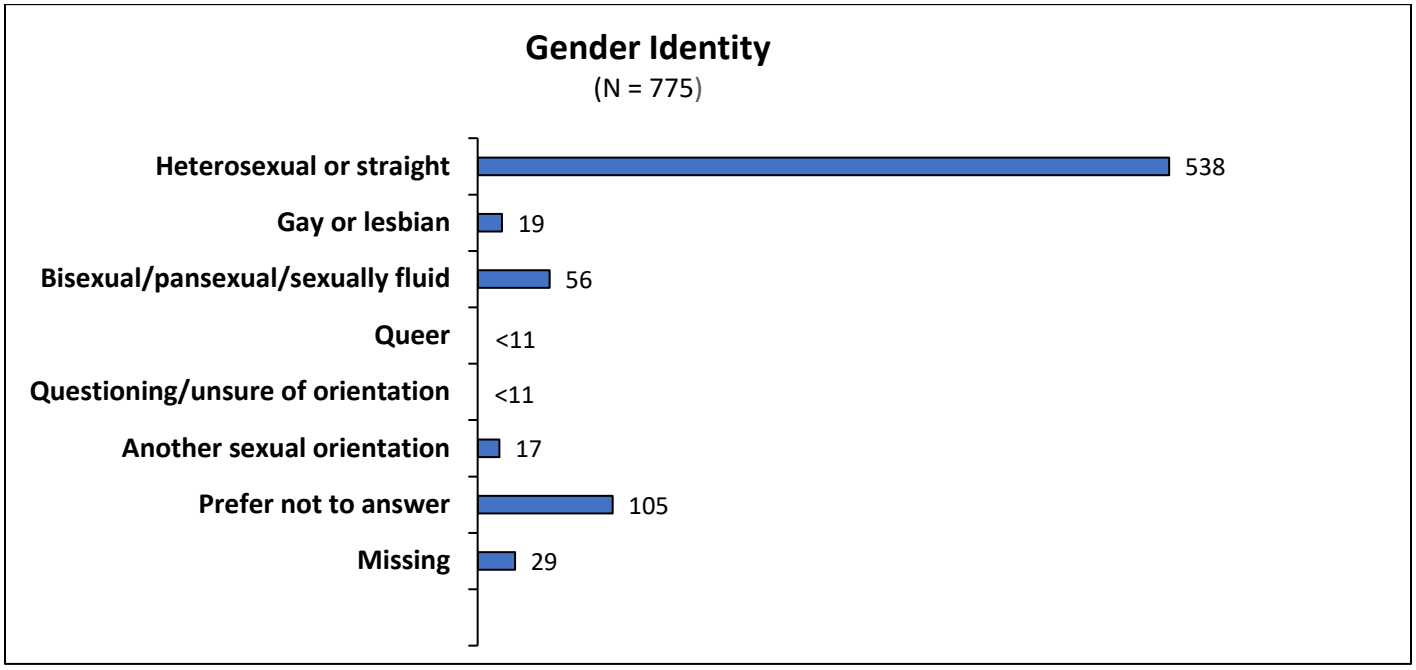

Primary Language
Top 5 most common answers
(N = 762)
English
736
Spanish
18
Portuguese
<11
American Sign Language
<11
Arabic
<11


Sexual Orientation
(N = 775)
Heterosexual or straight
538
Gay or lesbian
19
Bisexual/pansexual/sexually fluid
56
Queer
<11
Questioning/unsure of orientation
<11
Another sexual orientation
17
Prefer not to answer
105
Missing
29


Disabilites
(N = 775)
No, I do not have any of these disabilities
517
Prefer not to answer
24
Difficulty Seeing
44
Difficulty hearing or having speech understood
15
Other communication disability
<11
Learning disability
33
Developmental disability
<11
Dementia
<11
Other mental disability
16
Physical/mobility disability
18
Chronic health condition/chronic pain
14
Other
44
Prefer not to answer
24
Missing
39


Military Status (N = 775)
Never served in the military
734
Previous US military, honorable or general discharge
<11
Currently active duty
<11
Other
<11
Prefer not to answer
19
Missing
19


Sex on Birth Certificate
(N = 775)
Male
285
Female
417
Other
<11
Prefer not to answer
47
Missing
24


Gender Identity
(N = 775)
Heterosexual or straight
538
Gay or lesbian
19
Bisexual/pansexual/sexually fluid
56
Queer
<11
Questioning/unsure of orientation
<11
Another sexual orientation
17
Prefer not to answer
105
Missing
29

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

- Stand Against Stigma

10,000 total Individuals and potential responders served*

***(potential responders defined as the number of people the program's messaging reached)

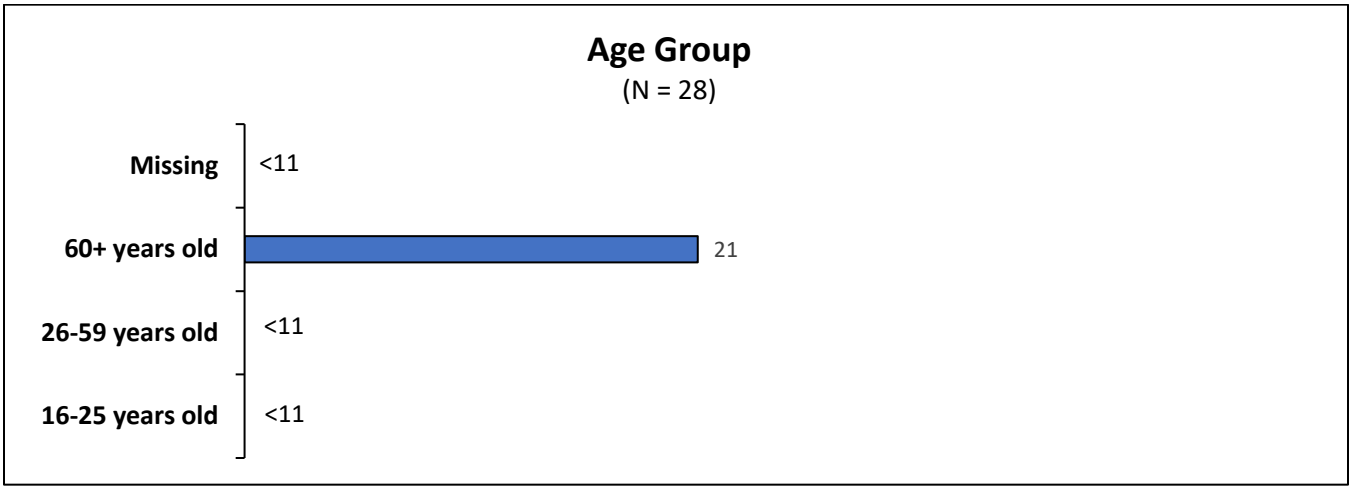
This program was implemented in various settings including:

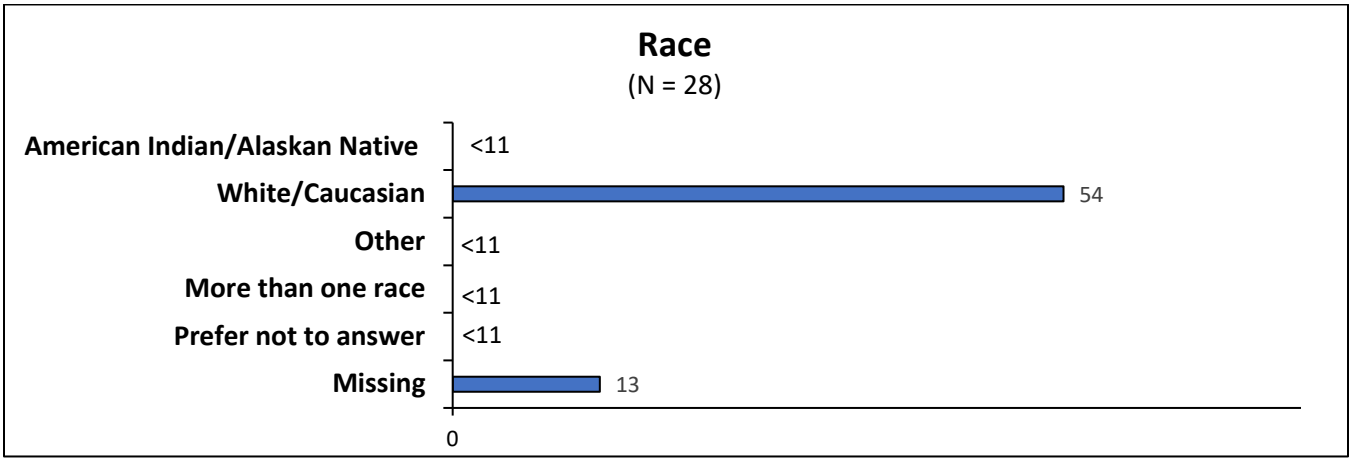
- **Domestic Abuse shelter**
- **CARE Center**
- **Wellness Centers**
- **Sundial Bridge**
- **Community Center**
- **Social Services Organization**

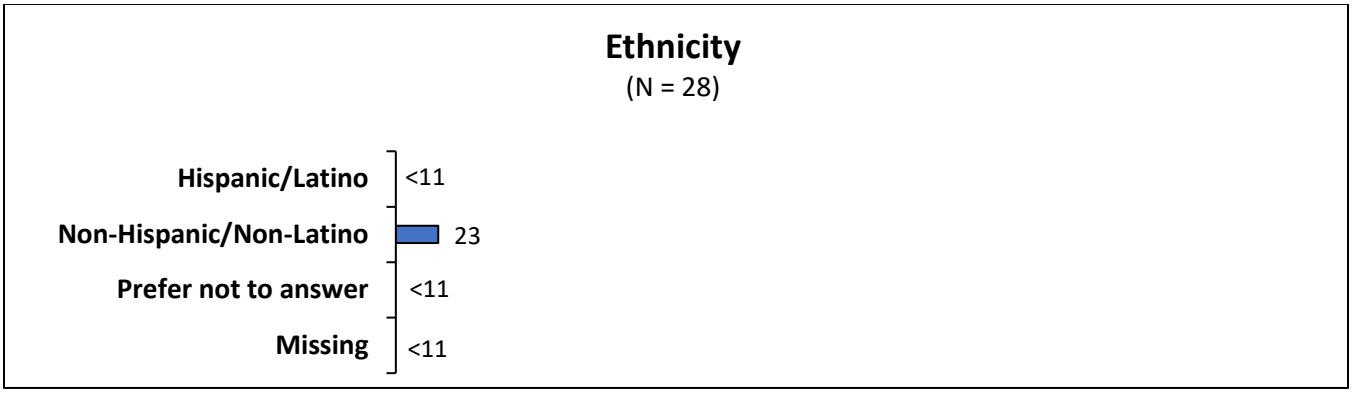
Types of potential responders:

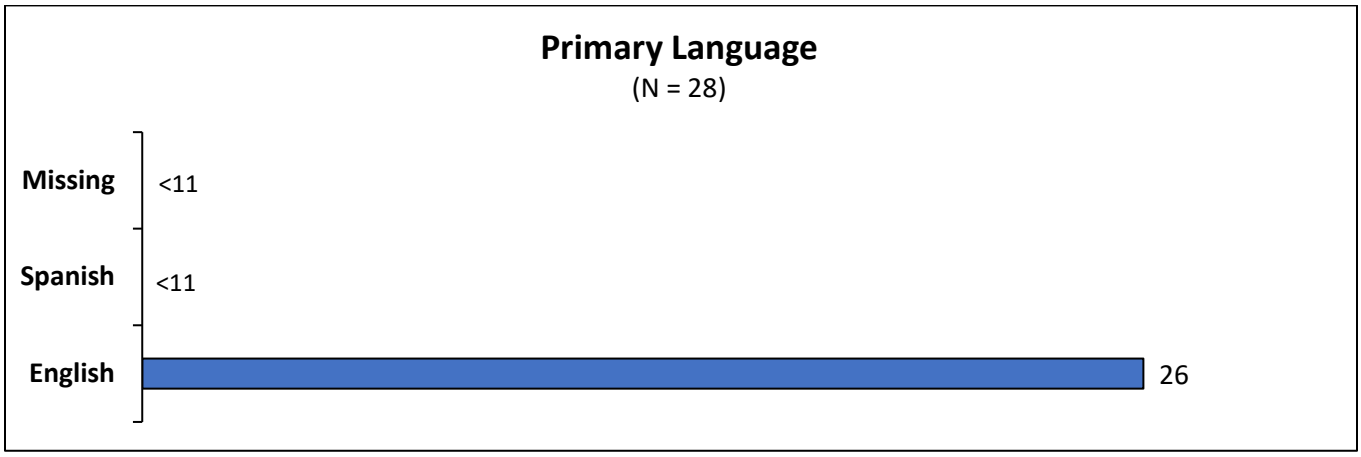
- **College Students**
- **High School Students**
- **Domestic abuse counselors**
- **Homeless population**
- **Continuation school students**
- **University students**
- **Community members**
- **Faith-based community**
- **Senior Citizens**
- **Nurses and other medical care providers**
- **Law enforcement**
- **Social service workers**

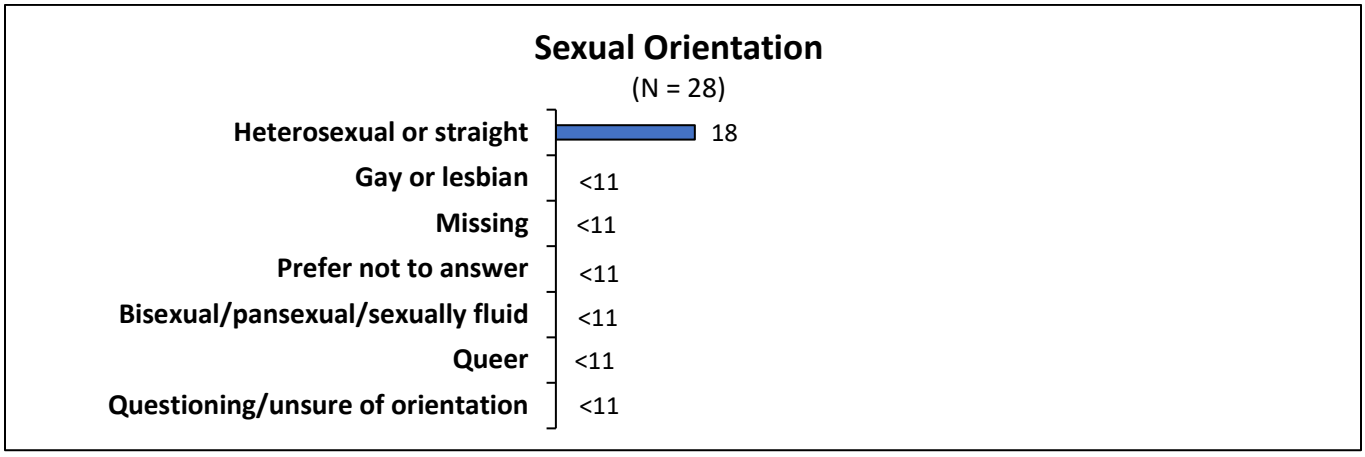
28 total individuals submitted data. Categories that received zero responses are not shown.

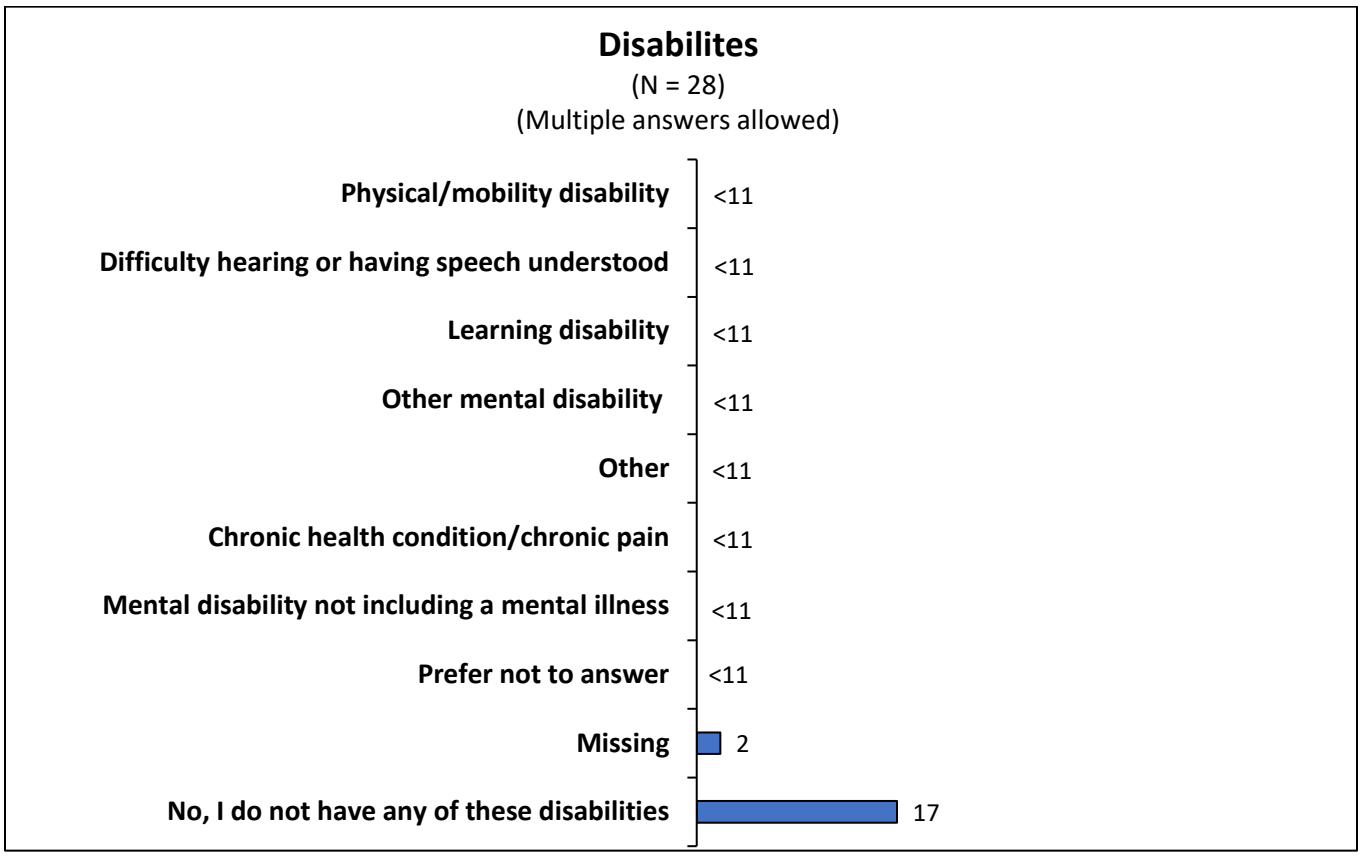


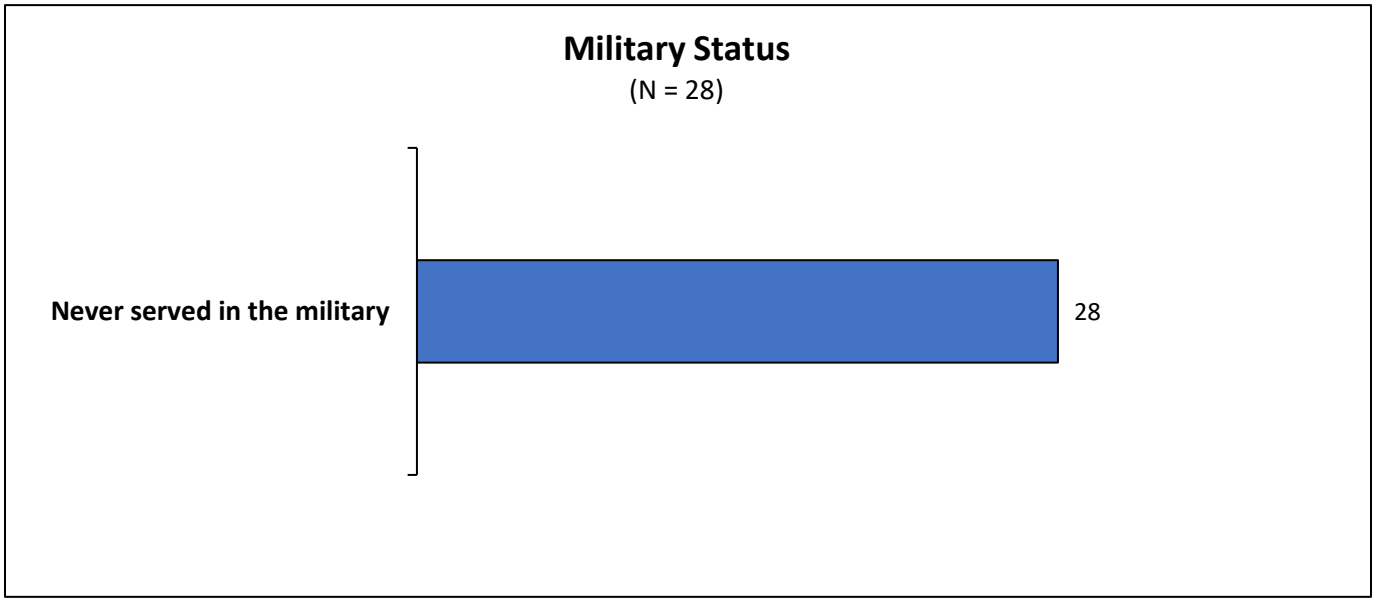

Race
(N = 28)
American Indian/Alaskan Native
<11
White/Caucasian
54
Other
<11
More than one race
<11
Prefer not to answer
<11
Missing
13
0

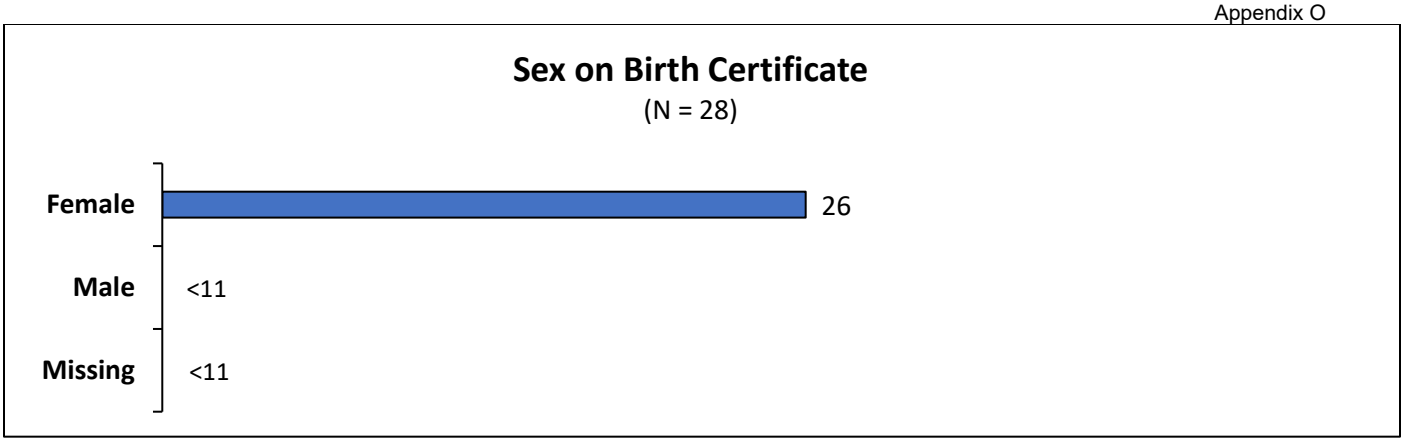

Ethnicity
(N = 28)
Hispanic/Latino
<11
Non-Hispanic/Non-Latino
23
Prefer not to answer
<11
Missing
<11

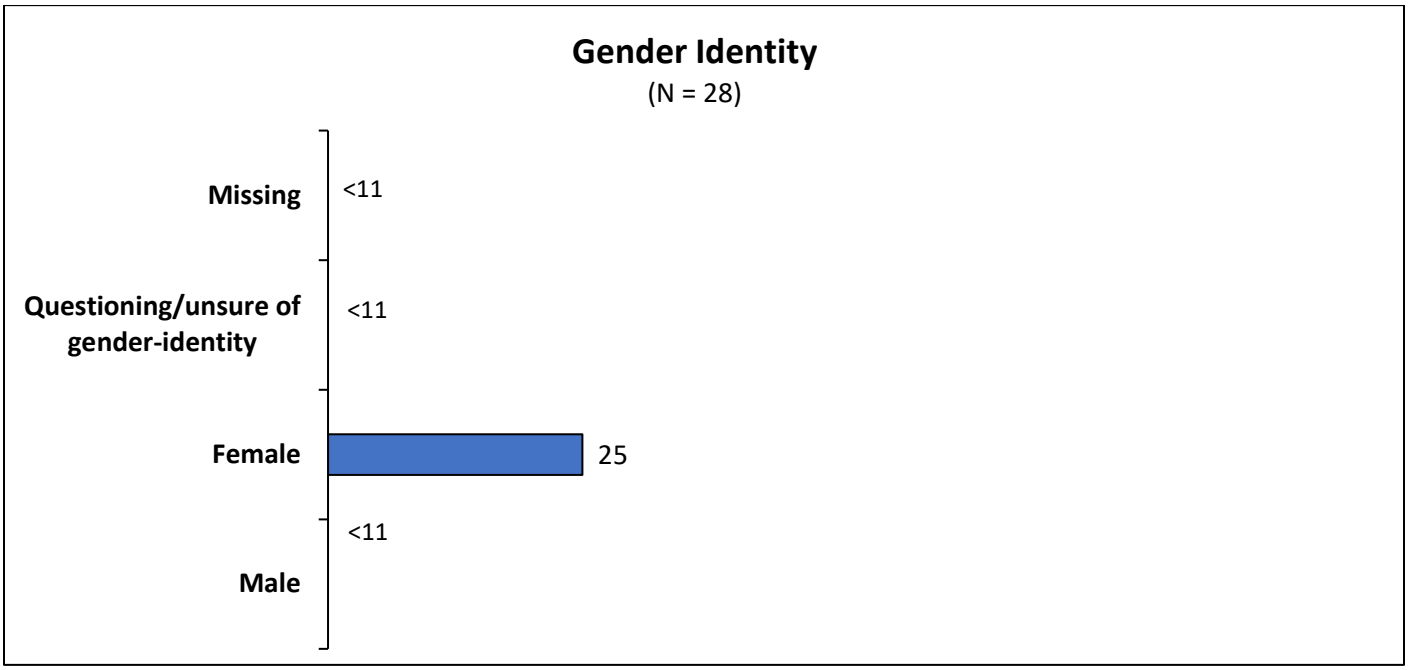

Primary Language
(N = 28)
Missing
<11
Spanish
<11
English
26


Sexual Orientation
(N = 28)
Heterosexual or straight
18
Gay or lesbian
<11
Missing
<11
Prefer not to answer
<11
Bisexual/pansexual/sexually fluid
<11
Queer
<11
Questioning/unsure of orientation
<11


Disabilites
(N = 28)
(Multiple answers allowed)
Physical/mobility disability
<11
Difficulty hearing or having speech understood
<11
Learning disability
<11
Other mental disability
<11
Other
<11
Chronic health condition/chronic pain
<11
Mental disability not including a mental illness
<11
Prefer not to answer
<11
Missing
2
No, I do not have any of these disabilities
17


Military Status
(N = 28)
Never served in the military
28


Sex on Birth Certificate
(N = 28)
Female
26
Male
<11
Missing
<11

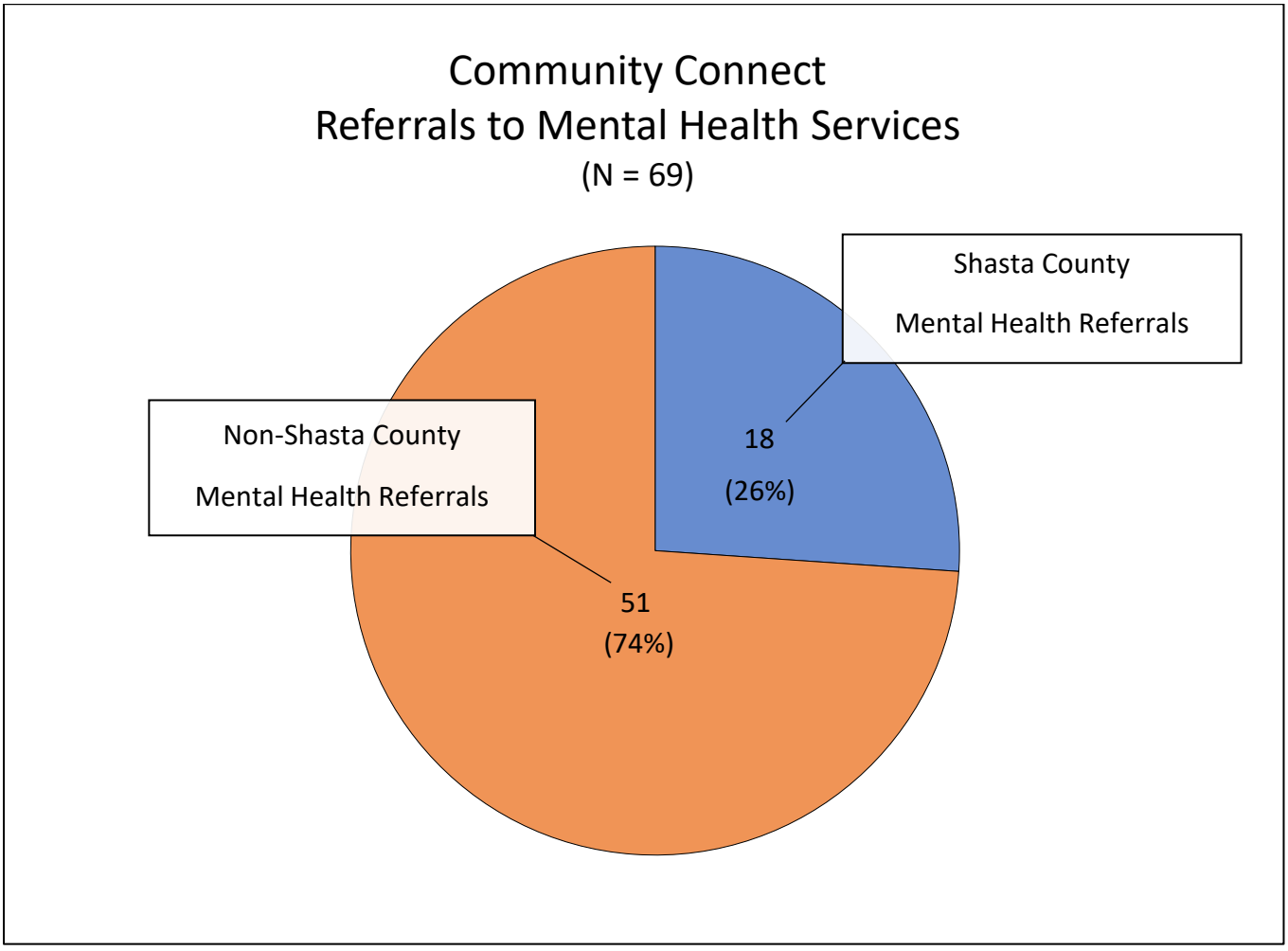

Gender Identity
(N = 28)
Missing
<11
Questioning/unsure of gender-identity
<11
Female
25
<11
Male

III. Access and Linkage to Treatment Strategy or Program Demographics

Community Connect

- 959 individuals were referred to Community Connect.
- 510 of whom accepted services.

43% of referrals were for behavior, 42% for attendance, and 15% for other/homelessness.



Data regarding the interval between the date of the referrals and the date the individuals began treatment was not collected by the Program.

Quarterly Report for the Hope Park Project
Fiscal Year 2021/2022 4th Quarter

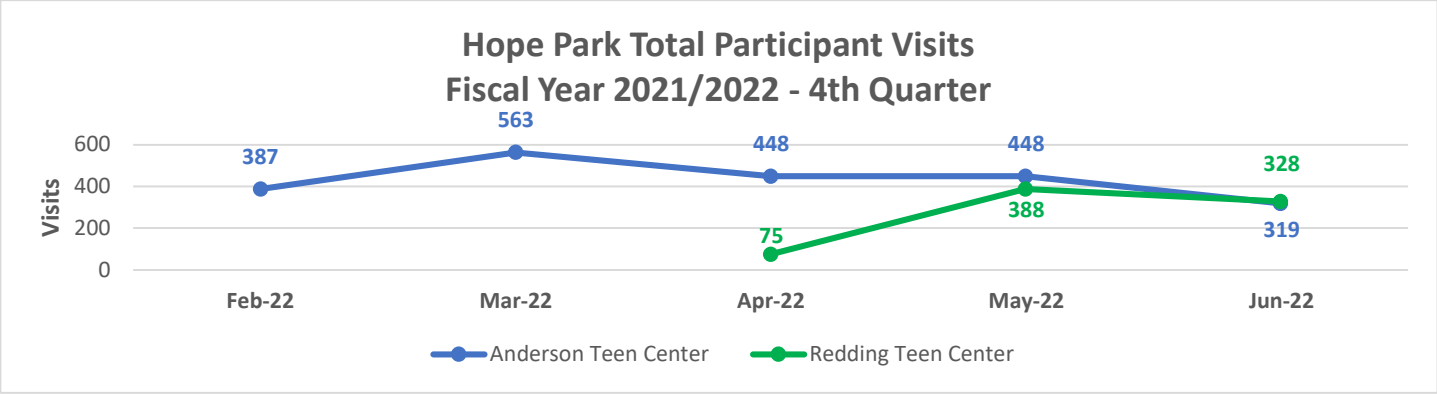
April 2022 – June 2022

*February 2022-March 2022 included in graphs to show progression of program

The Hope Park Project was initiated in February 2022 and uses an intergenerational approach to improve the Mental Health of the Teenage (12-18 years old) and Senior (60+ years old) populations in Redding, CA and Anderson, CA. The Hope Park Project focuses on bridging the generation gap by providing mentorship to teenagers to reduce the long-term effects of Adverse Childhood Experiences (ACEs) and offering meaningful activities to Senior Adults to help prevent the negative physical and mental health effects of loneliness. Shasta County has two participating centers; the Anderson Teen Center located at 2889 E Center St, Anderson, CA 96007, and the Redding Teen Center (Opened in April 2022) located at 2981 Churn Creek Road, Redding, CA 96002. Funding is provided through the Mental Health Services Act (MHSA).

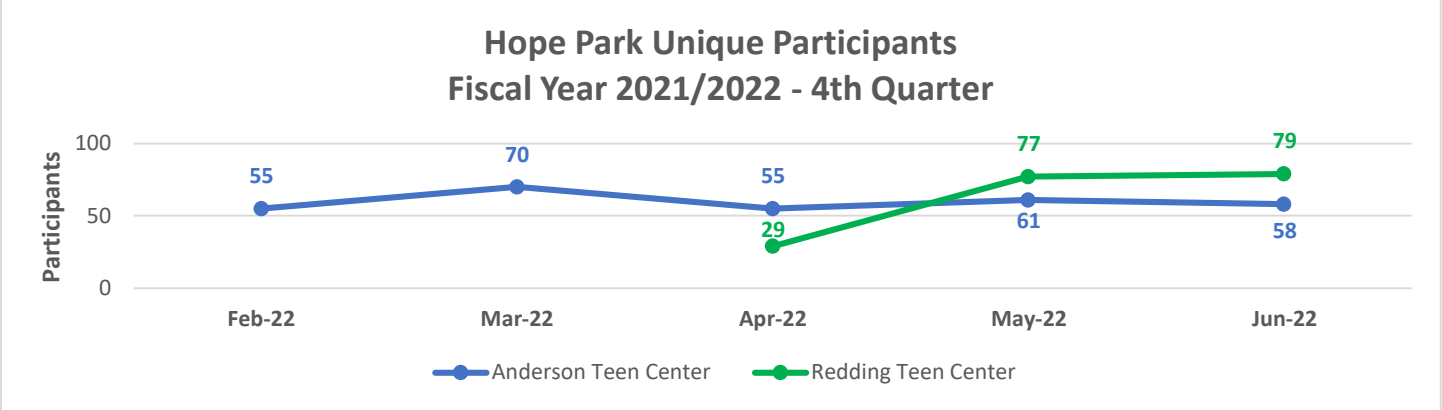
Community Participation:

The project goal is to serve 75 participants per day in the Teen Centers in Anderson and Redding combined, this comes to an estimated total of 1,550 visits per month or 19,000 visits per year between the two centers.



Individual Participation:

The goal is to serve 200 unique teenagers from Anderson and Redding during the first year of the project, then maintain 200 unique teenage participants for the life of the grant. Senior Adult volunteers can come from anywhere in Shasta County, and the goal is to engage 80 Senior Adult volunteers per fiscal year.



Age:

*The Mental Health Services Act (MHSA) uses four different age categories: **Youth** (Ages 0-15), **Transition Age Youth** (Ages 16-25), **Adult** (Ages 26-59) and **Older Adult** (Ages 60 and Up).*

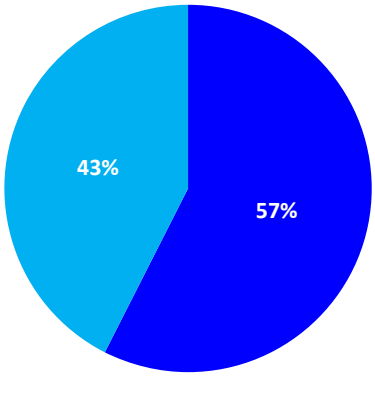
*The Hope Park Project specifically focuses on Teenagers and Senior Adults, so the following four age categories will be used instead: Teen ages **12-15**, Teen ages **16-18**, Senior Adults ages **60-70** and Senior Adults ages **70+**.*

4th Quarter Age Distribution

The Anderson Teen Center served an average of **58** unique individuals each month from **April 2022 – June 2022** with **57%** being 12-15 years old and **43%** being 16-18 years old.

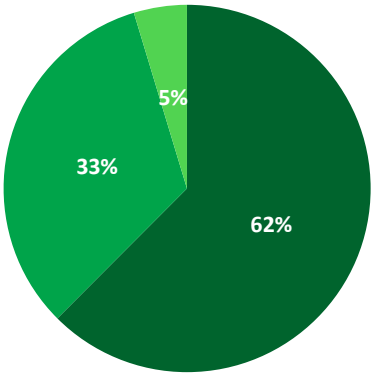
The Redding Teen Center served an average of **64** unique individuals each month from **April 2022 – June 2022** with **62%** being 12-15 years old, **33%** being 16-18 years old and **5%** being 60-70 years old.

No Senior Adult participation reported for **April 2022 – May 2022*



Age Distribution of Monthly Unique Participants 4th Quarter 2021/22 Anderson Teen Center

- 12-15 Years Old
- 16-18 Years Old
- 60-70 Years Old
- 71+ Years Old



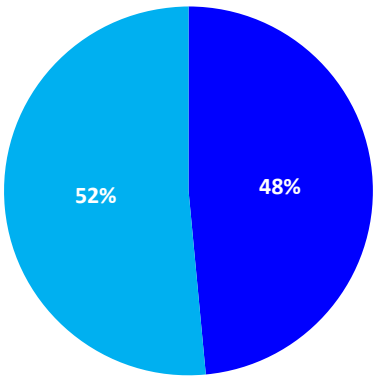
Age Distribution of Monthly Unique Participants 4th Quarter 2021/22 Redding Teen Center

- 12-15 Year Olds
- 16-18 Year Olds
- 60-70 Year Olds
- 71+ Year Olds

Average Age Distribution Since Inception of Hope Park:

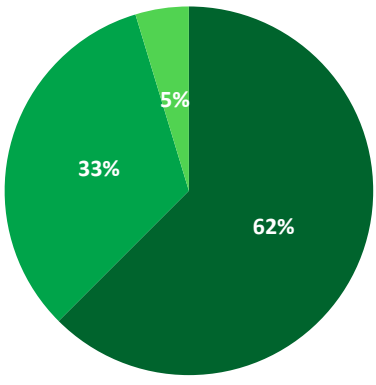
The Anderson Teen Center has averaged about **60** unique individuals per month since Hope Park Inception in February 2022 with **48%** being 12-15 years old and **52%** being 16-18 years old.

The Redding Teen Center has averaged about **64** unique individuals per month since opening in April 2022 with **62%** being 12-15 years old, **33%** being 16-18 years old and **5%** being 60-70 years old.



Age Distribution of Monthly Unique Participants Since February 2022 Anderson Teen Center

- 12-15 Years Old
- 16-18 Years Old
- 60-70 Years Old
- 71+ Years Old



Age Distribution of Monthly Unique Participants Since April 2022 Redding Teen Center

**Center Opened in April 2022*

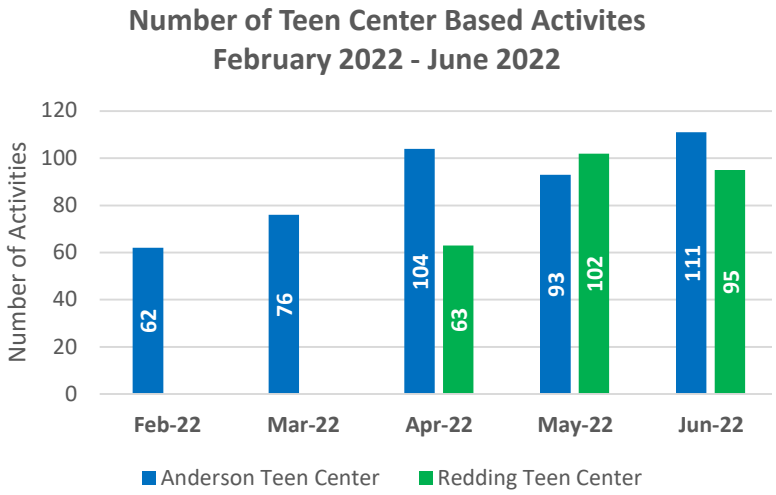
- 12-15 Years Old
- 16-18 Years Old
- 60-70 Years Old
- 71+ Years Old

Monthly Activities:

Programs at the Teen Centers engage older adults and teens in karate classes, yoga classes, financial literacy, life skills, basketball, and more, with a focus on accountability, respect, and bonding.

**Redding Teen Center Opened in April 2022*

***No Data Reported for January 2022*



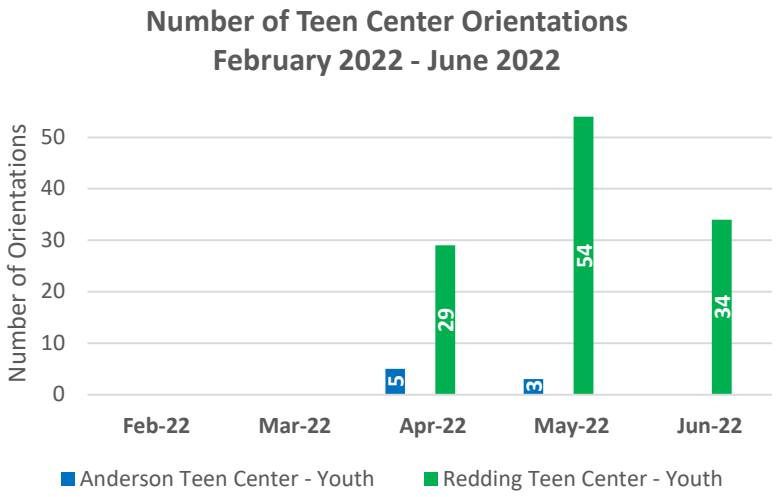
Teen Center Orientations:

Youth Orientation is held as needed for new youth participants and their parents. Orientation includes a tour of the center, an overview of offered programs, review of permission slips and flyers for the Teen Center as well as the Teen Centered App that the program uses.

**No Data Reported for January 2022*

***No Orientations reported for February and March 2022*

****No Adult Orientations reported for February through June 2022*



Overview for Anderson Teen Center

Youth engaged with Calfresh Nutrition Cooking Class for a six-week series of healthy cooking. Anderson Teen Center (ATC) youth and staff continue to engage with Anderson Partners and Neighbors for a Community Service based project to paint murals within the community.

The Anderson Teen Center held the following programs: Financial Literacy, Cooking Class, Boys Council, Towards No Drugs, CalFresh Healthy Living Nutrition Class, Community Service and Anderson Partners & Neighbors Collaboration for a Teen Center project. Anderson Teen Center youth submitted art entries for the Shasta District Fair and 2 of the youth were awarded placement ribbons. ATC held a graduation party celebrating the youth who graduated from High School with ice cream sundaes and decorating their graduation caps.
Anderson Teen Center Staff completed the following trainings: Girls Circle, Boys Council, Suicide ASIST, and Triple P Level 4 Group Teen.

Overview for Redding Teen Center

Redding Teen Center (RTC) Staff began developing relationships with the youth attending the Center by engaging in conversations, playing board/table-top games, creating art, and developing a LGBTQ+ club. A series of four SCOE Teen Cafés were held at the Redding Teen Center and had 1 Older Adult volunteer during the Teen Cafés. Incentives were given to each youth who participated in the Teen Cafés. Youth submitted art entries for the Shasta District Fair and 2 of the youth won placement awards. RTC held an end of the school year party to celebrate the youth.

Redding Teen Center Staff completed the following trainings: Girls Circle, Suicide ASIST, Triple P Level 4 Group Teen and Youth Mental Health First Aid.

Senior Adults/Hope Park

The Volunteer Coordinator continued to reach out to Senior Citizen homes, Senior Centers and other community locations to start recruiting Senior Adults for the Hope Park program. Volunteer Coordinator held three volunteer sessions as part of the recruitment process and then followed up with the interested individuals to continue with the recruitment process. Currently we have six Older Adult volunteers participating in the Volunteer Academy. The Volunteer Coordinator participated in various community outreach events and meetings to continue making connections with Older Adults.

Hope Park Accomplishments

The youth from the Teen Centers will be going on a 3-day camping trip to Lassen Volcanic Adventure Camp on July 5th-7th 2022. One of our youth from the Redding Teen Center shared with a staff member recently, “I feel like I’m no longer just surviving each day, now I feel like I’m living.” Another youth shared they were having thoughts of suicide, two of the Redding Teen Center Staff Members utilized the Suicide ASIST intervention skills and supported the youth through the intervention. The youth has consistently visited the Teen Center since talking with the Staff and when they arrive at the Teen Center, they give a check in about their mental/emotional health with the Staff and are connecting well with their peers.

Program Challenges/Solutions

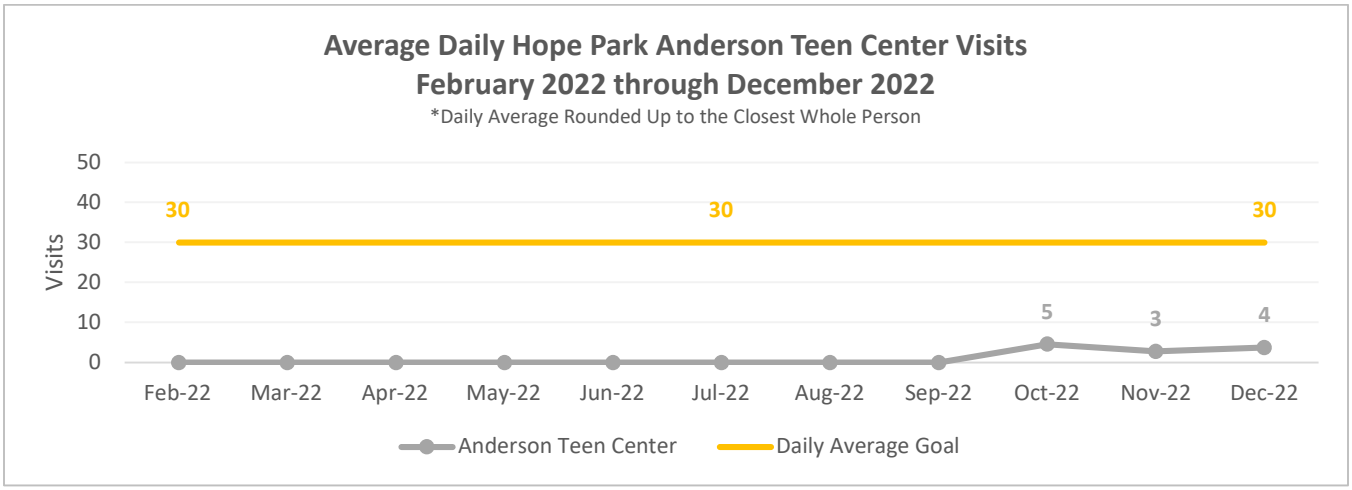
Hope Park challenges include acquiring the number of Senior Adults needed for the program. Potential causes of lack of follow through from Senior Adults seem to be fears of Covid exposure and inability to speak directly to the Senior Adults. The Volunteer Coordinator continues to make connections but encounters the challenge of the contact person/organization representative needing to speak with the Senior Adults first before the Volunteer Coordinator can have direct contact to speak to the groups of Senior Adults. The result is a significant delay in speaking with the potential Senior Adults or the contact person/organization representative doesn’t return phone calls or emails with the Volunteer Coordinator.

Year End Report for the Hope Park Project
February 2022 through December 2022

The Hope Park Project was initiated in February 2022 and uses an intergenerational approach to improve the Mental Health of the Youth (12-18 years old) and Older Adult (60+ years old) populations in Redding, CA and Anderson, CA. The Hope Park Project focuses on bridging the generation gap by providing mentorship to Youth to reduce the long-term effects of Adverse Childhood Experiences (ACEs) and offering meaningful activities to Older Adults to help prevent the negative physical and mental health effects of loneliness. Shasta County has two participating centers open Monday through Friday; the Anderson Teen Center located at 2889 E Center St, Anderson, CA 96007, and the Redding Teen Center (Opened in April 2022) located at 2981 Churn Creek Road, Redding, CA 96002. Funding is provided through the Mental Health Services Act (MHSA).

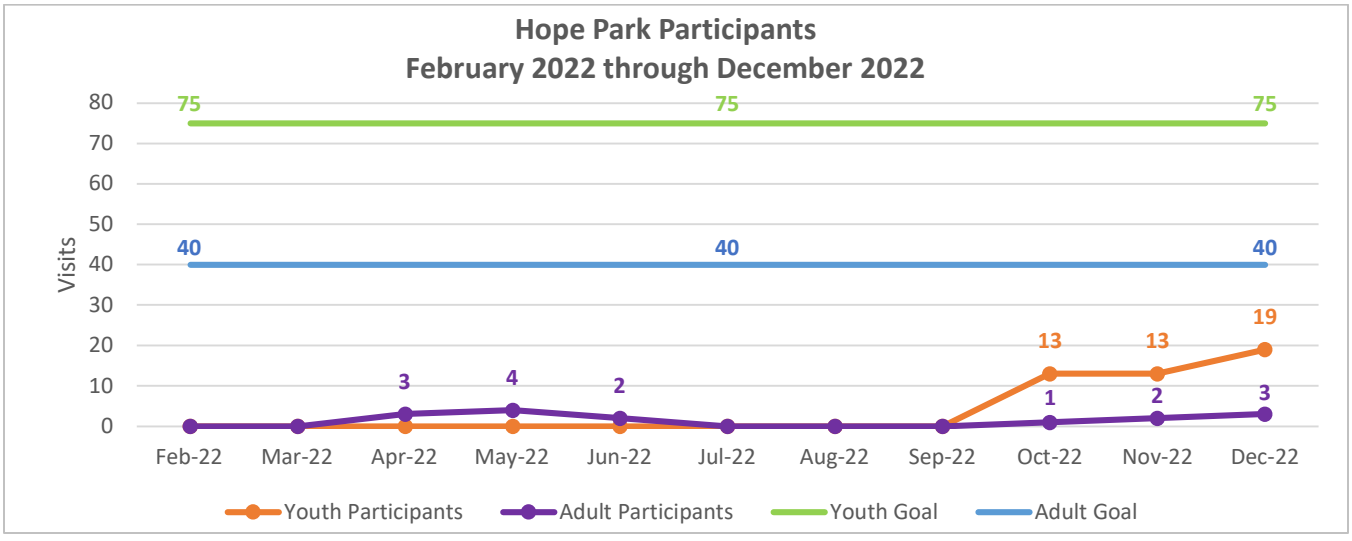
Year 1 Program Objectives:

1.) Build a daily average of 30 Hope Park Youth Visits at the Anderson Teen Center



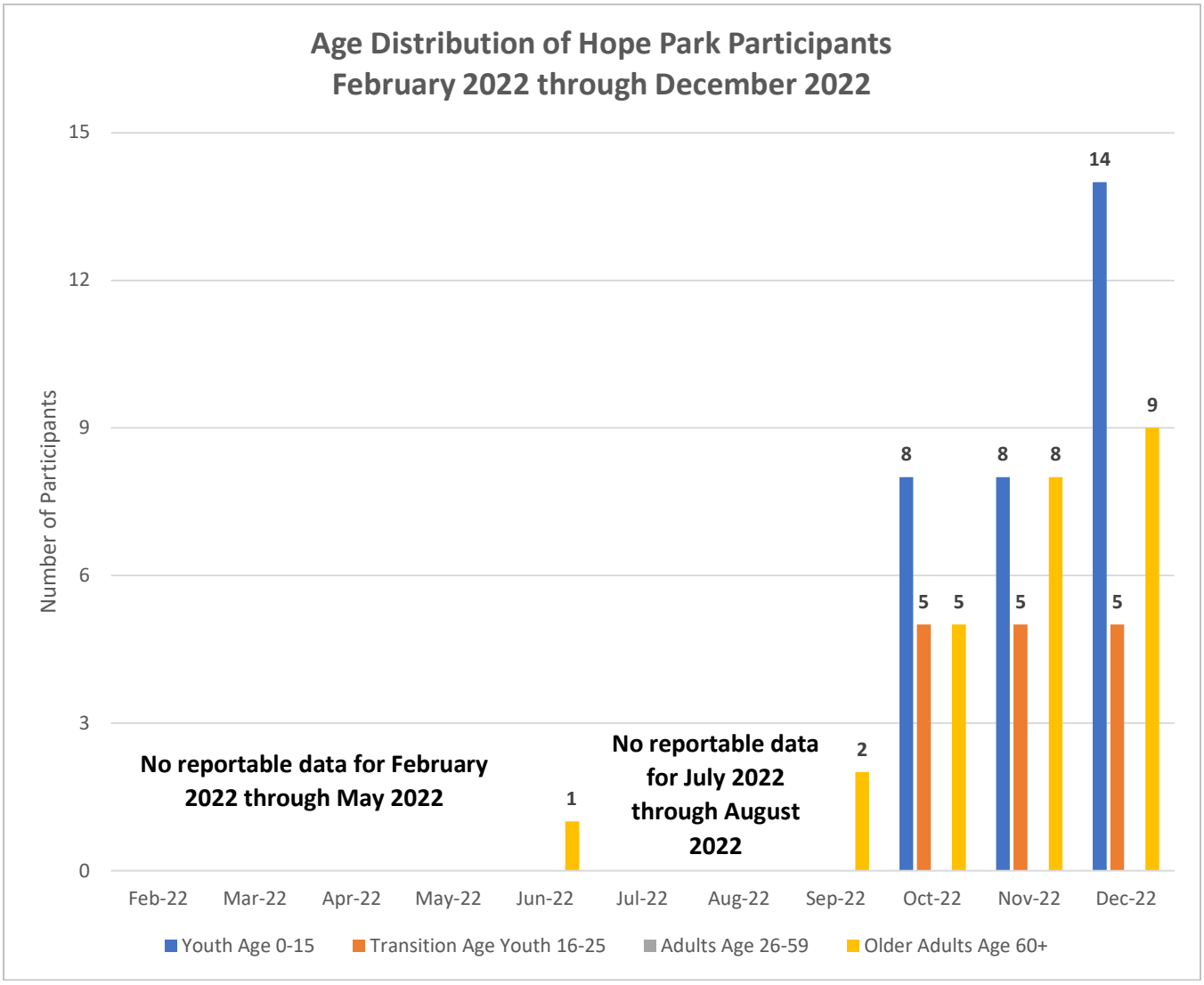
2.) Recruit 75 Youth participants from Anderson and Redding

3.) Recruit and Train 40 Older Adult volunteers



Age:

The Mental Health Services Act (MHSA) uses four different age categories: ***Youth*** *(Ages 0-15),* ***Transition Age Youth*** *(Ages 16-25),* ***Adult*** *(Ages 26-59) and* ***Older Adult*** *(Ages 60 and Up).*

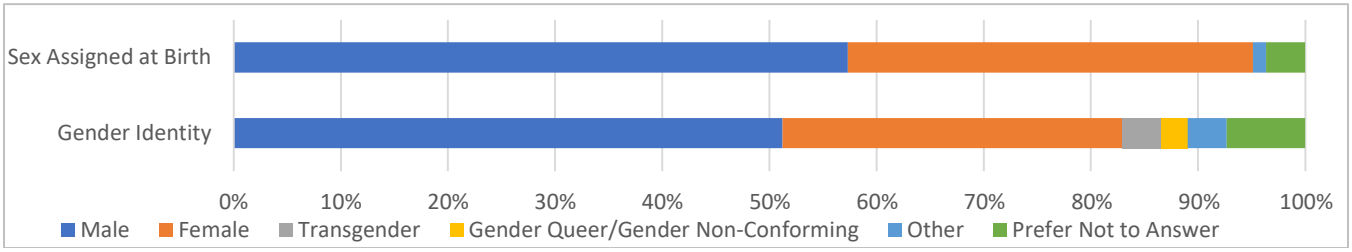


Teen Center Demographics:

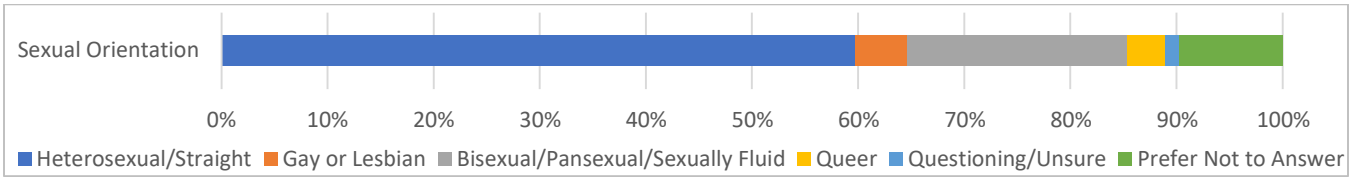
Demographic Surveys are taken by Teen Center participants and volunteers during orientation, the numbers below reflect the information for participants in both Teen Centers, not just Hope Park Participants, for **February 2022** through **December 2022**.

Because of the low gross numbers, actual counts are not reported to protect confidentiality.
****All demographic questions are optional, so each includes the category "Prefer Not to Answer"***

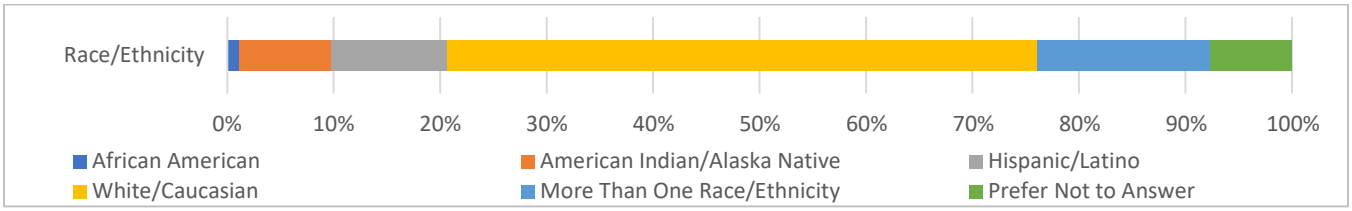
Sex Assigned at Birth and Gender Identity:



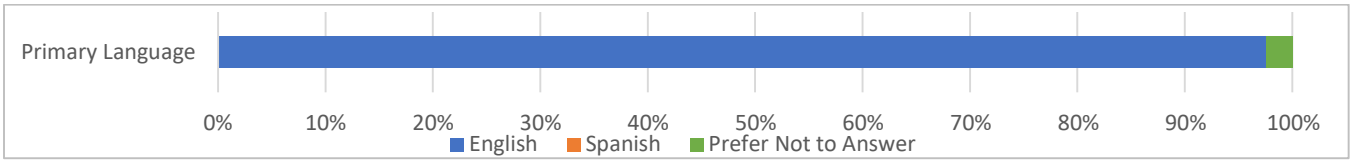
Sexual Orientation:



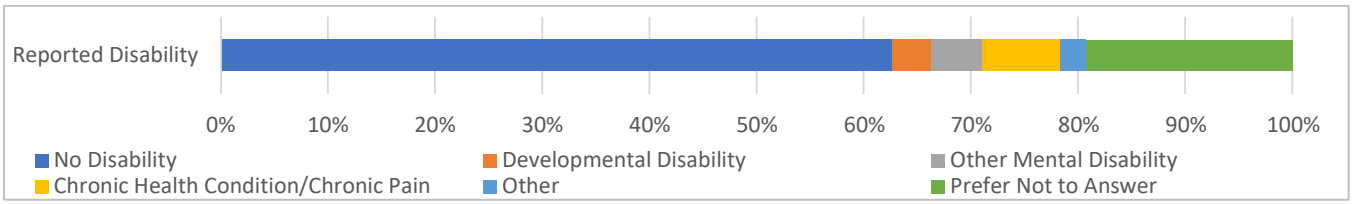
Race/Ethnicity:



Primary Language:



Disability:



May 15, 2023

Mental Health Services Oversight & Accountability Commission
1812 9th Street
Sacramento, CA 95811

Dear MHSOAC members:

This letter serves to inform the commission that a decision in support of early termination of an MHSA Innovations project has been reached. Program analysis and stakeholder engagement support the closure of Shasta County's Hope Park Project, currently delivered within the Redding and Anderson Teen Centers.

On May 3, 2023 a program update report was provided to the Mental Health, Alcohol and Drug Advisory Board (MHADAB). The report reviewed project goals. Hope Park Project met seven goals and did not meet thirteen. The board was apprised that monthly program improvement meetings were held with Hope Park Project leads. Insufficiency of program design to address and measure outcome goals was discussed. Stakeholder feedback unanimously supported early termination of the project in favor of alternative community supports.

The Hope Park Project aimed to alleviate isolation, depression, and suicidality among Shasta County's Older Adult population while preventing exposure and/or reducing the effect of ACEs in aged 12-18 Youth. The LEAPS project addresses issues affecting Older Adults, and additional focus on local development benefiting this demographic can be found within Master Plan on Aging activities. To address and alleviate the effects of ACEs on Youth, Shasta County is collaborating with stakeholders on a potential new Innovations project which provides extracurricular activity stipends to youth in foster care. Excitement for delivering future programming through the Redding and Anderson Teen Centers is high.

Thank you for your review of this notice of early termination. Please do not hesitate to contact me with any questions or concerns.

Sincerely,

DocuSigned by:
Miguel Rodriguez
1235765B45D137

Miguel Rodriguez, Director of Mental Health
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Behavioral Health & Social Services Branch
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Psychiatric Advance Directives (PADs) Innovations Project Update

In 2006, the Center for Medicare and Medicaid Services (CMS) clarified that Psychiatric Advance Directives (PADs) should be a part of psychiatric care. Approximately 27 states have enacted laws and policies recognizing PADs since the 1990s. However, PADs are often written with a focus on physical health, included in medical Advance Directives with little to no room for psychiatric health, plans, arrangements, or instructions to assist in the event of a mental health crisis. Also, the length and number of different PADs templates make it confusing for the individual filling out the PAD and the health care or first responder to comply with them. With such confusion, how can first responders or hospital staff know whether a PAD is valid or not?

As stated on the website of the National Resource Center (NRC), “Psychiatric Advance Directives are relatively new legal instruments that may be used to document a competent person's specific instructions or preferences regarding future mental health treatment. A PAD is used to plan for the possibility that someone may lose the capacity to give or withhold informed consent to treatment during acute mental health crisis ." The website further explains that California does not currently have a specific legal statute encouraging or recognizing PADs, thus leading to continued confusion and the underutilization of PADs in the state.

Californians with a mental health condition continue to face high rates of recidivism within inpatient non-voluntary hospitalization, homelessness, and incarceration. These problems persist despite the state’s efforts to avoid or reduce 5150 involuntary hospitalizations and incarceration. Unfortunately, these and other efforts have not led to meaningful reductions in hospitalization and incarceration, or improved treatment outcomes.

In a psychiatric emergency, when an individual experiences delusions or a psychotic episode, it may be impossible to engage in even the most basic conversations about patient care, symptoms, diagnosis, and treatment preferences. A PAD would help prevent the guesswork for a first responder or treating physician by providing a "blueprint" of the individual’s exact needs, medication support, and even the ability to contact their chosen “Agent,” who is their advocate (Consulting, 2021).

Most recently, California Assembly and Senate Bills have been marketed to include mental health language in items such as Care Courts Senate Bill 1338 or Advance Directives as in Assembly Bill 2288. Assembly Bill 2288 now includes the following statement, “This bill would clarify that health care decisions under those provisions include mental health conditions. The bill would revise the statutory advance health care directive form to clarify that a person may include instructions relating to mental health conditions” (Choi, 2022). It has been mentioned numerous times that an Advance Directive, even with this inclusion, puts medical care as the primary and mental health as the secondary. This does not

increase the ability of a 19-year-old who experiences their first schizophrenic episode to identify who is their chosen agent/advocate and how first responders can identify what medication they may be prescribed or how to de-escalate a mental health crisis. Adding language to an Advance Directive does not allow for in-the-moment solutions or resources in a crisis.

This project seeks to address what is lacking in California and current legislation while meeting several unmet needs throughout the state. This project will engage the expertise of ethnically and culturally diverse communities, threshold populations, Peers (identified in this document as those with lived mental health conditions), family advocacy groups, and disability rights groups. The project outline includes but is not limited to the following:

1. Provide standardized information regarding PADs for Peers and additional stakeholders.
2. Standardize a statewide PADs digital template.
3. Allow a PAD to be recognized as a legal document.
4. Standardize a PADs training "toolkit" to be easily replicated from county to county.
5. Utilize a technology platform to easily access PAD's information, training, and materials.
6. Utilize Peers to create PADs based on lived experience and understanding, which can lead to open dialog and trust.
7. Create a training curriculum to identify PADs understanding, digital literacy, and facilitation to create a PAD with a trained partner.
8. Create a technology platform to warehouse PADs for ease of access to an individual PAD in a crisis, providing mobility of PADs throughout the state.
9. Create legislation to enforce the use and acceptance of standardized PADs in California.
10. Create an outcome-driven continuous evaluation process, evaluating the ease of use of training, technology, and the PAD template.

The multi-County PADs Innovation Project went before the Mental Health Oversight and Accountability Commission (MHSOAC) on June 24, 2021. Counties sought to use Mental Health Services Act (MHSA) Innovations to fund this multi-County, multi-year project. After a presentation by Consultant and Lead Project Manager Concepts Forward Consulting (CFC), along with the original counties of Fresno, Mariposa, Monterey, Orange, and Shasta, the MHSOAC unanimously approved the project to proceed.

The first objective was to contract with a fiscal intermediary. In past Innovation projects, CalMHSA, a statewide Joint Powers Authority (JPA), was utilized as a fiscal intermediary. With this came a Memorandum of Understanding (MOU) as a pass-through for the funding to contractors. Other

MHSA projects that used a primary consultant are often funded through this JPA. A few counties opted not to utilize the JPA services for funding oversight on this project. In turn, the JPA opted not to participate as the project fiscal intermediary on the statewide portion; they contracted with Fresno County to assist in Fresno's additional direct fiscal contracting for PADs.

While in conversations with Syracuse University's (SU) Burton Blatt Institute (BBI) Chairman, Professor Peter Blanck, Dr. Blanck offered BBI's oversight SU as the fiscal intermediary for the project. BBI had been an integral part of the PADs project since the beginning in 2019, selected to participate by Elyn Saks, Associate Dean and Professor of Law at USC. The MHSOAC had previously contracted with USC to begin work on the PADs initiative. The MHSOAC identified a new direction to illicit additional county participation and concluded its contract with USC. Syracuse University was introduced to the five participating counties as a fiscal intermediary choice for review and discussion. The counties met with SU to hear what it meant to be the fiscal intermediary. The five counties decided a single Master Agreement representing consistent language and expectation for all counties, with the ability for each county to personalize where needed, would be the best outcome.

The five counties spent from July 1, 2021-April 30, 2022 working through the necessary steps to create a standard Master Agreement. During July 2021, CFC gathered operation agreements, master contracts, and MOU language from the five participating counties to provide SU with a starting point to create the master document. This process went through three drafts between July and October. In a county-to-county conversation, one county announced, "this process has been an innovation project on its own." By creating a cohesive document, additional multi-County collaborative projects become easier to contract and begin in a timely manner.

Each county had the ability to customize the language with minor adjustments to suit their specific needs to obtain external county staff and BOS approval. Concepts Forward Consulting coordinated and mediated each change, answered questions, and explained the counties' and university's perspectives to each other. Questions were answered as a collective or handled on a case-by-case request.

Additionally, the Master Agreement includes a scope of work and a budget narrative. Concepts Forward Consulting worked with SU to create deliverables and a payment schedule that worked for each county. Payment is flexible, whether an annual charge, per invoice, or lump sum. When Fresno, for example, needed to adjust its budget to a three-year verse four-year payment, SU, and Fresno agreed-upon a budget structure.

To achieve approval by a county, BOS takes specific actions. It is noted that numerous action items happen within a county prior to BOS approval, and these steps can take upwards of nine months to one year to accomplish. This is an important factor to consider when creating a multi-County relationship. Action steps that took place during FY 2021-22 were identified as the following:

1. The County contracts department will review the document for approved language and additional documentation needed, such as sole source. Upon their satisfaction with the contract language, they send the document to County Council.
2. County Council reviews and approves all language within any document prior to submission to the BOS. In this situation, this includes the Master Agreement, Scope of Work, and Budget Narrative. Items they seek to review include indemnification, insurance, timeline, terms of the agreement, performance standards, termination clause, and other requirements as needed.
3. Once County Council has approved the document language, there is approval to upload the document into the county routing system.
4. The document is routed to the County Auditor, who must approve the expenditure of funding. Upon approval, the Auditor's Office will sign the document.
5. Some counties will include signatures of Department Heads, such as the Director of Behavioral Health or Health Care Agency/Health and Human Services Agency and even the County CEO.
6. The BOS will receive a completed packet of information, including a description from MHSA staff regarding the project's need, approved document language, budget expenditures, and all required signatures.
7. The BOS will approve the document in a public meeting and, if contested, will listen to community comments. The BOS can also approve on consent.
8. The upload and routing process alone can take ten weeks in a county. This does not account for review time before the routing process.

During FY 2021-22, numerous challenges and lessons were learned, all culminating in an outstanding final accomplishment. The first challenge was when a few counties expressed the desire to have transparency with the oversight of their funding from a fiscal intermediary. The second was when the current JPA opted not to participate in the project. These challenges brought about the accomplishment of identifying a new and independent fiscal intermediary.

It has been said, “it should be easy to find a fiscal intermediary; any county could opt to be it for a project.” Well, in theory, perhaps, but that poses its own challenges. This project includes two large counties, a medium county, a small, and a super small county, and none with the bandwidth or fiscal capability to oversee a project of this scope, which is currently not the standard nor expectation on any statewide Innovations project.

The next challenge came with county-specific protocols, contract language, and procedures. Each county addressed these challenges by providing their prospective contracting department's documentation to SU for integration into one culminating document. In addition, all drafts from SU were approved by the county’s contracting departments and external county staff. This posed additional challenges, as external county staff is often unfamiliar with the MHSA, and especially the Innovations component. County staff may not understand the nuances of sub-contractors, funding language, timelines, and specific MHSA regulations, such as reversion. This posed an unexpected challenge at times within the counties as they gently maneuvered the politics and expectations of external county staff.

There were challenges in the timely approval of each draft agreement. Counties had the opportunity to read and edit all drafts of the Master Agreement; however, external county staff does not work on the same timeline. Some counties could report edits quickly, and others waited on external county staff to provide the needed modifications. Syracuse University was extremely accommodating with counties, answering each question as it arises but adding county-specific flexibility in language as required.

The biggest lesson learned in this part of the process was that of time. Even if it were the most straightforward contract, a county would need no less than ten weeks to calendar the BOS packet. Preparation for that packet could take no less than a month. The counties were already looking at two- and one-half-month to three months for BOS contract approval. Unexpected as it has been, the nine months this project took to create a brand-new county collaborative document and receive BOS approval is the norm.

Additional challenges encountered by the fiscal intermediary were counties not realizing timelines or funding they initially agreed to and needing to move budget items or the allocation period. These items include creating new draft or budget documents. Some county edits have been minor, and SU always explained why a change was being accepted or denied. Counties have all been agreeable to all information exchanged. Lessons learned in this process are numerous; below are a few examples:

- After MHSOAC approval, there is a significant lag between approval and implementation of an MHSA Innovations project. Counties are looking at a minimum of three months and upwards of nine months to complete the contracting process.
- Positions needing to be filled as part of the project cannot occur until the BOS approves the fiscal spending and contract language. The county hiring process can then take an additional nine months.
- Creating a true multi-County collaborative, where contract language is equal for each county, with county voice and county standards, was more encompassing than expected. This includes the unexpected wait times for document editing and the incorporation of edits by five individual counties.
- Counties rely on the project manager's expertise; direct county and MHSA experience is essential.
- It is imperative to keep a project moving forward by having bi-monthly meetings with counties. Plus, additional meetings with the fiscal intermediary and subcontractors as needed.
- Additional training is needed for external county staff and BOS to fully understand the unique nuances of MHSA and, more importantly, the ideas of multi-County collaboration and statewide initiatives.
- Counties being approached as separate entities on this collaborative project with the “threat” of state intervention to force “grant” and Request for Proposal (RFP) opportunities. This shows the lack of understanding by the public regarding the collaborative nature of the Innovation projects and decisions made collectively.

Throughout the initial creation of the project and while awaiting a BOS-approved fiscal contract, the counties and CFC met bi-monthly to continue moving the contracting process forward. This became an arena for discussion, suggestions, and decisions on moving the project forward. When one county requests specific information, such as “sole source” documentation, it usually will be a topic in another county. When one county receives requested information, the information is passed to all participating counties. The county-to-county allows counties to inquire how other counties handle specific contracting language nuances or differing opinions of eternal county staff. Additional workflow throughout the fiscal year 2021-2022 (FY 2021-22).

Unfortunately, due to the lack of accessible funding, it was not feasible to ask sub-contractors to expend unpaid time creating a scope of work and budget narrative when the counties could not precisely determine BOS approval. Counties each expressed the desire to move the contract along.

However, counties have described the many required steps in the approval process, which hinders a timely start date for the project.

In anticipation of contract approval during FY 2021-22, CFC moved to re-introduce RAND, the process Evaluator, and The Hallmark Compass, the PADs assigned subject matter expert (SME), to the counties. The initial introduction was to identify each county's priority population to begin pilot outreach and dialogue. RAND and BBI, both evaluators on the project, met with counties. Orange County will be utilizing BBI as expert evaluators for Orange County's participation in the Technical Platform build and roll-out. Working together, BBI and RAND will create a seamless evaluation plan, with BBI building off the process evaluation RAND will be conducting.

Though the challenges and lessons learned have been numerous, the accomplishments are monumental. The most important is a standardized Master Agreement and scope of work that any county can ultimately pick up and use. This document will offer outside organizations or agencies the ability to contract with a county on a specific project. With five counties approving the document, this document could go to all additional county Mental Health Plans for contracting approval, creating a statewide form. The document is essential as Innovation collaboratives increase and grow. With a document signature ready for a BOS packet, it could cut contracting time to no more than 60 days, which after MHSOAC approval, is ideal (Appendix A, Master Agreement).

An additional accomplishment is a collaboration by the counties. With open communication, willingness to work together, large counties assisting smaller counties, and the desire to meet bi-monthly, speak to the respect for each other. The counties remain individual, and nuances or timeline delays did not affect the camaraderie within the meetings. There is a mutual understanding of the complexities of working with multiple counties.

Finally, a significant accomplishment during this step is utilizing the skills of a lead project manager that understands MHSA and component regulations, vendor contracts, and country-specific nuances. The counties were open to discussing needed changes and working seamlessly with the project manager and SU. Though the process was time-consuming and lengthy, the counties each stepped up to do their part to keep the momentum within their counties and participate in additional activities. One such activity was NAMI California's Annual Conference in October 2021. Each county provided a representative. After the presentation, one county stated, "that was refreshing and energizing to go back to the beginning and remember why we are doing all of this. I cannot wait to get to that finish line. Go, team!"

The Standard Agreement, being finalized in April 2022, paved the way for the

additional Contra Costa and Tri-City counties to seamlessly onboard on July 1, 2022, without a lengthy delay in BOS approval. At this point, now into the fiscal year 2022-2023 (FY 2022-23), the identified subcontractors could contract with SU to begin working on and invoicing the project. The subcontractors beginning in March included CFC, and The Hallmark Compass. July 2022 brought on the additional subcontractors RAND, Idea Engineering, BBI, and Chorus Innovations. All subcontractors began to work with counties to identify a timeline, project roll-out, and meet with key stakeholders. A full convening of all participants took place on August 16, 2022, with host county Fresno. This was an opportunity for all involved to meet each other and identify project questions and timeline expectations(Appendix B-C).

In September 2022, it became apparent that The Hallmark Compass was not the right fit for the parameters of the Innovation project, and the subcontractor chose to resign from the project. On September 1, 2022, an RFP was posted to identify a contract for a Peer SME to provide the statewide "Peer voice." Painted Brain and their subcontractor CAMHPRO were awarded the contract on October 14, 2022. September also saw the launch of a new project website www.PADSca.org to update and provide ongoing information on the project (Appendix D, Website and Analytics).

With all subcontractors and counties now aligned in the necessary direction, the work began in earnest. Counties continued to meet monthly, with the added bi-monthly workgroup for all participants, a monthly subcontractor meeting, and several meetings that include the collaboration between subcontractors, meeting with stakeholders, and one-on-one calls with the counties. To quickly identify projects and accomplish goals, small workgroups were created to work on items such as informational flyers, marketing, website impact, and template categories. Due to the collaboration, the group quickly designed and modified flyers for immediate use (Appendix E, Flyers).

Moving into the third and fourth quarters of FY 2022-23, the expectation is to meet with each county's priority population group, Peers, first responders, hospital staff, and family members to identify what the PAD's template will include. Since many versions of the template nationwide exist, this project is not about starting over but enhancing and fine-tuning what already exists. One item of note is that currently, a PAD is not widely used due to the length of the paper format. Due to the innovative nature of the project, paper is no longer in the equation. Of course, a person can still print out a PDF version of their completed PAD or even print and hand fill, but participating counties now have an opportunity to change the

conversation to PAD “components.” The idea is to fill out as much or as little as an individual would opt to complete. One aspect of the project, however, is to identify what would be the most important questions or components to include in the event of a crisis (Appendix F, Components).

Along with the template identification, the conclusion of FY 2022-23 will facilitate Chorus Innovations ability to engage stakeholders in practical conversations around technology build. What would a first responder need to access a PAD? How would a Peer enter the information or provide consent? In addition to these working aspects, BBI and RAND will begin their evaluation process of stakeholder engagement and the technical build. Painted Brain and CAMHPRO will engage Peers, and Idea Engineering will work towards completing the needed training videos. Each subcontractor has provided a write-up on their accomplishments to date and projected activities through FY 2022-23 (Appendix G-L).

As with any complex multi-County project, the fluid idea is that by the conclusion of FY 2022-23, the project will have completed PADs template components, PADs logo or marketing identification, evaluation focus groups held for both process and technology build, engagement of a variety of stakeholders, including but not limited to, Peers, family members, first responders, and hospital staff. It is the planning that Painted Brain will identify a training curriculum to include PADs understanding, digital literacy, and PADs facilitation. Chorus Incorporated will have accomplished the initial build and begin beta testing on the newly developed technological PADs platform. As the project evolves and due to the human and technological elements, we leave space for growth, change, and innovations.

Moving into the fiscal year 2023-2024, the project will train identified PADs teams, or priority population Peers and professionals, in the facilitation of a PAD, continue beta testing and fine-tuning the technology platform, Fresno will sunset June 2024, and new opportunities for additional counties to identify priority populations, be trained in the technology platform and continue testing the project will become an option. In addition, FY 2023-24 will begin a collaborative effort to address the legislation needs to move PADs forward in California, both in use and, most importantly, in consent and autonomy of the individualized PAD.

Appendix

A. Master Agreement and Sub-Awards
B. August PADs Convening
C. Timeline
D. Website and Analytics
E. Flyers
F. Components
G. Burton Blatt Institute (BBI)
H. Chorus
I. Idea Engineering (IE)
J. Painted Brain and CAMHPRO
K. RAND
L. Syracuse University

References

Choi. (2022, 6 20). *Assembly Bill No. 2288*. Retrieved from Leginfo.legislature.ca.gov

Consulting, C. F. (2021). *PADs Innovation Project v9 Final ks.* MHSOAC.ca.gov

SHASTA COUNTY MENTAL HEALTH, ALCOHOL AND DRUG ADVISORY BOARD (MHADAB)
REGULAR MEETING
Minutes
February 1, 2023

Members: Ron Henninger, Kalyn Jones, David Kehoe, Heather Jones, Cindy Greene, Mary Rickert, Connie Webber, Angel Rocke, Charlie Menoher
Absent Members: Sam Major, Dale Marlar, Jo-Ann Medina, Anne Prielipp, Christine Stewart, Alan Mullikin
Shasta County Staff: Katie Cassidy, Katie McCullough, Kim Limon, Rene Bairos, Christina Stewart, Darlyn Carnate, Shawnna Flannigan, Leah Shuffleton, Genell Restivo, Christopher Diamond, April Jurisich, Nicole Carroll

Agenda Item	Discussion	Action	Individual Responsible
I. Call to Order & Welcome	➢ The meeting was called to order and all present parties were welcomed.		➢ MHADAB Chair Ron Henninger
II. Open Public Comment Period	➢ A public commenter spoke about County telehealth services. Clients may not know they can ask the 3rd party telehealth assistant to leave the room, or what other rights or protocols may be available for switching providers or voicing their needs. ➢ A public commenter relayed a family member's story, noting a history of misdiagnosis, lack of 5150 due to suspected drug use, and a parole officer being unsupportive of mental health treatment. A fear of police retribution upon complaint was described. ➢ John Serle, Chief Operating Officer for a new local provider, Community Behavioral Health, introduced himself and provided an overview of upcoming psychiatric services and opportunities for collaboration.		
III. Staff and Board Member Reports	➢ Staff addressed Public Comments from the previous meeting. o HHSA staff reached out to Mercy Medical center to investigate ER protocols. MCT and CIRT were designed with a continuum of mobile response in mind. The protocol for assisting uncooperative individuals in crisis may vary based on whether the call is placed to 911 or MCT. MCT is not able to restrain individuals who have been 5150'd. MCT calls law enforcement who can assess for danger, after which MCT clinicians can intervene. If an evaluation is achieved, Hill Country can issue a 5150. An overdose response team for follow up after Narcan issuance is in discussion and planning phases. o NorCal OUTreach communicated with HHSA	➢ A future agenda item on the crisis programs continuum and their effectiveness was requested.	➢ Deputy Branch Director Katie Cassidy ➢ Board Member Connie Webber

	leadership about addressing barriers to care. ○ HHSA continues to explore emergency housing challenges and the need for increased case management surrounding this issue. ➢ MHADAB Chair Ron Henninger reported safety concerns continue at Woodlands housing complex, but the vendor is taking steps to address this. Heather Jones will attend quarterly departmental NAMI meetings.		➢ MHADAB Chair Ron Henninger
IV. Consent Calendar	A. <u>Approval of Meeting Minutes</u> Board members reviewed minutes from the January 4, 2023 meeting. B. <u>Teleconferencing Vote</u> Pursuant to Assembly Bill No. 361, Section 54953(e)(3), consider voting to facilitate continued Teleconferencing in the form of "hybrid" meetings.	➢ Item IV.A. Approval of Meeting Minutes was not passed upon to lack of quorum due to abstention. Additions to public comments were suggested. Item IV.B. Teleconferencing Vote passed with eight (8) Ayes and zero (0) Nays, and one (1) abstention.	➢ Motion: Charlie Menoher Second: Kalyn Jones Abstention: Mary Rickert
V. Regular Calendar	➢ The Community Planning Process Policy and Procedure drafts were reviewed and discussed. Including protocols detailing the processing of stakeholder commentary and reporting back to stakeholders in a timely, meaningful manner were recommended.	➢ No action was taken.	➢ Interim MHSA Coordinator Nicole Carroll
VI. Presentations	A. An Access to Services Mock Screenings for adults and children were demonstrated by Clinical Program Coordinators and a Mental Health Clinician. One reported barrier to care is lack of available clinical professionals leading to wait times of approximately 3 months for clients needing initial psychiatric prescription. Supportive services are offered during that time. B. The Quality Improvement (QI) and Grievance Process was presented by Clinical Program Coordinator Leah Shuffleton.		➢ Clinical Program Coordinators Rene Bairos and Christine Stewart, Mental Health Clinician Darlyn Carnate ➢ Clinical Program Coordinator Leah Shuffleton
VII. Discussion Items	A. A Discussion on HHSA's Vision for SUD Services was tabled. B. Board members were invited to volunteer for the MHSA 3-Year Plan Committee. C. Board members were invited to suggest future agenda topics for consideration.		➢ Deputy Branch Director Katie Cassidy ➢ MHADAB Chair Ron Henninger ➢ MHADAB Chair Ron Henninger
VII. Adjournment		➢ Adjournment (7:40 p.m.)	

Ron Henninger, Chair

Nicole Carroll, Secretary

The following Policy and Procedure
is to be amended.

Effective date: August 13, 2020 Page 1 of 1

POLICY

See also: Mental Health Services Act Community Planning Process Procedure

CONDUCTING THE MENTAL HEALTH SERVICES ACT COMMUNITY PLANNING PROCESS IN SHASTA COUNTY

This policy delineates how Shasta County Health and Human Services Agency accesses stakeholder input in Mental Health Services Act (MHSA) planning.

1. The Mental Health Services Act Community Planning 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.

2. The Community Planning Process must 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 geographic regions of the county.

3. The Community Planning Process must occur throughout the year, in person and online, and at various locations.

4. The Community Planning Process must also incorporate regular communication with stakeholders, including through e-mail, websites, newsletters, social media, trainings and webinars.

5. Shasta County Mental Health Services Act staff must be trained in the Community Planning Process upon receiving an assignment to a position that is funded (in full or in part) by MHSA.

Effective date: August 13, 2020 Page 1 of 3

PROCEDURE

See also: Mental Health Services Act Community Planning Process Policy

CONDUCTING THE MENTAL HEALTH SERVICES ACT COMMUNITY PLANNING PROCESS IN SHASTA COUNTY

This procedure delineates how Shasta County Health and Human Services Agency accesses stakeholder input in Mental Health Services Act (MHSA) planning.

1. The Community Planning Process includes several standing committees and workgroups that 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. These committees include:

    a. **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. Any community member, including consumers, family members, Health and Human Services Agency staff, peer support staff and any other interested individual, organization or agency are invited to attend. This meeting is the platform where priorities for each component of MHSA are established and decisions about how to implement, improve or expand programs are made. Meetings are announced via a press release, social media, outreach to community partners and e-mail to the Mental Health Services Act distribution e-mail list.

    b. **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.

    c. **Suicide Prevention Collaborative:** This 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.

d. **The Mental Health, Alcohol and Drug Advisory Board** also provides opportunities for discussion, education and input at its meetings, and liaisons are assigned to all of the above workgroups. This board is appointed by the Shasta County Board of Supervisors. A Mental Health Services Act update report is given at its regular bi-monthly meeting, and the board hears periodic presentations on Mental Health Services Act programs.

e. The Community Planning Process also engages people who are not able to attend meetings in person. This is done through social media, press releases, outreach to community partners and e-mail to the Mental Health Services Act distribution e-mail list on items that are impacted by MHSA funding.

2. The following items require input using the Community Planning Process:

   a. **MHSA Three-Year Plan and/or Annual Update:** Stakeholder review is required by statute through the Mental Health Services Act. Every year, Shasta County MHSA staff conduct a community program planning process to review community programs for the next year. The results of the community program planning process are incorporated into the Three-Year Plan or Annual Update. This is done through a widely distributed online survey, which is publicized through a press release, social media, outreach to community partners and e-mail to the Mental Health Services Act distribution e-mail list. Feedback is also solicited in person through community meetings, including meetings at the County's MHSA-funded wellness centers. The purpose of this outreach is to determine who is actively participating in the stakeholder process, what target populations and programs the community feels MHSA funding should be focusing on, how effective the Health and Human Services Agency is in meeting the essential elements of the Act, and what additional programming is needed, if funding allows. Survey results are included in the published Three-Year Plan and/or Annual Update, which is posted for public comment for at least 30 days, reviewed and approved after a Public Hearing at a publicly noticed Mental Health Advisory Board meeting, and reviewed and approved by the Shasta County Board of Supervisors in a public meeting.

   b. Any new **Innovations project proposals** must also be reviewed through the process noted in item 2a.

   c. Any other MHSA-funded project that has not been discussed during regular MHSA stakeholder meetings.

3. In addition to ensuring representation from the demographic groups required by the Mental Health Services Act, the Community Planning Process intentionally seeks feedback from people with the following experience:

a. People who have severe mental illness

b. Families of children, adults, and seniors who have severe mental illness

c. People who provide mental health services

d. Law enforcement agencies

e. Educators

f. Social services agencies

g. Veterans

h. Providers of alcohol and drug services

i. Health care organizations

4. An updated list of organizations that are routinely included in Community Planning Process activities is included in the MHSA Three-Year Plan and/or Annual Update.

5. Reports based on the demographic and other information collected from surveys throughout the year, including who is involved in the Community Planning Process, are also included in the MHSA Three-Year Plan and/or Annual Update.

MENTAL HEALTH SERVICES ACT

THREE-YEAR PROGRAM AND EXPENDITURE PLAN

FISCAL YEARS
2023–24 through 2025–26

PUBLISHED JUNE 2023

INCLUDES DATA FROM FISCAL YEAR 2021–22

Shasta County
Health & Human Services Agency

TABLE OF CONTENTS

HHSA THREE-YEAR VISION

Recent years at the Shasta County Health and Human Services Agency (HHSA) have brought many changes. The spirit behind re-organization is to create an even more cohesive agency, aligning with California Advancing and Innovating Medi-Cal (CalAIM) by creating a branch that could provide services through the entire lifespan of our clients while decreasing barriers to treatment. 2022 saw the merging of our Children's and Adult Services branches, now the Behavioral Health and Social Services (BHSS) branch, where clients can receive services through a holistic lens by utilizing a whole-person care approach. It is with this mindset our vision is focused on…**"Improving the wellbeing of our community through integrated services."**

The vision also helps our staff better implement the "no wrong door" approach as we have already begun collaboration between programs which were previously siloed. In the months since the reorganization, we have experienced an improvement in access to care; however, even more exciting, we have experienced a decrease in barriers when connecting clients to auxiliary services.

Our "no wrong door" approach is reflected in the MHSA program plans throughout this 3-year report. The past few months have shown that clients who are directly connected to services through a wraparound approach are more likely to continue engagement in services, and our staff have become keenly aware of auxiliary services (such as In-Home Supportive Services) which may help our client meet their individualized goals.

As we continue to work towards increasing our internal programs and services in an effort improve our ability to meet community needs, staff shortages continues to remain a consistent challenge for our branch. We are hopeful that as we continue to address this barrier, we will not only improve our own internal service delivery system, but also increase our capacity to provide additional outreach efforts while creating an even stronger referral network.

PROGRAM PLAN GOAL THEMES IN THIS REPORT:

- Rebuilding staffing to better support and revitalize current programs.
- Identifying the best program outcome measures and improving monitoring and analysis through interdepartmental and community partner collaboration.
- Increasing educational events and training on evidence-based therapeutic modalities for staff and community partners.

Additional areas of focus during the next year are to increase availability of crisis services, residential services for children, availability of SUD services, and expansion of our peer-support specialist program/services.

Over the next three years, we will continue to make meaningful connections across branches in an effort to remove barriers our clients experience when accessing services. Going forward, our leadership team, with the feedback from the Mental Health Alcohol Drug Advisory Board, staff, community partners, and other stakeholders, will engage in a continuous improvement process to identify additional areas of focus and changes needed to improve client care and outcomes.

Miguel Rodriguez, Director of Mental Health

MENTAL HEALTH SERVICE 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.

WHAT IS COMMUNITY PROGRAM PLANNING (CPP)?

CPP is a collaborative stakeholder process that adheres to California Code of Regulations § 3320 to plan, implement and evaluate Shasta County's Mental Health Services Act programs.

The goal is 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 to gather diverse opinions to ensure that our wellness-, recovery- and resilience-focused programs will be successful.

Am I a stakeholder?

If you are a person living in Shasta County with an interest or concern in behavioral health services, you are a stakeholder!

Community program planning for the Mental Health Services Act in Shasta County happens throughout the year at locations all over the county. Participants are encouraged to complete a demographic survey to ensure that people of all ages, races, genders, income levels, etc. are fairly represented. This includes unserved, underserved, and fully served county residents who qualify for MHSA services. Communication to stakeholders may include e-mail, websites, social media, trainings, webinars, presentations and more.

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	Sunrise Mountain 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	
Northern Valley Catholic Social Service	Kings View
Area Agency on Aging	Tri-Counties Community Network
Shasta County Chemical People	Youth Violence Prevention Council
Community Foundation of the North State	United Way of Northern California
Pathways to Hope for Children	One SAFE Place
Good News Rescue Mission	Children's Legacy Center
ShiningCare	Dignity Health Connected Living
Dunamis Wellness Center	Family Dynamics
First 5 Shasta	Golden Umbrella
The McConnell Foundation	Visions of the Cross
Health care	
Hill Country Health and Wellness Center	Shasta Community Health Center
Mountain Valleys Health Center	Shingletown Medical Center
Dignity Health	Shasta Regional Medical Center
Mayers Memorial Hospital District	Health Alliance of Northern California
Veterans Administration	

Read more about CPP here.

COMMUNITY PROGRAM PLANNING

Regular stakeholder committees:
The following meetings were held during Fiscal Year 2021–22.

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: September 28, 2021, January 18, 2022, March 31, 2022, May 11, 2022; Shasta MHSA

Stand Against Stigma Committee:
This committee works to promote mental wellness, increase community awareness of mental health, and end the stigma surrounding mental illness, substance use, suicide and suicide loss. The committee helps brainstorm, guide and promote the activities of Stand Against Stigma and helps plan Mental Health Month events in May.

The community-based committee is supported by the Health and Human Services Agency and is open to all members of the public. The committee meets every other month.

Meeting dates: August 9, 2021, October 12, 2021, December 14, 2021, February 8, 2022, April 12, 2022, June 14, 2022; Stand Against Stigma Committee – Stand Against Stigma

Suicide Prevention Collaborative:
The Suicide Prevention Workgroup was renamed the Suicide Prevention Collaborative to better reflect its purpose. This local collaboration of community members and public and private agencies focuses on reducing suicide in Shasta County. It discusses the progress being made in suicide prevention, as well as action planning, implementation and evaluation. Because the suicide prevention coordinator was reassigned to COVID-19 duties during the pandemic, fewer meetings than usual were held.

Meeting dates: July 15, 2021, September 16, 2021, November 18, 2021, January 20, 2022, March 17, 2022, May 19, 2022; Shasta Suicide Prevention Collaborative

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 meetings, which were bi-monthly through 2022, and they hear periodic presentations on Mental Health Services Act programs.

Meeting dates: July 7, 2021, September 1, 2021, November 3, 2021, January 5, 2022, March 2, 2022, May 4, 2022; Mental Health, Alcohol and Drug Advisory Board

COMMUNITY PROGRAM PLANNING

By focusing on MHSA's core values, together we can increase community involvement and collaboration surrounding difficult issues.

- Community collaboration
- Cultural competence
- Consumer and family-driven services
- Focus on wellness, recovery, and resiliency
- Integrated service experience for clients and families

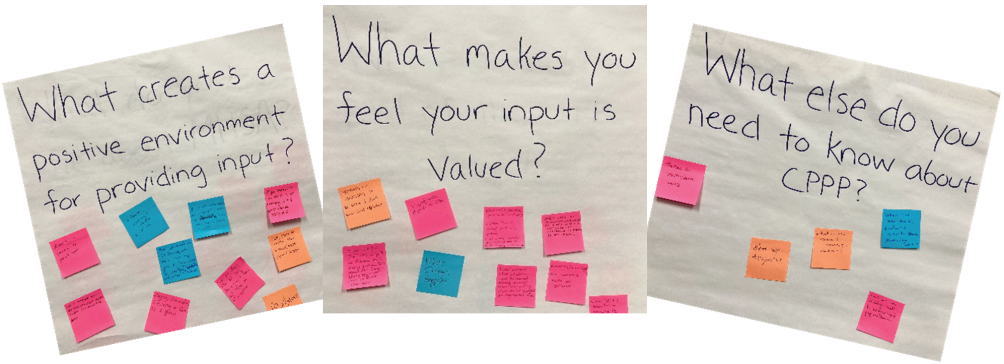
Community program planning 3-year goals

- Onboard MHSA staff to build capacity for procedural change
- Revitalize Community Program Planning processes*
- Expand outreach to center underserved Shasta County communities
- Streamline data collection and management (program data and stakeholder feedback)
- Analyze data for meaningful program development
- Improve agency communication to stakeholders
  - Webpage modernization
  - Accessible program information
  - Timely, reliable reporting
  - Community presentations
- Identify achievable and meaningful program goals and outcome measures
- Include one measurable goal for each MHSA program in the next Annual Update

* DHCS recommends updates to the CPP policies and procedures on file. Staffing shortages and turnover caused delays, however draft updates are in process and will be finalized within the next reporting cycle. CPP policy and procedure changes will undergo stakeholder review. Appendix R includes advisory board feedback on policy and procedure content.

2023 STAKEHOLDER FEEDBACK ON COMMUNITY PROGRAM PLANNING

MHSA Stakeholder Committee Discussion:
Attendees were invited to participate in an interactive exercise designed to capture insights into successes or gaps within the CPP process as currently implemented. Questions asked were, "What do you love about MHSA? What creates a positive environment for providing input? What makes you feel your input is valued? Who else (not currently present) should be part of CPP? What else do you need to know about the CPP process? What have we not considered?"



Stand Against Stigma Committee Discussion:
Since COVID-19 restrictions began, stakeholder surveys indicate meetings have been disproportionately attended by County professionals and to a lesser degree, local providers. Stand Against Stigma Committee discussed ways to make MHSA Stakeholder meetings more inclusive, increasing diverse participation from all community members. Ideas were themed around:

- Having volunteer greeters that can provide a warm welcome and help people become familiar with the meeting space. These can be professionals or peers, or peer professionals.
- Help everyone feel equal in the space by taking off ID badges. Don't ask for titles when doing introductions. Using badges and titles creates an "us vs. them" dynamic and could make some feel like they're less of a person because they aren't employed or don't have a professional job.
- Making the meeting environment and facilitation informal.
- Make the floorplan open and arrange chairs in a circle with tables on the outside edge so people still have a place to set stuff, but there aren't barriers in between people or people feel too close to each other.
- Provide additional ways to get feedback. One person suggested an option to have an advocate read feedback/suggestions (anonymously) for people who want to have a voice but are not comfortable speaking in front of others.
- Have a quick survey at the end of the meeting to get real time feedback about feelings of inclusivity.
- Provide healthy snacks and drinks.
- Place SWAG at the tables, along with fidgety type comforts (ex. coloring pages and pens, pipe cleaners, etc.)

MENTAL HEALTH SERVICES ACT PROGRAMS

Community Services and Supports	
Client and Family Operated Services	
NAMI	Wellness centers
STAR (Shasta Triumph and Recovery)	CARE Center
Rural Health Initiative	Housing continuum
Older adult services	Co-occurring disorders
Crisis services	Outreach
Prevention and Early Intervention (PEI)	
Children and Youth in Stressed Families	
A. Triple P B. Trauma-Focused Treatment C. At-Risk Middle School D. 0-5	A. Adverse Childhood Experiences B. Launch C. IMPACT D. MHSSA grant
Individuals experiencing the onset of serious psychiatric illness	
Stigma and discrimination reduction	
Suicide prevention	
CalMHSA statewide projects	
Workforce Education and Training (WET)	
Superior WET Partnership	

Innovation (INN)
Hope Park Project
Psychiatric Advance Directives (PADs)
Capital Facilities/Technological Needs (CF/TN)
None during this reporting period

CLIENT AND FAMILY-OPERATED SYSTEMS

Fiscal Year 2021–22 Expenditures:
$718,244 ↑3.75%

Number of people served:
Approximately 300

Who this program serves:
People 18 and over with mental illness and their families

What this program does:

- Operates two consumer-run wellness centers: **Sunrise Mountain Wellness Center** in Redding, operated by Kings View, and **Circle of Friends** in Burney, operated by Hill Country Health and Wellness Center.
- Funds the Shasta County National Alliance on Mental Illness (NAMI), which provides education programs in the community including NAMI Basics, NAMI Family-to-Family, NAMI Peer-to-Peer, Family Support Group and NAMI on Campus. NAMI operates out of the CARE Center and facilitates peer support groups and offers one-on-one mentoring.

Three-year goal:

A. Increase weekend hours at Sunrise Mountain Wellness Center, which are being heavily utilized by community members. Expand a bilingual 12-step program.

B. Supporting the family members reaching out for resources through collaboration with NAMI.

Acheived in previous year:

A. Sunrise Mountain Wellness Center began a bilingual 12-step program. Program popularity caused the program to move offsite due to capacity limitations at the Hilltop location.

in the community, and reduce adverse consequences of untreated or undertreated mental illness for individual participants.

C. For NAMI, provided at least four hours of peer support per month, one 10-week Peer-to-Peer program per fiscal year, one 12-week Family-to-Family program per fiscal year, one six-week NAMI Basics program per fiscal year, Family Support Group sessions at least twice a month, 20 hours of one-on-one mentoring, and NAMI On Campus for at least two local high schools.

D. NAMI volunteers ran Family Support Group sessions every two weeks, and an average of about 17 hours per month were spent on mentoring. There were facilitated peer support sessions, Peer-to-Peer, Family-to- Family and NAMI Basics programs.

Looking to next year:

A. Expand peer support services at Sunrise Mountain Wellness Center, improve hours of operation, expand upon access to 12-step recovery meetings in English and Spanish, and facilitate more socialization activities for clients.

B. Continue regular meetings between NAMI members and agency leadership to better inform resources provided to families.

For more information, see Appendix C and D.

SHASTA TRIUMPH AND RECOVERY (STAR)

Fiscal Year 2021–22 Expenditures:
$2,671,445 ↑23.96%

Number of people served:
199

Who this program serves:
Adults 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 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.

What this program does:
Supportive housing, linkage to services to maintain lowest level of care, therapy, crisis interventions, education regarding mental health symptoms and treatment, help identifying and practicing coping skills, around-the-clock support, medication support in the clinic, field-based medication support with nurses, alcohol and drug services, social group activities, employment preparations, peer support.

Three-year goal:
A. Continue outreach efforts to hardest-to-reach populations, including people who are homeless and suffer from severe and persistent mental illness.
B. Expand housing options with priority placement for FSP clients, both independent living and supportive housing, including at The Woodlands and by partnering with community organizations to develop room and board options.
C. Provide extensive social and supportive services with the goal of maintaining permanent housing.
D. Expand comprehensive and intensive STAR services for increased placement and stabilization within Shasta County.
E. Keep more clients off conservatorship and out of the hospital.

Achieved in previous year:
A. Increased the number of FSPs in The Woodlands housing and
B. Increased and added Assisted Outpatient Treatment (AOT) services.
C. Implemented wraparound supports such as discharge planning and community reintegration, promoting continuity of care.
D. Increased advocacy and communication efforts with clinicians to assist in treatment planning.

Looking to next year:
A. All 29 Woodlands FSP-allocated apartment units are filled with FSP clients.
B. Specific vehicles dedicated to STAR, including 4-wheel drives for clients in difficult to reach rural areas.
C. Develop portable toolkits for fieldwork including water, food, sanitary and clothing items.
D. Bring on a clinician to increase capacity to serve clients in IMDs and MHRCs.

RURAL HEALTH INITIATIVE

Fiscal Year 2021–22 Expenditures:
$816,006 ↓2.53%

Number of people served:
Approximately 5,000

Who this program serves:
People with severe and persistent mental illness who live in rural areas.

What this program does:
- 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.

Three-year goal:
A. 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.

B. Increase outreach activities informing community members of services provided.

Achieved in previous year:
A. Increased the number of people served by a Federally Qualified Health Center by 8.4%.

B. Total Visits for the Year:
- Hill Country Round Mountain: 32,046
- Shasta Community Health Center: 1,799
- Mountain Valley: 1,032
- Shingletown: 751

Looking to next year:
A. Increase access to telepsychiatry for individuals in the Intermountain Area of Shasta County.

B. Continue to achieve the Three-Year Goal.

For more information, see Appendix F.

OLDER ADULT

Fiscal Year 2021–22 Expenditures:
$11,298 ↑15.81%

Number of people served:
11

Who this program serves:
Adults aged 60 and older

What this program does:

- Outreach and engagement activities support recovery or rehabilitation as deemed appropriate by clients and their natural support system of family and community. Older Adult funding provides intensive case management to individuals who may require more care due to age-associated ailments. Services include medication management, therapy, case management, community connection and connection to transportation for medical appointments and more.
- Allows a social worker on the Outpatient team to specialize in working with Older Adults.
- Assesses the Level of Care of older adults and assists in maintaining the highest Level of Care possible for each unique individual.
- Case management may include eliminating barriers to achieving appropriate housing for older adults who may require subsidized housing and/or on-site medical care.

Three-year goal:

A. Continue to reduce the need for hospitalizations.

B. Ensure that outreach and stakeholder groups include older adults.

Achieved in previous year:

A. Outpatient is fully staffed with 8 social workers, allowing a social worker specializing in Older Adult care to provide more services to this demographic.

B. Older Adult clients were successful in getting into subsidized senior housing.

C. Older Adult clients experienced minimal hospitalizations within the 2021-22 fiscal year.

Looking to next year:

A. Continue to assist clients in securing appropriate housing and housing support.

B. Help older adult clients access Connected Living, formerly Gold Umbrella. Connected Living reopened their adult day healthcare program and lunch program, serving seniors in our community and providing transportation through Redding Area Bus Authority (RABA).

C. Train providers in Outpatient on Older Adult population outreach and stakeholder activities.

CRISIS SERVICES

Fiscal Year 2021–22 Expenditures:
$1,881,462 ↑11.82%

Number of people served:
1,428

Who this program serves:
People experiencing a mental health emergency, including those who come to local emergency departments on an involuntary mental health hold, people with a psychiatric diagnosis who visit emergency departments frequently, people who may need acute psychiatric hospitalization, and people who require services to maintain a lower level of care and stability.

What this program does:
- Case management, linkage to services, discharge planning to coordinate care.
- 24/7 telephone crisis services.
- Walk-in evaluation for mental health services by ACCESS Team clinicians. This evaluation may be during crisis and result in a 5150 hold when appropriate.
- Contracts with Hill Country Health and Wellness Center for a Mobile Crisis Team (MCT).
- Contracts with Redding Police Department for a Crisis Intervention Response Team (CIRT).

Three-year goal:
A. Coordinate with co-located emergency department crisis staff, HHSA outpatient services and community providers to help facilitate discharges from emergency departments and psychiatric hospitalizations, linking clients with ongoing services.

B. Identify and address challenges in the inpatient admissions and discharge processes.

Achieved in previous year:
A. Hired a second case manager to facilitate successful discharge of client from both the emergency department and inpatient facilities.

B. Increased coordination with emergency department and crisis staff, HHSA outpatient services, and community providers.

C. Established wraparound care connections to reduce the continued need for emergency interventions.

D. The Mobile Crisis Team (MCT) responded to 2,252 crisis calls.

Looking to next year:
A. Elevate conversations surrounding complex care management for people in crisis situations.

CRISIS SERVICES: CRISIS RESIDENTIAL AND RECOVERY CENTER

Fiscal Year 2021-22 Expenditures:
$1,357,390↑7.03%

Number of people served:
102

Who this program serves:
Clients 18 and older who have become suicidal, critically depressed, or otherwise psychiatrically incapacitated. Clients are either being released from a 5150 hold in a psychiatric hospital or are in jeopardy of being placed in a psychiatric facility in the next 30 days.

What this program does:
- Provides residential services for up to 30 days to adults following a mental health crisis to prevent the need for hospitalization.
- 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.
- Helps people move from crisis into short-term transitional housing and stabilization and Full-Service Partnership enrollment or to outpatient intensive case management and support, as needed.

Three-year goal:
A. To develop systems that accurately standardize practice and approach in service delivery so that we may adjust our current model to help clients connect to appropriate level of care.

B. Increase the level of clinical intervention and documentation within the center and linkage to outside clinical resources to prevent/reduce the need for future psychiatric hospital stays in Shasta County.

C. Foster engagement, connection and referral relationships with more community providers and services.

Achieved in previous year:
A. Increased client connection to resources and improved wraparound care.

Looking to next year:
A. Following completion of CRRC kitchen renovation in early 2023, increase bed count to maximum capacity of 15.

For more information, see Appendix E.

CRISIS SERVICES: ASSISTED OUTPATIENT TREATMENT ("LAURA'S LAW"): THIS PROGRAM IS PENDING

Fiscal Year 2021–22 Expenditures:
$545,824 (new)

Number of people served:
This program is pending

Who this program serves:
People 18 and older with a serious mental illness who have a recent history of psychiatric hospitalizations, incarcerations or threatened/attempted serious violent behavior toward themselves or others.

What this program does:
- This opt-in program establishes intention of a collaborative effort between judges, the County, and mental health service providers contracted by the County to provide Assisted Outpatient Treatment (AOT).

Three-year goal:
A. Use evidence-based practices to reduce the incidents and duration of psychiatric hospitalization, homelessness, incarcerations, and interactions with the criminal justice system while improving the health and social outcomes of people with serious mental illness.

B. Work with courts to allow people to obtain treatment while continuing to live in the community and their homes.

Achieved in previous year:
A. A local judge and two County Clinical Division Chiefs attended an AOT Laura's Law training conference in Sacramento.

B. A procedural case study was performed by clinical program staff and county counsel. Staffing issues have prevented court participation.

C. Kings View provided intensive outreach, therapy and FSP services to County clients who meet Laura's Law criteria.

Looking to next year:
A. Address staffing issues impacting the implementation of Laura's Law.

B. Partner and collaborate with the courts and service provider to create a smooth procedure for court referral and monitoring of AOT client mental health services.

CARE CENTER

Fiscal Year 2021–22 Expenditures:
$577,640 (new)

Number of people served:
3,912 total visits

Who this program serves:
People in mental health crisis

What this program does:

- CARE Center, operated Hill Country Health and Wellness Center, is an after-hours community mental health resource center that provides crisis services and support. Some services are available onsite, while other services are through a warm hand-off or referral. Visiting the CARE Center can be an alternative to 5150, as appropriate, for people experiencing urgent mental health needs.
- Provides more access to needed services with extended hours, and a more holistic approach to meeting various individual and family needs via a visit to one location.
- Engages mental health personnel to handle some situations that in the past were handled by law enforcement officers or busy emergency department personnel, moving the focus from short-term crisis management to advocacy and long-range solutions for wellness and recovery.
- Due to CARE Center's success as a former Innovations project, it is now supported by CSS funding.

Three-year goal:

A. Reduce emergency room visits.

B. Continue community outreach.

Achieved in previous year:

A. On average, over 200 unique individuals were assessed per quarter, exceeding service goals.

Looking to next year:

A. Work with Care Center to adopt new budgetary structures for value-based care.

For more information, see Appendix G.

HOUSING CONTINUUM

Fiscal Year 2021-22 Expenditures:
$143,621 ↑45.56%

Number of people served:
20

Who this program serves:
People with serious mental illness and their families who are homeless or at risk of homelessness.

What this program does:
- Provides access to housing options, both transitional and permanent supportive, in the least restrictive setting possible.
- Permanent Supportive Housing: The Woodlands (75 units, with 29 MHSA funded and designated for people eligible for Full-Service Partnership services) includes an HHSA case manager and peer support specialist, along with life skills classes provided by Northern Valley Catholic Social Service. Partners in Housing II is run by Shasta County Housing and offers case management.
- Transitional Housing: Affordable, accessible housing near clients' support systems with adequate access to transportation services, as found in board and care facilities.

Three-year goal:
A. Work collaboratively to identify ways to secure funding for housing in Shasta County.

B. Finalize completion of pending housing spaces and their associated programs, staffing, and supportive services.

Achieved in previous year:
A. The Center of Hope Apartments (98 units, 30 MHSA funded) are under construction next to Hill Country Community Clinic's new 40,000-square-foot medical facility. Currently, supportive services to be delivered within this housing program are in development.

B. Square 1 Homes, with services provided through Shasta Community Health Center, houses 13 seniors and/or medically fragile adults who are homeless or at risk of homelessness.

C. Christian Church Homes has been granted No Place Like Home funding to help build 59 units (9 supportive housing) for people 62 and older with a serious mental illness who are homeless or at risk of homelessness. Currently, supportive services to be delivered within this housing program are in development.

D. Construction for the 20-unit Burney Commons continues to move forward with a private developer.

Looking to next year:
A. Continue to look for opportunities to expand housing services.

B. Ensure service providers in place in all county-supported housing services.

For more information, see Appendix I.

CO-OCCURRING/PRIMARY CARE INTEGRATION

Fiscal Year 2021–22 Expenditures:
$513,233 ↑ 5.65%

Number of people served:
153

Who this 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.

What this program does:

- Connects people to primary care to provide coordinated care to treat the whole person and provides 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 diabetes, hypertension, Chronic Obstructive Pulmonary Disease, Hepatitis B or C, metabolic syndrome (anything that leads to obesity), and chronic heart failure.
- The In-Home Supportive Services (IHSS)/ Clinical support collaborative program was initiated to provide the best opportunity for all IHSS recipients to thrive in life. IHSS typically begins serving clients during a life altering event experienced by them or a family member. Offering Mental Health services at this juncture can be a crucial connection for clients who may otherwise not seek access to services.

Three-year goal:

A. Work with community providers to improve the integrated treatment of co-occurring disorders to improve the quality of life for people who have both co-occurring severe mental illness and substance use disorders.

B. See clients and families through difficult times and connect them to ongoing mental health services once stable.

C. Finally, this collaboration provides the opportunity for IHSS clients to receive supportive mental health services and interventions in their homes.

Achieved in previous year:

A. 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.

Looking to next year:

A. Cross-train Mental Health clinicians and IHSS assist employees in successfully navigating complex client needs.

B. Continue to achieve the Three-Year Goal.

OUTREACH

Fiscal Year 2021-22 Expenditures:
$1,259,583 ↑7.5%

Number of people served:
Approximately1,400

Who this program serves:
People who are unserved and underserved

What this program does:

- The Access Team screens everyone who is referred to or seeks to begin mental health support on a walk- in basis. Screening tools determine referral to the most appropriate level of care. There is no wrong door with the ACCESS Team. ACCESS endeavors to connect people with the right services, whether through the County or community providers, to meet their immediate mental health or substance use disorder needs.
- Case management, nursing and clinical staff reach out to bring people in need into the behavioral health system.
- Field-based nursing serves clients living with serious mental illness who are difficult to engage in ongoing treatment. Nurses help to reduce symptom relapse, decompensation, and hospitalization. They work to improve treatment engagement, therapeutic alliance, and accessibility of care in accordance with each client's unique goals.

Three-year goal:

A. Solidify community partnerships with ACCESS clinicians: Establish quarterly meetings, share service criteria, create procedures for information transfer, and build unified collaborative partnerships to eliminate extra steps for clients.

B. Improve understanding of culturally appropriate communication and care for diverse local ethnic groups to increase access to, and participation in, the public mental health system.

C. Expand Youth STAR outreach to the broader community including schools, with a focus on homeless youth populations and the underserved.

D. Continue to provide outreach to underserved people through the Access Team, field-based nursing, CIRT and other programs.

Achieved in previous year:

A. The Crisis Intervention Response Team (CIRT) includes two police officers with crisis intervention and mental health training, and an HHSA mental health clinician. CIRT works to deescalate mental health crisis situations and when appropriate, divert individuals from the criminal justice system and connect them to resources. HHSA is in the process of staffing a clinician for a second CIRT team, CIRT 2.

B. The ACCESS Team increased collaboration with Peer Support Specialists to assist clients seeking care in making the necessary first steps to create lasting change in their lives, tackle barriers, and provide wraparound care to County and community-based services.

C. Program managers over Youth services connected with 16 "gatekeepers" or key outreach contacts for service access throughout Shasta County.

Looking to next year:

A. Add a clinician to the new CIRT 2 unit.

B. Implement the new evidence based CalAIM Screening Tool, expedite transfers to community providers, and connect clients to peer support.

C. Schedule meetings with community providers to present the ACCESS program. Create connections and gather information on their programs.

CHILDREN AND YOUTH IN STRESSED FAMILIES: TRIPLE P

Fiscal Year 2021-22 Expenditures:
$403,561 ↓ 29.86%

Number of people served:
Approximately 433 representing practitioners, caregivers and youth, plus thousands reached by website and advertising

Who this program serves:
Parents

What this program does:
- This program is designed to enhance parents' knowledge, skills, and confidence in an evidenced-based format to prevent severe behavioral, emotional, and developmental problems in children.
- Multiple levels of interventions are tailored to meet each child and family's specific needs.
- This program is utilized in child welfare and outpatient children's mental health settings

Three-year goal:
A. Increase staffing to revamp Triple P engagement efforts. Loss of trained providers is a barrier to care.

B. Continue to help parents who engage with the program to become positive change agents for their children and enhance the community's capacity to support at- risk children and their families.

Achieved in previous year:
A. Two clinical staff completed training in Triple P, resulting in more people being served and increased outreach.

B. According to clinical observation, at-risk families were seen, including parent-child relationships, consistency, teamwork and encouragement and an overall strengthening of parenting skills.

Looking to next year:
A. Improve methods, procedures and staff training surrounding data storage and measuring program success.

B. Build upon outreach efforts to streamline referral partnerships and procedures.

For more information, see Appendix J.

CHILDREN AND YOUTH IN STRESSED FAMILIES: TRAUMA-FOCUSED TREATMENT

Fiscal Year 2021–22 Expenditures:
$4,842 ↑438%

Number of people served:
Organization of the electronic health record does not currently allow extraction of this information

Who this program serves:
Any youth receiving specialty mental health services with impairments due to trauma

What this program does:
A. Provides Trauma Focused – Dialectical Behavioral Therapy (DBT), Cognitive Behavioral Therapy (TF CBT), Eye Movement Desensitization and Reprocessing (EMDR), Trust Based Relational Interventions (TBRI) and Neurosequential Model of Therapeutics (NMT) assessments for youth with challenging behaviors due to trauma.

Three-year goal:
A. Decrease hospitalizations and length of stay in treatment, where appropriate.
B. Improve tracking mechanisms for therapeutic interventions provided.
C. Analyzing data for youth who have received interventions, answer the following questions. How many retained stable placement within child welfare system? Have trauma-informed interventions reduced the number of placements, or increased reunification?

Achieved in previous year:
A. Dialectical Behavioral Therapy (DBT), an evidence-based psychotherapy, was incorporated into services in 2022.
B. Six NMT assessments were completed and DBT groups for clients began.

Looking to next year:
A. Increase staff training in trauma-informed therapeutic modalities.
B. Develop outcome measures through tracking and analysis of length of hospital stays. This can be accomplished through implementation of CalAim's Transitioning Tool.

CHILDREN AND YOUTH IN STRESSED FAMILIES: AT-RISK MIDDLE SCHOOLERS

Fiscal Year 2021–22 Expenditures:
$296,735 ↑ 88.47%

Number of people served:
364

Who this program serves:
Middle schoolers

What this program does:
- Teaches youth the effects of substance use and healthier life choices, self-esteem and social skills, and relaxation techniques to cope with anxiety.
- Promotes healthy alternatives to risky behavior, such as peer pressure to smoke or use drugs and alcohol.

Three-year goal:
A. Increase awareness of peer-pressure related topics and decrease substance abuse among youth in middle school.

B. Strengthen service delivery in current schools, with a goal of increased engagement and participation.

Achieved in previous year:
A. With the addition of a pilot to expand to neurofeedback, mentoring and peer groups we did not see enough clients engaged and served based on contractual obligations for those additional services. As a result, the contract for the pilot was canceled in favor of streamlining service delivery.

Looking to next year:
A. Conduct outreach to schools providing Botvin. Offer interim County support to continue.

B. Successfully contract with a new provider to coordinate future Botvin LifeSkills implementation in middle schools.

C. Ensure proper completion of all required surveys to better track outcomes.

Turtle Bay

	Measure	6th grade Pre-Survey (N =59)	6th grade Post-Survey (N =59)	6th grade Change	7th grade Pre-Survey (N = 42)	7th grade Post-Survey (N = 42)	7th grade Change	8th grade Pre-Survey (N = 56)	8th grade Post-Survey (N = 56)	8th grade Change
Knowledge	Anti-drug	62.7%	65.6%	2.9%	63.7%	68.5%	4.8%	63.3%	63.4%	0.1%
	Life skills	67.5%	76.5%	9.0%	75.4%	79.1%	3.6%	76.6%	82.4%	5.8%
	Overall (combined)	65.5%	72.1%	6.5%	70.7%	74.8%	4.1%	71.2%	74.7%	3.5%
Attitudes	Anti-smoking	4.63	4.53	-0.10	4.52	4.42	-0.10	4.45	4.34	-0.11
	Anti-drinking	4.50	4.44	-0.06	4.46	4.36	-0.10	4.37	4.24	-0.13
	Anti-drug (combined)	4.56	4.49	-0.07	4.49	4.39	-0.10	4.41	4.29	-0.12
Life Skills	Drug refusal	2.83	3.56	0.73	2.78	3.19	0.41	3.86	3.96	0.10
	Assertiveness	3.37	3.42	0.05	3.55	3.56	0.01	3.37	3.44	0.07
	Relaxation	3.98	3.94	-0.04	3.87	3.87	0.00	3.69	3.90	0.21
	Self-control	3.74	3.75	0.01	3.74	3.52	-0.21	3.18	3.52	0.34

Note: Numbers may not add due to rounding.

Bella Vista

	Measure	6th grade Pre-Survey (N = 22)	6th grade Post-Survey (N = 22)	6th grade Change	7th grade Pre-Survey (N = 23)	7th grade Post-Survey (N = 23)	7th grade Change	8th grade Pre-Survey (N = 29)	8th grade Post-Survey (N = 29)	8th grade Change
Knowledge	Anti-drug	57.7%	65.7%	8.0%	58.8%	64.2%	5.4%	57.3%	64.5%	7.2%
	Life skills	71.8%	79.7%	7.9%	71.2%	70.9%	-0.2%	76.4%	78.4%	2.0%
	Overall (combined)	66.1%	74.0%	8.0%	66.1%	68.2%	2.1%	68.6%	72.7%	4.1%
Attitudes	Anti-smoking	4.33	4.42	0.09	4.66	4.41	-0.25	4.22	3.98	-0.23
	Anti-drinking	4.11	4.27	0.16	4.61	4.23	-0.38	4.09	3.91	-0.18
	Anti-drug (combined)	4.22	4.35	0.12	4.64	4.32	-0.32	4.16	3.95	-0.21
Life Skills	Drug refusal	3.86	3.04	-0.73	3.80	3.50	-0.30	3.47	3.55	0.08
	Assertiveness	3.32	3.70	0.38	3.32	3.46	0.14	3.33	3.37	0.03
	Relaxation	3.43	3.57	0.14	3.35	3.67	0.33	3.66	3.86	0.20
	Self-control	3.68	3.48	-0.20	3.61	3.50	-0.11	3.33	3.29	-0.03

Turtle Bay: Successfully completed year 3 of Botvin LifeSkills, with the 8th grade class having participated in 3 years' worth of lessons. Each sub-category in Knowledge showed improvement across all 3 grade levels. Additionally, we saw positive outcomes for Life skills pertaining to drug awareness and assertiveness.

Bella Vista: We can see positive outcomes in Knowledge for both subcategories for 6th and 8th grade as well as improvement in Anti-drug and overall knowledge for 7th graders. The remaining results show a mix of improved and decreased outcomes and will lend information on where additional engagement is needed going into the next year.

CHILDREN AND YOUTH IN STRESSED FAMILIES: 0-5 PROGRAM

Fiscal Year 2021–22 Expenditures:
$124,963 ↑ 143.08%

Number of people served:
111

Who this program serves:
Children ages 0-5

What this program does:
- Provides assessment, treatment planning, intensive care coordination, in-home behavioral services, Triple P, case management, individual and family therapy. Collaborates with Child Welfare Dept on referral basis.

Three-year goal:
A. Increase support for this underserved population in Shasta County by developing a Core group of community-wide service providers who offer 0-5 treatment.

B. Increase the number of community partners who accept referrals for clients in the 0-5 demographic.

C. Reduce the number of children who require ongoing specialty mental health services.

D. Assess whether the service re-entry rate has been maintained or improved for youth who receive 0-5 service modalities.

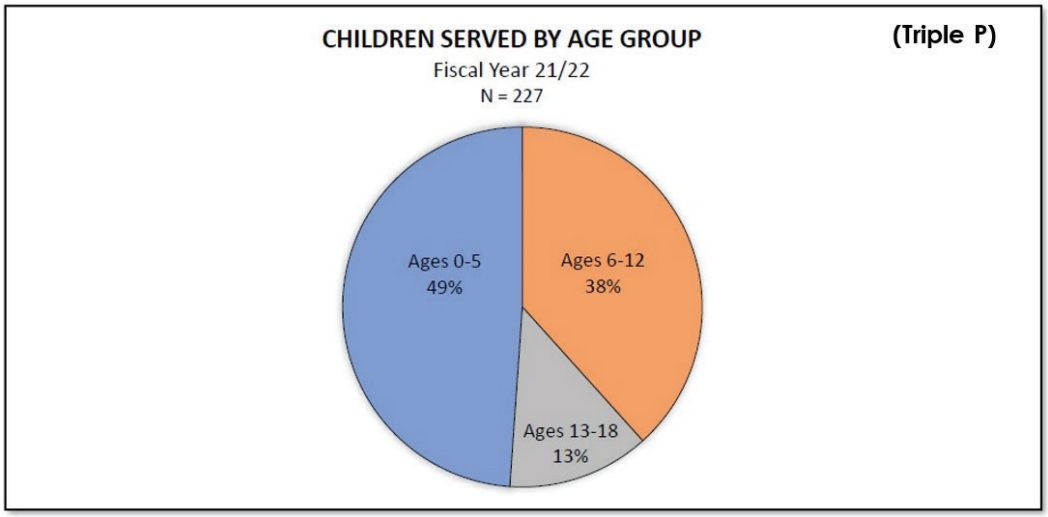
Achieved in previous year:
A. Throughout the pandemic, the program was able to sustain service delivery to children, with the aim of reducing the number of children who will experience ongoing mental health struggles throughout their childhood.

B. Increased County staffing for 0-5 supports up to three clinicians, including a full-time clinician devoted to the 0-5 program working primarily out of the SCOE office.

Looking to next year:
A. Continue outreach: 250 community partners and individuals were reached through health fairs and other events in 2023.

B. Train new and continuing County staff in evidenced-based practices for early childhood mental health.

C. Conduct provider trainings to assist more treatment professionals in developing 0-5 expertise.



CHILDREN AND YOUTH IN STRESSED FAMILIES: ADVERSE CHILDHOOD EXPERIENCES

Fiscal Year 2021-22 Expenditures:
$840,945 ↑333.92%

Number of people served:
More than 2,400

Who this program serves:
Parents, families, teachers, administrators, business owners, community leaders, law enforcement, the judicial system, the health system, faith-based communities, and others.

What this program does:
- Aims to educate Shasta County residents about the most common childhood traumas that affect the brains and bodies of developing children and have a profound impact on their health as adults.
- Through training, media campaigns, and community outreach, the ACE Coordinator helps build and support hope and resilience throughout the area so families can thrive.

Three-year goal:
A. Map Shasta County assets (programs, support, and services) related to ACE prevention and mitigation. Through this project, our community will be evaluated to identify strengths and gaps in services to families. Identified gaps will be reviewed to select evidence-based programs to initiate in Shasta County, directly through our program, or in collaboration with community partners.

B. Act on training opportunities to provide education to the local business community, housing programs, and continue to support local schools with trauma-informed education and resources to better understand and serve Shasta County residents.

Achieved in previous year:
A. Three-year goals were achieved:

1. 19 new Parent Café table hosts were trained. 5 ACE Master Trainers were trained. 30 ACE Presentations were provided to 517 attendees. 23 Parent Cafes were provided to 378 attendees. 13 Trauma-Informed Practices Trainings were provided to 424 attendees. 83 new Hope Navigators were trained in Shasta County.
2. Social media accounts engagement increased by 54%.

B. Partnered with Vital Art to create 15 murals around Shasta County to promote preventing ACEs and positive parenting.

Looking to next year:
A. Reduce school failure or dropout.

B. Reduce prolonged suffering (effects of trauma and toxic stress).

C. Reduce the number of children removed from the home.

D. Increase parenting skills through training, education, and access to support/community resources.

For more information, see Appendix L.

CHILDREN AND YOUTH IN STRESSED FAMILIES: LAUNCH

Fiscal Year 2021-22 Expenditures:
$73,707 ↑ 25.78%

Number of people served:
14

Who this program serves:
School-age children and their families

What this program does:

- Parent Partners provide supportive services such as SafeCare and Triple P (Positive Parenting Program, Trauma Focused Treatment, At Risk Middle School Students and Adverse Childhood Experiences). Parents become positive change agents for their children and enhance the community's capacity to support at-risk children and their families.
- Seeks to strengthen understanding of issues related to promoting healthy childhood development.
- Connects families to local resources.
- Provides parent cafes for parents of transitional kindergarten and kindergarten students at assigned schools.

Achieved in previous year:

A. The LAUNCH contract ended in September of 2022. This project has been discontinued.

CHILDREN AND YOUTH IN STRESSED FAMILIES: IMPACT

Fiscal Year 2021–22 Expenditures:
$345,252 ↑44.13%

Number of people served:
40

Who this program serves:
Students who are struggling, and/or who have Individual Educational Programs (IEP)

What this program does:
- This program refers to contracted providers for behavior therapy, individual/family therapy sessions (including substance use counseling), connects people to resources.

Three-year goal:
A. Connect struggling students with an Individual Educational Program (IEP) to supportive services.

B. Develop outcome goals and methods of measurement.

Achieved in previous year:
A. Began conversations with community providers to strengthen interagency collaboration.

Looking to next year:
A. Develop program processes to evaluate and address ways staffing changes may contribute to barriers.

B. Continue to update outcome evaluation methods.

C. Strengthen ongoing communication with interagency providers, minimize service delays, and eliminate waitlists.

CHILDREN AND YOUTH IN STRESSED FAMILIES: MENTAL HEALTH STUDENT SERVICE ACT GRANT (MHSSA)

Fiscal Year 2021–22 Expenditures:
$25,521 (new)

Number of people served:
113

Who this program serves:
Students at community day schools or alternative educational sites who, for a variety of reasons, have not been successful at a traditional school campus and have been expelled from school or who have problems with attendance or behavior.

What this program does:
- Hires personnel or peer support to enhance an existing county partnership with school-based programs, to expand access to mental health services for children and youth, including campus-based mental health services, and to facilitate linkage and access to ongoing and sustained services.

Three-year goal:
A. Update training both internally and with community partners, such as SCOE and Community Connect, to safeguard and improve program efficiency through staffing changes.

B. Enhance service flow and expedience to serve more clients.

Achieved in previous year:
A. Now fully staffed and operational, two clinician roles were filled.

B. Achieved a steady stream of referrals (113 total) through partnership with the Shasta County Office of Education and 9 school districts, representing 12 schools, to provide mental health services to youth attending community day schools and other alternative schools in Shasta County. These schools serve approximately 456 youth.

C. Ensure this vulnerable population has access to critical mental health services. The proposed program will allow improved access to needed mental health services for at-risk youth and will allow for early identification and treatment.

Looking to next year:
A. Establish monthly collaborative meetings with Community Connect to review program processes for administrative and clinical streamlining.

B. Analyze service delivery data to better inform outcome goals.

INDIVIDUALS EXPERIENCING ONSET OF MENTAL ILLNESS: EARLY ONSET

Fiscal Year 2021–22 Expenditures:
$169,059 ↑33.01%

Number of people served:
14

Who this program serves:
Youth ages 12 to 20.5 experiencing early onset psychosis

What this program does:
- Provides individual counseling and supportive services to the family through collaboration with mental health social workers, community mental health workers, peer support specialists and parent partners.
- Aims to decrease further psychotic episodes for the youth and provide education and support to the caregivers of the youth.
- A critical component of this program is outreach. Education through community events and activities, and within schools (typically junior high to high school level) promotes recognition of early onset symptoms and awareness of how to reach out.

Three-year goal:
A. Reduce active client hospitalizations and re-hospitalizations.

B. Monitor the number of youths successfully reintegrated into activities of daily living (education, employment, housing) and/or discharged to a lower level of care to measure the goal of decreasing incidence of psychotic breaks.

C. Continue to boost community education around early onset psychosis.

Achieved in previous year:
A. Upon improvement, successfully stepped down several youth clients to a lower level of treatment.

Looking to next year:
A. Increase community outreach activities.

B. Utilize California Advancing and Innovating Medi-Cal (CalAIM)'s Transitional Screening Tool to assess level of care.

C. Send clinicians to the Annual Psychotic Disorders Conference at UC Davis.

D. Increase training and implementation of interventions specific to the treatment of early onset psychosis (CBT-p therapy and medication management).

E. Dedicate an on-staff therapist to assess, screen and provide early onset psychosis therapeutic treatment.

F. Conduct outreach and education with community partners on CBT-p therapy.

G. Train a core of local therapists who can confidently treat early onset psychosis.

H. Explore and implement a treatment paradigm for clients suffering from co-occurring diagnoses of Substance Use Disorder (SUD) and early onset psychosis.

Community Mental Wellbeing

Fiscal Year 2021-22 Expenditures:
Please note: This position was vacant for FY 21–22 following staff reassignment to the COVID-19 Public Health Branch pandemic response.

Number of people served:
Thousands (anticipated)

Who this program serves:
All of Shasta County; target population includes youth and young adults ages 14–25, their parents, and Shasta County schools. Program activities will be delivered via training, outreach events, and education/information/resource sharing.

What this program does:

- Provide mental wellbeing programming, local resources and support to youth and young adults ages 14-25.
- Promote upstream prevention through mental wellness promotion; develop stress reduction and positive coping skills, build protective factors and emotional regulation skills, create awareness for warning signs/risk-factors, and promote/encourage help-seeking.
- Program development intends to engage youth in focus groups and key informant interviews to determine best ways to improve access for this demographic.

Three-year goal:

A. Reduced prolonged suffering as indicated through behavioral surveillance systems, community needs assessments, and other local wellness surveys.

B. Foster community engagement via quarterly newsletter; build and sustain network of partners.

C. Conduct 2–3 media campaigns that provide information about mindfulness and stress reduction skills in collaboration with other public health programs to share messaging on physical and mental wellness.

Achieved in Previous Year:
Please note: This position was vacant for FY 21–22 following staff reassignment to the COVID-19 Public Health Branch pandemic response. During FY 21–22, the Social Emotional Resiliency (SER) Unit was approved to hire a Community Education Specialist (CES) to begin Community Mental Wellbeing work using MHSA PEI funds.

A new Community Education Specialist was hired in January 2023. From their research of updated data sources, the program plans to primarily focus on programming to serve youth and young adults ages 14–25, a population significantly impacted by the COVID-19 pandemic.

Looking to next year:

A. Promote social connectedness and support through 3-5 outreach events to increase recognition of early signs of mental illness and promote access to mental health services as a preventative measure.

B. Provide 10–15 mindfulness and stress reduction skills small groups and/or workshops in collaboration with Shasta Self Care.

C. Provide 2–3 trainings on safe social media use for students, school staff, and parents.

D. Provide after school activities to 1–2 pre-determined school sites or organizations serving youth to promote and support student mental wellness, community engagement, and peer support.

STIGMA AND DISCRIMINATION REDUCTION

Fiscal Year 2021–22 Expenditures:
$446,055↑76.31%

Number of people served:
Thousands

Who this program serves:
People living with mental illness, including serious mental illness, parents, friends, families and community partners.

What this program does:
- Promotes mental wellness, increases community awareness of mental health, and aims to end the stigma surrounding mental illness and substance use.
- Provides education on mental health and wellness, community events and meetings, social connection for people living with mental illness and their supportive loved ones, and a sense of purpose through volunteer opportunities.

Three-year goal:
A. Continue community outreach and education activities, in person and through the website and social media, including launching the Minds Matter Podcast and revitalizing GetBetterTogether.net with the help of local youth.

B. Organize a training addressing stigma for medical professionals.

C. Work with peer support specialists and wellness centers to develop frequent and meaningful volunteer opportunities to increase integration of people with living with mental illness into the broader community.

D. Bring Stand Against Stigma activities to teen centers and campus wellness centers.

Achieved in previous year:
A. The Stand Against Stigma Committee met monthly. Brave Faces presentations were given to Simpson College Masters in Counseling students, One SAFE Place volunteers, Sunrise Mountain Wellness Center members and law enforcement.

B. The online forum "Untangling Uncertainty" was held, featuring HHSA leaders and peer support specialists, and an online Becoming Brave training was given to local wellness centers.

C. Offered Introduction to Wellness Recovery Action Plan (WRAP) and workshops on journaling, as well as two, 8-week, mind-body skills groups to help people cope with pandemic-related stress.

D. The Minds Matter Mental Health Fair was converted to a COVID-19-safe, drive-through event.

E. Launched the new Stand Against Stigma website.

F. Trained more than 30 HHSA staff in hope science to become Hope Navigators.

Looking to next year:
A. Give 15 Brave Faces presentations, produce at least two new Brave Faces galleries, provide at least two Becoming Brave trainings and organize at least three Hope Is Alive! Open Mics.

B. Implement items B, C, D, E and F in the Three-Year Goal. Find more information in Appendix N.

SUICIDE PREVENTION

Fiscal Year 2021–22 Expenditures:
$220,325↑31.58%

Number of people served:
Thousands

Who this program serves:
All of Shasta County; Target populations include cohorts and communities considered at high risk for suicide as evidenced by local, state, and national suicide statistics. Increased risk for suicide is attributed to stigma and a lack of resources and is **not** inherent to the communities and populations that are highly impacted by suicide.

Shasta County has the highest rate of age-adjusted suicide in the State of California with a rate of 24.9 as compared to the state at 10.5 per 100,000 people.

What this program does:

- The Suicide Prevention Program addresses community issues by making training, education, resources, and community outreach events available to underserved populations. For suicide prevention, underserved populations are made up of cohorts and communities considered at high risk for suicide.
- The Suicide Prevention Program provides resources for individuals that experience suicidal thoughts, have attempted suicide, and individuals that have lost someone to suicide.

Three-year goal:

A. Build a suicide safe Shasta County that includes a sustainable and coordinated approach to: increase help-seeking and access to support and crisis resources, increase awareness and knowledge through ongoing trainings and outreach to keep those at risk safe, and increase capacity building to actively support the commitment to suicide prevention.

B. Reduce suicide deaths and attempts, as measured by the number of suicide attempts and deaths that have previously occurred.

C. Promote and expand linkage to mental health and crisis resources through collaboration and outreach.

D. Offer suicide prevention training to residents and local providers that work in a healthcare setting (e.g., physicians, counselors, social workers, pharmacists, etc.).

E. Share information about stigma & safe messaging on Suicide Prevention website, monthly newsletter, Facebook page & with Collaborative members, and community partners.

F. Conduct media campaigns that provide information about suicide and available suicide prevention resources.

Achieved in Previous Year:

A. Development of a Suicide Fatality Review (SFR) team in collaboration with the Shata County's Coroner's Office.

B. An asset mapping survey was conducted to inform the goals and objectives of the Suicide Prevention Strategic Plan.

C. Ten Suicide Prevention training courses (QPR, SafeTALK, and ASIST) were provided to over 200 community members throughout fiscal year 21-22.

continued

SUICIDE PREVENTION, CONTINUED

Please note: COVID-19 caused various challenges for the Suicide Prevention Program throughout fiscal year 21-22. COVID-19 mandates impacted training, meetings, and outreach events by limiting opportunities to meet/interact with the community in-person. Virtual alternatives were implemented when possible. It is also important to note that many employees were required to conduct COVID-19 work to support pandemic efforts. As a result, staffing and program capacity were limited for suicide prevention activities.

Looking to next year:

A. Train gatekeepers to identify at-risk individuals and respond effectively in crisis.

B. Promote social connectedness and support, ensuring access to effective mental health treatment.

C. Provide immediate and long-term postvention.

D. Reduce access to lethal means and promote means safety.

For more information, see Appendix N.

CALMHSA STATEWIDE PROJECTS

Fiscal Year 2021–22 Expenditures:
$24,000 ↑ 60%

Number of people served:
Thousands

Who this program serves:
All Shasta County residents

What this program does:

- 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; and accountability at state, regional and local levels.

Three-year goal:

A. Administer the Suicide Prevention, Stigma and Discrimination Reduction, and Student Mental Health Initiative programs.

For previous year achievements and next year's plans:

A. Please refer to the Suicide Prevention and Stigma and Discrimination Reduction pages in this report.

SUPERIOR WET PARTNERSHIP

Fiscal Year 2021–22 Expenditures:
$0

Number of people served:
This is a pending program.

Who this program serves:
People in the public mental health workforce

What this program does:

- Aims to address the shortage of mental health practitioners in the public mental health system through a framework that engages regional partnerships.
- The Superior WET Partnership supports individuals through loan repayment, educational stipends, and peer scholarships.
- Pending contract approval, this program is still under development.

Three-year goal:

A. In partnership with CalMHSA, participate in loan repayment, educational stipend and peer scholarship programs.

This program is pending. Progress will be shared in the next report.

HOPE PARK

Fiscal Year 2021–22 Expenditures:
$247,982 (new)

Number of people served:
22 unique Hope Park participants

Who this program serves:
Teenagers and older adults

What this program does:

- The Hope Park program was established within the Anderson Teen Center and the new Redding Teen Center. The aim of Hope Park was to engage older adult volunteers and youth ages 13–18 in meaningful activities to help prevent the negative physical and mental health effects of loneliness for adults and provide mentorship to youth. This project focused on high-adventure activities as well as skill building activities within the Teen Centers.

Achieved in previous year:

A. Hope Park was launched in March 2022.

B. The Redding Teen Center opened to youth on April 11, 2022.

C. Recruitment for the Hope Park program and associated activities did not meet project goals.

Looking to next year:

A. As of the writing of this plan we are moving towards wrapping up this project in favor of alternate community supports.

For more information on Hope Park program performance, see Appendix P.

PSYCHIATRIC ADVANCE DIRECTIVES

Fiscal Year 2021–22 Expenditures:
$58,106 (new)

Number of people served:
This project is in development.

Who this program serves:
This developing project will center and serve individuals with psychiatric disorders across seven counties on a voluntary basis. It also aims to help their families, care teams and crisis workers to better support individuals with a PAD.

What this program does:

- A Psychiatric Advance Directive (PAD) is a self-determination document and allows people to use their own voice. Developing a PAD, with support from mental health professionals and others, clarifies preferences for treatment so that individuals in crisis will receive appropriate support and care.
- Seven counties, Fresno, Mariposa, Monterey, Orange, Contra Costa, Tri-City, and Shasta are currently collaborating to involve stakeholders in the creation of a standardized PADs template which will be tailored to an online format accessible to crisis responders across various sectors.
- Organizing collaborators are RAND, BBI, CHORUS, Idea Engineers, Painted Brain and CAHMPRO. Their areas of specialization include evaluation of outcomes processes, evaluation for technology processes, technology development, marketing, and peer involvement.
- When complete, this will build community capacity among law enforcement, peers, the court system, mental health care providers and others to ensure consumer choice and collaborative decision-making and improve participant care in a crisis. It aims to reduce recidivism and engage participants in their treatment and recovery.

Three-year goal:

A. Recruit individuals from a variety of backgrounds to provide input on the PADs template, online usability, and eventually participate in a pilot.

B. Continue to promote PADs project education and participation to maximize input from, and value to, Shasta County residents.

Achieved in previous year:

A. The Shasta County MHSA Coordinator and clinical program staff participated in meetings with collaborators and supporting organization and feedback efforts on template development.

B. The online platform is in development but not finalized .It will be informed by stakeholder feedback. Shasta County residents who want to participate in PADs project development may submit an email inquiry to mhsa@co.shasta.ca.us

Looking to next year:

A. Identify, involve, and develop training in collaboration with professionals who will implement and pilot PADs, including law enforcement, hospital staff, peer facilitators and patients' rights advocates.

B. Organize more PADs "Listening Sessions" between various stakeholder groups (such as peers, clinicians, and law enforcement) and PADs developers.

For more information, see Appendix Q, or...
View the PADs CA - Psychiatric Advance Directives website.

Funding Summary

County: Shasta

Date: 4/5/23

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2023/24 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	10,167,915	4,073,756	4,334,879	0	0	
2. Estimated New FY2023/24 Funding	10,032,000	2,508,000	660,000			
3. Transfer in FY2023/24a/	(156,103)			130,208	0	25,895
4. Access Local Prudent Reserve in FY2023/24						0
5. Estimated Available Funding for FY2023/24	20,043,811	6,581,756	4,994,879	130,208	0	
B. Estimated FY2023/24 MHSA Expenditures	13,206,294	3,896,213	2,026,865	130,208	0	
C. Estimated FY2024/25 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	6,837,517	2,685,543	2,968,014	0	0	
2. Estimated New FY2024/25 Funding	10,332,960	2,583,240	679,800			
3. Transfer in FY2024/25a/	(1,127,968)			0	1,100,000	27,968
4. Access Local Prudent Reserve in FY2024/25						0
5. Estimated Available Funding for FY2024/25	16,042,509	5,268,783	3,647,814	0	1,100,000	
D. Estimated FY2024/25 Expenditures	13,277,344	3,930,667	2,177,834	0	1,100,000	
E. Estimated FY2025/26 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	2,765,165	1,338,116	1,469,980	0	0	
2. Estimated New FY2025/26 Funding	10,642,949	2,660,737	700,194			
3. Transfer in FY2025/26a/	(39,605)			0	0	39,605
4. Access Local Prudent Reserve in FY2025/26						0
5. Estimated Available Funding for FY2025/26	13,368,509	3,998,854	2,170,174	0	0	
F. Estimated FY2025/26 Expenditures	13,348,836	3,969,974	2,118,812	0	0	
G. Estimated FY2025/26 Unspent Fund Balance	19,673	28,880	51,362	0	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2023	412,609
2. Contributions to the Local Prudent Reserve in FY 2023/24	25,895
3. Distributions from the Local Prudent Reserve in FY 2023/24	0
4. Estimated Local Prudent Reserve Balance on June 30, 2024	438,504
5. Contributions to the Local Prudent Reserve in FY 2024/25	27,968
6. Distributions from the Local Prudent Reserve in FY 2024/25	0
7. Estimated Local Prudent Reserve Balance on June 30, 2025	466,473
8. Contributions to the Local Prudent Reserve in FY 2025/26	39,605
9. Distributions from the Local Prudent Reserve in FY 2025/26	0
10. Estimated Local Prudent Reserve Balance on June 30, 2026	506,077

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

\\hipaa\HHShare\HHSA OD-BSS Restricted Access\Fiscal\MH Fiscal\MHSA - Prop 63\3-Year Plan\FY 23-24 to 25-26\3YrProgExpendPlan (FY 23-24 to 25-26) v3.xlsx

Community Services and Supports (CSS) Component Worksheet

County: Shasta Date: 4/5/23

	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Client Family Operating Services	674,085	674,085				
2. Shasta Triumph and Recovery	4,927,875	3,177,831	1,750,044			
3. Crisis Residential and Recovery	2,239,943	1,444,469	795,475			
4. Crisis Response	4,479,886	2,888,937	1,590,949			
5. Outreach-Access	2,239,943	1,444,469	795,475			
6. Housing	149,330	96,298	53,032			
7.						
Non-FSP Programs						
1. Rural Health Initiative	1,343,966	866,681	477,285			
2. Older Adult Services	20,906	13,482	7,424			
3. Co-Occurring/Primary Care Integration	746,648	481,490	265,158			
4. Laura's Law	746,648	481,490	265,158			
5.	0					
CSS Administration	1,637,064	1,637,064				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	19,206,294	13,206,294	6,000,000	0	0	0
FSP Programs as Percent of Total	76.6%					

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Client Family Operating Services	680,826	680,826				
2. Shasta Triumph and Recovery	4,959,358	3,191,813	1,767,545			
3. Crisis Residential and Recovery	2,254,254	1,450,824	803,429			
4. Crisis Response	4,508,507	2,901,648	1,606,859			
5. Outreach-Access	2,254,254	1,450,824	803,429			
6. Housing	150,284	96,722	53,562			
8.	0					
Non-FSP Programs						
1. Rural Health Initiative	1,352,552	870,494	482,058			
2. Older Adult Services	21,040	13,541	7,499			
3. Co-Occurring/Primary Care Integration	751,418	483,608	267,810			
4. Laura's Law	751,418	483,608	267,810			
19.	0					
CSS Administration	1,653,435	1,653,435				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	19,337,344	13,277,344	6,060,000	0	0	0
FSP Programs as Percent of Total	76.6%					

Community Services and Supports (CSS) Component Worksheet (Continued)

County: Shasta Date: 4/5/23

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Client Family Operating Services	687,634	687,634				
2. Shasta Triumph and Recovery	4,991,077	3,205,857	1,785,220			
3. Crisis Residential and Recovery	2,268,671	1,457,208	811,464			
4. Crisis Response	4,537,343	2,914,416	1,622,927			
5. Outreach-Access	2,268,671	1,457,208	811,464			
6. Housing	151,245	97,147	54,098			
7.						
Non-FSP Programs						
1. Rural Health Initiative	1,361,203	874,325	486,878			
2. Older Adult Services	21,174	13,601	7,574			
3. Co-Occurring/Primary Care Integration	756,224	485,736	270,488			
4. Laura's Law	756,224	485,736	270,488			
5.	0					
CSS Administration	1,669,969	1,669,969				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	19,469,436	13,348,836	6,120,600	0	0	0
FSP Programs as Percent of Total	76.6%					

Innovations (INN) Component Worksheet

County: Shasta Date: 4/5/23

	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi- Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Hope Park	370,000	370,000				
2. Psychiatric Advance Directives (PADs)	60,000	60,000				
3. Program Development and Implementation	1,500,000	1,500,000				
INN Administration	96,865	96,865				
Total INN Program Estimated Expenditures	**2,026,865**	2,026,865	0	0	0	0

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi- Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Hope Park	370,000	370,000				
2. Psychiatric Advance Directives (PADs)	60,000	60,000				
3. Program Development and Implementation	1,650,000	1,650,000				
INN Administration	97,834	97,834				
Total INN Program Estimated Expenditures	2,177,834	2,177,834	0	0	0	0

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi- Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Hope Park	370,000	370,000				
2. Psychiatric Advance Directives (PADs)	0	0				
3. Program Development and Implementation	1,650,000	1,650,000				
INN Administration	98,812	98,812				
Total INN Program Estimated Expenditures	2,118,812	2,118,812	0	0	0	0

Workforce, Education and Training (WET) Component Worksheet

County: Shasta Date: 4/5/23

	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Regional Partnership	130,208	130,208				
2.	0					
WET Administration	0					
Total WET Program Estimated Expenditures	**130,208**	130,208	0	0	0	0

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Statewide Programs	0	0				
2.	0					
WET Administration	0					
Total WET Program Estimated Expenditures	0	0	0	0	0	0

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Statewide Programs	0	0				
2.	0					
WET Administration	0					
Total WET Program Estimated Expenditures	0	0	0	0	0	0

Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Shasta Date: 4/5/23

	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0	0				
2.	0					
CFTN Programs - Technological Needs Projects						
11.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	0	0	0	0	0	0

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Building Acquisition	1,100,000	1,100,000				
2.	0					
CFTN Programs - Technological Needs Projects						
11.	0					
12.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	1,100,000	1,100,000	0	0	0	0

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0	0				
2.	0					
CFTN Programs - Technological Needs Projects						
11.	0					
12.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	0	0	0	0	0	0

FY 2023/24 Through FY 2025/26 Three-Year Mental Health Services Act Expenditure Plan

Enclosure 1

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: Shasta

- [x] Three-Year Program and Expenditure Plan
- [ ] Annual Update
- [ ] Annual Revenue and Expenditure Report

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Miguel Rodriguez	Name: Nolda Short
Telephone Number: (530) 225-5965	Telephone Number: (530) 245-6657
E-mail: marodriguez@co.shasta.ca.us	E-mail: nshort@co.shasta.ca.us
Local Mental Health Mailing Address: 2615 Breslaur Way, Building 5 Redding, CA 96001	

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

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

Miguel Rodriguez
Local Mental Health Director (PRINT)

DocuSigned by: Miguel Rodriguez 12357C50B45D437...

05/23/2023 | 6:18 PM PDT
Date

I hereby certify that for the fiscal year ended June 30, 2022, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated January 24, 2023 for the fiscal year ended June 30, 2022. I further certify that for the fiscal year ended June 30, 2022, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

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

Nolda Short
County Auditor Controller / City Financial Officer (PRINT)

DocuSigned by: Nolda Short 1F58E252445B44C...

3 | 8:37 AM PDT

[1] Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)
Three-Year Program and Expenditure Plan, Annual Update, and RER Certification (07/22/2013)

Three Year-Plan Public Comments Received

1. Comment
   I recently received the email regarding the public comment period for the MHSA 3-Year Plan. Upon review we noticed that the Community Mental Wellbeing program was not included in this draft. This may be due to our late submission of program reports. Will CMWB be featured in the next draft, prior to final review/approval?

   Would you like me to prepare a draft page of the program, or is this already in development with MHSA staff/analysts?

   Please let me know the status of including this MHSA funded program in the report, and if you would like my help in developing something.

   Correction
   Information on the Community Mental Wellbeing program was removed from the Early Onset category and given its own page (p.30).

2. Comment
   Hi there. I had a couple of questions; At the beginning of the plan it refers to many agencies involved with the county to provide services in our community. I saw Victor Youth Services, but wasn't sure if this is VCSS in Happy Valley? Victor Youth used to just be a residential placement, and I thought they closed. Another area discusses other agencies serving community members with mental illnesses, but does not mention Hill Country's outpatient mental health or North American mental Health Services, although county refers to these too very frequently. I also sent feedback to Cultural Competency education, as requested by them. It discusses every race, gender ID, nationality, cultural beliefs, etc. Does not address the culture of co-occurring disabilities other than substance abuse with mental illness. This is a big concern. People with physical disabilities and/or developmental disabilities have an extremely high rate of suicide. ALS is number 1, and other neurological disorders, such as MS follow closely. High risk with dementia, intellectual disabilities and ASD as well.

   Correction
   1. HHSA refers to Victor for outpatient counseling.
   2. Hill Country's MHSA-funded services are covered in this plan, which may include outpatient services through Care Center and the Rural Health Initiative.
   3. Increased training on co-occurring disability assessment has been highlighted as an area for staff and community development. How or whether this will fall under MHSA funding is not yet clear. This is an area of focus for upcoming discussion and may be included in the next Annual Update.

3. Comment
   Have any clients been able to even read your three year plan ? I don't believe you have had many clients to your meetings. Maybe if there were flyers at the place where clients recieve services you might have a little more feedback. Unless a rural county doesn't care that recieving services is so little and you don't care about people with serious mental illness. I guess because there are no services to actually benefits clients with serious mental illness unless you look at the county morgue. There is no services for people who are diagnosed and in your system for three months at a time. Three months is a long time to live when your in need. You make county policy that dictates to the

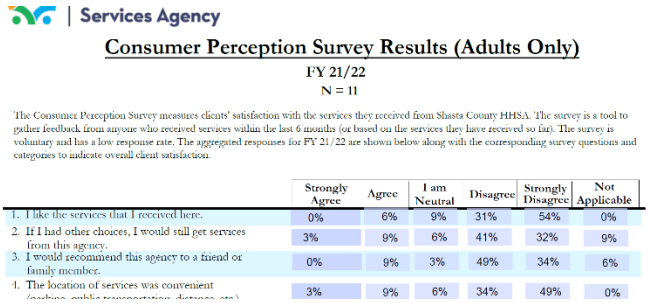
doctors what meds can be offered or not. You really don't know if you are helping or do you really care . The BO S don't care if we cost them money, being republican so what good are they? They were elected to take care of "all" their constituents without knowledge of their well being. No your not doing a good job in these maybe last days we all have. You'll just get at the most a fine, you don't take Medicare so no feds will ding you on that. Please excuse me, I don't see any clients who are seriously

Correction

Expansion of MHSA staffing and the Community Program Planning process have been made areas of focus over the next three years as described on p. 7, along with increased outreach efforts to underserved communities, and community meetings/presentations in wellness centers or other locations where services are provided.

4. Comment

I'm not sure this is a public comment but wanted to bring to your attention. Are the headers correct here? On the previous pages the ratings were reversed. So strongly disagree was on the left and strongly agree was on the right. Or, maybe things were just really bad for these 11 respondents!



| Services Agency

Consumer Perception Survey Results (Adults Only)

FY 21/22

N = 11

The Consumer Perception Survey measures clients' satisfaction with the services they received from Shasta County HHSA. The survey is a tool to gather feedback from anyone who received services within the last 6 months (or based on the services they have received so far). The survey is voluntary and has a low response rate. The aggregated responses for FY 21/22 are shown below along with the corresponding survey questions and categories to indicate overall client satisfaction.

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
1. I like the services that I received here.	0%	6%	9%	31%	54%	0%
2. If I had other choices, I would still get services from this agency.	3%	9%	6%	41%	32%	9%
3. I would recommend this agency to a friend or family member.	0%	9%	3%	49%	34%	6%
4. The location of services was convenient (parking, public transportation, distance, etc.)	3%	9%	6%	34%	49%	0%

Correction

Some of the headers on the Consumer Perception survey within the Appendices were in the wrong order, skewing results negatively. This was corrected.

MHSA 3-Year Plan Committee Feedback

1. Comment

Minor language changes were requested throughout the report for clarity.

Correction

All text that has changed since Committee Review is highlighted in yellow within this plan draft.

2. Comment

Whenever a program goal is to "increase" or "decrease" a service or effect, a measurable percentage goal should be included as a basis for program improvement discussion.

Correction

Program staff were contacted for any available percentage goals that might be incorporated within the current draft. To ensure all program goals are *achievable and meaningful,* the

solution provided was to add the following overarching goals to the plan for development over the next 1-3 years:

· Identify achievable and meaningful program goals and outcome measures
· Include one measurable goal for each MHSA program in the next Annual Update

3. Comment

The following changes were requested to Suicide Prevention, p. 32-33.

Looking to next year:

1. Finalize development of a Suicide Fatality Review (SFR) team.
2. Develop a dataset of local suicide attempt and completion demographics information including means. Dataset will include demographics on cases reviewed by the Suicide Fatality Review Team.
3. Develop regular communication with the County's Mental Health services department and the County Coroner.
4. Suicide Prevention designated staff members will provide quarterly updates to the Shasta County Mental Health, Alcohol and Drug Advisory Board showing monthly suicide rates and demographics for Shasta County.

Facts to add

1. Please include the number of County suicides (FY 21-22 or 22-23 would work) and the state rating in the content. I believe we are #1 in the state, do you happen to have total numbers of completed suicides for either of those FY's?
2. Could we include the "asset mapping survey" results or analysis in the appendices? If so can you send this to me?

Three year goal:

For the stated goal of "Reduce suicides, measured by the number of suicide attempts and deaths that occur throughout that year," they would like this goal to be measurable, ie: 5% reduction, etc. Would you be able to tell me a % reduction you feel is appropriate/achievable?

Correction

The requested changes were conveyed to Suicide Prevention program staff and the following changes were made. Some changes were assessed and not included for the reasons described below.

Looking to next year:

1. Development of a Suicide Fatality Review (SFR) team in collaboration with the Shasta County Coroner's Office.
2. For context, not to be included in report: FY data will be provided as requested below. Surveillance data is provided in our quarterly and annual MHSA reporting.
3. For context, not to be included in report: Staff from each of these departments are members of the SP Collaborative and are identified members of the developing Shasta SFR Team.
4. For context, not to be included in report: Surveillance data is provided in our quarterly and annual MHSA reporting. Data would not see significant change in the span of quarters --- and suicide death data (in that timeframe) will be too identifiable to be shared in public.

Facts to add

1. Please add the following statement to the "what this program does" section to provide context to readers: Shasta County has the highest rate of age-adjusted suicide in the state of California with a rate of 24.9 as compared to the state at 10.5 per 100,000 people. In FY 21-22, Shasta County lost 66 community members to suicide.
2. The survey did not undergo a specific analysis, the Qualtrics survey was reviewed for trends.

Three year goal:

While the above goal is what we are striving for, suicide prevention programs are discouraged from stating a percentage reduction due to by not achieving such a goal there can be a negative impact on programs such as community support. Instead, we would like to reframe the goal to be a more hopeful/positive outcome that reflects the work this program does:

Build a suicide safe Shasta County that includes a sustainable and coordinated approach to: increase help-seeking and access to support and crisis resources, increase awareness and knowledge through ongoing trainings and outreach to keep those at risk safe, and increase capacity building to actively support the commitment to suicide prevention.

In addition to the above, we would like to request the following edits to the SP report page:

Three-year goal:

Change to: A. Reduce suicide deaths and attempts, as measured by the number of suicide attempts and deaths that have previously occurred. (Population level change takes time, it is not common to see dramatic changes in a year, as we are working to shift perceptions and attitudes.)

Looking to next year:

Remove: ~~C. Support safe care transitions and create organizational linkages.~~