Public Notice
County of Shasta

Mental Health, Alcohol and Drug Advisory Board (MHADAB)

Regular Meeting Agenda

Wednesday, March 13, 2024, 5:30 pm
Mae Helene Bacon Boggs Conference Center
2420 Breslauer Way, Redding, CA 96001

Members of the public may attend via GoToMeeting
You can also dial in using your phone.

United States: +1 (408) 650-3123
Access Code: 510-166-341
This meeting will be audio recorded.

Board Members

Kalyn Jones, *Chair*

Heather Jones, *Vice Chair*

Alan Mullikin

Angel Rocke

Cindy Greene

Connie Webber

David Kehoe

Jo-Ann Medina

Mary Rickert

Ron Henninger

Samuel Major

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

Staff will address Public Comment, if needed, to follow up from the previous meeting.

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 January 10, 2024, Regular Meeting and February 14, 2024 Special Meeting

V. Presentations

A. Roughout Ranch Foundation Inc., Authentic Workshops and Horse Encounters, Kathy Rutan-Sprague and Kathy O'Donnell
B. 5150 Holds, Adam Hilton, Clinical Program Coordinator
C. CARE Court, Katie Nell, Sr Staff Services Analyst
D. MHSA Outcomes: IMPACT, Leah Moua

VI. Regular Calendar

Public Comment will be invited prior to the close of each item.

VII. Discussion Items

A. Board members may ask questions about the Director's Report.
B. Board members may make suggestions for future agenda consideration.
C. Ad Hoc Committee MHADAB Annual Report 2023
D. Ad Hoc Committee Update: Annual Report 2022
E. Data Notebook 2023

   Review the 2023 Shasta County Data Notebook as presented in written form and consider voting to approve for submission to the Board of Supervisors
F. MHSA Audit Findings – Ashley Saechao
G. Consider approval of the Crisis Residential Recovery Center Customer Satisfaction Survey

VIII. Board Member Committee Reports

Board members will report committee meeting updates.

IX. Adjourn

MHADAB Special Meeting
April 10, 2024, 5:30 pm
Location: TBD
Redding, CA 96001

Executive Committee Meeting
April 16, 2024, 11:00 am
HHSA BHSS Services Branch, Administrative Conference Room
2640 Breslauer Way,
Redding, CA 96001

Committees

Shasta Substance Use Coalition
March 12, 2024, 10:30 am
Virtual via Zoom
jill@shastatraining.org

Shasta Suicide Prevention Collaborative
March 12, 2024, 2:30 pm
For location, please email
sstinger@co.shasta.ca.us

Stand Against Stigma
April 9, 2023, 1:30 pm
Sunrise Mountain Wellness Center
1300 Hilltop Drive Suite 200
Redding, CA 96001
cdiamond@co.shasta.ca.us

MHSA Stakeholder Workgroup
May 22, 2024, 10:00 am
Boggs Building
2420 Breslauer Way
Redding, CA 96001
mhsa@co.shasta.ca.us

"The County of Shasta does not discriminate on the basis of disability in admission to, access to, or operation of its buildings, facilities, programs, services, or activities. The Shasta County Mental Health, Alcohol and Drug Advisory Board will make available to any member of the public who has a disability a needed modification or accommodation including an auxiliary aid or service, in order for that person to participate in the public meeting. A person needing assistance should contact Jacquelynn Rose by telephone at (530) 229-8266, or in person 2640 Breslauer Way, Redding, or by mail at P. O. Box 496048, Redding CA 96049-6048, or by e-mail at MHADAB@co.shasta.ca.us at least two (2) working days in advance. Accommodations may include, but are not limited to, interpreters, assistive listening devices, accessible seating, or documentation in an alternate format. If requested, this document and other agenda materials may be made available in an alternative format for persons with a disability who are covered by the Americans with Disabilities Act. Questions, complaints, or requests for additional information regarding the Americans with Disabilities Act (ADA) may be forwarded to the County's ADA Coordinator: Monica Fugitt, Director of Support Services, County of Shasta, 1450 Court Street, Room 348, Redding, CA 96001-2676 Phone: (530) 225-5515 Fax: (530) 225-5345 California Relay Service: 711 or 1-(800)-735-2922, E-mail: adacoordinator@co.shasta.ca.us.

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 may be recorded. If there are any questions regarding this agenda, please contact Jacquelynn Rose at 530-229-8266, or via e-mail at MHADAB@co.shasta.ca.us.

Shasta County Health and Human Services Agency
DRAFT SHASTA COUNTY Mental Health, ALCOHOL AND DRUG ADVISORY BOARD (MHADAB)
Regular Meeting
Wednesday, January 10, 2024

Attendees:

Kalyn Jones, Board Chair	√	Heather Jones, Board Vice-Chair	√	Ron Henninger, Past Chair	√
Alan Mullikin, Board Member		Connie Webber, Board Member		Mary Rickert, BOS Board Member	√
Angel Rocke, Board Member		David Kehoe, Board Member		Samuel Major, Board Member	√
Cindy Greene, Board Member		Jo-Ann Medina, Board Member	√	Jackie Rose, CDC	√
Miguel Rodriguez, MHSS/MH Director		Katie Nell, BHSS Sr. Analyst	√		
Katie Cassidy, BHSS Deputy Director	√	Mey Chao-Lee, BHSS Clinical Program Coordinator	√		

Community Members: 8 (Includes virtual attendees)

Agenda Item	Discussion/Conclusions/ Recommendations	Action/Follow-Up	Date Due/Status	Individual/ Department Responsible
I. Call to Order	Kalyn Jones, MHADAB chair extended a warm welcome to all attendees and called meeting to order at 5:34 p.m.	No action required.	N/A	Kalyn Jones, MHADAB chair
II. Public Comment	a. A representative from NAMI passed out a brochure to promote awareness and to seek membership for their organization. She talked about upcoming class that starts in January called Family-to-Family. b. A public commenter expressed concern about there being no warming centers on cold nights like this evening and that money is being spent on items that are already approved. Speeding up the process to get housing for homeless would benefit our community. c. A public comment submitted by email was shared. The commenter expressed personal experience with local authorities and Shasta County court system. They expressed concerns of not having enough support to stay on their feet now that they was finally there. They suggested to spend money in ways for every individual in society to have an equal opportunity at success.	a. N/A b. During the meeting Katie researched open warming centers. She reported that Good News Rescue Mission was the only one open. c. Miguel will address the email and pass along to appropriate parties.	a. N/A b. N/A c. 1/26/2024	a. N/A b. N/A c. Miguel Rodriguez
III. Announcements and Staff Updates	No Action required	N/A	N/A	N/A
IV. Consent Calendar A. A. Approval of	Minutes from November1, 2023 meeting were presented in written form.	The Consent Calendar was passed unanimously with six	N/A	**Motion:** Sam Major **Second:** Heather Jones

Agenda Item	Discussion/Conclusions/ Recommendations	Action/Follow-Up	Date Due/Status	Individual/ Department Responsible
MHADAB Minutes **B. Membership Committee's Nomination**	Recommend to the Board of Supervisors the Membership Committee's nomination of the following new members to fill the vacant MHADAB positions: Matilda Grace (Marlar) – term to expire 12/31/2025, Laurie Hicks (Menoher), Wesley Tucker (Stewart), Erin Dooley (Prielipp) – terms to expire 12/31/2026.	(6) Ayes, zero (0) Nays and zero (0) abstention.	1/11/2024	Jackie Rose, CSC
V. Regular Calendar	No Action required	N/A	N/A	N/A
VI. Presentations	a) <u>Shasta Triumph and Recovery Team (STAR)</u> Mey Chao-Lee provided a PowerPoint presentation on the voluntary program that focus on wellness, recovery, and resiliency. The social workers, clinicians and one nurse who make up this team practice the "whatever it takes' model to provide access services to those in need. b) <u>Peer Run Warm Line</u> Kalyn Jones provided a PowerPoint presentation about Mental Health Association of San Francisco and their Warm Line calling center. She gave information about their history and what they logo means. She explained the difference between a "warm line" and a hot line.	N/A	N/A	N/A
VII. Ad Hoc Committees	a. Board members may ask questions about the Director's Report. b. Board members may make suggestions for future agenda consideration. c. Ad Hoc Committee MHADAB Annual Report 2023 d. Ad Hoc Committee Update: Annual Report 2022 e. Ad Hoc Committee Update: Bylaws Recommend to the Board of Supervisors the updated	a. N/A b. N/A c. Table until next meeting d. Table until next meeting e. The Bylaws was passed unanimously with six (6)	a. N/A b. N/A c. 2/14/2024 d. 2/14/2024 e. N/A	a. N/A b. N/A c. Jackie Rose d. Jackie Rose n. **Motion:** Sam Major

Agenda Item	Discussion/Conclusions/ Recommendations	Action/Follow-Up	Date Due/Status	Individual/ Department Responsible
	bylaws as written for approval.	Ayes, zero (0) Nays and zero (0) abstention. Jackie will send to BOS for approval.		**Second:** Heather Jones Jackie Rose
	f. New Board Member Biography It was discussed that all MHADAB board members would present a biography to be displayed on the MHADAB webpage. This discussion will be put on the Executive MHADAB agenda.	f. Jackie to add to MHADAB Executive Agenda	f. 1/26/2024	f. Jackie Rose
	g. MHADAB New Member Orientation Kalyn talked about creating a new member Orientation for onboarding members.	g. Kalyn will create onboarding for new members.	g. 2/14/2024	g. Kalyn Jones h. Kalyn Jones Jackie Rose
	h. MHADAB Application and Interview Questions Kalyn talked about the application and interview questions for new member recruitment. She suggested to revamp the application and questions and will take this to the Executive meeting for discussion.	h. Kalyn will revamp the application and questions. Jackie will add to the Executive agenda for discussion.	h. 2/2/2024	i. N/A
	i. Woodlands Update Ron Henninger provided an update stating that concerns have been addressed. Cooperative effort with both North Valley and Woodlands has been aligned. Security seems to be an issue and needs to be more visible. Money is a factor in making this happen.	i. N/A	i. N/A	j. Jackie Rose
	j. 2024 Special Meetings (Site Visits) Discussion was had about additional presenters and site visits. A list was created and suggested it be taken back to the Executive Committee for scheduling.	j. Jackie will put on the next Executive Agenda for discussion.	j. 2/2/2024	k. Jackie Rose
	k. Board Member Committee Assignment It was suggested that this be send via email to all board members asking which committees would like to attend. Once new members come onboard, send this to them as well. All board members will provide updates during MHADAB meetings.	k. Jackie to send email regarding committees and participation.	k. 1/11/2024	

Agenda Item	Discussion/Conclusions/ Recommendations	Action/Follow-Up	Date Due/Status	Individual/ Department Responsible
	l. 2024 Executive Committee Meeting Dates It was suggested to move meetings to the 3rd Tuesday of every even month.	l. The Executive meeting dates schedule was passed unanimously with six (6) Ayes, zero (0) Nays and zero (0) abstention.	l. N/A	**Motion:** Kalyn Jones **Second:** Heather Jones
	m. Data Notebook 2023 Review the 2023 Shasta County Data Notebook as presented in written form and consider voting to approve for submission to the Board of Supervisors	m. Table until next meeting	m. 2/14/2024	m. Jackie Rose
VIII. Roundtable Discussion	No updates on committee reports were given.	No action required	N/A	N/A
I. VII. Adjournment	Call to adjourn meeting (7:41 PM)	No action required	N/A	N/A

Next Meeting is scheduled on: February 14, 2024 (Special Meeting)

Kalyn Jones
MHADAB Chair

Date

Shasta County Health and Human Services Agency
SHASTA COUNTY Mental Health, ALCOHOL AND DRUG ADVISORY BOARD (MHADAB)
SPECIAL Meeting
Wednesday, February 14, 2024

Attendees:

Kalyn Jones, Board Chair	√	Heather Jones, Board Vice-Chair	√	Ron Henninger, Past Chair	
Alan Mullikin, Board Member		Connie Webber, Board Member	√	Mary Rickert, BOS Board Member	√
Angel Rocke, Board Member	√	David Kehoe, Board Member		Samuel Major, Board Member	
Cindy Greene, Board Member		Jo-Ann Medina, Board Member		Jackie Rose, CDC	√
Miguel Rodriguez, MHSS/MH Director	√	Katie Nell, BHSS Sr. Analyst	√	Ashley Saechao, CDC	√
Katie Cassidy, BHSS Deputy Director		Mey Chao-Lee, BHSS Clinical Program Coordinator		Christopher Diamond, CDC	√

Community Members: 9 (Includes virtual attendees)

Agenda Item	Discussion/Conclusions/ Recommendations	Action/Follow-Up	Date Due/Status	Individual/ Department Responsible
I. Call to Order	Kalyn Jones, MHADAB chair extended a warm welcome to all attendees and called meeting to order at 5:35 p.m.	No action required.	N/A	Kalyn Jones, MHADAB chair
II. Public Comment	No public comment.	N/A	N/A	N/A
III. Discussion Items	a) Tour of Sunrise Mountain Wellness Center: Addie Jackson, Regional Director, and Julie Calkins, Program Manager provided an overview of services provided including Assisted Outpatient Treatment and the wellness center. A question-and-answer session took place with Board members. Julie Calkins conducted a tour of Sunrise Mountain Wellness Center.	N/A	N/A	N/A
IV. Adjournment	Call to adjourn meeting (7:00 PM)	No action required	N/A	N/A

Next Meeting is scheduled on: March 13, 2024

Kalyn Jones
MHADAB Chair

Date

Authenticity Workshops & Horse Encounters®

Kathy Rutan-Sprague & Kathy O'Donnell

"I don't need a certain number of friends, I need a number of friends that I am certain of."

--Linda Kavelin Popov

ROUGHOUT RANCH FOUNDATION

INSPIRE. MOTIVATE. ENRICH.

…Kathy Rutan-Sprague

Equine-assisted Learning Certifications

- OK Corral (EAGALA founder): Business, Veterans, Crisis, Mental Health

…Kathy O’Donnell

Equine-assisted Learning Certifications

- OK Corral (EAGALA founder): Family, Business, Veterans, Crisis, Mental Health
- Stable Moments: Children with complex trauma (Foster Kids)
- PATH International: Equine-assisted Learning

First, some serious facts about our community…

Northern CA & Sierra region has the highest percentage of adults with severe mental illness and one of the highest percentages of children with severe emotional disturbance. *CA Healthcare Fdtn*

10.5/100k

people take their lives yearly in CA

CDPH

In Shasta County alone…

24.9%

is our suicide rate

CDPH

38

people took their lives

5.4%

need services

20

of those 38 had a history of suicidal ideation

49

is our number of licensed psychologists

CA Dept Consumer Affairs, census.gov

9724

people

CDPH

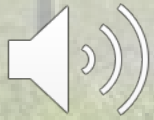
13

only could find treatment

CalVDRS

We have a critical need for community support…

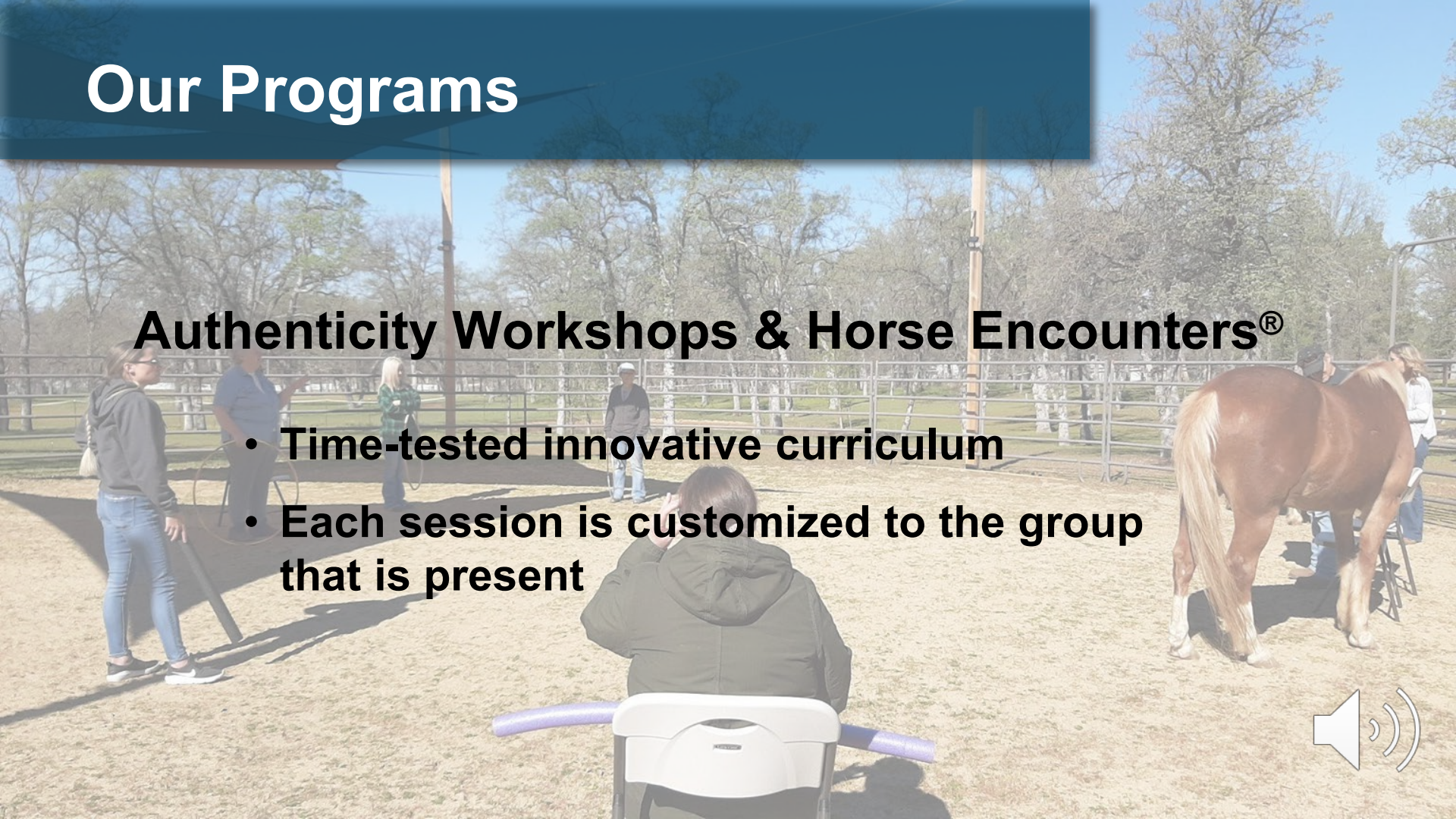
- Our LMFT's can see 3900-5200 clients per year
- Equine-assisted services have had the attention & respect of mental health providers since 1960
- Only a handful of local organizations provide equine services
  - Brenda Becker LMFT Leads to Change Coaching
  - Exodus Farms Therapeutic Riding & Horse Rescue
  - Harmony Haven Therapeutic Riding & Horse Rescue
  - DLB Ranch Equine-assisted Therapy & Learning
  - Roughout Ranch Equine-assisted Services (education, personal development, organization)



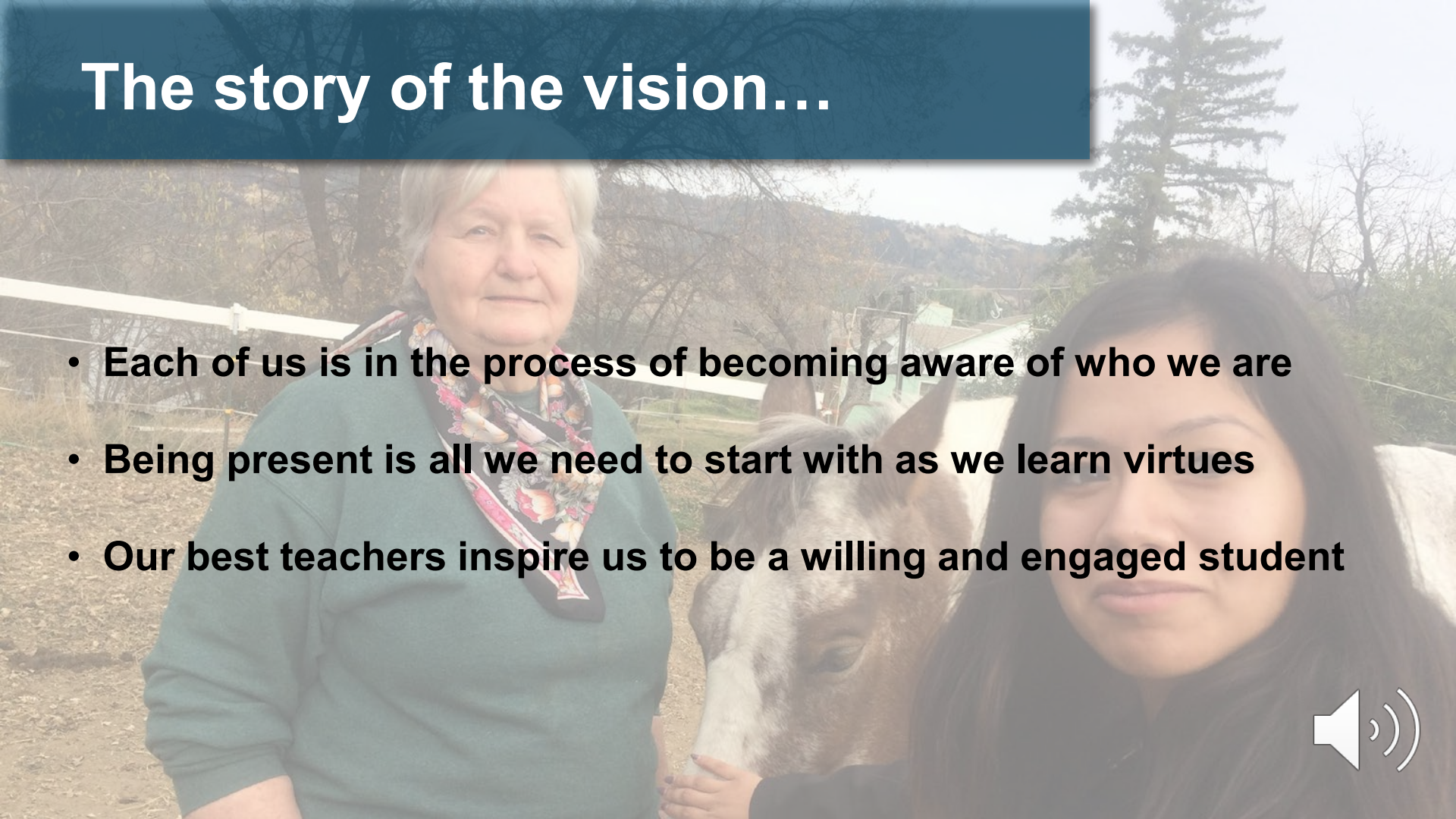
Our Programs

Authenticity Workshops & Horse Encounters®

- Time-tested innovative curriculum
- Each session is customized to the group that is present



The story of the vision…



- Each of us is in the process of becoming aware of who we are
- Being present is all we need to start with as we learn virtues
- Our best teachers inspire us to be a willing and engaged student

The story of the vision…

Here are some of Kathy RS inspiring teachers:

- **Enlo Behavioral Health Inpatient crisis clinic, Chico**
- **DayStar Ranch, Gerber**
- **Equine-Assisted Growth and Learning Association (EAGALA)**

Authenticity Workshops

Conscious Connection & Encouraging Engagement

- Twelve foundational sessions
- The first six focus on connecting
- Peer groups of at least two participants with two facilitators
- Explore reactions & reflections that can bring thoughts & feelings to awareness

Advanced Workshops

Four sets of twelve workshops that delve deeper

- **Partnering with Mutual Respect**
- **Leadership for Parents**
- **Recovery & Discovery**
- **Horse-*Woman*ship for Everyone**

Horse Encounters®

- All populations, 2 y/o & older
- On-going sessions, indefinitely
- One-on-one (1 client, 1 horse, 1 life coach)
- Peer support, groups up to six
- Equine-assisted activities & learning
- Focus is on self-growth & self-discovery
- Building confidence & self-esteem

Target Audience

Our workshops are designed for:

- **Children**
- **Young adults**
- **Mature adults**
- **Seniors**
- **Committed to creating supportive, understanding environments**

Revenue & Timeline

Year-One Timeline

- 0-3 Months: Outreach, training
- 4-6 Months: Ramping up session numbers & group sizes
- 7-12 Months: Advanced sessions & training professional helpers
- Innovative plan will span 3-5 years

Revenue Model

Capacity to provide 3,000 sessions at no cost to participants

Call to Action!

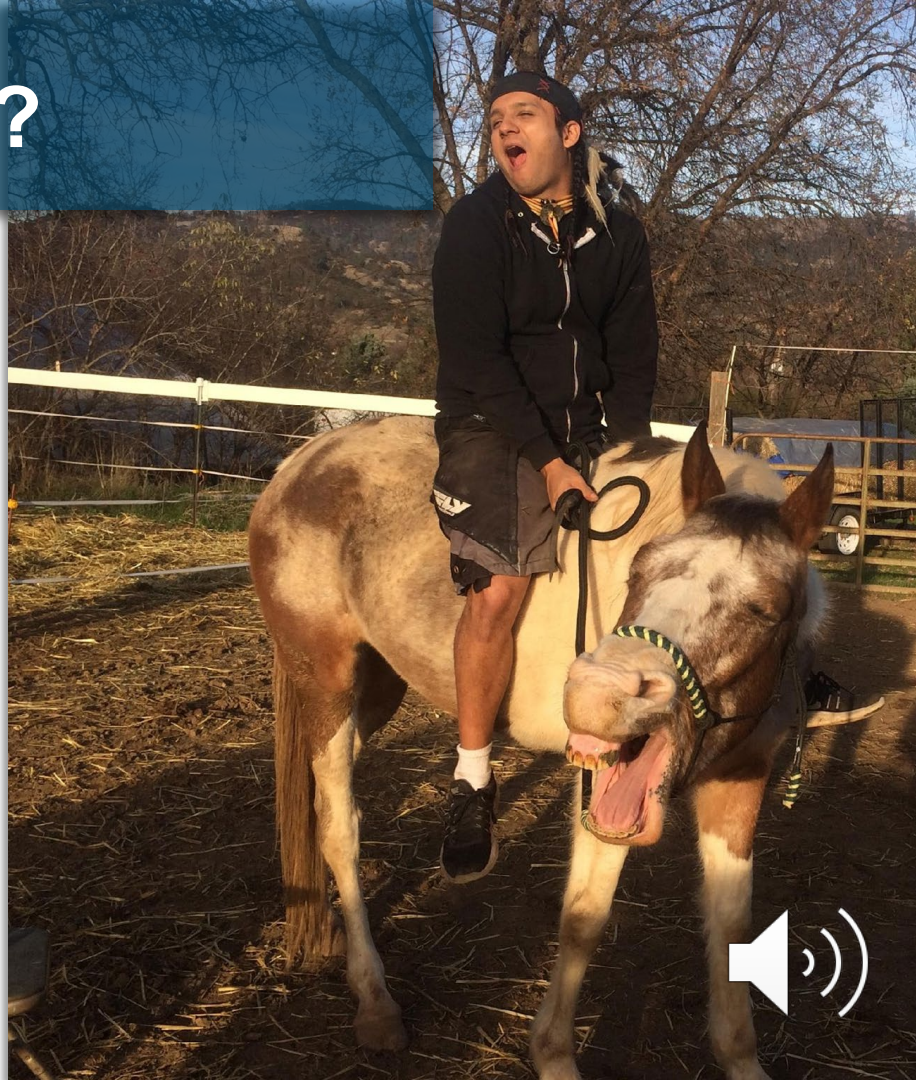
You are invited…

- **Come together, create rich relationships amongst good-hearted students of humanity & honest four-legged teachers**
- **Share in our skills, creativity & friendship**
- **Engage in each other's stories in ways that will bring us from a place of isolation to a place of beloved community**

Questions & Answers?

Kathy Rutan-Sprague
info@roughoutranch.org
(530) 526-3347

Kathy O'Donnell
info@roughoutranch.org
(209) 256-9640



Thank you for all you do!

Experience the ranch & join the herd!

ROUGHOUT RANCH FOUNDATION

INSPIRE. MOTIVATE. ENRICH.

Attachment A: Program Outline

PHASE I: STAFFING RECRUITMENT

PHASE II: PROFESSIONAL DEVELOPMENT

PHASE III: PROGRAM PREPARATION

PHASE IV: PARTICIPANT RECRUITMENT

PHASE I: STAFFING RECRUITMENT (6 weeks)

RRFI intends to onboard adequate staff to meet the demand. RRFI intends to certify them in the Authenticity Workshops and Horse Encounters Program. This ensures that trained individuals are always available during mentor sessions, a requirement for being a workshop location, and ensures program integrity and participant safety. The trained individuals will contribute to the goal of expanding the behavioral health workforce through innovative and non-clinical certifying activities and programs. The certification program provides three full workshops of hands-on/in-person training to give staff the best chance at understanding and retaining the necessary information for being a successful workshop facilitator. RRFI intends to place special emphasis on hiring individuals with lived experience to promote hope and resiliency within the context of recovery.

PHASE II: PROFESSIONAL DEVELOPMENT (6 weeks)

Currently, RRFI has two Program Directors for the Authenticity Workshops and Horse Encounters program. To support the mission of expanding an innovative behavioral health workforce, RRFI intends to develop a total of two new Program Directors, one for the Authenticity Workshops, and one for the Horse Encounters Program, to lead private and peer-to-peer group sessions. This ensures that program directors are always available during sessions, a requirement for being the Authenticity Workshops and Horse Encounters program, and prudent to ensure program integrity and participant safety. The Authenticity Workshops certification program provides three full workshops for our staff to ensure concepts are comprehended and retained.

Staff will be recruited through social media, radio, outreach, and presentations. RRFI will host an awareness event in the first quarter of contract inception, inviting community members to the ranch where they will learn about our services and opportunities.

In honor of the mission objective to promote outreach and awareness, referral relationships with Behavioral Health, Social Services, and other community-based organizations will also be cultivated to increase RRFI's presence in the community; additionally, RRFI will foster these connections to provide outside referrals as indicated for the following:

- Career counseling
- Training and development resources
- Placement/housing resources
- Post-placement support resources
- Evaluation and assessment resources
- Financial assistance resources
- Crisis support services
- Spiritual/Religious resources
- Substance abuse resources
- Physical healthcare resources

Orientation and Training

Co-facilitators of the Authenticity Workshops are graduates of the first twelve sessions and ideally identify as peers with lived experience. They have experience as interns that enables them to find confidence and inspiration to adapt the learning to their own style, and inevitably reach the point where they can lead independently. All graduates have lifelong access to continued customized sessions, consultation, and coaching in their own projects and programs. We do not compete; we collaborate and support each other.

Workshop Training

The foundational curriculum “Authenticity Workshops” is presented in small groups over twelve sessions. Group leaders and county staff benefit from taking the full course as a minimum to be better able to assist the growth and learning of their clients.

Kathy Rutan-Sprague and Kathy O’Donnell have many years of experience with horses and seminars presented by EAGALA and OK Corral, two well-known international creators of the art of using horses to promote human healing and learning.

PHASE III: PROGRAM PREPARATION

- Expand the marketing program by making presentations to community agencies that serve the other needs of our citizens
- Staff recruitment already started with tentative acceptance when we have the contract
- Participant recruitment (ideally done through follow-up of county referrals)
- Staff Training: Train five additional individuals through the first three workshops and plan an internship period before they become fully certified in the use of our curriculum. Our Program Director will train our Executive Director in all aspects of the work as well. Job sharing will allow people to work the hours they prefer. All staff will be trained in each area of the program to ensure schedule flexibility and 100% coverage ability in the event of absent staff or emergencies.
- Intake assessments
- Pre-test data collected
- Plans of care
- Peer matches made

PHASE IV: PARTICIPANT RECRUITMENT

Recruit participants and launch the program.

How Many Can We Serve

Up to 3,000 sessions a year, weather permitting.

SUPPLEMENTARY INFORMATION

The Authenticity Workshops Descriptions

Five initial sets of 12 workshops to serve specific topics and all age groups.

1. **Connect and Engage (Foundational Workshop)**

   Overview of this Curriculum – In the first six sessions, we practice changing our habits (unconscious actions) for a consciousness of being present. The “agenda” that is part of the usual task or goal-driven use of time gets set aside, and we focus our thoughts on being present in the moment. Each session reaffirms this and then offers some tools that are useful when interacting with the

environment, in this case, being in the defined space with the horses among us. We address the topics of boundaries, what they are, and how to protect them, and we practice listening to each other and the horses with the aim of understanding what we see, think, and feel. We share our stories with each other as freely as we feel safe to do so and receive the information without acting upon any need to make changes in each other. When we arrive at the new kind of presence, usually after at least six sessions, we begin to add a task to accomplish, with our focus being on awareness of the relationships as a primary concern.

Each session has a goal and objective to be ever more aware of our own thoughts, feelings, and core beliefs and to look later at what actions are coming from those parts of us and the effects they have on our sense of our own identity.

a. Peer group sessions for small groups 2 to 6

b. Adapted to the group being served

c. Initial 6 or more sessions focus on connecting without any agenda

d. The last 6 sessions begin the practice of serving an agenda with the awareness of the quality of the relationships as the priority

e. Can be offered once or twice a week for 6 to 12 weeks or one weekend a month for 3 or 4 weekends

f. The time between sessions is needed to process lessons

g. Each session allows for welcome time and adequate farewells

h. Facilitators will connect before and after the sessions

i. Reports will be done together with input from both facilitators and participants

j. As much as possible, all decisions will be consulted upon

2. Partnering with Mutual Respect

Is designed to support the skills of working with colleagues toward a shared goal. Participants must be peers with generally equal power and privilege in relationship to each other.

Assessments, goals, and progress will be tracked the same as for the Connect and Engage

Workshop **3. Parenting and Other Hierarchical Relationships**

a. Parents and children or Employees and Management will attend together but separately

b. The first six sessions will be with peers; each session will be given to both levels of authority, but with the peers so that parents will have sessions with other parents and children with other children. Employers will be with other employers of similar levels of authority, and workers with other similar powered workers.

c. The second six sessions can be with mixed couples (a child with a parent that is not their own) for at least 3 sessions before coming together for the last 3 sessions

d. Parenting sessions can be adapted to build connections between other parents; for foster, adoptive, and biological
e. Family sessions will allow other family members to take part as customized to each particular group or “chosen family” members

f. Assessments and progress reports will be inclusive of each participant's sense of progress toward their goals, and positive feedback from each other will support future efforts to address new challenges relevant to their dynamics.

4. Recovery from Past Experiences (all ages)

Building upon the insights gained from the first AW Connect and Engage, we will go into depth for twelve customized sessions with facilitation that include the presence of a licensed and competent therapist and the best team for each group,

Recognizing that all addictions come from traumas that run a range of intensity and happen in our most vulnerable years and situations, rather than directing our sessions to addictive behaviors, we will promote healing from past experiences.

5. Horsewomanship & Horsemanship

Specific training to work with horses, commonly called horsemanship, our sessions bring to bear the unique feminine qualities that are now being applied in the equine world. Horsemanship taught by the “masters” promoted empathy and consistency with conditioned response activities, which by some were called “natural”. us to be empathetic and patient when training horses and ultimately, the horsemen concluded that it is not about cues, but about the nature of the relationship. Now, there are trainers, many are women, who are leading the way to “positive” training and these lessons are so respectful and powerful, that the work being done is mostly within the human “trainer” with the horse helping with their always authentic responses. d. These sessions are open to all graduates of the Authenticity Workshop “Connect and Engage”, because the very first sessions begin with the awareness of the connection that we seek, and that we have, and give skills that apply beautifully to the goals. People with no previous horse training sometimes learn faster as they have less to unlearn and concentrate on the relationship first.

Customized to the clients, the sessions can include mounted activities and cart driving.

About the Creator of the Authenticity Workshops

Kathy Rutan-Sprague holds credentials as an RN and as a Certified Flight Instructor. Her nursing career included inpatient mental health, pediatrics, hospice, and intensive care nursery. She has a passion for teaching and has dedicated the past 30 years to sharing the power of horses with adults and youth for their own experience with self-confidence that is “horse-powered”. Becoming a pilot and then a flight instructor while living in the Panama Canal Zone added to her awareness of the perspective of the journey, we all are on in life. What do healing, flying, and horses have in common? *“We need to be well enough to feel fully alive, yet fully grounded by our own connections within ourselves, and still free enough and brave enough to fly to new horizons.”*

She benefitted from years of therapy to strengthen a struggling marriage and the courage to accept the inevitable separation, followed by years of being a single parent to four children, creating a lasting impact. Wondering what preparations could have been made to lead to a successful lifelong partnership inspired her. Realizing that her education was inadequate for the teen bride, started a search for what was missing. The hard-won lessons set her up well for the second marriage, which has been a happy one for 38 years.
With the full participation of her husband and many devoted friends, she grew a ranch and a large herd of

horses, bred for the purpose of teaching life skills to youth and adults in Tehama County. She had contracts for years with Tehama County Mental Health for adult outpatient education and with Social Services for foster and adopted youth. For four years, she provided weekly sessions for Salsbury High School students. These activities taught her what was effective for each, and after that began with the need to be heard and be respected. All of this, and a strong connection with the spiritual teachings of unity that result from seeing the divine in each person, has prompted her to create and share the innovative curriculum she has developed, which is called the Authenticity Workshops.

About the Founder and Creator of Horse Encounters

Kathy O'Donnell, also known by many as their favorite Aunt Kathy, has followed her dream to serve the needs of overlooked and challenged children and adults. Her interests in drama and performing, combined with the experience of the healing power of horses, found the path to offering what she has trademarked as Horse Encounters®. Professionally, she studied for years with Greg Kirsten of OK Corral Series and founder of EAGALA. Certified in 5 of his equine philosophy programs, she has continued to learn from Kathy Rutan-Sprague and to apply the insights gained to enrich and expand her skills in using horses for growth and learning.

She has owned horses for more than a decade and has invested in creating a safe and welcoming ranch that she loves to share with the community. Founder and partner in the nonprofit Roughout Ranch Foundation Inc., she has created strong connections within the local community and service agencies and won grants that help her to address the needs of families with special needs. She has expanded her services each year to serve the special needs community to support the dreams and efforts of others who can opt to use her ranch and horses to serve the clients that they bring to the ranch. Her education and skills as a graphic designer, and her ability to work with people, have been the driving force that successfully promotes each program offered now at Roughout Ranch.

PROGRAM PLAN

INNOVATION (INN)

PROJECT NUMBER/NAME: Roughout Ranch, Authentic Workshops and Horse Encounters

☐ **CONTINUED FROM PRIOR YEAR PLAN OR UPDATE**

☒ **NEW**

A. Expected start and end dates of this INN Project: July 1, 2024

B. The total time frame (duration) of this INN Project: 12 months

1. PROJECT OVERVIEW

A. Primary Problem

Provide a narrative summary of the challenge or problem identified and why it is important to solve for the community. Describe what led to the development of the idea for this INN Project and the reasons this project has been prioritized over alternative challenges identified during the Community Program Planning Process.

Roughout Ranch currently serves individuals based on donations received and personal finances of the developers and owners of the ranch. The project they are proposing would expand this service to individuals in Shasta County who are experience emotional distress due to various life experiences. Being able to offer this service to individuals, not just those served by county mental health, provides an opportunity for individuals to improve their overall wellness.

Authenticity Workshops and Horse Encounters are all about relationships and developing insights and practices that support new ways of thinking and personal growth. The Programs powerfully promote skills that connect participants to each other and are foundational to most of the other programs offered. Authenticity Workshop sessions are customized to fit any individual or peer group.

The Authenticity Workshops, Relationship Enrichment programs, bring each participant to a greater awareness of their own selves and the ability to maintain personal safety while venturing outside some comfort circles and discovering their own abilities. These workshops meet the needs of individuals who've experienced isolation from others, seeking the core beliefs that drive each person and supporting each one as they begin to evaluate their own beliefs and make choices for themselves that are most authentic.

Horse Encounters provides healing, growth, and inspiration to individuals with diverse needs through equine assisted activities and learning. Using the training from the Authenticity Workshops and Horsemanship, combined with horse and human relationship development, Horse Encounters improves the physical, cognitive, and social well-being of men, women, and children, one day at a time. Sessions can be scheduled weekly, bimonthly, or monthly. Horse Encounters programs are offered to special needs individuals utilizing the ranch and horses to assist those with physical differences, developmental delays, and foster/adopted children. RRFI has years of history serving this population with community integration support and innovative activities that empower and enhance their lives.

The goal of both programs is to create communities of trust that can work together for mutual benefit. In the short term, these sessions promote self-healing and empowerment and affect participants' ability to enjoy interacting with others. The objective is to increase each participant's sense of confidence. This is realized through deeply learned skills, including recognizing, and protecting personal boundaries and bringing to awareness the current environment and its threats and opportunities. As participants learn to visualize and ask for what they wish for, they overcome their responses to triggers, and they grow in confidence. Their ability to

protect healthy boundaries while being respectful of the relationship results in improved interpersonal connections and reduced social isolation.

B. Project Description

See Attachment A

1) Provide a narrative overview description of the Project, how the Project is being/will be implemented, the relevant participants/roles within the project, what participants typically experience, and any other key activities associated with Project development and implementation.

Challenge/Problem	Potential Solution

2) Identify which of the three INN project General Requirements the project is/will be implementing.

☐ Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention

☐ Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population

☒ Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system.

3) Briefly explain how the selected approach has been determined to be appropriate.

Shasta County Behavioral Health Branch Director and Deputy Branch Director met with the Roughout Ranch leaders, Kathy Rutan-Sprague, RN, and Kathy O'Donnell to learn about the service they have been offering to a small population in the county. Both women have worked in their fields of medicine and horse training their entire careers. The Roughout Ranch program is designed out of their compassion to provide healing through group teachings and caring for horses. Given what is known about the impact of equine therapy, although the model proposed is not equine therapy, it is an evolution to the equine technique. The relationships developed in the group setting can transition to the relationship with the horses in supporting individuals with various life stories develop trust and safety, which can infuse other areas of their life. Providing individuals with various behavioral health methods for healing is essential. This model provides that.

# of individuals to be Served (estimate)	Cost per Person

4) If applicable, estimate the total number of individuals expected to be served annually, cost per person and how these estimates were developed.

135	

5) If applicable, describe the population(s) to be served by the project, e.g., age group, gender identity, orientation, language spoken and other important demographics/characteristics.

Age Group	**# of individuals**	**Race**	**# of individuals**	**Sexual Orientation**	**# of individuals**	**Gender Identity**	**# of individuals**	**Language Spoken**	**# of individuals**
0-15 yrs.		White		Lesbian or Gay		Female		English	
16-25 yrs.		African American or Black		Heterosexual		Male		Spanish	
26-59 yrs.		Asian		Bisexual		Transgender woman		Vietnamese	
60 & older		Native Hawaiian or Other Pacific Islander		Queer, pansexual, and/or questioning		Transgender man		Cantonese	
		Alaska Native or Native American				Genderqueer		Mandarin	
		Other		Other		Other		Tagalog	
		More Than One Race		Declined to Answer		Declined to Answer			
		Declined to Answer		**Disability**			**# of individuals**	Cambodian	
Veteran	**# of individuals**	**Ethnicity**	**# of individuals**	**Communication**	**# of individuals**	Mental (not SMI)		Hmong	
				Seeing		Physical/Mobility		Russian	
Yes		Hispanic		Hearing or Having Speech Understood		Chronic Health Condition		Farsi	
No		Non-Hispanic						Arabic	
Declined to Answer		More Than One Ethnicity		Other (specify)		Other (specify)		Other	
				None		Declined to Answer			
Total Estimated Number of Individuals to Be Served:									

2. LEARNING GOALS/PROJECT AIMS

A. Describe the Project's learning goals/specific aims and what potential contributions will be made to the expansion of effective practices.

The goal of both programs is to create communities of trust that work together for mutual benefit. In the short term, these sessions promote self-healing and empowerment and affect participants' ability to enjoy

interacting with others. The objective is to increase each participant's sense of confidence. This is realized through deeply learned skills, including recognizing, and protecting personal boundaries and bringing to awareness the current environment and its threats and opportunities. As participants learn to visualize and ask for what they wish for, they overcome their responses to triggers, and they grow in confidence. Their ability to protect healthy boundaries while being respectful of the relationship results in improved interpersonal connections and reduced social isolation.

In looking at effective practices, during monthly meetings, program success and challenges will be discussed in efforts to create the most effective service for those individuals participating.

B. What does the County want to learn or better understand over the course of the INN Project, and why have these goals been prioritized?

The goal is to improve overall well being and functioning in multiple domains of an individual's life. If completion of the Authentic Workshops and Horse Encounters creates any improvement for an individual, the program is successful. Tracking an individual's functioning at referral then tracking it post program, the county will be able to determine the number of individuals reporting success.

C. How do the learning goals relate to the key elements/approaches that are new, changed or adapted in this Project?

This project is an adaptation of formal horse therapy which is associated with helping those who have experienced hardships and trauma in their life. If Authentic Workshops and Horse Encounters can demonstrate an 85% improvement for those who complete the program, this program lends itself to be further used in possible other areas of the county.

D. For continuing projects, include any modifications to the project learning goals/specific aims in response to lessons learned during project implementation.

This is a new program. Any modifications may be made after collaborative meetings with the county and Roughout Ranch are had.

3. ADDITIONAL INFORMATION

A. Explain how the Project is consistent with the priorities identified in the Community Program Planning Process.

Question is answered below in B.

B. Provide a description of how the current/proposed project relates to the General Standards of the MHSA.

- Community Collaboration: This project has been a community collaboration with private funders, Far Northern Regional Center and county mental health referrals and personal finances of the owners and developers of this project. The community who has utilized this service has advocated for an expansion of this service as they see the positive impact it has made on individuals, but the financial piece is becoming greater than they can manage.

- Cultural Competence: Cultural Competency around the needs of individuals who have experienced hardship and trauma is core to how this program delivers the service. Understanding an individual may not complete the program as others have, is accepted and plans are made to support an individual manage their ambivalence.
- Client and Family Driven: Program was presented to the county as clients and families encourage Roughout Ranch to look for funding to sustain and potentially expand the services they have been providing to date. Client's and families will be asked if they are interested in participating in quarterly meetings to share the success and challenges, they experience with the program.
- Wellness, recovery, and resilience focused: The program's goal is to improve wellness, recovery and resiliency of those who participate in the service. The skills of the Authenticity Workshops are designed to expose others to new ways of navigating the world and healing. Those skills can be practiced as they graduate to the Horse Encounter portion of the program.
- Integrated service experiences for clients and their families, i.e., the client, and when appropriate the client's family, accesses a full range of services provided by multiple agencies, programs, and funding sources in a comprehensive manner: This program is designed for the individual. Family members and other natural supports would not be detoured in collaborating with the program. Roughout Ranch recognize the importance of natural supports in a person's life.

C. Explain how the Project evaluation is/will be culturally competent and includes/will include meaningful stakeholder participation.

The project included statements from individuals and families who have actively participated in Authentic Workshop and Horse Encounters sharing how this program has improved their lives. These individuals from Roughout Ranch are invited to present their program at the Mental Health Alcohol and Drug Board meeting to allow board members and the community to ask specific questions they may have about this program.

D. Describe how community stakeholders are meaningfully involved in all phases of INN projects, including evaluation of INN projects and decision-making regarding whether to continue INN projects.

This project was posted for community member's comment. After public comment the project is placed on the Shasta County Mental Health and Alcohol Drug Board meeting for final approval.

E. If individuals with serious mental illness receive/will receive services from the continued/proposed project, describe the County's plan to protect and provide continuity of care for these individuals upon project completion.

The Authentic Workshops and Horse Encounters is a component of an individual's specialty mental health plan. By participating in this program, Shasta County may see clients transition out of specialty mental health as their overall wellbeing should improve. If an individual, continues to qualify and is in need of specialty mental health services, they will remain an active client at the county.

Roughout Ranch Foundation
Projected Annual Budget - Equine Programs

DIRECT EQUINE EXPENSE		notes
timothy hay	4,200.00	6 tons bi-annually, 5 equine
3 way hay	500.00	winter supplement, 5 equine
hoof trimming	2,000.00	horse health, 5 equine
medical supplies	1,800.00	vet wrap, gauze, ointments, fly spray, hoof care, fly masks
supplements	1,150.00	5 equine for 1 year ($100 alfalpha pellets, $100 timothy pellets, $100 timothly cubes, $400 trace minerals, $400 sandclear, $50 flax seed)
bedding/shavings	520.00	1 equine
deworming	200.00	5 equine
veterinarian and vaccines	1,600.00	5 equine
stall and shelter	3,000.00	1 equine
corral boards replacement	1,000.00	replacing chewed and weathered board with new ones in arena, corrals, stalls to keep equines and people safe
tack	1,500.00	saddles, halters, lead ropes, bridles, pads for activities
repairs/maintenance	1,000.00	new water line to arena
Total direct expense.....	**18,470.00**	*quarterly invoices or 1st invoice to county as lump sum*
PROGRAM EXPENSE		
Wages		
Trained		*48 week year; salary calculated less 6 week training period & less 6 week internship period*
Executive Director	57,600.00	salary; 100/hr, 4 hr/day, 4 days/week for 36 weeks
Program Director - HE	15,360.00	salary; 80/hr, 1 hr/day, 4 days/week for 48 weeks
Program Director - AW	69,120.00	salary; 90/hr, 4 hr/day, 4 days/week for 48 weeks
Program Director Assistant - AW	46,080.00	salary; 80/hr, 4 hr/day, 4 days/week for 36 weeks
Program Director Assistant - HE	46,080.00	salary; 80/hr, 4 hr/day, 4 days/week for 36 weeks
Equine Specialist 1 - JC	15,360.00	salary; 40/hr, 2 hr/day, 4 days/week for 48 weeks
Equine Specialist 2	11,520.00	salary; 40/hr, 2 hr/day, 4 days/week for 36 weeks
Facilitator 1	34,560.00	salary; 60/hr, 4 hr/day, 4 days/week for 36 weeks
Facilitator 2	34,560.00	salary; 60/hr, 4 hr/day, 4 days/week for 36 weeks
In training		*78 hr training (36 sessions @ 2 hrs each + 6 hr training period for legal requirement satisfaction i.e. sexual harassment training, onboarding paperwork)*
Executive Director	6,240.00	$80/hr
Program Director Assistant - AW	5,460.00	$70/hr
Program Director Assistant - HE	4,680.00	$60/hr
Facilitator 1	3,120.00	$40/hr
Facilitator 2	3,120.00	$40/hr
Equine Specialist 2	1,560.00	$20/hr
Internship		*78 hours, 6-8 weeks*
Executive Director	6,240.00	$80/hr
Program Director Assistant - AW	5,460.00	$70/hr
Program Director Assistant - HE	4,680.00	$60/hr
Facilitator 1	3,120.00	$40/hr
Facilitator 2	3,120.00	$40/hr
Equine Specialist 2	1,560.00	$20/hr
Wages total	378,600.00	
20% (work comp& taxes)	75,720.00	
Total Wages+Insur/Taxes.....	*454,320.00*	invoiced when people submit time cards
Participant transportation to/from facility		
Transportation Fund	90,000.00	uber gift cards, taxi service, public transportation
Staffing expenses		
staff recruiting and development	10,000.00	posting jobs, job boards, $44 per application fee; sexual harassment traning per employee 75+65+45+20- $205x2
kids & adult supplies	2,000.00	boots, gloves, hats, grooming bags, training sticks, sun screen, repellants
director & officers liability coverage	2,500.00	D&O, employee practices ins, fiduciary
shirts/uniforms (staff / volunteers)	1,800.00	
Facility Expenses - direct result of program needs		
portapotty service (3)	1,200.00	
new construction + labor	25,000.00	weatherproof areas so the program can operate even in harsher weather conditions
Total program expense.....	**586,820.00**	
OVERHEAD EXPENSE (30%)		
General Business Overhead		
facility lease	36,000.00	
location liability Insurance	10,000.00	
utilities & water	3,600.00	current cost
telephone	900.00	current cost
internet	720.00	current cost
dues & subscriptions	900.00	
office expense	7,500.00	pens, computers, IT, chairs, printing supplies, etc
Administrative Overhead		
bookkeeping & payroll service	10,000.00	abigails quote
banking fees	400.00	
legal & professional fees	10,000.00	
Research/Marketing Overhead		
Referral and Outreach, Marketing Services	15,000.00	
postage	480.00	
publications & books	500.00	
travel	2,400.00	
business cards	300.00	
property signs	500.00	
promotional items	900.00	
Total overhead	**100,100.00**	monthly invoicing
Grand total expense.....	**705,390.00**	

Shasta County
Health & Human Services Agency | Behavioral Health & Social Services Branch

Shasta County 5150 Overview

Adam Hilton, LMFT – Clinical Program Coordinator

Overview Of Today's Training

- Historical Framework of the Lanterman-Petris-Short Act and Welfare and Institutions Code 5150
- Legal and clinical criteria for involuntary holds and treatment
- Shasta County inpatient placement process and legal proceedings

Historical Framework of the LPS Act and W&IC 5150

- **Short-Doyle Act (1957)**
- In response to overcrowding in state hospitals and an identified need for local outpatient services, this legislation was enacted to organize and finance community mental health services for individuals with mental illness through locally administered and controlled community mental health programs.
- This led to a decrease in the hospital population and ultimately the closure of many state hospitals. Individuals with mental illness were then more prevalent in local communities and still in need of intensive services.

Lanterman-Petris-Short Act (WIC 5000-5556)

Enacted in 1968, the Lanterman-Petris-Short Act had as its legislative intent:

- **End the inappropriate, indefinite, and involuntary commitment**
- **Prompt evaluation and treatment**
- **Public safety**.
- **Individual rights**
- **Conservatorship program**
- **Prevent duplication of services**
- **Protect from criminal acts.**
- **Protection of the personal rights**
- **Least restrictive setting**

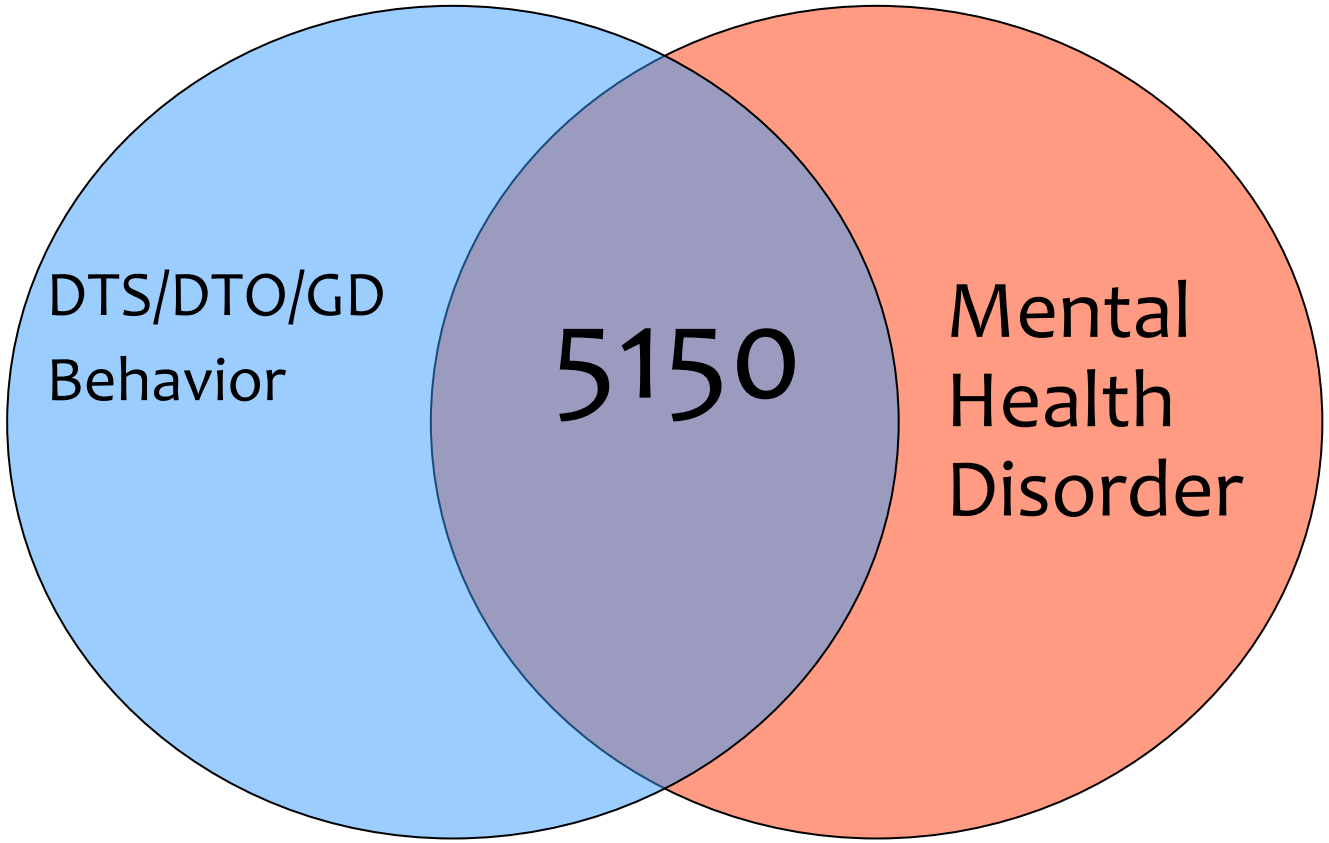
WIC 5001

WIC 5150

WIC 5150(a)

- When a person, **as a result of a mental health disorder**, is
  - a danger to others (DTO), or
  - to themselves (DTS), or
  - gravely disabled (GD),
  - ❖ a peace officer,
  - ❖ professional person in charge of a facility designated by the county for evaluation and treatment,
  - ❖ member of the attending staff, as defined by regulation, of a facility designated by the county for evaluation and treatment,
  - ❖ designated members of a mobile crisis team,
  - ❖ or professional person designated by the county
- may, upon **probable cause**, take, or cause to be taken, the person into custody for a period of up to 72 hours for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment in a facility designated by the county for evaluation and treatment and approved by the State Department of Health Care Services.
- The 72-hour period begins at the time when the person is first detained.

WIC 5150 – Nexus Requirement



Who is Authorized to Write a 5150 Hold?

Those who the County Designates

(WIC 5121; BOS Resolution 2020-135):

- Professional person in charge, or the attending staff, of an LPS designated facility
- Designated Members of a Mobile crisis team
- Any professional person designated by the county

Those who do not need county designation.

- Peace officers (local, state, federal)

For How Long is a Hold Valid?

An individual DOES NOT have to remain on a 5150 hold for the entire 72-hours allowed by the WIC.

The individual may be released from the hold AT ANY TIME during that 72-hours if they no longer meet criteria for the hold.

Admission to a medical floor can nullify a 5150 hold which can be reinstated after medical clearance

Criteria for a 5150 Hold

- Danger to Self
- Danger to Others
- Gravely Disabled

Shasta County 5150 Evaluation

- Emergency Department physicians determine medical clearance
- The individual is then referred to the county for evaluation
- County mental health clinicians determine if 5150 criteria is met or not

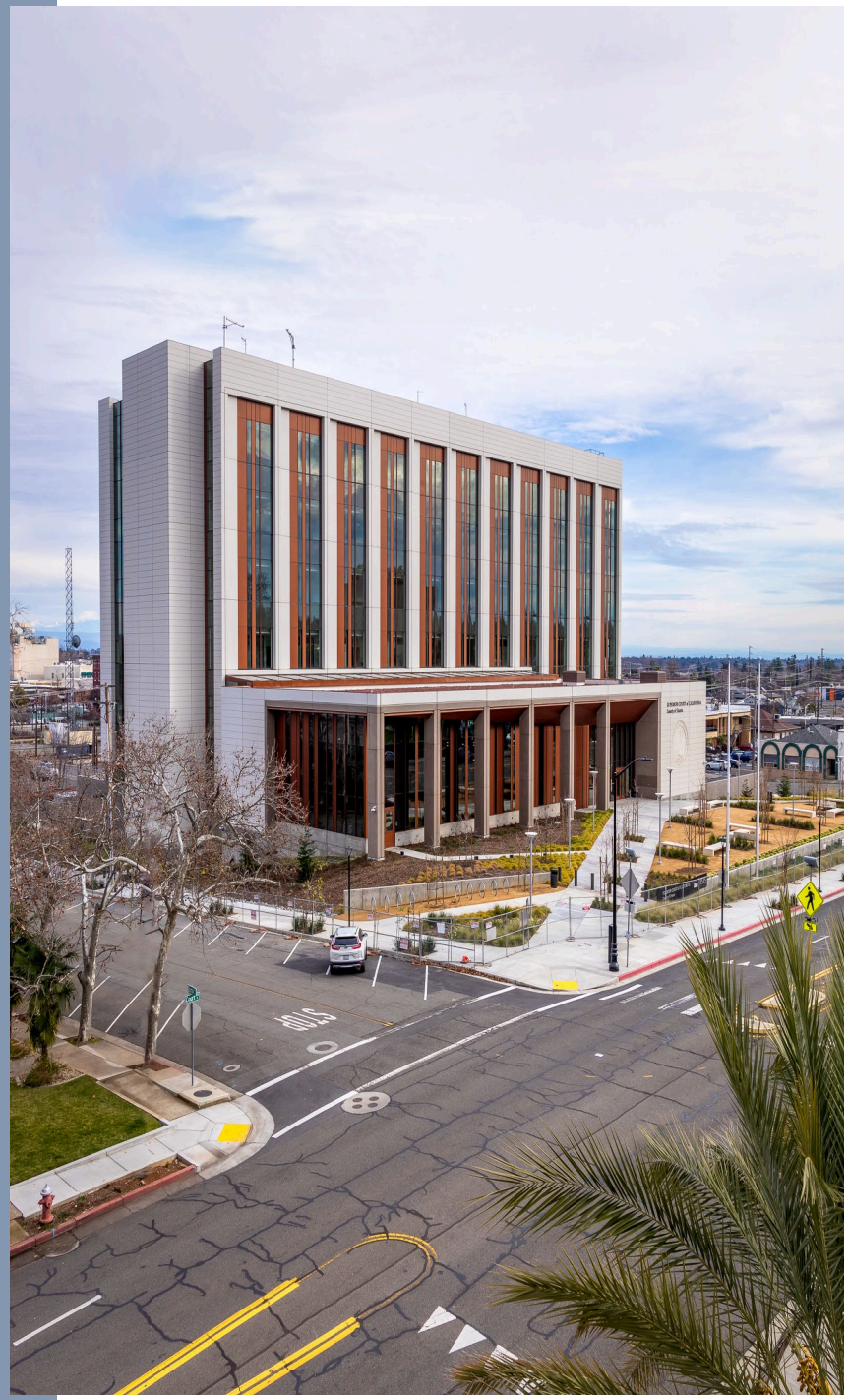
After the 5150 hold is written...

Shasta County begins seeking placement in a psychiatric facility

If the individual no longer meets criteria for the hold at any point – then a safety plan is developed for release.

When an individual is accepted, Shasta County provides transportation

Shasta County
Health & Human
Services Agency



What is CARE Act?

COMMUNITY

ASSISTANCE

RECOVERY

EMPOWERMENT

CARE is a new **civil** court process that is designed to do the following:

- Upstream diversion to prevent more restrictive conservatorships or incarceration
- Focus on those with untreated schizophrenia spectrum or other psychotic disorders
- Provide behavioral health services and other crucial resources

Who is eligible for CARE Court?

- Adults, 18 years or older
- Has a severe mental illness AND has been diagnosed with Schizophrenia or another psychotic disorder
- Not clinically stabilized in an on-going voluntary treatment
- Meets at least one of the following:
  - Unlikely to survive safely in community (unable to provide for their basic personal needs for food, clothing, or shelter) without supervision and their condition is substantially deteriorating
  - In need of services and supports to prevent relapse or deterioration that would likely result in grave disability or serious harm to the person/others
- Participating in CARE Court is the least restrictive option to ensure recovery and stability
- Would likely benefit from participation in CARE Plan or CARE Agreement

Who Can File a Petition?

Family/Home

- Spouse, parent, sibling, adult child, grandparents
- Person that respondent lives with
- Respondent (self-referral)

County

- County behavioral health director, or designee
- Public Guardian or designee
- Director of adult protective services or designee

Community

- First responders
- Director of a Hospital, or designee, where the respondent is hospitalized
- Licensed behavioral health professional, or designee, treating respondent for mental illness
- Director of a public/charitable organization providing behavioral health services or whose institution respondent resides

Tribal Jurisdiction

- Director of a California Indian health services program, California tribal behavioral health department, or designee
- Judge of a tribal court located in CA, or designee

Filing a Petition

How to File

- Complete petition (CARE-100) – remember to fill out **ALL** requested information
- Provide requested documentation:
  - Completed Mental Health Declaration (CARE-101) from a licensed behavioral health provider **OR**;
  - Evidence the Respondent was detained for a minimum of TWO periods of intensive treatment (WIC 5250 holds), the most recent episode being within the last 60 days

Where to File

- The county where the Respondent lives
- The county where the Respondent is found
- The county where the Respondent is facing criminal or civil proceedings

Fillable forms can be found at:

[Self-Help Guide to the California Courts | California Courts | Self Help Guide]

CONFIDENTIAL

CARE-100

ATTORNEY OR PETITIONER WITHOUT ATTORNEY	STATE BAR NUMBER:	FOR COURT USE ONLY
NAME:		
FIRM NAME:		
STREET ADDRESS:		
CITY:	STATE: ZIP CODE:	
TELEPHONE NO.:	FAX NO.:	
EMAIL ADDRESS:		
ATTORNEY FOR (*name*):		
SUPERIOR COURT OF CALIFORNIA, COUNTY OF		
STREET ADDRESS:		
MAILING ADDRESS:		
CITY AND ZIP CODE:		
BRANCH NAME:		
CARE ACT PROCEEDINGS FOR (*name*): RESPONDENT		
PETITION TO COMMENCE CARE ACT PROCEEDINGS		CASE NUMBER:

For information on completing this form, see *Information for Petitioners—About the CARE Act* (form CARE-050-INFO).

1. Petitioner (*name*): is 18 years of age or older and (*check all that apply*):
   - a. ☐ A person who lives with respondent.
   - b. ☐ A spouse or registered domestic partner, parent, sibling, child, or grandparent of respondent.
   - c. ☐ A person who stands in the place of a parent to respondent.
   - d. ☐ The director* of a hospital in which respondent is hospitalized.
   - e. ☐ The director* of a public or charitable organization, agency, or home
     - (1) ☐ who is or has been, within the past 30 days, providing behavioral health services to respondent; or
     - (2) ☐ in whose institution respondent resides.
   - f. ☐ A licensed behavioral health professional* who is or has been, within the past 30 days, treating or supervising the treatment of respondent.
   - g. ☐ A first responder, including a peace officer, firefighter, paramedic, emergency medical technician, mobile crisis response worker, or homeless outreach worker who has had repeated interactions with respondent.
   - h. ☐ The public guardian* or public conservator* of the county named above or a private conservator referred by the court under Welfare and Institutions Code section 5978.
   - i. ☐ The director* of the county behavioral health agency of the county named above.
   - j. ☐ The director* of adult protective services of the county named above.
   - k. ☐ The director* of a California Indian health services program or a California tribal behavioral health department.
   - l. ☐ A California tribal court judge.*
   - m. ☐ Respondent.

   * This person may designate someone else to file the petition on their behalf. If the petitioner is a designee, check this category and put designee's name in item 1, above.
2. a. Petitioner asks the court to find that respondent (*name*): is eligible to participate in the CARE Act process and to commence CARE Act proceedings for respondent.
   b. Petitioner's relationship to respondent (*specify and describe relationship*):

Form Adopted for Mandatory Use
Judicial Council of California
CARE-100 [New September 1, 2023]

Welfare & Institutions Code, §§ 5972–5975, 5977–5977.4, 5978
www.courts.ca.gov

CONFIDENTIAL

CARE-100

ATTORNEY OR PETITIONER WITHOUT ATTORNEY STATE BAR NUMBER: FOR COURT USE ONLY
NAME:
FIRM NAME:
STREET ADDRESS:
CITY: STATE: ZIP CODE:
TELEPHONE NO.: FAX NO.:
EMAIL ADDRESS:
ATTORNEY FOR (*name*):
SUPERIOR COURT OF CALIFORNIA, COUNTY OF
STREET ADDRESS:
MAILING ADDRESS:
CITY AND ZIP CODE:
BRANCH NAME:
CARE ACT PROCEEDINGS FOR (*name*): RESPONDENT
PETITION TO COMMENCE CARE ACT PROCEEDINGS CASE NUMBER:

For information on completing this form, see *Information for Petitioners—About the CARE Act* (form CARE-050-INFO).

1. Petitioner (*name*): is 18 years of age or older and (*check all that apply*):
   - a. ☐ A person who lives with respondent.
   - b. ☐ A spouse or registered domestic partner, parent, sibling, child, or grandparent of respondent.
   - c. ☐ A person who stands in the place of a parent to respondent.
   - d. ☐ The director* of a hospital in which respondent is hospitalized.
   - e. ☐ The director* of a public or charitable organization, agency, or home
     - (1) ☐ who is or has been, within the past 30 days, providing behavioral health services to respondent; or
     - (2) ☐ in whose institution respondent resides.
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   - j. ☐ The director* of adult protective services of the county named above.
   - k. ☐ The director* of a California Indian health services program or a California tribal behavioral health department.
   - l. ☐ A California tribal court judge.*
   - m. ☐ Respondent.

   * This person may designate someone else to file the petition on their behalf. If the petitioner is a designee, check this category and put designee's name in item 1, above.
2. a. Petitioner asks the court to find that respondent (*name*): is eligible to participate in the CARE Act process and to commence CARE Act proceedings for respondent.
   b. Petitioner's relationship to respondent (*specify and describe relationship*):

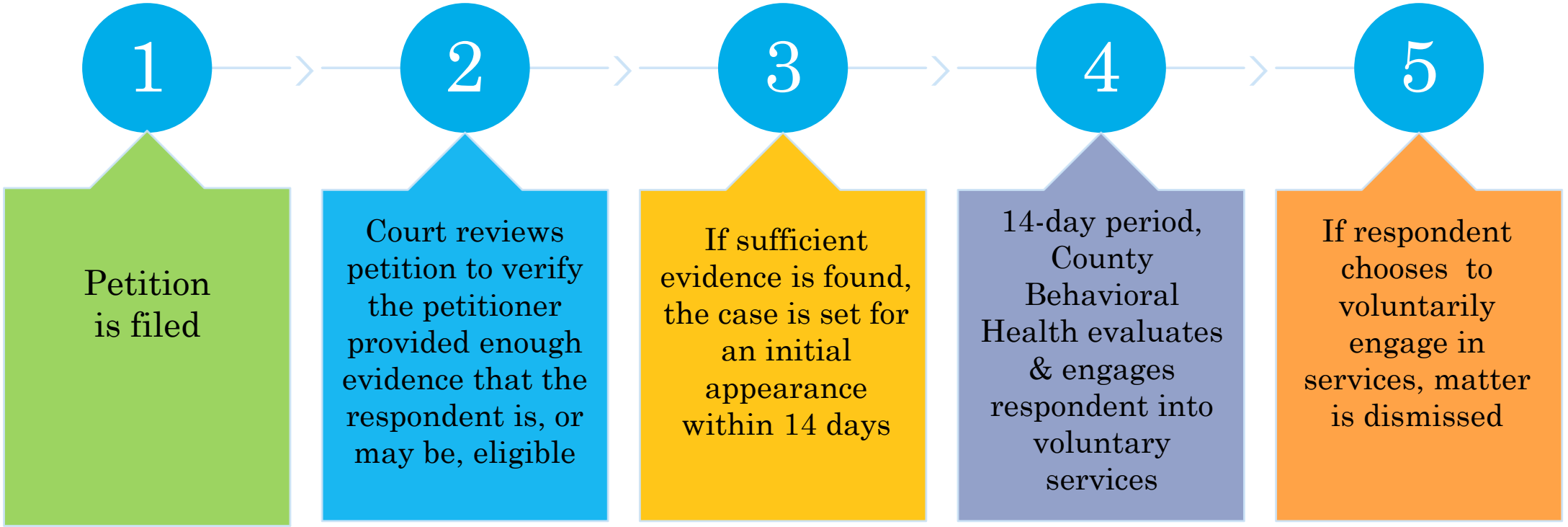
Page 1 of 6

Form Adopted for Mandatory Use
Judicial Council of California
CARE-100 [New September 1, 2023]

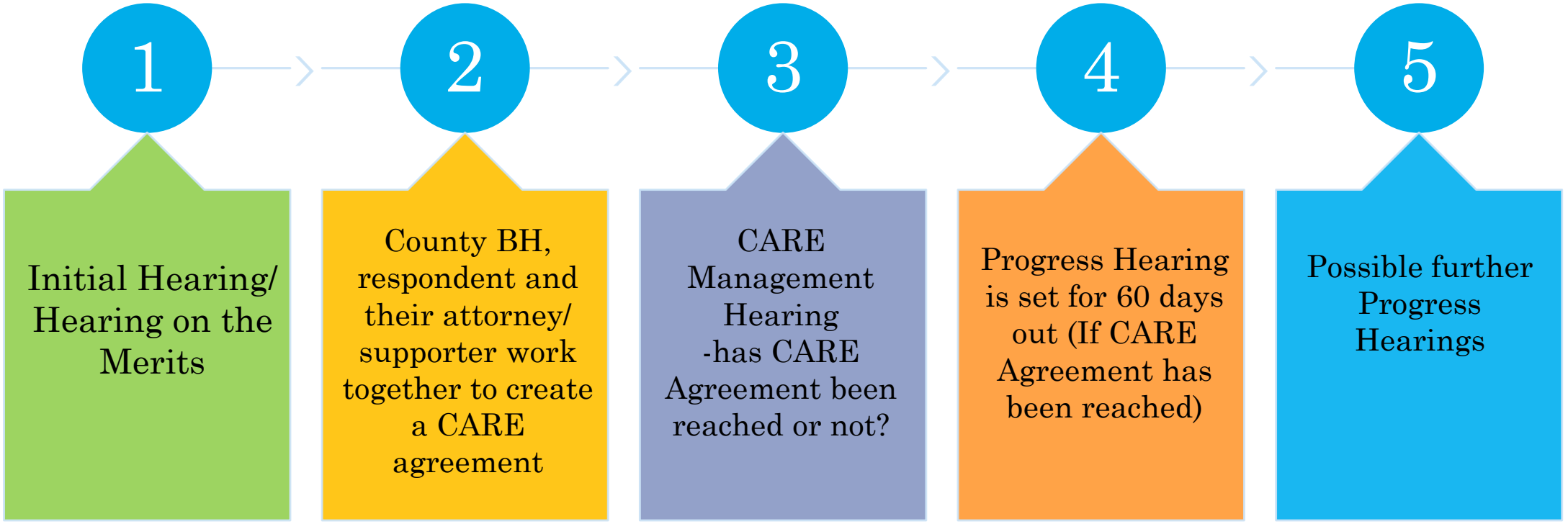
PETITION TO COMMENCE CARE ACT PROCEEDINGS

Welfare & Institutions Code, §§ 5972–5975, 5977–5977.4, 5978
www.courts.ca.gov

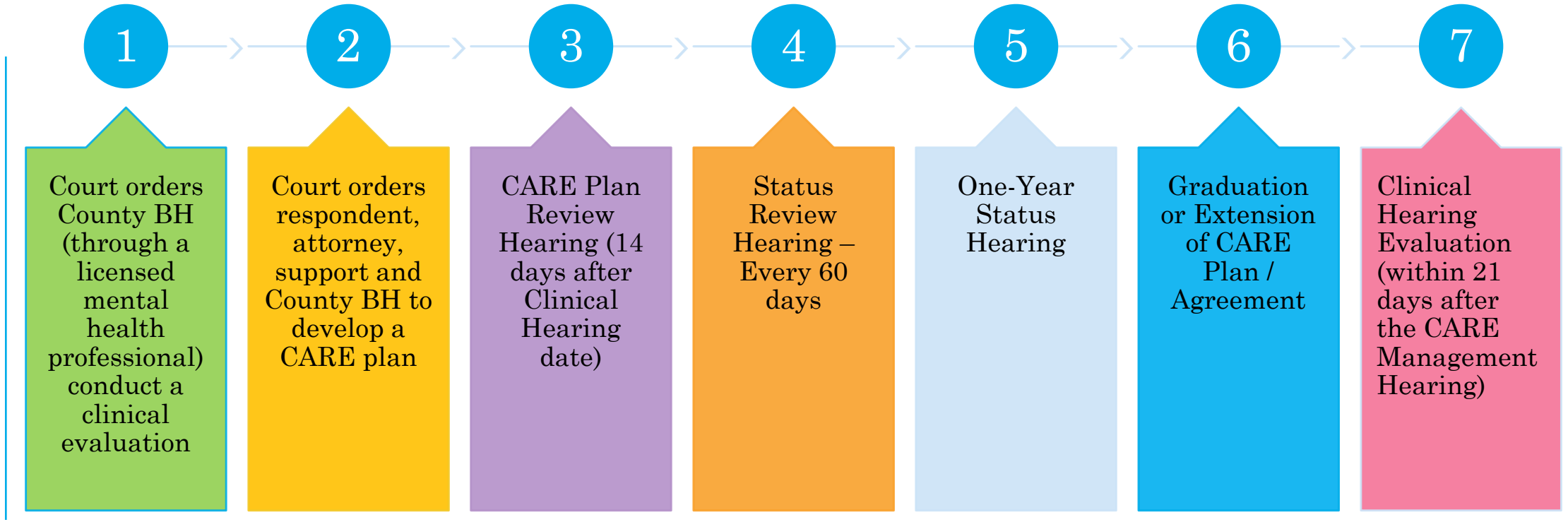
What happens after a petition is filed?



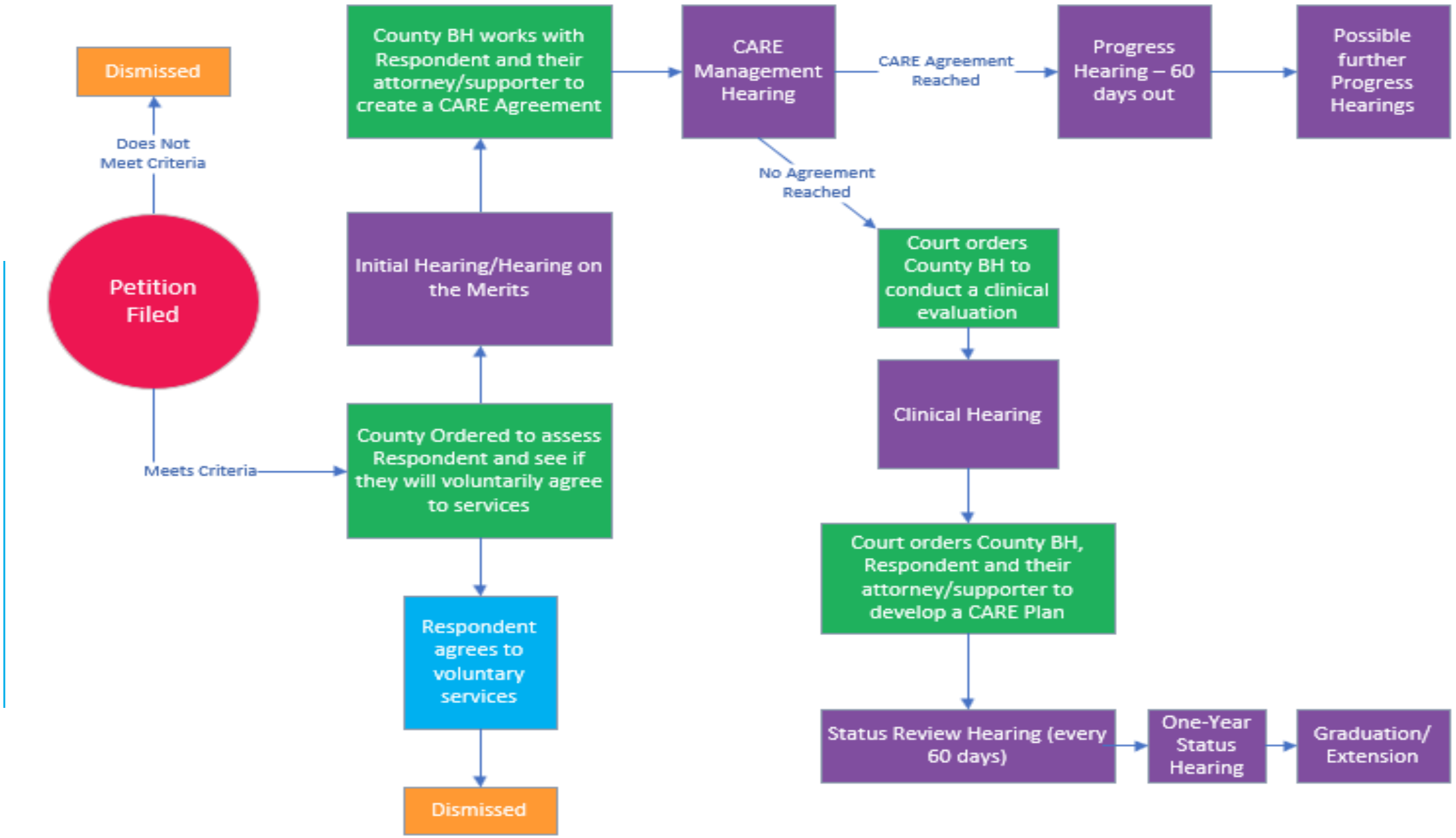
What happens if there is no voluntarily agreement?



What happens if a CARE Agreement is not reached?



CARE Court Flow Chart



What's the Difference?

Voluntary Engagement

- After court is petitioned
- County BH completed evaluation and submits CARE report
- Voluntary Engagement
- Respondent voluntarily decides to engage in services
- Court case closed

CARE Agreement

- Respondent does not initially voluntarily agree to services
- Respondent works with attorney/supporter and County BH to come to an agreement for services
- Will include an outline of treatment, medication*, housing, other support services.
- May include court oversight

CARE Plan

- Respondent does not voluntarily engage in services (CARE Agreement not reached)
- Court-Ordered psychiatric evaluation
- Goal is to still have Respondent and their attorney/supporter work with County BH to create a CARE plan that the court will adopt
- Will always include court oversite

*While stabilization medications can be court ordered, they **CANNOT** be forcibly administered **AND** the Respondent **CANNOT** be penalized for failure to comply with the medication order

What is in a CARE Agreement/Plan?

What if Respondent Does Not Participate in CARE Court?

- Court can terminate the CARE process if the Respondent does not comply
- If services can continue, County Behavioral Health and Community Supports providers can continue outreach to the respondent to offer treatment and other services/supports
- If eligible, the court/qualified petitioner may refer the respondent for the LPS rout (initial 5150, LPS conservatorship
  - To move forward with this, respondent must meet the threshold for referrals to LPS

Other Resources

NAMI California
National Alliance on Mental Illness

https://namica.org/care/

CalHHS

https://www.chhs.ca.gov/care-act-petitioners/

Shasta County
Health & Human
Services Agency

shastacounty.gov/hhsa

@ShastaHHSA

CARE Court will be available in Shasta County by 12/01/2024

CONFIDENTIAL

CARE-100

ATTORNEY OR PETITIONER WITHOUT ATTORNEY	STATE BAR NUMBER:	*FOR COURT USE ONLY*
NAME:		
FIRM NAME:		
STREET ADDRESS:		
CITY:	STATE: ZIP CODE:	
TELEPHONE NO.:	FAX NO.:	
EMAIL ADDRESS:		
ATTORNEY FOR (*name*):		
SUPERIOR COURT OF CALIFORNIA, COUNTY OF		
STREET ADDRESS:		
MAILING ADDRESS:		
CITY AND ZIP CODE:		
BRANCH NAME:		
CARE ACT PROCEEDINGS FOR *(name):* RESPONDENT		
PETITION TO COMMENCE CARE ACT PROCEEDINGS		CASE NUMBER:

For information on completing this form, see *Information for Petitioners—About the CARE Act* (form CARE-050-INFO).

1. Petitioner *(name):*
   is 18 years of age or older and *(check all that apply):*

   a. ☐ A person who lives with respondent.

   b. ☐ A spouse or registered domestic partner, parent, sibling, child, or grandparent of respondent.

   c. ☐ A person who stands in the place of a parent to respondent.

   d. ☐ The director* of a hospital in which respondent is hospitalized.

   e. ☐ The director* of a public or charitable organization, agency, or home

      (1) ☐ who is or has been, within the past 30 days, providing behavioral health services to respondent; or

      (2) ☐ in whose institution respondent resides.

   f. ☐ A licensed behavioral health professional* who is or has been, within the past 30 days, treating or supervising the treatment of respondent.

   g. ☐ A first responder, including a peace officer, firefighter, paramedic, emergency medical technician, mobile crisis response worker, or homeless outreach worker who has had repeated interactions with respondent.

   h. ☐ The public guardian* or public conservator* of the county named above or a private conservator referred by the court under Welfare and Institutions Code section 5978.

   i. ☐ The director* of the county behavioral health agency of the county named above.

   j. ☐ The director* of adult protective services of the county named above.

   k. ☐ The director* of a California Indian health services program or a California tribal behavioral health department.

   l. ☐ A California tribal court judge.*

   m. ☐ Respondent.

   * This person may designate someone else to file the petition on their behalf. If the petitioner is a designee, check this category and put designee's name in item 1, above.

2. a. Petitioner asks the court to find that respondent *(name):*
   is eligible to participate in the CARE Act process and to commence CARE Act proceedings for respondent.

   b. Petitioner's relationship to respondent *(specify and describe relationship):*

CARE ACT PROCEEDINGS FOR *(name)*: RESPONDENT	CASE NUMBER:

2. c. ☐ Petitioner's interactions with respondent *(if petitioner is specified in 1d, 1e, 1f, or 1g, specify the number of interactions with respondent and the date of the most recent interaction, and describe the nature and outcome of each interaction):*

☐ If you need additional space, please include on a separate piece of paper and label as Attachment 2c.

3. Respondent lives or was last found at *(give respondent's residential address, if known and one exists; otherwise, state that the address is unknown and provide the last known location and any additional contact information, such as a phone number, including whether the number can receive texts, or an email address):*

☐ If you need additional space, please include on a separate piece of paper and label as Attachment 3.

4. Respondent *(check all that apply):*
   a. ☐ Is a resident of the county named above.
   b. ☐ Is currently located in the county named above.
   c. ☐ Is a defendant or respondent in a criminal or civil proceeding pending in the superior court of the county named above.
   d. ☐ Is a resident of *(specify county if known and different from the county named above):*

5. Respondent meets each of the following requirements and is eligible to participate in the CARE Act process and receive services and support under a CARE agreement or CARE plan *(provide information below to support each requirement):*
   a. Respondent is 18 years of age or older. Date of birth *(if known):*
      Age in years *(if exact age not known, give approximate age):*
   b. Respondent has a diagnosis of a schizophrenia spectrum disorder or another psychotic disorder in the same class, as defined in the current *Diagnostic and Statistical Manual of Mental Disorders*. Diagnosis and additional information are provided
      ☐ on *Mental Health Declaration—CARE Act Proceedings* (form CARE-101), attached as Attachment 6a.
      ☐ on separate documents, attached and labeled as Attachment 5b.
      ☐ below.

CARE ACT PROCEEDINGS FOR *(name)*: RESPONDENT	CASE NUMBER:

5. c. Respondent is currently experiencing a severe mental illness, as defined in Welfare and Institutions Code section 5600.3(b)(2), in that the illness:
   (1) Is severe in degree and persistent in duration;
   (2) May cause behavior that interferes substantially with respondent's primary activities of daily living; ***and***
   (3) May result in respondent's inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period.

   Supporting information regarding the severity, duration, and risks of respondent's disorder is provided
   ☐ on *Mental Health Declaration—CARE Act Proceedings* (form CARE-101), attached as Attachment 6a.
   ☐ on separate documents, attached and labeled as Attachment 5c.
   ☐ below.

d. Respondent is not currently stabilized in ongoing voluntary treatment. Respondent's current stability and treatment are described
   ☐ on *Mental Health Declaration—CARE Act Proceedings* (form CARE-101), attached as Attachment 6a.
   ☐ on separate documents, attached and labeled as Attachment 5d.
   ☐ below.

CARE ACT PROCEEDINGS FOR *(name)*: RESPONDENT	CASE NUMBER:

5. e. At least one of these is true *(complete (1) or (2) or both):*

(1) ☐ Respondent is unlikely to survive safely in the community without supervision ***and*** respondent's condition is substantially deteriorating. Reasons that respondent is unlikely to survive safely in the community, the type of supervision respondent would need to survive safely, and the extent to which respondent's physical or mental condition has recently grown worse are described

- ☐ on *Mental Health Declaration—CARE Act Proceedings* (form CARE-101), attached as Attachment 6a.
- ☐ on separate documents, attached and labeled Attachment 5e(1).
- ☐ below.

(2) ☐ Respondent needs services and supports to prevent a relapse or deterioration that would be likely to lead to grave disability or serious harm to respondent or others. The services and supports needed by respondent and the reasons respondent would become gravely disabled or present a risk of harm to self or others are described

- ☐ on *Mental Health Declaration—CARE Act Proceedings* (form CARE-101), attached as Attachment 6a.
- ☐ on separate documents, attached and labeled Attachment 5e(2).
- ☐ below.

CARE ACT PROCEEDINGS FOR *(name)*: RESPONDENT	CASE NUMBER:

5. f. Participation in a CARE plan or CARE agreement would be the least restrictive alternative necessary to ensure respondent's recovery and stability. A description of available alternative treatment plans and an explanation why no alternative treatment plan that would be less restrictive of respondent's liberty could ensure respondent's recovery and stability are provided
   - ☐ on *Mental Health Declaration—CARE Act Proceedings* (form CARE-101), attached as Attachment 6a.
   - ☐ on separate documents, attached and labeled Attachment 5f.
   - ☐ below.

   g. Respondent is likely to benefit from participation in a CARE plan or CARE agreement. Reasons in support of this assertion are provided
   - ☐ on *Mental Health Declaration—CARE Act Proceedings* (form CARE-101), attached as Attachment 6a.
   - ☐ on separate documents, attached and labeled Attachment 5g.
   - ☐ below.

6. **Required Documentation**

   The evidence described below is attached in support of this petition. *(Attach the documents listed in a or b, or both, and check the box next to the description of each document or set of documents attached).*

   a. ☐ A completed *Mental Health Declaration—CARE Act Proceeding* (form CARE-101), the declaration of a licensed behavioral health professional stating that, no more than 60 days before this petition was filed, the professional or a person designated by them
      - (1) ☐ examined respondent and determined that respondent met the diagnostic criteria for eligibility to participate in the CARE Act proceedings; or
      - (2) ☐ made multiple attempts to examine respondent but was not successful in obtaining respondent's cooperation and has reasons, explained with specificity, to believe that respondent meets the diagnostic criteria for eligibility to participate in CARE Act proceedings.

      Attach *Mental Health Declaration—CARE Act Proceedings* (form CARE-101) and label it Attachment 6a.

CARE ACT PROCEEDINGS FOR *(name)*: RESPONDENT	CASE NUMBER:

6. b. ☐ Evidence that respondent was detained for at least two periods of intensive treatment, the most recent period within the past 60 days. Examples of evidence: a copy of the certification of intensive treatment, a declaration from a witness to the intensive treatment, or other documentation indicating involuntary detention and certification for up to 14 days of intensive treatment. *(Attach all supporting documents and label each, in order, Attachment 6b1, 6b2, 6b3, etc.)*

   Note: For purposes of the CARE Act, "intensive treatment" refers to involuntary treatment authorized by Welfare and Institutions Code section 5250. It does ***not*** refer to treatment authorized by any other statutes, including but not limited to Welfare and Institutions Code sections 5150, 5260, and 5270.15.

Optional information

7. Tribal affiliation
   a. ☐ Respondent is an enrolled member of a federally recognized Indian tribe.
   Tribe's name and mailing address:

   b. ☐ Respondent is receiving services from a California Indian health services program, a California tribal behavioral health department, or a California tribal court.
   Name and mailing address of program, department, or court:

8. ☐ This petition is based on a referral from another court proceeding.
   a. Court, department, and judicial officer:

   b. Case number:
   c. Type of proceeding from which respondent was referred:
      (1) ☐ Misdemeanor competence to stand trial (Penal Code, § 1370.01)
      (2) ☐ Assisted outpatient treatment (Welf. & Inst. Code, §§ 5346–5348)
      (3) ☐ Lanterman-Petris-Short Act conservatorship (Welf. & Inst. Code, §§ 5350–5372)
      ☐ Court order attached and labeled as Attachment 8 (optional).

9. Check any of the following statements that is true:
   a. ☐ Respondent needs interpreter services or an accommodation *(specify):*

   b. ☐ Respondent is under juvenile court jurisdiction *(specify which court):*
   c. ☐ Respondent is currently under conservatorship (*specify which court):*
   d. ☐ Respondent is served by a Regional Center *(specify which):*
   e. ☐ Respondent is a current or former member of the state or federal armed services or reserves *(specify which branch):*

10. Number of pages attached: _____

Date:

(TYPE OR PRINT NAME OF ATTORNEY) ▶ (SIGNATURE OF ATTORNEY)

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date:

(TYPE OR PRINT NAME OF PETITIONER) ▶ (SIGNATURE OF PETITIONER)

CONFIDENTIAL

CARE-101

ATTORNEY OR PARTY WITHOUT ATTORNEY	STATE BAR NUMBER:	*FOR COURT USE ONLY*
NAME:		
FIRM NAME:		
STREET ADDRESS:		
CITY:	STATE: ZIP CODE:	
TELEPHONE NO.:	FAX NO.:	
EMAIL ADDRESS:		
ATTORNEY FOR *(name)*:		
SUPERIOR COURT OF CALIFORNIA, COUNTY OF		
STREET ADDRESS:		
MAILING ADDRESS:		
CITY AND ZIP CODE:		
BRANCH NAME:		
CARE ACT PROCEEDINGS FOR *(name)*: RESPONDENT		
MENTAL HEALTH DECLARATION—CARE ACT PROCEEDINGS		CASE NUMBER:

TO LICENSED BEHAVIORAL HEALTH PROFESSIONAL
This form will be used to help the court determine whether respondent meets the diagnostic criteria for CARE Act proceedings.

GENERAL INFORMATION

1. Declarant's name:

2. Office address, telephone number, and email address:

3. **License status** *(complete either a or b)*:

   a. ☐ I am a licensed behavioral health professional and conducting the examination described on this form is within the scope of my license. I have a valid California license as a *(check one)*:

      (1) ☐ physician.
      (2) ☐ psychologist.
      (3) ☐ clinical social worker.
      (4) ☐ marriage and family therapist.
      (5) ☐ professional clinical counselor.

   b. ☐ I have been granted a waiver of licensure by the State Department of Health Care Services under Welfare and Institutions Code section 5751.2 because *(check one)*:

      (1) ☐ I am employed as a ☐ psychologist ☐ clinical social worker continuing my employment in the same class as of January 1, 1979, in the same program or facility.

      (2) ☐ I am registered with the licensing board of the State Department of Health Care Services for the purpose of acquiring the experience required for licensure and employed or under contract to provide mental health services as a *(check one)*:

         (a) ☐ clinical social worker.
         (b) ☐ marriage and family therapist.
         (c) ☐ professional clinical counselor.

      (3) ☐ I am employed or under contract to provide mental health services as a psychologist who is gaining experience required for licensure.

CARE ACT PROCEEDINGS FOR *(name)*: RESPONDENT	CASE NUMBER:

3. b. (4) ☐ I have been recruited for employment from outside this state, and my experience is sufficient to gain admission to a California licensing examination. I am employed or under contract to provide mental health services as a *(check one):*
   - (a) ☐ psychologist.
   - (b) ☐ clinical social worker.
   - (c) ☐ marriage and family therapist.
   - (d) ☐ professional clinical counselor.

4. Respondent *(name):*
   ☐ is ☐ is not a patient under my continuing care and treatment.

EXAMINATION OR ATTEMPTS MADE AT EXAMINATION OF RESPONDENT

5. Complete one of the following: *(both a and b must be within 60 days of the filling of the CARE Act petition)*
   a. ☐ I examined the respondent on *(date):* *(proceed to item 7).*
   b. ☐ On the following dates: I attempted to examine respondent but was unsuccessful due to respondent's lack of cooperation in submitting to an examination.

6. *(Answer only if 5b is checked.)* Explain in detail when, how many attempts, and the types of attempts that were made to examine respondent. Also explain respondent's response to those attempts and the outcome of each attempt.

7. Based on the following information, I have reason to believe respondent meets the diagnostic criteria for CARE Act proceedings *(each of the following requirements **must** be met for respondent to qualify for CARE Act proceedings):*
   a. Respondent has a diagnosis of a schizophrenia spectrum disorder or another psychotic disorder in the same class *(indicate the specific disorder):*

Note: Under Welfare and Institutions Code section 5972, a qualifying psychotic disorder must be primarily psychiatric in nature and not due to a medical condition such as a traumatic brain injury, autism, dementia, or a neurological condition. A person who has a current diagnosis of substance use disorder without also meeting the other statutory criteria, including a diagnosis of schizophrenia spectrum or other psychotic disorder, does not qualify.

   b. Respondent is experiencing a severe mental illness that *(**all** of the following must be completed):*
      (1) Is severe in degree and persistent in duration *(explain in detail):*

CARE ACT PROCEEDINGS FOR *(name)*: RESPONDENT	CASE NUMBER:

7. b. (2) May cause behavior that interferes substantially with the primary activities of daily living *(explain in detail):*

(3) May result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period *(explain in detail):*

c. Respondent is not clinically stabilized in ongoing voluntary treatment *(explain in detail):*

d. At least one of these is true *(complete one or both of the following):*

(1) ☐ Respondent is unlikely to survive safely in the community without supervision **and** respondent's condition is substantially deteriorating *(explain in detail):*

(2) ☐ Respondent needs services and supports to prevent a relapse or deterioration that would likely result in grave disability or serious harm to respondent or others *(explain in detail):*

CARE ACT PROCEEDINGS FOR *(name)*: RESPONDENT	CASE NUMBER:

7. e. Participation in a CARE plan or CARE agreement would be the least restrictive alternative necessary to ensure respondent's recovery and stability *(explain in detail):*

f. Respondent is likely to benefit from participation in a CARE plan or CARE agreement *(explain in detail):*

8. ☐ Additional information regarding my examination of respondent is ☐ as follows ☐ on Attachment 8.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date:

(TYPE OR PRINT DECLARANT'S NAME)

(SIGNATURE OF DECLARANT)

IMPACT

Mental Health Services Act (MHSA)
Prevention and Early Intervention (PEI) Program

Vendor:
INVO Healthcare Associate, LLC

WELLNESS • RECOVERY • RESILIENCE

Shasta County
Health & Human
Services Agency

What is IMPACT?

Integrated
Multi-disciplinary
Program to
Address
Childhood
Trauma

- Combination Of Mental Health and Applied Behavior Analysis (ABA)
- Support for teachers and administrators
- Serves Shasta County Youth
- Address Adverse Childhood Experiences (Aces)

INVO healthcare

SHASTA COUNTY OFFICE OF EDUCATION

Shasta County Health & Human Services Agency

IMPACT provides:

- Decrease in behavior incidents
- Flexibility in program design
- No-cost to the youth or the family
- Outcomes Validated by Clemson University's Center for Behavior Analysis

Students learn to:

- Build relationships
- Increase learning potential

IMPACT Case Study

Boy, Age 11

Referred for difficulties in:
Concentration I Work Completion I Social Skills I Attendance

Calvin has had one hospitalization in a five-month period of time. He was prescribed psychotropic medications. He was officially diagnosed with Disruptive Mood Dysregulation (DMDD).

Adverse Childhood Experiences (ACEs)

- Father's incarceration and registered as a sex offender
- Illness and death of his mother
- Victim of sexual abuse
- Lives with grandparents with dementia
- Poverty

Measured Outcomes at 30 Days

- 185% Increase in academic engagement
- 65% Increase in school attendance

Shasta County Schools that have been Supported by IMPACT Staff

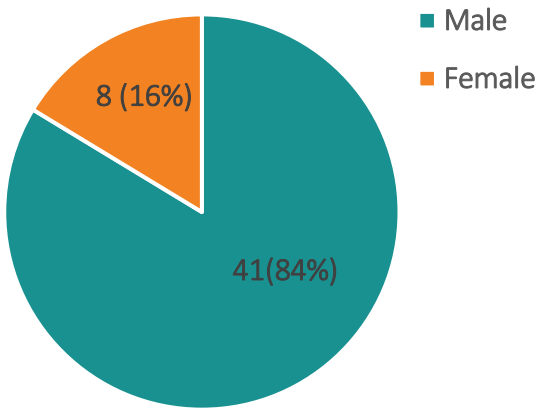
1	Anderson Heights Elementary School
2	Anderson High School
3	Anderson Middle School
4	Anderson New Technology High School
5	Bella Vista Elementary School
6	Black Butte Elementary
7	Bonny View Elementary School
8	Boulder Creek Elementary School
9	Buckeye School of the Arts
10	Burney Jr/Sr High School
11	Central Valley High School
12	Chrysalis Charter School
13	Columbia Elementary School
14	Cypress Elementary School
15	EXCEL Academy

16	Foothill High School
17	Grand Oaks Elementary School
18	Grant Elementary School
19	Happy Valley Elementary School
20	Junction School
21	Juniper School
22	Lassen View Elementary School
23	Manzanita Elementary School
24	Meadow Lane Elementary School
25	Mistletoe Elementary School
26	Mountain Lakes High School
27	Mountain View Continuation High School
28	Mountain View Middle School
29	North Cottonwood Elementary School
30	North State Aspire Academy

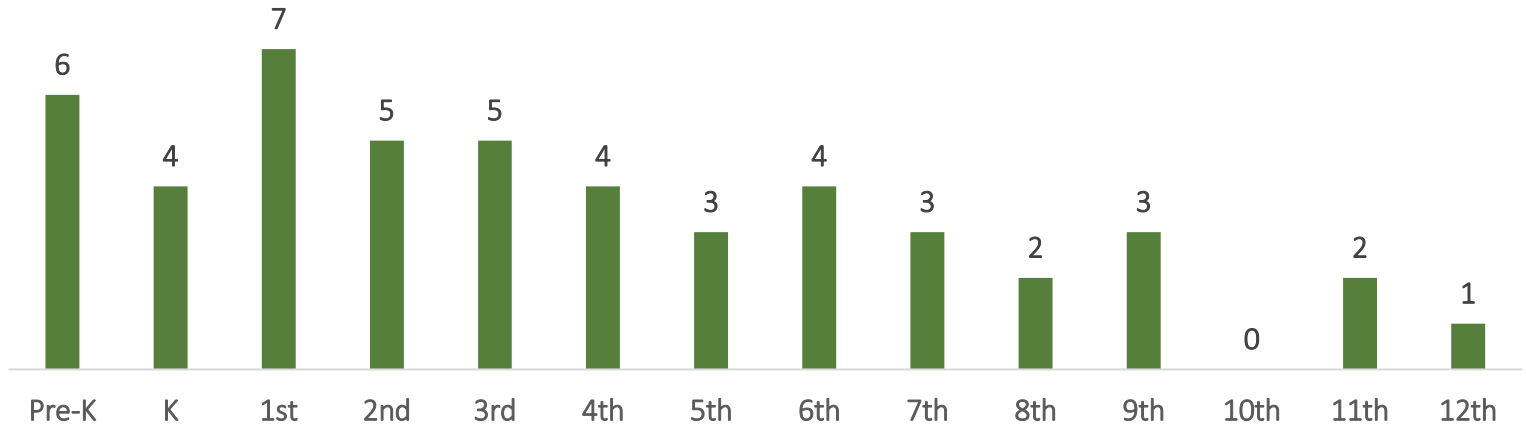
31	Northern Summit Academy
32	PACE Academy
33	Pacheco Elementary School
34	Parsons Jr. High
35	Redding School of the Arts
36	Redding STEM Academy
37	Rother Elementary School
38	Sequoia Middle School
39	Shasta County Independent Study
40	Shasta High School
41	Shasta Lake School
42	Shasta Meadows Elementary School
43	Sycamore Elementary School
44	Turtle Bay Elementary School
45	West Cottonwood Jr. High School

Demographics Oct. 2022 – Oct. 2023

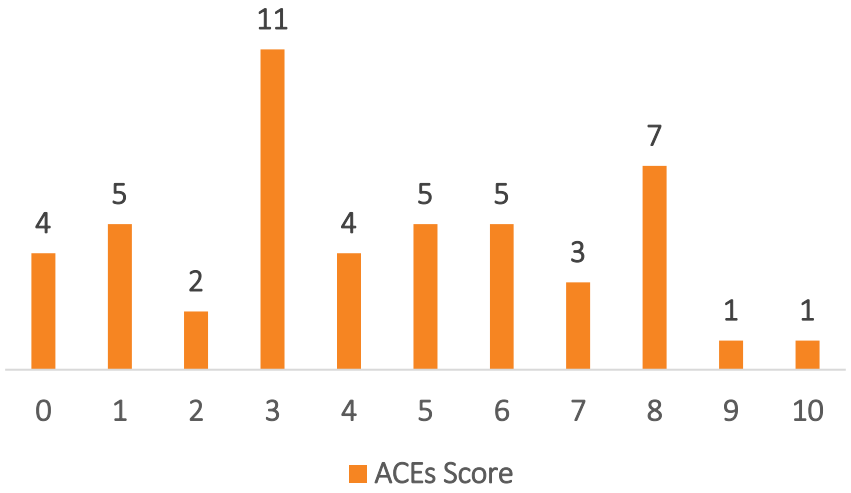
Student Gender



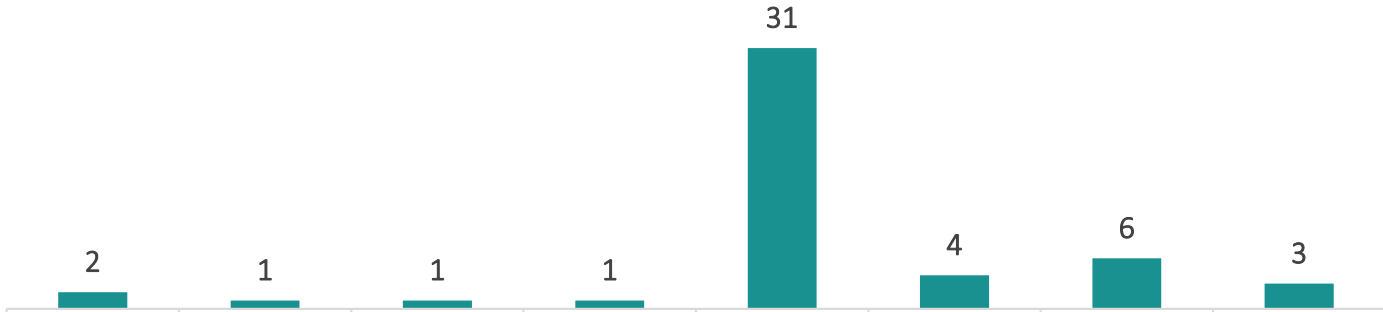
Number and Grade Students



Student ACEs Score



Student Race/Ethnicity



	American Indian/Alaska Native	Asian	Hispanic or Latino	Native Hawaiian and Other Pacific	White Non-Latino/Caucasian	Multiple Races	Prefer not to answer	Unknown
Race/Ethnicity	2	1	1	1	31	4	6	3

Outcomes Data	Oct. 2022 – June 2023		July 2023 – Dec. 2023
New Referrals Received	45 (5 per month)	~	19 (3 per month)
Number of New Shasta County Referrals	23 (3 per month)	~	15 (3 per month)
Number of New SCOE Referrals	22 (2 per month)	~	4 (1 per month)
Total Active Received Services This Month	274 (30 per month)	~	183 (31 per month)
BSS Individual, Family, and Teacher Sessions	670 (74 per month)	↑	527 (105 per month)
MH Assessments Treatment Plans Completed	50 (6 per month)	~	25 (4 per month)
MH Individual, Group, and Family Counseling	381 (42 per month)	↑	268 (54 per month)
BCBA Assessment and Treatment Plans	17 (4 per month) March – June Only	↑	42 (8 per month)
BCBA Individual, Family, and Teacher Sessions	24 (6 per month) March – June Only	~	50 (5 per month)
Total Clients Discharged-Successful	14 (2 per month)	~	6 (1 per month)

Reporting Deliverables (July 23 – Dec 24)

- PEI Surveys (Monthly) – Received All
- Updated Client List (Monthly) – Received All
- Statistical Report (Monthly) – Received All
- Quarterly Report (Oct, Jan, Apr, July) – Received All
- Semi-Annual Narratives (Nov & May) – Received All
- PM Quarterly Report (Oct, Jan, Apr, July) – Received All

Data Deliverables

- Provide Services to 200 Clients per year

Mental Health, Alcohol and Drug Advisory Board (MHADAB)

DIRECTOR'S REPORT

March 13, 2024.

Mental Health, Alcohol & Drug Advisory Board Previous Meeting Documents | Shasta County California

Shasta County
Health & Human
Services Agency

Board of Supervisors Updates: January - February

January 9, 2024

- **C5** Approve a retroactive amendment with Partnership HealthPlan of California for Enhanced Care Management Services (ECMS) which updates rates and adds indemnification language for using Collective Medical Technologies to provide ECMS to members.

January 23, 2024

- **C4** Approve an agreement with The Regents of the University of California on behalf of University of California, Davis, to provide youth psychological evaluations.

January 30, 2024

No contract update.

Board of Supervisors Updates Continued…

February 6, 2024

- **C2** Approve an agreement with California Mental Health Services Authority for participation in the Workforce Education and Training program.

February 27, 2024

- **C6** Approve a retroactive renewal agreement with the Shasta County Office of Education (SCOE) for foster youth education services and designate signing authority for amendments and termination.

MH & SUD Services Update

Crisis Services (ER) Activity Report January 2024

ER/ED Activity: There were **139** crisis evaluations performed at the Emergency Departments. Shasta Regional Medical Center had **83** evaluations, while Mercy Medical Center had **55** evaluations in November 2023.

Percentage of visits by hospital:

Shasta Regional Medical Center	60%
Mercy Medical Center	40%
Mayers Memorial Hospital	0%

Diagnosis:

Depressive Disorders	15%
Psychotic Disorders (not Schizophrenia)	12%
Bipolar Disorders	25%

Toxicology:

THC	59%
Amphetamines/Meth	36%
Fentanyl	11%

5150s Upheld:

- Of clients 5150'd, 24% were ultimately upheld and hospitalized.
- Of clients initially designated 1799.111 then became a 5150, 57% were upheld and ultimately hospitalized.
- Of 5150s to be released, 97% were reported as "Does not Meet Criteria."

MH & SUD Services Update

Notice of Adverse Benefit Determinations (NOABDs)

Quarterly reports detail Notice of Adverse Benefit Determinations (NOABDs) for both Adult and Children's Services Branches. NOABDs are issued when the plan decides to deny or terminate treatment.

In January 2024, 10 NOABDs were issued to Adult Services clients, and 1 NOABDs were issued to Children's Services clients.

MH & SUD Services Update

Notice of Adverse Benefit Determinations (NOABDs)

Delivery System Notices & Terminations 300

Most Common Reasons Cited for NOABDs in November 2023	Total Adult (10)	Total Child (1)
Not able to contact client, various reasons.	**6 (60%)**	**1 (100%)**
Mental health condition would be responsive to treatment by a physical health care provider.	**0 (N/A)**	**0 (N/A)**

MH & SUD Services Update

Mental Health Services Act (MHSA) Annual Update

The Mental Health Services Act (MHSA) provides approximately 25% of California's Mental Health services funding. The 3-Year Plan outlines available county mental health services and goals. MHADAB was created, in part, to oversee and guide the use of MHSA funding.

For an overview of current MHSA programs, look through Shasta County's most recently published 3-Year Plan.

The Annual Update to our current 3-Year Plan is in progress, your feedback on these programs is valued. Please reach out to our MHSA team with any commentary or suggestions regarding the Annual Update at mhsa@co.shasta.ca.us.

Learn more about Shasta County's MHSA activities at www.ShastaMHSA.com.

Mental Health Services Act (MHSA)
Workforce Education and Training (WET) Update

Workforce Education and Training (WET) is a category funded by the Mental Health Services Act (MHSA).

- Shasta County BHSS has entered a Superior Region Partnership with 15 northern California counties
- BHSS staff have been invited to apply for a Loan Repayment Program (educational loans)
  - Serving in hard-to-fill and hard-to-retain positions
  - Must commit to 18 months of service
  - May receive up to $20,000 paid to the financial institution
  - Administered by California Mental Health Services Authority (CalMHSA)
  - Application period is open and closes on March 8 at 5pm PST.

soluna

Mental health coaching and resources for teens and young adults ages 13-25

Learn More

BrightLife Kids

Mental health coaching and resources for parents with kids ages 0-12

Learn More

https://www.calhope.org/

"Engaging individuals, families and communities to protect and improve health and wellbeing."

Miguel Rodriguez, *LCSW, Behavioral Health and Social Services Branch Director*
Bailey Cogger, *Behavioral Health and Social Services Interim Deputy Branch Director*
Laura Stapp, *Behavioral Health and Social Services Deputy Branch Director*
Health & Human Services Agency | Shasta County California

Mental Health, Alcohol and Drug Advisory Board

Annual Report 2022

Shasta County
Health & Human Services Agency

Our Membership

Ronald Henninger (Chair)
Kalyn Jones (Vice Chair)

Alan Mullikin
Angel Rocke
Anne Prielipp
Charles Menoher
Christine Stewart
Cindy Greene
Connie Webber
Dale Marlar
David Kehoe
Heather Jones
Jo-Ann Medina
Mary Rickert
Sam Major

Table of Contents:

Dear Shasta County Board of Supervisors:

The members of the Shasta County Mental Health, Alcohol and Drug Advisory Board (SCMHADAB) are pleased to present to you the SCMHADAB 2022 Annual Report.

Sincerely,
Ron Henninger
Shasta County Mental Health, Alcohol and Drug Advisory Board Chair

Board Mission and Responsibilities

The mission of the Board is to inform and educate the public on alcohol, drug and mental health issues as well as to advise the Shasta County Mental Health Plan on program development, availability of services and planning efforts as established by Welfare and Institutions Code Section 5604.2. This includes the following responsibilities:

1. Review and evaluate the community's mental health, alcohol and/or drug treatment needs, services and special problems as related to the above.
2. Review performance contracts.
3. Advise the Board of Supervisors, the Shasta County Director of Mental Health Services and the County Alcohol and Drug Program Administrator to any aspect of Shasta County's mental health, alcohol and drug treatment and prevention services.
4. Ensure citizen, consumer and professional involvement in the Shasta County Mental Health Plan's delivery planning efforts.
5. Submit an annual report to the Board of Supervisors on the needs, challenges and performance of Shasta County's mental health, alcohol and drug treatment and prevention services.
6. Review, interview and make recommendations on applicants for appointment of the Director and Administrator.
7. Review and comment on Shasta County's performance outcome data and communicate its findings to the State of California Mental Health Planning Council and/or other appropriate entities.
8. Assess the impact of the realignment of services from the State of California on mental health services delivered to clients and within the Shasta County community.
9. Review draft Mental Health Services Act (Proposition 63, General Election of November 2004) plans and annual updates, make recommendations to the Director regarding the plans and updates, and make recommendations to the County Mental Health Department for revisions, as needed (per Welfare and Institutions Code Section 5848(b)).
10. Conduct public hearings on draft Mental Health Services Act plans, annual updates and other matters as appropriate.

Meetings: Action Items and Presentations

January

Discussions and Actions:

- Approved the Shasta County Data Notebook 2021

Presentations:

- **Adult Services ACCESS to Mental Health and Substance Use Disorder Services** – A PowerPoint presentation was presented by Deidra Ward, Mental Health Clinician. She provided an overview of services offered to clients and different avenues of treatment through the ACCESS Clinicians and County programs. ACCESS Clinicians are available to see walk-in clients between 8:00 and 3:30 p.m.

- **Children's Services Branch Behavioral Health Clinical Services** – A PowerPoint presentation was presented by Children's Services Branch Director Miguel Rodriguez, Deputy Branch Director Dwayne Green, HHSA Program Managers Cindy Lane, Tara Shanahan, Mary Jane Mathis, Pamela Ottinger, Laura Stapp, and Kiley Castaneda**.** They talked about different services that Children's branch offers including investigations and detentions, after hours response and family urgent response services, court interventions, intensive services, collaboration with local partners.

March

Discussions and Actions:

- The board welcomed new members Angel Rocke and Anne Prielipp
- Announcement of HHSA Director Donnell Ewert will retire in April of 2022. Donnell was with the county for 23 years.
- Presentation guidelines were sent out to all board members.

Presentations:

- **MORS II Outcome Data Tracking** – A PowerPoint presentation was presented by Paige Greene, Adult Services Branch Director. The Milestone of Recovery Scale (MORS) was created to capture aspects of recovery from the agency perspective such as client engagement and measurable progress.

- **Full-Service Partnership** – A PowerPoint presentation was presented by Genell Restivo, Clinical Division Chief of the Adult Services Branch. She described that Full-Service Partnership is a comprehensive and intensive program for adults with severe and persistent mental illness. This takes a "business as usual" approach away and utilizes a "whatever it takes" field-based approach using innovative interventions to help people reach their recovery goals.

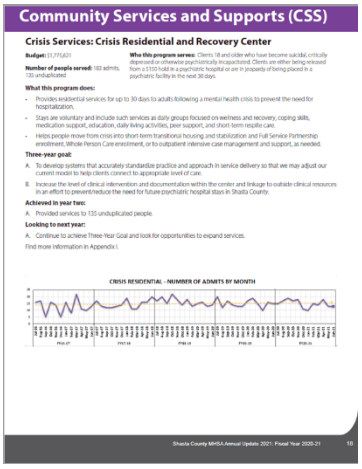
- **Continuation of Children's Services Branch Behavioral Health Clinical Services**– Laura Stapp, Clinical Division Chief and Kiley Castaneda, Clinical Division Chief presented on the remaining children services from the prior month.

May

Discussion and Action Items:

- Approval of the MHADAB 2021 Annual Report for Submission to the Shasta County Board of Supervisors.
- Ron Henninger, MHADAB Chair discussed security issues and the cost of security staff during a recent meeting at Woodlands Apartment Complex.

Presentations:



- **MHSA Annual Update Presentation** – A PowerPoint presentation was presented by Kerri Schuette, Deputy Branch Director. The update included the second and final updated for the current three-year program and expenditure plan. Changes to the report format based on recommendation to make it more clear, concise and easy to read.
- **Youth Innovation Toolkit** – A PowerPoint presentation was presented by Kalyn Jones, MHADAB Vice-Chair. The presentation included a guide to increase youth engagement and provide a tangible guild to self-advocacy, development tools, and youth-led labs to inform computer resources.
- **California Peer-Run Warming Line** – Kayln Jones Kalyn Jones, MHADAB Vice-Chair, described the Warming Line as a nonemergency resource call line and web chat for Californians seeking mental health and emotional support, where counselors are peers. The line provides 24/7 immediate support to help prevent mental health crisis.

June (Special Meeting)

Discussion and Action Items:

- Approved 2022 Mental Health Services Act Annual Update to the Three-year Program and Expenditure Plan, which covers Fiscal Years 2020-21. Recommend that Shasta County Board of Supervisors approve the plan as well.

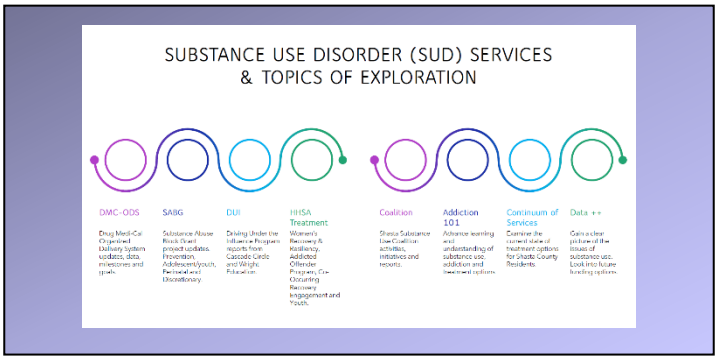
July

Discussion and Action Items:

- Updated members on meetings to discuss shared goals with Shasta County Board of Supervisors
- Establish a subcommittee to complete the Shasta County 2022 Data Notebook and Survey for Behavioral Health Boards and Commissions
- Establish a subcommittee for Substance Use Disorder in collaboration with Shasta Substance Use Coalition, with board assignment and committee reports.
- **Case Manager Services Upon Release from County Jail** – Board member Dale Marlar provided a discussion about Discharge planning is active in the jail. With 9,000 bookings per year, each is assessed by medical personnel upon entry and again prior to release. Limitations imposed by current law and case law dictate the role of law enforcement in determining release and services upon release. Public commentary spoke to frustrations with 5150 detainment protocols related to their use as a default means to access services on behalf of someone with SMI who is unwilling or unable to do so themselves. Lieutenant Marlar noted that it is more difficult to initiate the conservatorship process from jail than from a hospital or mental health facility. Members of the public wishing to provide medication history or other pertinent information on behalf of someone who has been booked may call the jail and request to speak with Lieutenant Marlar directly.

Presentations:

- Substance Use Disorder (SUD) Services and Topics of Exploration – A PowerPoint presentation was presented by Katie Cassidy, Adult Services Program Manager. Several areas were highlighted of exploration relevant to current issues, including the Drug Medi-Cal Organized Delivery System (DMC-ODS), Substance Abuse Block Grant (SABG) funding, current SUD research, and more.



- **Shasta County's Rising Fentanyl Problem Story Map** – A storymap presentation was presented by Jacob Hahn, Agency Staff Services Analyst. Fentanyl is synthetic opioid that is 80-100 times stronger than morphine and is commonly found mixed with other drugs. Statistics were shown about Shasta County's problem.

August (Special Meeting)

- Tour of Visions of the Cross

September

Discussion and Action Items:

- Approve 2023 MHADAB meeting dates
- Approve Substance Use Disorder (SUD) Subcommittee
- The 4th Annual Recovery Happens "Fun in Recovery" Event was be held Saturday, September 10, 2022.
- Adult Services hosts its Open House September 21, 2022
- Approved teleconferencing meetings in the form of hybrid meetings considered under emergency circumstances.

Presentation:

- Mental Health Services Budget – A PowerPoint presentation from Megan Dorney, Business and Support Services Branch Director was provided. The presentation included an overview of Mental Health Finances including upcoming changes to CalAIM Implementation, CARE Court, mobile services and increased collaboration with county partners.

Budget Unit	2020-21		2021-22		2022-23	
	General Fund	Federal/ State	General Fund	Federal/ State	General Fund	Federal/ State
410-Mental Health	$276,778	$33,238,389	$276,778	$36,745,581	$276,778	$39,076,500
422-Alcohol and Drug	$3,195	$7,514,595	$3,195	$8,959,800	$3,195	$10,021,795
425-Perinatal	$15,017	$762,197	$15,017	$1,007,338	$15,017	$883,134
Total	**$294,990**	**$41,515,181**	**$294,990**	**$46,712,719**	**$294,990**	**$49,981,429**

October (Special Meeting)

Discussion and Action Items:

- 2022 Assignment and Committee schedule was provided

Presentations:

- Brown Act training was provided to the Board Members from Rubin Cruse Jr., County Counsel

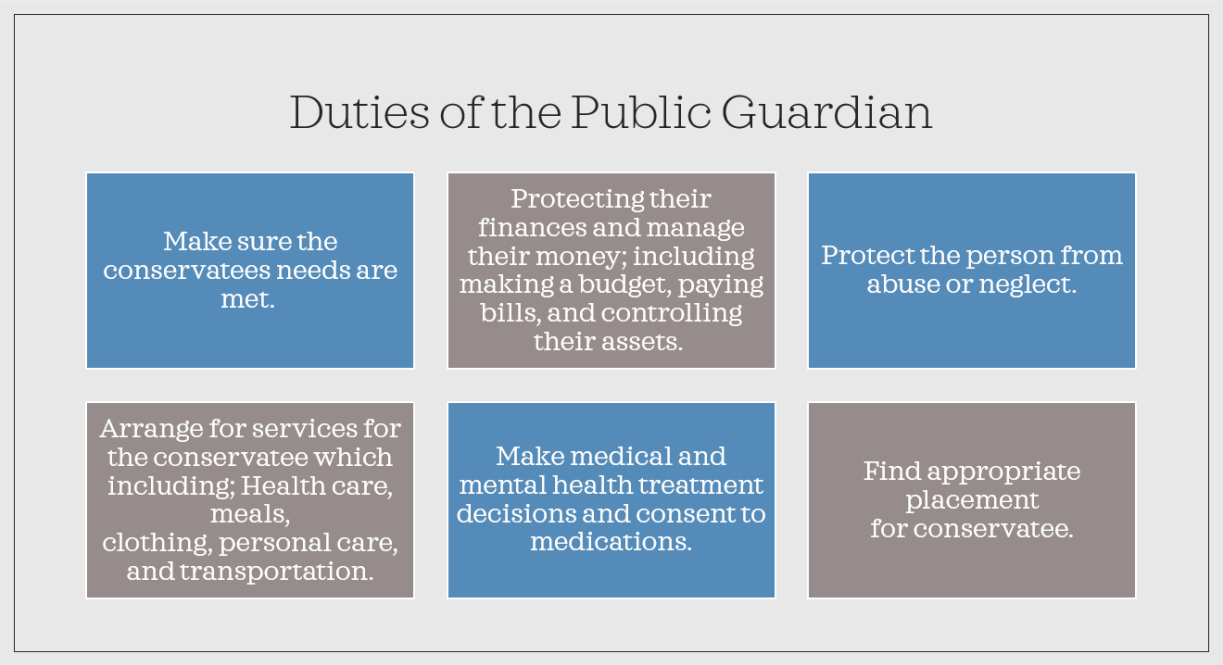
November

Discussions and Action items:

- Discussion of HHSA Director and Acting Mental Health Director appointments of Laura Burch and Miguel Rodriguez
- Approved three-year reappointments for MHADAB members Ron Henninger, Kayln Jones, Dale Marlar, Jo-Ann Medina and Connie Webber
- Approved the Shasta County Data Notebook 2022

Presentation:

- Public Guardian Conservatee Data – A PowerPoint presentation was provided by Supervising Deputy Public Guardian Shonda Cannelora. The presentation consisted of what Public Guardian is and what they do for members in the community. They also talked about involuntary mental health treatment (5150), conservatorship referral process, court process, placements, budget and how many clients are served.



November (Special Meeting)

Discussions and Action items:

- Matthew McOmber, County Counsel was introduced and provided details on meeting instructions.

  The Mental Health, Alcohol and Drug Advisory Board voted to recommend to the Shasta County Board of Supervisors the appointment of Miguel Rodriguez, LCSW as Director of Mental Health Services and authorize public disclosure of this recommendation.

Committees & Workgroups

Board members serve on various community and agency committees to share input, gather information and bring that knowledge back to their fellow board members. Committees include:

- Mental Health, Alcohol and Drug Advisory Board Executive Committee | Meet the 3rd Monday of every even month
  Board Member Assignment: Ron Henninger, Kalyn Jones, Sam Major

- California Association of Local Behavioral Health Boards and Commissions
  Board Member Assignment: All MHADAB Members

- Stand Against Stigma Committee (SASC)| Meet 2nd Tuesday ever other even month
  Board Member Assignment: Connie Webber, Kalyn Jones

- Mental Health Services Act Stakeholder Workgroup| Meet quarterly
  Board Member Assignment: Charlie Menoher, Christine Stewart, Kalyn Jones, Alan Mullikin

- Shasta Suicide Prevention Collaborative: | Meet the 3rd Thursday of every odd month
  Board Member Assignment: Kalyn Jones

- Continuum of Care (CoC) | Meet the 2nd Tuesday of each month
  Board Member Assignment: Ron Henninger, Alen Mullikin

- 2022 Shasta County Data Notebook Workgroup | October 2022
  Board Member Assignment: Connie Webber, Kalyn Jones, Ron Henninger

- ADP Provider Meeting | Meet quarterly
  Board Member Assignment: Christine Stewart, Cindy Greene, Jo-Ann Medina

Join us!

The Mental Health, Alcohol and Drug Advisory Board meets at 5:15 p.m. the first Wednesday of every other month - January, March, May, July, September, and November - with occasional special meetings in alternating months. The board is always looking for new members. For more information, go to www.shastahhsa.net. In the right-hand column under "Advisory Boards," click "Mental Health, Alcohol and Drug."

Summary

DATA NOTEBOOK 2023

FOR CALIFORNIA

BEHAVIORAL HEALTH BOARDS AND COMMISSIONS

Prepared by California Behavioral Health Planning Council, in collaboration with:
California Association of Local Behavioral Health Boards/Commissions

The California Behavioral Health Planning Council (Council) is under federal and state mandate to advocate on behalf of adults with severe mental illness and children with severe emotional disturbance and their families. The Council is also statutorily required to advise the Legislature on behavioral health issues, policies, and priorities in California. The Council advocates for an accountable system of seamless, responsive services that are strength-based, consumer and family member driven, recovery oriented, culturally, and linguistically responsive and cost effective. Council recommendations promote cross-system collaboration to address the issues of access and effective treatment for the recovery, resilience, and wellness of Californians living with severe mental illness.

For general information, you may contact the following email address or telephone number:
DataNotebook@CBHPC.dhcs.ca.gov
(916) 701-8211

Or, you may contact us by postal mail at:

Data Notebook
California Behavioral Health Planning Council
1501 Capitol Avenue, MS 2706
P.O. Box 997413 Sacramento, CA 95899-7413

For questions regarding the SurveyMonkey online survey, please contact Justin Boese at Justin.Boese@cbhpc.dhcs.ca.gov

NOTICE:

This document contains a textual **preview** of the California Behavioral Health Planning Council 2023 Data Notebook survey, as well as supplemental information and resources. It is meant as a **reference document only**. Some of the survey items appear differently on the live survey due to the difference in formatting.

DO NOT RETURN THIS DOCUMENT.

Please use it for preparation purposes only.

To complete your 2023 Data Notebook, please use the following link and fill out the survey online:
https://www.surveymonkey.com/r/DP8XG65

Please note, if you are working from a PDF, scanned image or photocopy, you will need to Copy/Paste or type the above address into your browser bar.

Table of Contents

CBHPC 2023 Data Notebook: Introduction

What is the Data Notebook? Purpose and Goals

The Data Notebook is a structured format to review information and report on aspects of each county's behavioral health services. A different part of the public behavioral health system is addressed each year, because the overall system is very large and complex. This system includes both mental health and substance use treatment services designed for individuals across the lifespan.

Local behavioral health boards/commissions are required to review performance outcomes data for their county and to report their findings to the California Behavioral Health Planning Council (Planning Council). To provide structure for the report and to make the reporting easier, each year a Data Notebook is created for local behavioral health boards to complete and submit to the Planning Council. Discussion questions seek input from local boards and their departments. These responses are analyzed by Planning Council staff to create annual reports to inform policy makers and the public.

The Data Notebook structure and questions are designed to meet important goals:

- To help local boards meet their legal mandates[1] to review and comment on their county's performance outcome data, and to communicate their findings to the Planning Council;
- To serve as an educational resource on behavioral health data;
- To obtain opinion and thoughts of local board members on specific topics;
- To identify unmet needs and make recommendations.

In 2019, we developed a section (Part I) with standard questions that are addressed each year to help us detect any trends in critical areas affecting our most vulnerable populations. These include foster youth, homeless individuals, and those with serious mental illness (SMI) who need housing in adult residential facilities (ARFs) and some other settings. These questions assist in the identification of unmet needs or gaps in services that may occur due to changes in population, resources, or public policy.

What's New This Year?

The topic selected for the 2023 Data Notebook is stakeholder engagement. The Planning Council has long supported upholding the principles of the Mental Health Services Act (MHSA) and encourages consumer and family member participation in the

[1] W.I.C. 5604.2, regarding mandated reporting roles of MH Boards and Commissions in California.

stakeholder process for behavioral health services through the Community Program Planning (CPP) process, as well as other stakeholder engagement activities.

How the Data Notebook Project Helps You

Understanding data empowers individuals and groups in their advocacy. The Planning Council encourages all members of local behavioral health boards/commissions to participate in developing the responses for the Data Notebook. This is an opportunity for local boards and their county behavioral health departments to work together to identify important issues in their community. This work informs county and state leadership about local behavioral health (BH) programs, needs, and services. Some local boards use their Data Notebook in their annual report to the County Board of Supervisors.

In addition, the Planning Council will provide our annual 'Overview Report', which is a compilation of information from all of the local behavioral health boards/commissions who completed their Data Notebooks. These reports feature prominently on the website[2] of the California Association of Local Mental Health Boards and Commissions. The Planning Council uses this information in their advocacy to the legislature, and to provide input to the state mental health block grant application to SAMHSA[3].

Example of Statewide Data for Specialty Mental Health and Access Rates

Tables 1-A and 1-B on the next two pages shows typical data and demographics for California recipients of Specialty Mental Health Services (SMHS) for fiscal year (FY) 2021-2022. These are the most recent data available at the time this document was prepared. SMHS are intended for adults with serious mental illness (SMI) and for children with serious emotional disorders (SED). The category of 'certified eligibles' means those persons (also called beneficiaries) who are eligible and approved to receive Medi-Cal benefits for health care.

These metrics are from datasets developed in accordance with California Welfare and Institutions code § 14707.7 (added as part of Assembly Bill 470 on 10/7/17). Due to recent changes in how AB 470 data is presented by DHCS in the Behavioral Health Demographic Dashboard[4], demographic metrics presented are not exact, as the dashboard rounds them to the nearest .1 thousand (k) or million (M).

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[2] See the annual Overview Reports on the Data Notebook posted at the California Association of Local Mental Health Boards and Commissions, https://www.CALBHBC.org.
[3] SAMHSA: Substance Abuse and Mental Health Services Administration, an agency of the Department of Health and Human Services in the U.S. federal government. For reports, see www.SAMHSA.gov.
[4] AB 470 Mental Health Services Demographics Dashboards, published by California Department of Health Care Services (DHCS) at: https://behavioralhealth-data.dhcs.ca.gov/

Table 1-A. California Children and Youth: Access Rates for Specialty Mental Health Services,[5] Fiscal Year 2021-22.

	Specialty Mental Health Services		
	FY 21-22		
	Number of Clients with MH Visits	Certified Eligibles	Rate
Children 0-2	6.8k	740.9k	0.9%
Children 3-5	15.9k	802.6k	2.0%
Children 6-11	68.5k	1.7m	4.0%
Children 12-17	119.2k	1.8m	6.7%
Youth 18-20	35.1k	79.1k	4.4%
Alaskan Native or American Indian	1k	12.3k	5.5%
Asian or Pacific Islander	7.4k	359.6k	2.0%
Black	23.7k	378.7k	6.3%
Hispanic	146.3k	3.3M	4.4%
Other	12.8k	445.5k	2.9%
Unknown	128.k	548.5k	2.5%
White	40.6k	750.3k	5.4%
Female	130.1k	2.8M	4.6%
Male	114.4k	3M	3.9%
Totals and Average Rates	244.5k	5.8M	4.3%

Notes: The first column presents the demographic groups of interest. Next there are three columns. The first column of numbers shows the number of clients who received one or more services, described as Specialty Mental Health Visits. The second column of numbers is labeled 'Certified Eligibles', which is the number of clients who were deemed eligible and approved to received health care paid by Medi-Cal. The third column of numbers represents the service penetration rates. These penetration rates are taken as one measure of Access. They are calculated by dividing the total number

[5] In contrast, non-specialty Mental Health Services (i.e., Managed Care (MC), Fee-for-Service (FFS), etc), services generally designed for people with mild-to-moderate mental health needs.

of Clients with MH visits by the total number of Medi-Cal Eligibles, multiply by 100 to express the result as a percentage; this is taken as the "Access Rate."

Table 1-B. California Adults and Older Adults, Access Rates for Specialty Mental Health Services, Fiscal Year 2021-22.[6]

	Specialty Mental Health Services		
	FY 21-22		
	Number of Clients with MH Visits	Certified Eligibles	Rate
Adults 21-32	102.2k	2.8M	3.6%
Adults 33-44	88.2k	2.3M	3.9%
Adults 45-56	71.5k	1.7M	4.1%
Adults 57-68	6.5k	1.6M	4.1%
Adults 69+	14.6k	1.1M	1.30%
Alaskan Native or American Indian	2.1k	38.8k	5.5%
Asian or Pacific Islander	19.4k	1.1M	1.8%
Black	50.3k	706.3k	7.1%
Hispanic	103.9k	4.1M	2.5%
Other	36.9k	977.8k	3.8%
Unknown	29.8k	684.6k	4.4%
White	99.1k	1.9M	5.1%
Female	177.3k	5.3M	3.3%
Male	164.2k	4.2M	3.9%
Totals and Access Rates	341.5k	9.5M	3.6%

Notes: The data for Adults and Older Adults were calculated similarly to the data for Children and Youth in Figure 1-A. For example, out of all Adult 9.5M Medi-Cal eligibles, a total of 341.5k individuals, i.e. 3.6% received Specialty Mental Health Services (SMHS).

[6] For comparison, the population of the state of California was **39,029,342** on April 1, 2020, according to the U.S. Census Bureau. https://www.census.gov/quickfacts/CA. Of those residents,24.3% of Californians were adults (age 21 and above) receiving Med-Cal benefits. Also, 14.9 % of Californians were children or youth ≤ 20 who received Medi-Cal benefits. These numbers show that 39.2 % of all Californians of all age groups received Medi-Cal in FY 2021-22.

CBHPC 2023 Data Notebook – Part I:

Standard Yearly Data and Questions for Counties and Local Boards

In recent years, changes in data availability permit local boards and other stakeholders to consult some Medi-Cal data online that is provided by the Department of Health Care Services (DHCS). These data include populations that receive Specialty Mental Health Services (SMHS) and Substance Use Disorder (SUD) treatment. Standard data are analyzed each year to evaluate the quality of county programs and those reports can be found at www.CalEQRO.com. Additionally, Mental Health Services Act (MHSA) data are found in the 'MHSA Transparency Tool' presented on the Mental Health Services Oversight and Accountability Commission (MHSOAC) website.[7]

The Planning Council would like to examine some county-level data that are not readily available online and for which there is no other public source. Please answer these questions using information for fiscal year (FY) 2022-2023 or the most recent fiscal year for which you have data. Not all counties will have readily available data for some of the questions asked below. In that case, please enter N/A for 'data not available.' We acknowledge and appreciate the necessary time and effort provided by local boards and their behavioral health departments to collect and discuss these data.

Adult Residential Care

There is little public data available about who is residing in licensed facilities listed on the website of the Community Care Licensing Division[8] at the CA Department of Social Services. This lack of data makes it difficult to know how many of the licensed Adult Residential Facilities (ARFs) operate with services to meet the needs of adults with chronic and/or serious mental illness (SMI), compared to other adults who have physical or developmental disabilities. In 2020, legislation was signed that requires collection of data from licensed operators about how many residents have SMI and whether these facilities have services to support client recovery or transition to other housing. The response rate from facility operators does not provide an accurate picture for our work.

The Planning Council wants to understand what types of data are currently available at the county level regarding ARFs and Institutions for Mental Diseases (IMDs)[9] available to serve individuals with SMI, and how many of these individuals (for whom the county has financial responsibility) are served in facilities such as ARFs or IMDs. 'Bed day' is

[7] www.mhsoac.ca.gov, see MHSA Transparency Tool, under 'Data and Reports'
[8] Link to Licensed Care directory at California Department of Social Services. https://www.ccld.dss.ca.gov/carefacilitysearch/
[9] Institution for Mental Diseases (IMD) List: https://www.dhcs.ca.gov/services/MH/Pages/IMD-List.aspx

defined as an occupancy or treatment slot for one person for one day. One major difference is that IMDs offer mental health treatment services in a psychiatric hospital or certain types of skilled nursing home facilities. In contrast, a non-psychiatric facility such as an ARF is a residential facility that may provide social support services like case management but not psychiatric treatment.

The following is a text summary of the survey questions for Part I of the 2023 Data Notebook. Please note that the questions are presented here in a different format than the finalized SurveyMonkey online survey.

Questions:

1) **Please identify your County / Local Board or Commission.**

   Shasta

2) **For how many individuals did your county behavioral health department pay some or all of the costs to reside in a licensed Adult Residential Care Facility (ARF), during the last fiscal year? 129**

3) **What is the total number of ARF bed-days paid for these individuals, during the last fiscal year? 35,803**

4) **Unmet needs: how many individuals served by your county behavioral health department need this type of housing but currently are not living in an ARF? N/A**

5) **Does your county have any 'Institutions for Mental Disease' (IMD)?**
   Yes, Shasta has 1 facility within the County.

6) **For how many individual clients did your county behavioral health department pay the costs for an IMD stay (either in or out of your county), during the last fiscal year?**
   In-county: **23** Out-of-county: **39**

7) **What is the total number of IMD bed-days paid for these individuals by your county behavioral health department during the same time period?**
   13,940 (4,880 in county, 9,060 out of county)

Homelessness: Programs and Services in California Counties

The Planning Council has a long history of advocacy for individuals with SMI who are homeless, or who are at-risk of becoming homeless. California's recent natural disasters and public health emergency have exacerbated the affordable housing crisis and homelessness. Federal funding was provided to states that could be used for temporary housing for individuals living on the streets as a method to stop the spread of the COVID-19 virus. Additional policy changes were made to mitigate the rate of evictions for persons who became unemployed as a result of the public health crisis.

Studies indicate that only one in three individuals who are homeless also have serious mental illness and/or a substance use disorder. The Planning Council does not endorse the idea that homelessness is caused by mental illness, nor that the public BH system is responsible to fix homelessness, financially or otherwise. However, we do know that recovery happens best when an individual has a safe, stable place to live.

The issue of homelessness is very complex and involves multiple systems and layers of interaction. Therefore, the Council will continue to track and report on the programs and supports offered by counties to assist homeless individuals who have SMI and/or SUD. Causes and contributory factors are complex, and thus our solutions will need to address numerous multidimensional and multi-systemic challenges.

Every year, the states, counties, and many cities perform a "Point-in-Time" count[10] of the homeless individuals in their counties, usually on a specific date in January. Such data are key to state and federal policy and funding decisions. The pandemic disrupted both the methods and the regular schedule for the count in 2021, during which there was no data collected for California's unsheltered population due to Covid-19 protocols. Those preliminary data were taken down subsequently for further review before re-posting. Therefore, the "percent increase" column for this table compares the 2022 totals with the totals for *2020*, for which there was complete data.

[10] Link to data for yearly Point-in-Time Count:
https://files.hudexchange.info/reports/published/CoC_PopSub_NatlTerrDC_2022.pdf

Table 3: State of California Estimates of Homeless Individuals Point in Time[11] Count 2022

Summary of Homeless individuals	SHELTERED	UNSHELTERED	TOTAL 2022	Percent Increase over 2022
Persons in households without children	34,545	110,888	145,433	7.7%
Persons in households with children	21,253	4,285	25,538	-0.9%
Unaccompanied homeless youth	2,828	6,762	9,590	-21.2%
Veterans	3,003	7,392	10,395	-8.8%
Chronically homeless individuals	15,773	45,132	60,905	17.6%
Total (2020) Homeless Persons in CA	56,030	115,491	171,521	6.2%
Total (2020) Homeless Persons, USA	348,630	233,832	582,462	.3%

[11] PIT Count = yearly January Point-in-Time Count of Homeless Individuals, conducted according to the guidance of the U.S. Department of Housing and Urban Development (www.HUD.gov). Sheltered persons include those who were in homeless shelters and various types of transitional or emergency housing.

Questions, continued:

8) **During fiscal year 2022-2023, what new programs were implemented, or existing programs were expanded, in your county to serve persons who are both homeless and have severe mental illness?** (Mark all that apply.)
   a. **Temporary Housing**
   b. **Supportive Housing**
   c. **Adult Residential Care Patch/Subsidy**

Child Welfare Services: Foster Children in Certain Types of Congregate Care

In California, about 60,000 children under the age of 18 are in foster care. They were removed from their homes because county child welfare departments, in conjunction with juvenile dependency courts, determined that these children could not live safely with their caregiver(s). Most children are placed with a family who receive foster children, but a small number of the children need a higher level of care and are placed in a setting with more sophisticated services.

California is striving to move away from facilities formerly known as long-term group homes, and prefers to place all youth in family settings, if possible. Regulations have revised the treatment facilities for children whose needs cannot be met safely in a family setting. The new facility type is called a Short-Term Residential Treatment Program (STRTP). STRTPs are designed to provide short-term placement that includes intensive behavioral health services.

All of California's counties are working toward closing long-term group homes and are establishing licensed STRTPs. This transition will take time and it is important for your board to talk with your county director about what is happening in your county for children in foster care who are not yet able to be placed in a family setting, or who are in a family setting and experience a crisis that requires short-term intensive treatment.

Some counties do not yet have STRTPs and may place children/youth in another county or even out-of-state. Recent legislation (AB 1299) directs that the Medi-Cal eligibility of the child be transferred to the receiving county. This means, the county receiving the child now becomes financially responsible for his/her Medi-Cal costs.

Examples of the foster care CDSS data for Q4, 2020, in CA:

- Total foster youth and children: 53,180

- Total placed in an STRTP: 2,444 (or 4.6% of foster youth)
- Total STRTP placed out-of-county: 1174 (or 2.2% of foster youth)
- Total STRTP placed out-of-state: 66 (or 0.12 % of foster youth)

Questions (continued):

9) **Do you think your county is doing enough to serve the foster children and youth in group care?**

The County faces barriers to providing services based on state regulations and challenges related to availability of placements. We need more placement resources locally who are willing and able to maintain children with complex behavioral difficulties.

10) **Has your county received any children needing "group home" level of care from another county?**

No

11) **Has your county placed any children needing "group home" level of care into another county?**

Yes, 6 of the 7 are placed outside of Shasta county.

CBHPC 2023 Data Notebook – Part II:

Stakeholder Engagement in the Public Mental Health System

Context and Background

The topic selected for the 2023 Data Notebook is “stakeholder engagement.” Stakeholder engagement refers to the active involvement of individuals or groups with a vested interest in the mental health system. These stakeholders include consumers of mental health services, their families, mental health professionals, government agencies, community organizations, advocacy groups, and policymakers. Engaging these stakeholders fosters a participatory approach, giving voice to diverse perspectives and enabling collective decision-making. Stakeholder engagement is integral to the implementation of the Mental Health Services Act (MHSA) in California. By involving a wide range of voices, the MHSA can develop and deliver programs and services that are responsive to community needs, ultimately improving mental health outcomes and well-being in California.

Stakeholder engagement offers numerous benefits in the context of mental health. Firstly, it enhances service delivery by allowing the mental health system to address the specific needs and preferences of individuals with mental health conditions. Through collaborative decision-making, services can be designed to be more accessible, culturally sensitive, and person-centered, ultimately leading to improved outcomes for those seeking support.

Secondly, stakeholder engagement empowers the community by providing opportunities for active participation and involvement in the development of mental health policies and programs. By valuing the perspectives of diverse stakeholders, the system becomes more responsive to the concerns, priorities, and aspirations of the community it serves. This active involvement fosters a sense of ownership and empowerment among community members, enabling them to contribute to shaping the mental health services available to them.

Thirdly, it plays a crucial role in ensuring accountability within the mental health system. By involving stakeholders, a system of checks and balances is created, promoting transparency and holding the system accountable for its actions and outcomes. This involvement helps to guarantee that resources are allocated effectively and efficiently, maximizing their impact and addressing any potential issues or discrepancies that may arise.

Overall, stakeholder engagement in mental health has far-reaching benefits. It leads to improved service delivery that is tailored to individual needs, empowers the community

by involving them in decision-making processes, and ensures accountability and transparency within the mental health system. By actively engaging stakeholders, mental health organizations can create a more inclusive and effective system that ultimately improves the well-being of individuals experiencing mental health conditions.

Challenges and Barriers

The effective engagement of stakeholders in the California public mental health system faces several barriers and challenges. One of the primary challenges is ensuring diverse representation among stakeholders. Overcoming language barriers, cultural differences, and limited outreach resources is crucial to capture a wide range of perspectives. Inadequate funding and staffing also pose significant challenges, hindering the capacity to hold regular meetings, conduct outreach efforts, and provide necessary support to stakeholders.

Some other potential barriers include:

- Stigma and discrimination surrounding mental health create additional obstacles to stakeholder engagement. Addressing stigma requires targeted educational campaigns, anti-stigma initiatives, and the creation of safe spaces that foster open dialogue and inclusivity.
- Power imbalances among stakeholders can also impede effective engagement. Achieving equitable representation and providing mechanisms to address power differentials are essential to foster an inclusive and democratic stakeholder engagement process.
- The complexity and fragmentation of the California public mental health system further present challenges. Effective communication strategies, standardized protocols, and clear channels of collaboration are necessary to engage stakeholders from different sectors and align their efforts.
- Limited accessibility poses another barrier to meaningful stakeholder engagement. Proactive measures such as providing accommodations, utilizing virtual platforms for remote participation, and ensuring inclusive physical spaces are essential to address accessibility barriers.
- Stakeholder engagement processes can be time-consuming and may lead to engagement fatigue over time. Balancing the need for sustained engagement with stakeholders' limited time and competing priorities requires clear goals, efficient processes, and recognition of stakeholders' contributions to maintain their interest and involvement.

Overcoming these barriers and challenges necessitates a comprehensive approach. By addressing these challenges, the California public mental health system can cultivate inclusive, responsive, and impactful mental health policies and programs.

Key Stakeholders

In the public mental health system, various stakeholders play vital roles in shaping policies, programs, and services. The California Code of Regulations provides the following definition of “stakeholders” within the public mental health system:

> **Cal. Code Regs. Tit. 9, § 3200.270 - Stakeholders**
> "Stakeholders" means individuals or entities with an interest in mental health services in the State of California, including but not limited to: individuals with serious mental illness and/or serious emotional disturbance and/or their families; providers of mental health and/or related services such as physical health care and/or social services; educators and/or representatives of education; representatives of law enforcement; and any other organization that represents the interests of individuals with serious mental illness/ and/or serious emotional disturbance and/or their families.

Additionally, California Welfare and Institutions Code provides a list of stakeholders for the Community Program Planning (CPP) Process:

> **California Code, Welfare and Institutions Code - WIC § 5848 (a)**
> Each three-year program and expenditure plan and update shall be developed with local stakeholders, including adults and seniors with severe mental illness, families of children, adults, and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies, veterans, representatives from veterans' organizations, providers of alcohol and drug services, health care organizations, and other important interests. Counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations.

Using these sources, we can identify key stakeholder groups for engagement. Here is a more detailed list of these key stakeholders:

Adults and Seniors with severe mental illness (SMI): This group represents individuals who are directly impacted by mental health conditions. Their perspectives and experiences are essential in understanding the unique challenges they face and in

developing services that meet their specific needs. Engaging adults and seniors with SMI ensures their voices are heard and helps tailor interventions to improve their overall well-being and recovery.

Families of children, adults, and seniors with SMI: Family members are crucial stakeholders as they provide support, care, and advocacy for their loved ones with mental illness. Their insights offer a valuable perspective on the challenges faced by individuals with SMI and the impact on the family unit. Involving families in decision-making processes helps ensure that services are holistic, family-centered, and responsive to the needs of both the individual and their support network.

Providers of Mental Health and/or Related Services: Mental health professionals, including psychiatrists, psychologists, counselors, and social workers, are instrumental in delivering quality care and support. Their expertise and frontline experience provide valuable input on service gaps, best practices, and areas for improvement within the mental health system. Engaging with mental health providers ensures that policies and programs are evidence-based, align with professional standards, and promote quality outcomes.

Law Enforcement Agencies: Law enforcement agencies often come into contact with individuals experiencing mental health crises. Their involvement in stakeholder engagement facilitates collaboration between mental health services and law enforcement, aiming to improve crisis intervention and diversion programs. This partnership can enhance community safety, reduce unnecessary arrests and incarcerations, and facilitate appropriate referrals to mental health services.

Educators and/or Representatives of Education: Educators play a significant role in identifying and supporting students with mental health needs. Their involvement as stakeholders contributes to the development of early intervention strategies, mental health promotion programs, and the implementation of appropriate supports within educational settings. Collaborating with educators helps create a nurturing environment that supports the academic, social, and emotional well-being of students.

Social Services Agencies: Social services agencies, such as those involved in housing, employment, and welfare, intersect with the mental health system. Their participation in stakeholder engagement ensures coordination and integration of services, addressing the complex needs of individuals with mental health conditions holistically. Collaboration with social services agencies supports efforts to provide stable housing, employment opportunities, and social support networks to promote recovery and community integration.

Veterans: Veterans, particularly those who have served in combat or experienced traumatic events, often face mental health challenges such as post-traumatic stress

disorder (PTSD) and depression. Engaging veterans as stakeholders enables the mental health system to address their unique needs and develop specialized programs tailored to their experiences. This collaboration ensures that mental health services for veterans are comprehensive, accessible, and culturally sensitive.

Representatives from Veterans Organizations: Representatives from veterans' organizations, such as advocacy groups or support networks, provide a platform for veterans' voices and perspectives to be heard. Their involvement in stakeholder engagement fosters collaboration and helps shape policies, programs, and services that meet the specific needs of veterans.

Providers of Alcohol and Drug Services: Substance use disorders frequently co-occur with mental health conditions, requiring integrated care approaches. Engaging providers of alcohol and drug services as stakeholders promotes collaboration between mental health and addiction treatment providers. This collaboration ensures a comprehensive approach to addressing the complex needs of individuals with co-occurring disorders, facilitating recovery and reducing barriers to treatment.

Health Care Organizations: Health care organizations, including hospitals, clinics, and primary care providers, are essential stakeholders in the mental health system. Collaboration with these organizations helps integrate mental health care into primary care settings, reduce stigma, and improve access to services. Involving health care organizations enhances the coordination of care and strengthens the overall continuum of mental health support.

Other important Interests: The mental health system involves numerous other stakeholders, such as policymakers, researchers, community leaders, advocacy groups, and philanthropic organizations. Each brings unique perspectives, expertise, and resources to the table. Their involvement in stakeholder engagement ensures that policies and programs are informed by evidence, responsive to community needs, and adequately resourced.

By engaging and involving these diverse stakeholders, the public mental health system can benefit from a comprehensive range of insights, expertise, and perspectives. This collaborative approach leads to more effective, inclusive, and person-centered mental health services that better serve the needs of individuals, families, and communities.

Best Practices for Stakeholder Engagement

There are many resources available regarding promising and best practices for stakeholder engagement. Some commonly identified guiding principles and best practices are:

1. **Inclusive Approach:** Ensure that the stakeholder engagement process is inclusive and representative of diverse perspectives. Include individuals with lived experience, family members, behavioral health service providers, advocacy groups, community organizations, and policymakers. Embrace diversity and strive for equity in representation.
2. **Early and Ongoing Engagement:** Engage stakeholders early in the decision-making process and maintain ongoing communication throughout the planning, implementation, and evaluation stages. Provide opportunities for input, collaboration, and feedback at various stages to ensure meaningful participation.
3. **Purposeful Communication:** Foster open and transparent communication with stakeholders. Provide clear information about goals, processes, and timelines. Use plain language and avoid jargon to ensure that all stakeholders can easily understand and contribute to the conversation. Likewise, practice active listening when stakeholders are speaking. Rather than assuming what they mean, ask follow-up questions to ensure that their input is understood.
4. **Collaboration and Co-creation:** Foster a collaborative environment that encourages stakeholders to actively participate in decision-making. Co-create solutions by involving stakeholders in the design and implementation of programs, policies, and services. Value their expertise and insights.
5. **Training and Education:** Provide stakeholders with relevant training and education to enhance their understanding of behavioral health issues, policies, and practices. Equip them with the knowledge necessary to contribute effectively and make informed decisions.
6. **Flexibility and Adaptability:** Recognize that stakeholders may have different levels of expertise, resources, and availability. Provide flexibility in engagement methods to accommodate diverse needs, such as offering virtual options, providing written materials, and conducting surveys or focus groups.
7. **Data-Informed Decision Making:** Use data and evidence to inform discussions and decision-making processes. Share relevant data with stakeholders to foster informed dialogue and facilitate collaborative problem-solving.
8. **Empowerment and Shared Leadership:** Empower stakeholders to actively contribute and take ownership of the process. Promote shared leadership by involving stakeholders in the development of agendas, facilitating meetings, and encouraging their participation in decision-making.
9. **Recognition and Appreciation:** Recognize and appreciate the contributions of stakeholders. Acknowledge their time, effort, and expertise. Provide opportunities for public recognition, such as featuring success stories or highlighting stakeholder involvement in reports and presentations.

10. **Evaluation and Continuous Improvement:** Regularly evaluate the effectiveness of stakeholder engagement efforts and seek feedback from participants. Use this feedback to refine engagement strategies and improve future processes.

These are just some of the many suggested best practices and guiding principles for quality stakeholder engagement. By incorporating these and other best practices, behavioral health systems can effectively engage stakeholders, leverage their expertise, and create more responsive, person-centered, and equitable services and policies.

MHSA Community Program Planning Process

One of the major ways that the MHSA includes stakeholder engagement is the MHSA Community Program Planning (CPP) Process. This state-mandated participatory process is a collaborative approach used in California to develop and refine mental health programs funded by the MHSA. Counties use the CPP process in the development of Three-Year Program and Expenditure Plans and updates. Counties work alongside stakeholders to analyze current community mental health needs, issues resulting from any lack of community services, and current system capacity, as well as evaluate priorities and strategies to meet the needs of the community.

California Codes and Regulations dictate that the MHSA CPP process should be:

- Based in community collaboration (CCR, 9 CA §3320 and 3200.060).
- Culturally competent (CCR, 9 CA §3320 and 3200.100).
- Client and family driven (CCR, 9 CA §3320, 3200.050 and 3200.120).
- Wellness, recovery and resilience-focused (CA WIC § 5813.5(d)).
- Focused on providing an integrated service experience for clients and their families (CCR, 9 CA §3320 and 3200.190).

MHSA CPP Processes must include the following regarding stakeholder participants:

- **Stakeholders** (as previously defined/discussed based on WIC, § 5848a).
- **Underserved populations.** Representatives from unserved and/or underserved populations and family members of unserved/underserved populations (CCR, 9 CA § 3300).
- **Diversity.** Participants that “reflect the diversity of the demographics of the County, including but not limited to, geographic location, age, gender, and race/ethnicity” (CCR, 9 CA § 3300).

Additionally, the CPP process should, at a minimum include the following things:

- Staffing for positions and/or units to facilitate the CPP process.

- Training for stakeholders and county staff.
- Outreach to consumers with SMI and their family members to ensure the opportunity to participate.
- A local review process that includes a 30-day public comment period prior to submitting the Three-Year Program and Expenditure Plans or Annual Updates.

The MHSA currently allows counties to use **up to 5% of their total Community Services and Support (CSS) funds** to facilitate a robust planning process. This includes using funding to accommodate stakeholder participation in the CPP process. All counties are required to use the CPP process and document the Three-Year Program and Expenditure Plans and Annual Updates. This includes descriptions of the methods used to collect stakeholder input, documentation that a public hearing was held, summary and analysis and a description of changes made based on community input.

The local MH/BH boards and commissions have the following responsibilities in this process:

- Review and approve the procedures used to ensure stakeholder involvement in all stages of the planning process.
- Review the adopted plan or update and make recommendations.
- Conduct MHSA public hearings at the close of the 30-day public comment periods.

Overall, the MHSA Community Program Planning Process fosters a participatory and community-driven approach to mental health program development. By engaging stakeholders and leveraging their expertise and insights, the CPP Process aims to create programs that are responsive, culturally sensitive, and tailored to the unique needs of the community. This collaborative effort ultimately leads to the implementation of effective and impactful mental health services in California communities.

While the MHSA CPP process is an important (and legally required) example of stakeholder engagement, the principles and practices of stakeholder engagement can be applied to many different programs and processes. This includes but is not limited to mental/behavioral health board/commission meetings, EQRO focus groups, and SAMHSA funded programs.

Resources

The following resources all pertain to stakeholder engagement in mental health, including the CPP process. We encourage counties to utilize these resources to learn more about responsive and effective engagement practices.

- CALBHBC: MHSA CPP One-Pager
- CALBHBC: Community Engagement PowerPoint
- MHSOAC: CPP Processes - Report of Other Public Community Planning Processes
- MHSOAC: Promising CPP Practices
- SAMHSA: Community Engagement – An Essential Component of an Effective and Equitable Substance Use Prevention Program

Part II: Data Notebook Questions

Please respond by means of the Survey Monkey link provided with this Data Notebook.

12. **For each of the following categories, please choose the option from the dropdown menu that best describes how often your county organizes stakeholder engagement meetings or events.**
    - **Quarterly (four times a year)**
    - **Categories:**
        - **MHSA Community Planning Process (CPP)**
        - **MHSA 3-year plan updates**
        - **EQRO focus groups**
        - **Mental/Behavioral Health Board/Commission Meetings**

13. **Estimate the number of people who participated in your stakeholder processes in fiscal year 2022/2023.** *(Numerical response)* **35**

14. **Approximately what percentage of stakeholder engagement events or efforts in your county were in-person only, virtual only, a combination of both in-person and virtual, or written communications** *(please answer with a whole number for each, such that the total of the four amounts to 100)*
    - **In-person only: 90**
    - **Virtual only: 10**

15. **Which of the following languages did your county use to conduct stakeholder meetings or outreach during fiscal year 2022/2023, with or without the use of interpreters?** *(Check all that apply)* **English**

This list of languages reflects the threshold and concentration languages for all counties as of July 2021 from the following DHCS document: Threshold and Concentration Languages (ca.gov)

16. **Which of the following stakeholder groups have you collected and implemented input from within the last year?** *(Check all that apply)*
    - **Adults with severe mental illness (SMI)**
    - **Older adults / Seniors with SMI**
    - **Families of children, adults and seniors with SMI**
    - **Individuals with developmental disabilities and/or their representatives**
    - **Providers of mental health and/or related services**
    - **Representatives of managed care plans**
    - **Law enforcement agencies**
    - Educators and/or representatives of education
    - **Social services agencies**
    - **Veterans**
    - Representative from veterans' organizations
    - **Providers of alcohol and drug services**
    - **Health care organizations**
    - **Hearing impaired individuals**
    - **LGBTQ+ individuals**
    - **Youth**
    - Other important interests (please specify)
    - **Specific racial/Ethnic groups (please specify): Southeast Asian and Latin X**

17. **Please describe how stakeholder input is communicated to the behavioral health director, the mental/behavioral health board/commission, and any other agencies or groups for informing policy.** *(Text response)*

    During the Mental Health Alcohol and Drugs Advisory Board (MHADAB), Meeting Minutes, Board of Supervisor Meetings, publishing agendas and minutes on MHADAB website and Shasta MHSA website

18. **Please describe how your county implements collected stakeholder input to actively inform policy and programs. Include how the county decides what ideas to implement or actions to take.** *(Text response)*

    Information is provided to our Quality Management team, reviewed, changes requested to Mental Health director, reviewed by Mental Health Deputy Directors, Clinical Division Chiefs and if needed

reviewed by Policy Council. However, we will need to meet with our QM team and create plans of action.

19. **Does your county have a Community Program Planning (CPP) plan in place?**
    - Yes, stakeholder input is gathered. Top concerns are identified. This information is provided to Mental Health leadership to address concerns and implementation.

      Process Summary: Stakeholders are notified via email and social media. Coordinate with local agencies to increase participation in stakeholder meetings. A stakeholders meeting is held to gather input (inquires can be sent via email as well). Meeting minutes are shared.

20. **Is your county supporting the CPP process in any of the following ways?** *(Please select all that apply)*
    a) Reimbursement of travel costs for stakeholders participating in in-person meetings or events.
    b) Providing refreshments or food for stakeholder participants
    c) Dedicated staff assistance to facilitate stakeholder meetings and events.
    d) Providing information and training for stakeholders on MHSA programs, regulations, and procedures.
    e) Holding meetings in physically/geographically accessible locations around the county.
    f) Utilizing language interpreting services.
    g) Holding meetings at times convenient to community stakeholders' schedules.
    h) Providing technical assistance for stakeholders participating in webinars or teleconferences.
    i) Other (please specify)
    j) None of the above

21. **Does your county provide training for staff on cultural awareness, community outreach, and stakeholder engagement? If yes, how? If no, why not?**
    - Yes (Our department provides interpreter training and cultural competency training)

22. **Which of the following barriers does your county face regarding achieving meaningful and impactful engagement of stakeholders (specifically, mental health consumers and family members)?** *(Check all that apply)*
    a. General difficulty with reaching stakeholders.
    b. Difficulty conducting community outreach to racial/ethnic communities or other specific communities of interest.

c. **Difficulty reaching stakeholders with disabilities.**
d. **Lack of funding or resources for stakeholder engagement efforts.**
e. **Shortage of properly trained staff to support and facilitate stakeholder engagement.**
f. **Difficulty adapting to virtual meetings/communications.**
g. **Difficulty providing accommodations to stakeholders.**
h. **Difficulty incorporating stakeholder input in the early stages of programming.**
i. Lack of "buy-in" from decision makers when it comes to implementing stakeholder input.
j. Other (please specify)

23. Are your behavioral health board/commission members involved in your county's stakeholder engagement and/or CPP processes? If yes, describe how.

a. **Yes (decisions go before the local mental health board for approval)**

Note: *California WIC 5892 allocates Mental Health Services Funds for county mental health programs to pay for the expenses of mental health board members to perform their duties, and to pay for the costs of consumers, family members, and other stakeholders to participate in the planning process. This includes 5% of total CSS funds to support a robust CPP process with community stakeholders.*

24. Has the COVID-19 pandemic increased or decreased the level of stakeholder engagement and input in your county?

a. Increased
b. **Decreased**
c. No change

25. Is there a fear or perception in your county that spending time, money, or other resources on stakeholder engagement conflicts with the need to provide direct services? *No*

26. What is one change or improvement regarding stakeholder engagement that your county would like to make within the next fiscal year? *(*Create clear communication and timelines to complete established goals.)

27. Do you have any other thoughts or comments regarding stakeholder engagement in your county or statewide? We are working to clarify the various opportunities for stakeholder input. We hope to better assist community members in attending the opportunities that most interest them and are most suited for the input they choose to provide.

Post-Survey Questionnaire

Completion of your Data Notebook helps fulfill the board's requirements for reporting to the California Behavioral Health Planning Council. Questions below ask about operations of mental health boards, and behavioral health boards or commissions, etc.

28. What process was used to complete this Data Notebook? (Please select all that apply)

a. MH board reviewed WIC 5604.2 regarding the reporting roles of mental health boards and commissions.
b. MH board completed majority of the Data Notebook.
c. Data Notebook placed on agenda and discussed at board meeting.
d. MH board work group or temporary ad hoc committee worked on it.
e. MH board partnered with county staff or director.
f. MH board submitted a copy of the Data Notebook to the County Board of Supervisors or other designated body as part of their reporting function.
g. Other (please specify)

29. Does your board have designated staff to support your activities?

a. Yes, Community Development Coordinator

30. Please provide contact information for this staff member or board liaison.

Name – Jacquelynn Rose
County – Shasta
Email Address – jmrose@co.shsata.ca.us
Phone Number – (530) 229-8266

31. Please provide contact information for your board's presiding officer (chair, etc.)

Name – Ron Henniger
County – Shasta
Email Address – drhenninger333@gmail.com
Phone Number – (530) 351-2330

32. Do you have any feedback or recommendations to improve the Data Notebook for next year?

Customer Satisfaction Survey

Shasta County Health & Human Services Agency

We value your opinion! Please complete this survey about the Crisis Residential and Recovery Center services provided by the Shasta County Health and Human Services Agency.

All answers are kept confidential.

Answer below or use the QR code at right to take the survey online.

Today's date: _____

	Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree
Staff were welcoming and engaging.	☐	☐	☐	☐	☐
I decided my wellness and recovery goals.	☐	☐	☐	☐	☐
Staff believed that I could grow and change.	☐	☐	☐	☐	☐
Staff were sensitive to my cultural needs.	☐	☐	☐	☐	☐
I feel safe to freely express my concerns.	☐	☐	☐	☐	☐
I benefited from the groups at the CRRC.	☐	☐	☐	☐	☐
I am better able to deal effectively with daily problems.	☐	☐	☐	☐	☐
I am better able to identify those who support me.	☐	☐	☐	☐	☐
Staff connected me to resources in the community.	☐	☐	☐	☐	☐

Where are you discharging to? _____

What classes or programs were most/least helpful in your recovery? _____

What features or services did you MOST LIKE about the Crisis Residential and Recovery Center? _____

What features or services did you LEAST LIKE about the Crisis Residential and Recovery Center? _____

How can the Crisis Residential and Recovery Center improve? _____

Additional comments: _____