Shasta County Health & Human Services Agency

MHSA Stakeholder Demographics

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

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

Q1) How many years old are you?

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

Q2) What is your military status?

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

Q3) What is your primary language?

- >90% identified English as their primary language

Q4) Do you have any disabilities?

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

Q5) What is your race/ethnicity?

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

Q6) What is your gender identity?

- >65% identified as female

Q7) What is your sexual orientation?

- >80% identified as heterosexual

Consumer Perception Survey Results (Youth Only)

FY 21/22

N = 56

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

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

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

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

Consumer Perception Survey Results (Families Only)

FY 21/22

N = 41

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

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

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

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

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

Consumer Perception Survey Results (Adults Only)

FY 21/22

N = 11

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

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

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

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

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

Shasta County Health & Human Services Agency

Wellness Center Summary Report

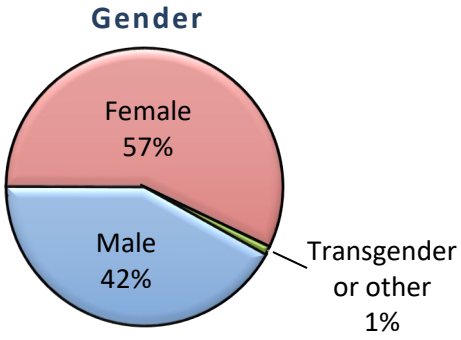
July 2021 – June 2022

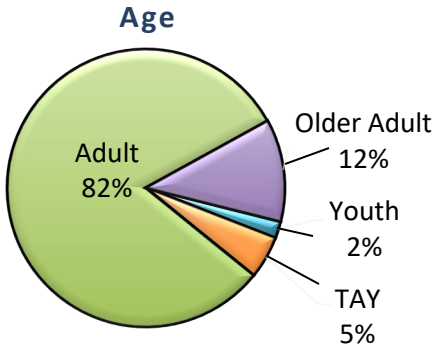
This report provides quarterly data collected from two wellness centers in Shasta County: Sunrise Mountain Wellness Center in Redding and Circle of Friends in Burney. Wellness centers provide support to anyone with mental health challenges through facilitated discussions and activities, transportation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

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

Combined wellness center demographics

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

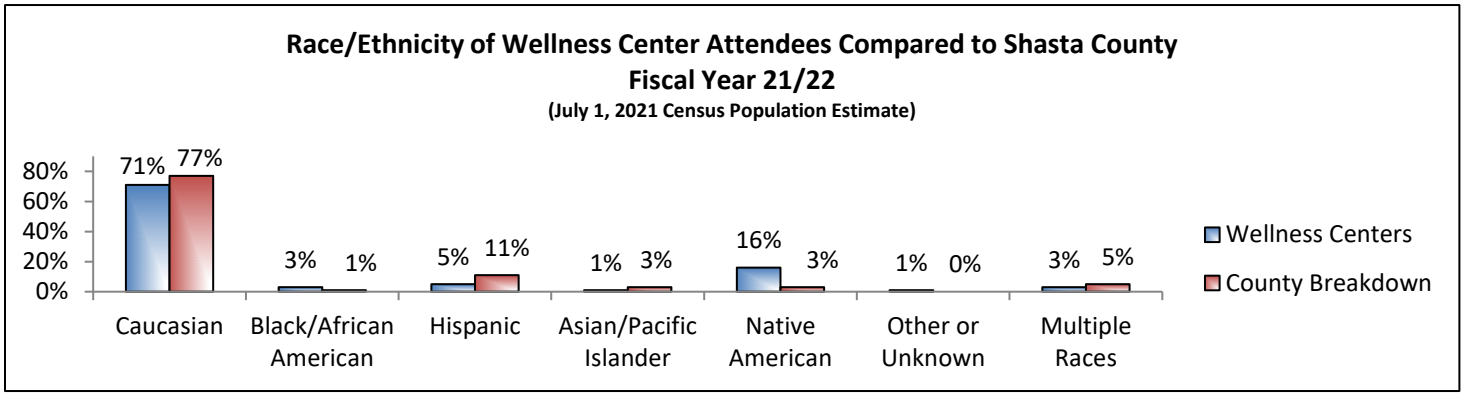




Approximately 2% of wellness center attendees were Youths (0-15 years of age), 5% were Transitional Age Youths (16-25 years of age), 82% were Adults (26-59 years of age), 12% were Older Adults (60+ years of age), and none were of unknown age.

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

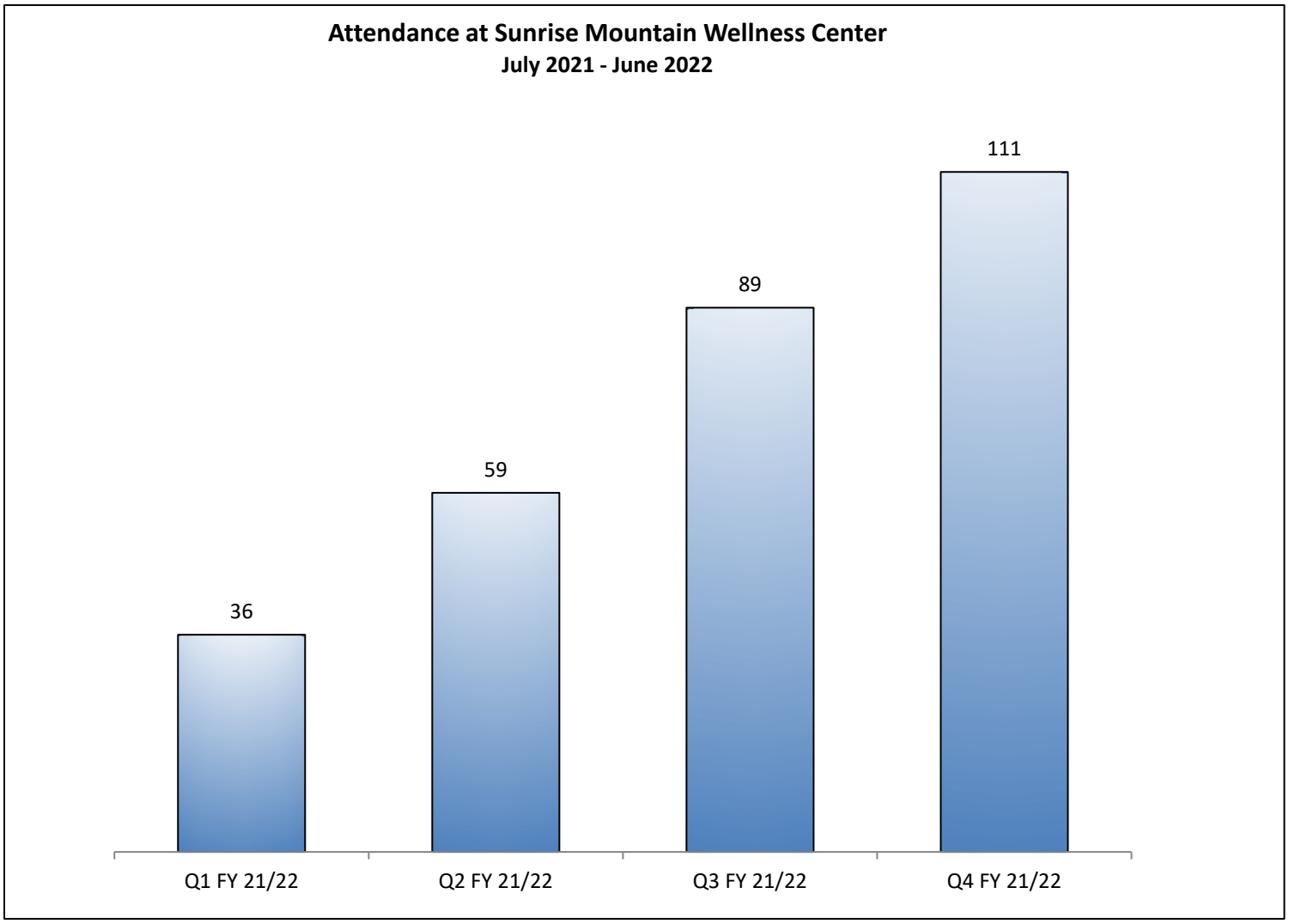
Caucasian, Hispanic, Asian/Pacific Islander, and Multiple Races were under-represented while Native American, Black/African American, and Other or Unknown were over-represented.



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

Sunrise Mountain Wellness Center

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



Demographics
On average, 100% of attendees were consumers. On average, 76% of staff members (including volunteers) were consumers and/or family members. In order to maintain confidentiality, age, gender and race/ethnicity is not broken down by individual wellness center.

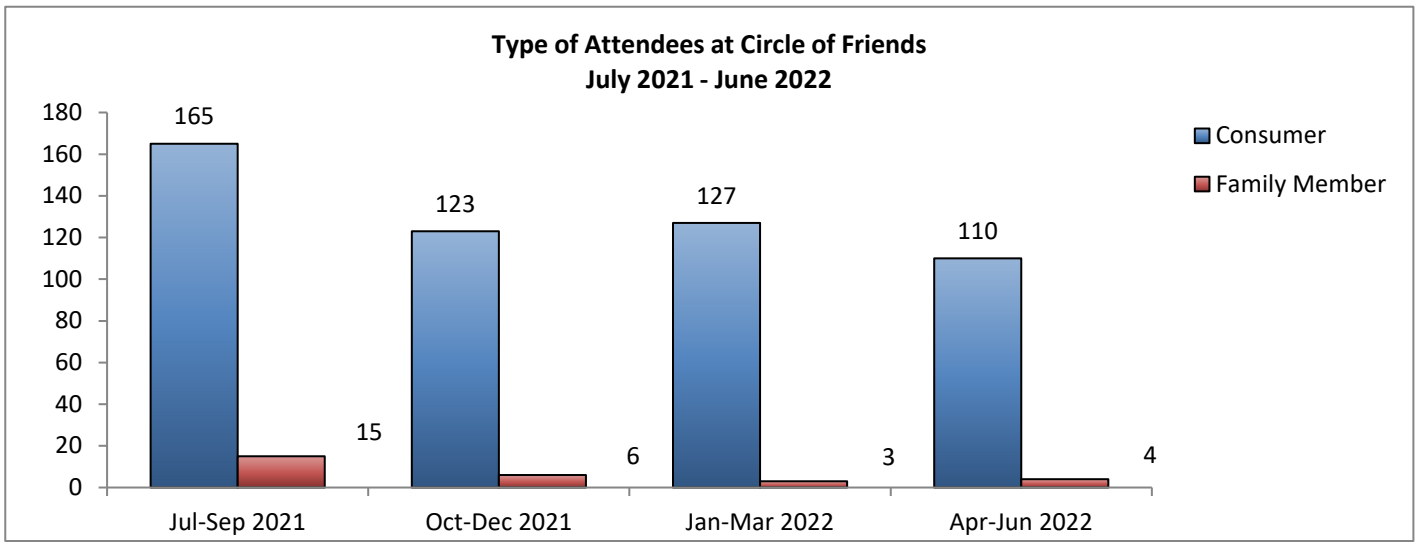
Services Provided
Sunrise Mountain Wellness Center's operating hours are 8:00am to 4:30pm Monday - Friday. From Q1 through Q4, there were 1,547 individual activities and groups available for participants.

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

Circle of Friends

Attendance

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



Demographics

Ninety-five percent of attendees were consumers and 5% were family members. Seventy-five percent of staff and 100% of volunteers were consumers and/or family members. In order to maintain confidentiality, age, gender and race/ethnicity is not broken down by individual wellness center.

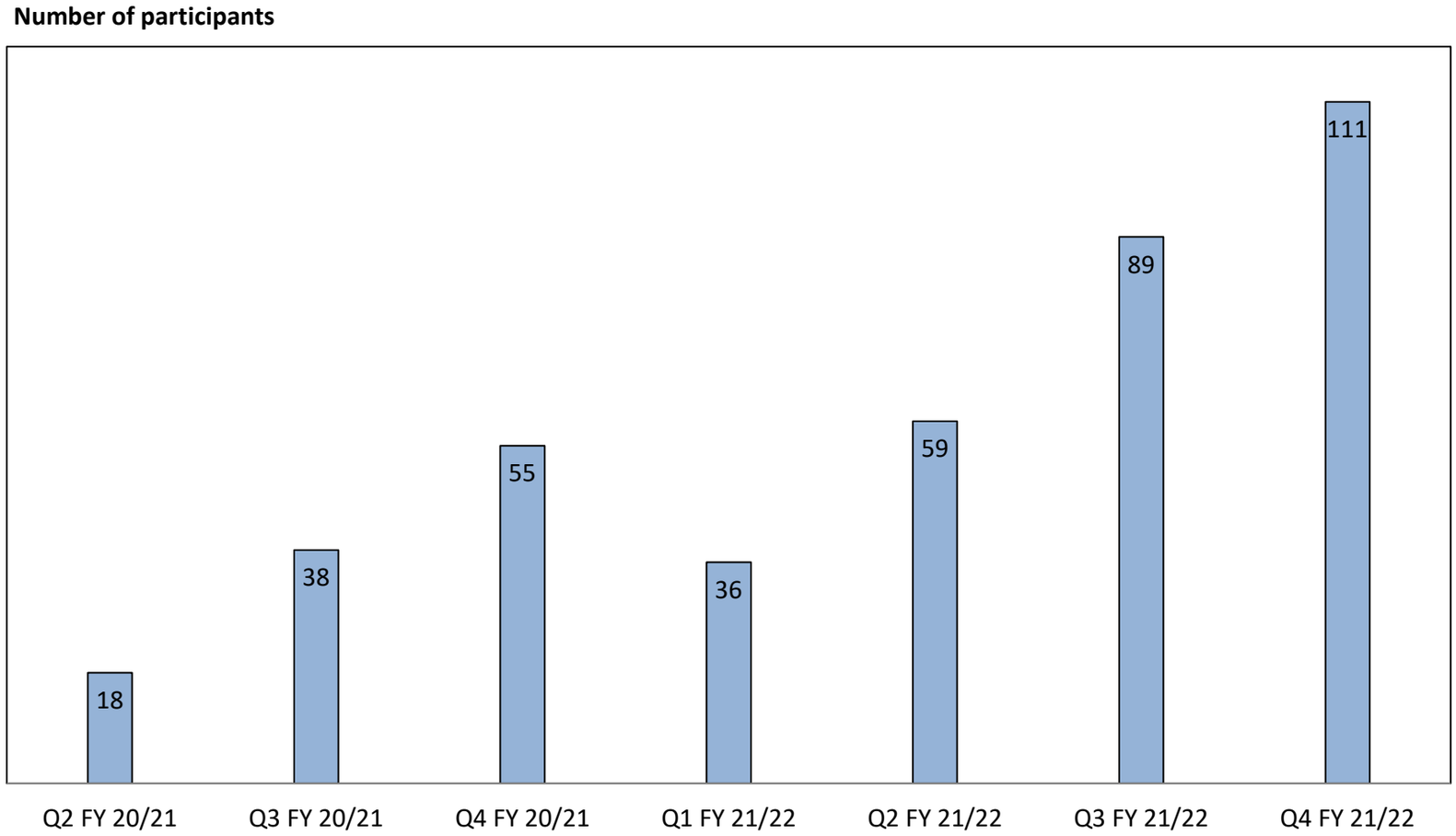
Services Provided

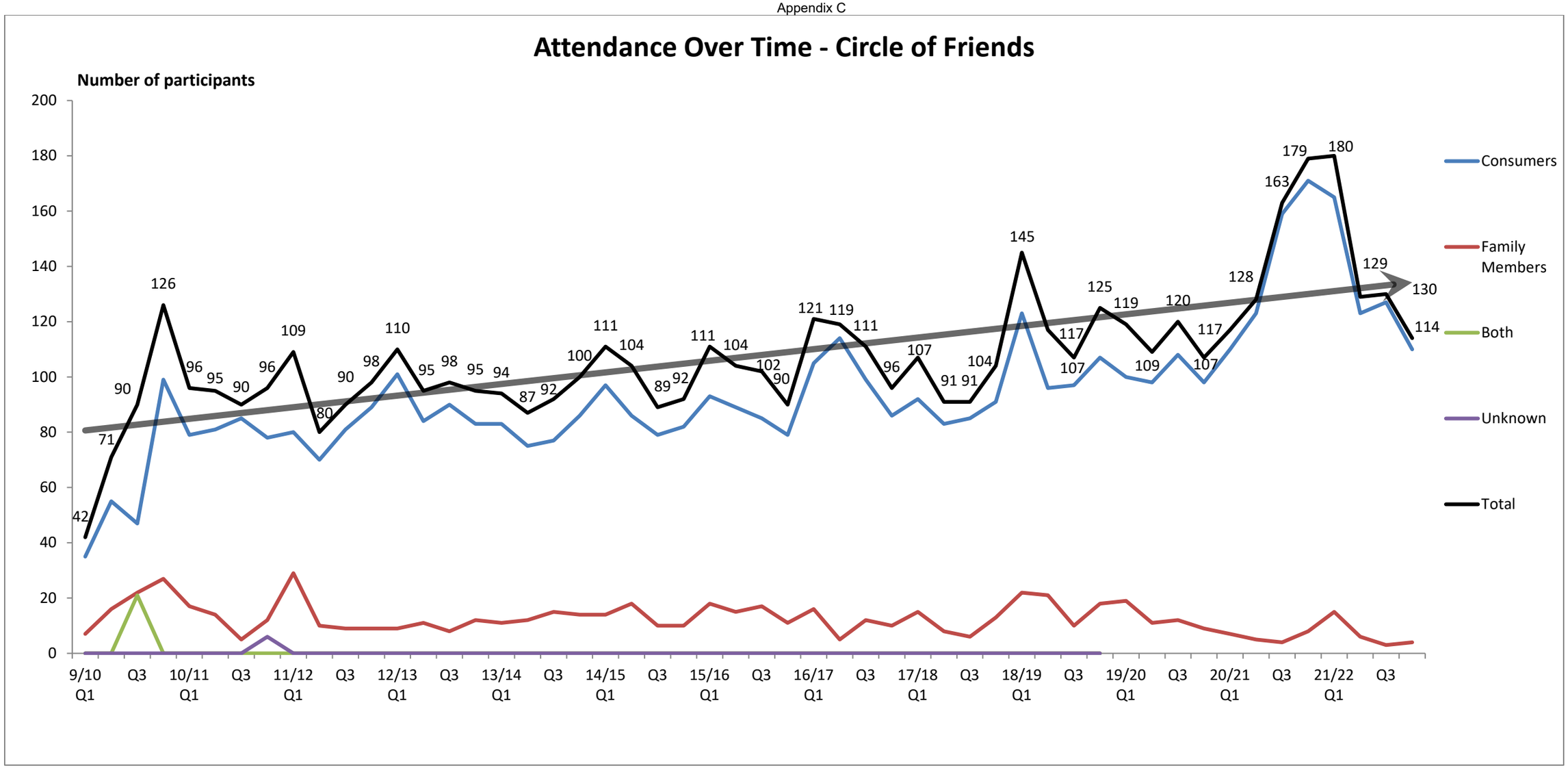
Circle of Friends Wellness Center was open for participant activities Monday, Wednesday, and Friday from 12:30 to 3:30. They are open for food and clothing distribution Monday through Friday from 8:00 to 4:30. During those hours they were available to address most concerns and requests that came their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

Attendee Direction

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

Attendance Over Time - Sunrise Mountain Wellness Center




Attendance Over Time - Circle of Friends
Number of participants
200
180
160
140
120
100
80
60
40
20
0
9/10 Q1
Q3
10/11 Q1
Q3
11/12 Q1
Q3
12/13 Q1
Q3
13/14 Q1
Q3
14/15 Q1
Q3
15/16 Q1
Q3
16/17 Q1
Q3
17/18 Q1
Q3
18/19 Q1
Q3
19/20 Q1
Q3
20/21 Q1
Q3
21/22 Q1
Q3
42 71 90 126 96 95 90 96 109 80 90 98 110 95 98 95 94 87 92 100 111 104 89 92 111 104 102 90 121 119 111 96 107 91 91 104 145 107 117 125 119 109 120 107 117 128 163 179 180 129 130 114
Consumers
Family Members
Both
Unknown
Total

Shasta County Health & Human Services Agency

NAMI Summary Report

July 2021 through June 2022

Program Offerings

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

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

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

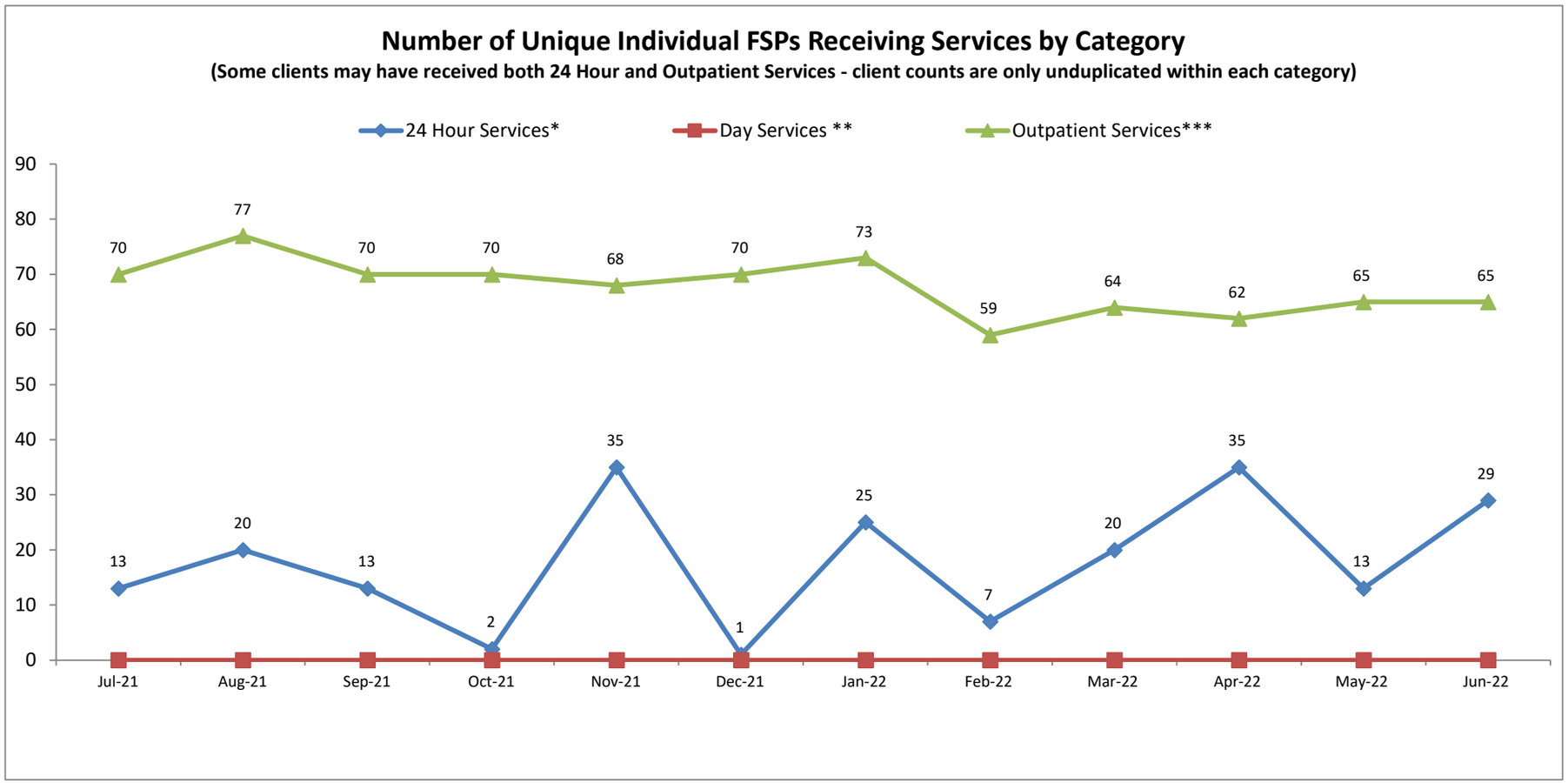
Successes: Family Support Group meetings were held online and in-person. NAMI's annual Christmas Party included gift bag giveaways to local supported housing facilities in lieu of an actual party due to Covid concerns. About 150 bags were distributed. NAMI members were active attendees at meetings for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

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

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

CSI AND FSP LINKED DATA – FISCAL YEAR 2021/2022

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

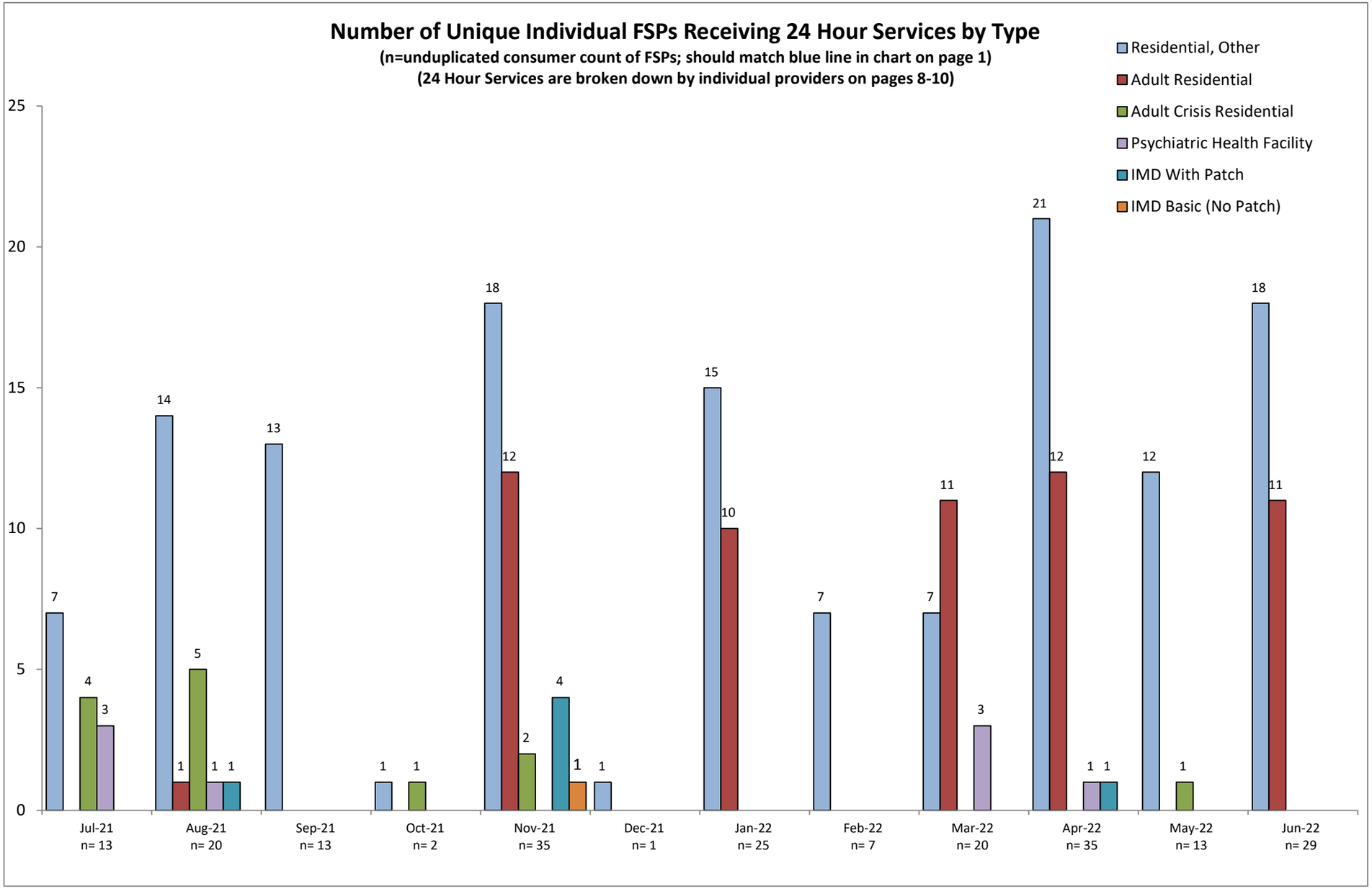


Mental Health Services are divided into three main categories: 24 Hour Services; Day Services; and, Outpatient Services.

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

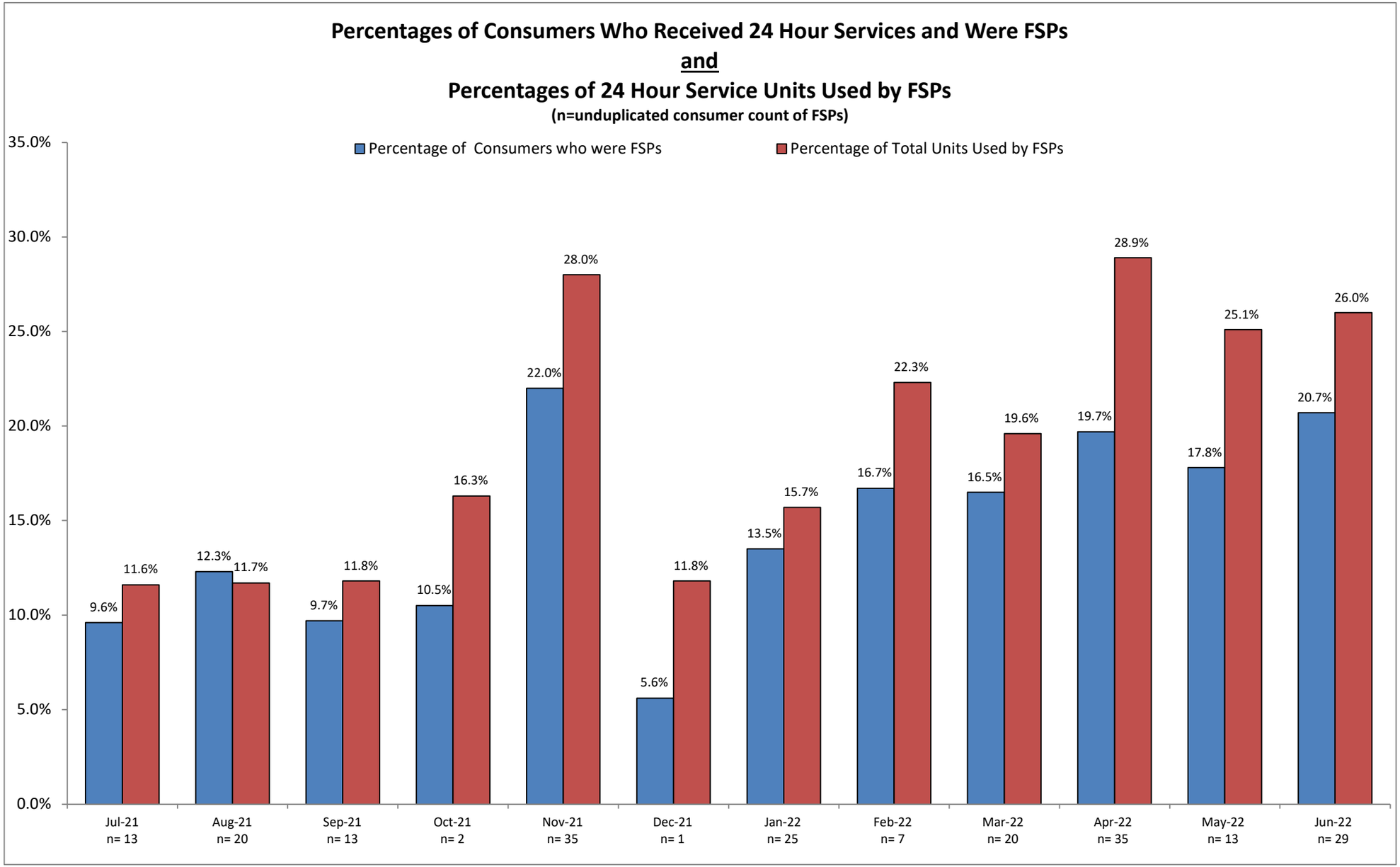
Day Services include things such as Day Treatment or Day Rehabilitation. These services are also billed for by the day, but differ from 24 Hour Services in that they do not provide over-night care.

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



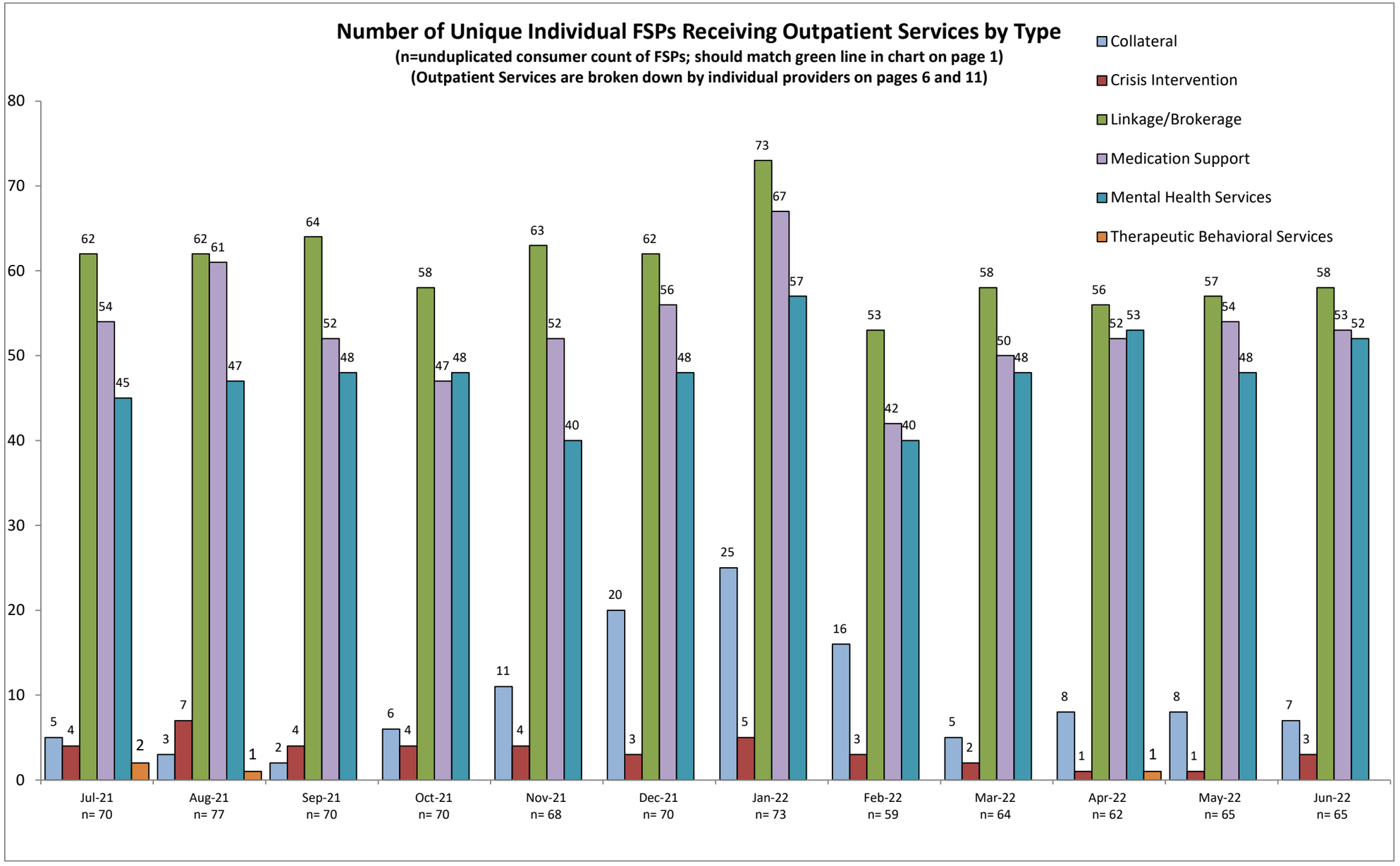
In this chart, the number of unduplicated Full Service Partners that received any type of 24 Hour Service is noted under the month as “n”.

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



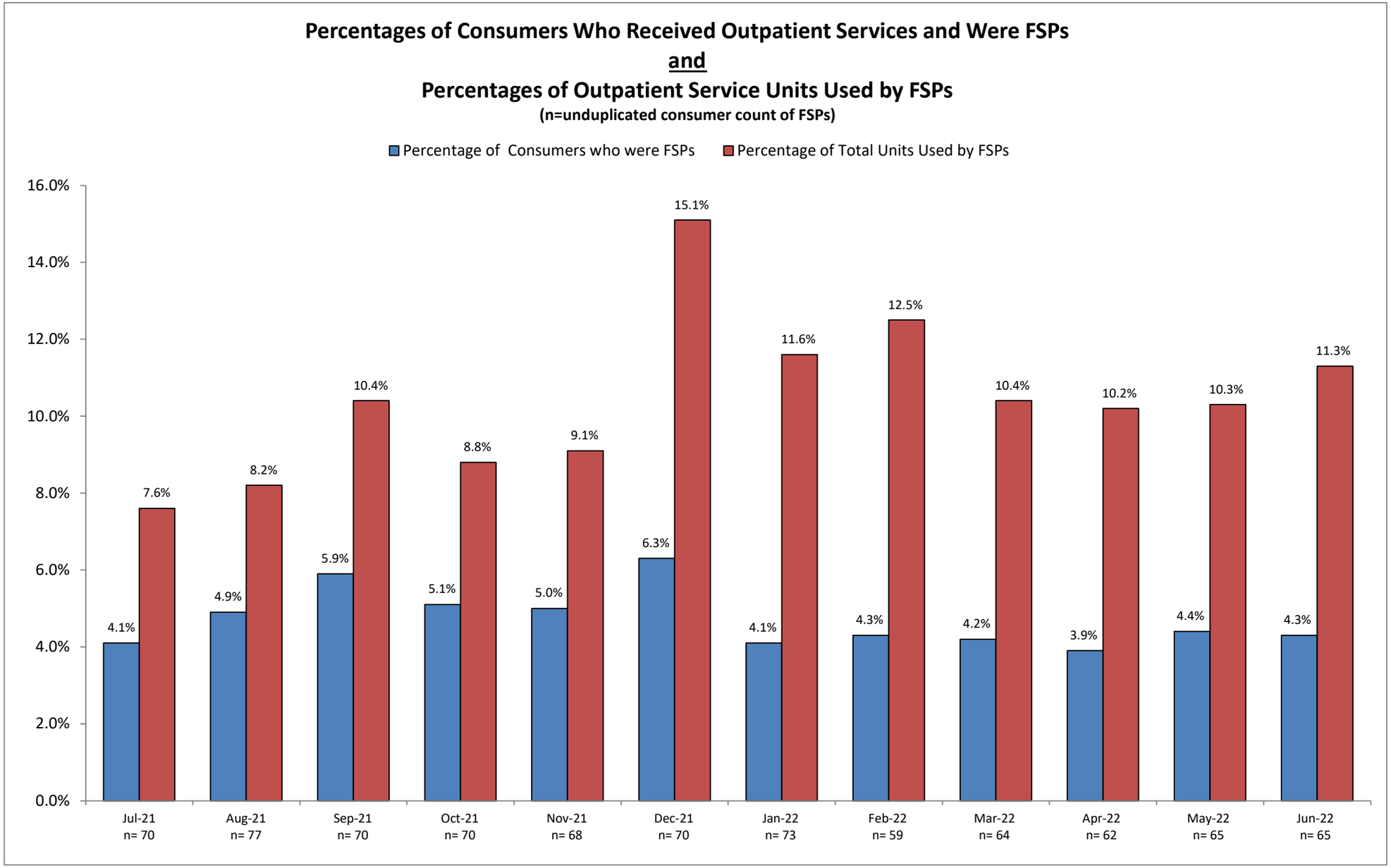
24 Hour Services are billed for by the day. This chart compares, by percentage, how many of the consumers that utilized 24 Hour Services were Full Service Partners, and how many of the days billed for were used by Full Service Partners.

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



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

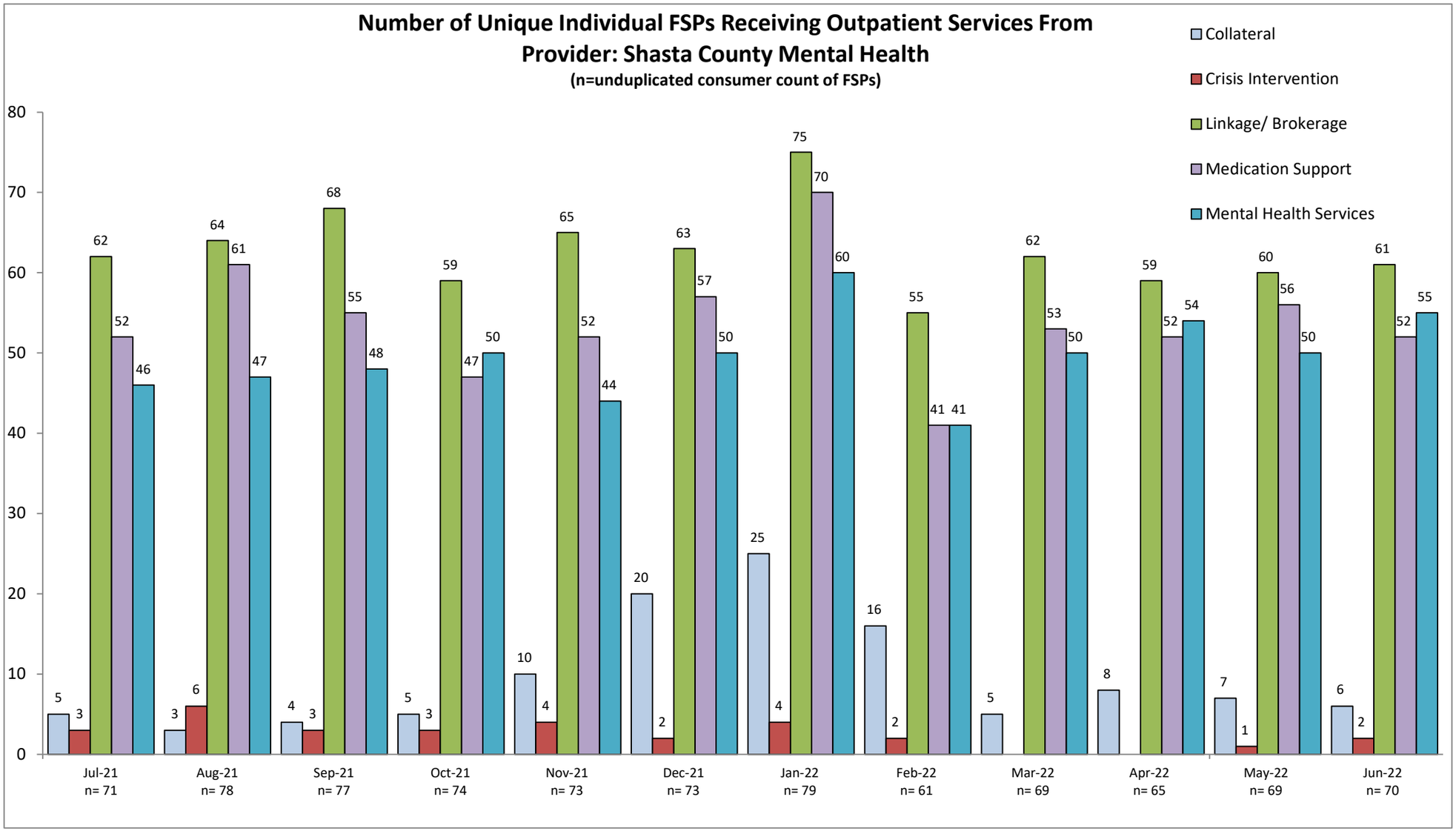
The bars above each month show how many of those unduplicated Full Service Partners received each type of Outpatient Service. Because consumers can, and often do, receive more than one kind of service in any given month, the combined number for the service types each month may add up to more than the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



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

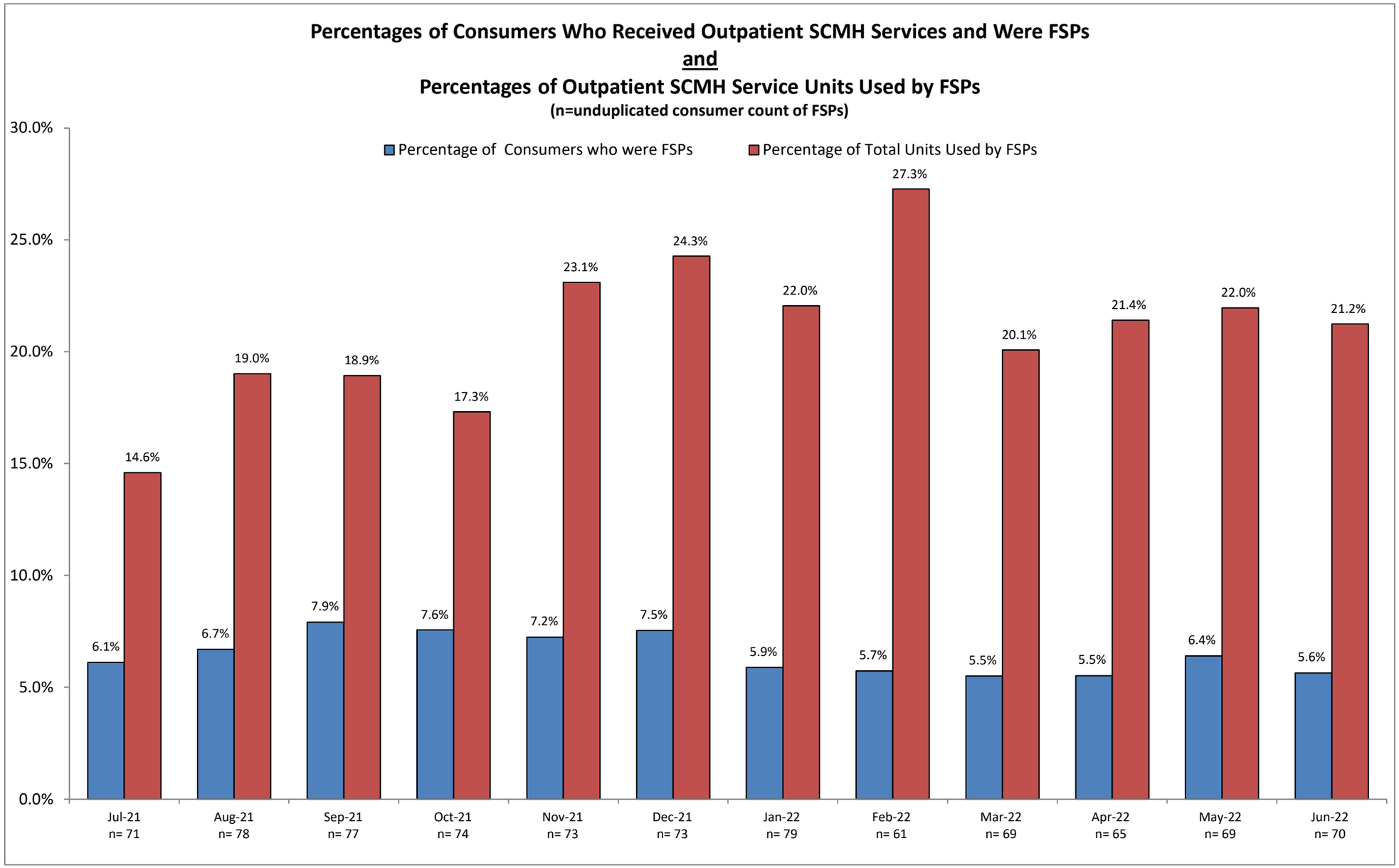
Because the Full Service Partnership program is designed to provide intensive services, it is expected that partners may utilize disproportionately more of the services than non-partner consumers.

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



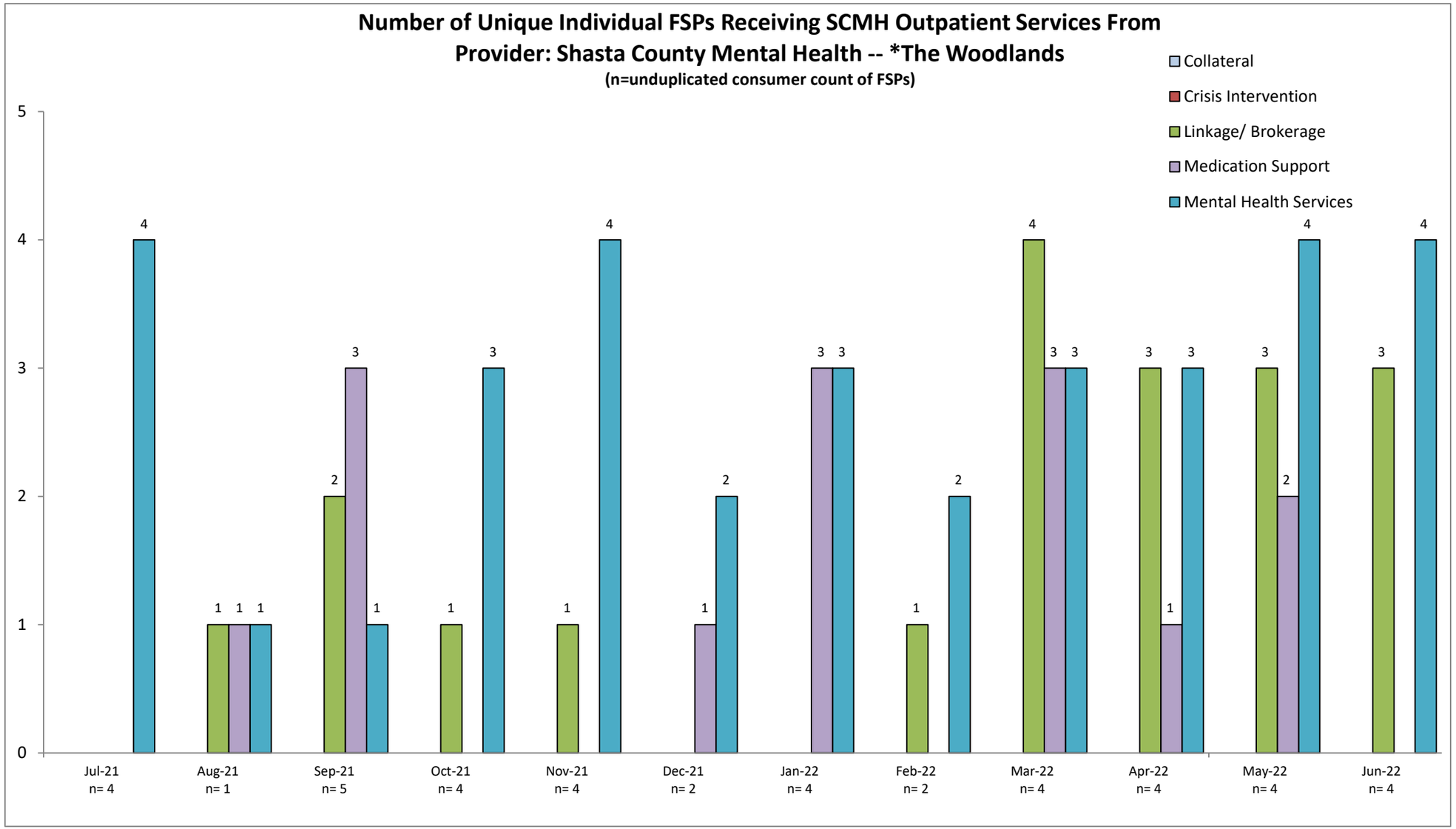
In this chart, the number of unduplicated Full Service Partners who received any type of Outpatient Service from SCMH is noted under the month as “n”.

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



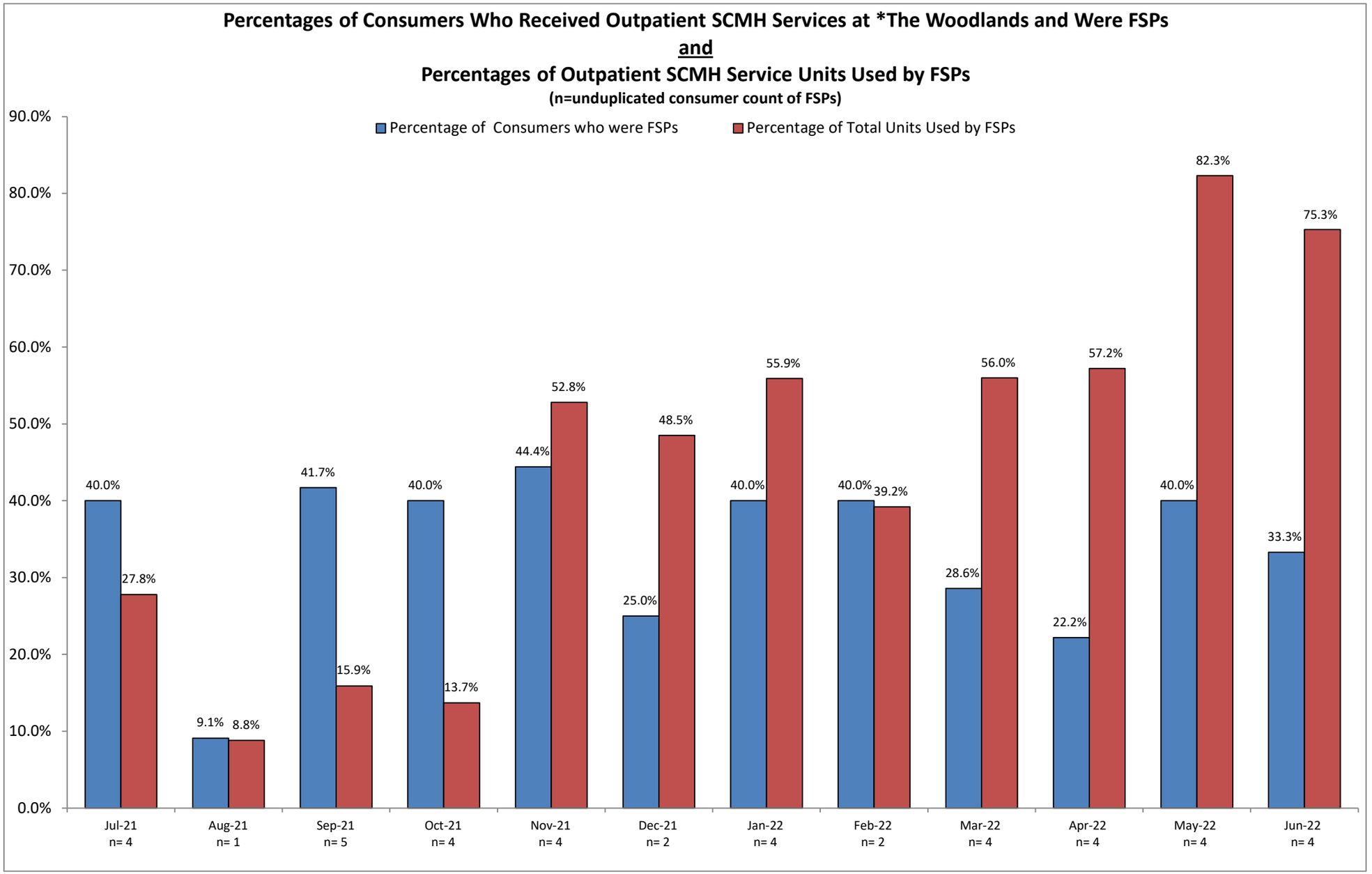
This chart compares, by percentage, how many of the consumers that utilized Outpatient Services were Full Service Partners, and how many of the minutes billed for were used by Full Service Partners.

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



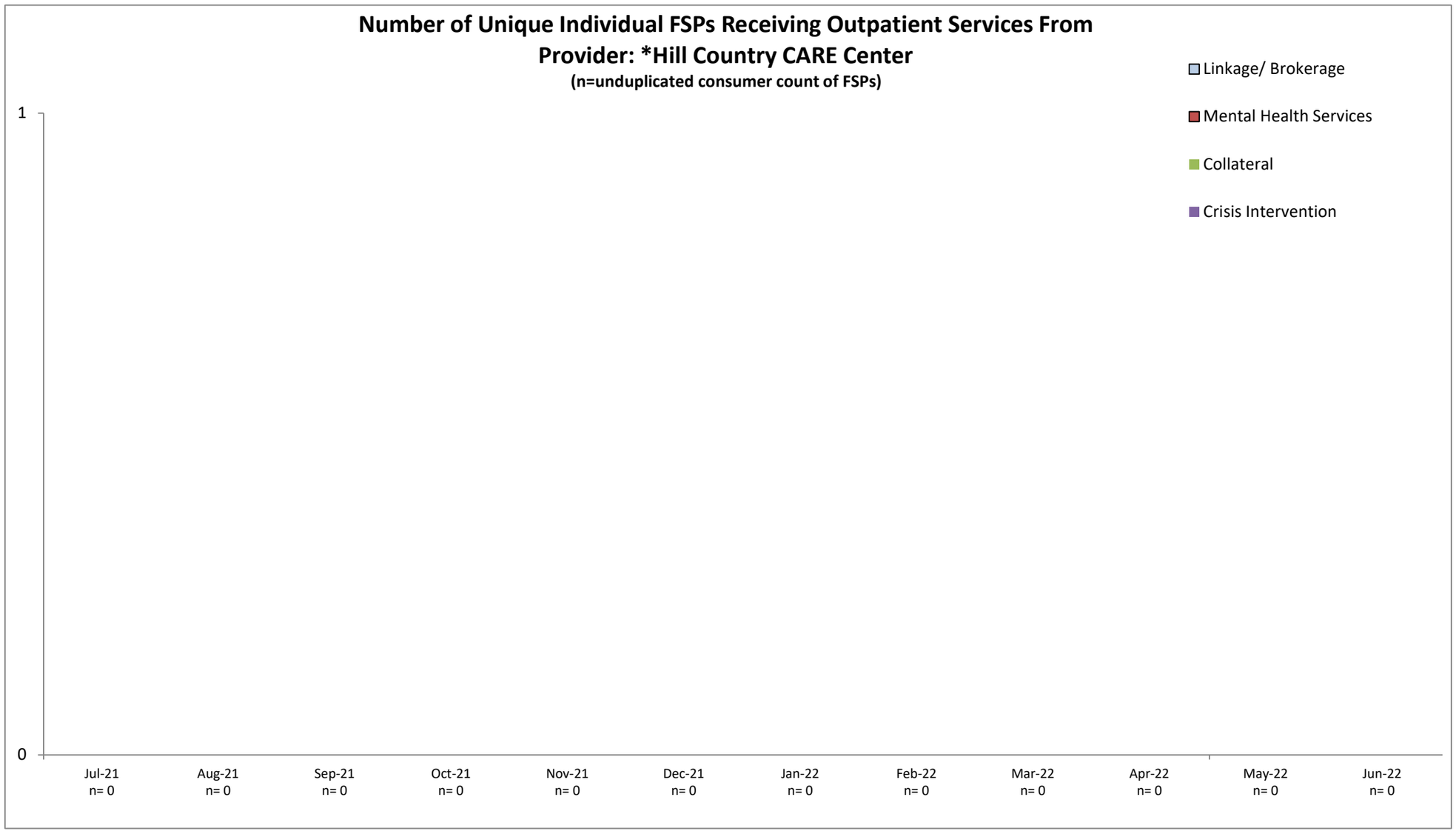
In this chart, the number of unduplicated Full Service Partners that received any type of Outpatient Service at The Woodlands Housing Project from SCMH is noted under the month as “n”.

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



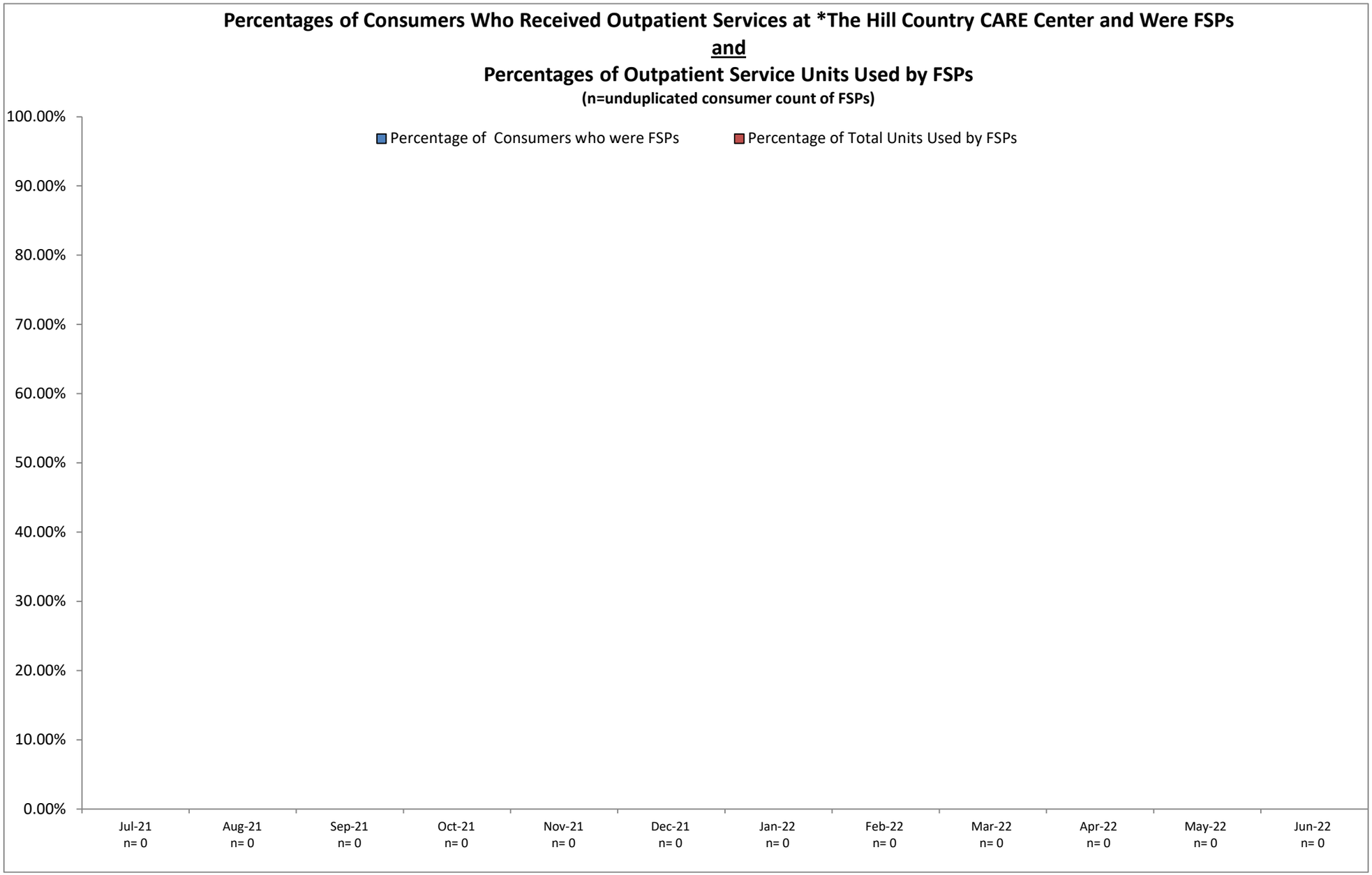
This chart compares, by percentage, how many of the consumers that utilized Outpatient Services at The Woodlands Housing Project were Full Service Partners, and how many of the minutes billed for were used by Full Service Partners.

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



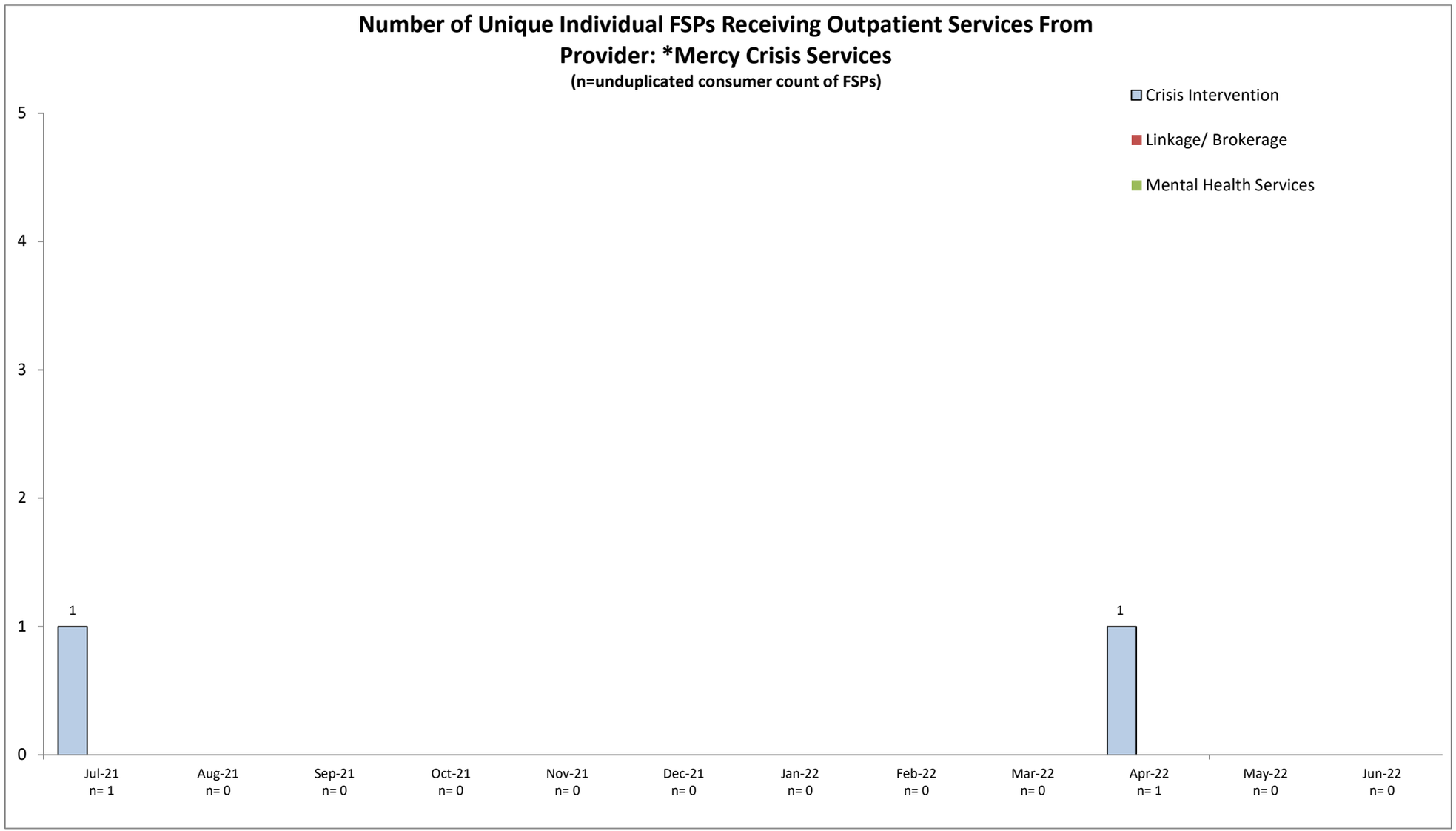
In this chart, the number of unduplicated Full Service Partners that received any type of Outpatient Services at the Hill Country CARE Center is noted under the month as "n".

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



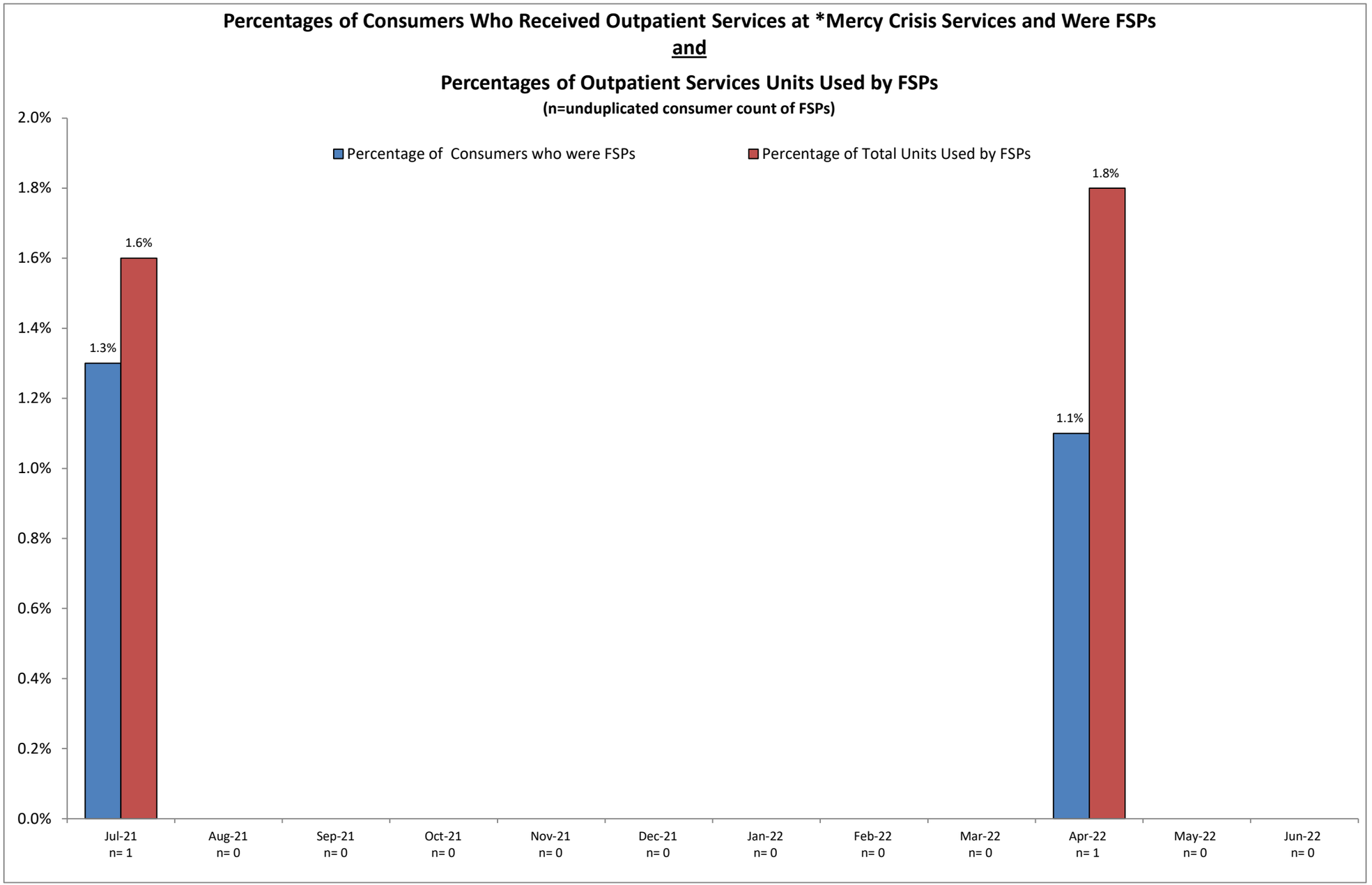
This chart compares, by percentage, how many of the consumers that utilized Outpatient Services at the Hill Country CARE Center were Full Service Partners, and how many of the minutes billed for were used by Full Service Partners.

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



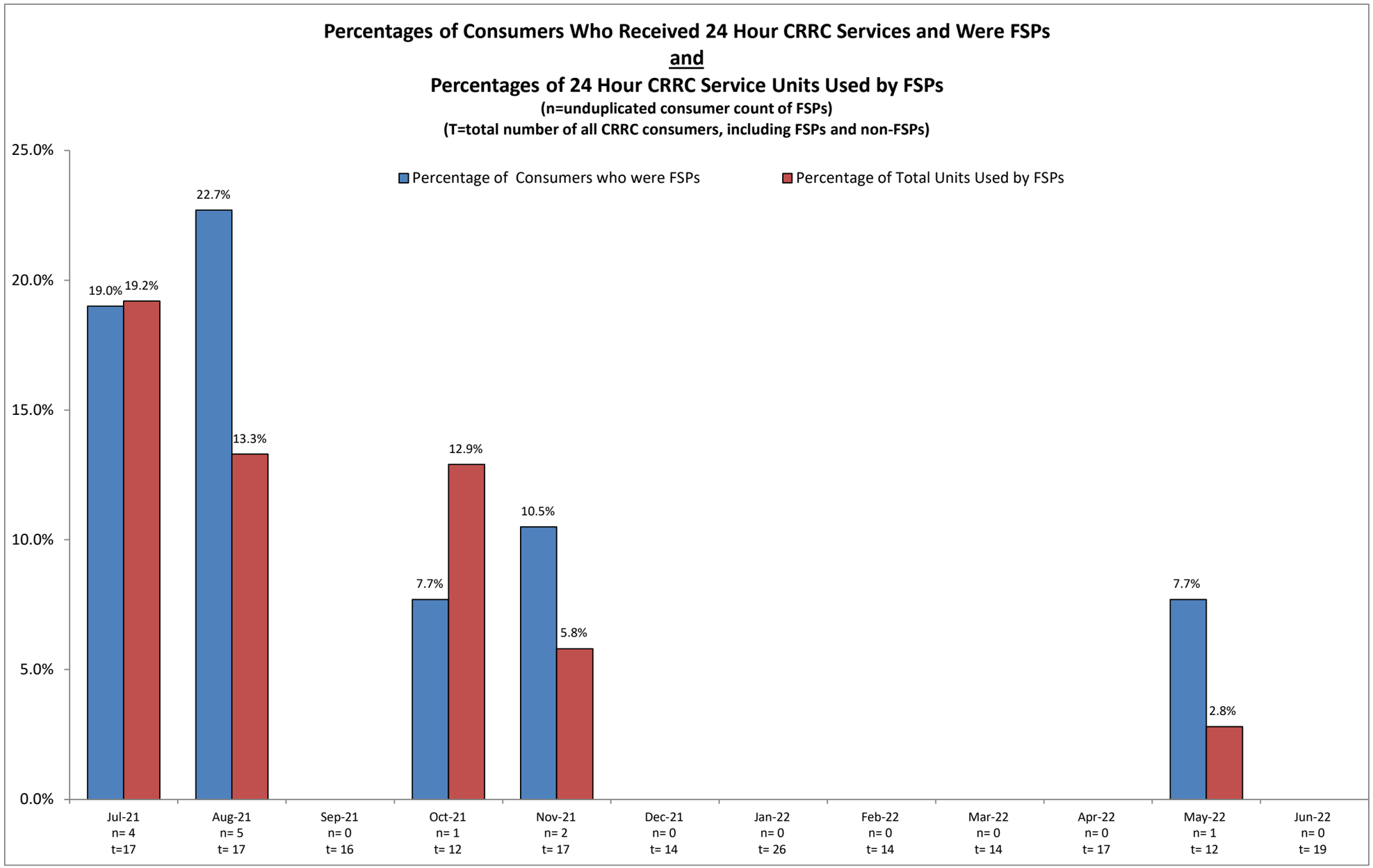
In this chart, the number of unduplicated Full Service Partners that received any type of Outpatient Service at Mercy Crisis Services is noted under the month as “n”.

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



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

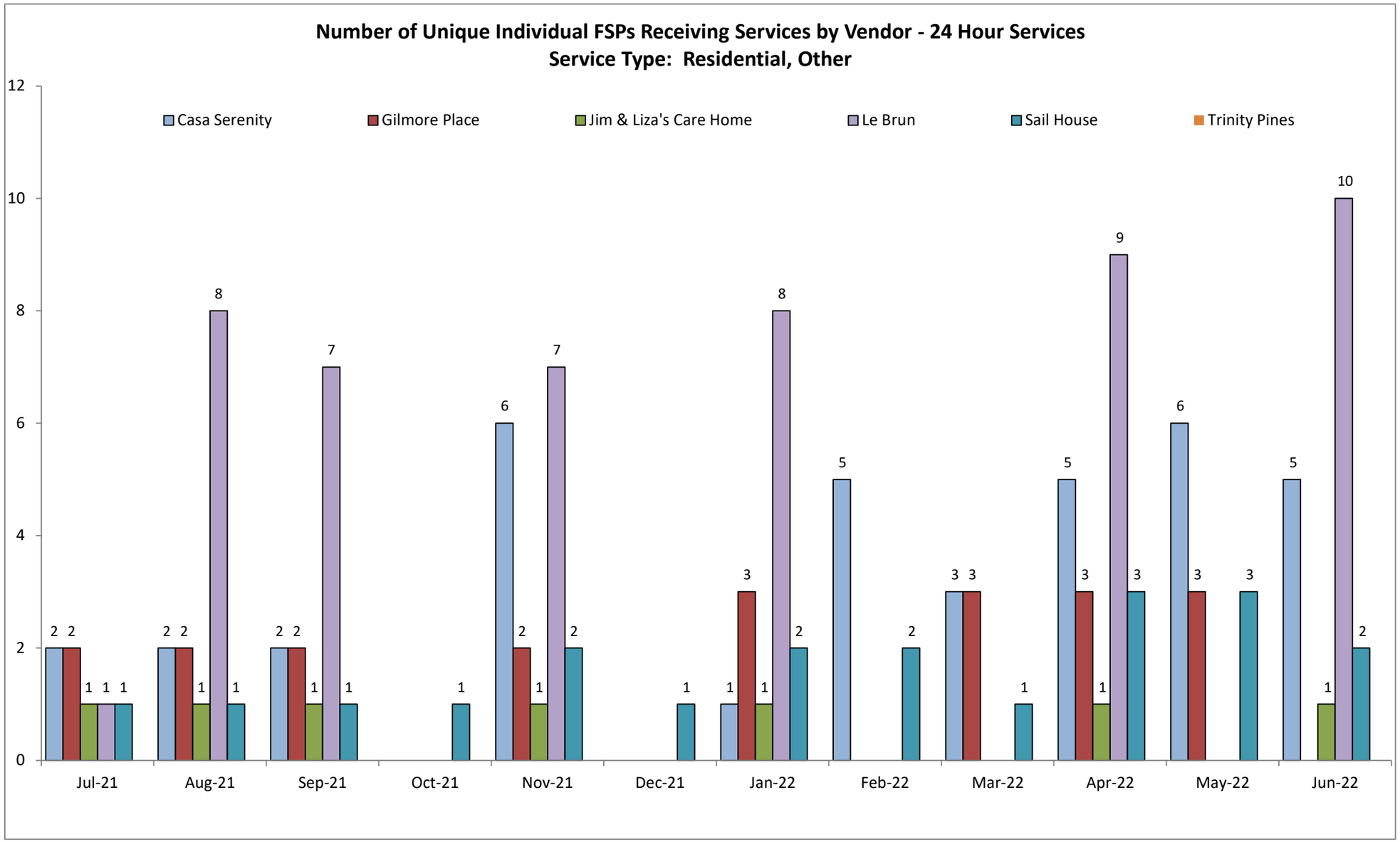
Because the Full Service Partnership program is designed to provide intensive services, and because case management of FSPs is handled by Mercy Crisis Services staff, it is expected that partners may utilize disproportionately more of the services than non-partner consumers.



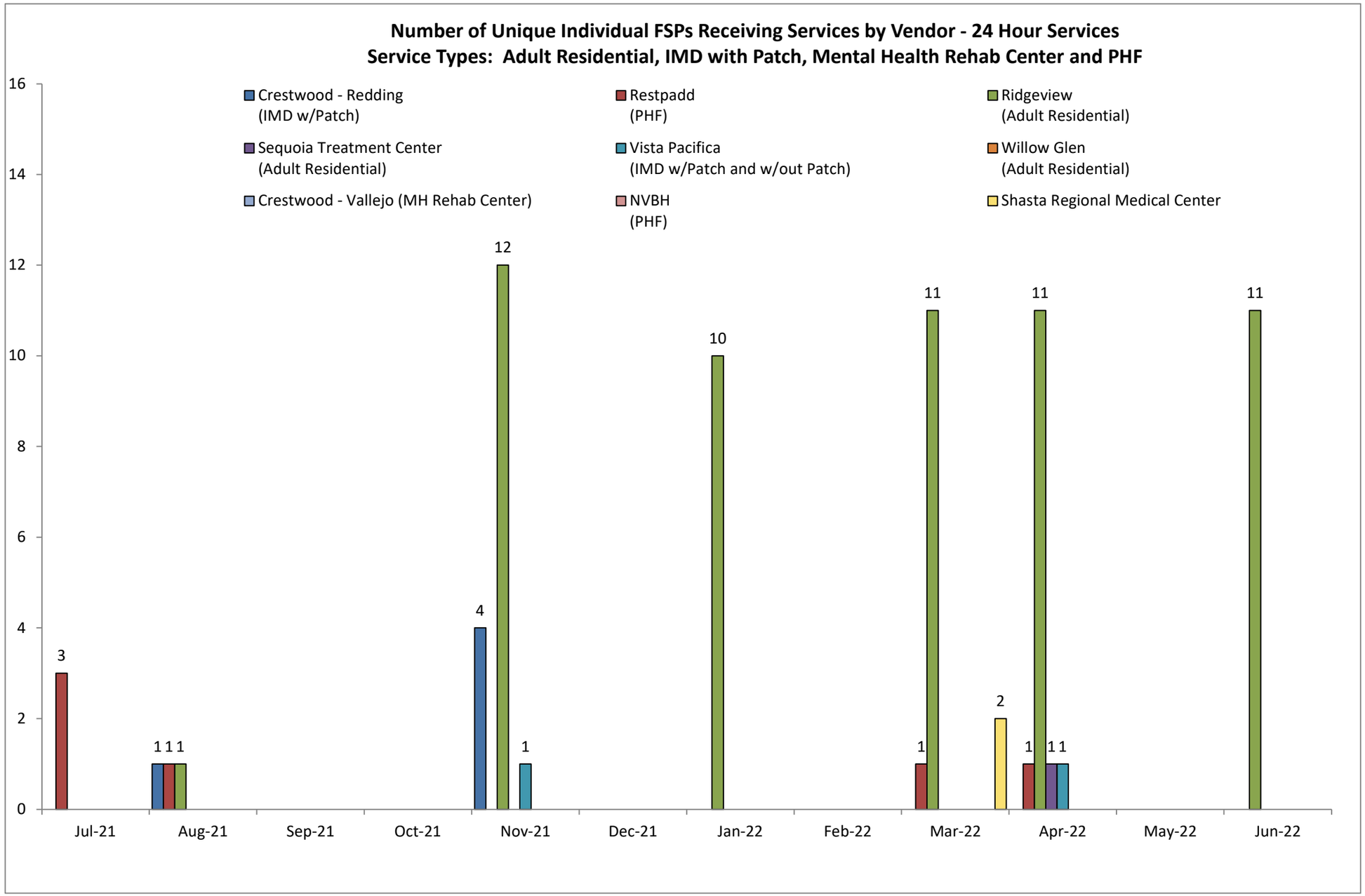
The only 24 Hour Service provided directly by Shasta County Mental Health is the Crisis Residential and Recovery Center (CRRC).

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

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



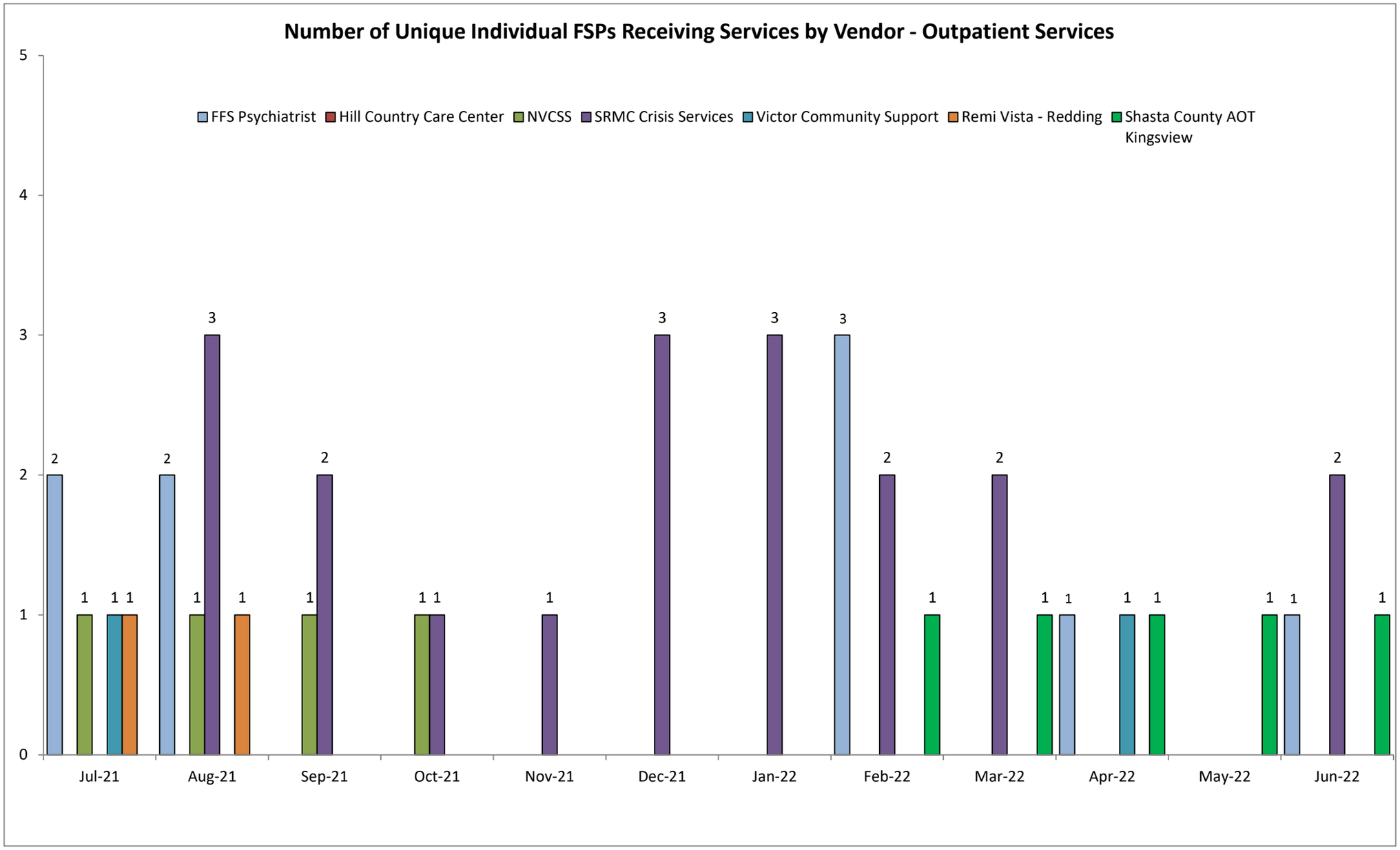
This chart shows the number of unduplicated Full Service Partners each individual vendor providing 24 Hour "Residential-Other" Services reported serving. Vendors provide some level of Board and Care setting. Because partners may have moved from one Board and Care to another in the same month, numbers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



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

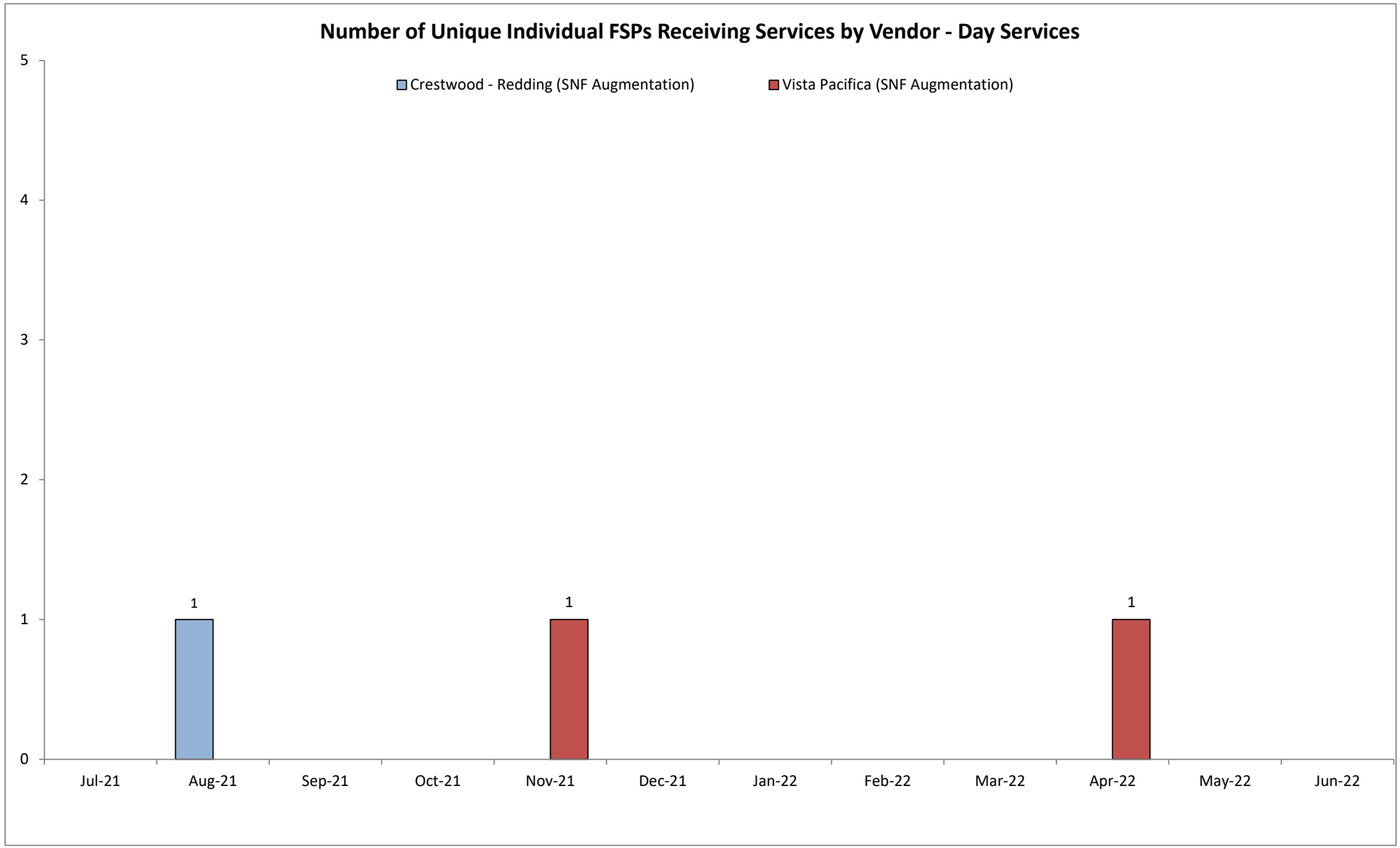
Because partners may have moved from one facility to another in the same month, numbers of partners are only unduplicated by individual vendor.

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



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

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



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

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

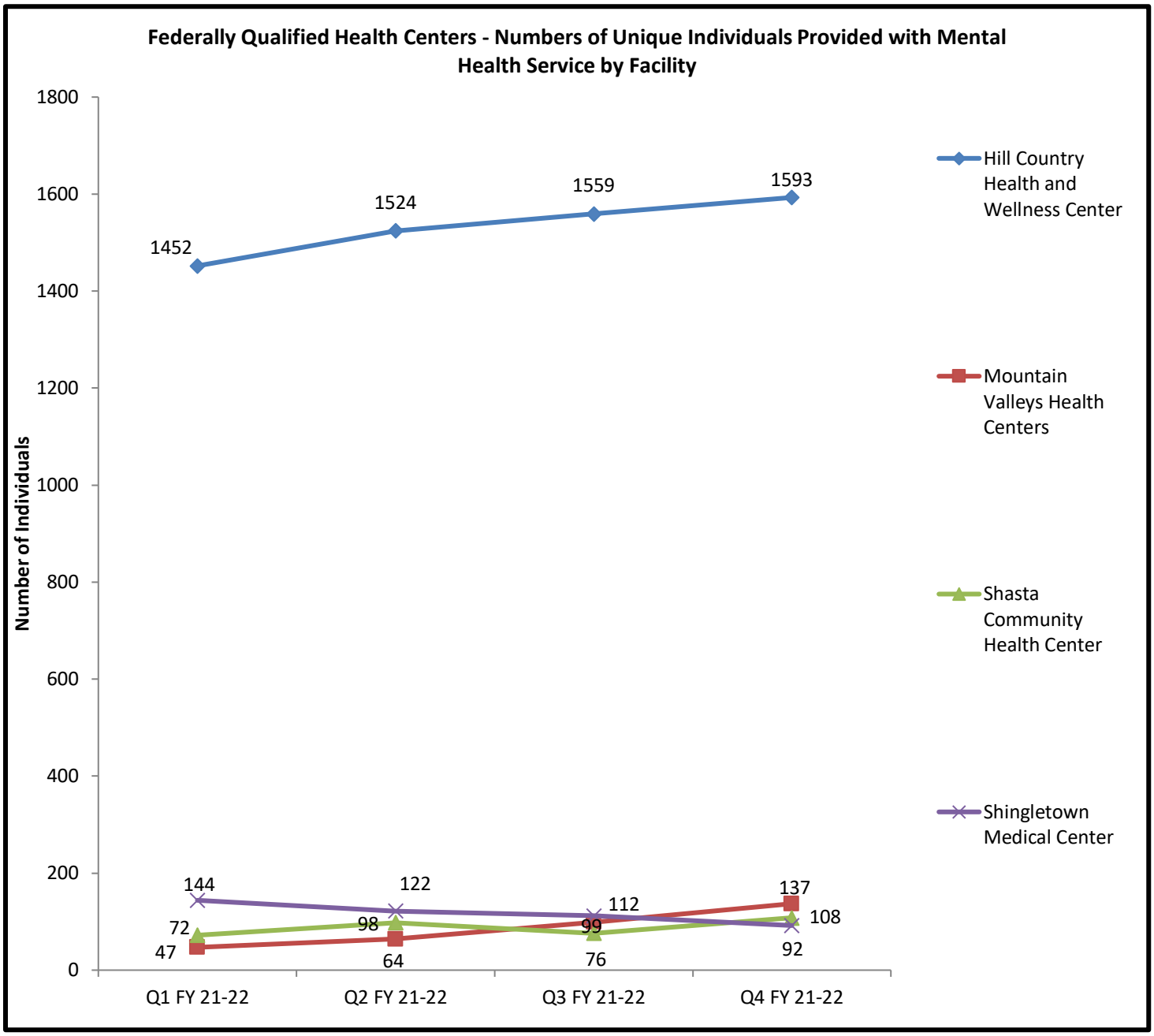
Federally Qualified Health Centers Annual Summary Report

July 2021 through June 2022

To better provide access to mental health services in Shasta County, the Shasta County Health and Human Services Agency has contracted with four different Federally Qualified Health Centers (FQHCs) to provide new or expanded mental health services, integrate mental health services with existing mental health and medical services provided by the FQHCs, and strengthen the relationship between the FQHCs and the County's public mental health system. Funding is provided through the Mental Health Services Act (MHSA). Shasta County had four FQHCs in operation during the 2021-2022 fiscal year: **Hill Country Health and Wellness Center** in Round Mountain; **Mountain Valleys Health Centers** in Burney; **Shasta Community Health Center** in Redding; and **Shingletown Medical Center** in Shingletown.

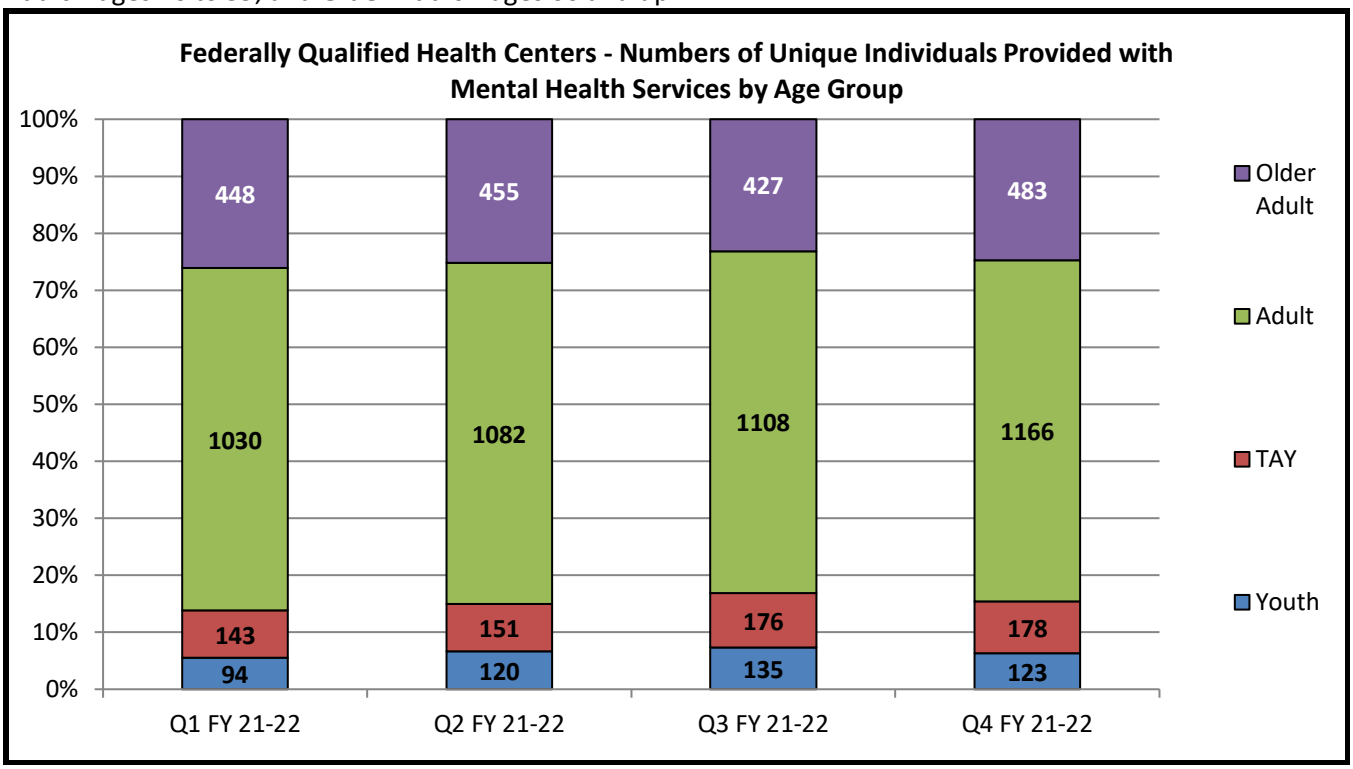
Attendance

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

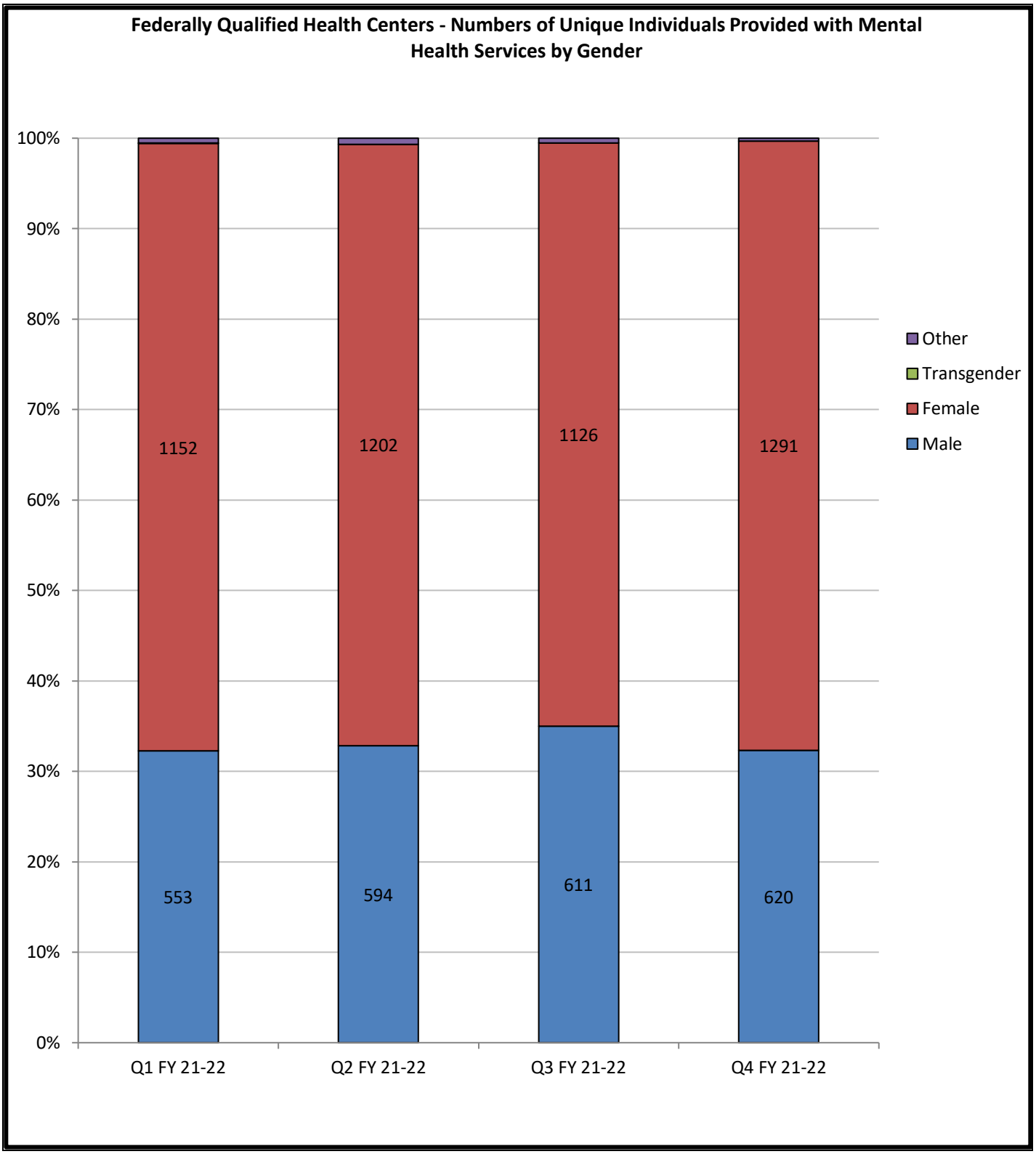


Demographics

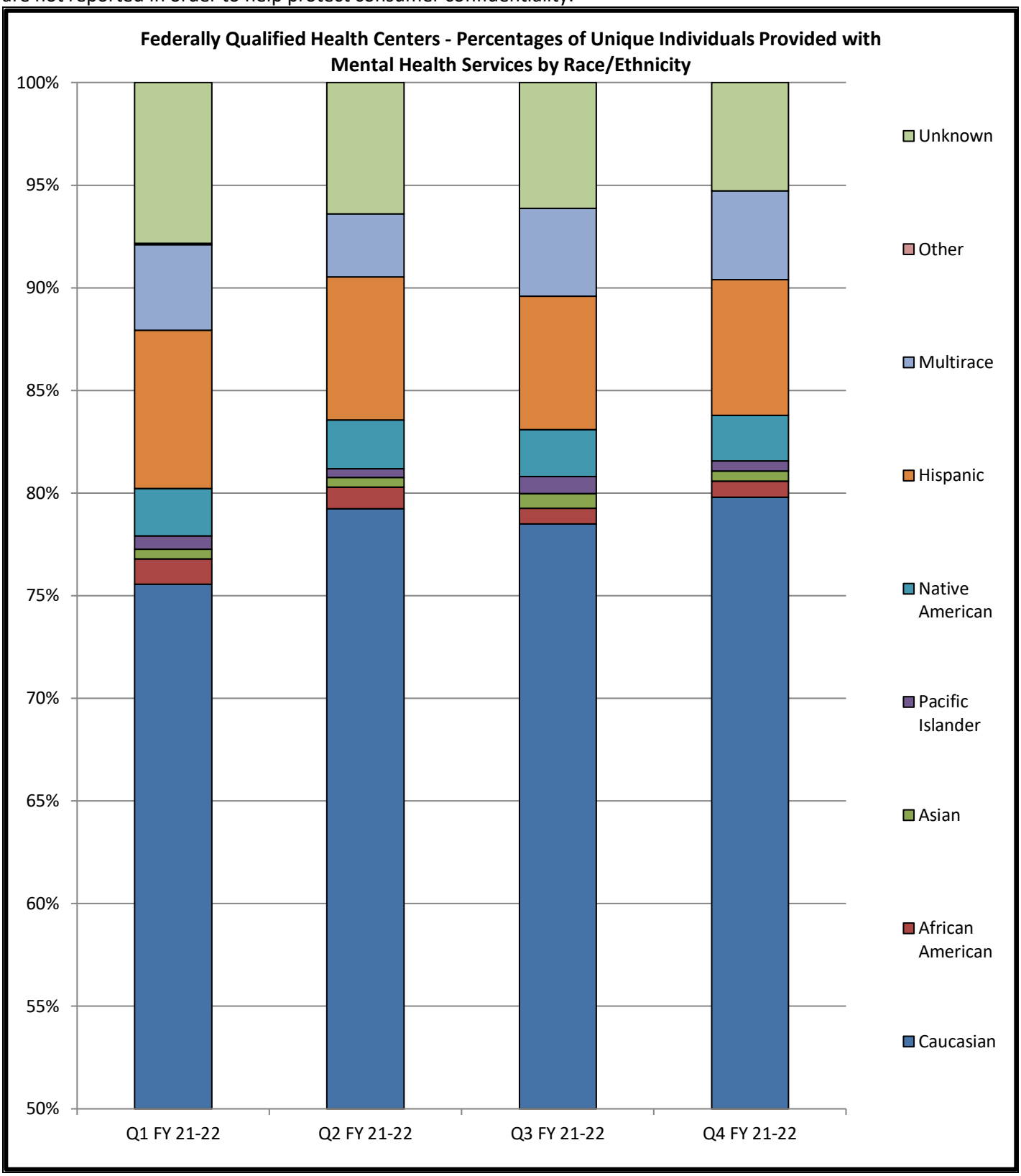
Age - The MHSA uses four age categories: **Youth** – ages 0 to 15, **Transition Aged Youth** (TAY) – ages 16 to 25, **Adult** – ages 26 to 59, and **Older Adult** – ages 60 and up.



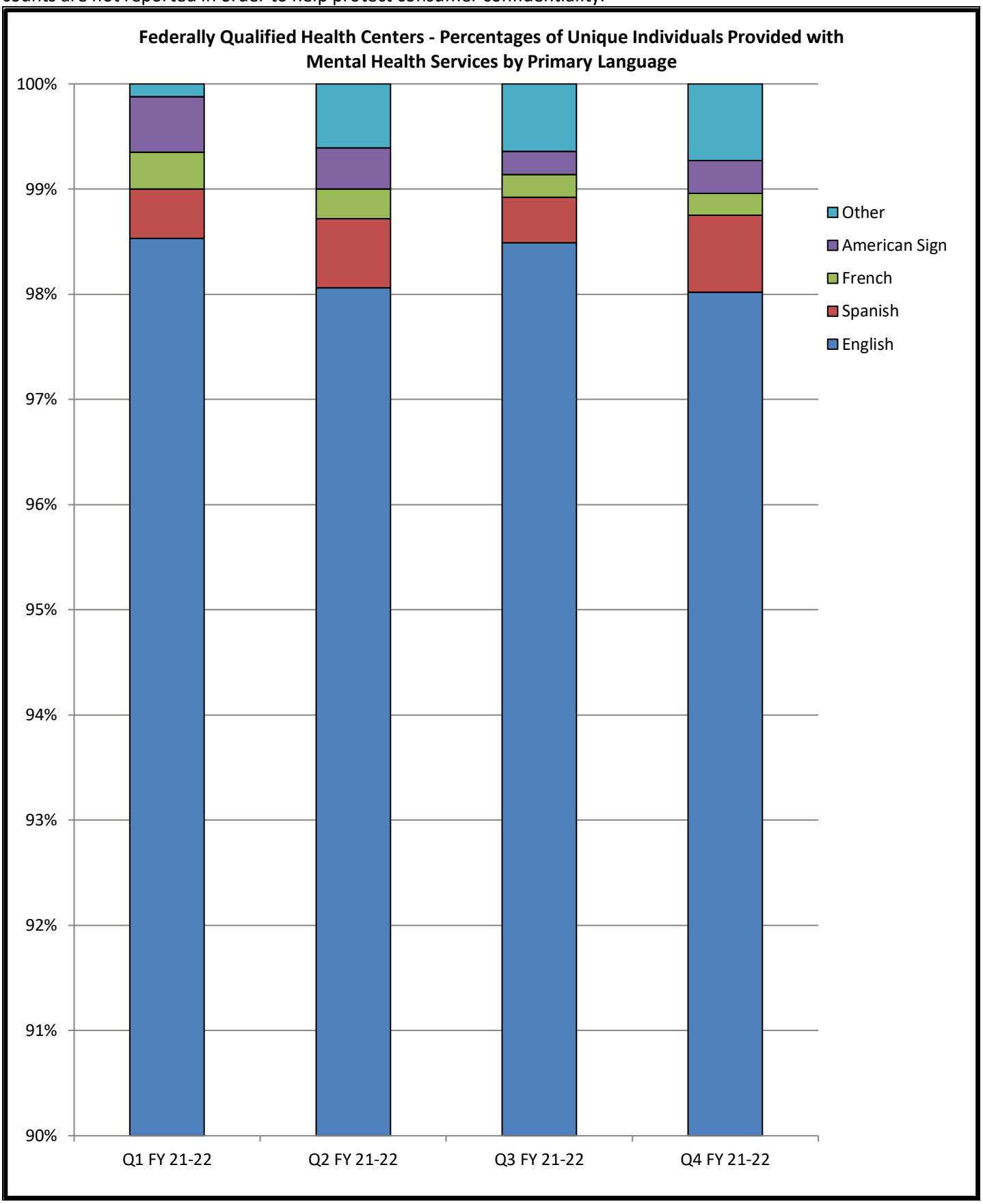
Gender - The MHSA uses four gender categories: **Male**, **Female**, **Transgender**, and **Other**. Counts of less than 20 individuals are not labeled to help maintain consumer confidentiality but are included in the chart.



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

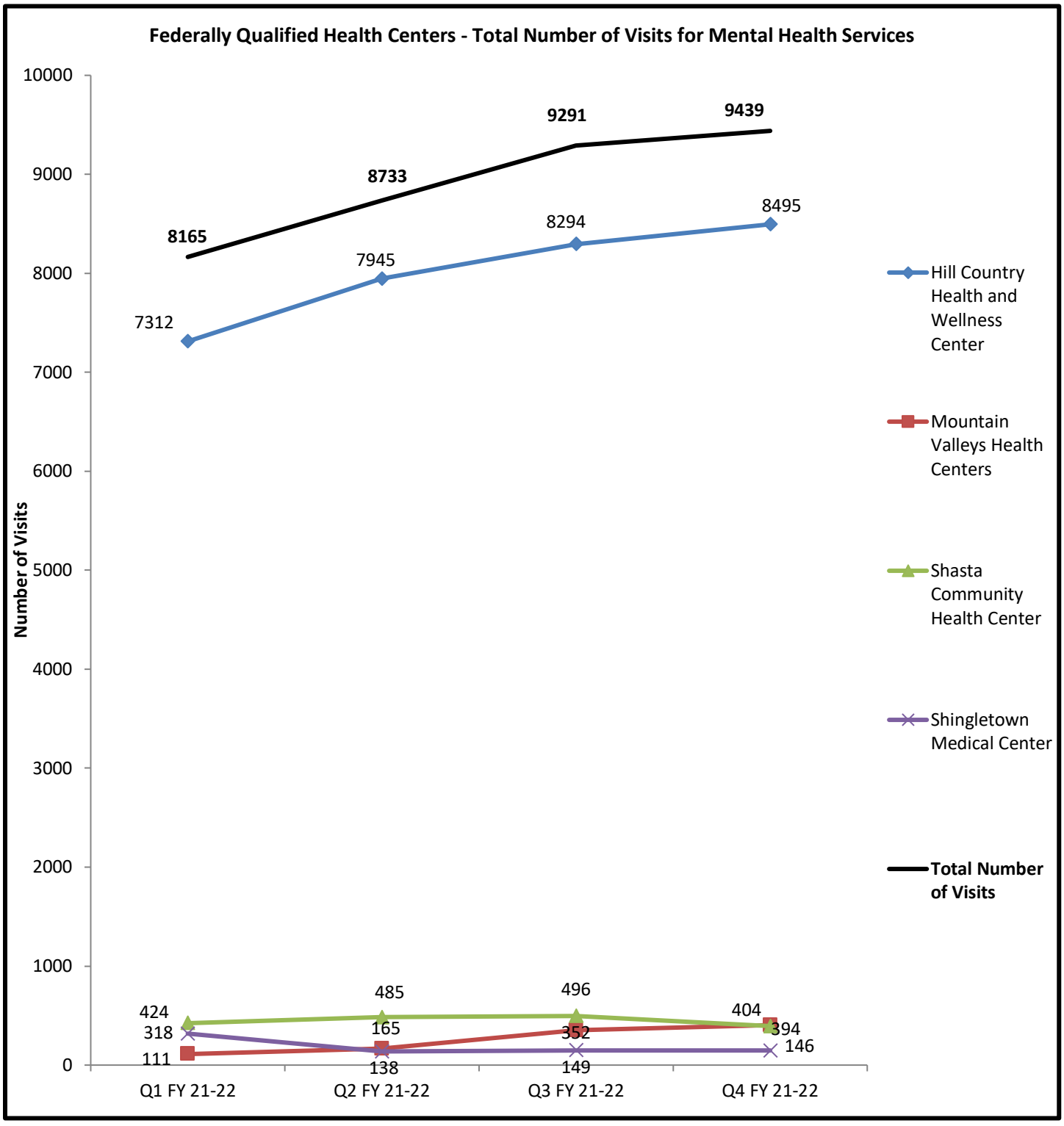


Primary Language - Because of the low gross numbers for some of these languages within small communities, actual counts are not reported in order to help protect consumer confidentiality.



Services Provided

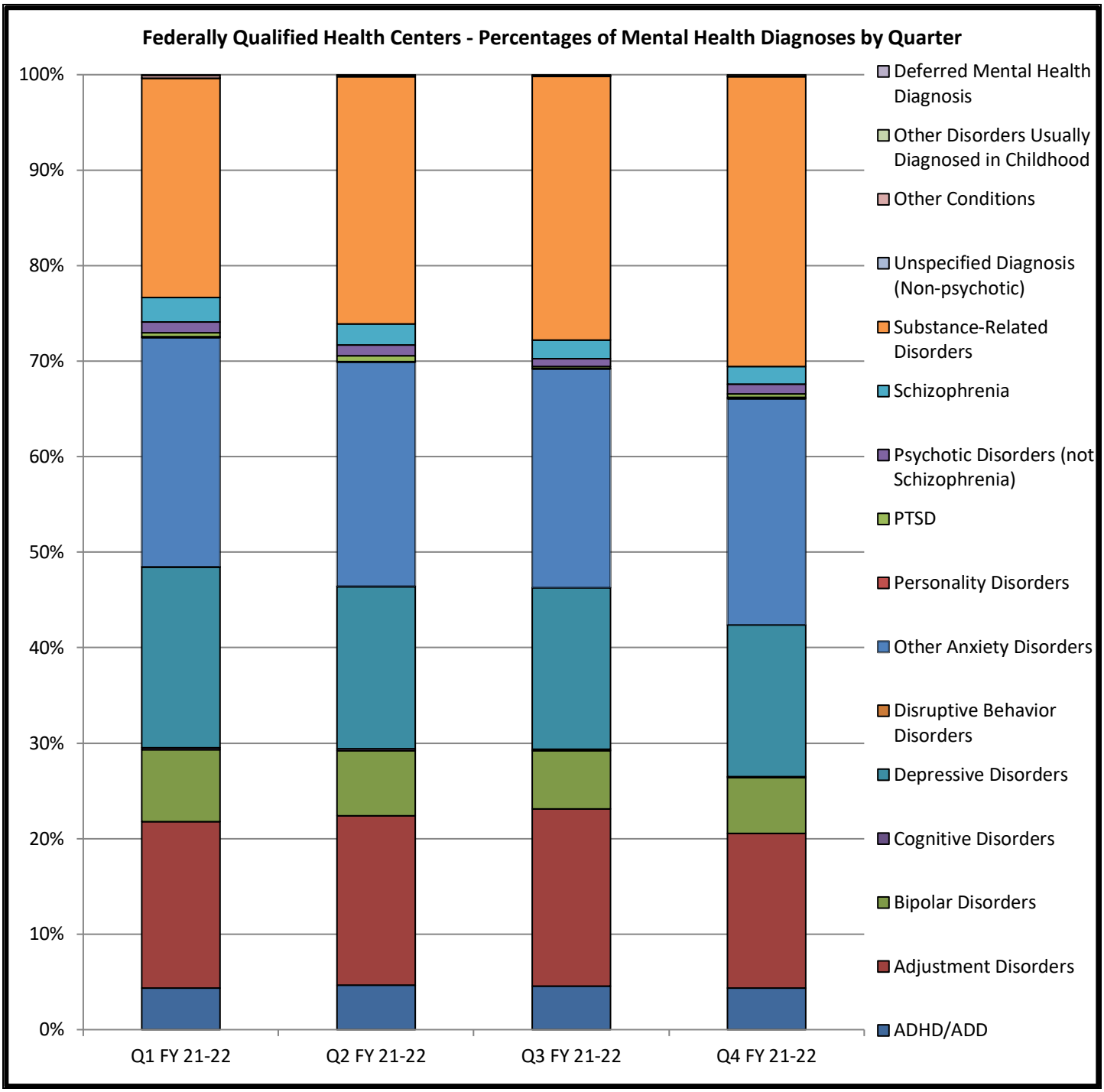
Most people will have multiple visits to the FQHC each quarter, and different types of service may be offered at different times in order to provide everyone with comprehensive and integrated age appropriate mental health services. Services provided may include such things as screenings, assessments,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



Primary Mental Health Diagnosis

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

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

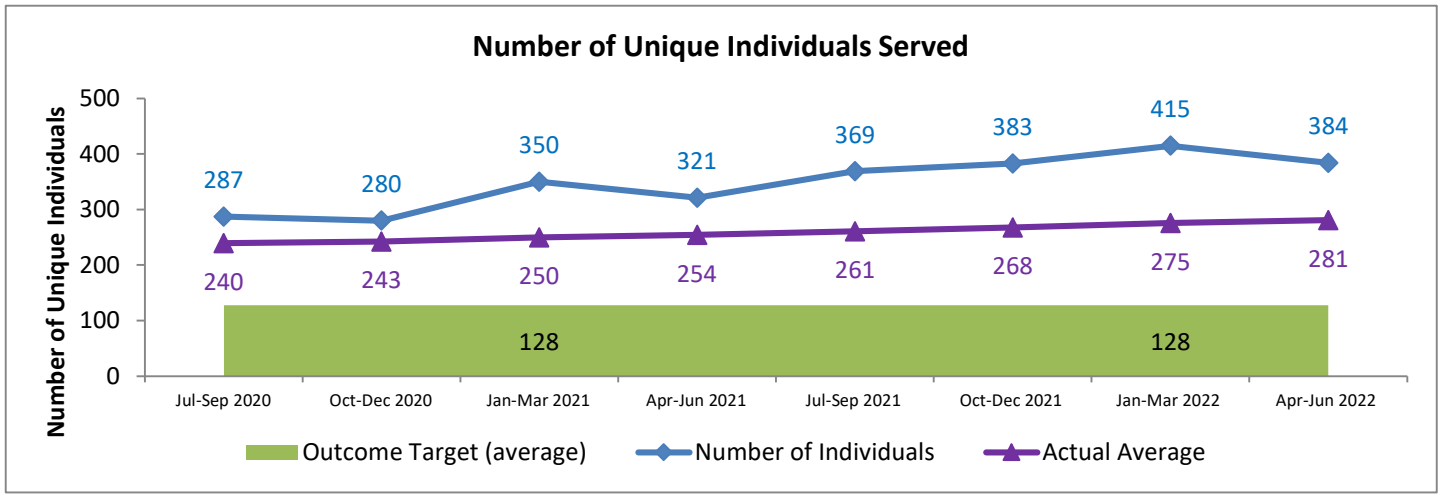


CARE Center Activity Report
July 2020 through June 2022

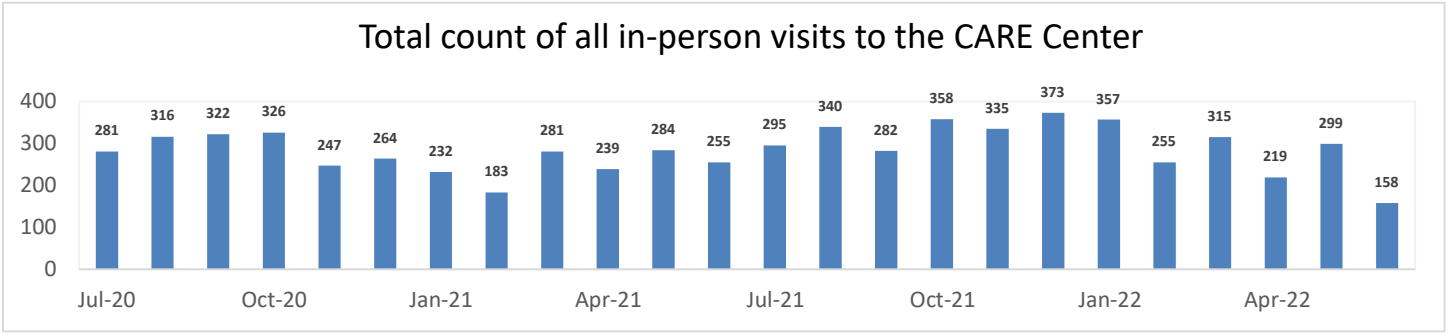
To determine if providing access to mental health services after traditional office hours will improve access to services, reduce mental health crisis (including trips to the hospital emergency departments) and bridge service gaps, the Shasta County Health and Human Services Agency has contracted with Hill County Health and Wellness Center to provide new and expanded mental health services at the Counseling and Recovery Engagement (CARE) Center. Funding is provided through the Mental Health Services Act (MHSA) for the Community Services and Support Project portion of this center. The CARE Center contract was approved as of January 2017, and they officially opened for business on March 12, 2017. For this report, data was gathered using the CARE Center Quarterly Progress Reports for July 2020 through June 2022. Please note that further refinement of the data collection is still underway for some measures.

INDIVIDUALS SERVED

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



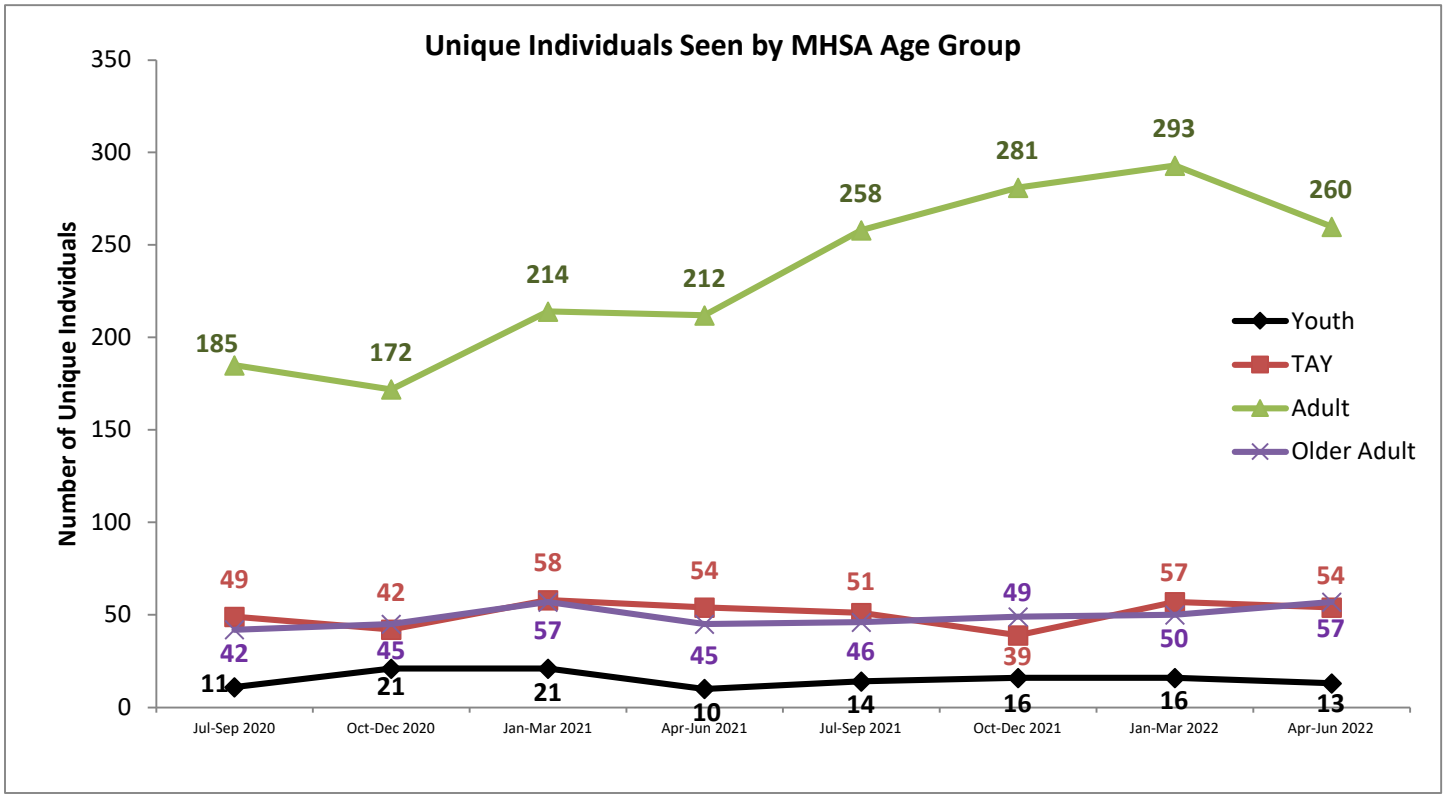
Please note that most clients visit more than once – the graph below is not an unduplicated person count.



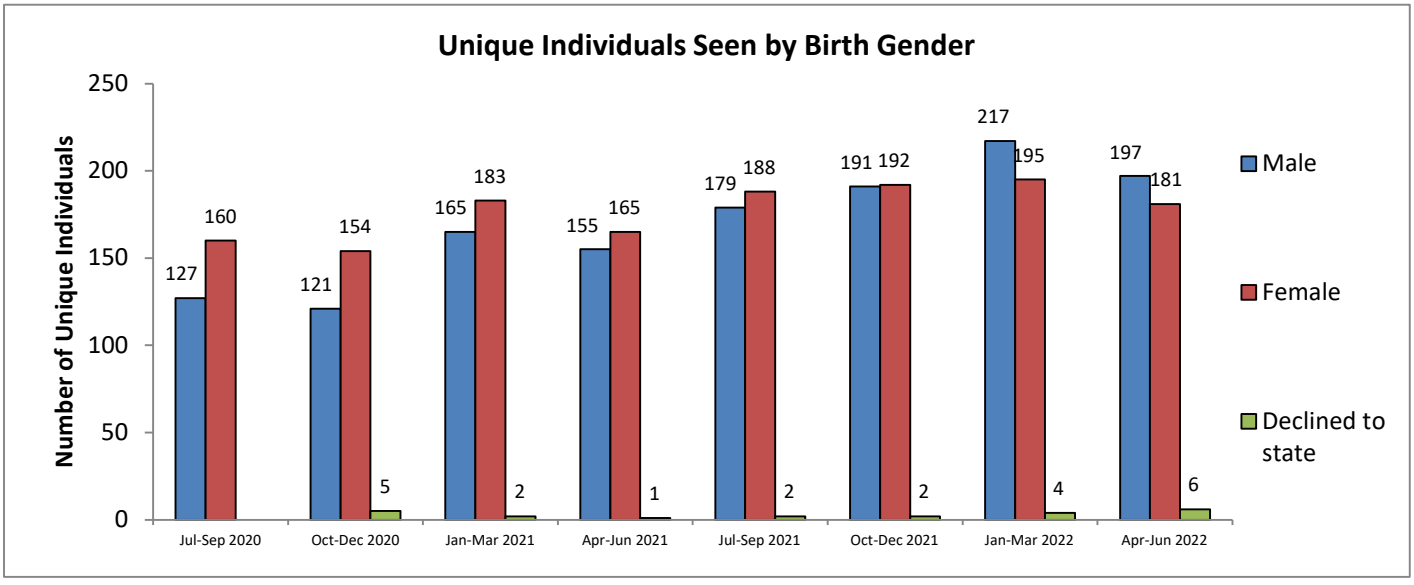
***All demographics questions are optional, so each includes the category "Declined to State".**

AGE

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

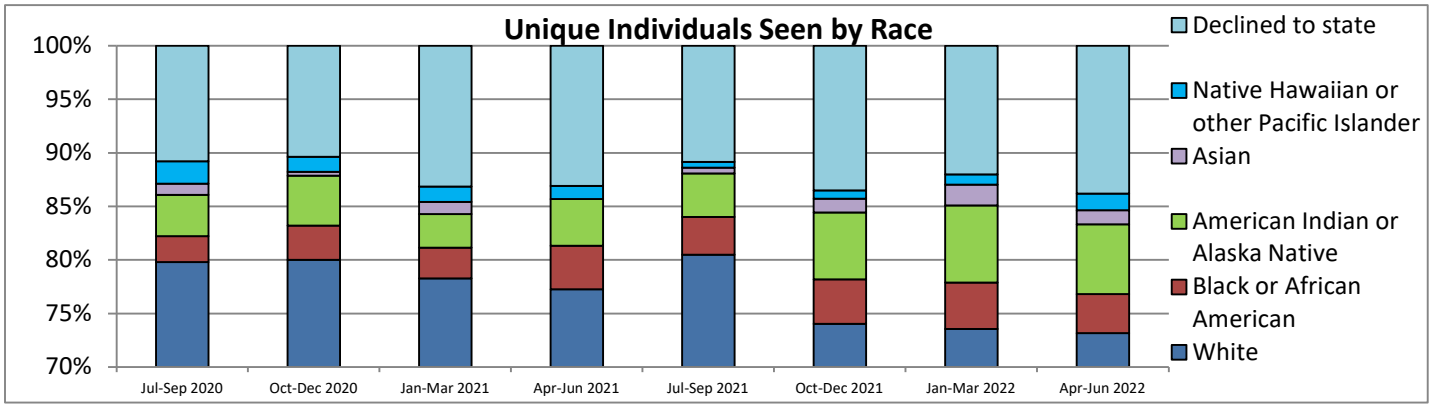


BIRTH GENDER



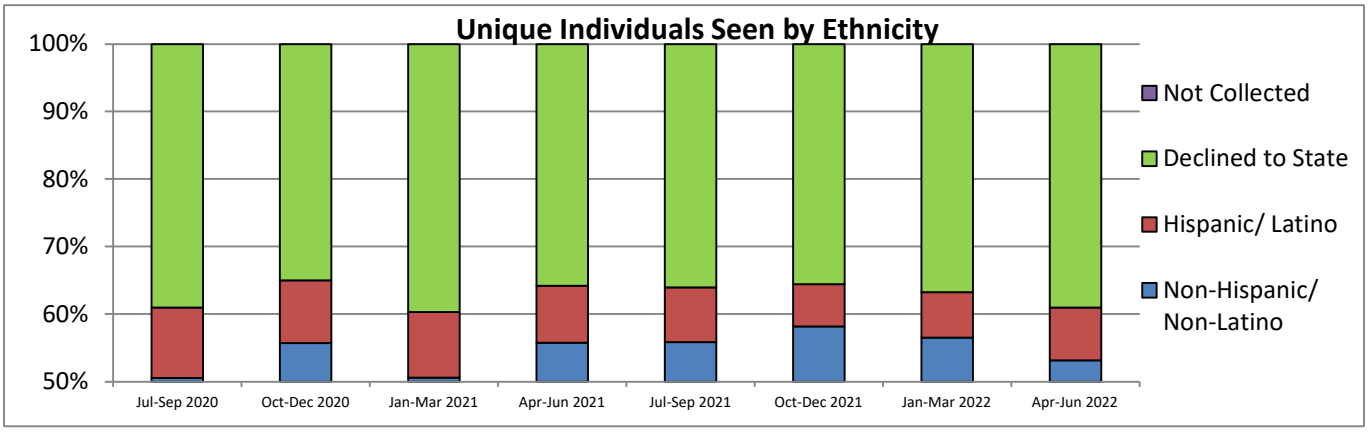
RACE

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



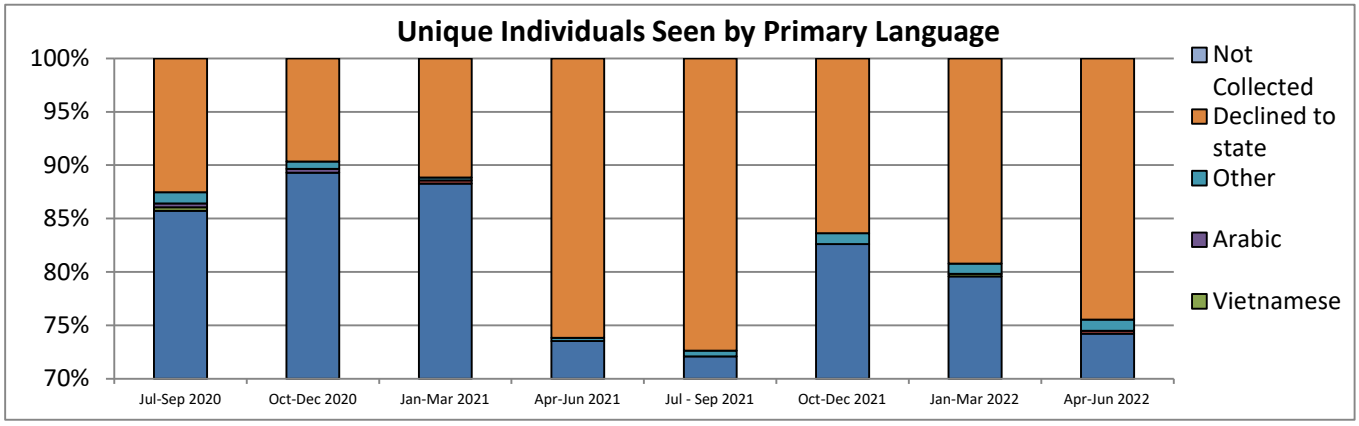
ETHNICITY

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

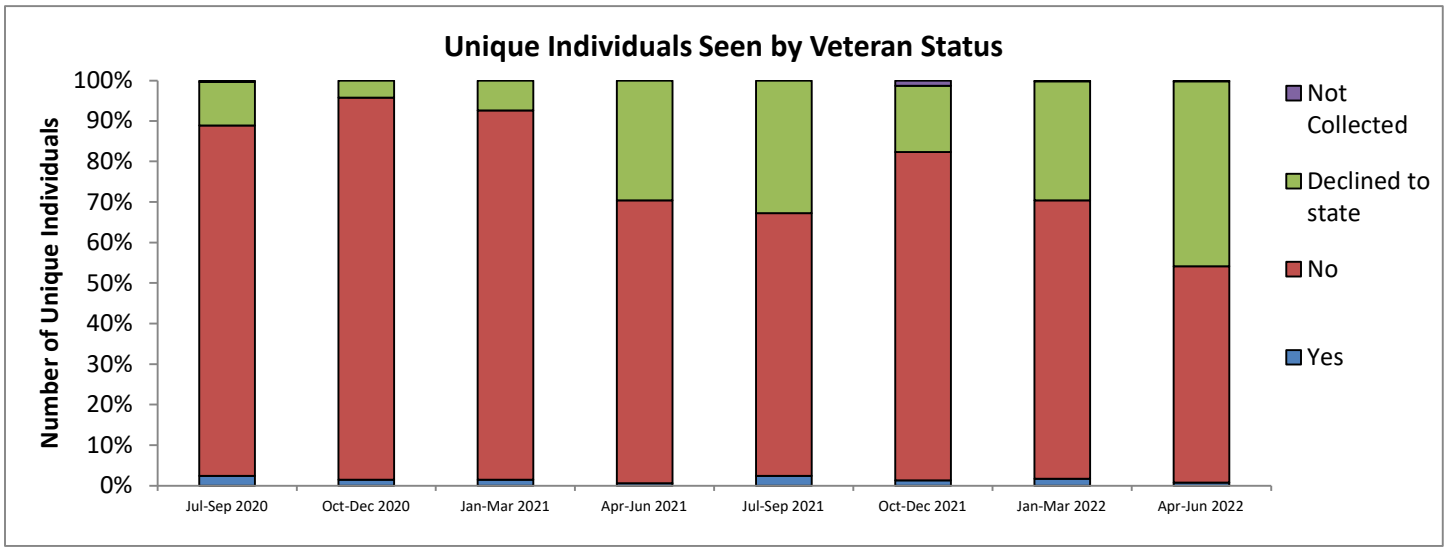


PRIMARY LANGUAGE

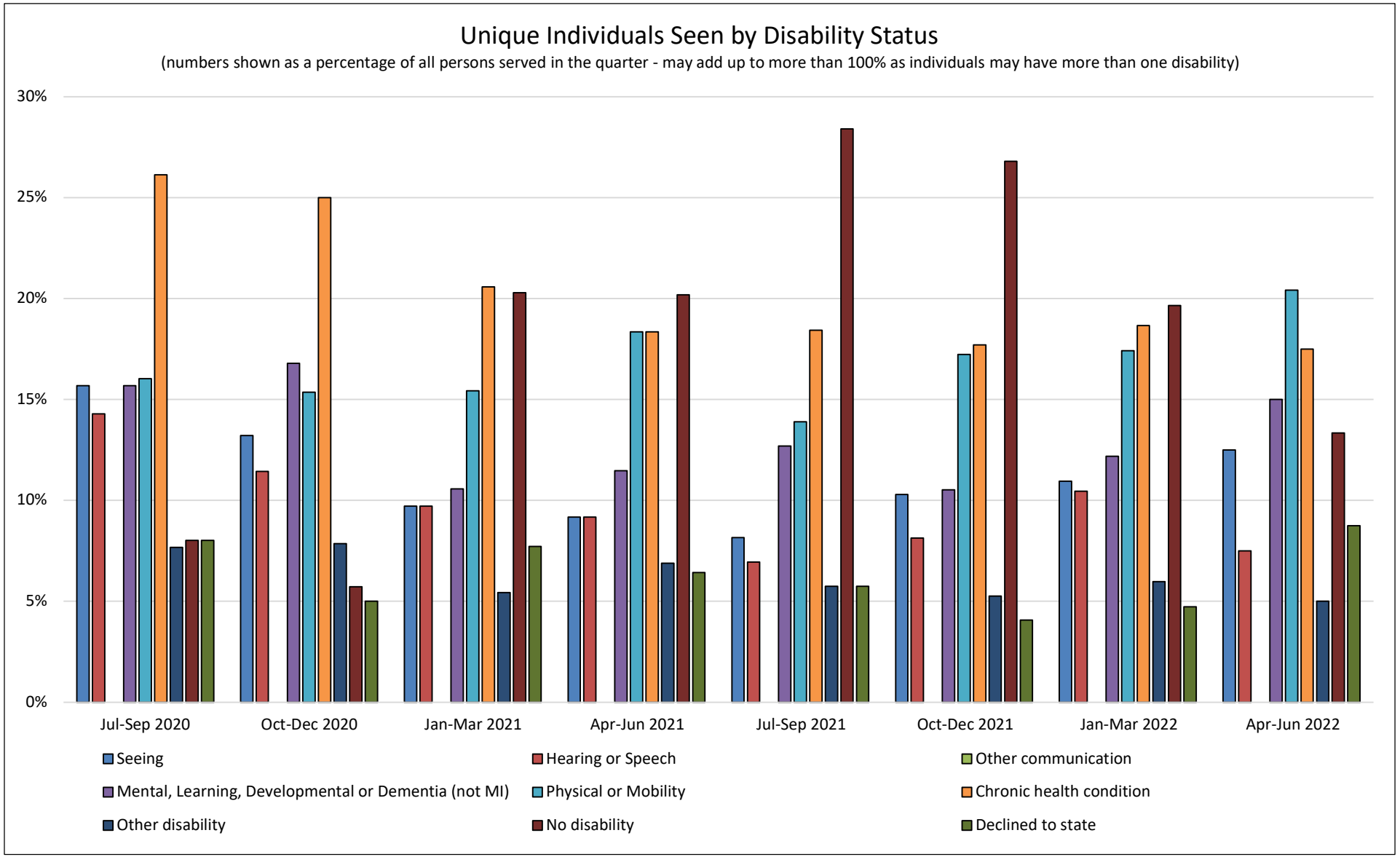
The primary language of consumers served by the CARE Center is English for nearly 100% of the people who chose to answer this question. Because of the low gross numbers for some reported languages, actual counts are not reported to help protect consumer confidentiality.



VETERAN STATUS



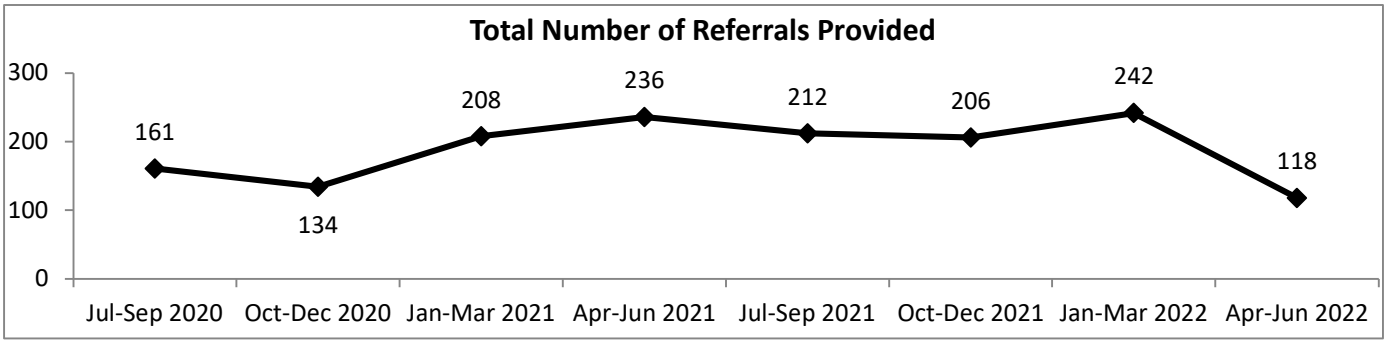
DISABILITY STATUS



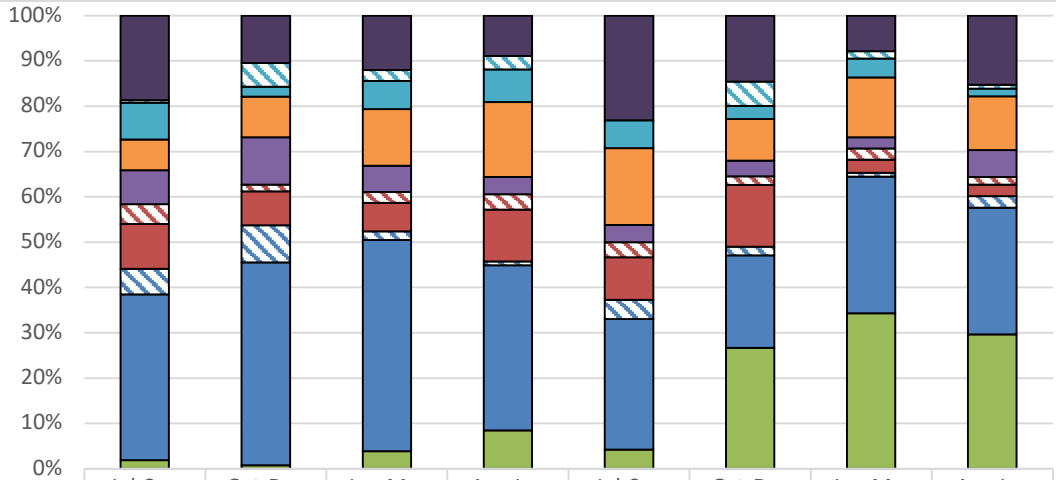
NUMBER OF OUTSIDE REFERRALS PROVIDED AND SUCCESSFULLY ACCESSED

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

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

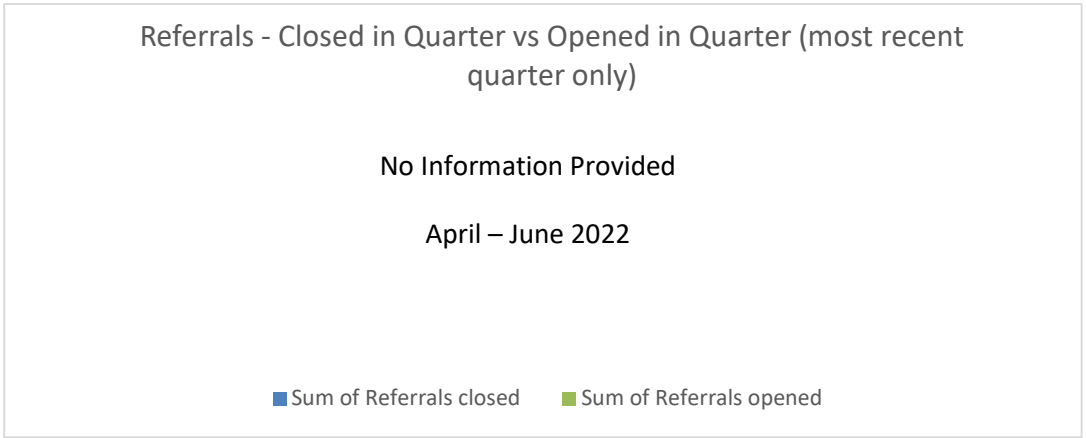


Referrals Provided by Category



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

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

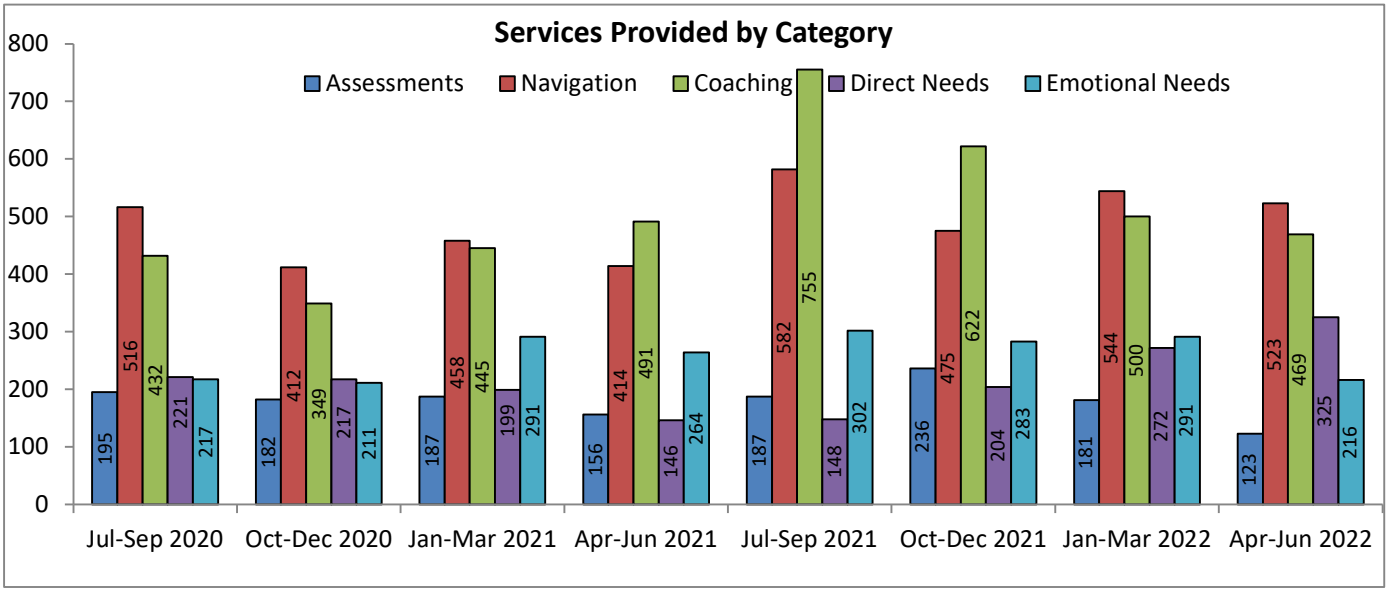


NUMBER OF SERVICES PROVIDED AND SUCCESSFULLY COMPLETED

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

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

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



HOUSING STATUS

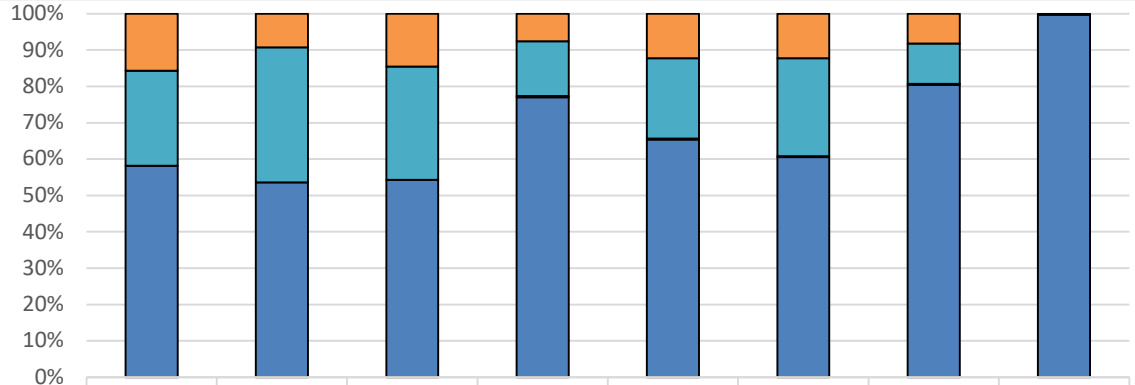
To help track the impact and effectiveness of services, the CARE Center has been asked to track the housing status of individuals accessing the project services at the time they first start services, and then at the 3-month point after that first service. The target outcome numbers are to see a 15% increase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

Housing status has been divided up into the following categories:

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

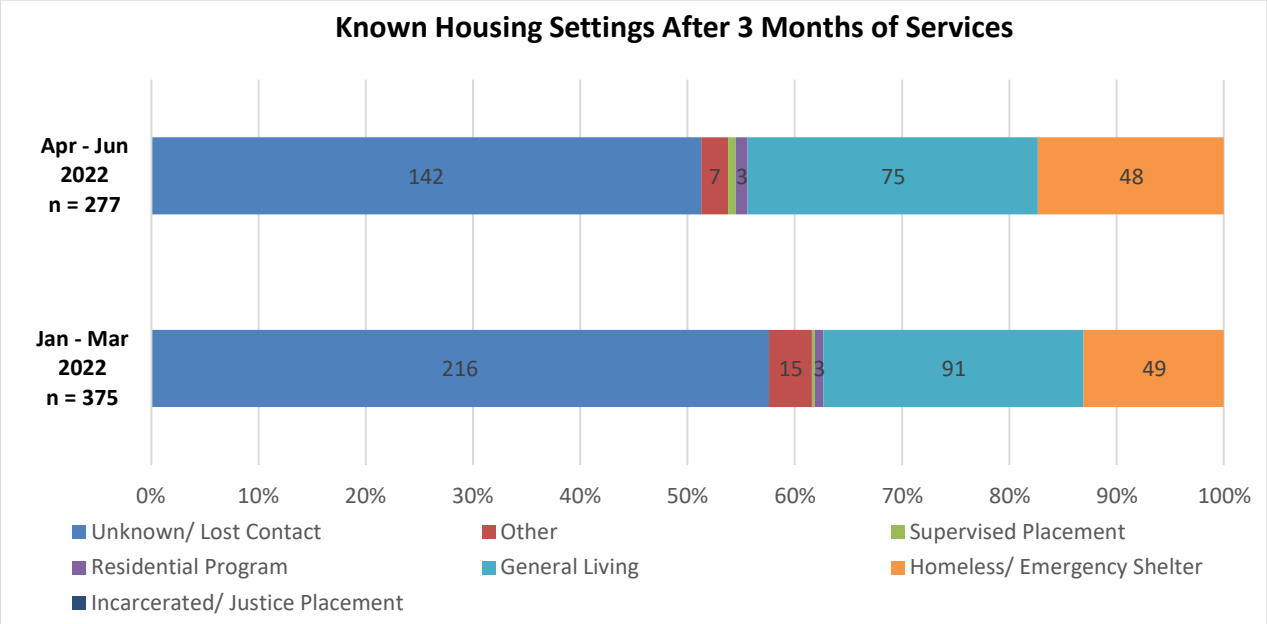
HOUSING STATUS AT START OF SERVICES

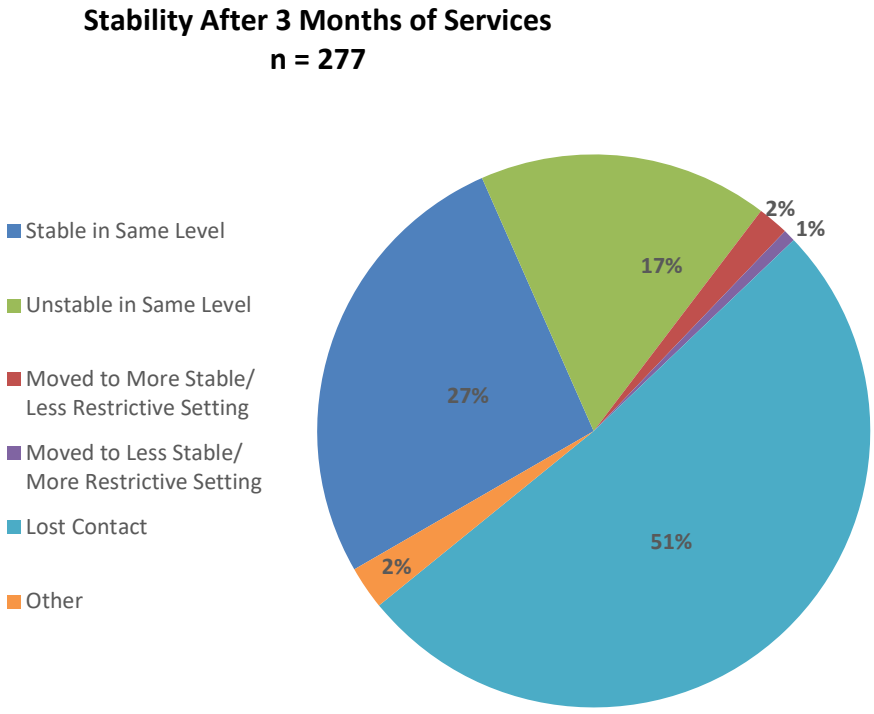
New Participant Housing Status at Intake



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

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





Changes for April-June 2022

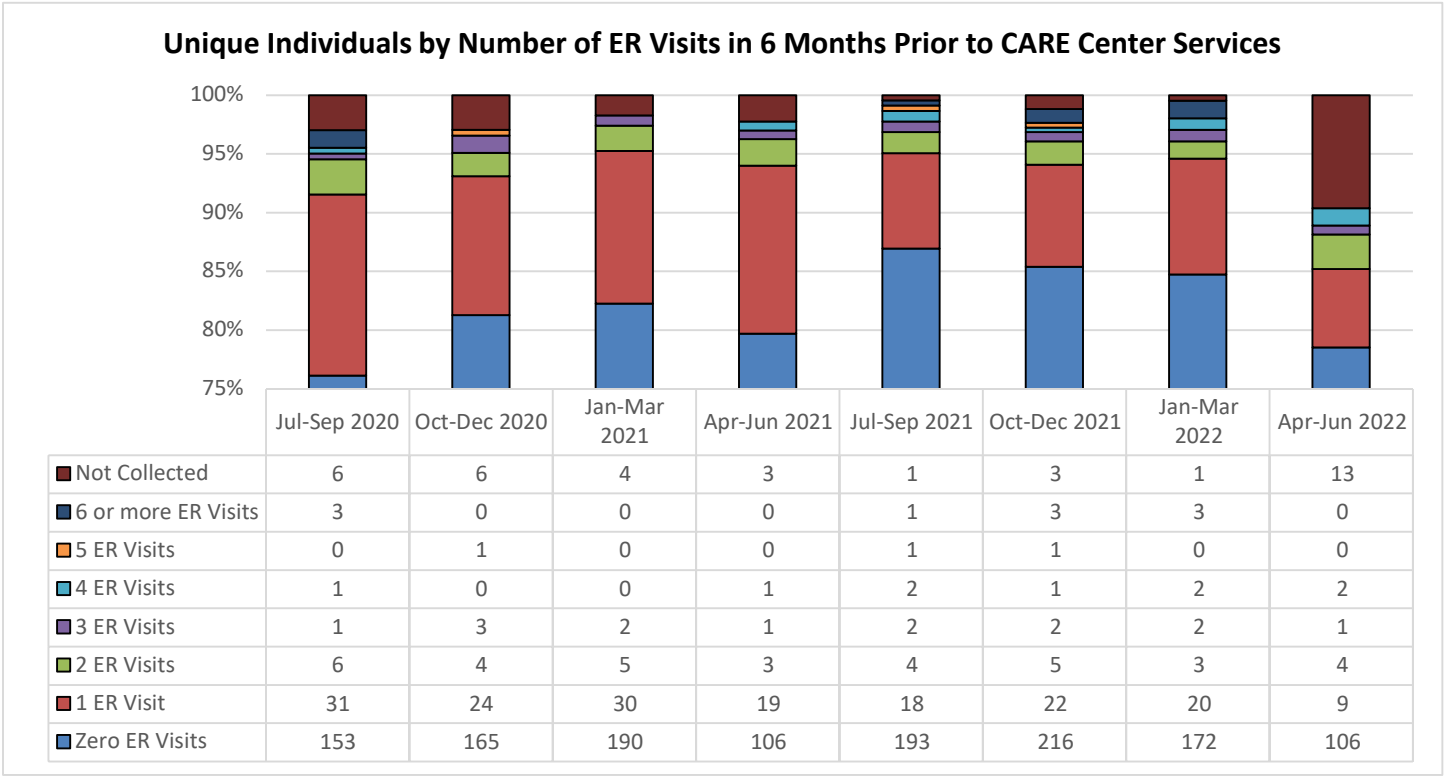
For the 5 people that moved to more stable/less restrictive settings, 2 transitioned from Homeless/E.S to General Living, 1 to a Motel Room through CEP, 1 moved back to family property and 1 moved from Supervised Placement to a Residential Program.

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

EMERGENCY DEPARTMENT VISITS

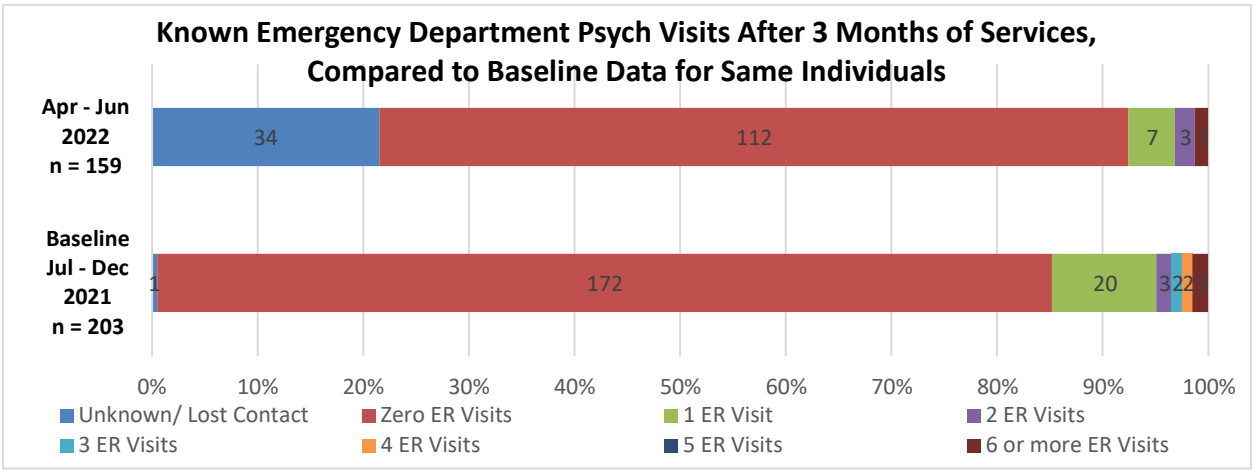
One of the goals of the project is to reduce the number of emergency department visits for psychiatric reasons. Statistics are being tracked directly from the hospitals, but to measure the impact and effectiveness for individuals, the CARE Center has been asked to track the number of ER visits individuals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

BASELINE EMERGENCY DEPARTMENT PSYCHIATRIC VISITS – PRIOR TO CARE CENTER SERVICES

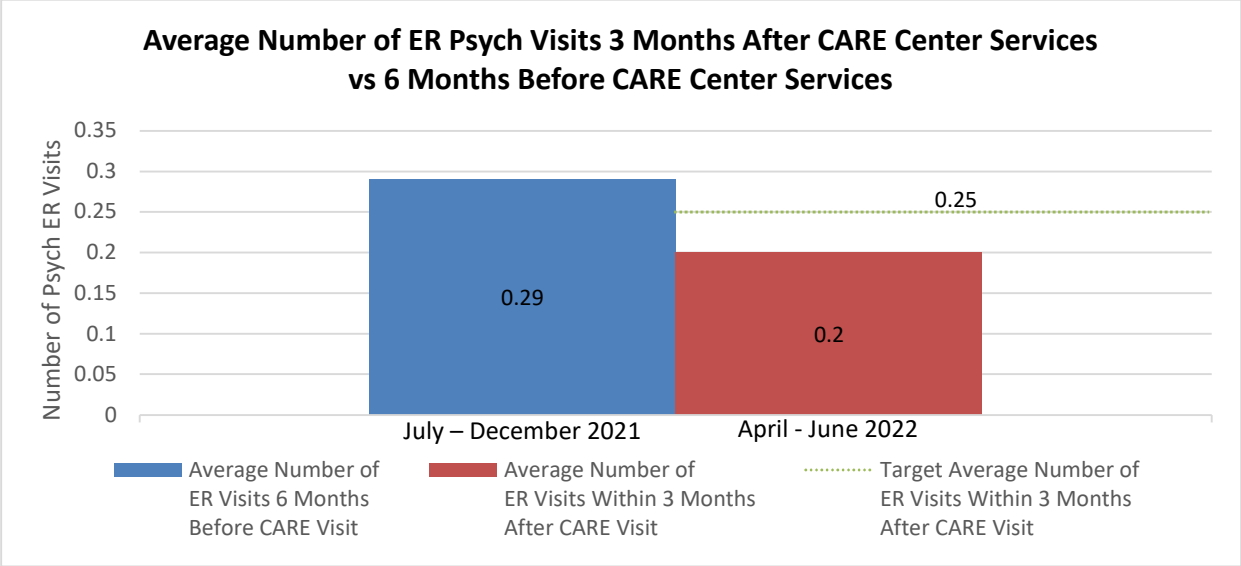


	Jul-Sep 2020	Oct-Dec 2020	Jan-Mar 2021	Apr-Jun 2021	Jul-Sep 2021	Oct-Dec 2021	Jan-Mar 2022	Apr-Jun 2022
Not Collected	6	6	4	3	1	3	1	13
6 or more ER Visits	3	0	0	0	1	3	3	0
5 ER Visits	0	1	0	0	1	1	0	0
4 ER Visits	1	0	0	1	2	1	2	2
3 ER Visits	1	3	2	1	2	2	2	1
2 ER Visits	6	4	5	3	4	5	3	4
1 ER Visit	31	24	30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

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



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

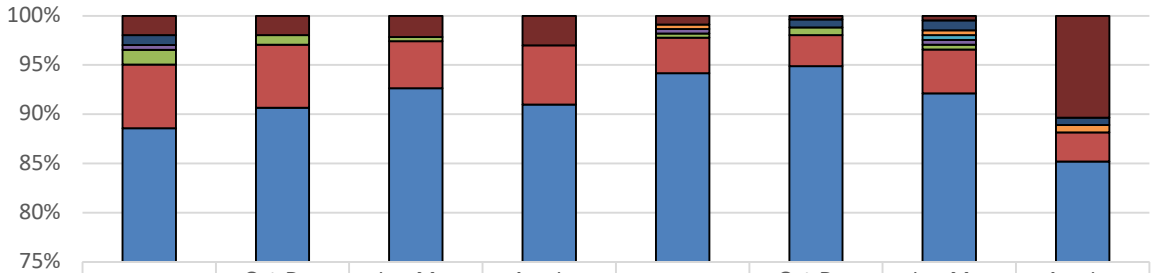


PSYCHIATRIC INPATIENT HOSPITALIZATIONS

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

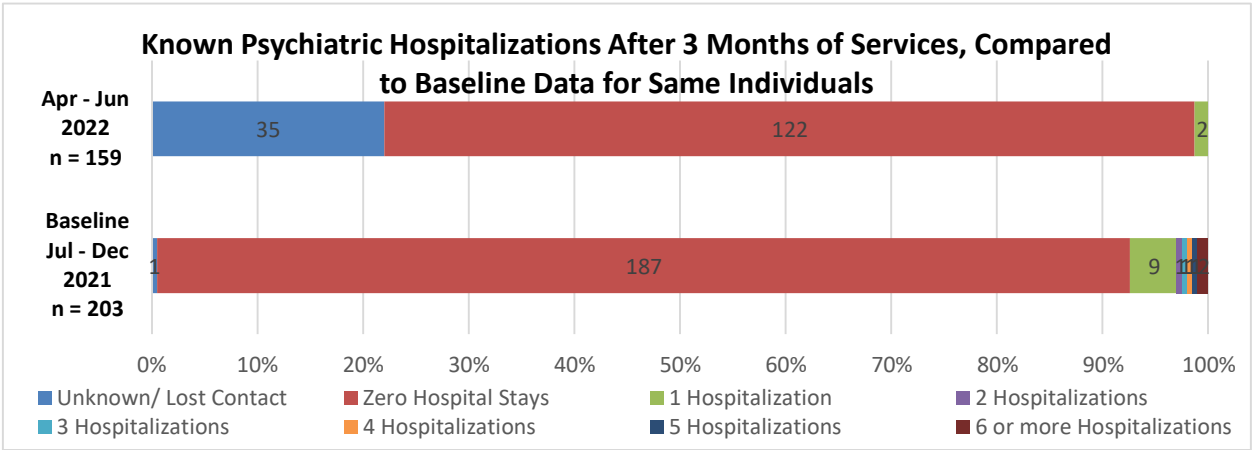
BASELINE PSYCHIATRIC HOSPITALIZATIONS – PRIOR TO CARE CENTER SERVICES

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

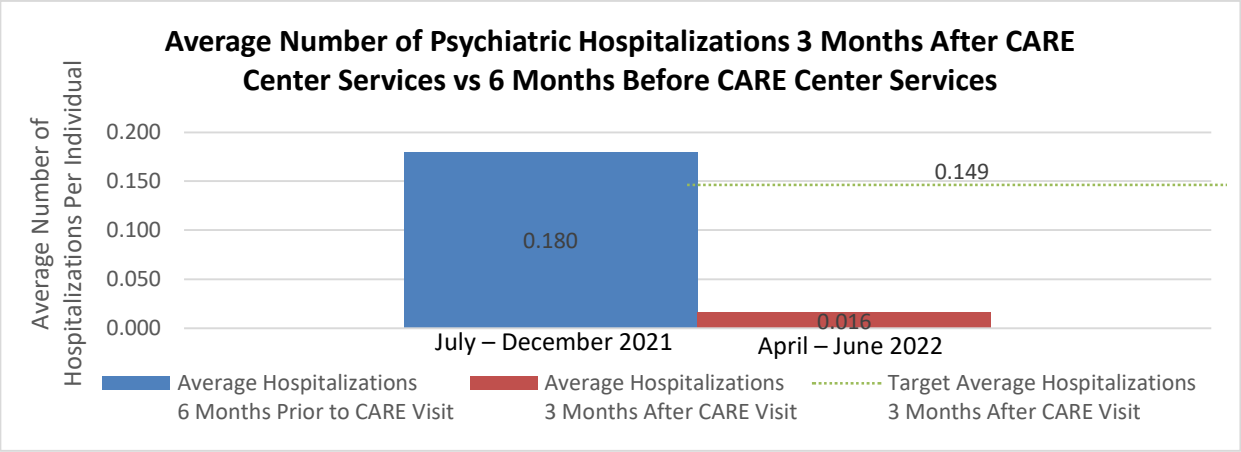


	Jul-Sep 2020	Oct-Dec 2020	Jan-Mar 2021	Apr-Jun 2021	Jul-Sep 2021	Oct-Dec 2021	Jan-Mar 2022	Apr-Jun 2022
Unknown	4	4	5	4	2	1	1	14
6 or more Hospitalizations	2	0	0	0	0	2	2	1
5 Hospitalizations	0	0	0	0	1	0	1	1
4 Hospitalizations	0	0	0	0	0	0	1	0
3 Hospitalizations	1	0	0	0	1	0	1	0
2 Hospitalizations	3	2	1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

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



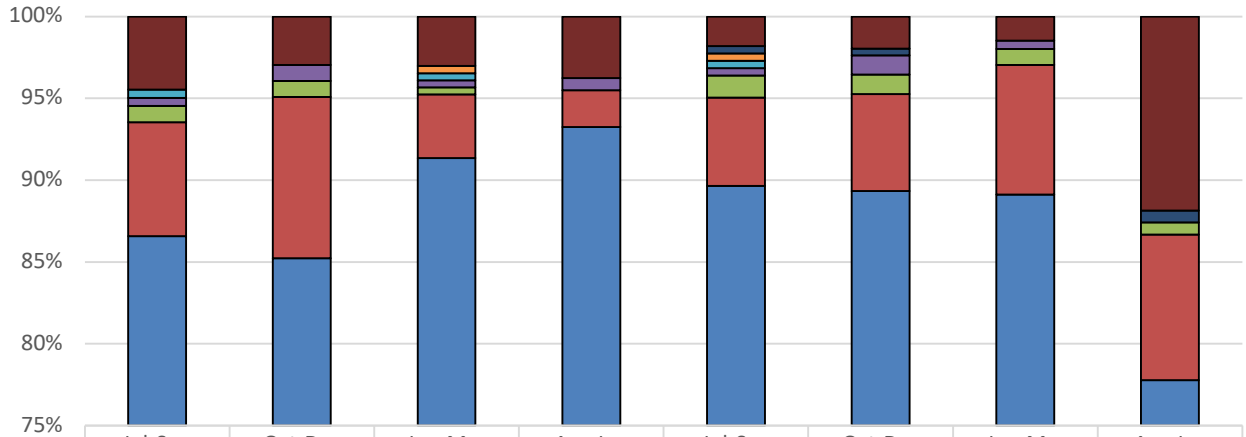
The average number of Psychiatric Hospitalizations in the 6 months prior to care, July - December 2021, was 0.180 Psychiatric Hospitalizations per individual who had visit data reported (excluding all in the Unknown/Lost Contact category). This makes the target number for the 3-months after care was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



ARRESTS

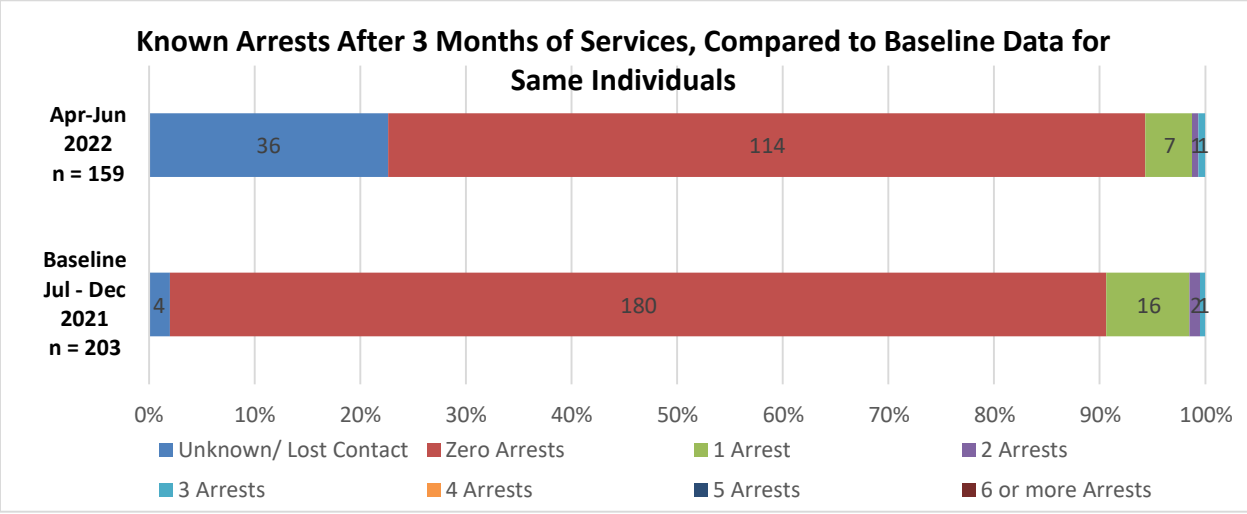
Another goal of the project is to reduce the number of arrests, and the number of days spent incarcerated. The CARE Center has been asked to track the number of arrests and number of days spent incarcerated that individuals report having made in the 6 months prior to the time they first start services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

BASELINE ARRESTS – PRIOR TO CARE CENTER SERVICES

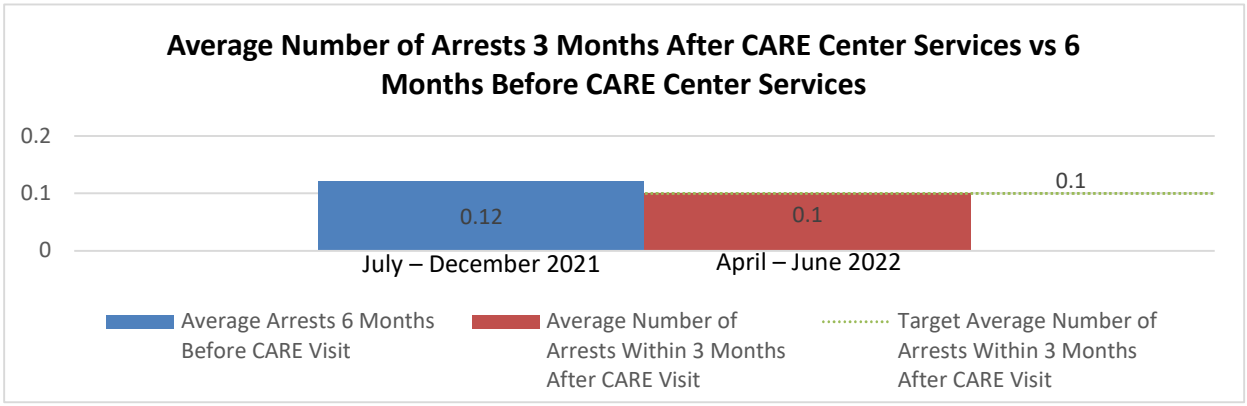


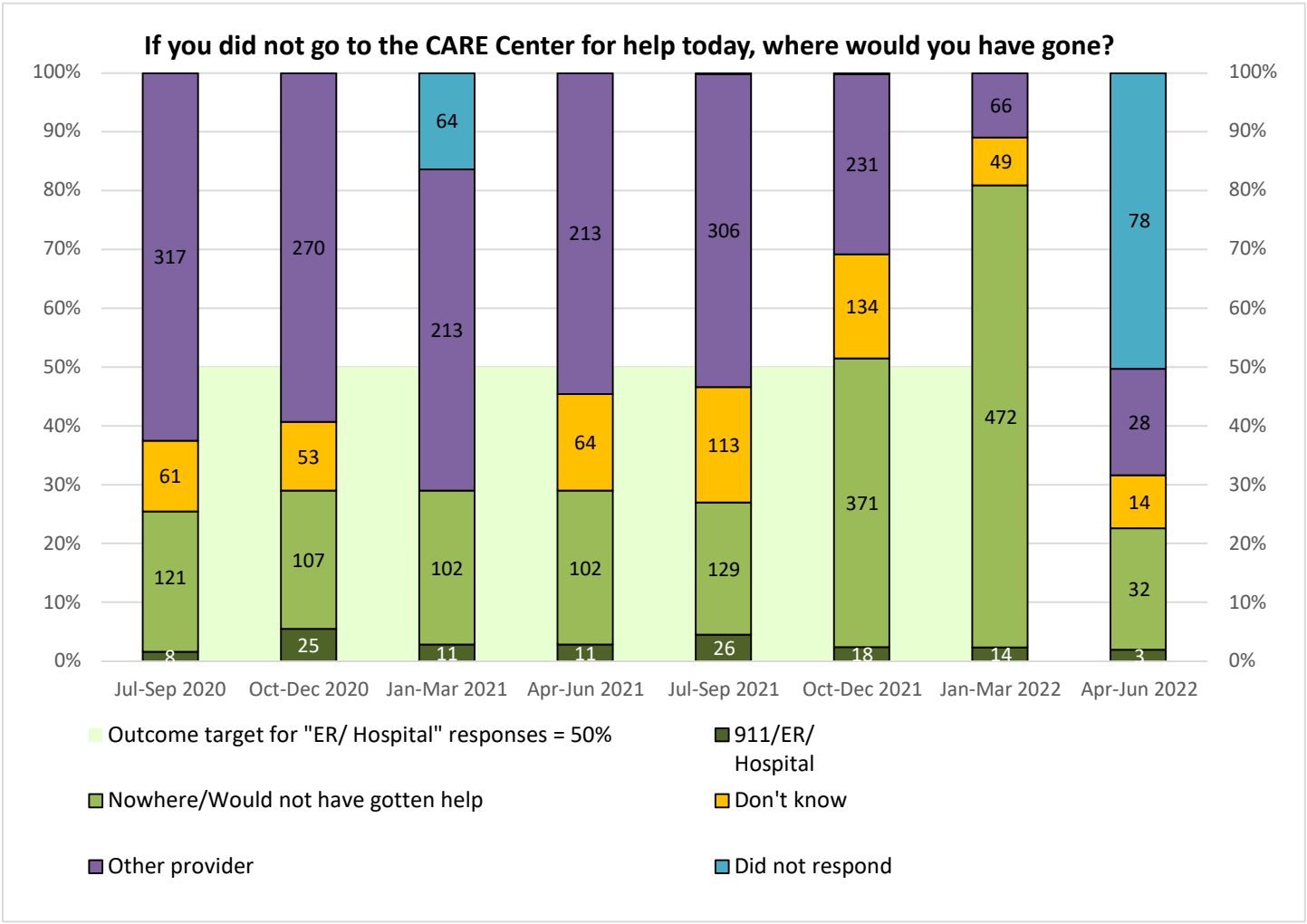
	Jul-Sep 2020	Oct-Dec 2020	Jan-Mar 2021	Apr-Jun 2021	Jul-Sep 2021	Oct-Dec 2021	Jan-Mar 2022	Apr-Jun 2022
Unknown	9	6	7	5	4	5	3	16
6 or more Arrests	0	0	0	0	1	1	0	1
5 Arrests	0	0	1	0	1	0	0	0
4 Arrests	1	0	1	0	1	0	0	0
3 Arrests	1	2	1	1	1	3	1	0
2 Arrests	2	2	1	0	3	3	2	1
1 Arrest	14	20	9	3	12	15	16	12
Zero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

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



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





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

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

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

Fiscal Year	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY Total	FY Change +/-**
2021-22	15	10	10	9	9	6	12	5	13	11	7	**18**	**125**	-31%
2020-21	15	17	19	17	**20**	11	10	15	14	18	12	14	**182**	1%
2019-20	**20**	12	17	14	13	13	17	19	15	10	16	15	**181**	-7%
2018-19	17	20	15	**22**	18	14	18	13	15	16	13	14	**195**	12%
2017-18	17	13	12	12	13	14	19	11	11	16	16	**20**	**174**	14%
2016-17	16	17	5	16	14	5	16	8	**22**	11	10	13	**153**	-13%
2015-16	18	9	15	20	14	11	12	15	10	**21**	11	19	**175**	-5%
2014-15	17	**23**	17	14	15	12	17	13	14	10	14	19	**185**	-1%
2013-14	17	17	19	19	12	15	**21**	6	19	15	10	16	**186**	-27%
2012-13	26	**28**	21	25	24	19	17	22	18	17	19	20	**256**	-3%

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

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

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

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

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

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

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Shasta County Health & Human Services Agency

The Woodlands Permanent Supportive Housing

Fiscal Year 2021/2022

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

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

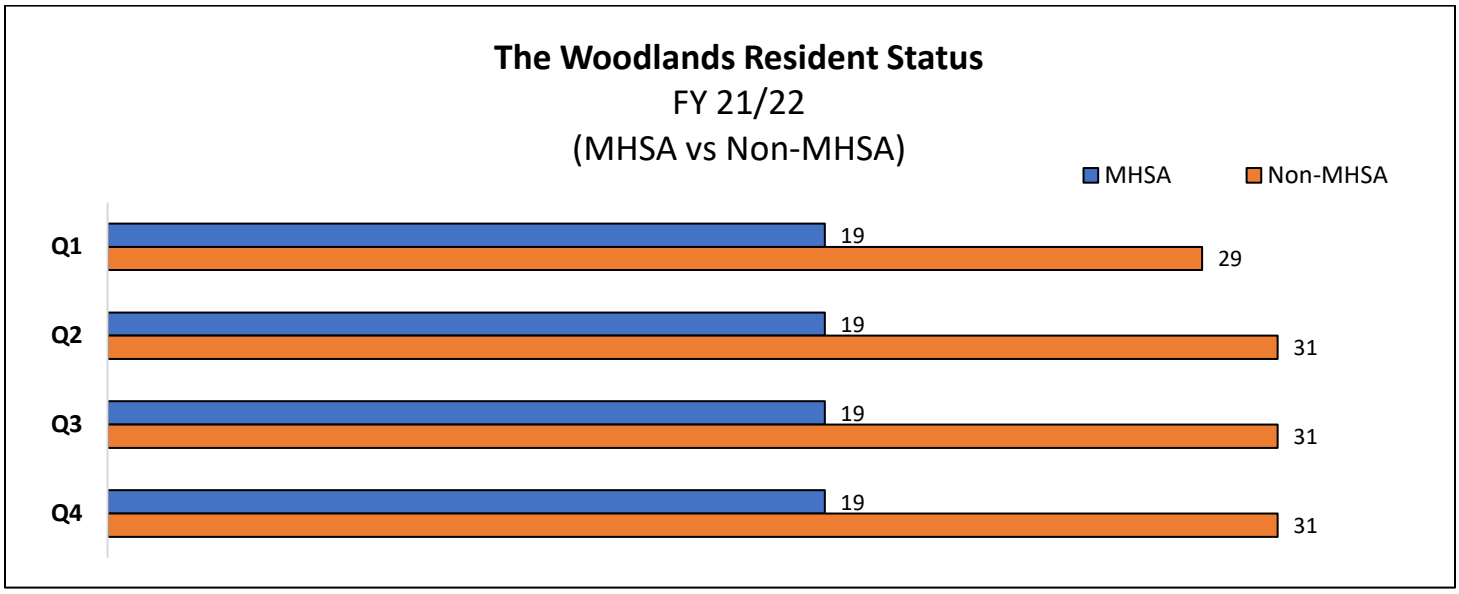
- Finance/Budgeting Classes
- Personal Income Tax Preparation
- Adult Education Classes
- Benefit/Entitlement Assistance
- After-School Activities
- Health and Wellness Classes.

The County also provides clients with supportive services such as:

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

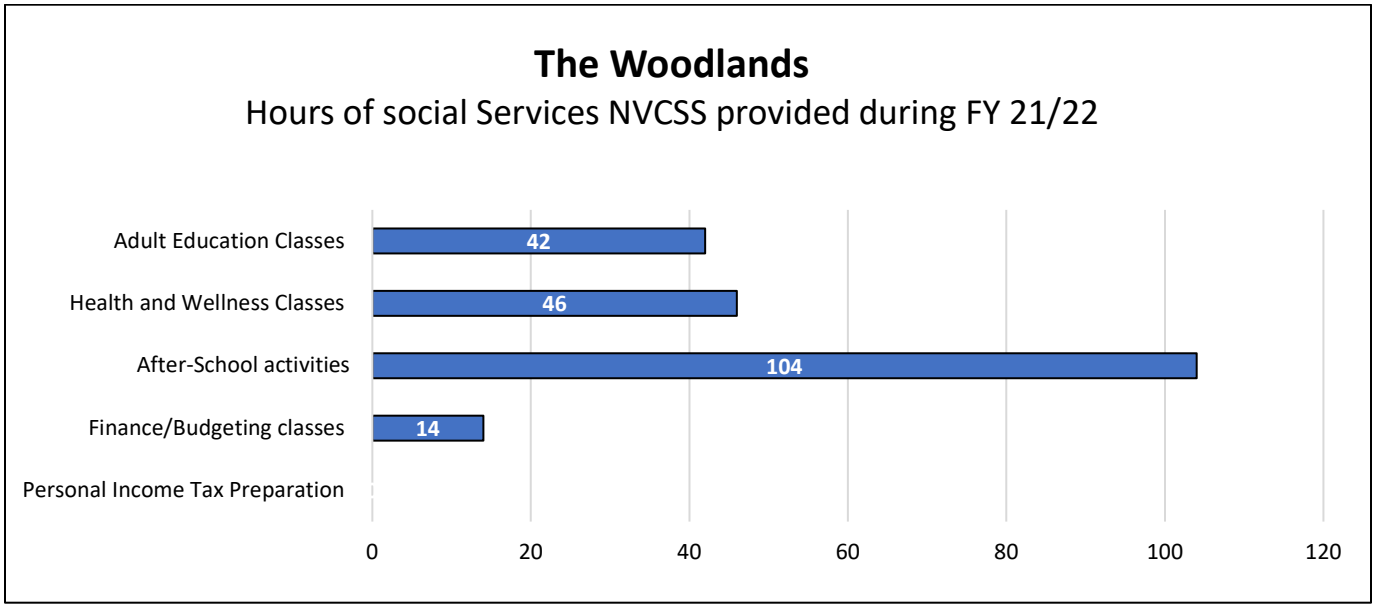
Ongoing social and supportive services are available to help clients maintain housing stability to prevent homelessness and substance abuse among other challenges. A caseworker and peer support specialist are stationed at the Woodlands to assist with these services.

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



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

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



Triple P Outcome Evaluation

Fiscal Year 21/22

Prepared by Shasta County Health and Human Services Agency

Shasta County Health & Human Services Agency

Introduction

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

Program overview

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

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

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

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

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

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

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

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

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

Versions of each level of Triple P

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

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

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

How the data in this report was collected

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

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

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

(ASRA) Automatic Scoring and Reporting Application data

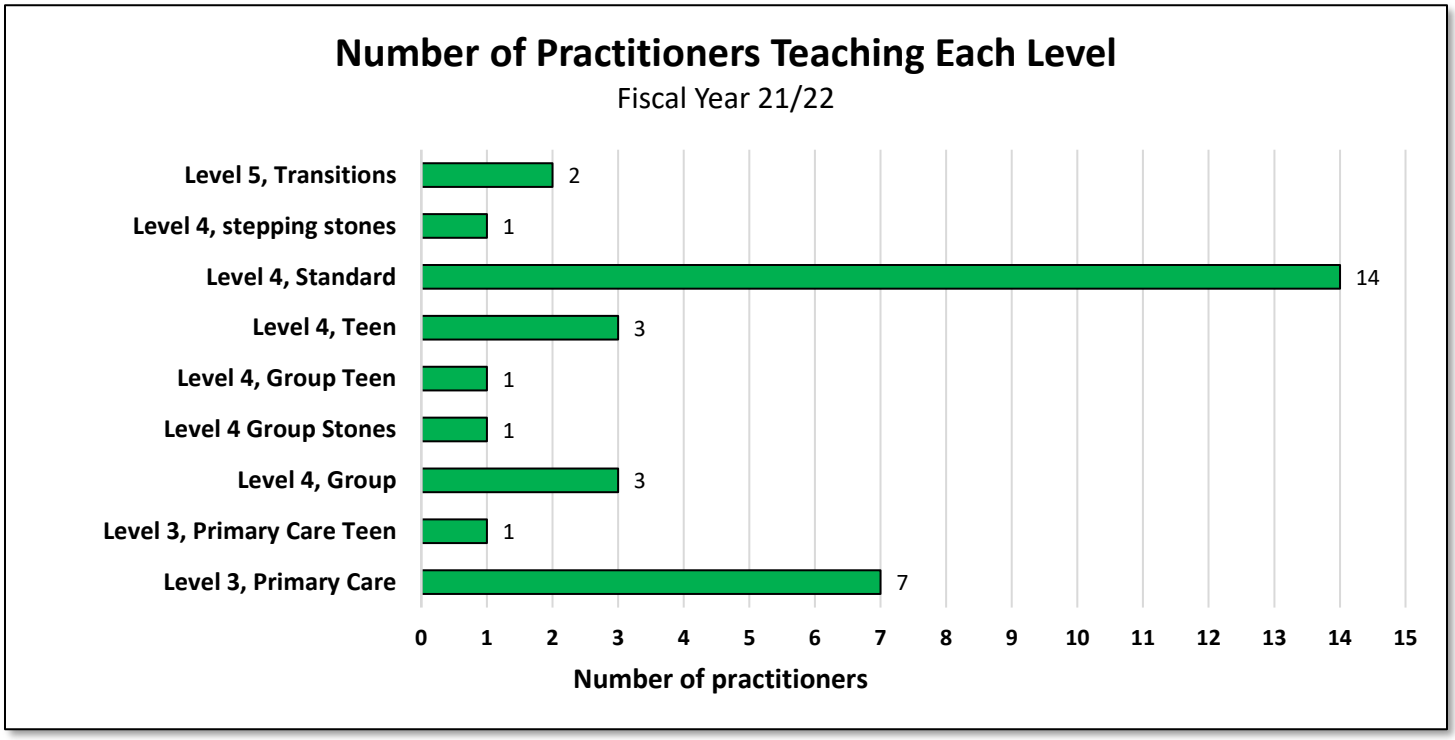
Overview

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

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

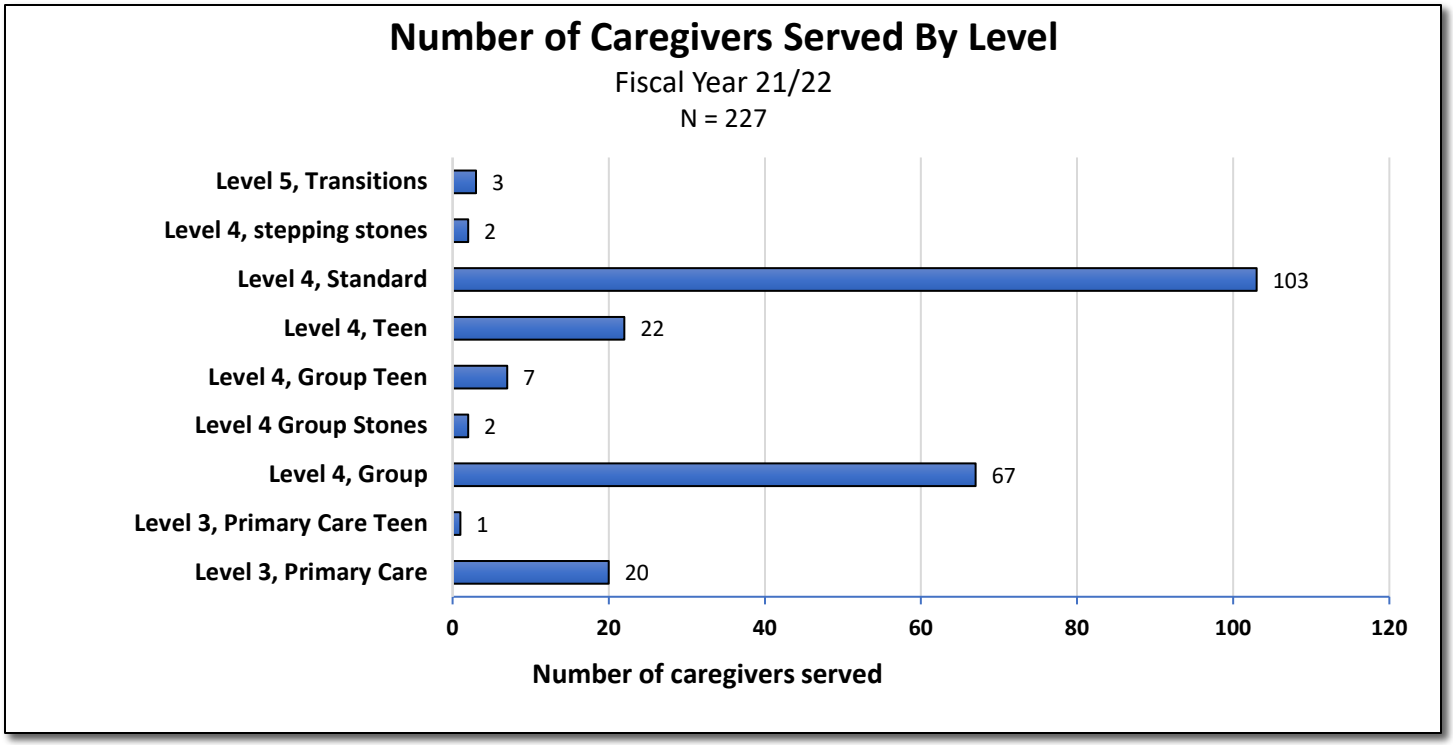
Some families may have received services in more than one organization, level, or version of Triple P. The information stored in the scoring application is anonymous (names were not collected). For this reason, the total number of unique caregivers and children/teens served between all levels couldn't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

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

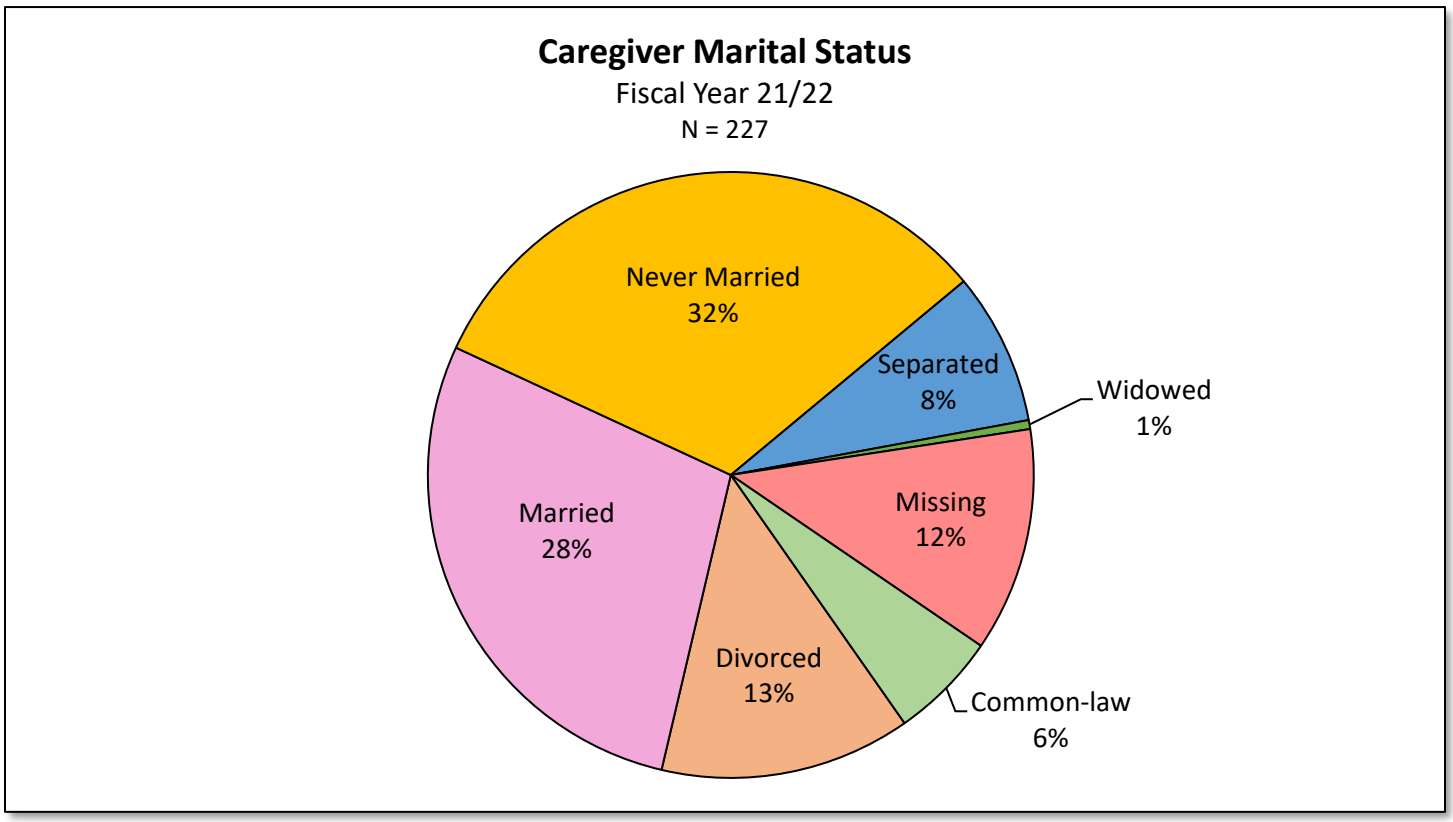


Data on the caregivers and their families

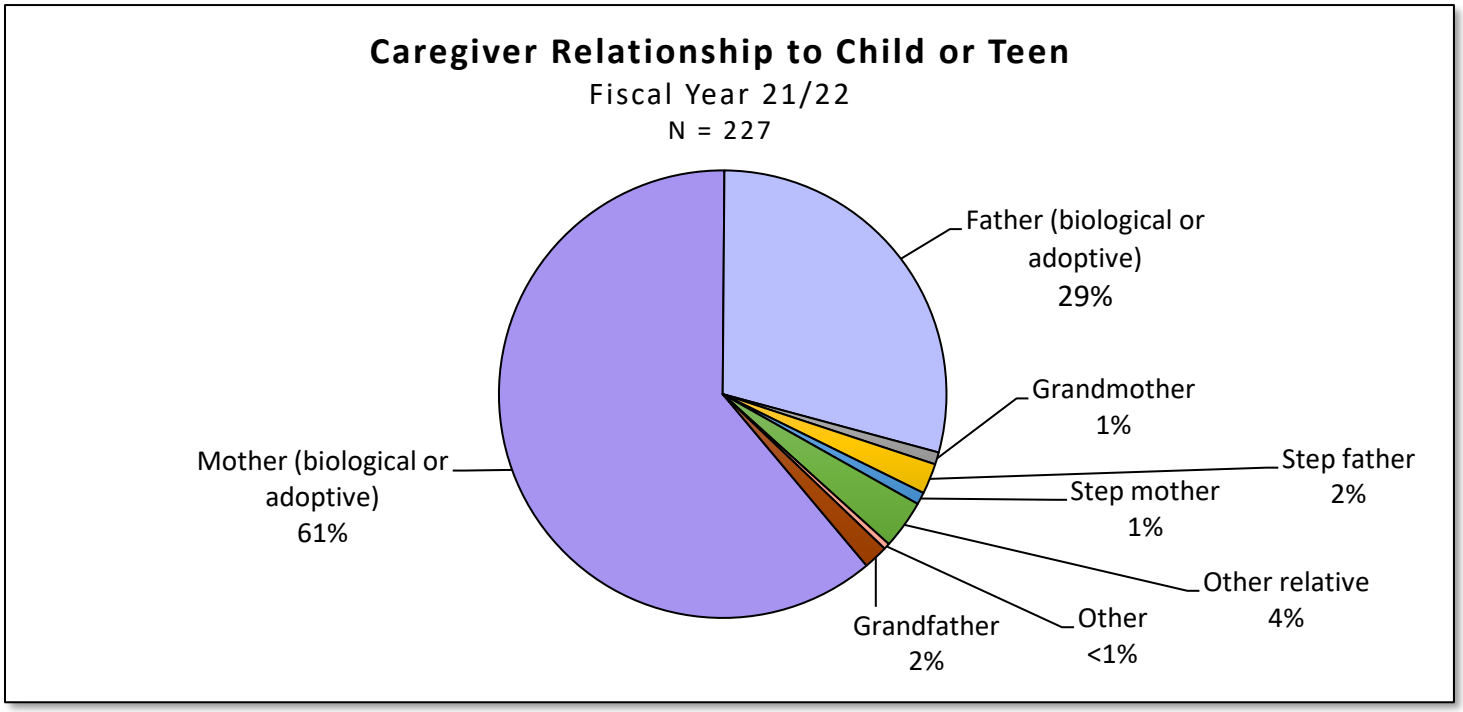
A total of 227 caregivers attended Triple P sessions. The number of caregivers in each level of Triple P is shown below:



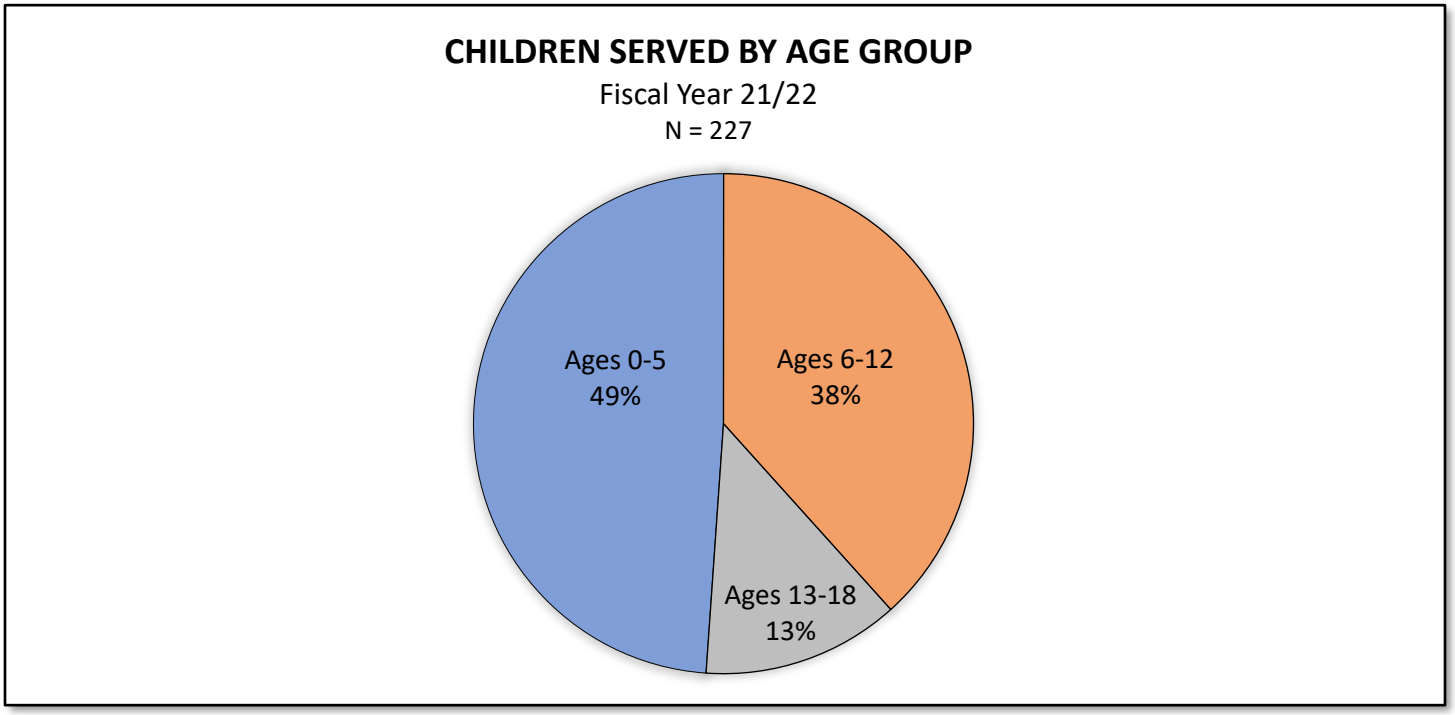
The marital status of the caregivers is pictured below:



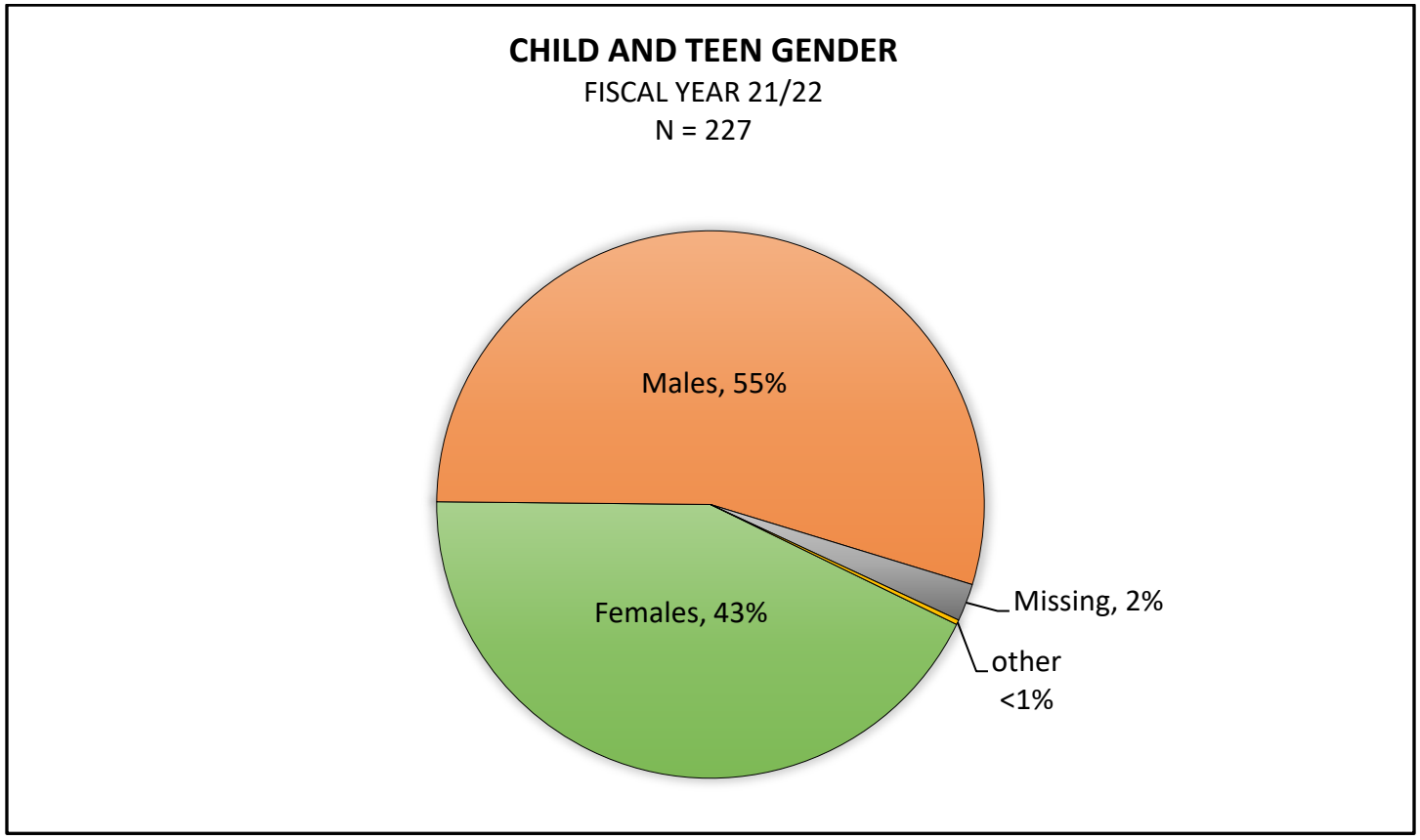
The pie chart below shows how the caregiver relates to the child or teen:



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



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



Outcomes and Measures

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

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

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

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

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

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

PAFAS Blank Assessment (example)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

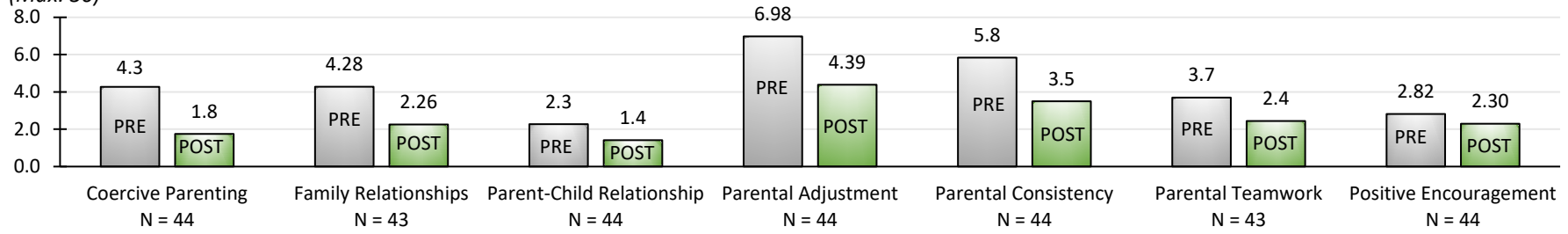
26. Our family members fight or argue	0	1	2	3		(Range) 0 – 12
27. Our family members criticize or put each other down	0	1	2	3		
24. Our family members help or support each other	0	1	2	3	(Reverse-scored)	
25. Our family members get on well with each other	0	1	2	3	(Reverse-scored)	

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

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

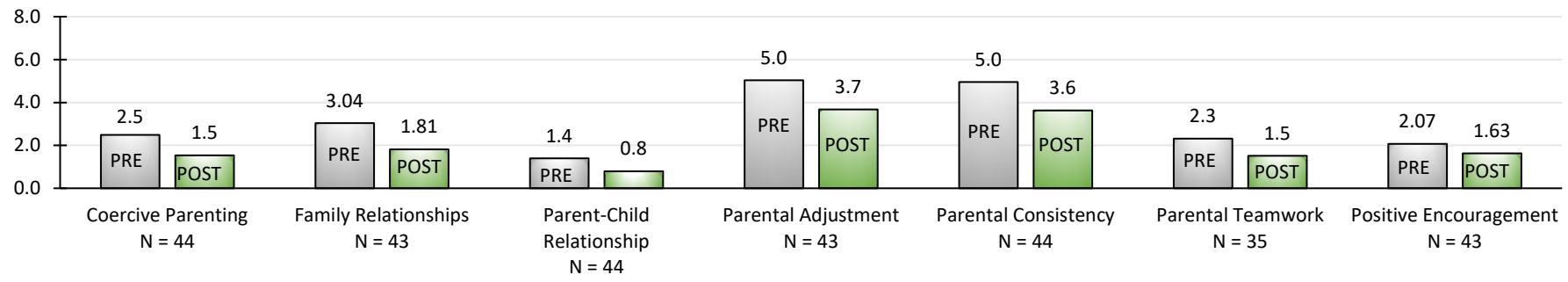
(PAFAS) Level 4 Standard

Problem score (lower preferred)
(Max: 30)



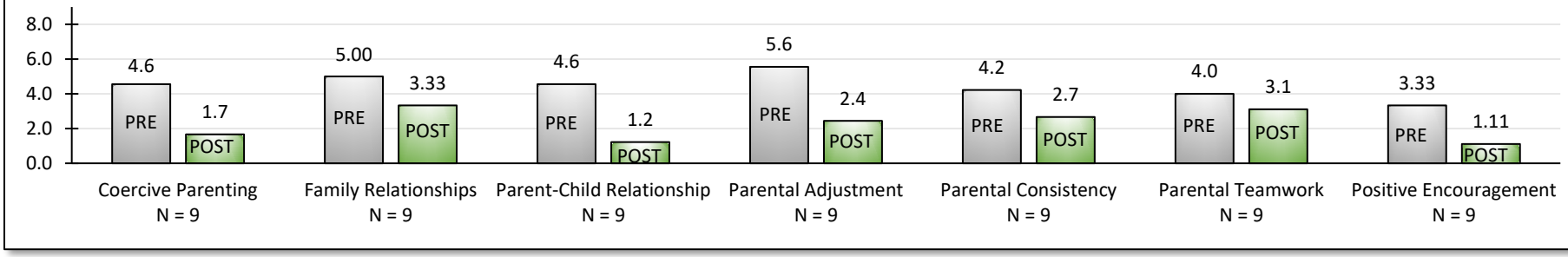
(PAFAS) Level 4 Group

Problem score (lower preferred)
(Max: 30)



(PAFAS) Level 4 Teen

Problem score (lower preferred)
(Max: 30)



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

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

There are three scored measures on the CAPES scale:

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

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

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

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

CAPES self-assessment (blank example)

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

CAPES self-assessment (scoring illustration)

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

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

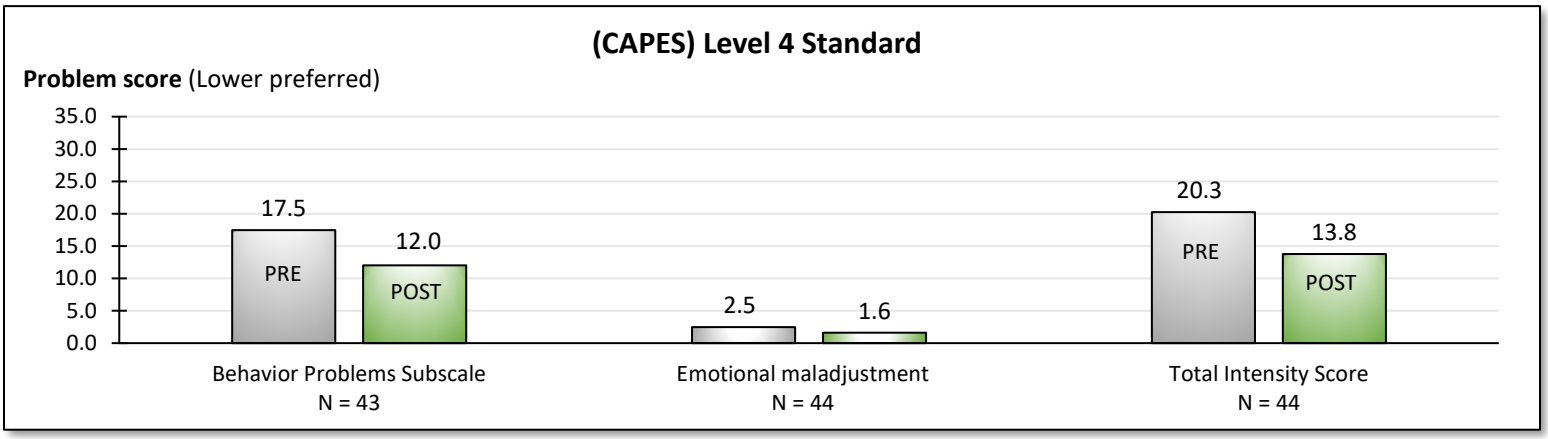
(Range) 0 – 9

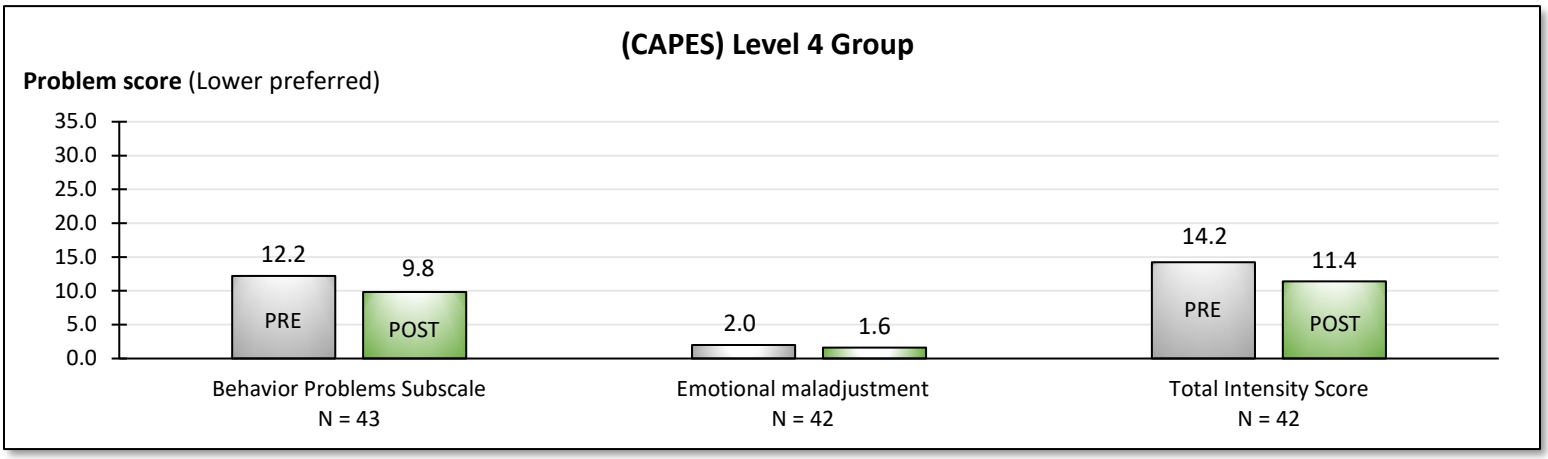
Behavioral Problems subscale scores are calculated by summing the scores for all remaining questions on the assessment:

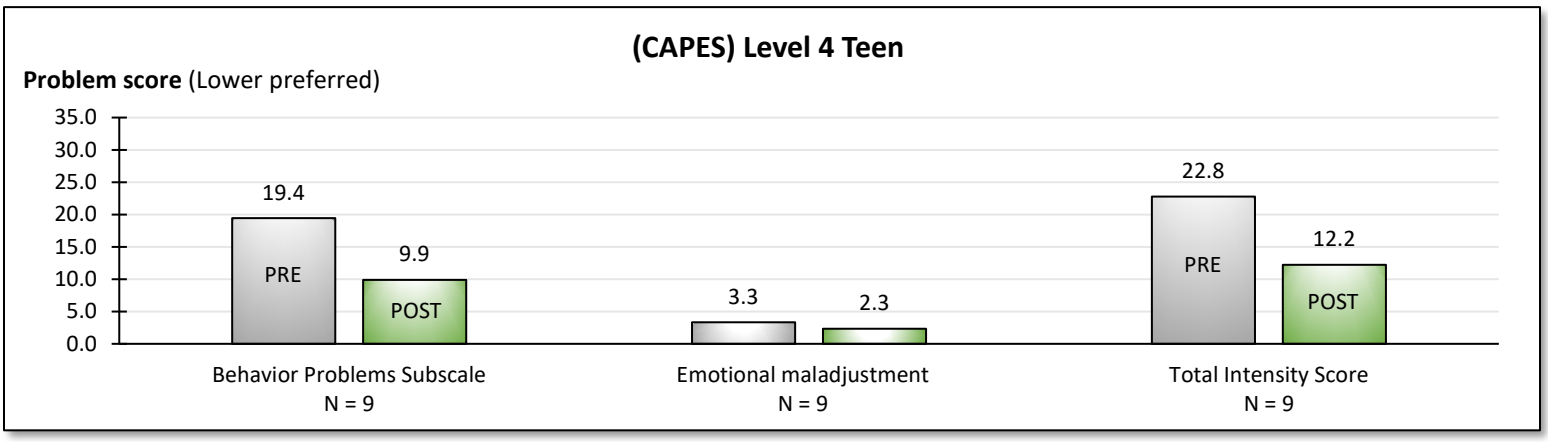
1. Gets upset or angry when they don't get their own way	0	1	2	3
2. Refuses to do jobs around the house when asked	0	1	2	3
4. Loses their temper	0	1	2	3
5. Misbehaves at mealtimes	0	1	2	3
6. Argues or fights with other children, brothers or sisters	0	1	2	3
7. Refuses to eat food made for them	0	1	2	3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

(Range) 0 – 72

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


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


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


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

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

(Page 1 of 2)

Client Satisfaction Questionnaire *(example)*

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

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

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

7	6	5	4	3	2	1
Excellent		Good		Fair		Poor

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(Page 2 of 2)

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

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

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

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

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

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

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

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

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

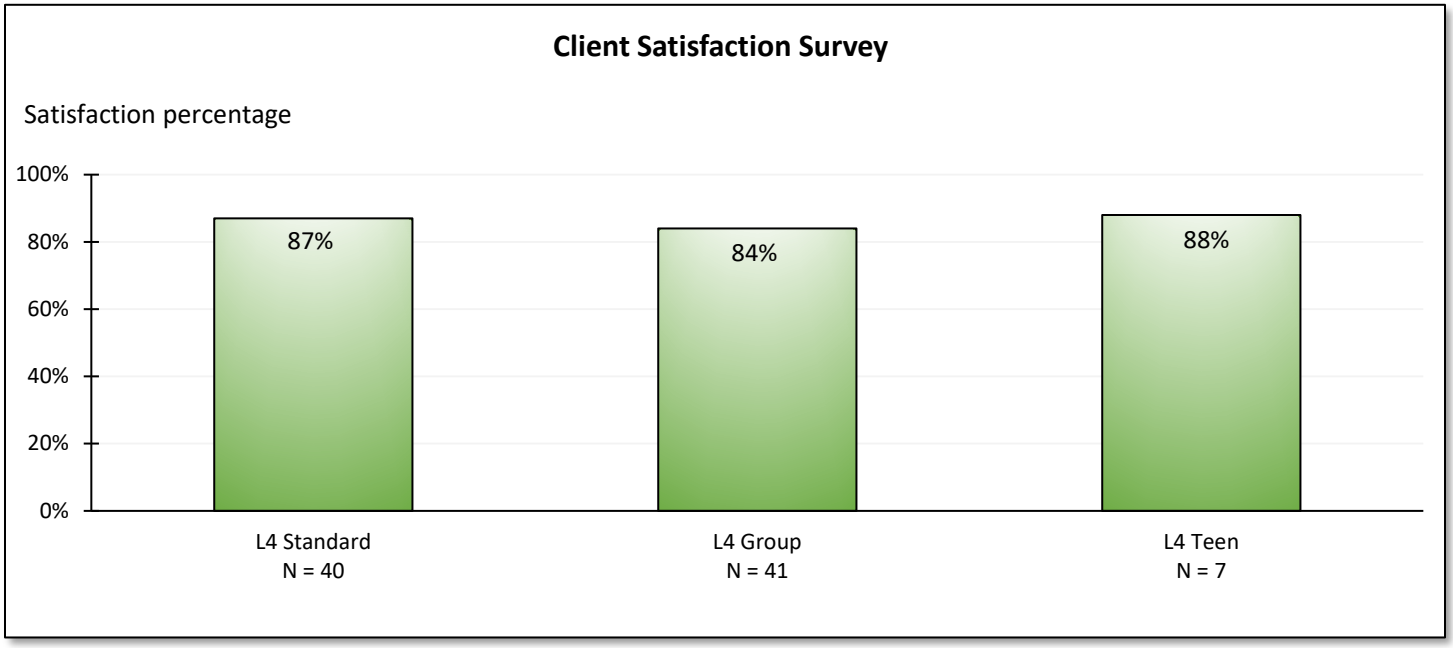
15. Have you had any other problems with your child which you feel may be related to the original difficulty?

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

Thank you

Client Satisfaction Questionnaire:

Client Satisfaction in each level was as follows:



Conclusion:

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

CAPES findings:

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

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

PAFAS findings:

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

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

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

References

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

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

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

Shasta County
Health & Human
Services Agency

Botvin LifeSkills
Outcome Evaluation

Fiscal Year 21/22

(July 1st, 2021 – June 30th, 2022)

Table of Contents

Introduction

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

The program was administered to 6th-8th grade students attending Turtle Bay, Bella Vista, and Happy Valley during Fiscal Year 21/22. The program promotes healthy alternatives to risky behavior through activities that help students resist peer pressure to smoke or use drugs and alcohol, develop greater self-esteem and social skills, learn about relaxation techniques to cope with anxiety, and learn about the effects of substance abuse and healthier lifestyle choices.

Method

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

Knowledge category

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

Attitudes category

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

Life Skills category

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

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

Results

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

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

Note: Numbers may not add due to rounding.

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

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

Note: Numbers may not add due to rounding.

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

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

Note: Numbers may not add due to rounding.

Conclusion

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

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

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

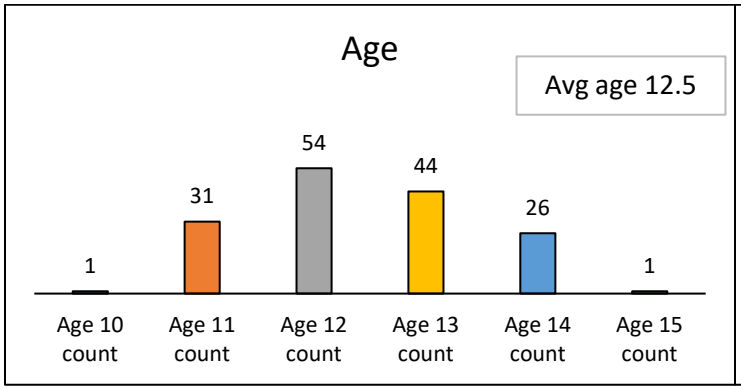
Data Analysis

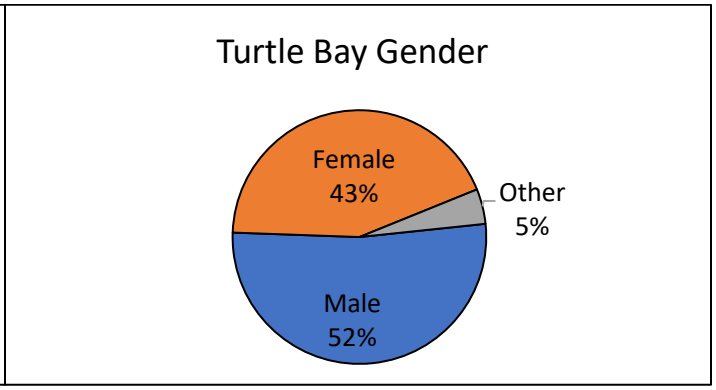
In the following section, information on the students' background (including demographic information) and how the scored measures were calculated will be explored in greater detail. Missing responses were ignored when calculating the scored measures, and missing responses were also not individually tracked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

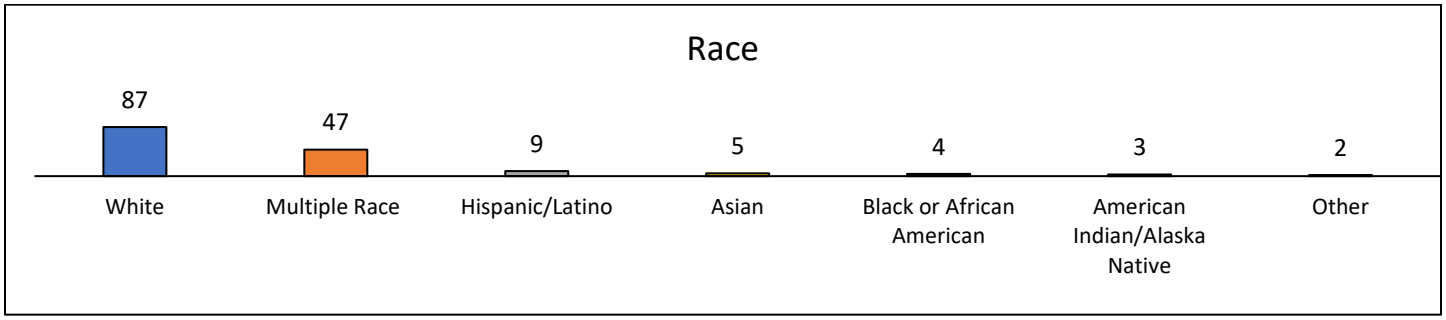
Section A: Student Background

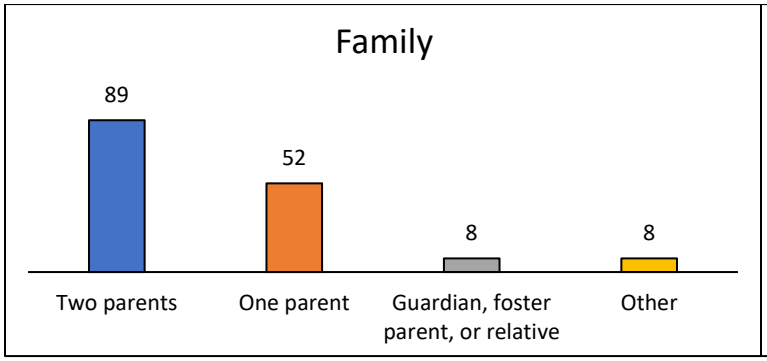
Turtle Bay Demographics

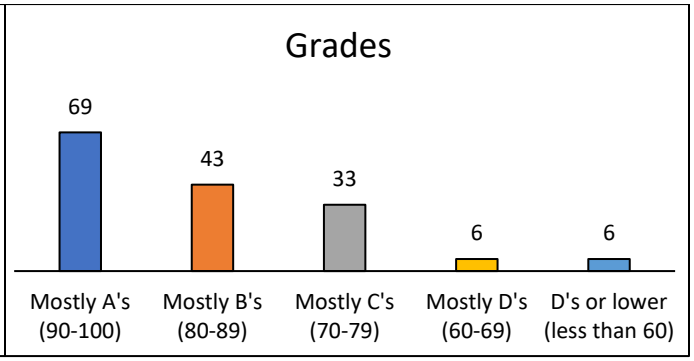
(6th-8th graders, N = up to 157)

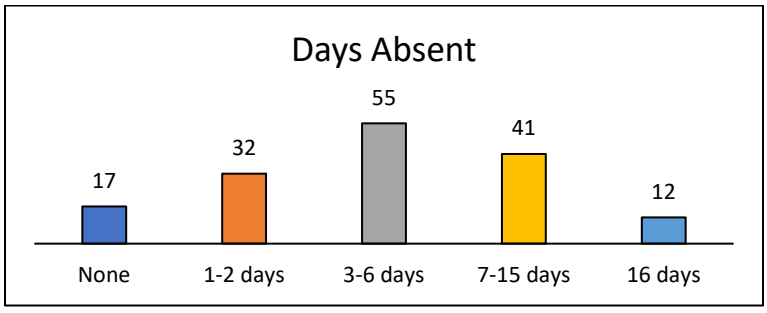












Section B: Knowledge measures (Anti-drug)

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

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

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

Section B: Knowledge measures (Life skills)

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

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

Section C: Attitude measures (Anti-drug)

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

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

6th grade		7th grade		8th grade	
PRE (N = 59)	POST (N = 59)	PRE (N = 42)	POST (N = 42)	PRE (N = 56)	POST (N = 56)
4.39	4.60	4.40	4.43	4.41	4.25
4.85	4.68	4.71	4.57	4.72	4.60
4.31	4.28	4.21	4.26	3.96	3.82
4.41	4.25	4.19	4.19	3.81	3.75
4.76	4.54	4.79	4.55	4.69	4.53
4.83	4.58	4.67	4.52	4.63	4.49
4.42	4.61	4.52	4.40	4.63	4.53
4.53	4.35	4.45	4.19	4.41	4.36
4.50	4.44	4.46	4.36	4.37	4.24
4.63	4.53	4.52	4.42	4.45	4.34
4.56	4.49	4.49	4.39	4.41	4.29

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

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

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

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

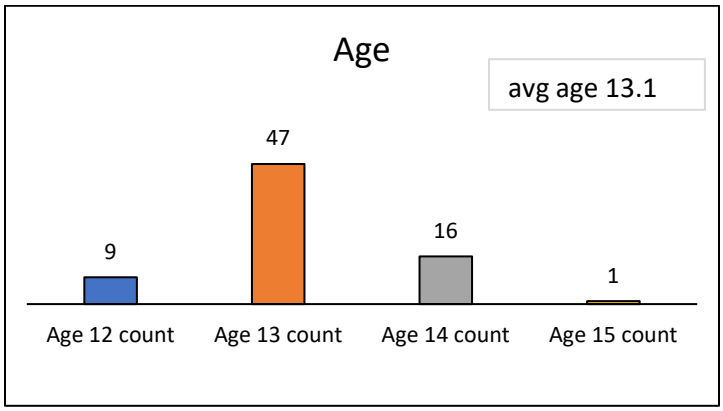
Section D: Life skills measures (Drug refusal, assertiveness, relaxation, and self-control)

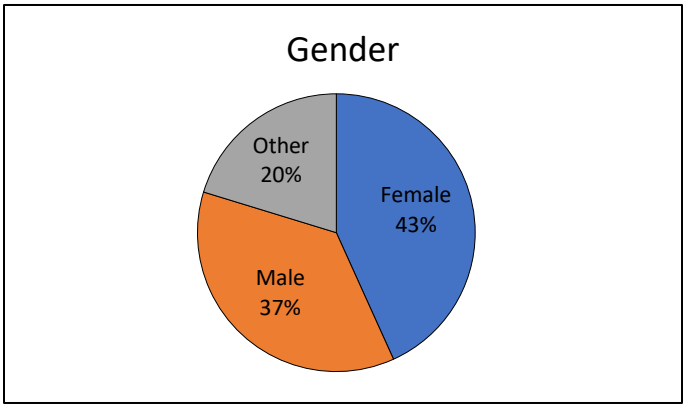
	Life skills (Turtle Bay)	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	6th grade PRE (N = 59)	6th grade POST (N = 59)	7th grade PRE (N = 42)	7th grade POST (N = 42)	8th grade PRE (N = 56)	8th grade POST (N = 56)
I would say NO if someone tried to get me to:												
1.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

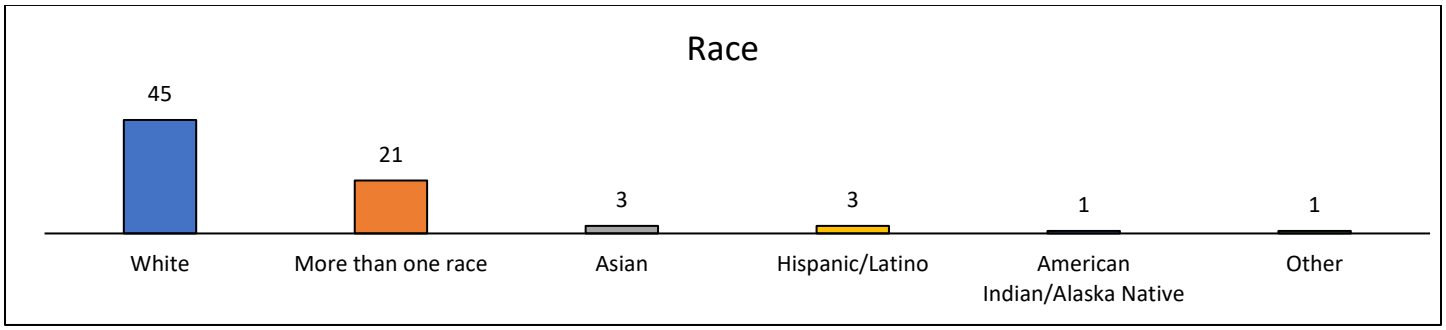
Section A: Student Background

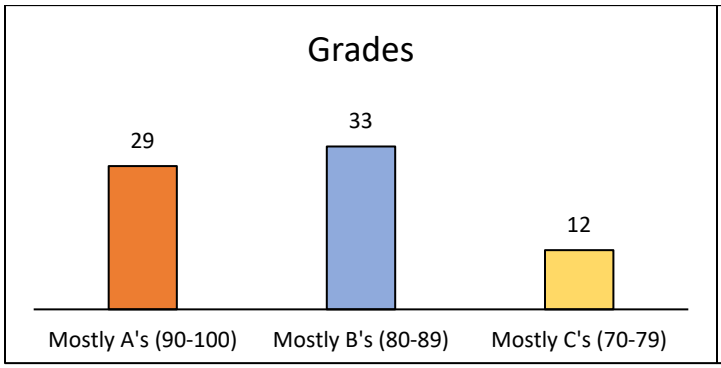
Bella Vista Demographics

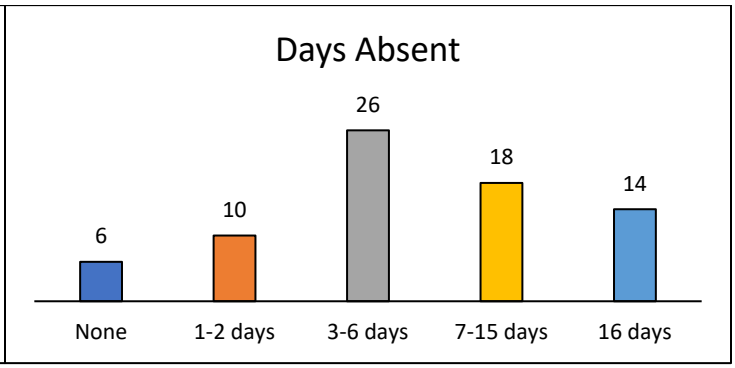
(6th-8th graders, N = up to 74)

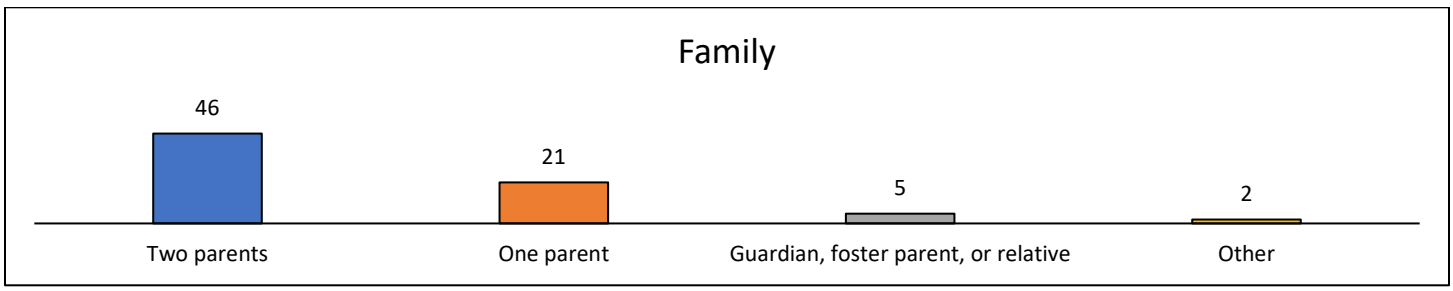












Section B: Knowledge measures (Anti-drug)

Bella Vista

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

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

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

Section B: Knowledge measures (Life skills)

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

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

Section C: Attitude measures (Anti-drug)

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

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

6th grade		7th grade		8th grade	
PRE (N = 22)	POST (N = 22)	PRE (N = 23)	POST (N = 23)	PRE (N = 29)	POST (N = 29)
3.91	4.55	4.52	4.39	4.14	3.97
4.64	4.73	4.87	4.48	4.45	4.03
4.05	3.64	4.35	3.91	4.14	3.79
3.95	3.91	4.35	4.30	4.07	3.76
4.41	4.41	4.91	4.35	4.28	4.00
4.41	4.59	4.78	4.48	4.21	4.14
4.32	4.45	4.65	4.39	4.14	4.00
4.09	4.50	4.65	4.26	3.83	3.90
4.11	**4.27**	**4.61**	**4.23**	**4.09**	**3.91**
4.33	**4.42**	**4.66**	**4.41**	**4.22**	**3.98**
4.22	**4.35**	**4.64**	**4.32**	**4.16**	**3.95**

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

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

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

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

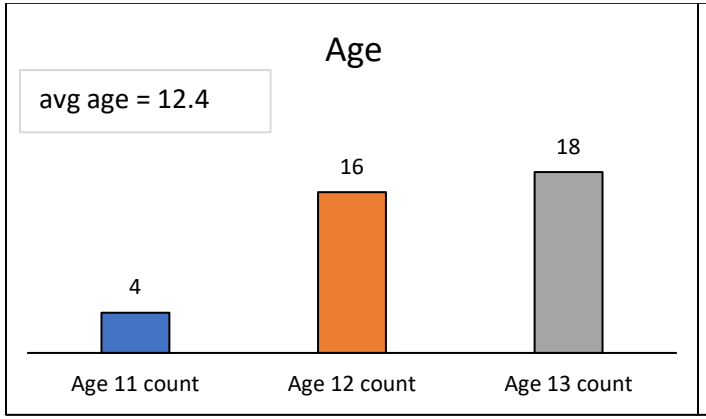
Section D: Life skills measures (Drug refusal, assertiveness, relaxation, and self-control)

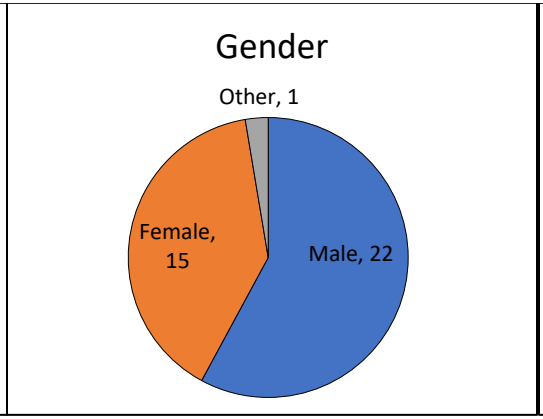
	Life skills (Bella Vista)	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	6th grade PRE (N = 22)	6th grade POST (N = 22)	7th grade PRE (N = 23)	7th grade POST (N = 23)	8th grade PRE (N = 29)	8th grade POST (N = 29)
I would say NO if someone tried to get me to:												
1.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

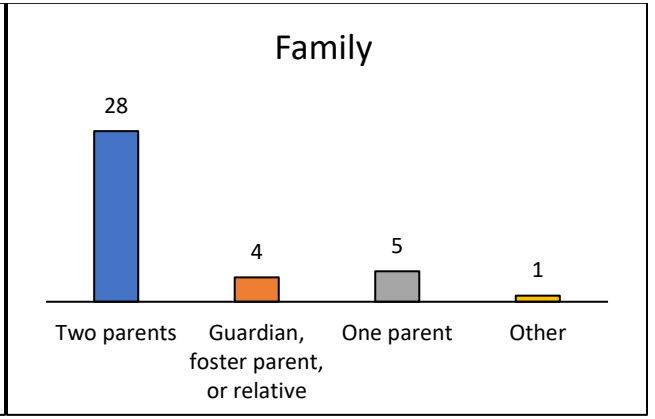
Section A: Student Background

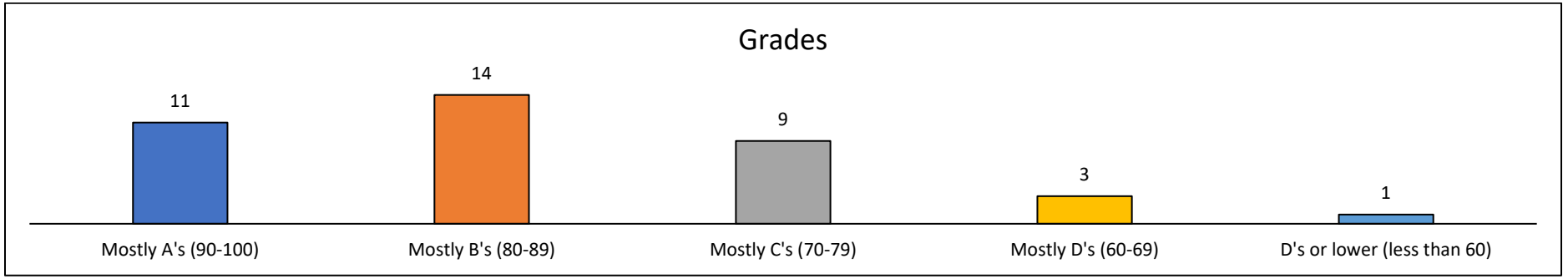
Happy Valley Demographics

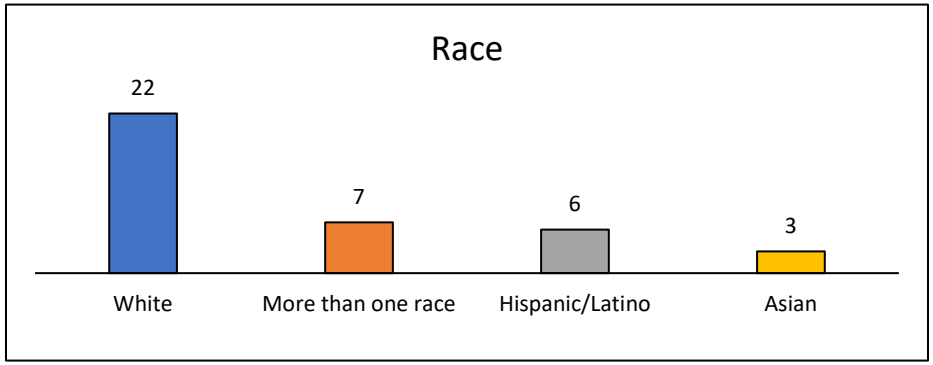
(6th-8th graders, N = up to 38)

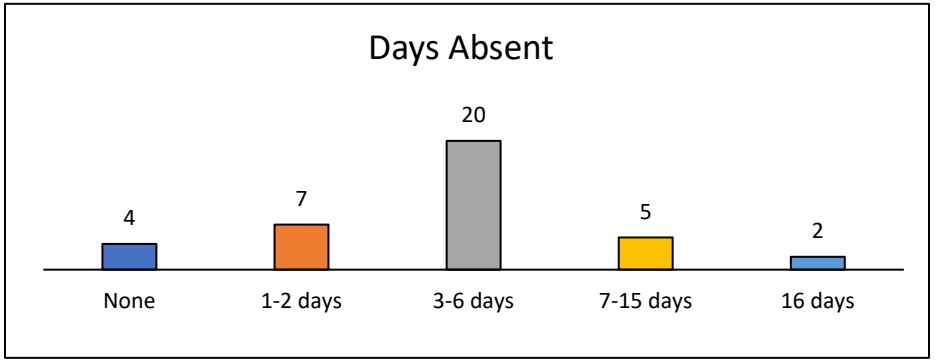












Section B: Knowledge measures (Anti-drug)

Happy Valley

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

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

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

Section B: Knowledge measures (Life skills)

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

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

Section C: Attitude measures (Anti-drug)

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

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

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

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

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

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

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

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

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

References

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

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

Shasta County Health & Human Services Agency

Adverse Childhood Experiences FY: 2021 -2022

Protective Factors

Parent Café's

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

Table Host Trainings

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

Trauma-Informed Practices Trainings

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

Protective Factors Trainings

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

Hope Navigators | Pathways to Hope for Children

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

Community Engagement

Strengthening Families Collaborative (SFC)

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

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

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

SFC Data Committee (sub-committee)

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

Meetings held during the reporting period focused on:

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

ACE Learning Community/ACE Interface Trainers

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

During this reporting period, Learning Community activities included:

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

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

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

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

ACE Events

ACE Luncheons

Two Luncheons were held during this reporting period:

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

ACE Presentations & Movie Showings

Appendix L

ACE Presentations

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

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

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

Shasta Strengthening Families Marketing

Social Media Engagement

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

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

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

Website

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

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

Public Service Announcements/Videos

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

Materials

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

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

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

Other

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

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

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

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

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

Shasta County Health & Human Services Agency

Stigma & Discrimination Reduction activities

Fiscal Year 2021-2022

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

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

Community Outreach and Education:

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

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

SUICIDE PREVENTION FISCAL YEAR JULY 21/JUNE 22 REPORT

STRATEGY: CREATE A SYSTEM OF SUICIDE PREVENTION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

July 1, 2021-June 30, 2022

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

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

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

STRATEGY 2: IMPLEMENT TRAINING AND WORKFORCE ENHANCEMENTS TO PREVENT SUICIDE

QPR

QPR Trainer Certification: August 2020

Shasta County QPR Trainers:

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

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

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

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

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

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

STRATEGY 3: EDUCATE COMMUNITIES TO TAKE ACTION TO PREVENT SUICIDE

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

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

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

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

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

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

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

STRATEGY 4: EDUCATE COMMUNITIES TO TAKE ACTION TO PREVENT SUICIDE

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

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

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

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

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

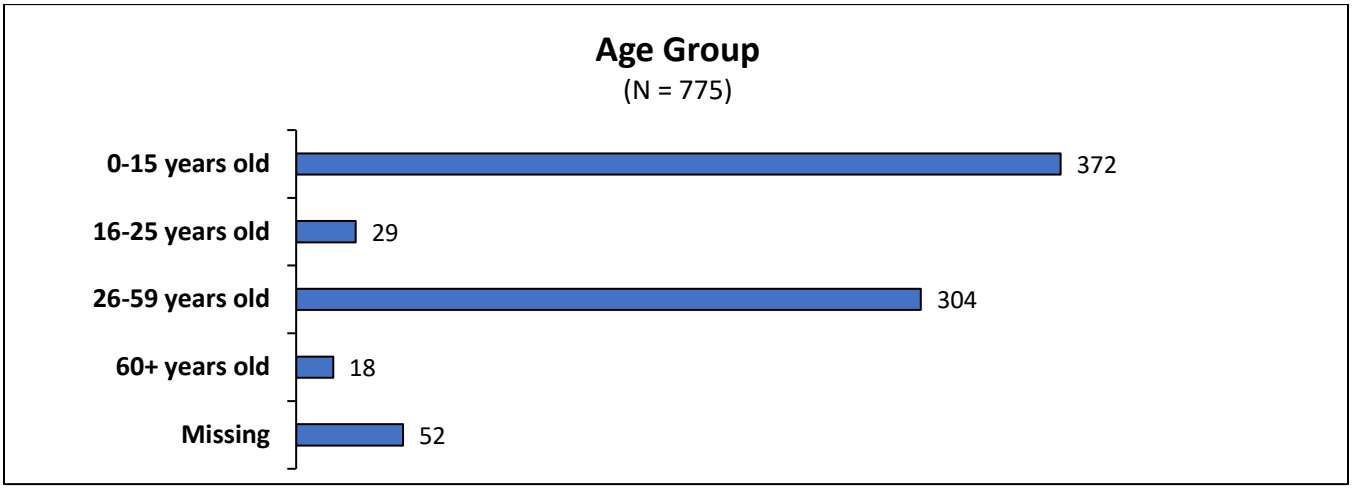
Shasta County Health & Human Services Agency

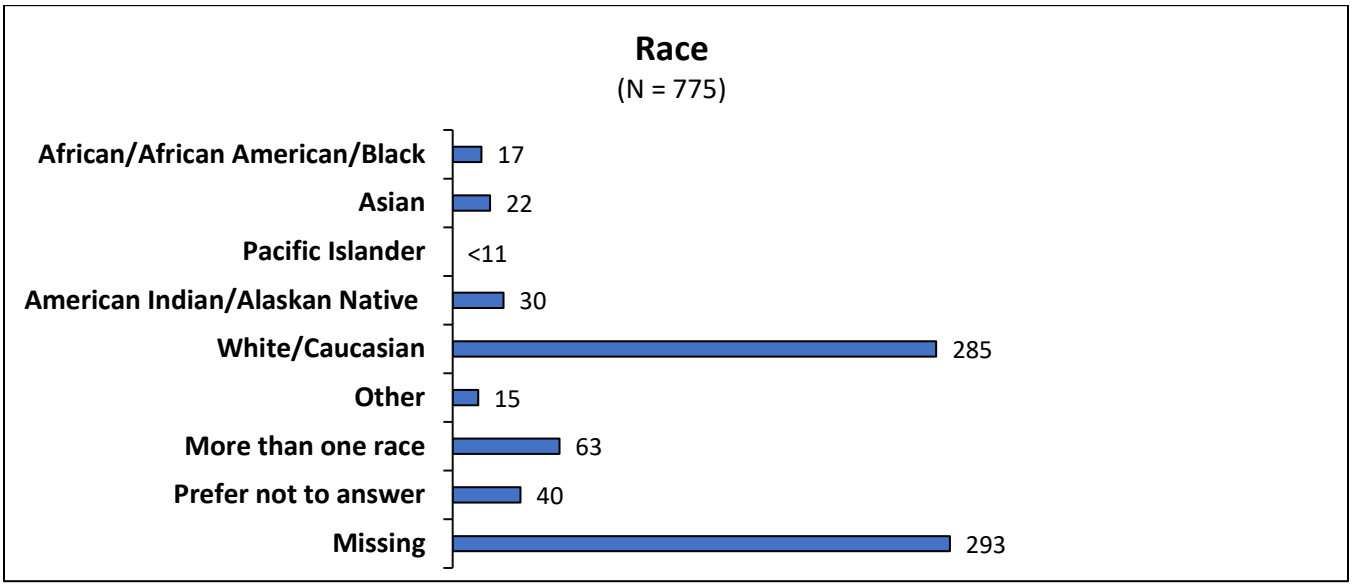
MHSA Prevention and Early Intervention Fiscal Year 21/22 Demographics Report

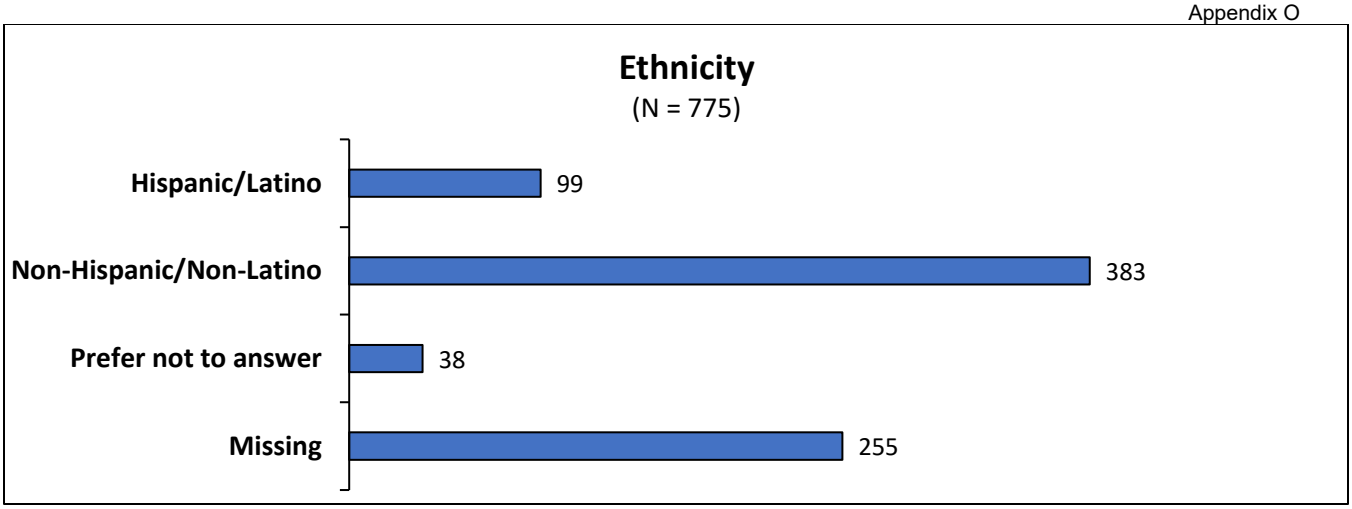
I. Prevention and Early Intervention Program Demographics

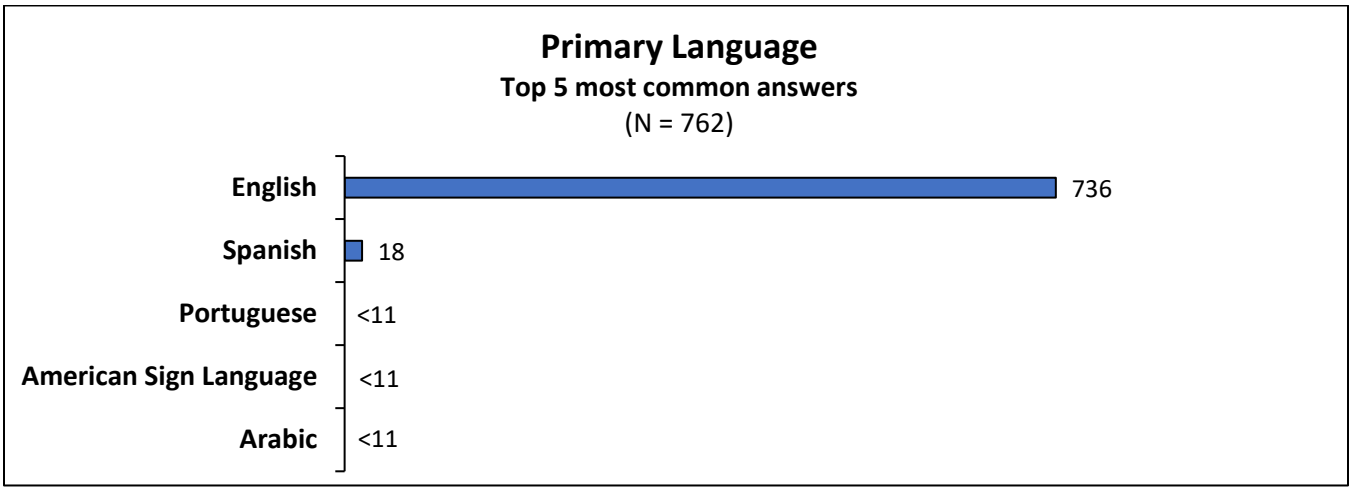
- Triple P (226)
- Botvin Lifeskills (364)
- Mental Health First Aid (69)
- Hope Navigator (62)
- LAUNCH (14)
- IMPACT (40)

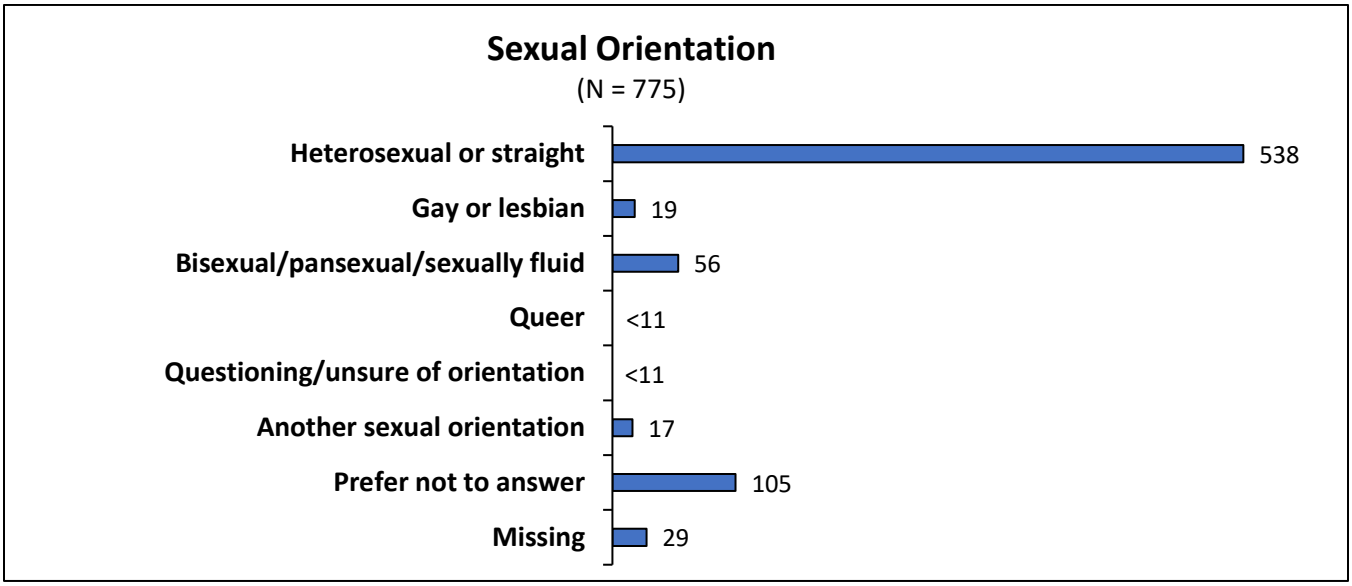
775 total individuals submitted data. Categories that received 11 or less responses are not labelled to help protect client confidentiality. Categories that received zero responses are not shown.

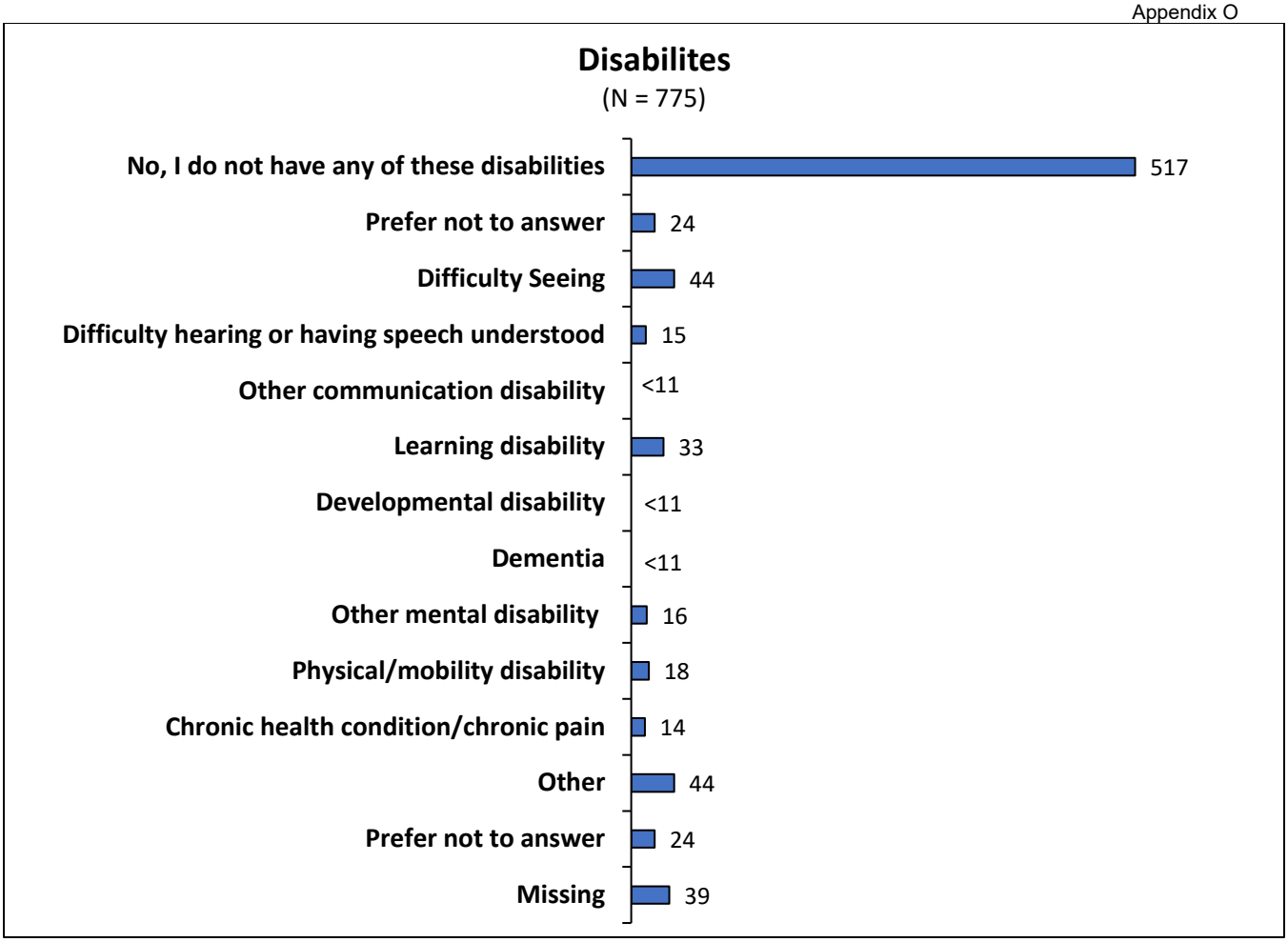


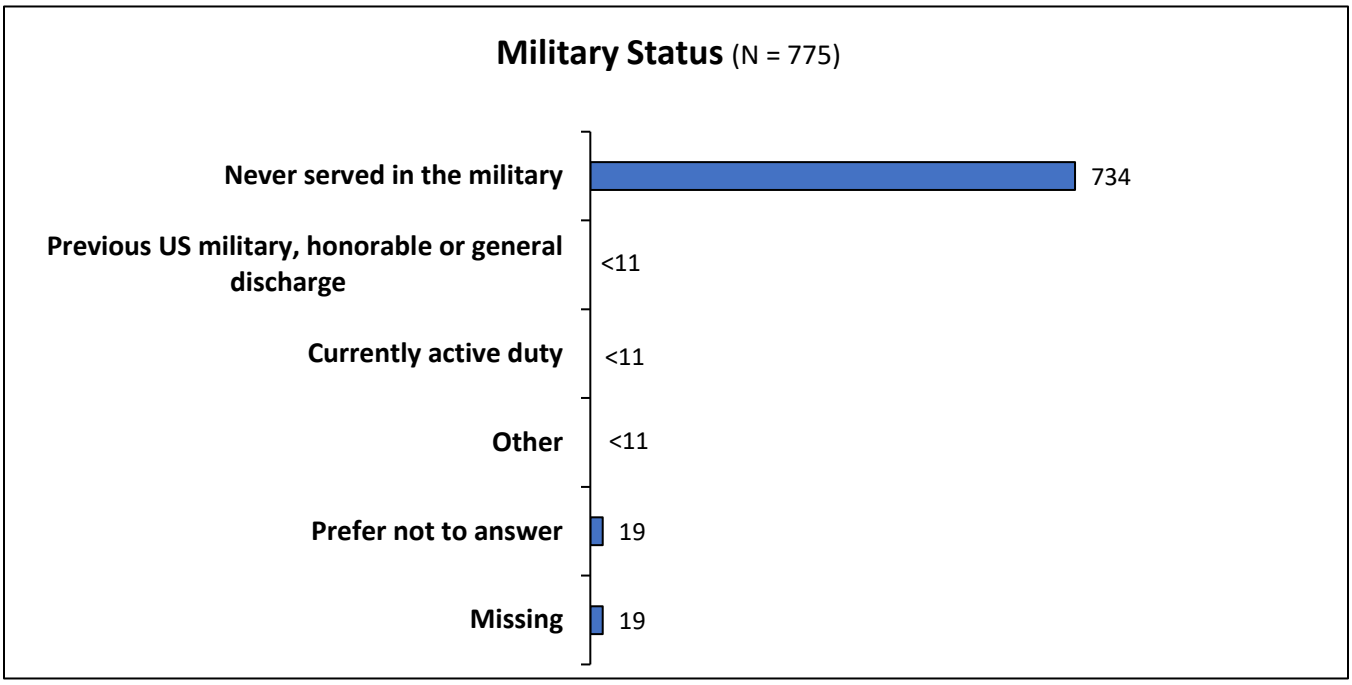


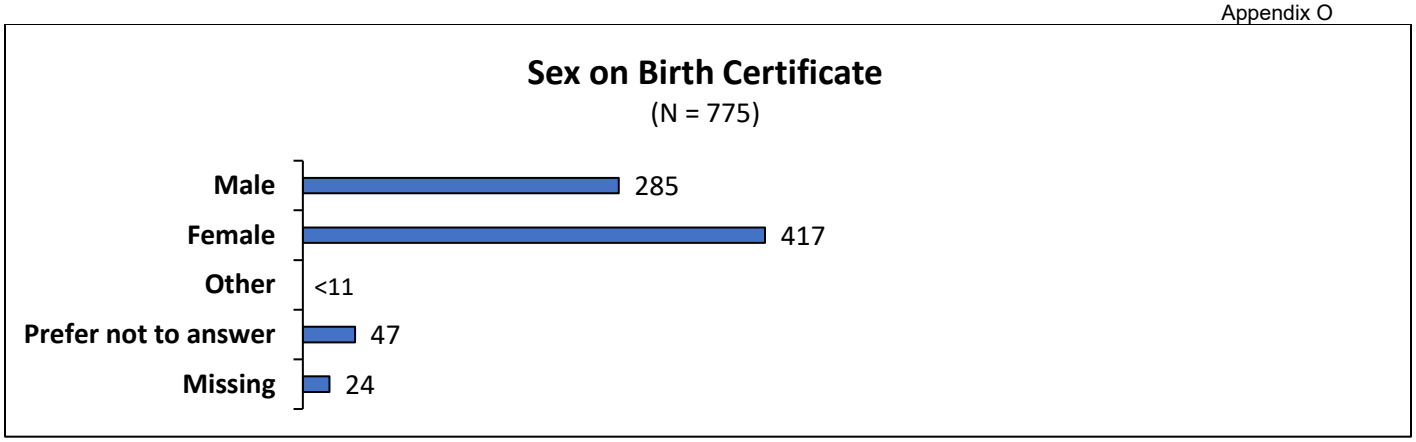

Ethnicity
(N = 775)
Hispanic/Latino
99
Non-Hispanic/Non-Latino
383
Prefer not to answer
38
Missing
255

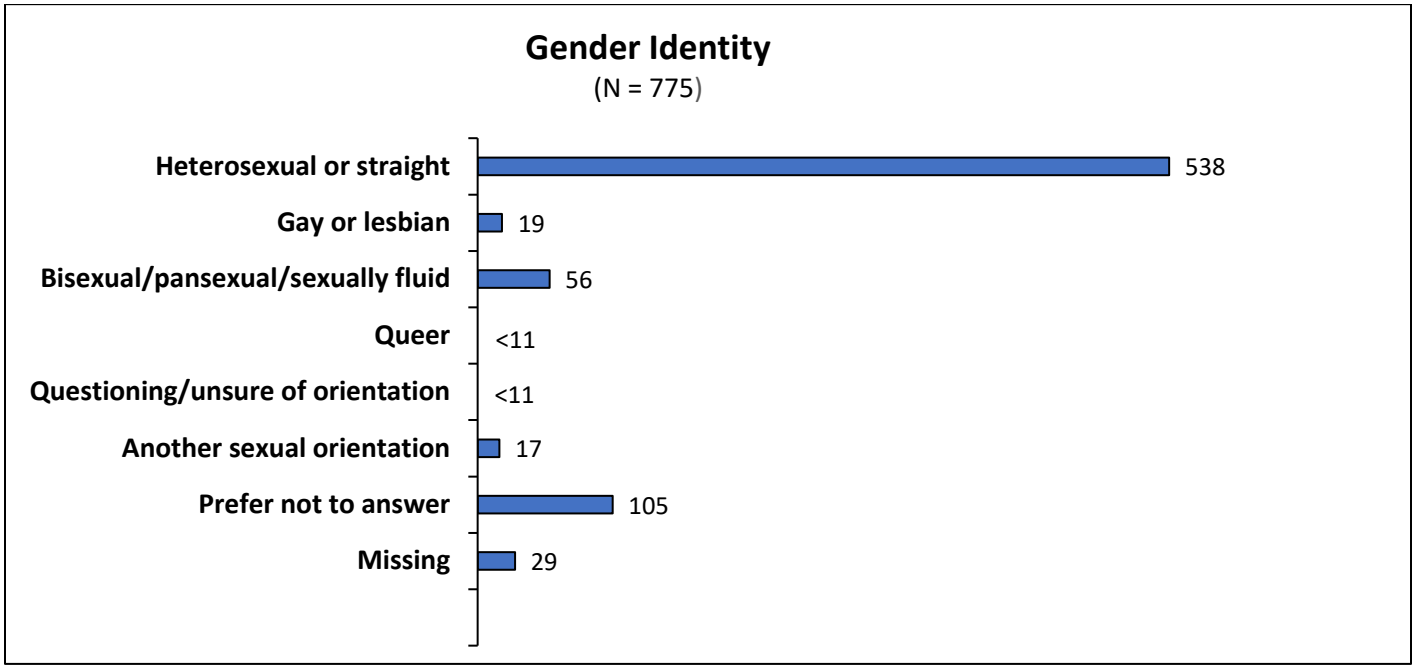

Primary Language
Top 5 most common answers
(N = 762)
English
736
Spanish
18
Portuguese
<11
American Sign Language
<11
Arabic
<11


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


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


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


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


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

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

- Stand Against Stigma

10,000 total Individuals and potential responders served*

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

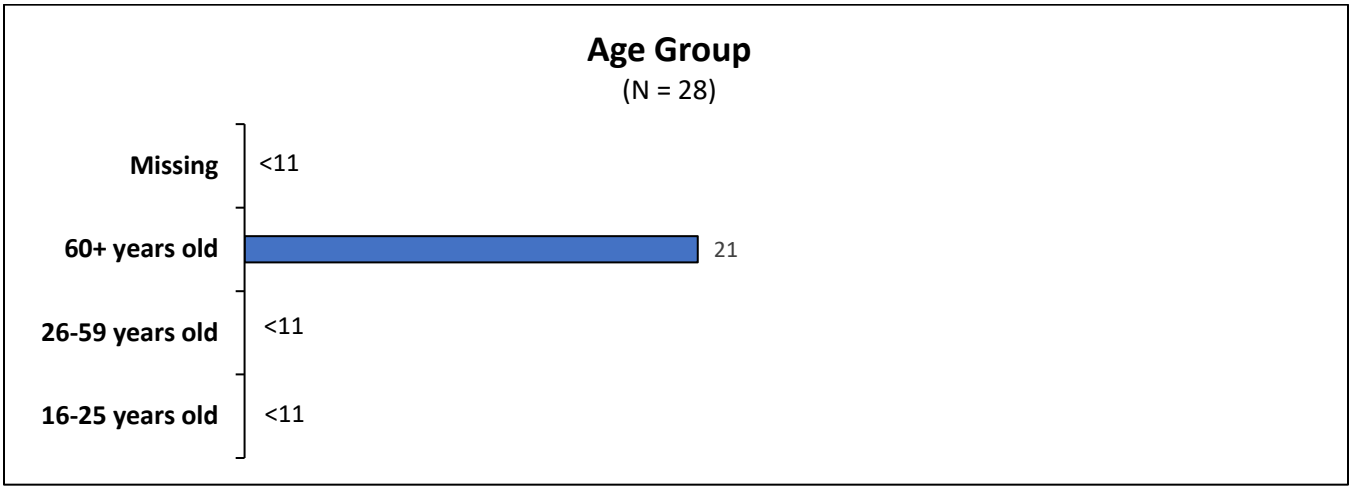
This program was implemented in various settings including:

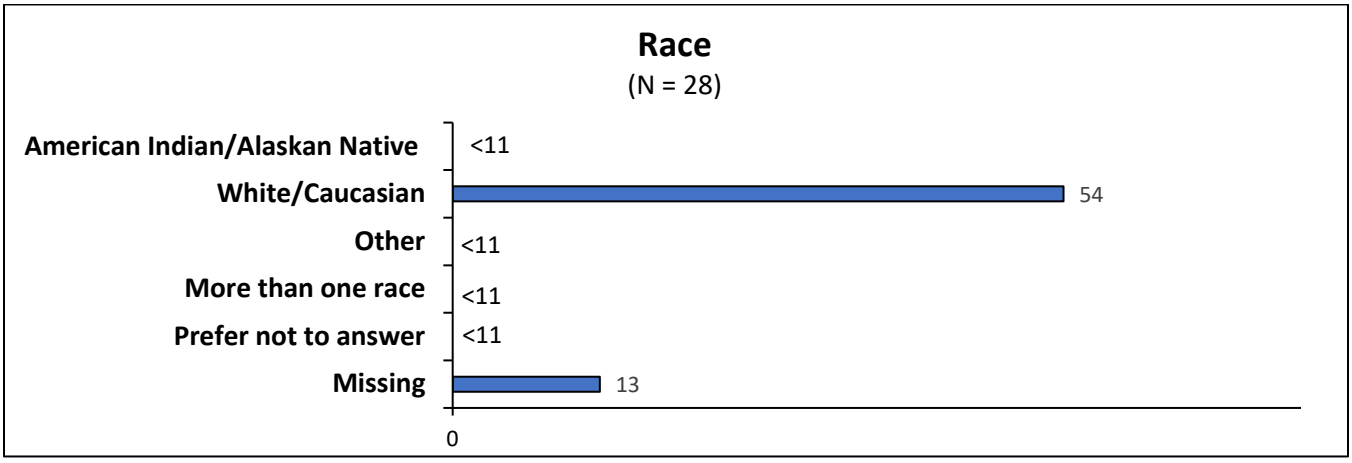
- **Domestic Abuse shelter**
- **CARE Center**
- **Wellness Centers**
- **Sundial Bridge**
- **Community Center**
- **Social Services Organization**

Types of potential responders:

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

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




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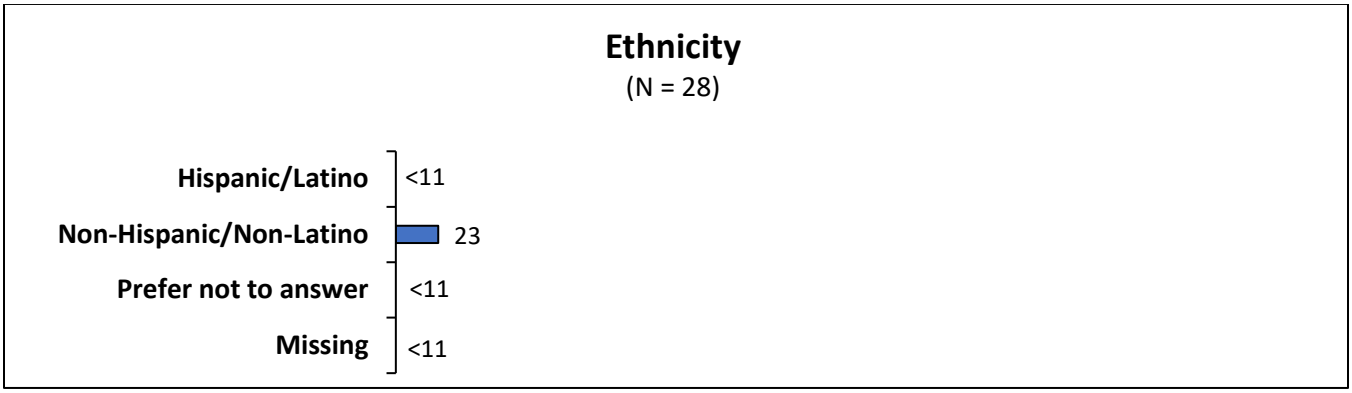
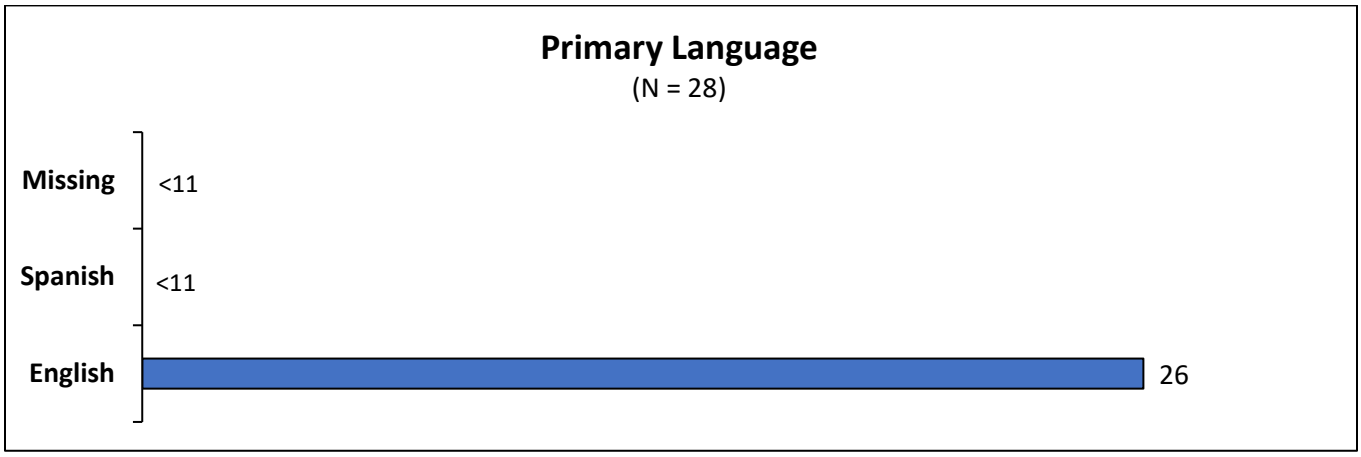
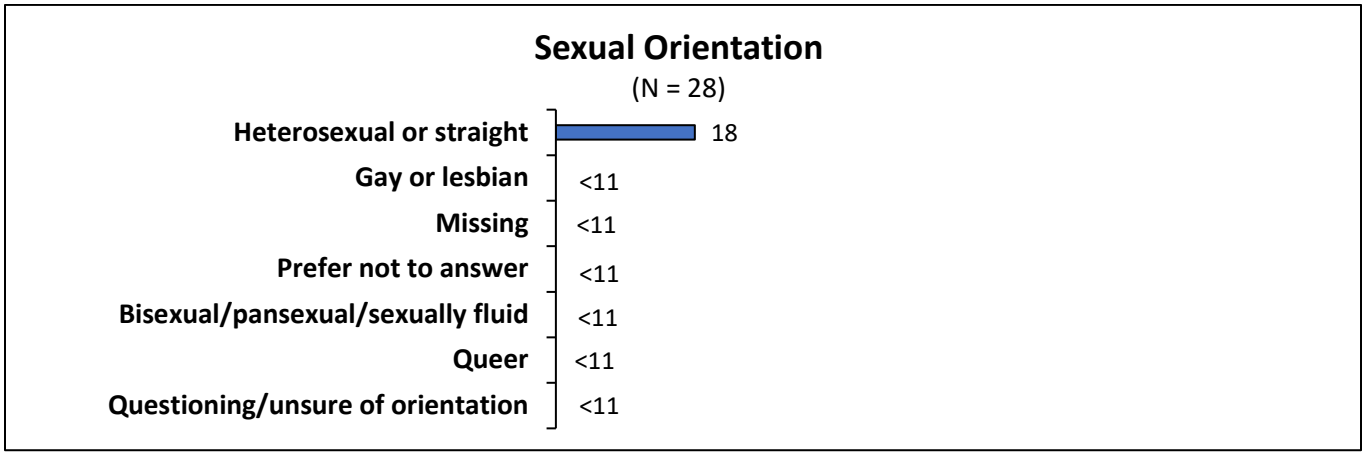
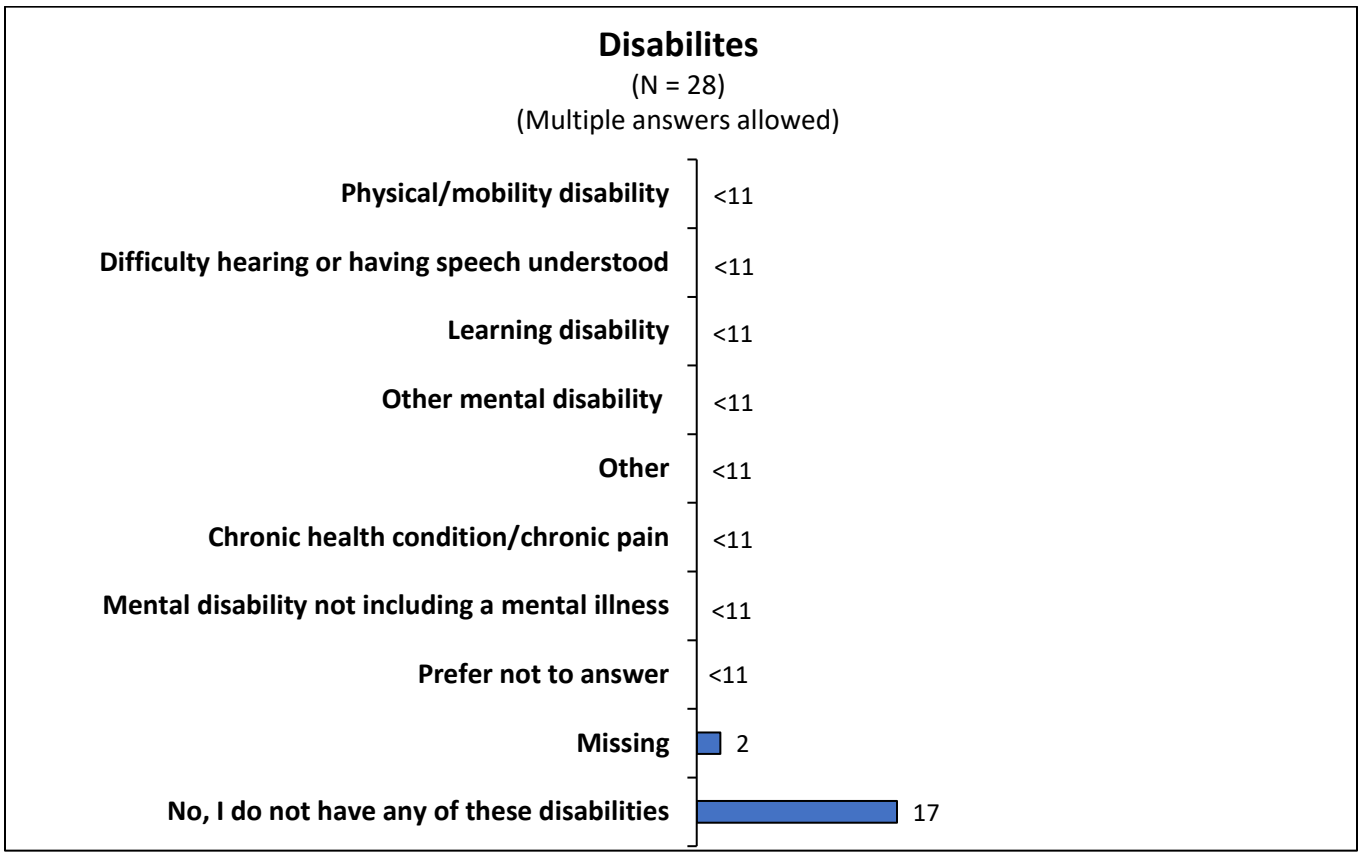
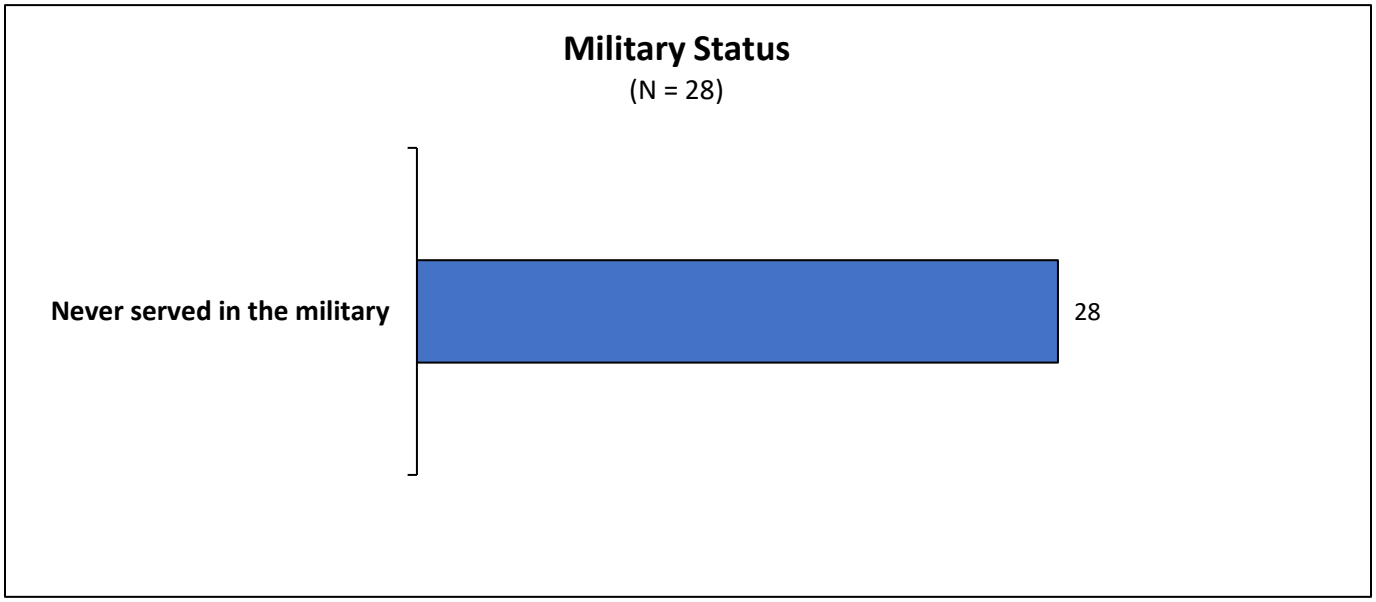
Other
<11
More than one race
<11
Prefer not to answer
<11
Missing
13
0

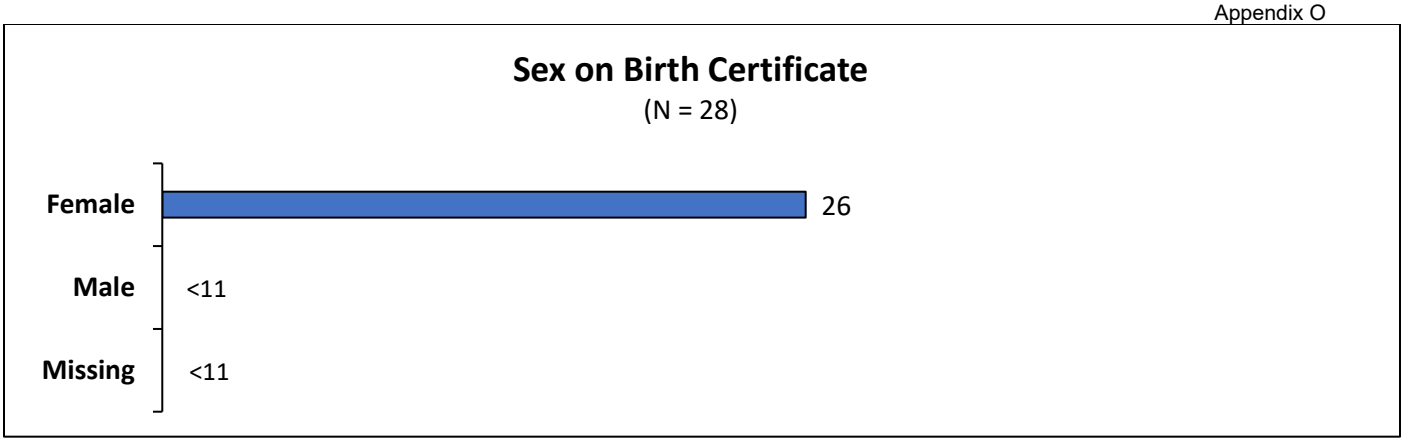

Ethnicity
(N = 28)
Hispanic/Latino
<11
Non-Hispanic/Non-Latino
23
Prefer not to answer
<11
Missing
<11

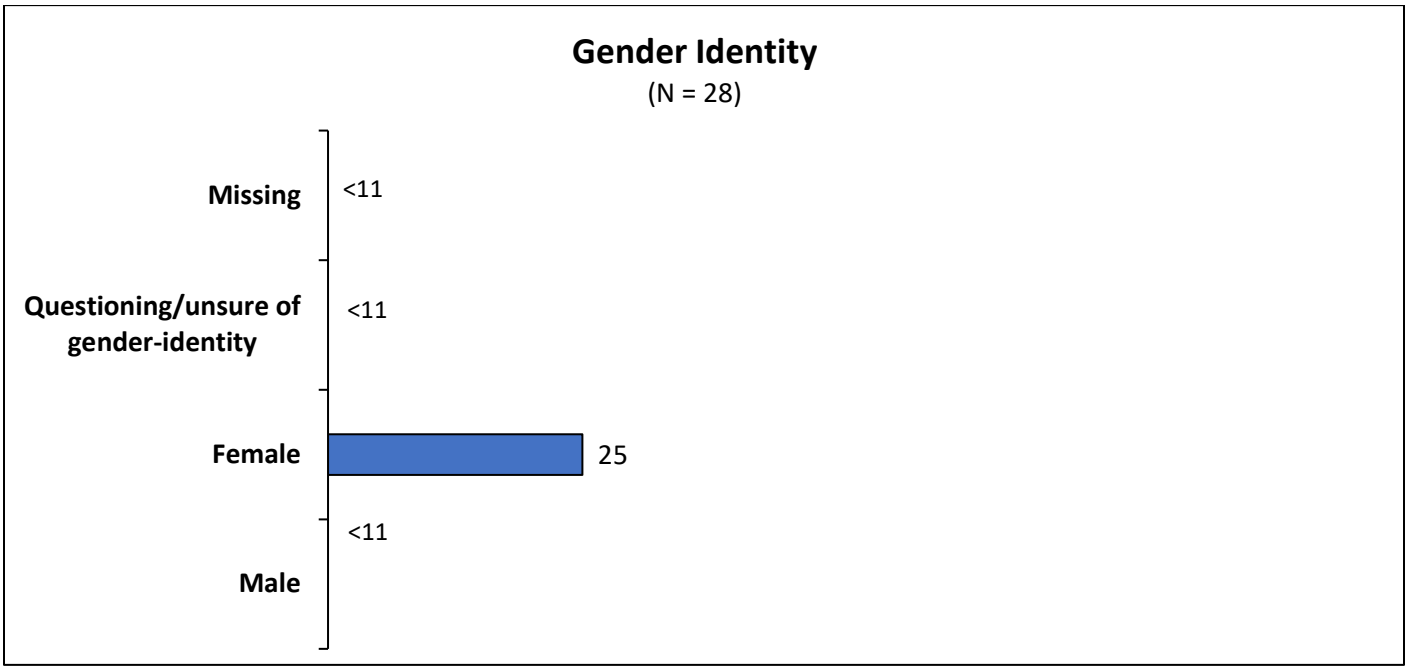

Primary Language
(N = 28)
Missing
<11
Spanish
<11
English
26


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


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


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


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

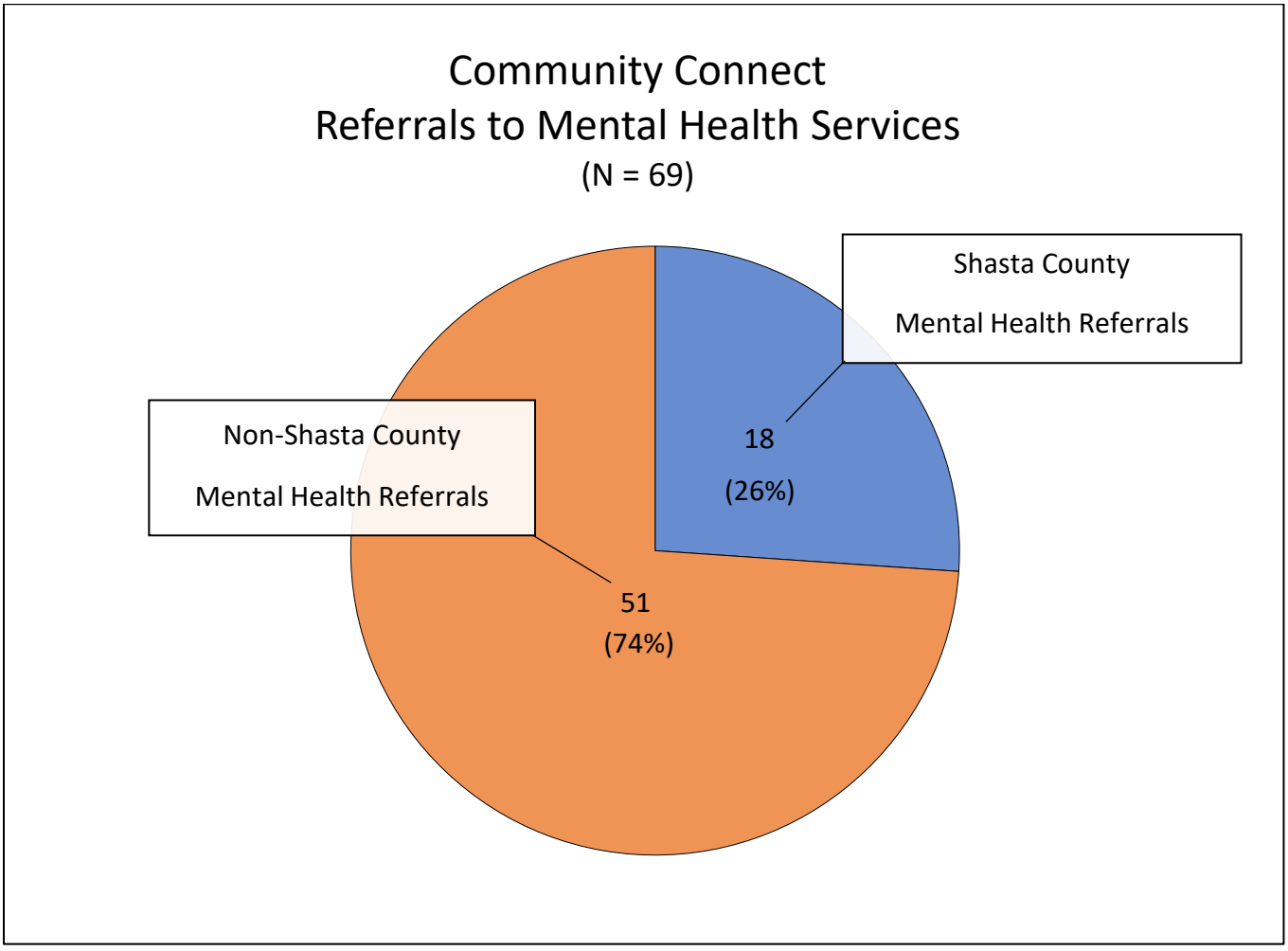

Gender Identity
(N = 28)
Missing
<11
Questioning/unsure of gender-identity
<11
Female
25
<11
Male

III. Access and Linkage to Treatment Strategy or Program Demographics

Community Connect

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

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



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

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

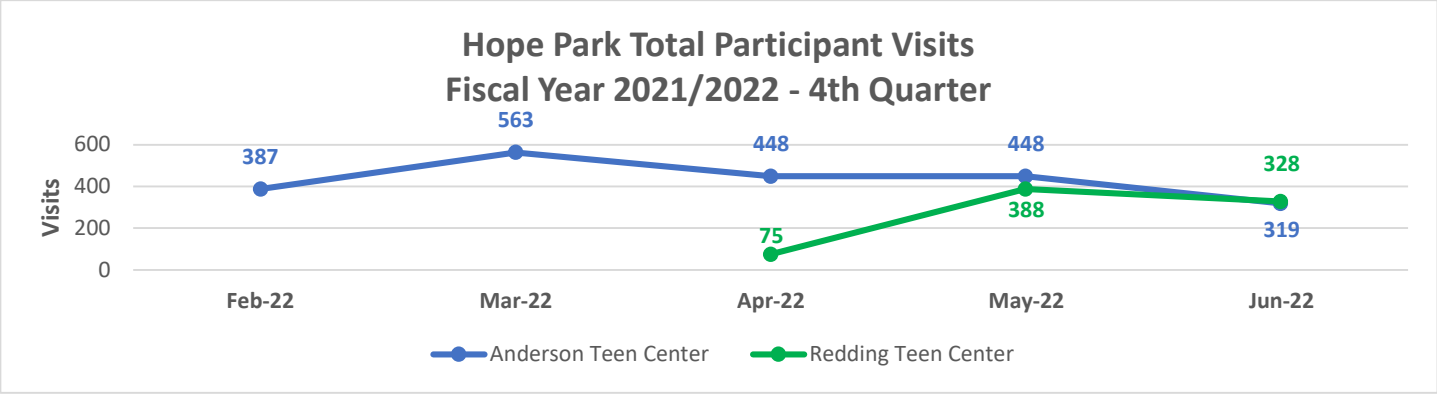
April 2022 – June 2022

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

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

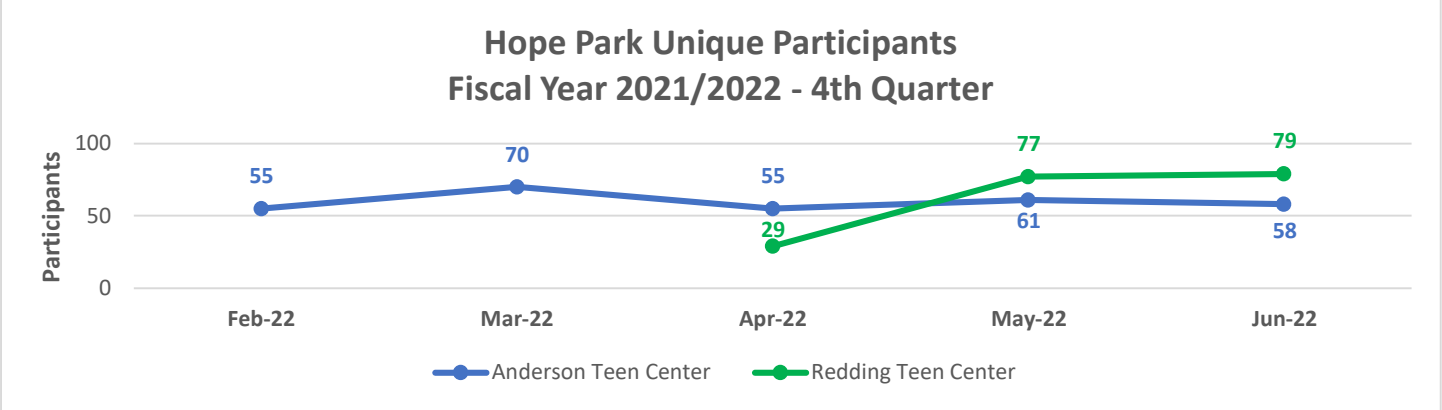
Community Participation:

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



Individual Participation:

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



Age:

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

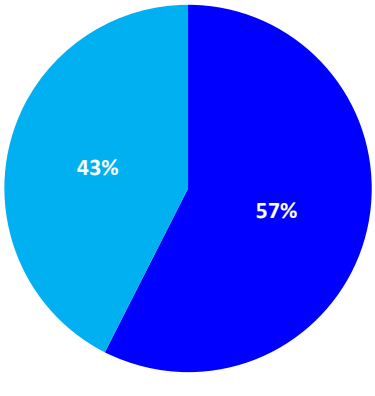
*The Hope Park Project specifically focuses on Teenagers and Senior Adults, so the following four age categories will be used instead: Teen ages **12-15**, Teen ages **16-18**, Senior Adults ages **60-70** and Senior Adults ages **70+**.*

4th Quarter Age Distribution

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

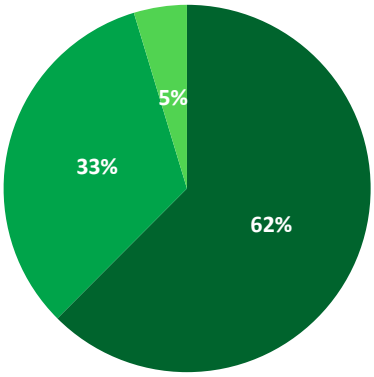
The Redding Teen Center served an average of **64** unique individuals each month from **April 2022 – June 2022** with **62%** being 12-15 years old, **33%** being 16-18 years old and **5%** being 60-70 years old.

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



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

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



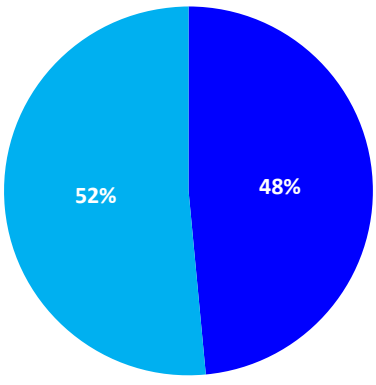
Age Distribution of Monthly Unique Participants 4th Quarter 2021/22 Redding Teen Center

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

Average Age Distribution Since Inception of Hope Park:

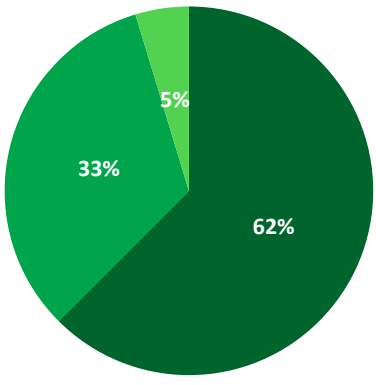
The Anderson Teen Center has averaged about **60** unique individuals per month since Hope Park Inception in February 2022 with **48%** being 12-15 years old and **52%** being 16-18 years old.

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



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

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



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

**Center Opened in April 2022*

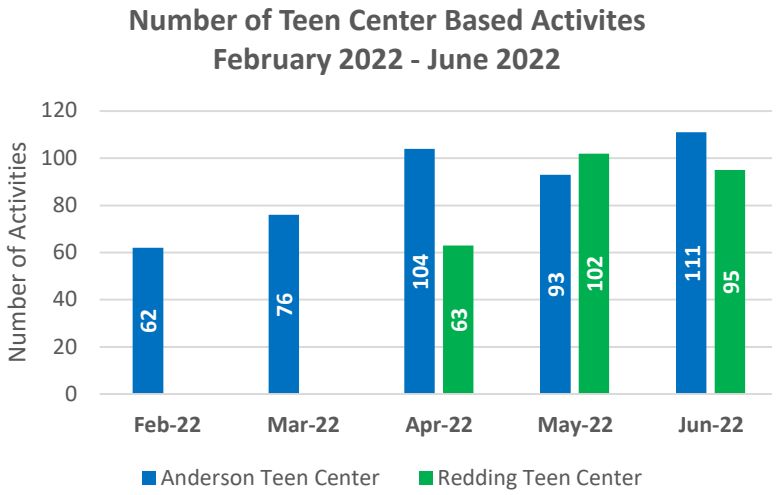
- 12-15 Years Old
- 16-18 Years Old
- 60-70 Years Old
- 71+ Years Old

Monthly Activities:

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

**Redding Teen Center Opened in April 2022*

***No Data Reported for January 2022*



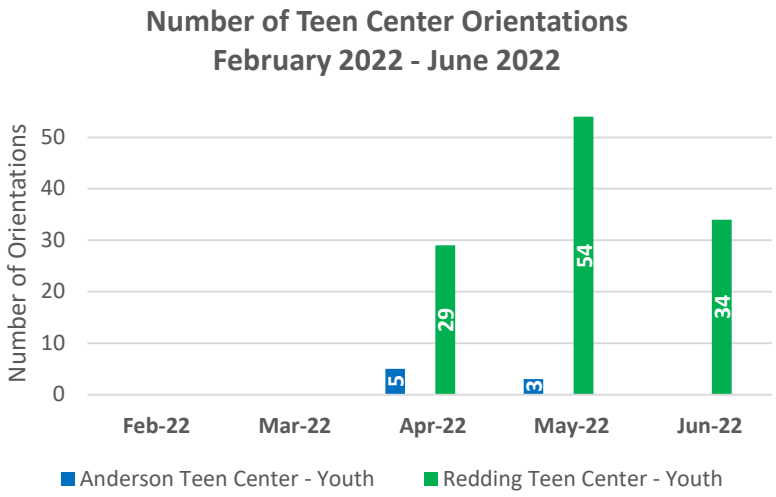
Teen Center Orientations:

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

**No Data Reported for January 2022*

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

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



Overview for Anderson Teen Center

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

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

Overview for Redding Teen Center

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

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

Senior Adults/Hope Park

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

Hope Park Accomplishments

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

Program Challenges/Solutions

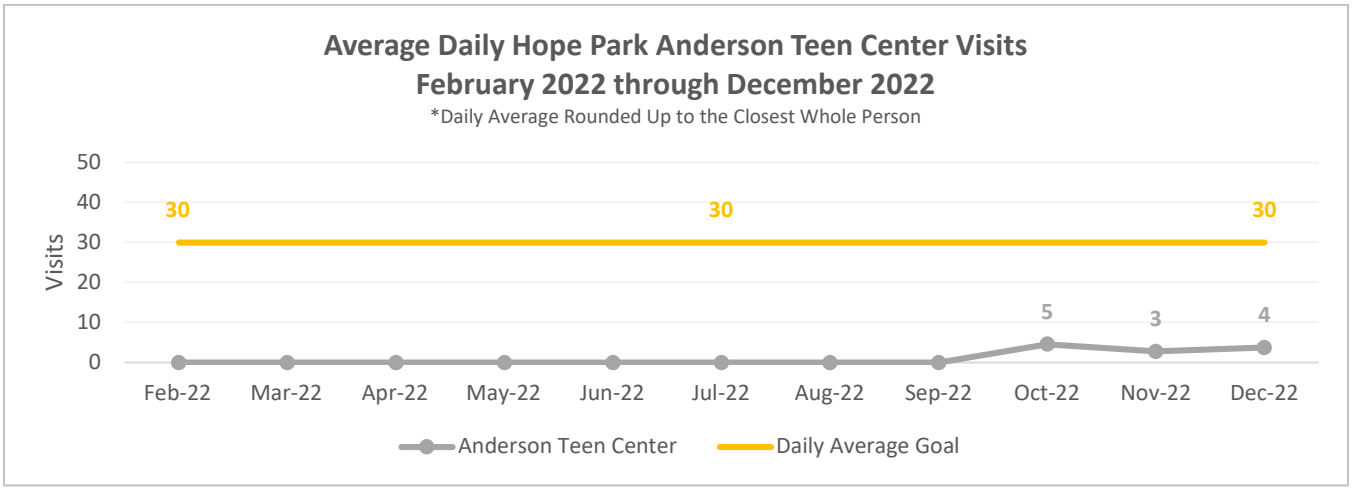
Hope Park challenges include acquiring the number of Senior Adults needed for the program. Potential causes of lack of follow through from Senior Adults seem to be fears of Covid exposure and inability to speak directly to the Senior Adults. The Volunteer Coordinator continues to make connections but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

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

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

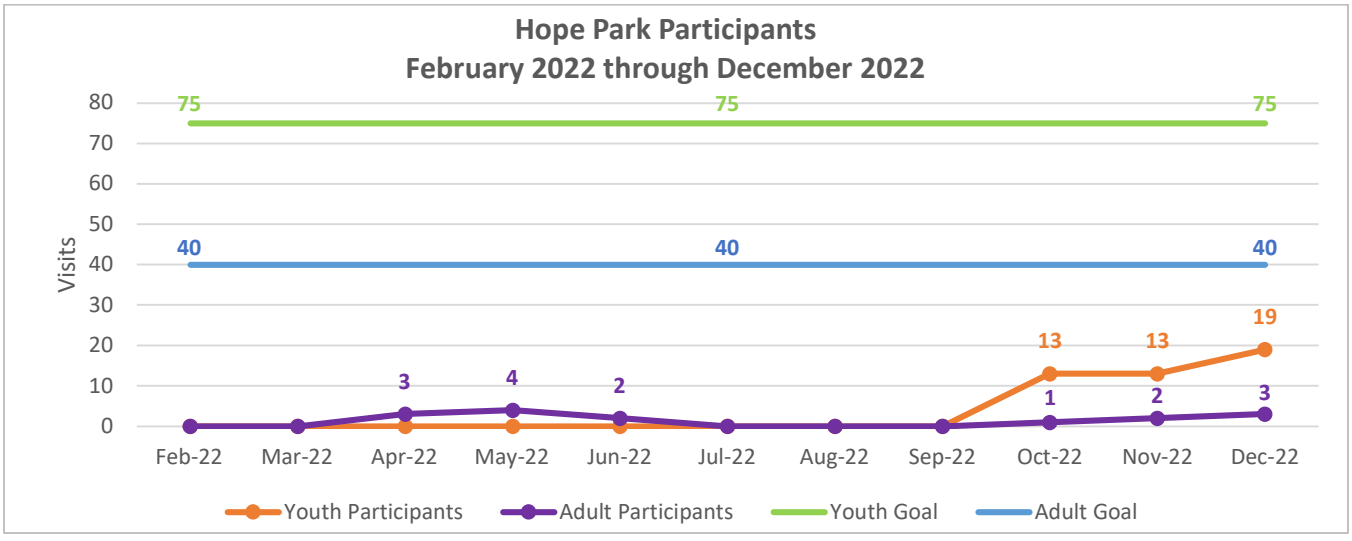
Year 1 Program Objectives:

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



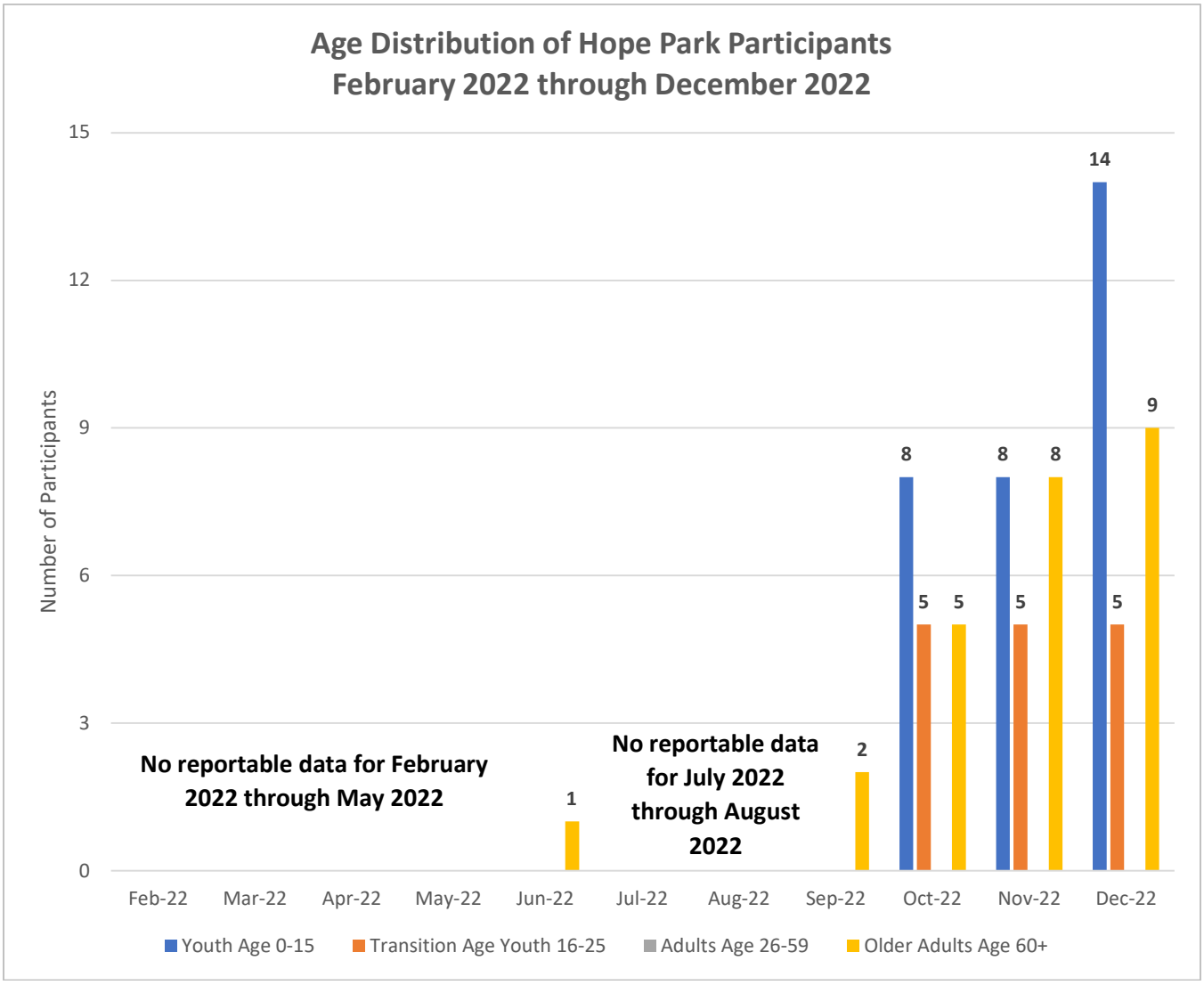
2.) Recruit 75 Youth participants from Anderson and Redding

3.) Recruit and Train 40 Older Adult volunteers



Age:

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

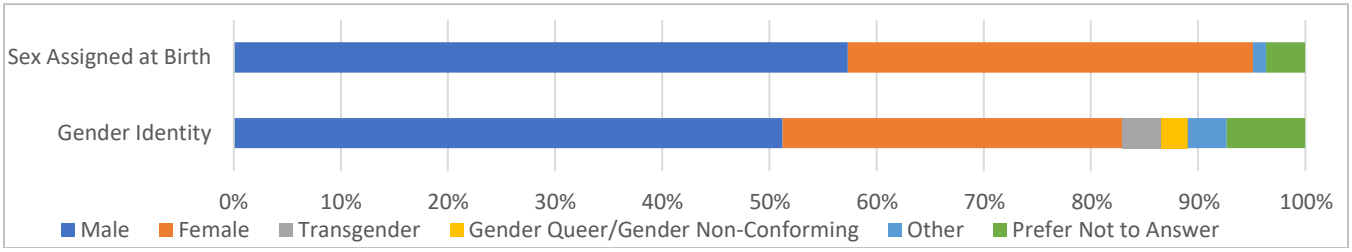


Teen Center Demographics:

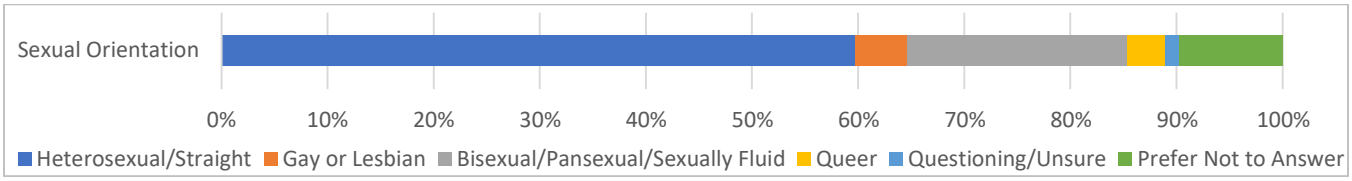
Demographic Surveys are taken by Teen Center participants and volunteers during orientation, the numbers below reflect the information for participants in both Teen Centers, not just Hope Park Participants, for **February 2022** through **December 2022**.

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

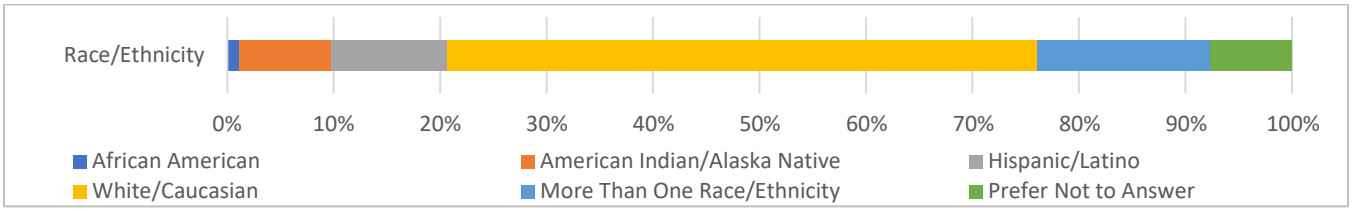
Sex Assigned at Birth and Gender Identity:



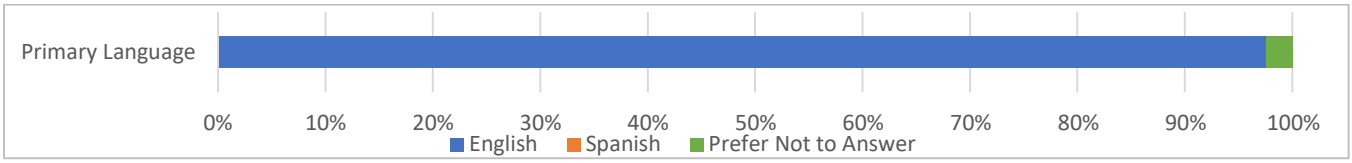
Sexual Orientation:



Race/Ethnicity:



Primary Language:



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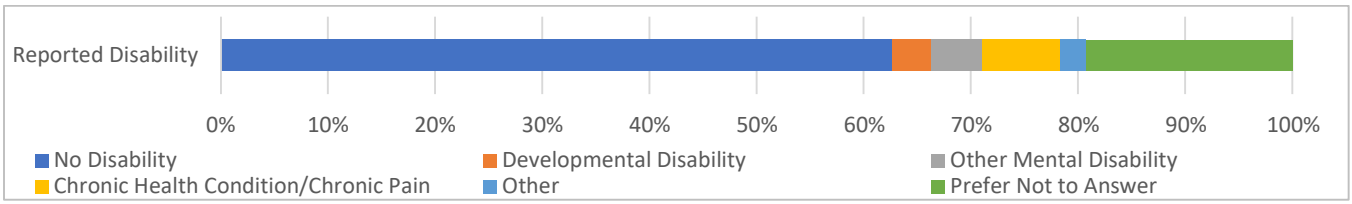

May 15, 2023

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

Dear MHSOAC members:

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

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

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

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

Sincerely,

DocuSigned by:
Miguel Rodriguez
1235765B45D137

Miguel Rodriguez, Director of Mental Health
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Psychiatric Advance Directives (PADs) Innovations Project Update

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix

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

References

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

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

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

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

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

Ron Henninger, Chair

Nicole Carroll, Secretary

The following Policy and Procedure
is to be amended.

Effective date: August 13, 2020 Page 1 of 1

POLICY

See also: Mental Health Services Act Community Planning Process Procedure

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

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

1. The Mental Health Services Act Community Planning Process is a collaboration that adheres to California Code of Regulations § 3320 to plan, implement and evaluate Shasta County's Mental Health Services Act programs.

2. The Community Planning Process must reach out to people of all ages, ethnicities and socioeconomic backgrounds, mental health clients and family members, people who provide services to people with mental health challenges and substance use disorders, and people from all geographic regions of the county.

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

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

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

Effective date: August 13, 2020 Page 1 of 3

PROCEDURE

See also: Mental Health Services Act Community Planning Process Policy

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

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

1. The Community Planning Process includes several standing committees and workgroups that actively involve a wide array of people and agencies, and their input helps guide the Health and Human Services Agency as it administers the Mental Health Services Act in Shasta County. These groups provide ideas and feedback for plans and updates, mental health policies, programs, budgets, and outreach and engagement efforts. These committees include:

    a. **MHSA Stakeholder Workgroup:** The MHSA Stakeholder Workgroup meets quarterly and as needed, depending upon the needs of the Health and Human Services Agency in administering the Mental Health Services Act. The workgroup provides input for the planning, implementation and oversight of the Mental Health Services Act. Any community member, including consumers, family members, Health and Human Services Agency staff, peer support staff and any other interested individual, organization or agency are invited to attend. This meeting is the platform where priorities for each component of MHSA are established and decisions about how to implement, improve or expand programs are made. Meetings are announced via a press release, social media, outreach to community partners and e-mail to the Mental Health Services Act distribution e-mail list.

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

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

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

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

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

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

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

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

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

a. People who have severe mental illness

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

c. People who provide mental health services

d. Law enforcement agencies

e. Educators

f. Social services agencies

g. Veterans

h. Providers of alcohol and drug services

i. Health care organizations

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

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