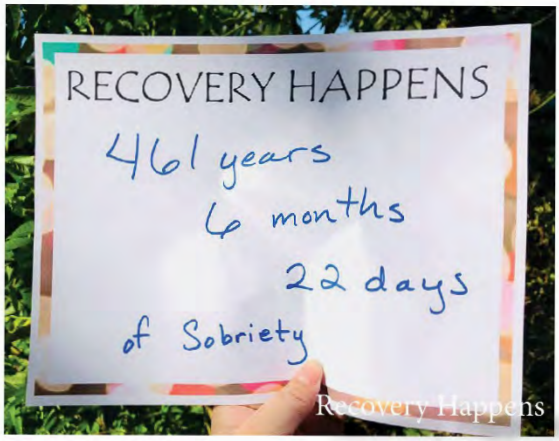
MENTAL HEALTH SERVICES ACT

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

JUNE 2018

Crisis Residential and Recovery Center

Men's Mental Health Campaign



Recovery Happens


Shasta MHSA Academy

Health and Human Services Agency

A Vision of Recovery

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

Supporting a Life in Recovery

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

Home*:* A stable and safe place to live.

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

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

Guiding Principles of Recovery

Recovery emerges from hope.

Recovery is person-driven.

Recovery occurs via many pathways.

Recovery is holistic.

Recovery is supported by peers and allies.

Recovery is supported through relationship and social networks.

Recovery is culturally-based and influenced.

Recovery is supported by addressing trauma.

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

Recovery is based on respect.

Source: Substance Abuse and Mental Health Services Administration (SAMHSA)

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MESSAGE FROM THE DIRECTOR

Our Mental Health Services Act programs continue to grow and thrive in Shasta County, and I'm pleased to share the highlights in this Fiscal Year 2018/2019 Annual Update.

The Mental Health Services Act was designed to create a system that promotes recovery and wellness for adults with serious mental illness and resiliency for children with severe emotional disturbance and their families. Thanks to collaboration among our clients, loved ones, service providers and many others, we continue to work diligently to provide people with the tools they need to make progress in their recovery from mental illness.

With the help of community partners, the Shasta County Health and Human Services Agency continues to provide Mental Health Services Act-funded programs that serve children, transitional age youth, adults and older adults. These programs align with our Agency's mission: "Engaging individuals, families and communities to protect and improve health and wellbeing."

We continue to grow and change our programs based on feedback from our community, and we measure the results of these programs to ensure that they are effective. This report outlines the progress we have made on some of the projects included in last year's Three-Year Program and Expenditure Plan, as well as our plans for the year to come. Because some people enjoy diving into the data more deeply than others, we have included more thorough reports in the Appendices section to supplement the summaries included in this report.

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

Sincerely,

Donnell Ewert, MPH
Shasta County Health and Human Services Agency Director
Mental Health Director

MENTAL HEALTH SERVICES ACT OVERVIEW

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

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

> To define serious mental illness among children, adults and seniors as a condition deserving priority attention, including prevention and early intervention services, and medical and supportive care.
>
> To reduce the long-term adverse impact on individuals, families, and state and local budgets resulting from untreated serious mental illness.
>
> To expand the kinds of successful, innovative service programs begun in California, including culturally and linguistically competent approaches for underserved populations. These programs have already demonstrated their effectiveness in providing outreach and integrated services, including medically necessary psychiatric services, and other services, to individuals most severely affected by or at risk of serious mental illness.
>
> To provide state and local funds to adequately meet the needs of all children and adults who can be identified and enrolled in programs under this measure. State funds shall be available to provide services that are not already covered by federally sponsored programs or by individuals' or families' insurance programs.
>
> To ensure that all funds are expended in the most cost-effective manner and services are provided in accordance with recommended best practices subject to local and state oversight to ensure accountability to taxpayers and to the public.

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

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

COMMUNITY PROGRAM PLANNING

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

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

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

Stakeholders	
Sector	**Organization**
Underserved cultural populations	Redding Rancheria
	Good News Rescue Mission
	Pit River Health Services
	Victor Youth Services (LGBT)
	Hispanic Latino Coalition
	Local Indians for Education
	Shasta County Citizens Against Racism
Consumer-based organizations	Olberg Wellness Center
	Circle of Friends Wellness Center
Consumer and/or family member	NAMI Shasta County
	Rowell Family Empowerment
	Mental Health, Alcohol and Drug Advisory Board
	Adult/Youth Consumers and Family Members
Health and Human Services Agency	Adult Services Branch
	Children's Services Branch
	Regional Services Branch
	Public Health Branch
	Office of Director
Law enforcement	Sheriff's Department
	Redding and Anderson police departments
	Shasta County Probation Department
Education	Shasta Community College
	Shasta County Office of Education
	Simpson University
	National University
Community-based organizations	Tri-Counties Community Network

	Youth Violence Prevention Council
	Shasta County Chemical People
Health care	Hill Country Health and Wellness Center
	Shasta Community Health Center
	Mountain Valleys Health Center
	Shingletown Medical Center

Stakeholder input meetings, 2017:

- January 25, 2017: Redding Library (At-Risk Middle School Program)
- March 15, 2017: Mental Health Administration Conference Room, 2640 Breslauer Way (gathering input from Community Services and Supports program staff)
- March 17, 2017: Mental Health Administration Conference Room, 2640 Breslauer Way (gathering input from Prevention and Early Intervention program staff)
- May 24, 2017: Olberg Wellness Center, Redding (Three-Year Program and Expenditure Plan)
- May 31, 2017: Circle of Friends, Burney (Three-Year Program and Expenditure Plan)
- May 31, 2017: Redding Library (Three-Year Program and Expenditure Plan)
- Online input for Three-Year Program and Expenditure Plan received from May 5-June 9, 2017
- Aug. 29, 2017: Redding Library, stakeholder review of comments received during Public Comment period for Three-Year Program and Expenditure Plan
- Dec. 6, 2017: General stakeholder meeting, Redding.

Regular stakeholder committees

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

Stand Against Stigma Committee: This committee (whose name was changed from Community Education Committee to better reflect its mission) 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. Its biggest annual events are Mental Health Month and Recovery Happens activities. The committee also organizes Becoming Brave trainings (which help people determine if, when and how to disclose mental health conditions); quarterly forums on specific mental health topics; open mic nights, which celebrate how art heals; and the Stand Against Stigma/Brave Faces portrait gallery.

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

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

COMMUNITY STAKEHOLDER MEETINGS

Six in-person community stakeholder meetings were held in 2017 to provide guidance on MHSA programs, including the completion of the MHSA Three-Year Program and Expenditure Plan. Each meeting included robust discussion about what stakeholders believe is working, what needs improvement and what is still missing from Shasta County's mental health services. An online survey was also distributed via email and social media channels, and 299 surveys were received from people who represented all of the following groups.

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

We have been heartened by the diverse, engaged people who have participated in our quarterly stakeholder meetings in the past year. They have provided useful feedback and ideas that are incorporated throughout this report.

In addition to our regular quarterly stakeholder meetings, we held a special stakeholder meeting on April 9, 2018, to solicit input on our application for an addition to The Woodlands permanent supportive housing complex. This would add 20 units, including five MHSA units, to the existing campus. Stakeholders provided resounding support for this effort, as housing is a growing challenge in our community. After receiving stakeholder endorsement, our proposal to submit an application for this project was heard and approved by our Mental Health, Alcohol and Drug Advisory Board on April 10, and subsequently approved by the Shasta County Board of Supervisors on April 24, 2018. The associated Supportive Services Plan was put into public comment on April 16, 2018. Stakeholders had minor edits to the plan, which were incorporated into the final document. The Mental Health, Alcohol and Drug Advisory Board will close the public comment on that document during their meeting on June 6, 2018, hold a public hearing, and consider recommending approval. If approved, it will go to the Shasta County Board of Supervisors for final approval on June 12, 2018.

All stakeholder meetings were advertised in press releases and on social media, and we encouraged our partners and committee members to also share them in their circles.

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

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

MENTAL HEALTH SERVICES ACT PROGRAMS

The following is a list of all Mental Health Services Act programs by component.

Community Services and Supports (CSS)
Client and Family Operated Services • Wellness centers • NAMI
STAR (Shasta Triumph and Recovery)
Rural Health Initiative
Older adult services
Crisis services
Housing continuum
Co-occurring disorders
Outreach
Prevention and Early Intervention (PEI)
Children and Youth in Stressed Families • Triple P • Trauma-Focused Treatment • Community programs for At-Risk Middle School Students • Adverse Childhood Experiences
Older adult
Individuals experiencing the onset of serious psychiatric illness
Stigma and discrimination reduction
Suicide prevention
Workforce Education and Training (WET)
Volunteer program
Comprehensive training program – MHSA Academy
Internship/residency program
Psychosocial rehabilitation program (discontinued)
Innovation (INN)
CARE Center
Community intervention pre-crisis team (completed)
Capital Facilities/Technological Needs (CF/TN)
Capital facilities project (completed)
Technological needs (completed)

PROGRAM OVERVIEW: COMMUNITY SERVICES AND SUPPORTS (CSS)

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

The nine CSS projects, along with the number of unique individuals served by HHSA staff in 2017, are:

1. Client- and family-operated systems (unduplicated number cannot be determined)
2. Shasta Triumph and Recovery (STAR) (98)
3. Rural health initiative (70)
4. Older adult (14)
5. Crisis services (990)
6. Crisis Residential and Recovery Center (279)
7. Housing continuum (68)
8. Co-occurring disorders integration (21)
9. Outreach/Access (1,665)

1. Client- and Family-Operated Systems

Shasta County has two consumer-run wellness centers: the Olberg Wellness Center in Redding, and Circle of Friends in Burney. Both wellness centers are funded through contracts with community providers. Circle of Friends is operated by Hill Country Health and Wellness Center, and the Olberg Wellness Center is operated by Northern Valley Catholic Social Service.

These multi-service mental health programs provide ethnically and culturally diverse opportunities in a healthy, inclusive manner with a wide spectrum of activities. Both centers provide services and activities for people with mental illness and/or their family members. In 2017, the centers offered more than 2,300 individual workshops, groups, activities and 12-step recovery meetings.

Sampling of Wellness Center activities

- Redding Library visits
- Stand Against Stigma Committee
- Farmers' Market
- Arts and crafts
- Veggie store food bank
- Thrift store shopping
- Movies
- Turtle Bay Exploration Park
- Healthy eating via SNAP-Ed training
- Salvation Army bell ringing

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

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

Also through Client- and Family-Operated Systems, the Health and Human Services Agency contracts with the Shasta County National Alliance on Mental Illness (NAMI) to provide education programs in the community:

- NAMI Basics is for parents and other family caregivers of children and adolescents who have either been diagnosed with a mental health condition or who are experiencing symptoms but have not yet been diagnosed.
- NAMI Family-to-Family is for families, partners and friends of individuals with mental illness. The course is designed to facilitate a better understanding of mental illness, increase coping skills and empower participants to become advocates for their family members.
- NAMI Peer-to-Peer is a recovery education course open to anyone experiencing a mental health challenge. The course is designed to encourage growth, healing and recovery among participants.

NAMI moved to the Hill Country CARE Center in March 2017, which improves the alignment of services and resources with Hill Country to provide services to the underserved. The NAMI Summary Report can be found in Appendix E. For more information on NAMI educational programs, please visit www.nami.org/find-support/nami-programs.

Three-Year Goal: Stakeholders would like to see more support groups for specific issues, such as eating disorders and depression. We would also like to continue increasing the number of clients who are served by our local wellness centers and by NAMI, which were praised by stakeholders for their compassionate support and assistance.
Year One Progress: Graduates from the MHSA academy are looking into ways to offer support groups as needs are identified at the wellness centers. The MHSA co-coordinator will also meet with wellness center staff to brainstorm strategies to increase attendance. NAMI On Campus has now been done by the California Heritage Youth Build Academy, and Shasta High School and Shasta College are looking to implement it. NAMI is also building a facilitated peer support group, which will meet at least twice a month. Due to its co-location with the CARE Center, NAMI now offers one-on-one mentoring in the office and on the phone for at least 20 hours a week.

2. Shasta Triumph and Recovery (STAR)

The requirements and guidelines for Full Service Partnership programs are contained in Title 9 of the California Code of Regulations. Each California county provides a Full Service Partnership program through the Mental Health Services Act. Shasta Triumph and Recovery (STAR) is the Full Service Partnership program in the urbanized I-5 corridor that includes Redding, Anderson, and the City of Shasta Lake. The STAR program serves all age groups, is enrollee-based, and can serve up to 60 people.

Full Service Partnership program outcomes, January-December 2017:

Of the 62 people who completed a year or more in the program:

- 66% fewer participants were hospitalized
- 79% fewer days spent hospitalized
- 16% fewer participants in residential treatment
- 39% fewer days spent in treatment

The Health and Human Services Agency also contracts with Hill Country Health and Wellness Center to provide a Full Service Partnership program in the Intermountain area with a capacity to serve up to 20

individuals, with a focus on children and transitional-age youth. Hill Country also provides Full Partnership Services in North Redding.

Full Service Partnership programs are wellness-, recovery-, and resiliency-based and practice the 24/7 "whatever it takes" model to provide access to services. People eligible for partnership include those with severe and persistent mental illness or children with severe emotional disturbance, who are homeless or at risk of homelessness and/or incarceration, have an increased risk of hospitalization, and who may also have a substance use disorder. The individuals who meet this criteria are provided with outreach until they either become a Full Service Partner or are transferred to other appropriate programs. Services include individual and group therapy, rehabilitation activities, case management, medication support, transportation, supports for housing, employment or employment preparation, peer relations, social activities and education. This program also has very strong links to the wellness centers, which provide additional support and services.

This year, housing for Full Service Partners and participants in other mental health programs was increased through the Housing Continuum projects, most notably The Woodlands supportive housing complex, which opened in late May. An application has been submitted to increase The Woodlands by 20 units, five of which would be for Full Service Partner-eligible tenants. Permanent supportive housing in the Burney area is also being pursued.

Shasta County tracks what treatments and services our Full Service Partners are receiving, and how they compare with other Shasta County consumers who are not part of the Full Service Partnership program. That report can be found in Appendix F.

Three-Year Goal: Full Service Partners living at The Woodlands will soon be receiving more extensive social and supportive services with the goal of maintaining permanent housing. The STAR Team will continue its efforts to reach out to the hardest-to-reach populations, including people who are homeless, which was identified as an underserved group by stakeholders.
Year One Progress: The Health and Human Services Agency's on-site case manager and peer support specialist have built relationships with tenants and are providing the supportive services that are critical to helping tenants maintain housing. Northern Valley Catholic Social Service is charged with providing support services, and MHSA staff will work with them to ensure that these services are fully implemented by July 1, 2018.

3. Rural Health Initiative

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

Federally Qualified Health Center use, 2017

- An average of 1,169 people visited a federally qualified health center in 2017 – an 8.6% increase from 2016
- There were a total of 18,209 visits to a federally qualified health center for mental health services – a 22.4% increase from the previous year.

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

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

4. Older Adult

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

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

Three-Year Goal: We will continue to ensure that outreach efforts and stakeholder groups include older adults.
Year One Progress: Of the stakeholders who filled out online surveys or participated in in-person meetings, 27 percent were older adults (60 and up). This is right on par with the proportion of Shasta County residents who are in this age group (25.9 percent).

5. Crisis Services

The Crisis Services work plan serves people experiencing a mental health emergency. Participants include people who come to local emergency rooms on an involuntary mental health hold, people with a psychiatric diagnosis who visit emergency rooms frequently, people who may need acute psychiatric hospitalization, and people who require specialized services to maintain a lower level of care and stability.

Services include discharge planning to coordinate and ease transition of care, emergency services and 24/7 telephone crisis services. Clinical staff are co-located in Redding's two emergency rooms. This allows for more rapid assessment and shortens the time people spend in the emergency room. For people who don't need inpatient psychiatric hospitalization, the time from evaluation to discharge is shorter.

Three-Year Goal: Stakeholders were vocal about the need for increased services for people in crisis. Options to achieve this could include mobile outreach, more wraparound services (where a multidisciplinary team works together to help someone after a crisis), or something else. The Intermountain area was specifically identified as an area where crisis services are lacking.
Year One Progress: A mobile crisis unit is being planned as part of the CARE Center. We will continue to look for ways to increase crisis services in the Intermountain area.

6. Crisis Residential and Recovery Center

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

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

Three-Year Goal: This center is rarely full, and stakeholders said many people are unaware that it exists. Mental health advocates added that they are not well-versed on who is eligible or how to refer someone. We will provide more community and provider education about this center so it can be used to its fullest capacity.
Year One Progress: The Crisis Residential and Recovery Center supervisor has been giving talks throughout the community to raise awareness about the center, and is working closely with the CARE Center to coordinate linkages among clients who could benefit from this service.

7. Housing Continuum

Housing continually arises as an unmet need for consumers. The Housing Continuum work plan was put in place to help address the need for housing for people with serious mental illness. The primary goal is to help people who have serious mental illness and their families who are homeless or at risk of homelessness by providing access to housing options, both transitional and permanent supportive, in the least restrictive setting possible.

Permanent Supportive Housing

The Health and Human Services Agency partnered with housing developer Palm Communities and Northern Valley Catholic Social Service to build a low-income apartment complex called The Woodlands. Located on Polk Street, the complex includes 55 units, 19 of which are designated for people who are eligible for Full Service Partnership services. Clients moved in at the end of May 2017, and 34 people live in the 19 MHSA units. At the Woodlands, a Health and Human Services Agency case manager and peer support specialist provide case management, links to community resources and more for people in the MHSA-funded apartments.

Northern Valley Catholic Social Service is responsible for providing various life skills classes that will help them maintain permanent housing. They have presented courses including "Being a Smart Tenant in California" and a computer literacy class, and will be expanding classes in the year to come. Activities like a holiday potluck and ice cream socials were well attended and helped build a sense of community. Classes offered to all Woodlands residents included Wellness Recovery Action Planning (WRAP), life skills, seeking safety and peer support. A residents' council helps tenants troubleshoot challenges at the complex.

Because of the success of The Woodlands, Palm Communities and Shasta County have applied to the California Housing Finance Agency (CalHFA) to receive funding to build 20 more units, including 5 for people who are eligible for Full Service Partnership services.

Transitional Housing

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

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

The Ridgeview Board and Care supportive transitional apartment complex in Shasta Lake City has increased housing options for MHSA clients. Board and care facilities in Shasta County are privately owned and receive their funding from residents. Most individuals receive Social Security Income, which pays for their board and care. Some residents require additional supports due to their mental illness, and in those instances, the Health and Human Services Agency will provide "patch" funding to cover the costs of the increased care.

Three-Year Goal: Housing was identified by stakeholders as a significant barrier to wellness, and fortunately, there are opportunities on the horizon to increase housing in our community. Whole Person Care, No Place Like Home and other programs provide opportunities for collaboration, and we will continue working collaboratively to identify ways to secure funding for housing in our county. We will also continue working on creative solutions to establish permanent supportive housing in the Intermountain area.
Year One Progress: As mentioned above, Phase 2 of The Woodlands is in progress now, and plans for No Place Like Home are moving forward. Housing is also one piece of the Whole Person Care pilot, which is designed to connect people to care. That program has helped 159 households and housed 17 of them; eligible participants must use Partnership HealthPlan, be homeless (or at risk), have visited the emergency room or been hospitalized multiple times in recent months, and have either a serious mental illness, substance use disorder or undiagnosed opioid addiction. For the Intermountain area, non-MHSA funding has been earmarked for housing that includes permanent supportive housing, and additional information should be available by year's end.

8. Co-occurring/Primary Care Integration

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

People with serious mental health conditions die an average of 25 years earlier than the general population. For those with a physical illness, the goal is to connect them to primary care in order to provide coordinated care to treat the whole person, and to provide services that focus not only on their mental illness, but also on their physical illness and how the two can interact. Medical and mental health providers will partner to coordinate the detection, treatment and follow-up of both mental and physical conditions. Services include outreach, education, case management, treatment, medication support, and clinical and nursing services. This program looks at the following diagnoses:

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

- Chronic Heart Failure

Three-Year Goal: The Health and Human Services Agency, along with community providers, will continue to work together to improve the integrated treatment of co-occurring disorders in order to improve the quality of life for people who have both co-occurring severe mental illness and substance use disorders.
Year One Progress: Siloed funding streams create challenges, but this is a key goal of the Health and Human Services Agency. Clinical staff continue to identify ways to effectively identify whether a client's symptoms are due to a mental health disorder or substance use, and treatment programs look at clients holistically.

9. Outreach

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

Outreach also includes field-based nursing services, which are provided in a client's home by registered nurses working in the field. Many clients have difficulty taking their medications correctly, are at risk of their medications being misused or stolen, or need education to feel more comfortable with their medication regime. Nursing staff can help clients set up their own medication systems, or even deliver medications. Over time, clients become more comfortable with managing medications on their own. During a home visit, the nurse may identify other issues the client is experiencing: they may have no food in the home, the home is in bad repair, hygiene needs are not being met, or the electricity is shut off. The nurse may be able to fix the issue or may work with the client's case manager for resolution. Nurses also spend time with the client to provide basic health education, and can work with the client's family members if desired. Field-based nursing allows clients to be served in their own environment where they are most comfortable.

Three-Year Goal: We will continue to work collaboratively with clients, health care providers and community partners to provide field-based nursing services to help people remain as stable and independent as possible.
Year One Progress: Work continues by to reach out to these difficult-to-reach clients and engage them in services.

PROGRAM OVERVIEW: PREVENTION AND EARLY INTERVENTION (PEI)

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

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

The five projects in Prevention and Early Intervention are:

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

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

1. Children and Youth in Stressed Families

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

Triple P – Positive Parenting Program®

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

The Triple P Sustainability Committee reconvened and continues to meet quarterly to discuss program barriers and successes. Recently, Shasta County presented the Triple P Automatic Scoring and Reporting Application (ASRA) to the Sustainability Committee. ASRA's features have been introduced to the Triple P community to help with better data entry and ease of surveying families. ASRA will replace the current Shasta County Triple P Scoring Application, which no longer meets program requirements and is not supported by Triple P America. ASRA should be implemented in the summer of 2018 with initial community training and ongoing support provided to community partners.

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

Three-Year Goal: Going forward, the Health and Human Services Agency will study how the program is being used, what barriers prevent the use of the program and its tools, how to address the barriers and how organizations can fund Triple P in the future. The Agency is also exploring a new version of the Triple P Scoring Application that Triple P Australia has built, specifically looking at ease of use for practitioners and the availability of data reports and their content.
Year One Progress: Efforts to meet program goals this year have been vast and successful in working to streamline and monitor program deliverables, update marketing materials and target training needs based on community input and support. The county secured contracts with four community organizations to deliver Triple P services in the community. The county also improved its claim forms to be more efficient. Several community providers attended local trainings for Level 5 Pathways, Level 5 Enhanced, and Level 5 Family Transitions. This increased the availability of the clinical based levels offered to caregivers that extends the intervention focus to include skills training, mood management, stress coping skills for parents, partner support and communication skills. Level 5 Family Transitions is a newer level that focuses on divorced or co-parenting families and has been welcomed by the community in helping to address the needs of many families experiencing separation. The Triple P Sustainability Committee reconvened and meets quarterly to discuss program barriers and successes. A new scoring application, the Triple P Automatic Scoring and Reporting Application (ASRA), will make it easier to survey families.

Trauma Focused Treatment

Trauma focused treatment is a necessity for serving youth and families today. Trauma-informed treatment addresses the unique needs of children with difficulties related to traumatic life experiences. This is imperative to helping those affected by Adverse Childhood Experiences move through their trauma so that they don't continue to affect them into adulthood. In the past, the Health and Human Services Agency has used Trauma Focused-Cognitive Behavioral Therapy, a psychotherapy model, to address these children's needs.

Three-Year Goal: The agency will be evaluating both evidence-based practices and promising practices to best meet the needs of the youth and families in our community.
Year One Progress: The Health and Human Services Agency is intensely focused on Adverse Childhood Experiences throughout the Agency, and work continues to figure out how to best address trauma among youth and families.

Community Implemented Programs for At-Risk Middle School Students

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

population for this strategy is at-risk middle school students from stressed families who either live in an underserved geographic location or are a member of an underserved cultural population.

Three-Year Goal: Through the community feedback process, we have reviewed different evidence-based programs that would serve the target population in the 2017-18 fiscal year. The Botvin LifeSkills Training Middle School program was selected, and we will partner with Shasta Lake City schools to bring a pilot prevention program to Shasta Lake Elementary. The training is comprehensive, dynamic and developmentally designed to promote positive development in youth in grades 6-8. Its focus is helping resist drug, alcohol and tobacco use while supporting reduction of violence and other high-risk behaviors. The competitive procurement process will be used to select a consultant that will support the implementation of the evidence-based program selected during the community feedback process.
Year One Progress: In 2017, plans were put in place to implement the At-Risk Middle School program Botvin LifeSkills which was selected to be introduced in the Shasta Lake City schools. This program will be used in the sixth through eighth grades. Training for four Shasta Lake Middle School staff members plus two Health and Human Services Agency staff was given in December 2017 and will be introduced to approximately 300 children during 2018.

Adverse Childhood Experiences

The experiences of childhood impact our health, behavior and overall well-being in adulthood - for better or worse. Adverse Childhood Experiences are traumatic experiences in the first 18 years of a person's life and include abuse, neglect and household dysfunction. Many children in Shasta County will suffer long-term consequences from this, including chronic disease, like heart disease and cancer, mental illness, substance abuse, homelessness and violent behavior in adulthood.

The Strengthening Families Collaborative was founded in 2012 to begin addressing the abnormally high numbers of Adverse Childhood Experiences in Shasta County. It focused on identifying better ways for family-serving agencies and medical providers to work as one. After five years of laying this groundwork, First 5 Shasta and the Health and Human Services Agency hosted an ACES Town Hall in April 2017 to put this important issue in the public spotlight, with nearly 400 people participating.

In May 2017, nationally recognized ACE experts Dr. Robert Anda and Laura Porter came to Shasta County to share the science behind the ACE research and give guidance to the Strengthening Families Collaborative and other community leaders. The goal is to support those in our community with high ACEs and break generational cycles. Porter described it as "a springboard for transformational change in Shasta County." In June, Anda and Porter returned to Shasta County to train 25 ACE Interface Trainers who can now present the Neuroscience, Epigenetics, Adverse Childhood Experiences and Resiliency (NEAR) Science evidence-informed curriculum to family-serving organizations, healthcare providers, community and faith-based partners, businesses, service clubs and schools throughout Shasta County. More about this work is available at www.shastastrongfamilies.org.

Three-Year Goal: The Strengthening Families Collaborative and newly trained ACE Interface Trainers will work on ways to reduce Adverse Childhood Experiences in Shasta County.
Year One Progress: A second Town Hall was held in May 2018 at the Cascade Theatre, and trainings have been held throughout the community. Television commercials, billboards and bus shelter ads are helping to spreading awareness about ACEs, and a data dashboard with 11 indicators is being developed. A Partnership HealthPlan grant is funding a training for medical professionals to learn how to screen all patients for ACEs. The www.shastastrongfamilies.org website is being expanded. This year's focus is to move from building awareness to building resiliency in those who have experienced ACEs.

2. Older Adult Gatekeeper Program

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

3. Individuals Experiencing Onset of Serious Psychiatric Illness

Because psychiatric illnesses such as schizophrenia and bipolar disorder often emerge in late adolescence or early adulthood, the Individuals Experiencing the Onset of Serious Psychiatric Illness (Early Onset) project targets individuals between ages 15 and 25 who have symptoms that might indicate the start of a serious and persistent mental illness. The priority focus is on early detection, prompt assessment and referral, treatment, family support and engagement, and community outreach and education.

Between January 1 and December 31, 2017,
19
unique clients received clinical services through the **Early Onset program**.

Early in 2017, a new clinician took over the Early Onset Project with an abundance of energy. Psycho-education, individual therapy, individual rehabilitation services, cognitive behavioral group therapy and collateral services are provided to support people on the Early Onset caseload as needed. The primary Early Onset clinician also partners with the Brave Faces project (see p. 22) to offer information on mental illness and how to seek help.

Challenges to the program are providing the best client care for engaged persons, while also doing outreach and community services. To meet these challenges, Early Onset has expanded to include a Peer Support Specialist as of spring 2018.

Three-Year Goal: The new Early Onset clinician will continue building rapport with gatekeepers and engaging in community outreach.
Year One Progress: The early onset clinician continually meets with Children's Access Team to give trainings regarding early signs and symptoms and when to refer to a clinician for further evaluations, when appopriate. This clinician has also provided information materials to local high schools, including continuation and independent study schools, and has met with the local school therapist who provides services to multiple school districts.

4. Stigma and Discrimination Reduction

To facilitate implementation of the Stigma and Discrimination Reduction project strategies, the Health and Human Services Agency organizes the monthly meetings of the Stand Against Stigma Committee and the Suicide Prevention Workgroup. These projects supplement and are coordinated with statewide stigma reduction and suicide prevention projects. Shasta County's Stand Against Stigma campaign works to promote mental wellness, increase community awareness of mental health and end the stigma surrounding mental illness and substance abuse. The stakeholder-developed messages used in this project are strength-based and focused on recovery:

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

Stand Against Stigma includes the following strategies:

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

Stand Against Stigma activities are directed by input and guidance from the Stand Against Stigma Committee, which includes many people with lived experience, family members, representatives from community-based organizations and members of the Shasta County Mental Health, Alcohol and Drug Advisory Board. The projects for this program include the Minds Matter Mental Health Resource Fair, the Brave Faces Portrait Gallery and Speakers Bureau, the "Stand Against Stigma: Changing Minds About Mental Illness" awareness campaign, the "Hope is Alive!" open mic series, quarterly Brave Faces public

forums, and promoting the "Get Better Together" campaign. During 2017, thousands of people witnessed or took part in Stand Against Stigma activities in person, and social media campaigns have reached tens of thousands more.

Since 1949, May has been recognized as Mental Health Awareness Month throughout the United States. To bring attention to the many issues related to mental health and wellness, Shasta County holds an annual Minds Matter Mental Health Resource Fair, which is designed to connect people with community resources and promote mental health and wellness. The 2017 fair was expanded to include a music festival, as our open mic nights have proven to be an effective way to encourage people to talk about mental health through the arts. The traditional resource fair featured about 30 exhibitors from community organizations, who made connections with more than 400 people. Once the fair concluded, three bands performed in the Promenade downtown, drawing more than 100 people.

The *Get Better Together* campaign aims to connect 16- to 25-year-olds with peers who are dealing with heavy issues, educating them about the normalcy of struggles with mental illness, asking them to help themselves, help others, and share what they live and know. Plans are under way to partner with other youth-focused programs and revitalize the *Get Better Together* website.

Shasta County's ***Stand Against Stigma: Changing Minds About Mental Illness*** campaign has been in place since 2012. Its strength-based messages promote mental wellness, and counter the discrimination and stigma associated with mental health problems. The logo is seen throughout the community on publications, advertisements, websites and at events.

In addition, the Stand Against Stigma Committee has collaborated with local musicians and performers to hold 13 Hope Is Alive! Open Mic nights over the past three years, which encourage any local performer to show up and present music, dance or art that connects with overcoming difficult times or promoting awareness of misunderstood issues. This theme has led to many performers sharing creative works that are mental health related. More than 800 people have attended the open mic nights, and more than 70 performers have participated.

The Brave Faces Portrait Gallery and True Colors Art Gallery use true stories of hope and recovery to fight stigma by improving our understanding of mental illness and suicide. About one in four people will struggle with a mental illness every year, and about 40 people in Shasta County die by suicide every year. Because of shame and discrimination associated with mental health problems, many people don't seek the help they need.

Brave Faces are people with lived experience of mental illness, suicide and substance abuse. They go into the community and talk about their lives and their experiences. They use their stories to offer hope and recovery, provide education, promote seeking help, end stigma and make a difference in the lives of those in our community. These presentations are made to a wide variety of audiences which include faith-based organizations, media organizations, local businesses, community-based organizations, cultural groups, county and state government agencies, junior high and high schools, and local colleges. In the past three years, more than 200 Brave Faces presentations have been done within our community, and more than 7,000 people have been reached through these presentations. Our growing number of speakers (about 30 active participants in total) allows us to effectively tailor our messages to the audiences we serve.

Stand Against Stigma also hosts semi-annual, open-to-the-public forums to increase the reach of Brave Faces speakers and to engage more community members on important topics. Forum topics have included suicide, substance use disorders, medication management and Adverse Childhood Experiences.

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

Three-Year Goal: In addition to all of the activities outlined above, we will continue producing short films and social media content to expand our reach. We are pursuing a Minds Matter podcast and television show in partnership with a local nonprofit. We will also actively participate in local Recovery Happens activities to focus more heavily on addiction related issues. We will continue to evaluate our cadre of Brave Faces speakers to ensure that they are a diverse and dynamic mix.
Year One Progress: In 2017, we hosted forums on ACEs and managing medications, two Becoming Brave trainings and three Hope is Alive! Open Mic Nights. We expanded the Minds Matter Mental Health Resource Fair to include a music festival. We hosted the first-ever "Recovery Happens: Celebrating Life, Community and Sobriety" event, which included educational booths and music in a local park, and more than 300 people attended. We also provided a free training called "Healing Through Performance" to help performers use their creativity to promote healing and understanding. A local videographer produced "Becoming Brave: Changing Minds About Mental Illness in Shasta County," a 16-minute documentary about the Brave Faces program featuring speakers who discuss suicide loss, PTSD, depression, substance abuse and historical trauma.

5. Suicide Prevention

From 2015 to 2017, an average of 44 Shasta County residents died by suicide each year. Hundreds more are left to cope with the aftermath. This does not include the many more who struggle to cope with or recover from attempted suicide or self-injury. Suicide Prevention project activities are implemented by the Health and Human Services Agency in partnership with the Shasta Suicide Prevention Workgroup, a local collaboration of public and private agencies and concerned community members, who meet monthly and are focused on reducing suicide in Shasta County.

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

A new men's mental health campaign was unveiled in 2017 to combat the societal pressures to repress emotions and not show weaknesses. Captain Awesome demystifies mental health and depression while giving men the tools to maintain their mental and emotional health.

Another educational program for students grades 8-12 called "More than Sad" is being implemented in local schools. This best practice program teaches teens to recognize signs of depression in themselves and others, challenges the stigma surrounding depression and demystifies the treatment process. Workgroups

also meet quarterly to educate media about the importance of appropriate and responsible reporting of suicide. Health fairs help raise awareness of suicide prevention.

Question, Persuade, Refer (QPR) trainings are a major focus of the Suicide Prevention program. This practice seeks to teach people the warning signs of suicide and provide them with tools to respond to an individual in suicide crisis. These trainings are given to groups or organizations in the county on request.

The Suicide Prevention Workgroup Facebook page encourages community involvement in efforts to reduce suicide in Shasta County by providing information and invitations to Question, Persuade, Refer (QPR) Suicide Prevention Trainings, which trained 551 people in 2017, and monthly Workgroup meetings.

> **"Keep giving hope to the community."**
>
> Attendee from Question, Persuade, Refer training

Community education about decreasing the access to lethal means for suicide attempts is another important activity of the Suicide Prevention project.

Additional suicide prevention activities include:

- Promotion of the Directing Change Program and Student Film Contest to local high schools.
- Annual Suicide Prevention and Mental Health Symposium.
- Workgroup maintains a presence at many community events, especially those concerning mental health, support services (health fairs) and suicide prevention, such as Running Brave, the American Foundation for Suicide Prevention's Out of the Darkness Walk, and Suicide Loss Survivor Day.

See Appendix J for the complete Suicide Prevention Report.

Three-Year Goal: We will roll out the men's mental health campaign. We will evaluate options for providing support follow-up after suicide attempts, either in-house or through a community partner. We will continue to work with law enforcement and help them work effectively with people exhibiting suicidal tendencies. We will explore the possibility of creating more wellness-based approaches to suicide prevention, including more wrap-around services for people who have experienced suicidal ideation.
Year One Progress: We rolled out the Captain Awesome men's mental health campaign, which features local men in advertisements to spread awareness about the need to care for one's mental health. We also presented the "More than Sad" program in grades 8-12. The second annual Suicide Prevention and Mental Health Symposium included evidenced-based suicide prevention training, a special presentation on resources for schools and families, and a panel discussion.

5. CalMHSA Statewide Projects

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

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

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

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

CalMHSA's work plan provides an outline for statewide implementation and includes program evaluation. A new report from the Rand Corporation's independent review of CalMHSA's Prevention and Early Intervention Initiatives concludes, "CalMHSA PEI initiatives are successfully launched and already showing positive outcomes in stigma and discrimination, suicide prevention, and promotion of student mental health." By working jointly through CalMHSA, California counties are delivering effective social marketing campaigns that change the conversation around mental health stigma and delivering value for Californians and taxpayers.

Key findings:

- Each dollar invested in stigma reduction is estimated to return $1,251 to California's economy, and $36 to state coffers by increasing employment and worker productivity.
- CalMHSA stigma reduction programs, including Each Mind Matters: California's Mental Health Movement, boosted the number of adults seeking help for psychological distress by 22% among those exposed to campaigns.
- As a result of these programs, an additional 120,000 Californians accessed mental health services.

Here are three examples of what CalMHSA's PEI initiatives have accomplished:

- **"Know the Signs" suicide prevention campaign empowers Californians to stop suicide.** Those who viewed these materials were more confident in intervening with those at risk of suicide, more comfortable discussing suicide and more aware of the warning signs.

- **Innovative stigma reduction efforts result in attitude changes.** Middle school students who attended "Walk in Our Shoes" presentations expressed less stigmatizing attitudes. They were more willingness to interact with fellow students with a mental health problem.

- **Trainings equip education systems to meet student mental health needs.** Trainings reached educators, students and staff in the state's K-12 and higher education systems. Participants reported greater confidence to intervene with students in distress, greater confidence to refer students to mental health resources, and greater likelihood to intervene or refer students in distress.

PROGRAM OVERVIEW: WORKFORCE EDUCATION AND TRAINING (WET)

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

These projects are included in the Health and Human Services Agency's WET plan, along with the estimated number of people who were reached:

1. Comprehensive Training (152)
2. Consumer and Family Member Volunteer Program (123)
3. Internship Program
4. Superior Region WET Partnership
5. Office of Statewide Health Planning and Development (more than 70 loan awards)

In addition to the WET projects, the Health and Human Services Agency employs three Peer Support Specialist staff members and will be hiring more. These Peer Support Specialists must successfully complete the Shasta Mental Health Services Act Academy prior to hire or within the first 6 months of employment.

1. Comprehensive Training Program

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

Because Shasta County does not have many local opportunities for mental health professionals to earn the continuing education units (CEU) required to maintain licensure, this program provides training opportunities that match the expressed interests of the public mental health workforce and allow both clinical and nursing professionals to obtain CEUs locally. CEUs are coordinated by the Health and Human Services Agency's human resources staff and are provided through the California Board of Behavioral Sciences and the American Nurses Credentialing Center.

Since 2014, the Health and Human Services Agency has provided Non-violent Crisis Intervention Training to all employees. The eight-hour training teaches people how to identify behaviors that could lead to a crisis, effectively respond to behaviors to prevent the situation from escalating, use verbal and nonverbal techniques to defuse hostile behavior and resolve a crisis before it becomes violent, cope with one's own fear and anxiety, and use the principles of personal safety to avoid injury if behavior does become physical.

A four-hour refresher training is also available to employees who have taken the training, but would like an update. Initial and refresher classes are offered on a bi-monthly basis.

Three Year Goal: The Health and Human Services Agency will continue coordinating CEUs, and it has applied to become a California Marriage and Family Therapy-Approved continuing education provider.
Year One Update: This program has been incorporated into our overall HHSA training coordination and is managed by our Business and Support Services Office and is no longer managed or funded by MHSA.

2. Volunteer Program

The Mental Health Services Act Volunteer Program addresses the WET goals of increasing mental health career development opportunities and promoting employment of consumers and family members. It establishes a career pathway and responds to the identified need to increase the public mental health workforce capacity while involving the community in a meaningful way in service delivery. This program is open to anyone over age 18 who desires an introduction to the public mental health system and the opportunity to explore their interest in and suitability for this type of work. Individuals are fingerprinted and complete background screening prior to participation in the program.

Between January 1, 2017 and December 31, 2017, we recruited new participants, but due to some complications with facilities and staffing, we dedicated our limited resources to sustaining the current volunteer base and activities. We resumed outreach to increase program participation again in May 2017.

The Volunteer Program has three main avenues for participation: General volunteering, the Shasta MSHA Academy, and the Shasta College Student Volunteer Internship Program. Though slightly different, all have the same purpose: to provide individuals training and hands-on exploration of what it is like to work in the public mental health field. Many individuals choose to participate through more than one avenue. Many start out as general volunteers or interns and then decide to also participate in the Academy.

MHSA Academy class practicing a stigma awareness exercise.

General volunteering: This portion of our program provides individuals with or without lived experience of mental illness a chance to not only give back to their community, but also get a broad introduction into what it is like to work in this field. Volunteers are oriented to the Agency and receive 16 hours of training. They learn about topics including wellness and recovery, stigma, ethics and boundaries, communication, strengths-based focus, professionalism and customer service. General volunteers assist staff in completing special projects and provide social enrichment activities in our Crisis Residential and Rehab Center and Board and Care Homes.

The MHSA Volunteer Program also partners with the HHSA CalWORKs Work Experience program. These participants are screened for their interest in pursuing a career in the mental health and/or social work field

"Thank you for all our discussions - it has been the first time in my wellness that I have legitimately spoken truth about my illness in a supportive and non-biased place."
- Academy participant

and then referred to the volunteer program, where they receive education, training and hands-on work experience. To date, there have been seven participants from the Work Experience program.

Shasta Mental Health Services Act Academy: This free 65–hour training program helps people prepare for careers in the public mental health field or to become peer mentors. Participants have opportunities to learn new information, strengthen skills and network with mental health professionals. The Academy is divided into two main parts: 45 hours of interactive classroom-based learning and 20 hours of hands-on learning. Classroom learning is based on curriculum from the International Association of Peer Specialists and reflects the national ethical guidelines and practice standards for peer supporters. Hands-on learning covers training in group dynamics, meeting facilitation, stakeholder engagement, peer interaction, and center-based program delivery. Participants spend time volunteering in local wellness centers and our main mental health facility, are required to participate in advisory groups and/or stakeholder meetings, and shadow staff.

Between January 1, 2017 and December 31, 2017, 44 people registered for the Academy. Of those, 26 completed all 65 hours and 15 more are scheduled to complete their hours in May 2018. The remaining three didn't finish the Academy for a variety of reasons, including job-related scheduling conflicts, lack of reliable childcare and/or transportation, and health issues. The Academy will continue to be offered multiple times per year in the Redding and Burney area.

One of the most exciting outcomes from the Academy is that the Health and Human Services Agency has hired two graduates to work as Peer Support Specialists. One is supporting the volunteer program, and the other is supporting the residents of The Woodlands, our new permanent supportive housing complex.

"Shadowing staff was the best experience, and gave me the most growth academically and professionally."
Volunteer Program participant

Shasta College Student Volunteer Internship Program: In September 2015, the Mental Health Services Act program began partnering with Shasta College to provide students interested in the mental health field with hands-on learning and experience through our volunteer program. Each student receives one unit of college credit for spending at least 60 hours volunteering and job shadowing mental health staff. Occasionally, we hear from a volunteer who has completed our program. We are aware of 10 people who graduated our program and went on to become employed in the public mental health field, and two who are in graduate school pursuing a degree in social work.

Between January 1, 2017 and December 31, 2017, 17 students applied for internships through the MHSA volunteer program. Of these 17, three successfully fulfilled the 60-hour requirement. The remaining students did not clear background in time to complete 60 hours before the end of the semester.

Mental Health Services Act staff have a strong partnership with Shasta College. In addition to the internship program through Shasta College's psychology department, the college has asked to incorporate the Shasta Mental Health Services Act Academy within its standard course offerings.

Looking forward: The addition of a peer support specialist to the volunteer program provides numerous new opportunities for growth. We plan to expand peer mentoring support throughout the community. The Volunteer Program will continue providing peer education and training and work with local agencies to place and supervise peer mentors. We will increase volunteer involvement at Hill Country CARE Center, Hill Country Community Health Center, the Olberg Wellness Center, Circle of Friends and the Woodlands Housing Project. We will also explore implementing peer support within our law enforcement agencies and hospitals. The Mental Health Services Act Academy is expanding curriculum to include comprehensive WRAP groups for volunteers and opportunities for peers to become WRAP group facilitators. We are also incorporating suicide prevention and non-violent crisis intervention into our peer training requirements. We are developing a peer-run "warm line" that will be staffed by peers a minimum of 10 hours per week, along with weekly tele-peer support groups. We are also increasing peer-led groups and activities within the Health and Human Services Agency's Crisis Residential and Recovery Center. One of our most exciting expansions is the incorporation of youth into the program. Staff is working with local high schools to educate and train youth interested in becoming peer mentors and/or exploring the field of public mental health. We continue to monitor California peer certification efforts and refine the Shasta Mental Health Services Act Academy to remain in line with expected standards. By structuring the academy to include all components outlined in state efforts, our goal is to have the curriculum approved for statewide certification. Mental Health Services Act staff is redesigning its Academy curriculum to also align with a more robust comprehensive psychosocial rehabilitation model of education. Once approved, the Academy will be offered at least once per year at Shasta College. We will also develop and use follow-up evaluations to officially track the impact of the volunteer program after 6 months and one year.
Year One Update: Between January 1, 2017 and December 31, 2017, we placed four peer volunteers at the Hill Country Care Center, four peer volunteers at the Olberg Wellness Center, and two volunteers in the Crisis Residential and Recovery Center (CRRC). In May 2017, one MHSA staff member and two staff members from Circle of Friends completed Level 3 WRAP training, becoming certified Advanced Level WRAP facilitators (ALFs). Throughout 2017, they provided WRAP Level 1 training at the Woodlands, Circle of Friends, Hill Country Counseling Center, the Olberg Wellness Center and on the HHSA campus, reaching a total of 34 individuals. Two Level 2 trainings were held during 2017 resulting in a total of 28 new, local certified WRAP facilitators (we partnered with Butte County to assist with their first Level 2 training which yielded 18 of the 28 new facilitators). In 2017, HHSA staff began to work with Circle of Friends to discuss implementation plans for a youth WRAP component and a youth MHSA Academy. MHSA Academy graduates also completed Question, Persuade, Refer suicide prevention training.

3. Internship Program

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

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

Three-Year Goal: The Health and Human Services Agency will continue working with California State University Chico, California State University Humboldt, Simpson University and National University to provide internship opportunities to students in their master's programs.
Year One Update: Interns continue to shadow staff to learn more about public mental health work.

4. Superior Region WET Partnership

WET funds from the state are paying for regional county partnerships throughout California that focus on increasing the education and training resources dedicated to the public mental health system workforce. These regional partnerships are supported by staff from participating counties. Shasta County is part of the Superior Region WET Partnership, which sponsors a variety of programs to meet WET goals:

- Working Well Together – A technical assistance center whose primary goal is to help counties ensure they are prepared to recruit, hire, train, support and retain consumers, family members and parents/caregivers as employees of the public mental health system.

- Distance learning – A partnership with several University of California systems within the Superior Region to provide online education for those wishing to further their education and already are, or would like to become, employed in the public mental health field.

- Mental Health Services Act Loan Assumption – An educational loan repayment program for eligible applicants employed in the public mental health system in hard-to-fill or hard-to-retain positions such as psychologist, marriage and family therapist, social worker, psychiatrist or psychiatric mental health nurse practitioner. In Shasta County, 59 people have received these awards to date.

5. Office of Statewide Health Planning and Development

The California Office of Statewide Health Planning and Development is responsible for the Mental Health Loan Assumption Program. Created through the Mental Health Services Act, this loan forgiveness program is designed to retain qualified professionals working within the public mental health system. Through Workforce Education and Training, $10 million is allocated yearly to loan assumption awards. An award recipient may receive up to $10,000 to repay educational loans in exchange for a 12-month service obligation in a hard-to-fill or retain position within the county public mental health system.

Counties determine which professions are eligible for their hard-to-fill or retain positions. Eligible professions often include Registered or Licensed Psychologists, Registered or Licensed Psychiatrists, Post-doctoral Psychological Assistants, Postdoctoral Psychological Trainees, Registered or Licensed Marriage and Family Therapists, Registered or Licensed Clinical Social Workers, Licensed Professional Clinical Counselors,

Licensed Professional Clinical Counselor Interns, Registered or Licensed Psychiatric Mental Health Nurse Practitioners, and managerial and/or fiscal positions.

The Mental Health Loan Assumption Program is a competitive process which requires an application. Since 2009, 59 awards have been given to people who work in Shasta County's public mental health system.

Three-Year Goal: The Health and Human Services Agency will continue to participate in the Superior WET Regional Partnership to bring statewide projects to Shasta County.
Year One Update: Staff continues to participate in monthly meetings.

Mental Health Loan Assumption Program		
Year	**Number of Awards**	**Total Amount of Awards**
2009	2	$ 10,200
2010	4	$ 30,200
2011	3	$ 20,800
2012	7	$ 48,538
2013	10	$ 50,668
2014	9	$ 48,537
2015	11	$ 58,531
2016	13	$ 67,071
2017	TBD	TBD
Total Award to Date		$ 334,545

PROGRAM OVERVIEW: INNOVATION (INN)

Innovation projects are novel, creative and/or ingenious mental health practices or approaches that contribute to learning. In December 2014, MHSA staff sought feedback from community stakeholders for a new Innovation project. The process focused on reviewing the current mental health continuum of care, identifying weaknesses or absences in services, and brainstorming ideas for a new project that would fill the identified gaps and better meet community needs. The idea that bubbled to the top was a Community Mental Health Resource Center.

The Mental Health Services Oversight and Accountability Commission approved this plan in January 2016, and Hill County Health and Wellness Center was selected to launch the Community Mental Health Resource Center in Redding. The Counseling and Recovery Engagement (CARE) Center opened in March 2017. The center is open 7 days a week, 365 days a year, in the afternoons and evenings. Hours are 2 to 11 pm Monday through Friday, and from 11 am to 11 pm on weekends and holidays. Services available at the center include:

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

In addition to the Innovation project, the center also includes two non-Mental Health Services Act funded projects: a Laura's Law pilot project and a foster youth/caregiver resource project (which is being discontinued in July 2018 due to state funding cuts).

The Innovation project has five objectives:

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

The program evaluation is built around these objectives.

Shasta County planned on a four-year overall timeframe for this Innovation project: six months of start-up activities (complete); three years of project implementation; and a final six months of wrap-up activities. Before any decision to recommend either continuing or discontinuing the project after the three-year pilot, a stakeholder process to share evaluation data and seek input will be initiated.

The CARE Center is already performing well above expectations. The goal was to serve 75 unique clients per quarter during 2017, and the center served 186 people. Clients have been referred to behavioral health services, community services, support groups, substance abuse treatment, housing services and more. About half of CARE Center visitors they would have either gone to the emergency room, called 911 or gone "nowhere" if this service hadn't been available.

Just 44 of the 699 referrals were to emergency departments, which indicates that hundreds of people who likely would have gone to the emergency department if the CARE Center didn't exist ended up being referred to lower-level, more appropriate and less expensive services. Remarkably, 173 of the 179 clients who completed a survey in 2017 said they felt welcome, safe and comfortable at the CARE Center, and all but six said staff provided them with support and helpful information about community resources.

The first CARE Center Quarterly Activity Report (which will be the basis for the annual report), and an Innovation Project Outcome Tracking Report can be found in Appendices M and N.

PROGRAM OVERVIEW: CAPITAL FACILITIES/TECHNOLOGICAL NEEDS

This refresh of the community mental health building was completed in 2016 and is therefore not included in this report.

FY 2017/18 Mental Health Services Act Annual Update
Funding Summary

County: Shasta Date: 5/2/18

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2017/18 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	4,400,886	2,515,265	2,647,694	0	0	
2. Estimated New FY 2017/18 Funding	6,429,235	1,202,280	735,302			
3. Transfer in FY 2017/18[a/]	0					
4. Access Local Prudent Reserve in FY 2017/18						0
5. Estimated Available Funding for FY 2017/18	10,830,121	3,717,545	3,382,996	0	0	
B. Estimated FY 2017/18 MHSA Expenditures	6,429,234	1,202,280	735,302	0	0	
G. Estimated FY 2017/18 Unspent Fund Balance	4,400,887	2,515,265	2,647,694	0	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2018	
2. Contributions to the Local Prudent Reserve in FY 2017/18	0
3. Distributions from the Local Prudent Reserve in FY 2017/18	0
4. Estimated Local Prudent Reserve Balance on June 30, 2018	0

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

FY 2017/18 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding

County: Shasta Date: 5/2/18

	Fiscal Year 2017/18					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Client Family Operating Services	428,435	424,370				4,065
2. Shasta Triumph and Recovery	1,578,458	885,197	669,905			23,356
3. Crisis Residential and Recovery	947,452	90,651	847,811			8,990
4. Crisis Response	1,804,831	1,311,290	476,415			17,126
5. Outreach-Access	1,587,726	1,188,479	374,152			25,095
6. Housing Continuum	40,337	39,954				383
7.	0					
Non-FSP Programs						
1. Rural Health Initiative	1,210,508	675,096	101,849			433,563
2. Older Adult Services	45,765	23,427	18,644			3,694
3. Co-occurring Integration	354,663	72,836	213,860			67,967
4. Laura's Law	344,899	341,626				3,273
5.	0					
CSS Administration	1,389,493	1,376,308				13,185
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	9,732,567	6,429,234	2,702,636	0	0	600,697
FSP Programs as Percent of Total	99.3%					

FY 2017/18 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: Shasta Date: 5/2/18

	Fiscal Year 2017/18					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Stigma and Discrimination	286,677	283,958				2,719
2. Suicide Prevention	220,633	218,541				2,092
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. Children and Youth in Stressed Families:	0					
Triple P	405,060	252,299	148,919			3,842
ACE	121,521	120,368				1,153
Middle School Youth at Risk	30,912	30,619				293
TFCBT	5,000	4,953				47
16. Individuals Experiencing Onset of Serious Psychiatric Illness	147,741	48,220	98,120			1,401
17.	0					
18.	0					
19.	0					
PEI Administration	245,652	243,322				2,330
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	1,463,196	1,202,280	247,039	0	0	13,877

FY 2017/18 Mental Health Services Act Annual Update
Innovations (INN) Funding

County: Shasta Date: 5/2/18

	Fiscal Year 2017/18					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Program Planning	0					
2. Program Implementation	742,346	735,302				7,044
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	0					
Total INN Program Estimated Expenditures	742,346	735,302	0	0	0	7,044

FY 2017/18 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Funding

County: Shasta Date:

	Fiscal Year 2017/18					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Comprehensive Training Program	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
WET Administration	0					
Total WET Program Estimated Expenditures	0	0	0	0	0	0

FY 2017/18 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Funding

County : Shasta Date:

	Fiscal Year 2017/18					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Remodel / Renovation	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs – Technological Needs Projects	0					
CFTN Administration						
Total CFTN Program Estimated Expenditures	0	0	0	0	0	0

PLAN FOR FUNDS SUBJECT TO REVERSION

Shasta County has a $1,784,475 balance in its Innovation funds from FY 2008-09 through FY 2014-15, including $337,661 that is subject to reversion in July 1, 2020.

Enclosure 1 4/24/2018

DEPARTMENT OF HEALTH CARE SERVICES

MHSA Funds Subject to Reversion by Fiscal Year by Component

Shasta	CSS	PEI	INN	WET	CFTN	Total
FY 2005-06	$ -					$ -
FY 2006-07	$ -			$ -		$ -
FY 2007-08	$ -	$ -			$422,238	$ 422,238
FY 2008-09	$ -	$ -	$ 337,661			$ 337,661
FY 2009-10	$ -	$ -	$ 315,781			$ 315,781
FY 2010-11	$ -	$ -	$ 407,796			$ 407,796
FY 2011-12	$ -	$ -	$ 13,008			$ 13,008
FY 2012-13	$ -	$ -	$ 352,047			$ 352,047
FY 2013-14	$ -	$ -	$ 281,056			$ 281,056
FY 2014-15	$ -	$ -	$ 77,126			$ 77,126
Total	$ -	$ -	$ 1,784,475	$ -	$ 422,238	$ 2,206,713

$ - No Funds Subject to Reversion
ARER expenditure data is not complete

Our Innovations project, the CARE Center, opened in early 2017. Our contract with Hill Country Community Clinic to operate this center is $740,000 per year in 2017, 2018 and 2019. Therefore, the funds in the chart above will be spent as follows:

- 2017: $337,661 (from 2008-09), $315,781 (from 2009-10), and $86,558 from 2010-11
- 2018: $321,238 (the balance from 2010-11), $13,009 (from 2011-12), $352,047 (2012-13), $53,707 from 2013-14
- 2019: $227,349 (the balance from 2013-14), $77,126 (2014-15), plus an additional $435,525 from FY 2015-16 and 2016-2017

This plan and its budget was approved by MHSOAC on Dec. 17, 2015, and it met all the required elements of an Innovative proposal as stated in the Innovation Regulations.

Shasta County is also showing that $422,238 from Capital Facilities and Technological Needs is subject to reversion, but that is being appealed. Shasta County incorrectly reported the CFTN money under the CSS component for 2016-17. The CFTN budget should be zero.

MHSA COUNTY COMPLIANCE CERTIFICATION

County: Shasta

County Mental Health Director	**Project Lead**
Name: Donnell Ewert, MPH	**Name:** Kerri Schuette
Telephone Number: (530) 245-6269	**Telephone Number:** (530) 245-6951
E-mail: dewert@co.shasta.ca.us	**E-mail:** kschuette@co.shasta.ca.us
Mailing Address: 2615 Breslauer Way Redding, CA 96001	

I hereby certify that I am the official responsible for the administration of Shasta County mental health services in and for said county and that the County has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this annual update, including stakeholder participation and nonsupplantation requirements.

This annual update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft annual update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the Shasta County Board of Supervisors on June 12, 2018.

Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant.

All documents in the attached annual update are true and correct.

Donnell Ewert, MPH
Shasta County Mental Health Director

Date

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County: Shasta

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

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

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

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

Donnell Ewert, MPH
Shasta County Mental Health Director

Date

I hereby certify that for the fiscal year ending June 30, 2018, Shasta County has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that Shasta County's financial statements are audited annually by an independent auditor and the most recent audit report is dated for the fiscal year ending June 30, 2016. I further certify that for the fiscal year ending June 30, 2016, the State MHSA distributions were recorded as revenues in the local MHS Fund; that Shasta County MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that Shasta County has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

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

Brian Muir
Shasta County Auditor-Controller

Date

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

30-Day Public Comment Period and Public Hearing

The public comment period for the MHSA Annual Update 2018-19 opened on May 4, 2018, and closed on June 4, 2018. A Public Hearing was conducted by the Shasta County Mental Health, Alcohol and Drug Advisory Board during their June 6, 2018.

Distribution

Public notice regarding the public comment period and public hearing was published in several local newspapers throughout Shasta County during the 30-day period of May 4, 2018, and June 4, 2018. Public notice and copy of the draft document was posted in several public locations throughout the community and made available online at the Shasta County Health and Human Services Agency website and via social media. The draft document was e-mailed to stakeholders, advisory board members and stakeholder workgroup members, and copies were available upon request.

Comments Received

- Xxxxxxxxxxx

Approval

At a special meeting on June 6, 2018, the Shasta County Mental Health, Alcohol and Drug Advisory Board voted to recommend that the Shasta County Board of Supervisors adopt the MHSA Annual Update Fiscal Year 2018-19. The Shasta County Board of Supervisors adopted the plan on June 12, 2018.

ONLINE RESOURCES

Shasta County Health and Human Services Agency
shastahhsa.net
shastamhsa.com

Stigma and Discrimination Reduction
standagainststigma.com
getbettertogether.net

California Stigma and Discrimination Reduction
eachmindmatters.org
reachout.com

Triple P - Positive Parenting Program
triplepshasta.com

Suicide Prevention
shastasuicideprevention.com

California Suicide Prevention
yourvoicecounts.org
suicideispreventable.org

Olberg Wellness Center
nvcss.org

Circle of Friends Wellness Center
hillcountryclinic.org

National Alliance on Mental Illness Shasta County
namishastacounty.org

Hill Country Health and Wellness Center
hillcountryclinic.org

Shingletown Medical Center
shingletownmedcenter.org

Mountain Valleys Health Centers
mtnvalleyhc.org

Shasta Community Health Center
shastahealth.org

Shasta Strengthening Families
shastastrongfamilies.org

CONTACT INFORMATION

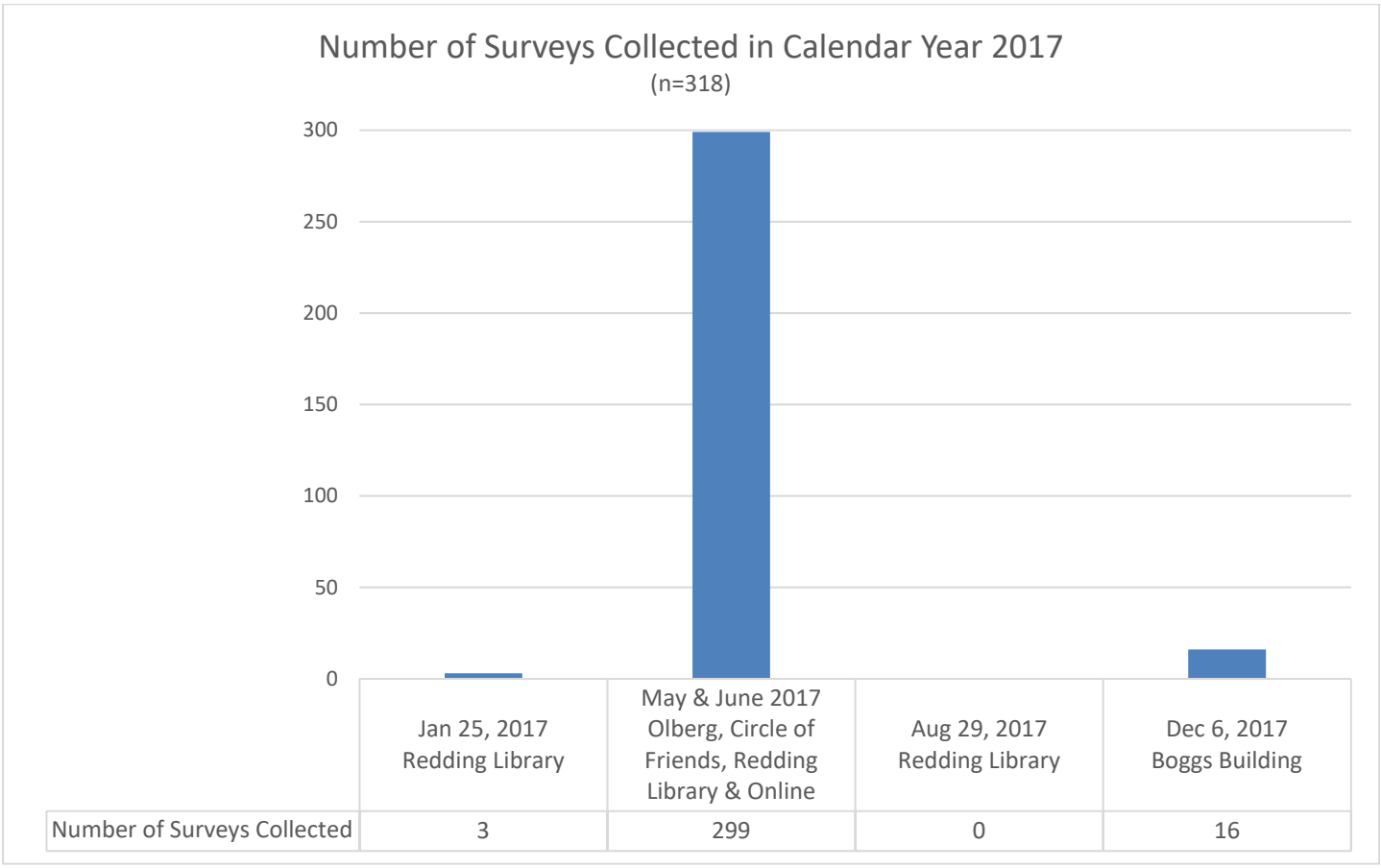
For information regarding this document, please contact:

Kerri Schuette, Mental Health Services Act Coordinator
Shasta County Health and Human Services Agency
2615 Breslauer Way
Redding, CA 96001
(530) 245-6951
kschuette@co.shasta.ca.us

Mental Health Services Act (MHSA)
Consolidated Community Stakeholder Meeting Survey Results
Data from Community Stakeholder Online Survey and
Paper Forms Made Available at Various Meetings between 1/1/17-12/31/17

During calendar year 2017, there were a total of 6 different in-person community stakeholder meetings held, as well as on online survey period. All survey information, both electronic and paper copies, was collected, and the data that follows is a consolidation of the results from both sources. A total of 318 surveys were collected. Please note that some surveys may have been completed by the same people at different meetings, or completed multiple times online, so this is not an unduplicated count. Additionally, the questions on the surveys varied slightly, as data collection points were refined by the county over time. Some questions were not asked on earlier or later surveys, so response rates may appear artificially low. The number of responses is noted in the title of each following chart.

The largest portion of these surveys (299 or 94%) were collected during the public comment and stakeholder input process for the Fiscal Year 2017-18 Through Fiscal Year 2019-20 Three-Year Program and Expenditure Plan report. This process included three in-person meetings (5/23/17 at Olberg Wellness Center, 5/31/17 at Circle of Friends Wellness Center, and 5/31/17 at the Redding Library) and then an on-line survey available 5/17/17 – 6/9/17. All responses from these various meetings and sources were consolidated.

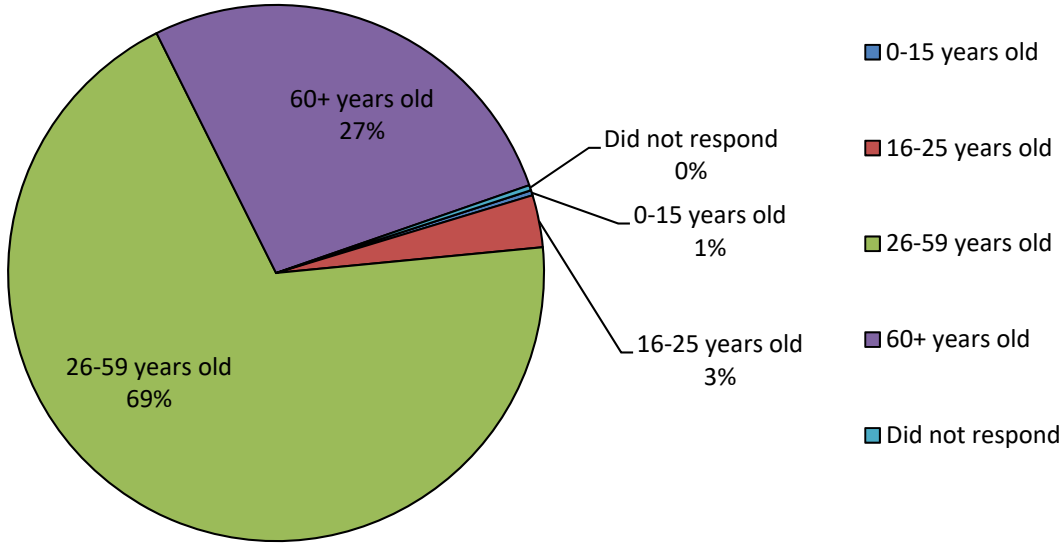


	Jan 25, 2017 Redding Library	May & June 2017 Olberg, Circle of Friends, Redding Library & Online	Aug 29, 2017 Redding Library	Dec 6, 2017 Boggs Building
Number of Surveys Collected	3	299	0	16

DEMOGRAPHICS

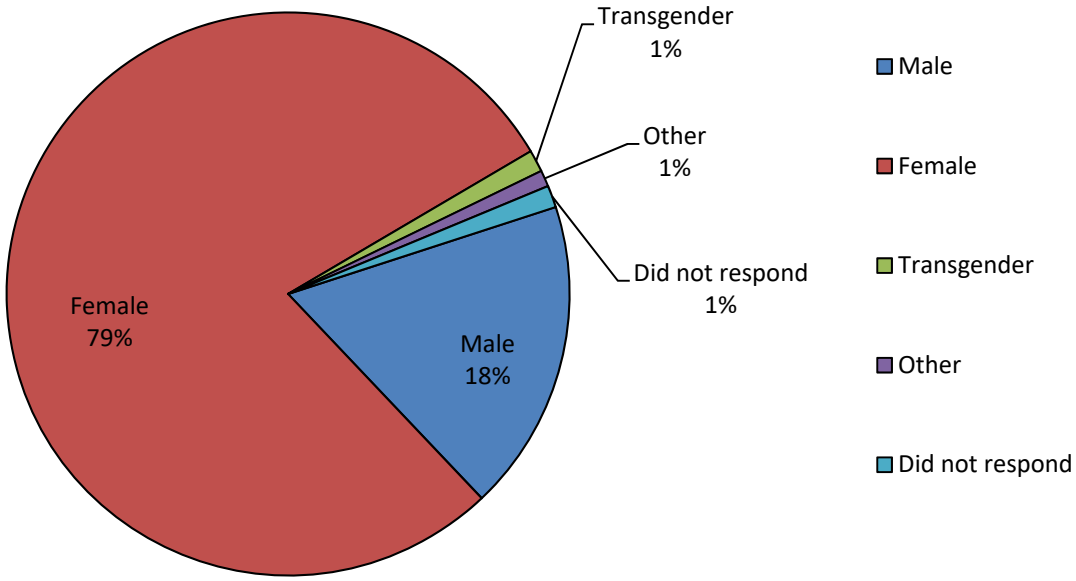
Age Groups Represented by Community Stakeholder Surveys

(n=318)



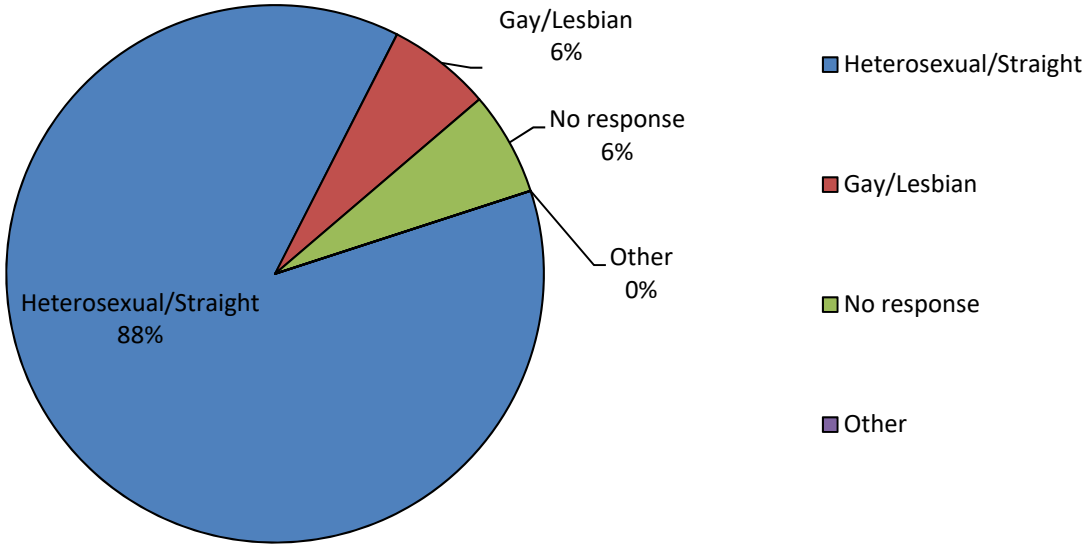
Genders Represented by Community Stakeholder Surveys

(n=318)



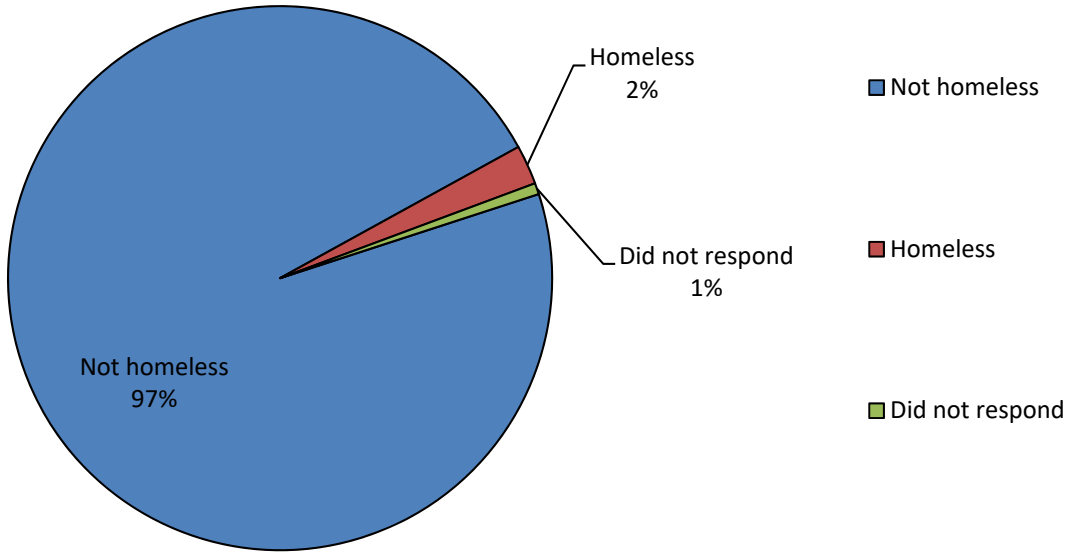
Sexual Orientations Represented by Community Stakeholder Surveys

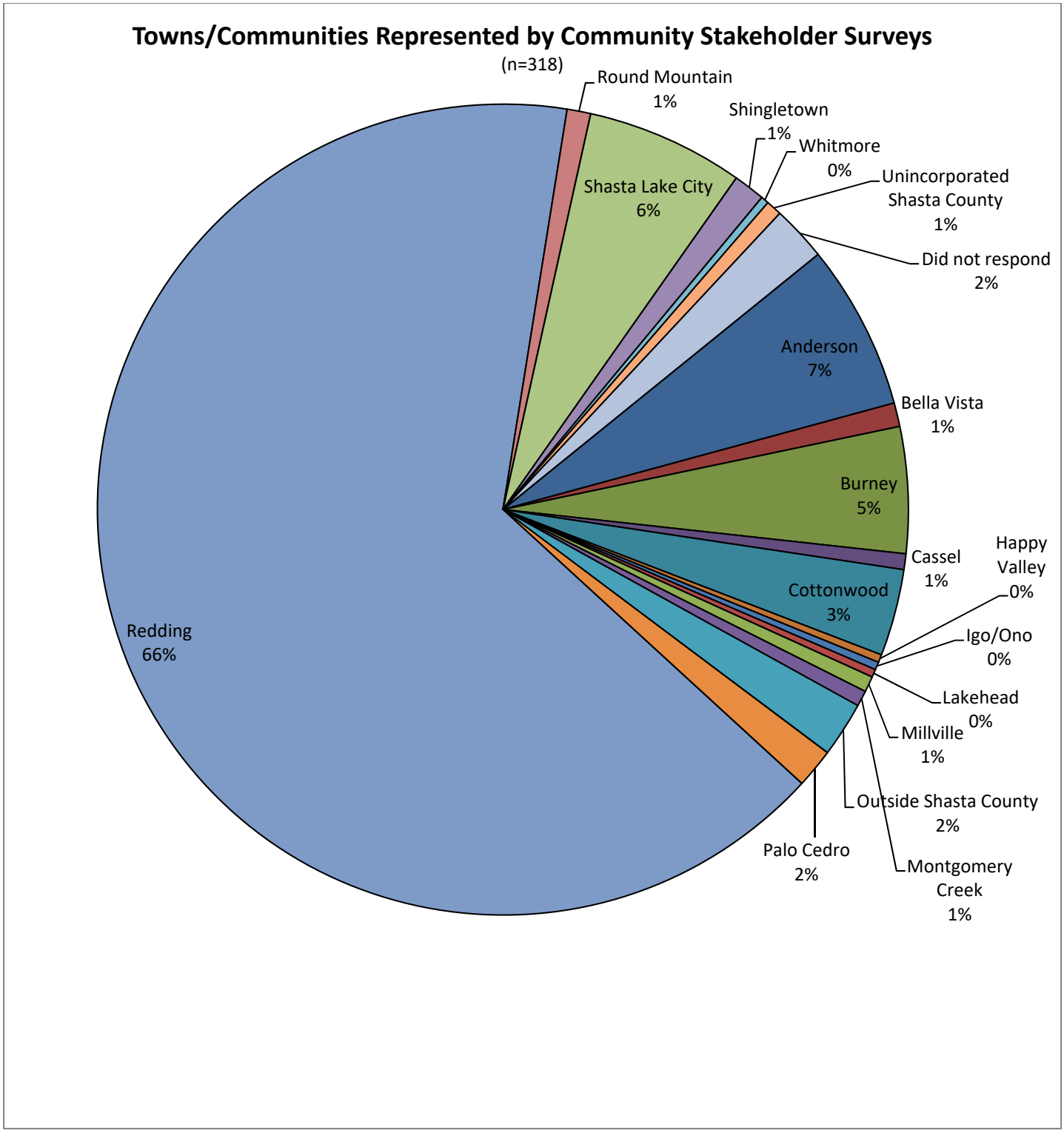
(n=16)



Homeless Represented by Community Stakeholder Surveys

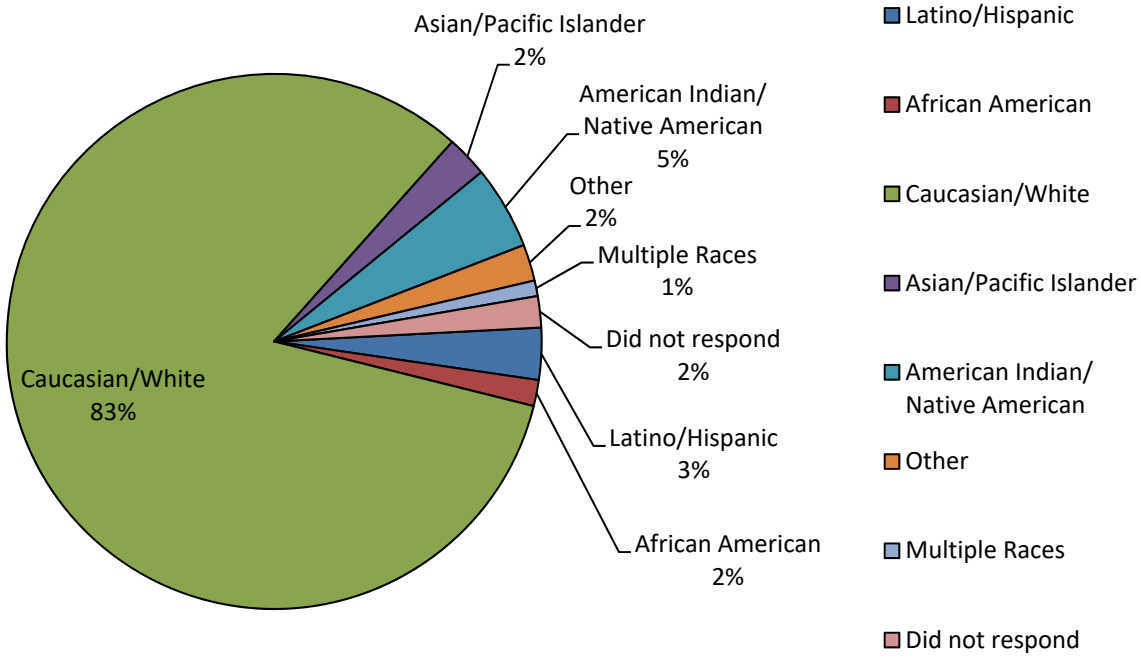
(n=299)




Towns/Communities Represented by Community Stakeholder Surveys
(n=318)
Round Mountain 1%
Shingletown 1%
Whitmore 0%
Shasta Lake City 6%
Unincorporated Shasta County 1%
Did not respond 2%
Anderson 7%
Bella Vista 1%
Burney 5%
Cassel 1%
Happy Valley 0%
Cottonwood 3%
Igo/Ono 0%
Redding 66%
Lakehead 0%
Millville 1%
Outside Shasta County 2%
Palo Cedro 2%
Montgomery Creek 1%

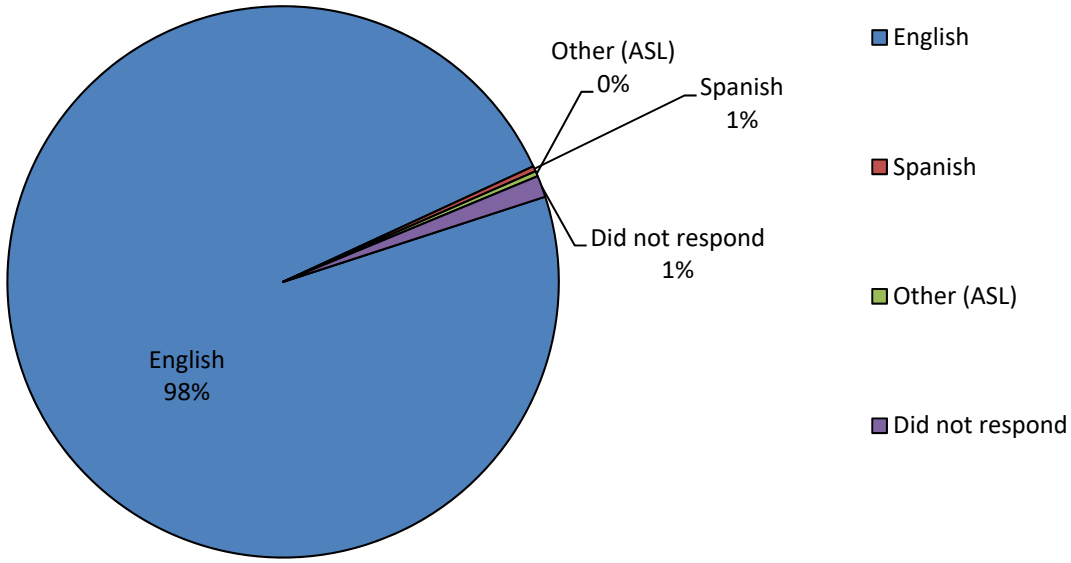
Race/Ethnicity Groups Represented by Community Stakeholder Surveys

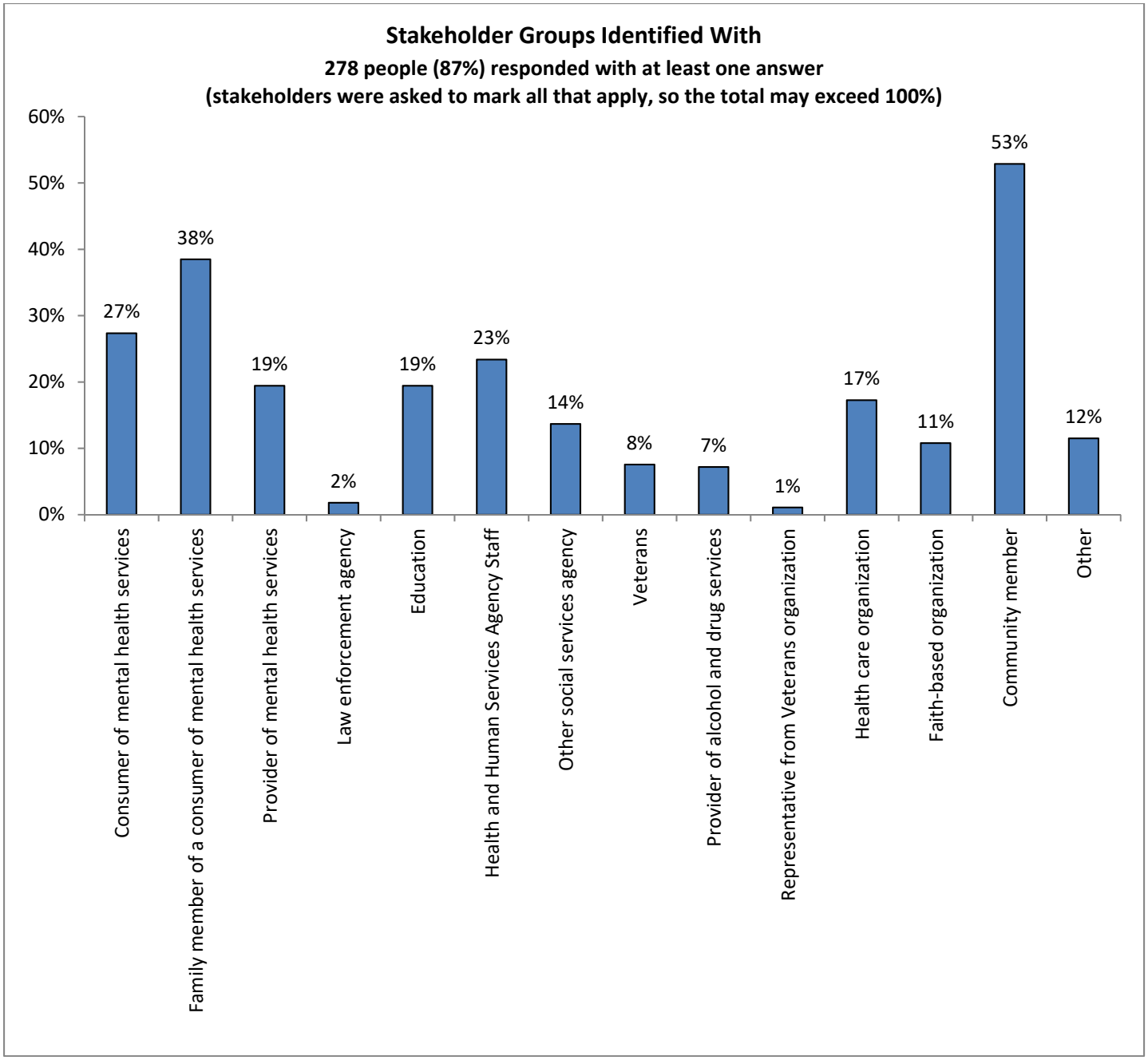
(n=318)



Primary Language Groups Represented by Community Stakeholder Surveys

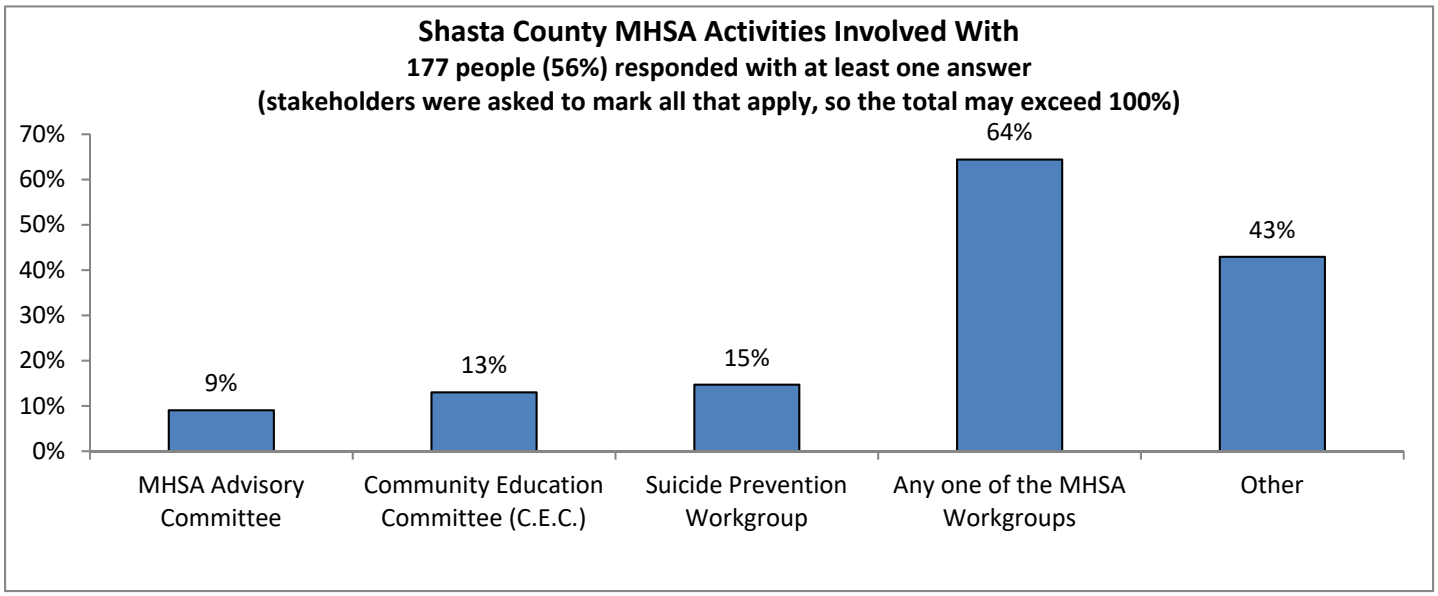
(n=318)



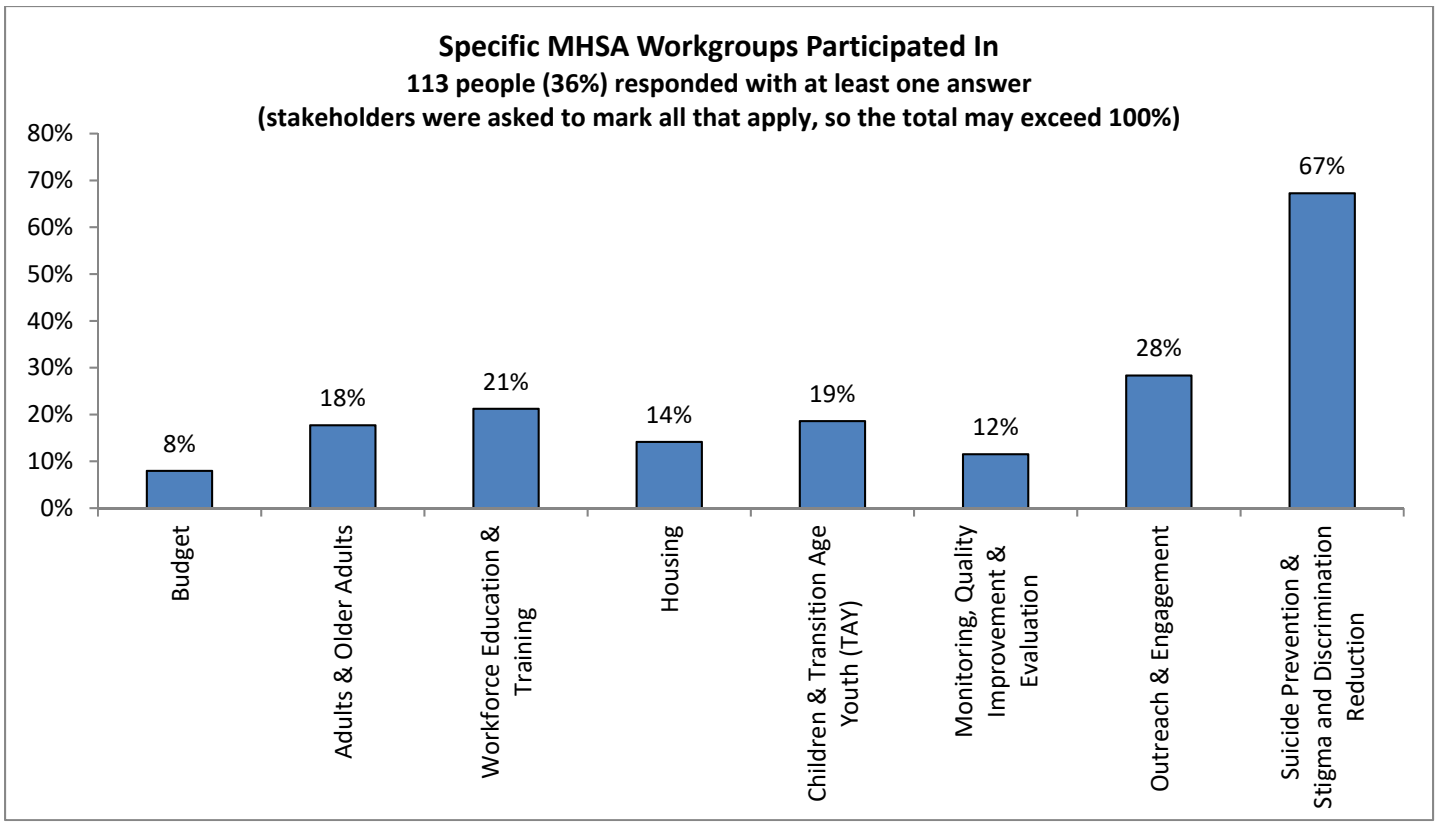


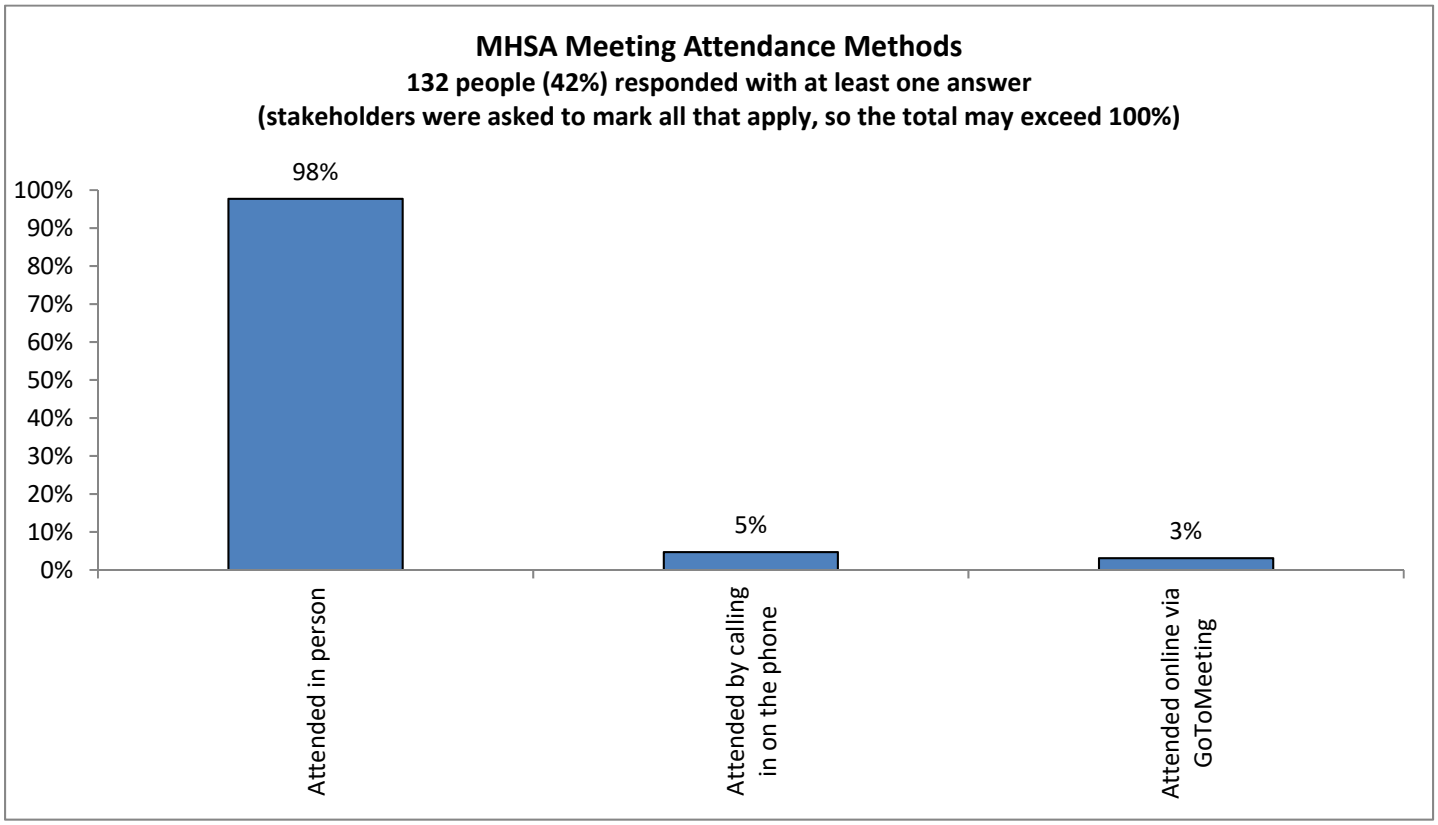
Other (please specify):	# of responses	Other (please specify):	# of responses
Brave Faces advocate/speaker	3	Government Agency	1
NAMI Shasta County	2	Handicapped. I think we need the Hope van here in Burney.	1
Non-profit	2	Licensed health provider	1
AA / Al-Anon (30 years alcohol / drug free)	1	MHSA Volunteer	1
admin of chronic illness support group	1	Partner in a small, independent community services center	1
chemical People	1	People of Progress-information center	1
City Councilmember	1	Planning	1
Community Partner Recreation Services	1	Positive thinking	1
Concerned "lifer"	1	Previously homeless 22 months ago.	1
County COC/non-profit	1	Public relations-investigative reporter	1
Court Appointed Special Advocate (CASA)	1	Teacher for Head Start	1
Design - Mental Health and Addiction	1	Triple P Practitioner	1
Family law attorney	1	Volunteer thrift shop; volunteer meal provider	1
Funder	1	Worked at Shasta Day School	1

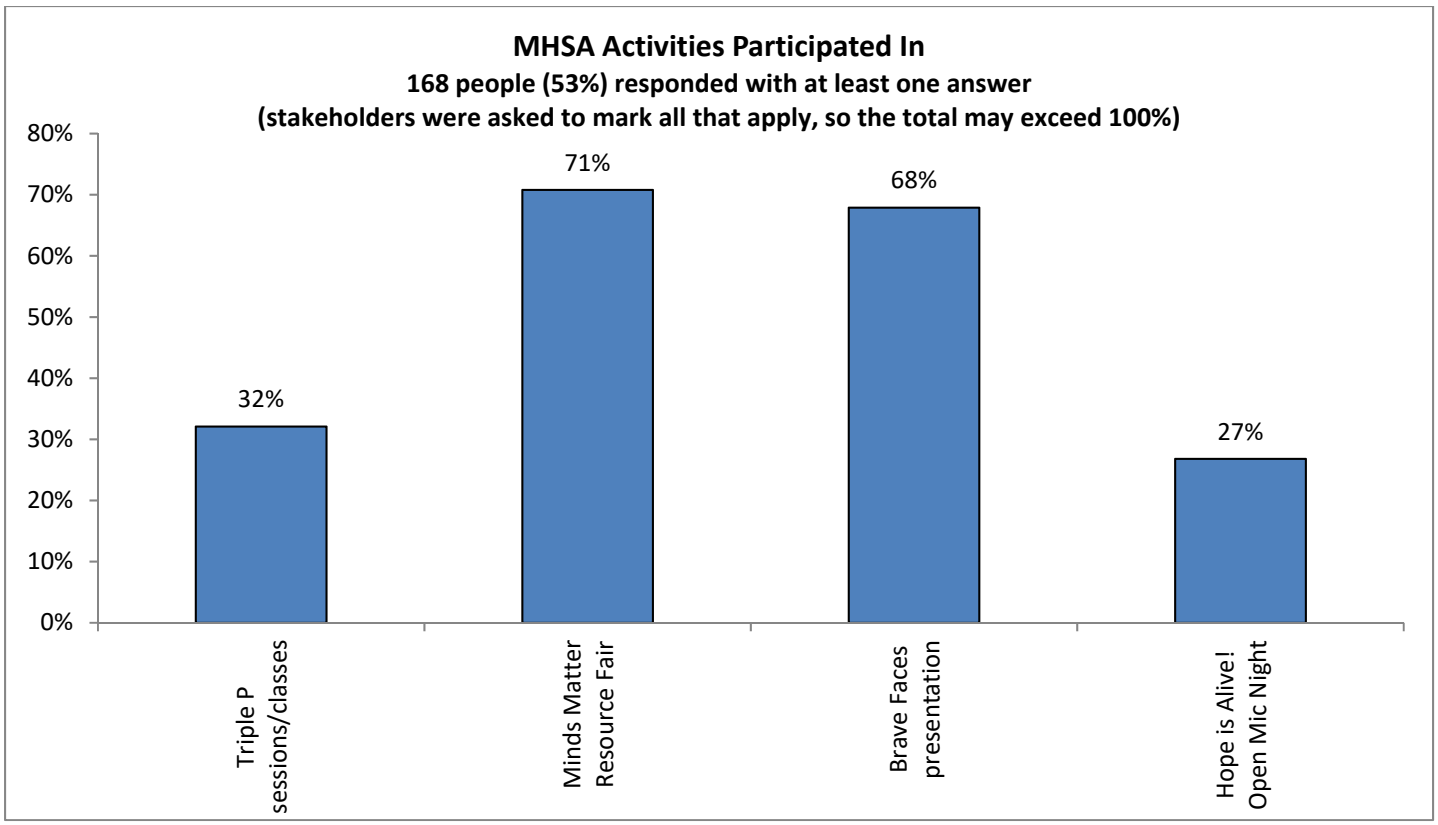
PERSONAL INVOLVEMENT / PUBLIC PRESENCE

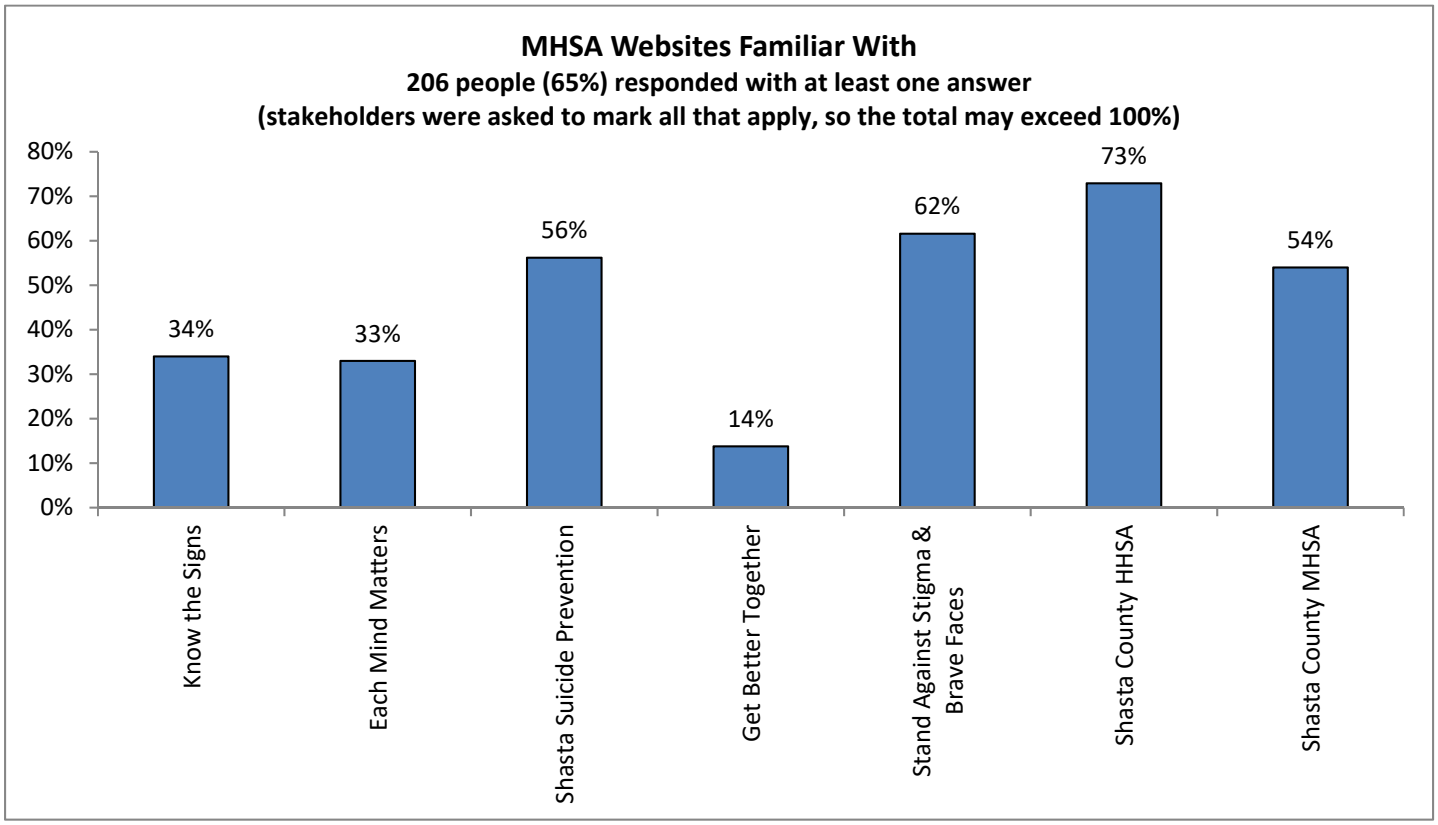


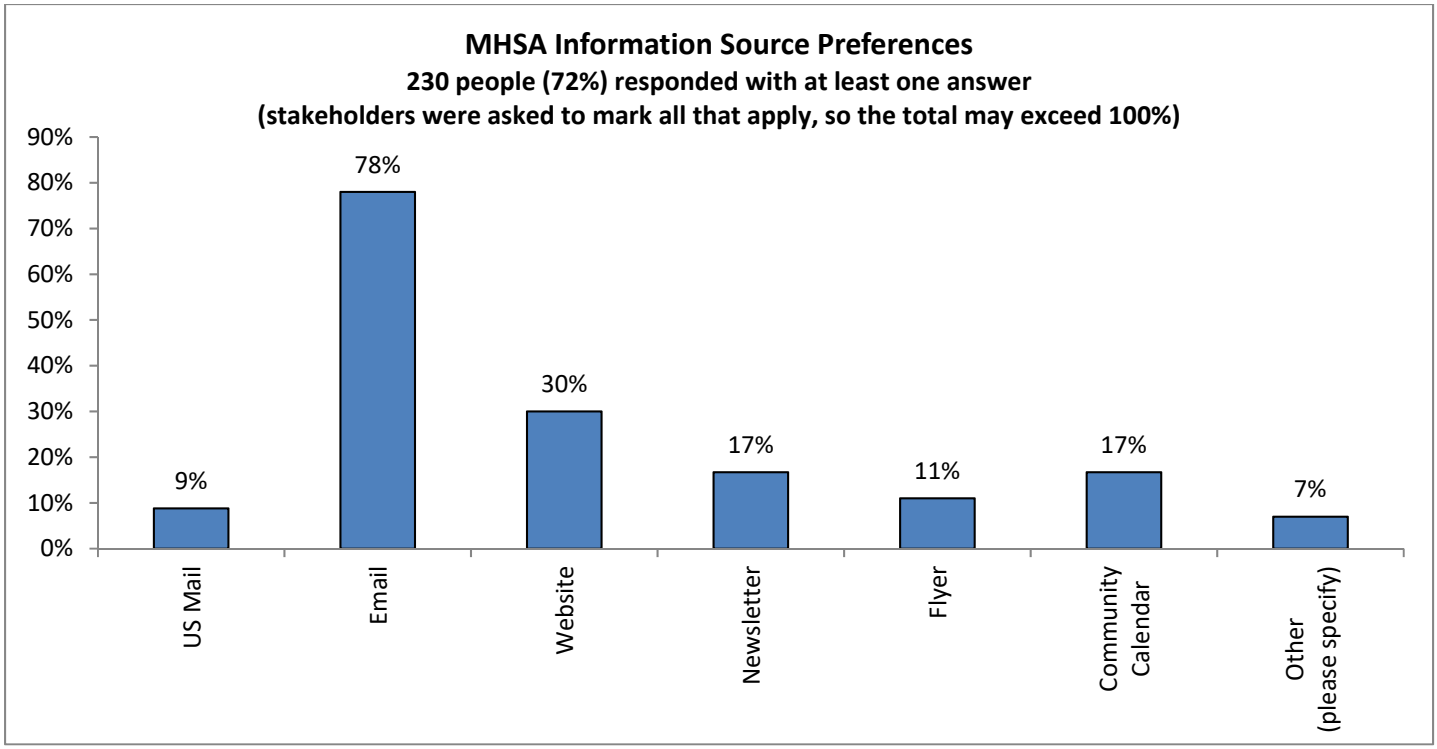
Other (please specify):	# of responses	Other (please specify):	# of responses
Did not know about them/not currently involved	22	I work with consumers who are served by MHSA	1
Attended Brave Faces/Stand Against Stigma events	4	I...refer clients to mental health services, I am a home visitor to help adults and children with mental health issues	1
MHSA Academy/Volunteer/Student Intern	4	I'm in therapy?	1
Staff in MHSA-funded programs	3	League of Women Voters of the Redding Area	1
Attended Suicide Prevention training	2	MHSA-PEI meetings	1
Employed by Health & Human Services Agency	2	My hospital is involved and it affects us on a daily basis	1
MHADAB member	2	Now disabled	1
ACE Prevention	1	other	1
Breaking Barriers, SCMH Placed Based Alignment Meeting	1	Partner	1
CA Mental Health Planning Council	1	Partner-support group	1
Community meetings, occasional	1	previously worked with Children's PEI	1
Drug Medi-Cal	1	Public Health Advisory Board	1
Have attended all the meetings listed above.	1	receive info from all above, share info to community partners	1
Held a meeting against stigma at our facility	1	Receive the Suicide Prevention Workgroup emails	1
I attended a few Suicide Prevention workgroup meetings	1	Redding CAMFT Monthly meeting	1
I formerly attended MHSA Advisory Committee meetings	1	Retired teacher of Special Needs Students	1
I have previously attended and participated in CEC meetings	1	School and community member	1
I participated in the initial formation of a group that was to come together during incidents the would have exceeded the strength of other medical assets.	1	service referrals	1
I publicize MHSA successes via Facebook / social media / email / smart phone to 3 peace based international organizations	1	Shasta County Interfaith Forum	1
I recieve invites to events and projects that I then forward out to my contacts.	1	Stakeholder, Program Support	1
I train future mental health practitioners in the requirements of the MHSA	1	support staff	1
I will be attending the Suicide Prevention Workgroup monthly meetings	1	Work in ER	1
I work in affordable housing	1	Would like more info/input from "old school"!	1


Specific MHSA Workgroups Participated In
113 people (36%) responded with at least one answer
(stakeholders were asked to mark all that apply, so the total may exceed 100%)
80%
70%
60%
50%
40%
30%
20%
10%
0%
8%
18%
21%
14%
19%
12%
28%
67%
Budget
Adults & Older Adults
Workforce Education & Training
Housing
Children & Transition Age Youth (TAY)
Monitoring, Quality Improvement & Evaluation
Outreach & Engagement
Suicide Prevention & Stigma and Discrimination Reduction


MHSA Meeting Attendance Methods
132 people (42%) responded with at least one answer
(stakeholders were asked to mark all that apply, so the total may exceed 100%)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
98%
5%
3%
Attended in person
Attended by calling in on the phone
Attended online via GoToMeeting


MHSA Activities Participated In
168 people (53%) responded with at least one answer
(stakeholders were asked to mark all that apply, so the total may exceed 100%)
80%
70%
60%
50%
40%
30%
20%
10%
0%
32%
71%
68%
27%
Triple P sessions/classes
Minds Matter Resource Fair
Brave Faces presentation
Hope is Alive! Open Mic Night


MHSA Websites Familiar With
206 people (65%) responded with at least one answer
(stakeholders were asked to mark all that apply, so the total may exceed 100%)
80%
70%
60%
50%
40%
30%
20%
10%
0%
34%
33%
56%
14%
62%
73%
54%
Know the Signs
Each Mind Matters
Shasta Suicide Prevention
Get Better Together
Stand Against Stigma & Brave Faces
Shasta County HHSA
Shasta County MHSA



Other (please specify):	# of responses
Facebook	5
Private email addresses shared	3
Record Searchlight Paper	2
Social Media	2
Word of mouth	2
CA Mental Health Planning Council	1
Community bulletin boards	1
Information is not getting to me as a retired person	1
Meetings and presentations. Formerly from the monthly Breslauer Bulletin. I feel like interagency communication and program knowledge could be better.	1
MHSA, City of Redding, Shasta Co?	1
Radio	1
Through the Wellness Center	1
Why are there not regular meeting where you give us information and there can be discussions?	1

MORS Assessment Report
FY2017-18 Q1

Introduction: The Milestones Of Recovery Scale (MORS) was adopted by Shasta County Adult Mental Health and has been in use since March 2014. MORS was created to capture aspects of recovery from the agency perspective. The scale consists of three underlying dimensions: the level of risk, the level of engagement with the mental health system, and the level of skills and supports that the client possesses. The MORS ranges from a score of one (extreme risk) to eight (advanced recovery).

MORS: Through 9/30/2017 5,482 MORS have been completed for 1,128 unduplicated Shasta County clients. Of these, 386 clients had at least one MORS assessment recorded in FY2017-18 Q1.

Length of Service: For those clients with at least one MORS in the reporting quarter, analyses were conducted to evaluate the change in MORS ratings over time. Ratings that were recorded at six, 12, 18, 24, and 30 or more months prior to the reporting quarter were compared to the most recent MORS assessment.

For those clients who had more than one MORS in any given quarter, the most recent rating is used.

There were 253 clients with at least one MORS assessment in the reporting quarter and at least one assessment in the second preceding quarter (six months). Of these, 28 (11.1%) improved, while 41 (16.2%) declined. This difference is not statistically significant ($p = 0.0960$). At the same time, the MORS ratings for 184 clients (72.7%) had not changed.

There were 222 clients with one or more MORS assessment in the reporting quarter and at least one in the fourth preceding quarter (12 months). Of these, 41 (18.5%) increased, while 44 (19.8%) decreased. This difference is not statistically significant ($p < 0.9140$). At the same time, the MORS ratings for 137 clients (61.7%) had not changed.

One hundred twenty-one clients had one or more MORS assessment in the reporting quarter and at least one in the sixth preceding quarter (18 months). Of these, 27 (22.3%) improved, while 38 (31.4%) declined. This difference is not statistically significant ($p = 0.1129$). At the same time, 56 clients (46.3%) had initial MORS ratings that were the same.

There were 153 clients with one or more MORS assessment in the reporting quarter and at least one in the eighth preceding quarter (24 months). Of these, 42 (27.5%) increased, while 41 (26.8%) decreased. This difference is not statistically significant ($p = 0.8907$). At the same time, 70 clients (45.8%) had MORS ratings were the same as their most recent ratings.

There were 149 clients with one or more MORS assessment in the reporting quarter and at least one in the twelfth preceding quarter (30 months) or earlier. Of these, 45 (30.2%) improved, while 40 (26.8%) declined. This difference is not statistically significant ($p = 0.5166$). At the same time, 64 clients (43.0%) had MORS ratings that were the same.

Tables 1 thought 5 provide a count of each initial MORS rating for all clients with one or more MORS assessment that was at least 6 but less than 12, at least 12 but less than 18, at least 18 but less than 24, at least 24 but less than 30, and at least 30 months after their initial MORS,

the percent of each MORS rating, the cross-tabulation for each initial MORS to the Final MORS ratings, the count of those Final ratings that decreased from the initial MORS, the count that were the same, and the count the increased. The green highlighted counts indicate improvement, the grey highlighted counts stayed the same, and the yellow highlighted counts went down.

Table 1: Change in MORS ratings from FY2016-17 Q3 to FY2017-18 Q1 (six months)

			FY2017-18 Q1 MORS										
6 Months	**Count of Clients**	**Percent**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**Decreased**	**Stayed the Same**	**Increased**
1	**0**	**0.0%**									N/A	0	0
2	**5**	**2.0%**	1	2	2						1	2	2
3	**14**	**5.5%**		1	4		6	3			1	4	9
4	**11**	**4.3%**		1	2	4	4				3	4	4
5	**153**	**60.5%**	2		8	2	129	12			12	129	12
6	**68**	**26.9%**	1		3	2	17	44	1		23	44	1
7	**2**	**0.8%**						1	1		1	1	0
8	**0**	**0.0%**									0	0	N/A
Total	**253**	**100.0%**	**4**	**4**	**19**	**8**	**156**	**60**	**2**	**0**	**41**	**184**	**28**
			1.6%	**1.6%**	**7.5%**	**3.2%**	**61.7%**	**23.7%**	**0.8%**	**0.0%**	**16.2%**	**72.7%**	**11.1%**

Percentages may not add up to 100% due to rounding.

Table 2: Change in MORS ratings from FY2016-17 Q1 to FY2017-18 Q1 (12 months)

			FY2017-18 Q1 MORS										
12 Months	**Count of Clients**	**Percent**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**Decreased**	**Stayed the Same**	**Increased**
1	**3**	**1.4%**					2	1			N/A	0	3
2	**3**	**1.4%**	1	1			1				1	1	1
3	**13**	**5.9%**				1	10	2			0	0	13
4	**11**	**5.0%**			1	4	5	1			1	4	6
5	**127**	**57.2%**	1	1	9	2	96	17	1		13	96	18
6	**59**	**26.6%**	1		3		21	34			25	34	0
7	**6**	**2.7%**				1	2	1	2		4	2	0
8	**0**	**0.0%**									0	0	N/A
Total	**222**	**100.0%**	**3**	**2**	**13**	**8**	**137**	**56**	**3**	**0**	**44**	**137**	**41**
			1.4%	**0.9%**	**5.9%**	**3.6%**	**61.7%**	**25.2%**	**1.4%**	**0.0%**	**19.8%**	**61.7%**	**18.5%**

Percentages may not add up to 100% due to rounding.

Table 3: Change in MORS ratings from FY2015-16 Q3 to FY2017-18 Q1 (18 months)

			FY2017-18 Q1 MORS										
18 Months	**Count of Clients**	**Percent**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**Decreased**	**Stayed the Same**	**Increased**
1	**1**	**0.8%**						1			N/A	0	1
2	**0**	**0.0%**									0	0	0
3	**9**	**7.4%**	1	1	1		5	1			2	1	6
4	**6**	**5.0%**			1		5				1	0	5
5	**66**	**54.5%**			7	2	42	15			9	42	15
6	**34**	**28.1%**		1		1	20	12			22	12	0
7	**5**	**4.1%**	1			1	1	1	1		4	1	0
8	**0**	**0.0%**									0	0	N/A
Total	**121**	**100.0%**	**2**	**2**	**9**	**4**	**73**	**30**	**1**	**0**	**38**	**56**	**27**
			1.7%	**1.7%**	**7.4%**	**3.3%**	**60.3%**	**24.8%**	**0.8%**	**0.0%**	**31.4%**	**46.3%**	**22.3%**

Percentages may not add up to 100% due to rounding.

Table 4: Change in MORS ratings from FY2015-16 Q1 to FY2017-18 Q1 (24 months)

			FY2017-18 Q1 MORS										
24 Months	**Count of Clients**	**Percent**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**Decreased**	**Stayed the Same**	**Increased**
1	**0**	**0.0%**									N/A	0	0
2	**3**	**2.0%**					2	1			0	0	3
3	**18**	**11.8%**		1	1	1	12	3			1	1	16
4	**8**	**5.2%**		1	2	1	4				3	1	4
5	**75**	**49.0%**	1		6		50	17	1		7	50	18
6	**44**	**28.8%**				2	24	17	1		26	17	1
7	**5**	**3.3%**	1	1			2		1		4	1	0
8	**0**	**0.0%**									0	0	N/A
Total	**153**	**100.0%**	**2**	**3**	**9**	**4**	**94**	**38**	**3**	**0**	**41**	**70**	**42**
			1.3%	**2.0%**	**5.9%**	**2.6%**	**61.4%**	**24.8%**	**2.0%**	**0.0%**	**26.8%**	**45.8%**	**27.5%**

Percentages may not add up to 100% due to rounding.

Table 4: Change in MORS ratings from FY2014-15 Q3 or previous, to FY2017-18 Q1 (30+ months)

			FY2017-18 Q1 MORS										
30+ Months	**Count of Clients**	**Percent**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**Decreased**	**Stayed the Same**	**Increased**
1	**2**	**1.3%**					2				N/A	0	2
2	**6**	**4.0%**		2	1		2	1			0	2	4
3	**17**	**11.4%**			2		11	4			0	2	15
4	**6**	**4.0%**					5	1			0	0	6
5	**79**	**53.0%**		1	9	1	51	17			11	51	17
6	**30**	**20.1%**			2	1	17	9	1		20	9	1
7	**8**	**5.4%**			1		2	5			8	0	0
8	**1**	**0.7%**						1			1	0	N/A
Total	**149**	**100.0%**	**0**	**3**	**15**	**2**	**90**	**38**	**1**	**0**	**40**	**64**	**45**
			0.0%	**2.0%**	**10.1%**	**1.3%**	**60.4%**	**25.5%**	**0.7%**	**0.0%**	**26.8%**	**43.0%**	**30.2%**

Percentages may not add up to 100% due to rounding.

Sources:

Cerner Client Assignments Report *and* Assessment Measures Report *downloaded 11/02/2017.*

Fisher, D. G., Pilon, D., Hershberger, S. L., Reynolds, G.L., LaMaster, S. C., & Davis, M. (2009). Psychometric Properties of an Assessment for Mental Health Recovery Programs. *Community Mental Health Journal, 45*(4), 246-250.

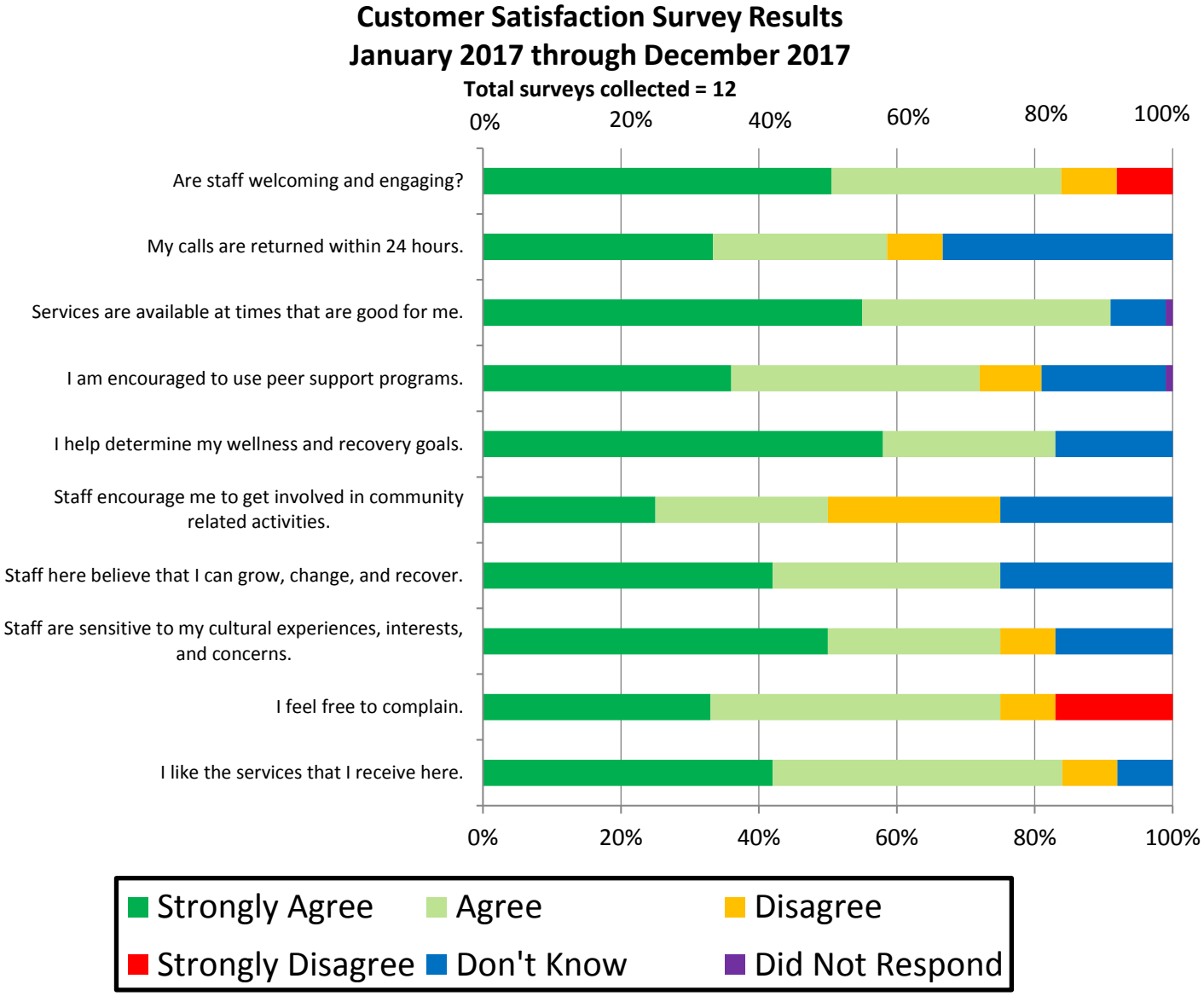
MORS database last updated 11/02/2017.

Appendix C

SERVICE SATISFACTION SURVEY

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

The overall survey results include data from people accessing the following service areas: adult mental health, adult alcohol and drug, fair hearings, long-term care, in-home supportive services, public authority, public guardian, and children's services.



Appendix D

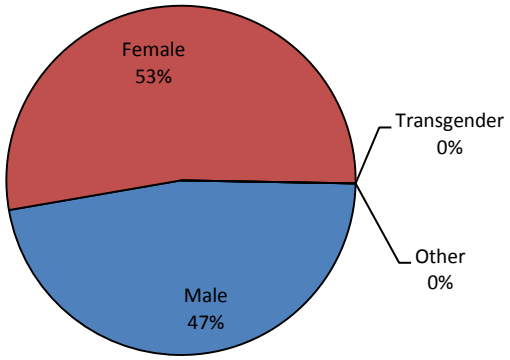
Wellness Centers Summary Report

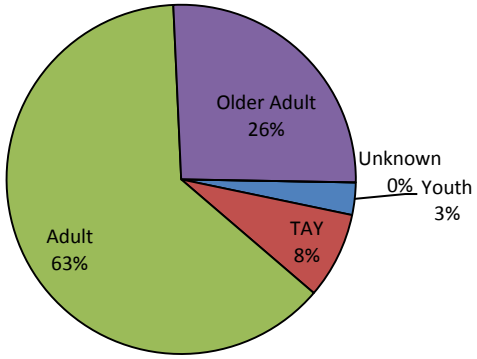
Jan 2017 through Dec 2017

Shasta County had two wellness centers in operation during the twelve-month period of January 2017 through December 2017: Olberg Wellness Center in Redding and Circle of Friends in Burney. Olberg Wellness Center is on a monthly reporting cycle, while Circle of Friends in on a quarterly reporting cycle. Because of this, some averaging was necessary for their data to be comparable, so all combined data is an approximation.

Demographics

Approximately 48% of wellness center attendees were male, 53% female, and 0% reported as transgender or other.

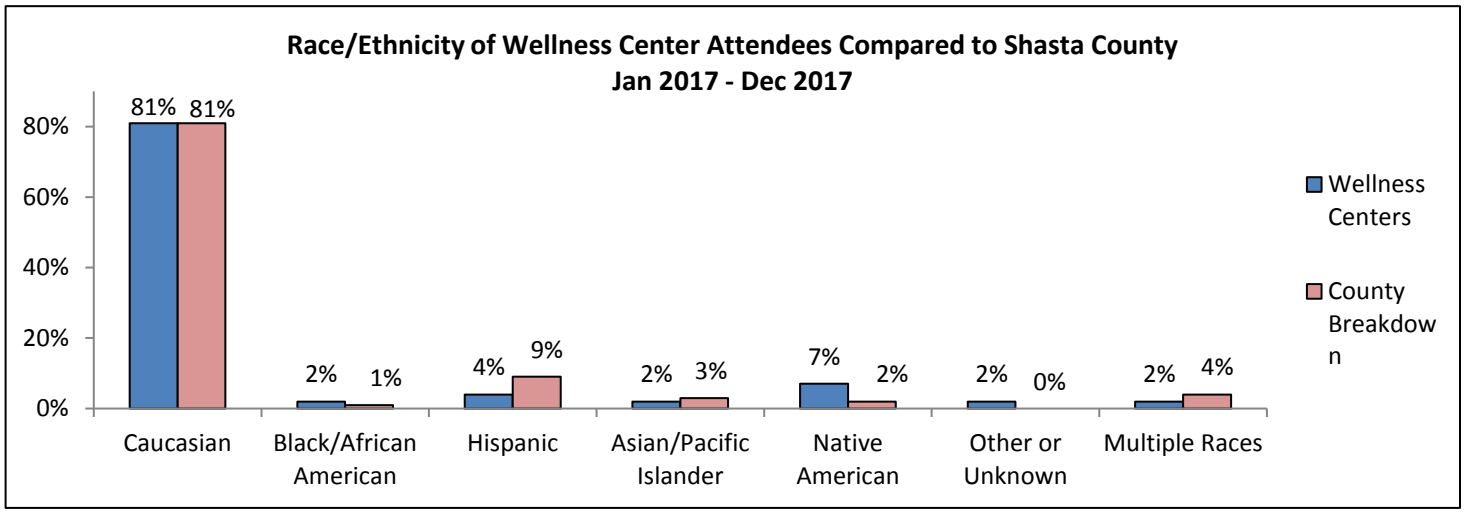




Approximately 3% of wellness center attendees were Youths (0-15 years of age), 8% were Transitional Age Youths (16-25 years of age), 63% were Adults (26-59 years of age), and 26% were Older Adults (60+ years of age), with 0% of unknown age.

Approximately 68% of wellness center attendees were consumers, 7% were family members of consumers, and 17% identified as both consumers and family members, with 8% unknown or declining to state.

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



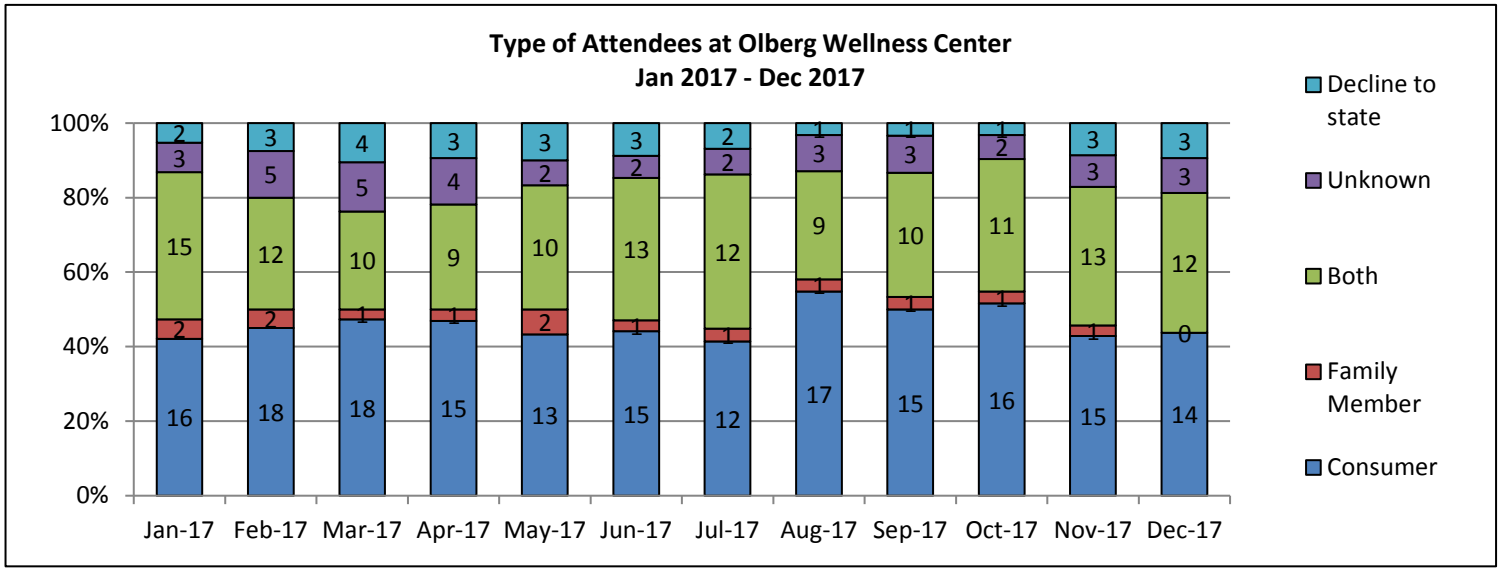
Services Provided

Overall, a total of 2,347 individual workshops, groups, activities, and 12-step recovery meetings were held during this twelve-month period.

Olberg Wellness Center

Attendance

Attendance was down 32% from the previous twelve-month period, with an average of 34 unduplicated participants each month.



Demographics

On average, 46% of attendees were consumers, 4% were family members, and 34% identified as both family members and consumers. An average of 9% of the participants were of unknown type, and 7% declined to state. On average, 93% of staff members (including volunteers) were consumers. In order to maintain confidentiality, age, gender and race/ethnicity is not broken down by individual wellness center.

Services Provided

Olberg Wellness Center is open Monday through Friday 10 am to 3 pm. During this twelve-month period, 1338 individual activities and groups were available for participants, with the average being 5 groups or activities offered per day. On the average, there were approximately 5 participants per activity.

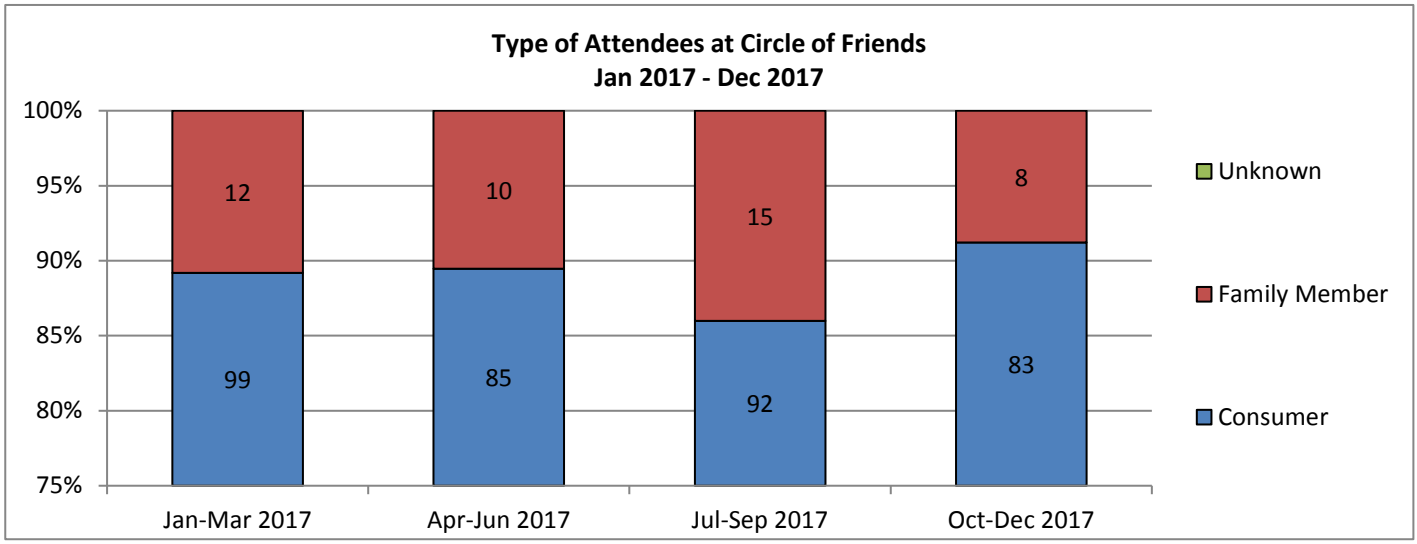
Attendee Direction

Olberg Wellness Center has weekly Members' Meetings and monthly Steering Committee Meetings, open to consumers and family members. During this twelve-month period, there were 55 of these types of meetings, and they had an average of 11 participants per meeting.

Circle of Friends

Attendance

Attendance was down 7% from the previous twelve-month period, with an average of 101 unduplicated people attending Circle of Friends each quarter.



Demographics

Eighty-nine percent of attendees were consumers and 11% were family members. Eighty-six percent of staff and 97% of volunteers were consumers. In order to maintain confidentiality, age, gender and race/ethnicity is not broken down by individual wellness center.

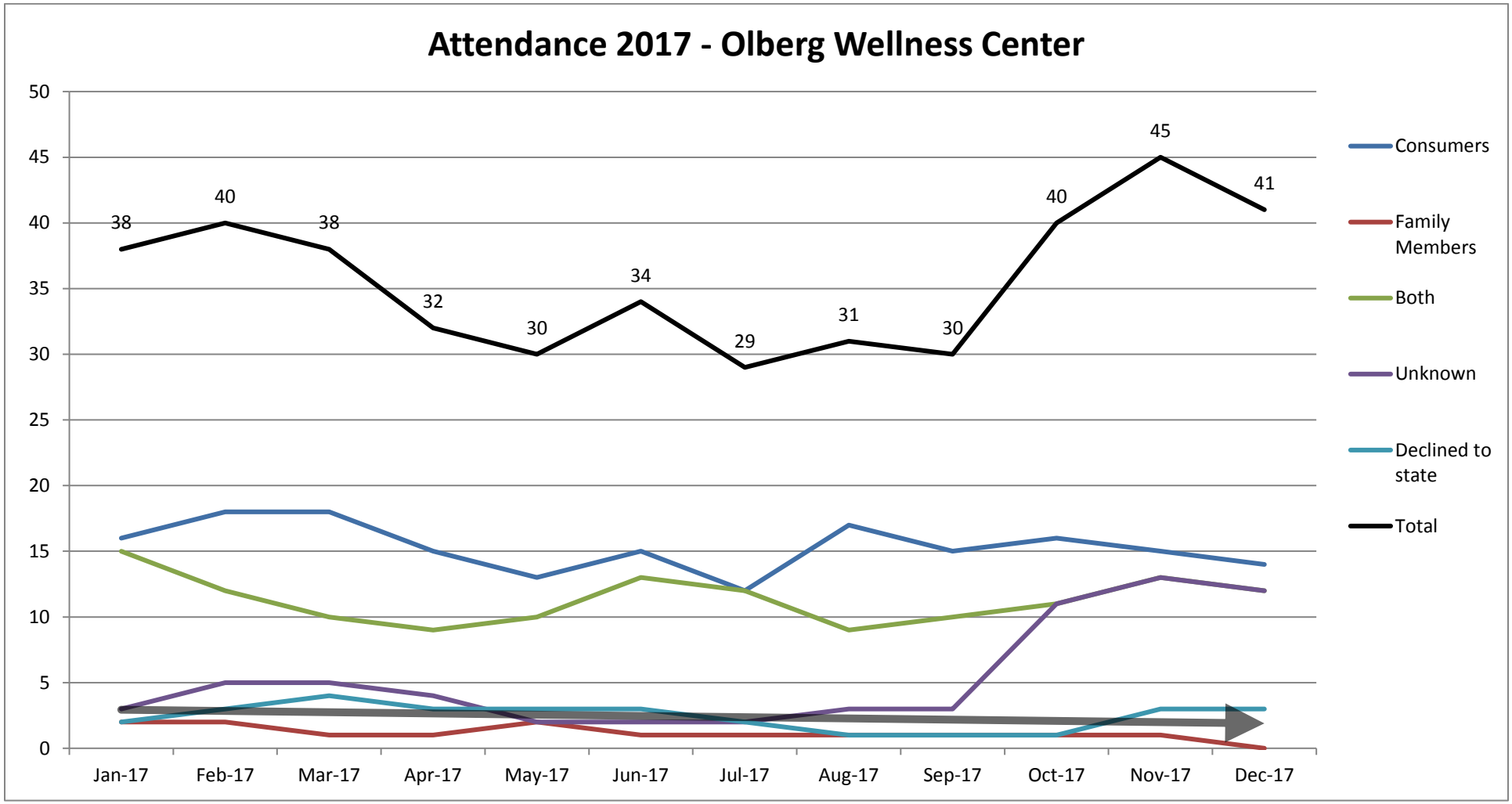
Services Provided

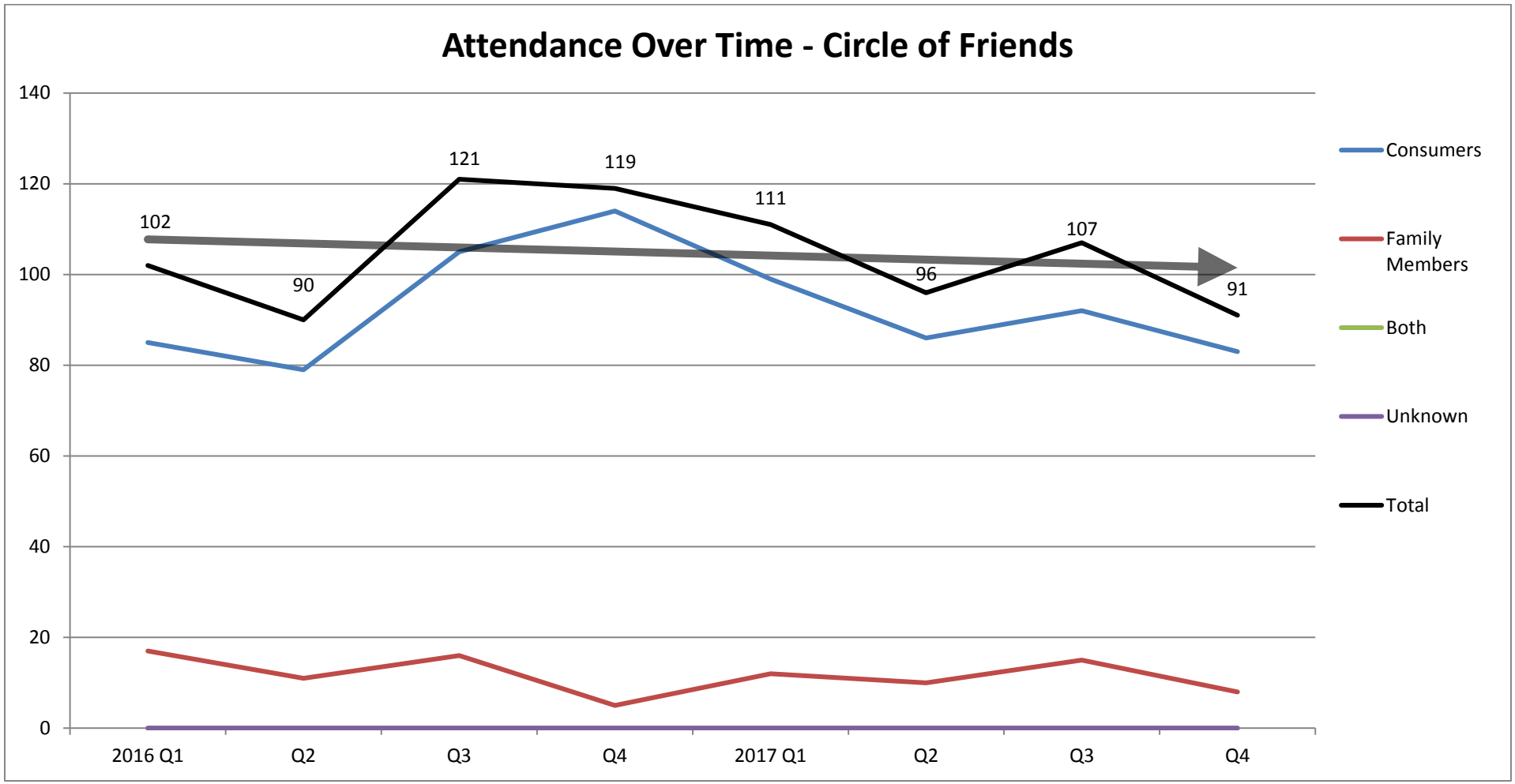
Circle of Friends is open in Burney Monday, Wednesday, and Friday 12:30 PM to 3:30 PM, and varying hours on Tuesdays and Thursday afternoons depending on the scheduled activity. They also offer services in Round Mountain from 9:00 AM to 11:30 AM Thursdays. In addition, many scheduled activities and outings, chosen by consumers, take place at other days and times, including evenings and weekends.

Fifty-six workshops, 2 different activities, and 19 different weekly/biweekly 12 step recovery meetings were held on a regular basis, which provided 1009 individual activities/groups for participants during this twelve-month period.

Attendee Direction

An average of 18 attendees (18%) contributed to the planning and direction of the program. All decisions relating to the Center are based on participant input through the Steering Committee, Community Education Committee Meetings, Walk for Wellness meetings, calendar and newsletter planning meetings, daily check-in time, daily discussions, coach advocate interviewing and other activity-specific planning meetings. Activities offered at the Center are based on participant preferences.


Attendance 2017 - Olberg Wellness Center
50
45
40
35
30
25
20
15
10
5
0
38
40
38
32
30
34
29
31
30
40
45
41
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Consumers
Family Members
Both
Unknown
Declined to state
Total

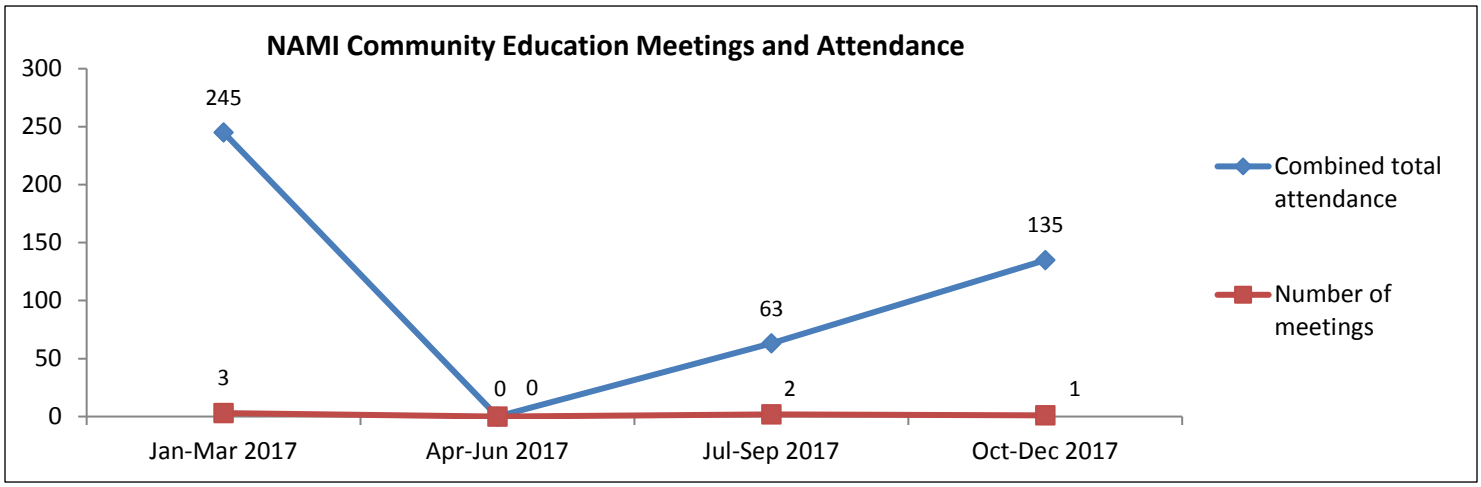

Attendance Over Time - Circle of Friends
140
120
100
80
60
40
20
0
102
90
121
119
111
96
107
91
2016 Q1
Q2
Q3
Q4
2017 Q1
Q2
Q3
Q4
Consumers
Family Members
Both
Unknown
Total

NAMI Summary Report

Jan 2017 through Dec 2017

Community Education

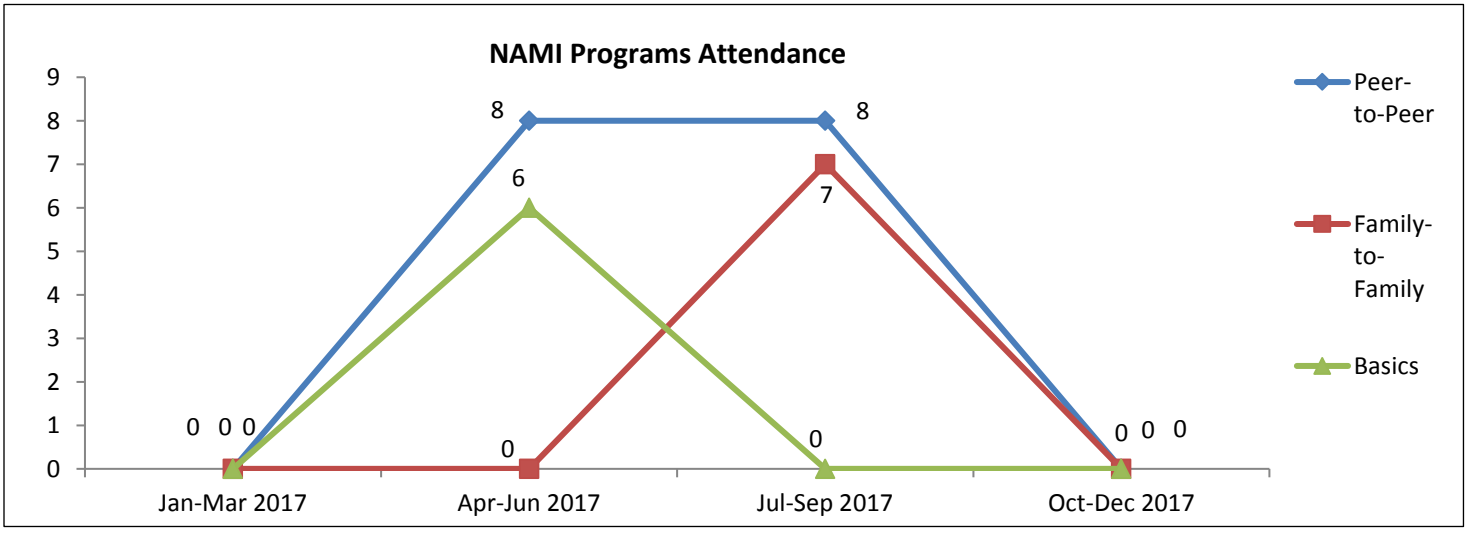
NAMI held 6 different community education meetings in the most recent 12 months tracked. An average of 74 people attended each meeting.



Program Offerings

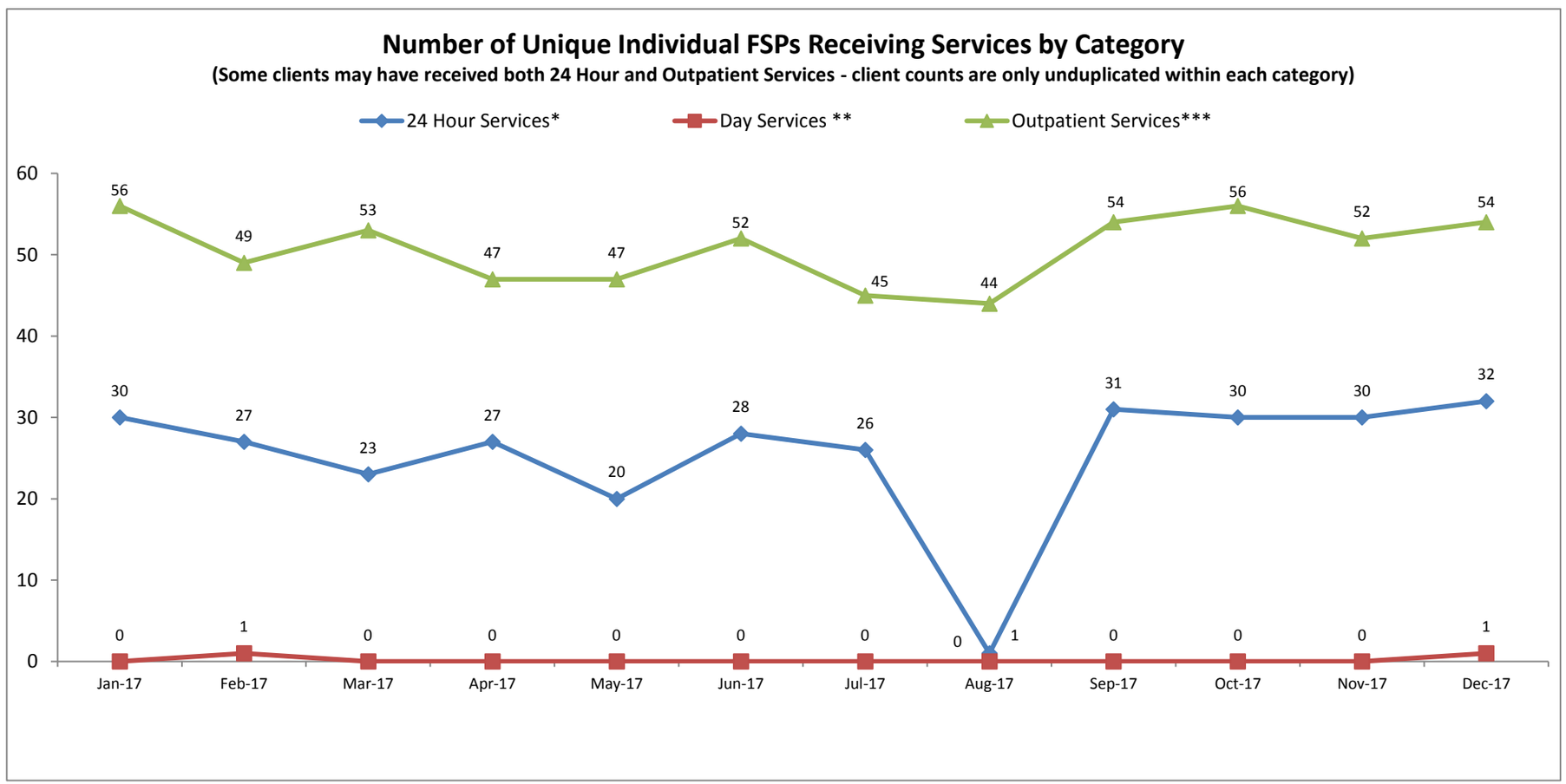
2017 was an eventful year for the NAMI Shasta County. In March, the NAMI office moved from the Market St. location to the new location at the Hill Country C.A.R.E Center. This move led to increases in both walk in and phone requests for help. 2017 also saw the completion of both Peer to Peer and Basics NAMI classes for the first time since 2014. The new location has resulted in an increased demand for NAMI services and programs.

Without additional volunteers to help NAMI operate, it is very challenging to meet the required obligations. As a result, NAMI is working with Shasta County to secure the services of MHSA Academy graduates who can volunteer to help with everyday operations. NAMI is working with NAMI State Trainers to have training provided to a higher percentage of volunteers to increase the number of Peer to Peer, Family to Family and Basics teachers. The center is also working with NAMI State as well as NAMI operations in Butte and Tehama counties to increase the number of training opportunities for the Shasta County NAMI volunteers.



CSI AND FSP LINKED DATA – 2017

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



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

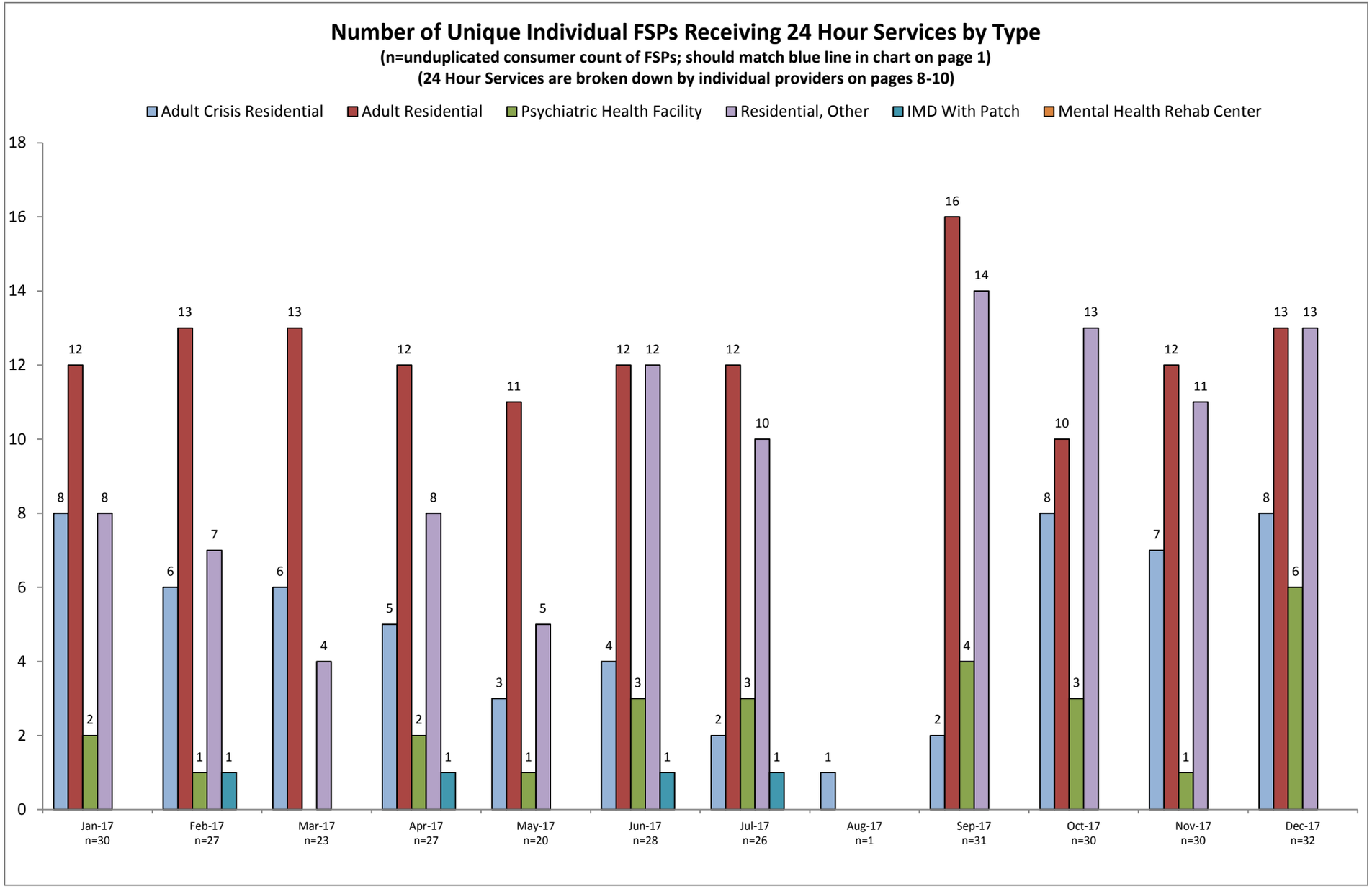
24 Hour Services include various types of residential services, such as Skilled Nursing Facilities, Mental Health Rehab Centers and Psychiatric Health Facilities. These services are billed for by the day.

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

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

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

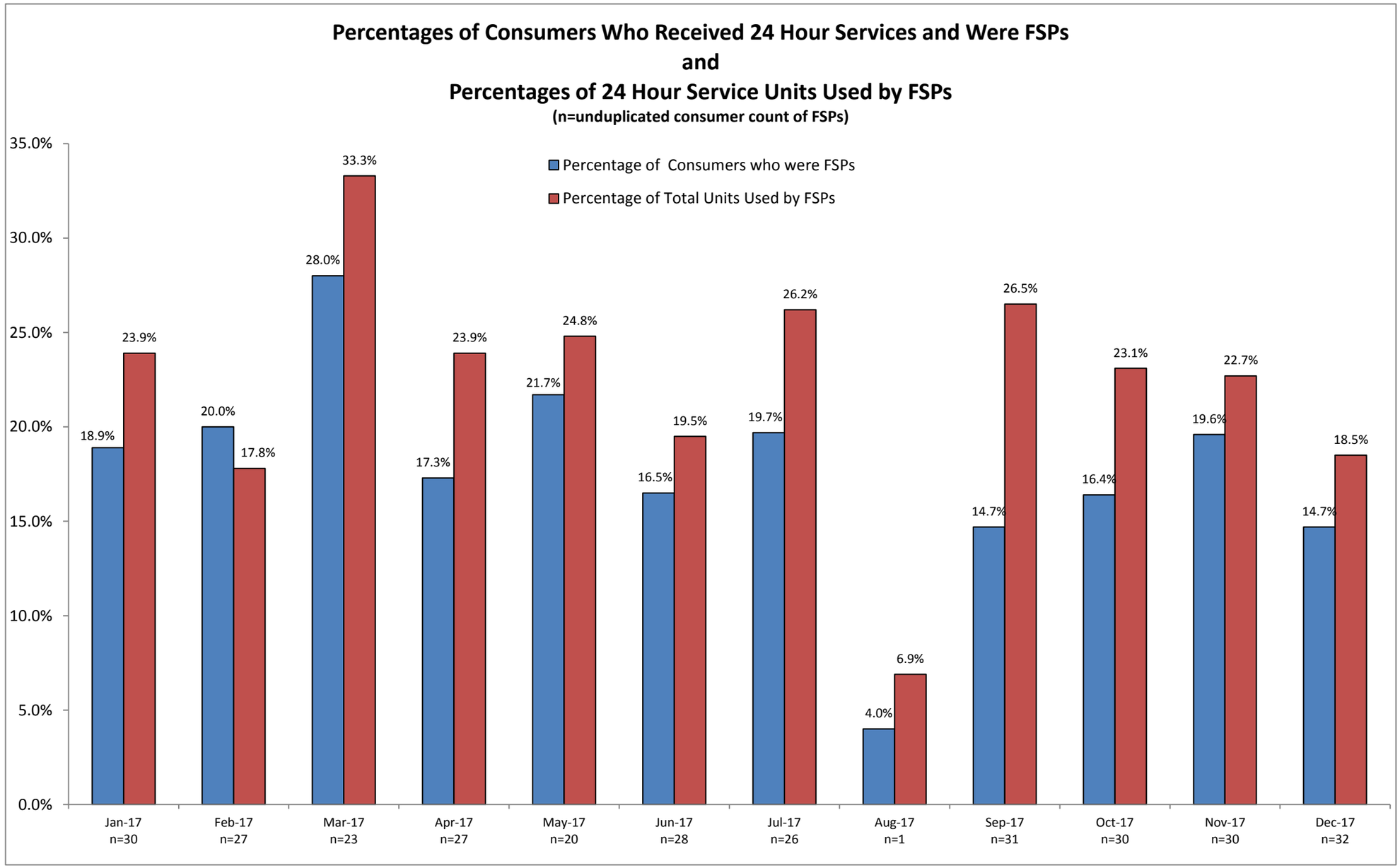
Data as of 10-27-2017



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

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

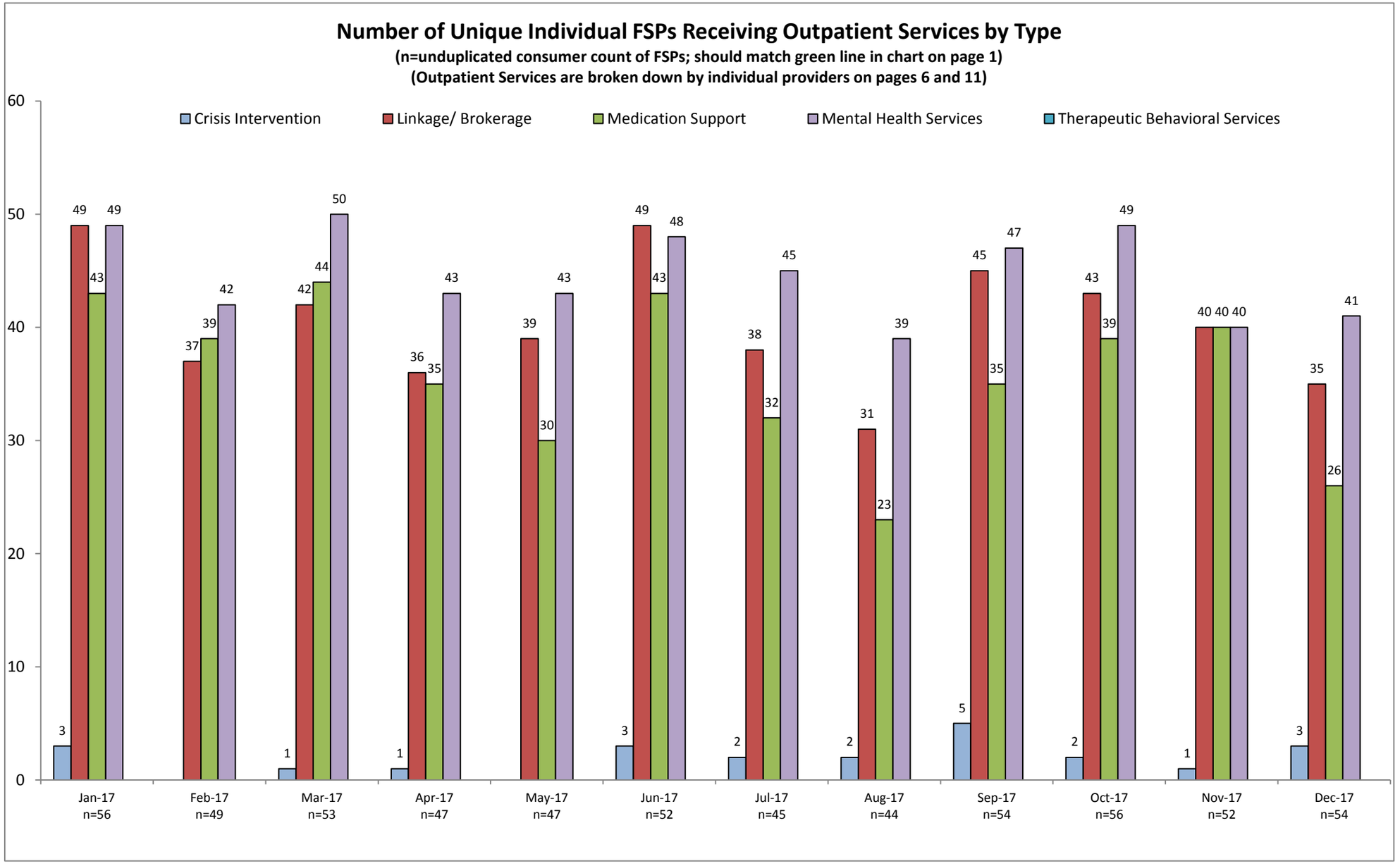
Data as of 10-27-2017



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

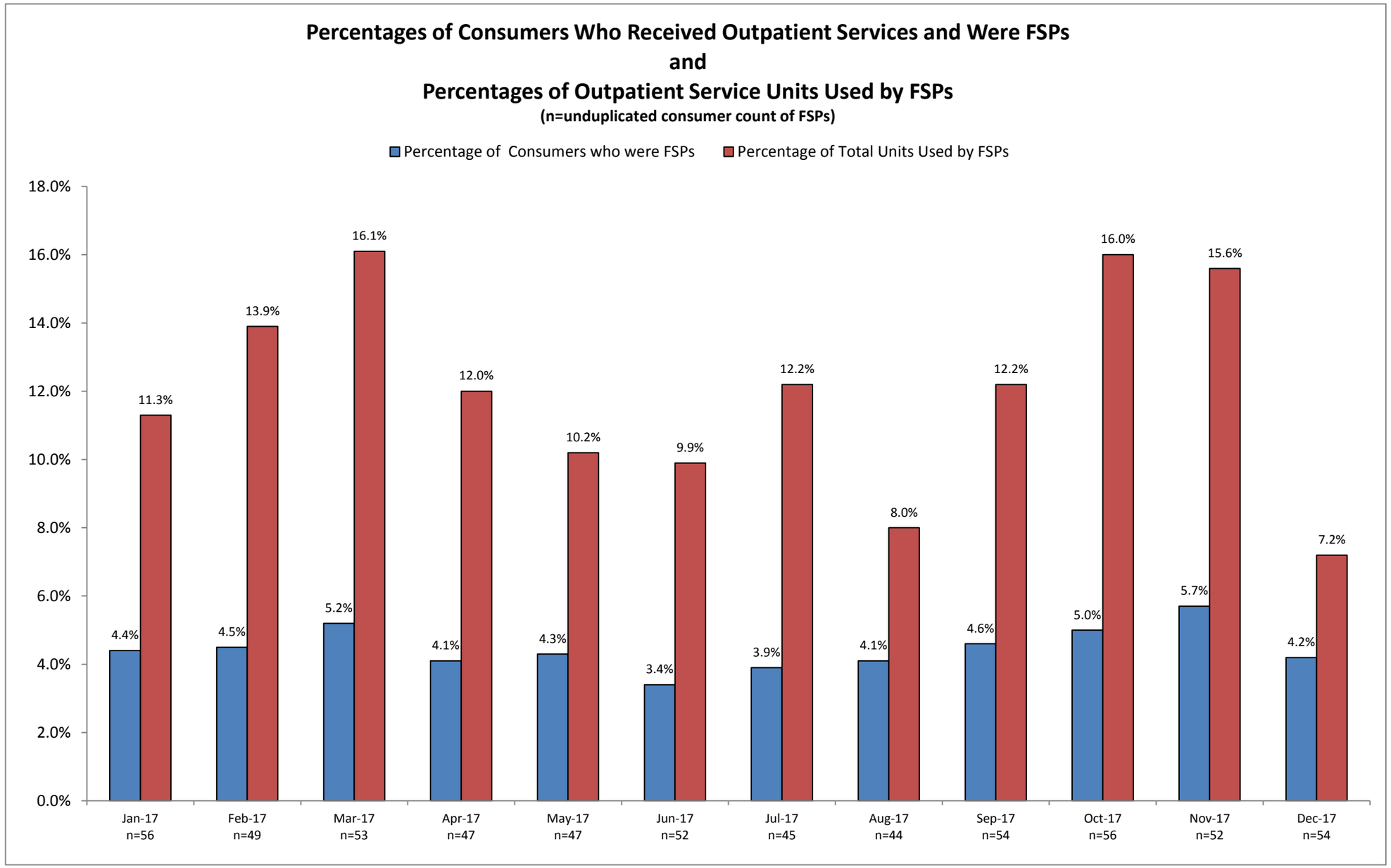
Because the Full Service Partnership program is designed to provide intensive services, it is expected that partners may utilize disproportionately more of the services than non-partner consumers.

Data as of 10-27-2017



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

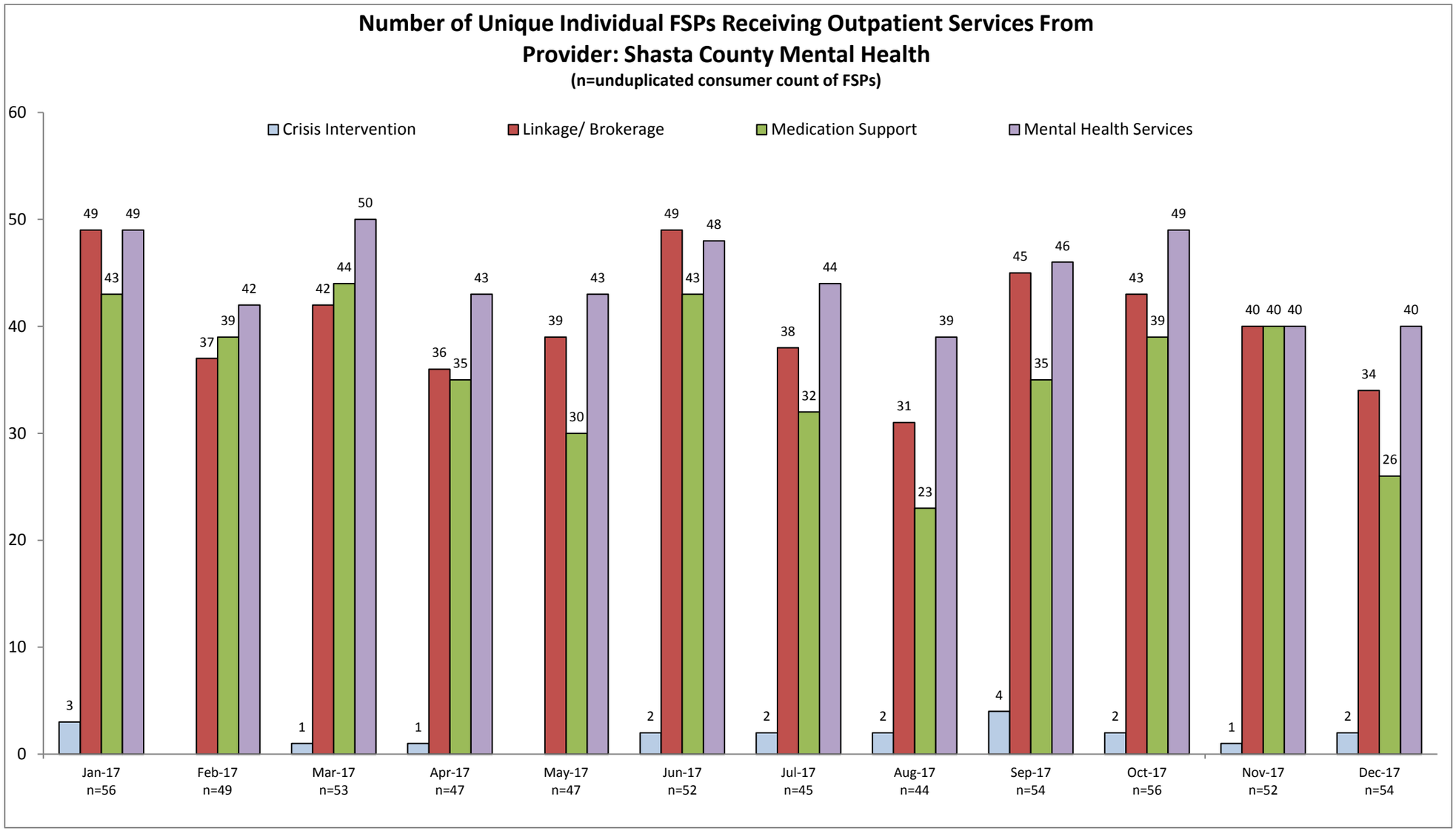
The bars above each month show how many of those unduplicated Full Service Partners received each type of Outpatient Service. Because consumers can, and often do, received more than one kind of service in any given month, the numbers for the services types each month may add up to more than the number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



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

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

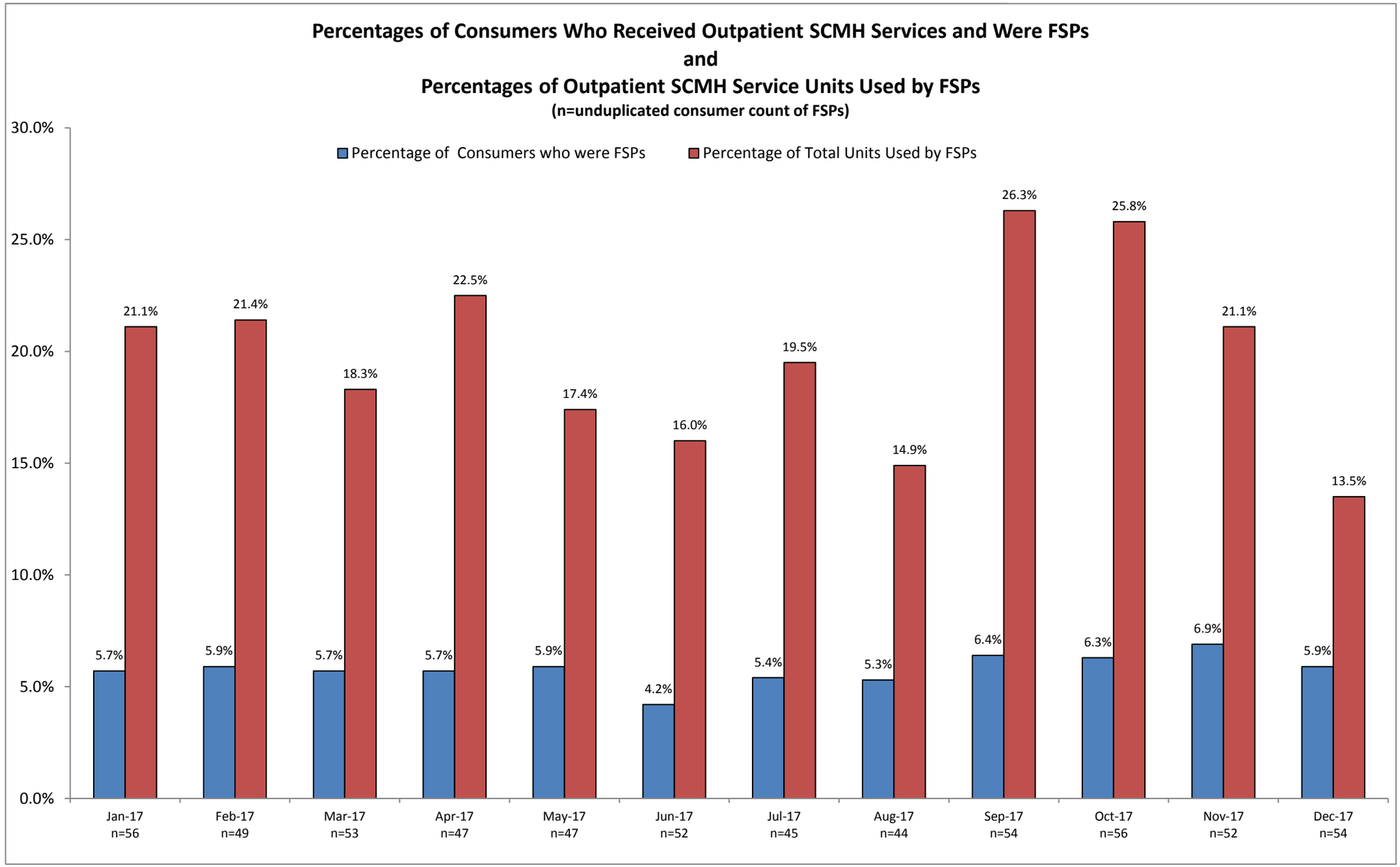
Data can be further narrowed down into specifics regarding who provided the services. Based on this, the following charts split out both Outpatient and 24 Hour Services into those provided by Shasta County Mental Health (SCMH) and those provided by outside vendors.



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

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

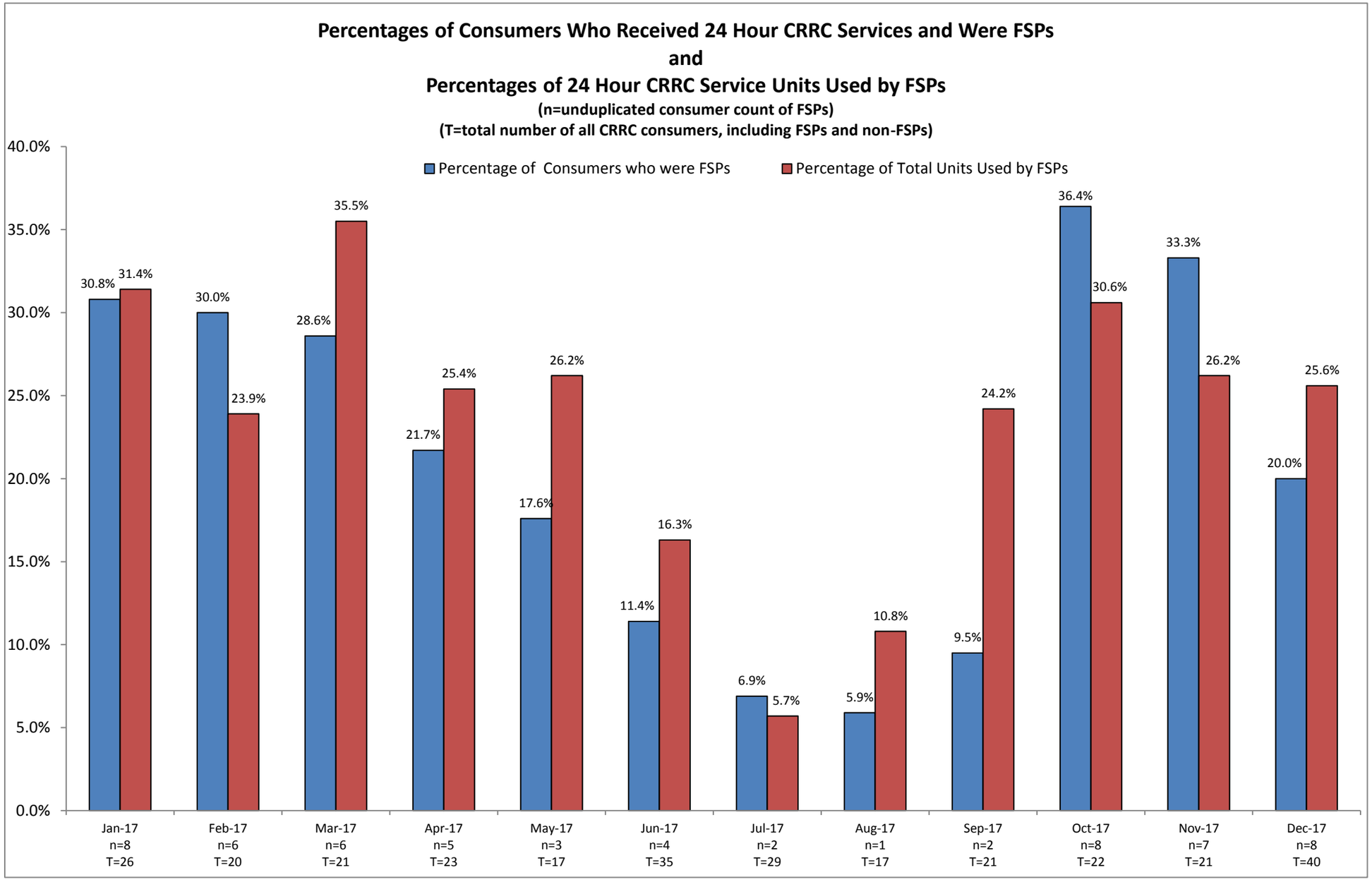
Data as of 10-27-2017



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

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

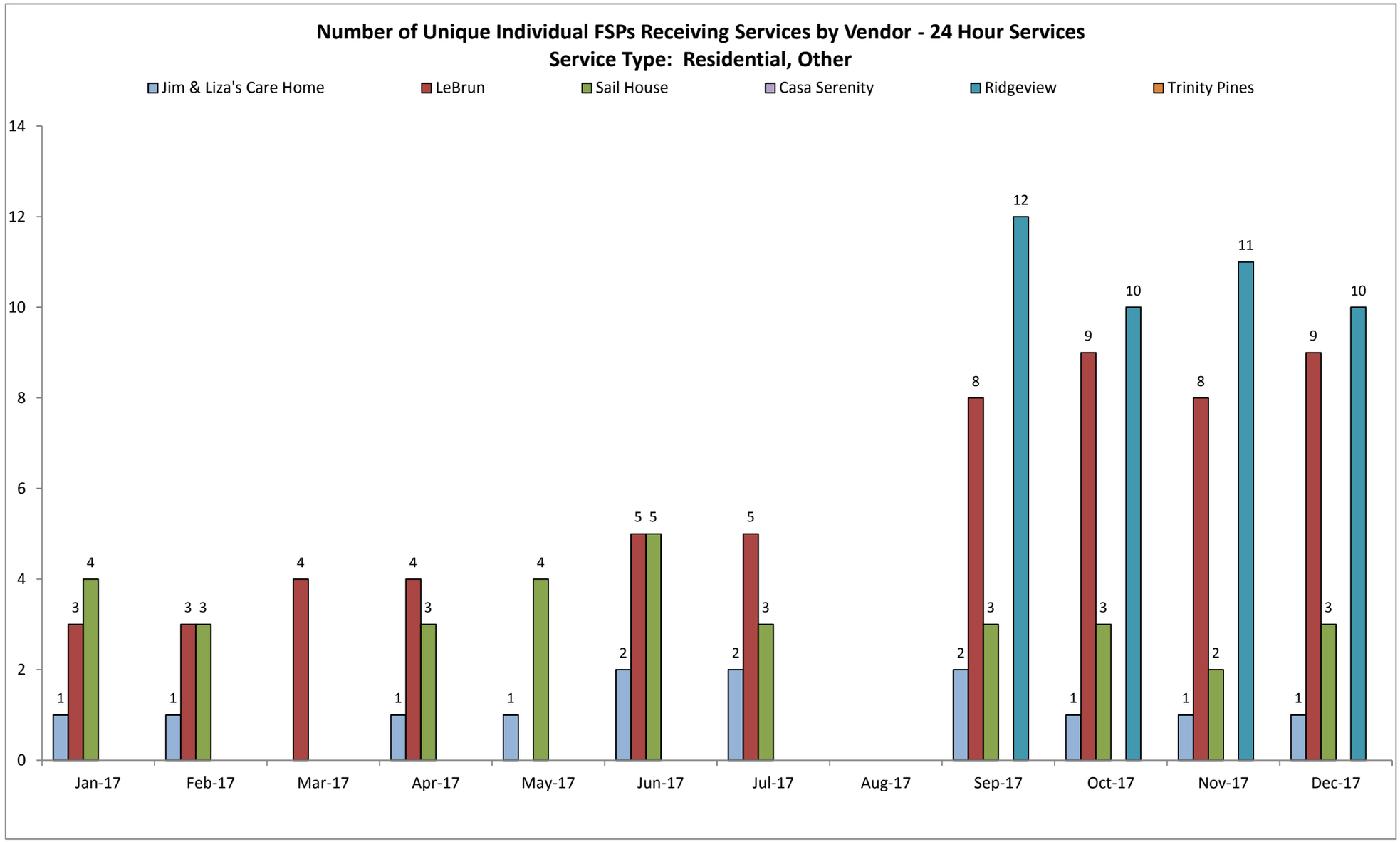
Data as of 10-27-2017



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

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

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

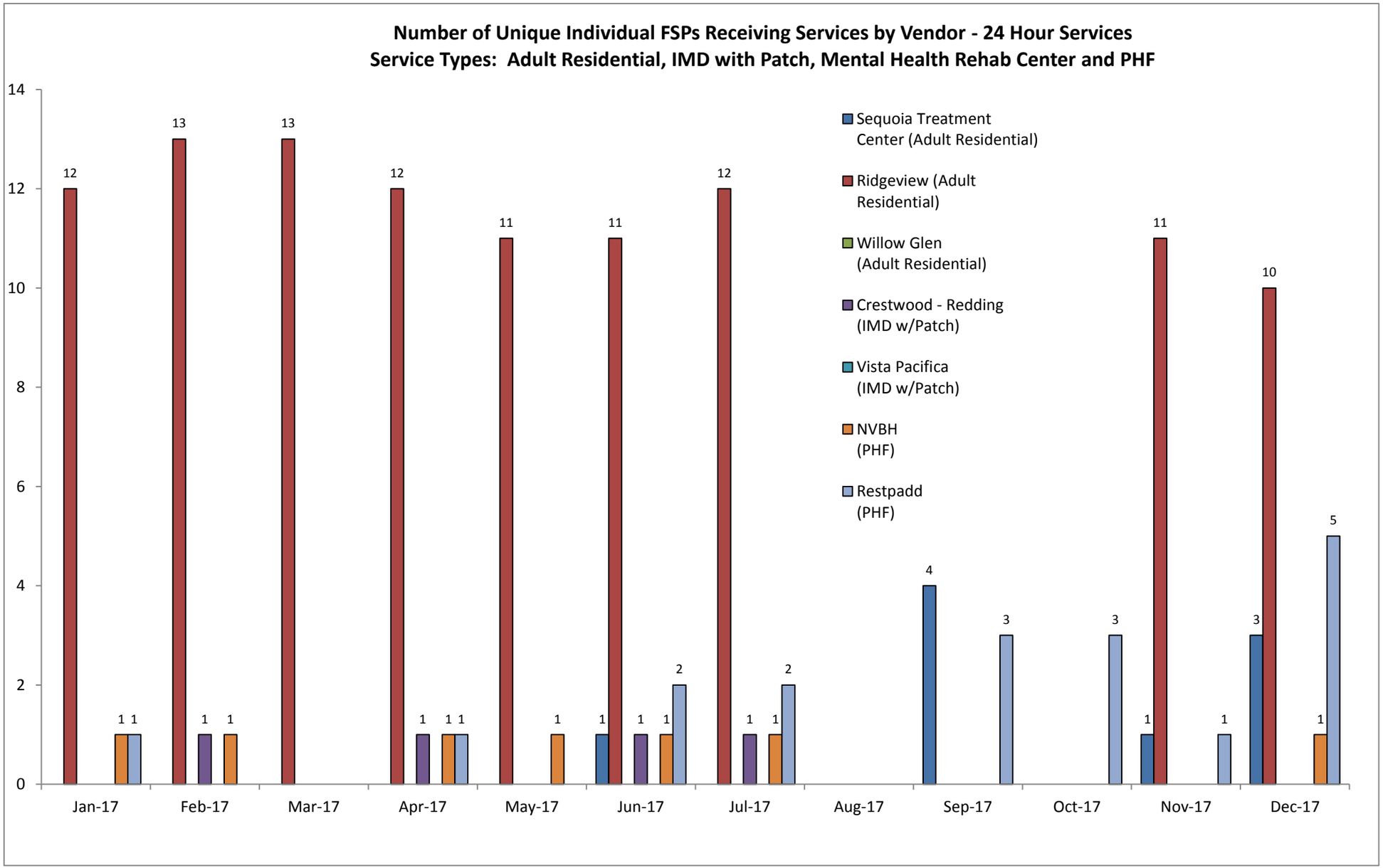


Data as of 10-27-2017

This chart shows how many unduplicated Full Service Partners each individual vendor providing 24 Hour "Residential-Other" Services reported serving. All these vendors appear to be some level of Board and Care setting.

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

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

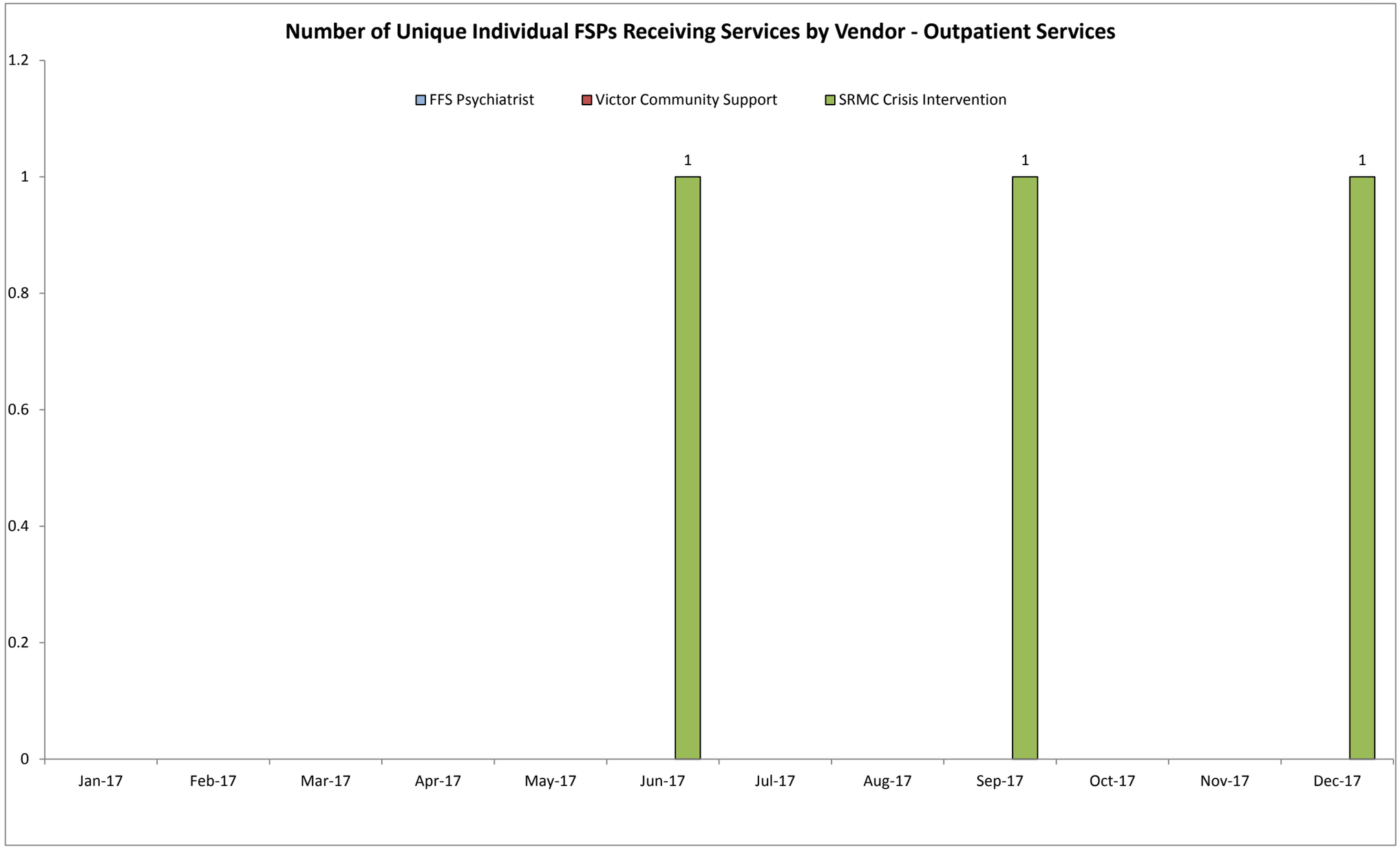


This chart shows how many unduplicated Full Service Partners each individual vendor providing all other 24 Hour Services reported serving. All these vendors appear to be providing services at a higher level of care than a standard Board and Care facility.

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

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

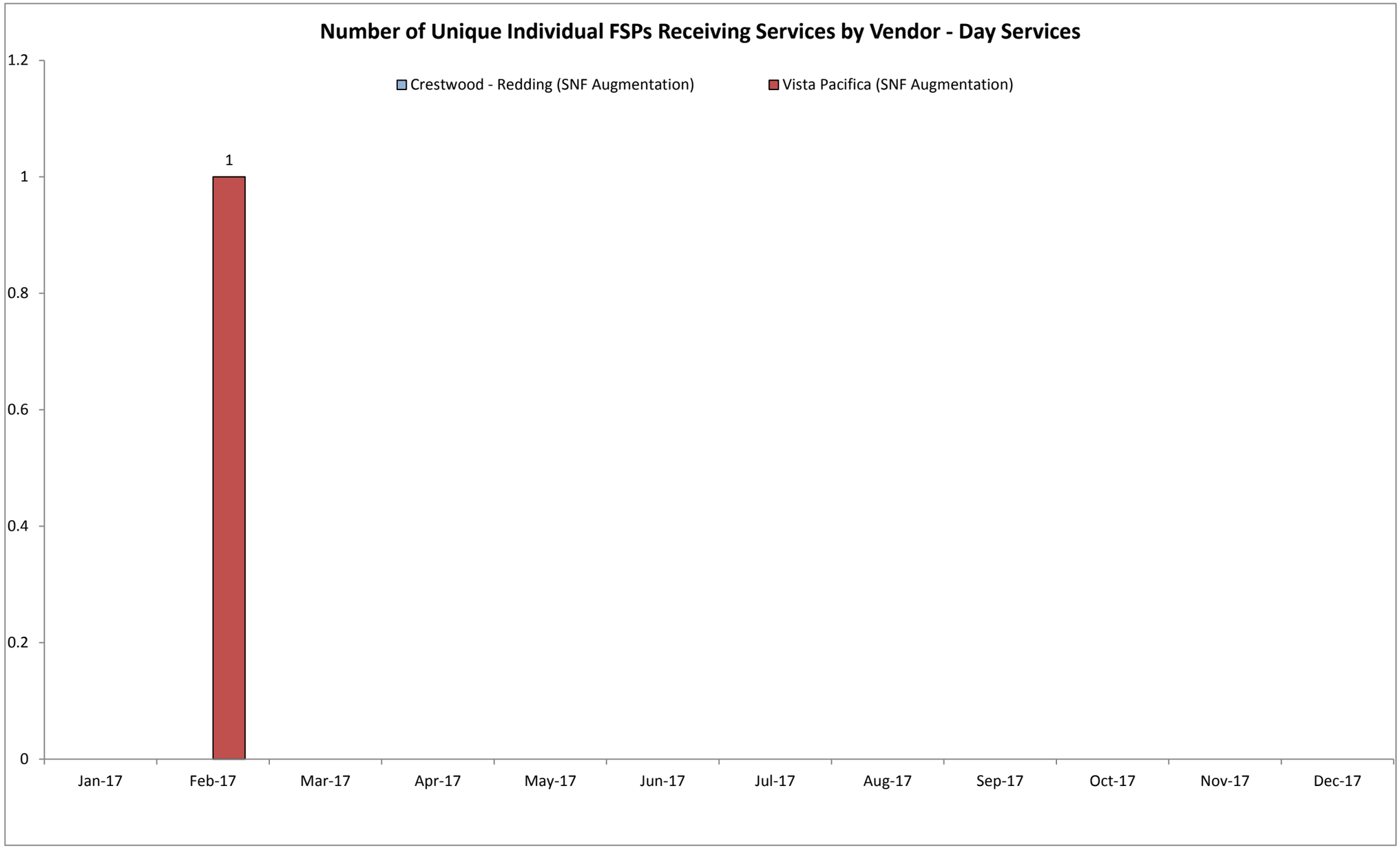
Data as of 10-27-2017



This chart shows how many 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.

Data as of 10-27-2017



This chart shows how many 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.

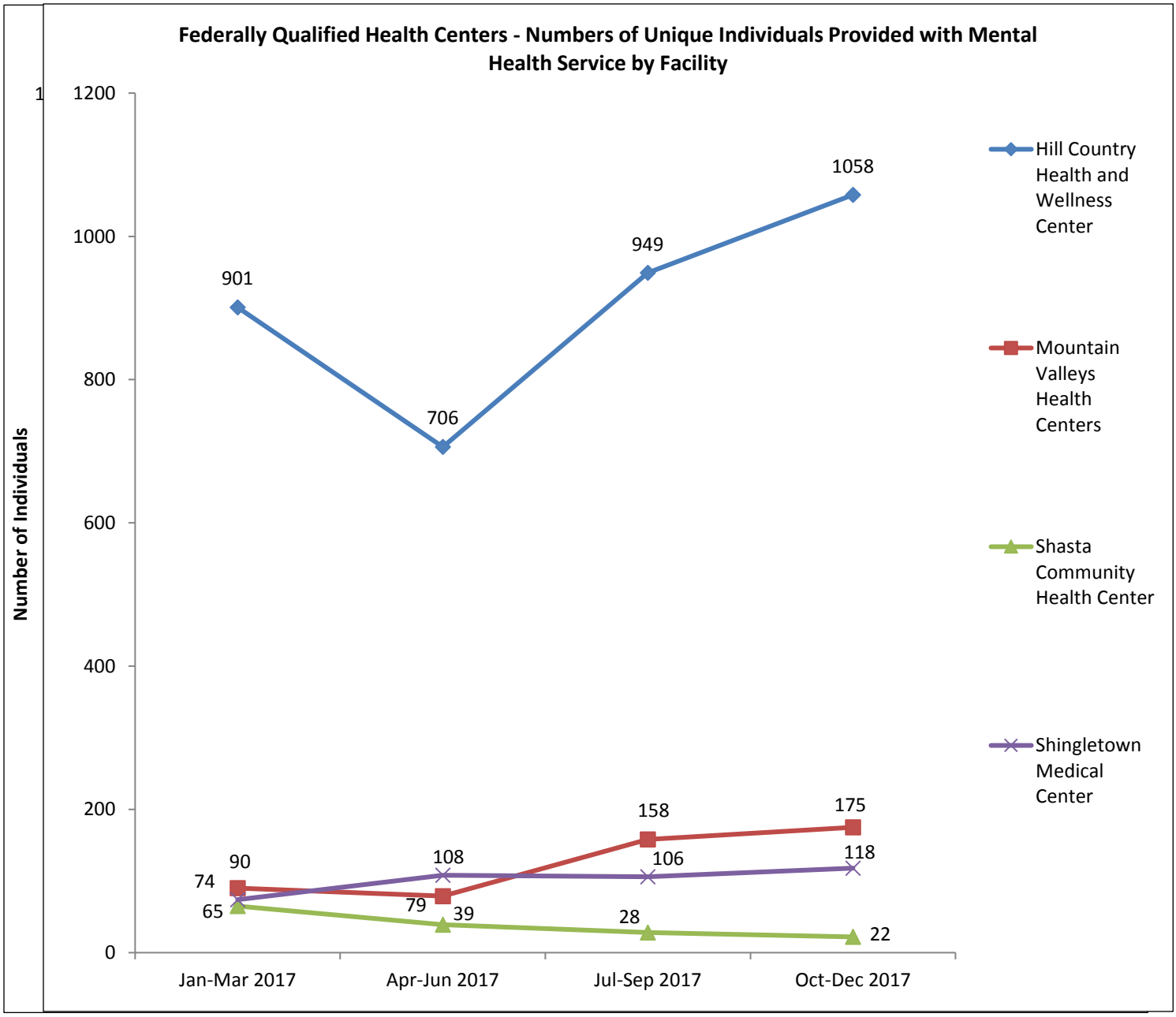
Federally Qualified Health Centers Annual Summary Report

January 2017 through December 2017

In order to better provide access to mental health services in Shasta County, the Shasta County Health and Human Services Agency has contracted with four different Federally Qualified Health Centers (FQHCs) to provide new or expanded mental health services, integrate mental health services with existing mental health and medical services provided by the FQHCs, and strengthen the relationship between the FQHCs and the County's public mental health system. Funding is provided through the Mental Health Services Act (MHSA). Shasta County had four federally qualified health centers in operation during 2017: 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.

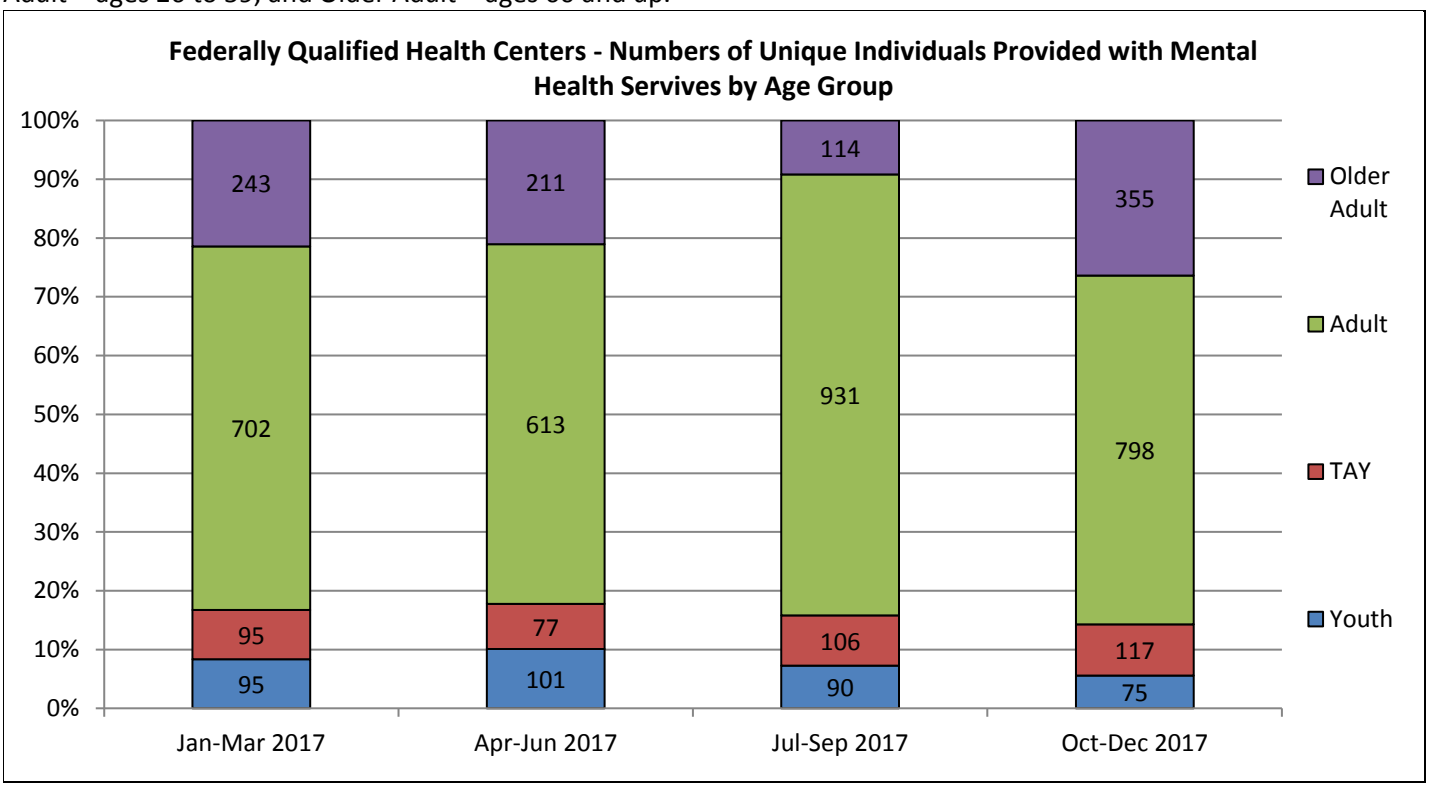
Attendance

An average of 1169 people visited a federally qualified health center in 2017. This is an 8.64% increase from the previous year.

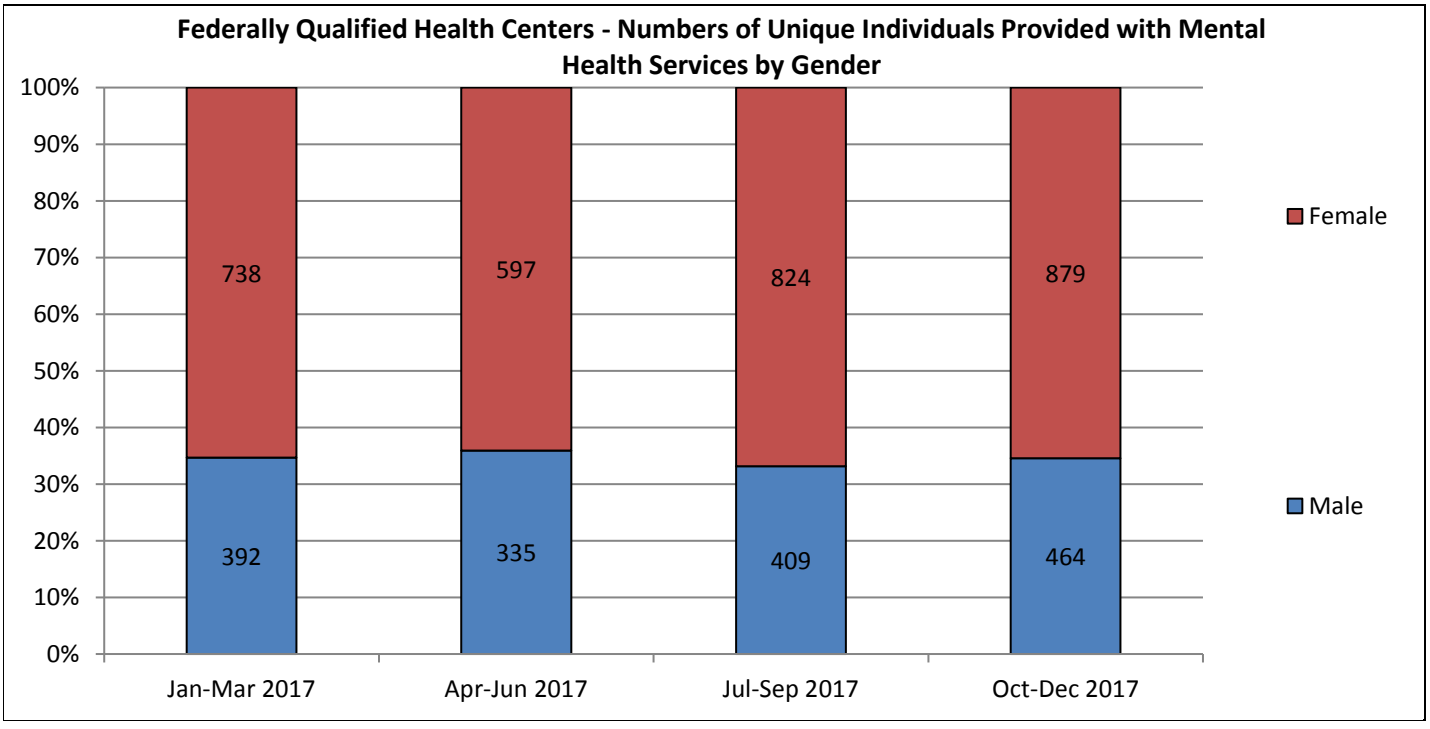


Demographics

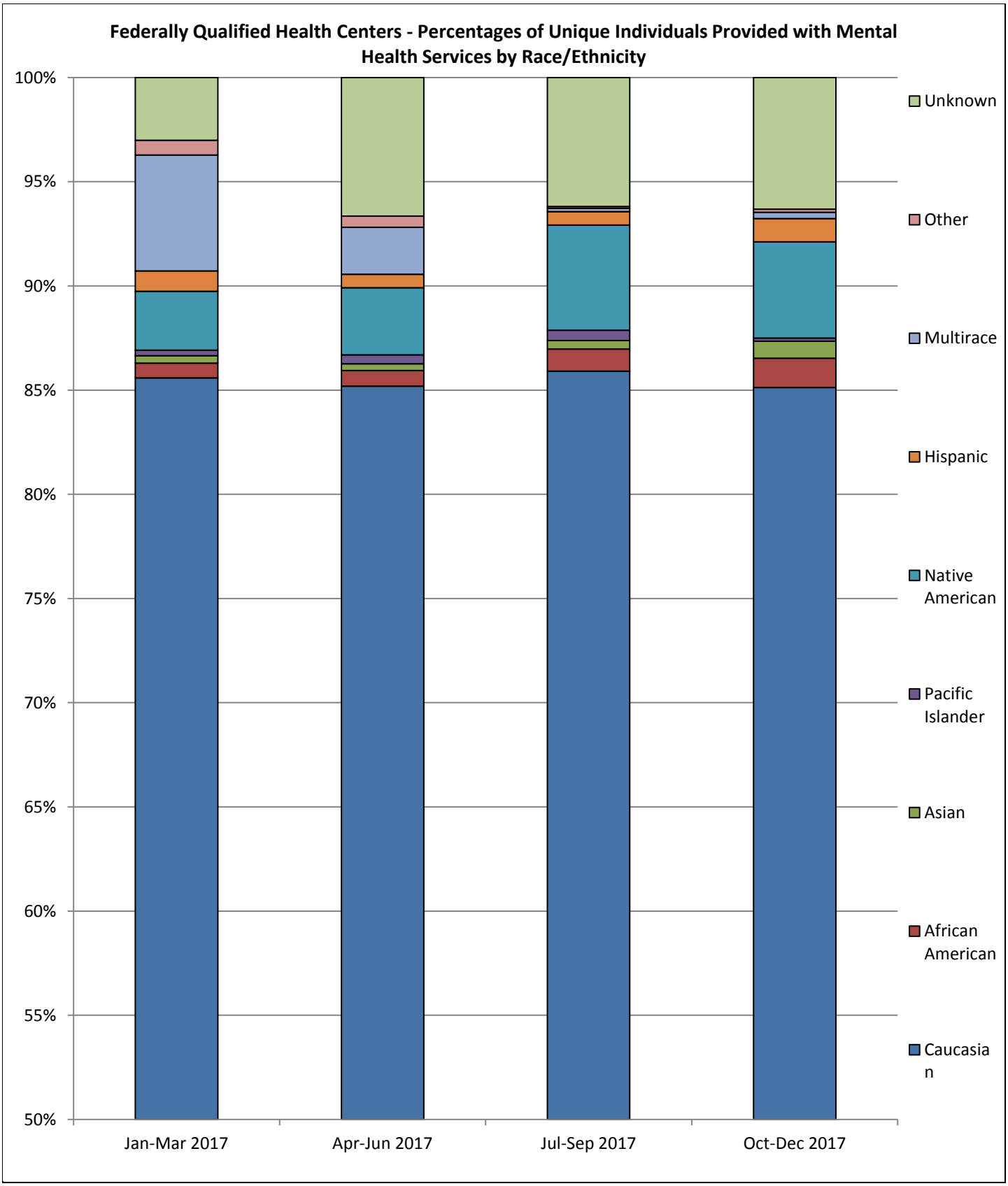
Age - The MHSA uses four age categories: Youth – ages 0 to 15, Transitional Aged Youth (TAY) – ages 16 to 25, Adult – ages 26 to 59, and Older Adult – ages 60 and up.



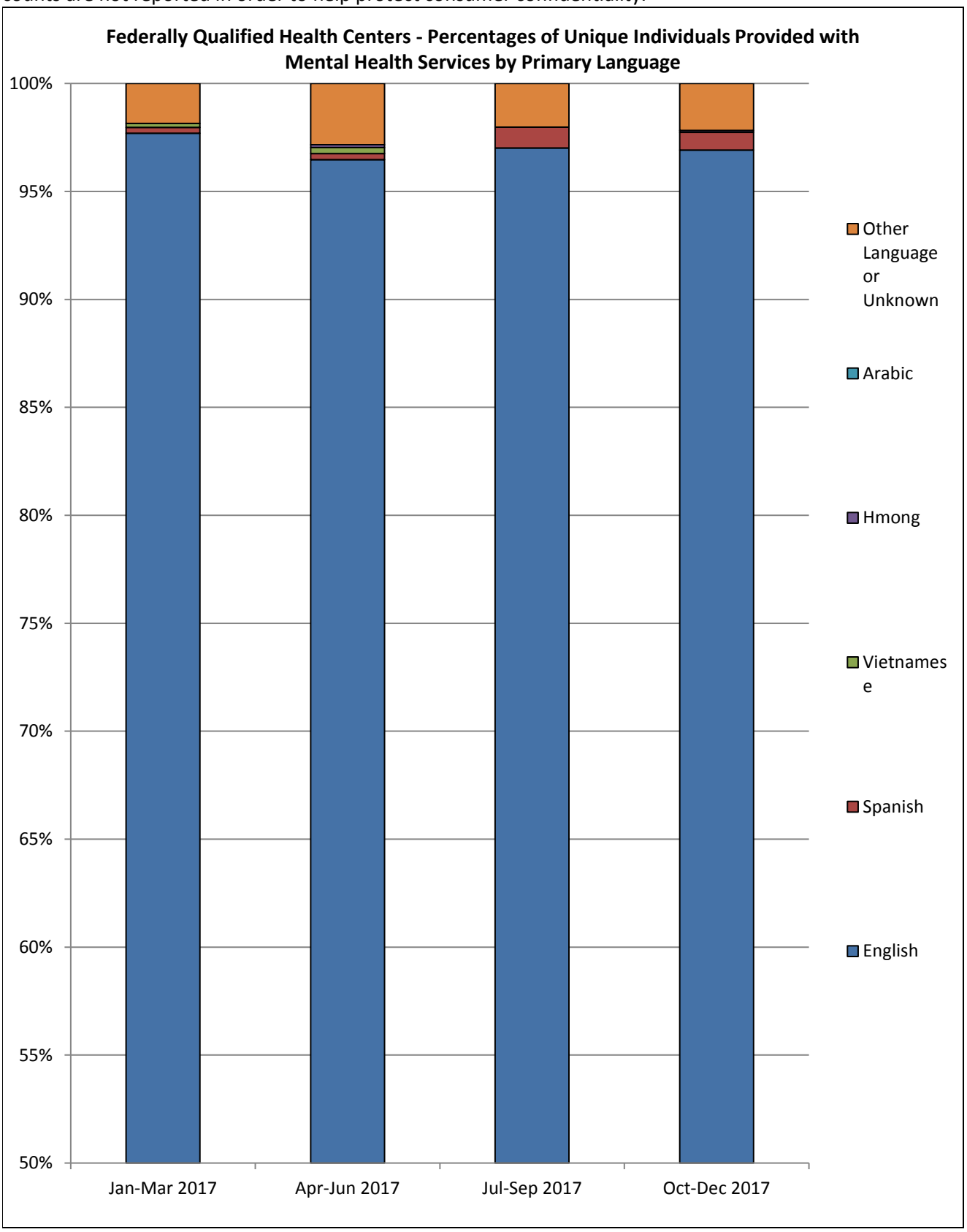
Gender - The MHSA uses four gender categories: Male, Female, Transgender, and Other. Counts of less than 20 individuals are not labeled, in order to help maintain consumer confidentiality, but are included in the chart. No data from any of the facilities was reported for the categories of Transgender or Other, so they are not included on 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.

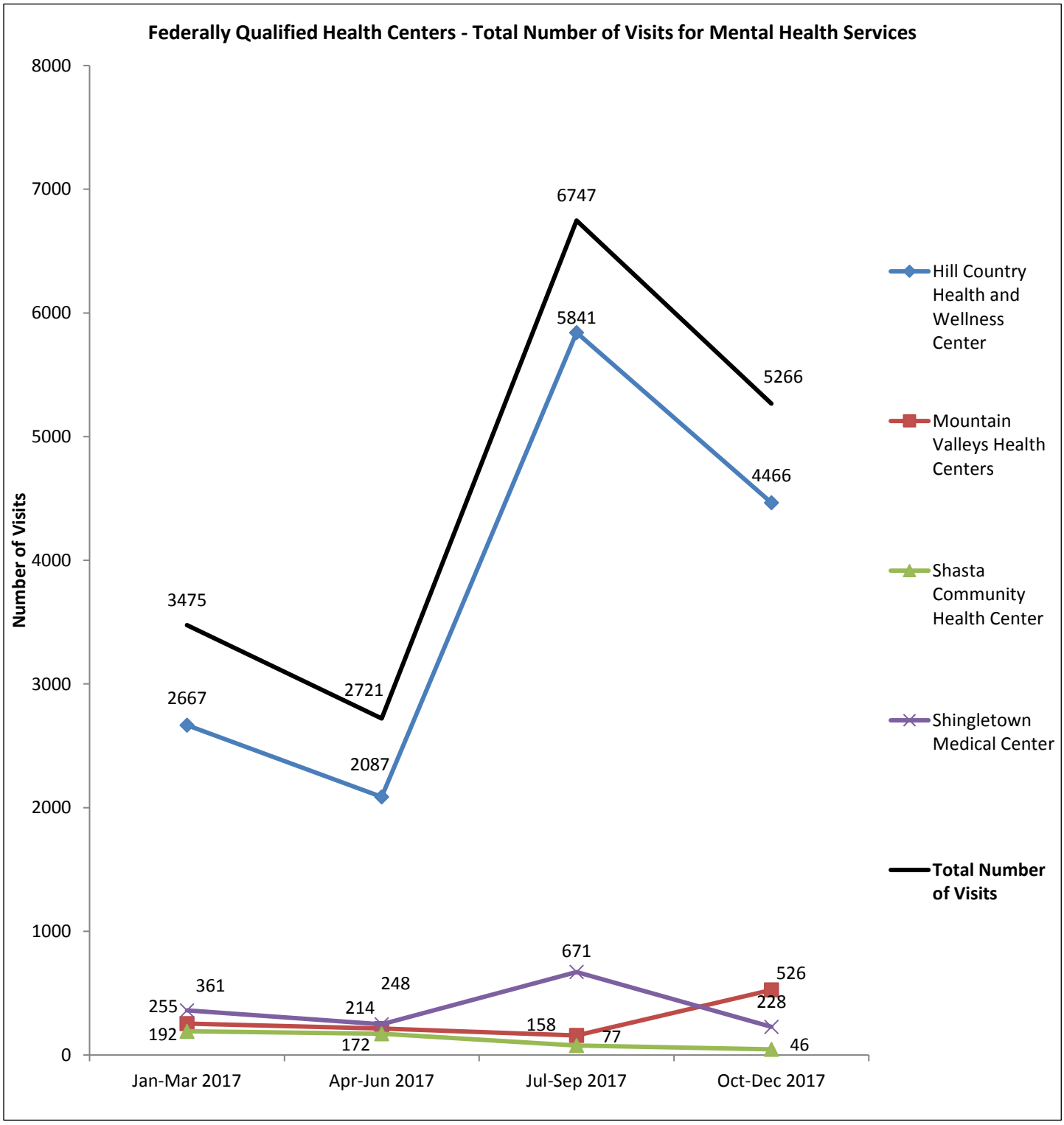


Primary Language - Because of the low gross numbers for some of these languages within small communities, actual counts are not reported in order to help protect consumer confidentiality.



Services Provided

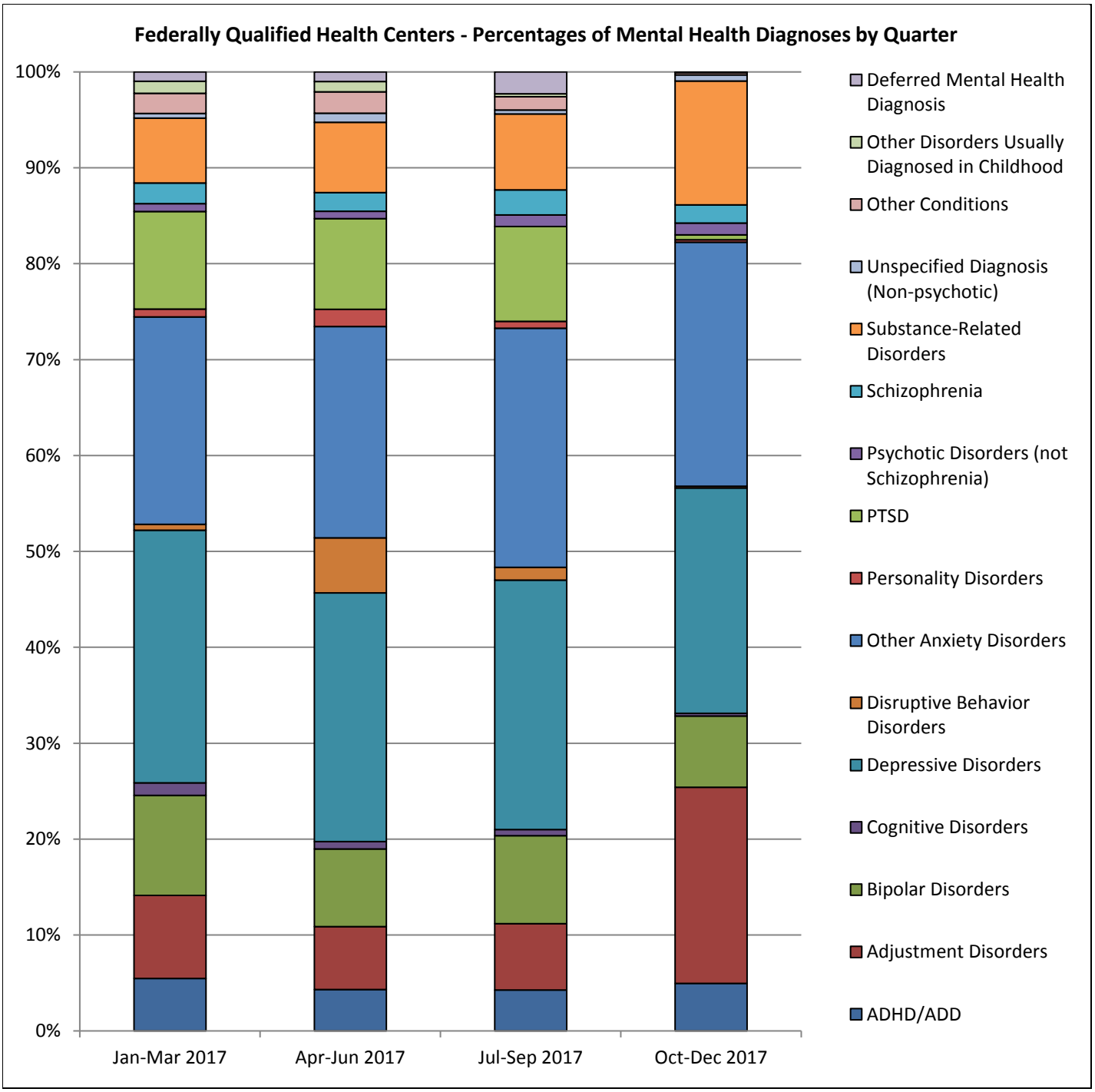
Most people will have multiple visits to the FQHC each quarter, and different types of service may be offered at different times in order to provide everyone with comprehensive and integrated age appropriate mental health services. Services provided may include such things as screenings, assessments, medication management, and individual or group psychotherapy sessions. For 2017, there were a total of 18,209 visits to a federally qualified health center for some type of mental health service. This is a 22.44% increase from the previous year.



Primary Mental Health Diagnosis

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

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



Shasta County Mental Health, Alcohol and Drug (SCMHAD)
Crisis Residential and Recovery Center (CRRC) Program Activity Through December 2017

Bolded and underlined numbers represent the highest number during the fiscal year. Bolded and italicized numbers represent Crestwood Elpida data. There were 14 CRRC admits in December, an 8% increase from November, and a 180% increase from the same month of the prior fiscal year. The CRRC bed days of 329 for December was a 27% increase from November, and a 174% increase over December of last year. The average length of stay during December was 24 days, an increase of 20% from last month, but no change from the same month in the previous year.

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

FY	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total*	Change +/-**
2017-18	***17***	13	12	12	13	14							**81**	-47%
2016-17	16	17	5	16	14	5	16	8	***22***	11	10	13	**153**	-13%
2015-16	18	9	15	20	14	11	12	15	10	***21***	11	19	**175**	-5%
2014-15	17	***23***	17	14	15	12	17	13	14	10	14	19	**185**	-1%
2013-14	17	17	19	19	12	15	***21***	6	19	15	10	16	**186**	-27%
2012-13	26	***28***	21	25	24	19	17	22	18	17	19	20	**256**	-3%
2011-12	24	23	27	20	11	23	21	22	***29***	18	22	25	**265**	-2%
2010-11	20	26	23	23	21	23	22	19	23	19	***30***	21	**270**	-6%
2009-10	24	26	25	27	***29***	15	23	24	27	20	22	24	**286**	-24%
2008-09	31	35	34	34	31	26	27	29	37	24	28	***39***	**375**	1%

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

FY	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total*	Change +/-**
2017-18	204	165	187	204	260	***329***	0	0	0	0	0	0	**1349**	**-49%**
2016-17	295	280	201	185	291	120	242	199	167	228	130	***314***	**2652**	-7%
2015-16	236	224	244	***342***	301	266	194	217	178	215	193	229	**2839**	-5%
2014-15	***345***	268	280	235	235	186	284	239	174	246	192	304	**2988**	-3%
2013-14	274	231	255	295	136	207	333	311	212	***335***	242	243	**3074**	-14%
2012-13	315	341	321	310	344	***361***	248	259	296	308	213	274	**3590**	20%
2011-12	216	202	296	***329***	209	196	247	191	279	291	267	268	**2991**	2%
2010-11	193	254	250	290	278	231	***307***	192	203	165	302	280	**2945**	-10%
2009-10	***356***	272	323	319	311	199	231	266	245	241	238	267	**3268**	-12%
2008-09	330	300	301	248	270	276	318	319	***366***	310	312	350	**3700**	50%

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

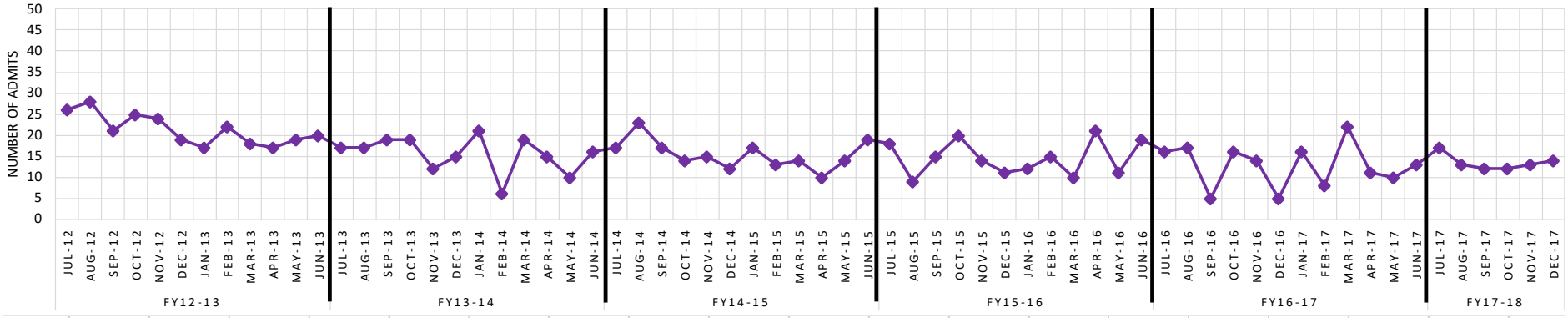
FY	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY Avg. LOS	Change +/-**
2017-18	12	13	16	17	20	***24***							**17**	-14%
2016-17	18	16	***40***	12	21	24	15	25	8	21	13	24	***20***	16%
2015-16	13	***25***	16	17	22	24	16	14	18	10	18	12	**17**	7%
2014-15	20	12	16	17	16	16	17	11	12	***25***	14	16	**16**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

* Current Fiscal Year is a projected yearend total.

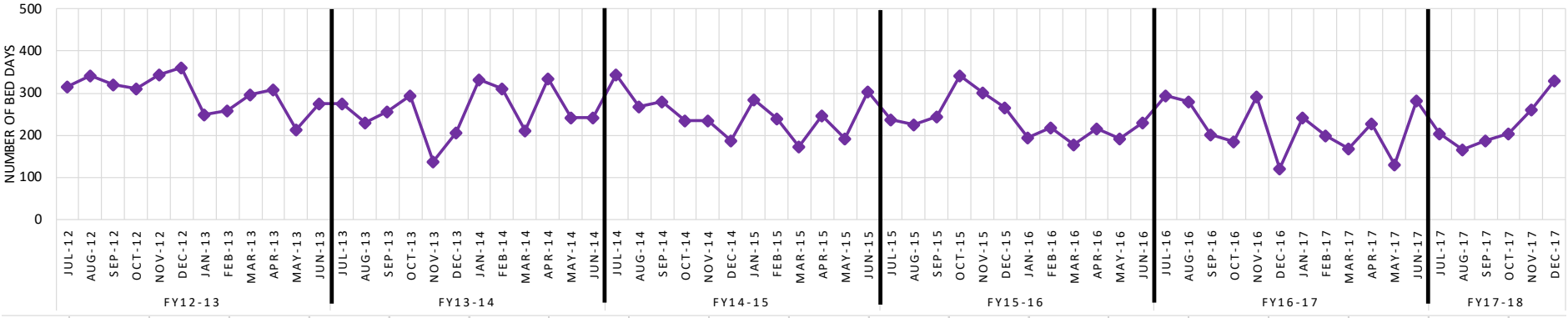
** Change +/- is calculated based on the prior Fiscal Year comparison to Current Fiscal Year.

Data as of: 1/15/18

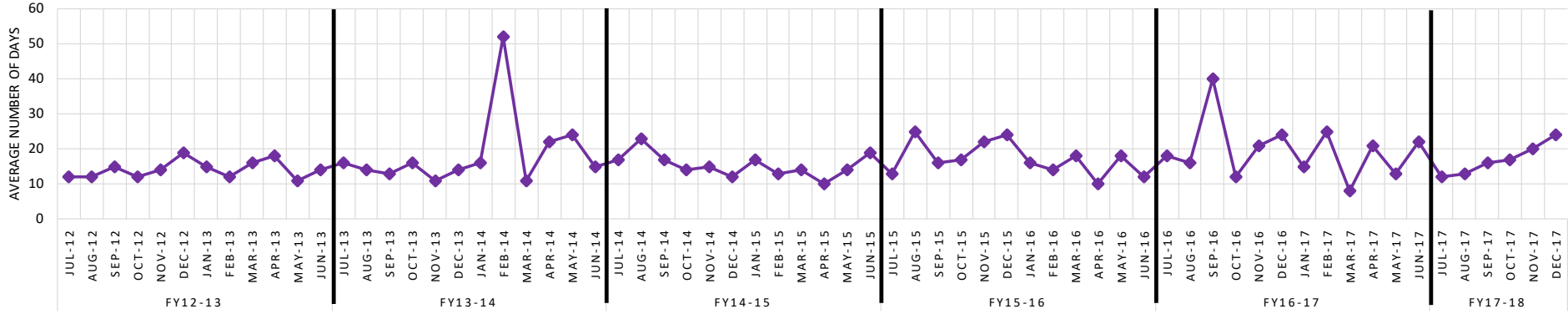
CRISIS RESIDENTIAL - NUMBER OF ADMITS BY MONTH



CRISIS RESIDENTIAL - TOTAL BED DAYS BY MONTH



CRISIS RESIDENTIAL - AVERAGE LENGTH OF STAY BY MONTH



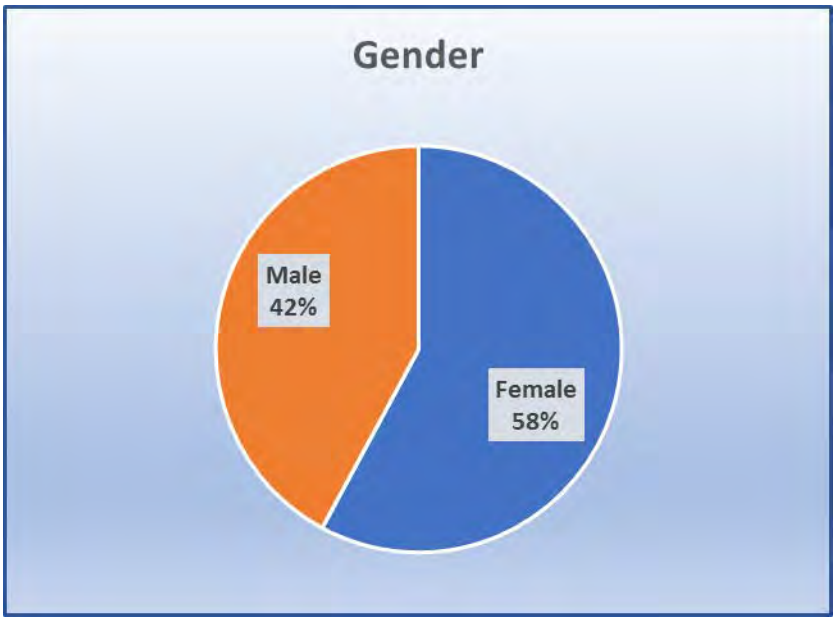
Length of stays are rounded numbers

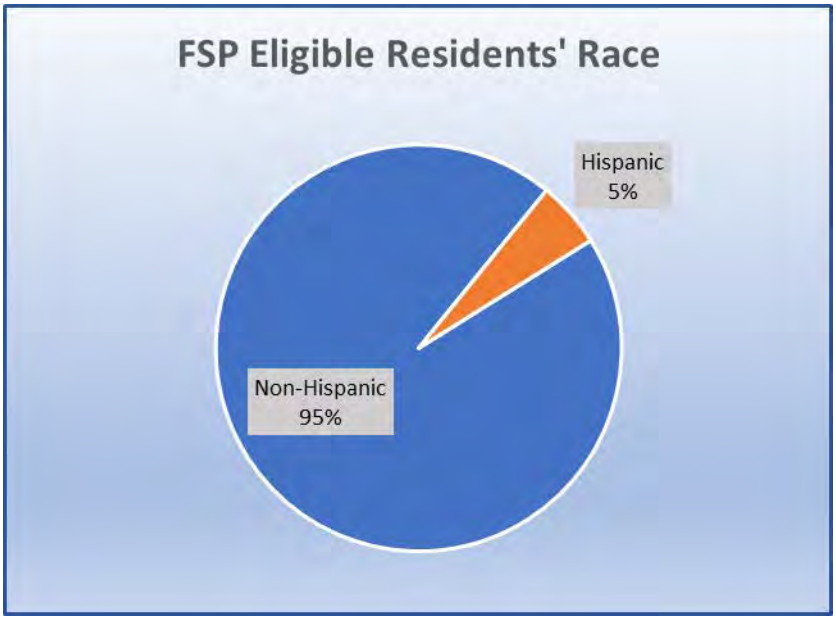
Data as of: 1/15/18

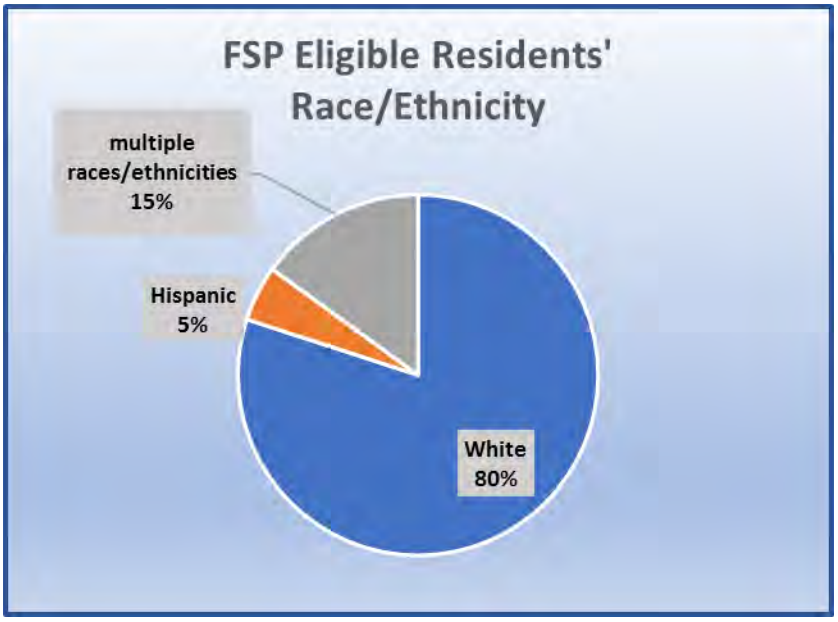
The Woodlands Permanent Supportive Housing
Demographics

All 19 apartments must have a person who is eligible for Full Service Partnership services. There are 34 people who live in these 19 units, and residents must have a severe and persistent mental illness (or a child with serious emotional disturbance), and have been homeless or at risk of homelessness.

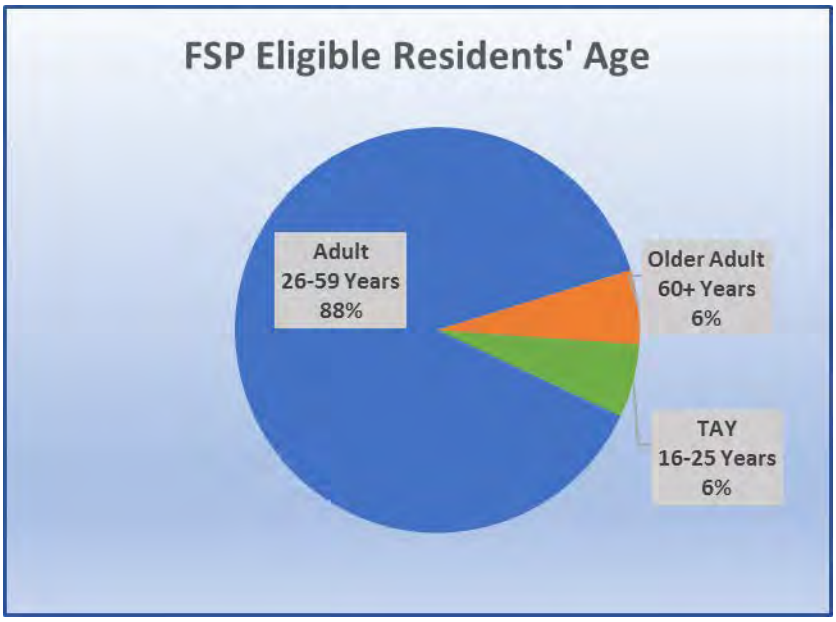
Below is a summary of the demographics of the people who live in these 19 units:







MHSA clients are grouped by different age categories. Child 0-15 years, Transitional Age Youth (TAY) 16-25 years, Adult 26-59 years and Older Adults 60+ years.



MHSA tenants have been making progress towards living in a community and are starting to adjust to the challenges that face them to keep striving towards independence.

Appendix J

Triple P – Shasta County

Triple P Program Performance Dashboard Report
2017 Data Submission
Prepared by Shasta County Health and Human Services Agency

This aggregate program performance dashboard report describes caregivers who participated in Triple P programs in Shasta County. This data is entered into the Shasta County Scoring Application reflecting caregivers served for 2017.

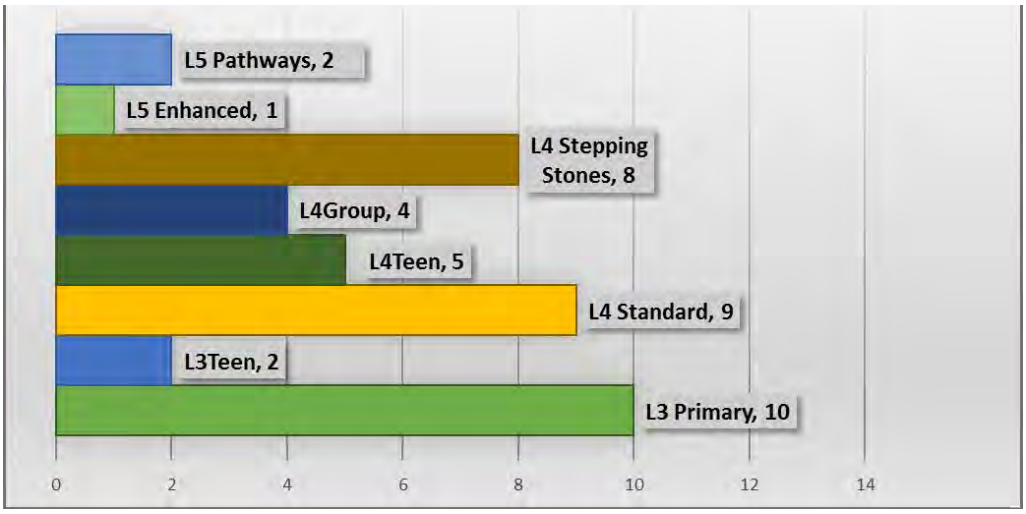
This dashboard report reflects a total of **497 Triple P caregivers** served in Shasta County, representing **395 children**. This signifies the addition of **394** new caregivers representing **313** children for 2017.

Practitioners from these organizations/private practices entered data into the Shasta County Scoring Application and served caregivers in 2017:

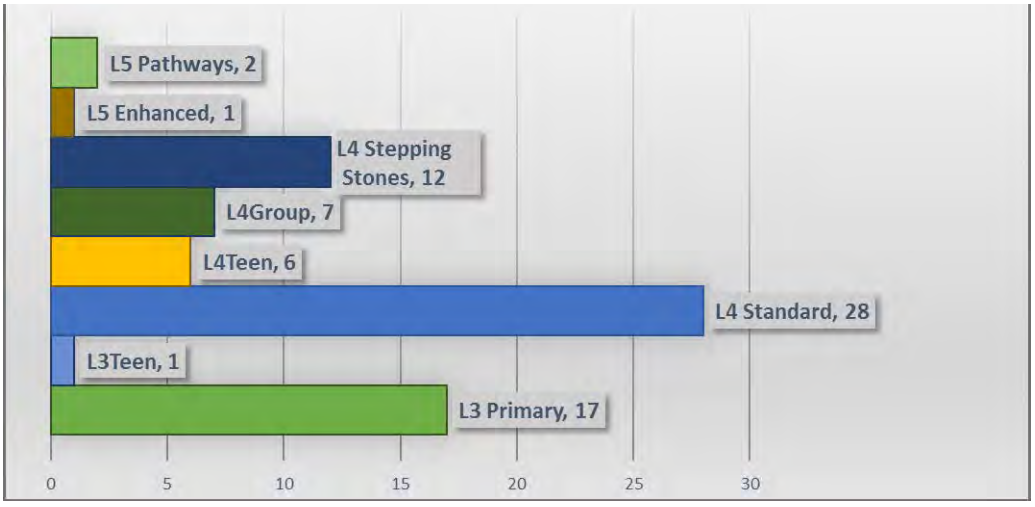
Table 1. Shasta County Triple P Programs Providing Data, 2017

Name of Organization	Number of Practitioners entering into Scoring Application 2017	Total Number of Caregivers receiving Triple P 2017
Bridges to Success/ Shasta County Office of Education: Early Childhood Services/VOICES	7	96
Child Abuse Prevention Coordinating Council of Shasta County (CAPCC)	5	25
Family Dynamics	6	97
Gateway Unified School District/Great Partnership	2	10
Northern Valley Catholic Social Service	7	59
Remi Vista	2	8
Right Road Recovery Programs	1	5
Shasta County Health & Human Services Agency: Children's Services	6	36
Tara Tate – Private Practice	1	8
Tri-Counties Community Network: Bright Futures	1	5
Victor Community Support Services	3	36
Wright Education Services	4	58
Youth and Family Programs	3	54

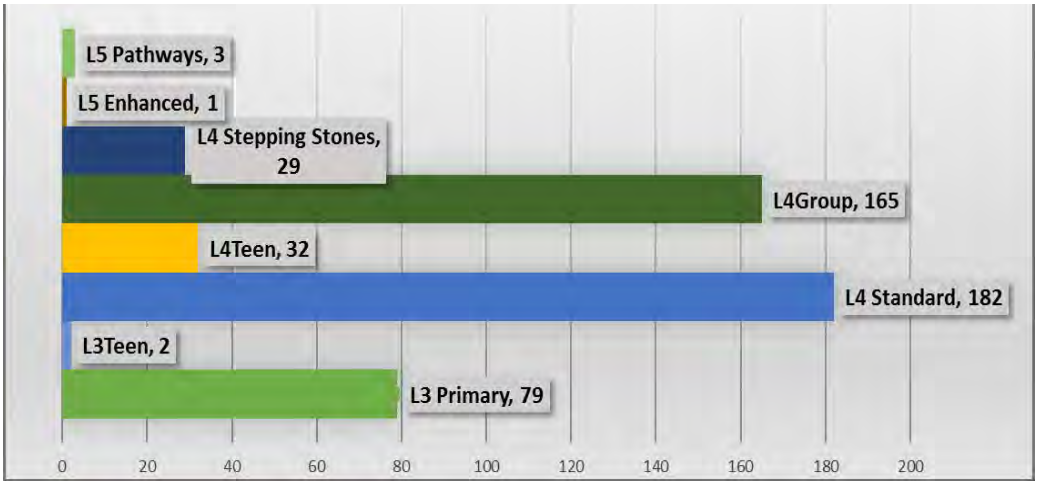
Thirteen organizations or private practice practitioners provided Triple P services in 2017. The chart below shows the number of organizations that provided the specific levels:



Of these 13 organizations, 44 practitioners provided Triple P services. Below is the number of practitioners that provided services in each level:

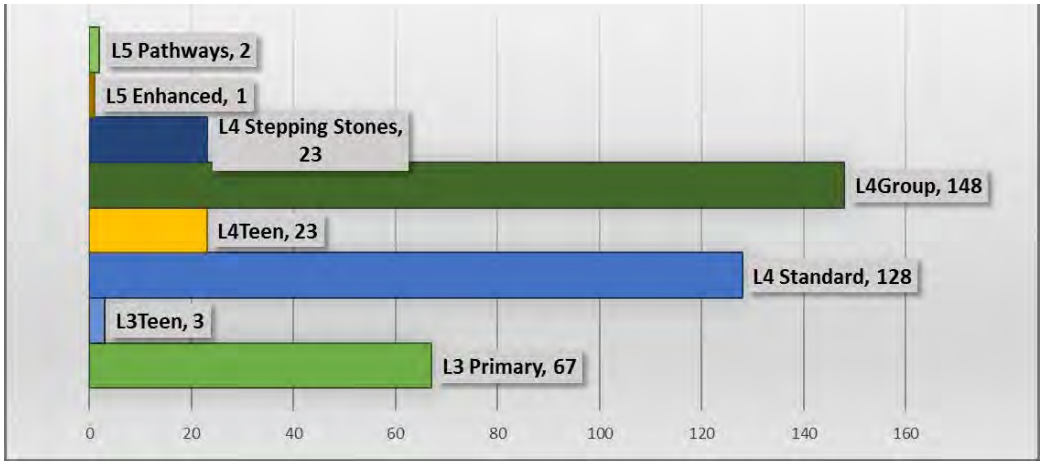


In 2017, 497 caregivers received Triple P services. The chart below shows the number of caregivers per level. Each caregiver is associated with a child, and there may be more than one caregiver per child:



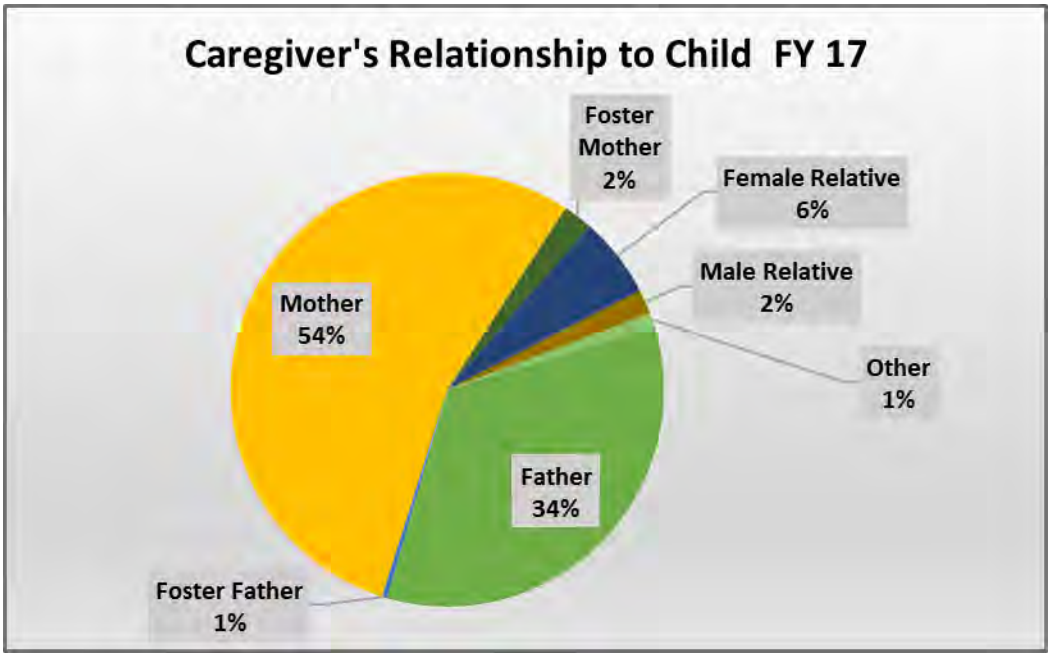
(Shasta County Scoring Application gives a point in time snapshot)

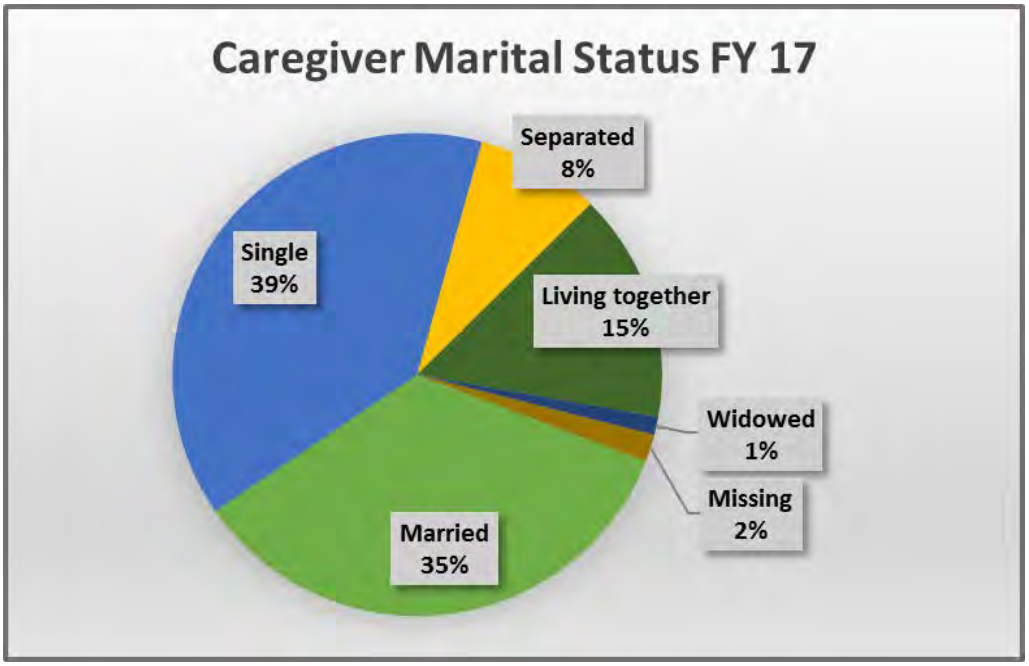
The total number of children represented by the caregivers in 2017 was 395. These levels were at a single point in time. There are instances where levels are changed as necessary types of help change.

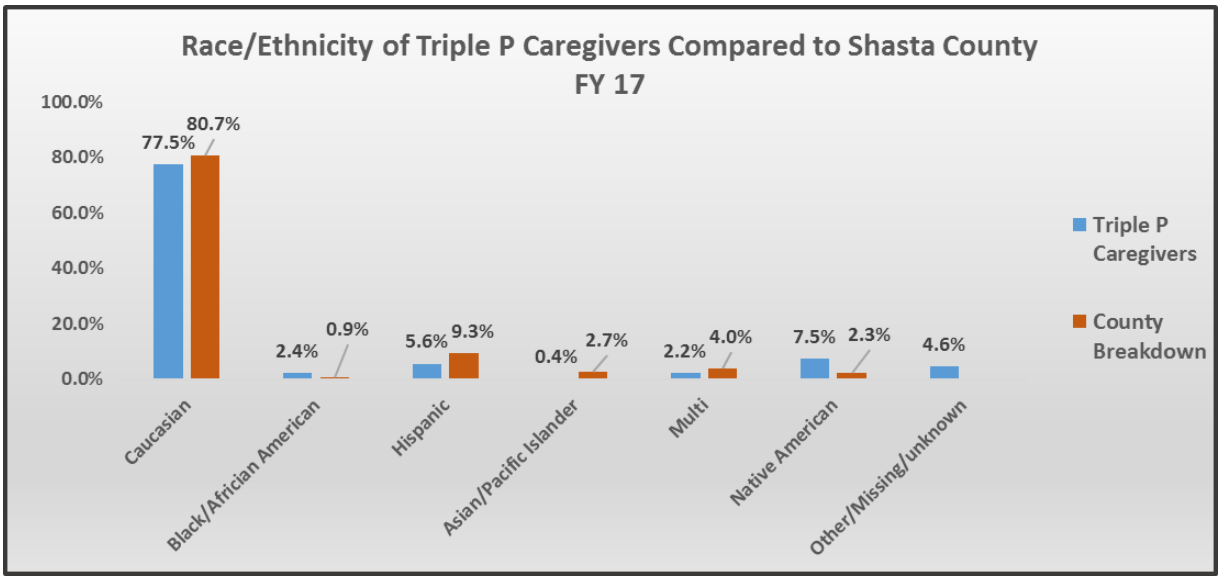


The largest group of children where caregivers are receiving Triple P services is 0-5 years (210 children), followed by ages 6-12 (156) and ages 13-18 (29). The average age is 6.

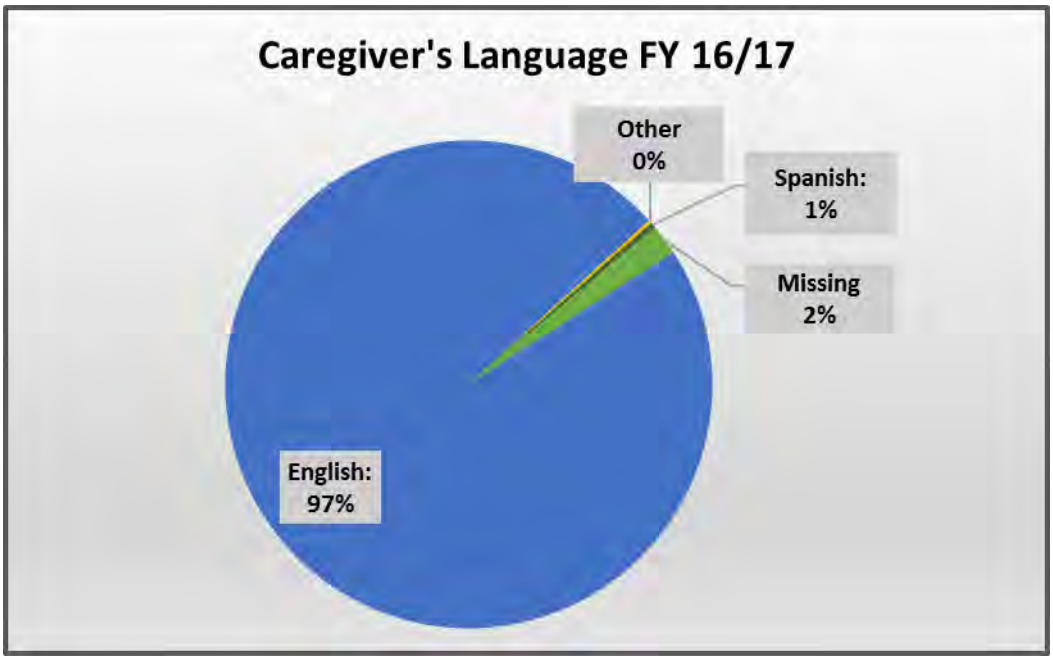
Demographic information for Triple P caregivers







*Hispanic includes respondents of any race. Other categories are non-Hispanic



Outcome Measures

All outcomes are reported as percentage of improvement from pre-Triple P participation to post-Triple P participation (e.g., improved parenting efficacy, improved parenting satisfaction).

Level 3 Primary Care & Level 3 Primary Care Teen

These levels are:

- A brief face-to-face or telephone intervention with a practitioner usually based around a certain problem or behavior
- Approximately four individual consultations lasting between 15 and 30 minutes
- Uses tip sheets and Positive Parenting Booklet to reinforce strategies
- For parents of children birth to 12 years

The two surveys used are the Parenting Experience and Strengths and Difficulties Questionnaire.

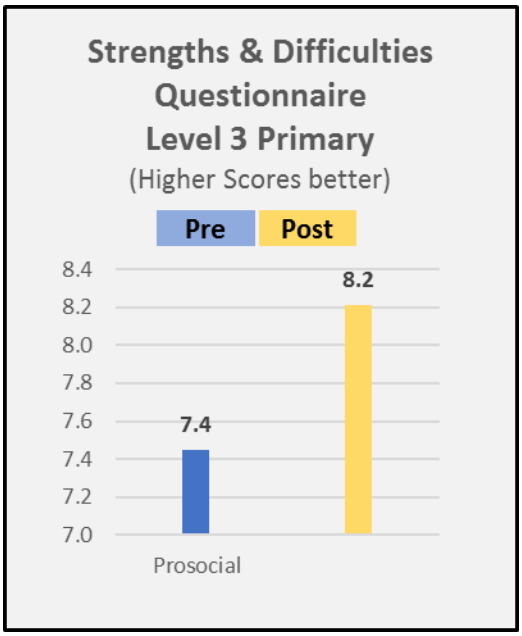
Parenting Experience Survey is a Level 3 Primary/Primary Teen questionnaire that includes questions about the child's behavior and issues related to being a parent. This survey gives practitioners information on how the parent perceives his or her parenting.

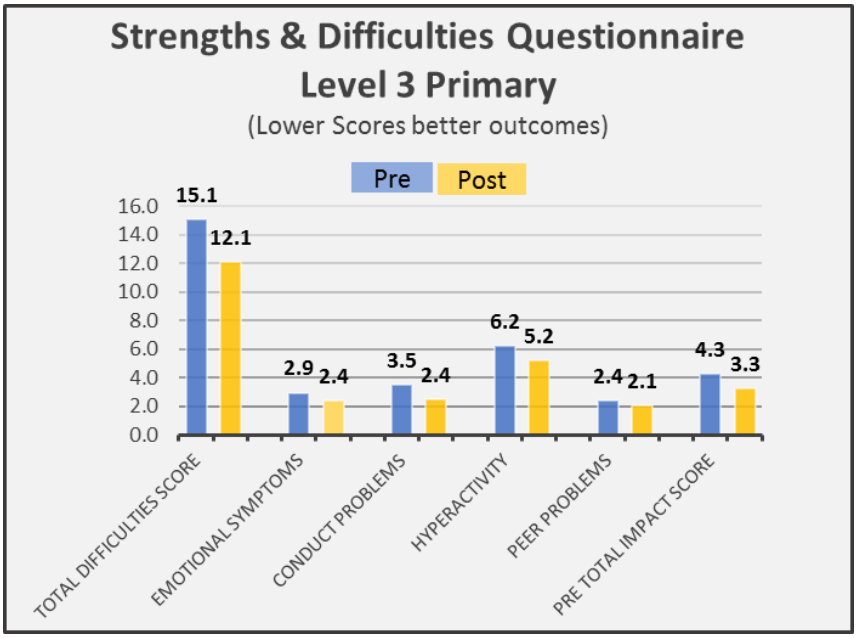
The Strengths and Difficulties Questionnaire (SDQ) is a brief behavioral screening questionnaire for children ages 3-16 years. It exists in several versions to meet the needs of researchers, clinicians and educators. This survey can give some idea on how the caregivers receiving Triple P have impacted the child.

Interpreting the SDQ			
Prosocial	higher score better		
all the rest	higher score greater difficulty		
Parent Versions	**This score is close to average - clinically significant problems in this area are unlikely**	**This score is slightly raised, which may reflect clinically significant problems**	**This score is high - there is a substantial risk of clinically significant problems in this area**
Total Difficulities	0-13	14-16	17-40
Emotional Symptoms	0-3	4	0-10
Conduct Problem	0-2	3	4-10
Hyperactivity Score	0-5	6	7-10
Peer Problem	0-2	3	4-10
Prosocial Behavior	6-10	5	0-4

"Before" and "after" SDQs can be used to audit everyday practice (e.g. in clinics or special schools) and to evaluate specific interventions (e.g. parenting groups). Studies using the SDQ along with research interviews and clinical ratings have shown that the SDQ is sensitive to treatment effects. Child and adolescent mental health services, and other specialist services for children with emotional and behavioral difficulties, can use an 'added value' score based on the SDQ as one index of how much help they are providing to the young people they see.

Overall, there has been a slight improvement in all areas of the Strengths & Difficulties Questionnaire which was taken by almost 40 caregivers. The Conduct Problem Score has decreased by 29.5% while the Prosocial has increase by 10.2%.





There is no data for Level 3 Primary Teen at this time.

Level 4 Standard

Level 4 is:

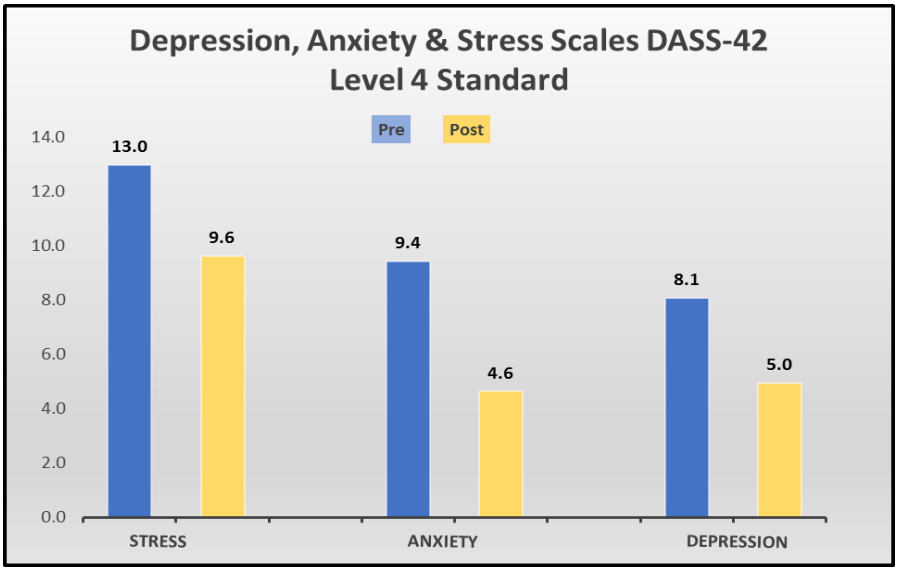
- For parents/caregivers of children from birth to 12 years with moderate to severe behavioral difficulties or ones who need intensive support
- Covers Triple P's 17 core positive parenting skills that can be adapted to a wide range of parenting situations
- Individual counseling is usually delivered over 10 one-hour sessions, but there can be more if needed

	Depression, Anxiety and Stress Score (DASS-42)		
	Depression Score	**Anxiety Score**	**Stress Score**
Normal	0-9	0-7	0-14
Mild	10-13	8-9	15-18
Moderate	14-20	10-14	19-25
Severe	21-27	15-19	26-33
Very Severe	28+	20+	34+

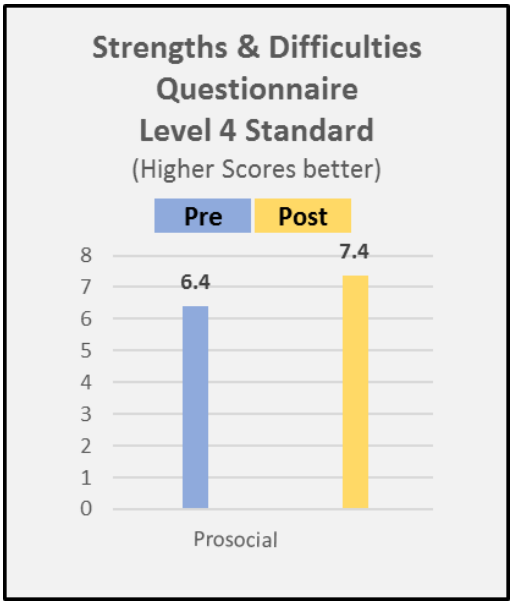
Depression Anxiety Stress Scale-42 (DASS42)

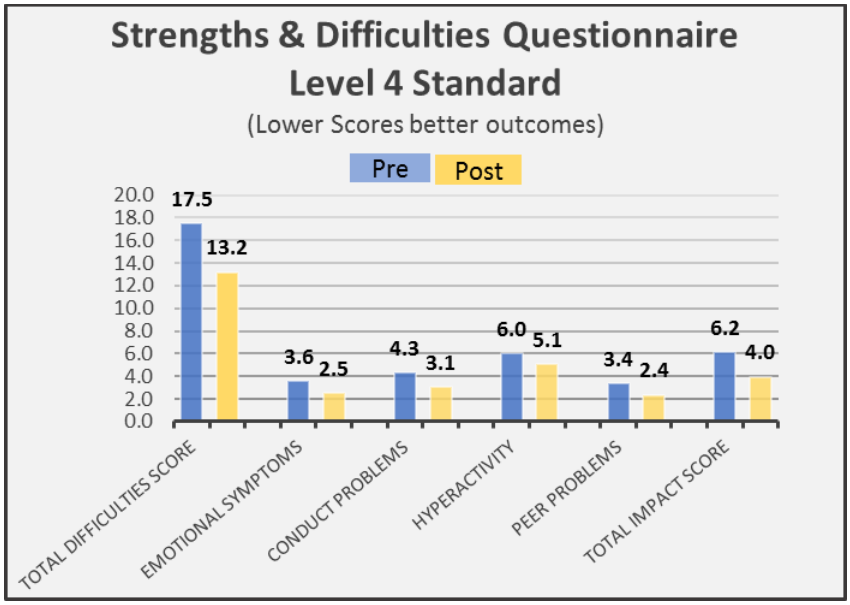
The *Depression Anxiety Stress Scale-42* (DASS42) is a self-report assessment completed before and after participation in Triple P Level 4 Standard. This 42-item assessment inventory measures symptoms of depression, anxiety and stress in adults. Scores have a possible range of 0-42. Clinical cutpoints are 14 for Depression, 10 for Anxiety, and 19 for Stress. Scores at or above these cutpoints are considered to be clinically significant.

Overall, there has been significant improvement in all areas of the DASS-42, which was taken by almost 70 caregivers. The Anxiety Score has decreased by 50.8%.



Overall, there has been a slight improvement in all areas of the Strengths & Difficulties Questionnaire (see page 6 for guidelines in interpreting the SDQ) which was taken by almost 70 caregivers. The Total Impact Score has decreased by 35.8%.



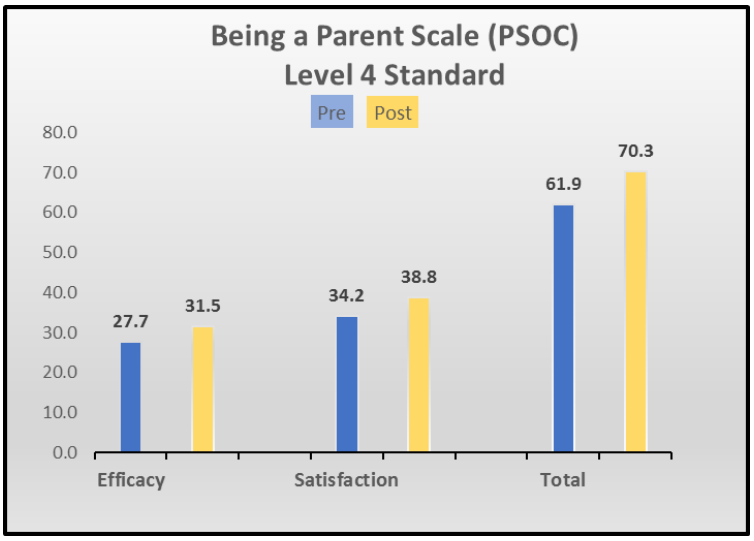


<u>Being a Parent Scale (PSOC)</u>

The *Being a Parent Scale* (PSOC) is completed before and after participation in Triple P Level 4 Standard and Level 4 Group. This 16-item assessment inventory measures parenting self-esteem, or efficacy, and satisfaction with parenting. Parents indicate their degree of satisfaction with their parenting role and their degree of confidence in carrying out their parenting role on a 6-point Likert scale (1 = strongly agree, 6 = strongly disagree).

Possible scores for the Efficacy scale range from 7-42, and for the Satisfaction scale from 9-54. Higher scores represent greater levels of parenting self-efficacy and parental satisfaction. Please note that the *Being a Parent Scale* is a strength-based measure. There are no clinical cutpoints, but

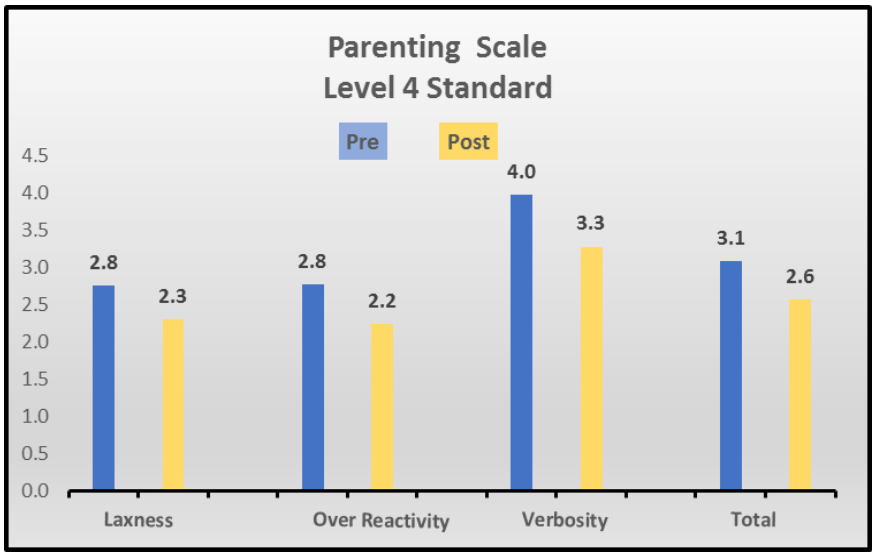
higher scores are better. With almost 55 caregivers completing the PSOC there has been improvement of about 13% in both areas.



Parenting Scale

The *Parenting Scale* is a self-report assessment completed before and after participation in Triple P Level 4 Standard Stepping Stones, Level 5 Enhanced and Level 5 Pathways. This 30-item questionnaire assesses parenting and disciplinary styles, particularly those found to be related to the development and/or maintenance of child disruptive behavior problems. It is completed by parents/caregivers of children ages 1-12.

The original factor structures of Laxness, Overreactivity, and Verbosity are reported, along with the Total Score. Clinical cutpoints in the original literature are not used, as they have not demonstrated stability over time. Possible scores on all factors and the total range from 1-7, as they each represent an average item response. Lower scores are better. With almost 55 caregivers completing the Parenting Scale there has been improvement of almost 17% for the total areas.



Level 4 Standard Teen

This level is:

- For parents/caregivers of children ages 12-18 years with severe behavioral difficulties or ones who need intensive support
- Covers Triple P's 17 core positive parenting skills that can be adapted to a wide range of parenting situations
- Individual counseling is usually delivered over ten (1 hour) sessions

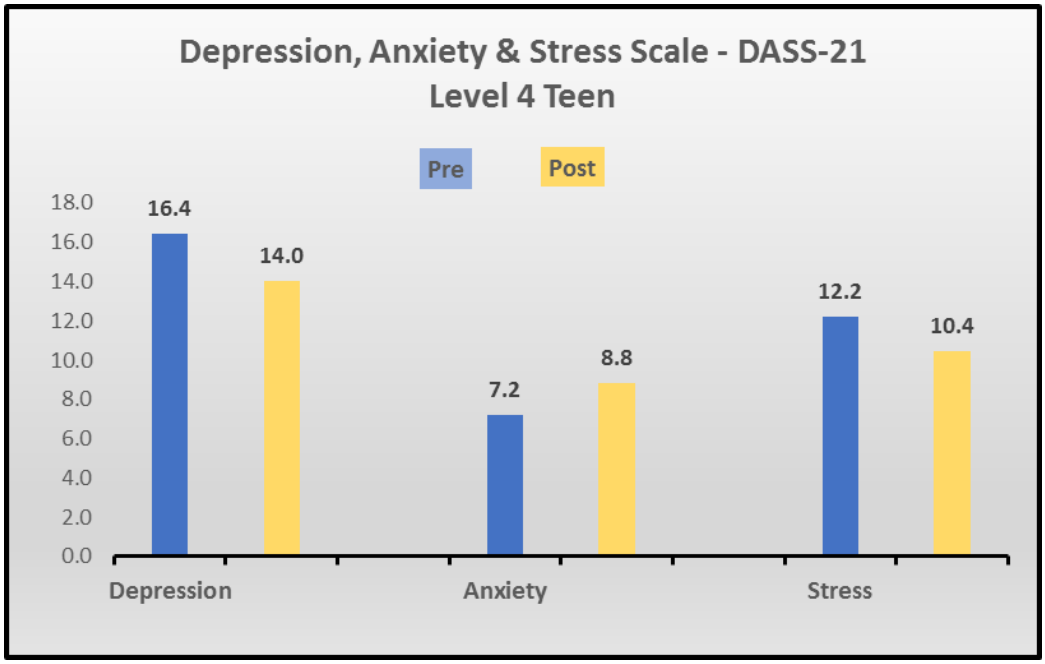
Depression Anxiety Stress Scale-21 (DASS21)

The *Depression Anxiety Stress Scale-21* (DASS21) is a self-report assessment completed before and after participation in Triple P Level 4 Standard Teen and Level 4 Group Teen. This 21-item assessment inventory is a short form of the DASS42 that measures symptoms of depression, anxiety and stress in adults.

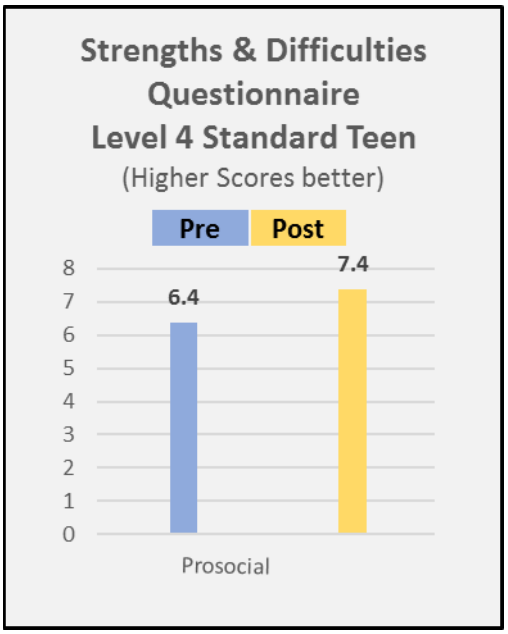
Each of the scale scores has a possible range of 0-42 (the raw DASS21 scale scores must be multiplied by two to be consistent with the DASS42 scale scores). Clinical cutpoints are 14 for Depression, 10 for Anxiety, and 17 for Stress. Scores at or above these cutpoints are considered to be clinically significant.

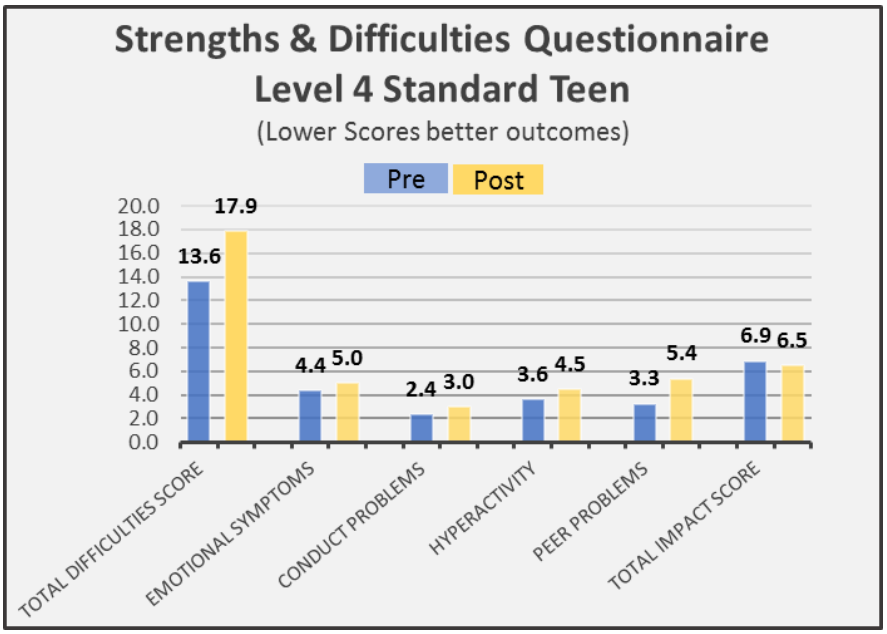
	DASS - 21 Score		
	Depression Score	**Anxiety Score**	**Stress Score**
Normal	0-4	0-3	0-7
Mild	5-6	4-5	8-9
Moderate	7-10	6-7	10-12
Severe	11-13	8-9	13-16
Extremely S	14+	10+	17+

Overall there was slight improvement in two areas, with a 22% increase in Anxiety. There were nearly 10 caregivers completing at least part of both pre- and post surveys.



Nearly 10 caregivers completed both the pre and post SDQ surveys (see page 6 for guidelines in interpreting the SDQ). There has been a slight improvement in the Total Impact Score.

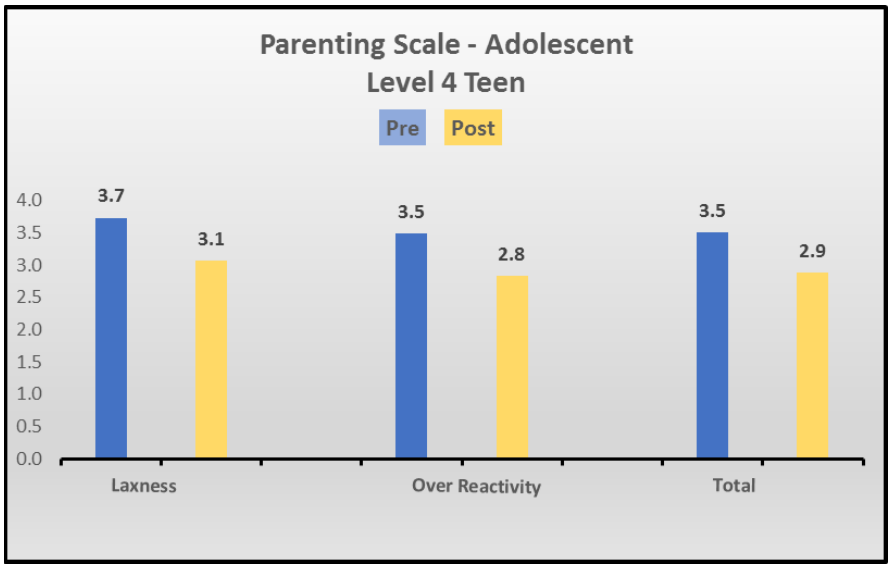




Parenting Scale – Adolescent Version

The *Parenting Scale-Adolescent Version* is a self-report assessment completed before and after participation in Triple P Level 4 Standard Teen and Level 4 Group Teen. This 13-item questionnaire is a shorter version of the Parenting Scale and assesses parenting and disciplinary styles, particularly those that are found to be related to the development and/or maintenance of disruptive behavior problems. It is completed by parents/caregivers of children ages 13 and higher.

This survey reports Laxness and Overreactivity. Clinical cutpoints have not yet been established. Possible scores range from 1-7, each representing an average item response. Lower scores are better. Almost 10 caregivers completed both the pre and the post surveys. There has been a slight improvement of approximately 18.5% overall.



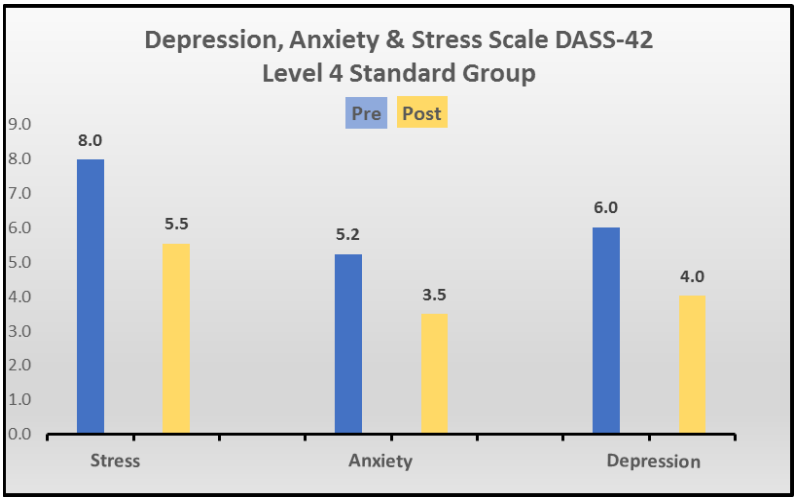
Level 4 Standard Group

This level is for parents/caregivers of children from birth to 12 years who are:

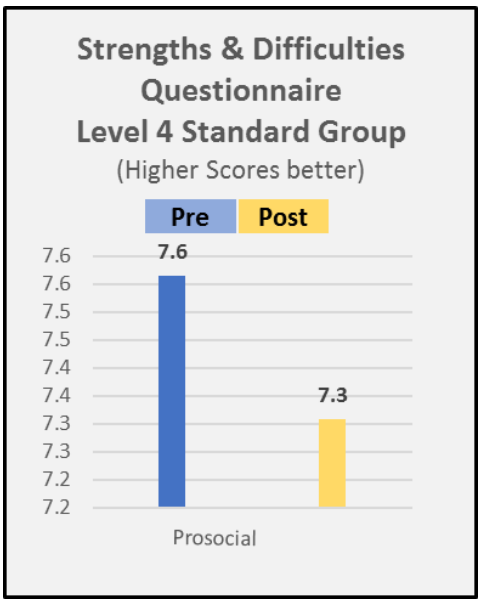
- Interested in promoting their child's development and potential OR
- May have concerns about their child's mild to moderate level of behavioral problems OR
- Simply wish to prevent behavior problems from developing

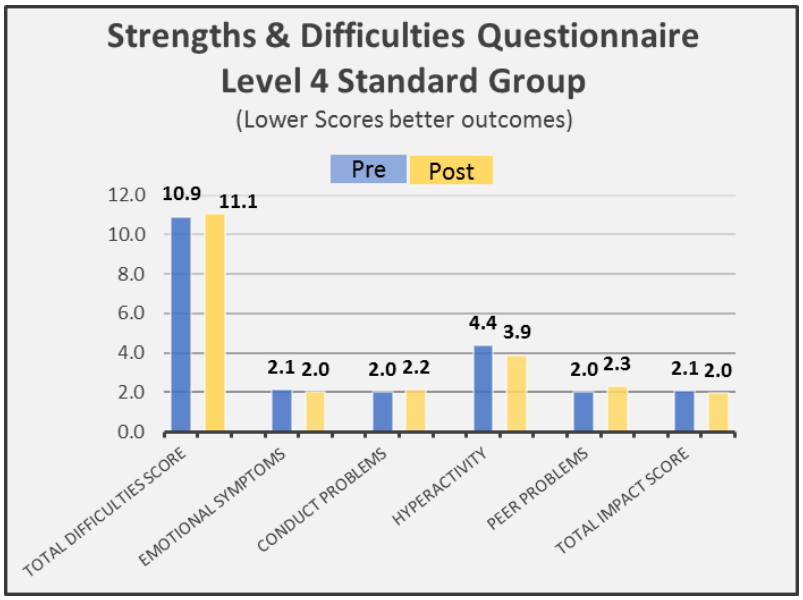
Group is a broad-based parenting intervention delivered over eight weeks which involves five (2-hour) group sessions of up to 12 parents. Parents actively participate in a range of exercises to learn about the causes of child behavior problems, setting specific goals, and using strategies to promote child development, manage misbehavior, and plan for high-risk situations. Then there are three (15 to 30 minute) individual telephone consultations to assist parents with independent problem solving while they are practicing the skills at home.

See p. 7 for guidelines in interpreting DASS42. Overall, nearly 90 caregivers completed pre and post surveys. There was an average of 33% decrease in all areas.



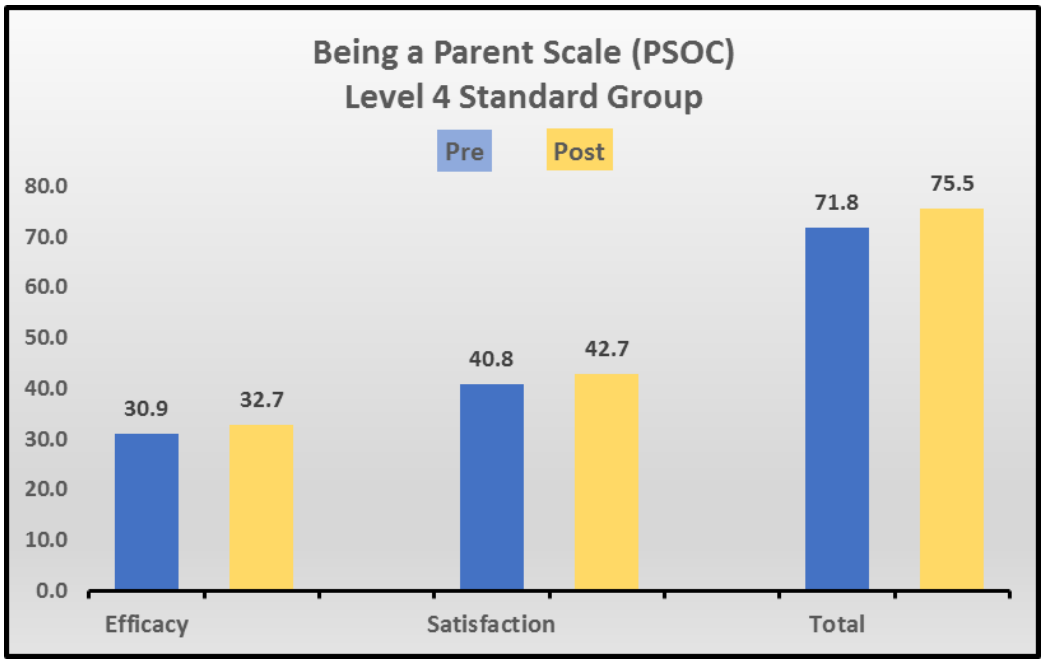
Nearly 80 caregivers completed both pre and post surveys for the SDQ (see page 6 for guidelines in interpreting the SDQ). Three areas showed improvement in symptoms.





Being a Parent Scale (PSOC)

With more than 80 caregivers completing both pre and post surveys, there has been a slight improvement of approximately 5% (see p. 6 for guidelines in interpreting this scale).



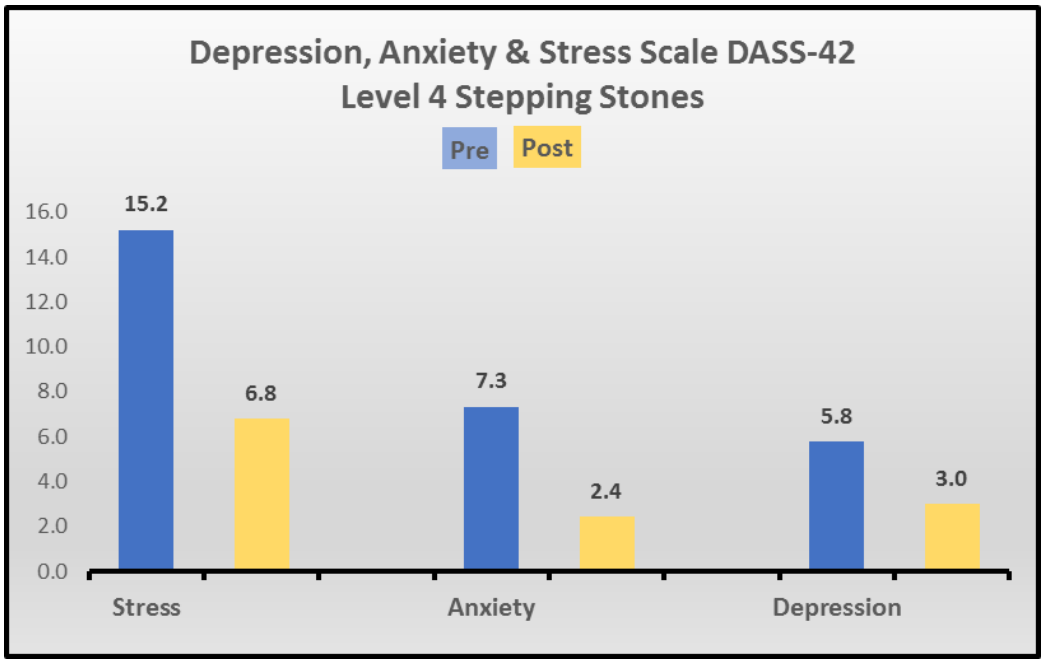
Level 4 Standard Stepping Stones

Stepping Stones Triple P is for parents of children who have a disability. It has been shown to work with children with intellectual and physical disabilities who also have disruptive behaviors. Stepping Stones gives support to help manage a child's behavior and prevent the kinds of problems that make family life stressful.

Stepping Stones is given over 8 to 10 individual sessions or as needed. Caregivers set their own goals and work out what changes they would like to see in their child's behavior. Caregivers learn the strategies they can use and adapt to suit their family's needs.

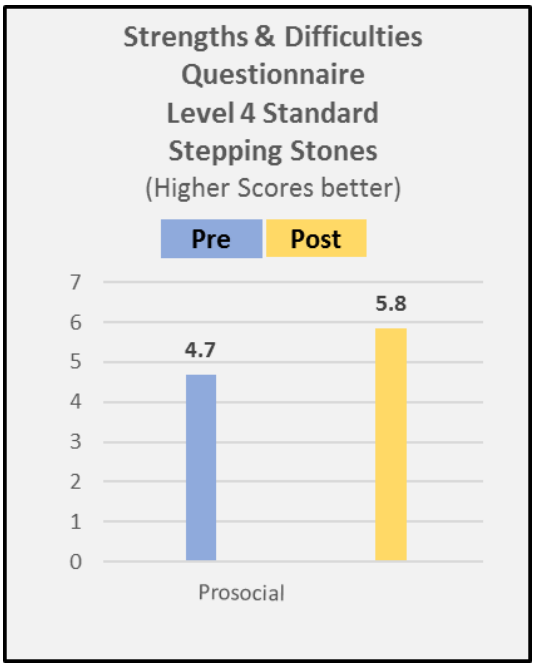
Depression Anxiety Stress Scale-42 (DASS42)

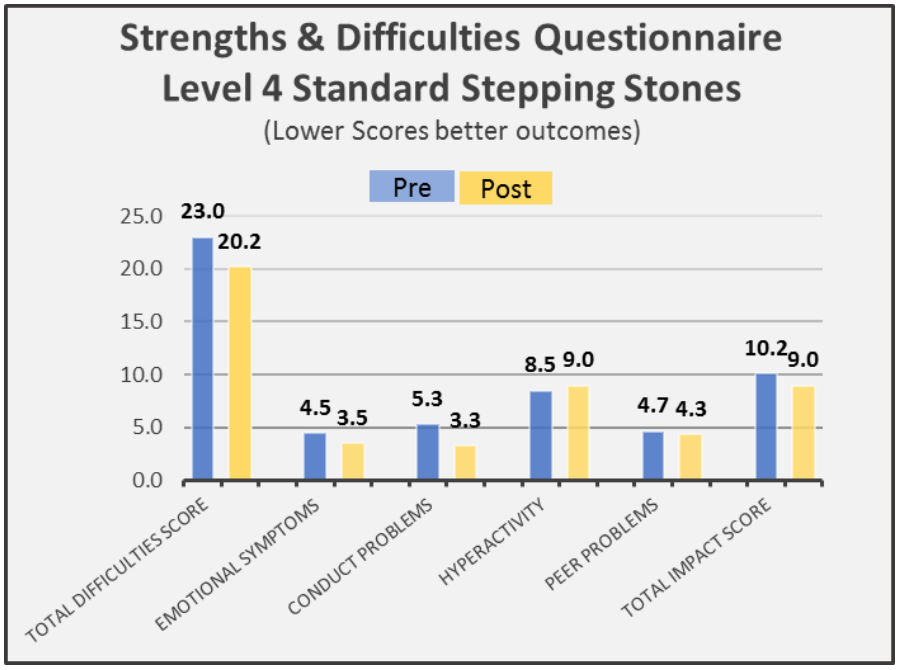
Nearly 10 caregivers completed pre and post surveys the results show a large improvement in all areas. The Anxiety score has improved by more than 66% (see p. 7 for guidelines on interpreting this scale).



The Strengths and Difficulties Questionnaire (SDQ)

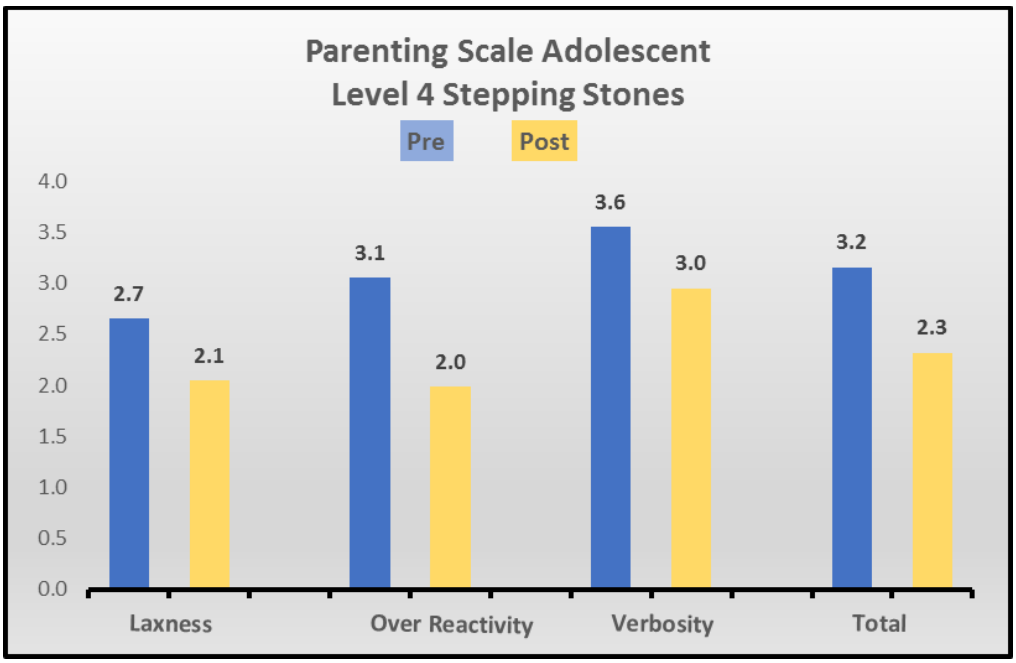
Nearly 10 caregivers that completed both pre and post surveys and most areas show an improvement. The Prosocial area has improved by 25% (see p. 6 for guidelines in interpreting the SDQ).





Parenting Scale – Adolescent Version

Nearly 10 caregivers completing both pre and post surveys there has been an improvement in all 3 areas (see p. 11 for guidelines on interpreting this scale).



Level 5 Enhanced/Pathways

This level provides intensive support for families with complex concerns. Parents must complete a Level 4 Standard or Group program before (or in conjunction with) a Level 5 course.

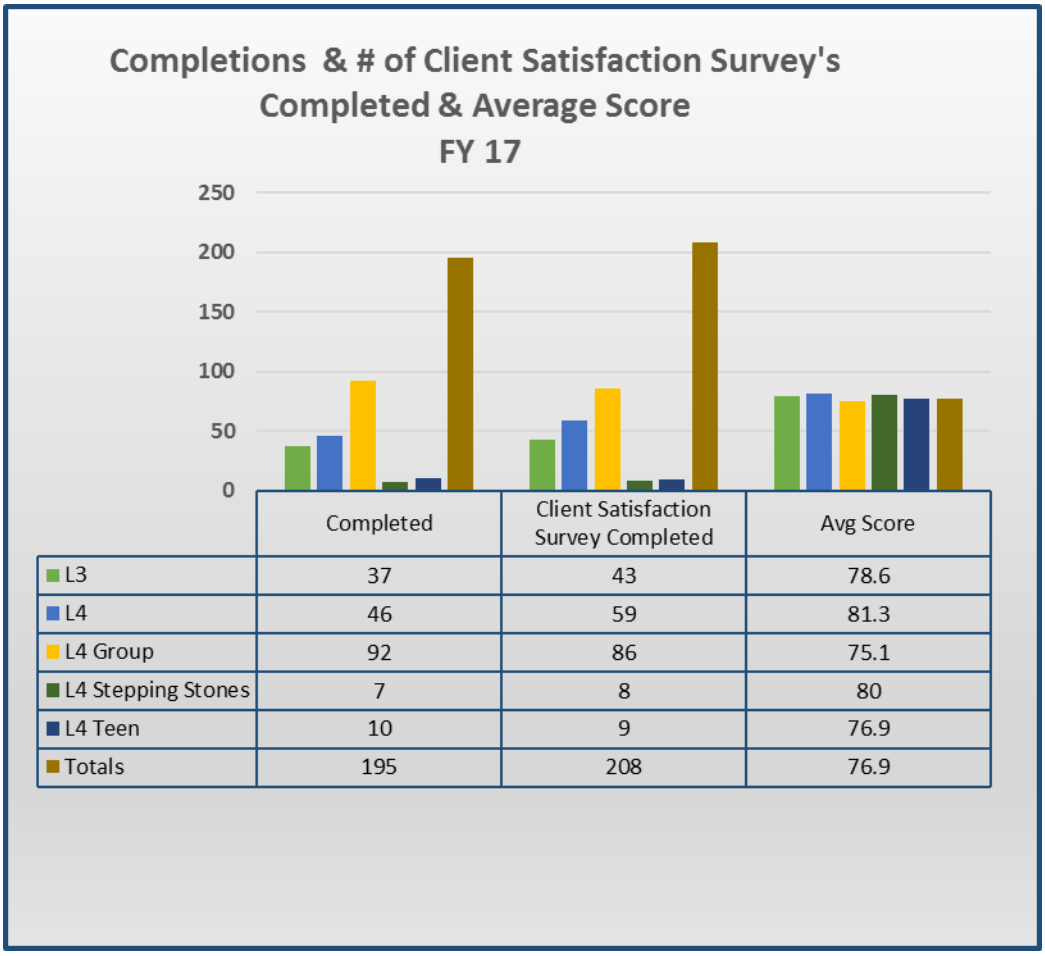
- **Enhanced Triple P –** This is for parents whose family situation is complicated by problems such as partner conflict, stress or mental health issues. Three modules target specific concerns. Parents can do one, two or three of the modules which work on partner relationships and communication, personal coping strategies for high stress situations and other positive parenting practice.
- **Pathways Triple P –** This is for parents at risk of child maltreatment. It covers anger management and other behavioral strategies to improve a parent's ability to cope with raising children.

As of March 26, 2018, there was only on caregiver for both Level 5 Enhanced and Level 5 Pathways.

Satisfaction Measure

Client Satisfaction Questionnaire (CSQ)

The *Client Satisfaction Questionnaire* (CSQ) measures consumer satisfaction after participation in all Triple P levels. It includes 13 items and scores range from 13-91. Higher scores are better. During 2017, 208 Client Satisfaction Surveys were completed with an average score of 76.9.



	Completed	Client Satisfaction Survey Completed	Avg Score
L3	37	43	78.6
L4	46	59	81.3
L4 Group	92	86	75.1
L4 Stepping Stones	7	8	80
L4 Teen	10	9	76.9
Totals	195	208	76.9

Summary of 2017 Triple P

All data entered into the Shasta County Scoring Application gives a snapshot in time.

A total of 3,722 caregivers have been entered into the Scoring Application since 2011. When a caregiver has completed a session, sometimes they want to either repeat that level or go on to another level. When this happens, it can result in duplicated numbers of caregivers.

Many more families have been introduced to Triple P, as several agencies provide Triple P in their counseling services. Shasta Head Start delivers Triple P to numerous families in Shasta County, but due to their structure, they are unable to enter data into the Shasta County Scoring Application.

Level 5 Transitions was recently introduced in Shasta County. Training was conducted in November 2017 and 13 practitioners were trained. This level will assist parents who need help with the transition from a two-parent to a single-parent family due to divorce.

Level 3 Discussions group series are also being given, which deal with commonly encountered problems such as disobedience, fighting and aggressions, and managing situations such as shopping with children and bedtime. These groups have four two-hour sessions. Due to the limitations of our Scoring Application, we are unable to enter this level's data.

A Level 5 Enhanced and Pathways training was conducted in December and was attended by 17 practitioners. This training will help to replace the practitioners that have left and are not providing Level 5 Enhanced or Pathways any longer. This level must be provided by a licensed clinician.

To learn more about local Triple P efforts, visit www.triplepshasta.com.

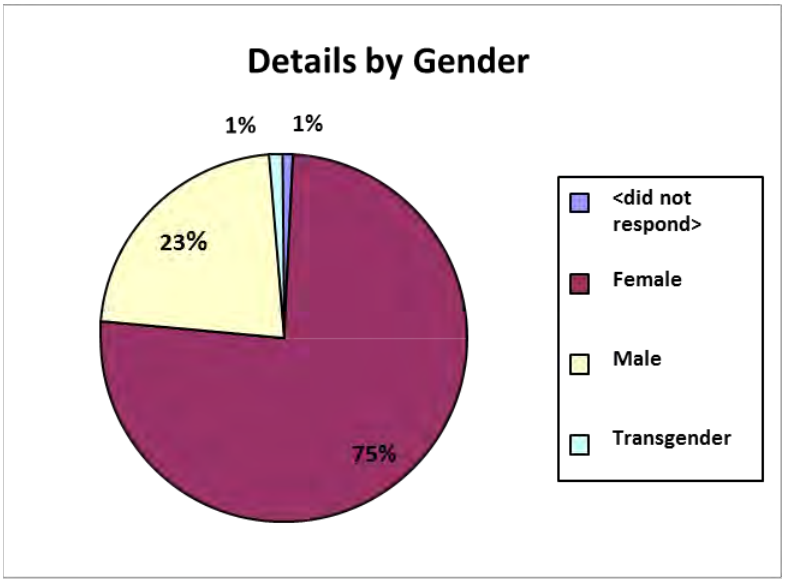
Stigma & Discrimination Reduction
Brave Faces
2017

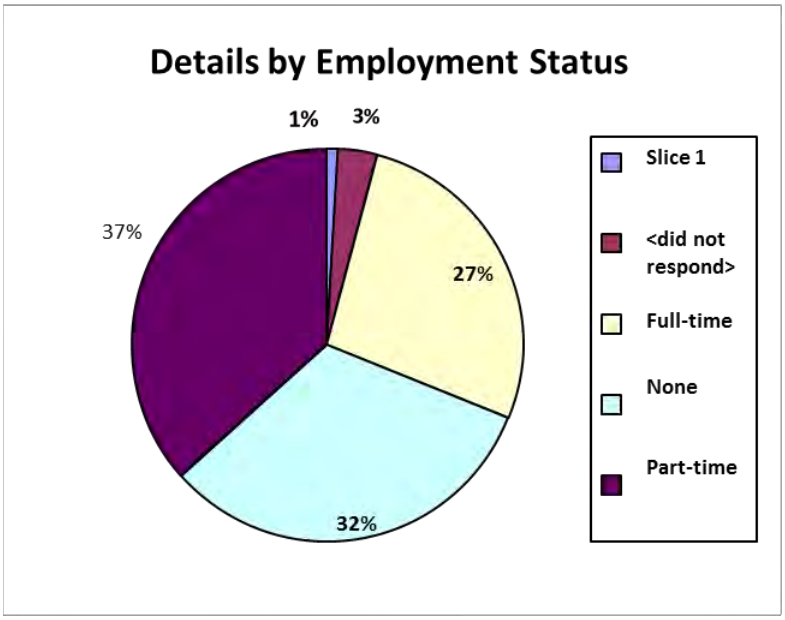
Brave Faces speakers did 44 presentations and events during 2017. Approximately 1,369 persons attended these events. In July and October, Becoming Brave trainings were held for 18 new Brave Faces speakers.

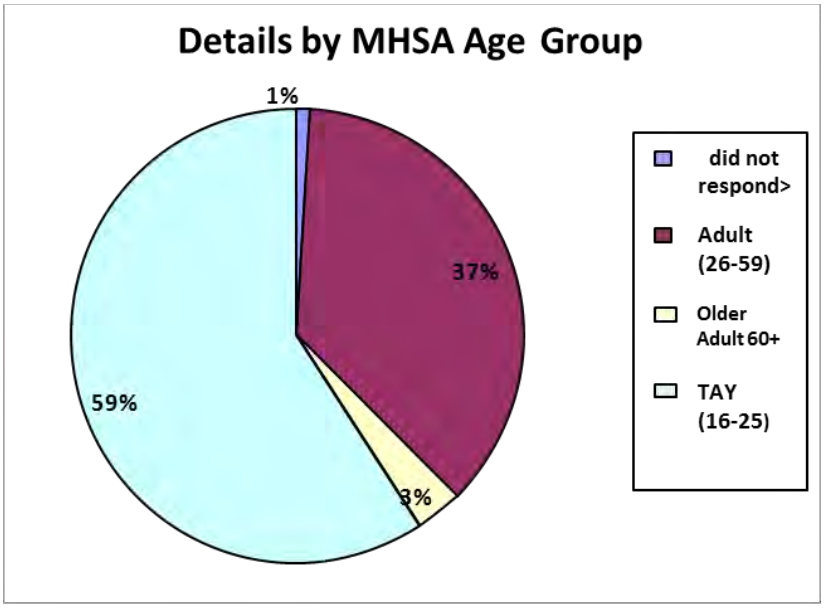
Additional events for the general public in 2017 included:

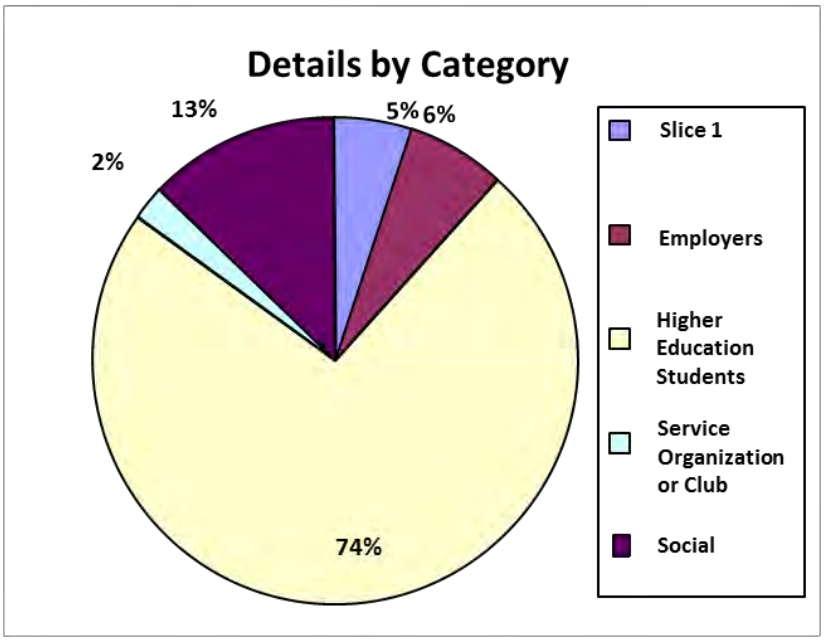
- **January:** Healing Through Performance, a free stigma and discrimination workshop
- **February:** Hope is Alive! 9 Open Mic Night; Brave Faces at Shasta College
- **March:** Managing Medications: A Stand Against Stigma Forum
- **May:** Minds Matter Mental Health Fair and Music Festival; Hope is Alive! 10 Open Mic Night
- **September:** Hope is Alive! 11 Open Mic Night; Recovery Happens festival
- **October:** Hope is Alive! 12 Open Mic Night
- **December:** Facing ACEs – a Stand Against Stigma forum on adverse childhood experiences

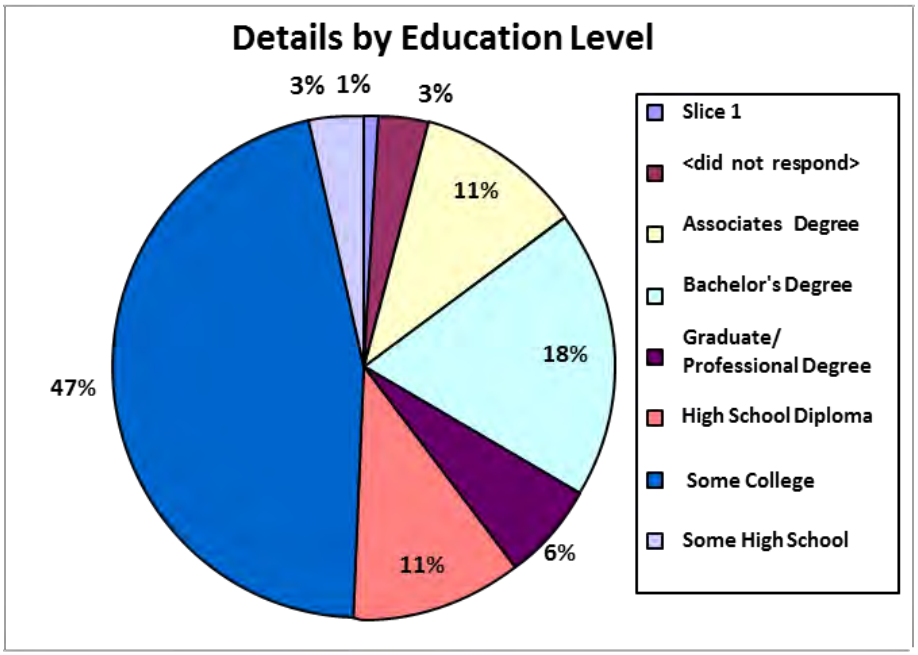
These charts represent the number of evaluations that were received for events during 2017.

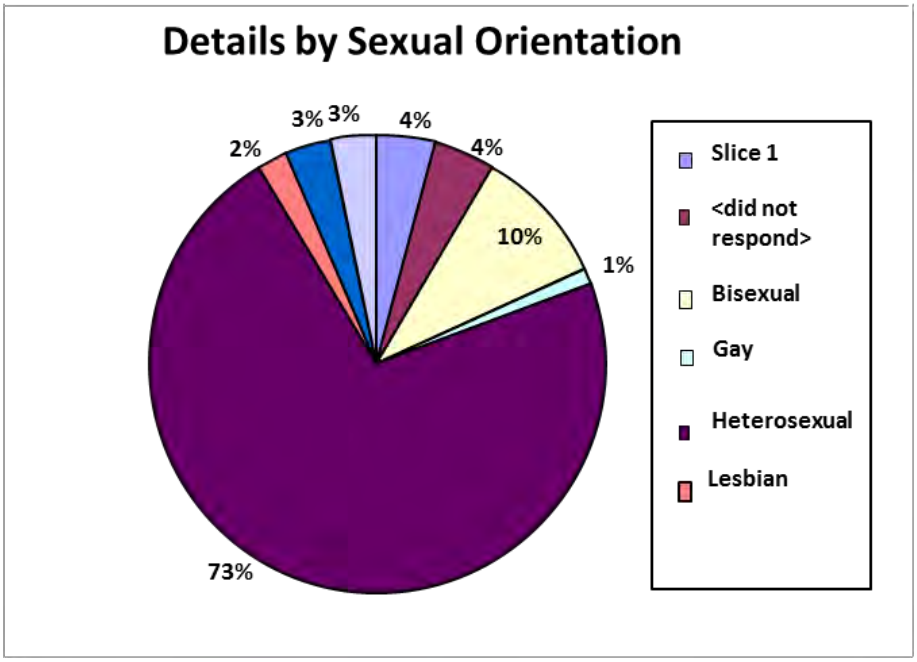





Details by MHSA Age Group
1%
37%
59%
3%
did not respond>
Adult (26-59)
Older Adult 60+
TAY (16-25)


Details by Category
13%
5%
6%
2%
74%
Slice 1
Employers
Higher Education Students
Service Organization or Club
Social


Details by Education Level
3%
1%
3%
11%
18%
6%
11%
47%
Slice 1
<did not respond>
Associates Degree
Bachelor's Degree
Graduate/ Professional Degree
High School Diploma
Some College
Some High School


Details by Sexual Orientation
3%
3%
4%
2%
4%
10%
1%
73%
Slice 1
<did not respond>
Bisexual
Gay
Heterosexual
Lesbian

Details by Race/Ethnicity

American Native/ Alaskan Native	Asian	Black or African American	Latino	Native Hawaiian/ Pacific Islander	White	Other	Total (n)
1	4	3	11	2	74	1	93
1.1%	4.3%	3.2%	11.8%	2.2%	79.6%	1.1%	

NOTE - Because individuals can select more than one race/ethnicity, the percentages may add up to more than 100%; and, because some individuals choose not to report their race/ethnicity, the percentages may add up to less than

Appendix L

Suicide Prevention Annual Report

January 2017 – December 2017

Suicide Prevention is one Shasta County programs under MHSA Prevention and Early Intervention. Activities must meet five fundamental concepts of the MHSA: cultural competence; wellness, recovery, resilience; community collaboration; client- and family-driven mental health system; and integrated service experience. A HHSA Suicide Prevention website is used to promote these ideas and keep the community up to date on any meetings, trainings or events scheduled.

Suicide Prevention has a new prevention campaign started in 2017 that is directed towards men due to the societal pressures that they feel has created barriers to suppress their emotions, and not to show weaknesses. Captain Awesome demystifies mental health and depression while giving men the tools to maintain their mental and emotional health.

Another educational program for students grades 8-12 called “More than Sad” has created a subcommittee to establish and implement this program in local schools. More than Sad is a Best Practice program that teaches teens to recognize the signs of depression in themselves and others, challenges the stigma surrounding depression, and demystifies the treatment process.

There are several workgroups that meet quarterly with the goal of educating media to the importance of appropriate and responsible reporting of suicide. This is also achieved with the help of the Stigma and Discrimination Reduction program, and aided by peer support groups that have also established a Facebook site that has over 564 likes.

The suicide prevention liaison continues to work with the Stigma and Discrimination Reduction program when appropriate due to the areas that affect both programs. Health Fairs are some events that have assisted with the awareness of Suicide Prevention.

QPR trainings are one of the major areas of the Suicide Prevention program. QPR stands for Question Persuade Refer which is a practice that seeks to provide individuals with an awareness of the warning signs of suicide.

QUESTION

Question the person about suicide. Ask if they've had any thoughts about it, feelings, or even plans? Do not be afraid to ask!

PERSUADE

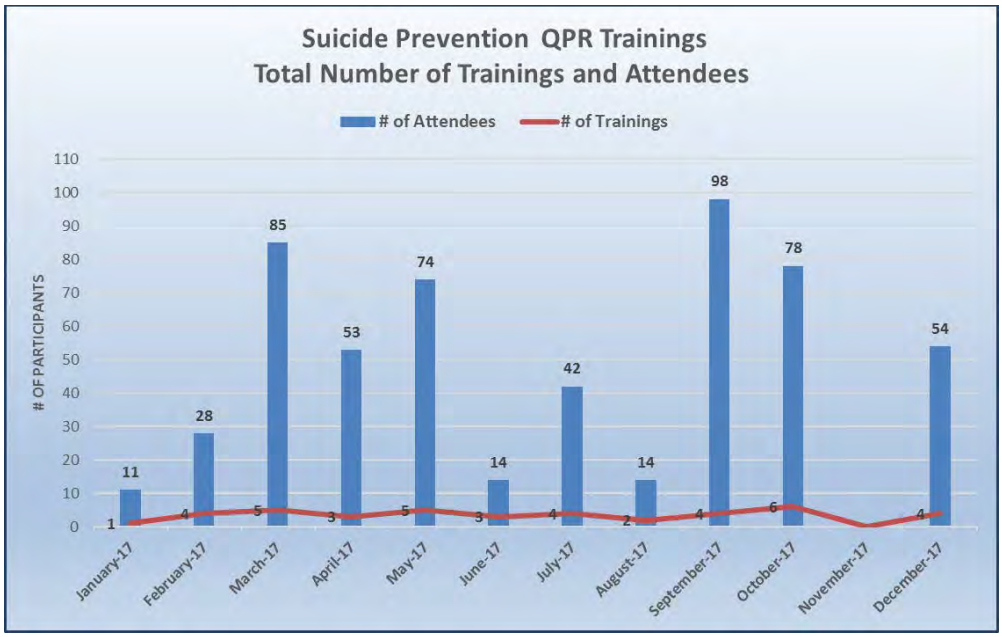
Persuade the person to get help. Remember to listen carefully and then say, "Let me help" or "Come with me to find help!"

REFER

Refer for help. If it is a child or adolescent, contact any adult, parents, minister, teacher, coach, or a counselor (1-800-866-HOPE)

It is a protocol that provides the individual with the tools to respond to an individual in suicide crisis. These trainings are given to groups or organizations in the county on request and ones that are scheduled on a regular basis.

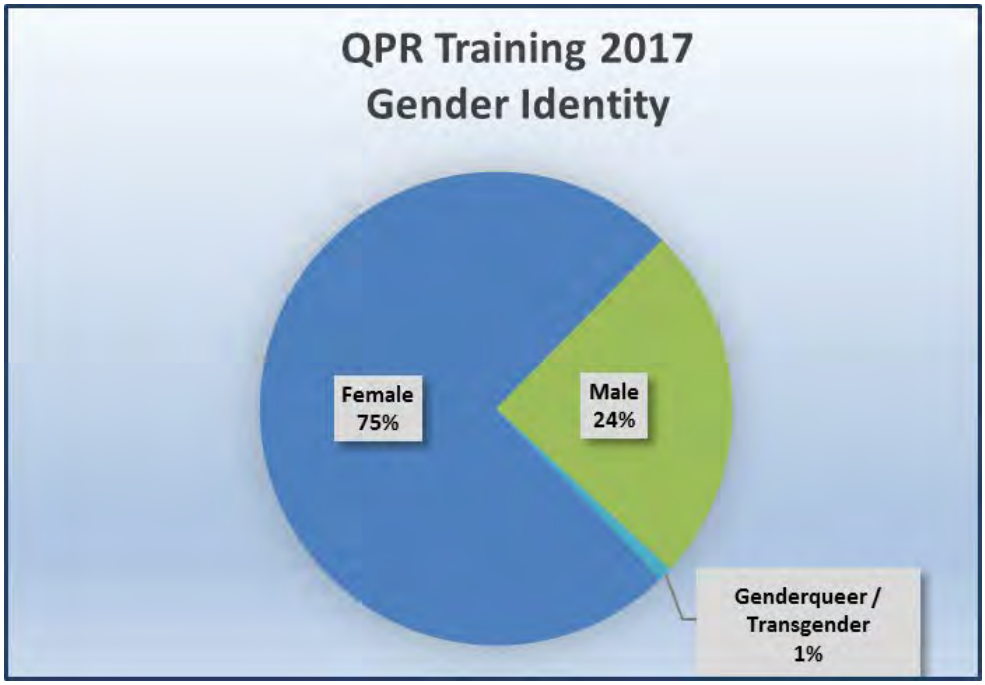
In 2017, there were approximately 41 QPR trainings with 551 attendees.

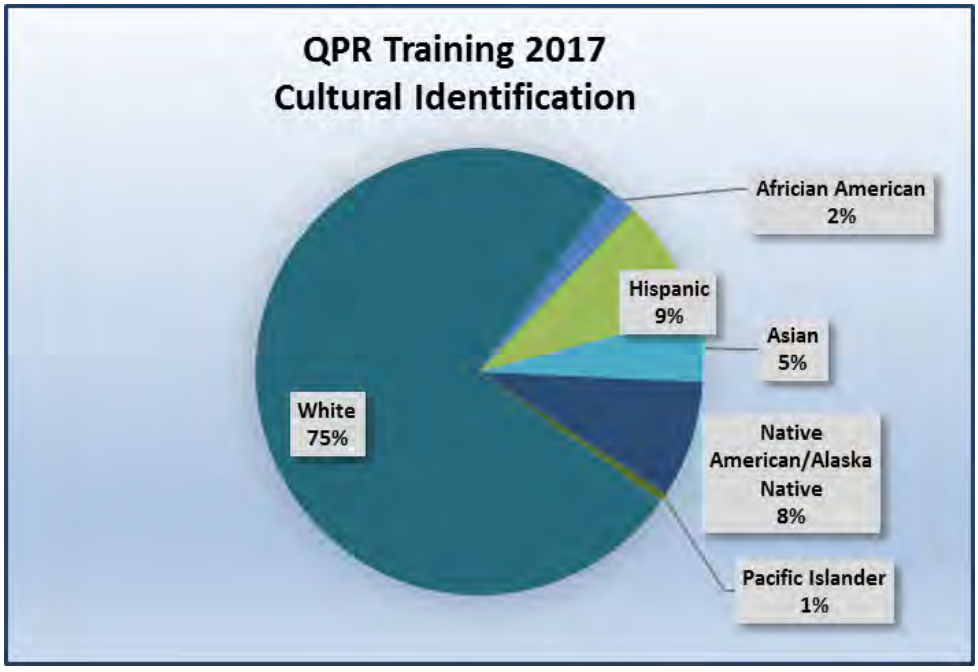


Of these, 5 of the trainings were for HHSA with 71 staff members attending.

Demographics

All demographics are displayed as a percentage of those who choose to respond. In order to protect participant confidentiality, the actual numbers for each category are not displayed, as some may be very small numbers (less than 10).

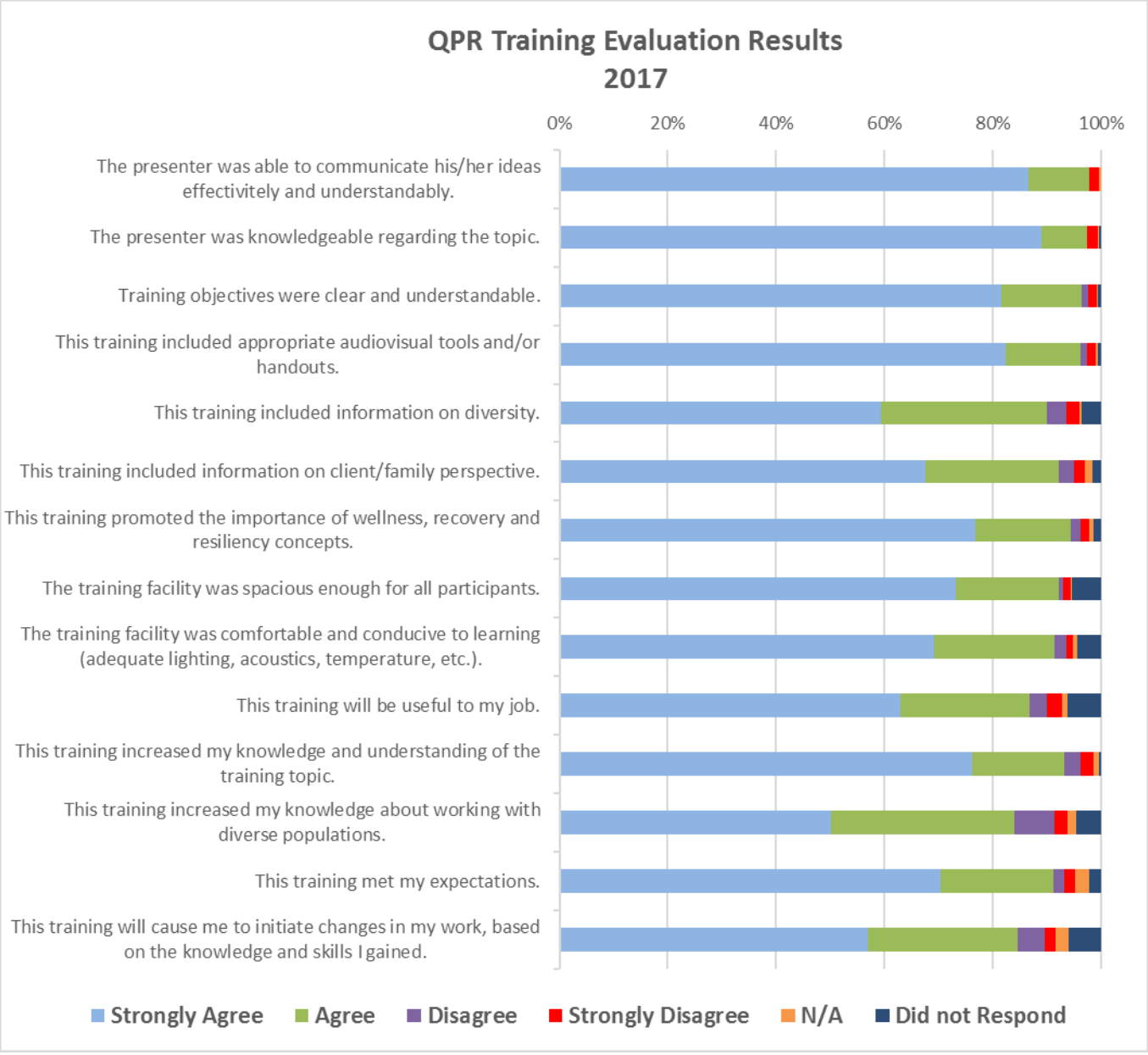




What best describes the organization you represent at this training?

At all the Question Persuade Refer (QPR) Suicide Prevention trainings attendees are given a Post Training Questionnaire. This questionnaire is used to give feedback to the trainer as a way of evaluating the training. This also gives an idea of what might be missing or trainings that might be valuable.

The 3 objectives that are on the Post Training Questionnaire for the QPR trainings are: 1) Recognize warning signs of suicide. 2) Learn how to ask someone if they are contemplating suicide. 3) Know resources for accessing help.



Due to the large volume of free text responses, answers for the following questions have been grouped, and only those comments with 2 or more people providing that response have been listed.

What barriers (if any) do you think would impact your ability to implement ideas presented in this training?

Barriers
No barriers. **74**
The barrier of time. **9**
My own comfort **7**
Having the correct relationship to implement this **6**
Feeling like you can't help. **4**
Personal beliefs **4**
A huge barrier is the lack of referrals and coordination of services. **3**
Being unsure of myself and my ability to say the wrong thing. **3**
Mental illness other than depression (in addition to depression). **3**
Access to reliable, safe services **3**

What were the strengths of this training?

Strengths
Excellent speaker and personable **88**
Amy was very thorough and knowledgable on the subject. **30**
Good, informative, and attention-keeping lecture and slides. You were very personal and that helps me relate to the discussion. **19**
Mythis and facts were very educational. **8**
What to say, when to say it, and that you should say something. **8**
Good useable information **6**
very interesting and easy to understand and learn. **6**
Resources, phone, web, etc. **5**
Stats and resources and very helpful! **5**
Real experience **4**

What suggestions or areas of improvement do you think would make this or future trainings more effective?

Suggestions
None **51**
I think you did a fantastic job! **27**
Implement more class involvement and brainstorming. **9**
A video instead of just PowerPoint. **8**
More interactive **4**
More time to go over same amount of material **4**
More early prevention, school age, more mental health, everyone needs therapy. **3**
More information on diversity. **3**
Maybe a practice dialogue? **2**
Maybe a quick break at one hour. **2**

What additional trainings would you like to see?

Additional trainings
No **35**
More training like this in the schools children and community. **10**
Don't know **10**
ACE **8**
more role playing **6**
Resources for drug addiction and homelessness. **6**
More mental health **4**
Building supportive community/communities **3**
Training for healthcare providers, workers. **3**
What to do after a crisis **3**

Is there another format you would have liked to receive this training in? Why?

Format
No **86**
No, it was a perfectly fine format. **20**
Video because it helps people to connect. **5**
Online webinar to be able to review it later. **5**

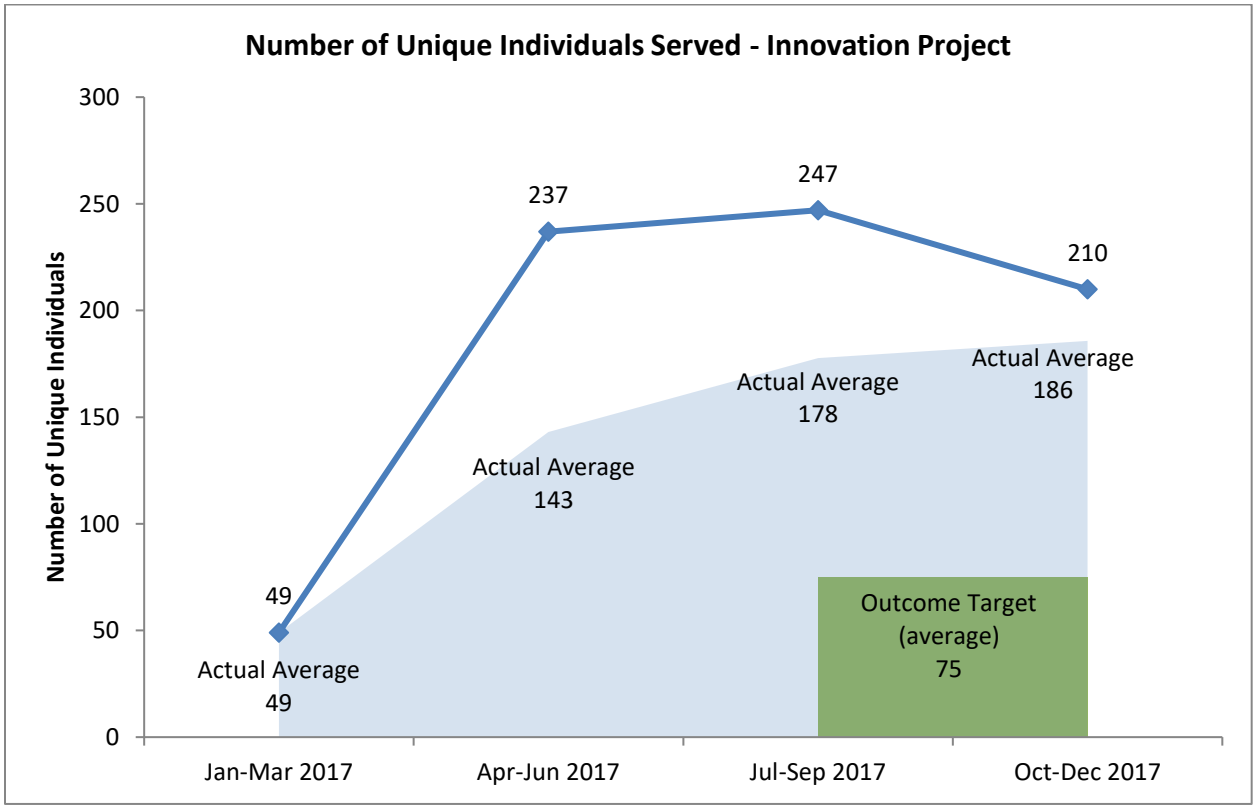
Do you have any other comments or suggestions?

Comments
Amazing presentation, it was a pleasure to see your heart for our community. **90**
No **55**
This was for personal knowledge for me. **3**
Keep giving hope to the community. **2**
This training would be great in surrounding high schools. There is a lot of suicidal ideation and self-injurous behaviors occurring. **2**
Play out situations. Visually experience incident. **2**

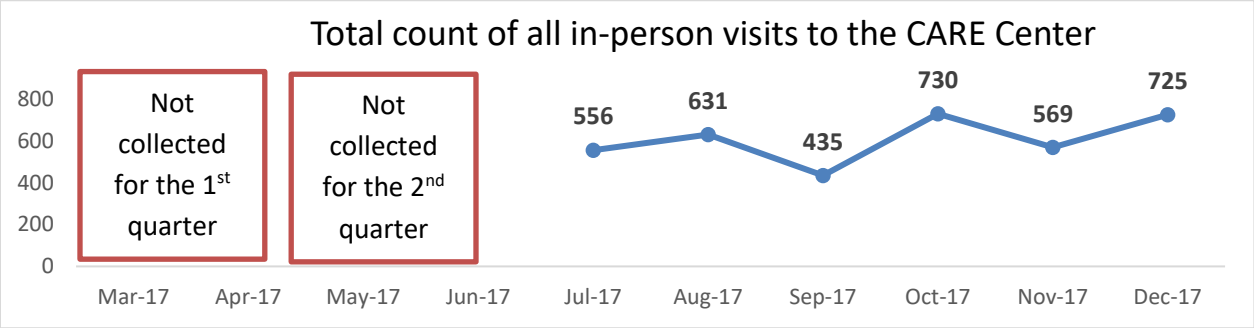
CARE Center Activity Report – Innovation Project
January 2017 through December 2017

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

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



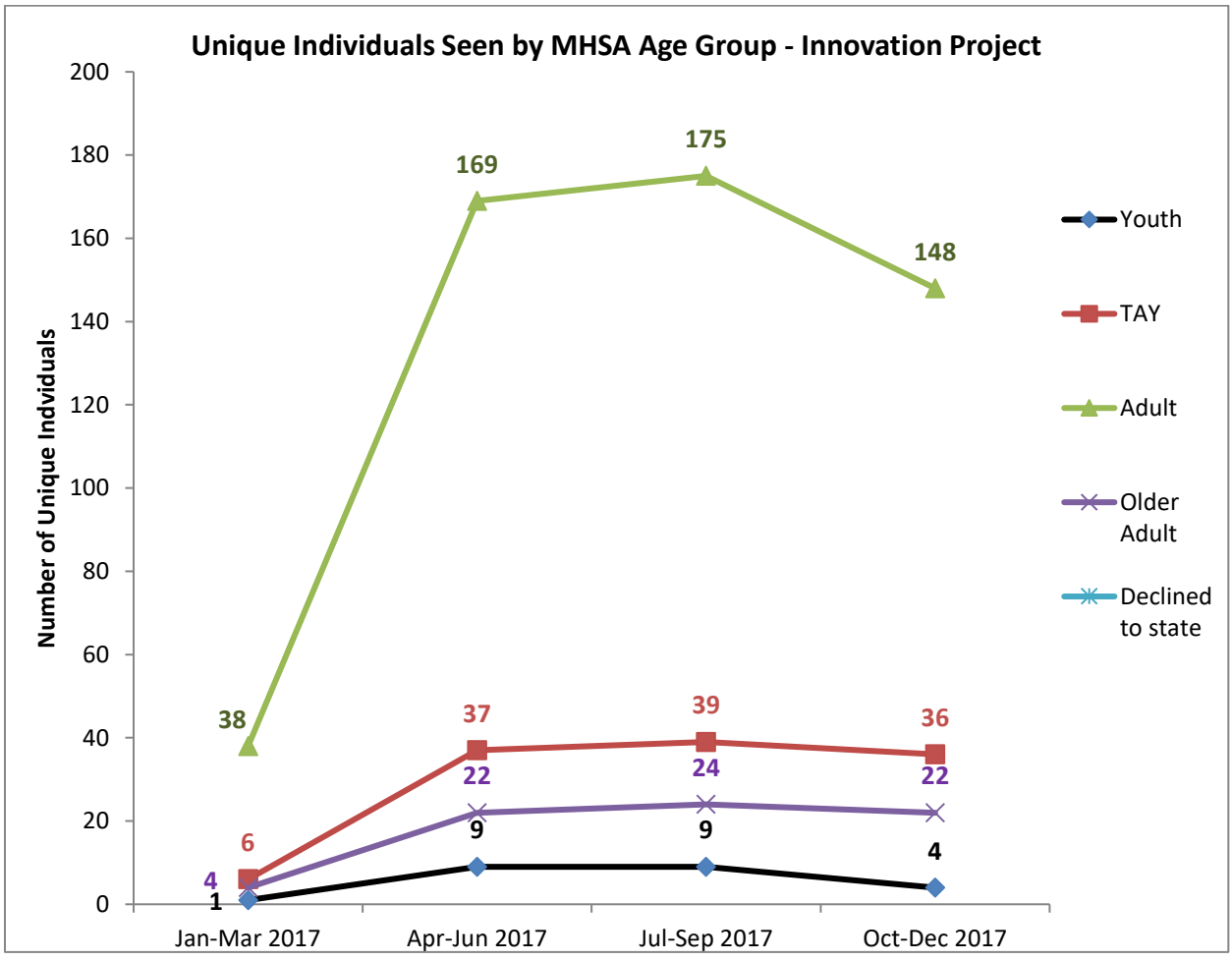
Due to much higher utilization of the Care Center than anticipated, the number of in-person visits per month are being tracked as of July 2017. Please note these do not include phone calls, and that most clients visit more than once - this is not an unduplicated person count.



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

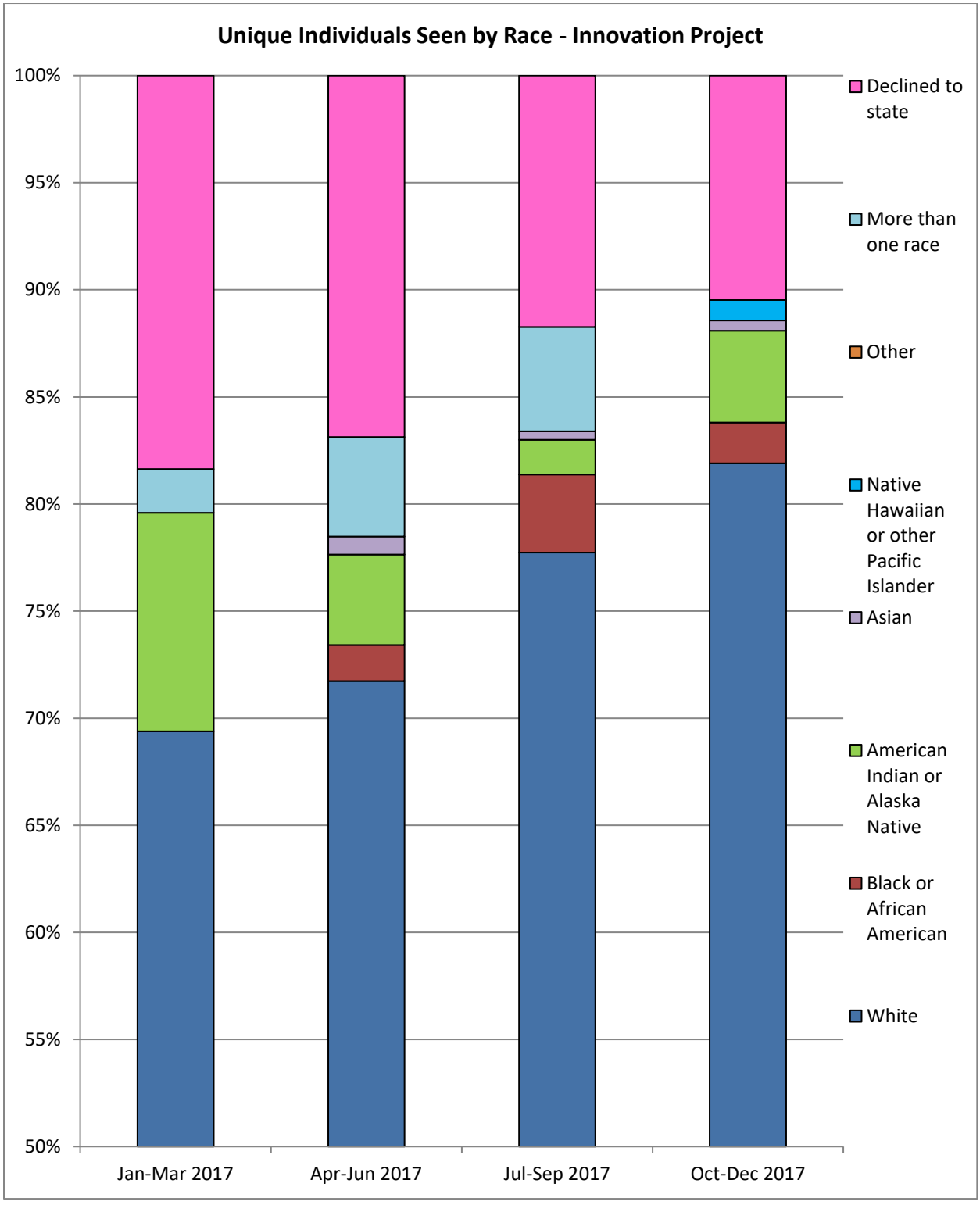
AGE

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.



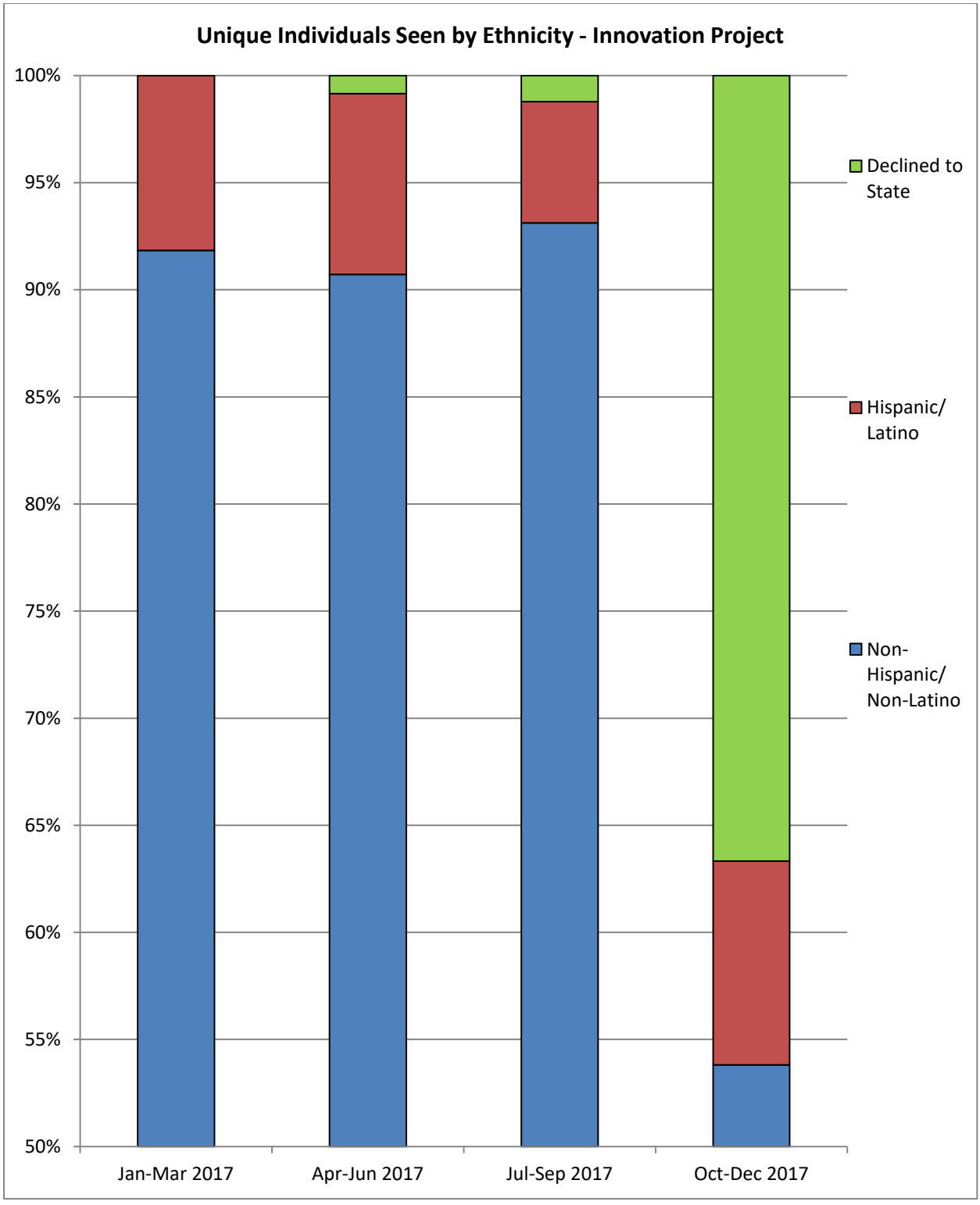
RACE

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



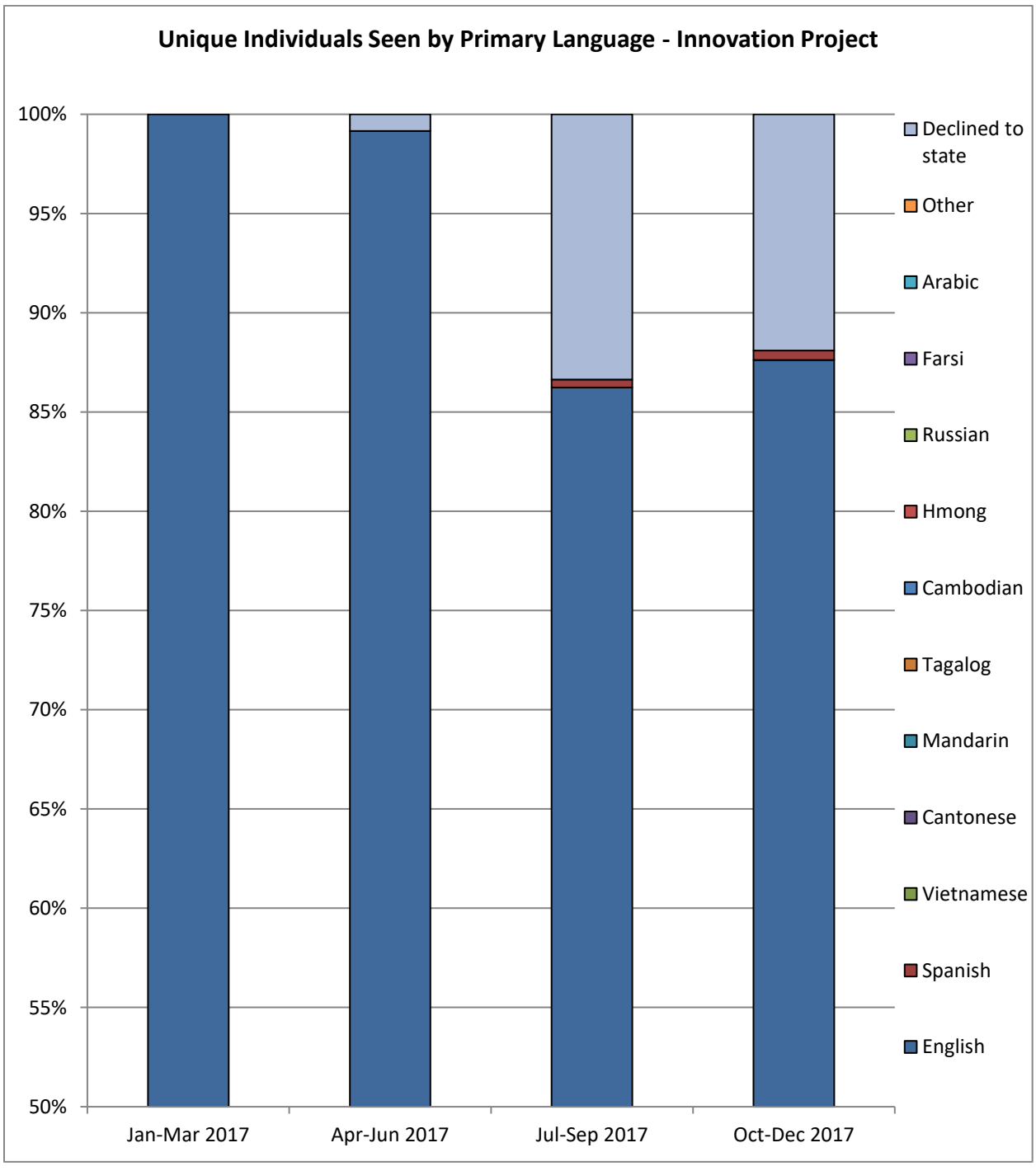
ETHNICITY

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

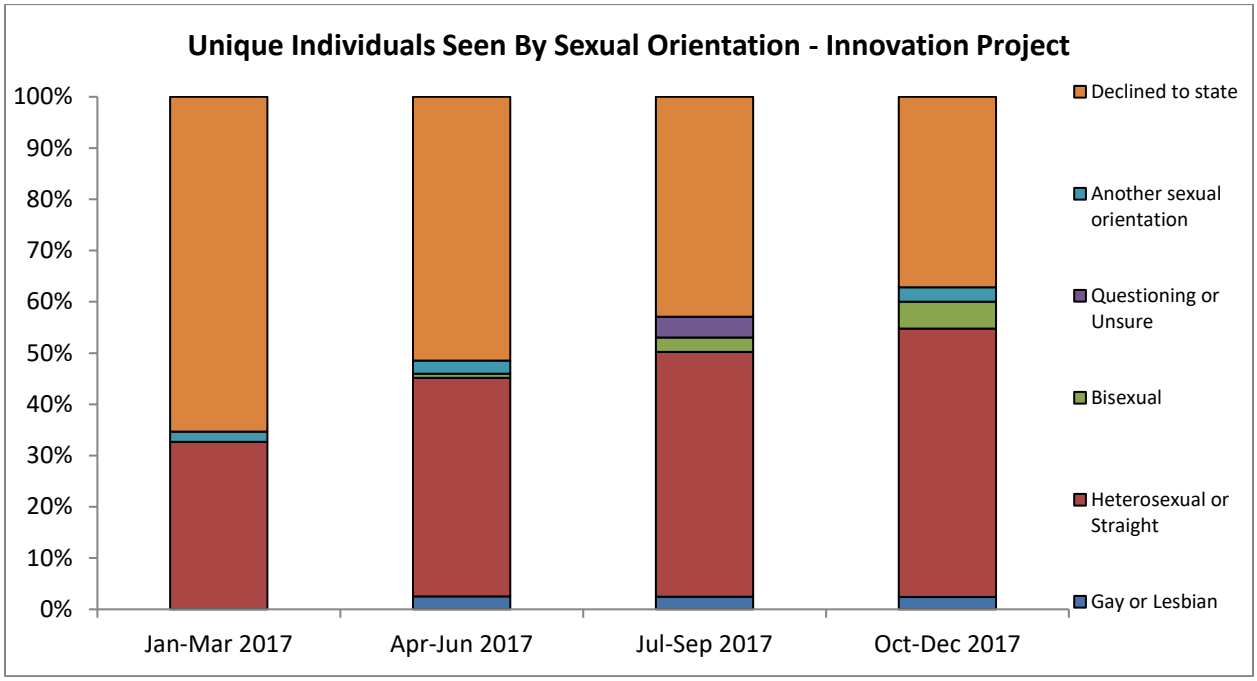


PRIMARY LANGUAGE

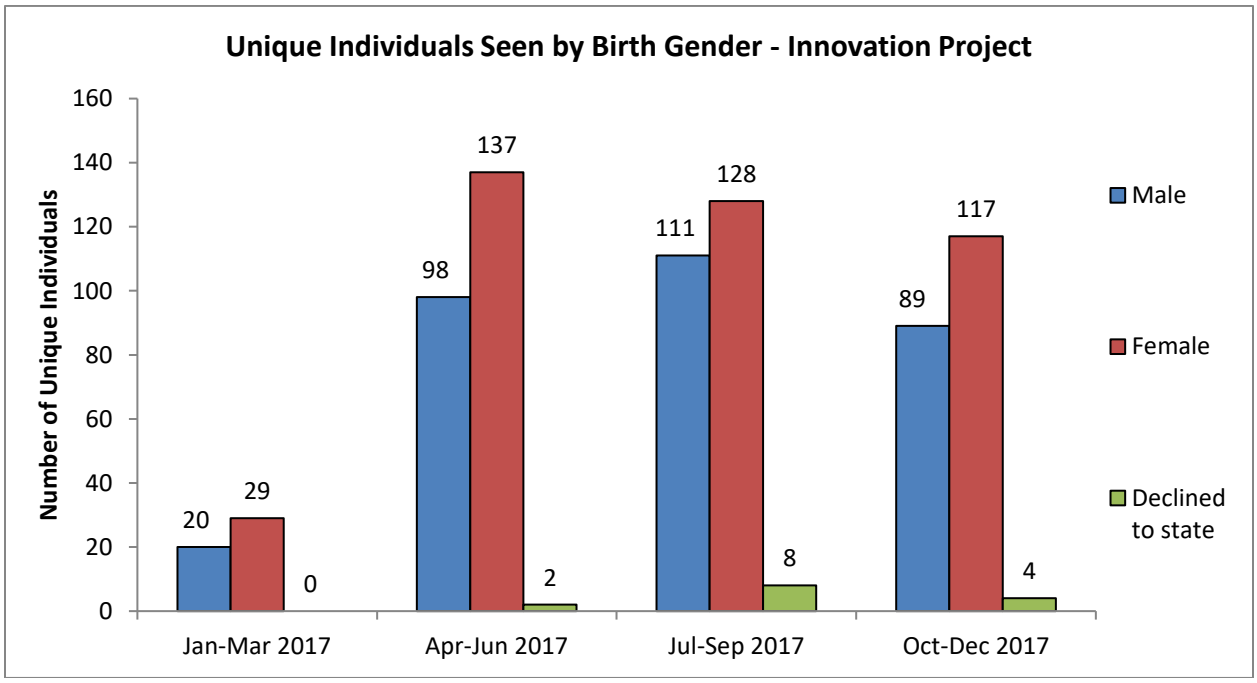
The primary language of consumers served by the CARE Center is English for nearly 100% of the people. Because of the low gross numbers for some reported languages, actual counts are not reported to help protect consumer confidentiality.



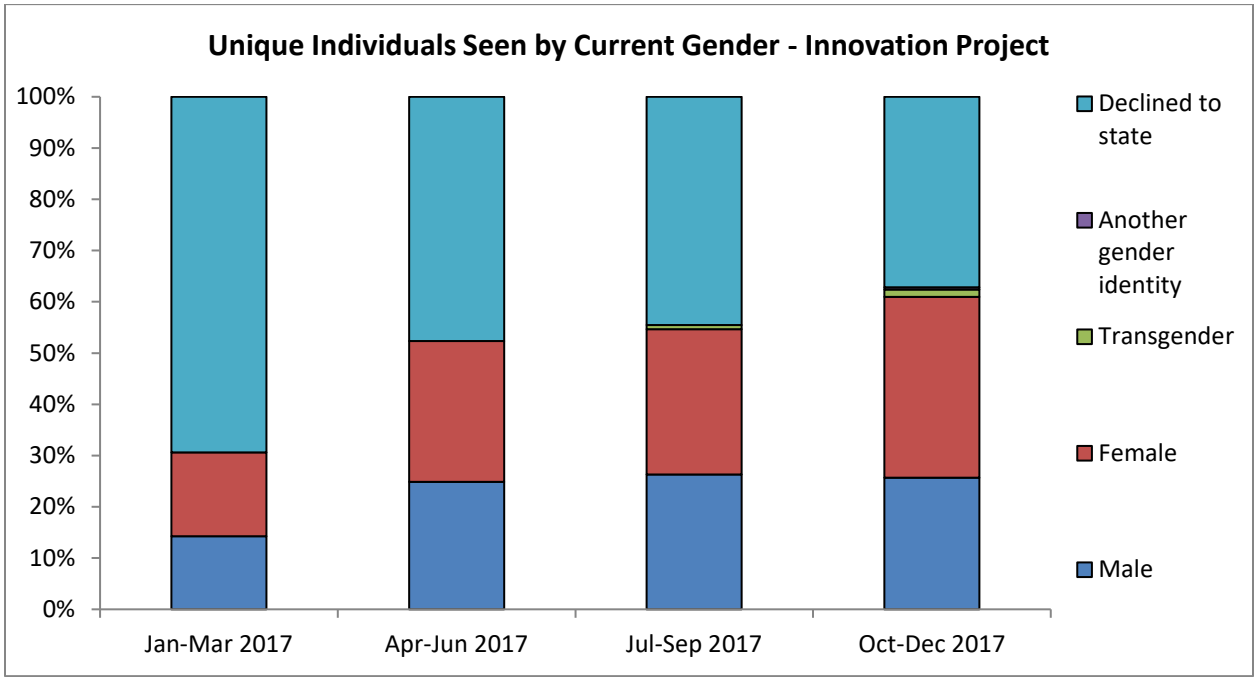
SEXUAL ORIENTATION



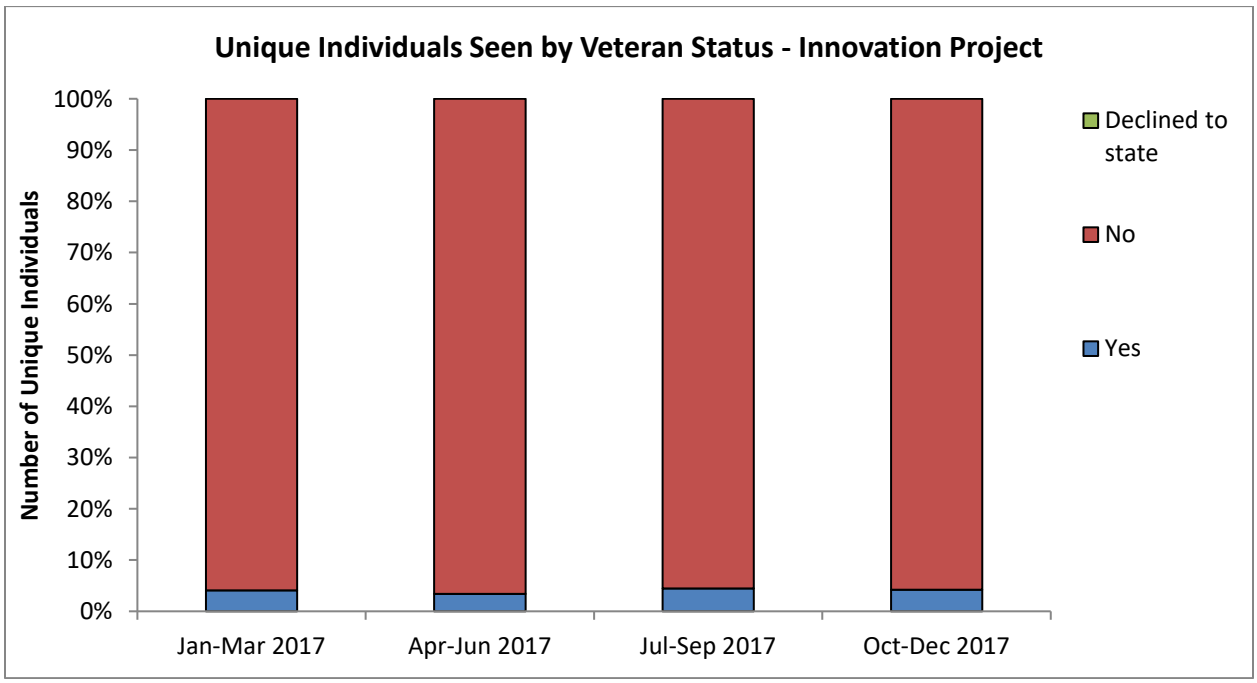
BIRTH GENDER



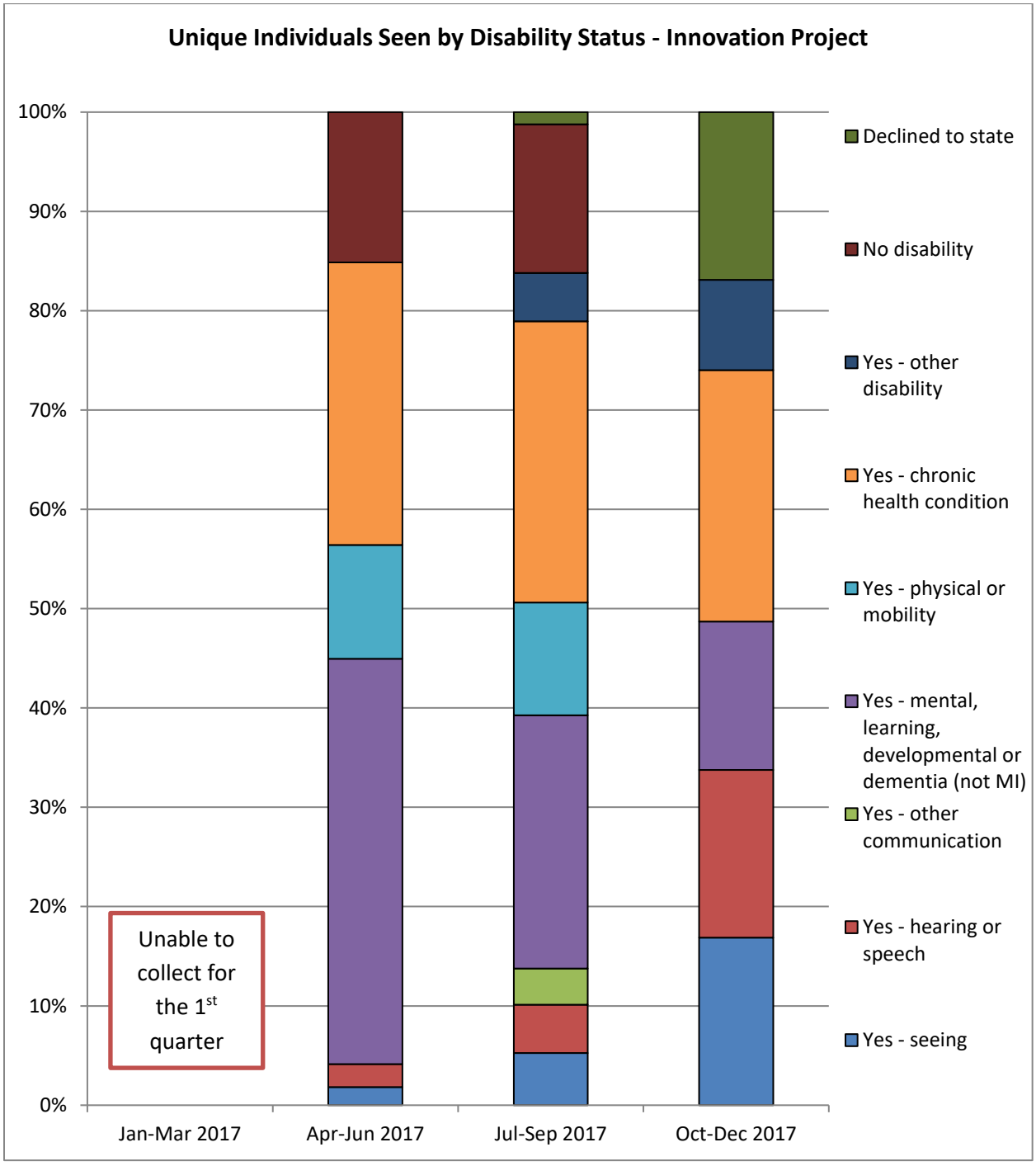
CURRENT GENDER



VETERAN STATUS



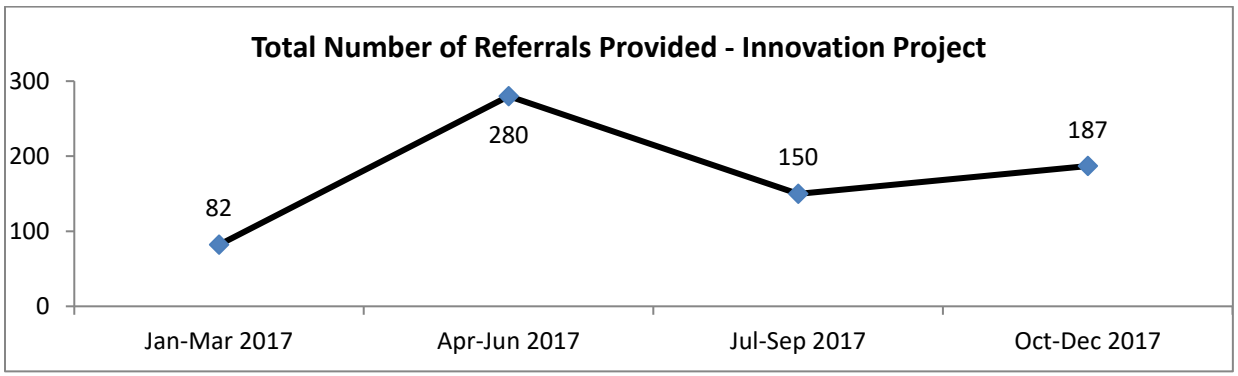
DISABILITY STATUS



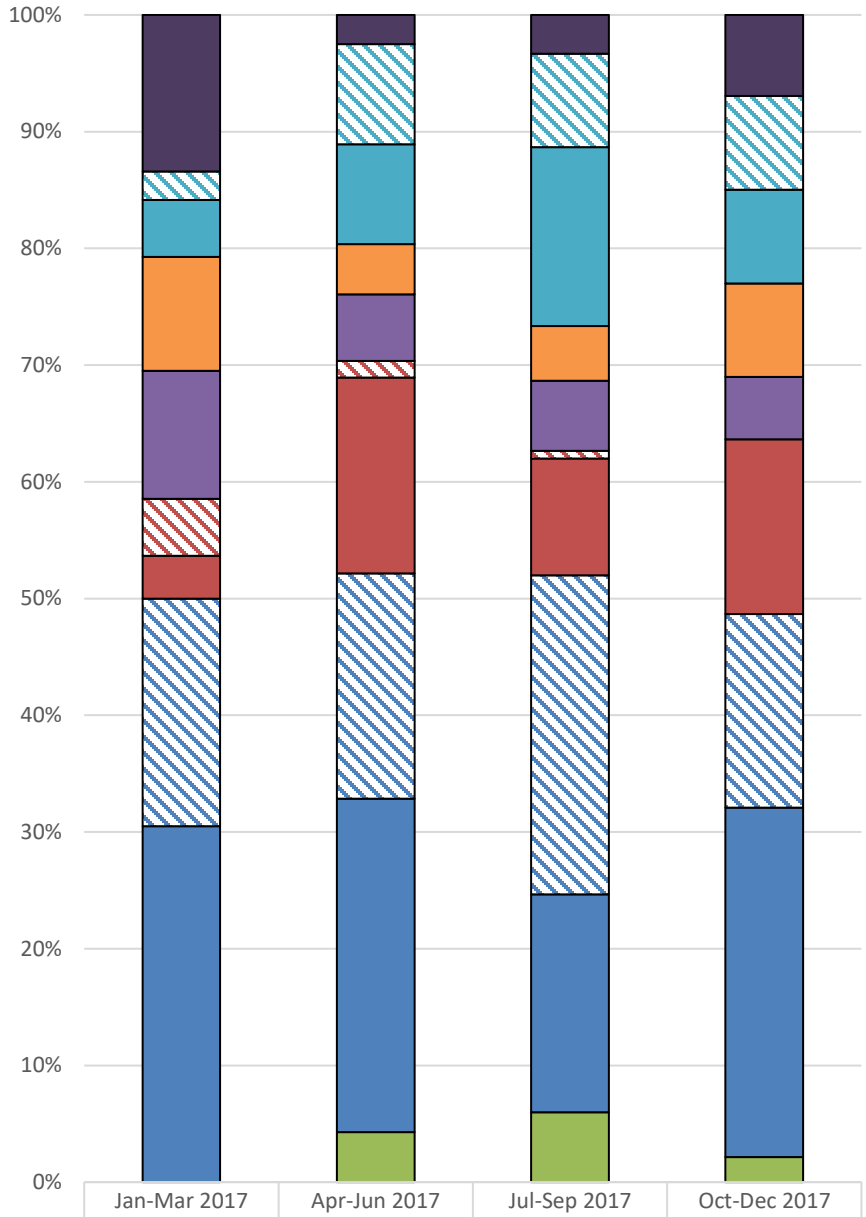
NUMBER OF OUTSIDE REFERRALS PROVIDED AND SUCCESSFULLY ACCESSED

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

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

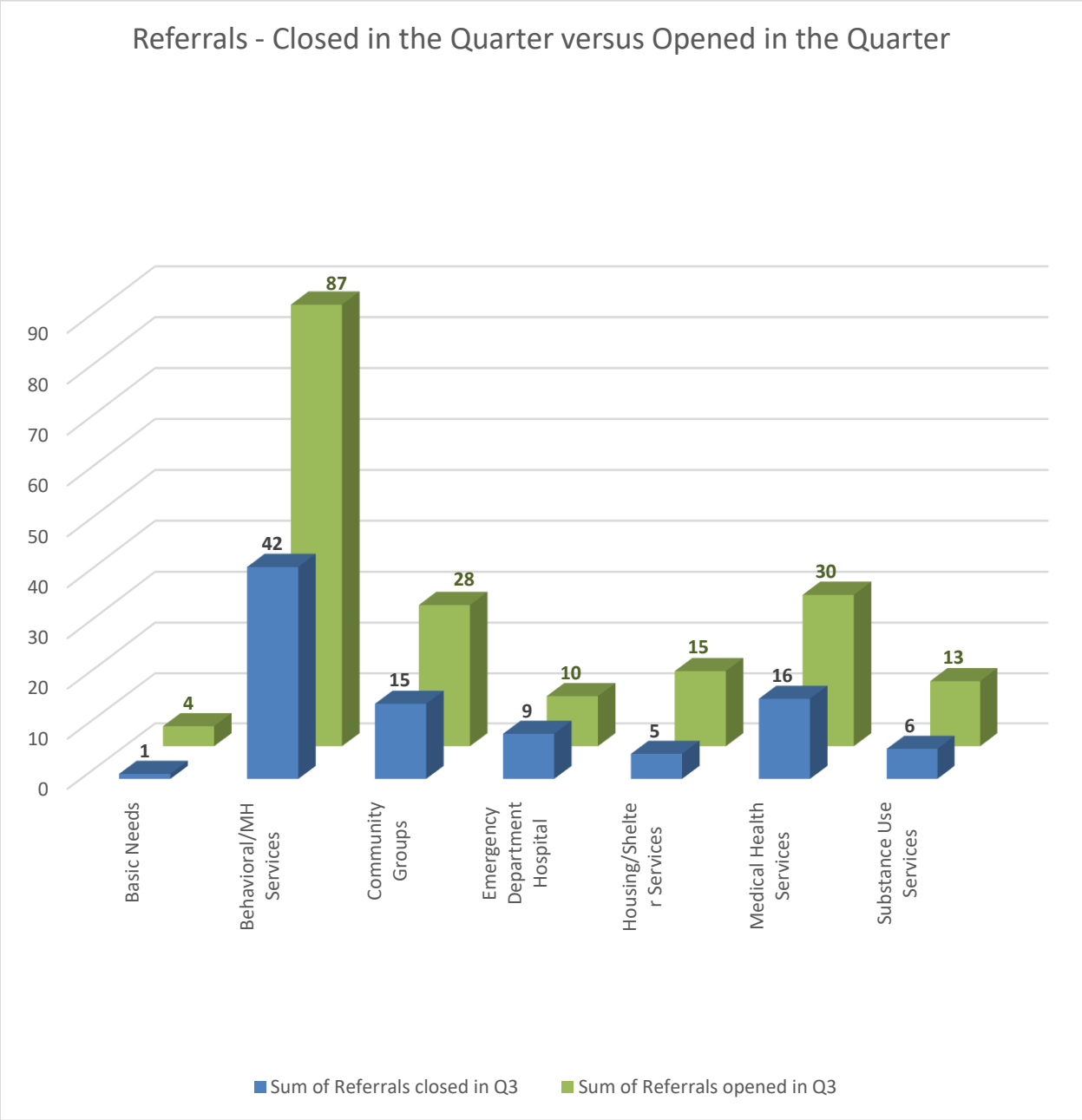


Referrals Provided by Category - Innovation Project



	Jan-Mar 2017	Apr-Jun 2017	Jul-Sep 2017	Oct-Dec 2017
Substance Use Services	11	7	5	13
Medical Health Services Hill Country	2	24	12	15
Medical Health Services External	4	24	23	15
Housing/Shelter Services	8	12	7	15
ED Hospital	9	16	9	10
Community Groups Hill Country	4	4	1	0
Community Groups External	3	47	15	28
Behavioral/MH Services Hill Country	16	54	41	31
Behavioral/MH Servivces External	25	80	28	56
Basic Needs	0	12	9	4

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

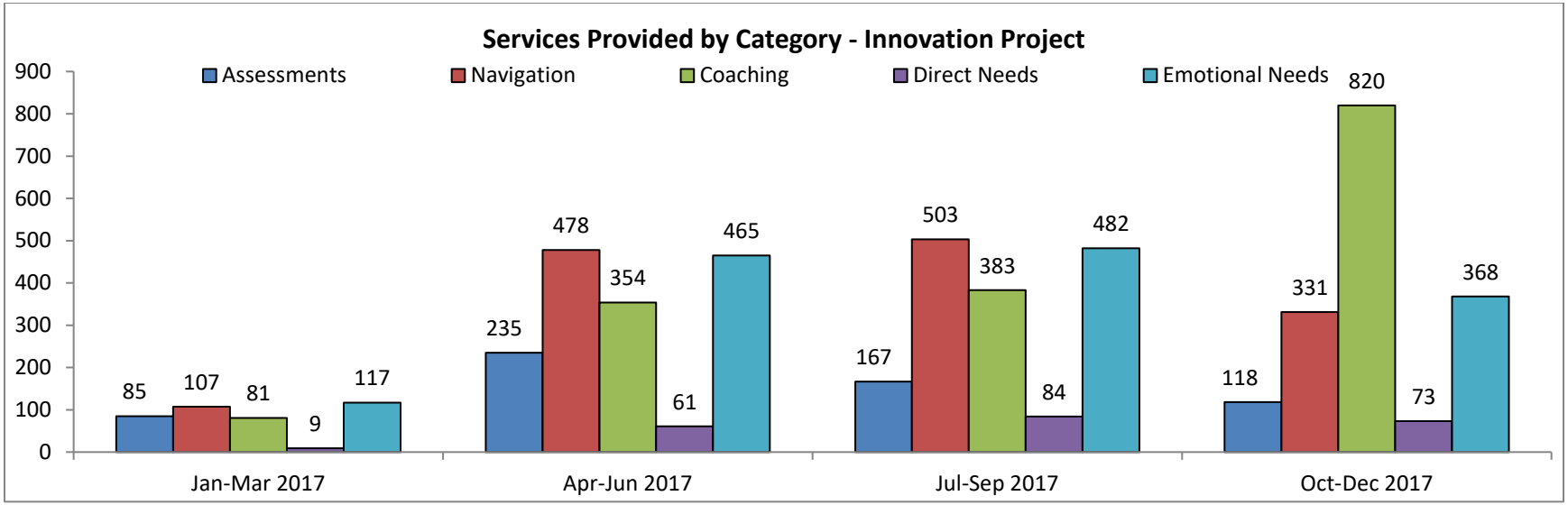


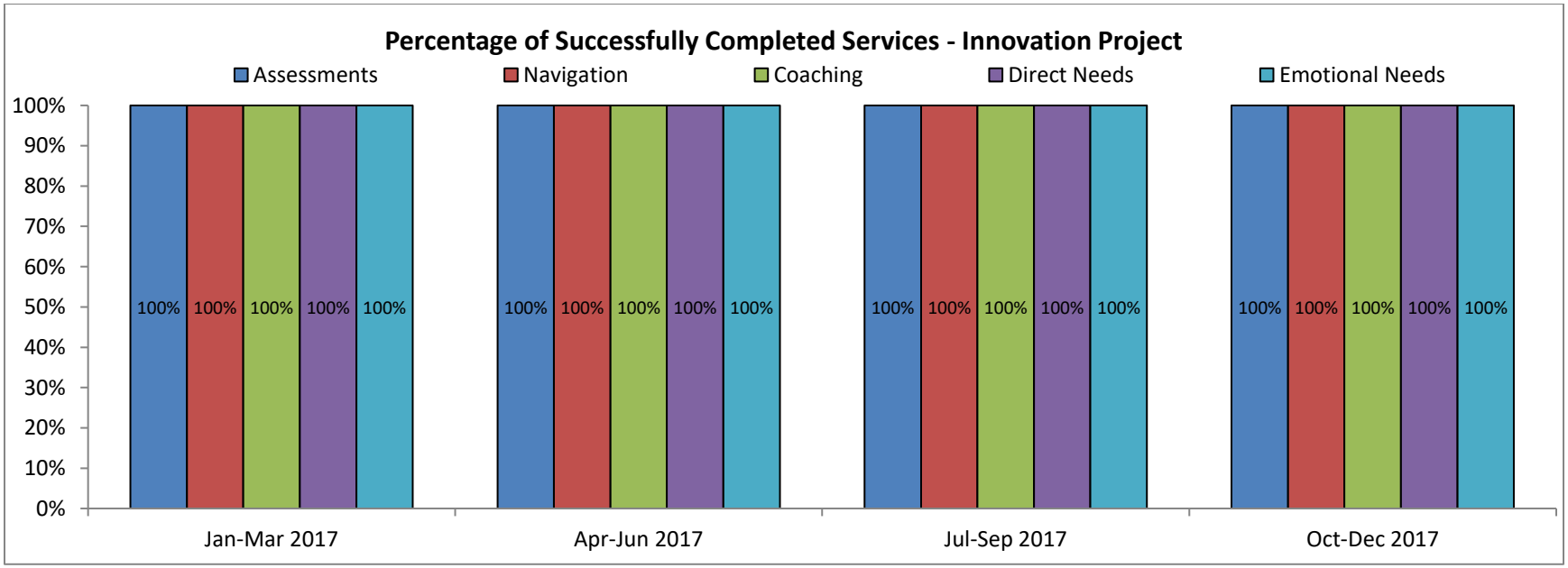
NUMBER OF SERVICES PROVIDED AND SUCCESSFULLY COMPLETED

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

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

Services are also tracked to see if the individuals who are needing the service(s) provided by the CARE Center are successful in accessing the services, and either completing the activities or receiving any tangible items involved with each service.


Services Provided by Category - Innovation Project
Assessments
Navigation
Coaching
Direct Needs
Emotional Needs
900
800
700
600
500
400
300
200
100
0
85
107
81
9
117
235
478
354
61
465
167
503
383
84
482
118
331
820
73
368
Jan-Mar 2017
Apr-Jun 2017
Jul-Sep 2017
Oct-Dec 2017


Percentage of Successfully Completed Services - Innovation Project
Assessments
Navigation
Coaching
Direct Needs
Emotional Needs
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
100%
Jan-Mar 2017
Apr-Jun 2017
Jul-Sep 2017
Oct-Dec 2017

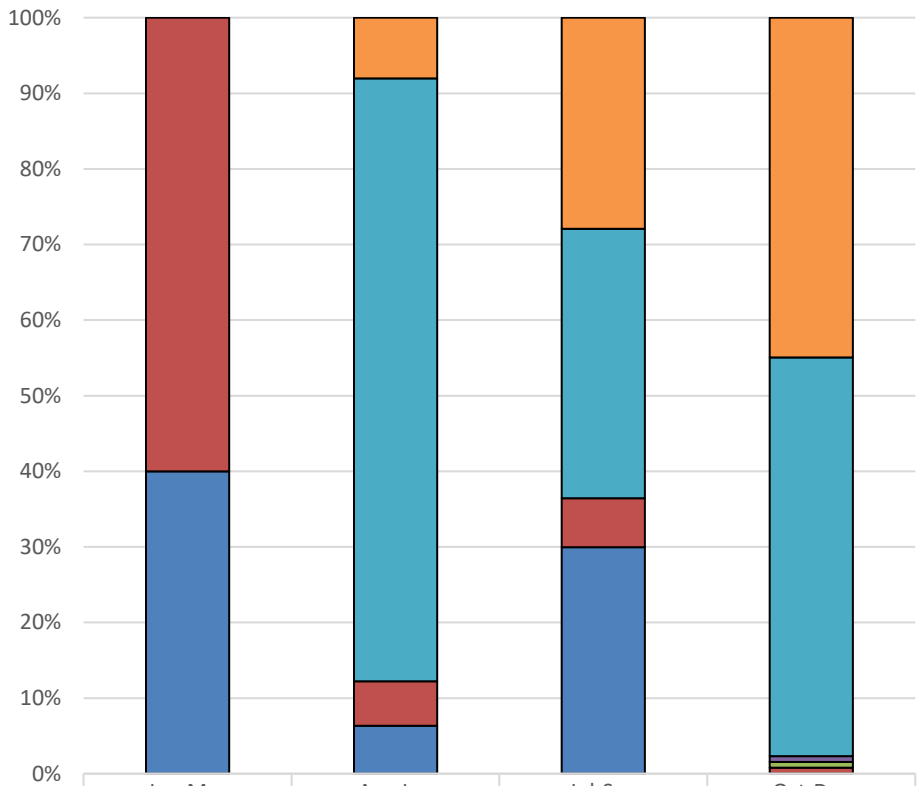
HOUSING STATUS

To help track the impact and effectiveness of services, the CARE Center has been asked to track the housing status of individuals accessing the Innovation Project services at the time they first start services, and then at the 3-month and 6-month points after that first service. The target outcome numbers are to see a 15% increase in housing stability/permanence at the 3-month mark, and a 20% increase at the 6-month mark.

Housing status has been divided up into the following categories:

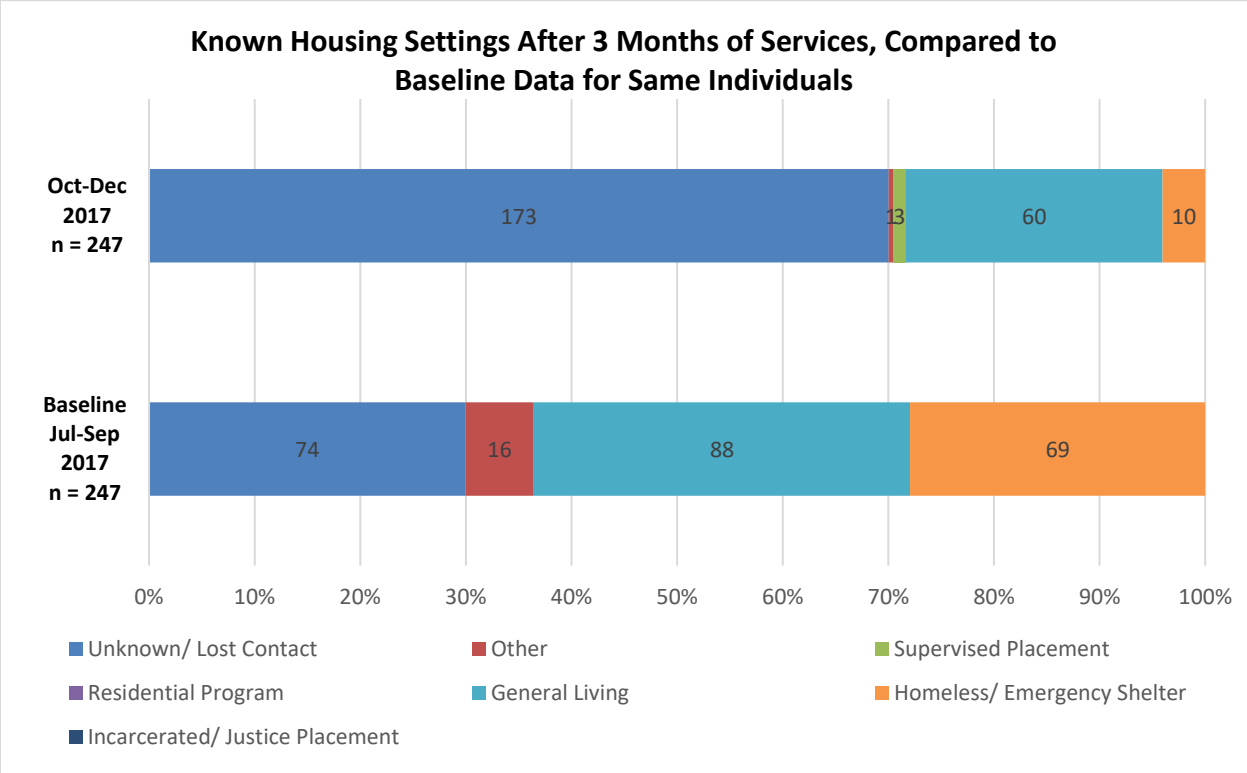
- Homeless/emergency shelter
- General living, which includes the following:
    - Apartment or house, alone or with family/roommates
    - Foster home
    - Single room occupancy
- Residential program, which includes the following:
    - Community treatment program
    - Group home (any level)
    -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

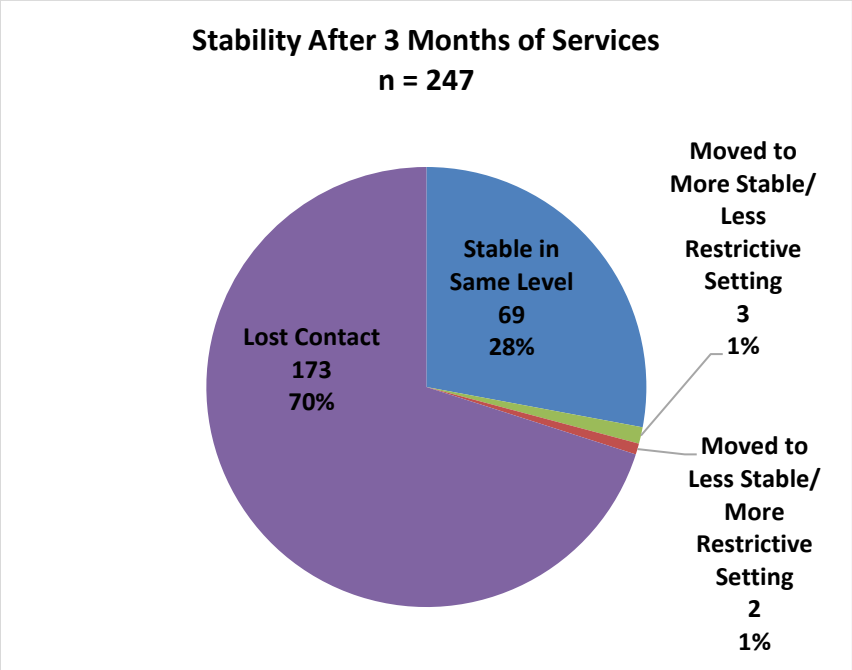
HOUSING STATUS AT START OF SERVICES



	Jan-Mar 2017	Apr-Jun 2017	Jul-Sep 2017	Oct-Dec 2017
Homeless/ Emergency Shelter		19	69	58
General Living		189	88	68
Residential Program				1
Supervised Placement				1
Other	3	14	16	1
Unknown	2	15	74	

HOUSING STABILITY 3 MONTHS AFTER SERVICES AT THE CARE CENTER

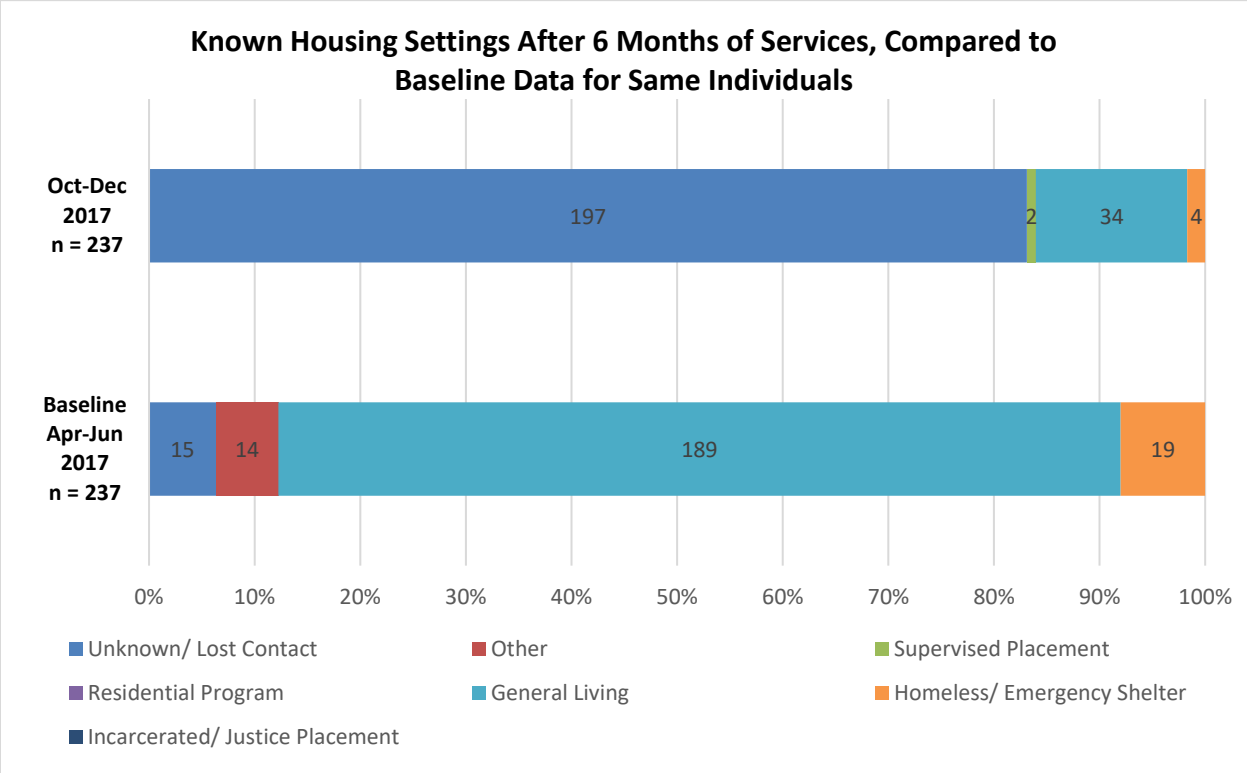


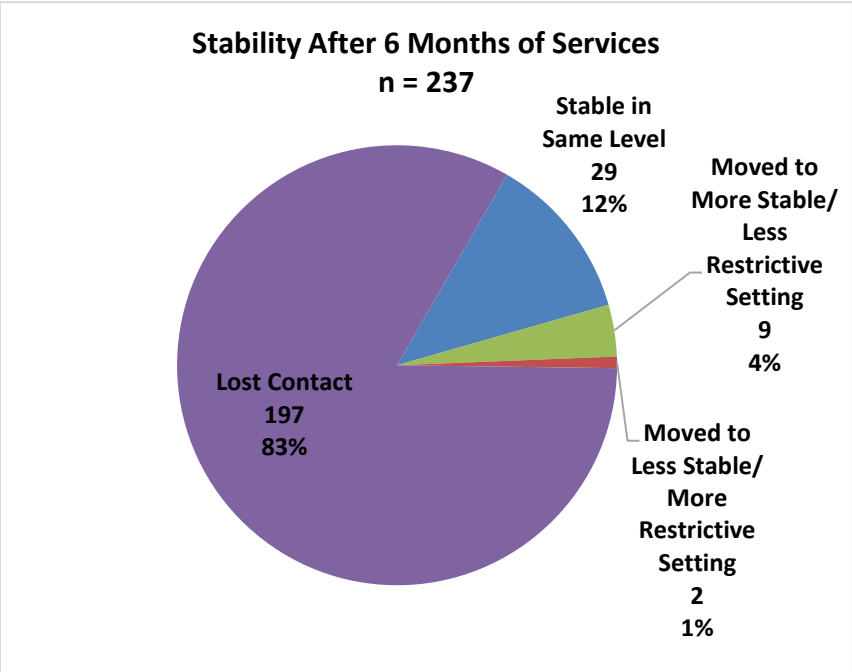


For those who moved to more stable/less restrictive settings, 1 transitioned from Homeless/E.S. to General Living, 1 from Homeless/E.S. to Supervised Placement, and 1 from Residential Program to General Living.

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

HOUSING STABILITY 6 MONTHS AFTER SERVICES AT THE CARE CENTER





For those who moved to more stable/less restrictive settings, 8 transitioned from Homeless/E.S. to General Living, and 1 transitioned from Homeless/E.S. to Supervised Placement.

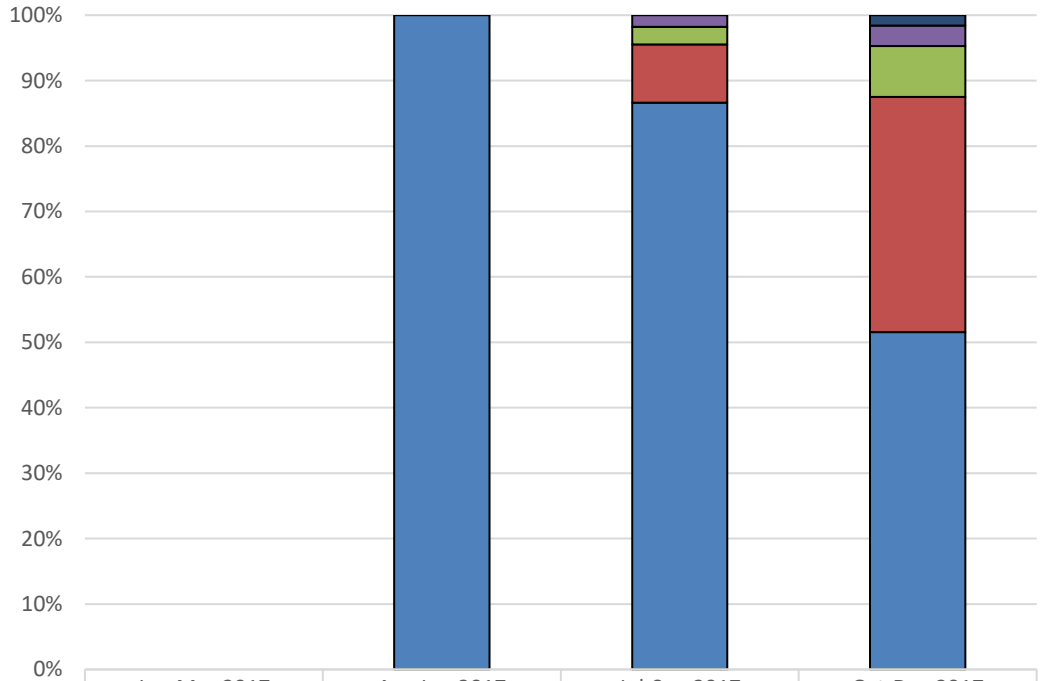
For the 2 people who moved to a less stable/more restrictive setting, one transitioned from General Living to Homeless/E.S. and the other from General Living to Supervised Placement.

EMERGENCY DEPARTMENT VISITS

One of the goals of the Innovation Project is to reduce the number of emergency department visits for psychiatric reasons. Statistics are being tracked directly from the hospitals, but to measure the impact and effectiveness for individuals, the CARE Center has been asked to track the number of ER visits individuals report having made in the 6 months prior to the time they first start services at the CARE Center, and then at the 3-month and 6-month points after that first service. The target outcome numbers are to see a 15% decrease in ER visits at the 3-month mark, and a 20% decrease at the 6-month mark.

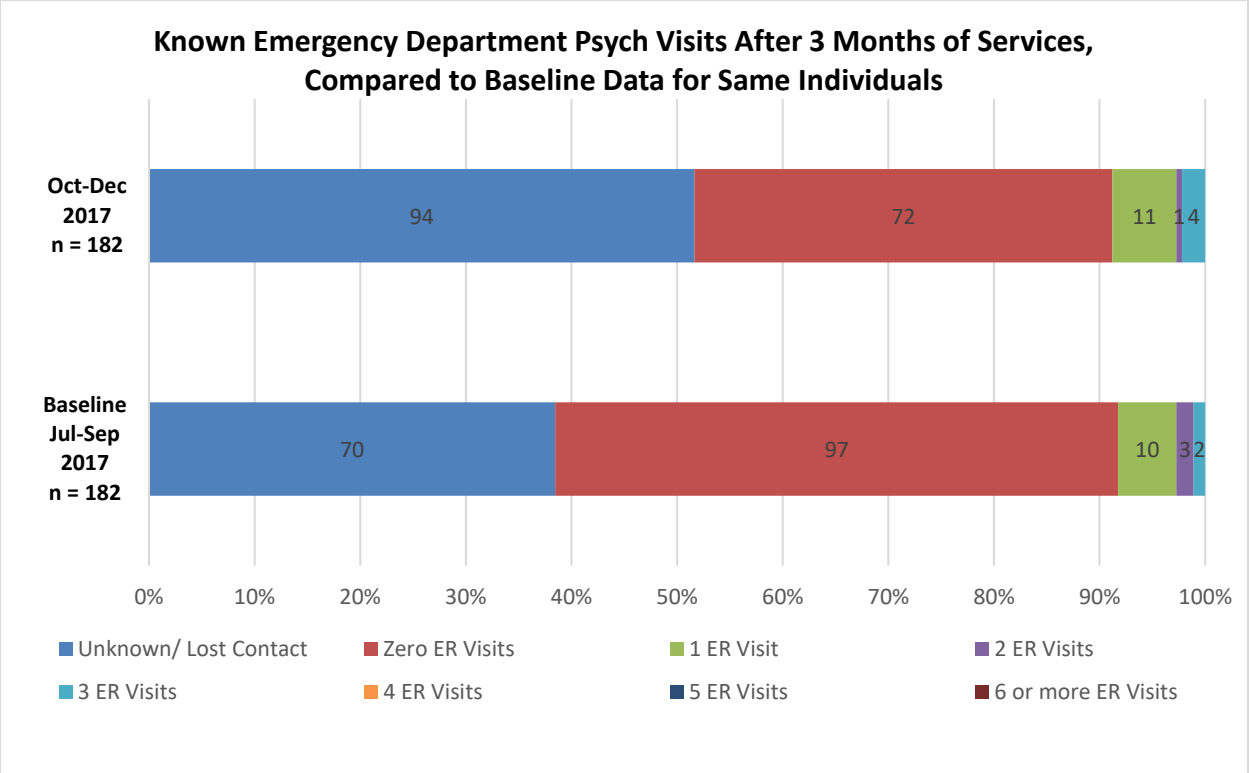
BASELINE EMERGENCY DEPARTMENT PSYCHIATRIC VISITS – PRIOR TO CARE CENTER SERVICES

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

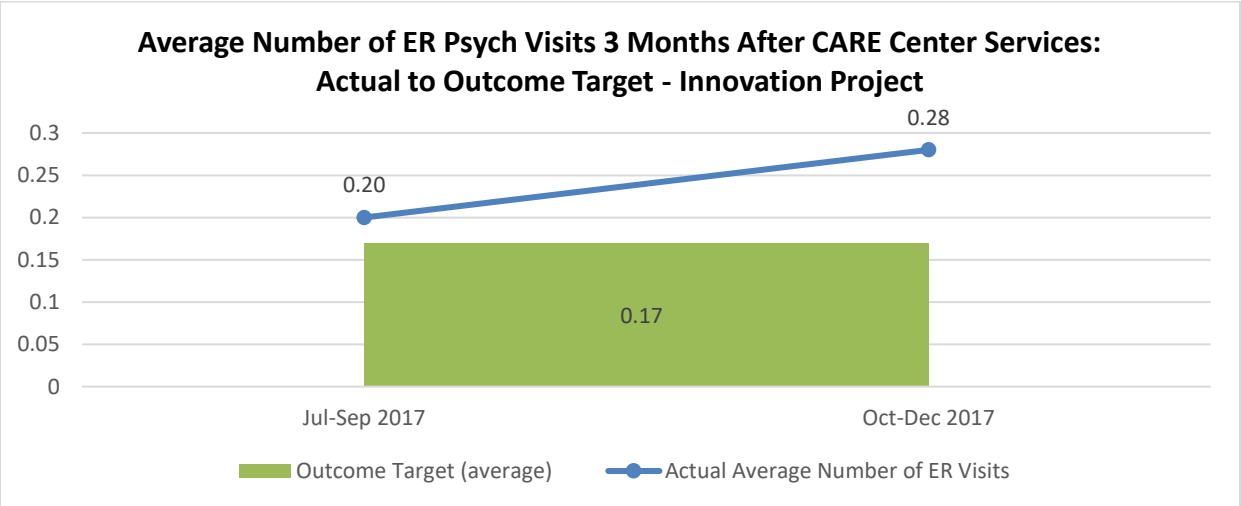


	Jan-Mar 2017	Apr-Jun 2017	Jul-Sep 2017	Oct-Dec 2017
6 or more ER Visits	Unable to collect for the 1st quarter	0	0	1
5 ER Visits		0	0	0
4 ER Visits		0	0	0
3 ER Visits		0	2	2
2 ER Visits		0	3	5
1 ER Visit		0	10	23
Zero ER Visits		14	97	33

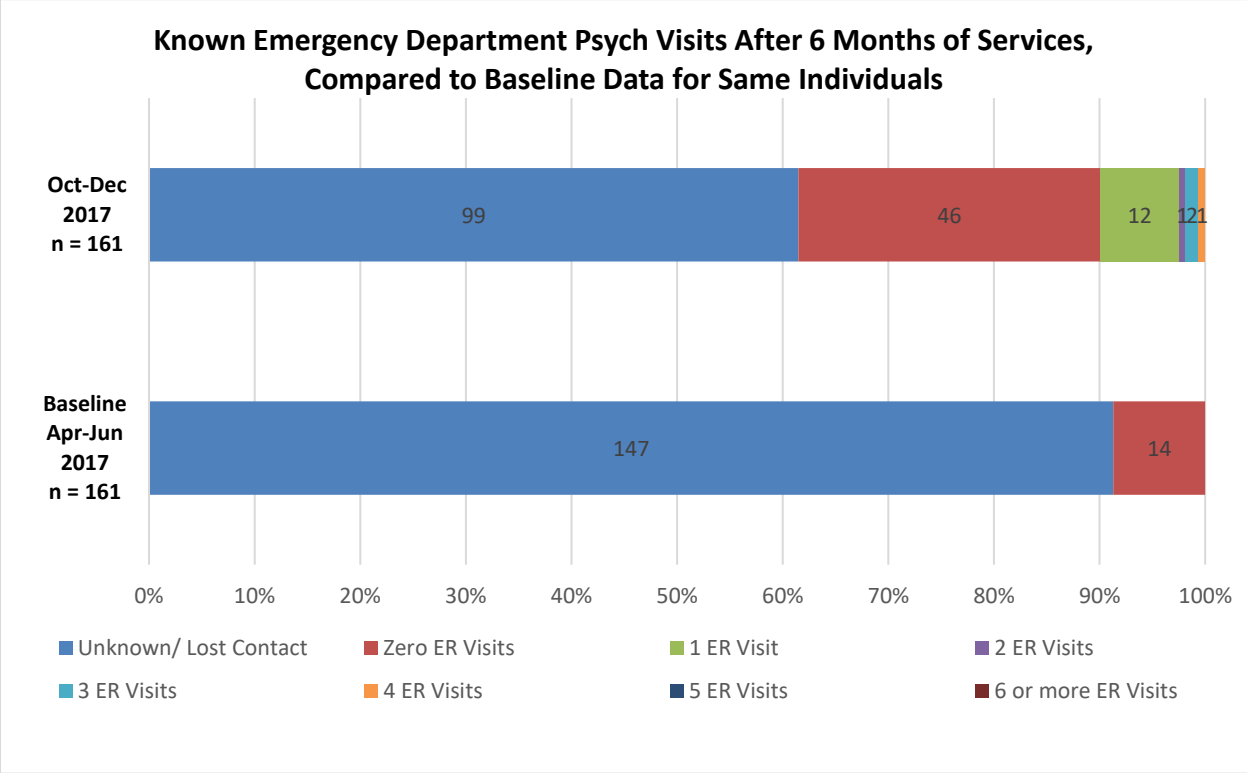
EMERGENCY DEPARTMENT PSYCH VISITS 3 MONTHS AFTER SERVICES AT THE CARE CENTER



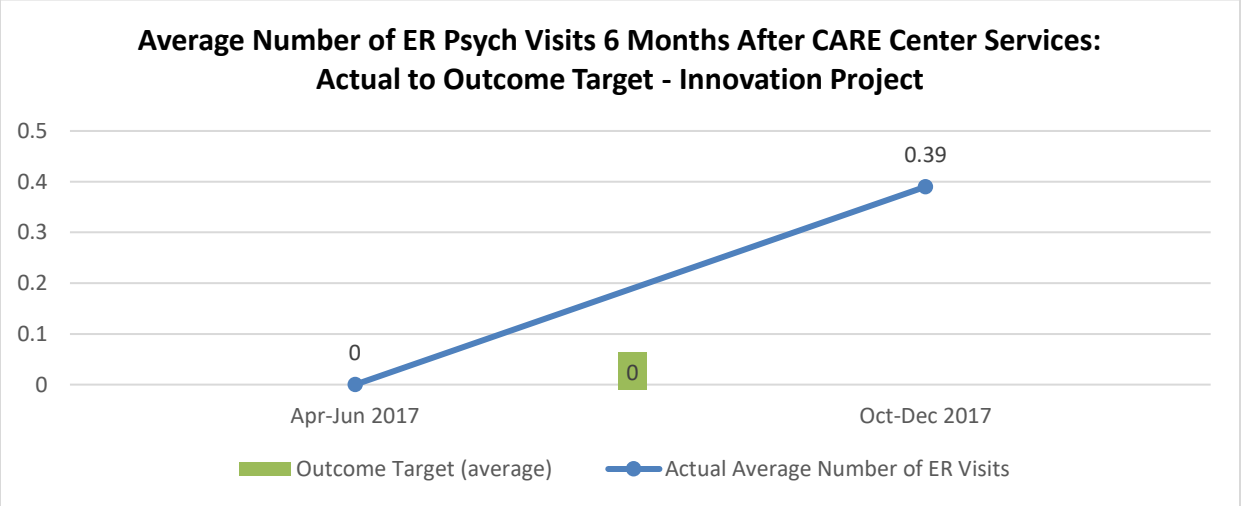
The average number of ER visits in the prior 6 months for the Jul-Sep 2017 quarter was 0.2 per individual who had visit data reported (excluding all in the Unknown/Lost Contact category). This makes the target number for the 3-month mark in the Oct-Dec 2017 quarter 0.17 or fewer ER visits on average.



EMERGENCY DEPARTMENT PSYCH VISITS 6 MONTHS AFTER SERVICES AT THE CARE CENTER



The average number of ER visits in the prior 6 months for the Apr-Jun 2017 quarter was zero as no individuals had any visits reported. This makes the target number for the 3-month mark in the Oct-Dec 2017 quarter zero ER visits on average as well.

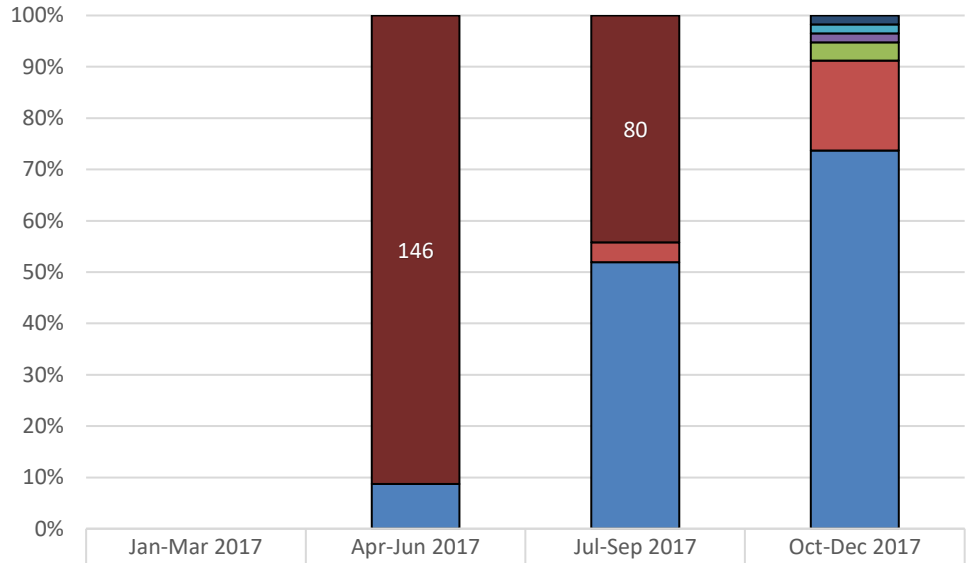


PSYCHIATRIC INPATIENT HOSPITALIZATIONS

Another goal of the Innovation Project is to reduce the number of psychiatric inpatient hospitalizations, and the number of days spent in the hospital during those hospitalizations. The CARE Center has been asked to track the number of psychiatric inpatient hospitalizations and number of days spent in the hospital that individuals report having made in the 6 months prior to the time they first start services at the CARE Center, and then at the 3-month and 6-month points 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, and a 20% decrease at the 6-month mark.

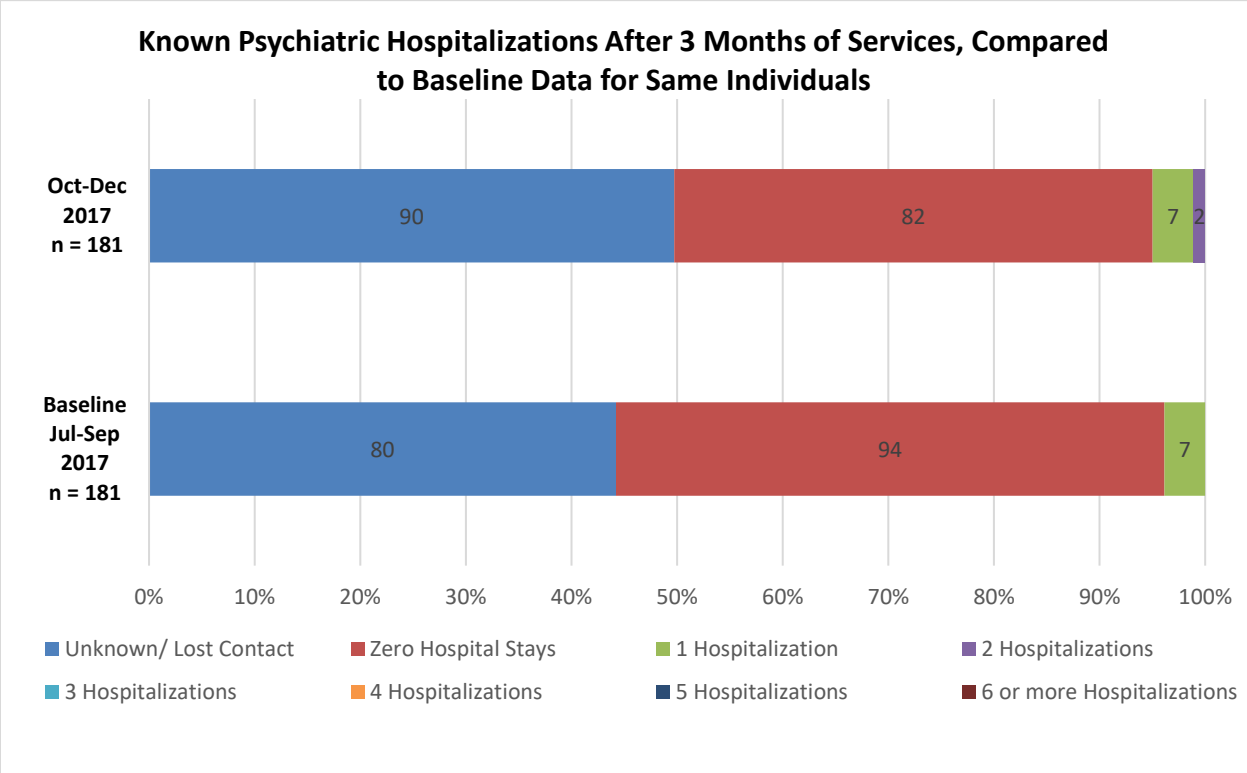
BASELINE PSYCHIATRIC HOSPITALIZATIONS – PRIOR TO CARE CENTER SERVICES

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

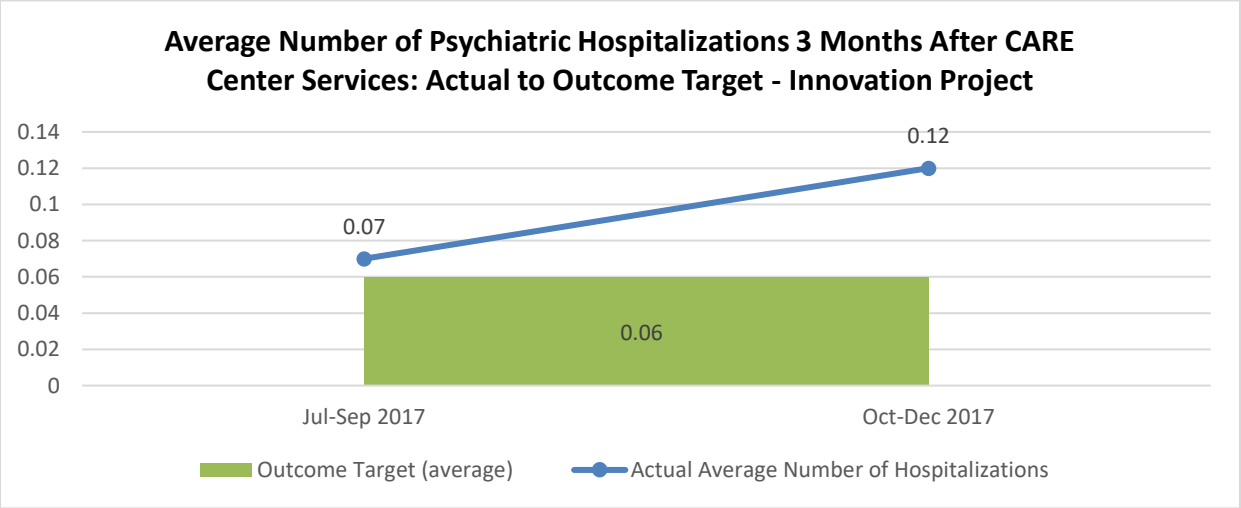


	Jan-Mar 2017	Apr-Jun 2017	Jul-Sep 2017	Oct-Dec 2017
Unknown		146	80	0
6 or more Hospitalizations		0	0	1
5 Hospitalizations	Unable to collect for the 1st quarter	0	0	0
4 Hospitalizations		0	0	1
3 Hospitalizations		0	0	1
2 Hospitalizations		0	0	2
1 Hospitalization		0	7	10
Zero Hospital Stays		14	94	42

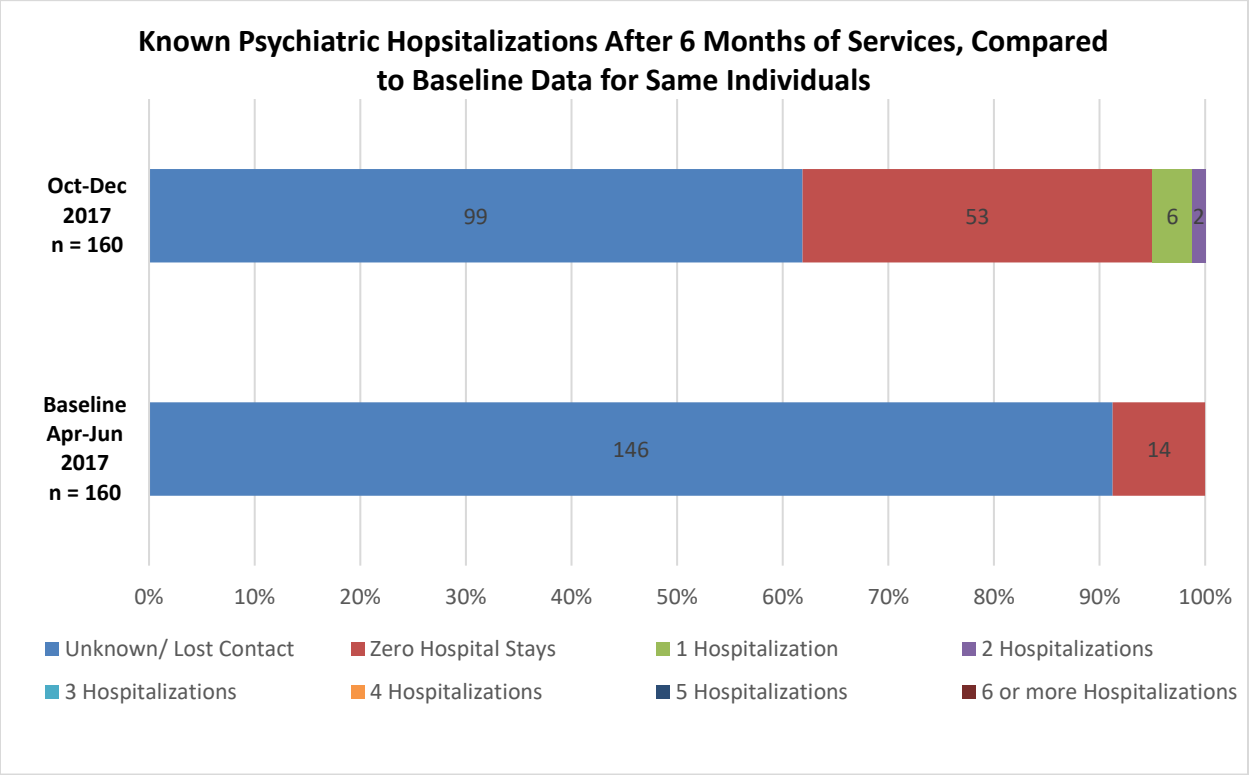
PSYCHIATRIC HOSPITALIZATIONS 3 MONTHS AFTER SERVICES AT THE CARE CENTER



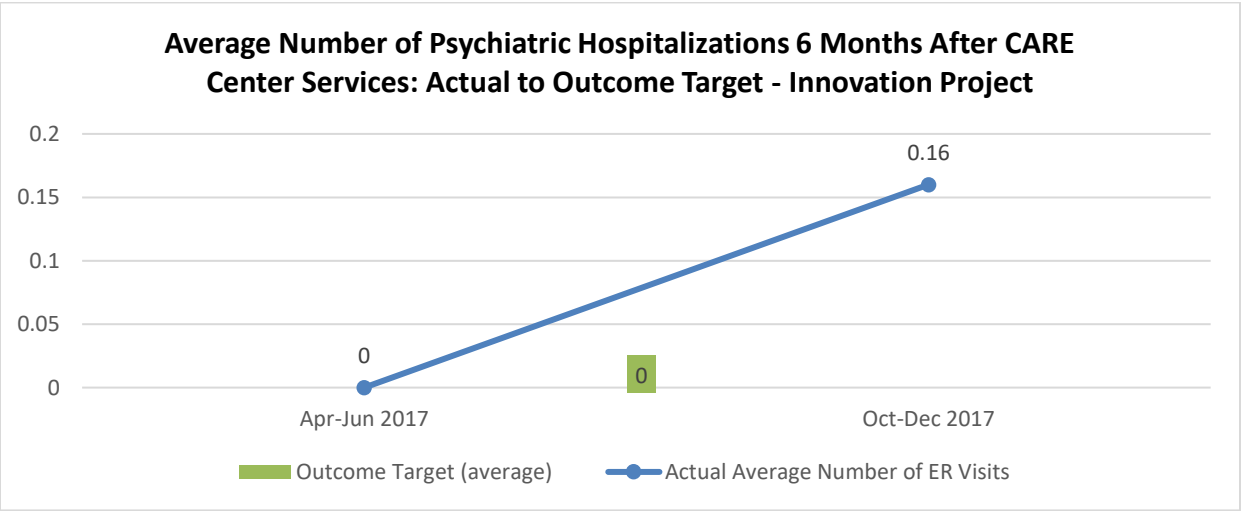
The average number of psychiatric hospitalizations in the prior 6 months for the Jul-Sep 2017 quarter was 0.07 per individual who had any hospitalizations. This makes the target number for the 3-month mark in the Oct-Dec 2017 quarter 0.06 or fewer hospitalizations on average.



PSYCHIATRIC HOSPITALIZATIONS 6 MONTHS AFTER SERVICES AT THE CARE CENTER



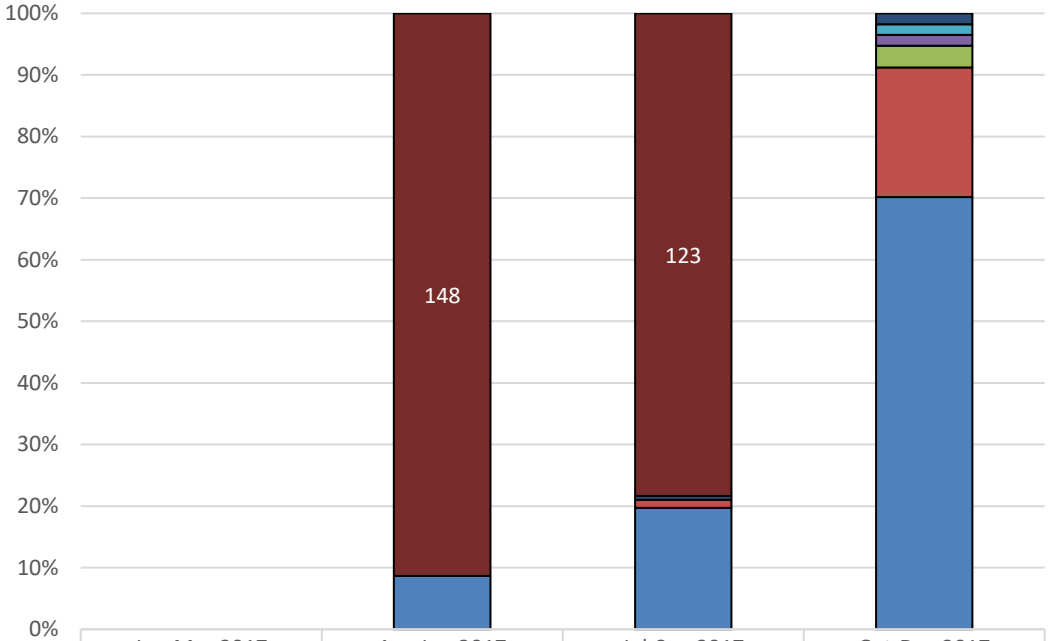
The average number of psychiatric hospitalizations in the prior 6 months for the Apr-Jun 2017 quarter was zero as no individuals had any hospitalizations reported. This makes the target number for the 3-month mark in the Oct-Dec 2017 quarter zero ER visits on average as well.



ARRESTS

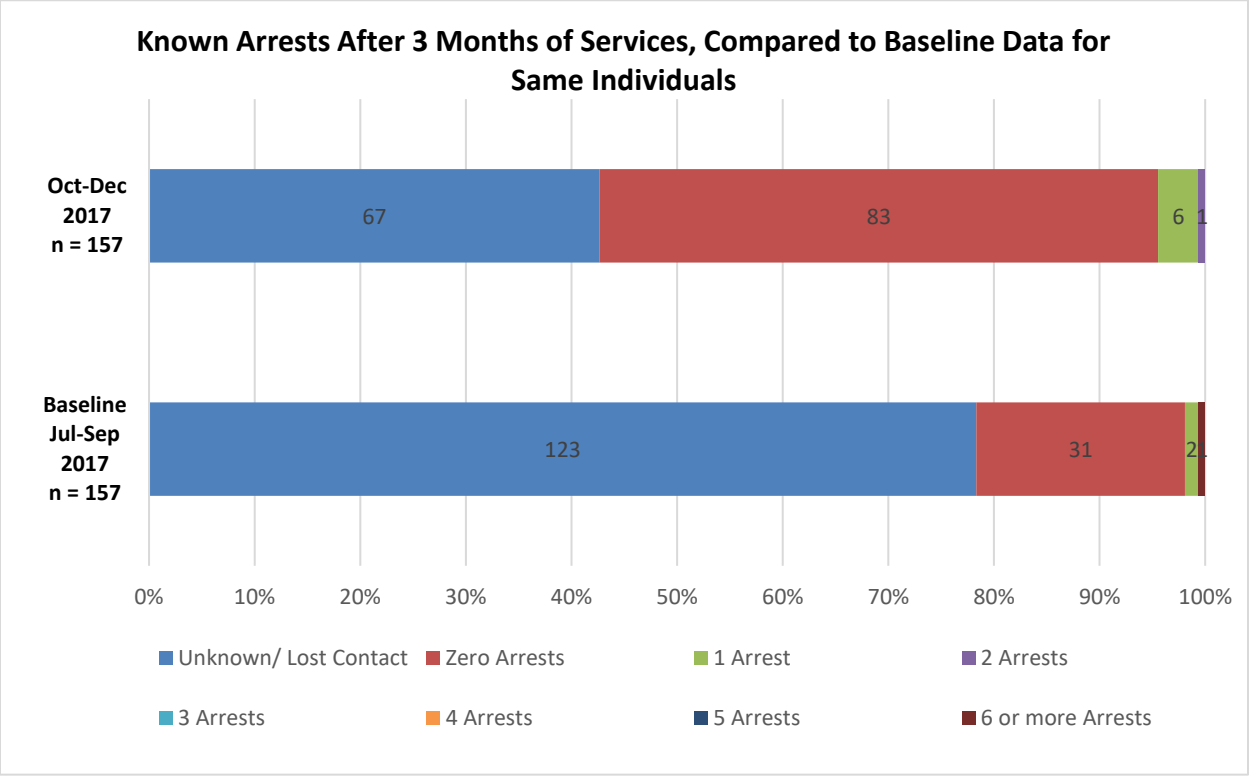
Another goal of the Innovation Project is to reduce the number of arrests, and the number of days spent incarcerated. The CARE Center has been asked to track the number of arrests and number of days spent incarcerated that individuals report having made in the 6 months prior to the time they first start services at the CARE Center, and then at the 3-month and 6-month points 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, and a 20% decrease at the 6-month mark.

BASELINE ARRESTS – PRIOR TO CARE CENTER SERVICES

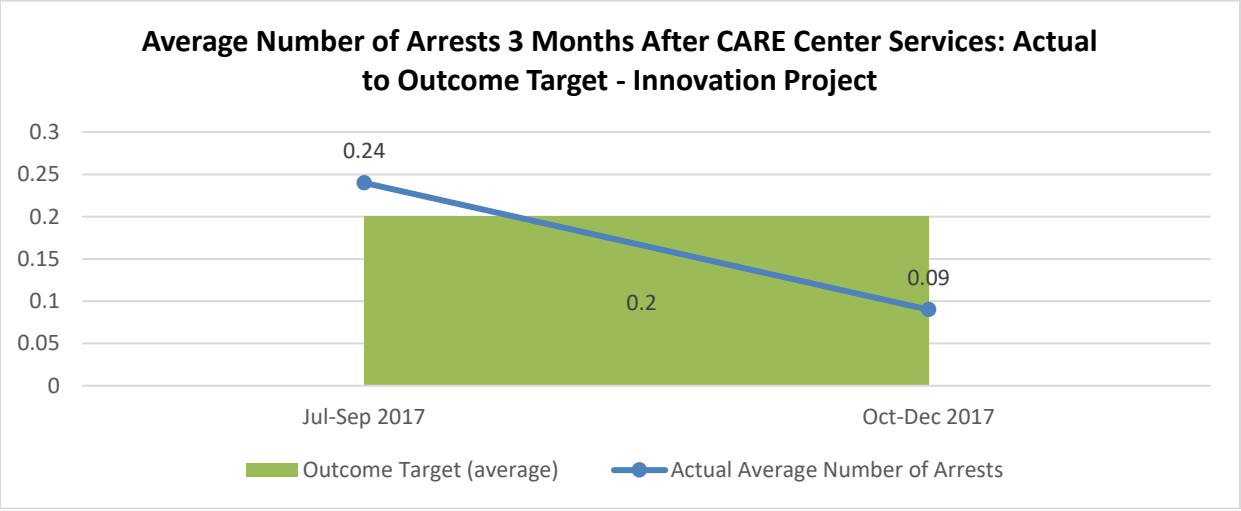


	Jan-Mar 2017	Apr-Jun 2017	Jul-Sep 2017	Oct-Dec 2017
Unknown		148	123	0
6 or more Arrests		0	1	1
5 Arrests	Unable to collect for the 1st quarter	0	0	0
4 Arrests		0	0	1
3 Arrests		0	0	1
2 Arrests		0	0	2
1 Arrest		0	2	12
Zero Arrests		14	31	40

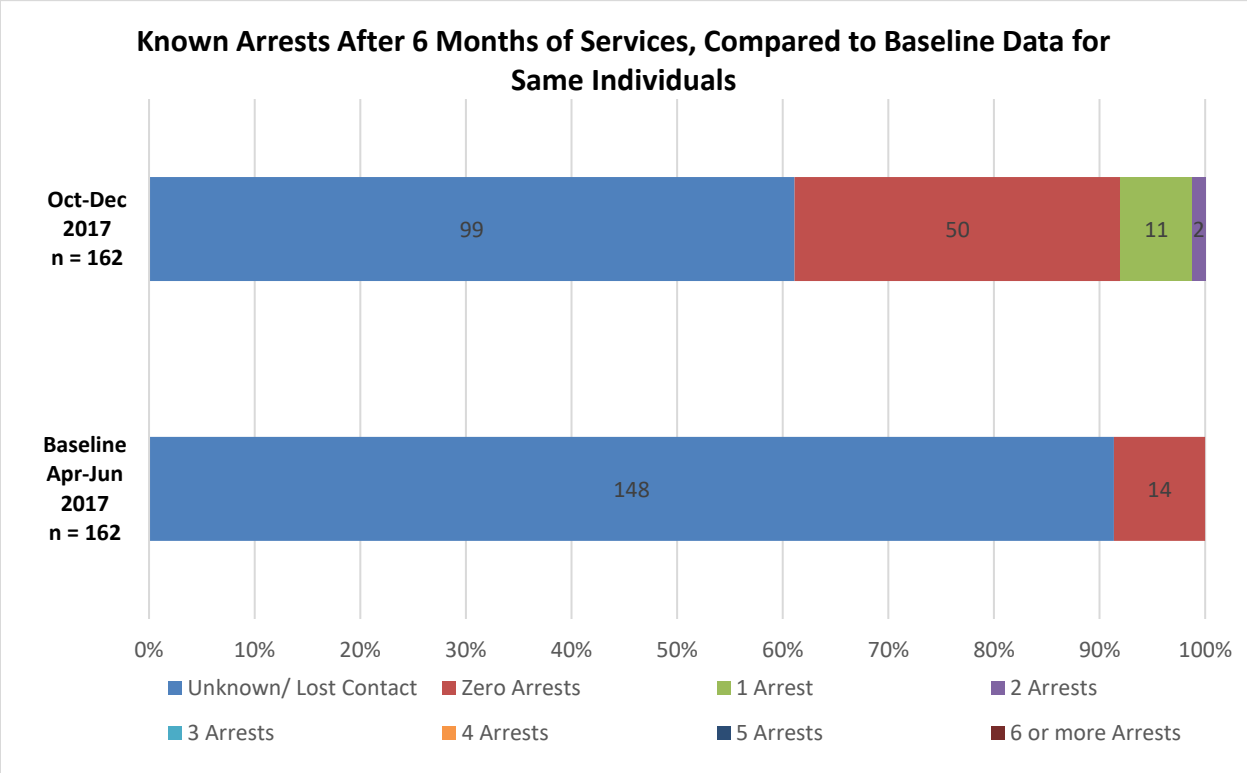
ARRESTS 3 MONTHS AFTER SERVICES AT THE CARE CENTER



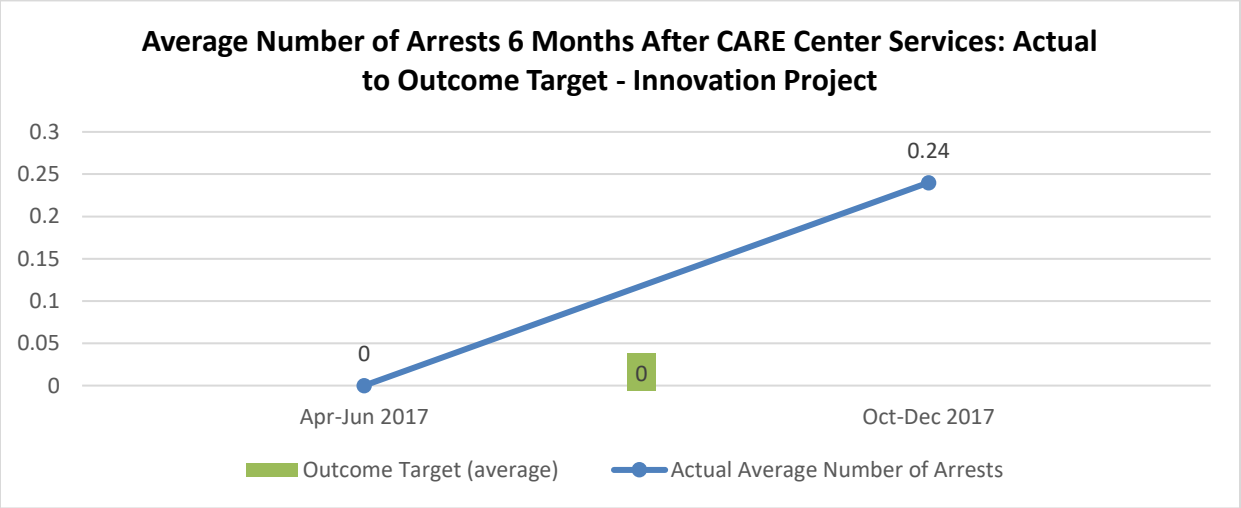
The average number of arrests in the prior 6 months for the Jul-Sep 2017 quarter was 0.24 per individual who had arrest data reported (excluding all in the Unknown/Lost Contact category). This makes the target number for the 3-month mark in the Oct-Dec 2017 quarter 0.20 or fewer arrests on average.



ARRESTS 6 MONTHS AFTER SERVICES AT THE CARE CENTER

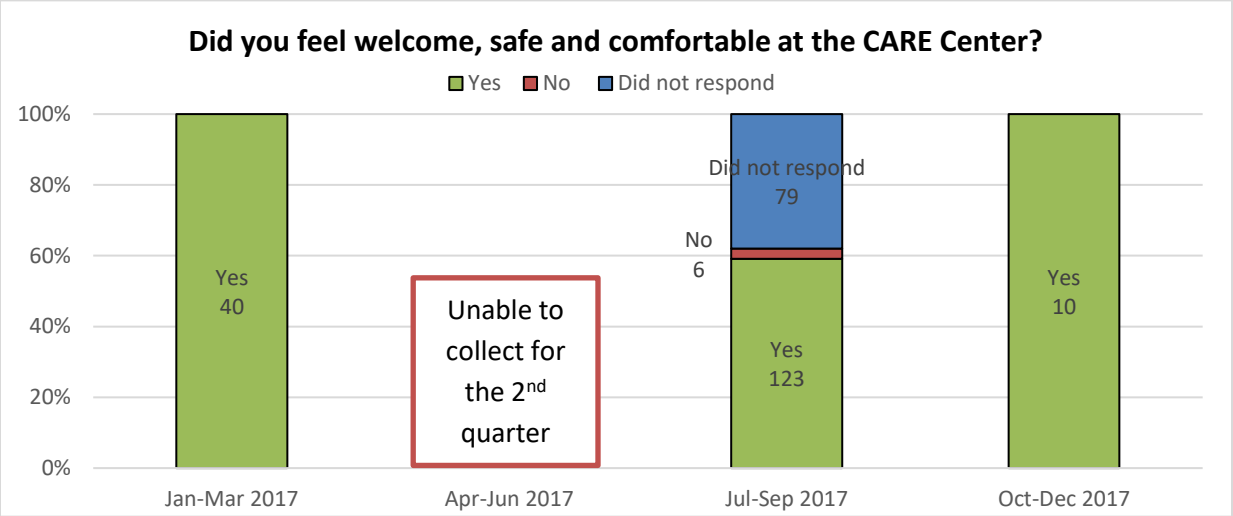


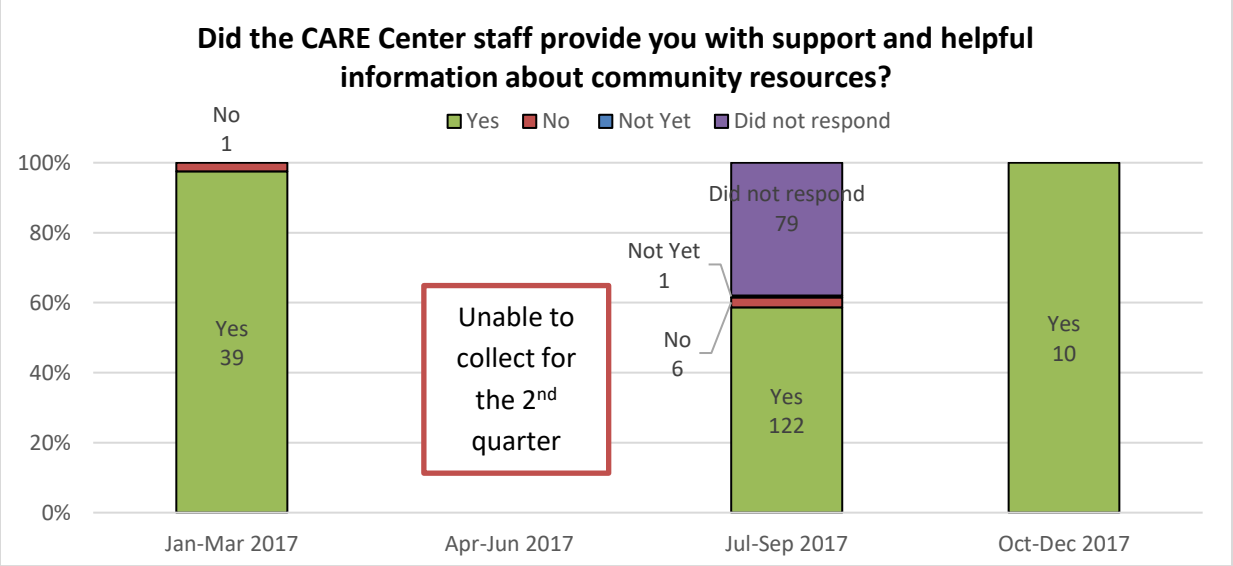
The average number of arrests in the prior 6 months for the Apr-Jun 2017 quarter was zero as no individuals had any arrests reported. This makes the target number for the 3-month mark in the Oct-Dec 2017 quarter zero arrests on average as well.

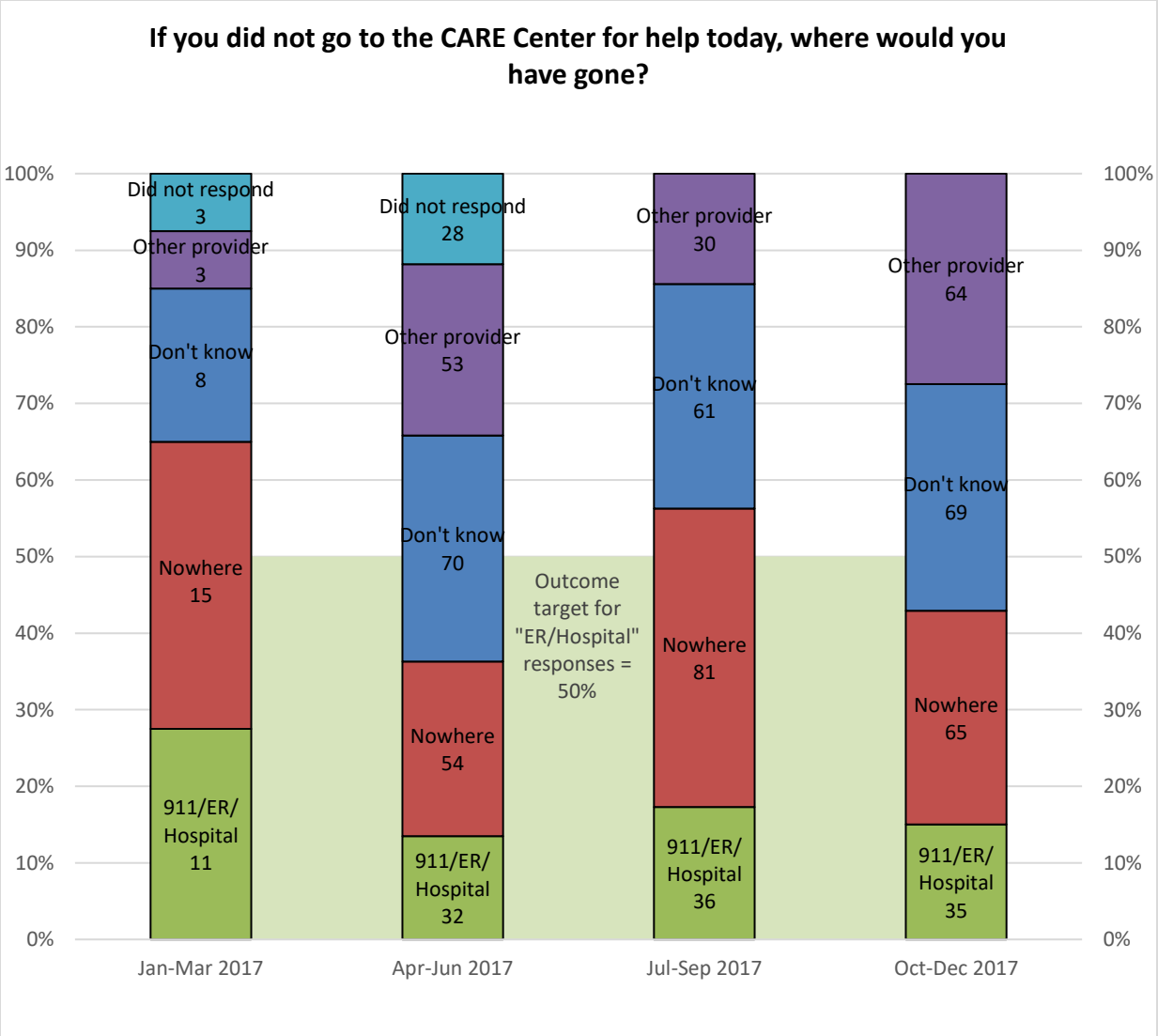


CUSTOMER SURVEYS

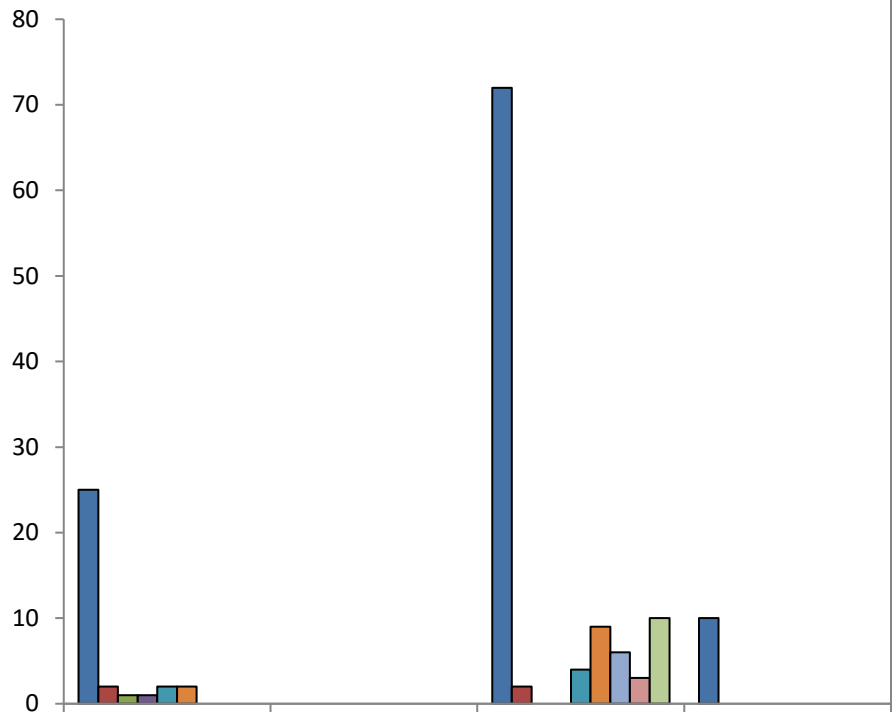
In the first quarter, each person served was offered the chance to complete a simple 4-question survey. Survey changes were made in the second quarter, and not all data points are available. Full survey results were again available in Jul-Sep 2017 quarter and moving forward.






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

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



	Jan-Mar 2017	Apr-Jun 2017	Jul-Sep 2017	Oct-Dec 2017
Happy with experience/ services	25		72	10
Medication	2		2	0
Dental Care	1		0	0
Services for alcoholics in crisis	1		0	0
More and/or different groups	2		4	0
Other facility amenities (music, TV, coffee, snacks etc.)	2		9	0
More staff/ better trained staff	0		6	0
Food & clothing	0		3	0
Other	0		10	0

Unable to collect for the 2nd quarter

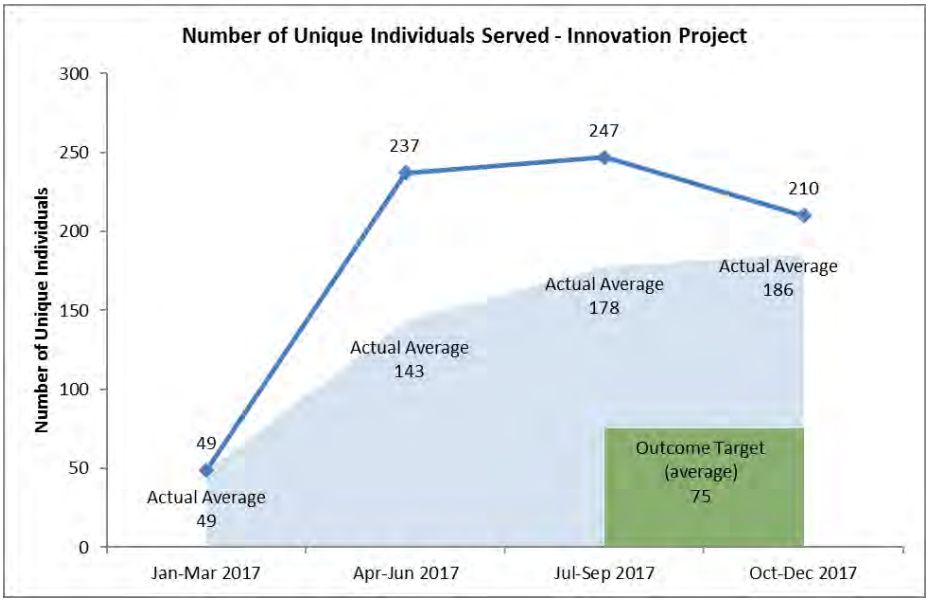
Innovation Project – CARE Center Year One Summary Report

Background

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

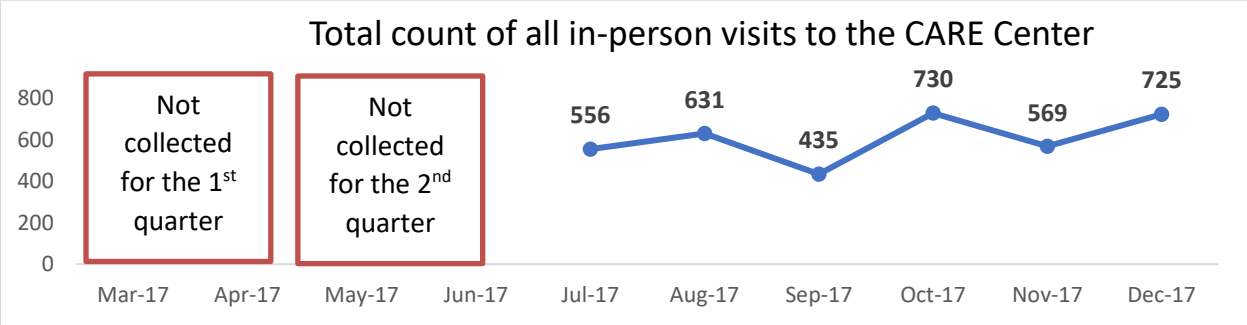
Numbers of People Seen and Services Provided

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

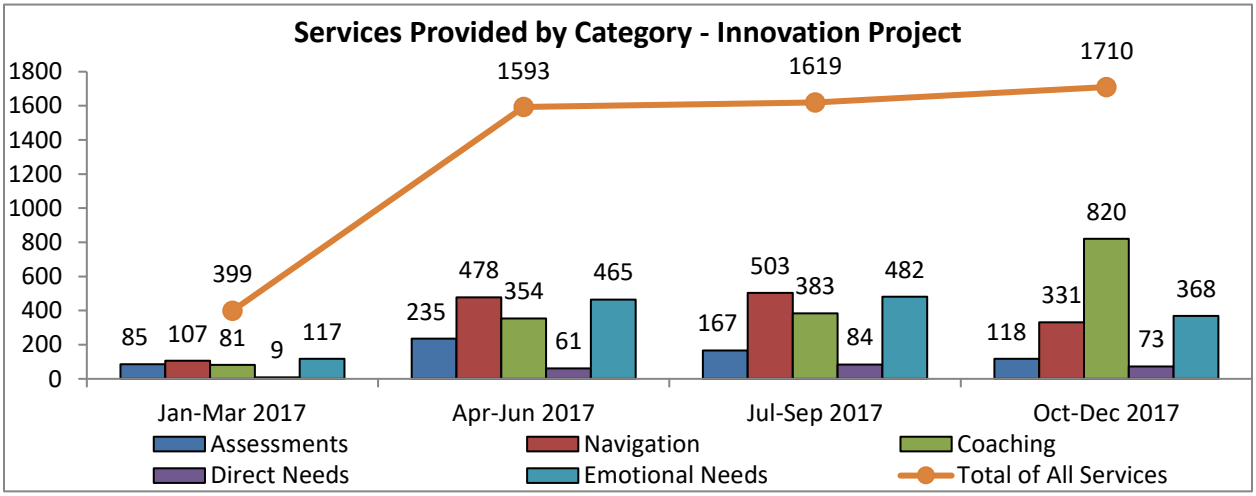


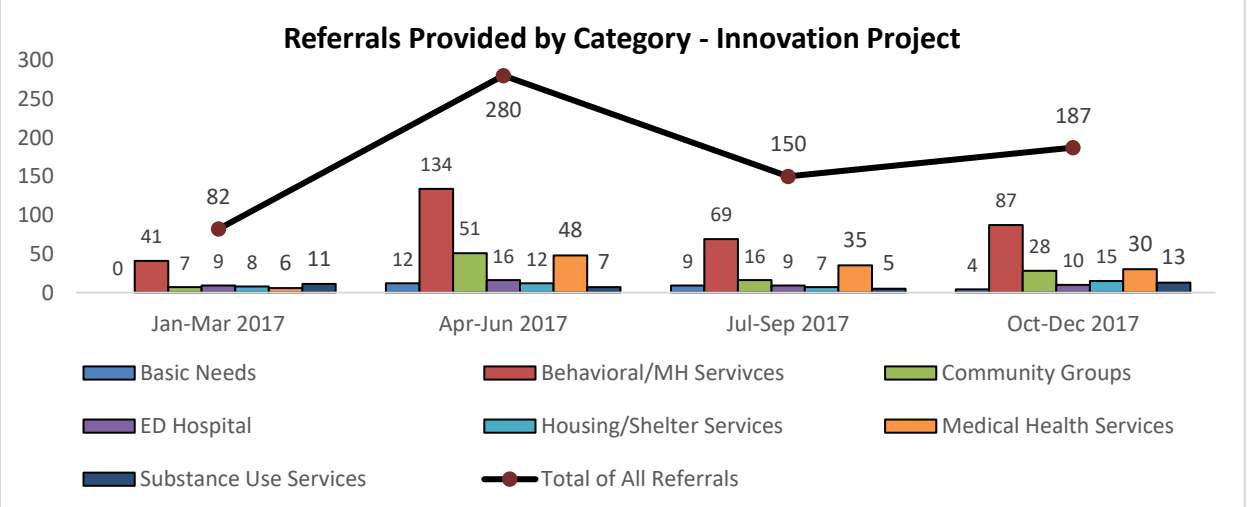
The target for year three was surpassed in the second quarter that the CARE Center was open. The quarterly average as of the end of year one is 186 unique individuals, which is 248% of the year one target, and 145% of the year three target number.

Due to this much higher utilization of the Care Center than was originally anticipated, the number of in-person visits were tracked beginning July 2017 (phone contacts are not counted). Dividing the number of visits per quarter by the unique number of individuals served each quarter, each person visited the CARE Center an average of 7 to 10 times per quarter.



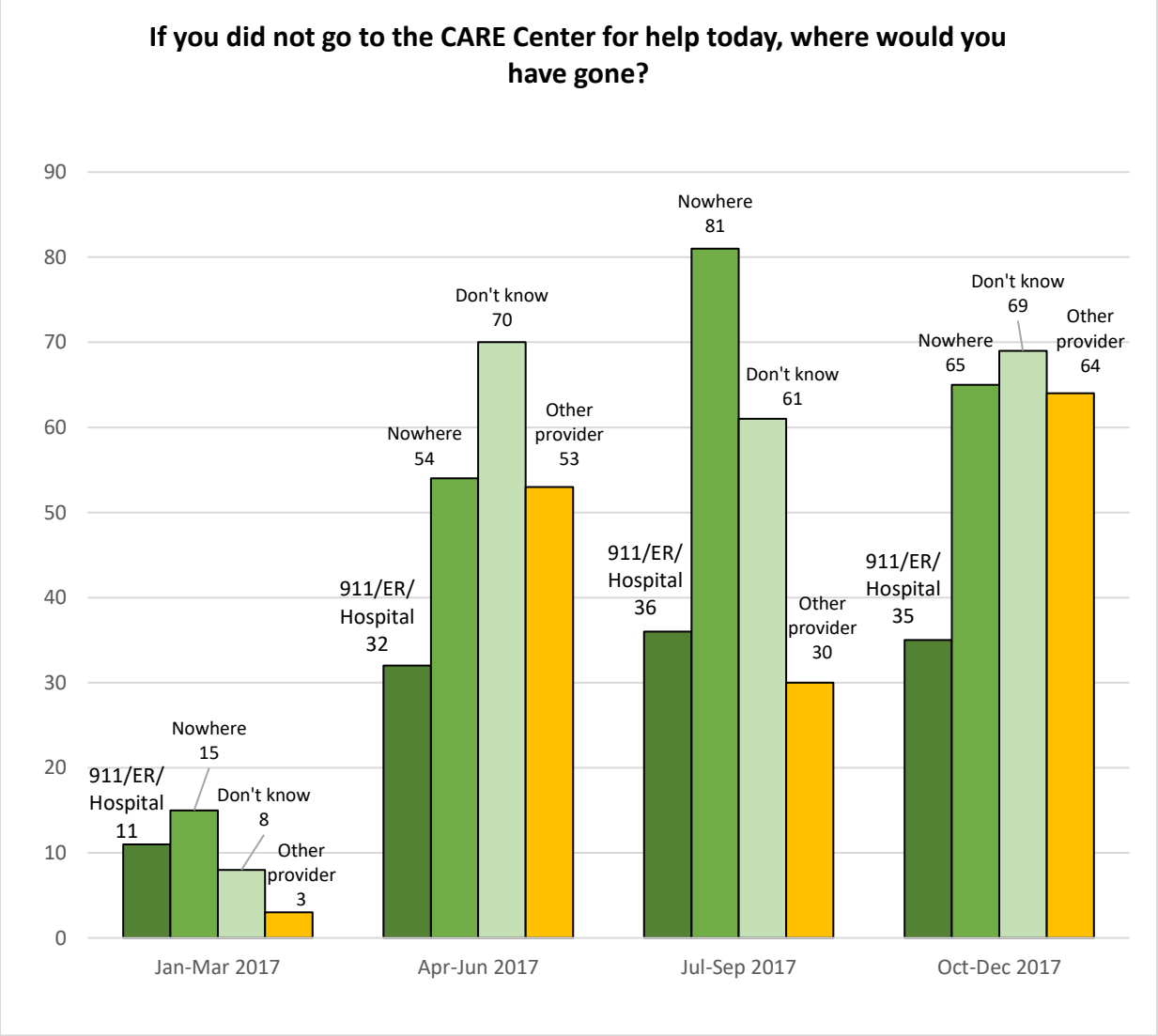
During these visits, people are provided with direct services from the CARE Center staff, and given any needed referrals for other services not offered at the CARE Center.





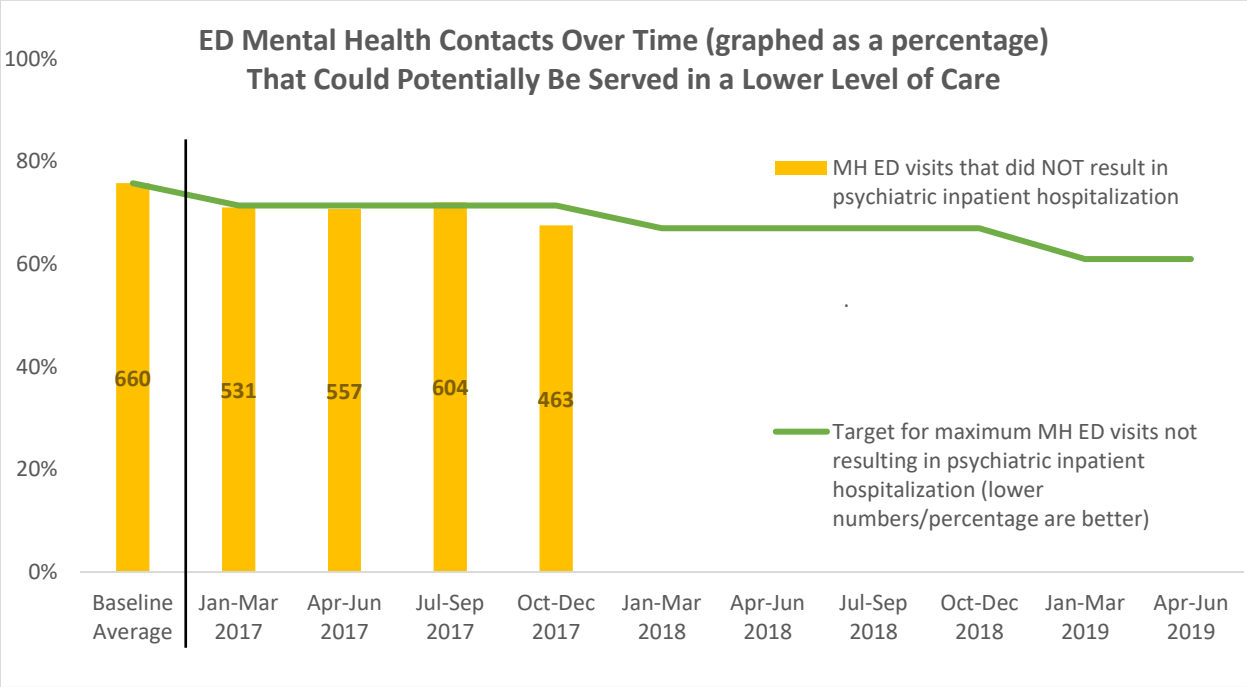
Measuring the Impact

One of the stated goals for this Innovation project is to reduce the numbers of hospital emergency department visits for mental health services, specifically those visits where a lower level of care is more appropriate. To help measure this, each person who visits the CARE Center was asked where they would have gone if the CARE Center was not available. Less than 30% specifically stated they would have called 911 or gone to the hospital if the CARE Center was not available (outcome target is 50%). However, if the numbers of people who did not know where else they would have gone, or those who simply wouldn't have sought help, are also taken into consideration (as it is likely that at least some portion of them may have ended up at the hospital), the numbers increase to the CARE Center providing 65-85% of the people they served a more appropriate, lower level of care in the place of an emergency department visit.

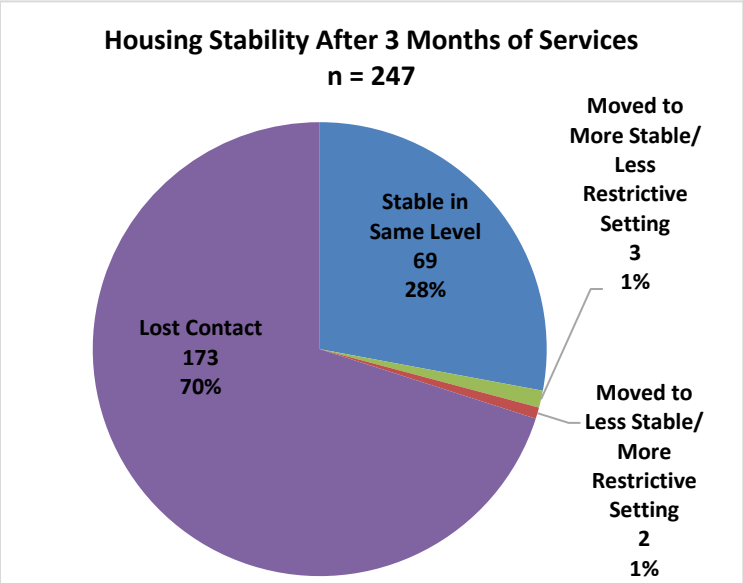


Data reported by the emergency departments to the California Office of Statewide Health Planning and Development was also reviewed, to compare numbers and percentages of emergency visits for mental health reasons over time. A baseline of quarterly numbers was created from calendar years 2015 and

2016 data, with the goal of reducing the number of emergency department visits for mental health issues that did not result in psychiatric inpatient hospitalization by 20% at the end of year one, 35% by the end of year two, and 50% by the mid-point of year three. The logic for this is that people who do not require intensive, inpatient services may be able to have their mental health needs more appropriately met with a lower level intervention in a less stressful setting. Data at the end of year one demonstrates meeting this goal so far, and testing verifies there is strong statistical significance to this trend (two-sample Wilcoxon rank-sum test shows p=0.0000, comparing 6974 observations pre-CARE Center opening to 3057 observations post-CARE Center opening).



Other measures were selected to help track the impact and effectiveness of CARE Center services on individuals. Baseline information on housing status, number of emergency department visits, number of arrests and number of psychiatric inpatient hospitalizations was requested for the 6-month period before each person's first visit to the CARE Center. Follow-up data at 3 months after and 6 months after that first CARE Center visit were then also requested.



Data collection for these measures is still being refined, but the available data at the end of year one reveals strong statistical significance (p=0.0000) to only one of these measures – the 3-month follow-up on housing status/stability.

Moving Forward into Year Two

It is clear the CARE Center is providing vital services and referrals to members of the Shasta County community, particularly in filling a gap between traditional outpatient services during standard business hours, and emergency department visits. From the data collected so far, it appears that the work being done at the CARE Center is having a positive and meaningful impact on reducing mental health visits to the local emergency departments. The CARE Center is successfully providing a lower cost, more appropriate level of care to meet the mental health needs of people, especially during days and times when they would otherwise have very few options besides the local emergency departments. Sustainability for this project at the end of the Innovation pilot project is already being explored by HHSA, with various funding options being considered.

As mentioned above, some data collection is still being refined. CARE Center staff report that trying to follow-up with individuals after 6 months is extremely difficult, with loss of contact severely curtailing the amount of data that can be collected. Considering the lack of statistical significance for any of the 6-month measures so far, it may be in the best interests of the project to cease tracking at the 6-month period, and focus on clean data collection at the time of first CARE Center contact and 3-months after. Additionally, extending the length of this pilot in order to collect additional data points may reveal trends with greater statistical significance.

Additional Detailed Information

For more information about the specifics of the demographics for the people served by the CARE Center, the granular break-down of types of services and referrals provided, or all the specific individual outcome measurements, please see the “CARE Center Activity Report – Innovation Project” report dated 3/9/18. To review the methodology and numbers tracked on emergency department visits, please see the “Innovation Project Outcome Tracking – Shasta County Emergency Department Contacts over Time” report dated 2/20/18.

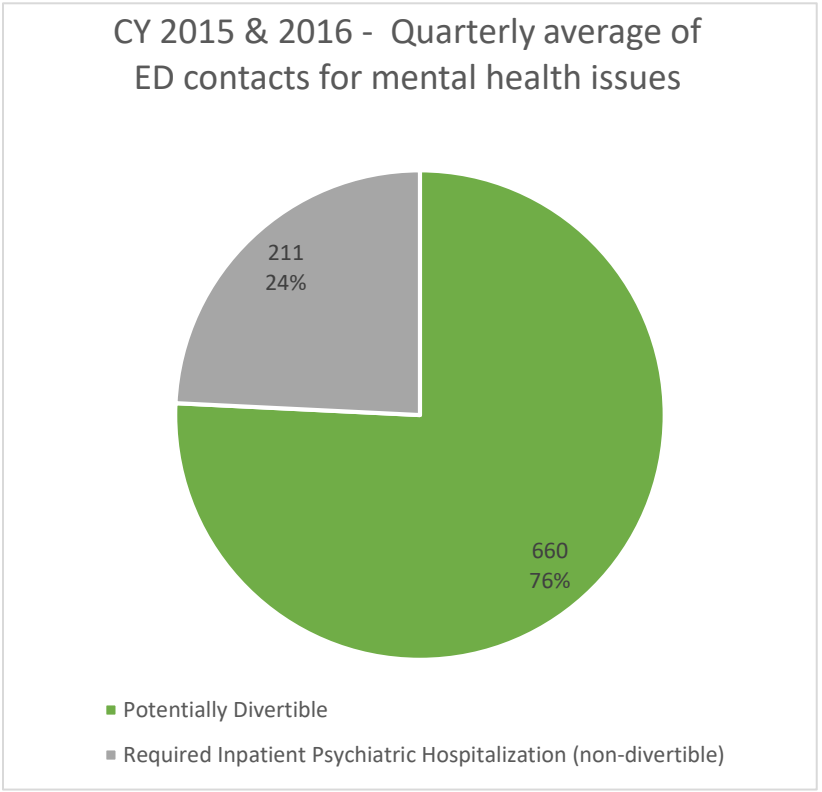
Data as of: 2/20/18

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

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

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

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

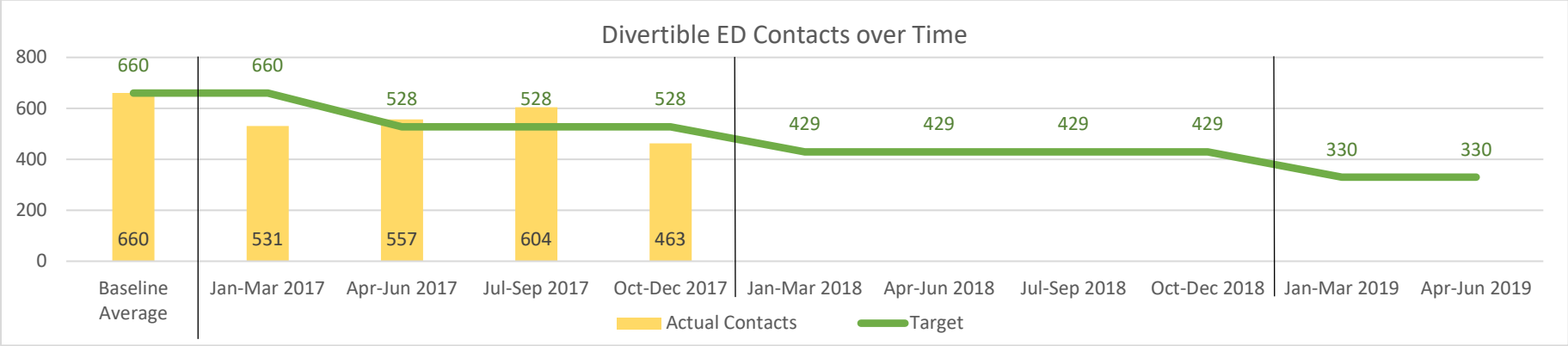


One of the goals for the Innovation Project, as approved by the state MHSOAC office and the Shasta County Board of Supervisors, is to reduce emergency department visits for mental health issues over time by the following amounts:

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

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

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



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

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

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