MENTAL HEALTH SERVICES ACT

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

JUNE 2019

Includes data from Fiscal Year 2017-18, along with the annual Innovations and Prevention and Early Intervention Project Reports

Shasta County
Health & Human Services Agency

A Vision of Recovery

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

Supporting a Life in Recovery

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

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

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

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

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 Annual Update, which features data from Fiscal Year 2017-18.

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 2017'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
	NorCal OUTReach
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
	Public Health Advisory Board
	Adult/Youth Consumers and Family Members
Health and Human Services Agency	
Law enforcement	Shasta County Sheriff's Department
	Redding and Anderson police departments
	Shasta County Probation Department
Education	Shasta Community College
	Shasta County Office of Education
	All Shasta County schools
	Simpson University
	National University
	Chico State University

Community-based organizations	Area Agency on Aging
	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, Fiscal Year 2017-2018:

- Suicide Prevention Workgroup, June 20, 2017, CARE Center, Redding.
- Stand Against Stigma Committee, July 11, 2017, Redding Library.
- Suicide Prevention Workgroup, July 18, 2017, CARE Center, Redding.
- Stand Against Stigma Committee, Aug. 8, 2017, Redding Library.
- Suicide Prevention Workgroup, Aug. 15, 2017, CARE Center, Redding.
- Stakeholder review of comments received during Public Comment period for Three-Year Program and Expenditure Plan, Aug. 29, 2017, Redding Library.
- Stand Against Stigma Committee, Sept. 12, 2017, Redding Library.
- Suicide Prevention Workgroup, Sept. 19, 2017, CARE Center, Redding.
- Stand Against Stigma Committee, Oct. 10, 2017, Redding Library.
- Suicide Prevention Workgroup, Oct. 17, 2017, CARE Center, Redding.
- Stand Against Stigma Committee, Nov. 14, 2017, Redding Library.
- Suicide Prevention Workgroup, Nov. 21, 2017, CARE Center, Redding.
- General stakeholder meeting, Dec. 6, 2017, Boggs Building, Redding.
- Stand Against Stigma Committee, Dec. 12, 2017, Redding Library.
- Suicide Prevention Workgroup, Dec. 19, 2017, CARE Center, Redding.
- Stand Against Stigma Committee, Jan. 9, 2018, Redding Library.
- Suicide Prevention Workgroup, Jan. 16, 2018, CARE Center, Redding.
- Stand Against Stigma Committee, Feb. 13, 2018, Redding Library.
- Suicide Prevention Workgroup, Feb. 20, 2018, CARE Center, Redding.
- General stakeholder meeting, March 7, 2018, Boggs Building, Redding.
- Stand Against Stigma Committee, March 13, 2018, Redding Library.
- Suicide Prevention Workgroup, March 20, 2018, CARE Center, Redding.
- Suicide Prevention Workgroup, April 17, 2018, CARE Center, Redding.
- Mental Health Services Oversight and Accountability Commission Suicide Prevention Subcommittee, May 23, 2018, McConnell Foundation, Redding.
- Stand Against Stigma Committee, April 10, 2018, CARE Center, Redding.
- Stand Against Stigma Committee, May 8, 2018, CARE Center, Redding.
- Suicide Prevention Workgroup, May 15, 2018, CARE Center, Redding.
- Stand Against Stigma Committee, June 12, 2018, CARE Center, Redding.
- Suicide Prevention Workgroup, June 19, 2018, CARE Center, Redding.
- General stakeholder meeting, June 27, 2018, Boggs Building, 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 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.

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

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

Four in-person general community stakeholder meetings were held in Fiscal Year 2017-18 to provide guidance on MHSA programs. Each meeting included updates on projects outlined in the Three-Year Program and Expenditure Plan, along with robust discussion about ideas for upcoming Innovations projects. Meetings included representatives from the following groups:

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

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 up to 10 MHSA units, to the existing campus. Stakeholders provided resounding support for this effort, as housing is a growing challenge in our community, particularly after the Carr Fire. 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 held a public hearing on that document during their meeting on June 6, 2018, and recommended approval. This plan has not yet gone to the Shasta County Board of Supervisors for final approval, as some of the details of the project have changed; an amended version will be circulated for public comment, advisory board endorsement and Board of Supervisors approval once all of those details are solidified.

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

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

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

HOW DO WE EVALUATE THE EFFECTIVENESS OF OUR PROGRAMS?

In the mental health treatment field, outcomes are often used to understand and measure how a person responds to treatment programs. They are important because they can help answer the following question:

Are we offering effective services that are helping individuals have more meaningful lives?

Shasta County Health and Human Services Agency is dedicated to developing and implementing tools that will assist with measuring mental health outcomes for the purpose of guiding treatment practices at both the individual and service level. Our youth mental health services uses the Child and Adolescent Needs and Strengths (CANS) survey, while our adult mental health services are measured by the Milestones of Recovery Scale (MORS).

CANS: Child and Adolescent Needs and Strengths

CANS is a multipurpose tool developed by Dr. John Lyons and the Praed Foundation for use in children's programs to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to support monitoring of client and service outcomes. It was developed from a communication perspective to help link the assessment process with the design of individualized service plans. The CANS is well-liked by parents, providers and other partners in the services system because it is easy to understand and does not necessarily require scoring in order to be meaningful to an individual child and family.

This tool looks at the mental health needs of children, youth and their families along with their strengths. The CANS is used to help develop the mental health treatment plan and monitor client progress. The Department of Health Care Services and California Department of Social Services have both elected to use CANS as the statewide tool to help determine outcomes for youth receiving specialty mental health services and those youth involved in foster care. The CANS 50 is the tool selected to be used by all counties, and Shasta County implemented the new CANS 50 plus 12 trauma questions on September 1, 2018. Along with the CANS to be completed initially and updated every 6 months for both sets of clients, the integration of the Pediatric Symptom Checklist 35 (PSC-35) has also been implemented to gather information from caregivers regarding concerns related to the child or youth.

All clinical staff from the Health and Human Services Agency Children Services Branch, Northern Valley Catholic Social Service, Victor Community Support Services, Kings View Behavioral Health and Remi Vista have been trained in the use of the CANS and are inputting their data into an online database. The database underwent updates to switch to the CANS 50 plus trauma and created a crosswalk to link back to the prior CANS versions to help with looking out outcomes since initial implementation of the CANS with mental health clients in 2012. Clinical staff are required to complete the CANS certification through the Praed Foundation annually. The CANS and PSC-35 data is collected and evaluated by Outcomes, Planning and Evaluation staff.

MORS: Milestones of Recovery Scale

The MORS is an effective evaluation tool for tracking the process of recovery for adults with persistent, serious mental illness. It is rooted in the principles of psychiatric rehabilitation and defines recovery as a process beyond symptom reduction, client compliance and use of services. It operates from a perspective that meaningful roles and relationships are the driving forces behind achieving recovery and leading a fuller life.

The MORS focuses on the here and now and provides a snapshot of an individual's progress toward recovery. It quantifies the stages of an individual's recovery using milestones that range from extreme risk to advanced recovery and everywhere in between. It has in-depth descriptions of what individuals at each stage might typically look like in terms of their levels or risk, engagement and support from others.

The MORS can help staff tailor services to fit each individual's needs, assign individuals to the right level of care and assist with treatment plan design. By administering the MORS on a regular basis, an individual's process of recovery can be monitored and treatment adjusted with the goal of achieving positive outcomes for the individual.

The MORS provides easy to use data that helps mental health systems understand/measure effectiveness of treatment and current client needs. It also provides reliable data that allows staff, supervisors, and administration to see how individual programs are performing.

Health and Human Services Agency, Adult Services Branch staff have been trained to use MORS. Data collection began in October 2014 and the first MORS Outcomes Report has been produced. The 2017 MORS Assessment can be found in Appendix B.

Client satisfaction

The Health and Human Services Agency uses feedback from clients, family members and the general public to help ensure a positive experience for people using our services. The Client Satisfaction Survey is available throughout the main community mental health building and is voluntary. Completed surveys are collected weekly and distributed to management staff and the Quality Improvement Committee for discussion. Another report that helps us determine client satisfaction is the Performance Outcomes Quality Improvement (POQI), which is conducted twice a year. The California Department of Health Care Services requires all California counties to make the survey available, but client participation is voluntary.

It is always challenging to encourage clients to fill out satisfaction surveys, and it is our goal in the upcoming year to encourage greater participation in all of these surveys. Results from the Client Satisfaction Survey are in Appendix C.

Three-Year Goal: Health and Human Services Agency staff will continue to look at ways to deliver excellent, timely and sensitive customer service to all people who walk through our doors. We will also work to increase participation in our surveys, so we can effectively respond to client feedback.

Year Two Progress: A new poster draws better attention to the Client Satisfaction Survey.

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 • 0-5 • Adverse Childhood Experiences
Older adult
Individuals experiencing the onset of serious psychiatric illness
Stigma and discrimination reduction
Suicide prevention
Workforce Education and Training (WET)
Volunteer program
Comprehensive training program – MHSA Academy
Internship/residency program
Psychosocial rehabilitation program (discontinued)
Innovation (INN)
CARE Center
Community intervention pre-crisis team (completed)
Capital Facilities/Technological Needs (CF/TN)
Capital facilities project (completed)
Technological needs (completed)

PROGRAM OVERVIEW: COMMUNITY SERVICES AND SUPPORTS (CSS)

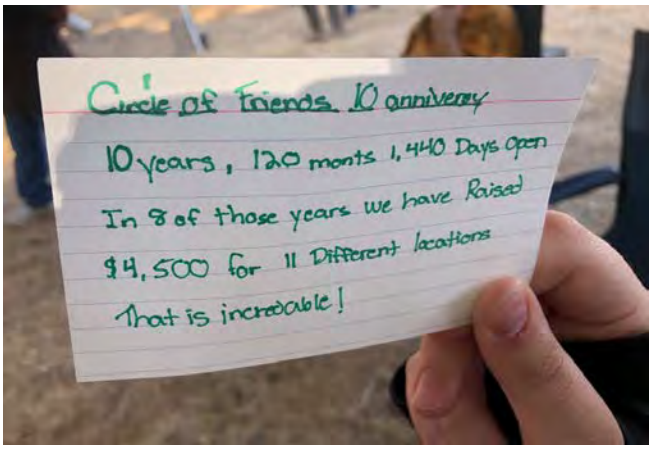
Community Services and Supports (CSS) programs aim to change the public mental health system by providing for system improvement, service expansion and new systems of delivery. CSS programs are designed with a comprehensive and inclusive approach for individuals with serious mental illness or serious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

The nine CSS projects, along with the number of unique individuals served by HHSA staff in Fiscal Year 2017-18, are:

1. Client- and family-operated systems (unduplicated number cannot be determined)
2. Shasta Triumph and Recovery (STAR) (101)
3. Rural health initiative (110)
4. Older adult (15)
5. Crisis services (891)
6. Crisis Residential and Recovery Center (140)
7. Housing continuum (137)
8. Co-occurring disorders integration (155)
9. Outreach/Access (1,596)

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 Fiscal Year 2017-18, the centers offered more than 2,200 individual workshops, groups, activities and 12-step recovery meetings.

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

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

Also through Client- and Family-Operated Systems, the Health and Human Services Agency contracts with the Shasta County National Alliance on Mental Illness (NAMI) to provide education programs in the community, including NAMI Basics, NAMI Family-to-Family, NAMI Peer-to-Peer, Family Support Group and NAMI On Campus, along with numerous community activities. They operate out of the Hill Country CARE Center, where they facilitate peer support groups and offer one-on-one mentoring in person and over the phone. The NAMI Summary Report can be found in Appendix E. For more information on NAMI educational programs, please visit www.nami.org/find-support/nami-programs.

Overall, a total of 2,237 individual workshops, groups, activities, and 12-step recovery meetings were held at wellness centers during this period.

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.

STAR Team

The Health and Human Services Agency also contracts with Hill Country Health and Wellness Center to provide a Full Service Partnership program, which has the capacity to serve up to 15 individuals in the Intermountain area, plus another five in North Redding.

Full Service Partnership programs are wellness-, recovery-, and resiliency-based and practice the 24/7 "whatever it takes" model to provide access to services. People eligible for partnership include those with severe and persistent mental illness or children with severe emotional disturbance, who are homeless or at risk of homelessness and/or incarceration, have an increased risk of hospitalization, 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.

Plans are under way to increase The Woodlands permanent supportive housing complex by 20 units, up to 10 of which would be for Full Service Partner-eligible tenants.

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 Two Progress: The Health and Human Services Agency's on-site case manager and peer support specialist have built relationships with tenants at The Woodlands and are supporting their efforts to maintain permanent housing. The STAR team slightly increased its caseload this year, and they continue to reach out and build relationships with the hardest-to-reach populations.

3. Rural Health Initiative

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

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

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 Two Progress: The number of people who received mental health services at a Federally Qualified Health Center increased by 26.2 percent this fiscal year, with most people seeking services for adjustment disorders, depression, anxiety, substance use or bipolar disorder. Mayers Memorial Hospital provided Crisis Intervention Training to staff. The Health and Human Services Agency continues to work closely with administrators to ensure that programs meet community needs.

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 and stakeholder groups include older adults.
Year Two Progress: Older adults continue to participate in stakeholder meetings at a rate that's proportional to the Shasta County overall population. The Area Agency on Aging is an active participant in stakeholder meetings.

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 Two Progress: A mobile crisis unit operated by Hill Country deployed in January and has already proven valuable to those who are using it. 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 Two Progress: The Crisis Residential and Recovery Center redesigned its intake packet and conducted an extensive awareness campaign, and today, the facility is almost always full. A multi-disciplinary treatment team develops and tracks client treatment plans on a weekly basis. Treatment records have been digitized. Alcoholics Anonymous groups and a chaplain are available on site. The team connects clients with housing and residential facilities. Historically, a primary barrier to clients using this service has been not knowing what to do with their pets during their stay; the facility now has the capacity to place animals in a kennel and provide vaccinations so they remain safe and healthy while the client is at the Crisis Residential and Recovery Center.

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 Woodlands permanent supportive housing complex is full, and of the 55 units, 19 are designated for people who are eligible for Full Service Partnership services. A Health and Human Services Agency case manager and peer support specialist provide case management, links to community resources and more for people in the MHSA-funded apartments.

Northern Valley Catholic Social Service is responsible for providing various life skills classes that will help them maintain permanent housing. 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, nutrition education, suicide prevention, seeking safety and peer support. Alcoholics Anonymous classes are offered weekly. A residents' council gives residents an avenue to address concerns and voice their opinions about decisions that affect them.

Because of the success of The Woodlands, Palm Communities, Shasta County and Northern Valley Catholic Social Service are working on plans to build 20 more units in the complex, including up to 10 for people who are eligible for Full Service Partnership services.

Permanent supportive housing in the Burney area is also moving forward; Northern Valley Catholic Social Service is purchasing a six-acre site off Main Street, where they plan to build a 20-unit complex. The land and infrastructure will be funded by Partnership HealthPlan and Community Development Block Grant dollars, and NVCSS will apply for HOME funds and tax credits to cover construction.

The Woodlands Permanent Supportive Housing Report can be viewed in Appendix I.

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 Two Progress: The Woodlands' MHSA units are all occupied, and staff continues to review available groups and services to ensure they meet residents' needs. Phase 2 of The Woodlands is in progress now, and plans for No Place Like Home are being developed. Housing is also one piece of the Whole Person Care pilot, which is designed to connect people to care. That program has helped 173 households and housed 43 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, Northern Valley Catholic Social Service is working with HHSA to build a 20-unit permanent supportive housing complex in Burney.

8. Co-occurring/Primary Care Integration

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

People with serious mental health conditions die an average of 25 years earlier than the general population. For those with a physical illness, the goal is to connect them to primary care to provide coordinated care to treat the whole person, and to provide services that focus on both their mental and physical illnesses and how the two can interact. Providers coordinate the detection, treatment and follow-up of mental and

physical conditions. Services include outreach, education, case management, treatment, medication support, and clinical and nursing services. This program looks at the following diagnoses:

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

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 Two Progress: Siloed funding streams create challenges, but this remains a 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. Whole Person Care is making significant progress in this work.

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 Two 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, At Risk Middle School Students, 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.

Triple P has been used with families of children age 0-5 as a helpful intervention for the most vulnerable populations through services provided by HHSA in partnership with the Shasta County Office of Education (SCOE) Bridges to Success Program. Shasta County has awarded contracts through the competitive procurement process to SCOE, Wright Education Services, Family Dynamics and Northern Valley Catholic Social

Service (NVCSS) to provide free or low-cost Triple P services to families in Shasta County. A new competitive procurement process is under way to select contractors for next fiscal year.

The Triple P Sustainability Committee continues to meet quarterly to discuss program barriers, successes and training needs. The Triple P Shasta County Evaluation Report can be found in Appendix J.

Participants who completed Level 4 Standard Triple P showed an increase in their child's prosocial behavior, and a decrease in their child's hyperactivity, emotional symptoms, conduct problems and peer problems. On average, parents also showed decreases in self-reported levels of stress (39%), anxiety (45%), and depression (51%).

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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 Two Progress: Efforts to meet program goals have been vast and successful in working to streamline and monitor program deliverables, update marketing materials and target training needs based on community input and support. Triple P Level 3 Standard and Teen Extension training were brought to the area in January in partnership with First 5 Shasta as an identified level needed to support ongoing Triple P sustainability. The new Triple P Automatic Scoring and Reporting Application (ASRA) supports better data entry and ease of surveying families.

Trauma Focused Treatment

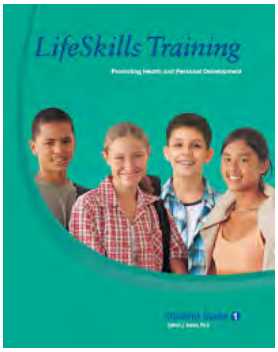
Trauma focused treatment is a necessity for serving youth and families today. Trauma-informed treatment addresses the unique needs of children with difficulties related to traumatic life experiences. This is imperative to helping those affected by Adverse Childhood Experiences move through their trauma and increase resiliency for the future. In the past, the Health and Human Services Agency has used Trauma Focused-Cognitive Behavioral Therapy, a psychotherapy model, to address these children's needs.

Another area of training includes the Trust-Based Relational Intervention (TBRI), an attachment-based, trauma-informed intervention that is designed to meet the complex needs of vulnerable children. TBRI is designed for children from "hard places" such as abuse, neglect and/or trauma. Because of their histories, it is often difficult for these children to trust the loving adults in their lives, which often results in perplexing behaviors. TBRI offers practical tools for parents, caregivers, teachers or anyone who works with children to see the "whole child" in their care and help that child reach his highest potential.

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 Two Progress: HHSA continues to have clinicians trained in the evidence-based Trauma-Focused Cognitive Behavioral Therapy, and three staff are being trained as trainers in Trust-Based Relational Intervention. HHSA also purchased 30-minute Bruce Perry videos that can be used as needed to train staff on trauma, brain development and trauma interventions.

Community Implemented Programs for At-Risk Middle School Students

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



Through community feedback, the Botvin LifeSkills Training for Middle School was selected, and training is provided by teachers trained in the evidence-based curriculum. The Botvin LifeSkills program is flexible in that it can be delivered by multiple different types of trained staff, and counselors are providing the training at Anderson Middle School and the Anderson Teen Center. Each school selected has committed to providing the curriculum for a three-year period to build upon student exposure and increase individual student outcomes in reduced harmful substance use, increased coping skills, and improved school attendance. The Botvin LifeSkills Evaluation Report can be found in Appendix K.

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 Two Progress: Shasta County launched the Botvin LifeSkills pilot at Shasta Lake Elementary in Spring 2018, where more than 200 students in grades 6-8 received the Level 1 training that includes self-image, drug and alcohol prevention, communication skills, coping with anger, anxiety, resolving conflicts, pressures of advertising/social media and making decisions. In January 2019, the Botvin LifeSkills Training was continued for a second year at Shasta Lake Elementary and expanded to pilot having counselors provide the training to students (grade 5-8) at Anderson Middle School and parent partners at the Anderson Teen Center as part of their after-school program. The County will evaluate these pilots to determine program outcomes and possible expansion to other schools in the future.

0-5 Program

The 0-5 program addresses concerns about toddlers who have significant emotional and behavioral challenges, and how these challenges keep them from being successful in preschool and unprepared for kindergarten. These early challenges and failures, if extreme enough, can set the stage for continuing school challenges, as behavior struggles increase with age and become more entrenched and difficult to manage. HHSA has partnered with Shasta County Office of Education (SCOE) and its

Bridges Program to provide support to children and their families. Increasing prevention efforts and responding to early signs of emotional and behavioral health problems among children aged 0-5 years old can reset the trajectory toward better health and success of children and young people.

The 0-5 clinician uses Triple P with parents of young children to get them focused on positive parenting, and uses Trauma-Focused Cognitive Behavioral Therapy with the little ones to address any traumatic events that may be driving the behavioral issues the children are exhibiting. This program interacted with 50 3-, 4- and 5-year-olds; of these, 22 graduated from services, 14 are still in care and making progress, 10 dropped out of services and 4 did not meet criteria after being assessed for services.

Adverse Childhood Experiences (ACEs)

The experiences of childhood impact our health, behavior and overall well-being in adulthood - for better or worse. Adverse Childhood Experiences (ACEs) are traumatic experiences in the first 18 years of a person's life and include abuse, neglect and household dysfunction, which produce toxic stress. Toxic stress harms the brains and bodies of children, increasing their likelihood of chronic disease, cancer, mental health issues, drug addiction, homelessness, incarceration, decreased work productivity and even early death.

The Strengthening Families Collaborative was founded in 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. This collaborative, along with the HHSA and ACE Interface Trainers, have partnered with the community to work toward building resilience and transformational change. This has included two well-attended town hall meetings. Nationally recognized ACE experts Dr. Robert Anda and Laura Porter came to Shasta County to share the science behind ACE research and provide guidance to community leaders, then returned to train 26 ACE Interface trainers who have since presented the Neuroscience, Epigenetics, Adverse Childhood Experiences and Resiliency (NEAR) Science evidence-informed curriculum to more than 2,000 people. Three community partners received Public Health Advisory Board awards for their work.

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 Two Progress: This year's focus shifted from building awareness about ACEs to building resiliency in those who have experienced ACEs. Laura Porter provided a two-day leadership training in December 2018 to enrich ACE Interface Trainer technical skills and empower community leaders to build resilience and reduce ACEs in their spheres of influence. Following this training, a new "meta-leader" open space quarterly meeting provided leaders with a place to brainstorm and take action to reduce ACEs. Television commercials, billboards and bus shelter ads are helping to spreading awareness about ACEs, and a data dashboard with 11 indicators continues to be developed. HHSA's child welfare offices, Mercy Family Health, Mercy Maternity Center, Shasta Community Health Center, Hill Country Health and Wellness Center, Child Abuse Prevention Coordinating Council and One SAFE Place have implemented ACEs screening for all patients/clients. Dr. Marie Mitchell provided onsite ACEs technical assistance training, clinic tours and a presentation at Mercy Medical Center Grand Round in September 2018. A pediatric symposium explored ways to implement ACEs into their practices. Nearly 30 parent cafes and other trainings have been provided to the community, and 14 showings of "Resilience: The Biology of Stress and the Science of Hope" have reached 1,000 people. Shasta County contracted with Shasta County Child Abuse Prevention Coordinating Council in November 2018 to add two parent partners to work with Shasta Community Health Center to provide Triple P and ACEs work around building protective factors for families, particularly in Shasta Lake City and Anderson.

2. Older Adult Gatekeeper Program

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

3. Individuals Experiencing Onset of Serious Psychiatric Illness

Early Onset

Serious psychiatric illnesses such as schizophrenia and bipolar often emerge in late adolescence or early adulthood. This project targets individuals between ages 15 and 25 who have symptoms that might indicate the start of a serious and persistent mental illness. The priority components of the Early Onset Program are early detection, engagement and prompt assessment, referral, treatment, and family support. In addition to the treatment interventions, outreach and education helps the community understand that this program has the expertise and resources to address the first signs of serious mental illness.

Treatment objectives of the program are psychoeducation for client and family on serious mental illness, individual therapy, individual rehabilitation services, family therapy, cognitive behavioral group therapy and parent support groups for families on the Early Onset caseload.

Challenges to the program continue to be providing the best client care for engaged people, while also being engaged in consistent outreach to community stakeholders. In 2018, the Early Onset Program expanded to include a Peer Support Specialist, who is providing support to the Early Onset clients.

Three-Year Goal: The new Early Onset clinician will continue building rapport with gatekeepers and engaging in community outreach.
Year Two Progress: The Early Onset clinician consistently met with the Children's Access Team, providing information regarding early signs and symptoms of serious mental illness and when to refer to the program for further evaluations. The Early Onset clinician and other children's mental health staff provided presentations and information at fairs, local colleges, high schools, continuation and independent study schools, and has met with local school counselors who provide services to multiple school districts. In 2018, the Early Onset Program expanded to include a Peer Support Specialist, and the team works with other Shasta County intensive programs and supportive staff such as the Parent Partner to increase service breadth and depth to clients.

4. Stigma and Discrimination Reduction

Shasta County's Stand Against Stigma campaign works to promote mental wellness, increase community awareness of mental health and end the stigma surrounding mental illness and substance abuse. The stakeholder-developed messages used in this project are strength-based and focused on recovery:

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

Stand Against Stigma includes the following strategies:

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

- Multimedia and short documentaries

Stand Against Stigma activities are directed by input and guidance from the Stand Against Stigma Committee, which includes people with lived experience, family members, representatives from community-based organizations and members of the Shasta County Mental Health, Alcohol and Drug Advisory Board. Thousands of people have witnessed or taken part in Stand Against Stigma activities in person, and social media campaigns have reached tens of thousands more.

Shasta County's *Stand Against Stigma: Changing Minds About Mental Illness* campaign has been in place since 2012. Its strength-based messages promote mental wellness, and counter the discrimination and stigma associated with mental health problems. The *Get Better Together* campaign aims to connect 16- to 25-year-olds with peers who are dealing with heavy issues, educating them about the normalcy of struggles with mental illness, asking them to help themselves, help others, and share what they live and know. Plans are under way to partner with the youth-focused programs and revitalize the *Get Better Together* website.

Brave Faces presentations were given to 29 organizations, businesses, schools and agencies, reaching some 850 people.

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In addition, the Stand Against Stigma Committee has collaborated with local musicians and performers to hold 18 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 100 performers have participated.

Minds Matter podcast

The Brave Faces Portrait Gallery and Speakers Bureau use true stories of hope and recovery to fight stigma by improving our understanding of mental illness and suicide. About one in four people will struggle with a mental illness every year, and about 45 people in Shasta County die by suicide every year. Because of shame and discrimination associated with mental health problems, many people don't seek the help they need. Brave Faces are people with lived experience of mental illness, suicide and substance abuse. They go into the community and talk about their lives and their experiences, using their stories to offer hope and recovery, provide education, promote seeking help and end stigma. Audiences include faith-based organizations, media organizations, local businesses, community-based organizations, cultural groups, county and state government agencies, junior high and high schools, local colleges and more. More than 250 Brave Faces presentations have been done within our community, and more than 7,000 people have been reached through these presentations. Our growing number of speakers (about 30 active participants in total) allows us to effectively tailor our messages to the audiences we serve.

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

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 Two Progress: In 2018, we hosted a forum called "Finding Hope In Our Neighbors" on the topic of peer support in Fall River Mills in rural Eastern Shasta County. The forum was part of the first Intermountain Mental Health Week. The week of activities was a collaboration between Stand Against Stigma and the Suicide Prevention Workgroup and featured a "Hope Is Alive!" Open Mic, a Becoming Brave Training and two Question, Persuade, Refer suicide intervention trainings (one in Burney and one in Shingletown). In the Redding area, we hosted four Becoming Brave trainings and two "Hope is Alive!" Open Mic Nights. Another open mic night was geared specifically toward youth at the Anderson Teen Center, which was also part of a spoken word workshop called DREAMERZ that we brought to the Anderson middle and high schools. The 11th Annual Minds Matter Mental Health Resource Fair and Music Festival was attended by about 500 people and 35 exhibitors. The event included a popular art activity area and an on-site Captain Awesome photoshoot. We also hosted the second annual "Recovery Happens: Celebrating Life, Community and Sobriety" event in September, which included 15 educational booths and live music in a local park, and more than 300 people attended the family-friendly event. This year, we also started production of the Minds Matter TV and Podcast which will feature conversations with Brave Faces speakers and local professionals about a variety of mental health and stigma-busting topics. The show will be published on social media, Soundcloud and iTunes.

5. Suicide Prevention

From 2016 to 2018, an average of 45 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.

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

Captain Awesome, a men's mental health campaign launched in 2017, continues to combat the societal pressures for men to repress emotions and not show weakness. Captain Awesome demystifies mental health and depression while giving men the tools to maintain their mental and emotional health. "More than Sad", an evidence-based educational program developed by the American Foundation for Suicide Prevention, teaches teens to recognize signs of depression in themselves and others, challenges the stigma surrounding depression, and demystifies the treatment process. Question, Persuade, Refer (QPR) trainings teaches people the warning signs of suicide and provide them with tools to respond to a person in suicide crisis. These trainings are given to groups or organizations in the county upon request. Since 2015, 1,355 people have received Question, Persuade, Refer (QPR) Suicide Prevention Training.

Additional suicide prevention activities include:

- Community education in collaboration with local law enforcement, firearms vendors and concealed weapon training instructors about decreasing the access to lethal means for suicide attempts.
- Participation at community outreach events (health fairs), especially those concerning mental health, support services and suicide prevention, such as Running Brave, the American Foundation for Suicide Prevention's Out of the Darkness Walk and Suicide Loss Survivor Day.
- Promotion of the Directing Change Program and Student Film Contest to local high schools.
- Annual Suicide Prevention and Mental Health Symposium.
- Educating local media and news outlets regarding the importance of appropriate and responsible reporting of suicide.
- Providing suicide prevention resources to local medical professionals.

575 people received Question, Persuade, Refer training during Fiscal Year 2017-18.

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

See Appendix M 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 Two Progress: The second flight of our Captain Awesome men's mental health campaign, featuring local men to spread awareness about the need to care for one's mental health, was promoted via billboard, web advertising and printed outreach materials. The "More than Sad" program was provided to five schools serving students grades 8-12 to help teens recognize the signs of depression in themselves and others and how to respond. In partnership with a local firearms vendor and training instructor, more than 1,200 firearms safety brochures were distributed to customers and class participants advising the safe removal of firearms during a mental health crisis.

5. CalMHSA Statewide Projects

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

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

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

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

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 willing 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:

1. Comprehensive Training
2. Consumer and Family Member Volunteer Program
3. Internship Program
4. Superior Region WET Partnership
5. Office of Statewide Health Planning and Development

In addition to the WET projects, the Health and Human Services Agency employs six 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

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.

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.

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 Two 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

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. Prior to volunteering, each participant completes the Shasta MHSA Academy training program.

> "I found the Academy and WRAP at a time when my daughter was struggling with emotional issues. I was frustrated not knowing how to fix the situation we found ourselves in. Through this program I learned it was not my place to 'fix' my daughter. I was there to support her and be her advocate. My daughter joined WRAP and this was a crucial change in our lives. She was able to learn coping skills and how to stay clear of triggering situations. We were prepared when she was in crisis. I am so thankful for the support of my facilitators. I have no doubt that WRAP saved my daughter's life."
>
> -Academy and WRAP Participant

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 volunteer in local wellness centers and our main mental health facility, participate in advisory groups and/or stakeholder meetings, and shadow staff.

One of the most exciting outcomes from the Academy is that HHSA hired two graduates to work as Peer Support Specialists. Four other Academy graduates have become HHSA employees in other job classifications. Many other graduates have gone on to receive further education in the field and are planning to become case managers, social workers, and psychologists upon graduating from college.

Shasta College Student Volunteer Internship Program

HHSA partners with Shasta College to provide students who are interested in the mental health field with hands-on learning and 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. At least 10 people who graduated our program have gone on to become employed in the public mental health field, and at least four are in graduate school pursuing a degree in social work. 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.

Wellness Recovery Action Planning (WRAP)

In May 2017, one HHSA staff member and two staff members from Circle of Friends completed Level 3 WRAP training to become certified Advanced Level WRAP facilitators (ALFs). The goal of this partnership is to increase the number of Copeland-certified WRAP facilitators available to implement local WRAP groups in accordance to evidence-based research. By doing this, we can use volunteer peers to conduct Level 1 WRAP groups with our clients and throughout the county. We can also offer the required two-year recertification training that our case managers and clinical staff need to remain in compliance with the evidence-based WRAP standards set forth by the Copeland Center. We have found WRAP to be an excellent tool for increasing the effectiveness of our volunteers and increasing placement opportunities.

Three-Year Goal: 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 Two Update: Between July 1, 2017 and June 30, 2018, we placed volunteers at the Hill Country Care Center, the Olberg Wellness Center, the Crisis Residential and Recovery Center (CRRC) and the Whole Person Care Program. Forty-two people participated in the Academy, and of those, 37 completed all 65 hours. Fourteen Shasta College students successfully fulfilled their MHSA internship requirement. We provided WRAP Level 1 training at the Woodlands, Circle of Friends, Hill Country Counseling Center, Hill Country CARE Center, the Olberg Wellness Center and on the HHSA campus; at least 50 people participated in WRAP groups. We also provided three Level 2 trainings during this reporting period, resulting in a total of 33 new, certified WRAP facilitators (we partnered with Butte County to assist with their first Level 2 training which accounted for 17 of the newly certified WRAP facilitators). HHSA staff began to work with Circle of Friends to discuss implementation plans for a youth WRAP component and a youth MHSA Academy. During this reporting period, we had one youth successfully complete both Level 1 and Level 2 WRAP and she has gone on to begin facilitating Level 1 WRAP groups with the Hill Country Teen Center. All 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 Two 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.

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.

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	7	$48,538
Total Award to Date		$ 383,083

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.

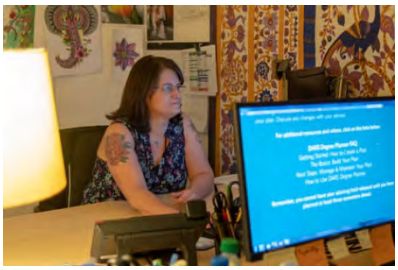
The Mental Health Loan Assumption Program is a competitive process which requires an application. Since 2009, 66 awards have been given to people who work in Shasta County's public mental health system.

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 Two Update: Staff continues to participate in monthly meetings.

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 Country 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. 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

The center also includes a Laura's Law pilot project.

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. Stakeholders, the Mental Health, Alcohol and Drug Advisory Board and the Shasta County Board of Supervisors approved requesting a one-year extension of the pilot project, which is currently under review by the Mental Health Services Oversight and Accountability Commission. Before any decision to recommend either continuing or discontinuing the project after the pilot, a stakeholder process to share evaluation data and seek input will be initiated.

During the first 18 months of operation, the CARE Center:

- Served an average of 199 unique people per quarter
- Provided 1,110 referrals to other providers/agencies
- Provided 8,114 direct services to people, including:
  - 889 assessments
  - 2,177 navigation/referral warm-hand-offs
  - 2,706 coaching/wellness skills activities
  - 372 direct needs (food/clothing/transportation) met
  - 1,970 emotional needs/supportive activities

The CARE Center is already performing well above expectations. The goal was to serve 113 unique clients per quarter by the end of 2018, and the center is serving well over 200 per quarter. 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 say they would have either gone to the emergency room, called 911 or gone "nowhere" if this service hadn't been available.

Fewer than 10 percent of referrals have been 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. The vast majority of visitors reported in a survey that they felt welcome, safe and comfortable at the CARE Center, and said staff provided them with support and helpful information about community resources.

The CARE Center Activity Report and the Innovation Project Outcome Tracking Report can be found in Appendices N and O.

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: 3/15/19

	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	1,755,150	1,631,027	2,600,368	0	0	
2. Estimated New FY 2017/18 Funding	7,383,261	1,845,816	485,741			
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	9,138,411	3,476,843	3,086,109	0	0	
B. Estimated FY 2017/18 MHSA Expenditures	5,665,986	1,283,901	758,781	0	0	0
G. Estimated FY 2017/18 Unspent Fund Balance	3,472,424	2,192,942	2,327,328	0	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: 3/15/19

	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	440,860	440,860				
2. Shasta Triumph and Recovery	1,404,764	838,223	545,922			20,618
3. Crisis Residential and Recovery	942,394	0	933,519			8,875
4. Crisis Response	1,354,401	895,118	404,503			54,780
5. Outreach-Access	1,263,562	877,693	349,775			36,094
6. Housing Continuum	54,272	0	11,272			43,000
7.						
Non-FSP Programs						
1. Rural Health Initiative	853,252	475,130	84,604			293,518
2. Older Adult Services	47,666	27,226	19,342			1,098
3. Co-occurring Integration	370,854	158,965	182,201			29,687
4. Laura's Law	345,799	345,799				
5.	0					
CSS Administration	1,606,971	1,606,971				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	8,684,795	5,665,986	2,531,138	0	0	487,671
FSP Programs as Percent of Total	96.4%					

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

County: Shasta

Date: 3/15/19

	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	304,893	304,893				
2. Suicide Prevention	159,269	159,269				
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
PEI Programs - Early Intervention						
Children/Youth in Stressed						
11. Families:	0					
Triple P	391,611	344,986	46,512			113
ACE	125,575	110,660	14,915			
Middle School Youth at Risk	22,949	20,223	2,726			
TFCBT	0	0	0			
16. Individuals Experiencing Onset of	154,211	39,232	113,549			1,430
Serious Psychiatric Illness	0					
17.	0					
18.	0					
19.	0					
PEI Administration	304,637	304,637				
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	1,463,145	1,283,901	177,702	0	0	1,542

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

County: Shasta Date: 3/15/19

	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	758,781	758,781				
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	758,781	758,781	0	0	0	0

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

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 18, 2019.

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

6/26/19
Date

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County: Shasta

- [ ] Three-Year Program and Expenditure Plan
- [x] 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

6/11/19
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, 2018. I further certify that for the fiscal year ending June 30, 2018, 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

June 6, 2019
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 March 29, 2019, and closed on June 5, 2019. A Public Hearing was conducted by the Shasta County Mental Health, Alcohol and Drug Advisory Board during their June 5, 2019, meeting.

Distribution

Public notice regarding the public comment period and public hearing 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

No comments were received from the public.

Approval

At a special meeting on June 5, 2019, 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 2019-20. The Shasta County Board of Supervisors adopted the plan on June 18, 2019.

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

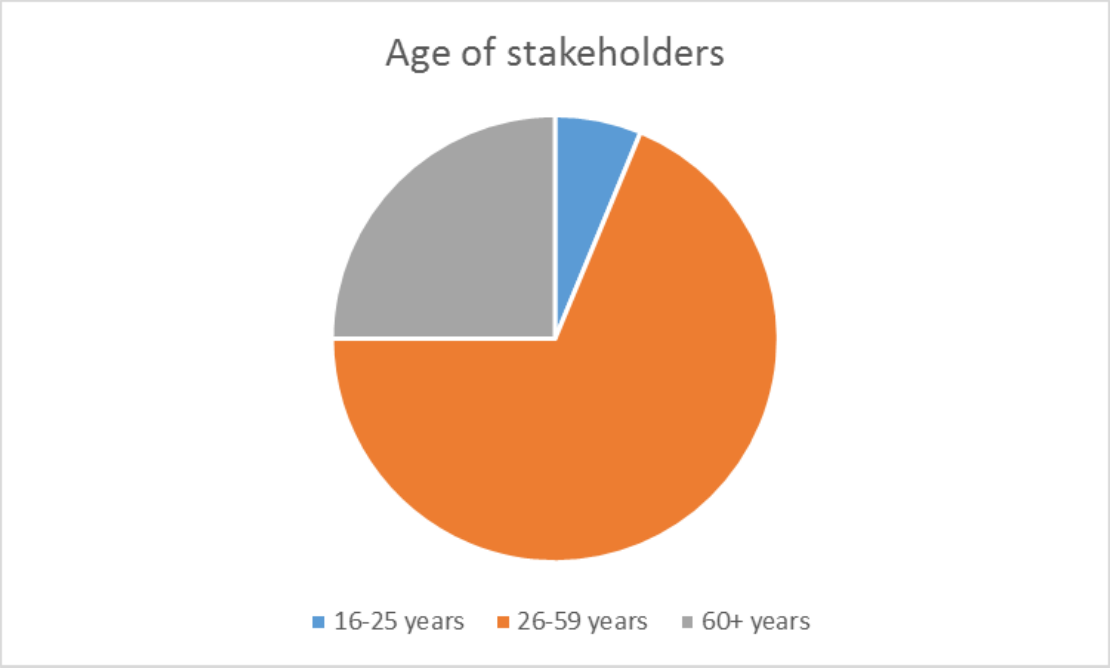
CONTACT INFORMATION

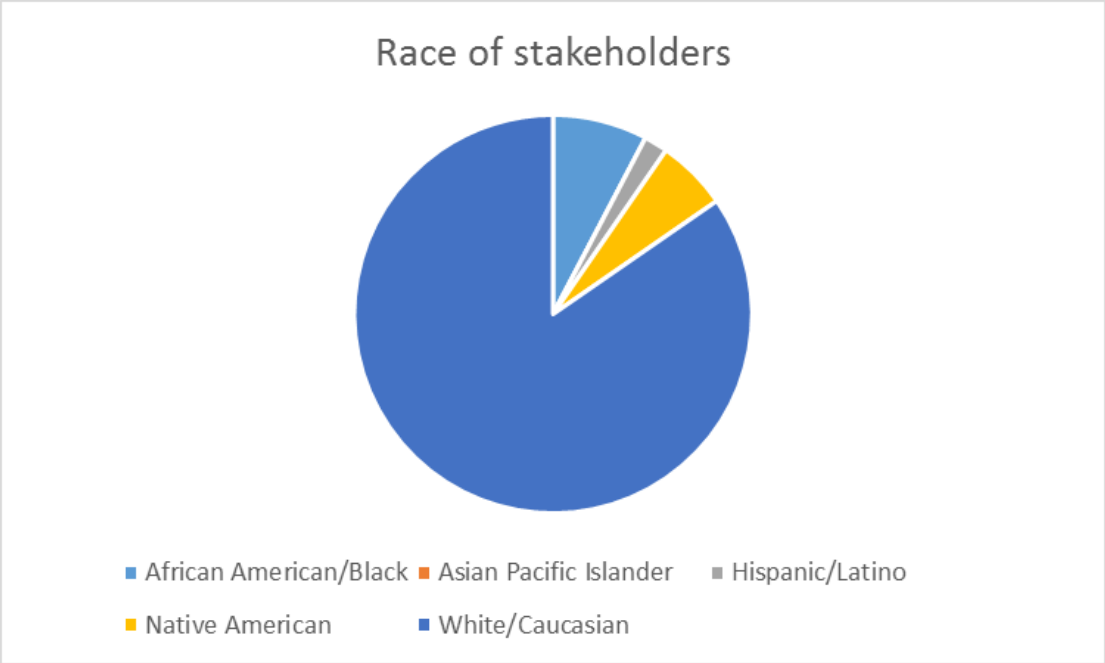
For information regarding this document, please contact:
Kerri Schuette, Mental Health Services Act Coordinator
Shasta County Health and Human Services Agency
2615 Breslauer Way, Redding, CA 96001
(530) 245-6951 kschuette@co.shasta.ca.us

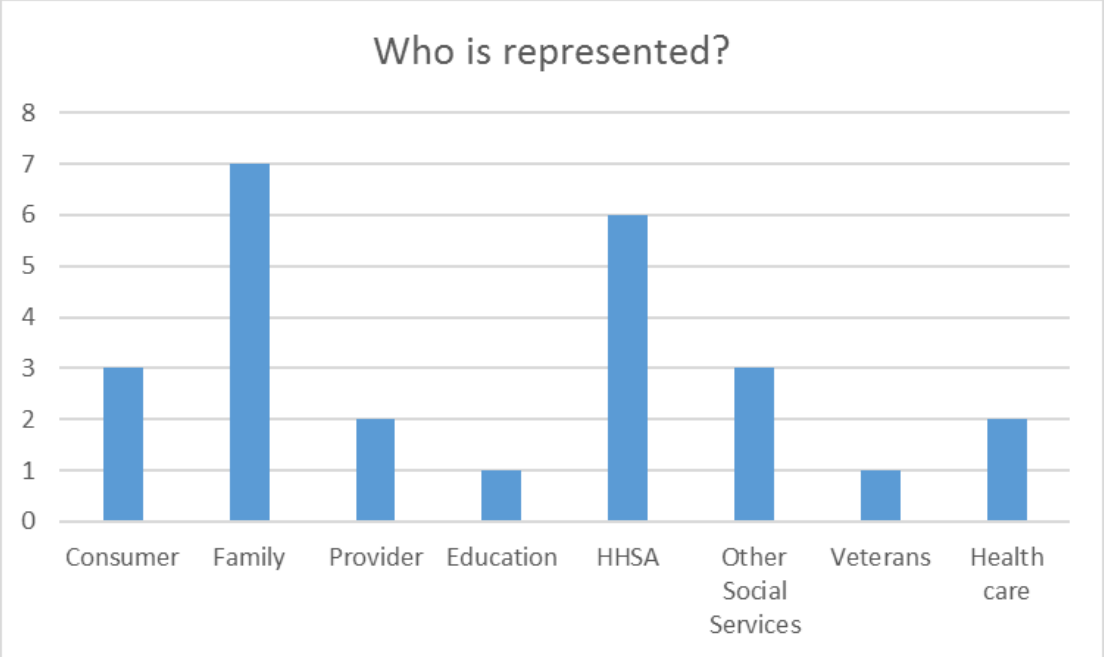
Shasta County Health & Human Services Agency

Mental Health Services Act (MHSA) Community Stakeholder Meetings

During Fiscal Year 2017-18, there were three general stakeholder meetings, which were each attended by approximately 40 people. Not all attendees completed the demographics survey. Below is the demographic breakdown of the 52 people who completed the survey.




Race of stakeholders
African American/Black
Asian Pacific Islander
Hispanic/Latino
Native American
White/Caucasian


Who is represented?
8
7
6
5
4
3
2
1
0
Consumer
Family
Provider
Education
HHSA
Other Social Services
Veterans
Health care

Appendix B

MORS Assessment Report
FY2017-2018 Quarter 4

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 6/30/2018, there have been 5,482 MORS completed for 1,264 unduplicated clients. Of these, 476 clients had at least one MORS assessment recorded in FY2017-18 Q4.

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, 30, and 36 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 349 clients with one or more MORS assessment in the reporting quarter and at least one assessment at least six and less than twelve months prior to the most recent MORS in the reporting quarter. Of these, 60 (17.2%) improved, while 41 (11.7%) declined. This difference is statistically significant ($p = 0.0417$). At the same time, the MORS ratings for 248 clients (71.1%) had not changed.

There were 308 clients with one or more MORS assessment in the reporting quarter and at least one assessment at least 12 and less than 18 months prior to the most recent MORS in the reporting quarter. Of these, 61 (19.8%) improved, while 56 (18.2%) declined. This difference is not statistically significant ($p = 0.6079$). At the same time, the MORS ratings for 191 clients (62.0%) had not changed.

Two hundred ninety-six clients had one or more MORS assessment in the reporting quarter and at least one assessment at least 18 and less than 24 months prior to the most recent MORS in the reporting quarter. Of these, 49 (16.6%) improved, while 72 (24.3%) declined. This difference is statistically significant ($p = 0.0197$). At the same time, 175 clients (59.1%) had initial MORS ratings that were the same.

There were 212 clients with one or more MORS assessment in the reporting quarter and at least one assessment at least 24 and less than 30 months prior to the most recent MORS in the reporting quarter. Of these, 54 (25.5%) improved, while 57 (26.9%) declined. This difference is not statistically significant ($p = 0.7407$). At the same time, 101 clients (47.6%) had MORS ratings were the same as their most recent ratings.

There were 210 clients with one or more MORS assessment at least 30 and less than 36 months prior to the most recent MORS in the reporting quarter. Of these, 59 (28.1%) improved, while 58 (27.6%) declined. This difference is not statistically significant ($p = 0.9134$). At the same time, 93 clients (44.3%) had MORS ratings that were the same.

There were 180 clients with one or more MORS assessment in the reporting quarter and at least one assessment at least 36 months prior to the most recent MORS in the reporting quarter. Of these, 51

(28.3%) improved, while 47 (26.1%) declined. This difference is not statistically significant (p = 0.6363). At the same time, 82 clients (45.6%) had MORS ratings that were the same.

Tables 1 thought 6 provide a count of each MORS rating for all clients with one or more assessment in FY2017-18Q4, and at least one MORS 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, at least 30 but less than 36, and at least 36 months prior to their most recent MORS in FY2017-18Q4, 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 six to twelve months prior to FY2017-18 Q4

			FY2017-18 Q4 MORS										
6-12 Months Prior	**Count of Clients**	**Percent**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**Improved**	**Stayed the Same**	**Declined**
1	**2**	**0.6%**						2			N/A	0	2
2	**2**	**0.6%**					1	1			0	0	2
3	**16**	**4.6%**		1	7		5	3			1	7	8
4	**8**	**2.3%**			1	1	4	2			1	1	6
5	**232**	**66.5%**	1		17	6	187	21			24	187	21
6	**81**	**23.2%**		1			28	50	2		29	50	2
7	**8**	**2.3%**					1	4	3		5	3	0
8	**0**	**0.0%**									0	0	N/A
Total	**349**	**100.0%**	**1**	**2**	**25**	**7**	**226**	**83**	**5**	**0**	**60**	**248**	**41**
			0.3%	**0.6%**	**7.2%**	**2.0%**	**64.8%**	**23.8%**	**1.4%**	**0.0%**	**17.2%**	**71.1%**	**11.7%**

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

Table 2: Change in MORS ratings from 12 to 18 months prior to FY2017-18 Q4

			FY2017-18 Q4 MORS										
12-18 Months Prior	**Count of Clients**	**Percent**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**Improved**	**Stayed the Same**	**Declined**
1	**2**	**0.6%**			1			1			N/A	0	2
2	**2**	**0.6%**					1	1			0	0	2
3	**16**	**5.2%**		1	3	2	5	5			1	3	12
4	**5**	**1.6%**				1	4				0	1	4
5	**205**	**66.6%**	1	1	13	6	149	35			21	149	35
6	**71**	**23.1%**		1			34	35	1		35	35	1
7	**7**	**2.3%**						4	3		4	3	0
8	**0**	**0.0%**									0	0	N/A
Total	**308**	**100.0%**	**1**	**3**	**17**	**9**	**193**	**81**	**4**	**0**	**61**	**191**	**56**
			0.3%	**1.0%**	**5.5%**	**2.9%**	**62.7%**	**26.3%**	**1.3%**	**0.0%**	**19.8%**	**62.0%**	**18.2%**

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

Table 3: Change in MORS ratings from 18 to 24 months prior to FY2017-18 Q4

			FY2017-18 Q4 MORS										
18-24 Months Prior	**Count of Clients**	**Percent**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**Improved**	**Stayed the Same**	**Declined**
1	**2**	**0.7%**			2						N/A	0	2
2	**2**	**0.7%**	1				1				1	0	1
3	**16**	**5.4%**		1	3	2	10				1	3	12
4	**6**	**2.0%**				1	3	2			0	1	5
5	**195**	**65.9%**	1	1	7	5	130	49	2		14	130	51
6	**68**	**23.0%**	1		1	1	24	40	1		27	40	1
7	**7**	**2.4%**		1	1		1	3	1		6	1	0
8	**0**	**0.0%**									0	0	N/A
Total	**296**	**100.0%**	**3**	**3**	**14**	**9**	**169**	**94**	**4**	**0**	**49**	**175**	**72**
			1.0%	**1.0%**	**4.7%**	**3.0%**	**57.1%**	**31.8%**	**1.4%**	**0.0%**	**16.6%**	**59.1%**	**24.3%**

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

Table 4: Change in MORS ratings from 24 to 30 months prior to FY2017-18 Q4

			FY2017-18 Q4 MORS										
24-36 Months Prior	**Count of Clients**	**Percent**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**Improved**	**Stayed the Same**	**Declined**
1	**1**	**0.5%**			1						N/A	0	1
2	**2**	**0.9%**					2				0	0	2
3	**11**	**5.2%**	1	1	2	1	4	2			2	2	7
4	**5**	**2.4%**					4	1			0	0	5
5	**138**	**65.1%**		4	12	4	80	36	2		20	80	38
6	**50**	**23.6%**		1	3	2	23	18	3		29	18	3
7	**5**	**2.4%**					2	1	1	1	3	1	1
8	**0**	**0.0%**									0	0	N/A
Total	**212**	**100.0%**	**1**	**6**	**18**	**7**	**115**	**58**	**6**	**1**	**54**	**101**	**57**
			0.5%	**2.8%**	**8.5%**	**3.3%**	**54.2%**	**27.4%**	**2.8%**	**0.5%**	**25.5%**	**47.6%**	**26.9%**

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

Table 5: Change in MORS ratings from 30 to 36 months prior to FY2017-18 Q4

			FY2017-18 Q4 MORS										
30-36 Months Prior	**Count of Clients**	**Percent**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**Improved**	**Stayed the Same**	**Declined**
1	**1**	**0.5%**						1			N/A	0	1
2	**1**	**0.5%**			1						0	0	1
3	**13**	**6.2%**		1	2	1	5	4			1	2	10
4	**4**	**1.9%**			1		2	1			1	0	3
5	**146**	**69.5%**		5	14	9	76	38	4		28	76	42
6	**42**	**20.0%**		3	8		16	14	1		27	14	1
7	**3**	**1.4%**					2		1		2	1	0
8	**0**	**0.0%**									0	0	N/A
Total	**210**	**100.0%**	**0**	**9**	**26**	**10**	**101**	**58**	**6**	**0**	**59**	**93**	**58**
			0.0%	**4.3%**	**12.4%**	**4.8%**	**48.1%**	**27.6%**	**2.9%**	**0.0%**	**28.1%**	**44.3%**	**27.6%**

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

Table 6: Change in MORS ratings from 36 or more months prior to FY2017-18 Q4

			FY2017-18 Q4 MORS										
36+ Months Prior	**Count of Clients**	**Percent**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**Improved**	**Stayed the Same**	**Declined**
1	**1**	**0.6%**		1							N/A	0	1
2	**2**	**1.1%**			1		1				0	0	2
3	**15**	**8.3%**			7	1	6	1			0	7	8
4	**3**	**1.7%**			1		1	1			1	0	2
5	**122**	**67.8%**	2	1	17	8	64	23	7		28	64	30
6	**33**	**18.3%**		1	2		17	10	3		20	10	3
7	**4**	**2.2%**				1		1	1	1	2	1	1
8	**0**	**0.0%**									0	0	N/A
Total	**180**	**100.0%**	**2**	**3**	**28**	**10**	**89**	**36**	**11**	**1**	**51**	**82**	**47**
			1.1%	**1.7%**	**15.6%**	**5.6%**	**49.4%**	**20.0%**	**6.1%**	**0.6%**	**28.3%**	**45.6%**	**26.1%**

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

Sources:

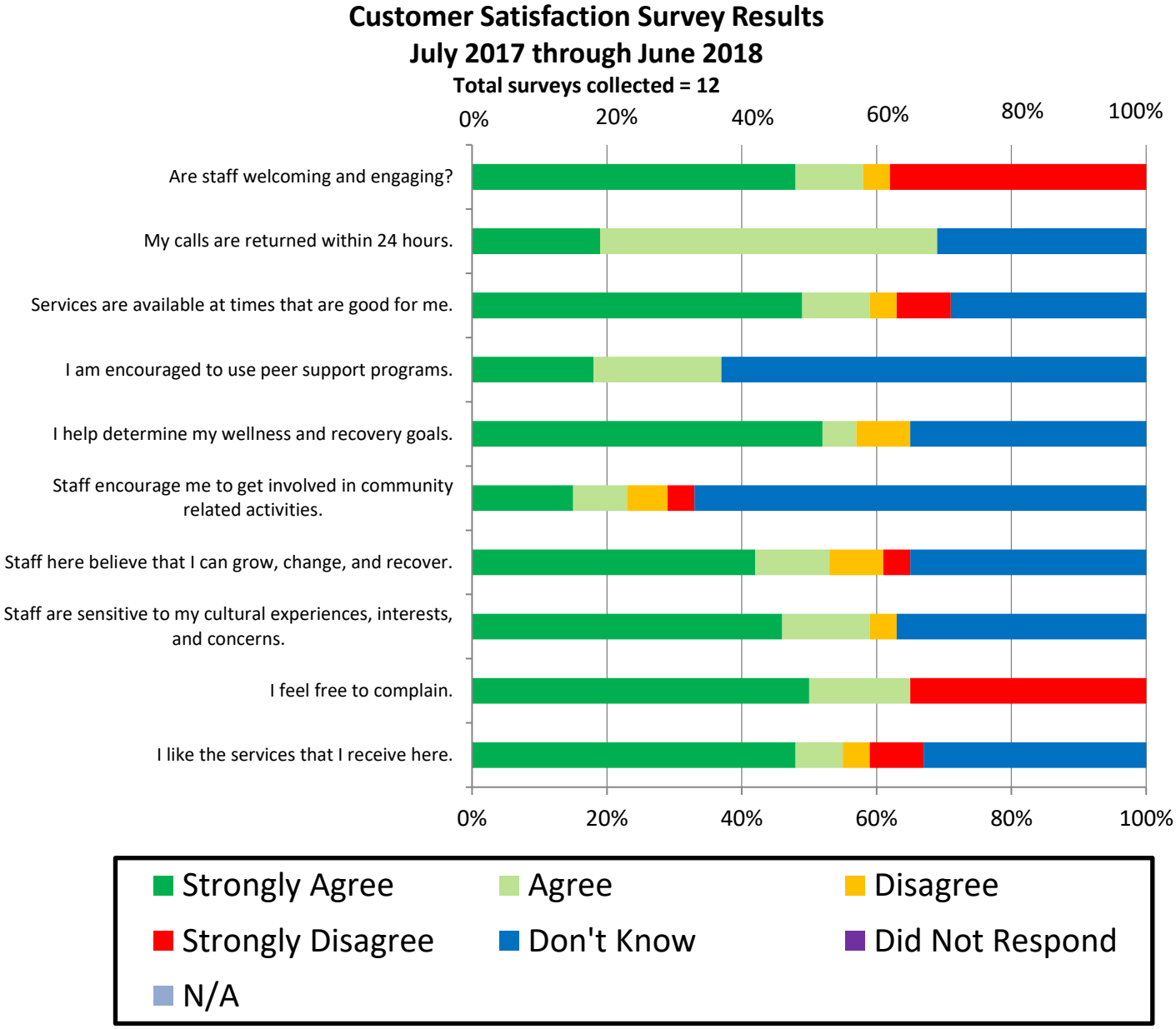
Fisher, D. G., Pilon, D., Hershberger, S. L., Reynolds, G.L., LaMaster, S. C., & Davis, M. (2009). Psychometric Properties of an Assessment for Mental Health Recovery Programs. *Community Mental Health Journal, 45*(4), 246-250.

MORS database last updated 3/5/2019.

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.



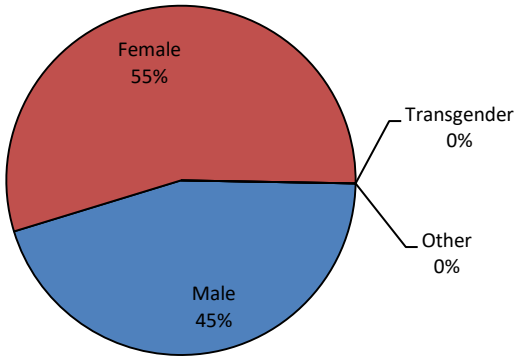
Wellness Center Summary Report

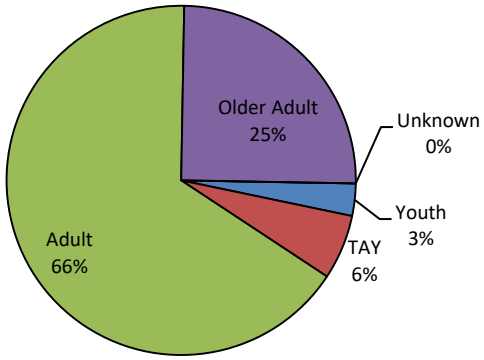
July 2017 through June 2018

Shasta County had two wellness centers in operation during the twelve-month period of July 2017 through June 2018: 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 45% of wellness center attendees were male, 55% female, and 0% reported as transgender or other.

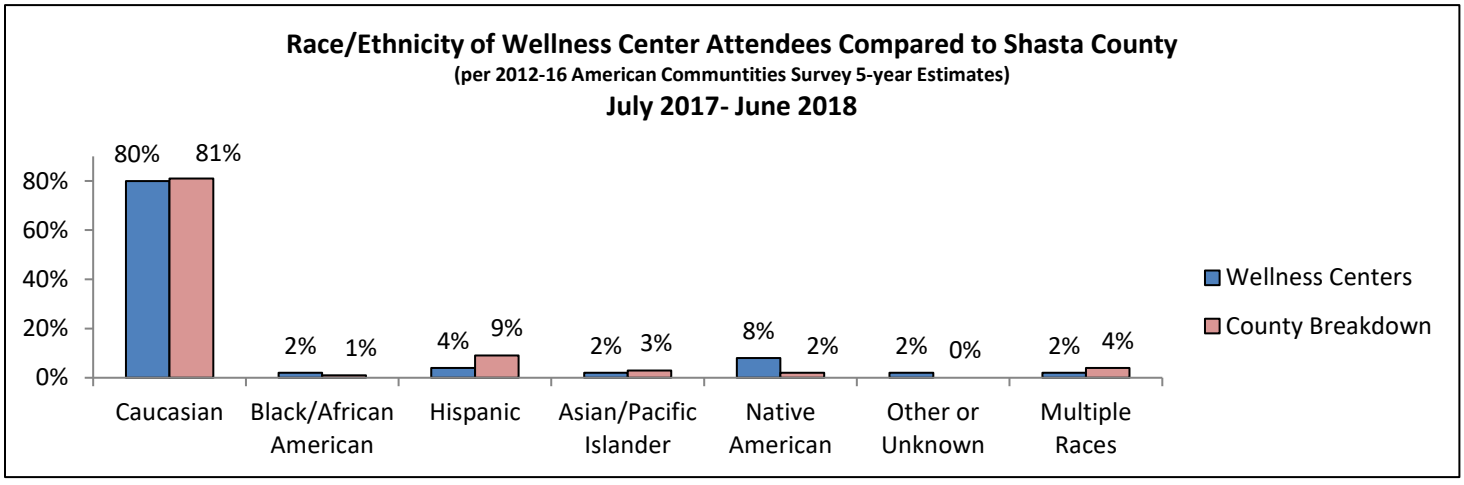




Approximately 3% of wellness center attendees were Youths (0-15 years of age), 6% were Transitional Age Youths (16-25 years of age), 66% were Adults (26-59 years of age), 25% were Older Adults (60+ years of age), and 0% were of unknown age.

Approximately 65% of wellness center attendees were consumers, 7% were family members of consumers, and 20% identified as both consumers and family members, with 8% unknown or declining to state.

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



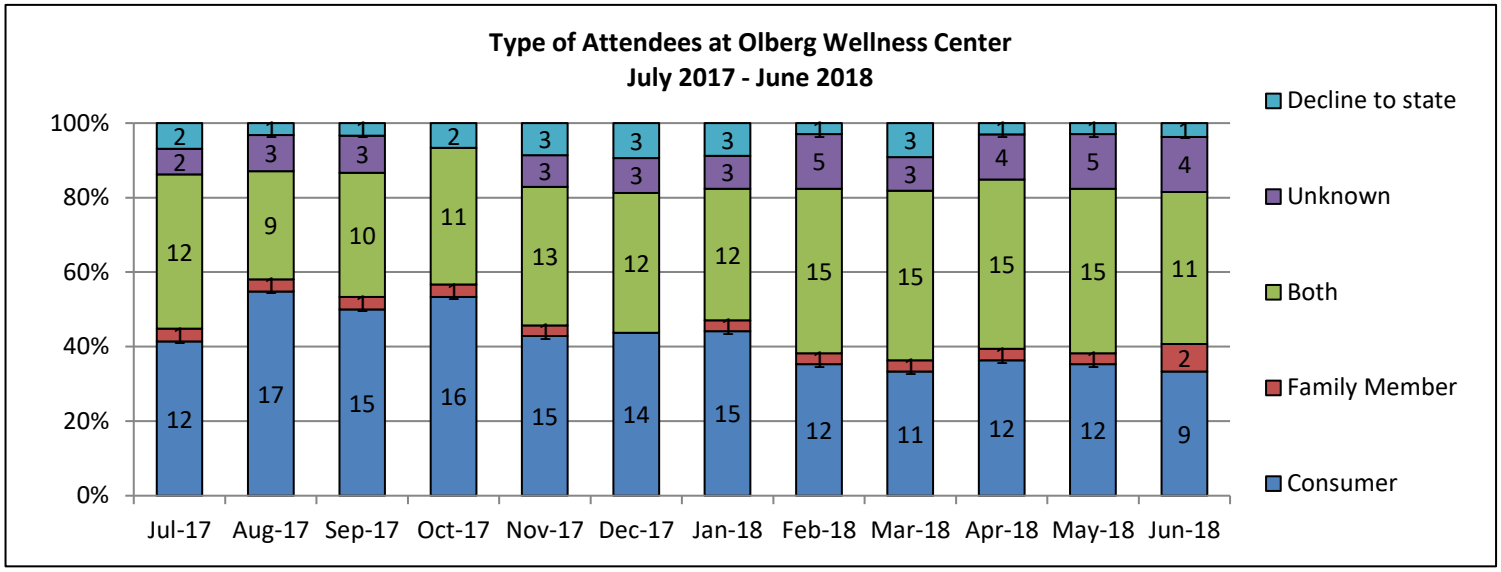
Services Provided

Overall, a total of 2,237 individual workshops, groups, activities, and 12-step recovery meetings were held during this twelve-month period.

Olberg Wellness Center

Attendance

Attendance decreased 15% from the previous twelve-month period, with an average of 32 unduplicated participants each month.



Demographics

On average, 44% of attendees were consumers, 4% were family members, and 38% identified as both family members and consumers. On average, 8% of the participants were of unknown type, and 6% declined to state. On average, 93% of staff members (including volunteers) were consumers and/or family members. In order to maintain confidentiality, age, gender and race/ethnicity is not broken down by individual wellness center.

Services Provided

Olberg Wellness Center is open Monday through Friday 10 am to 3 pm. During this twelve-month period 1,333 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.

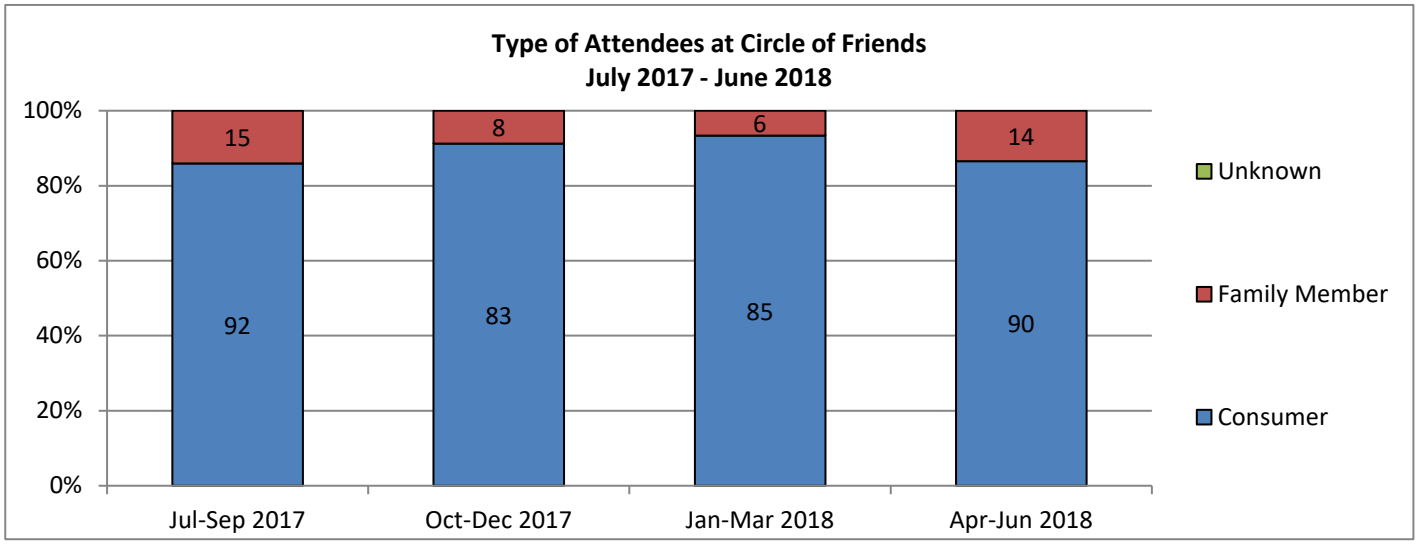
Attendee Direction

Olberg Wellness Center has weekly Members' Meetings and monthly Steering Committee Meetings, open to consumers and family members. During this twelve-month period, they had an average of 12 participants per meeting.

Circle of Friends

Attendance

Attendance decreased 12% from the previous twelve-month period, with an average of 98 unduplicated people attending Circle of Friends each quarter.



Demographics

Eighty-nine percent of attendees were consumers and 11% were family members. Eighty-four percent of staff and 96% of volunteers were consumers and/or family members. In order to maintain confidentiality, age, gender and race/ethnicity is not broken down by individual wellness center.

Services Provided

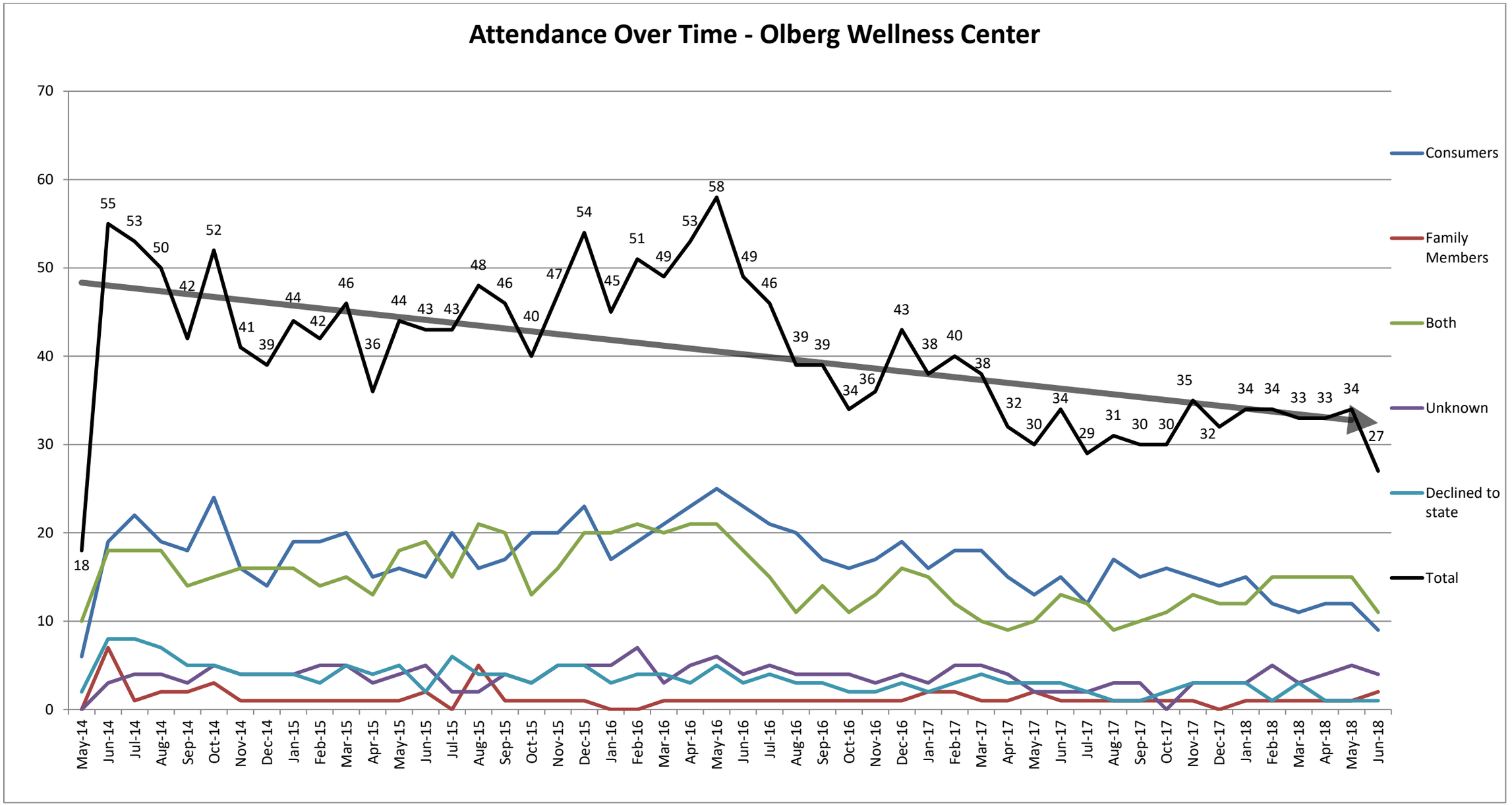
In Burney, the standard hours are 12:30 PM to 3:30 PM Monday, Wednesday, and Friday; and varying hours on Tuesdays and Thursday afternoons depending on the scheduled activity. In Round Mountain, activities are occasionally scheduled on Tuesdays or Thursdays. In addition, many scheduled activities and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

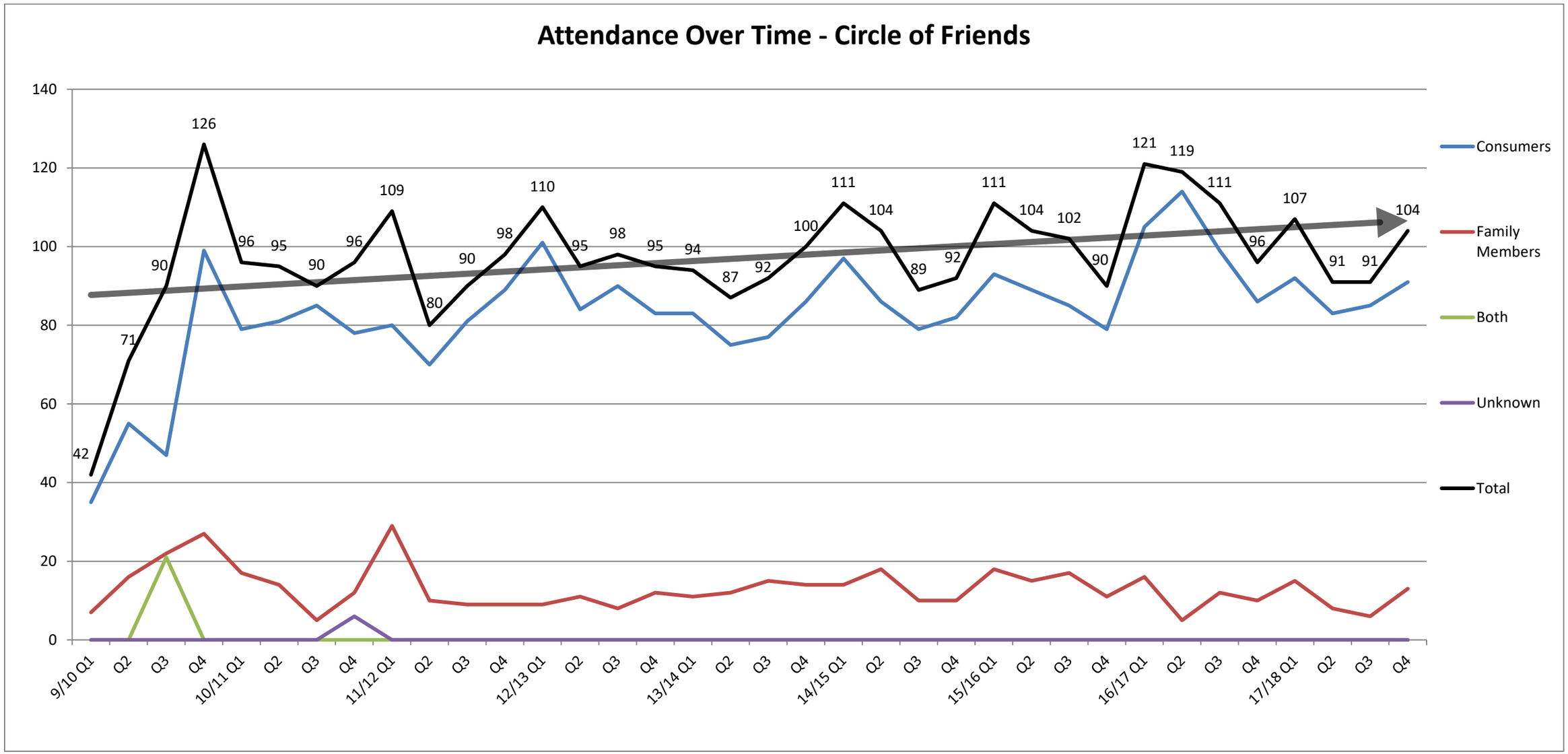
Eleven workshops, 240 different activities, and 21 different weekly/biweekly 12 step recovery meetings were held on a regular basis, which provided 904 individual activities/groups for participants during this twelve-month period.

Attendee Direction

An average of 23 attendees (23%) contributed to the planning and direction of the program each quarter. All decisions relating to the Center are based on participant input through the Steering Committee, Stand Against Stigma Committee, Community Education Committee, ACE's Community Meeting, Calendar and Newsletter Planning Meetings, daily check-in time, daily discussions, Burney Basin Days Parade, Community Solutions Forum, Pit River Health Fair Planning, Yard Sale Planning, Women's Group and other activity-specific planning meetings. Activities offered at the Center are based on participant preferences.

Attendance Over Time - Olberg Wellness Center




Attendance Over Time - Circle of Friends
140
120
100
80
60
40
20
0
42
71
90
126
96
95
90
96
109
80
90
98
110
95
98
95
94
87
92
100
111
104
89
92
111
104
102
90
121
119
111
96
107
91
91
104
9/10 Q1
Q2
Q3
Q4
10/11 Q1
Q2
Q3
Q4
11/12 Q1
Q2
Q3
Q4
12/13 Q1
Q2
Q3
Q4
13/14 Q1
Q2
Q3
Q4
14/15 Q1
Q2
Q3
Q4
15/16 Q1
Q2
Q3
Q4
16/17 Q1
Q2
Q3
Q4
17/18 Q1
Q2
Q3
Q4
Consumers
Family Members
Both
Unknown
Total

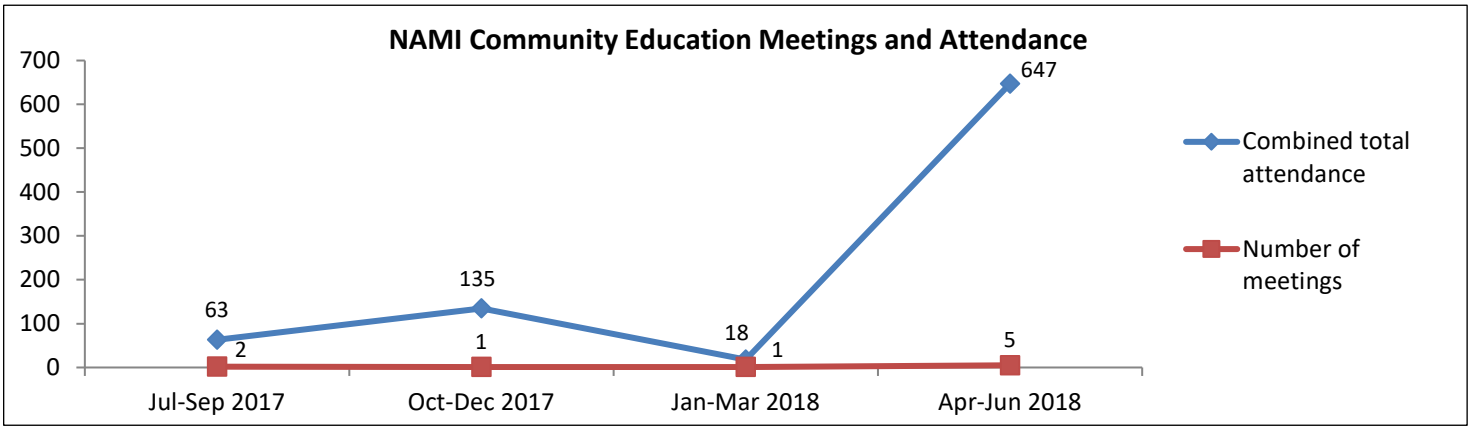
National Alliance on Mental Illness (NAMI) Longitudinal Tracking
Jul 2017 through Jun 2018

NAMI Summary Report

Jul 2017 through Jun 2018

Community Education

NAMI held 9 different community education meetings in the most recent 12 months tracked. An average of 96 people attended each meeting. The annual Minds Matter Mental Health Resource Fair was held in May 2018, with over 500 attendees reported. This accounts for the higher than usual numbers reported in the most recent quarter.

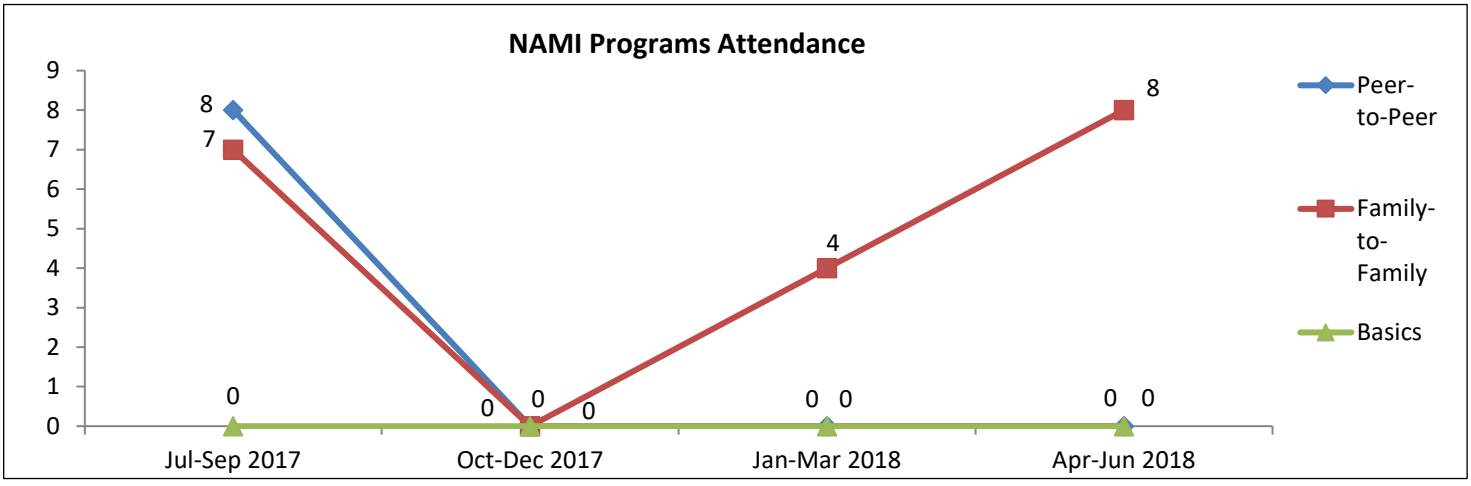


Program Offerings

NAMI Shasta County offered Family to Family, Family Support Group, and various community education activities this quarter including hosting a table at the annual Minds Matter Fair where they received exposure to hundreds of attendees.

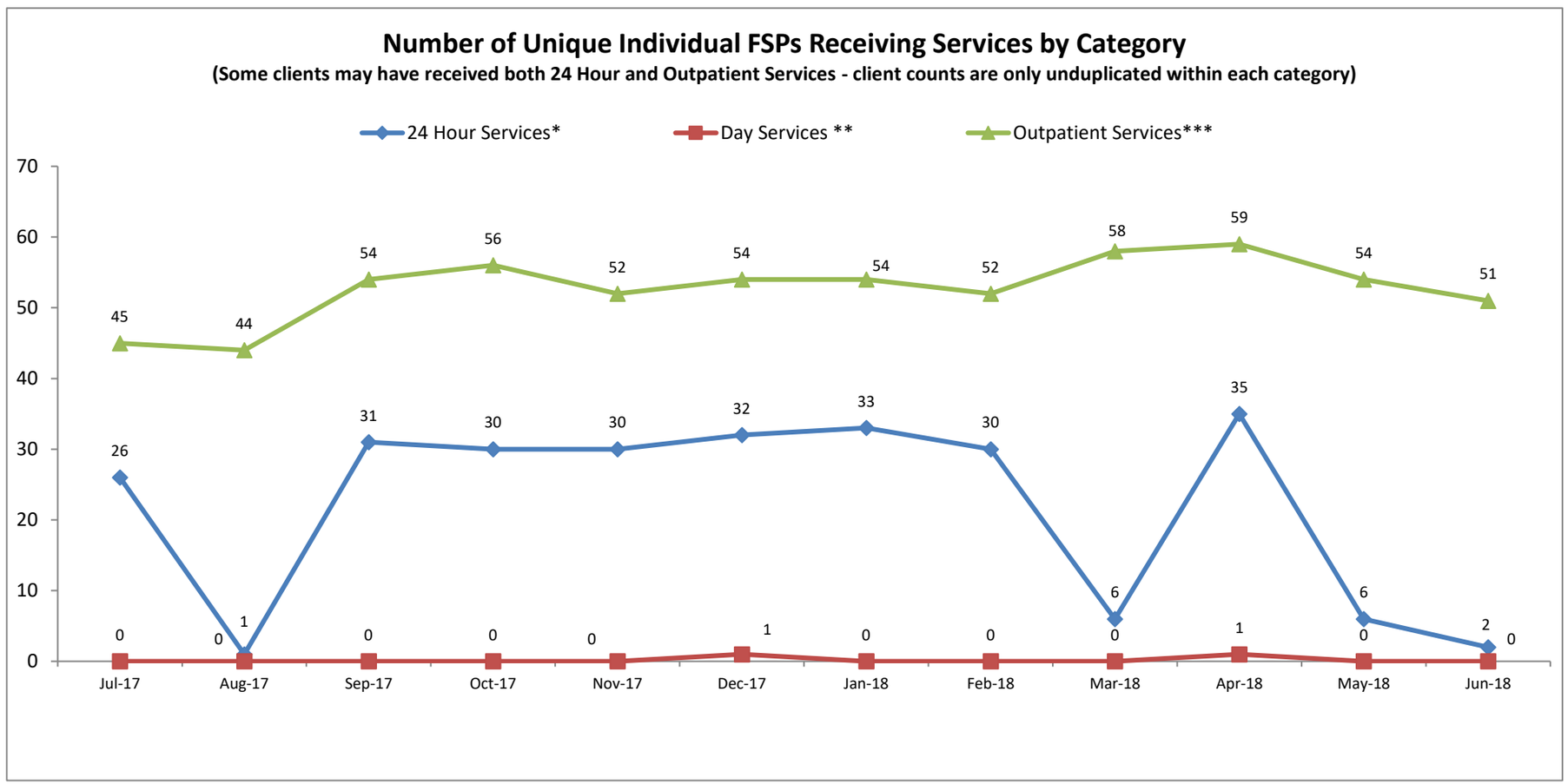
This quarter, families of NAMI's core volunteers faced difficult barriers including illness, mental health crises, and death. To cope with these challenges, NAMI prioritized their most important programs while slowing or putting other projects on hold including their website, membership drive, and a guideline for families who must call 911. Two people who signed up for Family to Family in Round Mountain stopped coming after the 4th class. NAMI is addressing these barriers by promoting self-care to get back on track and continues to work with the MHSA Academy to get volunteers.

Despite continuing family crises in many of their core volunteer families, successes included finishing their Family to Family Course, hosting a table at the Minds Matter Fair, and holding their Family Support Group twice a month. They successfully rewrote their contract with Shasta County MHSA, made progress on the NAMI re-affiliation processes which will be submitted to NAMI California by September 30, 2018 (due by December 30, 2018), local NAMI president Susan Power completed the MHSA academy in May, and two of NAMI's members now meet the criteria for certified peer support specialists.



CSI AND FSP LINKED DATA – FY 2017-18

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



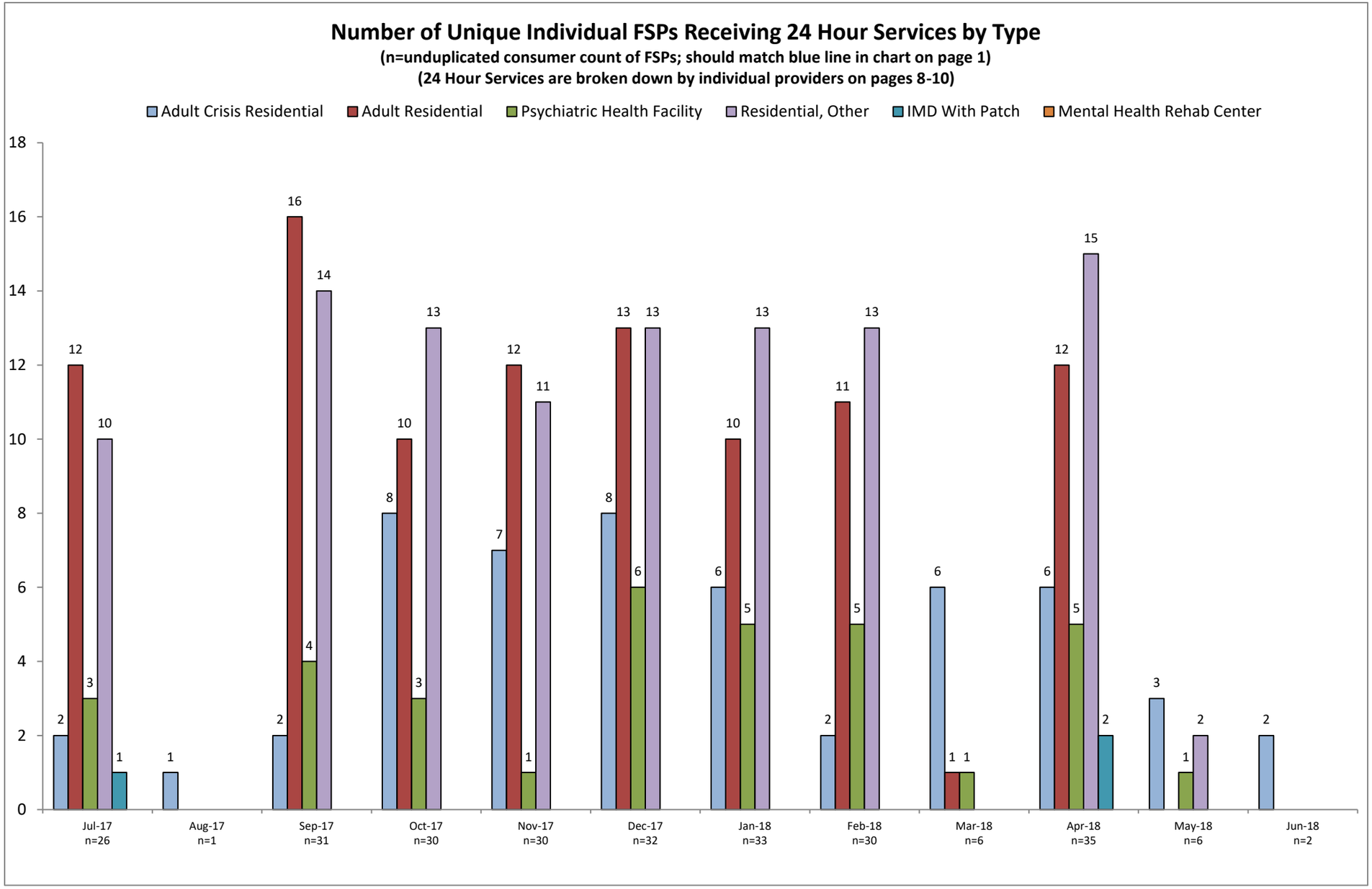
Mental Health Services are divided into three main categories: 24 Hour Services; Day Services; and, Outpatient Services.

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.

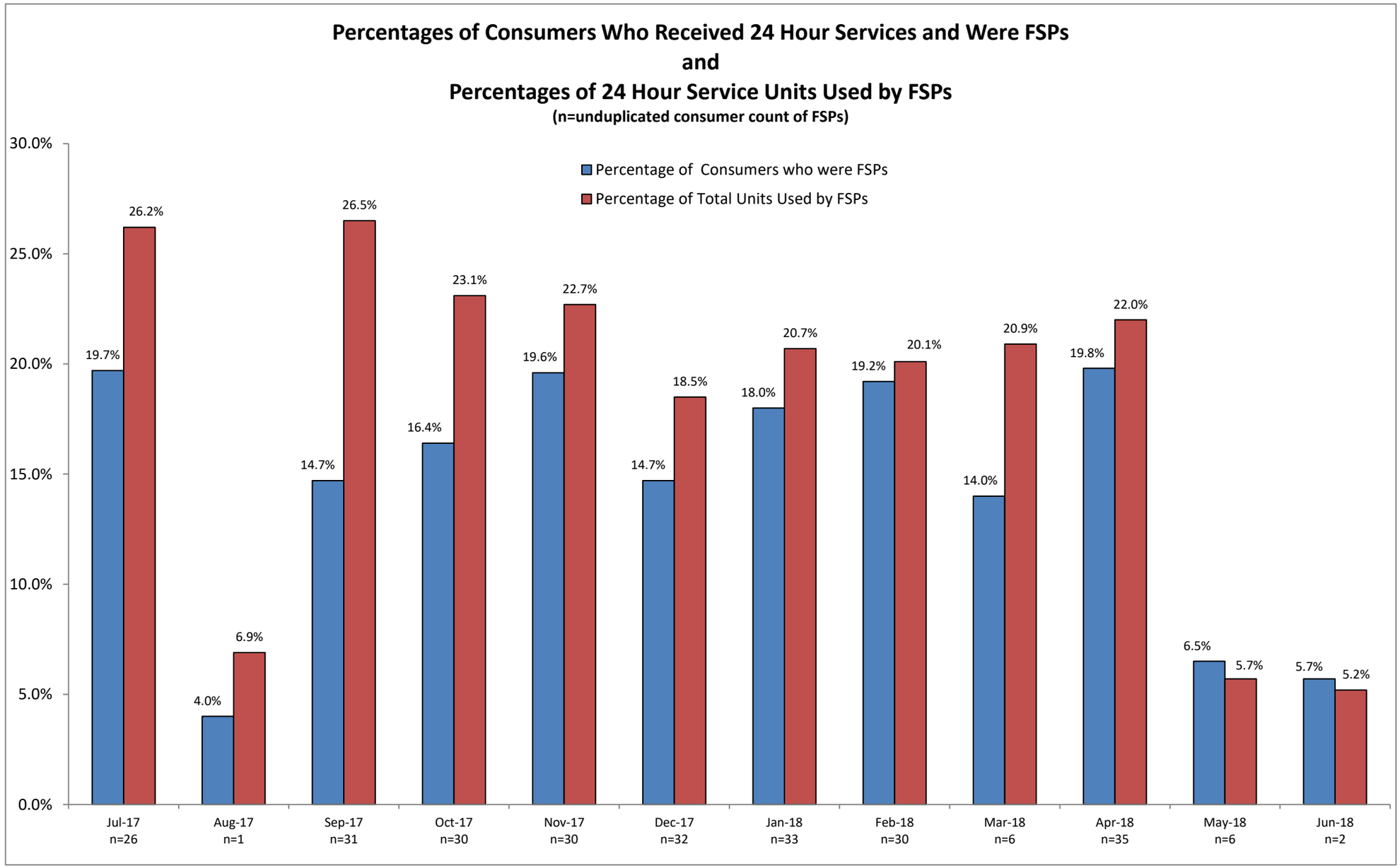
Outpatient Services include things such as Crisis Intervention, Linkage/ Brokerage and Medication Support. These services are billed for by the minute.

*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 & 7 (SCMH) and 11 (vendors)



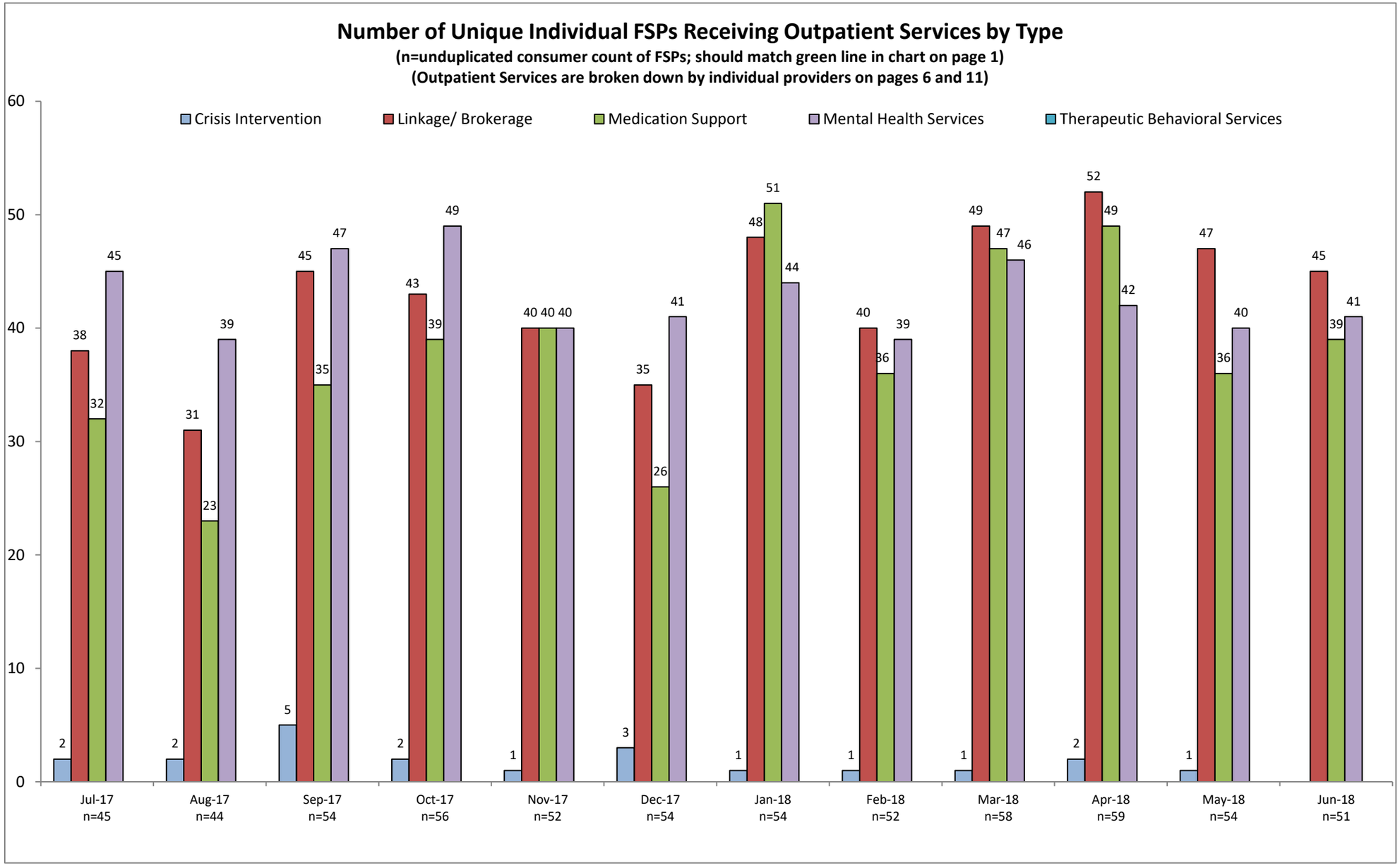
In this chart, the number of unduplicated Full Service Partners who received any type of 24 Hour Services is noted under the month as “n”.

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



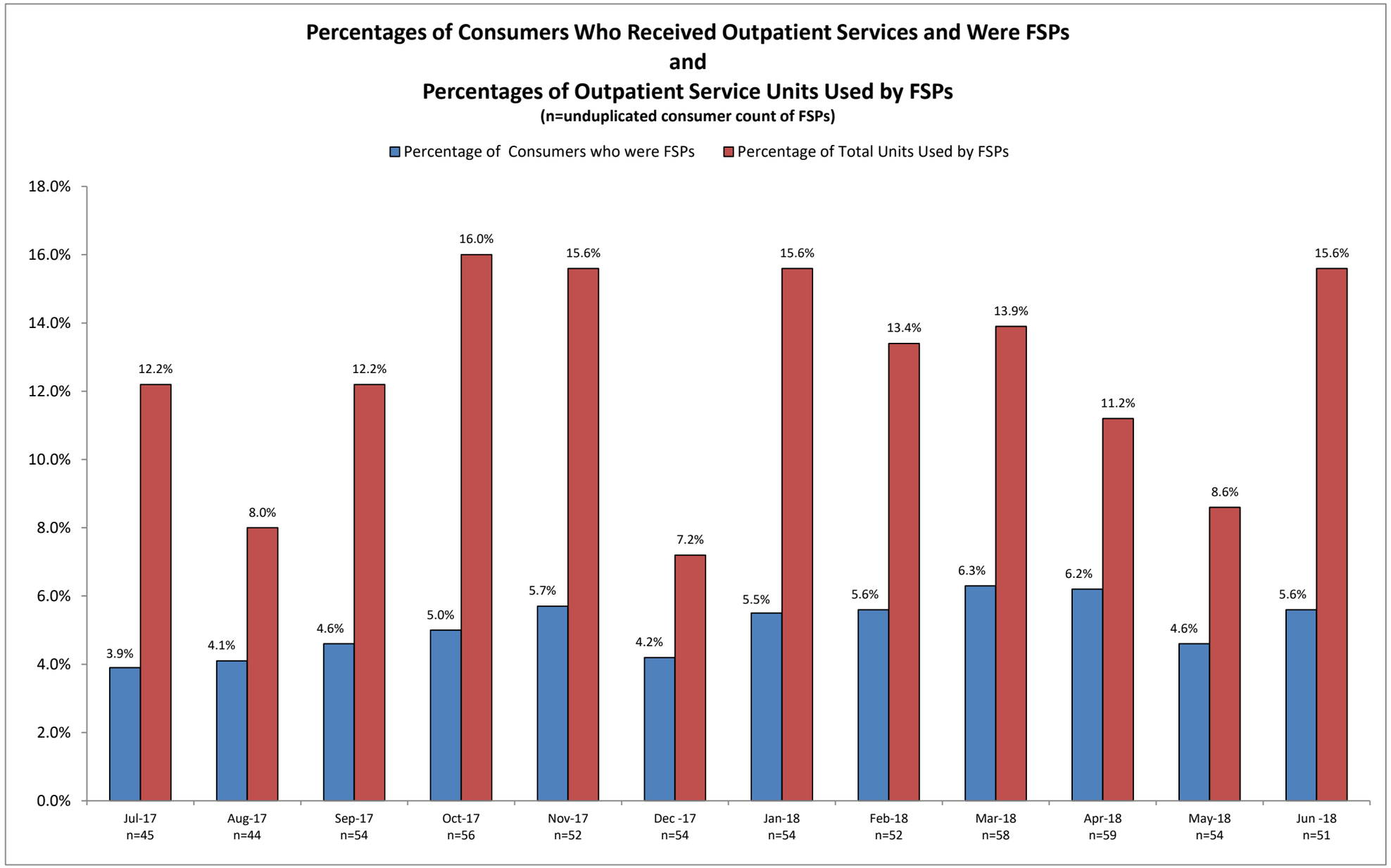
As mentioned before, 24 Hour Services are billed for by the day. This chart compares, by percentage, how many of the consumers who utilized 24 Hour Services were Full Service Partners, and how many of the days billed for were used by Full Service Partners.

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



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

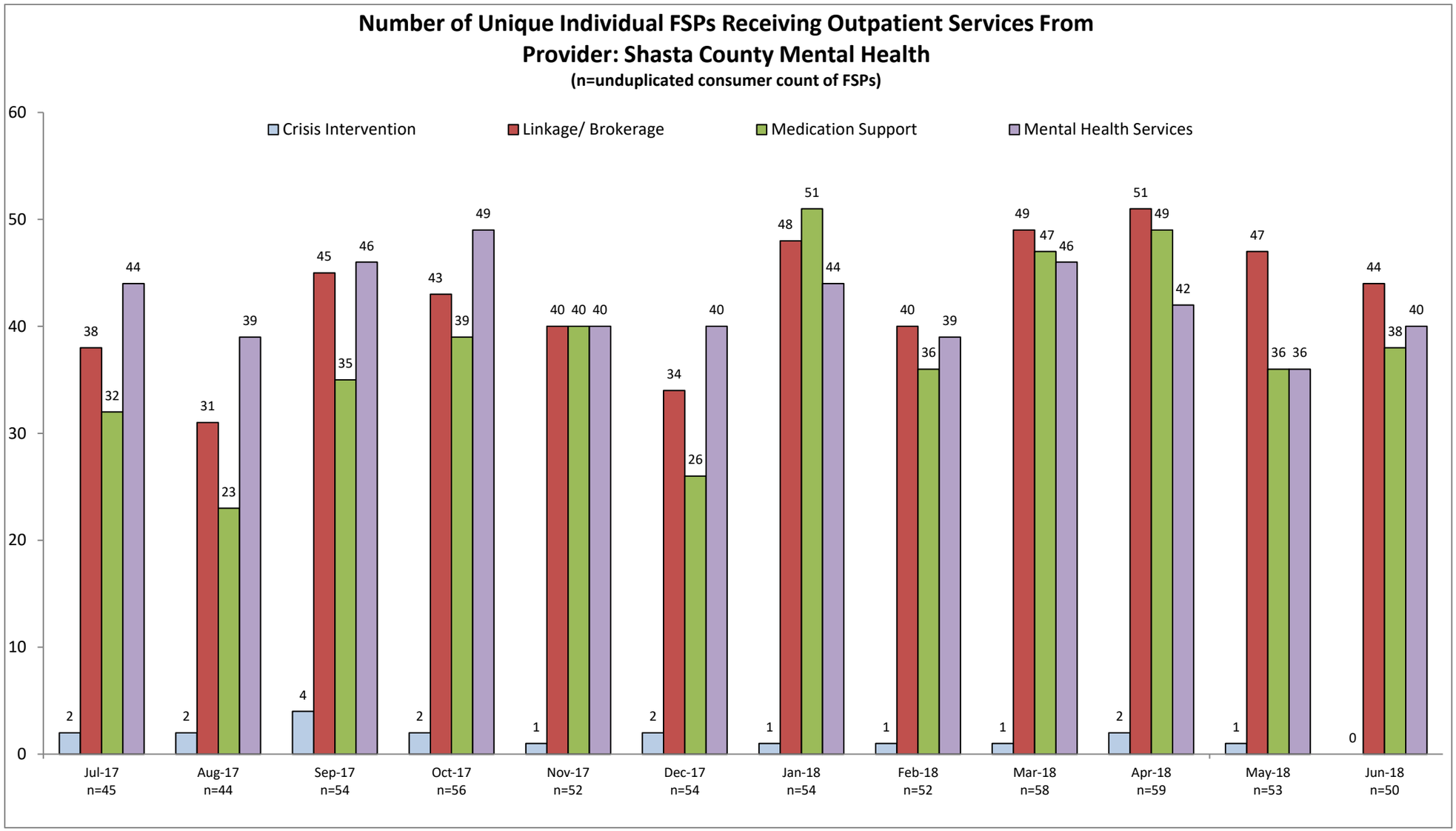
The bars above each month show how many of those unduplicated Full Service Partners received each type of Outpatient Service. Because consumers can, and often do, received more than one kind of service in any given month, the numbers for the services types each month may add up to more than the number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



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

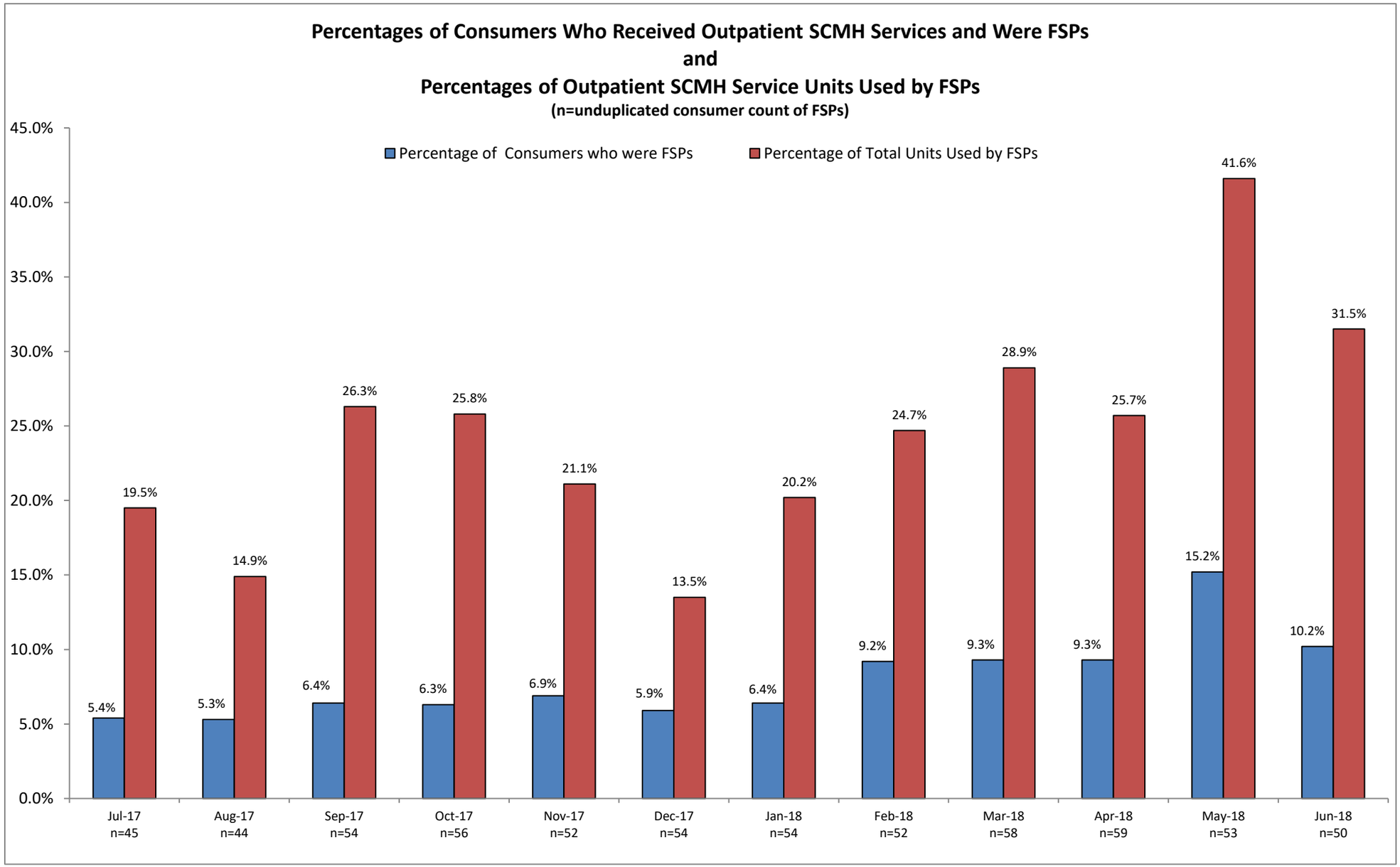
Because the Full Service Partnership program is designed to provide intensive services, it is expected that partners <u>may</u> utilize disproportionately more of the services than non-partner consumers.

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



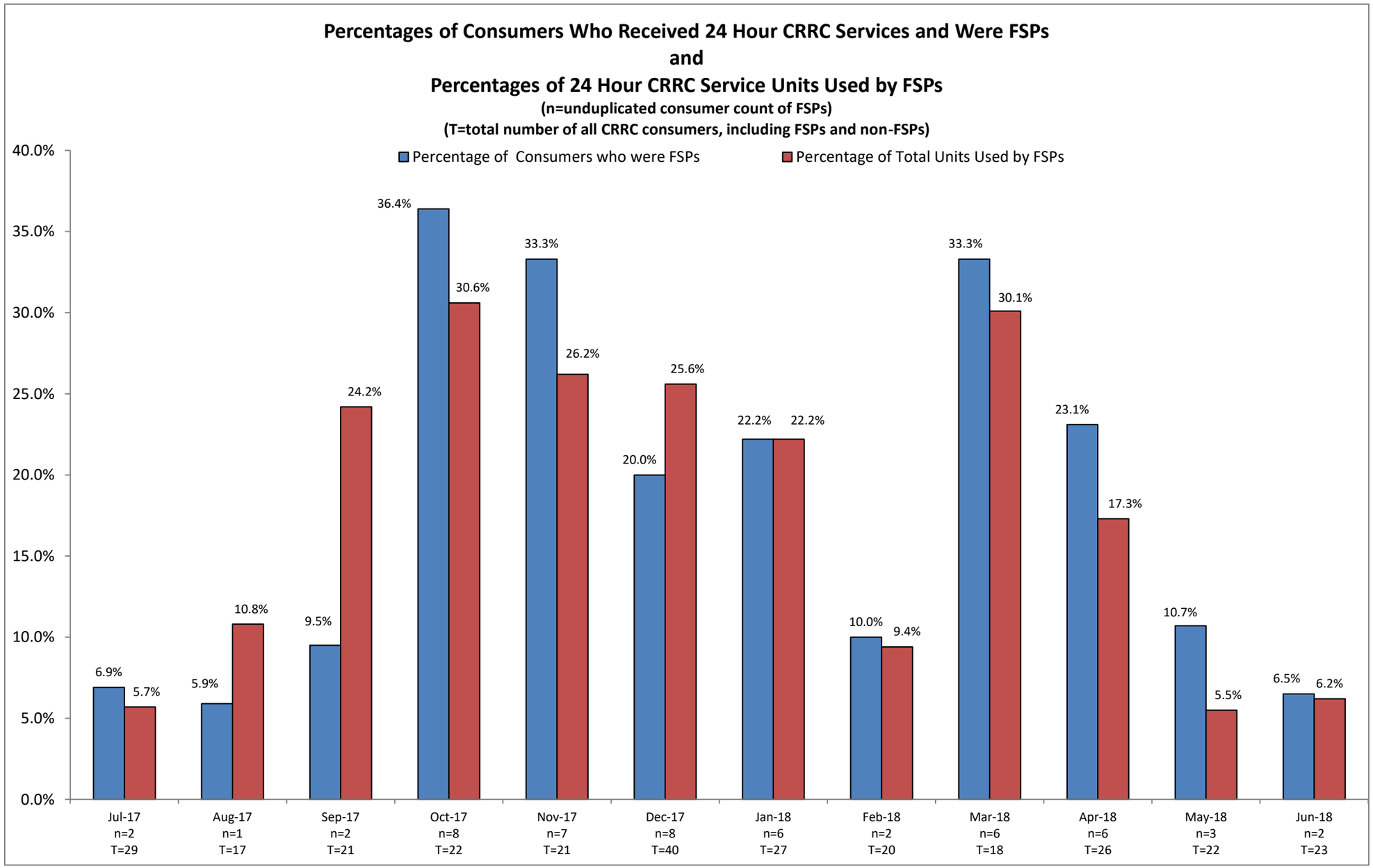
In this chart, the number of unduplicated Full Service Partners who received any type of Outpatient Services from SCMH is noted under the month as "n".

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



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

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

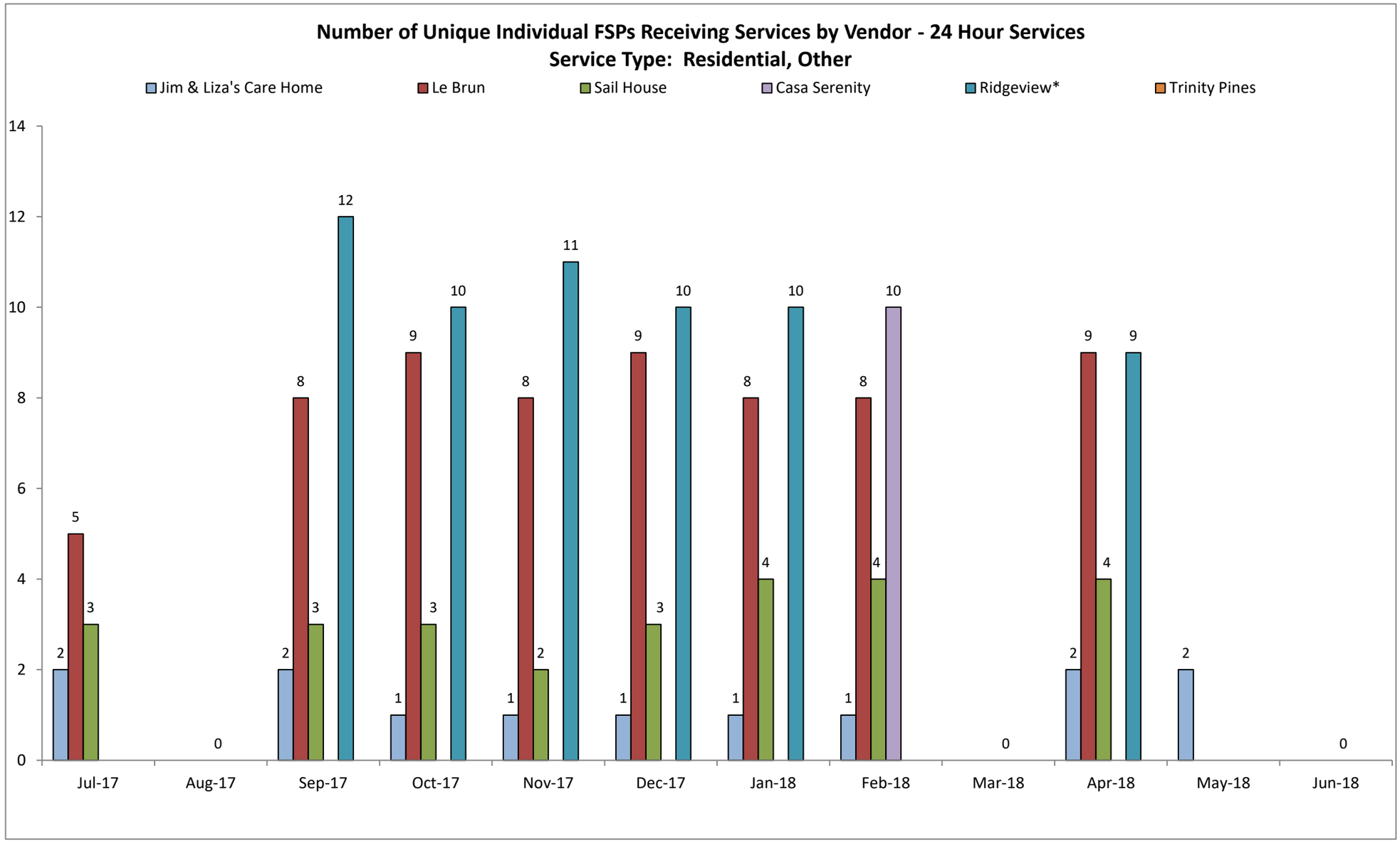


The only 24 Hour Service provided directly by Shasta County Mental Health is the Crisis Residential and Recovery Center (CRRC).

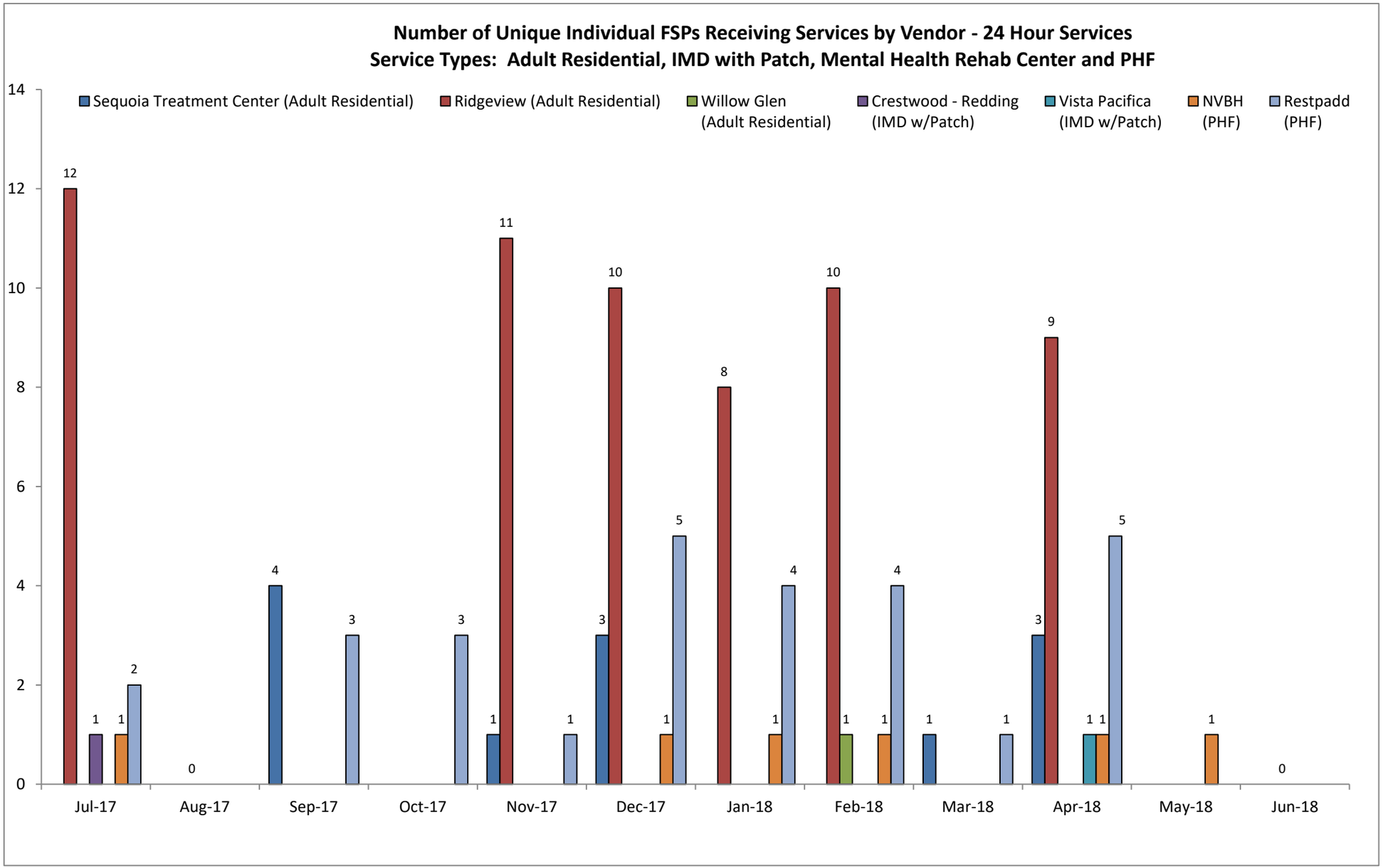
This chart compares, by percentage, how many of the consumers who utilized the CRRC were Full Service Partners, and how many of the days billed for were used by Full Service Partners.

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 12-2018



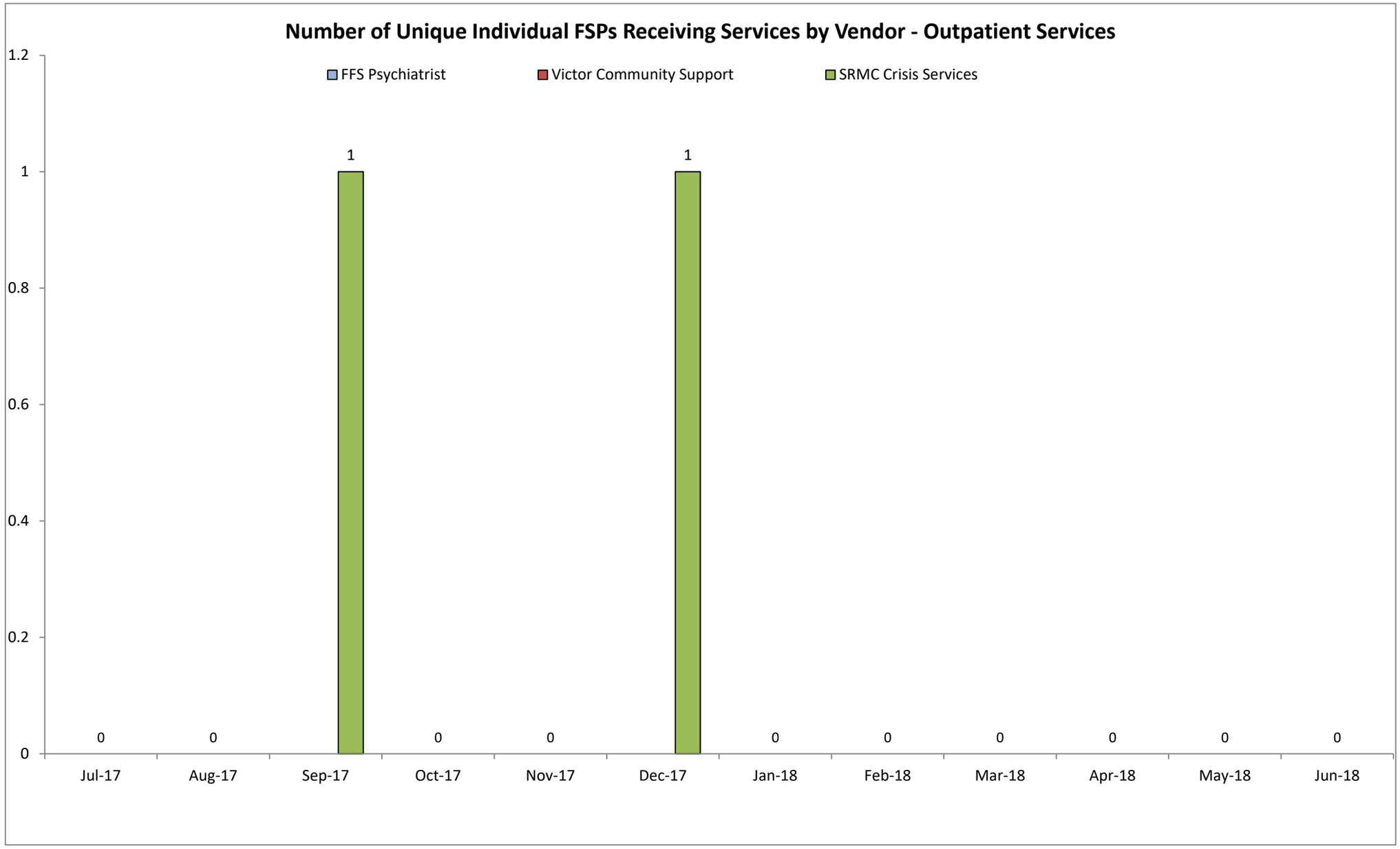
This chart shows the number of unduplicated Full Service Partners each individual vendor providing 24 Hour “Residential-Other” Services reported serving. Vendors appear to be some level of Board and Care setting. Because partners may have moved from one Board and Care to another in the same month, numbers of partners are only unduplicated by individual vendor. Due to the relatively large number of vendors, but small number of partners, no further breakdown of the data was performed. *Data no longer reported as of July 2018.



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

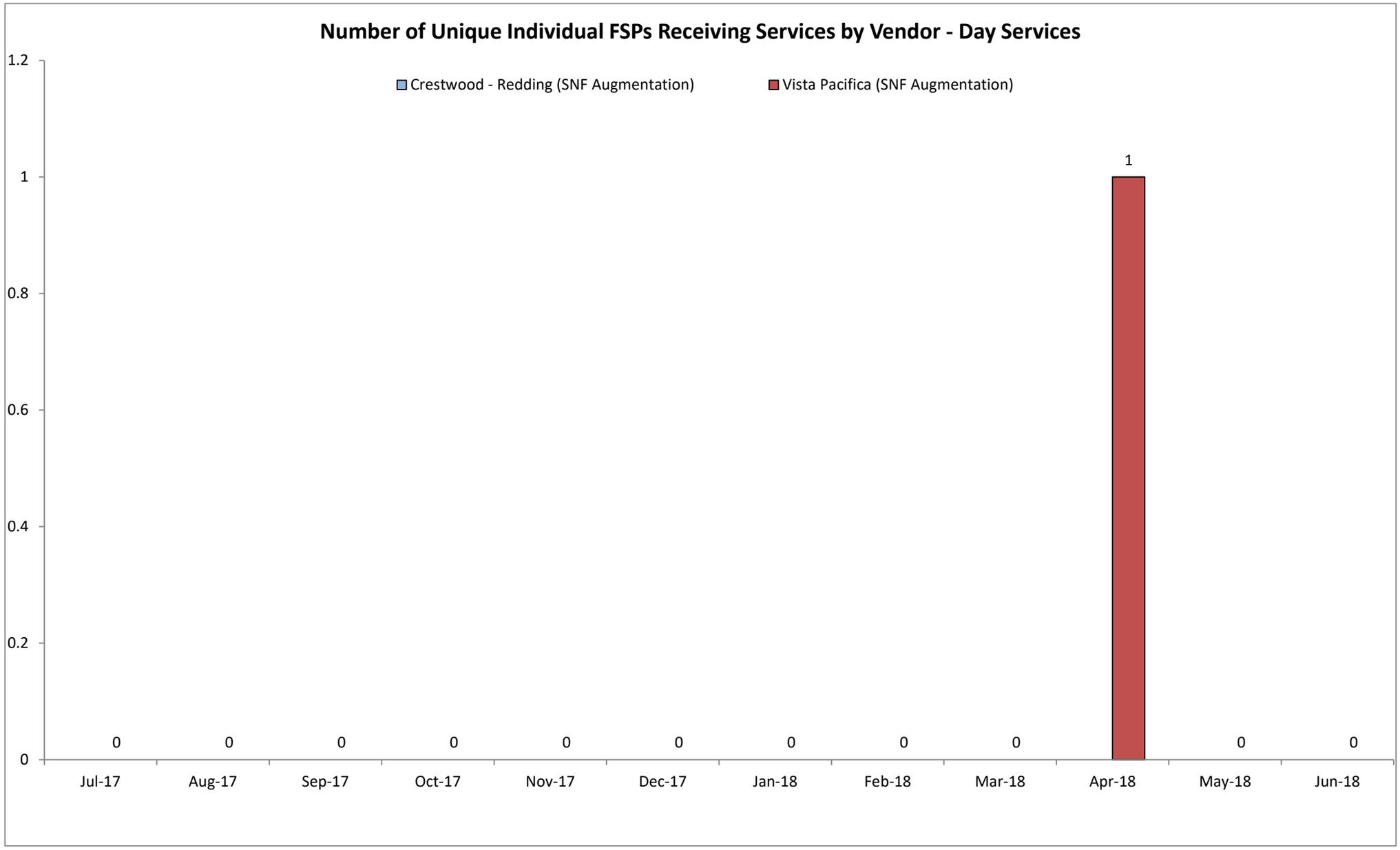
Because partners may have moved from one facility to another in the same month, numbers of partners are only unduplicated by individual vendor.

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



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

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



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

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

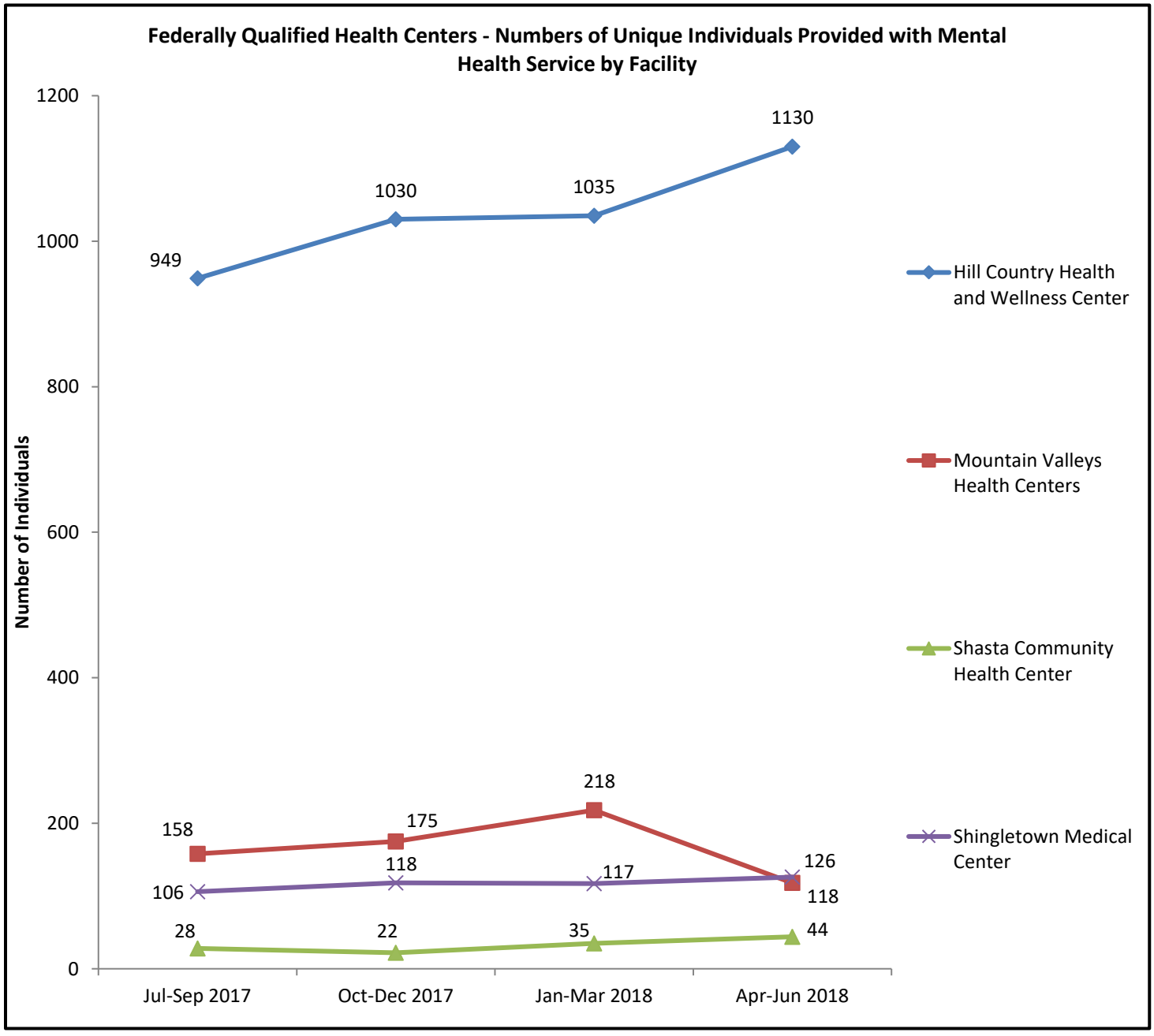
Federally Qualified Health Centers Annual Summary Report

July 2017 through June 2018

To provide better 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 via the Mental Health Services Act (MHSA). Shasta County had four federally qualified health centers in operation during FY 2017-18: 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.

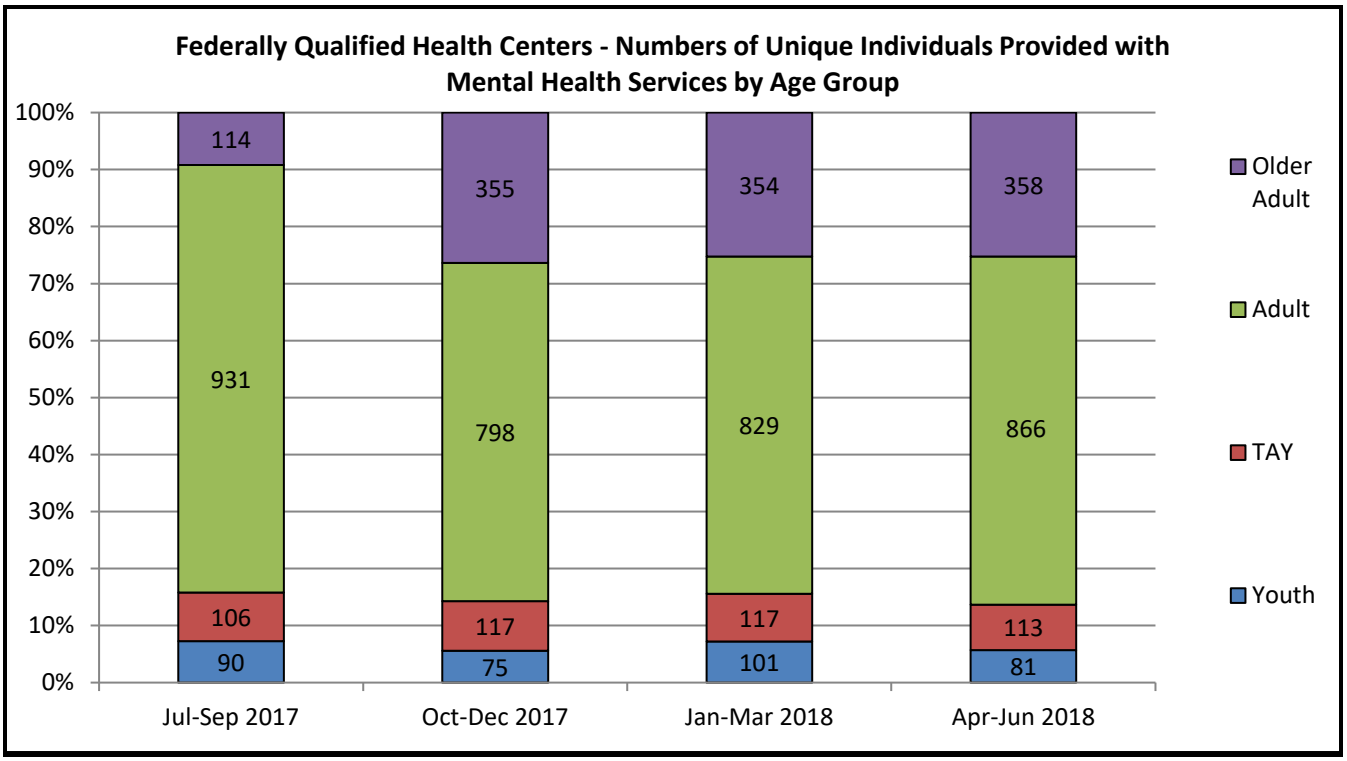
Attendance

An average of 1325 people visited a federally qualified health center in each quarter of FY 2017-18. This is a 26.2% increase over the previous FY of 2016-17.

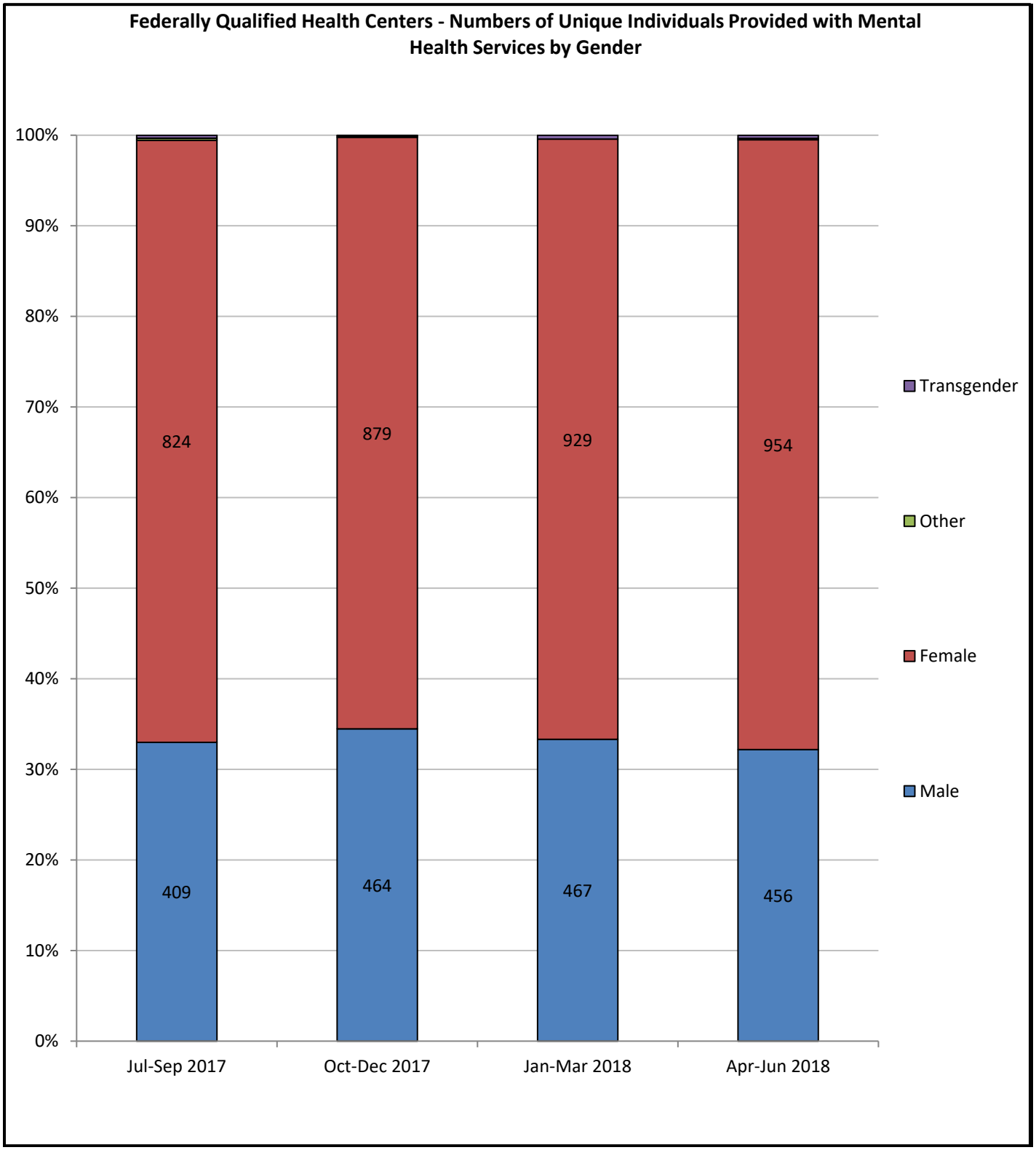


Demographics

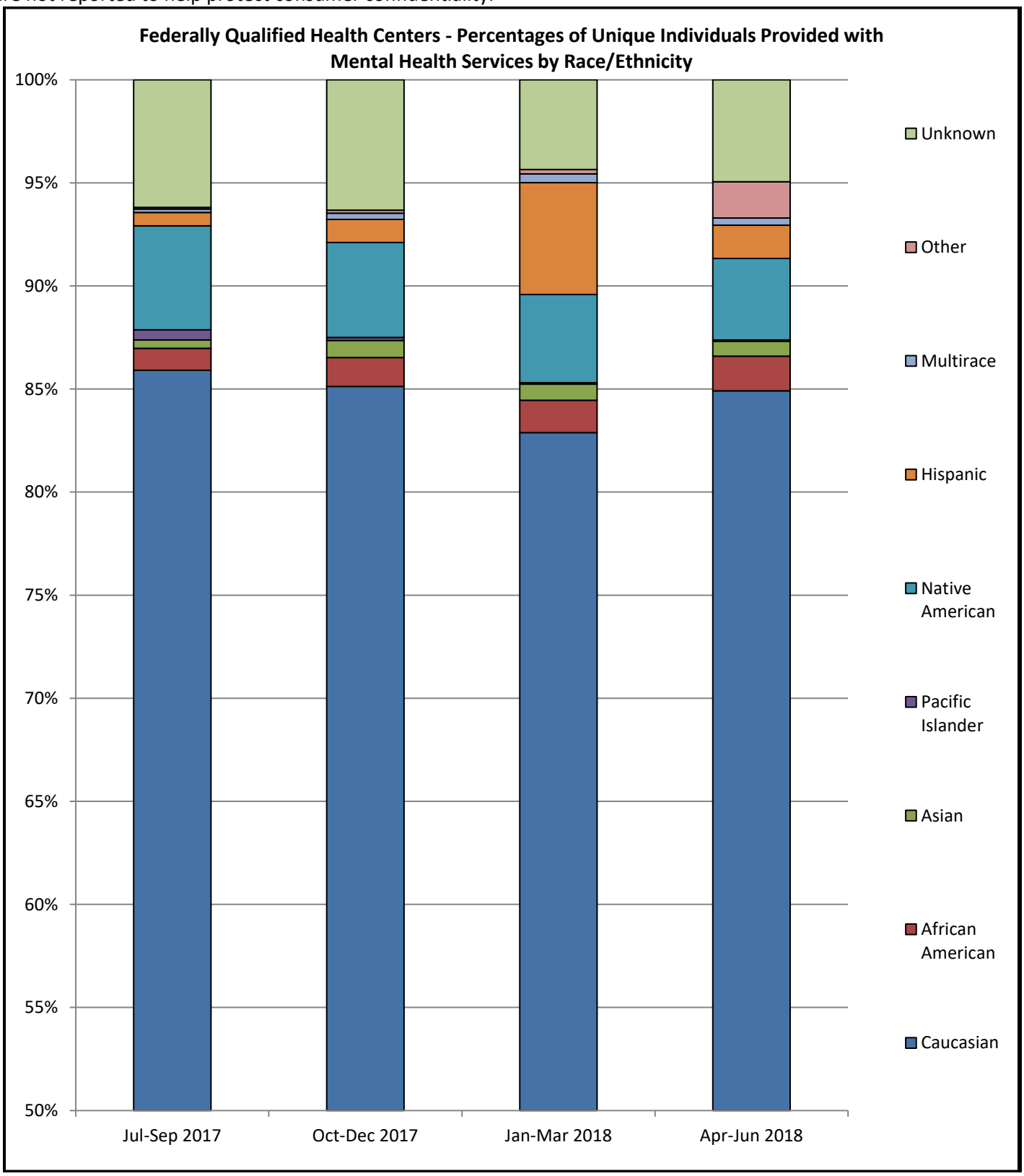
Age - The MHSA uses four age categories: Youth – ages 0 to 15, Transitional Aged Youth (TAY) – ages 16 to 25, Adult – ages 26 to 59, and Older Adult – ages 60 and up.



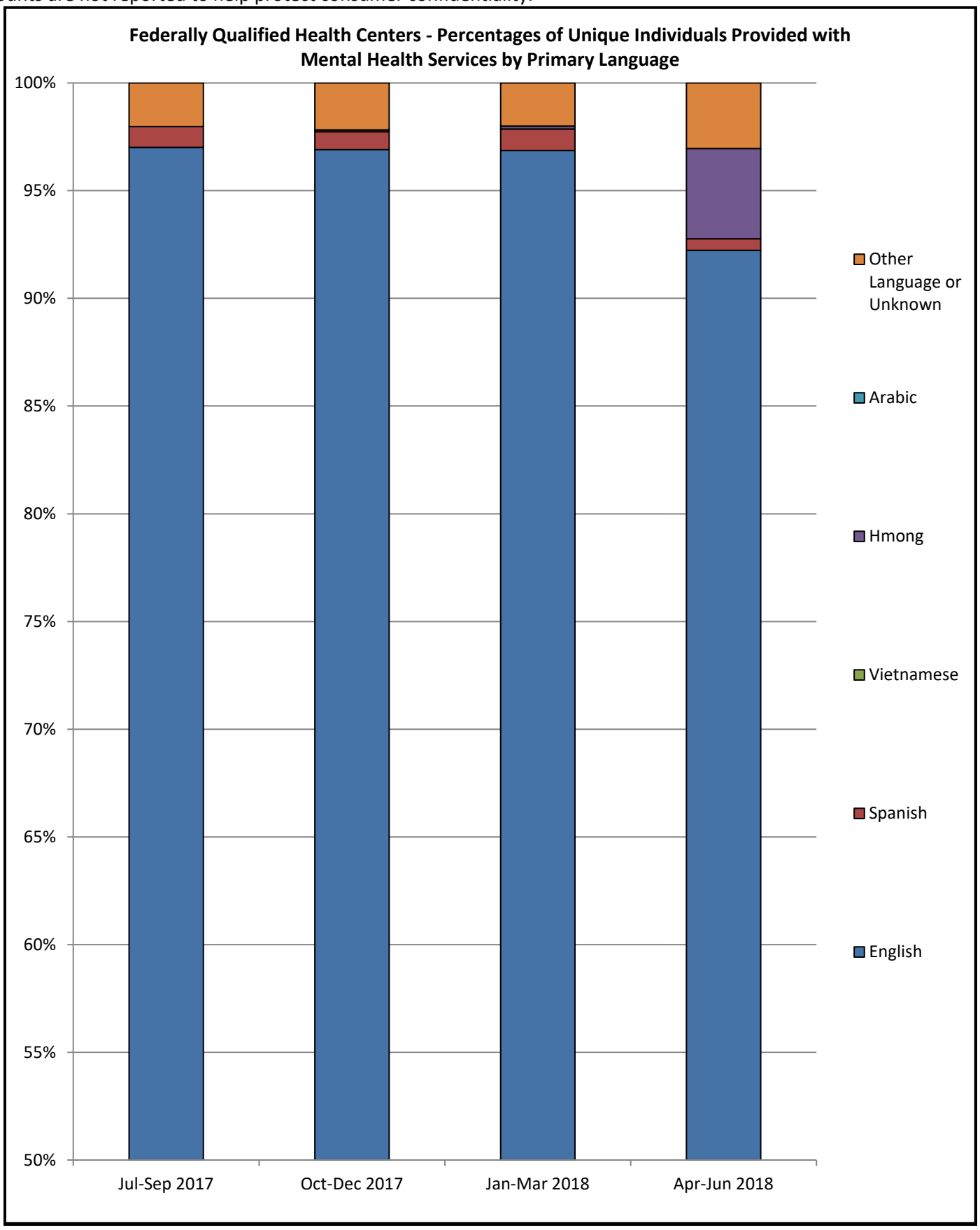
Gender - The MHSA uses four gender categories: Male, Female, Transgender, and Other. Counts of less than 20 individuals are not labeled to help maintain consumer confidentiality, but are included in the chart.



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

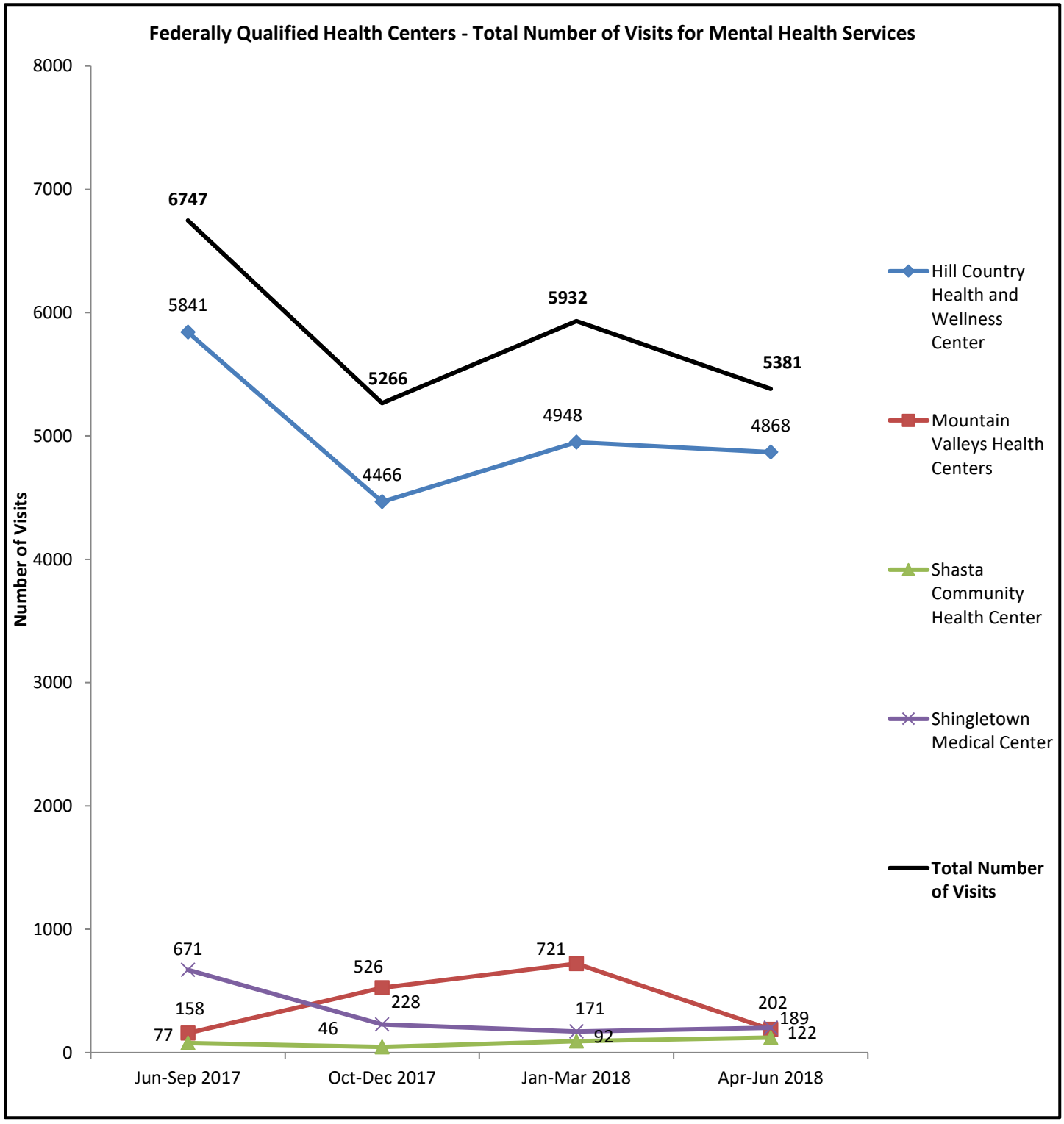


Primary Language - Because of the low gross numbers for some of these languages within small communities, actual counts are not reported to help protect consumer confidentiality.



Services Provided

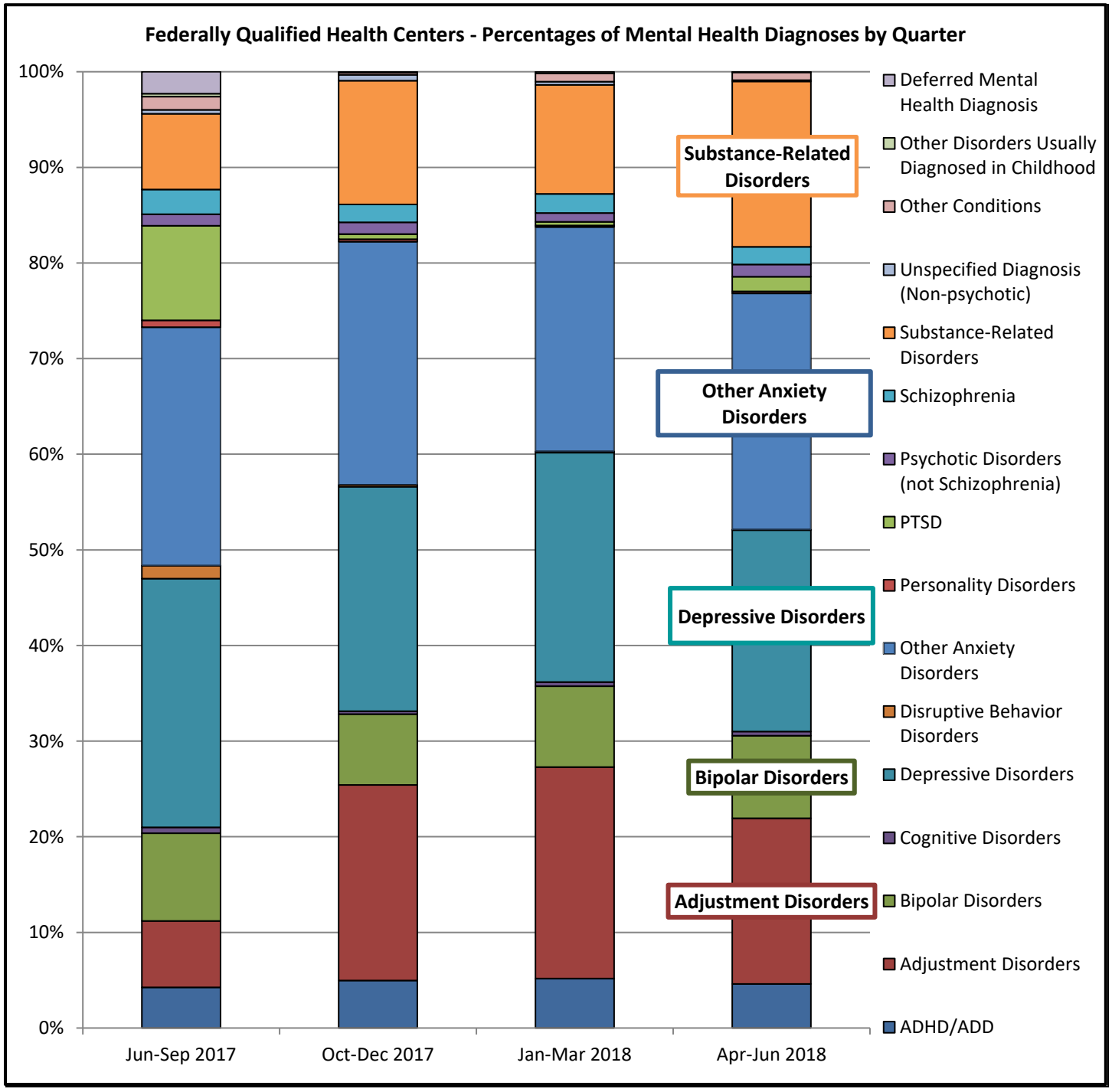
Most people will have multiple visits to the FQHC each quarter, and different types of service may be offered at different times to provide everyone with comprehensive and integrated age appropriate mental health services. Services provided may include such things as screenings, assessments, medication management, and individual or group psychotherapy sessions. For FY 2017-18, there were a total of 23,326 visits to a federally qualified health center for various types of mental health services. This is a 82.9% decrease from the previous FY 2016-17.



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."



Appendix H

Crisis Residential and Recovery Center (CRRC) Program Activity

Table 1: Bolded and underlined numbers represent the highest number during the fiscal year. There were 20 CRRC admits in June, which was a 25% increase from May (16), and a 54% increase from the same month of the prior fiscal year. The CRRC bed days of 339 for June was a 4% decrease from May, but an 8% increase from June of last year. The average length of stay during June was 17 days, a decrease of 23% from May, and a 29% decrease from June in the previous year.

CRRC/*Elpida* Admits (chart on page 2)

FY	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total*	Change +/-**
2017-18	17	13	12	12	13	14	19	10	**10**	**16**	**16**	***20***	**172**	12%
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 2)

FY	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total*	Change +/-**
2017-18	204	165	187	204	260	329	288	263	191	201	***353***	339	**2984**	**13%**
2016-17	295	280	201	185	291	120	242	199	167	228	130	***313***	**2651**	-7%
2015-16	236	224	244	***342***	301	266	194	217	178	215	193	229	**2839**	-5%
2014-15	***345***	268	280	235	235	186	284	239	174	246	192	304	**2988**	-3%
2013-14	274	231	255	295	136	207	333	311	212	***335***	242	243	**3074**	-14%
2012-13	315	341	321	310	344	***361***	248	259	296	308	213	274	**3590**	20%
2011-12	216	202	296	***329***	209	196	247	191	279	291	267	268	**2991**	2%
2010-11	193	254	250	290	278	231	***307***	192	203	165	302	280	**2945**	-10%
2009-10	***356***	272	323	319	311	199	231	266	245	241	238	267	**3268**	-12%
2008-09	330	300	301	248	270	276	318	319	***366***	310	312	350	**3700**	50%

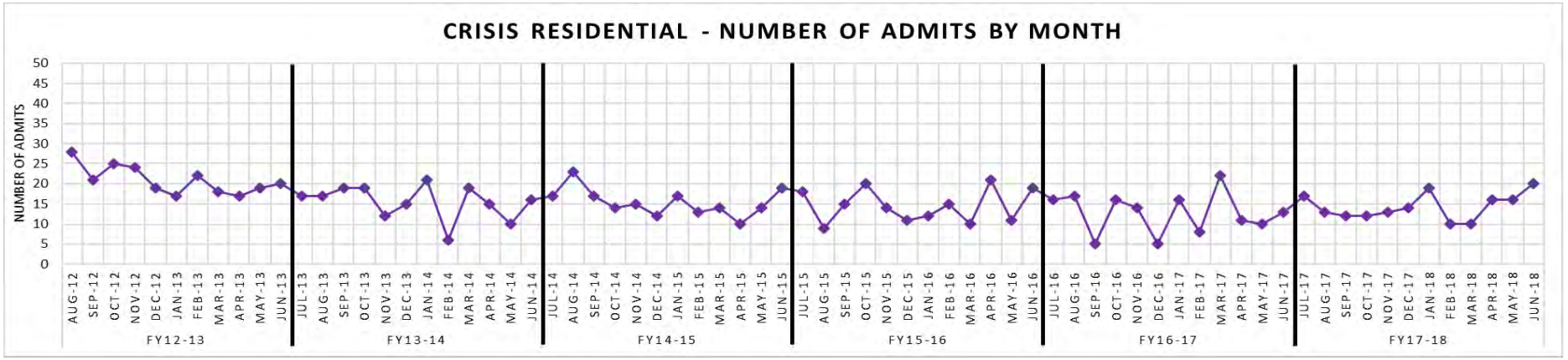
CRRC/*Elpida* Average Length of Stay (Bed Days/Discharge Count) - (chart on page 2)

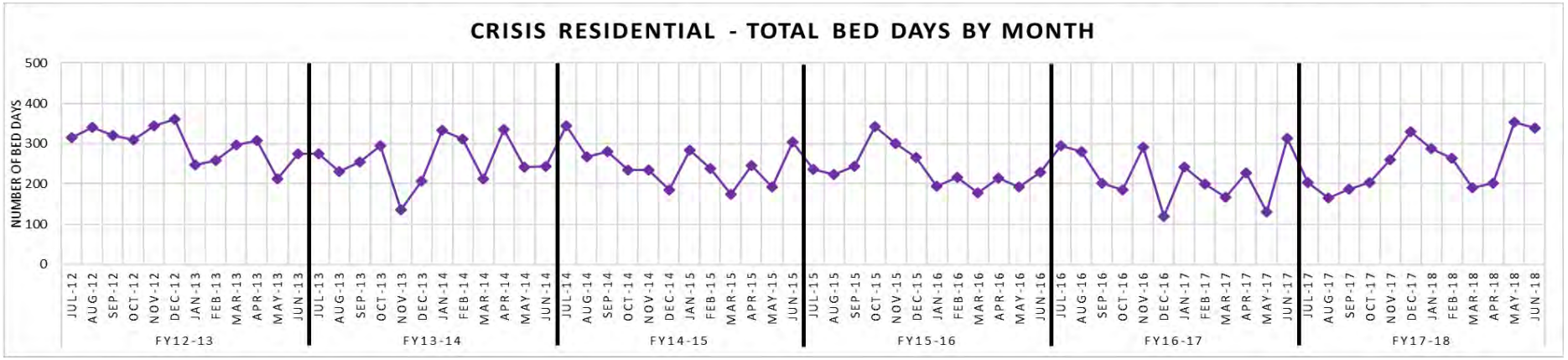
FY	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY Avg. LOS	Change +/-**
2017-18	12	13	16	17	20	24	15	***26***	19	13	22	17	**18**	-10%
2016-17	18	16	***40***	12	21	24	15	25	8	21	13	24	***20***	16%
2015-16	13	***25***	16	17	22	24	16	14	18	10	18	12	**17**	7%
2014-15	20	12	16	17	16	16	17	11	12	***25***	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%

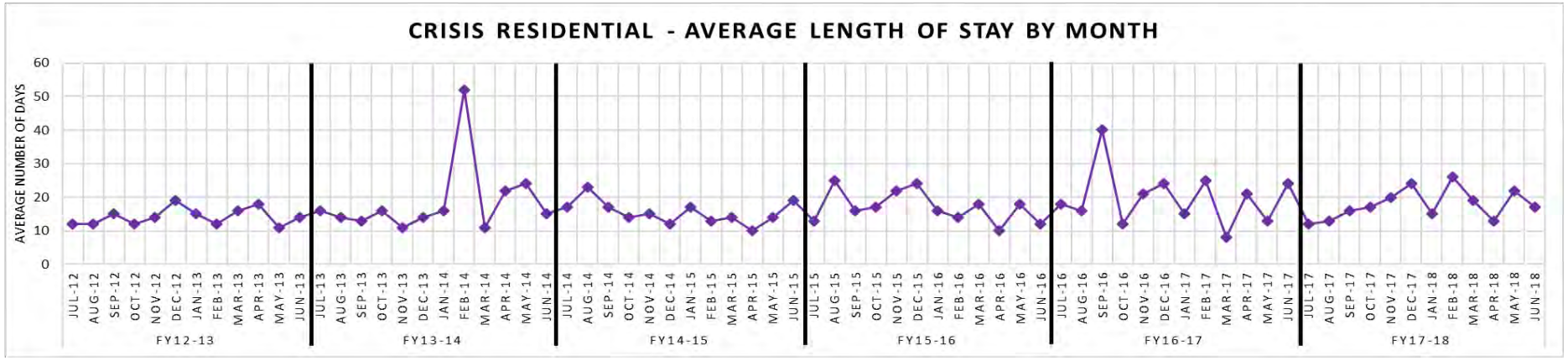
** Change +/- is calculated based on the prior Fiscal Year comparison to Current Fiscal Year.

Data as of: 7/10/18 OPE JC

Chart 2: Crisis Residential







Length of stays are rounded numbers.

Data as of: 7/10/18 OPE JC

The Woodlands Permanent Supportive Housing

Fiscal Year 2017/18

"The Woodlands" is a 55-unit affordable housing project located on 9.1 acres at 2950 Polk Street in Redding, California. 19 of those units are reserved for applicants who have met the screening criteria, as defined by MHSA Permanent Supportive Housing Project eligibility, for being homeless or at risk of homelessness, and for having a serious mental illness. Applicants who have met the criteria are referred to as "clients."

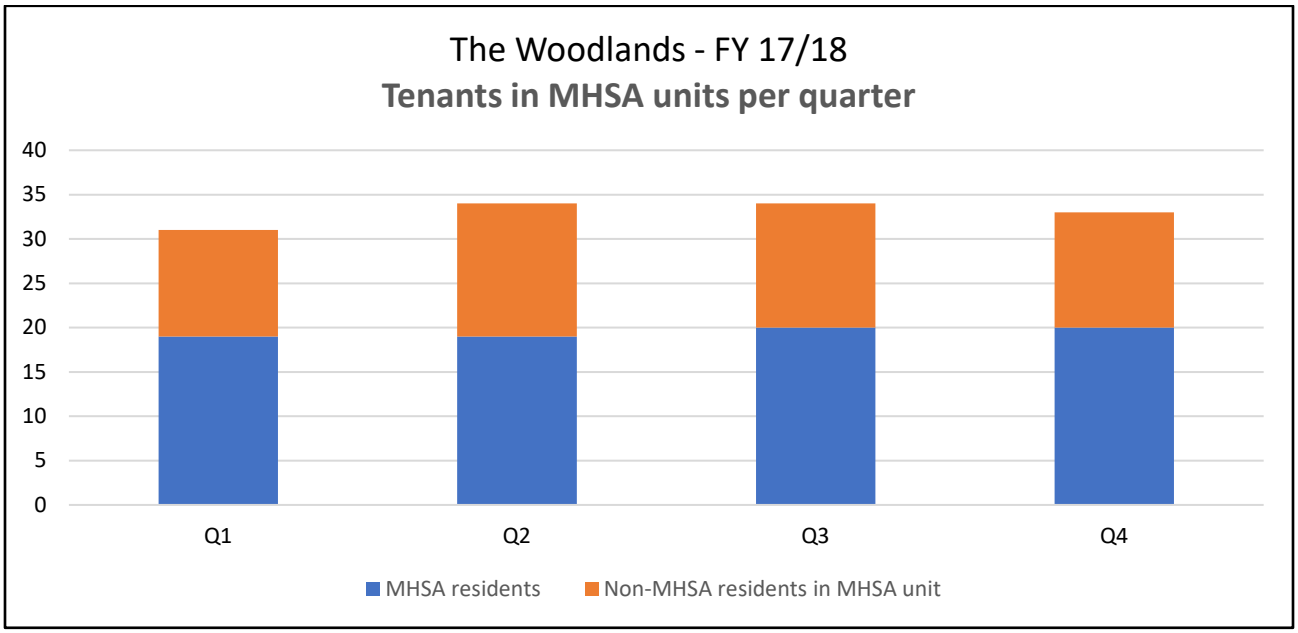
Of the 19 units that are reserved for clients, 14 are one-bedroom units and 5 two-bedroom units. Clients have access to an on-site community center that has a computer room, game room, activity room, laundry facilities, County staff office, and manager's unit. Other areas include a pool, social plaza, BBQ area, exercise circuit, children's play areas, and community garden along with other landscaped areas.

The County contracts with Northern Valley Catholic Social Services (NVCSS) to provide Clients with social services such as: Finance/budgeting classes, personal income tax preparation, adult education classes, benefit/entitlement assistance, after-school activities, and health and wellness classes.

The County also provides clients with supportive services such as: Case management, clinical support, crisis management, medication support, co-occurring treatment, In-Home Support Services, Wellness & Recovery Action Planning ("WRAP"), life skills training, peer support, family support, benefits counseling, Public Guardian, employment readiness and resources, Adult Protect Services, Representative Payee support, vocational services, and after-hours crisis support.

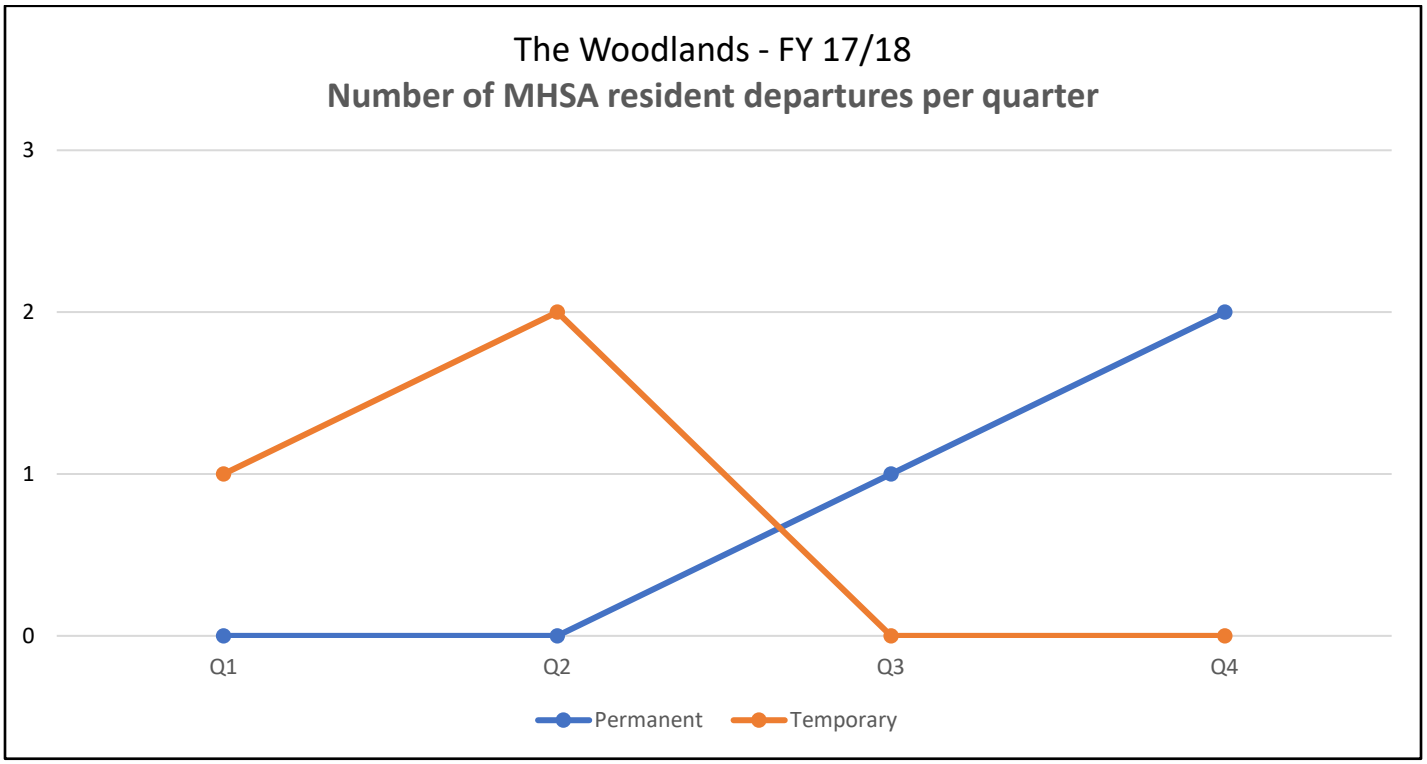
Ongoing social and supportive services are available to help clients maintain housing stability to prevent homelessness and substance abuse among other challenges. A caseworker and peer support specialist are stationed at the Woodlands to assist with these services.

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

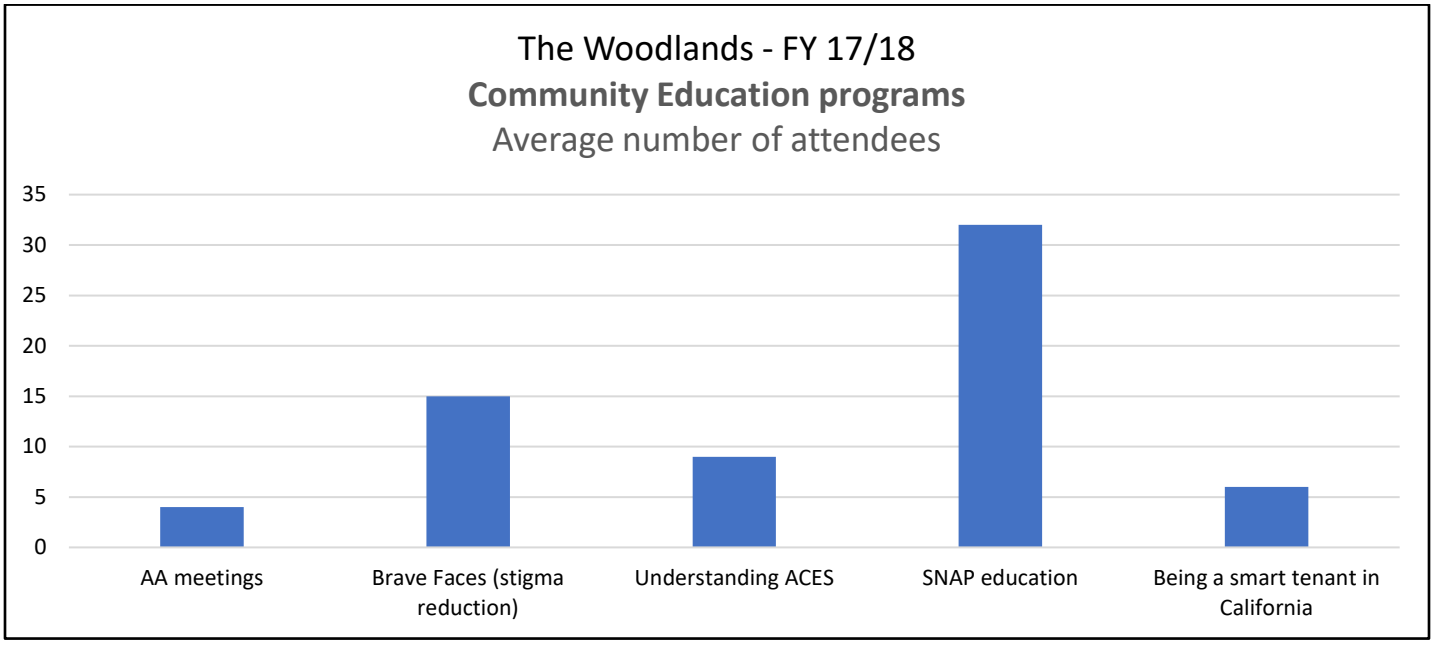


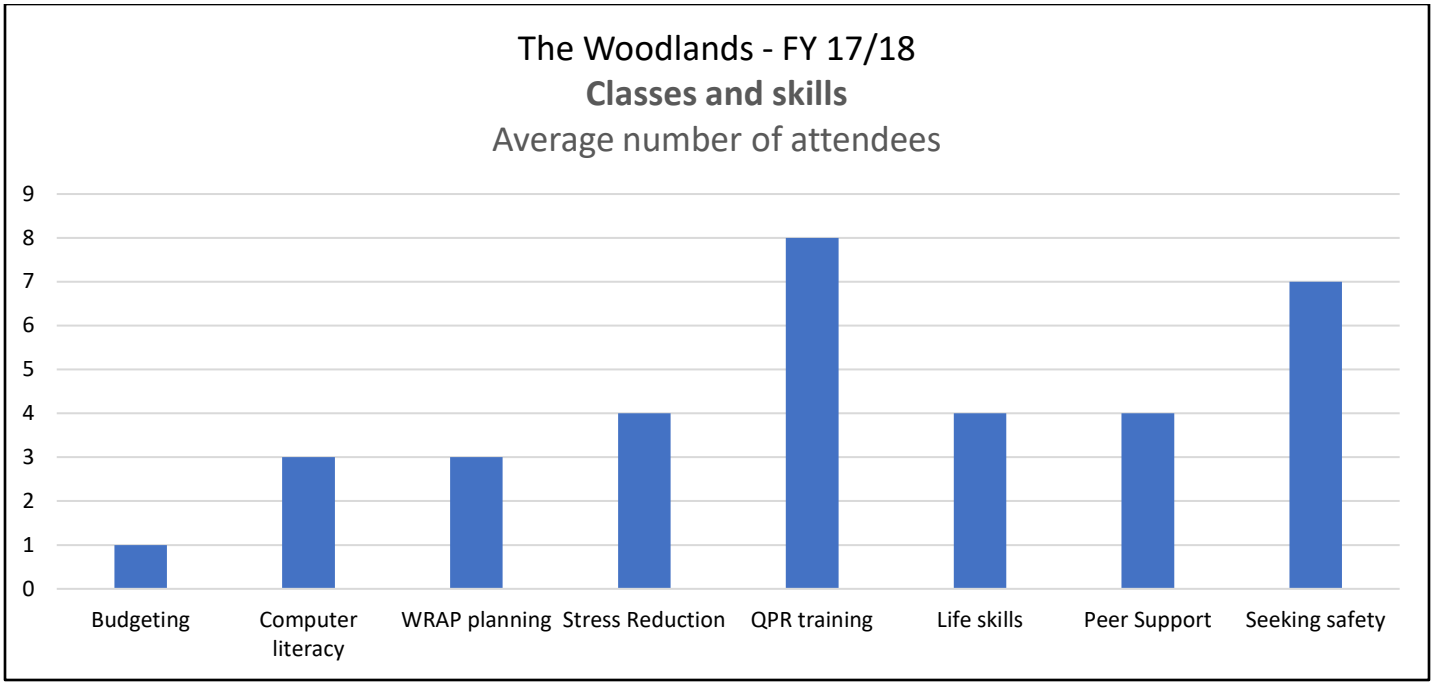
The Woodlands – Fiscal year 17/18

When tenants leave MHSA units, vacancies are quickly filled by those who are on the MHSA Permanent Supportive Housing Project waitlist. A line chart of the number of MHSA residents who left their units each quarter is shown below.



During Fiscal Year 17/18, clients engaged in a number of various social activities, community education programs, and classes to learn skills. It has been a challenge to maintain high participation in the ongoing classes, some of which were offered on a weekly basis (Seeking Safety, Stress Reduction, WRAP classes, Life Skills, and Peer Support). The average number of those who participated in community education programs and classes, based on the available data for FY 17/18, are as follows:





MHSA residents have begun to adapt to their new way of life which is supported by the ongoing services they are receiving. The goal of these services is to help build resiliency within themselves and to maintain housing stability. MHSA residents continue to strive towards independence.

Triple P – Shasta County
Program Performance and Outcome Evaluation Report

Fiscal Year 2017/2018
Prepared by Shasta County Health and Human Services Agency

What Triple P is and the purpose of this report

The Positive Parenting Program (also known as "Triple P") is an international and evidence-based program that teaches parents (or caregivers) how to effectively discipline children and teenagers with behavioral problems. This report looks at data collected from our local Triple P partners to get a clearer picture of the program's local scope and impact.

Overview of how the Triple P system works

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

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

(1) ensuring a safe and engaging environment
(2) keeping a positive learning environment
(3) using assertive (rule-based) discipline
(4) having realistic expectations
(5) taking care of yourself as a parent or caregiver

The Triple P program is divided into levels 1 through 5, where level 1 is least intense and level 5 is most intense:

- Level 1: using media to raise public awareness of Triple P.
- Level 2: a seminar or brief one-on-one consultation with a Triple P practitioner.
- Level 3: approximately four individual consultations with a Triple P practitioner lasting fifteen to thirty minutes each.
- Level 4: ten one-hour individual counseling sessions or small group sessions with a Triple P practitioner.
- Level 5: becomes available once a level 4 program has been completed (or is being taken concurrently) and pinpoints other complicating factors such as partner dysfunction, parents with mental health concerns, and situations that are causing a stressful environment ("Enhanced Triple P") or parents at risk of child maltreatment ("Pathways Triple P").

Different versions of some levels are available to specify whether the program is delivered in a group ("Group") versus one-on-one setting ("Standard"), whether it's geared towards children versus teenagers ("Teen"), and other considerations including whether the child has a disability ("Stepping Stones"), whether the parents are going through a divorce ("Family Transitions"), and more. The program is very customized to help ensure that parents and caregivers, in their own unique situations, are having their needs met.

How the data contained in this report was collected

Triple P practitioners administer the program from their local organization and enter the data that they've collected during their sessions with Triple P participants into Shasta County's web-based "Scoring application." Here they can add participants or track existing participants, enter and "score" the participant's survey data (pre- and post-survey responses are converted into numeric values and then compared – this process is referred to as "scoring"), and export data.

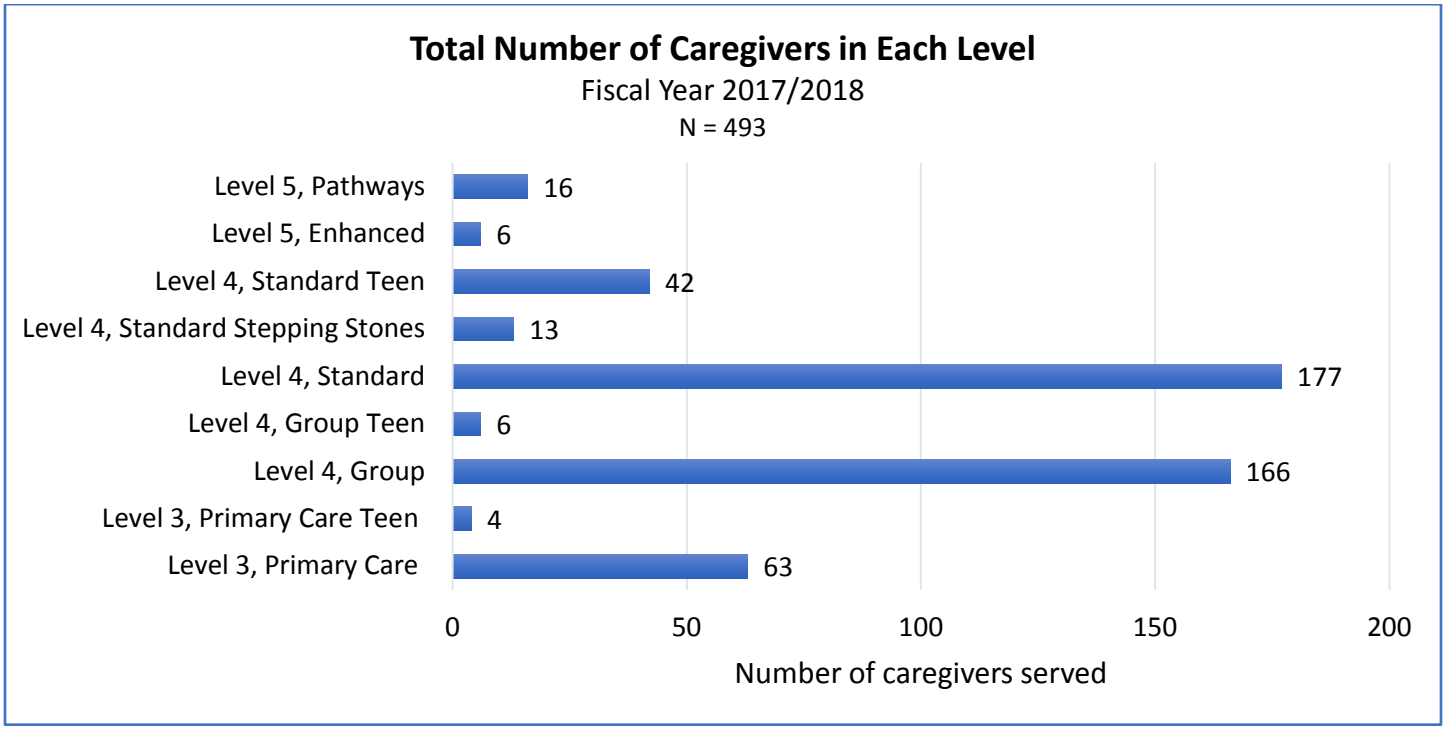
This report looks at data collected from all providers of Triple P who entered data into Shasta County's Triple P Scoring Application from July 1st, 2017 through June 30th, 2018 (Fiscal Year 17/18 or "FY 17/18"). The source data for this report is from the Shasta County Scoring Application only and does not include data received from other sources. There may be other providers in Shasta County who provide Triple P, but if they did not enter information into the Scoring Application, they are not included in this report.

The table below documents the total number of Triple practitioners who entered data into Shasta County's Triple P Scoring application during Fiscal Year 17/18, along with the organization they were with, and the total number of caregivers they served:

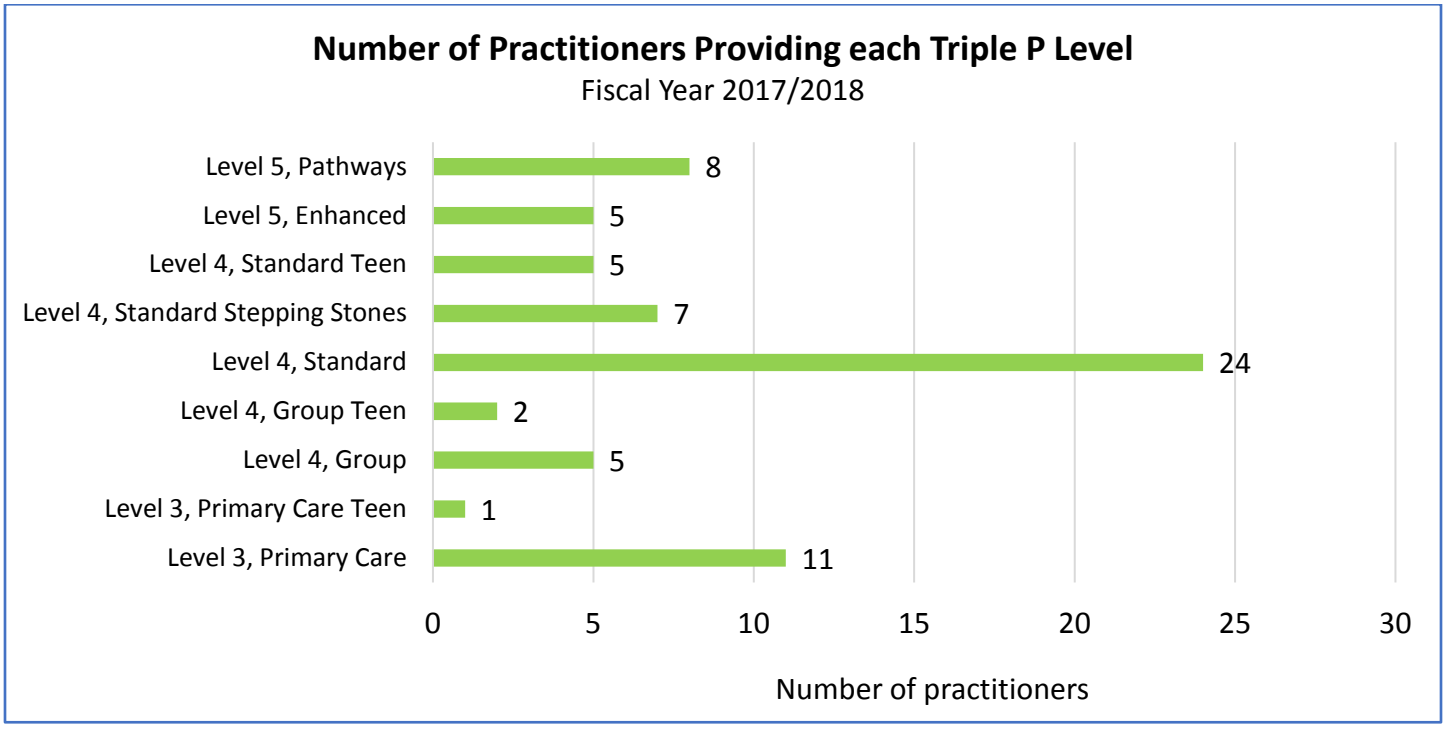
Shasta County Triple P Programs Providing Data During FY 17/18		
Organization	**Practitioners**	**Caregivers**
Bridges to Success/ Shasta County Office of Education: Early Childhood Services/VOICES	9	131
Child Abuse Prevention Coordinating Council of Shasta County (CAPCC)	4	20
Family Dynamics	5	114
Gateway Unified School District/Great Partnership	2	10
Northern Valley Catholic Social Service	6	68
Shasta County Health & Human Services Agency: Children's Services	5	20
Tara Tate – Private Practice	1	7
Tri-Counties Community Network: Bright Futures	1	1
Victor Community Support Services	1	9
Wright Education Services	4	72
Youth and Family Programs	3	41

Some caregivers may have received services in more than one Triple P level or version. A unique "Caregiver ID" number is created before the caregiver enrolls in Triple P and this Caregiver ID number is different for every level or version they participate in. The names of caregivers are not collected within the Scoring Application. For this reason, the total number of unduplicated caregivers served across all levels couldn't be determined. In addition, if a practitioner was still submitting data in the Scoring application after transitioning to a new organization during FY 17/18, they would be counted as a practitioner in each organization they were a part of.

A total of 493 caregivers were served during Fiscal Year 17/18. A breakdown of the number of caregivers served by each Triple P level is shown below:



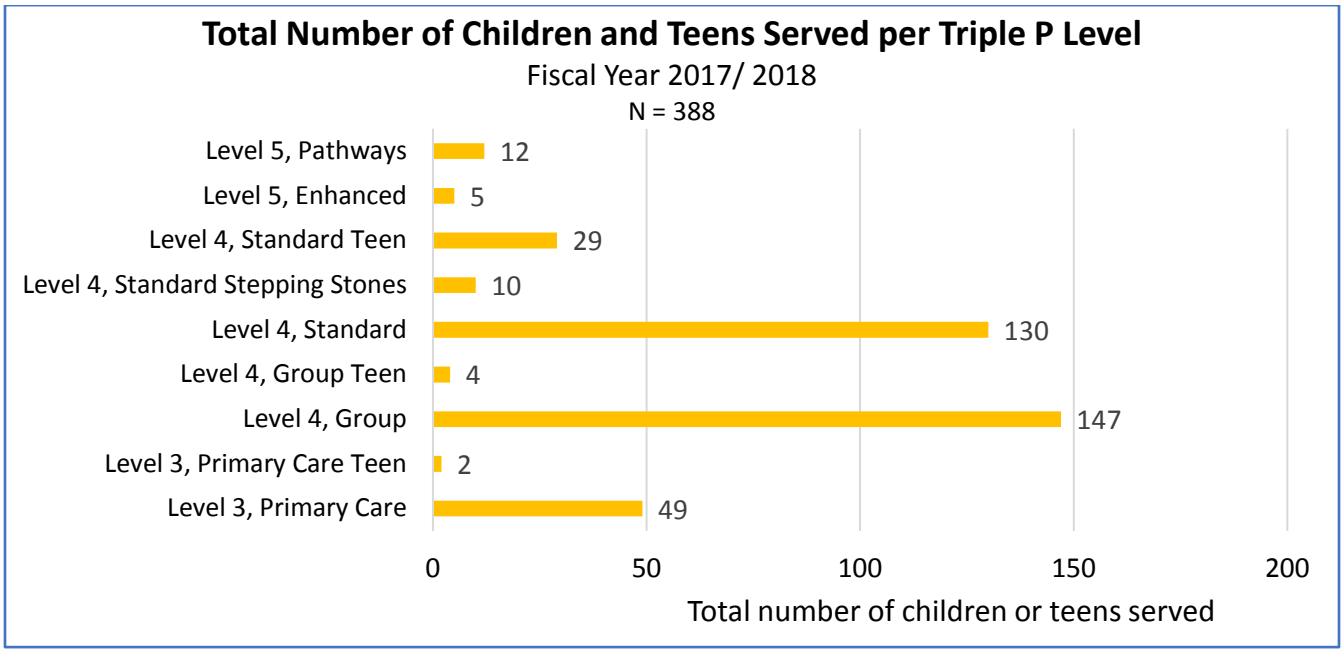
There were 37 unduplicated practitioners who provided Triple P services during FY 17/18. In the graph below, you can see the number of practitioners who provided the various Triple P levels (some practitioners are counted more than once as some practitioners are trained to teach more than one level):



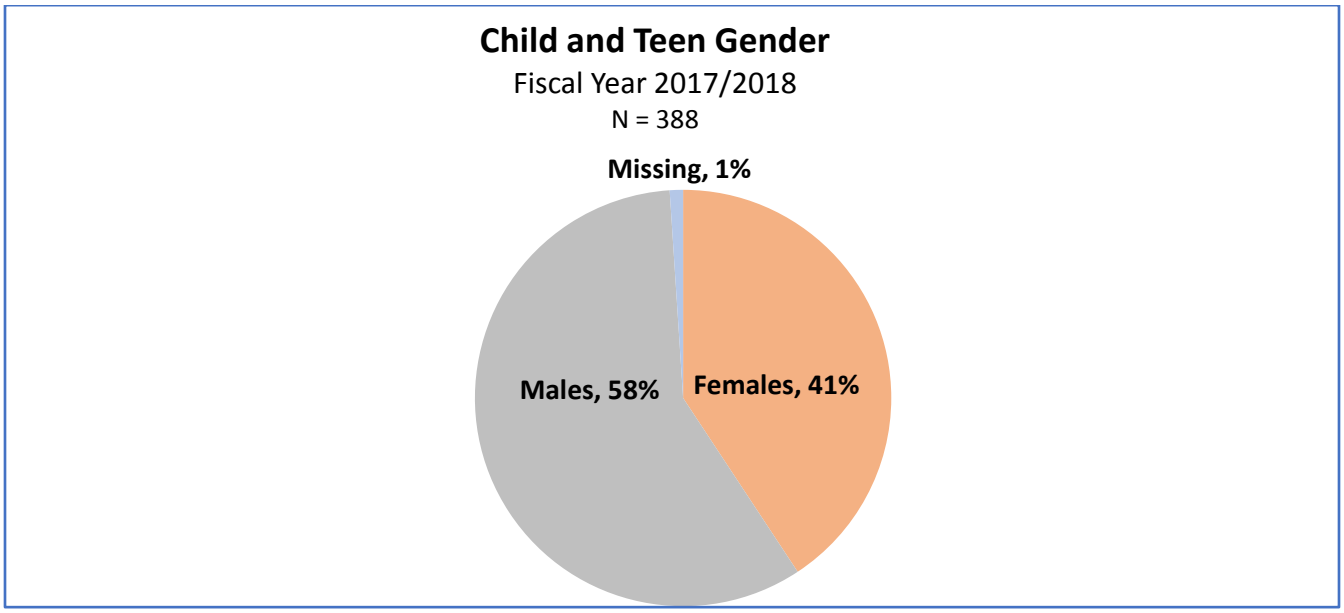
Information about the children or teenagers linked to caregivers

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

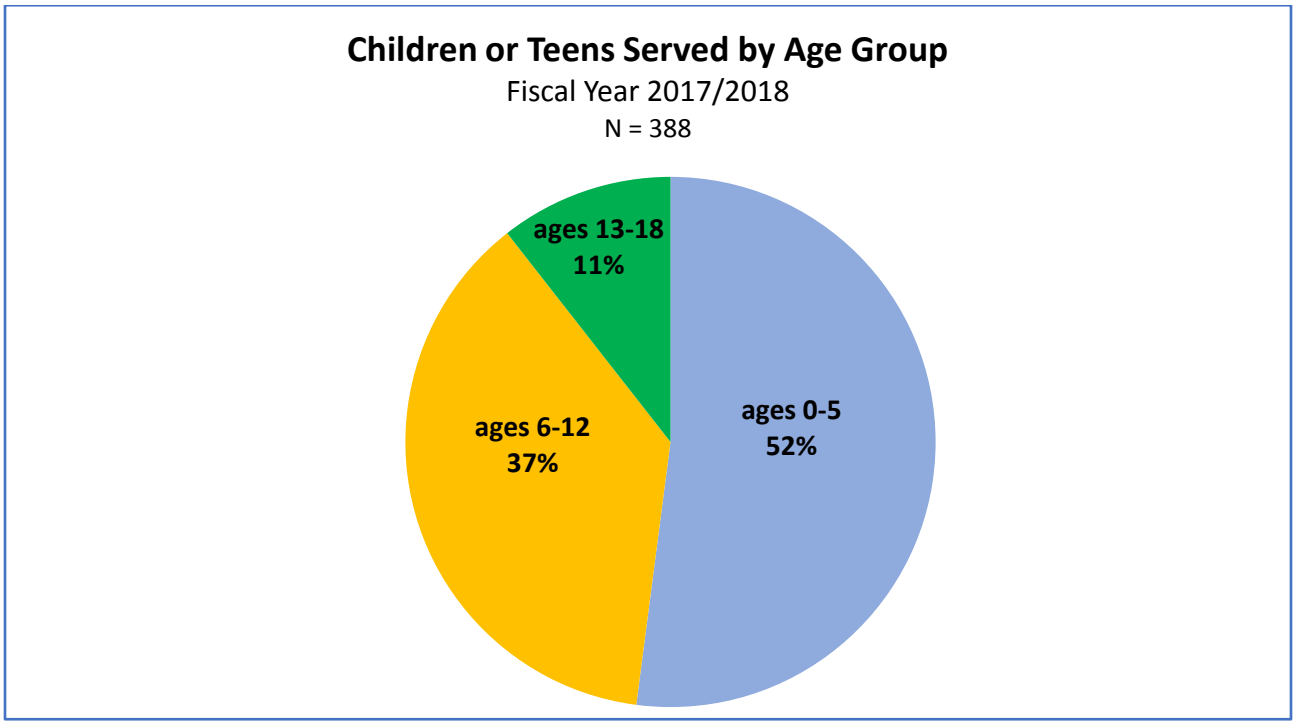
The total number of children and teenagers represented by caregivers during FY 17/18 was 388 as shown below:



In the pie chart below, you can see a breakdown of the child and teen genders. There were 158 females, 226 males, and 4 records were missing gender data:

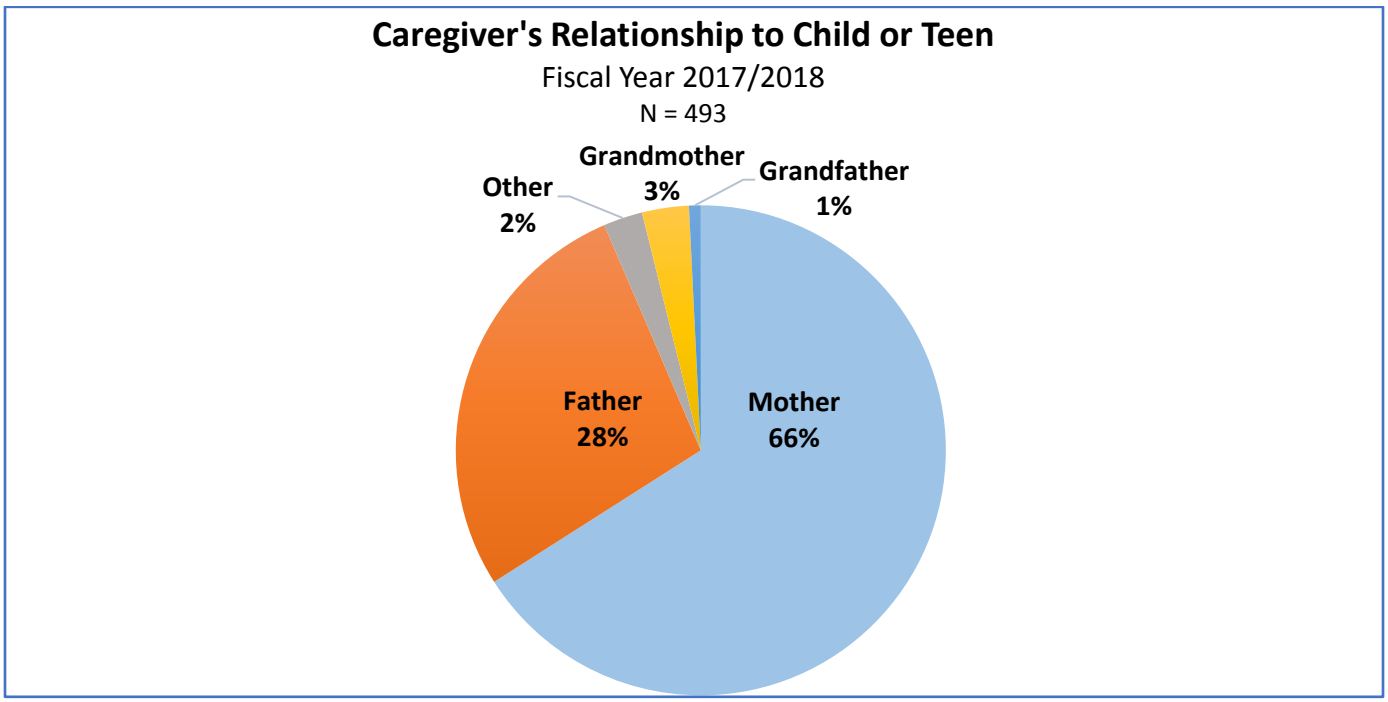


Below is a pie chart showing the percentage of children or teens served by age group. The age of the child or teen was recorded at the beginning of the session. 202 children were aged 5 or younger out of the total 388 and the average age was 6.

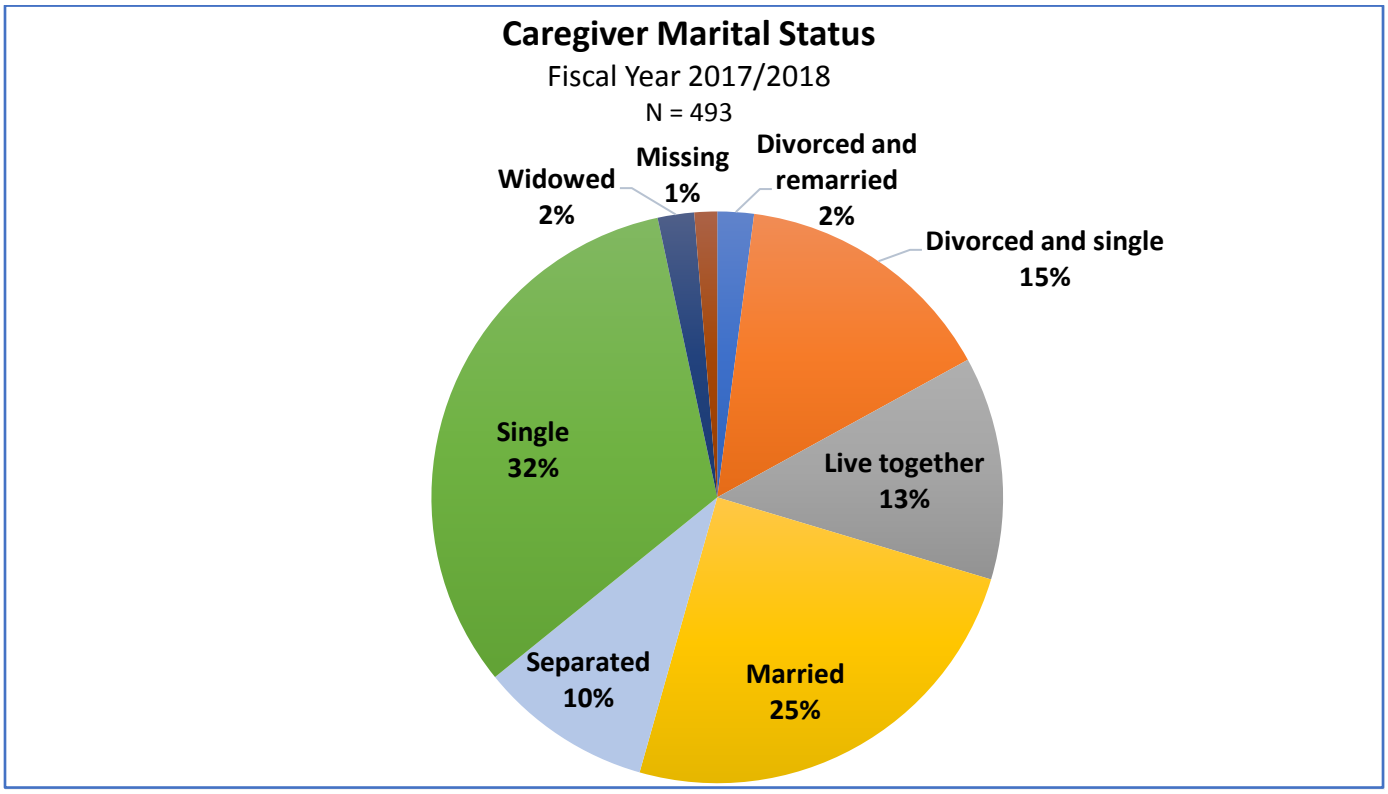


Demographic information on caregivers

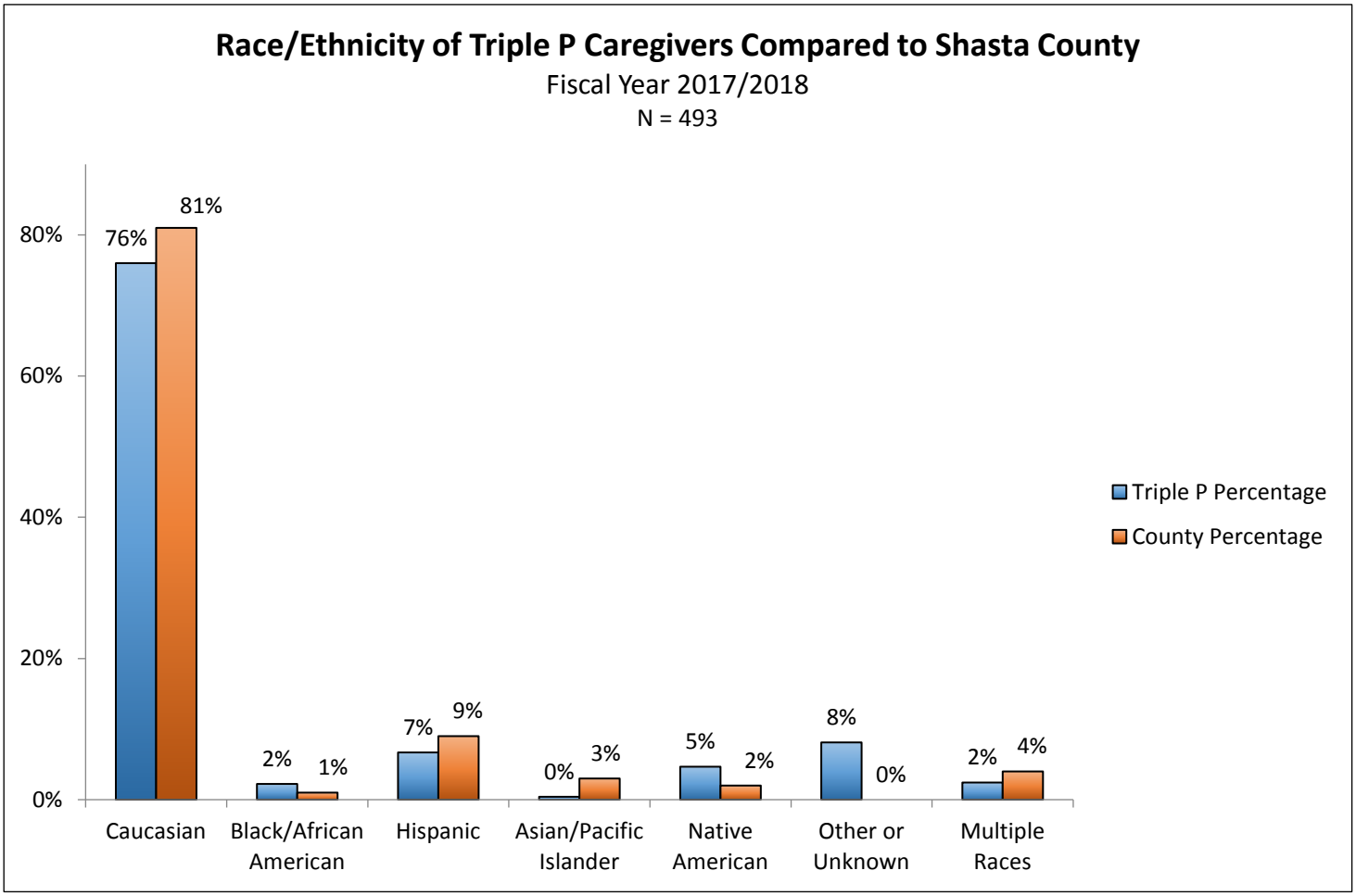
Below is a pie chart that shows the relationship that the caregivers had with the child or teen (foster mothers and fathers are included in the “Mother” or “Father” category):



In the pie chart below, you can see a breakdown of the marital status of the caregivers:



In the chart below, you can see a breakdown of the caregivers' ethnicities compared to Shasta County*:



* According to the 2012-2016 American Communities Survey 5-year Estimates.

Outcome Measures

Various self-assessments were given to participants both at the beginning and at the end of the program to benchmark their results on different measures of effective parenting. Some assessments were given to all participants and other assessments were only made available in certain levels. Outcomes are measured as a percentage change from their pre-Triple P assessment scores to their post-Triple P assessment scores.

A paired T-test was used to determine whether the differences between participants' pre-assessment scores and post-assessment scores were statistically significant at a 95% confidence interval. If an assessment received less than 20 pre- and post-responses within any group, that group's assessment was not included in this report. If a participant did not complete either a pre- or post-assessment, their results were not counted within the total number of participants who took that assessment.

Level 3

Versions: "Primary Care" and "Primary Care Teen"

This level is:

- 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
- Reinforcing parenting strategies using tip sheets and Positive Parenting Booklets.

The Level 3 "Primary Care" version is for parents of children from birth to 12 years old while the Level 3 "Primary Care Teen" version is for adolescents up to 16 years old.

No other versions of Level 3 were offered during Fiscal Year 17/18.

Assessments

Level 3 participants used the **Strengths and Difficulties Questionnaire (SDQ)** to identify strengths and problems with their child or teen's behavior. On the questionnaire, participants were instructed to indicate whether a series of statements relating to their child or teen's emotional symptoms, conduct problems, hyperactivity, problems with peers, or prosocial behavior was "Not true", "Somewhat true", or "Certainly true."

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

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

Strengths and Difficulties Questionnaire

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

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

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

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

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

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

• How long have these difficulties been present?

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

• Do the difficulties upset or distress your child?

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

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

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

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

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

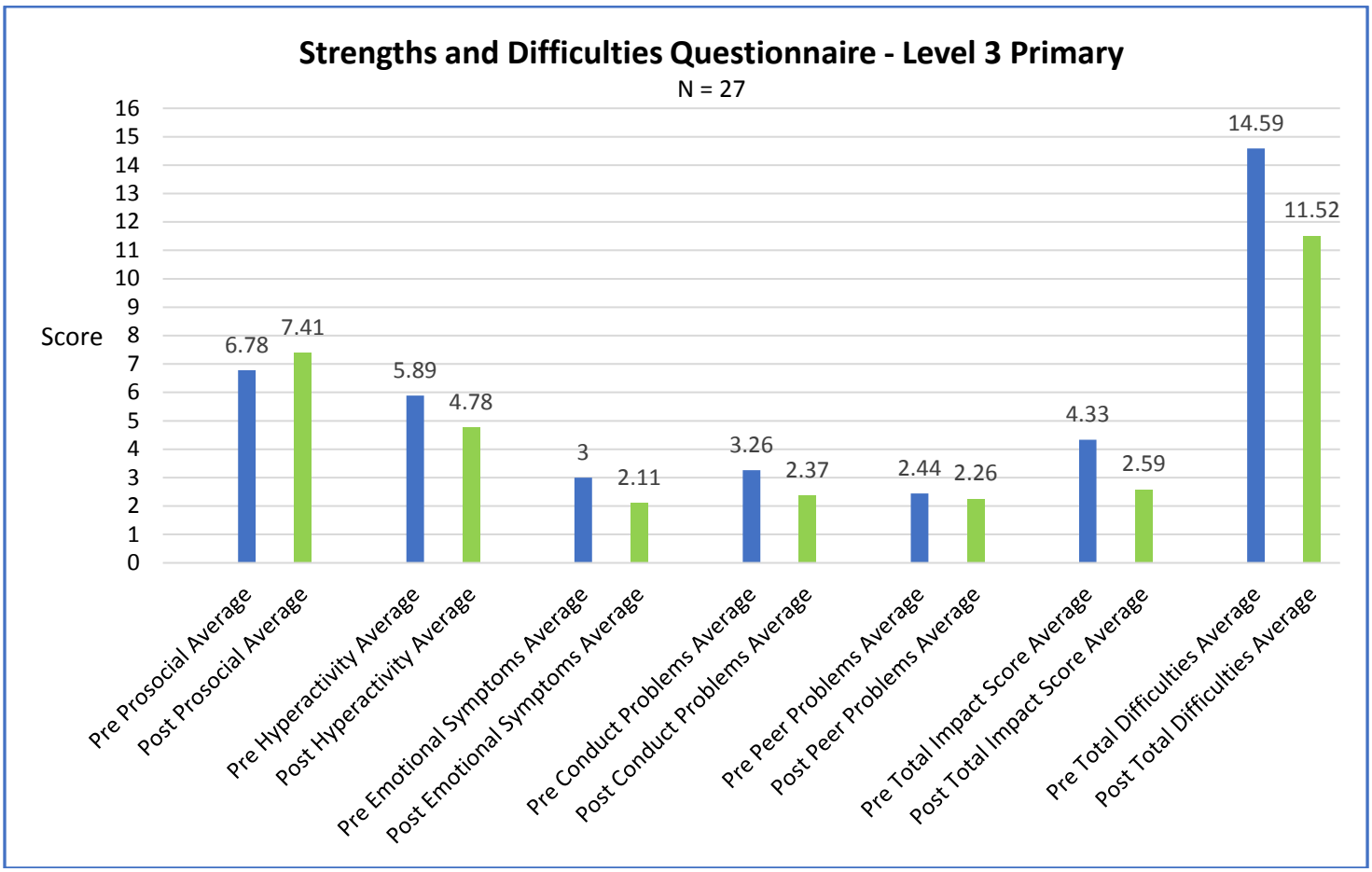
A "Total Impact Score" [2] can be calculated by adding up the numeric values that correspond with the caretaker's level of agreement on how strongly difficulties with emotions, concentration, behavior, or being able to get along with other people that the child or teen encounters, interferes with his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

Generating and interpreting Impact Scores

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

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

Results for the Strengths and Difficulties Questionnaire (SDQ) for Level 3 Primary are shown below:



Cut-points [3] for the Strengths and Difficulties questionnaire are shown below:

	Normal range	Borderline	Abnormal range	Improvement
Prosocial Behavior Score	6-10	5	0-4	HIGHER scores are better
Hyperactivity Score	0-5	6	7-10	LOWER scores are better
Emotional Symptoms Score	0-3	4	5-10	LOWER scores are better
Conduct Problems Score	0-2	3	4-10	LOWER scores are better
Peer Problems Score	0-2	3	4-10	LOWER scores are better
Impact Score	0	1	2-10	LOWER scores are better
Total Difficulties Score	0-13	14-16	17-40	LOWER scores are better

- The Prosocial score increased by 9%. **This is statistically significant. (P value = 0.0265)**
- The Hyperactivity score decreased by 19%. **This is statistically significant. (P value = 0.0310)**
- The Emotional Symptoms score decreased by 30%. **This is statistically significant. (P value = 0.0063)**
- The Conduct Problems score decreased by 27%. **This is statistically significant. (P value = 0.0043)**
- The Peer Problems score decreased by 7%. **This is NOT statistically significant. (P value = 0.6279)**
- The Total Impact Score decreased by 40%. **This is statistically significant. (P value = 0.0060)**
- The Total Difficulties score decreased by 21%. **This is statistically significant. (P = 0.0122)**

Level 4

Versions: “Standard”, “Standard Teen”, “Standard Stepping Stones”, “Group”, and “Group Teen”

This level is:

- For parents/caregivers of children who have severe behavioral difficulties or ones who need intensive support.
- About Triple P’s 17 core positive parenting skills which can be adapted to a wide range of parenting situations.

The “Standard” version includes one-on-one counseling over ten one-hour long sessions for children up to 12 years old. The “Standard Teen” version includes adolescents up to 16 years old. The “Standard Stepping Stones” version is suited for children with developmental disabilities. The “Group” version, instead of one-on-one counseling, includes small group sessions. The “Group Teen” version includes adolescents up to 16 years old.

Assessments

There were many assessments given in Level 4. Some assessments are only available in certain versions of level 4 as shown on the grid on the next page:

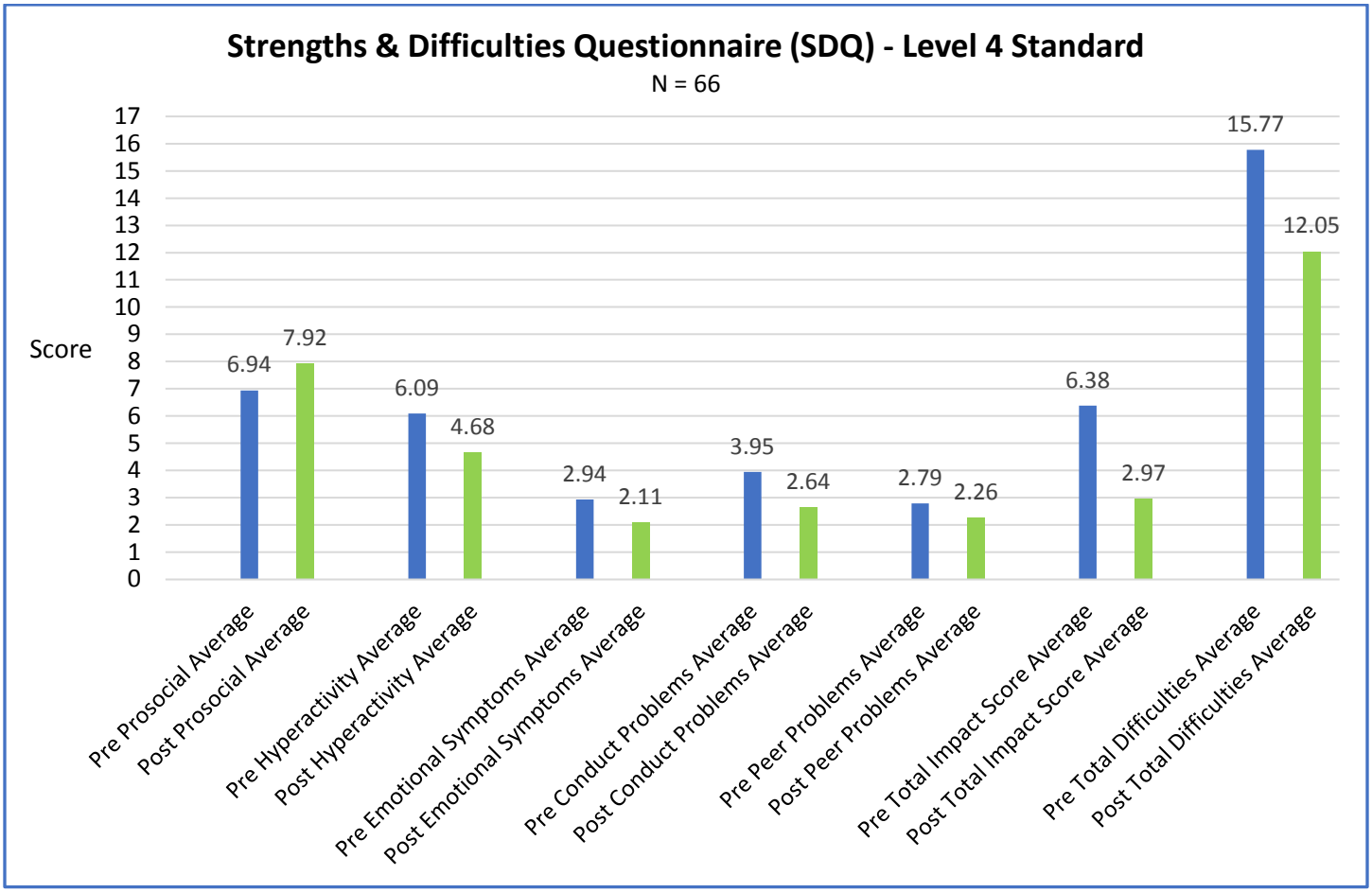
✓ means that this assessment was given and 20 or more participants completed it

✓ means that this assessment was given but less than 20 participants completed it

⊘ means that this assessment was not given in this version of Level 4

	Level 4 - Standard	Level 4 - Standard Teen	Level 4 - Group	Level 4 - Group Teen	Level 4 - Standard Stepping Stones
Strengths and Difficulties Questionnaire (SDQ)	✓	✓	✓	✓	✓
Depression Anxiety Stress Scales (DASS 42)	✓	⊘	✓	⊘	✓
Depression Anxiety Stress Scales (DASS 21)	⊘	✓	⊘	✓	⊘
Parenting Scale	✓	⊘	⊘	⊘	✓
Parenting Scale - Adolescent	⊘	✓	⊘	✓	⊘
Being a Parent Scale (PSOC)	✓	⊘	✓	⊘	✓

Results for the Strengths and Difficulties Questionnaire (SDQ) for Level 4 Standard are shown below:

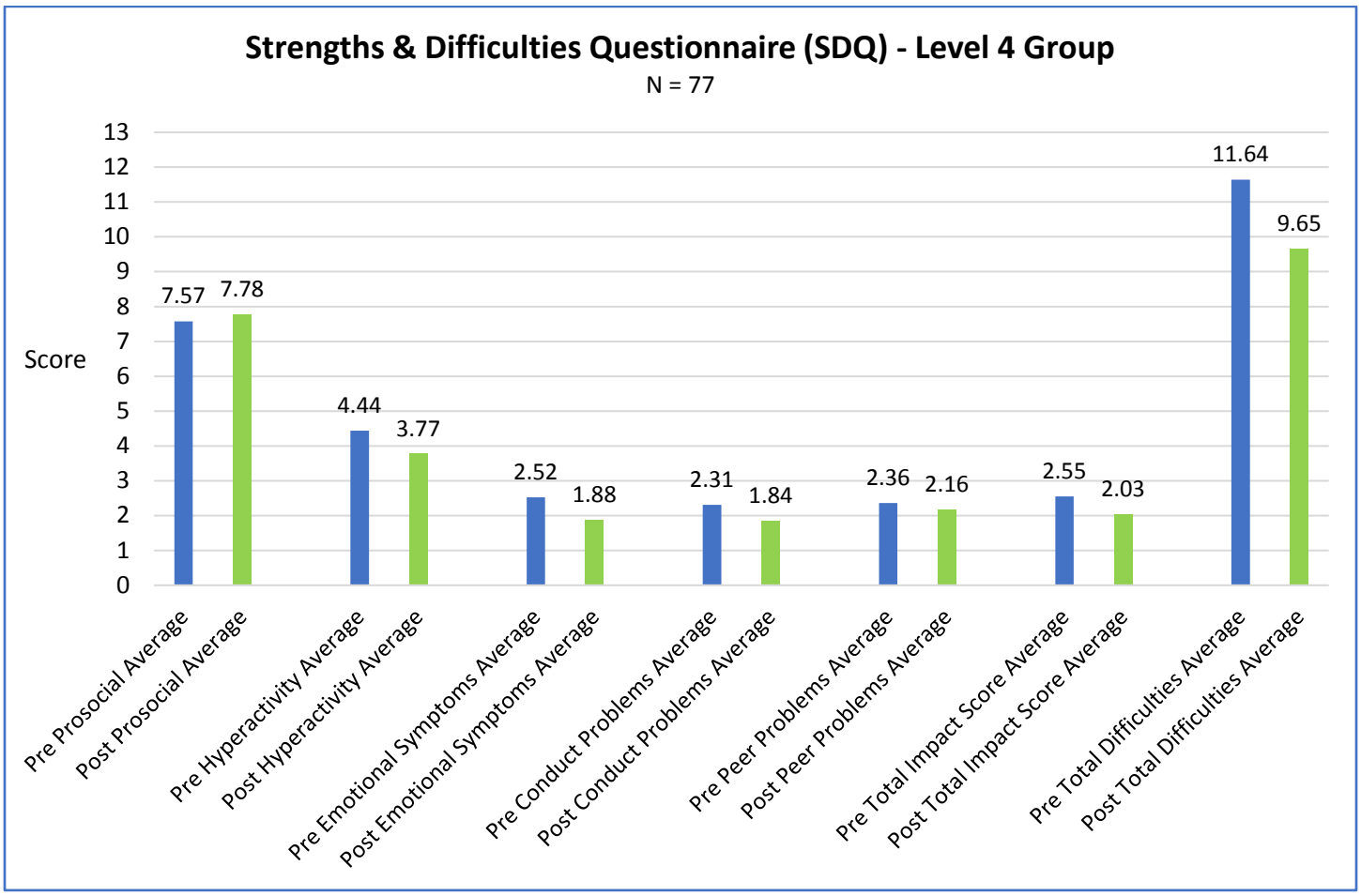


Cut-points [3] for the Strengths and Difficulties questionnaire are shown below:

	Normal	Borderline	Abnormal	Improvement
Prosocial Behavior Score	6-10	5	0-4	HIGHER scores are better
Hyperactivity Score	0-5	6	7-10	LOWER scores are better
Emotional Symptoms Score	0-3	4	5-10	LOWER scores are better
Conduct Problems Score	0-2	3	4-10	LOWER scores are better
Peer Problems Score	0-2	3	4-10	LOWER scores are better
Impact Score	0	1	2-10	LOWER scores are better
Total Difficulties Score	0-13	14-16	17-40	LOWER scores are better

- The Prosocial score increased by 14%. **This is statistically significant. (P = 0.0000)**
- The Hyperactivity score decreased by 23%. **This is statistically significant. (P = 0.0000)**
- The Emotional symptoms score decreased by 28%. **This is statistically significant. (P = 0.0003)**
- The Conduct Problems score decreased by 33%. **This is statistically significant. (P = 0.0000)**
- The Peer Problems score decreased by 19%. **This is statistically significant. (P = 0.0174)**
- The Total Impact Score decreased by 53%. **This is statistically significant. (P = 0.0000)**
- The Total Difficulties score decreased by 24%. **This is statistically significant. (P = 0.0000)**

The Strengths and Difficulties Questionnaire (SDQ) scores for Level 4 Group are shown below:



Cut-points [3] for the Strengths and Difficulties questionnaire are shown below:

	Normal	Borderline	Abnormal	Improvement
Prosocial Behavior Score	6-10	5	0-4	HIGHER scores are better
Hyperactivity Score	0-5	6	7-10	LOWER scores are better
Emotional Symptoms Score	0-3	4	5-10	LOWER scores are better
Conduct Problems Score	0-2	3	4-10	LOWER scores are better
Peer Problems Score	0-2	3	4-10	LOWER scores are better
Impact Score	0	1	2-10	LOWER scores are better
Total Difficulties Score	0-13	14-16	17-40	LOWER scores are better

- The Prosocial score increased by 3%. **This is NOT statistically significant. (P = 0.3352)**
- The Hyperactivity score decreased by 15%. **This is statistically significant. (P = 0.0200)**
- The Emotional Symptoms score decreased by 25%. **This is statistically significant. (P = 0.0017)**
- The Conduct Problems score decreased by 20%. **This is statistically significant. (P = 0.0212)**
- The Peer Problems score decreased by 8%. **This is NOT statistically significant. (P = 0.3128)**
- The Total Impact Score decreased by 20%. **This is NOT statistically significant. (P = 0.0840)**
- The Total Difficulties score decreased by 17%. **This is statistically significant. (P = 0.0025)**

The **Depression Anxiety Stress Scale-42 (DASS42)** is a 42-item self-assessment that measures symptoms of depression, anxiety, and stress in adults. The scale is shown below [4]:

DASS

Name: *Date:*

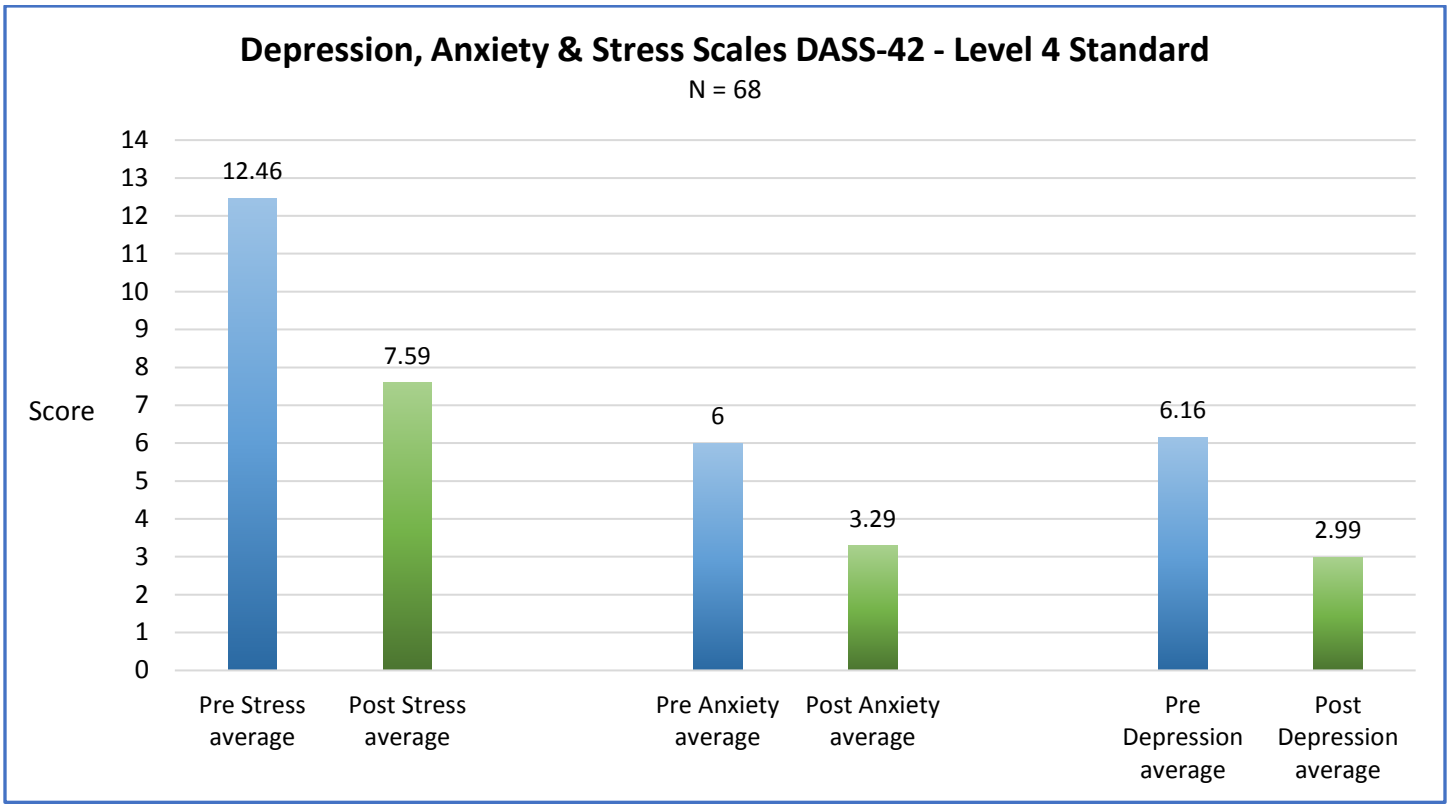
Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

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

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

A graph of the results of the Depression, Anxiety and Stress Scale (DASS-42) for Level 4 Standard is shown below:

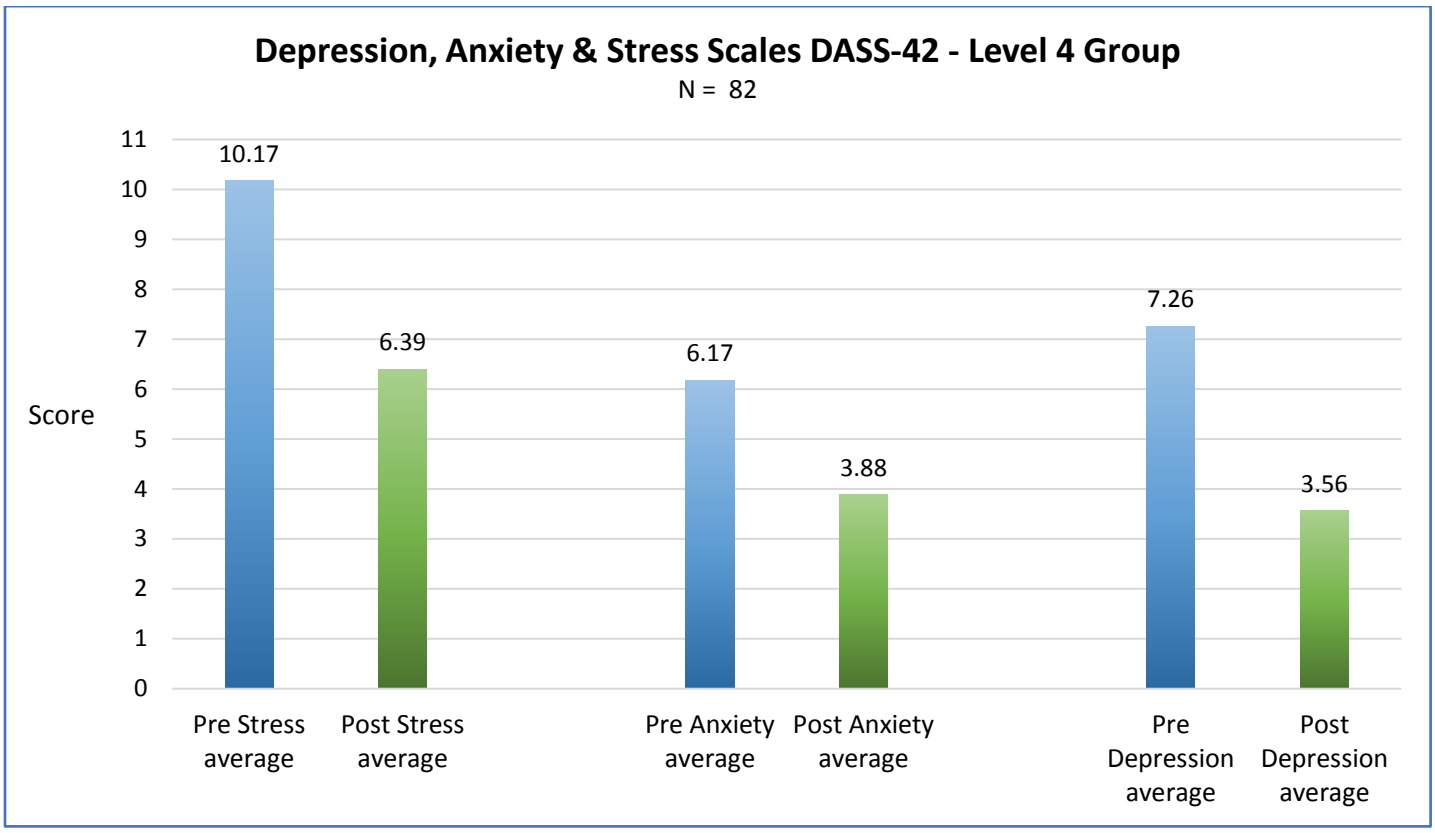


Clinically significant thresholds [5] for scores on the Depression Anxiety Stress Scale are shown below:

	Normal	Mild	Moderate	Severe	Very Severe	Improvement
Stress Score	0-14	15-18	19-25	26-33	34+	LOWER scores are better
Anxiety Score	0-7	8-9	10-14	15-19	20+	LOWER scores are better
Depression Score	0-9	10-13	14-20	21-27	28+	LOWER scores are better

- The Stress score decreased by 39%. **This is statistically significant. (P = 0.0000)**
- The Anxiety score decreased by 45%. **This is statistically significant. (P = 0.0003)**
- The Depression score decreased by 51%. **This is statistically significant. (P = 0.0001)**

A graph of the results of the Depression, Anxiety and Stress Scale (DASS-42) for Level 4 Group is shown below:



Clinically significant thresholds [5] for scores on the Depression Anxiety Stress Scale-42 are shown below:

	Normal	Mild	Moderate	Severe	Very Severe	Improvement
Stress Score	0-14	15-18	19-25	26-33	34+	LOWER scores are better
Anxiety Score	0-7	8-9	10-14	15-19	20+	LOWER scores are better
Depression Score	0-9	10-13	14-20	21-27	28+	LOWER scores are better

- The Stress score decreased by 37%. **This is statistically significant. (P = 0.0013)**
- The Anxiety score decreased by 37%. **This is statistically significant. (P = 0.0121)**
- The Depression score decreased by 51%. **This is statistically significant. (P = 0.0015)**

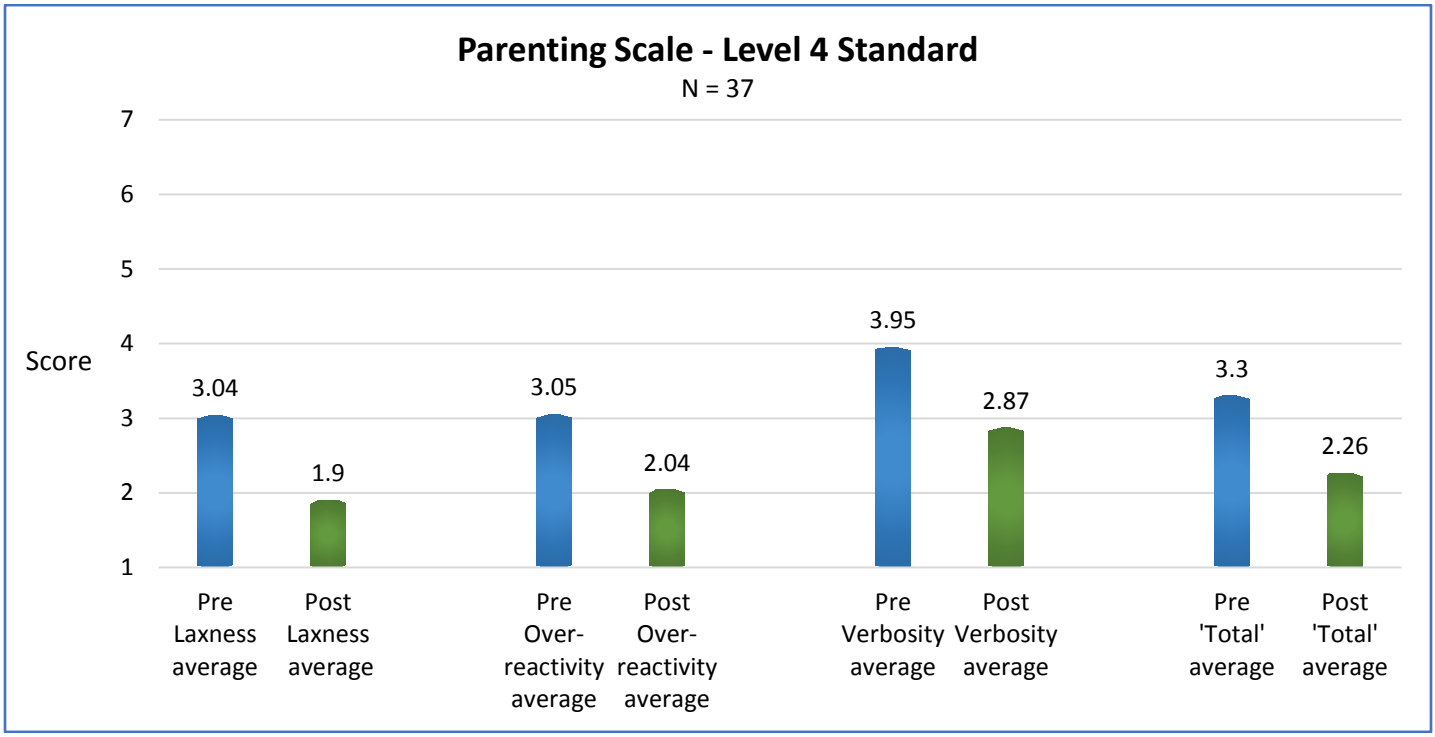
The **Parenting Scale** is a 30-item self-assessment to determine whether the participant has a parenting or disciplinary style that is associated with behavioral problems in children. It is completed by parents/caregivers of children ages 1-12.

The Parenting Scale measures the degree of “Laxness”, “Overreactivity”, and “Verbosity” in parenting styles. Laxness describes a parenting style that is permissive and inconsistent when it comes to disciplining. It includes a lack of consistency and ineffective limit-setting. Overreactivity is characterized by threats and physical punishment. Verbosity describes a parenting style of giving lengthy verbal reprimands instead of taking direct action. [6]

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

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

As shown in the chart below, all areas of the Parenting Scale for Level 4 Standard have improved:

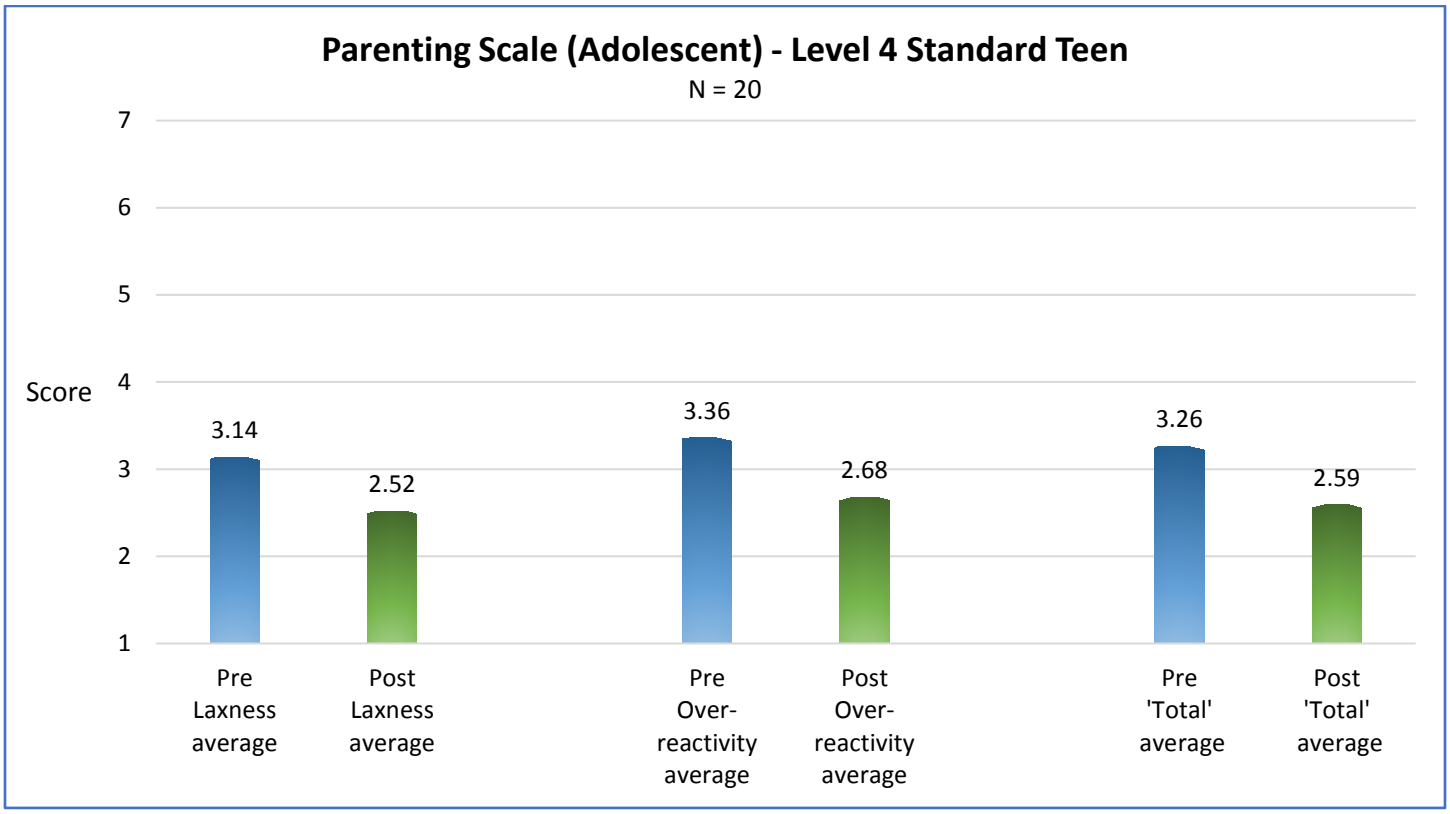


Clinically significant thresholds [7] for the Parenting Scale are shown below:

	Clinical Threshold	Improvement
Laxness Score	2.8 +	LOWER scores are better
Over-reactivity Score	3.0 +	LOWER scores are better
Verbosity Score	3.4 +	LOWER scores are better
Total Score	3.1 +	LOWER scores are better

- The Laxness score decreased by 38%. **This is statistically significant. (P = 0.0000)**
- The Over-reactivity score decreased by 33%. **This is statistically significant (P = 0.0000)**
- The Verbosity score decreased by 27%. **This is statistically significant (P = 0.0000)**
- The "Total" average score decreased by 32%. **This is statistically significant (P = 0.0000)**

The **Parenting Scale – Adolescent** is modified for use with parents of adolescents up to 16 years of age. Results on the Parenting Scale – Adolescent assessment for Level 4 Standard Teen are shown below:



Lower scores represent improved outcomes. No clinically significant thresholds for the Parenting Scale – Adolescent assessment were found.

- The Laxness score decreased by 20%. **This is statistically significant. (P = 0.0148)**
- The Over-reactivity score decreased by 20%. **This is NOT statistically significant. (P = 0.0782)**
- The "Total" average score decreased by 21%. **This is statistically significant. (P = 0.0205)**

The **Being a Parent Scale (PSOC)** is a 16-item assessment that measures parenting self-esteem, or efficacy, and satisfaction with the parenting role. Parents indicate their agreement with a series of statements about 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 Efficacy range from 7-42 and scores for Satisfaction range from 9-54. Higher scores represent greater levels of parenting self-efficacy and parental satisfaction. The "Being a Parent Scale" is a strength-based measure.

An example of the Being a Parent Scale is shown below [8]:

BEING A PARENT SCALE

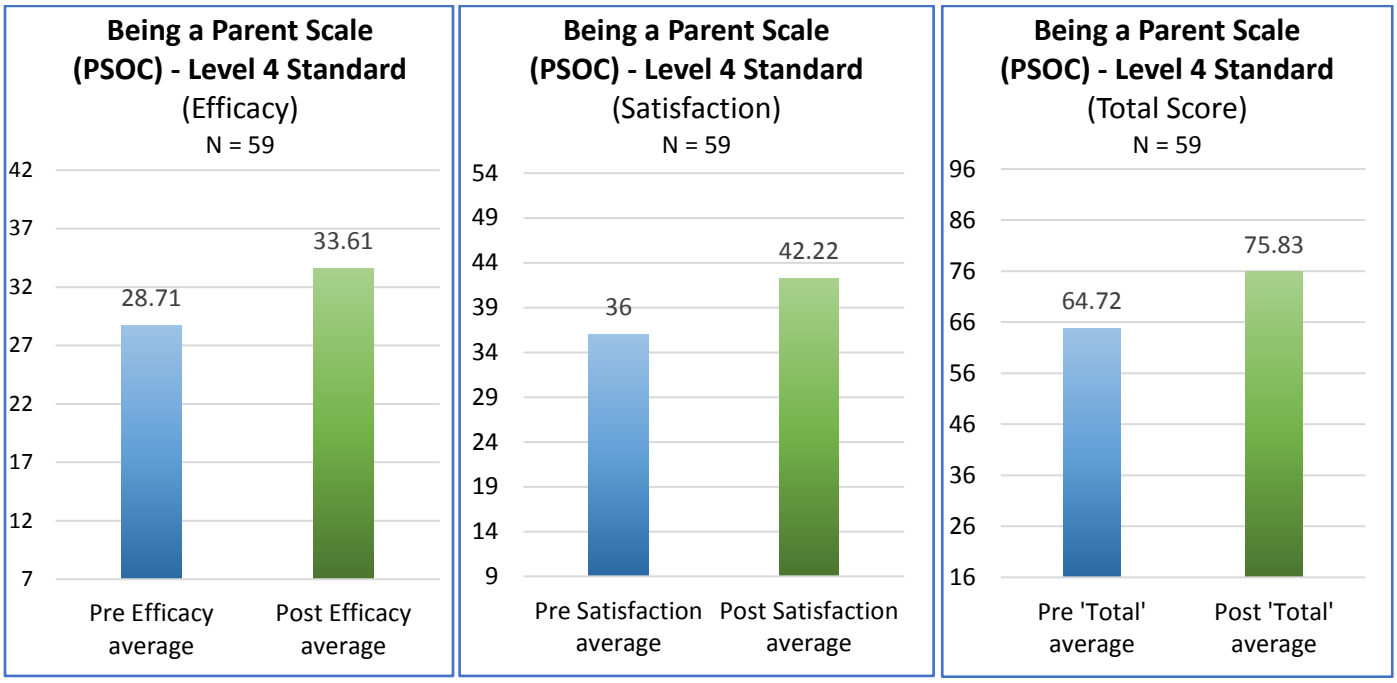
On this questionnaire are 16 items relating to your feelings about being a parent. Please read each item carefully and rate whether you feel it applies to you, by circling a number from 1 (strongly agree) to 6 (strongly disagree) on the scale.

The rating scale is as follows:

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

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

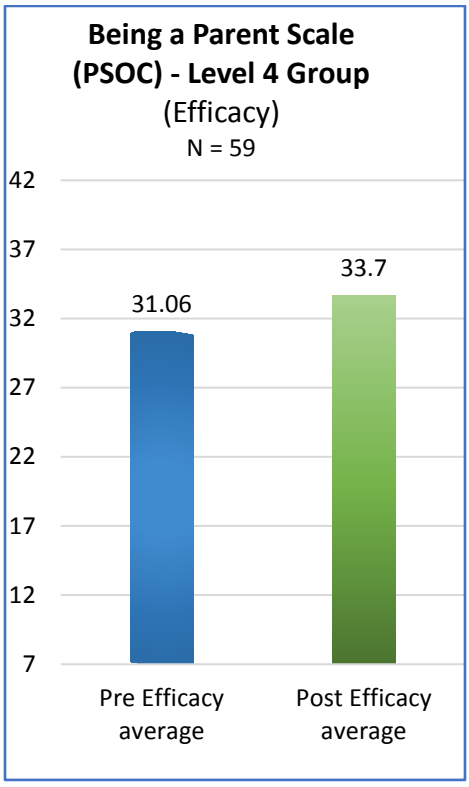
Scores on the Being a Parent Scale (PSOC) for Level 4 Standard are shown below. There has been improvement in all areas:

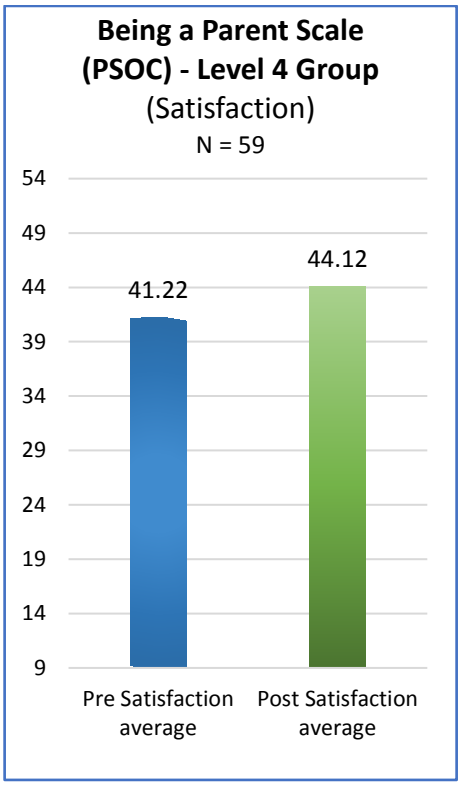


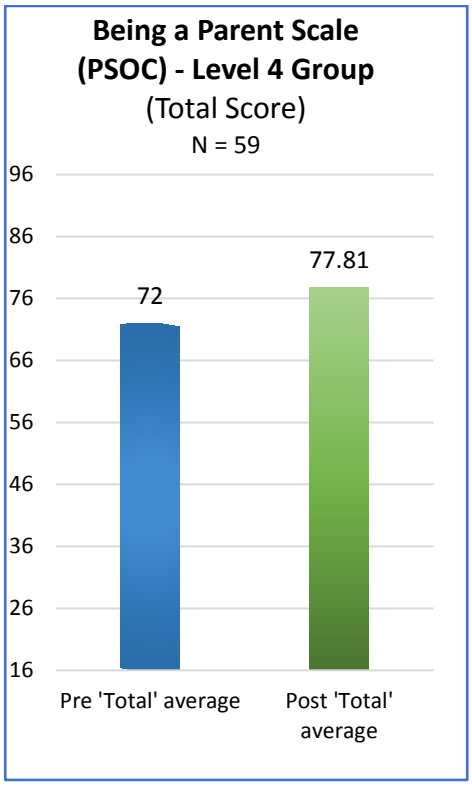
Higher scores represent improved outcomes. No clinical thresholds on the Being a Parent Scale (PSOC) were found.

- The Efficacy score increased by 17%. **This is statistically significant. (P = 0.0000)**
- The Satisfaction score increased by 17%. **This is statistically significant. (P = 0.0000)**
- The Total score increased by 17%. **This is statistically significant. (P = 0.0000)**

Scores on the Being a Parent Scale (PSOC) for Level 4 Group are shown below:







Higher scores represent improved outcomes. No clinical thresholds on the Being a Parent Scale (PSOC) were found.

- The Efficacy score increased by 9%. **This is statistically significant. (P = 0.0011)**
- The Satisfaction score increased by 7%. **This is statistically significant. (P = 0.0004)**
- The Total score increased by 8%. **This is statistically significant. (P = 0.0001)**

Level 5

Versions: “Enhanced” and “Pathways”

Both versions provide intensive support for families with complex concerns. Parents must complete a Level 4 program before (or in conjunction with) a Level 5 course.

Enhanced Triple P: This version of level 5 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 practices [9].

Pathways Triple P: This version of level 5 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 [9].

Assessments*

*Less than 20 participants completed both pre- and post-assessments in either version of level 5, so outcome measures for level 5 were not included.

Satisfaction Measure

The **Client Satisfaction Questionnaire (CSQ)** is a measure of client satisfaction and is given after completion of Levels 3 – 5*. This 13-item measure assesses participant satisfaction with the parent training program.

Possible scores range from 13-91. Higher scores represent improved outcomes. A graph of the results for the Client Satisfaction Questionnaire (CSQ) is shown below:

* If less than twenty Satisfaction surveys were completed within any level or version, the results were not included.

References

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

[2] Retrieved from https://www.cabarrushealth.org/DocumentCenter/

[3] Innovative solutions for education, health, care and prison services. Retrieved from http://www.ehcap.co.uk/

[4] The School of Psychology - UNSW. Retrieved from http://www2.psy.unsw.edu.au/

[5] Retrieved from https://www.psytoolkit.org/survey-library/depression-anxiety-stress-dass.html

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

[7] Children of Parents with a Mental Illness: Mental health information and resources for Australian parents, children, families, carers and health professionals. Retrieved from http://www.copmi.net.au/

[8] CT.GOV-Connecticut's Official State Website. Retrieved from https://portal.ct.gov/

[9] Level 5. Retrieved from https://www.triplep.net/glo-en/the-triple-p-system-at-work/the-system-explained/level-5/

Botvin LifeSkills
Outcome Evaluation Summary

Shasta Lake Elementary

Middle School Program

Prepared By:

Shasta County Health & Human Services Agency

June 2018

Botvin LifeSkills®Training
Evidence-Based Prevention Programs for Schools, Families, and Communities

Report Index

Introduction

Botvin LifeSkills is an evidence-based substance use and violence prevention program for adolescents and young teens, and is often implemented in schools. Botvin LifeSkills can be delivered through various approaches and has been proven effective in reducing tobacco, alcohol, opioid, and illicit drug use. Other included benefits are reductions in delinquency, fighting and verbal aggression as students learn valuable social and coping skills.

The program was implemented in Shasta Lake Elementary for grades 6-8 during Fiscal Year 17/18. The program promotes healthy alternatives to risky behavior through activities that are intended to: help students resist peer pressure to use drugs, alcohol, and smoke, develop greater self-esteem, develop effective anti-anxiety coping mechanisms, increase knowledge of the effects of substance abuse, and enhance general awareness of healthy lifestyle choices to prevent and/or reduce health risk behaviors.

Findings

Before analyzing the results, a note should be made about program fidelity. Fidelity is the "extent to which the delivery of an intervention adheres to the protocols and program model originally developed" (Mowbrey et al., 2003). Sixth and seventh graders completed all 14 lessons while eighth graders only completed lessons 1-3. For this reason, program fidelity will be lower for the eighth graders. A comparison of the results from the pre- and post-test scores are broken down into the sections shown below.

SECTION B results

Anti-Drug Knowledge:

Of the 13 questions pertaining to drug knowledge, grades 6-8 showed improved post-test scores on a majority of the questions asked. Sixth graders showed improved scores on 10/13 questions, seventh graders on 11/13 questions, and eighth graders on 7/13 questions. For this segment, the data indicates that the anti-drug knowledge portion of the program was less effective on the eighth graders, but each grade improved on a majority of the questions asked.

Life skills Knowledge:

Of the 19 questions pertaining to Life Skills Knowledge, grades 6-8 again showed improved post-test scores on a majority of the questions asked. Sixth graders showed improved scores on 15/19 questions, seventh graders on 10/19 questions, and eighth graders on 13/19 questions. For this segment, the data indicates that the Life Skills Knowledge portion of the program was most effective on the sixth graders.

SECTION C results

Anti-Substance Use Attitudes:

Of the 8 questions pertaining to Anti-Substance Use Attitudes, post-test results showed modest improvement for sixth graders and minimal improvement for seventh and eighth graders. Sixth graders had improved scores on 4/8 questions, seventh graders on 1/8 questions, and eighth graders on 1/8 questions.

Caution should be exercised when interpreting findings without a control group because drug use and risk factors tend to worsen during early adolescence, even during a prevention program. The best way to evaluate program effects is to compare the changes over time with those who received the program and a control group that did not.

SECTION D results

Life Skills Assessment:

Of the 11 questions pertaining to drug refusal and life skills, sixth graders had improved post-test scores on 10/11 questions, seventh graders on 3/11 questions, and eighth graders on 9/11 questions.

Summary

Overall, sixth graders showed the most post-test improvement from the program. The weakest area overall was Section C, questions pertaining to Anti-Substance Use Attitudes. Improved post-test scores varied by grade and by section. Data showing the pre-/post-test comparisons by grade for each question is graphed in sections B through D below.

Response and Participation:

- How many students took the pre and post surveys for each grade?

Grade	# of students that took pre test	# of students that took post test	% of responses (post/pre)
6th	96	72	75%
7th	119	102	86%
8th	89	79	89%
Total # of Students	**304**	**253**	**Overall Avg = 83%**

- How many students did pre survey's but NOT post surveys? **65**
- How many students did post survey's but NOT pre surveys? **23**
- The program evaluation survey was **47** questions.
- Average time to take the test (mm:ss):

Test	6th Grade	7th Grade	8th Grade
Pre Test	14:37	12:54	13:26
Post Test	9:23	8:26	7:01

- The following report represents **61** sixth graders, **95** seventh graders, and **71** eighth graders making a total of **227 students** that had both a pre and post test response.

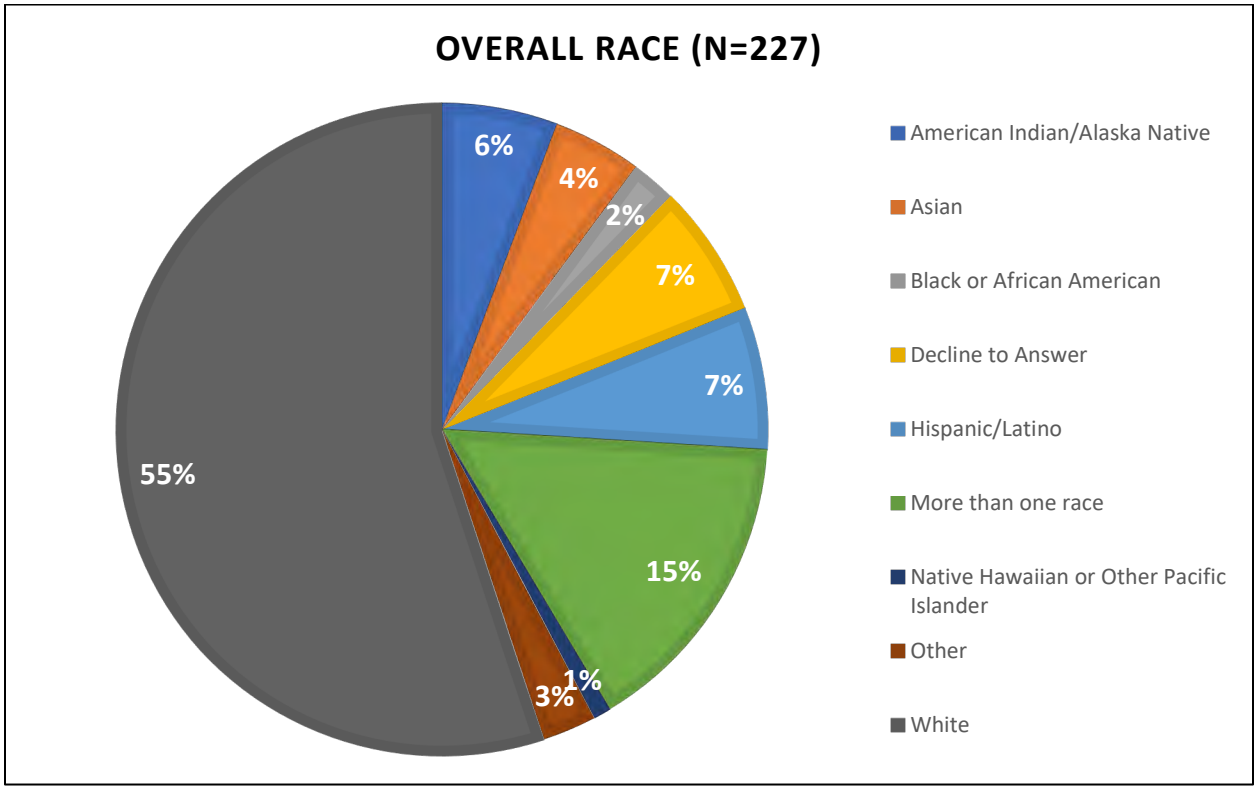
SECTION A

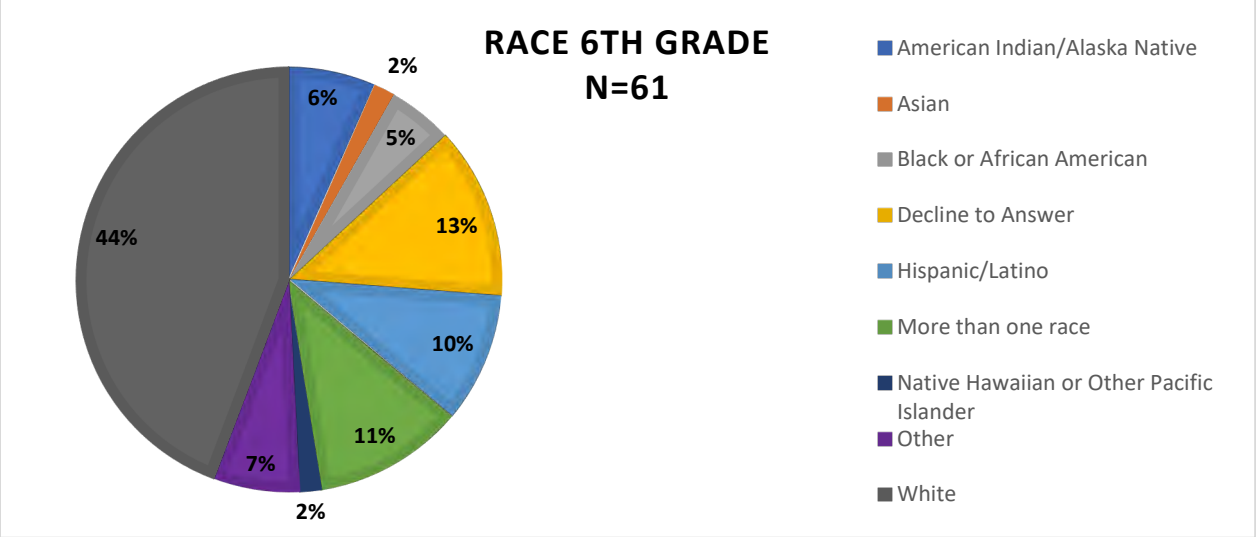
DEMOGRAPHICS:

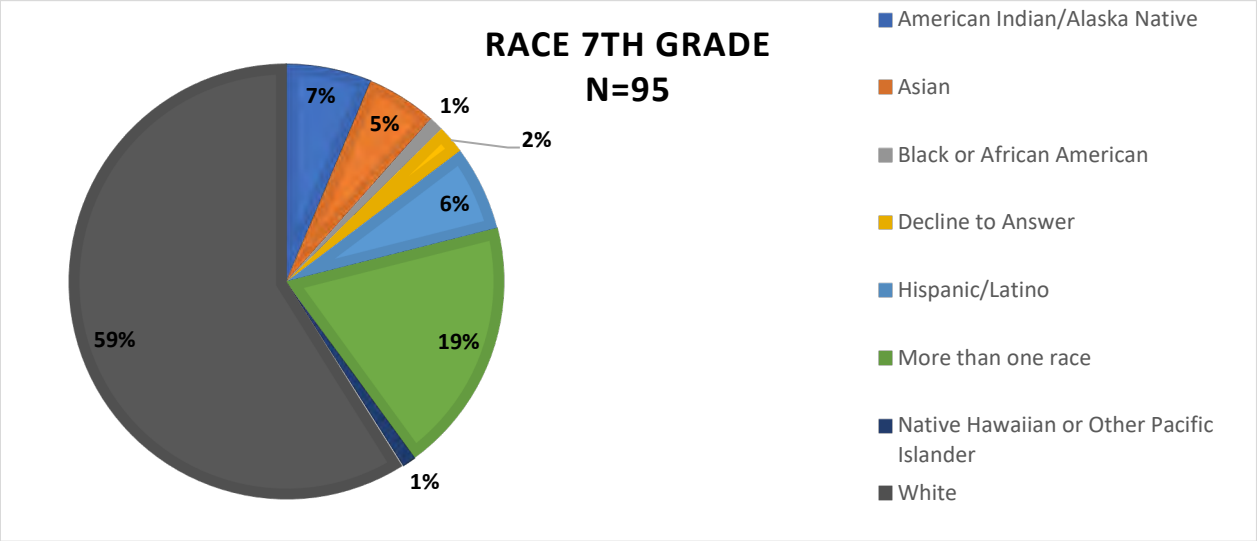
Student Age at Pre Survey

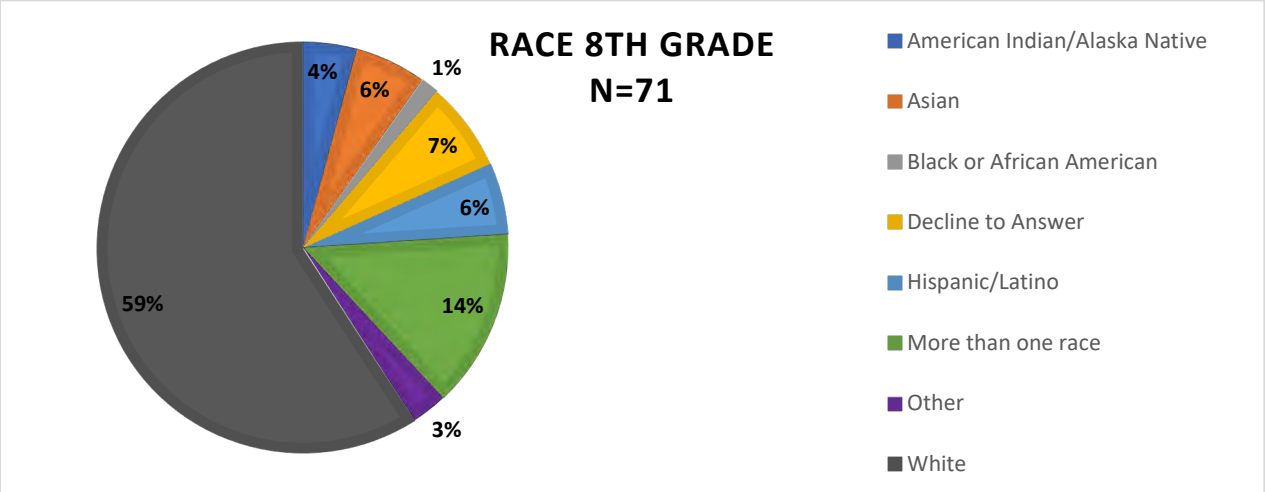
Age	6th Grade	7th Grade	8th Grade
11	39	0	0
12	22	61	0
13	0	31	46
14	0	3	25
# of students	**61**	**95**	**71**

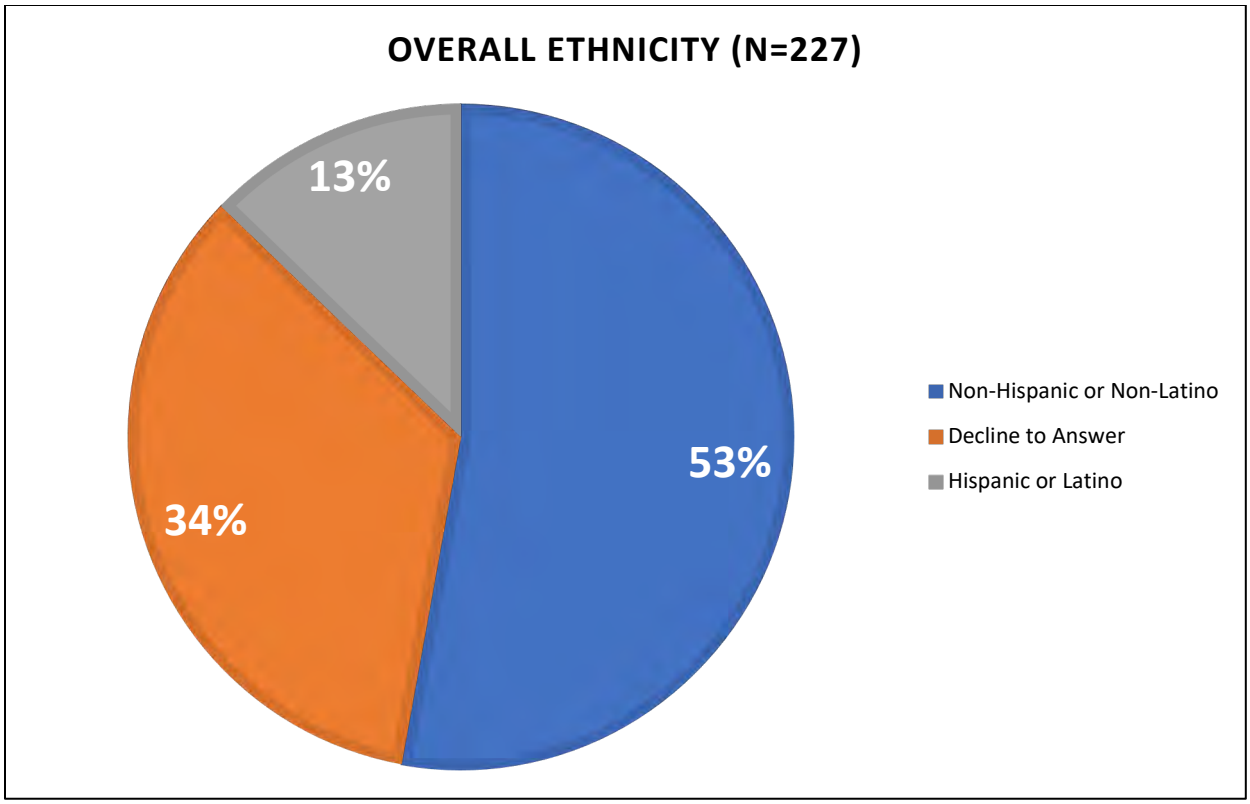
Student Race/Ethnicity:

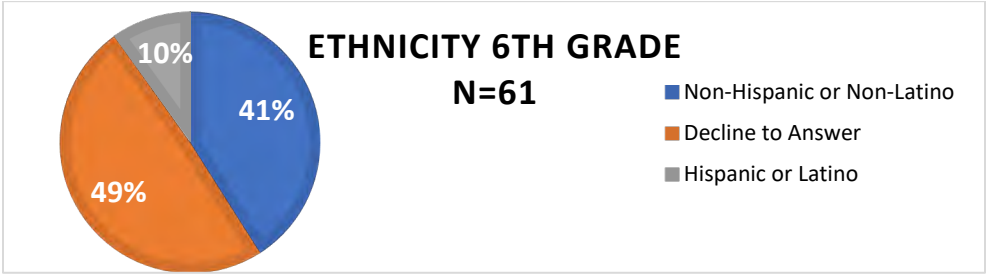


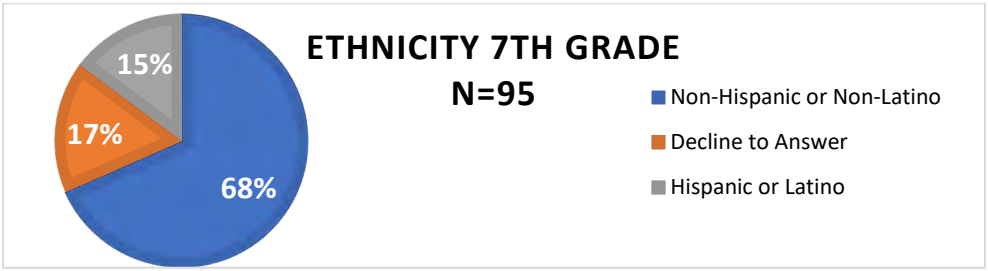

RACE 6TH GRADE
N=61
6%
2%
5%
13%
44%
10%
11%
7%
2%
American Indian/Alaska Native
Asian
Black or African American
Decline to Answer
Hispanic/Latino
More than one race
Native Hawaiian or Other Pacific Islander
Other
White

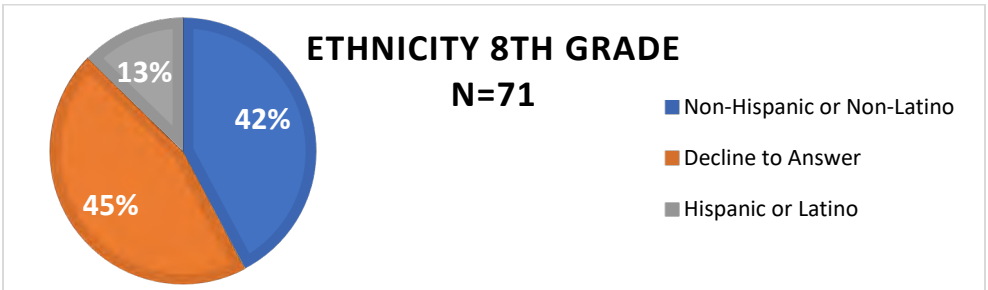

RACE 7TH GRADE
N=95
7%
5%
1%
2%
6%
19%
59%
1%
American Indian/Alaska Native
Asian
Black or African American
Decline to Answer
Hispanic/Latino
More than one race
Native Hawaiian or Other Pacific Islander
White


RACE 8TH GRADE
N=71
4%
6%
1%
7%
6%
59%
14%
3%
American Indian/Alaska Native
Asian
Black or African American
Decline to Answer
Hispanic/Latino
More than one race
Other
White

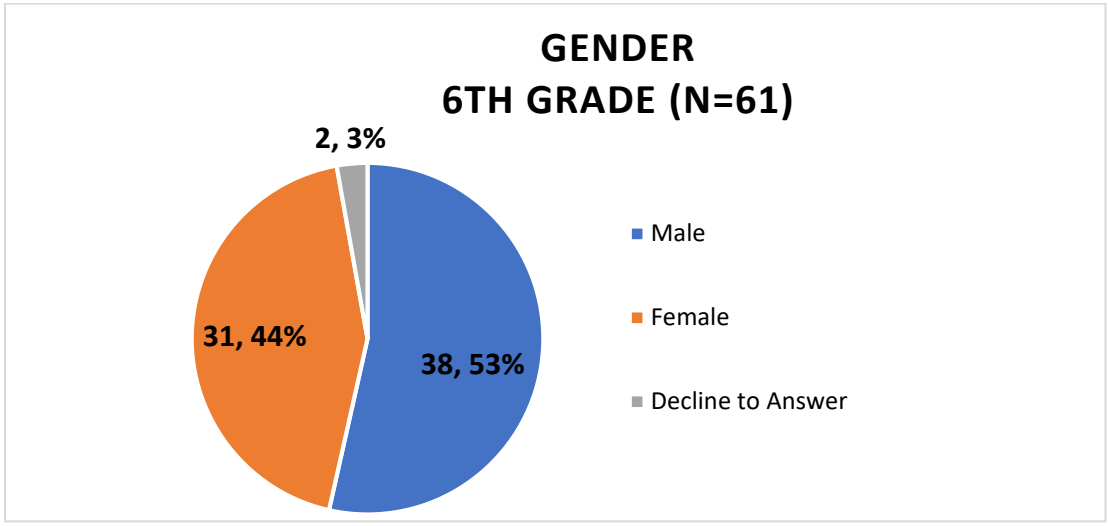

OVERALL ETHNICITY (N=227)
13%
53%
34%
Non-Hispanic or Non-Latino
Decline to Answer
Hispanic or Latino

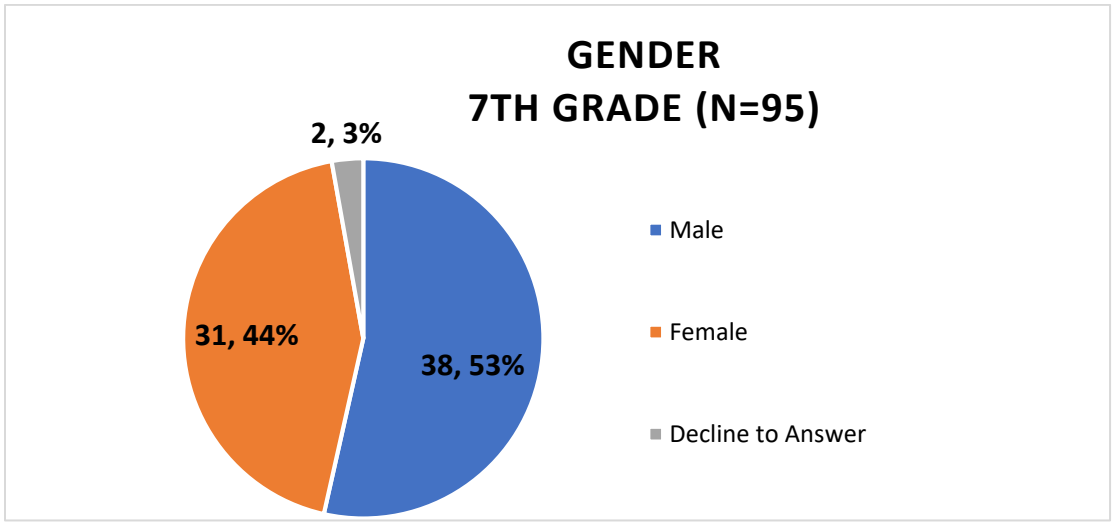

ETHNICITY 6TH GRADE
N=61
10%
41%
49%
Non-Hispanic or Non-Latino
Decline to Answer
Hispanic or Latino

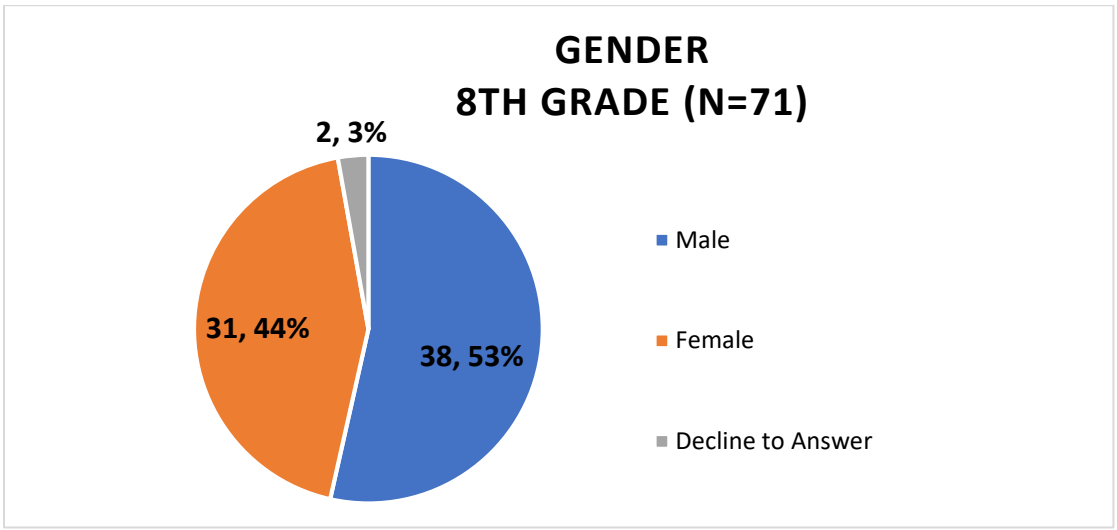

ETHNICITY 7TH GRADE
N=95
15%
17%
68%
Non-Hispanic or Non-Latino
Decline to Answer
Hispanic or Latino


ETHNICITY 8TH GRADE
N=71
13%
42%
45%
Non-Hispanic or Non-Latino
Decline to Answer
Hispanic or Latino

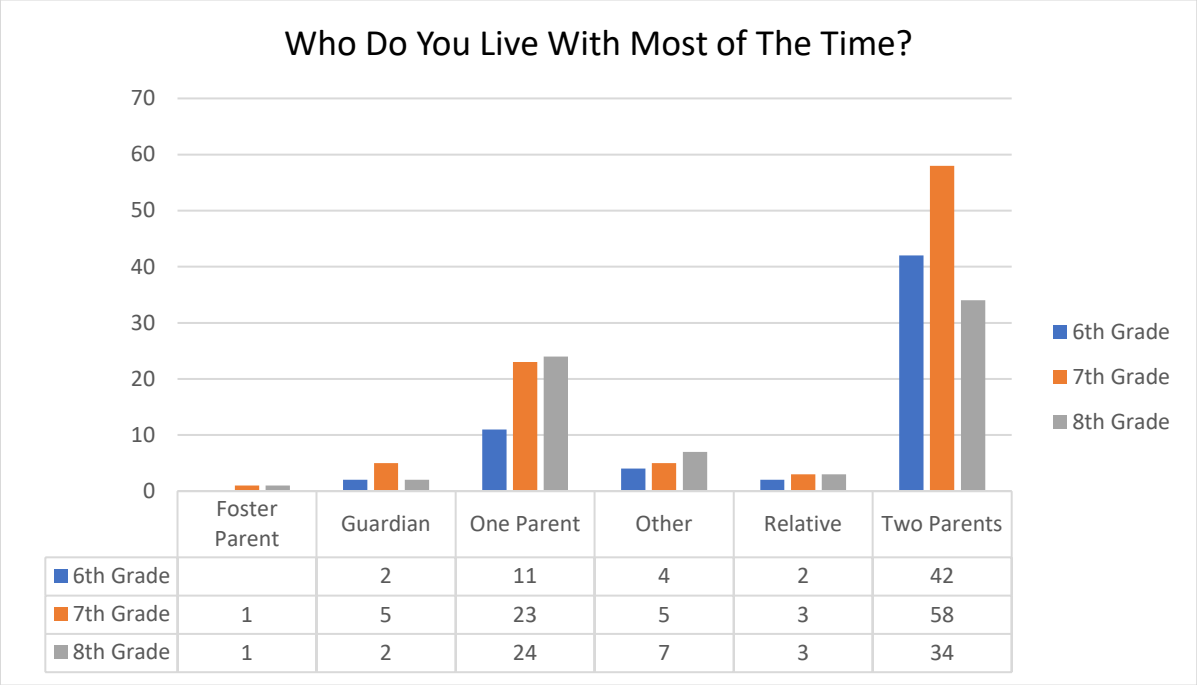
Gender:


GENDER
6TH GRADE (N=61)
2, 3%
31, 44%
38, 53%
Male
Female
Decline to Answer


GENDER
7TH GRADE (N=95)
2, 3%
31, 44%
38, 53%
Male
Female
Decline to Answer


GENDER
8TH GRADE (N=71)
2, 3%
31, 44%
38, 53%
Male
Female
Decline to Answer

Family Structure:

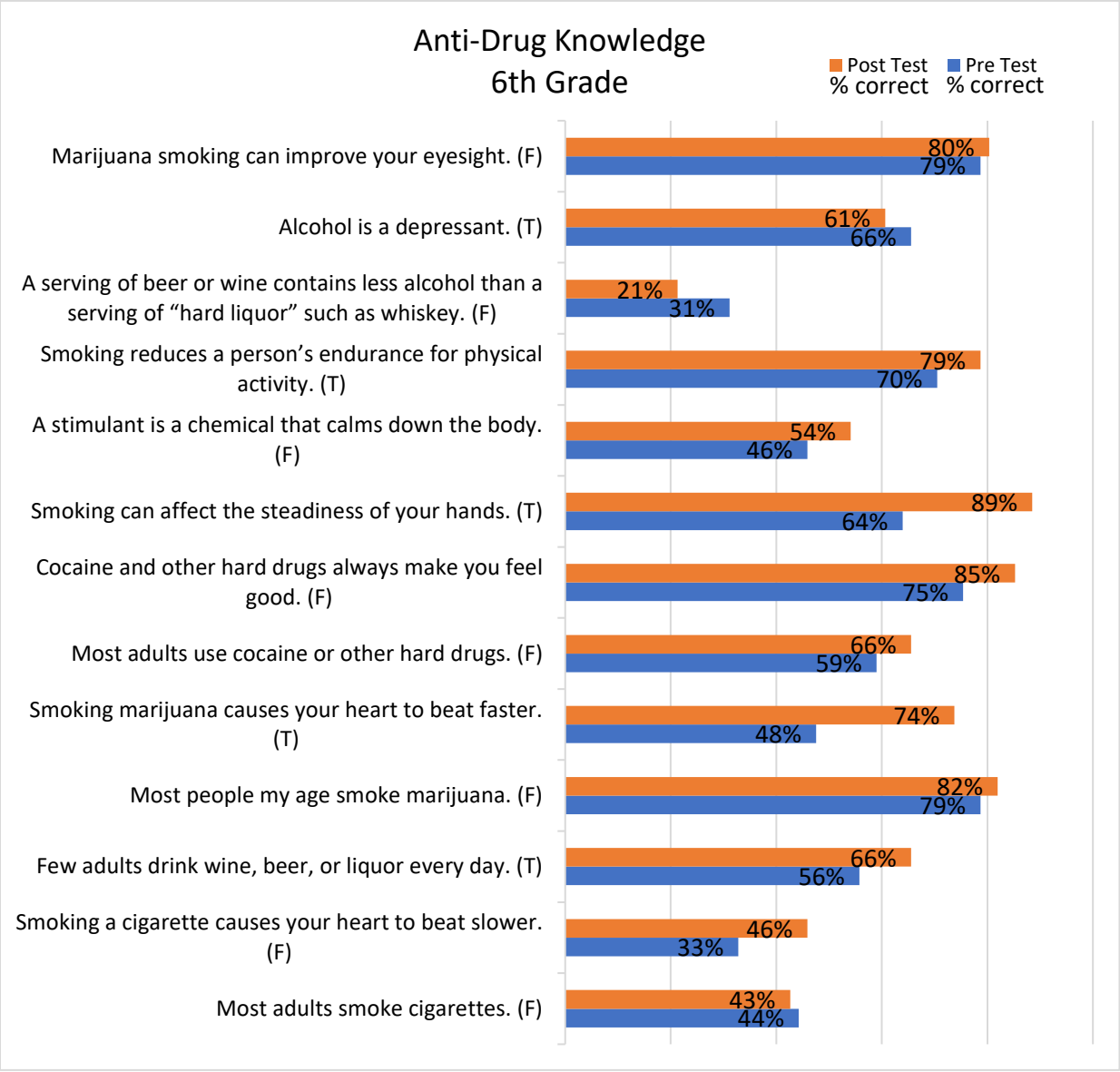


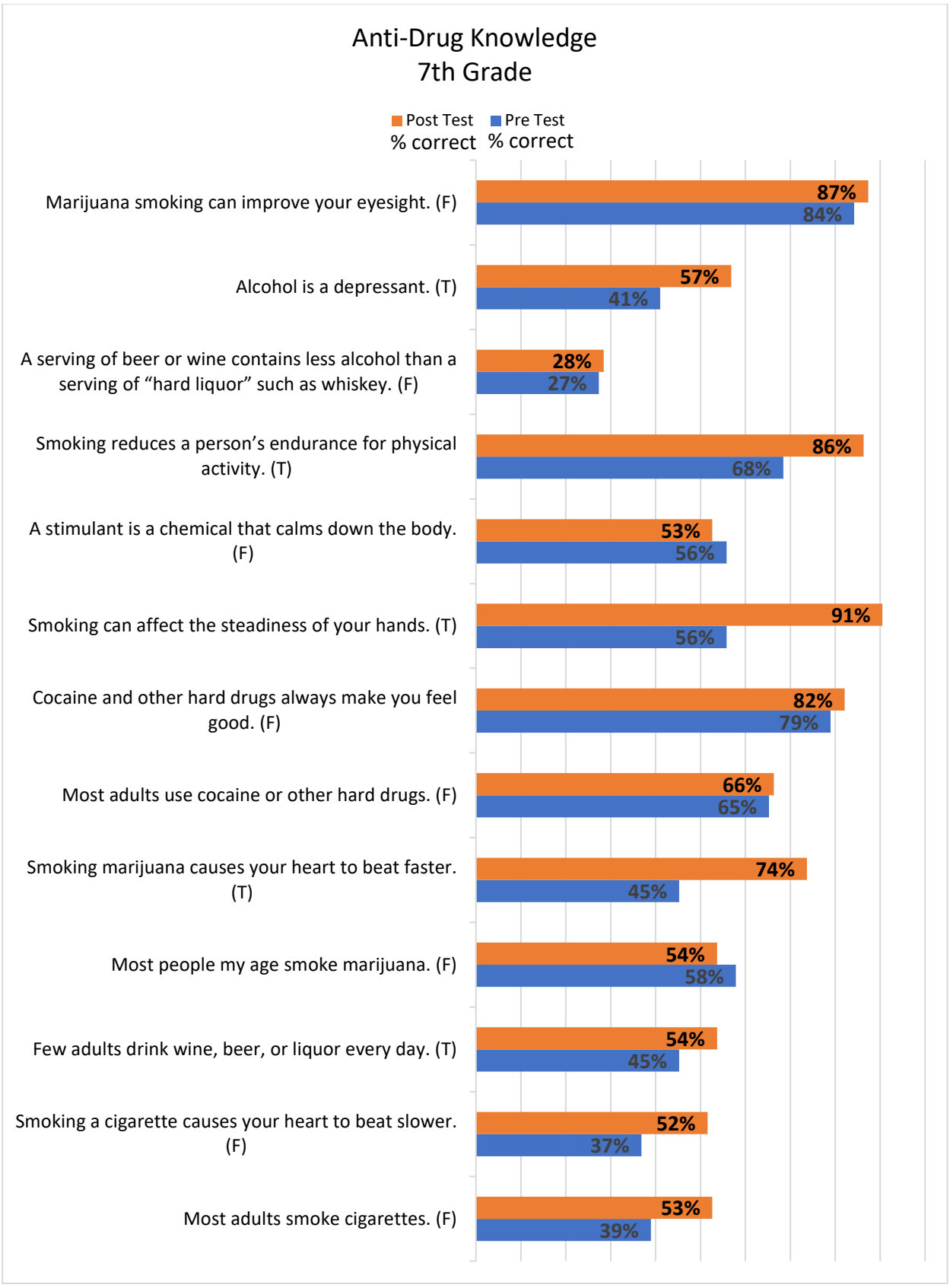
	Foster Parent	Guardian	One Parent	Other	Relative	Two Parents
6th Grade		2	11	4	2	42
7th Grade	1	5	23	5	3	58
8th Grade	1	2	24	7	3	34

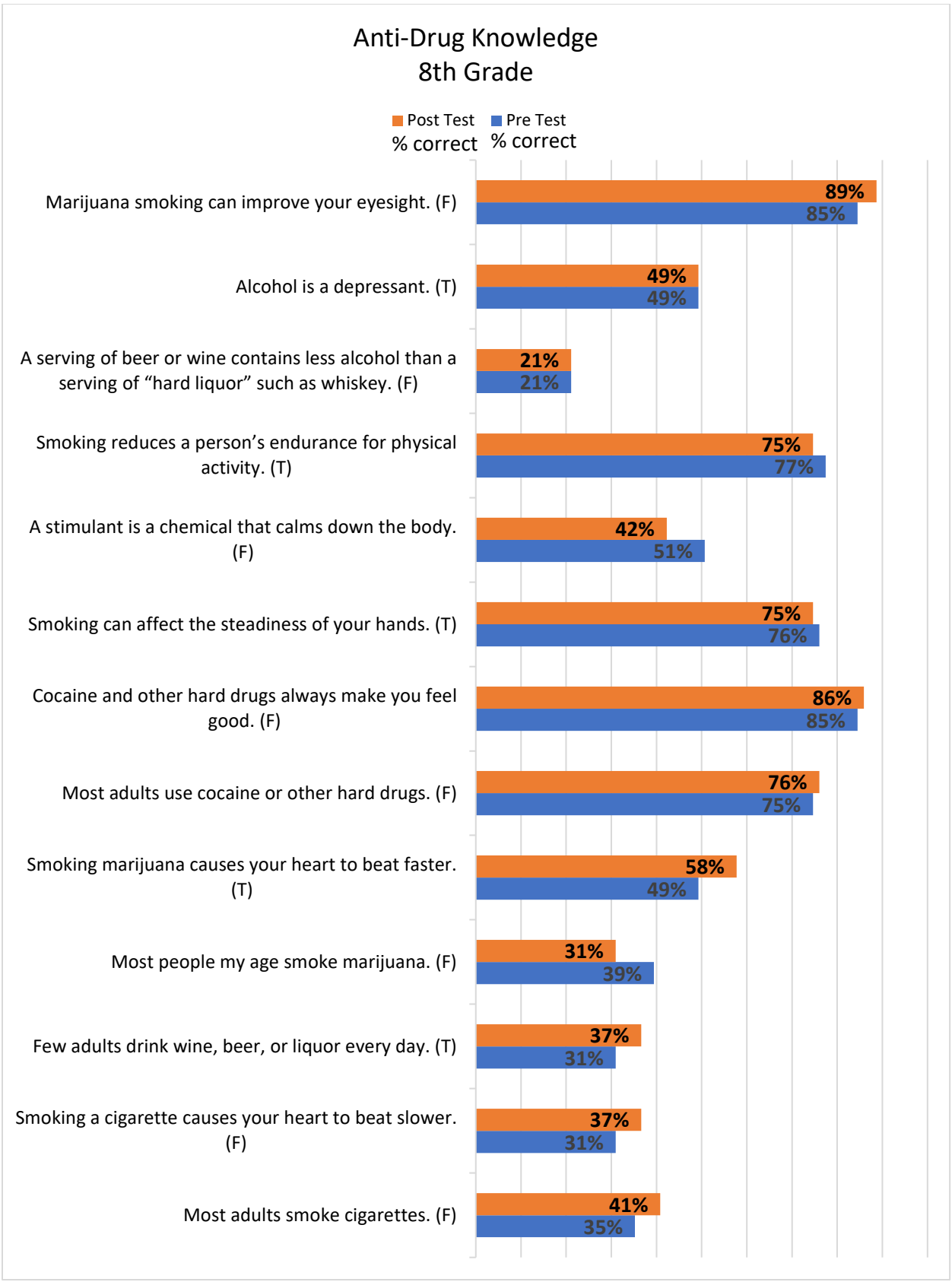
SECTION B

This section assesses knowledge of various Life Skills Training curriculum content areas; two summary scores are produced: Anti-Drug Knowledge and Life Skills Knowledge. The charts represent the % of correct answers to each question. Thus, **increases over time are desirable.**

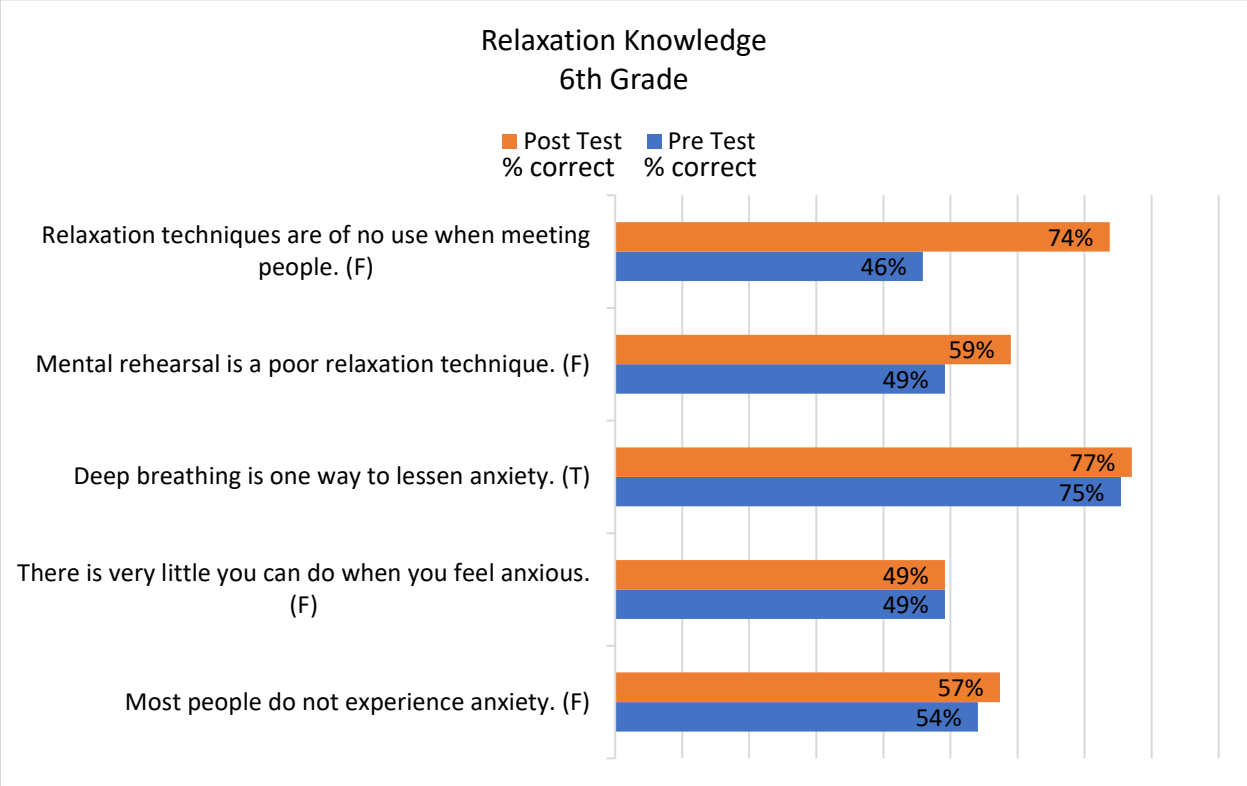
Anti-Drug Knowledge

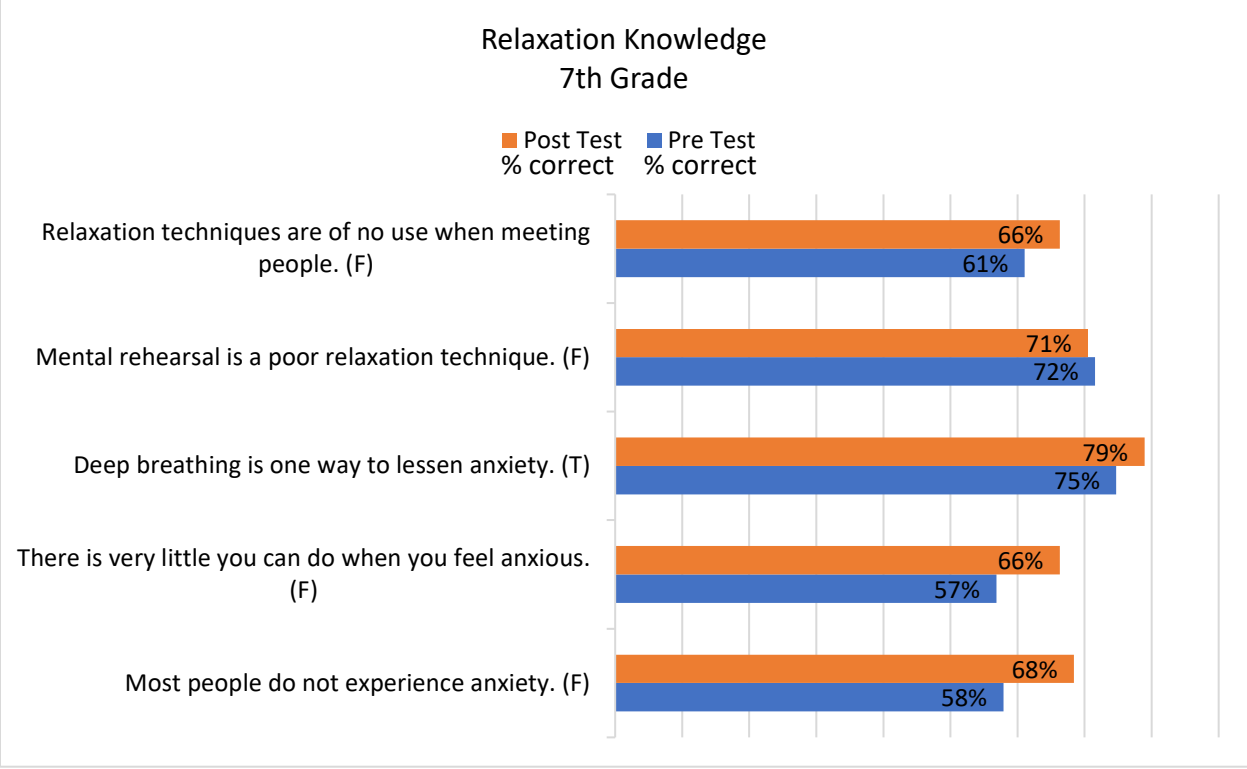


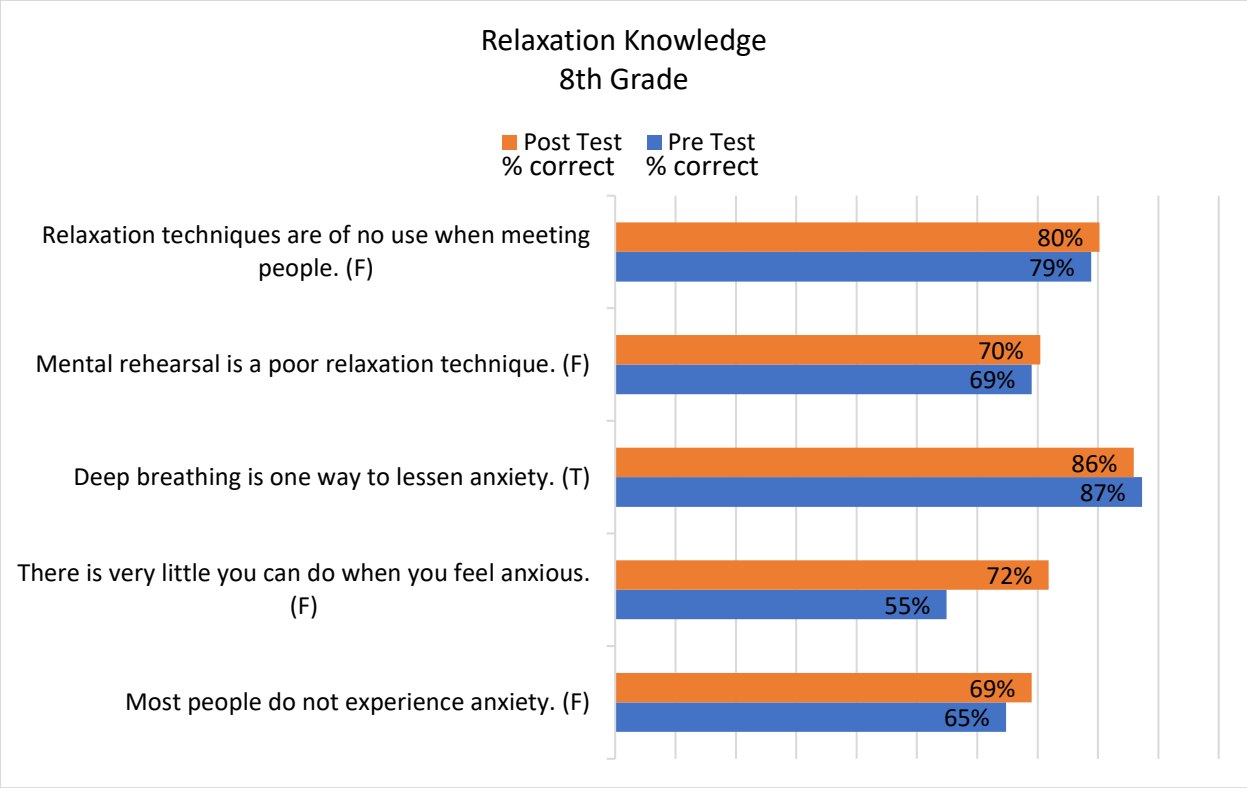

Anti-Drug Knowledge
7th Grade
Post Test % correct
Pre Test % correct
Marijuana smoking can improve your eyesight. (F)
87%
84%
Alcohol is a depressant. (T)
57%
41%
A serving of beer or wine contains less alcohol than a serving of "hard liquor" such as whiskey. (F)
28%
27%
Smoking reduces a person's endurance for physical activity. (T)
86%
68%
A stimulant is a chemical that calms down the body. (F)
53%
56%
Smoking can affect the steadiness of your hands. (T)
91%
56%
Cocaine and other hard drugs always make you feel good. (F)
82%
79%
Most adults use cocaine or other hard drugs. (F)
66%
65%
Smoking marijuana causes your heart to beat faster. (T)
74%
45%
Most people my age smoke marijuana. (F)
54%
58%
Few adults drink wine, beer, or liquor every day. (T)
54%
45%
Smoking a cigarette causes your heart to beat slower. (F)
52%
37%
Most adults smoke cigarettes. (F)
53%
39%


Anti-Drug Knowledge
8th Grade
Post Test % correct
Pre Test % correct
Marijuana smoking can improve your eyesight. (F)
89%
85%
Alcohol is a depressant. (T)
49%
49%
A serving of beer or wine contains less alcohol than a serving of "hard liquor" such as whiskey. (F)
21%
21%
Smoking reduces a person's endurance for physical activity. (T)
75%
77%
A stimulant is a chemical that calms down the body. (F)
42%
51%
Smoking can affect the steadiness of your hands. (T)
75%
76%
Cocaine and other hard drugs always make you feel good. (F)
86%
85%
Most adults use cocaine or other hard drugs. (F)
76%
75%
Smoking marijuana causes your heart to beat faster. (T)
58%
49%
Most people my age smoke marijuana. (F)
31%
39%
Few adults drink wine, beer, or liquor every day. (T)
37%
31%
Smoking a cigarette causes your heart to beat slower. (F)
37%
31%
Most adults smoke cigarettes. (F)
41%
35%

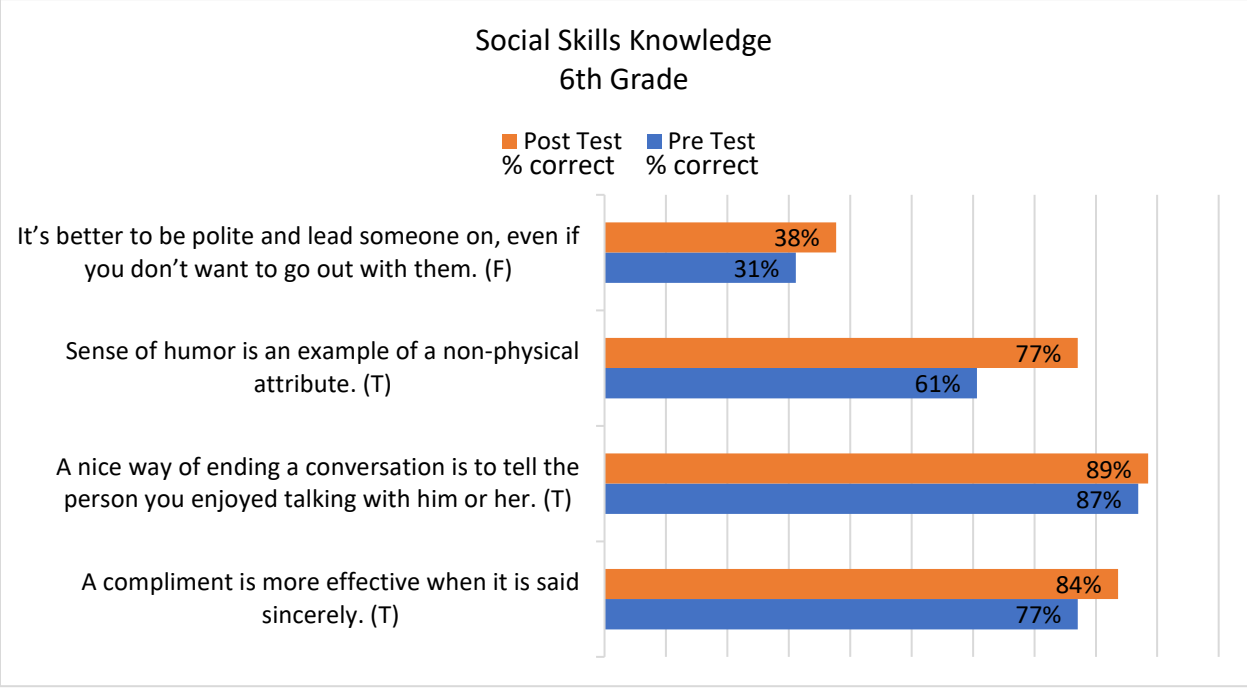
Relaxation Knowledge

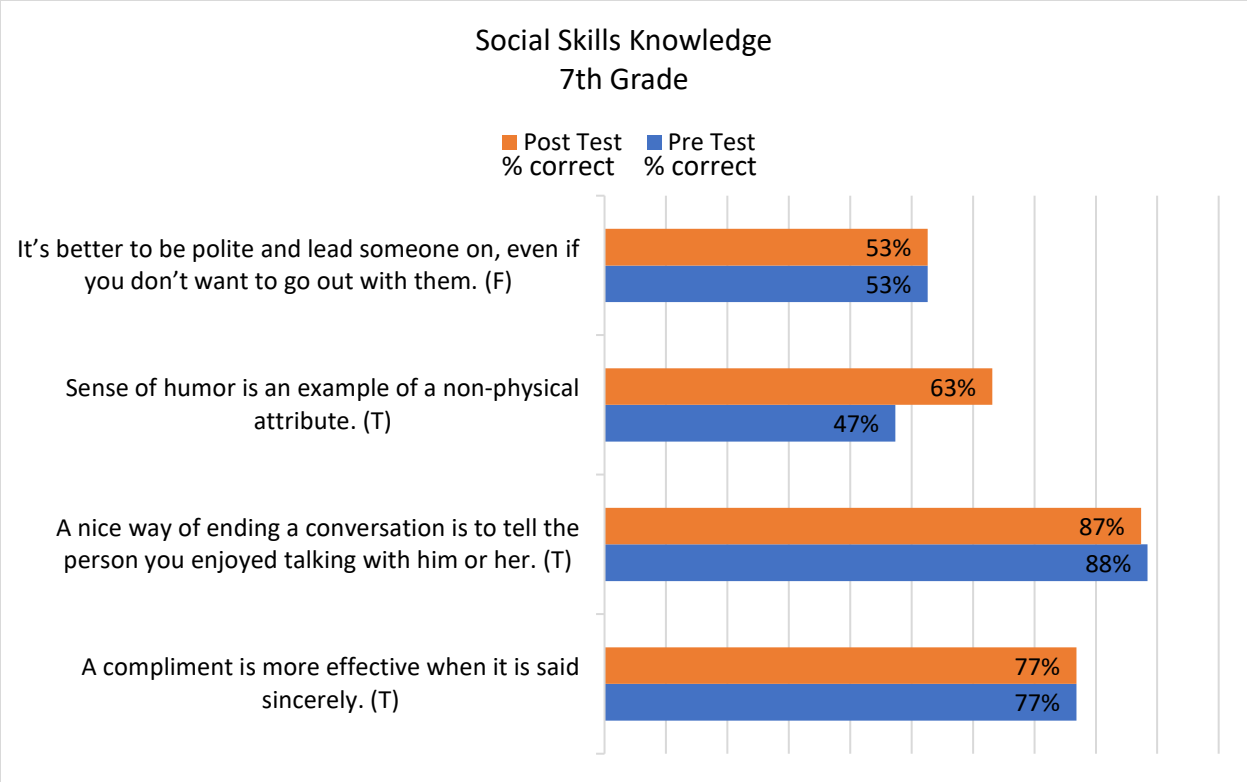


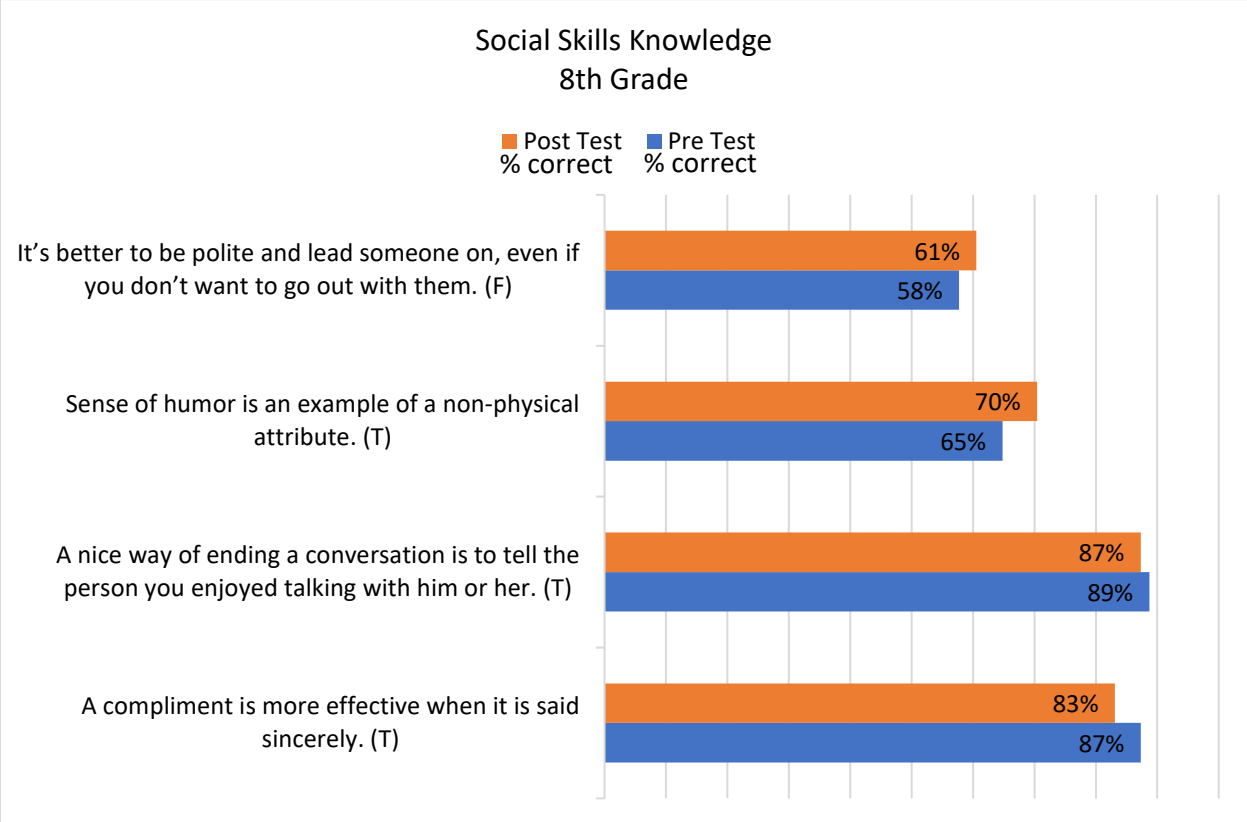




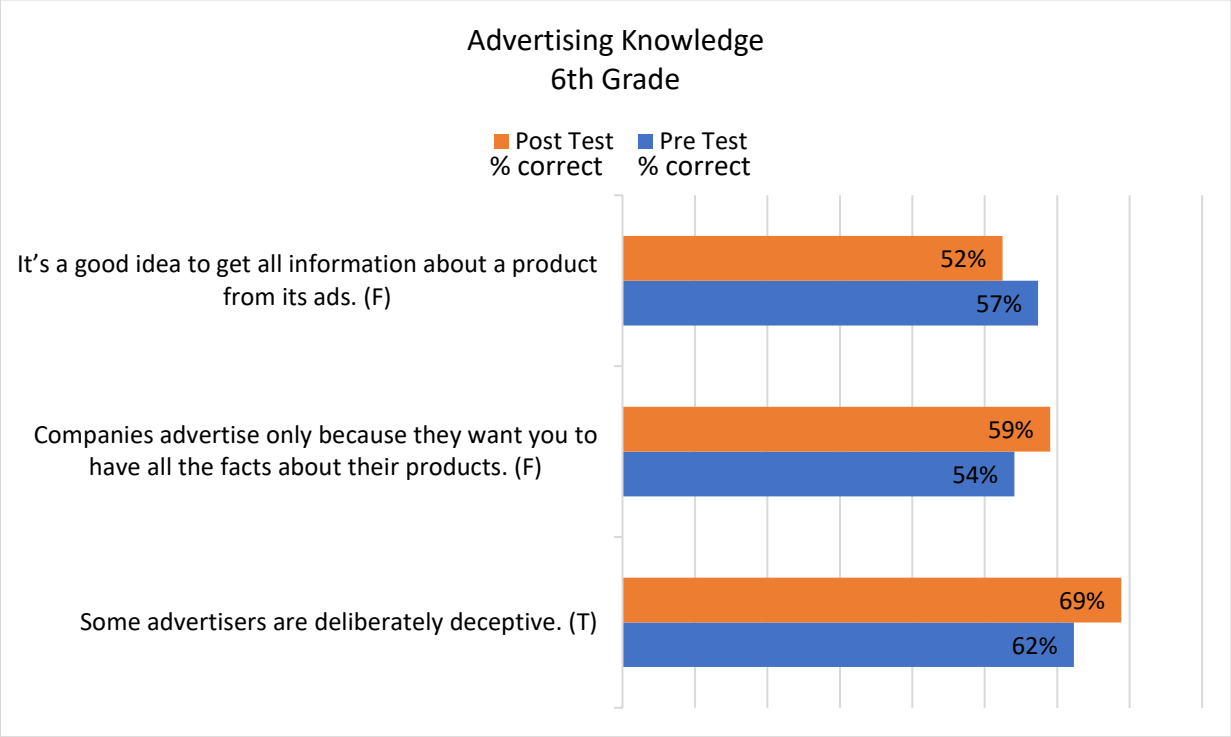
Social Skills Knowledge

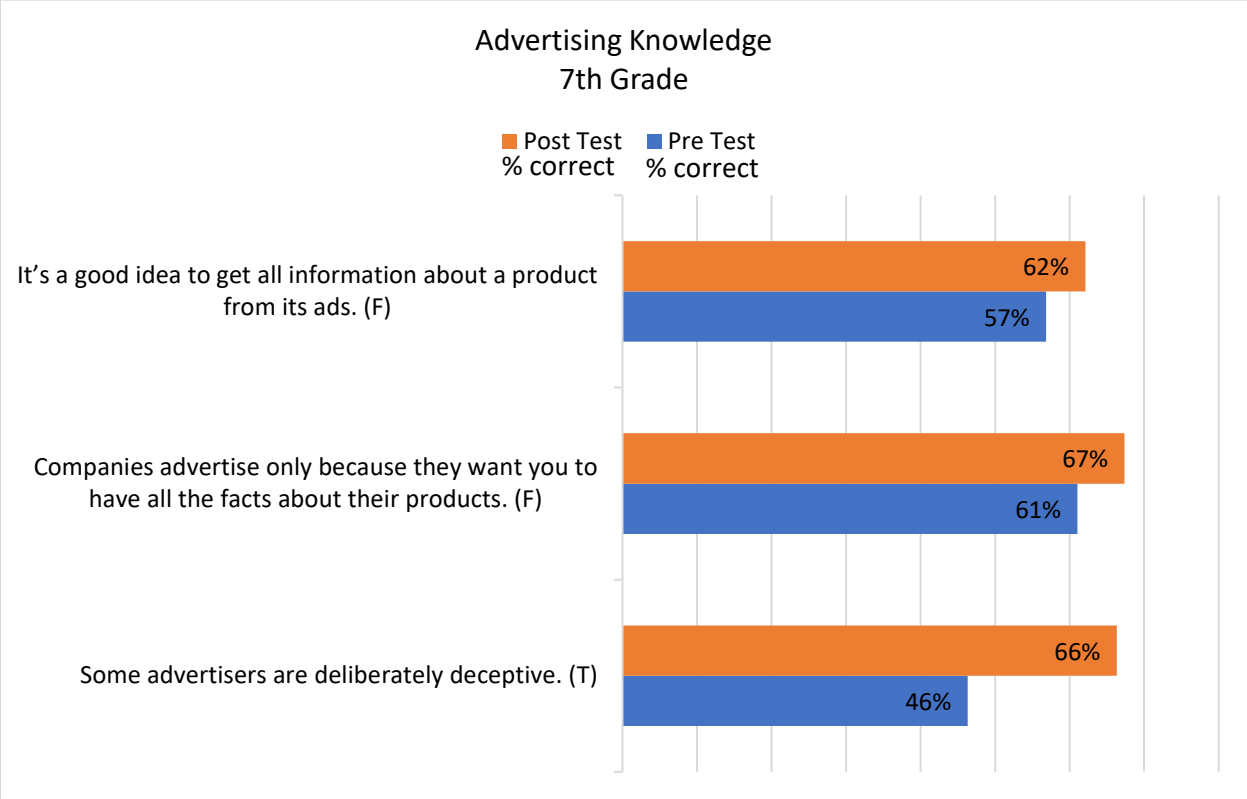


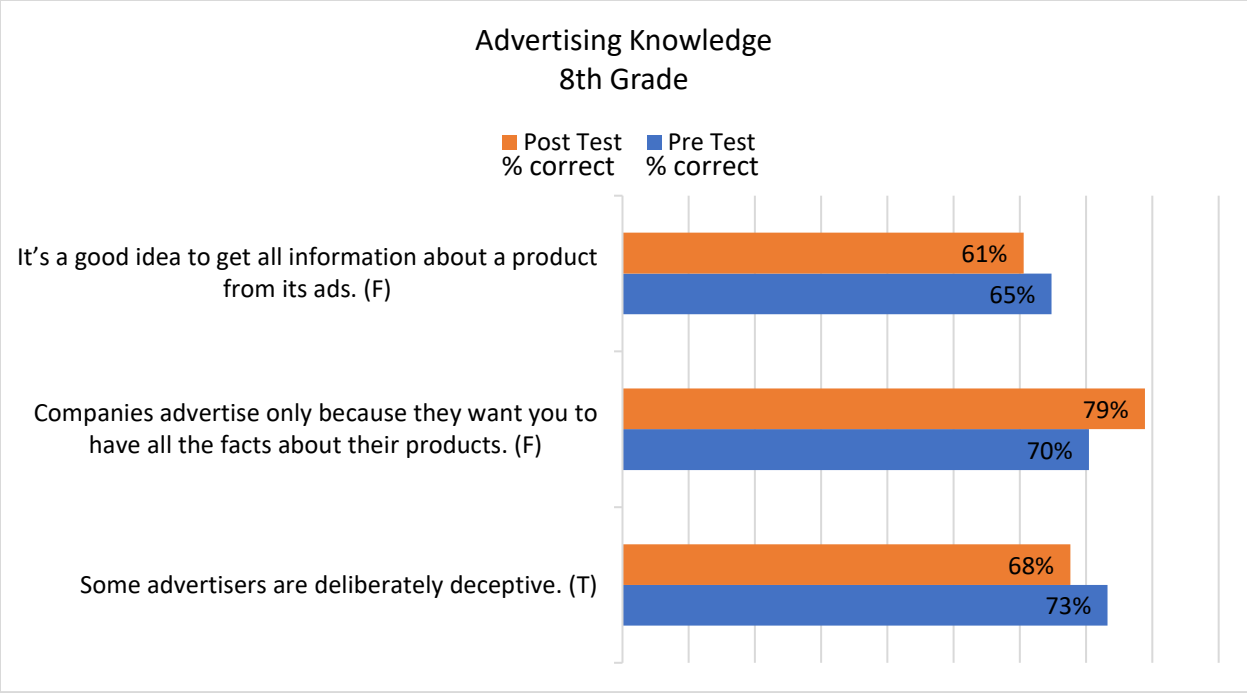

Social Skills Knowledge
7th Grade
Post Test % correct
Pre Test % correct
It's better to be polite and lead someone on, even if you don't want to go out with them. (F)
53%
53%
Sense of humor is an example of a non-physical attribute. (T)
63%
47%
A nice way of ending a conversation is to tell the person you enjoyed talking with him or her. (T)
87%
88%
A compliment is more effective when it is said sincerely. (T)
77%
77%


Social Skills Knowledge
8th Grade
Post Test % correct
Pre Test % correct
It's better to be polite and lead someone on, even if you don't want to go out with them. (F)
61%
58%
Sense of humor is an example of a non-physical attribute. (T)
70%
65%
A nice way of ending a conversation is to tell the person you enjoyed talking with him or her. (T)
87%
89%
A compliment is more effective when it is said sincerely. (T)
83%
87%

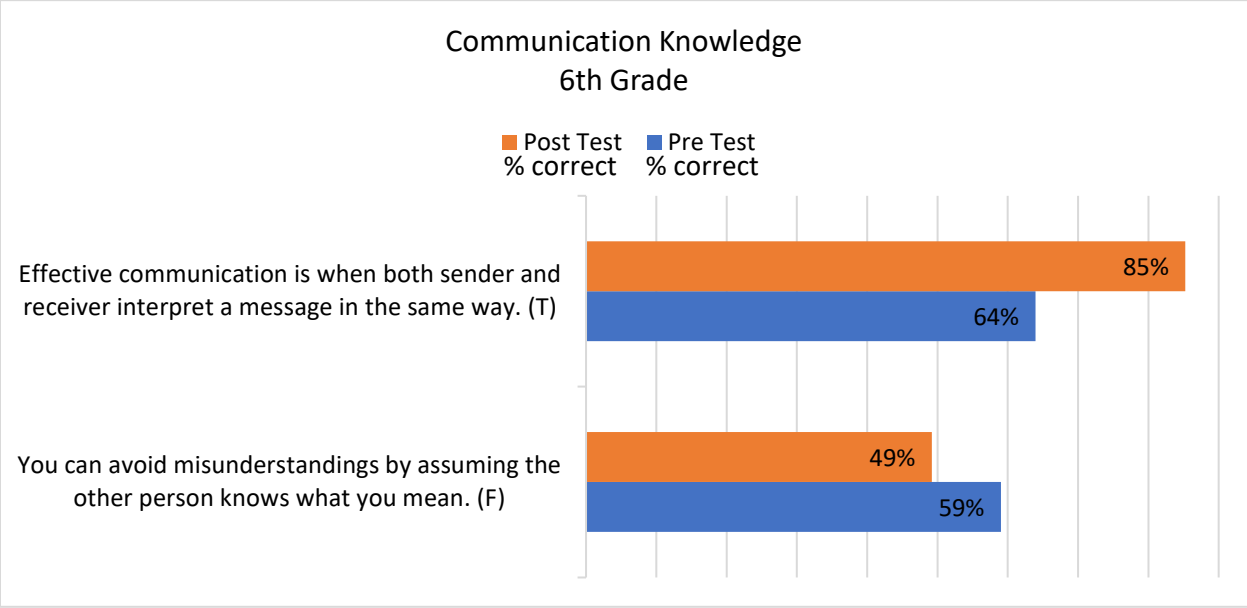
Advertising Knowledge

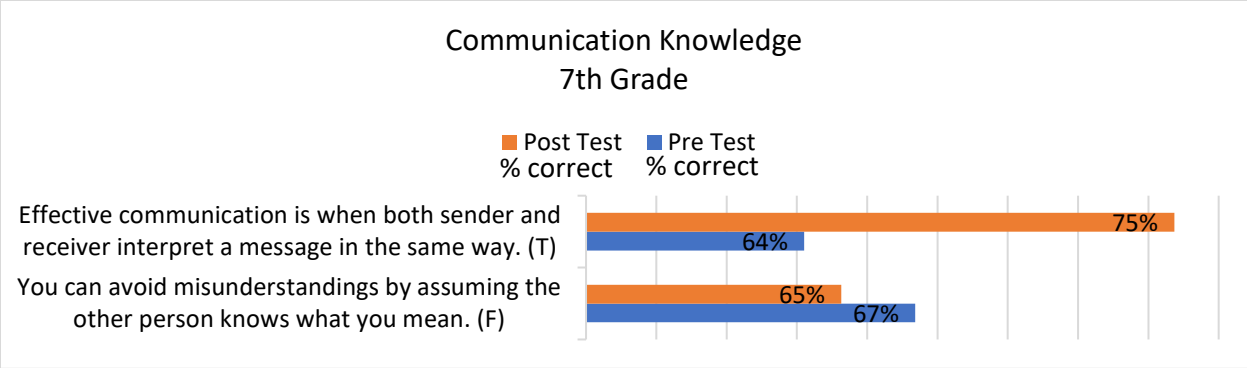


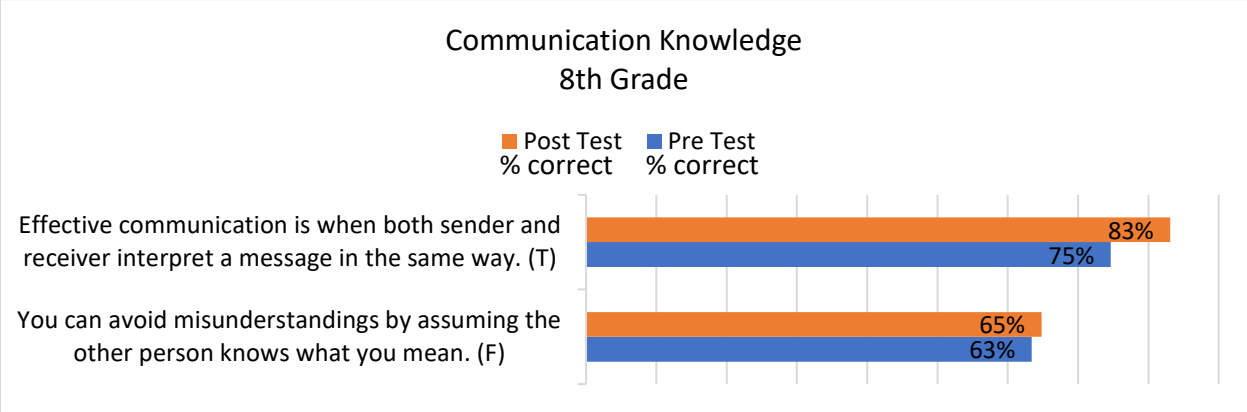




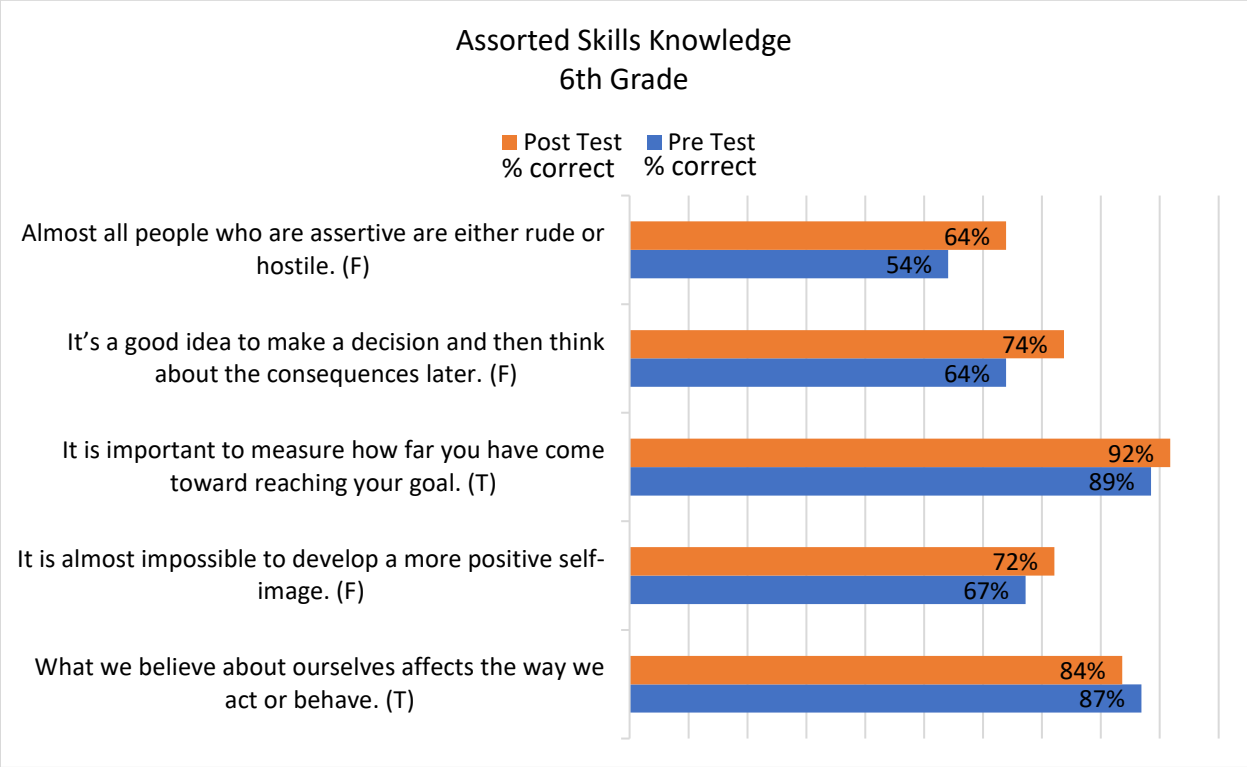
Communication Knowledge

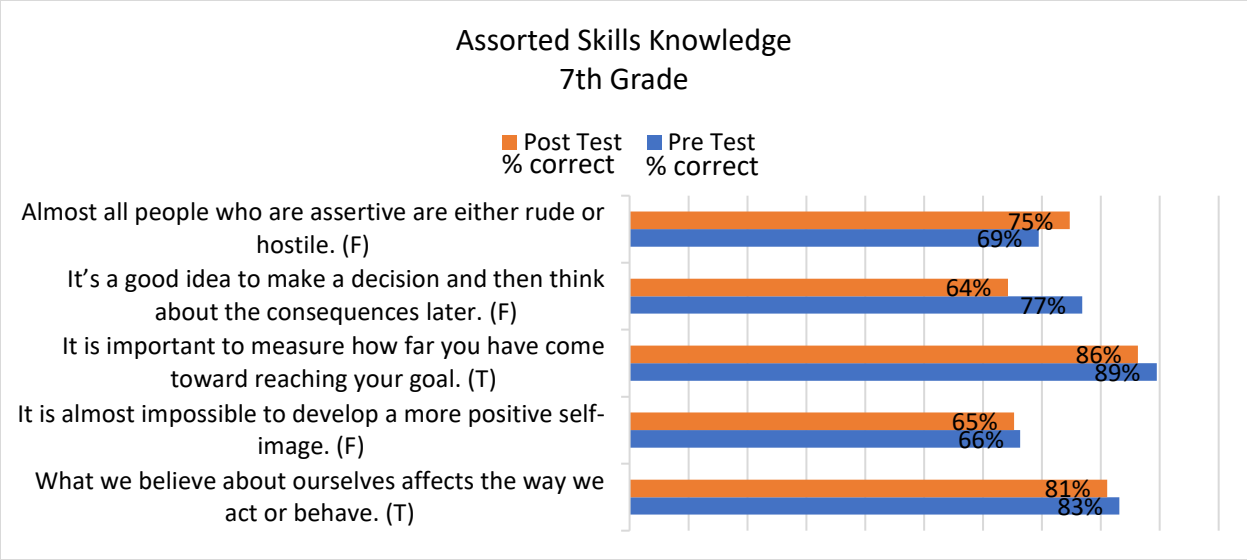


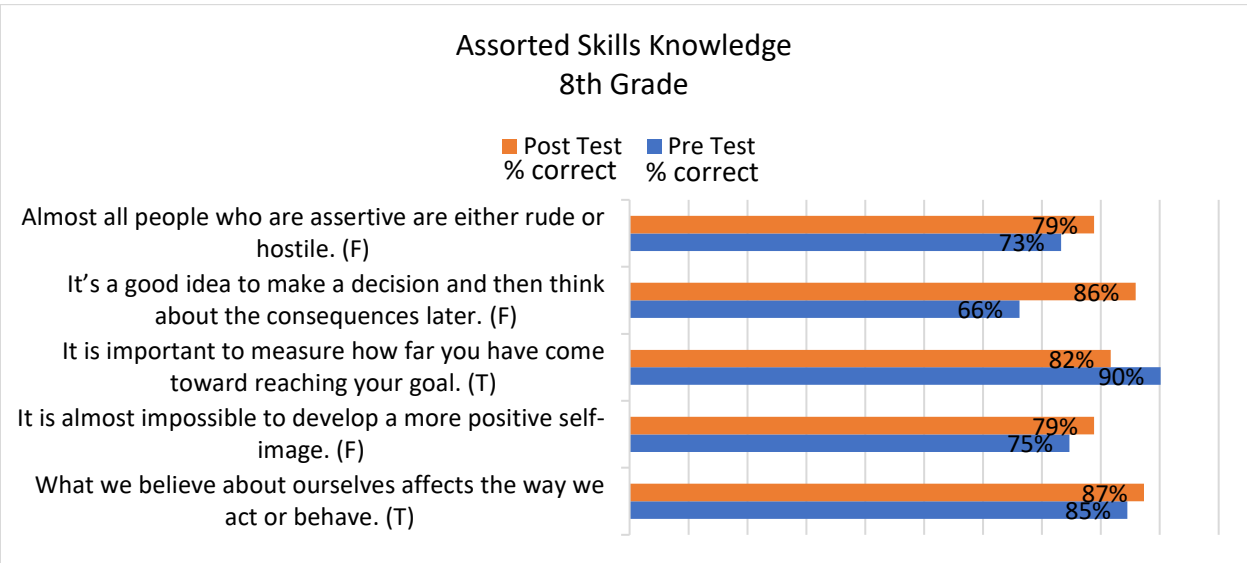




Assorted Skills Knowledge



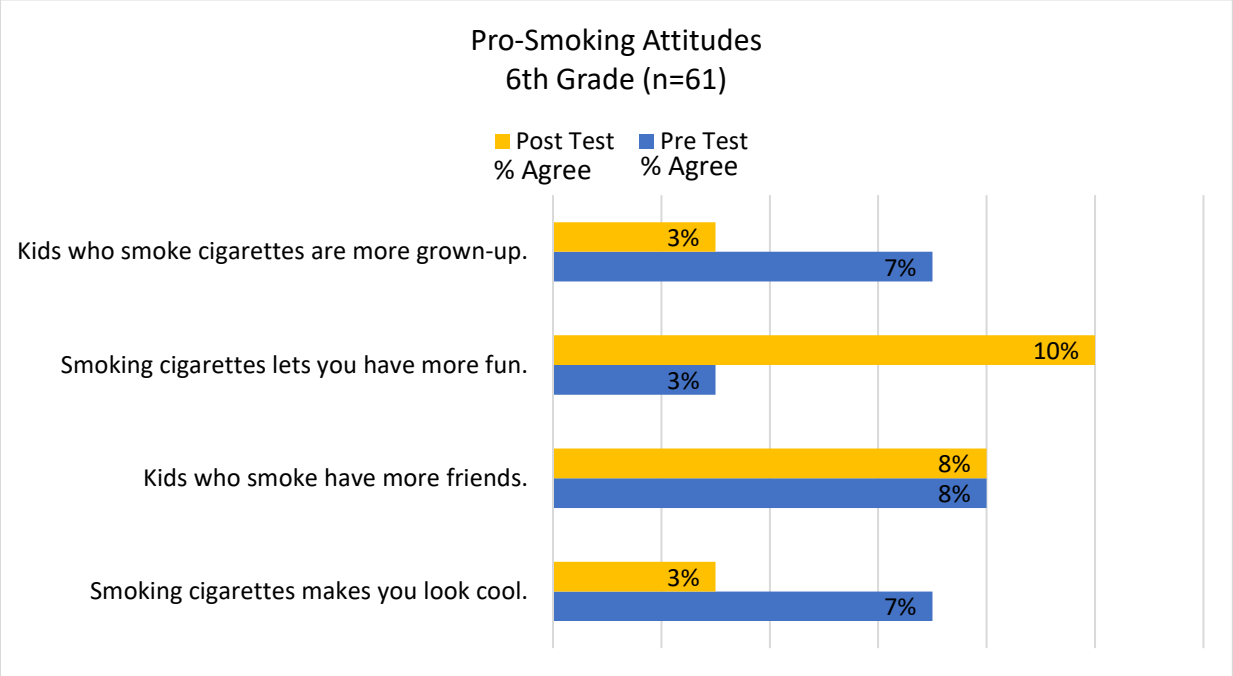

Assorted Skills Knowledge
7th Grade
Post Test % correct
Pre Test % correct
Almost all people who are assertive are either rude or hostile. (F)
It's a good idea to make a decision and then think about the consequences later. (F)
It is important to measure how far you have come toward reaching your goal. (T)
It is almost impossible to develop a more positive self-image. (F)
What we believe about ourselves affects the way we act or behave. (T)
75%
69%
64%
77%
86%
89%
65%
66%
81%
83%

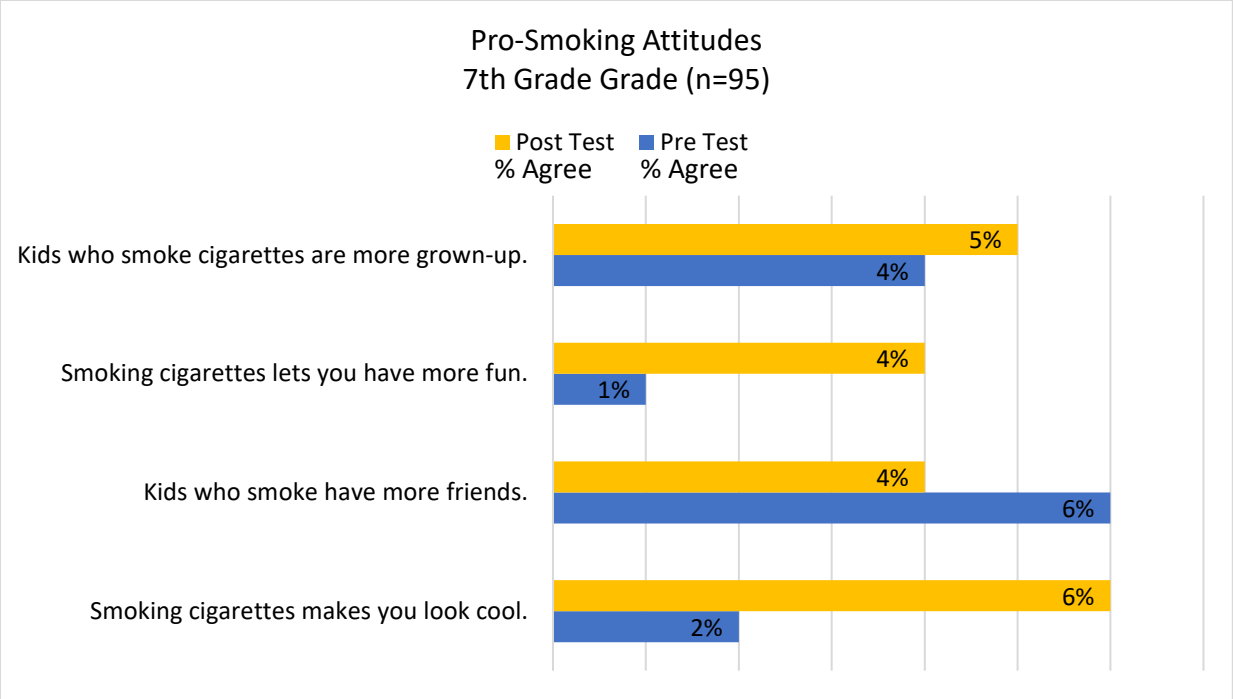

Assorted Skills Knowledge
8th Grade
Post Test % correct
Pre Test % correct
Almost all people who are assertive are either rude or hostile. (F)
It's a good idea to make a decision and then think about the consequences later. (F)
It is important to measure how far you have come toward reaching your goal. (T)
It is almost impossible to develop a more positive self-image. (F)
What we believe about ourselves affects the way we act or behave. (T)
79%
73%
86%
66%
82%
90%
79%
75%
87%
85%

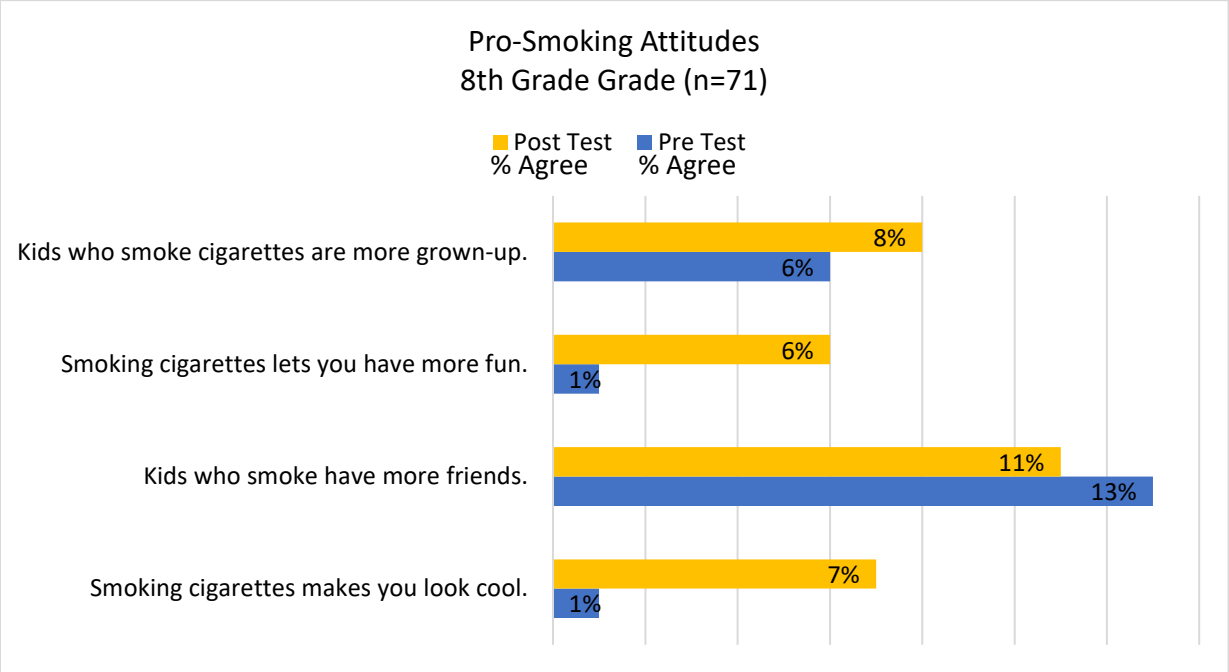
SECTION C

Anti-Substance Use Attitudes. This section assesses negative attitudes regarding alcohol, tobacco, and other drug use. It is preferable for students to ***strongly disagree*** with statements in this section. The following charts represent the % of students that *agree* to the question. **Decreases over time are desirable.**

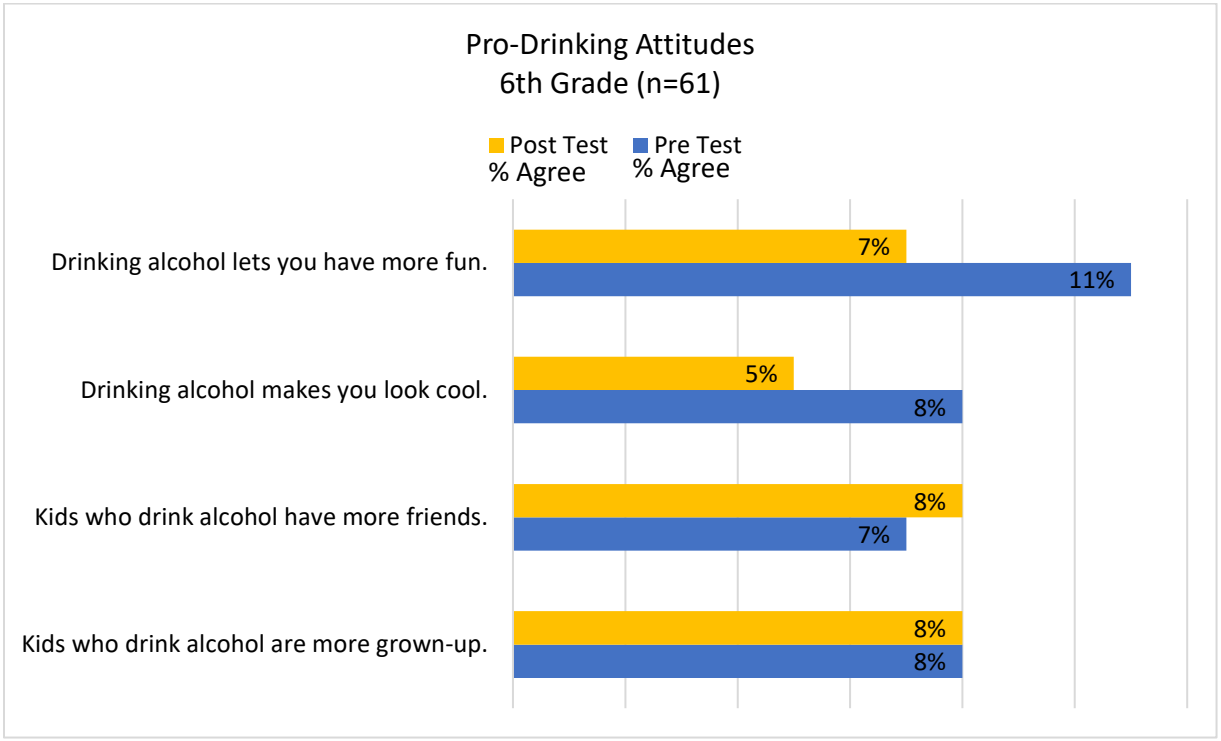
Pro-Smoking Attitudes

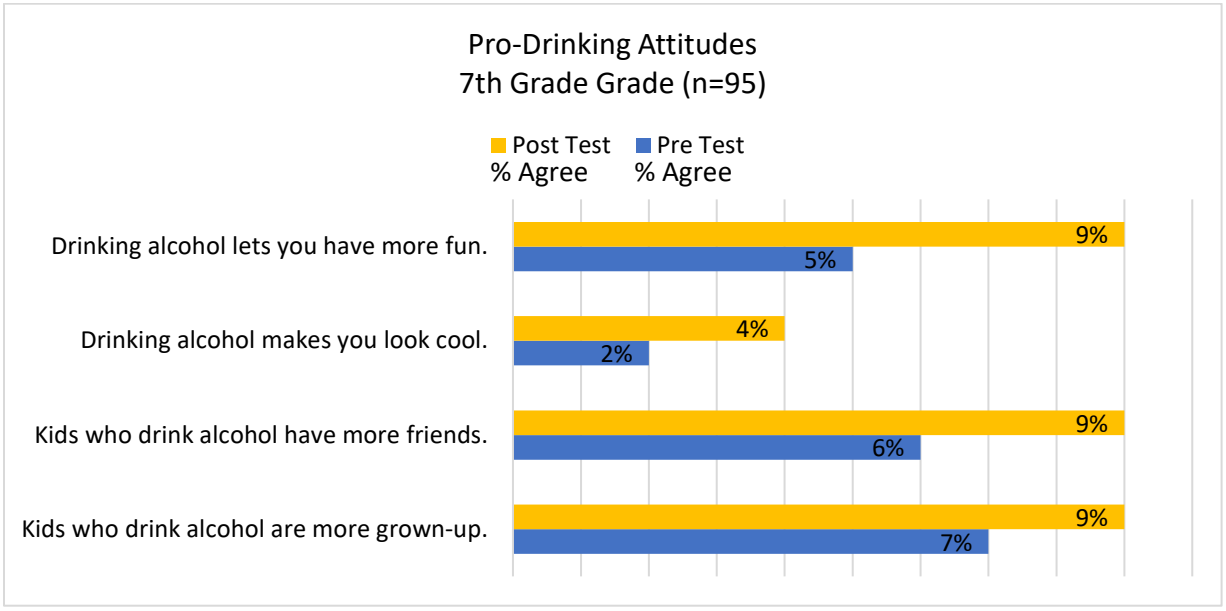


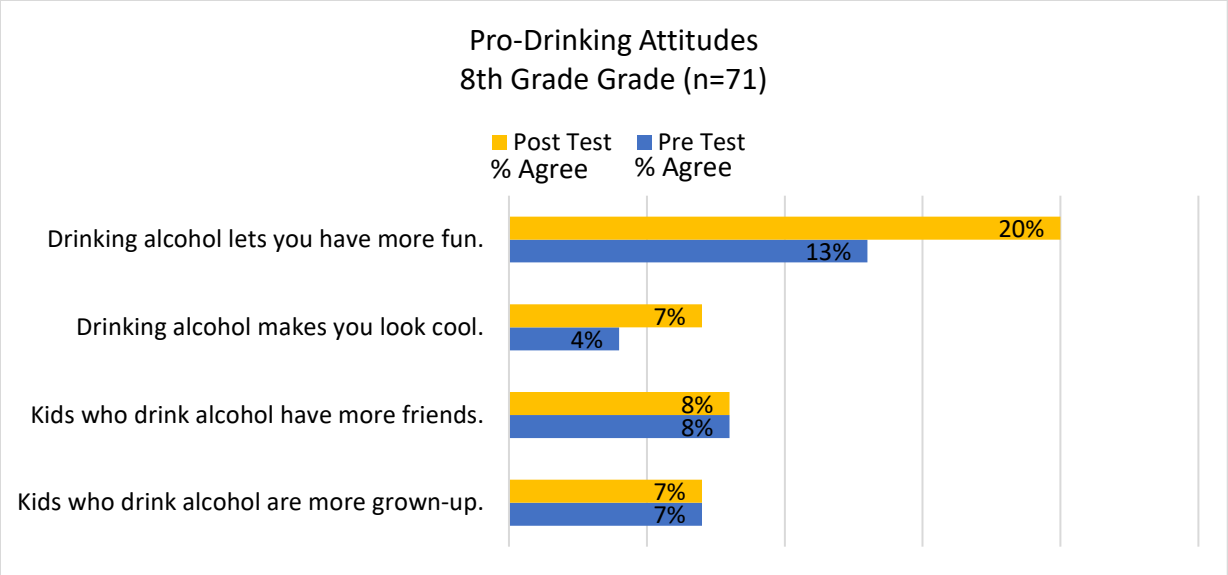

Pro-Smoking Attitudes
7th Grade Grade (n=95)
Post Test % Agree
Pre Test % Agree
Kids who smoke cigarettes are more grown-up.
5%
4%
Smoking cigarettes lets you have more fun.
4%
1%
Kids who smoke have more friends.
4%
6%
Smoking cigarettes makes you look cool.
6%
2%


Pro-Smoking Attitudes
8th Grade Grade (n=71)
Post Test % Agree
Pre Test % Agree
Kids who smoke cigarettes are more grown-up.
8%
6%
Smoking cigarettes lets you have more fun.
6%
1%
Kids who smoke have more friends.
11%
13%
Smoking cigarettes makes you look cool.
7%
1%

Pro-Drinking Attitudes

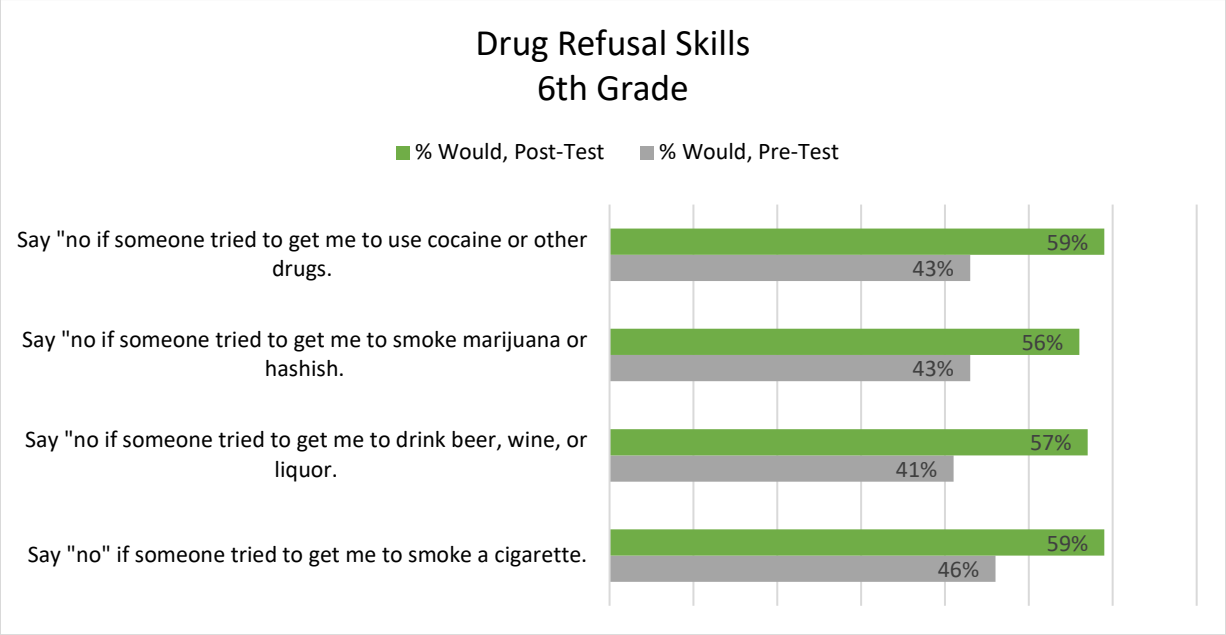


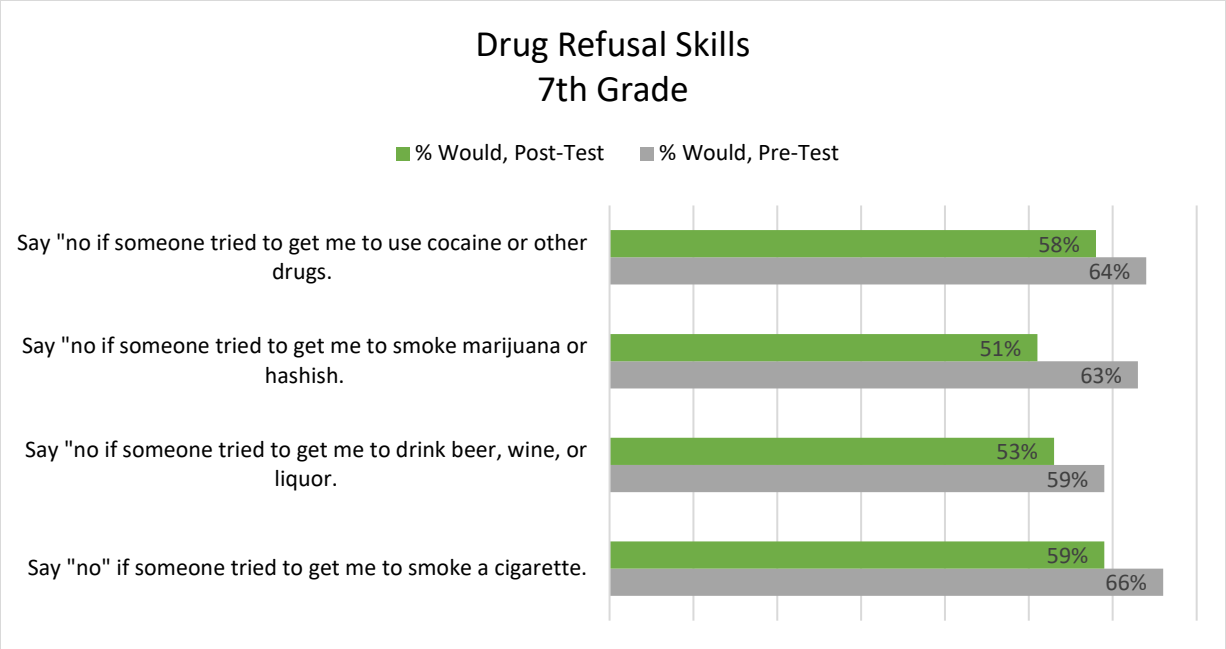


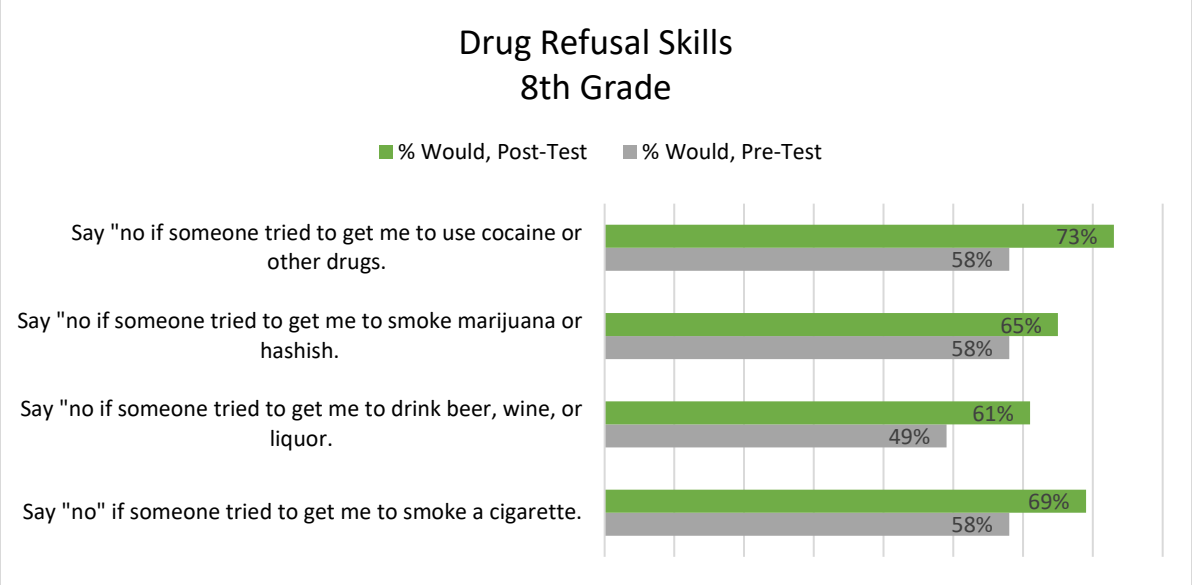


SECTION D

Life Skills. This section assesses several life skills taught in the program, including drug refusal skills, assertiveness skills, relaxation skills, and self-control skills. **Increases over time are desirable.**

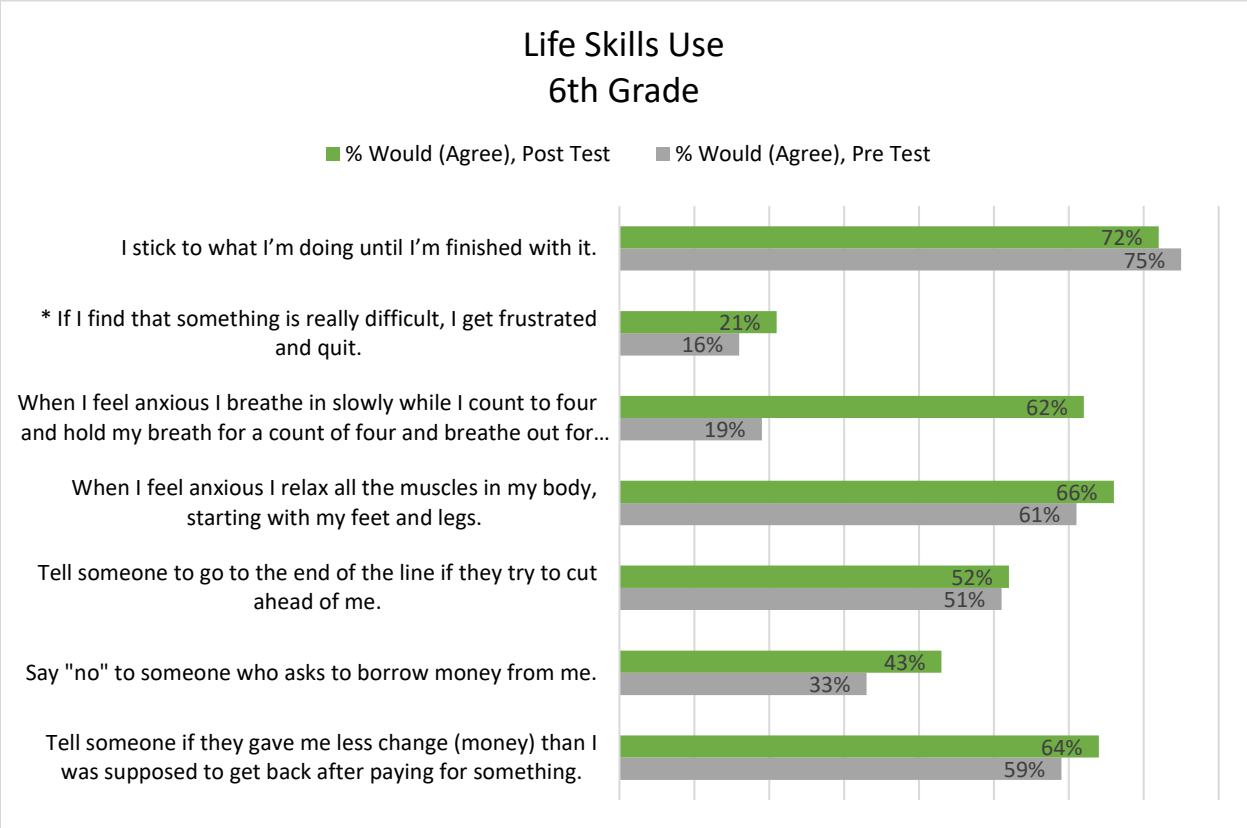


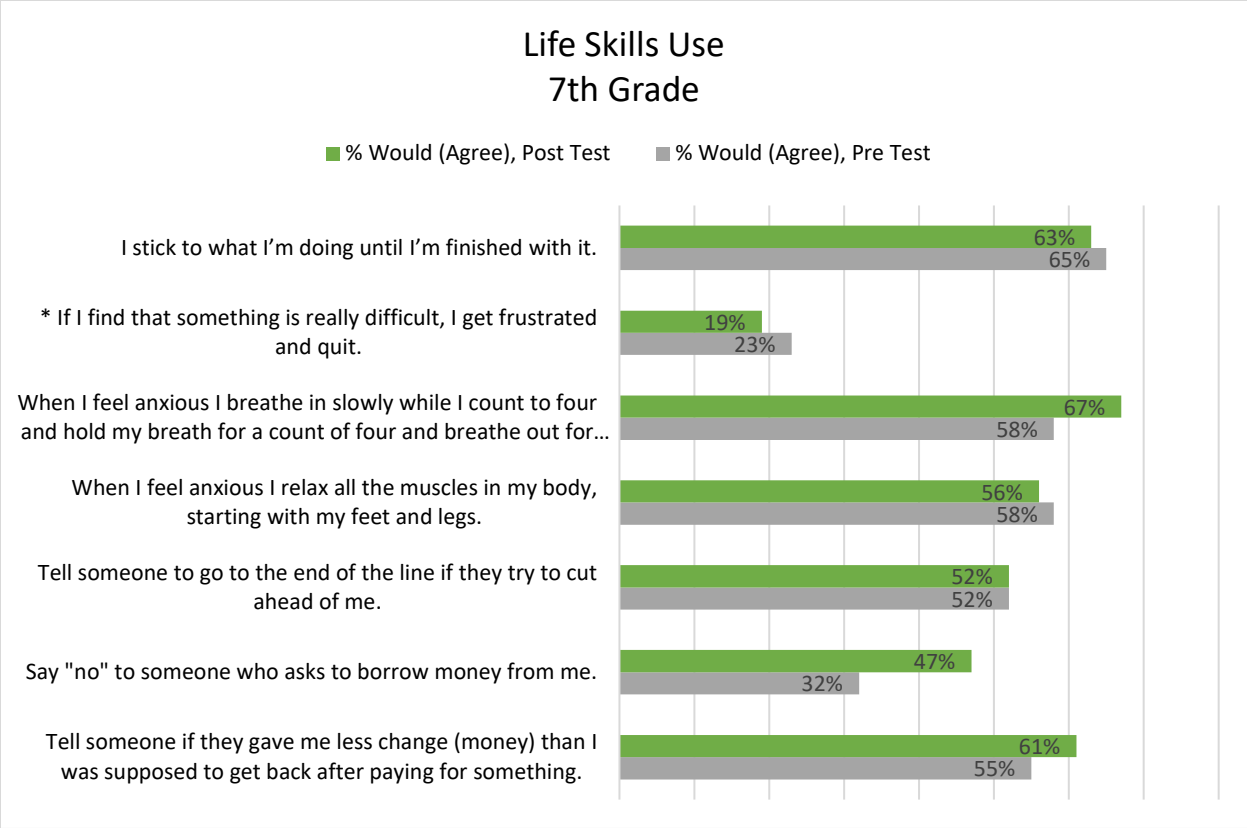

Drug Refusal Skills
7th Grade
% Would, Post-Test
% Would, Pre-Test
Say "no if someone tried to get me to use cocaine or other drugs.
58%
64%
Say "no if someone tried to get me to smoke marijuana or hashish.
51%
63%
Say "no if someone tried to get me to drink beer, wine, or liquor.
53%
59%
Say "no" if someone tried to get me to smoke a cigarette.
59%
66%

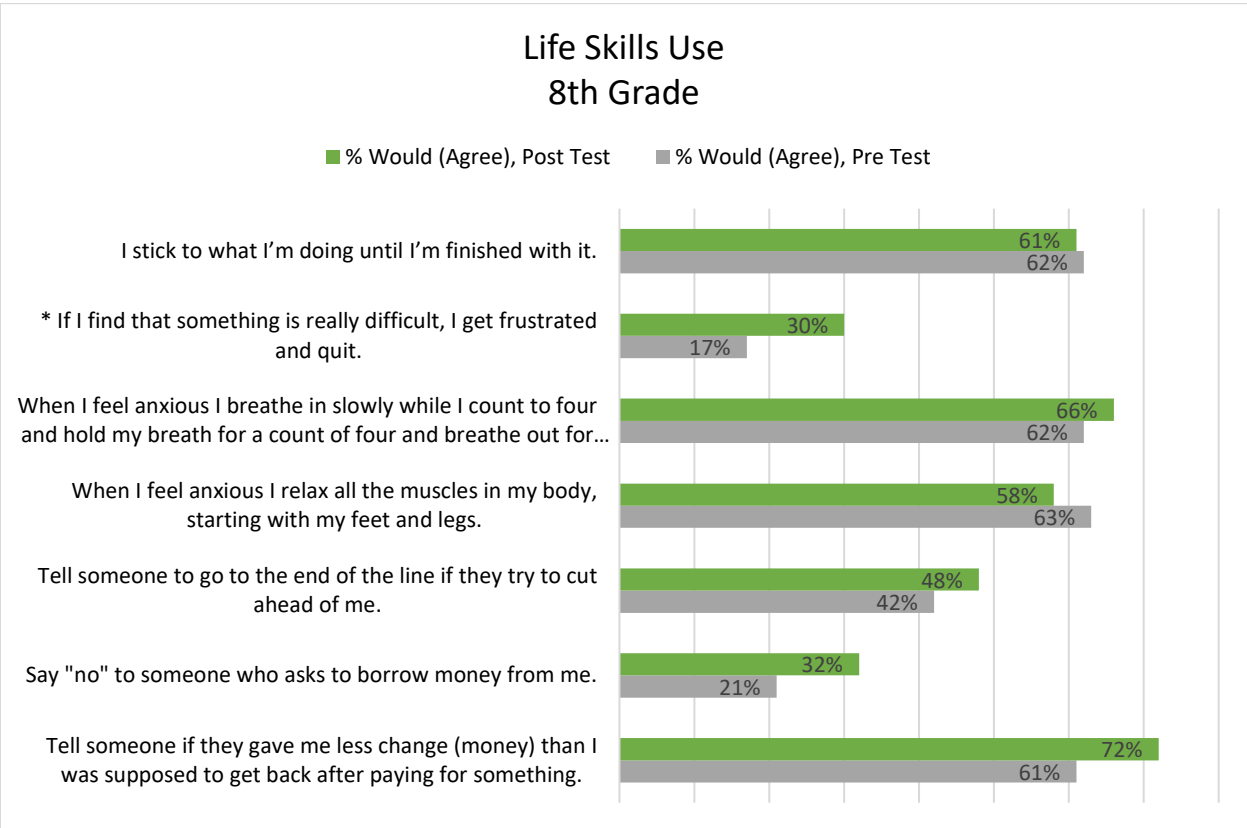

Drug Refusal Skills
8th Grade
% Would, Post-Test
% Would, Pre-Test
Say "no if someone tried to get me to use cocaine or other drugs.
73%
58%
Say "no if someone tried to get me to smoke marijuana or hashish.
65%
58%
Say "no if someone tried to get me to drink beer, wine, or liquor.
61%
49%
Say "no" if someone tried to get me to smoke a cigarette.
69%
58%

Life Skills Use

Increases over time are desirable, *unless otherwise indicated with an asterisk(*).*




Life Skills Use
7th Grade
% Would (Agree), Post Test
% Would (Agree), Pre Test
I stick to what I'm doing until I'm finished with it.
63%
65%
* If I find that something is really difficult, I get frustrated and quit.
19%
23%
When I feel anxious I breathe in slowly while I count to four and hold my breath for a count of four and breathe out for…
67%
58%
When I feel anxious I relax all the muscles in my body, starting with my feet and legs.
56%
58%
Tell someone to go to the end of the line if they try to cut ahead of me.
52%
52%
Say "no" to someone who asks to borrow money from me.
47%
32%
Tell someone if they gave me less change (money) than I was supposed to get back after paying for something.
61%
55%


Life Skills Use
8th Grade
% Would (Agree), Post Test
% Would (Agree), Pre Test
I stick to what I'm doing until I'm finished with it.
61%
62%
* If I find that something is really difficult, I get frustrated and quit.
30%
17%
When I feel anxious I breathe in slowly while I count to four and hold my breath for a count of four and breathe out for…
66%
62%
When I feel anxious I relax all the muscles in my body, starting with my feet and legs.
58%
63%
Tell someone to go to the end of the line if they try to cut ahead of me.
48%
42%
Say "no" to someone who asks to borrow money from me.
32%
21%
Tell someone if they gave me less change (money) than I was supposed to get back after paying for something.
72%
61%

References

MOWBRAY, C. "Fidelity Criteria: Development, Measurement, And Validation". *The American Journal Of Evaluation*, vol 24, no. 3, 2003, pp. 315-340. *Elsevier BV*, doi:10.1016/s1098-2140(03)00057-2.

Stigma & Discrimination Reduction
Fiscal Year 2017-18

"Stigma and Discrimination Reduction" is one of the projects within the Prevention and Early Intervention branch of the Mental Health Services Act. It consists of a workgroup and other volunteers who help provide various activities to reduce the negative perceptions surrounding mental illness through trainings, social media campaigns, speaking engagements, outreach exhibits, events, and more.

In each quarter, from July 2017 to June 2018, the Stigma and Discrimination Reduction activities were as follows:

Quarter 1 (July – September 2017)

Speaking Engagements:

Date	Brave Faces Advocate(s)	Presentation Type	Organizer	Location	Reach
08/09/2017	Chris Paradis and David Wharton	Formal Presentation & Discussion	Stand Against Stigma	The Woodlands	10
09/21/2017	David Martinez and Danielle Brewster	Panel Discussion	Shasta Suicide Prevention Workgroup	UPrep High School	30
09/28/2017	Amanda Flowers Peterson	Destig Intro & Brave Faces Talk	Stand Against Stigma	One Safe Place	18

Events:

Date	Brave Faces Advocate(s)	Event	Organizer	Location	Attendance
09/09/2017	Cherish Padro, Matthew Sprenger and 15 Performers	Hope Is Alive! Open Mic	Stand Against Stigma	Shasta County Arts Council	15 Performers / 75 Attendees
09/30/2017	Mike Skondin, Crystal Johnson, & Laura Burdick	Recovery Happens	Stand Against Stigma & Community Partners	Riverfront Park	200-300

Trainings:

Date	Facilitator	Event	Location	Attendees	Graduates
07/22/2017	Chris Paradis and Amanda Flowers Peterson	Becoming Brave Training	Boggs	9	9

Gallery:

Date	Portraits	Install or Publish	Location	Approx Reach
08/31/2017	Chris B. Susan G., Neil S., Shellissa & Cree, Sarah F., Mike S., Amanda P., Chante, Matthew S.	Install	Shasta County Arts Council	300

Outreach exhibits:

Date	HHSA Staff / Volunteer(s)	Event	Organizer	Location	Attendees Engaged
07/21/2017	Kathleen Deter and Marc Dadigan	Summer of Love Community Benefit Concert	FUMC	First United Methodist Church	20
08/02/2017	Carrie Jo Diamond and Marc Dadigan	Discover Health Fair	Redding Rancheria	Win River	65
08/23/2017	Carrie Jo Diamond	Shasta College Welcome Day	Shasta College	Shasta College	50
09/09/2017	Carrie Jo Diamond	Out of the Darkness Walk	AFSP	Caldwell Park	30
09/15/2017	Carrie Jo Diamond	Latino Independence Day	Shasta County Northern Hispanic Latino Coalition	Anderson River Park	20
09/21/2017	Carrie Jo Diamond	Suicide Prevention Symposium	Shasta Suicide Prevention Workgroup	UPrep High School	15
09/30/2017	Carrie Jo Diamond and Marc Dadigan / CAPCC AmeriCorps Member	Recovery Happens	Stand Against Stigma & Community Partners	Riverfront Park	100

Quarter 2 (October – December 2017)

Speaking Engagements:

Date	Brave Faces Advocate(s)	Presentation Type	Organizer	Location	Reach
11/02/2017	Dee Dee Lahey	Formal Presentation & Discussion	Burney Rotary	Gapettos Pizza Burney	25
11/28/2017	David Wharton and *Aiden Mares**	Formal Presentation & Discussion	Simpson College MFT Class - Ashley Brimager	Simpson College	15
12/07/2017	Matthew Sprenger, Mike Skondin, Danielle Brewster, Cherish Padro	Formal Presentation & Discussion	National University MSW Class - Angelique Gray	National University	10
12/12/2017	Aiden Mares	Destig Intro & Brave Faces Talk	Stand Against Stigma Committee	Redding Library	11

Events:

Date	Brave Faces Advocate(s)	Event	Organizer	Location	Attendance
10/06/2017	David Martinez	Hope Is Alive! Open Mic	Stand Against Stigma	Billy's Café Montgomery Creek	8 Performers / 50 Attendees
12/05/2017	Greg Burgin Jr., Dee Lahey, Crystal Johnson	Facing ACEs Forum	Stand Against Stigma	Redding First United Methodist Church	60

Trainings:

Date	Facilitator	Event	Location	Attendees	Graduates
10/20/2017	Carrie Jo Diamond	Destig 101	Boggs	8	N/A
10/21/2017	Chris Paradis and David Wharton	Becoming Brave	Boggs	10	10

Gallery:

Date	Portraits	Install or Published to Website	Location
10/12/2017	Chante, Greg Burgin Jr.	Install	HHSA Office of the Director
11/03/2017	Amanda Flowers Petersen, Mike Skondin	Install	Shingletown Medical Center
11/15/2017	Neil Shaw, Susan Guiton, Sarah Fabila	Install	Shingletown Medical Center
11/27/2017	Tammy Hebert, Danielle Brewster, Chris Brick, Matthew Sprenger	Install	Mountain Valley Medical Center

Outreach exhibits:

Date	HHSA Staff / Volunteer(s)	Event	Organizer	Location	Attendees Engaged
10/25/2017	Carrie Jo Diamond	Shasta College Human Library	Office of Access & Equity	Shasta College Library	20
11/16/2017	Carrie Jo Diamond	Sam Quinones Opioid Talk	Shasta County & Community Partners	Mercy Oaks	20
11/17/2017	Carrie Jo Diamond	MLK Resource Fair	Shasta County Probation and MLK Center	Redding MLK Center	20

Quarter 3 (January – March 2018)

Speaking Engagements:

Date	Brave Faces Advocate(s)	Presentation Type	Organization	Location	Reach
01/12/2018	David Wharton, Crystal Johnson and Mike Skondin	Formal Presentation & Discussion	Shasta CAPCC	United Way Conference Room	20
01/29/2018	David Martinez, David Wharton, Dee Lahey, Mike Skondin, Susan Power	Formal Presentation & Discussion	Happy Valley Elementary School	Mrs. Westby's P.E. Classes	150
02/01/2018	Crystal Johnson	Destig Intro & Brave Faces Talk	Lions Club	Country Waffle	30
02/09/2018	Ripley Wolf	Destig Intro & Brave Faces Talk	Crisis Residential and Recovery Center	Crisis Residential and Recovery Center	5
02/14/2018	David Wharton, Susan Power and Aiden Mares	Formal Presentation & Discussion	Institute of Technology Nursing Class	IOT	16
02/27/2018	Mike Skondin	Destig Intro & Brave Faces Talk	Project EX	Right Roads Recovery	12
03/12/2018	David Wharton and Aiden Mares	Formal Presentation & Discussion	Shasta College Sociology of Minorities Class	Heather Wylie	24
03/13/2018	*Tony Pisciotta**	Destig Intro & Brave Faces Talk	Stand Against Stigma Committee	Stand Against Stigma	18
03/23/2017	*Denise Green**	Destig Intro & Brave Faces Talk	Crisis Residential and Recovery Center	Crisis Residential and Recovery Center	6
03/30/2018	Susan Power	Formal Presentation & Discussion	MHSA Academy	Hill Country CARE Center	11

Events:

Date	Brave Faces Advocate(s)	Event	Organizer	Location	Attendance
01/12/2018	Brandon Leake and Aiden Mares	Hope Is Alive! Open Mic	Stand Against Stigma	Shasta County Arts Council	15 Performers / 75 Attendees

Trainings:

Date	Facilitator	Event	Organizer	Location	Attendees
01/27/2018	Susan Power and Justin Babb	Becoming Brave	Stand Against Stigma	Boggs	12
03/31/2018	Susan Power and Justin Babb	Becoming Brave	Stand Against Stigma	Boggs	5

Gallery:

Date	Portraits	Install or Published to Website	Requester	Location	Approximate Reach
02/05/2018	Kay Hicks	Install	Shasta County Admin	1450 Court St	500-1000

Outreach exhibits:

Date	HHSA Staff / Volunteer(s)	Event	Organizer	Location	Attendees Engaged
01/06/2018	Carrie Jo Diamond	Redding Health Expo	Shasta County & Community Partners	Mercy Oaks	200
01/20/2018	Carrie Jo Diamond	Multicultural Festival	Multicultural Festival Committee	Central Valley High School	50

Quarter 4 (April – June 2018)

Speaking engagements:

Date	Brave Faces Advocate(s)	Presentation Type	Organization	Location	Reach
04/05/2018	Kristen McChristian and Mike Skondin	Formal Presentation & Discussion	One Safe Place	One Safe Place	12
04/09/2018	Greg Burgin Jr and Aiden Mares	Formal Presentation & Discussion	CHYBA	CHYBA	40
04/25/2018	Crystal Johnson and Aiden Mares	Brave Faces Talk	Crisis Intervention Team Training	McFall Training Room	32
05/17/2018	David Wharton and Aiden Mares	Formal Presentation & Discussion	Uprep AP Psychology Class	Uprep	30
05/22/2018	Susan Power, Matthew Sprenger, Aiden Mares, David Wharton	Formal Presentation & Discussion	Foothill High School Freshman Health Class	Foothill High School	180
05/31/2018	Crystal Johnson and *Michael "Pom" Preston**	Destig Intro & Brave Faces Talk	Project EX - May Grads	Right Roads Redding	12
06/22/2018	Mike Skondin and David Martinez	Formal Presentation & Discussion	RPD Records Techs	RPD	32
06/25/2018	Michael "Pom" Preston	Brave Faces Talk	Wright Education Services	Wright Education Services	20
06/28/2018	Brave Faces Documentary & Info	Brave Faces Documentary & Info	HHSA Clearical All Staff	BOS Chambers	40
06/29/2018	Susan Power	Destig Intro & Brave Faces Talk	CRRC	CRRC	5

Events:

Date	Brave Faces Advocate(s)	Event	Organizer	Location	Attendance
04/13/2018	Brandon Leake	Promotion of DREAMERZ Spoken Word Workshop in Schools	Stand Against Stigma	NVHS, AMS, ANTHS	NVHS 30 / AMS 100 / ANTHS 200
04/13/2018	Brandon Leake	DREAMERZ Workshop	Stand Against Stigma	Anderson Teen Center	11
04/20/2018	Brandon Leake	Hope Is Alive! Open Mic at Anderson Teen Center	Stand Against Stigma	Anderson Teen Center	5 Youth & 1 Adult Performers/15 Attendees
05/05/2018	N/A	11th Annual Minds Matter Mental Health Fair and Music Festival	Stand Against Stigma	Atirum & South Promenade	40 Exhibitors and 500+ Attendees
05/15/2018	Susan Power, David Martinez, Denise Green	Finding Hope In Our Neighbors Quarterly Forum	Stand Against Stigma	McArthur	20
05/18/2018	Kimberly Davis and Michael	Hope Is Alive! Open Mic - Intermountain Edition	Stand Against Stigma	McArthur	8 Performers / 50 Attendees

Trainings:

Date	Facilitator	Event	Organizer	Location	Attendees
05/19/2018	Susan Power	Becoming Brave Training	Stand Against Stigma	Burney - Circle of Friends	8

Outreach exhibits:

Date	HHSA Staff / Volunteer(s)	Event	Organizer	Location	Attendees Engaged
4/7-4/8/2018	Carrie Jo Diamond	2018 Sportsman's Expo		Redding Civic Center	200
04/18/2018	Carrie Jo Diamond	Week of the Young Child	Shasta CAPCC	Mt. Shasta Mall	25
04/20/2018	Carrie Jo Diamond	Win River Earth Day	Redding Rancheria	Win River Casino	50
04/21/2018	Carrie Jo Diamond	Whole Earth and Watershed Festival	WEWF Committee	Redding City Hall	200
04/25/2018	Carrie Jo Diamond	Take Back the Night	Shasta College CARES Program	Shasta College	50
05/05/2018	Amy Sturgeon and HHSA Staff	11th Annual Minds Matter Mental Health Fair and Music Festival	Stand Against Stigma Committee	Atirum & South Promenade	100
06/10/2018	Volunteers	Running Brave - The Race to End Suicide	Alicia Cretaro	Riverfront Park	30
06/13/2018	Carrie Jo Diamond	Shasta County Employee Appreciation Day	Shasta County	Redding Civic Center	50

Suicide Prevention Report

Fiscal Year 17/18

Suicide Prevention is one of the Shasta County programs listed 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. An HHSA Suicide Prevention website is utilized to promote these ideas and keep the community up to date on any meetings, trainings or outreach events.

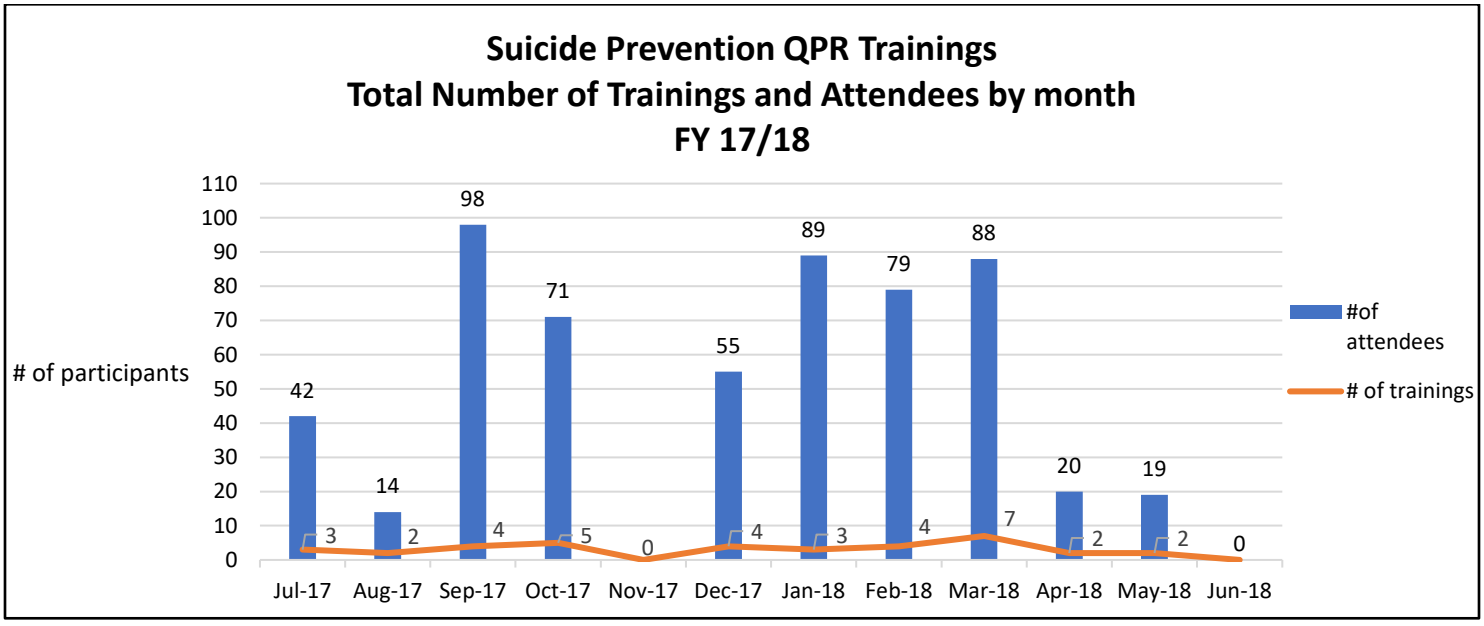
Suicide Prevention's newest prevention campaign, Captain Awesome, was created in 2017. The campaign is directed towards men to overcome barriers to expressing their emotions, and being vulnerable. Captain Awesome features local men demystifying mental health and depression and giving men the tools to maintain their mental and emotional health.

"More than Sad" is an evidence-based educational program developed by the American Foundation for Suicide Prevention to educate students grades 8-12 about depression and anxiety. A subcommittee of the Shasta Suicide Prevention Workgroup was created to implement the program 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.

Several workgroup members meet quarterly in collaboration with the Stand Against Stigma program to educate the local media on the importance of appropriate and responsible reporting of suicide. The suicide prevention liaison continues to work with the Stand Against Stigma program in community outreach and cross-promotion of program events. Health Fair participation has assisted with the awareness of Suicide Prevention and increasing community access to local resources.

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. This training protocol provides the individual with the tools to respond to an individual in suicide crisis. QPR suicide prevention trainings are given to groups or organizations in the county upon request.

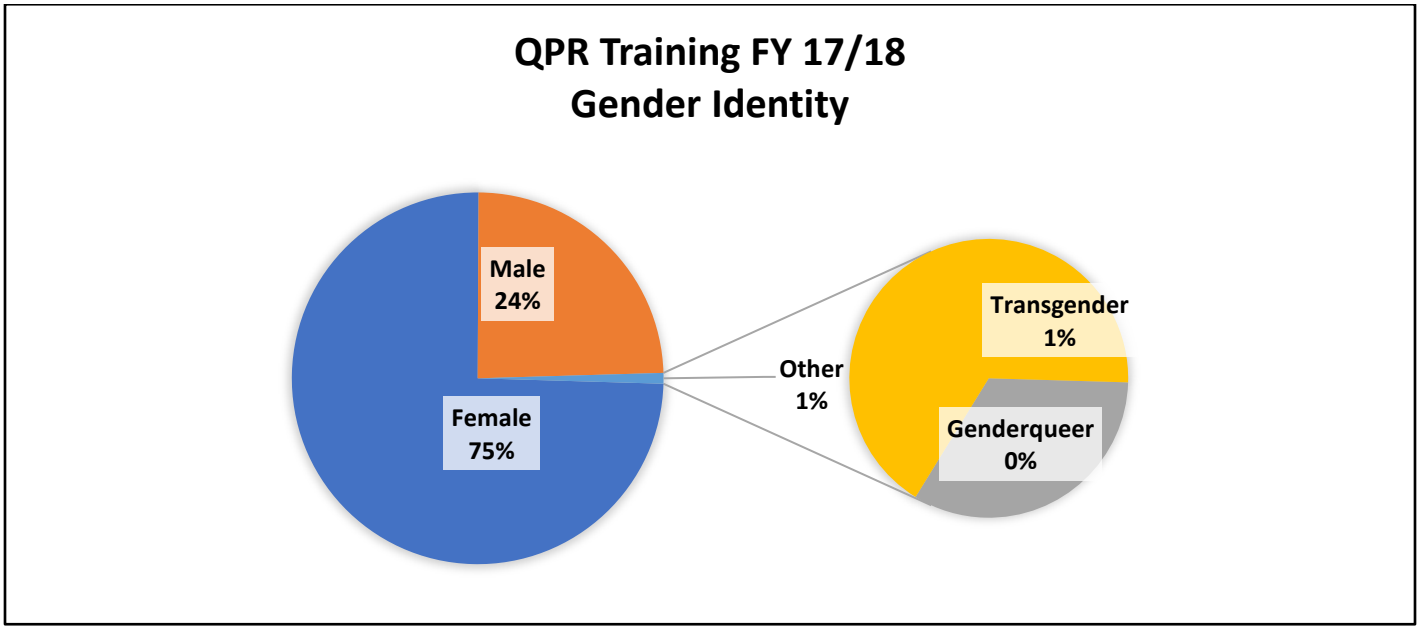
In Fiscal Year 17/18, there were 36 QPR trainings with 575 attendees.

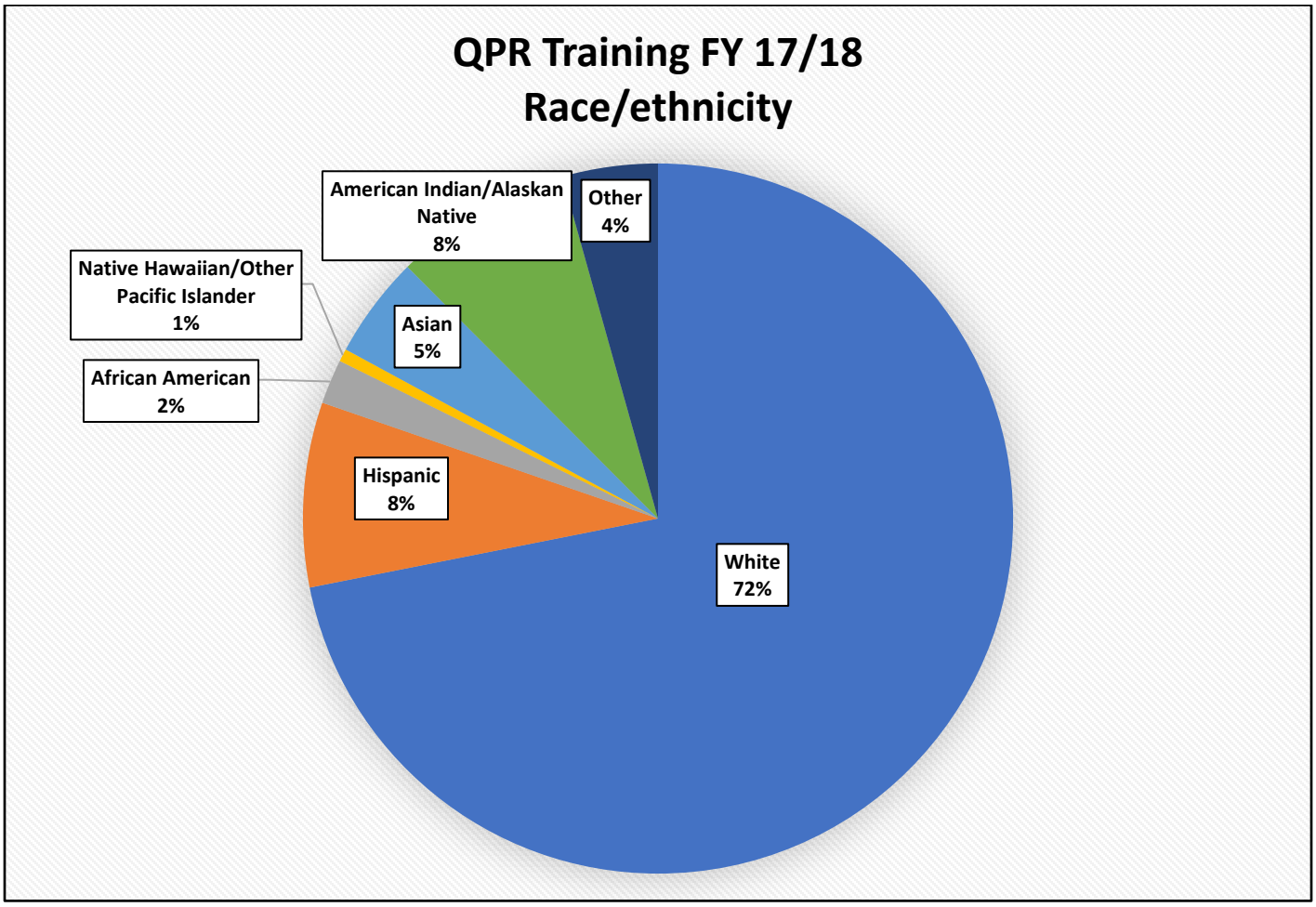


Suicide Prevention – FY 17/18

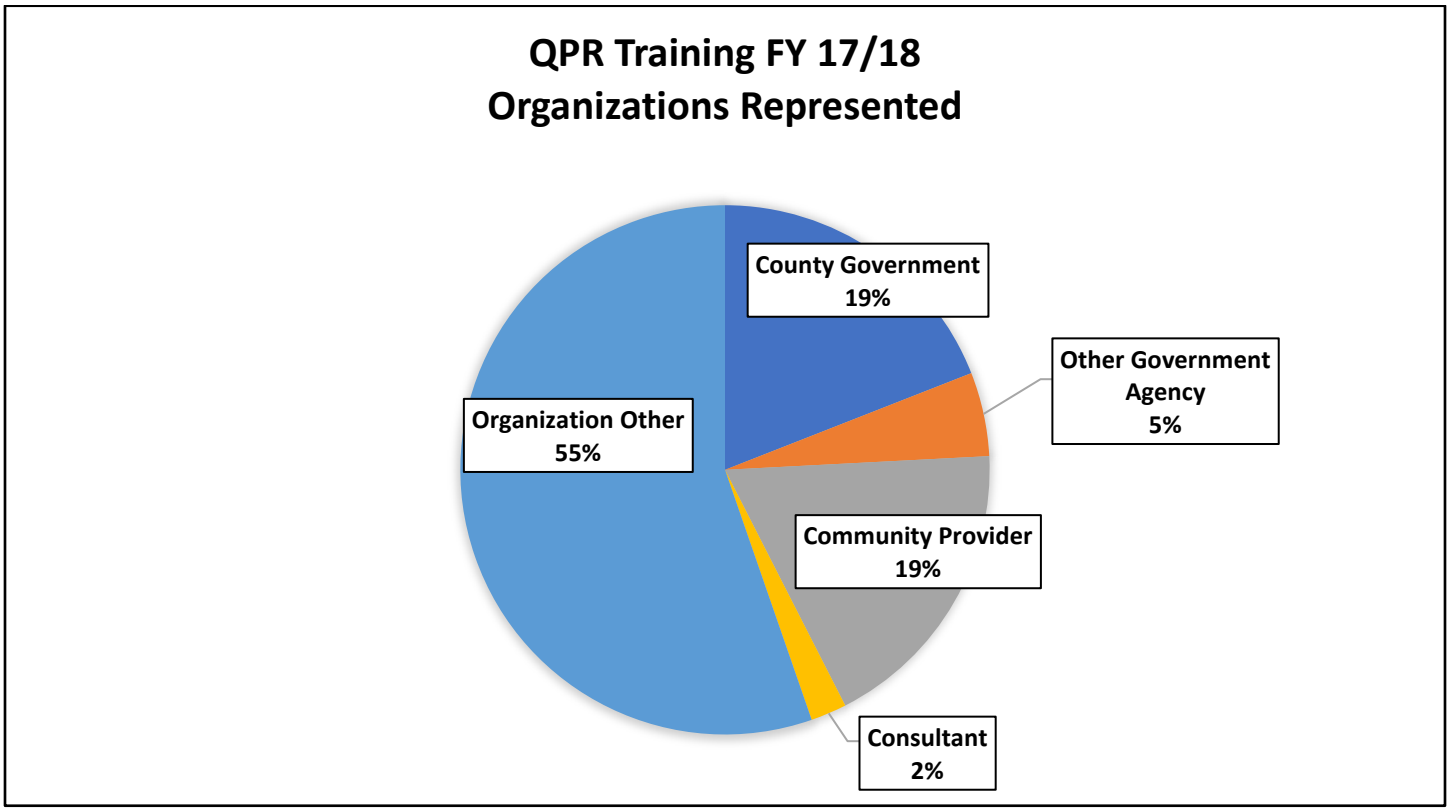
Demographics on those who attended QPR trainings

All demographics are displayed as a percentage of those who chose 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).



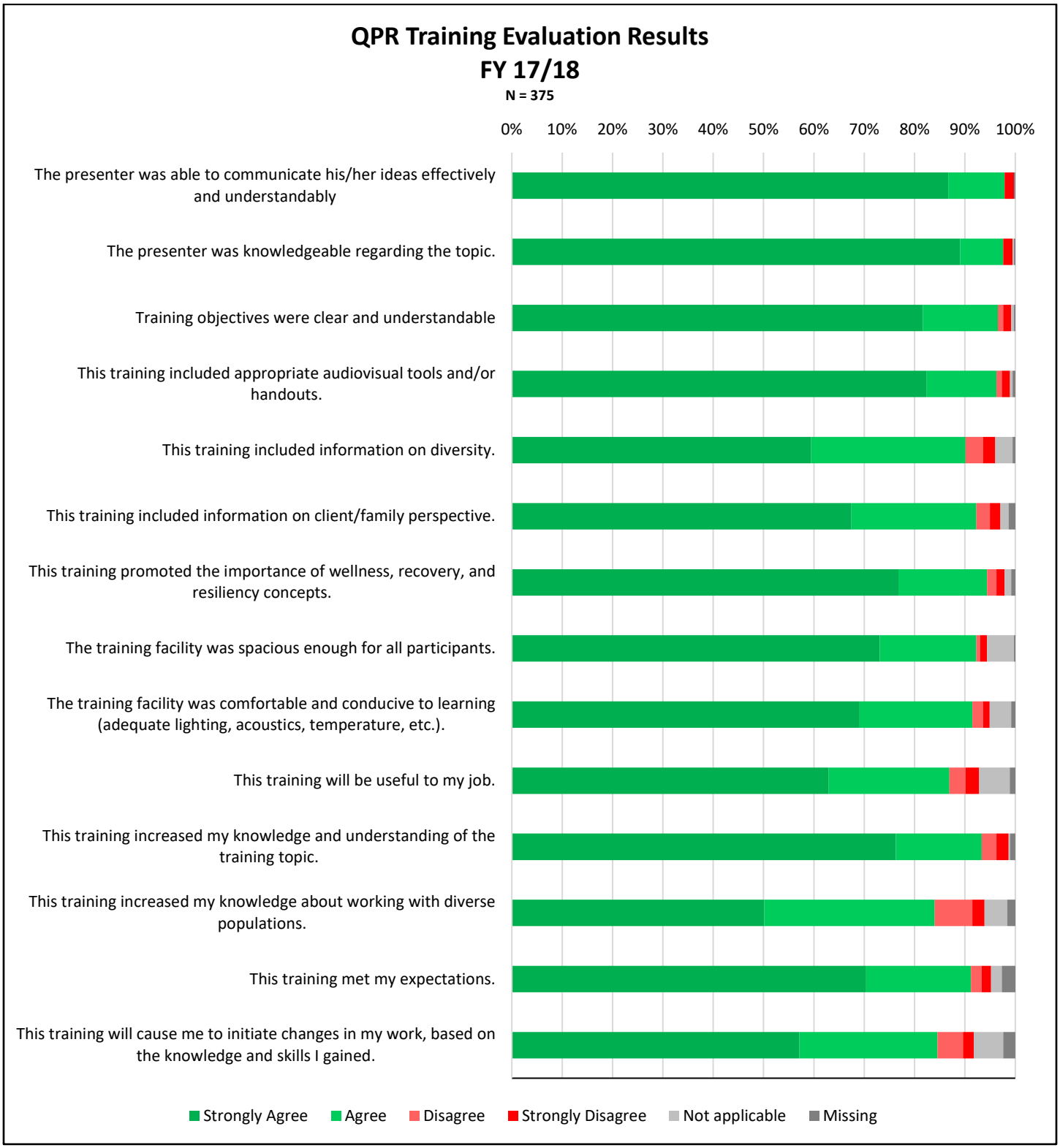


Participants were asked what best describes the organization they represented at this training. The results are shown below:



During all Question, Persuade, Refer (QPR) Suicide Prevention trainings, attendees receive a Post Training Questionnaire. This questionnaire is used to give feedback to the trainer as a way of evaluating the training. Questionnaires also identify content that might be missing or trainings that might be valuable.

The three objectives 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.
The post-evaluations from Fiscal Year 17/18 are shown below:



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 a similar response have been listed.

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

Barriers
None **(71)**
My own comfort **(17)**
The barrier of time **(9)**
Having the correct relationship to implement this **(8)**
Personal beliefs **(5)**
Feeling like you can't help **(2)**
A huge barrier is lack of referrals and coordination of services **(2)**
Mental illnesses other than depression **(2)**

What were the strengths of this training?

Strengths
Excellent speaker and personable **(96)**
Thorough and knowledgeable on the subject **(37)**
Resources, phone, web, etc **(26)**
Real experience **(23)**
Very interesting and easy to understand and learn **(9)**
Informative, relatable, and engaging lectures and slides **(8)**
What to say, when to say it, and that you should say something **(6)**
Myths and facts were very educational **(6)**
Good, usable information **(2)**

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

Suggestions
None **(64)**
You did a great job! **(26)**
More time to go over same amount of material **(10)**
A video instead of just powerpoint **(6)**
Maybe a practice dialogue **(3)**
More interactive **(2)**
More information on diversity **(2)**
Maybe a quick break at one hour **(2)**

What additional trainings would you like to see?

Additional trainings
None **(37)**
Not sure **(9)**
ACE **(8)**
More trainings like this in schools for children and the community **(4)**
More role playing **(4)**
More mental health **(4)**
What to do after a crisis **(3)**
Resources for drug addiction and homelessness **(2)**
Training for healthcare providers and workers **(2)**

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

Format
No (**81)**
N/A (**21)**
Online webinar to review later **(6)**
Video **(5)**

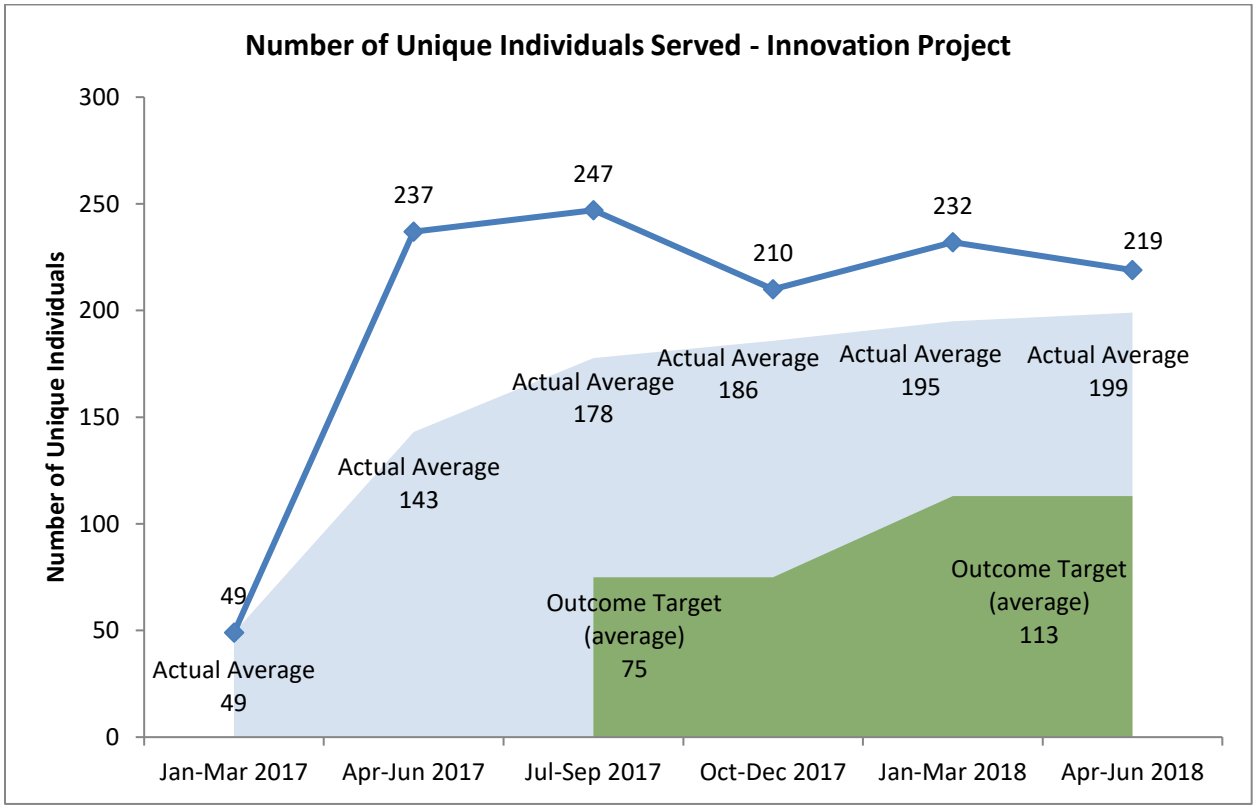
Do you have any other comments or suggestions?

Comments
Great presentation **(58)**
No **(56)**
This was personal knowledge for me **(3)**
Keep giving hope to the community **(2)**

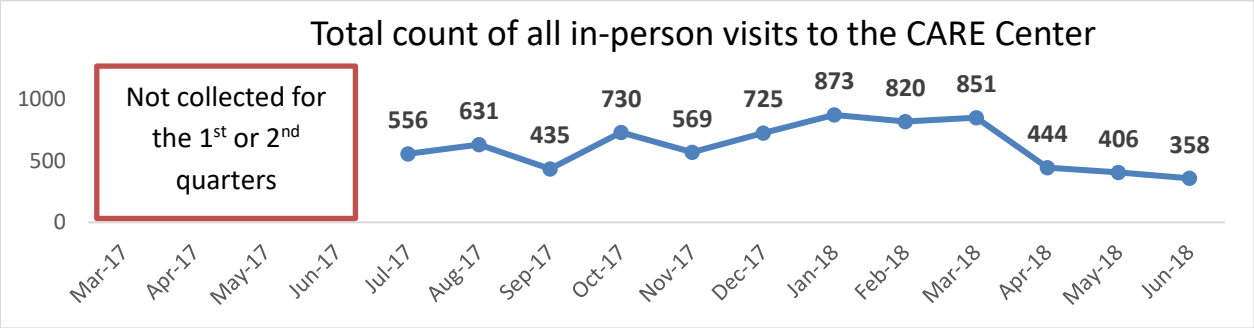
CARE Center Activity Report – Innovation Project
January 2017 through June 2018

To determine if providing access to mental health services after traditional office hours will improve access to services, reduce mental health crisis (including trips to the hospital emergency departments) and bridge service gaps, the Shasta County Health and Human Services Agency has contracted with Hill County Health and Wellness Center to provide new and expanded mental health services at the Counseling and Recovery Engagement (CARE) Center. Funding is provided through the Mental Health Services Act (MHSA) for the Innovation Project portion of this center. The CARE Center contract was approved as of January 2017, and they officially opened for business on March 12, 2017. For this report, data was gathered using the CARE Center Quarterly Progress Reports for January 2017 through June 2018. Please note that due to the CARE Center not actually opening for business until early March 2017, the first quarter reflects less than one month of data. Additionally, there are several measures where their data systems and/or electronic health record were in process, or where methodology changed, so they could not be tracked. As of the Oct-Dec 2017 quarter, all measures are now tracked and reported on, although further refinement of the data collection is still underway for some measures.

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



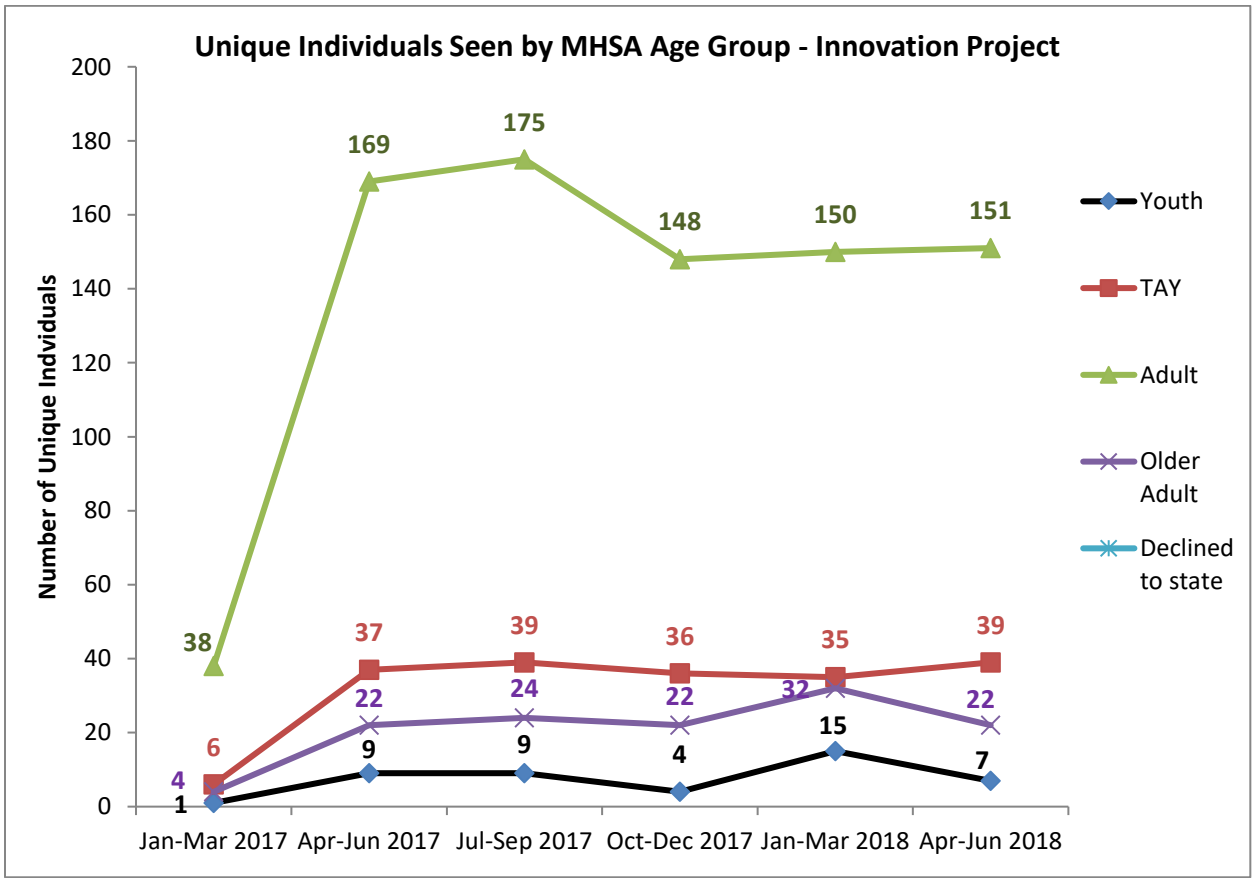
Due to much higher utilization of the Care Center than anticipated, the number of in-person visits per month are being tracked as of July 2017. Please note that most clients visit more than once - this is not an unduplicated person count. Refinement of the counting process occurred in the Apr-Jun 2018 quarter, with individuals visiting for meetings or standing workgroups being excluded, and all phone calls being tallied separately.



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

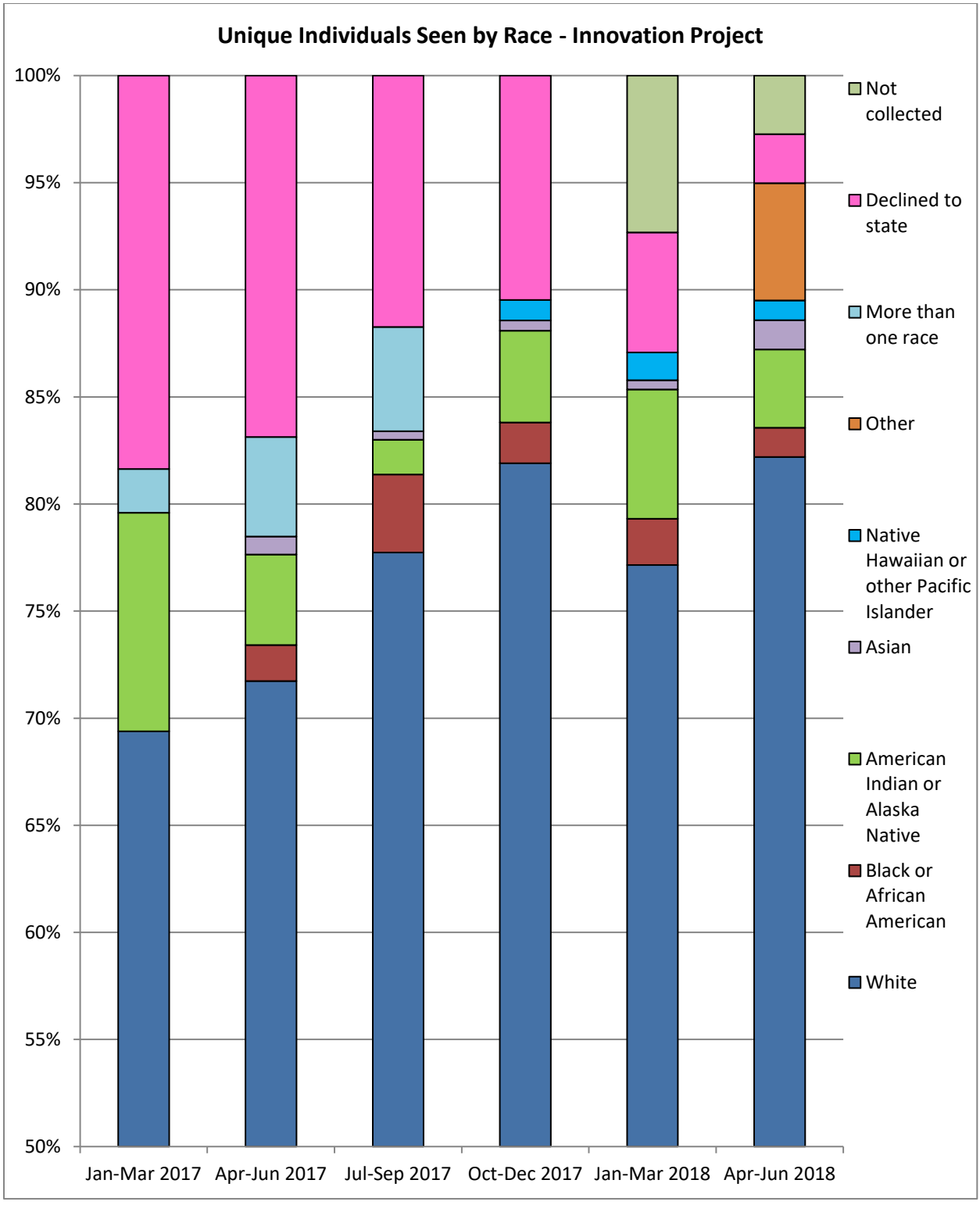
AGE

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



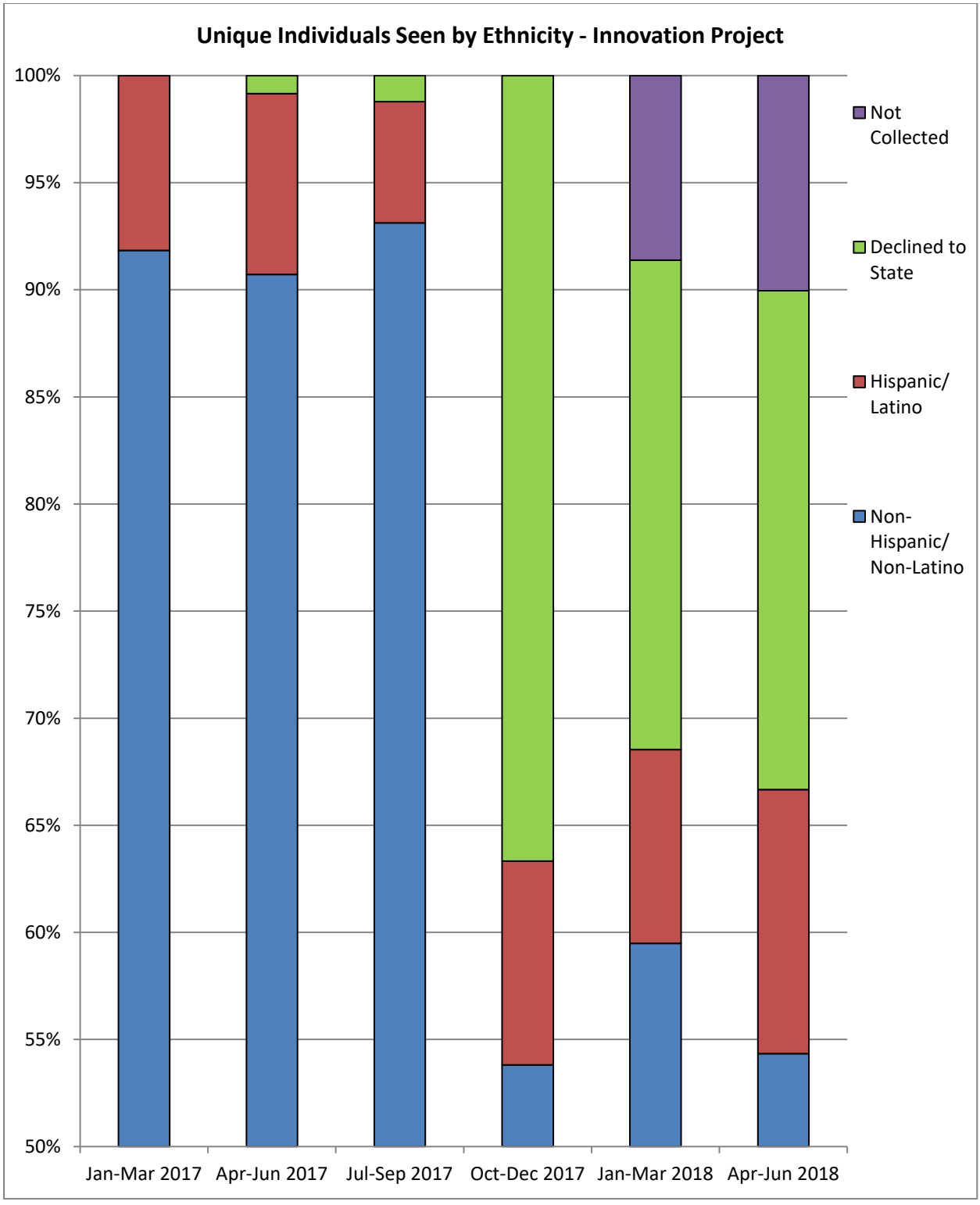
RACE

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



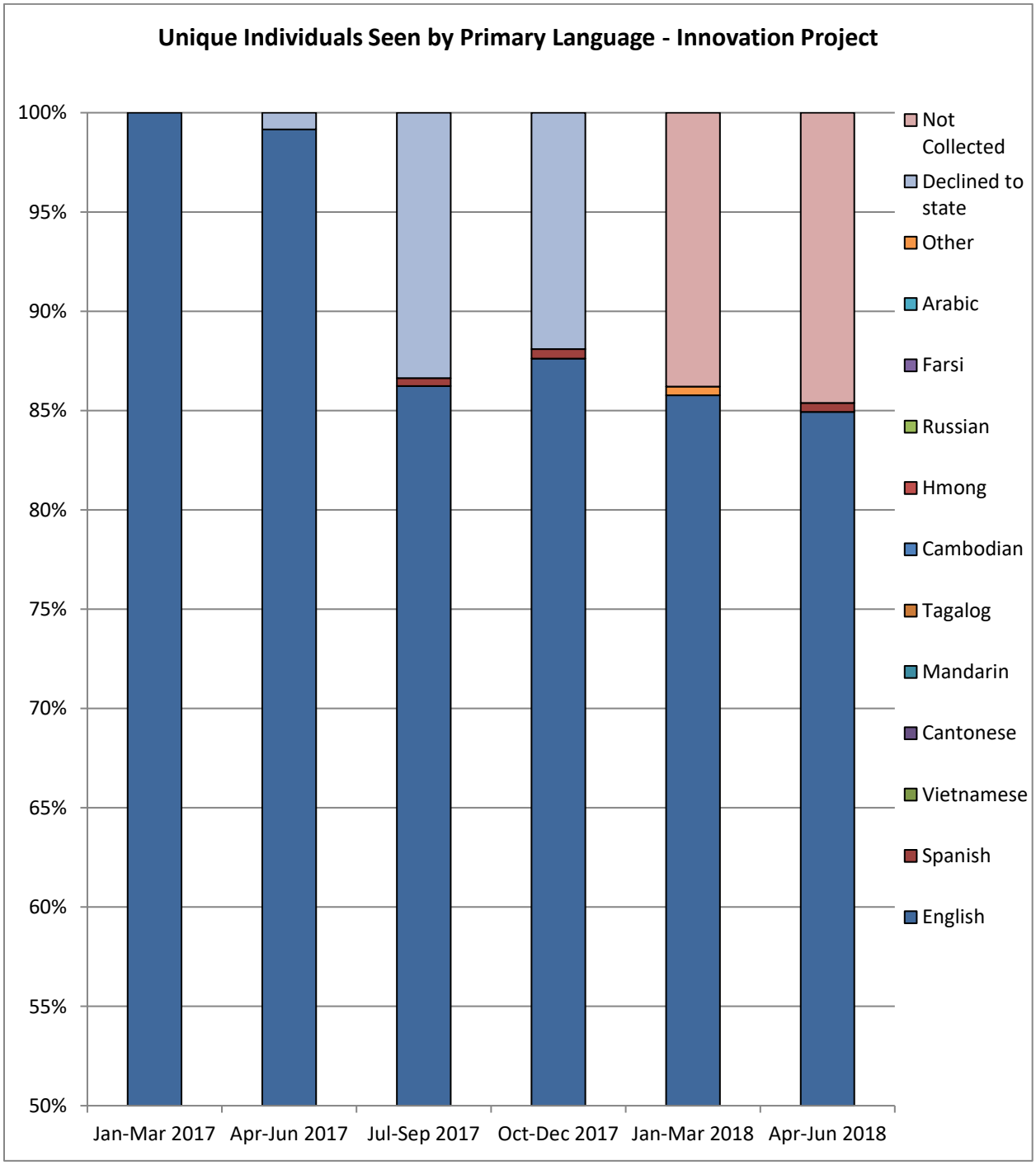
ETHNICITY

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

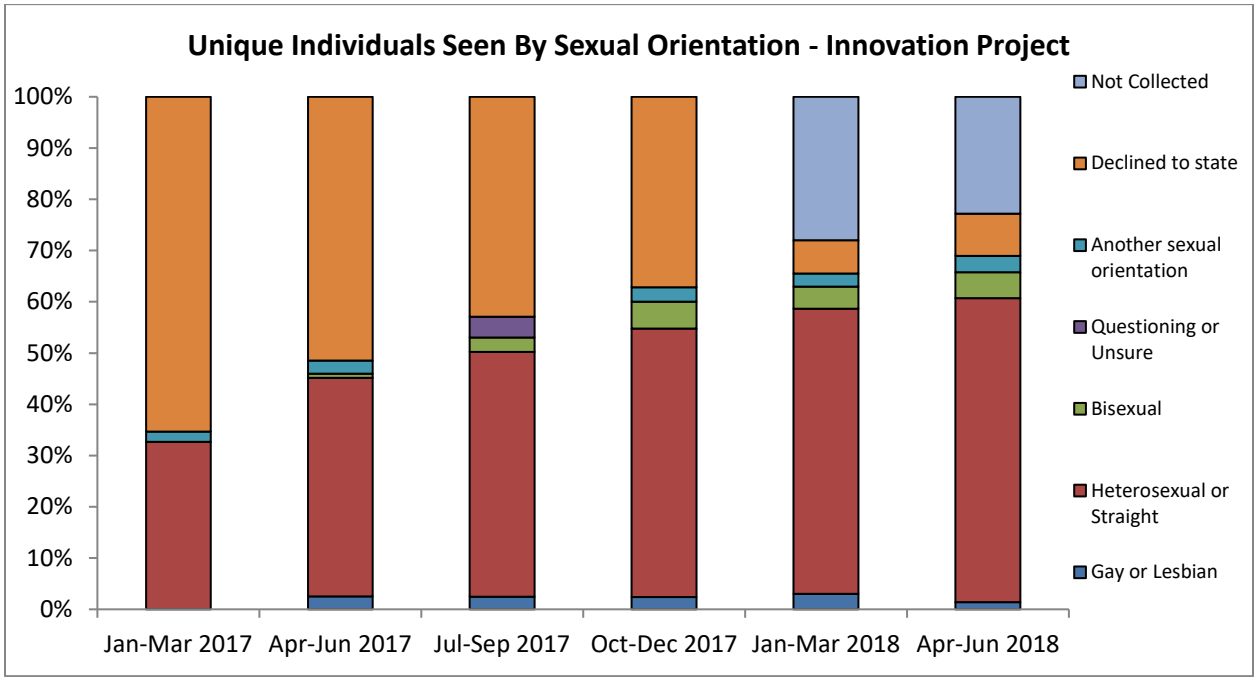


PRIMARY LANGUAGE

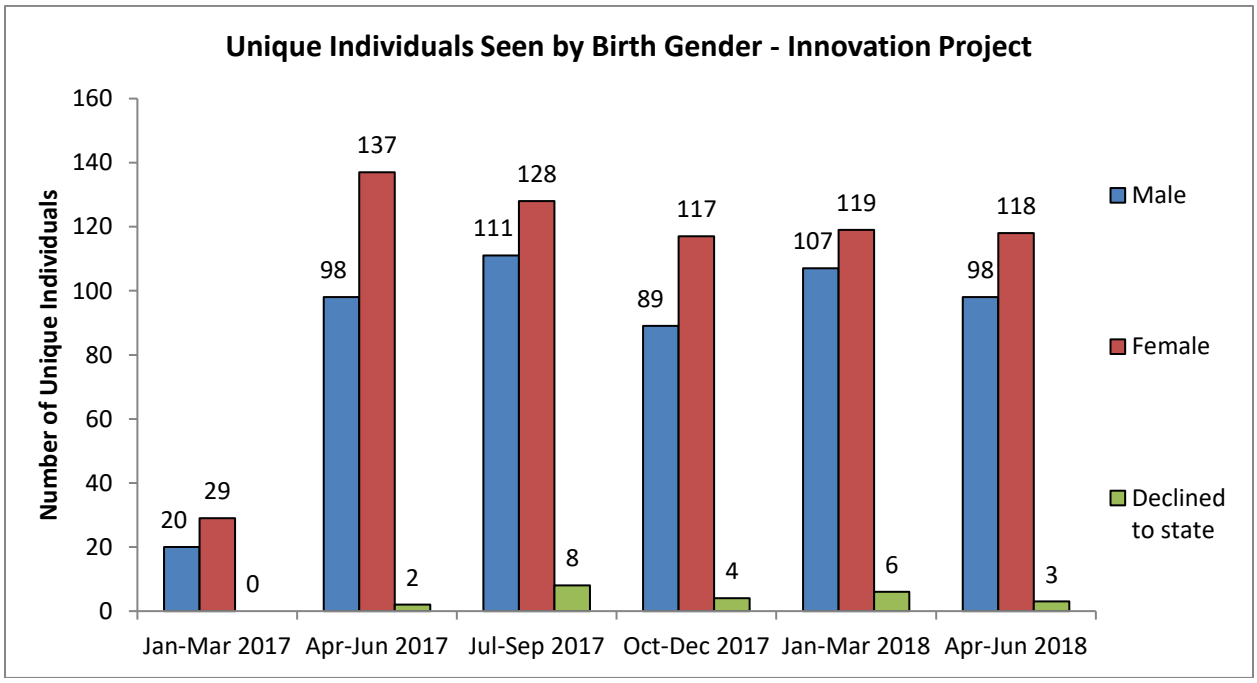
The primary language of consumers served by the CARE Center is English for nearly 100% of the people. Because of the low gross numbers for some reported languages, actual counts are not reported to help protect consumer confidentiality.



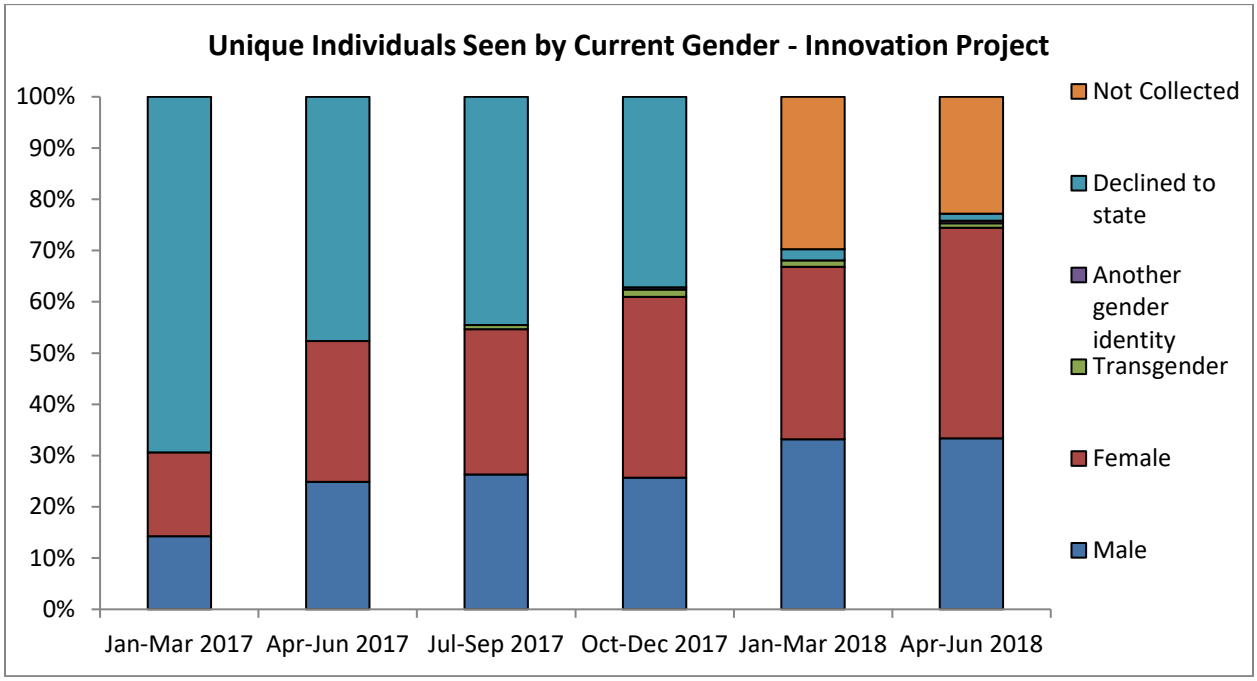
SEXUAL ORIENTATION



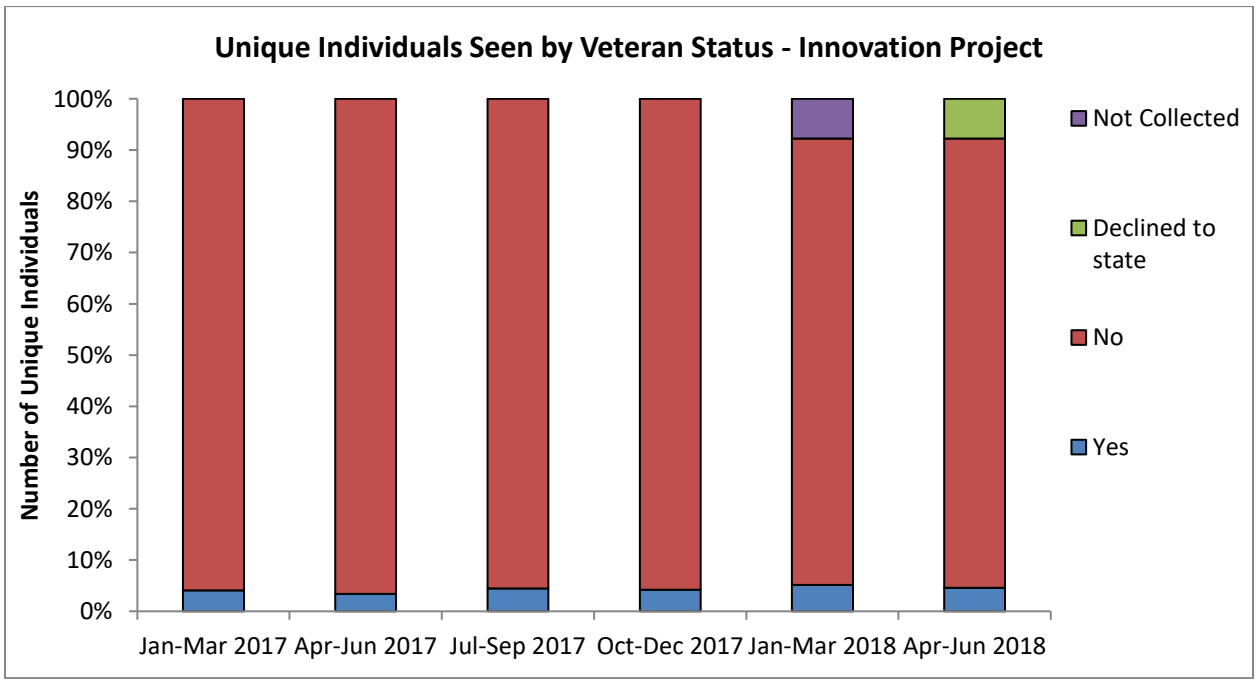
BIRTH GENDER



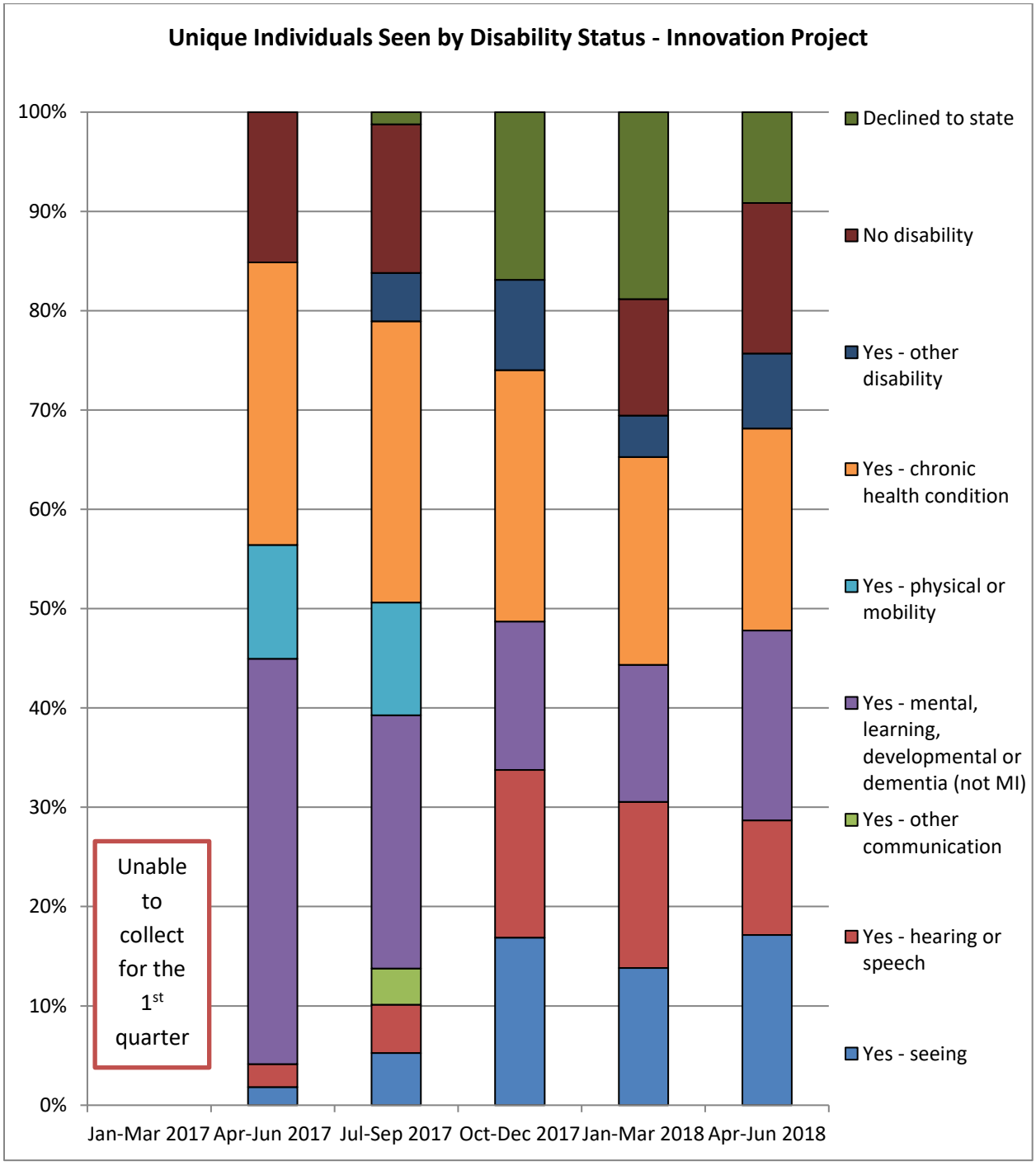
CURRENT GENDER



VETERAN STATUS



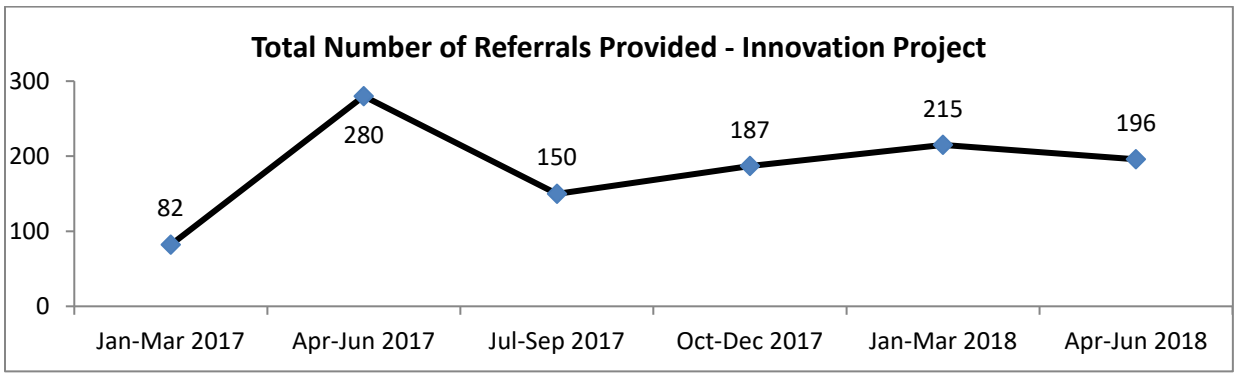
DISABILITY STATUS



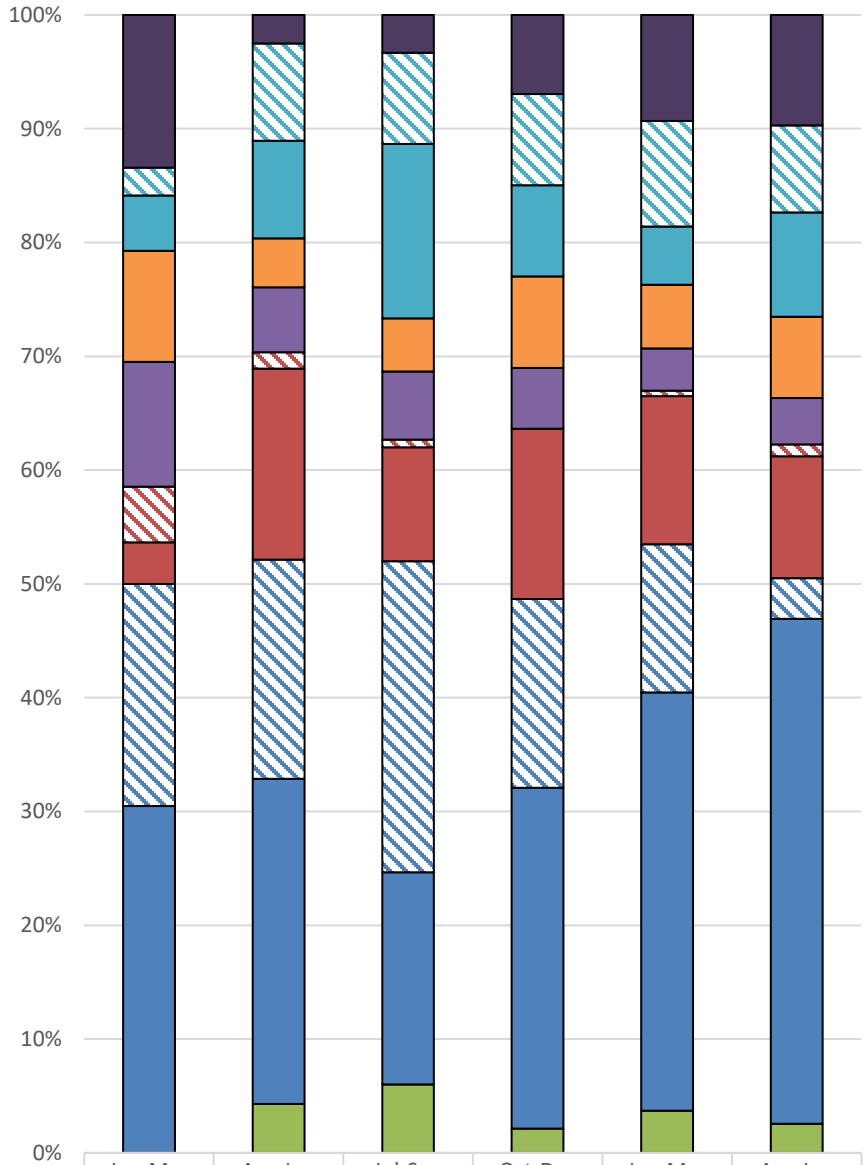
NUMBER OF OUTSIDE REFERRALS PROVIDED AND SUCCESSFULLY ACCESSED

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

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

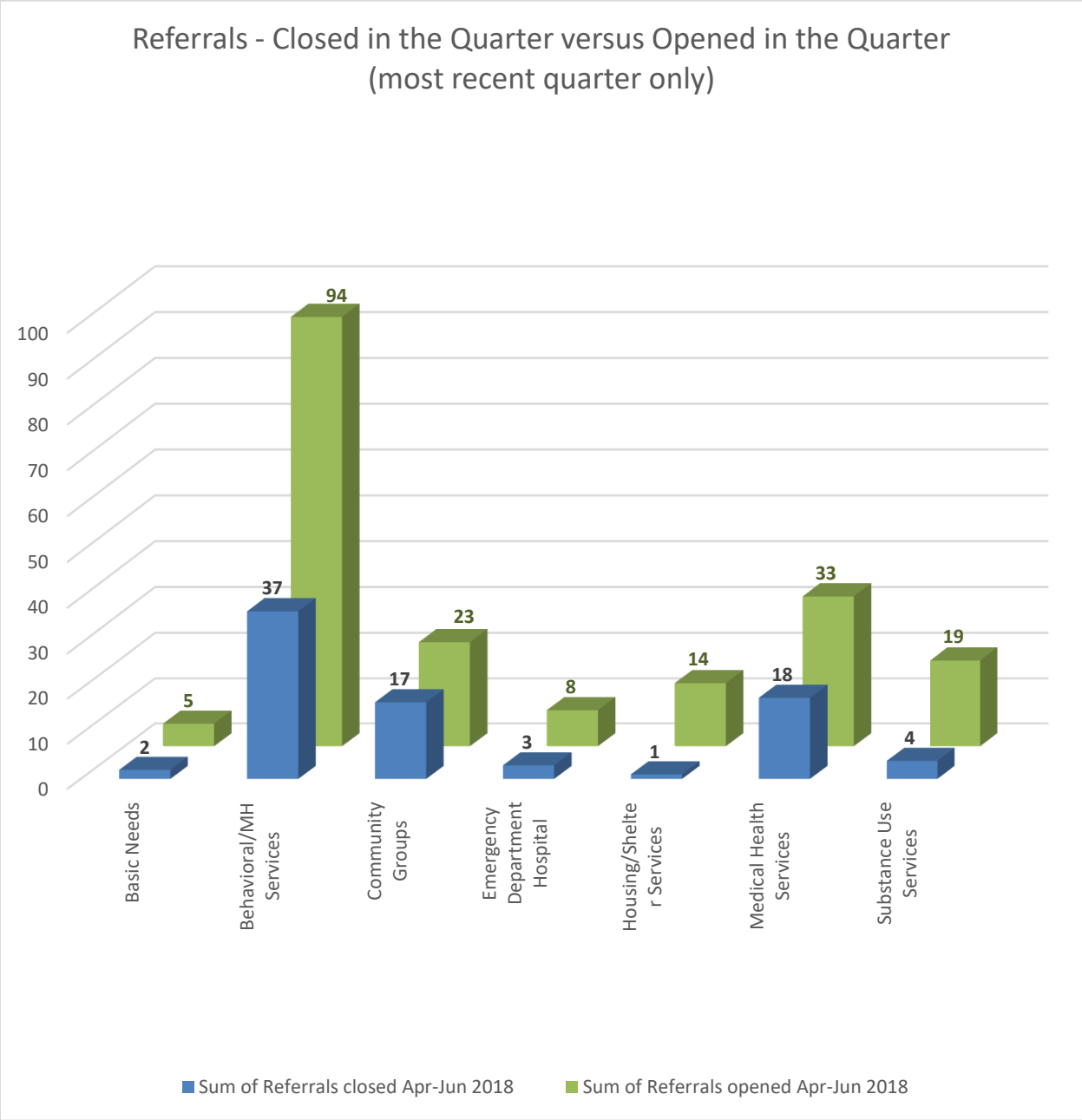


Referrals Provided by Category - Innovation Project



	Jan-Mar 2017	Apr-Jun 2017	Jul-Sep 2017	Oct-Dec 2017	Jan-Mar 2018	Apr-Jun 2018
Substance Use Services	11	7	5	13	20	19
Medical Health Services Hill Country	2	24	12	15	20	15
Medical Health Services External	4	24	23	15	11	18
Housing/Shelter Services	8	12	7	15	12	14
ED Hospital	9	16	9	10	8	8
Community Groups Hill Country	4	4	1	0	1	2
Community Groups External	3	47	15	28	28	21
Behavioral/MH Services Hill Country	16	54	41	31	28	7
Behavioral/MH Servivces External	25	80	28	56	79	87
Basic Needs	0	12	9	4	8	5

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.

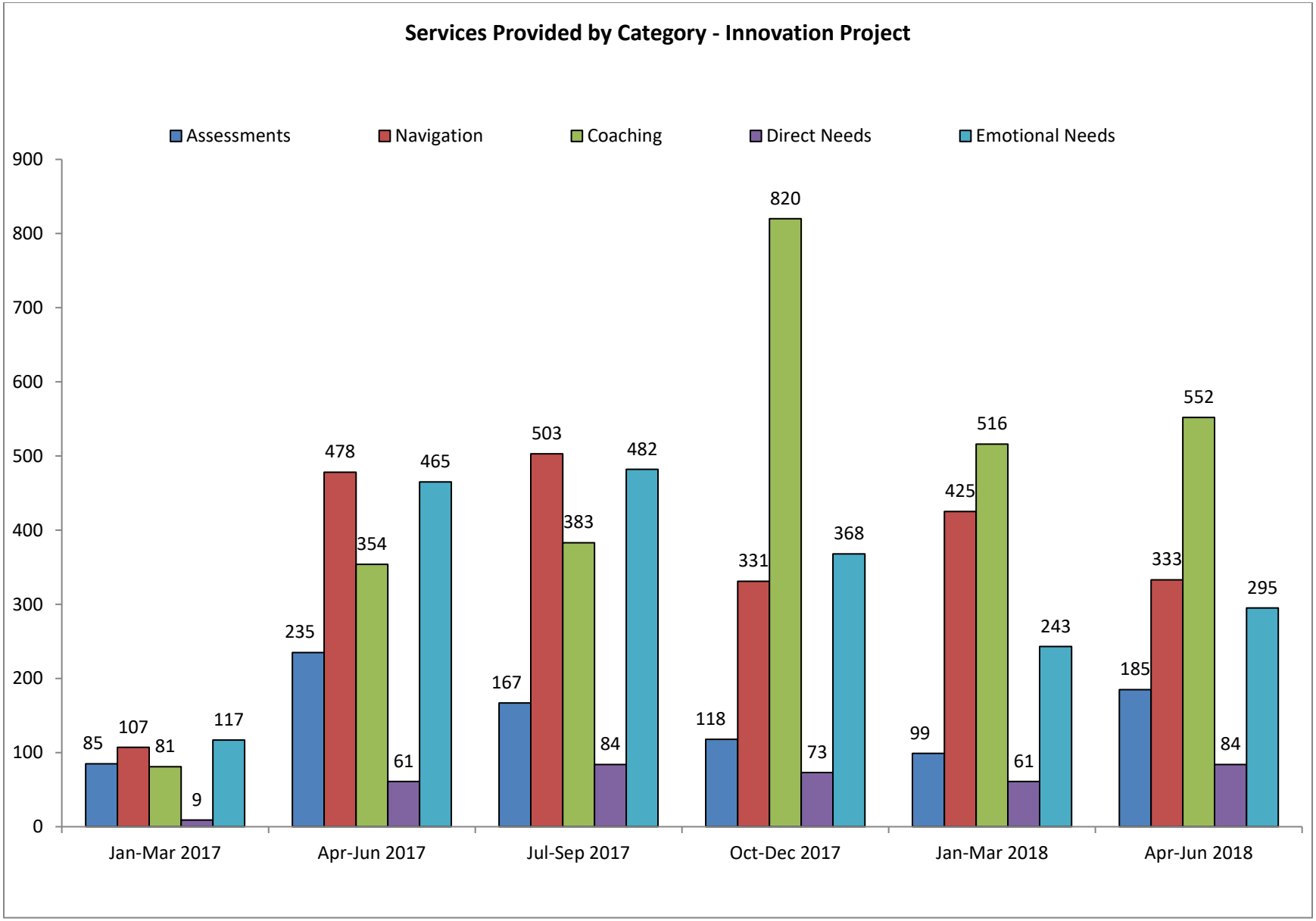


NUMBER OF SERVICES PROVIDED AND SUCCESSFULLY COMPLETED

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. To date, all services have been reported as successful at 100%.


Services Provided by Category - Innovation Project
Assessments
Navigation
Coaching
Direct Needs
Emotional Needs
900
800
700
600
500
400
300
200
100
0
85
107
81
9
117
235
478
354
61
465
167
503
383
84
482
118
331
820
73
368
99
425
516
61
243
185
333
552
84
295
Jan-Mar 2017
Apr-Jun 2017
Jul-Sep 2017
Oct-Dec 2017
Jan-Mar 2018
Apr-Jun 2018

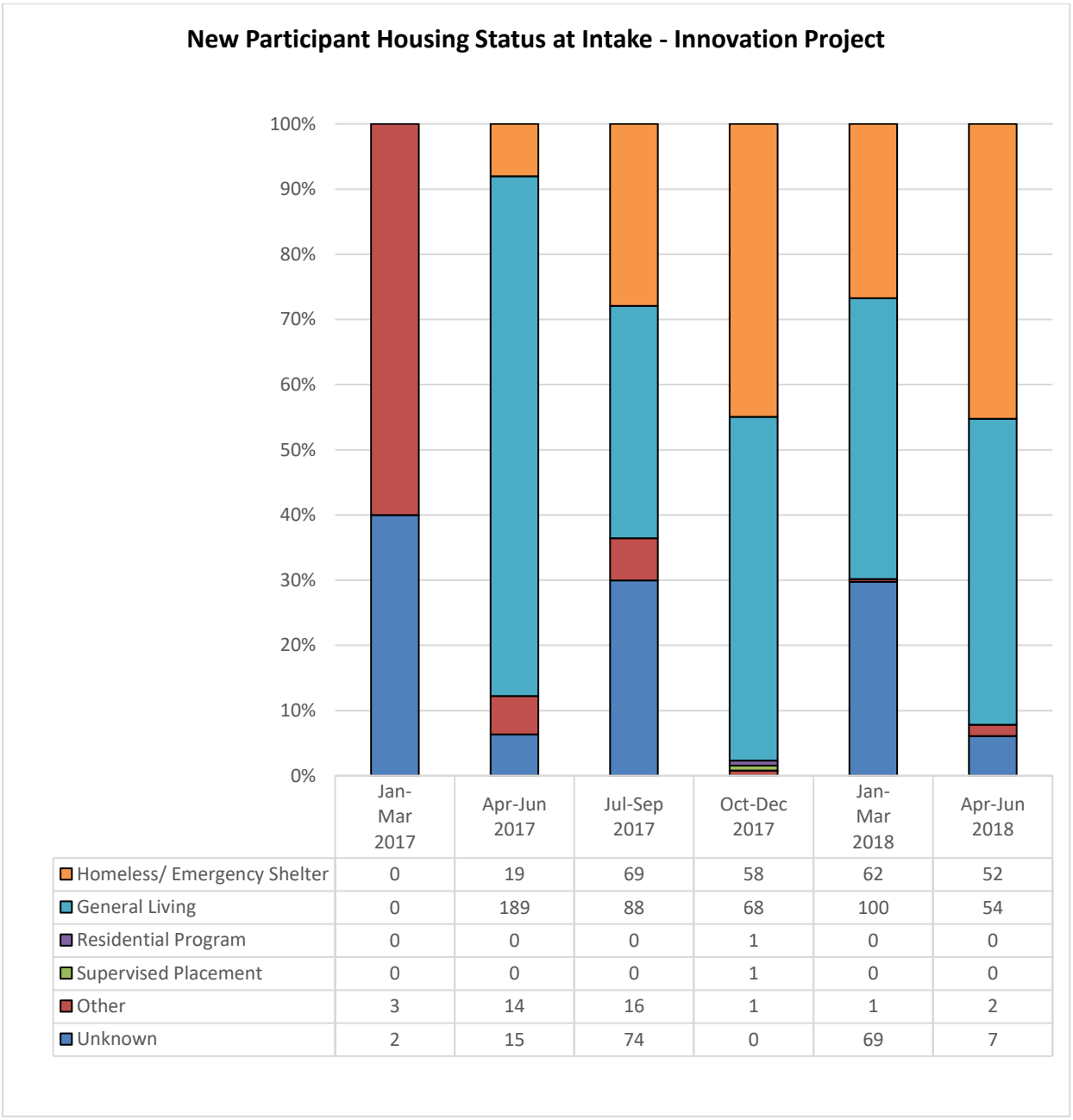
HOUSING STATUS

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

Housing status has been divided up into the following categories:

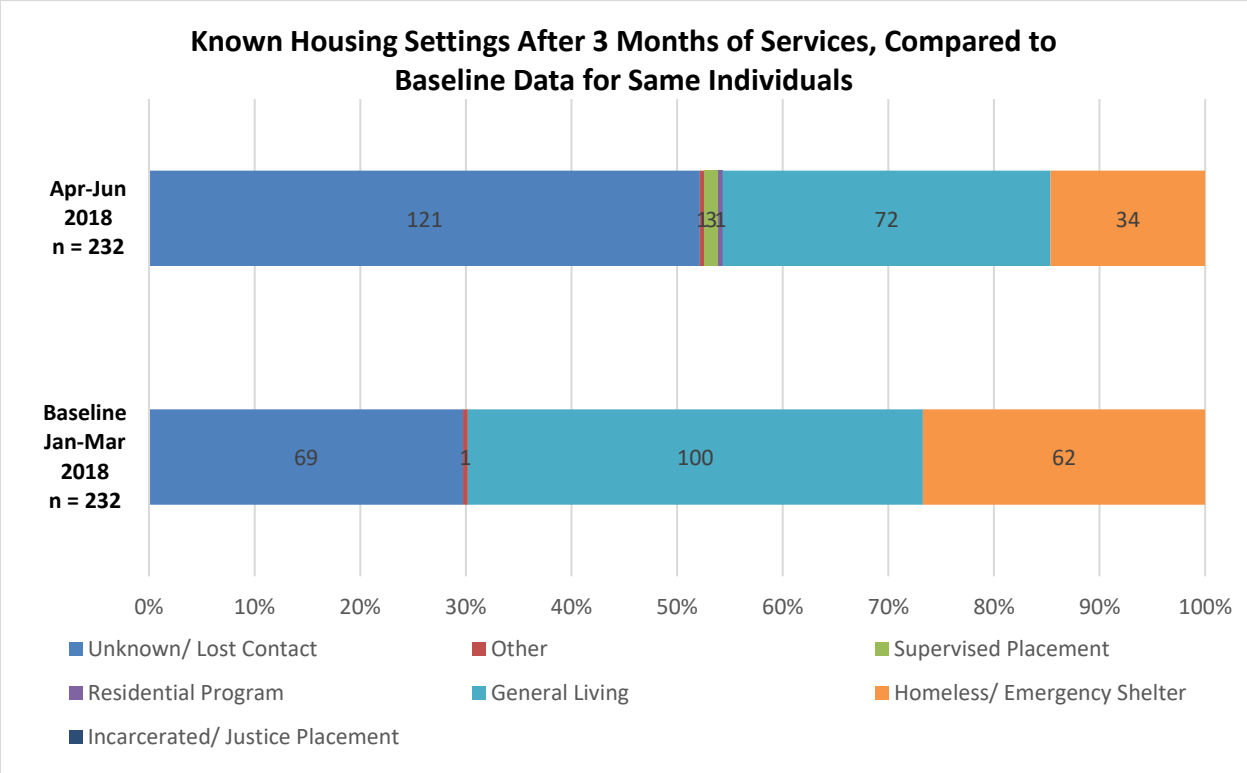
- Homeless/emergency shelter
- General living, which includes the following:
    - Apartment or house, alone or with family/roommates
    - Foster home
    - Single room occupancy
- Residential program, which includes the following:
    - Community treatment program
    - Group home (any level)
    -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

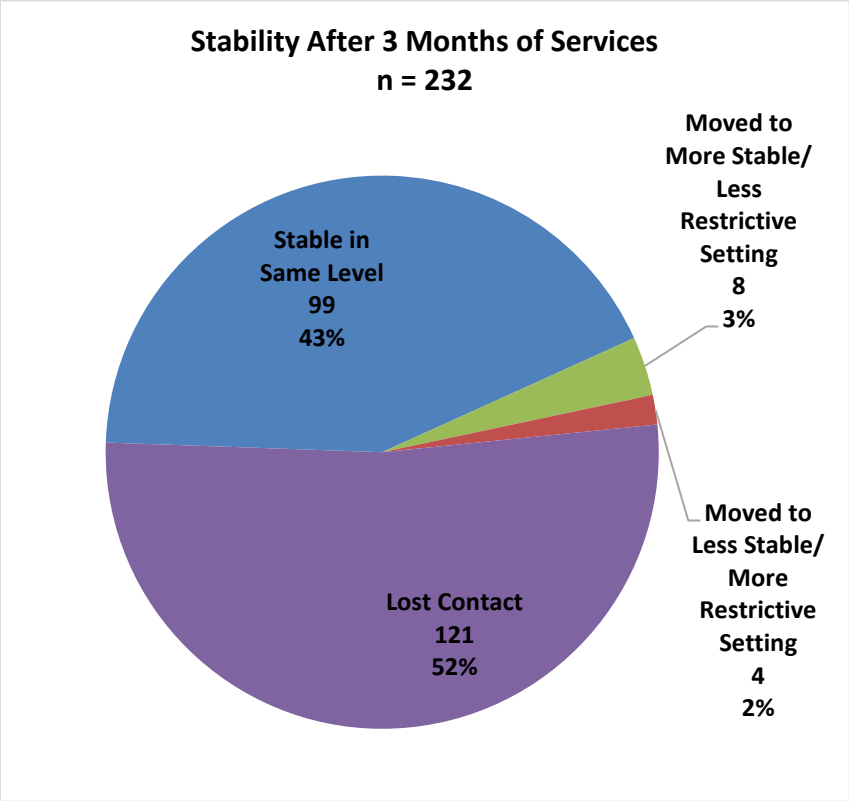
HOUSING STATUS AT START OF SERVICES



	Jan-Mar 2017	Apr-Jun 2017	Jul-Sep 2017	Oct-Dec 2017	Jan-Mar 2018	Apr-Jun 2018
Homeless/ Emergency Shelter	0	19	69	58	62	52
General Living	0	189	88	68	100	54
Residential Program	0	0	0	1	0	0
Supervised Placement	0	0	0	1	0	0
Other	3	14	16	1	1	2
Unknown	2	15	74	0	69	7

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





For those who moved to more stable/less restrictive settings, 7 transitioned from Homeless/E.S. to General Living, and 1 from Homeless/E.S. to Supervised Placement.

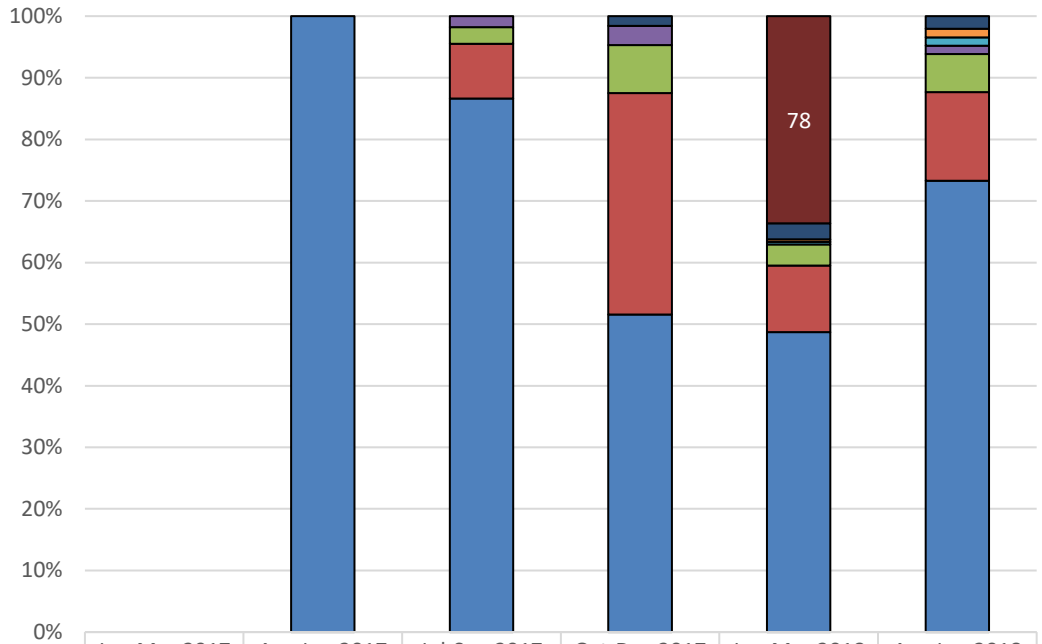
For the 4 people who moved to a less stable/more restrictive setting, 1 transitioned from General Living to Residential Program, 1 from General Living to Homeless/E.S,, 1 from General Living to Inpatient Psych Hospitalization, and 1 from Residential Program to Supervised Placement.

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 point after that first service. The target outcome numbers are to see a 15% decrease in ER visits at the 3-month mark.

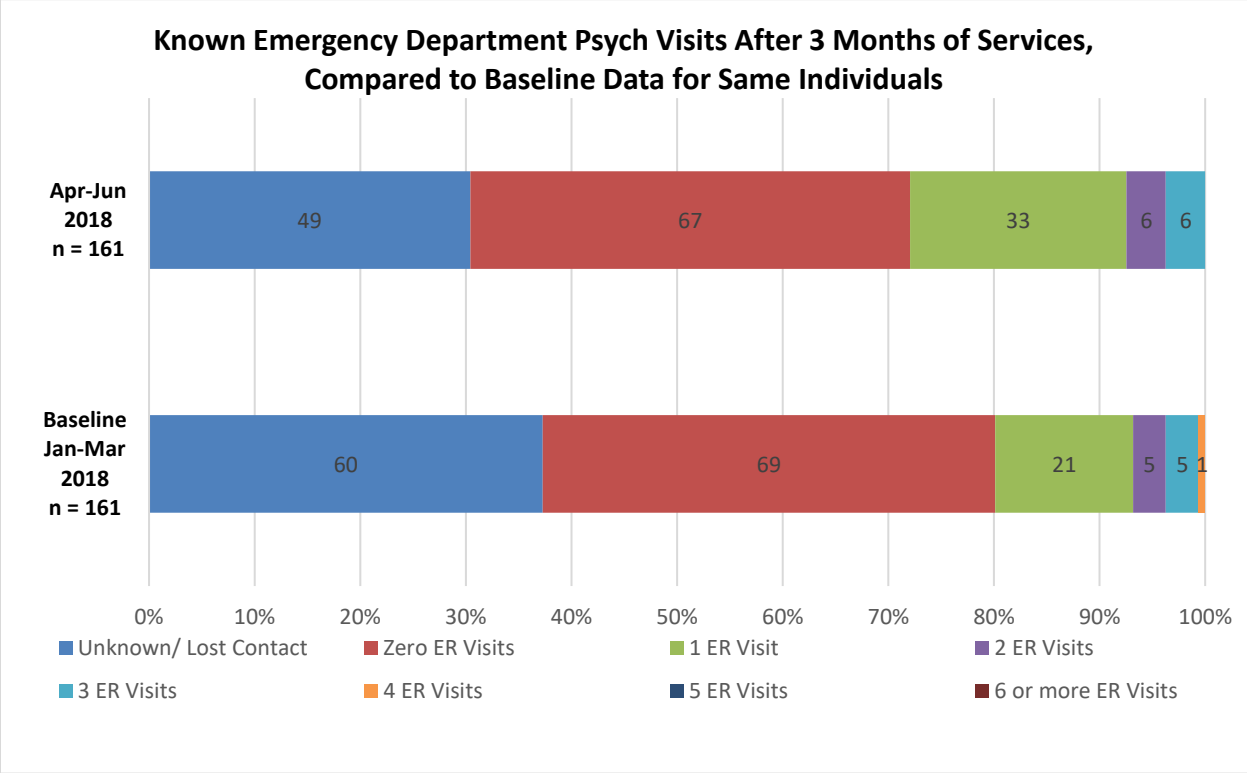
BASELINE EMERGENCY DEPARTMENT PSYCHIATRIC VISITS – PRIOR TO CARE CENTER SERVICES

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

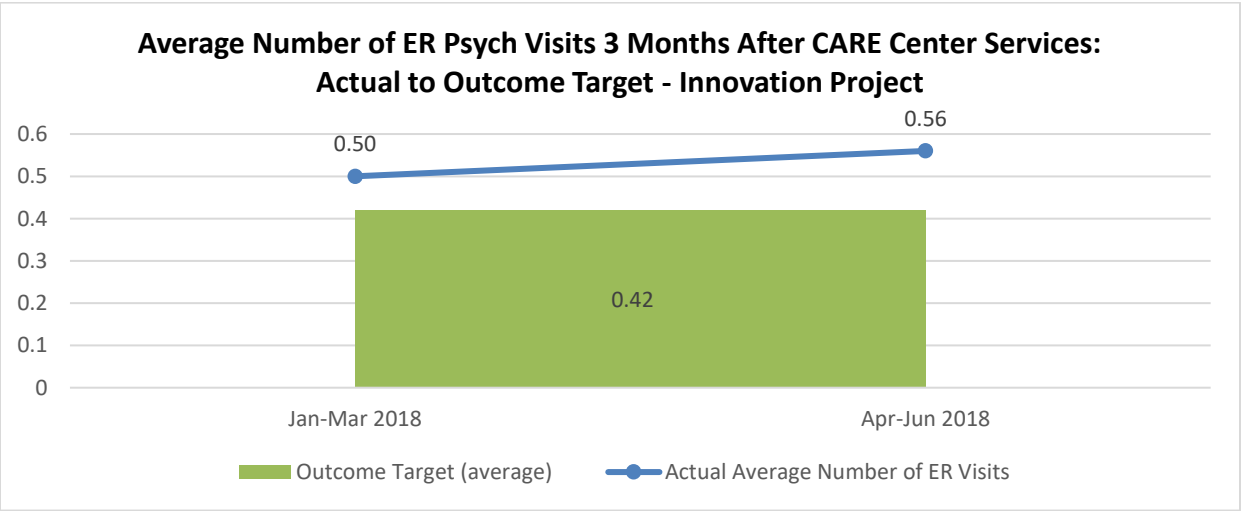


	Jan-Mar 2017	Apr-Jun 2017	Jul-Sep 2017	Oct-Dec 2017	Jan-Mar 2018	Apr-Jun 2018
Not Collected	Unable to collect for the 1st quarter	0	0	0	78	0
6 or more ER Visits		0	0	1	6	3
5 ER Visits		0	0	0	1	2
4 ER Visits		0	0	0	1	2
3 ER Visits		0	2	2	0	2
2 ER Visits		0	3	5	8	9
1 ER Visit		0	10	23	25	21
Zero ER Visits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

EMERGENCY DEPARTMENT PSYCH VISITS 3 MONTHS AFTER SERVICES AT THE CARE CENTER – Most Recent Quarter



The average number of ER visits in the prior 6 months for the Jan-Mar 2018 baseline quarter was 0.50 per individual who had visit data reported (excluding all in the Unknown/Lost Contact category). This makes the target number for the 3-month mark in the Apr-Jun 2018 quarter 0.42 or fewer ER visits on average.

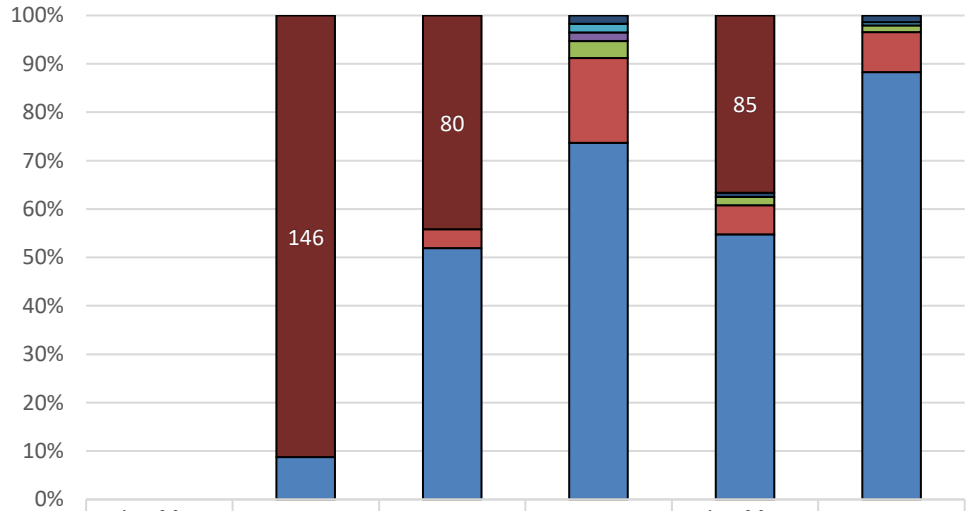


PSYCHIATRIC INPATIENT HOSPITALIZATIONS

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

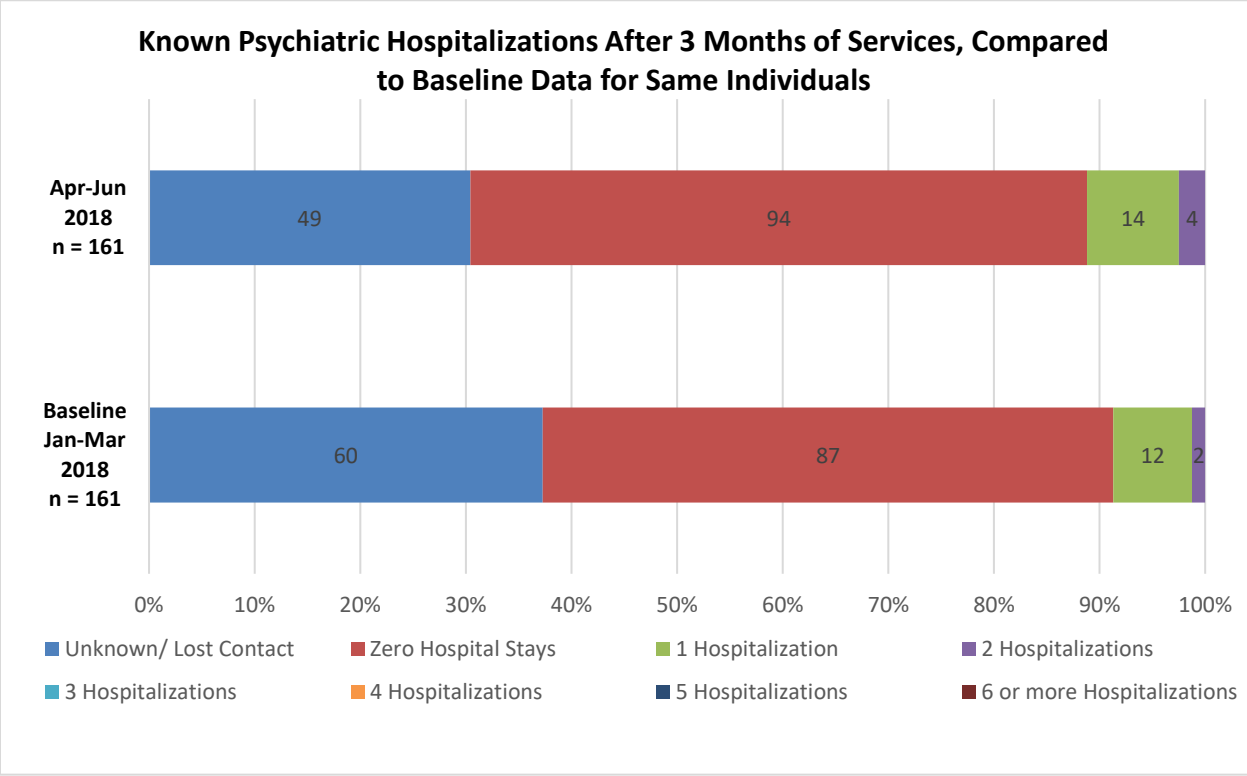
BASELINE PSYCHIATRIC HOSPITALIZATIONS – PRIOR TO CARE CENTER SERVICES

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

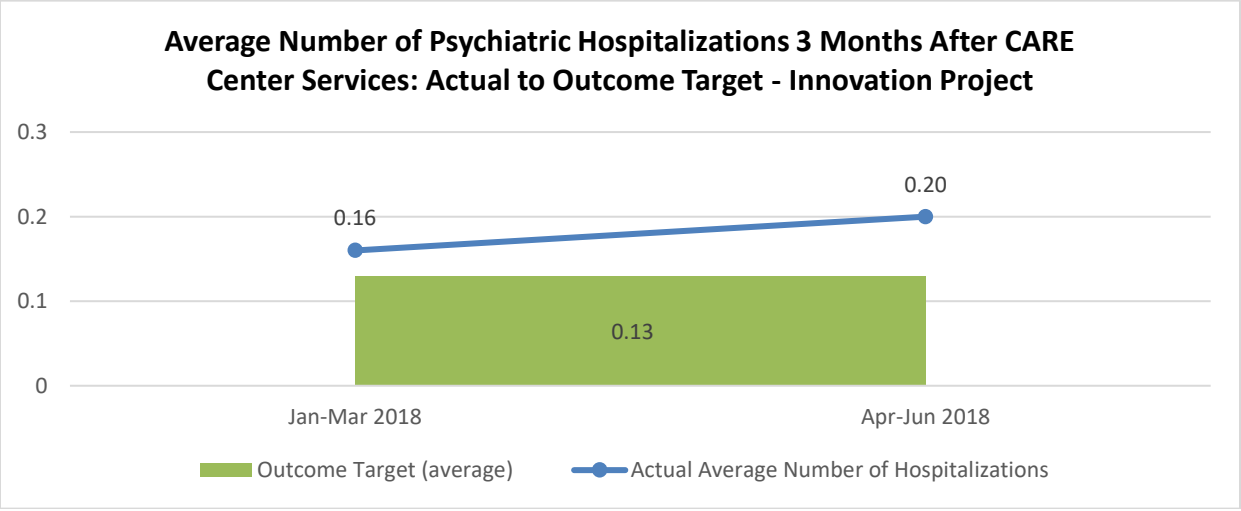


	Jan-Mar 2017	Apr-Jun 2017	Jul-Sep 2017	Oct-Dec 2017	Jan-Mar 2018	Apr-Jun 2018
Unknown	Unable to collect for the 1st quarter	146	80	0	85	0
6 or more Hospitalizations		0	0	1	2	2
5 Hospitalizations		0	0	0	0	0
4 Hospitalizations		0	0	1	0	1
3 Hospitalizations		0	0	1	0	0
2 Hospitalizations		0	0	2	4	2
1 Hospitalization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

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



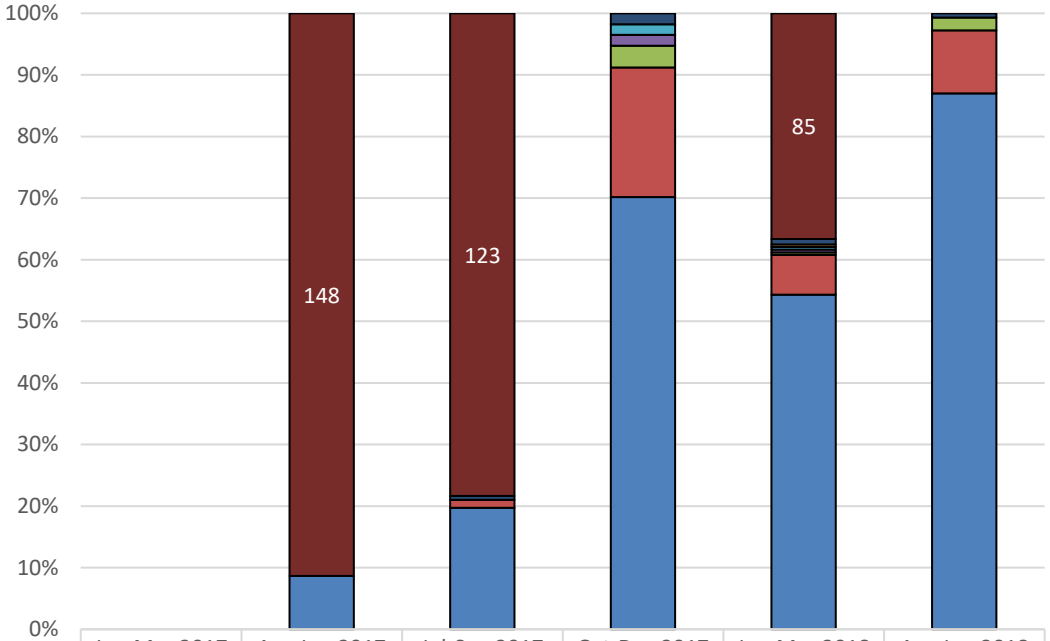
The average number of psychiatric hospitalizations in the prior 6 months for the Jan-Mar 2018 baseline quarter was 0.16 per individual who had any hospitalizations. This makes the target number for the 3-month mark in the Apr-Jun 2018 quarter 0.13 or fewer hospitalizations on average.



ARRESTS

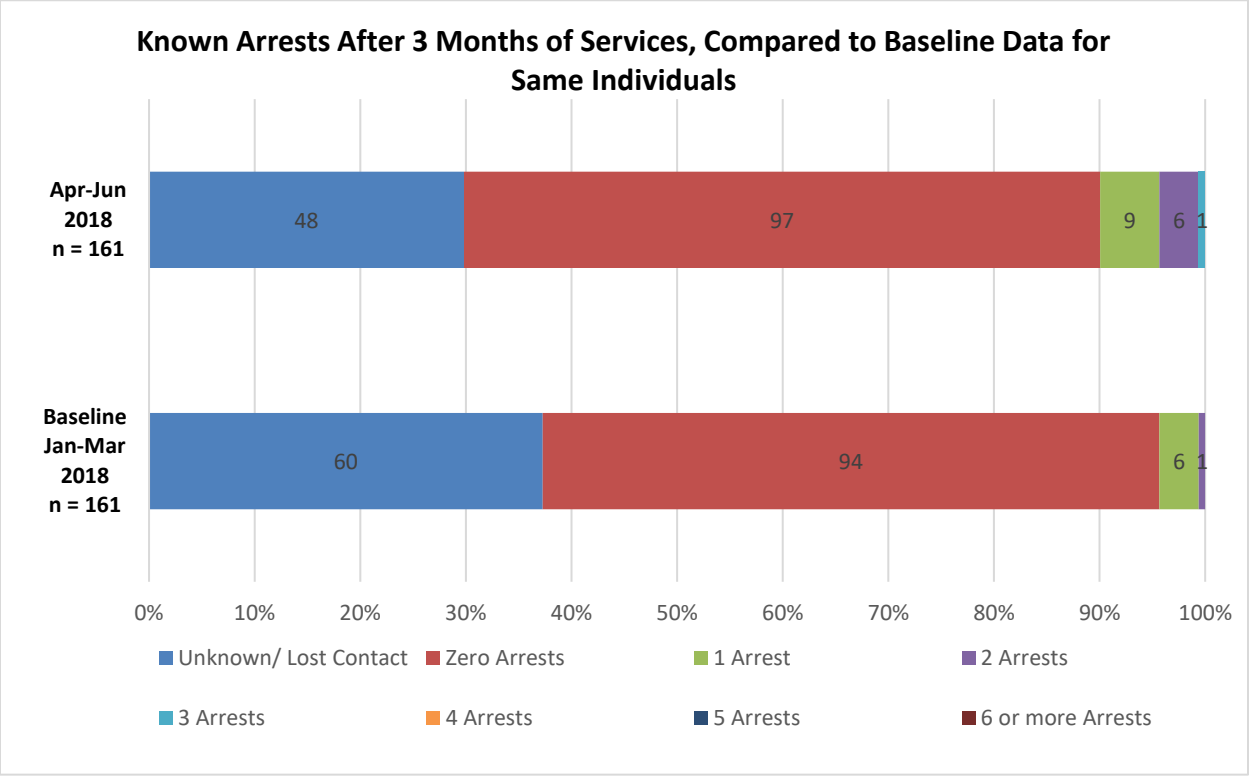
Another goal of the Innovation Project is to reduce the number of arrests, and the number of days spent incarcerated. The CARE Center has been asked to track the number of arrests and number of days spent incarcerated that individuals report having made in the 6 months prior to the time they first start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

BASELINE ARRESTS – PRIOR TO CARE CENTER SERVICES

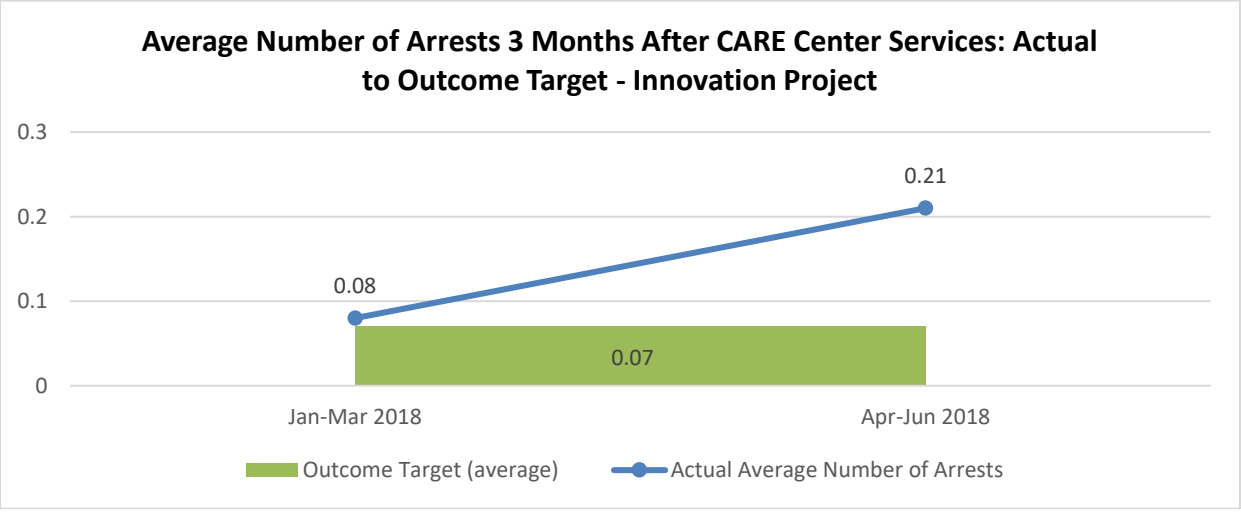


	Jan-Mar 2017	Apr-Jun 2017	Jul-Sep 2017	Oct-Dec 2017	Jan-Mar 2018	Apr-Jun 2018
Unknown	Unable to collect for the 1st quarter	148	123	0	85	0
6 or more Arrests		0	1	1	2	1
5 Arrests		0	0	0	1	0
4 Arrests		0	0	1	1	0
3 Arrests		0	0	1	1	0
2 Arrests		0	0	2	1	3
1 Arrest		0	2	12	15	15
Zero Arrests		14	31	40	126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

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

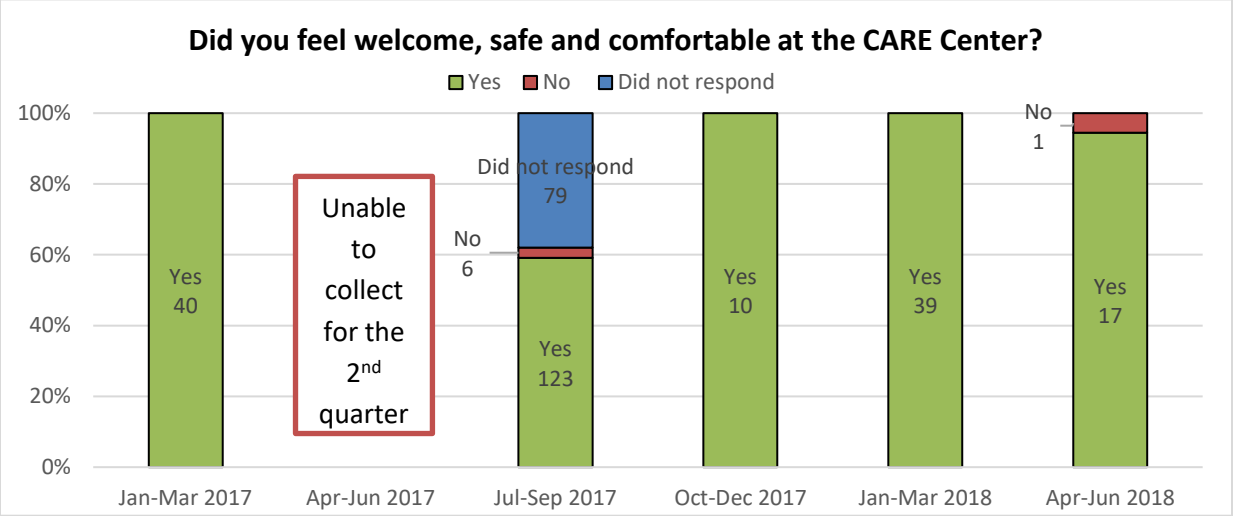


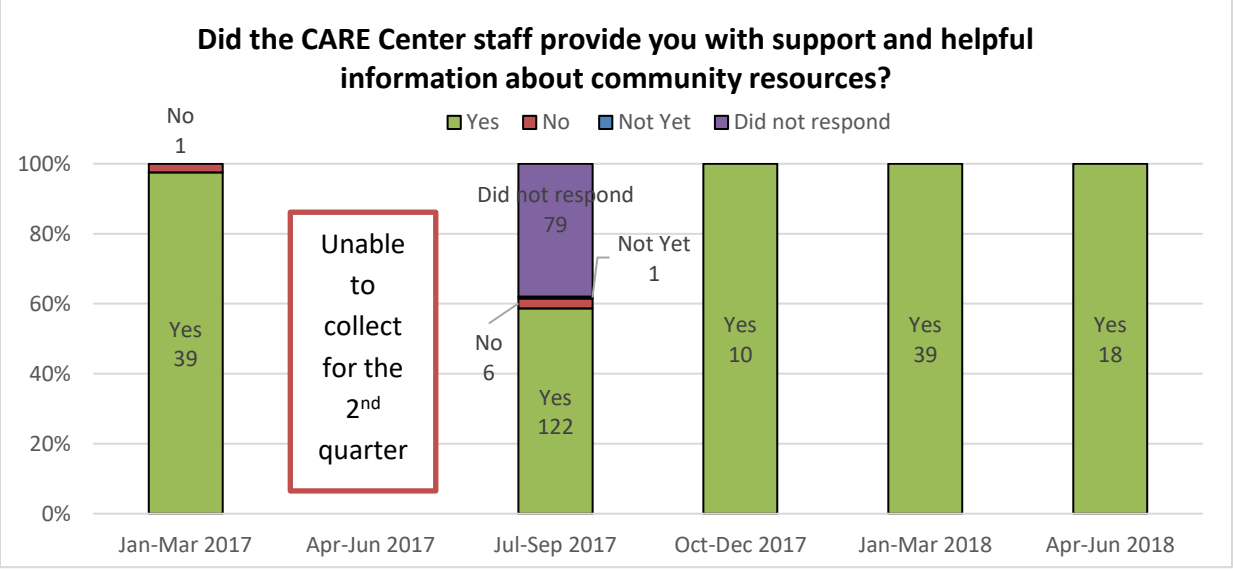
The average number of arrests in the prior 6 months for the Jan-Mar 2018 baseline quarter was 0.08 per individual who had arrest data reported (excluding all in the Unknown/Lost Contact category). This makes the target number for the 3-month mark in the Apr-Jun 2018 quarter 0.06 or fewer arrests on average.

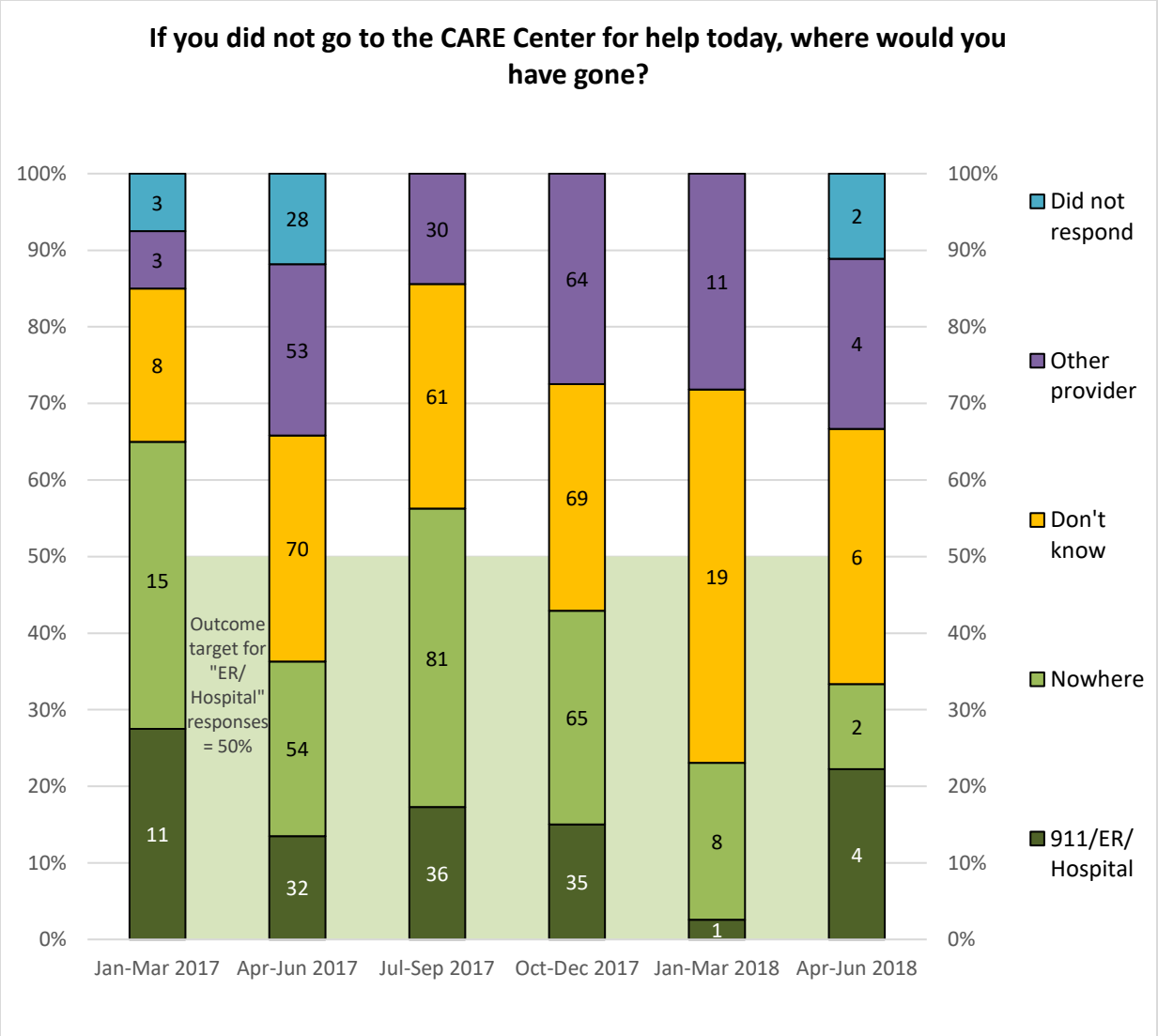


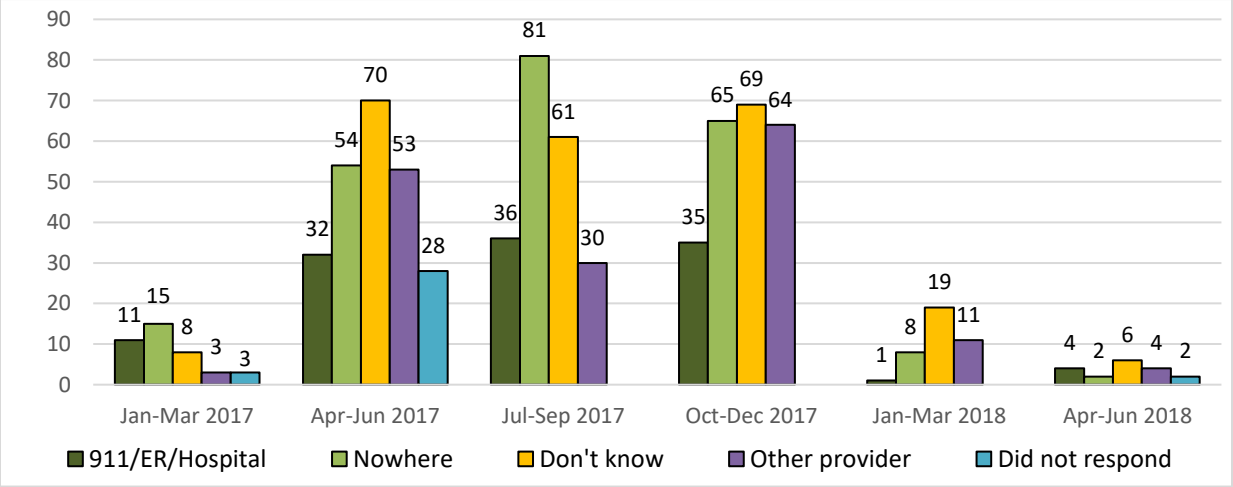
CUSTOMER SURVEYS

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

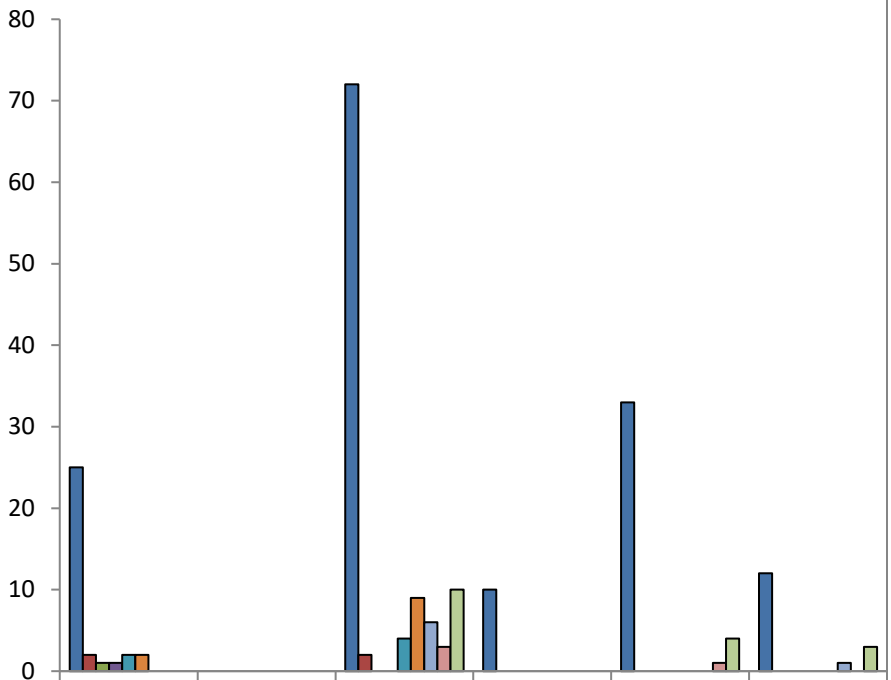





If you did not go to the CARE Center for help today, where would you have gone?
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Outcome target for "ER/ Hospital" responses = 50%
3
3
8
15
11
28
53
70
54
32
30
61
81
36
64
69
65
35
11
19
8
1
2
4
6
2
4
Jan-Mar 2017
Apr-Jun 2017
Jul-Sep 2017
Oct-Dec 2017
Jan-Mar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


90
80
70
60
50
40
30
20
10
0
11
15
8
3
3
32
54
70
53
28
36
81
61
30
35
65
69
64
1
8
19
11
4
2
6
4
2
Jan-Mar 2017
Apr-Jun 2017
Jul-Sep 2017
Oct-Dec 2017
Jan-Mar 2018
Apr-Jun 2018
911/ER/Hospital
Nowhere
Don't know
Other provider
Did not respond

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



	Jan-Mar 2017	Apr-Jun 2017	Jul-Sep 2017	Oct-Dec 2017	Jan-Mar 2018	Apr-Jun 2018
Happy with experience/ services	25		72	10	33	12
Medication	2	Unable to collect for the 2nd quarter	2	0	0	0
Dental Care	1		0	0	0	0
Services for alcoholics in crisis	1		0	0	0	0
More and/or different groups	2		4	0	0	0
Other facility amenities (music, TV, coffee, snacks etc.)	2		9	0	0	0
More staff/ better trained staff	0		6	0	0	1
Food & clothing	0		3	0	1	0
Other	0		10	0	4	3

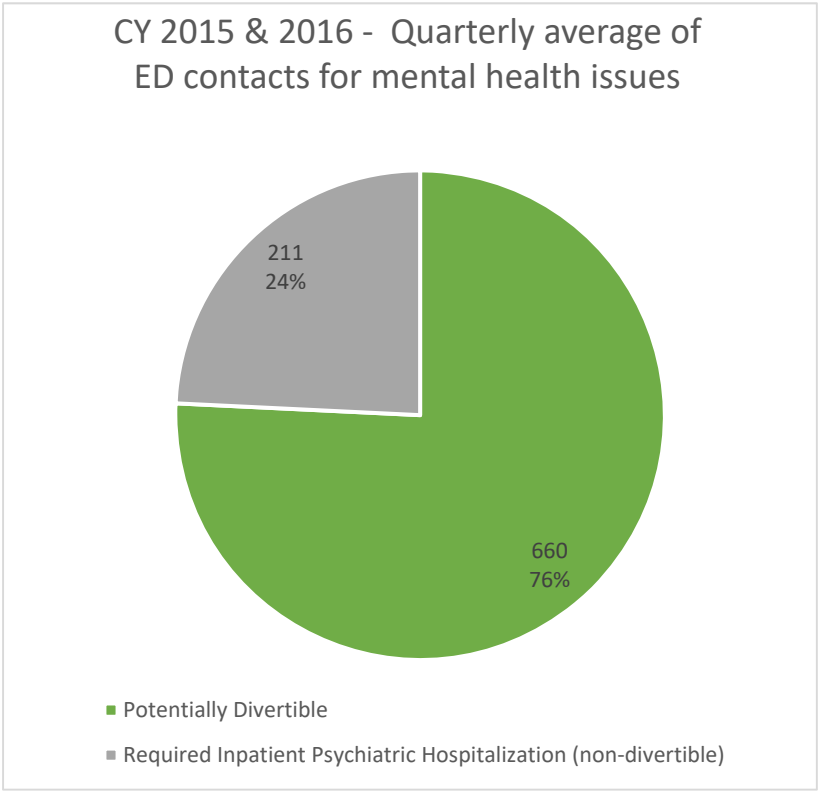
Data as of: 9/20/18

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.

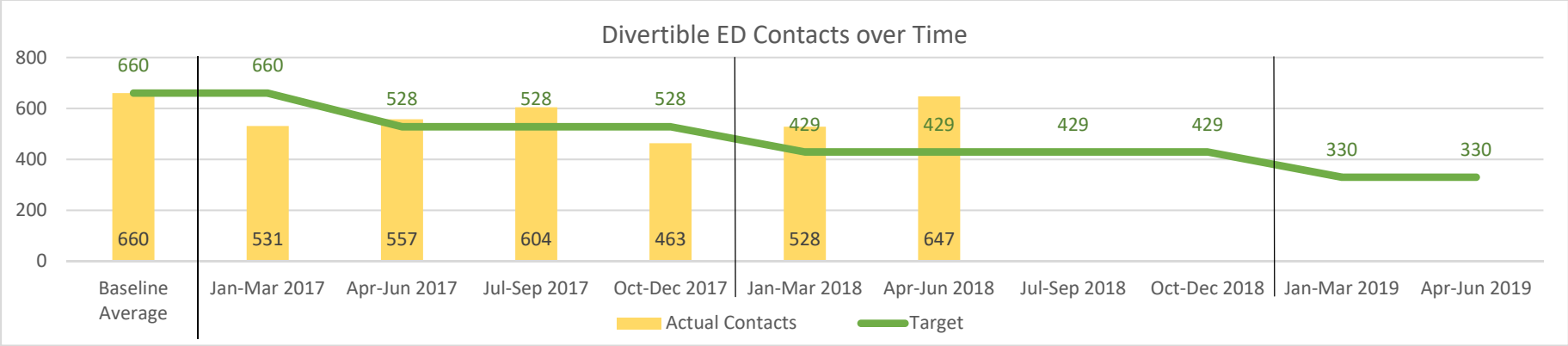


One of the goals for the Innovation Project, as approved by the state MHSOAC office and the Shasta County Board of Supervisors, is to reduce emergency department visits for mental health issues over time by the following amounts:

- 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)