# Shasta County
# Mental Health Services Act

# Fiscal Year 2016/2017 Annual Update

**June 2016**

Shasta County Health and Human Services Agency
2640 Breslauer Way, Redding, CA 96001

# A Vision of Recovery

Recovery is defined as a process of change through which individuals 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 well-being.

***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.

Taken from the Substance Abuse and Mental Health Services Administration (SAMHSA) website.
For more information, visit: blog.samhsa.gov/2012/03/23/definition-of-recovery-updated

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# A Message from the Director

Another year has passed and once again I am pleased to present Shasta County's progress report and upcoming plans for the Mental Health Services Act (MHSA) programs and activities: The Shasta County MHSA Fiscal Year 2016/17 Annual Update.

Along with our many community partners and stakeholders, Shasta County Health and Human Services Agency (HHSA) continues to expand our comprehensive behavioral health system of care using resources provided through the MHSA. Our vision is to create a local behavioral health system that meets the needs of our community and focuses on wellness, recovery, and empowerment of individuals to take ownership of their own care so they can made substantial and measurable progress in their recovery.

There are several exciting projects that we have been working on that are coming to fruition in the next fiscal year. The MHSA Permanent Supportive Housing Program has two projects in development: the Woodlands in Redding should be completed in the Spring of 2017, and we are partnering with a local provider to develop a project in Eastern Shasta County. We are also partnering with another local provider to implement our Innovation project, the Community Mental Health Resource Center, which should be open for business this summer, and we will be implementing a new prevention program for at-risk middle school students. As you read up on all these projects, you can see that the MHSA is alive and well in Shasta County, always with the goal of increasing access to and reducing disparities in behavioral health services for all residents of Shasta County.

Thank you for your review of Shasta County's MHSA programs and activities, and as always, that you for your valuable feedback and input that continues to assist with the development of the MHSA in order to meet the needs of our community.

Sincerely,

Donnell Ewert, MPH
Mental Health Director

*"Healthy People in Thriving and Safe Communities"*
www.shastahhsa.net

# County Certifications

- MHSA County Compliance Certification
- MHSA County Fiscal Accountability Certification

# MHSA COUNTY COMPLIANCE CERTIFICATION

**County:** Shasta

| County Mental Health Director | Project Lead |
|---|---|
| **Name:** Donnell Ewert, MPH<br>**Telephone Number:** 530/245-6269<br>**E-mail:** dewert@co.shasta.ca.us | **Name:** Jamie Hannigan<br>**Telephone Number:** 530/245-6419<br>**E-mail:** jhannigan@co.shasta.ca.us |
| **Mailing Address:**<br><br>2640 Breslauer Way<br>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 Shasta County has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this Three-Year Program and Expenditure Plan, including stakeholder participation and non-supplantation 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 plan, attached hereto, was adopted by the County Board of Supervisors on August 16, 2016.

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

8/24/16
Date

# MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

**County:** Shasta

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

| Local Mental Health Director | County Auditor-Controller |
|---|---|
| **Name:** Donnell Ewert, MPH<br>**Telephone Number:** 530/245-6269<br>**E-mail:** dewert@co.shasta.ca.us | **Name:** Brian Muir<br>**Telephone Number:** 530/225-5541<br>**E-mail:** bmuir@co.shasta.ca.us |
| **Mailing Address:**<br>2640 Breslauer Way<br>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 — Date: 7/11/16
Shasta County Mental Health Director

I hereby certify that for the fiscal year ending June 30, 2016, 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 December 22, 2015 for the fiscal year ending June 30, 2015. I further certify that for the fiscal year ending June 30, 2015, 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 — Date: 7/14/16
Shasta County Auditor-Controller

[1]Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)
Three-Year Program and Expenditure Plan, Annual Update, and RER Certification (02/14/2013)

# Definitions

The following are terms that are frequently used within this document.

California Department of Health Care Services (DHCS): DHCS administers and provides oversight for many programs that are mandated by state law and the federal government. Their mission is to provide Californians with access to affordable, high-quality health care, including medical, dental, mental health, substance use disorder services, and long-term services and supports. Their vision is to preserve and improve the physical and mental health of all Californians.

California Housing Finance Agency (CalHFA): CalHFA, along with the DHCS, jointly administers the MHSA Permanent Supportive Housing programs on behalf of counties.

California Mental Health Services Authority (CalMHSA): A Joint Powers Agreement between participating California counties which was formed in July 2009 to implement mental health initiative statewide.

Caregiver: Triple P services are provided to "caregivers" who are defined as any individual who provides care to a child or youth. Caregivers can include parents, grandparents, guardians, foster parents, and childcare workers.

Consumer: An individual who receives services for a mental illness.

Federally Qualified Health Center (FQHC): FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act. FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.

Full Service Partnership (FSP): Program for adults with serious mental illness or a child/youth with a serious emotional disturbance. The program is defined by the California Code of Regulations, Title 9, Section 3200.130 as "the collaborative relationship between the County and the client, and when appropriate the client's family, through which the County plans for and provides the full spectrum of community services so that the client can achieve the identified goals."

Intergovernmental Transfer (IGT): The IGT process is a funding strategy that states and/or local governments utilize to increase federal matching dollars for Medicaid programs. It is a new funding strategy for Shasta County due to participation in Medi-Cal Managed Care.

Intermountain Area: The Northeastern area of Shasta County California, including but not limited to the communities of Burney, Big Bend, Fall River Mills, Hat Creek, Old Station, McArthur, and Round Mountain.

**Mental Health Services Oversight and Accountability Commission** (MHSOAC): Established by Proposition 63, the role of the MHSOAC is to oversee the implementation of the MHSA by providing training and technical assistance for county mental health planning as needed. Additionally, the Commission evaluates MHSA-funded programs throughout the State as well as approves county Innovation plans. The MHSOAC receives all county 3-year plans, annual updates, and annual Revenue and Expenditure Reports.

**MHSA Community Stakeholder**: An MHSA community stakeholder is any individual, group, or organization that has an interest in the MHSA and wants to participate in the process. It includes consumers of mental health services and their families, service providers, educators, veterans, law enforcement, social service agencies, veterans, providers of alcohol and drug services, health care providers and **anyone** with an interest in mental health services.

**Proposition 63, Mental Health Services Act** (MHSA): The MHSA was approved by the California voters in November 2004 and became law in January 2005. It is funded by imposing an additional 1-percent tax on individual taxable income in excess of one million dollars and represents a comprehensive approach to the development of a system of community-based mental health services and supports.

**Serious Emotional Disturbance** (SED): Defined as a child who possesses a diagnosable, serious disorder such as pervasive developmental disorder, childhood schizophrenia, schizophrenia of adult-type manifesting in adolescence, conduct disorder, affective disorder, other disruptive behaviors, or other disorders with serious medical implications.

**Serious Mental Illness** (SMI): Persons 18 years and older who, at any time during a given year, had a diagnosable mental, behavioral, or emotional disorder that met the criteria of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and that has resulted in functional impairment which substantially interferes with or limits one or more major life activities.

**Shasta County Health and Human Services Agency** (HHSA): The HHSA is a governmental department within Shasta County. It includes an Office of the Director which oversees four branches: Adult Services, Children's Services, Regional Services, and Public Health.

**Shasta County Mental Health, Alcohol and Drug Advisory Board** (MHADAB): California code has provisions for community mental health, alcohol and drug services to have an advisory board. It is the mission of MHADAB to inform and educate the public on alcohol, drug, and mental health issues and to advise the HHSA on program development, availability of services, and planning efforts. The MHADAB members are from the community, as well as a representative from the Shasta County Board of Supervisors.

# Mental Health Services Act in Shasta County

Located in the northern Sacramento Valley, Shasta County's varied landscape provides numerous recreational areas, while also supporting an active agricultural community. Shasta County is surrounded by Siskiyou and Modoc counties to the north, Trinity to the west, Lassen to the east, and Tehama and Plumas to the south. With a total area of approximately 3,900 square miles, the county includes the cities of Anderson, Redding, and Shasta Lake, as well as several unincorporated towns. Residents of Shasta County are fortunate to enjoy rural, small-town living, while being located just a 2½-hour drive from Sacramento to the south.

In July of 2015, the estimated population of Shasta County was 179,533. The county's vast open spaces result in a population density of only 46 persons per square mile, as compared to 251 for the state of California. The racial makeup of the county is 83 percent White Non-Hispanic, 10 percent Hispanic or Latino, 3 percent American Indian or Alaskan Native, 3 percent Asian, and 1 percent African American. Over 4 percent of the population are of multi or other race and over 59 percent of the population are between the ages of 18 and 64. For those individuals under the age of 64, 13.2 percent of them are disabled.

Living in a rural area requires service providers to maximize available resources. Both financial and human capital is often spread thin. Overcoming the challenges presented by a smaller revenue base and the geographic isolation of small outlying communities requires creativity and collaboration within the service network to effectively address the area's needs. The past several years of Mental Health Services Act (MHSA) networking and planning have forged an effective team of diverse agencies and individuals, working together to implement the MHSA programs and activities in Shasta County.

Proposition 63, also known as the MHSA, was approved by the California voters in November 2004 and became law in January 2005. The MHSA is funded by imposing an additional 1-percent tax on individual taxable income in excess of one million dollars, and represents a comprehensive approach to the development of 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 MHSA is as follows:

- 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 MHSA 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 programs and activities under each of these components are planned, developed, approved, implemented, monitored, and updated.

Shasta County Health and Human Services Agency (HHSA) provides for 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 MHSA Community Stakeholder process is a community collaboration that adheres to the standards of the stakeholder process as defined in the California Code of Regulations § 3320 in planning, implementing, and evaluating MHSA programs in Shasta County. The process is culturally competent and includes individuals with mental illness and their families; is wellness-, recovery-, and resilience-focused; and provides an integrated service experience for clients and their families.

| Stakeholders | |
|---|---|
| **Sector** | **Organization** |
| Underserved Cultural Populations | Redding Rancheria |
| | Good News Rescue Mission |
| | Pit River Health Services |
| | Victor Youth Services (LGBT) |
| | Hispanic Latino Coalition |
| | Local Indians for Education |
| | Shasta County Citizens Against Racism |
| Consumer-Based Organizations | Olberg Wellness Center |
| | Circle Of Friends Wellness Center |
| Consumer and/or Family Member | NAMI Shasta County |
| | Rowell Family Empowerment |
| | Mental Health, Alcohol and Drug Advisory Board |
| | Adult/Youth Consumers and Family Members |
| Health and Human Services | Adult Services Branch of HHSA |
| | Children's Services Branch of HHSA |
| | Regional Services Branch of HHSA |
| | Public Health Branch of HHSA |
| Law Enforcement | Sheriff's Department |
| | Redding Police Department |
| | Shasta County Probation Department |
| Education | Shasta Community College |
| | Shasta County Office of Education |
| | Simpson University |
| | National University |
| Community-Based Organizations | Tri-Counties Community Network |
| | Youth Violence Prevention Council |
| | Shasta County Chemical People |
| Health Care | Hill Country Health and Wellness Center |
| | Shasta Community Health Center |
| | Mountain Valleys Health Center |
| | Shingletown Medical Center |

The community stakeholder process for the MHSA in Shasta County takes place throughout the year at various meetings and workgroups sponsored by HHSA. A wide array of individuals and agencies are represented at these events. Their interest and input regarding MHSA services provides guidance to the HHSA as it administers the MHSA in Shasta County. Meetings are held at various locations that are central to many communities in Shasta County. All meetings are in-person, and most provide participation via telephone conference and web-based conference services.

The foundation of the stakeholder process is an ongoing collaborative of eight workgroups that provides informed and thoughtful recommendations and guidance for the MHSA in our community. Each of the eight workgroups focuses on a specific population or topic. These workgroups were created to improve the ways in which HHSA provides information to and gathers input from community stakeholders regarding the MHSA in Shasta County.

Workgroup participants are involved in the development of plans and updates, creating and updating mental health policies, program planning, program implementation, program monitoring, quality improvement, program evaluation, budgeting, and outreach and engagement.

| PROCESS |
| --- |
| Outreach and Engagement |
| Budget |
| Monitoring, Quality Improvement, and Evaluation |

| PROGRAM |
| --- |
| Adults and Older Adults |
| Children and Transitional Age Youth |
| Housing |
| Suicide Prevention and Stigma/Discrimination Reduction |
| Workforce Education and Training |

The Mental Health, Alcohol and Drug Advisory Board also participates as MHSA stakeholders and provides opportunity for discussion, education, and input at their meetings. An MHSA update report is given at their regular bi-monthly meetings, as well as presentations on MHSA programs. The MHSA in Shasta County is also discussed at their bi-monthly Executive Committee Meetings.

## Other Regular MHSA Stakeholder Committees

MHSA Advisory Committee: The MHSA Advisory Committee (MHSAAC) meets on an as-needed basis depending upon the needs of the HHSA in administering the MHSA. The committee is tasked with providing input and guidance for the planning, implementation, and oversight of the MHSA

and has been meeting since February 2008. All eight MHSA Stakeholder Workgroups report to the MHSAAC.

Community Education Committee: The Community Education Committee (CEC) is a community-based committee supported by the HHSA that meets monthly and is open to all interested members of the public. The CEC works to promote mental wellness, increase community awareness of mental health, and end the stigma surrounding mental illness and substance abuse.

Suicide Prevention Workgroup: The Suicide Prevention Workgroup is a local collaboration of community members and both public and private agencies which focuses on reducing the number of suicides in Shasta County. The information presented and discussed at workgroup meetings relates to the continual progress being made in the overall suicide prevention program, as well as the continued action planning, implementation and evaluation efforts of the workgroup.

During fiscal year 2015/2016, there were over 28 different public meetings and workgroups in the community which provided meaningful opportunity for community members to participate and be involved in the MHSA in Shasta County.

Distributed throughout the year are two different satisfaction surveys. The Client Satisfaction survey is available throughout the main community mental health building and is voluntary. Completed surveys are collected on a weekly basis and distributed to management staff for discussion and circulation. The survey results are tabulated and presented in report format and distributed to management and the Quality Improvement Committee. Also available as set times during the year is the Performance Outcomes Quality Improvement (POQI). The POQI survey is a requirement of the California Department of Health Care Services, in that all California counties must make the survey available, however participation in the survey is voluntary. In the upcoming fiscal year, the MHSA Volunteer Program will be focusing on encouraging greater participation in both the POQI and the Client Satisfaction surveys. The Client Satisfaction, POQI Adult survey report and POQI Youth and Family survey report can be found at www.shastamhsa.com.

# Public Comment/Public Hearing

## 30-Day Public Comment Period and Public Hearing

The public comment period for the MHSA Fiscal Year 2016/2017 Annual Update opened on June 06, 2016 and closed on July 06, 2016. A Public Hearing was conducted by the Shasta County Mental Health, Alcohol and Drug Advisory Board (MHADAB) during their July 06, 2016 meeting.

## Distribution

Public notice regarding the public comment period and public hearing was published in several local newspapers throughout Shasta County during the 30-day period of June 06, 2016 through July 06, 2016. Public notice and copy of the draft document were posted in several public locations throughout the community and made available on-line at the Shasta County Health and Human Services Agency MHSA website. The draft document was e-mailed to all stakeholders including members of the MHADAB, and copies were also available upon request.

## Comments Received

Prior to the public comment period, HHSA staff met with members of the MHADAB MHSA Annual Report Ad-hoc Committee to review the content of the draft annual update. Their recommendations were addressed in the final draft document prior to the opening of public comment.

HHSA staff met with the MHADAB MHSA Annual Report Ad-hoc Committee during the public comment period to address some concerns the committee members had the content regarding two Prevention and Early Intervention, Children and Youth in Stressed Families programs: Triple P – Positive Parenting Program and the Program for At-Risk Middle School Students. The committee members expressed their concern that the updates for these two programs did not properly reflect the issues brought forward in the previous year's annual update, nor did the content reflect progress made towards resolving those issues. Both sections were rewritten to include the specific elements requested by the committee members. The final content for both programs was approved by the committee members prior to, and discussed at the Public Hearing.

In addition, HHSA staff received several positive comments from members of the public regarding the design of the annual update and how easy it is to read, as well as appreciation for all the program evaluation and data reports made available on-line.

## Approval

During their regular meeting on July 6, 2016, the MHADAB voted to recommend adoption of the MHSA Fiscal Year 2016/2017 Annual Update plan by the Shasta County Board of Supervisors. The Shasta County Board of Supervisors adopted the plan on August 16, 2016.

Electronic copy of the completed MHSA Fiscal Year 2015/2016 Annual Update resides on the HHSA MHSA web-page: shastamhsa.com.

# Community Services and Supports

The intent of Community Services and Supports (CSS) programs is to change the public mental health system by creating programs that provide 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.

There are nine projects in CSS. For each project that provides individual direct services, the number associated with the project name below is the number of unique individuals served by HHSA staff during calendar year 2015:

1. Client- and Family-Operated Systems
2. Shasta Triumph and Recovery (STAR) - 114
3. Rural Health Initiative - 119
4. Older Adult - 41
5. Crisis Services – 1,415
6. Crisis Residential Recovery Center - 116
7. Housing Continuum
8. Co-occurring Disorders Integration
   Behavioral Health/Primary Care – 273
   Behavioral Health/Substance Use - 45
9. Outreach/Access – 2,199

***Sampling of Wellness Center Activities***

- *Activities of Daily Living*
- *Arts and Crafts*
- *Brain Games*
- *Circle of Moms*
- *Computer Class*
- *Employment & Resource Fair*
- *Goals and Dreams Luau*
- *Holiday Stressors Group*
- *Medication Education*
- *Online Dating Safety*
- *Positive Thinking*
- *Social Skills*
- *Spring Colors Tour*
- *Walk for Wellness*
- *Worry Control Workshop*

## 1. Client- and Family-Operated Systems

Through this work plan, Shasta County has two consumer-run wellness centers in the community: the Olberg Wellness Center located in Redding, and Circle of Friends located in Burney. Both wellness centers are funded through contracts with community providers: Circle of Friends is operated by Hill Country Health and Wellness Center (HCHWC) and is located in Burney, though they also provide some limited services at the HCHWC location in Round Mountain; and the Olberg Wellness Center, which is operated by Northern Valley Catholic Social Service (NVCSS) and is located in the Enterprise area of Redding.

Both Circle of Friends and the Olberg Wellness Center are multi-service mental health programs that provide ethnically and culturally diverse opportunities in a healthy, inclusive manner with a wide spectrum of activities. Both centers provide services and activities for individuals with mental illness and/or their family members. During the period of July 2014 through June 2015, an average

***Between July 1, 2014 and June 30, 2015, a total of 194 wellness center participants reported the following:***

***71%*** *received support services that allowed them to live a more independent lifestyle.*

***59%*** *experienced fewer instances of homelessness.*

***51%*** *had fewer arrests.*

of 72 individuals participated in activities each month. During that same time period, there were over 2,000 individual workshops, groups, activities, and 12-step recovery meetings for people to participate in.

Some of the goals for the wellness center participants include an increased ability to spend time in meaningful activities, increased involvement in the community, 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 the services and activities that are provided. Staffing for the centers, including the use of volunteers, must meet requirements for consumer and/or family member employment. The services and activities provided 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 use a Participant Satisfaction Survey in order to capture information that assists with measuring progress towards reaching both wellness center goals and participant goals. The survey includes the following weighted statements:

1. I have increased my knowledge about where to go for help and services.
2. My knowledge about mental illness and SED disturbances has increased.
3. My family has improved in its ability to benefit from mental health services.
4. I have improved my ability to advocate for myself and/or my family regarding mental health services.
5. I have received support services that are allowing me to live a more independent lifestyle.
6. I have been better able to create and sustain personal relationships.
7. I have had fewer times when I have been homeless.
8. I am better able to participate in my community.
9. I have had fewer arrests.
10. I have a greater feeling of safety in my community.

The Wellness Centers Summary Report can be found at www.shastamhsa.com.

Also through Client- and Family-Operated Systems, HHSA has an ongoing contract with the Shasta County National Alliance on Mental Illness (NAMI) to provide education programs in the community, including the following three NAMI programs: Basics, Family-to-Family, and Peer-to-Peer.

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

The NAMI Summary Report can be found at www.shastamhsa.com. For more information on NAMI educational programs, please visit www.nami.org/find-support/nami-programs.

## 2. Shasta Triumph and Recovery (STAR)

The requirements and guidelines for Full Service Partnership (FSP) programs are contained in Title 9 of the California Code of Regulations. Each county in California provides a Full Service Partnership (FSP) program through the MHSA. Shasta Triumph and Recovery (STAR) is the FSP 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 has the capacity to serve 60 individuals.

In additional to the STAR program, HHSA also contracts with Hill Country Health and Wellness Center to provide an FSP program in the inter-mountain area with a capacity of up to 20 FSP slots with a focus on providing services to children and transitional age youths. It is estimated by HCHWC that 75% percent of those patients reside in the intermountain area and many would meet the eligibility requirements for the FSP program. In fiscal year 2016/2017, HCHWC will be providing FSP services for up to five individuals at their new Lake Blvd. site in Redding.

***Full Service Partnership Program – Participation by Age Group for Fiscal Year 2014/2015***

- ***3** Children (age 0-15)*
- ***14** Transition Age Youths (age 16-25)*
- ***39** Adults (age 26-59)*
- ***5** Older Adults (age 60+)*

FSP programs are wellness-, recovery-, and resiliency-based and practice the 24/7 "Whatever It Takes" model in providing access to services. Individuals 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 FSP criteria are provided with outreach until they either become an FSP 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.

For fiscal year 2016/2017, HHSA will attempt to expand the availability of psychiatric services to those individuals in the Full Service Partnership program, as well as to all individuals receiving mental health services through HHSA, by hiring two new psychiatrists. There are currently two vacant psychiatrist positions open for recruitment, one for adult services and one for children.

***Full Service Partnership Program – Outcomes for 167 program participants who completed 1 year or more in the program from January 1, 2007 through May 15, 2015***

***Psychiatric Hospitalization***
*14% fewer participants were hospitalized.*
*38% fewer days were spent in the hospital*

***Homelessness***
*33% fewer participants were homeless.*
*76% fewer days were spent homeless.*

***Incarceration***
*17% fewer participants were incarcerated.*
*Participants had 76% fewer arrests and spent 41% fewer days in jail.*

During fiscal year 2016/2017, it is anticipated that the availability of housing options for FSP participants, as well as participants in other mental health programs, will be increased through the Housing Continuum projects (item 7. Housing Continuum). By providing increased access to housing with several level-of-care options available, program participants will be better able to move through the continuum of care towards more independent living.

The FSP programs in Shasta County, as well as throughout California, are continuously evaluated. Individual and program outcomes are tracked through the statewide Data Collection and Reporting (DCR) system. The California Department of Health Care Services utilizes the data entered into the DCR system to create a Provider and Program Outcome Report. There is a high degree of integrity of the data contained in the DCR system for Shasta County. On a quarterly basis, FSP data from three different areas are audited and compared to ensure that all data entered into the DCR system is complete and correct. MHSA staff compare the data in DCR with both the FSP client data entered into the Anasazi electronic health record and also to the information contained in FSP client progress notes to assure that all FSP client and outcome data is being appropriately and correctly reported. As program reports are compiled and reviewed, changes in the structure of the FSP program are made accordingly.

The Steinberg Institute, a non-profit mental health public policy organization, in partnership with the California Behavioral Health Directors Association, released their annual evaluation of Proposition 63 (Mental Health Services Act) funded programs. Utilizing the most recent data, this report clearly illustrates the dramatic effects that comprehensive mental health services have on the most vulnerable citizens of California.

A copy of the Steinberg Institute CBHDA FSP Report can be found at the following link: www.shastamhsa.com.

### 3. Rural Health Initiative

The focus of the Rural Health Initiative is to engage those individuals living with severe and persistent mental illness of all ages who are un- or under-served and have previously not been able to access mental health services in the rural areas. Through the Rural Health Initiative, the Rural Mental Health Committee was created as a forum for service providers to meet on a regular basis and discuss barriers and options to services for the rural population. The committee meets on a monthly basis and is attended by HHSA staff and several inter-mountain area service providers, law enforcement, and community-based organizations.

Through extensive demographic data, it was determined that individuals of all ages and ethnic minorities were un- and under-served in the more rural areas of Shasta County. In order to better provide services with the rural communities, HHSA has contracts with the four Federally Qualified Health Centers (FQHC) in Shasta County. Through these contracts, the FQHCs provide integrated primary health care and mental health care to these priority populations. The four FQHCs are Hill Country Health and Wellness Center located in Round Mountain, Shingletown Medical Center located in Shingletown, Mountain Valleys Health Centers located in Burney, and Shasta Community Health Center located in Redding. Services include tele-psychiatry, intensive case management, medication management, crisis services and support, and integration with primary care physicians.

***FQHC Data:***
***Percentage of Those Served by FQHC who had one of the 3 Most Prevalent Diagnosis***

*Depressive Disorders* ***– 43%***

*Other Anxiety Disorders* ***– 35%***

*Bipolar Disorders* ***– 17%***

***Fiscal Year 2014/2015***

The FQHC Annual Summary Report can be found at www.shastamhsa.com.

### 4. Older Adult

Older adults with severe and persistent mental illness transitioning from acute care medical hospitals, psychiatric hospitals, board and care homes, or jail are the target population for this program. This population is currently both un-served and under-served.

The older adult caseload includes outreach and engagement activities within the community to identify individuals in need of services. The services provided are comprehensive, 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 individual requires.

In order to address the needs of this population, the HHSA is a participating member of the Shasta County Older Adult Policy Council. The Council meets on the first Thursday of every month and is a collaboration between multiple government and community-based agencies whose mission is to enhance the well-being of Shasta County adults aged 50 and older. The Council develops policies to increase resources and the effectiveness of services available to seniors in the community, and promotes partnerships, systems cooperation, identification of collaborative resources, and outreach and engagement strategies in the community for older adults. These interagency services address co-occurring substance use disorders, including prescription drug abuse, homelessness, physical disabilities, chronic serious medical illness, and risk of loss of independence.

## 5. Crisis Services

The Crisis Services work plan provides services for individuals who are experiencing a mental health crisis or emergency. Participants include individuals who present at the local emergency room on an involuntary mental health hold, frequent utilizers of local emergency rooms who have a psychiatric diagnosis, individuals who may require acute psychiatric hospitalization, and individuals who require specialized services in order 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.

During fiscal year 2015/2016, crisis services were expanded by locating clinical staff in the two local emergency rooms. This allows for more rapid assessment and shortens the time people spend in the emergency room. The initial reports from both hospitals are very favorable. For individuals not needing inpatient psychiatric hospitalization, the time from evaluation to discharge is noticeably shorter.

During the fiscal year 2014/2015, Shasta County responded to the local emergency rooms on an average of 151 times per month, a total of 1,813 calls. During the first three quarters of fiscal year 2015/2016, the number of responses was 1,318, which decreased the average to 146.

## 6. Crisis Residential Recovery Center

The Crisis Residential Recovery Center (CRRC) provides services for up to 30 days to individuals 18 years of age and older. The CRRC serves as a social rehabilitation facility whose services avert the need for hospitalization. Stays are voluntary and include such services as daily groups focused on wellness and recovery, coping skills, medication support, education, daily living activities, peer support, and short-term respite care for adults with mental illness who have become suicidal, critically depressed, or otherwise psychiatrically incapacitated. Utilizing the services provided in the CRRC helps facilitate an individual's move from crisis into short-term transitional housing and stabilization and Full Service Partnership

***CRRC***

*Number of Admissions – 185*
*Average Length of Stay – 16 days*

***Fiscal Year 2014/2015***

enrollment, or to outpatient intensive case management and support, as needed. For some individuals, the CRRC is the initial access point into the public mental health system. The CRRC Program Activity Report can be viewed at www.shastamhsa.com.

## 7. Housing Continuum

Throughout the stakeholder process for MHSA, housing is an issue that 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 individuals with a mental illness. The primary goal of the Housing Continuum work plan is to assist adults with serious mental illness and children/youth with serious emotional disturbance 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 as possible.

### Permanent Supportive Housing

Permanent supportive housing is a subcomponent of CSS in partnership with the California Housing Finance Agency (CalHFA). CalHFA receives MHSA housing dollars from counties to act as the fiscal agent and program administrator on behalf of counties. Project developers, in partnership and with support of counties, apply to CalHFA to receive funding for permanent supportive housing projects. MHSA Permanent Supportive Housing dollars are used to fund housing developments that will provide permanent supportive housing for individuals and their families who have a mental illness and are homeless or at risk of homelessness, have multiple hospitalizations, and/or frequent emergency room visits.

Permanent supportive housing is housing with no limit on length of stay and is linked to on- or off-site supportive services. The housing can be single-person units, multi-person units for shared housing (roommates), and/or family units. Supportive services are those that assist tenants in retaining their housing, support recovery and resiliency, and maximize the ability to live and work in the community.

HHSA has partnered with PC Redding Apartments (a partnership between Palm Communities, a housing developer, and Northern Valley Catholic Social Service) and the City of Redding to build a 54-unit affordable and low-income apartment complex called the Woodlands. The formal groundbreaking ceremony for the project, which is located at 909 East Grange Street in Redding, was held January 21, 2016. The development is for 54 units, of which 19 will be for MHSA eligible individuals/families. The MHSA units will include 14 one-bedroom and 5 two-bedroom furnished apartments and will be available to serve families, transitional age youth, adults, and older adults. There is a 14-month construction period, with an anticipated move-in date in early spring of 2017.

HHSA will be responsible for providing on-site supportive services to the MHSA residents of the Woodlands. Supportive services will include case management and linkage to community resources. NVCSS will be responsible for providing an on-site life skills program to all residents of

The Woodlands. All services are designed to provide residents with the skills and supports required to assist them in maintaining permanent housing.

A second Permanent Supportive Housing project, located in the eastern area of Shasta County, is currently in the early stages of development. HHSA is partnering with Northern Valley Catholic Social Service on this project and is currently looking at purchasing and rehabilitating an existing building with four to eight apartments. Community stakeholders, especially those living and working in the eastern part of Shasta County, will be involved at all levels of the decision-making process for this project. A Supportive Services Plan and development documents will need to be submitted to the MHADAB and the Shasta County Board of Supervisors for approval before a project can be funded.

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. It is the goal of HHSA to have individuals housed in the least restrictive setting possible at the time and to continue to move individuals toward permanent independent living situations.

Board and Care facilities in Shasta County are privately-owned entities that receive their funding from their residents. Most individuals, if not all, receive Supplemental Security Income (SSI) which pays for their board and care. Shasta County HHSA has many clients who are residents in a board and care facility. Though the number changes, on May 13, 2016 there were 71 clients residing in 8 different board and cares in the area. Some of those residents require additional supports due to their mental illness and in those instances, HHSA will provide "patch" funding to cover the costs of their increased care.

## 8. Co-occurring Disorders Integration

The Co-occurring Disorders Integration program serves individuals who have co-occurring disorders of mental illness and substance use, as well as those individuals who have a mental illness co-occurring with a physical illness. Integrated behavioral care acknowledges the mind's inextricable connection to the body and recognizes that what happens to one profoundly impacts the other. The purpose is to coordinate needed care for the whole person for easier access, greater consumer satisfaction, and better outcomes.

According to the National Association of State Mental Health Program Directors, individuals with serious mental health conditions are dying on average 25 years earlier than the general population. For those individuals with a physical illness, the goal is to connect them to primary care in order to provide coordinated care to treat the whole person, and to provide services that focus not only on their mental illness, but also on their physical illness and how the two can interact. Medical and mental health providers will partner to coordinate the detection, treatment, and follow-up of both mental and physical conditions. Services include outreach, education, case

management, treatment, medication support, and clinical and nursing services. In addition to substance use, this program looks at the following physical health diagnoses:

- Diabetes
- Hypertension
- Chronic Obstructive Pulmonary Disease
- Hepatitis B or C
- Metabolic Syndrome (could include any derivation of significant obesity)
- Chronic Heart Failure

Field-based nursing staff will continue to focus on the integrated treatment of co-occurring disorders when working out in the field in order to improve the quality of life for individuals with severe mental illness and a co-occurring disorder.

## 9. Outreach/Access

Outreach and Access services are designed to target individuals in the community who are un- and under-served, determine their appropriateness for services, and refer to the appropriate service provider. Access services are provided in the main mental health building and out in the field.

The Access Team provides evaluation and assessment of all individuals referred to or seeking mental health services. During this process, an individual's level of need is determined and they are referred to a service provider either within HHSA or in the community. Service providers include but are not limited to county mental health outpatient programs, contract service providers, primary care physicians, wellness centers, and other community behavioral health providers.

Case management, nursing, and clinical staff that work within the community provide outreach services to those individuals in need with the goal of bringing them into the behavioral health system, increasing their level of services to meet their needs, or linking them to appropriate community services.

Outreach also includes field-based nursing services which are provided in a client's home by Registered Nurses (RN) working in the field. HHSA currently has three nurses working in the field who each see an average of 8 to 10 clients per day. Many clients have difficulty taking their medications correctly, are at risk of their medications being misused or stolen, or need medication education to feel more comfortable with their medication regime. Nursing staff can set up medication systems for clients which might include the use of a pill box, assist clients in setting up their own medication systems, and even deliver medications. As the client begins to understand the medications, they become more comfortable and capable in managing on their own.

During a home visit, the RN 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 RNs may be able to fix the issue or may work with the client's case manager for resolution. RNs also spend time with the client providing basic health education and can work closely 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.

# Prevention and Early Intervention

Shasta County's PEI Plan includes prevention and early intervention programs to bring mental health awareness into the entire community through universal and targeted education initiatives and dialogue. Mental health can become part of wellness for both individuals and the community by reducing the potential for stigma and discrimination against individuals with mental illness. The early intervention programs provide assistance at the earliest possible signs of mental health problems and concerns, without having to wait for the problem to get worse before help is available.

Prevention in mental health involves reducing risk factors or stressors, building protective factors and skills, and increasing support in order to prevent the on-set of mental illness. Prevention promotes positive cognitive, social, and emotional development and encourages a state of well-being that allows the individual to function well in the face of changing and sometimes challenging circumstances.

Early intervention is directed toward individuals and families for whom a short duration and relatively low-intensity intervention is appropriate to measurably improve a mental health problem or concern very early in its manifestation, thereby avoiding the need for more extensive mental health treatment or services, or to prevent a mental health problem from getting worse.

There are five local projects in PEI, as well as the CalMHSA statewide projects:

1. Children and Youth in Stressed Families
2. Individuals Experiencing Onset of Serious Psychiatric Illness (Early Onset)
3. Adverse Childhood Experiences
4. Stigma and Discrimination Reduction
5. Suicide Prevention
6. CalMHSA Statewide Projects

## 1. Children and Youth in Stressed Families

### Triple P – Positive Parenting Program®

Triple P is a prevention program that 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 the knowledge, skills, and confidence of parents. The implementation of Triple P is done in partnership with First 5 Shasta.

Parents all over the world deal with temper tantrums, disobedience, bedtime dramas, homework problems and a whole host of other common parenting issues. Triple P is designed to provide solutions to a wide variety of parenting situations and is one of the few prevention programs that is evidence-based and has been shown to benefit families.

Being a parent can be an extremely rewarding and enjoyable experience, but not always an easy one. When children are born they don't come with an instruction manual, so when it comes to parenting, it's difficult to know what works best. The program is based on five main steps to positive parenting:

1. Ensure a safe and engaging environment.
2. Create a positive learning environment.
3. Use assertive discipline.
4. Have realistic expectations.
5. Take care of yourself as a parent.

The initial costs related to Triple P were associated with the large community and HHSA trainings, as well as the purchase of Triple P resources for use by trained and accredited Triple P practitioners. Both HHSA and First 5 Shasta have continued to partner to share the costs, with both agencies funding Triple P services in the community. Triple P trainings offered in the community are coordinated and shared, as are ongoing efforts to increase Triple P services in the community, increase participation in the Shasta County Triple P evaluation, and program sustainability planning.

***Parenting Tip #4***

*Give your child lots of descriptive praise when they do something that you would like to see more of, "Thank you for doing what I asked right away!"*

Triple P practitioners are given materials and resources through HHSA as they implement Triple P in the community. They have access to web-based materials, tip sheets, workbooks, and other resources, including HHSA support and administrative staff. In exchange, practitioners are required to participate in the program evaluation. The Shasta County Scoring Application survey input system, in combination with the Monthly Metrics form completed by practitioners, provides data on the number of children and families being served, as well as their demographics, and program outcomes.

***The 325 caregivers that completed both pre- and post-surveys for the Triple P program reported the following:***

***43.2%*** *of caregivers reported less depression, anxiety, and stress.*

***19.8%*** *of caregivers reported higher self-esteem, effectiveness, and satisfaction with their parenting.*

***December 2012 through December 2015***

As reported in the MHSA Fiscal Year 2014/2015 Annual Update, there were four areas of concern surrounding on-going Triple P implementation. Those areas of concern are listed below, as well as a review of the progress made during fiscal year 2015/2016 in each area.

1. The number of practitioners participating in the program evaluation is lower than expected when compared to the number of practitioners who received training.

Update: Looking back over the staff and community members initially trained, some of those individuals were supervisors who were trained in order to provide support to their staff who were Triple P practitioners. We also found that many of the staff initially trained have transferred to a different position within HHSA that does not utilize Triple P, have been promoted to supervisor, or are no longer employees of HHSA, all of which would change their status as a Triple P practitioner and had a large effect on the ratio of individuals trained to individuals providing services. This information has allowed HHSA to focus Triple P implementation expectations on those staff who should be providing Triple P in their current positions. It is also important to utilize Triple P training for those staff that have direct client contact and that training is provided that coincides with the age group they serve.

Through follow-up conversations with community agencies who originally had staff trained in Triple P, we found that a good percentage of those agencies decided, for various reasons, to implement on their own and not participate in the HHSA evaluation. This is particularly true of those community agencies that do not contract with HHSA. This also supports our thoughts that there is a lot of Triple P being provided in the community, though the evaluation participation data does not reflect that.

2. There is a lower than expected number of caregivers showing in the Scoring Application when compared to the number of practitioners who say they are providing Triple P.

Update: While researching this area of concern, three situations consistently arose: 1) we found many practitioners were failing to link their services to a child in the Scoring Application, thus rendering their data invalid, 2) several of our community providers do not allow their staff members to access the web-based Scoring Application, and 3) when a child is entered into the Scoring Application, a caregiver must also be entered and linked to the child. If this is not done, all data related to the caregiver disappears.

3. There is a low rate of completions showing in the Scoring Application when compared to the number of interventions started.

Update: Triple P data reflected a large percentage of caregivers receiving Triple P do not complete the intervention. When investigating this concern, the two most common reasons found are that the family is no longer receiving services from HHSA, or they choose not to continue the intervention. Most Triple P interventions are eight sessions long, and sometime after the fourth session, around the time when things start to improve, the caregiver does not feel the need to continue the intervention and drops out.

HHSA has changed the way intervention completions are tracked. When a practitioner completes a Triple P intervention with a caregiver, there is a place to enter the date of completion. If the intervention was not completed, the practitioner did not enter anything in the field. The "date of completion" field in the Scoring Application has now been changed to capture the last service date of the intervention and a check-box to indicate if the intervention was completed. Also, the "date of completion" field had a default of 11/30/99, which if not changed, stays the same. That default has now been removed. Up until the time these changes were made in the Scoring Application, there were over 500 caregivers with 11/30/99 entered as their date of completion.

4. There is currently no community-wide sustainability plan for the program.

Update: HHSA will be restarting the Triple P implementation and sustainability meetings. These meetings will happen quarterly and will be attended by HHSA staff and other community agencies involved in Triple P implementation in Shasta County. The meetings will focus on ways in which the program is being successfully implemented by practitioners, identifying barriers to using the program and the program tools, exploring additional funding options for training and sustainability, monitoring the HHSA Metrics Pilot, and brainstorming ways to address participation barriers for Triple P practitioners. The outcome of these meetings is to formulate a community sustainability plan for Triple P.

In 2015, HHSA met with staff and community partners to look at the areas of concern and as a result, created a Triple P Implementation Follow-Up Plan. The plan is focused on HHSA staff and those agencies that contract with HHSA to provide Triple P services. Though HHSA is continuing to work on implementing the strategies from the plan, the progress was initially slowed by a change in leadership experienced by HHSA Children's Services Branch and the staff responsible for implementation. The strategies, as well as a review of the progress made during fiscal year 2015/2016, are as follows:

Strategy 1. Continue to address identified barriers.

Update: HHSA continues to explore barriers to providing Triple P services, as well as possible solutions. There have been in-person meetings and communications with Triple P practitioners, as well as a survey that was sent to gather information. The survey and communication results will be brought to and discussed at the next implementation and sustainability meeting. The survey results from HHSA staff showed a need to continue to train and provide support in some areas including maintaining fidelity, discerning which Triple P level is appropriate, proper documentation and data entry, and some education on what an evidence-based practice is and why Triple P works.

Strategy 2. Implement use of the HHSA Triple P- HHSA Policies and Procedures document.

Update: HHSA has learned that when implementing any evidence-based practice, it is very important to have an implementation plan in place that looks at initial and long-term sustainability, policy and procedure development, initial and ongoing training, and data collection and evaluation standards. Over the last 2 years, HHSA has been looking at the way the program is used, identifying barriers and solutions, and trying to increase utilization by staff, and as a result has finalized Triple policies and procedures for staff in both mental health and the child welfare system. The results of this strategy continues to be monitored by HHSA leadership.

Strategy 3. Support substitute caregivers, such as foster parents, in building parenting capacity by providing Triple P services, and once children are unified with their parents, expand to home-based Level 3 interventions.

Update: Regarding this strategy, HHSA has been experiencing some resistance from the substitute caregivers. That issue is continually being worked on. For parents who have been reunified with their children, HHSA is utilizing Parent Partners and Family Workers who are providing Triple P services in the home with the parents.

Strategy 4. Build additional accountability and sustainability provisions into contracts.

Update: A review of Triple P contracts found inconsistencies in requirements, including those surrounding implementation and evaluation. During fiscal year 16/17, HHSA Children's Services will be conducting a competitive procurement process for community-based services provided to children. The resulting contracts will be consistent and clear regarding Triple P services and will contain elements related to accountability for program fidelity and evaluation participation.

Strategy 5. Continue to support implementation in the community.

Update: HHSA continues to support implementation in the community by keeping outreach materials up-to-date and available, maintaining the HHSA Triple P website with current information, and providing trainings in the community on the use of the Scoring Application and Metrics. HHSA will also inform community partners of upcoming trainings and offer a Level 4 Stepping Stones training in collaboration with First 5 Shasta in the late of 2016.

Strategy 6. Continue to support implementation with HHSA staff.

Update: On August 1, 2016, HHSA will begin a Triple P pilot that is designed to lessen the amount of paperwork and data-entry required for the program evaluation and monitor program fidelity. HHSA will be utilizing the electronic

health record system already in place to capture Triple P services and track the families receiving services, hopefully making the Metrics obsolete. Staff in the pilot will also have access to mobile technology which will allow them to complete surveys in the Scoring Application while they are with caregivers out in the field. The results of the 6-month pilot will be reviewed upon completion and if successful, an implemented throughout HHSA.

HHSA 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.

Strategy 7. Provision of Triple P materials to those who are participating in data collection.

Update: HHSA will no longer provide resources and materials to those agencies and practitioners who are not participating in the program evaluation as prescribed.

In fiscal year 2013/2014, HHSA started a Performance Improvement Plan (PIP) as part of the California Department of Health Care System's (DHCS) External Quality Review Oversight (EQRO) program for mental health services. The focus of the PIP was to identify and address the barriers to utilizing Triple P by HHSA staff and to increase the utilization in order to best meet the needs of families in the community. When presenting the PIP to the DHCS representative providing support to HHSA on the PIP, the lead reviewer stated the following, "In order for this to be considered a PIP, you would need to identify a particular child outcome that you think Triple P will impact. Then you may include interventions around staff using the practice, but ultimately the PIP should focus on something better that happens for the client and that would be the focus of the interventions. The focus is not that staff does the practice/intervention because staff needs to do the practice. The underlying focus should be on why they need to do this more – how will this benefit consumers." As a result, in 2014/2015 HHSA changed the focus of the PIP to specifically look at providing Triple P services to caregivers of children with the following behavioral disorders: primary or secondary diagnosis of Oppositional Defiant Disorder (ODD), Disruptive Behavior Disorder (DBD), and/or Attention Deficit/Hyperactivity Disorder (ADHD). The updated PIP was then reviewed by DHCS's EQRO team and was ultimately denied as it did not meet the State EQRO criteria for PIP's. However, the information gathered from the work done on the PIP has been used to inform the Tripe P Implementation Follow-up Plan.

Triple P, when used with fidelity, helps families have an increased knowledge and awareness of parenting and the importance of self-care. In order to positively impact the families in Shasta County, the concerns with Triple P implementation will be an ongoing focus over the next few years.

The Triple P Implementation and Outcomes Report and the Triple P All Shasta Evaluation Report can be found at www.shastamhsa.com.

## Trauma Focused – Cognitive Behavioral Therapy

Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) is a model of psychotherapy that addresses the unique needs of children with difficulties related to traumatic life experiences. This evidence-based practice is a components-based psycho-social treatment model that incorporates elements of cognitive-behavioral, attachment, humanistic, empowerment, and family therapy models. It includes several core treatment components designed to be provided in a flexible manner to address the unique needs of each child and family.

The TF-CBT strategy, completed in December 2012, was originally for a 3-year period which included training and implementation. The clinicians trained in TF-CBT will continue to provide this model of therapy to those clients who experience difficulties dealing with traumatic life experiences.

The on-going strategy for TF-CBT is to provide update training for those clinicians who were previously trained, and to provide initial training for newly employed clinicians within HHSA.

## Program 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 both their current and future mental well-being. This is especially true for children and youth in stressed families or in under-served populations. Evidence supports the idea that a prevention or early intervention approach which targets mental health during the adolescent years is both an appropriate and effective response, with both short-term and life-span benefits. The target population for this strategy is at-risk middle school students from stressed families who either live in an under-served geographic location or are a member of an under-served cultural population.

The program chosen for implementation is called Positive Action. Positive Action is an integrated comprehensive program designed to improve the academic achievement and multiple behaviors of children and adolescents ages 5 to 18 years. The program includes school, family, and community components that work together or stand alone. The curriculum has six units that focus on the following topics: self-concept, physical and intellectual positive actions for a healthy mind and body, social and emotional positive actions for managing yourself responsibly, social and emotional positive actions for being honest with yourself and others, and social and emotional positive actions for continuous self-improvement.

The Positive Action program was initially implemented during fiscal year 2013/2014 with the Redding School District in classes for students with various behavioral or academic issues. In the second year of the pilot, the program was expanded to include two additional mainstream classrooms at Sequoia Middle School and several classrooms in Intermountain Area schools.

Positive Action is a dosage-response program, meaning program outcomes are directly related to the number of program lessons a student receives - the greater the exposure, the greater the

outcomes. During the pilot it was discovered that those students receiving Positive Action in non-mainstream classes with Redding School District move in and out of the classroom at a more rapid rate which had a direct effect on the dosage those students received, which in turn equated to outcomes that were not as positive as anticipated for those students.

In prior research studies, Positive Action has been implemented from elementary school upwards, which provides students with a Positive Action foundation. Substantial positive outcomes were for middle schools where a large percentage of their students were exposed to Positive Action prior to starting middle school.

At the end of the 2-year pilot, the Positive Action contract with Redding School District was not renewed based upon feedback from teachers and staff that felt the youth in those classrooms were not benefiting from a prevention program and needed more direct services to address behavior difficulties. The contract with the Intermountain Area schools was re-negotiated. Curriculum has been taught in the elementary grades so the foundational concepts and background can be established sooner and have a greater impact on the students. This has brought program implementation more in line with the evidence-based practice and evaluation that is focused on program fidelity and creating a sustainability plan for the future.

The survey reporting alone has not shown significant improvement in the Intermountain Area. There are multiple factors that have created challenges in data collection including turnover in teaching staff and the learning curve for those teachers who are being exposed to a new curriculum. The number of required surveys posed a challenge for teachers as well. We have seen growth with those teachers who are now teaching Positive Action in their second year as it has become integrated into daily activities in the classroom as well as reducing the quantity of surveys collected with a focus on switching to the schools trimester system as opposed to quarterly.

While the numbers do not support the program, the family and community stories do. The Intermountain School Districts believe that with the funding for one more year they will be able to internalize the program making sustainability possible. The Intermountain Area schools will continue to implement Positive Action through the contract with support from HHSA staff until June 30, 2017 where at that time each school can elect to continue through their internal sustainability plans.

Through the Stakeholder process we will be evaluating different evidence based programs that would serve the target population in the 17/18 fiscal year. The Request for Proposal process will be utilized to select a provider for the Stakeholder selected evidence based program.

The Positive Action Evaluation Report Year 2 and its Executive Summary Report can be found at www.shastamhsa.com.

## Adverse Childhood Experiences

Adverse Childhood Experiences (ACE) are defined as traumatic experiences in an individual's first 18 years of life and include abuse, neglect, and household dysfunction. These problems often lead to more subtle effects on behavioral choices in childhood and adolescence that shape later adult lifestyles and may produce long-term negative health impacts. Because of the high number of ACE in children in Shasta County, they are at an increased risk to suffer long-term emotional consequences of maltreatment in childhood including depression, anxiety disorders, post-traumatic stress disorder, alcohol or drug abuse, and relationship problems.

Approximately 30 agencies from the community sectors of social services, public health, mental health, parent support services, and education are stakeholders participating in the Strengthening Families Community Collaborative (SFCC). The goal of the SFCC is to strengthen families and reduce ACE in Shasta County by increasing protective factors, coordinating service systems, and engaging the community. The outcomes are to increase the community's capacity to ensure quality and effective linkage to appropriate services and develop county-wide procedures to improve access to services for children and families. There are many activities that support strengthening families in Shasta County and reducing adverse childhood experiences.

In the previous fiscal year, the SFCC focused on two tracks of work within the community and with our partners. The first track focused on embedding the Center for the Study of Social Policy Strengthening Families Framework implementation into a small number of pilot programs. Implementation is achieved through five core functions: building an infrastructure to advance and sustain the work; building parent partnerships; deepening knowledge and understanding; shifting practice, policies and procedures; and ensuring accountability.

The pilot programs selected reach participants of varying ages and levels of in-care or at-risk populations.

1. Child Abuse Prevention Coordinating Council:
   - Anderson Teen Center
   - Community Parent Partners
   - Pathway Parent Partners
2. One Safe Place: Discovery Program
3. Rowell Family Empowerment of Northern California: Parent Support Program
4. Tri County Community Network
   - Bright Futures
   - Children's Program
5. Visions of the Cross: FLITE Sober Living Program
6. Youth Violence Prevention Council: Youth Peer Court

Training on protective factors was completed for all pilot program staff and supervisors. Action and evaluation planning and implementation was started in April 2015, with implementation running through December 2015.

In late January 2016 the following results were completed and compiled for each pilot program:

- Program Self Assessments - measures program use of everyday actions to build protective factors.
- Retrospective Pre/Post for each program staff person - measures each staff person's use of everyday actions.
- Retrospective Pre/Post for program participants - measures level of self-reported protective factors prior to and after program services.
- Log of each program and program staff members' participation in training, implementation, and support activities.

The second track focused on different methods of increasing a broad community awareness of strengthening families and protective factors, which includes access to concrete supports.

During fiscal year 2015-2016, the SFCC "brand" was created for community materials, a Strengthening Families Organizational Toolkit, and for use on social media. A graphic designer assisted with the process. Materials created include templates for PowerPoint, flyers, brochures, postcards, letterhead. Final products include, protective factor icons for both Adults and families and teens/youth, and a photo library to be available for all partners, as well as a SFCC standard brochure, and protective factors information one-sheets. Branding templates and finalized materials will be available for all SFCC members to use for their events and presentations.

The second track also included a direct parent engagement tool called Parent Cafes created by Be Strong Families. Parent Cafes include opportunities for parents to build their protective factors and be connected to a Parent Partner, who is also in attendance. Parent Cafes were hosted monthly, many months more than one was hosted, in various parts of the county, including Burney. Cafés were hosted in conjunction with our various partners, and several bilingual Cafes were made available to the public.

During the 2016/2017 fiscal year, the SFCC will use the information gathered during the pilot program implementation to expand Strengthening Families into other program throughout the county. SFCC will continue toward increased community awareness by making the branding materials available to partners and using them as information documents to increase protective factors. 24 providers with trained to be able to host Parent Cafes and a community calendar will be created to coordinate the cafes offered throughout the county. We will continue to support bilingual cafes as well as looking to increase topic and program specific cafes including Dad Cafes, Teen Cafes and Foster Parent Cafes as examples. Two sector specific committees are being formed: one to support an ACE screening pilot with some partnering medical providers, and the other to increase the training and implementation of trauma informed practices in the education system throughout the county.

The HHSA Know the Facts: Child Abuse and Neglect in Shasta County can be found at www.shastamhsa.com.

## 2. Individuals Experiencing Onset of Serious Psychiatric Illness

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

***Individuals Experiencing the Onset of Serious Psychiatric Illness***

***24*** *unique clients received clinical services*

***January 1, 2015 thru December 2015***

The Early Onset program is staffed by a full-time clinician and a one-quarter-time family support staff. Referrals are made directly to the clinician with the idea of creating a single-point of contact for the program which assists with engaging youths and families at the earliest possible opportunity. Clinical services focus on assessment, family support and education, medication management, cognitive behavioral individual and group therapy, and psychosocial rehabilitation.

Cognitive behavioral group therapy is used by clinicians to modify undesirable behavior in children and adults. Participants are taught how to replace their negative behaviors with positive ones through restructuring the way they think and manage emotions. In addition to group activities, participants are given exercises or assignments to complete on their own outside of the group setting.

The primary clinician for the Early Onset project makes contact with invested stakeholders to describe the program and the intent to connect with prodromal clients, or those experiencing the beginnings of a serious mental illness or serious emotional disturbance. The clinician has also partnered with the HHSA Brave Faces Project (PEI Stigma and Discrimination Reduction) to travel to schools during Brave Faces presentations to offer information on mental illness and how to seek help.

## 3. Stigma and Discrimination Reduction

To facilitate implementation of the Stigma and Discrimination Reduction (SDR) project strategies, HHSA sponsors the monthly meeting of the Community Education Committee (CEC). The stakeholder-developed messages used in this project are strength-based and focused on recovery. The messages include the following:

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

HHSA's SDR project includes the following strategies:

- Media campaign
- Community education and open-to-the-public forums
- Stigma and discrimination training
- Promoting and rewarding positive portrayals of people with mental health problems
- Brave Faces Speakers bureau featuring more than 25 local residents who share their experiences with mental illness, substance abuse disorders and suicide loss
- Collaborating with other community organizations to weave stigma reduction messages into their programs and events
- 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
- Social Media campaigns/awareness
- Multi-media and short documentaries

The activities of the SDR program are directed by input and guidance from the members of the CEC which include many people with lived experience and family members, as well as representatives from several community-based organizations and the Shasta County Mental Health, Alcohol and Drug Advisory Board. The projects for this program include the annual Minds Matter Mental Health Resource Fair, the Brave Faces Portrait Gallery and Speakers Bureau, the *Stand Against Stigma: Changing Minds About Mental Illness* campaign, the *Hope Is Alive! Open Mic* series, quarterly Brave Faces public forums, and promoting the *Get Better Together* campaign.

Since 1949, May has been recognized as Mental Health Awareness Month throughout the United States. In order to bring attention to the many issues related to mental health and wellness,

Shasta County holds an annual Minds Matter Mental Health Resource Fair. The purpose of the fair is to connect individuals with community resources and promote mental health and wellness. For 2016, the 9th annual Mental Health Resource Fair was revised by the CEC as a resource fair and concert in the park in hopes of drawing more families and people who don't usually attend the fair. This year's Minds Matter Mental Health Resource Fair and Music Festival was held outside at the Library Park in Downtown Redding where unfortunately, the weather did not cooperate and attendance was far lower than anticipated.

> *"Thank you for allowing me to attend. I am so grateful you are bringing awareness and taking a stand against the stigma of mental illness."*
>
> *- Hope Is Alive! Open Mic*
> ***May 8, 2015***

During fiscal year 2015-2016, the CEC collaborated with local musicians and performers to hold six *Hope Is Alive! Open Mic* nights, 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 500 people have attended the open mic nights, and more than 30 performers have participated. The CEC is currently collaborating with the Shasta Arts Council to turn *Hope Is Alive! Open Mic* into a scripted stage show that can be used as a vivid and entertaining stigma reduction tool across the county.

The *Get Better Together* campaign aims to connect 16-25 year olds with peers who are dealing with difficult issues and providing education to them about the normalcy of a struggle with mental illness, asking them to help themselves, help others, and share what they live and know. The *Get Better Together* website is designed to be very interactive and promotes seeking help from friends, family, and professionals.

Shasta County's *Stand Against Stigma: Changing Minds About Mental Illness* campaign has been in place since 2012. This logo represents strength-based messages that promote awareness of and counter the discrimination and stigma associated with mental health problems, and is seen throughout the community on publications, advertisements, websites, and at events. The campaign also has a Facebook page that currently has over 1486 "likes" and promotes many different activities related to reducing the stigma and discrimination of mental illness: www.facebook.com/standagainststigma.

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

Brave Faces are individuals who have lived experience of mental illness, suicide, and/or substance abuse. They go into the community and talk about their lives and their experiences. They use

their stories to offer hope and recovery, provide education, promote seeking help and the elimination the discrimination and stigmatization associated with mental illness, and to make a difference in the lives of those in our community.

Brave Faces presentations are made to a wide variety of audiences which include faith-based organizations, media organizations, local businesses, community-based organizations, cultural groups, county and state government agencies, junior high and high schools, and local colleges. During 2015, there were nearly 100 Brave Faces presentations made within our community and also outside Shasta County. It is estimated that more than 3500 individuals were reached through these presentations.

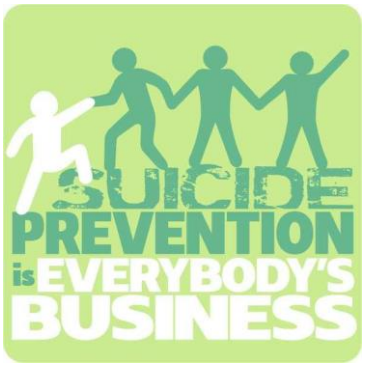
Brave Faces also provides community education and trainings. The *Becoming Brave* Training is a free training where community members can come together and learn how to erase the stigma related to mental health by sharing their stories. Thus far, more than 60 people have participated in Becoming Brave trainings, and we have more than 15 qualified trainers.

In 2016, the CEC initiated a plan to start holding quarterly open-to-the-public forums to increase the reach of Brave Faces speakers and to engage more community members on important topics. The first quarterly forum was focused on stigma faced by people who have suicidal ideation and who survive suicide attempts. More than 50 people attended the forum, and two of the speakers as well as staff were later featured on a Jefferson Exchange program about the same topic on Jefferson Public Radio, which broadcasts from Eugene to Chico. Forums are also planned to address stigma faced by people who are experiencing substance abuse disorders as well as the mental health effects on young people who face identity-based bullying, such as racism, sexism, or homophobia.

In 2015-16, the CEC began producing short documentaries and promoting them on social media as a way to reach more people online. The goal is also to have enough short documentaries to eventually do a mini-film festival. HHSA contracted with a videographer to produce *Becoming Brave: Changing Minds About Mental Illness* in Shasta County, a 16-minute documentary about the Brave Faces program featuring three speakers: Greg Burgin Jr., Neil Shaw and Susan Guiton. The speakers discuss suicide loss, PTSD, depression, substance abuse and historical trauma. According to Facebook statistics, more than 3,000 have played the video since it was published.

In January of 2016, staff produced the *I Am/Was Homeless* documentary, a 7-minute video about three local people who previously were homeless or are currently homeless. The video seeks to dispel myths about the people who experience homelessness and to increase the understanding of the public about how important stable housing is to wellness and recovery. Currently, two other video projects are in production and will focus on hearing voices and surviving a suicide attempt.

## 4. Suicide Prevention




From 2008 to 2013, Shasta County averaged approximately 40 suicide deaths per year, an increase from 38 per year during 2007 to 2009. Hundreds more individuals are left coping with the aftermath. This does not include the many more who struggle to cope with or recover from an attempted suicide of self-injury. The Suicide Prevention project activities are implemented by HHSA in partnership with the Shasta Suicide Prevention Workgroup, a local collaboration of public and private agencies and concerned community members, who meet quarterly and are focused on reducing the amount of suicides in Shasta County. Presentations and updates are given to community stakeholders through regular meetings of the Shasta County Mental Health, Alcohol and Drug Advisory Board, the MHSA Advisory Committee, the Public Health Advisory Board, the Community Education Committee, and at various other community meetings. The information presented and discussed relates to the continual progress being made in the overall suicide prevention program, as well as the continued action planning, implementation, and evaluation efforts of the workgroup.

The suicide prevention media campaign and social marketing campaign continues with the use of websites and social media, handouts, and flyers. The campaign promotes the workgroup, community events, resources, and additional information related to suicide prevention. The Suicide Prevention Workgroup has a Facebook page that currently has 288 "likes." The page also promotes resources including: the National Suicide Prevention Lifeline, which provides free and confidential emotional support 24/7 to people in suicidal crisis or emotional distress; and the Institute on Aging Friendship Line for older adults, a warm line that provides free counseling, referrals, grief support programs, and well-being checks in order to reduce loneliness, suffering, and isolation, which can all lead to suicide. The Alex Project Crisis Text Line operates via text communication in order to provide support for a multitude of crises. The Suicide Prevention Workgroup Facebook page encourages community involvement in efforts to reduce suicide in Shasta County by providing information and invitations to QPR (Question, Persuade, Refer) Suicide Prevention Trainings and monthly Workgroup meetings.

***Total Number of Calls from Shasta County Residents***

*Friendship Line*
***533***

*Suicide Prevention Lifeline*
***1,702***
***40.5**% were calls from veterans*

***January 2015 thru December 2015***

Community education about decreasing the access to lethal means for suicide attempts is an important activity of the Suicide Prevention project. Safeguarding lethal means continues to be promoted as an essential step when intervening with someone who may be contemplating suicide. Shasta County's Firearms Safety and Suicide Prevention Project was selected as an exemplary project from the Superior California Region The project continues to be promoted

through the Shasta County Sheriff's Office as well as local gun shop owners, and concealed carry (CCW) instructors.

The Suicide Prevention Workgroup and its partners continue to work throughout the community to provide culturally appropriate activities focused on reducing the amount of suicides in Shasta County.

The HHSA Know the Facts: Local Suicide Rates in Shasta County can be found at www.shastamhsa.com.

## 5. CalMHSA Statewide Projects

California counties, including Shasta, which provides member counties with a flexible, efficient, and effective administrative/fiscal structure focused on collaborative partnerships and pooling efforts in the following areas:

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

CalMHSA is responsible for administration of three MHSA Prevention and Intervention statewide initiatives on behalf of California counties:

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

CalMHSA provides member counties with an independent administrative and fiscal intergovernmental structure for jointly developing, funding, and implementing mental health services and educational programs at the state, regional, and local levels. As an on-going efficient delivery mechanism for statewide and other California mental health projects, a central component of CalMHSA's vision is to continually promote systems and services arising from a commitment to community mental health, and to the values of the California Mental Health Services Act.

In January 2011, CalMHSA's work plan was approved by the MHSOAC as an implementation guide for the three initiatives. The work plan provides an outline for statewide implementation and contains priorities and themes, and focuses on recommended actions and budget information. The work plan also includes a program evaluation component.

A new report from the Rand Corporation's independent review of CalMHSA's Prevention and Early Intervention Initiatives concludes, "CalMHSA PEI initiatives are successfully launched and already showing positive outcomes in stigma and discrimination, suicide prevention, and promotion of student mental health." The RAND report demonstrates the strong value statewide stigma

reduction efforts offered by the California Mental Health Services Authority. By working jointly through CalMHSA, California counties are delivering effective social marketing campaigns that change the conversation around mental health stigma and delivering value for Californians and taxpayers.

Key findings:

- Each dollar invested in stigma reduction is estimated to return $1251 dollars to the California economy, and $36 to state coffers by increasing employment and worker productivity.
- CalMHSA stigma reduction programs, including Each Mind Matters: California's Mental Health Movement, boosted the number of adults seeking help for psychological distress by 22% among those exposed to campaigns.
- As a result of these programs, an additional 120,000 Californians accessed mental health services.

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

- "Know the Signs" suicide prevention campaign empowers Californians to stop suicide. Those who viewed Know the Signs materials were more confident in intervening with those at risk of suicide, more comfortable discussing suicide, more aware of the warning signs, and felt they had greater skills and knowledge on intervening with or referring someone at risk to help. The RAND Corporation called the statewide "Know the Signs" social marketing campaign "one of the best media campaigns on the subject" of suicide prevention.

- Innovative Stigma Reduction Efforts Result in Attitude Changes. Middle school students who attended "Walk in Our Shoes" presentations expressed less stigmatizing attitudes. They expressed greater willingness to interact with fellow students with a mental health problem and more positive emotional responses to a hypothetical student with a mental health problem.

- Trainings equip education systems to meet student mental health needs. Trainings reached large numbers of educators, students and staff in the State's K-12 and higher education systems, including women and individuals from diverse racial/ethnic backgrounds. Training 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.

A copy of the CalMHSA 2016 Rand Infographic and the CalMHSA 2016 RAND Report for the statewide PEI Projects report can be found at www.shastamhsa.com.

# Workforce Education and Training

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.

There are three local projects in HHSA's WET plan, as well as a regional project:

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, MHSA staff is currently working with Shasta County human resources staff to create a new employment classification: Peer Support Specialist. All county employees who are hired as Peer Support Specialist will be required to successfully complete the Shasta MHSA Academy prior to hire or within the first 6 months of employment. Currently, the WET projects currently employ two extra-help Community Mental Health Workers (CMHW) with lived experience of mental illness who use that experience and understanding to provide peer support, training, and mentorship to participants.

During fiscal year 2016/2017, the MHSA Volunteer Program will continue to focus on growing our volunteer navigator base. HHSA staff are researching ways to increase volunteer retention through enhancing engagement and satisfaction. We are exploring additional ways to utilize volunteers' unique skill set and lived-experience through reshaping the scope of their duties to include more hands-on interaction through peer support and shared-decision making. We will also be implementing a kiosk system whereby volunteers will be placed prominently in the lobby and serve as the central welcoming and information point for individuals as they initially enter the clinic. We're also working to expand the scope of projects volunteers assist with.

The MHSA Volunteer Program Report can be found at www.shastamhsa.com.

## 1. Comprehensive Training

The Comprehensive Training project provides trainings on specific strategies and skills in order to assist those working in the public mental health field to achieve a greater knowledge base to support providing services that meet the community's needs. Trainings provide opportunities to

increase competencies of the community workforce and are available to HHSA staff, contract providers, private practice professionals, community-based organizations, consumers, family members, and students.

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

| **Calendar Year 2015 Training Name** | **Date of training** | **# of participants** | **# of CEUs** |
|---|---|---|---|
| ASIST: Applied Suicide Intervention Skills Training | 2/19/2015 | 14 | 2 |
| Cognitive Impairments and Cognitive Rehabilitation | 3/16/2015 | 23 | 23 |
| Life/Work Balance- Stress Management (Golden Umbrella) | 7/31/2015 | 10 | n/a |
| Wellness, Resiliency and Recovery (Golden Umbrella) | 9/15/2015 | 64 | n/a |
| Law and Ethics for County Health Care Providers | 9/24/2015 - 2 sessions | 254 | 28 |
| CPI Initial Training (8 hours) | multi - 5 sessions | 77 | n/a |
| CPI Refresher Training (4 hours) | multi - 3 sessions | 39 | n/a |
| **7 different trainings (3 of which offered CEUs), in 14 sessions** | **totals:** | **481** | **53** |

In 2014, HHSA completed a 2-year long process of providing Non-violent Crisis Intervention Training for approximately 900 HHSA staff members. The 8-hour training teaches individuals how to identify behaviors that could lead to a crisis, how to most effectively respond to each behavior to prevent the situation from escalating, how to use verbal and nonverbal techniques to defuse hostile behavior and resolve a crisis before it becomes violent, how to cope with your own fear and anxiety, and how to use the principles of personal safety to avoid injury if behavior does become physical. In 2015, HHSA began the process of providing 4-hour Non-violent Crisis Intervention Training update trainings for all staff members. We also continue to offer the initial 8-hour training to new staff. The 4-hour training is offered two times every other month and the 8-hour is offered during the opposite month.

A copy of the CPI Training 2 Year Report can be found at: www.shastamhsa.com.

## 2. MHSA Volunteer Program

The MHSA 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 the delivery of services. This program is being opened to any individual over the age of 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.

Despite staff turnover and being understaffed during the past year, the MHSA Volunteer Program experienced significant expansion both in terms of number of applicants and total number of participants. There was an 80% increase in the number of applications received (92 in twelve months compared to 51 over the previous 27 months) and a 159% increase in the number of participants (57 in twelve months compared to 22 over the previous 27 months). This success can be attributed to several factors:

- Revised program materials (posters, flyers, brochures) to be more informative and visually engaging,
- Web-based recruitment,
- Strong partnerships with key staff at Shasta College,
- Increased engagement with local wellness centers,
- Collaboration within the agency and with other local organizations,
- Expanded program activities.

Between April 2015 and March 2016, the MHSA Volunteer Program underwent significant change in design. The program expanded from one avenue for volunteers to participate to three avenues: General Volunteering, the Shasta MSHA Academy, and the Shasta College Student Volunteer Internship Program. Each of these areas is slightly different, but they all have the same underlying purpose: to provide individuals training and hands-on exploration of what it is like to work in the public mental health field.

General Volunteering: This portion of our program provides individuals with or without lived experience of mental illness a chance to not only give back to their community, but also get a broad introduction into what it is like to work in this field. Volunteers are provided with orientation to the Agency and 16 hours of training. Participants learn about a variety of topics including: wellness and recovery, stigma, ethics and boundaries, communication, strengths-based focus, professionalism, and customer service. General volunteers, also referred to as 'Navigators', spend their time helping to create a welcoming environment in the waiting area and assisting staff in completing special projects.

During this reporting period, the MHSA Volunteer Program formed a partnership with the HHSA CalWORKS Work Experience (WEX) program. WEX participants are screened for their interest in

pursuing a career in the mental health and/or social work field and then referred to the volunteer program. They are provided education, training, and hands-on work experience. To date there have been six WEX participants.

Shasta MHSA Academy: This free 65–hour training program helps individuals prepare for careers within the public mental health field and/or equips them to become peer mentors. Participants are provided with 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 Specialist (iNAPS) and reflects the national ethical guidelines and practice standards for peer supporters. Hands-on learning covers training in group dynamics, meeting facilitation, stakeholder engagement, peer interaction, and center-based program delivery. Participants spend time volunteering in local wellness centers and our main mental health facility, are required to participate in advisory groups and/or stakeholder meetings, and shadow staff.

The first round of the Academy was very well-received. There were three Academies per week, two located in Redding and one in Burney at Circle of Friends. A total of 12 individuals successfully completed the Academy. On February 23, 2016, the second round of classes began. There are 13 participants who meet Tuesday mornings from 8-12:30 through the end of May 2016. The Academy will continue to be offered multiple times per year. The next round is scheduled to begin Summer of 2016, with one class offered at Circle of Friends in Burney and one in Redding. The current waitlist for both classes is already at capacity.


MHSA Academy class in Redding hard at work in group discussions.

MHSA Academy graduates from the Burney class.

The Shasta MHSA Academy Course Evaluation report can be found at: www.shastamhsa.com.

**Shasta College Student Volunteer Internship Program:** In September of 2015, the MHSA program began partnering with Shasta College (our local community college) to provide students interested in the mental health field 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.

A total of 23 students have applied for internships. During the Fall 2015 semester, five students complete all 60 internship hours. As a direct result of the internship, one student is now employed with HHSA as a Community Mental Health Worker. The Spring 2016 semester is underway with seven students participating in internships.

Over the last year, MHSA staff has formed a strong partnership with Shasta College. In addition to implementation of the internship program through Shasta College's psychology department, the college has also asked to incorporate the Shasta MHSA Academy within their standard course offerings. MHSA staff is redesigning the curriculum to align with a more robust comprehensive psychosocial rehabilitation model of education. MHSA staff plans to work with the college to begin the curriculum approval process in the next fiscal year. Once approved, the Academy will be offered at least once per year at Shasta College.

The focus for the MHSA Volunteer Program during fiscal year 2016/2017 will be to continue to refine the Shasta MHSA Academy to reflect peer certification standards that are being pursued at the state level through SB 614. By restructuring the Shasta MHSA Academy to include all components outlined in SB 614, the hope is to have the curriculum approved for statewide certification. In addition, official certification of this program will benefit HHSA as we integrate the Shasta MHSA Academy at Shasta College.

### 3. Internship Program

This program provides the opportunity for individuals working towards a degree or licensure to gain the 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 HHSA staff, including the Chief Psychiatrist and a Marriage and Family Therapist.

Students, both HHSA employees and non-employees, are provided internship hours that are 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.

HHSA has established contracts 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.

### 4. Superior Region WET Partnership

MHSA WET funds from the state are being utilized to pay for regional county partnerships throughout California that focus on increasing the education and training resources dedicated to the public mental health system workforce. The regional partnerships are supported by staff from the 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 assist counties to 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 on-line education opportunities for those wishing to further their education that already are, or would like to become, employed in the public mental health field.

- MHSA 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. Shasta County has had 28 recipients of this program to date.

Currently the Superior Region Partnership is in the process of determining how to spend funds over the next three year period. They are gathering feedback from counties to determine if they should continue to provide peer provider core competency training through CASRA or apply for

funding through OSHPD instead. Building sustainability for the Distance Learning program is also a key concern for the Partnership. They are looking at establishing an endowment that would continue to fund Distance Learning past the next three years.

In April 2016, the Partnership sponsored a two-day basic WRAP trainings. Counties were invited to send individuals who were interested in becoming trained WRAP facilitators. Participants who successfully completed the initial two-day are invited back for a 5-day WRAP facilitators training in June 2016. After completing the 5-day in June, participants will be eligible to apply to attend another 5 day training to become WRAP trainers of trainers sometime in 2017.

HHSA will continue to participate in the Superior WET Regional Partnership to bring statewide projects to Shasta County.

### 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, which was created through the MHSA, is a loan forgiveness program in order to retain qualified professionals working within the Public Mental Health System (PMHS). Through the Workforce Education and Training component of the MHSA, $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 PMHS.

Counties determine which professions are eligible for their hard-to-fill or retain positions. Some of the eligible professions include, but are not limited to, 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 MHLAP is a competitive process which requires an application. Since 2009, over 46 awards have been given to individuals who work within the PMHS in Shasta County, with some individuals receiving the award multiple times.

| 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 |
| Total Award to Date | | $267,474 |

# Innovation

INN projects are novel, creative and/or ingenious mental health practices/approaches that contribute to learning. In December 2014, MHSA staff completed the community stakeholder process 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 the needs of the community. The results of that process was an idea for a Community Mental Health Resource Center.

The details of the idea were put into a draft Innovation Plan which was then approved by the MHADAB and the Shasta County Board of Supervisors in late 2015, and then by the Mental Health Services Oversight and Accountability Commission in January of 2016. A Request for Proposals was published in March of this year. HHSA received five responses and, through a committee review process, selected a local provider to implement the Community Mental Health Resource Center in Redding. Upon execution of a contract, implementation will start and the center should be operational later this summer.

The center will be open 7 days a week/365 days a year, in the afternoons and evenings. Services available at the center will 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, and
- A peer-staffed resource center which provides resources and information, assistance with linkage to benefits, resource materials, referrals, education, and support groups.

In addition to the Innovation project, the center will also include two other non-MHSA funded projects: a Laura's Law pilot project and a Foster Youth/Caregiver Resource project.

The Innovation project has five objectives:

1. Improve access to services, particularly for individuals currently un- or under-served by the existing mental health system.
2. Reduce mental health crises, included 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. Positively impact families by partnering with other agencies and community-based organizations, including family-focused services as a priority, 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 will be built around these five program objectives with evaluation reports being published annually.

# Capital Facilities

The Capital Facilities project is focused on the community mental health building located at 2640 Breslauer Way in Redding. The project includes the remodel of the front entrance/waiting room area, as well as a refresh of the main floor of the building, with the intended purpose of creating and facilitating easier and more comfortable access to services.

Most individuals receiving public mental health services, both directly and indirectly, start their process at the Breslauer facility for intake, assessment, and completion of administrative paperwork. Direct services are also provided in this building for individuals of all ages. Once completed, this project will help create a positive and welcoming environment for those individuals utilizing the building, including consumers, family members, staff, and visitors. The redesign will provide for consumer privacy, as well as improved safety and increased morale of both staff and others.


The remodel of the front entrance/waiting room area was completed Spring of 2015 and the response to the new look and design has been overwhelmingly positive from both staff and those who come for services.

The building refresh portion of the project has already begun. A new general contractor has been selected and the scope of the project has been outlined and contract agreements have been signed. The required initial preparation work throughout the main floor of the building should be completed May 2016. The refresh project is tentatively scheduled to be completed in October 2016.

# MHSA Budgets

The following budget sheet is an overall view of anticipated MHSA expenditures and revenue for fiscal year 2016/2017.

**FY 2016/17 Mental Health Services Act Annual Update**

**Funding Summary**

**County: Shasta** **Date: June 2016**

| | MHSA Funding | | | | | |
|---|---|---|---|---|---|---|
| | A | B | C | D | E | F |
| | Community Services and Supports | Prevention and Early Intervention | Innovation | Workforce Education and Training | Capital Facilities and Techno Needs | Prudent Reserve |
| **A. Estimated FY 2016/17 Funding** | | | | | | |
| 1. Estimated Unspent Funds from Prior Fiscal Years | 2,223,349 | 2,472,494 | 2,536,849 | 32,369 | 75,884 | |
| 2. Estimated New FY 2016/17 Funding | 5,931,800 | 1,482,950 | 390,250 | | | |
| 3. Transfer in FY 2016/17[a/] | 0 | | | | | |
| 4. Access Local Prudent Reserve in FY 2016/17 | | | | | | 0 |
| 5. Estimated Available Funding for FY 2016/17 | 8,155,149 | 3,955,444 | 2,997,099 | 32,369 | 75,884 | |
| **B. Estimated FY 2016/17 MHSA Expenditures** | 7,252,133 | 2,184,398 | 730,850 | 32,369 | 75,884 | |
| **G. Estimated FY 2016/17 Unspent Fund Balance** | 903,016 | 1,771,046 | 2,196,249 | 0 | 0 | |

| | |
|---|---|
| **H. Estimated Local Prudent Reserve Balance** | |
| 1. Estimated Local Prudent Reserve Balance on June 30, 2016 | 0 |
| 2. Contributions to the Local Prudent Reserve in FY 2016/17 | 0 |
| 3. Distributions from the Local Prudent Reserve in FY 2016/17 | 0 |
| 4. Estimated Local Prudent Reserve Balance on June 30, 2017 | 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.

b/ MHSA regulations required counties to maintain a Prudent Reserve account, to be funded within the first 5 years of MHSA, for the purpose of mitigating the impact of decreases in MHSA revenues from year-to-year. Shasta county's Prudent Reserve fund was utilized during fiscal years 2011/2012 and 2012/2013 to prevent any reductions in program as a result of the decreased revenue.

The following budget sheets reflect anticipated revenue and expenses for fiscal year 2016/2017. The following are brief explanations of each column in the five component worksheets:

A. Estimated Total Mental Health Expenditures: The costs associated with the program listed.
B. Estimated MHSA Funding: The amount of MHSA funding that is used to pay for the program expenditures listed in A.
C. Estimated Medi-Cal Federal Financial Participation: The amount of Medi-Cal state reimbursement funding that is used to pay for program expenditures listed in A.
D. Estimated 1991 Realignment: The amount of county revenue from Vehicle License Fees (VLF) and sales tax that is used to pay for program expenditures listed in A.
E. Estimated Behavioral Health Subaccount.
F. Estimated Other Funding: The amount of IGT funding that is used to pay for program expenditures listed in A.

**FY 2016/17 Mental Health Services Act Annual Update**
**Component: Community Services and Supports (CSS) Funding**

**County: Shasta** **Date: June 2016**

| | Fiscal Year 2016/17 | | | | | |
|---|---|---|---|---|---|---|
| | 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 | 431,254 | 431,254 | | | | |
| 2. Shasta Triumph and Recovery | 1,071,385 | 605,764 | 240,621 | | | 225,000 |
| 3. Crisis Residential and Recovery | 961,810 | 774,419 | 187,391 | | | |
| 4. Crisis Response | 1,414,390 | 958,127 | 256,263 | | | 200,000 |
| 5. Outreach | 1,501,407 | 1,159,834 | 191,573 | | | 150,000 |
| 6. Housing | 40,000 | 40,000 | | | | |
| 7. MHSA Volunteer Program | 28,000 | 28,000 | | | | |
| **Non-FSP Programs** | | | | | | |
| 1. Rural Health Initiative | 1,485,527 | 860,349 | 75,178 | | | 550,000 |
| 2. Older Adult Services | 76,523 | 61,354 | 15,169 | | | |
| 3. Co-occurring Integration | 735,826 | 556,642 | 179,184 | | | |
| **CSS Administration** | 1,096,394 | 1,096,394 | | | | |
| **CSS MHSA Housing Program Assigned Funds** | 679,996 | 679,996 | | | | |
| **Total CSS Program Estimated Expenditures** | 9,522,512 | 7,252,133 | 1,145,379 | 0 | 0 | 1,125,000 |
| **FSP Programs as Percent of Total** | 75.1% | | | | | |

## FY 2016/17 Mental Health Services Act Annual Update
## Component: Prevention and Early Intervention (PEI) Funding

**County: Shasta** **Date: June 2016**

| | Fiscal Year 2016/17 | | | | | |
|---|---|---|---|---|---|---|
| | 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 | 366,352 | 366,352 | | | | |
| 2. Suicide Prevention | 267,003 | 267,003 | | | | |
| 3. | 0 | | | | | |
| 4. | 0 | | | | | |
| 5. | 0 | | | | | |
| 6. | 0 | | | | | |
| **PEI Programs - Early Intervention** | | | | | | |
| 7. Children and Youth in Stressed Families: | | | | | | |
| Triple P | 622,174 | 589,999 | 32,175 | | | |
| ACE | 173,636 | 173,636 | | | | |
| Middle School Youth at Risk | 132,621 | 132,621 | | | | |
| TFCBT | 50,000 | 50,000 | | | | |
| 8. Individuals Experiencing Onset of | 366,126 | 350,341 | 15,785 | | | |
| Serious Psychiatric Illness | 0 | | | | | |
| | 0 | | | | | |
| **PEI Administration** | 254,446 | 254,446 | | | | |
| **PEI Assigned Funds** | 0 | | | | | |
| **Total PEI Program Estimated Expenditures** | 2,232,358 | 2,184,398 | 47,960 | 0 | 0 | 0 |

## FY 2016/17 Mental Health Services Act Annual Update
## Component: Innovations (INN) Funding

**County: Shasta** **Date: June 2016**

| | Fiscal Year 2016/17 | | | | | |
|---|---|---|---|---|---|---|
| | 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 | 748,250 | 730,850 | 17,400 | | | |
| 3. | 0 | | | | | |
| 4. | 0 | | | | | |
| 5. | 0 | | | | | |
| 6. | 0 | | | | | |
| **INN Administration** | 0 | | | | | |
| **Total INN Program Estimated Expenditures** | 748,250 | 730,850 | 17,400 | 0 | 0 | 0 |

## FY 2016/17 Mental Health Services Act Annual Update
## Component: Workforce Education and Training (WET) Funding

**County: Shasta** **Date: June 2016**

| | Fiscal Year 2016/17 | | | | | |
|---|---|---|---|---|---|---|
| | 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 | 32,369 | 32,369 | | | | |
| 2. | 0 | | | | | |
| 3. | 0 | | | | | |
| 4. | 0 | | | | | |
| 5. | 0 | | | | | |
| 6. | 0 | | | | | |
| **WET Administration** | 0 | | | | | |
| **Total WET Program Estimated Expenditures** | 32,369 | 32,369 | 0 | 0 | 0 | 0 |

## FY 2016/17 Mental Health Services Act Annual Update
## Component: Capital Facilities/Technological Needs (CFTN) Funding

**County: Shasta** **Date: June 2016**

| | Fiscal Year 2016/17 | | | | | |
|---|---|---|---|---|---|---|
| | A | B | C | D | E | F |
| | Estimated Total Mental Health Expenditures | Estimated CFTN Funding | Estimated Medi-Cal FFP | Estimated 1991 Realignment | Estimated Behavioral Health Subaccount | Estimated Other Funding |
| **CFTN Programs - Capital Facilities Projects** | | | | | | |
| 1. Remodel / Renovation | 48,453 | 48,453 | | | | |
| 2. | 0 | | | | | |
| 3. | 0 | | | | | |
| 4. | 0 | | | | | |
| **CFTN Programs - Technological Needs Projects** | | | | | | |
| 5. | 0 | | | | | |
| 6. | 0 | | | | | |
| 7. | 0 | | | | | |
| **CFTN Administration** | 27,431 | 27,431 | | | | |
| **Total CFTN Program Estimated Expenditures** | 75,884 | 75,884 | 0 | 0 | 0 | 0 |

# Program and Client Outcomes

What are outcomes? According to the *Merriam-Webster Dictionary*, the definition of "outcome" is "something that happens as a result of an activity or process." In the mental health treatment field, outcomes are often used to understand/measure an individual's response to treatment programs.

Why are outcome measures important? Because they can help answer the following question:

*Are we offering effective services that are helping individuals to achieve 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. The Youth System of Care has implemented the CANS: Child and Adolescent Needs and Strengths; while the Adult System of Care has implemented the MORS: Milestones of Recovery Scale.

## CANS: Child and Adolescent Needs and Strengths

The CANS is a multi-purpose tool developed for children's services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. It was developed from a communication perspective so as to facilitate the linkage between the assessment process and the design of individualized service plans, including the application of evidence-based practices. 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.

The CANS is a tool that addresses the mental health of children, youth, and their families. It is a comprehensive assessment of psychological and social factors, as well as the strengths of both the family/caregiver and child/youth, both for use in the planning of treatment. The CANS was developed with the objectives of permanency, safety, and improved quality of life. It looks primarily at the 30-day period prior to administration and provides for a structured assessment of children and youth along a set of dimensions relevant to service planning and decision-making.

HHSA Children's staff has been trained in the use of the CANS and currently, the HHSA Outcomes, Planning and Evaluation (OPE) division is working on a mechanism to capture data and report on outcomes from the CANS tool.

To read more about the CANS: praedfoundation.org

## MORS: Milestones of Recovery Scale

The MORS is an effective evaluation tool for tracking the process of recovery for adult individuals 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 service utilization. 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.

HHSA Adult staff has been trained in the use of the MORS. Data collection began in October of 2014 and the first MORS Outcomes Report has been produced. To read more about the MORS, please visit: milestonesofrecoveryscale.com. The MORS Outcome Report can be found at www.shastamhsa.com.

## Client Satisfaction

Distributed throughout the year are two different satisfaction surveys. The Client Satisfaction survey is available throughout the main community mental health building and is voluntary. Completed surveys are collected on a weekly basis and distributed to management staff for discussion and circulation. The survey results are tabulated and presented in report format and distributed to management and the Quality Improvement Committee.

Also available at set times during the year is the Performance Outcomes Quality Improvement (POQI). The POQI survey is a requirement of the California Department of Health Care Services, in that all California counties must make the survey available, however participation in the survey is voluntary. In the upcoming fiscal year, the MHSA Volunteer Program will be focusing on encouraging greater participation in both the POQI and the Client Satisfaction surveys. The Client Satisfaction Annual Report and POQI Performance Outcome reports for both the Adult and Youth Systems of Care can be found at www.shastamhsa.com.

## Shasta County MHSA Program Data/Evaluation Reports

All MHSA data and evaluation reports can be found at www.shastamhsa.com.

# On-Line Resources

Shasta County Mental Health Services Act
shastamhsa.com

Shasta County Health and Human Services Agency
shastahhsa.net

Stigma and Discrimination Reduction
standagainststigma.com
getbettertogether.net
facebook.com/StandAgainstStigma

California Stigma and Discrimination Reduction
eachmindmatters.org
reachout.com

Triple P - Positive Parenting Program
triplepshasta.com

Suicide Prevention
facebook.com/ShastaSuicidePreventionWorkgroup

California Suicide Prevention
yourvoicecounts.org
suicideispreventable.org

Network of Care
shasta.networkofcare.org

Olberg Wellness Center
nvcss.org

Circle of Friends Wellness Center
hillcountryclinic.org/OutreachPrograms/CircleofFriends.aspx

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

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