State of California
Health and Human Services Agency

Department of Health Care Services

ANNUAL MHSA REVENUE AND EXPENDITURE REPORT and ADJUSTMENT WORKSHEET COUNTY CERTIFICATION

County/City: Shasta

Local Mental Health Director

Name: Donnell Ewert

Telephone: 530-225-5900

Email: dewert@co.shasta.ca.us

Document for Certification:

Prudent Reserve Assessment FY: 2020-2021

I hereby certify[1] under penalty of perjury under the laws of the State of California that the attached Annual MHSA Revenue and Expenditure Report or Adjustments to Revenue or Expenditure Summary Worksheet is complete and accurate to the best of my knowledge.

Donnell Ewert
Local Mental Health Director (PRINT)

Signature

5/3/2021
Date

[1] Welfare and Institutions Code section 5899(a)

Shasta County
Prudent Reserve Calculations

	Fiscal Years: 2015-16 thru 2019-20 (five total)
	Cost Center: 40400
	Account: 536402
	Account Description: State Prop 63 MH Svs Act
	*Purpose: to establish a state required Prudent Reserve fund using the **minimum** allowable amount*
1	*Sources: California Code of Regulations (CCR) - 9 CCR 3420 Local MHSF: Allocation and Expenditure Requirements*
2	*Sources: DHCS Information Notice 19-037*
3	*Sources: California Code of Regulations (CCR) - 9 CCR 3420.30 Prudent Reserve Funding Levels - (a) thru (b)*

	FY	MHSA	CSS	PEI	INN
	Fiscal Year	Mental Health Services Act	Community Services and Supports	Prevention and Early Intervention	Innovations
			CCR 3420 (b)(3)	CCR 3420 (b)(2)	CCR 3420 (b)(1)
		40499 Roll-up	76%	19%	5%
4.a	2015-2016	$ 6,944,791.58	$ 5,278,041.60	$ 1,319,510.40	$ 347,239.58
4.b	2016-2017	$ 8,760,996.69	$ 6,658,357.48	$ 1,664,589.37	$ 438,049.83
4.c	2017-2018	$ 9,592,724.73	$ 7,290,470.79	$ 1,822,617.70	$ 479,636.24
4.d	2018-2019	$ 9,319,939.54	$ 7,083,154.05	$ 1,770,788.51	$ 465,996.98
4.e	2019-2020	$ 8,178,862.46	$ 6,215,935.47	$ 1,553,983.87	$ 408,943.12
4	Total GL Balance	$ 42,797,315.00	$ 32,525,959.40	$ 8,131,489.85	$ 2,139,865.75
5	MHSA Prop 63 Total:	$ 42,797,315.00	$ 32,525,959.40	$ 8,131,489.85	$ 2,139,865.75
	Difference	-	-	-	-

3 *DHCS Methodology:*

3.a	Total CSS Revenue over previous five full fiscal years:	$ 32,525,959.40	see CCR 3420 (b)(1)
3.b	Divide total CSS revenue by five fiscal years:	$ 6,505,191.88	see CCR 3420 (b)(2)
3.c	Multiply by 5% to calculate MINUMUM:	$ 325,259.59	see CCR 3420 (b)(3)
3.d	Multiply by 33% to calculate MAXIMUM:	$ 2,146,713.32	see CCR 3420 (b)(3)

3

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§ 3420.30. Prudent Reserve Funding Levels.
9 CA ADC § 3420.30
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
Title 9. Rehabilitative and Developmental Services
Division 1. Department of Mental Health
Chapter 14. Mental Health Services Act
Article 4. Funding Provisions

9 CCR § 3420.30

§ 3420.30. Prudent Reserve Funding Levels.

(a) A County shall fund its Prudent Reserve only with funds transferred from its CSS Account pursuant to section 3420.10.

(b) A County shall fund its Prudent Reserve at a minimum level of five (5) percent and a maximum level of thirty-three (33) percent of the average amount the County allocated to its CSS Account, pursuant to section 3420, over the previous five (5) fiscal years. The calculation for the minimum and maximum funding levels percentage shall be as follows:

(1) Add the total funds allocated to the County's CSS Account over the previous five (5) fiscal years.

(2) Divide the amount in subsection (b)(1) by five (5); and,

(3) Multiply the amount in subsection (b)(2) by five (5) percent to determine the minimum level, and multiply the amount in subsection (b)(2) by thirty-three (33) percent to determine the maximum level.

(c) A County shall assess its Prudent Reserve funding level as of July 1, 2019 and include the assessment in the County's Three-Year Program and Expenditure Plan or annual update for the 2019-20 Fiscal Year pursuant to sections 3310 and 3315. The assessment shall include the maximum funding level and the actual funding level of the County's Prudent Reserve as of July 1, 2019.

(d) A County shall reassess its Prudent Reserve funding levels as of July 1, 2024, and as of July 1 every five (5) fiscal years thereafter and include the reassessment in the applicable County Three-Year Program and Expenditure Plan pursuant to sections 3310 and 3315. The reassessment shall include the minimum and maximum funding levels and the actual funding level of the County's Prudent Reserve. A County may reassess its Prudent Reserve funding levels more frequently.

(e) A County shall submit a complete Mental Health Services Act Prudent Reserve Assessment/Reassessment form DHCS 1819 (02/19), hereby incorporated by reference, to the Department by email at MHSA@dhcs.ca.gov when submitting a County's Three Year Program and Expenditure Plan or annual update, beginning in fiscal year 2019-2020 and every five (5) fiscal years thereafter and during any other fiscal year a County assesses its Prudent Reserve levels.

(f) A County shall maintain a Prudent Reserve balance that does not exceed the maximum funding level as the County determined in its most recent assessment or reassessment, pursuant to subsections (c) and (d).

(g) A County shall transfer funds in excess of the County's maximum funding level into its CSS Account during fiscal year 2019-2020 and during each subsequent fiscal year in which the County reassesses its Prudent Reserve funding level pursuant to subsection (d). A County may transfer funds from its CSS Account to its CFTN Account, WET Account, PEI Account or JPA, pursuant to sections 3420.10, 3420.15 and 3420.20 during the same fiscal year in which the County transfers funds from its Prudent Reserve to its CSS Account pursuant to this subsection.

(h) A County that transferred funds from its PEI Account to its Prudent Reserve in fiscal year 2007-08 may transfer funds in excess of the County's maximum funding level into its PEI Account during fiscal year 2019-20, and during each subsequent fiscal year in which the County reassesses its Prudent Reserve funding level pursuant to subsection (d). A County may transfer funds from its Prudent Reserve to its PEI Account until the amount transferred equals the amount the County transferred from its PEI Account to its Prudent Reserve in fiscal year 2007-08.

(i) Funds a County transfers into its CSS Account pursuant to subsection (g) shall be subject to reversion, as specified in sections 3420.50 and 3420.55, 3420.60, and the applicable Reversion Period for those funds shall begin the fiscal year the County transferred the funds from the Prudent Reserve to the CSS Account.

Note: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5847(b)(7), 5892(b) and 5892(h), Welfare and Institutions Code.

Enclosure 1

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: Shasta

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

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

I hereby certify that the Three-Year Program and Expenditure Plan, Annual Update or Annual Revenue and Expenditure Report is true and correct and that the 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 — Local Mental Health Director (PRINT)

Signature — 5/3/2021 — Date

I hereby certify that for the fiscal year ended June 30, 2020, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated December 16, 2020 for the fiscal year ended June 30, 2020. I further certify that for the fiscal year ended June 30, 2020, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City 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 AUDITOR-CONTROLLER — County Auditor Controller / City Financial Officer (PRINT)

Signature — 5/10/21 — Date

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

FY 2019/20 Mental Health Services Act Annual Update
Funding Summary

County: Shasta Date: 5/10/21

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2019/20 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	5,531,883	2,760,712	2,163,462	0	0	
2. Estimated New FY 2019/20 Funding	6,423,207	1,605,802	422,579			
3. Transfer in FY 2019/20a/	0					
4. Access Local Prudent Reserve in FY 2019/20						0
5. Estimated Available Funding for FY 2019/20	11,955,090	4,366,514	2,586,041	0	0	
B. Estimated FY 2019/20 MHSA Expenditures	7,457,618	1,674,356	749,000	0	0	
G. Estimated FY 2019/20 Unspent Fund Balance	4,497,472	2,692,158	1,837,041	0	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2019	
2. Contributions to the Local Prudent Reserve in FY 2019/20	0
3. Distributions from the Local Prudent Reserve in FY 2019/20	0
4. Estimated Local Prudent Reserve Balance on June 30, 2020	0

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

FY 2019/20 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding

County: Shasta Date: 5/10/21

	Fiscal Year 2019/20					
	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	505,098	505,070				28
2. Shasta Triumph and Recovery	2,098,758	1,605,539	465,935			27,284
3. Crisis Residential and Recovery	896,177	0	893,560			2,617
4. Crisis Response	1,295,543	895,825	332,483			67,235
5. Outreach-Access	1,440,656	1,102,909	322,690			15,057
6. Housing Continuum	1,034,780	962,647	18,036			54,097
7.	0					
8.	0					
9.	0					
Non-FSP Programs						
1. Rural Health Initiative	905,799	457,890	99,541			348,368
2. Older Adult Services	46,423	24,876	19,357			2,190
3. Co-occurring Integration	252,261	48,123	167,817			36,321
4. Laura's Law	401,115	382,979	18,136			
5.	0					
6.	0					
7.	0					
CSS Administration	1,477,490	1,471,760				5,730
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	10,354,100	7,457,618	2,337,555	0	0	558,927
FSP Programs as Percent of Total	97.5%					

FY 2019/20 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: Shasta Date: 5/10/21

	Fiscal Year 2019/20					
	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	210,848	210,808				40
2. Suicide Prevention	228,913	228,913				
3.	0					
4.	0					
PEI Programs - Early Intervention						
11. Children and Youth in Stressed Families:	0					
Triple P	568,658	521,854	46,545			259
ACE	342,464	314,394	28,031			39
Middle School Youth at Risk	61,155	56,144	5,006			5
TFCBT	114	105	9			
16. Individuals Experiencing Onset of	106,302	75,201	30,869			232
Serious Psychiatric Illness	0					
17.	0					
PEI Administration	267,024	266,937				87
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	1,785,478	1,674,356	110,460	0	0	662

FY 2019/20 Mental Health Services Act Annual Update
Innovations (INN) Funding

County: Shasta

Date: 5/10/21

	Fiscal Year 2019/20					
	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. Counseling and Recovery Engagement Center	755,399	742,880	12,519			
2.	0					
3.	0					
INN Administration	6,120	6,120				
Total INN Program Estimated Expenditures	761,519	749,000	12,519	0	0	0

Appendix A

Shasta County Health & Human Services Agency

SHASTA COUNTY MHSA | Mental Health Services Act

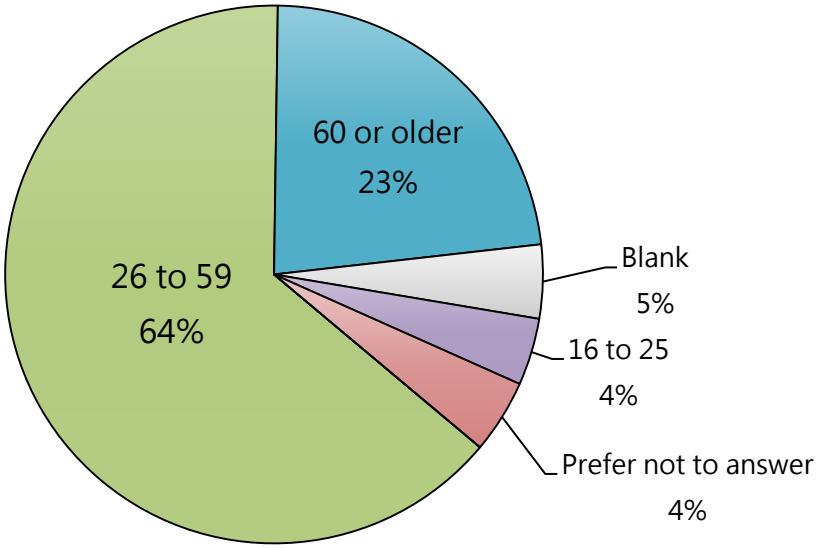
Community Stakeholder Survey Results (2019/2020) Mental Health Services Act (MHSA)

Electronic and paper versions of the Community Stakeholder Survey were consolidated in this report. A total of 248 surveys were collected. Please note that some surveys may have been completed by the same people at different meetings, or completed multiple times online, so this is not an unduplicated count.

DEMOGRAPHICS

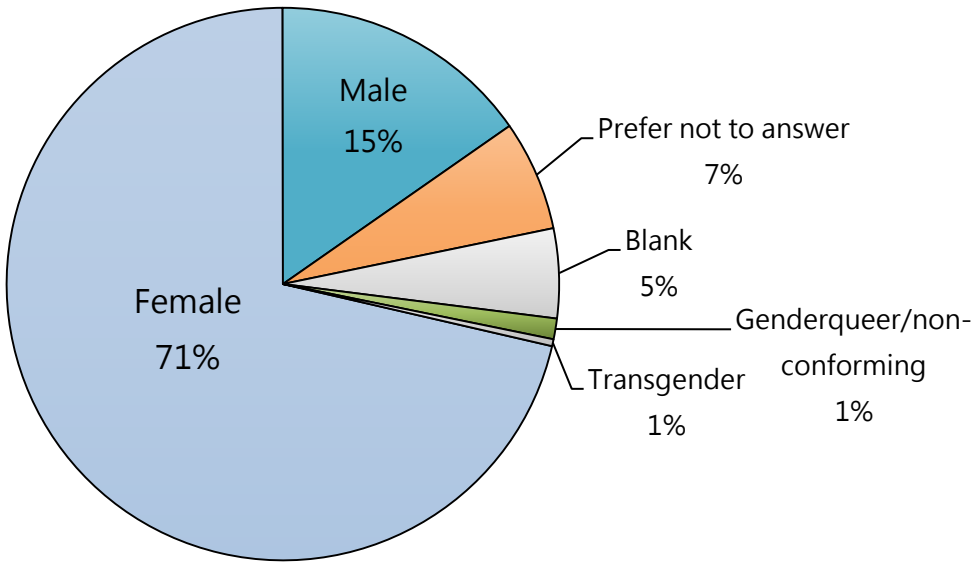
Age Groups Represented by Community Stakeholder Surveys

N = 248



Genders Represented by Community Stakeholder Surveys

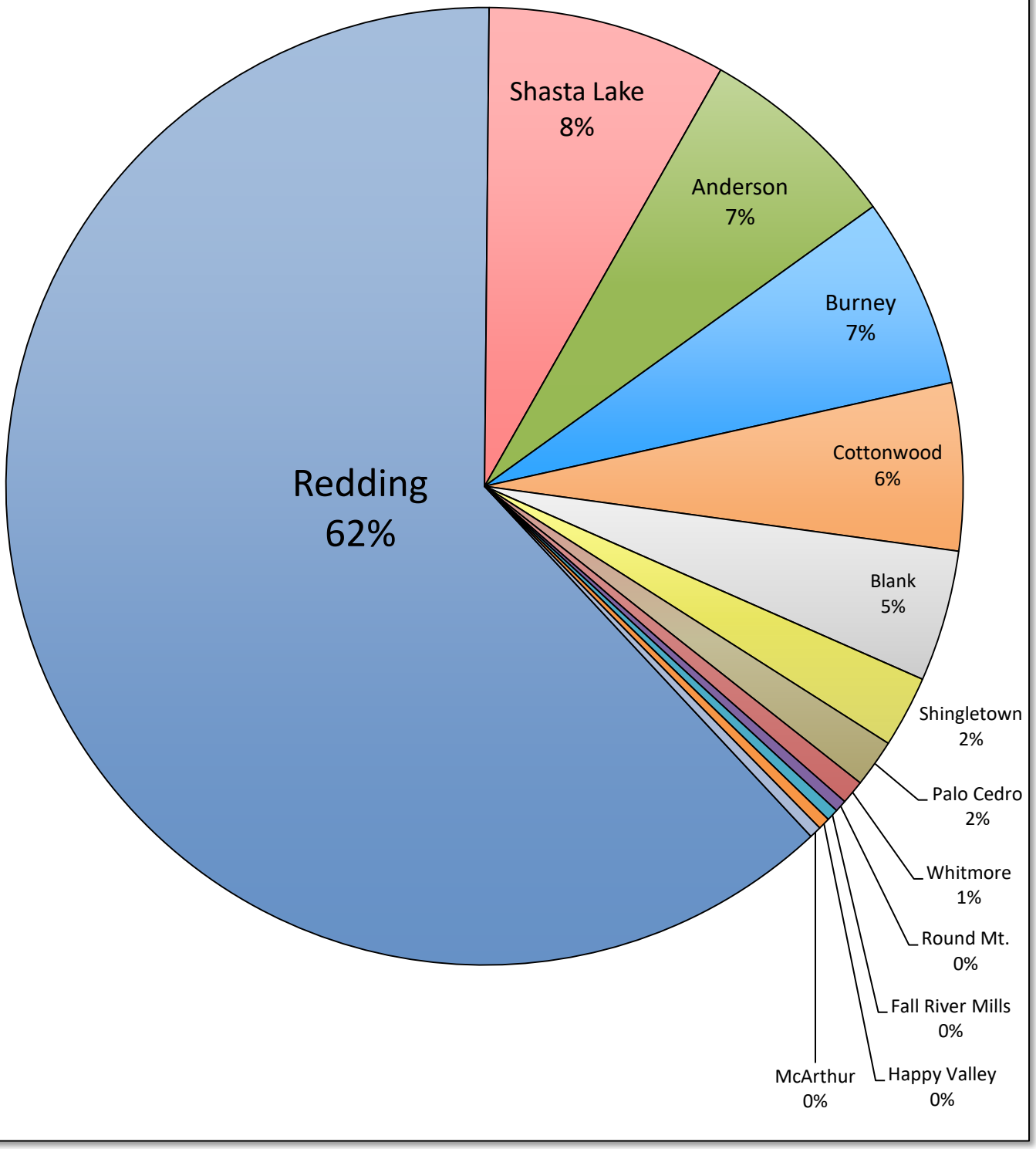
N = 248



Towns/Communities Represented by Community Stakeholder Surveys

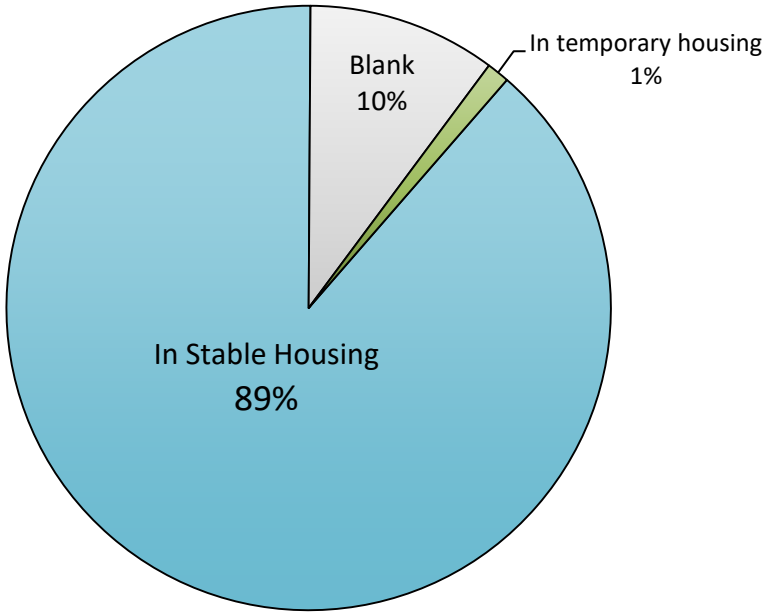
N = 248

(Percentages are rounded and may not add up to 100%)



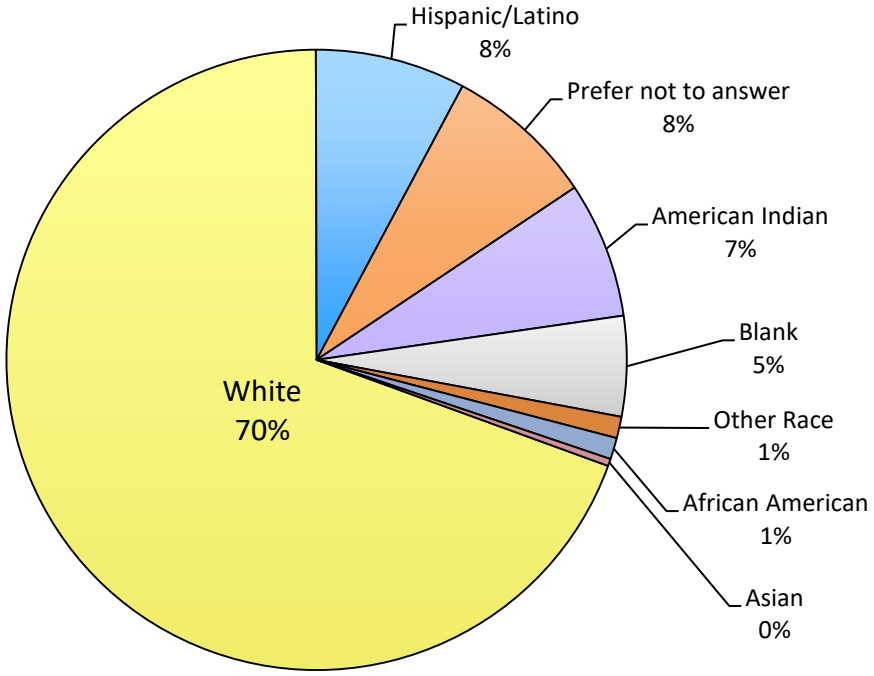
Homeless Represented by Community Stakeholder Survey

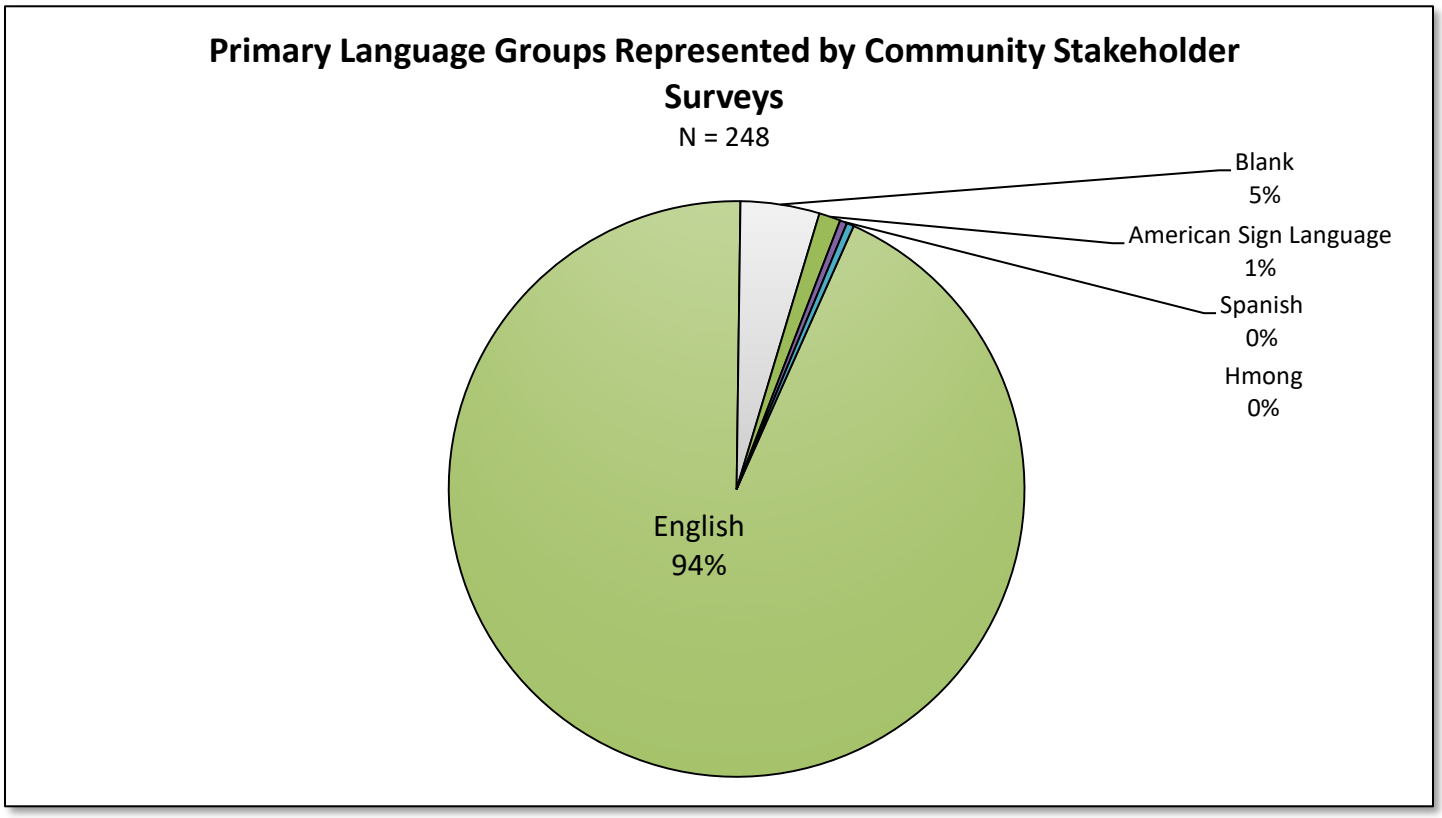
N = 248

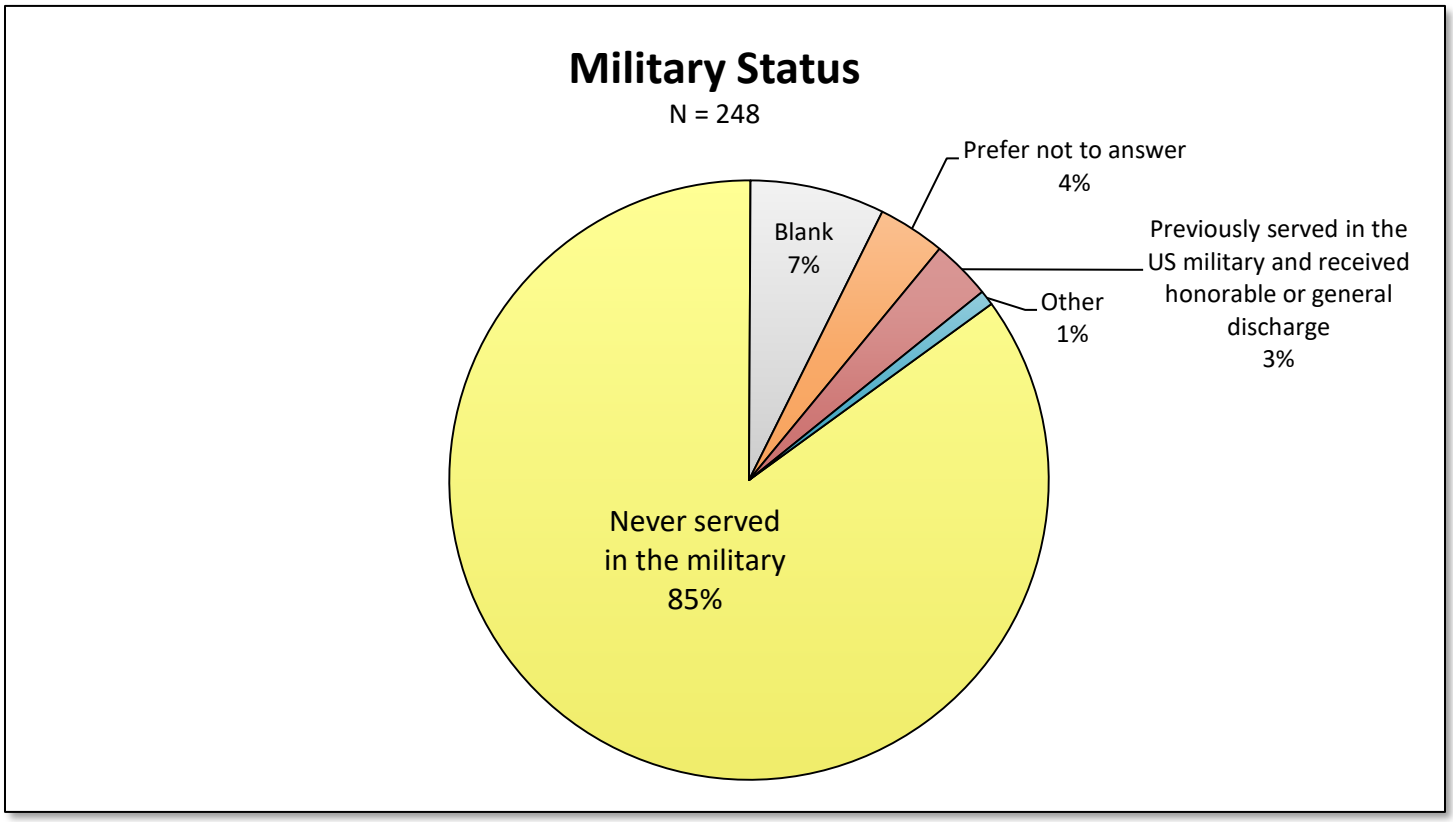


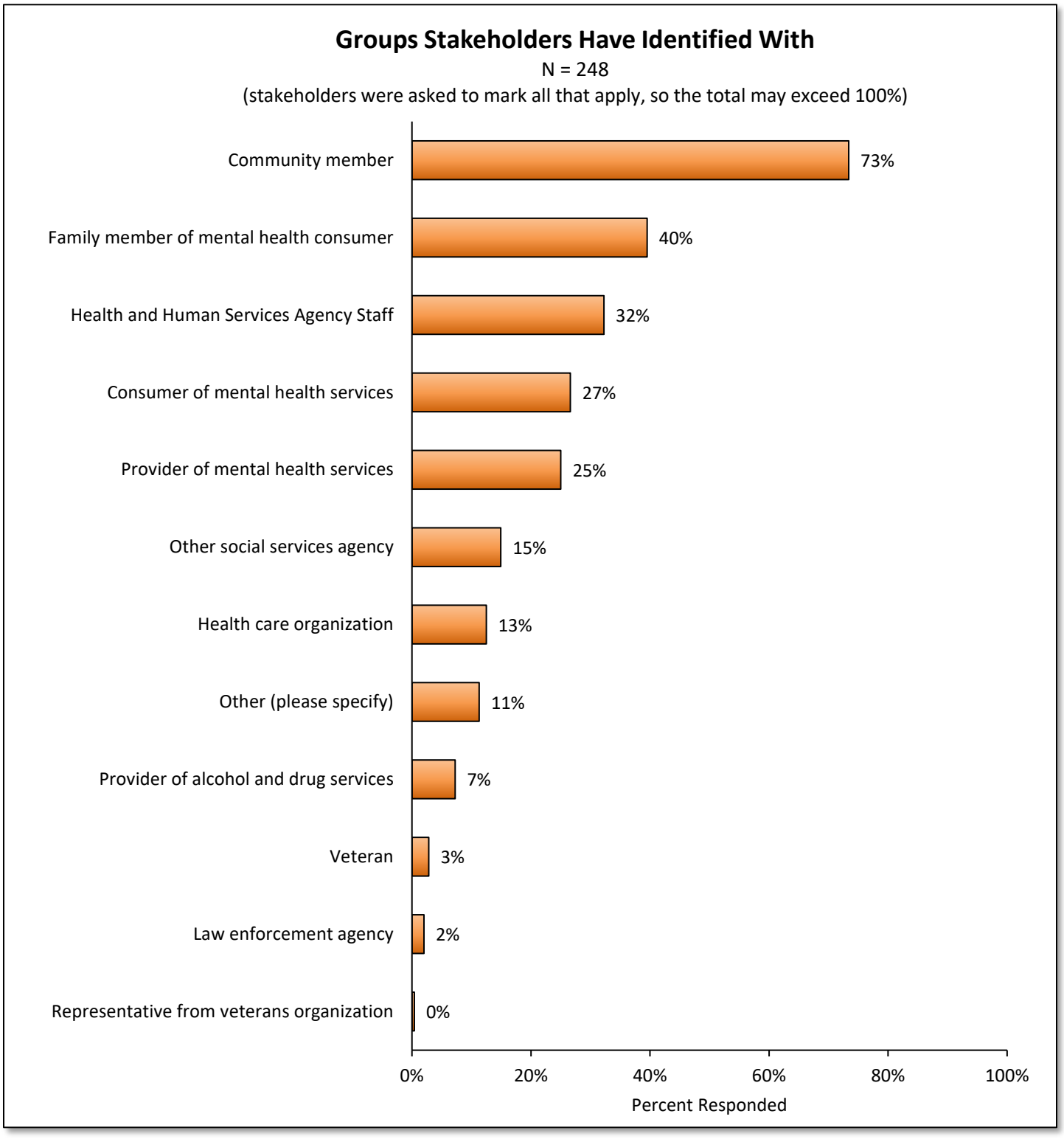
Race/Ethnicity Groups Represented by Community Stakeholder Surveys

N = 248

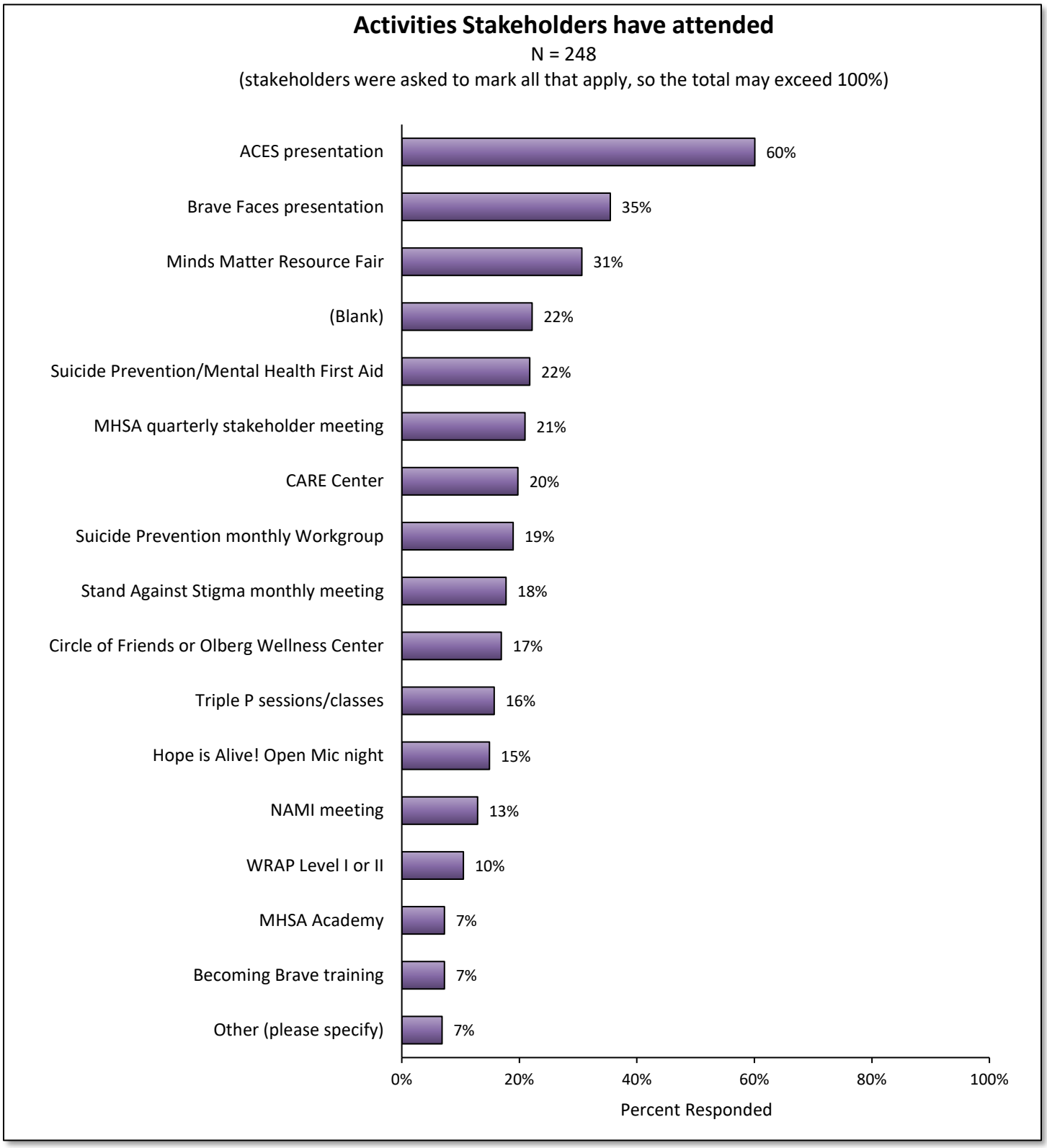



Primary Language Groups Represented by Community Stakeholder Surveys
N = 248
Blank
5%
American Sign Language
1%
Spanish
0%
Hmong
0%
English
94%


Military Status
N = 248
Prefer not to answer
4%
Blank
7%
Previously served in the US military and received honorable or general discharge
3%
Other
1%
Never served in the military
85%


Groups Stakeholders Have Identified With
N = 248
(stakeholders were asked to mark all that apply, so the total may exceed 100%)
Community member
73%
Family member of mental health consumer
40%
Health and Human Services Agency Staff
32%
Consumer of mental health services
27%
Provider of mental health services
25%
Other social services agency
15%
Health care organization
13%
Other (please specify)
11%
Provider of alcohol and drug services
7%
Veteran
3%
Law enforcement agency
2%
Representative from veterans organization
0%
0%
20%
40%
60%
80%
100%
Percent Responded

PERSONAL INVOLVEMENT / PUBLIC PRESENCE



MHSA EXISTING PROGRAM IMPORTANCE RANKINGS

People were asked to rank the importance of 5 existing programs within the Community Service and Supports category of MHSA services, and 5 existing programs within the Prevention & Early Intervention category of MHSA services. The ranking scale ranged from 1 being the most important to 5 being the least important. This ranking scale means that the lower the average rating number, the more important the program was rated by people. Results have been color coded to shade as follows:

Most Important / Most Responses				Least Important / Least Responses

Community Services and Supports (CSS) Programs N = 232	Rating Average	**1** Most Important	**2** Very Important	**3** Important	**4** A Little Important	**5** Least Important
Crisis Services	2.17	36%	27%	25%	9%	3%
Programs for people with both substance abuse & mental illness	2.51	25%	30%	22%	13%	9%
Housing Programs	3.11	19%	18%	18%	23%	22%
Education & Training Programs	3.45	13%	11%	20%	30%	26%
Wellness Centers (Olberg, Circle of Friends) & NAMI Programs	3.76	7%	13%	15%	25%	40%

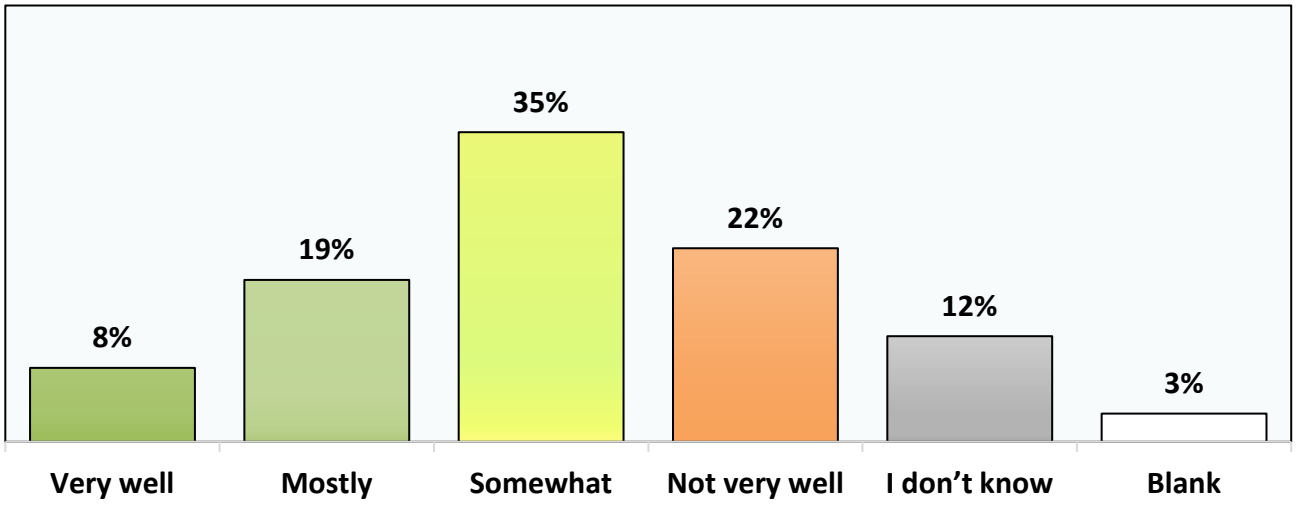
Prevention and Early Intervention (PEI) Programs N = 223	Rating Average	**1** Most Important	**2** Very Important	**3** Important	**4** A Little Important	**5** Least Important
Parenting skill programs	2.65	31%	17%	21%	19%	13%
Suicide Prevention	2.72	23%	21%	27%	21%	9%
Programs Educating middle school students about mental health issues	3.08	14%	25%	20%	20%	21%
Reducing Stigma about mental illness	3.23	18%	18%	15%	19%	30%
Preventing mental illness relapses	3.32	13%	19%	17%	22%	28%

MHSA SERVICE FEEDBACK

Stakeholders were asked a series of questions about how well MHSA services are working. Bar graphs representing MHSA Service feedback are shown below:

1.) How well do the MHSA services meet the needs of people in your community who have serious mental illness?

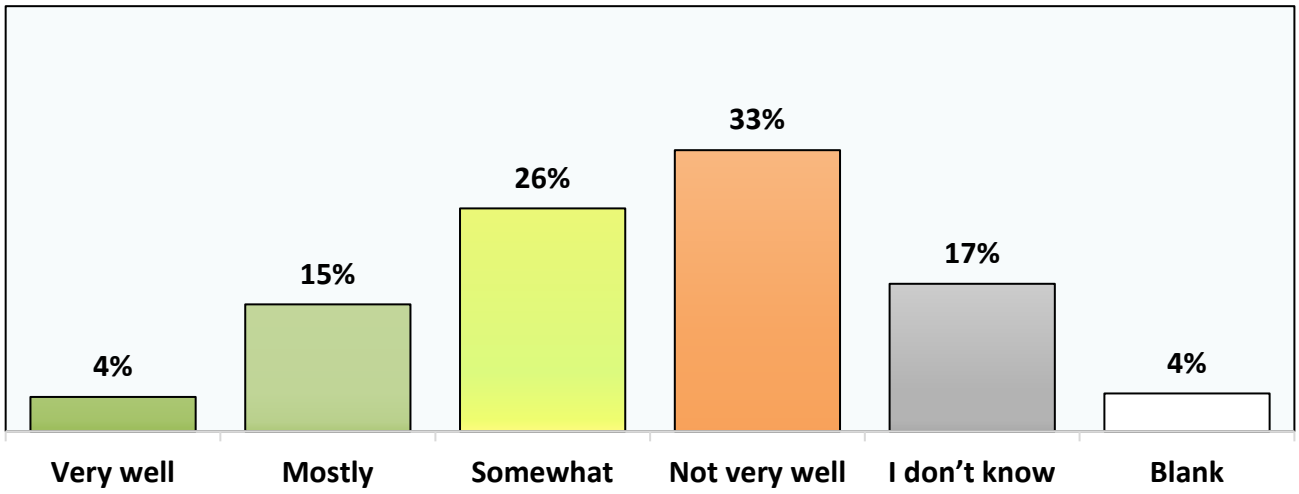
N = 248



Percent reponded. Figures may not add to 100% due to rounding

2.) How well do the MHSA services work to help people in your community BEFORE the development of serious mental illness?

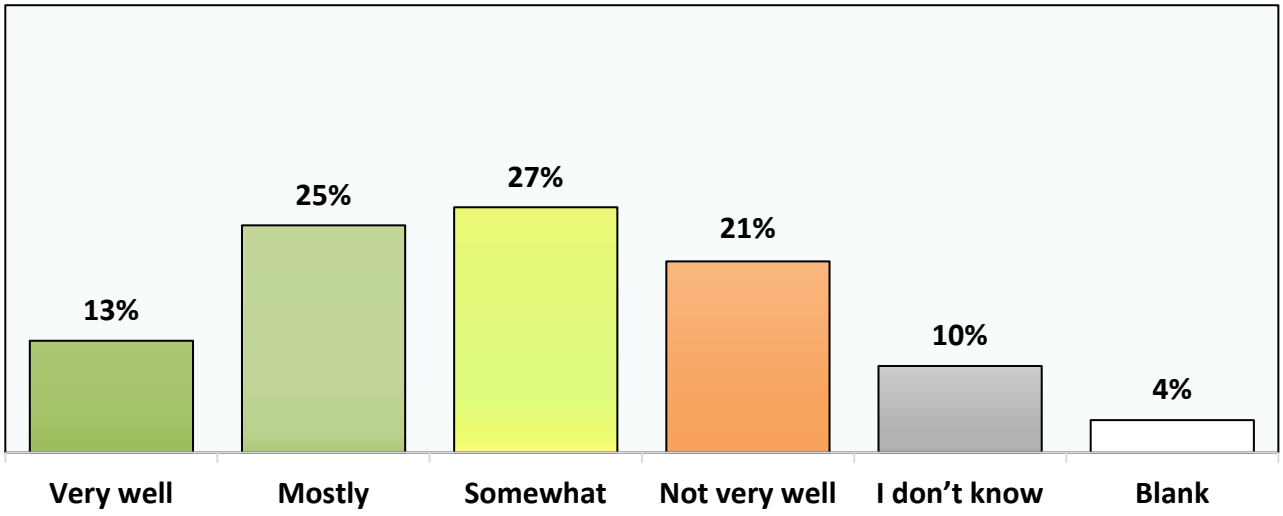
N = 248



Percent responded. Figures may not add to 100% due to rounding

3.) **How well do the MHSA services meet the needs of people in your community who are experiencing a mental health crisis?**

N = 248



Percent responded. Figures may not add to 100% due to rounding

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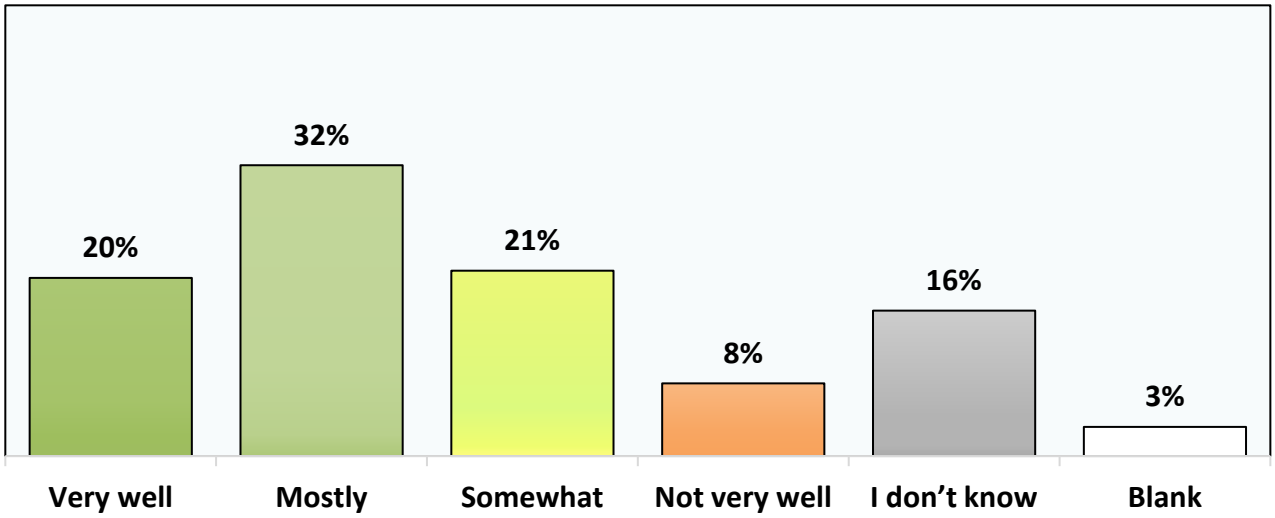
4.) **How well trained are mental health providers in meeting the needs of consumers?**

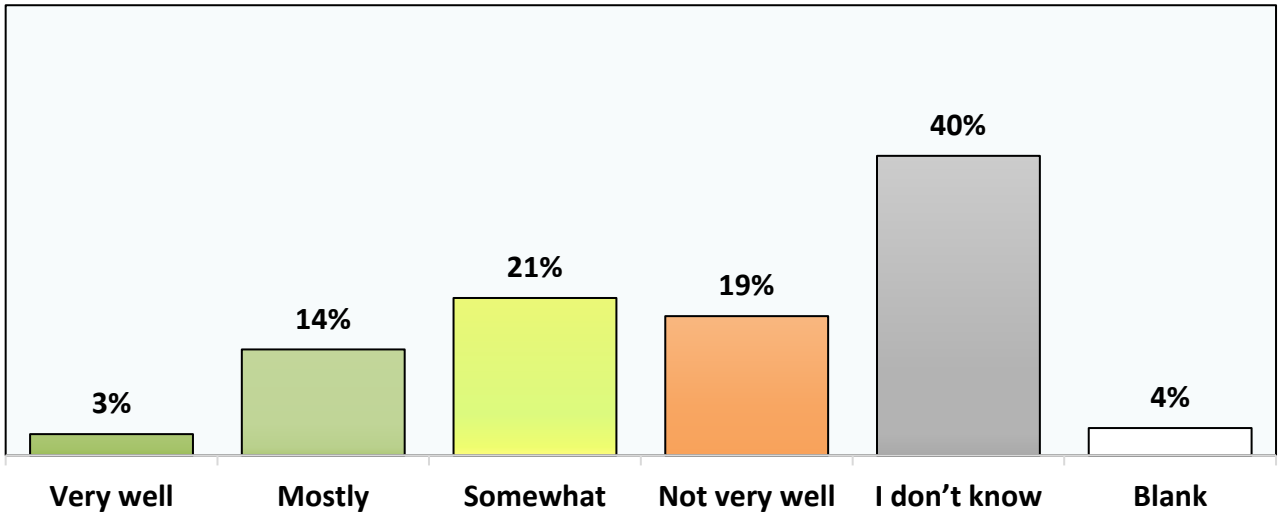
N = 248



Percent responded. Figures may not add to 100% due to rounding

5.) How well are job opportunities for clients and family members included in MHSA services?

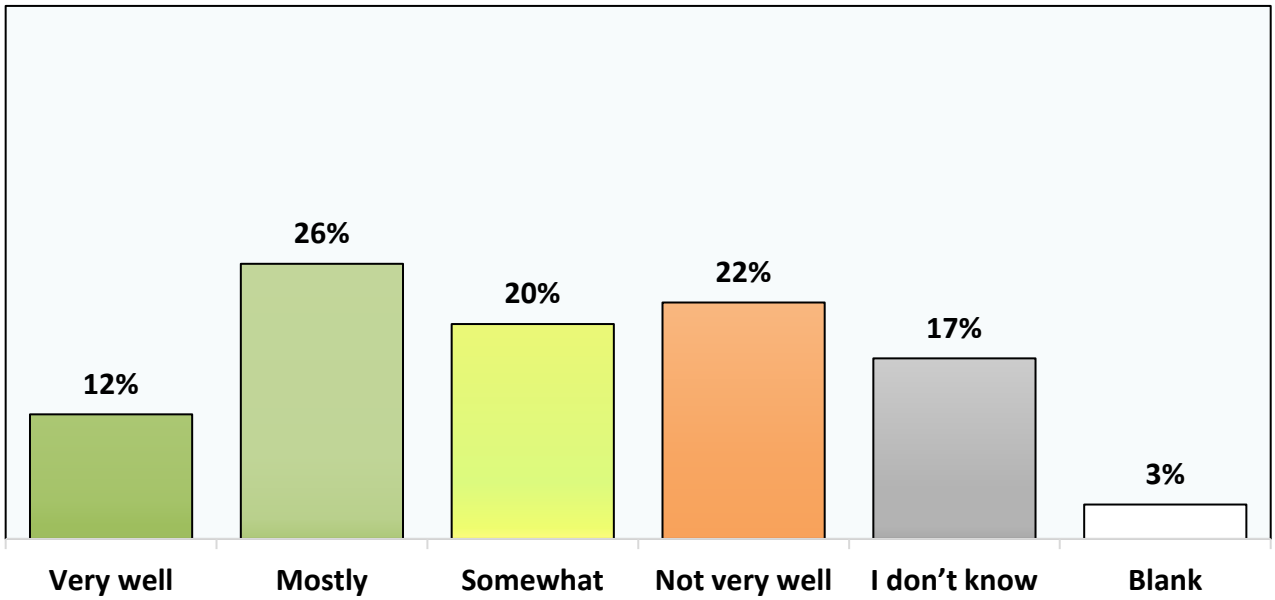
N = 248



Percent responded. Figures may not add to 100% due to rounding

6.) How well do agencies coordinate referrals for mental health services?

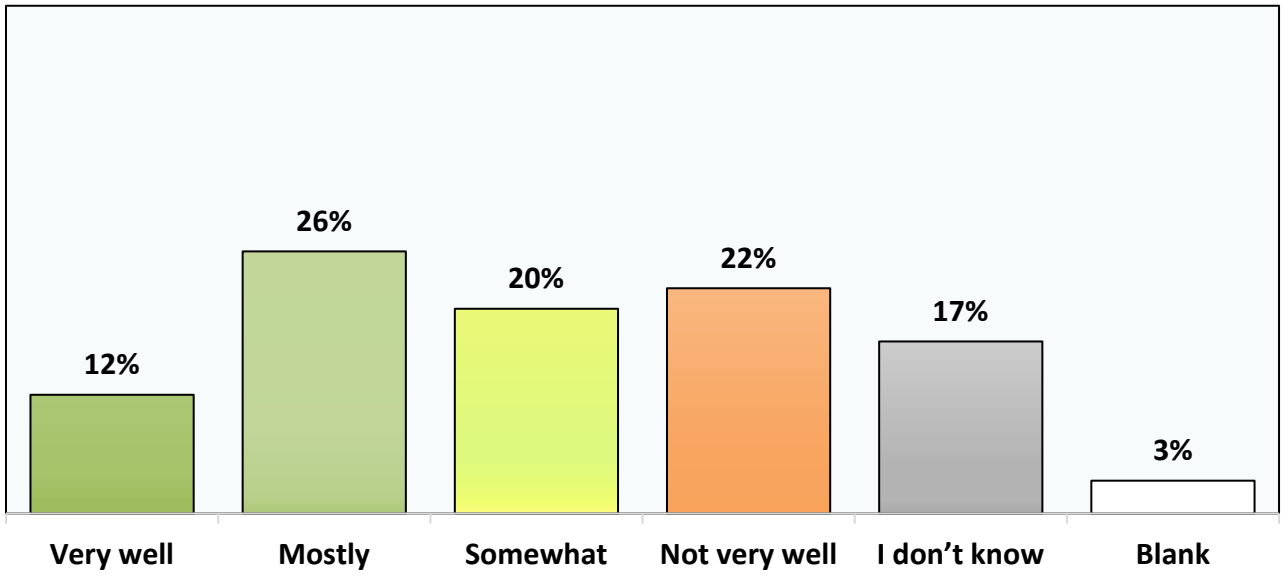
N = 248



Percent responded. Figures may not add to 100% due to rounding

7.) Services are focused on wellness, recovery, and resilience

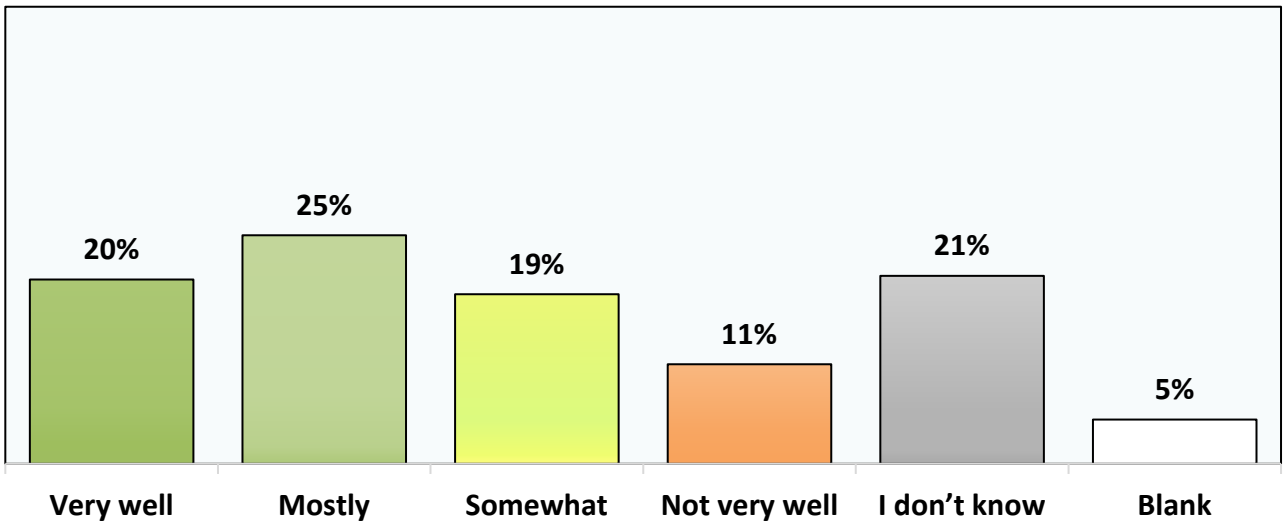
N = 248



Percent responded. Figures may not add to 100% due to rounding

8.) Services respect the culture and language of consumers and their families

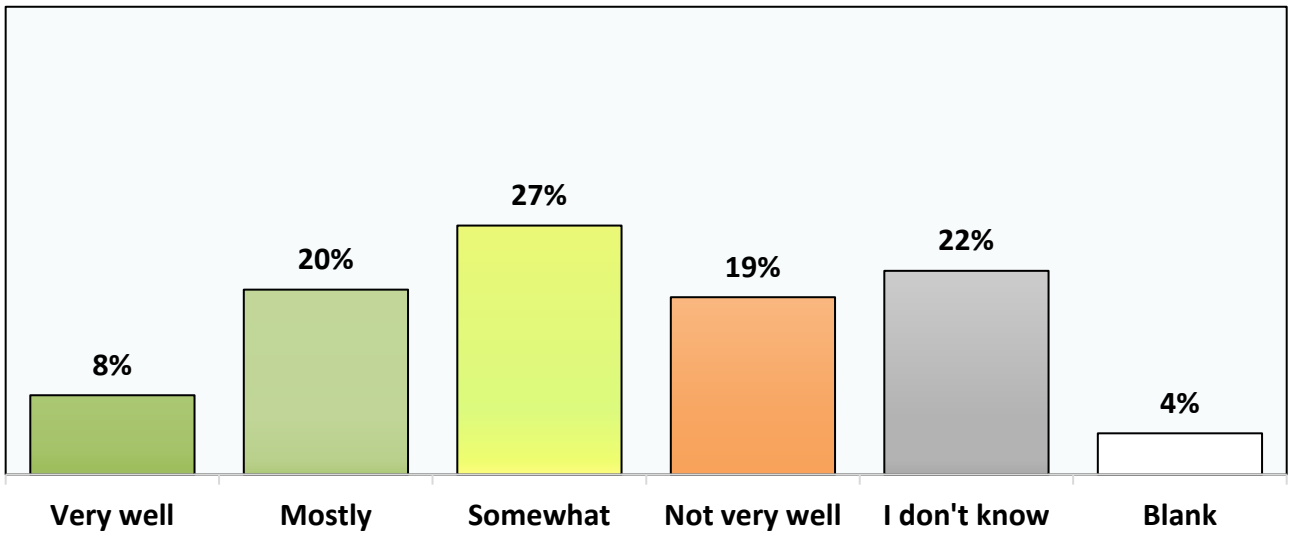
N = 248



Percent responded. Figures may not add to 100% due to rounding

9.) Consumers and families are involved in the design of mental health services

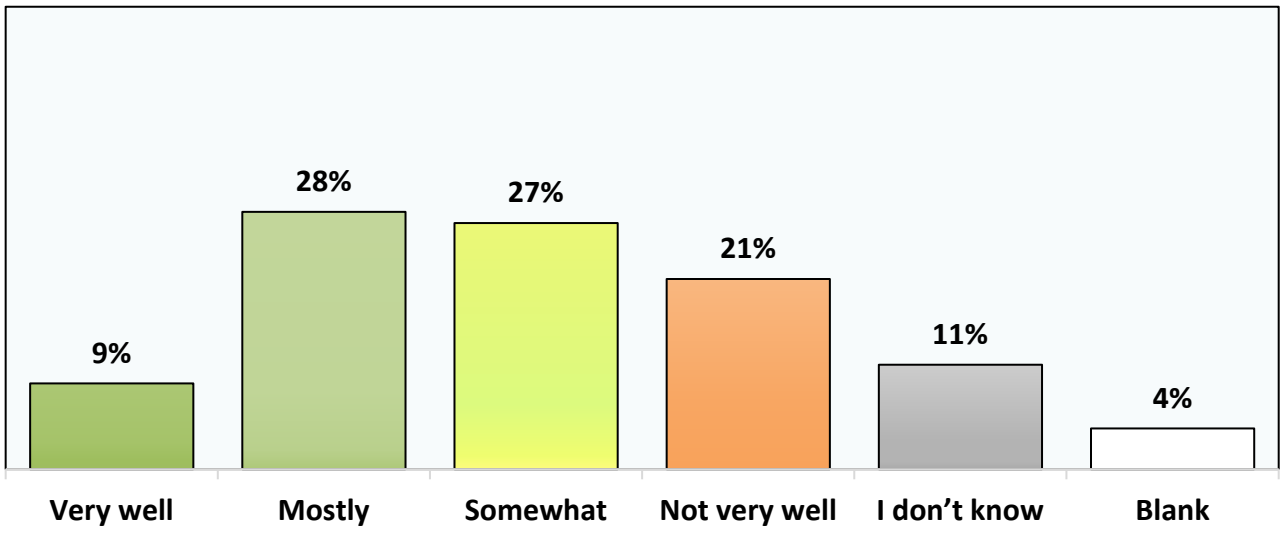
N = 248



Percent responded. Figures may not add to 100% due to rounding

10.) Agencies work together to coordinate mental health services for consumers

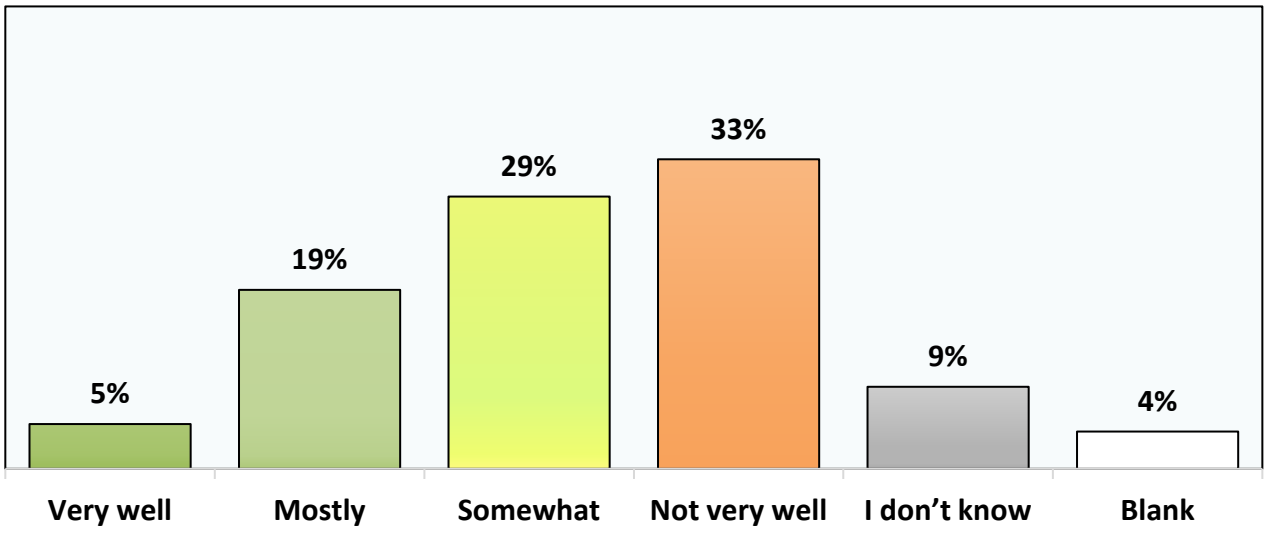
N = 248



Percent responded. Figures may not add to 100% due to rounding

11.) It is easy for consumers and family members to access mental health services

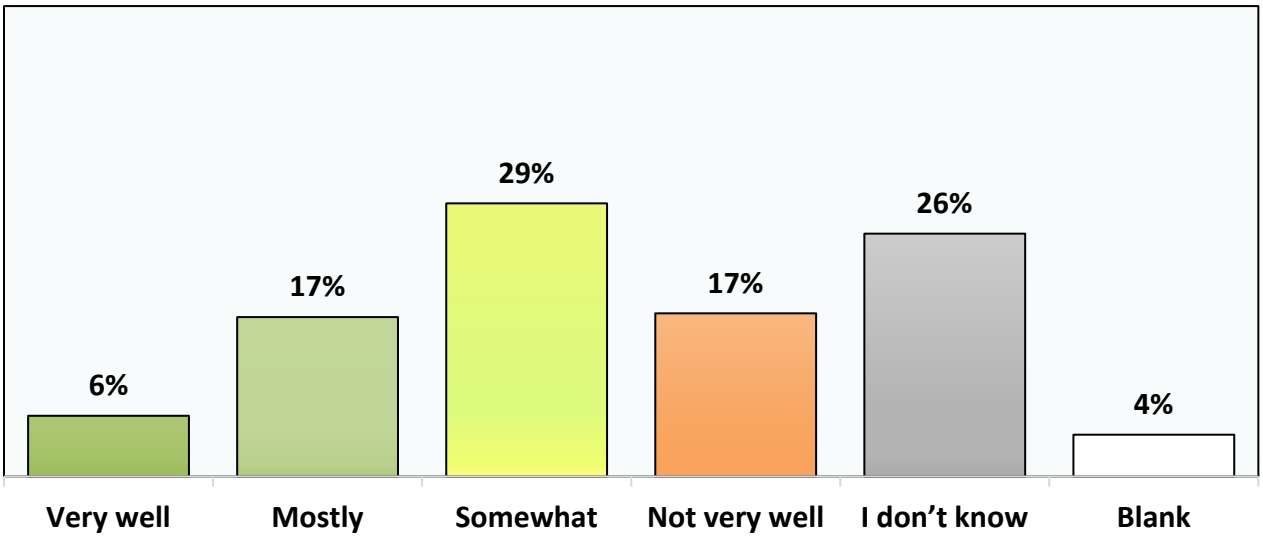
N = 248



Percent responded. Figures may not add to 100% due to rounding

12.) Members of the community are involved in the planning process for MHSA services

N = 248

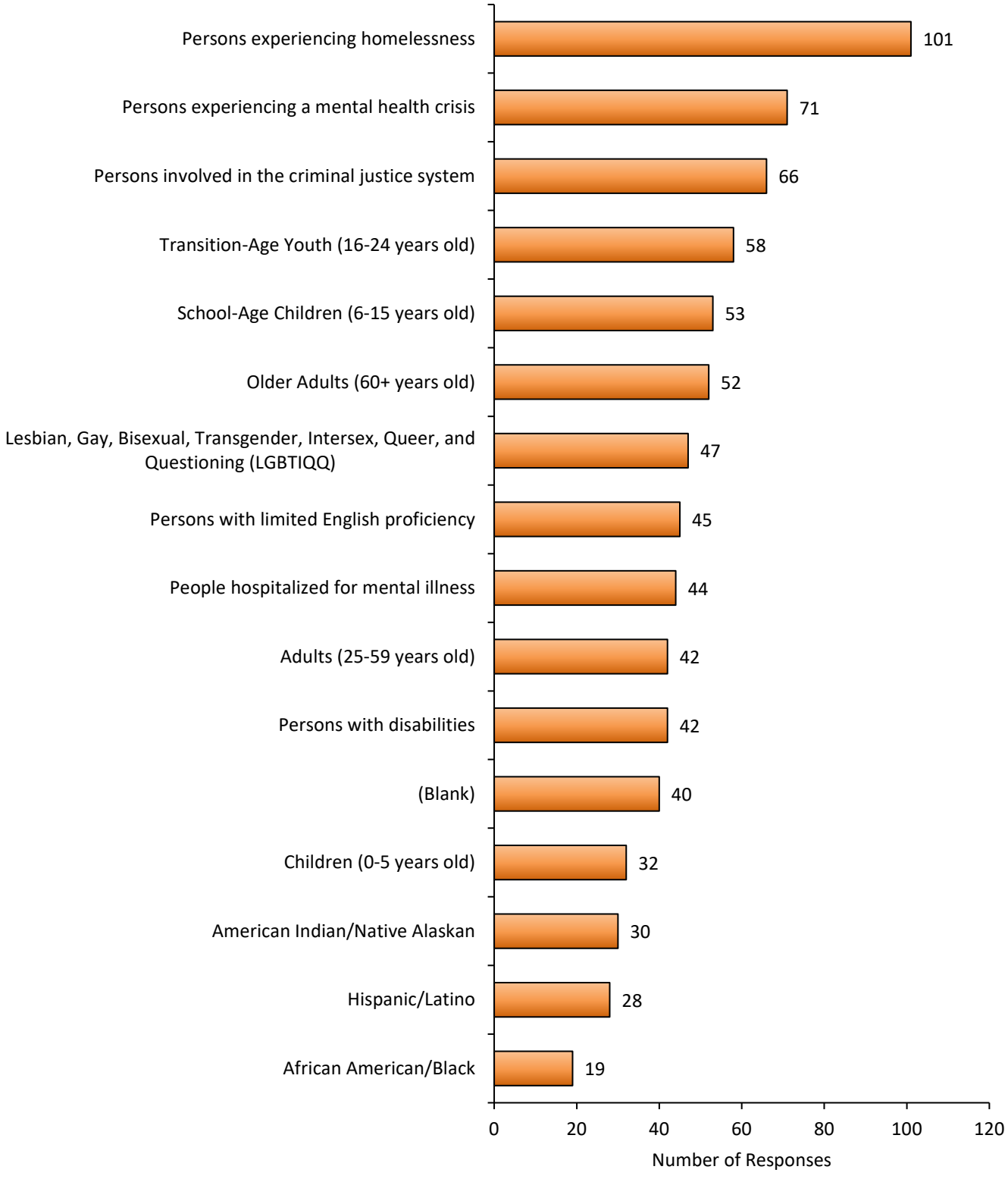


Percent responded. Figures may not add to 100% due to rounding

Are there any populations or groups of people who are not being adequately served by the current MHSA services?

(responders were asked to mark all that apply)

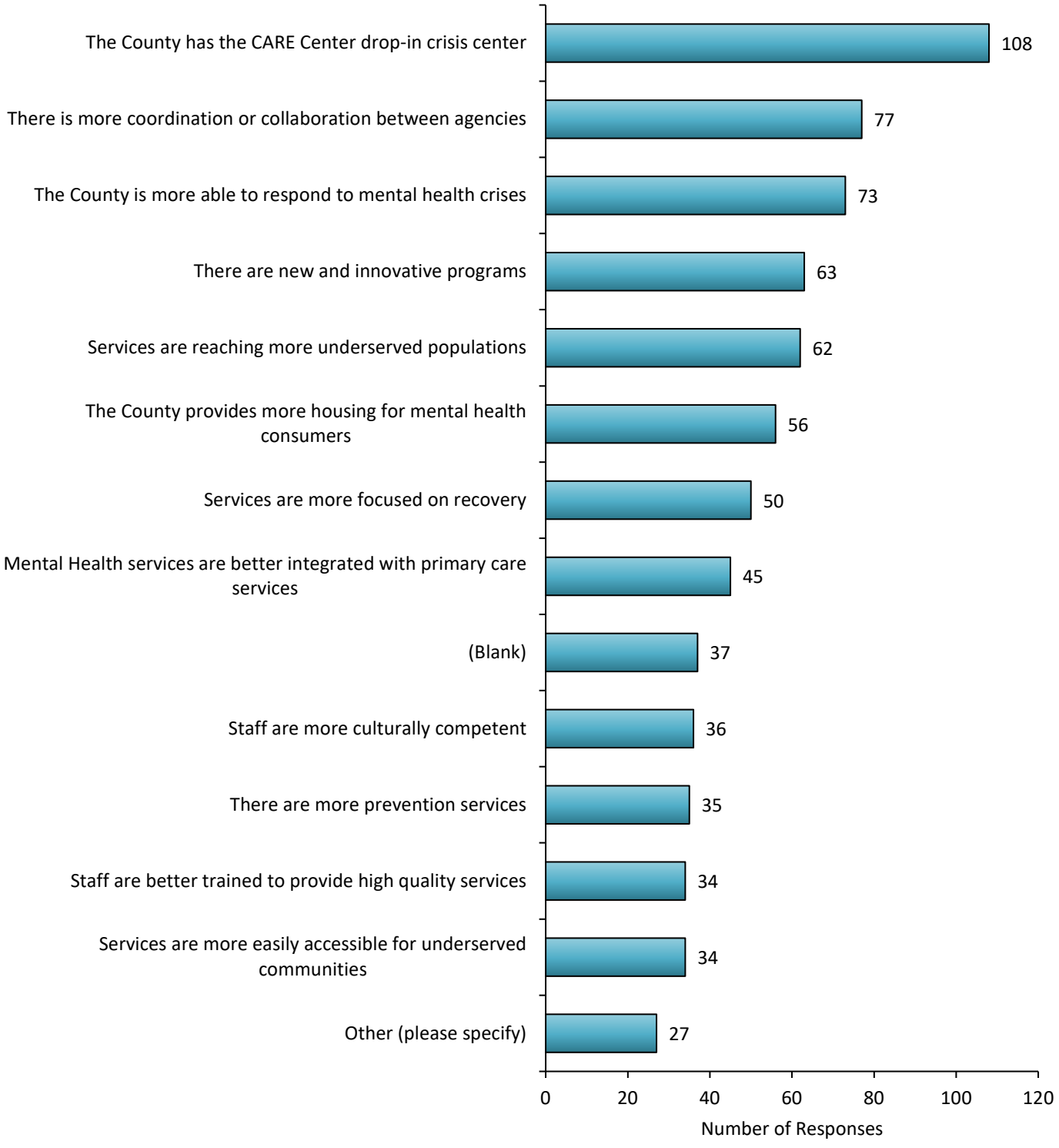
N = 248



Over the past five years, what have been the most helpful changes in the County's mental health services?

(responders were asked to mark all that apply)

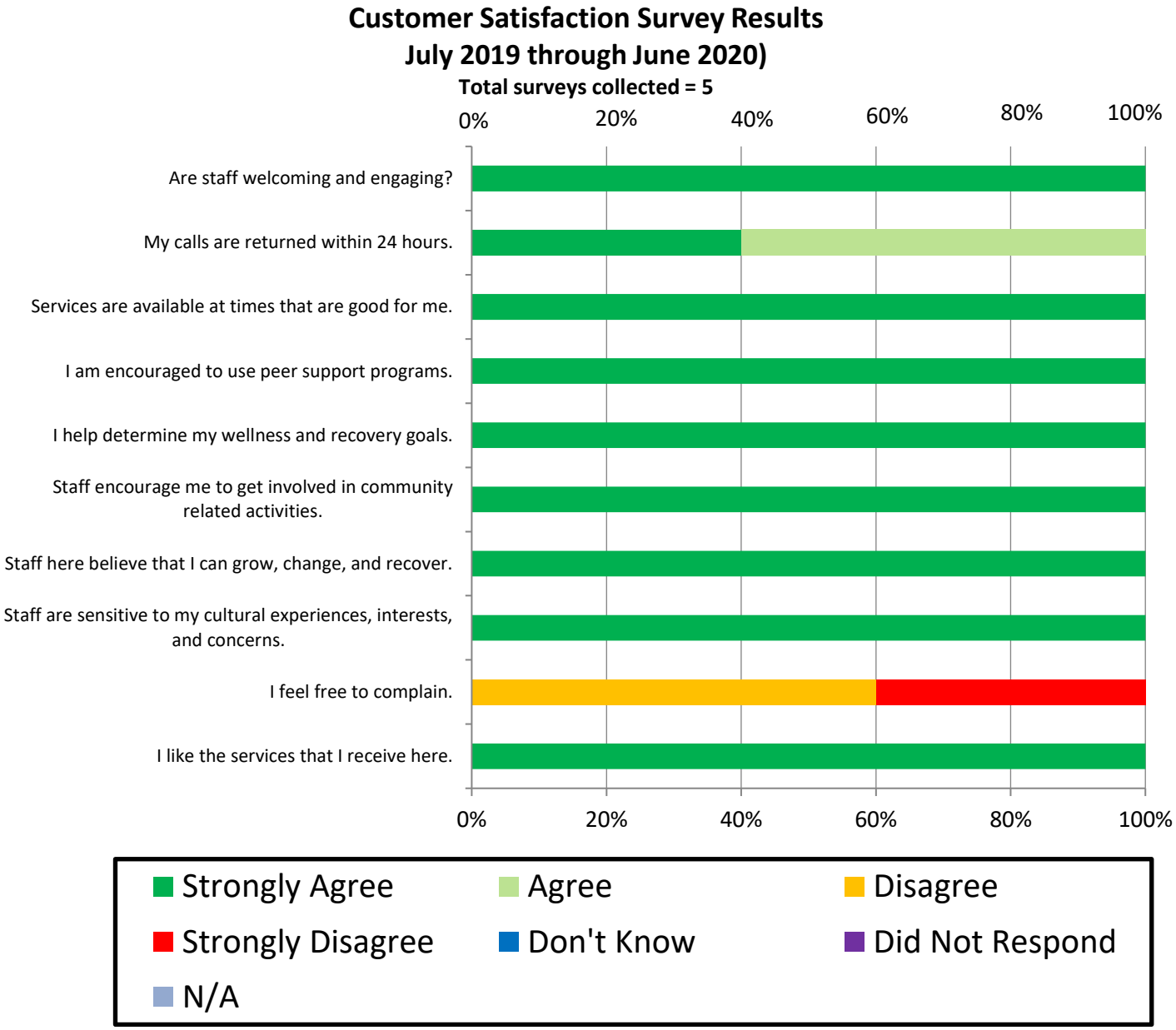
N = 248



SERVICE SATISFACTION SURVEY

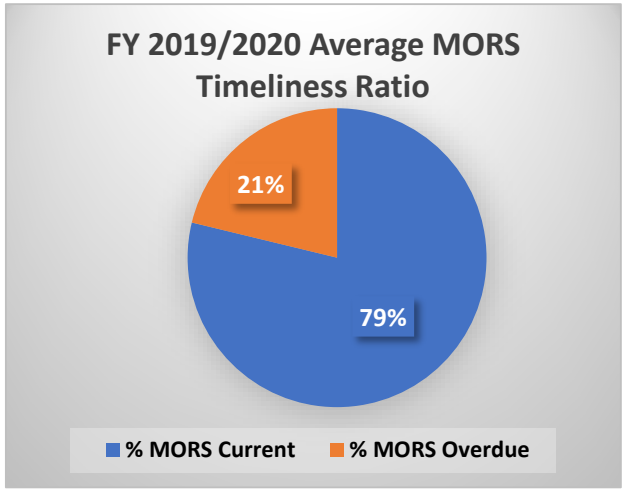
The Service Satisfaction Survey is provided to all individuals who visit the HHSA Adult Services Branch on Breslauer Way. The surveys are placed at the main entrance to the building and at the desk in the Crisis Recovery and Residential Center, where they are easily accessible to everyone. Surveys are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

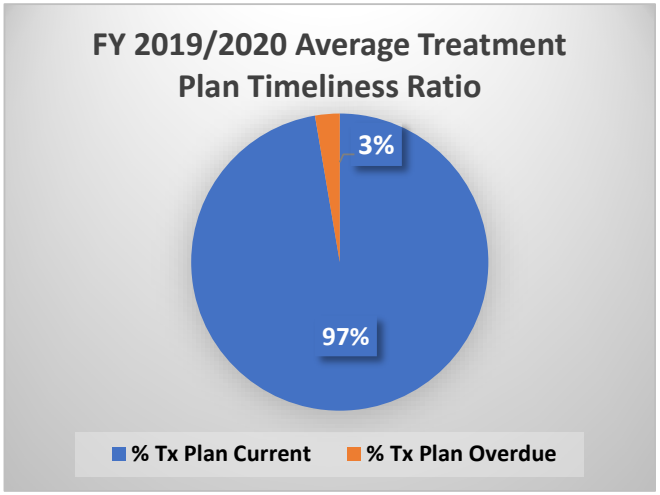
The overall survey results include data from people accessing the following service areas: adult mental health, adult alcohol and drug, in-home supportive services, public authority, and public guardian.

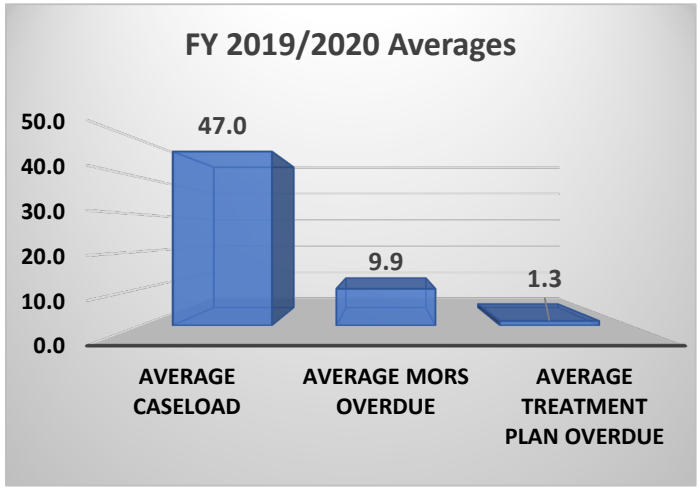


Fiscal Year 2019-2020 - Adult Services MORS/Treament Plan Timeliness Report

Month-Year	Count of Reported Staff	Total Caseload	MORS Current	MORS Overdue	Tx Plan Current	Tx Plan Overdue	% MORS Current	% MORS Overdue	% Tx Plan Current	% Tx Plan Overdue	Average Caseload	Average Number of MORS Overdue	Average Number of Tx Plans Overdue
July-19	11	496	374	122	481	15	75.4%	24.6%	97.0%	3.0%	45.1	11.1	1.4
August-19	11	484	357	126	471	13	73.8%	26.0%	97.3%	2.7%	44.0	11.5	1.2
September-19	**13**	535	418	119	523	12	78.1%	22.2%	97.8%	2.2%	41.2	9.2	0.9
October-19	12	531	414	118	513	18	78.0%	22.0%	96.6%	3.4%	44.3	9.8	1.5
November-19	11	527	302	226	476	51	57.2%	42.8%	90.3%	9.7%	47.9	20.5	4.6
December-19	11	**539**	443	95	532	7	82.2%	17.6%	98.7%	1.3%	49.0	8.6	0.6
January-20	11	537	421	115	531	6	78.4%	21.4%	98.9%	1.1%	48.8	10.5	0.5
February-20	11	526	439	86	519	7	83.5%	16.3%	98.7%	1.3%	47.8	7.8	0.6
March-20	11	514	434	80	506	8	84.4%	15.6%	98.4%	1.6%	46.7	7.3	0.7
April-20	11	516	445	71	502	14	86.2%	13.8%	97.3%	2.7%	46.9	6.5	1.3
May-20	10	515	431	84	505	10	83.7%	16.3%	98.1%	1.9%	51.5	8.4	1.0
June-20	10	505	424	80	499	6	84.0%	15.8%	98.8%	1.2%	50.5	8.0	0.6
Averages:	**11.1**	**518.8**	**408.5**	**110.2**	**504.8**	**13.9**	78.7%	21.2%	97.3%	2.7%	**47.0**	**9.9**	**1.3**





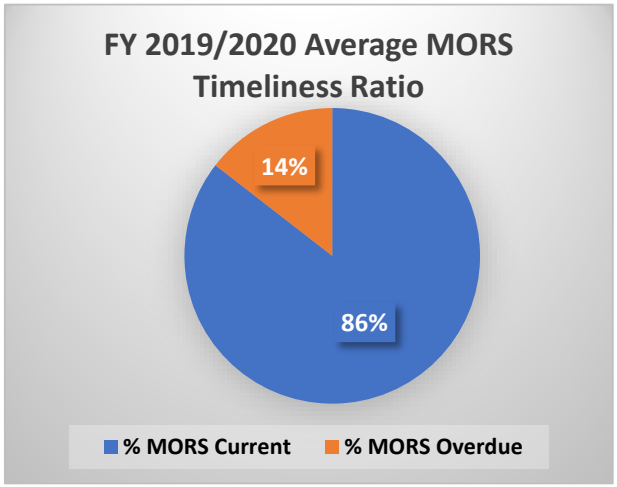


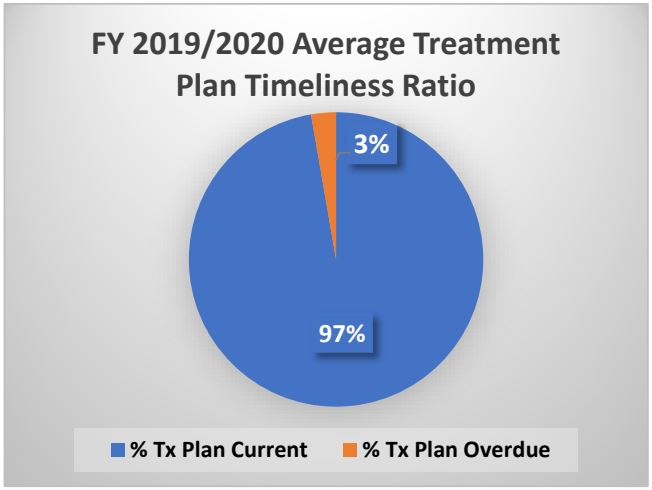
MORS: Milestones of Recovery Scale
Treatment Plan: Mental Health Treatment Plan

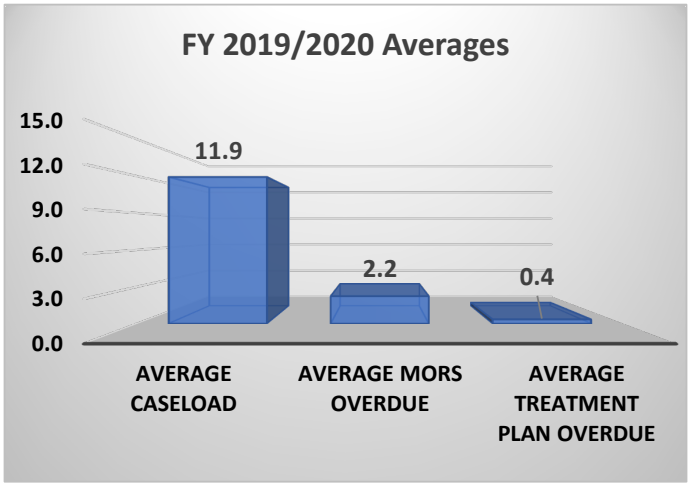
Prepared by Josette McKrola 06/10/2021

Fiscal Year 2019-2020 - Shasta Triumph and Recovery (STAR) TEAM MORS/Treament Plan Timeliness Report

Month-Year	Count of Reported Staff	Total Caseload	MORS Current	MORS Overdue	Tx Plan Current	Tx Plan Overdue	% MORS Current	% MORS Overdue	% Tx Plan Current	% Tx Plan Overdue	Average Caseload	Average Number of MORS Overdue	Average Number of Tx Plans Overdue
July-19	4	58	43	15	57	1	74%	26%	98%	2%	14.5	9.0	0.4
August-19	4	56	32	24	56	0	57%	43%	100%	0%	14.0	6.0	0.0
September-19	5	59	54	5	58	1	92%	9%	98%	2%	11.8	1.0	0.4
October-19	5	54	31	23	53	1	57%	43%	98%	2%	10.8	4.6	0.2
November-19	5	54	51	3	50	4	94%	6%	93%	7%	10.8	0.6	0.8
December-19	5	58	57	1	56	2	98%	2%	97%	3%	11.6	0.2	0.4
January-20	5	59	55	3	55	4	93%	5%	93%	7%	11.8	0.6	0.8
February-20	6	73	60	13	70	3	82%	18%	96%	4%	12.2	2.2	0.5
March-20	6	72	70	2	69	3	97%	3%	96%	4%	12.0	0.3	0.5
April-20	6	69	67	2	68	1	97%	3%	99%	1%	11.5	0.3	0.2
May-20	6	66	65	1	66	0	98%	2%	100%	0%	11.0	0.2	0.0
June-20	6	67	56	11	61	0	84%	16%	100%	0%	11.2	1.8	0.0
Averages:	**5.3**	**62.1**	**53.4**	**8.6**	**59.9**	**1.7**	**85.4%**	**14.5%**	**97.3%**	**2.7%**	**11.9**	**2.2**	**0.4**







MORS: Milestones of Recovery Scale
Treatment Plan: Mental Health Treatment Plan

Prepared by Josette McKrola 06/10/2021

Shasta County Health & Human Services Agency

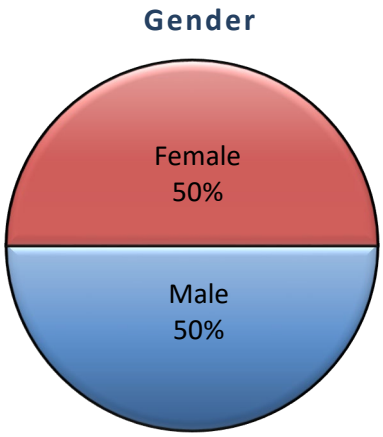
Wellness Center Summary Report

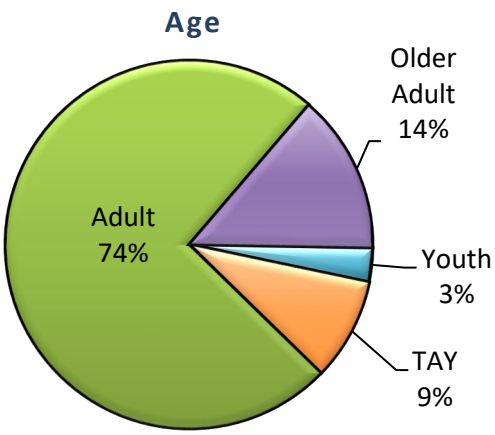
July 2019 – June 2020

Shasta County had two wellness centers in operation during the twelve-month period of July 2019 through June 2020: Olberg Wellness Center in Redding and Circle of Friends in Burney. Olberg Wellness Center is on a monthly reporting cycle, while Circle of Friends in on a quarterly reporting cycle. Because of this, some averaging was necessary for their data to be comparable, so all combined data is an approximation.

Demographics

Approximately 50% of wellness center attendees were male and 50% female. None reported as transgender or other.

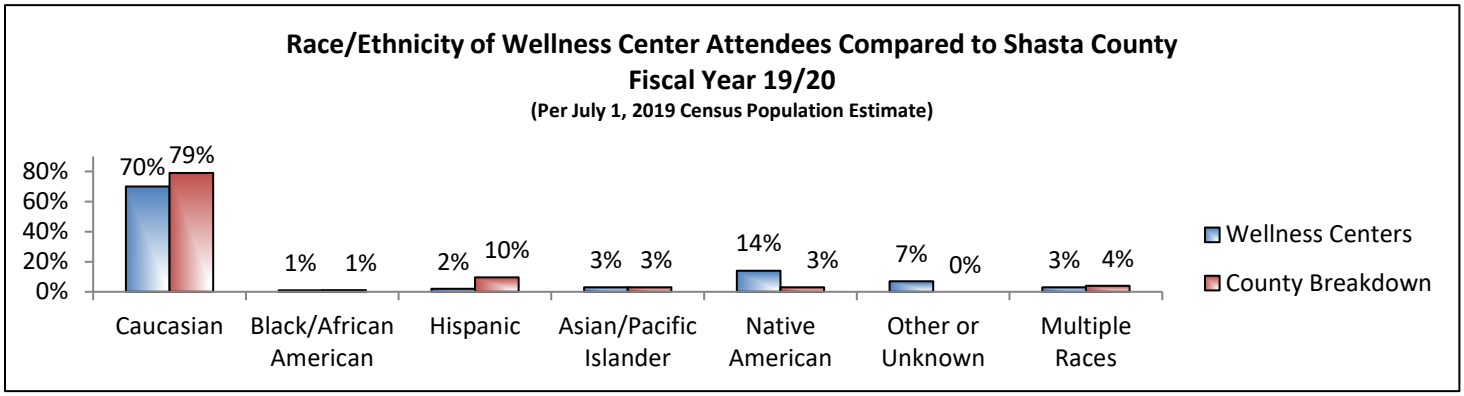




Approximately 3% of wellness center attendees were Youths (0-15 years of age), 9% were Transitional Age Youths (16-25 years of age), 74% were Adults (26-59 years of age), 14% were Older Adults (60+ years of age), and none were of unknown age.

Approximately 94% of wellness center attendees were consumers, 5% were family members of consumers, and 1% were unknown or declined to state.

Caucasians, Hispanics, and Multiple Races were under-represented while Native Americans and Other or Unknown were over-represented.

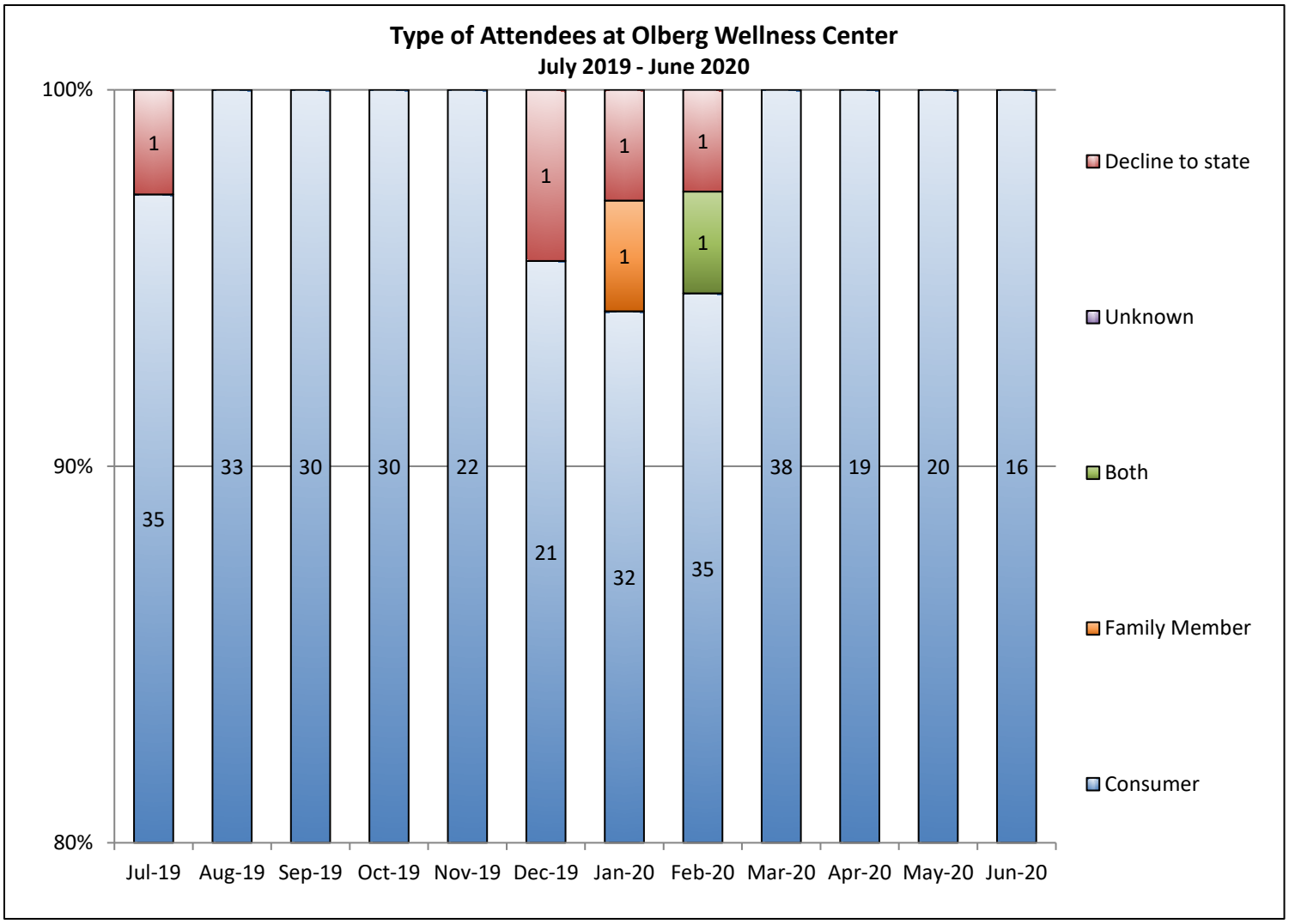


Services Provided

Overall, a total of 2,074 individual workshops, groups, activities, and 12-step recovery meetings were held during this twelve-month period.

Olberg Wellness Center

Attendance
Attendance decreased 20% from the previous twelve-month period, with an average of 28 unduplicated participants each month.



Demographics
On average, 99% of attendees were consumers. Less than 1% were the following: family members, both family members and consumers, participants of unknown type, and declined to state. On average, 90% of staff members (including volunteers) were consumers and/or family members. In order to maintain confidentiality, age, gender and race/ethnicity is not broken down by individual wellness center.

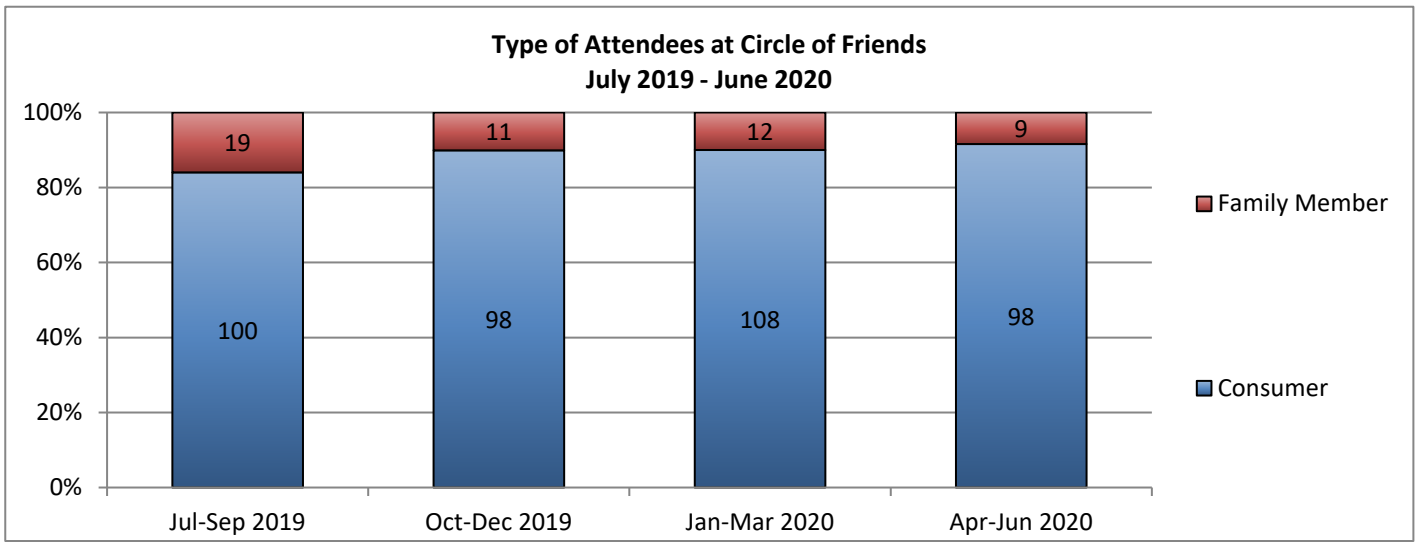
Services Provided
Olberg Wellness Center is open Monday through Friday 10 am to 3 pm. During this twelve-month period 1,362 individual activities and groups were available for participants, with the average being 6 groups or activities offered per day. On the average, there were approximately 5 participants per activity.

Attendee Direction
Olberg Wellness Center has weekly Members' Meetings and monthly Steering Committee Meetings, open to consumers and family members. During this twelve-month period, they had an average of 10 participants per meeting.

Circle of Friends

Attendance

Attendance decreased 8% from the previous twelve-month period, with an average of 114 unduplicated people attending Circle of Friends each quarter.



Demographics

Eighty-nine percent of attendees were consumers and 11% were family members. Eighty-two percent of staff and 99% of volunteers were consumers and/or family members. In order to maintain confidentiality, age, gender and race/ethnicity is not broken down by individual wellness center.

Services Provided

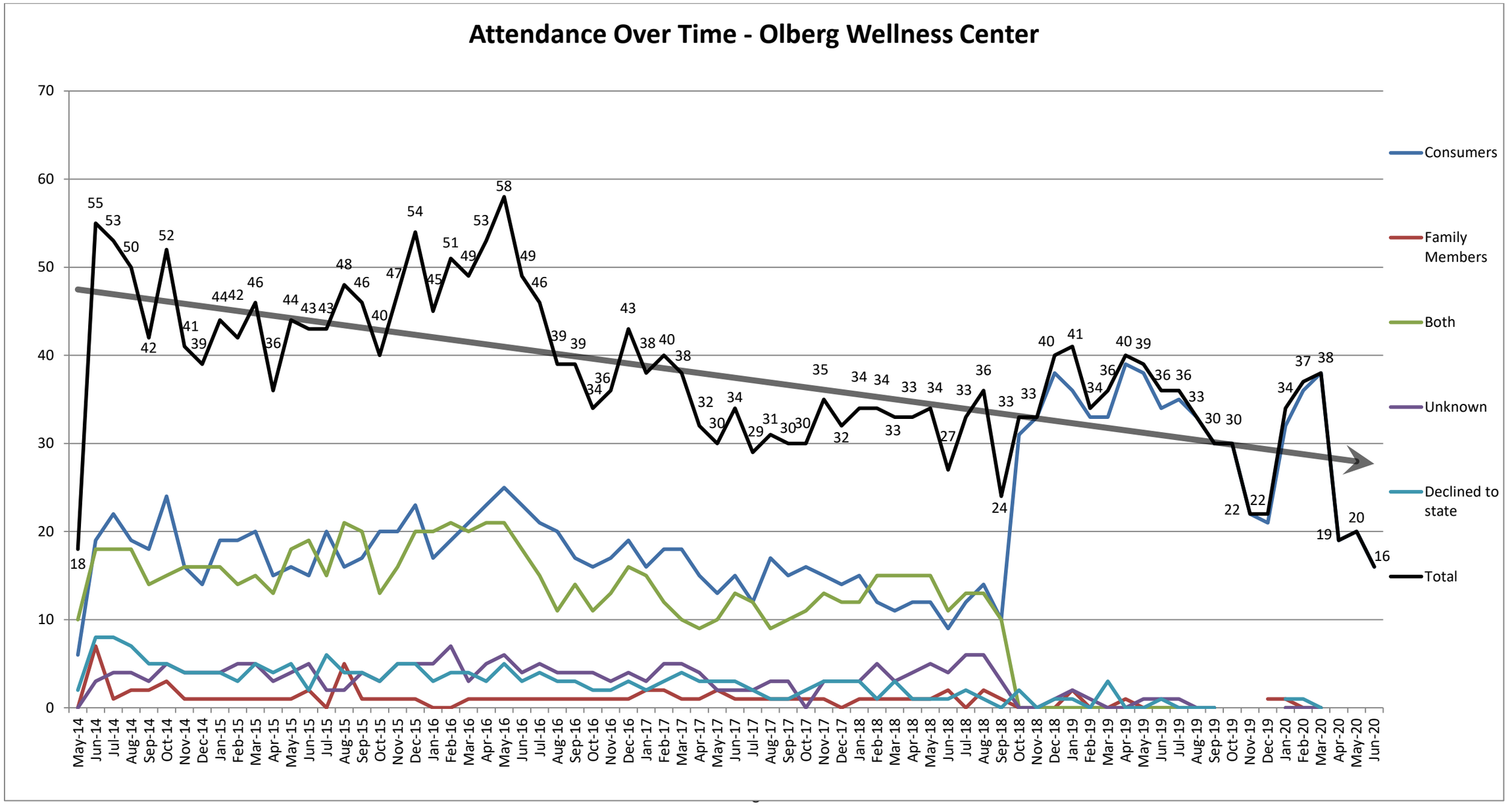
Virtual hours of operation are scheduled for Monday, Wednesday and Friday, 12:30-2:00 via Zoom. Outdoor gatherings are held every Wednesday from 10:00-11:00 at varying locations. Although the building is not open for activities during this time, they remain open for food and clothing distribution Monday through Friday from 8:00 to 4:30.

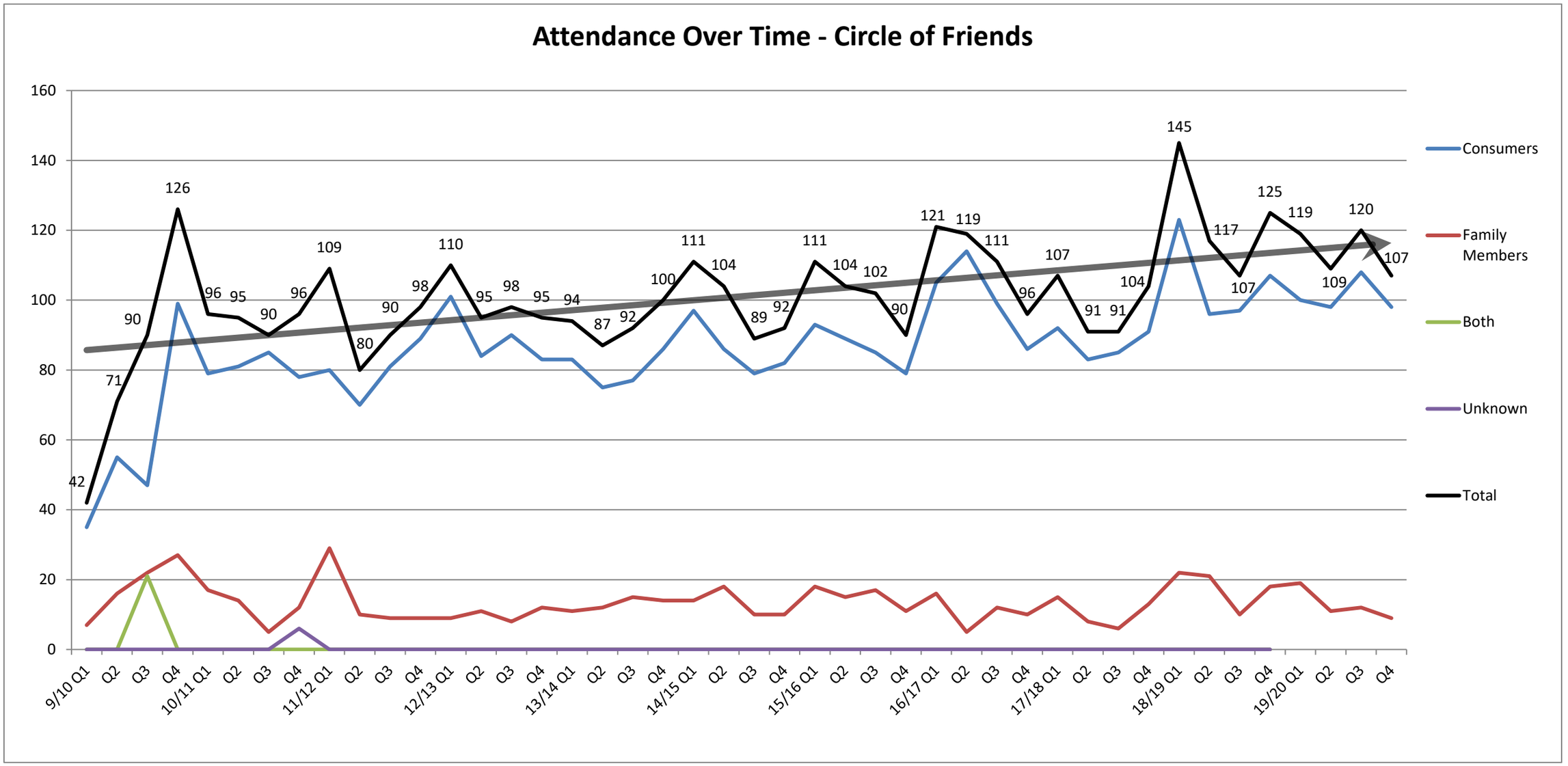
Five workshops, 208 different activities, and 12 step recovery meetings provided 712 individual activities/groups for participants during this twelve-month period.

Attendee Direction

An average of 26 attendees (23%) contributed to the planning and direction of the program each quarter. All decisions relating to the center were based on participant input through Stand Against Stigma Committee meetings; their Outdoor Gatherings; “My Favorite Things from the Weekly Packet Are…”; “Planning for Our Future”; “Something I Would Like to Do on Zoom”; “What are We Learning? Discussion – What Can We Take with Us Moving Forward?”; Zoom Planning; Quarantine Buster Packet Mailings and Deliveries, Check-In Time, the Steering Committee, Calendar and Newsletter Planning Meetings, Creating a Walk Bingo, Go to Meeting Planning, the Steinburg Institute visit, check-in time, Think Pink Week Planning, Fundraising Planning Meeting, MHSA Three-Year Plan Update, MHSA Stakeholders Meeting, Good Medicine Health Fair, and other activity-specific planning meetings. Activities offered are based on participant preferences.

Attendance Over Time - Olberg Wellness Center




Attendance Over Time - Circle of Friends
160
140
120
100
80
60
40
20
0
Consumers
Family Members
Both
Unknown
Total
9/10 Q1
Q2
Q3
Q4
10/11 Q1
11/12 Q1
12/13 Q1
13/14 Q1
14/15 Q1
15/16 Q1
16/17 Q1
17/18 Q1
18/19 Q1
19/20 Q1
42
71
90
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Appendix D

NAMI Summary Report

July 2019 through June 2020

Program Offerings

NAMI Shasta County offered Family to Family Support Group sessions and one-on-one mentoring sessions during Fiscal Year 19/20. The Family Support Group met every two weeks. Local NAMI president Susan Power, along with several volunteers, assisted with the one-on-one mentoring sessions. NAMI volunteers ran the family support group sessions. The average total number of hours volunteers spent on mentoring sessions each week was 7.5.

Location of Family Support Group Session	Date of Session	Length	Number of Attendees
Hill Country CARE Center	07/02/2019	2 hours	9
Hill Country CARE Center	07/16/2019	2 hours	5
Hill Country CARE Center	08/06/2019	2 hours	7
Hill Country CARE Center	08/20/2019	2 hours	10
Hill Country CARE Center	09/04/2019	2 hours	9
Hill Country CARE Center	09/18/2019	2 hours	6
Hill Country CARE Center	10/01/2019	2 hours	9
Hill Country CARE Center	10/15/2019	2 hours	10
Hill Country CARE Center	11/05/2019	2 hours	7
Hill Country CARE Center	11/19/2019	2 hours	5
Hill Country CARE Center	12/03/2019	2 hours	6
Hill Country CARE Center	12/17/2019	2 hours	7
Hill Country CARE Center	01/07/2020	2 hours	6
Hill Country CARE Center	01/21/2020	2 hours	7
Hill Country CARE Center	02/04/2020	2 hours	10
Hill Country CARE Center	02/18/2020	2 hours	5
Hill Country CARE Center	03/03/2020	2 hours	7
Hill Country CARE Center	03/17/2020	cancelled	cancelled
Hill Country CARE Center	06/16/2020	2 hours	6

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

The NAMI On Campus program was not implemented during Fiscal Year 19/20. In March, schools began closing.

Successes included having phone calls returned and holding family support group meetings every two weeks (until March).

Barriers included volunteers dealing with crises with their own families and challenges because of COVID-19.

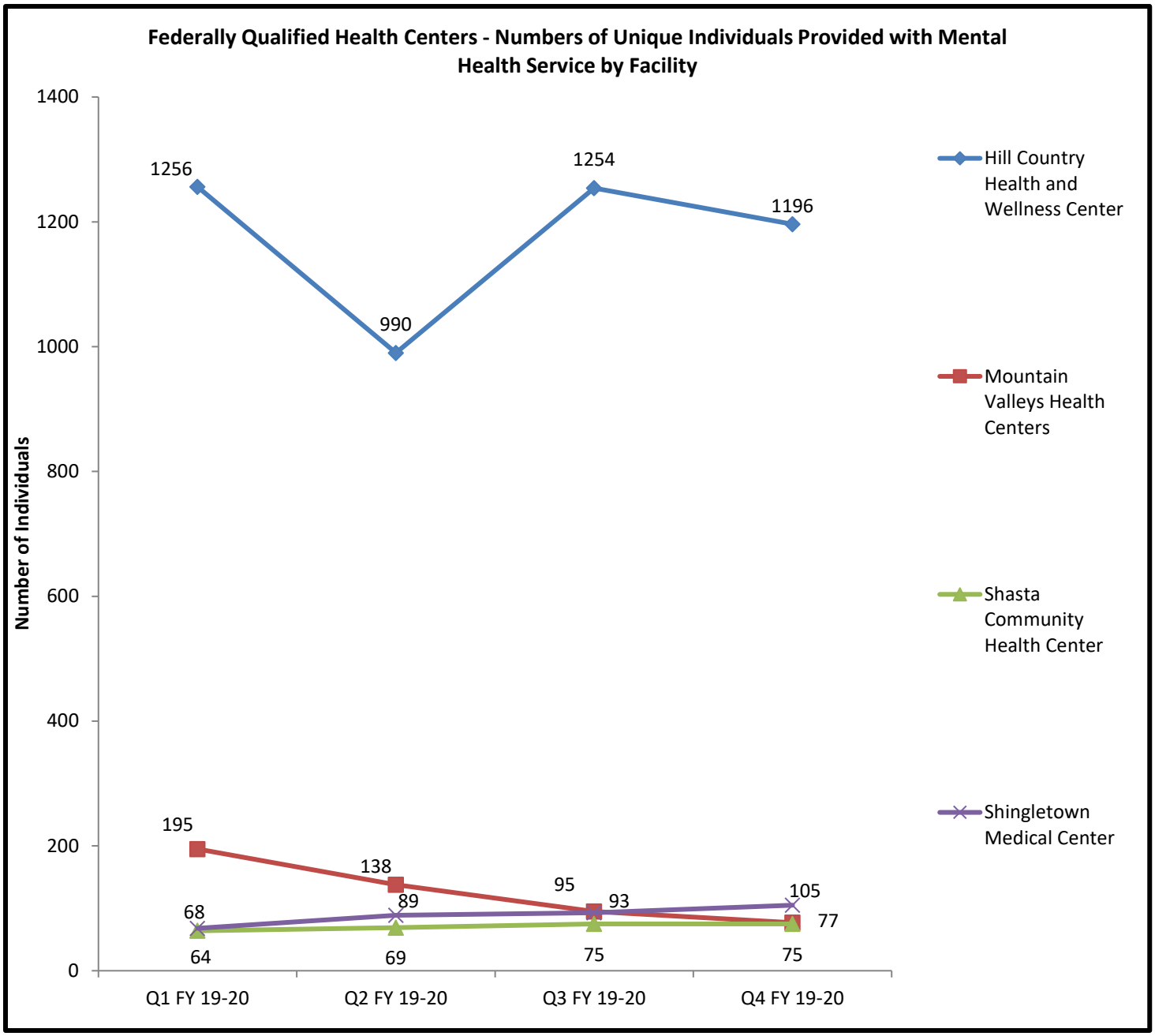
Federally Qualified Health Centers Annual Summary Report

July 2019 through June 2020

To better provide access to mental health services in Shasta County, the Shasta County Health and Human Services Agency has contracted with four different Federally Qualified Health Centers (FQHCs) to provide new or expanded mental health services, integrate mental health services with existing mental health and medical services provided by the FQHCs, and strengthen the relationship between the FQHCs and the County's public mental health system. Funding is provided through the Mental Health Services Act (MHSA). Shasta County had four federally qualified health centers in operation during the 2019-2020 fiscal year: Hill Country Health and Wellness Center in Round Mountain; Mountain Valleys Health Centers in Burney; Shasta Community Health Center in Redding; and, Shingletown Medical Center in Shingletown.

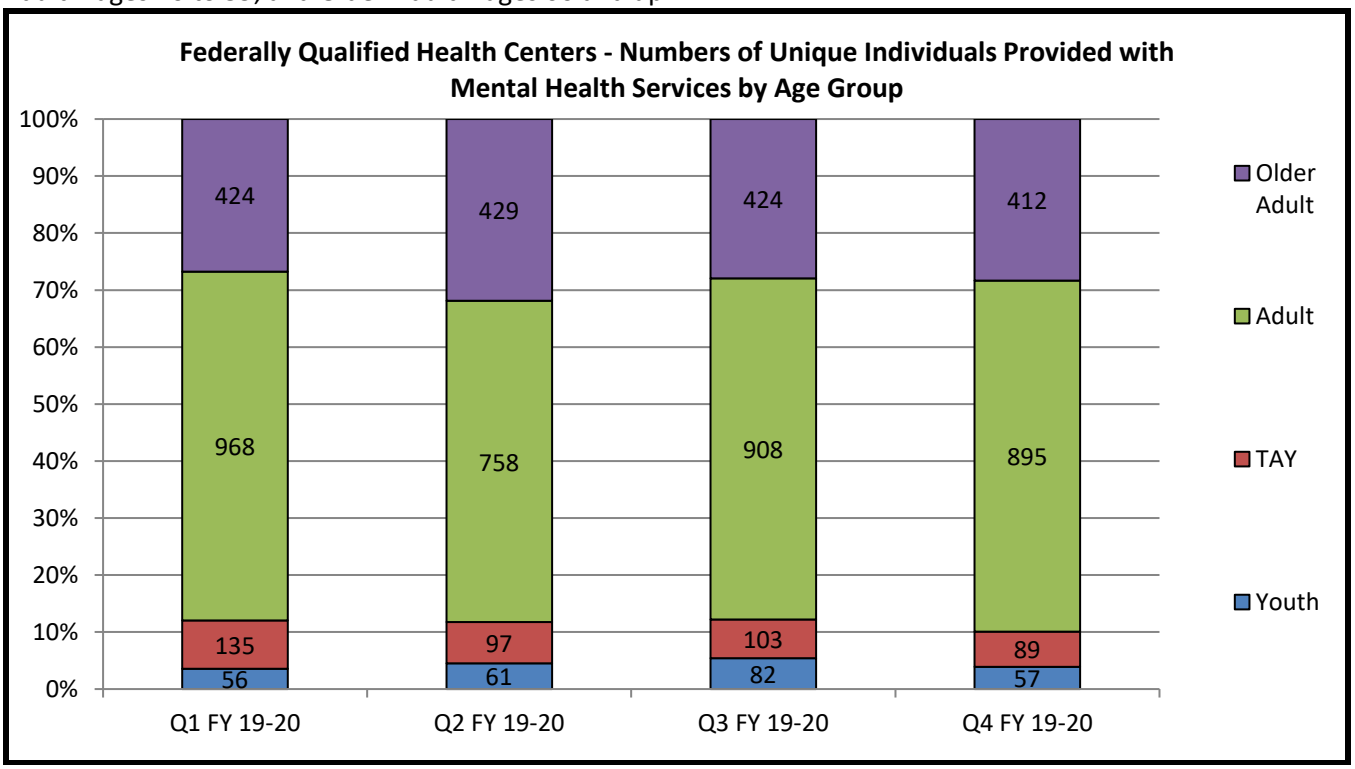
Attendance

An average of 1460 people visited a federally qualified health center in each quarter of fiscal year 2019-2020. This is a 4.39% decrease compared to the previous fiscal year.

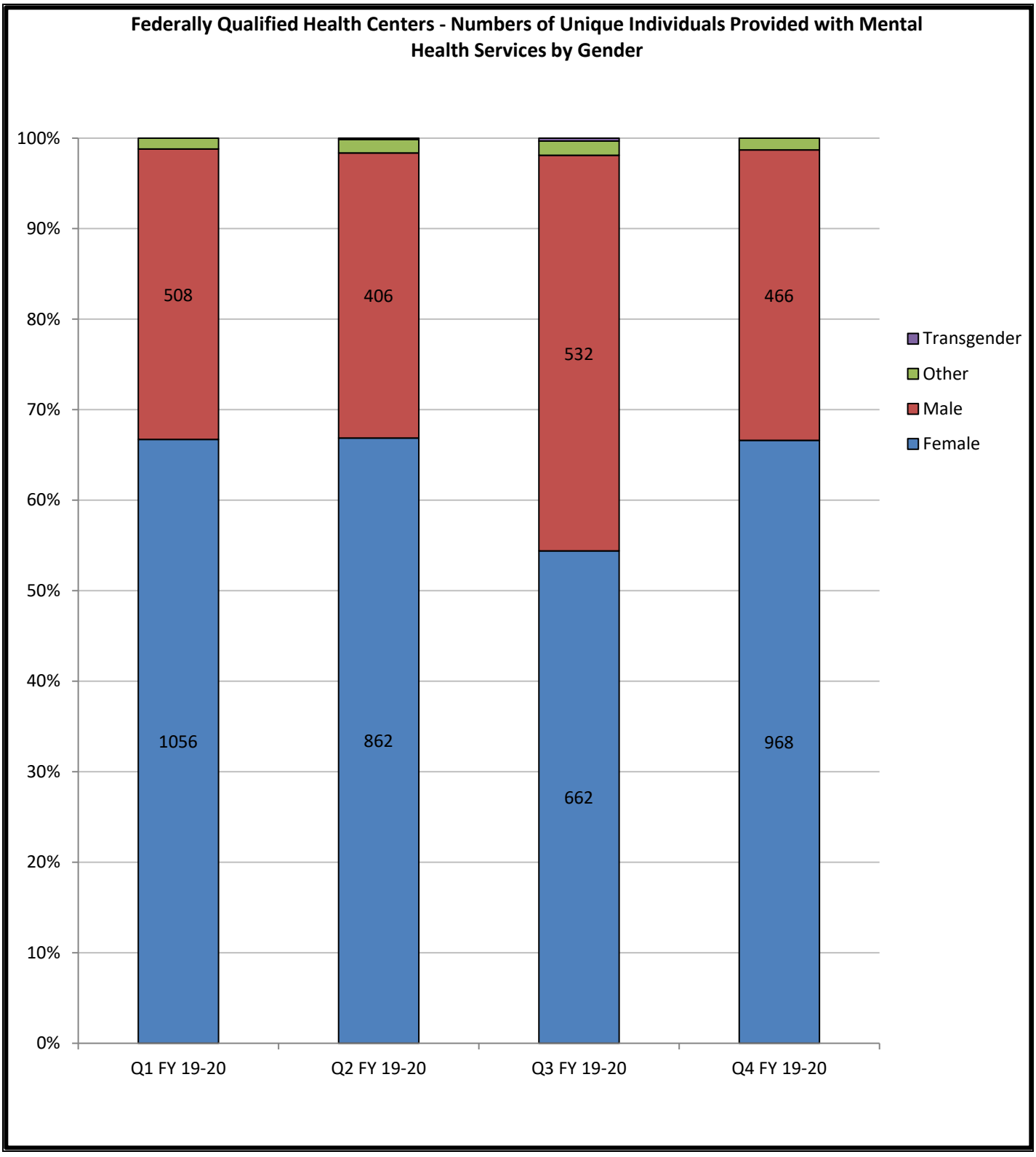


Demographics

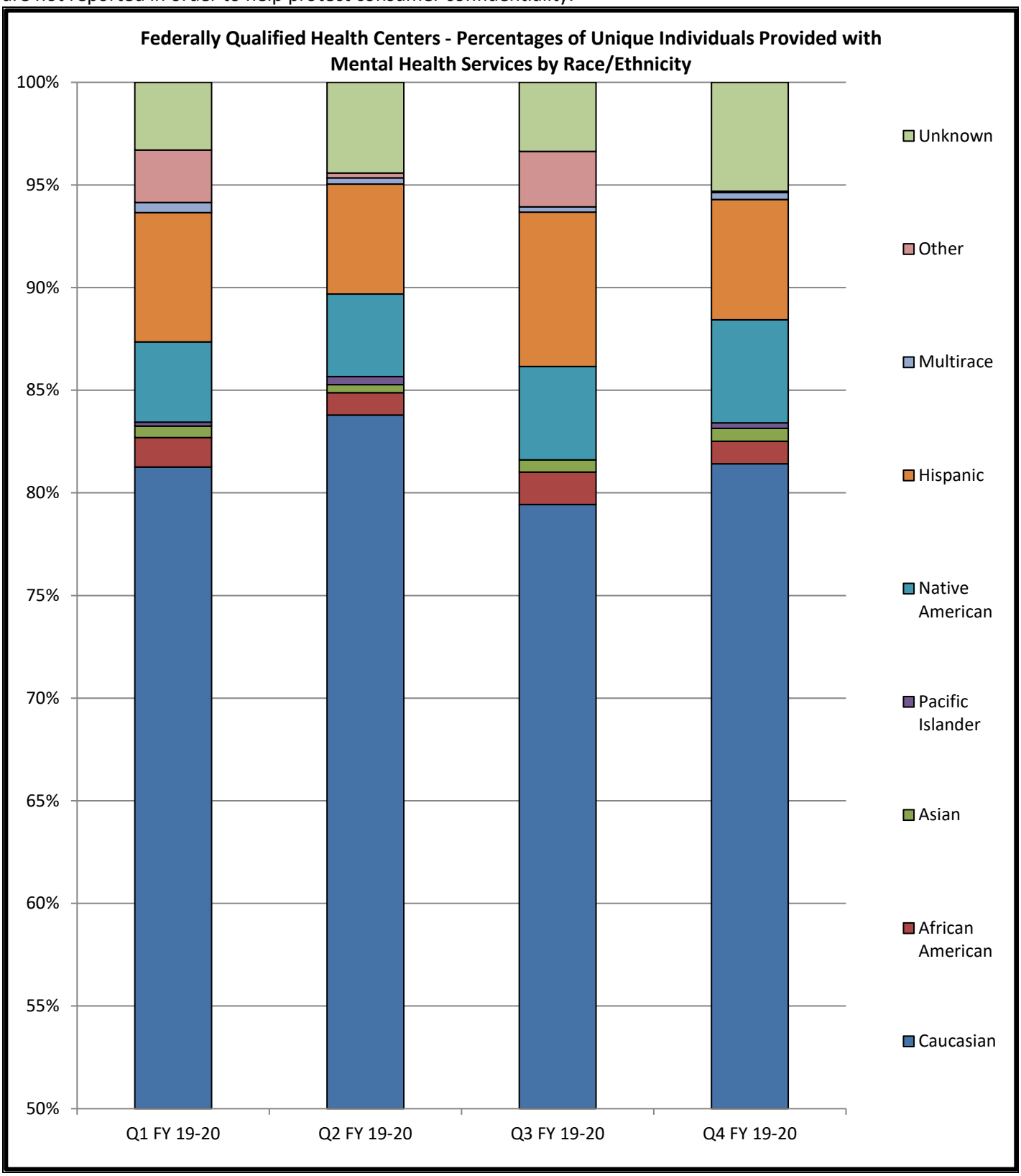
Age - The MHSA uses four age categories: Youth – ages 0 to 15, Transitional Aged Youth (TAY) – ages 16 to 25, Adult – ages 26 to 59, and Older Adult – ages 60 and up.



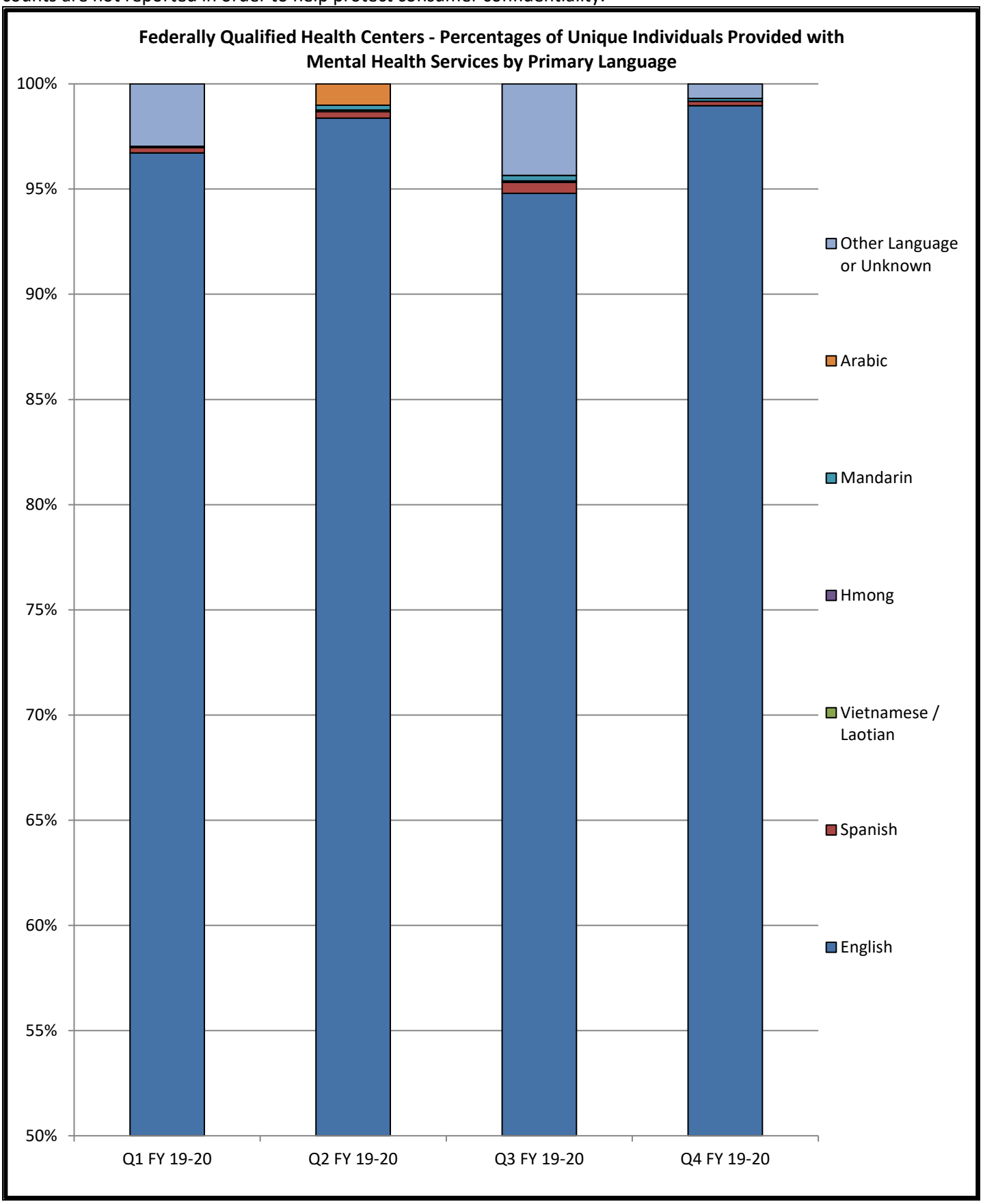
Gender - The MHSA uses four gender categories: Male, Female, Transgender, and Other. Counts of less than 20 individuals are not labeled to help maintain consumer confidentiality, but are included in the chart.



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

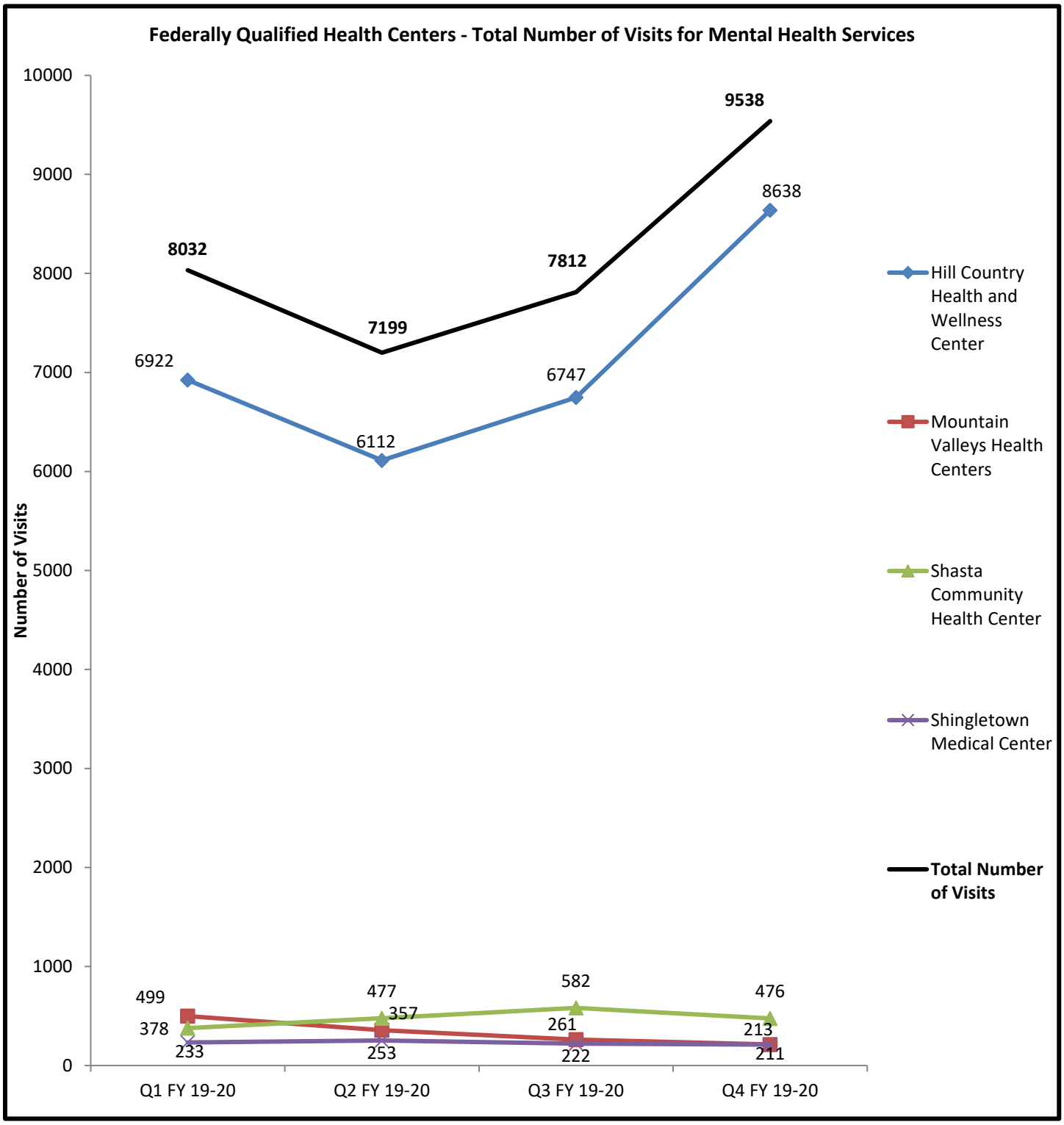


Primary Language - Because of the low gross numbers for some of these languages within small communities, actual counts are not reported in order to help protect consumer confidentiality.



Services Provided

Most people will have multiple visits to the FQHC each quarter, and different types of service may be offered at different times in order to provide everyone with comprehensive and integrated age appropriate mental health services. Services provided may include such things as screenings, assessments, medication management, and individual or group psychotherapy sessions. For fiscal year 2018-2019, there were a total of 29,258 visits to a federally qualified health center for some type of mental health service. This is a 25.43% increase compared to the previous fiscal year.



Primary Mental Health Diagnosis

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

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

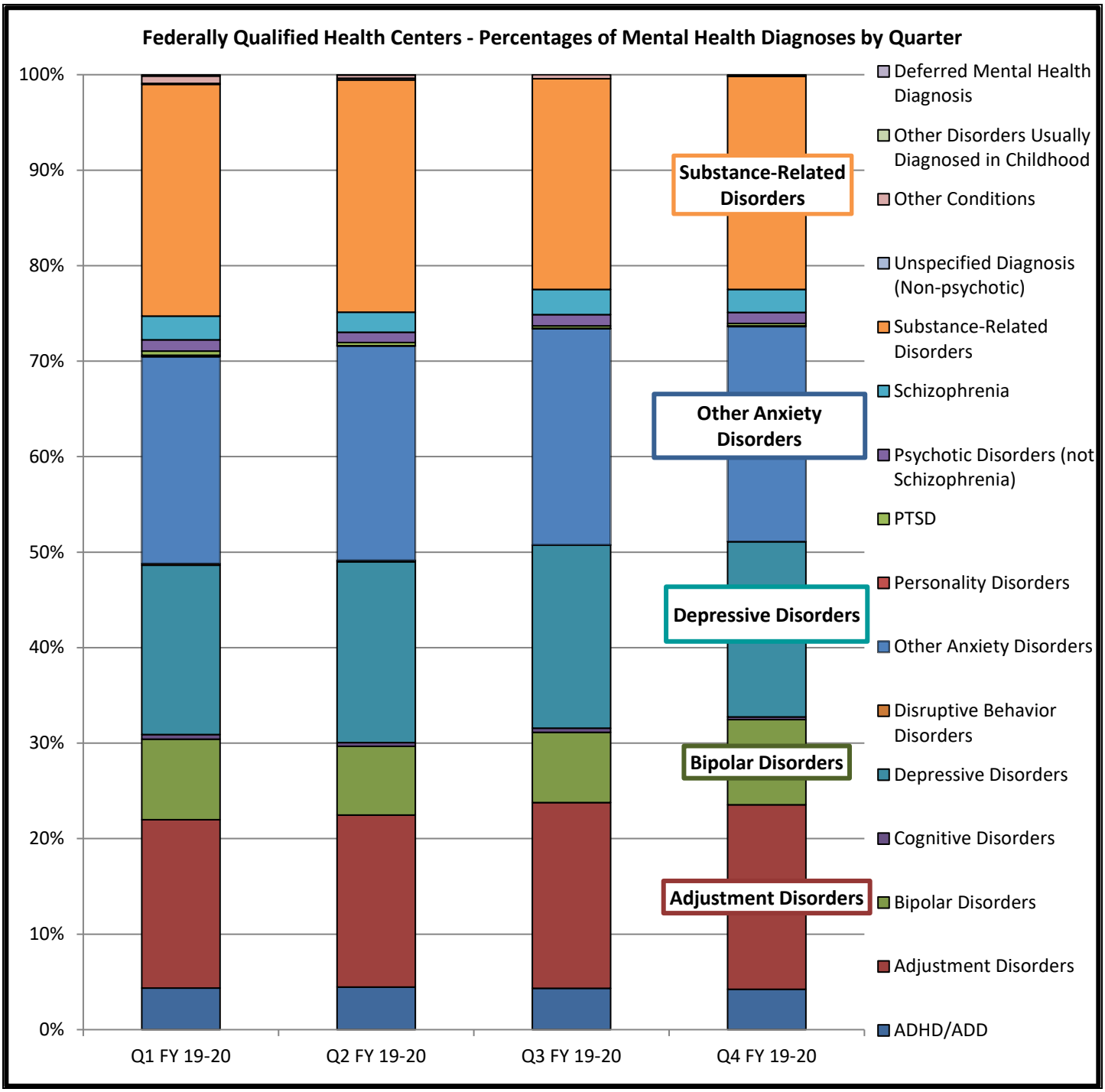


Table 3: Bolded and underlined numbers represent the highest number during the fiscal year. In June, the number of CRRC admits at 14 was a decrease of -13% compared to May and was the same as from the same month of last year. There were 241 CRRC bed days for June, -22% less than May, and a -37% decrease from the same month of the prior year. The average length of stay for June was 17 days, which was -2 less than May and -10 less than June of the previous year.

CRRC/*Elpida* Admits (chart on page 5)														
Fiscal Year	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY Total	FY Change +/-**
YTD Change +/-*	18%	-14%	-6%	-15%	-17%	-16%	-15%	-9%	-8%	-11%	-8%	-8%		
2019-20	**20**	12	17	14	13	13	17	19	15	10	16	14	**180**	-8%
2018-19	17	20	15	**22**	18	14	18	13	15	16	13	14	**195**	13%
2017-18	17	13	12	12	13	14	19	11	10	16	16	**20**	**173**	13%
2016-17	16	17	5	16	14	5	16	8	**22**	11	10	13	**153**	-13%
2015-16	18	9	15	20	14	11	12	15	10	**21**	11	19	**175**	-5%
2014-15	17	**23**	17	14	15	12	17	13	14	10	14	19	**185**	-1%
2013-14	17	17	19	19	12	15	**21**	6	19	15	10	16	**186**	-27%
2012-13	26	**28**	21	25	24	19	17	22	18	17	19	20	**256**	-3%
2011-12	24	23	27	20	11	23	21	22	**29**	18	22	25	**265**	-2%
2010-11	20	26	23	23	21	23	22	19	23	19	**30**	21	**270**	-6%

CRRC/*Elpida* Days (chart on page 5)														
Fiscal Year	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY Total	FY Change +/-**
YTD Change +/-*	-3%	-16%	-20%	-20%	-23%	-21%	-21%	-19%	-18%	-18%	-19%	-21%		
2019-20	**366**	291	**247**	314	235	260	294	317	360	313	309	241	**3,547**	-21%
2018-19	376	404	348	403	357	*285*	367	320	394	407	**437**	381	**4,479**	50%
2017-18	204	165	**187**	204	260	329	288	264	191	201	**353**	339	**2,985**	13%
2016-17	295	280	201	185	291	*120*	242	199	167	228	130	**313**	**2,651**	-7%
2015-16	236	224	244	**342**	301	266	194	217	178	215	193	229	**2,839**	-5%
2014-15	**345**	268	280	235	235	186	284	239	174	246	192	304	**2,988**	-3%
2013-14	274	231	255	295	136	207	333	311	212	**335**	242	243	**3,074**	-14%
2012-13	315	341	321	310	344	**361**	248	259	296	308	213	274	**3,590**	20%
2011-12	216	202	296	**329**	209	196	247	191	279	291	267	268	**2,991**	2%
2010-11	193	254	250	290	278	231	**307**	192	203	165	302	280	**2,945**	-10%

CRRC/*Elpida* Average Length of Stay (Bed Days/Discharge Count) - (chart on page 5)														
Fiscal Year	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY Avg. LOS	Change +/-**
2019-20	18	24	10	22	18	20	17	17	24	**31**	19	17	**20**	-13%
2018-19	22	20	23	18	20	20	20	25	26	25	34	27	**23**	35%
2017-18	12	13	16	17	20	24	15	24	19	13	22	17	**17**	0%
2016-17	18	16	**40**	12	21	24	15	25	8	21	13	24	**17**	6%
2015-16	13	**25**	16	17	22	24	16	14	18	10	18	12	**16**	-6%
2014-15	20	12	16	17	16	16	17	18	12	**25**	14	16	**17**	-11%
2013-14	16	14	13	16	11	14	16	**52**	11	22	24	15	**19**	36%
2012-13	12	12	15	12	14	**19**	15	12	16	18	11	14	**14**	17%
2011-12	9	9	11	16	**19**	9	12	9	10	16	12	11	**12**	9%
2010-11	10	10	11	13	13	10	**14**	10	9	9	10	13	**11**	-8%
2009-10	**15**	10	13	12	11	13	10	11	9	12	11	11	**12**	0%
2010-11	7	9	12	12	12	12	**18**	9	11	10	16	14	**12**	-8%

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

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

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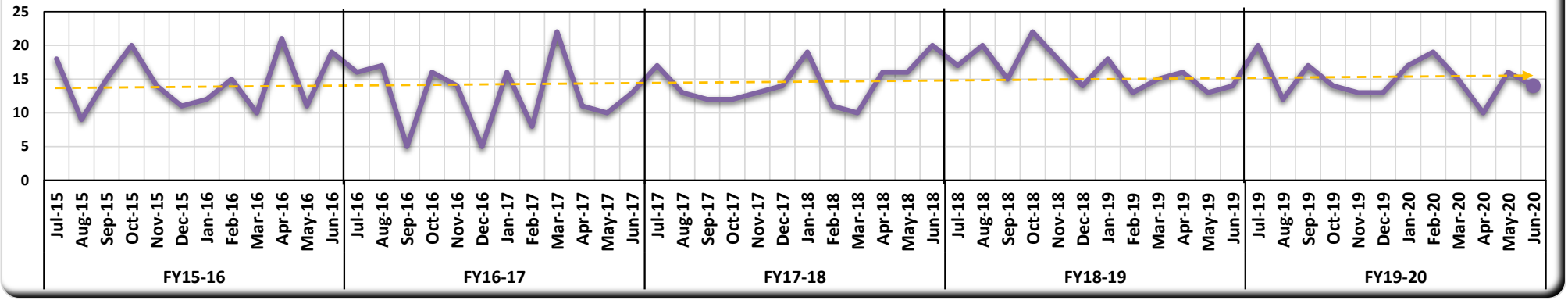
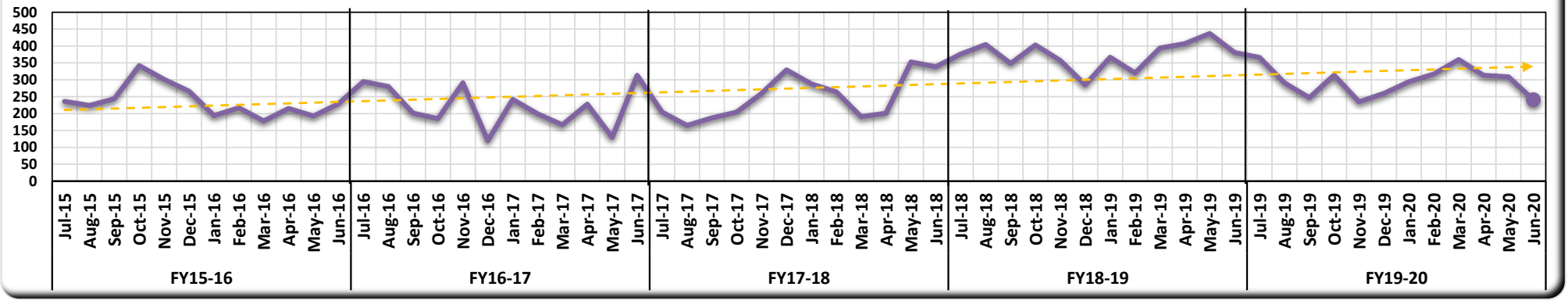
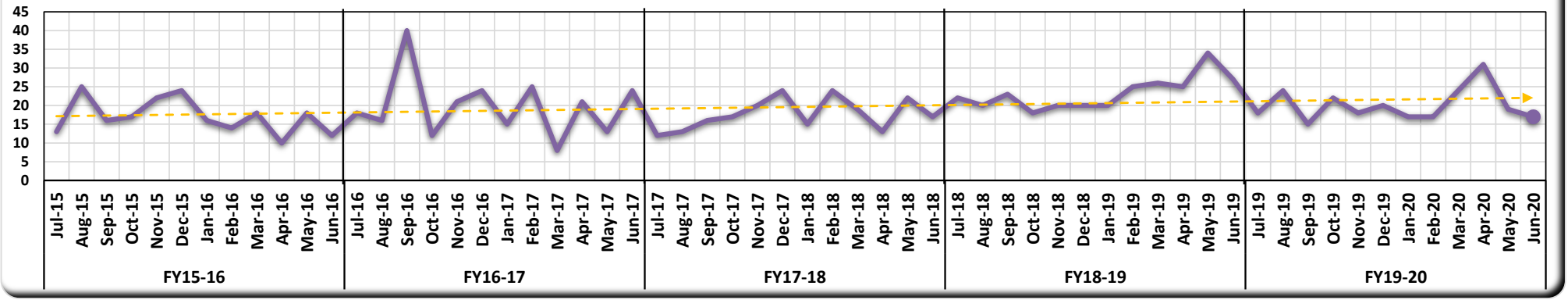
CRISIS RESIDENTIAL - NUMBER OF ADMITS BY MONTH



CRISIS RESIDENTIAL - TOTAL BED DAYS BY MONTH



CRISIS RESIDENTIAL - AVERAGE LENGTH OF STAY BY MONTH



\\Hipaa\mhshare\Urgent Care\Database\data\ITD Monthly Rpt\FY19-20\UC Reports
http://intranet/docs/libraries/hhsa-docs/data-and-maps/monthly-urgent-care-report

Shasta County Health & Human Services Agency

The Woodlands Permanent Supportive Housing

Fiscal Year 2019/2020

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

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

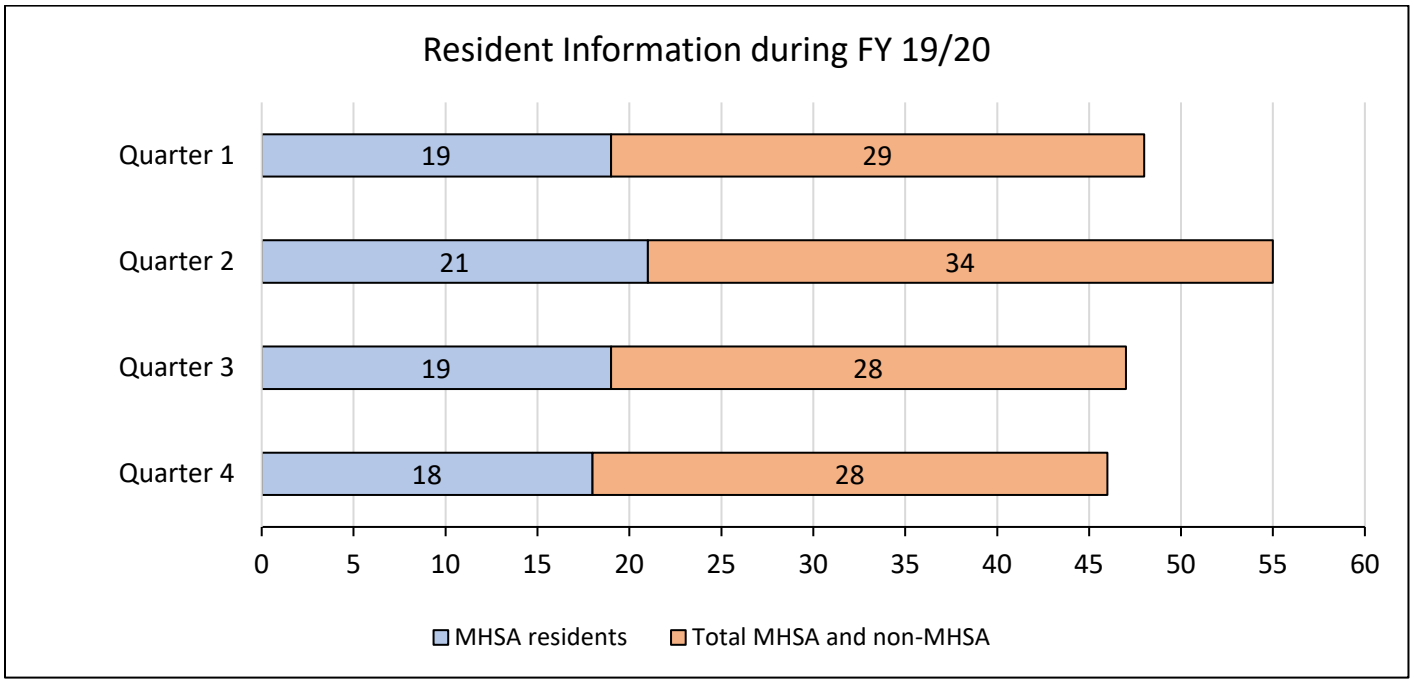
- Finance/Budgeting Classes
- Personal Income Tax Preparation
- Adult Education Classes
- Benefit/Entitlement Assistance
- After-School Activities
- Health and Wellness Classes.

The County also provides clients with supportive services such as:

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

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

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



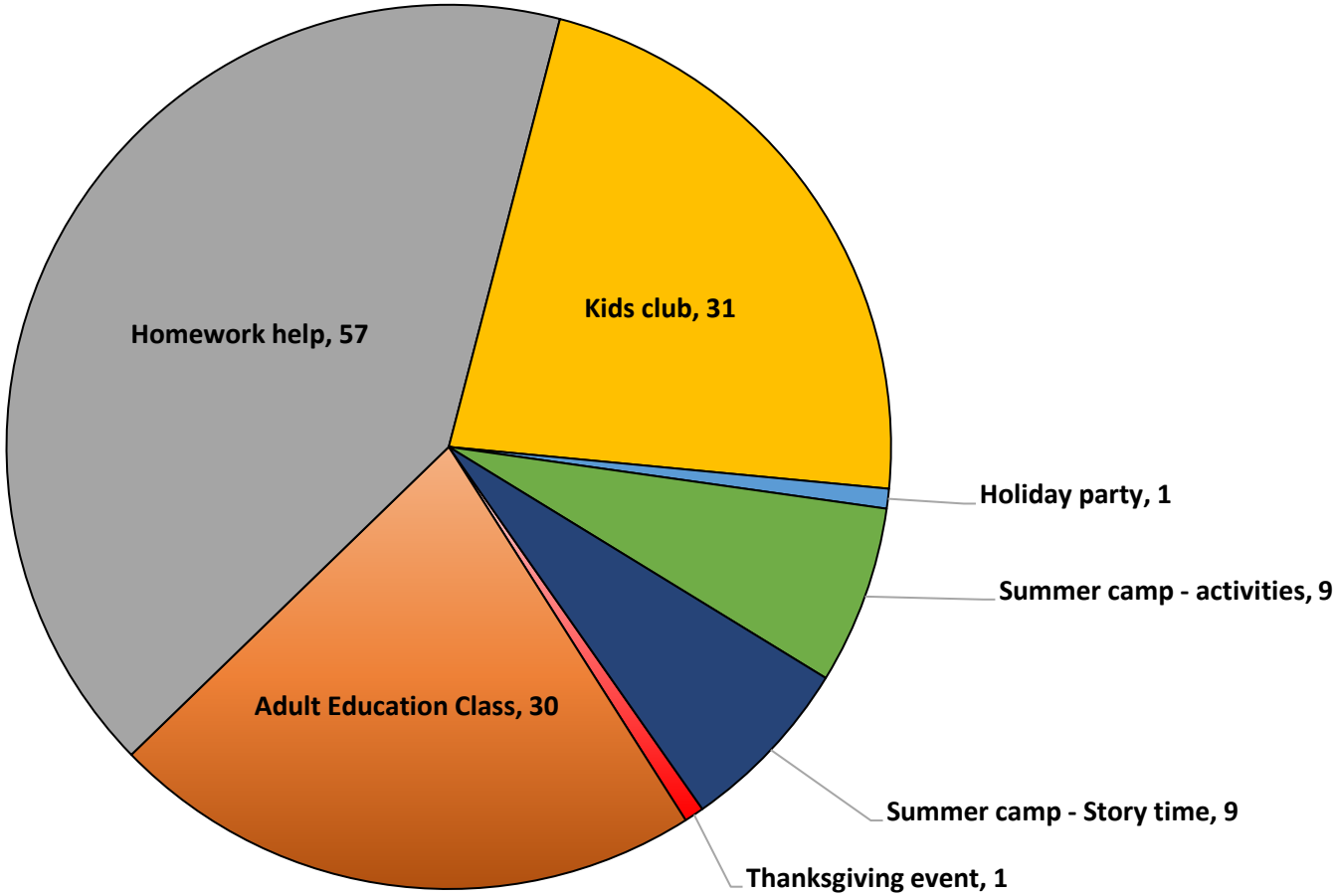
When tenants leave MHSA units, vacancies are quickly filled by those who are on the MHSA Permanent Supportive Housing Project waitlist. The total number of MHSA residents who left their units permanently during Fiscal Year 19/20 was 4.

During Fiscal Year 19/20, clients engaged in different activities, community education programs, and classes to learn skills. During April-June 2020, activities were cancelled due to COVID-19. The services provided, and the number of times those services have been provided, is summarized on the pie chart on the next page.

The Woodlands

Frequency of each social service provided

Fiscal Year 19/20



Does not include supportive services.

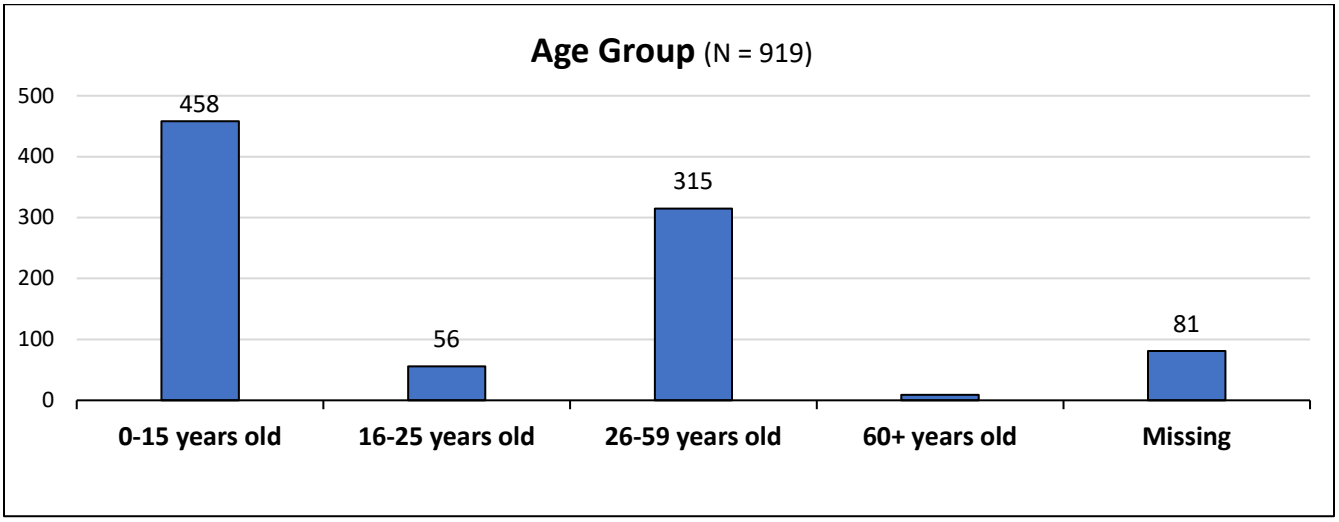
Shasta County Health & Human Services Agency

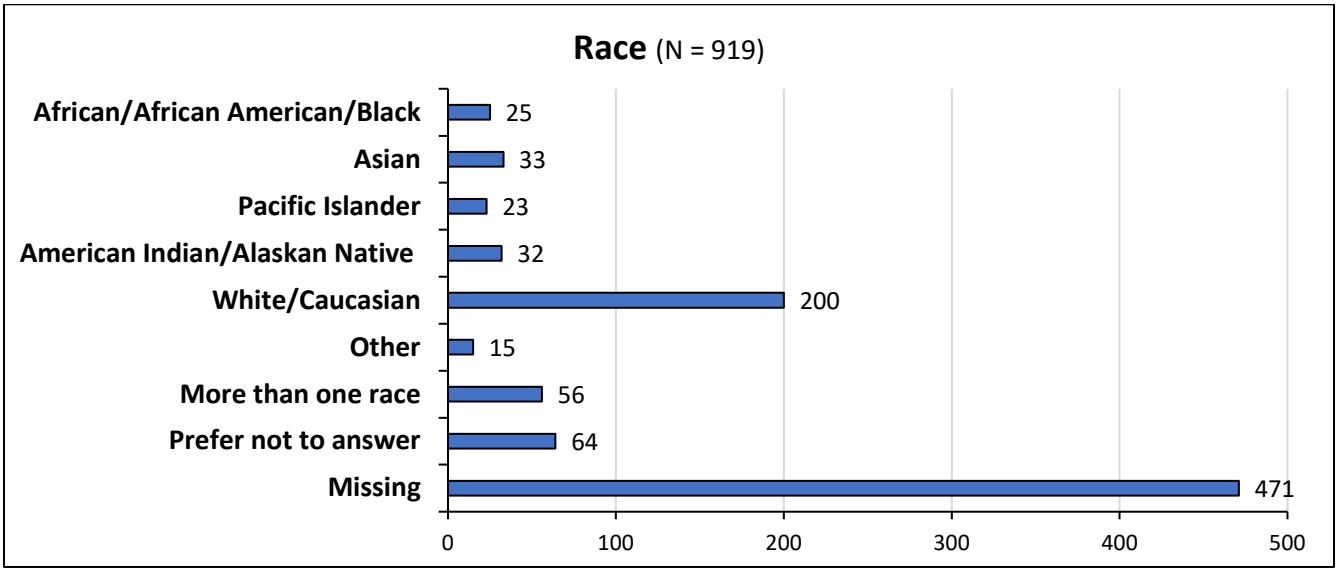
MHSA Prevention and Early Intervention Fiscal Year 19/20 Demographics Report

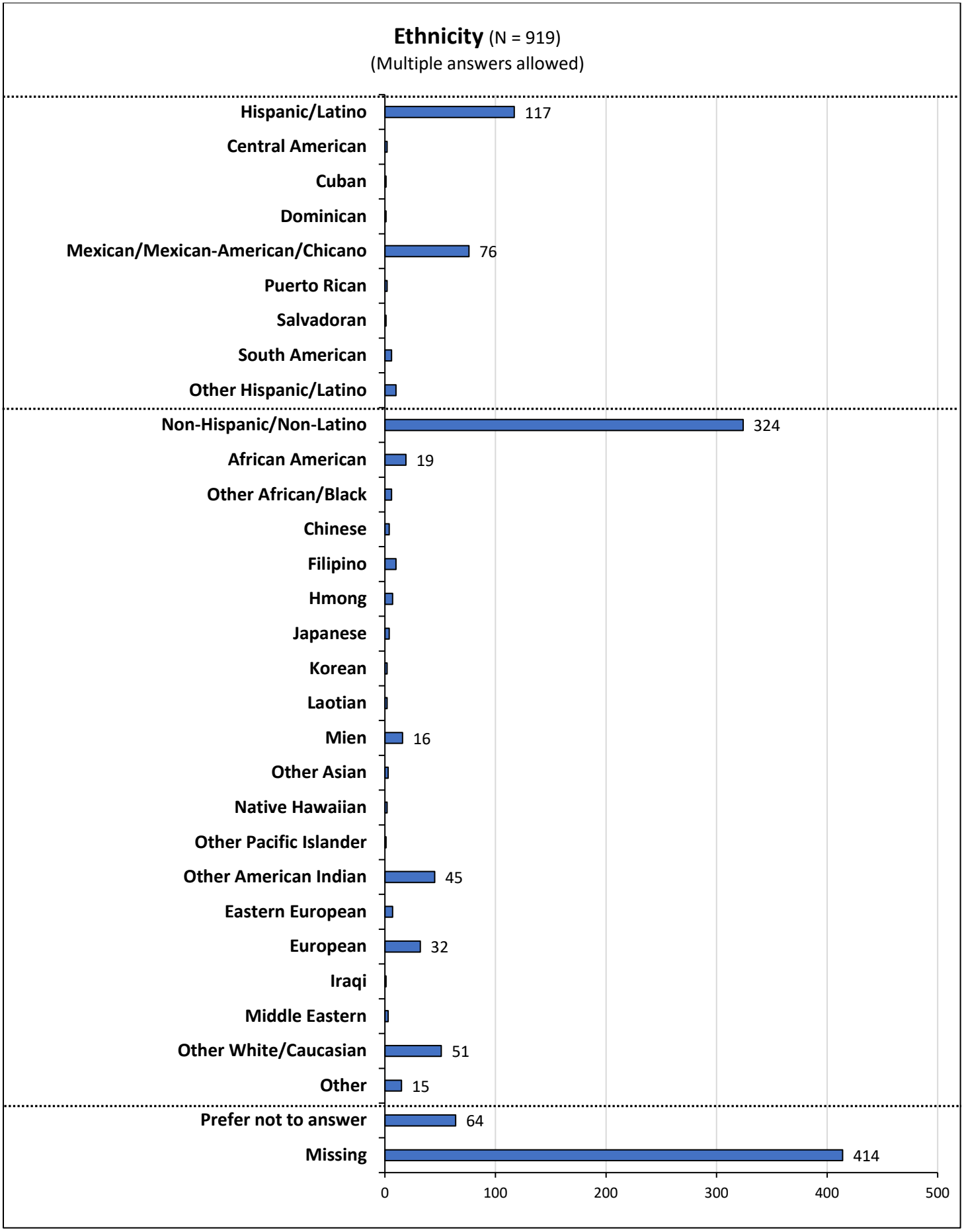
I. Prevention and Early Intervention Program Demographics

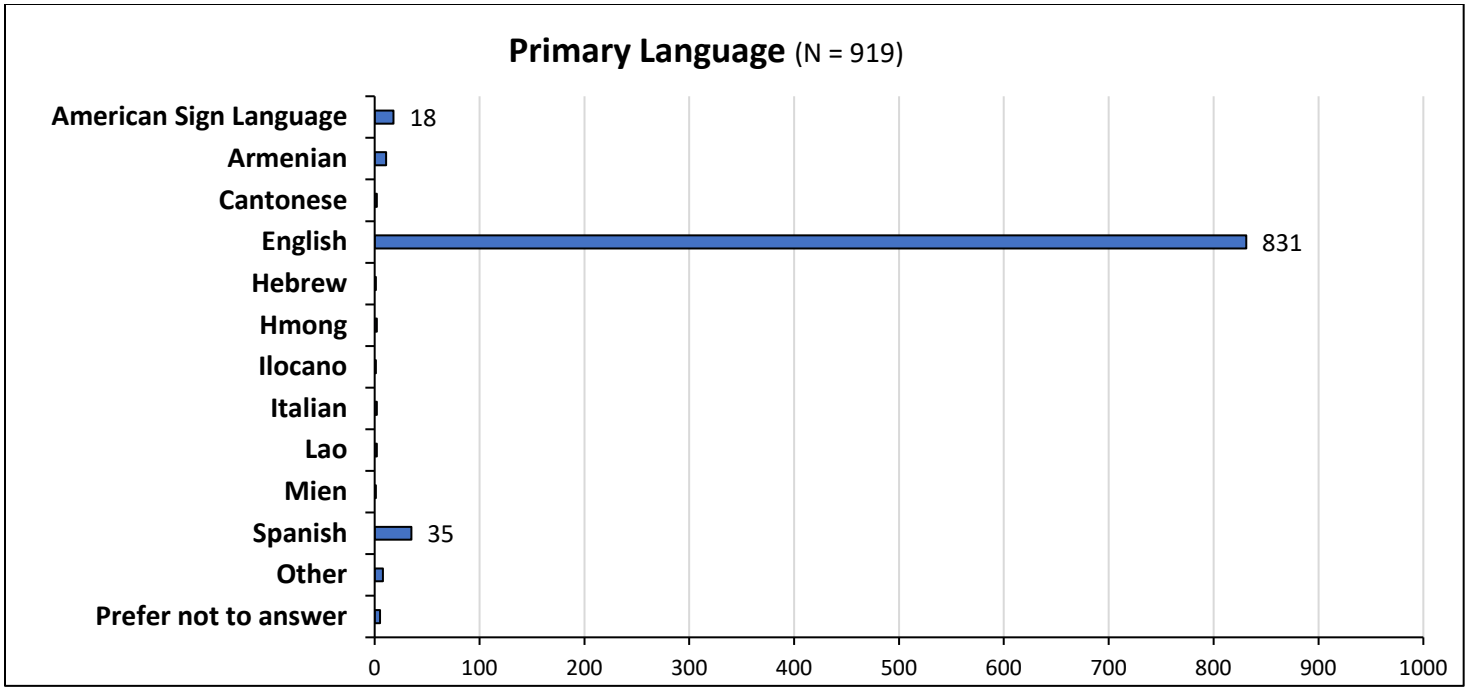
- Triple P (414 individuals submitted data)
- Botvin Lifeskills (505 individuals submitted data)

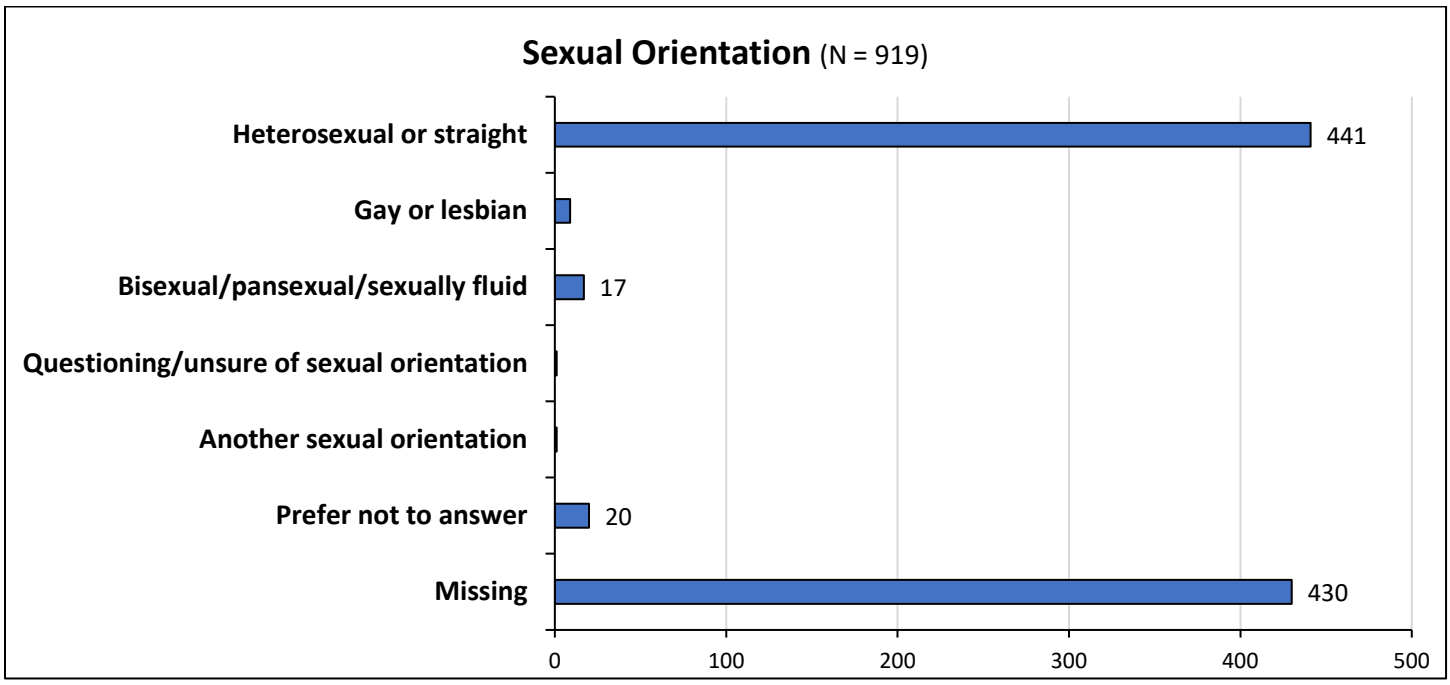
919 total individuals submitted data. Categories that received 11 or less responses are not labelled to help protect client confidentiality. Categories that received zero responses are not shown.

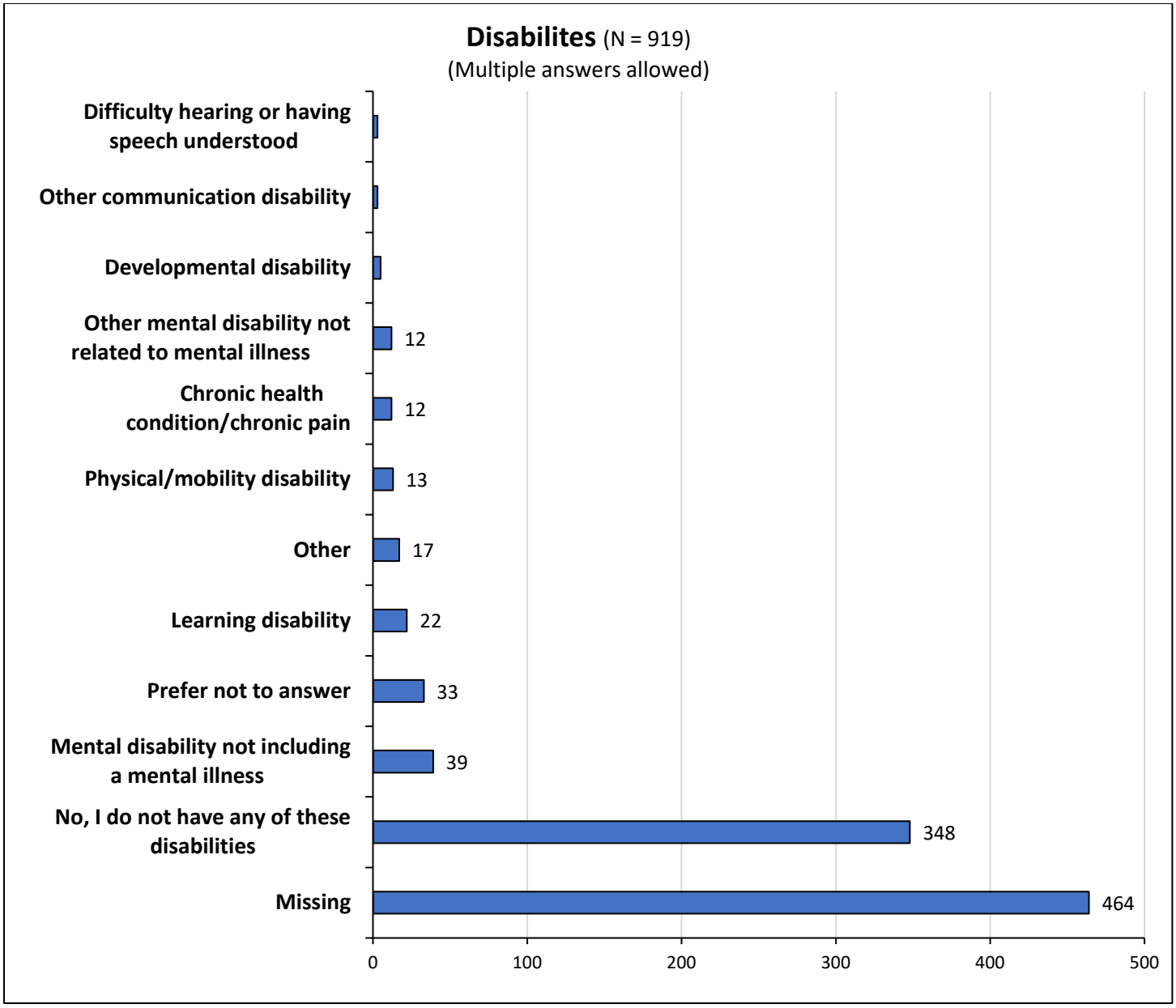


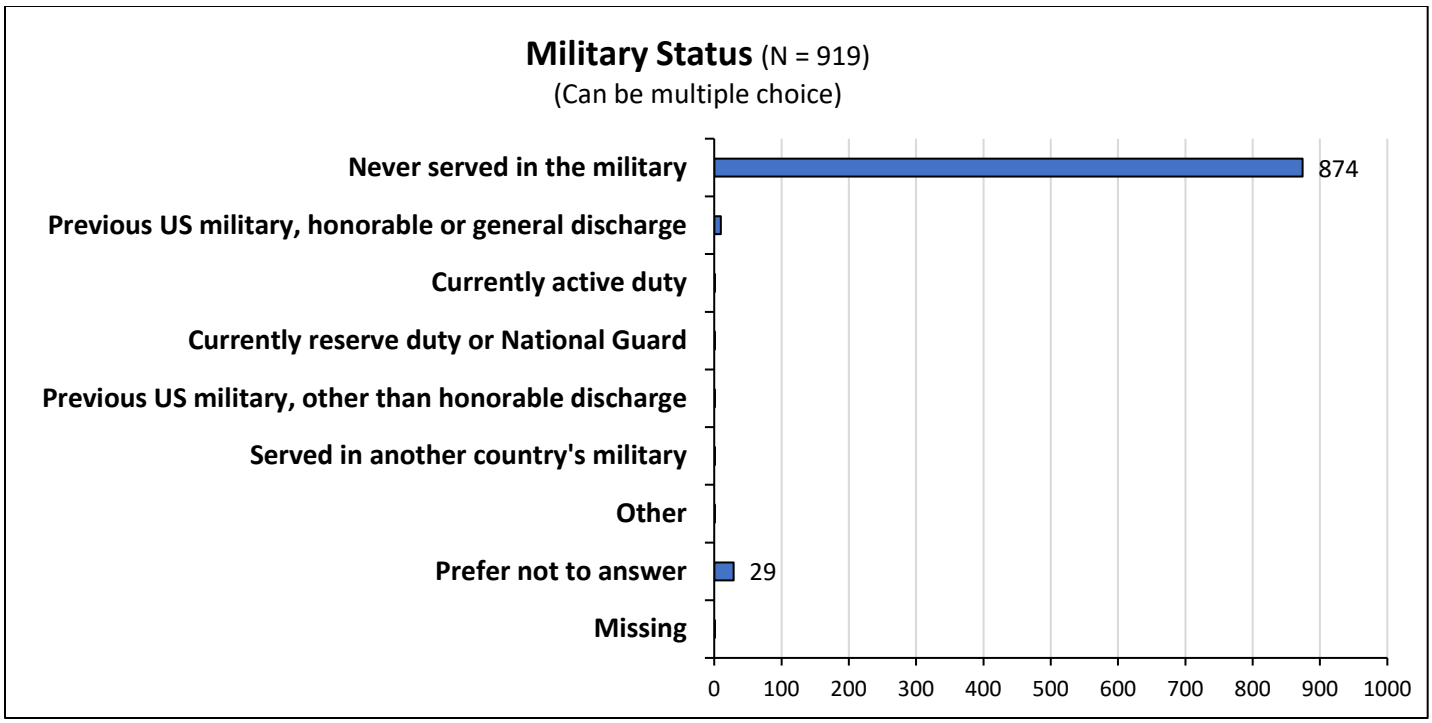


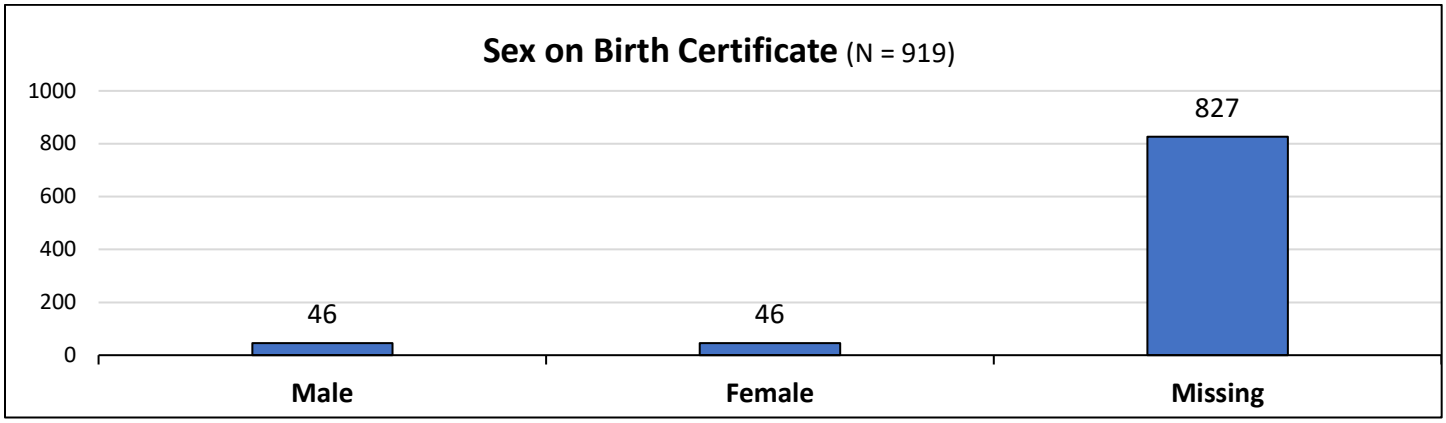

Ethnicity (N = 919)
(Multiple answers allowed)
Hispanic/Latino
117
Central American
Cuban
Dominican
Mexican/Mexican-American/Chicano
76
Puerto Rican
Salvadoran
South American
Other Hispanic/Latino
Non-Hispanic/Non-Latino
324
African American
19
Other African/Black
Chinese
Filipino
Hmong
Japanese
Korean
Laotian
Mien
16
Other Asian
Native Hawaiian
Other Pacific Islander
Other American Indian
45
Eastern European
European
32
Iraqi
Middle Eastern
Other White/Caucasian
51
Other
15
Prefer not to answer
64
Missing
414
0
100
200
300
400
500

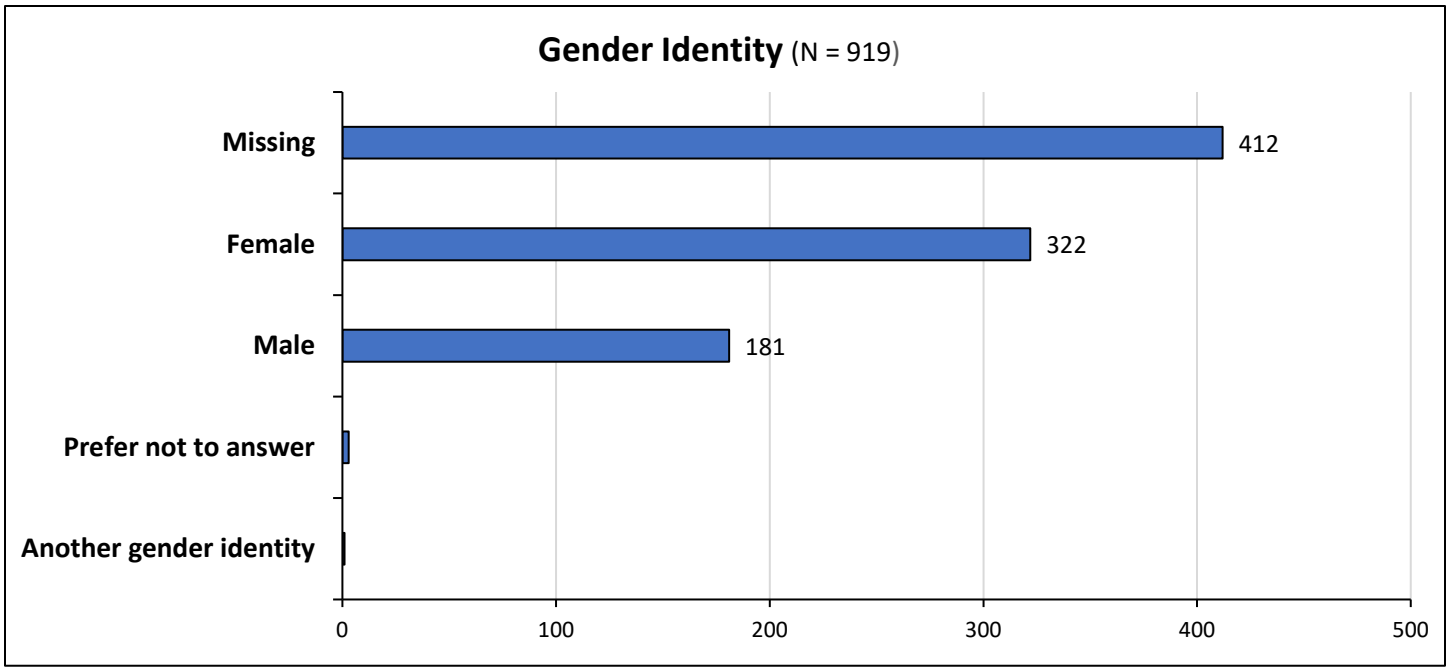

Primary Language (N = 919)
American Sign Language
Armenian
Cantonese
English
Hebrew
Hmong
Ilocano
Italian
Lao
Mien
Spanish
Other
Prefer not to answer
18
831
35
0
100
200
300
400
500
600
700
800
900
1000


Sexual Orientation (N = 919)
Heterosexual or straight
Gay or lesbian
Bisexual/pansexual/sexually fluid
Questioning/unsure of sexual orientation
Another sexual orientation
Prefer not to answer
Missing
441
17
20
430
0
100
200
300
400
500


Disabilites (N = 919)
(Multiple answers allowed)
Difficulty hearing or having speech understood
Other communication disability
Developmental disability
Other mental disability not related to mental illness
12
Chronic health condition/chronic pain
12
Physical/mobility disability
13
Other
17
Learning disability
22
Prefer not to answer
33
Mental disability not including a mental illness
39
No, I do not have any of these disabilities
348
Missing
464
0
100
200
300
400
500


Military Status (N = 919)
(Can be multiple choice)
Never served in the military
Previous US military, honorable or general discharge
Currently active duty
Currently reserve duty or National Guard
Previous US military, other than honorable discharge
Served in another country's military
Other
Prefer not to answer
Missing
874
29
0
100
200
300
400
500
600
700
800
900
1000

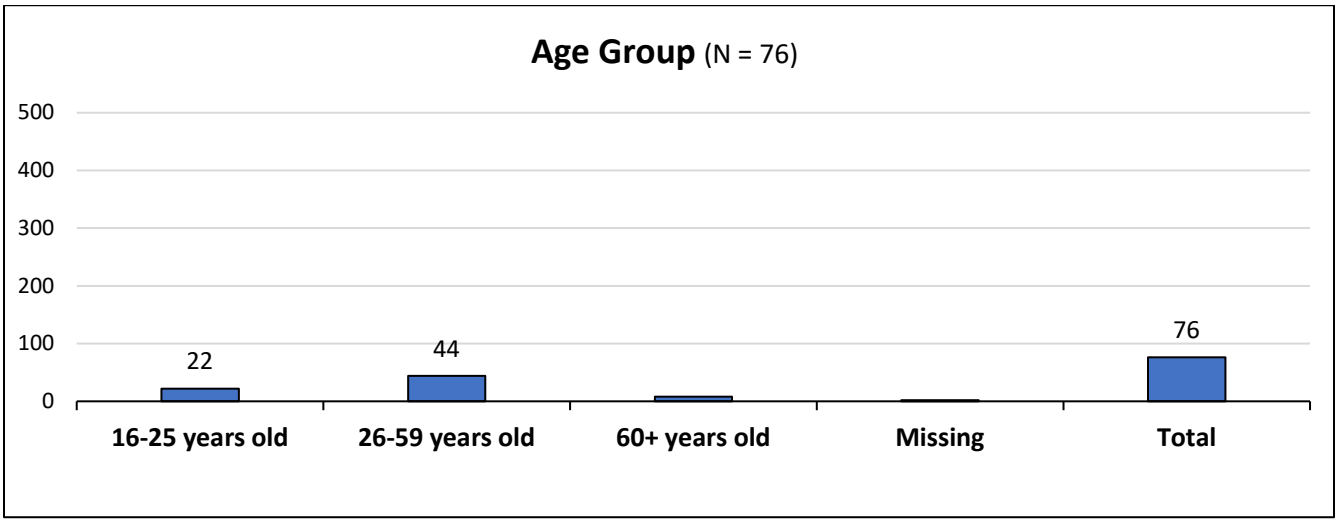

Sex on Birth Certificate (N = 919)
1000
800
600
400
200
0
46
46
827
Male
Female
Missing

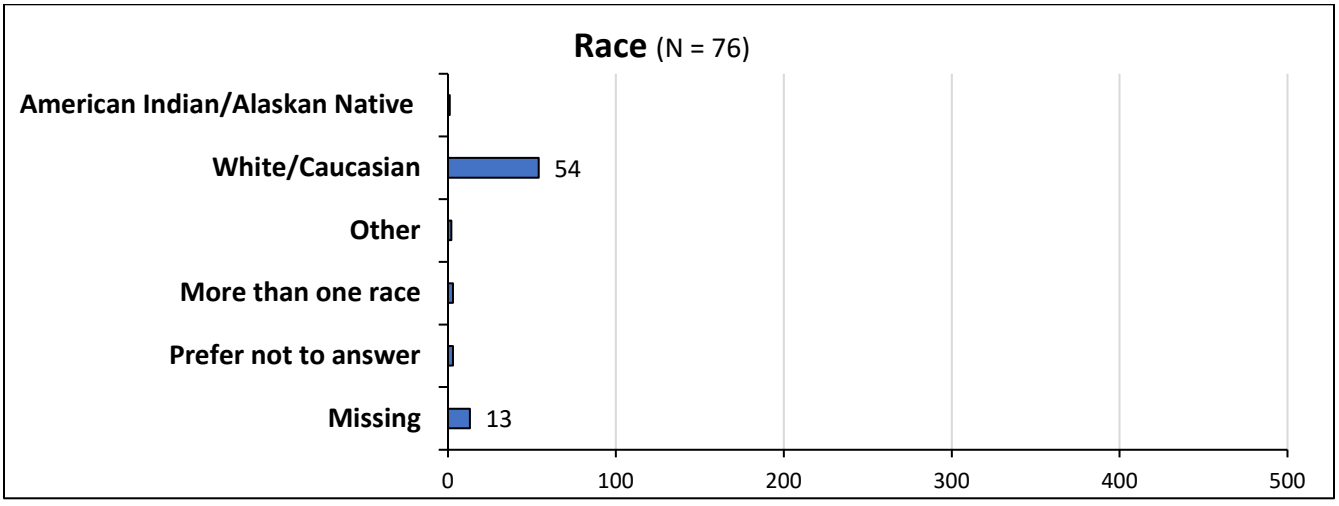

Gender Identity (N = 919)
Missing
Female
Male
Prefer not to answer
Another gender identity
412
322
181
0
100
200
300
400
500

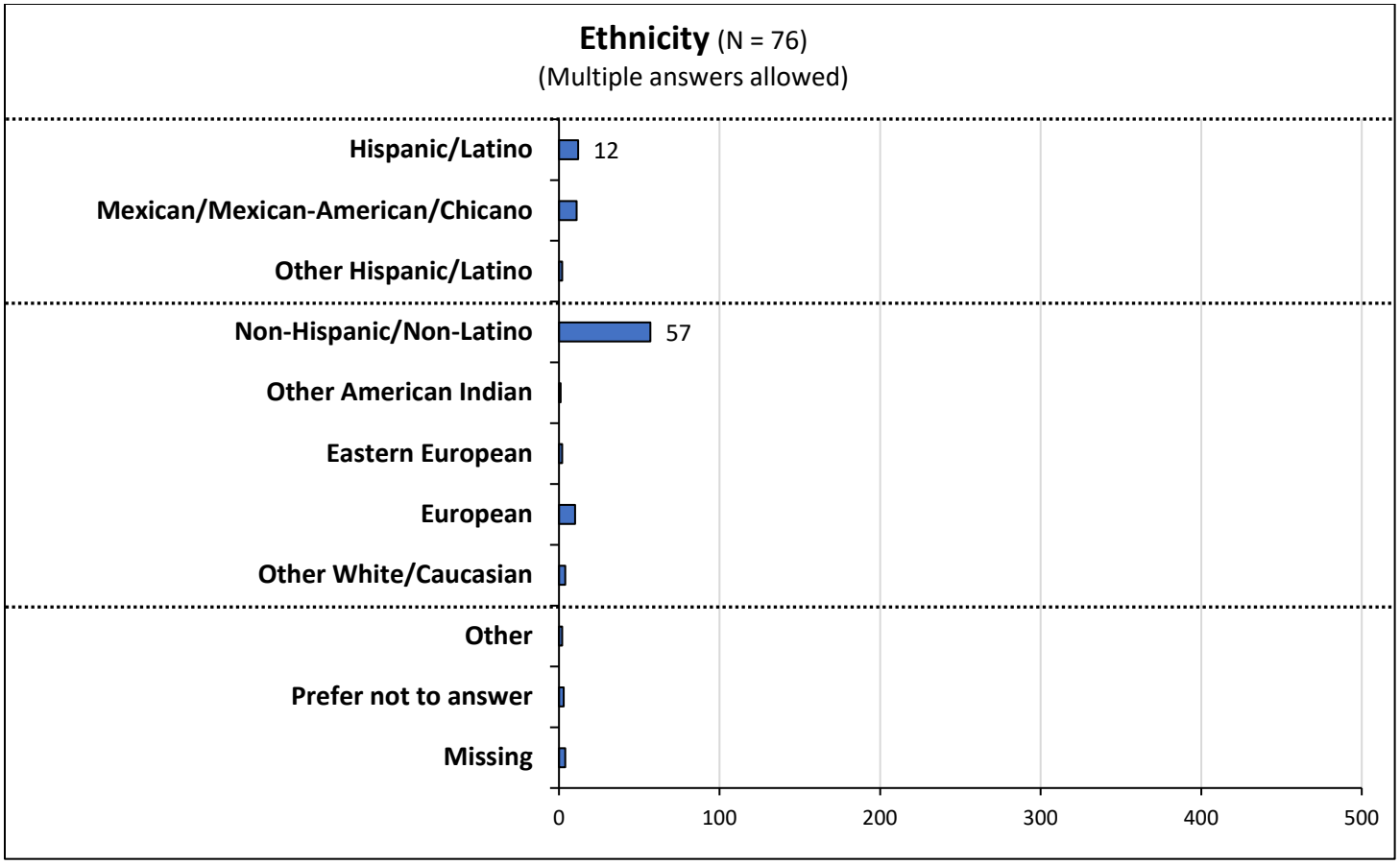
II. Outreach for Increasing Recognition of Early Signs of Mental Illness Program Demographics

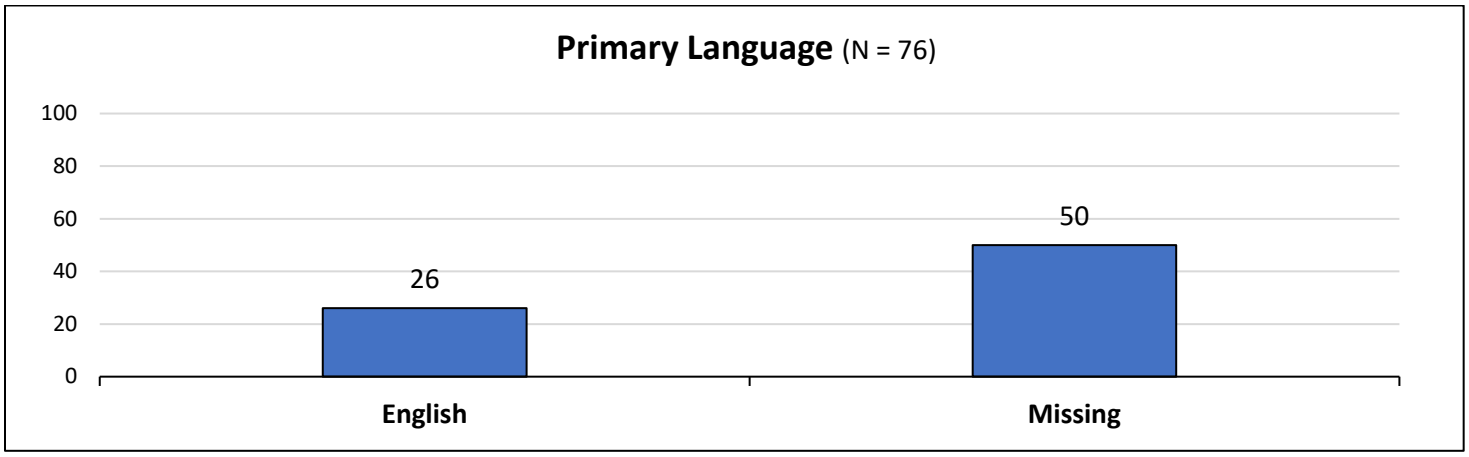
- Stand Against Stigma (48 individuals submitted data)
- ACES (28 individuals submitted data)

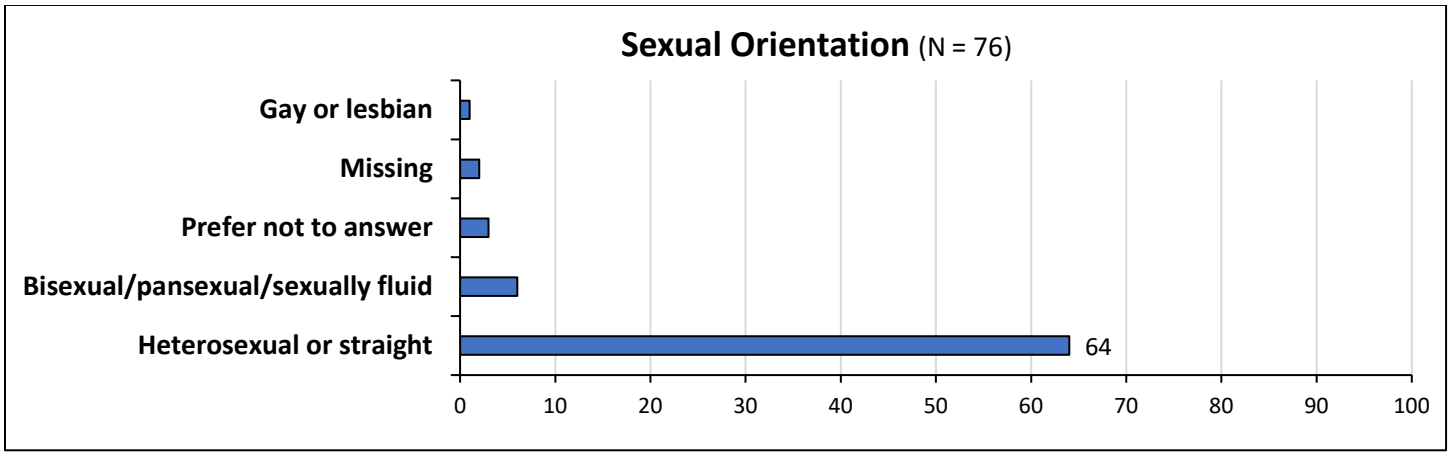
76 total individuals submitted data. Categories that received zero responses are not shown.

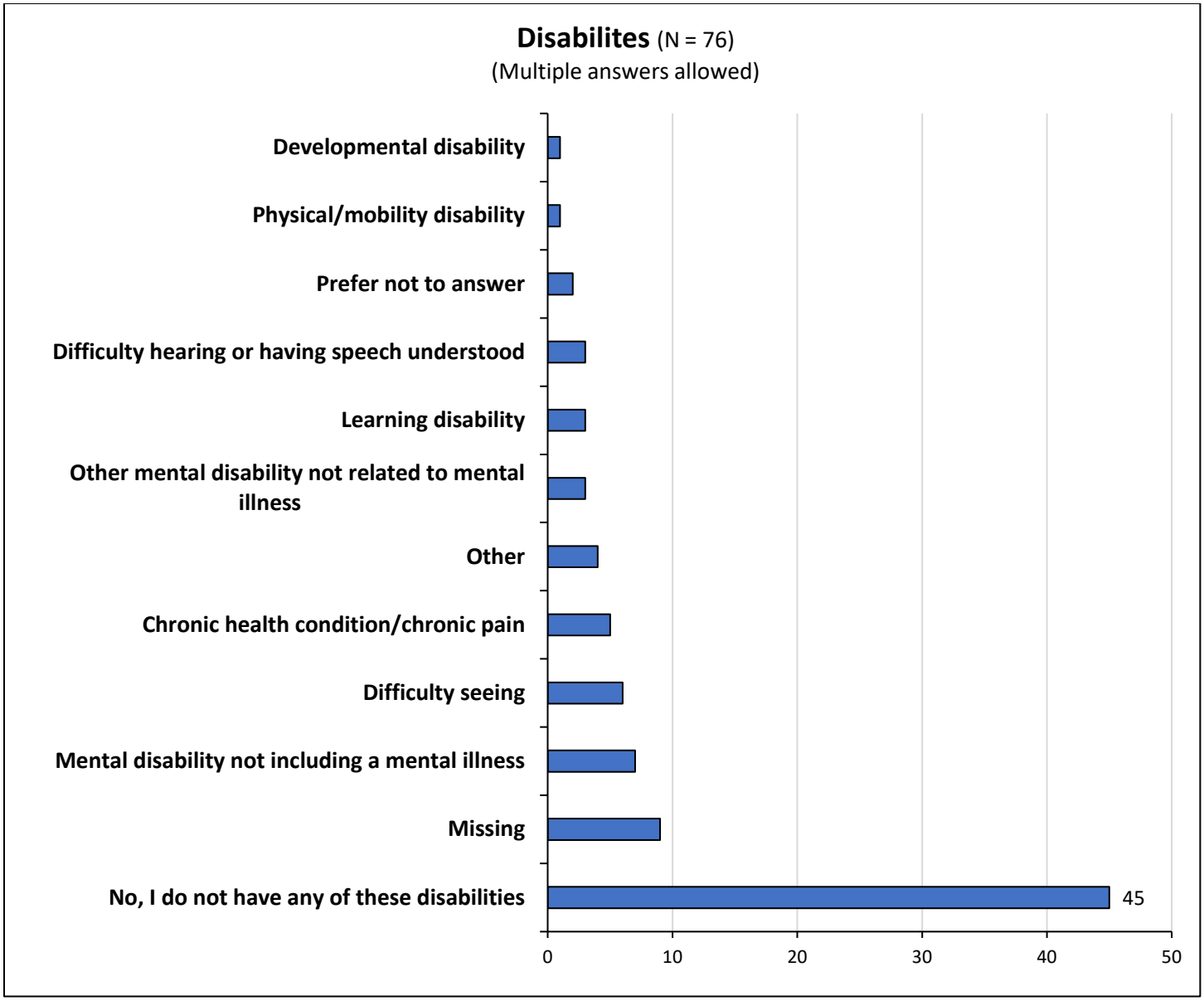


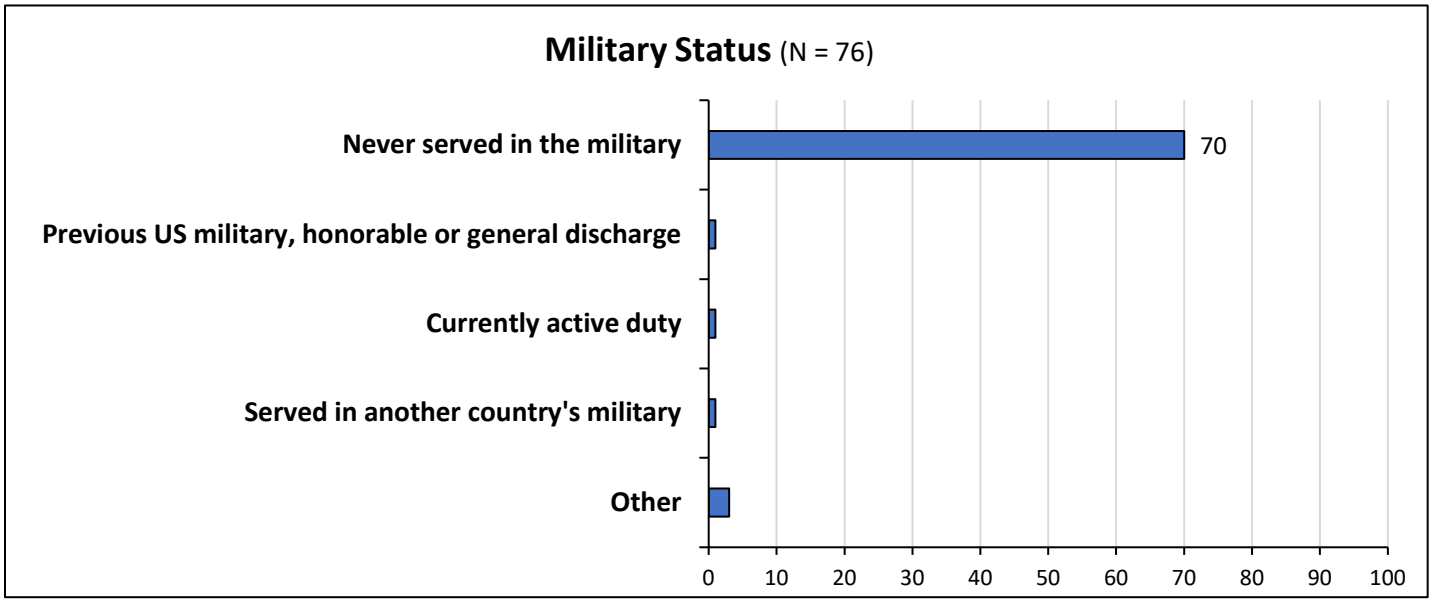


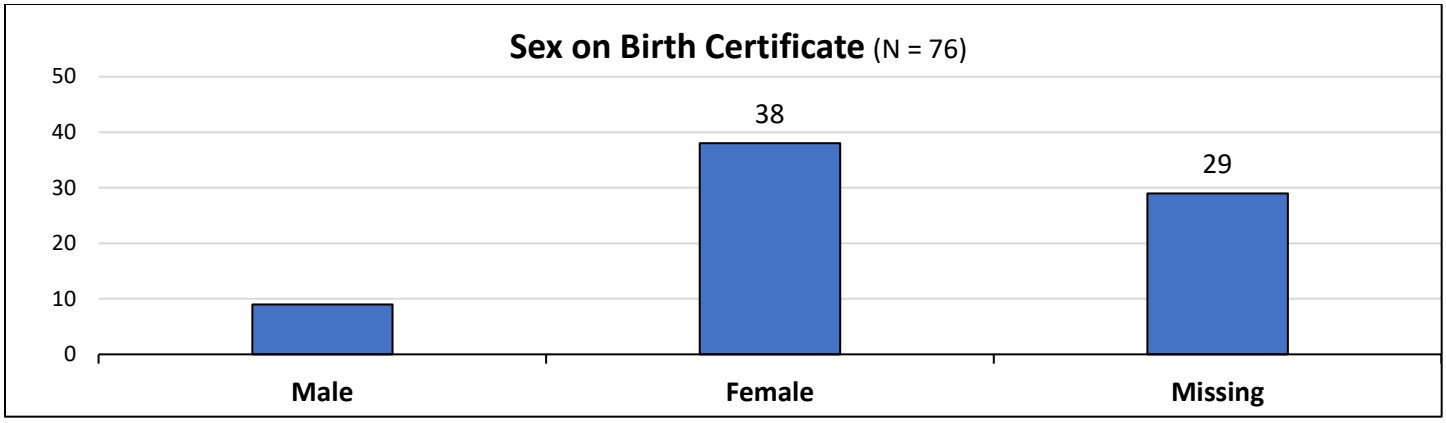

Ethnicity (N = 76)
(Multiple answers allowed)
Hispanic/Latino
12
Mexican/Mexican-American/Chicano
Other Hispanic/Latino
Non-Hispanic/Non-Latino
57
Other American Indian
Eastern European
European
Other White/Caucasian
Other
Prefer not to answer
Missing
0
100
200
300
400
500

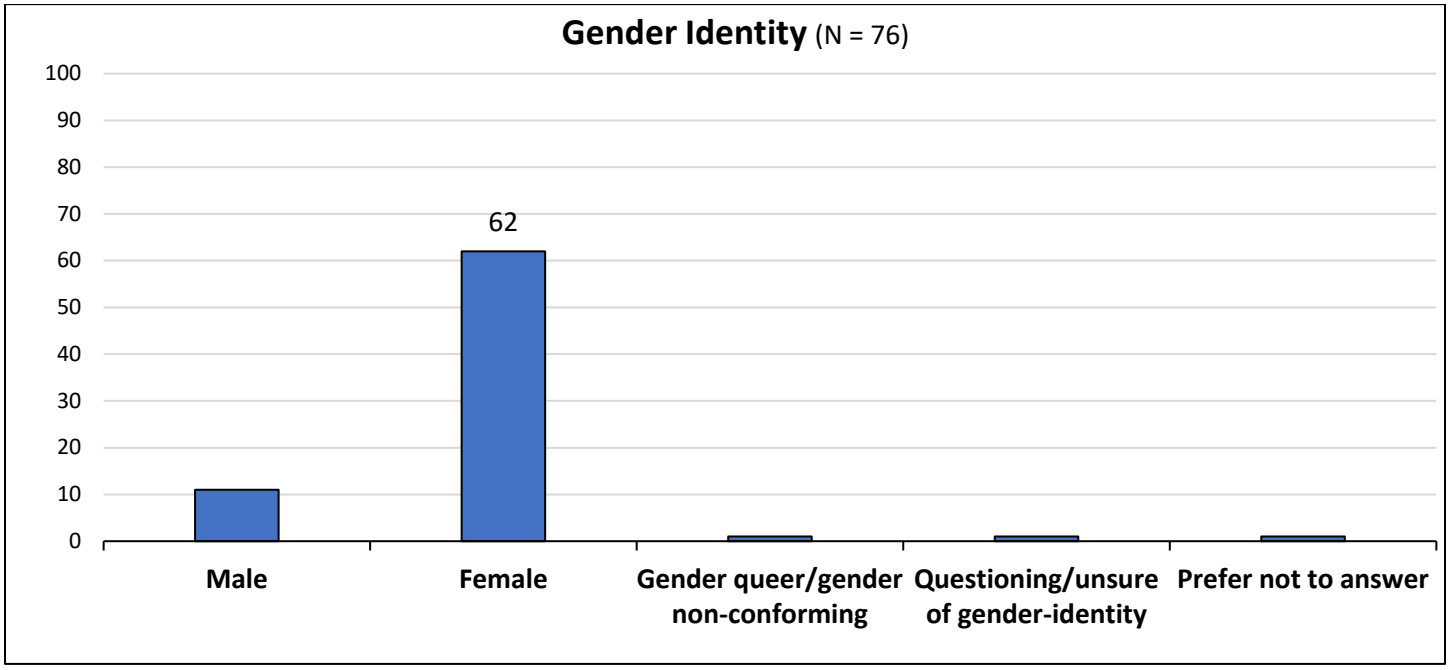

Primary Language (N = 76)
100
80
60
40
20
0
26
50
English
Missing


Sexual Orientation (N = 76)
Gay or lesbian
Missing
Prefer not to answer
Bisexual/pansexual/sexually fluid
Heterosexual or straight
64
0
10
20
30
40
50
60
70
80
90
100


Disabilites (N = 76)
(Multiple answers allowed)
Developmental disability
Physical/mobility disability
Prefer not to answer
Difficulty hearing or having speech understood
Learning disability
Other mental disability not related to mental illness
Other
Chronic health condition/chronic pain
Difficulty seeing
Mental disability not including a mental illness
Missing
No, I do not have any of these disabilities
45
0
10
20
30
40
50


Military Status (N = 76)
Never served in the military
Previous US military, honorable or general discharge
Currently active duty
Served in another country's military
Other
70
0
10
20
30
40
50
60
70
80
90
100


Sex on Birth Certificate (N = 76)
50
40
30
20
10
0
38
29
Male
Female
Missing


Gender Identity (N = 76)
100
90
80
70
60
50
40
30
20
10
0
62
Male
Female
Gender queer/gender non-conforming
Questioning/unsure of gender-identity
Prefer not to answer

III. Access and Linkage to Treatment Strategy or Program Demographics

- Early Onset

Demographic and referral data on this program is not made public due to a sample size too small to protect patient confidentiality.

Triple P Outcome Evaluation

Fiscal Year 19/20

Prepared by Shasta County Health and Human Services Agency

Shasta County Health & Human Services Agency

Introduction

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

Program overview

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

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

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

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

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

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

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

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

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

Versions of each level of Triple P

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

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

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

How the data in this report was collected

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

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

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

(ASRA) Automatic Scoring and Reporting Application data

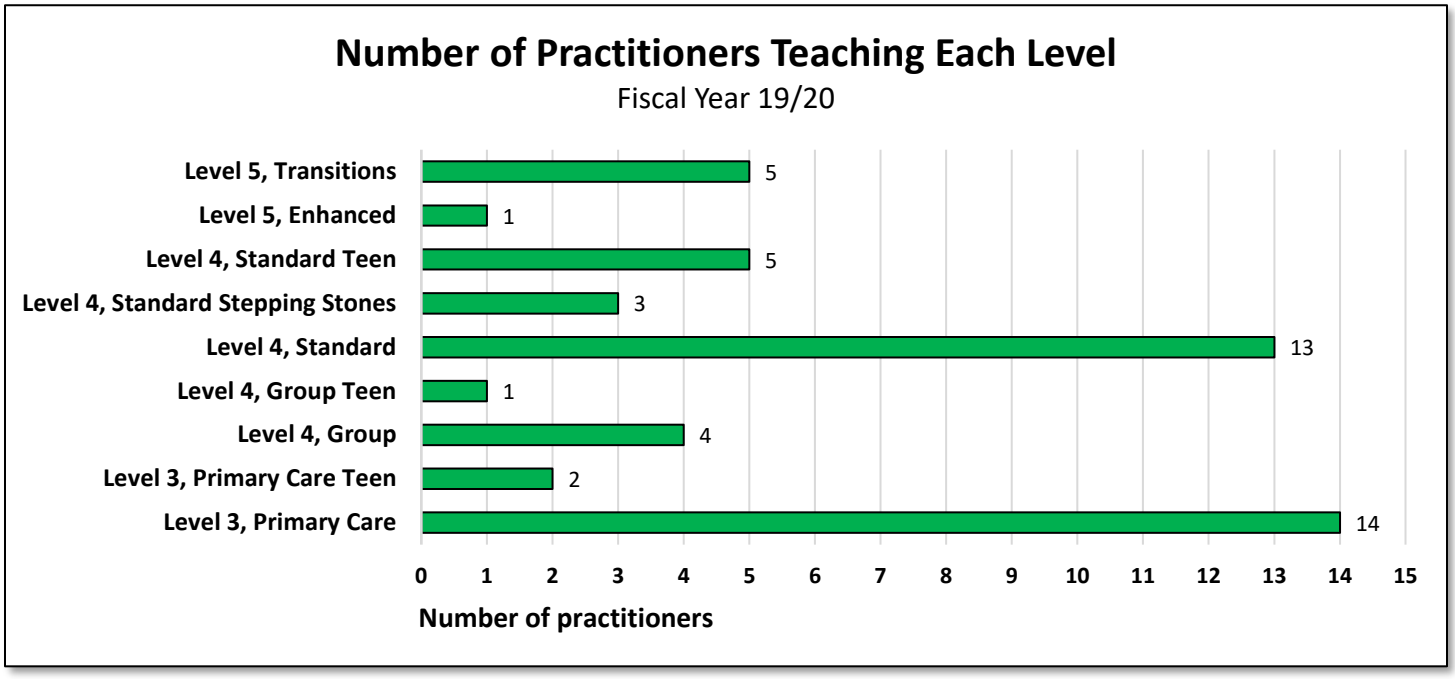
Overview

The table below shows the total number of Triple practitioners who entered data into the ASRA Scoring application during Fiscal Year 19/20, along with the organization they were with, and the total number of caregivers and families they served:

Partnered Organizations Providing Triple P Fiscal Year 19/20			
Organization	**Practitioners**	**Caregivers**	**Families**
Bridges to Success/ Shasta County Office of Education	5	110	92
Child Abuse Prevention Coordinating Council of Shasta County (CAPCC)	6	18	17
FaithWorks	1	2	2
Family Dynamics	4	66	66
Northern Valley Catholic Social Services	2	62	60
Shasta County Health & Human Services Agency: Children's Services	2	21	16
Wright Education Services	4	75	69
Youth and Family Programs	1	61	50
Totals:	**25**	**415**	**372**

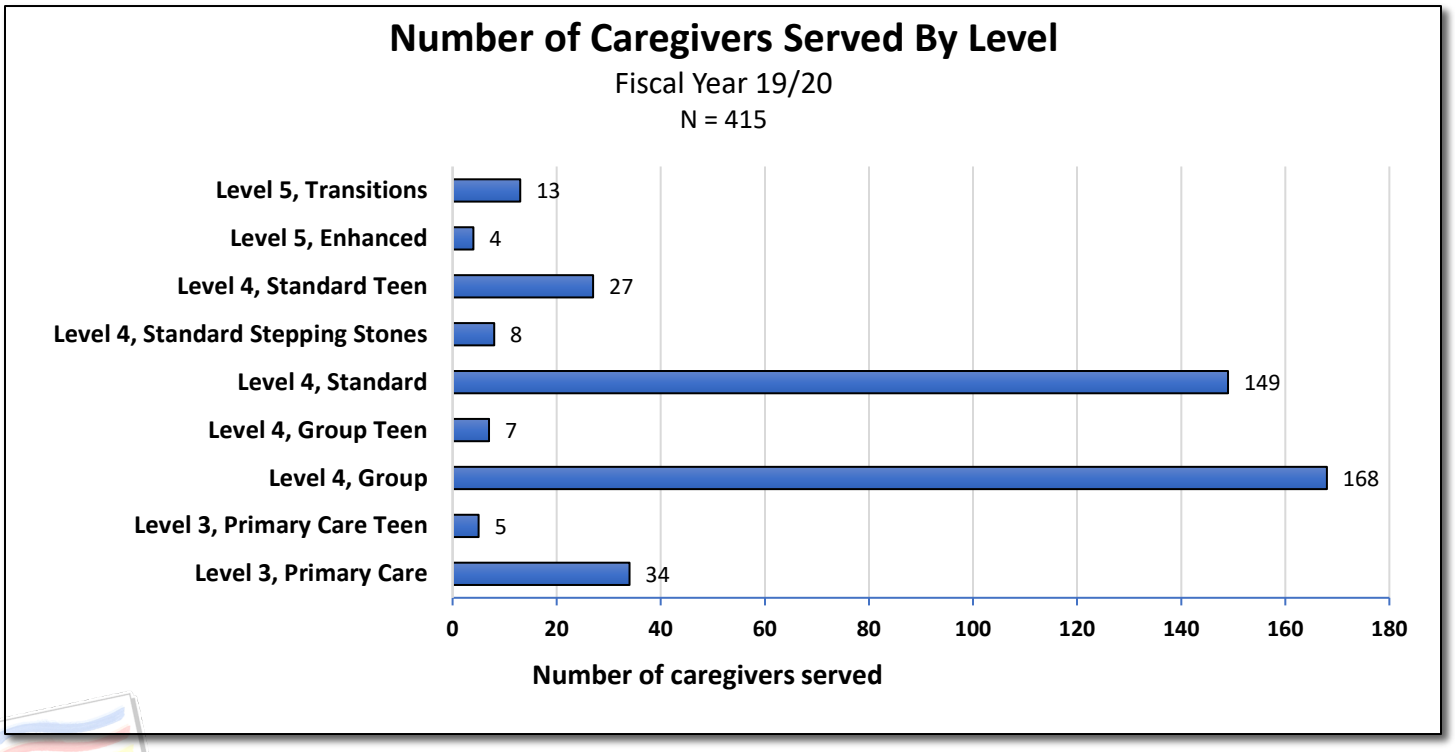
Some families may have received services in more than one organization, level, or version of Triple P. The information stored in the scoring application is anonymous (names were not collected). For this reason, the total number of unique caregivers and children/teens served between all levels couldn't be determined. In addition, if a practitioner was still submitting data in the Scoring application after transitioning to a new organization during Fiscal Year 19/20, they would be counted as a practitioner in each organization they were a part of.

There were 25 practitioners who provided Triple P services over this time period. In the graph below, you can see the number of practitioners who provided the various Triple P levels (some practitioners are counted more than once as some practitioners are trained to teach more than one level):

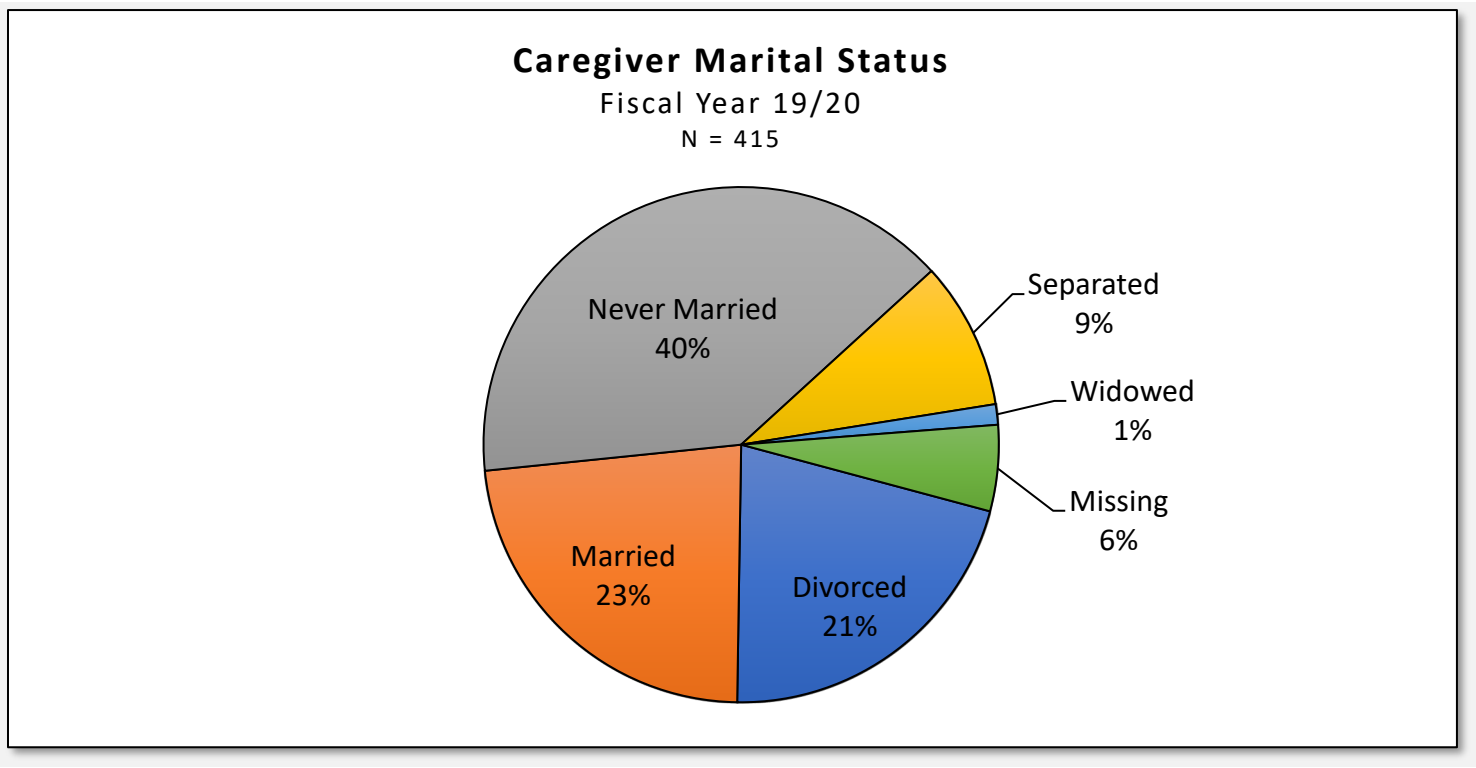


Data on the caregivers and their families

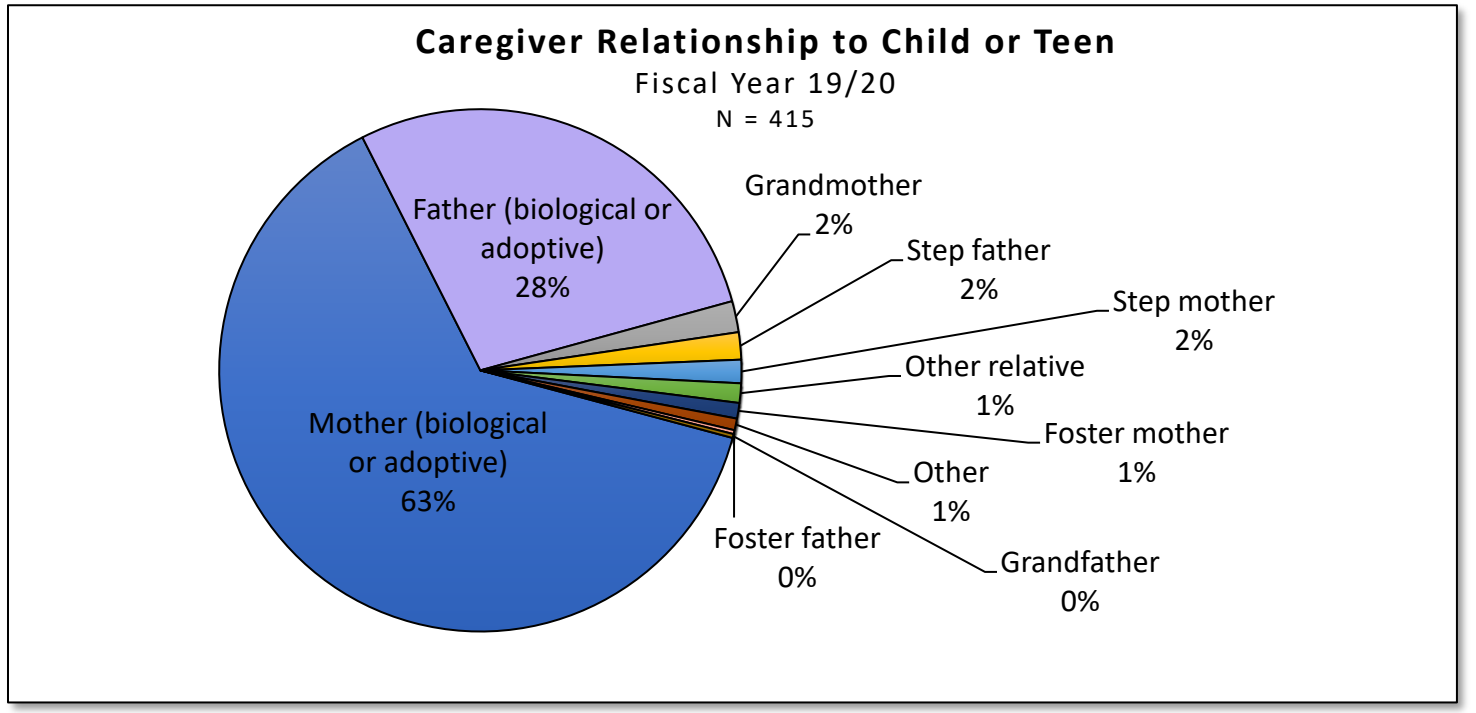
A total of 415 caregivers attended Triple P sessions. The number of caregivers in each level of Triple P is shown below:



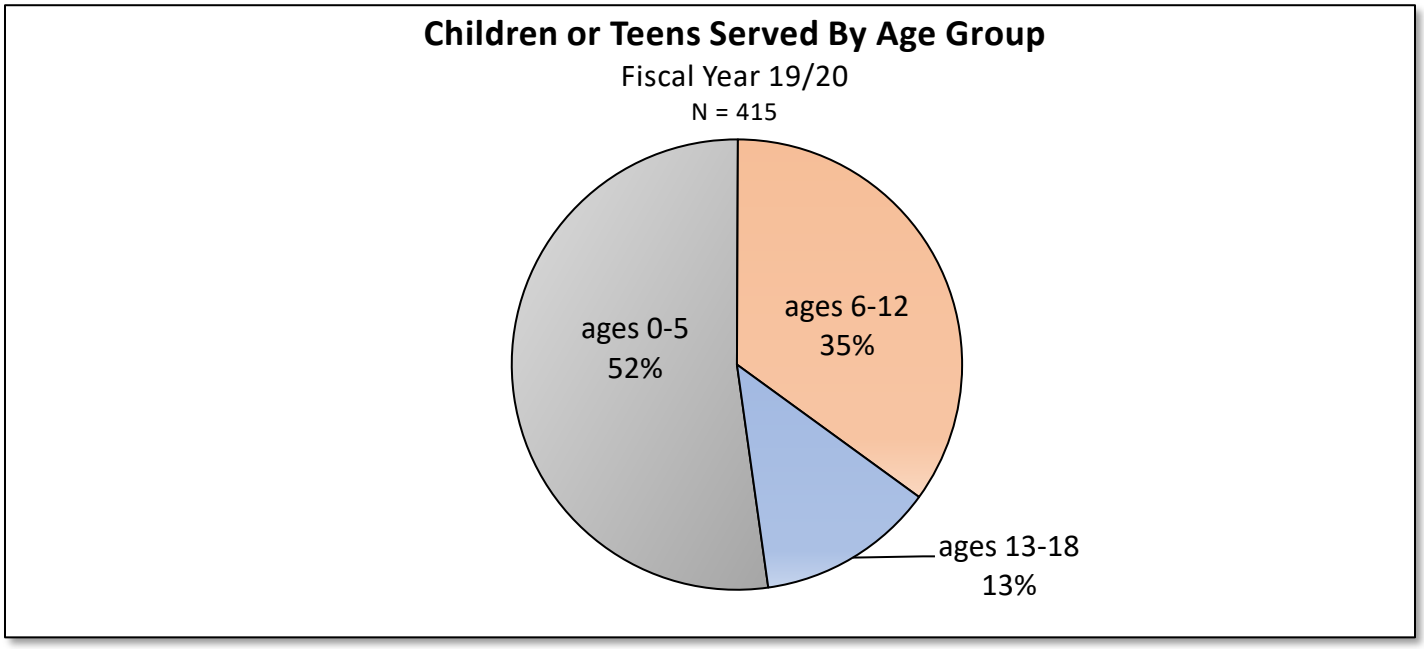
The marital status of the caregivers is pictured below:



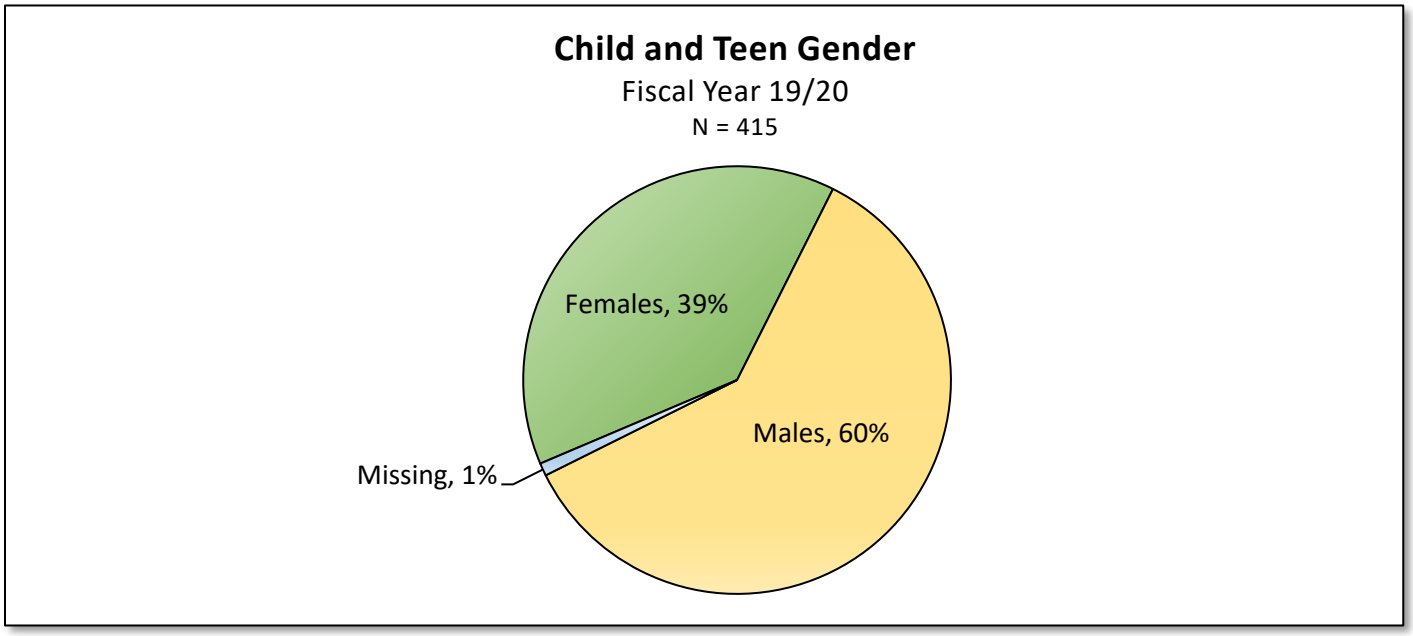
The pie chart below shows how the caregiver relates to the child or teen:



A pie chart showing the percentage of children or teens served by age group is shown below. The age of the child or teen was recorded at the beginning of the session. 217 children were aged 5 or younger out of the total 415 and the average age was 6.



There were 250 males, 161 females, and 4 records missing for child and teen gender data:



Outcomes and Measures

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

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

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

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

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

A blank example of the PAFAS survey is shown on page 8, a scoring illustration of the PAFAS is shown on page 9, and the actual pre-/post-average scores from the PAFAS survey during Fiscal Year 19/20 is shown on page 10.

PAFAS Blank Assessment (example)

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

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

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

PAFAS Scoring Illustration

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

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

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

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

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

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

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

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

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

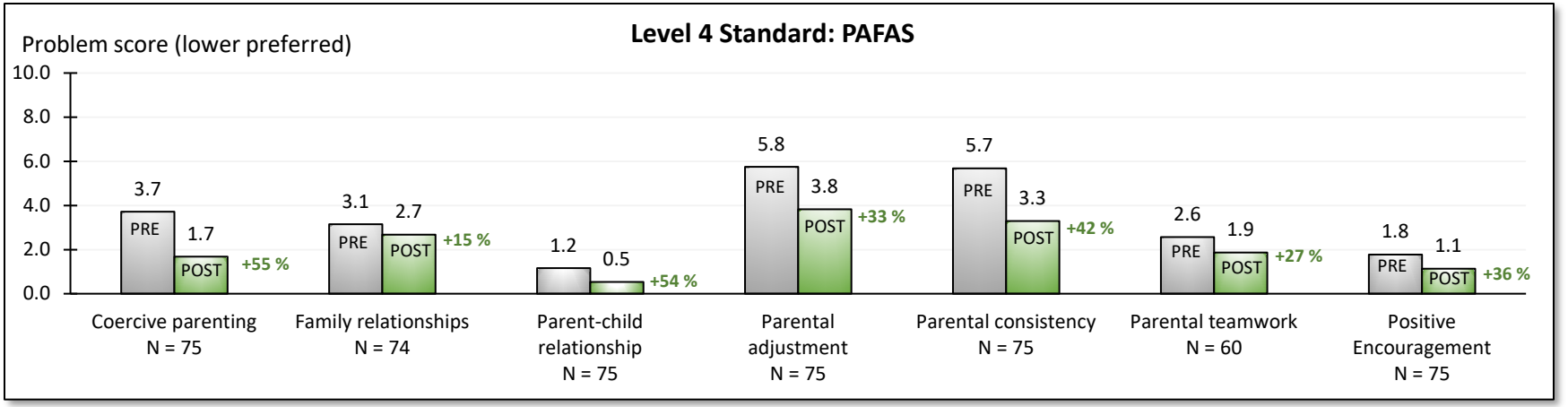
19. I feel stressed or worried	0	1	2	3		(Range) 0 – 15
21. I feel sad or depressed	0	1	2	3		
20. I feel happy	0	1	2	3	(Reverse-scored)	
22. I feel satisfied with my life	0	1	2	3	(Reverse-scored)	
23. I cope with the emotional demands of being a parent	0	1	2	3	(Reverse-scored)	

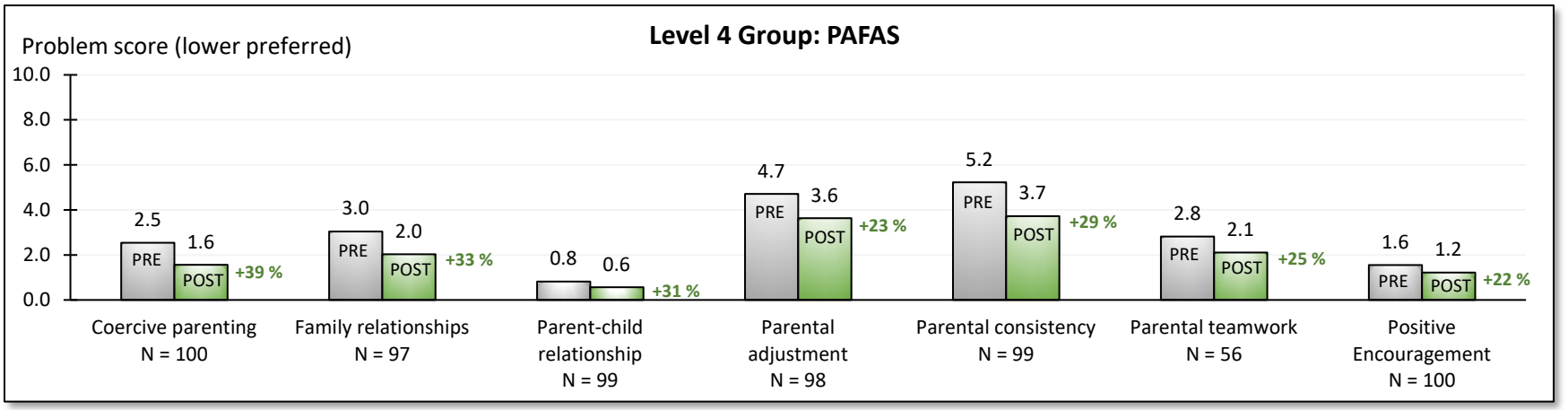
Family Relationships scores are calculated by adding scores for 26 and 27 with the reverse-scores for 24 & 25:

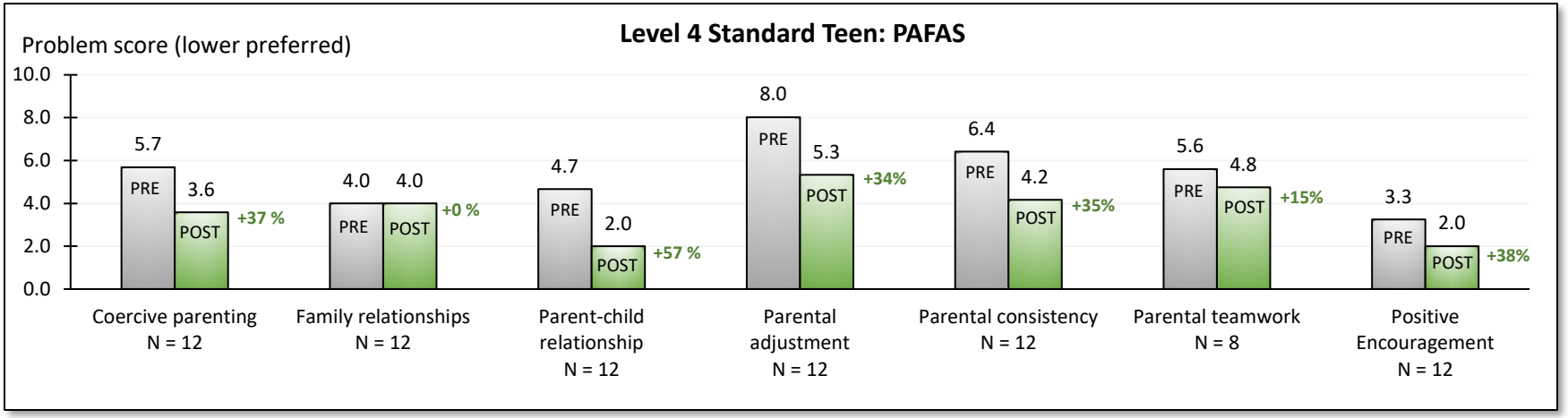
26. Our family members fight or argue	0	1	2	3		(Range) 0 – 12
27. Our family members criticize or put each other down	0	1	2	3		
24. Our family members help or support each other	0	1	2	3	(Reverse-scored)	
25. Our family members get on well with each other	0	1	2	3	(Reverse-scored)	

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

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


Level 4 Standard: PAFAS
Problem score (lower preferred)
10.0
8.0
6.0
4.0
2.0
0.0
3.7
PRE
1.7
POST
+55 %
3.1
PRE
2.7
POST
+15 %
1.2
0.5
+54 %
5.8
PRE
3.8
POST
+33 %
5.7
PRE
3.3
POST
+42 %
2.6
PRE
1.9
POST
+27 %
1.8
PRE
1.1
POST
+36 %
Coercive parenting
N = 75
Family relationships
N = 74
Parent-child relationship
N = 75
Parental adjustment
N = 75
Parental consistency
N = 75
Parental teamwork
N = 60
Positive Encouragement
N = 75


Level 4 Group: PAFAS
Problem score (lower preferred)
10.0
8.0
6.0
4.0
2.0
0.0
2.5
PRE
1.6
POST
+39 %
3.0
PRE
2.0
POST
+33 %
0.8
0.6
+31 %
4.7
PRE
3.6
POST
+23 %
5.2
PRE
3.7
POST
+29 %
2.8
PRE
2.1
POST
+25 %
1.6
PRE
1.2
POST
+22 %
Coercive parenting
N = 100
Family relationships
N = 97
Parent-child relationship
N = 99
Parental adjustment
N = 98
Parental consistency
N = 99
Parental teamwork
N = 56
Positive Encouragement
N = 100


Level 4 Standard Teen: PAFAS
Problem score (lower preferred)
10.0
8.0
6.0
4.0
2.0
0.0
5.7
PRE
3.6
POST
+37 %
4.0
PRE
4.0
POST
+0 %
4.7
PRE
2.0
POST
+57 %
8.0
PRE
5.3
POST
+34%
6.4
PRE
4.2
POST
+35%
5.6
PRE
4.8
POST
+15%
3.3
PRE
2.0
POST
+38%
Coercive parenting
N = 12
Family relationships
N = 12
Parent-child relationship
N = 12
Parental adjustment
N = 12
Parental consistency
N = 12
Parental teamwork
N = 8
Positive Encouragement
N = 12

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

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

There are three scored measures on the CAPES scale:

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

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

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

A blank example of the CAPES survey is shown on page 12, a scoring illustration of the CAPES survey is shown on page 13, and the actual pre-/post-average scores from the CAPES survey during Fiscal Year 19/20 is shown on page 14.

CAPES self-assessment (blank example)

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

CAPES self-assessment (scoring illustration)

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

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

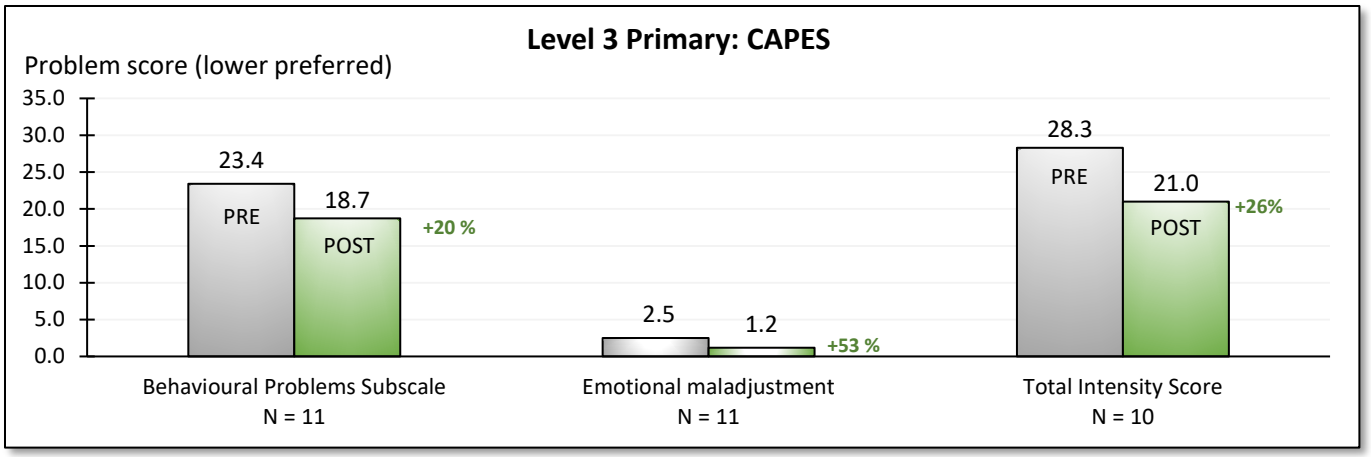
(Range) 0 – 9

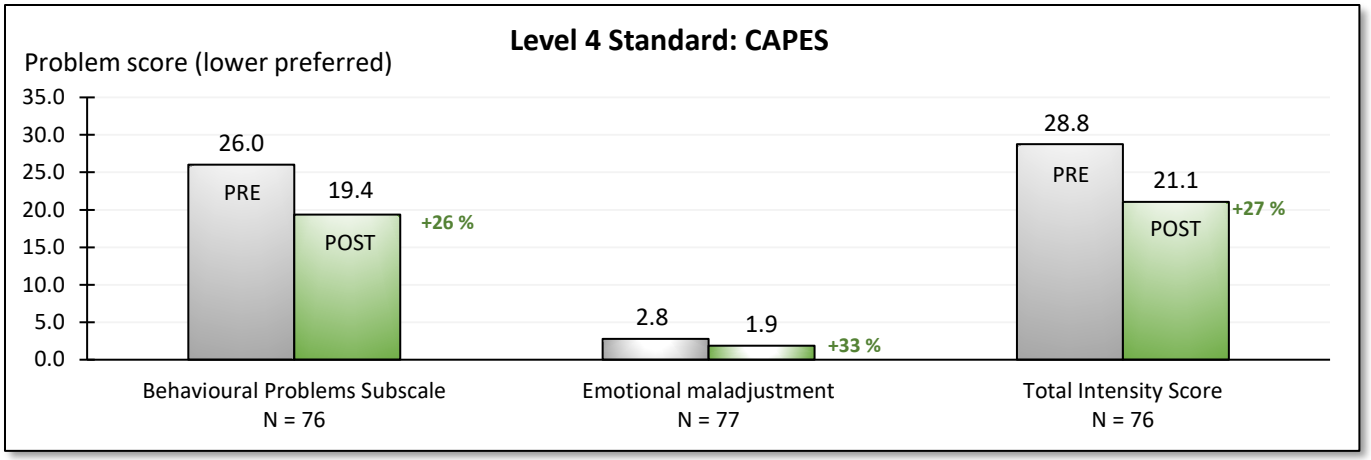
Behavioral Problems subscale scores are calculated by summing the scores for all remaining questions on the assessment:

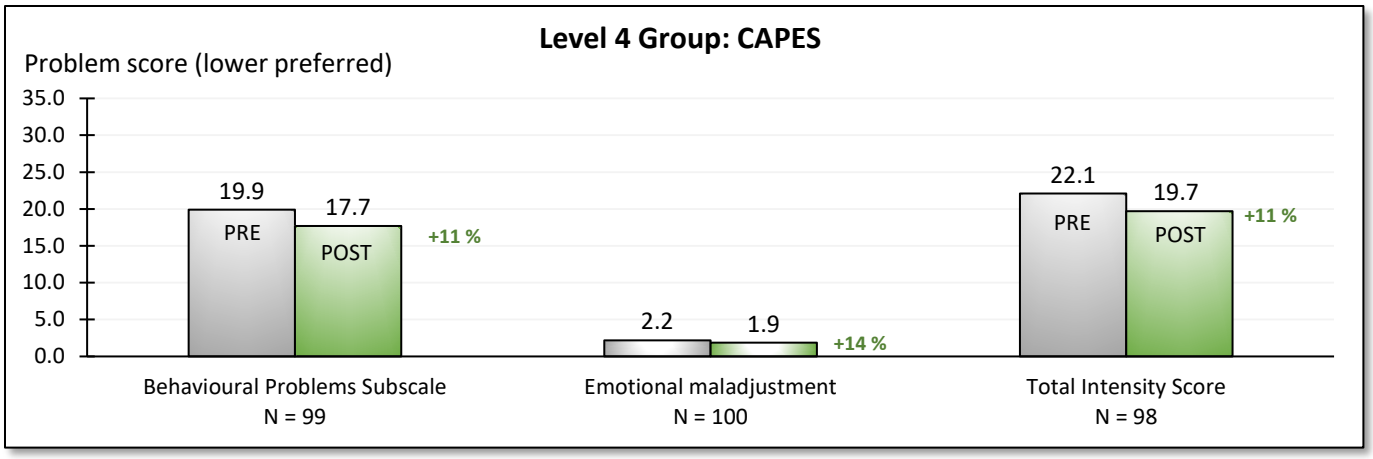
1. Gets upset or angry when they don't get their own way	0	1	2	3
2. Refuses to do jobs around the house when asked	0	1	2	3
4. Loses their temper	0	1	2	3
5. Misbehaves at mealtimes	0	1	2	3
6. Argues or fights with other children, brothers or sisters	0	1	2	3
7. Refuses to eat food made for them	0	1	2	3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

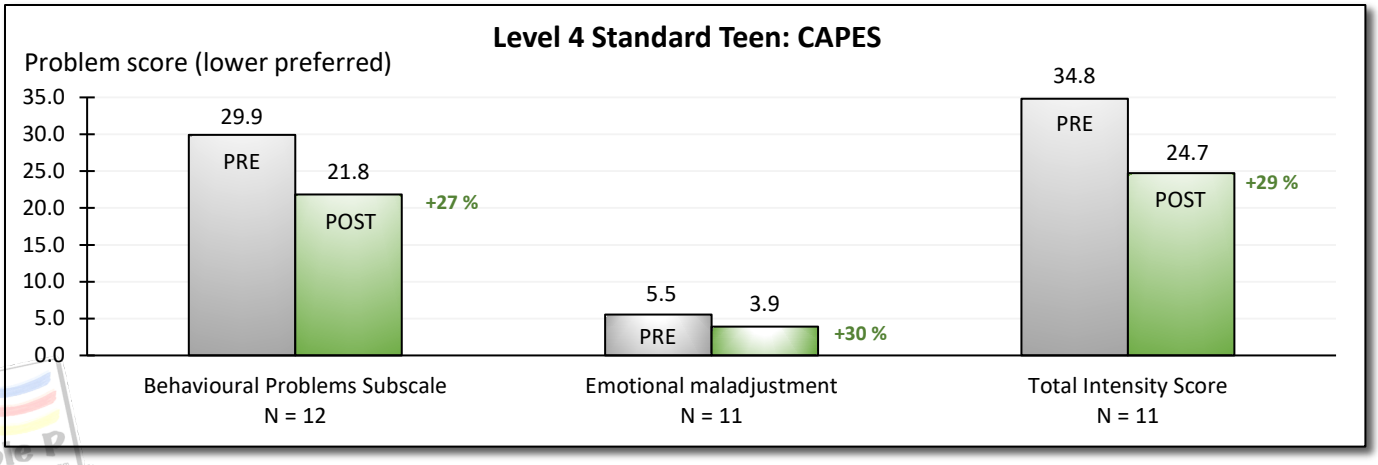
(Range) 0 – 72

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

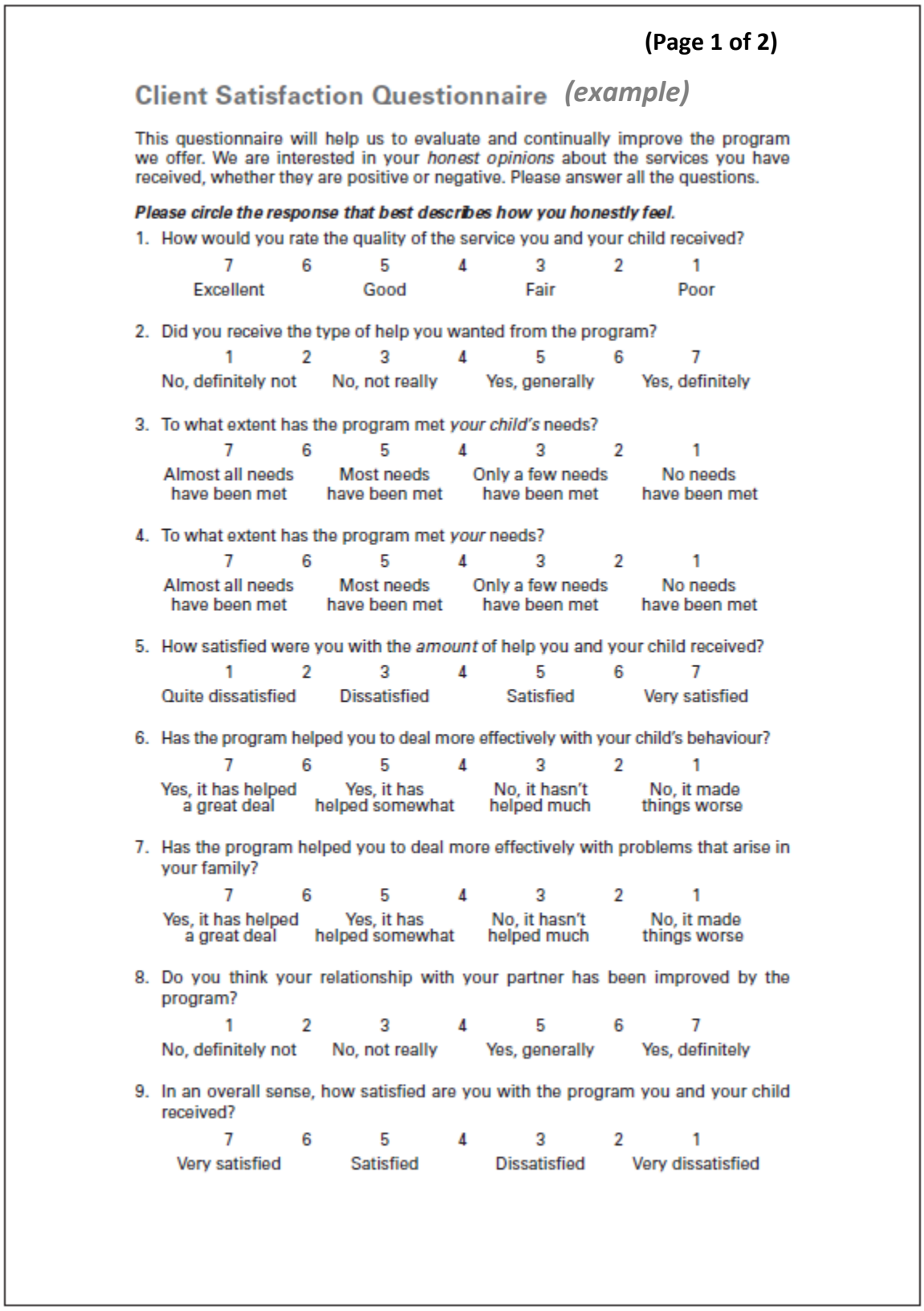

Level 3 Primary: CAPES
Problem score (lower preferred)
35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0
23.4
PRE
18.7
POST
+20 %
2.5
1.2
+53 %
28.3
PRE
21.0
POST
+26%
Behavioural Problems Subscale
N = 11
Emotional maladjustment
N = 11
Total Intensity Score
N = 10


Level 4 Standard: CAPES
Problem score (lower preferred)
35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0
26.0
PRE
19.4
POST
+26 %
2.8
1.9
+33 %
28.8
PRE
21.1
POST
+27 %
Behavioural Problems Subscale
N = 76
Emotional maladjustment
N = 77
Total Intensity Score
N = 76


Level 4 Group: CAPES
Problem score (lower preferred)
35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0
19.9
PRE
17.7
POST
+11 %
2.2
1.9
+14 %
22.1
PRE
19.7
POST
+11 %
Behavioural Problems Subscale
N = 99
Emotional maladjustment
N = 100
Total Intensity Score
N = 98


Level 4 Standard Teen: CAPES
Problem score (lower preferred)
35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0
29.9
PRE
21.8
POST
+27 %
5.5
PRE
3.9
+30 %
34.8
PRE
24.7
POST
+29 %
Behavioural Problems Subscale
N = 12
Emotional maladjustment
N = 11
Total Intensity Score
N = 11

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



(Page 1 of 2)

Client Satisfaction Questionnaire *(example)*

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

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

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

7	6	5	4	3	2	1
Excellent		Good		Fair		Poor

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

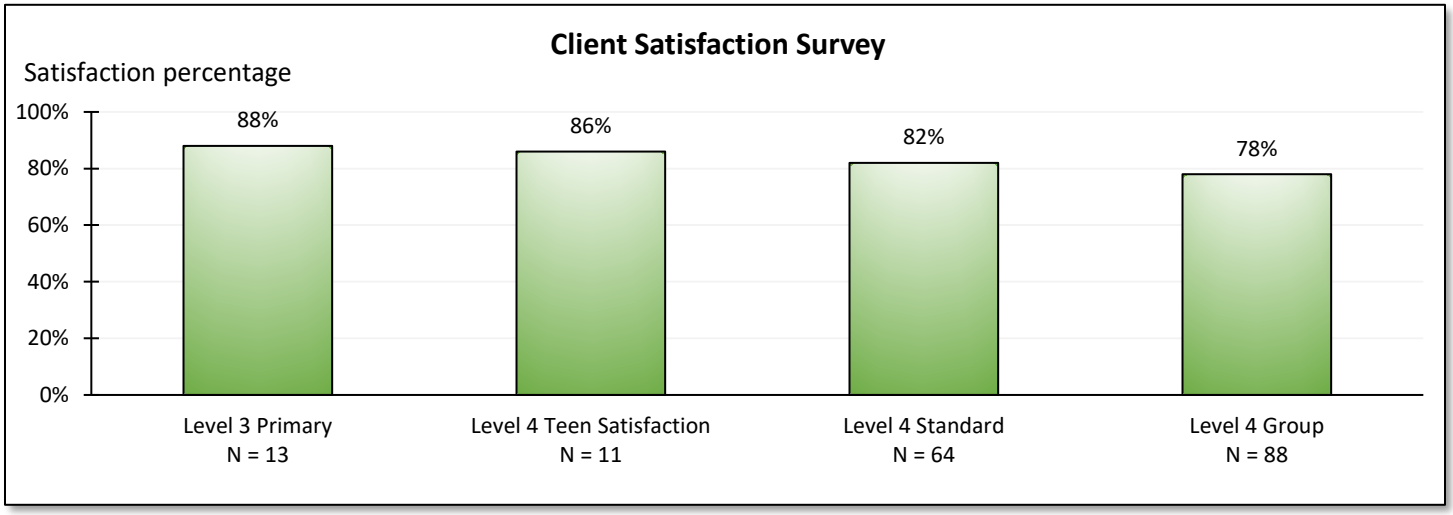
15. Have you had any other problems with your child which you feel may be related to the original difficulty?

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

Thank you

Client Satisfaction Questionnaire:

Client Satisfaction in each level was as follows:



Conclusion:

Outcomes showed decreased problem scores on both the PAFAS and CAPES assessments during Fiscal Year 19/20. In some levels, there was minimal participant data (N = < 5) and the results were not considered reliable enough to report on.

CAPES findings:

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

- 33% in Level 3 Primary
- 29% in Level 4 Teen
- 28% in Level 4 Standard
- 12% in Level 4 Group

PAFAS findings:

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

- 38% in Level 4 Standard
- 31% in Level 4 Teen
- 29% in Level 4 Group

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

References

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

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

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

Botvin LifeSkills Outcome Evaluation

Fiscal Year 19/20

(July 1st, 2019 – June 30th, 2020)

Shasta Lake and Anderson Middle School

Shasta County Health & Human Services Agency

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Introduction

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

The program was administered to 6th-8th grade students attending Shasta Lake and Anderson Middle School during Fiscal Year 19/20. The program promotes healthy alternatives to risky behavior through activities that help students resist peer pressure to smoke or use drugs and alcohol, develop greater self-esteem and social skills, learn about relaxation techniques to cope with anxiety, and learn about the effects of substance abuse and healthier lifestyle choices.

This is the third year of delivering Botvin Lifeskills in 6th-8th grades at Shasta Lake and the second year at Anderson Middle School. Shasta Lake had teachers trained to deliver the Botvin Lifeskills program. Anderson Middle School has a collaboration between trained teachers and a contracted counseling provider (Dunamis Wellness) delivering the Botvin Lifeskills program.

Method

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

Knowledge category

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

Attitudes category

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

Life Skills category

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

Each subgroup is a measure that is scored once the survey is completed. Measures in the *Knowledge* category were scored as a percentage (with 100% being the maximum score) while measures in the *Attitudes* and *Life Skills* categories

were each scored out of five possible points (with 5/5 being the maximum score). Under the "Data Analysis" section of this report, details of how the scores were generated for these measures are provided.

Results

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

		Shasta Lake School								
		6th grade			7th grade			8th grade		
	Measure	Pre-Survey (N = 7)	Post-Survey (N = 7)	Change	Pre-Survey (N = 21)	Post-Survey (N = 21)	Change	Pre-Survey (N = 84)	Post-Survey (N = 84)	Change
Knowledge	Anti-drug	56.04%	64.10%	+8.06% ↑	63.74%	68.86%	+5.12% ↑	67.58%	65.52%	-2.06% ↓
	Life skills	60.15%	72.81%	+12.66% ↑	65.66%	71.93%	+6.27% ↑	79.39%	82.56%	+3.17% ↑
	Overall (combined)	58.10%	68.46%	+10.36% ↑	64.70%	70.40%	+5.70% ↑	73.49%	74.04%	+0.55% ↑
Attitudes	Anti-smoking	4.18	4.79	+0.61 ↑	4.63	4.55	-0.08 ↓	4.48	4.33	-0.15 ↓
	Anti-drinking	4.14	4.71	+0.57 ↑	4.43	4.42	-0.01 ↓	4.37	4.18	-0.19 ↓
	Anti-drug (combined)	4.16	4.75	+0.59 ↑	4.53	4.48	-0.05 ↓	4.43	4.26	-0.17 ↓
Life Skills	Drug refusal	1.76	3.17	+1.41 ↑	3.68	3.05	-0.63 ↓	3.60	3.72	+0.12 ↑
	Assertiveness	3.62	3.11	-0.51 ↓	3.33	3.54	+0.21 ↑	3.46	3.44	-0.02 ↓
	Relaxation	3.64	3.67	+0.03 ↑	3.68	3.93	+0.25 ↑	4.01	4.07	+0.06 ↑
	Self-control	3.29	3.67	+0.38 ↑	3.70	3.81	+0.11 ↑	3.69	3.80	+ 0.11 ↑

Note: Numbers may not add due to rounding.

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

		Anderson Middle School								
		6th grade			7th grade			8th grade		
	Measure	Pre-Survey (N = 23)	Post-Survey (N = 23)	Change	Pre-Survey (N = 13)	Post-Survey (N = 13)	Change	Pre-Survey (N = 20)	Post-Survey (N = 20)	Change
Knowledge	Anti-drug	54.52%	66.08%	+11.57% ↑	71.79%	67.83%	-3.96% ↓	57.31%	69.68%	+12.38% ↑
	Life skills	63.39%	74.16%	+10.78% ↑	69.30%	76.56%	+7.26% ↑	70.53%	82.04%	+11.52% ↑
	Overall (combined)	58.96%	70.12%	+11.18% ↑	70.55%	72.20%	+1.65% ↑	63.92%	75.86%	+11.95% ↑
Attitudes	Anti-smoking	4.86	4.84	-0.02 ↓	3.90	4.41	+0.51 ↑	4.40	4.56	+0.16 ↑
	Anti-drinking	4.80	4.82	+0.02 ↑	4.10	4.39	+0.29 ↑	4.40	4.49	+0.09 ↑
	Anti-drug (combined)	4.83	4.83	No Change	4.00	4.40	+0.40 ↑	4.40	4.52	+0.12 ↑
Life Skills	Drug refusal	1.76	3.17	+1.41 ↑	2.7	4.02	+1.32 ↑	3.38	3.80	+0.42 ↑
	Assertiveness	3.20	3.73	+0.53 ↑	3.27	3.33	+0.06 ↑	3.60	3.78	+0.18 ↑
	Relaxation	3.61	3.76	+0.15 ↑	3.85	3.95	+0.10 ↑	4.21	3.85	-0.36 ↓
	Self-control	3.35	3.12	-0.23 ↓	3.38	2.95	-0.43 ↓	3.61	3.82	+0.21 ↑

Note: Numbers may not add due to rounding.

Before analyzing these results, consideration should be given to some data collection limitations.

Limitations

School Closures from COVID-19

When schools switched to distance learning due to the California Governor's stay-at-home order in March (from the Covid-19 pandemic), both schools had challenges with delivering the program and collecting surveys. School closures that began in March significantly lowered the number of Botvin Lifeskills lessons delivered, the Botvin Lifeskills post-survey participation rate, and program fidelity.

Survey Design

The "Drug refusal" score might have been adversely affected by the transition from survey Section C.) to Section D.). Section C.) had a series of statements representing attitudes towards drug use (i.e. "Smoking cigarettes makes you look cool") where students indicated where they agreed or disagreed with the statement in question. "Disagree" represented an anti-drug response across the entire section. The next section on the survey, Section D.), had a series of statements such as "Smoke a cigarette", "Use cocaine or other drugs" where, again, students indicated their agreement or disagreement, but, unlike the preceding section, "Agree" was the anti-drug response for this section due to a lead-in statement that read: "I would say NO if someone tried to get me to [Smoke a cigarette], [Use cocaine or other drugs], [etc.,]." In the preceding section C.), there was no lead-in statement. Students could have misinterpreted section D.) if they did not see the lead-in statement.

Conclusion

For both schools, the results indicate that the program was successful at improving students' overall (combined) anti-drug knowledge and life skills knowledge in each grade. For Anderson, overall anti-drug attitudes among the sixth graders did not change but overall anti-drug attitudes for seventh and eighth graders improved. For Shasta Lake, overall anti-drug attitudes among the sixth graders improved, but slightly worsened among the seventh and eighth graders. According to NHPA, caution should be exercised when interpreting findings without a control group because drug use and risk factors tend to worsen during early adolescence, even during a prevention program. The best way to evaluate program effects is to compare the changes over time with those who received the program and a control group that did not. Measures in the Life Skills category had mixed success for both schools, but most measures in this category showed improved post-survey scores.

Recommendations

Efforts should be made to continue improving the program. This would consist of addressing barriers to learning, changing attitudes, and implementing life skills. If it is feasible, program staff should consider adjusting the curriculum to better influence anti-drug attitudes and improve implementation of life skills learned by students. Ideally, program fidelity would not be impacted by external factors (like school closures). Also, perhaps tweaking the survey design between sections C.) and D.) would be ways to improve.

Data Analysis

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

Shasta Lake

- Section A: Student Background ..... Pages 8-9
- Section B: Knowledge Measures ..... Pages 10-11
- Section C: Attitude Measures ..... Page 12
- Section D: Life Skills Measures ..... Page 13

Anderson

- Section A: Student Background ..... Pages 14-15
- Section B: Knowledge Measures ..... Pages 16-17
- Section C: Attitude Measures ..... Page 18
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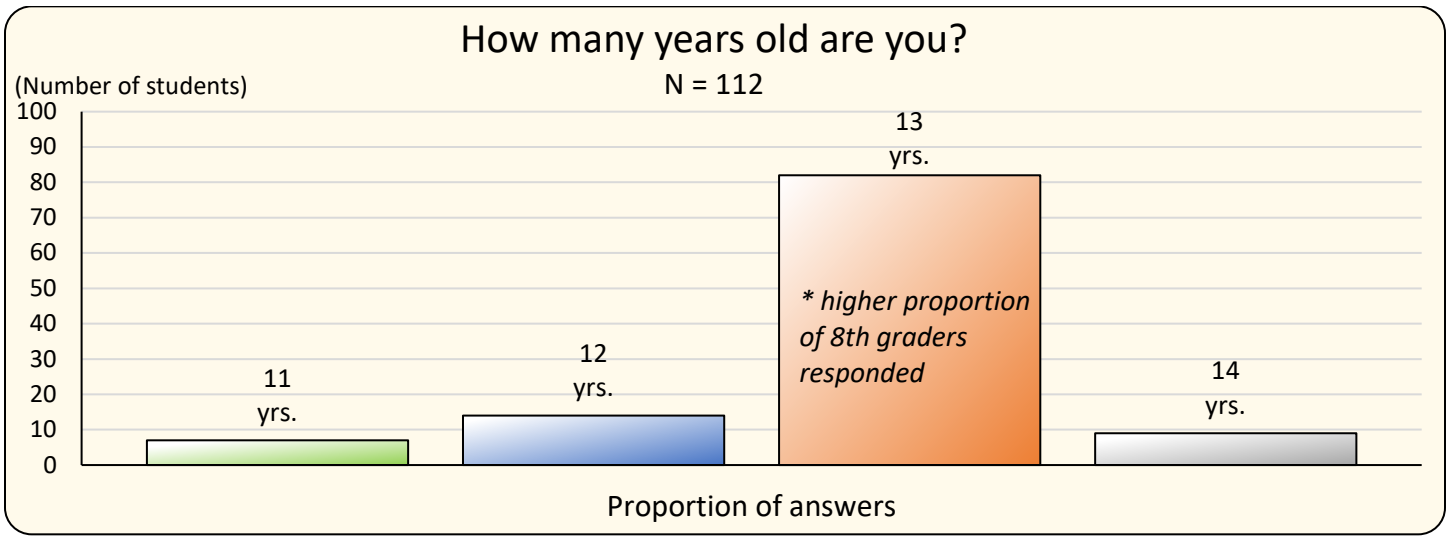
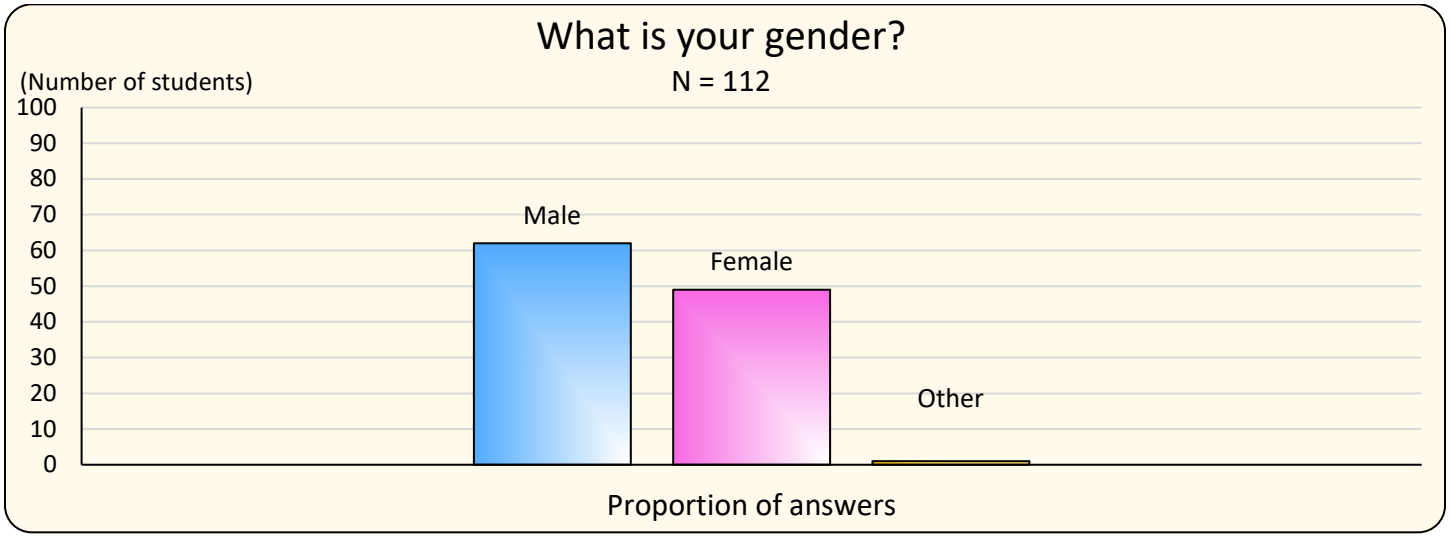
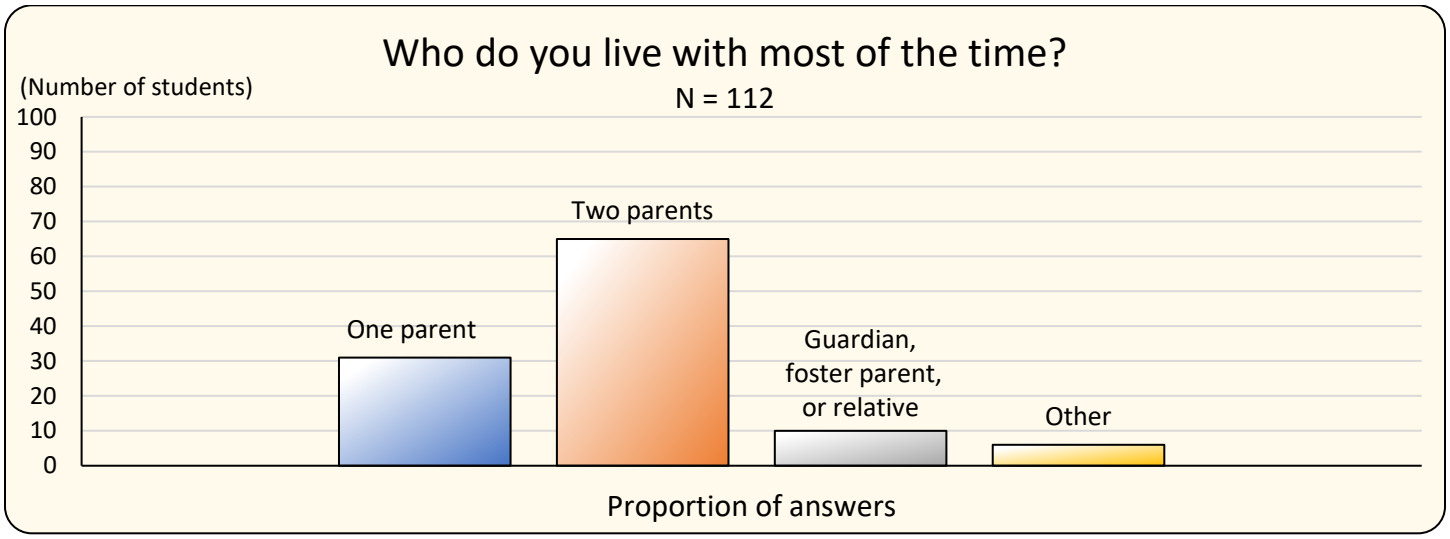
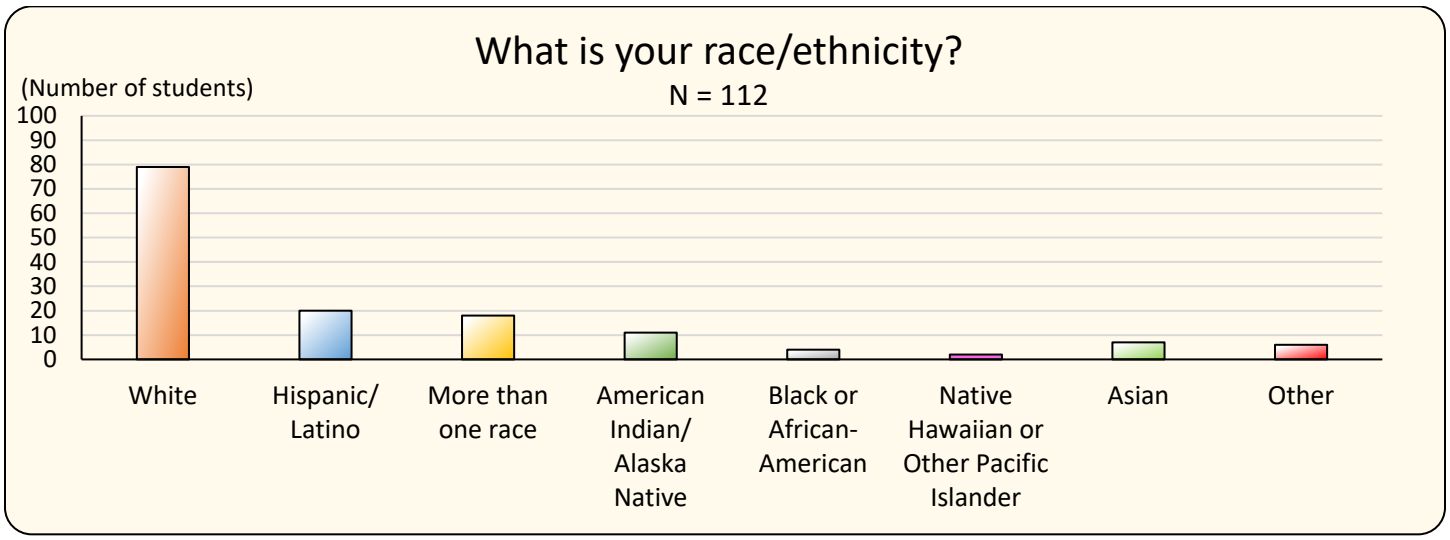
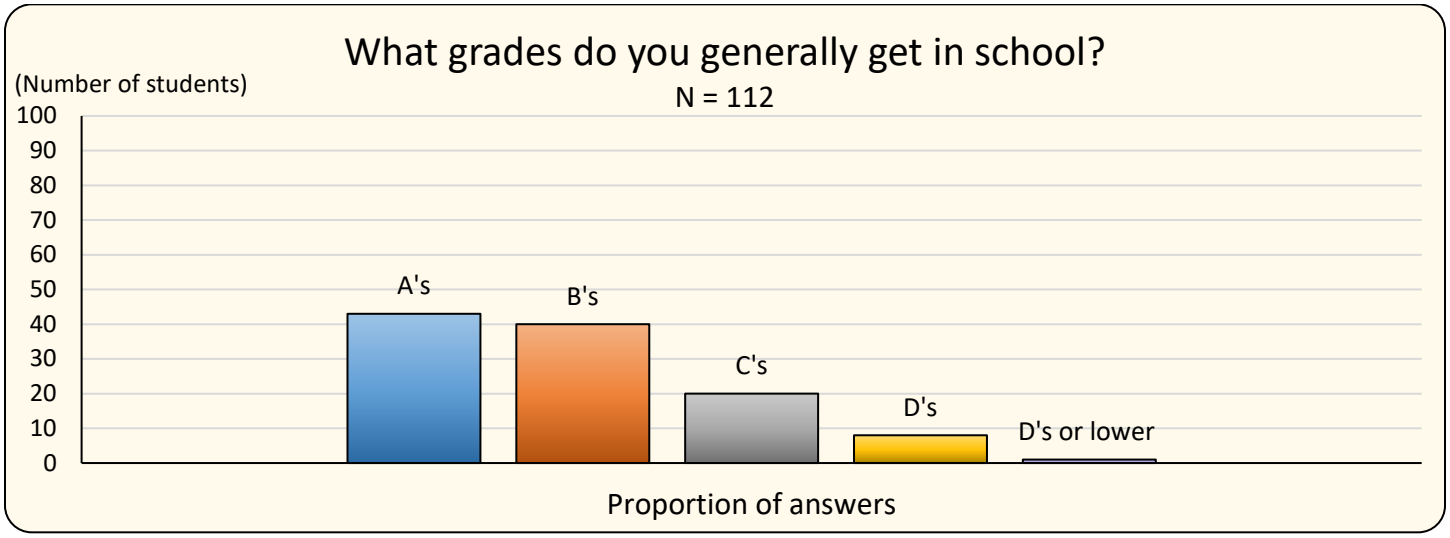
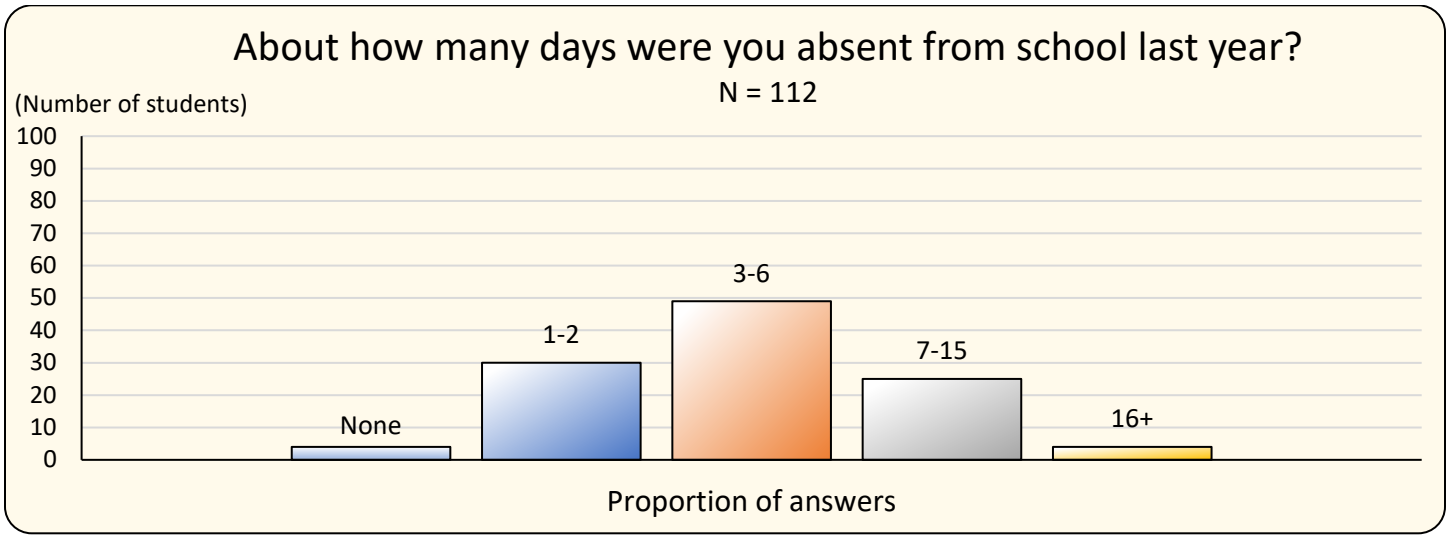

How many years old are you?
(Number of students)
N = 112
100
90
80
70
60
50
40
30
20
10
0
11 yrs.
12 yrs.
13 yrs.
* higher proportion of 8th graders responded
14 yrs.
Proportion of answers


What is your gender?
(Number of students)
N = 112
100
90
80
70
60
50
40
30
20
10
0
Male
Female
Other
Proportion of answers


Who do you live with most of the time?
(Number of students)
N = 112
100
90
80
70
60
50
40
30
20
10
0
One parent
Two parents
Guardian, foster parent, or relative
Other
Proportion of answers


What is your race/ethnicity?
N = 112
(Number of students)
100
90
80
70
60
50
40
30
20
10
0
White
Hispanic/ Latino
More than one race
American Indian/ Alaska Native
Black or African-American
Native Hawaiian or Other Pacific Islander
Asian
Other


What grades do you generally get in school?
N = 112
(Number of students)
100
90
80
70
60
50
40
30
20
10
0
A's
B's
C's
D's
D's or lower
Proportion of answers


About how many days were you absent from school last year?
N = 112
(Number of students)
100
90
80
70
60
50
40
30
20
10
0
None
1-2
3-6
7-15
16+
Proportion of answers

Section B: Knowledge measures (Anti-drug)

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

Anti-Drug knowledge items (Shasta Lake)		6th grade (% correct)			7th grade (% correct)			8th grade (% correct)		
		PRE (N = 7)	POST (N = 7)	Change	PRE (N = 21)	POST (N = 21)	Change	PRE (N = 84)	POST (N = 84)	Change
1.	Most adults smoke cigarettes. (F)	14.29%	50.00%	35.71%	42.86%	28.57%	-14.29%	57.14%	53.01%	-4.13%
2.	Smoking a cigarette causes your heart to beat slower. (F)	14.29%	50.00%	35.71%	42.86%	76.19%	33.33%	59.52%	63.86%	4.33%
3.	Few adults drink wine, beer, or liquor every day. (T)	57.14%	50.00%	-7.14%	42.86%	66.67%	23.81%	48.81%	45.78%	-3.03%
4.	Most people my age smoke marijuana. (F)	71.43%	50.00%	-21.43%	76.19%	57.14%	-19.05%	55.95%	55.42%	-0.53%
5.	Smoking marijuana causes your heart to beat faster. (T)	28.57%	83.33%	54.76%	76.19%	80.95%	4.76%	69.05%	66.27%	-2.78%
6.	Most adults use cocaine or other hard drugs. (F)	57.14%	66.67%	9.53%	61.90%	61.90%	0.00%	78.57%	78.31%	-0.26%
7.	Cocaine and other hard drugs always make you feel good. (F)	71.43%	83.33%	11.90%	80.95%	80.95%	0.00%	89.29%	90.36%	1.08%
12.	Smoking can affect the steadiness of your hands. (T)	85.71%	100%	14.29%	85.71%	100.00%	14.29%	94.05%	91.57%	-2.48%
13.	A stimulant is a chemical that calms down the body. (F)	71.43%	66.67%	-4.76%	66.67%	61.90%	-4.76%	54.76%	51.81%	-2.95%
14.	Smoking reduces a person's endurance for physical activity. (T)	85.71%	83.33%	-2.38%	80.95%	85.71%	4.76%	89.29%	87.95%	-1.33%
15.	A serving of beer or wine contains less alcohol than a serving of "hard liquor" such as whiskey. (F)	28.57%	16.67%	-11.90%	19.05%	33.33%	14.29%	29.76%	24.10%	-5.67%
16.	Alcohol is a depressant. (T)	71.43%	33.33%	-38.10%	57.14%	71.43%	14.29%	57.14%	50.60%	-6.54%
17.	Marijuana smoking can improve your eyesight. (F)	71.43%	100%	28.57%	95.24%	90.48%	-4.76%	95.24%	92.77%	-2.47%
	Anti-drug knowledge summary score (higher % is preferred):	**56.04%**	**64.10%**	**+8.06%**	**63.74%**	**68.86%**	**+5.12%**	**67.58%**	**65.52%**	**-2.06%**

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

Section B: Knowledge measures (Life skills)

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

Life skills knowledge items (Shasta Lake)		6th grade (% correct)			7th grade (% correct)			8th grade (% correct)		
		PRE (N = 7)	POST (N = 7)	Change	PRE (N = 21)	POST (N = 21)	Change	PRE (N = 84)	POST (N = 84)	Change
8.	What we believe about ourselves affects the way we act or behave. (T)	71.43%	83.33%	11.90%	95.24%	80.95%	-14.29%	91.67%	90.36%	-1.31%
9.	It is almost impossible to develop a more positive self-image. (F)	85.71%	100.00%	14.29%	76.19%	80.95%	4.76%	78.57%	80.72%	2.15%
10.	It is important to measure how far you have come toward reaching your goal. (T)	85.71%	100.00%	14.29%	85.71%	95.24%	9.52%	95.24%	92.77%	-2.47%
11.	It's a good idea to make a decision and then think about the consequences later. (F)	28.57%	50.00%	21.43%	71.43%	80.95%	9.52%	90.48%	93.98%	3.50%
18.	Some advertisers are deliberately deceptive. (T)	42.86%	66.67%	23.81%	80.95%	71.43%	-9.52%	71.43%	81.93%	10.50%
19.	Companies advertise only because they want you to have all the facts about their products. (F)	42.86%	66.67%	23.81%	52.38%	38.10%	-14.29%	64.29%	78.31%	14.03%
20.	It's a good idea to get all information about a product from its ads. (F)	42.86%	33.33%	-9.52%	61.90%	76.19%	14.29%	65.48%	71.08%	5.61%
21.	Most people do not experience anxiety. (F)	42.86%	83.33%	40.48%	61.90%	71.43%	9.52%	73.81%	81.93%	8.12%
22.	There is very little you can do when you feel anxious. (F)	57.14%	83.33%	26.19%	38.10%	57.14%	19.05%	70.24%	71.08%	0.85%
23.	Deep breathing is one way to lessen anxiety. (T)	85.71%	100.00%	14.29%	76.19%	95.24%	19.05%	92.86%	96.39%	3.53%
24.	Mental rehearsal is a poor relaxation technique. (F)	71.43%	66.67%	-4.76%	47.62%	71.43%	23.81%	72.62%	74.70%	2.08%
25.	You can avoid misunderstandings by assuming the other person knows what you mean. (F)	71.43%	66.67%	-4.76%	57.14%	71.43%	14.29%	75.00%	77.11%	2.11%
26.	Effective communication is when both sender and receiver interpret a message in the same way. (T)	57.14%	83.33%	26.19%	61.90%	66.67%	4.76%	85.71%	89.16%	3.44%
27.	Relaxation techniques are of no use when meeting people. (F)	85.71%	100.00%	14.29%	66.67%	80.95%	14.29%	80.95%	79.52%	-1.43%
28.	A compliment is more effective when it is said sincerely. (T)	85.71%	83.33%	-2.38%	85.71%	85.71%	0.00%	96.43%	93.98%	-2.45%
29.	A nice way of ending a conversation is to tell the person you enjoyed talking with him or her. (T)	71.43%	83.33%	11.90%	90.48%	80.95%	-9.52%	97.62%	96.39%	-1.23%
30.	Sense of humor is an example of a non-physical attribute. (T)	42.86%	50.00%	7.14%	52.38%	33.33%	-19.05%	66.67%	67.47%	0.80%
31.	It's better to be polite and lead someone on, even if you don't want to go out with them. (F)	28.57%	16.67%	--11.90%	28.57%	52.38%	23.81%	58.33%	71.08%	12.75%
32.	Almost all people who are assertive are either rude or hostile. (F)	42.86%	66.67%	23.81%	57.14%	76.19%	19.05%	80.95%	80.72%	-0.23%
	Life skills knowledge summary score (higher % is preferred):	**60.15%**	**72.81%**	**+12.66%**	**65.66%**	**71.93%**	**+6.27%**	**79.39%**	**82.56%**	**+3.18%**

Section C: Attitude measures (Anti-drug)

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

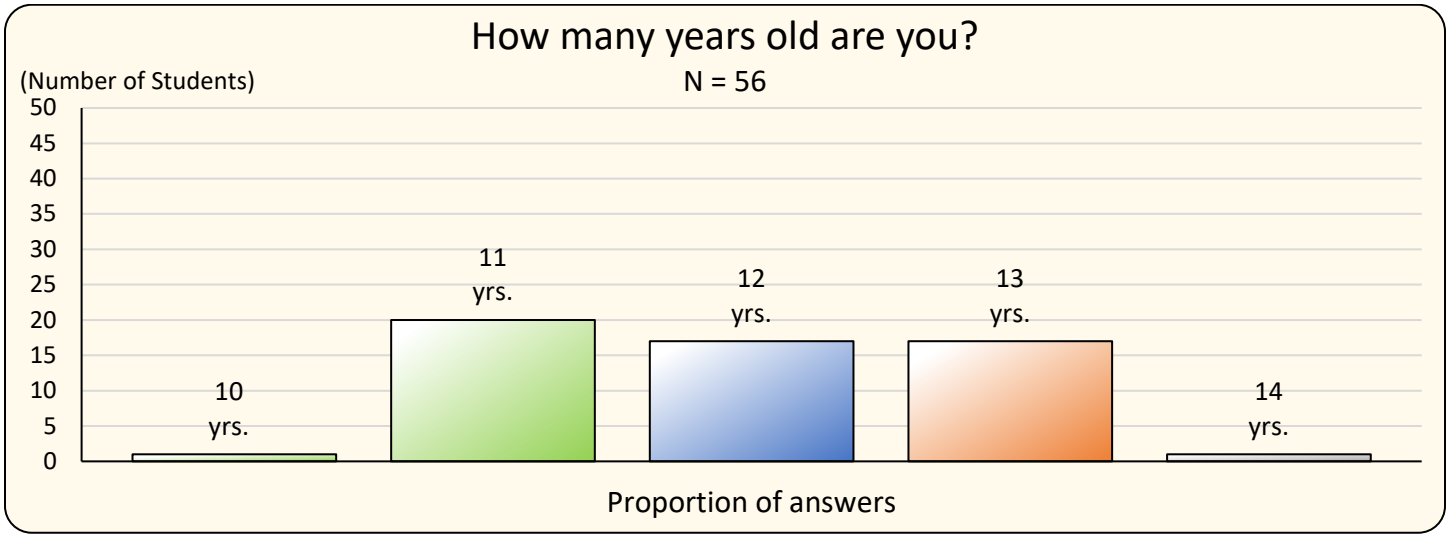
	Anti-drug attitudes (Shasta Lake)	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	6th grade		7th grade		8th grade	
							PRE (N = 7)	POST (N = 7)	PRE (N = 21)	POST (N = 21)	PRE (N = 84)	POST (N = 84)
1.	Kids who drink alcohol are more grown-up.	①	②	③	④	⑤	4.43	5.00	4.45	4.33	4.50	4.29
2.	Smoking cigarettes makes you look cool.	①	②	③	④	⑤	4.43	5.00	4.80	4.76	4.75	4.48
3.	Kids who drink alcohol have more friends.	①	②	③	④	⑤	3.43	4.50	4.15	4.14	4.08	3.93
4.	Kids who smoke have more friends.	①	②	③	④	⑤	3.43	4.50	4.30	4.29	4.00	3.83
5.	Drinking alcohol makes you look cool.	①	②	③	④	⑤	4.43	4.50	4.60	4.62	4.55	4.37
6.	Smoking cigarettes lets you have more fun.	①	②	③	④	⑤	4.14	4.67	4.85	4.67	4.58	4.51
7.	Kids who smoke cigarettes are more grown-up.	①	②	③	④	⑤	4.71	5.00	4.55	4.48	4.60	4.49
8.	Drinking alcohol lets you have more fun.	①	②	③	④	⑤	4.29	4.83	4.50	4.57	4.35	4.14
	Anti-drinking attitudes score (scores range from 1 to 5, scores closest to 5 are preferred):						**4.14**	**4.71**	**4.43**	**4.42**	**4.37**	**4.18**
	Anti-smoking attitudes score (scores range from 1 to 5, scores closest to 5 are preferred):						**4.18**	**4.79**	**4.63**	**4.55**	**4.48**	**4.33**
	Anti-drug attitudes summary score (scores range from 1 to 5, scores closest to 5 are preferred):						**4.16**	**4.75**	**4.53**	**4.48**	**4.43**	**4.26**

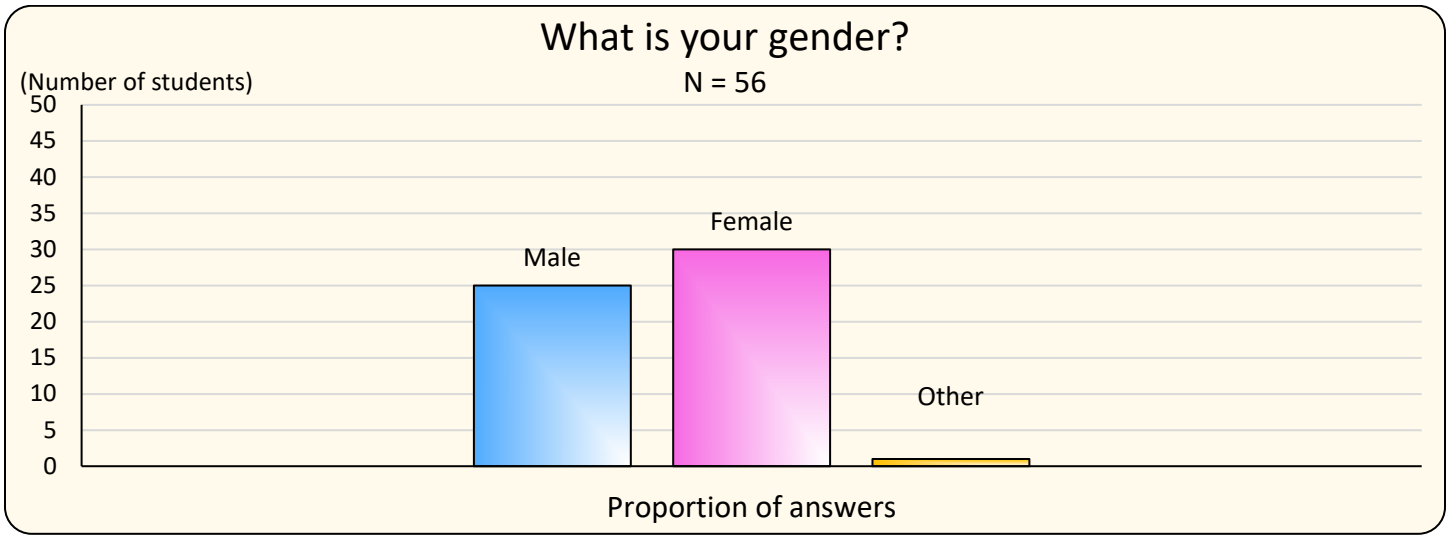
Legend
This question factors into the Anti-drinking attitudes score (Section C)
This question factors into the Anti-smoking attitudes score (Section C)
Post-improvement increased by more than 5% (Sections C & D)
Post-improvement decreased by more than 5% (Section C & D)

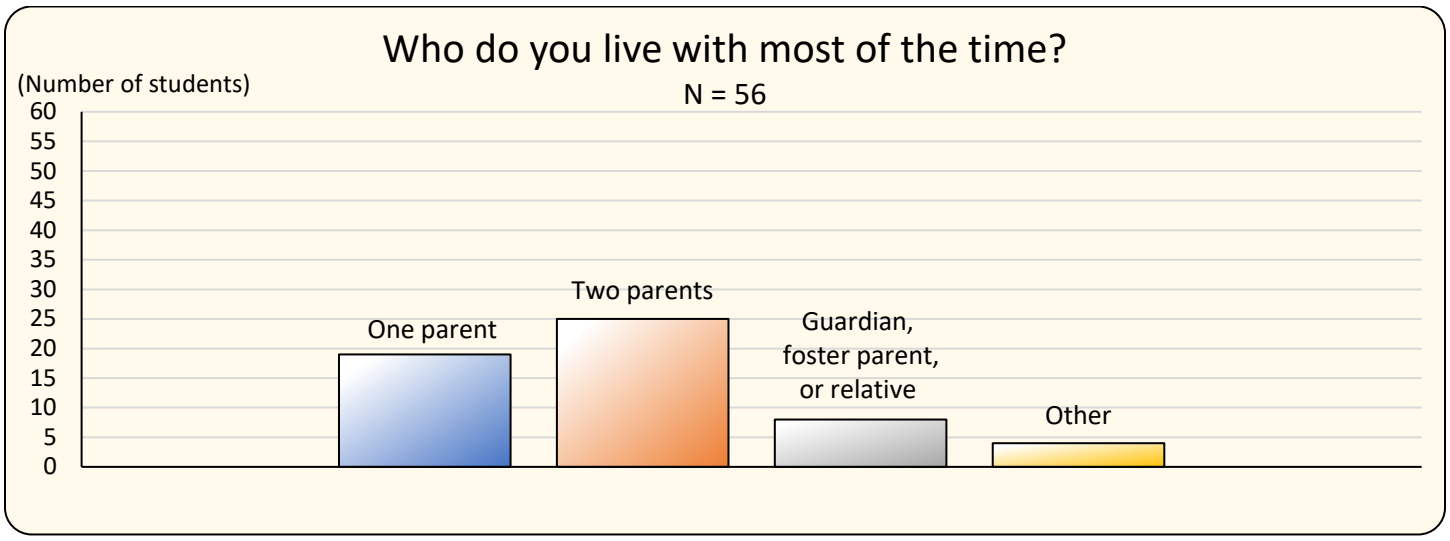
Section D: Life skills measures (Drug refusal, assertiveness, relaxation, and self-control)

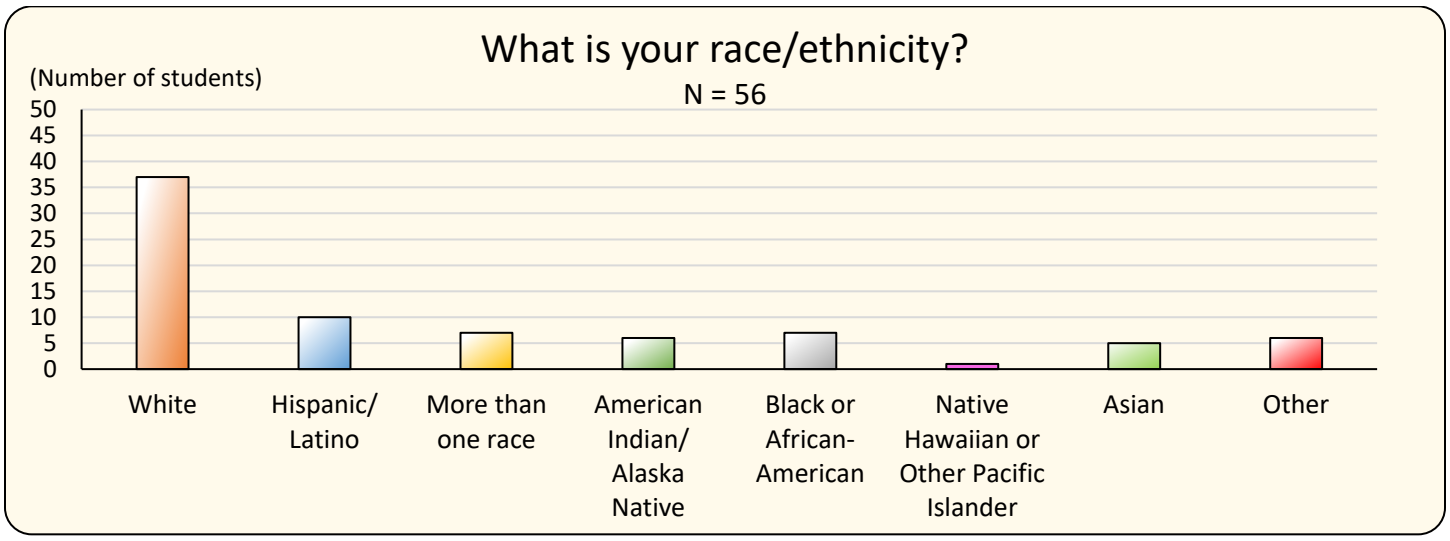
Shasta Lake

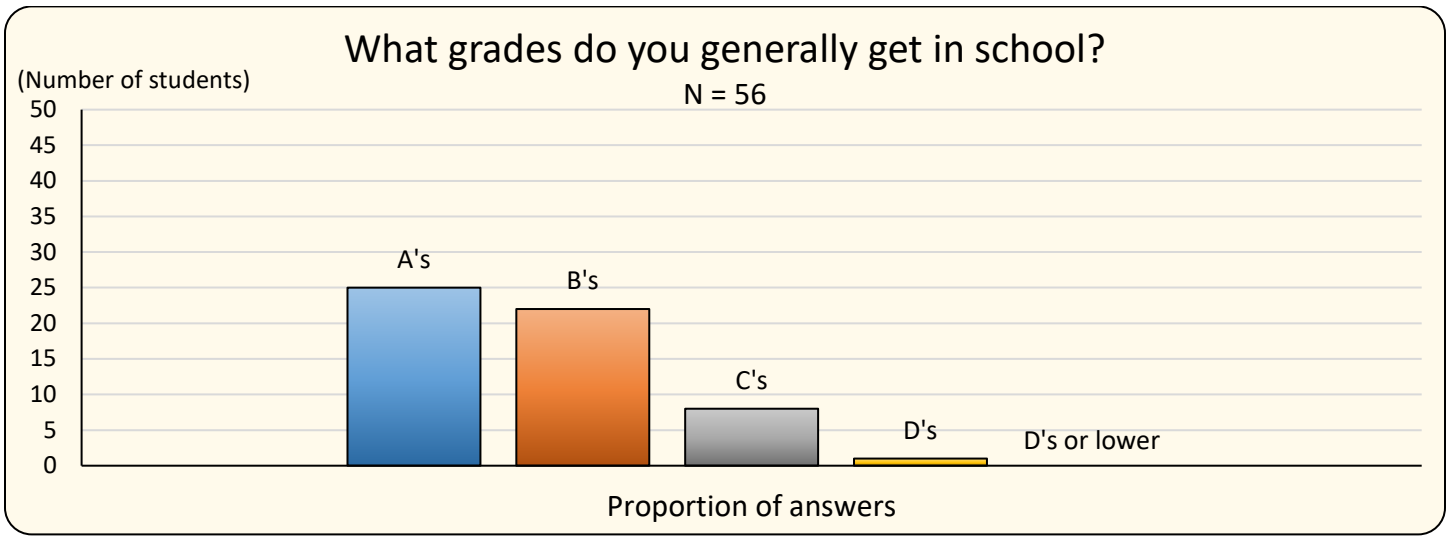
Life skills (Shasta Lake)		Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	6th grade		7th grade		8th grade	
							PRE (N = 7)	POST (N = 7)	PRE (N = 21)	POST (N = 21)	PRE (N = 84)	POST (N = 84)
I would say NO if someone tried to get me to:												
1.	Smoke a cigarette. ***[Lower scores preferred]***	①	②	③	④	⑤	4.29	2.83	2.40	2.86	2.25	2.18
2.	Drink beer, wine, or liquor. ***[Lower scores preferred]***	①	②	③	④	⑤	4.00	2.83	2.35	3.00	2.45	2.37
3.	Smoke marijuana or hashish. ***[Lower scores preferred]***	①	②	③	④	⑤	4.29	2.83	2.15	3.14	2.45	2.40
4.	Use cocaine or other drugs. ***[Lower scores preferred]***	①	②	③	④	⑤	4.29	2.83	2.30	2.81	2.29	2.18
5.	Use a prescription drug that was prescribed for someone else. ***[Lower scores preferred]***	①	②	③	④	⑤	4.29	2.83	2.25	2.76	2.40	2.25
6.	Vape or smoke an e-cigarette ***[Lower scores preferred]***	①	②	③	④	⑤	4.29	2.83	2.50	3.14	2.54	2.28
Drug refusal skill [2] *(Scores for Q's. 1-6 are averaged then subtracted from 6 to invert them -* ***higher scores are preferred****):*							**1.76**	**3.17**	**3.68**	**3.05**	**3.60**	**3.72**
I would:												
7.	Tell someone if they gave me less change(money) than I was supposed to get back after paying for something. ***[Lower scores preferred]***	①	②	③	④	⑤	2.71	2.67	2.20	2.29	2.11	2.17
8.	Say "no" to someone who asks to borrow money from me. ***[Lower scores preferred]***	①	②	③	④	⑤	2.29	2.83	2.95	2.57	2.71	2.60
9.	Tell someone to go to the end of the line if they try to cut ahead of me. ***[Lower scores preferred]***	①	②	③	④	⑤	2.14	3.17	2.85	2.52	2.81	2.92
Assertiveness skills [2] *(Scores for Q's. 7-9 are averaged then subtracted from 6 to invert them -* ***higher scores are preferred****):*							**3.62**	**3.11**	**3.33**	**3.54**	**3.46**	**3.44**
In order to cope with stress or anxiety, I would:												
10.	Relax all the muscles in my body, starting with my feet and legs. ***[Lower scores preferred]***	①	②	③	④	⑤	2.71	2.33	2.35	2.05	2.14	2.00
11.	Breathe in slowly for a count of four, then hold my breath in for a count of four, and slowly exhale for a count of four. ***[Lower scores preferred]***	①	②	③	④	⑤	2.00	2.33	2.30	2.10	1.83	1.87
Relaxation skills [2] *(Scores Q.10 & Q.11 are averaged then subtracted from 6 to invert them -* ***higher scores are preferred****):*							**3.64**	**3.67**	**3.68**	**3.93**	**4.01**	**4.07**
In general:												
12.	If I find that something is really difficult, I get frustrated and quit. ***[Higher scores preferred]***	①	②	③	④	⑤	3.14	3.67	3.5	3.62	3.48	3.63
13.	I stick to what I'm doing until I'm finished with it. ***[Lower scores preferred]***	①	②	③	④	⑤	2.57	2.33	2.1	2.00	2.10	2.04
Self-Control Skills [2] *(Score for Q. 13 is subtracted from 6 to invert it then averaged with Q. 12 –* ***higher scores are preferred****):*							**3.29**	**3.67**	**3.70**	**3.81**	**3.69**	**3.80**

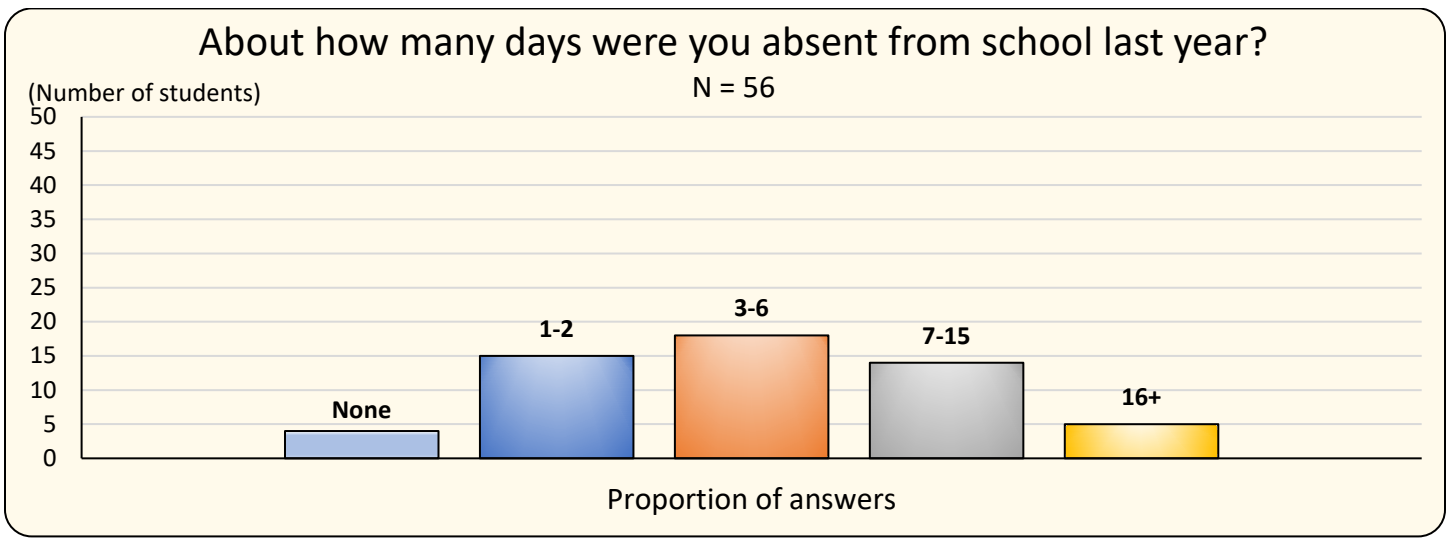

How many years old are you?
(Number of Students)
N = 56
50
45
40
35
30
25
20
15
10
5
0
10 yrs.
11 yrs.
12 yrs.
13 yrs.
14 yrs.
Proportion of answers


What is your gender?
(Number of students)
N = 56
50
45
40
35
30
25
20
15
10
5
0
Male
Female
Other
Proportion of answers


Who do you live with most of the time?
(Number of students)
N = 56
60
55
50
45
40
35
30
25
20
15
10
5
0
One parent
Two parents
Guardian, foster parent, or relative
Other


What is your race/ethnicity?
(Number of students)
N = 56
50
45
40
35
30
25
20
15
10
5
0
White
Hispanic/ Latino
More than one race
American Indian/ Alaska Native
Black or African-American
Native Hawaiian or Other Pacific Islander
Asian
Other


What grades do you generally get in school?
(Number of students)
N = 56
50
45
40
35
30
25
20
15
10
5
0
A's
B's
C's
D's
D's or lower
Proportion of answers


About how many days were you absent from school last year?
(Number of students)
N = 56
50
45
40
35
30
25
20
15
10
5
0
None
1-2
3-6
7-15
16+
Proportion of answers

Section B: Knowledge measures (Anti-drug)

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

	Anti-Drug knowledge items (Anderson)	6th grade (% correct)			7th grade (% correct)			8th grade (% correct)		
		PRE (N = 23)	POST (N = 23)	Change	PRE (N = 13)	POST (N = 13)	Change	PRE (N = 20)	POST (N = 20)	Change
1.	Most adults smoke cigarettes. (F)	30.43%	45.45%	15.02%	83.33%	54.55%	-28.79%	40.00%	70.59%	30.59%
2.	Smoking a cigarette causes your heart to beat slower. (F)	13.04%	27.27%	14.23%	66.67%	45.45%	-21.21%	45.00%	52.94%	7.94%
3.	Few adults drink wine, beer, or liquor every day. (T)	43.48%	45.45%	1.98%	33.33%	63.64%	30.30%	50.00%	47.06%	-2.94%
4.	Most people my age smoke marijuana. (F)	78.26%	77.27%	-0.99%	50.00%	45.45%	-4.55%	40.00%	35.29%	-4.71%
5.	Smoking marijuana causes your heart to beat faster. (T)	39.13%	50.00%	10.87%	83.33%	81.82%	-1.52%	45.00%	70.59%	25.59%
6.	Most adults use cocaine or other hard drugs. (F)	69.57%	81.82%	12.25%	83.33%	81.82%	-1.52%	65.00%	94.12%	29.12%
7.	Cocaine and other hard drugs always make you feel good. (F)	60.87%	100.00%	39.13%	66.67%	63.64%	-3.03%	60.00%	82.35%	22.35%
12.	Smoking can affect the steadiness of your hands. (T)	60.87%	86.36%	25.49%	83.33%	81.82%	-1.52%	90.00%	88.24%	-1.76%
13.	A stimulant is a chemical that calms down the body. (F)	56.52%	72.73%	16.21%	66.67%	63.64%	-3.03%	65.00%	58.82%	-6.18%
14.	Smoking reduces a person's endurance for physical activity. (T)	69.57%	77.27%	7.71%	100.00%	100.00%	0.00%	90.00%	94.12%	4.12%
15.	A serving of beer or wine contains less alcohol than a serving of "hard liquor" such as whiskey. (F)	39.13%	27.27%	-11.86%	83.33%	36.36%	-46.97%	20.00%	29.41%	9.41%
16.	Alcohol is a depressant. (T)	60.87%	68.18%	7.31%	66.67%	81.82%	15.15%	50.00%	88.24%	38.24%
17.	Marijuana smoking can improve your eyesight. (F)	86.96%	100.00%	13.04%	66.67%	81.82%	15.15%	85.00%	94.12%	9.12%
	Anti-drug knowledge summary score (higher % is preferred):	**54.52%**	**66.08%**	**+11.57%**	**71.79%**	**67.83%**	**-3.96%**	**57.31%**	**69.68%**	**+12.38%**

Section B: Knowledge measures (Life skills)

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

Life skills knowledge items (Anderson)		6th grade (% correct)			7th grade (% correct)			8th grade (% correct)		
		PRE (N = 23)	POST (N = 23)	Change	PRE (N = 13)	POST (N = 13)	Change	PRE (N = 20)	POST (N = 20)	Change
8.	What we believe about ourselves affects the way we act or behave. (T)	82.61%	77.27%	-5.34%	100%	100%	0.00%	85.00%	88.24%	3.24%
9.	It is almost impossible to develop a more positive self-image. (F)	52.17%	68.18%	16.01%	50.00%	54.55%	4.55%	70.00%	70.59%	0.59%
10.	It is important to measure how far you have come toward reaching your goal. (T)	86.96%	95.45%	8.50%	83.33%	100%	16.67%	90.00%	94.12%	4.12%
11.	It's a good idea to make a decision and then think about the consequences later. (F)	69.57%	72.73%	3.16%	66.67%	72.73%	6.06%	70.00%	82.35%	12.35%
18.	Some advertisers are deliberately deceptive. (T)	56.52%	77.27%	20.75%	66.67%	81.82%	15.15%	70.00%	70.59%	0.59%
19.	Companies advertise only because they want you to have all the facts about their products. (F)	56.52%	77.27%	20.75%	50.00%	45.45%	-4.55%	65.00%	70.59%	5.59%
20.	It's a good idea to get all information about a product from its ads. (F)	60.87%	59.09%	-1.78%	66.67%	72.73%	6.06%	35.00%	47.06%	12.06%
21.	Most people do not experience anxiety. (F)	56.52%	77.27%	20.75%	83.33%	81.82%	-1.52%	80.00%	88.24%	8.24%
22.	There is very little you can do when you feel anxious. (F)	30.43%	50.00%	19.57%	66.67%	54.55%	-12.12%	55.00%	76.47%	21.47%
23.	Deep breathing is one way to lessen anxiety. (T)	73.91%	81.82%	7.91%	66.67%	100%	33.33%	95.00%	100%	5.00%
24.	Mental rehearsal is a poor relaxation technique. (F)	73.91%	77.27%	3.36%	66.67%	72.73%	6.06%	85.00%	88.24%	3.24%
25.	You can avoid misunderstandings by assuming the other person knows what you mean. (F)	65.22%	72.73%	7.51%	66.67%	81.82%	15.15%	75.00%	76.47%	1.47%
26.	Effective communication is when both sender and receiver interpret a message in the same way. (T)	73.91%	68.18%	-5.73%	100%	63.64%	-36.36%	65.00%	94.12%	29.12%
27.	Relaxation techniques are of no use when meeting people. (F)	52.17%	77.27%	25.10%	66.67%	72.73%	6.06%	65.00%	94.12%	29.12%
28.	A compliment is more effective when it is said sincerely. (T)	78.26%	81.82%	3.56%	83.33%	100%	16.67%	85.00%	94.12%	9.12%
29.	A nice way of ending a conversation is to tell the person you enjoyed talking with him or her. (T)	78.26%	90.91%	12.65%	66.67%	100%	33.33%	95.00%	94.12%	-0.88%
30.	Sense of humor is an example of a non-physical attribute. (T)	52.17%	72.73%	20.55%	66.67%	63.64%	-3.03%	40.00%	58.82%	18.82%
31.	It's better to be polite and lead someone on, even if you don't want to go out with them. (F)	39.13%	59.09%	19.96%	50.00%	63.64%	13.64%	45.00%	88.24%	43.24%
32.	Almost all people who are assertive are either rude or hostile. (F)	65.22%	72.73%	7.51%	50.00%	72.73%	22.73%	70.00%	82.35%	12.35%
	Life skills knowledge summary score (higher % is preferred):	**63.39%**	**74.16%**	**+10.78%**	**69.30%**	**76.56%**	**+7.26%**	**70.53%**	**82.04%**	**+11.52%**

Section C: Attitude measures (Anti-drug)

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

	Anti-drug attitudes (Anderson)	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	6th grade		7th grade		8th grade	
							PRE (N = 23)	POST (N = 23)	PRE (N = 13)	POST (N = 13)	PRE (N = 20)	POST (N = 20)
1.	Kids who drink alcohol are more grown-up.	①	②	③	④	⑤	4.87	4.91	4.00	4.73	4.55	4.71
2.	Smoking cigarettes makes you look cool.	①	②	③	④	⑤	4.91	4.95	4.20	4.64	4.85	4.82
3.	Kids who drink alcohol have more friends.	①	②	③	④	⑤	4.83	4.68	4.00	4.09	3.85	4.00
4.	Kids who smoke have more friends.	①	②	③	④	⑤	4.74	4.68	3.60	3.73	3.80	4.00
5.	Drinking alcohol makes you look cool.	①	②	③	④	⑤	4.83	4.95	4.80	4.64	4.80	4.76
6.	Smoking cigarettes lets you have more fun.	①	②	③	④	⑤	4.91	4.77	3.80	4.64	4.45	4.71
7.	Kids who smoke cigarettes are more grown-up.	①	②	③	④	⑤	4.87	4.95	4.00	4.64	4.50	4.71
8.	Drinking alcohol lets you have more fun.	①	②	③	④	⑤	4.70	4.73	3.60	4.09	4.40	4.47
	Anti-drinking attitudes score (scores range from 1 to 5, scores closest to 5 are preferred):						**4.80**	**4.82**	**4.10**	**4.39**	**4.40**	**4.49**
	Anti-smoking attitudes score (scores range from 1 to 5, scores closest to 5 are preferred):						**4.86**	**4.84**	**3.90**	**4.41**	**4.40**	**4.56**
	Anti-drug attitudes summary score (scores range from 1 to 5, scores closest to 5 are preferred):						**4.83**	**4.83**	**4.00**	**4.40**	**4.40**	**4.52**

Life skills (Anderson)		Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	6th grade		7th grade		8th grade	
							PRE (N = 23)	POST (N = 23)	PRE (N = 13)	POST (N = 13)	PRE (N = 20)	POST (N = 20)
I would say NO if someone tried to get me to:												
1.	Smoke a cigarette. ***[Lower scores preferred]***	①	②	③	④	⑤	3.22	2.38	3.20	2.00	2.58	2.24
2.	Drink beer, wine, or liquor. ***[Lower scores preferred]***	①	②	③	④	⑤	3.22	2.38	2.80	1.91	2.68	2.06
3.	Smoke marijuana or hashish. ***[Lower scores preferred]***	①	②	③	④	⑤	3.17	2.38	3.40	1.91	2.68	2.18
4.	Use cocaine or other drugs. ***[Lower scores preferred]***	①	②	③	④	⑤	3.09	2.33	3.60	2.00	2.63	2.24
5.	Use a prescription drug that was prescribed for someone else. ***[Lower scores preferred]***	①	②	③	④	⑤	3.17	2.38	3.80	2.09	2.68	2.18
6.	Vape or smoke an e-cigarette ***[Lower scores preferred]***	①	②	③	④	⑤	3.17	2.38	3.00	2.00	2.47	2.29
Drug refusal skill [2]*(Scores for Q's. 1-6 are averaged then subtracted from 6 to invert them - **higher scores are preferred**):*							**2.83**	**3.63**	**2.7**	**4.02**	**3.38**	**3.80**
I would:												
7.	Tell someone if they gave me less change (money) than I was supposed to get back after paying for something. ***[Lower scores preferred]***	①	②	③	④	⑤	2.70	2.24	2.40	2.55	2.42	1.76
8.	Say "no" to someone who asks to borrow money from me. ***[Lower scores preferred]***	①	②	③	④	⑤	3.13	2.29	3.00	2.82	2.53	2.71
9.	Tell someone to go to the end of the line if they try to cut ahead of me. ***[Lower scores preferred]***	①	②	③	④	⑤	2.57	2.29	2.80	2.64	2.26	2.18
Assertiveness skills [2]*(Scores for Q's. 7-9 are averaged then subtracted from 6 to invert them - **higher scores are preferred**):*							**3.20**	**3.73**	**3.27**	**3.33**	**3.60**	**3.78**
In order to cope with stress or anxiety, I would:												
10.	Relax all the muscles in my body, starting with my feet and legs. ***[Lower scores preferred]***	①	②	③	④	⑤	2.48	2.38	3.00	2.18	1.89	2.18
11.	Breathe in slowly for a count of four, then hold my breath in for a count of four, and slowly exhale for a count of four. ***[Lower scores preferred]***	①	②	③	④	⑤	2.30	2.10	2.00	1.91	1.68	2.12
Relaxation skills [2]*(Scores for Q's 10 & 11 are averaged then subtracted from 6 to invert them - **higher scores are preferred**):*							**3.61**	**3.76**	**3.85**	**3.95**	**4.21**	**3.85**
In general:												
12.	If I find that something is really difficult, I get frustrated and quit. **[Higher scores preferred]**	①	②	③	④	⑤	2.91	2.76	3	2.73	3.37	3.65
13.	I stick to what I'm doing until I'm finished with it. ***[Lower scores preferred]***	①	②	③	④	⑤	2.22	2.52	2.25	2.82	2.16	2.00
Self-Control Skills [2]*(Score for Q. 13 is subtracted from 6 to invert it then averaged with Q. 12 – **higher scores are preferred**):*							**3.35**	**3.12**	**3.38**	**2.95**	**3.61**	**3.82**

References

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

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

Shasta County Health & Human Services Agency

Stigma & Discrimination Reduction activities

Fiscal Year 2019-2020

Stigma and Discrimination Reduction activities are performed by the Stand Against Stigma workgroup and as well as other volunteers. The goal of the various activities is to reduce the negative perceptions surrounding mental illness through trainings, social media campaigns, speaking engagements, outreach exhibits, events, and more. In each quarter, from July 2019 to June 2020, the Stigma and Discrimination Reduction activities were as follows:

Quarter 1 (July – September 2019)

Speaking Engagements:

Date	Brave Faces Advocate(s)	Presentation Type	Organizer	Location	Reach
07/23/2019	Aiden Mares, Emalee Mims and David Wharton	Formal	Simpson College Human Sexuality Class	Simpson College Library	8
07/26/2019	Denise Green and Jullie Calkins	Destig Intro and Discussion	Adult Services Outpatient Staff	Adult Services	20
08/21/2019	Denise Green	Destig Intro and Discussion	One Safe Place Staff	One Safe Place	15
08/24/2019	Mike Skondin and Cherish Padro	Speaking Engagment at Event	Lotus Educational Services, Stand Against Stigma and Suicide Prevention	Old City Hall`	37
08/26/2019	Denise Green	Destig Intro and Discussion	Olberg Wellness Center	Olberg Wellness Center	15
09/23/2019	Josie Englin	Formal	One Safe Place DV/SA Class	One Safe Place	11

Events:

Date	Brave Faces Advocate(s)	Event	Organizer	Location	Attendance
08/24/2019	Mike Skondin and Cherish Padro	S Word Screening & Hope Is Alive! Open Mic	Lotus Educational Services, Stand Against Stigma and Suicide Prevention	Old City Hall`	37
09/29/2019	Mike Skondin, Jullie Calkins and Crystal Johnson	Recovery Happens	Community Collaboration	Lake Redding Park Gazebo	500

Trainings:

Date	Facilitator	Event	Location	Attendees	Graduates
08/17/2019	Emalee Mims and Jullie Calkins	Becoming Brave Training	Stand Against Stigma	Boggs	10

Gallery:

Date	Portraits	Install or Publish	Location	Approx Reach
08/06/2019	David Wharton	Website and Facebook	Online	591

Outreach exhibits:

Date	HHSA Staff / Volunteer(s)	Event	Organizer	Location	Attendees Engaged
07/12/2019	Carrie Jo Diamond	Good Medicine Health Fair	Pitt River Tribe	Burney	200
07/27/2019	Carrie Jo Diamond	Plugging In and Powering Up Wildfire Survivior Resource Fair	Cal HOPE Shasta	City Hall Community Room	100
08/07/2019	Carrie Jo Diamond	Redding Rancheria Health Fair	Redding Rancheria	Win River	100
08/28/2019	Carrie Jo Diamond	Shasta College Welcome Day	Shasta College	Shasta College Quad	200
09/05/2019	Carrie Jo Diamond	Shasta College Health and Safety Fair	Shasta College	Shasta College Quad	50
09/12/2019	Carrie Jo Diamond	Written Off	Dignity Health	Casade Theatre	100

Quarter 2 (October – December 2019)

Speaking Engagements:

Date	Brave Faces Advocate(s)	Presentation Type	Organizer	Location	Reach
10/11/2019	Mike Skondin and Jullie Calkins	Formal	ACEs Learning Community	First 5 Shasta	8
10/16/2019	David Wharton and Aiden Mares	Speaking Engagment at Event	All Things [Not] Being Equal	Shasta College	30
11/13/2019	David Martinez and Mike Skondin	Formal	Institute of Techonology	IOT	Not recorded

11/15/2019	Aiden Mares	Formal	MHSA Academy	Shasta Lake Regional Services Office	Not recorded
12/10/2019	Jullie Calkins, Cherish Padro, David Matinez, Matt Sprenger	Formal	National University Case Management Class	National University	Not recorded

Events:

Date	Brave Faces Advocate(s)	Event	Organizer	Location	Attendance
11/01/2019	Jullie Calkins	Hope Is Alive! Open Mic (AFTA)	Stand Against Stigma/ART from the ashes	Old City Hall	Not recorded

Trainings:

Date	Facilitator	Event	Location	Attendees	Graduates
11/16/2019	Josie Englin and Aiden Mares	Becoming Brave	Boggs	Not recorded	12

Quarter 3 (January – March 2020)

Speaking Engagements:

Date	Brave Faces Advocate(s)	Presentation Type	Organization	Location	Reach
01/14/2020	Josie Englin*	Destig Intro and Discussion	Stand Against Stigma	CARE Center	Not recorded
02/27/2020	Mike Skondin, Jullie Calkins, David Wharton	Formal	Dignity Health Connected Living	Dignity Health Connected Living	Not recorded

Outreach exhibits:

Date	HHSA Staff / Volunteer(s)	Event	Organizer	Location	Attendees Engaged
01/04/2020	Christopher Diamond	Redding Health Expo	Redding Health Expo	Redding Civic Center	500
Not recorded	Christopher Diamond	Dr. Lake Anti-bullying Presentation	Beloved Community	Shasta College	75

Quarter 4 (April – June 2020)

Speaking engagements:

Date	Brave Faces Advocate(s)	Presentation Type	Organization	Location	Reach
04/30/2020	Jullie Calkins	Informal	One Safe Place	Zoom Meeting	Not recorded

Events and outreach activities for April-June were cancelled due to COVID-19.

Shasta County Health & Human Services Agency

Brave Faces: Pre/Post Survey Analysis

Results for Fiscal Year 2019/2020

Brave Faces is a part of Shasta County's Stigma and Discrimination Reduction project

Introduction

"Brave Faces" is an event where a person who has experienced a serious mental illness shares their story with others to promote recovery, hope, and wellness. At the event, viewers are given surveys to assess their attitudes towards mental illness before and after listening to the Brave Faces speaker. The purpose of this analysis is to explore any changes in the attitudes participants had towards mental illness before and after viewing the presentation using their pre-/post-surveys.

Survey Tool

The survey listed 18 statements about mental illness and the participant was instructed to indicate how strongly they agreed or disagreed with each statement using a Likert Scale from 1-9 where selecting "1" meant "strongly agree" and selecting "9" meant "strongly disagree."

Statements on the survey were divided into four subjects: Attitudes towards a character with a serious mental illness (7 statements), their overall opinion about people with mental illness (2 statements), their overall perspective on the value of people with mental illness (3 statements), and their willingness to seek help if they themselves became mentally ill (6 statements). The survey also collected demographic information on the respondent such as their age, gender, level of education, race, sexual orientation, and employment status. Their completed pre/post-surveys were collected to assess any changes in attitudes. This analysis looks at the change in pre-/post-survey scores during Fiscal Year 2019/2020.

Analysis

Statistically significant differences between the pre-and post-score averages for each survey statement were assessed using a paired t-test at a 95% confidence interval. This analysis excluded participants who were missing either a pre- or post-survey. If post-survey scores moved closer to the "1" side of the Likert Scale, this means that participants, on average, agreed more strongly than before. Stronger agreement represents an increasingly positive attitude towards those who have mental illnesses. Results for Fiscal Year 2019/2020 are shown on the next page.

On a scale from 1-9, select "1" if you strongly agree with the statement and select "9" if you strongly disagree with the statement

Fiscal Year 19/20

Harry's story	Average Score PRE	Average Score POST	Change	Statistically significant change? (95% confidence)	P Value	N
I would be friends with Harry.	3.9	3.1	0.80	✓	0.0004	40
Harry would be successful at his job.	4.4	3.2	1.23	✓	0.0000	40
If I had a problem, I'd ask for Harry's opinion.	4.8	3.4	1.33	✓	0.0000	40
If Harry said he needed someone to talk to, I would listen.	2.5	2.0	0.55	✓	0.0001	40
I would think Harry is a part of my community.	2.5	2.1	0.38	✓	0.0101	40
Harry's hospitalizations are going to help him get better.	3.5	3.0	0.53	✓	0.0054	40
It's encouraging that Harry is taking his medications.	2.4	2.1	0.33	✓	0.0397	40

Overall Opinion about people with mental illness	Average Score PRE	Average Score POST	Change	Statistically significant change? (95% confidence)	P Value	N
People with mental illness have goals in life they want to reach.	1.7	1.7	-0.03	⊘	0.5941	40
Coping with mental illness is not the main focus of the lives of people with mental illness.	4.2	3.3	0.93	✓	0.0074	40

Overall Perspective on the Value of People with Mental Illness	Average Score PRE	Average Score POST	Change	Statistically significant change? (95% confidence)	P Value	N
I feel people with mental illness are persons of worth.	1.6	1.7	-0.08	⊘	0.7939	40
I see people with mental illness as capable people.	1.9	1.8	0.10	⊘	0.2559	40
People with mental illness are able to do things as well as most other people.	2.2	2.3	-0.10	⊘	0.6573	40

Willingness to seek help	Average Score PRE	Average Score POST	Change	Statistically significant change? (95% confidence)	P Value	N
I would speak to a primary care doctor if I were significantly anxious or depressed.	3.0	2.5	0.46	✓	0.0101	39
I would speak to a psychiatrist if I were significantly anxious or depressed.	3.4	2.7	0.72	✓	0.0017	39
I would speak to a counselor if I were significantly anxious or depressed.	2.1	1.9	0.23	✓	0.0053	39
I would speak to a minister or other clergy member if I were significantly anxious or depressed.	4.3	3.7	0.54	✓	0.0155	39
I would speak to a friend or family member if I were significantly anxious or depressed.	2.3	2.4	-0.11	⊘	0.7715	38
I would seek help from a peer support or self-help program if I were significantly anxious or depressed.	3.2	2.9	0.21	⊘	0.2416	39

Results and Conclusion

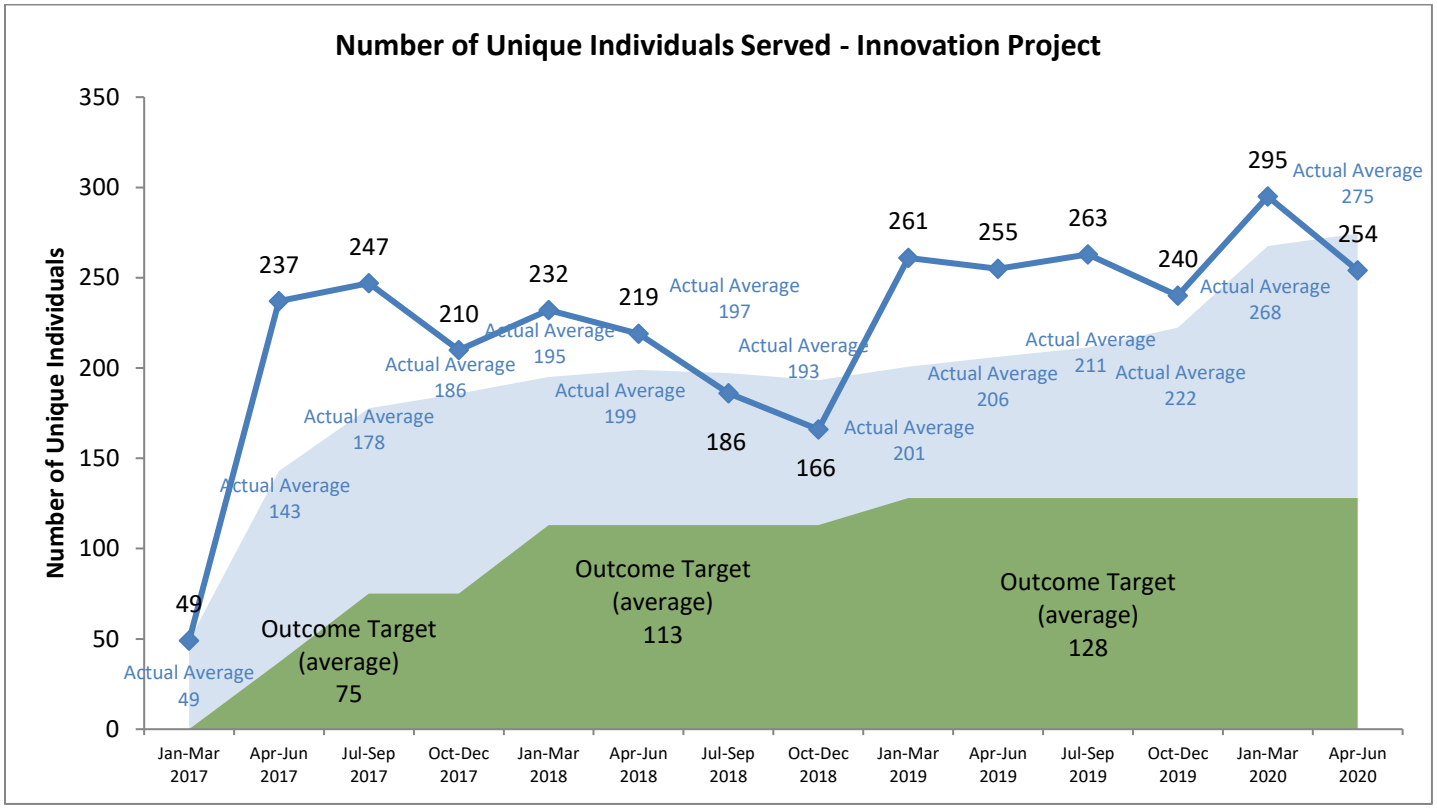
Participants' average pre-survey scores indicated agreement on all 18 statements. There were 12 statements that had statistically significant differences in average post-survey scores. The direction of those 12 differences all represented stronger agreement than before. The minimum number of responses received was 38. The number of responses received was lower compared to previous years due to the COVID-19 pandemic limiting gatherings and events.

These results indicate Brave Faces presentations during Fiscal Year 19/20 had a positive impact on their audience's attitudes towards mental illness. This presentation format seems effective and beneficial for stigma and discrimination reduction efforts and has been successful in changing people's attitudes towards mental illness.

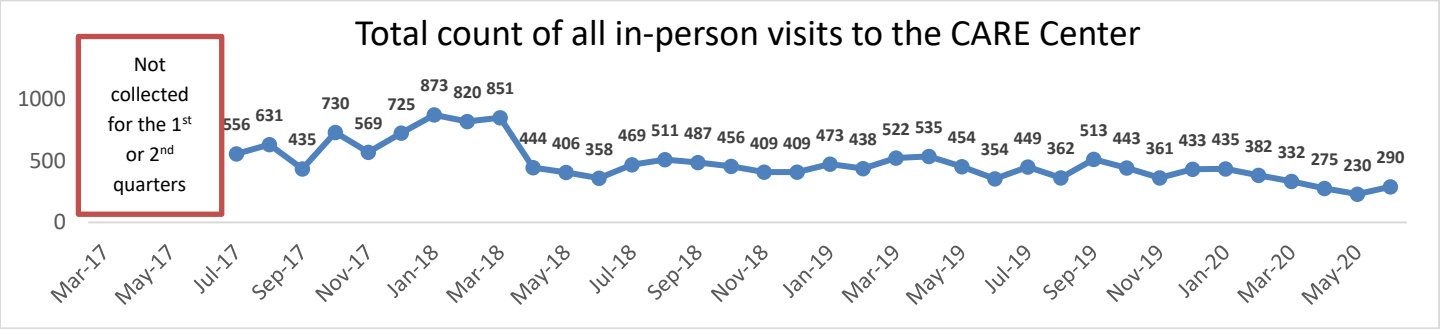
CARE Center Activity Report – Innovation Project
January 2017 through June 2020

To determine if providing access to mental health services after traditional office hours will improve access to services, reduce mental health crisis (including trips to the hospital emergency departments) and bridge service gaps, the Shasta County Health and Human Services Agency has contracted with Hill County Health and Wellness Center to provide new and expanded mental health services at the Counseling and Recovery Engagement (CARE) Center. Funding is provided through the Mental Health Services Act (MHSA) for the Innovation Project portion of this center. The CARE Center contract was approved as of January 2017, and they officially opened for business on March 12, 2017. For this report, data was gathered using the CARE Center Quarterly Progress Reports for January 2017 through June 2019. Please note that due to the CARE Center not actually opening for business until early March 2017, the first quarter reflects less than one month of data. Additionally, there are several measures where their data systems and/or electronic health record were in process, or where methodology changed, so they could not be tracked. As of the Oct-Dec 2017 quarter, all measures are now tracked and reported on, although further refinement of the data collection is still underway for some measures.

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



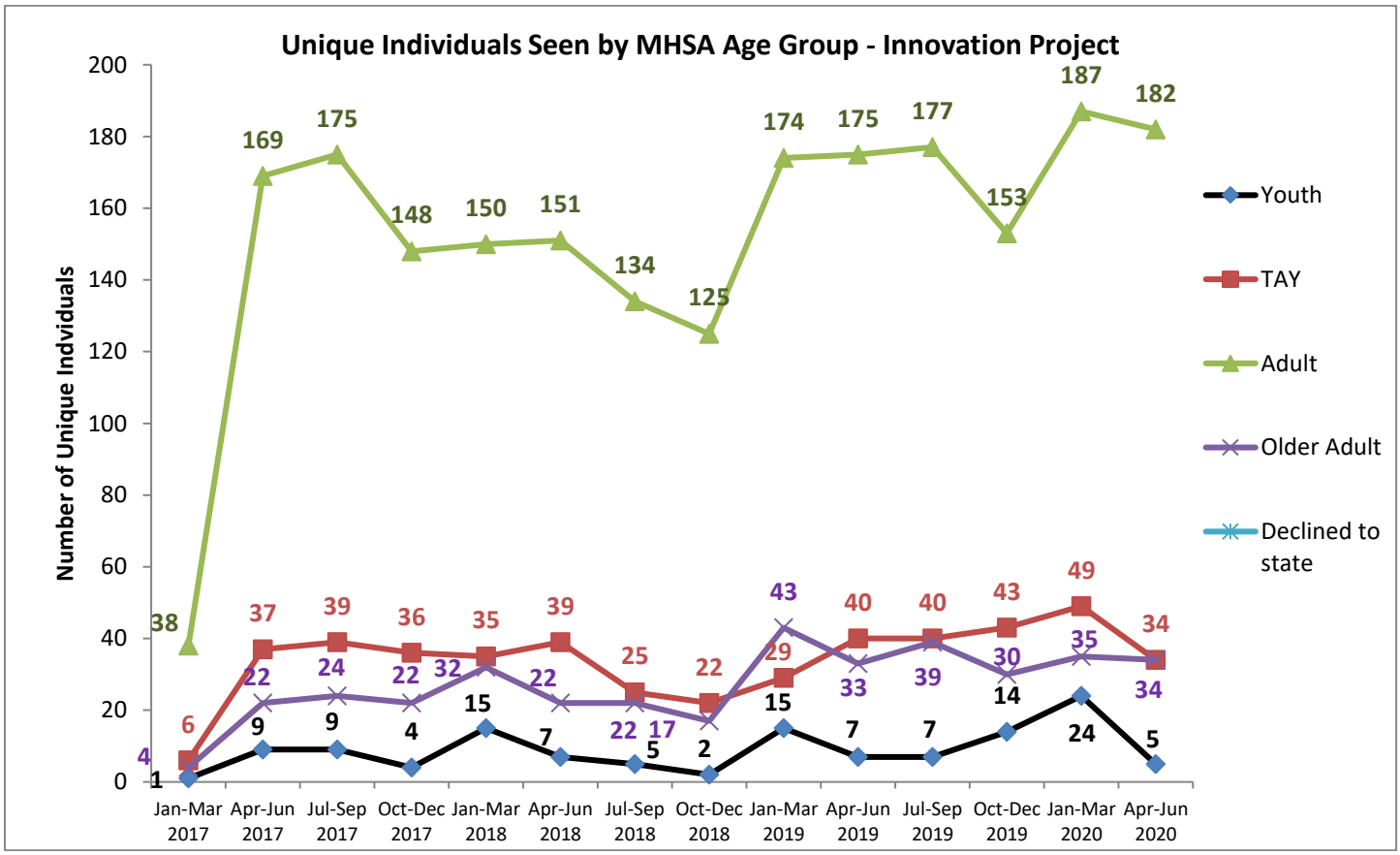
Due to much higher utilization of the Care Center than anticipated, the number of in-person visits per month are being tracked as of July 2017. Please note that most clients visit more than once - this is not an unduplicated person count. Refinement of the counting process occurred in the Apr-Jun 2018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



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

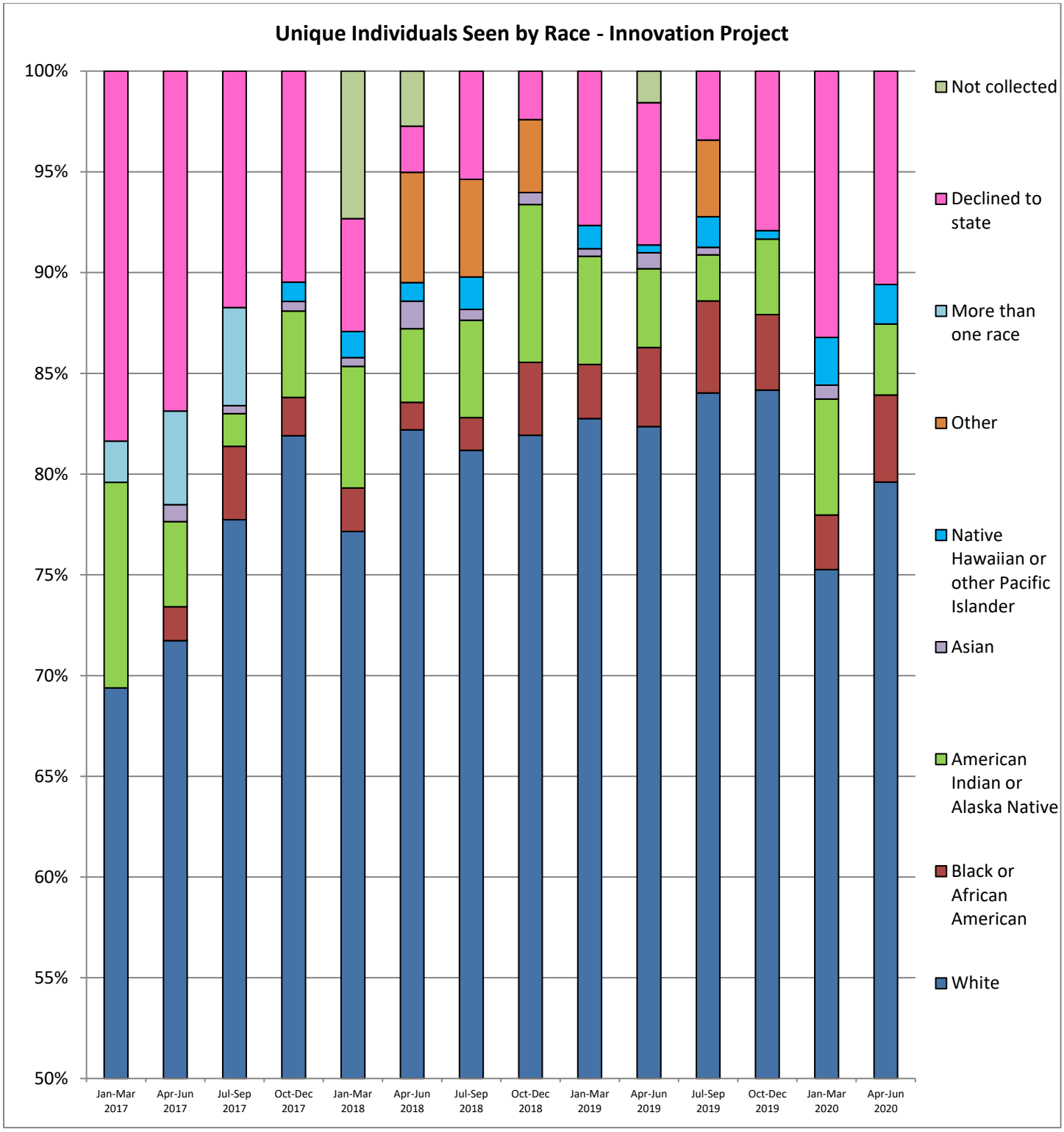
AGE

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



RACE

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



ETHNICITY

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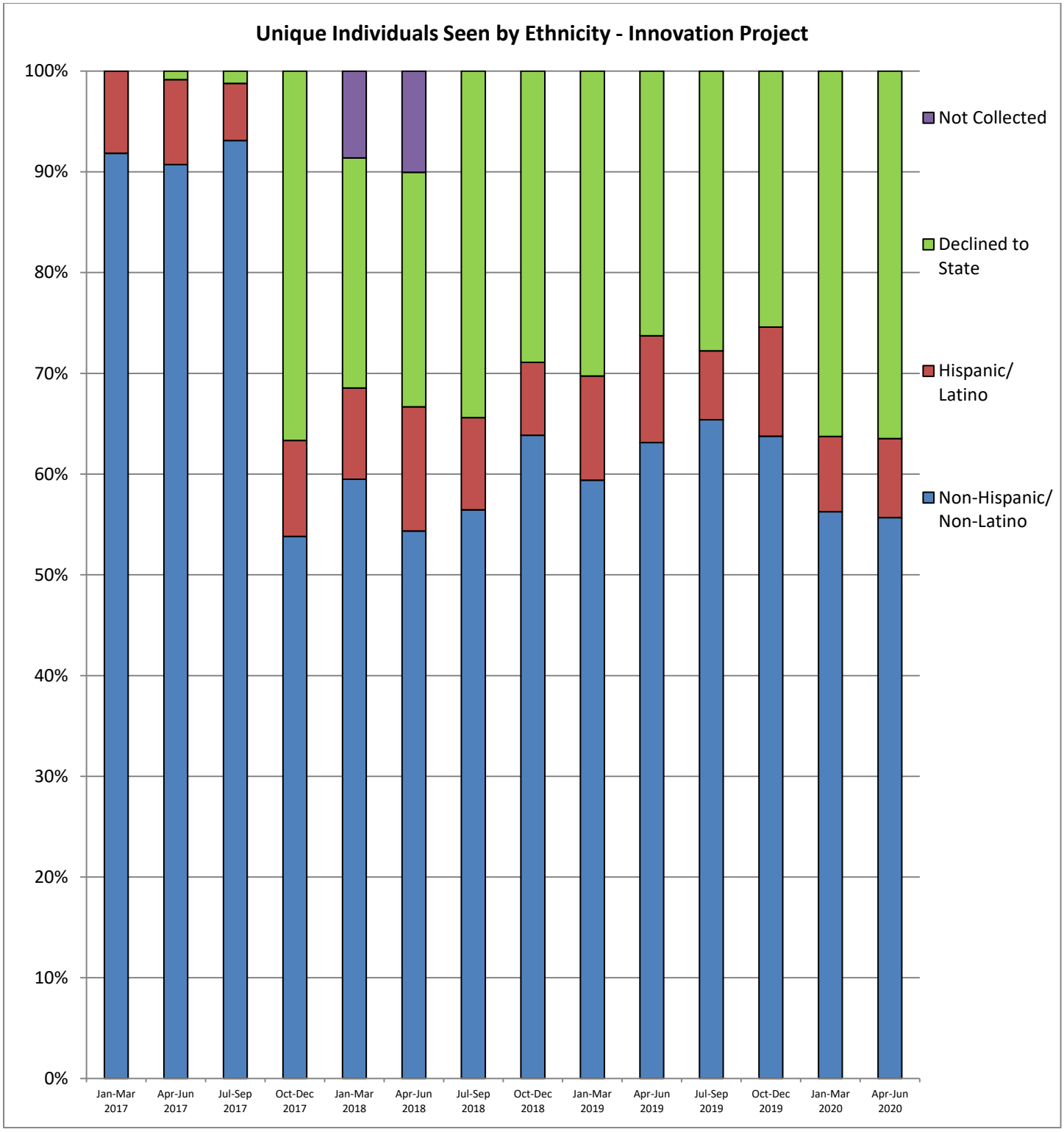
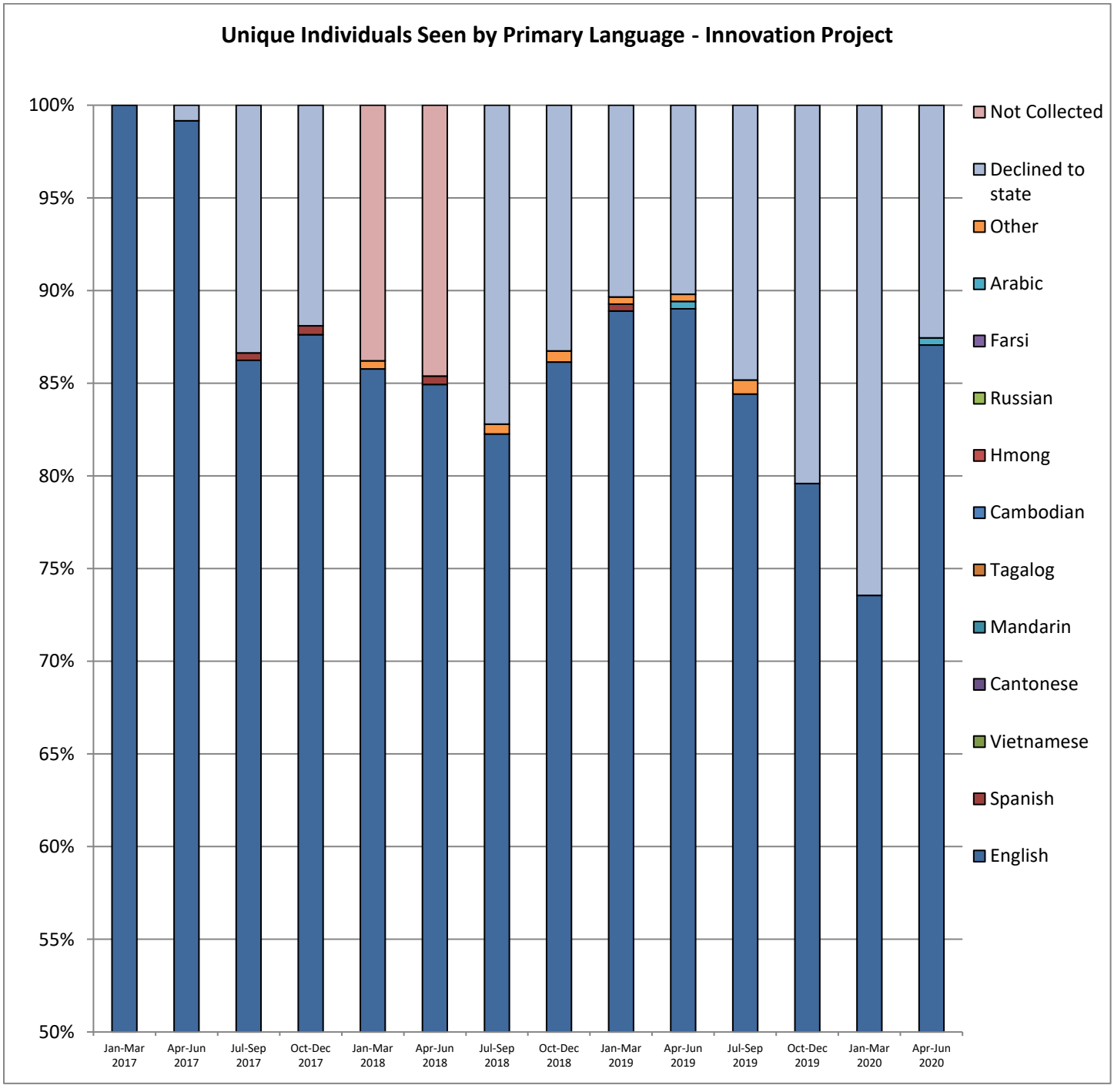
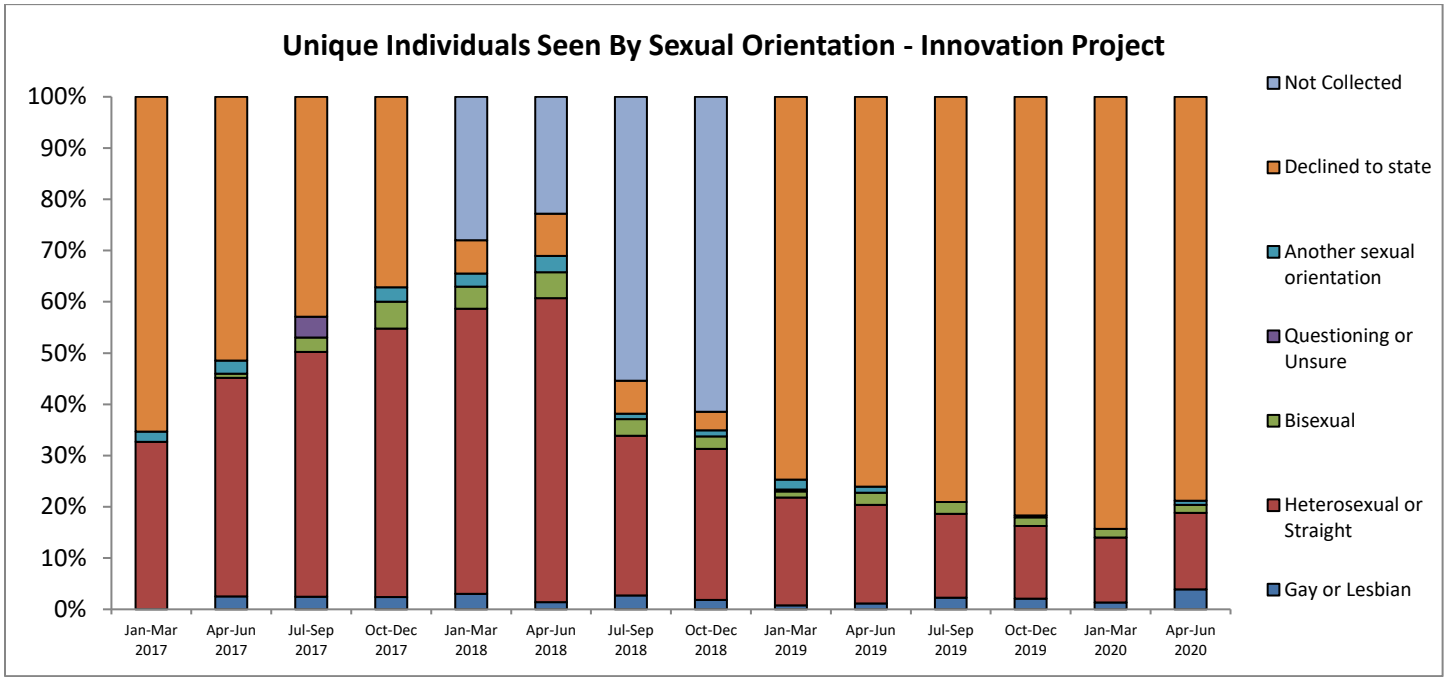


PRIMARY LANGUAGE

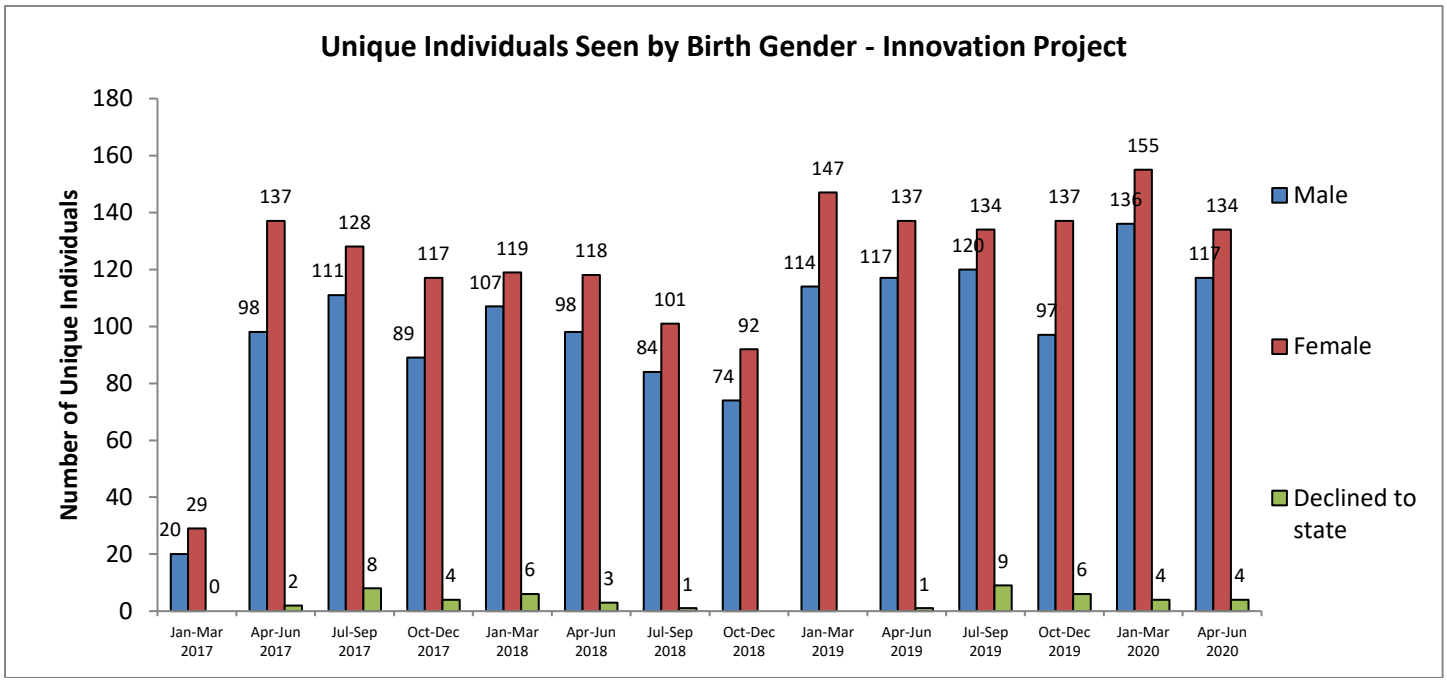
The primary language of consumers served by the CARE Center is English for nearly 100% of the people. Because of the low gross numbers for some reported languages, actual counts are not reported to help protect consumer confidentiality.



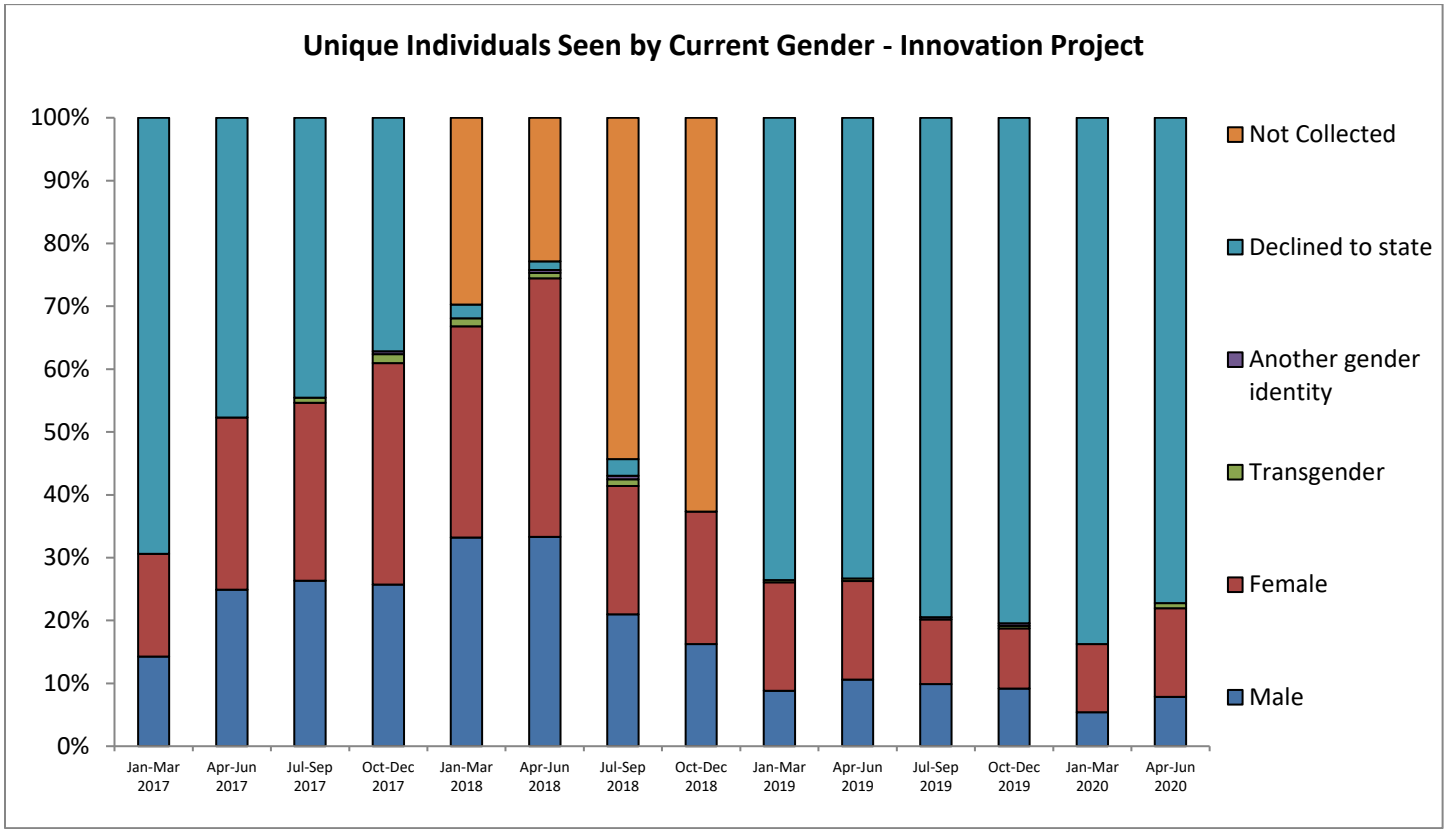
SEXUAL ORIENTATION



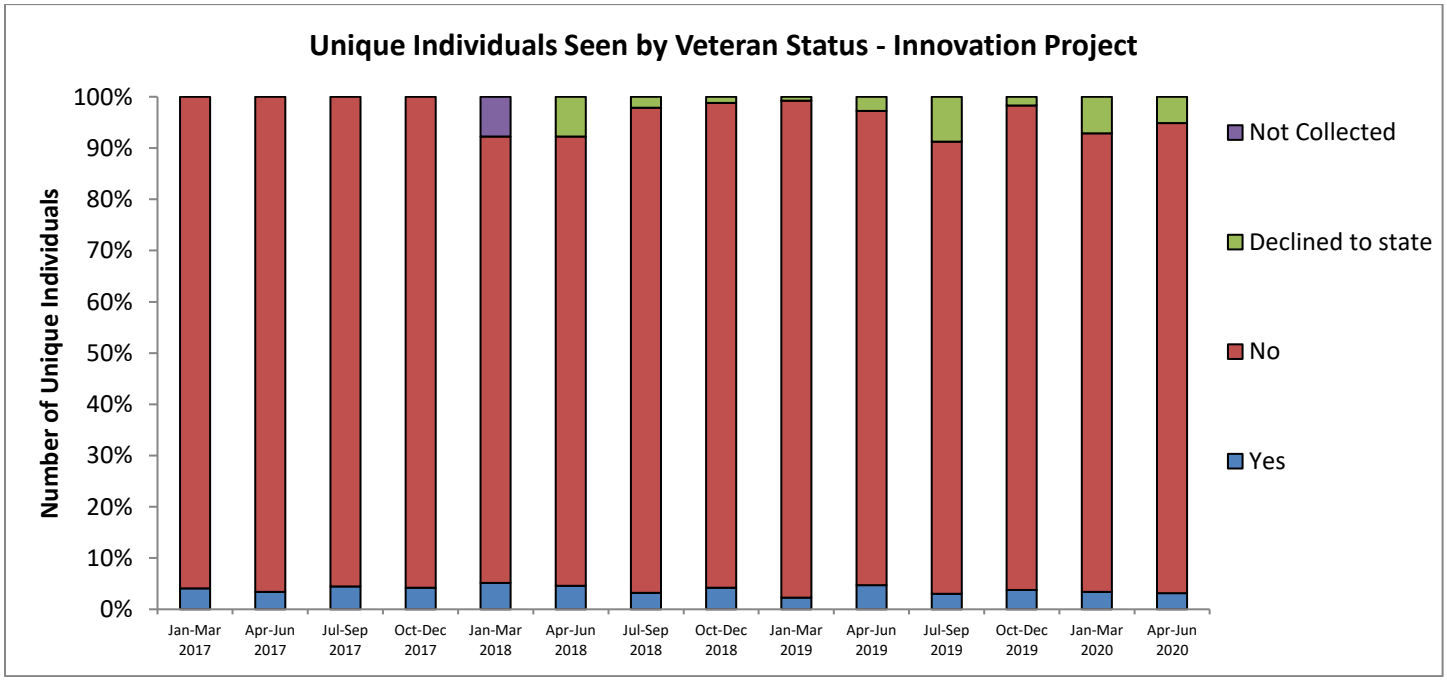
BIRTH GENDER



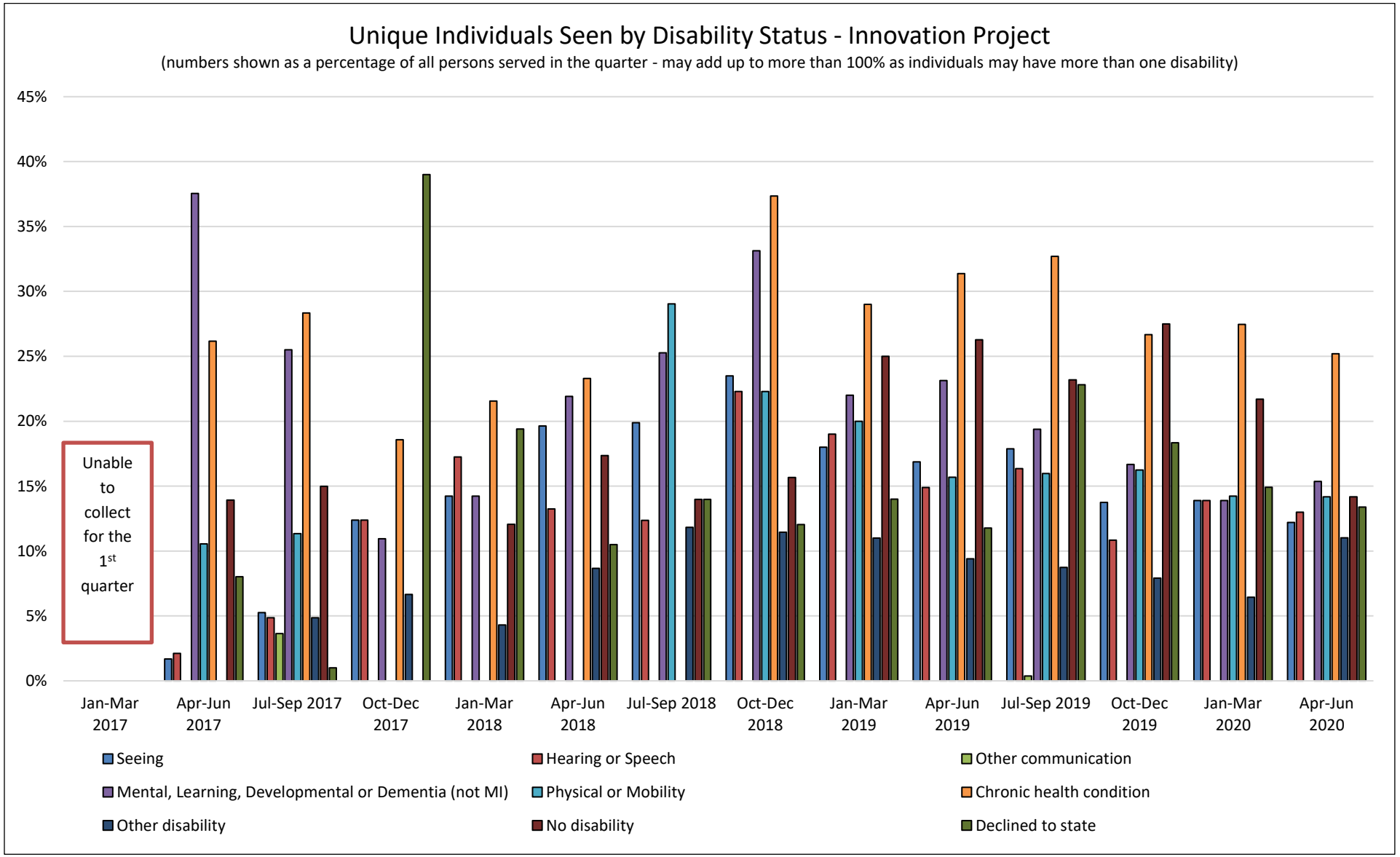
CURRENT GENDER



VETERAN STATUS



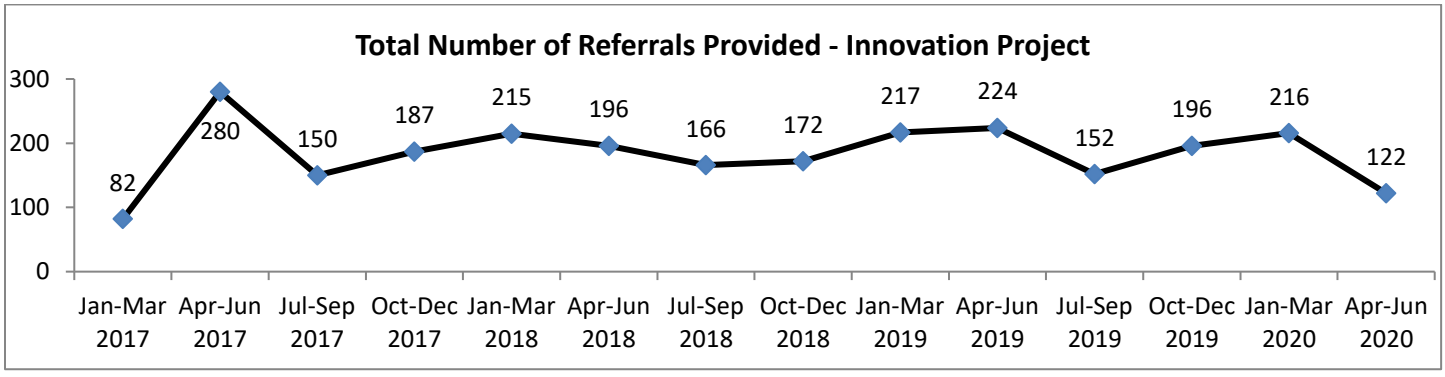
DISABILITY STATUS



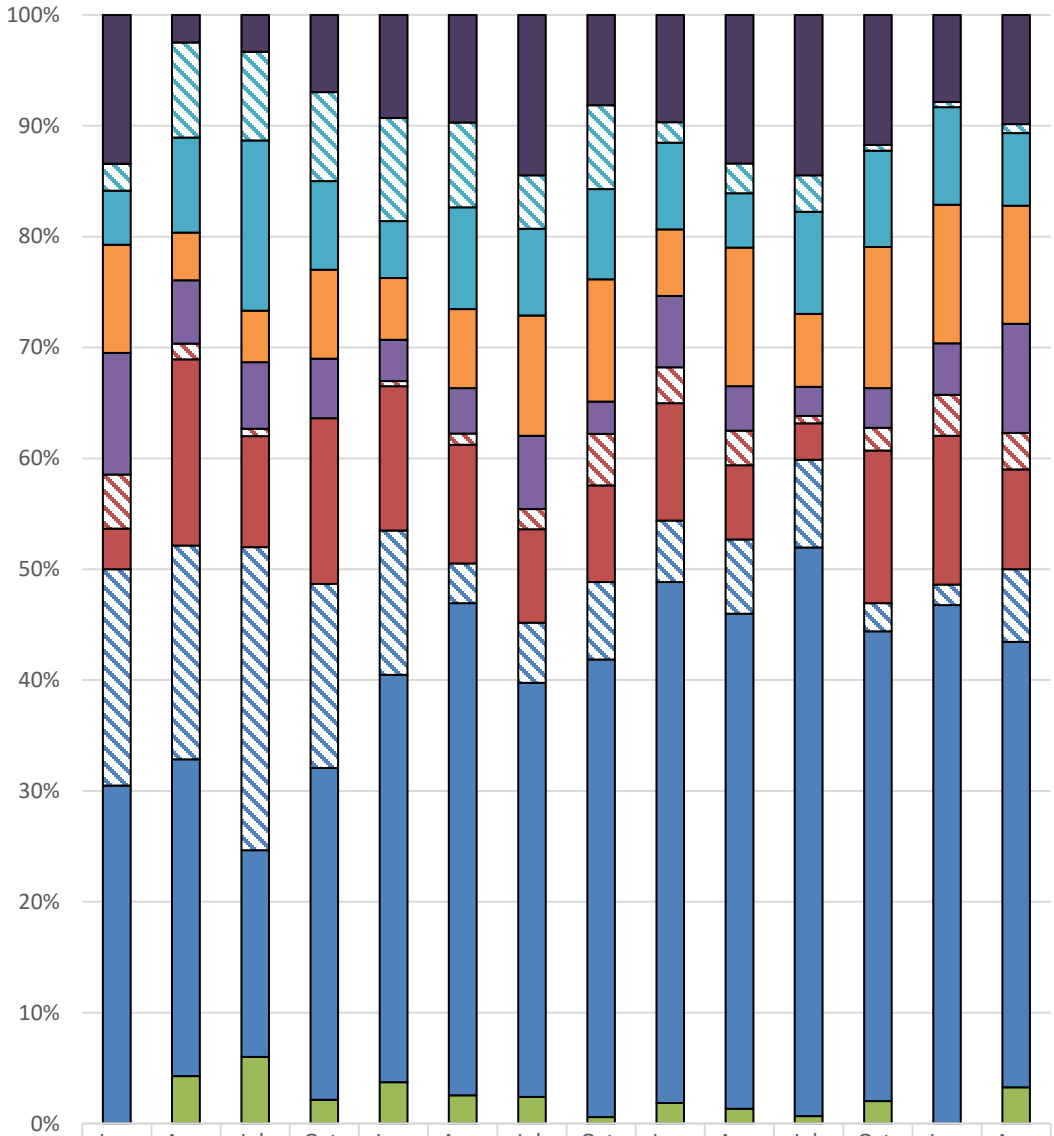
NUMBER OF OUTSIDE REFERRALS PROVIDED AND SUCCESSFULLY ACCESSED

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

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

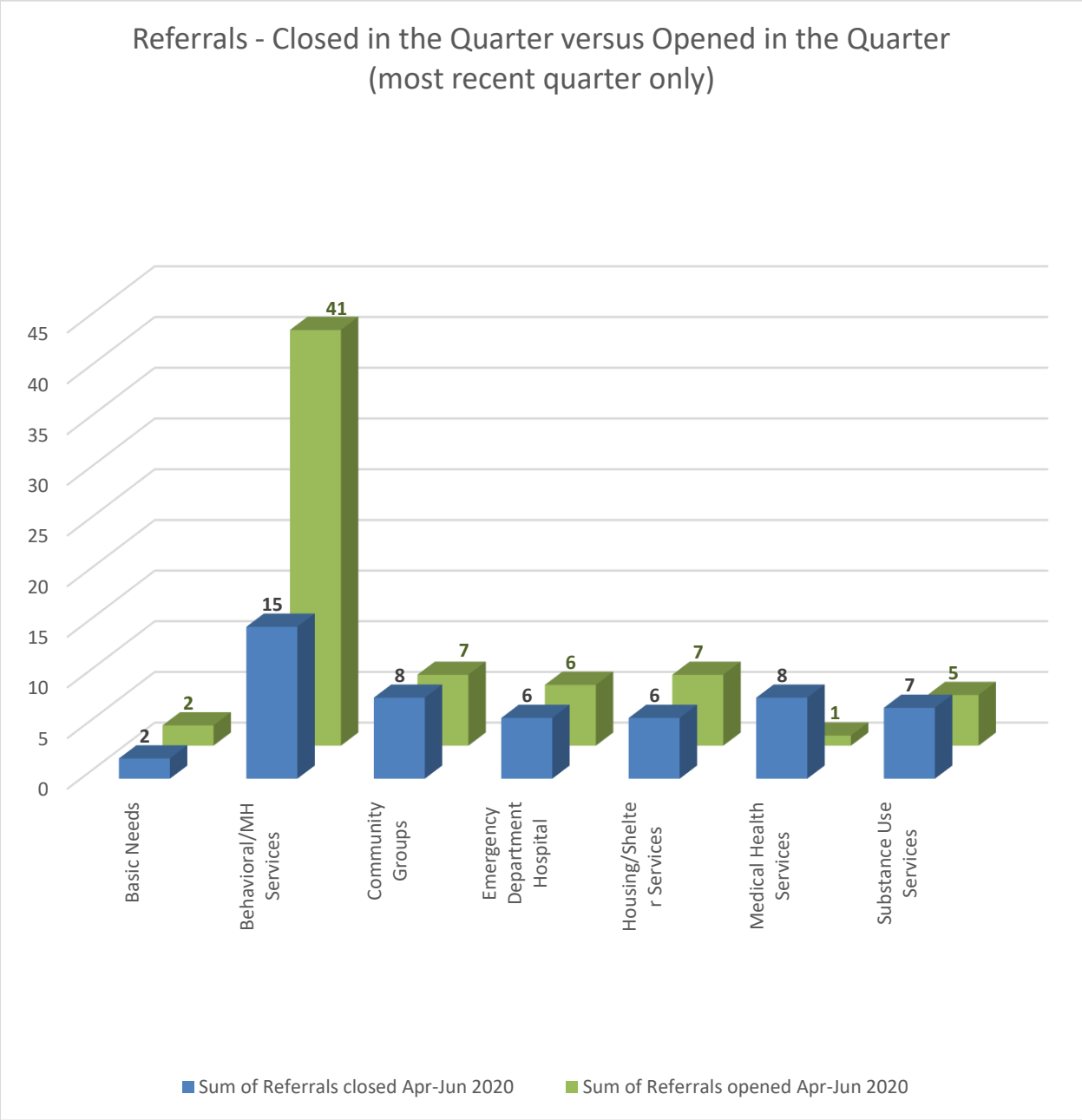


Referrals Provided by Category - Innovation Project



	Jan-Mar 2017	Apr-Jun 2017	Jul-Sep 2017	Oct-Dec 2017	Jan-Mar 2018	Apr-Jun 2018	Jul-Sep 2018	Oct-Dec 2018	Jan-Mar 2019	Apr-Jun 2019	Jul-Sep 2019	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020
Substance Use Services	11	7	5	13	20	19	24	14	21	30	22	23	17	12
Medical Health Services Hill Country	2	24	12	15	20	15	8	13	4	6	5	1	1	1
Medical Health Services External	4	24	23	15	11	18	13	14	17	11	14	17	19	8
Housing/Shelter Services	8	12	7	15	12	14	18	19	13	28	10	25	27	13
ED Hospital	9	16	9	10	8	8	11	5	14	9	4	7	10	12
Community Groups Hill Country	4	4	1	0	1	2	3	8	7	7	1	4	8	4
Community Groups External	3	47	15	28	28	21	14	15	23	15	5	27	29	11
Behavioral/MH Services Hill Country	16	54	41	31	28	7	9	12	12	15	12	5	4	8
Behavioral/MH Servivces External	25	80	28	56	79	87	62	71	102	100	78	83	101	49
Basic Needs	0	12	9	4	8	5	4	1	4	3	1	4	0	4

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

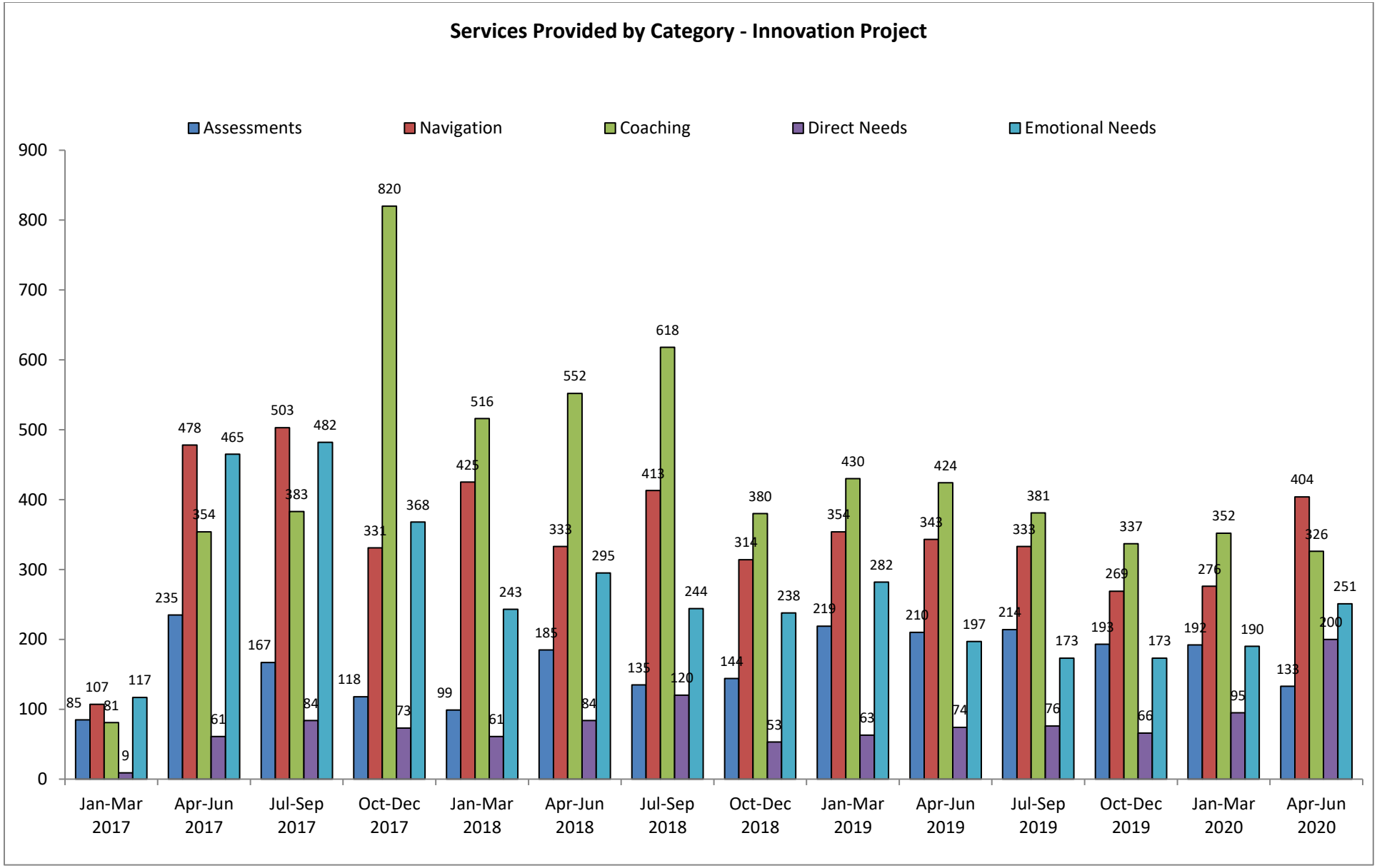


NUMBER OF SERVICES PROVIDED AND SUCCESSFULLY COMPLETED

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

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

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


Services Provided by Category - Innovation Project
Assessments
Navigation
Coaching
Direct Needs
Emotional Needs
900
800
700
600
500
400
300
200
100
0
85 107 81 9 117
235 478 354 61 465
167 503 383 84 482
118 331 820 73 368
99 425 516 61 243
185 333 552 84 295
135 413 618 120 244
144 314 380 53 238
219 354 430 63 282
210 343 424 74 197
214 333 381 76 173
193 269 337 66 173
192 276 352 95 190
133 404 326 200 251
Jan-Mar 2017
Apr-Jun 2017
Jul-Sep 2017
Oct-Dec 2017
Jan-Mar 2018
Apr-Jun 2018
Jul-Sep 2018
Oct-Dec 2018
Jan-Mar 2019
Apr-Jun 2019
Jul-Sep 2019
Oct-Dec 2019
Jan-Mar 2020
Apr-Jun 2020

HOUSING STATUS

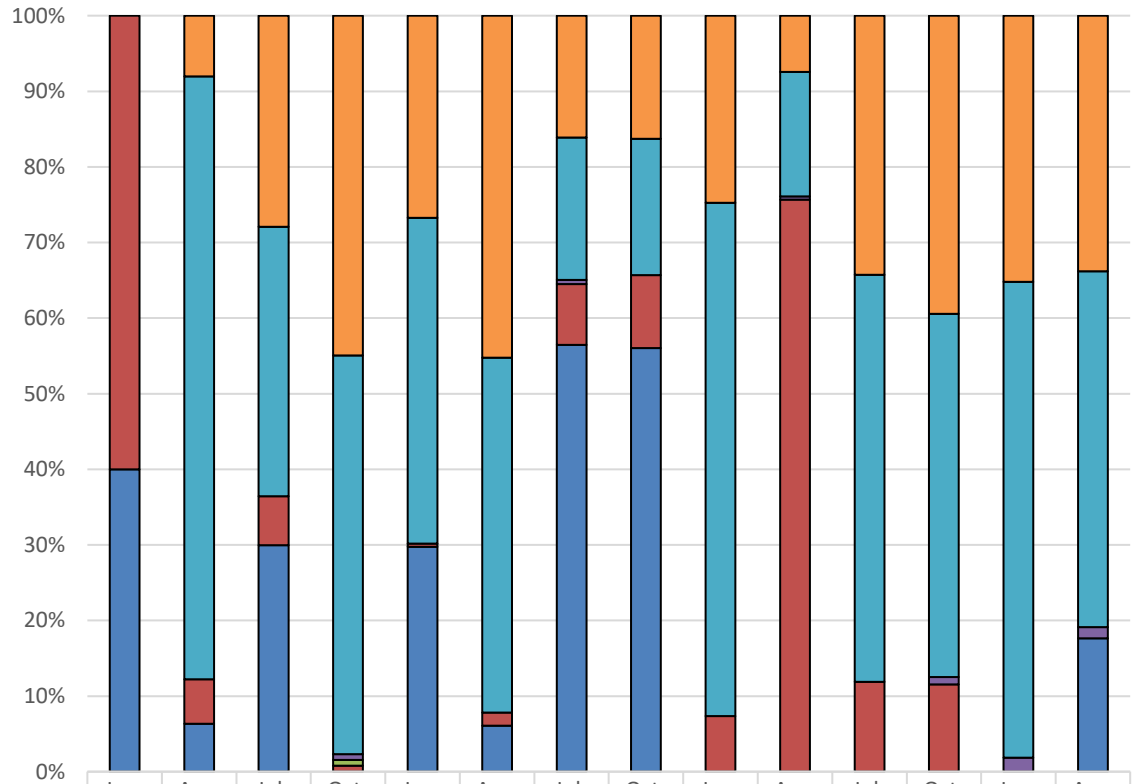
To help track the impact and effectiveness of services, the CARE Center has been asked to track the housing status of individuals accessing the Innovation Project services at the time they first start services, and then at the 3-month point after that first service. The target outcome numbers are to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

Housing status has been divided up into the following categories:

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

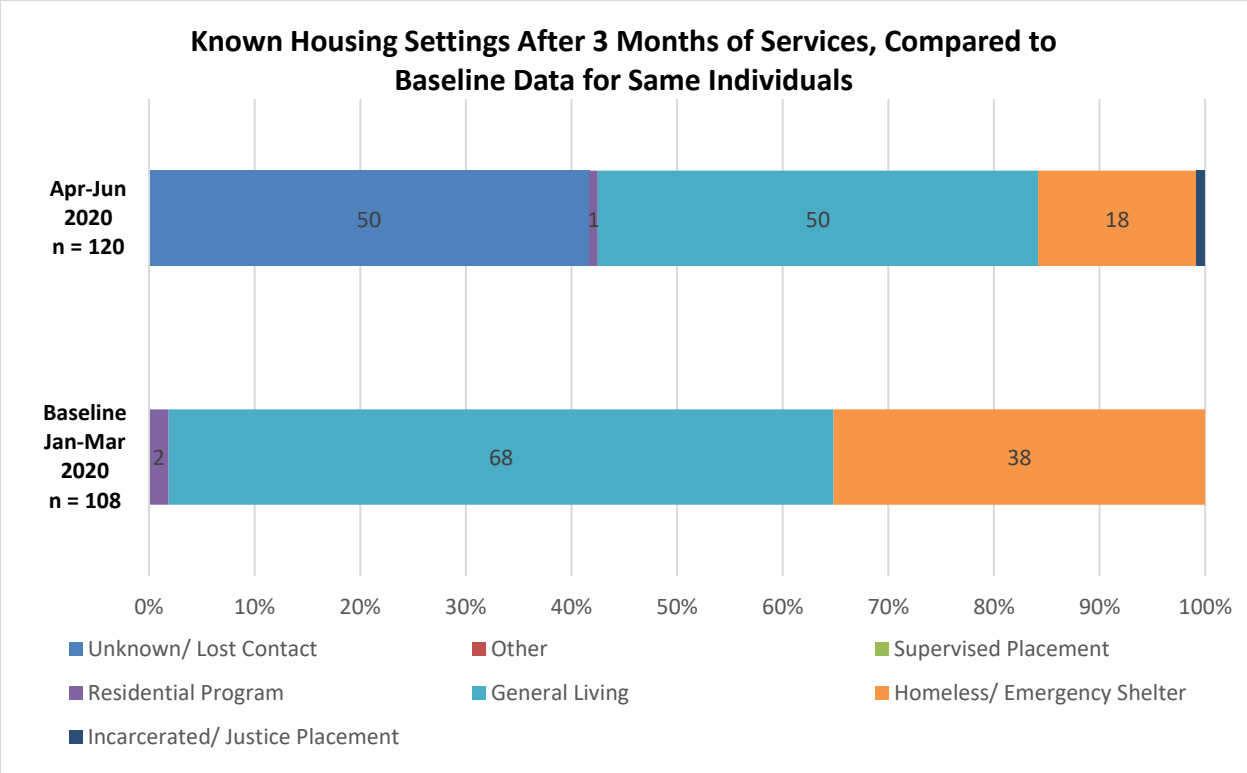
HOUSING STATUS AT START OF SERVICES

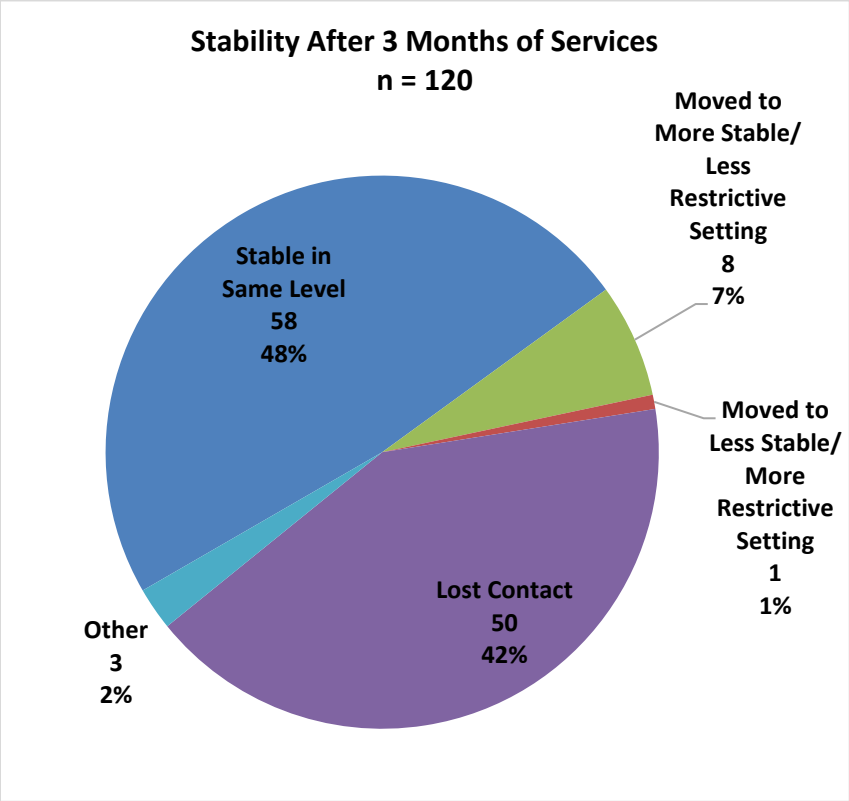
New Participant Housing Status at Intake - Innovation Project



	Jan-Mar 2017	Apr-Jun 2017	Jul-Sep 2017	Oct-Dec 2017	Jan-Mar 2018	Apr-Jun 2018	Jul-Sep 2018	Oct-Dec 2018	Jan-Mar 2019	Apr-Jun 2019	Jul-Sep 2019	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020
Homeless/ Emergency Shelter	0	19	69	58	62	52	30	27	27	19	49	41	38	23
General Living	0	189	88	68	100	54	35	30	74	42	77	50	68	32
Residential Program	0	0	0	1	0	0	1	0	0	1	0	1	2	1
Supervised Placement	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Other	3	14	16	1	1	2	15	16	8	193	17	12	0	0
Unknown	2	15	74	0	69	7	105	93	0	0	0	0	0	12

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





For the 8 people who moved to more stable/less restrictive settings in this quarter 6 transitioned from Homeless/E.S. to General Living, and 2 transitioned from a Residential Program to General Living.

For the 1 person who moved to a less stable/more restrictive setting, they were incarcerated.

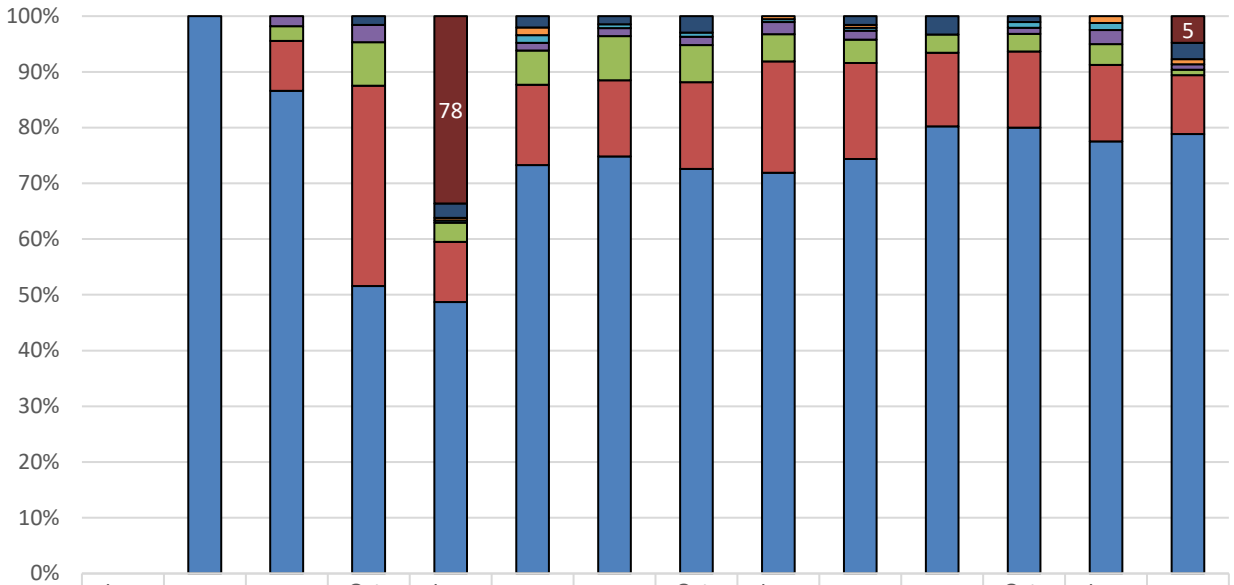
The 3 "Others" did not list their original setting, so it is unclear if the move was positive or negative. One entered sober living, one a hotel, and one moved out of state.

EMERGENCY DEPARTMENT VISITS

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

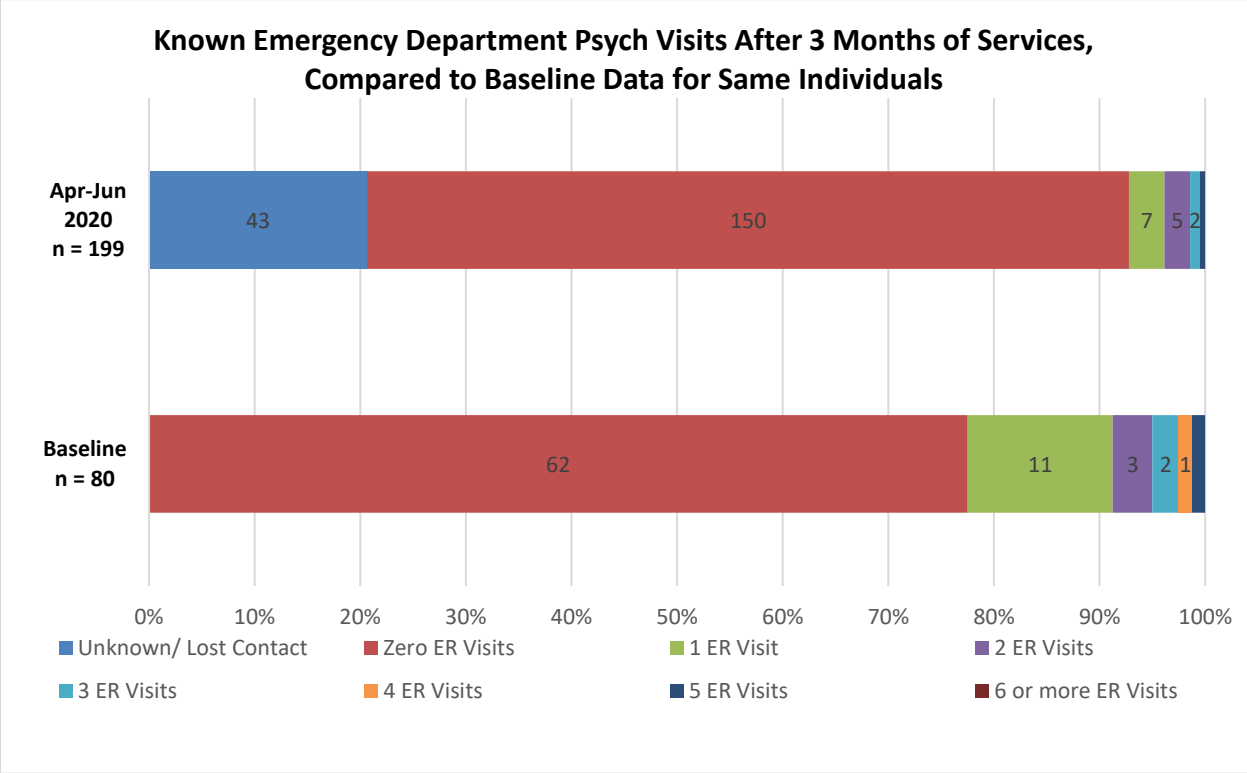
BASELINE EMERGENCY DEPARTMENT PSYCHIATRIC VISITS – PRIOR TO CARE CENTER SERVICES

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

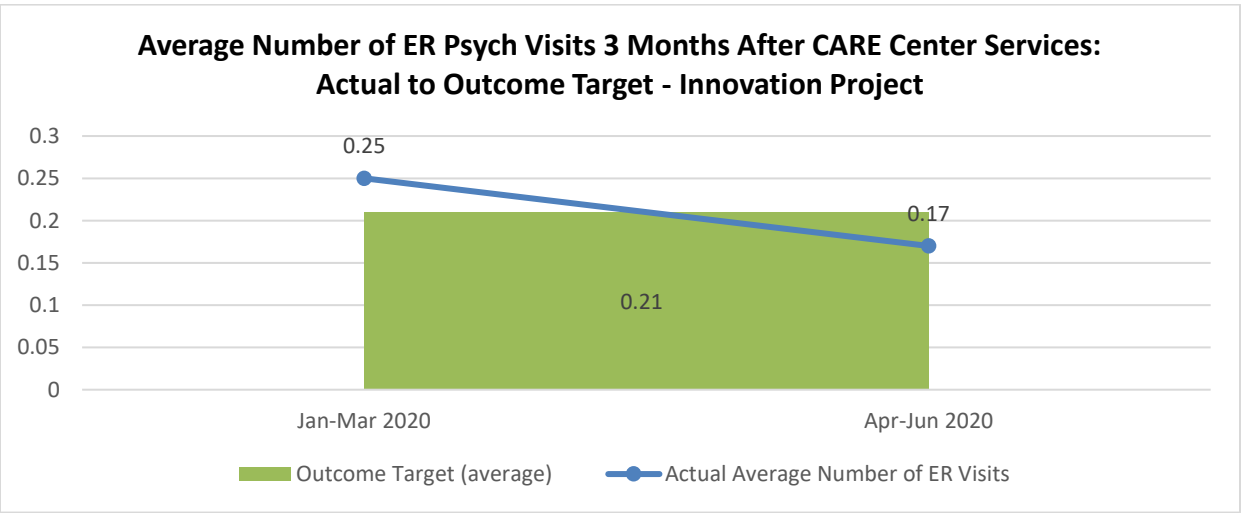


	Jan-Mar 2017	Apr-Jun 2017	Jul-Sep 2017	Oct-Dec 2017	Jan-Mar 2018	Apr-Jun 2018	Jul-Sep 2018	Oct-Dec 2018	Jan-Mar 2019	Apr-Jun 2019	Jul-Sep 2019	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020
Not Collected	Unable to collect for the 1st quarter	0	0	0	78	0	0	0	0	0	0	0	0	5
6 or more ER Visits		0	0	1	6	3	2	4	0	3	3	1	0	3
5 ER Visits		0	0	0	1	2	0	0	1	1	0	0	1	1
4 ER Visits		0	0	0	1	2	1	1	1	1	0	1	1	0
3 ER Visits		0	2	2	0	2	2	2	4	3	0	1	2	1
2 ER Visits		0	3	5	8	9	11	9	9	8	3	3	3	1
1 ER Visit		0	10	23	25	21	19	21	37	33	12	13	11	11
Zero ER Visits		14	97	33	113	107	104	98	133	142	73	76	62	82

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



The average number of ER visits in the prior 6 months for the Jan-Mar 2020 baseline quarter was 0.25 per individual who had visit data reported (excluding all in the Unknown/Lost Contact category). This makes the target number for the 3-month mark in the Apr-Jun 2020 quarter 0.21 or fewer ER visits on average.

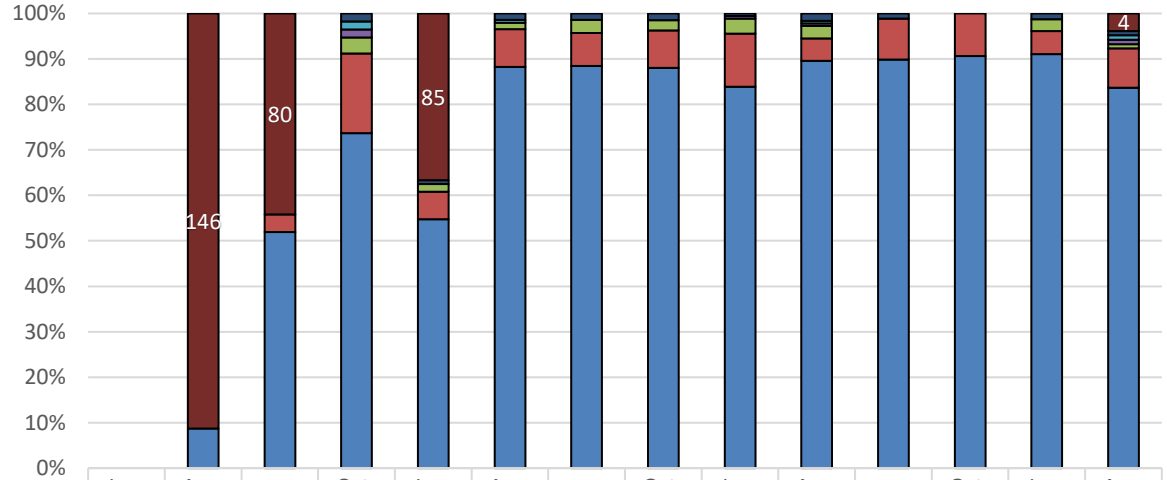


PSYCHIATRIC INPATIENT HOSPITALIZATIONS

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

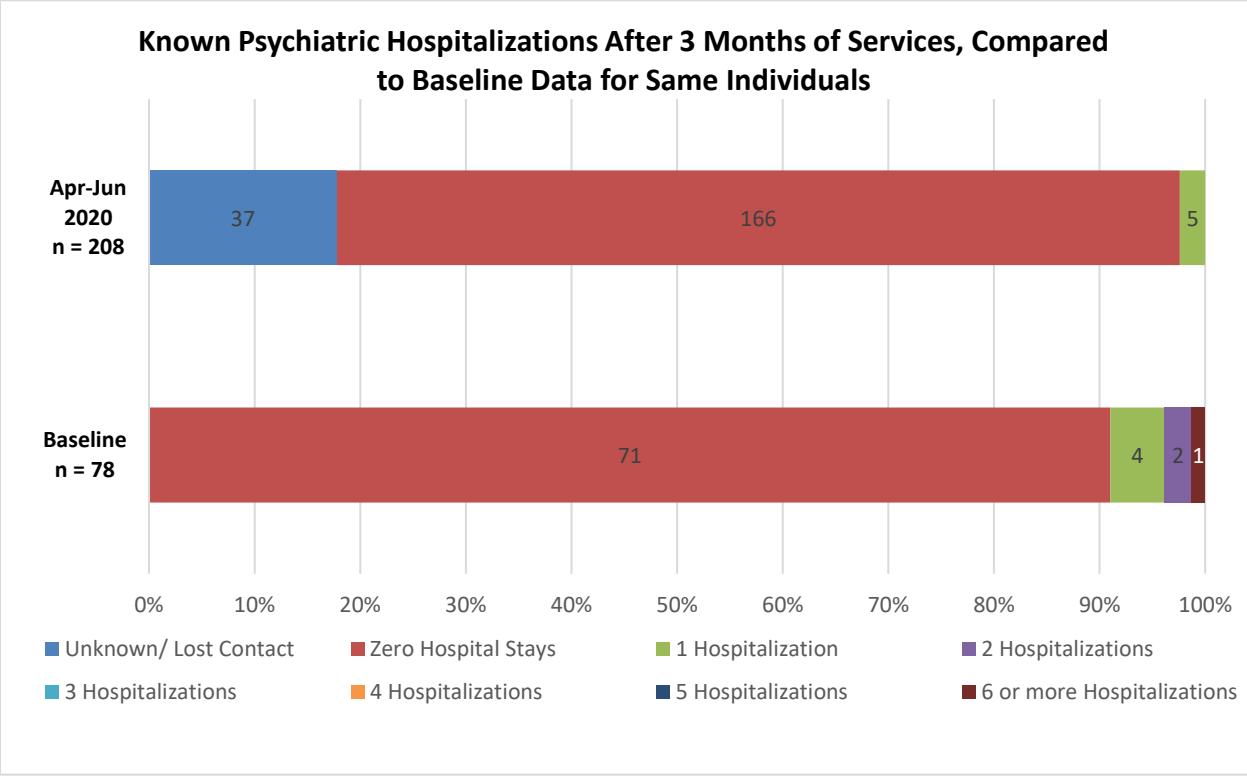
BASELINE PSYCHIATRIC HOSPITALIZATIONS – PRIOR TO CARE CENTER SERVICES

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

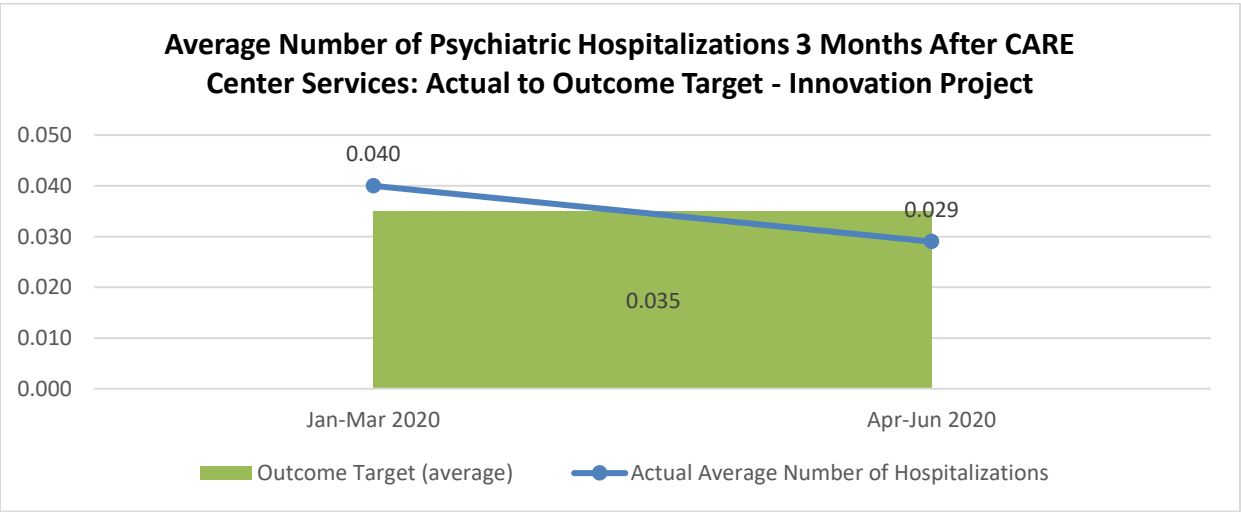


	Jan-Mar 2017	Apr-Jun 2017	Jul-Sep 2017	Oct-Dec 2017	Jan-Mar 2018	Apr-Jun 2018	Jul-Sep 2018	Oct-Dec 2018	Jan-Mar 2019	Apr-Jun 2019	Jul-Sep 2019	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020
Unknown	Unable to collect for the 1st quarter	146	80	0	85	0	0	0	0	0	0	0	0	4
6 or more Hospitalizations		0	0	1	2	2	2	2	1	3	1	0	1	1
5 Hospitalizations		0	0	0	0	0	0	0	0	0	0	0	0	0
4 Hospitalizations		0	0	1	0	1	0	0	0	1	0	0	0	1
3 Hospitalizations		0	0	1	0	0	0	0	1	1	0	0	0	1
2 Hospitalizations		0	0	2	4	2	4	3	6	5	0	0	2	1
1 Hospitalization		0	7	10	14	12	10	11	21	9	8	9	4	9
Zero Hospital Stays		14	94	42	127	128	123	118	151	163	80	87	71	87

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



The average number of psychiatric hospitalizations in the prior 6 months for the Jan-Mar 2020 baseline quarter was 0.040 per individual who had any hospitalizations. This makes the target number for the 3-month mark in the Apr-Jun 2020 quarter 0.035 or fewer hospitalizations on average.

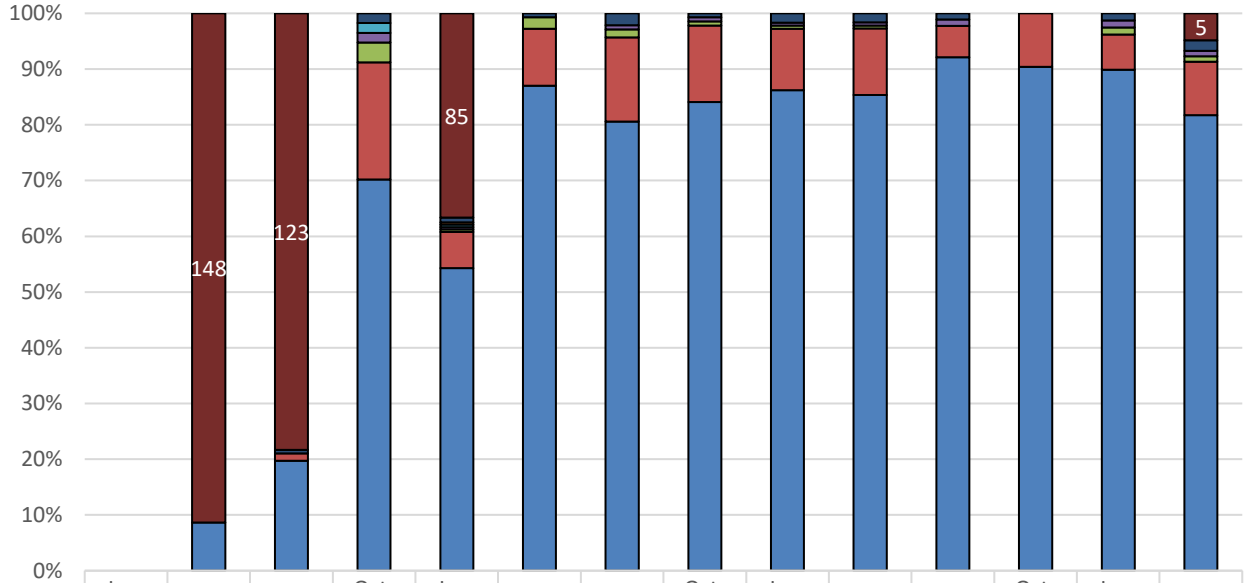


ARRESTS

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

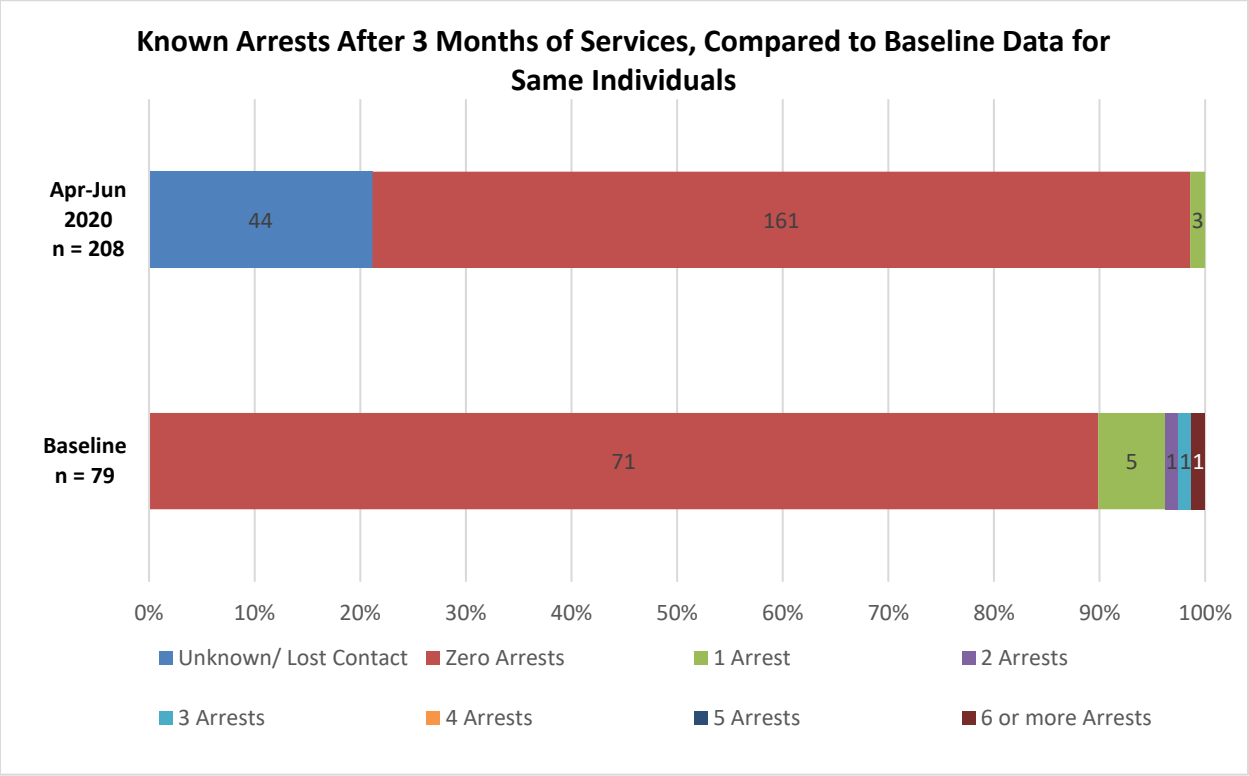
BASELINE ARRESTS – PRIOR TO CARE CENTER SERVICES

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

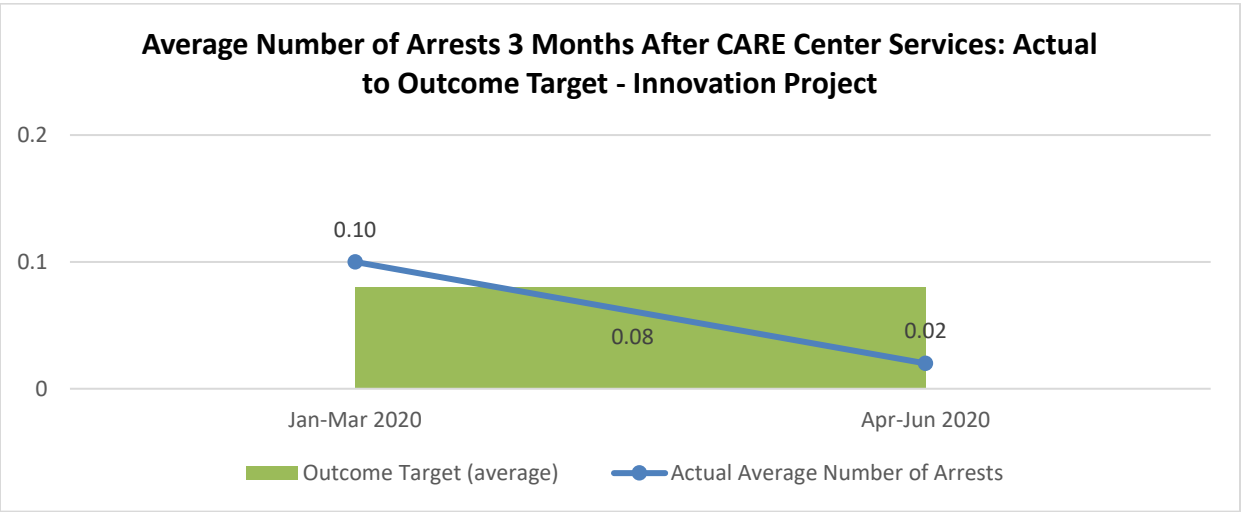


	Jan-Mar 2017	Apr-Jun 2017	Jul-Sep 2017	Oct-Dec 2017	Jan-Mar 2018	Apr-Jun 2018	Jul-Sep 2018	Oct-Dec 2018	Jan-Mar 2019	Apr-Jun 2019	Jul-Sep 2019	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020
Unknown	Unable to collect for the 1st quarter	148	123	0	85	0	0	0	0	0	0	0	0	5
6 or more Arrests		0	1	1	2	1	3	1	3	3	1	0	1	2
5 Arrests		0	0	0	1	0	0	0	0	0	0	0	0	0
4 Arrests		0	0	1	1	0	0	0	0	0	0	0	0	0
3 Arrests		0	0	1	1	0	1	1	1	1	1	0	1	1
2 Arrests		0	0	2	1	3	2	1	1	1	0	0	1	1
1 Arrest		0	2	12	15	15	21	19	20	22	5	9	5	10
Zero Arrests		14	31	40	126	127	112	116	156	157	82	85	71	85

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

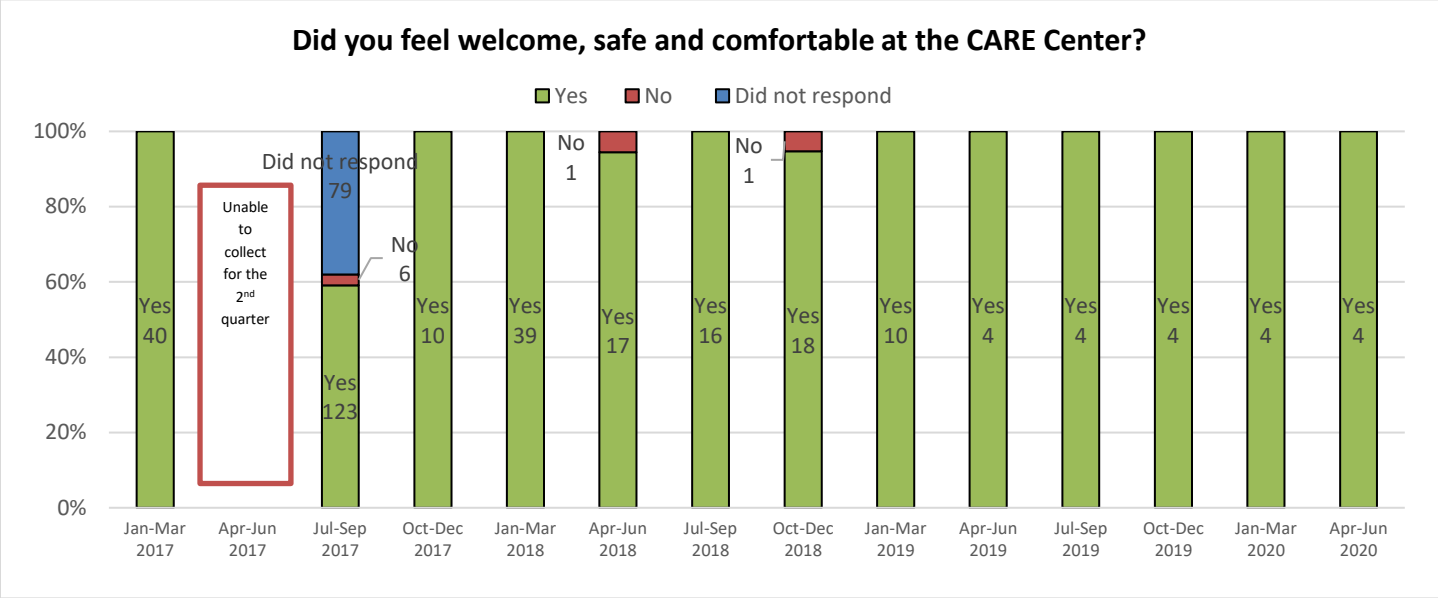


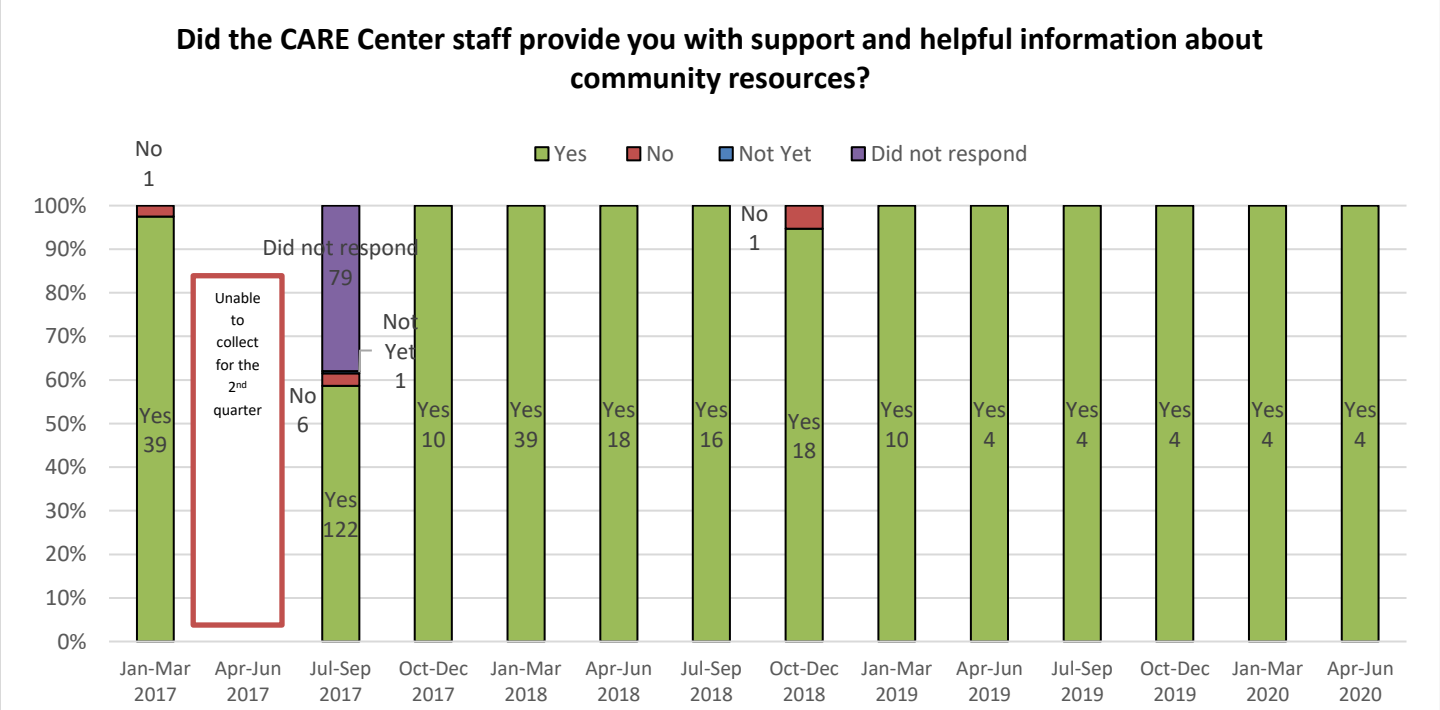
The average number of arrests in the prior 6 months for the Jan-Mar 2020 baseline quarter was 0.10 per individual who had arrest data reported (excluding all in the Unknown/Lost Contact category). This makes the target number for the 3-month mark in the Apr-Jun 2020 quarter 0.08 or fewer arrests on average.

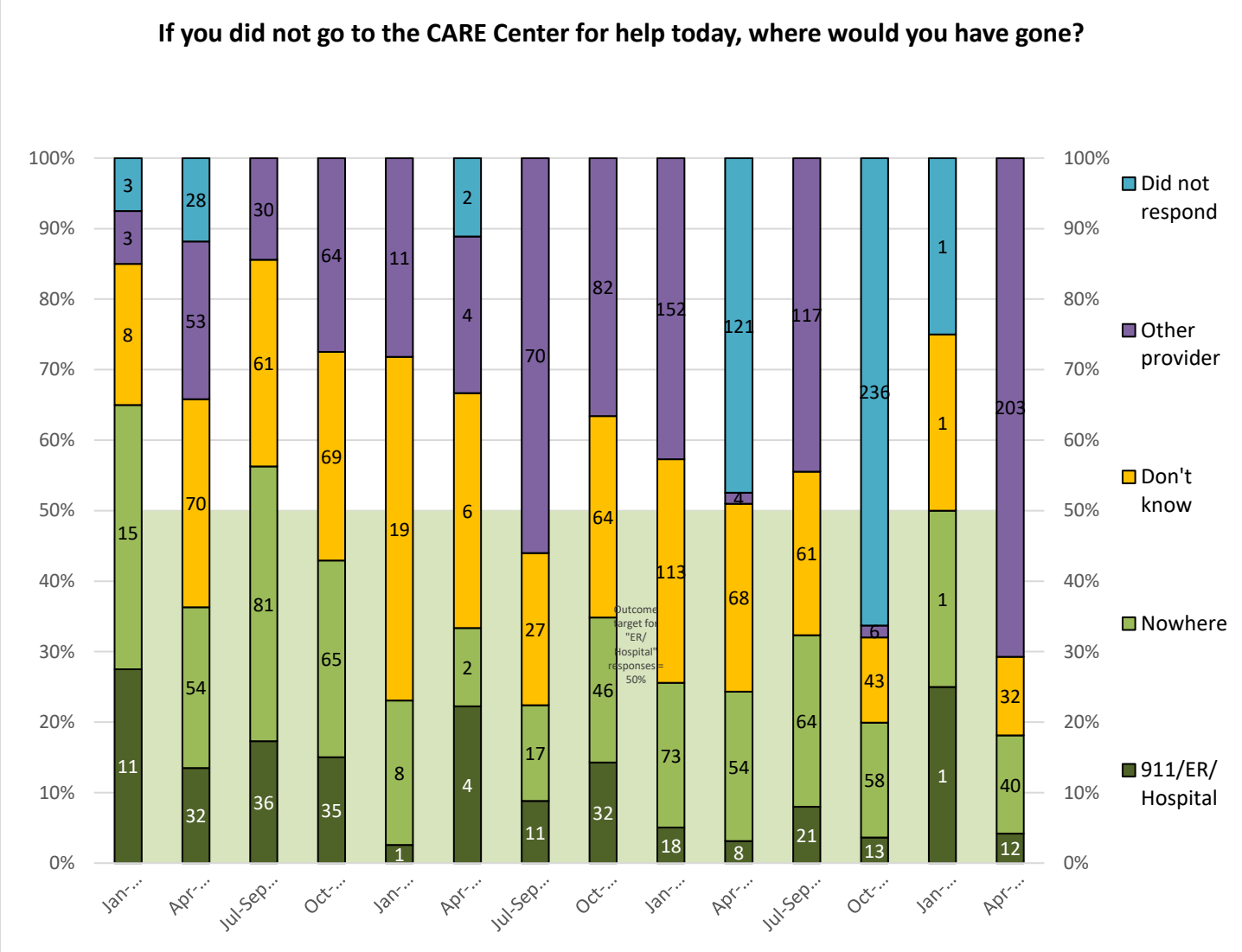


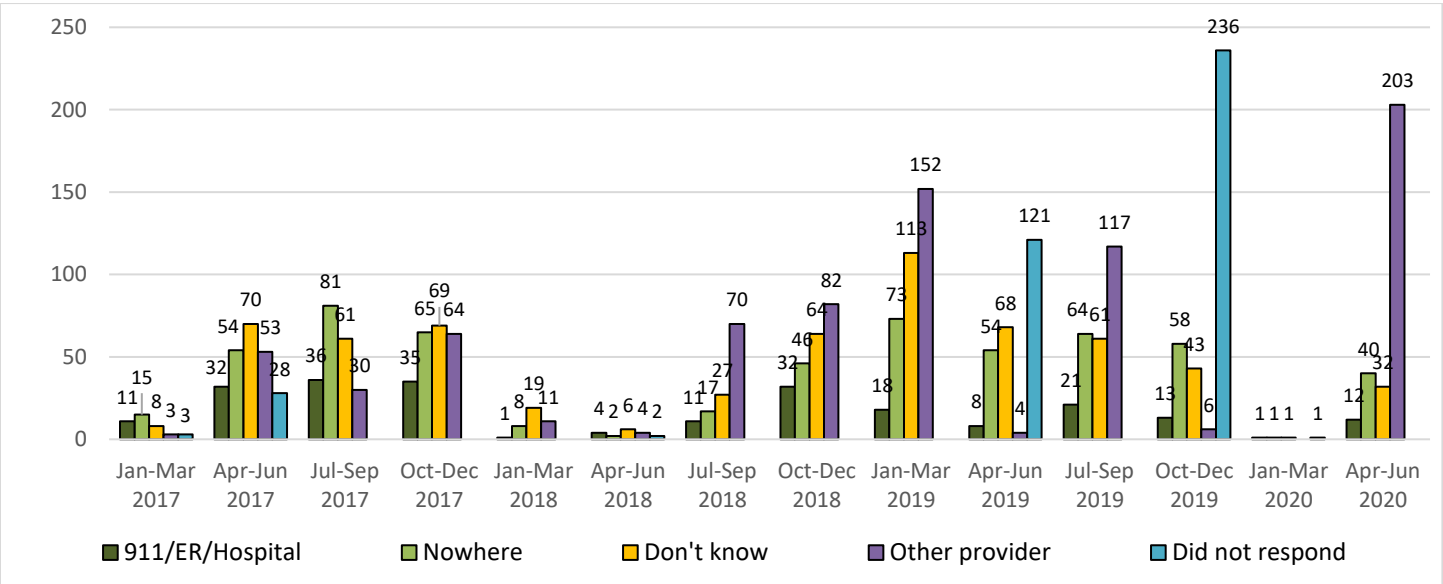
CUSTOMER SURVEYS

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

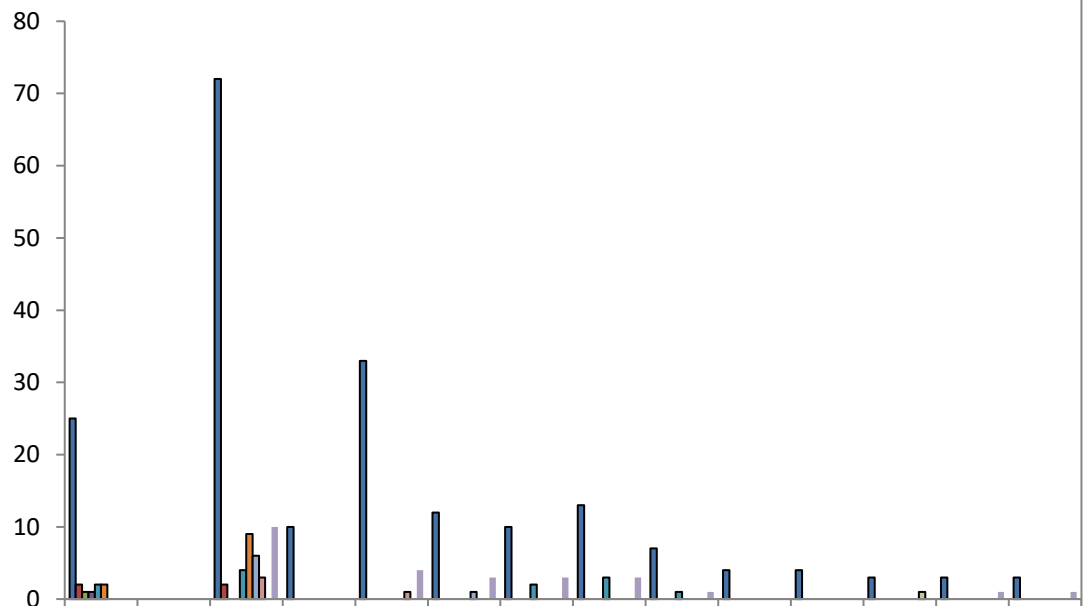





If you did not go to the CARE Center for help today, where would you have gone?
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Did not respond
Other provider
Don't know
Nowhere
911/ER/ Hospital
Outcome target for "ER/ Hospital" responses = 50%
Jan-...
Apr-...
Jul-Sep...
Oct-...
Jan-...
Apr-...
Jul-Sep...
Oct-...
Jan-...
Apr-...
Jul-Sep...
Oct-...
Jan-...
Apr-...


250
200
150
100
50
0
Jan-Mar 2017
Apr-Jun 2017
Jul-Sep 2017
Oct-Dec 2017
Jan-Mar 2018
Apr-Jun 2018
Jul-Sep 2018
Oct-Dec 2018
Jan-Mar 2019
Apr-Jun 2019
Jul-Sep 2019
Oct-Dec 2019
Jan-Mar 2020
Apr-Jun 2020
911/ER/Hospital
Nowhere
Don't know
Other provider
Did not respond

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



	Jan-Mar 2017	Apr-Jun 2017	Jul-Sep 2017	Oct-Dec 2017	Jan-Mar 2018	Apr-Jun 2018	Jul-Sep 2018	Oct-Dec 2018	Jan-Mar 2019	Apr-Jun 2019	Jul-Sep 2019	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020
Happy with experience/ services	25		72	10	33	12	10	13	7	4	4	3	3	3
Medication	2	Unable to collect for the 2nd quarter	2	0	0	0	0	0	0	0	0	0	0	0
Dental Care	1		0	0	0	0	0	0	0	0	0	0	0	0
Services for alcoholics in crisis	1		0	0	0	0	0	0	0	0	0	0	0	0
More and/or different groups	2		4	0	0	0	2	3	1	0	0	0	0	0
Other facility amenities (music, TV, coffee, snacks etc.)	2		9	0	0	0	0	0	0	0	0	0	0	0
More staff/ better trained staff	0		6	0	0	1	0	0	0	0	0	0	0	0
Food & clothing	0		3	0	1	0	0	0	0	0	0	0	0	0
Immediate Shelter	0		0	0	0	0	0	0	0	0	0	1	0	0
Other	0		10	0	4	3	3	3	1	0	0	0	1	1

Data as of: 8/28/2020

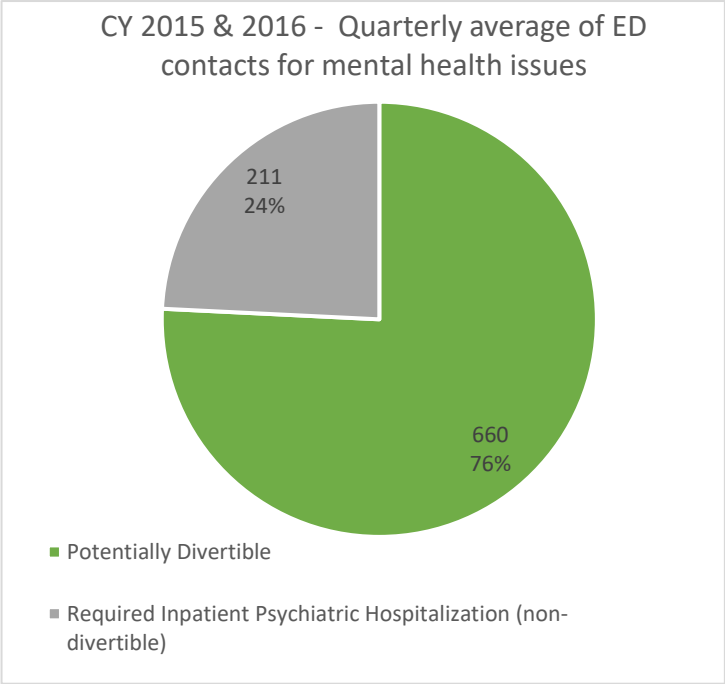
Innovation Project Outcome Tracking – Shasta County Emergency Department Contacts over Time

Appendix M

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

One additional consideration which was not identified in the original plan is the impact of community-wide catastrophes and pervasive trauma to everyone in Shasta county and the surrounding areas. Thousands of people were displaced by the Carr, Delta, Hirz, Camp and other fires in summer 2018, with historic numbers of homes destroyed and lives lost. Winter 2018/19 was also difficult on the community with record snowfall, pervasive power outages, and widespread property damage. The COVID-19 pandemic struck the entire world the end of 2019 and continues to current date. All of this has had a huge impact on the emotional and mental well-being of everyone living in the greater North State area, and it remains to be seen how much data trends could change over time, based on these possible additional needs for support and assistance.

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



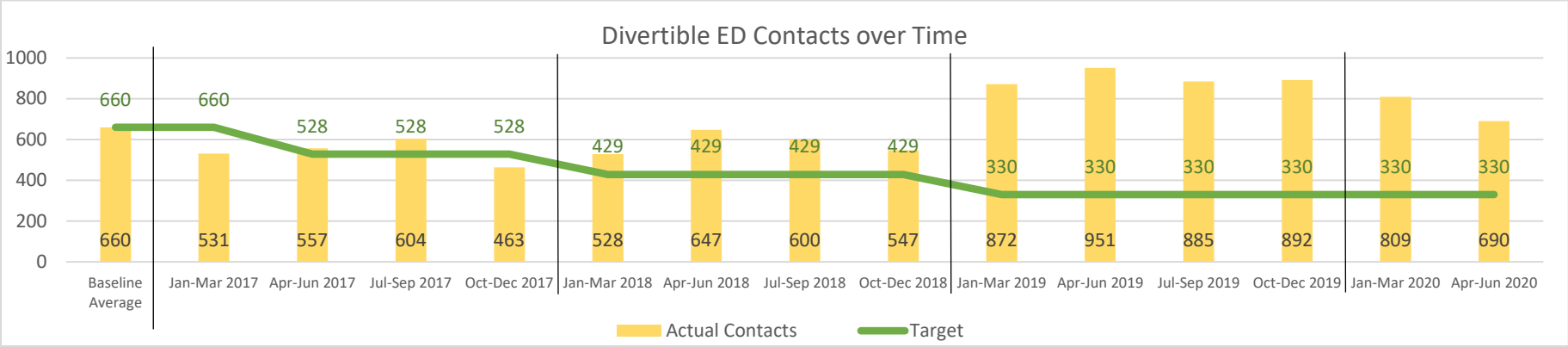
Looking at numbers from the Shasta County hospitals with emergency departments for calendar year 2015 and 2016, the average is 660 potentially divertible contacts for mental health issues (76%), and 211 non-divertible (24%) each quarter.

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

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

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

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



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

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

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