Community Service and Supports

Performance Outcomes

Fiscal Year 2022-2023

Please see the following attached appendices for a detailed breakdown:

Appendix C – Wellness Centers

Appendix D – NAMI

Appendix E – CSI & Full Service Partners

Appendix F – Federally Qualified Health Centers

Appendix G – CARE Center

Appendix H – Crisis Residential Recovery Center

Appendix I – Woodlands

Community Services & Supports (CSS)				
Fiscal Year	2022-2023	Estimated Annual Cost per person		$ 1,595
Total Expenditures	$ 7,560,889	Age Group	# of individuals served	Estimated Annual Cost per group
Estimated # of individuals served	4741	Child & 0-15	401	$ 639,510
		TAY 16-25	596	$ 950,494
		Adults 26-59	2907	$ 4,636,048
		Older Adults 60+	837	$ 1,334,837

Full Service Partnership (FSP)				
Fiscal Year	2022-2023	Estimated Annual Cost per person		$ 30,759
Total Expenditures	$ 3,168,181	Age Group	# of individuals served	Estimated Annual Cost per group
Estimated # of individuals served	103	Child & 0-15	5	$ 153,795
		TAY 16-25	18	$ 553,663
		Adults 26-59	66	$ 2,030,097
		Older Adults 60+	14	$ 430,627

Prevention and Early Intervention

Performance Outcomes

Fiscal Year 2022-2023

Please see the following attached appendices for a detailed breakdown:

Appendix J – Triple P

Appendix K – Botvin

Appendix L – Adverse Childhood Experiences

Appendix M – Stand Against Stigma

Appendix N – Suicide Prevention

Appendix O – PEI Demographics Report (includes IMPACT, Stigma, Suicide Prevention)

Prevention & Early Intervention (PEI)				
Fiscal Year	2022-2023	Estimated Annual Cost per person		$ 479
Total Expenditures	$ 2,545,894	Age Group	# of individuals served	Estimated Annual Cost per group
Estimated # of individuals served	5316	Child & 0-15	339	$ 162,351
		TAY 16-25	65	$ 31,129
		Adults 26-59	369	$ 176,718
		Older Adults 60+	23	$ 11,015
		Unknown	4520	$ 2,164,680

There is an additional 35,000 plus individuals served virtually through online marketing, websites, and campaigns.

Innovation

Performance Outcomes

Fiscal Year 2022-2023

Please see the following attached appendices for a detailed breakdown:

Appendix P – Hope Park

Appendix Q – Psychiatric Advance Directives

Innovation (INN)				
Fiscal Year	2022-2023	Estimated Annual Cost per person		$ 1,985
Total Expenditures	$ 192,592	Age Group	# of individuals served	Estimated Annual Cost per group
Estimated # of individuals served	97	Child & 0-15	66	$ 131,042
		TAY 16-25	22	$ 43,681
		Adults 26-59	0	$ -
		Older Adults 60+	9	$ 17,869

Note: Psychiatric Advance Directives (PADs) was not factored in the above chart. PADs is an ongoing grass roots project. During Phase I the project created a statewide PADs template, a PADs facilitator training curriculum and present a train-the-trainer model for facilitation, a sustainable technology that is an easily reproducible approach that can be used across California and focused on Legislative and policy advocacy to create a legal structure to recognize PADs.

Shasta County Health & Human Services Agency

Effective date: August 13, 2020 Page 1 of 1

POLICY

See also: Mental Health Services Act Community Planning Process Procedure

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

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

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

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

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

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

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

Effective date: August 13, 2020 Page 1 of 1

PROCEDURE

See also: Mental Health Services Act Community Planning Process Policy

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

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

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

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

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

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

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

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

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

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

   b. Any new **Innovations project proposals** must also be reviewed through the process noted in item 3a.

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

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

a. People who have severe mental illness

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

c. People who provide mental health services

d. Law enforcement agencies

e. Educators

f. Social services agencies

g. Veterans

h. Providers of alcohol and drug services

i. Health care organizations

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

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

Shasta County Health & Human Services Agency

MHSA Stakeholder Demographics

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

The number of responses varied by question. The number of responses received were 22, but not every survey was answered fully. To protect participant confidentiality, only summary statistics are provided below.

Q1) How many years old are you?

- Mean Age = 53
- Median Age = 57
- Age Range = 26 - 79

Q2) What is your military status?

- >77% of respondents had never served in the military

Q3) What is your primary language?

- >90% identified English as their primary language

Q4) Do you have any disabilities?

- 50% identified as having a disability. Difficulty hearing or having speech understood, chronic health condition/chronic pain, and learning disability were the most reported.

Q5) What is your race/ethnicity?

- >81% identified as being white and <19% identified as a race/ethnicity other than white.

Q6) What is your gender identity?

- >63% identified as female

Q7) What is your sexual orientation?

- >86% identified as heterosexual

CONSUMER PERCEPTION SURVEY

Shasta County Report
May 2023 Survey Period

Prepared by University of California, Los Angeles
Integrated Substance Abuse Programs
December 2023

Table 1A: Surveys Received vs. Surveys Completed - Shasta County

	Received	Completed	Not Completed	% Completed	% Not Completed	Statewide % Completed	Statewide % Not Completed
Family	35	35	0	100.00%	0.00%	78.92%	21.08%
Youth	54	47	7	87.04%	12.96%	76.34%	23.66%
Adult	80	37	43	46.25%	53.75%	73.63%	26.37%
Older Adult	26	12	14	46.15%	53.85%	76.31%	23.69%
Total	**195**	**131**	**64**	**67.18%**	**32.82%**	**75.92%**	**24.1%**

Table 1B: Reasons for not completing the survey by Form Type - Shasta County

	Reason for not completing survey					County %	Statewide %
	Refused	Impairment	Language	Other	Total		
Family	0	0	0	0	0	0.00%	25.23%
Youth	6	0	0	1	7	10.94%	21.46%
Adult	29	2	0	12	43	67.19%	46.78%
Older Adult	4	0	0	10	14	21.88%	6.53%
Total	39	2	0	23	64	100.00%	100.00%

Table 1C: Paper vs. Online Survey Received by Form Type - Shasta County

	Family		Youth		Adult		Older Adult	
	N	%	N	%	N	%	N	%
Online Survey	14	40.00%	8	14.81%	11	13.75%	1	3.85%
Paper Survey	21	60.00%	46	85.19%	69	86.25%	25	96.15%
Unknown	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Total	35	100.00%	54	100.00%	80	100.00%	26	100.00%

Table 1D: Surveys Received by Language and Form Type - Shasta County

	Family		Youth		Adult		Older Adult	
	N	%	N	%	N	%	N	%
Arabic								
Armenian								
Chinese								
English	35	100.00%	54	100.00%	80	100.00%	26	100.00%
Farsi								
Hmong								
Khmer								
Korean								
Russian								
Spanish								
Tagalog								
Vietnamese								
Total	35	100.00%	54	100.00%	80	100.00%	26	100.00%

Surveys < 11 nor shown in Table 1D.

Table 2: Demographics - Shasta County

Demographics	Family		Youth		Adult		Older Adult	
	N	%	N	%	N	%	N	%
Gender								
(Multiple responses allowed)								
Female	13	40.63%	21	52.50%	13	46.43%	**	**
Male	19	59.38%	19	47.50%	15	53.57%	**	**
Other	0	0.00%	**	**	0	0.00%	0	0.00%
Ethnicity								
Hispanic								
Yes	**	**	**	**	**	**	**	**
No	23	100.00%	31	65.96%	22	28.21%	**	**
Undecided, Missing	**	**	16	34.04%	56	71.79%	18	100.00%
Race								
(Only one response per client)								
American Indian/Alaska Native	**	**	**	**	**	**	0	0.00%
Asian	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Black	**	**	**	**	**	**	0	0.00%
Native Hawaiian/ Other Pacific Islander	0	0.00%	**	**	0	0.00%	0	0.00%
White/Caucasian	23	100.00%	27	100.00%	21	100.00%	**	**
Other	**	**	**	**	**	**	0	0.00%
Two or more races	**	**	**	**	**	**	**	**
Total (Excludes missing responses)	23	100.00%	27	100.00%	21	100.00%	**	100.00%
How long have you received services here?								
Less Than One Month	4	12.50%	1	2.33%	0	0.00%	1	11.11%
One to 5 Months	10	31.25%	14	32.56%	3	33.33%	2	22.22%
6 Months to One Year	10	31.25%	12	27.91%	2	22.22%	0	0.00%
More Than One Year	8	25.00%	16	37.21%	4	44.44%	6	66.67%
Were the services you received provided in the langauge you prefer?								
Yes	31	96.88%	41	95.35%	30	96.77%	11	100.00%
No	1	3.13%	2	4.65%	1	3.23%	0	0.00%
Was written information available to you in the language you prefer?								
Yes	32	100.00%	39	97.50%	29	96.67%	12	100.00%
No	0	0.00%	1	2.50%	1	3.33%	0	0.00%
What was the primary reason you became involved with this program?								
I decided to come on my own	N/A		N/A		8	27.59%	3	30.00%
Someone else recommended that I come in	N/A		N/A		19	65.52%	7	70.00%
I came in against my will	N/A		N/A		2	6.90%	0	0.00%

****** Data suppressed due to small N and/or meet data suppression requirement

Table 3A: Satisfaction Score by Domain: Family and Youth - Shasta County

	Family					Youth				
	Mean Score	CI	Percent Agree 3.5+	SW* Mean Score	SW % Agree 3.5+	Mean Score	CI	Percent Agree 3.5+	SW* Mean Score	SW % Agree 3.5+
Access	4.58	4.39-4.76	100.0%	4.44	95.0%	4.34	4.14-4.54	93.5%	4.21	91.3%
General satisfaction	4.62	4.45-4.79	97.1%	4.38	93.0%	4.42	4.27-4.57	95.7%	4.21	89.8%
Outcome	4.1	3.89-4.31	87.5%	3.94	78.2%	3.89	3.66-4.11	75.6%	3.82	74.0%
Participation in Treatment Planning	4.35	4.10-4.61	90.3%	4.32	92.2%	4.31	4.14-4.48	91.3%	4.08	84.1%
Cultural Appropriateness	4.78	4.64-4.92	100.0%	4.58	98.0%	4.54	4.38-4.70	97.8%	4.38	95.3%
Social Connectedness	4.45	4.22-4.67	93.8%	4.27	92.9%	4.13	3.90-4.35	91.1%	4.10	89.1%
Functioning	4.08	3.87-4.28	87.1%	3.96	77.7%	3.97	3.76-4.18	77.8%	3.87	74.3%

Table 3B: Satisfaction Score by Domain: Adult and Older Adult - Shasta County

	Adult					Older Adults				
	Mean Score	CI	Percent Agree 3.5+	SW* Mean Score	SW % Agree 3.5+	Mean Score	CI	Percent Agree 3.5+	SW* Mean Score	SW % Agree 3.5+
Access	4.36	4.11-4.60	90.6%	4.33	91.0%	4.63	4.33-4.92	100.0%	4.31	90.6%
General satisfaction	4.46	4.20-4.73	97.5%	4.42	91.1%	4.78	4.55-5.01	100.0%	4.48	93.1%
Outcome	3.99	3.69-4.29	80.7%	4.00	77.4%	4.59	4.28-4.89	100.0%	4.02	79.5%
Participation in Treatment Planning	4.45	4.19-4.72	93.6%	4.33	91.5%	4.71	4.42-4.99	100.0%	4.32	91.5%
Quality	4.33	4.05-4.60	83.9%	4.34	90.6%	4.6	4.24-4.96	91.7%	4.33	91.1%
Social Connectedness	3.86	3.50-4.22	71.0%	3.98	77.1%	4.42	3.95-4.90	83.3%	3.97	79.2%
Functioning	3.96	3.67-4.26	77.4%	3.98	74.5%	4.57	4.19-4.95	90.9%	3.97	75.8%

CI = 95% Confidence Interval

* Statewide

Table 4: Quality of Life Questions: Adult and Older Adult - Shasta County

	Adult****		Older Adult****	
	N	%	N	%
How do you feel about life in general?				
Unhappy				
Mixed				
Satisfied				
How do you feel about the living arrangement where you live?				
Unhappy				
Mixed				
Satisfied				
How do you feel about the privacy you have there?				
Unhappy				
Mixed				
Satisfied				
How do you feel about the prospect of staying on where you currently live for a long period of time?				
Unhappy				
Mixed				
Satisfied				
How do you feel about the way you spend your spare time?				
Unhappy				
Mixed				
Satisfied				
How do you feel about the chance you have to enjoy pleasant or beautiful thing?				
Unhappy				
Mixed				
Satisfied				
How do you feel about the amount of fun you have?				
Unhappy				
Mixed				
Satisfied				

Table 4: Quality of Life Questions: Adult and Older Adult - Shasta County

	Adult****		Older Adult****	
	N	%	N	%
How do you feel about the amount of relaxation in your life?				
Unhappy				
Mixed				
Satisfied				
In general, how often do you get together with a member of your family?				
1-not at all			N/A	N/A
2-Less than once a month			N/A	N/A
3-at least once a month			N/A	N/A
4-at least once a week			N/A	N/A
5-at least once a day			N/A	N/A
8-no family/ not applicable			N/A	N/A
Total				
How do you feel about the way you and your family act toward each other?				
Unhappy				
Mixed				
Satisfied				
no family/ not applicable				
How do you feel about the way things are in general between you and your family?				
Unhappy				
Mixed				
Satisfied				
no family/ not applicable				
How often do you visit with someone who does not live with you?				
Not al all			N/A	N/A
Less than once a month			N/A	N/A
At least once a month			N/A	N/A
At least once a week			N/A	N/A
At least once a day			N/A	N/A
Not applicable			N/A	N/A
Total				

Table 4: Quality of Life Questions: Adult and Older Adult - Shasta County

	Adult****		Older Adult****	
	N	%	N	%
How often do you spend time with someone you consider more than a friend, like a spouse, a boyfriend or a girlfriend?				
Not al all			N/A	N/A
Less than once a month			N/A	N/A
At least once a month			N/A	N/A
At least once a week			N/A	N/A
At least once a day			N/A	N/A
Not applicable			N/A	N/A
Total				
How do you feel about:				
things you do with other people?				
Unhappy				
Mixed				
Satisfied				
the amount of time you spend with other people				
Unhappy				
Mixed				
Satisfied				
the people you see socially				
Unhappy				
Mixed				
Satisfied				
the amount of friendships in your life				
Unhappy				
Mixed				
Satisfied				
During the past month, did you generally have enough money to cover the following items?				
Food (Yes)			N/A	N/A
Clothing (Yes)			N/A	N/A
Housing (Yes)			N/A	N/A
Travelling around for things like shopping, medical appointments, or visiting friends and relatives.			N/A	N/A
Social activities like movies or eating in restaurants			N/A	N/A

Table 4: Quality of Life Questions: Adult and Older Adult - Shasta County

	Adult****		Older Adult****	
	N	%	N	%
In the past month were you a victim of a violent crime such as assault, rape, mugging or robbery				
In the past month were you a victim of nonviolent crimes such as burglary, theft of your property or money, or being cheated				
In the past month, how many times have you been arested for any crimes				
No arrests				
One arrest				
Two arrests				
Three arrests				
Four or more arrests				
How do you feel about how safe you are on the streets in your neighborhood				
Unhappy				
Mixed				
Satisfied				
How do you feel about how safe you are where you live				
Unhappy				
Mixed				
Satisfied				
How do you feel about the protection you have against being robbed or attacked				
Unhappy				
Mixed				
Satisfied				
How do you feel about your health in general				
Unhappy				
Mixed				
Satisfied				
How do you feel about your physical condition				
Unhappy				
Mixed				
Satisfied				
How do you feel about your emotional well-being				
Unhappy				
Mixed				
Satisfied				

N/A = Question not asked in the survey
**** No surveys

Table 5: Medication, School Attendance and Living Situation: Family and Youth - Shasta County

	Family		Youth	
	N	**%**	**N**	**%**
Are you on medication for emotional / behavioral problems?	11	35.48%	23	56.10%
In the last year, did you see a medical doctor (or nurse) for a health check-up or because you were sick?				
Yes, in a clinic or office	23	71.88%	25	59.52%
Yes, but only in a hospital ER	1	3.13%	3	7.14%
No	6	18.75%	6	14.29%
Do not remember	2	6.25%	8	19.05%
Total	32	100.00%	42	100.00%
Approximately, how long have you received services here?				
Less than One Month	4	12.50%	1	2.33%
One to Five Months	10	31.25%	14	32.56%
Six Months to One Year	10	31.25%	12	27.91%
More Than one Year	8	25.00%	16	37.21%
Total	32	100.00%	43	100.00%
School Suspension				
Services more than 1 year:				
Was your child/ you expelled or suspended from school in the past 12 months?	1	11.11%	3	13.64%
Was your child/ you expelled or suspended from school in the 12 months prior to that?	1	11.11%	6	19.35%
Over the last year, number of days you were in school:				
Greater	2	25.00%	12	63.16%
About the same	5	62.50%	4	21.05%
Less	0	0.00%	2	10.53%
Does not apply	1	12.50%	1	5.26%
Total	8	100.00%	19	100.00%

Table 5: Medication, School Attendance and Living Situation: Family and Youth - Shasta County

	Family		Youth	
	N	**%**	**N**	**%**
Services less than 1 year:				
Was your child/ you expelled or suspended from school since beginning services?	6	25.00%	7	25.00%
Was your child/you expelled or suspended during the 12 months prior to that?	7	29.17%	7	24.14%
Since starting to receive services, the number of days your child/you were in school:				
Greater	6	26.09%	7	28.00%
About the same	10	43.48%	16	64.00%
Less	1	4.35%	0	0.00%
Does not apply	6	26.09%	2	8.00%
Total	23	100.00%	25	100.00%
Have you lived in any of the following places in the last 6 months?				
With one or both parents	22	62.86%	26	50.00%
With another family member	**	**	**	**
Foster home	**	**	**	**
Therapeutic foster home	0	0.00%	0	0.00%
Crisis shelter	**	**	**	**
Homeless shelter	**	**	0	0.00%
Group home	0	0.00%	**	**
Residential treatment center	0	0.00%	**	**
Hospital	0	0.00%	**	**
Local jail or detention center	0	0.00%	0	0.00%
State correctional facility	0	0.00%	**	**
Runaway/Homeless/On the streets	**	**	**	**
Other (describe)	**	**	**	**

** Data suppressed due to small N and/or to meet data suppression requirement.

Table 6: Arrest History - Adult, Older Adult, Youth and Family - Shasta County

	Adults		Youth	
	%	SW* %	%	SW* %
Have you been arrested in the past 12 months? **				
Yes	10.26%	8.61%	5.33%	3.21%
No	89.74%	91.39%	94.67%	96.79%
Total***	100.00%	100.00%	100.00%	100.00%
Since you began to receive mental health services, have your encounters with police**				
Reduced	10.53%	18.64%	14.08%	7.92%
Stayed the same	10.53%	8.18%	14.08%	5.22%
Increased	5.26%	2.12%	2.82%	1.95%
Not applicable (had no police encounters this year or last year)	73.68%	71.05%	69.01%	84.91%
Total***	100.00%	100.00%	100.00%	100.00%

* Statewide

** Combines consumers who received services for less than AND more than one year at the service location.

*** Excludes missing data.

Wellness Center Annual Report

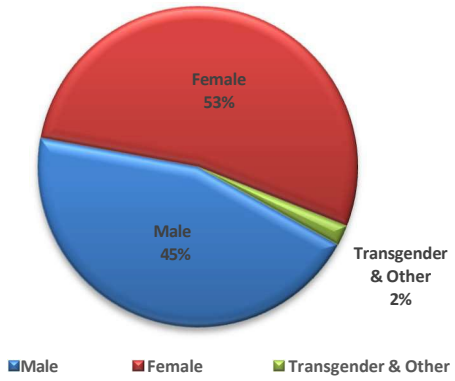
July 2022 through June 2023

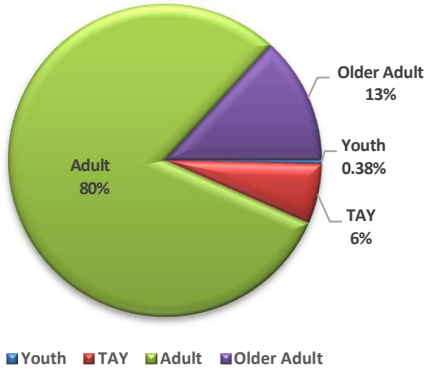
This report provides quarterly data collected from two wellness centers in Shasta County: Sunrise Mountain Wellness Center in Redding and Circle of Friends in Burney. Wellness centers provide support to anyone with mental health challenges through facilitated discussions and activities, transportation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

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

Combined Wellness Center Demographics

Approximately 45% of wellness center attendees were male and 53% female. 2% reported as transgender or other.

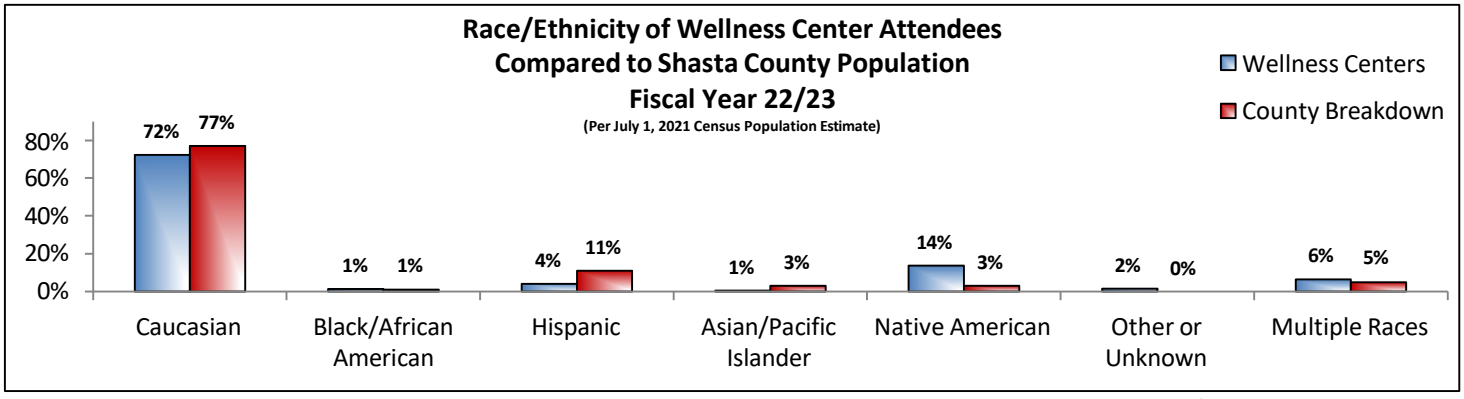




Less than 1% of wellness center attendees were Youths (0-15 years of age), 6% were Transitional Age Youths (16-25 years of age), 80% were Adults (26-59 years of age), 13% were Older Adults (60+ years of age), and none were of unknown age.

Approximately 98% of wellness center attendees were consumers and 2% were family members of consumers.

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

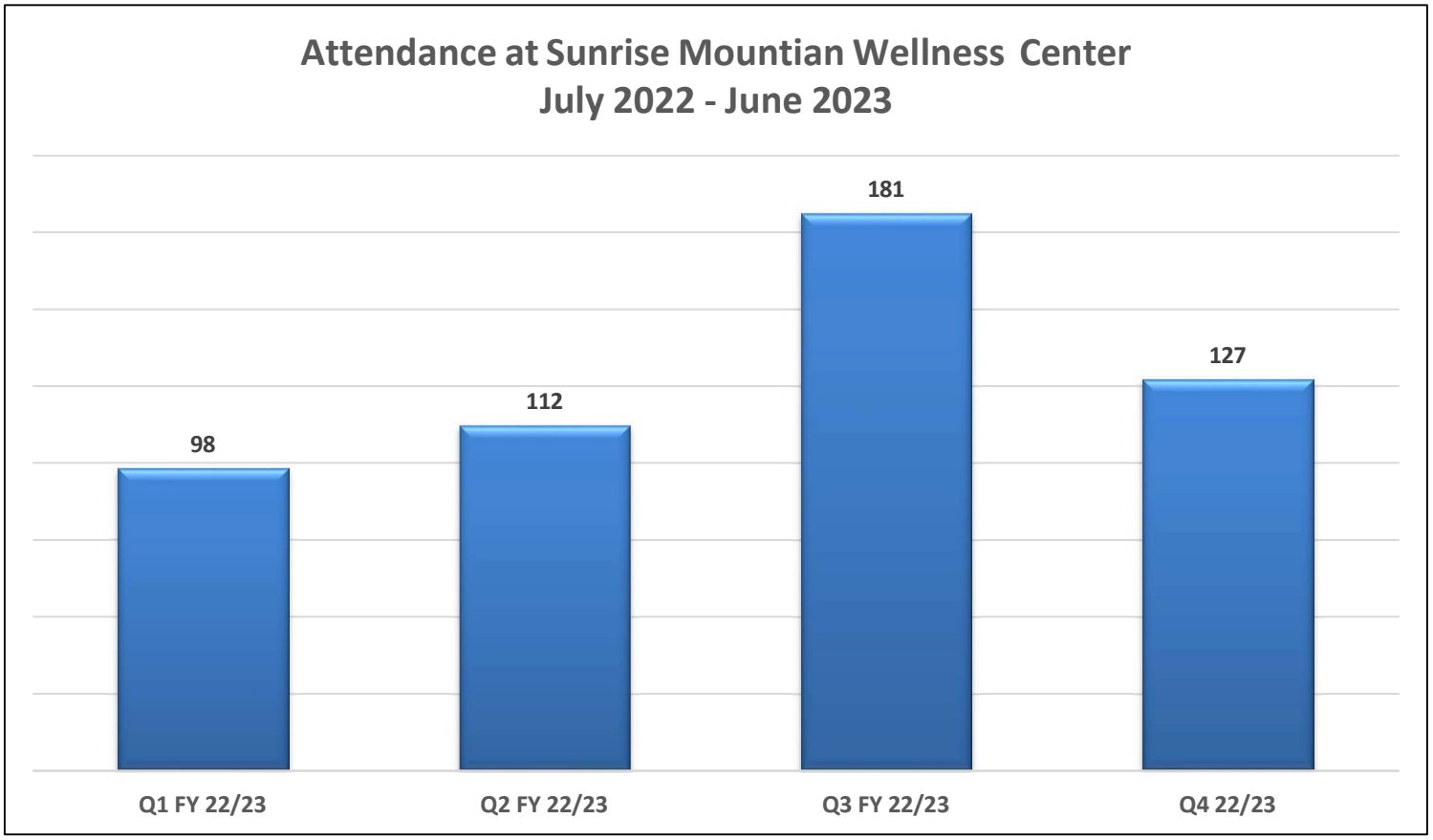


Overall, a total of 230 unique workshops, groups, activities, and meetings were held during the 2022/2023 Fiscal Year.

Sunrise Mountain Wellness Center

Attendance

An average of 129 unduplicated participants attended Sunrise Mountain Wellness Center each quarter.



Demographics

On average, 100% of attendees were consumers. On average, 75% of staff members (including volunteers) were consumers and/or family members. In order to maintain confidentiality, age, gender and race/ethnicity is not broken down by individual wellness center.

Services Provided

Sunrise Mountain Wellness Center's operating hours are 8:00am to 4:30pm Monday - Friday. For the 2022/2023 Fiscal Year, there were 44 different activities, groups and workshops available for participants, with 1,714 opportunities to participate.

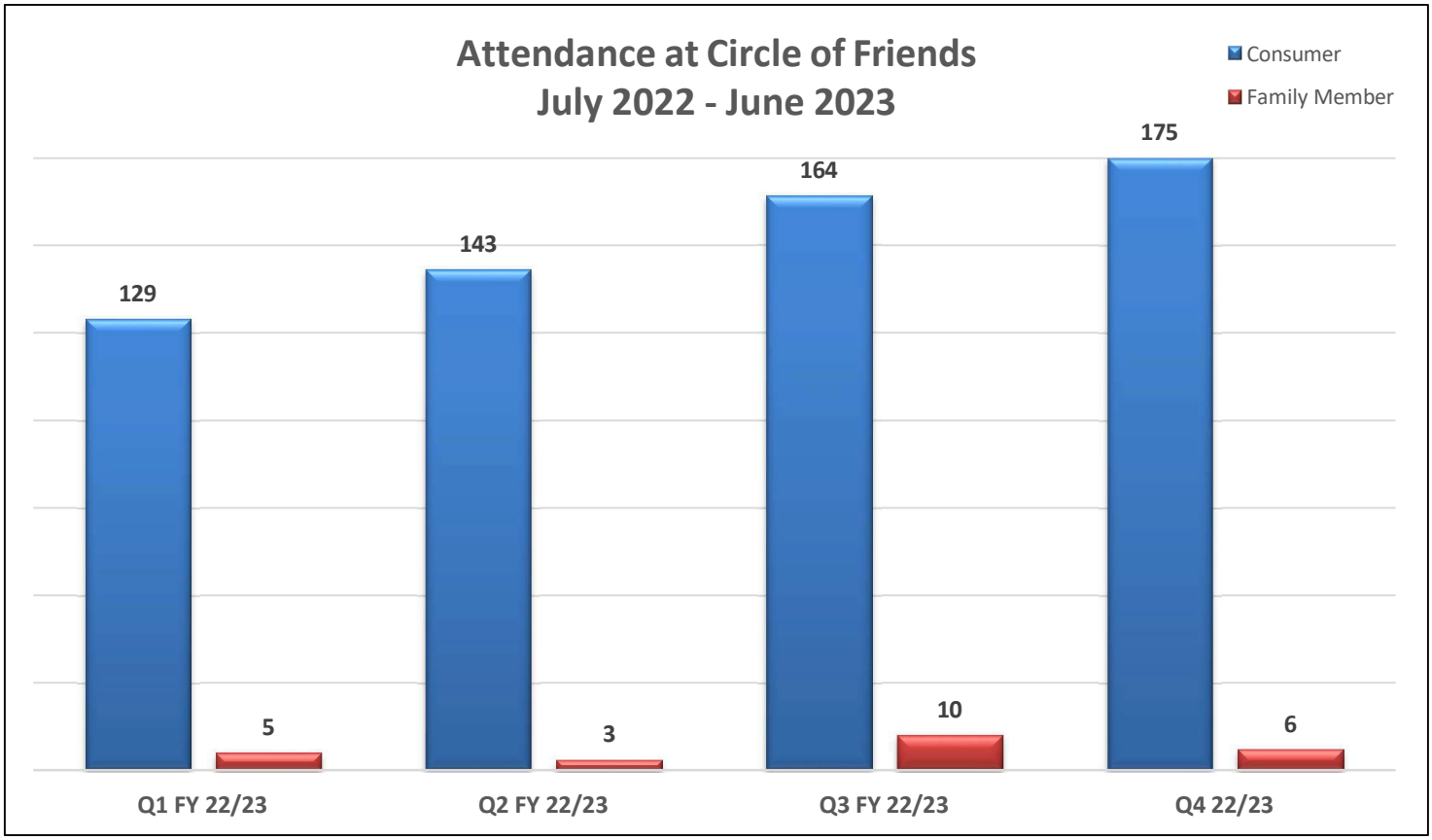
Attendee Direction

Sunrise Mountain Wellness Center had weekly center advisory meetings (open to consumers and family members) to contribute to the direction and planning of the program. From Q1 through Q4, they had a total of 28 unique participants for these meetings.

Circle of Friends Wellness Center

Attendance

An average of 159 unduplicated participants attended Circle of Friends Wellness Center each quarter.



Demographics

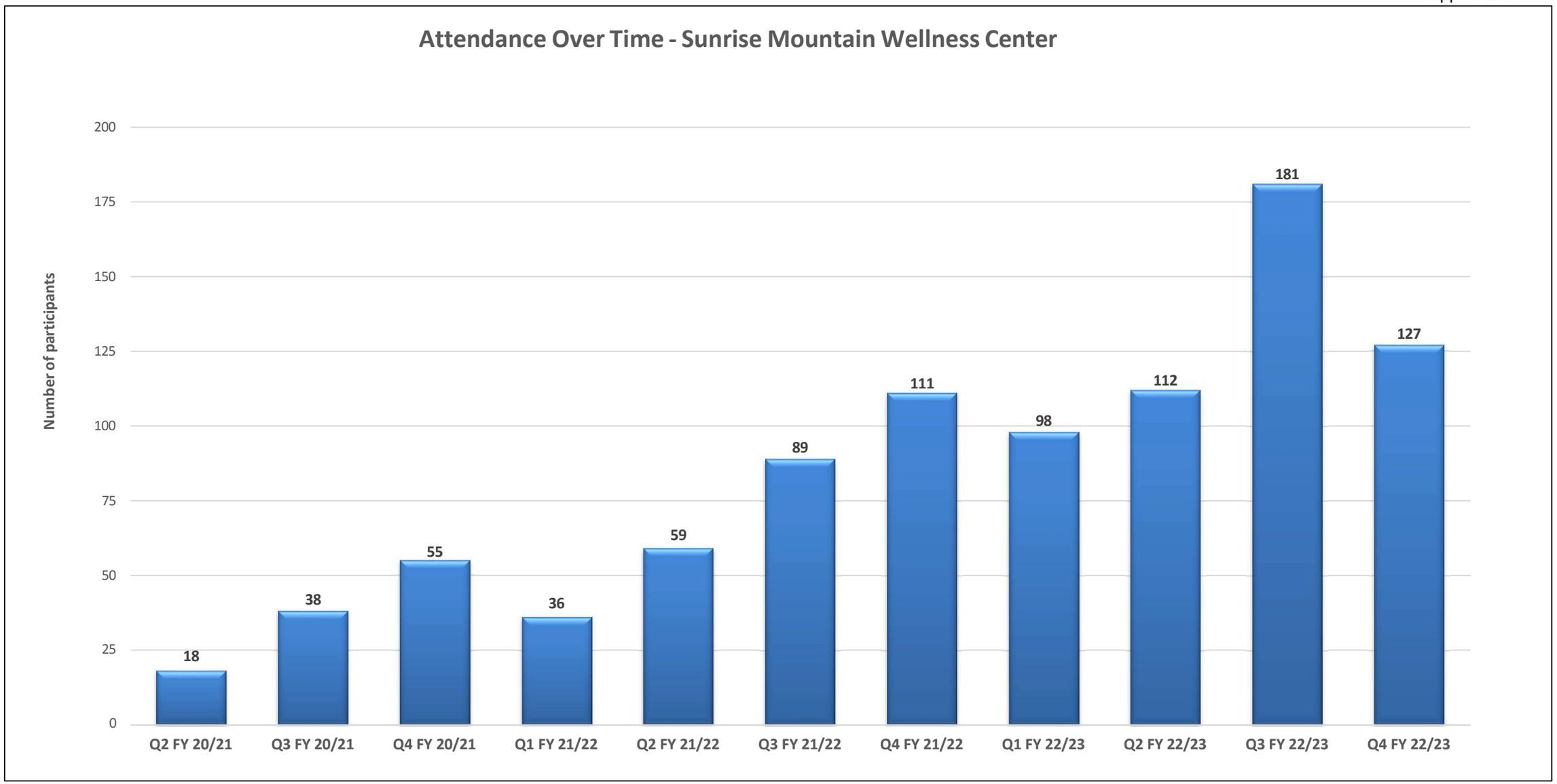
96% of attendees were consumers and 4% were family members. 75% of staff and 84% of volunteers were consumers and/or family members. In order to maintain confidentiality, age, gender and race/ethnicity is not broken down by individual wellness center.

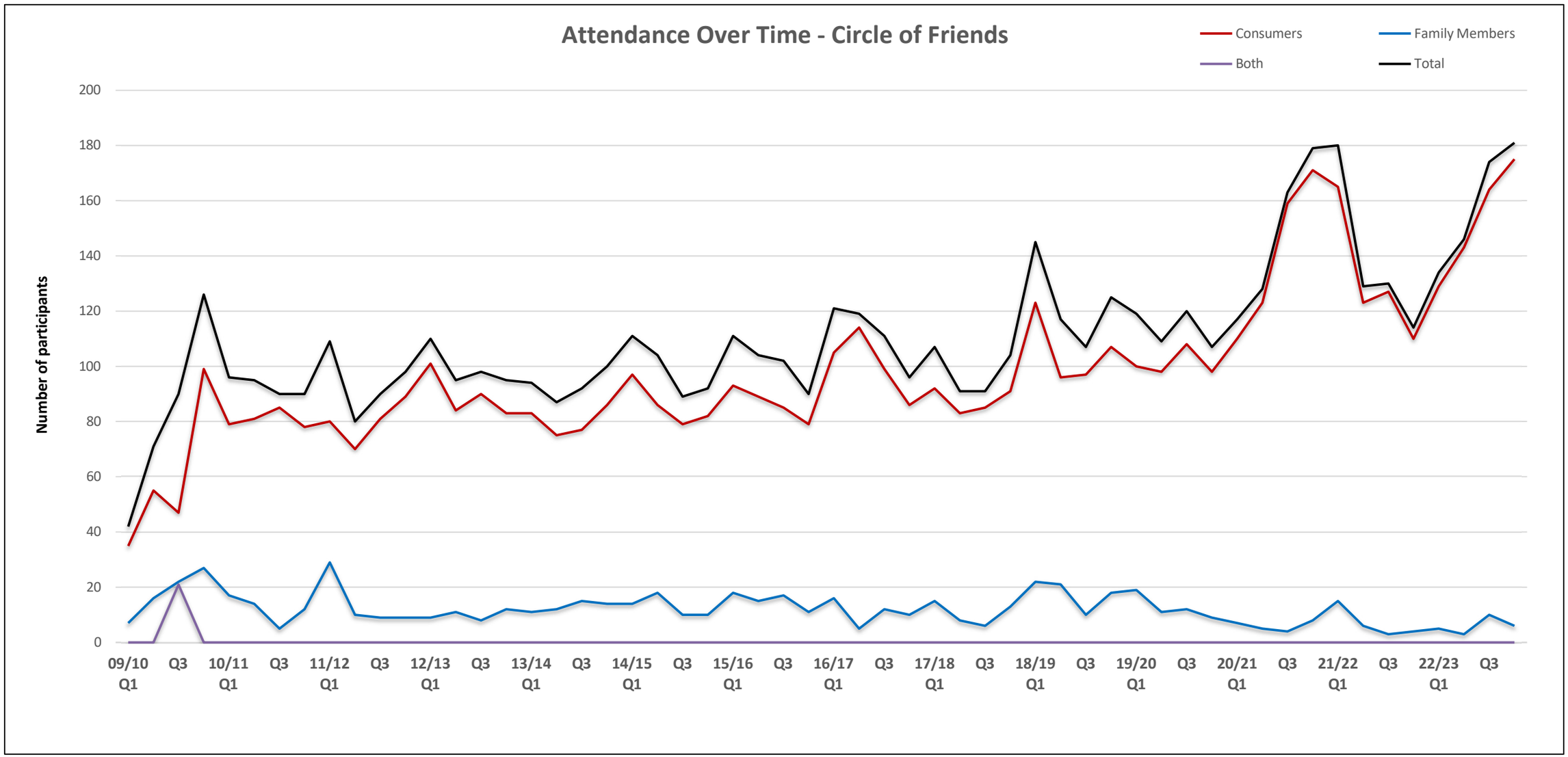
Services Provided

Circle of Friends Wellness Center was open for participant activities Monday, Wednesday, and Friday from 12:30 to 3:30. They are open for food and clothing distribution Monday through Friday from 8:00 to 4:30. During those hours they were available to address most concerns and requests that came their way; everything from using the phone or Wi-Fi, to managing homelessness. Showers were available Tuesdays and Thursdays as staffing was available. For the 2022/2023 Fiscal Year, there were 186 different activities, groups and workshops available for participants, with 719 opportunities to participate.

Attendee Direction

An average of 21 attendees (13%) contributed to the planning and direction of the program each quarter. All decisions relating to the center were based on participant input through activity-specific planning meetings.


Attendance Over Time - Sunrise Mountain Wellness Center
Number of participants
200
175
150
125
100
75
50
25
0
18
38
55
36
59
89
111
98
112
181
127
Q2 FY 20/21
Q3 FY 20/21
Q4 FY 20/21
Q1 FY 21/22
Q2 FY 21/22
Q3 FY 21/22
Q4 FY 21/22
Q1 FY 22/23
Q2 FY 22/23
Q3 FY 22/23
Q4 FY 22/23


Attendance Over Time - Circle of Friends
Consumers
Family Members
Both
Total
Number of participants
200
180
160
140
120
100
80
60
40
20
0
09/10 Q1
Q3
10/11 Q1
Q3
11/12 Q1
Q3
12/13 Q1
Q3
13/14 Q1
Q3
14/15 Q1
Q3
15/16 Q1
Q3
16/17 Q1
Q3
17/18 Q1
Q3
18/19 Q1
Q3
19/20 Q1
Q3
20/21 Q1
Q3
21/22 Q1
Q3
22/23 Q1
Q3

Shasta County Health & Human Services Agency

NAMI Summary Report

July 2022 through June 2023

Program Offerings

NAMI Shasta County offered Family to Family Support Group sessions and one-on-one mentoring sessions during Fiscal Year 22/23. The Family Support Group met every two weeks. Local NAMI president Matilda Grace, along with several volunteers, assisted with the one-on-one mentoring sessions. NAMI volunteers ran the family support group sessions.

In Fiscal Year 22/23, there were 23 Family Support Group Sessions, each lasting 2 hours. There was an average of 10 participants per Family Support Group Sessions.

Family Support Group Sessions (twice a month)				
Length - Hours	2	2	2	2
List Dates Held	07/05/2022	10/04/2022	01/03/2023	04/11/2023
	07/19/2022	10/18/2022	01/17/2023	04/25/2023
	08/02/2022	11/01/2022	02/07/2023	05/09/2023
	08/16/2022	(No Meeting)	02/21/2023	05/23/2023
	09/16/2022	12/20/2022	03/07/2023	06/06/2023
	09/20/2022	12/20/2022	03/21/2023	06/20/2023

In Fiscal Year 22/23, there was an average of 4 hours of facilitated One-on-One Mentoring held per week, with an average of 18 per month.

One-on-One Mentoring				
Hours Per Week	2	Unknown	5	5
Participants	24	10	Unknown	Unknown

In Fiscal Year 22/23, NAMI participated in 2 Special Events: 2023 Mind Matters and 2023 NorCal Pride.

There were no facilitated Family-to-Family programs offered during this reporting period.

Successes: Our website, namishasta.org is now live, and current. Family Support Group meetings are progressing well, with many active participants. NAMI members actively participate or are members of local advisory boards, including Stand Against Stigma, MHADAB, and The Woodlands (assisted housing).

One person has been trained in March; another is scheduled for training in May. Our expectations are to start a class before the end of June.

Our Family Support Group meetings are now hosted at Shasta Community Health Center on Placer St. The newly renovated meeting rooms have updated technology that allow us to reliably offer a hybrid format so individuals can participate through Zoom. New call forwarding system and volunteers to staff the line allowing us to follow up with calls beyond office hours. Phone line is staffed 12 hours/day.

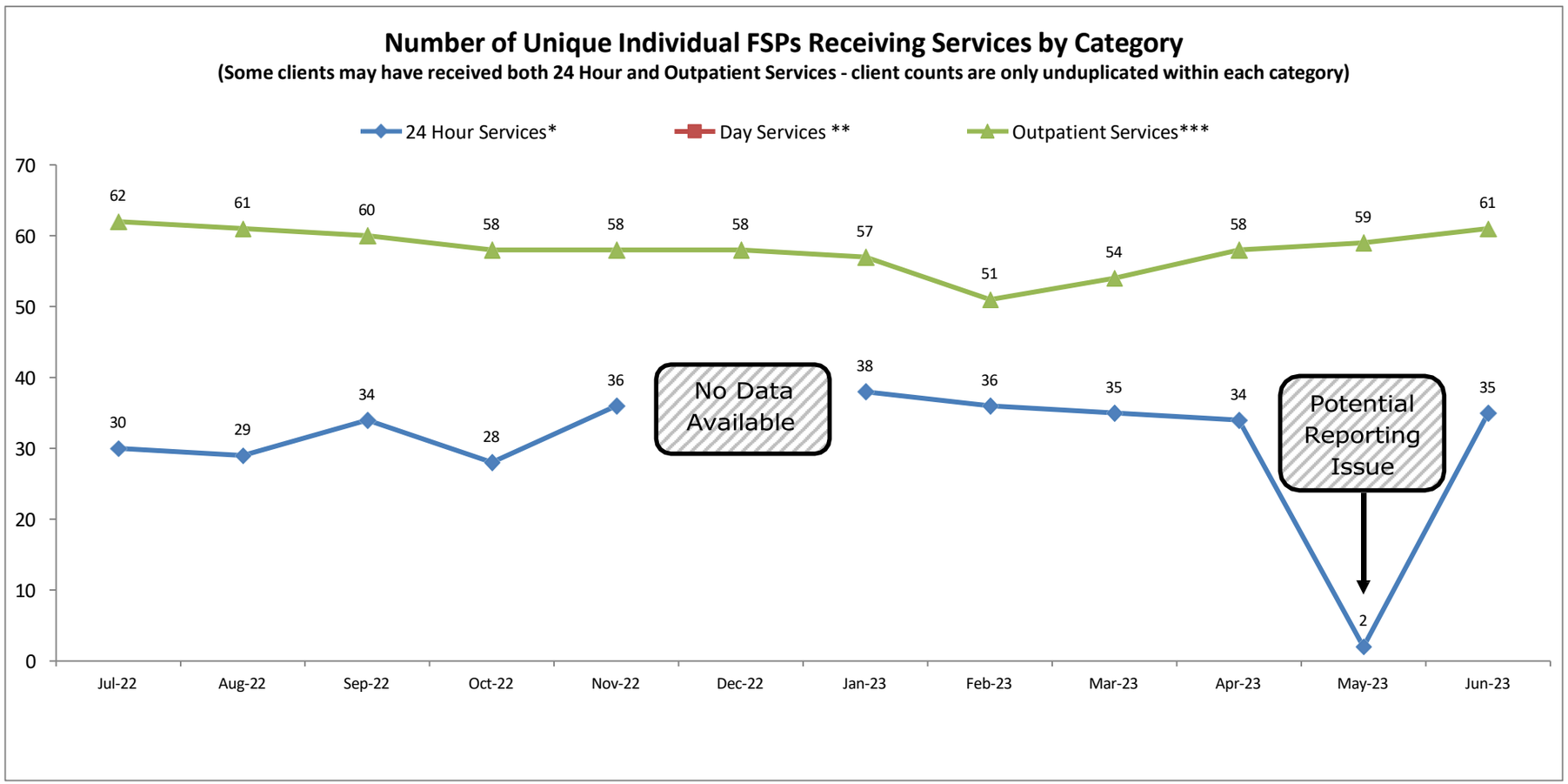
Barriers: The NAMI office is being used on a limited basis. The office is shared with Hill Country CEP (Community Engagement Program) staff, and their occasional clients. Since we are separate agencies, confidentiality and phone calls are a problem when both are in the office at the same time. The new manager for Hill Country CARE Center is working to get a separate office for NAMI.

NAMI is in discussions with Kings View Services to have a person answer calls for NAMI through their office during the day. Many NAMI m embers are in the higher COVID 19 risk groups and are extra cautious. Most meetings now allow online participation. Many NAMI clients and some members lack basic computer knowledge. Many do not know how to use GoToMeeting, let alone login to a computer. Classes are still not being provided due to lack of available trained instructors. We are trying to find people willing to take training, but volunteers have not come forward.

We now have two trained teachers for this program, which is the minimum number of teachers to offer this program. Upcoming date for the next class is September 21st-November 16th 2023.

CSI AND FSP LINKED DATA – FISCAL YEAR 2022/2023

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

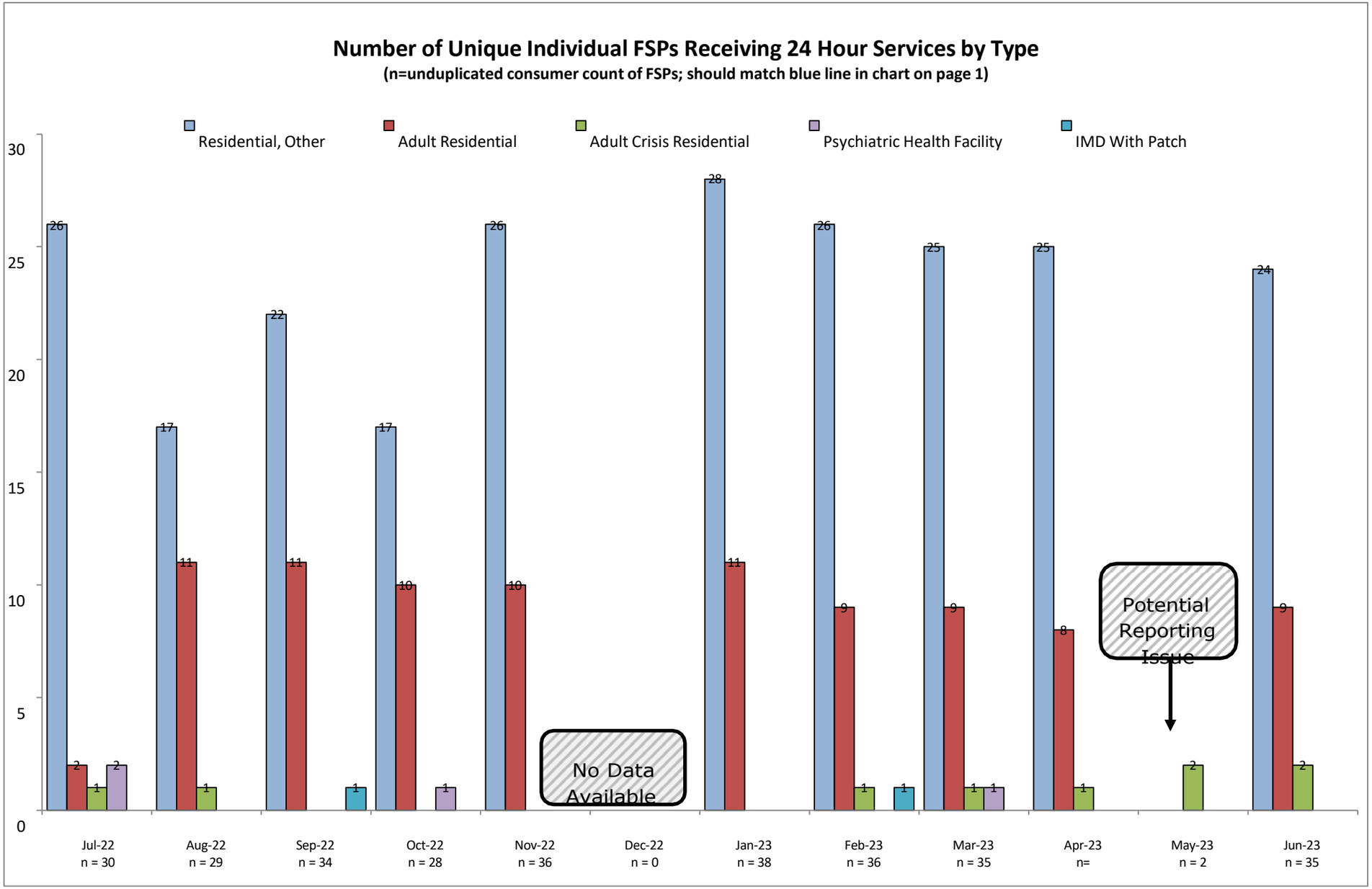


Mental Health Services are divided into three main categories: 24 Hour Services; Day Services; and, Outpatient Services.

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

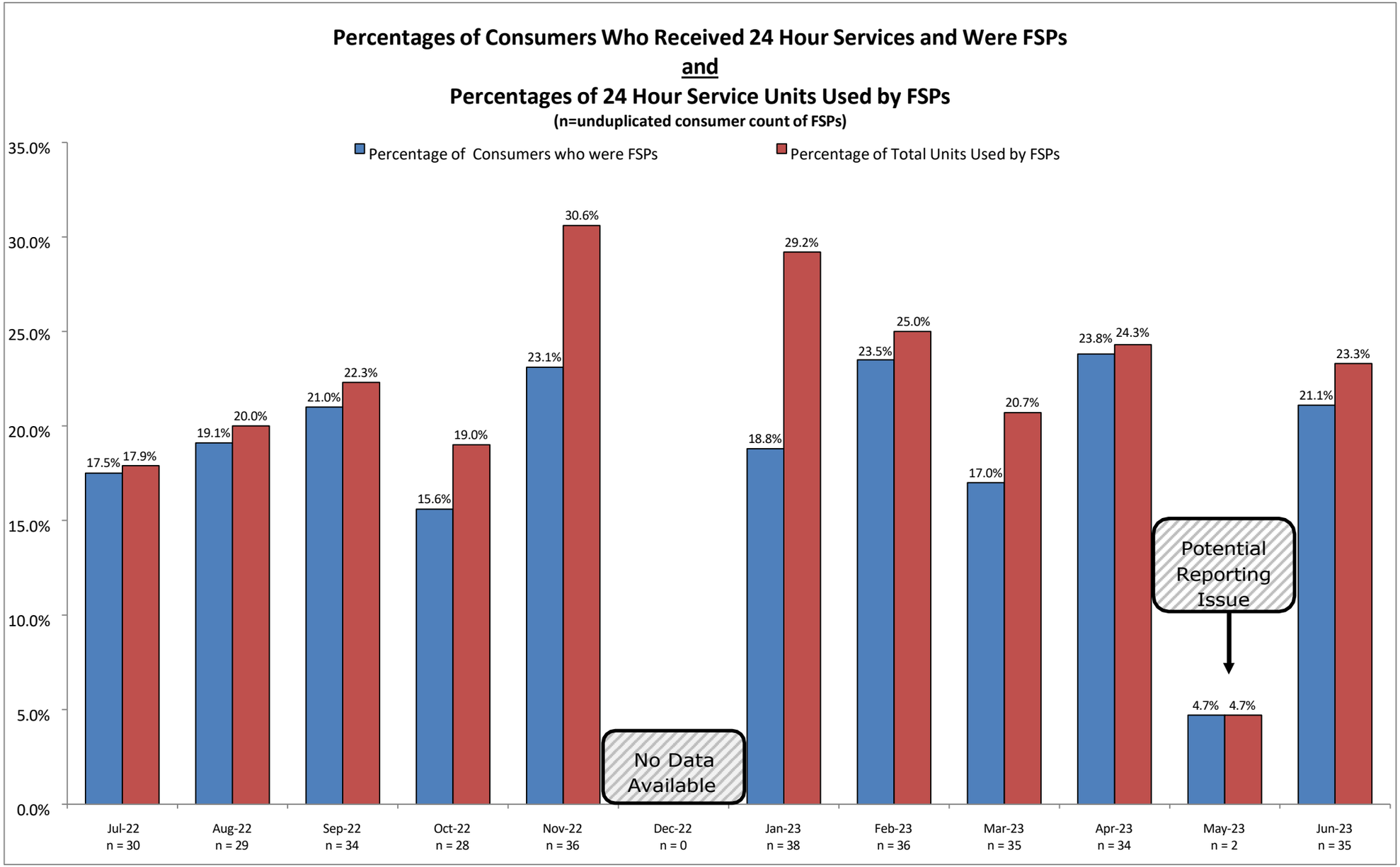
Day Services include things such as Day Treatment or Day Rehabilitation. These services are also billed for by the day, but differ from 24 Hour Services in that they do not provide over-night care.

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



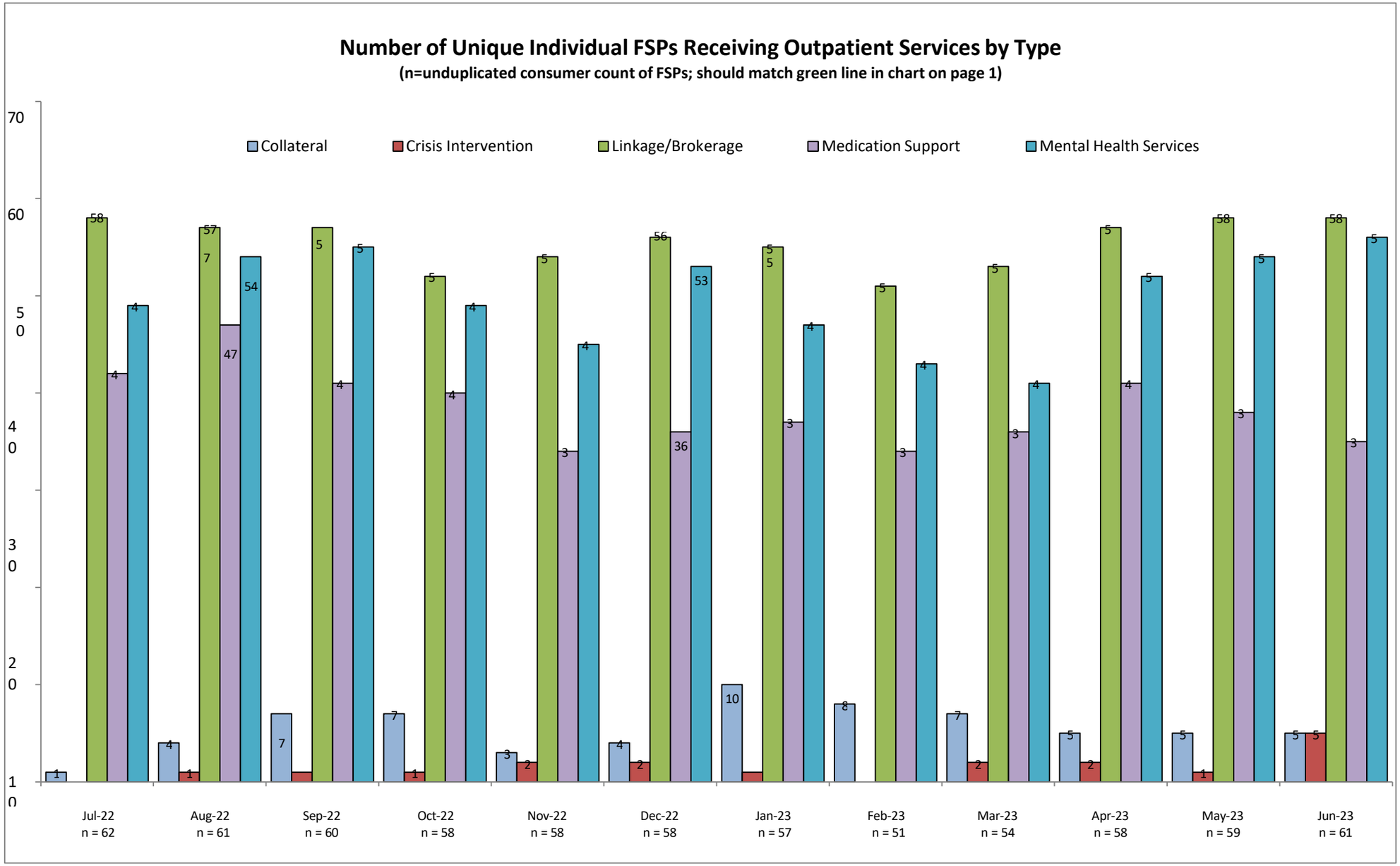
In this chart, the number of unduplicated Full Service Partners that received any type of 24 Hour Service is noted under the month as “n”.

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



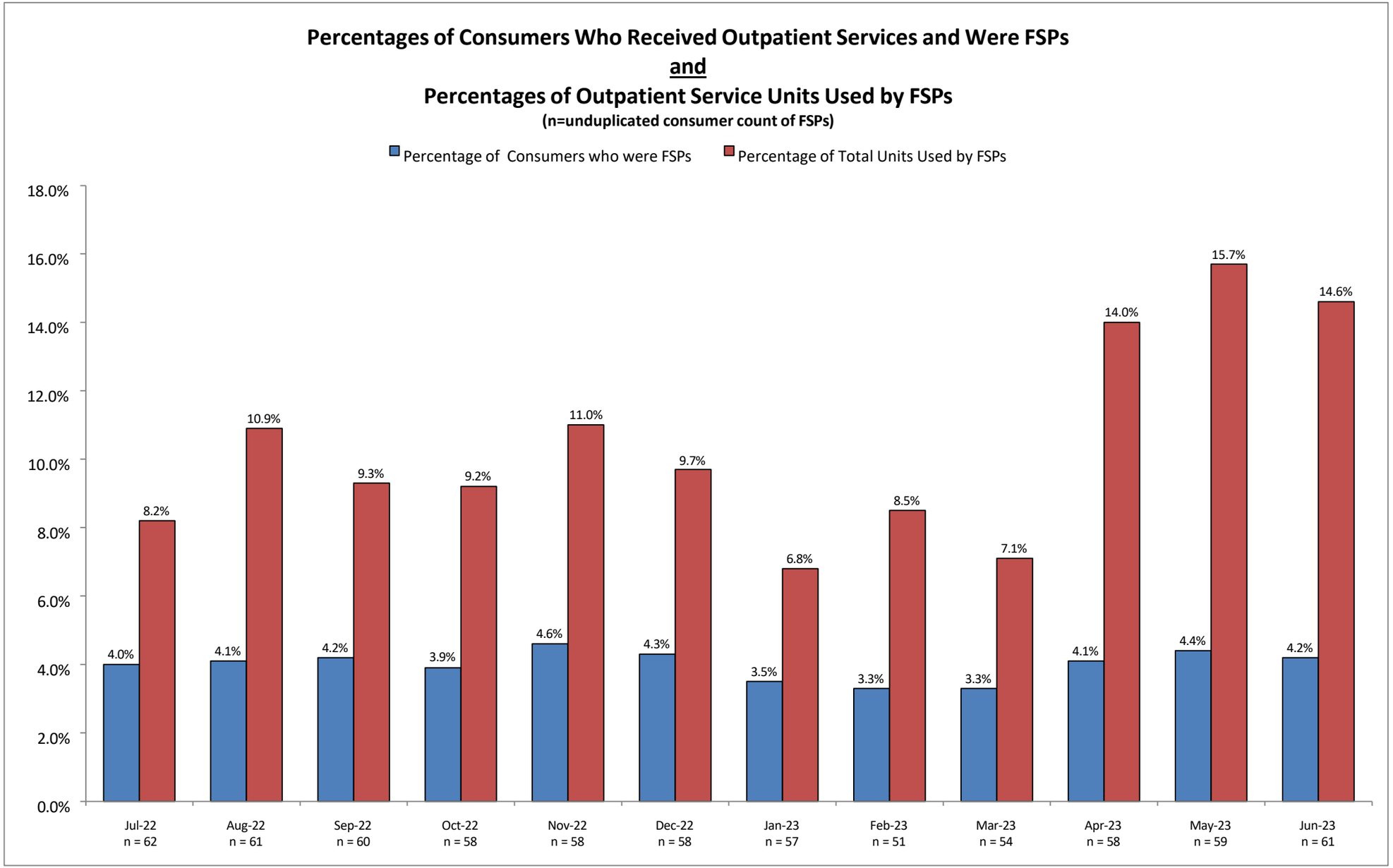
24 Hour Services are billed for by the day. This chart compares, by percentage, how many of the consumers that utilized 24 Hour Services were Full Service Partners, and how many of the days billed for were used by Full Service Partners.

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



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

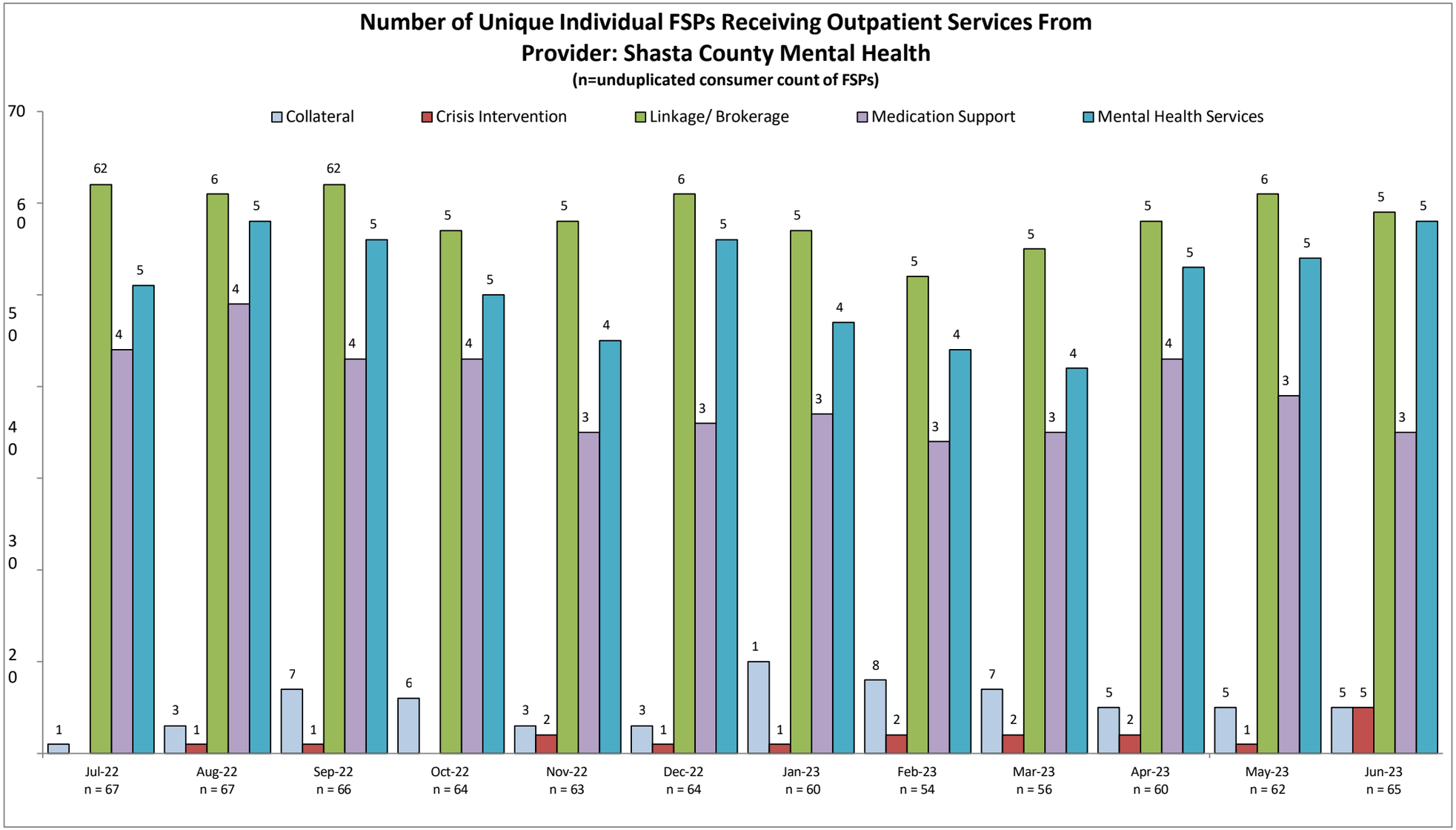
The bars above each month show how many of those unduplicated Full Service Partners received each type of Outpatient Service. Because consumers can, and often do, receive more than one kind of service in any given month, the combined number for the service types each month may add up to more than the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



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

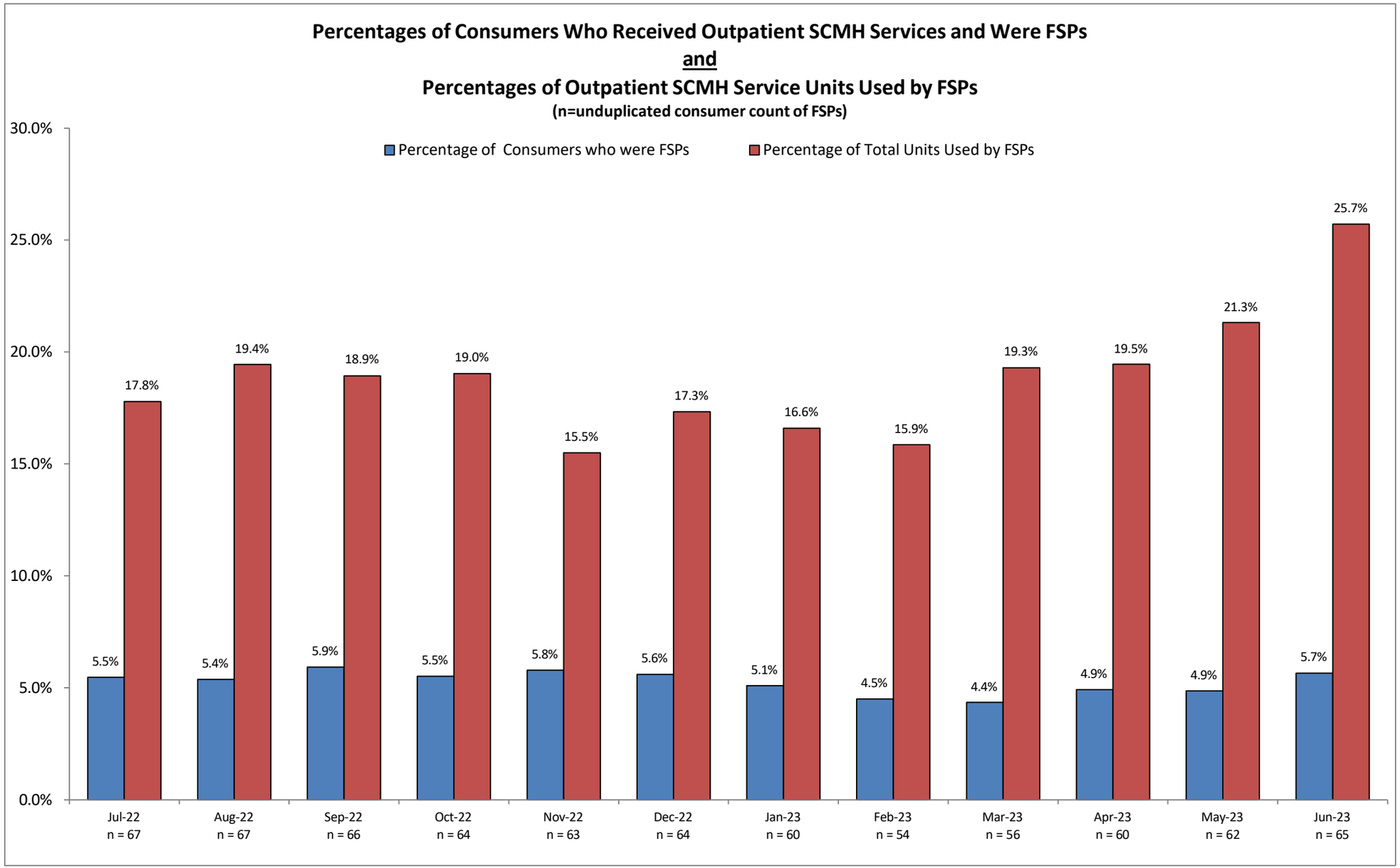
Because the Full Service Partnership program is designed to provide intensive services, it is expected that partners may utilize disproportionately more of the services than non-partner consumers.

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



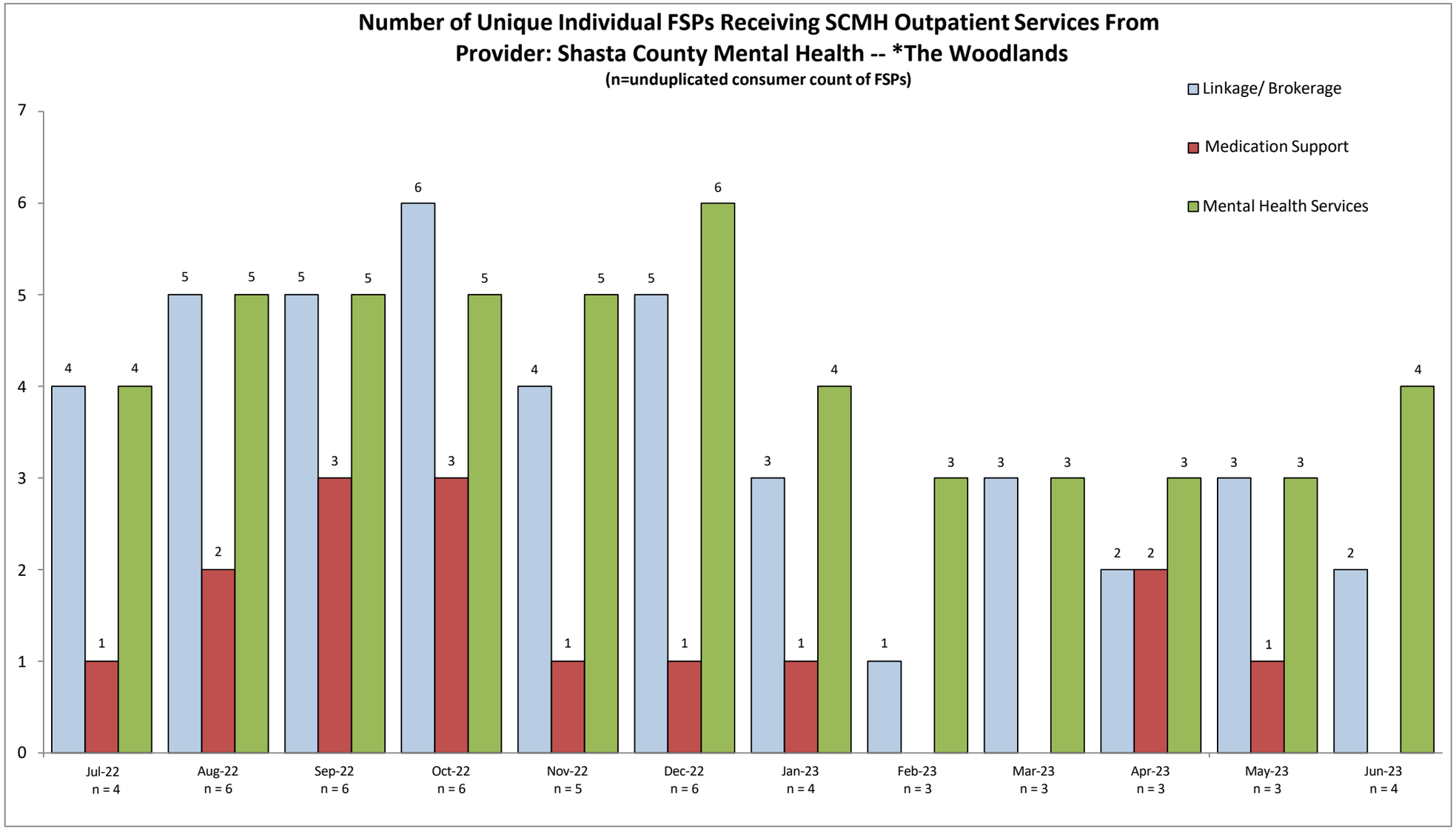
In this chart, the number of unduplicated Full Service Partners who received any type of Outpatient Service from SCMH is noted under the month as "n".

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



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

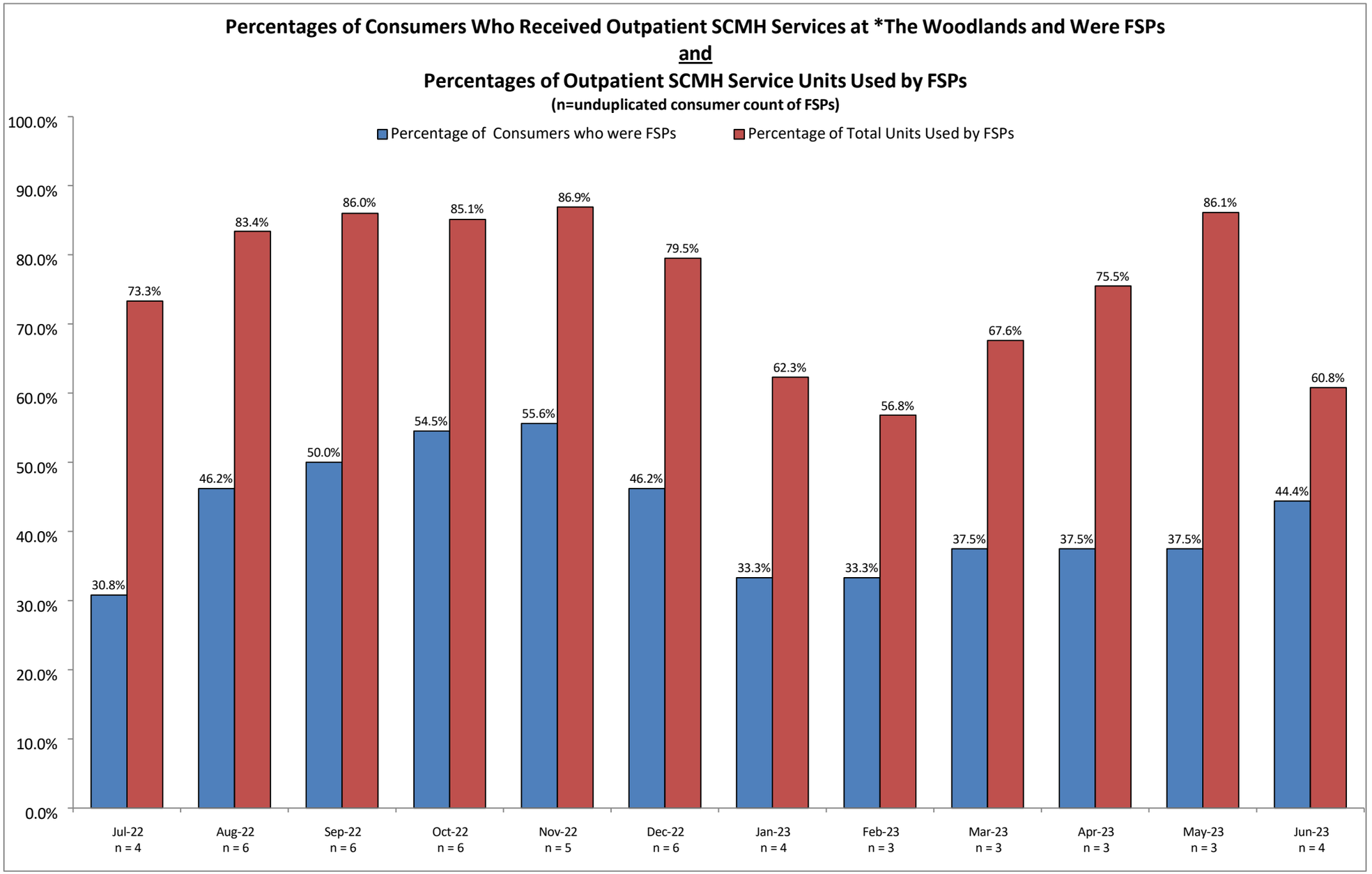
Because the Full Service Partnership program is designed to provide intensive services, and because case management of FSPs is handled by SCMH staff, it is expected that partners may utilize disproportionately more services than non-partner consumers.



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

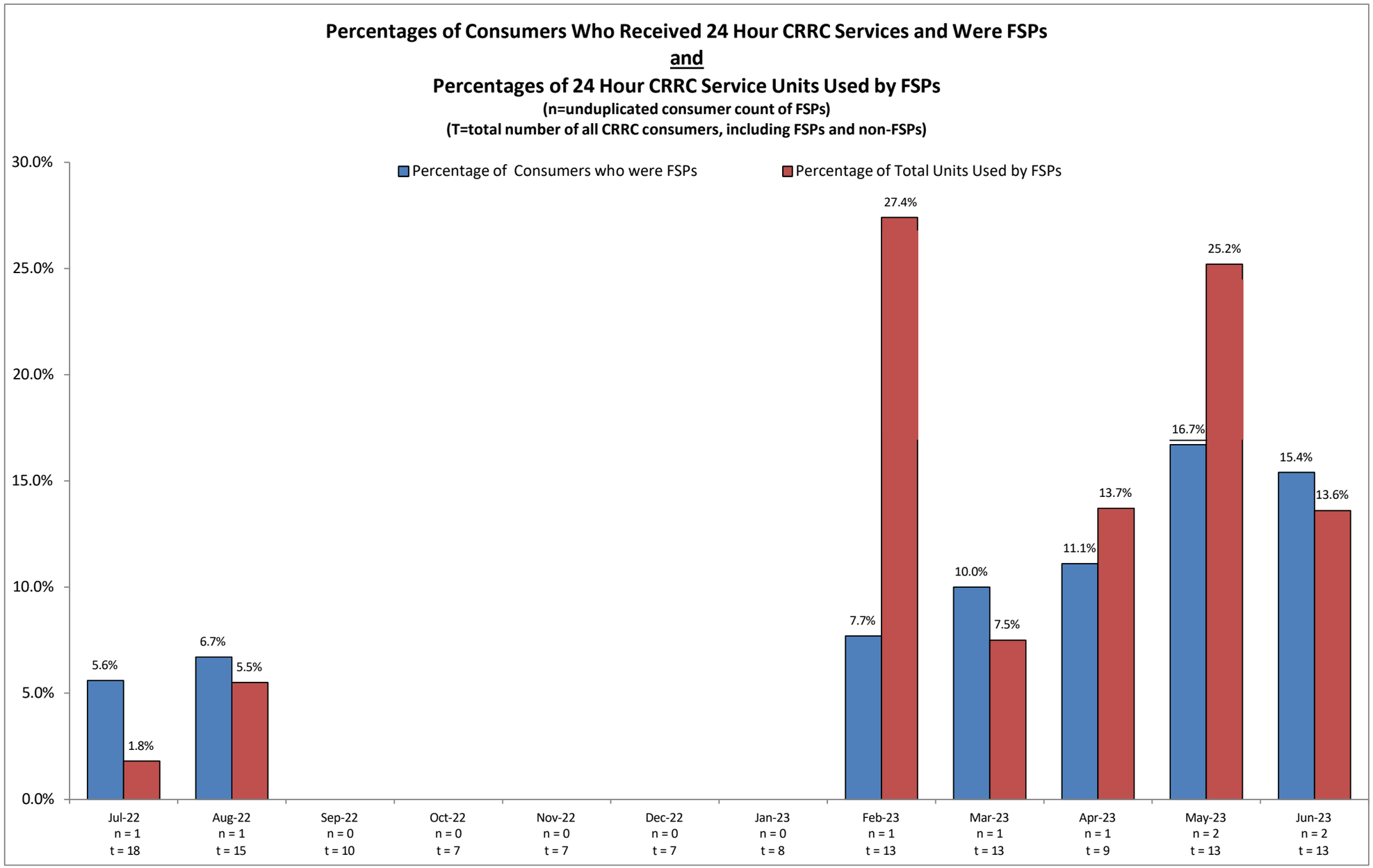
The bars above each month show how many unduplicated Full Service Partners received each type of Outpatient Service.

Because consumers can, and often do, receive more than one kind of service in any given month, the combined number for the service types each month may add up to more than the number listed as “n”.



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

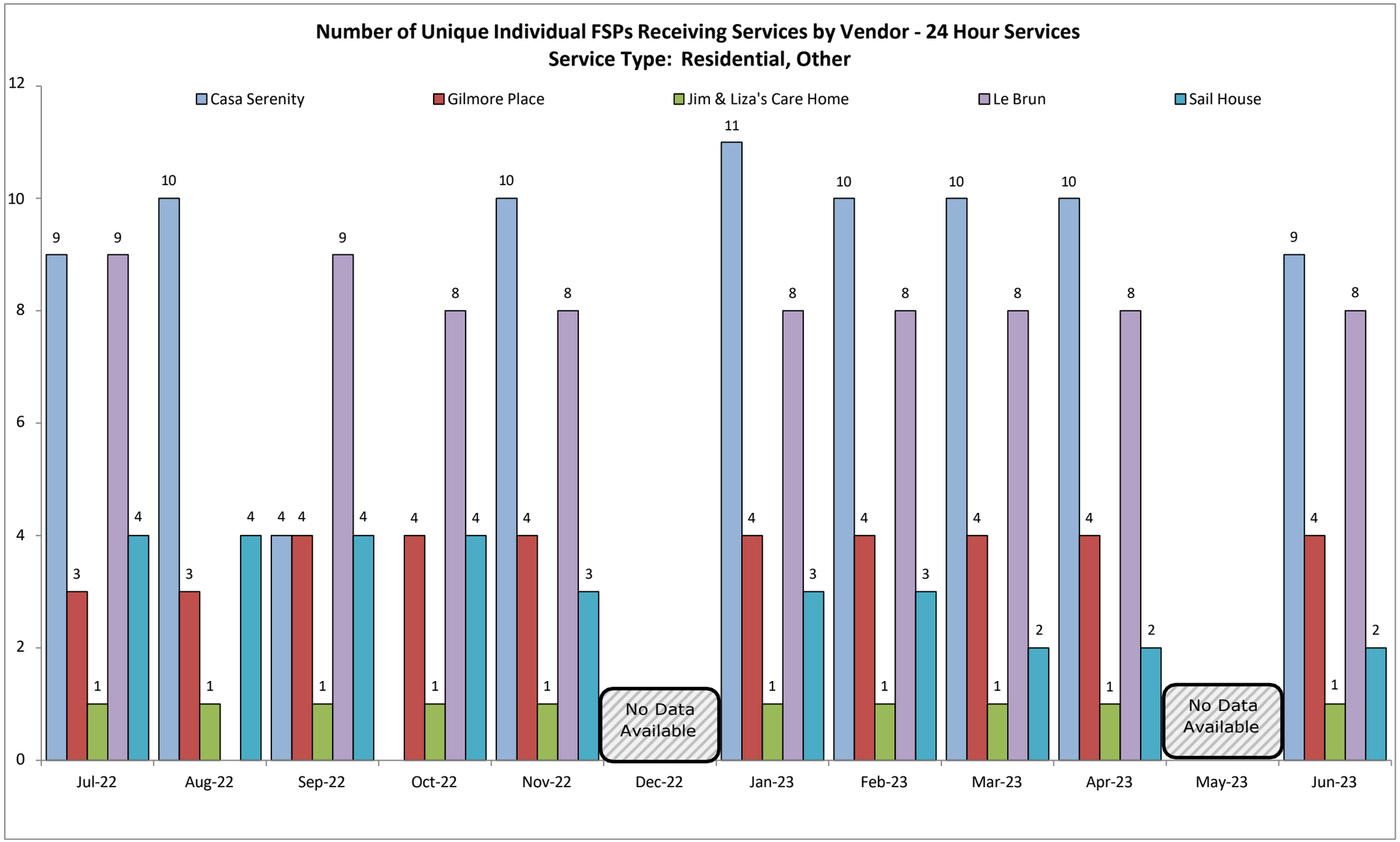
Because the Full Service Partnership program is designed to provide intensive services, and because case management of FSPs is handled by SCMH staff, it is expected that partners may utilize disproportionately more of the services than non-partner consumers.



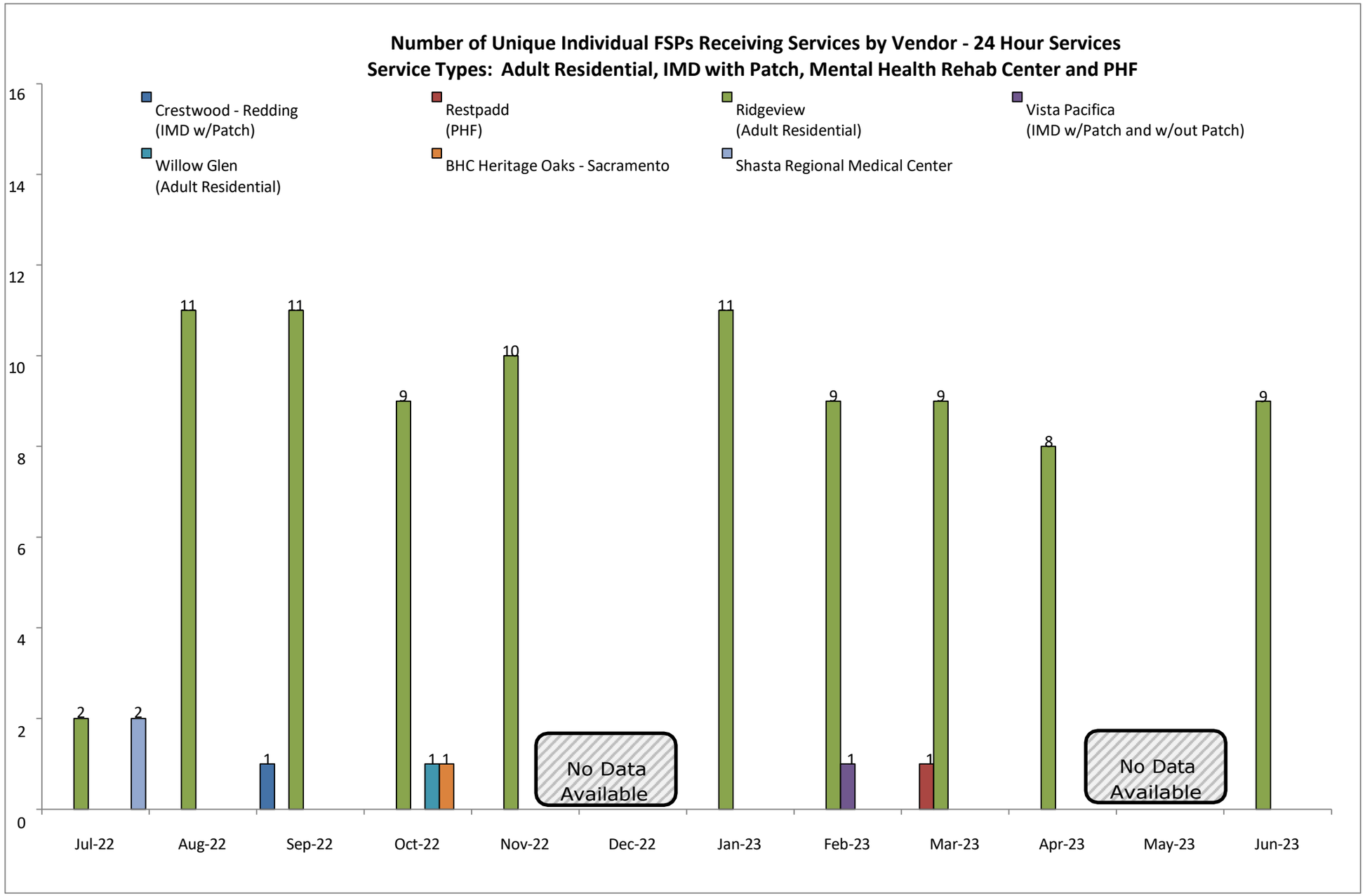
The only 24 Hour Service provided directly by Shasta County Mental Health is the Crisis Residential and Recovery Center (CRRC).

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

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



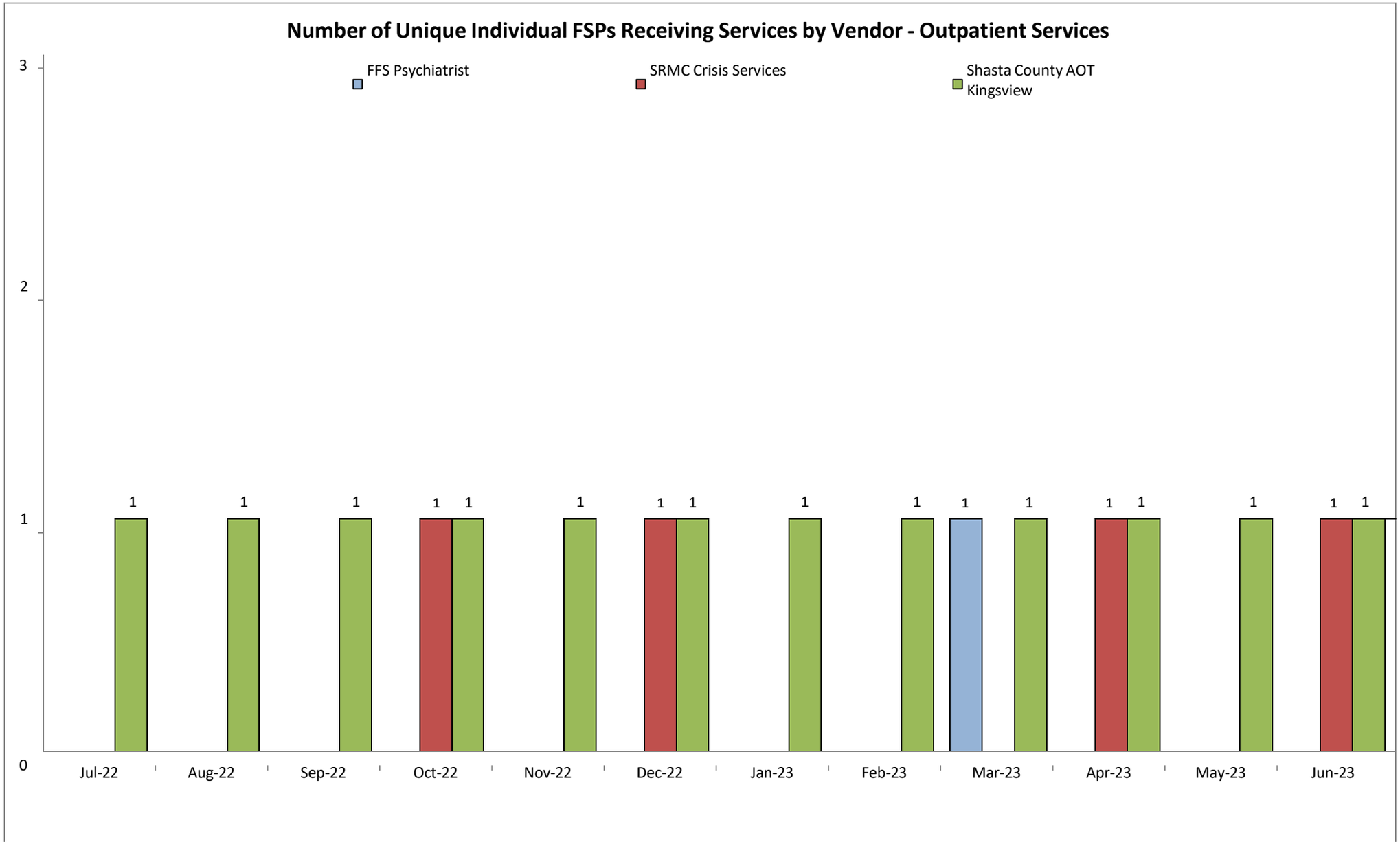
This chart shows the number of unduplicated Full Service Partners each individual vendor providing 24 Hour "Residential-Other" Services reported serving. Vendors provide some level of Board and Care setting. Because partners may have moved from one Board and Care to another in the same month, numbers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



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

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

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



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

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

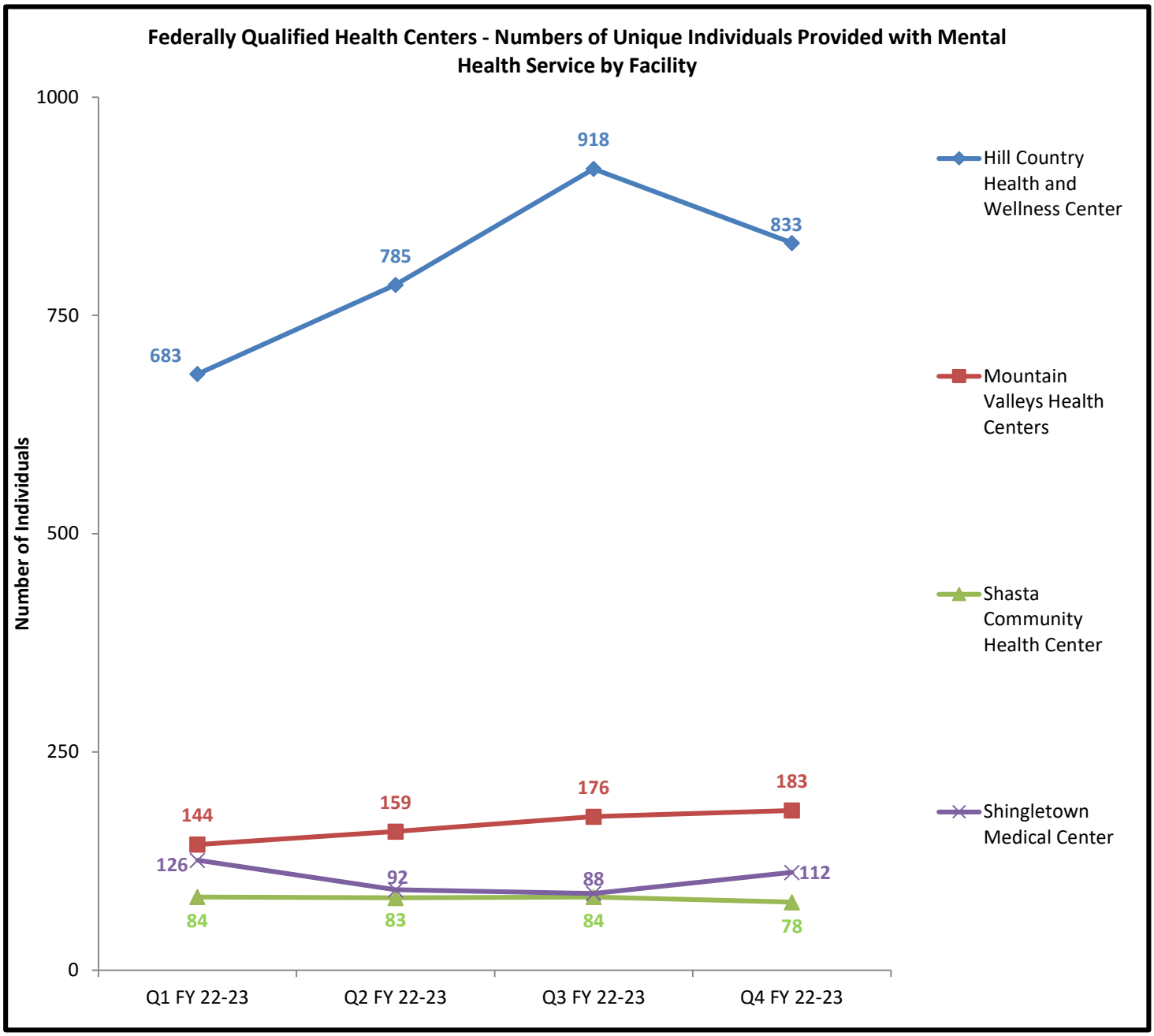
Federally Qualified Health Centers Annual Summary Report

July 2022 through June 2023

To better provide access to mental health services in Shasta County, the Shasta County Health and Human Services Agency has contracted with four different Federally Qualified Health Centers (FQHCs) to provide new or expanded mental health services, integrate mental health services with existing mental health and medical services provided by the FQHCs, and strengthen the relationship between the FQHCs and the County's public mental health system. Funding is provided through the Mental Health Services Act (MHSA). Shasta County had four FQHCs in operation during the 2022-2023 fiscal year: **Hill Country Health and Wellness Center** in Round Mountain; **Mountain Valleys Health Centers** in Burney; **Shasta Community Health Center** in Redding; and **Shingletown Medical Center** in Shingletown.

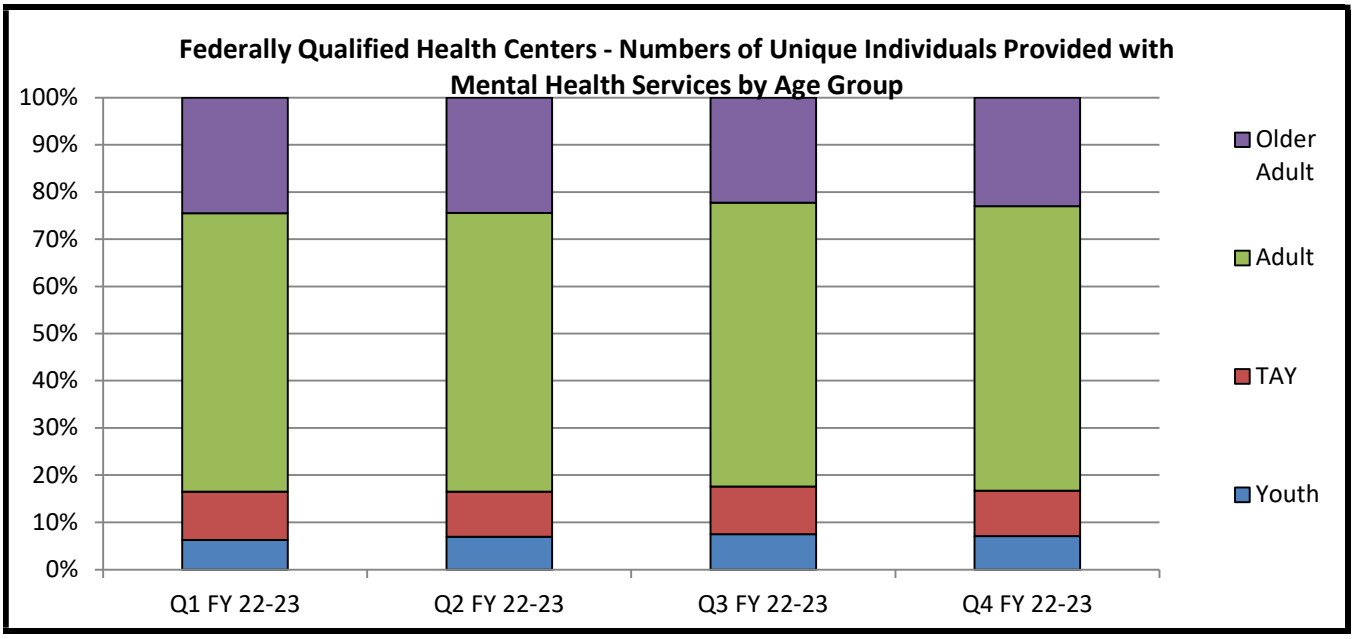
Attendance

An average of **1,157** unique individuals visited a FQHC in each quarter of fiscal year **2022-2023**.

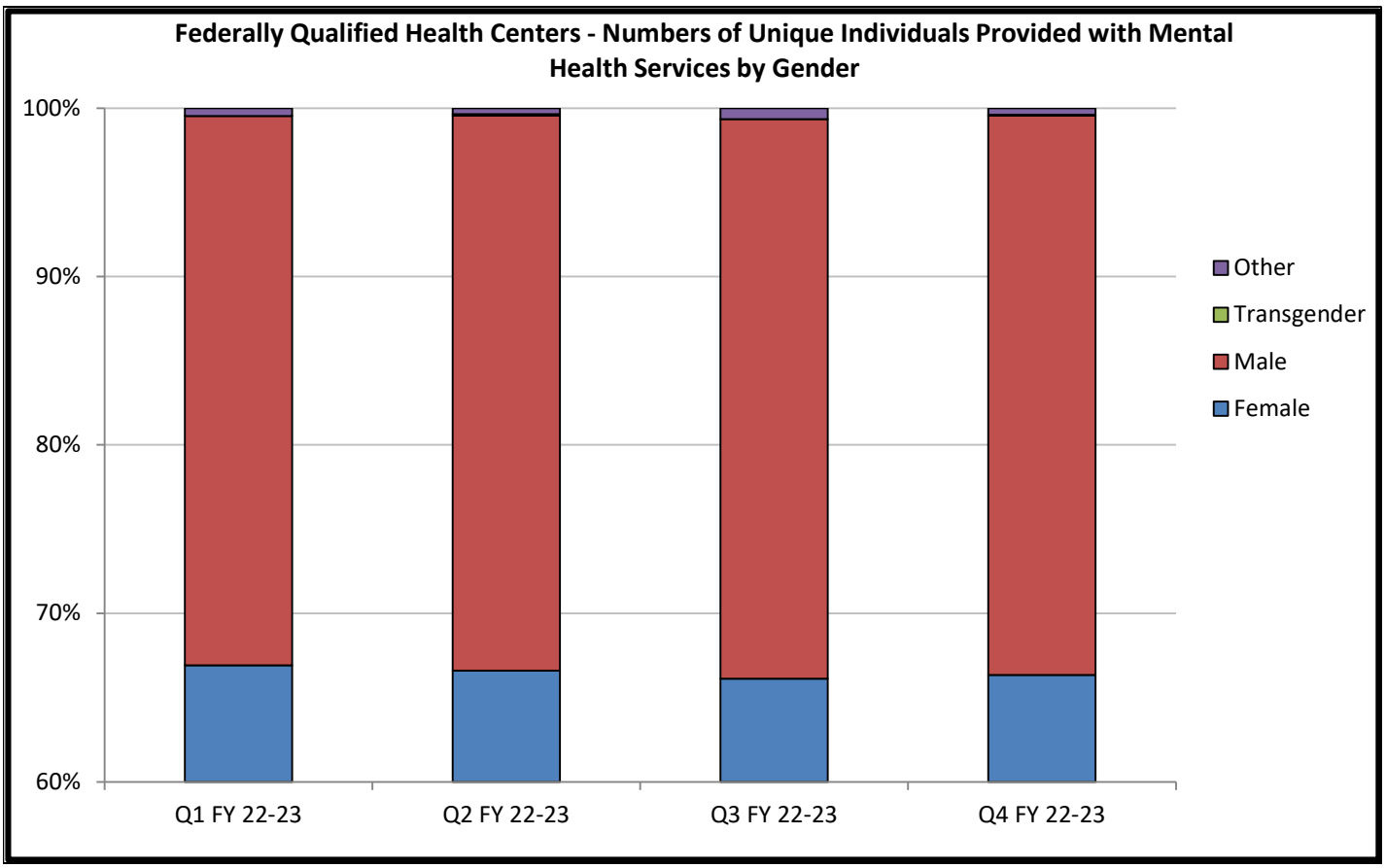


Demographics

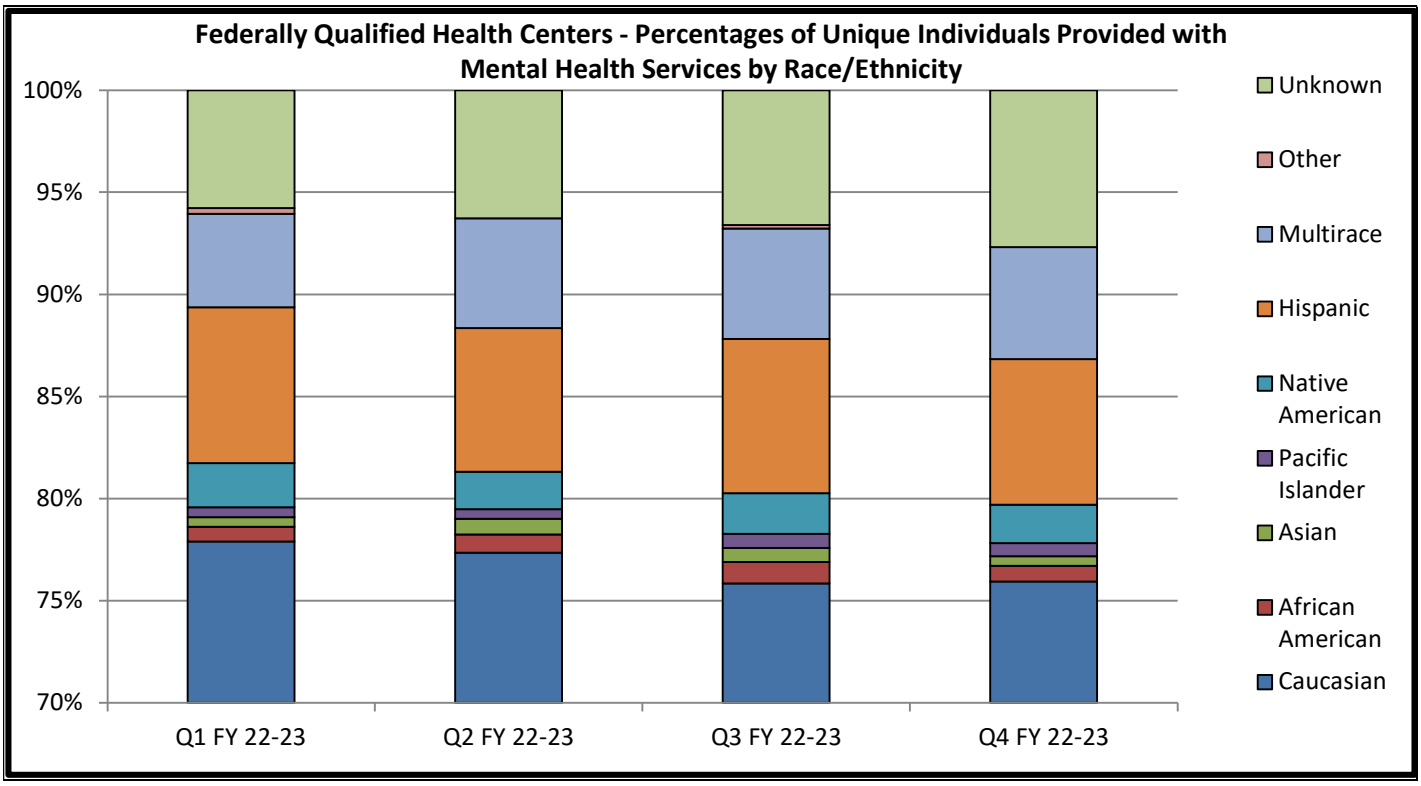
Age - The MHSA uses four age categories: **Youth** – ages 0 to 15, **Transition Aged Youth** (TAY) – ages 16 to 25, **Adult** – ages 26 to 59, and **Older Adult** – ages 60 and up.



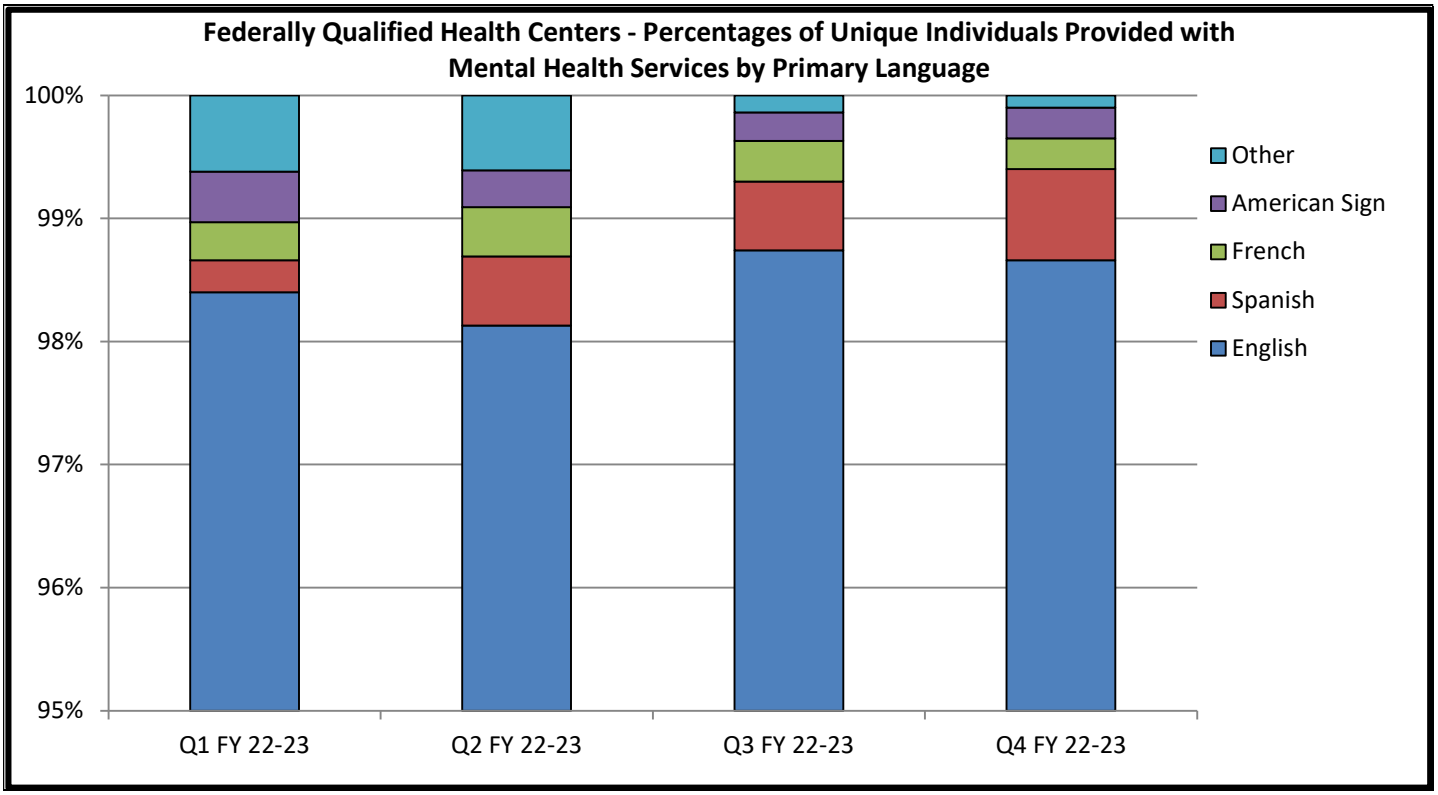
Gender - The MHSA uses four gender categories: **Male**, **Female**, **Transgender**, and **Other**. Counts of less than 20 individuals are not labeled to help maintain consumer confidentiality but are included in the chart.



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

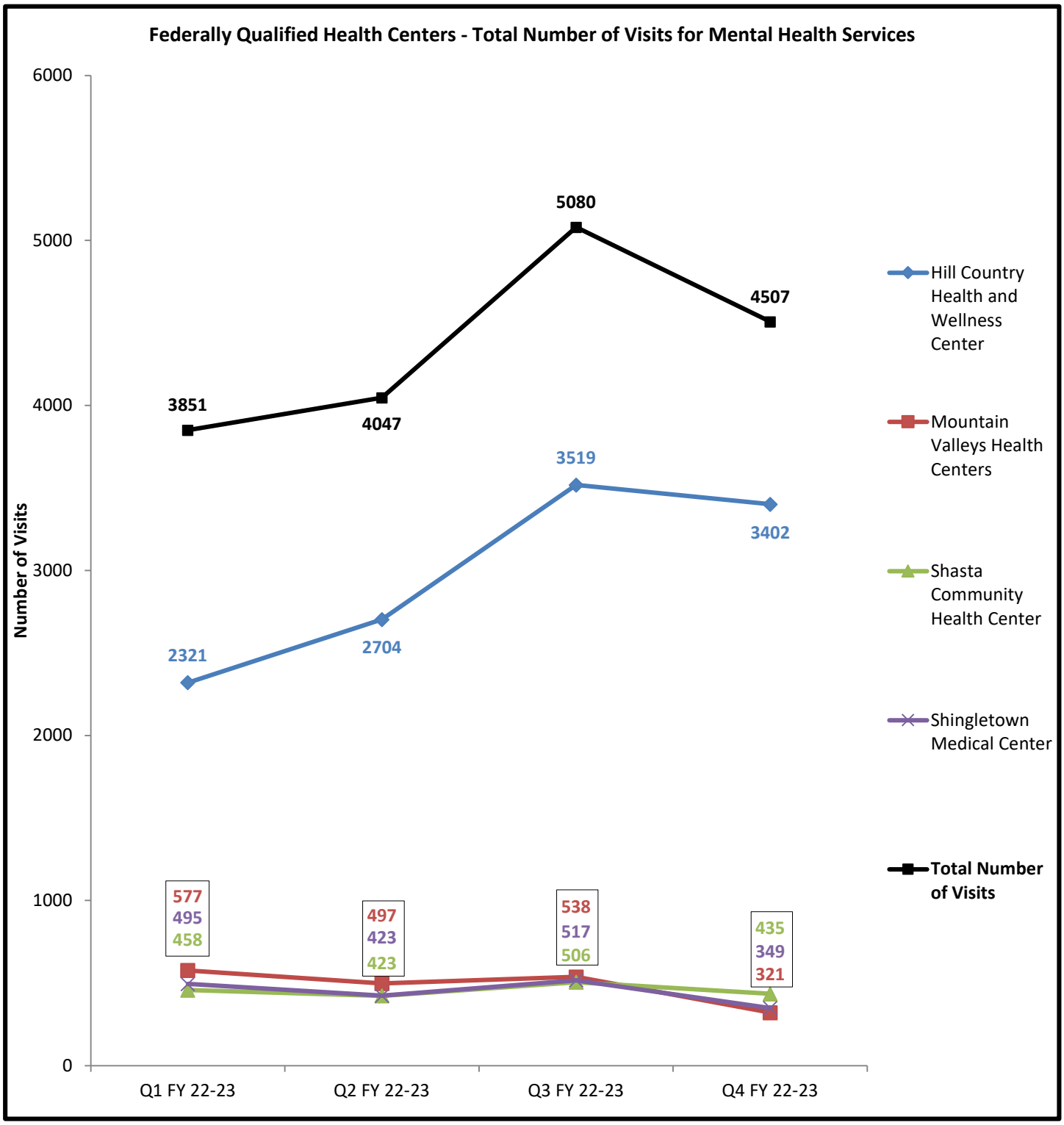


Primary Language - Because of the low gross numbers for some of these languages within small communities, actual counts are not reported in order to help protect consumer confidentiality.



Services Provided

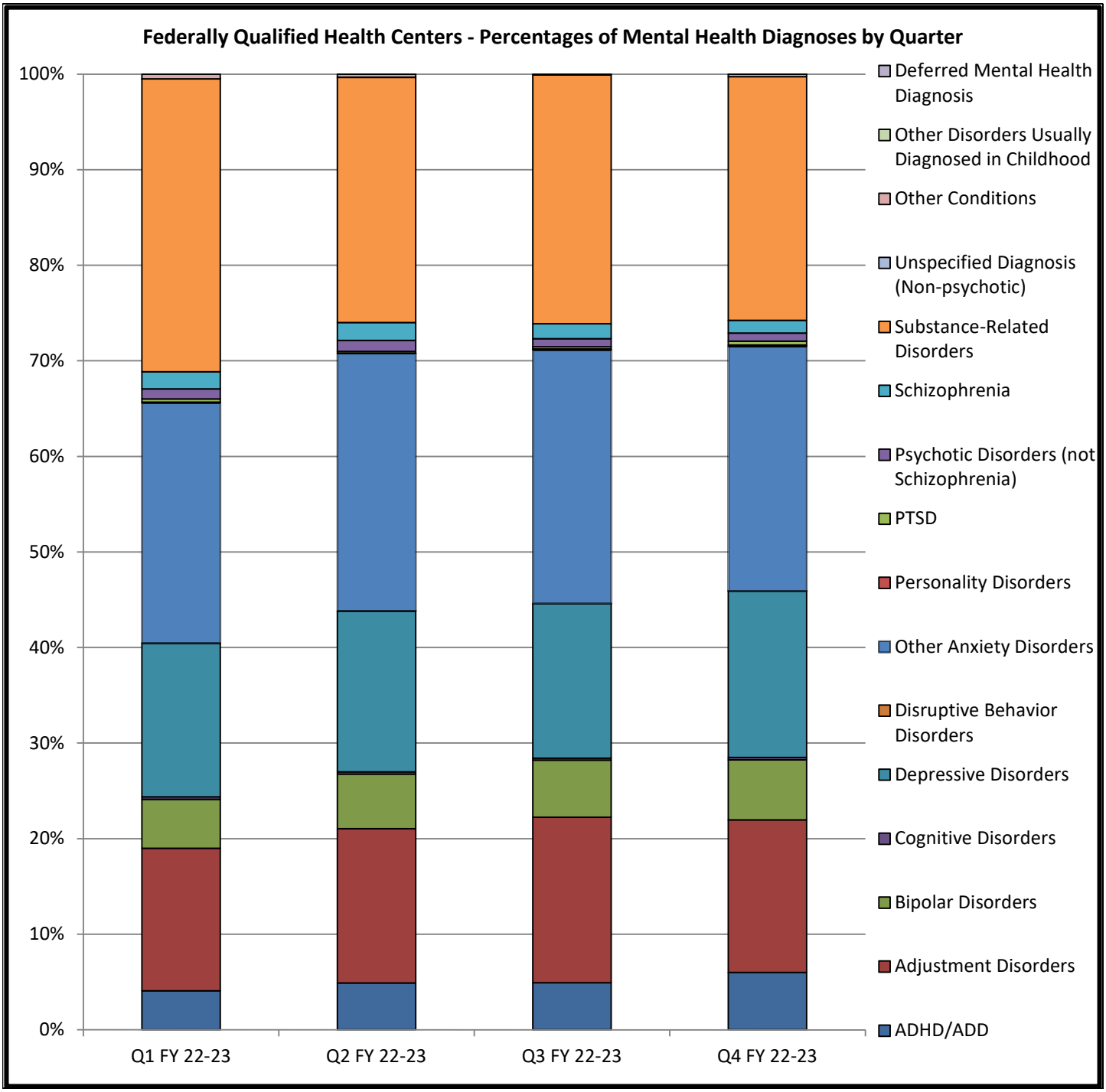
Most people will have multiple visits to the FQHC each quarter, and different types of service may be offered at different times in order to provide everyone with comprehensive and integrated age appropriate mental health services. Services provided may include such things as screenings, assessments, medication management, and individual or group psychotherapy sessions. For fiscal year **2022-2023**, there were a total of **17,484** visits to a FQHC for some type of mental health service.



Primary Mental Health Diagnosis

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

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

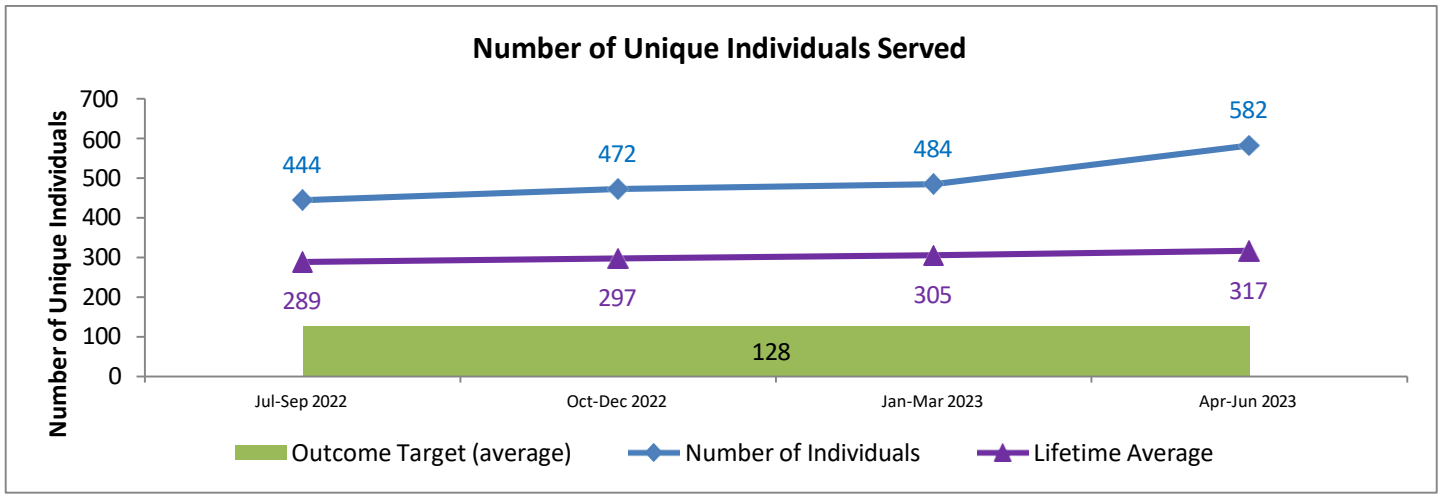


CARE Center Activity Report
July 2022 through June 2023

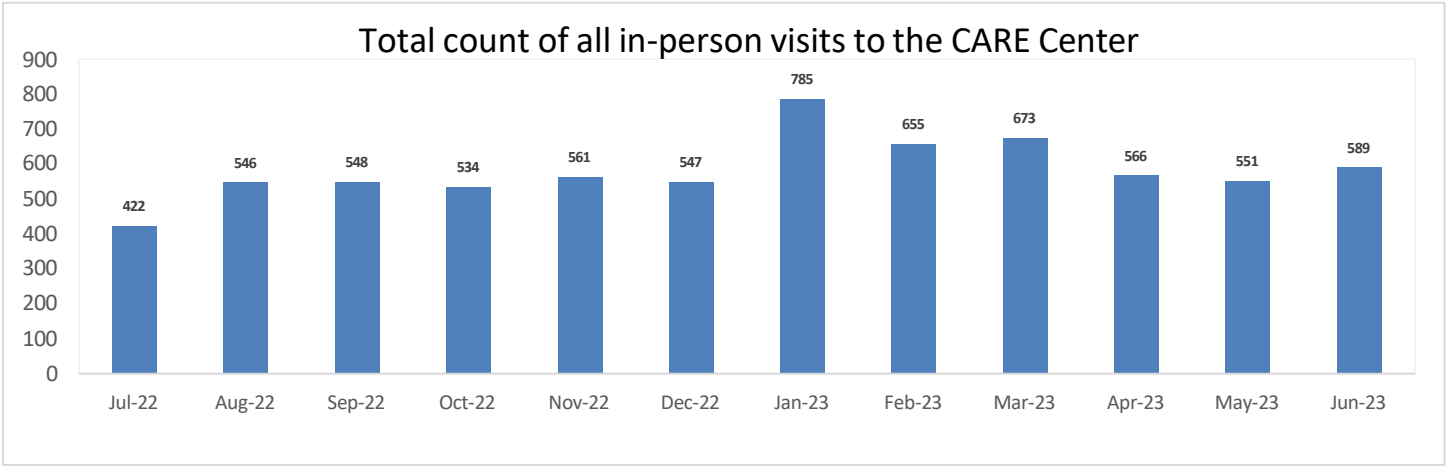
To determine if providing access to mental health services after traditional office hours will improve access to services, reduce mental health crisis (including trips to the hospital emergency departments) and bridge service gaps, the Shasta County Health and Human Services Agency has contracted with Hill County Health and Wellness Center to provide new and expanded mental health services at the Counseling and Recovery Engagement (CARE) Center. Funding is provided through the Mental Health Services Act (MHSA) for the Community Services and Support Project portion of this center. The CARE Center contract was approved as of January 2017, and they officially opened for business on March 12, 2017. For this report, data was gathered using the CARE Center Quarterly Progress Reports for **July 2022** through **June 2023**.

INDIVIDUALS SERVED

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



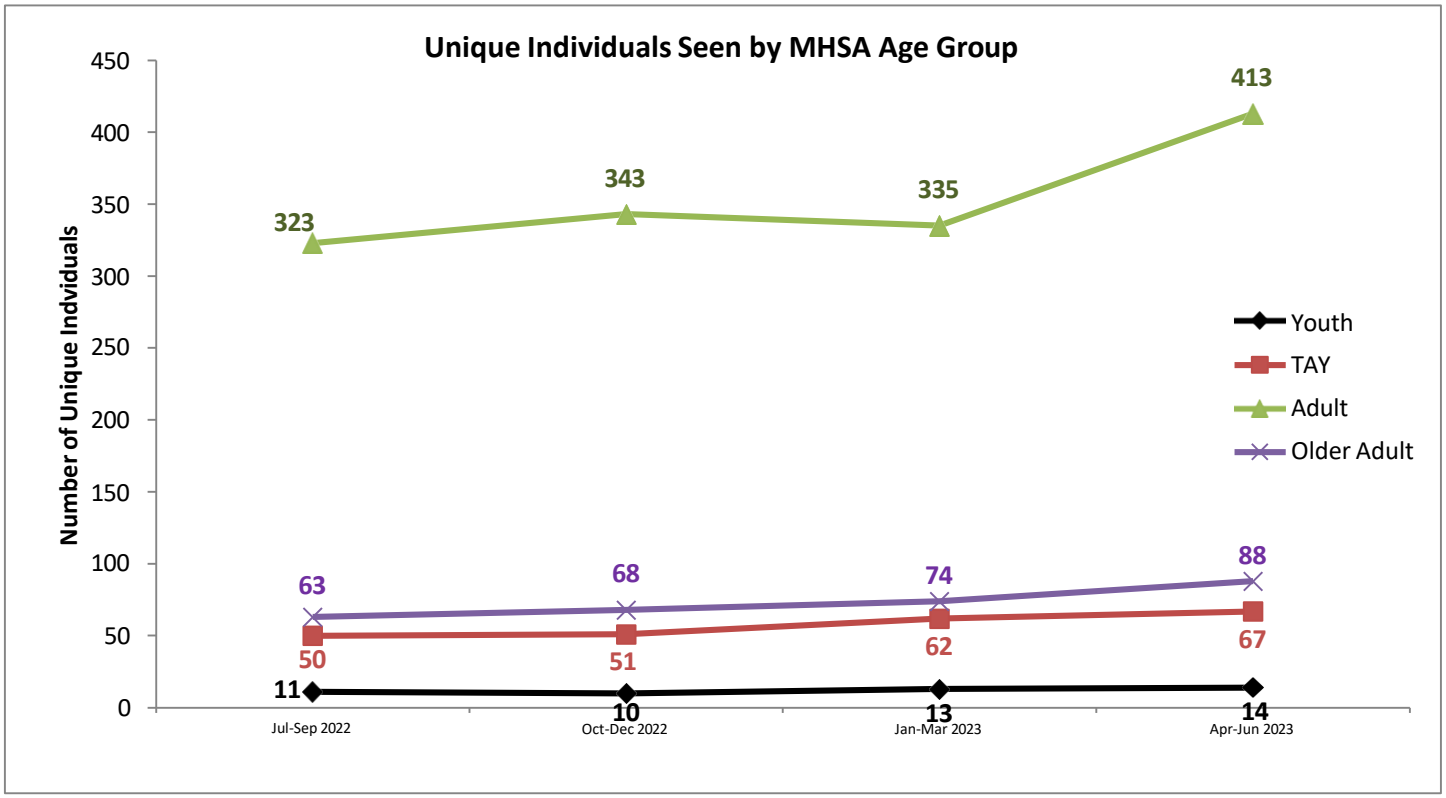
Please note that most clients visit more than once – the graph below is not an unduplicated person count.



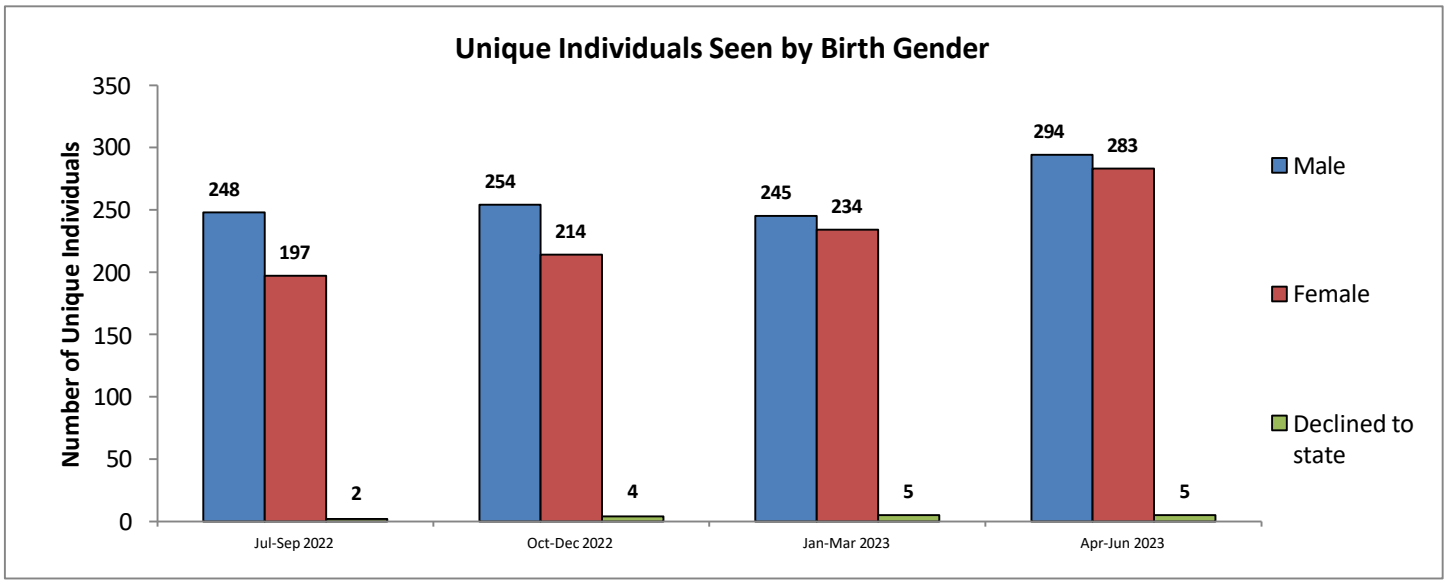
***All demographics questions are optional, so each includes the category "Declined to State".**

AGE

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

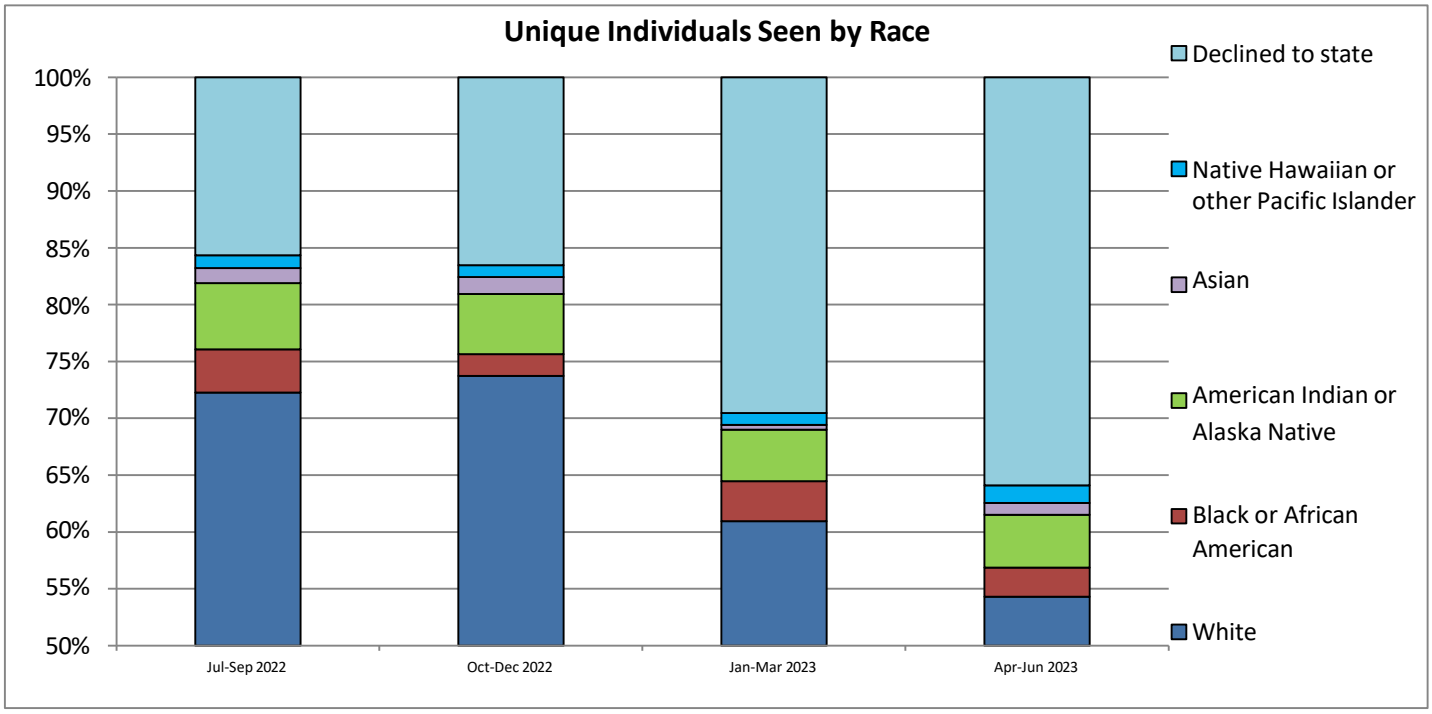


BIRTH GENDER



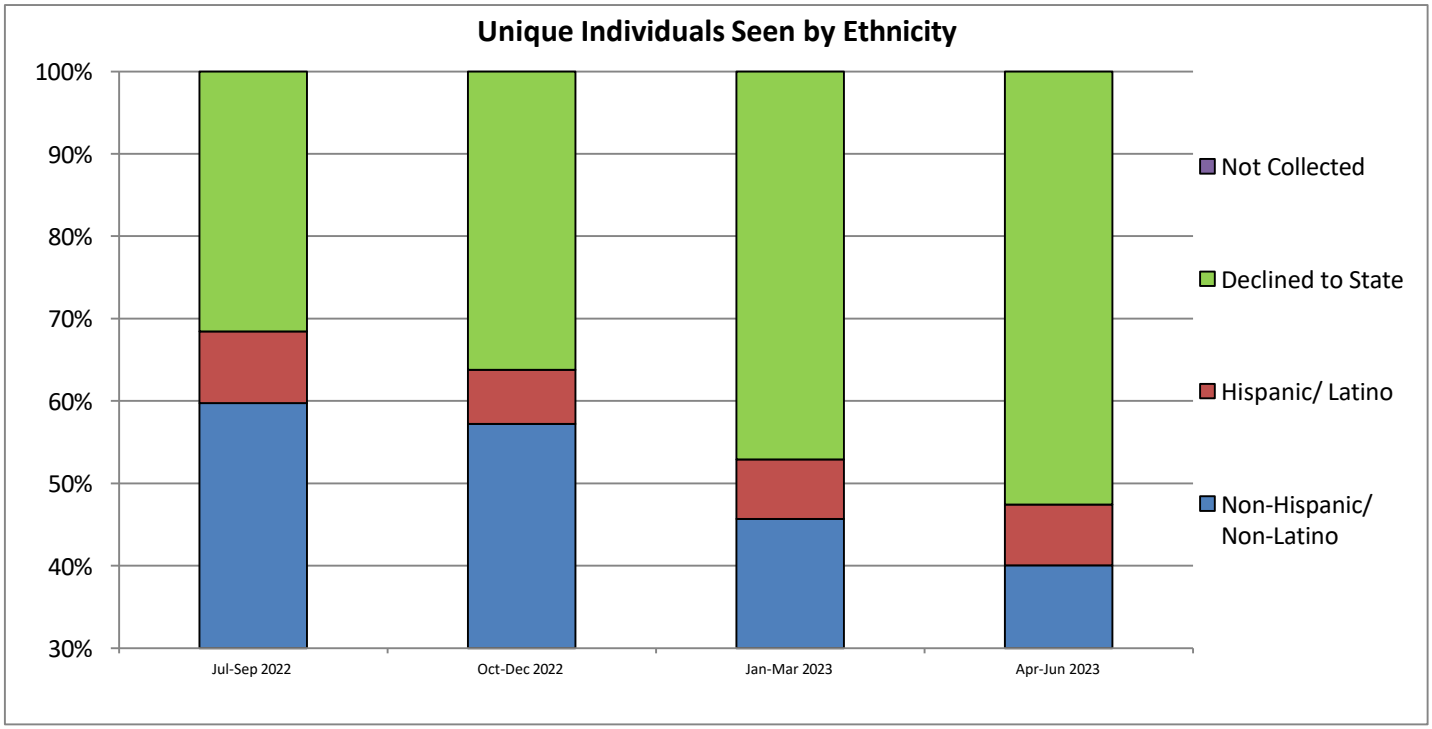
RACE

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



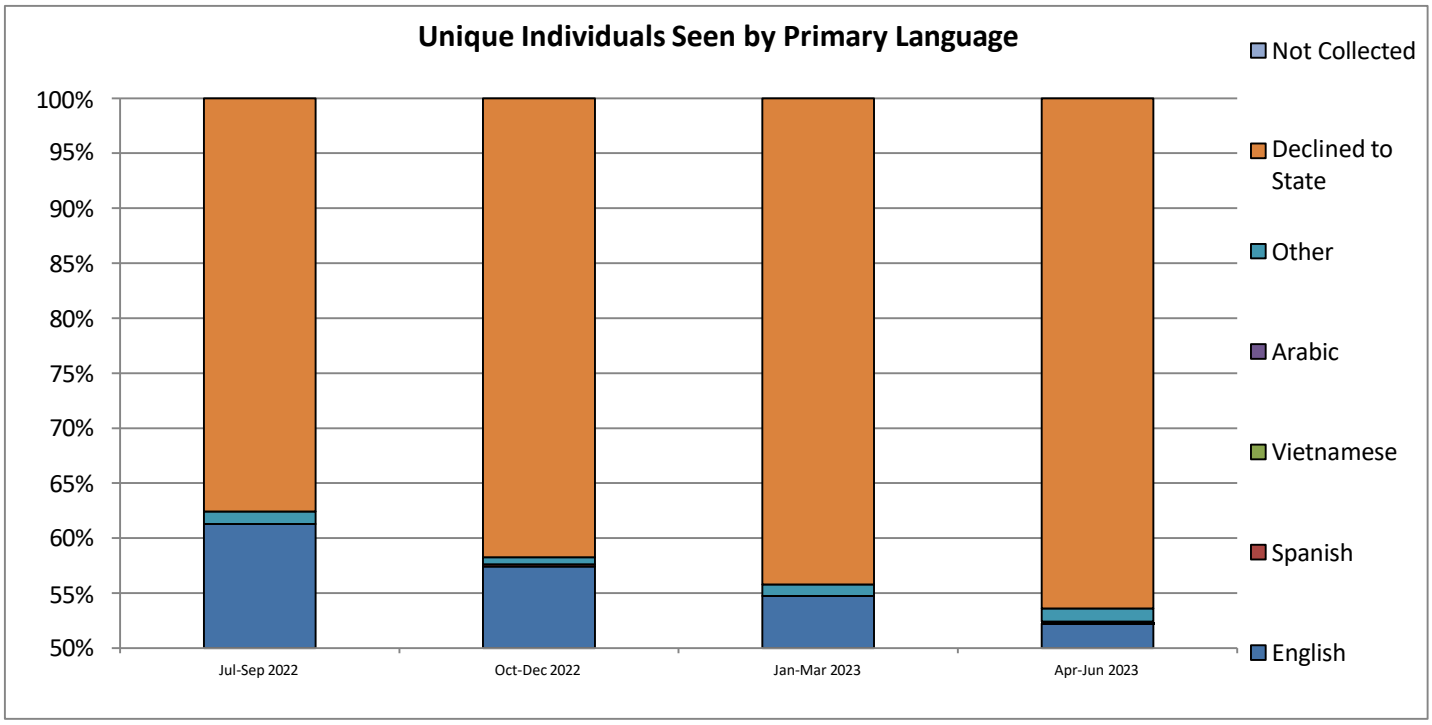
ETHNICITY

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

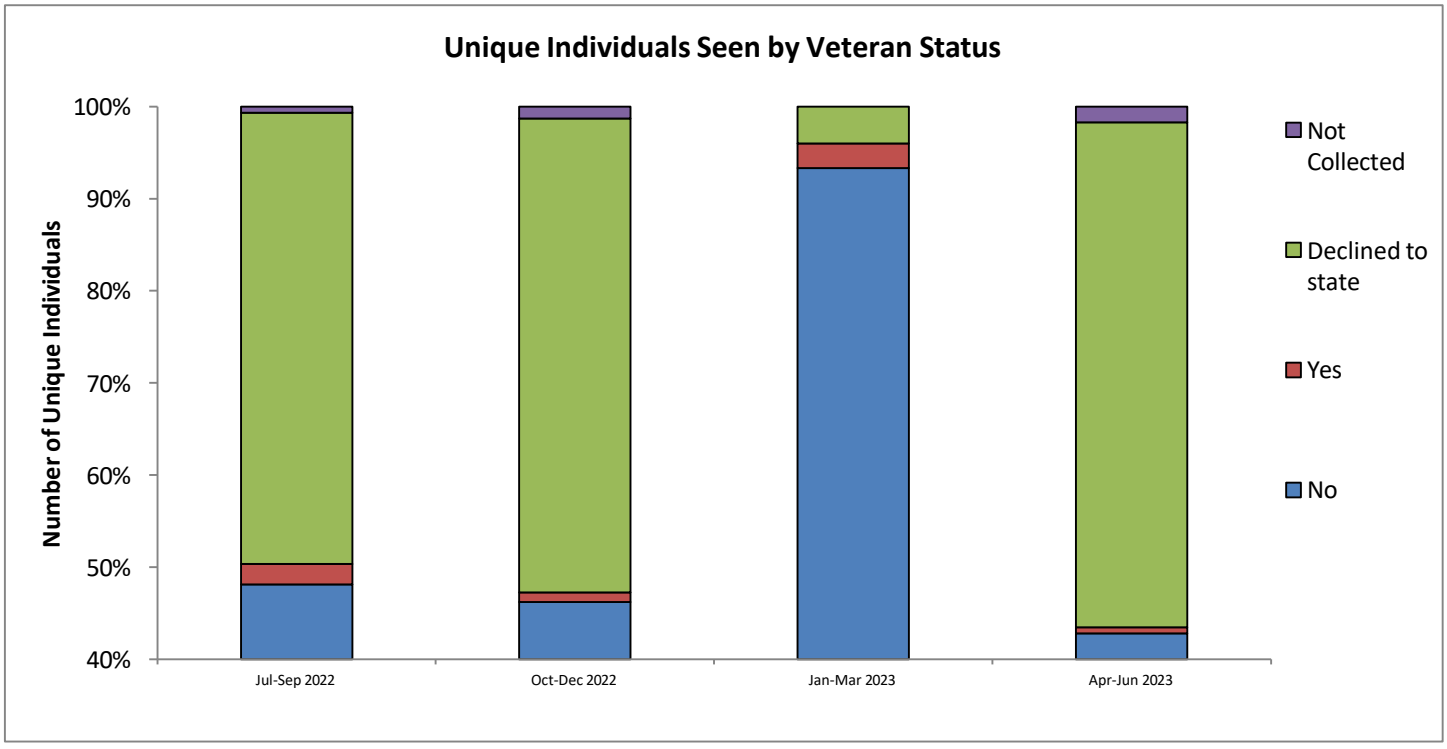


PRIMARY LANGUAGE

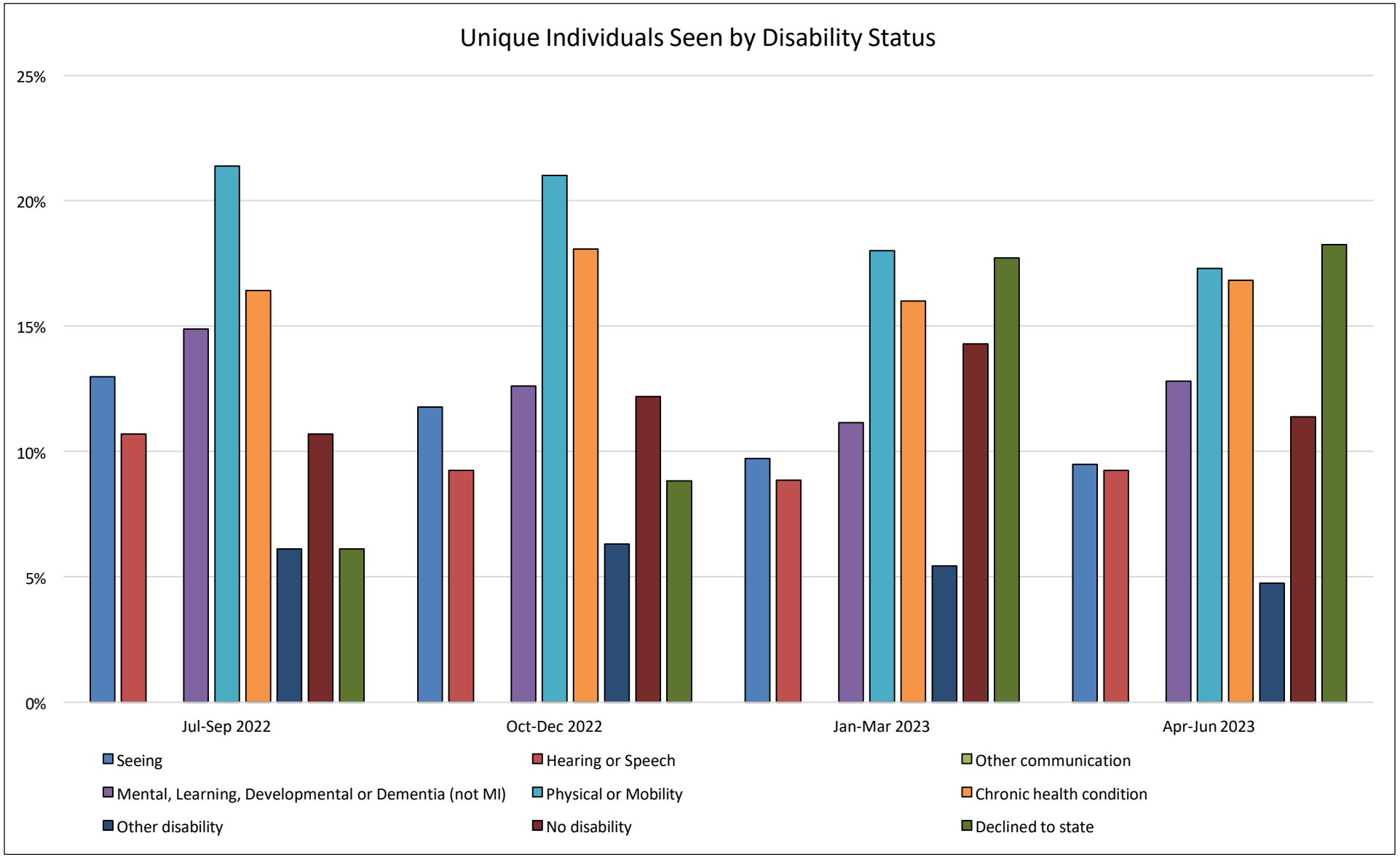
The primary language of consumers served by the CARE Center is English for nearly 100% of the people who chose to answer this question. Because of the low gross numbers for some reported languages, actual counts are not reported to help protect consumer confidentiality.



VETERAN STATUS



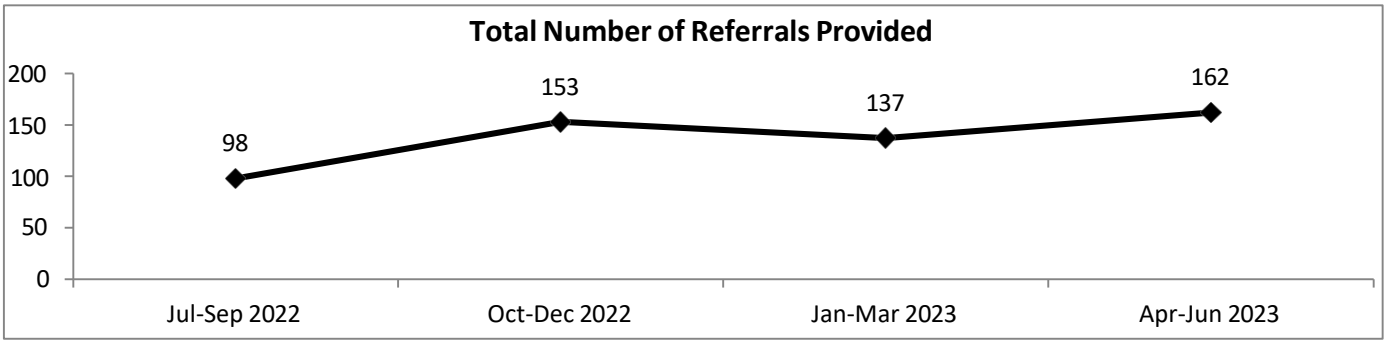
DISABILITY STATUS



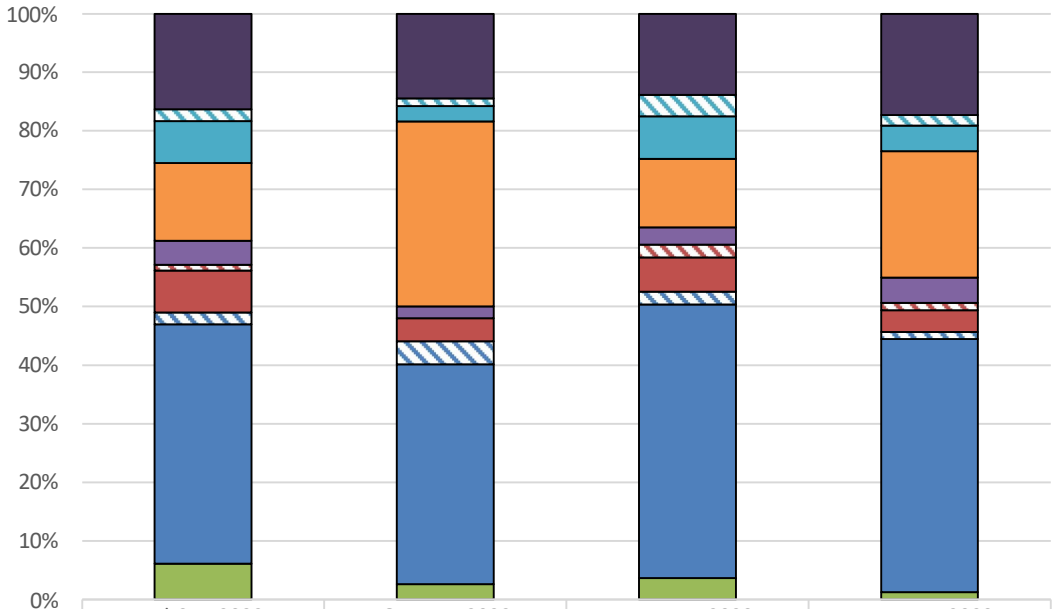
NUMBER OF OUTSIDE REFERRALS PROVIDED AND SUCCESSFULLY ACCESSED

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

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



Referrals Provided by Category



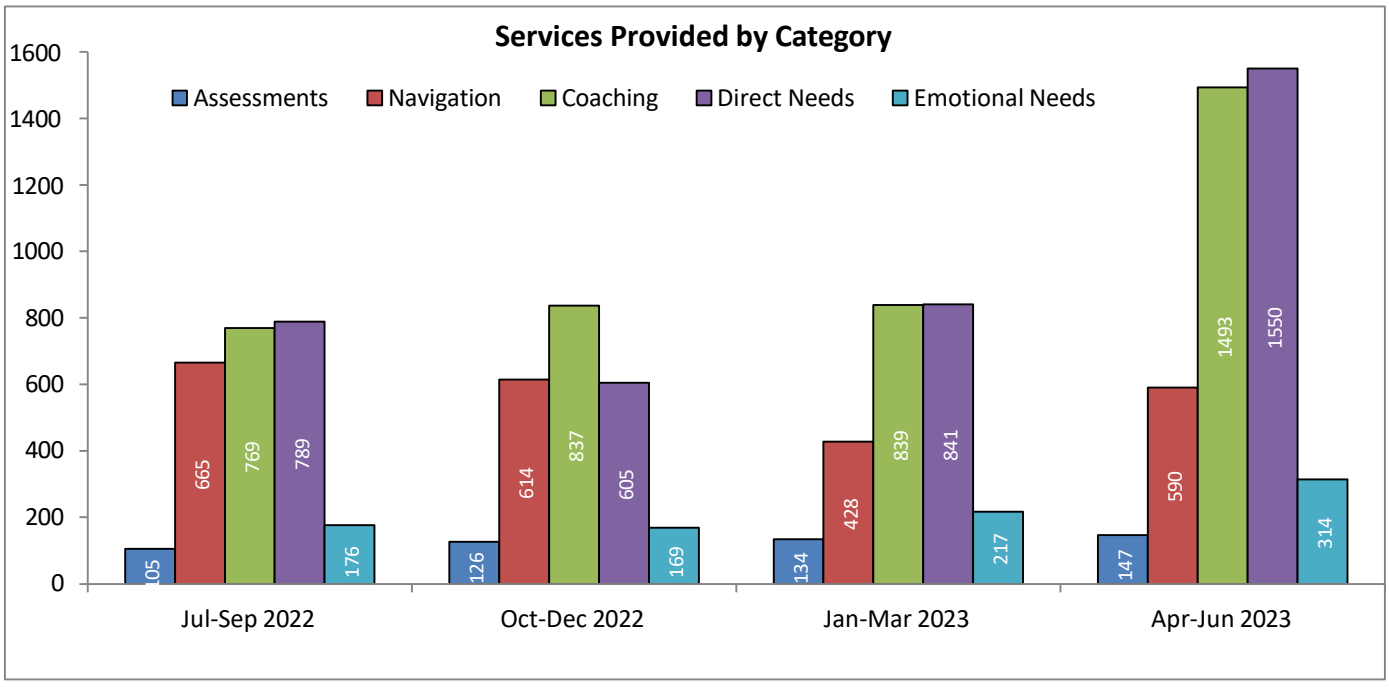
	Jul-Sep 2022	Oct-Dec 2022	Jan-Mar 2023	Apr-Jun 2023
Substance Use Services	16	22	19	28
Medical Health Services Hill Country	2	2	5	3
Medical Health Services External	7	4	10	7
Housing/Shelter Services	13	48	16	35
ED Hospital	4	3	4	7
Community Groups Hill Country	1	0	3	2
Community Groups External	7	6	8	6
Behavioral/MH Services Hill Country	2	6	3	2
Behavioral/MH Services External	40	57	64	70
Basic Needs	6	4	5	2

NUMBER OF SERVICES PROVIDED

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

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



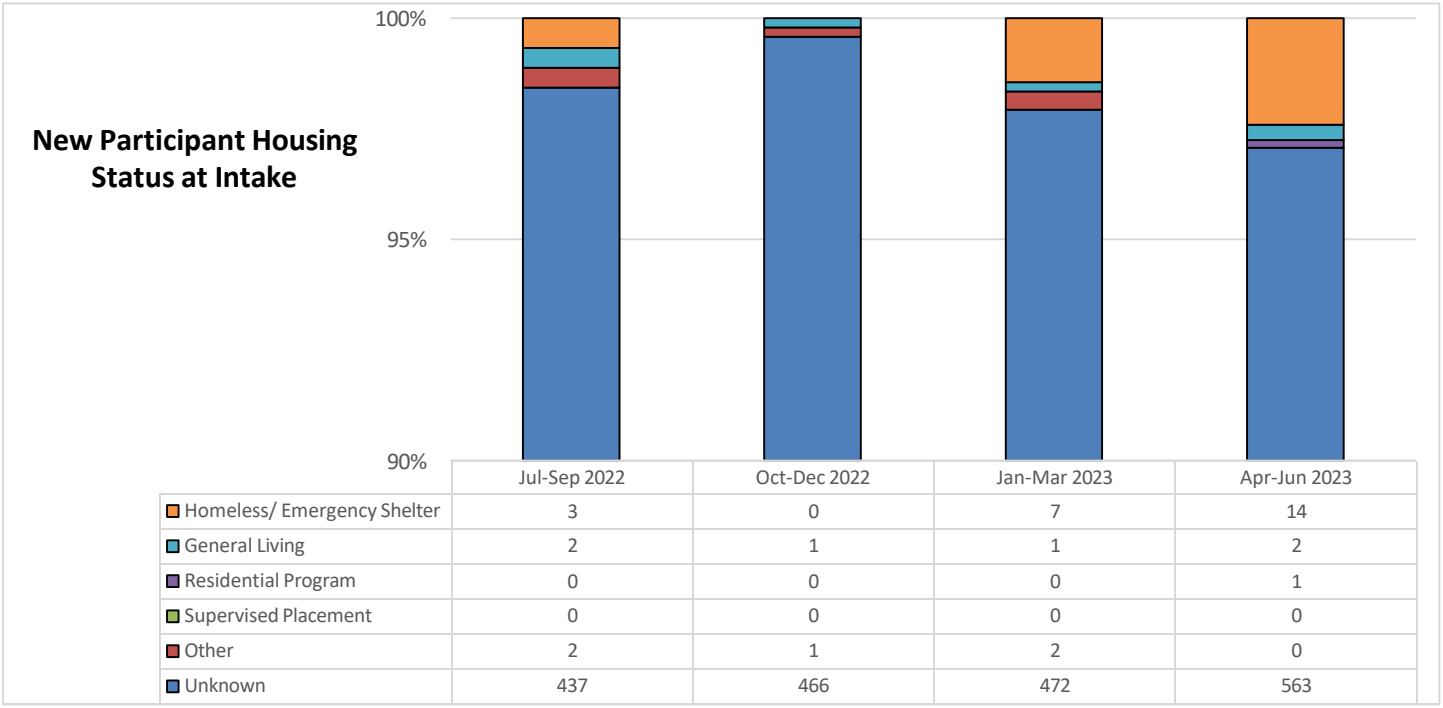
HOUSING STATUS

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

Housing status has been divided up into the following categories:

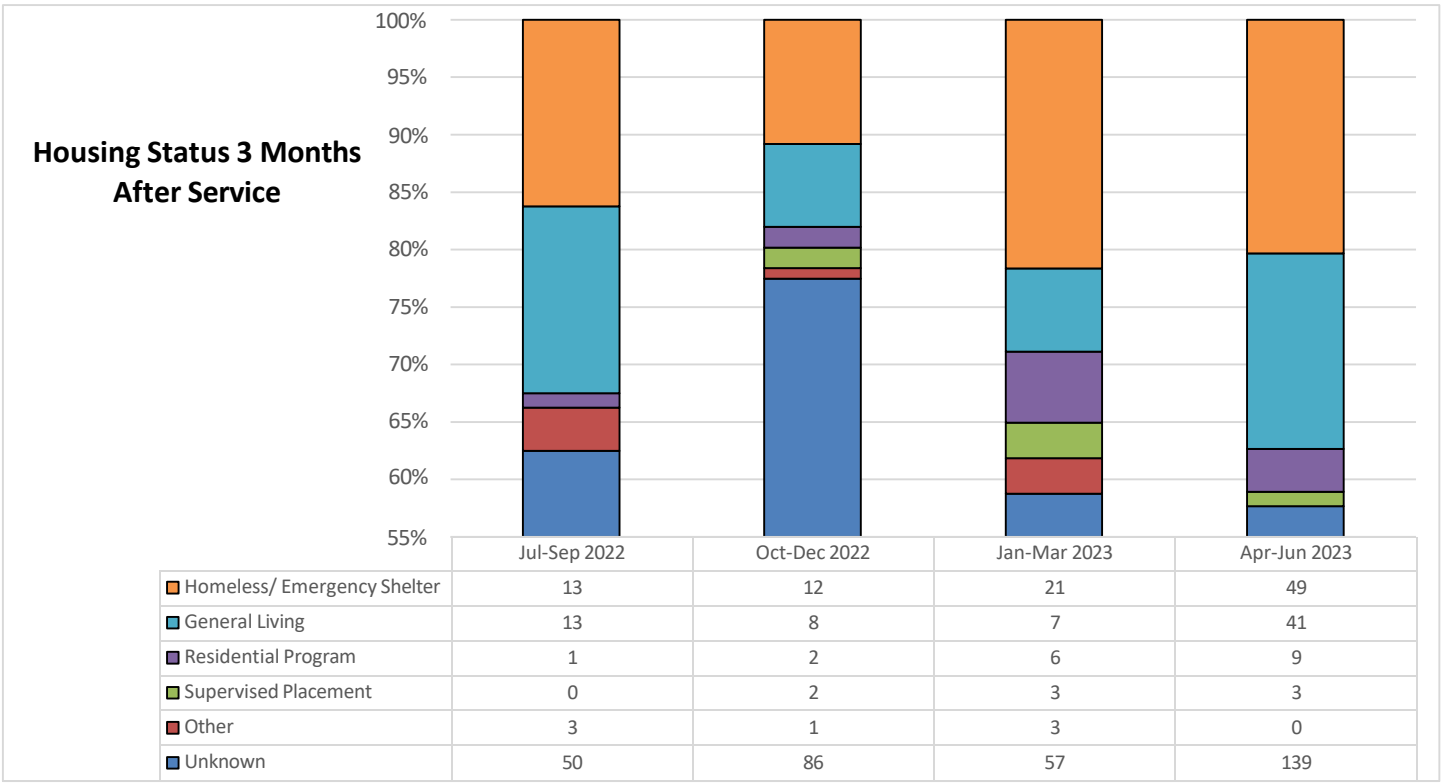
- "**Homeless/Emergency Shelter**"
- "**General Living**" which includes
  - Apartment or house, alone or with family/roommates
  - Foster home
  - Single room occupancy
- "**Supervised Placement**" which includes
  - Assisted living facility
  - Community care facility, such as a Board and Care
  -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

HOUSING STATUS AT START OF SERVICES

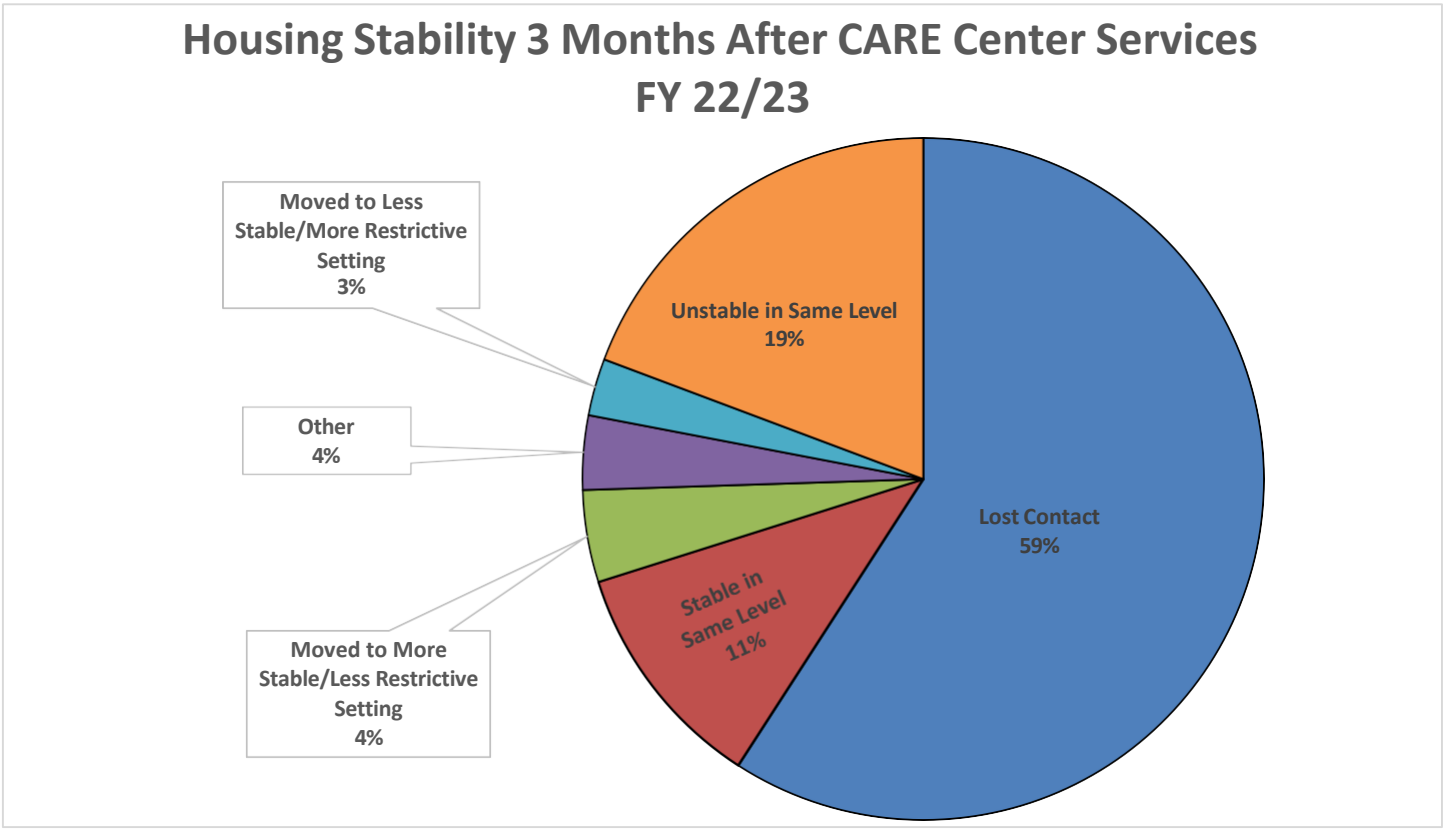


	Jul-Sep 2022	Oct-Dec 2022	Jan-Mar 2023	Apr-Jun 2023
Homeless/ Emergency Shelter	3	0	7	14
General Living	2	1	1	2
Residential Program	0	0	0	1
Supervised Placement	0	0	0	0
Other	2	1	2	0
Unknown	437	466	472	563

HOUSING STABILITY 3 MONTHS AFTER SERVICES AT THE CARE CENTER



	Jul-Sep 2022	Oct-Dec 2022	Jan-Mar 2023	Apr-Jun 2023
Homeless/ Emergency Shelter	13	12	21	49
General Living	13	8	7	41
Residential Program	1	2	6	9
Supervised Placement	0	2	3	3
Other	3	1	3	0
Unknown	50	86	57	139

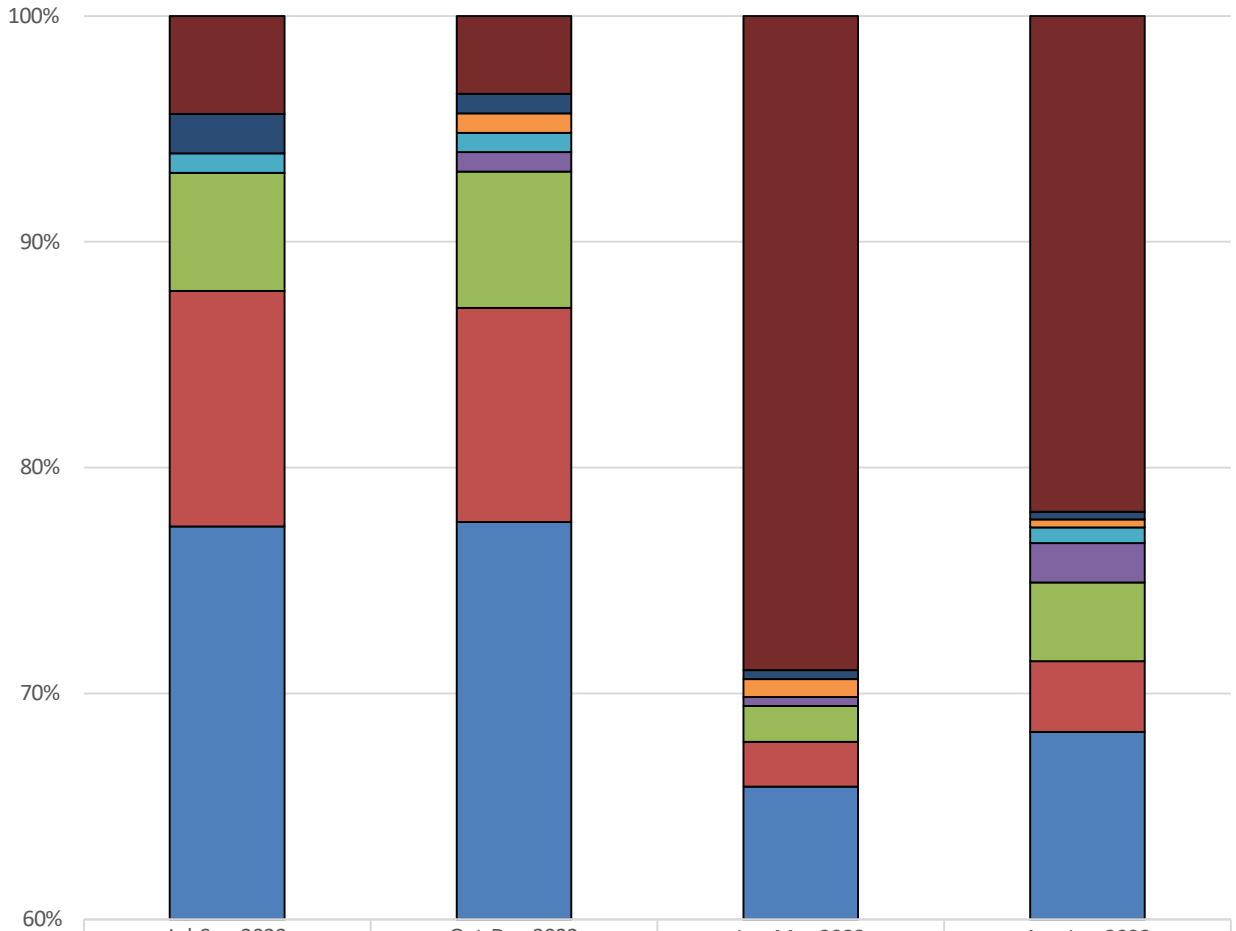


EMERGENCY DEPARTMENT VISITS

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

BASELINE EMERGENCY DEPARTMENT PSYCHIATRIC VISITS – PRIOR TO CARE CENTER SERVICES

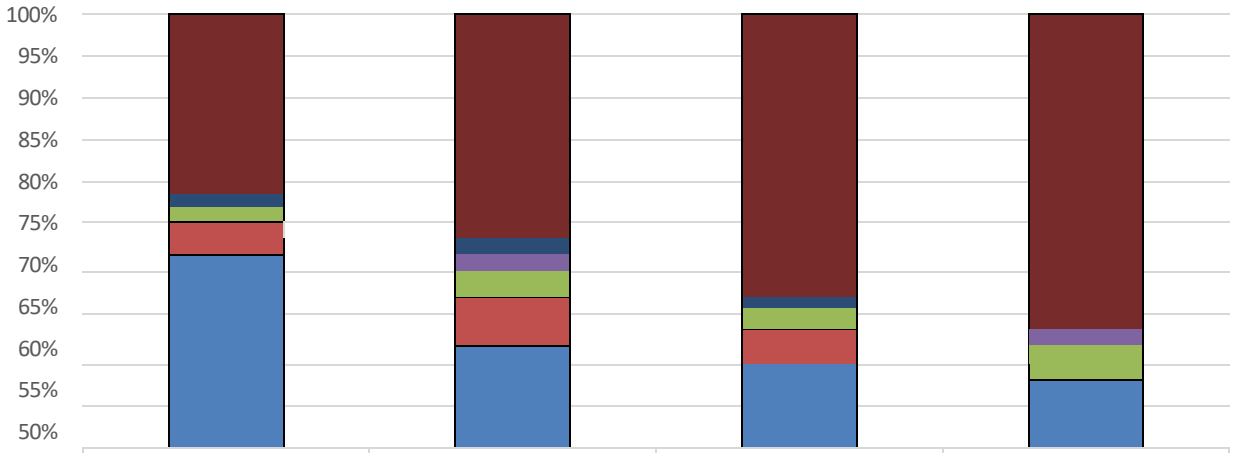
Unique Individuals by Number of ER Visits in 6 Months Prior to CARE Center Services



	Jul-Sep 2022	Oct-Dec 2022	Jan-Mar 2023	Apr-Jun 2023
Not Collected	5	4	73	63
6 or more ER Visits	2	1	1	1
5 ER Visits	0	1	2	1
4 ER Visits	1	1	0	2
3 ER Visits	0	1	1	5
2 ER Visits	6	7	4	10
1 ER Visit	12	11	5	9
Zero ER Visits	89	90	166	196

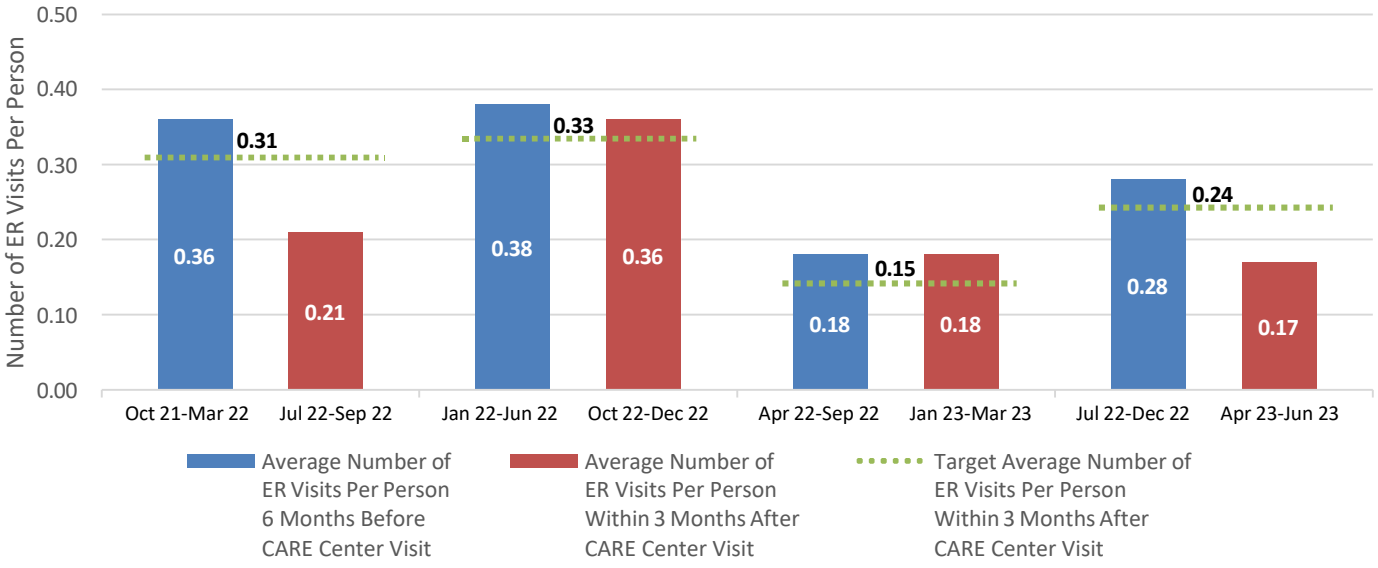
EMERGENCY DEPARTMENT PSYCH VISITS 3 MONTHS AFTER SERVICES

Unique Individuals by Number of ER Visits in 3 Months After CARE Center Services



	Jul-Sep 2022	Oct-Dec 2022	Jan-Mar 2023	Apr-Jun 2023
Not Collected	27	29	83	117
6 or more ER Visits	2	1	2	1
5 ER Visits	0	0	0	0
4 ER Visits	0	1	0	0
3 ER Visits	0	2	0	3
2 ER Visits	2	4	7	6
1 ER Visit	5	6	5	8
Zero ER Visits	90	70	154	188

Average Number of ER Visits 3 Months After CARE Center Services vs 6 Months Before CARE Center Services - FY 22/23

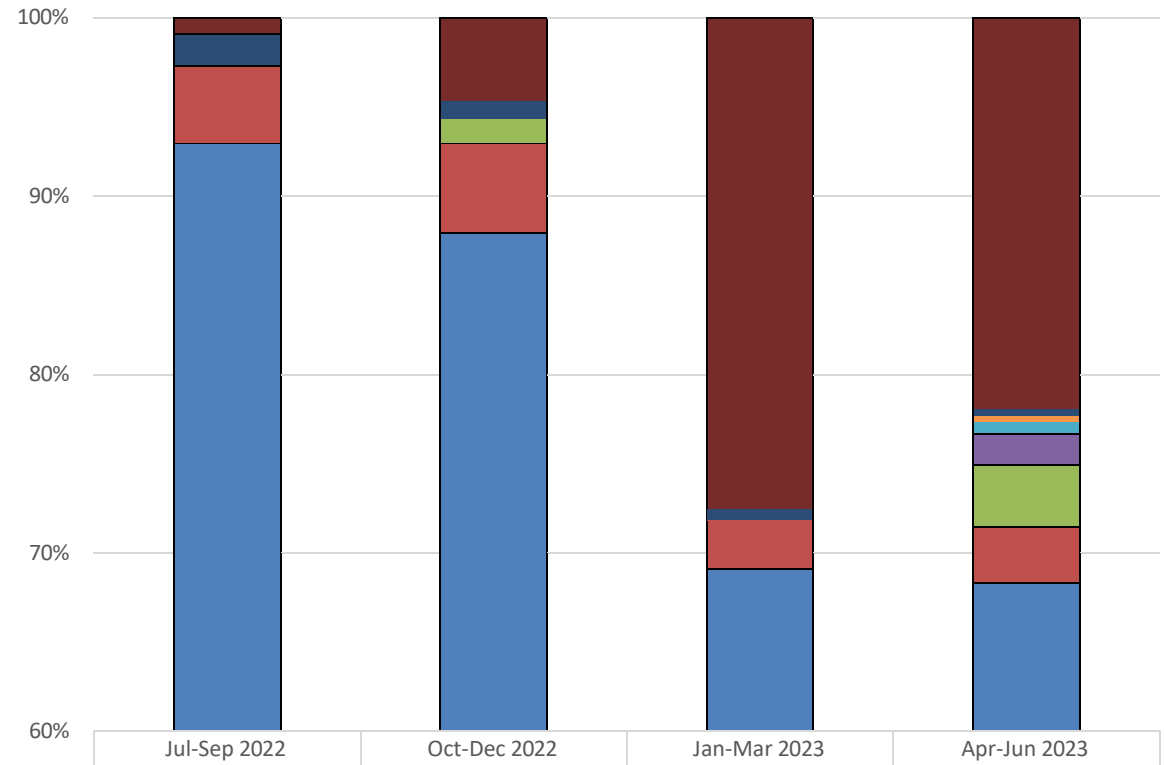


PSYCHIATRIC INPATIENT HOSPITALIZATIONS

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

BASELINE PSYCHIATRIC HOSPITALIZATIONS – PRIOR TO CARE CENTER SERVICES

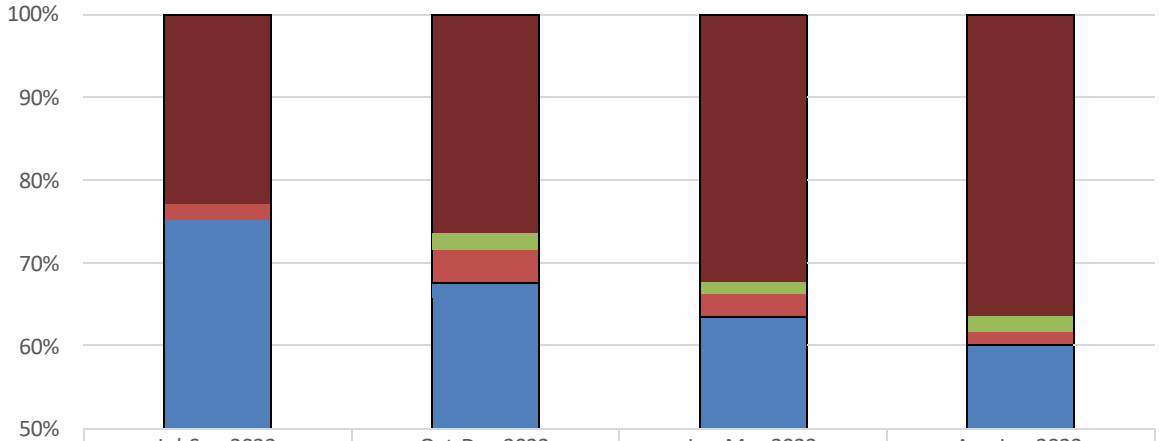
Unique Individuals by Number of Psychiatric Hospitalizations in 6 Months Prior to CARE Center Services



	Jul-Sep 2022	Oct-Dec 2022	Jan-Mar 2023	Apr-Jun 2023
Unknown	1	5	69	63
6 or more Hospitalizations	2	1	1	1
5 Hospitalizations	0	0	0	1
4 Hospitalizations	0	0	0	2
3 Hospitalizations	0	0	0	5
2 Hospitalizations	0	2	0	10
1 Hospitalization	5	6	8	9
Zero Hospital Stays	103	102	174	196

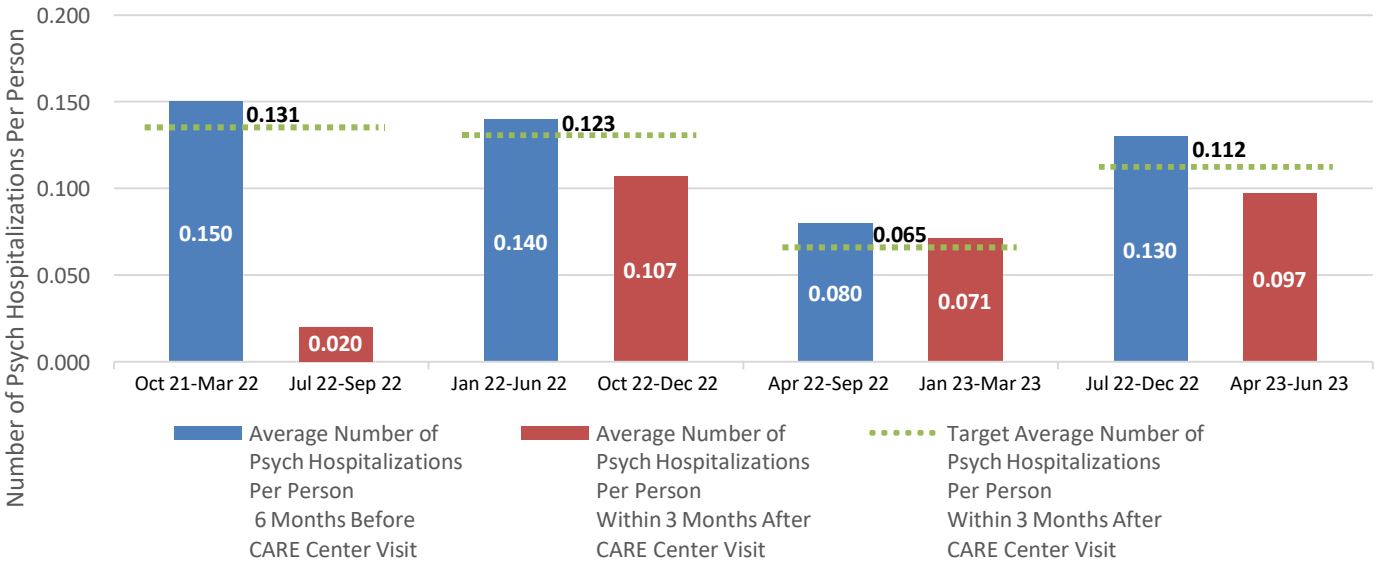
PSYCHIATRIC HOSPITALIZATIONS – AFTER CARE CENTER SERVICES

Unique Individuals by Number of Psychiatric Hospitalizations in 3 Months after CARE Center Services



	Jul-Sep 2022	Oct-Dec 2022	Jan-Mar 2023	Apr-Jun 2023
Unknown	28	29	82	116
6 or more Hospitalizations	0	0	0	1
5 Hospitalizations	0	0	0	0
4 Hospitalizations	0	0	0	0
3 Hospitalizations	0	0	0	0
2 Hospitalizations	0	2	2	3
1 Hospitalization	2	5	8	8
Zero Hospital Stays	96	77	159	195

Average Number of Psych Hospitalizations 3 Months After CARE Center Services vs 6 Months Before CARE Center Services - FY 22/23

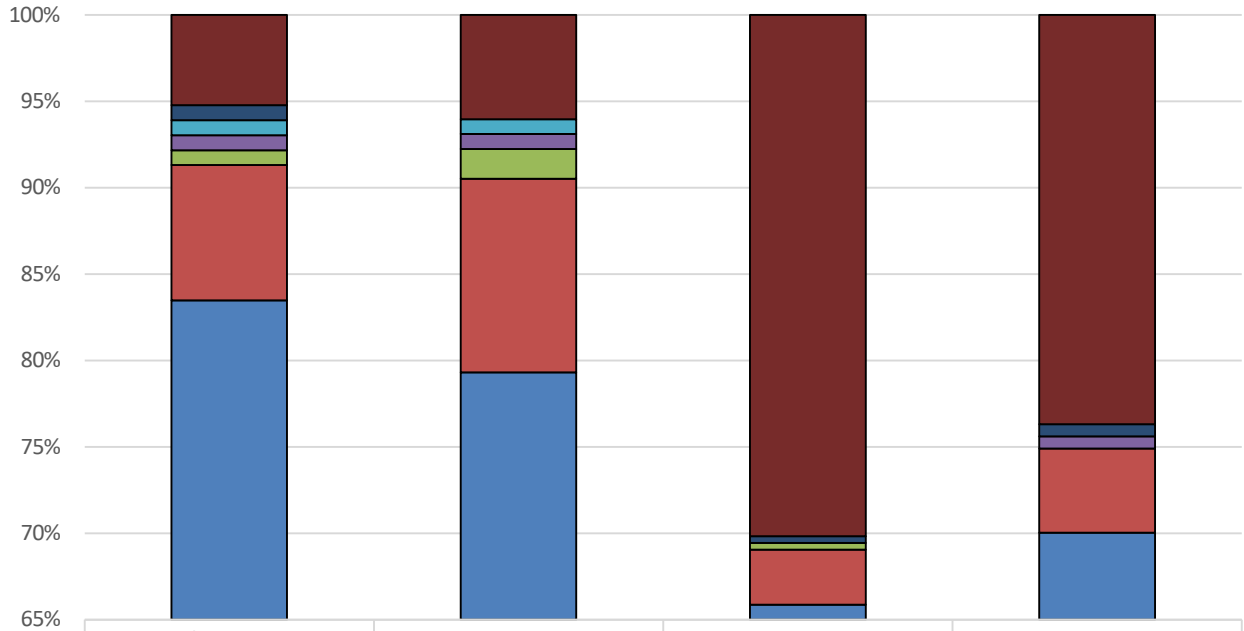


ARRESTS

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

BASELINE ARRESTS – PRIOR TO CARE CENTER SERVICES

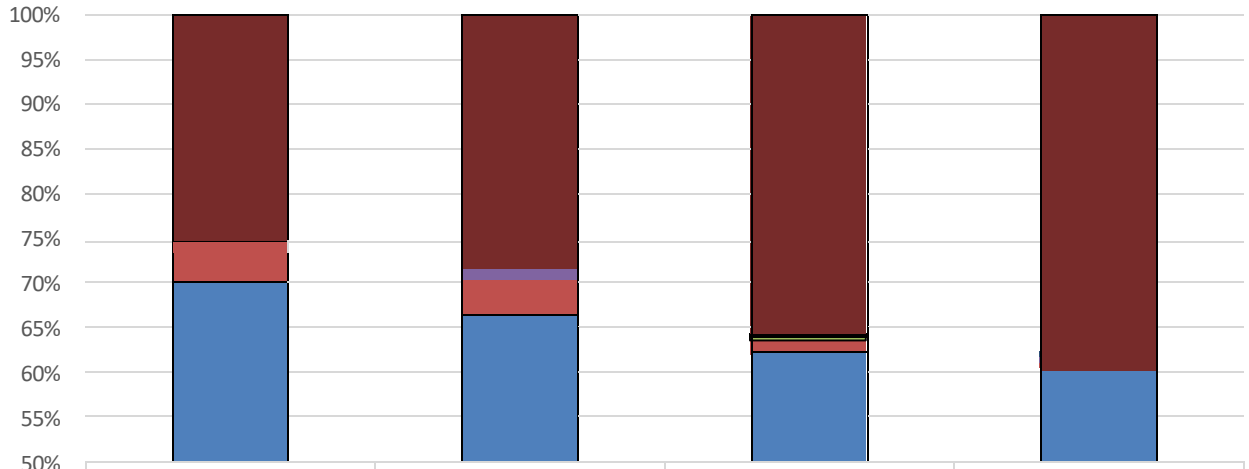
Unique Individuals by Number of Arrests in 6 Months Prior to CARE Center Services



	Jul-Sep 2022	Oct-Dec 2022	Jan-Mar 2023	Apr-Jun 2023
Unknown	6	7	76	68
6 or more Arrests	1	0	1	2
5 Arrests	0	0	0	0
4 Arrests	1	1	0	0
3 Arrests	1	1	0	2
2 Arrests	1	2	1	0
1 Arrest	9	13	8	14
Zero Arrests	96	92	166	201

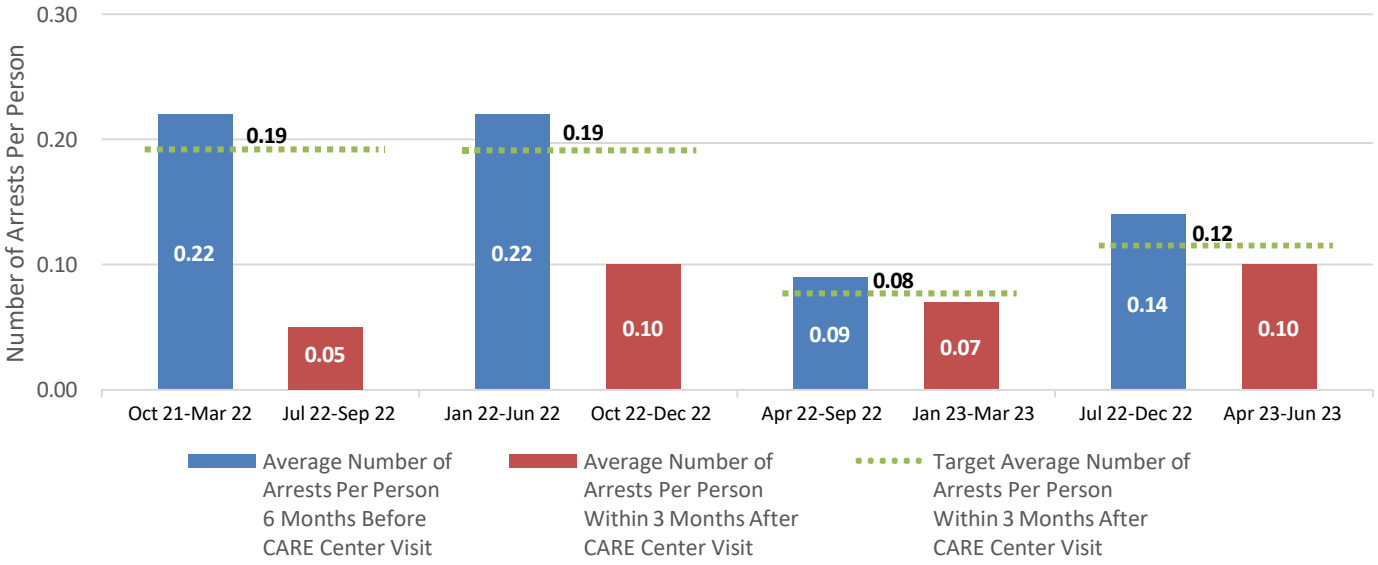
ARRESTS 3 MONTHS AFTER SERVICES AT THE CARE CENTER

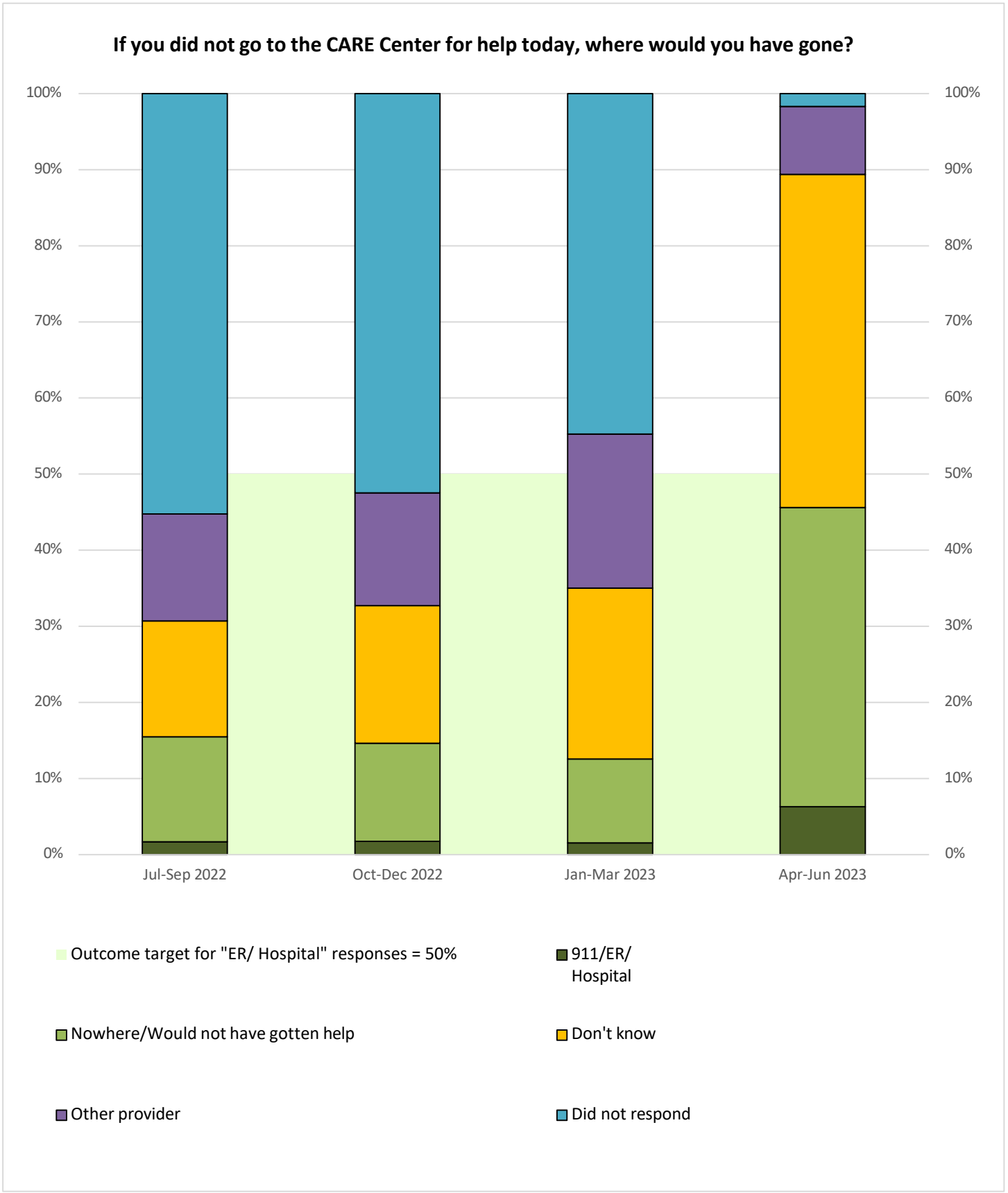
Unique Individuals by Number of Arrests in 3 Months After CARE Center Services



	Jul-Sep 2022	Oct-Dec 2022	Jan-Mar 2023	Apr-Jun 2023
Unknown	33	32	89	121
6 or more Arrests	0	0	1	2
5 Arrests	0	0	0	0
4 Arrests	0	0	0	0
3 Arrests	0	1	0	2
2 Arrests	0	0	1	0
1 Arrest	5	5	4	2
Zero Arrests	88	75	156	196

Average Number of Arrests 3 Months After CARE Center Services vs 6 Months Before CARE Center Services - FY 22/23




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%
Jul-Sep 2022
Oct-Dec 2022
Jan-Mar 2023
Apr-Jun 2023
Outcome target for "ER/ Hospital" responses = 50%
911/ER/ Hospital
Nowhere/Would not have gotten help
Don't know
Other provider
Did not respond

Shasta County Mental Health, Alcohol and Drug (SCMHAD)
June FY22-23 CRRC Report (Prior month and year information is updated to current information)

Table 3: Bolded and underlined numbers represent the highest number during the fiscal year. In June, the number of CRRC admits at 11 was a decrease of -8% from May and decreased -39% from the same month of last year. There were 173 CRRC bed days for June, -25% less than May, and a -26% decrease from the same month of the prior year. The average length of stay for June was 16 days, which was -3 less than May and 3 more than June of the previous year.

CRRC/Elpida Admits (chart on page 4)														
Fiscal Year	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun		
YTD Change +/-*	-40%	-20%	-29%	-30%	-34%	-29%	-32%	-24%	-19%	-23%	-17%	-20%	FY Total	FY Change +/-**
2022-2023	9	11	5	6	4	7	6	10	14	5	12	11	**100**	-20%
2021-2022	15	10	10	9	9	6	12	5	13	11	7	18	**125**	-31%
2020-2021	15	17	19	17	20	11	10	15	14	18	12	14	**182**	1%
2019-2020	20	12	17	14	13	13	17	19	15	10	16	15	**181**	-7%
2018-2019	17	20	15	22	18	14	18	13	15	16	13	14	**195**	12%
2017-2018	17	13	12	12	13	14	19	11	11	16	16	20	**174**	14%
2016-2017	16	17	5	16	14	5	16	8	22	11	10	13	**153**	-13%
2015-2016	18	9	15	20	14	11	12	15	10	**21**	11	19	**175**	-5%
2014-2015	17	23	17	14	15	12	17	13	14	10	14	19	**185**	-1%
2013-2014	17	17	19	19	12	15	**21**	6	19	15	10	16	**186**	-27%
2012-2013	26	**28**	21	25	24	19	17	22	18	17	19	20	**256**	24%

CRRC/Elpida Days (chart on page 4)														
Fiscal Year	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun		
YTD Change +/-*	6%	4%	-7%	-18%	-29%	-32%	-32%	-29%	-25%	-20%	-16%	-17%	FY Total	FY Change +/-**
2022-2023	362	274	174	129	84	157	141	166	240	281	232	173	**2413**	-17%
2021-2022	343	268	257	282	289	300	211	138	211	209	149	234	**2891**	-9%
2020-2021	306	276	276	278	203	235	165	251	323	360	288	215	**3176**	-11%
2019-2020	**366**	291	247	314	235	260	294	317	360	313	309	270	**3576**	-20%
2018-2019	376	404	348	403	357	285	367	320	394	407	**437**	381	**4479**	50%
2017-2018	204	165	187	204	260	329	288	264	194	201	353	339	**2988**	13%
2016-2017	295	280	201	185	291	120	242	199	167	228	130	313	**2651**	-7%
2015-2016	236	224	244	342	301	266	194	220	178	215	193	229	**2842**	-5%
2014-2015	345	268	280	235	235	186	284	239	174	246	192	304	**2988**	-3%
2013-2014	274	231	255	295	136	207	333	311	212	335	242	243	**3074**	-14%
2012-2013	315	341	321	310	344	361	248	259	296	308	213	274	**3590**	20%

CRRC/Elpida – Average Length of Stay (Bed Days/Admit Count) - (chart on page 4)														
Fiscal Year	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY Avg. LOS	FY Change +/-**
2022-2023	40	25	35	22	21	22	24	17	17	**56**	19	16	**24**	4%
2021-2022	23	27	26	31	32	50	18	28	16	19	21	13	**23**	35%
2020-2021	20	16	15	16	10	21	17	17	23	20	24	15	**17**	-15%
2019-2020	18	24	15	22	18	20	17	17	24	31	19	18	**20**	-13%
2018-2019	22	20	23	18	20	20	20	25	26	25	34	27	**23**	35%
2017-2018	12	13	16	17	20	24	15	24	18	13	22	17	**17**	0%
2016-2017	18	16	40	12	21	24	15	25	8	21	13	24	**17**	6%
2015-2016	13	25	16	17	22	24	16	15	18	10	18	12	**16**	0%
2014-2015	20	12	16	17	16	16	17	18	12	25	14	16	**16**	-6%
2013-2014	16	14	13	16	11	14	16	**52**	11	22	24	15	**17**	21%
2012-2013	12	12	15	12	14	19	15	12	16	18	11	14	**14**	0%

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

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

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Shasta County Mental Health, Alcohol and Drug (SCMHAD)
June FY23-24 CRRC Report (Prior month and year information is updated to current information)

CRRC Charts

Chart 4

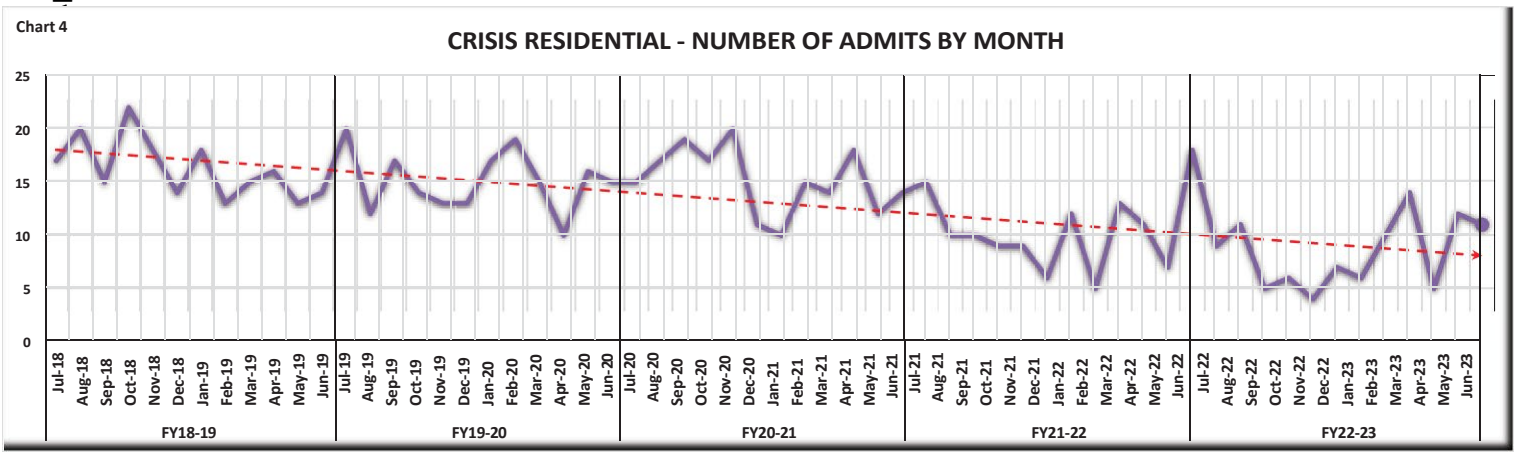


Chart 5

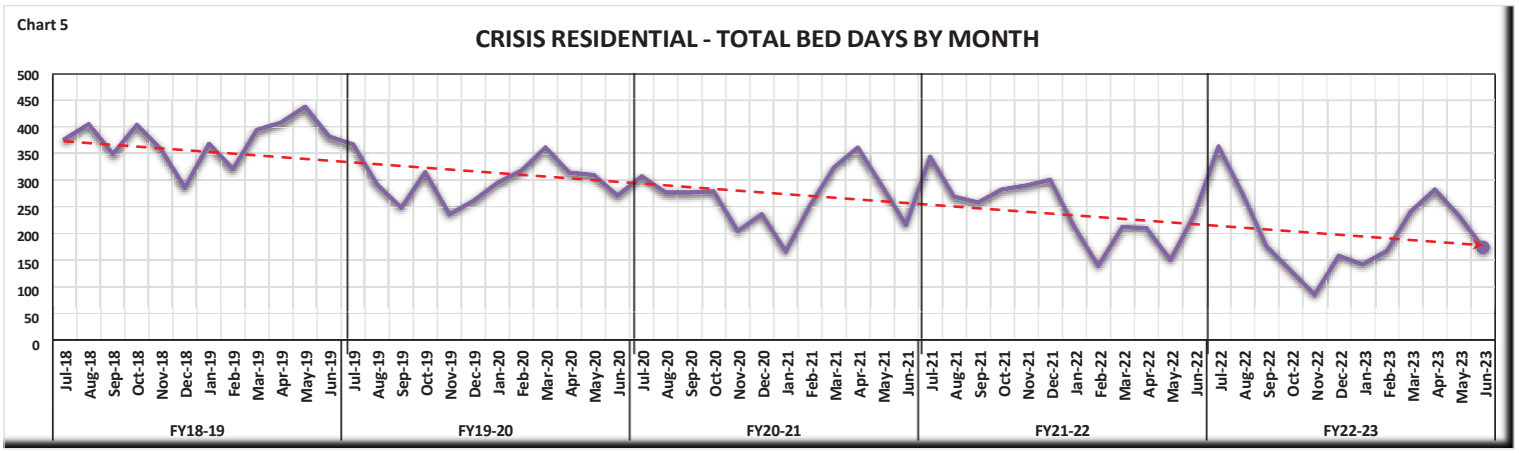
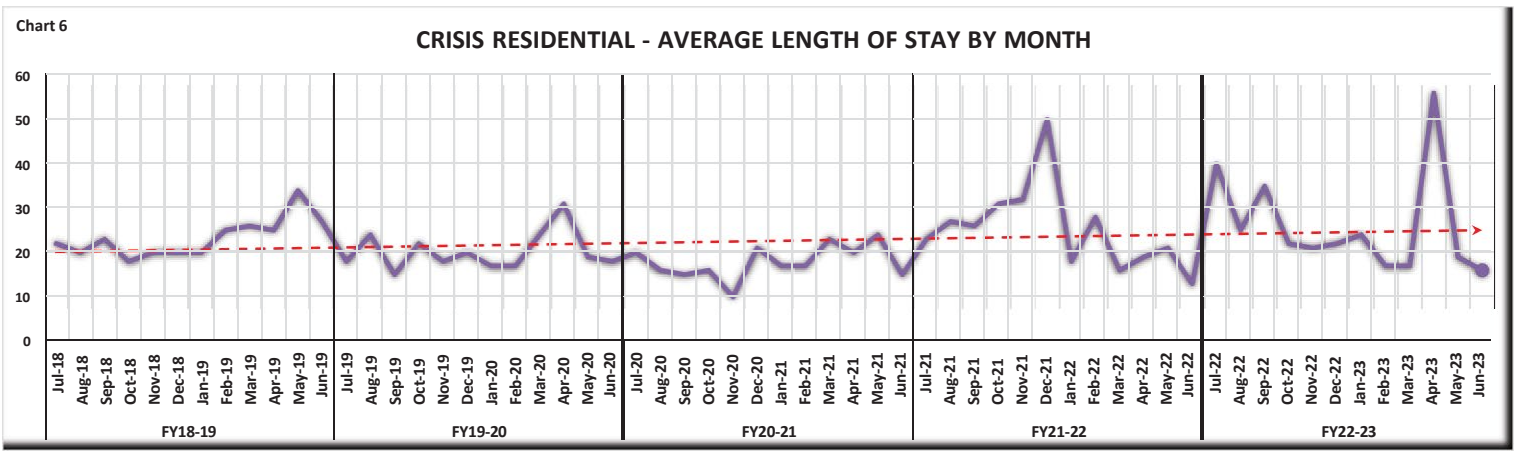


Chart 6



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Shasta County Health & Human Services Agency

The Woodlands Permanent Supportive Housing

Fiscal Year 2022-2023

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

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

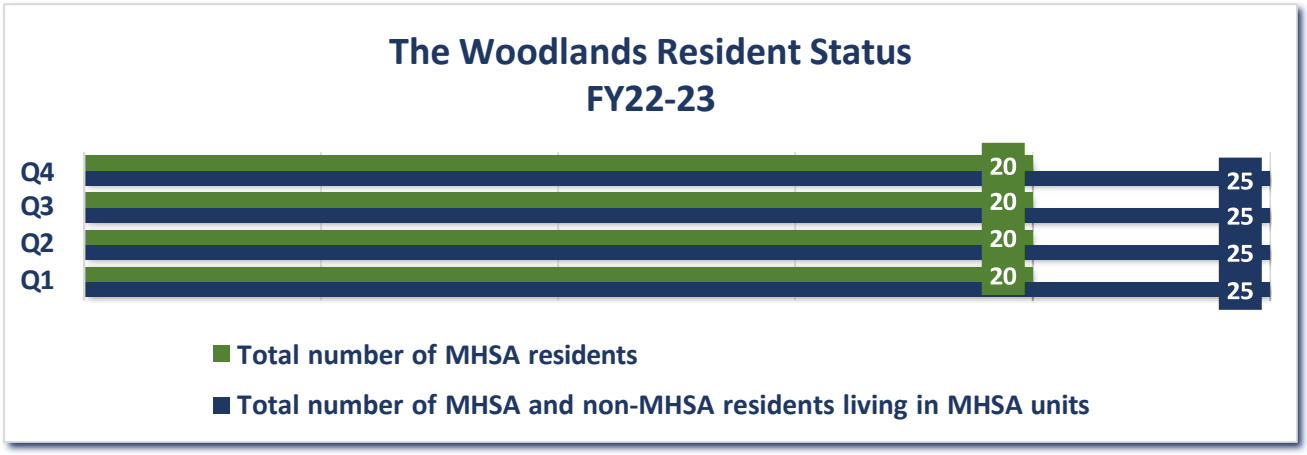
- Finance/Budgeting Classes
- Personal Income Tax Preparation
- Adult Education Classes
- Benefit/Entitlement Assistance
- After-School Activities
- Health and Wellness Classes.

The County also provides clients with supportive services such as:

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

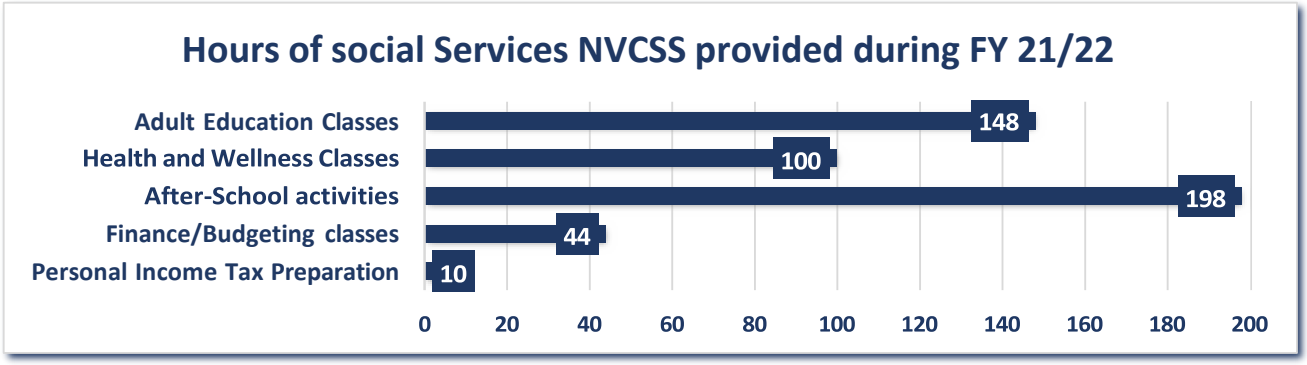
Ongoing social and supportive services are available to help clients maintain housing stability to prevent homelessness and substance abuse among other challenges. A caseworker and peer support specialist are stationed at the Woodlands to assist with these services.

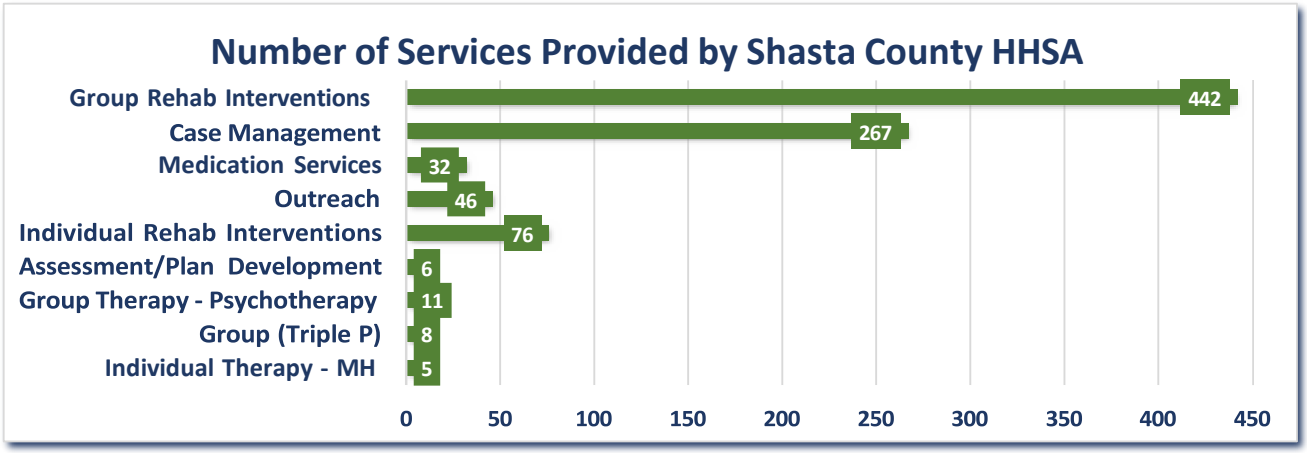
Data on the Woodlands residents, classes, and activities are shown below. To maintain confidentiality, demographic information on residents is not reported on. A bar chart representing the number of tenants in MHSA units each quarter is shown below.



When tenants leave MHSA units, vacancies are quickly filled by those who are on the MHSA Permanent Supportive Housing Project waitlist. There were 2 permanent departure from a MHSA-designated unit during FY22-23.

During FY22-23, clients engaged in many different activities, community education programs, and classes to learn skills. The types of social services provided, and the number of times those services have been provided, is summarized on the charts below.





Triple P Outcome Evaluation

Fiscal Year 22/23

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),

(ASRA) Automatic Scoring and Reporting Application data

Overview

*NOTE - 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.

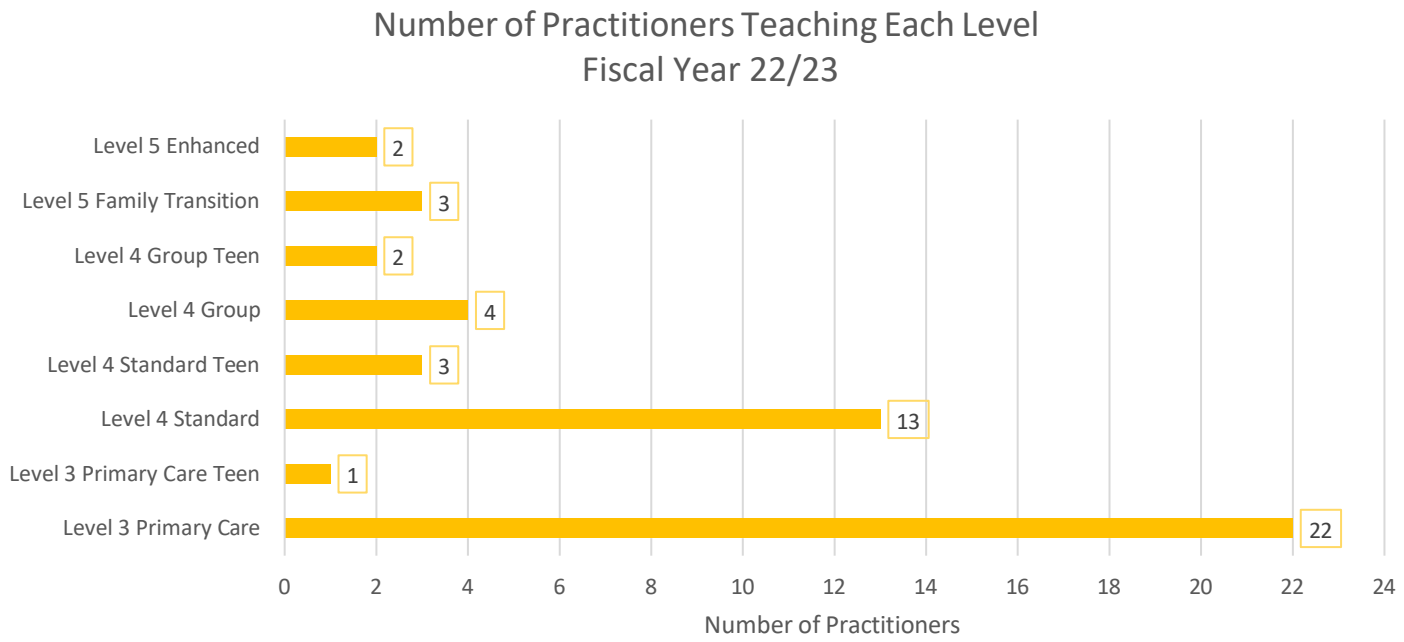
The table below shows the total number of Triple practitioners who entered data into the ASRA Scoring application during Fiscal Year 22/23, along with the organization they were with, and the total number of caregivers and families they served:

Partnered Organizations Providing Triple P Fiscal Year 22/23			
Organizations	**Practitioners**	**Caregivers**	**Children**
Child Abuse Prevention Coordinating Council of Shasta County (CAPCC)	17	117	109
Faith Works	3	8	7
Family Dynamics	2	31	31
Shasta County Office of Education	13	99	81
Shasta County Health and Human Services Agency	1	1	1
Wright Education Services	2	7	5
Totals:	**38**	**263**	**238**

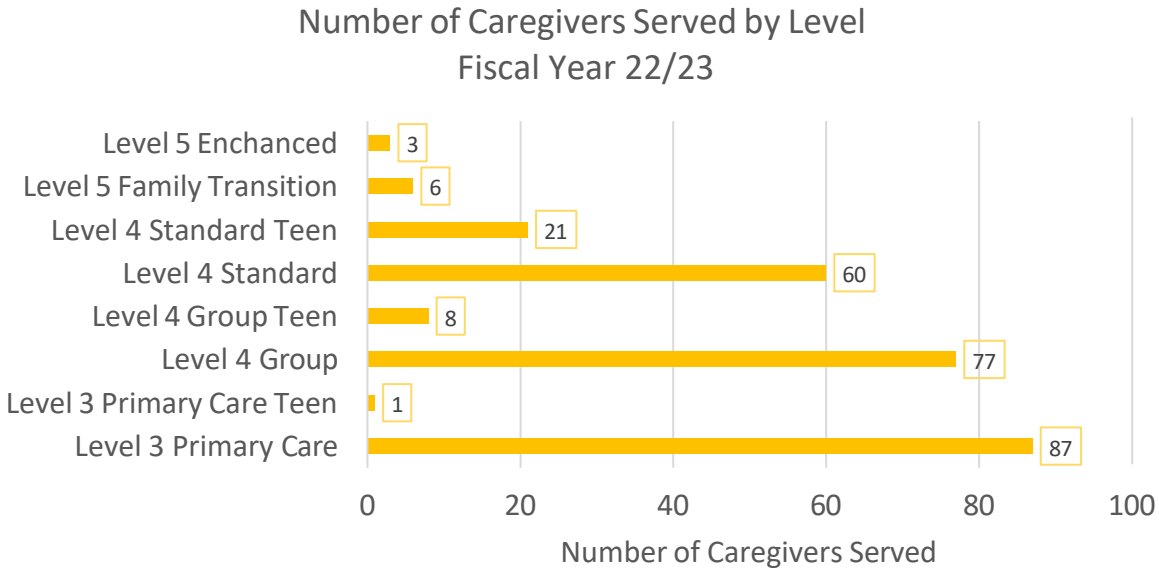
Some families may have received services in more than one organization, level, or version of Triple P. The information stored in the scoring application is anonymous (names were not collected). For this reason, the total number of ***unique*** caregivers and children/teens served between all levels couldn't be determined. In addition, if a practitioner was still submitting data in the Scoring application after transitioning to a new organization during Fiscal Year 22/23, they would be counted as a practitioner in each organization they were a part of.

Data on Practitioners and Caregivers by Level

There were 38 practitioners who provided Triple P services during 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):

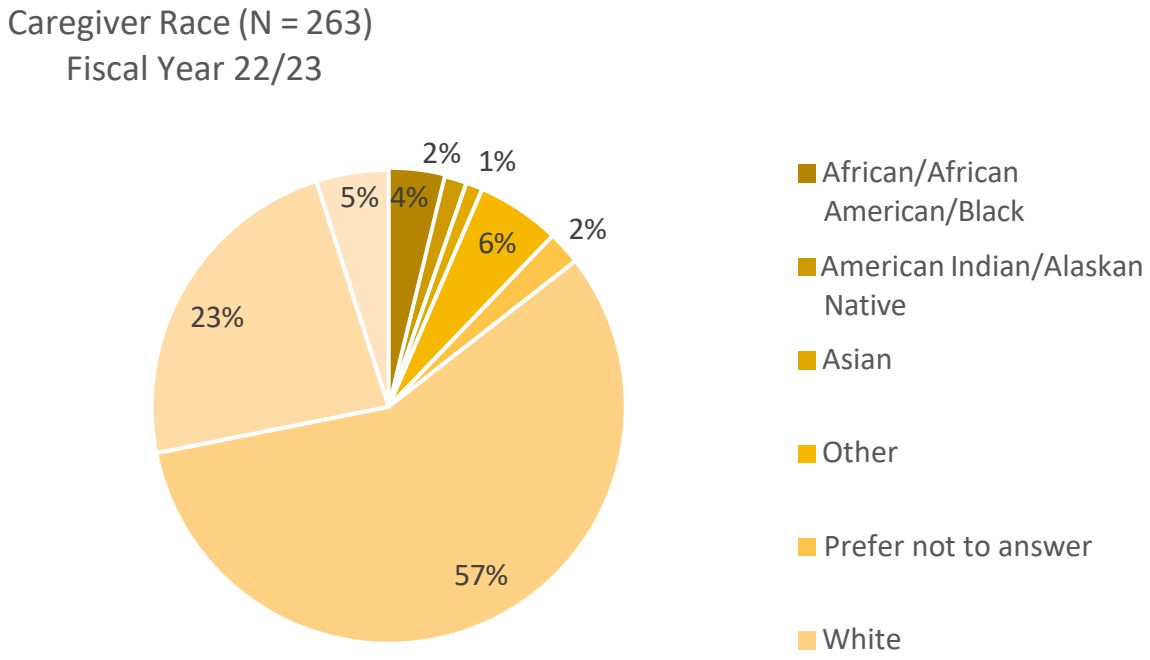


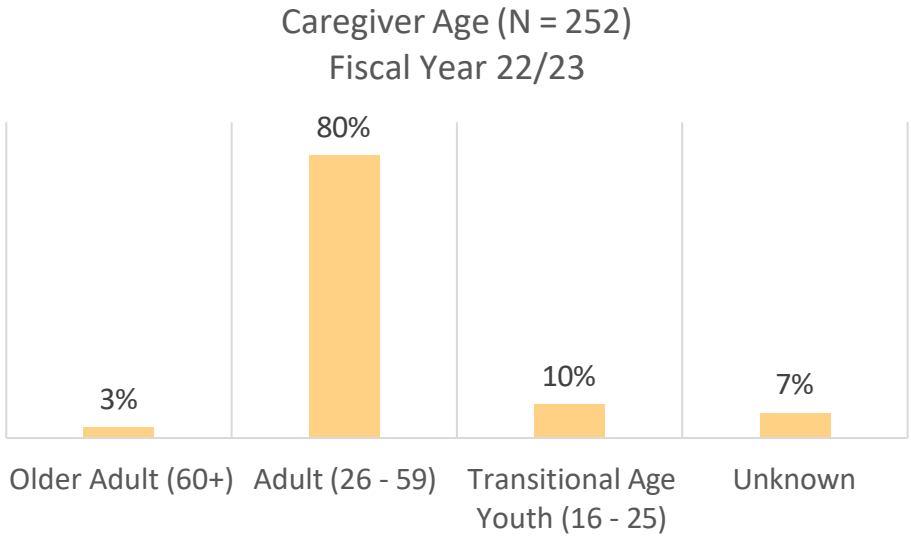
A total of 263 caregivers attended Triple P sessions. The number of caregivers in each level of Triple P is shown below:

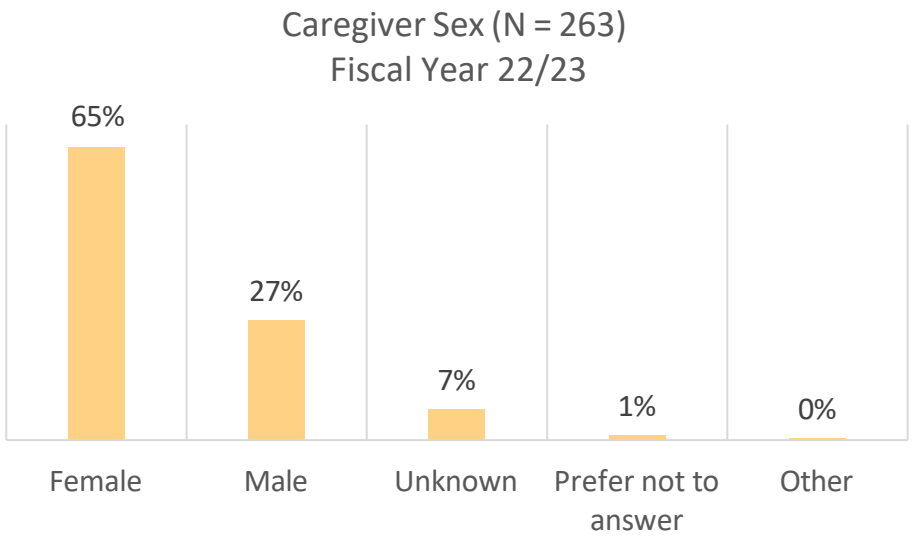


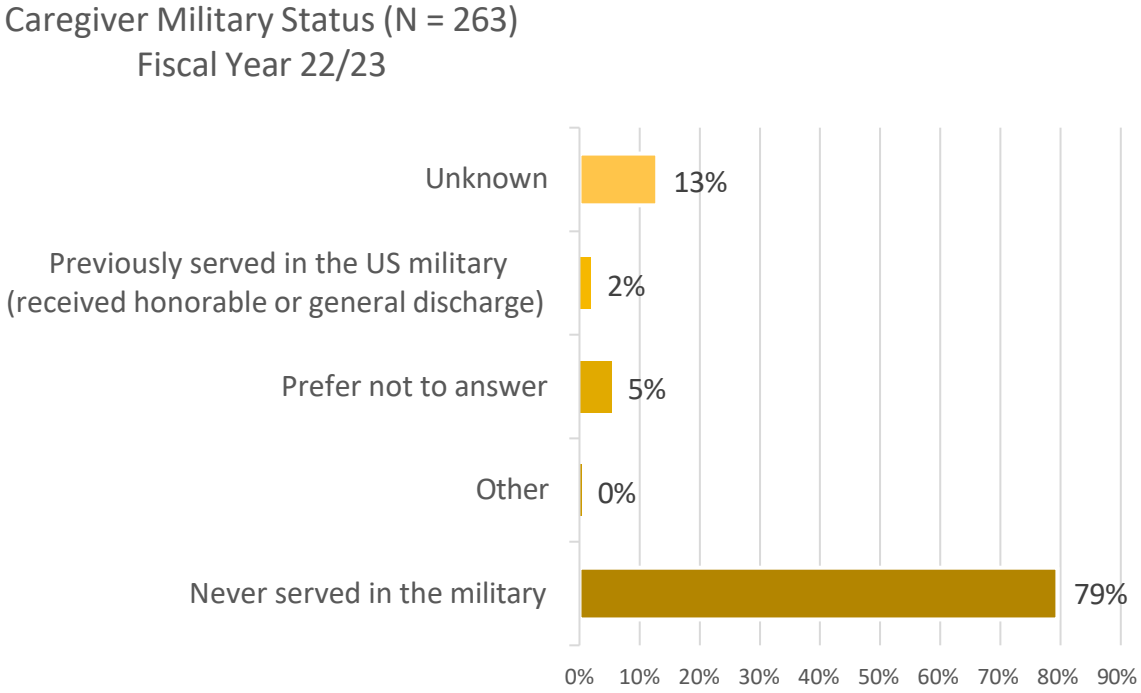
Demographic Data on Caregivers and Families

Of the 263 caregivers 98% spoke English (2% other) and 78% identified as heterosexual or straight (12% unknown, 8% prefer not to answer, and 1% bisexual/pansexual/sexually fluid). 199 (76%) caregivers indicated there had no disability, 16 (6%) preferred not to answer, 22 (8%) didn't respond to the question, the remaining 10% indicated having some disability (the largest being 9 or 3% identifying as having a learning disability). The remaining demographics (Race, Age, Sex, Relationship with Child or Teen, and Military Status) are shown below. Although a total of 263 caregivers were served, some demographic data points are filled out in error, in those cases N (number are participants) is adjusted to reflect corrected identified data (e.g., Caregiver Age: N = 252).

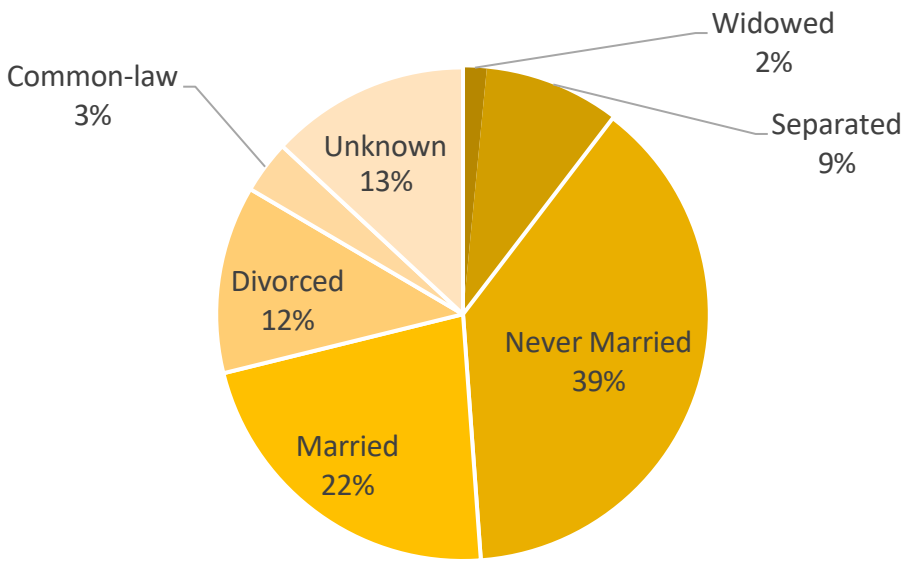




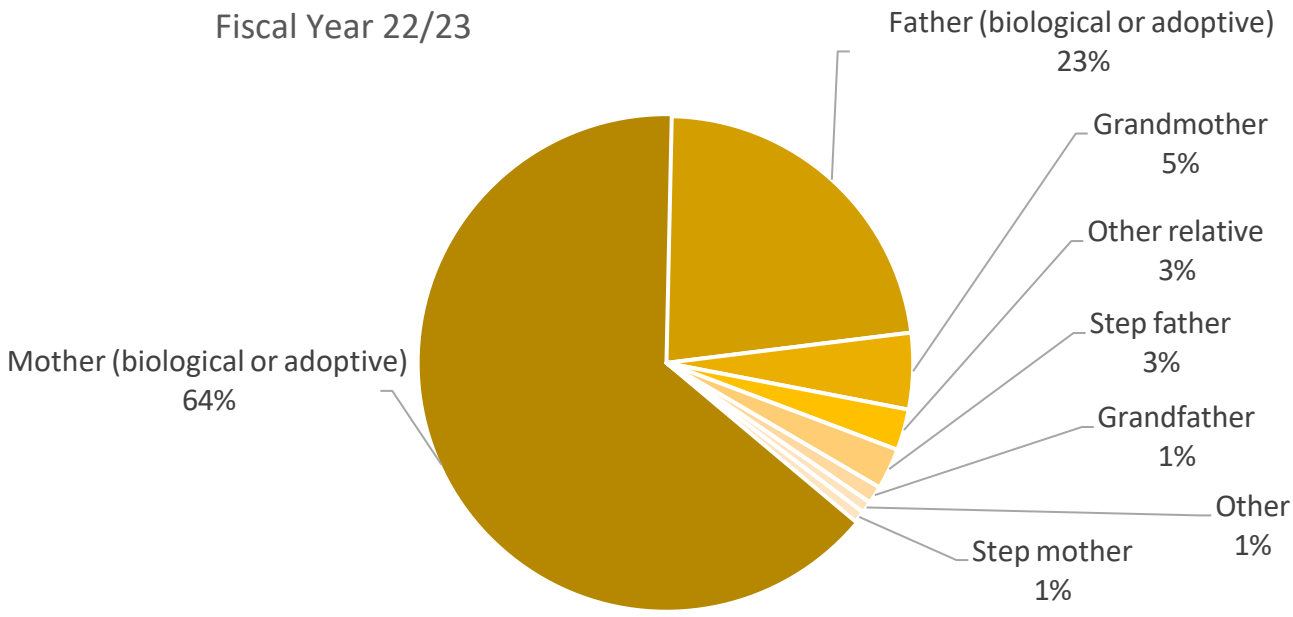

Caregiver Sex (N = 263)
Fiscal Year 22/23
65%
27%
7%
1%
0%
Female
Male
Unknown
Prefer not to answer
Other


Caregiver Military Status (N = 263)
Fiscal Year 22/23
Unknown
13%
Previously served in the US military (received honorable or general discharge)
2%
Prefer not to answer
5%
Other
0%
Never served in the military
79%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%

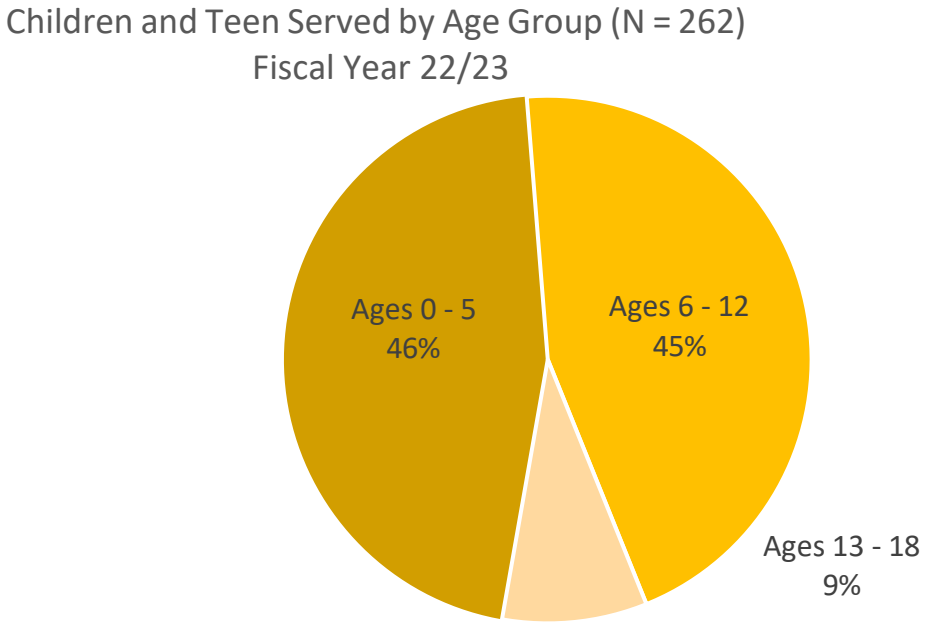
Caregiver Marital Status (N = 263)
Fiscal Year 22/23



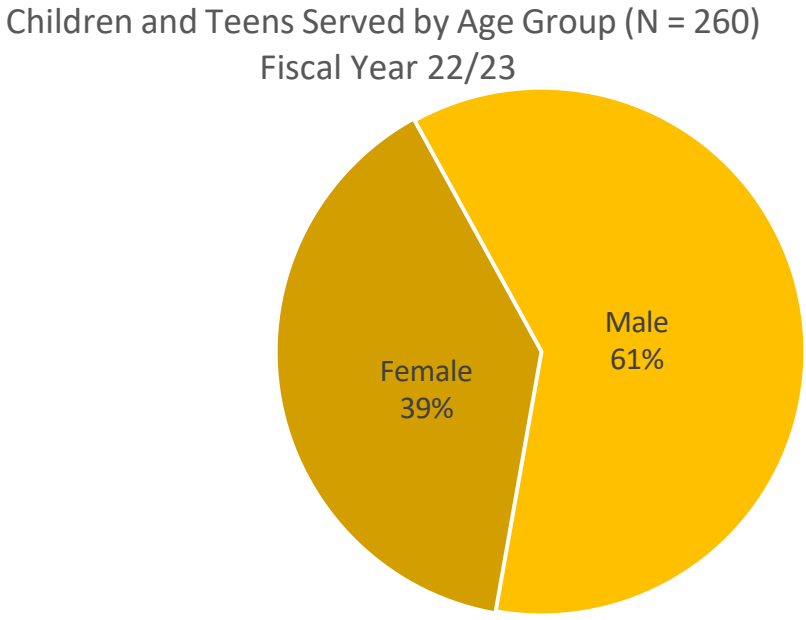
Caregiver Relationship to Child or Teen (N = 263)
Fiscal Year 22/23



The age of the child or teen was recorded at the beginning of the session. 121 children were aged 5 or younger, 118 ages 6 – 12 years old, and 23 between the ages of 13 and 18 (there was one error in age data entry). out of the total 234 and the average age was 6.



There were 158 male and 102 female children and teens served:



Outcomes and Measures

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 via pre-assessment and post-assessment scores. The required self-assessment – The Parenting and Family Adjustment Scale Self-Assessment is described in 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 respondents are instructed to indicate (on a scale from 0-3) how true each statement on the survey was for them (over the past 4 weeks). "0" meant that the statement was not true, while "3" meant that the statement was true or true most of the time.[2]

A blank example of the PAFAS survey is shown on page 9, a scoring illustration of the PAFAS is shown on page 10, and the actual pre-/post-average scores from the PAFAS survey during Fiscal Year 22/23 is shown on page 11.

PAFAS Blank Assessment (example)

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

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:

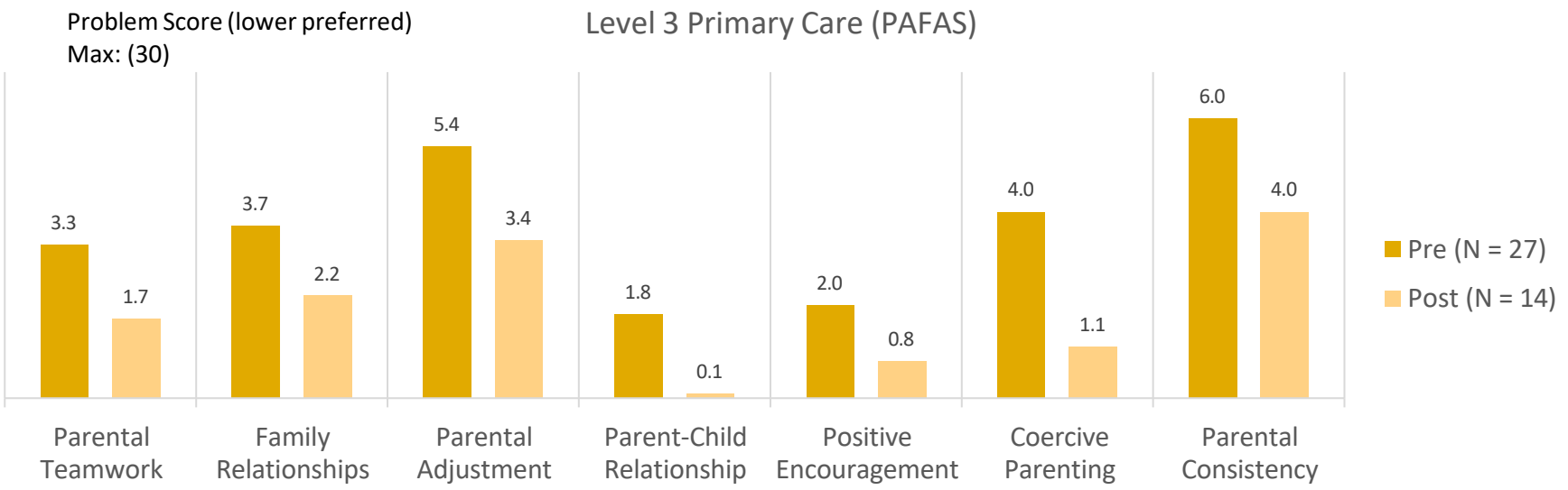
19. I feel stressed or worried	0	1	2	3		(Range) 0 – 15
21. I feel sad or depressed	0	1	2	3		
20. I feel happy	0	1	2	3	(Reverse-scored)	
22. I feel satisfied with my life	0	1	2	3	(Reverse-scored)	
23. I cope with the emotional demands of being a parent	0	1	2	3	(Reverse-scored)	

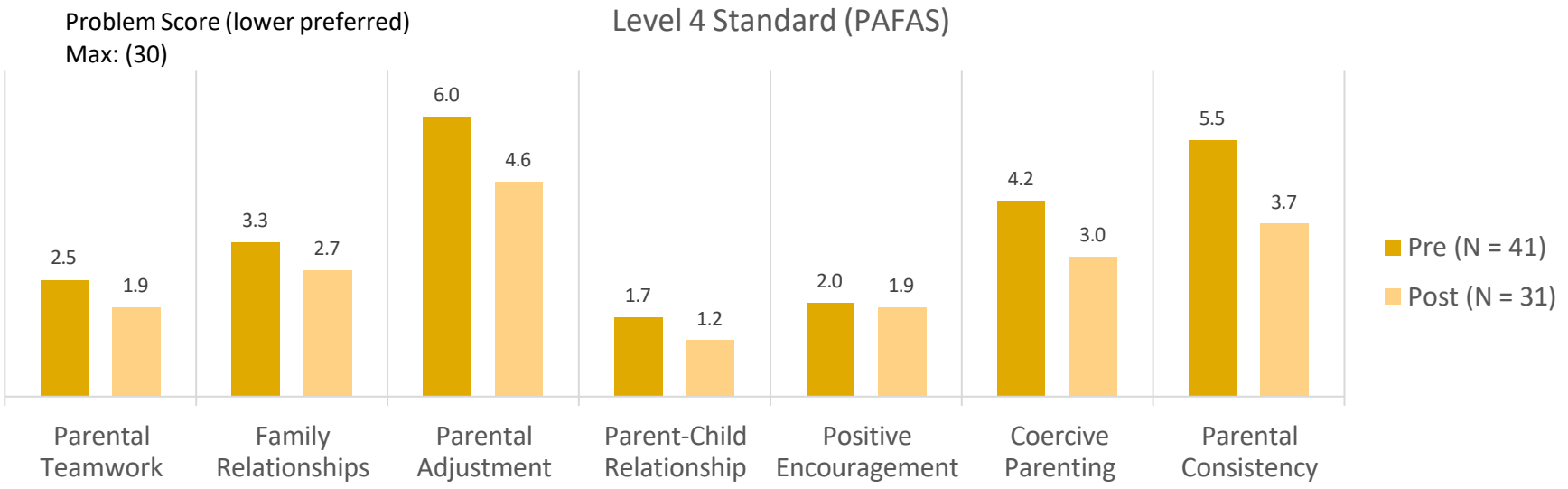
Family Relationships scores are calculated by adding scores for 26 and 27 with the reverse-scores for 24 & 25:

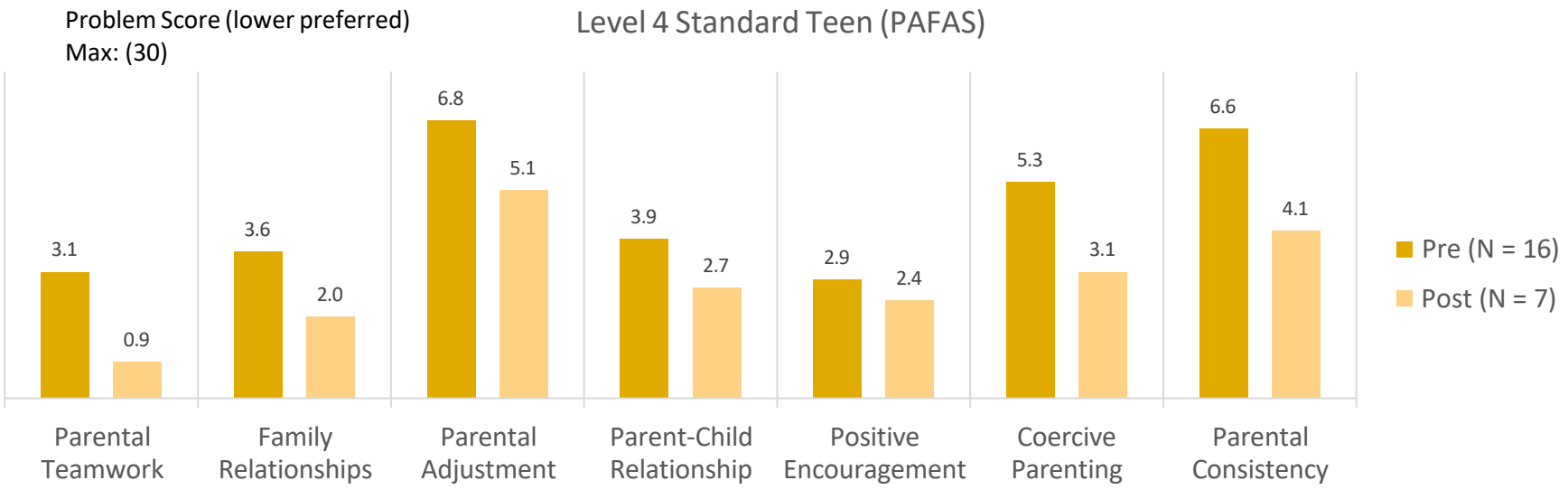
26. Our family members fight or argue	0	1	2	3		(Range) 0 – 12
27. Our family members criticize or put each other down	0	1	2	3		
24. Our family members help or support each other	0	1	2	3	(Reverse-scored)	
25. Our family members get on well with each other	0	1	2	3	(Reverse-scored)	

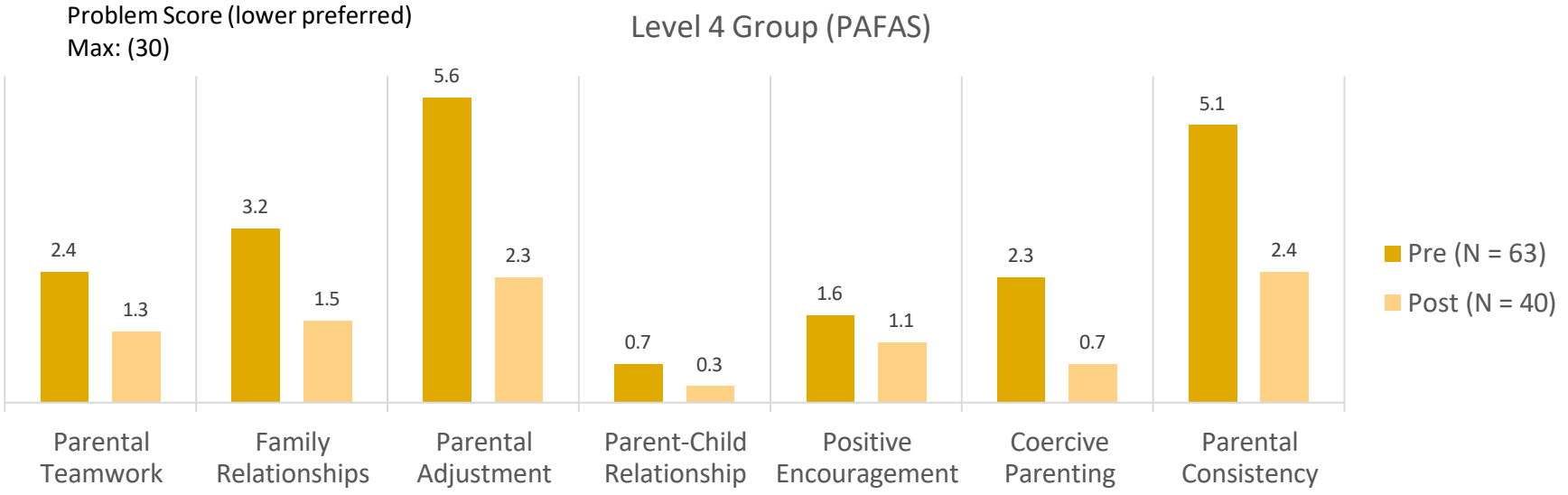
Parental Teamwork scores are calculated by adding the score for 29 with the reverse-scores for 28 and 30:

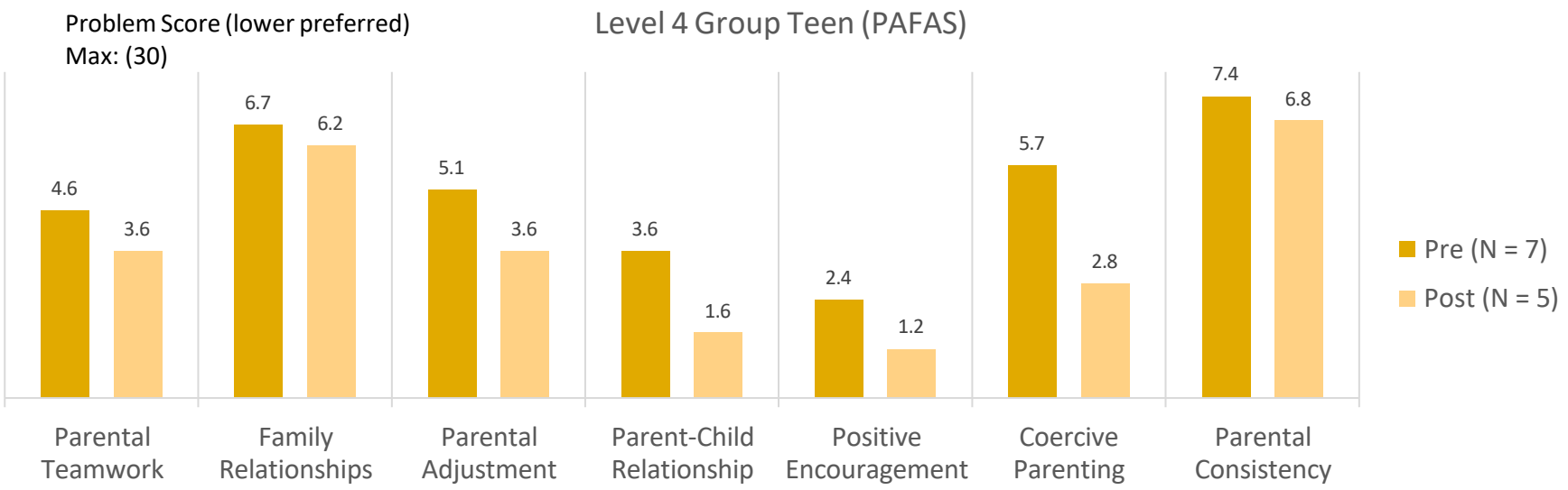
29. I disagree with my partner about parenting	0	1	2	3		(Range)
28. I work as a team with my partner in parenting	0	1	2	3	(Reverse-scored)	
30. I have a good relationship with my partner	0	1	2	3	(Reverse scored)	

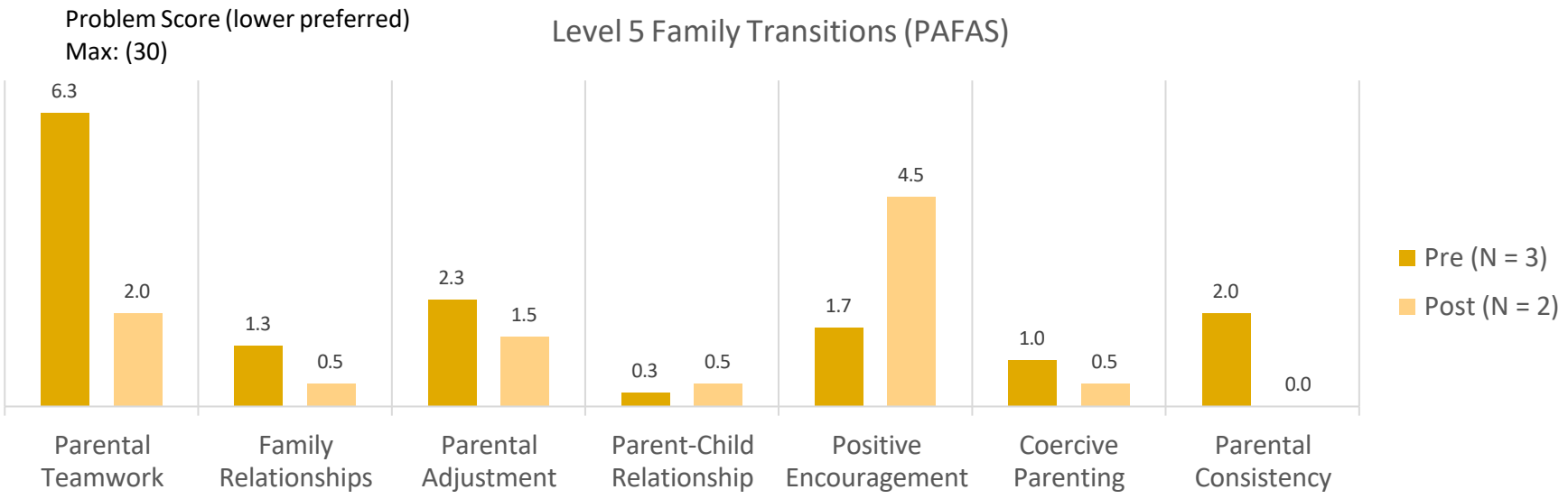

Problem Score (lower preferred)
Max: (30)
Level 3 Primary Care (PAFAS)
3.3
1.7
3.7
2.2
5.4
3.4
1.8
0.1
2.0
0.8
4.0
1.1
6.0
4.0
Parental Teamwork
Family Relationships
Parental Adjustment
Parent-Child Relationship
Positive Encouragement
Coercive Parenting
Parental Consistency
Pre (N = 27)
Post (N = 14)


Problem Score (lower preferred)
Max: (30)
Level 4 Standard (PAFAS)
2.5
1.9
3.3
2.7
6.0
4.6
1.7
1.2
2.0
1.9
4.2
3.0
5.5
3.7
Parental Teamwork
Family Relationships
Parental Adjustment
Parent-Child Relationship
Positive Encouragement
Coercive Parenting
Parental Consistency
Pre (N = 41)
Post (N = 31)


Problem Score (lower preferred)
Max: (30)
Level 4 Standard Teen (PAFAS)
3.1
0.9
3.6
2.0
6.8
5.1
3.9
2.7
2.9
2.4
5.3
3.1
6.6
4.1
Parental Teamwork
Family Relationships
Parental Adjustment
Parent-Child Relationship
Positive Encouragement
Coercive Parenting
Parental Consistency
Pre (N = 16)
Post (N = 7)


Problem Score (lower preferred)
Max: (30)
Level 4 Group (PAFAS)
2.4
1.3
3.2
1.5
5.6
2.3
0.7
0.3
1.6
1.1
2.3
0.7
5.1
2.4
Parental Teamwork
Family Relationships
Parental Adjustment
Parent-Child Relationship
Positive Encouragement
Coercive Parenting
Parental Consistency
Pre (N = 63)
Post (N = 40)


Problem Score (lower preferred)
Max: (30)
Level 4 Group Teen (PAFAS)
4.6
3.6
6.7
6.2
5.1
3.6
3.6
1.6
2.4
1.2
5.7
2.8
7.4
6.8
Parental Teamwork
Family Relationships
Parental Adjustment
Parent-Child Relationship
Positive Encouragement
Coercive Parenting
Parental Consistency
Pre (N = 7)
Post (N = 5)


Problem Score (lower preferred)
Max: (30)
Level 5 Family Transitions (PAFAS)
6.3
2.0
1.3
0.5
2.3
1.5
0.3
0.5
1.7
4.5
1.0
0.5
2.0
0.0
Parental Teamwork
Family Relationships
Parental Adjustment
Parent-Child Relationship
Positive Encouragement
Coercive Parenting
Parental Consistency
Pre (N = 3)
Post (N = 2)

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 are 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 are also asked to rate their level of confidence/self-efficacy in managing their child's behavioral problems on a scale ranging from 1 (I cannot manage it) to 10 (I can manage it).

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

A blank example of the CAPES survey is shown on page 13, a scoring illustration of the CAPES survey is shown on page 14, and the actual pre-/post-average scores from the CAPES survey during Fiscal Year 22/23 is shown on page 15.

CAPES self-assessment (blank example)

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

CAPES self-assessment (scoring illustration)

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

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

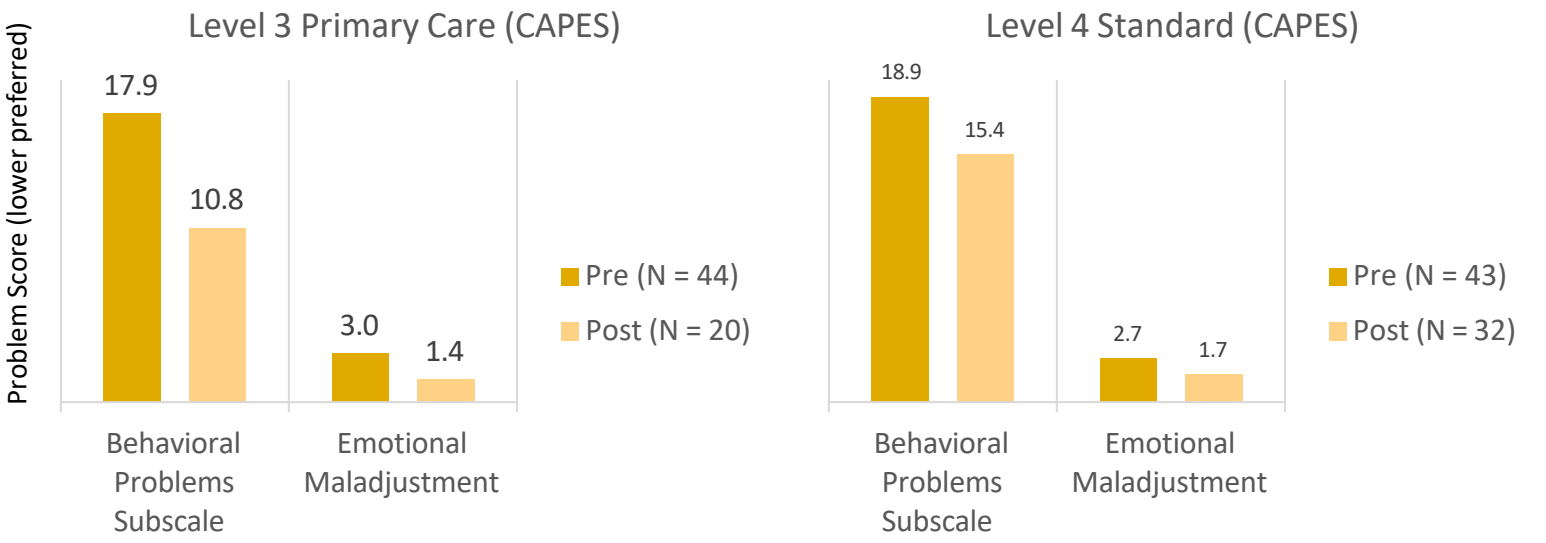
(Range) 0 – 9

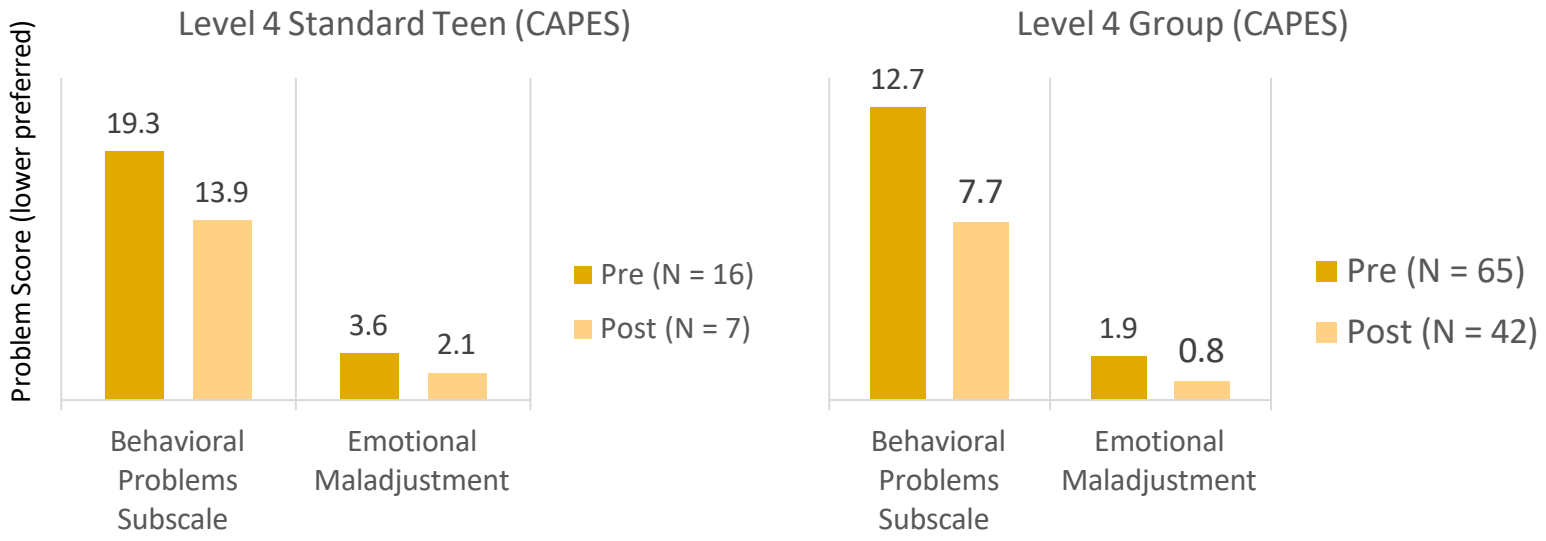
Behavioral Problems subscale scores are calculated by summing the scores for all remaining questions on the assessment:

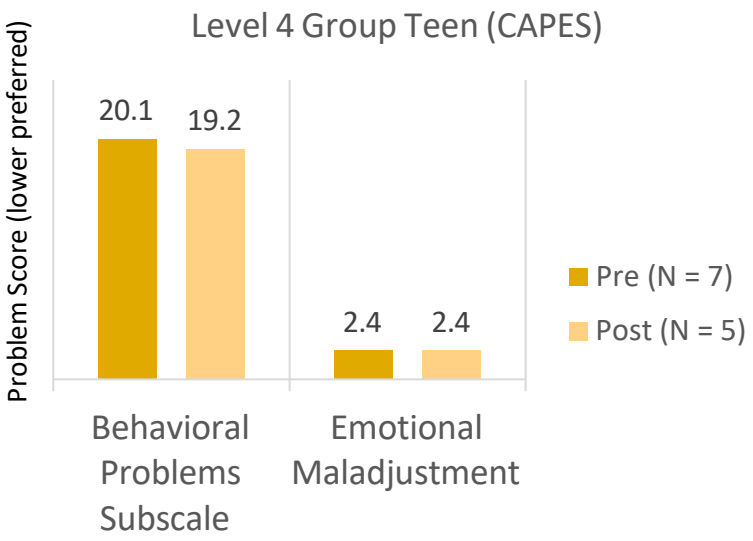
1. Gets upset or angry when they don't get their own way	0	1	2	3
2. Refuses to do jobs around the house when asked	0	1	2	3
4. Loses their temper	0	1	2	3
5. Misbehaves at mealtimes	0	1	2	3
6. Argues or fights with other children, brothers or sisters	0	1	2	3
7. Refuses to eat food made for them	0	1	2	3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

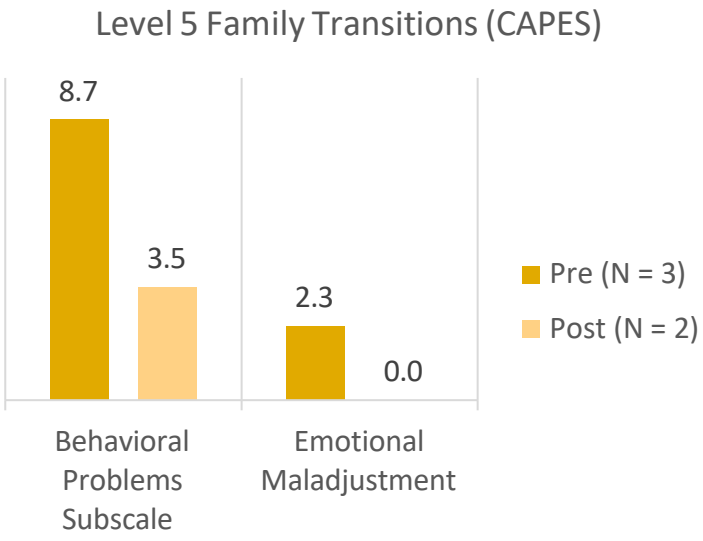
(Range) 0 – 72

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


Level 3 Primary Care (CAPES)
Problem Score (lower preferred)
17.9
10.8
3.0
1.4
Pre (N = 44)
Post (N = 20)
Behavioral Problems Subscale
Emotional Maladjustment
Level 4 Standard (CAPES)
18.9
15.4
2.7
1.7
Pre (N = 43)
Post (N = 32)
Behavioral Problems Subscale
Emotional Maladjustment


Level 4 Standard Teen (CAPES)
Problem Score (lower preferred)
19.3
13.9
3.6
2.1
Pre (N = 16)
Post (N = 7)
Behavioral Problems Subscale
Emotional Maladjustment
Level 4 Group (CAPES)
12.7
7.7
1.9
0.8
Pre (N = 65)
Post (N = 42)
Behavioral Problems Subscale
Emotional Maladjustment


Level 4 Group Teen (CAPES)
Problem Score (lower preferred)
20.1
19.2
2.4
2.4
Behavioral Problems Subscale
Emotional Maladjustment
Pre (N = 7)
Post (N = 5)


Level 5 Family Transitions (CAPES)
8.7
3.5
2.3
0.0
Behavioral Problems Subscale
Emotional Maladjustment
Pre (N = 3)
Post (N = 2)

Depression, Anxiety and Stress Scale - 21 Items (DASS-21)

The Depression, Anxiety and Stress Scale - 21 Items (DASS-21) is a set of three self-report scales designed to measure the emotional states of depression, anxiety, and stress.

Each of the three DASS-21 scales contains 7 items, divided into subscales with similar content. The depression scale assesses dysphoria, hopelessness, devaluation of life, self-deprecation, lack of interest / involvement, anhedonia, and inertia. The anxiety scale assesses autonomic arousal, skeletal muscle effects, situational anxiety, and subjective experience of anxious affect. The stress scale is sensitive to levels of chronic nonspecific arousal. It assesses difficulty relaxing, nervous arousal, and being easily upset / agitated, irritable / over-reactive and impatient. Scores for depression, anxiety and stress are calculated by summing the scores for the relevant items.

The DASS-21 is based on a dimensional rather than a categorical conception of psychological disorder. The assumption on which the DASS-21 development was based (and which was confirmed by the research data) is that the differences between the depression, anxiety and the stress experienced by normal subjects and clinical populations are essentially differences of degree. The DASS-21 therefore has no direct implications for the allocation of patients to discrete diagnostic categories postulated in classificatory systems such as the DSM and ICD.

Recommended cut-off scores for conventional severity labels (normal, moderate, severe) are as follows:

	Depression	Anxiety	Stress
Normal	0 – 9	0 – 7	0 – 14
Mild	10 – 13	8 – 9	15 – 18
Moderate	14 – 20	10 – 14	19 – 25
Severe	21 – 27	15 – 19	26 – 33
Extreme	28+	20+	34+

Depression, Anxiety and Stress Scale - 21 Items (DASS-21) BLANK EXAMPLE

DASS21

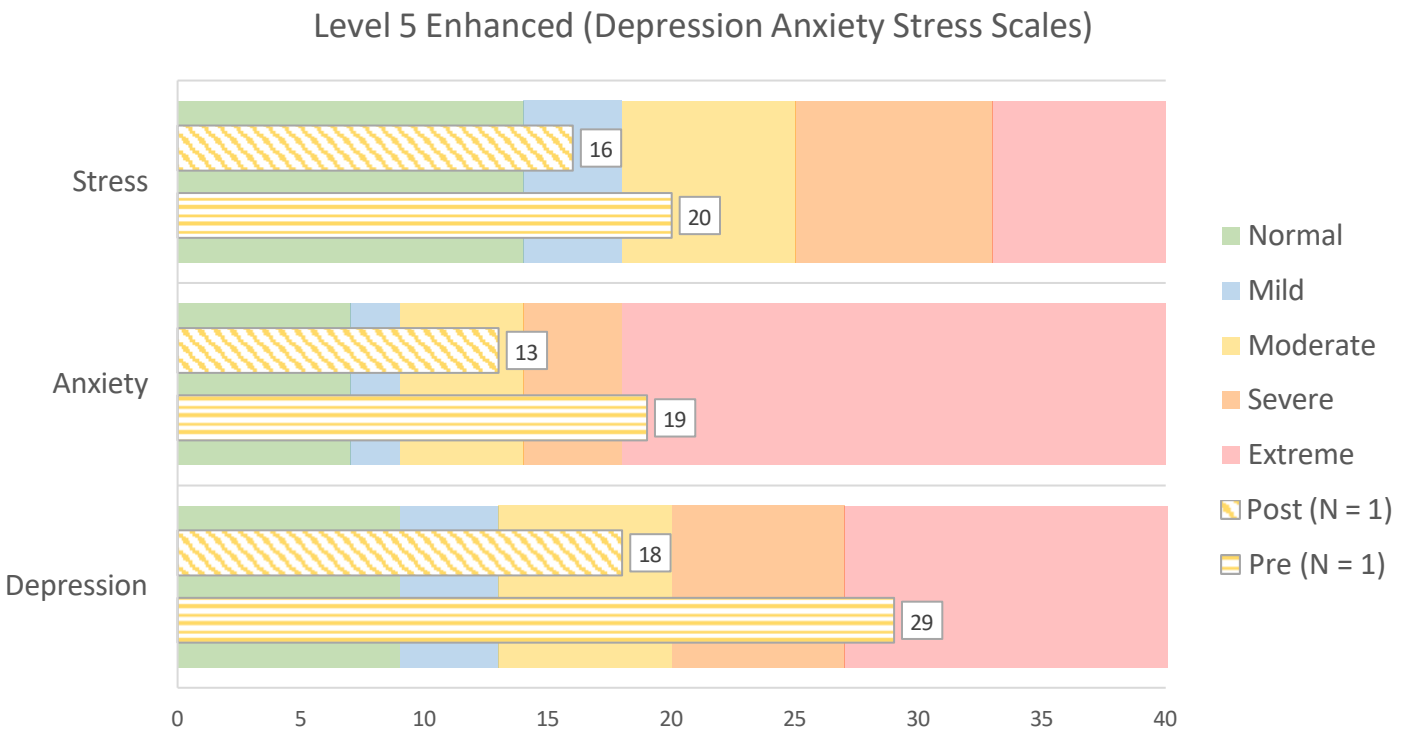
Name: Date:

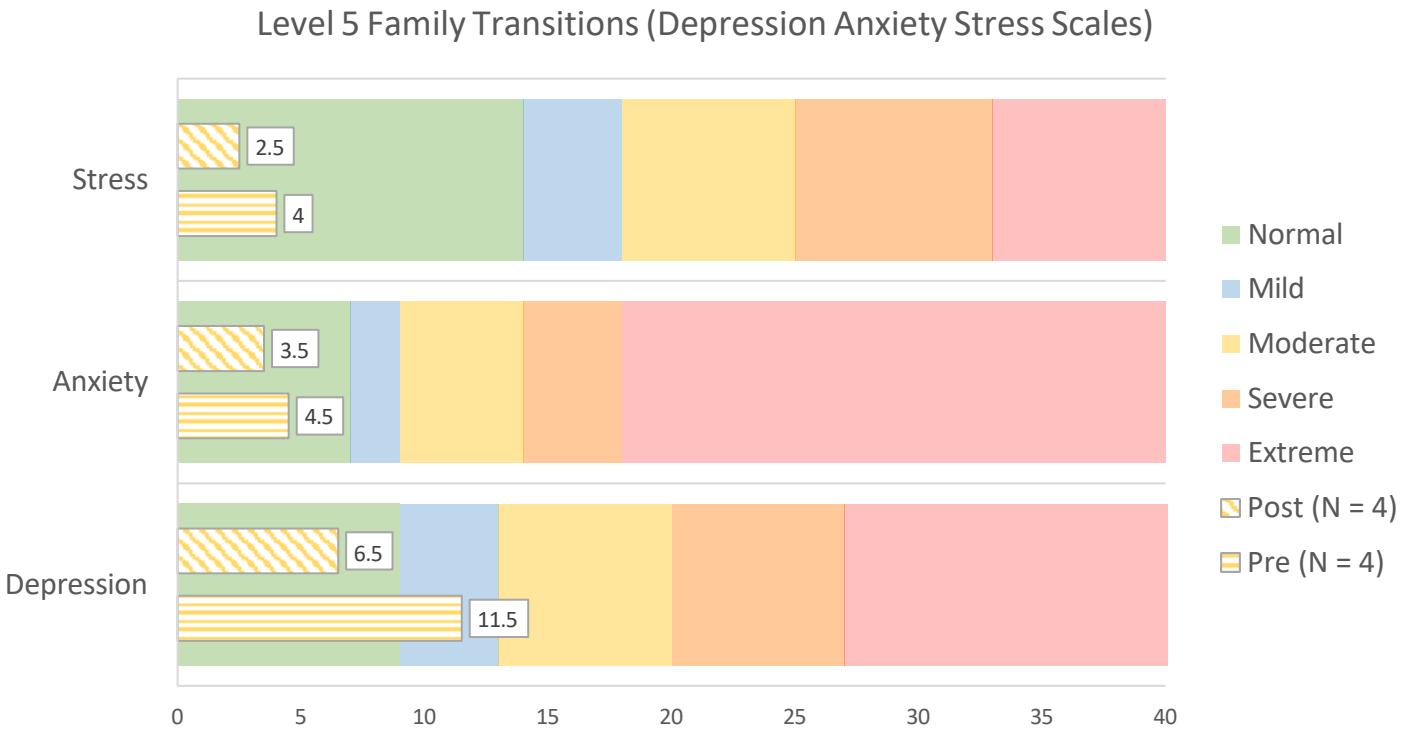
Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you **over the past week**. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

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

1 (s)	I found it hard to wind down	0	1	2	3
2 (a)	I was aware of dryness of my mouth	0	1	2	3
3 (d)	I couldn't seem to experience any positive feeling at all	0	1	2	3
4 (a)	I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5 (d)	I found it difficult to work up the initiative to do things	0	1	2	3
6 (s)	I tended to over-react to situations	0	1	2	3
7 (a)	I experienced trembling (e.g. in the hands)	0	1	2	3
8 (s)	I felt that I was using a lot of nervous energy	0	1	2	3
9 (a)	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10 (d)	I felt that I had nothing to look forward to	0	1	2	3
11 (s)	I found myself getting agitated	0	1	2	3
12 (s)	I found it difficult to relax	0	1	2	3
13 (d)	I felt down-hearted and blue	0	1	2	3
14 (s)	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15 (a)	I felt I was close to panic	0	1	2	3
16 (d)	I was unable to become enthusiastic about anything	0	1	2	3
17 (d)	I felt I wasn't worth much as a person	0	1	2	3
18 (s)	I felt that I was rather touchy	0	1	2	3
19 (a)	I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat)	0	1	2	3
20 (a)	I felt scared without any good reason	0	1	2	3
21 (d)	I felt that life was meaningless	0	1	2	3


Level 5 Enhanced (Depression Anxiety Stress Scales)
Stress
Anxiety
Depression
16
20
13
19
18
29
0
5
10
15
20
25
30
35
40
Normal
Mild
Moderate
Severe
Extreme
Post (N = 1)
Pre (N = 1)


Level 5 Family Transitions (Depression Anxiety Stress Scales)
Stress
Anxiety
Depression
2.5
4
3.5
4.5
6.5
11.5
0
5
10
15
20
25
30
35
40
Normal
Mild
Moderate
Severe
Extreme
Post (N = 4)
Pre (N = 4)

In addition to the required PAFAS, CAPES, and DASS assessments**,** the Client Satisfaction Questionnaires (CSQ) are also given to participants. This survey is meant to voice how satisfied they were with the program (example below):

(Page 1 of 2)

Client Satisfaction Questionnaire *(example)*

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

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

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

7	6	5	4	3	2	1
Excellent		Good		Fair		Poor

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(Page 2 of 2)

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

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

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

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

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

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

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

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

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

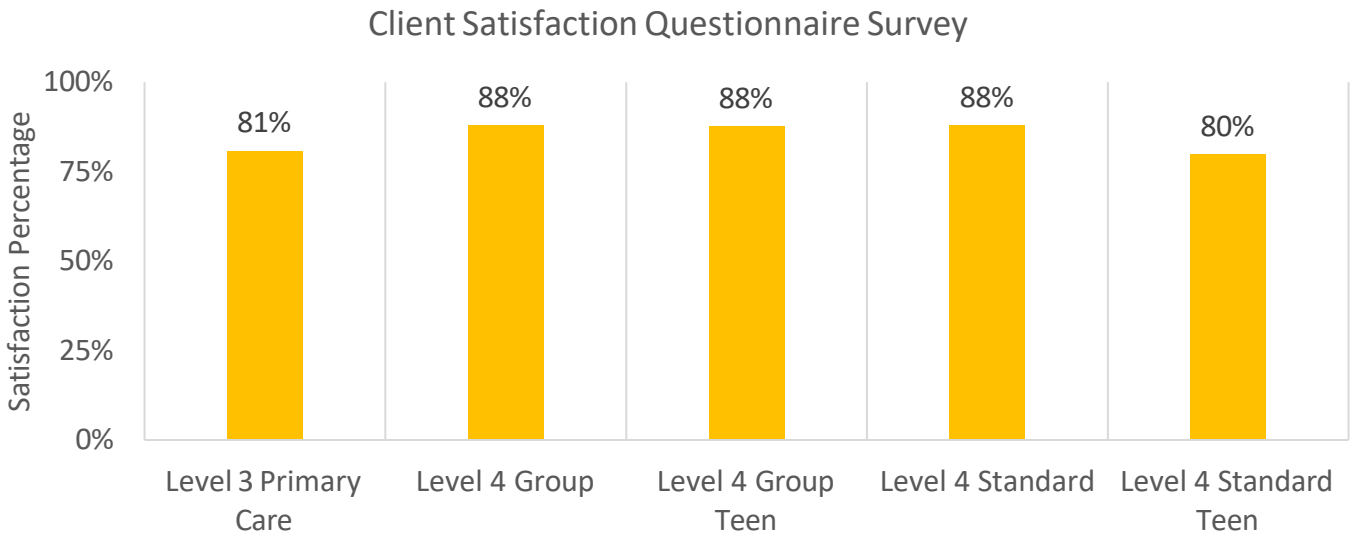
15. Have you had any other problems with your child which you feel may be related to the original difficulty?

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

Thank you

Client Satisfaction Questionnaire:

Client Satisfaction in each level was as follows:



Conclusion:

Outcomes showed decreased problem scores on the PAFAS, CAPES, and DASS assessments during Fiscal Year 22/23. In several levels and various assessments, there was minimal participant data (participant total is indicated by "N =" on graph). The results of assessments with minimal participants (e.g., Level 5 DASS, Level 4 Group Teen PAFAS) are still shown but should considered as not representative of the entire level.

PAFAS findings:

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

- 55% in Level 3 Primary Care
- 39% in Level 4 Standard
- 38% in Level 4 Standard Teen
- 53% in Level Group
- 32% in Level 4 Group Teen (low participation – not representative of whole population)
- 12% in Level 5 Family Transition (low participation – not representative of whole population)

CAPES findings:

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

- 46% in Level 3 Primary Care
- 28% in Level 4 Standard
- 35% in Level 4 Standard Teen
- 49% in Level Group
- 02% in Level 4 Group Teen (low participation – not representative of whole population)
- 80% in Level 5 Family Transition (low participation – not representative of whole population)

The results of the PAFAS and CAPES surveys indicate that the program had an appreciable impact on improving participants' skills, knowledge, and confidence in their parenting for the following Levels: Primary Care (Level 3), Standard and Standard Teen (Level 4), and Group (Level 4). No overall conclusions can be drawn regarding program effectiveness in Group Teen (Level 4) and Family Transition (Level 5) because of the low survey participant.

DASS findings:

Participants showed a **decrease** in all categories of the Depression, Anxiety, Stress Scales:

Level 5 Enhanced (low participation – not representative of whole population)

- Depression: 38%
- Anxiety: 32%
- Stress: 20%

Level 5 Family Transition (low participation – not representative of whole population)

- Depression: 43%
- Anxiety: 22%
- Stress: 38%

No overall conclusions can be drawn regarding program effectiveness for the DASS surveys, because of the low survey participation in Group Teen (Level 4) and Family Transition (Level 5). Based on anecdotal evidence, it can be concluded that the programs were effective (based on the DASS survey) for the small number of participants in the program.

References

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

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

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

Shasta County Health & Human Services Agency

Botvin LifeSkills

Outcome Evaluation

Fiscal Year 22/23

Table of Contents

Introduction

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

The program was administered to 6th-8th grade students attending Turtle Bay and Bella Vista during Fiscal Year 22/23. The program promotes healthy alternatives to risky behavior through activities that help students resist peer pressure to smoke or use drugs and alcohol, develop greater self-esteem and social skills, learn about relaxation techniques to cope with anxiety, and learn about the effects of substance abuse and healthier lifestyle choices.

Method

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

Knowledge category

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

Attitudes category

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

Life Skills category

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

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

Results

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

		Turtle Bay								
		6th grade			7th grade			8th grade		
	Measure	Pre-Survey (N = 45)	Post-Survey (N = 45)	Change	Pre-Survey (N = 56)	Post-Survey (N = 56)	Change	Pre-Survey (N = 33)	Post-Survey (N = 33)	Change
Knowledge	Anti-drug	59%	74%	+15% ↑	65%	67%	+2%	63%	66%	+3%
	Life skills	68%	76%	+8% ↑	75%	81%	+6% ↑	78%	79%	+1%
	Overall (combined)	64%	75%	+11% ↑	70%	74%	+4% ↑	71%	73%	+2%
Attitudes	Anti-smoking	4.60	4.71	+0.11	4.63	4.53	-0.10	4.44	4.08	-0.36 ↓
	Anti-drinking	4.54	4.68	+0.14	4.56	4.48	-0.08	4.41	4.06	-0.35 ↓
	Anti-drug (combined)	4.57	4.70	+0.13	4.59	4.51	-0.08	4.42	4.07	-0.35 ↓
Life Skills	Drug refusal	2.92	3.50	+0.58 ↑	4.00	4.44	+0.44 ↑	3.36	3.85	+0.49 ↑
	Assertiveness	3.22	3.33	+0.11	3.23	3.47	+0.24 ↑	3.32	3.62	+0.30 ↑
	Relaxation	3.90	3.73	-0.17	3.57	3.52	-0.05	3.43	3.55	+0.12
	Self-control	3.73	3.37	-0.36 ↓	3.70	3.55	-0.15	3.60	3.71	+0.11

Note: Numbers may not add due to rounding.

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

		Bella Vista								
		6th grade			7th grade			8th grade		
	Measure	Pre-Survey (N = 27)	Post-Survey (N = 27)	Change	Pre-Survey (N = 22)	Post-Survey (N = 22)	Change	Pre-Survey (N = 21)	Post-Survey (N = 21)	Change
Knowledge	Anti-drug	59%	67%	+8% ↑	69%	70%	+1%	64%	77%	+13% ↑
	Life skills	77%	81%	+4% ↑	82%	81%	-1%	70%	80%	+10% ↑
	Overall (combined)	68%	74%	+6% ↑	76%	76%	0%	67%	79%	+12% ↑
Attitudes	Anti-smoking	4.74	4.64	-0.10	4.66	4.38	-0.28 ↓	4.63	4.37	-0.26 ↓
	Anti-drinking	4.66	4.52	-0.14	4.60	4.38	-0.22	4.54	4.36	-0.18
	Anti-drug (combined)	4.70	4.58	-0.12	4.63	4.38	-0.25	4.57	4.38	-0.19
Life Skills	Drug refusal	2.92	3.50	+0.58 ↑	4.00	4.44	+0.44 ↑	3.36	3.85	+0.49 ↑
	Assertiveness	3.22	3.33	+0.11	3.23	3.47	+0.24 ↑	3.32	3.62	+0.30 ↑
	Relaxation	3.90	3.73	-0.17	3.57	3.52	-0.05	3.43	3.55	+0.12
	Self-control	3.73	3.37	-0.36	3.70	3.55	-0.15	3.60	3.71	+0.11

Note: Numbers may not add due to rounding.

Conclusion

Overall, the Botvin Lifeskills Program has shown effectiveness at improving anti-drug and life skills knowledge – especially for sixth graders. The sixth graders appear to be at an impressionable age and are particularly receptive to learning facts about drug use and the associated harmful effects. Bella Vista's 8th graders have also shown large improvement in this area.

The "Life Skills" category showed significant improvement in terms of assertiveness and drug refusal. The remaining categories of "Relaxation" and "Self-control" showed mixed results.

Attitudes towards drug use slightly worsened (overall). 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.

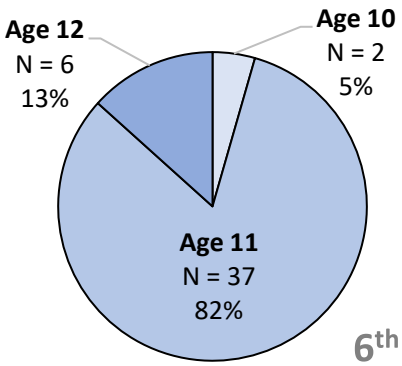
The effectiveness of the Botvin Lifeskills program is largely influenced by program fidelity and the ability of the instructor to relay the course content in a way that resonates with the students.

Data Analysis

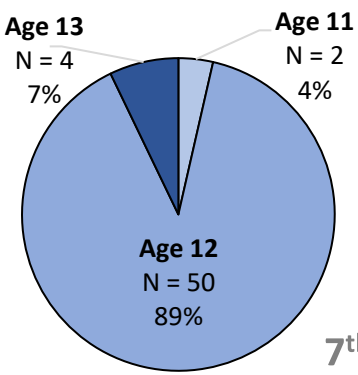
In the following section, information on the students' background (including demographic information) and how the scored measures were calculated will be explored in greater detail. Missing responses were ignored when calculating the scored measures, and missing responses were also not individually tracked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

Section A: Student Background - **Turtle Bay Demographics (Pt. 1 of 2)**

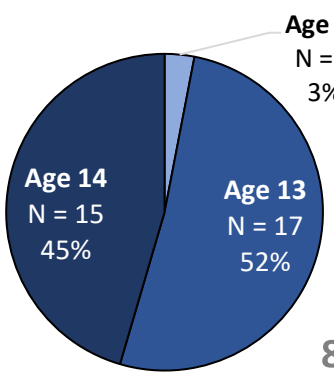
Age



6th Grade

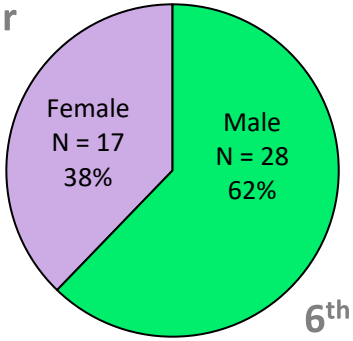


7th Grade



8th Grade

Gender



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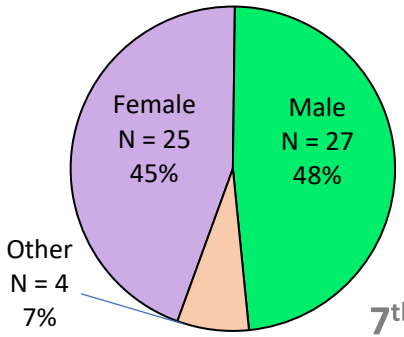

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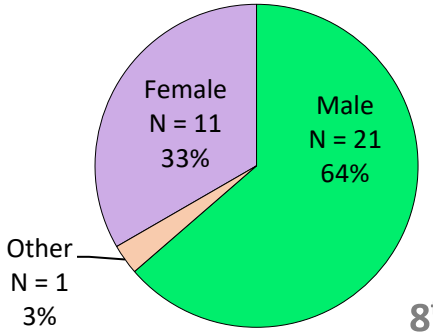
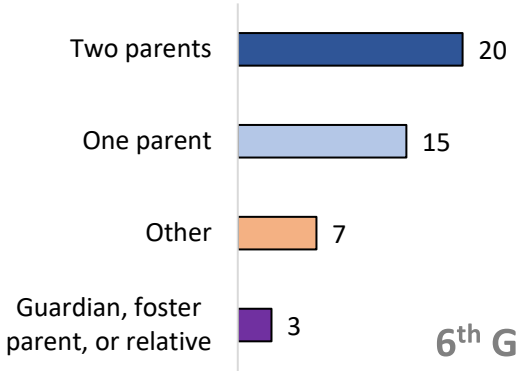
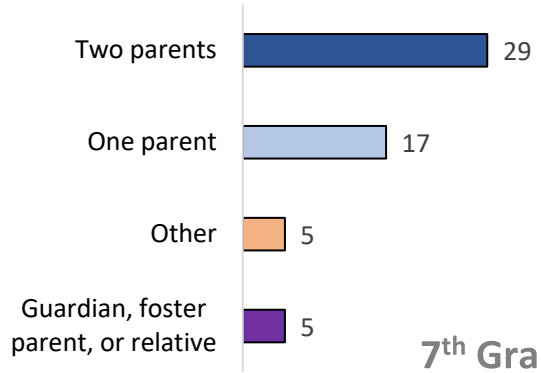


8th Grade

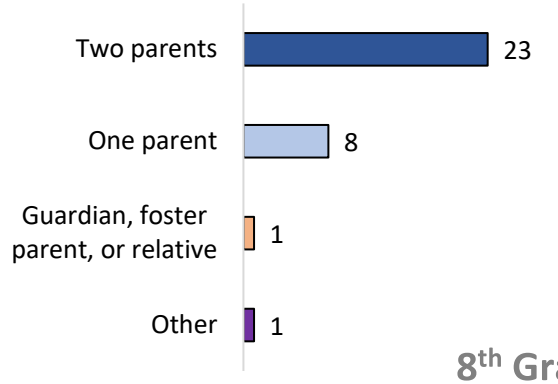
Parental Structure



6th Grade



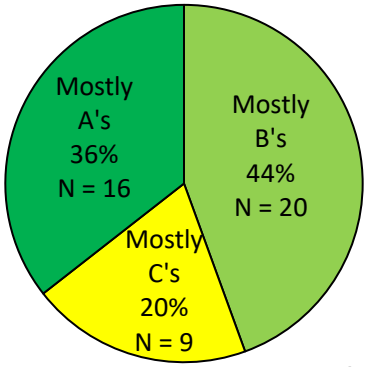
7th Grade



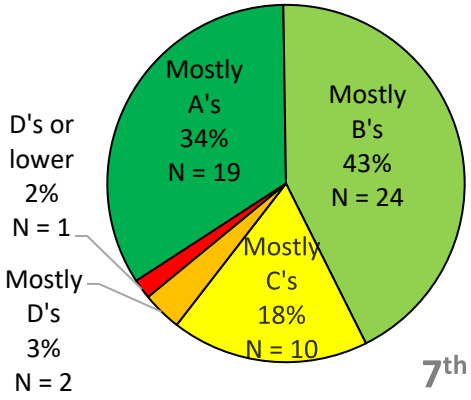
8th Grade

Section A: Student Background - **Turtle Bay Demographics (Pt. 2 of 2)**

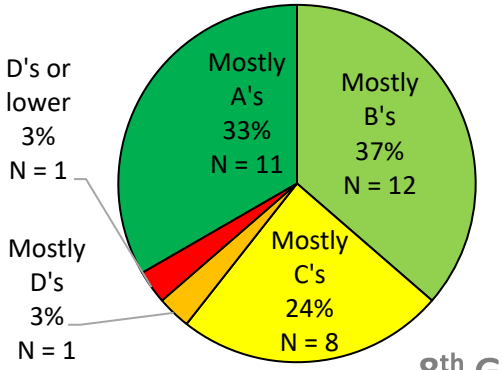
Grades



6th Grade

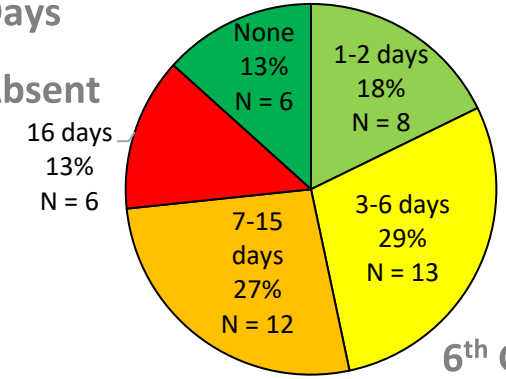


7th Grade

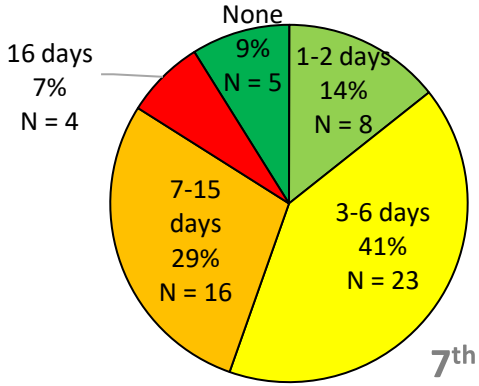


8th Grade

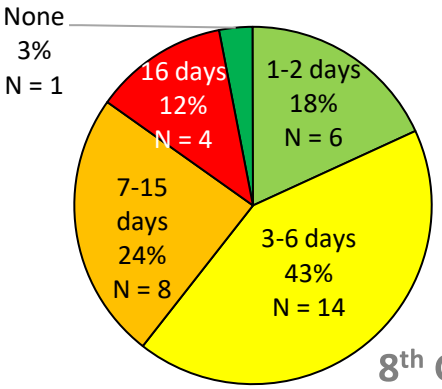
Days Absent



6th Grade

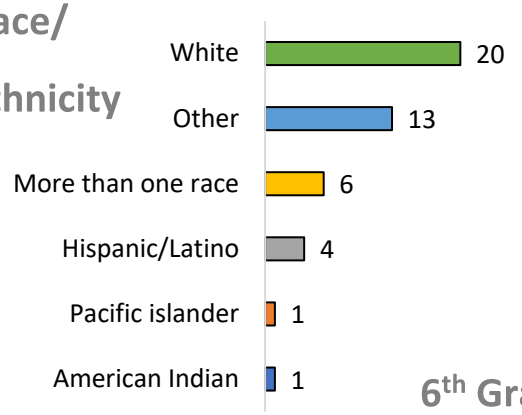


7th Grade

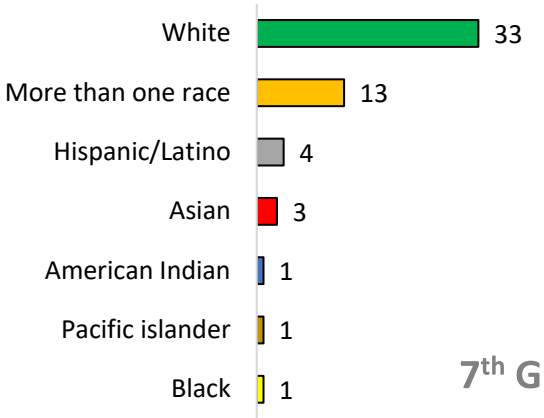


8th Grade

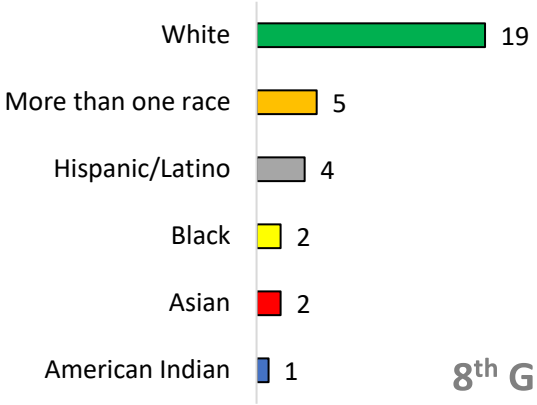
Race/ Ethnicity



6th Grade



7th Grade



8th Grade

Section B: Knowledge measures (Anti-drug)

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

	Anti-Drug knowledge items (Turtle Bay)	6th grade (% correct)			7th grade (% correct)			8th grade (% correct)		
		PRE (N = 59)	POST (N = 59)	Change	PRE (N = 42)	POST (N = 42)	Change	PRE (N = 56)	POST (N = 56)	Change
1.	Most adults smoke cigarettes. (F)	44%	64%	20%	41%	57%	16%	44%	58%	14%
2.	Smoking a cigarette causes your heart to beat slower. (F)	27%	53%	26%	20%	32%	12%	41%	27%	-14%
3.	Few adults drink wine, beer, or liquor every day. (T)	53%	60%	7%	52%	50%	-2%	38%	42%	4%
4.	Most people my age smoke marijuana. (F)	96%	84%	-12%	75%	71%	-4%	72%	82%	10%
5.	Smoking marijuana causes your heart to beat faster. (T)	44%	73%	29%	64%	79%	15%	66%	73%	7%
6.	Most adults use cocaine or other hard drugs. (F)	69%	76%	7%	71%	71%	0%	78%	79%	1%
7.	Cocaine and other hard drugs always make you feel good. (F)	80%	93%	13%	89%	84%	-5%	88%	91%	3%
12.	Smoking can affect the steadiness of your hands. (T)	56%	78%	22%	80%	80%	0%	78%	82%	4%
13.	A stimulant is a chemical that calms down the body. (F)	69%	80%	11%	75%	63%	-12%	63%	79%	16%
14.	Smoking reduces a person's endurance for physical activity. (T)	56%	80%	24%	82%	82%	0%	78%	82%	4%
15.	A serving of beer or wine contains less alcohol than a serving of "hard liquor" such as whiskey. (F)	24%	44%	20%	43%	39%	-4%	19%	24%	5%
16.	Alcohol is a depressant. (T)	58%	87%	29%	64%	64%	0%	56%	55%	-1%
17.	Marijuana smoking can improve your eyesight. (F)	93%	93%	0%	91%	95%	4%	97%	88%	-9%
	Anti-drug knowledge summary score (higher % is preferred):	**59%**	**74%**	**+15%** ↑	**65%**	**67%**	**+2%** ↑	**63%**	**66%**	**+3%** ↑

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

Section B: Knowledge measures (Life skills)

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

Life skills knowledge items (Turtle Bay)		6th grade (% correct)			7th grade (% correct)			8th grade (% correct)		
		PRE (N = 59)	POST (N = 59)	Change	PRE (N = 42)	POST (N = 42)	Change	PRE (N = 56)	POST (N = 56)	Change
8.	What we believe about ourselves affects the way we act or behave. (T)	91%	91%	0%	91%	95%	4%	94%	100%	6%
9.	It is almost impossible to develop a more positive self-image. (F)	84%	82%	-2%	79%	82%	3%	75%	67%	-8%
10.	It is important to measure how far you have come toward reaching your goal. (T)	89%	96%	7%	88%	91%	3%	91%	82%	-9%
11.	It's a good idea to make a decision and then think about the consequences later. (F)	71%	80%	9%	91%	80%	-11%	84%	73%	-11%
18.	Some advertisers are deliberately deceptive. (T)	62%	89%	27%	77%	77%	0%	75%	73%	-2%
19.	Companies advertise only because they want you to have all the facts about their products. (F)	53%	56%	3%	63%	73%	10%	78%	85%	7%
20.	It's a good idea to get all information about a product from its ads. (F)	51%	60%	9%	64%	71%	7%	56%	64%	8%
21.	Most people do not experience anxiety. (F)	73%	78%	5%	66%	88%	22%	91%	97%	6%
22.	There is very little you can do when you feel anxious. (F)	62%	69%	7%	59%	70%	11%	63%	85%	22%
23.	Deep breathing is one way to lessen anxiety. (T)	87%	100%	13%	79%	96%	17%	88%	91%	3%
24.	Mental rehearsal is a poor relaxation technique. (F)	71%	80%	9%	77%	71%	-6%	78%	85%	7%
25.	You can avoid misunderstandings by assuming the other person knows what you mean. (F)	67%	67%	0%	82%	75%	-7%	78%	85%	7%
26.	Effective communication is when both sender and receiver interpret a message in the same way. (T)	60%	73%	13%	80%	79%	-1%	88%	70%	-18%
27.	Relaxation techniques are of no use when meeting people. (F)	69%	80%	11%	70%	86%	16%	72%	85%	13%
28.	A compliment is more effective when it is said sincerely. (T)	71%	78%	7%	84%	89%	5%	81%	79%	-2%
29.	A nice way of ending a conversation is to tell the person you enjoyed talking with him or her. (T)	84%	93%	9%	91%	100%	9%	91%	88%	-3%
30.	Sense of humor is an example of a non-physical attribute. (T)	60%	67%	7%	59%	68%	9%	63%	55%	-8%
31.	It's better to be polite and lead someone on, even if you don't want to go out with them. (F)	33%	44%	11%	55%	64%	9%	50%	61%	11%
32.	Almost all people who are assertive are either rude or hostile. (F)	44%	64%	20%	75%	82%	7%	84%	82%	-2%
	Life skills knowledge summary score (higher % is preferred):	**68%**	**76%**	**+8%** ⇧	**75%**	**81%**	**+6%** ⇧	**78%**	**79%**	**+1%** ⇧

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

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

6th grade		7th grade		8th grade	
PRE (N = 59)	POST (N = 59)	PRE (N = 42)	POST (N = 42)	PRE (N = 56)	POST (N = 56)
4.38	4.6	4.55	4.54	4.38	4.24
4.73	4.82	4.75	4.64	4.5	4.18
4.51	4.64	4.53	4.37	4.46	3.81
4.55	4.64	4.55	4.39	4.37	3.75
4.75	4.77	4.58	4.62	4.53	4.06
4.66	4.77	4.66	4.60	4.56	4.15
4.57	4.66	4.64	4.69	4.62	4.27
4.53	4.71	4.55	4.39	4.25	4.12
4.54	**4.68**	**4.56**	**4.48**	**4.41**	**4.06**
4.60	**4.71**	**4.63**	**4.53**	**4.44**	**4.08**
4.57	**4.70**	**4.59**	**4.51**	**4.42**	**4.07**

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

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

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

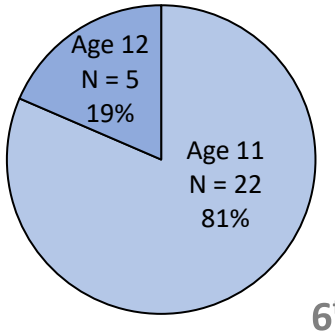
Legend
This question factors into the Anti-drinking attitudes score (Section C)
This question factors into the Anti-smoking attitudes score (Section C)
Post-improvement increased by more than 5% (Sections C & D)
Post-improvement decreased by more than 5% (Section C & D)

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

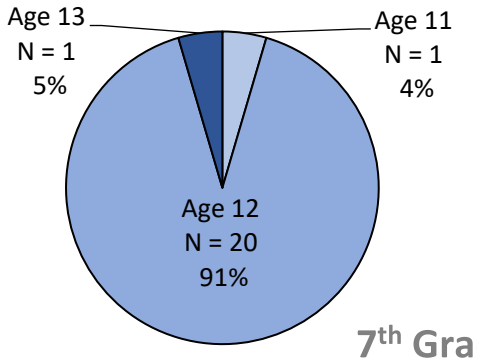
	Life skills (Turtle Bay)	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	6th grade		7th grade		8th grade	
							PRE (N = 59)	POST (N = 59)	PRE (N = 42)	POST (N = 42)	PRE (N = 56)	POST (N = 56)
I would say NO if someone tried to get me to:												
1.	Smoke a cigarette. ***[Lower scores preferred]***	①	②	③	④	⑤	3.44	3.13	3.44	3.13	2.16	2.30
2.	Drink beer, wine, or liquor. ***[Lower scores preferred]***	①	②	③	④	⑤	3.48	3.13	3.49	3.13	2.16	2.42
3.	Smoke marijuana or hashish. ***[Lower scores preferred]***	①	②	③	④	⑤	3.48	3.13	3.49	3.13	2.03	2.24
4.	Use cocaine or other drugs. ***[Lower scores preferred]***	①	②	③	④	⑤	3.46	3.17	3.47	3.18	2.06	2.24
5.	Use a prescription drug that was prescribed for someone else. ***[Lower scores preferred]***	①	②	③	④	⑤	3.37	3.15	3.38	3.16	2.09	2.24
6.	Vape or smoke an e-cigarette ***[Lower scores preferred]***	①	②	③	④	⑤	3.44	3.13	3.44	3.13	2.13	2.24
	Drug refusal skill [2]*(Scores for Q's. 1-6 are averaged then subtracted from 6 to invert them - **higher scores are preferred**):*						**2.55**	**2.86**	**3.50**	**4.18**	**3.90**	**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	2.73	2.31	2.73	2.31	2.03	2.48
8.	Say "no" to someone who asks to borrow money from me. ***[Lower scores preferred]***	①	②	③	④	⑤	3.02	2.6	3.02	2.60	2.34	2.39
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	2.88	2.82	2.89	2.82	2.34	2.48
	Assertiveness skills [2]*(Scores for Q's. 7-9 are averaged then subtracted from 6 to invert them - **higher scores are preferred**):*						**3.12**	**3.42**	**3.54**	**3.42**	**3.76**	**3.55**
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	2.46	2.28	2.47	2.29	2.34	2.24
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	2.2	2	2.20	2.00	2.22	2.21
	Relaxation skills [2]*(Scores Q.10 & Q.11 are averaged then subtracted from 6 to invert them - **higher scores are preferred**):*						**3.67**	**3.86**	**3.91**	**3.85**	**3.72**	**3.77**
In general:												
12.	If I find that something is really difficult, I get frustrated and quit. ***[Higher scores preferred]***	①	②	③	④	⑤	3.08	3.6	3.09	3.60	3.56	3.45
13.	I stick to what I'm doing until I'm finished with it. ***[Lower scores preferred]***	①	②	③	④	⑤	2.62	2.4	2.62	2.40	2.25	2.42
	Self-Control Skills [2]*(Score for Q. 13 is subtracted from 6 to invert it then averaged with Q. 12 – **higher scores are preferred**):*						**3.23**	**3.60**	**3.64**	**3.71**	**3.66**	**3.52**

Section A: Student Background - **Bella Vista (Pt. 1 of 2)**

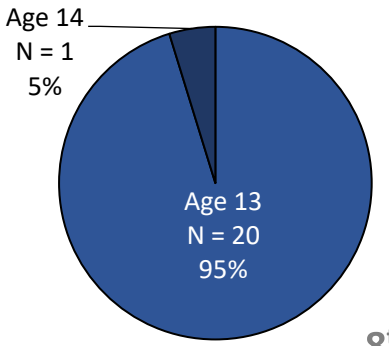
Age



6th Grade

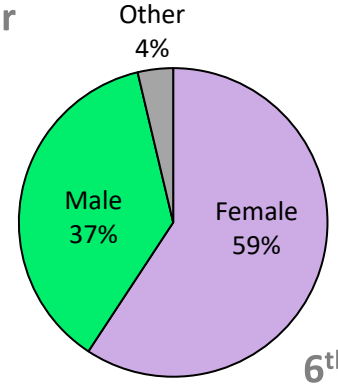


7th Grade

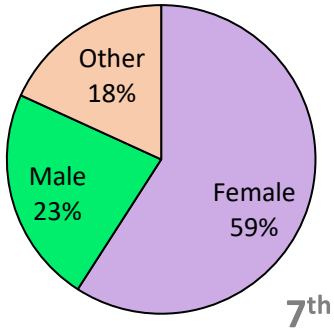


8th Grade

Gender



6th Grade



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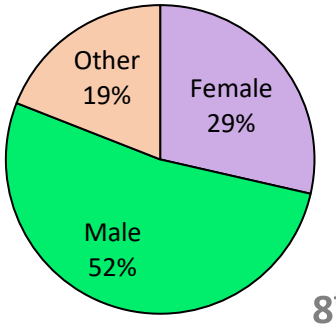
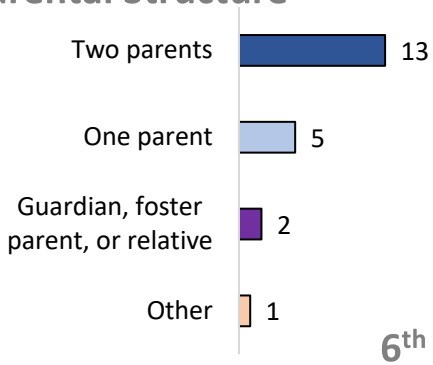


8th Grade

Parental Structure



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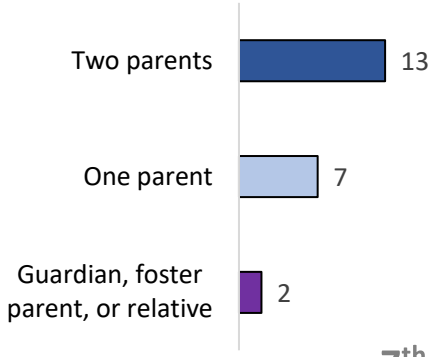

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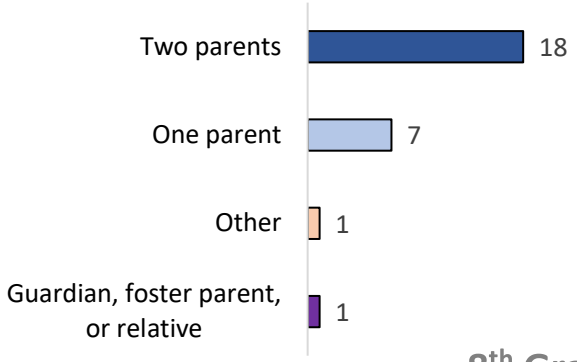
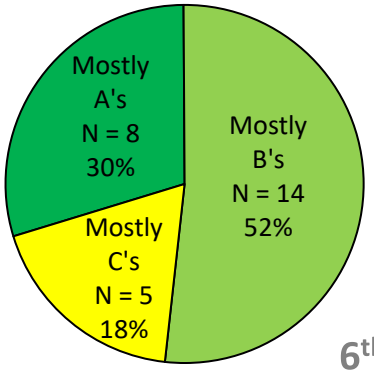
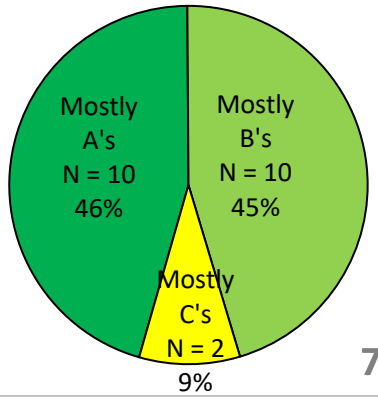


8th Grade

Grades



6th Grade



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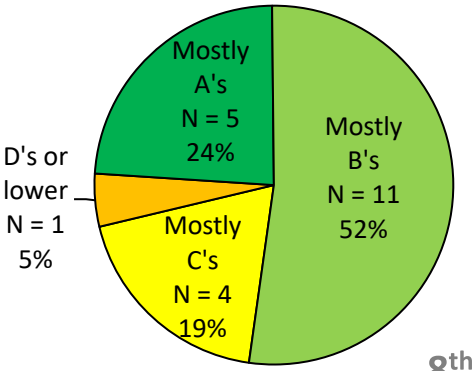
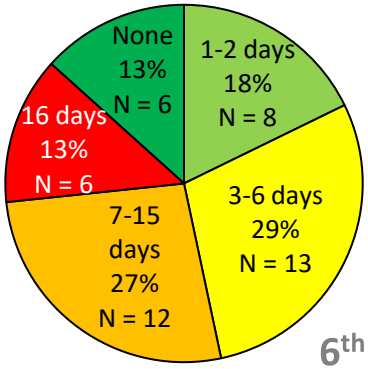
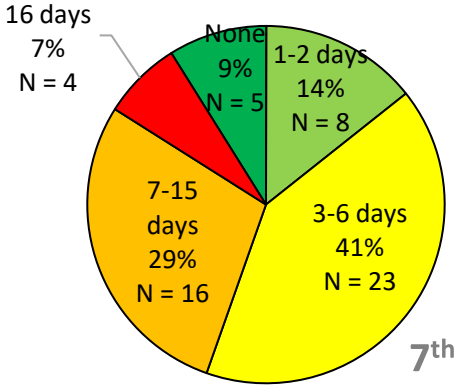


8th Grade

Days Absent



6th Grade



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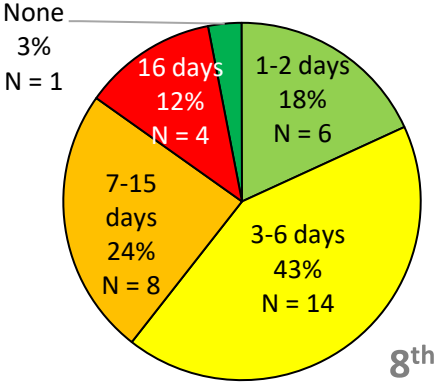
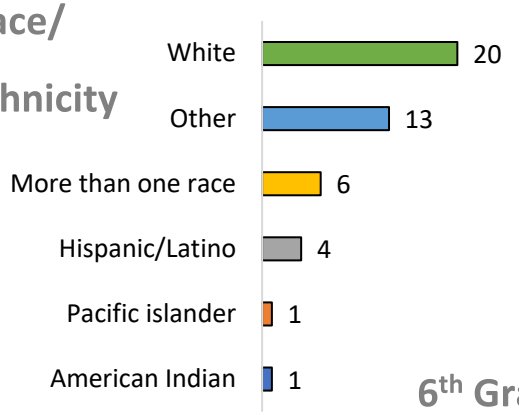
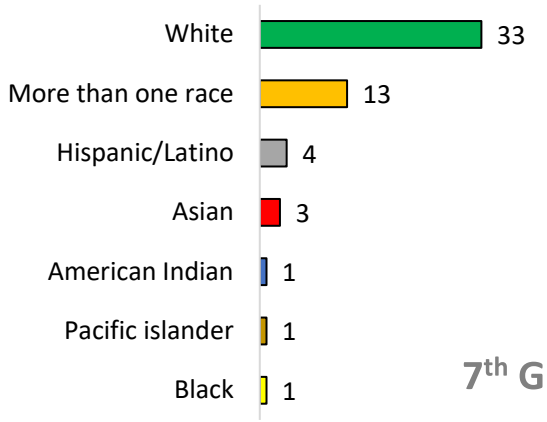


8th Grade

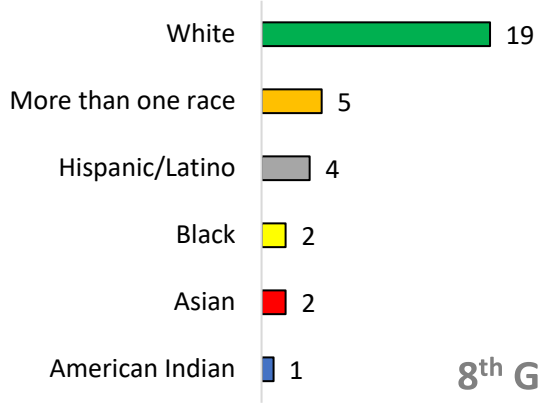
Race/ Ethnicity



6th Grade



7th Grade



8th Grade

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 (Bella Vista)	6th grade (% correct)			7th grade (% correct)			8th grade (% correct)		
		PRE (N = 22)	POST (N = 22)	Change	PRE (N = 23)	POST (N = 23)	Change	PRE (N = 29)	POST (N = 29)	Change
1.	Most adults smoke cigarettes. (F)	31%	46%	15%	45%	36%	9%	43%	43%	0%
2.	Smoking a cigarette causes your heart to beat slower. (F)	27%	42%	15%	41%	45%	-4%	43%	38%	-5%
3.	Few adults drink wine, beer, or liquor every day. (T)	54%	35%	-19%	45%	32%	13%	29%	24%	-5%
4.	Most people my age smoke marijuana. (F)	81%	85%	4%	82%	68%	14%	76%	90%	14%
5.	Smoking marijuana causes your heart to beat faster. (T)	46%	77%	31%	59%	86%	-27%	76%	95%	19%
6.	Most adults use cocaine or other hard drugs. (F)	58%	65%	7%	82%	82%	0%	62%	71%	9%
7.	Cocaine and other hard drugs always make you feel good. (F)	88%	96%	8%	86%	91%	-5%	90%	100%	10%
12.	Smoking can affect the steadiness of your hands. (T)	69%	81%	12%	82%	86%	-4%	81%	100%	19%
13.	A stimulant is a chemical that calms down the body. (F)	50%	62%	12%	82%	82%	0%	71%	67%	-4%
14.	Smoking reduces a person's endurance for physical activity. (T)	85%	77%	-8%	86%	91%	-5%	76%	81%	5%
15.	A serving of beer or wine contains less alcohol than a serving of "hard liquor" such as whiskey. (F)	27%	38%	11%	32%	27%	5%	43%	29%	-14%
16.	Alcohol is a depressant. (T)	50%	77%	27%	73%	77%	-4%	52%	67%	15%
17.	Marijuana smoking can improve your eyesight. (F)	100%	92%	-8%	100%	100%	0%	95%	100%	5%
	Anti-drug knowledge summary score (higher % is preferred):	**59%**	**67%**	**8%**	**69%**	**70%**	**1%**	**64%**	**70%**	**6%**

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

Section B: Knowledge measures (Life skills)

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

	Life skills knowledge items (Bella Vista)	6th grade (% correct)			7th grade (% correct)			8th grade (% correct)		
		PRE (N = 22)	POST (N = 22)	Change	PRE (N = 23)	POST (N = 23)	Change	PRE (N = 29)	POST (N = 29)	Change
8.	What we believe about ourselves affects the way we act or behave. (T)	92%	92%	0%	95%	95%	0%	86%	90%	4%
9.	It is almost impossible to develop a more positive self-image. (F)	85%	85%	0%	77%	64%	-13%	62%	81%	19%
10.	It is important to measure how far you have come toward reaching your goal. (T)	88%	92%	4%	82%	86%	4%	86%	90%	4%
11.	It's a good idea to make a decision and then think about the consequences later. (F)	77%	77%	0%	73%	77%	4%	86%	90%	4%
18.	Some advertisers are deliberately deceptive. (T)	73%	92%	19%	82%	77%	-5%	67%	81%	14%
19.	Companies advertise only because they want you to have all the facts about their products. (F)	65%	81%	16%	82%	82%	0%	81%	71%	-10%
20.	It's a good idea to get all information about a product from its ads. (F)	58%	73%	15%	86%	73%	-13%	62%	86%	24%
21.	Most people do not experience anxiety. (F)	81%	85%	4%	86%	91%	5%	90%	90%	0%
22.	There is very little you can do when you feel anxious. (F)	69%	81%	12%	64%	68%	4%	67%	67%	0%
23.	Deep breathing is one way to lessen anxiety. (T)	96%	85%	-11%	86%	86%	0%	81%	90%	9%
24.	Mental rehearsal is a poor relaxation technique. (F)	77%	85%	8%	86%	86%	0%	71%	81%	10%
25.	You can avoid misunderstandings by assuming the other person knows what you mean. (F)	73%	73%	0%	86%	82%	-4%	76%	76%	0%
26.	Effective communication is when both sender and receiver interpret a message in the same way. (T)	81%	85%	4%	82%	77%	-5%	81%	76%	-5%
27.	Relaxation techniques are of no use when meeting people. (F)	81%	85%	4%	91%	77%	-14%	71%	76%	5%
28.	A compliment is more effective when it is said sincerely. (T)	88%	88%	0%	91%	95%	4%	86%	90%	4%
29.	A nice way of ending a conversation is to tell the person you enjoyed talking with him or her. (T)	100%	92%	-8%	91%	100%	9%	86%	95%	9%
30.	Sense of humor is an example of a non-physical attribute. (T)	54%	65%	11%	68%	68%	0%	76%	67%	-9%
31.	It's better to be polite and lead someone on, even if you don't want to go out with them. (F)	46%	54%	8%	64%	77%	13%	76%	62%	-14%
32.	Almost all people who are assertive are either rude or hostile. (F)	69%	69%	0%	82%	77%	-5%	67%	57%	-10%
	Life skills knowledge summary score (higher % is preferred):	59%	67%	**8%**	69%	70%	**1%**	64%	70%	**6%**

Section C: Attitude measures (Anti-drug)

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

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

6th grade		7th grade		8th grade	
PRE (N = 22)	POST (N = 22)	PRE (N = 23)	POST (N = 23)	PRE (N = 29)	POST (N = 29)
4.77	4.69	4.68	4.45	4.29	4.43
4.73	4.73	4.82	4.64	4.67	4.38
4.65	4.42	4.41	3.77	4.52	4.29
4.58	4.50	4.36	3.77	4.62	4.19
4.54	4.58	4.59	4.68	4.67	4.48
4.85	4.58	4.77	4.64	4.71	4.48
4.81	4.77	4.73	4.50	4.52	4.43
4.69	4.38	4.73	4.59	4.52	4.33
4.66	**4.52**	**4.60**	**4.38**	**4.54**	**4.36**
4.74	**4.64**	**4.66**	**4.38**	**4.63**	**4.37**
4.70	**4.58**	**4.63**	**4.38**	**4.57**	**4.38**

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

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

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

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

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

Life skills (Bella Vista)		Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	6th grade PRE (N = 22)	6th grade POST (N = 22)	7th grade PRE (N = 23)	7th grade POST (N = 23)	8th grade PRE (N = 29)	8th grade POST (N = 29)
I would say NO if someone tried to get me to:												
1.	Smoke a cigarette. ***[Lower scores preferred]***	①	②	③	④	⑤	3.12	2.54	2.09	1.55	2.62	2.19
2.	Drink beer, wine, or liquor. ***[Lower scores preferred]***	①	②	③	④	⑤	2.96	2.62	2.09	1.64	2.81	2.24
3.	Smoke marijuana or hashish. ***[Lower scores preferred]***	①	②	③	④	⑤	3.12	2.50	1.91	1.55	2.57	2.10
4.	Use cocaine or other drugs. ***[Lower scores preferred]***	①	②	③	④	⑤	3.04	2.35	1.91	1.55	2.62	2.14
5.	Use a prescription drug that was prescribed for someone else. ***[Lower scores preferred]***	①	②	③	④	⑤	3.12	2.50	2.00	1.61	2.62	2.14
6.	Vape or smoke an e-cigarette ***[Lower scores preferred]***	①	②	③	④	⑤	3.12	2.50	2.00	1.50	2.62	2.10
Drug refusal skill [2]*(Scores for Q's. 1-6 are averaged then subtracted from 6 to invert them - **higher scores are preferred**):*							**2.92**	**3.50**	**4.00**	**4.44**	**3.36**	**3.86**
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	2.77	2.65	2.77	2.50	2.48	2.29
8.	Say "no" to someone who asks to borrow money from me. ***[Lower scores preferred]***	①	②	③	④	⑤	2.92	2.62	2.95	2.73	2.62	2.33
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	2.65	2.73	2.59	2.36	2.95	2.52
Assertiveness skills [2]*(Scores for Q's. 7-9 are averaged then subtracted from 6 to invert them - **higher scores are preferred**):*							**3.22**	**3.33**	**3.23**	**3.47**	**3.32**	**3.62**
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	2.31	2.31	2.55	2.41	2.62	2.48
11.	Breathe in slowly for a count of four, then hold my breath in for a count of four, and slowly exhale for a count of four. ***[Lower scores preferred]***	①	②	③	④	⑤	1.88	2.23	2.32	2.55	2.52	2.43
Relaxation skills [2]*(Scores for Q's 10 & 11 are averaged then subtracted from 6 to invert them - **higher scores are preferred**):*							**3.90**	**3.73**	**3.57**	**3.52**	**3.43**	**3.55**
In general:												
12.	If I find that something is really difficult, I get frustrated and quit. **[Higher scores preferred]**	①	②	③	④	⑤	3.65	3.19	3.59	3.23	3.33	3.48
13.	I stick to what I'm doing until I'm finished with it. ***[Lower scores preferred]***	①	②	③	④	⑤	2.19	2.46	2.18	2.14	2.14	2.05
Self-Control Skills [2]*(Score for Q. 13 is subtracted from 6 to invert it then averaged with Q. 12 – **higher scores are preferred**):*							**3.73**	**3.37**	**3.70**	**3.55**	**3.60**	**3.71**

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.

ACEs Prevention Program FY 2022-2023 (July 1, 2022 – June 30, 2023)

Protective Factors

Parent Cafés

During this reporting period, the following Parent Cafés were hosted in Shasta County.

- Pathways to Hope for Children hosted 6 Parent Cafés that served 131 attendees
- Tri County Community Network hosted 1 Parent Café that served 4 attendees
- Shasta Head Start hosted 3 Parent Cafés that served 70 attendees
- Bright Futures hosted 2 Parent Cafés that served 43 attendees

Table Host Trainings

In FY 2022-23, Pathways to Hope for Children trained 16 attendees to be Parent Café Table Hosts.

Trauma-Informed Practices Trainings

During FY 2022-23, the following Trauma-Informed Trainings took place in Shasta County.

- SCOE facilitated 4 trainings that served a total of 148 attendees
- Pathways to Hope for Children trained 2 volunteers

Protective Factors Trainings

During this reporting period, Pathways to Hope for Children hosted 3 Protective Factors Trainings to 23 attendees and Youth Options Shasta provided 3 Developmental Assets and Developmental Relationships Trainings to 67 attendees.

Hope Navigators | Pathways to Hope for Children

- A Hope Summit was hosted that served 110 attendees.
- A Hope Navigator Training was held that trained 126 new Hope Navigators. This brought the total number of Trained Hope Navigators to 390.
- Three Monthly Hope Navigator Support Meetings were held that served 62 attendees total.

Culture of Poverty Trainings

- First 5 Shasta hosted 2 Culture of Poverty Trainings that served a total of 62 attendees.

Community Engagement

Strengthening Families Collaborative (SFC) *[meets every third Monday from 3-5PM || First 5 Shasta]*

Members | Far Northern Regional Center · First 5 Shasta · Northern Valley Catholic Social Service · One Safe Place · Pathways to Hope for Children · Shasta County Health & Human Services Agency (Behavioral Health and Social Services Branch and Public Health Branch) · Shasta County Office of Education · Shasta County Probation · Shasta Head Start · Youth Options Shasta

For the calendar year 2023, Tracie Neal from Shasta County Probation is Chair, Mike Freeman from Shasta County Office of Education is Chair Elect, and Mike Burke from Pathways to Hope for Children is Past Chair. Wendy Dickens from First 5 Shasta stepped into the Past Chair role again when Mike Burke left his position with Pathways to Hope for Children.

Meeting agendas during this reporting period included discussion relating to: SFC Charter and Strategy, SFC Chair Elect, New members, Hope Leadership Advisory Committee, Social media, website, and SFC materials, Lunch and Learns, Town Halls and Hope Summit, Camp Hope, Hope Navigator Trainings, ACE Interface Learning Community,

Hope Evaluation on Pathways to Hope for Children, Creation of Public Service Announcements, and ACE Proclamation Week.

Notes

- Public Health ACEs Community Education Specialist no longer coordinates or provides clerical support for these meetings.
- One Safe Place was not represented as of January 2023 and Pathways to Hope for Children was not represented as of June 2023.

SFC Data Committee (sub-committee) *[meets as necessary]*

Members | First 5 Shasta · One Safe Place · Shasta County Health and Human Services Agency (Behavioral Health and Social Services Branch and Public Health Branch) · Shasta County Probation · Youth Options Shasta

The meeting held during this fiscal year focused on creating a plan to receive missing data and how to best move forward. The Data Dashboard link is included on the Shasta Strengthening Families website.

ACE Learning Community/ACE Interface Presenters *[meets quarterly]*

Learning Community Members | American Red Cross · Children's Legacy Center · District Attorney · First 5 Shasta · Health and Human Services Agency (Behavioral Health and Social Services Branch and Public Health Branch) · Northern Valley Catholic Social Service · Shasta County Office of Education · Shasta Head Start · Youth Options Shasta

During FY 2022-23, Learning Community activities included:

- Sharing community engagement successes and testimonials
- Reviewing ACE Trainer surveys
- Reviewing ACE Trainer discussion questions
- Coordinating with Master ACE Trainers to train new ACE Presenters
- Consensus Workshop to determine community sectors that need to be reached with ACE Presentations
- Introduction of the new Public Health Community Education Specialist to facilitate the Learning Community
- Discussing plans for a Refresher Training and next steps after new presenters are trained

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

ACE Master Trainers met monthly to complete:

- Discussions to plan and debrief ACE Presentations and Learning Community Meetings
- Discussions of ACE Presenter Trainings and Community Workshops

ACE Events

ACE Luncheons

Two Lunch & Learns were held:

- From ACEs to Hope: Back to School - Setting Goals for a Successful School with 30 attendees
- Nurturing Fathers with 6 attendees

ACE Presentations & Movie Showings

The following ACE Presentations were given in FY 2022-23.

- 2 community presentations to 54 total attendees
- 3 presentations to HHSA staff to 32 total attendees
- 3 presentations to HHSA Children's Services Branch to 64 total attendees
- 1 presentation to law enforcement with 8 attendees

- 1 presentation to NVCSS staff with 20 attendees
- 2 presentations to One Safe Place Discovery Groups
- 1 presentation at Simpson College
- 3 presentations to Pathways to Hope for Children volunteers with 4 total attendees
- 1 presentation to American Association of University Women

A total of 17 presentations to over 185 individuals.

Movie Showings *(Resilience, Paper Tigers, and Broken Places)*

- No Movie Showings occurred during this reporting period.
- Coordinated with RoCo Films for First 5 Shasta to purchase the three movies.

Other Events

During Quarter 3 of this FY, a Proclamation proclaimed March as ACEs, Resilience and Hope Awareness Month. This was recognized by the City of Anderson, the City of Shasta Lake, the City of Redding, and the Shasta County Board of Supervisors.

SFC Members participated in the following:

- Facilitated a discussion around ACEs at a Fentanyl Forum
- Spoke on a radio show about ACEs and trauma-informed care
- Attended the virtual Northern ACEs Collaborative Quarterly Convening
- Hosted Parent Groups at Youth Options Shasta

The Public Health Community Education Specialist attended a community event, the Redding Health Expo, to share information and resources about toxic stress prevention and positive childhood experiences. It is estimated this event had over 5,000 attendees.

Shasta Strengthening Families Marketing

Website | ShastaStrengtheningFamilies.org

During Quarter 2 of this FY, the new Shasta Strengthening Families website went live. The contracted vendor, Pacific Sky, completed 4 videos that were included on the website. Edits and website support are provided monthly by Pacific Sky, with whom a contract was renewed for three more years.

SFC Social Media

Instagram followers increased from 908 to 944 and Facebook followers increased from 558 to 661. Shasta County HHSA collaborated with Think Again Shasta to share ACE information on their social media accounts. Administration of social media accounts was changed from Shasta County HHSA to First 5 Shasta.

Public Service Announcements

During this fiscal year, a contract was finalized with Faires Wheel Films to deliver 4 video ads and 4 static ads. Video topics include an overview of ACEs and Positive Childhood Experiences (PCEs), school engagement as a youth developmental asset, normalizing parents/caregivers needing parenting support, and promoting fatherhood support.

Materials

Distribution Tracking

Q1

- July 13th · 31 stickers, 1 backpack, 1to-go container, 1 stress ball, 2 magnets · Community ACE Presentation
- July 26th · 25 backpacks, 25 to-go containers, 25 chip clips · Shasta Family YMCA

- August 24th · 50 magnets, 26 stickers, 1 backpack, 1 chip clip, 1 to-go container, 1 sunglasses · ACE Lunch & Learn
- August 25th · 10 magnets, 10 stickers, 10 backpacks, 10 sunglasses, 10 chip clips, 10 to-go containers, 5 stress balls, 5 bouncy balls · Alcohol and Other Drugs program
- September 21st · 40 magnets, 29 stickers, 1 bouncy ball, 1 chip clip, 1 to-go container, 1 stress ball · Community ACE Presentation
- September 22nd · 150 stickers · State of the City/Kristen Schreder

Q2

First 5 Shasta:

- October 26th – Walk Thru Trunk or Treat Event || Pathways to Hope for Children
  - 76 ChapSticks Distributed
- October 29th Food Truck or Treat Event || Anderson River Park
  - 100 ChapSticks Distributed

Q3

Pathways to Hope for Children:

- ACE materials distributed at outreach events:
  - ACE infographics and ACE statistical graphs of Shasta County and State averages
- Presentation to Redding Newcomers & Friends; approximately 100 attendees
  - ACE infographics, Protective Factors handouts, information on services and resources available through Pathways to Hope

HHSA Public Health:

- Materials distributed at HHSA Staff Presentations:
  - ACE Screeners, Pair of ACEs, 40 Developmental Assts & Protective Factor handouts, ACE stickers

Q4

HHSA Public Health:

- Materials distributed at HHSA Staff Presentations and Community Events:
  - ACE Screeners, Pair of ACEs, 40 Developmental Assts & Protective Factor handouts, and ACE stickers
  - New ACEs rack cards, Positive Childhood Experiences handouts, Family Conversation Starters and recipe cards, Developmental Relationship magnets, stickers, sunglasses, bouncy balls, ChapSticks, and chip clips

New Materials Designed

A new ACEs Rack Card was designed about ACEs prevention and increasing positive outcomes. This material was received and shared at a community event and will continue to be shared with community partners.

Other

During this reporting period, a Vital Art Murals project was completed in which 15 murals were placed at various locations, including Lake Blvd., Buckeye School of the Arts, Downtown Grounds, Redding School of the Arts, Industrial St., Americana Lodge, One SAFE Place, Stardust Motel, Walgreens, and the downtown area. The total cost of this project was $47,997.60.

The ACE Prevention Coordinator position became vacant in the second quarter, leaving the program with no full-time staff. Coverage was provided by the Supervisor during the time the position was vacant. In March of this fiscal year, the new ACE Prevention Coordinator position was filled. For the first month of the position, the Coordinator was .50 FTE, split between two programs before becoming full time.

The ACE Prevention Coordinator worked on asset mapping for toxic stress prevention services and resources in the community to identify gaps and areas of need. Through networking with community partners and learning about existing community assets for ACEs and toxic stress prevention, the program narrowed down possible gaps it can fill to better our community and support families.

Additionally, the ACE Prevention Coordinator developed materials and community engagement resources for community events. The ACE Prevention Coordinator attended a health fair to connect directly with the community and parents and to distribute resources.

Shasta County Health & Human Services Agency

Stigma & Discrimination Reduction activities

Fiscal Year 2022-2023

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

In 2022-2023, Stand Against Stigma adapted its activities due to the pandemic.

Community Outreach and Education:

- The Stand Against Stigma Committee continued to meet every other month and resumed in-person meetings in February 2023. Meeting attendance ranges from 10 – 20 people.
- Refreshed the Brave Faces physical galleries hanging in the Shasta County Mental Health Building for an open house event. About 150 people attended. The galleries remain up and were viewed by staff and clients seeking services. Galleries are also hanging in eastern Shasta County at Shingletown Medical Center and Circle of Friends in Burney.
- Brave Faces shared their stories at a Crisis Intervention Team training.
- Published one Brave Faces gallery – Denise Green - a social worker, wife, mother and homesteader who manages a diagnosis of schizophrenia.
- A Hope Is Alive! Open Mic events were held in August, December and May at Sunrise Mountain Wellness Center. On average, attendance at open mics is between 20-40 people, and 8 – 10 performers.
- This first Recovery Happens celebration since 2019 happened in September 2022. The event had an estimated attendance of 600. More than 30 different recovery related programs exhibited and offered resources. Between 2017 – 2022, the planning committee has grown from 20 to 70 members.
- Partnered with Burney Circle of Friends to host a gallery opening event. The permanent gallery was installed at Circle of Friends in Burney in 2021. Circle of Friends members were some of the first to share their recovery stories through the program. Five galleries of the members are on display. It was attended by 22 people – Circle of Friends members and individuals from the community. Brave Faces were given certificates of appreciation for their courage and years of service.

- The Minds Matter Mental Health Resource Fair returned to its pre-pandemic format. In the past, the event typically attracted 35+ exhibitors and 300+ attendees. The 2023 event was an opportunity to rebuild and network. It attracted 20+ organizations. Overall, about 100 people attended. One new feature - mini workshops on wellness tools taught by peer support specialists – was a popular addition to the event. Topics included Intro to Wellness Recovery Action Plan (WRAP), laughing meditation, journaling and healthy relationships.

- Planned, recorded and produced the video: "HHSA Peer Support: Transforming Communities." The project had a dual purpose. First, it was presented to the Shasta County Board of Supervisors to educate them about the power of peer support. Second, oral histories were also recorded for Peer Support Specialists who expressed interested in sharing their stories through the Brave Faces Gallery and Speaker's Bureau. Several of the peers also participated in a Becoming Brave Training to develop their stories and be mindful of what they disclose. The video included peers from Child Welfare, Mental Health and Recovery Coaches, peer supervisors, and HHSA leadership. The video was also made available on social media and the "Community Support" page of the Stand Against Stigma website.

- The Stand Against Stigma website had 8,295 unique visitors throughout the year. Visitors viewed an average of 8 pages per visit. An uptick in visitors corresponded to times when ads ran on social media (Facebook and Instagram). Ads included Brave Faces galleries and events, like Hope Is Alive! Open Mic.

- Conducted table outreach at the Redding Rancheria Discover Health Fair, Redding LGBTQ+ Pride, Project Homeless Connect, and the Redding Health Expo. In total, approximately 300 people engaged with the exhibit.

- In collaboration with Lotus Educational Services, Inc, trained 171 individuals in Mental Health First Aid (MHFA). A total of 87 people took Adult MHFA training and 84 took Youth MHFA training. Trainings were offered in Redding and Burney.

SUICIDE PREVENTION FISCAL YEAR JULY 22-JUNE 23 REPORT

STRATEGY: CREATE A SYSTEM OF SUICIDE PREVENTION

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

A new Suicide Prevention Coordinator was hired and began work in August 2022.

The Shasta Suicide Prevention Collaborative (SPC) updated their bi-monthly meeting schedule to the second Tuesday of the month from 2:30-4pm. The SPC met five times during this reporting period. Highlights from each SPC meeting are summarized below:

- September 2022: Reviewed the launch of the 988 Suicide and Crisis Lifeline, National Suicide Prevention Awareness Month activities, upcoming events and training opportunities. A hybrid approach was implemented so that members who could not attend in-person were able to join the meeting virtually. Five members attended in-person and three attended online for a total of eight attendees.
- November 2022: Reviewed the goals and objectives of the draft Shasta Suicide Prevention Strategic Plan. Collaborative members provided feedback on the goals, discussed which objectives were already being addressed in the community, and offered input for potential revisions. Four members attended in-person and six attended online for a total of ten attendees.
- January 2023: Guest speaker presented on Carrying Heroes, a local program where veterans, first responders, and other emergency personnel can work alongside rescue horses to help ease the effects of cumulative stress. Six members attended in-person and six attended online for a total of twelve attendees.
- March 2023: Guest speaker shared information about the Veterans Affairs (VA) new Suicide Prevention Program. Seven members attended in-person. The hybrid meeting approach was discontinued during March and all remaining meetings for this reporting period were held in-person to reinforce participation and encourage collective action.
- May 2023: Planning & Service Area 2 Area Agent on Aging (PSA 2) staff members attended as guest speakers and presented on PSA 2 programs and resources. The Suicide Prevention Coordinator shared information and resources for Mental Health Month, promoted the Minds Matter Mental Health Resource Fair, and reviewed the concept of Collective Impact with members. The Collective Impact model will be integrated into Collaborative meetings to encourage member engagement and increase coordinated efforts. Ten members attended in-person.

The Shasta Suicide Prevention Collaborative continued to encourage older adults to use the Institute on Aging Friendship Line. There were **482** calls from Shasta County to the warmline during this fiscal year. The Warmline allows callers to remain anonymous, so the actual number of callers from Shasta County could be higher because they may not have identified their county of residence. On July 16, 2022, the 988 Suicide & Crisis Lifeline launched. The Suicide Prevention Program acquired one hundred 988 wallet cards to distribute and assisted with the slow rollout of the new lifeline number. National Suicide Prevention Lifeline data was provided by Suicide Prevention of Yolo County (SPYC) in partnership with North Valley Suicide Prevention Hotline during 2022. The crisis line received the following calls from residents of Shasta County from **July 2022 – December 2022 = 351 calls**. SPYC suspended services on February 16, 2023. The final report noted that the North Valley Suicide Prevention Hotline received the following calls from residents of Shasta County from **January 1, 2023 – February 15, 2023 = 59 calls**. Of the 59 calls, 9 were considered moderate or high lethality calls, 3 imminently lethal callers were deescalated, 12 callers required follow-up, and there were 0 active rescues. It is also important to note that following the launch of the 988 Suicide and Crisis Lifeline, Vibrant Emotional Health has since suspended providing data.

Members of the Shasta Suicide Prevention Collaborative continued to promote and distribute the National Suicide Prevention Lifeline and Crisis Text Line cards to increase community members' access to crisis resources. Cards were distributed during trainings, health fairs, directly to schools, and other points of contact during outreach efforts. During this reporting period, prevention resources were directly distributed to Lotus Educational Services, Inc., Hill Country CARE Center, Shingletown Medical Center, Women's Health Specialists, Code 9 training attendees, Alcohol and Other Drugs Program, Tobacco & Obesity Prevention Program, and HHSA's Economic Mobility and Adult & Children's Services Branches.

The Suicide Prevention Program, with support from Stand Against Stigma, continued to promote the Captain Awesome mental health/suicide prevention campaign which focuses on men in their middle and later years, a cohort at higher risk for suicide. The Captain Awesome campaign was developed to help reduce stigma associated with mental health, increase understanding of mental health and suicide, encourage help-seeking, and promote crisis resources among men in Shasta County. The campaign included print, social media, and online advertising materials promoting men's mental health. Media flights featured local men who elected to participate in the campaign. The new Captain Awesome website launched on December 15, 2022, to help promote the campaign and increase ease of access to mental health and suicide prevention resources designed for men. These resources were previously included on the suicide prevention website. The Captain Awesome site can be found at the following web address: www.captain-awesome.org. Two new individuals posed for the Captain Awesome campaign during the summer of 2023 and their media materials are being developed. The Suicide Prevention Program promoted the Captain Awesome website and encouraged Men's Advisory Group (MAG) recruitment using targeted advertising on the Shasta County Health & Human Services Facebook page during May 2023. Advertising metrics indicated that the Facebook post reached 1,841 people and engagement consisted of 38 link clicks to the Captain Awesome website, 25 post reactions, 10 post shares, and 2 comments. The MAG members met during May 2023 and shared ideas for the development of promotional materials and offered suggestions for Captain Awesome recruitment.

On August 30, 2022, Dr. Kimberly Repp provided a brief onboarding of the Suicide Fatality Review (SFR) Team process to the new Deputy Coroner from the Shasta County Sheriff's Office and the new Suicide Prevention Coordinator. The implementation of an SFR team will help the Suicide Prevention Program identify trends in risk factors for the development of targeted suicide prevention activities. In collaboration with HHSA's Outcomes, Planning, and Evaluation and the Shasta County Sheriff's Office, the Suicide Prevention Coordinator revised the SFR charter and advising documents to prepare them for review by Branch and County leadership. On November 8, 2022, participating California counties attended the Suicide Death Fatality Review Team Collaborative meeting to discuss the status and development of their suicide fatality review (SFR) teams and provide advice and suggestions for counties interested in forming a SFR team. The Suicide Prevention Coordinator and division leadership arranged for a meeting with the HIPAA Privacy team in July 2023 to review SFR documentation and ensure the outlined processes align with county regulation and state law.

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

The Suicide Prevention Coordinator attended and completed a SafeTALK Train the Trainer (T4T) series in June 2023. The T4T series consisted of two, 8-hour, in-person training sessions. Instruction focused on expanding participants' knowledge of the SafeTALK curriculum and their ability to present the content in an easy-to-understand manner. At the end of the T4T series, the Suicide Prevention Coordinator received a certificate identifying them as a provisional SafeTALK instructor and approval for conducting SafeTALK trainings independently. Requirements for achieving the status of a registered SafeTALK trainer include delivering a minimum of three trainings and facilitating each part of the training at least once by June 1, 2024. To maintain active status as a registered trainer, the Coordinator must conduct a minimum of two trainings per year and attend an ASIST workshop every four years. The Coordinator will host SafeTALK trainings during 2023 with HHSA staff to expand knowledge of suicide warning signs and skills to support individuals at risk.

The Suicide Prevention Coordinator conducted outreach with local, independent pharmacies to promote the Pharmacists as Gatekeepers in Suicide Prevention training and encouraged attendance for the Train the Trainer (T4T) series scheduled for February 2023. The training opportunities were also advertised on the Shasta Suicide Prevention Collaborative Facebook page and monthly newsletter. A staff member from Anderson RX was contacted by the program in December 2022 to discuss the pharmacist's

experience participating in the gatekeeper training. The Suicide Prevention Coordinator attended and completed the Pharmacists as Gatekeepers T4T series in February 2023. The T4T series consisted of three training sessions. Instruction focused on expanding participants' knowledge of the subject matter and enhancing their ability to present the material to pharmacists in an easy-to-understand manner. Attendees were provided multiple opportunities to practice presenting. The coordinator will utilize their T4T training to deliver suicide prevention gatekeeper training to local pharmacists and pharmacists-in-training to support their knowledge of suicide warning signs, discussing suicide risk associated with medication use with patients, and connecting patients at risk to appropriate support.

The Suicide Prevention Coordinator promoted National Suicide Prevention Awareness Month in September and International Survivors of Suicide Loss Day in November on the Shasta Suicide Prevention Collaborative Facebook page and monthly newsletter. The Suicide Prevention Coordinator shared activities for National Suicide Prevention Awareness Week using materials provided by the Know the Signs Annual Suicide Prevention Week Activation Kit. The Suicide Prevention Coordinator also shared information for a Survivor's Day event hosted by Lotus Educational Services, Inc. on November 19, 2022. The event was designed to support individuals and families impacted by suicide loss by giving them an opportunity to connect with fellow suicide loss survivors in a safe and caring environment.

The Shasta County Suicide Prevention (SP) program received a five-year grant award from the California Department of Public Health (CDPH) in August 2021. The Suicide Prevention Program was offered additional funding of $190,000 from the California Comprehensive Suicide Prevention (CSP) Program for years 3, 4, and 5 to supplement suicide prevention activities. Shasta County confirmed acceptance of the additional funds on December 30, 2022. Grant objectives include creating protective environments and identifying and supporting people at risk. MHSA-PEI funds will be braided at times to increase reach and effectiveness for CDPH funded activities. Current CDPH grant activities include the following:

- Create Protective Environments – Code 9 workshops were completed during February-March and May of 2023. Code 9 is a training program designed for first responders that provides education for integrating suicide prevention, means safety, responder wellbeing, and peer support into department programming. The Suicide Prevention Coordinator promoted the workshops in radio ads, social media, the monthly Shasta Suicide Prevention Collaborative newsletter, and via email and in-person correspondence with community partners. Resources were offered to all Code 9 attendees to support their wellbeing and increase their ability to connect community members to support. Resources included firearm safety brochures and wallet cards containing mental health crisis and helpline numbers that offer specialized support for first responders. Remaining wallet cards and firearm safety brochures were distributed to 15 first responder departments including local law enforcement agencies and fire departments.

- Identify & Support People at Risk – The Coordinator created and administered a survey to local behavioral health professionals and medical professionals to determine suicide prevention training needs. Professionals that completed the survey expressed high interest in the following training programs: Assessing and Managing Suicide Risk (AMSR), Recognizing and Responding to Suicide Risk (RRSR), and Counseling on Access to Lethal Means (CALM). Representatives from each training program were contacted to discuss costs for hosting in-person trainings for local providers. A spending proposal was drafted and reviewed to begin the contract process.

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

The website www.ShastaSuicidePrevention.com remained live for the community and included national and local resources for suicide prevention, counseling and medical care, and supportive programs for specific needs and groups.

The Suicide Prevention Program continued to promote the suicide loss and attempt support group "Speaking of Suicide" (SOS). The group met several times during 2022 at the Lotus Educational Services, Inc. office. Regular SOS meetings were suspended during March 2023 due to low attendance. The Suicide Prevention Coordinator and SOS Facilitator continue to promote SOS to encourage participation for community members that could benefit from a support group.

HHSA's behavioral health staff, including the ACCESS team, provided Suicide Prevention resources to the community as needed. Representatives from the Behavioral Health and Socials Services branch remain connected to Suicide Prevention Program updates via Collaborative meetings and email announcements.

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

The Suicide Prevention Coordinator maintained contact with older adult care service providers, including the PSA 2 Area Agency on Aging. A representative from PSA 2 remained connected to Suicide Prevention Program updates via Collaborative meetings and email announcements.

The Suicide Prevention Coordinator also maintained ongoing communication with community partners including NorCal OUTreach, Aegis Pinnacle Treatment, Carrying Heroes Program, Dignity Health, Hill Country Clinic, Lotus Educational Services, Inc., Pathways to Hope for Children, Shasta Family YMCA, Shasta High Wellness Center, Shasta College, Veterans Affairs, Whiskeytown National Forest Recreation staff, local licensed clinical social workers (LCSW), and others to encourage opportunities to discuss collaboration and support.

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

The Suicide Prevention Collaborative met bi-monthly during this reporting period to discuss current suicide prevention activities and develop implementation plans for strategies to reduce suicide attempts and deaths in Shasta County. Collaborative members also stayed connected through email, the Collaborative Facebook page, and the monthly newsletter.

The use of local, state, and national hotline services were promoted during this reporting period were as follows:
National Suicide Prevention Lifeline data was previously provided by Vibrant Emotional Health. With the development of the 988 Suicide and Crisis Lifeline, Vibrant suspended providing data. The Suicide Prevention Program promoted the 988 Lifeline and provided updates about the Lifeline to the community as needed.

Suicide Prevention of Yolo County (SPYC) provided lifeline services to Shasta County residents. From 2022 to February 15, 2023, SPYC, in partnership with North Valley Suicide Prevention Hotline, provided crisis support for Shasta County callers routed from the National Suicide Prevention Lifeline. SPYC suspended services on February 16, 2023. The final report noted that the North Valley Suicide Prevention Hotline received the following calls from residents of Shasta County from **January 1, 2023 – February 15, 2023 = 59 calls**.

(Jan 1, 2023 – February 15, 2023 = 59 calls)

Callers Identified as Shasta County Residents	59
Moderate/ High Lethality Calls	9
Active Rescue Calls	0
Callers Requiring Follow Up	12

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

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

QPR

QPR Trainer Certification: August 2020

Shasta County QPR Trainer: **Lindsay Heuer** – Shasta County HHSA, Public Health

QPR Trainings Provided (7/2022 – 6/2023):

Training Date	Organization	Number of Participants
7/27/2022	HHSA Adult Services	25
10/5/2022	HHSA Suicide Prevention Coordinator	1
3/16/2023	HHSA Economic Mobility	22
4/6/2023	HHSA Economic Mobility	24
Total Number of Trained Participants		**72**

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

SafeTALK (4-hour training)		
Date	**Morning Session # of Attendees**	**Afternoon Session # of Attendees**
11/4/2022	20	8
3/28/2023	19	14
Total Number of Trained Participants		**61**

ASIST (2-days; 16 hours)	
Date	**Number of Participants**
8/1-2/2022	27
10/13-14/2022	25
2/15-16/2023	10
5/11-12/2023	17
Total Number of Trained Participants	**79**

Many participants who attended the suicide prevention trainings shared positive feedback such as:

- "Everyone should take the time to complete the course – it can and will save lives. Trainings like this eliminate the stigma & protect those from suffering in silence." – SafeTALK participant
- "Great introduction to how to talk to someone wo may be considering suicide for people who have never done it before, are scared to, or want a more empathetic and effective approach." – SafeTALK participant
- "I feel 100% more prepared to support someone at risk than I did prior to the training." – ASIST participant

STRATEGY 3: EDUCATE COMMUNITIES TO TAKE ACTION TO PREVENT SUICIDE

Date of Event	Event	# of Materials
9/8/2022	Shasta College Health and Safety Fair	40
9/24/2022	Redding Pride	100+
9/2022	Recovery Happens	100+
9/2022	Back-to-School Night (Anderson and Sequoia Middle School)	40
10/7/2022	Redding School of the Arts	35
11/18/2022	STEM Fair	200+
3/25/2023	Clean California	100
3/22/2023	Caregiver Conference	65
5/15/2023	Project Homeless Connect	200
5/20/2023	Minds Matter Mental Health Resource Fair	50
6/3/2023	Redding Pride	200+

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

The Speaking of Suicide (SOS) support group met in-person on Wednesdays from 5:30PM – 7PM at the Lotus Educational Services office. Regular SOS meetings were suspended during March 2023 due to low attendance. The Suicide Prevention Coordinator and SOS Facilitator continue to promote SOS to encourage participation for community members that could benefit from a support group. SOS support group meetings were promoted through the Shasta Suicide Prevention Collaborative monthly newsletter, Facebook page, and Collaborative meetings.

During the previous reporting period, Facebook "Likes" were at 683, and at the end of this reporting period there were 713 likes on the page. Engagement on posts rose with the regular posting schedule of two-three times per week. The content shared on this page ranged from resources for those who have attempted suicide, friends and family of those that experience suicidal thoughts, and those who have lost someone to suicide. The page often shared ways to cope with loss, stress, loneliness, etc. and/or local and national events and resources surrounding suicide prevention.

Performance data indicates that an average of 388 individuals received the Shasta Suicide Prevention Collaborative newsletter each month and approximately 166 accessed the newsletter monthly from July 2022 to June 2023. Similar to the suicide prevention Facebook page, the newsletter also shared information about resources, training opportunities, and upcoming events with the community to increase awareness of suicide in Shasta County, promote connectedness, and improve linkage to crisis and mental health services.

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

The Firearm Safety brochures, which stresses the need for increased awareness and prevention efforts when it is suspected that an individual is in crisis or suicidal, were distributed to law enforcement and CCW/firearm vendor contacts along with other suicide prevention resource materials. The Firearm Safety brochures were also distributed during outreach events as resources for the

community. In addition to print materials, the Suicide Prevention Program offers firearm safety cable locks to gun owners in the community to help support securing firearms safely.

The California Department of Public Health (CDPH) provided 50 lock boxes to the Suicide Prevention Program to be used to safely store medication or firearms. No lockboxes were administered during this reporting period.

The Suicide Prevention Program has elected to participate in the Striving for Safety Firearms Means Safety Project. For the project, Shasta County will help to identify and recruit community ambassadors that would like to champion means safety education efforts. The selected ambassadors will receive training from CDPH and learn how to provide means safety education to local gun shops. Project timelines and additional instruction will be provided by the Firearms Means Safety Project lead, Stan Collins, in the following months.

STRATEGY 4: EDUCATE COMMUNITIES TO TAKE ACTION TO PREVENT SUICIDE

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

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

Epidemiologists provided updated data to the Suicide Prevention Program in preparation for a presentation to the MHADAB board. Data will be used to demonstrate the prevalence of suicide in Shasta County and the populations most impacted by suicide in the community.

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

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

Resource Dissemination Shasta County Suicide Prevention Program	Trevor Project	Know the Signs		Suicide Prev. Hotline			211 Materials	Friendship Line	Directing Change	Mental Health Kits	LGBTQ+ Resources	Suicide Attempt/Loss Brochures	Mobile Crisis Outreach	Estimated Reach
	Flyers	English	Spanish	Cards	Pens	Crisis Text Line								
Shasta College Health and Safety Fair		X	X	X	X	X	X	X	X	X	X	X	X	40
Redding Pride	X	X	X	X	X	X			X	X	X	X	X	100+
Recovery Happens		X		X	X	X	X	X	X		X	X	X	100+
Back-to-School Night (Anderson and Sequoia Middle School)		X	X	X	X	X	X		X	X	X	X		40
Redding School of the Arts		X		X	X	X			X					35
STEM Fair		X		X		X			X					200+
Clean California		X		X										100
Caregiver Conference		X		X	X	X	X	X	X			X	X	65
Project Homeless Connect		X	X	X	X	X	X	X				X	X	200+
Minds Matter Mental Health Resource Fair		X	X	X	X	X	X	X	X	X	X	X	X	60+
Redding Pride	X	X	X	X	X	X	X	X		X	X	X	X	200+

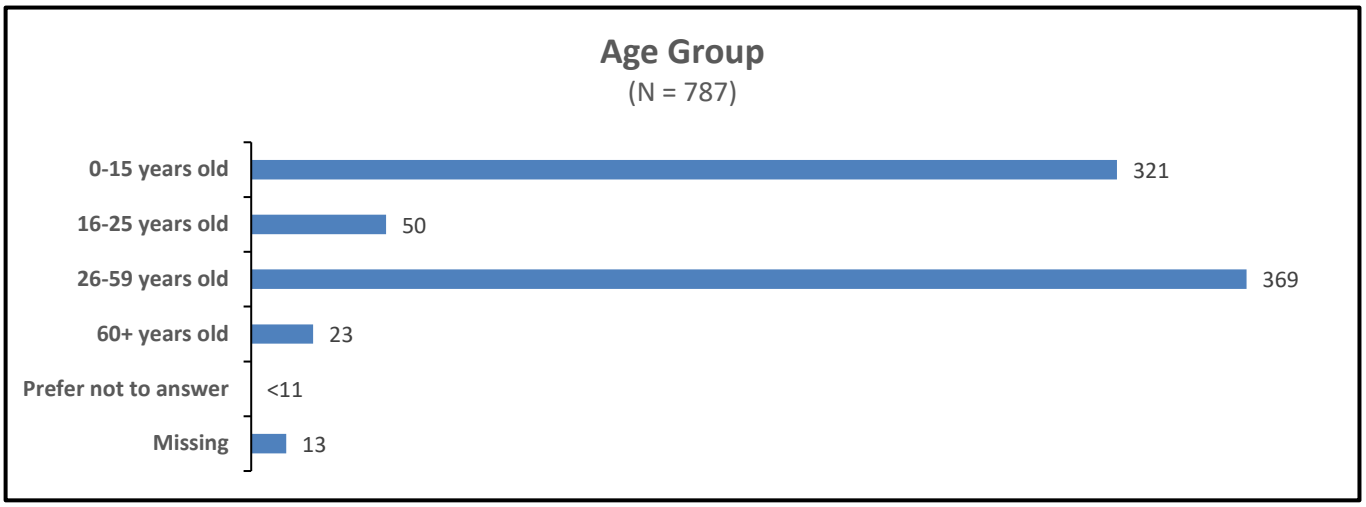
Shasta County Health & Human Services Agency

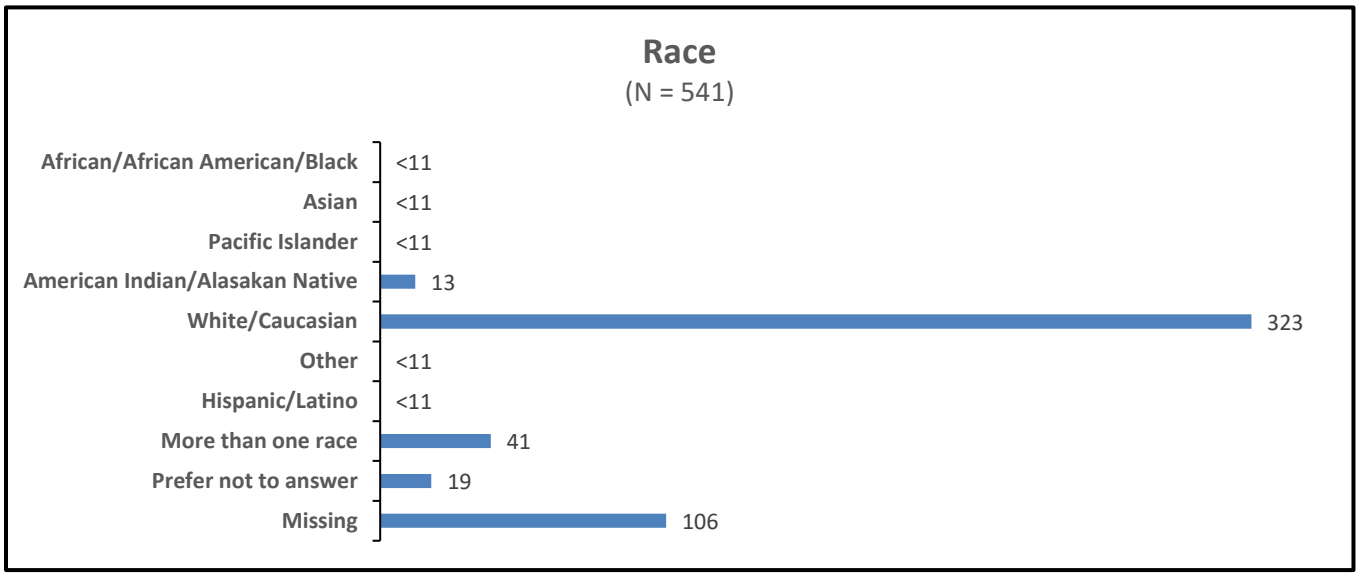
MHSA Prevention and Early Intervention Fiscal Year 22/23 Demographics Report

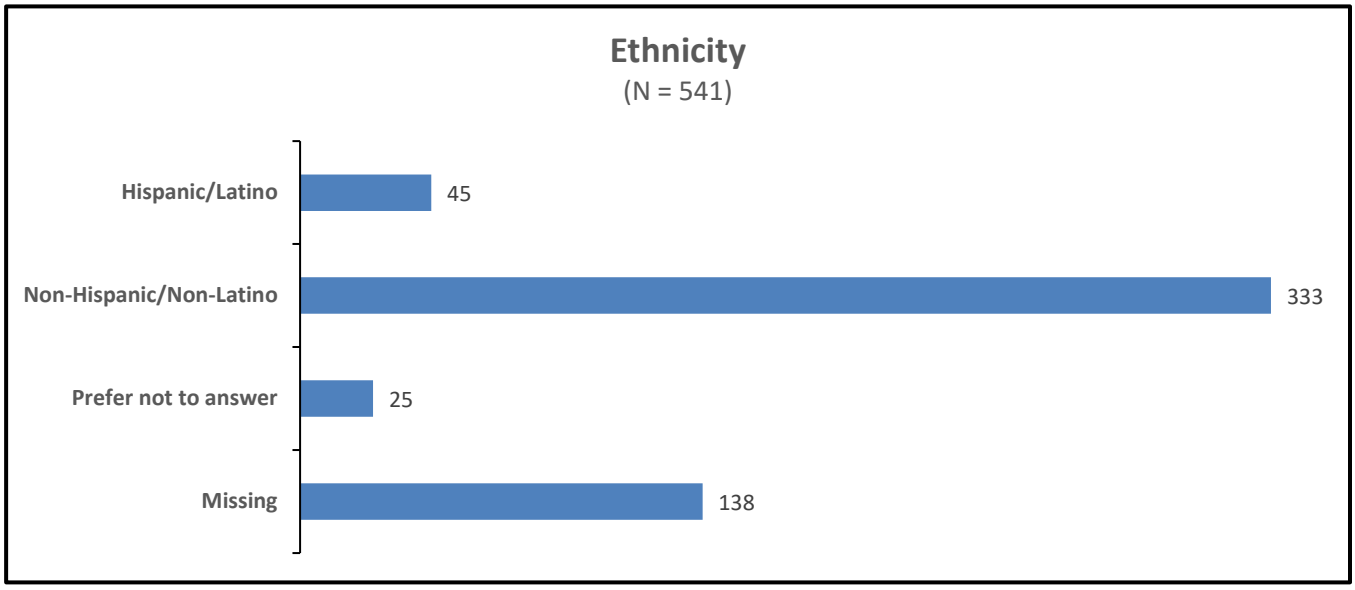
I. Prevention and Early Intervention Program Demographics

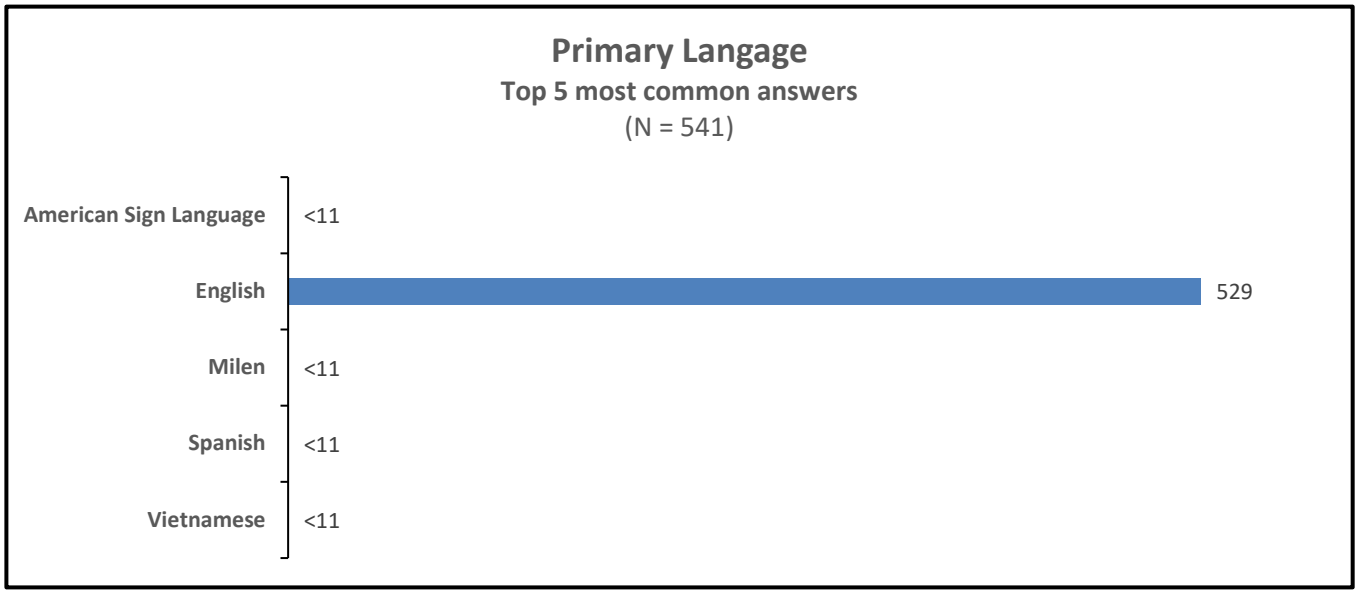
- Triple P (522)
- Mental Health First Aid (48)
- Suicide Prevention (116)
- Stand Against Stigma (25)
- IMPACT (52)
- Adverse Childhood Experiences (33)

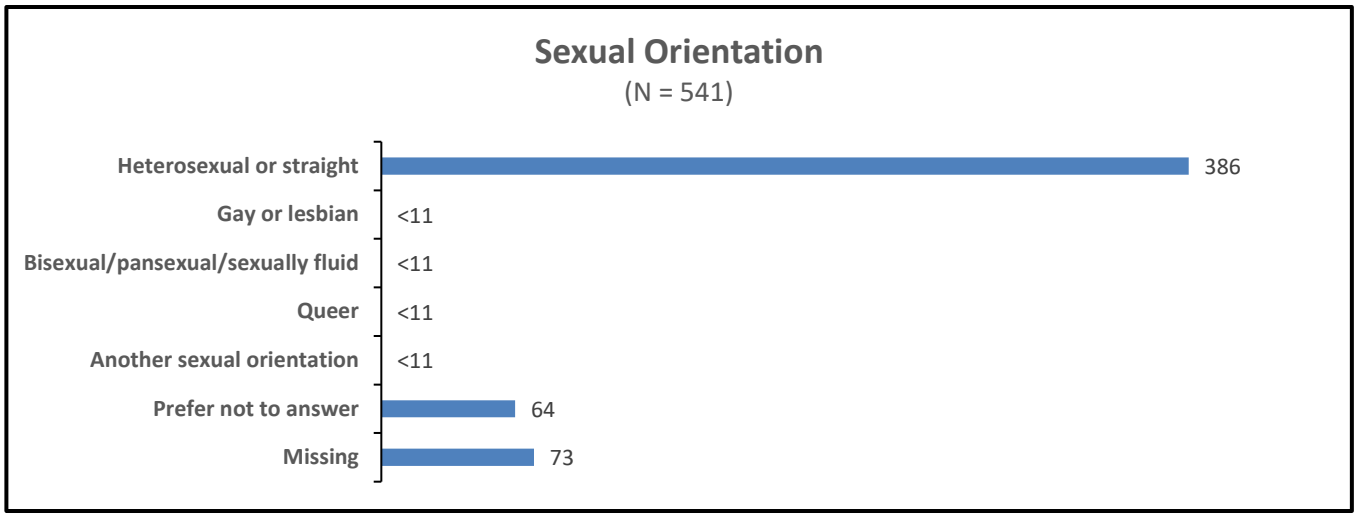
796 total individuals submitted demographic data forms. Please note: only age data was collected on Triple P child/youth participants. Categories that received 11 or less responses are not labelled to help protect client confidentiality. Categories that received zero responses are not shown.

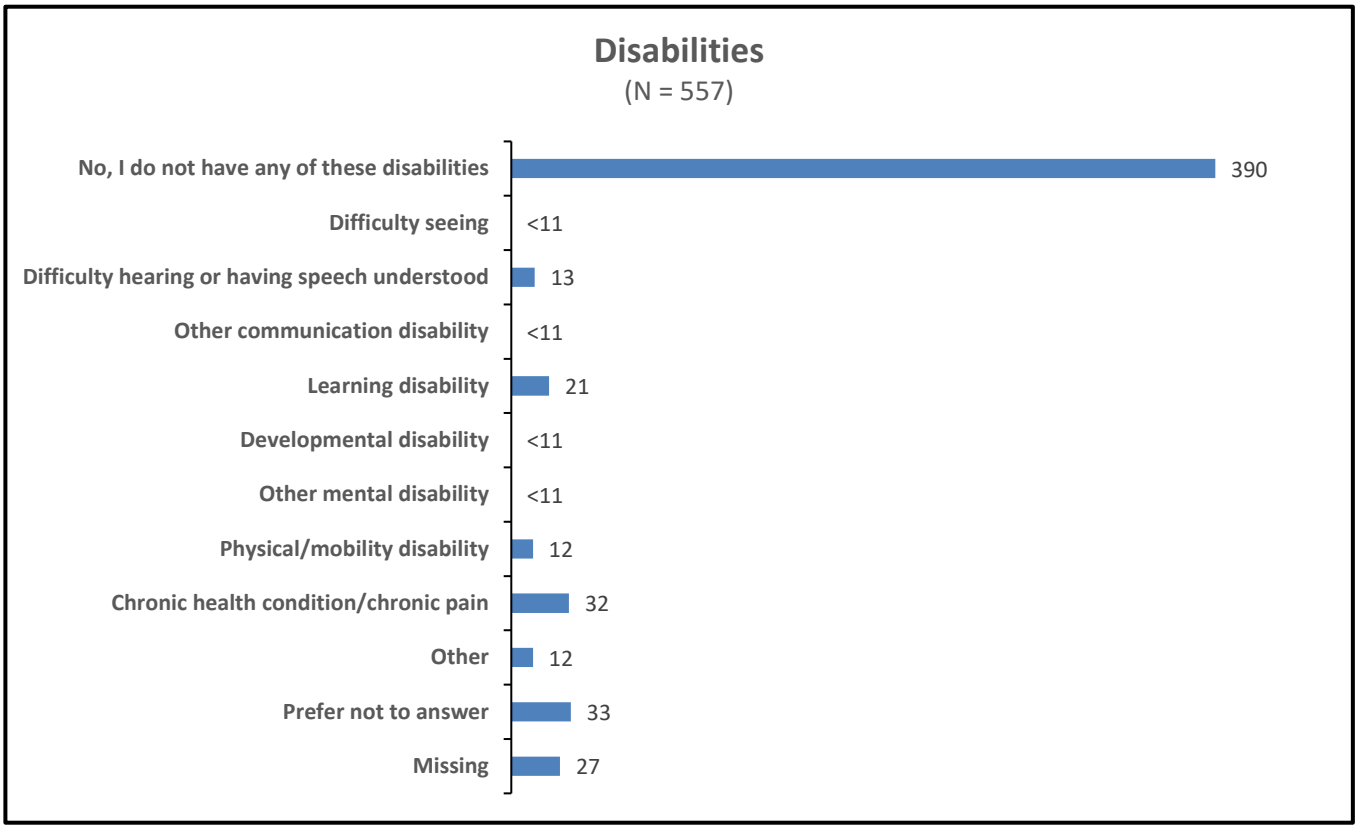


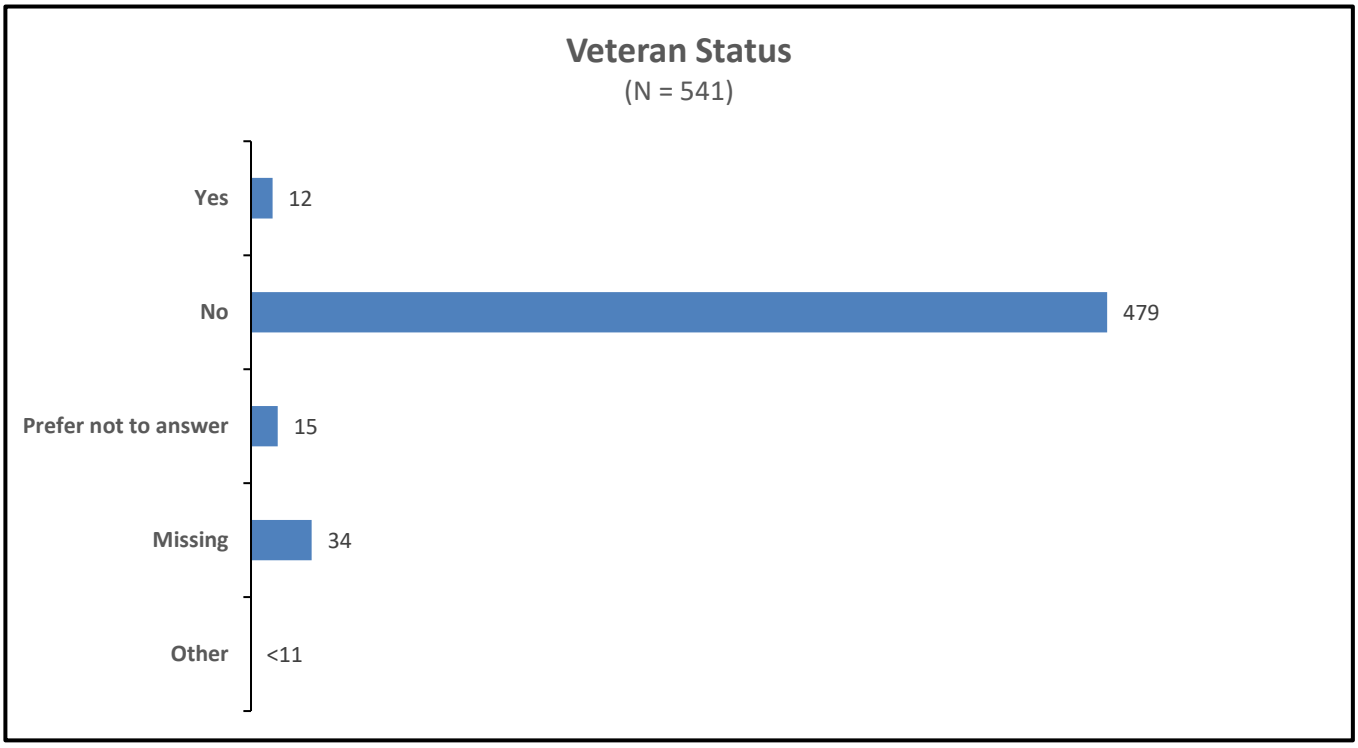


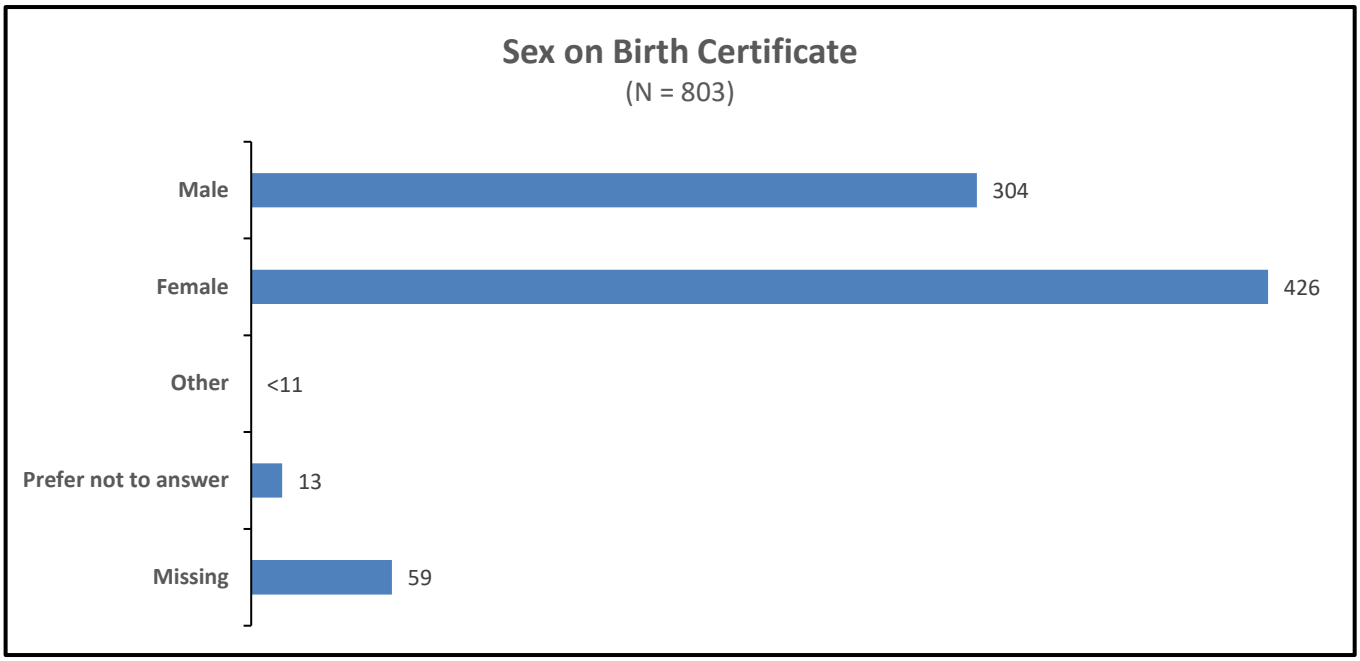

Ethnicity
(N = 541)
Hispanic/Latino
45
Non-Hispanic/Non-Latino
333
Prefer not to answer
25
Missing
138

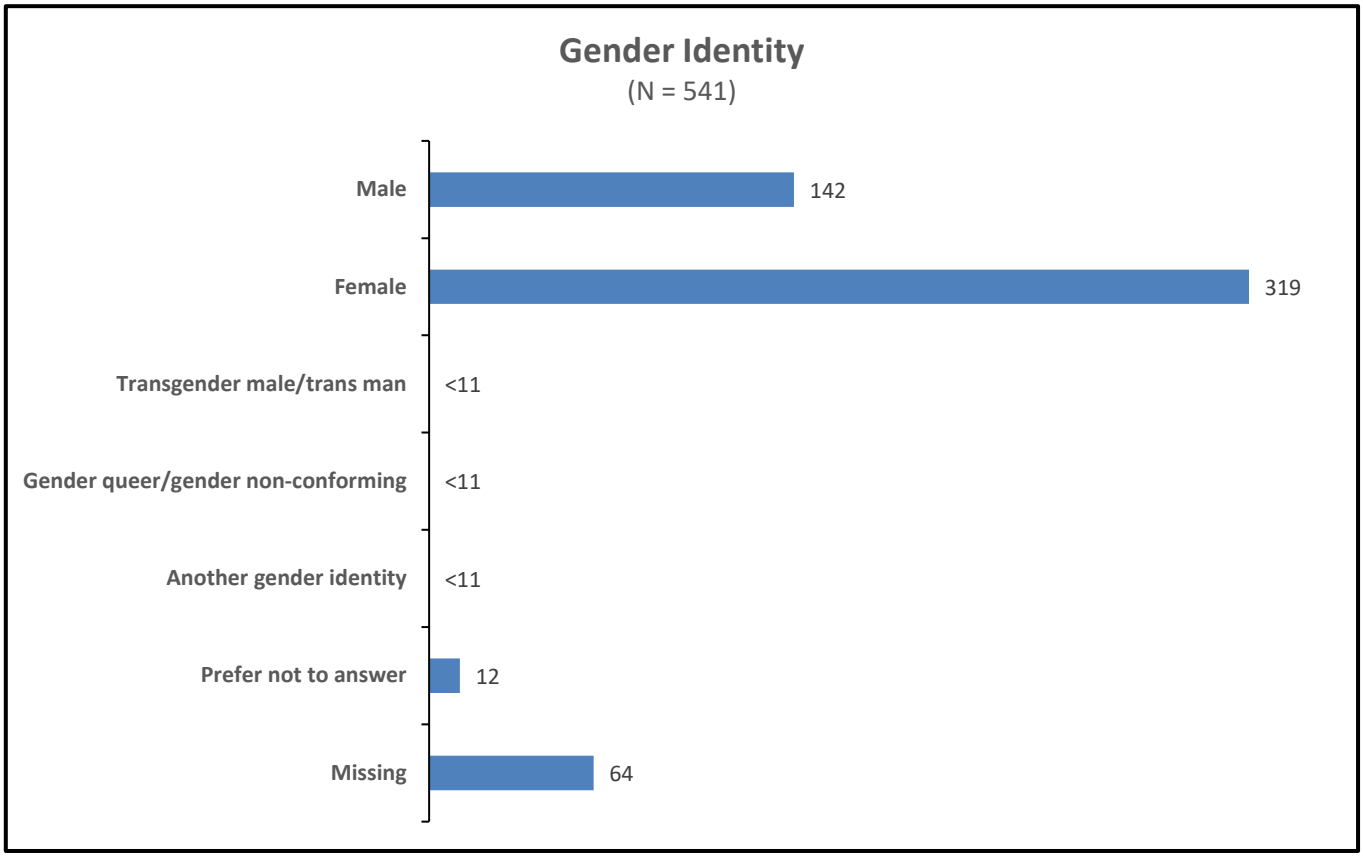

Primary Langage
Top 5 most common answers
(N = 541)
American Sign Language
<11
English
529
Milen
<11
Spanish
<11
Vietnamese
<11


Sexual Orientation
(N = 541)
Heterosexual or straight
386
Gay or lesbian
<11
Bisexual/pansexual/sexually fluid
<11
Queer
<11
Another sexual orientation
<11
Prefer not to answer
64
Missing
73


Disabilities
(N = 557)
No, I do not have any of these disabilities
390
Difficulty seeing
<11
Difficulty hearing or having speech understood
13
Other communication disability
<11
Learning disability
21
Developmental disability
<11
Other mental disability
<11
Physical/mobility disability
12
Chronic health condition/chronic pain
32
Other
12
Prefer not to answer
33
Missing
27


Veteran Status
(N = 541)
Yes
12
No
479
Prefer not to answer
15
Missing
34
Other
<11


Sex on Birth Certificate
(N = 803)
Male
304
Female
426
Other
<11
Prefer not to answer
13
Missing
59


Gender Identity
(N = 541)
Male
142
Female
319
Transgender male/trans man
<11
Gender queer/gender non-conforming
<11
Another gender identity
<11
Prefer not to answer
12
Missing
64

- **Stand Against Stigma**

10,000 total Individuals and potential responders served*

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

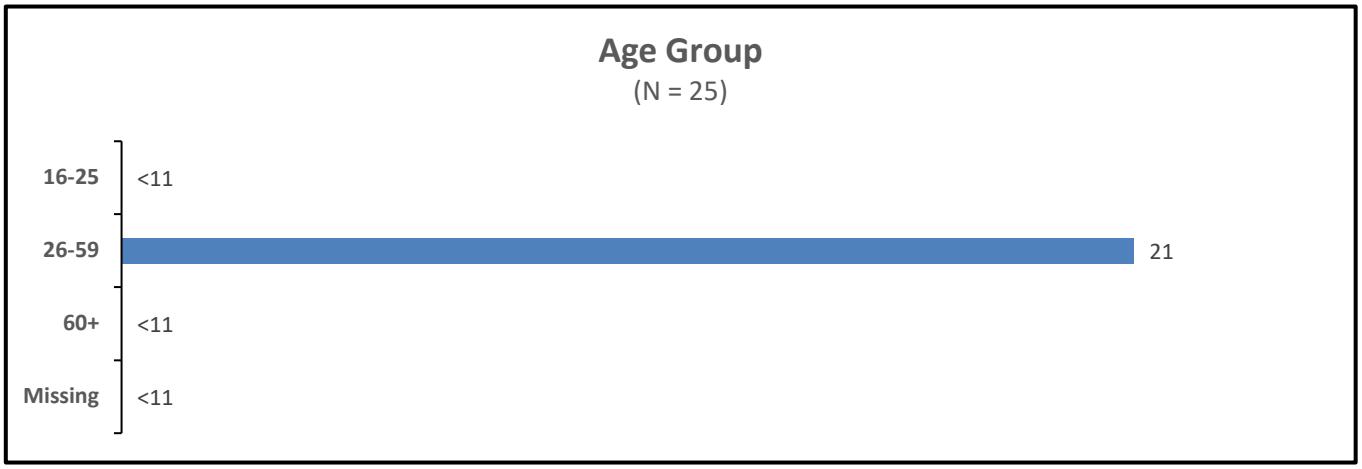
This program was implemented in various settings including:

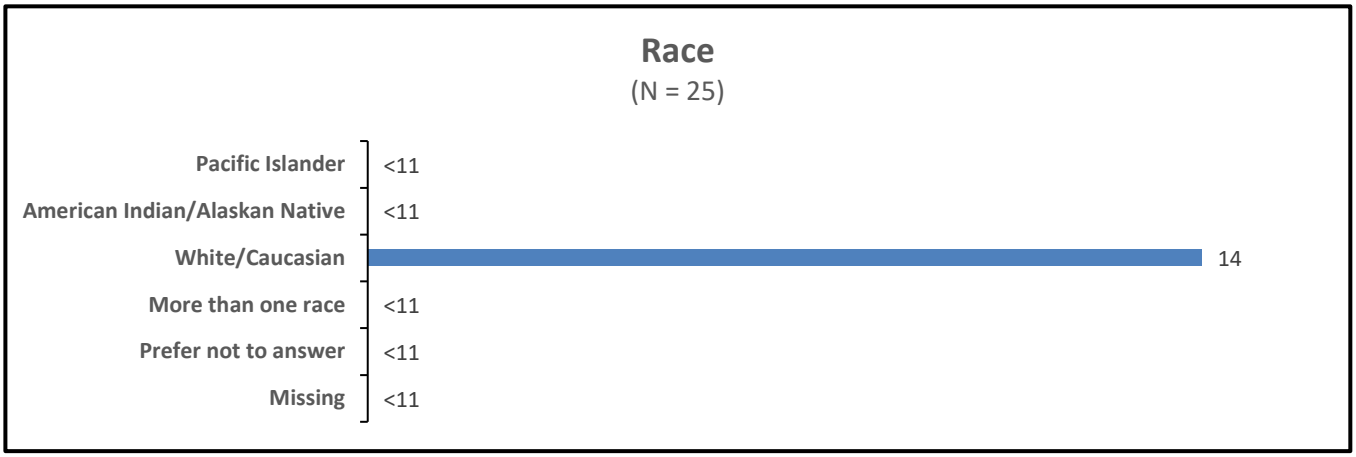
- **Domestic Abuse shelter**
- **CARE Center**
- **Wellness Centers**
- **Sundial Bridge**
- **Community Center**
- **Social Services Organization**

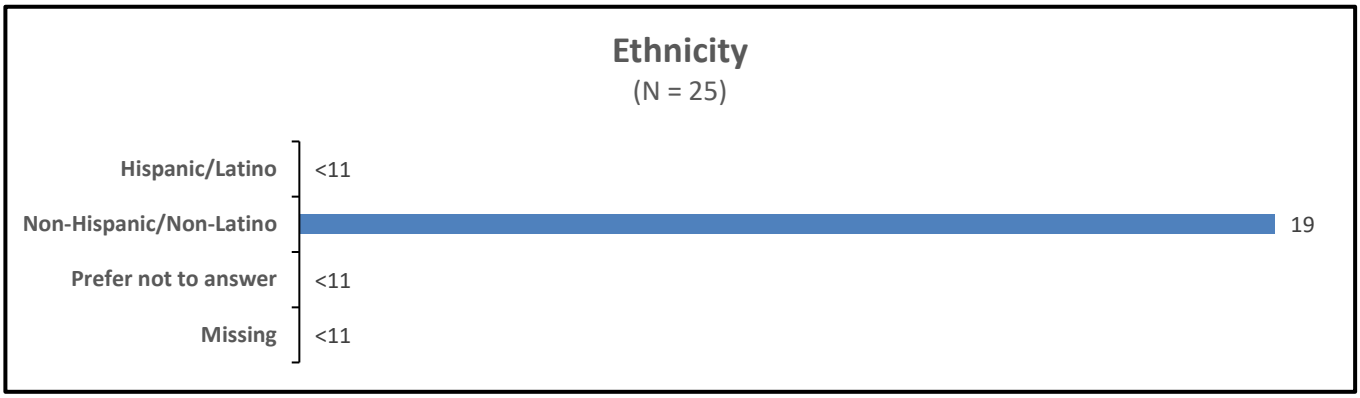
Types of potential responders:

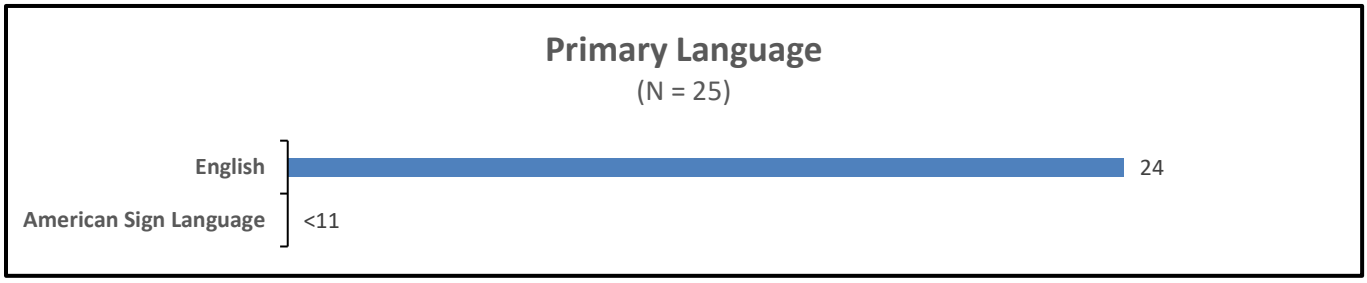
- **College Students**
- **High School Students**
- **Domestic abuse counselors**
- **Homeless population**
- **Continuation school students**
- **University students**
- **Community members**
- **Faith-based community**
- **Senior Citizens**
- **Nurses and other medical care providers**
- **Law enforcement**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

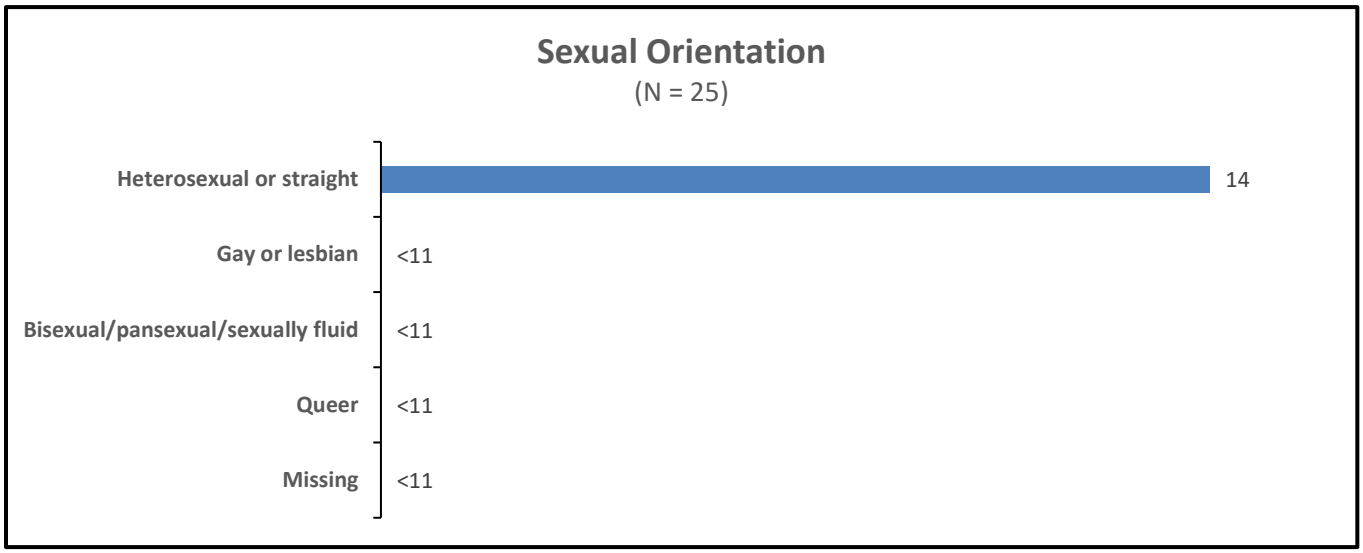
25 total individuals submitted data. Categories that received zero responses are not shown.

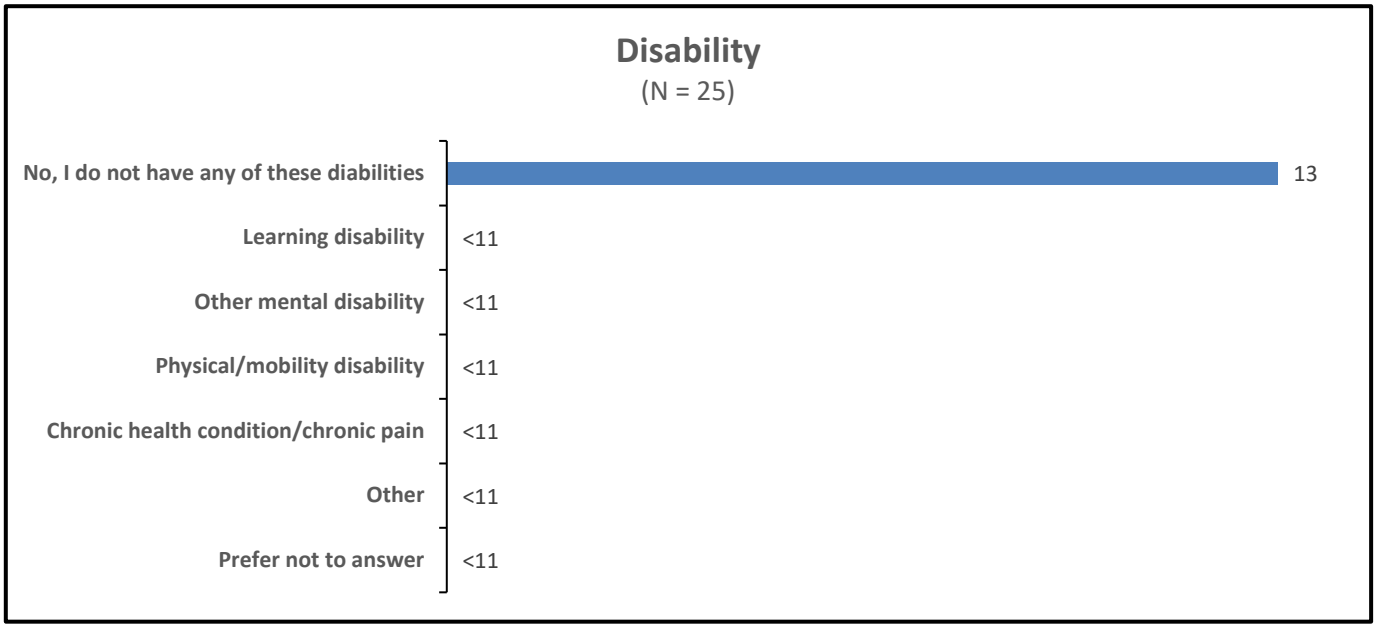


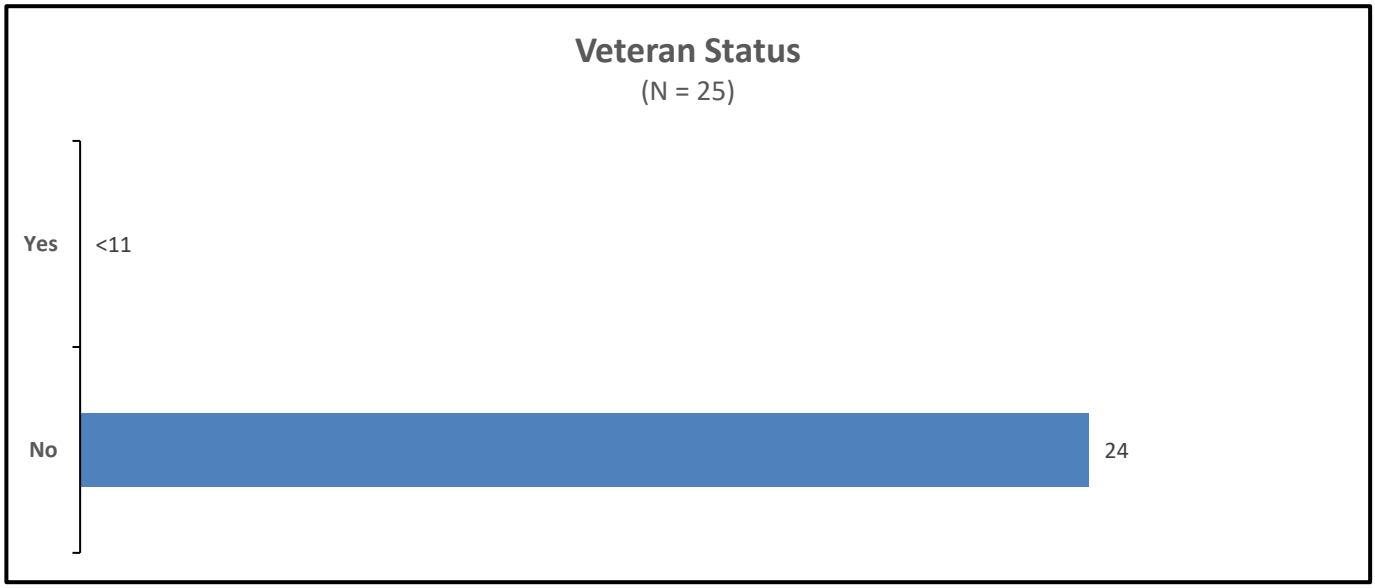

Race
(N = 25)
Pacific Islander
<11
American Indian/Alaskan Native
<11
White/Caucasian
14
More than one race
<11
Prefer not to answer
<11
Missing
<11

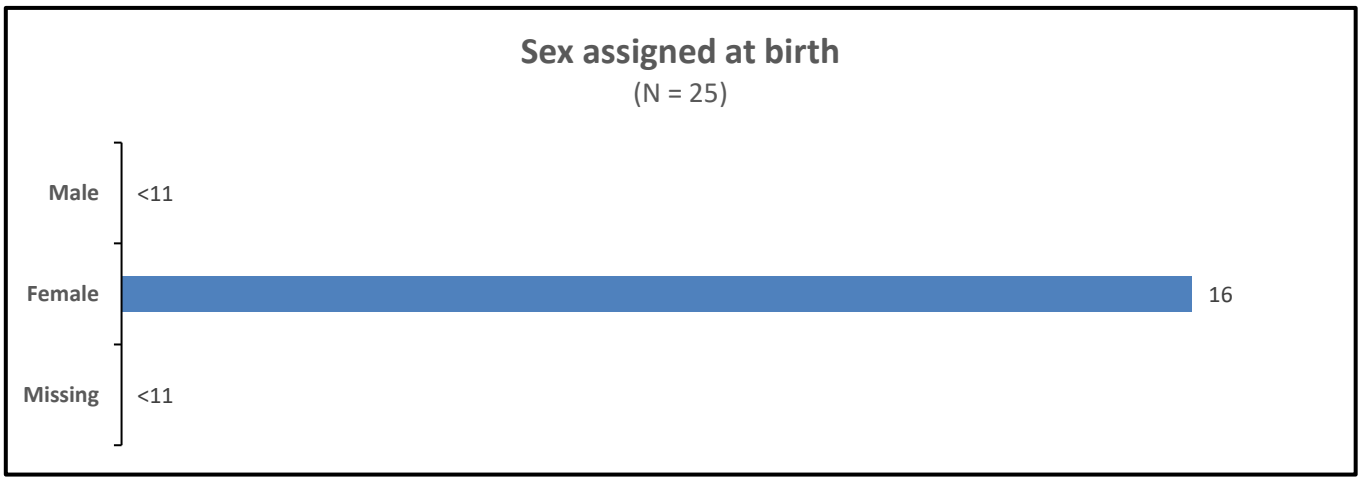

Ethnicity
(N = 25)
Hispanic/Latino
<11
Non-Hispanic/Non-Latino
19
Prefer not to answer
<11
Missing
<11

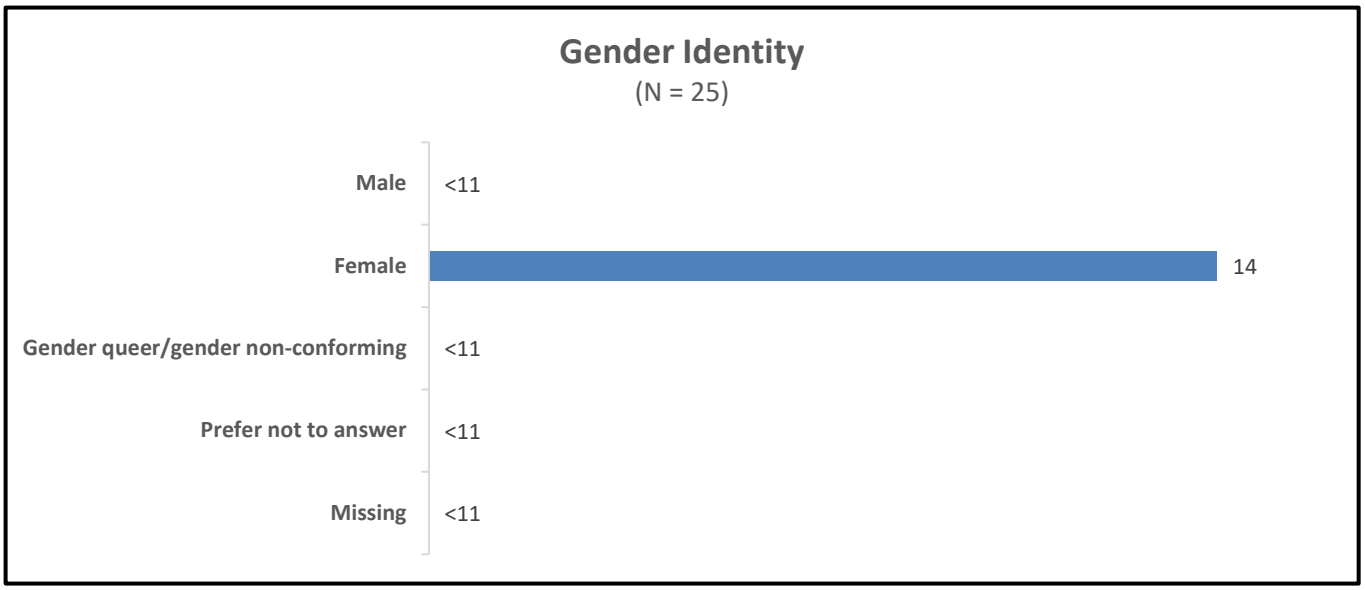

Primary Language
(N = 25)
English
24
American Sign Language
<11


Sexual Orientation
(N = 25)
Heterosexual or straight
14
Gay or lesbian
<11
Bisexual/pansexual/sexually fluid
<11
Queer
<11
Missing
<11


Disability
(N = 25)
No, I do not have any of these diabilities
13
Learning disability
<11
Other mental disability
<11
Physical/mobility disability
<11
Chronic health condition/chronic pain
<11
Other
<11
Prefer not to answer
<11


Veteran Status
(N = 25)
Yes
<11
No
24


Sex assigned at birth
(N = 25)
Male
<11
Female
16
Missing
<11

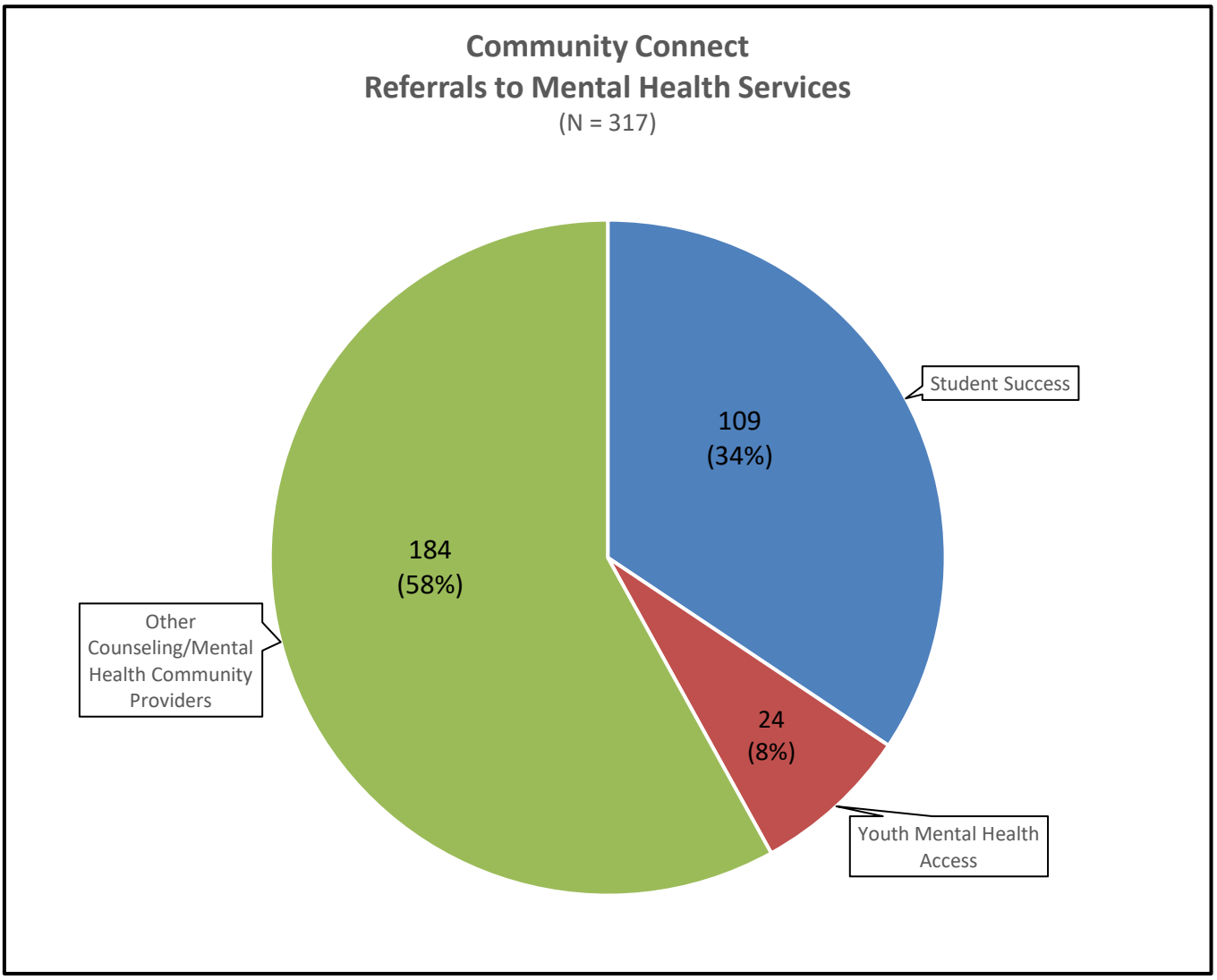

Gender Identity
(N = 25)
Male
<11
Female
14
Gender queer/gender non-conforming
<11
Prefer not to answer
<11
Missing
<11

II. Access and Linkage to Treatment Strategy or Program Demographics

- **Community Connect**

- 1,791 total referrals made by Community Connect.
- 1,399 referrals were connected with services.
- 1,040 referrals for service were accepted.

922 (51%) of referrals were for attendance, 618 (35%) for behavior, and 251 (14%) for other. Note: Referrals are not unique to individuals.



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

- Early Onset (18 referrals)

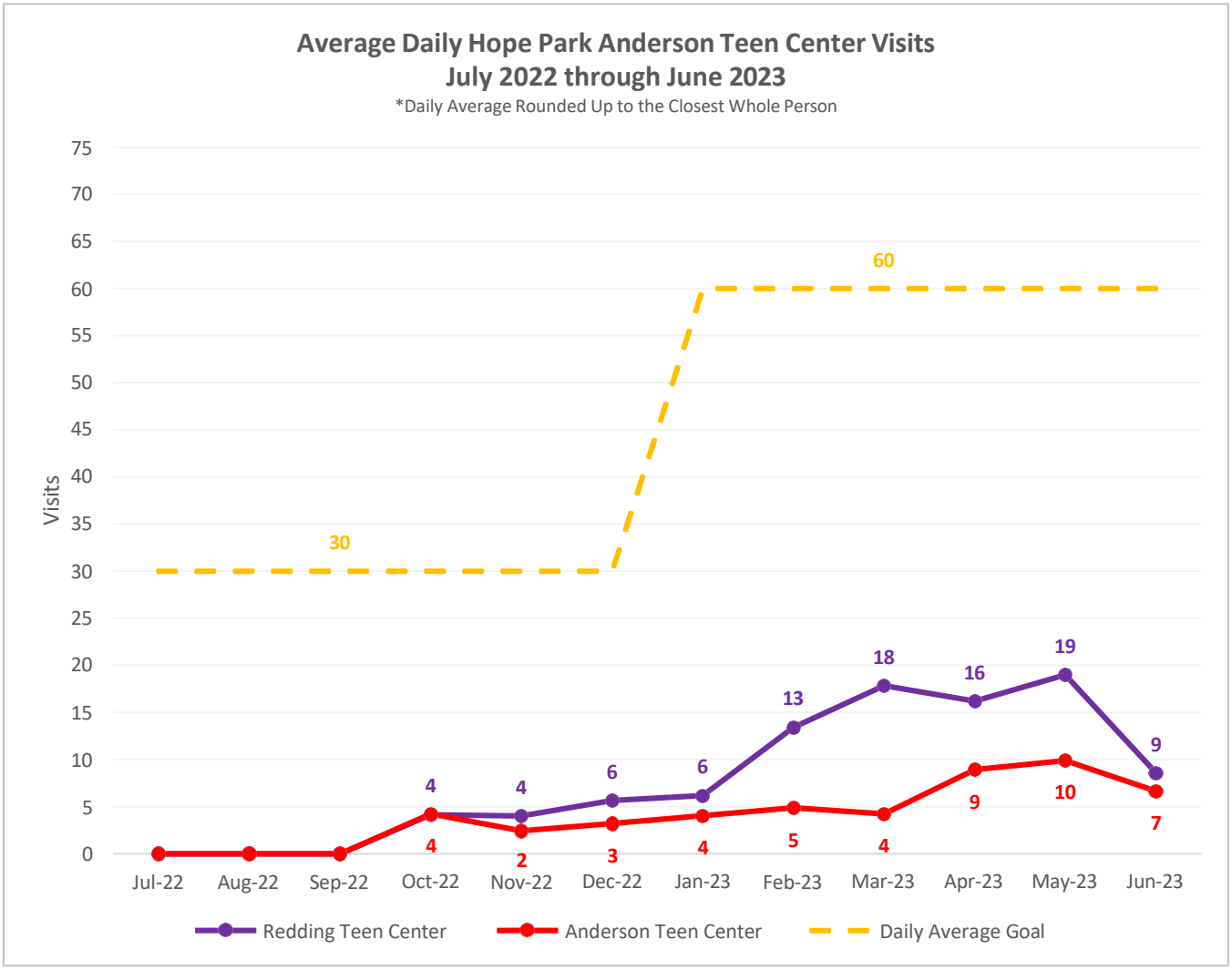
To protect client confidentiality, demographic and referral data on this program is not made public.

Year End Report for the Hope Park Project
July 2022 through June 2023

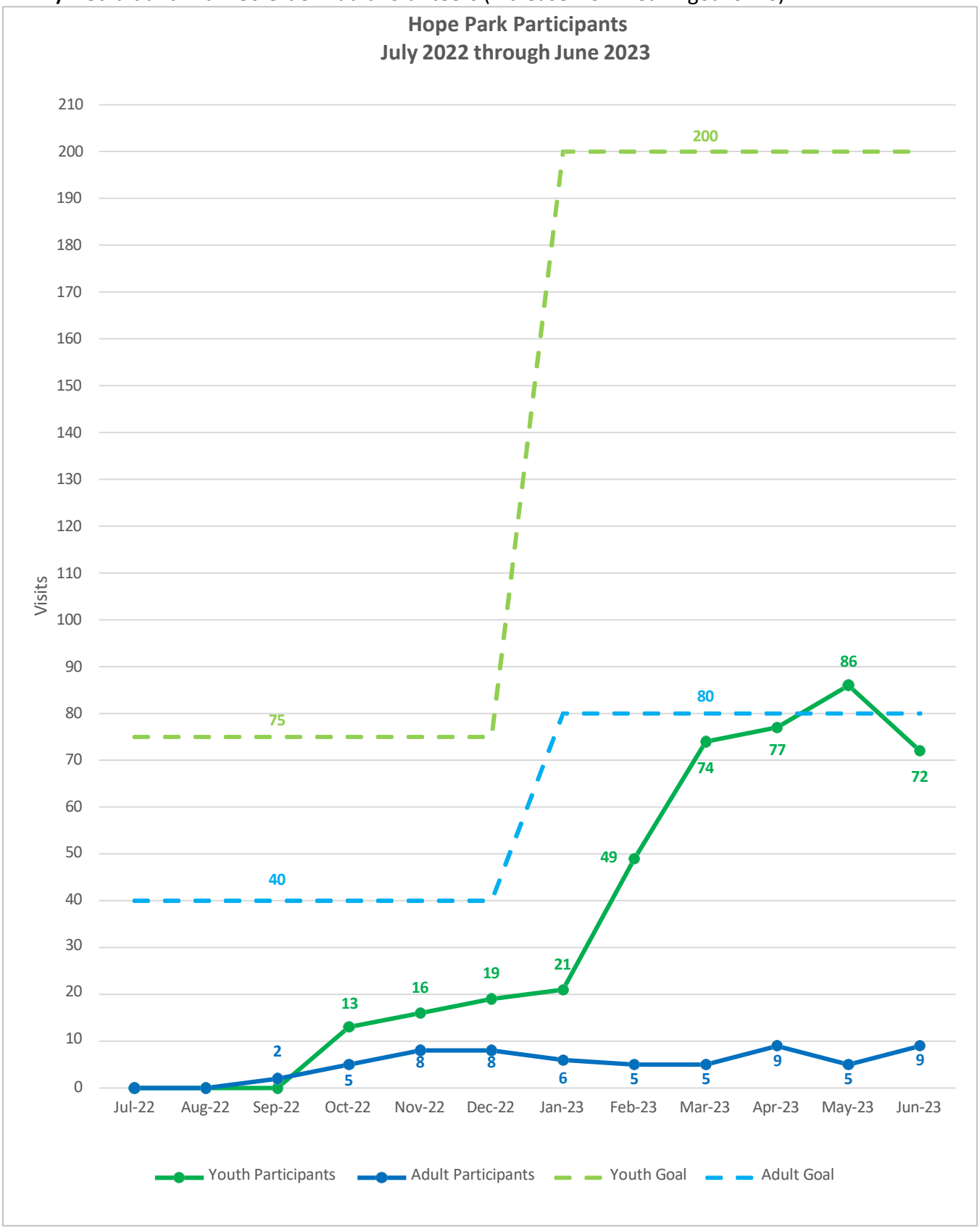
The Hope Park Project was initiated in February 2022 and uses an intergenerational approach to improve the Mental Health of the Youth (12-18 years old) and Older Adult (60+ years old) populations in Redding, CA and Anderson, CA. The Hope Park Project focuses on bridging the generation gap by providing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

Year 2 Program Objectives:

1.) Build a daily average of 60 Youth visits each at the Anderson Teen Center and Redding Teen Center (increase from Year 1 goal of 30)

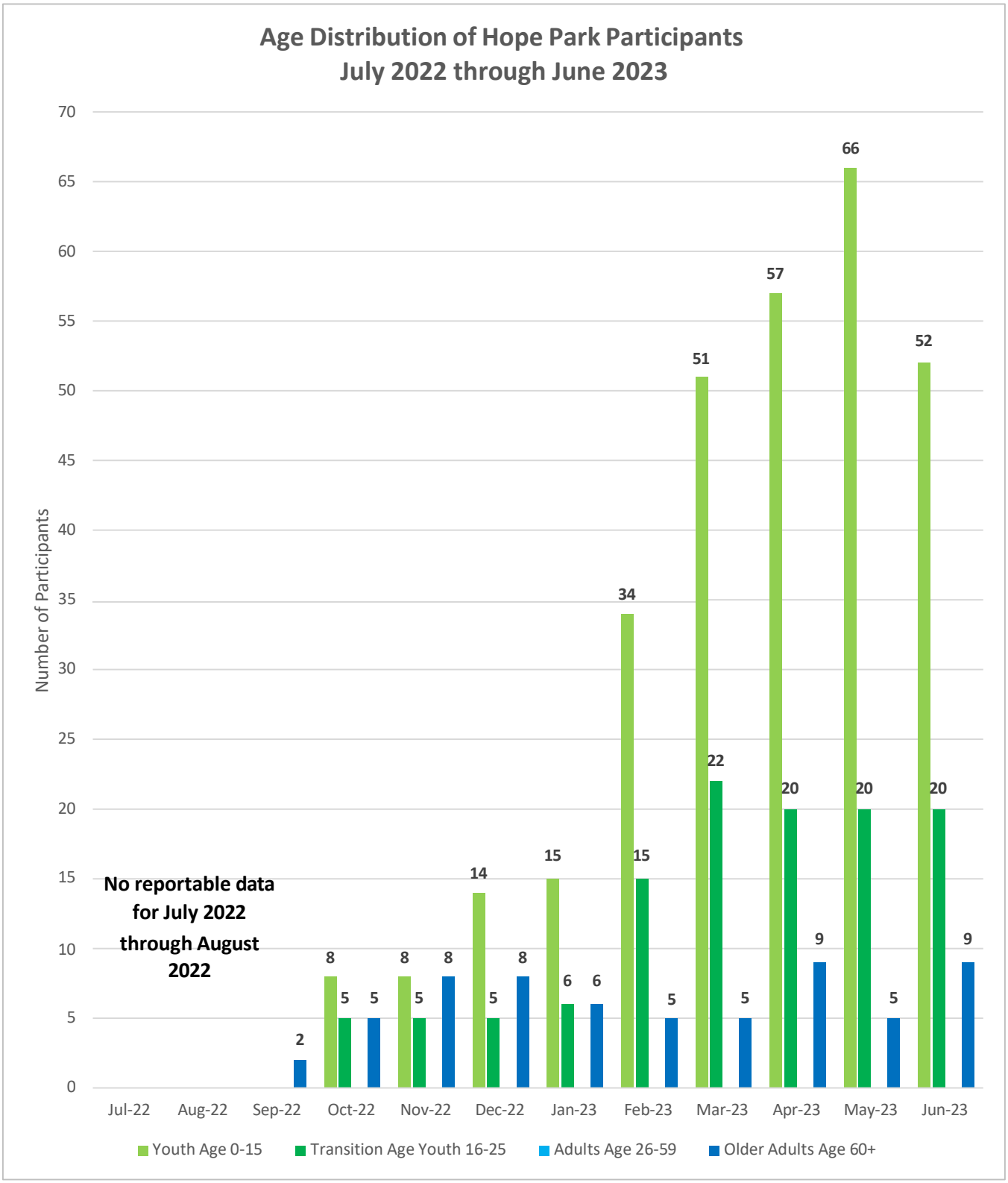


1.) Recruit 200 Youth participants from Anderson and Redding (increase from Year 1 goal of 75)
2.) Recruit and Train 80 Older Adult volunteers (increase from Year 1 goal of 40)



Age:

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

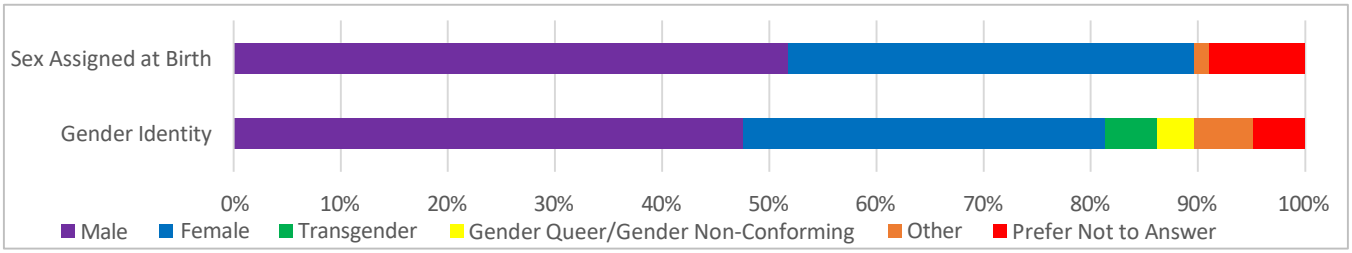


Teen Center Demographics:

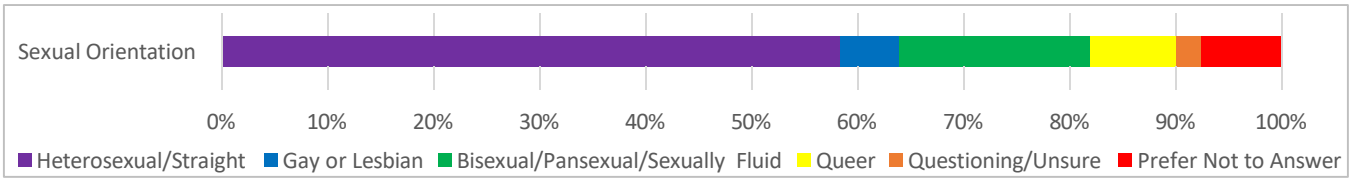
Demographic Surveys are taken by Teen Center participants and volunteers during orientation, the numbers below reflect the information for participants in both Teen Centers, not just Hope Park Participants, received **February 2022** through **May 2023** (no information provided for June 2023).

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

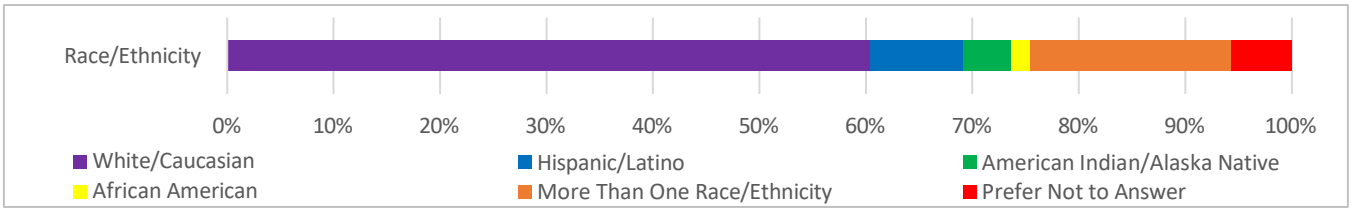
Sex Assigned at Birth and Gender Identity:



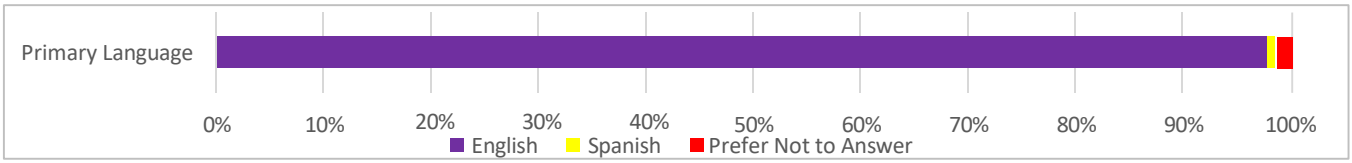
Sexual Orientation:



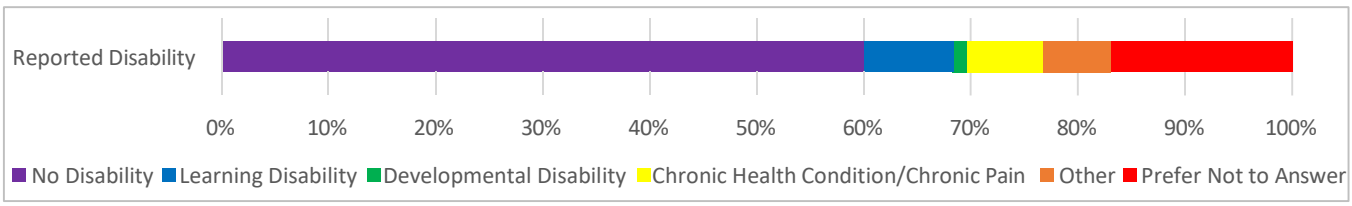
Race/Ethnicity:



Primary Language:



Disability:



Shasta County Health & Human Services Agency

Shasta County Health & Human Services Agency | Behavioral Health & Social Services Branch

shastacounty.gov/hhsa
@ShastaHHSA

May 15, 2023

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

Dear MHSOAC members:

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

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

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

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

Sincerely,

DocuSigned by:
Miguel Rodriguez
[illegible]

Miguel Rodriguez, Director of Mental Health
Shasta County Health and Human Services Agency
Behavioral Health & Social Services Branch
2640 Breslauer Way
Redding, CA 96001
Phone: 530-225-5965
Fax: 530-225-5190
marodriguez@co.shasta.ca.us
mhsa@co.shasta.ca.us

CONCEPTS FORWARD CONSULTING

Multi-County PADs Innovation Project

Annual Report
Calendar Year 2023

Created by Kiran Sahota, President
Concepts Forward Consulting
Project Director

The Multi-County Mental Health Services Act (MHSA) Psychiatric Advance Directive (PADs) Innovation's project, with the seven collaborating counties of, Contra Costa, Fresno, Mariposa, Monterey, Orange, Shasta, and Tri-City Mental Health Authority completed two and a half years of the four-year project as of December 31, 2023. Please note, Fresno County began the project in 2019, and will finalize their participation in the Phase One build as of June 30, 2024.

The PADs project, initially approved by the Mental Health Oversight and Accountability Commission (MHSOAC) on June 24, 2021, continued the momentum of the previous year. The subcontractor timeline was followed to achieve a streamlined effort of activities and expectations of the participating counties. This was no easy task as there were many overlaying activities that had to happen simultaneously. In addition, many challenges arose throughout the year with the change of staffing in both the counties and within the subcontractors.

Though the project objectives remain the same, as with any innovative project, a realistic look at what can be accomplished has been part of the evaluation of accomplishments throughout the year. The proposed project, as originally written, will engage the expertise of ethnically and culturally diverse communities, threshold populations, consumers, peers with lived experience, consumer and family advocacy groups, and disability rights groups. The project proposes to meet several unmet needs throughout the state. These objectives continued as follows:

1. Provide a standardized level of training regarding PADS for both communities and stakeholders.
2. Standardize a statewide PADs template.
3. Allow PADs to be a separate recognized document from a medical advance directive.
4. Standardize a PADs training "toolkit" to be easily replicated from county to county.
5. Align behavioral health PADs with medical Advanced Directives so both physical and mental health needs are equally addressed.
6. Utilize a Learning Management System (LMS) for ease of county access to PADs training and materials.
7. Utilize peers to create PADs based on lived experience and understanding, which can lead to open dialog and trust.
8. Create infrastructure for a cloud-based data warehouse for ease of access to PADs in a crisis, providing mobility of PADs throughout the state.
9. Create legislation to enforce the use and acceptance of standardized PADs in California.
10. Create a continuous evaluation process that is outcome driven, evaluating training, PADs template ease of use, and PADs utilization.

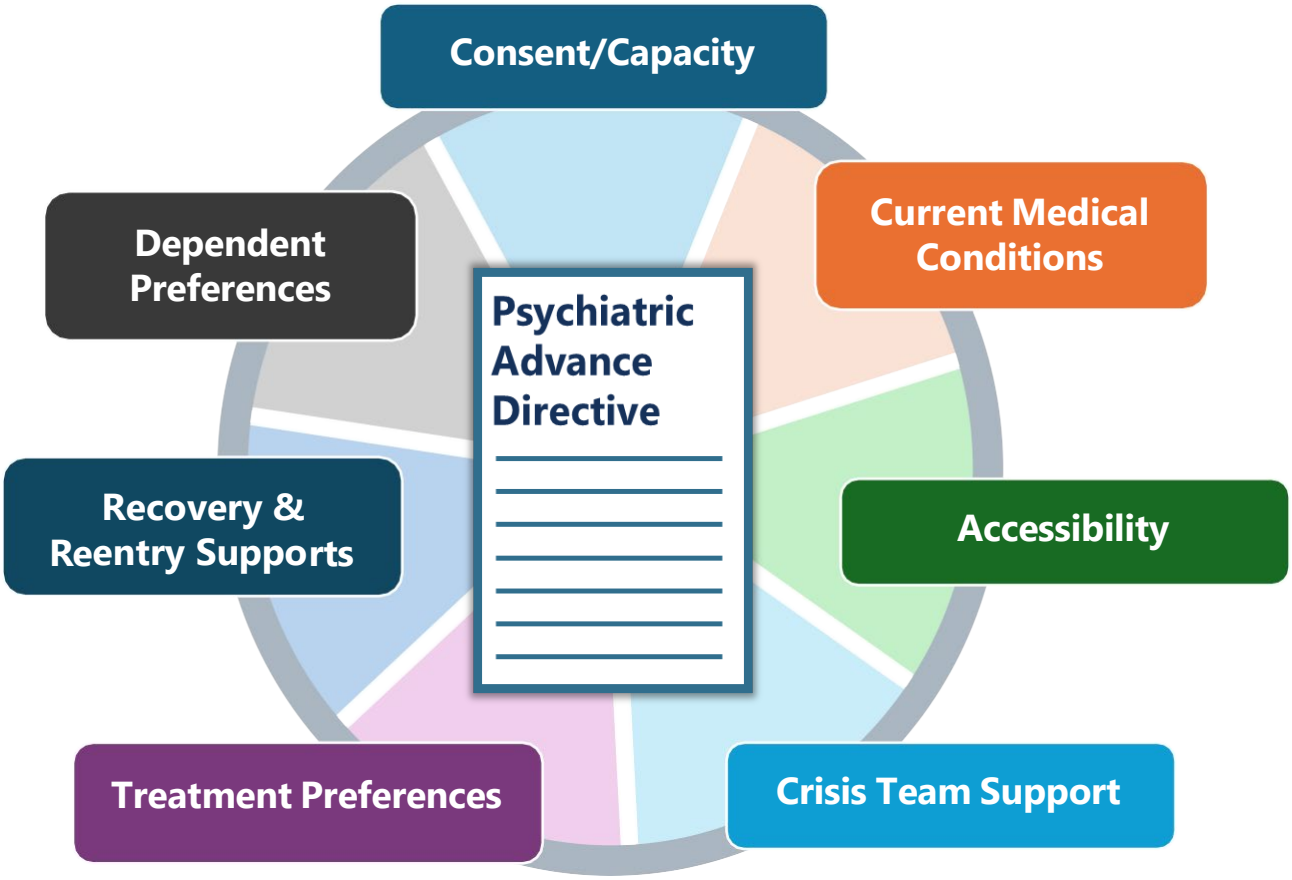
This annual report covers calendar year 2023, or fiscal years (FY) quarter three and four of FY 2022-23, and first and second quarter of FY 2023-24. The following is a recap of activities, with detailed subcontractor write-ups in the Appendix section at the of the report, with the fiscal intermediary review as concluding document.

In order to meet the requirement of ethnic and cultural diversity, the counties along with several subcontractors identified the need for ongoing translation and interpretative services that would fall outside of the scope of work and funding allocated by the counties. The project identified the ability to repurpose funding remaining from the previous FY. The company Alpha Omega was vetted and hired to create multi-lingual documents, interpretation, and interviews throughout the

project. Alpha Omega ensures the ability to address the multiple threshold languages identified within the participating counties.

Through the evaluation period it was clearly identified that this stage of the project is outlined as the technology platform build or Phase One PADs technology build. At no time during this phase of the project will the platform be “live” for access to the PAD in the public setting. The project's main priority continued with a build to streamline a PAD template/component(s) and move forward the components to be uploaded into the technology platform build.

Painted Brain and their subcontractor CAMHPRO worked with county peer support specialists, persons with a lived mental health condition, family member/caretakers and first responders in a series of listening sessions, ongoing workgroups, and cross-contractor collaboration. Painted Brain completed an exhaustive template review and submitted the components to Chorus for upload to the platform build. An idea of how the components will be address are as follows:



Their next step was to create a PADs facilitator curriculum to complement component understanding, digital literacy, and PADs within the platform. The curriculum was completed and submitted to counties for input. Once finalized, this curriculum will be part of the platform “toolkit.”

The template components once sent to Chorus allowed for the ability to build the infrastructure of the digital PAD. Parallel to the digital formation of the PAD, the flow of use, and Terms of Services were identified as areas to address. A county workgroup was created to work with the teams to identify appropriate language. This remains an ongoing workgroup.

Monthly participatory and community-centered stakeholder workgroups continued throughout the year, to discuss the technology build with county peer specialists, persons with a lived mental health condition, family member/caretakers and first responders. Chorus was able to create a mock design using “Richard” as a sample of how the PAD could look in the digital format.

Feeding into the design of the platform is the parallel layer of branding and marketing. Idea Engineering, worked through the Marketing Sub-Workgroup to identify a PAD logo, a logo that was easily identifiable by a person filling out a PAD or for a first responder, as identification and recognition of a PAD. With county peers and Peer Specialist as the prominent voice, the outcome was as follows:

Idea Engineering updated all print material, and the public facing website to highlight the efforts of the project and the unified voice of what the PAD means to those involved in the project.

Evaluation of the project fell to both RAND and the Burton Blatt Institute (BBI), which both had to delay their work in waiting for sections of the project to be completed. RAND developed and finalized the training evaluation protocol and workflow to enable a “two-level” evaluation with PADs platform users. It is expected that this evaluation will take place beginning in April 2024.

Though the BBI evaluation is managed by Orange County, it has been identified to represent the project in totality. Working with all seven counties, BBI used a qualitative research approach and conducted individual semi-structured interviews throughout the year. The evaluation framework will be looking at the direct and indirect benefit of a web-based platform, how the development of the PAD impacts the rates of homelessness, incarceration, and hospitalization of those that fill out the PAD, in this first phase of the project build. As this is the initial build phase, in theory, this will impact systemwide change.

As overall Project Director, Concepts Forward Consulting continued to move the project through each phase by allowing for input from all entities involved, but also setting appropriate boundaries with regards to potential “scope-creep” and finalization of decisions. The counties

have all agreed to provide their input within the period requested, and if they do not the project must move on regardless, to accomplish our projected goals.

The Project Director began the process of engaging legislation. A time-limited workgroup was created that included the support from the Painted Brain peer run services, California Hospital Association, State Psychiatric Association representatives, NAMI California, MHSOAC, California Behavioral Health Directors, and Patient Rights and Lanterman Petris Short act knowledgeable attorneys. Through this group it has been identified that legislation to move the PAD forward will take a legislative champion, which is currently the highest priority to achieve within the next calendar year. The idea will be to align PAD's language within the Probate and Welfare and Institution codes to create a streamlined PAD's statute, one that recognizes a PAD as a document of self-determination and autonomy.

Discussions were also held with law enforcement and Executive Officer Council on Criminal Justice and Behavioral Health California Department of Corrections and Rehabilitation, as the project sought to engage the Department of Justice in the investigation of the integration of the PAD's platform into the California Law Enforcement Telecommunication System (CLETS). This one connection would allow crisis teams, first responders and dispatch in-the-moment access to a PAD when dispatched to a call for service. This activity will continue into the next year.

Throughout the project the importance of in-person discussions, learning, and planning has been showcased in bi-annual convenings. During the FY, two in-person convenings were held. Monterey County hosted in the spring and Orange County hosted in the fall. Both convenings were showcased on the project website www.padsCA.org.

There is a certain depth of learning and momentum that takes place after a convening. The counties decided that the Spring 2024 convening needed to allow for more discussion and planning, and not just updates from the subcontractors. The counties opted for a two-day event to create time for learning and further development of the project goals or adjustments. Sharing the hosting responsibilities with all participating counties, Shasta County was chosen to host the next convening.

The project has not been without challenges. As with many employers in California, our counties and subcontractors encountered several staffing challenges throughout the year, this impacted the timeliness of goals. Some counties are small and have a small community of stakeholders, or a high staffing vacancy rate. The subcontractors experienced staffing turnover which created a domino effect as each layer of the project relies on each other. Staffing challenges also arose in the lack of peer staff. This is where the peer contract was invaluable to enlist the voice of the peer/person(s) with lived mental health experience throughout the project.

As this project is innovative, timeliness of goal completion was also a challenge. Aspects of the time needed to complete activities could not have been calculated in advance. This can be seen in the amount of work Painted Brain needed to cull through multiple nationwide PAD documents to create meaningful template discussion and present the components. When Painted Brain submitted the component questions to Chorus, it could not be anticipated that to create the digital PAD, each component question needed meaning attached to determine the best phrasing and digital location. The delay of the template components delayed the creation of the

PAD facilitator training curriculum, which in turn delayed the ability to provide and evaluate the training.

The project has met challenges as referenced above and throughout FY 2023, each project goal has been addressed, completed, or will continue to be shaped in the coming year. As we plan for 2024, the following prospective activities are anticipated.

- Two-day Spring convening in Shasta County.
- Facilitator Train the Trainer completed, edited, and finalized.
- County pilot populations test usage of the digital PAD.
- RAND and BBI to continue their evaluation efforts.
- Information videos created in multiple threshold languages.
- A legislative champion is identified, and legislative language moves forward.
- Investigate the feasibility of the CLETS integration.
- Fresno County sunsets their Phase One participation.
- Phase Two “live” roll-out and training planning and write-up finalized.
- Continued improvement to the platform Phase One build.

The counties all continue in the most collaborative nature, meeting multiple times a month and sending a variety of staff to the following meetings: individual county meetings with subcontractors, large full project meeting, county to county, sub- workgroups in template creation, technology, terms of service, and marketing. In addition, providing staff or county collaborators time for interviews with project evaluators. Overall, the accomplishments of calendar year 2023 outweighed the challenges. The project remains challenging in commitment and time, yet the reward of an innovated digital PAD is truly on the horizon and will be accomplished within this project Phase One build.

Appendix Section:

Alpha Omega- Translation/Interpretation
Burton Blatt Institute- Evaluation/Technology
Chorus Innovations-Technology
Idea Engineering- Marketing and Website
Painted Brain- Peer Voice
RAND- Evaluation/User experience
Syracuse University-Fiscal Intermediary

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Summary of activities for year 2023.

A. Summary of Activities and Accomplishments During the Reporting Period
B. Challenges Encountered and Resolved During the Reporting Period
C. Plans and Expectations for the Next Reporting Period
D. Attachments

A. Summary of Activities and Accomplishments During the Reporting Period

Customers:
Concept Forward
Idea Engineering Anthony

Translation of 73 document(s) from English (USA) to Arabic, Chinese, Farsi, Korean, Vietnamese for Idea Engineering
Service requested by Antony Del Castillo Schickram – **invoice I-06055**

Translation of 1 document(s) from English (USA) to Spanish for Idea Engineering
Service requested by Antony Del Castillo Schickram
Invoice **I-06228**

Translation of 2 document(s) from English (USA) to Arabic, Chinese, Farsi, Hmong, Korean, Vietnamese for Idea Engineering
Service requested by Jeanne Spencer
Invoice I-06214

Virtual interpreting from English (USA) to Spanish for Concepts Forward
Service requested by Kiran Sahota
Invoice I-06242

B. Challenges Encountered and Resolved During the Reporting Period

No challenges recorded. Customer expressed satisfaction with deliverables.

E. Plans and Expectations for the Next Reporting Period

Translation and interpretation projects as described in Master Contract.

A. Attachments

N/A

Report on Implementation of the Evaluation of Orange County Innovation Activities, with Particular Focus on Development and Outcomes of a PADs Technology Platform

Date Submitted: December 29, 2023

Period(s) Covered: January 1, 2023-December 31, 2023

Submitted by:
Gary Shaheen, Ph.D.
Project Director
Burton Blatt Institute
Syracuse University

Summary of the Qualitative Evaluation

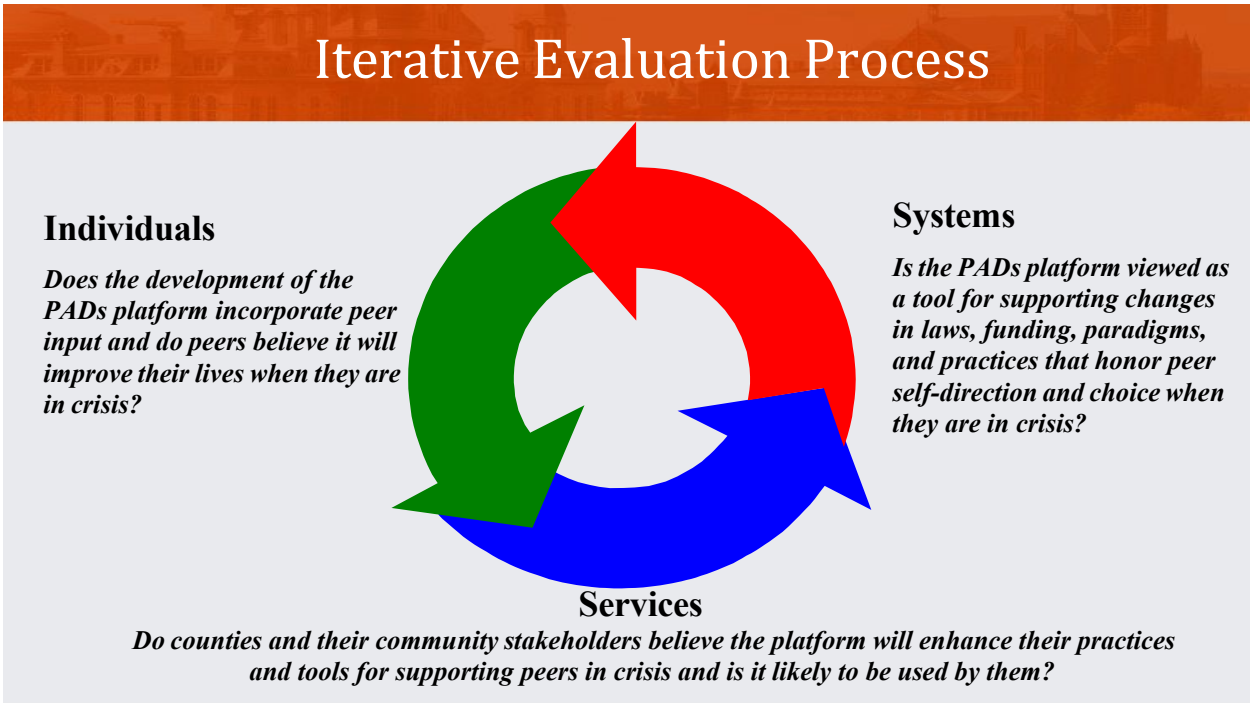
The Syracuse University (SU) Burton Blatt Institute (BBI) was tasked by Orange County, California to conduct a multi-year process and outcome qualitative evaluation of the web-based platform supporting Psychiatric Advanced Directives (PADs) implemented by 7 California counties. These 7 counties are Fresno, Mariposa, Monterey, Shasta, Tr-City, Contra Costa, and Orange counties who are using their Mental Health Administration Innovation Funds to support their efforts. BBI works directly with Project Manager Kiran Sahota, all 7 counties, and project subcontractors Chorus, Idea, Painted Brain, CAMPHRO, and Rand Corporation to obtain data supporting the evaluation. BBI also works with the Project Manager and SU's Office of Sponsored Programs to administer the requirements of the Orange County contract and for fiscal administration of County and Sub-Contractor sub-awards, including timely payments based upon submission and review of invoices. This Annual Project Report summarizes only the evaluation project activities implemented by BBI during the Project Year 1/1/2023-12/29/2023.

BBI uses a qualitative research approach. This included participant observations of in person and virtual meetings and workgroups, as well as conducting individual semi-structured interviews with PADS project County Managers, staff, and community stakeholders. The research objectives and methodological foundations are grounded in a comprehensive literature review focused on Psychiatric Advanced Directives for people with mental illnesses and disability studies. BBI collected data during the year by and by conducting participant observations and individual, semi-structured interviews with PADs Project County Mangers and staff, and with identified community project stakeholders who are participating in the PADs project

We have developed evaluation indicators framework (input, process and outcome) to document information at different stages of the project lifecycle. The indicators fall into three categories:

- Input indicators: to measure the contributions necessary to enable the program to be implemented (e.g., funding, staff, key partners, infrastructure).
- Process indicators: to measure the program's activities and outputs (direct deliverables of the activities).
- Outcome indicators: to measure whether the program is achieving the expected effects/changes in the short, intermediate, and long terms. BBI also gathers data on factors influencing adoption of the PADs web-based platform within county mental health departments and among staff who manage or support their county's PADs project.

BBI's evaluation framework is intended to describe the direct and indirect benefits of the web-based platform among county staff and Peers ("individual level"), its impact upon mental health and related services provided by agencies when they utilize PADs to support Peers who are in crisis ("services level"), and how the development and use of a PADs web-based platform influences public attitudes, policy, funding, law and regulations, and inter-agency dialogue and partnerships, as well as reduce the overall rates of homelessness, and incarceration among Peers ("systems level"). These dimensions are illustrated below:



We have also framed the development and use of the product as one element of a systems change process being articulated by the Project Manager. To measure these systems change dimensions, we have adopted the rubric for systems change developed by the Corporation for Supportive Housing:

Building Blocks of Systems Change: *(https://www.csh.org/resources/laying-a-new-foundation-changing-the-systems-that-create-and-sustain-supportive-housing/)*

"Achieving a real change in a system is different from making the system do something new. A real change in a system is one in which people habitually do the new thing, using resources, authority, technology, and ideas that are routinely associated with the new activity. You can recognize system change more easily when it is complete, or nearly complete, by these five signs:"

● **A change in power**: There are designated positions—people with formal authority—responsible for the new activity (not just committed or skillful individuals who happen to care about it).

● **A change in money**: Routine funding is earmarked for the new activity in a new way—or, failing that, there is a pattern of recurring special funding on which most actors in the system can rely.

● **A change in habits**: Participants in a system interact with each other to carry out the new activity as part of their normal routine—not just in response to a special initiative, demonstration, or project. If top-level authorities have to "command" such interactions to take place, then the system has not absorbed them, and thus has not yet changed.

● **A change in technology or skills**: There is a growing cadre of skilled practitioners at most or all levels in the delivery chain, practicing methods that were not previously common or considered desirable. These practitioners are now expert in the skills that the new system demands and have set a standard for effective delivery of the new system's intended results.

● **A change in ideas or values**: There is a new definition of performance or success, and often anew understanding of the people to be served and the problem to be solved. The new definition and understanding are commonly held among most or all actors in the system, such that they are no longer in great dispute.

Summary of the Evaluation:

Since formal data analysis and coding will not occur until 2024, BBI can only report on our assumptions of the emerging trends and issues. Many of these were included in a presentation we delivered at the September 2023 all-county convening event. A copy of our presentation detailing these assumptions is attached to this report (Attachment 1).

Project Implementation:

- BBI hired Dr. Nare Galstyan as Senior Research Associate and Ms. Isabel Torrence as Research Assistant to directly assist in implementing the evaluation.
- We scheduled and participated in regular teleconference meetings and e-mail exchanges with Concepts Forward Consulting, Chorus, Idea and Rand as needed to discuss and coordinate respective roles and deliverables.
- BBI submitted and received SU IRB approval to implement County Manager and community stakeholder interviews that were conducted throughout the year.
- We prepared presentation materials and participated in two PADs County and

Stakeholder in-person meetings in Monterey and Orange Counties that were held respectively on March 7, and September 12, 2023.

- BBI continued to add references to the comprehensive PADs Literature Review to strengthen the empirical basis for implementing BBI's evaluation.

- A summary of our observation and interview activities is provided below:
  - County – specific Subcontractor meeting observations: **63**
  - County Champions and other project meeting observations: **33**
  - Technology, PADs Template, and Marketing Workgroup observations: **70**
  - In-person Chorus – led County provider and partner on-site meetings: **12**
  - Interviews with County Managers, County-employed Peer Specialists and County Community Partners/Stakeholders: **34**
  - Annual Project Convenings: **2**

Preliminary Assumptions from the Research

Observation and interview data that we obtained throughout the year have yet to be coded and analyzed in order to report findings with empirical validity. Interviews with key community stakeholders including hospitals, law enforcement, other crisis and first responder agencies, and priority population providers were begun during the year and will continue during 2024. The data that was obtained and reviewed over the course of the year nonetheless allows BBI to present some emerging assumptions and concerns related to the process and outcomes associated with the design and implementation of the web-based PADs platform and address each component of the CSH Systems Change Framework.

- **Key Signs of Changes to Power**:

1) BBI observed that Peers from almost all participating counties were involved in meetings and workgroups from the start of the project, and their perspectives and input on the template, web-based platform and marketing were sought, valued and included in plans and products. They also helped ensure that the language, format, and intent of the web-based platform reflected perspectives gained from their lived experiences. Inclusion of the Peer voice was further strengthened by the addition of Peer-run advocacy organizations Painted Brain and Camphro as key project partners tasked with designing the PADs template upon which the platform will be based.

   Challenges: Peer participation in Technology and other workgroups has been primarily from county-employed Certified Peer Specialists. However not all counties have these staff. We note that in order for the project to be viewed as Peer -advised and enabled across all 7 counties, those counties without Peer representatives should consider how to make the voices of their Peer constituencies heard.

2) We also observe that development of the power to implement systems change is also being addressed by the active participation of some of the community agency stakeholders who would be likely to encounter peers in crisis when a PAD might be used. Our preliminary assumptions imply that including law enforcement, hospital staff, MH Crisis Teams and others in workgroups to share how they would access and use web-based PADs in their line of duty potentially empowers them and their sponsoring agencies to 'own' the product and may strengthen its potential for adoption and use.

   Challenges: Although most counties are represented in workgroups by law enforcement, hospitals, and other community partners and stakeholders, not all counties are so represented. Without stakeholder participation from all counties, varying levels of acceptance and use of the platform among community stakeholders, and/or delay in its testing while these issues are identified and resolved may emerge.

- **Key Signs of Changes to Money:**

1) A key feature of this project is its designation, use and incorporation of Mental Health Services Act (MHSA) "Innovation Funds" to support its development and implementation. County Managers talked about how the funding source allows them to exercise creativity and encourages them to develop the internal and external partners needed to address the myriad elements of the project. It also supports their allocation of time to the project in addition to their other responsibilities. It appears that having a dedicated funding stream used by all counties may also contribute to a shared sense of project-identity among counties, that BBI will explore more fully in its research.

2) BBI observes that the way that the PADs Innovation Funding as a funding source shared by 7 counties who pursue the same goals and outcomes and work with the same subcontractors may help to avoid the fragmentation and overlap that challenges many projects of this scale and scope. The project funding scheme also designates a single management and oversight entity, Concepts Forward Consulting that has been instrumental in ensuring that the project is implemented according to its goals, adheres to its timeline, and that all subcontractors and partners work closely with counties and each other as an integrated team,

   Challenges: Potential changes in the Mental Health Service Act could significantly impact the amount of funds counties have to continue programs. County staff often mention future funding as a concern in continuing and scaling up their PADs projects.

- **Key Signs of Changes in Habits:**

1) The PADs Innovation Project is somewhat unique in the experiences of counties who have generally implemented their own MH projects, but who have rarely participated with other counties to implement a joint initiative. Our preliminary assumption is that

regular zoom and in-person regular meetings as a group has begun to positively influence changes in habits among counties often heretofore pursuing separate initiatives. We are beginning to observe that they share a sense of project-identity, participate in regular cross county communication and knowledge exchange, and are developing a general familiarity with each other's challenges and successes that had not occurred previously.

2) PADs county MH Departments and their community partners and stakeholders appear to be developing a pattern of interaction across their respective services and systems. Ongoing communication with each other, primarily through Technology Workgroups includes discussions about embedding the web-based platform as component in the regular routines and operating procedures of law enforcement and hospitals. We note that the intent by county MH departments to reach out and involve these agencies and discuss how they can use the platform within their service systems represents another potential project innovation.

   Challenges: We observed varying levels of engagement among counties in providing input and feedback on the content, design, and marketing of the PAD's platform, with some counties demonstrating more active participation than others. This could also be due to the staff turnover among some counties, with new PADs Managers entering the project at various times in its development.

- **Key Signs of Changes in Technology and Skills:**

1) A key feature of the 7 county PADs Innovation Project in the opinion of the Project Manager and many County Managers is the development of its web-based platform. PADs in some form are being implemented across 27 states, and SAMHSA and its partner the American Psychiatric Association (APA) have developed and promulgated a web-based PAD application supported by a website, webinars and supporting materials. (https://smiadviser.org/padapp) BBI notes that many of the definitions and response fields developed for the SAMHSA/APA web-based PAD parallel those that are being developed in California. Both products could be accessible and used by Peers through their smart phone and using a QR code. However, the CA PADs project is also attempting to customize its product for Peers who may be challenged by diverse other conditions that may compromise their ability to develop and retrieve their data. These can include being homeless or being incarcerated, as well as having poor literacy skills and technology skills and for those requiring the App in languages other than English. Preliminary interview data suggests that these and other barriers are not only being recognized by CA PADs project partners, but efforts to consider how the app can be accessible to all Peer users are being seriously considered.

2) In addition to police officers and hospitals, we note that the platform is being developed within the context of CA Senate Bill 43 that establishes 'Care Courts' that would require counties to provide comprehensive treatment to the most severely impaired and untreated Californians and hold patients accountable to their treatment plan. Discussions about promoting the PADs web-based platform as a resource that Care Courts could consider when determining how to provide treatment that honors a Peer's preferences are also

occurring. Furthermore, preliminary efforts are being made to determine how the web-based PADs platform can be integrated into the CLETS system. This case identification technology is mandated for use by law enforcement and Crisis Teams among all counties.

Challenges: The SAMHSA/APA app as currently available requires Peers to have some familiarity with the use of technology and sufficient literacy skills to comprehend the instructions. Staff and partners we have interviewed identified three main barriers to the use of the PADs platform by peers. As the platform is tested and deployed, these barriers should be considered:

- Challenges with technology
- Reading comprehension
- The time it might take to complete a PAD.
- The availability of staff support to assist Peers in completing, accessing and updating their web-based PAD.

- **Key Signs of Changes in Ideas or Values**:

1) County Managers and staff, including Peer Specialists, community partners and stakeholders, and family members and others who have participated in workgroups articulate the belief that the web-based platform is a potentially valuable tool for ensuring Peer human rights and self-determination. Counties have identified a diverse range of conditions and circumstances affecting treatment and recovery of Peers. They may interact differently with MH services, legal authorities, personal support systems and these may also be influenced by the urban and rural communities where they reside. Chorus has been clear that the initial 'build' phase of the project will establish a foundation for future customization that directly applies to diverse Peer constituencies. While BBI will continue to gather data on this progress, we note that consensus about the ideas and values of self-determination is a foundation that guides project implementation.

   Challenges: The web-based platform is intended for use by Peers with diverse conditions and circumstances. Chorus implemented a series of county-level direct information sessions with agencies serving county identified Peer priority groups. However, it appears that more intensive efforts to obtain greater Peer priority population representation from all counties in the build and testing phases may be necessary.

Challenges Encountered and Resolved During the Reporting Period

- Dr. Galstyan took maternity leave from mid-September through mid-December. Dr. Shaheen and Ms. Torrence, assisted by other members of the BBI research team were able to continue to implement the evaluation and meet all deliverables during that time period.
- Identifying community partner agency, law enforcement and other stakeholders and obtaining their participation in interviews continues to be a challenge in some counties.
- Fresno ends its Phase 1 project by June 30, 2024. However, we have been challenged to

identify and interview community agency partners and stakeholders who also know enough about the project to provide useful data. BBI and Fresno PADs Managers will address this concern early in 2024.

Plans and Expectations for Calendar Year 2024

- We will seek approval from the SU IRB during the First Quarter of 2024, enabling BBI to schedule and conduct interviews Peers identified as county priority populations to obtain their insight into the access, use, and potential value of the PADs web-based platform.
- We will continue to update the BBI implementation plan located on the PADs share drive.
- BBI expects to participate in person at the April partners convening in Shasta.
- We will work closely with Fresno County PADs Managers to fast track their schedule of stakeholder and Peer interviews so that we can summarize their data for a brief report we will provide to them after July 1, 2024.
- BBI is preparing work plans and budgets to support the expected expansion of the PADs project to additional counties in 2024.

Chorus Innovations: Year End Project Update

Summary of Work Completed January - December 2023

1. Summary of Activities and Accomplishments

Chorus Innovations (Chorus) has embarked on a transformative journey over the past year, marked by a series of dynamic activities and notable accomplishments.

Participatory and Community-Centered Engagement Activities:

- Chorus, in partnership with Concepts Forward Consulting, Painted Brain, CAMHPRO, and the participating counties, started three monthly technology workgroups for peers, caregivers & family members, and first responders & services providers with participants across all of the seven counties. Chorus has maintained these monthly meetings throughout the year and used these workgroups to obtain valuable community feedback.

- In partnership with peers from the technology workgroups, Painted Brain, and CAMHPRO, Chorus created the user persona of Richard, whose story has been used to highlight the profound impact of the digital PAD. This persona has been utilized in multiple in-person workgroups with peers within the participating counties and in various presentations to the community about the PADs project.

- Chorus provided in-person community engagement sessions in Fresno, Shasta, Mariposa, Orange, Monterey, and Contra Costa counties to peers, caregivers and family members, and law enforcement. The purpose of these sessions was to obtain community feedback and build ongoing community relationships where participants can join Chorus' monthly technology workgroups in the future. In addition, Chorus staff participated in three ride along activities with law enforcement in Mariposa and Orange County to better understand how a PAD would be utilized by first responders in the field.

- In partnership with Concepts Forward Consulting and participating counties, additional presentations were provided to Orange County MHSA Planning Advisory Committee (PAC), Contra Costa Forensic Mental Health Team, and Shasta County's Mental Health Alcohol and Drug Advisory Board to share information about the PADs project to a larger community audience.

- In partnership with Concepts Forward Consulting and participating counties, co-led ongoing Terms of Service and Privacy Notice Workgroup meetings where a draft Terms of Service document is being developed and refined.

- In partnership with Concepts Forward Consulting, participated in an ongoing Legal and Legislative Workgroup where representatives from legal and psychiatric fields as well as from the California Behavioral Health Directors Association, Disability Rights California, Painted Brain, the California Hospital Association, Mental Health Services Oversight and Accountability Commission, NAMI California, and Patient's Rights San Diego have been present to discuss the PADs project.

Application Development and Design

- Over the course of the year, Chorus created and refined the product development process, eventually landing on a Hub and Spoke interface which centralizes the app experience to the Crisis Directives page. The Crisis Directives page, or the “Hub,” acts as the primary touch point before branching out to other crisis and treatment related preferences within the PAD. The benefit to this approach includes the ability to adapt to a non-linear experience where completion of the PAD template has no bound sequence or order. As a result, Chorus is able to explore UX and design patterns that encourage both guidance and a voice to peers as they complete their PAD.

- In partnership with Painted Brain and CAMHPRO, Chorus assisted with reorganizing the PADs template into an app friendly format to be used in the build of the technology. So far, the following sections are in strong consideration to be incorporated into the full PAD:
    - Onboarding
    - My Profile (Crisis Directives)
    - My Support System
    - My Dependents & Pets
    - Supporting Me During a Crisis
    - Current Medications and Preferences
    - My Psychiatric Treatment Preferences
    - My Medical Conditions and Treatment Preferences
    - Gender Affirming Treatment
    - Sign and Activate my PAD

  The following sections are being considered but require more follow-up from other stakeholders. Chorus is working with these stakeholders to refine these sections as appropriate:
    - Reproductive Health
    - Recovery and Reentry Support

- Over the course of the year, Chorus continued to evolve the wireframes of the application and developed an initial prototype for the peer experience of the PAD based on insights and feedback received during the many technology workgroups. This prototype has been displayed to participating counties and subcontractors during the September PADs Convening in Orange County.

- Over the course of its development, the design of the application has undergone a remarkable transformation, evolving from its initial iteration into a more sophisticated and user-centric interface. User feedback from all of the collective workgroups played a pivotal role, illuminating areas for improvement and guiding the design towards a more intuitive user experience.

- Chorus began building v1 of the application, with the focus on the peer experience. The Crisis Directives are slated to be completed and ready for initial testing by January. The remaining Treatment Directives are anticipated to be completed by February.

2. Challenges Encountered and Resolved

Template Refinement

The PADs template required ongoing revisions as various stakeholders shared their feedback. As a result, Chorus worked closely with Painted Brain and CAMHPRO to restructure and reorganize the PADs template into a more app friendly format, with the focus on the Crisis Directives profile and putting a hold on other areas that require more stakeholder feedback.

Legal/Legislative and Terms of Service

Through discussions in the technology workgroups as well as in internal discussions, Chorus identified several compliance and risk issues that will need to be addressed in the terms of service/privacy policy created for the website application being developed. Several questions have also come up that pertain to the broader legal and legislative component of this project. In response to these questions, Concepts Forward Consulting convened an ongoing Legal and Legislative Workgroup, in which Chorus is participating. During these workgroups, concerns continue to be discussed and addressed to help move the PADs project forward. In addition, Concepts Forward Consulting and Chorus convened an ongoing Terms of Service/Privacy Notice Workgroup with representatives from all seven counties. This workgroup has led to a collaborative effort to create and review a Terms of Service draft document that is currently in the process of being refined and finalized.

3. Plans and Expectations for 2024

From January to December 2024, Chorus will plan for the following:

- Chorus to complete the peer experience build
- Begin testing of the web application with Painted Brain and CAMHPRO as well as peers involved with the PADs project to obtain feedback and iterate on the product design and functionality.
- Build out the full first responder/service provider experience in the web application
- Build out the healthcare agent experience in the web application
- Continue to host monthly workgroups to gather feedback
- Continue to engage in in-person community engagement activities with all participating counties
- Expand testing of the web application with the participating counties' priority population user groups
- Conduct tabletop exercises with all user groups present to simulate actual scenarios of web application usage
- Continue to iterate and improve on the product design and functionality
- Explore application and account access for all PAD users

4. Attachments

Richard's Story

WHO IT WILL SERVE

Meet Richard.

He's an uncle, an artist, and Dodger fan who experiences a mental health condition.

Like everybody else, sometimes he needs his community to support him.

Let's see how the platform will support him and the various service providers.

ONBOARDING & SETUP

His decisions, His voice, His choice.

He's especially vulnerable when in a moment of crisis, so it's important that we understand him.

- Move from a 50-page medical form to a social media-like profile
- Ensure it's quick, personalized, and easy to comprehend
- Empowered with simple security and sharing preferences

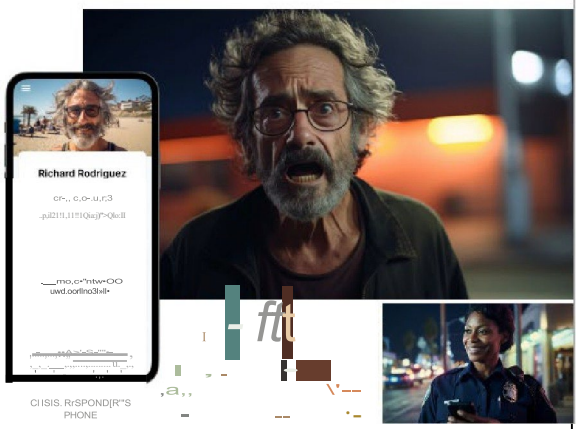
RICHARD'S PHONE

CRISIS RESPONSE EXPERIENCE

Reduce harm to him in his time of need.

Clarity of communication is- crucial, as mishandling a peer's care during a moment of crisis could lead to harm or trauma.

- Remind crisis teams that the peer's current state is not representati1,1e of them at all times
- Provide a clear understanding of how one reacts during moments of crisis, and the best approach to support them
- Design a simple experience with the most important info at a glance



CI ISIS. RrSPOND[R"'S PHONE

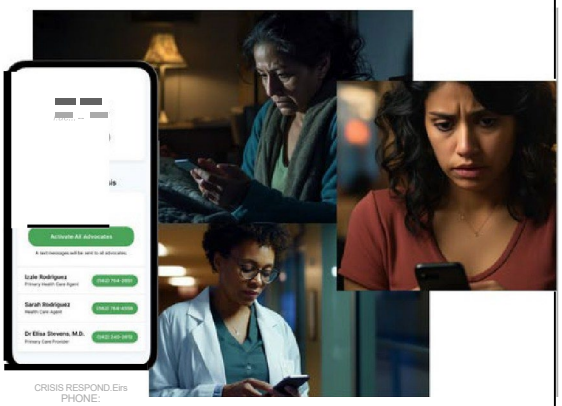
ACTIVATING ADVOCATES

Activate his community in one place.

By activating his chosen advocates with a simple push of a button, he will feel supported.

- Allow for the ability to notify all o, select advocates to help everyone involved care for a peer in a well- informed and timely manner.

Richard Rodriguez I$ in cri$1. HisPsychiatric Advance Directive has been activated. .ind hemayneed your support. Please reach out toichard's advocate Izzy adriguez at (S62} 764 265'1



CRISIS RESPOND.Eirs PHONE:

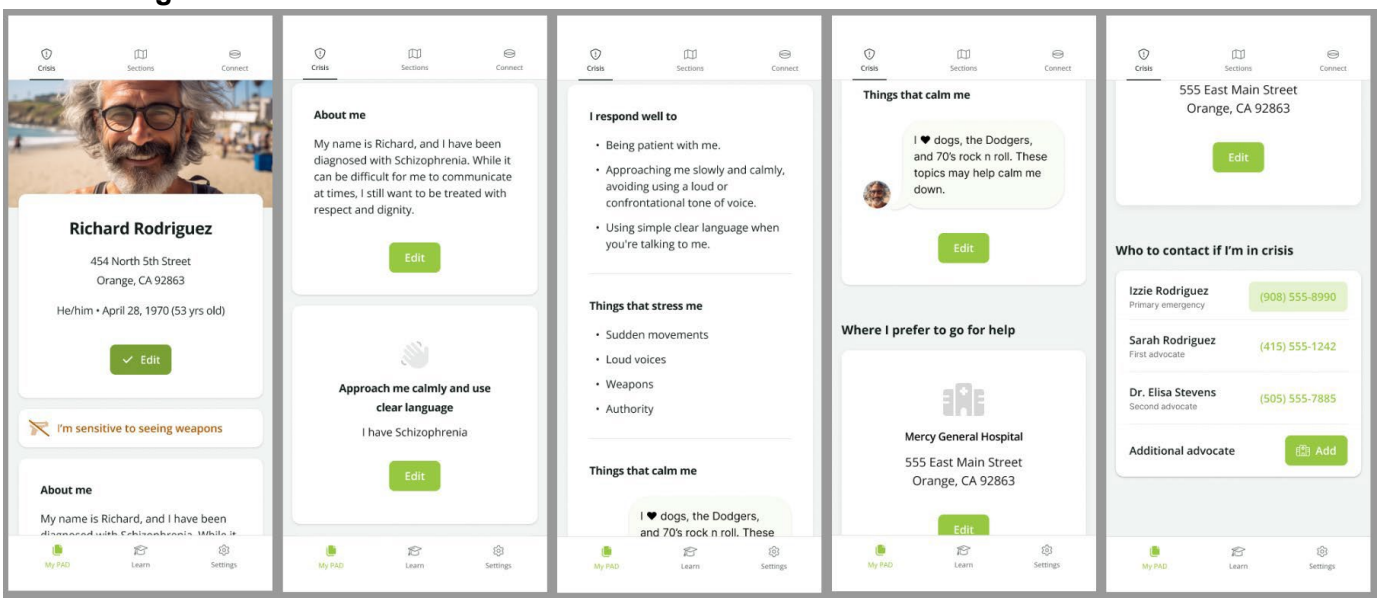
THE GOAL

His wellness, His community, His life.

The goal of the Psychiatric Advance Directive is to help him be the best version of himself.

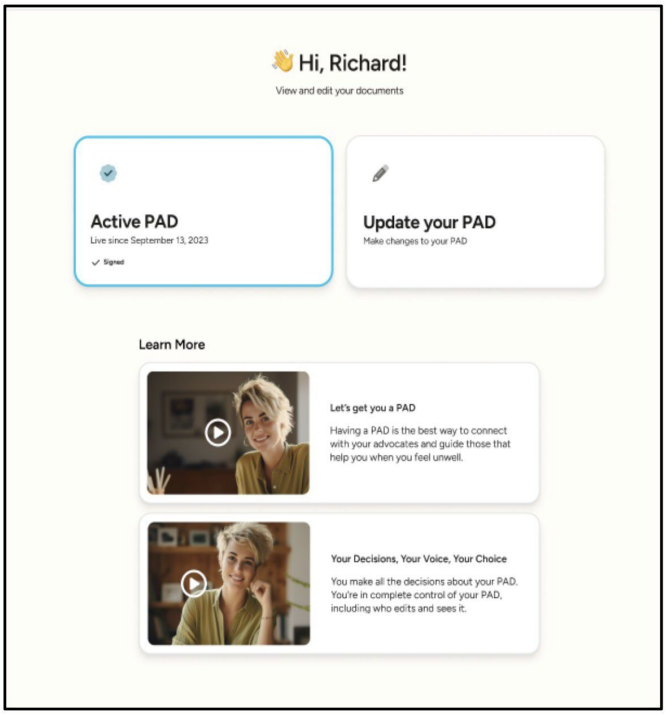
Thank you for helping him and making his voice heard.

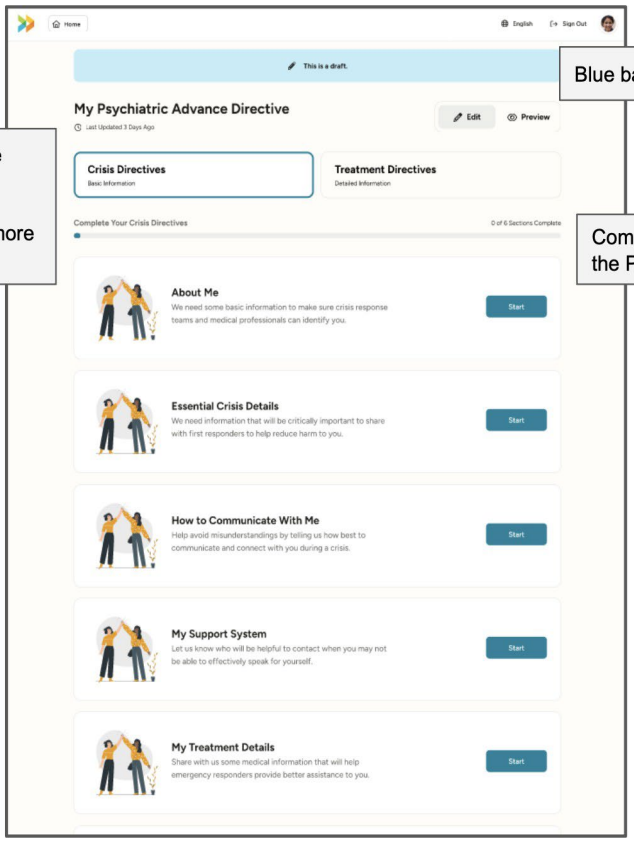
Wireframe Designs



Community Engagement in Mariposa County

Current App Designs



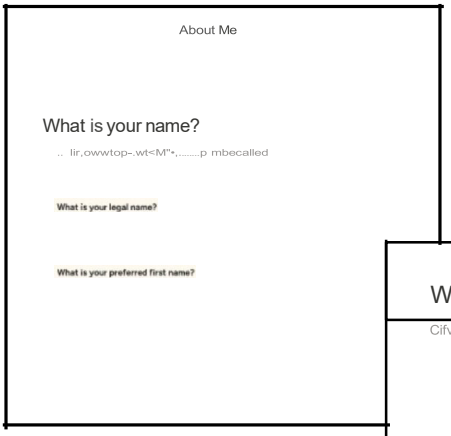


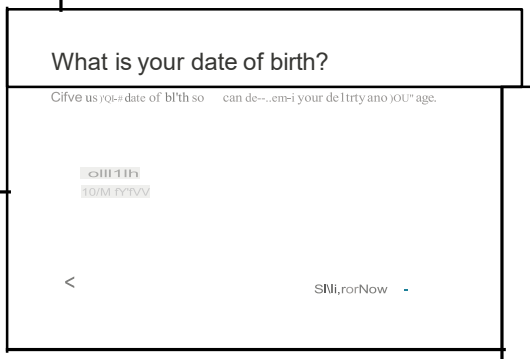
Crisis Directives - displays profile information

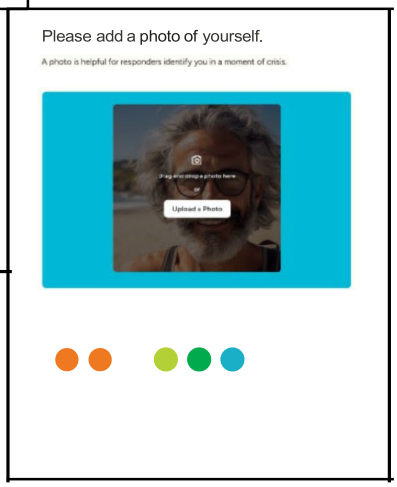
Treatment Directives - displays more detailed information

Blue bar shows the PAD is in draft

Completion bar shows how much of the PAD has been completed



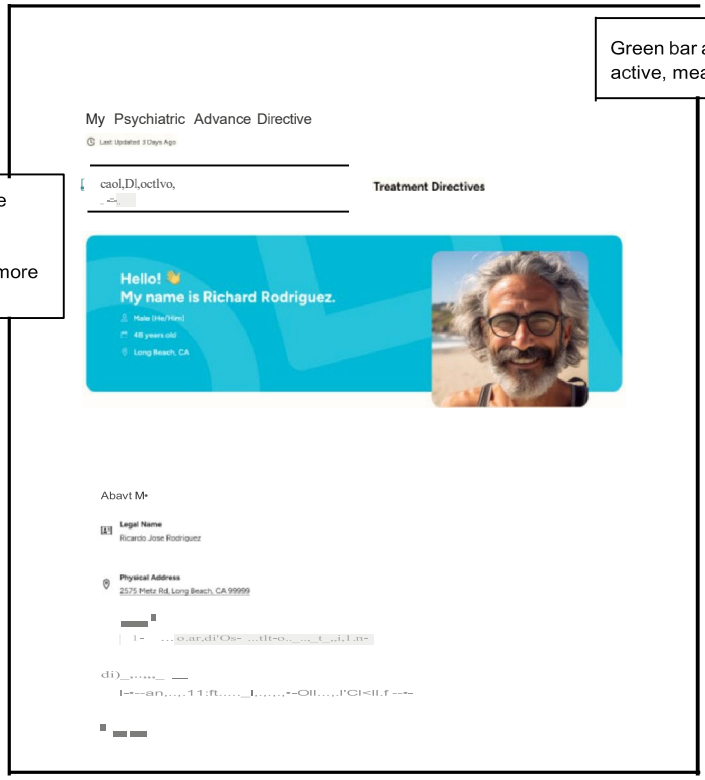




Green bar and check mark shows PAD is active, meaning that is has been signed

Crisis Directives - displays profile information

Treatment Directives - displays more detailed information



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Psychiatric Advance Directives 2023 Summary Report

Introduction

During 2023, Idea Engineering (IE) led the development of a unique brand identity for the Psychiatric Advance Directive (PAD) project. Extensive input from stakeholders led to a selection of a logo, tagline and branding direction, and updates to all communications materials with the new brand.

The introductory videos for the project were also in development during the year, with scripting, reviews, planning, filming and editing of three videos: English and Spanish versions for peers, family members and caregivers, and the general public, and an English version for first responders, healthcare and other service providers.

Collaborative Development

Throughout the year, IE participated in collaborative planning sessions with county staff and other subcontractors. They included convenings with representatives from all counties and subcontractors in Monterey County in March and Orange County in September. Monthly meetings included the full workgroup, subcontractors, "wrap" meetings with each county, marketing sub-workgroup meetings led by IE, and meetings with other subcontractors as needed. IE also visited tech and peer workgroups as needed to share logo, tagline and video concepts and request feedback from these stakeholders. The ongoing communication with shared perspectives and knowledge has contributed to the development of meaningful and cohesive branding and communications materials.

Marketing Sub-workgroup

Monthly meetings of the marketing sub-workgroup facilitated by Idea Engineering have provided valuable input as the branding and introductory videos developed. A focused group of county staff and subcontractors have reviewed communications materials in development before sharing with county leads for final approval. The marketing sub-workgroup will continue on an as needed basis going forward in 2024.

Psychiatric Advance Directive Branding

In 2023, logo and branding concepts were developed for the project, with ongoing input from key stakeholders including additional peer interviews, reviews at marketing and other meetings with county staff and subcontractors, and meeting with the Peer Template Workgroup and Technology Workgroups.

Branding

In the spring, a preliminary branding guidelines document was shared for review, with support agreed upon for the tone of the project, a balance of being "warm and inviting" with "professional and trustworthy." This and supporting language in the brand platform became the framework for developing and evaluating the logo and other identity materials as they were developed.

Logo

After initial exploration, the counties determined that the name would be "Psychiatric Advance Directive," to aid in building recognition for the phrase. Logo concepts included distinctive icons to aid in visual recognition when someone is in a crisis. The logo designs evolved during multiple rounds of feedback, then three options were shared via an online survey in English and Spanish. After a first round with input from peers and county outreach to priority populations and stakeholders, a second round of the logo survey was distributed online in collaboration with Chorus. The second round was narrowed to two logo options, and

audiences were targeted to include demographic gaps identified in the first survey. Alpha Omega reviewed both logo options with an eye to all upcoming threshold language needs and confirmed both options would work well across cultures. Upon review of survey results and recommendations from IE and Chorus, County representatives approved the logo design selection at the August Project Workgroup meeting.

Tagline
Tagline development was similar with multiple rounds of input and refining based on feedback, including reviews at Tech Workgroup meetings in September. At the Convening in September, County representatives voted to select "My Plan • My Voice" as the tagline for the project. The tagline provides a tone of personal power that supports the brand personality.

Branding
At the same Convening, IE shared initial options for visual directions for how the branding might extend to the website and other communications materials. The options were narrowed and revised based on input by peers and others from that meeting and following ones. In early November, county leads voted, selecting a branding design direction that includes engaging use of color, translucence and curves. IE began incorporating it across all materials and developing a brand guidelines document for use by all subcontractors and counties for unified messaging.

IE also drafted a shared Communications Guidelines document incorporating input from other subcontractors and disussions throughout the year, to support the goal of consistent written language for the PADs project. It includes a comprehensive list of key terms and phrases such as "peers" and "recovery" and style guidelines such as when to use the acronym "PAD." Initial feedback was received and will be incorporated with upcoming input from Painted Brain and CAMHPRO. Going forward, when agreed upon, all tems will be provided in both English and Spanish, and it will be shared with Alpha Omega for reference and for expansion to other languages as needed.

Stakeholder Engagement Promotional Materials

A standard PowerPoint template was developed for use by all subcontractors and county staff. Flyers were updated as needed, and expanded to additional audiences. They included a legislative advocacy sheet and a flyer for an informational session for Family Members & Caregivers. IE supported Painted Brain and CAMHPRO in customizing the PowerPoint presentation and flyers as needed.

Updates to all flyer and PowerPoint templates with the new branding were completed in December.

PAD Template Development

Idea Engineering participated in reviews of the template content and design at meetings led by CAMHPRO, Painted Brain and Chorus. IE and Chorus have met regularly to align development of the branding with the PAD template and technology platform.

PAD Introductory Videos

At the beginning of 2023, short, preliminary versions of the videos were proposed during planning meetings and filming was planned for February. Due to scheduling constraints, the preliminary versions were canceled before filming, and planning began for the videos as originally specified, 3-5 minute introductions to the project and what Psychiatric Advance Directives are for peers, family members, caregivers, and the general public, as well as a version for first responders, healthcare and other service

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providers. The peer/general version will be delivered in eight threshold languages, and the complex planning for interpretation and translation needs included consultation with subcontractor Alpha Omega.

Scripts and storyboard concepts were developed to include a balance between short clips from peer, first responder and healthcare provider interviews with a narrator speaking while scenes illustrate the value of PADs. Planning was discussed and storyboards reviewed during meetings with county staff and subcontractors, at Marketing meetings and at Peer ad Professional Tech Workgroup meetings. The script was fine-tuned based on responses from peers and others during the process.

A key part of the videos are interviews with peers, first responders and healthcare providers. Recruiting and scheduling proved to be extremely challenging, with only one healthcare provider available, and first resopnders and Spanish peers being represented by actors. However, the three peers who participated provided valuable points of view, which will make the video extremely relatable and engaging.

Filming took place over multiple days, with interviews and actors speaking to the camera in October, and b-roll scenes in November. They included scenes of a peer in crisis, with first responders; and of peers with facilitators, healthcare providers, family members and by themselves, looking at their PAD on a variety of devices. The actors show diversity in race, age and gender, reinforcing the accessibility of PADs. Photos were also taken of key scenes for potential use in other communications materials such as the website and flyers. Editing is in progress for the English and Spanish versions with delivery anticipated in early 2024.

Website

The website www.padsca.org serves as the public facing online information portal for the project. During 2023, content updates included a new "For Peers" page with informational sessions listed, and a new "Technology" page featuring the advantages of a digital system, a technology overview, and updates from ongoing workgroup sessions, and a Contact page. IE continued to provide hosting and technical maintenance for the website, and monthly analytics reports.

In fall of 2023 a new website design was developed incorporating the new branding. The design was approved and programming is in progress, with content updates being incorporated based on input from the Marketing sub-workgroup. The new site is expected to go live in early 2024.

Upcoming

- In 2024, Psychiatric Advance Directive brand identity usage guidelines will be completed, as well as the shared Communications Guidelines.
- IE will continue developing PADs Toolkit promotional materials such as brochures, postcards and social media graphics.
- Stakeholder communications will include new handouts for Healthcare Agents and Family Members & Caregivers, with content currently in development by Painted Brain & CAMHPRO.
- The introductory videos in English and Spanish will be completed, and customized versions for the other threshold languages will be developed.
- The training videos are anticipated to begin development in summer 2024.
- The new website will go live, with ongoing content updates and technical support.

Psychiatric Advance Directive™

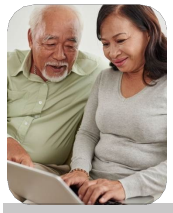
My Plan • My Voice

LOGO INPUT – RESULTS

Psychiatric Advance Directive	Psychiatric Advance Directive	Psychiatric Advance Directive
• All: 75 • Peers: 43 • Chorus • Idea Engineering	• All: 73 • Peers: 41	• All: 25 • Peers: 6

Logo & Tagline

Psychiatric Advance Directive™
My Plan • My Voice



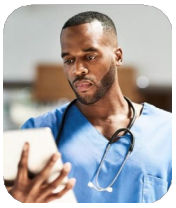
Title Text

Subtitle Text

Sample text.

Sample highlighted text.

Psychiatric Advance Directive™
My Plan • My Voice



Your Expertise & Input Are Needed

First Responders • Medical & Clinical Staff

When you encounter someone experiencing a mental health crisis, what would you need to know in order to best inform your ability to care, treat or provide resources? As a subject matter expert in your line of work, we are requesting your participation in one or more input sessions as we create a Psychiatric Advance Directive template in California.

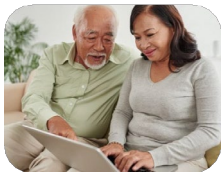
If you are interested in helping develop this important tool, please contact:

OPTIONAL:
ADD COUNTY LOGO HERE

Benefits include:

- Allowing individuals to take responsibility for their recovery
- Allowing an appointed person to assist in making decisions during times when the person's capacity is impaired

Psychiatric Advance Directive™
My Plan • My Voice



Your Voice is Needed

Peers • Family Members • Caregivers

In a mental health crisis, what would you want hospital staff or first responders to know about you or a loved one? We're looking for people who have lived experience with mental health and recovery. Individuals, family members, caregivers, your voice is needed.

We are requesting your participation in one or more input sessions as we create a Psychiatric Advance Directive template in California.
If you are interested in helping develop this important tool, please contact:

Name, Title
Department
Email
Phone

OPTIONAL:
ADD COUNTY LOGO HERE

What is a Psychiatric Advance Directive?

A Psychiatric Advance Directive is a legal document allowing people with mental health conditions to identify their preferences for treatment in advance of a crisis.

Psychiatric Advance Directives are a voluntary tool to help assist individuals in mental health crises to communicate in their own voices with first responders, hospital personnel and others.

Benefits include:

- Allowing individuals to take responsibility for their recovery
- Allowing an appointed person to assist in making decisions during times when the person's capacity is impaired
- De-escalating potential crisis situations
- Providing appropriate and supportive care

LEARN MORE: www.padsca.org

The Multi-County Psychiatric Advance Directives Innovation Project is funded by Mental Health Services Act.

Psychiatric Advance Directive™
My Plan • My Voice

How to Use Stakeholder Input Flyer Templates

Step 1: Replace Contact Information

Step 2: Add County Logo (Optional)

Delete placeholder county logo graphic.

To add your county's logo:
Windows: Select *Insert > Pictures > Insert Picture From This Device*
MacOS: Select *Insert > Pictures > Picture from File*
Navigate to the logo file, select it, and click Insert

Step 3: Replace or Delete Photo

To replace:
Windows: Right click on the photo, select *Change Picture > This Device*
MacOS: Right click on the photo, select *Change Picture > From a File*
Navigate to the new photo, select it, and click Insert

Step 4: Save as PDF

Select *File > Save As*
Choose the location to save the PDF
In the dropdown menu titled *Save as type (Windows)* or *File Format (MacOS)*, select PDF
Select Save

Please note: Image in background will appear faded until saved as PDF.

The Multi-County Psychiatric Advance Directives Innovation Project is funded by Mental Health Services Act.

Flyer Templates

Psychiatric
Advance Directive™
My Plan · My Voice

Presentation Title Goes Here (Up to 3 Lines)

[Date]

Presented by
[Name, Organization]

OPTIONAL LOGO

OPTIONAL LOGO

Section Title

2

Page Title Here

Optional Subhead

- Lorem ipsum dolor sit amet, consectetuer adipiscing elit.
  - Maecenas porttitor congue massa. Fusce posuere, magna sed pulvinar ultricies, quis urna.
- **Bold text to highlight as needed**

PRESENTATION TITLE – UPDATE FOOTER 3

Page Title Here

Optional Subhead

- Nunc viverra imperdiet enim. Fusce est. Vivamus a tellus.
- Lorem ipsum dolor sit amet, consectetuer adipiscing elit.
- **Bold text to highlight as needed**

Callout

Nunc viverra imperdiet enim. Fusce est. Vivamus a tellus. Lorem ipsum dolor sit amet, consectetuer adipiscing elit. Maecenas porttitor congue massa. Fusce posuere, magna sed pulvinar ultricies, quis urna.

PRESENTATION TITLE – UPDATE FOOTER 4

Page Title Here

Lorem ipsum dolor sit amet, consectetuer adipiscing elit. Maecenas porttitor congue massa. Fusce posuere, magna sed pulvinar ultricies, purus lectus malesuada libero, sit amet commodo magna eros quis urna.

Nunc viverra imperdiet enim. Fusce est. Vivamus a tellus. Lorem ipsum dolor sit amet, consectetuer adipiscing elit. Maecenas porttitor congue massa. Fusce posuere, magna sed pulvinar ultricies, quis urna.

Bold text to highlight as needed

PRESENTATION TITLE – UPDATE FOOTER 5

PowerPoint Template

HOME ABOUT TECHNOLOGY NEWS & UPDATES FOR PEERS COUNTIES SEARCH

Digital PADs are coming in 2025. Contact us if your county is interested. >

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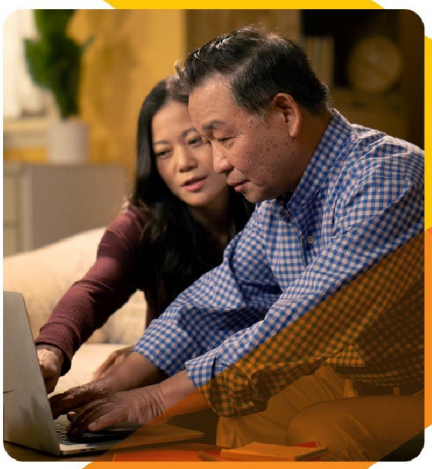
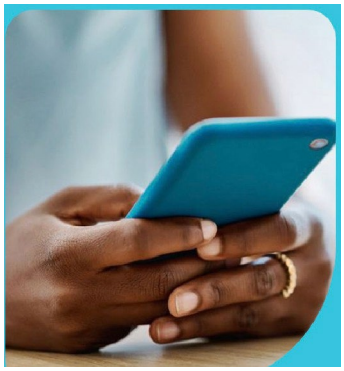


A multi-county collaborative has joined together in a Mental Health Services Act Innovations Project to develop and test the feasibility of Psychiatric Advance Directives in California.

Each county is identifying priority populations to focus on during this pilot project, such as foster youth. older adults. or people who experience homelessness. Priority populations are determined based on their robust stakeholder processes.

Learn More



Technology

A key part of this project is the development of a user-friendly and secure online tool for Psychiatric Advance Directives in California.

With this interactive app, people will be able to **learn** about. complete. **and store their Psychiatric Advance Directives.**

Learn More

Peers

Ongoing collaboration with peers, people with lived experience with mental health conditions. is integral to the development approach of this project.

A Psychiatric Advance Directive is a valuable tool empowering a person's voice and personal choices.The purpose is to assist in a quick recovery from a crisis situation. However, it benefits overall recovery as well, encouraging listening, being seen as a whole person, supporting self-direction and wellness.

Learn More

0

Website (in Progress)

Psychiatric Advance Directive™
My Plan • My Voice

www.padsca.org
All Traffic Overview

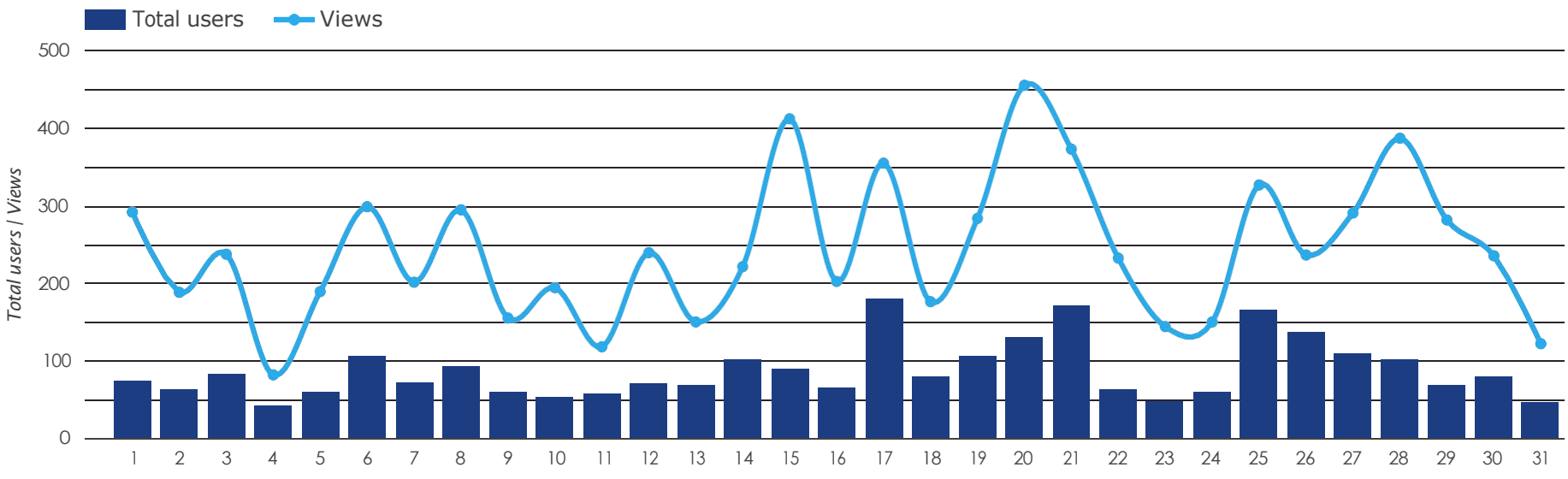
Jan 1, 2023 - Dec 31, 2023

Overview

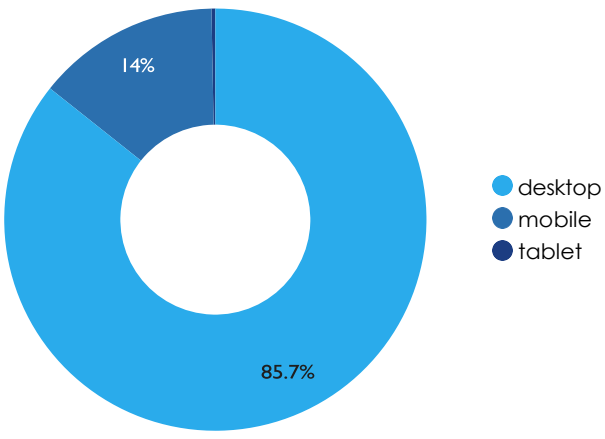
Total users	Active users	Views	Sessions
2,048	2,048	7,542	3,596
↑ 505.9%	↑ 505.9%	↑ 268.8%	↑ 479.1%

New users	Returning Users	Views per session	Average session duration
2,025	23	2.1	00:03:00
↑ 493.8%	↑ 866.7%	↓ -36.3%	↓ -24.4%

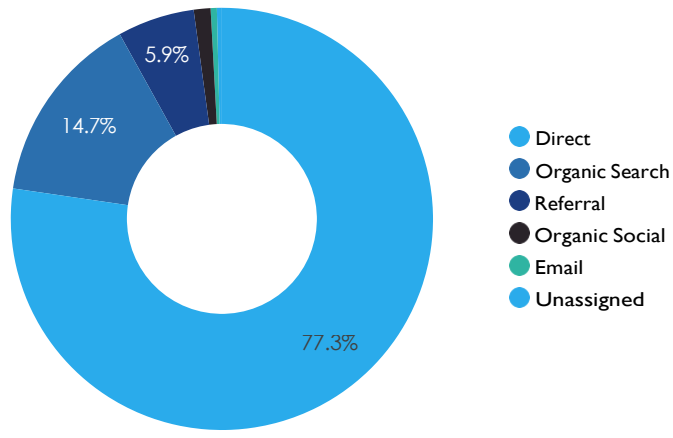
Daily Users & Pageviews



Users By Device Type



Users By Traffic Source



	Device category	Total users
1.	desktop	1,759
2.	mobile	288
3.	tablet	6
	Grand total	**2,048**

	Channel Group	Total users
1.	Direct	1,625
2.	Organic Search	308
3.	Referral	124
4.	Organic Social	27
5.	Email	10

User Location

	City	Views ▾
1.	Los Angeles	919
2.	Santa Maria	563
3.	Santa Barbara	532
4.	Goleta	400
5.	Oxnard	315
6.	Sacramento	287
7.	Cheyenne	277
8.	Moses Lake	276
9.	Undetermined	249
	Grand total	**7,542**

1 - 100 / 358

Users by Language

	Language	Views ▾
1.	English	7,538
2.	Spanish	3
3.	German	1
	Grand total	**7,542**

1 - 3 / 3

Top Page Views

	Page Title	Views
1.	PADs CA - Psychiatric Advance Directives	3,129
2.	Counties	791
3.	What is a PAD?	678
4.	News & Updates	531
5.	For Peers	508
6.	Technology	440
7.	Orange County	181
8.	Contra Costa County	120
9.	Shasta County	116
10.	Tri-City Mental Health Authority	107
	Grand total	**7,542**

1 - 10 / 44

Top User Engagement

	Page Title	Avg Time ▾
1.	About	00:04:44
2.	Technology	00:01:56
3.	Counties Testing	00:01:42
4.	What is a PAD?	00:01:13
5.	Technology	00:01:03
6.	For Peers	00:00:54
7.	Monterey County	00:00:47
8.	Fresno County	00:00:36
9.	Counties	00:00:35
10.	Planning Meeting in Orange County	00:00:33
	Grand total	**00:01:03**

00 01:40 03:20

1 - 10 / 37

Deinitions

Total Users
Count of distinct visitors over a specific period, encompassing new and returning visitors.

Active Users
Number of unique recent visitors, indicating current user engagement.

New Users
Count of first-time visitors within a timeframe, reflecting marketing effectiveness.

Returning Users
Visitors who have interacted before, indicating user loyalty and retention efforts' success.

Views
Total instances a specific page or content is seen, providing insight into content popularity.

Views per Session
Average pages viewed in a single session, indicating user engagement depth.

Sessions
Total individual visits within a timeframe, starting upon access and ending with inactivity or exit.

Session Duration
Average time users spend on the site or app during a session, reflecting user engagement and experience quality.

Daily Users
Unique visitors accessing the website or app within a single day, indicating daily reach.

Pageviews
Total number of pages viewed, showing user engagement with content.

Users by Device Type
Categorizes visitors by devices (desktop, mobile, tablet) used to access, aiding in optimizing user experience.

Users by Traffic Source
Segments visitors based on channels (direct, search, social) they come from, assessing marketing effectiveness.

User Location
Provides geographic data (country, region, city) about visitors, enabling regional content customization.

Top Pages
Displays most visited pages, helping identify popular content and user interests.

Time on Page
Average duration users spend on a specific page, indicating content relevance and user engagement depth.

Disclaimer

This dashboard utilizes data from Google Analytics, a widely-used web analytics tool. While Google Analytics provides valuable insights, it may have limitations such as sampling, potential inaccuracies, and challenges in distinguishing bot traffic. Please be aware that the data presented here should be considered as estimates rather than precise figures. It's advisable to interpret the information in this dashboard with caution and to cross-reference it with other sources for a comprehensive understanding of your website's performance.

Painted Brain and CAMHPRO: Annual Report for MHSA's Multi-County Innovations Project

Over the contract year 2023, Painted Brain and CAMHPRO have exceeded contract deliverables for the MHSA Multi-County Psychiatric Advance Directive Innovations Project. Below is a detailed overview of the program outcomes, challenges and outlook for the year 2024.

A. Summary of Activities and Accomplishments During the Reporting Period

Listening sessions

- Painted Brain and CAMHPRO (PB & CAMHPRO) had two in-person listening sessions per county between the months of February to March. This totaled 14 in-person listening sessions. The purpose of these listening sessions was to gather information on what peers and community members thought of Psychiatric Advance Directives.
    - In Each County, over the course of 2 days PB & CAMHPRO had a virtual meeting for peers and a separate meeting for community members.
    - PB & CAMHPRO had an additional monthly virtual listening session which was open to peers and community members in all 7 counties.
- PB & CAMHPRO had one virtual listening session in October that focused on training curriculum development. PB & CAMHPRO received input from the county peers about what they would like to see covered in the curriculum.

Work Groups

- PB & CAMHPRO hosted monthly virtual Peer Template Workgroups, where peers from all 7 counties reviewed the PADs template together. These meetings took place from January-July of 2023.

Cross-Contractor Collaboration

- PB & CAMHPRO have been working closely with Chorus to support the development of language for the mock-ups and final version of the PADs Digital Platform website.
- PB & CAMHPRO have been working with RAND to support the development of the training survey to include recovery language and measurable peer values.
- PB & CAMHPRO attended a monthly Tech Workgroup facilitated by Idea Engineering and provided feedback on a variety of topics, including:
    - Marketing materials such as recovery language on flyers
    - Verbiage for the official PADs website
    - Feedback for the PADs website user interface
    - Other feedback as necessary.
- PB & CAMHPRO participated in the recording of promotional videos for Idea Engineering relative to the Innovations project. The peers shared their story and provided perspective on why PADs are important.

Milestones

- PB & CAMHPRO and the County Peers worked together to get the first draft of the PAD template sent to Chorus so they could begin implementing the template in the Digital PADs Platform
- PB & CAMHPRO successfully incorporated Peer Values into the PAD template and eliminated stigmatizing language
- PB & CAMHPRO incorporated the peer voices and feedback from all 7 counties into the train-the-trainer curriculum and PAD template
- PB & CAMHPRO presented about project at SHARE's Peer Workforce Conference "Bridging Research and Practice"
- PB & and Kiran Sahota presented with Health Management Association (HMA) on PADs for the CARE Act
- PB brought peer needs and concerns to the PADs legislative workgroup
- PB & CAMHPRO made significant progress on the Train the Trainer Curriculum
- PB & CAMHPRO met all deliverables
- PB & CAMHPRO have made the PADs template so exhaustive that it serves as a "tool-box" for individuals in a mental health crisis

B. Challenges Encountered and Resolved During the Reporting Period

1) Balancing the needs of all counties.
   - Varying size of counties.
   - Population size, diversity and resources vary.
   - The amount of peers employed to send to work groups vary.
   - Some Counties face unique transportation issues due to the rural setting.
   - Some Counties face internet and technology inequity.

As a result the project began meeting with Counties on a separate basis so that we could assess and address the needs of each county.

2) There were several unanticipated challenges with getting feedback from the nine identified threshold language groups. Next year, we hope to focus on receiving feedback from target groups.

C. Plans and Expectations for the Next Reporting Period

- Complete Train the Trainer Curriculum and receive feedback from all 7 counties
- Train peers in all 7 counties to be trainer
- Develop peer advocacy groups to support the peer voice in PADs

D. Attachments

Attendance info:
https://drive.google.com/drive/folders/1LjubSb5Tja0bwEsQ5mXca3C_VAGucpIL

Convening Slideshow:
https://docs.google.com/presentation/d/1ZEC6_7t-h7Eb4EwsB1BKTZY52DSL9BiW/edit?usp=sharing&ouid=104331190930935840814&rtpof=true&sd=true

RAND – PADs Evaluation 2023 Year-End Summary

Summary of Activities and Accomplishments During the Reporting Period

RAND has attended ongoing meetings with subcontractors and/or counties in order to plan the evaluation and revise our approach based on the overall platform development. RAND has also met with Chorus and BBI on a 1:1: basis to discuss specific aspects of the proposed evaluation and to tailor the evaluations to reduce participant and/or county burden. RAND has also had monthly or bimonthly meetings with Painted Brain/CAMHPRO since May. These meetings have been used to discuss various aspects of the training evaluation, to learn more about the training curriculum under development, and to solicit feedback from Painted Brain/CAMHPRO on the evaluation survey with trainees.

RAND leads (Eberhart, Siconolfi) attended the September 2023 in-person convening in Orange County. RAND delivered a presentation on our work to-date and the proposed evaluation design for Peer Supporters (training evaluation) and Peers who completed a PAD (outcomes evaluation). The meeting also included group discussions and planning for a range of implementation and evaluation decisions.

Finally, the RAND team has continued biweekly internal team meetings for strategic planning between these larger, multi-stakeholder meetings.

Training evaluation

RAND developed and finalized the training evaluation protocol. This included a literature review to identify relevant constructs/measures, the development of a retrospective post-training survey and a post-training focus group protocol, and preparation of various logistics and administrative materials (e.g., recruitment materials, consent forms, info sheets, etc.). We submitted the training evaluation packet for Institutional Review Board (IRB) review/approval by RAND's internal IRB in December 2023.

Evaluation with Peers who completed a PAD

RAND also developed a workflow to enable a "two-level" evaluation with PADs platform users. The first level is a Mini Survey, an optional feedback form within the platform that elicits basic demographics, basic feedback on the PADs experience, and permission for future outreach by RAND. The second level is the "full evaluation" with PADs users. The sample for the full evaluation will be drawn from the Mini Survey participants who consented to outreach by RAND. We iterated the Mini Survey and its workflow (level 1) in consultation with counties and other subcontractors in 2023, and have finalized a working model. This aspect of the protocol was also submitted to RAND's IRB in December 2023. RAND is currently developing the remaining evaluation protocols (survey and/or interview/focus group protocols) for the Peer/PADs Consumer evaluation.

Challenges Encountered and Resolved During the Reporting Period

RAND has continued to adapt our originally-proposed evaluation to recent changes in the scope and focus of the innovation project.

RAND's evaluation activities inherently dependent on the development and implementation of the PADs Peer Supporter training and the launch of the PADs platform. In Fall 2023, RAND identified potential challenges to implementing the full evaluation within the remaining Phase 1 time (ending June 2025) if the launch of the training and/or platform was pushed back beyond early 2024. Our evaluation design includes longer-term follow-up windows (e.g., interviews/focus groups with trainees several months after they completed the training and have accrued "live" experience in the field facilitating PADs; surveys/interviews/focus groups with PADs consumers several months after they have completed their PAD). Further delays in the launch of the training and/or platform will shorten the period of time available for follow-up, because RAND will need time to analyze the data and prepare the final report before the project ends in June 2025.

We have communicated these potential challenges to the project coordinator and larger PADs Innovation group. As of December 2023, we believe we will still be able to implement the training and outcomes evaluations as-planned if the training and platform hit the launch targets of January/February 2024. Based on the degree of timeline slippage for training/platform launch beyond that target, we may need to shorten follow-up windows, or truncate some evaluation activities.

Plans and Expectations for the Next Reporting Period

The RAND team expects that data collection for its evaluation will begin shortly after the New Year.

RAND will also finalize the remaining evaluation protocols (survey and/or focus groups with Peers who have completed a PAD) and submit this for IRB review and approval. Following approval, we expect to launch this aspect of data collection in Spring 2024.

RAND will also begin working on analysis and reporting, following the implementation of data collection.

Anticipated accomplishments by end of FY2024

Based on the current overall project timeline, we anticipate that RAND will have launched and implemented training-related evaluation activities. We also expect that we will have developed and launched activities focused on the Peer-level impacts of PADs.

Burton Blatt Institute
SYRACUSE UNIVERSITY

Fiscal Intermediary Updates for 2023

Overview

Syracuse University continued to serve in the role of Fiscal Intermediary for the Psychiatric Advance Directives (PADs) Project, which is a Mental Health Services Act Innovations Project involving the collaboration of multiple California Counties; namely, Contra Costa County, Fresno County, Mariposa County, Monterey County, Orange County, Shasta County and the Tri-City Mental Health Authority. In addition to the expertise and excellence in the programmatic areas of Disability Research and Advocacy that Syracuse University's Burton Blatt Institute brings forth to the PADs Project, Syracuse University has a dynamic research administration team that supports the world-class, top-tier research performed on campus and around the world. Syracuse University's Office of Sponsored Programs and Office of Sponsored Accounting provide the critical infrastructure to support the PADs Project contract(s) administration and fiscal oversight. Our offices primary functions are to facilitate the responsible and efficient stewardship of grant and contract funded projects from various external funding agencies. As a result of the significant federally funded research conducted by Syracuse University, we are required by federal policy, law, and regulations to have rigorous and well-documented fiscal oversight measures in place to responsibly administer these funds. Syracuse University routinely undergoes multiple audits from various agencies and external auditors with no material weaknesses noted in past years. Lastly, Syracuse University is a proud member of the Federal Demonstration Partnership (FDP), which is a cooperative of 10 federal agencies and over 200 research intensive institutions with the primary purpose to reduce the administrative burdens associated with research grants and contracts.

Why is this important to the PADs Project which is not federally funded? Syracuse University is able to leverage the best practices learned through its FDP membership to the benefit of all externally sponsored projects, including the PADs project. A prime example of this benefit is the University's enrollment in the FDP Expanded Clearinghouse which essentially provides a public facing organizational profile of Syracuse University, including audit and financial data that is regularly updated on an annual basis. To review Syracuse University's profile at any given time, simply navigate to this website (https://fdpclearinghouse.org/organizations/196) for the most recent information.

2023 Updates

Representatives from Syracuse University attended and presented at the PADs Project meeting held in Anaheim, CA September 11-12, 2023. Stuart Taub, Director, Office of Sponsored Programs, provided an overview presentation on Syracuse University's role, responsibility and financial update as the fiscal intermediary and fielded questions from the County representatives in attendance. Gary Shaheen, Project Director, Burton Blatt Institute, provided a presentation reflecting the Burton Blatt Institute at Syracuse University's progress on the Orange County Evaluation engagement with the PADs Project, and each fielded questions from County representatives following his presentation.

Seven (7) California Counties are actively engaged in funding the PADs Project, and with their authorization Syracuse University engaged subcontractors providing the necessary services for the PADs Project in the areas of Lead Project Management, Technology Platform Development, Marketing & Communications, PADs Advisory and Training, Peer Organization and Evaluation. During the 2023, with authorization from the Counties Syracuse University closed out the subcontract with Hallmark Compass and engaged Alpha Omega Translations.

Payment of subcontractor invoices continued in 2023 based on the proportional allocation distribution as originally established and each with approval from the Lead Project Manager. In **Table 1** below, we provide a fiscal status update of the PADs Project through December 31, 2023, on a County-by-County basis. Cumulatively across all counties, the project expenditures are tracking at 53.9% of the current **PADs Project** budget period which is from inception through June 30, 2025. **Table 2** reflects subrecipient spending to date. The "Obligated Amount" reflects each subcontractor's total budget for the period through June 30, 2024.

Please note, the time frames in which certain counties and subcontractors became engaged impacted the rates of expenditures shown. Contra Costa County's and Tri-City Mental Health Authority's involvement began months later that the other Counties. The largest portion of Mariposa County's budget is allocated to a Peer Organization for which Contra Costa County and Tri-City Mental Health Authority also include in their budgets but with subsequent start dates. The subcontract with Alpha Omega Translations was not executed until the summer of 2023. However, it is still expected the rate of expenditures for these counties will become more aligned with the overall allocation by the period ending June 30, 2024. Also, Fresno County's budget is compressed and scheduled to fully expend by June 30, 2024 compared to the others which are expected to end by June 30, 2025.

Table 1

Total Project Spending

County	Total Budget ending 6/30/24*	Actual Expenditures	% Expended
Contra Costa	**$1,211,136**	**$386,125**	**31.9%**
Fresno	**$863,087**	**$555,968**	**64.4%**
Mariposa	**$79,660**	**$61,650**	**77.4%**
Monterey	**$498,828**	**$256,606**	**51.4%**
Orange	**$9,545,470**	**$5,382,257**	**56.4%**
Shasta	**$207,735**	**$107,779**	**51.9%**
Tri-City	**$313,264**	**$104,355**	**33.3%**
PADS Project Sponsors	**$12,719,180**	**$6,854740**	**53.9%**

Table 2

Subrecipient Spending

Subcontractor	Invoiced through	Obligated Amount	Actual Expenditures	% Expended
Concepts Forward	11/30/2023	$656,181	$449,828	**68.6%**
Chorus	11/30/2023	$7,300,000	$5,491,665	**75.2%**
Idea	10/31/2023	$478,215	$302,435	**63.2%**
Rand	10/22/2023	$647,270	$137,310	**21.2%**
Painted Brain	7/31/2023	$296,593	$175,037	**59.0%**
Hallmark	06/30/2023	$73,440	$73,440	**100%**
Alpha Omega	8/31/2023	$206,607	$1,650	**0.8%**

Shasta County Health and Human Services Agency
DRAFT SHASTA COUNTY Mental Health, ALCOHOL AND DRUG ADVISORY BOARD (MHADAB)
SPECIAL Meeting
Monday, October 21, 2024

Attendees:

Kalyn Jones, Board Chair	√	Heather Jones, Board Vice-Chair	√	Ron Henninger, Past Chair	
Connie Webber, Board Member	√	Jo-Ann Medina, Board Member	√	Mary Rickert, BOS Board Member	√
Cindy Greene, Board Member	√	David Kehoe, Board Member		Samuel Major, Board Member	
Matilda Grace	√	Erin Dooley	√		
Jackie Rose, CDC	√	Christy Coleman, Acting HHSA Agency Director	√	Dwayne Green, Acting HHSA Agency Deputy Director	√
Bailey Cogger, BHSS Deputy Director	√	Rachel Ibarra, BHSS Program Manager	√	Marie Marks, CSC	√
Amber Brock, Sr. Staff Services Analyst	√	Katie Nell, BHSS Sr. Analyst	√	Ashley Saechao, BHSS CDC	√

Community Members: 2 (Includes virtual attendees) *Not all signed in*

Agenda Item	Discussion/Conclusions/ Recommendations	Action/Follow-Up	Date Due/Status	Individual/ Department Responsible
I. Call to Order	Kalyn Jones, MHADAB chair extended a warm welcome to all attendees and called meeting to order at 5:32 p.m.	No action required.	N/A	Kalyn Jones, MHADAB chair
II. Public Comment	No public comments	N/A	N/A	N/A
III. Regular Calendar	A. Open/Close public hearing to receive comments on the "Fiscal Year 2024/2025 MHSA Annual Update" Ashley Saechao MHSA Coordinator provided a community planning process report, this included the Community Program Planning outline of dates met and the 2 public comments that were made during the public comment period. No discussion or comments were made from the Board. B. Consider approval of the "Fiscal Year 2024/2025 MHSA Annual Update" and consider recommending that the Shasta County Board of Supervisors.	A. No action required. B. Motion passed unanimously with seven (7) Ayes, zero (0) Nays and zero (0) abstention.	N/A N/A	N/A N/A
I. VII. Adjournment	Call to adjourn meeting (5:39 PM)	No action required	N/A	**Motion:** Erin Dooley **Second:** Matilda Grace

Next Meeting is scheduled on: November 18, 2024 (Regular Meeting)

MHADAB Chair