

**PEI COMPONENT OF THE THREE-YEAR PROGRAM AND
EXPENDITURE PLAN FACE SHEET**

Form No. 1

**MENTAL HEALTH SERVICES ACT (MHSA)
PREVENTION AND EARLY INTERVENTION COMPONENT
OF THE THREE-YEAR
PROGRAM AND EXPENDITURE PLAN
Fiscal Years 2008/09 and 2009/10**

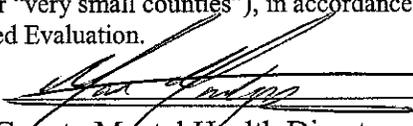
County Name: Shasta County	Date: April 03, 2009
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COUNTY'S AUTHORIZED REPRESENTATIVE AND CONTACT PERSON(S):

County Mental Health Director	Project Lead
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AUTHORIZING SIGNATURE

I HEREBY CERTIFY that I am the official responsible for the administration of Community Mental Health Services in and for said County; that the county has complied with all pertinent regulations, laws and statutes. The county has not violated any of the provisions of Section 5891 of the Welfare and Institution Code in that all identified funding requirements (in all related program budgets and the administration budget) represent costs related to the expansion of mental health services since passage of the MHSA and do not represent supplanting of expenditures; that fiscal year 2007-08, 2008-09 funds required to be incurred on mental health services will be used in providing such services; and that to the best of my knowledge and belief the administration budget and all related program budgets in all respects are true, correct and in accordance with the law. I have considered non-traditional mental health settings in designing the County PEI component and in selecting PEI implementation providers. I agree to conduct a local outcome evaluation for at least one PEI Project, as identified in the County PEI component (optional for "very small counties"), in accordance with state parameters and will fully participate in the State Administered Evaluation.

Signature 	April 03, 2009
County Mental Health Director	Date

Executed at Redding, California

PEI Community Program Planning Process

County Staffing

Shasta County ensured that the Community Program Planning Process was adequately staffed by the following team:

Responsible for the overall Community Program Planning:

- Mark Montgomery:
 - Director, Shasta County Mental Health, Alcohol and Drug
- David Reiten:
 - Deputy Director, Shasta County Mental Health, Alcohol and Drug
- Shasta County Mental Health Board

Responsible for the coordination and management of the Community Program Planning Process:

- Jamie Hannigan:
 - Mental Health Services Act Manager
- Maxine Wayda:
 - Clinical Division Chief, Youth System of Care
- Shasta County Mental Health Board Executive Committee

Responsible for ensuring that stakeholders had the opportunity to participate in the Community Program Planning Process:

- Joy Garcia:
 - Community Education Specialist II

Community Program Planning Process: Internal Meetings

- On-going internal meetings occurred between Shasta County Mental Health staff, the Mental Health Board Executive Committee, and staff PEI Workgroup.
- These meetings were held throughout the PEI planning process to accomplish the following:
 - i. Create the PEI planning process framework
 - Included the creation of a document called the MHSA PEI: Community Mental Health Assessment. The document provided a foundation of local, relevant information and data for those involved in the PEI planning process.
 - ii. Provide guidance for the direction of the process to allow for flexibility, transparency and inclusiveness.
 - iii. Offer expertise in various arenas to assure the process met state guidelines

	Internal Planning Group	Members
Weekly	Mental Health Board Executive Committee	Chair, Vice Chair, Mental Health Services Act Advisory Committee Chair
Bi-Monthly	PEI Workgroup	HHSA Director, HHSA Epidemiologist, MH Director, MH Deputy Director, MH Clinical Division Chief, PH Health Officer, PH Manager, PH Suicide Prevention Specialist

Supporting Staff for the Community Program Planning Process:

Staff Name	HHSA Agency	Position
Dr. Andrew Deckert	Public Health	Health Officer
Brandy Isola	HHSA	Epidemiologist
Elaine Minami	HHSA	Community Relations Specialist
Katherine Sellman	Public Health	Suicide Prevention Specialist
Erin Ceccarelli & Lorilei Ruddell	Mental Health	Fiscal
Mey Chao-Lee	Mental Health	Cultural Competency Coordinator
Nancy Greer & Robin Thomas	Mental Health	Consumer & Family Service Specialists
Georgia Haddon	Mental Health	Typist Clerk

Overview of the PEI Planning Process

1.) Orientation to PEI

- A PEI informational presentation was developed and presented by the PEI Community Education Specialist. The presentation summarized PEI guidelines, informed stakeholders about the PEI planning process, and identified opportunities for stakeholders to participate in PEI planning. The presentation also prepared stakeholders to participate in PEI planning by explaining what prevention and early intervention means in mental health terms, and what type of programs are available for PEI projects. The presentation was offered to the following groups by methods identified below:
 - i. Advertised by flyer, email, mailing lists and press release
 - Community Meetings: This included over 40 attendees from required and recommended sectors such as community-based organizations, ethnic coalitions, health care providers, public health, social services, education, law enforcement, and consumers and family members as well as individual stakeholders.
 - ii. Presentation during regular meeting times
 - County Staff
 - Mental Health, Adult System of Care
 - Mental Health, Youth System of Care
 - Community Groups
 - Mental Health Board
 - Mental Health Services Act Advisory Committee
 - Older Adult Policy Council
 - Alcohol and Drug Advisory Board
 - NAMI of Shasta County
 - iii. The PEI Community Education Specialist met with, and was also available to, individuals or small groups and organizations to present information about PEI and answer questions on a flexible basis. An example of this would be daily phone calls or attending the local Hispanic/Latino Coalition meeting.
 - iv. PEI orientation summary was presented at the beginning of community focus groups (described below).

2.) Stakeholder Input

- To help create an accessible and inclusive PEI planning process, three stakeholder input tools were developed. The tools and techniques used to gather stakeholder input were designed and tested to be user-friendly and to allow for meaningful stakeholder input and involvement. They were also designed to provide decision-making data. All priority funding areas, projects, and outcomes were based on data collected during the stakeholder input process.
- Opportunities to participate in PEI stakeholder input activities were advertised extensively via brochures, emails, mailing lists, flyers, personal outreach, local public calendars, newsletters, mental health website, press releases, newspapers, and radio. Four \$50.00 food cards were used as incentives for participation.
 - i. **Stakeholder Input Tool 1: Survey** The survey allowed stakeholders to rank priority populations, key mental health needs, protective factors, risk factors, and negative outcomes
 - 546 participants
 - The survey was available online and in hard copy.
 - The survey was available in Spanish.
 - Hard copy surveys were distributed in the following locations: HHSA regional offices, NAMI, local schools, First 5 Shasta, Lions Club, bicycle helmet classes, car seat classes, YMCA, WIC, Food Group locations, Coalitions, Healthy Aging Summit, House of Hope, SMART Business Resource Center, Good News Rescue Mission, NVCSS Second Home, Multi-cultural Celebration.
 - Some sites provided reading and language assistance with the survey.
 - Survey results were posted on the Mental Health Website.
 - ii. **Stakeholder Input Tool 2: Focus Groups** Stakeholders were given a brief PEI orientation using individual visual guides before focus groups began. Then stakeholders ranked age groups, priority populations, and key mental health needs. Next, using a consensus workshop format, participants shared their input about types of services, supports, and interventions that should be included in the PEI plan.
 - 218 participants.
 - Originally 14 focus groups were scheduled throughout the county. Three additional consumer and family member focus groups were included and the process slightly modified at the request of local consumer advocates.
 - Focus Group meetings were open to all community members and were held in natural community settings or during regular group meetings.
 - Focus groups were also organized for required stakeholder sectors to ensure participation.
 - Focus group results were compiled after every meeting and sent via email to participants. They were also available on the Mental Health Website

	Participants	Host	Date	Time	Location	Attendance
1	CBO & MH Providers	NVCSS	02/11/08	2:00 – 4:00	NVCSS	14
2	Youth: HIP		02/11/08	6:30 – 8:30	Health Improvement Partnership	6
3	Education	SCOE	02/25/08	10:00 – 12:00	Shasta County Office of Education	28
4	Regional: Shingletown	MHB Member	03/03/08	11:30 – 1:30	Grass Roots	7
5	Youth: Oasis		03/04/08	12:00 – 2:00	Oasis School	18
6	Regional: Redding	MHB Member	03/04/08	7:00 – 9:00	NVCSS	38
7	Underserved Cultural Populations		03/06/08	11:30 – 1:30	Anderson Teen Center	20
8	Regional: Shasta Lake City	MHB Member	03/06/08	6:00 – 8:00	John Beaudet Community Center	0
9	Regional: Anderson	MHB Member	03/11/08	6:00 – 8:00	Anderson Library	6
10	Regional: Burney	MHB Member	03/12/08	6:00 – 8:00	Intermountain Community Clinic	9
11	HHSA Expanded Cabinet	HHSA	03/18/08	1:30 – 3:30	Shasta County Public Health	16
12	Mental Health Staff	MH	03/19/08	12:00 – 2:00	Shasta County Mental Health	10
13	Alcohol & Drug Advisory Board		03/19/08	4:00 – 6:00	Blood Source	16
14	Consumer		03/31/08	12:00 – 2:00	NVCSS	10
15	Consumer & Family Members		03/31/08	6:00 – 8:00	Boggs Conference Center	10
16	Consumer		04/01/08	5:00 – 7:00	NVCSS 2 nd Home	10

- iii. **Stakeholder Input Tool 3: Key Informant Interview** Key informant interviews allowed for in-depth discussion surrounding PEI planning, projects, and outcomes. Key Informants were also asked to rank priority populations, key mental health needs, protective factors, risk factors and negative outcomes.
- o 32 participants.
 - o Key informant interviews provided opportunities to reach gaps in stakeholder input representation and information.
 - o Key informant interview results were available on the Mental Health website.
 - o Key informant interview schedule was extended, at the request of the Mental Health Board, to allow individuals interested in being interviewed to be contacted and scheduled.

Required Sector	# of Key Informants	Participants
Mental Health Providers	5	CBO directors, MH clinician and staff
Consumer & Family Members	3	Family advocate, Foster Parent, Consumer
Education	3	Elementary Principal, Secondary Principal, Librarian
Health	6	Physicians, Nurses, Physician Assistant
Law Enforcement	6	Dispatcher, Coroner, Probation, Youth Court, Sheriff, Police
Social Services	6	Social Workers, Nurse, Home Health Provider
Underserved Cultural Populations	3	Community Health Advocates

3.) Stakeholder Input Results Meeting

- o Community members were provided an overview of the Prevention & Early Intervention planning process, community input gathering strategies, and stakeholder input results at a community meeting and through the Mental Health website.
 - Meeting advertised via email, Mental Health website, and flyer.
 - Fifteen stakeholders representing community-based organizations, NAMI, mental health providers, consumers, family members, and health care were in attendance.
 - Meeting documents and presentation materials were made available on the Mental Health website.

4.) PEI Expert Panel

- A PEI workgroup consisting of individuals representing mental health, prevention, health care, cultural competency, and consumers and family members was convened to organize stakeholder input data and data from the PEI Community Mental Health Assessment into PEI projects. The workgroup met for 3 hours on four different occasions. Each meeting included numerous hours of “homework” for each participant to complete before the next meeting.

Panel Member	Title	Sector
Dr. Andrew Deckert	Public Health Officer/Physician	Public Health
Becky Bogener	Mental Health Clinician	TAY/Mental Health/Education
Brandy Isola	Epidemiologist	Health and Human Services
Dr. Ron Sand	Physician	Older Adults/ Health Care
Jeanie Jacobs	Mental Health Clinician	Children/Mental Health/Education
Maxine Wayda	Mental Health Clinician	Mental Health Department
Mey Chao-Lee	Cultural Competency Coordinator / MH Case Manager	Underserved Cultural Populations
Sherrie Allan	Nurse/Support Group Leader	Consumer and/or Family Member
Therese Standridge	Educator	Consumer and/or Family Member/Education

- The work of the PEI Expert Panel included the following:
 - i. Synthesis of Stakeholder Data to Arrive at Priority Funding Areas
 - This was accomplished by compiling all stakeholder input results and review of the MHSA PEI: Community Mental Health Assessment.
 - ii. Review of Evidence-Based Practices and Other Programs
 - Evidence-Based Practices and Promising Practices that corresponded to stakeholder input regarding priority funding areas, interventions, and outcomes were evaluated for the following characteristics:
 - a. Number of individuals impacted in relation to cost
 - b. Intensity of program strategy
 - c. Level of training required to implement
 - d. Level of fidelity monitoring required for effective implementation
 - e. What type of evaluation tools are available
 - f. Can it “stand alone”
 - g. Leveraging resources: other funding sources, shared training resources, and other agency implementation
 - h. What protective factors, risk factors and negative outcomes will be addressed by the program
 - i. What type of intervention is the program: universal prevention, selective prevention or early intervention
 - iii. Development of Recommendations to the Mental Health Services Act Advisory Committee:
 - Project recommendations based on stakeholder input and the PEI Community Mental Health Assessment including:
 - a. Target populations
 - b. Intervention Strategies
 - c. Evidence-based practices or promising practices
 - d. Outcomes
 - Six foundational concepts, identified by stakeholders and the PEI Expert Panel, that should be evident throughout the PEI plan including:

- a. Cultural competence, incorporated into all aspects of policy-making, program design, administration, and service delivery.
- b. Decrease disparities in access to mental health services.
- c. Reduce stigma and discrimination affecting individuals with mental illness and mental health problems.
- d. Recognize and address the underlying role of poverty and other environmental and social factors that impact individual wellness.
- e. Decrease the pervasive effects of alcohol and substance abuse.
- f. Increase assets in children and youth.

5.) Mental Health Services Act Advisory Committee (MHSAAC)

- o February 2008 was the first meeting of the MHSAAC. It is a subcommittee of the Mental Health Board with designated sector representatives from various stakeholder groups such as underserved populations, consumers and family members, law enforcement, education, health care, health and human services agencies, and community-based organizations. The Mental Health Board and Shasta County Mental Health formed the group to provide input and guidance for the planning, implementation, and oversight of the MHSA.

Name	PEI Required Sector	Organization
Amy Brom	Underserved Cultural Populations	Redding Rancheria
Denny Mills	Education	Shasta County Office of Education
Diana Clayton	Consumer and/or Family Member	NAMI
Don VanBuskirk	Law Enforcement	Sheriff's Department
Donnell Ewert	Health & Human Services	Public Health
Doreen Bradshaw	Health Care	Shasta Consortium of Community Health Centers
Greg White	Education	National University
Jane Work	Health & Human Services	Social Services
Joanne McCarley	Community-Based Organization	Compass Care Services
Karen Crum	Consumer and/or Family Member	Rowell Family Empowerment
Lee Macey	Underserved Cultural Populations	Shasta County Citizens Against Racism
Maxine Wayda	Health & Human Services	Mental Health
Michelle Gazzigli	Consumer and/or Family Member	Alcohol & Drug Advisory Board
Micoa Furr	Underserved Cultural Populations	Good News Rescue Mission
Rachel Freeman	Underserved Cultural Populations	Victor Youth Services / LGBT
Rodger Moore	Law Enforcement	Redding Police Department
Sherri Leitem	Law Enforcement	Probation
Stephanie Stringfield	Health Care	Mercy Medical Center ER
Susan Wilson	Community-Based Organization	Health Improvement Partnership
Theresa Bible	Underserved Cultural Populations	Hispanic/Latino Coalition
Tracy Ray	Education	The Great Partnership

- The MHSAAAC played the following role in PEI planning
 - Were educated about all MHSAA components including PEI.
 - Were updated and informed about the PEI planning process.
 - Participated in stakeholder input gathering including surveys, focus groups, and key informant interviews.
 - Reviewed and commented on the PEI Expert Panel's recommendations and the PEI draft plan prior to and during the 30-day public comment period.
 - Recommended approval of the PEI plan by the Mental Health Board.

MHSAAAC Meeting Date	PEI Information Covered During MHSAAAC Meeting
03/21/08	PEI focus group schedules, survey and key informant deadlines
04/11/08	Review of stakeholder input tools, conducted a PEI focus group for members
05/16/08	Distribution of PEI Expert Panel analysis of stakeholder input results and PEI Mental Health Assessment, Review of PEI plan requirements and evaluation, evidence-based programs and enclosure 6 of the PEI guidelines
06/27/08	Review and Discuss: PEI Expert Panel, PEI project recommendations, foundational concepts, plan framework and the spectrum of prevention Set priorities for PEI funding and program implementation, discuss target populations and possible county locations for recommended PEI projects
08/22/08	Review PEI Draft Plan
09/05/08	Review PEI Draft Plan: follow-up and discussion
09/19/08	Review PEI Draft Plan: continued work and discussion
10/03/08	Review PEI Draft Plan: use DAC review tool to check if plan meets guideline requirements, Prepare recommendation approval of the plan by the Mental Health Board
11/07/08	PEI Process Debrief: discussion of process, what went right, what could be better

Participation of Key Groups

The Shasta County PEI planning process provided opportunities for diverse participation.

Shasta County Demographics:

Age	Number	Percent
0-14	32,039	18%
15-24	26,478	15%
25-59	83,380	47%
60+	36,642	21%
Total	178,539	100%

Race/Ethnicity	Percent of County Population	Percent of Public MH Population
White	84%	84%
Hispanic	7%	6%
American Indian/Alaskan Native	3%	2%
Asian/Pacific Islander	2%	5%
Black/African American	1%	2%
Two or more races	2%	1%

Source: U.S. Census Bureau, 2005-2007 American Community Survey WET Exhibit 3

Geographic Location: The community planning process took place in each of Shasta County's cities and towns. Stakeholders also included representatives of all communities. Special arrangements were made to hold public events in natural community settings such as the library, a teen center, schools, and community centers.

Age: Special efforts were made to ensure involvement in the PEI planning process of all age groups.

- Early Childhood: Stakeholders included representatives of Shasta First 5, schools, day cares, community-based organizations and mental health clinicians providing services to this population.
 - The PEI Expert Panel workgroup were also provided with the following documents:
 - Mental Health Assessment/Redesign Collaborative (MHARC) Prevention and Early Intervention Plan
 - Shasta Children and Families First Commission's School Readiness Survey
- Youth and Transitional Age Youth (TAY): Two special focus groups were organized especially for TAY. One group included youth from a community leadership group and the other were students from a local alternative school. In addition, youth and TAY were represented by family members, staff responsible for children's services, educators, school districts, juvenile probation, and community-based organizations providing services to children and families.
- Older Adults: Older adults were represented individually and by family members and community-based organizations that serve older adults, mental health, and primary health care providers. The Older Adult Policy Council devoted two full meetings to learn about MHSA and PEI, and to participate in a focus group to determine PEI needs of our older adult population.

Underserved Cultural Populations: Stakeholders represented multiple ethnic and cultural groups, including LGBT. Intentional efforts were made to ensure involvement of ethnic/cultural groups, including working with our Cultural Competence Coordinator to help guide the process. The PEI Community Program Planning Process reflected the demographics of Shasta County.

- Community Health Advocates and Community Health Organizers for local cultural communities were involved in the PEI Community Program Planning Process. They distributed surveys, participated in focus groups, and helped locate key informants. Their efforts helped to ensure that members of local ethnic communities participated in all aspects of the PEI planning process.
- Surveys were available to members of underserved cultural populations. For example, a Spanish version of the survey was used and distributed by the local Hispanic/Latino Coalition. Also, surveys were available at a booth during a multi-cultural celebration in Shasta Lake City. The annual event was attended by over 500 community members of diverse age and ethnic groups.
- Key informant interview participants included members of underserved cultural populations.
 - Underserved cultural populations were a sector that was targeted for interviews.
 - Some individuals that were interviewed as members of other sectors, such as law enforcement or health care, were also members of underserved cultural populations.
- A special focus group was organized for underserved cultural populations. Representatives from the following communities attended:

- Asian Pacific Islander
- Native American / Alaskan Native
- Hispanic/Latino
- African American
- LGBT
- Deaf / Hard of Hearing
- Consumers and Family Members
- Rural Communities

Consumers and Family Members: Outreach to consumers and family members during the PEI planning process was extensive. Advertisements and announcements were distributed at Shasta County Mental Health, local mental health providers, wellness centers, Good News Rescue Mission, Shasta College, Mental Health Board, MHSA Advisory Committee, Drug and Alcohol Advisory Board, local board and care facilities, and NAMI.

- Advocates for consumers, family members, and cultural communities were made aware of PEI planning and were involved in PEI stakeholder input efforts. They distributed surveys, participated in focus groups, helped locate key informants, and promoted PEI planning.
- Consumers and family members were targeted during distribution of hard-copy surveys.
- A PEI orientation and a regional focus group were held during regularly scheduled NAMI meetings.
- Originally, 14 focus groups were scheduled through out the county. Four additional focus groups were included in the schedule and the process slightly modified at the request of local consumer advocates. Two of the four additional focus groups were combined due to lack of attendance.
- Consumers and family members have been a part of all PEI planning groups including the Mental Health Board, the Mental Health Services Act Advisory Committee, and the PEI Expert Panel.

Lessons Learned During the CSS Planning Process

Shasta County Mental Health learned key lessons during the CSS Community Planning Process that have been applied to the PEI process.

Lesson #1: The process must be transparent. Since the approval of the CSS plan, criticism has been raised about the transparency of the CSS process.

During PEI planning, significant attention has been paid to transparency in the following ways:

- *Genuine Open Planning Direction:* The County was very careful to not set internal PEI plan direction or priorities prior to community planning efforts. This allowed for unbiased stakeholder input gathering.
- *Stakeholder Input Process:* Stakeholder input methods were developed with transparency and flexibility in mind. The community was asked to rank age groups, priority populations, key mental health needs, negative outcomes (PEI Guidelines), risk factors, and protective factors. The data from this process was used to set funding priorities for the PEI plan. Using a consensus workshop format, stakeholders

also shared their input about the type of services, supports, and interventions that should be included in the PEI plan. This data was used to select project activities and outcomes.

- *Community Updates:* All PEI activities, documents, presentations, and data was made available for stakeholder viewing. For example, the day after focus groups were completed, the data was compiled, sent to all participants, and posted on the Mental Health website.

Lesson #2: Stakeholders must make key decisions. Several CSS stakeholders claimed that they were not significantly involved in making decisions regarding the allocation of CSS funding.

During the PEI process, stakeholders made key decisions

- *Project Selection:* Project target group, intervention, program, and outcome selections were based directly upon the input provided by 796 stakeholders.
- *PEI Expert Panel:* The PEI Expert Panel synthesized all stakeholder input data to determine priority funding areas. Once these were established the workgroup searched for program activities that would target priority funding areas and match stakeholder suggestions. The work of the PEI Expert Panel was assembled into a PEI plan recommendation which included priorities for funding based on analysis of stakeholder input, project activities, and foundational concepts.
- *MHSA Advisory Committee:* The MHSAAAC, a stakeholder subcommittee of the Mental Health Board, received recommendations from the PEI Expert Panel about priority funding areas and projects that should be included in the PEI plan. The Committee reviewed, provided input, and commented on the draft PEI plan and recommended approval of the plan by the Mental Health Board.

Lesson #3: Stakeholders must be informed. During CSS planning many stakeholders misunderstood their role in the process. Many believed that all individual community input would be included in the plan and when it wasn't, they were left with mistrust of the process.

Stakeholders were informed about the PEI planning process.

- *PEI Orientation:* PEI orientation was provided throughout the County and at the beginning of every focus group. The orientation included detailed descriptions of the County's PEI budget, what type of services could be included in PEI plans, and how stakeholder input would be used. This assisted the County in setting realistic expectations for the PEI plan.
- *Community Updates:* In an attempt to keep stakeholders informed, all PEI activities, documents, presentations, and data were made available for stakeholder viewing. The secondary rationale for this was to remind stakeholders that a broad inclusive community process creates broad and diverse ideas. It was also important for each stakeholder group to recognize that their priorities were not the same as other groups.

Lesson #4: Stakeholders must be provided an opportunity for meaningful participation. At the completion of the CSS process, there was concern surrounding the methods used to gather stakeholder input. For example, focus group facilitators and participants believe some people felt uncomfortable providing their opinions while others dominated the conversation.

- *Stakeholder Input Tools:* Three stakeholder input tools were used to gather input. This gave stakeholders the opportunity to participate using a method they felt comfortable with.

- *PEI Promotion:* Some PEI promotions, such as flyers and invitations, were developed for specific target groups. For instance, the Cultural Competency Coordinator suggested the focus group for underserved cultural populations be referred to as a meeting and lunch be provided to help alleviate some leanness about the process. A special flyer was created for the focus group and distributed by the Cultural Competency Coordinator.
- *PEI Documents and Educational Materials:* The PEI Community Education Specialist created numerous PEI documents and educational materials to facilitate participant involvement and understanding. Special attention was focused upon reading level of the materials. Often, visuals were prepared to aid in the communication regarding lengthy or complex documents.
- *Focus Group Method:* The ToP® Consensus Workshop method was used to facilitate each focus group. The goal of the method is to produce consensus-based decisions that respect the diversity of perspectives within the group, inspire individual action, and move the group toward joint resolve and action. Individual participation is honored by focusing on the insight within each idea.

Measures of Success: Inclusive and Effective PEI Planning Process

The following are measures of success that outreach efforts produced an inclusive and effective community program planning process with participation by individuals who are part of PEI priority populations, including Transition Age Youth.

Measures include:

- *Community Participation:* 796 community members provided stakeholder input. Over 100 individuals attended PEI orientations, meetings, or served on stakeholder workgroups and committees.
- *Community Updates:* Documents produced regarding PEI were made available on the Mental Health website. Use of the Mental Health website increased during the PEI planning process. Approximately 900 page-views occurred on the PEI page from February 2008 to April 2008.
- *Flexibility:* A PEI planning flowchart was created at the beginning of the process. Steps and activities were modified to accommodate stakeholder participation and suggestions. Two examples include providing additional focus groups with modified process for consumers and family members (at the request of advocates), and increasing the deadline for key informant interviews (at the request of the Mental Health Board).
- *Diversity of PEI Participants:* Stakeholders who participated in the PEI Community Program Planning Process reflected the diversity and demographics of our County. Members of underserved cultural populations were meaningfully engaged in every aspect of the process from filling out a survey to sitting on the Mental Health Services Act Advisory Committee.
- *Expressions of Satisfaction with the Process:* Many stakeholders expressed positive opinions about the PEI Community Program Planning Process. Some were happy with the stakeholder input tools, many enjoyed the unusual facilitation method used for the focus groups, and others were pleased with the

overall process. In general, Shasta County received positive feedback regard the PEI planning process.

- *PEI Projects and Budget Directly Reflect Stakeholder Input Overall:* Stakeholder input was used to make key decisions on priority funding areas, project activities, and outcomes.
- *PEI Orientation:* The PEI planning process included orientation for stakeholders. A Community Education Specialist was utilized for the presentation and creation of PEI educational materials. Special efforts were made to create easy to understand documents, procedures, and visuals.
- *PEI Promotion:* In an effort to create an inclusive process, numerous media forms and venues were used to promote the PEI planning process, including brochures, email, mailing lists, flyers, personal outreach, local public calendars, newsletters, the Mental Health website, press releases, newspaper, and radio.
- *Partnership with Public Health:* PEI Workgroup internal meetings were held throughout the PEI planning process. The workgroup consisted of Health and Human Services, Mental Health, and Public Health staff. Public Health provided guidance, education, and expertise regarding prevention. This partnership facilitated PEI projects with genuine primary prevention activities.
- *Stakeholder Input Tools:* Multiple community input tools were developed to ensure an inclusive and user-friendly process. The County worked with professional evaluators, our Cultural Competency Coordinator, Spanish interpreters and consumer and family member advocates to develop the stakeholder input tools. This was done to enhance the effectiveness and appropriateness of each tool and allow for meaningful stakeholder input and involvement.
 - *Surveys:* Surveys were available in hard copy or on-line. They were also available in Spanish. Distribution of surveys was extensive and included intentional delivery to PEI required sectors.
 - *Focus Groups:* Focus Groups were held in diverse natural settings and locations throughout the County. Special efforts were made to include individuals from PEI age groups and required sectors particularly underserved cultural populations and consumers and family members.
 - *Key Informant Interviews:* Key informant interviews allowed for in-depth discussion with individual stakeholders about PEI. They also provided the opportunity to supplement stakeholder input representation and information.
- *Process Reflection:* The MHSA Advisory Committee and Mental Health staff had the opportunity to be part of the PEI planning process from beginning to end. After the PEI plan was submitted to the state, a two-hour meeting was dedicated to reflection of the process. Topics of discussion included: what went well, what could be improved, and what we learned for future MHSA components.

County Public Hearing

- 30-day Public Comment Period and Public Hearing:
The 30-day public comment period was opened March 2, 2009 and closed April 1, 2009. The public hearing was conducted by the Shasta County Mental Health Board during their regular meeting on April 1, 2009.
- Plan Distribution:
Public notice regarding the 30-day public comment period and public hearing was published weekly from March 1, 2009 through April 1, 2009 in seven local newspapers throughout Shasta County. Public notice and copy of the draft plan was posted in several public locations throughout the community and available on-line at the Shasta County Mental Health website. The draft plan was circulated along with a descriptive overview to every attendee of a focus group who requested it. The plan was e-mailed to all stakeholder partnerships, who were then asked to circulate it to their stakeholder participants. Members of the MHSA Advisory Committee and the Shasta County Mental Health Board received copies prior to the opening of the public comment period and copies were available upon request.
- Summary and Analysis of Substantive Recommendations for Revisions:
There were no recommendations for revisions during the public comment period.
- The Estimated Number of Participants:
There were approximately 30 individuals present at the public hearing. Of those, approximately 6 were Shasta County Mental Health staff members.

Project 1: Children and Youth in Stressed Families

PEI Project Name: Children and Youth in Stressed Families

PEI Key Community Mental Health Needs	AGE Group			
	Children/Youth	TAY	Adult	Older Adult
Disparities in Access to Mental Health Services				
Psycho-Social Impact of Trauma	X	X		
At-Risk Children, Youth and Young Adult Populations	X	X		
Stigma and Discrimination				
Suicide Risk				

PEI Priority Population(s)	AGE Group			
	Children/Youth	TAY	Adult	Older Adult
Trauma Exposed Individuals				
Individuals Experiencing Onset of Serious Psychiatric Illness				
Children and Youth in Stressed Families	X	X		
Children and Youth at Risk for School Failure				
Children and Youth at Risk of or Experiencing Juvenile Justice Involvement				
Underserved Cultural Populations				

Stakeholder Input and Data Analysis

PEI Stakeholder Information:

- During the Stakeholder Input process, community members were asked to rank, in order of importance, the Prevention and Early Intervention Priority Populations and Key Mental Health Needs. They were also asked to rank Protective Factors, Risk Factors, and Negative Outcomes that may result from untreated mental illness (W&I Code, Division 5, Part 3.6, section 5840 d). Their results included:
 - *Priority Population:*
 - #1 ranking: Children and youth in stressed families
 - #2 ranking: Trauma exposed individuals
 - *Key Mental Health Needs:*
 - #1 ranking: Increase prevention efforts and response to early signs of emotional and behavioral health problems among at-risk children, youth, and young adult populations

- *Protective Factors:*
 - #1 ranking: Positive child/adult relationships
 - #2 ranking: Sense of belonging
- *Risk Factors:*
 - #1 ranking: Child abuse or neglect
 - #2 ranking: Alcohol and other drug use
- *Negative Outcomes:*
 - #1 ranking: Suicide
 - #2 ranking: School failure/drop-out
- During the stakeholder input process the Priority Population: children and youth in stressed families received the majority of attention and input. Discussions with stakeholders revealed the belief that children and youth in stressed families may also fit into other Priority Population groups like: trauma exposed individuals, children and youth at-risk of school failure, and children and youth at risk of juvenile justice involvement.
- Transitional aged youth (TAY) participated in general stakeholder input opportunities. They were also part of 2 special TAY focus group sessions that focused on the types of PEI services and supports they felt were needed in our community. The focus group results include the following priorities:
 - Promote Mental Wellbeing
 - Increase Awareness of MH Issues
 - Increase Access to MH Services
 - Positive Activities
 - Increase Support & Support Groups
 - School Outreach, Support, & Resources
 - Family Support
 - Economic Support
- Stakeholders suggested the use of the following PEI strategies to serve Children and Youth in Stressed Families
 - Provide families with mental health resources, support and education
 - Raise awareness of mental wellbeing and mental health issues by educating the community, especially parents and key professionals who serve children and their families.
 - Provide interventions and supports for children and youth, that increase protective factors and decrease risk factor for mental health problems
 - Increase access and linkages to services

CSS Stakeholder Information:

- During the Stakeholder Input process for CSS, the following PEI information was collected regarding the prevention needs of children, youth and their families:
 - Isolation, lack of access to services and stigma result in the delay or avoidance of addressing mental health and behavioral disorders until serious consequences result for children and their families.
 - Identification and treatment rates are low for serious problems resulting from substance abuse by parents and children.
 - Opportunities for the support of recovery and hope are not available, due to a lack of jobs, limited college availability, isolation, and systematic stigmatization in the press of mental health consumers and services.

- Many parents do not have support and information in how to parent successfully.
- Single parents are especially vulnerable to delayed access to mental health and substance abuse care, and this affects women in particular.
- Parenting needs of young people and adults are generally unmet in the mental health system.

Data: PEI Community Mental Health Assessment (attachment)

- Promoting Community Wellbeing – Protective Factors: pp 1 – 7
- Preventing Mental Disorders – Risk Factors (Adverse Childhood Events): pp 8 -9
- Preventing Mental Disorders – Risk Factors (Intimate Partner Violence): p 11
- Prevalence of Mental Illness / Suffering: pp 16 - 19
- Prevalence of Alcohol and Other Drug Abuse: pp 20 – 31
- Early Intervention: pp 32 – 37
- Outcomes That May Relate to Mental Illness – Removal of children from their homes: p 42
- Outcomes That May Relate to Mental Illness – School Failure or Dropout: pp 45 -46

Data: Example of Other Sources

- *SAMHSA Promotion and Prevention in Mental Health: Strengthening Parenting and Enhancing Child Resilience*
 - Emphasizes that the use of research-based approaches that provide parenting support skills and child resilience - even in the face of adversity help prevent mental health problems from developing or can greatly mitigate them if they do occur - especially among children and youth.
- *National Longitudinal Study of Adolescent Health (Blum et. al, 2000)*
 - The findings from the National Longitudinal Study of Adolescent Health point to the importance of the parent. This study surveyed 90,000 middle and high school students and interviewed a 20,000-student sample plus their parents. Researchers concluded that commonly regarded “predictors” of adolescent behavior – race/ethnicity, family income, and family structure – turn out to be relatively weak. Instead, in a more fine-grained analysis of the data, Blum, Shew, Beuhring, and others report, “The one most consistently protective factor found was the presence of a positive parent-family relationship.”
- *Surgeon General’s Workshop on Women’s Mental Health: A. Kathryn Power, M.Ed., Director, Center for Mental Health Services, SAMHSA*
 - What is known regarding the impact of trauma:
 - Trauma is no longer regarded as an anomalous experience. It is increasingly seen as a widely prevalent experience of public mental health and human service recipients.
 - Addressing trauma is increasingly recognized as essential for recovery for other mental health disorders such as substance abuse. Improvement in symptoms such as depression and substance-use disorders will not occur without integrating a focus on an underlying history of trauma.
 - A recovery-oriented system is not possible if we do not integrate trauma into mental health services.
 - The failure to address trauma results in major and costly human service systems failures, such as seclusion and restraint, self-injury in adult criminal and juvenile justice, repeated failures to maintain housing or employment, heavy use of health care services, and suicide.

- Childhood physical and sexual abuse may lead to harmful coping strategies such as dissociation, self-injury, eating disorders, running away, and substance use that may delay development and create a legacy of lifetime disabilities associated with chronic mental health problems, addictions, and major health problems.
 - The intergenerational and historical costs of trauma are being increasingly recognized.
 - “Treatment as usual” that does not address trauma results in spiraling costs, lack of reduction in symptoms and misery, and continued cynicism regarding recovery on the part of consumers.
- *The Health and Social Impact of Growing Up with Adverse Childhood Experiences (Robert Anda)*
 - The key concept underlying the ACE Study is that stressful or traumatic childhood experiences such as abuse, neglect, witnessing domestic violence, or growing up with alcohol or other substance abuse, mental illness, parental discord, or crime in the home (which we term ACEs) are a common pathway to social, emotional, and cognitive impairments that lead to increased risk of unhealthy behaviors, risk of violence or re-victimization, disease, disability and premature mortality. We now know from breakthroughs in neurobiology the ACEs disrupt neurodevelopment and can have lasting effects on brain structure and function – the biologic pathways that likely explain the strength of finding from the ACE Study.
- Adverse Childhood Experiences and Prescribed Psychotropic Medication in Adults (Anda et. al, 2007)
 - Childhood abuse and related traumatic stressors are well-established risk factors for developing acute and chronic mental illness. Numerous studies have documented these relationships. Data from the ACE Study, have demonstrated that an integer count of the number of categories of abuse, exposure to domestic violence, and other forms of serious household dysfunction (ACE Score) experienced during childhood has a strong, graded relationship to a wide variety of health and social problems from adolescence to adulthood including depressive disorders, suicide attempts, anxiety, hallucinations, panic reactions, sleep disturbances, and memory disturbances.
 - The strong relationship of the ACE Score to increased utilization of psychotropic medications underscores the contribution of childhood experience to the burden of adult mental illness. Moreover, the huge economic costs associated with the use of psychotropic medications provide additional incentive to address the high prevalence and consequences of childhood traumatic stressors.
- *Center for Disease Control and Prevention (CDC):*
 - The CDC recognizes child maltreatment as a serious public health problem with extensive short and long term health consequences. In addition to the immediate physical and emotional effects of maltreatment, children who have experienced abuse and neglect are at increased risk of adverse health outcomes and risky health behaviors in adolescence and adulthood. Child maltreatment has been linked to higher rates of alcoholism, drug abuse, depression, multiple sexual partners, suicide, and chronic disease.

Project Summary

Shasta County Mental Health's Children and Youth in Stressed Families Project is composed of four interrelated strategies, which address the identified needs of children and youth that meet one or more of the following criteria:

- Children 0 – 18 years of age who are still dependent upon a family structure
- Children who have families dealing with issues related to substance abuse
- Children who have families dealing with issues related to violence
- Children who may be dealing with Adverse Childhood Experiences

The aim of the project is two-fold: to help parents become positive change agents for their children and enhance the community's capacity to support at-risk children and their families. Project 1 will include the following strategies:

1. *Triple P*: The Triple P-Positive Parenting Program is a multi-level, parenting and family support strategy that aims to prevent severe behavioral, emotional and developmental problems in children by enhancing the knowledge, skills and confidence of parents.
2. *Trauma Focused Cognitive Behavioral Therapy*: Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a components-based model of psychotherapy that addresses the unique needs of children with Post Traumatic Stress Disorder (PTSD) symptoms, depression, behavior problems, and other difficulties related to traumatic life experiences.
3. *Community Implemented Programs for At-Risk Middle School Students*: Community organizations will be contracted to provide programs for at-risk middle school students. The goal of each program will be to enhance the resiliency of children in order to promote mental wellbeing, positive development and prevent them from engaging in high-risk behaviors such as substance use, early sexual activity, or violence.
4. *Adverse Childhood Experience (ACE)*: Shasta County Mental Health will participate in the Prevent Team's effort to decrease ACE and effectively serve children and families dealing with ACE. Shasta County Mental Health's participation will include the utilization of PEI and Prevent Team efforts to identify and coordinate current resources addressing ACE and provide assistance in the development of infrastructure for effective evidence-based practice implementation across community settings.

Project Strategies

Strategy 1: Triple P

- a. Shasta County will coordinate with and leverage the efforts of First 5 Shasta to create a county-wide Triple P implementation. The Triple P-Positive Parenting Program is a multi-level, parenting and family support strategy that aims to prevent severe behavioral, emotional and developmental problems in children by enhancing the knowledge, skills and confidence of parents. Triple P incorporates five levels of intervention of increasing strength for parents of children from birth to age twelve. Triple P interventions can also be tailored in such a way as to respect and not undermine the cultural values, aspirations, traditions and needs of different ethnic groups. It has been proven effective for use with various underserved geographic and cultural populations.

- Level 1: a universal parent information strategy provides parents with access to information about parenting through a coordinated media and promotional campaign using print and electronic media. This level of intervention aims to increase community awareness of parenting resources, to encourage parents to participate in programs, and to create a sense of optimism by depicting solutions to common behavioral and developmental concerns.
 - Level 2: is a brief, 1 or 2-session intervention providing anticipatory developmental guidance to parents of children with mild behavior difficulties, with the aid of user-friendly parenting tip sheets and videotapes that demonstrate specific parenting strategies.
 - Level 3: a 4-session intervention, targets children with mild to moderate behavior difficulties and includes active skills training for parents.
 - Level 4: is an intensive 8 to 10-session individual, group or self-help parenting program for parents of children with more severe behavior difficulties.
 - Level 5: is an enhanced behavioral family intervention program for families where parenting difficulties are complicated by other sources of family distress (e.g. relationship conflict, parental depression or high levels of stress).
- b. County-wide implementation of Triple P will be accomplished in the following ways:
1. *Community Capacity Building via Training*: Shasta County Mental Health will provide Triple P training to clinicians, paraprofessionals, parent partners, home visitors, various types of family service providers, medical staff, etc. Training and materials for Triple P levels 2 – 5 will be provided free of charge to key professionals who serve the Project's target population and agree to Project requirements, fidelity guidelines and evaluation protocol. Biannual implementation meetings will be held for Triple P providers to discuss challenges and barriers to implementation, review fidelity and evaluation reports and share experiences with Triple P implementation. On-going technical assistance for each Triple P provider will also be offered by Shasta County Mental Health.
 2. *Contract Clinician*: Shasta County Mental Health will contract with a clinician to provide services dedicated to the needs of children 0 – 5 years of age exhibiting early sign and symptoms of a mental disorder. The clinician will be used to support local programs that serve the target population using a family engagement and consultative model. The role of the clinician will be to increase family engagement by providing assessments of identified target population children, comprehensive service planning regarding needs identified by the family, and parenting support activities including Triple P.
 3. *Fund Matching*: Shasta County Mental Health will provide matching funds (EPSDT/Medi-Cal) for eligible services provided by contract providers using Triple P level 4 and 5. (see budget and budget narrative)
 4. *Triple P Level Implementation*: Triple P will be established in the community by first providing the more intensive levels (4/5) of Triple P service and then the less intensive levels (2/3). This sequence of implementation is preferred by the program developer. First clinicians will be trained in levels 4 and 5. Then paraprofessionals, parent partners, and the like will be trained in levels 2 and 3. When this is accomplished, Level 1 will be

implemented. This level of intervention will increase the community's awareness of Triple P parenting resources and encourage parents to participate in Triple P programs.

Milestones and Timelines for Implementation

- Within 6 months after a contract has been signed with Shasta County, 20 clinicians will be trained to provide Triple P levels 4 and 5 services and a clinician will be contracted.
- Within 12 months, Triple P training for levels 2 and 3 will be provided for 20 providers and a Triple P implementation meeting will be held.

Intended Outcomes

- See Form 7: This Project was selected for Local Evaluation

Strategy 2: Trauma Focused Cognitive Behavioral Therapy

a. Many children in our target population have experienced traumatic experiences such as various forms of child abuse that can negatively affect their mental wellbeing. In an effort to meet the Project aim of supporting at-risk children and their families and also to integrate trauma into mental health services, community clinicians will be trained to provide TF-CBT services. TF-CBT is a short-term treatment approach (12 sessions) that addressed the unique needs of children with PTSD, depression, behavior problems, or other difficulties related to traumatic life experiences. This evidence-based practice is a components-based psychosocial treatment model that incorporates elements of cognitive-behavioral, attachment, humanistic, empowerment, and family therapy models. It includes several core treatment components designed to be provided in a flexible manner to address the unique needs of each child and family. There is strong scientific evidence that this therapy works in treating trauma symptoms in children, adolescents, and their parents. TF-CBT fosters cultural competence and has been used to successfully reduce PTSD and other difficulties in children from many different cultural backgrounds. Strategy 2 is an integral piece of Project 1's interrelated strategies and will:

- Increase the number of local clinicians trained to provide TF-CBT
- Increase the number of child and families who receive TF-CBT

b. Implementation of this Strategy will include:

1. *TF-CBT Awareness Activities:* Various means of communication will be used to inform the public and private sector about TF-CBT and its need and uses in the community. We will also hold a Pre-implementation workshop that will be used to inform the community, local therapists, and organizations including those serving underserved cultural populations about TF-CBT. The workshop will be advertised locally and invitations will be sent to local clinicians, and organizations who service at-risk children. The workshop will provide information about ACE, local data involving ACE, information regarding trauma and its effects on children, and an in-depth look at TF-CBT. Participants will also be asked to provide input regarding Project implementation.
2. *Recruitment of Key Professionals:* Clinicians who are interested in being trained to use TF-CBT will be invited to participate in the implementation of PEI Project 1. Each clinician will be required to meet certain requirements and obligations.
3. *Training of Key Professionals:* Clinicians who agree to the terms of PEI Project 1 will be trained to implement TF-CBT. They will be required to complete the web-based training, live training, and

ongoing expert consultation. Each clinician will also be required to meet fidelity and evaluation guidelines. Shasta County Mental Health will provide each clinician with the training and materials needed for implementation and evaluation of TF-CBT services.

4. *Support and Monitor Implementation:* Shasta County Mental Health will contract with a TF-CBT expert clinician to provide technical assistance to each trained clinician. We will also hold two mandatory meetings annually to gather TF-CBT providers together. The purpose of the meetings will be to support clinicians, discuss challenges and barriers to implementation, review fidelity and evaluation reports and share experiences with TF-CBT.
5. *Refer to TF-CBT Services:* Once TF-CBT clinicians are trained and ready to provide services, community-based organizations that serve at-risk children and families and organizations that refer consumers to each clinician and county mental health will be informed. A list of TF-CBT providers will also be available on the Mental Health website and on our Network of Care.

Milestones and Timeline for Implementation

- Within 3 months after a contract has been signed with Shasta County, TF-CBT Awareness activities will be complete.
- Within 6 months, at least 20 clinicians will be recruited for TF-CBT training and will begin their web-based training.
- Within 12 months, at least 20 clinicians will be trained to provide TF-CBT services and appropriate referral sources will be made aware of the service availability.

Intended Outcomes

- See Form 7: This Project was selected for Local Evaluation

Strategy 3: Community Programs for At-Risk Middle School Students

- a. During the transition from middle school to high school, adolescents frequently establish patterns of behavior and make lifestyle choices that affect both their current and future mental wellbeing. This is especially true for children and youth in stressed families or in underserved populations. For example, according to statistics many local youth begin to increase risk taking behaviors between middle school and high school. For example, when comparing 7th grade California Health Kids Survey results from 2004 with 9th grade survey results in 2006, the use of at least one drink of alcohol doubled, binge drinking and the use of marijuana almost tripled. Evidence supports the idea that a prevention or early intervention approach that targets mental health during the adolescent years is both an appropriate and effective response, with both short-term and life span benefits.
- b. Shasta County Mental Health will contract with community-based organizations to provide prevention and early intervention programs to at-risk middle school students from stressed families who either live in an underserved geographic location or are a member of an underserved cultural population. Research shows that the programs that are most effective at promoting positive outcomes for youth are framed in terms of the constructive assets they seek to build, rather than only negative behaviors they seek to avoid. With this in mind, the purpose of each program will be:
 - increase program participants' positive coping skills and psychosocial development
 - enhance the resiliency of children in order to promote mental wellbeing and other protective factors
 - support at-risk middle school students and their families in addressing risk factors
 - increase program participant's linkage to other needed and appropriate services in the community

- decrease program participants' engagement in high-risk behaviors such as substance use, violence or sexual activity
- c. Shasta County Mental Health will issue a Request for Proposal (RFP) seeking community-based organizations that can provide programs for at-risk middle school students. The programs provided must be either evidence-based or a promising practice that have been proven effective for program goals and include fidelity and evaluation measures. Using community-based organizations to provide programs increases access to programs within communities that are provided by community members.

Milestones and Timelines for Implementation

- Within 3 months after a contract has been signed with Shasta County, a RFP will be completed
- Within 6 months, PEI contracts will be awarded
- Within 12 months, program providers will report on program effectiveness and participant outcomes using program fidelity and evaluation tools

Intended Outcomes

- See Form 7: This Project was selected for Local Evaluation

Strategy 4: Adverse Childhood Experience

- a. Child abuse has been found repeatedly to be a major risk factor for many mental health disorders, emotional problems, behavior difficulties, substance abuse, delinquency, and health problems. Many children in Shasta County will suffer long term emotional consequences of maltreatment in childhood, including depression, anxiety disorders, posttraumatic stress disorder, alcohol or drug abuse, and relationship problems. These problems often lead to more subtle effects on behavioral choices in childhood and adolescence that shape later adult life styles and produce long term health impacts. Despite tremendous efforts for prevention and intervention, child abuse remains the most common type of major childhood trauma today, and its impact is pervasive in society. In Shasta County, there are approximately 3000 children referred to Children and Family Services every year for suspected maltreatment. Shasta County's rate of substantiated child maltreatment is twice that of California's rate.
- b. In an effort to decrease child maltreatment rates and better serve the children and families that deal with ACE, Shasta County Mental Health will participate in the PREVENT Team's project. The PREVENT Team was selected to participate in the "2008 PREVENT Maltreatment Institute: Enhancing Leadership in Child Maltreatment Prevention". The team is made up of leaders from the following organizations:
- Maternal and Child Health Program/Public Health
 - Health and Human Services Agency
 - Child and Youth Services/Mental Health
 - Children and Family Services
 - Shasta County Child Abuse Prevention Coordinating Council
 - First 5 Shasta
- c. Shasta County Mental Health's participation will include:
1. *ACE Community Collaboration*: Shasta County Mental Health will participate in an ACE Community Collaborative. The initial members of the Collaborative will be the PREVENT Team. Then we will work to actively involve other concerned professionals from a wide range

of different sectors, geographic regions, and cultural groups who have experience in dealing with relevant ACE protective and risk factors. Special efforts will be made to bring in agencies and community groups not traditionally considered as connected with ACE, but whose activities can have a significant impact on the protective and risk factors. The purpose of convening this group will be to:

- identify and coordinate current and future ACE resources
- increase community's capacity to ensure linkage to quality, effective and appropriate services
- increase the number and quality of linkage and coordination relationships with organizations and systems that deal with ACE
- develop county-wide procedures to improve access to services for children and families
- create united Collaborative objectives that include county-wide outcomes

2. *PEI Evidence-Based Practice (EBP) Coordination, Implementation and Monitoring:* Shasta County Mental Health will be responsible for the coordination, implementation and monitoring of all EBP's in the PEI plan (see above). Because the use of best practices are new to many of the organizations serving children and their families, this activity will help to develop a system and infrastructure to support the dissemination of best practices in Shasta County.

Milestones and Timelines for Implementation

- Within 6 months after a contract has been signed with Shasta County, the ACE Community Collaborative will be organized and ready to begin meeting.
- Within 12 months, the ACE Community Collaborative will have an established membership and regular meeting times. The Collaborative will be working on objectives described above.

Intended Outcomes

- See Form 7: This Project was selected for Local Evaluation

Programs

Program Title	Proposed number of individuals or families through PEI to be served through June 2010		Number of months in operation through June 2010
	<i>Prevention</i>	<i>Early Intervention</i>	
Triple P	Individuals: Families: 150	Individuals: Families: 150	12
Triple P Clinician for 0-5 At-Risk Population	Individuals: Families:	Individuals: Families: 45	12
TF-CBT	Individuals: Families:	Individuals: 100 Families:	12
Programs for At-Risk Middle School Students	Individuals: Families:	Individuals: 100 Families:	12
ACE Activities+	Individuals: Families: 150	Individuals: Families: 195	6
Total PEI Project Estimated Unduplicated Count of Individuals to be Served	Individuals: Families: 150	Individuals: Families: 350	

Decrease Disparities in Access

Providing culturally competent and appropriate programs:

- To help assure that activities in the Shasta County's PEI Plan are culturally competent and meeting cultural community needs, a meeting will be held at least three times a year between the Shasta County Mental Health PEI Coordinator, the PEI Community Education Specialist, and Community Health Advocates (CHA). CHAs are respected members of cultural communities that are responsible for the following services:
 - *Community Outreach:* disseminate health education information and teach basic health practices; relay and discuss findings on health needs and cultural attitudes of the community to HHSa departments; represent HHSa staff on selected community organizations and committees; act as catalyst for culturally appropriate problem solving through community networks to reduce health access barriers; collaborate in the development of culturally attuned services and outreach strategies; and act as liaison between community and HHSa for improved service delivery.
 - *Referral Based Follow up Activities:* support the work of the HHSa Nurses; provide appropriate consumer based interventions and follow up to improve identified health problems according to HHSa Nurse referrals and guidance; clarify professional and medical instructions to community and referred consumers; track and locate consumers in support of HHSa Nurse follow up care; facilitate community and consumer coordination of HHSa Services with other appropriate services; and facilitate culturally competent follow up especially with high risk consumers.
 - *Community Organizing:* may conduct and maintain needs assessment and resource inventory for community; may generate networks and effective community advisory groups to motivate positive health related change in the community and in health care services.
 - *Interpret/Translate:* may translate on behalf of consumers when no alternative translator is available and will perform other duties as assigned
- Meetings will be 2 hours in length and include a brief mental health lesson and dialogue between PEI staff and Community Health Advocates. The dialogue will be used to:
 - determine the technical assistance needs of CHAs so they will be better able to serve their communities regarding mental health issues
 - establish mental health training needs of CHAs
 - allow CHAs the opportunity to discuss the mental health issues, concerns, and needs of the communities they serve, to help better connect Mental Health services to those communities in a culturally competent and effective way.
 - review PEI Plan activities to discuss specific communities needs, for instance cultural norms to be aware of, program locations that would be appropriate, etc.

- Current client demographic data and US Census Bureau data demonstrates that members of minority cultural populations do not experience increased disparities in access to public mental health services provided by Shasta County (see page 8). Project 1 strategies were selected as a way to provide culturally competent services to the ethnic and cultural populations of Shasta County in appropriate community settings.
- Strategy 1 and 2 will include training key professionals from ethnic/cultural organization and organizations that service diverse clientele such as organizational providers in regional areas, faith-based organizations and parent partners. In Shasta County, individuals who live in rural areas are among our most underserved. Both strategies were selected because they demonstrated effectiveness in rural areas. Providers who serve in rural areas and cultural populations will be targeted for participation in training for both strategies.
- Strategy 3 will use community-based organizations to provide programs that specifically target youth who are underserved due to geographic location or inclusion in an ethnic/cultural group. The RFP will only be awarded to organizations that can demonstrate cultural competence and/or will be providing a program that has demonstrated effectiveness with the population they intend to serve.
- Strategy 4 will create an ACE Community Collaborative that includes members of underserved cultural populations and represent ethnic/cultural coalitions, organizations and/or service providers. During our efforts to identify and coordinate current community resources addressing ACE, particular attention will be paid to services provided to rural and ethnic populations.

Facilitating access to PEI programs:

- Increased outreach, engagement and services for Children and Youth in Stress Families will help overcome some of the barriers to accessing services.
- The practices selected for implemented in this Project have evidence of their effectiveness with various cultural and geographic populations.
- Training culturally competent key professionals throughout the county and from various locations and cultures helps to ensure services to underserved cultural populations as well and underserved areas of our County. Examples of providers include bilingual providers, providers who's clientele include a large percentage of individuals from specific populations or providers from local Rancherias and Federally Qualified Health Clinics.
- Training key professionals who naturally come in contact with families from various cultures helps increase the likelihood of engagement. Children and their families may feel more comfortable with individuals they are already familiar with. Facilitating access to PEI programs in natural community setting helps to decrease disparities in accessing mental health services in community such as Shingletown, Burney, Fall River Mills and Cottonwood.
- Using community-based organizations to provide programs to at-risk middle school students from underserved populations allows for easier access to programs within their own community and provided by members of their community.

Improving individual outcomes of participant in PEI programs:

- Training culturally appropriate key professionals throughout the county and from various locations and cultures increases the likelihood of successful identification, engagement and follow through on linkage/referrals. It also increases the probability of the families' satisfaction with services provided.
- By creating an ACE Community Collaborative we aim to improve individual outcomes for children in our community by decreasing the rate of child maltreatment and better serving families currently in need of

services. This problem disproportionately affects families with low socio-economic status who often face challenges in accessing services.

Linkage To County Mental Health and Providers of Other Needed Services

- Strategy 1 and 2 will first link key professional to continuing educational opportunities which will increase the community's capacity to service children and youth in stressed families. Then families who are in need of parenting support or treatment for exposure to trauma will be linked to professionals who can provide evidence-based services. By leveraging other efforts in the community these services will be available county-wide and in various intensity levels. This implementation will allow for appropriate level services for each family in need. If a family in lower level services are in need of more intensive interventions those will be available to them locally.
- Strategy 3 will link at-risk middle school students to programs that can increase each child's linkage to positive adult and peer relationships within their community. Program implementation will allow group leaders to become familiar with each participant and their family. If the program leader believes that the participant or their family is in need of other service they will be required to offer help to link them to other needed services.
- All Project intervention providers including clinicians being trained and contracted community-based organizations will be made aware of the transformational concepts inherent in MHSA and PEI. They will also be asked to help link all Project participants to other appropriate services such as housing, education, employment, food, etc.
- Strategy 4 will create links between systems that address ACE. This integration will create webs of appropriate service delivery for the families in need. This will also help families link with services that address risk factors that affect the rate of ACE. Services such as basic needs; employment, housing, food, parenting support classes or substance abuse counseling.

Collaboration and System Enhancement

- Project 1 Strategies 1 and 2 directly align with local Shasta County Mental Health EPSDT data for individuals served by Children and Youth Services. According to local statistics, a large percentage of children served have a diagnosis of ADHD, PTSD or Oppositional Defiant Disorder. Triple P and TF-CBT are both evidence-based practices that have the potential to greatly enhance Shasta County Mental Health's and community provider's capacity to appropriately and effectively serve these children and their families.
- Project 1 Strategy 1 includes collaboration with First 5 Shasta. Collaboration and leveraging of training funds will allow for county-wide implementation of the Triple P Positive Parenting Program. Initial training investments will start high and dramatically drop in subsequent years. After the initial implementation investment, training costs will include new providers and organizational turnover. Training of professionals through-out the County is a cost effective and sustainable approach to program implementation. Funding training and material costs for community providers dramatically increases the community's capacity to implement Triple P in various community settings for minimal costs due to leveraging.
- This Project will enhance the quantity and quality of cooperative relationships with other organizations and systems that serve Children and Youth in Stressed Families. Providing training for Project interventions to key professionals from community organizations develops relationships to improve access for referred individuals.

- The focus of parents as change agents for their children helps address attitudes that shame and blame parents. This Project aims to create a system of support and skill building. It can enhance the knowledge, skills and confidence of each parent and in turn can have a significant positive impact on rates of child maltreatment.
- Many children and adolescents experience trauma and although some children demonstrate extraordinary resilience in the aftermath of these experiences, many have significant distress or develop psychological difficulties that can be serious or long lasting. This project will bring systems together to address and treat the effects of trauma and ACE. This focus will not only enhance the community's knowledge of these issues, it will also help us collaborate to better address and service Children and Youth in Stressed Families.
- An aim of Strategy 4 is to create and/or enhance links between systems and programs so services addressing ACE will reflect integration among agencies, organizations and individuals providing prevention, intervention and postvention services.

Coordination with MHSA

- The Mental Health Services Advisory Committee will continue to be used to advise, monitor and provide input and feedback on all MHSA components.
- This project includes activities aligned with those proposed by the California Department of Mental Health's PEI Statewide Projects guidelines. Shasta County will use a portion of its PEI statewide allocation to partially fund these activities.

Form No. 7

PEI Project Name: Project 1 - Children and Youth in Stressed Families

Identify the programs the county will evaluate and report on to the State.

All four implementation strategies for Project 1 will be included in our local evaluation. They include:

- Triple P-Positive Parenting Program
 - Evidence-based Practice
- Trauma-Focused Cognitive Behavioral Therapy
 - Evidence-based Practice
- Community Implemented Programs for At-Risk Middle School Students
 - Evidence-based or Promising Practice
- Adverse Childhood Experience

Explain how this PEI Project and its programs were selected for local evaluation.

- *Relevance and Importance of Programs:* This project was developed in direct response to the overwhelming input provided by stakeholders to serve children and their families. When stakeholders were asked to rank, in order of importance, the Prevention and Early Intervention priority populations and key mental health needs, the obvious frontrunners were children and youth in stressed families, and increasing prevention efforts and response to the early signs of emotional and behavioral health problems among at-risk children, youth, and young adult populations. Stakeholders also ranked family dynamic aspects such as positive child/adult relationships and child abuse or neglect as the most important protective and risk factors to address. Program selection and activities are also directly based upon input from stakeholders regarding the types of PEI services and supports they believe were needed in our community. It is likely to have measurable results that can have profound effects upon individuals and the community.
- *Clarity of the Outcomes:* This Project was also selected because it has the potential to have the most clearly defined outcomes. Outcome clarity will be achieved by using evidence-based or promising practice for three of the four implementation strategies. These strategies have been identified as approaches to preventing and treating mental and/or substance use disorders and have been scientifically tested. Each program includes fidelity and evaluation materials. These materials will be used to determine the effectiveness of local implementation.
- *Extent of Devoted Resources:* Project 1 was developed in direct response to the stakeholder's priorities and will therefore receive the greatest amount of funding. Each program was also carefully selected to leverage current community interventions and funding. Strategy 1 will leverage the efforts of First 5 Shasta to create a county-wide implementation of Triple P. First 5 Shasta has funded training, materials, support, and evaluation of Triple P in county Head Start programs. Strategies 1 and 2 will leverage the expertise and time of key professionals from local organizations. They will be trained free of charge to deliver Triple P and TF-CBT services. This will allow for greater access to these services in natural locales throughout the Shasta County. Strategy 3 will work with local community-based organizations to provide programs for at-risk middle school students. This will allow program funds to serve more participants in underserved geographic and cultural populations. Strategy 4 will leverage effort from each system involved in the ACE Community Collaborative. The products created in Strategy 4 will also have the potential to bring greater funding into the community to address ACE.

- *Capacity of Partner Organizations:* Organizations involved in Strategies 1 through 3 will be using evidence-based practices. They will all be required to demonstrate fidelity to program implementation. Each program includes fidelity checklists. Individuals who deliver services will use these fidelity checklists to monitor their service delivery. Each program also includes evaluation tools. Some of the evaluation tools will be used to determine the effectiveness of program implementation and participant's satisfaction with the service. Strategies 1 and 2 include implementation meetings that will be used to gather fidelity and evaluation data. Shasta County's Outcomes Planning and Evaluation staff will gather data and information from each program. The information will be compiled and the results will inform the implementation process and be used to monitor and increase program effectiveness. A Memorandum of Understanding (MOU) will be signed by all key professionals who receive program training and materials. Part of the MOU will address the expectations in relation to fidelity and evaluation.

Persons to Receive Intervention

Population Demographics	Priority Populations						
	Trauma	First Onset	C/Y Stressed Families	C/Y School Failure	C/Y Juv. Justice	Suicide Prevention	Stigma & Discrimination
Ethnicity/Culture							
African American				4			
Asian/Pacific/Islander				15			
Hispanic				48			
Native American				15			
Caucasian				418			
Other							
Age Groups							
C/Y (0 – 17)				200			
TAY (16 – 25)							
Adult (18 – 59)				300			
Older Adult (>60)							
Total							
Total PEI project estimated unduplicated count of individuals to be served >500							

What are the expected individual level and program/system level outcomes for each program?
 How will achievement of the outcomes and objectives be measured?
 What outcome measurements will be used and when will they be measured?

Strategy 1: Triple P

- Individual
 - Level 2/3 Training Participants
 - Upon completion of training, participants will have knowledge and skills in the following areas:
 - early detection and effective management of child behavior problems
 - core principles of positive parenting and behavior change
 - specific positive parenting strategies for promoting children's development
 - responding to parents questions and effective parent consultation
 - identification of indicators suggesting more intervention is required and appropriate referral procedures

- Level 4/5 Training Participants
 - Upon completion of training, participants will have knowledge and skills in the following areas:
 - early detection and effective management of child behavior problems
 - risk and protective factors operating within families
 - core principles of positive parenting and behavior change
 - advanced assessment of child and family functioning
 - application of key parenting strategies to a broad range of target behaviors
 - strategies for promoting generalization and maintenance of behavior change
 - identification of indicators suggesting more intervention is required
 - appropriate referral procedures
 - specific strategies for improving personal coping skills and reducing parenting stress, anxiety, and depression
 - reducing parenting conflict, improving parents' communication skills and promoting partner support
 - the delivery of interventions targeting additional risk factors, including anger management training and cognitive restructuring skills

- These outcomes will be measured:
 - at the end of training using a Triple P assessment tool
 - 8 – 12 weeks after initial training, each training participant will also be required to participate in a 1 day accreditation workshop. Participants will be required to:
 - Prepare core practitioner competencies for demonstration via role play
 - Participate in a feedback process with the Triple P trainer regarding strengths and goals for change
 - at each biannual meeting, training participants will be required to turn in Triple P fidelity checklists and program evaluation results.

- Parents who receive Triple P services will:
 - Increase the five core positive parenting principles. The use of these principles will address specific risk and protective factors known to predict positive developmental and mental health outcomes in children:
 - Ensuring a safe and engaging environment
 - Creating a positive learning environment
 - Using assertive discipline
 - Having realistic expectations
 - Taking care of oneself as a parent

- These outcomes will be measured using evaluation tools developed and provided by Triple P. Each Triple P provider will be responsible for having parents complete appropriate evaluation tool(s). Program evaluation results will be gathered from Triple P providers at biannual meetings.

- Program/System
 - enhance capacity of local organizations, including those that serve cultural population and rural communities, to provide Triple P program services
 - Outcome will be measured by: the number and demographic information of individuals and organizations that have certified Triple P providers. This will be compiled using training documentation.
 - increase in the number of families, including members of cultural populations and rural communities, who receive Triple P program services
 - Outcome will be measured by: the number and demographics of families served by Triple P providers trained by Shasta County Mental Health. This information will be gathered at biannual meetings.
 - increase the development of non-violent, protective and nurturing environments for children
 - Outcome will be measured by: the use of evaluation tools developed and provided by Triple P. (see above)
 - reduce the incidence of child maltreatment
 - Outcome will be measured by: tracking referrals to Children and Family Services and confirmed cases of child maltreatment with in Shasta County. This information will be gathered every 6 months.

Strategy 2: TF-CBT

- Individual
 - TF-CBT Training Participants
 - Upon completion of training, participants will have knowledge and skills in the following areas:
 - psycho-education
 - stress management
 - affect expression and modulation
 - cognitive coping
 - creating the trauma narrative
 - cognitive processing
 - behavior management
 - parent – child sessions
 - These outcomes will be measured:
 - at the end of web-based and live training using a TF-CBT assessment tool
 - at each biannual meeting, training participants will be required to turn in TF-CBT fidelity checklists and program evaluation results.
 - Individuals who receive TF-CBT services
 - Improvement in:
 - PTSD symptoms
 - depression
 - negative attributions (such as self-blame) about the traumatic event
 - defiant and oppositional behaviors
 - anxiety
 - These outcomes will be measured by: using an evaluation tool developed and provided by TF-CBT. Each TF-CBT provider will be responsible for completing appropriate evaluation tool(s) to

monitor treatment outcomes. Program evaluation results will be gathered from TF-CBT providers at biannual meetings.

- Program/System
 - increase community's capacity to provide appropriate services for children and youth who have experienced traumatic events.
 - Outcome will be measured by: the number of individuals and organizations who have certified TF-CBT providers. This will be compiled using training documentation.
 - increase the number of children and youth who have experienced traumatic events who received appropriate services.
 - Outcome will be measured by: the number of families served by TF-CBT providers trained by Shasta County Mental Health. This information will be gathered at biannual meetings.

Strategy 3: Community Implemented Programs for At-Risk Middle School Students

- Individual
 - increase program participants' positive coping skills and psychosocial development
 - enhance the resiliency of children in order to promote mental wellbeing and other protective factors
 - support at-risk middle school students and their families in addressing risk factors
 - increase program participant's linkage to other needed and appropriate services in the community
 - decrease program participants' engagement in high-risk behaviors such as substance use, violence or sexual activity
- These outcomes will be measured by: using evaluation tools developed and provided by the evidence-based or promising practice selected by the program provider. Each program provider will be responsible for completing appropriate evaluation tool(s) to monitor intervention outcomes. Program evaluation results will be gathered from program providers twice a year.
- Program/System
 - increase in the number of prevention programs and early intervention activities in the community.
 - Outcome will be measured by: the number of organizations who provide services via this strategy. This will be compiled using RFP documentation.
 - increase in the number of individuals who receive prevention and early intervention services.
 - Outcome will be measured by: the number of middle school students served by program providers funded by Shasta County Mental Health. This information will be gathered twice a year.

Strategy 4: Adverse Childhood Experience

- Program/System
 - enhanced quantity and quality of cooperative relationships with other organizations and systems including enhanced partnering with ethnic/cultural organizations
 - Outcome will be measured by: membership and activity records of the ACE Community Collaborative and record of local efforts and funds dedicated to ACE issues.

- increase community's capacity to ensure quality and effective linkage to appropriate services and develop county-wide procedures to improve access to services for children and families
 - Outcome will be measured by: ACE Community Collaborative membership and records of their service delivery modifications and referral summaries.
- reduce the incidence of child maltreatment
 - Outcome will be measured by: tracking referrals to Children and Family Services and confirmed cases of child maltreatment with in Shasta County. This information will be gathered every 6 months.

How will data be collected and analyzed?

Strategies 1 through 3: Project service providers will be required to collect program evaluation data using program specific fidelity and evaluation tools. This data will be collected quarterly, at a minimum. Shasta County's Health and Human Services Agency Outcome Planning and Evaluation staff will be responsible for compiling all data. They will generate summary reports that will include findings for individual, program and system outcomes. This data will also be used to support and guide providers. Individual and group reports will be distributed to providers bi-annually. This will help support implementation, guide changes, and reinforce successes. A yearly report will be compiled for the Project to demonstrate system changes over time.

Strategy 4: Data will be gathered from ACE Community Collaborative members. Data collection will initially depend upon information and evaluation tools that are currently available. If gaps in information exist, we will work with appropriate local agencies to gather additional data.

How will cultural competency be incorporated into the programs and the evaluation?

Strategies 1 through 3 are all evidence-based or promising practices that have been tested effective for a broad range of cultural groups. Materials and evaluation tools are also available for many languages. Cultural competency for providers is also directly addressed within training modules for both Triple P and TF-CBT. Community-based organizations that apply for funding for Strategy 3 will be required to demonstrate cultural competence and will be reviewed by a member of our Cultural Competence Committee.

Strategy 4 will include collaborative relationships with other organizations and systems including partnering with ethnic/cultural organizations.

What procedure will be used to ensure fidelity in implementing the model and any adaptation(s)?

Strategies 1 through 3 are all evidence-based or promising practices that include fidelity measures. Program providers will be required to meet all fidelity guidelines including filling out fidelity checklists provided by each practice. Fidelity in implementation will be addressed and monitored at each biannual meeting.

How will the report on the evaluation be disseminated to interested local constituencies?

PEI Progress reports will be given monthly to both the Mental Health Services Act Advisory Committee and the Shasta County Mental Health Board. Reports will include summaries of project evaluations. When local implementation of more MHSA components begins, we will start an MHSA newsletter that will include MHSA news, schedules, progress reports, and impact information. A yearly report of PEI evaluations will also be available on the Mental Health Website.

Project 2: Older Adults

PEI Project Name: Older Adults

PEI Key Community Mental Health Needs	AGE Group			
	Children/Youth	TAY	Adult	Older Adult
Disparities in Access to Mental Health Services				
Psycho-Social Impact of Trauma				X
At-Risk Children, Youth and Young Adult Populations				
Stigma and Discrimination				
Suicide Risk				

PEI Priority Population(s)	AGE Group			
	Children/Youth	TAY	Adult	Older Adult
Trauma Exposed Individuals				X
Individuals Experiencing Onset of Serious Psychiatric Illness				
Children and Youth in Stressed Families				
Children and Youth at Risk for School Failure				
Children and Youth at Risk of or Experiencing Juvenile Justice Involvement				
Underserved Cultural Populations				

Stakeholder Input and Data Analysis

PEI Stakeholder Information:

- During the Stakeholder Input process, community members were asked to rank, in order of importance, the Prevention and Early Intervention Priority Populations and Key Mental Health Needs. They were also asked to rank Protective Factors, Risk Factors, and Negative Outcomes that may result from untreated mental illness (W&I Code, Division 5, Part 3.6, section 5840 d). Their results included:
 - *Priority Population:*
 - #2 ranking: Trauma-exposed individuals
 - *Key Mental Health Needs:*
 - #2 ranking: Reduce disparities in access to mental health services
 - #3 ranking: Reduce the negative psycho-social impact of trauma on all ages
 - *Protective Factors:*
 - #2 ranking: Sense of belonging
 - *Risk Factors:*
 - #2 ranking: Alcohol and other drug use
 - *Negative Outcomes:*
 - #1 ranking: Suicide

- During in-depth discussions with focus groups, key informants and the Older Adult Policy Council, it was determined that of the high ranking priorities listed above all are related to the concerns for our Older Adult population. For example, Shasta County has a high rate of Older Adult suicide. Many isolated seniors suffer from depression and trauma surrounding the loss of loved ones, independence, physical health, etc. This group also has a high rate of substance abuse problems.
- The Older Adult Policy Council (OAPC) participated in general stakeholder input opportunities. They were also part of a special focus group session regarding the types of mental health services and supports Older Adults need. The focus group results include ten categories:
 - Integrated System of Care
 - Risk Identification
 - Person-centered Service Coordination
 - Peer and Community Outreach and Support
 - Advocating for Policy Changes to Preserve Independence
 - Socialization Opportunities
 - Medication Management
 - Prevention Support Services
 - Public Awareness and Education
 - Financial Management and Support
- Stakeholders suggested the use of the following PEI strategies to serve Older Adults
 - Train non-traditional gatekeepers that come in contact with isolated Older Adults
 - Prompt assessments and referral
 - Mental health integrated with medical services

CSS Stakeholder Information:

- During the Stakeholder Input process for CSS, the following PEI information was collected:
 - *Difficulty Maintaining Independence:*
 - All of the challenges faced by rural residents, including a lack of early intervention or treatment services, lack of transportation, social and physical isolation are magnified for older adults who are vulnerable.
 - Isolation and lack of a service system specific to older adults has led to a lower seeking of treatment by older adults with mental illness.
 - Redding has a high number of nursing homes that are the primary method of delivering care to older adults. Support services to permit older adults to maintain themselves at home are limited.
 - *Frequent Medical Care and Hospitalization*
 - Co-occurring disorders affect a significant number of older adults and result in severe health problems.
 - There is insufficient coordination of services and case planning between the mental health and health systems.
 - *Isolation*
 - Many individuals who move to rural areas upon retirement face the challenges of aging and illness, including mental illness, separated from family and friends, with higher demands and fewer physical and fiscal resources for the necessities of daily life.

- *Access Barriers*
 - Long waits for services, paperwork requirements, and systems that can be confusing for Older Adults and sometimes not welcoming.
 - Lack of transportation
 - Lack of financial resources and insurance
 - Lack of knowledge about available services
 - Stigma

Data: PEI Community Mental Health Assessment (attachment)

- Promoting Community Wellbeing – Social Support/Social Capital/Network of Meaningful Relationships: pp 3 – 7
- Preventing Mental Disorders – Elder Abuse: p 12
- Prevalence of Mental Illness / Suffering: pp 16 - 19
- Prevalence of Alcohol and Other Drug Abuse: pp 20 – 31
- Early Intervention: Help Seeking Behavior/Access to Mental Health Treatment: pp 32 - 37
- Outcomes that May Relate to Mental Illness – Prolonged Suffering/Suicide: pp 38 - 40

Data: Examples of Other Sources

- *Consensus Statement on the Upcoming Crisis in Geriatric Mental Health (Jeste et al, 1999):*
 - It is estimated that by 2030, more than 15 million older adults will experience a mental illness.
 - One-quarter of today's older adults experience some mental disorder.
 - In general, older adults with mental illnesses experience high medical comorbidity.
 - Older adults with significant depression have total health care costs that are roughly 50 percent higher than those without depression
 - Compared to other age categories older adults have the highest suicide rate in the country.
- *Older Adult Policy Council's Older Adult Population Report*
 - The living arrangements of older adults are important indicators because they are linked to income, health status, and the availability of caregivers. Older people who live alone are more likely than older people who live with their spouses to be in poverty. There are 17,345 households or 27.3% of the total households with individuals aged 65 and over. A total of 10% of all households have someone aged 65 and older who is living alone.

OLDER ADULT POPULATION BY AGE and SEX					
Years of Age	SHASTA COUNTY				% of California in Population Age Group
	Males	Females	Total Population	% of Shasta Population	
All Ages	79,572	83,684	163,256	100.0	100.0
55-59	4,673	4,865	9,538	5.8	4.3
60-64	3,657	3,869	7,526	4.6	3.4
65-69	3,176	3,513	6,689	4.1	2.9
70-74	2,840	3,400	6,240	3.8	2.7
75-79	2,452	3,028	5,480	3.4	2.3
80-84	1,420	2,157	3,577	2.2	1.5
85+	927	1,948	2,875	1.8	0.8

Project Summary

- Shasta County Mental Health will partner with the Older Adult Policy Council to develop and implement a community Gatekeeper Program for Older Adults. Project 2 will target vulnerable and isolated Older Adults who are in need of assistance due to trauma such as loss of key relationships, valued roles, physical and/or mental health, independence, etc. They may possibly be at-risk for suicide or serious mental illness. The goal of this project is to reduce the negative consequences of isolation, trauma and untreated serious mental illness for Older Adults by identifying, referring and linking them to services as quickly and effectively as possible.
 - The Gatekeeper Program will be based on the model developed by Raymond Raschko, and input gathered from a meeting with the Older Adult Policy Council focusing on a Gatekeeper Program. It will include:
 1. *Gatekeeper Recruitment and Training.* Gatekeeper recruitment will focus on individuals with the greatest opportunity for interaction with isolated Older Adults. Gatekeepers will be trained to recognize signs and symptoms that may indicate an elderly person is in need of help and how to link that individual to the Gatekeeper Program's Referral System.
 2. *Referral System.* The Gatekeeper Program's Referral System will include a single point of contact. Once a referral is received from a Gatekeeper or community member, the referral will be reviewed by a case manager and appropriate action will be taken. This may involve a call to the community service organization already involved with the elder or referral into the Gatekeeper Program's Response System.
 3. *Response System.* The Response System will include an assessment by the case manager to evaluate the individual's overall needs. A linkage plan will be developed to address their needs. A variety of services will be utilized to provide individualized and tailored care.

Project Strategies

Strategy 1: Gatekeeper Recruitment and Training

- a. Non-traditional Gatekeepers will be trained to locate and identify at-risk Older Adults, particularly those who are isolated, living alone and in need of some type of assistance to maintain their independence. Gatekeepers could include employees of businesses and organizations or caregivers, peers and family members who in the course of their daily activities, come into contact with Older Adults in the community. Examples may include: postal workers, police officers, senior and recreation center personnel, "Meals on Wheels" drivers, bank tellers, peers, faith-based leaders, primary care physicians, and family members, to name a few. The role of the Gatekeeper will be to recognize signs and symptoms that may indicate that an elderly person is in need of assistance and to refer that person to the Gatekeeper Program's Referral System. Recruitment of Gatekeepers will be organized by the OAPC. It will include telephone calls, face-to-face contacts, letters introducing the model and inviting participation, and public media announcements.
- b. Key stakeholders, the OAPC, a Shasta County Mental Health Clinician and Community Education Specialist will develop Gatekeeper trainings to review the effects of trauma, recognize signs and symptoms that may indicate an elderly person is in need of help and how to refer that individual to the Gatekeeper Program's Referral System. The Gatekeepers will be trained to identify and refer Older Adults who are experiencing a serious and persistent mental illness, emotional or behavioral problems,

suicide risk, poor health, social isolation, abuse or neglect, substance abuse problems, and reluctance or inability to seek help on their own behalf or the absence of someone to seek help for them. The type and method of training will be based upon further input from key stakeholders and the OAPC. They will also be dependent upon the needs of each Gatekeeper group. For example, the “Meal on Wheels” program has suggested the use of a Gatekeeper training DVD that could be part of their new employee orientation. Special efforts will be made to prepare culturally appropriate training and training materials for underserved cultural populations.

Milestones and Timelines for Implementation

- Within 6 months after a contract has been signed with Shasta County, Project training and resources will be developed
- Within 12 months, at least 100 Gatekeepers, including individuals from underserved cultural populations will be trained

Intended Outcomes

- Individual
 - increase training participants’ ability to recognize signs and symptoms that may indicate an elderly person is in need of help and how to refer that individual to the Gatekeeper Program.
 - increase in the number of at-risk Older Adults identified as needing prevention programs and early intervention programs
 - increase the number of isolated and vulnerable Older Adults who ultimately receive needed and appropriate services
- Program/System
 - increase in the number of organizations with a formal process for identifying and referring at-risk Older Adults
- Process Measures
 - sign-in sheets
 - gatekeeper training schedule or training distribution
 - community event schedule
 - referral logs
- Impact Measures
 - pre and post training assessments
 - number of referrals to “single point of contact”

Strategy 2: Referral System

- a. The Gatekeeper training activities in Strategy 1 will provide our County with a Gatekeeper Program referral phone number. The number will be open to all possible sources including Gatekeepers, friends or families, physicians, faith-based institutions, etc.... This creates a single point of contact for all Project referrals.
- b. Once a call is initiated, an experienced clinician working as a case manager will respond:
 1. First the case manager will discuss the referral with the Gatekeeper or other referral source. The case manager will try to obtain an idea of the situation and indicators that

- instigated the referral. They will also try to gain other information about the at-risk Older Adult that will help them to outreach and engage them in Project interventions.
2. The case worker will then work to outreach and engage the referred at-risk Older Adult. The clinician will be skilled in establishing relationships with the elderly and overcoming any initial resistance from an older person who is suspicious, hostile or fearful. Cultivating rapport and trust is imperative in the Referral System because it provides the conduit for Project interventions.
 3. If warranted after the initial engagement of the individual and with the individual's approval, the case manager will provide the services available in the Gatekeeper Program's Response System.
 4. The case manager will then inform the Gatekeeper that action was taken and their efforts are appreciated.
- c. Shasta County Mental Health will contract with a local community-based organization that currently provides services for Older Adults to serve as the single point of contact and case management for the Gatekeeper Program's Referral and Response Systems.

Milestones and Timeline for Implementation

- Within 6 months after a contract has been signed with Shasta County, a clinician will be contracted, trained and ready to implement the Referral System strategy. Response will commence upon first referral.

Intended Outcomes

- Individual
 - increase in the number of at-risk older adults that receive needed and appropriate project interventions.
- Program/System
 - increase in number of appropriate referrals received by single point of contact, including referrals from underserved cultural populations.
- Process Measures
 - referral log
 - clinician trained to implement strategy
- Impact Measures
 - referral/contact assessment

Strategy 3: Response System

- a. The Response System will include an assessment by the case manager to evaluate the individual's overall needs. The assessment will include the use of a depression screening tool.
- b. The Response System assessment will conclude in a discussion with the elder and, as appropriate, family members about the clinician's impressions. The clinician will then suggest a plan of action with input from the Older Adult.
- c. A plan will be developed to address the elder's needs and a variety of services will be utilized to provide individualized and tailored care. The goals will be to:

1. Link the individual to needed and appropriate local resources and services.
 - Local services will be provided from a number of agencies (e.g. mental health, in-home support services, meals service, health care, caregiver respite, in-home pharmacy services, adult day programs, minor home repair, legal or financial assistance).
 2. Coordinate, support, assist and monitor the elder's linkage referrals for up to 3 months.
 - if intensive support and services are needed due to a mental illness, individuals will be referred to Full Service Partnerships or other appropriate and available programs
- d. Shasta County Mental Health will contract with a local community-based organization that currently provides services for Older Adults to serve as the single point of contact and case manager for the Gatekeeper Program's Referral and Response Systems.

Milestones and Timelines for Implementation

- Within 6 months after a contract has been signed with Shasta County, a clinician will be contracted, trained and ready to implement the Response System strategy. Assessments and linkage to services will commence upon first referral.

Intended Outcomes

- Individual
 - increase protective factors and decrease risk factors for at-risk Older Adults by linking them to Mental Health and other critical services
 - increase in number of at-risk Older Adults who receive assessments including individuals from underserved cultural populations.
- Program/System
 - increase in the number and quality of linkage relationships for at-risk Older Adults to Mental Health and other critical services
- Process Measure:
 - clinician trained to implement strategy
 - assessment and linkage log
- Impact Measure:
 - number of at-risk Older Adults assessed
 - pre and post quality of life assessment

Programs

Program Title	Proposed number of individuals or families through PEI to be served through June 2010		Number of months in operation through June 2010
	<i>Prevention</i>	<i>Early Intervention</i>	
Gatekeeper Recruitment and Training	Individuals: 100	Individuals:	12
	Families:	Families:	
Referral System	Individuals:	Individuals: 50	12
	Families:	Families:	
Response System	Individuals:	Individuals: 20	12
	Families:	Families:	
Total PEI Project Estimated Unduplicated Count of Individuals to be Served	Individuals: 100	Individuals: 52	
	Families:	Families:	

Decrease Disparities in Access

Providing culturally competent and appropriate programs:

- See Project 1
- Strategy 1 will include training gatekeepers from ethnic/cultural organization and organizations that service diverse clientele such as Meals on Wheels and Faith-based organizations.
- Strategy 2 will include the use of culturally competent and appropriate staff. If assessments need to be completed or facilitated by an interpreter, appropriate resources will be utilized.
- Strategy 3 will coordinate, support and link clientele to appropriate resources in the community. The case manager will work to create a web of resources that work together for the benefit of the individual. These will include resources provided by ethnic/cultural organizations.

Facilitating access to PEI programs:

- Increased identification, outreach and engagement of at-risk Older Adults will help overcome some of the barriers to appropriate help-seeking behavior and accessing services.
- Training gatekeepers throughout the county and from various locations and cultures helps to ensure services to underserved cultural populations as well and underserved areas of our County.
- Training gatekeepers who naturally come in contact with Older Adults and from various cultures helps increase the likelihood of identification and engagement.

Improving individual outcomes of participant in PEI programs:

- Training gatekeepers throughout the county and from various locations and cultures increases the likelihood of successful identification, engagement and follow through on linkage/referrals. It also increases the probability of the elders' satisfaction with the process.
- The overall Project will strive to decrease the isolation, effects of trauma and prolonged suffering of Older Adults in our community. This will be especially important for elders in communities that have traditionally been unserved or underserved.

Linkage To County Mental Health and Providers of Other Needed Services

- Strategy 1 will link Gatekeepers and the organizations they represent to a single contact. Those Gatekeepers will then be able to link the community to Project interventions.

- Strategy 3 will link at-risk Older Adults to community mental health, health, social service, and other support resources based upon their need and eligibility.
- The goal of this project is to reduce the negative consequences of isolation, trauma and untreated serious mental illness for Older Adults by identifying, referring and linking them to services as quickly and effectively as possible.

Collaboration and System Enhancement

- This Project will enhance the quantity and quality of cooperative relationships among organizations and systems that serve Older Adults. Providing training and a single point of contact for Project interventions for Gatekeepers in the community develops procedures to improve access for referred individuals.
- Referral of Older Adults for services will include collaborations between Shasta County Mental Health, Gatekeepers and the organizations they represent and local support services (see above Strategy 3c).
- Activities like the Gatekeeper Program help to increase a sense of community. The Project has the potential to increase participant's sense of belonging which is an important mental health protective factor.

Coordination with MHSA

- The Mental Health Services Act Advisory Committee will continue to be used to advise, monitor and provide input and feedback on all MHSA components.
- Community Services and Supports including Full Service Partnerships, Crisis Stabilization Services and the Crisis Residential Recovery Clinic will be an integral part of Strategy 3. Crisis and follow-up services can be provided by these units. (These services will only be needed in the case of serious mental illness and/or crisis interventions)
- MHSA Housing opportunities maybe appropriate for Older Adults served by this Project

Project 3: Individuals Experiencing the Onset of Serious Psychiatric Illness

PEI Project Name: Individuals Experiencing the Onset of Serious Psychiatric Illness

PEI Key Community Mental Health Needs	AGE Group			
	Children/Youth	TAY	Adult	Older Adult
Disparities in Access to Mental Health Services	X	X	X	
Psycho-Social Impact of Trauma				
At-Risk Children, Youth and Young Adult Populations				
Stigma and Discrimination				
Suicide Risk				

PEI Priority Population(s)	AGE Group			
	Children/Youth	TAY	Adult	Older Adult
Trauma Exposed Individuals				
Individuals Experiencing Onset of Serious Psychiatric Illness	X	X	X	
Children and Youth in Stressed Families				
Children and Youth at Risk for School Failure				
Children and Youth at Risk of or Experiencing Juvenile Justice Involvement				
Underserved Cultural Populations				

Stakeholder Input and Data Analysis

PEI Stakeholder Information:

- During the Stakeholder Input process, community members were asked to rank, in order of importance, the Prevention and Early Intervention Priority Populations. Individuals Experiencing the Onset of Serious Psychiatric Illness were ranked as the third most important population to address.
- Many stakeholders suggested the prevention of crisis situations and intervening early in a person's illness would significantly reduce the suffering and trauma associated with first break episodes.
- Stakeholders suggested the use of the following PEI strategies to serve Individuals Experiencing the Onset of Serious Psychiatric Illness
 - Gatekeeper trainings that improve early recognition of psychosis
 - Prompt referral and assessments
 - Support and utilize families knowledge and resources to assist their loved ones

CSS Stakeholder Information:

- During the Stakeholder Input process for CSS, the following PEI information was collected:
 - Shasta County has a higher percentage of persons with serious mental illness and serious emotional disturbance who will utilize the public mental health system than most other counties: According to the 2000 census data provided by the Department of Mental Health for purposes of MHSA analysis, Shasta County's prevalence rate is 9.23% the 7th highest in the State.
 - Persons in crisis, and persons new to the system, have a difficult time navigating initial contacts.
 - Lack of services and duration of untreated psychosis (DUP) leads to emergency room treatment, recurring hospitalization, substance use, and law enforcement involvement.

Data: PEI Community Mental Health Assessment (attachment)

- Prevalence of Mental Illness / Suffering: pp 16 - 19

Data: Examples of Other Sources

- *Early Intervention in Psychosis: The critical period hypothesis (Birchwood et al, 1998):*
 - The potential benefits of early intervention for first episode psychosis include: reduced morbidity; more rapid recovery; better prognosis; preservation of social skill, family and social supports; and decreased need for hospitalization.
- *Promotion, Prevention and Early Intervention of Mental Health (2000)*
 - While there is presently no known prevention for psychotic disorders, such as schizophrenia and bipolar disorder, research shows the positive effects of early intervention. Arguments for early intervention include recognition that there are often major delays in the provision of treatment for psychotic disorders, with an average of one year between the time of on-set of psychotic symptoms and treatment. Longer lengths of time from onset of symptoms to first presentation for treatment were associated with increasing complications, including severe behavioral disturbances and family difficulty. Taking more than one year to access services was associated with a threefold increase in relapse rates over the following two years. Time to remission and level of remission was related to duration of untreated psychosis. It has been demonstrated that early detection of psychotic symptoms and effective treatment may lead to a dramatic reduction in severity of symptoms and the development of a chronic debilitating disorder.

Project Summary

Shasta County's Individuals Experiencing the Onset of Serious Psychiatric Illness Project will target individuals who are between the ages of 15 and 30. Typically, psychotic illnesses such as schizophrenia and bipolar disorder first emerge in late adolescence or early adulthood. The Project will be based upon two programs successfully serving individuals experiencing first-episode psychosis (FEP). The first program model is the Prevention and Early Intervention Program for Psychoses (PEPP) and the other is the Portland Identification and Early Referral Program (PIER). Shasta County's Project 3 will include the following:

- A Project team will be comprised of highly trained and well-experienced mental health professionals and educators available to:

1. *Reduce Duration of Untreated Psychosis (DUP)*: Reduce delay in initiating early intervention for psychosis through early detection strategies. This information will be provided with a sense of optimism concerning treatment and outcome.
 - Educate and train gatekeepers such as, school professional work force and other key professionals who encounter young persons in the early stages of symptom onset and development of psychosis.
 - Identify, and help others to identify, young people who are manifesting prodromal (early signs) or active symptoms and signs of schizophrenia and other major psychotic disorders.
2. *Outreach and Engagement*: Provide optimum and safe outreach and engagement to individuals with FEP in accordance with each patient and their family's needs. This will include staff training regarding family engagement strategies
3. *Assessment*: Provide screening and assessment to evaluate an individuals' risk for actual psychosis.
4. *Treatment Referral*: Referral to appropriate treatment for those who are psychotic or at substantial risk for psychosis.

Project Strategies

Strategy 1: Reduce Duration of Untreated Psychosis

- a. A Shasta County Mental Health Clinician and Community Education Specialist will develop training tools based upon PEPP and PEIR guidelines to educate local gatekeepers in the helping professions about psychosis and recognizing the early signs of FEP. Gatekeepers will include school counselors, mental health professionals, primary care physicians and other key professionals.
 1. Training tools will be based upon the amount of time a group of gatekeepers are willing or able to devote to the Project and the likelihood they would come in contact with a young person in the early stages of deterioration toward psychosis.
 - Example: Training of primary care physicians would include a small easy to use pocket guide or a scheduled training during grand rounds at our local hospital.
 - Example: Training of school counselors and mental health professionals would include a workshop covering psychosis, recognizing prodromal psychosis, how to refer for assessment, etc.
 2. A community education and awareness tool will be developed and distributed county-wide. It will include a brief description of psychosis, a list of signs and symptoms, a list of symptoms that need immediate attention and a referral phone number.
 - Community distribution will include: availability at health fairs, online posting, direct mailing, etc.
 - Community education will also focus on locations were young adults may receive the information such as our local community college or high school events.

Milestones and Timelines for Implementation

- Within 6 months after a contract has been signed with Shasta County, Project training tools will be developed
- Within 12 months, at least 3 gatekeeper training activities will be complete

Intended Outcomes

- Individual
 - increase training participants ability to identify and recognize the early signs of FEP
 - increase community members' awareness of the early signs of psychosis and the single point of contact available for referrals
- Program/System
 - increase in the number of organizations with a formal process for identifying and referring young people who are manifesting prodromal or active symptoms and signs of major psychotic disorders
 - increase in the number of organizations with capacity to ensure effective linkage to services
- Process Measures
 - sign-in sheets
 - gatekeeper training schedule or training tool distribution
 - community event schedule
 - referral logs
- Impact Measures
 - pre and post training assessments
 - number of referrals to "single point of contact"
 - number of organizations who refer to program

Strategy 2: Outreach and Engagement

- a. The training and community awareness activities in Strategy 1 will provide our County with a Project outreach and engagement referral phone number. The number will be open to all possible sources including prospective patients, their friends or families, gatekeepers, physicians, educational institutions. This creates a single point of contact for all Project referrals.
- b. Once a call is initiated, an experienced clinician will respond. If there is any indication that the person may have psychotic symptoms or be at high or imminent risk for psychosis, or the clinician is in doubt, engagement services will be offered.
- c. Engagement will follow the PEPP and PIER models. The outreach and engagement clinician will initiate contact with the consumer or referral source and arrange an immediate appointment. "The initial contact with the consumer and family is of utmost significance and must be responded to with sensitivity as successful engagement of the young adult is often dependent upon a good first impression being made by the clinician. It is important to avoid alarming the consumer and family with labels and other medical jargon. It is better to concentrate on initiating and forming a therapeutic relationship with the consumer and family. A friendly and helpful attitude combined with a general interest in the family is often an effective means to successful engagement. Every effort will be made to involve family in the screening procedure. This may be the most crucial time to connect with the family while also obtaining valuable information regarding the consumer and his/her presenting problems" (PEPP Screening and Assessment).
- d. If warranted and the consumer and their family agree, the clinician will set up an appointment for assessment and referral services
- e. Shasta County Mental Health Staff and organizational providers will be trained in family engagement strategies, including approaches that are respectful of diverse families in Shasta County. These trainings will help increase clinicians' capacity to include family members in the treatment and recovery of their family member.

Milestones and Timeline for Implementation

- Within 6 months after a contract has been signed with Shasta County, a clinician will be trained and ready to implement the Outreach and Engagement strategy. Outreach and engagement will commence upon first referral.
- Within 12 months, family engagement strategy training will be offered to staff

Intended Outcomes

- Individual
 - decrease DUP for Individuals Experiencing the Onset of Serious Psychiatric Illness
 - individuals and families dealing with first episode psychosis will feel supported by Project services
- Program/System
 - increase in number of individuals experiencing psychotic symptoms or at high or imminent risk for psychosis who receive outreach and engagement including individuals from underserved cultural populations.
- Process Measures
 - referral log
 - clinician trained to implement strategy
 - staff training schedule and sign-in sheet
- Impact Measures
 - measurement of referred individuals' DUP
 - referral assessment (type of referral, referral organization, outreach and engagement summary, assessment option, etc.)

Strategy 3: Assessment

- a. Individuals referred from Outreach and Engagement will be screened for psychosis.
 1. Assessment interviews will allow the consumer to express their problems in their own words. The clinician will try to obtain a picture of the person, problems, cultural context and social situation. Areas that will be reviewed include psychotic and prodromal symptoms, substance use, suicide risk, and risk for violence toward others
 2. A screening tool such as the structured interview for prodromal symptoms utilized in the PEIR model will be administered by a clinician
- b. Assessment interviews will conclude in a discussion with the person and, with the referred person's permission, the family about the clinician's impressions. If warranted, the clinician will suggest movement to the Treatment Referral (see strategy 4).

Milestones and Timelines for Implementation

- Within 6 months after a contract has been signed with Shasta County, a clinician will be trained and ready to implement the Assessment strategy. Assessment interviews will commence upon first referral.

Intended Outcomes

- Individual
 - decrease DUP for Individuals Experiencing the Onset of Serious Psychiatric Illness
 - individuals and families dealing with first episode psychosis will feel supported by Project services

- Program/System
 - increase in number of individuals experiencing psychotic symptoms or at high or imminent risk for psychosis who receive assessments including individuals from underserved cultural populations.
- Process Measure:
 - clinicians trained to implement strategy
 - assessment log
- Impact Measure:
 - number of individuals assessed
 - number of individuals referred to Treatment Referral
 - assessment of DUP for Project participants compared to current SCMH consumers with similar diagnosis

Strategy 4: Treatment Referral

- a. Individuals assessed who appear to be exhibiting signs and symptoms of psychosis, will be referred to appropriate treatment options which include but are not limited to:
 1. Primary care physician for specific lab tests such as urine drug screening to rule out drug induced psychosis.
 2. Psychiatrist for assessment and management through
 - Shasta County Mental Health (if consumer meets eligibility requirements) or,
 - Local or nearest available community providers
 3. Shasta County Crisis Stabilization Services (23-hour unit for adults and youth)
 4. Shasta County Crisis Residential Recovery Clinic (up to 30 days for adults)
 5. MHA Community Services and Supports: Full Service Partnership for an array of community supports
 6. Hospitalization
 7. Other needed services: The clinician will link consumers and their families with other resources in the community including social services, social supports and income supports. For example, NAMI provides two Family to Family and Peer to Peer classes every year, as well as associated support groups.

Milestones and Timelines for Implementation

- Within 6 months after a contract has been signed with Shasta County, a clinician will be trained and ready to implement the Treatment Referral strategy. Treatment referrals will commence upon first referral.

Intended Outcomes

- Individual
 - decrease DUP for Individuals Experiencing the Onset of Serious Psychiatric Illness
 - increase social supports for Individuals Experiencing the Onset of Serious Psychiatric Illness and their families
- Program/System
 - Increase in the number and quality of linkage relationships to Mental Health and other critical service organizations
 - Increase the number of appropriate referrals to Shasta County Mental Health

- Process Measures:
 - clinician trained to implement strategy
- Impact Measures:
 - number of individuals referred for treatment and other services
 - measurement of referred individuals' DUP

Programs

Program Title	Proposed number of individuals or families through PEI to be served through June 2010		Number of months in operation through June 2010
	<i>Prevention</i>	<i>Early Intervention</i>	
Reduce DUP: Gatekeeper Training	Individuals:	Individuals: 50	12
	Families:	Families:	
Reduce DUP: Community Awareness	Individuals:	Individuals: 200	12
	Families:	Families: 125	
Outreach and Engagement	Individuals:	Individuals: 30	12
	Families:	Families: 20	
Outreach and Engagement: Family Engagement Strategies Training for Staff	Individuals:	Individuals: 50	12
	Families:	Families:	
Assessment	Individuals:	Individuals: 20	12
	Families:	Families:	
Treatment Referral	Individuals:	Individuals: 20	12
	Families:	Families:	
Total PEI Project Estimated Unduplicated Count of Individuals to be Served	Individuals:	Individuals: 250	
	Families:	Families: 50	

Decrease Disparities in Access

Providing culturally competent and appropriate programs:

- Strategy 1 will include training key professionals from ethnic/cultural organization and organizations that serve diverse clientele such as Redding Rancheria, New Directions to Hope, Northern Valley Catholic Social Services, Remi-Vista, and local school clinicians.
- Strategy 2 and 3 will include the use of culturally competent and appropriate staff. If outreach and engagement or assessments need to be completed or facilitated by an interpreter, appropriate staff will be utilized.
- Strategy 4 will link clientele to appropriate resources in the community. These will include resources provided by ethnic/cultural organizations such as the Life Center.

Facilitating access to PEI programs:

- Increased identification, outreach and engagement of individuals at risk of or experiencing the onset of serious psychiatric illness will help overcome some of the difficulties people with these mental health problems face, one of which is facilitating access to services.
- Training gatekeepers throughout the county and from various locations and cultures helps to ensure services to underserved cultural populations as well and underserved areas of our County.

- Training gatekeepers who naturally come in contact with young adults and from various cultures helps increase the likelihood of engagement. Consumers and their families may feel more comfortable with gatekeepers they are already familiar with.

Improving individual outcomes of participant in PEI programs:

- Training gatekeepers throughout the county and from various locations and cultures increases the likelihood of successful outreach, engagement and follow through on linkage/referrals. It also increases the probability of the consumer and their families' satisfaction with the process.
- The overall Project will strive to decrease the duration of untreated psychosis. This will be especially important for individuals in communities that have traditionally been unserved or underserved.

Linkage To County Mental Health and Providers of Other Needed Services

- Strategy 1 will link key professional gatekeepers and the organizations they represent to a single contact at Shasta County Mental Health. Those key professional's will then be able to link the community to Project interventions. Community education and awareness activities in Strategy 1 will also provide the single point of contact number.
- Strategy 4 will link individuals at-risk of or experiencing serious psychiatric illness to community mental health, social service, and support resources based upon their need and eligibility. (see lists above) This will also include links to services, such as employment, social opportunities and support, housing, etc. These types of links can be critical issues for people dealing with first episode psychosis.
- The goal of this project is to link consumers to services as quickly and effectively as possible to reduce the duration of untreated psychosis and reduce the negative consequences of untreated serious mental illness.

Collaboration and System Enhancement

- This Project will enhance the quantity and quality of cooperative relationships with other health, mental health, social service, culturally and community-based organizations and local support systems. Providing training and a single point of contact for Project interventions to local key professionals develops procedures to improve access for referred individuals and families.
- Referral of individuals for services will include collaborations between Shasta County Mental Health and local key professionals. The following organizations and agencies may be include:
 - Organizational Providers
 - Examples: New Directions to Hope, Remi-Vista, Northern Valley Catholic Social Services
 - Underserved Cultural Population Providers
 - Examples: Redding Rancheria, Pit River Health
 - School Clinicians
 - Examples: Building Bridges, The Great Partnership, Shasta College
 - Federally Qualified Health Clinics
 - Local Primary Care and Mental Health Clinicians
 - Wellness Centers
 - NAMI
 - Basic Needs: employment, housing, food, social support

Coordination with MHSA

- The Mental Health Services Act Advisory Committee will continue to be used to advise, monitor and provide input and feedback on all MHSA components.
- Community Services and Supports: Full Service Partnerships, Crisis Stabilization Services and the Crisis Residential Recovery Clinic will be an integral part of Strategy 4, crisis and follow-up services can be provided by these units.
- MHSA Housing opportunities maybe appropriate for individuals served by this Project
- This project includes activities aligned with those proposed by the California Department of Mental Health's PEI Statewide Projects guidelines. Shasta County will use a portion of its PEI statewide allocation to partially fund these activities.

Project 4: Stigma and Discrimination

PEI Project Name: Stigma and Discrimination

PEI Key Community Mental Health Needs	AGE Group			
	Children/Youth	TAY	Adult	Older Adult
Disparities in Access to Mental Health Services				
Psycho-Social Impact of Trauma				
At-Risk Children, Youth and Young Adult Populations				
Stigma and Discrimination	X	X	X	X
Suicide Risk				

Stakeholder Input and Data Analysis

PEI Stakeholder Information:

- During the Stakeholder input process, focus group participants shared their input about type of services, supports, and interventions that should be included in the PEI plan. Many of the focus groups expressed a need for destigmatization activities. Stakeholders' common belief about stigma and discrimination included:
 - Stigma is a major barrier to help-seeking behavior.
 - Stigma reduction could be a very effective PEI strategy to help people before crisis and to increase understanding and support in the community.
 - Self Stigma:
 - People don't want to be stereotyped as mentally ill.
 - People are not aware of their mental health.
 - Shame, self-blame, embarrassment.
 - Public Stigma
 - Public does not understand or are not aware of mental health issues
 - Public does not believe in "recovery."
 - Public discrimination leads to loss of hope, jobs, and housing.
 - Institutional Stigma
 - Public policy and funding stigmatize and discriminate against individuals with mental illness and/or those with substance use issues.
 - Discrimination
 - Discrimination against people with mental illness causes problems in many areas like housing and employment.
- Stakeholders suggested the use of the following strategies to address stigma and discrimination:
 - Community education and awareness activities including information about co-occurring disorders.
 - Gatekeeper trainings that include promotion of mental wellbeing and signs of mental illness and co-occurring disorders.
 - Media campaign.

CSS Stakeholder Information:

- During the Stakeholder input process for CSS, the following PEI information was collected:
 - Stigma was identified as a barrier to identification and treatment of mental illness.
 - Public education is needed to reduce the stigma associated with seeking care.
 - Peer outreach and engagement is lacking and may be a tool to reduce resistance to seeking care.
 - Stigma results in the delay or avoidance of addressing mental health issues until serious consequences result.
 - The education systems lacks knowledge of mental health issues which results in high rates of school exclusions due to emotional and behavioral issues.

Data: PEI Community Mental Health Assessment (attachment)

- Prevalence of Mental Illness / Suffering: pp 16 - 19
- Prevalence of Alcohol and Other Drug Abuse: pp 20 – 31
- Early Intervention: Help Seeking Behavior pp 32 - 34

Data: Examples of Other Sources

- *Mental Health: A Report of the Surgeon General*
 - “Nearly two-thirds of all people with diagnosable mental disorders do not seek treatment (Regier et al., 1993; Kessler et al., 1996). Stigma surrounding the receipt of mental health treatment is among the many barriers that discourage people from seeking treatment (Sussman et al., 1987; Cooper-Patrick et al., 1997). Concern about stigma appears to be heightened in rural areas in relation to larger towns or cities (Hoyt et al., 1997).”
 - “In general, 19% of the adult U.S. population has a mental disorder alone (in 1 year); 3% have both mental and addictive disorders; and 6% have addictive disorders alone. Consequently, about 28 to 30% of the population has either a mental or addictive disorder.”
 - Serious Emotional Disturbance (children and adolescents with severe functional limitations)
 - 5 to 9 % of U.S. children ages 9 – 17

Project Summary

Shasta County Mental Health will partner with the Community Education Committee (CEC), a subcommittee of the Mental Health Board (CEC) to implement a Stigma and Discrimination Project. The Project will coordinate with the Statewide Stigma and Discrimination Project and be based upon the Substance Abuse and Mental Health Services Administration’s (SAMHSA) stigma reduction program called the Elimination of Barriers Initiative (EBI). The initiative and our Project aim to build awareness of and counter the discrimination and stigma associated with mental health problems.

The EBI stakeholder-developed messages to be used in the Project will be strength-based and focused on recovery. They include:

- Mental health problems affect almost every family in America.
- People with mental health problems make important contributions to our families and our communities.
- People with mental health problems recover, often by working with mental health professional and by using medication, self-help strategies, and community supports.
- Stigma and fear of discrimination are key barriers that keep many people from seeking help.
- You can make a difference in the way people see mental health problems if you:

- Learn and share the facts about mental health and about people with mental health problems, especially if you hear or read something that isn't true;
- Treat people with mental health problems with respect and dignity; and
- Support the development of community resources for people with mental health problems and their friends and family.

Target audience for the Project will include:

- General public (adults age 25 – 54)
- Media
- Faith-based Community
- Educators
- Health and Human Services

Social Marketing strategies that will be used by Project 4 and shown by researchers to effectively reduce discrimination and stigma include:

- *Public Education*
 - A media campaign developed by a social marketing firm.
 - Materials and media such as promotional items, drop-in articles, and public service announcements to support Project activities
 - Engage communities via events such as "May is Mental Health Month."
 - Attend community events, including ethnic/cultural events, to provide educational and referral materials.
 - Stigma and discrimination trainings for media, educators, advocates, consumers, underserved cultural populations, health advocates, health and human services agencies, and the faith community.
- *Direct Contact with Mental Health and/or Substance Use Treatment Consumers*
 - Use of consumer spokesperson(s) for media campaign and community events.
 - Use of local speakers bureau for community events and trainings.
 - Provide advocate training and volunteer positions for consumers and family members to assist in project implementation
- *Reward for Positive Portrayals of People with Mental Health Problems*
 - Media watch program will promote accurate, responsible, and sensitive portrayal of mental health problems.

Individuals with both mental health and substance abuse problems (co-occurring disorders) are frequently underserved by both providers of mental health and substance abuse treatment services. This results in over-utilization of criminal justice, health care, child protective services, and homeless shelter services. This issue is exacerbated by stigma and discrimination surrounding not only mental health problems, but substance abuse problems as well. Co-occurring disorders will be addressed by this Project.

Project Strategies

Strategy 1: Media Campaign

Shasta County Mental Health and the Community Education Committee (CEC) will work with Runyon, Saltzman and Einhorn (RSE) to develop a social marketing campaign targeting stigma and discrimination.

- a. Phase 1: Planning
 1. *Kick-off Meeting*: A public meeting will be held to begin campaign development. Campaign objectives, target audience, and possible challenges will be discussed.
 2. *Research & Strategy Development*: RSE will conduct research to understand the target audience and current local situation. Secondary research will include interviews with key informants to gain further insight on the target and social issues.
 3. *Media Planning and Recommendation*: Based on assessments of the research gathered, a media plan will be developed and presented. Media mediums will also be selected.
- b. Phase 2: Creative Development
 1. *Message and Concept Development*: RSE will develop various messaging concepts. Concepts will be selected by the CEC. They will then be refined for concept testing.
 2. *Concept Focus Groups*: Selected concepts will be tested in focus groups with the target audience to determine the level of interest and whether the target can relate to the creative material, importance and credibility of the messages, and overall appeal and image of the brand. Testing will also help clear up confusing language and provide insights to refining and strengthening concepts with the most impact.
 3. *Production*: Concepts will then enter the final stage of development and are prepared for production. Materials could consist of television and/or radio spots, posters and brochures, tool kits, internet banner ads, or other forms of advertising.
- c. Phase 3: Campaign Execution
 1. *Launch of Campaign*: Once all components are developed, the campaign will be launched in conjunction with and to complement other Project strategies. Some materials maybe used in other strategies. For example, a tool kit maybe developed for the training of the faith-based communities or brochures could be distributed at community events. A media plan will be developed to determine the most effective use of materials.

Milestones and Timelines for Implementation

- Within 3 months after a contract has been signed with Shasta County, Phase 1 will be complete
- Within 6 months, Phase 2 will be complete
- Within 12 months, Phase 3 will occur

Intended Outcomes

- Individual
 - increase appropriate help-seeking behavior
- Program/System
 - decrease myths and misconceptions about individuals with mental health problems therefore decreasing stigma and discrimination
- Process Measures
 - creative materials
 - media plan
- Impact Measures
 - retrospective assessments
 - media campaign

Strategy 2: Stigma and Discrimination Community Education

- a. *Engage Community:* At least four education and awareness activities will be organized annually during the month of May to celebrate and recognize Mental Health Month. One event will be a Mental Health Resource Fair that will include representatives from local mental health resources. Other events may include trainings, workshops, movies that include positive portrayals of people with mental health problems, art exhibits, etc. Promotion of events will include a county proclamation, press release, placement on local calendars, public service announcements, flyers, etc. Event spokesperson(s) will be consumers of mental health or substance use services. Volunteer positions for advocates, consumers and family members will be available.
- b. *Attend Community Events:* Mental health staff and consumers and/or family members will participate in at least 5 local health fairs or other appropriate community events annually. At least two of the five events attended will be cultural celebrations or gatherings such as a Mien Neighborhood Fair or the annual Multicultural Celebration in Shasta Lake City. An educational exhibit including stigma and discrimination materials will be developed to be displayed. Information about co-occurring disorders will be included. Resources will be available in appropriate languages when available and appropriate Community Health Advocates, consumers and family members will attend.
- c. *Use of Materials and Media to Support Project:* Project support materials will be developed and distributed to reinforce and enhance Project activities. Media such as public services announcements, community calendars, newsletters, press releases, opinion editorials, letters to the editor, and drop-in articles will be utilized. Interested advocates and consumers will be trained and encouraged to utilize media outlets and Project messages listed above. Culturally and geographically appropriate Community Health Advocates will be used to develop and distribute materials in an effort to decrease not only stigma and discrimination but disparities in access as well. Other Project support materials such as promotional items will be developed and distributed.

Milestones and Timeline for Implementation

- Within 12 months after a contract has been signed with Shasta County, at least four education and awareness activities will be conducted during Mental Health Month and five community events will be attended.

Intended Outcomes

- Individual
 - increase awareness of the prevalence of mental health problems
 - decrease myths and misconceptions of individuals with mental health problems therefore decreasing stigma and discrimination
- Program/System
 - increase participation by local agencies, organization and community members in stigma and discrimination activities
- Process Measures
 - event calendar
 - log of materials distributed
 - media binder

- Impact Measures
 - attitude and beliefs questionnaire
 - number of attendees at the Mental Health Resource Fair

Strategy 3: Stigma and Discrimination Training

- a. *Media*: The media has an important role to play in informing and influencing community attitudes towards mental health and people affected by mental health problems. While reporting that stereotypes and perpetuates myths can lead to negative community attitudes, responsible and accurate reporting has the potential to increase understanding of mental health and substance use issues in the general community and decrease the stigma and discrimination experienced by people living with these issues. Resources from “Mindframe” the national media initiative in Australia will be used. The following three groups will be targeted to address this issue:
 1. *Media Sectors*: A workshop will be organized for local media including newspaper, radio, and magazines. The goal of the workshop will be to educate at least 10 members of the local media about the importance of appropriate and responsible reporting regarding mental health and substance abuse issues. The consumer speaker’s bureau will be used during the workshop.
 2. *Law Enforcement*: A short training will be developed and delivered to approximately 20 local law enforcement officers. The training will be delivered by a fellow officer. Incidents involving suicide, mental illness, or substance abuse are often seen as newsworthy and law enforcement may be the first to field media inquiries. For this reason, law enforcement has an important role to play in supporting appropriate media coverage of these issues. The training will provide officers with practical advice to support their interactions with the media and suggest forms of communicating regarding incidents that are consistent with best practice guidelines for reporting.
 3. *Advocates and Consumers*: Direct contact and personal stories are powerful ways to impart messages that can reduce stigma and discrimination related to mental health problems. Research shows personal contact to be one of the most effective ways of bridging the gap between misconceptions and the truth. Advocates and consumers will be encouraged to use the media in a positive way to decrease stigma and discrimination surrounding mental health problems. Interested advocates and consumers will be invited to attend trainings pertaining to the use of media opportunities to increase the reach of our stigma and discrimination project. A minimum of 5 trainings will be held in natural locations such as local wellness centers and topics will include:
 - How to develop and use talking points
 - Media interviews
 - Public speaking
 - Event promotion
 - Written media: press releases, drop-in articles, opinion-editorials, letter-to-the-editor, etc.

- b. *Education:* Creating schools with tolerant, accepting attitudes toward people with mental health problems can go a long way toward reducing stigma and discrimination. Two curriculum will be used to accomplish this:
1. Eliminating Barriers for Learning:
 - Curriculum Source: SAMHSA
 - Target: At least 50 local secondary school teachers and staff
 - Description: A continuing education program for secondary school teachers and staff that focuses on social-emotional wellness, its impact on classroom behavior and student learning, and practical techniques and methods teachers can use to promote social-emotional wellness.
 2. Unlocking the Mysteries of Children's Mental Health
 - Curriculum Source: Minnesota Association for Children's Mental Health and Department of Education
 - Target: At least 50 future teachers and local school teachers
 - Description: A continuing education program designed to help teachers understand and effectively teach children who have a diagnosed or undiagnosed mental health problem. Teachers will understand the barriers to learning and acquire tools for effectively teaching children who have mental health problems. It will also encourage teachers to consider each child with a mental health problem individually, gain an introductory understanding of positive behavior supports, and learn how to use simple modifications and adaptations that coincide with the trend toward brain-based teaching.
- c. *Faith-Based Community:* Nearly 40% of Americans attend at least one religious or faith-related meeting weekly. Instead of seeking treatment, people suffering from mental health or co-occurring disorders often approach their clergy or spiritual advisor, whom they trust and respect, for assistance and support. This strategy also helps us reach individuals who may otherwise have difficulty accessing mental health services. Our faith-based effort will be based upon the "Partners in Healing" model from the Greater Houston Mental Health Association. Services will aim to assist local clergy in responding more effectively and efficiently to their congregants with mental health needs. Faith-based activities will include:
1. *Education about Mental Health Problems:* A workshop for local clergy will be designed to address:
 - Stigma and discrimination surrounding mental health problems
 - Recognizing the symptoms of mental health problems
 - Determining when it is appropriate to make a referral to a mental health professional
 - Effectively make and support mental health referrals.
 2. *Consultant Services:* Clinical staff will be available to individual clergy or groups to answer questions.
 3. *Resource Materials:* Brochures, fact sheets, referral information, etc. will be provided to local clergy

4. *Dialogue*: Interactive dialogues between clergy, consumers, family members, and mental health professionals will be held biannually.
- d. *Health and Human Services Agency*: Due to cutbacks in funding for public mental health care, community health clinics and social service agencies that do not ordinarily focus on mental health increasingly assist patients or consumers experiencing mental health problems or serious mental illnesses. A workshop will be organized that provides at least 100 professionals and paraprofessionals providing direct services, which may have little knowledge about mental health care, an opportunity to increase their skills and knowledge base. The workshop will be advertised county-wide and invitations will be sent to appropriate agencies.

Milestones and Timelines for Implementation

- Within 3 months after a contract has been signed with Shasta County, trainings for advocates and consumers will begin,
- Within 6 months, workshop for media sectors, health and human services agencies and trainings for law enforcement will be complete,
- Within 12 months, faith-based workshop and dialogues as well as trainings for school teachers and staff will be complete

Intended Outcomes

- Individual
 - increase education, faith-based, and health and human service agencies training participants' awareness of stigma and discrimination affecting people with mental health problems.
 - increase media training participants' adherence to best practice guidelines for reporting.
- Program/System
 - increase the community's capacity to support people with mental health problems
- Process Measures:
 - media binder
 - training schedule
 - copies of training presentations, educational materials and distribution lists
- Impact Measures:
 - training pre and post assessments
 - Patrick W. Corrigan's Attribution Questionnaire - 27

Strategy 4: Promote and Reward Positive Portrayals of People with Mental health problems

- a. *Media Watch Program*: The Media Watch Program will be coordinated by the CEC. It will promote accurate, responsible and sensitive portrayal of mental health problems. Local media will be monitored for news regarding mental health problems. Community Health Advocates will be used to monitor local ethnic media, such as the Mien and Spanish radio station, in a culturally competent way. If a piece is judged as stigmatizing, the media outlet will be contacted with an explanation of the concern, a suggestion for correction, and an explanation of the harm stigma causes. Conversely, news that follows reporting guidelines will be positively acknowledged. Annually a list of positively acknowledged media sources will be published and distributed county-wide.

Milestones and Timelines for Implementation

- Within 6 months after a contract has been signed with Shasta County, the CEC will develop and coordinate a media monitoring and response system
- Within 12 months, the CEC will compile a Media Watch Program binder including all media (pro & con) responses and publish a list of positive acknowledgements.

Intended Outcomes

- Program/System
 - increase local media’s capacity to adhere to best practice guidelines for reporting.
 - decrease the community’s misconceptions surrounding mental health problems
- Process Measure:
 - media binder
- Impact Measure:
 - positive acknowledgement list and distribution

Programs

Program Title	Proposed number of individuals or families through PEI to be served through June 2010		Number of months in operation through June 2010
	<i>Prevention</i>	<i>Early Intervention</i>	
Media Campaign	Individuals: 25,000	Individuals:	12
	Families:	Families:	
Stigma and Discrimination Education and Awareness Activities	Individuals: 1000	Individuals:	12
	Families:	Families:	
Training for Media Sectors	Individuals: 10	Individuals:	12
	Families:	Families:	
Training for Education	Individuals: 100	Individuals:	12
	Families:	Families:	
Faith-based Community Activities	Individuals: 25	Individuals:	12
	Families:	Families:	
Health and Human Services Training	Individuals: 100	Individuals:	12
	Families:	Families:	
Media Watch Program	Individuals: 10	Individuals:	12
	Families:	Families:	
Total PEI Project Estimated Unduplicated Count of Individuals to be Served	Individuals: 24,000	Individuals:	
	Families:	Families:	

Decrease Disparities in Access

Providing culturally competent and appropriate programs:

- See Project 1
- Health and Human Services' and Project specific Community Health Advocates will be included in appropriate project activities including trainings. This will provide culturally competent individuals to serve and inform the following communities:
 - African American
 - Asian/ Pacific Islander
 - Hispanic/ Latino
 - Native American/ Alaskan Native
 - Rural / Low SES
- Community outreach and engagement efforts will include racial/ethnic and rural community events and groups. Local ethnic coalitions and Community Health Advocates frequently organize and attend these type of events. An example of an annual event that is well attended and held in Anderson by the Hispanic/Latino Coalition is the Independence Day Fiesta. Culturally appropriate materials will be used when available.

Facilitating access to PEI programs:

- Increase knowledge of stigma and discrimination throughout the County including stigmas held by various cultural groups.
- Community outreach and engagement will occur in various natural locations county-wide including ethnic and rural communities.
- Trainings will be provided to gatekeepers who naturally come in contact with diverse populations this will be a particular important strategy when providing services to members of cultural and ethnic populations.

Improving individual outcomes of participants in PEI programs:

- Training participants, including members of cultural populations will be aware of the stigma and discrimination affecting individuals with mental health problems.
- Trained gatekeepers in all communities and a stigma aware community will help to create a supportive environment for individuals with mental health problems. This strategy has the potential to decrease the current disparities in access in our County.

Linkage To County Mental Health and Providers of Other Needed Services

Although funding for mental health services are being cut, there are numerous providers and resources in Shasta County. This Project will help encourage the following:

- Appropriate linkage to county mental health services for severe and persistently mentally ill individuals
- Linkage to community mental health and substance use resources
- Promotion of community support systems such as support groups or faith-based services

By combating stigma and discrimination, community members maybe more likely to address problems early and seek help to alleviate mental health stressors. This will also allow for improvement of protective factors, including linking participants to other needed services such as housing, food, jobs, etc. that affect their mental wellbeing.

Collaboration and System Enhancement

The Stigma and Discrimination Project will be collaboration between Shasta County Mental Health and the Community Education Committee (CEC). The CEC is comprised of representatives from local community-based organizations, NAMI, and the Mental Health Board. It also includes individual community members from PEI required sectors such as consumers, family members, education, and law enforcement.

This Project will also entail consistent collaboration with consumer groups and speaker's bureau.

Strategy 1: Shasta County Mental Health, the CEC, Runyon Saltzman and Einhorn will collaborate with local key stakeholders and gatekeepers to select and focus group test media campaign concepts. This will help to enhance the impact and appropriateness of our message and campaign.

Strategy 2: Mental Health Month activities will provide the opportunity for collaboration between Shasta County Mental Health and numerous community mental health providers. This health fair will be the only one in the county to solely focus on mental health. It will create greater awareness of the issues and local resources. It will also provide an opportunity for participating organizations to network and to learn about the services available in the county.

Shasta County Mental Health will also have the opportunity to work with other agencies that organize community events and health fairs. Many of these organizations will either be health care or culturally based. This will enhance our efforts to integrate primary health care and mental health as well as work with community agencies that provide services for our local cultural populations. Examples of events to attend could be the Marketfest health booth that is sponsored by Mercy Medical Center or the Pit River Health Fair that is sponsored by the Pit River Indian Health Clinic.

Strategy 3: The media has a great impact upon the stigma and discrimination affecting individuals with mental health problems. The Media activities in Strategy 3 will be collaboration between Shasta County Mental Health, the CEC, the local media, local law enforcement and community advocates and consumers. These groups have the greatest potential to effect the portrayal of individuals with mental health problems in our local media.

Shasta County Mental Health will also be working with local school districts to offer trainings for school teachers and staff. Research shows that schools that promote mental health report higher academic achievement, lower absenteeism and fewer behavior problems. These types of trainings can help create the kind of positive climate that enhances social and emotional development and promotes a healthy learning environment for both students and staff.

Faith-based leaders county-wide will be invited to participate in our Project activities. Each clergy member will have the opportunity to positively affect each member in their congregations. By participating in Project activities they will be able to help individuals and family members dealing with mental health problems. They will also be able to deliver messages that can combat stigma and discrimination.

Strategy 3 activities will also collaborate with local health and human service providers. County staff, organizational providers and other local service providers who participate in Project activities will serve numerous community members. Their understanding of mental health problems and co-occurring disorders and attitudes towards individuals with these issues will be affected in a positive way. They will also feel

more competent to handle difficult situations in an appropriate way. This combination has the potential to greatly decrease the stigma and discrimination individuals feel when acquiring local services.

Key Informants from each target group will be used to inform training development and implementation.

Strategy 4: The CEC will work with local advocate and consumer groups to implement Strategy 4. This work will not only help to change local media regarding mental health news, it will also help to empower local advocates.

Coordination with MHSA

- The Mental Health Services Act Advisory Committee will continue to be used to advise, monitor and provide input and feedback on all MHSA components.
- Project 4 will be coordinated with Workforce Education and Training and Shasta County's Comprehensive Continuous, Integrated System of Care for Co-occurring Psychiatric and Substance Disorders. Staff will be trained regarding co-occurring disorders and work to increase dual diagnosis competency for all staff.
- Project 4 will also be closely tied to PEI Project 5: Suicide Prevention. Many of the community education and awareness activities will combine stigma, discrimination and suicide information.
- This project includes activities aligned with those proposed by the California Department of Mental Health's PEI Statewide Projects guidelines. Shasta County will use a portion of its PEI statewide allocation to partially fund these activities.

Project 5: Suicide Prevention

PEI Project Name: Suicide Prevention

PEI Key Community Mental Health Needs	AGE Group			
	Children/Youth	TAY	Adult	Older Adult
Disparities in Access to Mental Health Services				
Psycho-Social Impact of Trauma				
At-Risk Children, Youth and Young Adult Populations				
Stigma and Discrimination				
Suicide Risk	X	X	X	X

Stakeholder Input and Data Analysis

PEI Stakeholder Information:

- During the stakeholder input process, community members were asked to rank, in order of importance, the negative outcomes that may result from untreated mental illness (W&I Code, Division 5, Part 3.6, section 5840 d). Suicide was ranked as the most important negative outcome to address.
- Stakeholders suggested the use of the following strategies to address suicide:
 - Community, educator, and family education and awareness activities
 - Gatekeeper trainings that include suicide sign recognition and appropriate response, such as *Question, Persuade, Refer* (QPR).
 - Postvention supports for individuals and their families

CSS Stakeholder Information:

- During the Stakeholder Input process for CSS, the following PEI information was collected:
- Isolation is a problem, including:
 - Rural isolation
 - Lack of social supports
- Lack of access to services.
- Stigma results in the delay or avoidance of addressing mental health issues until serious consequences result.

Data: PEI Community Mental Health Assessment (attachment)

- Suicide Deaths
 - An average of 35 Shasta County residents dies per year of suicide.
 - Shasta County's suicide death rate is significantly higher (16.7 deaths per 100,000 residents) than California's (9.3 per 100,000 residents).
- Non-fatal Suicide Hospitalizations
 - There are an average of 107 nonfatal suicide attempts that are serious enough to result in hospitalized among Shasta County residents each year.

Data: Examples of Other Sources

- *Shasta County Suicide Data*
 - In 2007, there were 42 suicide deaths. The Years of Potential Life Lost (YPLL) (calculated by the difference in the age at death and 75 years) were 1,185 years or an average of 48 years of potential life lost per each death.
 - In both 2006 and 2007, suicide was the 9th leading cause of death and the 3rd leading cause of premature death in Shasta County.

Self-Inflicted Injury Data for Shasta County Residents			
	DEATHS	Non-Fatal HOSPITALIZATIONS	Non-Hospitalized ER VISITS
1999	39		***
2000	24		***
2001	40		***
2002	38		***
2003	27		***
2004	30		***
2005	34		349
2006	43		335
2007	42 [§]		349

*** Data not available prior to 2005.

§ Data from a different data query system than previous years in this column.

- *California Strategic Plan on Suicide Prevention*
 - Suicide is the 10th leading cause of death in California.
 - In California, more suicide deaths are reported than deaths by homicides.
- *National Institute of Mental Health*
 - It is estimated that as many as 90 percent of individuals who die by suicide had a diagnosable mental illness or substance abuse disorder.

Project Summary

Shasta County's Suicide Prevention Project 5 will be based upon the local level recommendations provided by the California Strategic Plan on Suicide Prevention. The Project will include locally and culturally appropriate activities for the following state-provided strategic directions:

1. *Create a System of Suicide Prevention:* Shasta County will work to increase collaboration among state and local agencies, organizations, and communities by coordinating and improving suicide prevention activities and services.
2. *Implement Training and Workforce Enhancements to Prevent Suicide:* Service and training to promote effective and consistent suicide prevention, early identification, referral, intervention, and follow-up care across local service providers will be developed and implemented.
3. *Educate communities to Take Action to Prevent Suicide:* Shasta County will work to promote awareness that suicide is preventable and create an environment that supports suicide prevention and help-seeking behaviors.
4. *Improve Suicide Prevention Program Effectiveness and System Accountability:* Shasta County will work to improve our local data collection, surveillance and program evaluation and help to design responsive policies and effective programs to reduce the impact of suicide.

Project Strategies

Strategy 1: Create a System of Suicide Prevention

- a. A Shasta County liaison will work with the state Office of Suicide Prevention. The liaison will provide a single point of contact and central point of dissemination for information, resources, and data about local suicide prevention efforts.
- b. A Shasta County suicide prevention Workgroup will be established. The Workgroup will consist of individuals from the community and MHSAs required and recommended sectors. They will coordinate local suicide prevention efforts including assessment, planning, implementation of evidence-based programs, and evaluation. A regular 2-hour meeting will be held every other month, or on an as needed basis. Activities of the Workgroup will include:
 1. A comprehensive assessment of the existing county suicide prevention services and supports.
 2. Work to enhance links and integration among Shasta County systems and programs, including health, mental health, aging, social services, first responders, and hotlines, to increase their capacity to provide effective crisis intervention and suicide prevention.
- c. Promote use of local, state and national hotline services.

Milestones and Timelines for Implementation

- Within 3 months after a contract has been signed with Shasta County, a qualified suicide prevention liaison will be appointed.
- Within 6 months, a suicide prevention Workgroup will be convened.
- Within 12 months, comprehensive assessment of county suicide prevention services and supports will be completed.

Intended Outcomes

- Individual
 - increase outreach and access to suicide prevention services
 - increase awareness of suicide hotline supports
- Program/System
 - increase the number of local suicide prevention services and supports
 - increase participation by local agencies, organization and community members in suicide prevention activities
- Process Measures
 - call logs
 - media binders
 - sign-in sheets
- Impact Measures
 - A comprehensive assessment of the existing county suicide prevention services and supports retrospective/current assessments
 - Enhanced links and integration among Shasta County systems and programs, including health, mental health, aging, social services, first responders, and hotlines, to increase their capacity to provide effective crisis intervention and suicide prevention.

Strategy 2: Implement Training and Workforce Enhancements to Prevent Suicide

- a. Shasta County Mental Health will include suicide prevention training and technical assistance questions within a Workforce Education and Training (WET) survey. The survey assessment will help to expand suicide prevention training for indicated occupations, facilities, and providers.

- b. Provide suicide prevention trainings to a minimum of 300 individuals from the target groups below. Training will include various methods and evidence-based practices such as *Question, Persuade, Refer* (QPR). Trainings will be available county-wide and will initially focus on the following target groups:
1. Medical providers
 2. Educators
 3. Faith-Based Community

Milestones and Timeline for Implementation

- Within 3 months after a contract has been signed with Shasta County, the Shasta County suicide prevention liaison will be trained in QPR.
- Within 6 months, WET survey including suicide prevention questions will be completed. Suicide prevention training specific target groups and training methods will be determined.
- Within 12 months, educators from at least 3 local high schools will be trained in QPR.

Intended Outcomes

- Individual
 - increase training participants' awareness of suicide prevention strategies and resources
 - decrease suicide attempts by increasing training participants' ability to recognize and respond to the signs of suicide
- Program/System
 - increase community's capacity to recognize and respond to the signs of suicide
 - increase participation by local agencies, organization and community members in suicide prevention activities
- Process Measures
 - training requests, advertisements, and calendar
 - WET survey and assessment
- Impact Measures
 - pre and post training assessments
 - number of suicide attempts

Strategy 3: Educate Communities to Take Action to Prevent Suicide

- a. Hold a workshop for a minimum of 10 members of the local media to educate them on the importance of appropriate and responsible reporting about suicide. Promote a greater understanding of the risk and protective factors related to suicide and how to get help by engaging and educating local media about their role in promoting suicide prevention and adhering to suicide reporting guidelines.
- b. Reach out to gatekeepers to increase their awareness and participation in suicide prevention efforts by:
1. Providing county-wide QPR trainings
 - Including trainings to local ethnic/cultural coalitions and organizations
 2. Participating in community events such as health fairs
 - Including events sponsored by local ethnic/cultural coalitions and organizations
 3. Using social marketing techniques to create and distribute suicide prevention awareness and educational materials
- c. The suicide prevention Workgroup will:

1. Foster the development of 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.
2. Educate the community about how to safely handle potentially lethal materials from fire arms to medications to help save lives.

Milestones and Timelines for Implementation

- Within 3 months after a contract has been signed with Shasta County, a qualified suicide prevention liaison will be trained in QPR.
- Within 6 months, the suicide prevention liaison will participate in at least 3 appropriate community events with an educational display including suicide prevention materials and hold 1 workshop for at least 10 members of the local media.
- Within 12 months, the suicide prevention liaison will provide at least 2 community QPR trainings for approximately 30 gatekeepers and the suicide prevention Workgroup will determine the community organizations that are interested in providing support programs.

Intended Outcomes

- Individual
 - increase outreach and access to suicide prevention services
 - increase QPR training participant's awareness of suicide prevention strategies and resources
 - increase media workshop participants' adherence to suicide reporting guidelines
- Program/System
 - increase community's capacity to recognize and respond to the signs of suicide
 - decrease community's misconceptions surrounding suicide
- Process Measures:
 - media binder
 - health fair schedule
 - copies of educational materials and distribution lists
- Impact Measures:
 - training pre and post assessments
 - suicide reporting guideline assessment

Strategy 4: Improve Suicide Prevention Program Effectiveness and System Accountability

- a. Shasta County suicide prevention liaison and Workgroup will work with the Shasta County Health and Human Services department, local coroner, medical examiner and Public Health department to:
 1. Increase local capacity for suicide attempt and suicide data collection, reporting, surveillance, and dissemination.
 2. Determine how to enhance reporting systems to improve the consistency and accuracy of data about suicide death.

This information will then be used to inform prevention and early intervention program selection and implementation. It will also help us to better understand suicide trends and the impact of protective and risk factors.

Milestones and Timelines for Implementation

- Within 3 months after a contract has been signed with Shasta County, an inventory of current data collection sources will be compiled.
- Within 6 months, the suicide prevention liaison and Workgroup will meet with the Shasta County Health and Human Services department, local coroner, medical examiner and Public Health department to plan for task 1 and 2 above.

Intended Outcomes

- Program/System
 - establish an effective system for collecting and disseminating suicide related data
- Process Measures
 - meeting agenda and minutes
 - inventory of data collection sources
- Impact Measures
 - retrospective assessment
 - suicide data collection system report

Programs

Program Title	Proposed number of individuals or families through PEI to be served through June 2010		Number of months in operation through June 2010
	<i>Prevention</i>	<i>Early Intervention</i>	
Suicide Prevention Workgroup: Building a suicide system of care	Individuals: 20	Individuals:	6
	Families:	Families:	
Suicide Awareness and Training for Medical Care Providers	Individuals: 100	Individuals:	9
	Families:	Families:	
QPR Training for Educators and Faith-Based Leaders	Individuals: 200	Individuals:	9
	Families:	Families:	
QPR Training for Community Members	Individuals: 30	Individuals:	9
	Families:	Families:	
Suicide Education and Awareness Activities: health fairs and other community events	Individuals: 1000	Individuals:	9
	Families:	Families:	
Suicide Reporting Guideline Workshop	Individuals: 10	Individuals:	6
	Families:	Families:	
Total PEI Project Estimated Unduplicated Count of Individuals to be Served	Individuals: 1000	Individuals:	
	Families:	Families:	

Decrease Disparities in Access

Providing culturally competent and appropriate programs:

- See Project 1
- Community Health Advocates will be trained in QPR. This will provide culturally competent individuals to serve and inform the following communities:
 - African American
 - Asian/ Pacific Islander
 - Hispanic/ Latino
 - Native American/Alaskan Native
 - Rural/Low SES

- Community outreach and engagement efforts will include racial/ethnic community events and groups. For instance:
 - Annual Multicultural Celebration
 - Coalition events such as the Hispanic/Latino Independence Day Celebration
 - Events hosted by underserved cultural population organizations such as the Pit River or Redding Rancheria Health Fair
- We will work through Community Health Advocates to become a mental health resource to underserved cultural population coalitions and organization.
- Culturally appropriate materials will be used when available.

Facilitating access to PEI programs:

- Increase available suicide prevention services throughout the County
- Community outreach and engagement will occur in various natural locations such as ethnic coalition sponsored events or public locations that are readily used by underserved cultural populations.
- Trainings will be provided to gatekeepers who naturally come in contact with diverse populations

Improving individual outcomes of participant in PEI programs:

- Training participants will be aware of the signs of suicide, appropriate interventions and resources. They will feel competent to help a person contemplating suicide access additional services.
- Trained gatekeepers and a suicide aware community will help to create a supportive environment for individuals contemplating suicide, survivors and their families.

Linkage to County Mental Health and Providers of Other Needed Services

One of the main goals of this Project is to create and/or enhance links between systems and programs so suicide services will reflect integration among agencies, organizations and individuals providing suicide prevention, intervention and postvention services. Shasta County does not currently have a system of care to serving those at risk of attempting suicide, those who have attempted suicide or their families. The system of care will include appropriate referrals to local services, county mental health and if needed, Full Service Partnerships. Our Project will work to create these linkages between existing services and help increase the capacity of existing services.

Strategy 2 and 3 will include trainings regarding suicide. Suicide risk and protective factors will be discussed. Training participants will be encouraged to increase a suicidal individual and their family's protective factors. This will include linking them to various survival-oriented services or other systems of support.

Collaboration and System Enhancement

Suicide prevention will depend upon a wide range of prevention, intervention and postvention strategies. Shasta County Mental Health will be partnering with Shasta County Public Health to implement Project 5. A community education specialist from Public Health will serve as the Project's suicide prevention liaison.

Strategy 1: Participation by local agencies, organizations and individuals will be coordinated by the suicide prevention Workgroup. The suicide prevention Workgroup will be made up of individuals who are interested in suicide services or who represent organizations who are. Currently interested parties include: public health, mental health, social services, local mental health providers, Older Adult Policy Council, primary care providers, NAMI, HELP Inc, law enforcement, and local business owners.

There are some local suicide prevention services currently in existence, for example NAMI provides community QPR training, and HELP Inc. runs a suicide hotline and a survivor support group. The Workgroup will also help increase capacity of these services.

Strategy 2: This strategy is working to specifically collaborate with mental health providers, primary care providers, and educators to enhance their knowledge of suicide prevention, appropriate interventions and referrals.

Strategy 3: Shasta County suicide prevention liaison will collaborate with local media to prepare, educate, and inform them regarding suicide reporting guidelines and current suicide information. This will help enhance the community outreach portion of this activity. Outreach and engagement of the community will increase their knowledge and awareness of suicide prevention strategies, local resources and ultimately create a supportive environment.

Strategy 4: Local agencies responsible for suicide data collection, evaluation and dissemination will collaborate to improve Shasta County's reporting system. This information will then be used to inform prevention and early intervention program selection and implementation. It will also help us to better understand suicide trends and the impact of protective and risk factors.

Coordination with MHSA

- The Mental Health Services Act Advisory Committee will continue to be used to advise, monitor and provide input and feedback on all MHSA components.
- Workforce Education and Training: WET surveys will include questions regarding suicide prevention training needs. The survey assessment will help to expand suicide prevention training for indicated occupations and facilities.
- Community Services and Supports: Crisis Stabilization Services (23-hour unit for adults and youth) and the Crisis Residential Recovery Center (up to 30 days for adults) will be an integral part of Strategy 1. Crisis and follow-up services can be provided by these units.
- This project includes activities aligned with those proposed by the California Department of Mental Health's PEI Statewide Projects guidelines. Shasta County will use a portion of its PEI statewide allocation to partially fund these activities.

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

Instructions: Please complete one budget Form No. 4 for each PEI Project and each selected PEI provider.

County Name: **Shasta** Date: 3/3/09
 PEI Project Name: **Project 1 - Children and Youth in Stressed Families**
 Provider Name (if known):
 Intended Provider Category: **County Agency**
 Proposed Total Number of Individuals to be served: FY 08-09 _____ FY 09-10 500
 Total Number of Individuals currently being served: FY 08-09 _____ FY 09-10 _____
 Total Number of Individuals to be served through PEI
 Expansion: FY 08-09 0 FY 09-10 500
 Months of Operation: FY 08-09 _____ FY 09-10 12

Proposed Expenses and Revenues	Total Program/PEI Project Budget		
	FY 08-09	FY 09-10	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages	\$0	\$0	\$0
Clinical Division Chief (.15 FTE)	\$13,880	\$14,123	\$28,003
Community Health Advocate (.50 FTE)	\$15,354	\$16,404	\$31,758
Administrative Secretary (.20 FTE)	\$5,851	\$6,251	\$12,102
Agency Staff Services Analyst (.10 FTE)	\$4,406	\$4,708	\$9,114
HSA Program Manager (.05 FTE)	\$3,696	\$3,949	\$7,645
Senior Staff Analyst (.05 FTE)	\$2,348	\$2,508	\$4,856
b. Benefits and Taxes @ 51 %	\$23,223	\$24,451	\$47,674
c. Total Personnel Expenditures	\$68,758	\$72,394	\$141,152
2. Operating Expenditures			
a. Facility Cost	\$2,625	\$2,887	\$5,512
b. Other Operating Expenses	\$123,972	\$103,649	\$227,621
c. Total Operating Expenses	\$126,597	\$106,536	\$233,133
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Triple P Trainings	\$210,000	\$175,000	\$385,000
Community Based Contracts	\$40,000	\$60,000	\$100,000
Trauma Based Trainings	\$20,000	\$22,000	\$42,000
Triple P Provider Contracts	\$667,000	\$667,000	\$1,334,000
a. Total Subcontracts	\$937,000	\$924,000	\$1,861,000
4. Total Proposed PEI Project Budget	\$1,132,355	\$1,102,930	\$2,235,285
B. Revenues (list/itemize by fund source)			
Medi Cal FFP	\$334,000	\$334,000	\$668,000
Medi Cal EPSDT	\$233,000	\$233,000	\$466,000
1. Total Revenue	\$567,000	\$567,000	\$1,134,000
5. Total Funding Requested for PEI Project	\$565,355	\$535,930	\$1,101,285
6. Total In-Kind Contributions	\$0	\$0	\$0

Budget Narrative: Project 1 – Children and Youth in Stressed Families

Summary:

This request includes funding for FY 08/09 and FY 09/10 and represents Project 1 - Children and Youth in Stressed Families, of the Shasta County MHSA PEI plan. Shasta County will use a portion of its PEI Statewide Projects allocation of \$176,100 per year for FY 08/09 and FY 09/10 to partially fund activities for this project and will align activities with PEI Statewide Projects guidelines.

A. Expenditures \$ 2,235,285

1. Personnel: \$ 141,152
Shasta County Mental Health (SCMH) staff assigned to this project includes the following: support staff, data and outcome evaluation staff, and clinical staff. Year 2 allows for scheduled step increases and cost-of-living increases. Benefits and taxes include FICA, health, dental and vision coverage, Workers' Compensation, SDI, and state and federal payroll taxes.
2. Operating Expenditures: \$ 233,133
Operating expenses include the following: facilities maintenance, general and office expenses, technology support, and communication expenses. Also included program materials for providers of Triple P and TF-CBT, as well as meeting location costs and travel expenses for SCMH staff training. Initial start-up costs will include office equipment for new staff and the purchase of a vehicle to be used by program staff.
3. Subcontracts/Professional Services \$ 1,861,000
Year 1 consists of costs associated with training (8 trainings with an average cost of \$25,000) a cadre (over 150 providers based on recommendations from Triple P for our population) of community professionals to provide Triple P levels 2, 3, 4, and 5, and follow-up certification. Year 1 also includes a contract with CIMH's evidence-based practice development team. Training costs include training manuals for each participant. Triple P services provided through community organizations leverages provider time and other funding resources. Years 2 and 3 will include needed trainings in all Triple P levels at a lower number likely through purchasing spots in statewide trainings provided by CIMH, as well as costs for program support, technical assistance, and training.

Strategy 1 – Includes the costs for Triple P trainings and leveraging of PEI funds for implementation of contracts with providers for Triple P programs.

Strategy 2 – Includes the costs of training clinicians to provide Trauma Focused-Cognitive Behavioral Therapy.

Strategy 3 – SCMH will be requesting proposals seeking contracts with community-based organizations to provide programs for at risk middle school students.

B. Revenue (other funding) \$ 1,134,000

Medi-Cal will be billed for Triple P services provided to Medi-Cal eligible clients by community providers. These funds (Medi-Cal FFP and EPSDT) will be leveraged against the implementation costs included as part of the Subcontracts/Professional Services line item.

Total Funding Request for PEI Project 1 \$ 1,101,285

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

Instructions: Please complete one budget Form No. 4 for each PEI Project and each selected PEI provider.

County Name: **Shasta** Date: 3/3/09
 PEI Project Name: **Project 2 - Older Adults**
 Provider Name (if known):
 Intended Provider Category: **County Agency**
 Proposed Total Number of Individuals to be served: FY 08-09 _____ FY 09-10 152
 Total Number of Individuals currently being served: FY 08-09 _____ FY 09-10 _____
 Total Number of Individuals to be served through PEI Expansion: FY 08-09 0 FY 09-10 152
 Months of Operation: FY 08-09 _____ FY 09-10 12

Proposed Expenses and Revenues	Total Program/PEI Project Budget		
	FY 08-09	FY 09-10	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages	\$0	\$0	\$0
Administrative Secretary (.20 FTE)	\$5,851	\$6,251	\$12,102
Agency Staff Services Analyst (.10 FTE)	\$4,406	\$4,708	\$9,114
HSA Program Manager (.05 FTE)	\$3,696	\$3,949	\$7,645
Senior Staff Analyst (.05 FTE)	\$2,348	\$2,508	\$4,856
b. Benefits and Taxes @ 51 %	\$8,314	\$8,882	\$17,196
c. Total Personnel Expenditures	\$24,615	\$26,298	\$50,913
2. Operating Expenditures			
a. Facility Cost	\$1,000	\$1,100	\$2,100
b. Other Operating Expenses	\$31,580	\$34,838	\$66,418
c. Total Operating Expenses	\$32,580	\$35,938	\$68,518
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Gatekeeper RFP	\$60,000	\$80,000	\$140,000
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
a. Total Subcontracts	\$60,000	\$80,000	\$140,000
4. Total Proposed PEI Project Budget	\$117,195	\$142,236	\$259,431
B. Revenues (list/itemize by fund source)			
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
1. Total Revenue	\$0	\$0	\$0
5. Total Funding Requested for PEI Project	\$117,195	\$142,236	\$259,431
6. Total In-Kind Contributions	\$0	\$0	\$0

Budget Narrative: Project 2 – Older Adults

Summary:

This request includes funding for FY 08/09 and FY 09/10 and represents Project 2 - Older Adults, of the Shasta County MHSA PEI plan.

A. Expenditures \$ 259,431

1. Personnel: \$ 50,913

Shasta County Mental Health (SCMH) staff assigned to this project includes the following: support staff and data and outcome evaluation staff. Year 2 allows for scheduled step increases and cost-of-living increases. Benefits and taxes include FICA, health, dental and vision coverage, Workers' Compensation, SDI, and state and federal payroll taxes.

2. Operating Expenditures: \$ 68,518

Operating expenses include the following: facilities maintenance, general and office expenses, technology support, and communication expenses. Also included are meeting location costs and travel expenses for SCMH staff training.

3. Subcontracts/Professional Services \$ 140,000

Strategy 1 – SCMH will work with the Older Adult Policy Council and seek contract(s) with local community organizations to set up and implement a Gatekeeper Recruitment and training program.

B. Revenue \$ 0

Through subcontracts, trainings, and other collaborations with community-based organizations, services will be provided throughout the community. It is difficult to project a monetary value associated with these partnerships and the leveraged dollars.

Total Funding Request for PEI Project 2 \$ 259,431

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

Instructions: Please complete one budget Form No. 4 for each PEI Project and each selected PEI provider.

County Name: **Shasta** Date: 3/3/09
 PEI Project Name: **Project 3 - Individuals Experiencing the Onset of Serious Psychiatric Illness**
 Provider Name (if known):
 Intended Provider Category: **County Agency**
 Proposed Total Number of Individuals to be served: FY 08-09 _____ FY 09-10 24,000
 Total Number of Individuals currently being served: FY 08-09 _____ FY 09-10 _____
 Total Number of Individuals to be served through PEI Expansion: FY 08-09 0 FY 09-10 24,000
 Months of Operation: FY 08-09 _____ FY 09-10 12

Proposed Expenses and Revenues	Total Program/PEI Project Budget		
	FY 08-09	FY 09-10	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages	\$0	\$0	\$0
Clinician I/II (.50 FTE)	\$27,840	\$29,744	\$57,584
Social Worker (.50 FTE)	\$20,274	\$21,660	\$41,934
Administrative Secretary (.20 FTE)	\$5,851	\$6,251	\$12,102
Agency Staff Services Analyst (.10 FTE)	\$4,406	\$4,708	\$9,114
HHS Program Manager (.05 FTE)	\$3,696	\$3,949	\$7,645
Senior Staff Analyst (.05 FTE)	\$2,348	\$2,508	\$4,856
b. Benefits and Taxes @ 51 %	\$32,852	\$35,098	\$67,950
c. Total Personnel Expenditures	\$97,267	\$103,918	\$201,185
2. Operating Expenditures			
a. Facility Cost	\$3,500	\$3,850	\$7,350
b. Other Operating Expenses	\$23,030	\$41,933	\$64,963
c. Total Operating Expenses	\$26,530	\$45,783	\$72,313
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Consultant	\$10,000	\$10,000	\$20,000
Social Marketing	\$0	\$30,000	\$30,000
a. Total Subcontracts	\$10,000	\$40,000	\$50,000
4. Total Proposed PEI Project Budget	\$133,797	\$189,701	\$323,498
B. Revenues (list/itemize by fund source)			
_____	\$0	\$0	\$0
_____		\$0	\$0
1. Total Revenue	\$0	\$0	\$0
5. Total Funding Requested for PEI Project	\$133,797	\$189,701	\$323,498
6. Total In-Kind Contributions	\$0	\$0	\$0

Budget Narrative: Project 3 – Individuals Experiencing the Onset of Serious Psychiatric Illness

Summary:

This request includes funding for FY 08/09 and FY 09/10 and represents Project 3 - Individuals Experiencing the Onset of Serious Psychiatric Illness of the Shasta County MHSA PEI plan. Shasta County will use a portion of its PEI Statewide Projects allocation of \$176,100 per year for FY 08/09 and FY 09/10 to partially fund activities for this project and will align activities with PEI Statewide Projects guidelines.

A. Expenditures **\$ 323,498**

1. Personnel: \$ 201,185

Shasta County Mental Health (SCMH) staff assigned to this project includes the following: support staff, oversight staff, data and outcome evaluation staff, and clinical staff. Year 2 allows for scheduled step increases and cost-of-living increases. Benefits and taxes include FICA, health, dental and vision coverage, Workers' Compensation, SDI, and state and federal payroll taxes.

2. Operating Expenditures: \$ 72,313

Operating expenses include the following: facilities maintenance, general and office expenses, technology support, and communication expenses. Also included are meeting location costs and travel expenses for SCMH staff training as well as initial start-up costs for office equipment related to new staff.

3. Subcontracts/Professional Services: \$ 50,000

Strategy 1, 2, 3, and 4 – Includes the costs for consultant to facilitate collaboration in the first year, as well as costs for social marketing or additional contracting in year 2.

B. Revenue **\$ 0**

Through subcontracts, trainings, and other collaborations with community-based organizations, services will be provided throughout the community. It is difficult to project a monetary value associated with these partnerships and the leveraged dollars.

Total Funding Request for PEI Project 3 **\$ 323,498**

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

Instructions: Please complete one budget Form No. 4 for each PEI Project and each selected PEI provider.

County Name: **Shasta** Date: 3/3/09
 PEI Project Name: **Project 4 - Stigma and Discrimination**
 Provider Name (if known):
 Intended Provider Category: **County Agency**
 Proposed Total Number of Individuals to be served: FY 08-09 _____ FY 09-10 1000
 Total Number of Individuals currently being served: FY 08-09 _____ FY 09-10 _____
 Total Number of Individuals to be served through PEI
 Expansion: FY 08-09 0 FY 09-10 1000
 Months of Operation: FY 08-09 _____ FY 09-10 12

Proposed Expenses and Revenues	Total Program/PEI Project Budget		
	FY 08-09	FY 09-10	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages	\$0	\$0	\$0
Clinician I/II (.25 FTE)	\$13,920	\$14,872	\$28,792
Community Health Advocate (.50 FTE)**	\$15,550	\$18,050	\$33,600
Community Education Specialist I/II (1.0 FTE)	\$54,152	\$56,418	\$110,570
Administrative Secretary (.20 FTE)	\$5,851	\$6,251	\$12,102
Agency Staff Services Analyst (.10 FTE)	\$4,408	\$4,709	\$9,117
b. Benefits and Taxes @ 51 %	\$47,879	\$51,153	\$99,032
c. Total Personnel Expenditures	\$141,760	\$151,453	\$293,213
2. Operating Expenditures			
a. Facility Cost	\$5,125	\$5,637	\$10,762
b. Other Operating Expenses	\$41,223	\$90,545	\$131,768
c. Total Operating Expenses	\$46,348	\$96,182	\$142,530
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Contracts / Social Marketing**	\$135,000	\$80,000	\$215,000
_____	\$0	\$0	\$0
a. Total Subcontracts	\$135,000	\$80,000	\$215,000
4. Total Proposed PEI Project Budget	\$323,108	\$327,635	\$650,743
B. Revenues (list/itemize by fund source)			
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
1. Total Revenue	\$0	\$0	\$0
5. Total Funding Requested for PEI Project	\$323,108	\$327,635	\$650,743
6. Total In-Kind Contributions	\$0	\$0	\$0

**Funding Source: PEI State-Administered Project Planning Estimates

Budget Narrative: Project 4 – Stigma and Discrimination

Summary:

This request includes funding for FY 08/09 and FY 09/10 and represents Project 1 - Children and Youth in Stressed Families, of the Shasta County MHSA PEI plan. Shasta County will use a portion of its PEI Statewide Projects allocation of \$176,100 per year for FY 08/09 and FY 09/10 to partially fund activities for this project and will align activities with PEI Statewide Projects guidelines.

A. Expenditures \$ 650,743

1. Personnel: \$ 293,213

Shasta County Mental Health (SCMH) staff assigned to this project includes the following: support staff, data and outcome evaluation staff, clinical staff, and community advocacy and education staff. Year 2 allows for scheduled step increases and cost-of-living increases. Benefits and taxes include FICA, health, dental and vision coverage, Workers' Compensation, SDI, and state and federal payroll taxes.

2. Operating Expenditures: \$ 142,530

Operating expenses include the following: facilities maintenance, general and office expenses, technology support, and communication expenses. Also included are training materials, curriculum, and other program materials for providers of Triple P and TF-CBT, as well as meeting location costs and travel expenses for SCMH staff training. Initial start-up costs will include office equipment for new staff and the purchase of a vehicle to be used by program staff.

3. Subcontracts/Professional Services \$ 215,000

Strategy 1, 2, 3 and 4 – Includes contracts for social marketing/media campaign of various messaging concepts targeting stigma and discrimination.

B. Revenue \$ 0

Through subcontracts, trainings, and other collaborations with community-based organizations, services will be provided throughout the community. It is difficult to project a monetary value associated with these partnerships and the leveraged dollars.

Total Funding Request for PEI Project 4 \$ 650,743

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

Instructions: Please complete one budget Form No. 4 for each PEI Project and each selected PEI provider.

County Name: **Shasta** Date: 3/3/09
 PEI Project Name: **Project 5 - Suicide Prevention**
 Provider Name (if known):
 Intended Provider Category: **County Agency**
 Proposed Total Number of Individuals to be served: FY 08-09 142 FY 09-10 1000
 Total Number of Individuals currently being served: FY 08-09 _____ FY 09-10 _____
 Total Number of Individuals to be served through PEI
 Expansion: FY 08-09 142 FY 09-10 1000
 Months of Operation: FY 08-09 2 FY 09-10 12

Proposed Expenses and Revenues	Total Program/PEI Project Budget		
	FY 08-09	FY 09-10	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages	\$0	\$0	\$0
Clinician I/II (.25 FTE)	\$13,920	\$14,872	\$28,792
Community Health Advocate (.50 FTE)**	\$15,550	\$18,050	\$33,600
Community Education Specialist I/II (1.0 FTE)	\$45,392	\$47,059	\$92,451
Administrative Secretary (.20 FTE)	\$5,851	\$6,251	\$12,102
Agency Staff Services Analyst (.10 FTE)	\$4,408	\$4,709	\$9,117
b. Benefits and Taxes @ 51 %	\$43,412	\$46,380	\$89,792
c. Total Personnel Expenditures	\$128,533	\$137,321	\$265,854
2. Operating Expenditures			
a. Facility Cost	\$5,125	\$5,638	\$10,763
b. Other Operating Expenses	\$64,222	\$70,545	\$134,767
c. Total Operating Expenses	\$69,347	\$76,183	\$145,530
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Social Marketing **	\$10,000	\$60,000	\$70,000
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
a. Total Subcontracts	\$10,000	\$60,000	\$70,000
4. Total Proposed PEI Project Budget	\$207,880	\$273,504	\$481,384
B. Revenues (list/itemize by fund source)			
_____	\$0	\$0	\$0
_____	\$0	\$0	\$0
1. Total Revenue	\$0	\$0	\$0
5. Total Funding Requested for PEI Project	\$207,880	\$273,504	\$481,384
6. Total In-Kind Contributions	\$0	\$0	\$0

****Funding Source: PEI State-Administered Project Planning Estimates**

Budget Narrative: Project 5 – Suicide Prevention

Summary:

This request includes funding for FY 08/09 and FY 09/10 and represents Project 1 - Children and Youth in Stressed Families, of the Shasta County MHSA PEI plan. Shasta County will use a portion of its PEI Statewide Projects allocation of \$176,100 per year for FY 08/09 and FY 09/10 to partially fund activities for this project and will align activities with PEI Statewide Projects guidelines.

A. Expenditures \$ 481,384

1. Personnel: \$ 265,854

Shasta County Mental Health (SCMH) staff assigned to this project includes the following: support staff, data and outcome evaluation staff, clinical staff, and community advocacy and education staff. Year 2 allows for scheduled step increases and cost-of-living increases. Benefits and taxes include FICA, health, dental and vision coverage, Workers' Compensation, SDI, and state and federal payroll taxes.

2. Operating Expenditures: \$ 145,530

Operating expenses include the following: facilities maintenance, general and office expenses, technology support, and communication expenses. Also included are meeting location costs and travel expenses for SCMH staff training. Initial start-up costs include office equipment for new staff and the purchase of a vehicle to be used by program staff.

3. Subcontracts/Professional Services \$ 70,000

Strategy 1, 2, 3 and 4 – Includes costs for a social marketing/media campaign of various messaging concepts targeting suicide prevention.

B. Revenue \$ 0

Through subcontracts, trainings, and other collaborations with community-based organizations, services will be provided throughout the community. It is difficult to project a monetary value associated with these partnerships and the leveraged dollars.

Total Funding Request for PEI Project 5 \$ 481,384

PEI Administration Budget Worksheet

Form No. 5

County: ShastaDate: 02/18/2009

	Client and Family Member, FTEs	Total FTEs	Budgeted Expenditure FY 2008-09	Budgeted Expenditure FY 2009-10	Total
A. Expenditures					
1. Personnel Expenditures					
a. PEI Coordinator		1.00	\$53,304	\$56,949	\$110,253
b. PEI Support Staff					\$0
c. Other Personnel (list all classifications) Staff Services Manager / MHSA Coordinator		0.10	\$5,708	\$6,099	\$11,807
					\$0
d. Employee Benefits			\$30,097	\$32,154	\$62,251
e. Total Personnel Expenditures			\$89,109	\$95,202	\$184,311
2. Operating Expenditures					
a. Facility Costs			\$2,750	\$3,025	\$5,775
b. Other Operating Expenditures			\$13,595	\$17,304	\$30,899
c. Total Operating Expenditures			\$16,345	\$20,329	\$36,674
3. County Allocated Administration					
a. Total County Administration Cost			\$51,211	\$53,163	\$104,374
4. Total PEI Funding Request for County Administration Budget			\$156,665	\$168,694	\$325,359
B. Revenue					
1 Total Revenue			\$0	\$0	\$0
C. Total Funding Requirements			\$156,665	\$168,694	\$325,359
D. Total In-Kind Contributions			\$0	\$0	\$0

Budget Narrative: Administration

Summary:

This request includes funding for FY 08/09 and FY 09/10 and represents the Administration Budget of the Shasta County MHSA PEI plan.

A. Expenditures \$ 325,359

1. Personnel: \$ 184,311

Shasta County Mental Health (SCMH) staff assigned to the Administration Budget includes a full-time PEI Coordinator and 10% of a Staff Services Manager. Year 2 allows for scheduled step increases and cost-of-living increases. Benefits and taxes include FICA, health, dental and vision coverage, Workers' Compensation, SDI, and state and federal payroll taxes.

2. Operating Expenses: \$ 36,674

Operating expenses include the following: facilities maintenance, general and office expenses, technology support, and communication expenses and travel expenses for SCMH staff training.

3. County Allocated Administration: \$ 104,374

Countywide Administrative Costs (A-87) and other administration includes Health and Human Services Administration, purchasing, payroll, human resources activities and administrative support and represent approximate 3.32% of MHSA budgeted expenditures.

B. Revenue \$ 0

There is no revenue associated with this project.

Total Funding Request for Administration \$ 325,359

PREVENTION AND EARLY INTERVENTION BUDGET SUMMARY

Form No. 6

Instruction: Please provide a listing of all PEI projects submitted for which PEI funding is being requested. This form provides a PEI project number and name that will be used consistently on all related PEI project documents. It identifies the funding being requested for each PEI project from Form No. 4 for each PEI project by the age group to be served, and the total PEI funding request. Also insert the Administration funding being requested from Form No.5 (line C).

County:	Shasta
Date:	02/18/2009

#	List each PEI Project	Fiscal Year			Funds Requested by Age Group			
		FY 08/09	FY 09/10	Total	*Children, Youth, and their Families	*Transition Age Youth	Adult	Older Adult
1	Children and Youth in Stressed Families	\$565,355	\$535,930	\$1,101,285	\$881,028	\$220,257		
2	Older Adults	\$117,195	\$142,236	\$259,431				\$259,431
3	Individuals Experiencing the Onset of Serious Psychiatric Illness	\$133,797	\$189,701	\$323,498	\$32,350	\$258,798	\$32,350	
4	Stigma and Discrimination	\$323,108	\$327,635	\$650,743	\$162,686	\$162,686	\$162,686	\$162,685
5	Suicide Prevention	\$207,880	\$273,504	\$481,384	\$120,346	\$120,346	\$120,346	\$120,346
	Administration		\$168,694	\$325,359				
	Total PEI Funds Requested:	\$1,504,000	\$1,637,700	\$3,141,700	\$1,196,410	\$762,087	\$315,382	\$542,462

***A minimum of 51 percent of the overall PEI component budget must be dedicated to individuals who are between the ages of 0 and 25 (“small counties” are excluded from this requirement).**

Shasta County Mental Health

Mental Health Services Act

Prevention and Early Intervention

Community Mental Health Assessment

About This Document

The purpose of this document is to provide a foundation of local, relevant information for those involved in the Prevention and Early Intervention planning process. It is in draft form because we hope to refine and improve this document as we receive input from local experts and stakeholders throughout the planning process. It will also assist with monitoring, over time the long-term effectiveness of local Mental Health Services Act (MHSA), Prevention and Early Intervention efforts.

This assessment is by no means a comprehensive report on the multitude of complex and interactive factors that influence a person's or a community's mental well-being. Nor is it a complete picture of the outcomes resulting from untreated mental illness. It is a report of as much local data as is available at this time on factors strongly correlated with mental well-being. It also includes measures of population-based, self-reported mental health status. An Appendix at the end of the document briefly describes each source of local data and how the information is collected. There are important mental health issues, such as maternal depression that we don't have local measurements of but that are still included in this document. Over time, if resources allow, we hope to build a better base of local knowledge about some of these problems and/or strengths.

As alluded to in the previous paragraph, the indicators in this report were chosen because of their research-based correlation with mental-well being and/or mental illness. Underneath each section, we have tried to provide a short but comprehensive description of the research linking it to mental well-being or mental illness.

This project was a collaborative effort between Shasta County Mental Health; Shasta County Public Health; and Shasta County Health and Human Services' Outcomes, Planning and Evaluation Division. We hope that it is useful and that it will become better with continuous feedback and refining.

To provide feedback about this document, please contact:

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Shasta County Health and Human Services Agency
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530-245-6861

CONTENTS

Promoting Community Mental Well-Beingpp 1

40 Developmental Assets

Social Support / Social Capital / Network of Meaningful Relationships

Civic Engagement

Contact with Nature

Physical Activity

Preventing Mental Disorderspp 8

Adverse Childhood Events

Screen Time, Especially Violent Media

Intimate Partner Violence

Elder Abuse

Maternal Depression

Teen Birth (Fertility) Rate

Preterm Births / Low Birth Weight

CONTENTS – cont'd

Prevalence of Mental Illness / Suffering..... pp 16

Mental Illness – General Definitions

Mental Illness – Local Prevalence Estimates

Adult

Adolescent

Mental Health Department Data (Treatment)

Prevalence of Alcohol and Other Drug Abuse.....pp 20

Underage Drinking

Binge Drinking

Chronic Drinking

Drinking and Driving

Illicit Drug Use

Early Intervention.....pp 32

Help Seeking Behavior

Help Seeking for Mental or Emotional Problems

Help Seeking for Alcohol or Drug Related Problems

Access to Mental Health Treatment

Mental Health Client Demographics (Access Disparities)

CONTENTS – cont'd

Outcomes That May Relate to Mental Illnesspp 38

Prolonged Suffering

Suicide Deaths

Nonfatal Suicide Hospitalizations

Disability due to Mental Illness

Removal of children from their homes

Homelessness

Unemployment

Incarceration

School Failure or Dropout

Local Data Sources..... Appendix

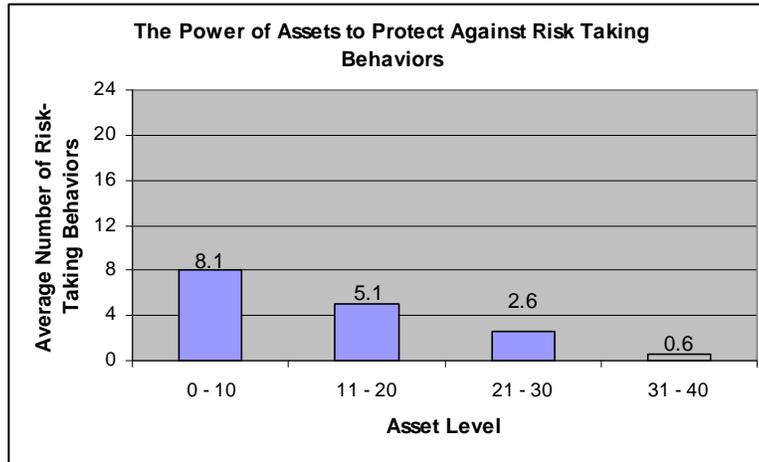
Community Mental Health Assessment

Promoting Community Mental Well-Being (Protective Factors of Mental Well-Being)

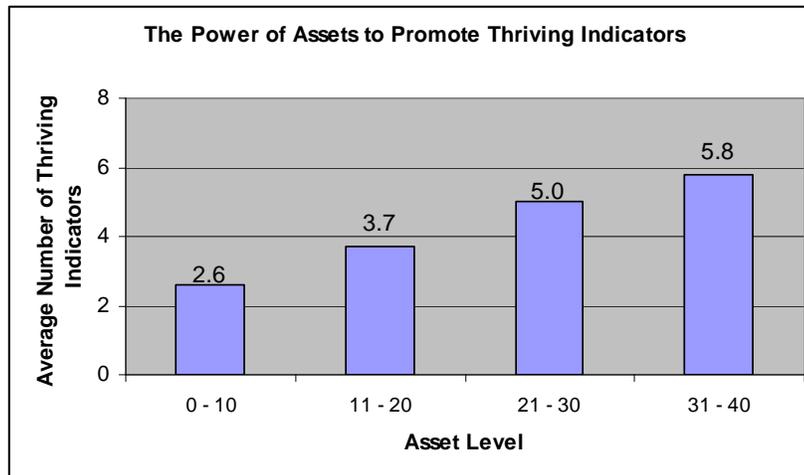
40 Developmental Assets

- Research indicates that there is a positive correlation between the number of developmental assets and the number of thriving indicators that a child exhibits. Conversely, there is a negative correlation between the number of developmental assets and the number of risk-taking behaviors, including eating disorder, depression and attempted suicide, which a child exhibits.

See the following graphs for an illustration:



The 24 risk taking behaviors are: alcohol use, binge drinking, smoking, smokeless tobacco use, inhalants, marijuana, other illicit drugs, drinking and driving, riding with a driver who has been drinking, sexual intercourse, shoplifting, vandalism, trouble with police, hitting someone, hurting someone, use of a weapon, group fighting, carrying a weapon for protection, threatening physical harm, skipping school, gambling, eating disorders, depression, and attempted suicide.



The eight thriving indicators are: school success, informal helping, valuing diversity, maintaining good health, exhibiting leadership, resisting danger, impulse control, and overcoming adversity.

(Source: Search Institute, <http://www.search-institute.org/>)

Shasta County: Mental Health Services Act – Prevention and Early Intervention

Last Updated: 04/18/2008

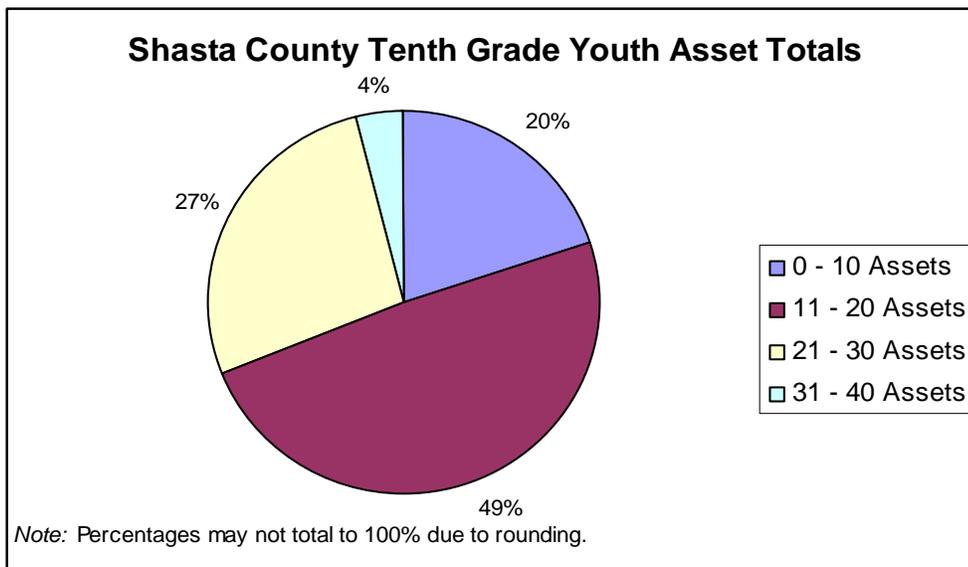
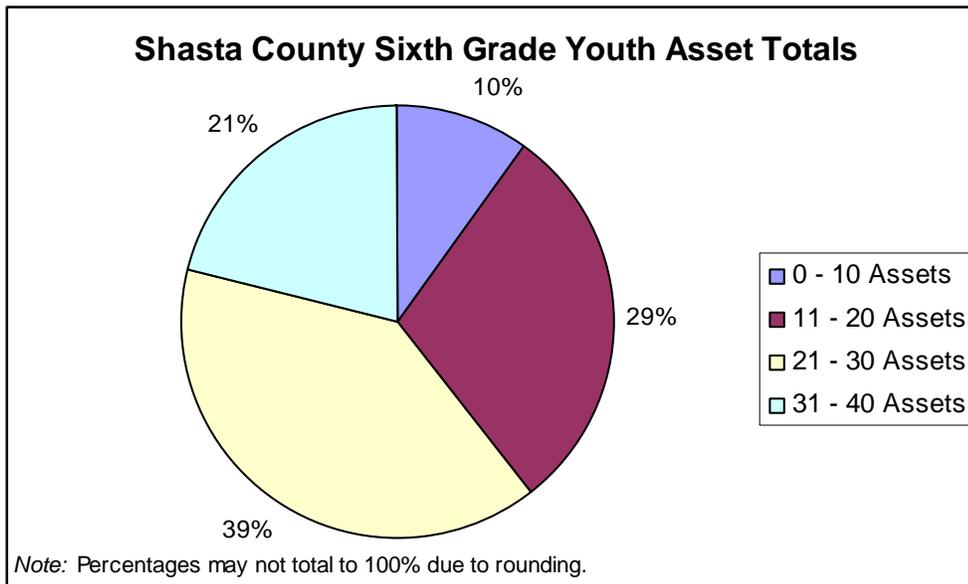
Page 1

Community Mental Health Assessment

Promoting Community Mental Well-Being (Protective Factors of Mental Well-Being) (cont'd)

40 Developmental Assets (cont'd)

- According to a 2005 survey, Shasta County 6th and 10th grade students have an average of 22.8 and 17.1 of the 40 developmental assets respectively.
- Approximately 60% of Shasta County sixth grade students exhibit more than half of the 40 developmental assets.
- Approximately 31% of Shasta County 10th graders exhibit more than half of the 40 developmental assets.



(Source: 2005 Developmental Assets Survey, <http://www.hipshasta.org>)

Community Mental Health Assessment

Promoting Community Mental Well-Being (Protective Factors of Mental Well-Being) (cont'd)

Social Support / Social Capital / Network of Meaningful Relationships

- Social capital “refers to features of social organization such as networks, norms, and social trust that facilitate coordination and cooperation for mutual benefit” (Putnam 1995).
- Social networks are believed to promote social cohesion, informal caring, protection during crises, better health education, and better access to health services, and to enforce or change societal norms that have an impact on health.
(Source: Promoting Mental Health, World Health Organization 2004)

- Social capital consists of five principal characteristics:
 - 1) Community networks, voluntary, state, personal networks, and density;
 - 2) Civic engagement, participation, and use of civic networks;
 - 3) Local civic identity—sense of belonging, solidarity, and equality with other members;
 - 4) Reciprocity and norms of cooperation, a sense of obligation to help others, and confidence in return of assistance;
 - 5) Trust in the community.

(Source: Journal of Epidemiology and Community Health. *Social Capital and Mental Illness: A Systematic Review*. DeSilva, MJ, et al. Aug 2005.)

A variety of studies have been conducted connecting social support and social capital with mental well-being among diverse groups. Here is a sampling:

- High perceived support from family, friends, and other adults offset poor mental health in 7th-12th graders.
- Low-income pregnant women with higher quality support experienced less postpartum depression.
- Mental health was positively associated with social support among university students.
- Social support protected against the incidence of depressive and anxiety disorders among working men and women aged 18 to 65.
- Variations in anti-social and suicidal behavior have been traced to strengths or absences of social cohesion.

Community Mental Health Assessment

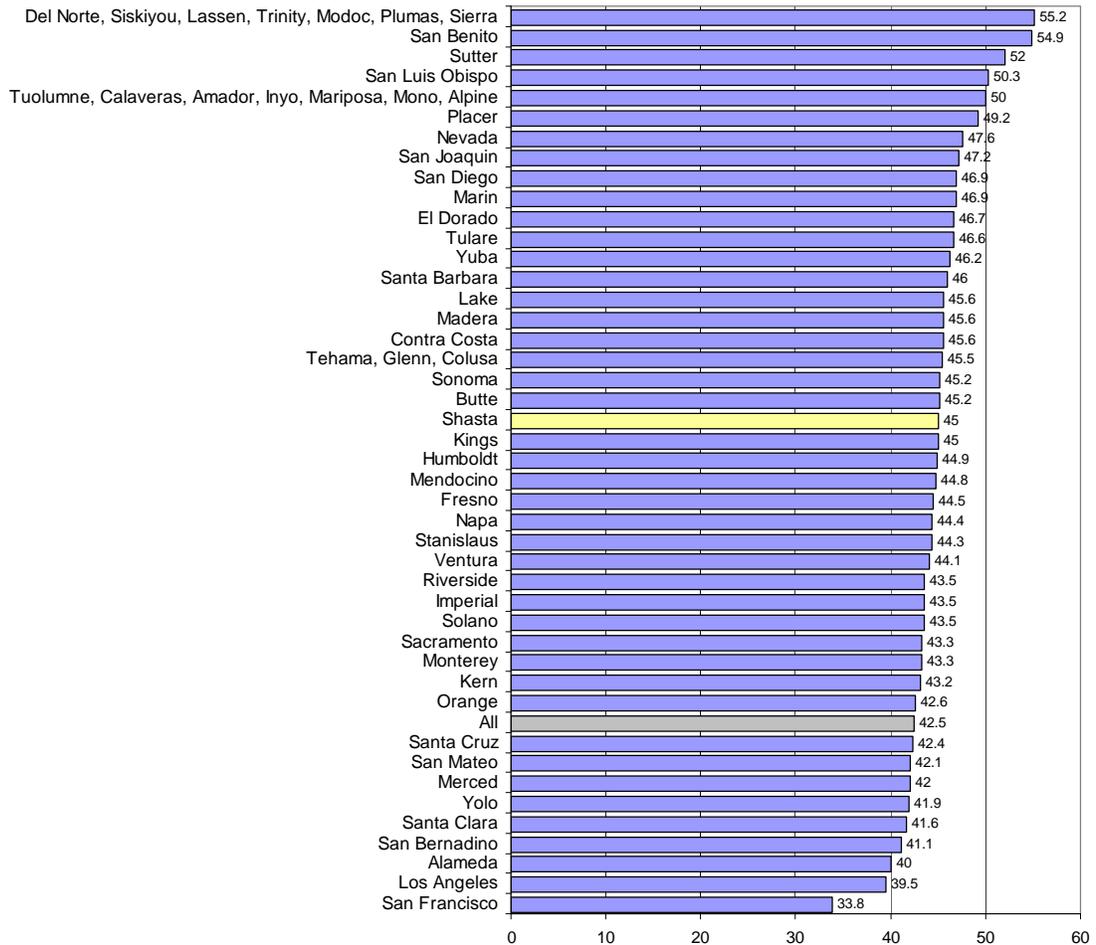
Promoting Community Mental Well-Being (Protective Factors of Mental Well-Being) (cont'd)

Social Support / Social Capital / Network of Meaningful Relationships (cont'd)

- A 2003 statewide survey found that 61% of Shasta County adults reported that someone is always available that loves them and makes them feel wanted. This is statistically similar to California adults (58%).
- Additionally, 45% of Shasta County adults reported always having someone available to understand their problems. This is slightly higher than, but statistically similar to the 42.5% of California adults who reported always having someone available to understand their problems. See graph below

(Source: 2003 California Health Interview Survey)

Someone is always available for understanding problems
CHIS, 2003



Community Mental Health Assessment

Promoting Community Mental Well-Being (Protective Factors of Mental Well-Being) (cont'd)

Civic Engagement

- Volunteering has been shown to improve life satisfaction and sense of purpose, to reduce the risk of depression, and to enhance social connections, which serve to buffer stress and protect against isolation during difficult periods. While most research has been conducted with older adults and most benefits have been found to be greater among older volunteers than younger ones, adolescents and young adults who volunteer show increased personal efficacy, self-esteem, and empathic understanding. Additionally, adolescents who volunteer have been shown to be less likely to become involved in deviant behaviors, including using drugs and becoming involved in the criminal justice system.
- **In 2003, approximately 42% of Shasta County teens (12-17 year olds) reported having done volunteer or community service work in the past year. This is statistically similar to the percentage of California teens who reported doing volunteer work (50%).**
(Source: 2003 California Health Interview Survey)

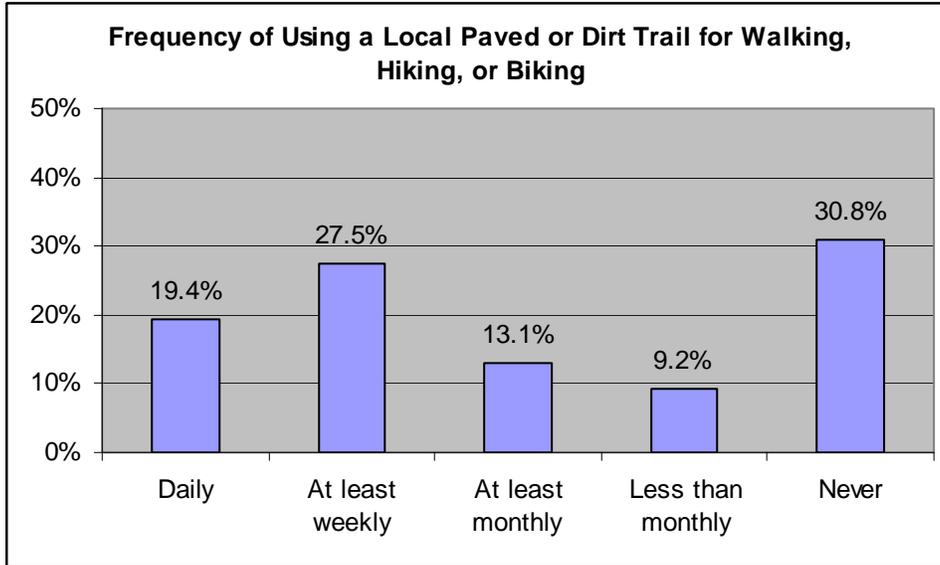
Contact with Nature

- Contact with nature can improve people's overall well-being and has been shown to have both immediate and longer term benefits to mental health. Studies have shown that viewing nature is an effective way for people to relieve stress and positively impact their outlook on life. Viewing nature-dominated scenes has been shown to be associated with quicker recovery from stress and greater immunization to subsequent stress. The psychological response to nature involves reduced negative emotions, such as anger and anxiety, and proximity to natural areas has been shown to reduce aggression. In children, contact with nature has been shown to enhance emotional development and to improve attention among those with attention deficit disorder. Additionally, a major study recently showed that while people living in rural areas had a much lower prevalence of mental disorder, those living in built up areas with access to gardens or green, open spaces had a lower prevalence than did people living in built up areas without such access.
- **According to a 2005, statewide telephone survey, significantly less Shasta County children (17.5%) reported walking, biking or skating to or from school in the past week than all children in California (29.3%).**
(Source: 2005 California Health Interview Survey)
- **According to a 2004 telephone survey among adults in Shasta, Tehama and Siskiyou Counties, 19.4% of Shasta County adults reported using a local paved or dirt trail for walking, hiking, or biking. An additional 27.5% reported using a local trail at least weekly.**
(Source: 2004 Community Health Assessment, Catholic Healthcare West)

Community Mental Health Assessment

Promoting Community Mental Well-Being (Protective Factors of Mental Well-Being) (cont'd)

Contact With Nature (cont'd)



(Source: 2004 Community Health Assessment, Catholic Healthcare West)

Community Mental Health Assessment

Promoting Community Mental Well-Being (Protective Factors of Mental Well-Being) (cont'd)

Physical Activity

- Regular physical activity has been shown to reduce morbidity and mortality from mental health disorders, including reducing the risk of developing depression.
- The mental health benefits enjoyed by physically active people include positive self-concept, self-esteem, mood elevation, self-efficacy, resilience to stress, and improved sleep.
- Young people and adults appear to benefit equally from the promotion of mental well-being that comes from engaging in physical activity.
- In addition to acting as a protective factor, physical activity has been used to treat, or to enhance the effectiveness of therapies that treat a wide range of mental health problems, including depression and anxiety.
- Exercise has been shown to help alleviate or serve as a coping strategy for symptoms of schizophrenia, such as hallucinations. *Journal of Mental Health Promotion: Promoting mental health through physical activity: examples from practice, March 2004*
- **According to a 2005 statewide telephone survey, a significantly higher proportion of Shasta County adults (35.9%) reported getting no physical activity compared to California adults (26%). See table below for more information.**

Level of physical activity	Shasta County 2005	California 2005
No physical activity	35.9%	26%
Moderate physical activity	31.7%	41.3%
Vigorous physical activity	32.4%	32.7%

(Source: 2005 California Health Interview Survey)

Community Mental Health Assessment

Preventing Mental Disorders (Risk Factors of Mental Disorders)

Adverse Childhood Events

Adverse childhood events, including physical abuse, sexual abuse, household mental illnesses, household substance abuse, parental separation or divorce, witnessing domestic violence, and household member incarcerated, have been shown to have a dose-response relationship as well as individual relationships with a range of poor mental health, substance abuse, and poor social functioning outcomes, even decades into adulthood. Loss of a parent and foster (or kin) care has also shown similar challenges for children in later adult life.

For example:

- Children experiencing the death of a close family member have an increased risk of depression, somatization, and obsessive compulsive disorder.
- Children who have witnessed domestic violence have high rates of internalizing and externalizing disorders, such as depression, aggression, and alcohol or drug use.
- Having a parent who is mentally ill is associated with increased rates of mood disorders, anxiety disorders, and addictive disorders beyond what can be accounted for by genetics.
- Five or more years of foster care is associated with poorer social functioning among adults and with elevated rates of various psychiatric symptoms and diagnoses including self-destructive and high-risk behaviors, substance use, depression and other mood disorders, and anxiety disorders. Bereavement in childhood is related to depression in adulthood.
- Childhood abuse is a risk factor for attempted suicide, and childhood sexual abuse confers increased risk for social anxiety and major depression as well.
- People reporting four or more categories of adverse childhood events are at a 4- to 12-fold increased risk for alcoholism, drug abuse, depression, and suicide attempt compared to those reporting no adverse childhood events.
- People with 5 or more adverse events in childhood had a huge increase in prescribed psychotropic medication as adults: a 3-fold increase in antidepressant, 10-fold increase for anti-psychotic and 17-fold increase in bipolar medication prescription rates.

For more information on the origins of the research behind adverse childhood events and their correlation with poor outcomes later in life, go to www.cestudy.org

- *We use data on child abuse referral and substantiated cases of child abuse and neglect as a proxy for adverse childhood events. This is undoubtedly an underestimate of the issue but gives you an idea of the most severe cases and how Shasta County compares to other areas and to California as a whole.*

Community Mental Health Assessment

Preventing Mental Disorders (Risk Factors of Mental Disorders)(cont'd)

Adverse Childhood Events (cont'd)

- There are about 3,000 Shasta County children referred to Children and Family Services every year for suspected maltreatment.
- About 30 percent of those are found to be confirmed cases of maltreatment, (950 children in 2006).
- Shasta County's rate of substantiated child maltreatment is twice that of California's rate.



(Source: <http://www.dss.cahwnet.gov>)

Community Mental Health Assessment

Preventing Mental Disorders (Risk Factors of Mental Disorders) (cont'd)

Screen Time, Especially Violent Media

From the American Academy of Pediatrics

Research has associated exposure to media violence with a variety of physical and mental health problems for children and adolescents, including aggressive behavior, desensitization to violence, fear, depression, nightmares, and sleep disturbances. More than 3500 research studies have examined the association between media violence and violent behavior; all but 18 have shown a positive relationship. Consistent and strong associations between media exposure and increases in aggression have been found in population-based epidemiologic investigations of violence in American society, cross-cultural studies, experimental and "natural" laboratory research, and longitudinal studies that show that aggressive behavior associated with media exposure persists for decades.

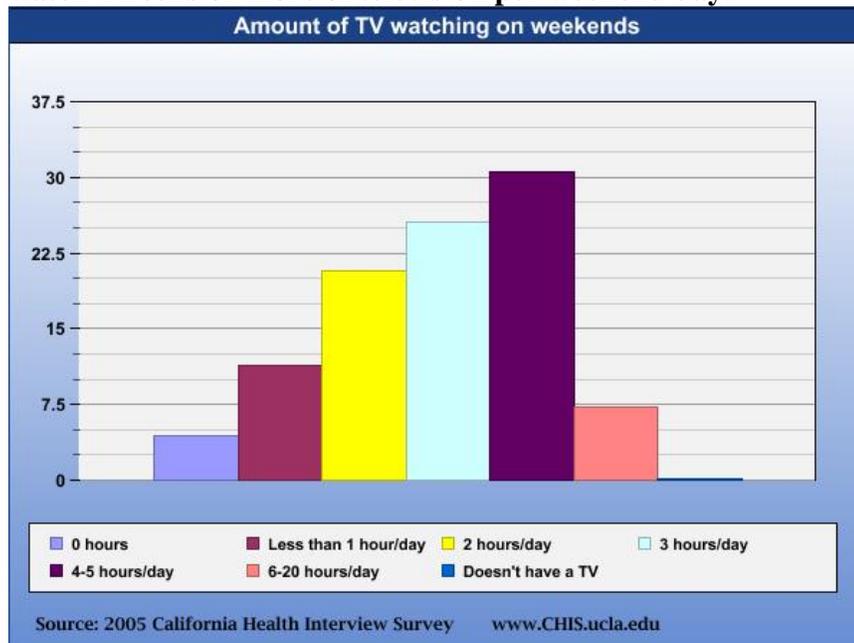
The strength of the correlation between media violence and aggressive behavior found on meta-analysis is greater than the correlations between calcium intake and bone mass, lead ingestion and lower IQ, condom nonuse and sexually acquired human immunodeficiency virus infection, or environmental tobacco smoke and lung cancer—associations clinicians accept and on which preventive medicine is based without question.

Children are influenced by media—they learn by observing, imitating, and making behaviors their own. Aggressive attitudes and behaviors are learned by imitating observed models. Research has shown that the strongest single correlate with violent behavior is previous exposure to violence.”

(Source: November, 2001 Policy Statement from the American Academy of Pediatrics.)

[For a free copy of this policy statement click here.](#)

- **In 2005, approximately 38% of children aged 3-17 years old reported that they watch 4 hours or more of television per weekend day.**



(Source: 2005 California Health Interview Survey)

Shasta County: Mental Health Services Act – Prevention and Early Intervention

Last Updated: 04/18/2008

Page 10

Community Mental Health Assessment

Preventing Mental Disorders (Risk Factors of Mental Disorders) (cont'd)

Intimate Partner Violence

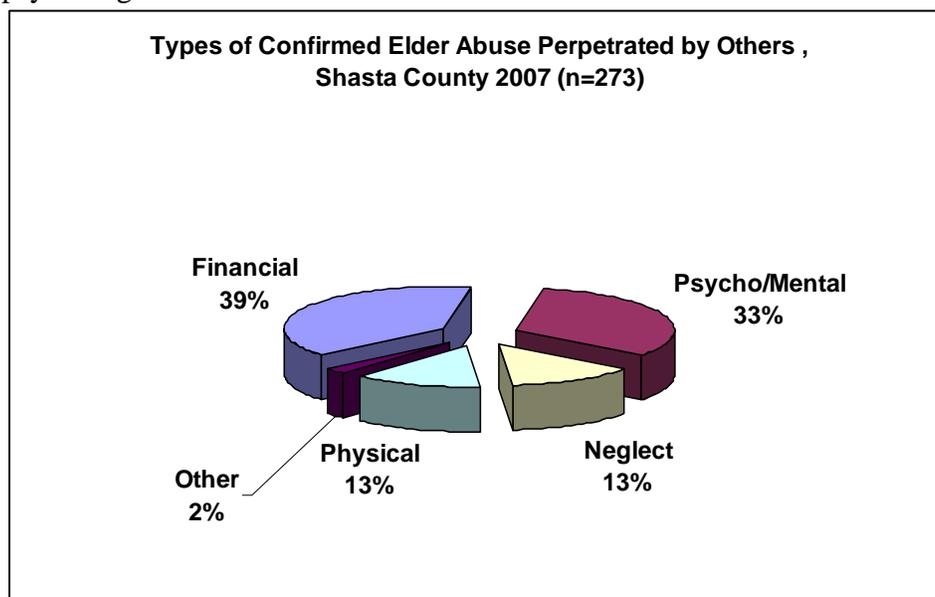
- Female survivors of intimate partner violence (IPV) are at increased risk for mental health problems, including depression, substance abuse, suicide ideation and attempt, panic attacks, sleep disorders, and posttraumatic stress disorder. These problems can continue for years after the abuse has ended.
- Both male and female victims of IPV have been shown to have an increased risk of depressive symptoms, substance abuse, and developing a chronic mental illness.
- Studies have found that women experiencing IPV are more than three times more likely than other women to have been depressed for over half of the past month, and that both suicide ideation and actual suicide attempts are six to nine times as common among adolescent girls who reported having been sexually or physically hurt by dating partners compared to those who reported no abuse.
- In addition to these increases in risk for mental health problems, victims of IPV are also twice as likely as nonvictims to report unmet need for mental health treatment - they perceive a need for mental health treatment but do not receive it - even when controlling for socioeconomic factors and substance abuse.
- **According to a 2004 Community Health Assessment, 3.9% of Shasta County adult respondents reported actual or threatened violence by a current or former intimate partner in the last 12 months.**
(Source: 2004 Community Health Assessment, Catholic Healthcare West)
- This assessment indicates that reports of domestic violence in Shasta County are significantly higher among;
 - Women (4.4%);
 - adults under the age of 40 (6.7%); and
 - Persons living below the poverty level (12.5%).*(Source: Community Health Assessment, 2004)*
- **Of the 7th, 9th and 11th grade students in Shasta County who reported having a boyfriend or girlfriend in the past year, 8.5%, 9.1%, and 10.6% of them, respectively reported being hit, slapped or physically hurt by them on purpose.**
(Source: Community Health Assessment, 2004)

Community Mental Health Assessment

Preventing Mental Disorders (Risk Factors of Mental Disorders) (cont'd)

Elder Abuse

- Victims of elder abuse are often over-controlled in their management of feelings and impulses, which significantly increases their risk for developing psychopathology.
- Indicators of elder abuse include blunted affect, fear, withdrawal or aggression, depression, anxiety, and obsessive-compulsive behavior, and several studies have revealed a much higher rate of depression among victims of elder abuse compared to nonvictims.
- It is not clear whether their depression preceded the abuse, or whether it was a consequence of the abuse, and research on the mental health effects of victims of elder abuse is limited because of the complexity of the interrelated effects of aging, and disease in old age, and the impact of abuse or neglect.
- Posttraumatic stress disorder has been suggested as a consequence of elder abuse, with symptoms including withdrawal, distrust, and dysphoria.
- Elderly female victims of partner abuse have been shown to suffer effects including lowered self-esteem, confusion, a sense of powerlessness and helplessness, increased dependency on others, depression, disturbed eating and sleeping patterns, and a sense of isolation.
- Shasta County's rate of reported elder abuse is twice as high as that of California.
 - In 2007, there were 998 reported cases of elder abuse in Shasta County for a rate of 36 reports per 1,000 Shasta County residents 65 years and older. California's reported rate of elder abuse for that same year was 18 reports per 1,000 California residents 65 years and older.
- **In 2007, 60% of the 676 confirmed cases of elder abuse were cases of self-neglect.**
- The leading types of elder abuse that was perpetrated by others were financial and psychological/mental abuse.



(Source: California Department of Social Services, Report SOC242)

Community Mental Health Assessment

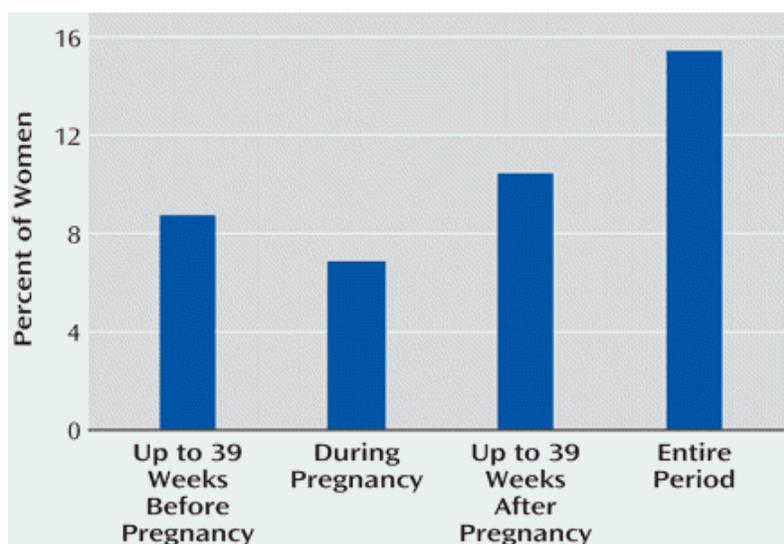
Preventing Mental Disorders (Risk Factors of Mental Disorders) (cont'd)

Maternal Depression

Children of mothers who experienced depression early in the child's life are more likely to develop depression themselves, as well as other disorders including anxiety. These disorders begin early and often continue into adulthood. In infancy, depression in the mother can impair attachment and lead to abuse or neglect. Mothers who experienced depressive symptoms postpartum have been found to be less sensitive, responsive, and nurturing in their interactions with their child at toddler age and less likely to engage in child development practices such as talking to and playing with their child. They have also been found to be more negative in their interactions with their child, and are more likely to report using harsh punishment including slapping the child in the face or spanking them with an object. Mothers who develop postpartum depression are more likely to experience subsequent depression than those who do not, which can also affect the child's socio-emotional development. Adolescent children of depressed mothers are more than twice as likely to develop diagnosable depression as those of never-depressed mothers, and the risk is elevated even if the mother only experienced major depression for one or two months, or mild depression for 12 months.

There is a lack of knowledge about the prevalence of maternal depression in Shasta County.

However, a study conducted at Stanford University among pregnant women delivering at least one live birth from 1998 to 2001 at a large HMO in western Oregon and Washington State found that 10.4% of pregnant women experienced depression after pregnancy. The study was among 4,398 women continuously enrolled from 39 weeks before birth to 39 weeks after birth. This study also found that women, who experienced depression before pregnancy, had a much higher chance of experiencing depression after pregnancy. See chart below for more information.



Percent of Women with Diagnosed Depression Before, During, and After Pregnancy
(Source: *American Journal of Psychiatry*, October 2007. "Maternal Depression Before, During, and After Pregnancy". Dietz. Et al.)

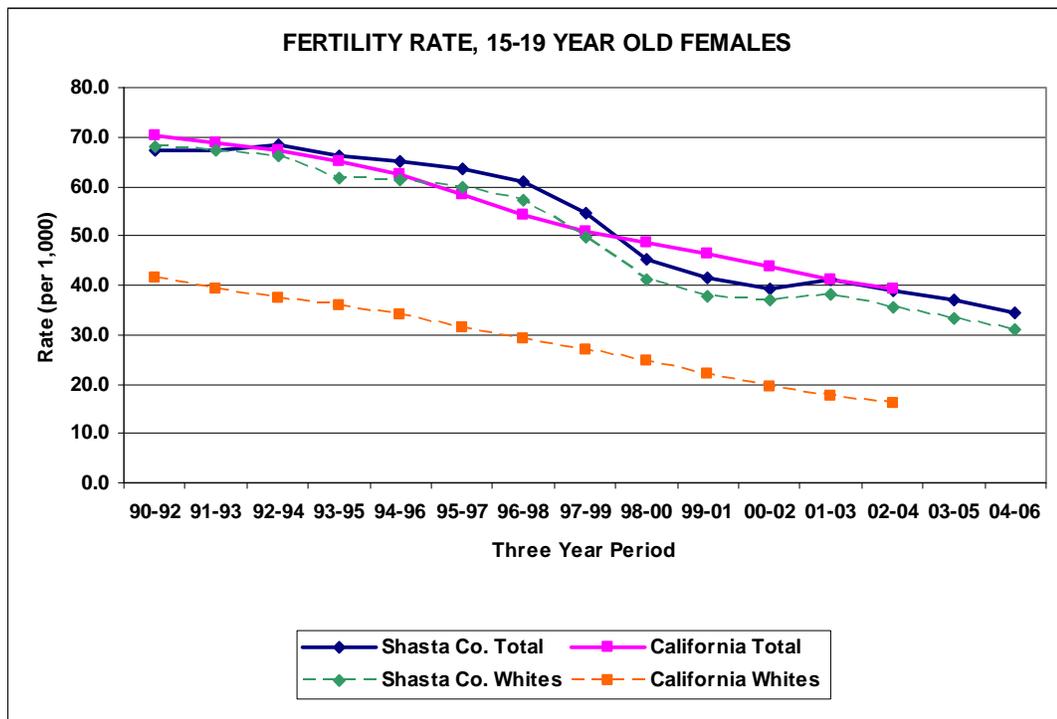
Community Mental Health Assessment

Preventing Mental Disorders (Risk Factors of Mental Disorders) (cont'd)

Teen Birth (Fertility) Rate

While teen birth, preterm birth, and low birth weight are all risk factors for mental illness, they are also interrelated.

- The proportion of babies with low birth weight is higher among teens than among adult mothers.
- In addition to being more likely to be born preterm and with a low birth weight, infants born to teen mothers are at greater risk for chemical dependence and developmental problems.
- Children born to teen mothers are at increased risk of poor parenting because their mothers are still developing themselves and are often unable to provide the kind of environment that infants and young children require for optimal development, while their fathers are often absent.
- Teen mothers are twice as likely as adult mothers to experience depression, which increases the risk of child abuse and neglect, and adverse effects on the child's psychosocial functioning. Rates of child abuse and neglect in families headed by teen mothers are more than twice as high as in families headed by mothers in their early twenties.
- Female children of teen mothers are more likely to become teen mothers themselves, and male children of teen mothers are more likely to be arrested and jailed.



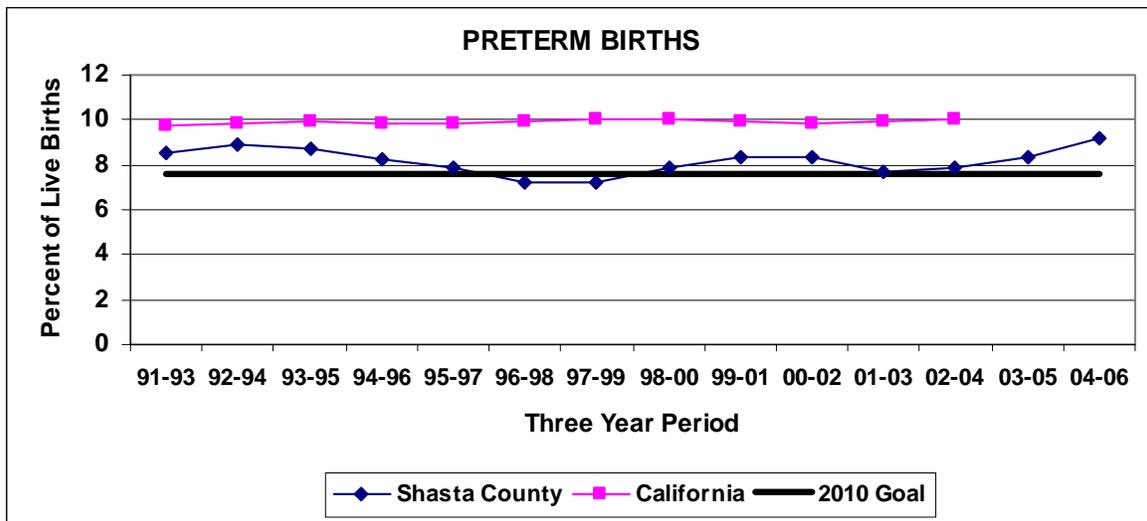
(Source: Shasta County Public Health, Vital Records Office)

Community Mental Health Assessment

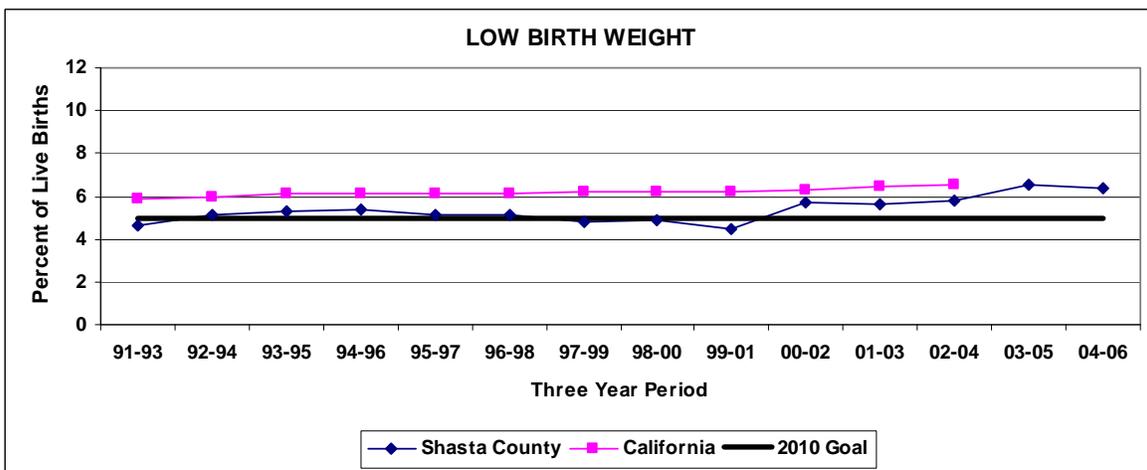
Preventing Mental Disorders (Risk Factors of Mental Disorders)

Preterm Births / Low Birth Weight

- Babies born preterm have an increased risk of lasting disability, including mental retardation.
- Children born extremely preterm have been shown to have significantly more problems with internalizing behaviors (anxiety/depression, withdrawn, and somatic problems) and attention and social problems than children born full term.
- Babies with low birth weights are at increased risk of mental retardation and mental illness, and are at double the risk of normal weight babies of later being diagnosed with hyperactivity.
- Preterm birth and low birth weight have been shown to independently increase the risk of hyperactivity.



(Source: Shasta County Public Health, Vital Records Office)



(Source: Shasta County Public Health, Vital Records Office)

Community Mental Health Assessment

Prevalence of Mental Illness / Suffering

Mental Illness – General Definitions

Taken from “Mental Health: A Report of the Surgeon General, Chapter 2 – Epidemiology of Mental Illness (<http://www.surgeongeneral.gov/library/mentalhealth/home.html>)

“The current prevalence estimate is that about 20 percent of the U.S. population is affected by mental disorders during a given year. This estimate comes from two epidemiologic surveys: the Epidemiologic Catchment Area (ECA) study of the early 1980s and the National Comorbidity Survey (NCS) of the early 1990s. Those surveys defined mental illness according to the prevailing editions of the *Diagnostic and Statistical Manual of Mental Disorders* (i.e., DSM-III and DSM-III-R). **The surveys estimate that during a 1-year period, 22 to 23 percent of the U.S. adult population—or 44 million people—have diagnosable mental disorders**, according to reliable, established criteria. In general, 19 percent of the adult U.S. population has a mental disorder alone (in 1 year); 3 percent have both mental and addictive disorders; and 6 percent have addictive disorders alone. Consequently, about 28 to 30 percent of the population has either a mental *or* addictive disorder (Regier et al., 1993b; Kessler et al., 1994).”

Serious Mental Illness

Based on data on functional impairment, it is estimated that 9 percent of all U.S. adults have mental disorders *and* experience some significant functional impairment (National Advisory Mental Health Council [NAMHC], 1993). Most (7 percent of adults) have disorders that persist for at least 1 year (Regier et al., 1993b; Regier et al., in press). **A subpopulation of 5.4 percent of adults is considered to have a “serious” mental illness (SMI) (Kessler et al., 1996).** Serious mental illness is a term defined by Federal regulations that generally applies to mental disorders that interfere with some area of social functioning.

Severe and Persistent Mental Illness

About half of those with SMI (or 2.6 percent of all adults) were identified as being even more seriously affected, that is, by having “severe and persistent” mental illness (SPMI) (NAMHC, 1993; Kessler et al., 1996). This category includes schizophrenia, bipolar disorder, other severe forms of depression, panic disorder, and obsessive-compulsive disorder. Among those most severely disabled are the approximately 0.5 percent of the population who receive disability benefits for mental health-related reasons from the Social Security Administration (NAMHC, 1993). *It is this group of individuals, which fall under the treatment responsibility of the County Mental Health Department per Welfare and Institutions Code, 5600.3 to the extent resources are available.* [Click here to read the code.](#)

Serious Emotional Disturbances

Federal regulations also define a sub-population of children and adolescents with more severe functional limitations, known as “serious emotional disturbance” (SED). Children and adolescents with SED number approximately 5 to 9 percent of children ages 9 to 17 (Friedman et al., 1996b).

Community Mental Health Assessment

Prevalence of Mental Illness / Suffering (cont'd)

Mental Illness – Local Prevalence Estimates

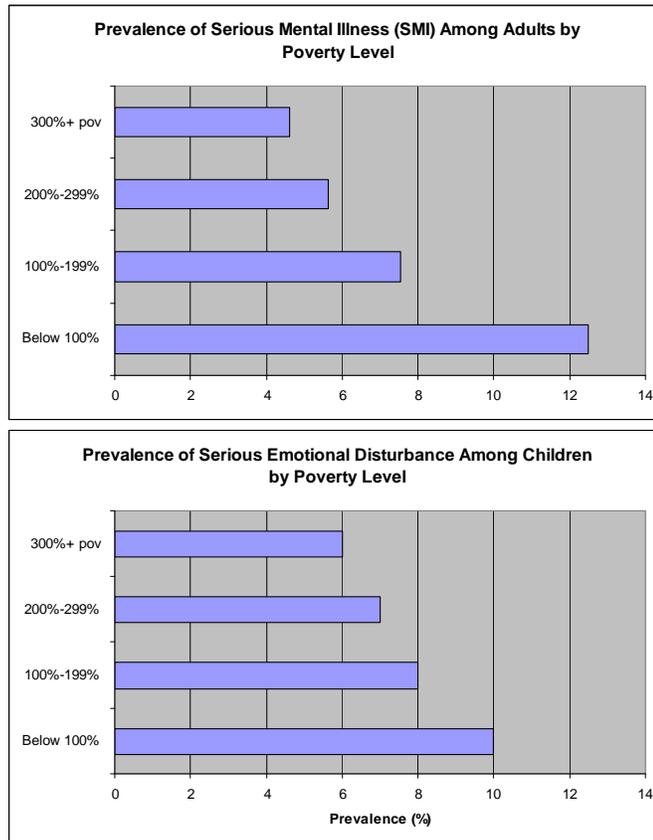
Detailed mental illness prevalence estimates are provided here through a contract between the California State Department of Mental Health and Charles Holzer, PhD, of the University of Texas, Medical Branch. These prevalence rates are estimates that were calculated by applying prediction weights, developed from previous nationally prominent survey studies, to California County population demographics. Thus these rates should be understood as reasonable estimates of serious mental illness prevalence rates, rather than counts of actual individuals.

- According to the California State Department of Mental Health, **approximately 7% of Shasta County residents** could be suffering from Serious Mental Illness (adults) or Serious Emotional Disturbance (children). The prevalence of Serious Emotional Disturbance in children is slightly higher at 7.7% than the prevalence of Serious Mental Illness in adults at 6.8%. These prevalence estimates also vary by age among youth and adults, poverty level, education, marital status (adults), and race/ethnicity.
- This study found that SMI or SED disproportionately affects those who are:
 - Living below the poverty level (12.5% of adults and 10% of children)
 - 18-20 years old (11.2%).
 - Separated, widowed or divorced (10.4%) compared to those who are married (4.4%), or single (8.2%)
 - Females (7.9%) compared to males (4.9%)
- Living in poverty seems to have a dose-response relationship with mental illness in all areas where it is measured. It also seems to have a stronger relationship among adults than among children. (see graphs depicting Shasta County prevalence estimates by poverty level among adults and children below)

Community Mental Health Assessment

Prevalence of Mental Illness / Suffering (cont'd)

Mental Illness – Shasta County Prevalence Estimates (cont'd)



(Source: California Department of Mental Health
http://www.dmh.cahwnet.gov/Statistics_and_Data_Analysis/Prevalence_Rates.asp)

- A local telephone survey conducted in 2005 found that **between 3% and 9% of Shasta County adults** suffer from psychological distress in the last 30 days as measured by the Kessler 6 index. This is not significantly higher than the State of California as a whole. The Kessler 6 index is a sensitive population measure of DSM-IV mood or anxiety disorders.

(Source: 2005 California Health Interview Survey)

Community Mental Health Assessment

Prevalence of Mental Illness / Suffering (cont'd)

(Adolescent)

- Every two years, schools are required to administer the California Healthy Kids Survey. The following table is from the Fall 2006 results of this survey conducted in Shasta County. All 7th, 9th, and 11th graders were asked the following question: **During the past 12 months, did you ever feel so sad and hopeless almost every day for two weeks or more that you stopped doing some usual activities?**

Shasta County Adolescents

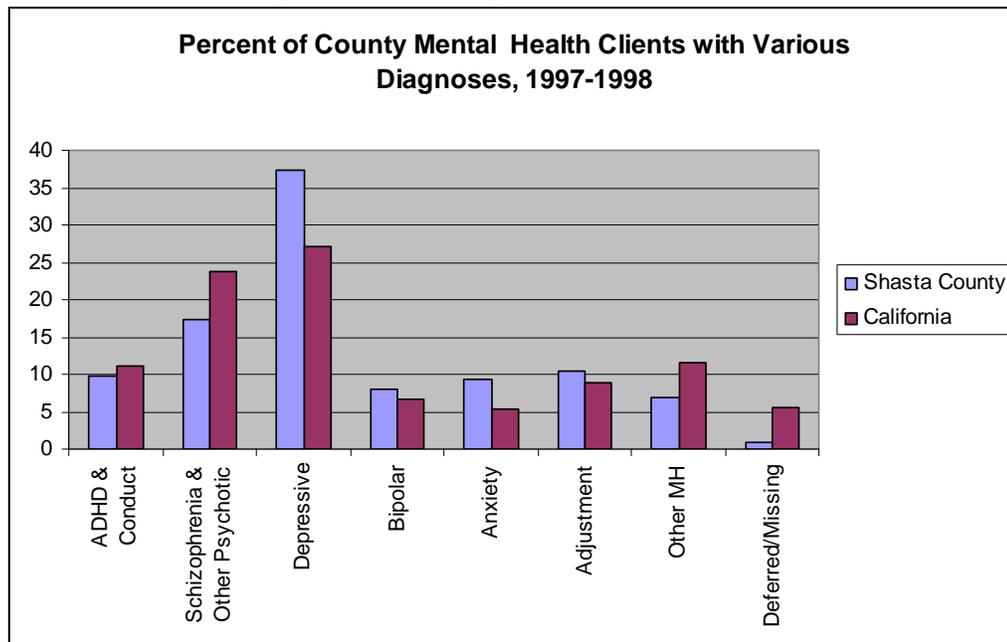
Frequency of Sad and Hopeless Feelings, Past 12 Months

	7th Grade	9th Grade	11th Grade
No	73%	72%	67%
Yes	27%	28%	33%

Question: During the past 12 months did you ever feel so sad and hopeless almost every day for two weeks or more that you stopped doing some usual activities?

Mental Health Department Data (Treatment)

- In the 1997-1998 fiscal year, (most recent data available) Shasta County Mental Health saw 3,806 unduplicated clients (2.4% of the population). The largest percentage of those clients (37%) was diagnosed with a depressive disorder.



(Source: http://www.dmh.cahwnet.gov/Statistics_and_Data_Analysis/County_Mental_Hospital_Data.asp)

Community Mental Health Assessment

Prevalence of Alcohol and Other Drug Abuse

Co-Occurring Disorders

The relationship between substance abuse and mental illness is complex. Substance abuse can cause mental illness, unmask the expression of a tendency toward (ie trigger) mental illness, be a co-occurring primary disorder, or be a consequence of mental illness (such as self-medication of psychic pain). Mental disorders caused by substance abuse can be short term, such as depression following a cocaine crash or hallucinations that result from the use of PCP or it can also be more delayed, like the impact of teen alcohol use on brain development leading to an increased likelihood of adult depression. In the vast majority of cases, entrenched addiction does not resolve after psychiatric stabilization alone.

In a 2002 Report to Congress (www.samhsa.gov/reports/congress2002/index.html), the Substance Abuse and Mental Health Services Administration (SAMHSA) addressed the prevention and treatment of co-occurring substance abuse disorders and mental disorders. They acknowledge that “despite strides in the research base over the past two decades, little remains known about the etiology and temporal ordering of co-occurring substance abuse disorders and mental disorders. For this reason, many researchers and clinicians believe that *both disorders must be considered as primary and treated as such.*”

In order to develop effective prevention strategies, all possible theories of the relationship between substance abuse disorders and mental disorders need to be taken into consideration. Muesler, et al. (1998) reviewed two decades worth of theories and offered 4 general models that synthesized then current thinking in the field regarding the etiology of co-occurring substance abuse disorders and mental disorders.

- ***Common factor models.*** High rates of co-morbidity are the result of risk factors shared across both severe mental illness and substance abuse disorders.
- ***Secondary substance abuse disorder models.*** Severe mental illness increases a person's chances of developing a substance abuse disorder.
- ***Secondary mental/psychiatric disorder model.*** Substance abuse precipitates severe mental illness in people who would not otherwise develop a severe mental illness.
- ***Bi-directional models.*** Either severe mental illness or substance abuse disorders can increase a person's vulnerability to developing the other disorder.

The researchers found modest support for a connection between antisocial personality disorders and increased co morbidity (an example of the common factor model), and for a secondary substance use model in which a person with a mental disorder is biologically vulnerable to develop a substance abuse disorder if they use even small amounts of alcohol or other drugs (Mueser et al., 1998). However, the lack of longitudinal assessment data limited evaluation of these models. Antisocial personality is often associated with alcoholism, particularly with an earlier age of alcohol abuse.

For other individuals, substance abuse disorders may precede or precipitate the onset of a mental disorder. Data from one study reveal that mood and anxiety disorders diagnosed in individuals with a substance abuse disorder may be an artifact of their substance abuse and may improve with recovery from substance abuse (Verheul et al., 2000). This study found little support, however, for the theory that personality disorders also may be secondary to substance abuse.

Community Mental Health Assessment

Prevalence of Alcohol and Other Drug Abuse (cont'd)

Co-Occurring Disorders (cont'd)

RachBeisel and McDuff (1995) note that depression and psychosis may be precipitated by substance abuse. However, they caution that differentiating a substance-induced or secondary mental illness from a primary disorder is complex and imprecise. Chronic use of alcohol, opiates, and cocaine is the most common factor leading to depressive symptoms. Psychotic disorders have been identified as secondary to a wide variety of addictive substances, including PCP, crack cocaine, hallucinogens, alcohol, and ecstasy. The type of depression seen as secondary to substance abuse is similar to a primary depressive disorder, except the symptoms are likely to be mild to moderate rather than severe (RachBeisel and McDuff, 1995). Alcohol induced depression is indistinguishable from major depression on a cross-sectional basis. Longitudinally, it can be distinguished by its tendency to clear within 2 weeks of sobriety.

Suicide, associated with depression, is a serious concern for individuals with co-occurring disorders: 15 to 25 percent of suicides are committed by individuals who abuse alcohol, and between 5 and 27 percent of all deaths in individuals who abuse alcohol are due to suicide, compared to 1 percent in the general population (Jaffee and Ciraulo, 1986, in RachBeisel and McDuff, 1995). Psychotic episodes, including suicide, may be associated with intoxication or withdrawal from addictive substances, or may be a lasting result of chronic substance abuse.

Finally, substance abuse among persons with mental illness has been associated with relapse and rehospitalization, more psychotic symptoms, greater depression and suicidality, incarceration, inability to manage finances and daily needs, housing instability and homelessness, noncompliance with medication regimens and other treatments, HIV, hepatitis, lower satisfaction with familial relationships, increased family burden and higher service use and cost. Thus, in addition to the role of substance abuse prevention in preventing some mental illness, mitigating substance abuse among those with primary mental disorders makes sense from a patient outcomes and impact on mental health delivery of service perspectives.

The Effect on Others

Alcohol use is associated with 2 out of 3 incidents of intimate partner violence. Studies have also shown that alcohol is a leading factor in child maltreatment and neglect cases, and is the most frequent substance abused among these parents involved in such child maltreatment--not methamphetamine. The Centers for Disease Control and Prevention (CDC) estimates that in 2001, 16% of child maltreatment cases (1 in 6) could be attributed to alcohol use.

A study published in 2005 reported that varying but often high percentages of perpetrators of crime had been drinking at the time the crime was committed. Crime (% perpetrators drinking)—murder (28-86%), robbery (7-72%), assault (24-37%), sexual offenses (13-60%).

About 100,000 students are victims of alcohol related sexual assault or date rape (Hingson et al. 2005). And a certain percent of these sexual assault cases will result in Post-Traumatic Stress Disorder (PTSD) and other psychiatric conditions (eg depression, etc).

Considering methods of preventing alcohol and other drug abuse, especially early in life may be effective at preventing other mental illness in individuals.

Community Mental Health Assessment

Prevalence of Alcohol and Other Drug Abuse (cont'd)

Underage Drinking

Evidence suggests that the earlier the age at which young people take their first drink of alcohol, the greater the risk of abusive consumption and the development of serious problems, including alcohol disorders.

- One study found that after ten years, 13.5% of participants who began to drink at ages 11 and 12 met the criteria for a diagnosis of alcohol abuse, and 15.9% had a diagnosis of dependence. Rates for those who began to drink at ages 13 and 14 were 13.7% and 9.0%, respectively. In contrast, rates for those who started drinking at ages 19 and older were 2.0% and 1.0%.
- Another study found that early drinkers (current drinkers at grade 7) and experimenters (those who'd experimented with alcohol just once or twice during the past year at grade 7) were more likely than nondrinkers to report academic problems, substance abuse, and delinquent behavior in both middle school and high school, and that by young adulthood early alcohol use was associated with employment problems, other substance abuse, and criminal and violent behavior. These associations remained even after controlling for gender, race/ethnicity, age, parental education, family structure, and other types of early adolescent substance use and problem behaviors.

Alcohol use in adolescence is associated not only with alcohol but also other substance abuse later in life. It is also associated with psychological distress, depression, and suicide later in life.

- In a study of adolescents who were current drinkers, 31% exhibited extreme levels of psychological distress.
- In another study of adolescent girls, those who were current drinkers were four times more likely than their non-drinking peers to suffer depression.
- Numerous studies have shown a positive correlation between adolescent drinking and suicide ideation and attempts, with suicide attempts among heavy-drinking adolescents being three to four times greater than among abstainers, and suicide attempts being strongly associated with alcohol abuse and dependence even after controlling for depression. The relationship between alcohol and suicidality may involve the disinhibitory effects of alcohol intoxication, the increase in vulnerability for depression resulting from chronic alcohol abuse, as well as possible self-medication for depressive symptoms.

Community Mental Health Assessment

Prevalence of Alcohol and Other Drug Abuse (cont'd)

Underage Drinking (cont'd)

- *It is important to note that this is self-reported behavior among adolescents. While the accuracy of the percentages may be questionable, the differences over time and between Shasta County and California adolescents should be reliable.*
- In 2006, 3% of Shasta County 5th graders reported drinking a full drink of beer, wine or other alcohol in the last month. This is statistically similar to the 2% of California 5th graders who reported drinking one full glass of beer, wine or other alcohol in the last month.

Adolescent Alcohol and Marijuana Use in Shasta County, 2006

% Reported in the last 30 Days	7th grade	9th grade	11th grade
At least one drink*	12	26	36
Binge Drinking (5 or more drinks in a row within a couple of hours)	6	15	24
Use Marijuana	5	11	19

* It is not specified whether this is one sip or one full glass of alcohol and thus cannot be compared to data collected among 5th graders.

Adolescent Alcohol and Marijuana Use in Shasta County, 2004

% Reported in the last 30 Days	7th grade	9th grade	11th grade
At least one drink	13	30	40
Binge Drinking (5 or more drinks in a row within a couple of hours)	5	16	27
Use Marijuana	4	14	20

* It is not specified whether this is one sip or one full glass of alcohol and thus cannot be compared to data collected among 5th graders.

- Comparing 7th grade survey results from 2004 with 9th grade survey results in 2006, the use of at least one drink of alcohol doubled, binge drinking tripled and the use of marijuana almost tripled.
- Comparing 9th grade survey results from 2004 with 11th grade survey results in 2006, the use of at least one drink of alcohol increased 20%, the report of binge drinking increased 50% and the report of marijuana use increased 35%.
- This might indicate an opportunity for intervention between 7th and 9th grade to keep adolescents from beginning to use alcohol or other drugs.
(Source: 2006 California Healthy Kids Survey)

Community Mental Health Assessment

Prevalence of Alcohol and Other Drug Abuse (cont'd)

Underage Drinking (cont'd)

% Reported in the last 30 Days	7th grade	9th grade	11th grade
At least one drink*	13	28	37
Binge Drinking (5 or more drinks in a row within a couple of hours)	4	13	21
Use Marijuana	4	12	16

* This information was collected in schools all across California during the 2004-05 and 2005-06 school years.

- Comparing 2004 Shasta County data to the data collected in California;
 - Shasta County 7th and 9th graders are statistically more likely to report having at least one drink of alcohol in the last 30 days, while Shasta County 11th graders are similar in their reported alcohol use to other Californians in the same grade.
 - Shasta County 7th and 9th graders are statistically more likely to report binge drinking in the last 30 days, while Shasta County 11th graders are similar in their reported binge drinking behavior to other Californians in the same grade.
 - Shasta County 7th, 9th and 11th graders are not statistically more or less likely to report having used marijuana in the last 30 days than California 7th, 9th and 11th graders.

Community Mental Health Assessment

Prevalence of Alcohol and Other Drug Abuse (cont'd)

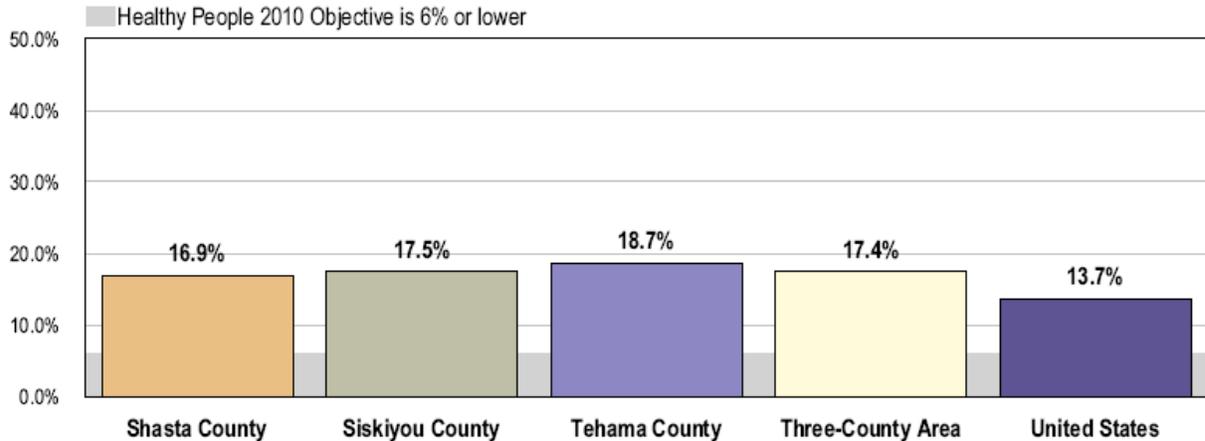
Binge Drinking

Binge drinkers are defined as respondents who report that there was as one or more times in the past month when they drank five or more drinks on a single occasion.

17.4% of Three-County Area adults are binge drinkers.

- Less favorable than national findings (13.7%).
- Fails to satisfy the Healthy People 2010 target (6% or lower).
- Similarly high in each of the three counties.

Binge Drinkers (By County; 2004)



Sources: • 2004 PRC Community Health Survey, Professional Research Consultants. [Item 148]
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC).
• 2003 PRC National Health Survey, Professional Research Consultants.
• Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 26-11c]

Notes: • Reflects the total sample of respondents.
• Binge drinkers are those who have had 5 or more alcoholic drinks on any one occasion at least once in the past month.

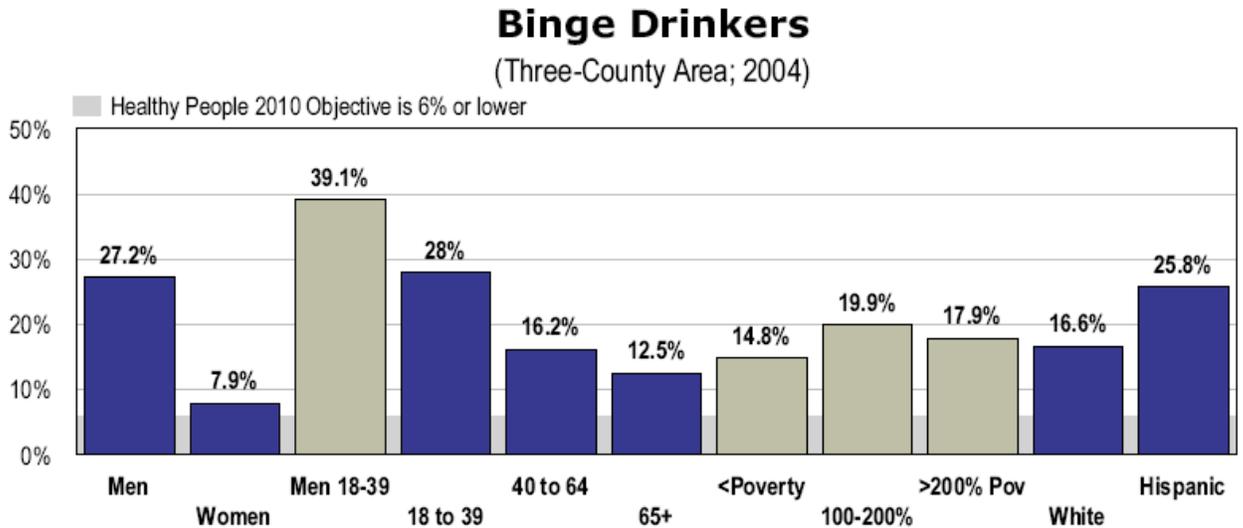
The proportion of adults binge drinking in the Three-County Area has increased significantly since 1999.

(Source: 2004 Community Health Assessment, Catholic Healthcare West)

Community Mental Health Assessment

Prevalence of Alcohol and Other Drug Abuse (cont'd)

Binge Drinking (cont'd)



- Sources:
- 2004 PRC Community Health Survey, Professional Research Consultants. [Item 148]
 - Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 26-11c]
- Notes:
- Reflects the total sample of respondents.
 - Binge drinkers are those who have had 5 or more alcoholic drinks on any one occasion at least once during the past month.

(Source: 2004 Community Health Assessment, Catholic Healthcare West)

Community Mental Health Assessment

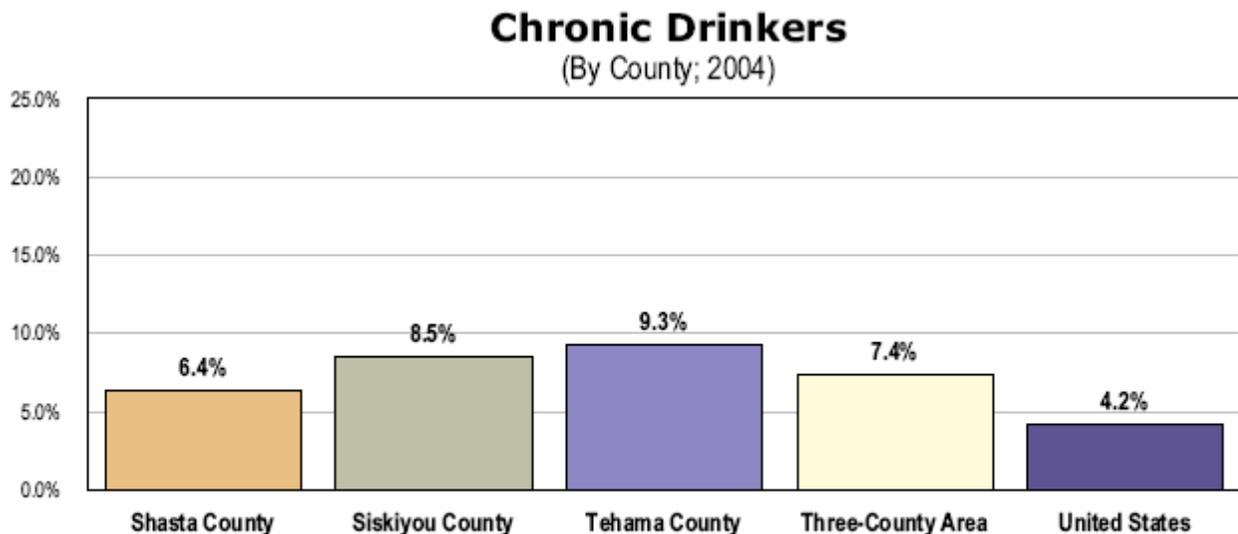
Prevalence of Alcohol and Other Drug Abuse (cont'd)

Chronic Drinking

- Alterations of brain chemistry from chronic exposure to alcohol can produce affective symptoms, such as depression and psychotic symptoms, such as Korsakoff's psychosis or the hallucinations and paranoia seen in some alcohol withdrawal. Alcohol in particular, among various substances abused, is strongly associated with depression and suicidality.
- In a local survey, chronic drinkers are defined as those respondents reporting 60 or more drinks of alcohol in the month preceding the interview. For the purposes of this study, a "drink" is considered one can or bottle of beer, one glass of wine, one can or bottle of wine cooler, one cocktail or one shot of liquor.

7.4% of Three-County Area adults report an average of two or more drinks of alcohol per day in the past month.

- Less favorable than national findings (4.2%).
- Statistically similar findings among the three counties.



Sources: • 2004 PRC Community Health Survey, Professional Research Consultants. [Item 147]
• 2003 PRC National Health Survey, Professional Research Consultants.

Notes: • Reflects the total sample of respondents.
• Chronic drinkers are defined as those who have had at least 60 drinks of alcoholic beverages during the past month.
• California data not available.

(Source: 2004 Community Health Assessment, Catholic Healthcare West)

Community Mental Health Assessment

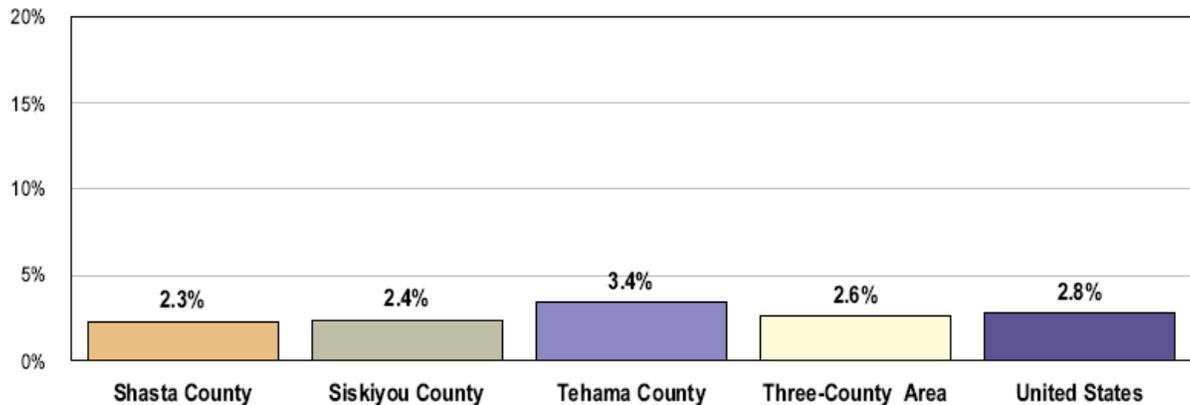
Prevalence of Alcohol and Other Drug Abuse (cont'd)

Drinking & Driving

2.6% of Three-County Area adults acknowledge having driven a vehicle in the past month after they had perhaps too much to drink.

- Statistically similar to national findings (2.8%).
- Does not vary significantly by county.
- Based on current population estimates, this figure represents approximately 5,500 drunk drivers on the streets of Three-County Area in the past month.

**Have Driven in the Past Month
After Perhaps Having Too Much to Drink**
(By County; 2004)



Sources: • 2004 PRC Community Health Survey, Professional Research Consultants. [Item 66]
• 2003 PRC National Health Survey, Professional Research Consultants.

Notes: • Asked of all respondents.

(Source: 2004 Community Health Assessment, Catholic Healthcare West)

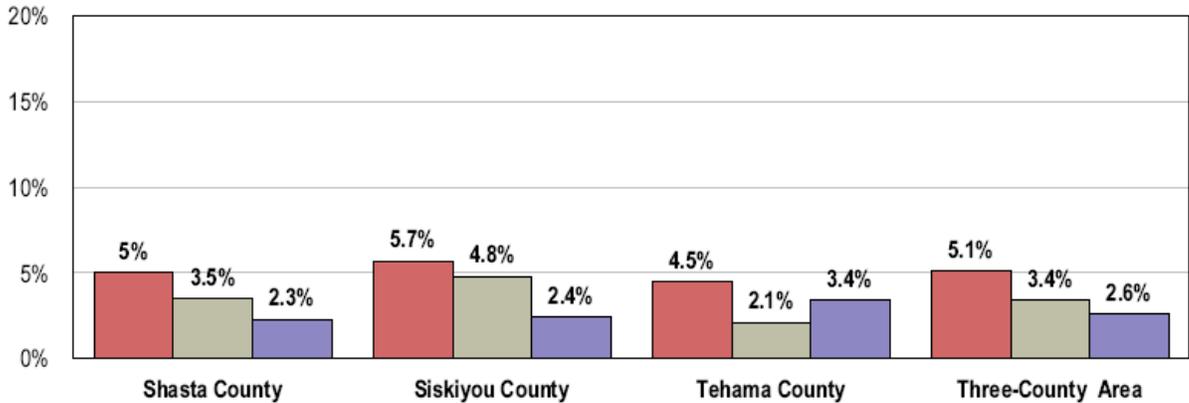
Community Mental Health Assessment

Prevalence of Alcohol and Other Drug Abuse (cont'd)

Drinking and Driving (cont'd)

Self-reported drinking and driving has declined significantly since the 1999 survey.

Trend in Drinking and Driving
(By County)



Sources: • 1999/2002/2004 PRC Community Health Surveys, Professional Research Consultants. [Item 66]
Notes: • Asked of all respondents.

(Source: 2004 Community Health Assessment, Catholic Healthcare West)

- In 2006, 7% of 11 grade students reported driving while being under the influence of driving.
(Source: 2006 California Healthy Kids Survey)

Community Mental Health Assessment

Prevalence of Alcohol and Other Drug Abuse (cont'd)

Self-Reported Illicit Drug Use

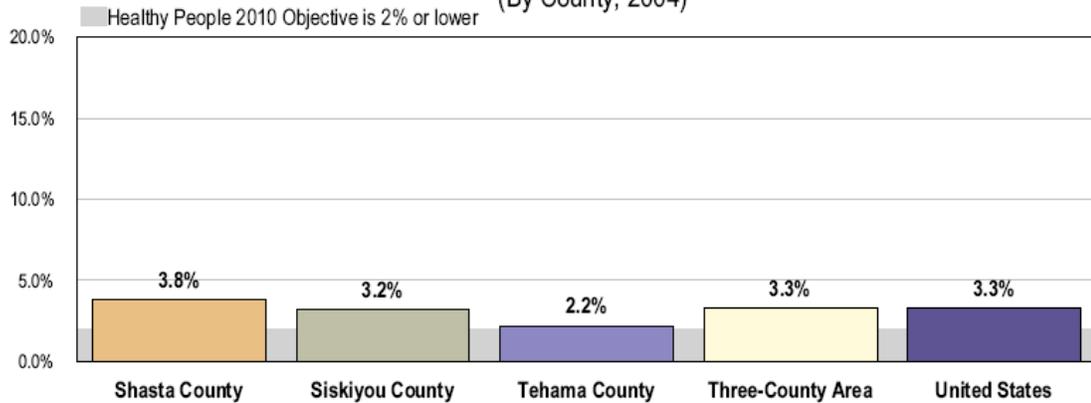
For the purposes of this survey, “illicit drug use” includes use of illegal substances or of prescription drugs taken without a physician’s order.

3.3% of Three-County Area adults acknowledge using an illicit drug in the past month.

- Identical to national findings (3.3%).
- Fails to satisfy the Healthy People 2010 target (2% or lower).
- Does not vary significantly by county.

Self-Reported Illicit Drug Use in the Past Month

(By County; 2004)



Sources: • 2004 PRC Community Health Survey, Professional Research Consultants. [Item 68]
• 2003 PRC National Health Survey, Professional Research Consultants.
• Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 26-10c]

Notes: • Asked of all respondents.
• In this case, the term "illicit drug use" includes use of an illegal drug and/or use of a prescription drug without a physician's orders.
• This exact inquiry was not addressed in previous studies for the Three-County Area.

(Source: 2004 Community Health Assessment, Catholic Healthcare West)

Community Mental Health Assessment

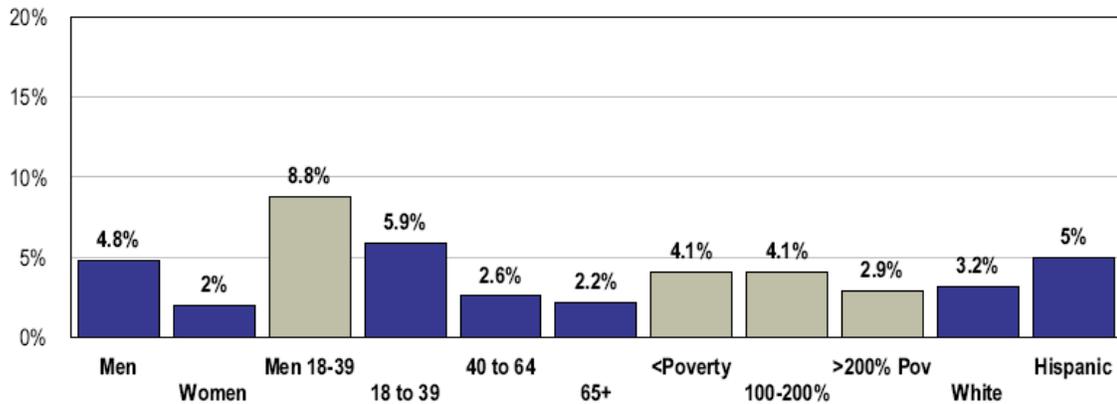
Prevalence of Alcohol and Other Drug Abuse (cont'd)

Self-Reported Illicit Drug Use (cont'd)

Males aged 18 through 39 are most likely to acknowledge using illicit drugs in the past month.

Self-Reported Illicit Drug Use in the Past Month

(Three-County Area; 2004)



Sources: • 2004 PRC Community Health Survey, Professional Research Consultants. [Item 68]

Notes: • Asked of all respondents.

Less than one percent (0.9%) of adults acknowledge having used an injection drug (aside from insulin injections, fertility shots, steroid shots for MS, etc.) in the past year.

(Source: 2004 Community Health Assessment, Catholic Healthcare West)

Community Mental Health Assessment

Early Intervention

Help Seeking Behavior

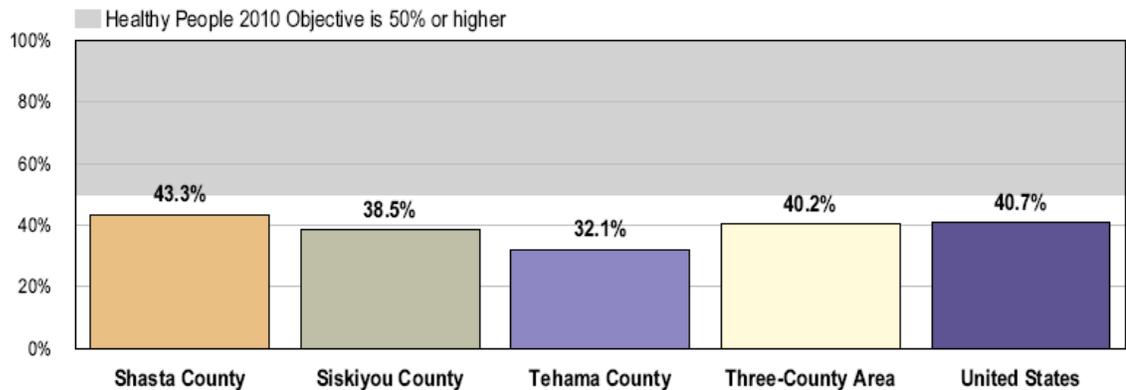
Help Seeking for Mental or Emotional Problems

Among survey respondents reporting major or chronic depression, 40.2% acknowledge that they have sought professional help for a mental or emotional problem.

- Statistically similar to national findings (40.7%).
- Fails to satisfy the Healthy People 2010 Objective (50% or higher).
- Highest in Shasta County (43.3%).

Have Sought Professional Help With a Mental or Emotional Problem

(By County, 2004; Among Persons With Recognized Depression)



Sources: • 2004 PRC Community Health Survey, Professional Research Consultants. [Item 164]
• 2003 PRC National Health Survey, Professional Research Consultants.
• Healthy People 2010, 2nd Edition. U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, November 2000. [Objective 18-9b]

Notes: • Among respondents who have been diagnosed with major depression or who have experienced two or more years of depression at some point in their lives.
• California data not available.

(Source: 2004 Community Health Assessment, Catholic Healthcare West)

Community Mental Health Assessment

Early Intervention (cont'd)

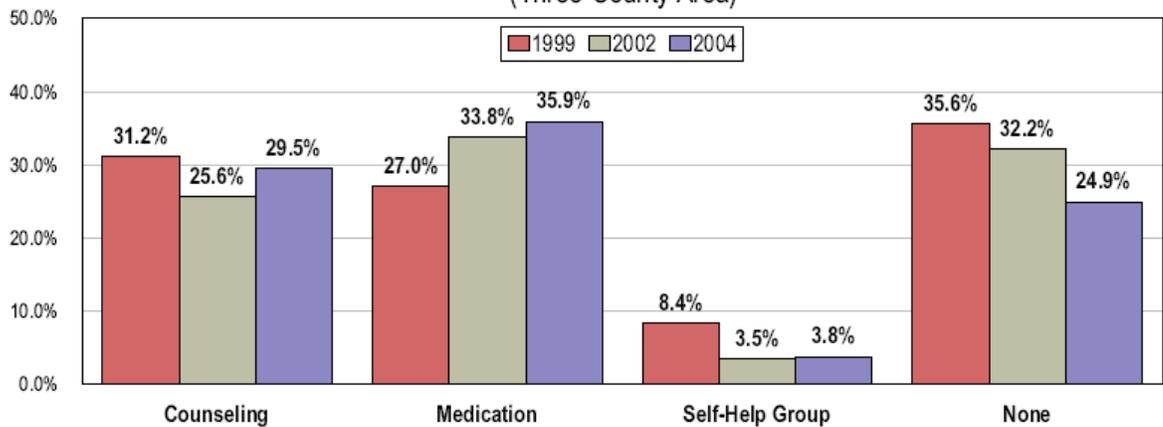
Help Seeking Behavior (cont'd)

Help Seeking for Mental or Emotional Problems (cont'd)

When asked to describe the type of professional help sought for mental or emotional problems, over one-third of adults with depression who have sought help mentioned receiving medication.

- Note the increase in medication as the type of help received among adults with depression, and the subsequent decrease in “none” responses.

Trend in Type of Help Received During Depression
(Three-County Area)



Sources: • 1999/2002/2004 PRC Community Health Surveys, Professional Research Consultants. [Item 112]

Notes: • Asked of those respondents who experienced two or more years of depression.

• Responses may total more than 100 percent as some respondents identified more than one type of help.

(Source: 2004 Community Health Assessment, Catholic Healthcare West)

Community Mental Health Assessment

Early Intervention (cont'd)

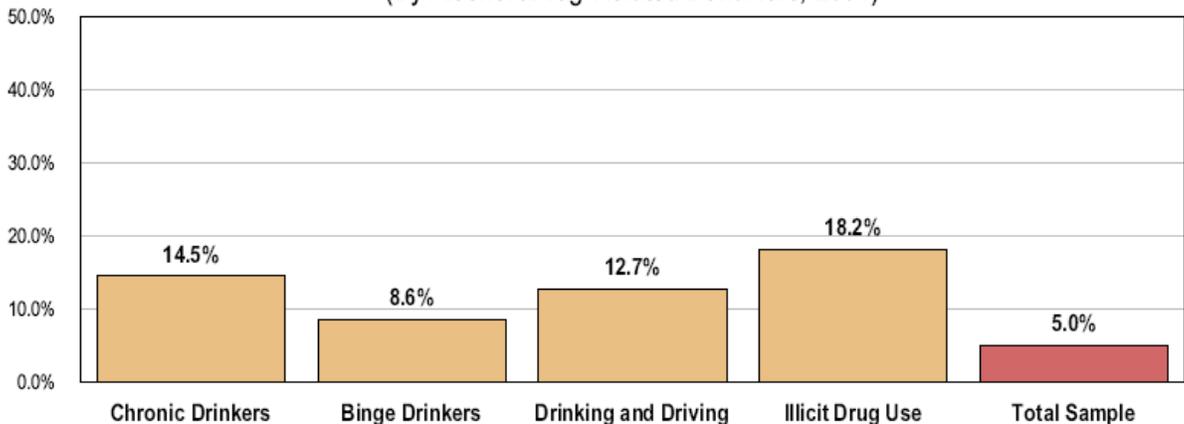
Help Seeking Behavior (cont'd)

Help Seeking for Alcohol or Drug Related Problems

18.2% of illicit drug users have sought professional help for an alcohol- or drug-related problem.

- Includes: 14.5% among chronic drinkers; 12.7% among those reporting drinking and driving; and 8.6% among binge drinkers.
- Keep in mind that some of these subsamples represent very small numbers of survey respondents.

Have Ever Sought Professional Help for an Alcohol- or Drug-Related Problem
(By Alcohol-/Drug-Related Behaviors; 2004)



Sources: • 2004 PRC Community Health Survey, Professional Research Consultants. [Item 70]

Notes: • Asked of those respondents who are classified as chronic or binge drinkers, those who drink and drive, and those who admit to illicit drug use.

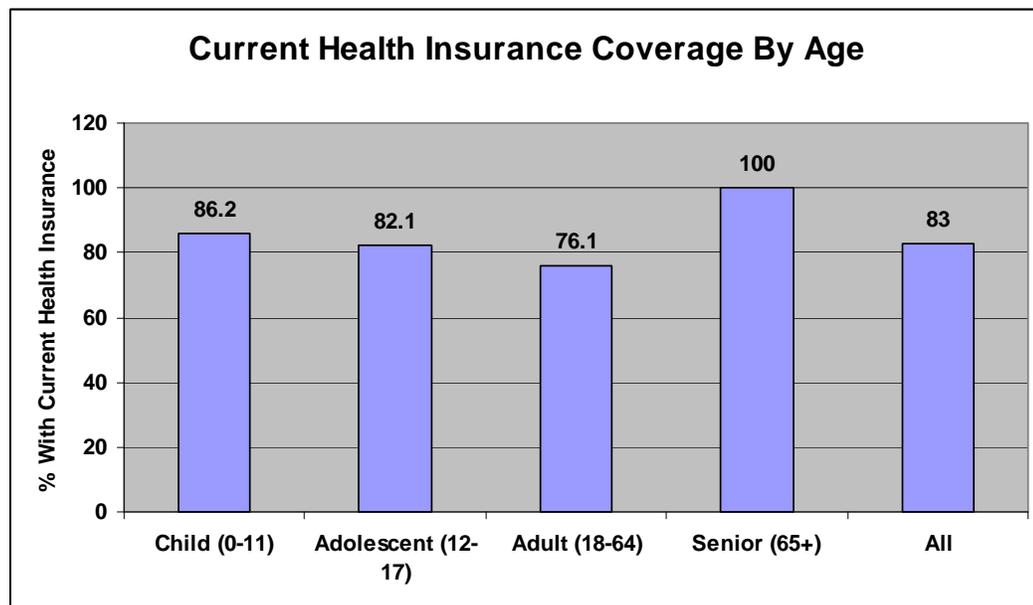
(Source: 2004 Community Health Assessment, Catholic Healthcare West)

Community Mental Health Assessment

Early Intervention (cont'd)

Access to Mental Health Treatment

- A primary factor to achieving early intervention of mental health problems is access to the appropriate mental health professionals. It is difficult to measure access to mental health treatment. Oftentimes, even if mental health issues are covered by one's health insurance, the coverage level varies greatly from plan to plan. Certain mental health issues might be covered under one plan but not another. Plans also vary in the amount of financial assistance they offer for different mental health services.
- **In 2005, 83% of Shasta County residents were covered by health insurance at the time they were surveyed. This coverage varies by age. See the chart below.**



(Source: 2005 California Health Interview Survey)

- **In 2005, 17% of adults who expressed a need for mental health treatment and who had health insurance coverage, reported that mental health was not covered by their insurance.**

(Source: 2005 California Health Interview Survey)

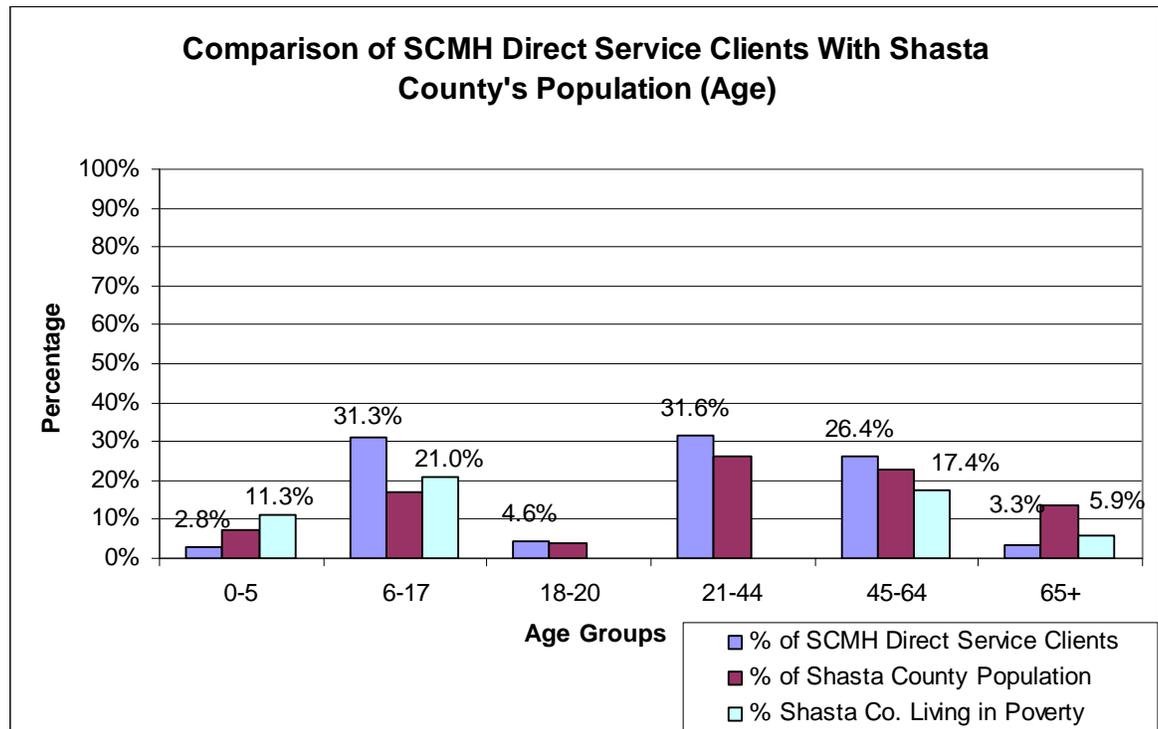
- Having adequate insurance that covers mental health services does not always guarantee access. Sometimes the services needed are not readily available in the community where one lives, such as specialty psychiatric services. Also, finding mental health providers that accept specific types of insurance and getting services in the time they are needed can be difficult.

Community Mental Health Assessment

Early Intervention (cont'd)

Mental Health Client Demographics (Access Disparities)

- The Shasta County Mental Health Department provides services to clients with serious and persistent mental illness who are Medi-Cal eligible or are indigent (have no insurance).



(Source: Shasta County Mental Health, 2006-07; State of California, US Census Bureau, 2000 Census.)

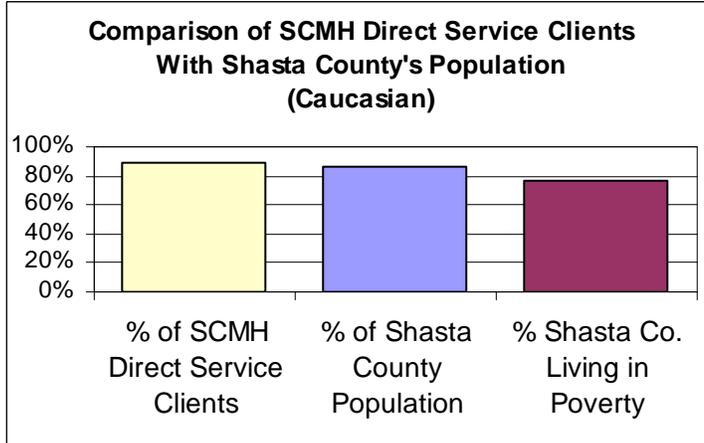
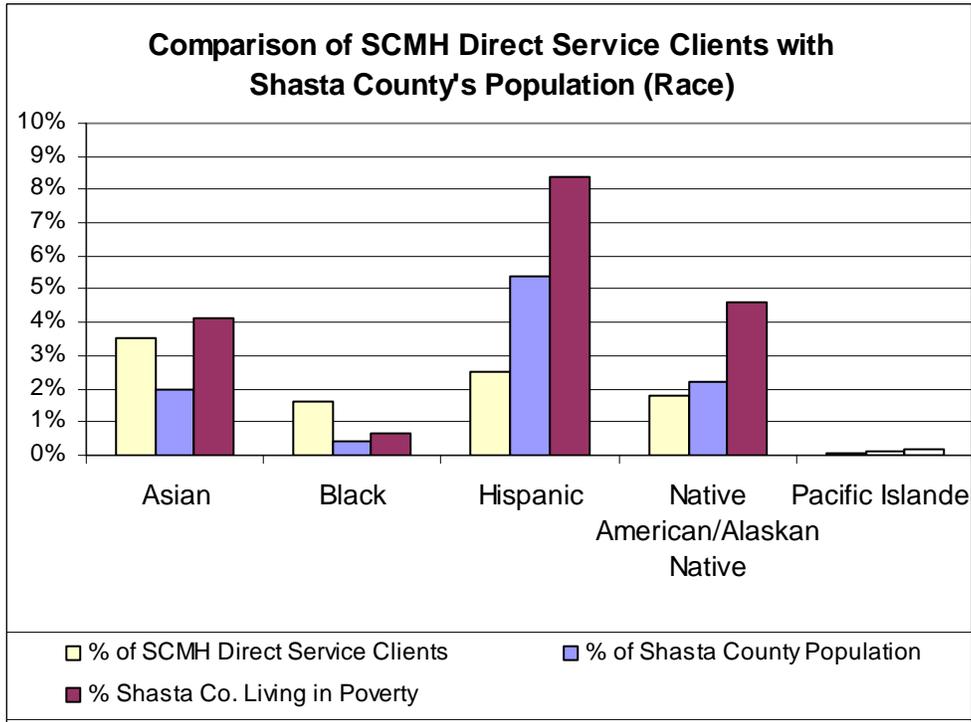
Note: The data on age and poverty level on two age groups was not available from the US Census in the age categories 18-20 and 21-44.

- When compared to Shasta County's population and Shasta County's population living in poverty, 6-17 year olds are over-represented and people 65 and older and under-represented among SCMH Direct Service Clients.

Community Mental Health Assessment

Early Intervention (cont'd)

Mental Health Client Demographics (Access Disparities)



Source: Shasta County Mental Health, 2006-07; United States Census Bureau, 2000 Census.

Note: The percentages for Shasta County Population and Shasta County Living in Poverty do not add up to 100% because they exclude people who chose more than one race.

These comparisons and proportions should be considered rough estimates.

- When compared to Shasta County's population and Shasta County's population living in poverty, who are more likely to be eligible for SCMH services due to their low-income status, Hispanic people are the most under-represented among Shasta County Mental Health clients while there is an over-representation of White and Black clients.

Community Mental Health Assessment

Outcomes That May Relate to Mental Illness

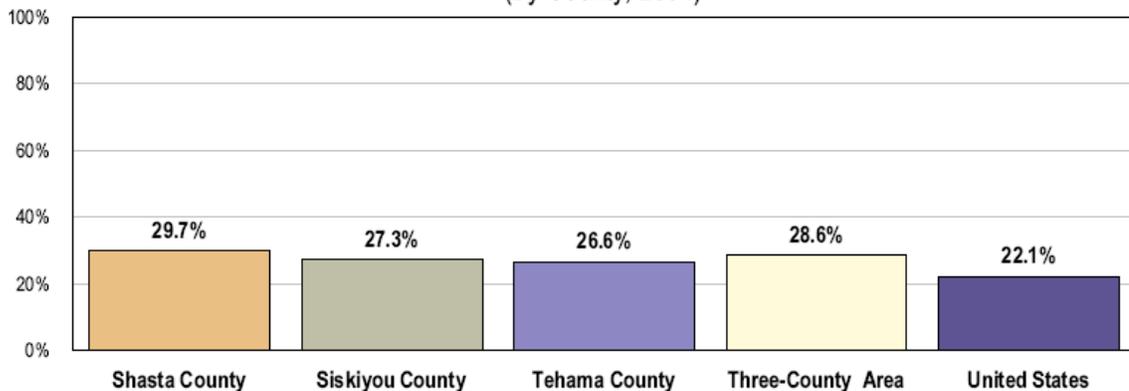
Prolonged Suffering

Experience of Chronic Depression

Nearly three in 10 survey respondents (28.6%) report that they have had two or more years in their lives when they felt depressed or sad on most days, although they may have felt okay sometimes.

- Less favorable than national findings (22.1%).
- Varies little by county.
- This represents approximately 60,260 adults in the Three-County Area who have faced or are facing prolonged bouts with depression.

Have Experienced Periods of Depression Which Lasted Two or More Years
(By County; 2004)



Sources: • 2004 PRC Community Health Survey, Professional Research Consultants. [Item 111]
• 2003 PRC National Health Survey, Professional Research Consultants.
Notes: • Asked of all respondents.
• California data not available.

(Source: 2004 Community Health Assessment, Catholic Healthcare West)

Community Mental Health Assessment

Outcomes That May Relate to Mental Illness (cont'd)

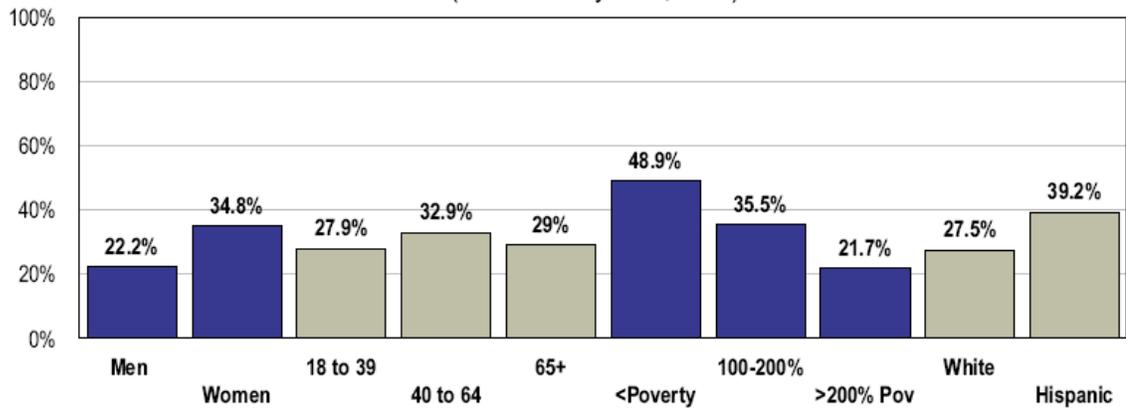
Prolonged Suffering (cont'd)

The following chart illustrates differences found among key demographic groups. Note that the prevalence of chronic depression is notably higher among:

- Persons living below the federal poverty level.
- Hispanic respondents.
- Women.

Have Experienced Periods of Depression Which Lasted Two or More Years

(Three-County Area; 2004)



Sources: • 2004 PRC Community Health Survey, Professional Research Consultants [Item 111]

Notes: • Asked of all respondents.

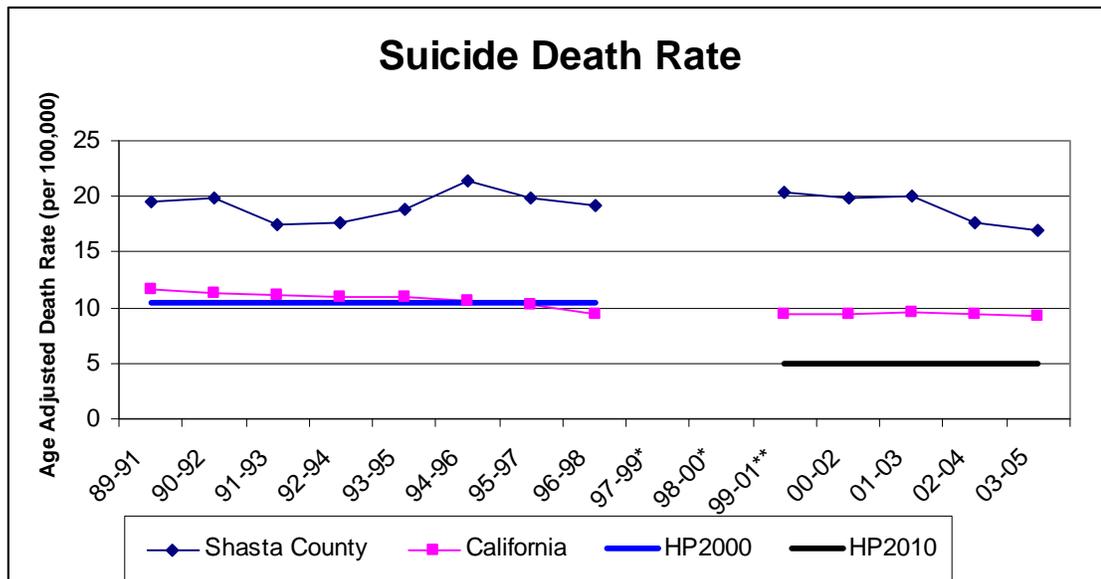
(Source: 2004 Community Health Assessment, Catholic Healthcare West)

Community Mental Health Assessment

Outcomes That May Relate to Mental Illness (cont'd)

Suicide Deaths

- An average of 34 Shasta County residents die per year of suicide (2001-2005).
- Shasta County's suicide death rate is significantly higher (16.7 deaths per 100,000 residents) than California's (9.3 per 100,000 residents).
- 78% of Suicide deaths are male. The rate of suicide death is highest among people 65 years and older.
- 60% of suicide deaths are caused by a firearm.



** Data for these time periods has not been calculated because a change in cause of death coding procedure changed in 1999, making previous years' data incomparable.
(Source: Shasta County Public Health, Vital Records Office)

Nonfatal Suicide Hospitalizations

- There are an average of 107 nonfatal suicide attempts that are serious enough to be hospitalized among Shasta County residents each year.
 - The rate of suicide hospitalization is highest among 25-44 year olds.
 - 40% of nonfatal self-inflicted injuries are male.
 - 90% of non-fatal suicide hospitalizations are poisonings.
 - The older the person is who attempts suicide, the more likely they are to die as a result of that attempt.
 - Sixty-nine percent of suicide attempts among Shasta County residents 65 years and older resulted in death.
 - Twenty-three percent of suicide attempts among 21-44 year olds results in death.
- (Source: California Office of Statewide Hospital and Planning Department (OSHPD), Patient Discharge Data)

Community Mental Health Assessment

Outcomes That May Relate to Mental Illness (cont'd)

Disability due to Mental Illness

- In December, 2006 there were 40,650 Shasta County residents receiving social security benefits and 23 percent were receiving social security benefits due to a disability. There were 7,610 disabled workers in Shasta County.

The breakdown of diagnoses causing a person's disability status was not available at the County population level from the Social Security Administration due to confidentiality. Reports of diagnoses causing disability are available for all states.

- Of all the people receiving disability benefits in California, 36% of them are due to mental disorders, including mental retardation.
- 32% of California's disability beneficiaries are disabled due to a mental disorder or than mental retardation which includes all categories of diagnosable mental illness and organic mental disorders.
- If this percentage were applied to Shasta County residents receiving disability benefits, there would be approximately 2400 Shasta County workers disabled due to a mental disorder other than Mental Retardation. This is an estimate and includes people with organic mental disorders.

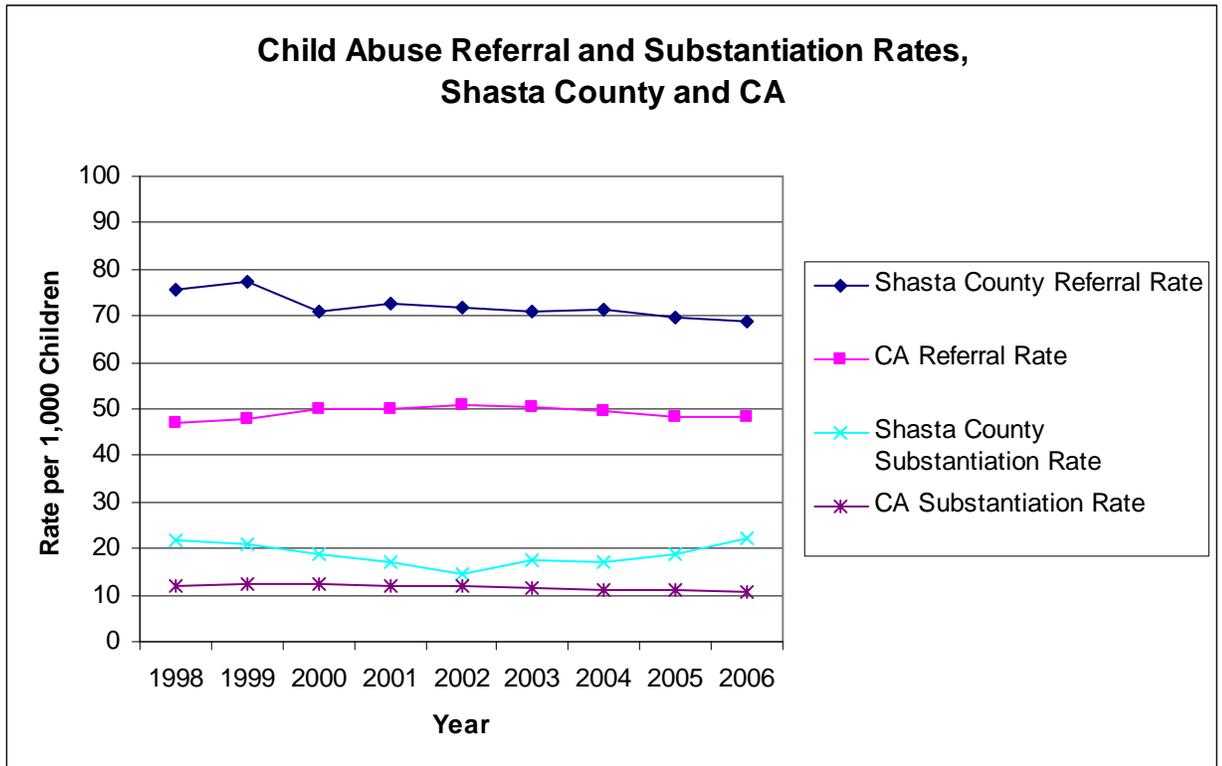
(Source: 2006 Annual Statistical Report on the Social Security Disability Insurance Program, <http://www.socialsecurity.gov/policy/data.html>)

Community Mental Health Assessment

Outcomes That May Relate to Mental Illness (cont'd)

Removal of children from their homes

- Each year, there are about 8 children for every 1,000 children in Shasta County who are removed from their home due to substantiated child maltreatment.
- On July 1, 2006 there were 568 children in foster care in Shasta County.



- The rate of suspected child maltreatment referral is highest among children less than one.
- The rate of confirmed child maltreatment is twice as high among children less than one as children 1-2 years old and the rate more gradually decreases after two years.

Source: Needell, B., Webster, D., Armijo, M., Lee, S., Cuccaro-Alamin, S., Shaw, T., Dawson, W., Piccus, W., Magruder, J., Exel, M., Smith, J., Dunn, A., Frerer, K., Putnam Hornstein, E., Ataie, Y., Atkinson, L., & Lee, S.H. (2007). *Child Welfare Services Reports for California*. Retrieved [month day, year], from University of California at Berkeley Center for Social Services Research website. URL: <http://cssr.berkeley.edu/CWSCMSreports/> (January 17-31, 2008)

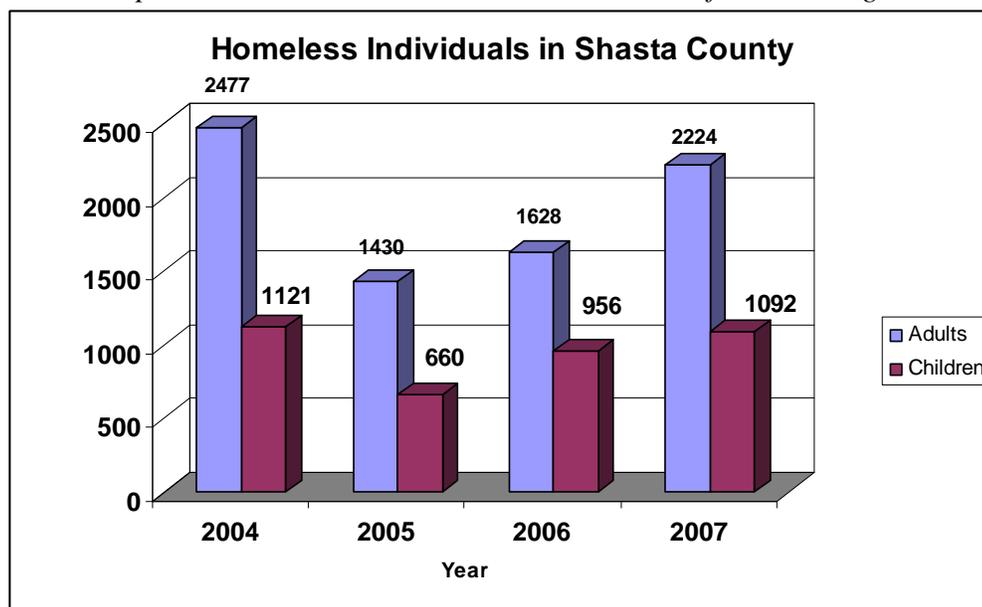
Community Mental Health Assessment

Outcomes That May Relate to Mental Illness (cont'd)

Homelessness

Shasta Homeless Continuum of Care Year-long Survey

- The number of homeless people in Shasta County has been rising since 2005 and is approaching the four-year high in 2004.
- According to the information collected from the Shasta County Continuum of Care, in 2007 there were 126 people who listed mental health issues as a reason for becoming homeless and 160 who listed substance abuse as a reason for becoming homeless.
- *Note: People are allowed to list more than one reason for becoming homeless.*



(Source: Continuum of Care, Year-Long Survey)

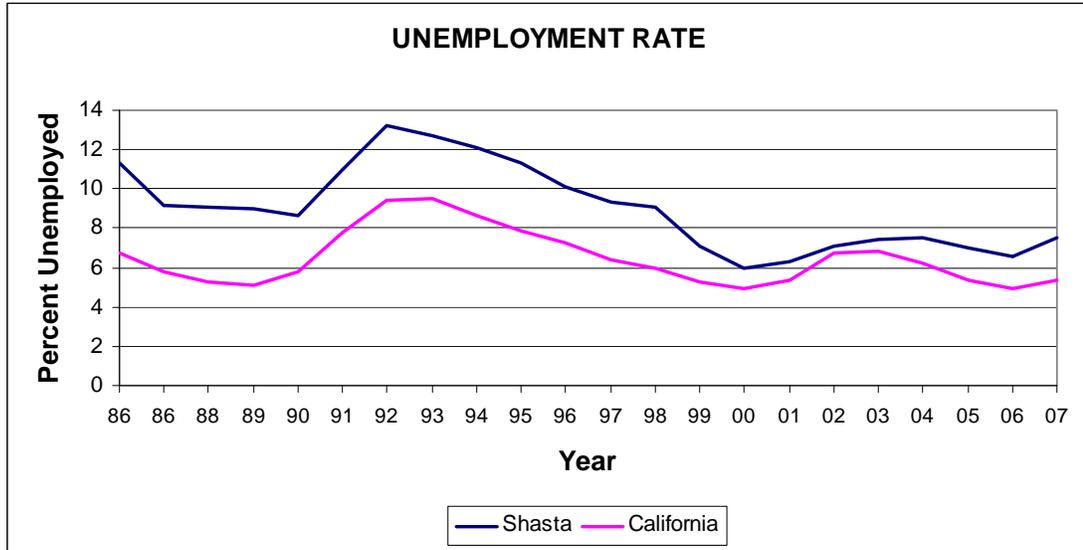
Catholic Healthcare West Community Health Assessment Survey

- Homelessness is a difficult problem to measure. Telephone surveys are an inadequate method of measuring true homelessness in a community. The following data is most likely an underestimate of homelessness but gives an idea of the magnitude of the problem.
 - In a 2004 Community Health Assessment survey, almost an equal amount of survey respondents considered homelessness a “major problem” (16.5%) in Shasta County as “not a problem” (14.4%).
 - 1 in 10 Shasta County adults (representing about 13,400) have had to go live with a friend or relative in the past two years because of an emergency housing situation.
 - 3% of Shasta county adults (representing about 3,800 adults) have been homeless and lived in a car, shelter, or on the street at some point in the past two years. (Note that these only represent residents who had been previously homeless but now are housed.)
- (Source: 2004 Community Health Assessment, Catholic Healthcare West)

Community Mental Health Assessment

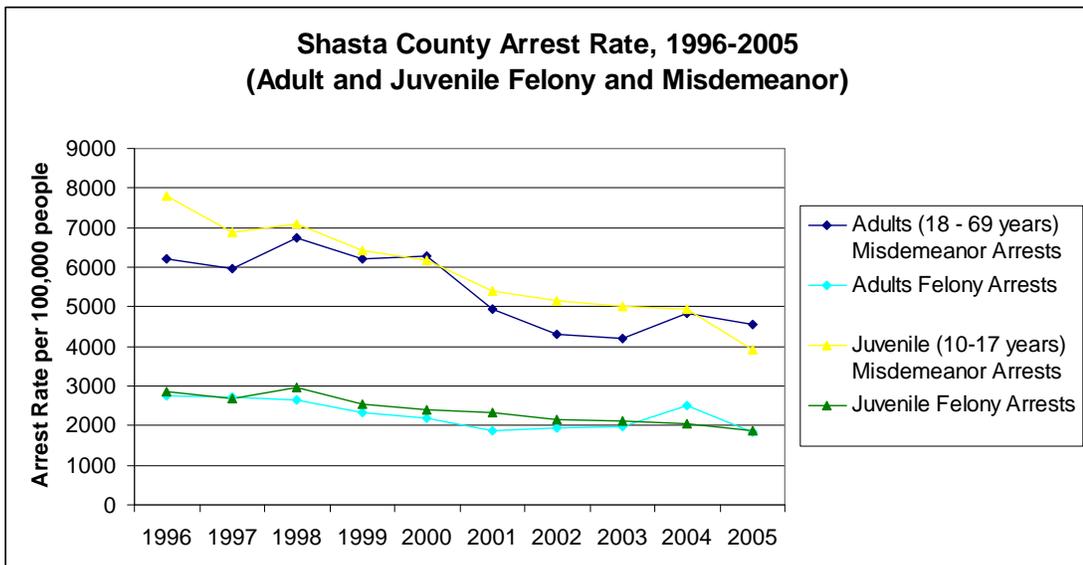
Outcomes That May Relate to Mental Illness (cont'd)

Unemployment



(Source: California Employment Development Department, <http://www.labormarketinfo.edd.ca.gov/>)

Incarceration



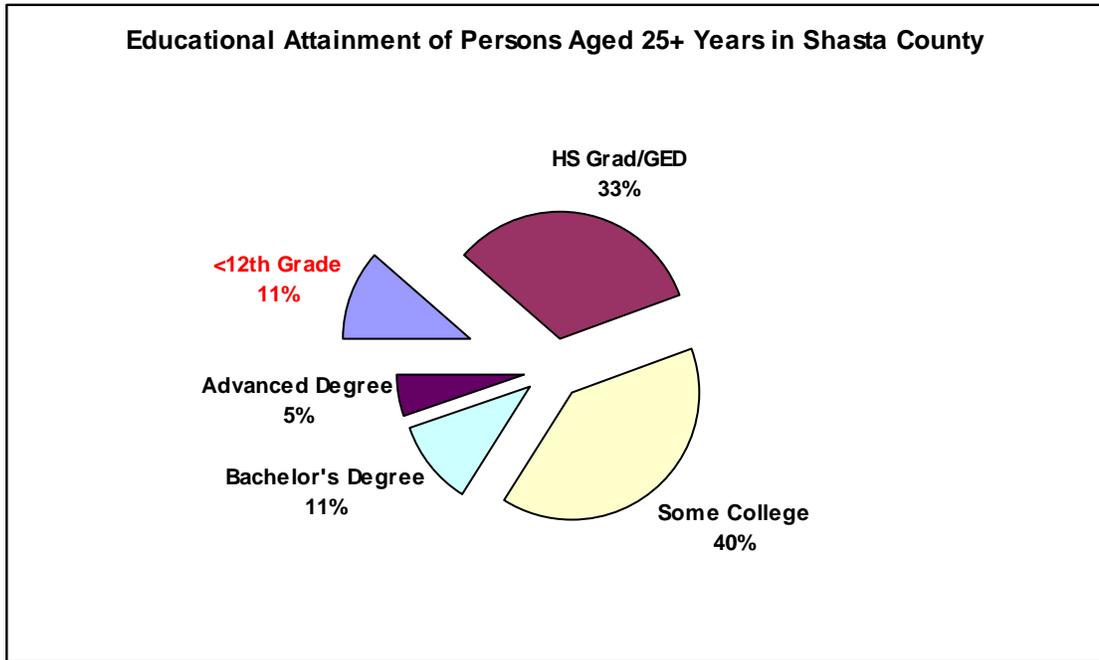
(Source: California Department of Justice, 2008)

- In 2006, Shasta County made up only .5% of California's population but 1% of California's felon new admissions to prison. Shasta County had a prison incarceration rate that was 339 prison admissions per 100,000 residents of Shasta County, higher than all but three California Counties.

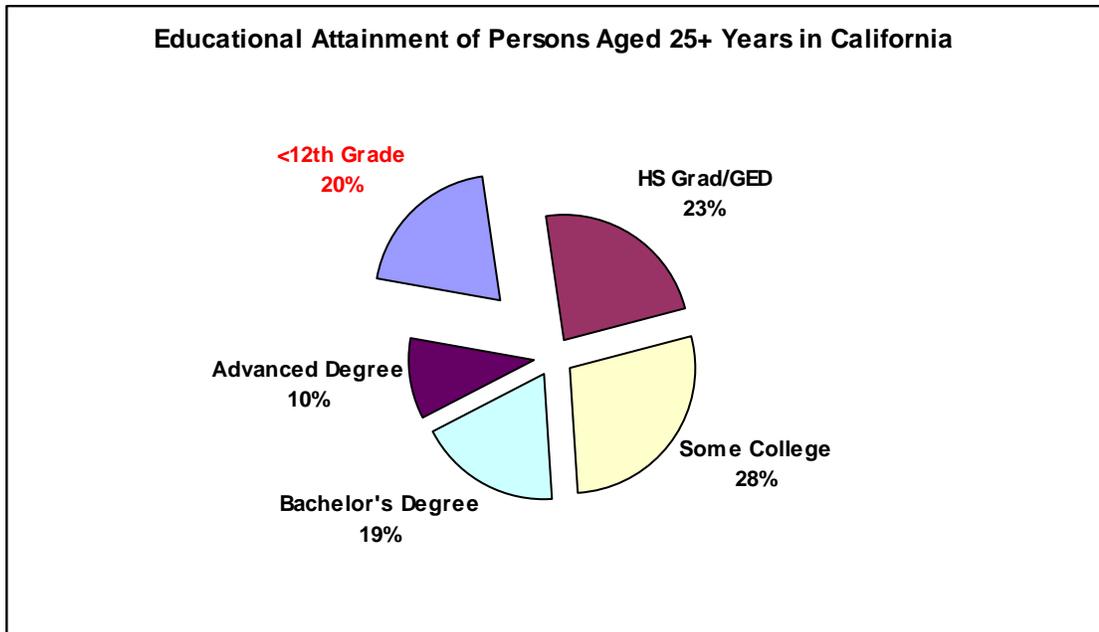
Community Mental Health Assessment

Outcomes That May Relate to Mental Illness (cont'd)

School Failure or Dropout



(Source: 2006 American Community Survey, United States Census Bureau)

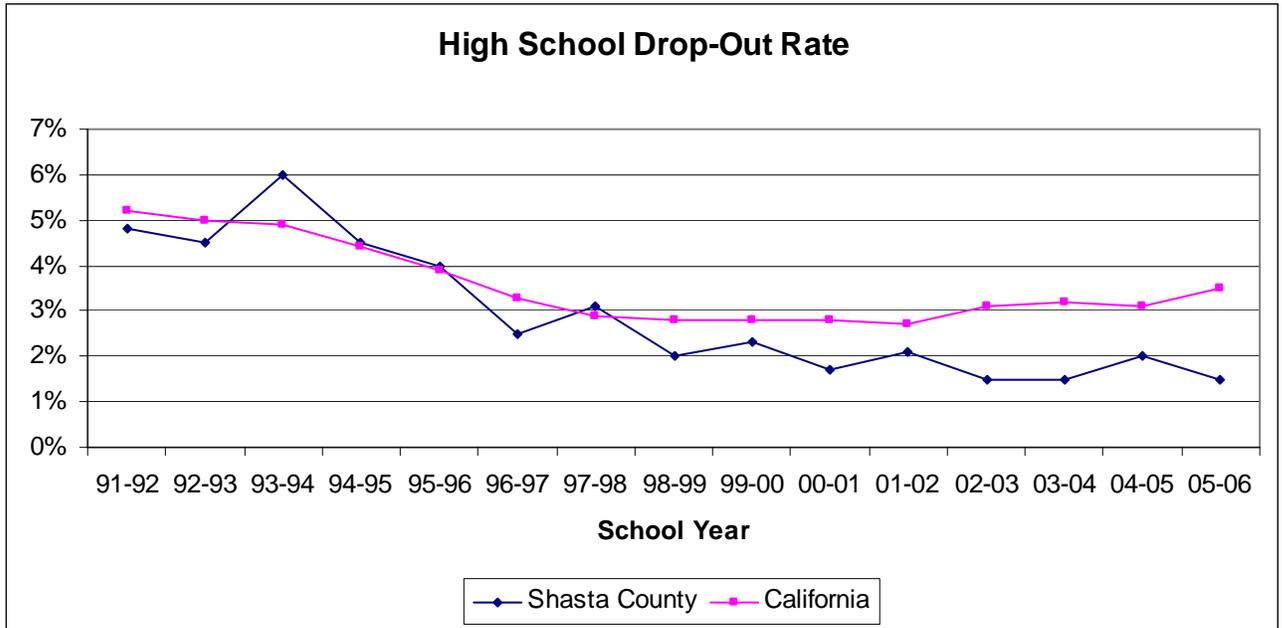


(Source: 2006 American Community Survey, United States Census Bureau)

Community Mental Health Assessment

Outcomes That May Relate to Mental Illness (cont'd)

School Failure or Dropout (cont'd)



(Source: California Department of Education, 2008)

Appendix - Local Data Sources

In order they first appear in the report

Developmental Assets Survey: In 2005 there were two surveys done in Shasta County. One was in 6th grade students and one was in 10th grade students. The survey was paid for by the Health Improvement Partnership (HIP) of Shasta County in partnership with these sponsors: [YMCA](#), [City of Redding](#), [Mercy CHW Redding](#), and [Shasta County Public Health](#). The survey and reports were implemented by the Search Institute. The survey was conducted with 720 6th grade students and 1045 10th grade students in the following schools: Anderson Middle School, Parsons Jr. High, St. Francis Middle School, Sequoia Middle School, Shasta Lake Middle School, Anderson High School, Bishop Quinn High School, Central Valley High School, Enterprise High School, Foothill High School, and Shasta High School. For more information about the 40 Developmental Assets go to: <http://www.search-institute.org/> For more information about the survey, go to: <http://www.hipshasta.org>

CHIS: California Health Interview Survey, a random digit dial telephone survey conducted throughout the state with adults, adolescents, and the parents or guardians of children, and broken down by county of residence.

Community Health Assessment, Catholic Healthcare West: this data source is also referred to as “PRC Community Health Survey, Professional Research Consultants”. Every 2-3 years, Catholic Healthcare West sponsors a community health assessment which includes a telephone survey conducted by Professional Research Consultants (PRC). The telephone survey is conducted with adults in a northern California three-county area, broken down by county of residence. PRC also does a national survey, which is used here for comparison. The report also includes California data where available. As with the CHKS data, we do not have raw data from this source, so we have no way of figuring whether our rates are statistically significantly different from the national rates except where the summary report indicates a significant difference or similar results.

California Department of Social Services (<http://www.dss.cahwnet.gov>): This is the data source for both elder and child abuse and neglect. Information is gathered by county social services departments and aggregated and published by the state.

Shasta County Public Health, Vital Records Office: Birth and death certificate data are used to measure certain characteristics associated with births and causes of death for the people who are born in and die in Shasta County. The information is collected on standardized forms and registered with the Vital Records Office.

Shasta County and California Department of Mental Health: Data on clients and services provided through Shasta County Mental Health were provided either by the County Mental Health Department directly, or if otherwise noted, taken from the California Department of Mental Health website. Additional information about mental illness prevalence was provided by the California Department of Mental Health through a contractor with a research consultant (http://www.dmh.cahwnet.gov/Statistics_and_Data_Analysis/Prevalence_Rates.asp).

CHKS: California Healthy Kids Survey, a written survey conducted in schools throughout the state with 5th, 7th, 9th, and 11th graders. This survey is now tied to funding for the schools, so most of the schools in the county participate, resulting in a county-level report of the results.

Appendix - Local Data Sources (cont'd)

In order they first appear in the report

California Office of Statewide Planning and Development (OSHPD), Patient Discharge Data: When patients are discharged from the hospital, a discharge record is complete and sent to the California OSHPD Department. This data is available to the community via an application process and includes information about the diagnoses that caused the hospitalization. This data is for all Shasta County residents who were discharged from any California Hospital.

Social Security Administration: Annual Statistical Report and a variety of other publications are available at the Social Security Administration's website. When they were contacted for more specific data on Shasta County, they declined giving additional County-level data due to confidentiality policies. <http://www.socialsecurity.gov/policy/data.html>

University of California, Berkeley: The California Department of Social Services contracts with UC Berkeley's Center for Social Sciences Research to monitor and track federal and California outcomes for Children and Family Services. They also provide a variety of other evaluation services. Some of the data for this report was retrieved directly from UC Berkeley's website. <http://cssr.berkeley.edu/CWSCMSreports/>

Shasta County Continuum of Care: The City of Redding and Shasta County Homeless Continuum of Care Council is a regional-based organization comprised of service providers, developers, governmental entities and leaders, faith-based organizations and community members dedicated to end homelessness. Each year, they work with local service providers to collect information from people that are homeless or at-risk of being homeless to better understand their needs. This is what they call their "year-long" survey as opposed to their "point in time" survey which is an annual "census" of homeless people that is conducted on one chosen day.

California Employment Development Department: This agency has a place on their website where they provide labor market information. <http://www.labormarketinfo.edd.ca.gov/> The data for this report was extracted exclusively from this website.

California Department of Justice: This information was extracted from the Criminal Justice Statistics Center within the California Department of Justice. An additional resource was linked from this website and includes information from the Department of Corrections (incarceration data). <http://ag.ca.gov/cjsc/>

American Community Survey, United States Census Bureau: The American Community Survey is conducted every year by the United States Census Bureau in every county, American Indian and Alaska Native Area, and Hawaiian Home Land. It was started in 1996 and only recently (2005) became available for use in Shasta County. It does not replace the decennial census but provides an estimate of various characteristics in our county on a more frequent schedule. <http://www.census.gov/acs/www>

California Department of Education: Information extracted directly from the California Department of Education's website. <http://www.cde.ca.gov/ds/>