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 2007-08 and 2008-09

County Name: Shasta County	Date: October 15, 2008

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 _____ October 15, 2008

County Mental Health Director Date

Executed at _____Redding_____, California

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

Form No. 2

PEI Community Program Planning Process, Form #2:

Attachment A, PEI Planning Process Documents, includes all documentation related to the community planning process. These documents were developed for the purpose of getting stakeholders involved and keeping the community informed. In addition to being utilized during the planning process, all documents are available to the public on the Shasta County Mental Health website. This attachment includes general PEI informational documents, the community mental health assessment, stakeholder input materials, and community planning process outcomes.

1. The county shall ensure that the Community Program Planning Process is adequately staffed. Describe which positions and/or units assumed the following responsibilities:

a. The overall Community Program Planning Process

Mark Montgomery, Psy.D., Mental Health Director, was responsible for overall Community Program Planning.

b. Coordination and management of Community Program Planning

Maxine Wayda, L.C.S.W., Clinical Division Chief, coordinated and managed Community Program Planning.

c. Ensuring that stakeholders have the opportunity to participate in the Community Program Planning

Joy Garcia, M.A.T., Community Education Specialist, ensured that stakeholders had the opportunity to participate in Community Program Planning.

2. Explain how the county ensured that the stakeholder participation process accomplished the following objectives:

a. Included representatives of unserved and/or underserved populations and family members of unserved/underserved populations.

The County began by identifying unserved and underserved populations that were identified in the county's Community Services and Supports (CSS) planning process. These populations include the following:

- The county has a higher percentage of families living in poverty than the state, and unemployment rates are typically higher than elsewhere in California.
- Individuals living in rural parts of the county had less access to mental health services than the more urban parts of the county.
- Hispanic and Native American individuals were significantly underserved compared to their population numbers.

The County developed additional information about unserved and underserved populations to be included in the PEI planning process from the following:

Participants in the CSS process informed us that cultural groups in particular believed that the CSS process did not specifically reach out to their communities. Our strategies, especially focus groups and survey distribution, were based on the input of these cultural leaders and assured that focus groups and community meetings were held in neutral locations, refreshments or lunch was served, and results promptly provided to participants. This input was further enriched by consultation with the county's Cultural Competence Coordinator, who assisted in planning and facilitating outreach and engagement for planning with members of ethnic communities. As a result, outreach to cultural groups and rural and low socioeconomic status groups was strengthened and included participation of key members of the lesbian/gay/bisexual/transgender (LGBT) community and some disabled individuals.

The county used the following mechanisms to include members of unserved and/or underserved populations in our planning process:

Shasta County began the PEI planning process with an Informational Meeting to kick off the stakeholder process. The goal of the meeting was to provide an overview of PEI planning elements and an outline of the Shasta County PEI planning process, and to spread the word to community members and partners that they could participate in the process. An informational brochure was created and distributed in the community. The distribution of the brochure was also aided by Community Health Advocates in ethnic communities. Central to the planning process were three mechanisms to assure that unserved and/or underserved populations participated in the planning process:

- Creation of the Mental Health Services Act Advisory Committee (MHSAAC) as a subcommittee of the Shasta County Mental Health Board. The Committee's role is to participate in the stakeholder and review process, and to make recommendations to the Mental Health Board. Committee membership includes up to 25 individuals, representing the following seven groups: county staff, underserved populations, education, clients and family members, health care, law enforcement, and community-based organizations.

- Key informant interviews with community leaders, gatekeepers and other individuals knowledgeable about their constituency and key community mental health needs. These interviews included leaders in the Southeast Asian, African American, Native American, Hispanic, Disabled, Lesbian/Gay/Bisexual/Transgender communities, and leaders knowledgeable about the low income community. Key informant interviews were also conducted with members of the state PEI-required sectors, such as educators and law enforcement. Client and Family Advisory advocates and the county's Cultural Competence Coordinator provided additional key informant interviews. A copy of the Key Informant Interview Tool is attached.
- Stakeholder surveys designed to ascertain stakeholder input about key community mental health needs and priority populations were made available for community distribution in numerous public locations throughout the county. Surveys were available in Spanish. Surveys were available at the community annual Multicultural Celebration, and distributed via Community Health Advocates to local ethnic coalitions. The survey was also available on the website www.shastamentalhealth.net. Copies of the Hardcopy and Online Survey Tools are attached.
- Focus groups were held throughout the county to solicit input from the community and collaborating partners in underserved communities, education, youth, client and family member organizations, providers of mental health services, healthcare and social services, and in rural areas of the county. A copy of the Focus Group Tool, including a brief agenda and the Consensus Workshop format, is attached.
- Newspapers, newsletters and radio media as well as stakeholder outreach through natural communication linkages were used to assure that the surveys and focus groups reached the broadest number of individuals possible.
- Translators were available at community and focus groups meetings. Outreach information offered transportation, translation and other supports upon request.

b. Provided opportunities to participate for individuals reflecting the diversity of the demographics of the County, including but not limited to, geographic location, age, gender, race/ethnicity and language

The county identified cultural diversity, including Hispanic, Native American, African American, Southeast Asian communities. There is some language diversity in the Hispanic and Southeast Asian communities, although the numbers requiring translation are small. There is significant socioeconomic diversity. There is significant geographic diversity, including several rural areas with distance and weather challenges at some times of the year. Lesbian/gay/bisexual/transgender communities have not in the past received specific outreach.

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

Form No. 2

We used the following mechanisms to assure that our planning process reached diverse audiences:

- Conducted planning activities with a diverse and representative MHSA Advisory Committee.
- Conducted surveys online and through hardcopies, reaching 176 individuals online and 370 individuals in hard copy.
- Conducted key informant interviews with 32 leaders. Information about these individuals is discussed below under 2 (c).
- Conducted 16 focus groups with a format that included a consensus-building activity. The format of our focus groups was selected for its consensus-building ability, but also for its user-friendly structure. These focus groups allowed individuals to be heard without having to speak out in large groups, and allowed full participation within varying cultural norms. These focus groups included geographically diverse settings, specific outreach to community-based organizations, education groups, cultural populations, staff, clients and family members.
- Conducted interviews and focus groups with diverse groups in neutral settings and with the assistance of natural and/or local leaders from the community.
- Offered translators and transportation to assure accessibility.
- Offered incentives for participation in the survey, in the form of food gifts in a drawing for participants

c. Included outreach to clients with serious mental illness and/or serious emotional disturbance and their family members, to ensure the opportunity to participate.

Our outreach to clients and family members included the following efforts:

- Consumer and family representatives serve on the MHSA Advisory Committee
- Key informant interviews were held with a family advocate, foster parent and client.
- Clients and family members helped with distributing surveys and locating and planning focus groups targeting their constituencies.
- Consumer and family member employees were used to plan focus groups in times and places that reached their constituencies and to distribute surveys.
- Clients and family members were targeted for every stakeholder input tool. They also were invited to and participated in regional focus groups in Redding, Anderson, Shasta Lake City, Burney and Shingletown. The Redding focus group was held at the monthly NAMI meeting. Upon request for more opportunities for family members and clients to participate in the process, three additional focus group meetings were held.

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

Form No. 2

3. Explain how the county ensured that the Community Program Planning Process included the following required stakeholders and training:

a. Participation of stakeholders as defined in Title 9, California Code of Regulations (CCR), Chapter 14, Article 2, Section 3200.270, including, but not limited to:

We assured the participation of required stakeholders, specifically:

Individuals with serious mental illness and/or serious emotional disturbance and/or their families:

As indicated above, consumers and family members are included on our planning body, and participated in surveys, key informant interviews and focus groups. When our consumer and family member advisors believed that clients and family members did not fully participate in the regional focus group areas, three additional focus groups were held to reach out specifically to these important groups. NAMI and client leaders provided significant assistance with distributing surveys in client and clinic and community-based settings where clients and family members might have access.

Providers of mental health and/or related services such as physical health care and/or social services:

Mental health, physical health and social services providers are included on our planning body, and participated in surveys and the distribution of surveys, key informant interviews and focus groups. Community based organization directors, mental health providers, and health care providers including nurses, public health nurses and physicians were included in key informant interviews. Social service providers, including providers with expertise in employment, income benefits, adult protective services, and child welfare were included in key informant interviews. Providers serving homeless and rural communities were included as key informants. Focus groups were held with community-based organizations and mental health providers, and in several community-based organization settings with outreach to their communities and clients. Finally, focus groups were held with mental health staff and the Health and Human Services Agency staff.

Educators and/or representatives of education:

Educators are included on our planning body, and education representatives from elementary, secondary and library services were included in key informant interviews. These leaders helped assure that surveys reached education providers and students. A specific focus group was held with assistance from the Shasta County

Office of Education and attendance at that focus group by a broad section of individuals involved in educational services indicated interest and participation. In addition, outreach to young people occurred with help from education to hold two youth focus groups.

Representatives of law enforcement:

Law enforcement representatives are included on our planning body. Key informant interviews reached representatives of the Sheriff, Coroner, Probation, Forest Service and City Police.

Other organizations that represent the interests of individuals with serious mental illness and/or serious emotional disturbance and/or their families:

Homeless providers, representatives of rural service providers, and Native American leaders were included in our key informant interviews. Rural focus groups brought together representatives of community based organizations serving the broad needs of rural communities. Surveys were distributed by, and focus groups held under the leadership of, Northern Valley Catholic Social Services, a young people's health improvement group, a teen center, the Older Adult Policy Council and public health leadership. Health and Human Services staff involved with social services and employment services participated in the process. Disability groups were invited to the Underserved Cultural Population focus group. The PEI process was publicized through radio, newsletters, press releases, flyers, brochures and the county mental health web site.

b. Training for county staff and stakeholders participating in the Community Program Planning Process

The County Mental Health Director and the Community Education Specialist provided training for staff and stakeholders at our community meetings, MHSA Advisory Committee, key informant interviews and focus groups. An outline of training material is attached.

When community, survey, key informant and focus group information was gathered, we convened an Expert Panel, a small group consisting of individuals representing mental health professionals with mental health and education related experience, the medical community, a public health prevention officer, individuals with cultural competency expertise, clients and family members. It was the task of this Expert Panel to synthesize Shasta County PEI information into priority funding areas and matching evidence-based programs. This synthesis was utilized by the MHSA Advisory Committee to provide the Mental Health Board with recommendations for

the PEI Plan. This Expert Panel benefited from training on PEI planning requirements by the community health educator. Additionally, data related to PEI priority populations and key mental health needs was compiled by the Shasta County Health Officer and an epidemiologist employed by the Shasta County Health and Human Services Agency and shared with the Expert Panel to provide grounding in prevention, early intervention, and evidence-based interventions.

4. Provide a summary of the effectiveness of the process by addressing the following aspects:

a. The lessons learned from the CSS process and how these were applied in the PEI process.

The county found the following tools and processes most productive when we conducted our CSS planning:

Focus groups and surveys reached a significant number of individuals during our CSS planning process. Demographic and service data analysis helped us identify gaps and service needs. As a result, we retained strong survey and focus group elements to our PEI planning process. We have incorporated our CSS data into PEI planning, and added an Expert Panel to provide technical and research information on prevention, early intervention and evidence-based practice to inform our identification of programs to meet community needs.

The county experienced challenges in conducting our CSS Planning. In each case, we have attempted to address the challenges in our PEI Planning.

Based on our community meetings and community discussions at the start of our PEI planning process, we believe that significant numbers of individuals felt that their input had been solicited in the CSS process, but that the planning and feedback was insufficient to inform final decision-making.

Responding to that community input, we have formalized stakeholder representation through an MHSA Advisory Committee structure. We have developed an Advisory Committee with diverse representatives from major constituency groups, and have included representation from the Mental Health Assessment and Redesign Collaborative that operated during the two years between our CSS Planning Process and PEI Planning Process.

In addition, we created a formal and comprehensive Key Informant process that identified natural leaders in ethnic, geographic, underserved, client and family communities. These informants provided assistance to assure that surveys and focus

groups were truly accessible to their constituencies. In addition, each provided content information representative of their communities to inform the process of selecting community mental health needs and priority populations.

Our CSS planning process created unrealistic expectations about the impact of CSS on our public mental health program. We strengthened our training component, including the addition of an Expert Panel, to assure that our plans appropriately address community needs and priority populations with programs that include evidence of efficacy in addressing those needs. To increase transparency, the input of each focus group was given in written summary to participants and posted on line. A community meeting was also held at the end of the community input process to review the input with interested community members.

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

Our program planning process reached a diverse community of individuals from throughout the county. Early on, we decided to develop strategies that seek out the diversity of the county but that did not identify/spotlight that diversity in individual responses.

Our survey tool did not ask for demographic information. However, the response rate of 176 surveys online and 370 hard copy surveys returned, for a total of 547 responses, assures us that the survey reached diverse communities, including the distribution of surveys by leadership from diverse communities. The survey was distributed at the county's annual Multi-Cultural Celebration, by the Hispanic/Latino Coalition in Spanish, in NAMI gatherings, and in client support groups and clinic meetings, among other outreach activities

Focus group meetings were designed to reach out to specific communities in their natural gathering places. In some cases, focus group locations were modified to meet the special needs of underserved or target communities. For example, three additional focus groups were held to assure that client and family members had an opportunity to participate in the discussion. Additionally, two focus groups were held to reach out to young people, one in a location sponsored by a mainstream youth group, and another separate focus group in a location that serves a special needs youth population.

Our program planning process also included the following stakeholders required to participate. Each group is represented on our MHSA Advisory Committee

- Consumers and family members*:* 30 consumers and family members participated in three focus groups specifically designed to reach their community; consumers and family members participated in focus groups in other community and geographically diverse settings
- Providers: 40 community based, provider group and staff members participated in focus groups specifically designed to reach them. Providers participated in focus groups in other community and geographically diverse settings.
- Educators: 28 educators participated in a focus group specifically designed to reach them; educators participated in additional focus group settings
- Law Enforcement*:* 6 law enforcement individuals participated in key informant interviews
- Other organizations: Drug and Alcohol Advisory Board members (16), social services and health providers/staff members (16) participated in focus groups. Focus groups were held in Shingletown (7), Anderson (6), and Burney (9).

5. Provide the following information about the required county public hearing:

a. The date of the public hearing:

The 30-day stakeholder review and public comment period was opened on September 3, 2008 and closed on October 8, 2008 by the Shasta County Mental Health Board. A public hearing was conducted by the Shasta County Mental Health Board on October 8, 2008.

b. A description of how the PEI Component of the Three-Year Program and Expenditure Plan was circulated to representatives of stakeholder interests and any other interested parties who requested it.

Public notice regarding the stakeholder review and public comment period was published weekly from September 3, 2008 through October 8, 2008 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 on-line at the Shasta County Mental Health website. The draft PEI Plan was e-mailed to all stakeholder partnerships, who were asked to circulate it to their stakeholder participants. Members of the MHSA Advisory Committee and the Shasta County Mental Health Board received copies. A copy of the report was also available upon request, and the county circulated a description of the PEI Component and draft plan to every attendee of a focus group who requested it.

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

Form No. 2

c. A summary and analysis of any substantive recommendations for revisions

1) The following substantive recommendations were made. Each is followed by the county's response:

During the public comment period, the majority of comments were received from members of the MHSA Advisory Committee. Most of these comments were given verbally during their plan review meetings. In addition, we received comments from five community members. Attachment B, Public Comment, is an effort to capture the questions, comments, and suggestions from the MHSA Advisory Committee, as well as the other five communications received.

Within the 30-day comment period, the MHSA Advisory Committee held three 2-hour meetings to discuss the draft PEI Plan. During their October 3, 2008 meeting, the plan was reviewed using the Mental Health Services Oversight and Accountability Commission (MHSOAC) PEI review. At the conclusion of this meeting, the Advisory Committee voted to recommend approval of the PEI Plan by the Mental Health Board.

Many of the comments received were questions regarding process, with great discussion on lessons learned from the planning process, and suggestions for future MHSA planning. Shasta County Mental Health will implement those suggestions in future planning processes. There were also some complaints that the California Department of Mental Health (DMH) requirements were cumbersome, resulting in a plan document that is not user-friendly and difficult to read and evaluate. The MHSA Advisory Committee came up with a few suggestions on how to better the presentation process. Attachment C, Executive Summary, is a result of their suggestions.

A majority of the comments made did not pertain to the planning process, but rather to the implementation process, which we will begin planning upon plan approval from DMH. It was made clear to the MHSA Advisory Committee, as there were some questions regarding the impression that agreements with partners were already in place, that there are no agreements in place, nor are any given partners already chosen. Shasta County Mental Health assured the MHSA Advisory Committee that the community input process will continue throughout implementation.

There was conversation and questions surrounding the budget. Shasta county Mental Health fiscal staff went over each of the three budgets by line item and provided explanations for each.

There were several questions regarding how the implementation of Triple P is not considered supplantation, as the program it is currently being provided in the community. Shasta County Mental Health staff explained that the Triple P program is currently being offered by one agency in the community, with limited community access. The PEI Plan proposes to implement the program through multiple types of service settings, maintaining program consistency, and conducting an evaluation of effectiveness of implementation community-wide.

2) The county made the following changes based on recommendations received during the public hearing:

A few of the comments require minor language changes to the PEI Plan. These changes were made prior to submission to DMH. Overall, there were no substantive recommendations made.

d. The estimated number of participants in the public hearing:

During the public hearing, there were only two individuals requesting to comment. Both individuals provided written comment to the Mental Health Board, which are included in Attachment B, Public Comment.

Form 3

County: Shasta

PEI Project Name: Project 1 - Community Education and Awareness

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	X	X	X	X
2. Psycho-Social Impact of Trauma	☐	☐	☐	☐
3. At-Risk Children, Youth and Young Adult Populations	☐	☐		
4. Stigma and Discrimination	X	X	X	X
5. Suicide Risk	X	X	X	X

2. PEI Priority Population(s) **Note: All PEI projects must address underserved racial/ethnic and cultural populations.**	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
A. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	☐	☐	☐	☐
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☐	☐	☐	☐
3. Children and Youth in Stressed Families	X	X		
4. Children and Youth at Risk for School Failure	☐	☐		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☐	☐		
6. Underserved Cultural Populations	X	X	X	X

Form 3
County: Shasta
PEI Project Name: Project 1 - Community Education and Awareness

B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).

1) CSS Plan Identification of Community Needs and Priority Populations

During the county's CSS Planning process we identified the following community need(s) and priority populations that were more appropriate to the PEI process and that are addressed in this PEI Project:

Community Needs:

Shasta County's CSS Planning process identified specific needs that can more appropriately be addressed in the PEI portion of the MHSA. Several issues were identified in all age groups during the CSS process. Access to care at all levels, including a full continuum of care once a problem was identified, was seen as a problem in all parts of the county. Lack of insurance, complicated intake processes and insufficient resources were all cited as barriers to care. Stigma and discrimination regarding mental illness was identified as a problem in both rural and urban parts of the county. Cultural issues, including the lack of culturally appropriate services and rural isolation and culture, impede access for some children and families. Public education to reduce the stigma associated with seeking care early in the course of illness and public information to broaden access to existing resources at all levels of the continuum were called for. Girls and young women were found to be especially underserved, and Hispanic and Native American communities were found to be underserved.

The CSS plan drafted by the county specifically addressed access issues, especially in rural parts of the county, and for older adults. Partnerships with Federally Qualified Health Clinics (FQHC) and development of a more elaborated crisis and emergency response system have provided improved access to care. The CSS plan did not directly address community education and stigma and discrimination issues, except through the development of improved and increased partnerships with FQHC clinics and other community organizations and providers with existing ties to underserved communities.

Priority Populations:

As summarized above, our CSS plan identified access to a full continuum of care for all age groups as a need in all parts of the county. Stigma and discrimination were issues that our community committed to address when PEI funding became available.

2) CSS Implementation Identification of Needs

Our CSS programs and services to date have not specifically identified Prevention and Early Intervention needs. We have instead conducted a Community Mental Health Assessment that reexamined demographic and service data compared to a variety of factors that influence a person's or a community's mental well-being. This Assessment will be discussed in more detail below. This Assessment included overall data on services by Shasta County Mental Health compared to county residents, and to residents living in poverty. These figures,

however, provide only a picture of comparative services by age group and by race; they do not address a lack of access perceived by the community and our stakeholders.

3) Stakeholder Identification of Needs and Priority Population

Reduction of stigma and discrimination ranked somewhat highly in our online and hard copy survey results, along with a reduction of disparities in access to early mental health intervention. Suicide was also identified as a significant negative outcome that may result from mental illness and that respondents believed PEI should target.

Key Informant Interviews also identified suicide, along with prolonged suffering, as a significant negative outcome resulting from mental illness that they would like to address.

More strikingly, in the interactive PEI Focus Groups Consensus Workshops, Community Education and Awareness, Increasing Access and Linkage to Services and Public Awareness: Destigmatization were all identified as interventions that should be included in the PEI plan.

4) Additional data analysis:

Health and Human Services Agency staff of the Mental Health Department, Public Health Department, and Outcomes, Planning and Evaluation Division collaborated on development of the "Mental Health Services Act Prevention and Early Intervention Community Mental Health Assessment." The document provides stakeholders, experts and advisory board members with information on the factors that influence a person's or a community's mental well-being, including research-based data and as much local data as is available on these factors. The report is included in our packet for your information, but we list here a few of the items included.

- A report on Shasta County Developmental Assets for 6th and 10th graders
- Assessment of adult and child contact with nature (walking, biking, etc.) and civic engagement
- Measures of adverse childhood events for Shasta County Children
- Prevalence of mental illness and treatment data
- Prevalence of alcohol and other drug abuse and help-seeking patterns
- Homelessness, unemployment, arrest rates, and school failure

This information assisted our PEI process participants to identify protective factors, risk factors and negative outcomes; this in turn assisted all participants to identify the programs and practices that will help us address our community need.

5) Results

As a result of this input and analysis, key community needs and priority population(s) and age groups that would be addressed by PEI Project 1, Community Education and Awareness were selected.

Form 3
County: Shasta
PEI Project Name: Project 1 - Community Education and Awareness

3. PEI Project Description

A. Project meets key community needs, priority populations and desired outcomes:

Our community process, enhanced by data analysis and research information, resulted in a commitment to a comprehensive Prevention and Early Intervention plan that addresses the entire community in all its socioeconomic diversity, geographic diversity and ethnic and cultural diversity. To the extent we can identify resources and collaborative partners to extend those resources, our goal is to produce a range of projects that can address the foundational concepts of prevention and early intervention and support activities across the spectrum of prevention activities.

The foundational concepts that helped determine our three projects are:

- Cultural Competence, incorporated into all aspects of policy-making, program design, administration and service delivery;
- Decrease Disparities in Access to Mental Health Services;
- Reduce Stigma and Discrimination affecting individuals with mental illness and mental health problems;
- Recognize and Address the Underlying Role of Poverty and other environmental and social factors that impact individual wellness;
- Decrease the Pervasive Effects of Alcohol and Substance Abuse;
- Increase Assets in Children and Youth.

Project 1, Community Education and Awareness, provides programs that address the Universal Prevention and Selective Prevention portion of the spectrum of Prevention and Early Intervention activities. This project, by its broad nature, will address all age groups, ethnic and cultural groups and all parts of the county. This project is intended to build community awareness and engagement in activities to improve mental wellbeing. It is also intended to build linkages with community partners and community members toward broadening the scope of community involvement in future planning, and promoting linkages to more community resources for individuals with mental health challenges.

B. Implementation Partners and Project Settings

We identified implementation partners based on input and information from our focus groups. These groups identified a list of interventions and activities categorized as

Community Education and Awareness activities. These activities will take place in cooperation with the following target groups:

- Local Education Agencies (teachers, other staff, students)
- Parents and Caregivers
- National Alliance for Mental Illness (NAMI) Shasta County
- Law Enforcement
- Health Care Providers, including community clinics, public health nurses and primary care physicians
- Social Services
- Faith Community
- Businesses
- Older Adults
- Community Leaders and Members, including cultural and ethnic groups, LGBT groups and communities of low socioeconomic status
- Education Subcommittee of the Mental Health Board
- Older Adult Policy Council

This project will include Trainings and Workshops, Events and Health Fairs and a Media Campaign. The project will take place in locations that are relative to the implementation partners. Health education is "the process of influencing people's behavior, producing changes in knowledge, attitudes and skills required to maintain and improve health. Thus, health education is not just the process of giving information but rather an active process that facilitates the use of the information to improve decision making, change behavior and ultimately lead to positive health outcomes." (Health Education 2007)

C. Community Demographics

Consistent with the goals of this project, to provide Universal Prevention services to the entire community, this project will target the community, including ethnic, cultural, geographic, sexual orientation and socio-economically diverse communities and implementation partners.

D. Program Highlights

The goals of the Community Education and Awareness project are to:

- Promote mental wellbeing in the community
- Increase the community's knowledge of mental health issues and available mental health services
- Decrease the stigma and discrimination associated with mental health problems
- Enhance the community's capacity to recognize the early signs and symptoms of mental health problems and provide appropriate support for individuals who experience mental illness

Form 3

County: Shasta

PEI Project Name: Project 1 - Community Education and Awareness

Project Activities:

- **Destigmatization** (School, Business, Community)
  Outreach, education, information and media for schools, businesses and communities to decrease stigma surrounding mental illness
- **Suicide Prevention**
  Training to teach the warning signs of suicide (community, workplace, schools) and curriculum to raise awareness of suicide and related issues (high school and middle school); collaborative work with the Public Health Suicide Collaborative
- **Training for Education**
  Introduction to children's mental health for teachers and student teachers, including information on specific disorders and strategies for success in the general education classroom
- **Identification of High-risk Older Adults**
  Organization and training of nontraditional community referral sources to identify high-risk older adults, including referral and assessment capacity
- **Faith Community**
  Program to increase collaboration between mental health professionals and the faith community, including activities to decrease the stigma of mental illness within communities of faith
- **Health Care and Social Services**
  Curriculum to provide health care and social service agencies with information to assist in the early intervention and treatment of mental health disorders and mental health emergencies
- **Health Care**
  Utilize information distribution contacts by public health nurses with primary care physicians to address mental health topics
- **Community Education**
  Educate culturally and linguistically diverse Community Health Advocates from the Shasta County Health and Human Services Agency and local ethnic coalitions about basic mental health topics, early signs of mental health problems, and resource support

E. Project Implementation, including milestones and timeline

Activity	Milestone	Timeline
Plan Development: Mental Health Board Community Education Sub-Committee, NAMI, consumers, and other local coalitions	Plan coordinated with partners	January 09-ongoing
Identify Community Education Specialist	Staff Assigned	October 08
Destigmatization: Develop Stigma Reduction Initiative manual (for example, SAMHSA's Mental Health – It's Part of All Our Lives) for outreach, education, information and media	Destigmatization activities to implement initiative	Planning: January 09 Implementation: June 09-ongoing

Form 3
County: Shasta
PEI Project Name: Project 1 - Community Education and Awareness

Suicide Prevention: Coordinate with Public Health Suicide Collaborative's Strategic Plan for Suicide Prevention	Collaborative established	November 08-ongoing
Suicide Prevention: Increase access to and resources for training on suicide prevention (for example, Question Persuade Refer); coordinate with NAMI, consumers, and statewide suicide preventive strategies	Training made available in community, workplace, schools	November 08-ongoing
Suicide Prevention: Adopt and implement curriculum on suicide prevention, including depression screening and other risk factors (for example, Sign of Suicide)	Coordinate with high school and middle school partners	Begin coordination of partnerships: March 09
Education: Identify training for teachers and future teachers in children's mental health (for example, Unlocking the Mysteries of Children's Mental Health: An Introduction for Future Teachers	Coordinate with school training programs	Begin coordination of partnerships: January 09 Teacher training: June-September 09
Older Adults: Identify Gatekeeper Case Finding and Response System with nontraditional community referral sources	Gatekeepers identified and trained; referral system in place	Begin planning: March 09 Implement Training/Referral System: September 09
Faith Community: Identify dialogues and workshops with religious leaders/advisors, mental health professionals and family members/consumers to increase collaboration to decrease stigma and increase community knowledge (for example, Partners in Healing)	Workshop schedule developed	Schedule published: April 09 Two workshops implemented: June 09
Health Care & Social Services: Adopt a curriculum series for health care and social service agencies on mental health problems and issues (for example, Responding Effectively: A Mental Health Curriculum)	Curriculum identified and implemented	Curriculum identified: July 09 Curriculum implemented: December 09

Form 3
County: Shasta
PEI Project Name: Project 1 - Community Education and Awareness

Health Care: Establish mental health topics for mental health awareness and stigma reduction for regular meetings between public health nurses and primary care physicians	Topic series scheduled	Management presentation: January 09 Nurse training: May 09
Community: Educational program for culturally and linguistically diverse Community Health Advocates, including early signs and symptoms of mental health problems and tools to provide support ;	Program developed and scheduled	Program development: May 09 Training scheduled: July 09
Expand community education program to include family and consumer outreach, as resources are available. (Consider NAMI and UACF education programs as well as statewide consumer and family technical assistance resources.)	Consider for July 09expansion	
Outcomes: Identify process for identifying generally outcomes for this project	Establish project outcomes and tracking system	Coordinate with Outcomes, Planning and Evaluation Division: January 09

Planning activities and outreach and collaboration activities have begun and will continue as a part of our Prevention and Early Intervention Planning activities, using Planning funds.

4. Project

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2009 by type		Number of months in operation through June 2009
	Prevention	Early Intervention	
Destigmatization Reduction Initiative: Mental Health: It's Part of All Our Lives	Individuals: Families:	Individuals: Families:	3 months: planning stages

Suicide Prevention: Question Persuade Refer	Individuals: 20-30/training (2 trainings) Families:	Individuals: Families:	6 months (training provided by NAMI
Suicide Prevention: Signs of Suicide	Individuals: Families:	Individuals: Families:	6 months: planning stages
Teacher Training: Unlocking the Mysteries	Individuals: Families:	Individuals: Families:	6 months: planning stages
Faith Community: Partners in Healing	Individuals: 15-20/workshop; 5 workshops Families:	Individuals: Families:	6 months (4 months planning)
Health Care & Social Services: Responding Effectively	Individuals: Families:	Individuals: Families:	6 months: planning stages
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Individuals: 100-150 Families**:	**Individuals: Families**:	

Timelines may shift into 2009-10, depending on the pace of development of collaborative schedules with our partners.

5. Linkages to County Mental Health and Providers of Other Needed Services

A. Project Linkages

This PEI Project was designed in an inclusive planning process that included county and private providers of healthcare, education representatives, substance abuse treatment representatives, domestic/sexual violence prevention and intervention, basic needs, and mental health. We believe that these community partner agencies are key partners in the strengthened network of care we are building. As a result, our Community Education and Awareness project will link individuals and family members to other needed services,

including those provided by community agencies not traditionally identified as mental health providers that have established meaningful relationships with our at-risk populations. The project will develop specific and formal referral linkages to assessment and treatment resources when participants believe that more extensive treatment is needed. These referral mechanisms will include access to primary care providers, private or public mental health service providers, or MHSA programs established under the CSS program.

B. Project Resource Adequacy

Programs Can Achieve Outcomes

Individual Outcomes: Our planning for this project included extensive review of the research and literature as to effective education and awareness programs. We will use proven curricula and training models with the goal of improving individual and family outcomes. Each researched-based health education and awareness tool model will be reviewed with our community partners for effectiveness. For example, we intend to use the "Question Persuade Refer" model, or a program similarly proven, for suicide prevention training in the community, workplace and schools. We intend to use "Unlocking the Mysteries of Children's Mental Health: An Introduction for Future Teachers" as an introduction for future teachers to children's mental health. And, we will continue to review and use state-level information as the state develops Prevention and Early Intervention information.

Program/System Outcomes: It is our belief that the activities/programs identified will result in an improvement in the mental wellbeing of the community; increase the community's knowledge of mental health challenges and available services; will decrease the stigma and discrimination associated with mental health; enhance the community's capacity to recognize the early signs and symptoms of mental health problems; and provide appropriate support for individuals and families suffering from mental health related challenges . Our collaborative activities (outlined below) identify the partner and leveraging opportunities that will assure program implementation. These leveraged and collaborative resources include the following:

- Outreach and engagement for trainings, workshops, events and health fairs
- Targeted community relationships that can help assure comprehensive community coverage and cultural competence
- Locations, transportation, food and other assets to encourage participation in trainings/events
- Participation on policy councils that can review implementation, assess outcomes, and advise changes
- Improved referrals for health, social services and other community services

Form 3
County: Shasta
PEI Project Name: Project 1 - Community Education and Awareness

6. Collaboration and System Enhancement

The Community Education and Awareness Project will receive policy guidance from the Mental Health Board Community Education Sub-Committee and the Mental Health Services Act Advisory Committee. The MHSA Advisory Committee was developed to provide input from key community partners including education, health care, consumer groups, family members, law enforcement, underserved populations, and community-based organizations throughout the community. The selection of the projects for this PEI plan were made with the input and participation of these groups, in addition to the more elaborated focus groups and key informant interviews.

Shasta County Mental Health is now a part of the Health and Human Services Agency (HHSA), a unified agency that includes health and social services programs. This organizational design makes it possible for Community Education Specialist hired for this project to coordinate activities with our culturally and linguistically diverse Community Health Advocates. This collaboration utilizes the extensive public health experience of our Health and Human Services Agency, and will assure that the linkages already established with underserved cultural populations are leveraged for this project. Representatives of the PEI Community Education and Awareness Project will be an active participant in the stakeholder group implementing the Public Health Strategic Plan for Suicide Prevention.

The planned development of this project will take place within existing collaboratives, and will require the development of more elaborate collaborative efforts with partners who contributes ideas toward the development of the plan. For example, participants in the education focus group requested training to build capacity of educators to address the needs of children with emotional and behavioral challenges in their classrooms. This will require collaboration with local institutions of higher education that provide teacher training, as well as coordination with local education agencies who are interested in providing and receiving in-service staff trainings. For the most part, existing curricula will be implemented within the context of the Health and Human Services Agency, and will include partners in the private health and social services delivery system, whose members participated in the development of this plan. Finally, this project will require the development of improved collaborative efforts with community referral re linked to at-risk older adults, primary health care, and faith communities.

Through our CSS Plan, SCMH has developed a network of collaborative services with Federally Qualified Health Centers (FQHC) throughout the county. Policy advice is provided by a Rural Mental Health Policy Council that meets monthly. We anticipate that this existing collaborative effort with our community FQHCs will provide additional opportunities for trainings and workshops in the area of Community Education and Awareness. Moreover, for both CSS and Community Education and Awareness, ongoing work with additional private health care

providers and hospitals will continue, offering opportunities to extend the capacity of this project.

Because this project consists primarily of trainings and workshops, events, health fairs, and a media campaign, we do not anticipate that our collaborations will be formalized, except in the case of the Mental Health Board Community Education Sub-Committee and the Mental Health Services Act Advisory Committee. Instead, we anticipate that partner agencies such as education, law enforcement, consumers, family members, health care providers, faith community leaders, businesses, and other community leaders , will assist by providing outreach, targeting project activities, including the development of training and workshop events where developed curricula and information can be presented.

Monitoring of outcomes will be done in a community process, using the advisory committee structure. This process will allow all the partners that participated in development of this plan, and who participate in its implementation, to assess success and areas for refinement and improvement as the Prevention and Early Intervention process continues.

We anticipate that this program will be an ongoing PEI project, depending on community review at periodic intervals, and assessment of the extent to which this project meets the identified individual, system and community outcomes.

7. Intended Outcomes

A. Individual and Family Outcomes

We anticipate that individuals with mental illness and their families will be beneficiaries of improved education that leads to early identification and referral to services. In all of our community outreach and focus group activities, individuals and families cited destigmatization as a key need in the community. We anticipate an increase in help-seeking behavior among those with mental or emotional problems. In a 2007 Community Health Assessment, it was estimated that 58% of Shasta County adults with recognized depression have sought help for a mental or emotional problem. This number is lower among adults 75 and over (23%), for example. We believe that destigmatization activities can raise these numbers, especially among communities currently underserved. We anticipate that membership in consumer wellness groups and family groups will increase as stigma is reduced. Moreover, we believe that public health education will assist in the reduction of suicide, isolation and other negative outcomes associated with mental illness.

B. Program Outcomes

We anticipate developing a county-wide program of education and awareness activities that can be tracked and reported, using our community collaboratives to assure that we are

reaching underserved areas of the county and underserved economic and cultural groups. A pre- and post-test evaluation will be completed to determine if awareness increased and attitudes changed. We anticipate tracking measures that will provide our network of care with information about the reach of this project:

- Collaborative Log of PEI required sector or project target population
  Meeting minutes/agenda
- Curriculum/Program Reviews
- Training/Workshops Target Group Subject, Curriculum or Program
  Participant sign in sheets
  Curriculum/Program Evaluation as needed, such as Pre and Post tests
- Health Fair/Event Attendance
- Media Campaign Activities
  Related Evaluation

C. System Outcomes

We anticipate that a successful program will result in improved individual and family outcomes, as outlined above. The development of collaborative relationships to provide the training, workshops, curriculum and media will strengthen collaborations with other agencies, including improvements in the timeliness and efficiency of referrals. Additionally, this project will continue community outreach and engagement regarding various aspects of mental health and illness toward the understanding and support of members of our community who experiences challenges associated with a mental health condition.

We anticipate that the development of the Community Education and Awareness Project will also be coordinated with developing state level Prevention and Early Intervention activities. We anticipate, for example, that our Suicide Prevention curriculum will be consistent with state activities, and will utilize state level resources to expand the reach of this program. Similarly, we anticipate that the school-based curricula and teacher training programs will be coordinated with the state's Student Mental Health Initiative.

D. What Will Be Different and How Will We Know?

Our primary assessment of success in this area will be the monitoring and assessment by our advisory structure and collaborative partners. We anticipate an ongoing assessment of the extent to which these activities broaden community information about mental illness and improve access to resources to address mental illness and accompanying health and social needs. We will review the process outcomes outlined above under 'Program Outcomes' to assure that we are using our resources wisely and reaching into the geographic and cultural diversity of our county. We will monitor consumer and family reports on the extent to which this program assists access to services. We will monitor help-seeking behavior when this information is available from health system assessments. These process and outcome

measures will inform the MHSA Advisory Committee about changes to this project, including whether to continue its development in future PEI plans.

8. Coordination with Other MHSA Components

A. Coordination with CSS

As indicated above, we anticipate more formal and efficient referrals from collaborating partners to the CSS program and the entire range of public and private mental health programs in the county. Improved access, including to the CSS programs currently operating, is a primary goal of our stakeholders. Staff from this program will meet regularly with the MHSA staff to coordinate activities and share implementation information. We anticipate that the consumer and family activities funded by our CSS program will be especially coordinated with the Community Education and Awareness program, and will provide a key referral location for individuals identified as needing mental health or other services as a result of this project. We also anticipate that the FQHC primary care providers will be central to offering non-stigmatizing services to individuals identified in this project.

B. Coordination with Workforce Education and Training

Our Workforce Education and Training plan is not yet complete. We will include PEI project needs in our assessment as we develop that plan.

C. Coordination with Capital Facilities and Information Technology

Our Capital Facilities and Technology plan is not yet complete. We will include PEI project needs in our assessment as we develop that plan.

D. Coordination with Innovation

Our Innovation plan is not yet complete. We will include PEI project needs in our assessment as we develop that plan.

Form 3
County: **Shasta**
PEI Project Name: **Project 2 - Evidence-based Interventions**

1. PEI Key Community Mental Health Needs	**Age Group**			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	☐	☐	☐	☐
2. Psycho-Social Impact of Trauma		☐	☐	☐
3. At-Risk Children, Youth and Young Adult Populations	X	X		
4. Stigma and Discrimination	☐	☐	☐	☐
5. Suicide Risk		☐	☐	☐

2. PEI Priority Population(s) **Note: All PEI projects must address underserved racial/ethnic and cultural populations.**	**Age Group**			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
A. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	X	X	X	☐
2. Individuals Experiencing Onset of Serious Psychiatric Illness	X	X	☐	☐
3. Children and Youth in Stressed Families	X	☐		
4. Children and Youth at Risk for School Failure	☐	☐		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☐	☐		
6. Underserved Cultural Populations		☐	☐	☐

Form 3
County: Shasta
PEI Project Name: Project 2 - Evidence-based Interventions

B. Stakeholder Input

1) CSS Plan Identification of Community Needs and Priority Populations

During the county's CSS Planning process we identified the following community needs and priority populations that were more appropriate to the PEI process and that are addressed in this PEI Project:

Community Needs:

Shasta County's CSS Planning process identified specific needs of children, youth and young adult populations. The inability to remain in a mainstream school environment, involvement in the justice system, and peer as well as family problems were identified as key community needs for children and for transition age youth. Access to care was recognized as a problem, including attaining access to a full continuum of services. Stigma and discrimination regarding mental illness was identified as a problem, and isolation and a lack of opportunities for social interaction were identified in both Redding and the rural parts of the county. School difficulties are high for some children, and adult transience related to economic challenges create difficulties for children and young people. Cultural issues, including the lack of culturally appropriate services and rural isolation and culture, impede access for some families. Stigma and the lack of peer support resources were cited as difficulties. Girls and young women are especially underserved, along with Hispanic and Native American groups identified as underserved.

Because children and transition age youth were found to be comparatively better served than other age groups, the county's CSS plan focused initially on addressing other identified needs. Despite this focus, the development of a Shasta Mental Health Rural Initiative, including partnerships with FQHC clinics and extension of an intensive treatment team in the south county area, has improved access for children, young people and families by bringing CSS services to areas that have been significantly underserved. Regardless, our stakeholders and public believe strongly that the PEI component to the Mental Health Services Act must address children and transition age youth.

Priority Populations:

As summarized above, our CSS plan identified children and youth in stressed families, children and youth at risk for school failure, and children and youth at risk of experiencing juvenile justice involvement as having unmet needs.

2) CSS Implementation Identification of Needs

Our CSS programs and services to date have not specifically identified Prevention and Early Intervention needs. We have instead conducted a Community Mental Health Assessment that reexamined demographic and service data compared to a variety of factors that influence a person's or a community's mental well-being. This Assessment will be discussed in more detail below. This Assessment included overall data on services by Shasta County Mental Health compared to county residents, and to residents living in poverty. These figures,

however, provide only a picture of comparative services by age group and by race; they do not address a lack of access perceived by the community and our stakeholders.

3) Stakeholder Identification of Needs and Priority Populations

Our stakeholder process clearly identified the following community need and priority populations addressed in this PEI Project. This need was identified through focus groups, survey, and key informant discussions as summarized in Form #2, Community Program Planning Process.

Community Needs:

Our stakeholder process identified At-Risk Children, Youth and Young Adult Populations as the key issue we will address with PEI funding. Specifically, the process identified a need to increase prevention efforts and response to the early signs of emotional and behavioral health problems among at-risk children, youth and young adult populations.

As discussed above, our process included an initial community informational meeting, Stakeholder Surveys in hard copy and on-line, Key Informant Interviews, and Focus Groups. Surveys asked respondents to identify Key Community Mental Health Needs and PEI Priority Populations. They also offered an opportunity to identify Protective Factors important to preventing mental illness or promoting mental well-being, Risk Factors that contribute to mental illness, and Negative Outcomes that the PEI plan should target.

Key Informant Interviews also asked respondents to identify key mental health needs. In addition, these informants identified existing programs that address these needs, and identified programs or services that might meet the need effectively. Informants were asked to identify priority population groups, and to identify programs already addressing those populations and those interventions that might address those populations. Key Informants identified Protective Factors, Risk Factors, and Negative Outcomes, including programs that address them and that might be effective.

Focus Group meetings were designed to solicit input from the community and collaborating partners. Participants ranked their priority for age groups, key mental health needs, and priority populations. Ranking of the priorities was determined by totals for each group. Focus group participants were asked to individually brainstorm what interventions should be included in the PEI Plan. These ideas were then clustered and named using a facilitation method called Consensus Workshop.

Participants in our PEI focus groups identified children and youth 0-15 as their first priority, and young people age 16-25 as their second priority. Every process used, including surveys, informant interviews and focus groups, identified “Increase prevention efforts and response to early signs of emotional and behavioral health problems among at-risk populations” as their first priority mental health need.

Priority Populations:

As indicated above, the results of each piece of stakeholder input were analyzed and ranked. Individuals identified Children and Youth in Stressed Families as the first priority

population. Trauma-Exposed Individuals and Individuals Experiencing the Onset of Serious Psychiatric Illness were next in order of the rankings. These needs have been identified in our plan as important issues to address as we move forward.

Our PEI Expert Panel, having reviewed the Stakeholder Process input, recommended that at least 51% of the overall PEI Budget be spent on children and youth between the ages of 0-25. They further recommended that the 0-5 population be a priority for a portion of PEI efforts. The preventative value of early intervention with at-risk 0-5 year old was emphasized.

4) Additional Data Analysis

We conducted the following additional data analysis:

Shasta County Mental Health, Shasta County Public Health, and Shasta County Health and Human Services' Outcomes, Planning and Evaluation Division collaborated on development of the "Mental Health Services Act Prevention and Early Intervention Community Mental Health Assessment." The document provides stakeholders, experts and advisory board members with information on the factors that influence a person's or a community's mental well-being, including research-based data and as much local data as is available on these factors. The report is included in our packet for your information, but we list here a few of the items included.

- A report on Shasta County Developmental Assets for 6th and 10th graders
- Assessment of adult and child contact with nature (walking, biking, etc.) and civic engagement
- Measures of adverse childhood events for Shasta County Children
- Prevalence of mental illness and treatment data
- Prevalence of alcohol and other drug abuse and help-seeking patterns
- Homelessness, unemployment, arrest rates, and school failure

This information assisted our PEI process participants to identify protective factors, risk factors and negative outcomes; this in turn assisted all participants to identify the programs and practices that will help us address our community need.

Two of the elements listed above highlighted a need to have an evidence-based program that targeted middle-school aged children. The 2005 Developmental Assets survey indicated a large difference in the percentage of 6th grade students exhibiting between 21 and 40 developmental assets (60%) and the percentage of 10th grade students exhibiting between 21 and 40 developmental assets (31%). This might indicate an opportunity among 7th – 9th graders to promote developmental assets to prevent the decline seen in 10th graders. The California Healthy Kids Survey conducted by the California Department of Education also shows a troubling increase in binge drinking between 7th and 9th grades. While 6% of 7th grade students reported binge drinking in 2004, 16% reported binge drinking in 2006. This also identifies an opportunity to intervene and increase resiliency among 7th and 8th grade students in Shasta County.

5) Results

As a result of this input and analysis, key community needs and priority population(s) and age groups that would be addressed by PEI Project 2, Evidence-based Interventions were selected.

3. PEI Project Description

A. Project meets key community needs, priority populations and desired outcomes:

Our community process, enhanced by data analysis and research information, committed to a comprehensive Prevention and Early Intervention plan that addresses the entire community in all its socioeconomic diversity, geographic diversity, and ethnic and cultural diversity. We have developed projects that address Community Education and Awareness (Project 1), and strategic planning that aims to reduce Adverse Childhood Experiences (Project 3). The goal of Project 2 is to implement prevention and early intervention supports, services, and evidence-based programs in Shasta County that will specifically address PEI areas selected by the community during the stakeholder input process.

This project will focus on four areas:

- Triple P Positive Parenting program designed to establish a widely available support and education resource for parents and other primary caregivers of children with emotional and behavioral challenges
- Pilot program targeting at-risk middle school students to provide support groups that promote a sense of belonging and skills training to enhance daily functioning to decrease engagement in high risk behaviors
- Program development activities and training to increase early intervention resources for trauma-exposed individuals
- Program development and training to increase early identification and referral to intervention resources for individuals experiencing the onset of serious psychiatric illness

Stakeholder input through multiple modalities contained recurrent themes of recognizing early signs of mental health issues, and providing resources to aid people dealing with those challenges. Given the feedback to address issues related to children and youth in the stakeholder input process, our review and selection of intervention strategies turned toward evidence based practices that can benefit families taking care of children who display early signs of mental health issues. In this selection process we recognized the central role of primary caregivers, usually parents, in promoting the social, emotional and physical development of their children. Community input also reinforced the difficulty a parent faces in determining how or when to seek support to address concerns about their child's well being.

Triple P, an evidence-based positive parenting program, was selected for several reasons. It is indicated for and contains developmentally appropriate interventions for multiple age groups from infancy through adolescence. Triple P has multiple levels of program intensity to match the differing needs of parents and consequently be of value to a broad array of families. Various types of service providers, including medical providers, parent educators and therapists can be trained to provide Triple P, allowing access and service delivery through multiple types of community services. Additionally, Triple P exposes parents to a wide range of parenting strategies so that parents can make choices and select goals they want to achieve through this service informed by personal, familial and cultural factors. Recent research on Triple P outcomes suggest Triple P is effective in reducing child maltreatment referrals.

Another selection criteria utilized was to look for areas of common need and program development activities among community stakeholders so that resources can be used to collaborate on program development toward expanding existing initiatives or leveraging resources for a new program development when possible. Consideration of evidence-based practices in the areas of supporting at-risk young adolescents and trauma exposed children is motivated in part by current or planned development of intervention for these target populations among other community agencies.

Finally, the strategy of educating providers reaches an influential group of individuals in and out of the health field who have daily contact with large numbers of people at high risk for negative health outcomes. By educating providers to identify and intervene in mental health issues, professionals, paraprofessionals and community activists working with the public can become frontline advocates for mental health. In the area of early intervention with traumatized individuals training of treatment providers will be used to increase community capacity to address this early intervention need. Similarly training of community service providers in early identification of individuals at risk of development of serious mental illness will facilitate earlier identification and referral for intervention.

B. Implementation Partners and Project Settings

<u>Positive Parenting Program (Triple P)</u>
Potential partners may include, but not be limited to:

- Shasta County Children and Family Services (CFS)
  Foster parents
  Individuals who supervise and support parents during visitation with their children in foster care
- Shasta County Probation Department
- Child Abuse Prevention Council
  Parent partners

- Shasta County Mental Health treatment providers
  Providers who receive differential response referrals and have Mental Health Plan responsibility for provision of service to Medi-Cal beneficiaries on a regional basis
- Bright Futures, a rural First 5 Shasta funded family support program
- Federally Qualified Health Centers
- Pit River Health Services
- Shasta County Office of Education, early childhood staff services
- Local Education Agencies
- Shasta County Head Start
- Community organizations, including the faith community and youth providers such as YMCA, as resources become available

During the PEI planning process there was a convergence of interest in the implementation of Triple P in our communities. Shasta County Head Start, with funding from Shasta County Children and Families First Commission (First 5 Shasta), is implementing Triple in their center based and home visiting programs. Additionally, a collaborative of rural Federally Qualified Health Centers and an outreach and parent support program, Bright Futures, selected Triple P as an evidence-based practice they would like to implement through a grant application which is still pending.

Our proposal consists of making Triple P training resources available to staff who work with low income children who are at risk. We will develop an implementation plan to identify community partners who are engaged in supporting parents in the care of their children, who agree to implement Triple P in the course of their work as well as participate in program coordination and evaluation activities. In the absence of other available resources, we will make training resources available for staff of those agencies to utilize Triple P in the natural settings where staff already works with children and their families. Our goal will be to effectively utilize training resources across community agencies to expand Triple P availability across community agencies. As this program is developed over time, and as resources are available, and as evaluations show this is an effective parent support program, we will expand our training and support resources to additional community collaborating partners, including the faith community and youth providers. Our implementation plan is flexible and will develop over time.

Our role in collaborating with Head Start will be to work with them to support implementation of this evidence based practice with consistency and fidelity across community settings, and to implement a training plan that maximizes access to various levels of providers across service modalities and regions.

Pilot Middle School Program
Potential partners include:

- Local education agencies and/or community based youth-oriented programs

We have identified Girls Circle/Boys Council and Life Skills as possible alternatives for this project and will consider other evidence-based programs targeting at-risk youth 9 to 13 years of age. We believe that such a program should include personal resource development activities, such as learning problem solving skills, and activities to increase a sense of belonging, resiliency and self-esteem, such as peer support activities and community service opportunities. The Shasta County Office of Education and other local educational agencies have a plan for the implementation of Life Skills in some but not all junior high school settings in Shasta County. The Shasta County Health Improvement Partnership, Shasta County Probation and the Anderson Teen Center are involved in the implementation of Girls Circle/Boys Council, programs with similar aims as Life Skills. Neither of these programs is available in all regions of the county. Our goal is to increase availability of this type of program in underserved geographic regions, assuring that implementation of a program to build resilience in middle-school young occurs with fidelity and appropriate evaluation resources.

Trauma-Exposed Individuals and Individuals Experiencing the Onset of Serious Psychiatric Illness
Potential partners include:

- Shasta County Children and Family Services
- Federally Qualified Health Centers and other medical providers
- Mental Health treatment providers
- Domestic Violence treatment providers
- Local educational agencies
- Shasta County Probation Department

We plan to provide trainings to develop additional community capacity to address interventions with trauma-exposed children and adults.

Early Identification and Referral of Individuals Experiencing On-set of Serious Psychiatric Illness
Potential partners include:

- Federally Qualified Health Centers and other medical providers
- Mental Health treatment providers
- Local educational agencies, including institutions serving college-age students
- Shasta County Probation Department

We will provide training to increase knowledge of early signs and symptoms of mental illness, screening strategies and referral resources, particularly focusing on identification of

early on-set of psychiatric disorders. Training for community and public providers will occur in settings where these providers normally access training and support.

C. Community Demographics

Triple P: Our target population is children and youth in stressed families at risk of negative outcomes, children showing early signs of behavioral and emotional difficulties and underserved individuals. By focusing our activities on training and implementation support with partnering community agencies, consumers and family members, we expect to maximize the impact of available resources.

Partnering with Shasta County Children and Family Services and Probation, the opportunity to serve families throughout the county at risk of negative outcomes will improve, including those receiving differential response services or who have children receiving foster care. Providing Triple P services using Mental Health Plan community providers will assure capacity for broad-based access to the parenting support program for families with at risk children. Partnering with home visiting programs, parent support, and medical providers will create opportunity for outreach and engagement by community organizations not traditionally involved in mental health services. This outreach has especially identified rural families, Hispanic and Native American families, and individuals without other access to health services. Partnering with Pit River Health Services will help support services in that Native American nation. Partnering with organizations that serve young children will help assure that our Triple P services can reach those community systems that serve children 0-5 and their families, while Federally Qualified Health Centers will help us reach families in every part of the county, especially rural areas. Finally, Partnering with the Shasta County Office of Education and Local Education Agencies will potentially reach throughout the county to families at risk from all demographic communities. As our program is developed over time, we will look to expand our partnerships to other organizations motivated to participate; this may include the faith community and youth-serving community agencies.

Pilot Program Targeting At-Risk Middle School Students: Our target population is at-risk middle school students.

The target population of this program is middle school children who are at risk and would otherwise not have access to programs of this type. Selection of program and service delivery strategy will be made based on the willingness of partner organizations to support such a program, having an implementation strategy that assures at risk youth can access services and that the program will be implemented with fidelity.

Training Options for Treatment of Trauma-Exposed Individuals and Individuals Experiencing the Onset of Serious Psychiatric Illness: We will provide training opportunities for private and public providers who come into contact with trauma-exposed individuals.

Early Identification and Referral of Individuals Experiencing On-set of Serious Psychiatric Illness: We will provide training on signs and symptoms of early on-set of serious psychiatric illness and screening strategies for public and private individuals and organization who have opportunity to provide screening and referral activities. We anticipate that this culturally and ethnic-sensitive training will provide a positive impact on individuals throughout the county.

D. Program Highlights

Triple P:
As stated previously, our target population is children and youth in stressed families and children showing early signs of behavioral and emotional difficulties. We will develop an; implementation plan involving community organizations and providers service target population children and their families. PEI resources will provide training, written materials and evaluation supports for implementation of Triple P interventions among community agencies.

This program will serve children and youth in stressed families who are involved with the Children and Families Services by providing resources to match Title IVE training funds targeting the training of individuals who serve children involved in child protection services. Triple P training will be provided to individuals offering foster parent training. Additional Triple P training will be provided to mental health care providers who are involved in the provision of parenting skills training, child and family mental health interventions for children in foster care and their parents and those individuals who supervise and support parent visitation.

In the Shasta County communities along the I-5 corridor, this program will support implementation of Triple P among outreach and engagement home visiting providers and parenting education providers who are in contact with at risk children and stressed families. This may include parent partners who provide outreach and engagement services for families in the differential response system. Differential response services are designed to assist families who have had referrals regarding child abuse or neglect that do not require on-going involvement with or oversight by Children and Family Services. To the degree that resources are available, this project will make Triple P training available to staff who work with low income at-risk children, including local education agencies staff serving young children in early childhood services settings like state preschools, supporting families involved in CalWORKS and supporting family child care providers. A more intensive level of intervention will be available through training MHP providers in the Triple P model. PEI funds will be used for local match to provide increased capacity among providers who serve children who meet clinical target population for provision of services utilizing the Triple P evidence based practices.

For underserved individuals, including those living in rural areas of Shasta County, the PEI program will collaborate with Federally Qualified Health Centers (FQHCs) and family

support/outreach service providers. The Pit River Tribal Council through the Pit River Health Service, two other FQHCs (Hill Country Community Clinic and Mountain Valley Clinic) and the Bright Futures Program, a First 5 Shasta funded family support program, have proposed to implement Triple P through application for Project Launch grant funding. In the absence of grant funding to support Triple P implementation, PEI funds will be utilized to support the implementation of Triple P among these community partners. In the event that the Project Launch application is successful and to the degree that resources are available if there is no Project Launch funding, PEI support for implementation of Triple P would be offered to other FQHCs in the rural and central areas of the county. These medical clinics are significant points of contact for families who are experiencing challenges with their children's social, emotional and behavioral development.

Additionally, SCMH will collaborate with Head Start in Shasta County as they implement Triple P at their centers and home visiting programs with First 5 Shasta funding to ensure that Triple P training resources are coordinated to achieve maximum effective utilization and impact across our community.

The Triple P Training Plan provides various levels of training. Our current training plan includes the following:

Level 4 Standard & 5 Enhanced *
Targeting: Clinical providers such as MHP clinical providers, FQHC Clinical staff, SCOE and LEA Early childhood services providers, Visitation Program Clinical staff.

Level 2 Selected Triple P and 3 Primary Care Triple P
Targeting: Bright Futures family support staff, other home visiting/outreach program staff; FQHC medical support staff

Level 4 Standard or Group
Targeting: Children and Family Services Social Service Aides, Probation Department service providers, Foster Parent Trainers, Visitation Center staff, parenting skills trainers from SCOE or other educational agencies

Level 5 Pathways
Targeting: Clinicians who are working with parents involved in domestic violence or Children and Family Services due to child abuse allegations.

<u>Pilot Program Targeting At-Risk Middle School Students</u>

Our PEI planning process identified middle school students as a target population. Local statistics, found in the Shasta County Mental Health Assessment, documented that youth begin to increase risk taking behaviors between middle school and high school. For example, when comparing 7th grade California Healthy Kids 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.

As a part of our PEI project we plan to collaborate with community agencies to identify and recruit a program site or sites willing to operate a pilot program designed to provide early prevention when early signs of emotional and behavioral health problems emerge. Our provider and site selection will attempt to assure that the array of skill-building and early intervention efforts reach the maximum number of middle school students with programs that can be evaluated for impact on risk-taking choices.

Training Options for Treatment of Trauma-Exposed Individuals

Our stakeholder and analytical needs assessment processes advised that finding programs that address the impact of trauma on individuals is an important community goal. We anticipate that through the course of our strategic planning activities we will gain knowledge to develop additional strategies for the implementation of evidence based practice in this area. However, in the interim we want to support the availability of community resources in this area by providing limited training activities addressing early interventions with traumatized individuals, both children and adults. We will provide training for programs or providers that come into contact with trauma-exposed individuals to identify trauma as a part of intake and problem identification, to guide clinical interventions and address the consequences of trauma through other service resources. We will evaluate if there are opportunities to maximize training activities or broaden availability of training in our development of this part of the project through collaboration with other community entities.

Early Identification and Referral of Individuals Experiencing On-set of Serious Psychiatric Illness

Evidence indicates that individuals experiencing the onset of serious psychiatric illness can benefit from early intervention in the course of the disorder. Research finds that there are often major delays in the provision of treatment for psychotic disorders, with an average of one year between the time of first presentation with psychotic symptoms and treatment. Longer lengths of time from first presentation to 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 three-fold increase in relapse rates over the following two years. Time to remission and level of remission was related to duration of untreated psychosis. Promotion of awareness and education about risk factors and signs and symptoms associated with the early phase is recommended to inform parents, teachers, school counselors, general practitioners, health professionals and other relevant groups. (Promotion, Prevention and Early Intervention of Mental Health 2000)

The focus of the early onset identification activity is two-fold, including identification of individuals at risk of the onset of serious psychiatric illness and referral to available community resources. Identification of screening strategies and referral processes would be

the program development activities. Training would be provided to the education professional work force, medical providers, and other key professionals who encounter young persons in the early stages of psychosis, to help others to identify young people who are manifesting early signs or active symptoms and signs of schizophrenia and other major mental health disorders. These efforts should help professionals to identify individuals at risk, and promote the referral and treatment of those at substantial risk. Training will also emphasize development of a relationship with individuals referred and their families to provide the support needed. The Portland Identification and Early Referral Program is an example of such a program that is now being replicated for evaluation. These strategies may build toward further local program development in this area.

We anticipate that this program will provide outreach to community members and providers of community-based services and training activities. We will select training programs and outreach targets in collaboration with our stakeholders and partners. We anticipate that experience in this area after the first year or two will offer guidance for additional expansion, as funds and collaborative resources are available.

E. Project implementation, including milestones and timeline

Triple P:

Activity	**Milestone**	**Timeline**
Identify lead staff to coordinate implementation activities and set up program evaluation activities.	Staff assigned	When plan approved by MHB
Create implementation plan with community partners, including staff who will be trained, service volume expected and evaluation data to be collected	Formal implementation Plan completed	January 2009
Contract established for Triple P Training	Contract completed	January 2009
Initiate training components	Training will be ongoing	February 2009 forward
Initiate data collection	Evaluation will be ongoing	With implementation – February 2009 forward
Review of evaluation data by MHSA Advisory Committee and Shasta County Mental Health Board	Review and program adjustment	July 2009

Form 3
County: Shasta
PEI Project Name: Project 2 - Evidence-based Interventions

Pilot Program Targeting At-Risk Middle School Students

Activity	Milestone	Timeline
Identify staff to coordinate program implementation activities	Staff assigned	When plan approved
Final selection of pilot program	Program selected	12/08
Implementation criteria established for request for proposal	RFP completed	January
Contract for selected program, site for service delivery and # of youth to be served.	Contract completed	March 2009
Pilot program initiated	Program initiated	April 2009
Collect implementation data-dates, # served etc.	Evaluation will be ongoing	April 2009 forward
Review of evaluation data by MHSA Advisory Committee and Shasta County Mental Health Board	Review and program adjustment	July 2009

Training Options for Treatment of Trauma-Exposed Individuals and Individuals Experiencing the Onset of Serious Psychiatric Illness

Activity	Milestone	Timeline
Identify staff to coordinate program	Staff assigned	When plan approved
Develop training plan with input from community providers	Training plan completed	April 2009
Contract for training related to trauma exposed individuals	Contract(s) completed	May 2009
Outreach to community providers	Trainees identified	June 2009
Training delivered	Training delivered	June 2009 forward
Evaluation	Evaluation will be ongoing	June 2009 forward by training session
Identify screening strategies and prepare training material	Training information prepared	April 2009
Outreach to community providers and scheduling of training activities	Schedule planned	May 2009

Form 3
County: Shasta
PEI Project Name: Project 2 - Evidence-based Interventions

Training implemented	Training provided	June 2009 and after
Evaluation	Evaluation will be on-going	June 2009 by training session
Review of evaluation data by MHSA Advisory Committee and Shasta County Mental Health Board	Review and program adjustment	July 2009

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2009 by type		Number of months in operation through June 2009
	Prevention	**Early Intervention**	
Triple P Level 2/3: Brief Parenting Guidance: 150 children Level 4: Parenting: 100 children Level 5: Enhanced Family Intervention: 50 children	Individuals: Families:	Individuals: 300 children Families:	3 - 4
Pilot Program/Middle School Students	Individuals: Families:	Individuals: 60 students Families:	2 - 3
Training: Trauma/Exposed and Individuals Experiencing Onset of Illness	Individuals: Families:	Individuals: Families: 30 professionals trained	2 - 3
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED	**Individuals:** **Families**:	**Individuals: 390 children/young people** **Families**: 30 professionals trained	

Form 3
County: Shasta
PEI Project Name: Project 2 - Evidence-based Interventions

5. Linkages to County Mental Health and Providers of Other Needed Services

A. Project Linkages

This PEI Project was designed in an inclusive planning process that included county and private providers of health, primary care, and mental health. We believe that these community partner agencies, including schools, probation, health and primary care providers, and community agencies are key partners in the strengthened network of care we are building. As a result, our collaboration with project implementers, and our project utilization of outreach and engagement and other county and contract provider staffs, will require specific and formal referral linkages to assessment and treatment resources when participants believe that more extensive treatment is needed. A clinician position is included in the plan to increase capacity for clinical coordination and access functions. The referral and access mechanisms will include access to primary care providers, private or public mental health service providers, or MHSA programs established under the CSS program.

This PEI Project will include specific and formal referral linkages to the following services. All these agencies have been involved in the PEI community planning process as key informants and stakeholders, and are interested in participating in the development of this strengthened network of care:

- Substance abuse diagnosis and treatment providers
- Domestic violence prevention and intervention
- Social services, including food, income support and protective services
- Employment training and referral
- Housing assistance and emergency support

B. Project Resource Adequacy

At the individual/family level, we know that the interventions we have selected are sufficient to achieve the individual/family outcomes we have selected, based on the research. Triple P provides a tiered multi-level strategy that recognizes that parents have differing needs and desires regarding the type, intensity and mode of assistance they may require. The Triple P system is designed to maximize efficiency, contain costs and ensure the program has wide reach in the community. The program targets five different developmental periods from infancy to adolescence. Within each developmental period the reach of the intervention can vary from being very broad (targeting an entire population) to quite narrow (targeting only high-risk children). We have selected levels of Triple P to target the appropriate target population for each collaborating agency. Triple P has been developed through more than 20 years of clinical and prevention research trials. We will be using evaluation tested by Triple

P to determine that our program is meeting the needs of families enrolled, and providing the tools for family change and growth.

Although we have not made a final selection for the Pilot Program Targeting At-Risk Middle School Students, we have selected two potential programs, Girls Circle/Boys Council and Life Skills Training, that have evidence based documentation and evaluation tools that assure that the programs are administered with fidelity. We will make a final selection based on both evidence and the efficiency and locations most appropriate to our collaborators. Evaluation strategies for the program will be designed after an evidence-based practice is selected.

We have also not made a final determination as to the training programs to use to identify and address Trauma-Exposed Individuals and Individuals Experiencing the Onset of Serious Psychiatric Illness. We intend to identify research-based screening tools and outreach and engagement activities can assist in identifying individuals before or at the onset of serious psychiatric illness. We intend to identify training modules that will assist practitioners in the health, mental health, and community support service world to identify trauma and adapt treatment or service plans to address trauma in the lives of individuals. Evaluation strategies will be identified as implementation plans are developed.

We have sufficient activities/programs to achieve the program/system outcomes we have listed in question 8. Our collaborative activities (outlined in question 7 below) identify the partner and leveraged resources that will assure we can implement the program(s) we have selected with fidelity and that the program(s) will achieve our objectives. These leveraged and collaborative resources include the following:

- Additional funds
- Assigned staff
- Added services to program participants
- Facilitated referrals

For example, our Triple P programs provide training and materials for training individuals that have existing relationships with parents at risk of family disruption or maltreatment, as with families experiencing the differential response services of Shasta Child and Family Services. Our budget does not provide salaries or payment for individuals receiving the training, as these will be provided by our collaborating partners. However, the formal implementation planning with community partners who serve at-risk children will consider barriers to partnering that may be addressed through PEI funds allocated to the Triple P program implementation to the degree resources are available and necessary to service target population children and their families. We will provide Triple P training services in coordination with others in the community who are delivering such training, as with Shasta Head Start. We anticipate that our integration with activities by our range of collaborating partners will provide maximum reach and impact in the system of services to parents and children in Shasta County.

Form 3
County: Shasta
PEI Project Name: Project 2 - Evidence-based Interventions

6. Collaboration and System Enhancements

A. Collaboration

This project will be operated under collaborative agreements with the partner agency/agencies listed under response 3.2 above. Outreach and identification of participants will be coordinated with the same agencies/community groups. Our plan is to support parenting education and support activities in organizations or individual providers that are embedded in local communities, and that bring outreach and engagement relationships to the partnership, as well as continuing support resources for families and children. Collaboration is a very local affair.

Individuals participating in this project will need and want additional services in some cases. Referral protocols have been described above and will assist individuals participating in the project.

Monitoring of outcomes will be done in a community process that includes the MHSA Advisory Committee. This process will allow us to consider future extension of this project or other programs to achieve desirable individual, system and community outcomes.

Our project includes specific and formal collaboration with community-based mental health clinics and services, to assure that services are available to high priority populations, and that referrals for follow-up mental health treatment and services are timely and appropriate

Our project includes services provided in collaboration with Federally Qualified Health Centers and local educational agencies such as the Shasta County Office of Education.

B. System Enhancements

We have built the budget for this PEI project based on collaboration with other entities and funding sources that serve stressed families, or families facing trauma and other difficulties, including economic challenges. We are using our scarce PEI resources to provide training, program support and evaluation services, while our partners are providing the staff and volunteers to receive the training to support families in the course of their on-going service provision. We are coordinating with other entities, including Shasta Head Start, Shasta County Office of Education and Federally Qualified Health Care Centers and other local agencies to assure that our services taken together reach the maximum number of stressed families in diverse geographic and cultural settings in the county.

We anticipate that this project will be an ongoing PEI project, depending on community review at periodic intervals, and assessment of the extent to which this project meets the identified individual, system and community outcomes. Adoption of the specific programs, such as Triple P, will be based on evaluation information and continued discussion with our collaborative partners.

7. Intended Outcomes (Provide any research evidence or local evidence)

A. Triple P – Positive Parenting Program

1) Individual and Family Outcomes: We anticipate that the Triple P Program will result in a decrease in observed and parent-reported child disruptive behavior as well as an increase in the implementation of targeted parenting strategies. 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; promoting the independence and health of families, by enhancing parents' knowledge, skills and confidence; promoting the development of non-violent, protective and nurturing environments for children; promoting the development, growth, health and social competencies of children; reducing the incidence of child abuse, mental illness, behavioral problems, delinquency and related problems; enhancing the competence, resourcefulness and self-sufficiency of parents in raising their children. Research has shown that when Triple P is implemented broadly in a community, there is a reduction of substantiated child maltreatment cases within that community.

2) System Outcomes: By partnering with community providers to provide the less-intensive services of this program, we will accomplish two things. The first is that we will strengthen the Department's relationship with the providers by being seen as a resource to them and their clients. The second goal we will accomplish is to broaden the reach of this program and take advantage of the existing trust between the community providers and the clients of focus for this program.

3) Program Outcomes: We will thoroughly evaluate the success of the Triple P- Positive Parenting program by utilizing the evaluation tools that are part of this evidence-based program. It is yet to be determined whether we will utilize the Health and Human Services Agency's Outcomes, Planning and Evaluation team to evaluate this program or if we will hire an independent consultant to evaluate this program. There is a local evaluator who has been hired to evaluate the Triple P program being implemented through Shasta First 5 and it might be beneficial to utilize one evaluator for all Triple P programs in the community.

4) What Will be Different and How Will We Know: We anticipate that Triple P will result in a reduction of family stress and ultimately family violence and child maltreatment by giving high-risk families strategies to cope with their child's behavioral and emotional

problems that have been proven effective through multiple program evaluations and research studies. Additionally, each family served by this program will experience the outcomes outlined in the section above. While we are still uncertain about whether or not the program will reach enough families to impact the overall county rate of child abuse and neglect, we will develop a system that allows for the evaluation of short term outcomes and success of the families that are reached.

B. Pilot Program for Middle School Students

1) Individual and Family Outcomes: Because we haven't finalized the program that will be implemented with high-risk middle-school aged children, we are not sure what specific outcomes will result. However, because it is a program that will be targeted toward at-risk middle-school aged children, the outcomes will most likely be related to increasing resiliency and improving developmental assets in some way.

2) System and Program Outcomes: Once a pilot program and program site is chosen, an evaluation plan for that program will be developed in concert with the staff from the Outcomes, Planning and Evaluation team of the Health and Human Services Agency. Since an evidence-based program will be selected, the evaluation will include any methods and tools already developed and tested in previous program evaluations as well as fidelity measures deemed critical in previous program evaluations.

3) What will be different and how will we know: As a result of the Pilot Program for Middle-School aged children, we will see an improvement in resiliency and an increase in developmental assets in the children served. We will know through effective program evaluation methods and systematic monitoring of fidelity measures to whatever evidence-based practice that is chosen in collaboration with participating community partners. An example of an evaluation method that might be utilized is the pre and post assessment of program participants along with the appropriate statistical tests on gathered data.

C. Training Options for Treatment of Trauma-Exposed Individuals and Individuals Experiencing the Onset of Serious Psychiatric Illness

1) Individual and Family Outcomes: We anticipate that the Training Options for Treatment of Trauma-Exposed Individuals and Individuals Experiencing the Onset of Serious Psychiatric Illness will result in fewer individuals experiencing severe and persistent mental illness through increased identification of early signs and symptoms and appropriate referral and treatment. It is likely that this first year (through June 2009) the benefits of training might not actually be realized in the community population, but that through thorough research of best practices, program planning and community partner identification, the second year will see substantial benefit to the community.

2) System and Program Outcomes: Measures of success will be developed as part of the evaluation plan once this program is more specifically defined. Methods for measuring the

success for this program might include: evaluating any training that is conducted to assure that the training goals were met to ensure knowledge was increased; doing a pre and post assessment of trained partners to evaluate if their referrals have increased and/or their feeling of competency in identifying the early stages of psychosis or other major mental illness has increased.

3) What will be different and how will we know: We anticipate that Training Options for Treatment of Trauma-Exposed Individuals and Individuals Experiencing the Onset of Serious Psychiatric Illness will result in increased utilization of evidenced based practices by community providers, and decreased psychiatric hospitalizations as measured through annual hospital discharge data by the Outcomes, Planning and Evaluation team of the Health and Human Services Agency.

8. Coordination with Other MHSA Components

A. Coordination with CSS

As indicated above, we anticipate more formal and efficient referrals from collaborating partners to the CSS program, and the entire range of public and private mental health programs in the county. Improved access, including to the CSS programs currently operating, is a primary goal of our stakeholders. Staff from this PEI program will meet regularly with the MHSA staff to coordinate activities and share implementation information. We anticipate that newly strengthened ties to FQHC primary care providers and to school personnel will be central to offering services to individuals identified in this project.

B. Coordination with Workforce Education and Training

Our Workforce Education and Training plan is not yet complete. We will include PEI project needs in our assessment as we develop that plan.

C. Coordination with Capital Facilities and Information Technology

Our Capital Facilities and Technology plan is not yet complete. We will include PEI project needs in our assessment as we develop that plan.

D. Coordination with Innovation

Our Innovation plan is not yet complete. We will include PEI project needs in our assessment as we develop that plan.

Form 3

County: Shasta

PEI Project Name: Project 3 - Adverse Childhood Experience Prevention

1. PEI Key Community Mental Health Needs	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	☐	☐	☐	☐
2. Psycho-Social Impact of Trauma	X	X	X	☐
3. At-Risk Children, Youth and Young Adult Populations	X	X		
4. Stigma and Discrimination	☐	☐	☐	☐
5. Suicide Risk	☐	☐	☐	☐

2. PEI Priority Population(s) **Note: All PEI projects must address underserved racial/ethnic and cultural populations.**	Age Group			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
A. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	X	X	X	☐
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☐	☐		☐
3. Children and Youth in Stressed Families	X	X		
4. Children and Youth at Risk for School Failure	☐	☐		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☐	☐	☐	
6. Underserved Cultural Populations	☐	☐		☐

Form 3
County: Shasta
PEI Project Name: Project 3 - Adverse Childhood Experience Prevention

B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).

1) CSS Plan Identification of Community Needs and Priority Populations

During the county's CSS Planning process we identified the following community need(s) and priority populations that were more appropriate to the PEI process and that are addressed in this PEI Project:

Community Needs:

Shasta County's CSS Planning process identified specific needs of children, youth and young adult populations. The inability to remain in a mainstream school environment, involvement in the justice system, and peer and family problems were identified as key community needs for children and for transition age youth. Access to care, including a full continuum of care once a problem was identified, was cited as a problem. Stigma and discrimination regarding mental illness was identified as a problem, and isolation and a lack of opportunities for social interaction were identified in both Redding and the rural parts of the county. School difficulties are high for some children, and adult transience related to economic challenges create difficulties for children and young people. Cultural issues, including the lack of culturally appropriate services and rural isolation and culture, impede access for some families. Stigma and the lack of peer support resources were cited as difficulties. Girls and young women are especially underserved, along with Hispanic and Native American groups identified as underserved.

Because children and transition age youth were found to be comparatively better served than other age groups, the county's CSS plan focused initially on addressing other identified needs. Despite this focus, the development of a Shasta Mental Health Rural Initiative, including partnerships with FQHCs and extension of an intensive treatment team in the south county area, has improved access for children, young people and families by bringing CSS services to areas that have been significantly underserved. Regardless, our stakeholders and public believe strongly that the PEI component to the Mental Health Services Act must address children and transition age youth, to prevent human suffering and the need for intense, long-term services.

Priority Populations:

As summarized above, our CSS plan identified children and youth in stressed families, children and youth at risk for school failure and children and youth at risk of experiencing juvenile justice involvement as having unmet needs.

2) CSS Implementation Identification of Needs

Our CSS programs and services to date have not specifically identified Prevention and Early Intervention needs. We have instead conducted a Community Mental Health Assessment that reexamined demographic and service data compared to a variety of factors that influence a person's or a community's mental well-being. This Assessment will be discussed in more

detail below. This Assessment included overall data on services by Shasta County Mental Health compared to county residents, and to residents living in poverty. These figures, however, provide only a picture of comparative services by age group and by race; they do not address a lack of access perceived by the community and our stakeholders.

3) Stakeholder Identification of Needs and Priority Populations

Stakeholder input from both the PEI survey and key informant interviews suggested that the community recognizes and prioritizes the negative effects of risk factors linked to Adverse Childhood Experiences. Specifically, the on-line and hard-copy survey ranked Child Abuse and Neglect, and Alcohol and Other Drug Abuse as the top risk factors they would like to see our PEI plan address. Key Informant Interviews ranked Alcohol and Other Drug Abuse and Child Abuse and Neglect as the top two risk factors they would like to see our PEI plan address. Planning and program initiatives in Shasta County related to exposure to violence and substance abuse have identified that trauma from various forms of violence, including child maltreatment and domestic violence are often inter-related with the effects of substance abuse by family members and early exposure of children to alcohol and other drugs. Furthermore, an effective intervention strategy must be multi-sectorial and comprehensively address the challenges of impacted individuals and families or multiple strategies across sectors must be done in concert.

Our PEI Expert Panel, reviewing all elements of the Shasta County PEI Stakeholder Process recommended that at least 51% of the overall PEI budget be spent on children and youth between the ages of 0-25. They further recommended that the 0-5 population be a priority for a portion of PEI efforts. Early childhood is a critical period for the onset of emotional and behavioral impairments. Moreover, young children are increasingly identified with behaviors and social or emotional problems that evidence suggests will effect their development and success.

4) Additional Data Analysis

Shasta County HHSA Mental Health Department, Public Health Department, and Outcomes, Planning and Evaluation Division collaborated on development of the "Mental Health Services Act Prevention and Early Intervention Community Mental Health Assessment." The document provides stakeholders, experts and advisory board members with information on the factors that influence a person's or a community's mental well-being, including research-based data and as much local data as is available on these factors. The report is included in our packet for your information. This effort to pull together existing data recognizes the value of empirical validation of community perception in decision making. It also is an effort to establish baseline data for ongoing evaluation of community characteristics related to desired PEI outcomes.

This assessment includes a section on 'Preventing Mental Disorders (Risk of Mental Disorders)' with a summary of research on the impact of adverse childhood experiences on a range of poor mental health, physical health, substance abuse, and social functioning

outcomes. Child abuse referrals and substantiated cases of child abuse and neglect are used as a proxy for adverse childhood experiences: Shasta County's rate of substantiated child maltreatment, similar to other rural counties, is twice that of California's rate, and affected 950 children in 2006.

Stakeholders and experts understand that mental illness has strong biological and heritability factors. Historically, stigma against family members of persons with mental illness, especially parents, has been pervasive and damaging, including discouraging help-seeking PEI community education will work to dispel myths about mental illness. However, the biology of mental illness, including severity and symptom development, is affected by early life experiences, increasing the frequency of prescriptions for drugs treating mental illness , depressive disorders, suicide attempts, anxiety, hallucinations, panic reactions, sleep and memory disturbances ("Adverse Childhood Experiences and Prescribed Psychotropic Medications in Adults" American Journal of Preventive Medicine 2007).

This project seeks to impact the occurrence of preventable adverse childhood experiences based on research findings indicating that these experiences can be contributing factors in the development of mental illness for some individuals. Additionally, it is recognized that mental illness for some individuals is not preventable. Thus, MHSA activities focused on recovery and mitigating the impacts of mental illness remains vital.

5) Results

As a result of this input and analysis, key community needs and priority population(s) and age groups that would be addressed by PEI Project 3, Adverse Childhood Experience Prevention were selected.

3. PEI Project Description

A. Project meets key community needs, priority populations and desired outcomes:

Our community process, enhanced by data analysis and research information, led to a formulation of a comprehensive Prevention and Early Intervention plan that includes a broad spectrum of prevention and early intervention activities, and that includes a focus on children, especially including children 0-5. As summarized above, stakeholder input from both the PEI survey and key informant interviews indicated that the community would address the negative effects of child abuse/neglect and alcohol and other drug abuse. The research information on adverse childhood experiences demonstrates that such experiences have a strong and graded relationship, or dose effect, on negative health and mental health outcomes, including illicit drug use, smoking, sexual activity, adolescent pregnancies, suicide attempts and use of psychotropic medications in adulthood. Moreover, reduction of adverse childhood experiences also directly addresses our Foundational Concepts, including

specifically decreasing the pervasive effects of alcohol and substance abuse and increasing assets in children and youth.

B. Implementation Partners and Project Settings

The initial steps of the Adverse Childhood Experience project will be to develop a strategic plan for Adverse Childhood Experience (ACE) prevention, in concert with the widest possible collaborative of concerned professionals and agencies and community groups whose activities have an impact on protective and risk factors. This project will provide project management and staff support from the Prevention and Early Intervention component of Shasta County Mental Health, but will draw extensively on the leadership and expertise of other branches of the Shasta County HHSA, the Shasta Children & Families First Commission (First 5 Shasta) and Shasta County Child Abuse Prevention Council, as well. Through broad-based community involvement including individuals who participate in mental health services and family members, this project will seek to inform future PEI plan development, as well as activities and resources in other sectors of the community in a coordinated manner. Until the structure of the planning process is developed, specific settings for implementation are not identified.

C. Community Demographics

This project will prepare a strategic plan to address the entire community, including ethnic, cultural, geographic, sexual orientation and socio-economically diverse communities and implementation partners.

D. Program Highlights

The goals of the ACE project are to:

- Develop, via strategic planning, a systematic, multi-sectorial collaborative approach to documenting and decreasing ACE in Shasta County
- Collaborate with community partners to implement hands-on community based strategies and to evaluate PEI evidence-based strategies and programs to decrease ACE in Shasta County.

Adverse Childhood Events as defined in the research include the following:

- Abuse
  - Emotional – recurrent humiliation
  - Physical – beating, not spanking
  - Contact sexual abuse
- Household dysfunction
  - Mother treated violently
  - House member was alcoholic or drug user

Household member was imprisoned
Household member was chronically depressed, suicidal, mentally ill, in psychiatric hospital
Not raised by both biological parents

- Neglect
  Physical
  Emotional

Project Activities:

The structure of this project will be partially driven by recommendations from The World Health Organization and International Society for Prevention of Child Abuse and Neglect's guidebook called "Preventing Child Maltreatment: a guide to taking action and generating evidence." The elements included in this approach include:

- **Gathering Information**: Information that can be used to direct and monitor preventive action and service provisions. For example local surveys of children and adults can be obtained to assess the impact of exposure to adverse factors, on their health-risk behaviors and on their current health status. This information can be used as a leveraging tool to secure grant funding for community projects.
- **Promoting the Prevention of ACE**: Prevention efforts in the community can be coordinated to avoid duplication of services, decrease gaps in prevention activities, identify deficiencies in resources, increase effectiveness of current funding, etc. Prevention efforts could be designed through strategic planning activities with a broad base of community and agency representation, evidence of effective interventions, and be set up to meet the criteria for outcome evaluations.
- **Provide Evaluation of Intervention Strategies:** Large amounts of human and financial resources are currently invested in this area. There is a need for interventions that are evaluated for outcome measures to see whether or not they achieve their intended effects. Many service protocols are based only on intuition, anecdotal information or political considerations; without taking into account scientific evidence, services may be not only ineffective, but possibly even harmful.

Form 3
County: Shasta
PEI Project Name: Project 3 - Adverse Childhood Experience Prevention

E. Project Implementation, including milestones and timelines

Activity	Milestone	Timeline
Identify lead staff	Staff identified	November 08
Involve concerned professionals from a wide range of different sectors who have experience in dealing with relevant ACE protective and risk factors. 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.	Collaborative established	January 09
Prepare a report on the current state of epidemiological knowledge on ACE in the county and the efforts across the sectors to prevent it.	Report released	March 09
Develop a strategic plan among participating entities to promote protective factors and mitigate the risk factors.	Plan released	May 09
Draw up a document outlining the community strategy on ACE prevention, including a plan of action containing specific objectives, actions and indicators.	Implementation strategy released	June 09

Planning and collaboration activities have begun and will continue as a part of our Prevention and Early Intervention Planning activities, using Planning funds.

4. Project

No individuals or families will be served through June 2009; this is a strategic planning project and will not result in service, but will be completed with individuals and family members' participation.

Form 3
County: Shasta
PEI Project Name: Project 3 - Adverse Childhood Experience Prevention

5. Linkages to County Mental Health and Providers of Other Needed Services

A. Project Linkages

This project is a data gathering and strategic planning project. The project will utilize a panel of concerned professionals from a wide range of field and sectors who have experience dealing with adverse childhood experience protective and risk factors, including agencies and community groups and consumers and family members whose activities and experiences can help identify protective and risk factors and develop evidence-based strategies to reduce the risk factors and increase the protective factors in our community. Direct service is not anticipated through June 2009. Thus, formal referral linkages to assessment and treatment resources are not anticipated.

B. Project Resource Adequacy

This project is based on recommendations from The World health Organization and International Society for Prevention of Child Abuse and Neglect. The elements recommended by these entities include gathering information, promoting the prevention of adverse childhood experiences and providing evaluation of intervention strategies. Furthermore, we are basing this project on parallel work done by our Public Health Department and the Shasta Children and Families First Commission (Shasta First 5) to begin the process of community-wide assessment of the problem and development of strategies that have a proven track record of addressing those problems effectively. We have interest and commitment from a range of community professionals and providers to participate in this strategic plan. We believe that we can be successful in the development of a consensus-based plan of action with specific objectives, actions and indicators.

6. Collaboration and System Enhancements

As we have described above, this project will begin with a collaborative including concerned professionals from a range of different sectors and fields, including agencies and community groups involved in the well-being of children. Health and Human Services Agency will provide the framework for leadership, including leadership and staff support from Mental Health, Social Services, Public Health and Support Services departments. Preliminary meetings of this group have formed an ACE County Leadership Team using funds from Public Health. In addition,

First 5 Shasta and the Child Abuse Prevention Council have participated in preliminary activities.

As indicated, we anticipate leadership and technical assistance from current partners in the ACE County Leadership Team. The Leadership Team has been selected to participate in a National Child Maltreatment Institute partially funded by the Institute and limited PEI resources that will provide technical assistance for this project.

Because this project is a strategic planning activity, we do not have specifics about whether, and how, it will be sustained. A primary outcome of this project is a plan of action that will include specific objectives, actions and indicators. This action plan will be community wide, and will explore how existing activities, programs and community resources can be strengthened or built upon to assure that evidence based effective activities are available to children and their families. We anticipate that by June 2009 we will be able to provide the MHSA Advisory Committee and Mental Health Board with specific recommendations about how these community resources, including future PEI resources, can be used most effectively.

7. Intended Outcomes

A. Individual, Family and Program Outcomes

Until a strategic planning process and development of an action plan have been completed, specific individual and family outcomes and means to measure them are not available. However, our community input, findings in the research literature and our local experience suggest that the issues that have most significance in prevention and early intervention in negative outcomes for children are:

- Decreasing exposure to violence
- Decreasing consequences of substance abuse, including early onset of substance abuse
- Increasing early identification of difficulty in social, emotional and behavioral development or functioning
- Increasing access to adequate services

We anticipate that these issues will be an initial focus of planning and data development, and that the reduction of exposure to violence and the consequences of substance abuse, coupled with early identification of problems and access to services will be outcomes that rank high in our planning process. We also will work closely with the Community Education and Awareness Program to assure that our activities support families and do not contribute to stigmatization of families or individuals struggling with mental illness. We will have the support of the Health and Human Services Agency's Outcomes, Planning and Evaluation unit in developing objectives and measurement strategies for this plan.

B. System Outcomes

We anticipate that this project will result in development of a regular report format on ACE in the county and efforts across several sectors to prevent it. We anticipate development of an engaged and diverse collaborative of community members addressing ACE, and a strategic plan that includes a locally-based, hands-on community strategy and plan of action to address the reduction of adverse childhood experiences.

Over a longer time horizon we expect this project to identify where the community is currently spending funds on conditions and activities that result in adverse childhood experiences, where funds are utilized to duplicate efforts, where there are gaps in community efforts, and where research suggests funds, activities and other resources can best be directed to affect the growth and development of young children.

This project will use specific process measures to assure that funds are appropriately used:

- Shasta County ACE Report, including ACE incidence in the priority populations identified in this plan
- Meeting Log, including minutes, agendas and participant sign in sheets
- Strategic Plan
- Final Shasta County ACE Prevention information, strategic plan, and action objectives

C. What Will Be Different and How Will We Know?

At the end of the initial phase of this project, we will know more about the incidence of adverse childhood experiences for young children in diverse parts of the county, from ethnic and cultural groups, from families of various socioeconomic sectors. We will know more about funds and resources currently being spent on the reduction of ACE in the county. And we will have developed a specific action plan, based on research and experience, to address those issues most likely to result in a reduction of ACE.

8. Coordination with Other MHSA Components

A. Coordination with Community Services and Supports

The collaborative effort of the Shasta County ACE Leadership Team will include data, information and policy participation from the Community Services and Supports program, as well as the entire county mental health system. We anticipate that in the future, ACE efforts will have direct and measurable effects on children and families that otherwise might be a part of the mental health system.

B. Coordination with Workforce Education and Training

Our Workforce Education and Training plan is not yet complete. We will include PEI project needs in our assessment as we develop that plan.

C. Capital Facilities and Information Technology

Our Capital Facilities and Technology plan is not yet complete. We will include PEI project needs in our assessment as we develop that plan.

D. Innovation

Our Innovation plan is not yet complete. We will include PEI project needs in our assessment as we develop that plan.

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: Date: 8/18/08

PEI Project Name: Community Education and Awareness

Provider Name (if known):

Intended Provider Category: County Agency

Proposed Total Number of Individuals to be served:	FY 07-08	0	FY 08-09	150
Total Number of Individuals currently being served:	FY 07-08	0	FY 08-09	0
Total Number of Individuals to be served through PEI Expansion:	FY 07-08	0	FY 08-09	150
Months of Operation:	FY 07-08	0	FY 08-09	12

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 07-08	FY 08-09	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages	$0	$0	$0
Community Education Specialist (1.5 FTE	$0	$71,690	$71,690
Social Worker (.25 FTE)	$0	$9,892	$9,892
HHSA Program Manager (.05 FTE)	$0	$3,660	$3,660
Senior Staff Analyst (.05 FTE)	$0	$2,306	$2,306
Agency Staff Services Analyst (.15 FTE)	$0	$6,208	$6,208
Typist Clerk II (.25 FTE)	$0	$6,103	$6,103
b. Benefits and Taxes @ %	$0	$51,928	$51,928
c. Total Personnel Expenditures	$0	$151,787	$151,787
2. Operating Expenditures			
a. Facility Cost	$0	$5,625	$5,625
b. Other Operating Expenses	$0	$82,061	$82,061
c. Total Operating Expenses	$0	$87,686	$87,686
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Advertising/Material Development	$0	$150,000	$150,000
	$0	$0	$0
	$0	$0	$0
a. Total Subcontracts	$0	$150,000	$150,000
4. Total Proposed PEI Project Budget	$0	$389,473	$389,473
B. Revenues (list/itemize by fund source)			0
	$0	$0	$0
	$0	$0	$0
1. Total Revenue	$0	$0	$0
5. Total Funding Requested for PEI Project	$0	$389,473	$389,473
6. Total In-Kind Contributions	$0	$0	$0

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: Date: 8/18/08

PEI Project Name: Evidence-based Interventions

Provider Name (if known):

Intended Provider Category: County Agency

Proposed Total Number of Individuals to be served:	FY 07-08	0	FY 08-09	390
Total Number of Individuals currently being served:	FY 07-08	0	FY 08-09	0
Total Number of Individuals to be served through PEI Expansion:	FY 07-08	0	FY 08-09	390
Months of Operation:	FY 07-08	0	FY 08-09	12

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 07-08	FY 08-09	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages	$0	$0	$0
Community Education Specialist (.75 FTE	$0	$41,761	$41,761
Clinician I/II (1.0 FTE)	$0	$55,958	$55,958
Community Health Advocate (1.0 FTE)	$0	$29,957	$29,957
HHSA Program Manager (.1 FTE)	$0	$7,321	$7,321
Senior Staff Analyst (.1 FTE)	$0	$4,612	$4,612
Agency Staff Services Analyst (.4 FTE)	$0	$16,554	$16,554
Typist Clerk II (.25 FTE)	$0	$6,102	$6,102
b. Benefits and Taxes @ %	$0	$83,808	$83,808
c. Total Personnel Expenditures	$0	$246,073	$246,073
2. Operating Expenditures			
a. Facility Cost	$0	$9,000	$9,000
b. Other Operating Expenses	$0	$145,420	$145,420
c. Total Operating Expenses	$0	$154,420	$154,420
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Triple P Trainings	$0	$210,000	$210,000
Life Skills or Girls Circle/Boys Council	$0	$30,000	$30,000
Triple P Provider EPSDT Match	$0	$100,000	$100,000
a. Total Subcontracts	$0	$340,000	$340,000
4. Total Proposed PEI Project Budget	$0	$740,493	$740,493
B. Revenues (list/itemize by fund source)			0
	$0	$0	$0
	$0	$0	$0
1. Total Revenue	$0	$0	$0
5. Total Funding Requested for PEI Project	$0	$740,493	$740,493
6. Total In-Kind Contributions	$0	$0	$0

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: Date: 8/18/08

PEI Project Name: Adverse Childhood Experiences Prevention

Provider Name (if known):

Intended Provider Category: County Agency

Proposed Total Number of Individuals to be served:	FY 07-08	0	FY 08-09	0
Total Number of Individuals currently being served:	FY 07-08	0	FY 08-09	0
Total Number of Individuals to be served through PEI Expansion:	FY 07-08	0	FY 08-09	0
Months of Operation:	FY 07-08	0	FY 08-09	12

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 07-08	FY 08-09	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages	$0	$0	$0
Community Education Specialist (.25 FTE	$0	$13,920	$13,920
Clinical Division Chief (.1 FTE)	$0	$9,163	$9,163
HHSA Program Manager (.02 FTE)	$0	$1,464	$1,464
Senior Staff Analyst (.02 FTE)	$0	$922	$922
Agency Staff Services Analyst (.14 FTE)	$0	$5,794	$5,794
Typist Clerk II (.25 FTE)	$0	$6,102	$6,102
b. Benefits and Taxes @ %	$0	$19,248	$19,248
c. Total Personnel Expenditures	$0	$56,613	$56,613
2. Operating Expenditures			
a. Facility Cost	$0	$1,950	$1,950
b. Other Operating Expenses	$0	$20,031	$20,031
c. Total Operating Expenses	$0	$21,981	$21,981
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Consultant for Collaborative	$0	$10,000	$10,000
	$0		$0
	$0		$0
a. Total Subcontracts	$0	$10,000	$10,000
4. Total Proposed PEI Project Budget	$0	$88,594	$88,594
B. Revenues (list/itemize by fund source)			0
	$0	$0	$0
	$0	$0	$0
1. Total Revenue	$0	$0	$0
5. Total Funding Requested for PEI Project	$0	$88,594	$88,594
6. Total In-Kind Contributions	$0	$0	$0

Enclosure 3B

PEI Administration Budget Worksheet

Form No. 5

County: Shasta Date: 08/18/2008

	Client and Family Member, FTEs	Total FTEs	Budgeted Expenditure FY 2007-08	Budgeted Expenditure FY 2008-09	Total
A. Expenditures					
1. Personnel Expenditures					
a. PEI Coordinator		1		$73,551	$73,551
b. PEI Support Staff		0.25		$6,102	$6,102
c. Other Personnel (list all classifications)					$0
Agency Staff Services Analyst		0.06		$2,483	$2,483
Clinical Division Chief		0.15		$13,744	$13,744
					$0
					$0
d. Employee Benefits				$47,940	$47,940
e. Total Personnel Expenditures			$0	$143,820	$143,820
2. Operating Expenditures					
a. Facility Costs				$3,650	$3,650
b. Other Operating Expenditures				$16,417	$16,417
c. Total Operating Expenditures			$0	$20,067	$20,067
3.County Allocated Administration					
a. Total County Administration Cost			$0	$51,153	$51,153
4. Total PEI Funding Request for County Administration Budget			$0	$215,040	$215,040
B. Revenue					
1 Total Revenue			$0	$0	$0
C. Total Funding Requirements			$0	$215,040	$215,040
D. Total In-Kind Contributions			$0	$0	$0

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:	08/18/2008

		Fiscal Year			Funds Requested by Age Group			
#	List each PEI Project	**FY 07/08**	**FY 08/09**	**Total**	*Children, Youth, and their Families	*Transition Age Youth	Adult	Older Adult
1	Community Education & Awareness	$0	$389,473	$389,473	$149,775	$112,331	$74,887	$52,480
2	Prevention and Early Intervention		$740,493	$740,493	$636,104	$69,259	$17,565	$17,565
3	Adverse Childhood Experiences Prevention		$88,594	$88,594	$88,594			
				$0				
				$0				
				$0				
				$0				
				$0				
				$0				
	Administration		$215,040	$215,040	$154,319	$32,045	$16,315	$12,361
	Total PEI Funds Requested:	$0	$1,433,600	$1,433,600	$1,028,792	$213,635	$108,767	$82,406

***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).**

County: Shasta

☐ Check this box if this is a "very small county" (see glossary for definition) and the county is electing the option to waive the requirement to conduct a local evaluation of a PEI project. Very small counties electing this option do not need to complete the remainder of this form.

PEI Project Name:

1. a. Identify the programs (from Form No. 3 PEI Project Summary), the county will evaluate and report on to the State.

The county will evaluate Project 3: Prevention and Early Intervention Programs, which will include the following evidence-based programs; Triple P (Positive Parenting Program); an evidence based program to reduce engagement in high-risk behaviors among at-risk middle school students by promoting a sense of belonging and improving skills to enhance daily functioning; activities to develop programs and provide training that will increase early intervention resources for trauma-exposed individuals and activities to promote early identification of individuals experiencing the onset of serious psychiatric illness.

1. b. Explain how this PEI project and its programs were selected for local evaluation.

The major reason this project was selected for evaluation was the amount of resources that would be invested and the desire to make sure that the intended outcomes are being achieved. Triple P was recommended by the expert panel because the outcomes it has produced meet the needs of the community planning recommendation. The target population and need of at-risk middle school students was selected based on information gathered through a needs assessment, while the expert panel identified multiple possible evidence-based practices that could be applied locally. Additionally, local evaluation of Triple P and the other evidence-based programs that are selected must demonstrate the fidelity of models and produce proven effective programs at the local level.

2. What are the expected person/family-level and program/system-level outcomes for each program?

Triple P: The person/family – level outcomes for Triple P in Shasta County are; a decrease in observed and parent-reported child disruptive behavior; an increase in the implementation of targeted parenting strategies. This program aims to enhance the competence, resourcefulness and self-sufficiency of parents in raising their children. Previous evaluations have shown that when Triple P is implemented broadly in the community there is a reduction of substantiated child maltreatment cases within that community.

The evidence-based program chosen to target at-risk middle school students will be targeting the person-level outcomes of increased resiliency and developmental assets that will result in decreased engagement in high-risk behaviors.

The anticipated programs/system-level outcomes of building capacity among community providers to deliver early intervention services and improved relationships with these community providers will be subjectively evaluated. These outcomes will result from the above-identified programs, the activities related to early intervention with trauma exposed individuals, and identification of individuals experiencing the onset of serious psychiatric illness.

3. The following count includes 300 children being served by Triple P and an additional 60 children served by the pilot program targeting at-risk middle school students. Assuming one child and a two parent household, Triple P could actually reach as many as 900 individuals; this number grows with the number of children in each family. The numbers per ethnic group was determined proportionately to the population base in Shasta County in 2007. It is estimated that an additional 60 middle school students will be served by the other program.

PERSONS TO RECEIVE INTERVENTION

POPULATION DEMOGRAPHICS	PRIORITY POPULATIONS						
	TRAUMA	FIRST ONSET	CHILD/YOUTH STRESSED FAMILIES	CHILD/YOUTH SCHOOL FAILURE	CHILD/YOUTH JUV. JUSTICE	SUICIDE PREVENTION	STIGMA/ DISCRIMINATION
ETHNICITY/ CULTURE							
African American			3				
Asian Pacific Islander			11				
Latino			34				
Native American			11				
Caucasian			282				
Other (Indicate if possible)							
AGE GROUPS							
Children & Youth (0-17)			300				
Transition Age Youth (16-25)							
Adult (18-59)							
Older Adult (>60)							
TOTAL							

Total PEI project estimated ***unduplicated*** count of individuals to be served: **300 – 900 (see description above)**

** Please note that these numbers do not include the Training Options for Trauma-Exposed Individuals and Individual Experiencing the Onset of Serious Psychiatric Illness. This is a program to train professionals and we don't anticipate tracking the number of clients they serve or that will benefit from the training.

4. How will achievement of the outcomes and objectives be measured? What outcome measurements will be used and when will they be measured?

   Most Evidence-Based programs have evaluation tools already developed. This is the case for Triple P and will most likely be the case for the other evidence-based programs that are selected for at-risk middle school aged students.

   Triple P: The evaluation plan has not been finalized and will be based on information received from Triple P experts and review the evaluation tools available. However, we do know that there will be pre- and post-evaluations done on individual clients (which could include ratings by parents regarding child functioning, parenting, and satisfaction) receiving the intervention and the evaluation will be appropriate for the level of intervention received. It is possible that the Shasta County Mental Health Department will develop an RFP to hire an outside evaluator for the Prevention and Early Intervention projects as a whole or specifically for the evaluation of Triple P. As part of the Heal and Human Services Agency, Shasta County Mental Health Department has access to a unit of Epidemiologists and data analysts that are trained and experienced at program evaluation who may also be tasked with developing the evaluation plan as well as training and overseeing the implementation of the evaluation. The anticipated difficulties with the evaluation of this program will be the consistent implementation of evaluation tools and the collection of evaluation information across participating providers. Since the Shasta County Mental Health Department plans on offering the training to a number of community providers, it might be difficult to manage the information collection process and maintain quality data.

   Pilot Program Targeting At-Risk Middle School Students: As mentioned above, it is likely that any evidence-based practice will include developed and tested evaluation tools that can be utilized in our local evaluation. If the program is intended to increase developmental assets, the evaluation question could read: did the students participating in the intervention experience an increase in resiliency. This could be measured through a pre and post assessment among intervention students and compare it to data already collected on 7th, 9th and 11th grade students in all of Shasta County.

   Interventions for Trauma Exposed Individuals: training activity date and attendance will be tracked.

   Early Identification of On-set of Serious Psychiatric Illness: truancy dates and attendance.

5. How will data be collected and analyzed?

   The evaluation plan is under development and will include sufficient detail to describe what data needs to be collected, how it should be collected, training methods on proper data collection techniques and a data analysis plan. The team tasked with the program evaluation, either the Health and Human Services evaluation team or an outside Evaluator will be responsible for including this level of detail. For Triple P, it will be the community providers that will need to collect individual-level information on their clients and share it with the county so that the information can be sufficiently analyzed on a program level.

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

   The collaborative approach to program implementation will partner with agencies and providers in the community who are experts at delivering services and working with diverse groups within their communities. Cultural competency will be ensured in our evidence-based program delivery through the use of materials in non-English languages and use of personnel who speak languages of ethnic communities as appropriate for Shasta County demographics. Any evaluation done will be sure to call upon the developers of the intervention and their expertise with evaluating the diverse populations that have previously been served.

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

   Most evidence-based programs come with fidelity measures that are critical to uphold in order to ensure successful outcome achievement. The evaluator will work with the project coordinator to develop systems to track adherence to all identified fidelity measures. These fidelity measures will be listed individually in the evaluation plan along with systems and activities to monitor them. A plan to adhere to them will be built into the program implementation plan.

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

   As part of the evaluation plan that will be developed in parallel with the program implementation plan, regularly scheduled evaluation reports will be written. The evaluator and the project coordinator will agree upon critical components for each evaluation report and who the audience will be for each. As the Prevention and Early Intervention planning process involved such a large number of community stakeholders, it will be important to communicate to the public about how effective the program is at achieving its intended outcomes. Evaluation and progress reports will be given on a regular basis to Mental Health Administrators, the Shasta County Mental Health Board and the Mental Health Services Act Advisory Committee. Additionally, when appropriate, findings will be released to the public through the Health and Human Services Agency's Community Relations unit.

Attachment A

PEI Planning Process Documents

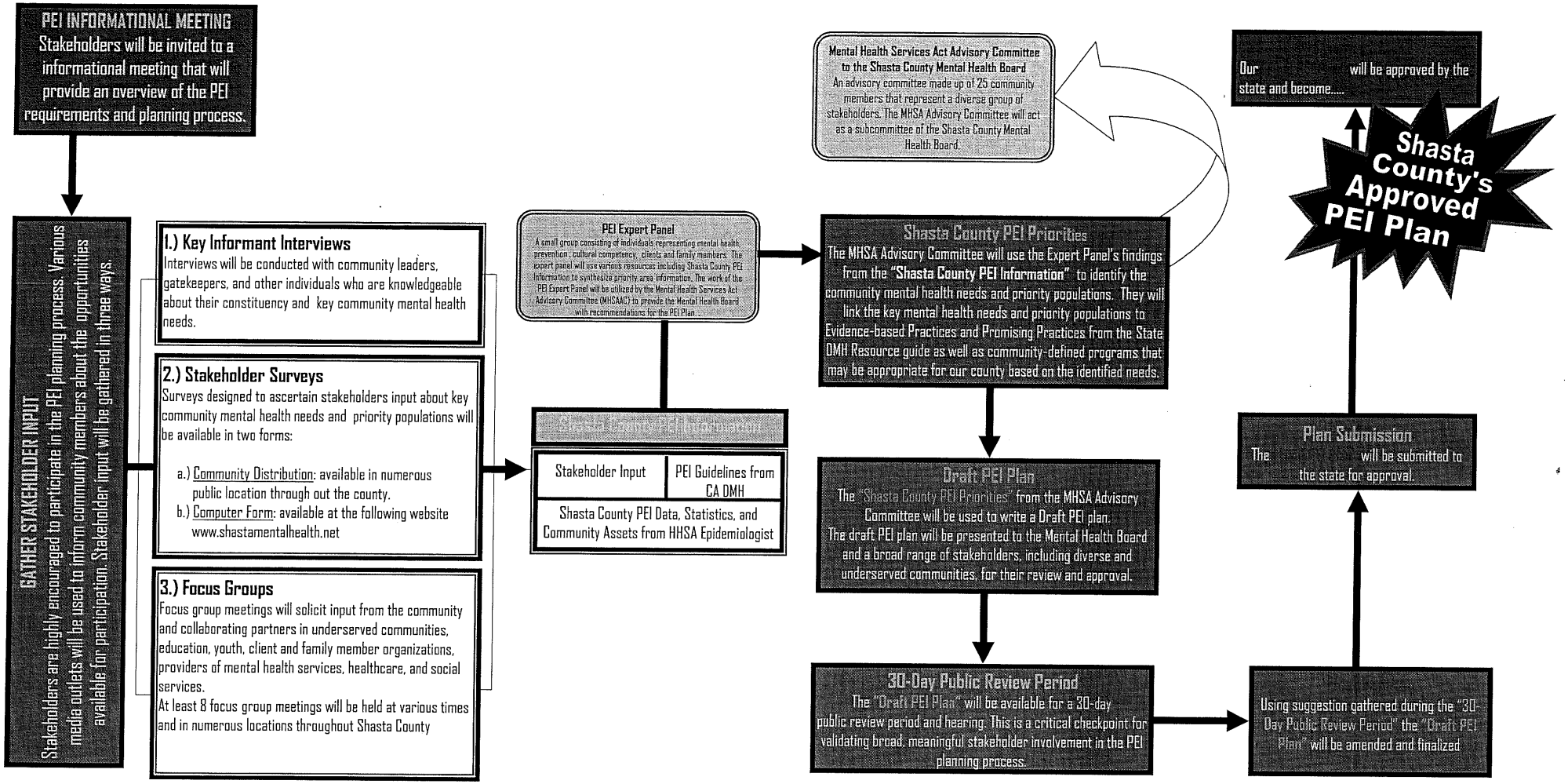
Shasta County PEI Plan
Attachment A Table of Contents

Shasta County PEI Plan
Attachment A Table of Contents

General PEI Documents

Planning Flowcharts
Informational Brochure
Shasta County Mental Health MHSA PEI Community Mental Health Assessment

Prevention and Early Intervention Planning Flowchart 2008



Prevention Early Intervention

P E I

Complete a survey for a chance to win a $25 gift card to Safeway!

P

Help us improve mental health in YOUR community.

There are 2 Easy Ways to Participate...

L

A

I

Yes YOU can participate!

1. Fill out a survey

2. Attend a focus group

Share your concerns, opinions and recommendations.

Why should I help?

Shasta County Mental Health is currently in the planning stage for a new Mental Health Services Act phase called Prevention and Early Intervention (PEI). Community participation is an important part of the planning process.

The focus on prevention and early intervention for mental health problems represents a major and exciting direction for mental health activities in Shasta County, adding to the traditional focus on treatment.

How can I help?

The Mental Health Services Act Oversight and Accountability Commission and the State Department of Mental Health have targeted five key community health needs and six priority populations for the PEI plan.

Based on these guidelines, community members will help Shasta County Mental Health decide how the county's PEI money should be used. You can do this by attending a PEI focus group or filling out a survey.

PEI SURVEY

Fill out a survey on key community mental health needs and priority populations and enter a drawing for a chance to win a $25 gift card to Safeway. To fill out a survey online or to find a survey near you go to

www.shastamentalhealth.net

ONLINE RESOURCES

Want to know more about PEI? Check out the following websites.

www.dmh.ca.gov

Click on "MHSA (Prop 63)" and then "Prevention and Early Intervention." You can also read about the Mental Health Services Oversight and Accountability Commission by clicking on "Commission (MHSOAC)."

www.shastamentalhealth.net

Click on "Mental Health Services Act" and then "Prevention and Early Intervention."

To track the progress of the PEI plan, we encourage you to visit our website at www.shastamentalhealth.net.

Let's Talk!

PEI FOCUS GROUPS

What is a PEI focus group?

A group of people that meet to discuss the mental health needs of our community in order to learn about each person's concerns, opinions, and recommendations for mental health prevention and early intervention strategies.

Who should attend?

Anyone interested in the community's health!

How can I participate?

Several meetings will be held throughout Shasta County. Pick one that works for you. No need to register or RSVP, just show up and be ready to share your ideas!

What if I need special accommodations?

For transportation, interpreter and other accommodations contact Joy Garcia at 225-5985.

For more information:

Visit us at www.shastamentalhealth.net or call 225-5985.

PEI FOCUS GROUP SCHEDULE

Shingletown

March 3, 2008
11:30 am - 1:30 pm
To Be Announced

Redding

March 4, 2008
7:00 pm - 9:00 pm
Northern Valley Catholic Social Services

Shasta Lake City

March 6, 2008
6:00 pm - 8:00 pm
John Beaudet Community Center

Anderson

March 11, 2008
6:00 pm - 8:00 pm
Anderson Public Library

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Shasta County Mental Health
Prevention and Early Intervention
2640 Breslauer Way
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Created on 2/22/08

Help us plan to INCREASE MENTAL HEALTH SUPPORTS in your community!

P E I

Prevention and Early Intervention

Shasta County Mental Health

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.

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CONTENTS

CONTENTS – cont'd

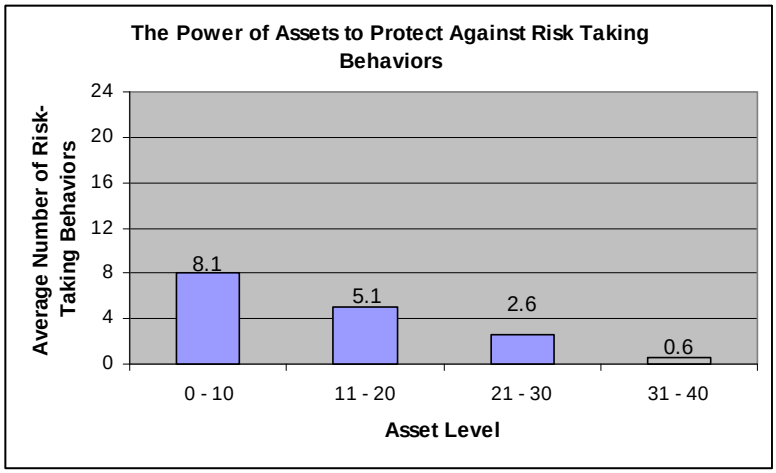
CONTENTS – cont'd

Community Mental Health Assessment

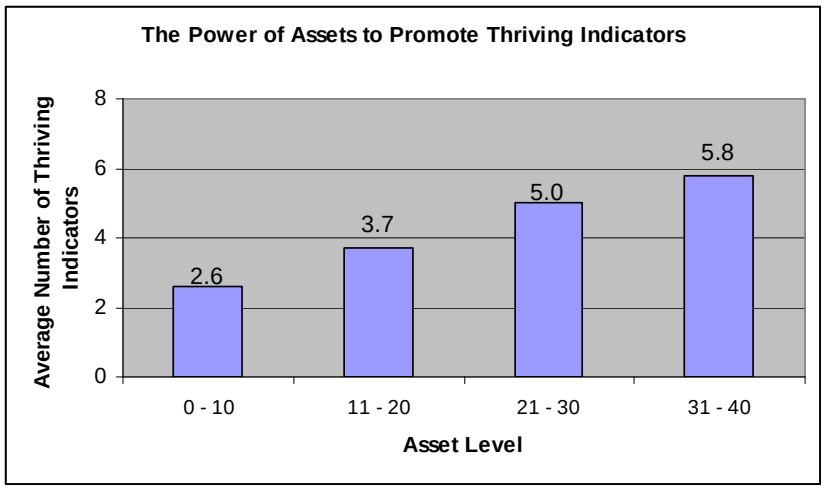
Promoting Community Mental Well-Being (Protective Factors of Mental Well-Being)

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.

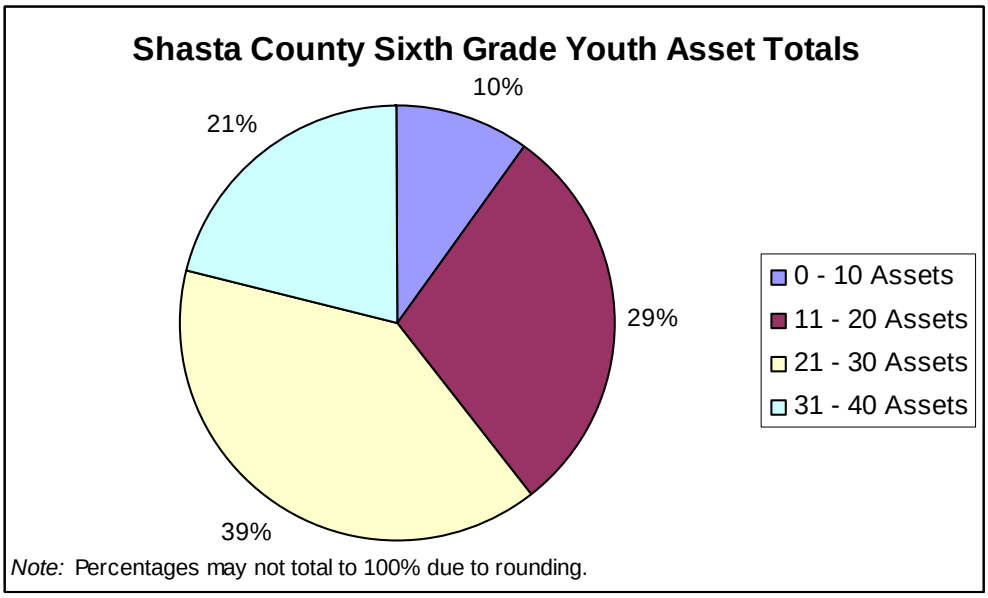
(Source: Search Institute, http://www.search-institute.org/)

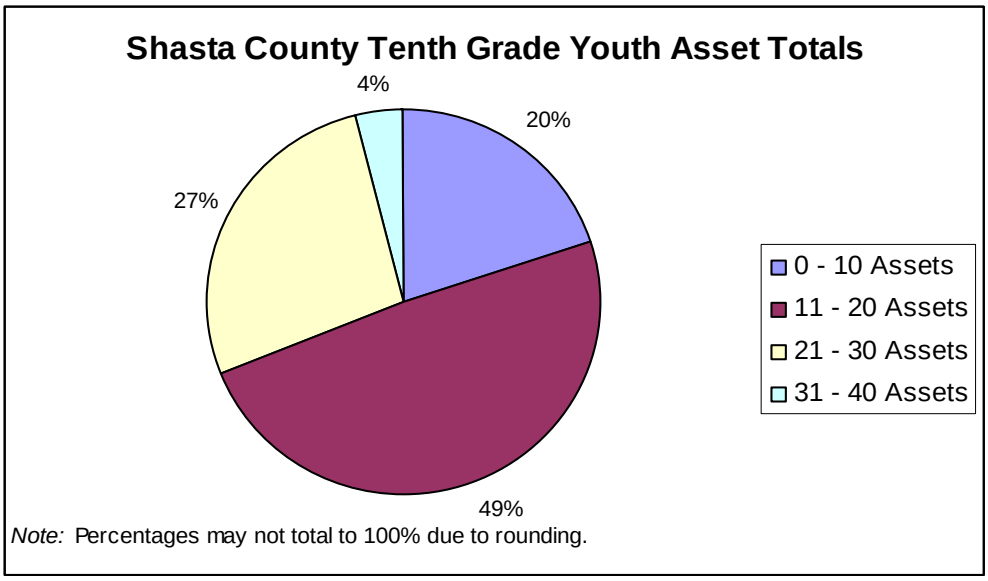
Community Mental Health Assessment

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:

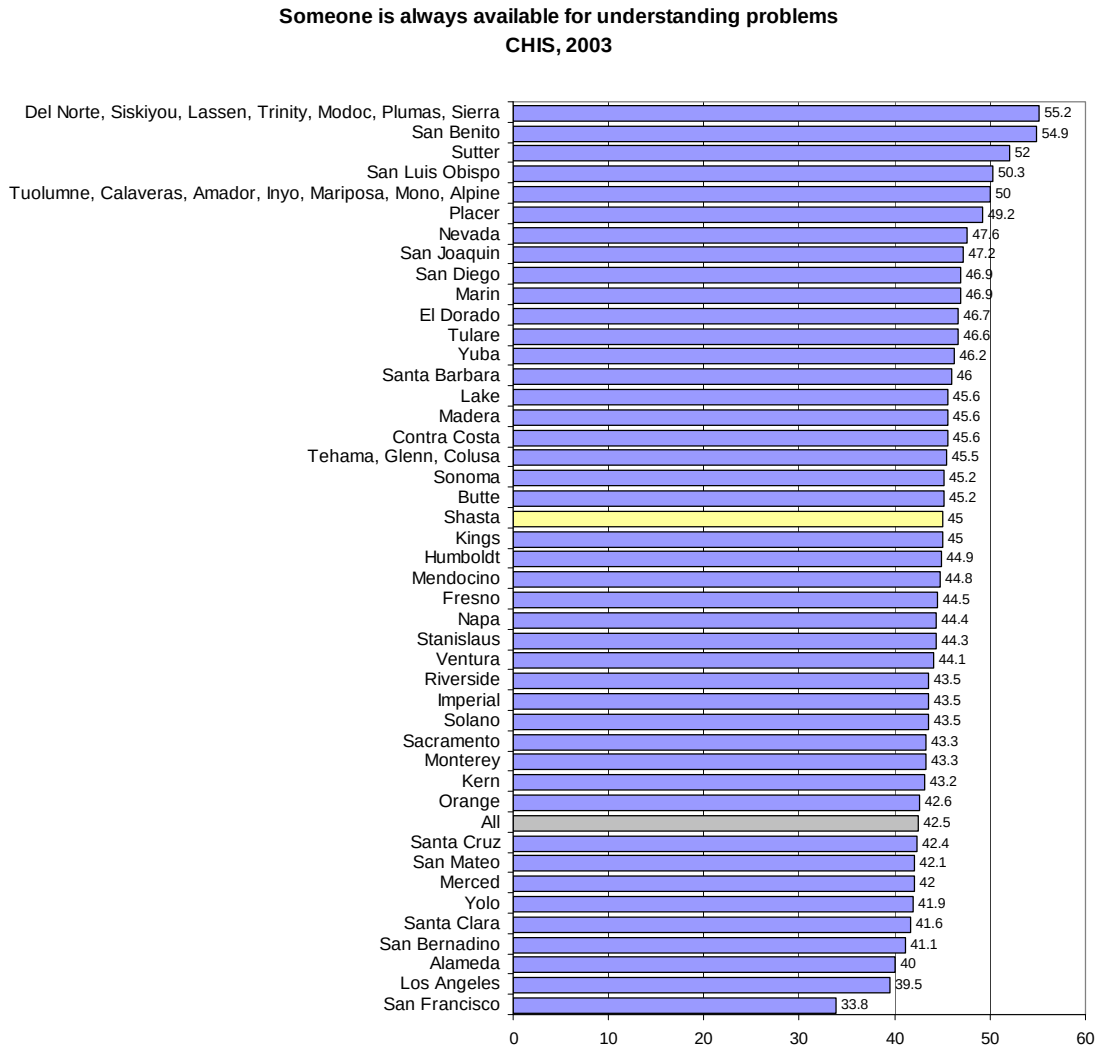
- High perceived support from family, friends, and other adults offset poor mental health in 7th-12th graders.
- Low-income pregnant women with higher quality support experienced less postpartum depression.
- Mental health was positively associated with social support among university students.
- Social 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)



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.

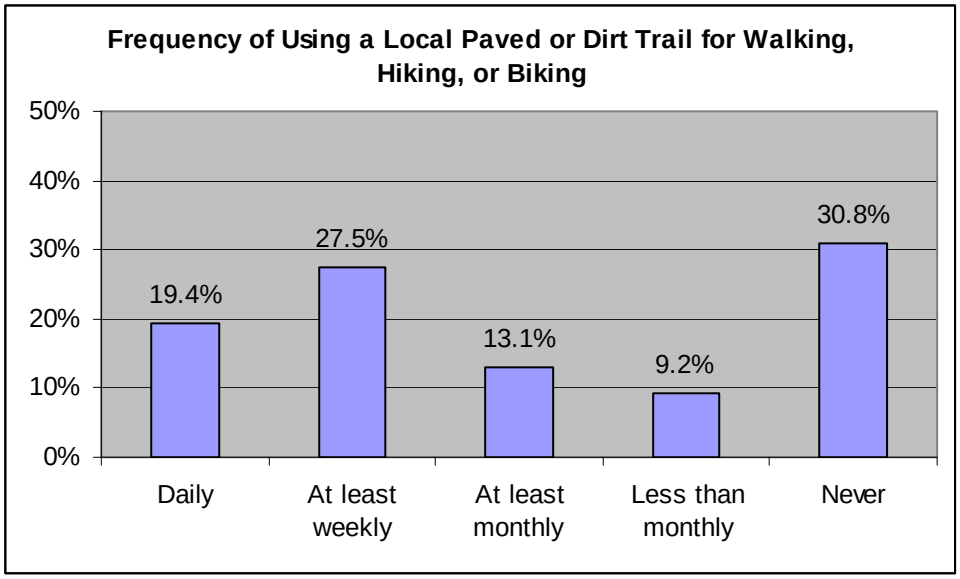
- **According to a 2005, statewide telephone survey, significantly less Shasta County children (17.5%) reported walking, biking or skating to or from school in the past week than all children in California (29.3%).**
  (Source: 2005 California Health Interview Survey)

- **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)

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.

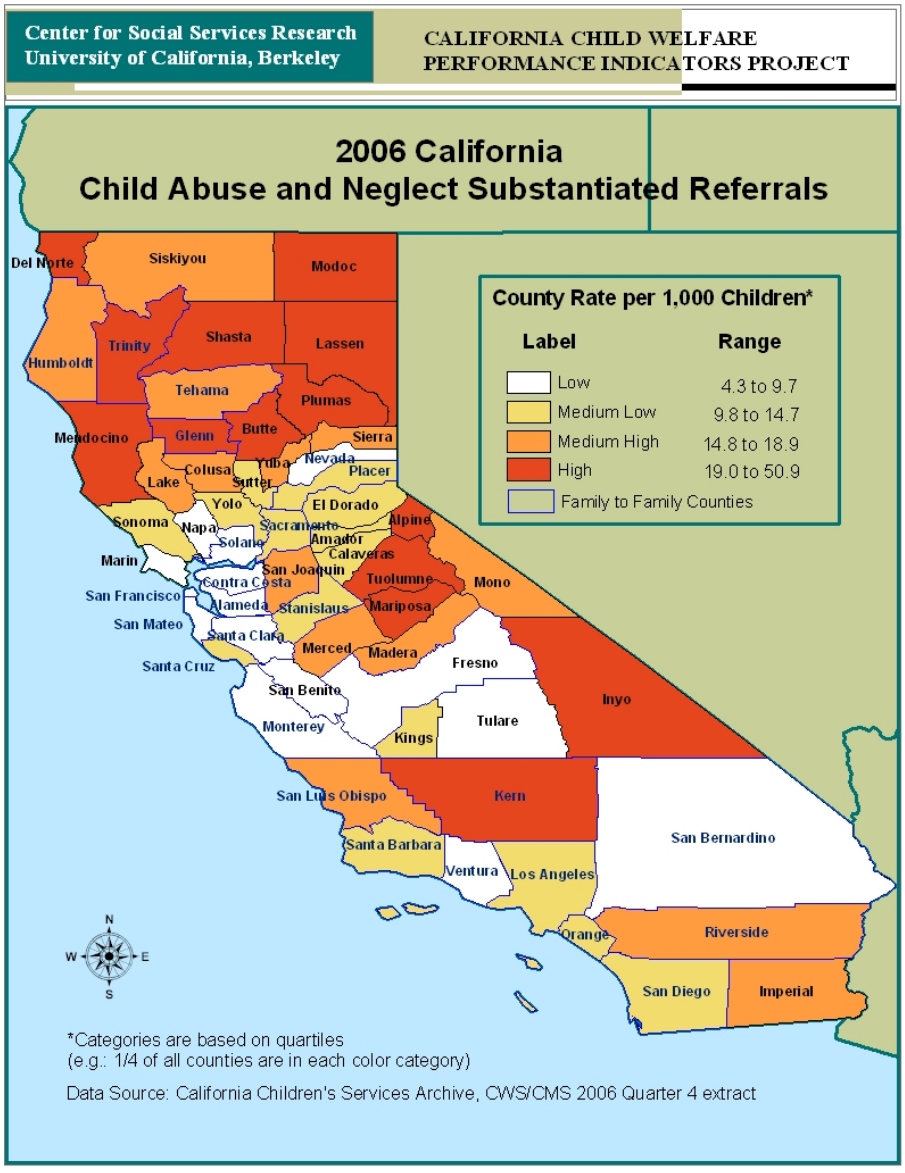
For more information on the origins of the research behind adverse childhood events and their correlation with poor outcomes later in life, go to www.acestudy.org

- ***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.***

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)

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.

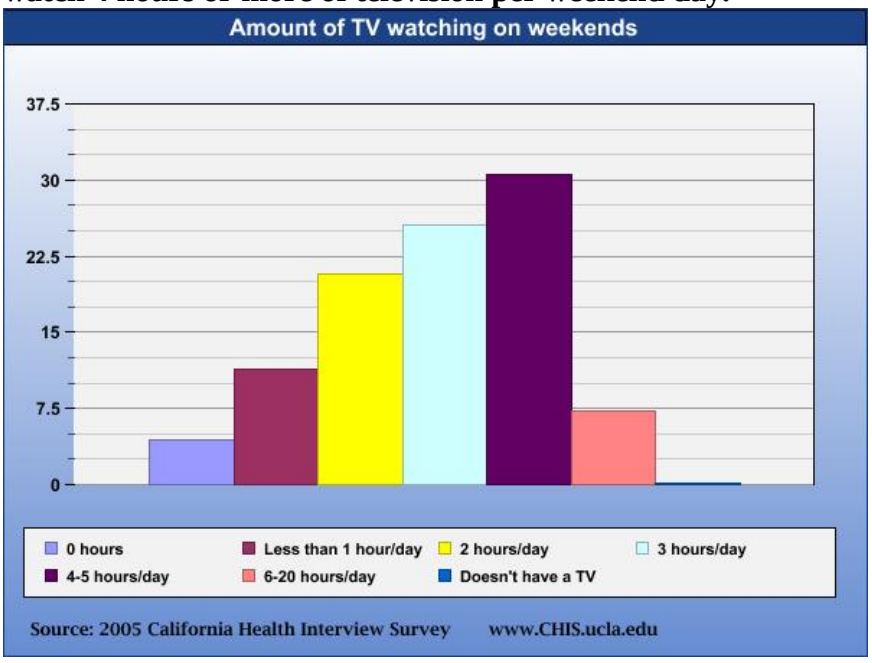
The strength of the correlation between media violence and aggressive behavior found on meta-analysis is greater than the correlations between calcium intake and bone mass, lead ingestion and lower IQ, condom nonuse and sexually acquired human immunodeficiency virus infection, or environmental tobacco 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)

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)

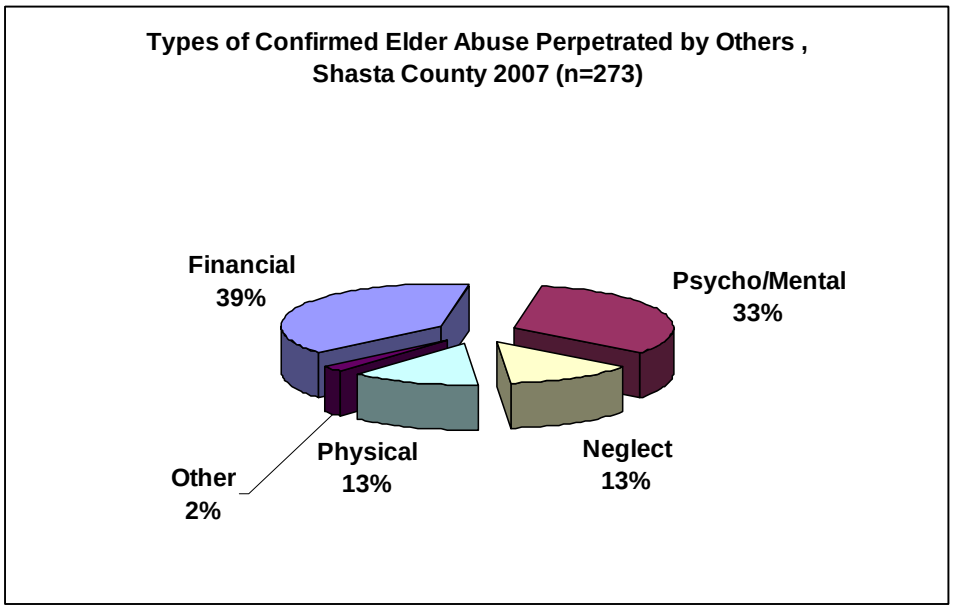
- **Of the 7th, 9th and 11th grade students in Shasta County who reported having a boyfriend or girlfriend in the past year, 8.5%, 9.1%, and 10.6% of them, respectively reported being hit, slapped or physically hurt by them on purpose.**
  (Source: Community Health Assessment, 2004)

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.

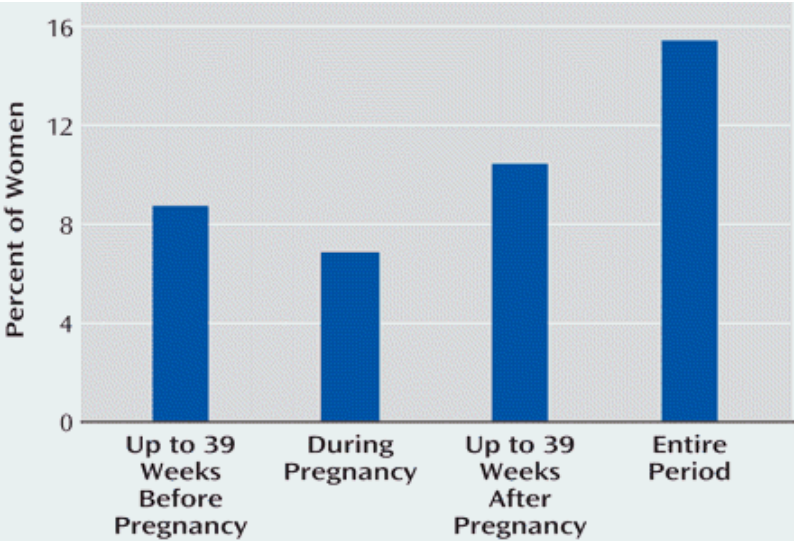


(Source: California Department of Social Services, Report SOC242)

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 moths, 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.



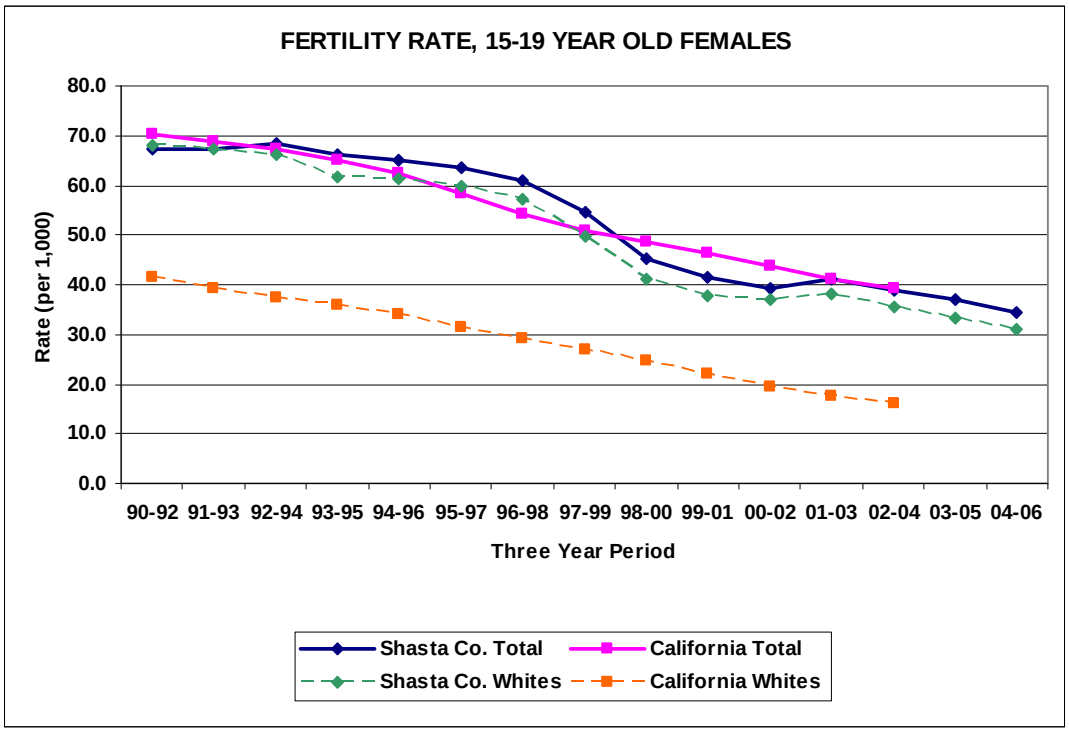
Percent of Women with Diagnosed Depression Before, During, and After Pregnancy
(Source: American Journal of Psychiatry, October 2007. "Maternal Depression Before, During, and After Pregnancy". Dietz. Et al.)

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.



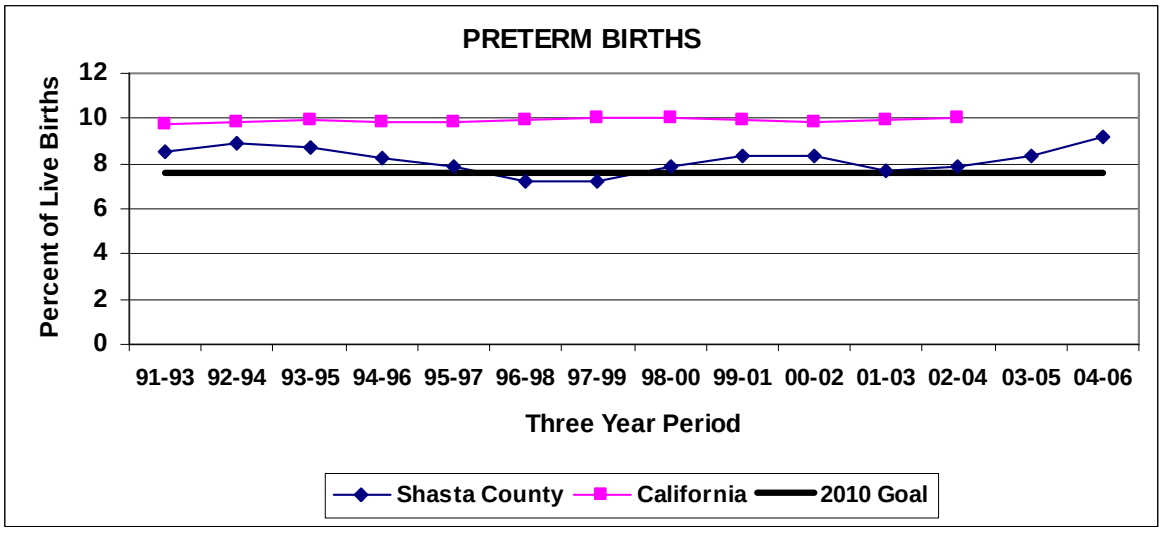
(Source: Shasta County Public Health, Vital Records Office)

Community Mental Health Assessment

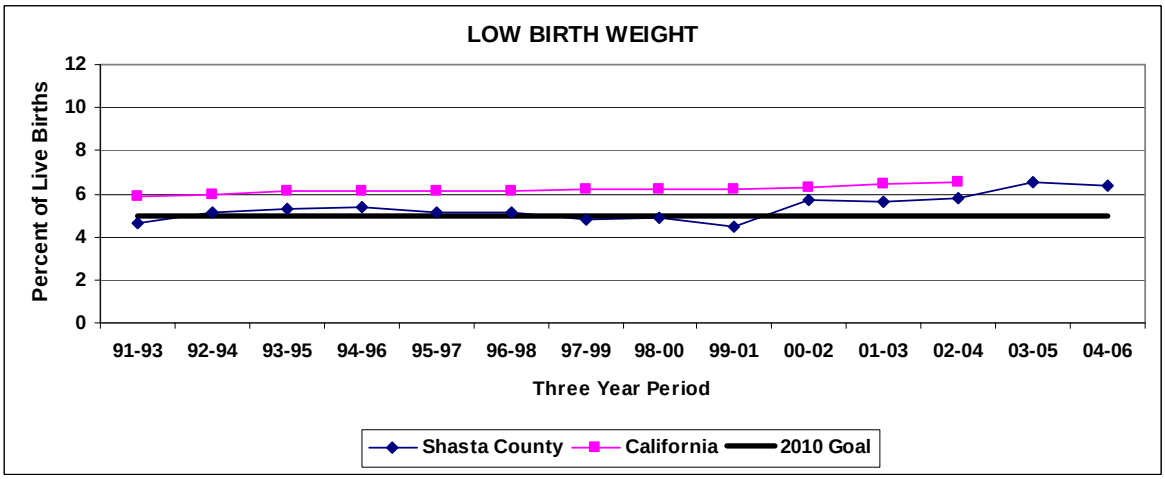
Preventing Mental Disorders (Risk Factors of Mental Disorders)

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-IIIR). **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.

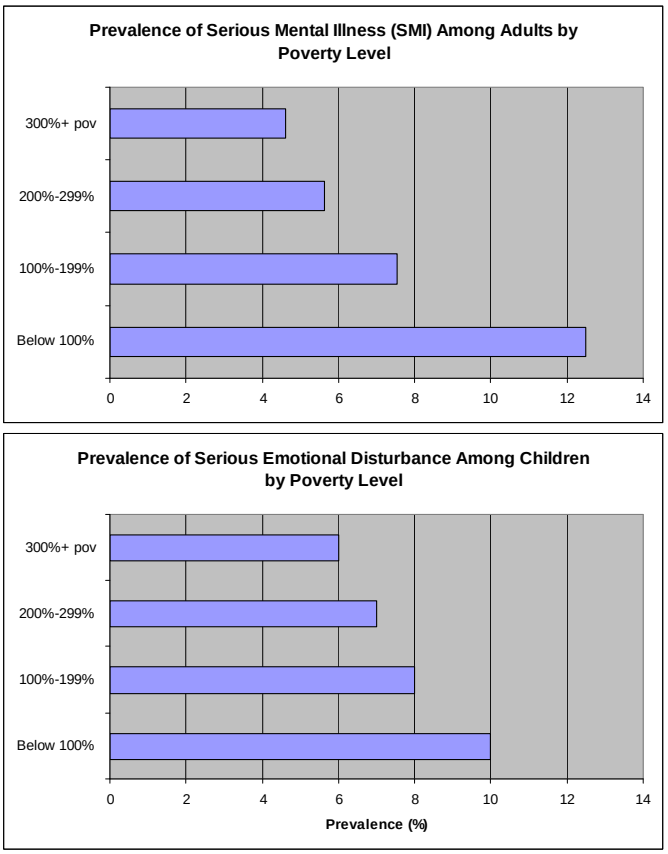
- This study found that SMI or SED disproportionately affects those who are:
  - Living below the poverty level (12.5% of adults and 10% of children)
  - 18-20 years old (11.2%).
  - Separated, widowed or divorced (10.4%) compared to those who are married (4.4%), or single (8.2%)
  - Females (7.9%) compared 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

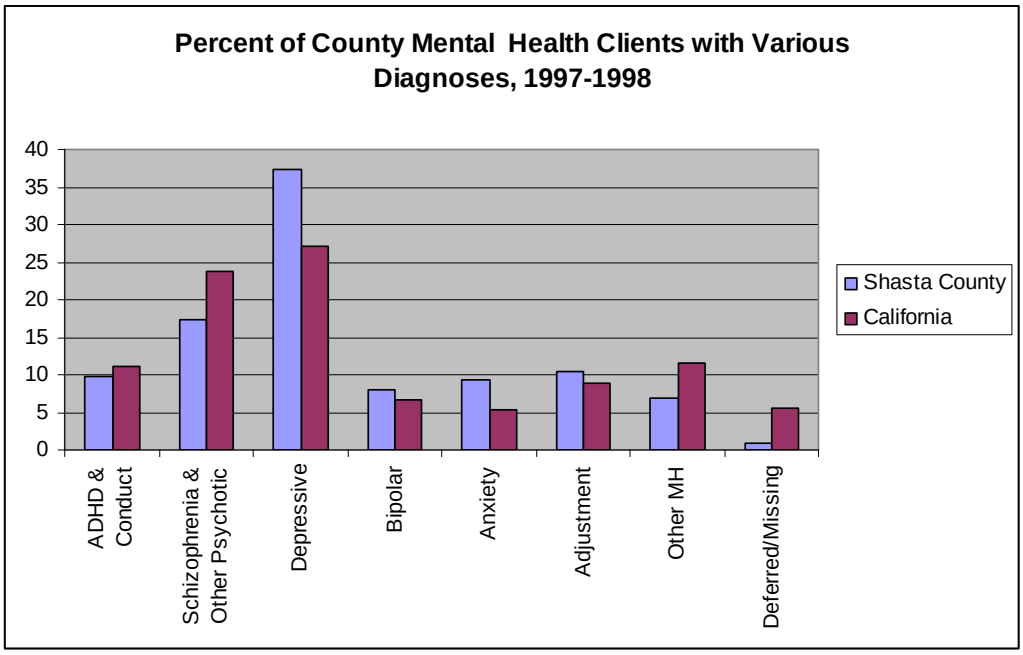
Frequency of Sad and Hopeless Feelings, Past 12 Months

	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)

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.

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.

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)

Adolescent Alcohol and Marijuana Use in *California*, 2004 - 2006

% 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 lest 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.

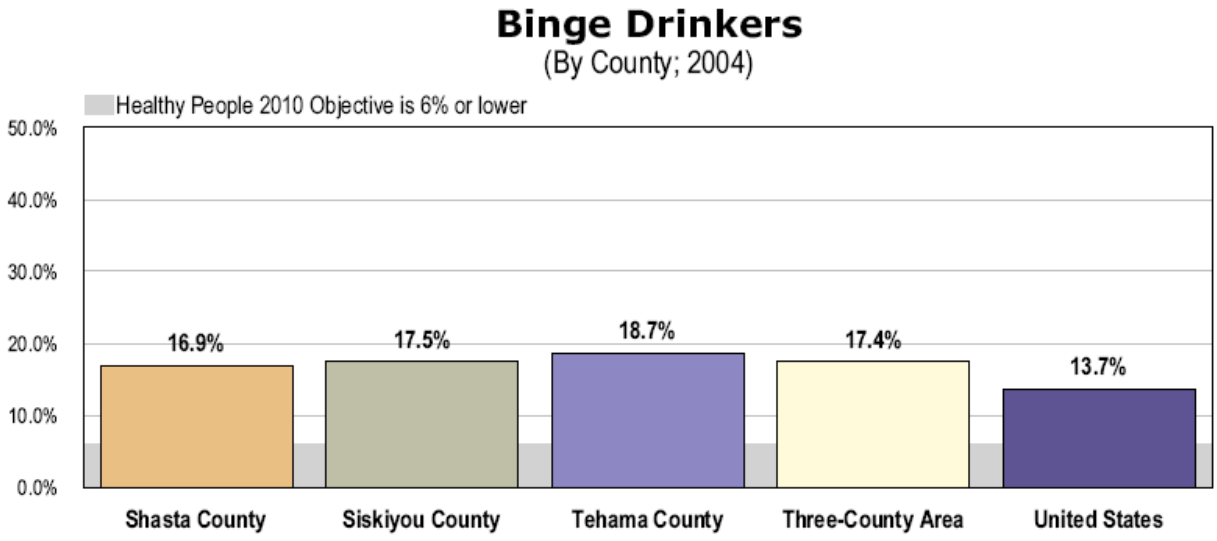
Prevalence of Alcohol and Other Drug Abuse (cont'd)

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.



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]

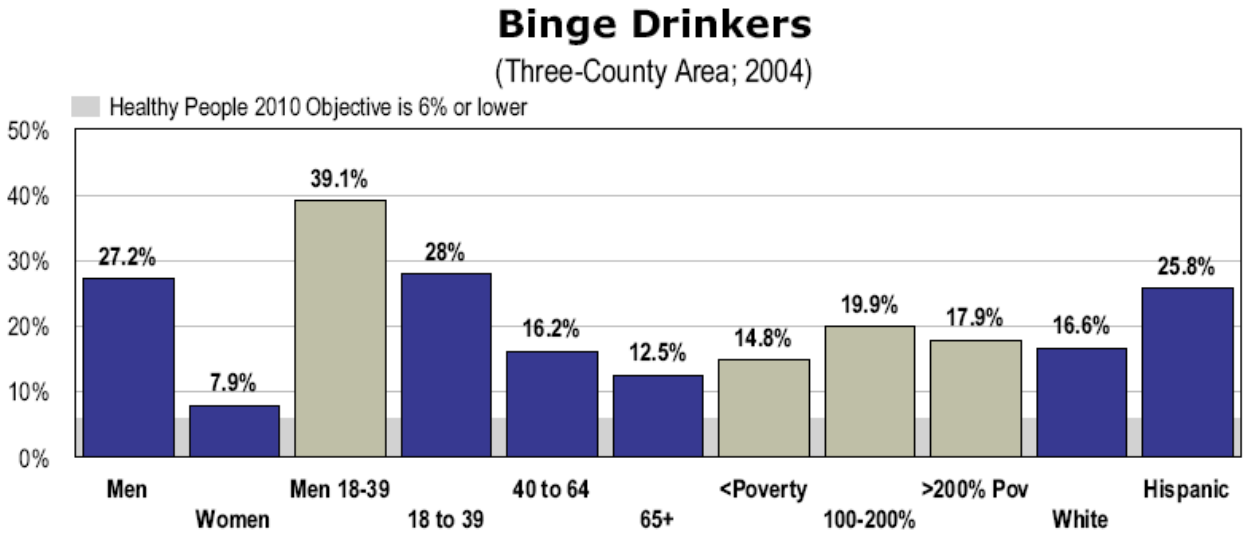
Notes:
- Reflects the total sample of respondents.
- Binge drinkers are those who have had 5 or more alcoholic drinks on any one occasion at least once in the past month.

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)

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

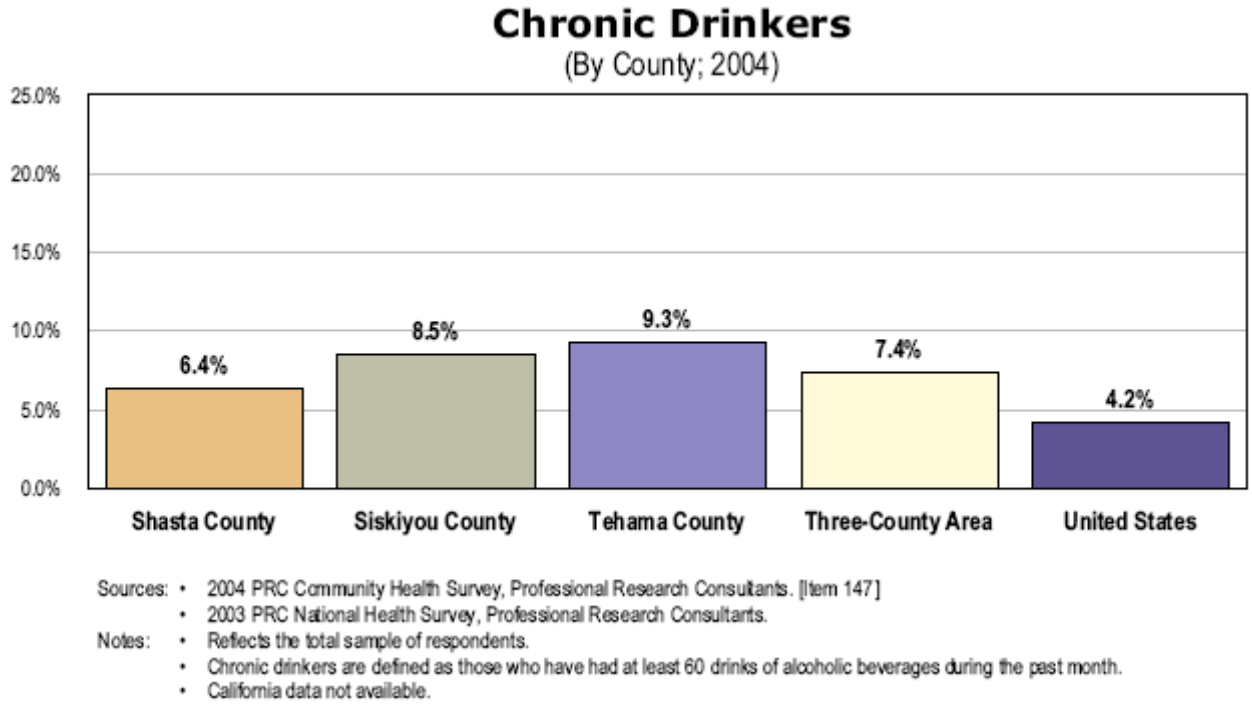
Chronic Drinking

- 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.



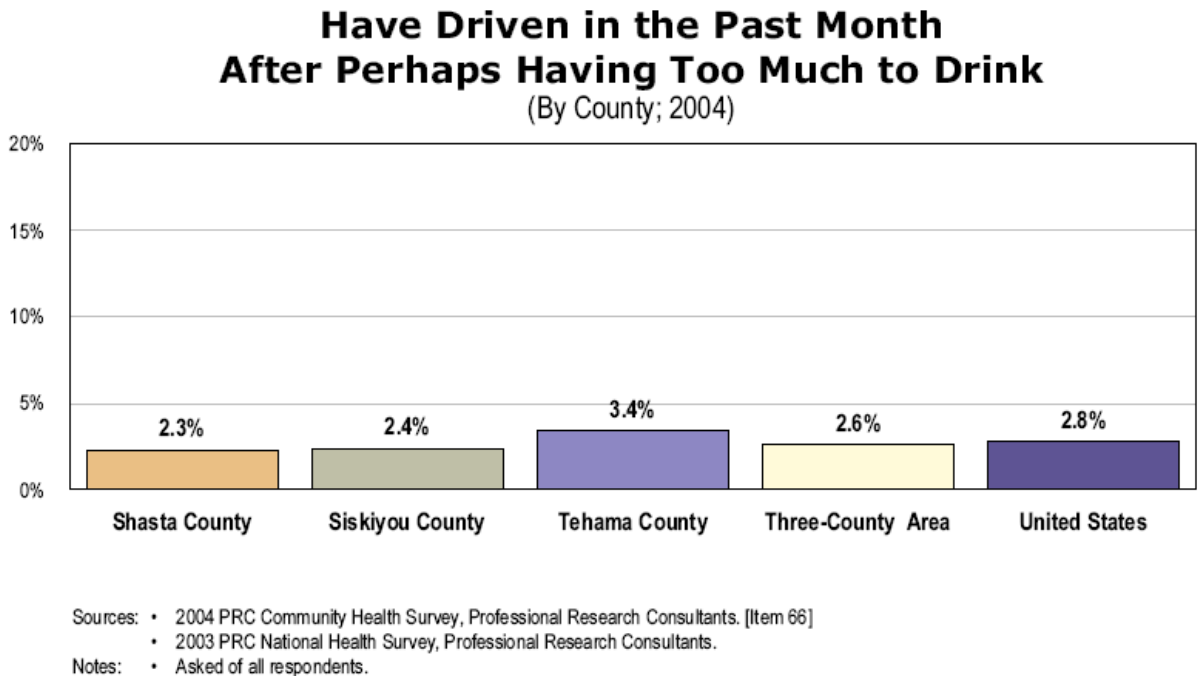
(Source: 2004 Community Health Assessment, Catholic Healthcare West)

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.



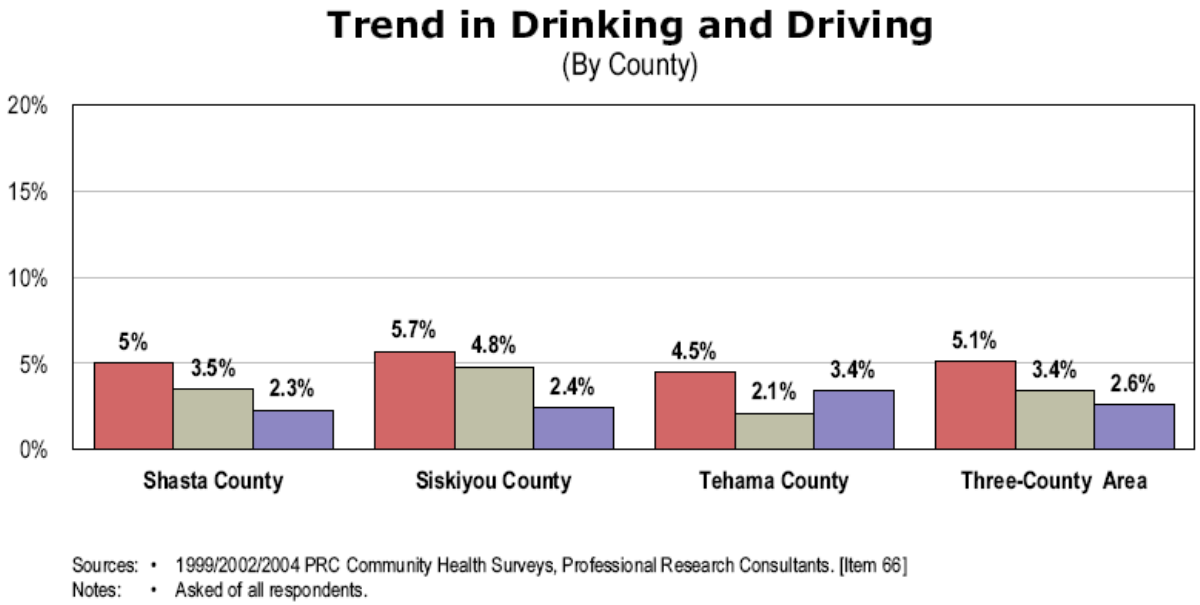
(Source: 2004 Community Health Assessment, Catholic Healthcare West)

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.



(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)*

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

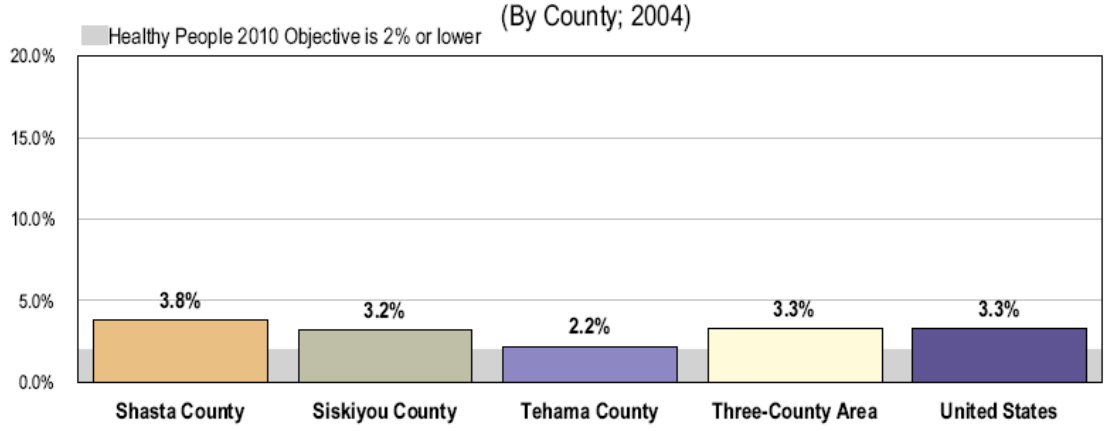
Self-Reported Illicit Drug Use

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]

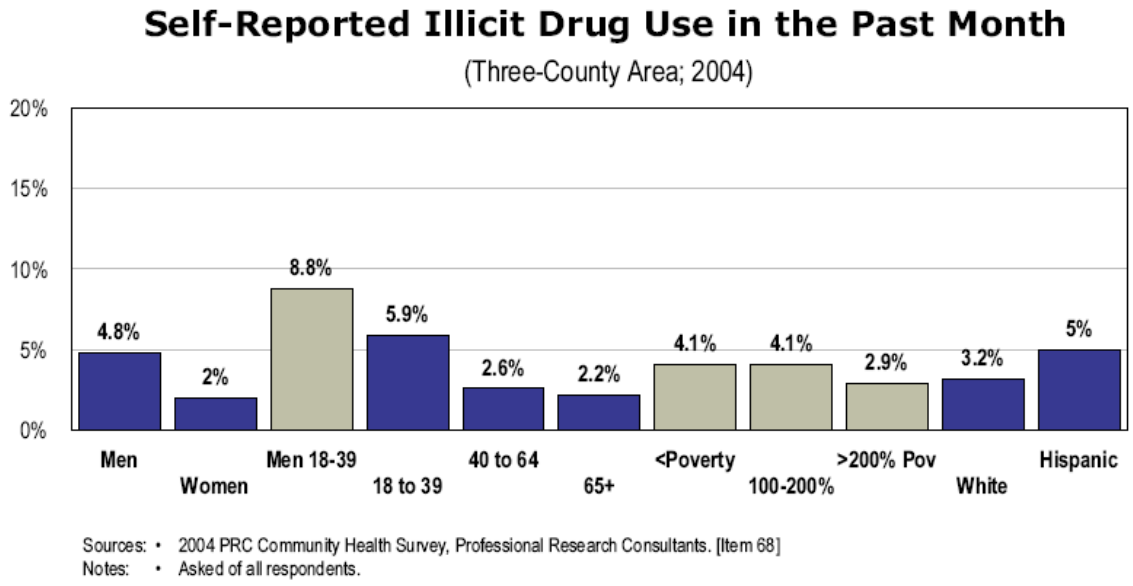
Notes:
- Asked of all respondents.
- In this case, the term "illicit drug use" includes use of an illegal drug and/or use of a prescription drug without a physician's orders.
- This exact inquiry was not addressed in previous studies for the Three-County Area.

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

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.



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

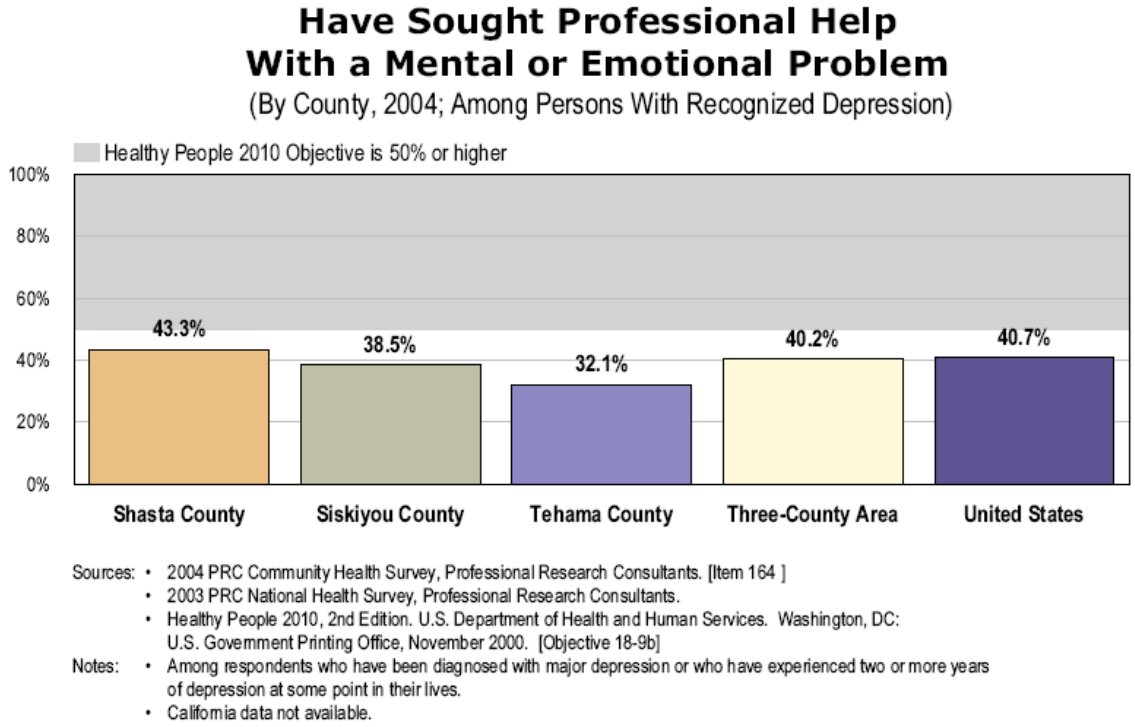
Early Intervention

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%).



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

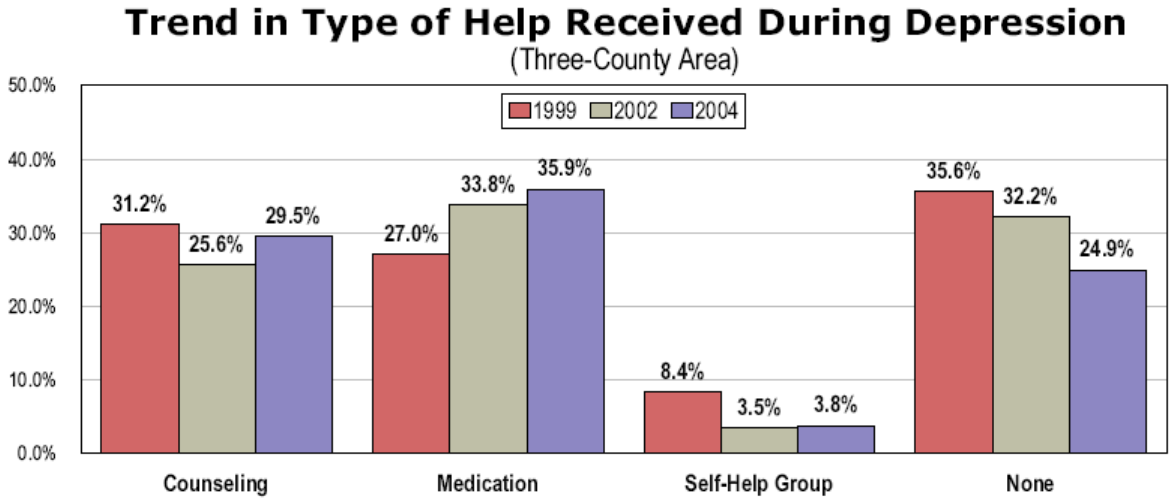
Early Intervention (cont'd)

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.



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)

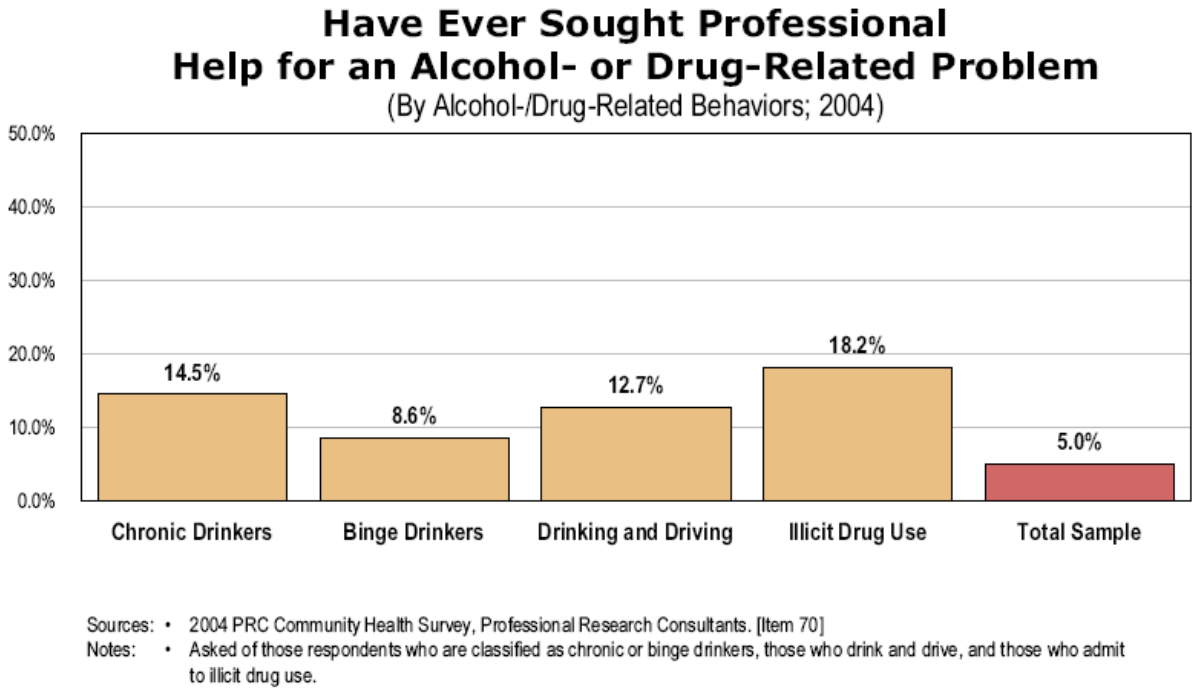
Early Intervention (cont'd)

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.



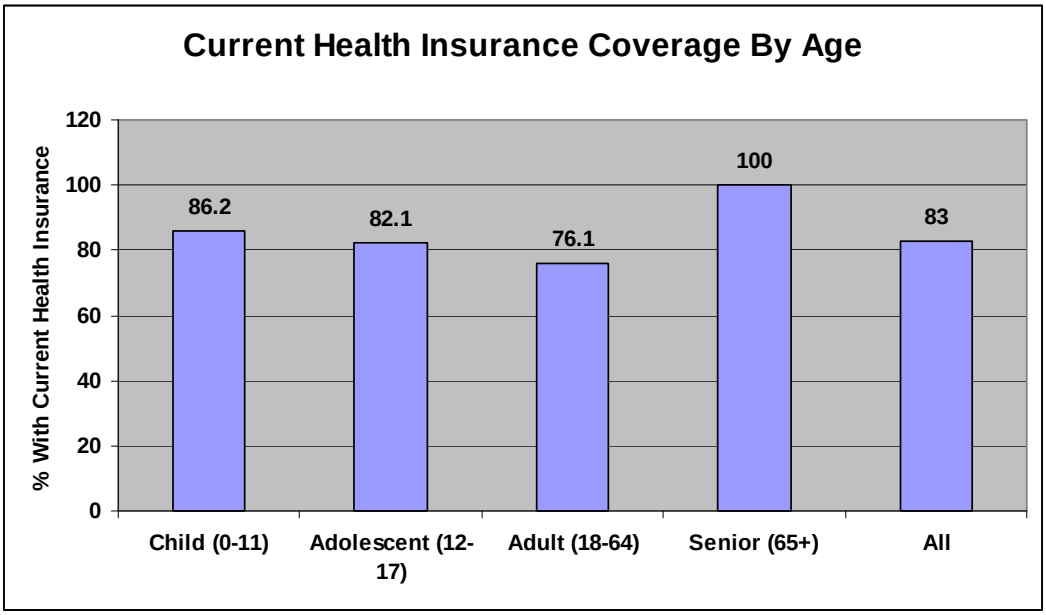
(Source: 2004 Community Health Assessment, Catholic Healthcare West)

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)

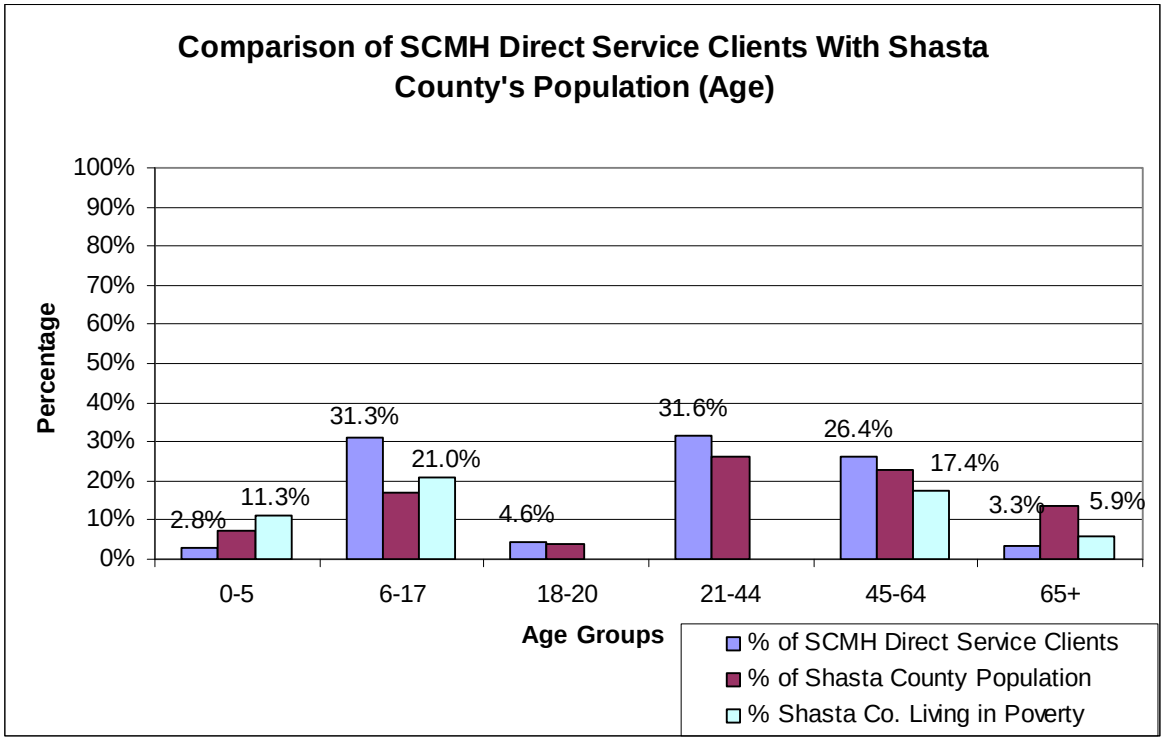
- Having adequate insurance that covers mental health services does not always guarantee access. Sometimes the services needed are not readily available in the community where one lives, such as specialty psychiatric services. Also, finding mental health providers that accept specific types of insurance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



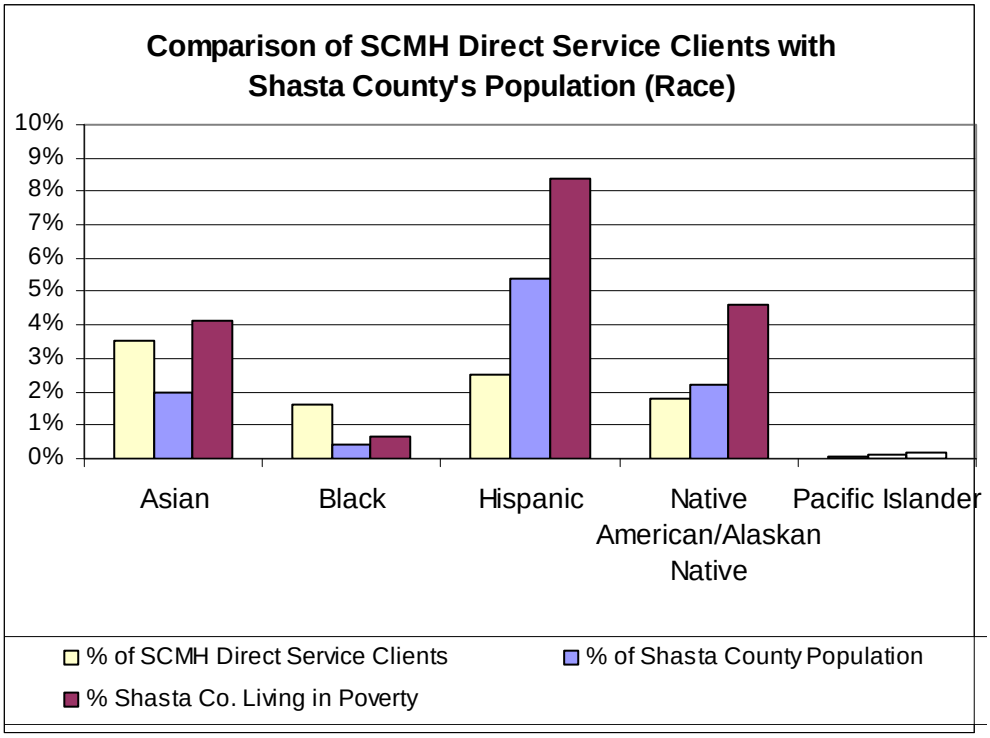
(Source: Shasta County Mental Health, 2006-07; State of California, US Census Bureau, 2000 Census.)
Note: The data on age and poverty level on two age groups was not available from the US Census in the age categories 18-20 and 21-44.

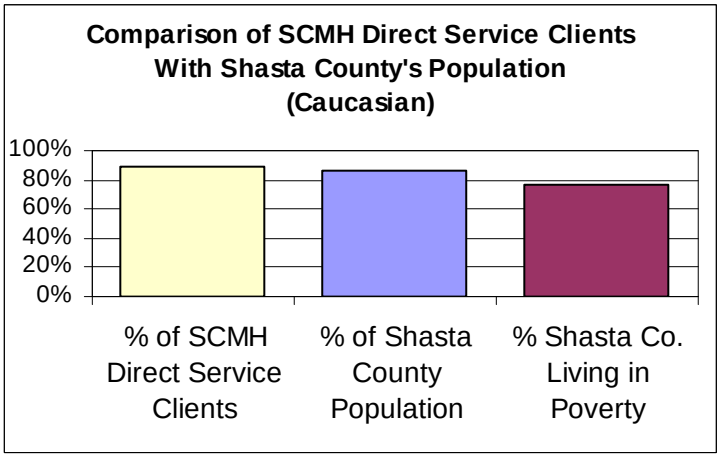
- When compared to Shasta County's population and Shasta County's population living in poverty, 6-17 year olds are over-represented and people 65 and older and under-represented among SCMH Direct Service Clients.

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.

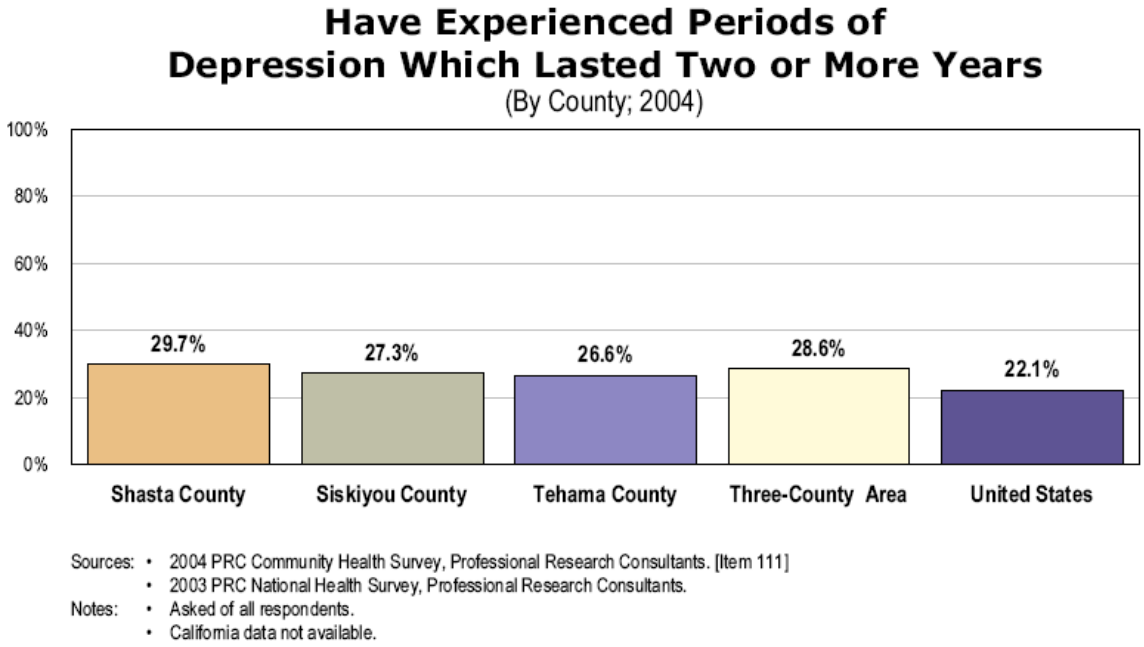
Outcomes That May Relate to Mental Illness

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.



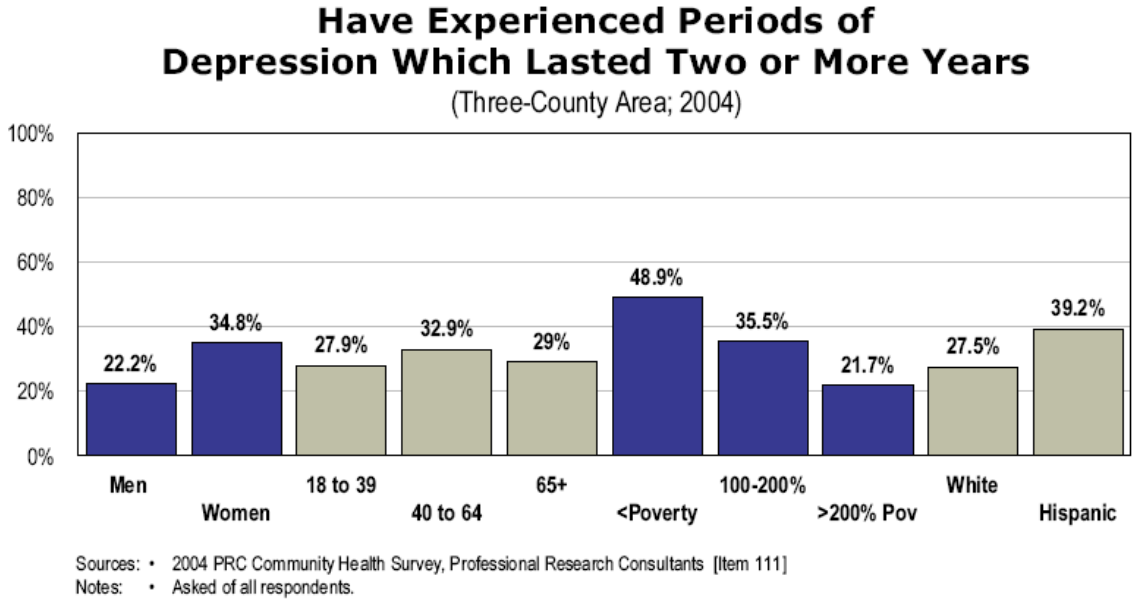
(Source: 2004 Community Health Assessment, Catholic Healthcare West)

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.

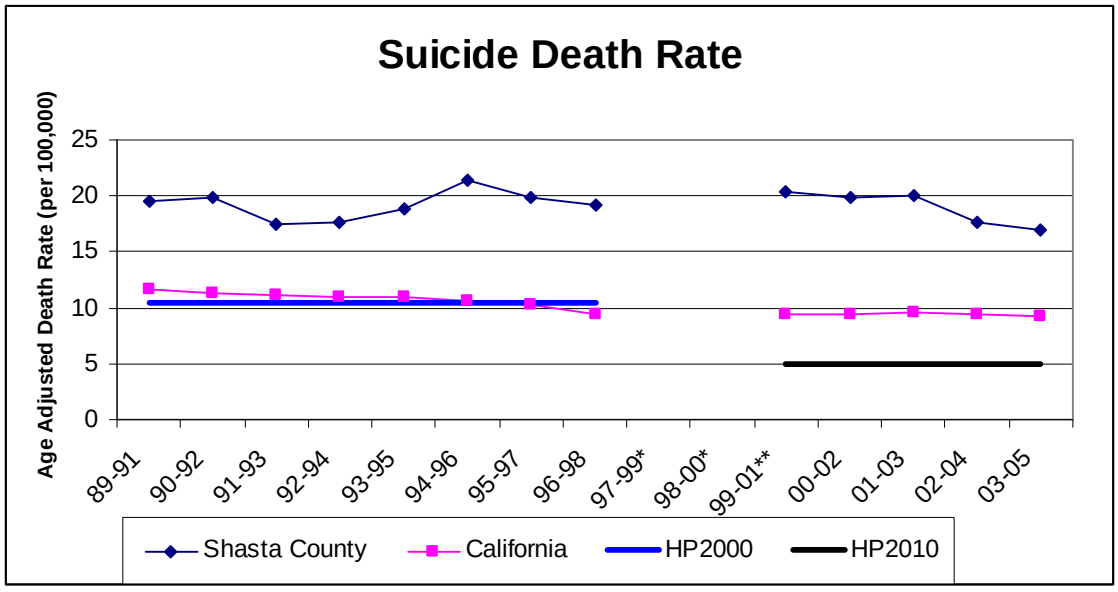


(Source: 2004 Community Health Assessment, Catholic Healthcare West)

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.

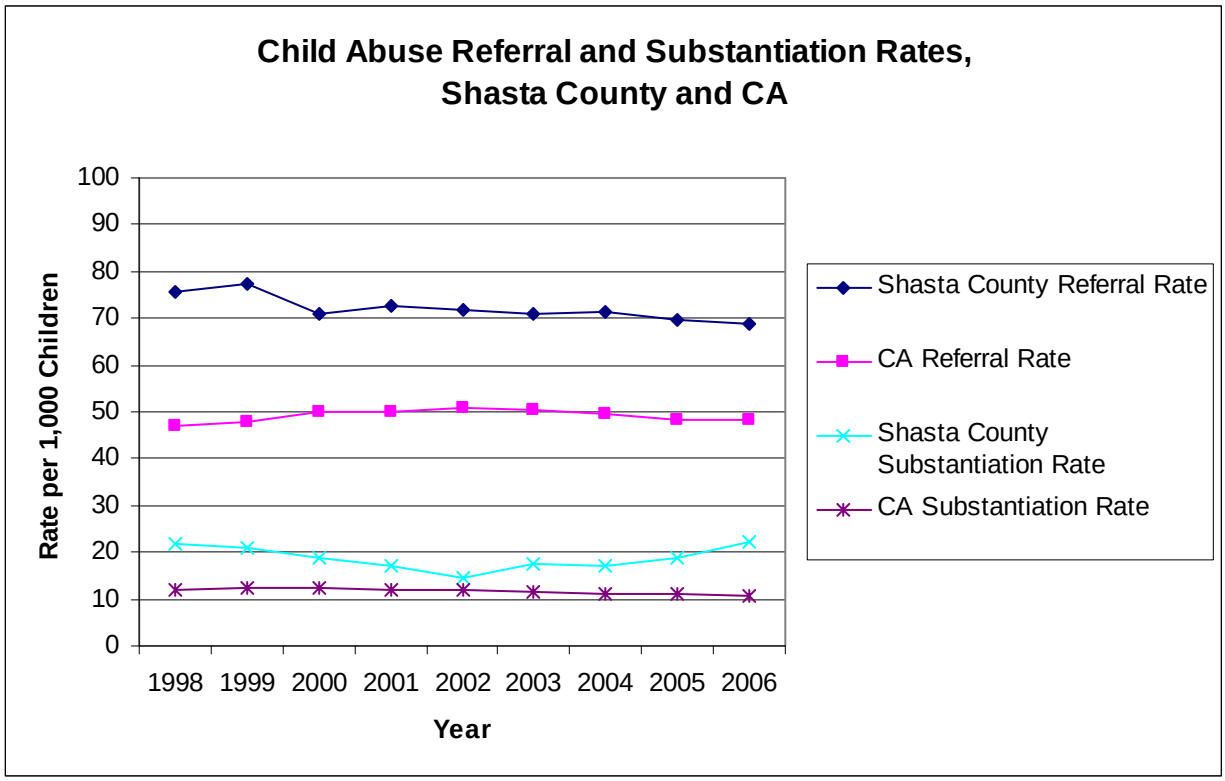
  (Source: 2006 Annual Statistical Report on the Social Security Disability Insurance Program, ***http://www.socialsecurity.gov/policy/data.html***)

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.

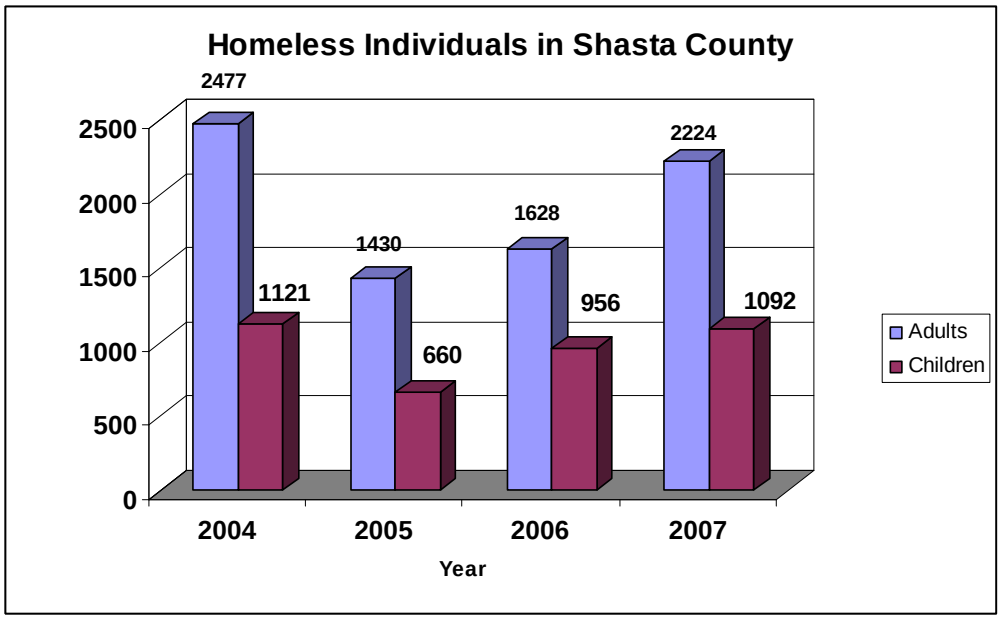
Source: Needell, B., Webster, D., Armijo, M., Lee, S., Cuccaro-Alamin, S., Shaw, T., Dawson, W., Piccus, W., Magruder, J., Exel, M., Smith, J. , Dunn, A., Frerer, K., Putnam Hornstein, E., Ataie, Y., Atkinson, L., & Lee, S.H. (2007). *Child Welfare Services Reports for California*. Retrieved [month day,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

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.*



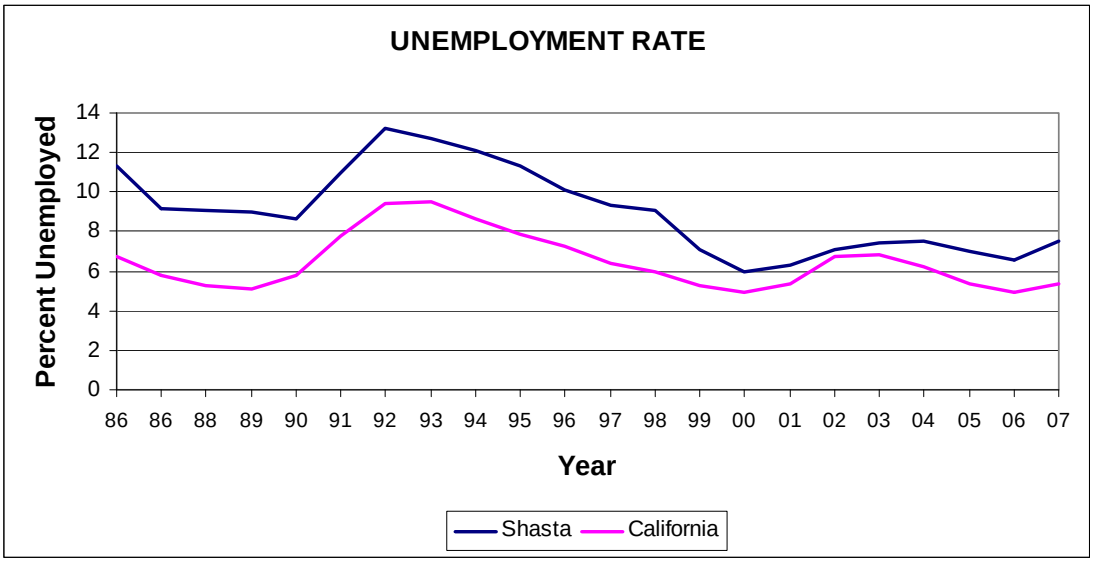
(Source: Continuum of Care, Year-Long Survey)

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)*

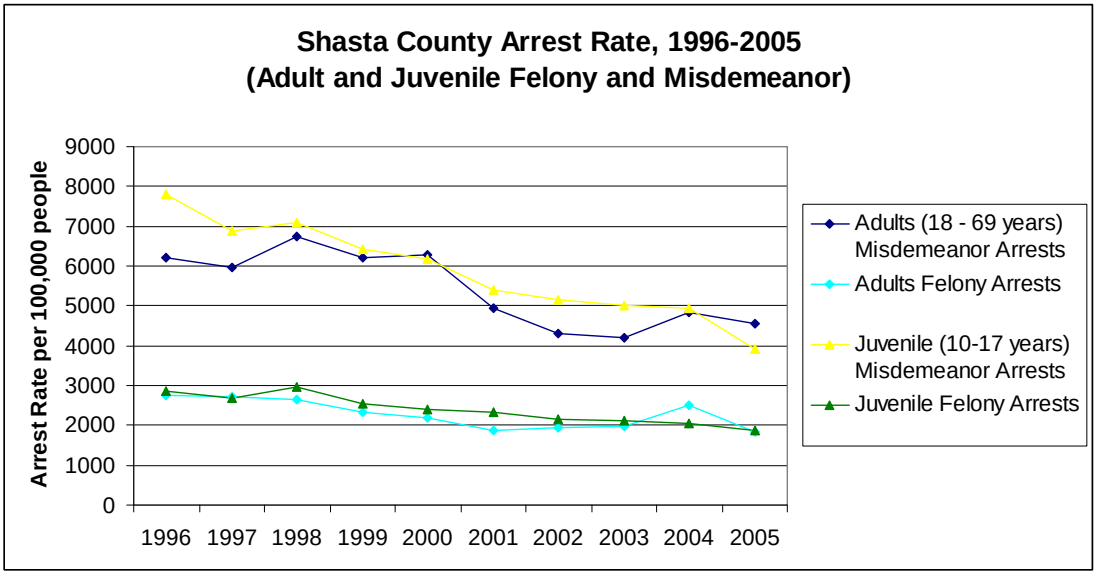
Outcomes That May Relate to Mental Illness (cont'd)

Unemployment



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

Incarceration



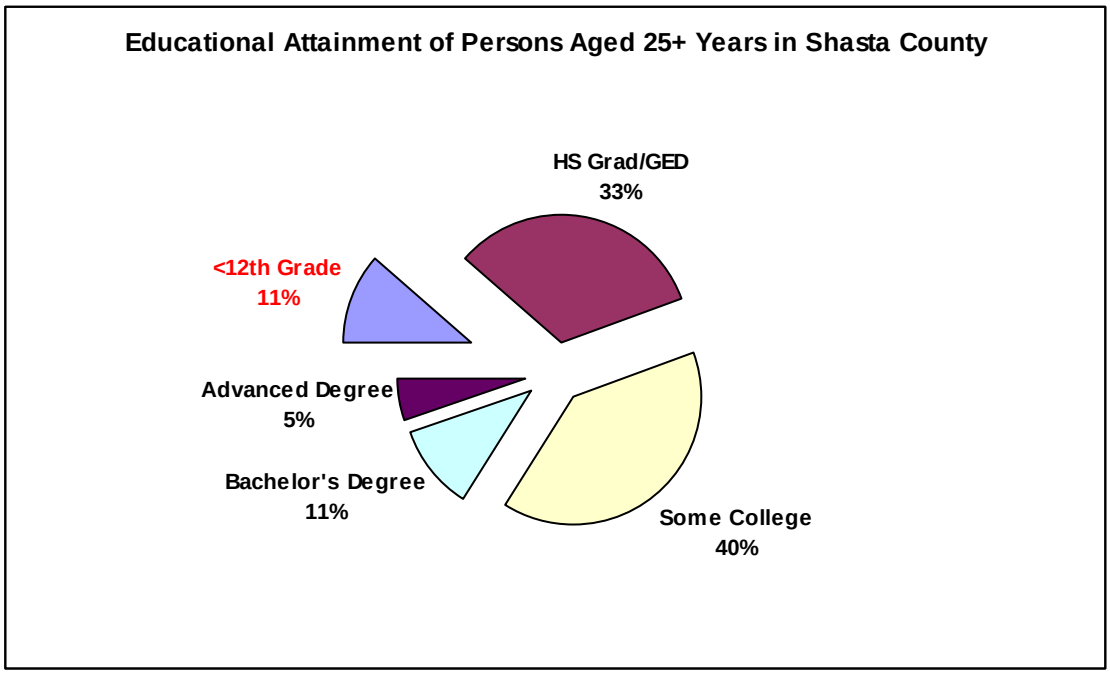
(Source: California Department of Justice, 2008)

- 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.

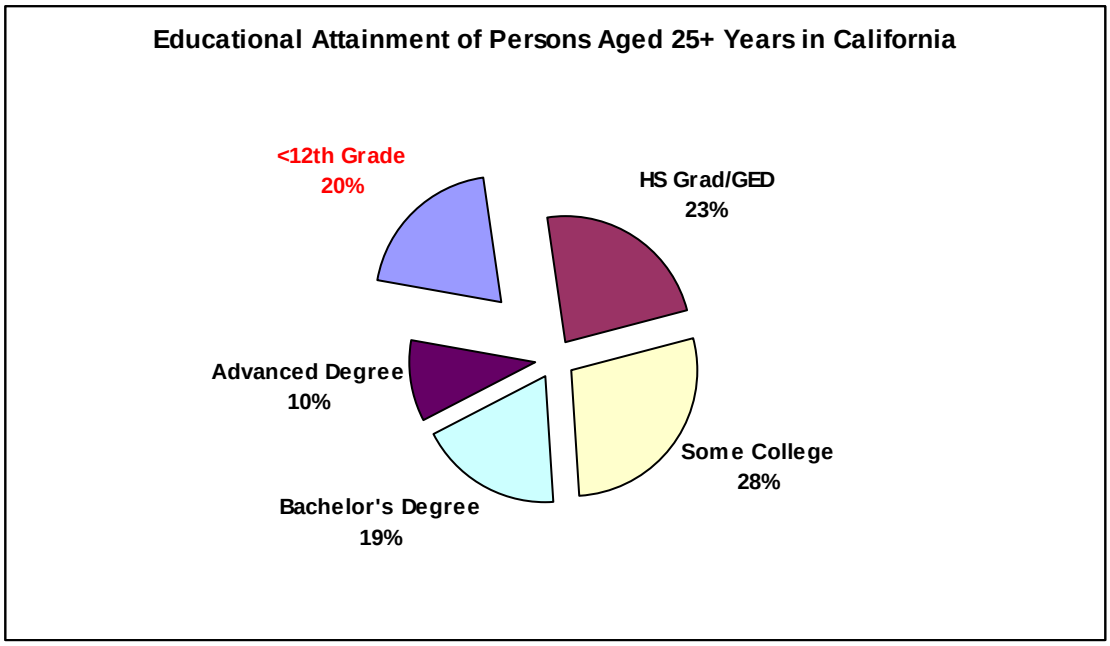
Community Mental Health Assessment

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

School Failure or Dropout



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

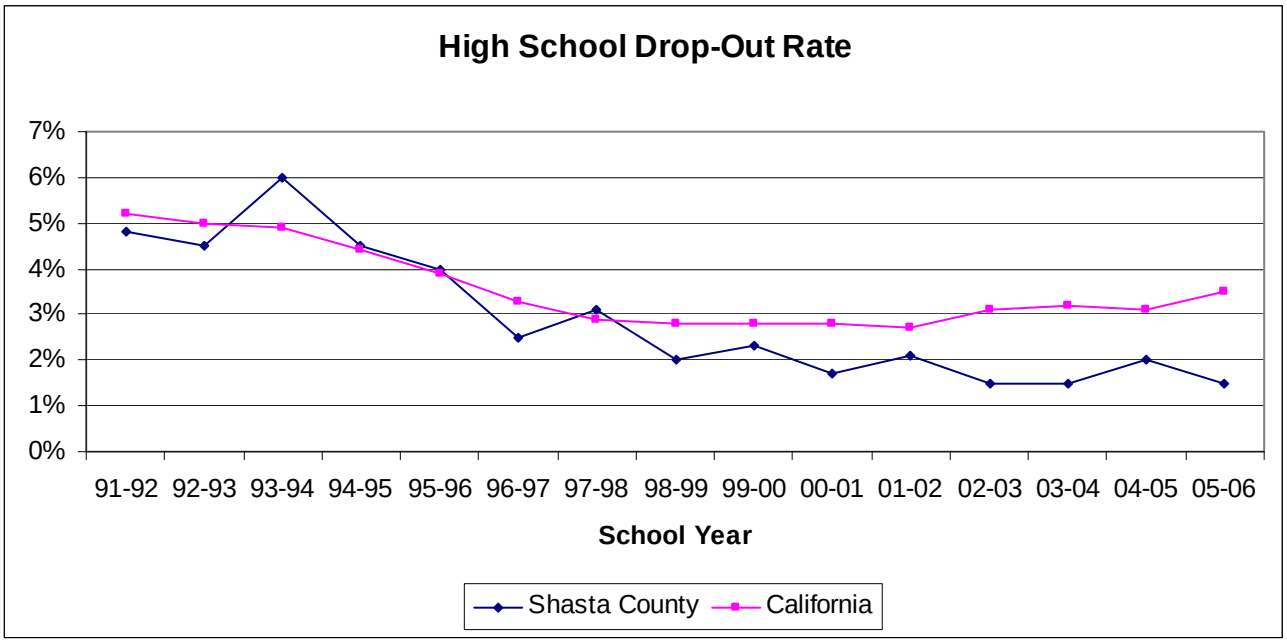


(Source: 2006 American Community Survey, United States Census Bureau)

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/

PEI Informational Meeting Documents

Informational Meeting Flyer
Informational Meeting Presentation

Mental Health Prevention and Early Intervention (PEI)

Shasta County Mental Health is creating its PEI plan and needs your input!

To decrease the impacts of mental illness in our community.



Do you care about your community's mental health?

WE NEED YOUR INPUT **Attend an informational meeting to learn more.**

Informational Meeting

- Anyone who has an interest in our community members' mental health is encouraged to attend.
- Learn about guidelines for the PEI plan, mental health prevention, early intervention, and evidence-based practices.
- Learn how you can participate in future PEI planning activities.

February 6, 2008
3:30 - 5:00 pm
Redding Public Library
Community Room

For more information go to:
shastamentalhealth.net
Or call 225-5985

COUNTY OF SHASTA CALIFORNIA

Prevention and Early Intervention Informational Meeting

02/06/08

3:30 – 5:00

Redding Library Community Room

This Power Point presentation was used to guide the discuss of the Prevention and Early Intervention Informational Meeting.

It does **not** contain all of the information that was presented at the meeting.

If you need more information about the Mental Health Services Act or Prevention and Early Intervention, you can contact Joy Garcia at 225-5985 or jdgarcia@co.shasta.ca.us

MEETING GOAL:

Inform and educate stakeholders about the Mental Health Services Act component called Prevention and Early Intervention

MEETING OBJECTIVES:

- Summarize PEI guidelines
- Inform stakeholders about the PEI planning process
- Identify opportunities for stakeholders to participate in PEI planning
- Prepare stakeholders to participate in PEI planning by explaining…
  - What does prevention and early intervention look like in MH terms?
  - What type of programs are available for PEI projects?

Mental Health Services Act

GENERAL INFORMATION:

- Proposition 63
- Passed in 2004
- Dedicated a portion of income tax receipts to improve mental health care in California

Mental Health Services Act

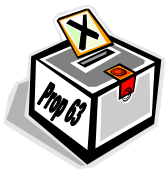
THE PURPOSE OF MHSA:

Define serious mental illness as a condition deserving priority attention

Reduce long-term adverse impacts on individuals resulting from untreated mental illness

Expand successful innovative services, including culturally and linguistically competent approaches for underserved populations

Ensure that funds are used in the most cost effective manner to ensure accountability to taxpayers and the public



Mental Health Services Act

Department of Mental Health:

Welfare and Institutions Code 5848 authorizes the DMH to establish guidelines for the content of the counties' PEI plan.

Website: www. **dmh.cahwnet.gov**

Mental Health Services Oversight and Accountability Commission:

PEI Guidelines were developed through a comprehensive stakeholder process based on principles and priorities adopted by the MHSOAC with stakeholder input.

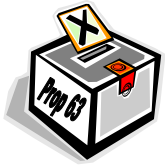
Website: www. **dmh.ca.gov/MHSOAC**

* Final PEI Plan must be submitted and approved by both groups

Mental Health Services Act

COMPONENTS OF MHSA:

- Community Services and Supports
- Capital and Information Technology
- Education and Training
- **Prevention and Early Intervention**
- Innovation

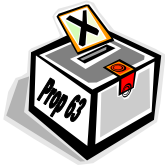


Mental Health Services Act

The first phase of the MHSA – implementation of Community Services and Supports – is now underway, and the first generation of new services is now a reality in Shasta County

Community Services and Supports:

- Wellness & Recovery Centers
- Services for Co-Occurring Disorders
- Community Outreach Teams
- Full Service Partnerships



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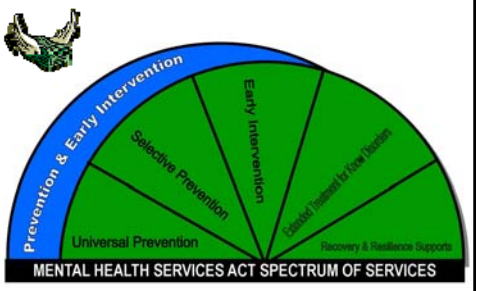

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Fiscal Year	Shasta County Mental Health PEI Estimated Funding
2007 – 2008	$ 508,000 *includes $105,000 in planning funds
2008 - 2009	$ 854, 000
Total	$ 1,363,000

PEI is a "Help-First" Approach:

PEI programs can bring mental health awareness into the lives of all members of the community through public education initiatives and dialogue

PEI may build capacity for services at sites where people go for other routine activities (e.g., health care, schools, community events and organizations) and in a culturally and linguistically appropriate manner

PEI programs facilitate promotion of protective factors, prevention of risk factors, and access to supports at the earliest possible signs of mental health concerns or problems

PEI activities could allow mental health to become part of wellness for individuals and communities, reducing the potential for stigma and discrimination against individuals with mental illness

PEI Key Community Mental Health Needs:

1. Reduce disparities in access to early mental health interventions
2. Reduce the negative psycho-social impact of trauma on all ages
3. Increase prevention efforts and response to early signs of emotional and behavioral health problems among at-risk children, youth, and young adult populations
4. Reduce stigma and discrimination affecting individuals with mental health problems
5. Increase public knowledge of the signs of suicide risk and appropriate actions to prevent suicide.

PEI Priority Populations:

1. Underserved cultural populations
2. Individuals experiencing onset of serious psychiatric illness
3. Children/youth in stressed families
4. Trauma-exposed
5. Children/youth at risk for school failure
6. Children/youth at risk of juvenile justice involvement

PEI Age Groups:

Children and Youth	0 – 15
Transitional Age Youth	16 – 25
Adults	26 – 59
Older Adults	60+

The PEI plan can reflect programs that address all age groups

The PEI Plan Will Be Aim To:

Promote mental well-being of community members.

Prevent mental illness from becoming severe and disabling.

Increase communities' ability to recognize the early signs of potentially severe and disabling mental illnesses.

Increase access and linkage to medically necessary care as early in the onset of mental conditions as feasible.

Reduce stigma and discrimination.

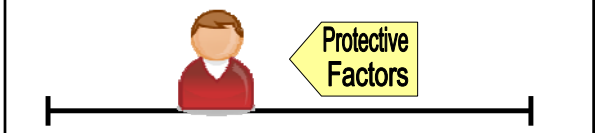
Reduce the duration of untreated severe mental illness.

Reduce the following negative outcomes that may result from untreated mental illness:

- Suicide
- Incarcerations
- School Failure/Dropout
- Removal of Children from their Homes
- Prolonged Suffering
- Homelessness
- Unemployment

Risk Factors:

Genetics	Family Violence	School Failure
Prenatal Care	Parent Substance Abuse	Death of Loved One
Poor Social Skills	War or Natural Disaster	Unemployment



Protective Factors:

Easy Temperament	Family Harmony	School Achievement
Sense of Belonging	Good Physical Health	Access to Support
Social Skills	Positive Self Image	Economic Security

Prevention:

Prevention in a mental health context involves reducing risk factors and increasing protective factors to help prevent the initial onset of mental illness.

Prevention promotes positive cognitive, social, and emotional development, and encourages a state of well-being

Three types of prevention:
1. Universal
2. Selective
3. Indicated

Universal Prevention:

Universal prevention strategies are targeted to whole population groups regardless of their level of risk

Universal prevention interventions target the general public or a whole population group that has not been identified on the basis of individual risk. They are based on the premise that it is not necessary to be able to identify the specific individuals at risk within the population in order to help them

Universal interventions are deemed to be desirable and risk-free for everyone within the population group

Due to their wide scope, universal interventions generally have low cost per individual and are acceptable to the members of the population within which they are being implemented.

Examples: Good prenatal care , programs to prevent bullying in schools or 40 Developmental Assets

Selective Prevention:

Selective interventions are targeted to population groups at higher than average risk of developing mental health problems and mental disorders

Selective prevention interventions target population subgroups whose risk of becoming ill is above average. Population subgroups at higher risk can be distinguished by characteristics such as age, gender, occupation, or exposure to known risk factors (like divorce or living in a disadvantaged community).

Individual pathways to mental health problems and mental disorders are not predicted very well by these types of risk factors, but the probability that an individual exposed to them will develop a mental health problem or mental disorder is above average; consequently they can be a guide for more targeted interventions.

Selective interventions generally do not exceed a moderate level of cost and the potential negative effects are minimal or nonexistent

Examples: Support for children of parents with a mental disorder, bereavement support groups, psychosocial support for people experiencing physical illness, social support programs to prevent depression for older people in residential care

Indicated Prevention:

Indicated prevention interventions are targeted to people at the highest level of risk

Indicated prevention is distinguished from both universal and selective prevention interventions by its focus on individuals, rather than population groups.

Indicated prevention is concerned with people who are showing signs of mental health problems and mental disorders, rather than people who are currently non-symptomatic.

Indicated prevention can be incorporated within Early Intervention

Examples: Parenting programs for parents of preschool children who display aggression and noncompliance, programs for children identified at school with some signs of behavior problems, or identification of adolescent social withdrawal that may be a component of a emerging thought disorder

Risk Factors & Protective Factors : Schizophrenia Example

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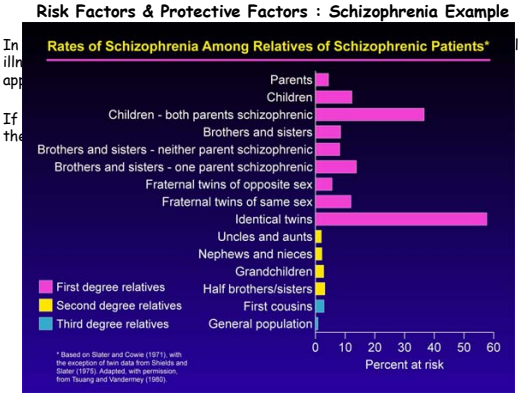
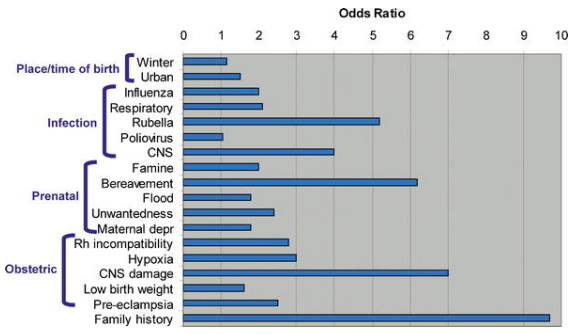
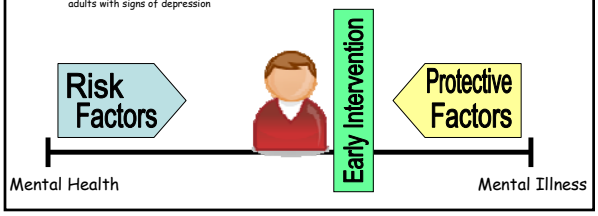


Risk Factors & Protective Factors : Schizophrenia Example



Early Intervention:

- Addresses a condition early in its manifestation
- Is of relatively low intensity
- Is of relatively short duration (usually less than one year)
- Has the goal of supporting well-being in major life domains and avoiding the need for more extensive mental health services
- May include individual screening for confirmation of potential mental health needs
- Examples:
  - Mental Health consultation/with interventions in child care environments
  - Parent-child interaction training for children with behavioral problems
  - Interventions for individuals who experience trauma
  - Socialization programs with mental health emphasis for home-bound older adults with signs of depression



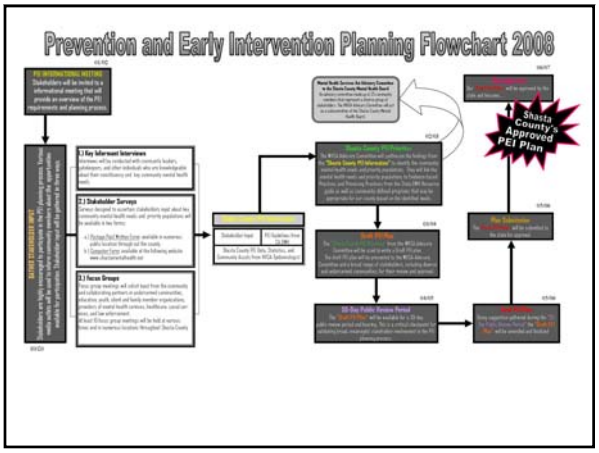
Early Intervention: PTSD Example

Prolonged Exposure Therapy for Posttraumatic Stress is an example of a Early Intervention program.

Individuals suffering PTSD symptoms such as including intrusive thoughts, intense emotional distress, nightmares, etc… due to exposure to a traumatic event, receive a cognitive-behavioral treatment program that consists of nine to twelve, 90 minute sessions.

Results include:

- 70% to 90% of clients no longer have the diagnosis of PTSD after a 9- to 12- session course of PE therapy (i.e., they have a highly significant reduction in trauma-related symptoms, including distressing thoughts, feelings, and flashbacks; avoidance of thoughts and other reminders of the traumatic event; and hyperarousal symptoms).
- Improved daily functioning, including substantial reduction in depression, general anxiety, and anger, has been observed in clients treated with PE.
- Treatment gains are maintained for at least I year after treatment ends.



PEI Planning: Step 1

PEI INFORMATIONAL MEETING

Stakeholders will be invited to a informational meeting that will provide an overview of the PEI requirements and planning process.

PEI Planning: Step 2

GATHER STAKEHOLDER INPUT

Stakeholders are highly encouraged to partic pate in the PEI planning process. Various media outlets w be used to inform community members about the opportunities ava lab e for participation Stakeho der input will be gathered n three ways

1.) Key Informant Interviews
Interviews will be conducted with community leaders, gatekeepers, and other individuals who are knowledgeable about their constituency and key community mental health needs.

2.) Stakeholder Surveys
Surveys designed to ascertain stakeholders input about key community mental health needs and priority populations will be available in two forms:

a.) Community Distribution: available in numerous public location through out the county.

b.) Computer Form: available at the following website www.shastamentalhealth.net

3.) Focus Groups
Focus group meetings will solicit input from the community and collaborating partners in underserved communities, education, youth, client and family member organizations, providers of mental health services, healthcare, and social services.
At least 8 focus group meetings will be held at various times and in numerous locations throughout Shasta County

PEI Planning: Step 3

Shasta County PEI Information

Shasta County PEI Data, Statistics, and Community Assets	PEI Guidelines from CA DMH

Stakeholder Input

PEI Planning: Step 3

Shasta County PEI information will be synthesized to:

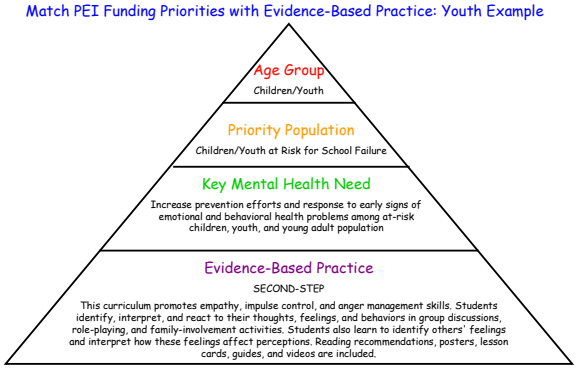
Determine PEI funding priorities for…

- PEI Priority Populations
- PEI Key Mental Health Needs
- PEI Age Groups

Match PEI funding priorities with Evidence-Based Practice

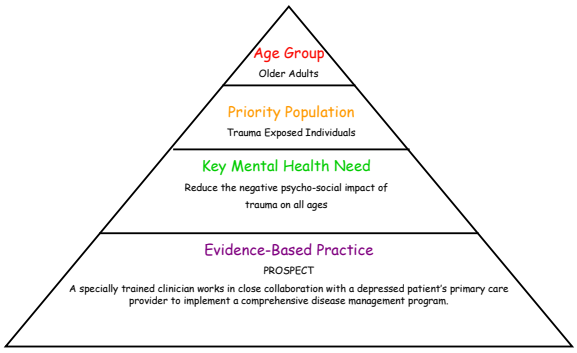
PEI Planning: Step 3

Match PEI Funding Priorities with Evidence-Based Practice: Youth Example

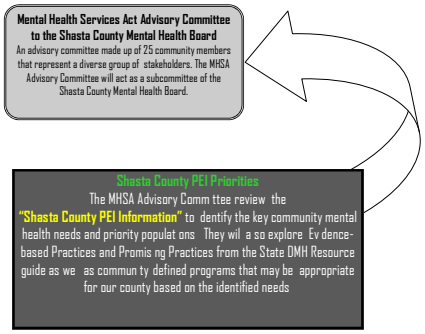


PEI Planning: Step 3

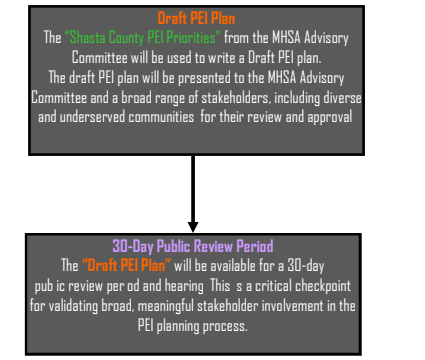
Match PEI Funding Priorities with Evidence-Based Practice: Adult Example



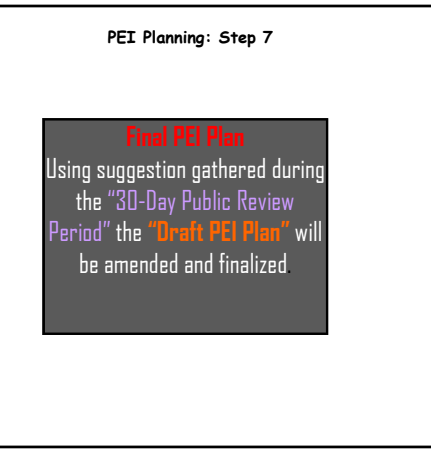
PEI Planning: Step 4

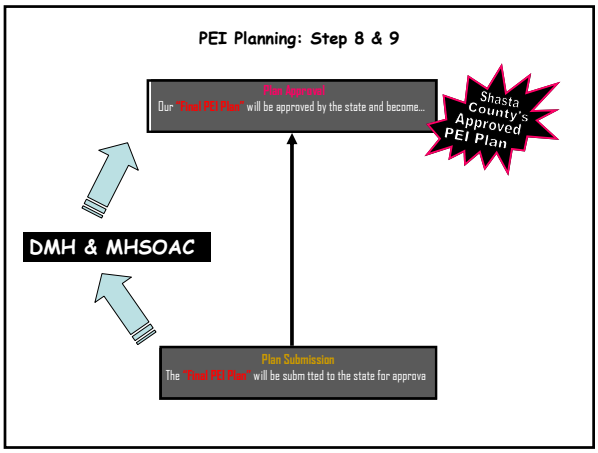


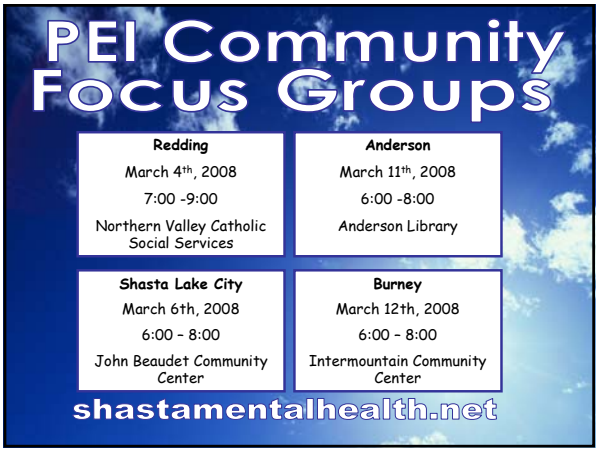
PEI Planning: Step 5 & 6



PEI Planning: Step 7




PEI Planning: Step 8 & 9
Plan Approval
Our "Final PEI Plan" will be approved by the state and become...
Shasta County's Approved PEI Plan
DMH & MHSOAC
Plan Submission
The "Final PEI Plan" will be submitted to the state for approva


PEI Community Focus Groups
Redding
March 4th, 2008
7:00 -9:00
Northern Valley Catholic Social Services
Anderson
March 11th, 2008
6:00 -8:00
Anderson Library
Shasta Lake City
March 6th, 2008
6:00 – 8:00
John Beaudet Community Center
Burney
March 12th, 2008
6:00 – 8:00
Intermountain Community Center
shastamentalhealth.net

PEI Focus Group Documents

Focus Group Schedule Flyer
Focus Group Invitation Examples
Focus Group Description and Process
Focus Group General Information
Focus Group Result Summaries

P E

Prevention

Early

Intervention

Help us plan to INCREASE MENTAL HEALTH SUPPORTS in your community!

Tell us what you think!
Attend a PEI Focus Group

Why Attend a PEI Focus Group?
Share your recommendations for mental health prevention and early intervention in Shasta County.

How Can You Participate?
Select a focus group from the list below, and show up! No need to register.

Need Special Accommodations?
For transportation, interpreters or other accommodations, contact Joy Garcia at 225-5985.

PEI FOCUS GROUP SCHEDULE

Let's Talk!

Shingletown
March 3, 2008
11:30 a.m.- 1:30 p.m.
To Be Announced

Redding
March 4, 2008
7:00 p.m.- 9:00 p.m.
Northern Valley Catholic Social Services

Shasta Lake City
March 6, 2008
6:00 p.m.- 8:00 p.m.
John Beaudet Community Center

Anderson
March 11, 2008
6:00 p.m.- 8:00 p.m.
Anderson Public Library

Burney
March 12, 2008
6:00 p.m.- 8:00 pm
Intermountain Community Center

COUNTY OF SHASTA CALIFORNIA

For more information, go to www.shastamentalhealth.net or call 225-5985.

You Are Invited

MENTAL HEALTH PREVENTION and EARLY INTERVENTION FOCUS GROUP

Prevention and Early Intervention Planning …

The Mental Health Services Act (MHSA) emphasizes prevention and early intervention as key strategies to transform California's mental health system. The MHSA provides funding to help prevent the development of serious emotional disorders and mental illness. This component of the MHSA, referred to as Prevention and Early Intervention (PEI), focuses interventions and programs for individuals across the life span to prevent or mitigate the impact of mental illness.

The Shasta County Department of Mental Health is undertaking an intensive, inclusive, and multi-faceted approach to developing the County's PEI Plan. Meaningful involvement and engagement of diverse communities and potential individual participants, their families and other community stakeholders will occur using a community program planning process.

Stakeholder input will be collected by means of survey, key informant interviews, and focus groups.

The Focus Group's Focus …

The Mental Health Services Oversight and Accountability Commission and State Department of Mental Health have targeted five **Key Community Mental Health Needs** and six **Priority Populations** for PEI planning

Focus Groups will explore these key mental health needs and priority populations to identify the focus group members' concerns, issues, and recommendations for PEI funding priorities, as well as, explore strategies for PEI program implementation.

Questions or Concerns …

Contact Joy Garcia at 225-5985 or jdgarcia@co.shasta.ca.us

- **Hosted by**:
  Tom Armelino
- **Facilitated by**:
  Shasta County Mental Health
- **Location**:
  Shasta County Office of Education Redwood Conference Room
- **Date:**
  February 25th, 2008
- **Time:**
  10:00 – 12:00

WE LOOK FORWARD TO YOUR PARTICIPATION IN THE PREVENTION AND EARLY INTERVENTION PLANNING PROCESS

WHERE

Anderson Teen Center

2041 Howard St

Anderson, CA 96007

Mental Health Prevention & Early Intervention Meeting for Underserved Cultural Populations

This meeting will gather input from individuals who represent Shasta County's Underserved Cultural Populations.

Participants will explore key mental health needs and priority populations to identify their concerns, issues, and recommendations for Prevention and Early Intervention funding priorities, as well as, explore strategies for PEI program implementation.

TIME

11:30 - 1:30

DATE

03/06/08

RSVP

(530) 225.5985 or jdgarcia@co.shasta.ca.us

LUNCH WILL BE PROVIDED

Mental Health
Prevention & Early Intervention

Help us plan to increase mental health supports in our community

Tell us what you think!

Attend a **PEI** focus group for clients & family members

If you have questions or concerns …

Iris Sanders	Nancy Greer	Robin Thomas
247-3321	245-6745	245-6428

If you need special accommodations …

Joy Garcia
225-5985

Client & Family Member PEI Focus Group Schedule

Client Focus Group	**Family Member & Youth Client (14 - 24) Focus Groups**	**Client Focus Group**
03/31/08	03/31/08	04/01/08
12:00 - 2:00 p.m.	6:00 - 8:00 p.m.	5:00 - 7:00 p.m.
NVCSS 2400 Washington Ave Redding, CA	Mae Helene Bacon Boggs 2420 Breslauer Way Redding, CA	NVCSS Second Home 1250 California St Redding, CA

Refreshments Provided

Focus Group

- Focus group meetings were designed to solicit input from the community and collaborating partners in underserved communities, education, youth, client and family member organizations, providers of mental health services, healthcare, and social services.

- 15 focus group meetings were held at various times and in numerous locations throughout Shasta County. Over 200 community members participated in PEI focus groups.

Focus Group Tool

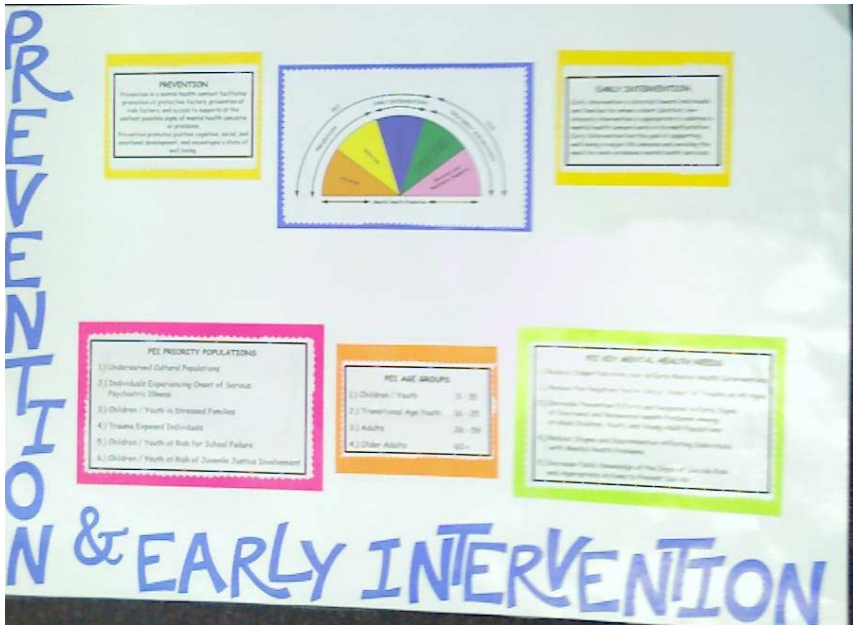
- Brief Overview of Prevention & Early Intervention

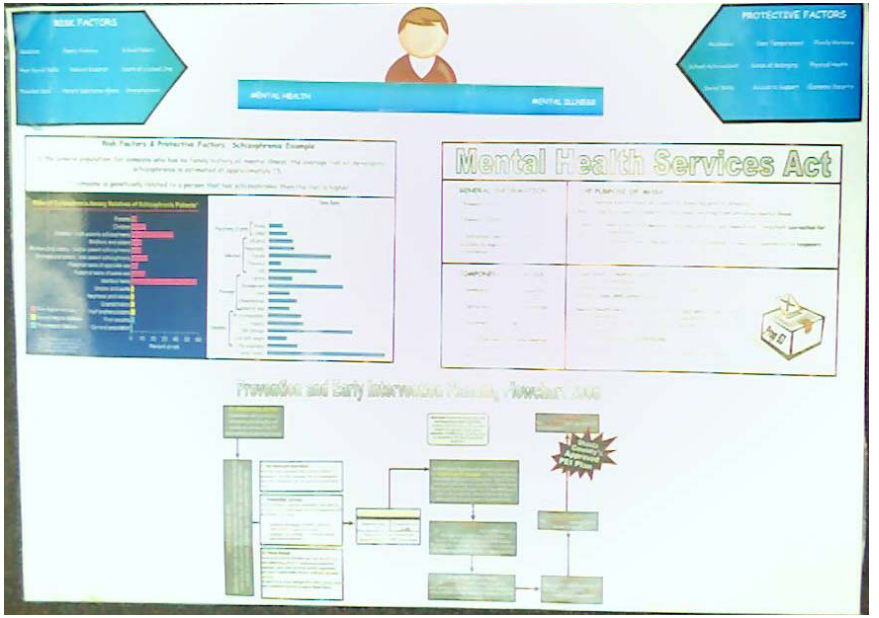
- Activity 1: Priority Area Ranking
  - Focus group participants were allowed to rank the following areas: age groups, key mental health needs, and priority populations.
  - Ranking was determined by group totals

- Activity 2: Consensus Workshop
  - Focus group participants were asked to individually brainstorm around the following focus question: What interventions should be included in the Prevention & Early Intervention Plan?
  - Ideas presented by the group were clustered and named using a facilitation method called Consensus Workshop.

Focus Group Tool

- A brief PEI presentation was delivered at the beginning of each focus group.
  - To facilitate stakeholder understanding and to make it easier to participate in focus group activities, a visual display called the PEI placemat was created and utilized.





Prevention & Early Intervention Focus Group General Information

	Participants	Date	Time	Location	# of Participants
1	CBO & MH Providers	02/11/08	2:00 – 4:00	Northern Valley Catholic Social Services	14
2	Youth: HIP	02/11/08	6:30 – 8:30	Health Improvement Partnership	6
3	Education	02/25/08	10:00 - 12:00	Shasta County Office of Education	28
4	Shingletown	03/03/08	11:30 – 1:30	Grass Roots	7
5	Youth: Oasis School	03/04/08	12:00 – 2:00	Oasis School	18
6	Redding	03/04/08	7:00 – 9:00	Northern Valley Catholic Social Services	38
7	Underserved Cultural Populations	03/06/08	11:30 – 1:30	Anderson Teen Center	20
8	Shasta Lake City	03/06/08	6:00 – 8:00	Jon Beaudet Community Center	0
9	Anderson	03/11/08	6:00 – 8:00	Anderson Library	6
10	Burney	03/12/08	6:00 – 8:00	Intermountain Community Clinic	9
11	HHSA Expanded Cabinet	03/18/08	1:30 – 3:30	Shasta County Public Health	16
12	Mental Health Staff	03/19/08	12:00 – 2:00	Shasta County Mental Health	10
13	Drug & Alcohol Advisory Board	03/19/08	4:00 – 6:00	Bloodsource	16
14	Client 1	03/31/08	12:00 – 2:00	Northern Valley Catholic Social Services	10
15	Client & Family Member	03/31/08	6:00 – 8:00	Shasta County Mae Helene Bacon Boggs Conference Center	10
16	Client 2	04/01/08	5:00 – 7:00	NVCSS 2nd Home	10

PEI Focus Group Results: Age Groups

	Children/Youth 0 – 15 years	Transitional Age Youth 16 – 25 years	Adults 26 – 59 years	Older Adults 60 + years
CBO & MH Providers	1	2	3	4
Youth: HIP	2	1	3	4
Education	1	2	3	4
Shingletown	1	2	4	3
Youth:Oasis School	1 TIE	1 TIE	3	4
Redding	2	1	3	4
Underserved CulturalPopulation	2	1	3	4
Anderson	1	2	3 TIE	3 TIE
Burney	1	2	4	3
HHSA Expanded Cabinet	1	2	4	3
Mental Health Staff	2	1	3	4
Drug & Alcohol Advisory Board	1	2	3	4
Client 1	3	1	2	4
Client & Family Member	1	2	3	4
Client 2	2 TIE	4	2 TIE	1
Total	22	26	46	57

PEI Focus Group Results: Key Mental Health Needs

	Reduce disparities in access to early mental health interventions	Reduce the negative psycho-social impact of trauma on all ages	Increase prevention efforts and response to early signs of emotional and behavioral health problems among at-risk children, youth, and young adult populations	Reduce stigma and discrimination affecting individuals with mental health problems	Increase public knowledge of the signs of suicide risk and appropriate actions to prevent
CBO & MH Providers	3	2	1	4	5
Youth: HIP	2	3	1	5	4
Education	2	3	1	5	4
Shingletown	1	4	1	3	5
Youth:Oasis School	4tie	4tie	3	2	1
Redding	3	5	1	4	2
Underserved CulturalPopulation	4tie	3	1	2	4tie
Anderson	4	3	1	5	2
Burney	5	4	1	2	3
HHSA Expanded Cabinet	3	1	2	4	5
Mental Health Staff	4	3	1	2	5
Drug & Alcohol Advisory Board	2tie	1	2tie	4tie	4tie
Client 1	5	2	3	1	3
Client & Family Member	3	2	1	4	5
Client 2	2	1	3	5	4
Total	47	41	23	52	56

PEI Focus Group Results: Priority Populations

	Underserved cultural populations	Individuals experiencing onset of serious psychiatric illness	Children/youth in stressed families	Trauma-exposed individuals	Children/youth at risk for school failure	Children/youth at risk of juvenile justice involvement
CBO & MH Providers	3	6	1	2	4	5
Youth: HIP	1	3	4	2	6	5
Education	6	5	2	3	1	4
Shingletown	6	1	2 TIE	2 TIE	5	4
Youth:Oasis School	6	1	2	3	5	4
Redding	6	1	3	2	4	5
Underserved CulturalPopulation	3	1TIE	1 TIE	4	5	6
Anderson	6	3	1	2	4	5
Burney	6	5	1	2 TIE	4	2 TIE
HHSA Expanded Cabinet	6	3	1	2	5	4
Mental Health Staff	5	1	4	2	3	6
Drug & Alcohol Advisory Board	6	4	2	5	1	3
Client 1	6	3	1	2	4	5
Client & Family Member	6	1	2	3	5	4
Client 2	6	4	1	3	5	2
Total	78	42	28	39	61	64

PEI Focus Group Results: Consensus Workshop

CBO & MH Providers	Community Education & Interventions for Targeted Populations	Early Childhood Interventions	Integrated Health Services	Parent / Caregiver Education & Support	Cultural & Community Based Support	Public Awareness via Media Outlets
Youth: HIP	Increase Awareness of	Increase Access	Increase Support	Positive Activities	School Outreach	Promote Mental Health
Education	Support Groups	Educational Staff Awareness & Intervention Training	Campus-Based Services	Parent Education & Support	Community Education	Increase School-Based Mental Health Staff
	Perinatal Services					
Shingletown	Alternatives & Supports for Children / Youth	Parent Education & Support	Support Groups	Broaden Services & Access	Community Education	Senior Support
	Support & Linkage to Services					
Youth:Oasis School	After-School Activities for Youth	Support Groups	School Success Support & Resources	Family Support	Economic Support	
Redding	Specialized Training for Educators	Peer to Peer Social Networks	Access to Housing & Shelter	Suicide Prevention & Education	Family Respite, Education & Support	Mental Health Court
	Adoption Education & Support Services	Public Awareness Campaign to Decrease Stigma	Mobile Outreach	Early Intervention for 0 – 5	Crisis Residential for Youth	

Underserved CulturalPopulation	Increase Access	Community Outreach, Education & Support	Culturally Competent Services & Staff	Mental Health Services for 0 – 5	Youth Friendly Services & Supports	Perinatal Services
	Increase Access to Basic Needs					
Anderson	Education for Community & School	Increase Access to Services	Early Diagnosis & Intervention	Infant Mental Health Services	Increase Support Groups	Meet Basic Needs
	Awareness for Youth					
Burney	Community Education & Interventions	Education & Interventions for Youth	Community Suicide Prevention Programs	Increase Culturally Competent Services	Pregnancy Support	Education & Support for Families
HHSA Expanded Cabinet	Expand 40 Developmental Assets Awareness	Suicide Prevention & Awareness	Violence Awareness & Prevention	Destigmatization	Enhanced Supports for Children in CFS	Bereavement Support
	Nurse Family Partnerships	Design Communities to Promote Mental Wellbeing	Training for & Screening by Primary Care Providers			
Mental Health Staff	Increase Community Prevention & Early Intervention	Increase Understanding & Awareness for Schools	Culturally Competent Community Outreach	Increasing Community-Based Services	User Friendly Services	
Drug & Alcohol Advisory Board	Increase Youth Awareness, Prevention & Early Intervention	Increase Awareness & Education	Crisis Interventions	Parent Education & Support	Support Groups	Employment Assistance

Client 1	Provide Supportive Programs	Create Training & Learning Opportunities	Increase Community Activities	Increase Outreach & Access	Prevention & Early Intervention Services & Supports	Help with Basic Needs
Client & Family Member	Crisis Prevention & Early Intervention	Family Support & Services	Appropriate School Environment	Youth Interventions & Supports	Help Legal System Understand MI & Appropriate Interventions	Family Focused Substance Abuse Services
	Cool Down Place for Youth	Increase Training & Awareness for School Staff	Decrease Stigma			
Client 2	Provide Help & Supportive Programs	Help with Basic Needs	Family Resources & Support	Increased Community Activities	Provide Learning & Training Opportunities	Increase MH Training for Community

PEI Survey Documents

Survey Description
Hard-Copy Survey
Online Survey (English)
Online Survey (Spanish)
Survey Result Summaries

Survey

- Surveys were designed to ascertain stakeholders input about key community mental health needs, priority populations, protective factors, risk factors and negative outcomes.

- Surveys were available online at shastamentalhealth.net. The online survey also provided participants with the opportunity to comment on selections. 175 community members filled out a online survey.

- Surveys were also available in hardcopy form in community locations. A variety of locations such as WIC, NVCSS 2nd Home, NAMI, Public Health Regional Offices, YMCA, Multicultural Celebration, etc… were selected to allow for diverse participation. 370 community members filled out a hardcopy survey.

MENTAL HEALTH PREVENTION AND EARLY INTERVENTION SURVEY

Shasta County Mental Health is planning a new program called Prevention and Early Intervention (PEI). The PEI plan will include interventions that will prevent or decrease mental illness. Fill out both sides of this survey and help set priorities for the PEI plan.

KEY PEI COMMUNITY MENTAL HEALTH NEEDS

Mark the box next to the 2 Key PEI Community Mental Health Needs you think could have the most impact on our community.

- ☐ Decrease disparities in access to mental health services
- ☐ Decrease the negative impact of trauma on all ages
- ☐ Decrease stigma and discrimination affecting individuals with mental illness
- ☐ Increase knowledge of the signs of suicide risk and appropriate actions to prevent suicide
- ☐ Increase prevention efforts and response to early signs of emotional and behavioral health problems among youth

PEI PRIORITY POPULATIONS

Mark the box next to the 2 PEI Priority Populations you think need the most help from PEI programs.

- ☐ Underserved cultural populations
- ☐ People who are experiencing the onset of serious psychiatric illness
- ☐ Children/youth in stressed families
- ☐ Trauma-exposed individuals (e.g., child abuse, domestic violence, war veterans, etc…)
- ☐ Children/youth at risk for school failure
- ☐ Children/youth at risk of juvenile justice involvement

WIN A PRIZE

Thank you for participating in this survey and the PEI planning process.
If you would like to be entered into a drawing for $100 worth of prizes ($25 gift cards), please fill in the information below.

Name:_____ Phone #:_____

Address: _____

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Name:_____ Phone #:_____

Address: _____

PEI PROTECTIVE FACTORS

Mark the box next to the 2 PEI Protective Factors you think are the most important to preventing mental illness or promoting mental well-being.

- ☐ Positive child/adult relationships
- ☐ ivity, which decreases depression
- ☐ Physical act
- ☐ Contact with nature
- ☐ Adequate housing
- ☐ Sense of belonging to a community or social connectedness
- ☐ Overall happiness of the community

PEI RISK FACTORS

Mark the box next to the 2 PEI Risk Factors you think are the most important in contributing to mental illness.

- ☐ Child abuse or neglect
- ☐ Maternal depression or infant bonding
- ☐ lent media viewing (screen time)
- ☐ Excess vio
- ☐ Alcohol and other drug abuse
- ☐ Teen pregnancy/ low birth weight/ premature birth
- ☐ lence
- ☐ Domestic Vio

NEGATIVE OUTCOMES TO DECREASE

Mark the box next to the 2 Negative Outcomes that may result from mental illness that you think PEI should target first:

- ☐ Suicide
- ☐ Jail or Prison
- ☐ School Failure / Drop Out
- ☐ Unemployment
- ☐ Prolonged Suffering
- ☐ Homelessness
- ☐ Removal of Children from Their Homes

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- ☐ Homelessness
- ☐ Removal of Children from Their Homes

MH Prevention & Early Intervention Survey

Mental Health Prevention and Early Intervention Survey

Shasta County Mental Health is currently in the planning stage for a new Mental Health Services Act component called Prevention and Early Intervention (PEI).

The focus on prevention and early intervention for mental health problems and mental disorders represents a major and exciting direction for mental health activities in Shasta County, complementing and expanding the current focus on treatment.

A PEI approach to mental health, prevents and intervenes early in the pathways to mental illness through strategies involving individuals, communities and whole population groups.

The PEI plan will aim to provide a comprehensive range of high-quality, mental health promoting programs, while striving to achieve equity of mental health service access and utilization across the population.

However, resources are limited and choices must be made about which services can be offered to whom, and those decisions on allocating resources must be based on evidence of need and stakeholder input .

The Mental Health Services Oversight and Accountability Commission and State Department of Mental Health have targeted five key community health needs and six priority populations for PEI planning. Please fill out this survey and help SCMH set funding priorities based on these guidelines.

Thank you.

MH Prevention & Early Intervention Survey

Key PEI Community Mental Health Needs

Mark the box next to the 2 Key PEI Community Mental Health Needs you think could have the most impact on our community.

- [ ] Decrease disparities in access to mental health services
- [ ] Decrease the negative impact of trauma on all ages
- [ ] Decrease stigma and discrimination affecting individuals with mental illness
- [ ] Increase knowledge of the signs of suicide risk and appropriate actions to prevent suicide
- [ ] Increase prevention efforts and response to early signs of emotional and behavioral health problems among youth

Please explain why you chose these or add any other comment you have about Community Mental Health Needs (optional)

MH Prevention & Early Intervention Survey

PEI Priority Populations

Mark the box next to the 2 PEI Priority Populations you think need the most help from PEI programs.

- [ ] Underserved cultural populations
- [ ] People who are experiencing the onset of serious psychiatric illness
- [ ] Children/youth in stressed families
- [ ] Trauma-exposed individuals (e.g., child abuse, domestic violence, etc...)
- [ ] Children/youth at risk for school failure
- [ ] Children/youth at risk of juvenile justice involvement

Please explain why you chose these or add any other comment you have about Priority Populations (optional)

MH Prevention & Early Intervention Survey

PEI Protective Factors

Mark the box next to the 2 PEI Protective Factors you think are the most important to preventing mental illness or promoting mental well-being.

- [ ] Positive child/adult relationships
- [ ] Physical Activity, which decreases depression
- [ ] Contact with nature
- [ ] Adequate housing
- [ ] Sense of belonging to a community or social connectedness
- [ ] Overall happiness of the community

Please explain why you chose these or add any other comment you have about Protective Factors (optional)

MH Prevention & Early Intervention Survey

PEI Risk Factors

Mark the box next to the 2 PEI Risk Factors you think are the most important in contributing to mental illness.

- [ ] Child abuse or neglect
- [ ] Maternal depression or infant bonding
- [ ] Excess violent media viewing (screen time)
- [ ] Alcohol and other drug abuse
- [ ] Teen pregnancy/low birth weight/premature birth
- [ ] Domestic Violence

Please explain why you chose these or add any other comment you have about Risk Factors (optional)

MH Prevention & Early Intervention Survey

Negative Outcomes to Decrease

Mark the box next to the 2 Negative Outcomes that may result from mental illness that you think PEI should target first.

- [ ] Suicide
- [ ] Jail or Prison
- [ ] School Failure/Drop Out
- [ ] Unemployment
- [ ] Prolonged Suffering
- [ ] Homelessness
- [ ] Removal of Children from Their Homes

Please explain why you chose these or add any other comment you have about Negative Outcomes (optional)

MH Prevention & Early Intervention Survey

Win a Prize

Thank you for participating in this survey and the PEI planning process. If you would like to be entered into a drawing for a $25 gift card, please fill in the information below.

Name:

Address:

Phone #:

Spanish MH Prevention & Early Intervention Survey

Encuesta para la prevención e intervención precoz (o temprana) acerca de sa...

El departamento de Salud Mental del Condado de Shasta está a pasos de planificar una nueva componente de de la ley conocida como MHSA (Mental Health Services Act por sus siglas en inglés). Esta nueva componente, se la conocerá como PEI (Prevention and Early Intervención por sus siglas en inglés). La cual traducida al español quiere decir: (Prevención e Intervención precoz).

El centro de atención a la prevención e intervención temprana hacia los problemas o desórdenes de salud mental, representa una nueva y amplia dirección para las actividades de atención a los miembros de nuestra comunidad así mismo complementando y ampliando el presente enfoque de tratamiento.

Usando el PEI para mantener la salud mental, previene y se interviene a tiempo y antes especialmente cuando los síntomas de enfermedades mentales empiezan a brotar. Esto se hace involucrando a personas individualmente, a la comunidad y a toda clase de grupo en nuestra población.

El plan PEI tratara de proveer una escala muy detallada y de gran calidad para fomentar programas de salud mental, al mismo tiempo tratando de lograr igualdad para obtener servicios de salud mental así como el derecho de usarlos por toda la población.

Sin embargo, los recursos son limitados y las alternativas que se tomen deben considerar que servicios se deben prestar a quienes y estas decisiones de cómo asignar estos recursos deben estar establecidas por evidente necesidad y también teniendo aporte de personas que están afectadas o interesadas.

La comisión estatal que supervisa servicios de salud mental (The Mental Health Services Oversight and Accountability Commission) Así como el departamento estatal de salud mental (State Department of Mental Health) han decidido de enfocar a cinco aspectos necesarios para la salud mental de la comunidad así como a seis partes de la población que tuvieran prioridad en la planificación del PEI. Por favor sea gentil y llene esta encuesta para ayudar al departamento de salud mental del Condado de Shasta (Shasta County Mental Health; SCMH por sus siglas en inglés) como decidir prioridad de financiación usando estas normas.

Gracias

Spanish MH Prevention & Early Intervention Survey

Necesidades urgentes definidas por el PEI para solucionar insuficiencias qu...

Anote en sus cuadrados respectivos, 2 necesidades urgentes que usted piensa, tendrán el mayor impacto en la implementación de PEI (planificación) de salud mental para nuestra comunidad.

- [ ] Disminución de disparidades para poder recibir servicios de salud mental
- [ ] Disminuir el impacto negativo de un trauma a toda edad
- [ ] Disminuir el estigma y la discriminación que afecta a personas que sufren de enfermedades mentales.
- [ ] Ampliar el reconocimiento de síntomas o señales de personas que corren riesgo de suicidio y que acciones pueden prevenirlo
- [ ] Aumentar los esfuerzos de prevención y como responder a tiempo cuando hay síntomas o señales de problemas emocionales o de comportamiento entre o de jóvenes

Por favor anote la razón por la cual usted escogió lo que escogió o añada cualquier comentario que usted tenga acerca de la salud mental de nuestra comunidad. (Opcional)

Spanish MH Prevention & Early Intervention Survey

Sectores de la población que tienen prioridad de acuerdo al PEI

Anote en sus cuadrados respectivos cuales usted piensa son los 2 Sectores de la población que tienen prioridad de acuerdo al PEI que necesitan mas atención y ayuda.

- [ ] Sectores culturales de la comunidad que están desatendidos o reciben servicios incompletos
- [ ] Personas que sienten el comienzo o están comenzando a sentirse enfermas con problemas psiquiátricos
- [ ] Niños o adolescentes (jóvenes) que provienen de familias estresadas
- [ ] Personas expuestas a un trauma (ejemplo: maltrato doméstico, maltrato o abuso corporal o sexual de niños, etcétera)
- [ ] Niños o adolescentes (jóvenes) que están a riesgo de fracasar en la escuela o colegio
- [ ] Niños o adolescentes (jóvenes) que están a riesgo de deslizarse a ser parte del sistema juvenil de justicia

Por favor anote la razón por la cual usted escogió lo que escogió o añada cualquier comentario que usted tenga acerca de Sectores de la población que tienen prioridad de acuerdo al PEI. (Opcional)

Spanish MH Prevention & Early Intervention Survey

Factores de protección del PEI

Anote en sus cuadrados respectivos cuales usted piensa son los 2 Factores de protección del PEI que son mas importantes en la prevención de enfermedades mentales o para fomentar el bienestar mental.

- [ ] Relaciones o comportamiento positivo entre adultos y niños
- [ ] Ejercicios o actividad física lo cual disminuye la depresión
- [ ] Empezar a hacer contacto con la naturaleza.
- [ ] Vivienda tolerable
- [ ] Sentirse como parte de una comunidad o sentir estar emparentado socialmente
- [ ] Bienestar general de la comunidad

Por favor anote la razón por la cual usted escogió lo que escogió o añada cualquier comentario que usted tenga acerca Factores de protección del PEI (Opcional)

Spanish MH Prevention & Early Intervention Survey

Peligros vistos por PEI que contribuyen a salud mental

Anote en sus cuadrados respectivos cuales usted piensa son los 2 Peligros vistos por PEI que contribuyen a salud mental.

- [ ] Maltrato o abuso corporal o sexual de niños
- [ ] Depresión maternal (de parto) o adherirse al bebé
- [ ] Exceso de ver violencia en películas o televisión o de juegos violentos
- [ ] Abuso de alcohol o drogas ilegales
- [ ] Embarazo de mujeres menores/nacimiento con paso muy liviano/o nacimiento prematuro
- [ ] Maltrato doméstico

Por favor anote la razón por la cual usted escogió lo que escogió o añada cualquier comentario que usted tenga acerca Peligros vistos por PEI que contribuyen a salud mental (Opcional)

Spanish MH Prevention & Early Intervention Survey

Resultados negativos a decrecer

Anote en sus cuadrados respectivos 2 Resultados negativos quienes resultarían de haber tenido o teniendo enfermedad mental y en los cuales PEI debería de concentrarse.

- [ ] Suicidio
- [ ] Cárcel o prisión
- [ ] Fracasar en la escuela o colegio o dejar de estudiar por flojera
- [ ] Desempleo
- [ ] Sufrimiento prolongado
- [ ] Personas (forasteros) sin hogar
- [ ] Descartar a niños (o niñas) de sus hogares llevándolos a otro lugar

Por favor anote la razón por la cual usted escogió lo que escogió o añada cualquier comentario que usted tenga acerca Peligros vistos por PEI que contribuyen a salud mental (opcional)

Spanish MH Prevention & Early Intervention Survey

Gane un premio

Gracias por tomar parte en esta encuesta y en el proceso de la planificación por el PEI. Si desea, llene ese formulario para un sorteo de una tarjeta de regalo que esta avaluada en $25,00 dólares.

Nombre:

Dirección:

Numero de telefono:

PEI Survey Results: Key Mental Health Needs

Ranking

	Reduce disparities in access to early mental health interventions	Reduce the negative psycho-social impact of trauma on all ages	Increase prevention efforts and response to early signs of emotional and behavioral health problems among at-risk children, youth, and young adult populations	Reduce stigma and discrimination affecting individuals with mental health problems	Increase public knowledge of the signs of suicide risk and appropriate actions to prevent
Online	2	4 tie	1	3	4 tie
Percentage	43%	22%	74%	36%	22%
Response	75	38	130	63	38
Hardcopy	3	5	1	4	2
Percentage	33%	24%	68%	27%	40%
Response	119	88	247	99	145

Online Comments

1. It is difficult for people to access care. They have no insurance, they don't make enough money to pay for the care but make to much to qualify for public assistance or granted programs to get help. 2. Youth are under a lot more stress than in the
Access to mental health services is crucial to maintaining stability to existing clients & new. Stability and autonomy is imperative
Access to services proves difficult in many ways at all income levels and can be impetus for potential benficiaries of services giving up. The emotional issues of young people are often discounted as "a phase" or put down as bad behavior rather than re
All of these issues are vitally important. Because I work with populations of generally very limited financial resources, access is a major issue. Acceptance of the need and of the help available is an issue for all ages and income strata.
As a MH service provider, I perceive that the stigma of mental illness is a significant factor impacting funding for services. This, of course, means fewer services and those in existence stretched very thin. I think this happens at all levels, up to and
Child/Adult abuse can cause or trigger many mental illnesses. Education and Prevention is the key!
Decreasing stigma should help people seek services more readily (earlier). Decreasing stigma is also critical to recovery (being accepted and recognized as important is necessary for anyone's mental health and well being). Prevention and response to ear
early id and intervention with young people will decrease the #'s of problems that escalate. Ability of people to access services early and continuously in a timely manner will also decrease escalation.
Early intervention has the most chance of success and overcoming stigmas will reduce a barrier to getting help.
early prevention and recognizing those early signs is most necessary and may prevent long term or extreme consequences
Early prevention would help children have a better chance at education, treatment, and be able to interact with others.
Effective mental health/psychiatric services are unavailable to a large proportion of our population - the working poor, uninsured, underiinsured. Mental health services tend to focus on those who are already dysfunctional and ignores those who could be h
Helping indigent, unisured population first. Calworks and SSI recipients have medi-cal, therefore they can receive needed services.
I also think better education to the public about signs of mental health problems especially in youth would be great. I wish I'd known more and I often wonder if I had, if I would've been able to identify the early signs of mental illness for my daughter.

I am currently working as a MFT Trainee at a local school and see that kids already have the idea that seeing a counselor means that thay are "screwed up" and I also believe that the earlier we start with intervention the better chance an individual has f
I believe if we, as a community, can recognize early, early signs of mental health issues, we can prevent by intervention. For those of us who struggle with mental health issues, it's important to know we can ask for help without prejudice.
I believe PEI efforts need to be very broad --- ALL parents of young children need information of early signs of emotional or behavioral health problems and related tools or resources to ensure quick intervention. Early intervention will provide success
I believe prevention is an essential key. It would be benefical for the whole community to increase knowledge and to help youth who are trying to understand themselves and do not know what may be happening to them mentally. Youth need to understand that
I believe that if you decrease negative trauma and identify that as a cause for mental Health hchallenges instead of labeling and isolating individuals thus causing them to self stigmatize and be stigmatized by family and community. Mental Health Drugs a
I believe that Prevention and early intervention for substance abusers would be my second prioritiy if it had been listed.
I chose those responses because of my own personal life. Both my husband and I were taught from a very young age that seeking help for mental illness was "wrong" or not needed. People need to realize that it is a mental ILLNESS, just like a heart conditio
I feel people would be more likely to seek help if the stigma and discrimination associated with mental health were reduced or eliminated.
I feel prevention dollars are better spent trying to head off a problem before it escalates.
I think that when people hear "Mental Illness" there is an automatic response of awkwardness or uncomfortable with the issue. I feel like this is due to people not having full understanding of what "Mental Illness" really means. I also feel like preventio
I think these questions are written very poorly, and I am wondering if you really want information from all segments of our population.
I think we all need to learn to treat everyone with compassion and understanding and know that mental illness is as serious as a physical illness and can stem from physical problems in the brain. Suicide rate is too high in Shasta County! We need to let
If mental health issues can be addressed BEFORE they manifest into anti-social behavior, society would be better off and there would be less of a need for mental health services.
If the gateway has fewer barriers, then more people will access services earlier and timely. This will help prevent escalation and all the fallout -- loss of job and housing and diminished quality of life and family turmoil.
If we can redirect the youth, thru intervention, assessment and treatment, most can become contributing adults who can and will take responsibility for their actions - to the extent their limitations allow. Most youth grow up thinking they are "Normal" an
If we can save one life we are ahead of the game. Having this knowledge to detect the risk of suicide is a plus so that we can work with the individual to stop him/her from hurting themselves or someone else.
If we really want to deter our suicide rate we need to start young in the prevention efforts because youth are the ones when they can't cope with emotions or trauma need help so they don't feel hopeless in life. Also, decreasing stigma will make it easier
If we were more aware of early signs some of emotional problems that happen with our youth
If you can prevent mental health issues, there is less of a problem. We need to work with the low income population and let them have early access to services (Even letting them know what MediCal covers -- like therapies and such-- and finding ways to
If you prevent and treat emotional and behavioral health problems in the youth, my thought is you will create a healthier adult population. You cannot help those in need without access.
In the first 3-5 years of life, the foundation for mental and emotional health is laid. Preventing adverse experiences and offering early intervention to emotional and behavioral problems during these years has been strongly demonstrated to have positive
It is difficult to have access to services in rural areas. Medical Doctors are prescribing mood-altering drugs without ever addressing the patients actual problems.
It is next to impossible to get a patient in to County Mental Health

It is very hard for people to access m\h resources in our community and th qualtiy of care is poor. I also feel that the earlier that an issue is addressed the better the treatment outcome will be
Mental Health services need to be provided when a person is not in crisis. A lot of the MH focus in this community is on crisis response. There needs to be much more focus on prevention.
My impression is that mental health services are available in our community, but are not always accessed. If we increase prevention efforts and make it okay to access services we will reduce the number who need services and increase the chance that they
PEOPLE NEED ACCESS TO MENTAL HEALTH PROFESSIONALS WHEN THEY HAVE ISSUES DESPITE WHAT THEIR INCOME IS. THEY NEED HELP UNTIL THE ISSUES ARE RESOLVED, NOT WHEN THE AUTHORIZATION OR MONEY RUNS OUT.
People who do not understand mental illness or how it can affect the individual and the family of the individual wouldn't be so intimidated by someone with a mental illness. They might learn how to be compassionate toward these individuals. Awareness is a
people with mental illness need help right away, not have to make a future appt that they may not be able, or will not attend, because they are ill NOW. they may feel fine on the scheduled appt day and not attend but the next day they may have serious is
preventing trauma, such as child abuse or intimate partner violence, is feasible, prevents long-term suffering and physical and mental illness, and saves cost. focusing on mental well-being of children and youth through supporting protective factors as
Prevention is so important, yet there are limited resources available for preventative programs.
rationale: disparities in access to care are well documented and access to care assurance is a core structural componant of preventive mental health services. Focusing on youth makes the most sense in terms of economics, potential for safety and stabilit
Should be more proactive with the mental health population especially children to get them tied into mental health services early on to prevent later problems.
Stigma and discrimination promotes denial of a problem. In order to tackle and win over mental illness we all need to acknowledge it's real, it can be solved and anyone is vulnerable. The younger we start preventing and/or treating the less pain and su
Suicide rates are very high in our county. This is a large problem. However, it is fairly far downstream, and perhaps intervening earlier may be more effective. As I understand it, many mental health problems have roots in early development. Starting y
The community needs to be educated on risk factors, signs of suicide, and how they can help. We can't help others if we don't know what to do or how to connect individuals to help. Prevention is key!
The most common complaint I hear from the recipient's that use the Mental Health system is they have to wait forever for an appt. or they can never get ahold of their Doctor.
The power to change things lies within our young and giving them knowledge is giving them power.
The statments above seem to suggest doing something will control Mental Health Problems. The creation of M:H proboems is cpmplex and the treatment also will be complex. 1 thing is trying to see the extent that parents play in the manifestion of a child il
The stigma attached to mental illness may prevent those afflicted from seeking help. Members of the community may react fearfully and negatively toward those displaying acute symptoms. Many may shy away from these people. If a person displayed symptoms
The world is a different place than years past - much more stress, people not living near loving relatives, everything more expensive. People need to feel "safe" in their environment or they will begin to have issues like OCD, PTSD, etc.
There are numerous needs in the community. Access to services do rank among the highest in all areas.
There are youth out there who need help and adults think it's just their rebellious stage. It is important that more people are made aware of the signs of suicide; it only takes one person to prevent someone from ending their life.
There is confusion in the general population about how a person goes about getting mental/emotional help. If this is what is meant by "decrease the disparities..." then yes, make it easier for all folks tog oto a location and speak with someone about thei
There is only one! None of the others matter if there is no access to basic mental health care.
Trauma occurs to a large number of individuals of all ages and other demographic factors in this county. Trauma often causes long-term mental health issues and difficulty in forming healthy relationships. I think research shows that stress increases the

PEI Survey Results: Priority Populations

Ranking

	Underserved cultural populations	Individuals experiencing onset of serious psychiatric illness	Children/youth in stressed families	Trauma-exposed individuals	Children/youth at risk for school failure	Children/youth at risk of juvenile justice involvement
On-Line	6	3	2	1	5	4
Percentage	9%	45	50%	52%	19%	21%
Response	16	77	85	89	33	36
Hardcopy	6	3	1	2	4	5
Percentage	11%	34%	52%	51%	25%	22%
Response	38	125	187	185	90	78

Online Comments

Again, a very difficult choice to limit my selection to only 2 groups. Stressed families lead to all of the other issues with youth: trauma, school failure and juvenile justice involvment. Help for stressed families may decrease the progression to need of the other services. The onset of a serious psych illness needs immediate, compassionate available assistance.
Again, both of these with earlier interventions would lessen mental health issues long term and perhaps avoid you treating them as adults or treating their coping solutions such as drug/alcohol abuse, gambling, or abusing or being violent to others.
allocating signficant portion of PEI funding to children and youth will yield the most long-term positive impact for the limited resources available, before the onset of mental illness in young adulthood or later life. preventing adverse childhood experiences, such as experiencing or witnessing trauma, has huge payoff to individuals, families and society based on a very solid scientific evidence base and common sense.
As with any chronic illness, the need for support and information is right after diagnosis. Enabling a person with mental illness with information and the tools to "self manage" their condition eventually has got to be priority #1. After this-- it gets very hard to prioritize. Kids need basic mental health skills to take them through adulthood. Hopefully, this reduces the number of "stressed families" and trauma exposed individuals in the next generation.... hopefully. If numbers don't bear this out, then I suppose I would rethink this.
Children are our future. If we can help one child or prevent one child with dealing with stress it may keep some children from being at risk of being in the juvenille and adult justice system.
Difficult decision but I think that by helping the individuals we have a chance of them creating a more stable environment for their children, thus having less abuse and traumatic situations. Also, I think that this would decrease the stigma about seeing a mental health professional and increase awareness of the onset of more serious illness.
Early intervention among children & youth has most chance of success
Early intervention!
Families offer the most critical experiences in a young child's emotional, mental and behavioral development. Families in stress through poverty, alcohol and drug influences, inadequate resources and inadequate skills for parenting are most apt to offer negative experiences that impact a child through a lifespan. If a child reaches kindergarten ill-prepared to learn, distracted by emotional, mental and behavioral stress, the trajectory for future success is bleak.

Helping families cope and teaching children healthy coping strategies can reduce problems in future generations. I think research shows that for those with genetic predisposition to schizophrenia, exposure to stress makes them much more likely to manifest the disorder. While the onset of serious psychiatric illness may be too late to prevent the illness itself, it is an opportunity to help the individual and family cope and enter treatment. This area probably needs policy change, such as ammending the "danger to self or others" criterion before treatment can be imposed. It may also require expanding group housing and other housing options.
Hopefully, better addressing this iwll prevent escalation to the other categories.
How can you only pick 2...all of these populations need help.
I ACTUALLY THINK THAT EVERYONE WHO NEEDS HELP SHOULD BE ABLE TO GET IT, BUT I CHOSE THE CHILDREN UNDER STRESS AND TRAUMA BECAUSE THEY HAVE IMMEDIATE NEEDS.
I believe that these two would be important because if we can change the behavioral patterns of those who are trauma-exposed and at risk for school failure. If children succeed in school they are less likely to drop out and get into other forms of trouble.
I chose the 2 areas I feel will lead to the school failure and juvenile justice involvement if we do not step up and help families.
I lot of good can come from diverting psychiatric illness, and a little money would go a long way in identifying those approaching crisis. And I always answer youth.
I think PEI should address populations that are at risk of mental illness, not those already experiencing mental illness. PEI is about prevention.
I think they are underserved and there are alot of people not getting help
I think we need to stave off the risk of suicide in the high risk group of people with serious psychiatric illnesses. If trauma can lead to serious mental health issues, we need to nip that in the bud quickly!
If we can assist them at this age it may help stop the crime as they get older.
If we can get a grip of the youth, our following generations will benefit immensely.
Intervention early in children's lives can do so much to prevent issues of Juvenile justice and school failure.
Issues surfacing in connection to school failure may be a reflection of deeper issues that could be addressed, improving the lives of children/youth and helping them continue with meaningful education efforts. Trauma exposure trips up everyone in the community with a snowball effect.
Many times I ahve talked with people who really want to help a person they know who is experiencing serious psychic problems and don't know how to help them. Where to advise them to go. Children, being "our" future can benefit from resources outside of their family situation to help them understand that they are involved yes but can learn how to deal with their situation i such a way that the scars heal to allow them to reach their own life without the baggage from their families inhibiting them. ("Group therapy in every school as the first class of the day..." :)
once again, the sooner the better
See my previous comments for question 1. Trauma stays with you your whole life unless you actively work with a therapist. Even if you do not remember trauma, your physical body remembers it and will act accordingly.
single adults are a very much underserved group
So many people don't get the help they need because they are poor or don't know the resources available to them. I also think that especially children who come from abusive environments don't get the help they need for them to get mentally and physically better.
The homeless population or those at risk for becoming homeless (transitional housing, "couch-surfing" is a significant population not mentioned here. This population cannot provide basic needs for themselves, partly because they have significant mental health issues that are not being addressed/treated. This population also has a very difficult time accessing and/or qualifying for services.
The majority of the choices above will manifest in teh schools and in potential juvenile involvement with law enforcement.
The substance abusing population would be my second priority.
There are already programs out there to help juveniles, domestic violence and child abuse.
There are many psychiatric needs all around us. We are sometimes very helpless to meet those needs, even though it is very apparent they are there.
There must be an equal emphasis on those people who are chronic and persistently mentally ill and who already have been identified

There needs to be more bilingual mental health professionals who understand hispanic and other minorities. There doesnt seem to be any programs for at risk youth as a preventative and specialized, and we dont have any inpatient hospitals here locally that can assist w/ support and stabilization of acute psychiatric illnesses
There seem to be several people in our community that are either not getting mental health services that desperately need it or they are not taking their meds. The children/youth need more services that can be available to them without the "stigma" that is attached
These kids can only change by learning what is different. Prevention can teach them what is wrong in their enviroment and give them the tools to change things for their future.
they all are important but i see at calworks stressed and abused people on a daily basis & wish i had the knowledge to help.
This was a tough choice. I think that, because of the cultural orientation of most MH and perhaps other service providers, we tend to more readily recognize distress in others of our cultural group. This means that, in yet another way, those of other cultures often remain invisible. We need to be actively learning to reach out across the cultural barrier and training ourselves to see distress wherever it exists. We already know that most children in stressed families are in some form of distress, whether or not they are currently "symptomatic." Intervening to support the family and children, even before we actually have symptoms and impairment simply makes more sense and is more humane.
Those people who are in the highest risk categories (i.e., chronic homeless mentally ill and those with serious mental illness)should be prioritized.
Tough call. I felt these two categories involved a higher risk for future mental health problems.I also wanted to check the children/youth in stressed families as well as children/youth at risk for school failure.
Trauma exposed individuals and Children/Youth in stressed families are a close call. We have to start somewhere. Once we get those who are having issues now under control, maybe we can take care of those at risk for future issues taken care of.
Trauma is a pre-cursor to a lot of MH issues. If the trauma is addressed with some form of intervention, then it could potentially avert any serious MH issues later.
Two most at risk populations also influence YPLL of communities. Cross cutting strategy of reducing family violence and substance abuse apparent. The health inequities grant should give us a better platform to address the culturally underserved, but we should not act until we have the data. Sadly, our county is not as culturally diverse as many other regions in California, so funding would be better spent looking at entire populations rather than only a few small groups. Other populations mentione have many structures already in place (i.e. SARB, Wright educational and councilling services, Rowell Family Empowerment, NVCSS, Shasta Fix, and non- preventive MH branch services such as the crisis unit). MH management should be engaging in dialogue with these agencies to ensure they have the structure, mission, vision, funding, staff competence, and training to provide a seemless early intervention and prevention delivery system.- Matt Richards RN, PHN
We need to have early interventions
Whether it is a single-parent home, a blended family, or some sort of abuse, these children are being affected and I certainly feel this area should be a priority.
While people experiencing the onset of serious psychiatric illness need help, they are served (to an extent) by the traditional treatment programs we have already. More can be done here, but this wouldn't be my highest priority. Again, starting with youth at risk and helping families in trouble avoid more serious situations seems a good place to start with a prevention program. Helping families function more effectively can help all concerned avoid more serious problems down the line. Again, trauma is such a serious issue, that more needs to be done to help these individuals to prevent serious problems later.

PEI Survey Results: Protective Factors

Ranking

	Positive Adult – Child Relationship	Physical Activity	Contact with Nature	Adequate Housing	Sense of Belonging	Overall Happiness
On-Line	1	4	5	3	2	6
Percentage	75%	14%	7%	36%	63%	6%
Response #	126	24	11	61	106	10
Hardcopy	1	3	6	4	2	5
Percentage	64%	39%	11%	32%	41%	11.%
Response #	230	142	38	115	148	41

Online Comments

A sense of belonging to a community or being socially connected often comes from being gainfully employed. Job readiness, career/job counseling, job centers, and job fairs are a vital part of this process that assists individuals and families to become "connected".
a sense of security and acceptance and belonging are needed for self esteem
Adequate housing (shelter) is critical to survival and as such it is a basic, survival need. The sense of belonging tells us that we have a foundation, which seems very critcal to well-being. I also consider the positve child/adult relationship critical because adults can advocate for children -- and i think that having a sense of belonging would need to include building a positive child/adult relationship (otherwise the children are left to belonging essentially to other children or groups of other children who can give them a sense of belonging and advocate for them -- something like a gang).
All children need positive adult support in their lives, in order to develop normally. That's simply a fact of nature. It's the same for sense of belonging/connectedness. We are social animals and we tend to function better and stay more healthy if we have that.
all of these are important! Housing and employment are problems nationwide, there doesnt seem to be a lot of support for individuals who are struggling and have no money for college or work related training, there should be a type of wrap around for mental health
all of these are important; it's hard to prioritize them. nonetheless, social connectednesss, whether to a parent, nurturing adults other than parents, and youth knowing the community values them through attention, opportunity and voice, has huge mental well-being impact on kids for a lifetime. communities that have high life satisfaction measures have much better mental well-being and much less impact from mental disorders,
All of these seem important.
Although I was tempted to choose physical activity, I think a sense of community/social connectedness can have a tendency toward encouraging "getting out" which may increase physical activity.
Besides genes, parents have by far the most influence on the health and resilience of their children.
Children/teens who have adults in their lives who they can depend upon and trust (which include parents) is mandatory to a healthy life. One does not destroy a community if one feels a part of it.
Education and parenting skills are a key factor.
Everyone has to feel important. If they are given an opportunity to get involved then I believe they will take advantage of that opportunity.

Everyone needs a sense they belong, that the are valued by others and aren't on the earth just taking up space and oxygen. So many people have difficulty reaching out to others or they move away from or out live their family, friends, and support systems.
Good parenting is key to lifetime happiness and success
Homelessness from evictions foreclosures or what ever is enough to make even the strongest individual crack from the pressure and check out mentally
Human beings are social beings whose optimal development is dependent on relationships and a sense of belonging. Our sense of ethics and commitment to a world outside of ourselves is based on ths sense of belonging. Young children's most important influences and models are adults; children of all ages are dependent on and learn who they are from the types of relationships they have with adults.
Human beings are social beings. Positive relationships are vital for mental and emotional health, at any age.
I feel if youth have those two protective factors in their lives things like physical activites and contact with nature might also be in the mix for them.
I feel that adequate housing and postive child/adult relationships are very big contributors to a positive outlook on life. Feeling secure in these two places is surely a stress reliever.
I think all the above is important I think you need to add a spiritual component to the above
I think that people who are suffering from mental illness, may feel isolated by our society and we need to promote positive relationships and help them feel connected to our community.
I think that social connectedness is really important because say a individual is experiencing a traumatic event at home they need the love and support of other in order to work through the difficult situation and feel like they are normal. Also, I think that if children have strong adult connections that they can make it through many traumatic situations.
I THINK THE QUESTION IS DECEPTIVE, INSINUATING THAT MENTAL ILLNESS IS PREVENTABLE. THAT IS NOT A TRUE STATEMENT FOR MOST MENTAL ILLNESSES.
It starts with a postitive relationship and then adequate housing
Kids emulate those they are in very close contact with in most instances. If they feel they belong to our society and experience a sense of safety with a parent or mentor or other caring adult who models love and acceptance, while encouraging and maintaining accountability, the kids have a headstart in becoming connected and contributing adults.
Let's focus on establishing a healthy bond between babies and their major caregivers so that children will have a strong foundation to grow on. Isolation -- physical and/or social -- should be addressed before it leads to a deterioration of mental health.
Maslow's Hierarchy of Needs tells us that those who are hungry, without shelter or clothing are unlikely to be able to concentrate on much else. Getting people into safe and secure environments reduces their stress and need to self-medicate with alcohol/drugs and frees them to concentrate on more meaningful pursuits. Social support reduces stress and also helps someone with mental illness cope. This is true for all ages, though especially true in the formative years, so the first factor is also critical.
Mental illness is a biological brain disorder. While I think that many of these factors could promote "well-being", I don't see any of them as being preventative measures, except perhaps physical activity. This kind of questioning could lead to people thinking that for example, negative child/adult relationships contribute to mental illness.
Most people who go thru trama do not have any positive adults in their life. It is the basis of most therapy to develop a positive & trusting relationship with at least 1 peer. Also, there are many homeless people who are mentally ill, or who are veterans that should be provided for.
Must address basic needs
my first reaction was to check PA, but contact with nature often includes or leads to PA
NONE
People need to be connected and have a sense of belonging as well as stabilized in housing.
People need to have their basic needs met and housing and jobs (not listed) are two fundamental needs. Once these are met contact with nature allows for physical activity and new studies are showing the mental health benefits of nature. Our community really needs to address the jobs/housing balance.
Physical activity in the sense of how we design our communities so people can walk, bike to be more connected in their communities (reduce violence, injury, getting to know neighbors).

positive relationships with involved positive adults help young people possibly see something better than their current situation. belonging to a community or social group helps them feel part of something, that they are needed
rational: having positive child/adult relationships is a assett that crosscuts through other developmental assets (i.e.family support, safety, creative activities, planning and decision making, self esteem, positive values, etc.). This asset can also nurture strategies of increasing physical activity, social connectedness, and overall happiness. Adaquate housing can have an enabling context in our current eligibility and housing provision structure. Contact with nature can be a crosscutting strategy as there is evidence of decreasing depression AND obesity (Dr. Dick Jackson presentation at Simpson college c. 1995). Both depression and obesity can be risk factors for progressive and continued destabilized and dehabilitative conditions. - Matt Richards RN, PHN
Role models beyond their own families are essential. Even the best of families can benefit from the children observing and interacting with people from different backgroungs, abilities and interest areas as well as emotional development. Community connectedness also helps to build a sense of balance in a young person. Learning how to satisfy the many faceted parts of the human being is a long process and takes many experiences. Building up the self-esteem that is needed as an adult in some young people takes a long time.
Social support lessens stress and some triggers of mental illness, and makes individuals more likely to get effective treatment. Maslow's Hierarchy of Needs tells us that those without shelter, food, and clothing are unlikely to be able to deal with other problems. Taking care of these basics is necessary to free the person to be able to concentrate on creating a meaningful life.
Support and a sense of belonging are imperative. Close relationships not only help promote mental well-being, they also provide someone who can key in on indicators of mental illness onset.
The feeling that we belong and are part of something is incredibly important. Connecting with others connects us to ourselves.
The two I checked both seem to relate to the resiliency factor affecting at-risk youth, though I think every program should be designed with some recognition of the importance of physical activity and contact with nature.
these are both things seriously lacking in our community!!
These two speak for themselves.
We need to help support families social and emotional wellbeing. Families need more trained professionals in Redding.
Without a roof over their head they will never believe in themselves and move on to be productive individuals with in the community.
Without adequate housing all else pales.

PEI Survey Results: Risk Factors

Ranking

	Child Abuse or Neglect	Maternal Depression	Excess Violent Media View	Alcohol & Drug Abuse	Teen Pregnancy Low Birth Weight Premature Birth	Domestic Violence
On-Line	1	4	5	2	6	3
Percentage	72%	19%	9%	69%	4%	26%
Response	119	31	14	114	6	42
Hardcopy	1	5	4	2	6	3
Percentage	69%	15%	15%	58%	8%	33%
Response	249	53	54	207	30	119

Online Comments

again, loneliness and insecurity cause all sorts of frightening behavior
All categories seem important, however substance abuse and child abuse seem to be prevalent.
All Probably
Being subjected to violence or other abuse is traumatizing and seems to have a very long-term impact on the ability to form healthy relationships and find happiness/meaning in life. It also seems to perpetuate itself across generations. While alcohol and drug abuse are likely linked to mental health issues, they may not be direct causes, but correlated with having experienced abuse or other extreme stressful situations - they are unhealthy attempts to deal with exisiting problems that then worsen those problems. I think poor parenting skills overall area also a factor contributing to mental illness, whether caused by youth, abuse, depression, or other factors.
Child abuse can lead to domestic violence, teen pregnancy, drug and alchol use. Also, maternal/pregnancy issues and the inability to bond with a child adds to the mix of all types of problems.
Children are like sponges... soaking up the feelings, patterns, love or alienation around them. ABuse or neglect does not allow them to mentally grow to their potential and in my opinion, esculates and mental abnormalities. The bonding with the mother and her attentiviness is a natural, physical, mental and spiritual connection - remove one or more and that area suffers and does not develop in a normal manner. This in no way, however, implies that there cannot be physical/heridity/chemical imbalances which will manifest in mental illness. I just believe it is minimized when safety, love, bonding and lack of violence is present. Neglect is rampant and destructive.
Difficult choice because they are so interrelated. It seems that alcohol and other drug abuse could be the primary reason for lack of infant bonding and a contributing factor to maternal depression that wouldn't be otherwise noticed/treated by a physician in post delivery care.
Domestic Violence can contribute to so many mental disorders with in a family.
Domestic violence would be my #3. All of these are important risk factors.
I believe excessive screen time viewing many of the currently available programs is detrimental to our health in all ways. Time spent looking at TV or video games is time not used to participate in family or other social activities, exposes the viewer passively to unrealistic situations including much violence, and does not help the viewer develop health relationships and responses to life stresses. It is self-explanatory that substance abuse leads to poor mental health.

I believe that genetics plays a role in contributing to mental illness and I don't know that there's a way to address that.
I chose alcohol and other drug abuse because I think it changes the chemistry of the brain and in youth, the developing the brain. I had a difficult time selecting the second factor, but think abuse and neglect might emotionally scar and blunt the developing child.
I don't really know. It seems like others things, not listed, may be risk factors, too. Lack of positive adult relationships. Lack of social support, etc.
I had to pick three - I think the domestic violence/child abuse or neglect go hand in hand.
I think much (but not all) mental illness could be prevented by proper parenting/health families. As youth grow up in neglect or in drug/alcohol abusing homes, kids are not given good "mental health skills" by their families, creating an ugly cycle that expands with time.
I think that the two biggest factors are not mentioned. Unemployment/underemployment and lack of comprehensive health care services for uninsured individuals contribute significantly to a person's mental health outlook.
If a child is abused or severely neglected s/he is less able to develop the resilience and security that is necessary for mental, emotional and cognitive health. Exposure to violence, whether via media or in the home/community, establishes emotional reactions based on fear and has been strongly linked to aggressive behavior, reliance on alcohol and drugs and impaires social skills.
If by mental illness, you mean depression, then I think teen pregnancy, violent media viewing or domestic violence could contribute. But if you are talking about schizophrenia, bi-polar, obsessive-compulsive behavior, then this question is not appropriate.
I'm not the expert on the statistics but have worked with this population for nearly twenty years and have seen these common factors repeatedly in those who develop mental illness.
I'm not the expert, but when I look at those I know these appear to stand out as the significant contributors.
Make sure young children are growing in a safe and nurturing environment and the need for prisons will decrease.
Mental abuse seems to go along with child abuse and drugs and alcohol only make things worse. If it were possible to get a hold of the households that have a parent or other household member or friend and get them on the road to recovery, then we can possible have a greater chance of saving a childs mental health and prevent them from doing the same to their children.
Most of these are interrelated
Most of these tend to focus on youth which I realize is a prevention strategy but another crucial time is young adulthood. I think a good prevention strategy is for the community to look at bringing in a 4 year public university making higher education a more realistic option for local high school grads.
Of all these huge risk factors, DV (which includes child abuse or neglect) and lack of object constancy are able to be prevented/controlled through education and modeling. AOD would be next on my list, then media violence and teen pregnancy/low birth weight/premature birth.
One thing that I think is left out is really not just maternal depression but paternal depression. Mental health and illness is connected to people's genetic make-up and I think that has a lot to do with overall mental health.
Poor parenting (whether due to teen parents, parents on alcohol/drugs, violent parents, disinterested, depressed, or absent parents) is probably a large contributor. Kids need to have a secure attachment and good models of healthy relationships to be successful/happy in life. Trauma generally has extremely serious mental health consequences and often perpetuates itself across generations. While alcohol and drug abuse are probably correlated with mental health problems, they may just be a symptom of those problems or an ineffective attempt at coping with them.
rationale: both well documented when correlating broadly. Maternal depression is an issue but it is only one condition in one subpopulation group (albeit a vital one). Maternal depression is also not a risk factor. It is a psychiatric condition influenced by metabolism, biology, physiology, social network, access to care, education, and other factors. Excess vilent media certainly is related to antisocial and desensitized behavior and could plausibly be a risk factor (minimally on a theoretical basis) for anxiety and mood disorders and possibly for other disorders with delusional and hallucinogenic characterizations. I hesitate to choose excess violent media viewing because it incorrectly is listed with screen time in parentheses. Exposure to violent media is one factor and screen time is another more broad catagory that includes length of exposure, and viewing of unhealthy or sexually explicit material and TV adds. Due to the lack of clarity, I must choose more substitively. The vast majority of MH patients have substance abuse issues that both contribute to and cloud MH diagnoses and treatment pathways. Child abuse and neglect is growing exponentially and is unequivically linked to MH. In addition there is a confusing dicotomy in the digestion and application of evidence based environmental and social change

conducive to reducing recividism or recurrent offenses to the child and family. Matt Richards RN, PHN
The drug and alcohol problems lead to a lot of the other items on the list. The neglect and trauma our children have lived with creates many of the mental health issues.
the scientific evidence is overwhelming in increased violent media viewing related to curreent and later life aggression, violence, conduct disorder, oppositional defiance disorder and attention deficit disorder with hyperactivity. this is an area not too costly for individuals, families and communities to do something about. 90% of people completing suicides have alcohol abuse, schizophrenia or depression. Alcohol contributes to family violence, adverse childhood experiences such as child neglect ot abuse, trauma from sexual assault,fighting or vehicular injury. Shasta County has very high rates of binge drinking, underage drinking and drinking and driving, all of which are amenable to proven community interventions to lower these excesses and illegal activities. Other drugs also impact mental health and expression of mental illness, such as methamphetamine.
The things you experience from childhood shape the way your brain thinks, even when you do not remember experiences. Also, teenagers are unable to provide for children in every aspect. They cannot be good parents because they themselves are not adults yet and still children. It is a tragedy that children are allowed to give birth to other human beings, and usually results in severe problems for both the underage child, and the child they are bearing.
the TV sucks us in and children and many adults believe what they see as normal behavior. Subliminal messages also, which should be against the law. Alcohol and drug use often leads to all of the other facors.
There is no box for natural onset of mental illness
these are used sometimes to self-soothe and mask symptoms but only make them much worse and increase risk of additional problems
These contributos say it all.
These questions seem to identify the outcome of mental illness not the cause
These substances are often used to self medicate. Changing that view in lives can make a big difference.
This does not of course count for the biological predisposition that some people face when there is a family history.
THIS IS AGAIN A DECEPTIVE QUESTION. THERE ARE MANY CAUSES FOR MENTAL ILLNESS, MANY OF THEM PHYSICAL AND NOT PREVENTABLE.
too many young pregnancies, too much exposure to drugs/alcohol at very young ages
Too often , mothers give birtha nd have no attachment to the baby. This is in part because they aren't given the opportunity to actually expierience labor without being given an instant epidural. The post pardon doesn't seem to be accessed and it is a huge barrier.
When there are no other options available to people to alleviate their pain or boredom then alchohol & drugs is an easy choice. Offering young people especially, options about the lifestyle choices that they make can break the cycle and allow them to get out from under a bad situation. I would add here that in many ways our current school system in California can be listed as a factor as well. When bright young minds (especially boys) are not challenged or appreciated for the gifts they do have, frequently at an early age they just give up trying and waste the time, becoming "bored" and then going for the easy fixes out of lack of imagniation being nutured. This boredom can be seen as "witholding" of their talents, abilities and skills until they suffer from such low self-esteem that they can see no way out.

PEI Survey Results: Negative Outcomes

Ranking

	Suicide	Jail or Prison	School Failure/Dropout	Unemployment	Prolonged Suffering	Homelessness	Removal of Children from their Homes
On-Line	2	5	3	6	4	1	7
Percentage	37%	26%	34%	20%	30%	39%	15%
Response	62	43	56	34	50	65	25
Hardcopy	1	5	2	7	4	3	6
Percentage	48%	24%	33%	15%	26%	29%	23%
Response	174	86	117	55	92	103	84

Online Comments

a sense of failure and suffering ruin lives. i have a difficult time targetting any one thing as they all are inter-related.
Again, I'm no expert. I do believe, however, that preventing entrance to the judicial system and ensuring individuals make it through school will give them better odds at being successful in other arenas.
All are very important and need to be addressed.
All of the above
Anything that has to do with children should be targeted first as long as parents are involved when appropriate.
Being suicidal is not a feeling, it is your brain not being able to see any other appropriate choice out of the mental distress you are in. People should not take this lightly! If someone even jokes about being suicidal, there may be many things going on you do not know about and it may be less of a joke than you know. Everyone deserves respect and medical care when they have thoughts of suicide. Failure of the community and their families to support and understand individuals who are suicidal leads to prolonged suffering and further mental illness. It also leads to drug abuse, physical abuse and many other "escape" tactics to stop feeling suicidal.
Both have impact on people's self-esteem. Where they have sucess they have more hope and feeling of being able to persevere and to cope with temporary or short-term problems.
Both of these more specifically address adults. I think if adults have purpose, feel of value,and can support themselves and their children, they function better, and their children, therefore, do better. The other factors are also very important; this was another tough choice.
Catching a child's interest to make it possible for him to be at least a little interested in completing school would be a great thing. Children are the future of course. Most local kids have no idea of what possibilities are out there for them if they apply themselves. Options are crucail, real talk about jumping through hoops to get to the "other side" are rare. Feeling awful in school does not have to last a lifetime. There is very little of this language being used in school lately to the detriment of the local economy.
Homelessness seemed to be the easy first choice with employment second because many can not hold a job and that brings even more problems.
I think one of the main negative outcomes from mental illness is self-medication/drug abuse.
I think that dealing with issues surrouding suicide can also address other mental health problems. Mental illness is very prevalent in our jail pop. plus our juvenile hall pop.
If people are released to the streets over and over again with out getting rehab. they can not get the concept that there is a better way of life and things can be done differently.
jail/prison = "train wreck" School failure/Drop out = early prevention of future potential train wrecks
Not sure. Homelessness is certainly a good thing to work on, but it may require other interventions first.

rationale: Suicide should read unintentional deaths to encompass homicide. It would then be more easily considered as a top negative outcome to address. Jail or Prison, unemployment and homelessness are is an outcome that are inexorably linked to school failure. Removal of children from their homes, although far from the path reunification advocacy laws may actually be a healthy outcome in many circumstances. Prolonged suffering is the result of failure preventing harm to oneself and others; preventing harm is a hallmark strategy of MH systems and medical as well as social ethics. Prolonged suffering is an outcome that describes the magnetude of the impact to a community from all the other sequelae. Matt Richards RN, PHN
School failure and unemployment ruins self-effacacy which develops self-esteem. No self-esteem when one is challenged by mental illness can lead to homelessness, etc.
Sometimes it's best to remove the children from their homes. children do consider themselves failures when confronted with the negative things in their lives. Teens especially go through a lot and need more people out there with the sources to help them, they are the tough group to deal with, afterall they are almost adults. Kids suffer through many things they do not need to be seeing, hearing or have done to them.
Suicide is preventable. It is the ultimate response to hopelessness, isolation and a sense of helplessness. A community widely capable of recognizing and responding to warning signs of potential suicidal intent has been shown to decrease the incidence of completed suicides. School failure/drop-out puts youth in a seriously negative trajectory for a lifetime and is linked to isolation, povery, anti-social behavior.
Suicide seems to have a ripple effect that reaches broad circles within the community. There is also a familial component and is viewed as a preventable death. Another negative outcome is substance abuse. With self medication as the first initiation for some people, it seems that we could address some of the other listed survey outcomes by early intervention for substance abusers.
There is not enough assesment to the underlying problems, it is convict and evict.They escalate the problems, they don't resolve them.
These populations are underserved and do not have enough support so they end up back where they started! There needs to be supportive programs to help them as they are often ostracized!
these two outcomes are more likely to involve children or youth, and focusing on that end of the age spectrum has the most long-term individual, family and societal impact for the dollars expended.
This is a hard one since all are extremely important results of mental illness. I do believe that both prisoners and childrem removed from their natural home suffes a lot of alienation and separation anxiety. The returning ex-offender, if not assessed and treated, repeat the contributing factors to their family and close relationships which in many instances resulted in their incarceration. Children - if treated with the natural parents - would have a lot better chance. Foster care is much needed and in many cases, critical but I believe that healing the family not only is critical to those involved but in the generations they produce.
this is where you can save the most money overall & optimize your mental health resources at a state and local level
What about substance abuse?
Working with adult MH population this is what I see.

PEI Key Informant Interview Documents

Key Informant Interview Description
Key Informant Interview Tool
Key Informant Interview Result Summaries

Key Informant Interview

- Approximately 30 interviews will be conducted with community leaders, gatekeepers, and other individuals who are knowledgeable about their constituency and key community mental health needs.

- Key Informant Interviews will allow for more in depth discussion surrounding priority areas, community needs and strengths.

- Key Informant Interviews will also provide an opportunity to fill in stakeholder information gaps.

PEI Key Informant Interview

Job Description or Title (nurse, police officer, doctor, teacher, etc) _____

Stakeholder Represented:

- ☐ Underserved Communities
- ☐ Education
- ☐ Individuals with Serious Mental Illness and/or Their Families
- ☐ Providers of Mental Health Services
- ☐ Health
- ☐ Social Services
- ☐ Law Enforcement

Date of Contact_____ Callback_____ Date Completed_____

Key Mental Health Needs

1. What are the two most important mental health needs in Shasta County? Choose from:

   - Reducing disparities in access to mental health services
   - Reducing the negative psycho-social impact of trauma on all ages
   - Increasing prevention efforts and response to early signs of emotional and behavioral health problems among at-risk children, youth, and young adult populations
   - Reducing stigma and discrimination affecting individuals with mental health illness
   - Increasing public knowledge of the signs of suicide risk and appropriate actions to prevent suicide

   a.

   b.

2. Why did you choose (Need A)?

3. What program or service for (Need A) is already meeting this need?

4. What other program or service for (Need A) might meet Need A?

5. What program or service for (Need A) could reach the most people?

6. Why did you choose (Need B)?

7. What program or service for (Need B) is already meeting this need?

8. What other program or service for (Need B) might meet Need B?

9. What program or service for (Need B) could reach the most people?

Priority Population Groups

10. What are the two most important population groups needing Prevention and Early Intervention (PEI) mental health services? Choose from:

    - Underserved cultural populations
    - Individuals experiencing onset of serious psychiatric illness
    - Children/youth in stressed families
    - Trauma-exposed
    - Children/youth at risk for school failure
    - Children/youth at risk of juvenile justice involvement

    a.

    b.

11. Why did you choose (Group A)?

12. What program or service for (Group A) is already meeting their needs?

13. What other program or service for (Group A) might meet that group's needs?

14. What program or service for (Group A) could reach the most people?

15. Why did you choose (Group B)?

16. What program or service for (Group B) is already meeting their needs?

17. What other program or service for (Group B) might meet that group's needs?

18. What program or service for (Group B) could reach the most people?

Key Mental Health Protective Factors

19. Select the 2 Key Mental Health Protective Factors you think are the most important to prevent mental illness or promote mental well-being. Choose from:

    - Positive Child – Adult Relationships (40 Developmental Assets)
    - Physical Activity which Decreases Depression
    - Contact with Nature
    - Adequate Housing
    - Sense of Belonging to a Community & Social Connectedness
    - Overall Happiness of the Community
    - Other

      a.

      b.

20. Why did you choose (Group A)?

21. What program or service for (Group A) is already meeting their needs?

22. What other program or service for (Group A) might meet that group's needs?

23. What program or service for (Group A) could reach the most people?

24. Why did you choose (Group B)?

25. What program or service for (Group B) is already meeting their needs?

26. What other program or service for (Group B) might meet that group's needs?

27. What program or service for (Group B) could reach the most people?

Mental Illness Preventable Risk Factors

28. Select the 2 Key Preventable Risk Factors you think are the most important to contributing to mental illness. Choose from:

    - Child Abuse or Neglect
    - Maternal Depression or Infant Bonding
    - Excess Violent Media Viewing (Screen Time)
    - Alcohol & Other Drug Abuse
    - Teen Pregnancy/ Low Birth Weight/ Premature Birth
    - Domestic Violence
    - Other

      a.

      b.

29. Why did you choose (Group A)?

30. What program or service for (Group A) is already meeting their needs?

31. What other program or service for (Group A) might meet that group's needs?

32. What program or service for (Group A) could reach the most people?

33. Why did you choose (Group B)?

34. What program or service for (Group B) is already meeting their needs?

35. What other program or service for (Group B) might meet that group's needs?

36. What program or service for (Group B) could reach the most people?

Priority Outcome to Decrease

37. Select the 2 Negative Outcomes that may result from mental illness that you think PEI should target first. Choose from:

    - Suicide
    - Jail or Prison
    - School Failure / Drop Out
    - Unemployment
    - Prolonged Suffering
    - Homelessness
    - Removal of Children from Their Homes

    a.

    b.

38. Why did you choose (Group A)?

39. What program or service for (Group A) is already meeting their needs?

40. What other program or service for (Group A) might meet that group's needs?

41. What program or service for (Group A) could reach the most people?

42. Why did you choose (Group B)?

43. What program or service for (Group B) is already meeting their needs?

44. What other program or service for (Group B) might meet that group's needs?

45. What program or service for (Group B) could reach the most people?

46. What programs, services, or events in Shasta County could be a resource for the PEI program?

KII SUMMARY
KEY MENTAL HEALTH NEEDS

1. Reduce disparities in access to early mental health interventions
2. Reduce the negative psycho-social impact of trauma on all ages
3. Increase prevention efforts and response to early signs of emotional and behavioral health problems among at-risk children, youth, and young adult populations
4. Reduce stigma and discrimination affecting individuals with mental health problems
5. Increase public knowledge of the signs of suicide risk and appropriate actions to prevent suicide

KII SUMMARY
TOTALS

1	2	3	4	5		
12	11	31	6	4		

	1	2	3	4	5
Community-Based Organization & Mental Health Providers					
CBO Director 1	X		X		
CBO Director 2		X	X		
MH Provider 1			X	X	
MH Provider 2	X		X		
MH Provider 3		X	X		
Client & Family Members					
Family Advocate			X		X
Foster Parent		X	X		
Client		X	X		
Education					
Elem Principal		X	X		
Sec Principal		X	X		
Librarian		X	X		
Health Care					
PPN	X		X		
HIV RN			X	X	
PHN FC	X		X		
RN PHN		X	X		
Physician (a)	X			X	
Physician (b)	X		X		
Law Enforcement					
Dispatcher			X	X	
Coroner			X	X	
Probation			X		X
USFS/YVPC			X		X
Lieutenant		X	X		
Lieutenant—R	X		X		
Social Services					
SSWOP			X	X	
SWII (a)	X		X		
SWII (b)	X		X		
APS	X		X		
SoA		X	X		
CFS PM		X	X		
Underserved Cultural Populations					
CHA Homeless	X		X		
CHA Rural			X		X
Native American	X		X		

KII SUMMARY PRIORITY POPULATION

1. Underserved cultural populations
2. Individuals experiencing the onset of serious psychiatric illness
3. Children/Youth in stressed families
4. Trauma-exposed individuals
5. Children/Youth at risk of school failure
6. Children/Youth at risk for juvenile justice involvement

KII SUMMARY TOTALS

1	2	3	4	5	6	
5	15	18	11	12	3	

	1	2	3	4	5	6
Community-Based Organization & Mental Health Providers						
CBO Director 1			X		X	
CBO Director 2			X	X		
MH Provider 1		X				X
MH Provider 2		X	X			
MH Provider 3			X	X		
Client & Family Members						
Family Advocate		X		X		
Foster Parent			X	X		
Client		X		X		
Education						
Elem Principal			X		X	
Sec Principal			X		X	
Librarian					X	X
Health Care						
PPN			X		X	
HIV RN				X	X	
PHN FC		X	X			
RN PHN		X	X			
Physician (a)		X	X			
Physician (b)		X			X	
Law Enforcement						
Dispatcher	X		X			
Coroner	X				X	
Probation			X		X	
USFS/YVPC		X			X	
Lieutenant		X		X		
Lieutenant—R		X				X
Social Services						
SSWOP			X		X	
SWII (a)	X		X			
SWII (b)		X	X			
APS		X		X		
SoA			X	X		
CFS PM		X			X	
Underserved Cultural Populations						
CHA Homeless	X			X		
CHA Rural		X	X			
Native American	X			X		

KII SUMMARY PROTECTIVE FACTORS

1. Positive Child/ Adult Relationships
2. Physical Activity
3. Contact with Nature
4. Adequate Housing
5. Sense of Belonging/ Social Connectedness
6. Happiness of Community
7. Other

KII SUMMARY TOTALS

1	2	3	4	5	6	7
23	7	0	6	23	1	4

	1	2	3	4	5	6	7
Community-Based Organization & Mental Health Providers							
CBO Director 1					X	X	
CBO Director 2	X				X		
MH Provider 1	X				X		
MH Provider 2	X				X		
MH Provider 3	X				X		
Client & Family Members							
Family Ad				X			X*
Foster Parent	X				X		
Client	X				X		
Education							
Elem Principal	X				X		
Sec Principal	X				X		
Librarian				X	X		
Health Care							
PPN	X	X					
HIV RN	X				X		
PHN FC	X				X		
RN PHN	X	X					
Physician (a)	X	X					
Physician (b)	X				X		
Law Enforcement							
Dispatcher		X			X		
Coroner	X	X					
Probation				X	X		
USFS/YVPC	X				X		
Lieutenant	X	X					
Lieutenant—R	X			X			
Social Services							
SSWOP	X				X		
SWII (a)	X				X		
SWII (b)				X	X		
APS	X				X		
SoA	X						X*
CFS PM		X			X		
Underserved Cultural Populations							
CHA Homeless				X	X		
CHA Rural	X						X*
Native Am					X		X*

KII SUMMARY RISK FACTORS

1. Child abuse or neglect
2. Maternal depression or infant bonding
3. Excess violent media viewing (Screen Time)
4. Alcohol & other drug abuse
5. Teen pregnancy, low birth weight, premature birth
6. Domestic violence
7. Other

KII SUMMARY TOTALS

1	2	3	4	5	6	7
19	9	4	20	2	7	2

	1	2	3	4	5	6	7
Community-Based Organization & Mental Health Providers							
CBO Director 1		X		X			
CBO Director 2	X	X					
MH Provider 1	X			X			
MH Provider 2	X	X					
MH Provider 3	X	X					
Client & Family Members							
Family Ad							X*
Foster Parent				X		X	
Client	X					X	
Education							
Elem Principal			X	X			
Sec Principal			X	X			
Librarian		X	X				
Health Care							
PPN		X			X		
HIV RN	X			X			
PHN FC	X			X			
RN PHN	X					X	
Physician (a)	X			X			
Physician (b)	X			X			
Law Enforcement							
Dispatcher	X			X			
Coroner				X	X		
Probation				X		X	
USFS/YVPC	X			X			
Lieutenant	X		X				
Lieutenant—R				X		X	
Social Services							
SSWOP	X					X	
SWII (a)	X						X
SWII (b)	X			X			
APS		X		X			
SoA	X			X			
CFS PM	X			X			
Underserved Cultural Populations							
CHA Homeless		X		X			
CHA Rural	X					X	
Native Am		X		X			

KII SUMMARY NEGATIVE OUTCOMES

1. Suicide
2. Jail or prison
3. School failure / dropout
4. Unemployment
5. Prolonged suffering
6. Homelessness
7. Removal of children from their homes

KII SUMMARY TOTALS

1	2	3	4	5	6	7
11	5	15	8	11	8	5

	1	2	3	4	5	6	7
Community-Based Organization & Mental Health Providers							
CBO Director 1			X	X			
CBO Director 2			X				X
MH Provider 1						X	X
MH Provider 2			X		X		
MH Provider 3					X		
Client & Family Members							
Family Ad		X					X
Foster Parent			X		X		
Client	X	X					
Education							
Elem Principal			X	X			
Sec Principal	X				X		
Librarian			X	X			
Health Care							
PPN			X				X
HIV RN	X		X				
PHN FC	X			X			
RN PHN	X	X					
Physician (a)	X			X			
Physician (b)			X	X			
Law Enforcement							
Dispatcher				X			X
Coroner	X		X				
Probation			X			X	
USFS/YVPC			X			X	
Lieutenant	X	X					
Lieutenant—R					X	X	
Social Services							
SSWOP			X	X			
SWII (a)			X		X		
SWII (b)					X	X	
APS	X					X	
SoA			X		X		
CFS PM					X	X	
Underserved Cultural Populations							
CHA Homeless		X				X	
CHA Rural	X				X		
Native Am	X				X		

Stakeholder Results Document

Final Stakeholder Result Summaries

PEI Stakeholder Input: Priority Area Ranking Results

AGE GROUPS

1. Children
   0 - 15 years
2. Youth
   16 - 25 years
3. Adult
   26 - 59 years
4. Older Adults
   60 years

KEY MENTAL HEALTH NEEDS

1. Reduce disparities in access to early mental health interventions
2. Reduce the negative psycho-social impact of trauma on all ages
3. Increase prevention efforts and response to early signs of emotional and behavioral health problems among at-risk children, youth, and young adult populations
4. Reduce stigma and discrimination affecting individuals with mental health problems
5. Increase public knowledge of the signs of suicide risk and appropriate actions to prevent suicide

PRIORITY POPULATIONS

1. Underserved cultural populations
2. Individuals experiencing the onset of serious psychiatric illness
3. Children/Youth in stressed families
4. Trauma-exposed individuals
5. Children/Youth at risk of school failure
6. Children/Youth at risk for juvenile justice involvement

	Total # Response	% of Total Response	AGE GROUPS				KEY MENTAL HEALTH NEEDS					PRIORITY POPULATIONS					
			1	2	3	4	1	2	3	4	5	1	2	3	4	5	6
ONLINE SURVEY	176	22%	X	X	X	X	2	4	1	3	4	6	3	2	1	5	4
HARDCOPY SURVEY	370	46%	X	X	X	X	3	5	1	4	2	6	3	1	2	4	5
KEY INFORMANT INTERVIEWS	32	4%	X	X	X	X	2	3	1	4	5	5	2	1	4	3	6
FOCUS GROUPS	218	27%	1	2	3	4	3	2	1	4	5	6	3	1	2	4	5
TOTALS	796	100%	1	2	3	4	2	3	1	4	5	6	3	1	2	4	5
	Weighted Totals		X	X	X	X	2	5	1	4	3	6	3	1	2	4	5
FINAL RANKING			**1**	**2**	**3**	**4**	**2**	*	**1**	**4**	*	**6**	**3**	**1**	**2**	**4**	**5**

PEI Stakeholder Input: Priority Area & Intervention Results

PEI Age Groups

Rank	Age Group Category	
1	Children / Youth	0 - 15 years
2	Youth	
3	Its	26 - 59 years
4	Older Adults	60+ years

PEI Interventions

Selected by 5 or more Focus Groups		
Community Education & Awareness	School Staff Education & Awareness	Family Resources, Support & Education
Increase Access & Linkage to Services	Public Awareness: Destigmatization	Support Groups
Children, Youth & TAY Interventions & Support	Provide Basic Needs	
Selected by 3 or more Focus Groups		
Early Childhood Interventions	Integrated Health Services	Community Activities
Employment, Training, School	Perinatal Services	School-Based Services
Culturally Competent Services		

PEI Priority Populations

Rank	Total	Priority Population Category	Weighted Rank	Total
1	5	Children/Youth in Stressed Families	1	1.21
2	9	Trauma Exposed Individuals	2	1.84
3	11	Individuals Experiencing the Onset of Serious Psychiatric Illness	3	2.93
4	16	Children/Youth at Risk of School Failure	4	4.14
5	20	Children/Youth at Risk of Juvenile Justice Involvement	5	4.77
6	22	Underserved Cultural Populations	6	5.9

PEI Key Mental Health Needs

Rank	Total	Key Mental Health Needs	Weighted Rank	Total
1	4	Increase prevention efforts and response to early signs of emotional and behavioral health problems among at-risk children, youth, and young adult populations.	1	0.99
2	10	Reduce disparities in access to mental health services	2	2.71
3	14	Reduce the negative psycho-social impact of trauma on all ages	5	3.84
4	15	Reduce stigma and discrimination affecting individuals with mental health problems	4	3.74
5	16	Increase public knowledge of the signs of suicide risk and appropriate actions to prevent suicide	3	3.35

PEI Stakeholder Input: Prevention Area Ranking Results

PROTECTIVE FACTORS
1. Positive Child/ Adult Relationships
2. Physical Activity
3. Contact with Nature
4. Adequate Housing
5. Sense of Belonging/Social Connectedness
6. Happiness of Community
7. Other

RISK FACTORS
1. Child abuse or neglect
2. Maternal depression or infant bonding
3. Excess violent media viewing (Screen Time)
4. Alcohol & other drug abuse
5. Teen pregnancy, low birth weight, premature birth
6. Domestic violence
7. Other

NEGATIVE OUTCOMES
1. Suicide
2. Jail or prison
3. School failure / dropout
4. Unemployment
5. Prolonged suffering
6. Homelessness
7. Removal of children from their homes

	Total # Response	% of Total Response	PROTECTIVE FACTORS						RISK FACTORS						NEGATIVE OUTCOMES						
			1	2	3	4	5	6	1	2	3	4	5	6	1	2	3	4	5	6	7
ONLINE SURVEY	176	30%	1	4	5	3	2	6	1	4	5	2	6	3	2	5	3	6	4	1	7
HARDCOPY SURVEY	370	64%	1	3	6	4	2	5	1	5	4	2	6	3	1	5	2	7	4	3	6
KEY INFORMANT INTERVIEWS	32	6%	1	2	5	3	1	4	2	3	5	1	6	4	2	4	1	3	2	3	4
TOTALS	578	100%	1	3	6	4	2	5	1	4	5	2	6	3	1	5	2	6	4	3	7
	Weighted Totals		1	3	6	4	2	5	1	5	4	2	6	3	1	5	2	7	4	3	6
FINAL RANKING			**1**	**3**	**6**	**4**	**2**	**5**	**1**	*****	*****	**2**	**6**	**3**	**1**	**5**	**2**	*****	**4**	**3**	*****

PEI Stakeholder Input: Prevention Area Results

PROTECTIVE FACTORS

Rank	Total	Protective Factor	Weighted Rank	Total
1	4	Positive Child/Adult Relationships	1	1.0
2	7	Sense of Belonging/ Social Connectedness	2	1.94
3	12	Physical Activity	3	3.24
4	14	Adequate Housing	4	3.64
5	20	Happiness of Community	5	5.24
6	22	Contact with Nature	6	5.64

RISK FACTORS

Rank	Total	Risk Factor	Weighted Rank	Total
1	5	Child Abuse or Neglect	1	1.06
2	7	Alcohol & Other Drug Use	2	1.94
3	13	Domestic Violence	3	3.06
4	16	Maternal Depression & Infant Bonding	5	4.58
5	19	Excess Violent Media Viewing & Screen Time	4	4.36
6	24	Teen Pregnancy, Low Birth Weight, Premature Birth	6	6.0

LEVERAGE

NEGATIVE OUTCOMES

Rank	Total	Negative Outcomes	Weighted Rank	Total
1	6	Suicide	1	1.36
2	8	School Failure / Drop-out	2	2.24
3	10	Homelessness	3	2.4
4	14	Prolonged Suffering	4	3.88
5	19	Jail or Prison	5	4.94
6	22	Unemployment	7	6.46
7	24	Removal of Children from their Homes	6	6.18

PEI Expert Panel Documents

Expert Panel Purpose and Product
Meeting Agendas

PEI Expert Panel
Purpose & Product

- A small group consisting of individuals representing mental health, prevention, cultural competency, clients and family members.

- Synthesize Shasta County PEI information into priority funding areas and matching evidence-based programs.

- The work of the PEI Expert panel will be utilized by the Mental Health Services Act Advisory Committee to provide the Mental Health Board with recommendations for the PEI Plan.

Meeting Agenda

04/11/08 (Meeting 1)

- **Welcome, Thank You & Introductions**
- **PEI Expert Panel Review**
  - Who we are
  - Where we fit into the building of the PEI Plan
  - What resources we will use
  - What product we will create
- **PEI Guideline Review**
  - Enclosure 1
  - Review Tool
- **Stakeholder Input Results & Priority Areas**
  - Surveys
  - Key Informant Interviews
  - Focus Group: Activity 1

  } Combined Priority Areas

  - Focus Group: Activity 2 → Link with Priority Areas

Meeting Agenda

04/25/08 (Meeting 2)

- **Welcome, Thank You & Introductions**

- **PEI Expert Panel Stakeholder Results Analysis**
  - A review and brief discussion of the PEI Expert Panel's analysis of stakeholder results that determine the priority funding areas

- **Shasta County Mental Health Assessment**
  - A review and discussion of the Shasta County Mental Health Assessment data document

- **PEI Plan Vision**
  - Discussion of PEI Plan vision and direction.

- **Program Review & Selection**
  - Select evidence-based programs that will target priority funding areas

Meeting Agenda

05/09/08 (Meeting 3)

- **Welcome & Thank You**

- **PEI Expert Panel Purpose & Product**
  - A review of the PEI Expert Panel's role in the PEI planning process
  - A discussion about the product that will be produced by the PEI Expert Panel and how it will be used

- **Evidence-Based Program Review**
  - A review and brief discussion of the PEI Expert Panel's selection of EBP's that target the priority funding areas

- **Small Group Evidence-Based Program Analysis**
  - The panel will be broken into 3 small groups to read, analysis and review the EBP's for one of the 3 PEI priority populations.
  - Each group will then present their EBP reviews and recommendations to the larger group

- **PEI Plan Vision**
  - Discussion of PEI Plan vision and direction with suggestions and recommendation from the PEI Expert Panel

Attachment B

Public Comment

Shasta County Mental Health, Alcohol and Drug Programs
Mental Health Services Act
Prevention and Early Intervention Plan
Public Comments

MHSA Advisory Committee Comments

The MHSA Advisory Committee held three 2-hour meetings within the 30-day Public Comment Period. The following is an effort to capture the questions and comments of individual committee members. (Attached to this document is an MHSA Advisory Committee membership roster.)

Planning Process:

- Because of prevention focus, was there any outreach to the population at-large?
- NAMI believes the stakeholder input was only 25% consumer/family members. They'd like to see more outreach done.

Plan Contents:

- Plan proposes to provide training and materials cost, not staff costs for those agencies that receive the training. LEAs (local educational agencies) may not be able to participate.
- The current budget is worrisome. Agencies who might participate have already completed their 07/08 budgets, which do not include support for these programs.
- Seems there is a lot of money in one program.
- Would like the plan to consider earlier interventions, 3-5 year olds in preschool settings with serious emotional disturbances; consider now instead of at implementation.
- Like the "kitchen sink" approach.
- The Plan contains too many acronyms.
- Page 3: Define role of MHSA Advisory Committee.
- Page 8: Identify challenges with CSS planning.
- Page 10: Why are these topic areas defined? Health looks minimal.
- Page 14: Who selected key community needs?
- Page 17-19: Work plans should be combined.
- Page 21: MHSA Advisory Committee did not select projects.
- Page 22: Network of collaborative services - not just a couple. Define policy advice from rural group.
- Page 23: Where's the prevention population? Under Program Outcomes, need consumer/family involvement and add reach/retention.
- Page 30: Where's the #2 project? Is that what we are focusing on?
- Page 31: Partners may include, but not be limited to. Triple P not realistic for most health providers.
- Page 32: Need to highlight rural FQHCs.

- Page 33: How do you define underserved region?
- Page 56: PEI budget (in-house) versus CSS budget (outsourced).
- Would like to see a family advocate in the budget.
- In Project 1, would like explanation of advertising budget.
- In Project 1, NAMI would like to see their programs listed. NAMI would like the advertising budget of $150k cut by $50k, with that $50k put into a line item for a consumer/family member position to recruit volunteers and encourage larger participation.
- In Project 2, NAMI believe this project is at the expense of families who can't get diagnosed. They would like to see more money go towards the identification of diagnosis instead of Triple P
- In Project 3, ACE should be delayed and funds should be transferred to get kids diagnosed. "Diagnosis first, them get the parent help."
- Would like to see stronger language regarding substance abuse.
- Page 13: Info should be made available at MLK, No. CA Hispanic Coalition, Church in Anderson, Mien and Hispanic radio, and interpreters should be made available.
- Page 16, paragraph 1, line 2: Give example of "natural" locations.
- Page 16, paragraph C: Who is the target community?
- Page 17, Faith Community: Inter-faith group?
- Page 17, Community Education: Who? Mien radio, multi-cultural celebration at CVHS.
- Page 22, paragraph 3: What is mandated through the state for teacher training? Is this included or is it necessary to work at the state level or through CTA?
- Page 22, paragraph 4: Maybe a representative from Mental Health can come to a SCCAR meeting and see how the two groups might work together. SCCAR does work on setting up forums. Maybe a column in the SCCAR Newsletter.
- Page 29, paragraph 5: Be sure to share this with middle school principals, teachers, counselors and all staff.
- Page 30: Regarding at-risk middle school students, just being a middle schooler puts a person at risk. Community service projects help middle school students feel positive and help reverse the bad image they have in the community.
- Page 32, Pilot Middle School Program: SCCAR is currently working on a cyber-bullying presentation and some SCCAR people might be interested in working with Mental Health.
- Page 38, Pilot Middle School Program: Why would you initiate a program near the end of the school year?
- Page 44, paragraph 3: Consider talking with Helen Herd, principal at Shasta Lake School.
- Page 50, Program Highlights: Work with same gender families who are successful and other successful families.

Implementation:

- In Project 1, destig needs to be stressed. Include clients/family members heavily in implementation planning, parents and volunteers.
- In Project 2, NAMI believe this project is at the expense of families who can't get diagnosed. They would like to see more money go towards the identification of diagnosis instead of Triple P.
- Implementation is a critical part.
- Implementation is a concern. How are we going to engage families?
- Implementation should include a strategy for substance abuse issues - a bridge to services is needed.
- Probation would like to be involved in implementation.
- In Project 1, make sure when we co outreach to include the "whole" family, which includes our older adults.
- Project 1, Project Implementation - Coordinate with PFLAG, talk with Dough Mathers regarding a compassionate listening program, have interpreters available.
- YMCA and other community groups should be included in order to reach a broader section of people and you might want to imbed a program in a particular school, but keep it in a place that will provide stable access for the family.
- We need to include help for parents who have problems in the home, which affects children's health in general.

General:

- The DMH Guidelines are not very user-friendly, subsequently rendering the plan document somewhat cumbersome. For easier reading/evaluation of future plans, the county should create an overview document based on the MHSOAC Review Tool for Prevention and Early Intervention. This overview document should provide encapsulated information on how each MHSOAC plan requirement was met and the location of that information in the plan. Maybe also create a condensed version of the plan.
- This PEI Plan will make Triple P available to a greater population and will allow it to be used more consistently throughout the county.
- Looks forward to the plan being implemented. It's very exciting. Suggest we consider spending money on gas/meals/snacks in order to bring families in.
- In general, the plan is good and will probably work. It's been a long time coming and we're anxious to get started.
- The beauty of the plan is that it's a growing fluid document which gives the community an opportunity for continual input.
- Reminded the Advisory Committee that the Plan is based on what the community wants, not what the Committee wants.

Other Public Comments

Attached:

09/25/08, 2-page letter
Tracy Ray, Director
The Great Partnership

09/29/08, 1-page email
Cindy Dodds, Executive Director
Tri County Community Network

09/30/08, 2-page letter
Donnell Ewert, MPH, Director
Shasta County Public Health

10/04/08, 4-page letter
Marjorie Hall, President
NAMI Shasta County

10/06/08, 2-page letter
Tish Harris, Community and Family Member, Contributing Health Professional

10/07/08, 1-page email
Lynn Dorroh, LMFT, Executive Director
Hill Country Community Clinic

Mental Health Services Act Advisory Committee (MHSAAC)

Shasta County Board of Supervisor

Shasta County Mental Health Board

Mental Health Services Act Advisory Committee
Chair: Susan Wilson

COUNTY STAFF	UNDERSERVED POPULATION	EDUCATION	CLIENTS & FAMILY MEMBERS	HEALTH CARE	LAW ENFORCEMENT	COMMUNITY BASED ORGANIZATION
Mental Health Maxine Wayda	Cultural Diversity Theresa Bible	Shasta County Office of Education Denny Mills	National Alliance on Mental Illness Diana Clayton	Hospitals Stephanie Stringfield	Police Department Roger Moore	CBO: Rural vacant
Social Services Jane Work	Cultural Diversity Lee Macey	School Districts Tracy Ray	Drug & Alcohol Advisory Board Michelle Gazzigli	Northern Valley Medical Association vacant	Sheriff's Department Don VanBuskirk	CBO: Youth Susan Wilson
Public Health Donnell Ewert	Cultural Diversity Chrissie Whipple	College & Universities Greg White	Adult Client or Family Member vacant	Shasta Consortium of Community Health Centers Doreen Bradshaw	Probation/Parole Sherri Leitem	CBO: Seniors Joanne McCarley
	Cultural Diversity Rachel Freemon		Youth Client or Family Member Karen Crum			
	Cultural Diversity Amy Brom					

MHSAAC Role

Provide input and guidance for the planning, implementation and oversight of the Mental Health Services Act (MHSA).

Act as a subcommittee of the Shasta County Mental Health Board

The MHSA Advisory Committee (MHSAAC) will include 25 members of the community that will represent various stakeholder groups such as underserved populations, clients and family members, law enforcement, education, etc…

MHSAAC Creation

MHSAAC Structure:
Advisory committee required by State Department of Mental Health for planning, implementation and oversight of the MHSA
Stakeholder groups to be included in the advisory committee are required by the State
Advisory committee structure finalized by the MHSA Planning Committee
Structure approved by the Mental Health Board

MHSAAC Member Recommendations:
Individuals were recommended by members of the MHSA Planning Committee and community
Consideration for advisory committee was based on criteria (see next page)
Individuals recommended for filled positions will be notified of the recommendation and contacted if a vacancy on the MHSAAC occurs.

MHSAAC Member Criteria & Responsibilities

MHSAAC Member Criteria:

Knowledge
Experience
Interest
Represent MHSA Sector
Capable & Willing to Serve

MHSAAC Member Responsibilities:

Serve a 1, 2, or 3 year term by lottery selection
Regularly attend meetings
Commitment
Attend special meetings that will be called as needed

MHSA Planning Committee

Mental Health Board Executive Committee

Lowell Streiker
Mary Rickert
Susan Wilson
Marj Hall

Mental Health Staff

Mark Montgomery
David Reiten
Maxine Wayda
Joy Garcia

3450 Tamarack
Redding, California 96003

Phone (530) 225-0411
Fax (530) 225-0413
tray@gwusd.org

The GREAT Partnership

Gateway, Redding, Enterprise
Achieving Together

September 25, 2008

Dear Mental Health Board Members,

As a member of the MHSA committee, a member of the local educational community since 1991 and a family member of a consumer, I find it imperative that I inform you of the flaws in the current PEI plan being presented. The plan states that a "comprehensive Prevention and Early Intervention plan that addresses the entire community in all its socioeconomic diversity, geographic diversity, and ethnic and cultural diversity " is being put before you. It goes on to state that the goal of the project is to: implement Prevention and Early Intervention supports, services, and evidence based programs in Shasta County that will address PEI areas selected by the community during the process. The current plan misses this mark in many areas:
- lack of an early intervention component,
-lack of sensitivity to the needs of consumers and family members,
-funding of an extremely expensive parenting component that augments an existing program being implemented by Shasta County Headstart.

County staff have commented that the PEI funds could not supplant any existing programs and in the same time they suggest that it is important to support what already exists in our county. This contradiction is confusing and troubling.

The plan includes a very expensive, research based parent program, Triple P. However, there is no early intervention component that engages the educational system until students are in junior high school. The plan suggests a "pilot" program targeting at-risk middle school students to provide a sense of belonging by building developmental assets. As an educator I can tell you that age 13 is not considered early intervention. Sex, drugs and other risk taking behaviors have already been initiated by many in this age group. Many, have already been removed from a comprehensive school campus and are in alternative educational settings. Moreover, we have missed the optimal opportunity to intervene as adults at this point in their development; they are peer centered at this stage in life, and research to support this is well documented.

County staff continue to support the idea of prevention through the augmentation of an existing parenting program that is currently implemented by Shasta County Headstart. As an educator, I realize the importance of having a supportive family behind our students, but I also recognize that today's parents often have different priorities as demonstrated in the research by Dr. Ruby Payne.

Her work emphasizes that families of poverty have very different priorities than the middle class educators attempting to reach them. Dr. Payne states " resources of students and adults should be analyzed before dispensing advice or seeking solutions to the situation. What may seem to be very workable suggestions from a middle-class point of view may be virtually impossible given the resources available to those in poverty." When I read the PEI plan, I was reminded of Dr. Payne's work. This plan has the majority of resources going to premises that we are going to step in and tell parents how to do things. I am not confident this approach will have the anticipated, long term outcomes we seek. I am suggesting that we include in the PEI plan some earlier intervention in the school setting. Children as young as kindergarten are being removed from school due to extreme behaviors.

Do you know that there are children in our community by age 3 that are in an educational/daycare setting for up to 10 hours per day? Preschool beginning at age 3 is not uncommon and by age 5 when a child is in

kindergarten they attend school 6 hours per day. As an educator, I know we can make a difference in children's lives during the time we have them in program. What we need are:
- researched approaches
- staff training
-support to keep our most challenging students in our classrooms.

Over the past 10 years education has focused on developing programs to address students with Autism. Research based practices, staff training and support have been wrapped around this group of children. We see huge gains in children with this disability who receive early intervention services and appropriate programming. It is my contention, that we need to put the same efforts into developing adequate programs for children with severe emotional disturbances. In Shasta County, the current number of children diagnosed educationally with Severe Emotional Disturbance is 243, number of children diagnosed educationally with Autism is 194. (Shasta County SELPA).

Improve the PEI plan by including, an early intervention component that would allow educators the opportunity for training on how to work with the young child experiencing early signs of mental illness. Then offer the supports necessary to keep these young children in school. Help educators develop strong, research based practices that will assist the education of this population of children. Our educational resources alone can not begin to address the numbers of children we are seeing with early signs of mental illness. We now have children as young as 3 years old that are on medications.

You have an incredibly important responsibility by approving the PEI plan before you. I ask that you strongly consider adding an early intervention component that would address intervention at the preschool age. My siblings became ill in their late teens, but demonstrated risk factors at a much earlier age. As an educator, I have long been involved in bringing an early intervention piece into practice and had such high hopes for the MSHA funding. Please, take the time to question the current plan, ask where the early intervention portion of the plan is... take a strong stand for the young child in Shasta County, they are counting on you.

Sincerely

Tracy Ray
Director, GREAT Partnership

Jamie Hannigan

From: Tri County Community Network [tccn@richm.twcbc.com]

Sent: Monday, September 29, 2008 2:55 PM

To: Jamie Hannigan

Subject: PEI feedback

Hi Jamie -

I have had a little time to go over the PEI plan. I applaud the plans to shed light on MH, thus reducing stigma, and the emphasis on Triple P. While I am a big fan of the ACE research, Project 3 makes me a little apprehensive.

I would ask that you consider using existing collaborative groups to the extent possible, and resist the temptation to spend the resources ($) for this project to fill funding gaps in HHSA agencies.

That's all I've got . . .

Hope all is well with you!

Cindy Dodds, Executive Director
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Shasta County

Health and Human Services Agency

Marta McKenzie, R.D., M.P.H., Director

Public Health

Donnell Ewert, M.P.H., Director
Andrew Deckert, M.D., M.P.H., Health Officer

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October 8, 2008

Jamie Hannigan
SCDMH Administration
2640 Breslauer Way
Redding, CA 96001

Dear Ms. Hannigan:

I am writing to comment on the Mental Health Services Act (MHSA), Prevention and Early Intervention (PEI) draft plan for Shasta County. First, I believe the process for creating the MHSA-PEI plan has been very thorough and has extensively engaged both the professional and client populations and important stakeholders. Several staff members from my department were involved in the planning process, and others participated in focus groups. Shasta County's Health Officer, Dr. Andrew Deckert, served on the expert panel created to evaluate possible programs for funding through MHSA-PEI, and I very much commend Shasta County Mental Health for seriously addressing the primary (universal) prevention perspective in the planning process. I think the inclusion of the public health perspective emphasized that the entire population, not just mental health clients, have a stake in preventing mental illness.

In regard to the programs recommended for funding in the plan, I think the plan is quite balanced between prevention and early intervention. I think there is always a temptation to pay more attention to the urgent and important issues (early intervention and treatment) and shortchange the not urgent yet important issues (prevention). It is true that we do not know how to prevent all mental illness. Yet this plan does not ignore the fact that some mental illness is preventable, and residents of this county will benefit by the forward thinking of this plan which strives to prevent mental illness that could occur decades from now due to childhood trauma.

One of the great strengths of the plan is the effort to address adverse childhood experiences (ACE), which have been clearly associated with increased adulthood mental illness, high risk behaviors such as tobacco and substance abuse, and obesity and other chronic diseases. While this plan does not specify interventions related to ACE that will be funded by MHSA-PEI, the development of a strategic plan to prevent childhood trauma is the first step in reducing these experiences and improving the life course of many children.

The evidence based program called Triple P is a well known and evaluated intervention that already has some traction here in Shasta County. Shasta County Public Health (SCPH) and First 5 Shasta (FFS) have joined together to fund an initiative to prevent early childhood exposure to violence, and Shasta Head Start was funded through that initiative to implement Levels 2-5 of Triple P within their centers. They will institutionalize the program over the next two years, and it will continue without further financial support from SCPH and FFS. Through MHSA-PEI, the opportunity to greatly expand the reach of Triple P in our community is great, and I think it is very strategic to build on something already going on in our community, rather than funding another competing intervention.

The community education and awareness aspect of the MHSA-PEI plan is valuable for prevention on many levels, but I will highlight just a few. Destigmatizing mental illness is a key to enabling more people with early signs of mental illness to seek care. Engaging faith communities is a good approach to destigmatization, as they are well organized and can reach a lot of people with any given message. Additionally, a group already exists to address health within faith communities. Educating our local ethnic minority communities about mental health and mental illness is a challenge, and the PEI plan addresses this crucial health equity need head on. Finally, educating primary health providers about mental health topics can help improve care to many people in our community who access care through the private sector.

Suicide prevention is a significant component in the community education and awareness section of the plan. Suicide is a significant cause of death in Shasta County and our suicide completion rate is twice as high as the State of California. In 2006, 43 Shasta County residents died from suicide, the highest number ever recorded in one year. I am pleased that the MHSA-PEI plan has included suicide prevention. SCPH adopted a strategic plan for suicide prevention in 2007 and stands ready to partner with Mental Health in implementing interventions in our community to reduce suicide. The Signs of Suicide program and the QPR training currently conducted by NAMI on a volunteer basis are two excellent interventions mentioned in the plan. Addressing safe gun storage is also a necessary component of any suicide prevention plan in Shasta County, as one reason our suicide rate is so high is because guns are a very lethal means and they are often used in suicide attempts here due to our high degree of gun ownership.

I am supportive of the MHSA-PEI plan as it is written, and look forward to improvements in mental well being in the Shasta County population as a result of this progressive planning effort.

Sincerely,

Donnell Ewert, MPH
Director of Public Health

Line reference

NAMI SHASTA COUNTY
1250 CALIFORNIA STREET REDDING, CA 96001
EMAIL namisc2008@charterinternet.com
530-605-1647

OCTOBER 4, 2008

Dear Shasta County Department of Human Health Services, Marta McKenzie, Director
Shasta County Department of Mental Health, Mark Montgomery, Director
Shasta County Board of Supervisors, David Kehoe, Supervisor
Shasta County Mental Health Board, Mary Rickart, Chair
Shasta County Mental Health Services Act Advisory Committee, Sue Wilson, Chair
National Alliance on Mental Illness California, Dede Ranahan, MHSA Coordinator

Re: Shasta County Mental Health Services Act Prevention and Early Intervention (PEI) Plan

NAMI Shasta County is a grassroots organization for people living with mental illnesses and their families. We are NAMI Shasta County, affiliates of the National Alliance on Mental Illness and the National Alliance on Mental Illness California.

We are angry, concerned, and disappointed with the proposed Prevention and Early Intervention Plan for our county. We are alarmed over the inequity between the prevention and early intervention strategies. The imbalance in the plan is that it offers a great deal of education regarding prevention, but it offers little to nothing to intervene when there are prodromal symptoms of serious mental illness, or when the first psychotic break occurs. We are especially alarmed over the lack of priority and compassion for individuals experiencing their first psychotic break in all age groups. In the PEI plan, this population has been put on the back burner, with emphasis on more studies and strategic planning regarding adverse childhood experience prevention (i.e. child maltreatment/abuse) which says nothing about the neurobiological aspect of serious and persistent mental illnesses. It has been NAMI's "ray of hope for years" that early recognition of undiagnosed mental illnesses will lead to critical and immediate intervention. Early intervention can lead to better chances for successes in recovery, wellness and resiliency for the entire family unit. Due to the nature of the mental illnesses and where causes are not clearly defined, early intervention is vital. The intent of the MHSA is to move away from a "fail first" system.

THE STAKE HOLDER PROCESS:

As this process has evolved, the primary stakeholders were not adequately prepared. However, we are the recipients of services and we have been requesting early identification and intervention for many years. As clients and family members, we were not familiar with the "consensus building" process, and were dismayed that our priorities were regulated to last place. The process was confusing and hard to understand. Everything mentioned in the consensus building experience was important, however because the plan **is** Prevention and Early Intervention, many people thought that early intervention of serious and persistent mental illnesses was assumed to be a major priority.

Although the stakeholder process invited and heard many people, the ratio between family members and consumers, direct recipients of services, was about 25% family and consumer, and 75% professional and providers. The ratio for consumer participation is even less. This suggests that the voices of direct recipients, consumers and family members, are more symbolic in participation and are consistently overshadowed by professional and provider opinions. The strength in the MHSA is that the transformation

of the mental health system is to be client and family driven in all aspects from inception to implementation. Many people did not recognize that the process was about setting priorities. We understood that the process was about ideas or creating a wish list in or about a two-hour activity. We thought these ideas would enhance the concept of prevention and early invention. In no way, did we think it would delay program implementation for early intervention.

Recommendation 1: [1]

This recommendation comes directly from the California Network of clients and is a recommendation that NAMI Shasta County agrees with:

> "A client- and family-driven process calls for majority representation Taking our cue from local mental health boards and commissions, a minimum of fifty (50) percent plus one (1) client and family members (including parents or caregivers of children or youth) should be required in the membership of all local steering committees and other stakeholder decision-making bodies before those bodies can be permitted to make legally binding decisions regarding plans. No less than twenty-five (25) percent plus one (1) of the total membership and no less than fifty (50) percent plus one (1) of the client and family membership should be comprised of clients/survivors."

Project 1: COMMUNITY EDUCATION AND AWARENESS

In principle, we agree with Project One.
National Alliance on Mental Illness of Shasta County (NAMI) has a strong record of accomplishment for reaching people in Shasta County who need, and want, education on prevention and intervention for people seriously impacted by chronic and persistent mental illness. These include programs that are specific to mental illness awareness and education, such as *Crisis Intervention Team (CIT) Training*, *Family-to-Family Education*, *Parents and Teachers as Allies*, *Peer to Peer*, and *Provider Education*. These programs fit into the PEI Plan requirements.

Recommendation 2:

NAMI (National Alliance on Mental Illness) Shasta County recommends that the advertising budget be reduced by fifty thousand dollars, and add line items to the budget that specify a family specialist and a consumer specialist whose focus is on mental illness and who are not employed by Shasta County. These individuals will be paid as consultants, equal to other mental health specialists employed by the system, to directly represent clients and families according to the Mental Health Services Act intent, which is to be consumer and family driven. This would give consumers and families direct access to share concerns, and give input into the process of planning and implementation. These individuals should represent their constituency and be included in the budget, because the MHSA requires that consumers and families be in actively at the table in every phase of the MHSA process.

Recommendation 3:

NAMI programs that are geared to education and awareness, specific to mental illnesses need to be included in the plan under "Program Titles" listed under Project 1. People want to learn about symptoms of mental illnesses to be able to take early action when needed.

[1] *California Network of Clients Position on Client Involvement in Local Mental Health Services Act (MHSA (p.7).* main@californiaclients.org _ Web: www.californiaclients.org

The following is an excerpt from the mental health services act oversight and accountability commission *Stigma and Discrimination Report (p.16).*

> . "The NAMI Family-to-Family peer support and education program introduces family members to the challenges of stigma and discrimination: "If someone has never been subjected to the systematic discrimination which occurs in mental illness, they cannot remotely imagine how terrible it feels, how it mitigates against the hope and optimism we need to take risks and move on with our lives . . . this is the bizarre aspect of recovering from mental illness. It requires us to endure public scorn while we try to heal" (NAMI, 1998, p. 11.1). "[2]

Project 2: PREVENTION AND EARLY INTERVENTION PROGRAMS

The Triple P program is geared to training the professionals and paraprofessionals who by design already have training in teaching family skills. Families need enhanced skills, to address the unique issues specific to parents and others living with individuals 24/7 who have diagnosed, or undiagnosed mental illnesses.

We are concerned that Triple P will be focused on basic parenting skills, with the focus on maladaptive parenting vs. recognizing that there is a medical reason for the child's behaviors. NAMI has advocated hard and long against stigma and discrimination toward families who have a loved one who is acting "differently" often with undiagnosed mental illness.

> From the Mental Health Services Act on Stigma and Discrimination (p.7)
> "Family members are frequently stigmatized, especially by clinicians and the mental health system but also by society at large, judged responsible for a loved one's mental illness and treated with suspicion or disapproval. These views can be damaging to people who are already struggling under challenging circumstances, leading to isolation and a high risk of developing clinical depression themselves (Gray, 2003)."[3]

Our fear is that focusing on parenting will stigmatize and increase the stresses of parenting an ill child and will strain the family even more, creating barriers to seeking services, because of the fear of appearing to be a "bad parent". When parents are identified as inappropriate, or inadequate, in their parenting skills due to their child's undiagnosed mental illness, they often are terrified that their child may be taken away from them.

Recommendation 4:

Re-examine the overall value of Triple P. We recommend that the Triple P be modified, or examine less costly, family friendly programs. We know that most families who are in crisis face obstacles that will make it difficult or impossible to attend classes for parenting.

The purpose of this recommendation is to find effective programs at a more reasonable cost, so that there are resources available to address, with equity, the need for immediate and effective early intervention for individuals experiencing prodromal symptoms of mental illnesses, or a first psychotic break.

[2] MHSOAC Report on Stigma and Discrimination
http://www.dmh.ca.gov/MHSOAC/docs/StigmaAndDiscriminationReport07Jun12.pdf
[3] R MHSOAC Report on Stigma and Discrimination eport on Stigma and Discrimination
http://www.dmh.ca.gov/MHSOAC/docs/StigmaAndDiscriminationReport07Jun12.pdf

Project 3: ADVERSE CHILDHOOD EXPERIENCE (ACE)

Recommendation 5:

Delay the study, and immediately put the money into identification and intervention programs for individuals experiencing the onset of serious psychiatric illnesses. The Portland Identification and Early Referral Program (PIER) will address the very first signs of psychosis between the ages of 12 and 35 years of age. Other programs address identification and intervention of very young children. *All people* deserve early intervention, regardless of age.

Summary Conclusion:

We are alarmed over the inequity between the prevention and early intervention strategies. The imbalance in the plan is that it offers a great deal of education regarding prevention, but it lacks immediate programs on early intervention for individuals experiencing the onset of serious mental illnesses. We are especially upset over the lack of priority for individuals experiencing their first psychotic break in all age groups. In the plan, this fragile population has been put on the back burner once again, with the emphasis on more studies and strategic planning regarding adverse childhood experience prevention (i.e. child maltreatment/abuse) which says nothing about the neurobiological aspect of serious and persistent mental illnesses, nor does it provide any kind of immediate intervention for individuals of any age. The plan suggests early intervention for this population *might* take place in a couple of years if funding and resources are available. This is unacceptable. We think intervention strategies need to be included in this plan equitably, and not be relegated to some other component of the MHSA master plan.

We ask that you look at the inequity between prevention and intervention and re-examine the plan, and our recommendations. Earlier intervention has been a long time hope and request from family members. NAMI Shasta County hopes that the reviewers of the PEI plan will take our statement seriously, and consider the need for early intervention to be on par with prevention and community awareness activities.

Our commitment to the MHSA ideal of transformation of services is of utmost concern because it originally gave a new ray of hope that help would be coming, especially for early intervention. We hope that help is truly on the way.

Sincerely,

Marjorie Hall, President
NAMI Shasta County
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Redding, CA 96001
(530) 605-1647 fax (530) 605-1648
Namisc2008@charterinternet.com
or
Email: marjhall@charter.net
(530) 221-3163
or
Email: dianaeclayton@aol.com
cc: NAMI Shasta County Officers

October 6, 2008

Mark Montgomery, Ph.D.
Director, Shasta County Mental Health
Redding, CA 96003

Mark,

Thank you for your time and consideration. I have read the PEI Guidelines and the Dept.'s PEI Plan. I have also attended the Advisory Committee Meetings as my schedule has allowed, and supported Doreen with research and opinion regarding the Plan.
I know the County is a "slave to many masters" when it comes to the 5 Component Plans of MHSA and I am also aware that a lot of hard work has been accepted and accomplished through the process.
The following are my concerns regarding the Shasta County MHSA/PEI Plan:

Is the Recovery Philosophy evident in this plan? Family members and clients are named as "beneficiaries" and are not included in any aspect of the activities of implementation, evaluation or the budget. Wouldn't this be the perfect opportunity to begin "walking the walk" of Recovery with some of our citizens who struggle with mental health?

Community members, including members of the Advisory Committee say that they have trouble understanding the Plan. I have seen Dept. Staff attempt to simplify the material through graphs, organizational charts and other tools, but the bottom line is, it's not "user friendly to allow meaningful stakeholder input and involvement" as prescribed in the guidelines.

I am concerned about the lack of funding for "new" hires. The perception is that the county is subsidizing current positions. Is this consistent with "non supplant" requirements?

The **funding of a "study" for $88,000 that provides services to no one increases the belief that the department and public health ARE subsidizing their organizations** rather than serving the people.

One of the strengths of the PEI idealism is that “non traditional” points of access for prevention and early intervention would be optimized. FQHC’s, among others are designated in the Shasta Plan as sites for staff training through Triple P, as “when resources become available”. **Because FQHC’s are also described in the Plan, as “…significant points of contact for families who are experiencing challenges with their children’s social, emotional and behavioral development”, it seems inconsistent to relegate resources “as available” rather than as a significant priority.**

The pilot program targeting At-Risk Youth is a concern on several levels:

1. Should these resources support the notion that strengthening developmental assets for someone who is experiencing mental illness or having a first break will contribute to the improvement of their health?
2. There is the perception of a conflict of interest regarding a staff member who is contracted to manage the Youth Program cited in the Plan in addition to sitting on the MHB, and managing the MHSA/PEI Advisory Committee.
3. The Plan admits, “we are not sure what specific outcomes will result”.

And finally, **do you believe this Plan is “transformational**” for our community families, children and teens who will encounter for the first time the predictable horrific social, psychological, physical and economic consequences of mental illness?

I look forward to our meeting and the discussion of our county’s plan.

Sincerely,

Tish Harris
Community Member
Family Member
Contributing Health Professional

Jamie Hannigan

From: Lynn Dorroh [ldorroh@hillcountryclinic.org]

Sent: Tuesday, October 07, 2008 11:21 AM

To: Jamie Hannigan

Cc: Mark Montgomery

Subject: PEI Comment

I want to comment on Shasta County's draft Prevention and Early Intervention Plan which is part of the Mental Health Services Act. The goals and target population in the plan are admirable.

. I have been working to prevent and treat adverse childhood experiences in Eastern Shasta County for twenty-five years. My concerns about the plan relate to the public health approach that is very evident throughout the plan. The Public Health Department's focus on primary prevention and population based strategies is appropriate in many situations. However, the prevention of adverse childhood experiences cannot be fully accomplished without direct intervention in a generation. Someone, whether it be school, health care provider, neighbor or social services, must signal the alarm that adverse childhood experiences are taking place, and an appropriate intervention designed and implemented.

Dollars for this type of work are precious and few. I am concerned that too many PEI dollars will be directed towards population based strategies that in and of themselves are good, but not at the heart of early intervention. I hope as the plan moves into the future that maximum funding will be provided to people doing work with stressed families and trauma-exposed individuals.

Sincerely,

Lynn Dorroh, LMFT
Executive Director
Hill Country Community Clinic

Attachment C

Executive Summary

Shasta County Mental Health Prevention & Early Intervention Plan

Stakeholder Input Ranking of PEI Priority Areas

Priority Populations * from PEI Guidelines	Key Mental Health Needs * from PEI Guidelines	Protective Factors	Risk Factors	Negative Outcomes * from PEI Guidelines
1 Children/Youth in Stressed Families	**1** Increase prevention efforts and response to early signs of emotional and behavioral health problems among at-risk children, youth, and young adult populations.	**1** Positive Child/Adult Relationships	**1** Child Abuse or Neglect	**1** Suicide
2 Trauma Exposed Individuals	**2** Reduce disparities in access to mental health services	**2** Sense of Belonging/ Social Connectedness	**2** Alcohol & Other Drug Use	**2** School Failure / Drop-out
3 Individuals Experiencing the Onset of Serious Psychiatric Illness	**3** Reduce the negative psycho-social impact of trauma on all ages	**3** Physical Activity	**3** Domestic Violence	**3** Homelessness
4 Children/Youth at Risk of School Failure	**4** Reduce stigma and discrimination affecting individuals with mental health problems	**4** Adequate Housing	**4** Maternal Depression & Infant Bonding	**4** Prolonged Suffering
5 Children/Youth at Risk of Juvenile Justice Involvement	**5** Increase public knowledge of the signs of suicide risk and appropriate actions to prevent suicide	**5** Happiness of Community	**5** Excess Violent Media Viewing & Screen Time	**5** Jail or Prison
6 Underserved Cultural Populations		**6** Contact with Nature	**6** Teen Pregnancy, Low Birth Weight, Premature Birth	**6** Unemployment
				7 Removal of Children from their Homes

Shasta County Mental Health Prevention & Early Intervention Plan

Project 1: Community Education and Awareness

Project Goals

The goal of the *Community Education and Awareness* project is to:

- increase the community's knowledge of mental health issues and available mental health services
- decrease the stigma and discrimination associated with mental health problems
- enhance the community's capacity to recognize the early signs and symptoms of mental health problem and provide appropriate support for individuals and families who experience mental illness including linkage to available mental health services
- promote mental wellbeing in the community

Project Programs and Activities

The table below contains examples of potential activities for Project 1. Stakeholders overwhelmingly suggested community education and awareness activities to be part of the PEI plan.

Topic or Target Group
Program Example
Educational program that addresses the topic or target population

Destigmatization *Program Example* SAMHSA: Mental Health It's Part of All of Our Lives	**Suicide Prevention** *Program Examples* QPR and SOS
Educators *Program Examples* Unlocking the Mysteries of Children's Mental Health and Parents & Teachers as Allies	**Older Adults** *Program Example* Gatekeeper Case Finding & Response System
Faith Community *Program Example* Partners in Healing	**Health/Social Service Providers** *Program Example* Responding Effectively: A Mental Health Curriculum
Health Care Providers *Program Example* Academic Detailing by CHDP Nurses	**Underserved Communities** *Program Example* Educate underserved community leaders in Mental Health

Methods of program delivery suggested by the community:
Collaborate with Mental Health Board Community Education Subcommittee
Trainings & Workshops
Media Campaign
Events & Health Fair

Project Outcomes

Project outcomes include:

- individuals with mental illness and their families will be beneficiaries of improved education that leads to early identification and referral to mental health services
- increase help-seeking behavior
- decrease negative outcomes associated with mental illness such as suicide and isolation
- improve access to resources to address mental illness and accompanying health and social needs particularly for underserved areas of the county and underserved economic and cultural groups
- strengthen collaborations with other agencies, including improvements in the timelines and efficiency of referrals

Project Budget

*approximation

$389,473

Shasta County Mental Health Prevention & Early Intervention Plan

Project 2: Evidence-Based Interventions

Project Goals

The goal of the *Evidence-based Interventions* project is to:

- implement PEI supports, services, and evidence-based programs in Shasta County that will specifically address priority PEI areas and populations selected by the community during the stakeholder input process
- recognize the early signs of mental health issues and provide resources to aid people dealing with those challenges

Project Programs and Activities

The table below contains examples of specific programs and potential activities for Project 2. Project implementation includes prevention and early intervention activities that specifically address PEI Priority Populations, Key Mental Health Needs, Protective Factors and Risk Factors selected by the community during the stakeholder input process.

Triple P: Positive Parenting Program *Program Example* 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 5 levels of intervention of increasing strength for parents of children. Early implementation will target birth to age 12.
Program Targeting: At-Risk Middle School Students *Program Examples* Life Skills Training Across the Ages Girls Circle/Boys Council
Interventions Targeting: Trauma-Exposed Individuals *Program Example* Program development and trainings for child and adult populations.
Early Identification and Engagement of: Individuals Experiencing the Onset of Serious Psychiatric Illness *Program Example* Program development that includes education, screening and outreach.

Project Outcomes

Project outcomes include:

- decrease in observed and parent-reported child disruptive behavior as well as an increase in the implementation of targeted parenting strategies
- prevent severe behavioral, emotional and developmental problems in children
- increase at-risk middle school students resiliency and developmental assets
- strengthen the Department's relationship with providers and broaden the reach of this program and take advantage of the existing trust between community providers and the clients of focus
- reduction of family stress and ultimately family violence and child maltreatment by giving high-risk families strategies to cope with their child's behavioral and emotional problems
- increase the identification of the early signs and symptoms of serious psychiatric illness and appropriate referral and treatment

Project Budget

*approximation

$740,493

Shasta County Mental Health Prevention & Early Intervention Plan

Project 3: Adverse Childhood Experience

Project Goals

The goal of the *Adverse Childhood Experience* project is to:

- develop, via strategic planning, a systematic, multi-sectored collaborative approach to documenting and decreasing Adverse Childhood Experience (ACE) in our community
- collaborate with community partners to implement and evaluate evidence-based programs/strategies to decrease ACE

Project Programs and Activities

The table below contains examples of potential activities for Project 2.
The Adverse Childhood Experiences (ACE) Study is one of the largest investigations ever conducted on the links between childhood maltreatment and later-life health and well-being. These experiences are major risk factors for negative physical and mental health outcomes, as well as poor quality of life. ACE include: 1.)Recurrent physical abuse, 2.)Recurrent emotional abuse, 3.) Contact sexual abuse, 4.)An alcohol and/or drug abuser in the household, 5.)An incarcerated household member, 6.) Someone who is chronically depressed, mentally ill, institutionalized, or suicidal, 7.)Mother is treated violently, 8.)One or no parents, 9.)Emotional or physical neglect.

I. Strategic Planning for ACE Prevention

Program Example

Strategic Planning & Community Collaboration

Steps include:
Prepare report of ACE evidence
Form community collaborative
Strategic Plan to prevent and decrease ACE
Outline community strategy on ACE prevention

II. Coordination of Implementation & Evaluation of EBP

Program Example

Community Collaboration for Effective Implementation of EBP

Project Outcomes

Project outcomes include:

- decrease exposure to violence
- decrease the consequences of substance abuse, including the early onset of substance use
- increase early identification of difficulty in social, emotional and behavioral development or functioning
- increase access to adequate services
- create a new level of community collaboration to systematically and effectively address ACE
- identify where community funds addressing ACE are currently directed, where funds are being used for duplicate efforts, where there are gaps in funding, and where research suggest resources can best be directed to reduce ACE
- establish a strategic plan that includes a community plan of action to reduce ACE
- development of a regular report on ACE in the county and efforts across community sectors to address it

Project Budget

*approximation

$88,594