Mental Health Services Act Three-Year Program and Expenditure Plan FY 2023/24-FY 2025/26

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Introduction

In 2004, California voters approved Proposition 63 to enact the Mental Health Services Act (MHSA) with the goal of transforming public behavioral health systems across the state. More than two million children, adults and seniors in California are affected by a potentially disabling mental illness each year. In Humboldt County, it is estimated that the rate of adult serious mental illness is 5.7% (Mapping the Gaps: Mental Health in California, California Health Care Foundation, July 2013). Californians approved the MHSA to create a mental health system that can guarantee the same level of care already extended to those who face other kinds of illness. Failure to address and treat mental illness as a public health issue not only creates grief and emotional pain, but it undoubtedly imposes significant public costs from increased levels of hospitalizations, unemployment, homelessness, academic failure and incarcerations. With the funding and regulatory support of the MHSA, counties can build capacity and implement systems of care, resulting in greater accessibility and effectiveness of treatment services across the continuum of prevention to recovery. MHSA funds can also be used to develop a skilled workforce that builds cultures of acceptance and awareness of behavioral health issues and resources throughout their communities. The MHSA can also fund capital projects and technological infrastructure.

The MHSA created a dedicated funding source by imposing a 1% tax on California residents with personal incomes greater than one million dollars. MHSA funds are accumulated by the State before being redistributed to each behavioral health jurisdiction (all 58 counties, and 2 cities) according to their population size and other factors. To receive MHSA funds, jurisdictions must produce and locally approve a stakeholder-informed plan describing how funds will be utilized. These MHSA program and expenditure plans are required in three-year cycles, with annual updates required in the interim years. This document fulfills this regulatory requirement.

MHSA Plans identify services across the age span, with age groups identified as children (0-16 years), transition age youth/TAY (16-26 years), adults (26-59 years) and older adults (60 years and older). Originally, MHSA plans needed to identify programs according to these five (5) MHSA components: Community Services & Supports (CSS); Prevention & Early Intervention (PEI); Innovations (INN); Workforce, Education & Training (WET); and Capital Facilities & Technological Needs (CFTN). In years after Fiscal Year (FY) 2007-08, programs for CFTN programs were not required, but could be supported as needed. Descriptions of these components and their programs are described in their respective sections in this document.

This document will be informed by stakeholder input and feedback received during the stakeholder meeting component of the Community Program Planning Process (CPPP). Following a section about Humboldt County's demographics and characteristics, the process, and results of the CPPP will be presented in the Three-Year Plan after its completion.

Humboldt County Demographics and Characteristics

Humboldt County is located on the coast of northwestern California, 225 miles north of San Francisco and 70 miles south of the Oregon border. The County is rural in nature, with a population of 135,558 spread over 3,567 square miles, or 38 persons per square mile. Forty-nine percent of residents live around the Humboldt Bay area, while the other half live in the outlying rural areas of the county. The county's residents include those from eight federally recognized American Indian Tribes: Yurok, Karuk, Hupa, Wiyot, Cher-Ae Heights Indian Community of Trinidad Rancheria, Bear River Band of Rohnerville Rancheria, Blue Lake Rancheria and Big Lagoon Rancheria.
Humboldt County is often discussed in terms of five regions: Eureka, Northern Humboldt, Eastern Humboldt, Southern Humboldt and the Eel River Valley. Eureka is the largest city and the county seat of government, and there are several small communities right outside the city limits that are included in this region. Northern Humboldt includes the cities of Arcata and Blue Lake, the unincorporated town of McKinleyville, the Blue Lake Rancheria, Trinidad Rancheria, and Big Lagoon Rancheria, as well as other smaller communities. Eastern Humboldt includes the unincorporated towns of Willow Creek and Hoopa, the Hupa Reservation, and other smaller communities. Southern Humboldt includes the unincorporated towns of Garberville and Redway, and many other smaller communities. The Eel River Valley includes the cities of Fortuna, Ferndale and Rio Dell, the Bear River Band of Rohnerville Rancheria and the Wiyot Tribe, as well as other smaller communities. While the headquarters of the Yurok and Karuk Tribes are in neighboring counties, many tribal members live in Humboldt County.

Sixteen percent of the population is ages 0-15; 15% are ages 16-26; 44% are ages 25-59; and 25% are age 60+. Females are 51% of the population and males are 49%. Residents speaking a language other than English at home are 12% of the population. The majority of these speak Spanish (8%). Of those speaking any language other than English at home, 29% speak English less than "very well." For Spanish speakers, 18% speak English less than "very well." Residents who are foreign born are approximately 5.4% of the population. (Data from the American Community Survey, estimates for 2021).

Sixty-eight percent of the population is White; 1% is Black/African American; 5% American Indian/Alaska Native; 3% Asian/Pacific Islander; 8% Multiracial; and 14% Hispanic or Latino (U.S. Census 2020.)

Stakeholder Meetings

The Community Program Planning Process (CPPP) has three components: stakeholder meetings, the 30-day public comment period, and the public hearing. During the stakeholder meeting component, stakeholders will provide input by attending a stakeholder meeting and providing verbal comments; by sending comments to the MHSA email address; by leaving a message on the MHSA voice mail; by providing written comments using the MHSA Comment Form; and by using the "Chat" function on the Zoom platform to make a written comment. The Draft Three-Year Plan for 2023-2026 and associated MHSA information will also be sent via email to stakeholder groups and individuals to provide an opportunity to provide input. For this Three-Year Plan, an online Community Survey was made available to stakeholders so they could provide input into the process.

Due to lingering concerns of the COVID-19 pandemic, community meetings with stakeholders were conducted by using the Zoom virtual platform, in person, and/or as a hybrid of in-person and Zoom. Materials were provided to attendees via email and were shared on the screen during the virtual/hybrid meetings and shared via PowerPoint with people attending the in-person meetings. The materials included:

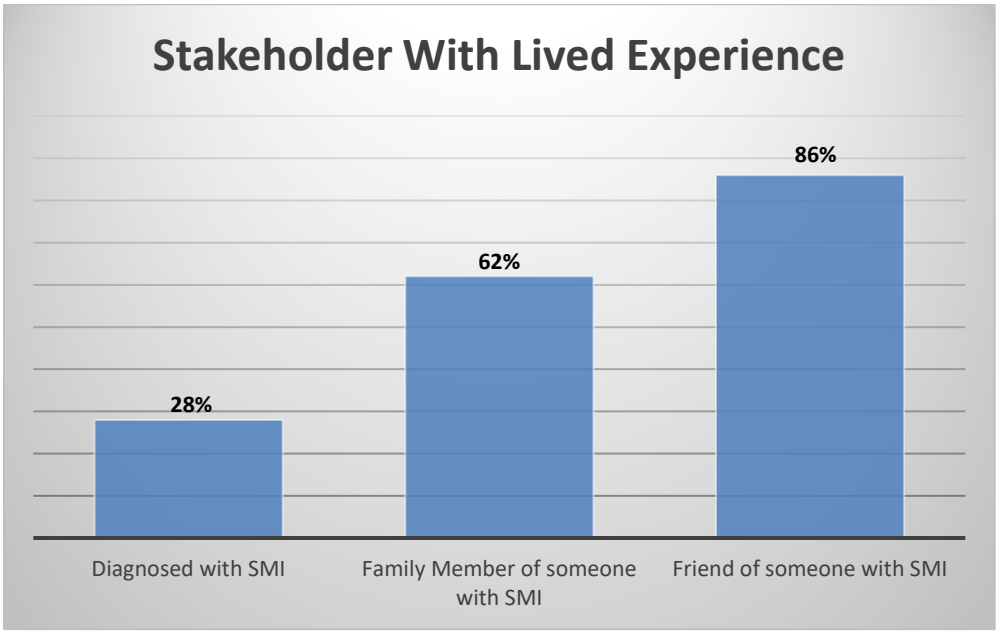
- Draft MHSA Three-Year Plan for 2023-2026, including the draft budget for 2023-2026
- MHSA Fundamental Concepts handout
- MHSA Information Form handout
- MHSA Current Programs handout
- Services Provided by DHHS Behavioral Health handout
- Definitions of Serious Mental Illness and Serious Emotional Disturbance handout
- PowerPoint presentation including information on all MHSA components
- The MHSA demographic questionnaire and MHSA Comment Form will be provided to meeting participants via a link during the meeting for those attending virtually and in paper format for those attending in person
- Fliers for upcoming stakeholder events
- A link to the Community Survey

After the stakeholder meetings were completed, the notes from each meeting, the Comment Forms received at each meeting, and the comments received from the MHSA email and phone line were reviewed. A stakeholder meeting report was prepared and presented to Behavioral Health Administration for consideration of changes to programs based on the input. The Three-Year Plan was revised based on that input, as appropriate. The stakeholder meeting report was posted to the Mental Health Services Act webpage on the County website on April 26th, 2023.

Stakeholders attending community meetings were invited to complete the demographic questionnaire. During the months of November 2022 through May 2023, a total of 23 stakeholder meetings and one Public Hearing were held with a total of 218 individuals

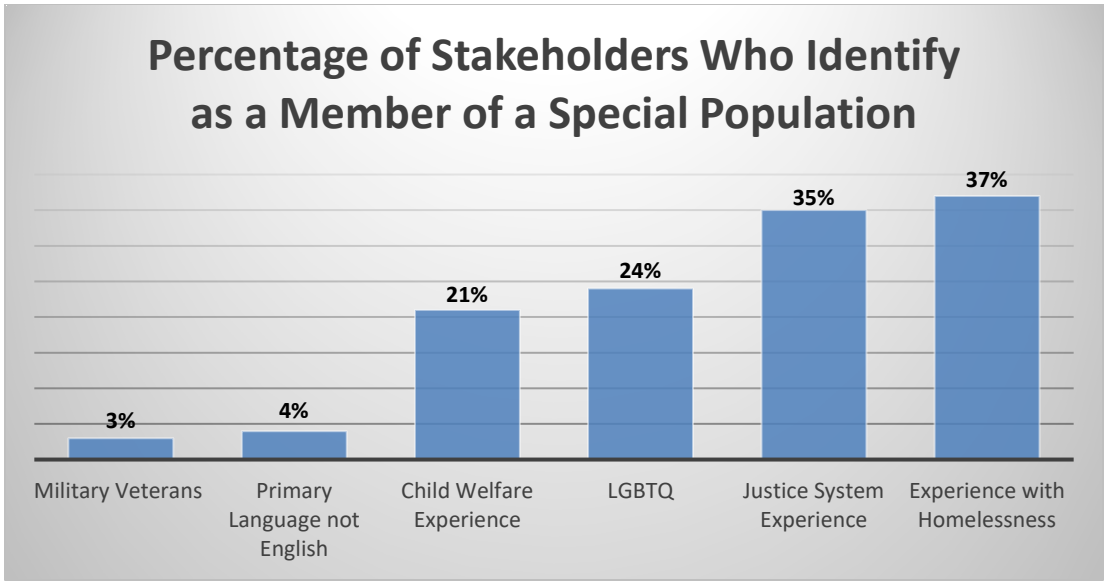
attending. Of the 218 individuals that attended, 71 (33%) of them filled out the demographic questionnaire.

Individuals with lived experience of a mental illness are recognized as a vital voice in the MHSA planning process. In this stakeholder process, 28% of people participating identified as having a serious mental illness (SMI), 62% identified as a family member of someone with an SMI, and 86% identified as a friend of someone with a SMI.

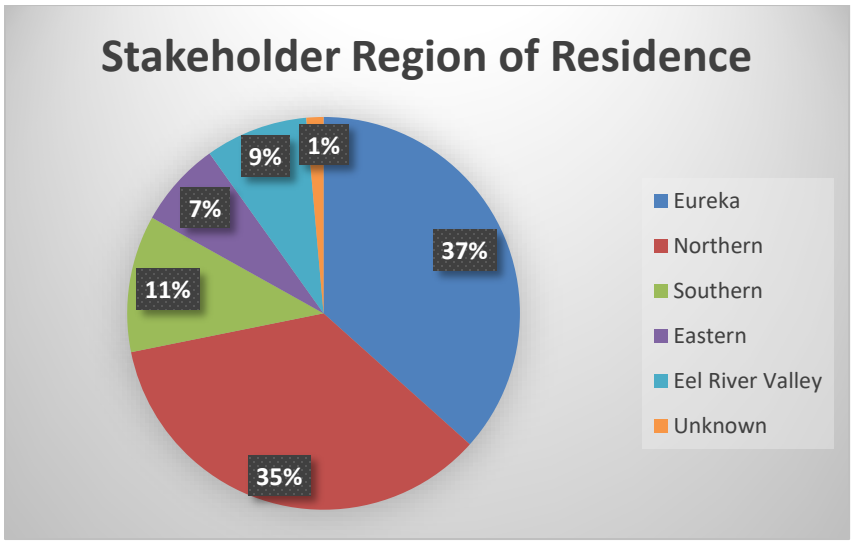


Additional life experiences have been identified as valuable voices for the planning process, so they are also monitored for inclusion. Sexual orientation, experience with homelessness, justice system experience, Child Welfare experience, people who are veterans, and having a primary language other than English are all life experiences and conditions that may result in challenges to successful mental health treatment. Outreach efforts included people with these experiences:

- 24% identified as LGBTQ
- 37% identified as having experience with homelessness
- 35% had justice system experience
- 21% had a Child Welfare experience
- 4% identified as not having English as their primary language
- 3% identified being a veteran



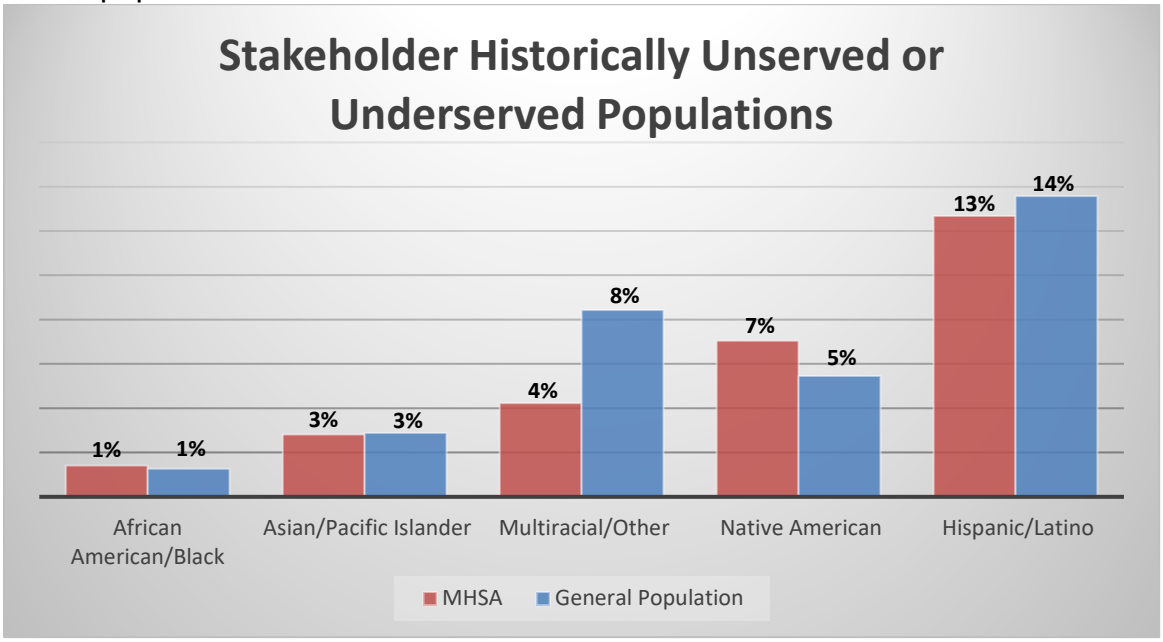
Another priority for representation in the planning process is regional. Most of the MHSA stakeholders attending meetings lived in regions close to the Humboldt Bay: Eureka at 37% and Northern Humboldt at 35%, while 11% lived in Southern Humboldt, 7% lived in Eastern Humboldt, 9% lived in the Eel River Valley area, and 1% did not respond to the question or indicated they lived in another region outside of Humboldt County.



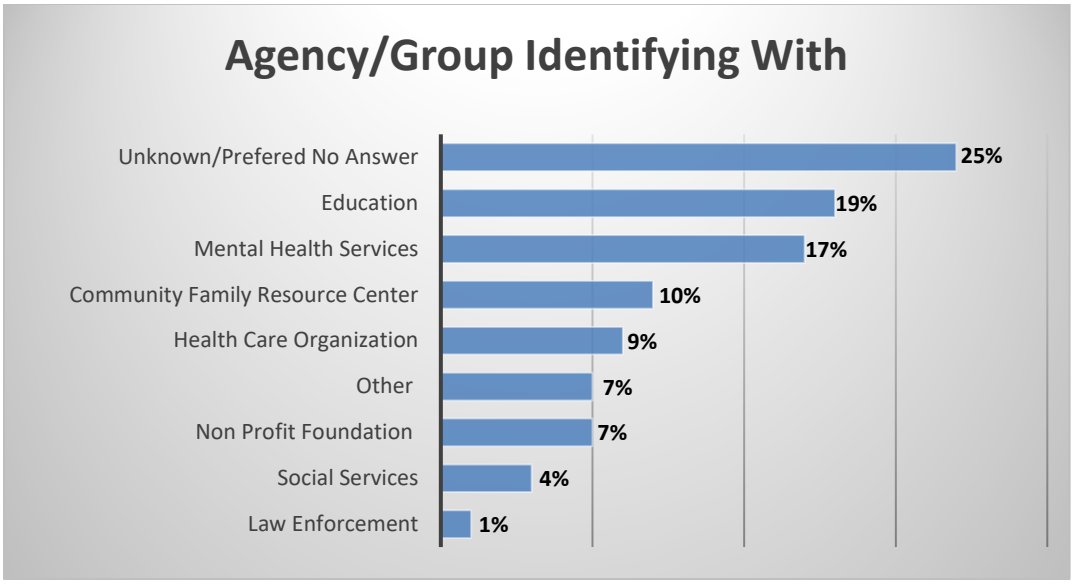
Participants in the stakeholder meetings came from different racial and ethnic categories. Note that percentages for the general population are from the 2020 Census.

- One percent were African American/Black, compared to 1% of the general population.
- Three percent were Asian/Pacific Islander, compared to 3% of the general population.
- Four percent were Multiracial/Other, compared to 8% of the general population.

- Seven percent were Native American, compared to 5% of the general population.
- Thirteen percent were Hispanic/Latino, compared to 14% of the general population.



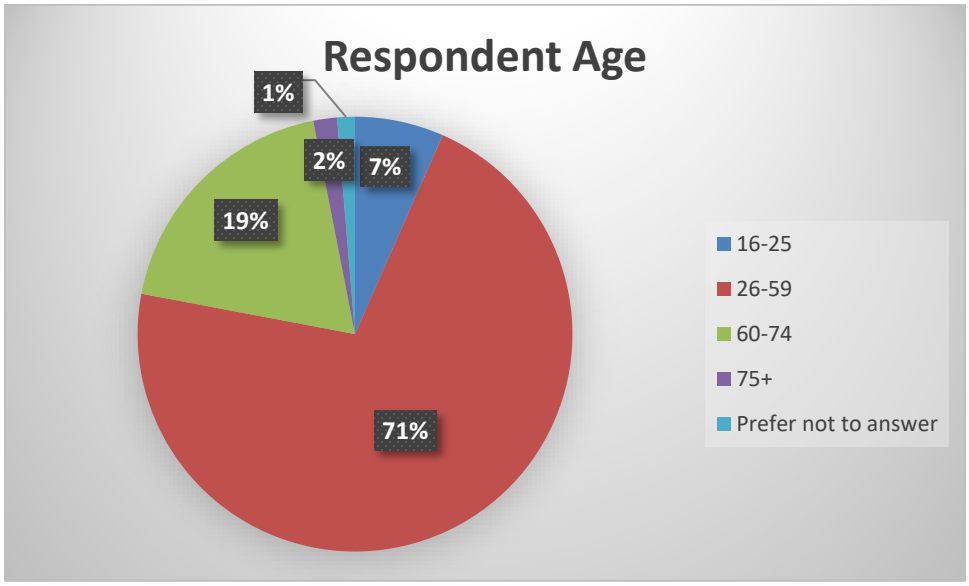
The stakeholder meetings included representation from agencies that provided services. The process included individuals from education (19%), mental health services (17%), community family resource center (10%), health care organization (9%), nonprofit foundation (7%), social services (4%), law enforcement (1%), and "other" (7%). Twenty-five percent did not answer/preferred not to answer the question.



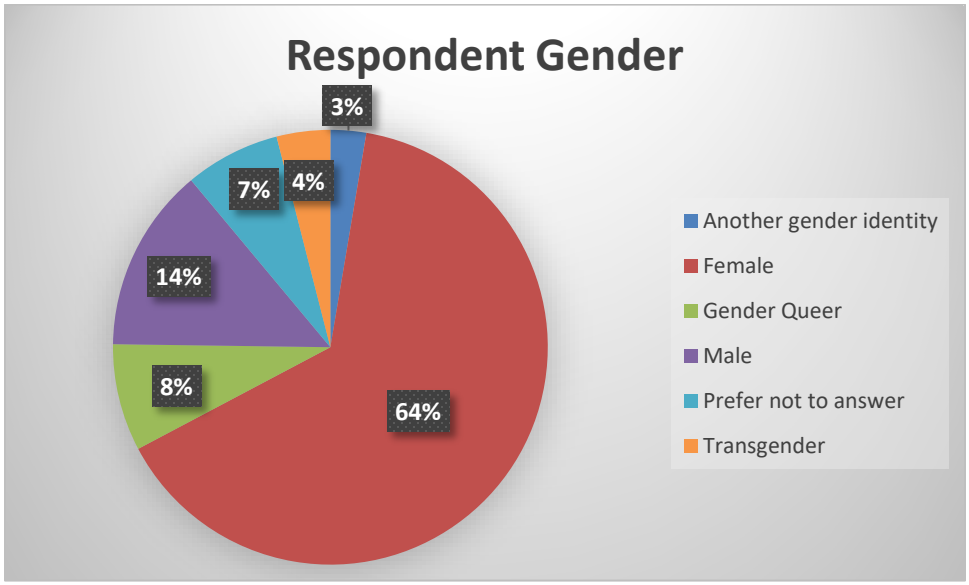
Stakeholders completing the Community Survey

A Community Survey was developed and made available online. A total of 229 responses were received. Of the responses, 195 people, 85%, stated it was their first-time providing input and information for the MHSA process. For 34 people, 15%, it was not the first time they had provided input. The demographics of those completing the Community Survey are presented below.

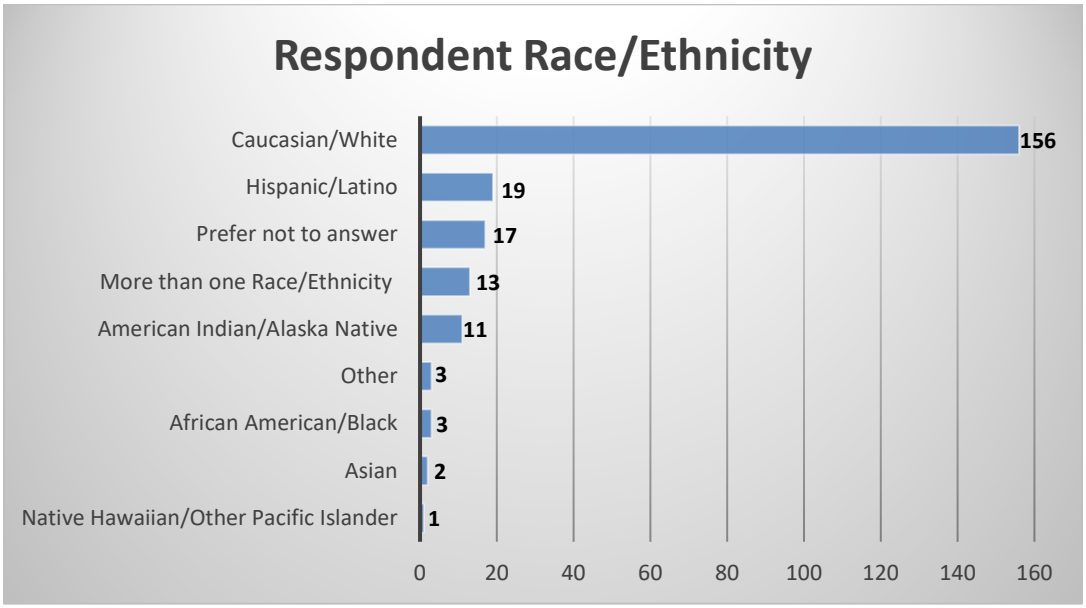
Seven percent of respondents, sixteen people, were ages 16-25; 71% of respondents, 163 people, were ages 26-59; 19% of respondents, 44 people, were ages 60-74; 2% of respondents, 5 people, were age 75+; and 1% of respondents, 2 people, did not answer.



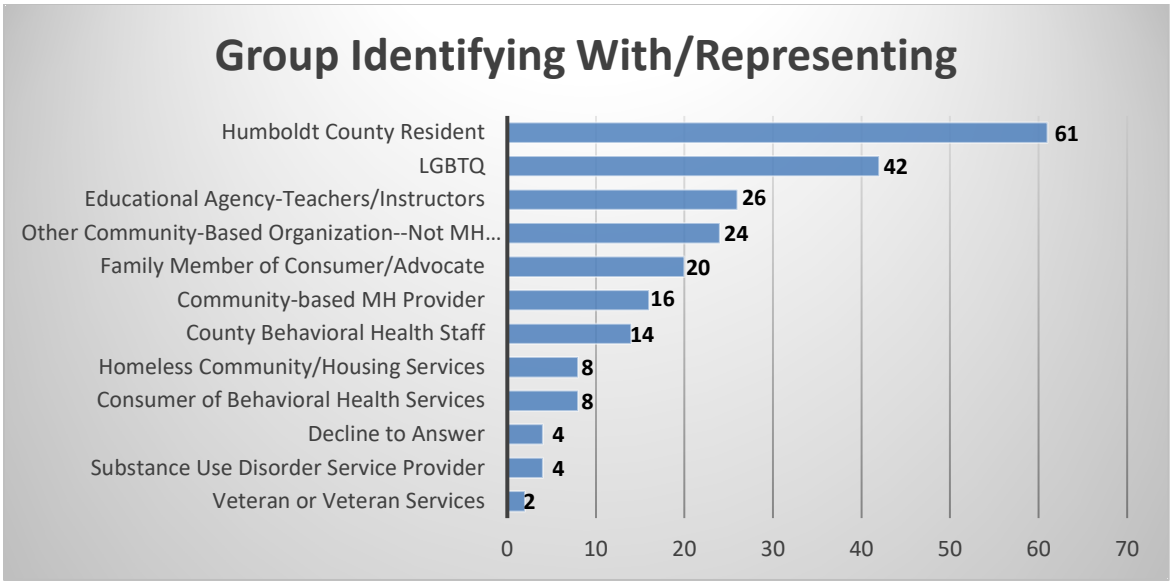
Eight percent of respondents were gender queer, 64.6% female, 13.7% male, 4% transgender, 2.7% were another gender identity, and 7.1% did not answer.



Out of the 229 respondents, 156, 69.3%, were Caucasian/White; 13 respondents, 5.8%, were Multiracial; 19 respondents, 8.4%, were Hispanic/Latino; 11 respondents, 4.9%, were American Indian/Alaska Native; 3 respondents, 1.3%, were Other; 3 respondents, 1.3%, were African American/Black; 1 respondent, .4%, were Pacific Islander; and 2 respondents, .9%, were Asian. 17 respondents, 7.6%, did not answer.



Survey respondents were asked to identify the group that they primarily identify with or represent. 11.6% indicated educational agency; 27.1% indicated an interested member of the community; 10.7% indicated Other; 3.6% indicated mental health client/consumer; 8.9% indicated family member of a client/consumer; 10.7% indicated another community based organization, not mental health; 7.1% indicated a community mental health provider; ;6.2% indicated County Behavioral Health staff, 1% were affiliated with veteran services; 18.7% LGBTQ; 2% substance use disorder service provider; and 3.8% identified with homeless community/housing services.



Summary of Findings from the Community Program Planning Process (CPPP)
Between the input from community stakeholder meetings, comments made through the MHSA Phone Line and MHSA Comments Email, and the Community Survey, a total of 428 responses were provided as input into the Draft Three-Year Plan 2023-2026. An analysis of all input shows that the top priorities identified by respondents were as follows. Programs and services identified in this Plan to support these priorities are also indicated.

- Expand housing opportunities and support. Some examples of this priority are to provide financial opportunities for those that struggle paying for rent and medication, create/support housing situations for those experiencing serious mental illnesses, and provide funding/resources to emergency shelters experiencing budget shortages. Programs such as Resident Engagement Support Team (REST), Comprehensive Community Treatment (CCT), and Crisis Residential Treatment support people with serious mental illnesses find stable housing options.
- Increase and expand behavioral health services. Some examples of this priority are: Have more services available in more communities in the county (including but not limited to Southern, Eastern, and Eel River Valley regions of Humboldt); increase the number of psychiatrists, counselors, and other behavioral health professionals; have more programs available; provide individual, one-to-one counseling; provide services and supports to everyone who needs them, which includes accepting private insurances; expand virtual/remote services and the infrastructures needed to support them. Outreach done by Older Adults, Suicide Prevention, and Regional Services help spread awareness of behavioral health services. Local Implementation Agreements help create and fund partnerships with local organization providers that promote the development of needed services. The new initiatives proposed under the Three-Year Plan such as the Latinx Liaison position, Warm Line, and PEI Assigned Funds will increase Behavioral Health's ability to reach more people in all regions of Humboldt County.
- Substance Use Disorder (SUD) services. Although MHSA does not fund a program focusing on SUD services, programs that are funded in part through MHSA help with this endeavor. Regional Services has SUD counselors within its work force and referrals are made to SUD services when needed, Crisis Residential Treatment utilizes SUD data as an outcome measure for services, the Hope Center consists of qualified peer support providers who assist individuals with recovery from mental illness and SUD, and TAY assists its population with linkage and referrals to the Adolescent Treatment Program and other substance use disorder services.
- Increase support for school age youth and provide more behavioral health counselors and other behavioral health supports at schools. Some examples of this priority include providing services and supports for first break psychosis, crisis support, and strengthening the continuity of care for families. The School Climate Curriculum Plan/MTSS Program of this Three-Year Plan will contribute to increasing behavioral health supports at schools. Though not part of this Three-Year Plan, DHHS Children's Behavioral Health has used Mental Health Student

Services Act grant funding provided through the Mental Health Services Oversight and Accountability Commission (MHSOAC) to support a school-based crisis triage program. This program focuses on short-term crisis intervention and linking students to behavioral health supports in schools and the community.

- Workforce Support. Some examples of this priority are: Recruit more providers, retain these providers, and train them—the behavioral health workforce as well as other service providers who may encounter people needing behavioral health services. Law enforcement, childcare providers, and teachers are included as part of the workforce perspective. The Workforce Education and Training (WET) component of this Plan addresses this priority by increasing the training available to DHHS-BH staff through Relias E-Learning. In addition, the WET Regional Partnership grants (such as Loan Repayment, Peer Scholarships, and Graduate Stipends) address this priority.
- Continuity of care for clients released from Sempervirens (SV), Crisis Stabilization Unit (CSU), Jail, and other transition services. Examples of this priority are to provide discharge plans, warm handoffs, transitional housing/placements for clients released from the psychiatric hospital, crisis services, the jail, and any other programs where a warm handoff is beneficial. Crisis Residential Treatment is a program in development and through partnership with Willow Glen will address this priority through providing transitional housing and placements for clients needing these services.
- Expand bilingual, culturally competent mental health services. Some examples of this priority are to increase behavioral health outreach to underserved and underrepresented populations, expand accessibility to services by having a better equipped work force, and be able to provide information in a way that is helpful. Although it is not part of the Three-Year Plan, Behavioral Health conducts outreach through MIST and partners with HOME's Mobile Outreach team to reach various communities that are located in the outskirts of Humboldt County. Through Workforce Education and Training, MHSA supports Peer Support Specialists with Peer Scholarships, which helps cover training expenses that expand staffing capabilities and improve service delivery. DHHS services have access to a language line for translation services when needed along with the ability to translate documents upon request. The proposed Latinx Liaison position could help with this priority by providing outreach to Spanish speaking populations along with providing support to staff.

The top five populations that respondents felt were unserved/underserved by current MHSA programs are:

- Persons with serious mental illness. Feedback indicated that access to services has been impacted for the past couple of years. Some contributing factors would be the COVID-19 pandemic and the various systemic obstacles it placed, a higher demand in behavioral health services, BH having vacancy of about 30% of its clinician work force, and difficulty in recruiting and retaining new staff. As mentioned above, the Warm Line initiative could increase access and linkage to services. The Latinx Liaison position could increase BH's ability to provide

culturally responsive services and outreach. Workforce Education and Training will continue to provide financial incentives to recruit, retain, and train staff.

- Those at risk of having a mental illness. This population along with feedback provided by community members follows the same points outlined within the "persons with serious mental illness" population, which can be found above.
- Persons experiencing homelessness. Services and support to this population will be done through REST. In addition, this population is being served by the DHHS participation in the No Place Like Home Initiative.
- Minority Groups. Services and support to this population could be increased through the Latinx Liaison initiative. Culturally responsive services will continue to be expanded throughout DHHS by following goals set within the Racial Equity Strategic Plan.
- LGBTQ Populations. The TAY Advocacy and Peer Support Program provides advocacy by conducting policy recommendations to leadership along with pronoun trainings to staff. Feedback was recorded and is reflected in the CPPP Report.

The top challenges to receiving behavioral health services were described as the lack of appointments, lack of transportation, and the locations of services. These identified challenges reinforce the priority of expanding and increasing access to services. Systemic strengths and weaknesses can be seen in the Behavioral Health Capacity Assessment section.

The programs proposed to be supported, contingent upon the availability of funds, in this Three-Year Plan will address many of these identified priorities. The CPPP Report can be found on the Humboldt County website, MHSA webpage, at Mental Health Services Act (MHSA) | Humboldt County, CA - Official Website (humboldtgov.org) and provides details of the input received during the CPPP. Archived documents including, but not limited to, previous Three-Year Plans, CPPP reports, and Annual Updates can be found at: https://humboldtgov.org/Archive.aspx?AMID=60

30-Day Public Review and Comment Period and Public Hearing

In accordance with MHSA regulations, the Three-Year Plan for 2023-2026 was made available for public review and comment for a 30-day period from April 26th through May 25th, 2023.The Behavioral Health Board (BHB) conducted a Public Hearing on the Three-Year Plan at its May 25th, 2023 meeting. The Three-Year Plan 2023-2026 was available to stakeholders through the following methods:

- The Humboldt County Department of Health and Human Services, MHSA webpage.
- An informational email sent to stakeholders who participated in the stakeholder process.
- Emailed to recipients on local organizational e-mail distribution lists.

- Emailed to people who requested a copy.
- Announcements in local media about the Three-Year Plan's availability, where to obtain it, where to make comments, and where/when/how the public hearing was to be held.

Three written comments were received via e-mail to the MHSA Email Comment address and three filled out demographic surveys were obtained.

Public Hearing Information
The BHB conducted a Public Hearing on the Three-Year Plan 2023-2026 at their regular meeting on May 25, 2023, 12:15-2:15pm. Due to COVID-19 precautions and to ensure inclusivity, the meeting was conducted in a hybrid format. Community members had the opportunity to attend the meeting either in person or via Zoom. There were 27 people in attendance at the Public Hearing.

Public Comment Summary
Three written comments were provided for the Three-Year Plan through email to the MHSA Comment Email during the 30-day public comment period. There were 6 comments on the Three-Year Plan that were made orally during the Public Hearing. The comments are summarized below and following each is the Behavioral Health response for those that had questions. No substantive changes were made to the draft Three-Year Plan as a result of the Public Comment period and Hearing.

1. In two emails, one person recommended the following: 1) Add a statement within the Three-Year Plan about recognizing the value of mental health early intervention and prevention programs that match LGBTQ+ therapists with LGBTQ+ clients. 2) Add a statement that all organizations funded through Humboldt's MHSA funds will be required to affirm their commitment to providing culturally relevant care, including sexual orientation and gender affirming care, to the clients they serve. 3) Add a requirement that all agencies funded through MHSA have all staff working within the MHSA funded program complete a minimum of two hours of LGBTQ+ focused training annually.
Response: Part of the Department of Health and Human Services (DHHS) Racial Equity Strategic Plan is to establish a series of trainings that further improve equity work. These trainings that are being created will increase how responsive staff are to all populations, including people the LGBTQ+ community.

2. A member of the LGBTQIA+ Mental Health Task Force recommended via email the following: 1) Having direct services for members of the LGBTQIA+ community that are accessible to all Humboldt County residents that identify as being part of the LGBTQIA+ community. 2) Create a standard of care across all organizations that receive funding to serve the LGBTQIA+ community where everyone is required to be trained in working with the LGBTQIA+ population and providing affirming care.
Response: Please the above response to comment #1.

3. The current draft identifies disparities and needs in the LGBTQIA+ community but does not reference or address quality of care efforts in the county. They also commented that the plan does not reference Neurodivergence, autism, queer, or similar items. The same person also commented that they see the data but are confused as to why there aren't specific services for the LGBTQIA+ community; there is no reference to community partners doing the work nor does it show an effort for county Behavioral Health to build partnerships within the community. What is being done?
Response: A representative from the Transition Age Youth Program (TAY) provided clarity to the work TAY and the Youth Advisory Board (YAB) are conducting in their meeting and their legislative policy group which are funded in part by MHSA. The MHSA Coordinator also shared information regarding the new Local Implementation Agreement (LIA) partnership with Queer Humboldt for FY 2023-24.

4. A lot of time the people we support realize their condition is worsening. However, there is stigma when pursing services, which causes fear of losing licensing/jobs. Nothing is being done to improve the transportation variable to better help these people with behavioral health needs. It was recommended to include transportation incentives and services as a solution in the Three-Year Plan in the form of an Innovation project. The following question was asked in relation to the Latinx Liaison position initiative: how many Latinx organizations have been coordinated with?
Response: A presentation was made to Promotores, which includes leaders and attendees from many Spanish speaking organizations throughout the county.

5. 1) Expand local crisis services to the homeless that go to hospitals. 2) Have an on-call pharmacist for medication support. 3) Consider if MHSA can partner with community hospitals to make facility improvements and have on staff clinicians in the hospitals. 4) Expand services to rural communities. 5) Fund Adult Outpatient Treatment with MHSA funding.
Response: Although not specific to MHSA, County Behavioral Health (BH) already partners with local emergency rooms to ensure continuity of care for people experiencing a mental health crisis along with medication support. There is work already being done within the BH branch to establish a new mobile response service, as part of the mobile response benefit being rolled out by the state. Expanding services to rural communities, is a priority that was identified through this Three-Year Plan's Community Program Planning Process. At the time of this Three-Year Plan's completion, there are Local Implementation Agreements (LIA) with Queer Humboldt and Redwood Rural Health Center. The LIA with Queer Humboldt is meant to provide outreach to rural areas of Eastern Humboldt with an emphasis in linkage to BH services. The Redwood Rural Health Center LIA is meant to make training more accessible to their workforce located in Southern Humboldt.

6. Another community member suggested the idea of funding mobile outreach services to families. They also mentioned that families need supportive in-home counseling and services.
Response: Please see the above response to comment #5.

7. It was recommended to include in the Three-Year Plan support for training and workforce development around people living with disabilities. A community member mentioned that people have called for help and have been told by staff they are not adequately trained to deal with their disabilities and were turned away as a result. It was suggested that staff need to be trained to be able to handle clients with disabilities.
Response: Part of the Department of Health and Human Services (DHHS) Racial Equity Strategic Plan is to establish a series of trainings that further improve equity work. These trainings that are being created will increase how responsive staff are to all populations, including people with disabilities.

8. A recommendation was made to create emphasis and increase the support for the use of therapeutic counseling.
Response: BH supports all levels of staff to engage in therapeutic services and will continue to expand its responsive capabilities to fit the needs of as many populations as possible.

9. A community member mentioned that the plan does not contain references to increasing or dealing with housing issues. It is recommended to incorporate housing components into the plan. It was also mentioned that homelessness and many mental health needs cannot be addressed without addressing housing first.
Response: Historically, Humboldt County has not utilized MHSA for homelessness issues due to there being multiple community resources already established. However, this is a recommendation that was received multiple times during the Community Program Planning Process and has been recorded for leadership to consider for future MHSA Annual Updates and Three-Year Plans.

Complaints and Grievances
If there is a complaint, dispute or grievance from the general public about MHSA program planning, the MHSA manager will address. If there is a complaint dispute or grievance about an MHSA program, the MHSA Issue Resolution Policy and Procedure will be followed. This procedure is as follows. The issue is forwarded to the MHSA Program Manager (MHSA-PM) or designee through either US Postal Service mail: MHSA Program Manager, DHHS Behavioral Health, 720 Wood St. Eureka CA 95501, or email MHSAcomments@co.humboldt.ca.us. Issues will be recorded at time of receipt in the DHHS-BH Client Concerns Log and forwarded to the Program Lead of the program involved. Once a resolution is decided upon by the Program Lead the MHSA-PM will contact the originator of the issue to notify them of the resolution. Issues will be

followed up on within five working days. Resolution of the issue will be enacted within 30 days from receipt of issue.

Behavioral Health Capacity Assessment

The following sources of information were reviewed to assess Humboldt County Behavioral Health's capacity to implement the proposed MHSA programs. This assessment includes the strengths and limitations to meet the needs of racially and ethnically diverse populations, bilingual proficiency in threshold languages, and percentages of diverse cultural, racial/ethnic and linguistic groups represented among direct service providers, as compared to the population needing services and the total population being served.

1. The MHSA Community Program Planning Process (CPPP) for gathering community input into the Three-Year Plan for 2023-2026 and the Annual Update for 2022-2023 will provide information directly from stakeholders. This Capacity Assessment uses information from prior MHSA CPPPs, including the Annual Update for 2022-2023.
2. Updated annually, the Mental Health Cultural Competence Plan (BHCCP) provides data on the racially and ethnically diverse populations served, bilingual proficiency in threshold languages, and percentages of diverse cultural, racial/ethnic and linguistic groups represented among direct service providers, as compared to the population needing services and the total population being served. The BHCCP provides the most relevant and pertinent information on the topic of racial/ethnic/linguistic capacity. The 2021 BHCCP is located here: https://humboldtgov.org/DocumentCenter/View/70542/Behavioral-Health---Cultural-Competency-Plan---Updated-2021?bidId=
3. The DHHS Workforce Survey, conducted in August-September 2021, provides information about the demographics of the workforce.
4. The Network Adequacy Certification Tool (NACT) and other required documentation report on standards of time, distance, and timely access requirements with which the Mental Health Plan must comply. Network Certification provides assurances of adequate capacity and services and demonstrates that the Mental Health Plan offers an appropriate range of services that is adequate for the anticipated number of beneficiaries for the service areas and maintains a network of providers that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of beneficiaries in the service area. The NACT for FY 2021-2022 was accepted and found to be in compliance. The most recent NACT and supporting documentation was submitted August 26, 2022 and results have not been yet received.
5. Employee Services was contacted in order to obtain a vacancy report within Behavioral Health. As of September 2022, Behavioral Health has a 33% vacancy rate in the Mental Health Clinician job category.
6. The County Behavioral Health Directors Association (CBHDA) hosts state-wide meetings for MHSA Program Managers and Ethnic Services Managers. These meetings give counties the ability to communicate with each other by asking program questions, sharing updates, and providing guidance with program

development. The CBHDA site also provides statewide reports, learning tools, and insight on how to implement MHSA programs.

System Strengths

The Network Adequacy Certification Tool (NACT) documents the federal standards of time, distance, and timely access requirements with which the Mental Health Plan must comply. Time and distance standards are up to 60 miles and 90-minute drive from the beneficiary's place of residence to the provider's site. Timely access requires the Plan to meet State standards, taking into account the urgency of the need. The standards are documented with Geographic Access Maps provided by DHCS, showing beneficiary and provider locations. NACT includes information on language capacity for Russian, Spanish, Tagalog, Vietnamese, American Sign Language, and whether Language Line is available. Humboldt County's NACT also included the American Indian health facilities in the county. DHCS' evaluation of the 2021 NACT indicated that DHHS Behavioral Health is meeting the required standards. Another NACT will not be submitted until July 2023 pending county mental health plan 274 standard provider network data reporting launch. The 274 standard is an Electronic Data Interchange standard selected by DHCS to ensure provider network data submitted to DHCS is consistent, uniform, and aligns with national standards. NACT is transitioning to a different file submission format starting September 2022.

The Behavioral Health Cultural Responsiveness Committee (BHCRC) is a strength in the agency. BHCRC facilitates projects to gather data and address issues surrounding diversity. The Client Information Form was modified to increase the number of choices for ethnicity and to add choices for gender identity and sexual orientation. BHCRC oversees and approves the development of the annual Cultural Competence Plan.

The Quality Improvement (QI) Unit works consistently to address access to services for all populations. Some examples of QI projects and responsibilities that impact the capacity of the agency to address diversity are listed below.

- Updating the progress notes in the Electronic Health Record to expand the categories to capture the use of interpretation services. Choices for mode of interpretation now include whether a bilingual practitioner provided the service. QI also provides quarterly reports on interpretation services and includes whether bilingual services were conducted in-person or if they utilized the language line.
- A continuing contract with Language Line services to ensure services are available in a client's preferred language. Training on using the Language Line is required annually for all staff.
- Maintenance of the contractual relationship with organizational provider Two Feathers Native American Family Services, which serve diverse populations. QI ensures that organizational providers receive cultural competence training annually.

- Update and maintenance of the local interpreter list, which provides information about the interpreters who have contracted with Behavioral Health to provide live interpretation for clients requesting this service.
- Maintenance of the Behavioral Health Cultural Responsiveness Resource Page, available on the DHHS Intranet and on the county website, which provides links to resources, trainings, and other information for staff. The Resource List that is a part of this Webpage is updated quarterly.
- Maintenance of the Relias E-Learning contract, which provides cultural competence as well as many other online trainings for staff. This contract is supported by MHSA Workforce, Education and Training (WET).
- Development of the Cultural Awareness Training, which is offered either in an in-person setting or through NeoGov, and monitoring to assess compliance with the training requirements.
- The DHHS training on Common Racial Equity Terms was launched and is required by all DHHS staff.
- Roll-out California Advancing and Innovating Medi-Cal (CalAIM) plans for transforming and strengthening Medi-Cal to offer people services that are more equitable for diverse populations, coordinated, and follow a person-centered approach.
- BH has worked and continues to work diligently to get into compliance with the recent CalAIM initiatives which are being rolled out at the state level. These initiatives impact the way beneficiaries access services and reduces paperwork load burden on direct services staff to allow for more quality in direct care.
- As part of CalAIM and the Behavioral Health Quality Improvement Plan (BHQIP) BH has joined with CalMHSA to implement three Performance Improvement Projects (PIPs) associated with three Healthcare Effectiveness Data and Information Set (HEDIS) measures (Follow-Up After Emergency Department Visit for Substance Use (FUA), Follow-Up After Emergency Department Visit for Mental Illness (FUM), and Pharmacotherapy for Opioid Use Disorder (POD)). All three focus on removing racial disparities and seek to implement interventions to improve upon health outcomes for beneficiaries as it relates to BH emergency department follow up and opioid treatment follow through.
- BH has started to review key services utilization data on a quarterly basis. Review of this data consists of evaluating the needs of higher cost beneficiaries receiving care. BH is paying particular attention to details as they relate to racial disparities, which informs programmatic decision making.

Behavioral Health is working with the Humboldt Area Foundation and Stepping Stone Consulting as a component of a DHHS contract with these organizations.
The purpose of the BH component on this work is to build upon the initiatives already underway in BH to further advance racial equity at all levels of the department. The desired outcomes include coaching, support and consultation to BH leadership, as well as managers and teams, to support staff in advancing racial equity across programs, learn about staff experiences and perspectives and what is needed to help them adapt to new and emerging commitments to racial support changes to BH policy and practice

and provide training around facilitating conversations about race and racism in the workplace, among other things.

Three new policies and procedures were developed in 2021 that focus on racial and cultural equity. The foundational policy's purpose is "To set forth the intention of Humboldt County Behavioral Health (BH) to work to advance racial and cultural equity by dismantling systemic (institutional) and structural racism and structural inequality, and to set the foundation for all actions and decisions made by BH and its staff in this regard." A second policy's purpose is "To ensure that all Behavioral Health policies, procedures and forms will be developed and reviewed with a conscious consideration to advance racial and cultural equity and dismantle systemic (institutional) and structural racism and structural inequality." A Policy, Procedure and Form Review Tool was developed and is in use to implement this policy. The Ethnic Services Manager (ESM) now reviews all new policies, existing policies that are due for review, and documents using the Tool to identify language that could be changed or added to advance racial and cultural equity. From September 2021 through September 2022, a combined total of 266 Behavioral Health policies, procedures, and documents received ESM review. The purpose of the third policy is "To ensure that Behavioral Health budgets are developed and reviewed with a conscious consideration to advance racial and cultural equity and dismantle systemic (institutional) and structural racism and structural inequality." An existing Budget Planning Questionnaire was modified to implement this policy. The revised Budget Questionnaire was used during the budget cycle in early 2022.

System Limitations

The sources listed below give a picture of the limitations faced in serving diverse racial/ethnic populations in Humboldt County, which is a remote, rural county located on the North Coast of California. There are few culturally and linguistically diverse staff in the agency, and it is difficult to hire staff due to behavioral health staff shortages, which is true throughout California as well as the nation. It should be noted that for several years Humboldt County's threshold language was Spanish, and it was a limitation of the system that there were few providers who were bilingual in both Spanish and English. Recent data from the California Department of Health Care Services, Research and Analytic Studies Division, however, indicates that Humboldt County has had no threshold language since January 2015. Threshold language is defined as 3,000 Medi-Cal beneficiaries or 5 percent of each county's total Medi-Cal Beneficiary population, whichever is lower. Though there is currently no threshold language, DHHS Behavioral Health remains committed to providing services to clients in their preferred languages through the use of the Language Line, or through providing a local interpreter if one is available in the client's preferred language.

The MHSA CPPP for the Three-Year Plan 2020-2023, the Annual Update 2021-2022, and the Annual Update 2022-2023 provided information on diverse populations. For the priority category Providing Bilingual and Culturally Responsive Services:

- Stakeholders at community meetings ranked this as number 13 among all priorities for the Three-Year Plan, and it was one of the top five priorities for the Annual Update for 2021-2022 and for 2022-2023. For the Annual Update comments included providing better training; healthy cultural activities and services validating the knowledge and experience of tribes; and education, outreach and programs with more Spanish-speaking clinicians and services to the Spanish-speaking community.
- Stakeholders completing the Community Survey for the Three-Year Plan ranked this as 13 among all priorities and indicated that racial/ethnic populations are among those not adequately served by current MHSA programs. These racial/ethnic populations included the African American, Asian, Latino, Native American and Pacific Islander communities.

In the Behavioral Health Cultural Competence Plan (BHCCP), an analysis of disparities for those in Humboldt County with Medi-Cal versus those that are served by DHHS Behavioral Health was performed for calendar year 2019. This was a simple descriptive analysis about disparities in each population served by Behavioral Health. Disparities were found in serving Asian/Pacific Islanders, multiracial populations, for people whose primary language was not English, and for children ages 0-5.

- Three percent of those with Medi-Cal were Asian Pacific Islander, and 1% used DHHS-Behavioral Health services.
- Sixteen percent of those with Medi-Cal were multiracial, and 13% used DHHS-Behavioral Health services.
- Three percent of those with Medi-Cal had a primary language that was not English, and 1% used DHHS-Behavioral Health services.
- Eleven percent of those with Medi-Cal were children aged 0-5, and 3% used DHHS-Behavioral Health Services.

There could be many reasons that these Medi-Cal populations do not use DHHS Behavioral Health services. Asian/Pacific Islanders may not use County services because of levels of acculturation within their communities, or because there are no providers speaking their languages. For people whose primary language is not English, they may not use DHHS Behavioral Health services due to levels of acculturation, cultural beliefs about behavioral health issues and origins, lack of knowledge about available services, or because of the scarcity of providers that can speak their language. These reasons may be applicable to the multiracial population as well. Children 0-5 may not utilize DHHS Behavioral Health services due to their family's cultural beliefs, conflicts in parent work schedule, parental figures not having enough knowledge of Behavioral Health services, and perhaps parental figures not realizing their child may qualify for, or even need, Behavioral Health services.

In addition to looking at disparities among Medi-Cal beneficiaries and their use of Behavioral Health services, the BHCCP reported on the data available for the Behavioral Health workforce. The September 2022 DHHS Employee Services database showed that Whites are overrepresented in the workforce, and Multiracial and Native Americans are underrepresented in the workforce, as compared to Medi-Cal client utilization. Data from the DHHS Workforce Demographic Survey conducted in August-September 2021 also showed racial/ethnic disparities in the workforce as compared to client utilization for all categories other than White. Detailed information is available in the BHCCP.

While DHHS Behavioral Health does face challenges in serving diverse racial/ethnic populations, there are continued efforts to address issues to make improvements. These efforts include continuing to contract with the Language Line to ensure that behavioral health services are provided in a client's preferred language, the continuing development and monitoring of staff training, the work with Humboldt Area Foundation and Stepping Stone Consulting, and the consistent updating of cultural competence resources, all of which contribute to the conclusion that the agency will have the capacity to implement MHSA programs that serve the community.

Community Services and Supports (CSS) Component

Seventy-six percent (76%) of MHSA funds received by counties must be allocated for the CSS component. MHSA funds may only be used to pay for those portions of the behavioral health programs/services for which there is no other source of funding available. CSS programs serve individuals affected by moderate to severe mental illness and their families. These services must be community based, recovery-oriented and culturally competent. Funding can only be used for voluntary services and no less than 50% must be allocated to Full-Service Partnerships (FSPs). The remaining funds in the CSS component are for General System Development programs that provide a less-intensive level of mental health treatment and supportive services, and counties may develop and operate Outreach and Engagement Programs to identify unserved individuals in order to engage them and, when appropriate, their families. The following pages describe the CSS programs that are planned to be included in the Three-Year Plan.

Community Services & Supports: Full-Service Partnership, Comprehensive Community Treatment

Full-Service Partnerships (FSP) offer a range of services and supports to persons impacted by severe mental illness, falling under General Services and Development (GSD). FSP services provide a "whatever it takes" level of services, also referred to as "wraparound" services, to support the most severely mentally ill clients and their families, twenty-four hours a day, seven days a week. These wraparound services include treatment, crisis intervention, medication management, case management, peer

support, support with transportation to access appointments. Services also include housing support, crisis intervention, family education, connection to vocational training and employment services, education and treatment for co-occurring disorders, as well as socialization and recreational activities, based upon the individual's needs and goals. It additionally provides for non-behavioral health services such as accessing food and housing resources in the community. The term "Full-Service Partnership" refers to the commitment on the part of the client, the family, and their service providers to determine the needs of the client and family and to work together to support the client in their recovery. FSP addresses the priorities of the CPPP to increase support for the seriously mentally ill.

Within the scope of this intensive program, Partners are provided 24 hour, seven days a week crisis response service through the Crisis Stabilization Unit. When a Partner in crisis needs acute care treatment, they can access Sempervirens Hospital, Humboldt County's psychiatric health facility. The FSP staff works closely with inpatient staff to address discharge planning needs in order to support the FSP client's return to the community and to avoid re-hospitalization.

Partners are served through various DHHS Behavioral Health programs including Children and Family Services Transition Age Youth Division, Housing, Outreach and Mobile Engagement (HOME), and Older Adults programs. However, Full-Service Partners are primarily served through the Comprehensive Community Treatment (CCT) program. Inspired by the evidence-based program Assertive Community Treatment, CCT provides intensive behavioral health services and community supports to assist clients in their recovery. These include access to housing, medical, educational, social, vocational, rehabilitative, or other needed community services for those with serious mental illness who are at-risk for psychiatric hospitalization, incarceration, homelessness, or placement in more restrictive facilities.

Children's Behavioral Health has identified 275 youth, from 0-15 years old, that would be eligible for FSP during the 21/22 fiscal year. While youth up to age 21 have previously been enrolled in FSP, due to staffing constraints and an inability to meet the 24/7 availability of staff, these currently eligible youth have not been enrolled in FSP but are eligible to receive our full behavioral health service array. These services include Assessment, Individual/Family Therapy, Targeted Case Management, Intensive Care Coordination, Intensive Home-Based Services, Therapeutic Behavioral Services, Medication Evaluation, Medication Support, Parent Partner/Peer Coaching, and Mobile Crisis services. In addition, staff anticipate being able to offer Therapeutic Foster Care and an in-county Short Term Residential Treatment Program during the current fiscal year, through a local organizational provider. The mobile crisis services for youth are limited due to staffing issues, but Humboldt County does maintain a 24-hour hotline to triage crisis calls and this service is available to anyone experiencing a crisis situation. Staff work closely with local Emergency Rooms to coordinate care for youth

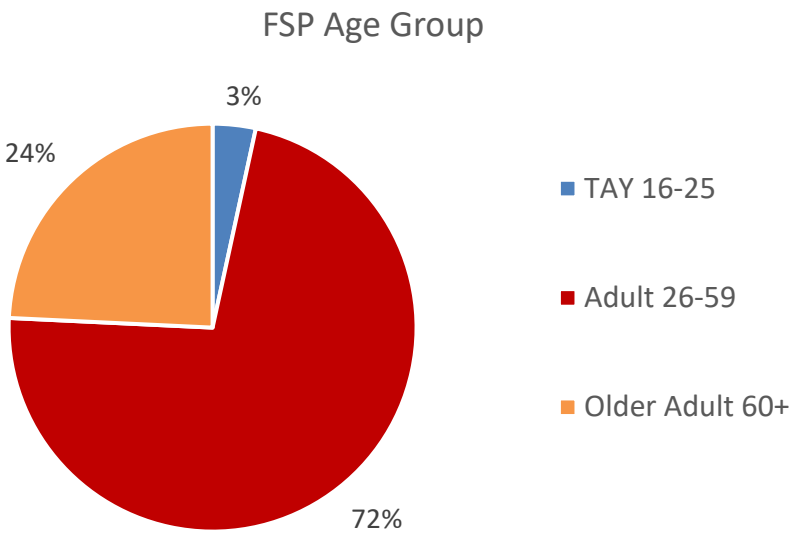
that go there due to a behavioral health crisis. For current and former foster youth and caregivers, there is coordination with the Family Urgent Response System (FURS) which can respond 24/7 if there are urgent needs that require in-person response. Additionally, in order to meet Family First Prevention Services Act (FFPSA) requirements, the intent is to contract with an Organizational Provider in the next year to provide Wraparound services. The intent is to build capacity within this contract to provide High Fidelity Wraparound services to FSP eligible youth, including 24/7 availability.

An estimated 216 clients could be served annually as FSPs. The age groups anticipated to be served are:
TAY: 11
Adults: 149
Older Adults: 56

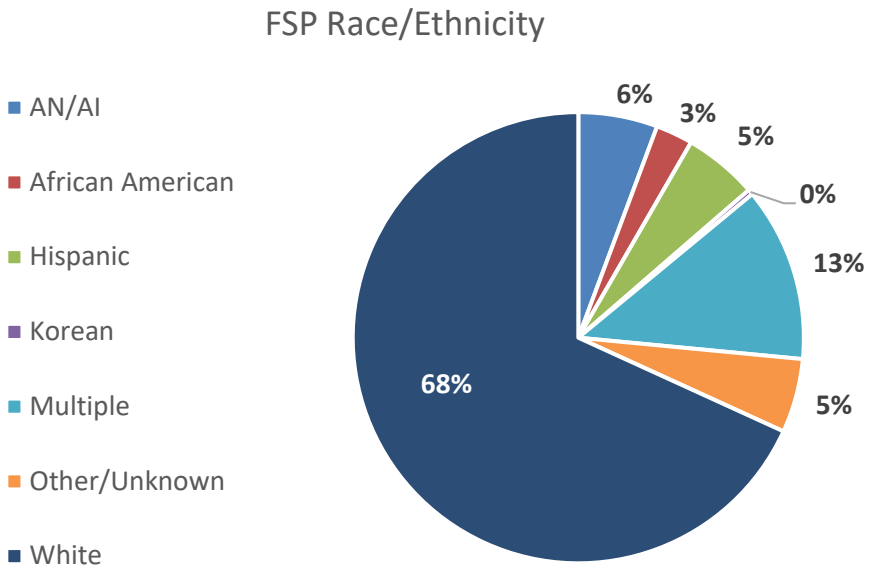
Outcomes for FSPs are monitored through the Data Collection and Reporting (DCR) system of the California Department of Health Care Services. Expected outcomes include:

- Decrease in homelessness days
- Decrease in behavioral health emergencies
- Decrease in psychiatric hospitalizations
- Decrease in arrests
- Decrease in incarcerations

Report for FY 2021-2022
There were 264 Full-Service Partners (FSPs) enrolled for the period July 1, 2021, through June 30, 2022. Three percent of FSPs were ages 16-26, 72% were ages 26-59, and 24% were age 60+. While enrollment as an FSP is assessed for children under the age of 16 who meet the FSP eligibility requirements, to date the full spectrum of services have been provided through alternate programs and funding sources other than MHSA FSP funding, as described above.



As the chart below shows, for the period July 1, 2021, through June 30, 2022, the percentage of FSPs who identified as White was 68%; the percentage who identified as American Indian/Alaska Native was 6%; the percentage who identified as African American was 3%; the percentage who identified as Hispanic/Latino was 5%; the percentage who identified as Multiracial was 13%; less than 1% identified as Korean and 5% were Other/Unknown.



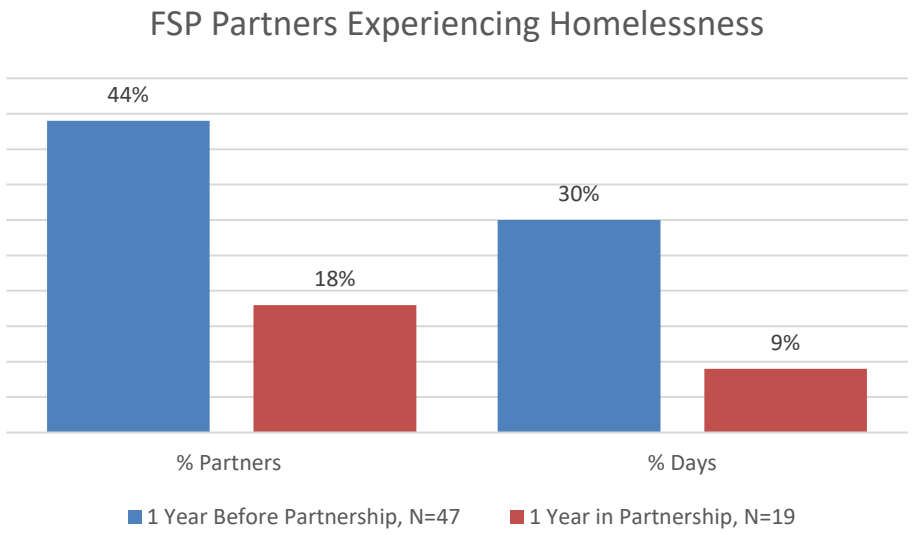
Forty-three percent of FSP clients for the period July 1, 2021, through June 30, 2022, were female and 57% were male.

FSPs exit a Partnership due to a variety of reasons. During the period July 1, 2021, through June 30, 2022, 50 FSPs were discharged from the program for the following reasons.

Discharge Reason	# Discharged	Percentage ALL FSP	Percentage TAY	Percentage Adult	Percentage 60+
Met Goals	9	18%	25%	18%	14%
Met Target Criteria	2	4%	25%	3%	0%
Not Located	14	28%	25%	31%	14%
Moved	12	24%	25%	26%	14%
Deceased	5	10%	0%	8%	29%
Discontinue	4	8%	0%	8%	14%
Serving Jail	4	8%	0%	8%	14%
Institution		0%	0%	0%	0%

HOMELESSNESS

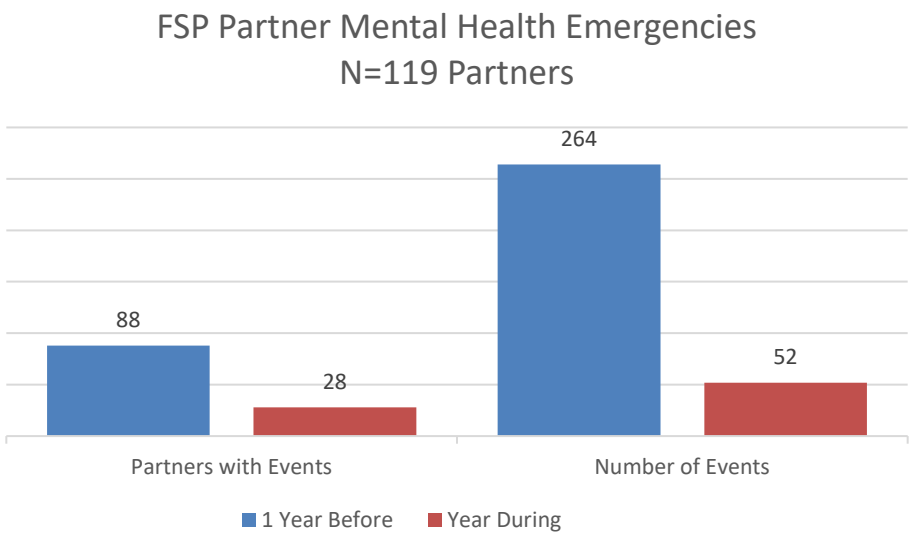
For the 119 who enrolled in an FSP, 47 experienced 11,894 days of homelessness in the year prior to enrollment. In the most recent year in the FSP, 19 partners experienced 3,401 days of homelessness. This represents 44% of partners experiencing 30% of homelessness days one year before the partnership, and 18% of partners experiencing 9% of homelessness days after one year in partnership.



Mental Health Emergency

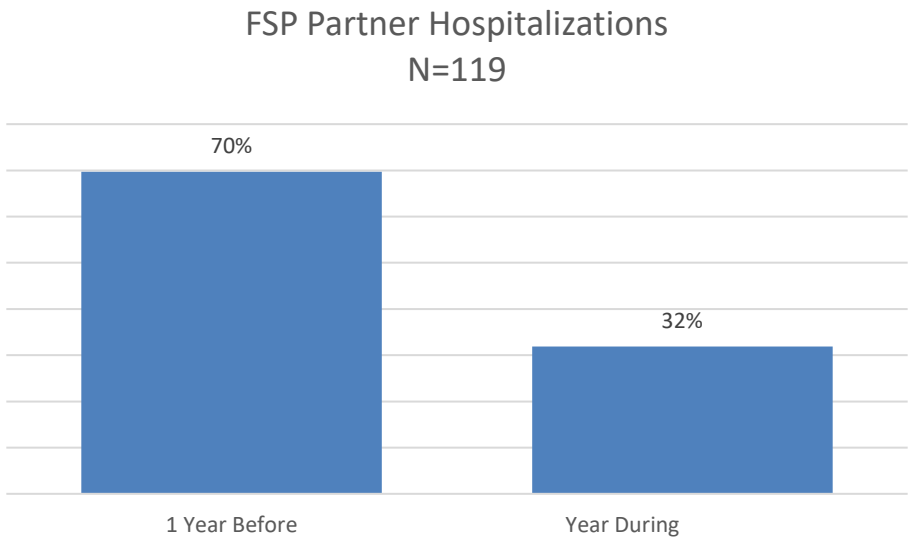
Of the 119 Full-Service Partners enrolled in FSP there were 28 (24%) who participated at least one year in the program. Of these 119, 88 (74%) experienced 264 mental health emergencies in the year prior to enrollment as an FSP. In the most recent year during

enrollment, 28 (24%) experienced 52 mental health emergencies, a decrease of 212 events.



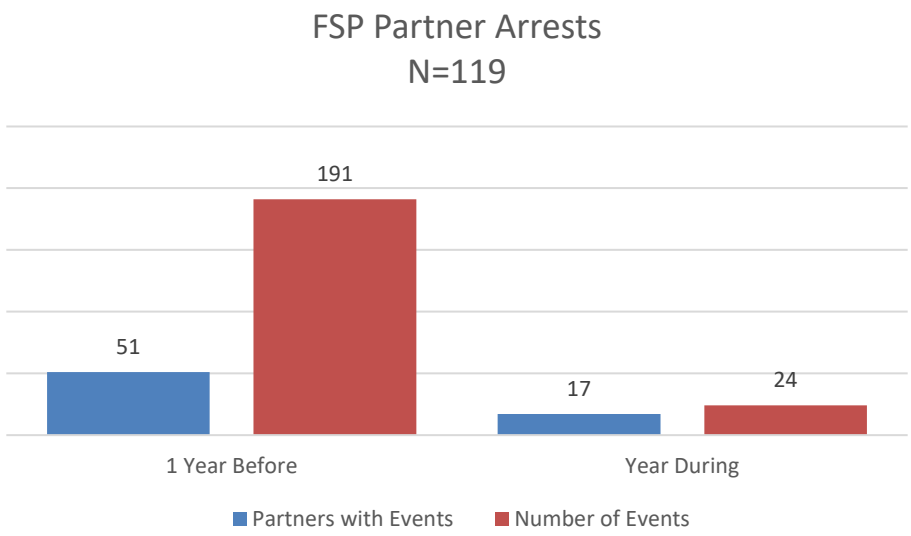
HOSPITALIZATION

Of the 119 Full-Service Partners who participated at least one year in the program, 83 (70%) experienced psychiatric hospitalization in the year prior to enrollment as an FSP. In the most recent year during enrollment 38 (32%) experienced psychiatric hospitalizations.



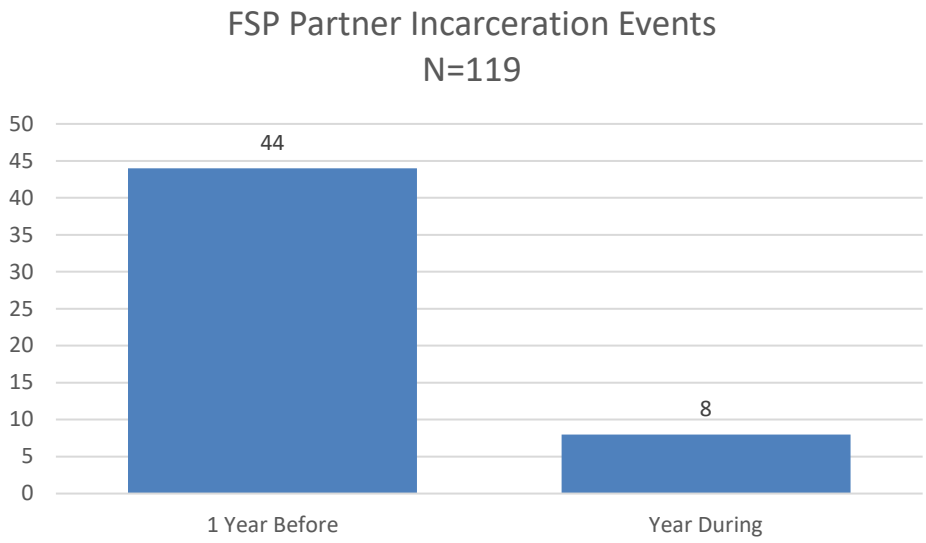
ARRESTS

Of the 119 Full-Service Partners who served at least one year in the program, 51 (43%) experienced 191 arrests in the year prior to enrollment. In the most recent year during enrollment seventeen partners experienced 24 arrests.



INCARCERATION

Among the 119 Full-Service Partners who served at least one year in the program there were 44 incarceration events for 2,766 days in the year prior to enrollment as a Partner. In the most recent year during enrollment there were 8 incarceration events.



Community Services and Supports: Regional Services

DHHS-Behavioral Health Regional Services falls under General System Development (GSD) and Outreach and Engagement (O&E). As GSD, Regional Services focuses on the stabilization, management, and reduction of psychiatric symptoms; on the restoration and maintenance of functioning; on the improvement of interpersonal effectiveness; and on the development and maintenance of healthy support systems for clients. As O&E, Regional Services reaches out and engages adults living in all areas of Humboldt County including Eureka, Fortuna to Garberville, McKinleyville to Orick, and

Willow Creek to Orleans—that have a scarcity of behavioral health services and provides services to them as needed. This meets the need to increase and expand behavioral health services.

Regional Services are provided in full accordance with the DHHS-BH mission and philosophy of providing comprehensive behavioral health care within a system of care framework. Regional Services follows the guidelines set forth in DHHS-BH's Administrative Policy & Procedure Manual and the Mental Health Plan Contract, including guidelines for target population and services provided. Consumers seeking services must meet medical necessity criteria, have a qualifying DSM-5 diagnosis, meet functional impairment criteria, and meet intervention related criteria in order to receive ongoing Specialty Mental Health Services.

Regional Services receives referrals from other programs within DHHS as well as from many community providers. These community providers include multiple tribes, K'ima:w Medical Center on the Hupa Reservation, United Indian Health Services, Willow Creek Community Health Center, Willow Creek Community Resource Center, Redwoods Rural Health Center, Jerold Phelps Community Hospital, Mateel Community Center, The Healy Senior Center, Family Resource Centers, and Law Enforcement Agencies.

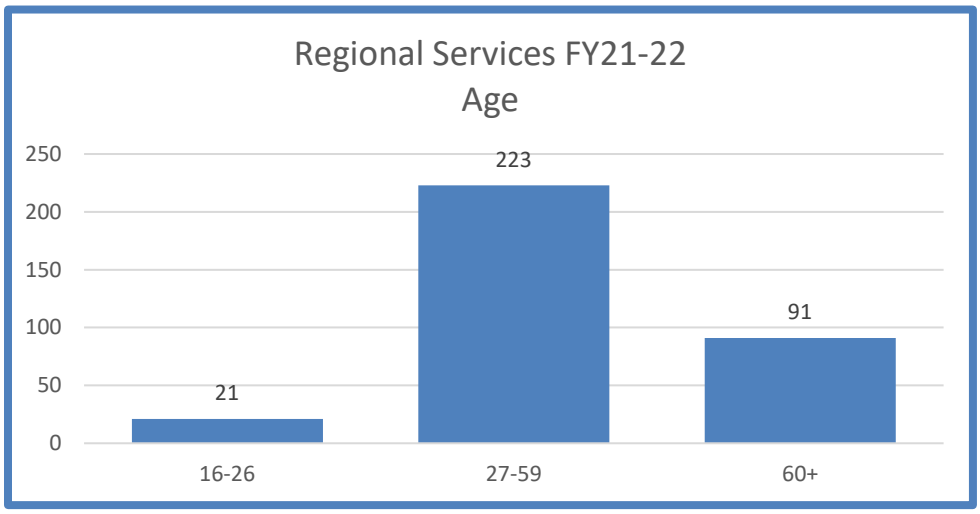
Clients can be met in their homes or in different community sites. Regional Services staff utilize offices in Eureka, Garberville, Willow Creek, and Weitchpec. Staff have also developed close working relationships with many community partners that allow them to utilize office space as needed in other rural locations.

Regional Services includes Behavioral Health Clinicians, Case Managers and Substance Use Disorder Counselors. Staff provide outreach in the community to individuals in need of services and work to link individuals with appropriate services. Behavioral Health Clinicians screen and assess individuals requesting access to behavioral health services, provide ongoing individual therapy as indicated, and provide clinical guidance to the teams. Case Managers work with open DHHS-BH clients to provide case management brokerage and rehabilitation services to connect them with resources and support them with moving forward in their recovery processes. Referrals are made to substance use disorder (SUD) services as needed. Staff attend community meetings/outreach events to provide education to other community providers about County services and to engage new client referrals.

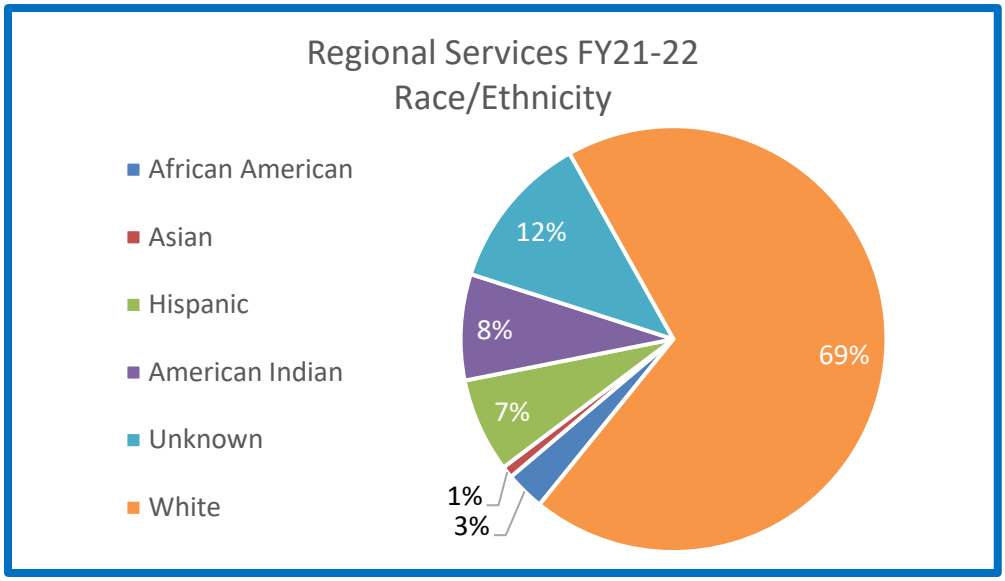
MHSA CSS funding will continue to support a proportion of the salary costs for Regional Services staff. Outcomes will be measured by the number of clients reached and the program aims to complete 50 new client assessments per year.

Report for Fiscal Year 2021-2022

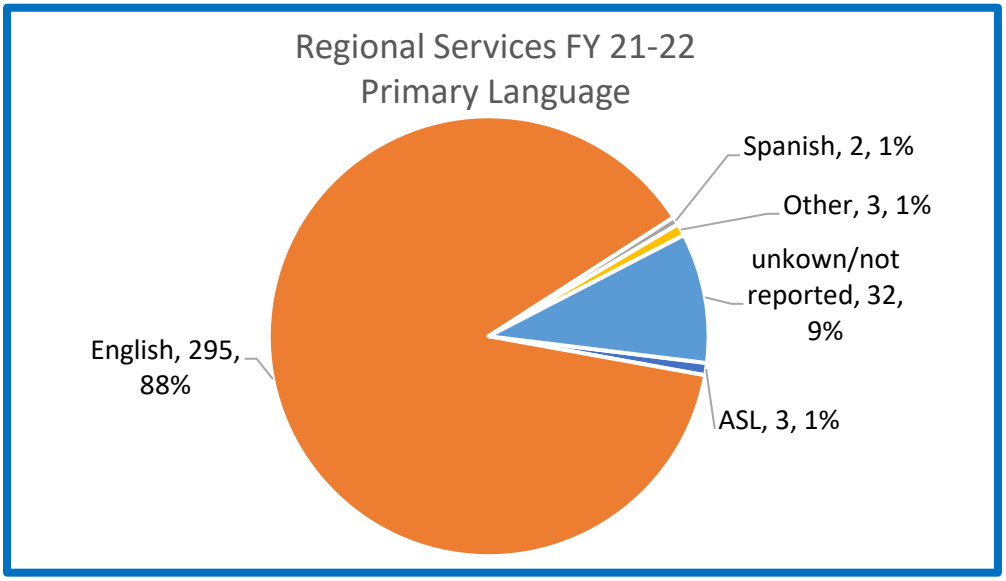
Among the 335 participants served in FY 21/22, 21 (6%) were among the 16-26 age group, 223 (67%) were among the 27-59 age group, and 91 (27%) were among the 60+ group.



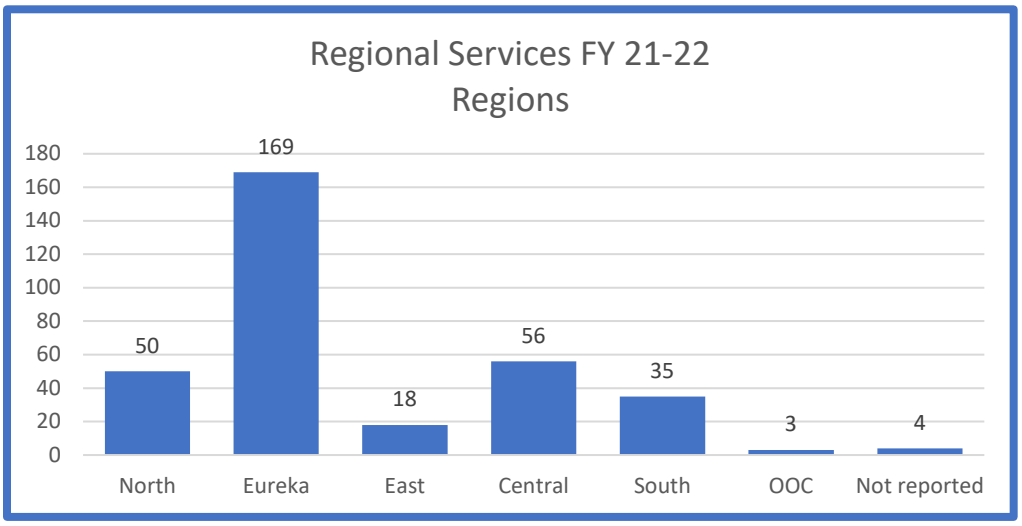
Of the 335 participants served in the Regional Services Program for FY 21/22, 10 (3%) were African American, 3 (1%) were Asian, 24 (7%) were Hispanic, 27 (8%) were American Indian, 231 (69%) were White, and 40 (12%) are Unknown.



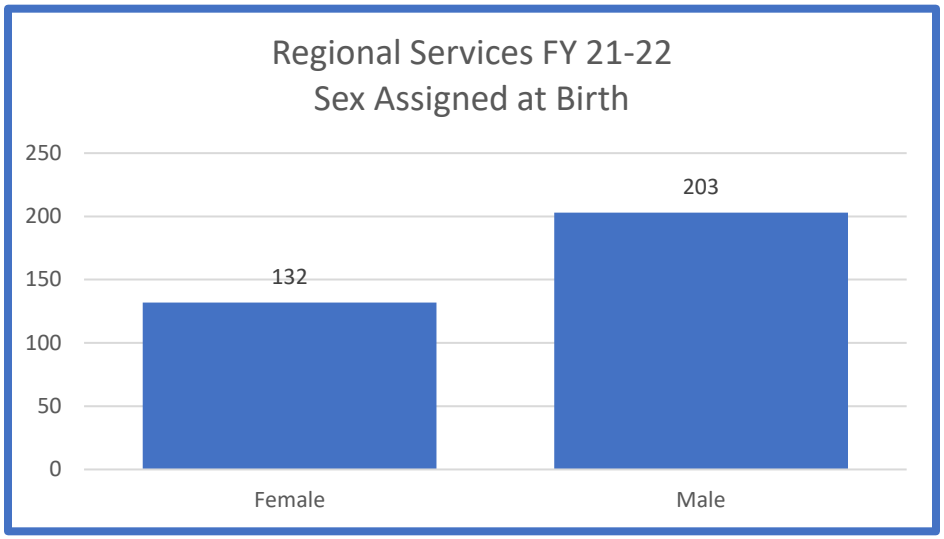
Out of the 335 participants served in the Regional Services Program for FY 21/22, 295 (88%) listed English as their primary language, 3 (1%) listed ASL, 2 (1%) listed Spanish, 3 (1%) listed the Other category 32 (9%) did not report their primary language.



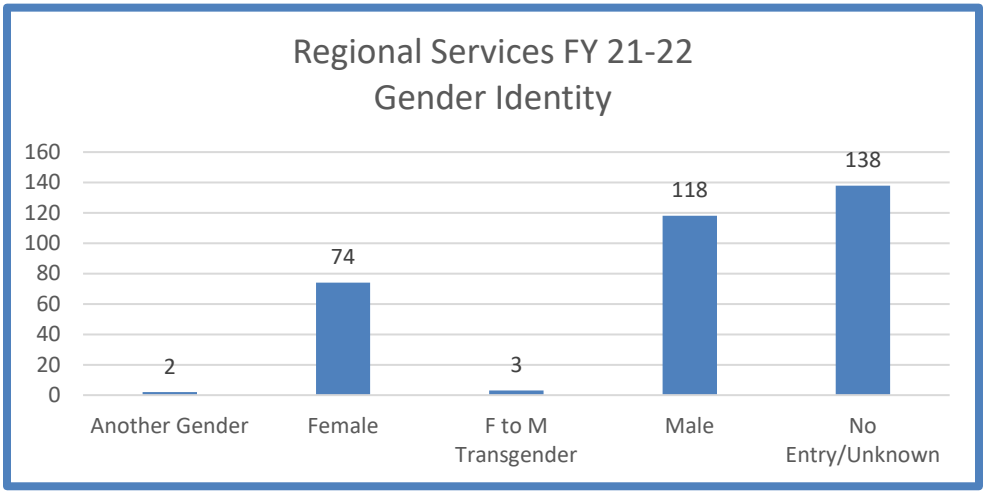
Among the 335 Regional Services participants for FY 21/22, 50 (15%) were from Northern Humboldt, 169 (50%) were from Eureka, 18 (5%) were from Eastern Humboldt, 56 (17%) were from Central Humboldt, 35 (10%) were from Southern Humboldt, 3 (.9%) were from Out of County, and 4 (1%) of the participants did not report the region they live in.



Out of the 335 individuals served by Regional Services in FY 21-22, 132 (40%) identified as female and 203 (60%) identified as male.



Out of the 335 Regional Services participants, 2 (.6%) identified as another gender, 74 (22%) identified as Female, 3 (.9%) from Female to Male Transgender, 118 (35%) as Male, and 138 (41%) did not enter gender identity.



Community Services & Supports: Older Adults

The Older Adults Program has two components. One component is Outreach, Prevention and Education, an Outreach and Engagement (O&E) program under Community Services and Supports, whose purpose is to identify unserved individuals in order to engage them. The second component is a General System Development (GSD) program under Community Services and Supports, whose purpose is to provide mental health services to older adults.

Outreach, Prevention and Education

The Mental Health Clinician assigned to the Older Adults program provides outreach, prevention and education to older adults. The clinician is contacted by an agency or organization, such as Adult Protective Services, In Home Supportive Services, or community services such as Open Door Community Clinic, local hospitals or PACE, and is informed of an older adult who may need behavioral health or prevention services, or education. If a behavioral health need is identified, the clinician then assists the client in navigating the BH system and identifies appropriate referrals to offer specialized support to the client.

Many of these clients are reaching out for the first time. The program strives to reduce the stigma of behavioral health labels by offering personalized care, education, intervention, and connections to services in the community.

Outcomes that are tracked include the following:

- Number/percent assisted with outreach to a community provider
- Number/percent provided services by DHHS-BH staff
- Number/percent referred to other DHHS programs
- Number/percent provided services in collaboration with DHHS BH staff.

An estimated 150 individuals will be contacted through outreach, prevention and education during fiscal year 2023-2024. With the definition of Older Adults being lowered to the age of 60, there is potential for the number of individuals contacted to increase.

Behavioral Health Services to Clients

In addition to contacts made through outreach, prevention and education, older adults are provided services as clients of DHHS Behavioral Health. An estimated 100 clients will be served over the next year. Clients will receive a variety of services that can include Psychiatry, Medication Support, Group Treatment, Individual Therapy, and Intensive Case Management.

Client Outcomes that are tracked:

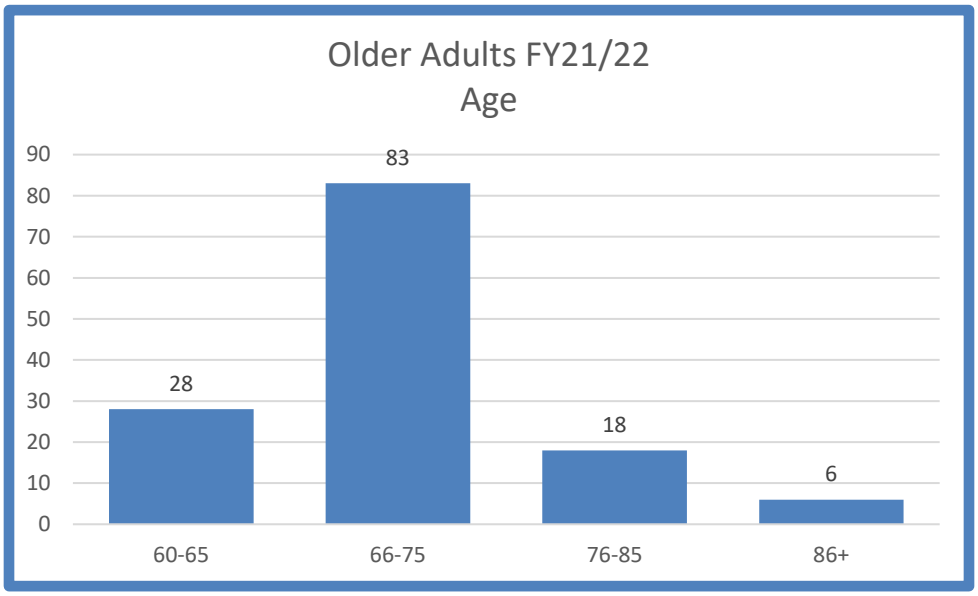
- Reduced mental health symptoms
- Increased coping skills
- Increased access to services
- Increased communication between providers/agencies
- Education about mental health
- Information about the community to support wellness

Outreach, Prevention and Education

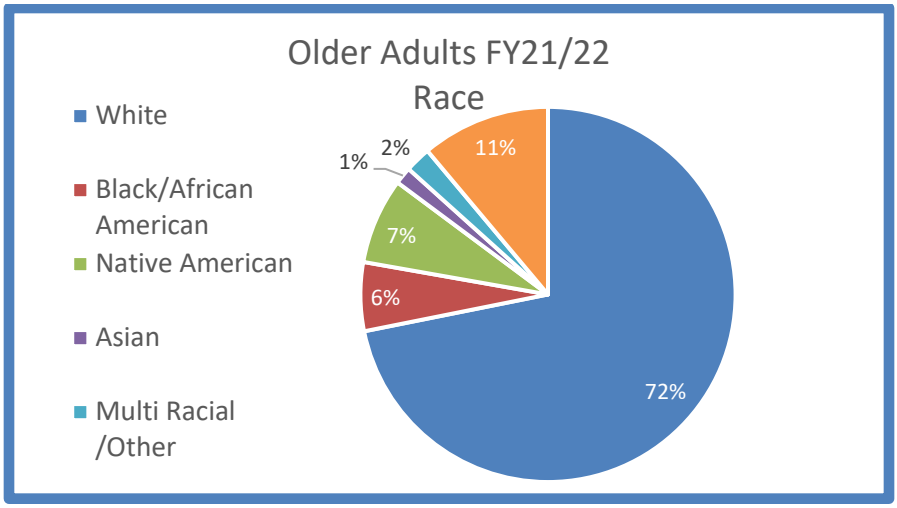
During Fiscal Year 21/22 a total of 135 individuals were contacted by the Behavioral Health Clinician assigned to the Older Adults program, primarily through outreach, prevention and education activities.

Descriptive statistics for participants in the Outreach, Prevention and Education component of the Older Adult program for FY 21/22 are discussed below.

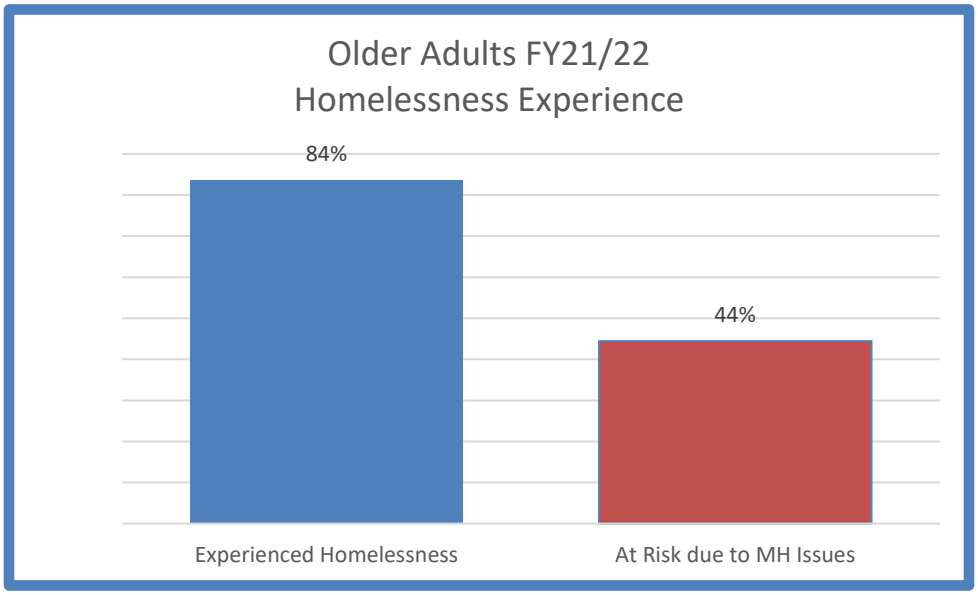
Sixty-five (47%) of the participants were male, 71 (53%) were female. Twenty-eight (21%) were ages 60-65, 83 (61%) between ages 66-75, 18 (13%) between ages 76-85 and 6 (4%) were 86+.



Among the 135 Older Adults served in FY21/22, 97 (72%) were White, 8 (6%) were African American, 10 (7%) were Native American, 2 (1%) were Asian, and 3 (2%) were Multiracial or other and 15 (11%) of the participants were Hispanic.

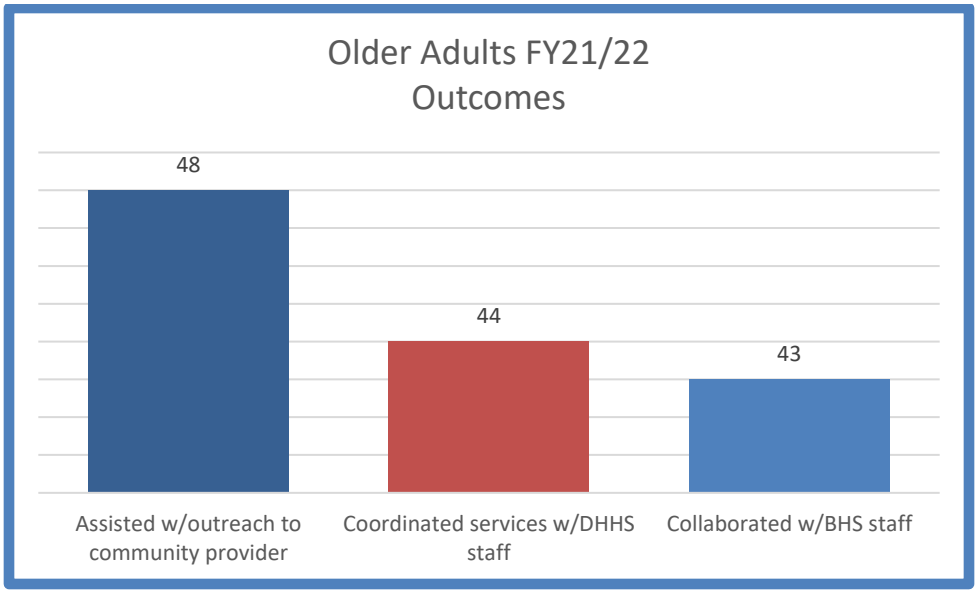


Of the 135 participants in the Older Adult program in FY21/22 113 (84%) self-identified as having experienced homelessness at some time and 60 (44%) expressed feeling at risk of homelessness due to mental health issues.



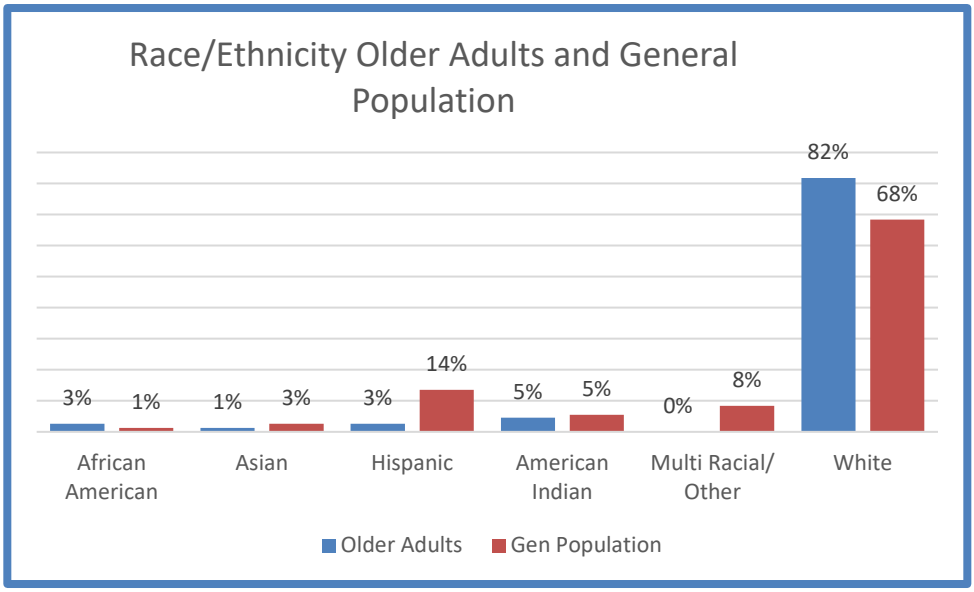
Outcomes

For these 135 Older Adult participants 48 (36%) were assisted with outreach to a community provider; for 44 (33%) services were coordinated with DHHS staff; for 43 (32%) collaboration with Behavioral Health staff was implemented.

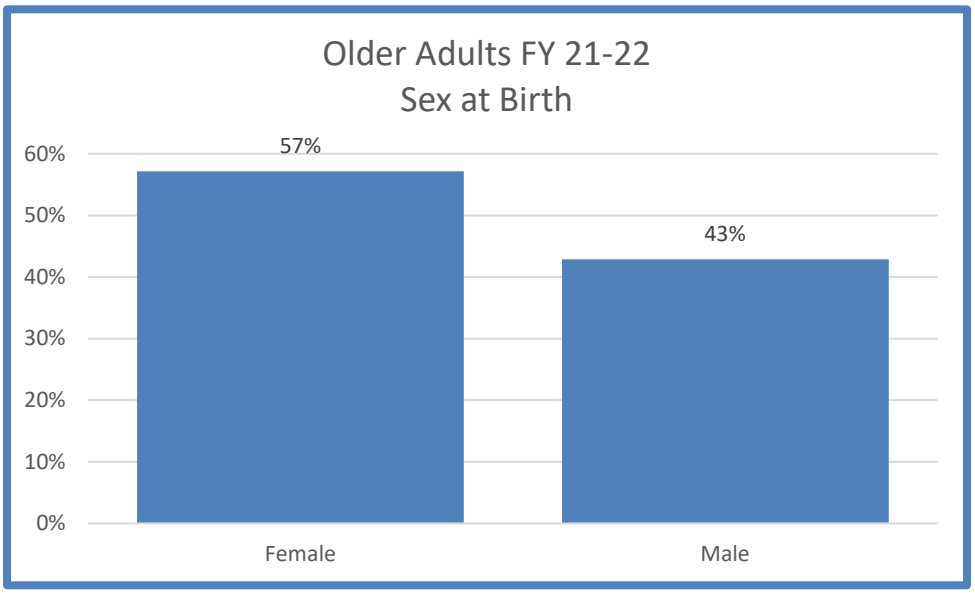


Mental Health Services to Clients

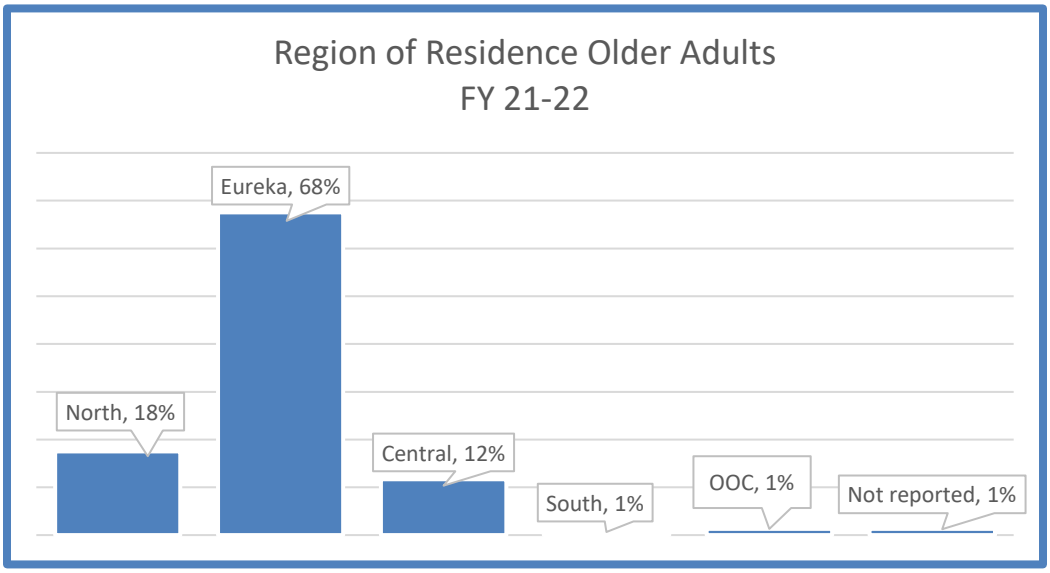
In addition to contacts made through outreach, prevention and education, 154 individuals were provided services as clients of Behavioral Health for Fiscal Year 2021-2022. Of these, 82% were White, compared to 68% of the general population; 5% were American Indian, compared to 5% of the general population; 3% were Hispanic compared to 14% of the general population; 3% were African American, compared to 1% of the general population; 1% were Asian, compared to 3% of the general population; and no clients were Multi Racial/Other compared to 6% of the general population.



Fifty-seven percent of clients served were female, and 43% male.



Sixty-eight of those served reside in Eureka, 18% in Northern Humboldt, 12% in Central Humboldt, 1% in Southern Humboldt, 1% reside out-of-county (OOC), and 1% not reported.



Community Services and Supports: Crisis Residential Treatment

Based on input from stakeholders over the past several years, including in the CPPP for the Three-Year Plan 2020-2023, in FY 2019-2020 Humboldt County Behavioral Health (DHHS-BH) sent out a Request for Proposals for qualified behavioral health treatment facilities to provide sub-acute transitional behavioral health, specialty behavioral health and/or social rehabilitation services to eligible DHHS-BH clients as part of a long-term adult residential treatment and/or supportive living program.

Behavioral Health received three proposals in response to the RFP. Through analysis and interviews with the proposers the RFP selection committee selected Willow Glen as the successful proposer. Willow Glen is working to establish a Crisis Residential Treatment (CRT) program in our community. As of October 2022, Willow Glen has been able to acquire a property in Eureka and is currently working on remodeling efforts and additional planning. The hope is to have the CRT in operation by late summer or early fall of 2023.

Crisis Residential Treatment is a Medi-Cal billable service that allows eligible Medi-Cal beneficiaries to receive immediate housing and treatment when stepping down from an Acute Psychiatric Hospitalization and/or when in danger of worsening symptoms requiring emergency Psychiatric Hospitalization. Crisis Residential Treatment allows for a stay up to 90 days. During that time clients continue to receive ongoing stabilization and support from Behavioral Health staff. Clients would not need to be an established Behavioral Health client with an assessment and treatment plan but would need to have a diagnosed mental illness and be in jeopardy of needing higher level of care, such as inpatient psychiatric hospitalization and/or incarceration.

While a resident at the Crisis Residential Treatment facility, the client will be linked to various programs within DHHS such as the HOME program or Social Services programs, as well as other community and natural resources such as physical health care.

In addition to referrals from Psychiatric Health Facilities, clients can be referred from other programs such as CalWORKs, County Probation, and local housing resources such as shelters.

The program will assist to reduce and prevent homelessness, involvement in the criminal justice system, acute psychiatric hospital admissions and length of stays and admission/re-admission to Institute for Mental Disease (IMD) and Mental Health Rehabilitation Center (MHRC) facilities. This program should benefit individuals on our Lanterman Petris Short (LPS) Conservatorship as well as clients involved in the Assisted Outpatient Treatment Program (AOT).

Outcome Measures will be tracked through the State Data Collection and Reporting (DCR) system for those clients who meet criteria for Full-Service Partnerships. Outcome measures include:

- Psychiatric hospitalizations
- Incarcerations,
- Housing status, including number of nights homeless if applicable,
- Law Enforcement contacts, including probation/parole status if applicable,
- LPS status, including tracking those who are able to get off of LPS,

- Starting or stopping schooling and/or employment
- Starting or stopping Substance Use Disorder Treatment
- Currently enrolled with a Primary Care Provider
- Number of children in Child Welfare system

Innovation (INN) Component: Resident Engagement and Support Team (REST)

The Resident Engagement and Support Team (REST) project applies a promising community driven practice or approach that has been successful in a non-mental health context or setting for those experience mental health challenges. This approach is Housing First. The project's primary purpose is to increase access to mental health services to underserved groups. These groups are homeless individuals or those who are at risk of becoming homeless.

This project will expand on current efforts of the county regarding the overarching goal of improving housing stability. This goal has been a jointly identified need by various county agencies, including Humboldt County Department of Health and Human Services HOME program, Arcata House Partnership, Eureka City Council and the Department of Housing and Urban Development (HUD) to name a few. Currently these efforts exist to find permanent supportive housing for homeless and unsheltered individuals in the county. REST addresses a missing component within this continuum by helping individuals remain housed while assisting in transition them to HUD programs.

REST can be viewed as a "Post-Housing" Housing First model. The project will consist of assigning case managers and peer coaches to the Adult Outpatient Program to work with the identified population. The population to be served will be DHHS-Behavioral Health consumers, age 18 or older, who do not meet the level of care indicated for Full-Service Partnership. They are those individuals at risk of homelessness or who are homeless, and may include:

- Consumers stepping down from HOME services
- Consumers that are leaving SV or the CSU
- Consumers who are stepping down from the Full-Service Partnership level of care and still need case management services
- Individuals who are currently Adult Outpatient consumers

The case managers and peer coaches will work with consumers to help them maintain their housing. Activities to be provided could include helping consumers create a structure and routine in their daily lives to get their needs met; coordinating care with other agencies providing services/supports to the consumer; linking the consumer to physical and mental health services; coordinating care and problem solving with landlords; working collaboratively with family members; helping consumers develop

coping strategies; supporting consumers in learning and practicing activities of daily living; and many more activities designed to assist consumers in maintaining housing.

REST was approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC) on June 24, 2021, and by the Humboldt County Board of Supervisors on August 10, 2021. Services for consumers were expected to begin by January 2022. However, hiring Case Managers for the program has proven to be challenging. Limited services began in July of 2022. Currently one is position filled and active recruitment is happening to fill all remaining vacancies for this program.

The full proposal for the REST project can be found in the MHSA Annual Update for 2021-2022, available on the County website at Annual Update.

Prevention & Early Intervention (PEI) Component

Nineteen percent (19%) of MHSA funds received by counties must be allocated for PEI services, designed to prevent mental illnesses from becoming severe and disabling. PEI services focus on preventing the onset of mental health issues and/or providing early intervention treatment and referral services. MHSA regulations require PEI plans to include at least one program focused on delivering services for the following service categories: 1) Prevention, 2) Early intervention, 3) Stigma and discrimination reduction, 4) Recognizing early signs of mental illness, and 5) Promoting greater access and linkage to treatment. Suicide prevention programs also fit within the PEI component.

Per the requirements of SB 1004, as listed in the chart below under the column SB 1004 Priorities, the programs in the five service categories listed above should focus on six priorities. Humboldt County's PEI programs include the six priorities, as indicated in the table below. Because in most cases more than one PEI program addresses each of the priorities, determining the share of PEI funding that is received by each priority is difficult. An estimate is 17% for childhood trauma prevention and early intervention; 13% for suicide prevention; 14% for youth outreach and engagement; 17% for culturally competent and linguistically appropriate prevention and intervention; 8% for older adults; and 31% for early identification programming. The PEI programs are supported by stakeholder engagement and contribution. Themes from stakeholders over the past years include increasing bilingual and culturally competent services; focusing on early childhood mental health, including trauma prevention and early intervention; and increasing support for school age and transition age youth. It should be noted that Humboldt Behavioral Health has an Early Psychosis program meeting the priority of early psychosis and mood disorder detection and intervention that is not funded by MHSA, and the Older Adults program, funded by MHSA CSS dollars, includes an outreach, education and engagement component that fits under the priority of strategies targeting the mental health needs of older adults.

SB 1004 Priorities	Humboldt PEI Programs
Childhood trauma prevention and early intervention	• Parent Partners • Local Implementation Agreements • MTSS • Early Childhood Treatment Cert.
Early psychosis and mood disorder detection and intervention and mood disorder and suicide prevention programming that occurs across the lifespan (Note: all programs are for suicide prevention)	• Suicide Prevention • Suicide Prevention Hotline • Warm Line • QI Initiative • CalMHSA PEI Program
Youth outreach and engagement strategies that target secondary school and transition age youth and youth not in college, with a priority on partnership with college mental health programs	• TAY Advocacy and Peer Support • MTSS • CalMHSA PEI Program
Culturally competent and linguistically appropriate prevention and intervention	• Hope Center • Local Implementation Agreements • Embedded in all PEI programs • Latinx Liaison • CalMHSA PEI Program
Strategies targeting the mental health needs of older adults	• Suicide Prevention • Suicide Prevention Hotline • CalMHSA PEI Programs
Early identification programming of mental health symptoms and disorders	• Hope Center • TAY Advocacy and Peer Support • Parent Partners • MTSS • Warm Line

At least fifty-one percent (51%) of PEI funds must be allocated for serving individuals who are 25 years old or younger. Programs that serve parents, caregivers or family members with the goal of addressing children and youth at risk of or with early onset of

a mental illness can be counted as serving children and youth. The following pages describe the PEI programs and services that reflect the themes and priority areas identified in the CPPP.

Prevention and Early Intervention: Hope Center

The Hope Center serves unserved and underserved populations of transition age youth, adults and older adults who have behavioral health challenges as well as their family members. The Center meets the need in the community to provide a safe, welcoming environment based on the dimensions of wellness from the Substance Abuse Mental Health Services Administration (SAMHSA), and the resources necessary for people with and without a behavioral health diagnosis and their families to be empowered in their choices to be self-sufficient. The Hope Center provides prevention and early intervention activities that reduce stigma and discrimination and provide access and linkage to treatment. Hope Center activities are culturally responsive and linguistically appropriate and help provide early identification of mental health symptoms and disorders, meeting the SB 1004 priorities. These activities contribute to the reduction of the negative outcomes that may result from untreated behavioral health challenges and illness.

The Hope Center is Peer driven. Peer Support is an evidence-based practice. In a letter dated August 15, 2007, the Director of the Center for Medicaid and State Operations declared peer support services “an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders.” The letter further states, “CMS recognizes that the experiences of peer support providers, as consumers of mental health and substance use services, can be an important component in a State’s delivery of effective treatment. CMS is reaffirming its commitment to State flexibility, increased innovation, consumer choice, self-direction, recovery, and consumer protection through approval of these services.”

The Hope Center has a Peer Coach lll position along with Peer Coach I and II positions. Due to recent legislation changes all Peer Support staff have the opportunity to be certified through CalMHSA as Peer Support Specialists. Many of them are completing their education and training requirements for this certification already. Once this is done, they will take the Peer Certification test administered by CalMHSA. This certification will allow for Medi-Cal to be billed for the service of Peer Support creating an additional funding mechanism to help sustain peer programs, including the HOPE Center. In addition to this, two of Hope Center Peer Coach ll’s have completed the Wellness Recovery Action Plan (WRAP) training. This is an evidence-based practice that emphasizes recovery and resiliency for those consumers who at times struggle with their stability.
Hope Center goals are to:

- Build on the dimensions of wellness
- Incorporate recovery pathways
- Validate strengths and honor the person
- Build sustainable living skills
- Build community engagement
- Promote self-advocacy
- Keep Hope Center a safe location for all participants
- Reduce stigma and discrimination within the system of care and the broader community
- Developing an inviting community space alongside an educational setting
- Encourage individuals to find their personal strengths and identify their personal recovery goals
- Develop a more sustainable hybrid setup, to allow access to all who want to participate
- Break the stigma of “us and them”

The Center works from the recovery pathways: Hope, Choice, Empowerment, Recovery Environment, Spirituality (purpose/meaning). The Center provides many resources including classes, self-advocacy education, peer support, system navigation, and linkage to services in the community. Outreach efforts are made by Hope Center peers to people with a behavioral health diagnosis. The Hope Center has been slowly returning to in person services while maintaining a Zoom community. Hybrid classes will be added to our calendar in the following year. Hope Center has introduced Recovery Innovations “My Wellness plan” course to the curriculum as well as a reading club focused on individuals’ experiences with mental health. The Center has created a stronger community connection by tabling at local events. In 2018 the Hope Center created an Advisory Board made up of four participants and a staff member. Unfortunately, the Advisory Board was unable to sustain during the coronavirus outbreak, but staff are working diligently to support participants in re-establishing this Advisory Board. The Advisory Board’s job is to be a voice for the Center and give input to staff. Participants meet once a month to discuss topics of concern, ideas, and thoughts about Mental Health and the role of the Center in the community. The Hope Center has consistent and active members of the community who contribute services such as outreach, education, and coordination of special events.

Hope Center continuing projects include:

- Peer workforce training for the current and future workforce
- Zoom and Hybrid (in person and online simultaneously) meetings and classes
- Leadership training
- Healthy Harvest--fresh fruits and vegetables for participants to supplement their diet
- Work towards Cultural inclusion
- The Hope Center Advisory Board
- Hope ambassadors (participants who know and talk about the recovery pathways)

- Training staff on Wellness Recovery Action Plan facilitation
- Teaching interns about Peer Empowerment and use of the recovery language in their future work.
- May is Mental Health Matters Month participation
- Classes, workshops, and education that focus on individuality, mindfulness, nutrition, resilience, fun, building skills, wellness, building community, facing challenges, and building confidence
- One on one Peer Support as needed.

Unfortunately, due to the pandemic, and a lack of available staff due to supporting other programs in need, data has not been maintained well. A total of 112~ unduplicated participants for FY 2021-22 were recorded. The number of duplicated participants is 3,824 for FY 2021-22 which includes individual peer support engagement on site, in Zoom meetings, and in-person with social distancing, & masking. Additionally, hybrid classes have been added.

Plans for the next year include training and reintroduction of WRAP, in-person services, Zoom and hybrid classes, monthly wellness center meetings, Peer support services and community outreach.

Hope Center activities contribute to the reduction of negative outcomes that can result from untreated mental illness. Besides basic process evaluation that includes numbers reached and events held, the program will measure increases in participants' knowledge, awareness, attitudes and beliefs towards recovery and wellness and any increase in social connections they may experience. This will be measured through training/class evaluations and surveys offered on a periodic basis. In addition, program staff will use a newly developing form with participants, when indicated, to identify if a participant has had past symptoms of mental illness, whether they were treated for these symptoms, and to what service/program a participant may have been referred.

Hope Center Stigma and Discrimination Reduction

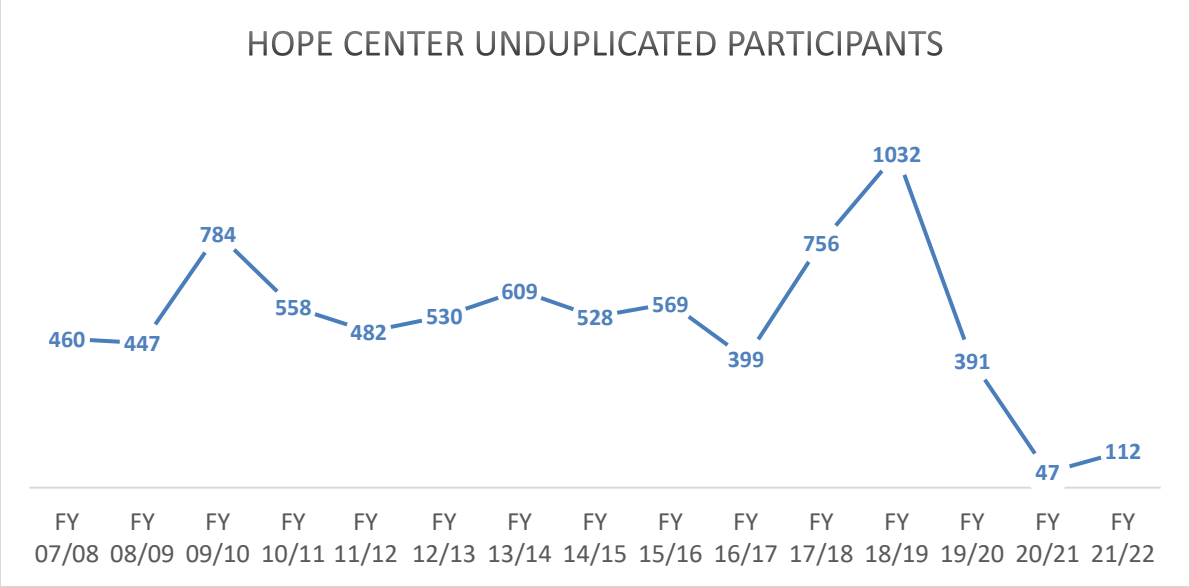
The Hope Center is one of the central programs that Humboldt County Behavioral Health has for furthering the efforts of stigma and discrimination reduction with adults. As discussed earlier in this section, the Hope Center is peer led, and peer support is an evidence-based practice. Over the years of operation, the Hope Center has provided a location for individuals in the community that offers a variety of services and programs without the need of becoming a formal mental health client. These services and programs have been identified as "classes" as they are intended to assist individuals in the community with education on a variety of topics, and have the goal of allowing all participants to gain a level of self-sufficiency and self-reliance. The program is intended to influence those living with a mental illness, those who have not been diagnosed with a mental illness but who are experiencing some symptoms that are challenging, and community members who may want to participate in classes or events that are of interest to them.

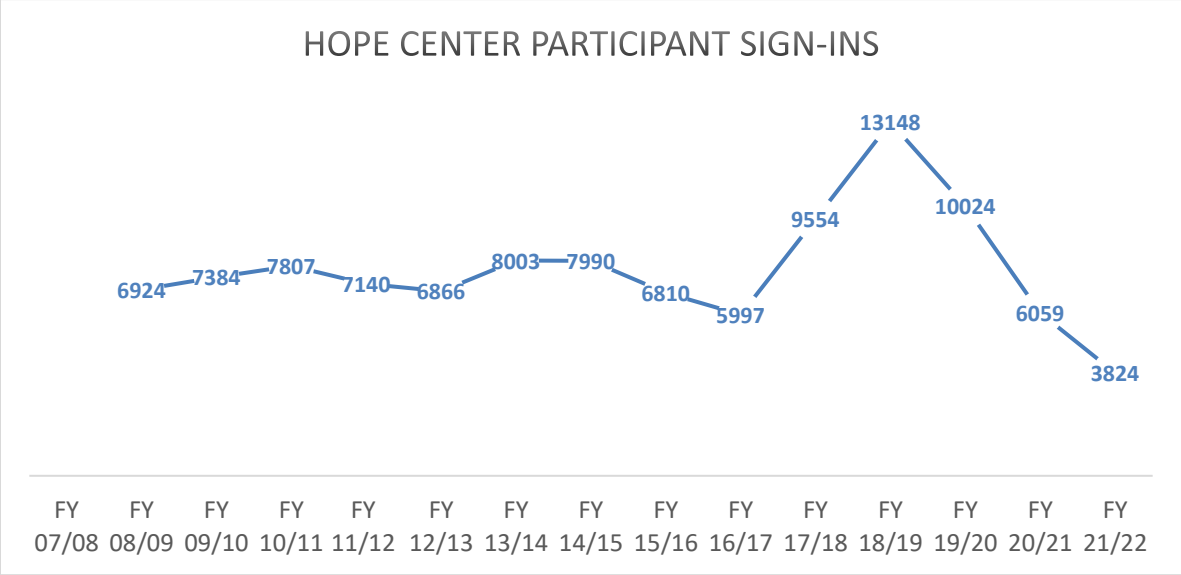
The methods and activities used to change attitudes, knowledge, and/or behavior regarding being diagnosed with a mental illness, having a mental illness and/or seeking mental health services is addressed in the following ways. The Hope Center participant does not need to be a mental health client and there is no requirement to self-disclose a diagnosis or any other mental health symptom to participate. There are classes focused on coping skills, symptom management, and reducing functional impairments, but there are other classes designed to promote activities of daily living including budgeting, gardening, cooking, smoking cessation, and are rotated throughout the year. When participants are not engaged in classes, they are involved in an environment whose primary aim is to promote inclusion and acceptance. Participants are empowered to make decisions for themselves and the program to further ensure that the community has a venue where stigma and discrimination are not tolerated. Events that have been coordinated by the Hope Center with this purpose in mind include yearly Arts Alive nights, where participants' art is shown at an actual art gallery; May Is Mental Health Month Community Walk; Quarterly Community BBQ's; participation and advocacy at the local Behavioral Health Board. The classes and environment of the Hope Center have been one of the most important community efforts to date in reducing stigma and discrimination in Humboldt County.

Fidelity to the evidence-based peer support practice is ensured through the certification process of Recovery Innovations (RI) International. All Peer Coaches are trained as Certified Peer Support Specialists through RI International.

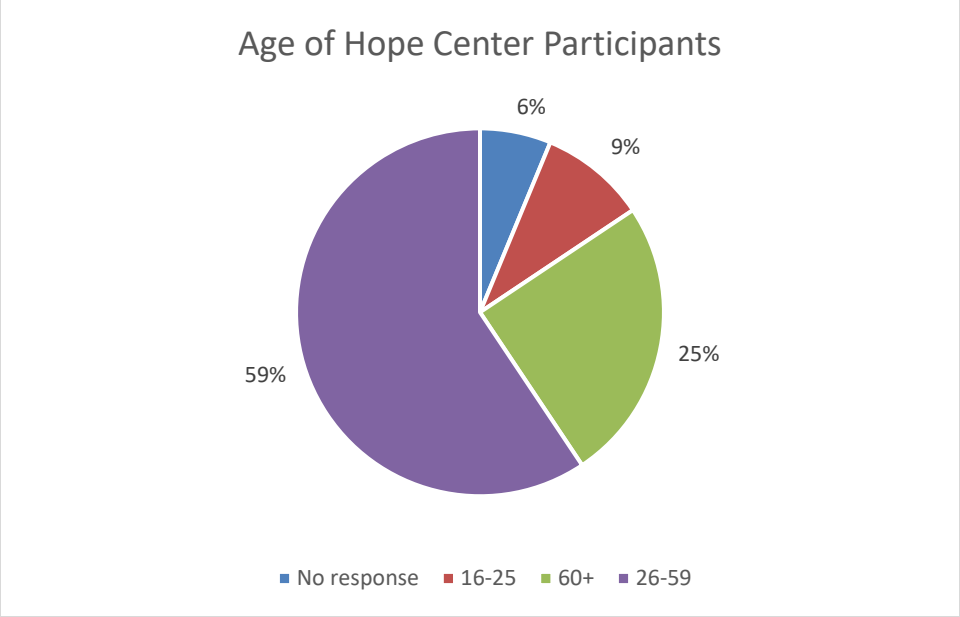
Below is the report for the Hope Center for Fiscal Year 2021-2022

During Fiscal Year 2021-2022 the Hope Center interfaced with 112 unduplicated individuals. There were 3,824 sign-ins to the program. These are reduced from pre COVID but the unduplicated totals increased significantly from 2020-2021 fiscal year. There were no volunteer hours for this fiscal year, but Hope Center is developing the volunteer process in 2022-2023 fiscal year.

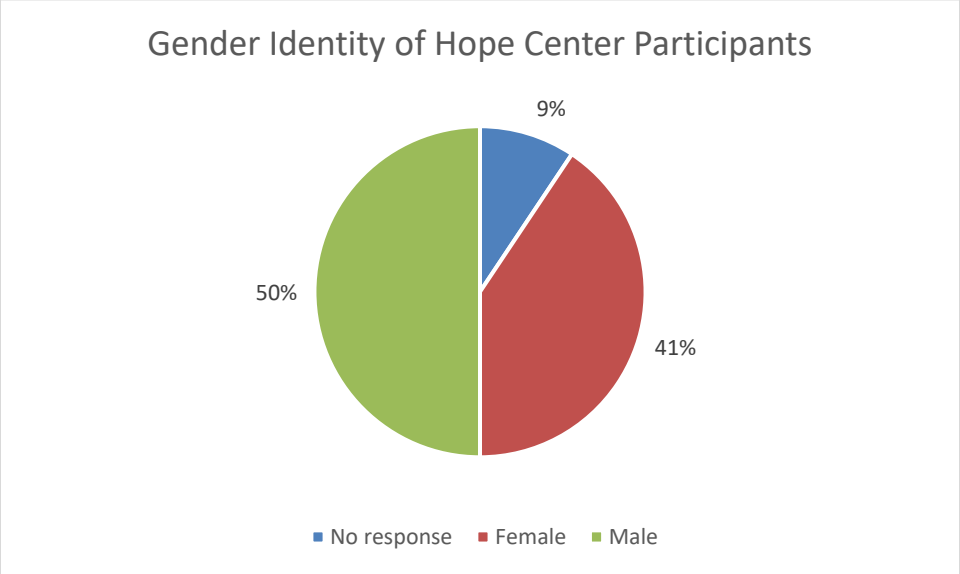




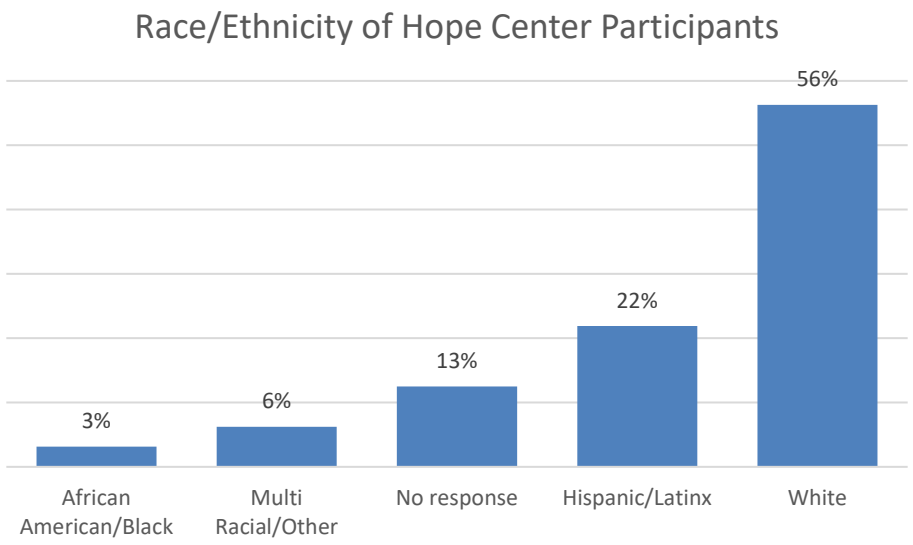
Demographic Data. Of the 112 Hope Center participants, 32 (29%) completed demographic forms. Demographic data is presented in the charts below.
Of those who responded, 9% of participants were ages 16-26, 59% of participants were ages 26-59, and 25% were age 60+. 6% percent did not answer this question.



Of those who responded, 41% were female, 50% male, 9% did not answer this question.

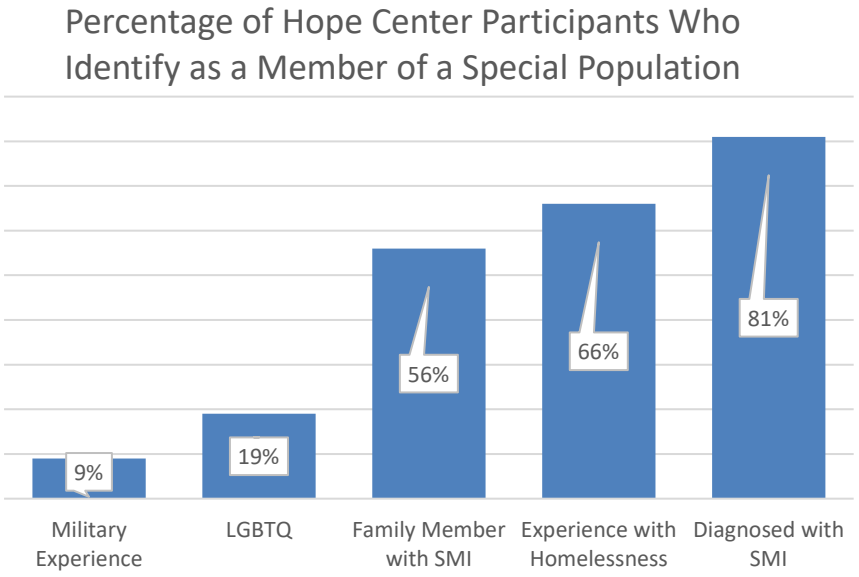


Of those that responded, 56% were White, 6% were Multiracial/Other, 22% were Hispanic/Latinx and 3% were Black/African American. 13% did not answer this question.



94% percent of the Hope Center participants who completed the form, spoke English as their primary language.

19% identified as LGBTQ, 56% had experience with homelessness, 81% had been diagnosed with a serious mental illness (SMI), 56% had a family member diagnosed with SMI, and 9% had military experience.



Prevention & Early Intervention: TAY Advocacy and Peer Support

Introduction

There are two components to this **Prevention and Early Intervention Program: Transition Age Youth (TAY) Advocacy**, through the Humboldt County Transition Age Youth Collaboration (HCTAYC), and **Peer Support** through TAY Peer Coaching services. Both components serve youth and young adults ages 16-26, and both components are a part of the Humboldt County DHHS TAY Division. The TAY Division consists of co-located DHHS services, including Behavioral Health (BH), Extended Foster Care (EFC), Independent Living Skills (ILS), HCTAYC and TAY Peer Coaches. In addition, the TAY Division utilizes supports and services from DHHS departments including Employment Training Division, CalFresh, Medi-Cal, Substance Use Disorder services, and collaborates with community partners such as Juvenile Probation and Family Resource Centers.

TAY Division services and staff include but are not limited to:

- A behavioral health team providing specialty mental health services (individual and family therapy, case management, and referrals for psychiatric services), including a supervisor, clinicians, and case managers
- Linkage and referrals to Adolescent Treatment Program and other substance use disorder services
- Child Welfare Services (CWS) Independent Living Skills (ILS) program serving youth ages 16 to 21
- CWS Extended Foster Care (EFC) Unit
- HCTAYC staff and Youth Advocacy Board (YAB)
- Peer Coaches who serve across the TAY Division
- A Vocational Counselor from the DHHS Employment Training Division
- Linkage and referrals to intensive case coordination services as needed

Target Population

Both HCTAYC and Peer Coaching programs serve Humboldt County youth ages 16-26 who have or are experiencing homelessness, current or historic interaction with the juvenile justice system and/or Child Welfare Services, youth who opted into the Extended Foster Care program, those experiencing behavioral health needs, those experiencing issues with substance use, parenting TAY and youth seeking employment.

TAY Advocacy—HCTAYC

The TAY Advocacy elements of the TAY Division are rooted in the 2004/2005 MHSA Stakeholder process, where a significant need was identified to address poor outcomes for unserved and underserved youth with a severe mental illness or whose risk of developing a severe mental illness is significantly higher than average. A modest initial MHSA Community Services and Supports investment fostered a TAY Advocacy work plan that led to a community-wide mapping of “what was working well, what needed

improvement, and what were the gaps" for TAY throughout DHHS and the broader community.

The TAY Advocacy Program, HCTAYC, launched in 2008. Program collaborators have changed over time and currently consist of **youth ages 16-26**, **DHHS**, **California Youth Connection** (CYC), **National Network for Youth** (NN4Y), **Youth Law Center** (YLC), and **Youth MOVE National** (YMN). HCTAYC works to improve the services youth receive as they transition into adulthood and become independent.

HCTAYC fosters positive youth development, youth advocacy and leadership, community engagement, and promotes youth wellness. HCTAYC provides a youth voice that informs system policy, regulations, and practice at the local, state, and national levels with the purpose of cultivating better outcomes for unserved and underserved youth with a severe mental illness or who are at a significantly higher than average risk of developing a severe mental illness. The program directly impacts the TAY system of care, making it more responsive to young people's needs, resulting in these larger system outcomes. It also directly impacts the lives of system-impacted youth at-risk of, or struggling with, mental health challenges through the development of resilience and self-efficacy via leadership development.

It is the result of this advocacy program that needed systems and services, such as the creation of the aforementioned TAY Division in 2012, have come to fruition. This advocacy has also contributed to the passage of legislation and state policy, including the Foster Care Bill of Rights, Foster Care Psychotropic Medication Management, and the California Department of Social Services implementation of the Child and Adolescent Needs and Strengths (CANS) tool. These policies have all significantly contributed to the statewide transition-age youth system of care's ability to best serve youth.

It is evident that there is a significant need for the creation of a youth-positive environment so that youth may participate as fully engaged participants in society, shaping their lives and fostering collective wellness.

Large-scale impacts of system change at local, state, or national levels, particularly policy advocacy, are difficult to measure as they are collaborative and span multiple years without the possibility of before or after impact evaluations that measure efficacy and attitudinal change. However, measurable data can be obtained from program operationalization through public awareness events directed at youth and community members; trainings provided to staff and community partners on effectively engaging youth and developing youth-informed approaches; and leadership development opportunities provided to youth participants.

The TAY Advocacy is a prevention program which, along with TAY Peer Coaches, addresses components of early intervention, stigma and discrimination reduction, and outreach for increasing the recognition of early signs of mental illness. The TAY Advocacy and Peer Support activities meet the SB 1004 priority of youth outreach and engagement targeting transition age youth and the priority of early identification of mental health symptoms and disorders. As a rural, poverty-stricken community, access and knowledge regarding the aforementioned subjects, particularly for systems-impacted youth are limited. There is a significant need to address the hopelessness, lack of self-efficacy, and significant independent living skill deficit that exacerbate existing social determinants of health.

Key Activities

The TAY Advocacy Program/HCTAYC consists of a shared Supervising Mental Health Clinician, three Youth Organizers, and Youth Advocacy Board (YAB) that provides input and brings a youth voice to program development. The HCTAYC YAB is trained extensively in facilitation, public speaking, and leadership. HCTAYC's areas of focus for systems improvement include behavioral health, homelessness, foster care, juvenile justice, alcohol and drug abuse, transitional housing, employment services, and many other services for transition age youth.

There are three major components of **HCTAYC Program Activities**. 1. Trainings and Events, 2. Advocacy, and 3. Youth Leadership Development.

1. Trainings take a cultural competence and/or cultural humility approach. With a specific youth-developed curriculum, training focuses on youth culture and the ways in which systems impact youth wellness. Events focus on concepts of behavioral health stigma reduction, outreach and information regarding behavioral health services, and wellness resilience development. These events occur in multiple formats, all of which are youth driven.
    a. Trainings for professionals and community members focus on TAY-specific mental health challenges and the engagement of this population. This includes special populations particularly impacted by stigma and discrimination such as LGBTQ youth, Indigenous Youth, foster youth, juvenile justice youth, homeless youth, and youth experiencing substance use related issues.

2. Advocacy is operationalized through two means; *systems change* and *individual advocacy*.
    a. *Systems change* is enacted through youth organizers supporting the YAB to attend and participate in policy setting, decision making tables, and correspondence. This includes participation at local, state, and national policy tables and related coalitions or collaboratives.
    b. *Individual advocacy* occurs when HCTAYC Youth Organizers support TAY youth in self-advocacy during their own care coordination. This is also

done through participating in advocacy to amplify the youth's wishes, assisting youth in preparing speaking points for their case planning meetings, and attending said meetings to support the youth's desired outcome.

3. Youth Leadership Development is perhaps the most transformative element of the HCTAYC program, consciously targeting the three base psychological needs identified in self-determination theory: *autonomy*, *competence*, and *relatedness*. These three components aid to prevent the emergence of behavioral health conditions or reduce prolonged suffering and progression.
    a. This development is the transference of skills to, and the continual support and supervision of, YAB members. By creating a system of tiered levels of leadership, board members are given the opportunity to experience, develop, and practice leadership skills in a gradual progression of intensity, while emphasizing increased peer engagement and relationship building.
    b. Participants receive periodic trainings on different elements of leadership and topical education on advocacy topics. Higher-level leaders go through a multi-week orientation process and attend a three-day retreat.
    c. The format of the YAB, with multiple affinity-based committees, allows members to develop *relatedness* with peers with similar lived experiences, while also receiving consistent support and guidance from HCTAYC youth organizers.
    d. Youth exercise *autonomy* through identifying program priorities, modifying program function, and by driving content creation.
    e. Youth exercise *competence* via the provision of trainings, engaging in advocacy, and successfully planning events. As board members plan their transition from active membership, they put together an accumulative leadership portfolio demonstrating their strengths and successes as youth leaders.
    f. Additionally, extensive studies have demonstrated that youth leadership programming increases self-efficacy[1] - which is an important indicator for the reduction of harmful actions such as self-harm and suicide[2].

Expected Outcomes

Expected Outcomes for Fiscal Year 2023-2024 (FY 23-24):

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[1] Dominique Perreault, Lori R. Cohen & Céline M. Blanchard (2016) Fostering transformational leadership among young adults: a basic psychological needs approach, International Journal of Adolescence and Youth, 21:3, 341-355, DOI: 10.1080/02673843.2015.1083451

[2] Han, J., Wong, I., Christensen, H. et al. Resilience to suicidal behavior in young adults: a cross-sectional study. Sci Rep 12, 11419 (2022). https://doi.org/10.1038/s41598-022-15468-0

- Gather comprehensive outcomes data to report on leadership development as well as outcomes related to the specific PEI domains for Youth Leadership Development
- YAB committees will facilitate at least one (1) completely youth-driven project per year
- Facilitate at least three (3) youth-leadership development trainings for HCTAYC members and the general transition-age youth community per year
- Implement policy recommendations for LGBTQIA+ and Two-Spirit Youth Across-Systems
- Participate in various advocacy and policy setting tables at the local, state, and national level
- One (1) creative leadership retreat or intensive workshop per year
- Maintenance of youth homelessness reduction collaborative, minimum of nine (9) meetings per year
- Ongoing advocacy for houseless resources and services for TAY, including coordination of data entry into the Department of Housing and Urban Development (HUD) Homeless Management Information System (HMIS) data system for youth experiencing homelessness
- At least one-week (total) of comprehensive wellness programming per year focusing on the eight (8) domains of wellness identified by SAMHSA. These include:
    - Emotional
    - Spiritual
    - Intellectual
    - Physical
    - Environmental
    - Financial
    - Occupational
    - Social

How Outcomes are Measured

Outcomes are measured in multiple ways, depending upon the element of the program.

Youth leadership development and wellness skills data are collected through individual leadership plans, a *Leadership Skills Self-Assessment*, and the *Wellness Empowerment & Successful Transitions (WEST) Survey*–a strengths-based, youth-adult-partnership-developed measure created by HCTAYC to meet the outcomes domains of the PEI funding source.

There is collection of standardized, yet voluntary demographic data collected during peer led groups, workshops or events.

The provision of trainings is measured through execution, attendance, and a youth-adult partnership developed pre-post survey for stigma and discrimination reduction.

Advocacy goals are measured through the accomplishment of advocacy goals, participation in meetings or testimony, and/or the creation of documents, tools, reports, or statements.

Estimated Number to be reached in FY 23-24
The program is estimated to maintain or exceed 6-12 consistent Youth Advocacy Board members each year. During this new reporting period, the YAB maintains a committee structure that aligns their work with their individual lived experience, with some members returning to the board after absence due to the more specialized nature of the committees. Inconsistent participants are difficult to gauge in number, but will be measured based upon referrals, outreach, and attendance at committees. It is estimated that FY 23-24 will bring perhaps 15 engagements with young people interested in the Youth Advocacy Board that do not result in consistent membership.

The program plans to continue towards implementation of our LGBTQIA+ & Two-Spirit Policy Recommendations. It is estimated that recommendation workgroup engagement will consist of approximately 15 community members (excluding YAB & staff) consistently engaged, with larger engagements of up to 50 individuals. System changes and programs created as a result of this advocacy are capable of reaching hundreds, and the direct and indirect number of individuals reached as a result are difficult to gauge, especially considering the circulation of related publications developed by the program.

Continuing the work from the previous Alcohol and Other Drugs (AOD) policy recommendations, it is anticipated that there will be implementation of a youth-driven peer support group regarding substance dependence and healing. The belief is that this group will reach 10-15 youth during FY 23-24.

It is anticipated that there will be complete development of one youth-driven training curriculum, engaging 3-8 young people in its creation. Four to six youth leadership development trainings to youth in Humboldt County are estimated to be provided, consisting of 5-12 young people each. At least three youth-driven trainings to professionals will occur, with participation at each training ranging from 12-35 participants.

It is expected that advocacy at local, statewide, and national policy setting tables will reach at minimum the participants of those policy setting tables. Membership of tables range from 7 - 30 participants each, with multiple meetings per month.

It is estimated that there will be engagement of 8-12 youth in a creative leadership retreat or intensive workshop per year.

The program plans to provide outreach via tabling at various events which will include educational and informational resources regarding services and supports available to transition-age youth, advocacy, and information regarding the recognition of early signs of mental illness and social determinants that contribute to such. There are plans to table at three events, reaching approximately 60-75 individuals.

The wellness programming is expected to reach approximately 30 young people.

TAY Peer Support—Peer Coaching Program

The integration of Peer Coaches within the TAY Division is a peer support prevention program with components of early intervention, access and linkage to treatment, stigma and discrimination reduction, and outreach for increasing recognition of early signs of mental illness. The TAY Peer Coaching program consists of a shared Supervising Mental Health Clinician and five full-time Peer Coaches. Peer Coaches are an integral part of the multidisciplinary team at the TAY Division, and support each of the Division's programs (HCTAYC, Behavioral Health, Independent Living Skills, and the TAY Center).

Peer Coaches operate from the lens of empowerment and recovery and integrate into the division in four main ways: 1. *relationship building and mentoring*, 2. *outreach and engagement*, 3. *linkage to resources,* and 4. *activity coordination*.

1. *Relationship building and mentorin*g is done by Peer Coaches using their personal lived experiences to connect with young people ages 16-26 and focuses on mentoring, instilling hope, empowering and helping young people build self-esteem, and assisting in system navigation and self-advocacy. Peer Coaches have the capacity to engage with young people through shared lived experiences.
    a. Peer Coaches believe young people can grow. This makes them unique in their ability to relate, provide support, and model self-advocacy, recovery, and self-care skills.
    b. Peer Coaches build relationships with young people in ways that create validation, inspire hope, and support program participants through empowerment and trust.
    c. Peer Coaches build mutuality in their relationships with young people, creating a relationship built on respect, compassion, and reciprocity. Through this unique relationship, young people are able to build self-determination, self-esteem, and gain skills necessary for transition into adulthood.
    d. Peer Coaches approach this work from a youth-adult partnership model that allows young people to drive the services and support the goals they need. Relationship building is done by providing individual meetings both at the TAY Center and in the community, utilizing shared experiences, in-vivo role modeling, teaching, and exploring the strengths and needs of the young person from the Transition to Independence Process (TIP) model.

e. Peer Coaches are able to assist young people in building their relational capacity by supporting them when accessing social, vocational, or educational opportunities.

2. *Outreach and engagement* are provided to young people by linkage to services and to the community. This serves to inform them of services available to transition age youth and supports the reduction of stigma and discrimination toward the systems-involved transition age population. Outreach is provided in multiple ways including referrals for services, the TAY Center, community-wide presentations and in-services, and tabling events in the community.
    a. Peer Coaches provide regular outreach to the psychiatric hospital, jail, juvenile hall, schools, family resource centers, tribal organizations, and team with other community partners for street outreach to youth experiencing homelessness. Overall, peer coaching contributes to participant engagement with care, increased effectiveness of services, reduced barriers to services and supports, improved outcomes, reduced hospitalization or incarceration, and increased support for educational and vocational success.
    b. Peer Coaches are the primary staff that oversee the TAY Center and drop-in hours.

3. *Linkage to resources* is available through multiple agencies and helps to support increased youth engagement across programs, improve access to needed services, stigma reduction, greater understanding of lived experiences, increased advocacy, improved relationship with providers, and the ability to show staff and youth that recovery is possible.
    a. Peer Coaches assist young people in navigating the systems, help with referrals to services and support them in appointments, activities, and supporting documents.
    b. Peer Coaches often serve as a bridge between the young person and services, providing warm hand offs from psychiatric hospitalizations, incarceration, or walk-ins to service providers, activities, or other resources.

4. *Activity coordination* is done to provide transition age skill development opportunities, wellness and self-care, and community building skills for young people.
    a. Peer Coaches collaborate on and mostly lead many TAY Division workshops and events, often in response to youth requests and identified needs. Activity coordination varies from regular oversight of the TAY Center drop-in hours, where young people can access service providers, computers, linkage with CalFresh and food resources, clothing closet and hygiene supplies, to facilitating workshops on self-care, healthy relationships, wellness, and life skills.

Key Activities

- Mentorship
- Outreach and engagement to youth, local agencies and organizations, providing in-services about TAY programs
- Tabling events
- Linkage and system navigation to resources/services
- Facilitate peer lead group activities
- Coordinate and facilitate workshop and events
- Attend trainings to increase skill development
- Gather comprehensive outcomes data for peer coaching through sign-in sheets, demographics, assignment tracking sheet and Wellness Empowerment and Successful Transitions (WEST) survey
- Participate in community advocacy settings, including the homelessness reduction collaborative
- Support HCTAYC in wellness programming activities

Expected Outcomes

The expected outcomes for FY 23-24 are:

- Staff the TAY Center drop-in hours
- Provide individual mentorship to assigned caseload from referral process
- Ensure cross-training of Peer Coaches in each area of the TAY Division (ILS, BH, HCTAYC)
- Bill Medi-Cal through direct service to TAY youth, utilizing an electronic health record system
- Provide outreach and information to needed populations by providing presentations, tabling, and street outreach
- Engage youth in activities at TAY
- Build relationships while youth are waiting to receive or to be connected to other needed services
- Outreach to homeless youth and collaborate with other community youth serving agencies

How Outcomes are Measured

- Access to the TAY Center, drop-in hours and selected events and workshops are measured by sign-in sheets
- Tracking referrals for individual Peer Coach mentorship, including management of caseloads, date referral is received, assigned and when first contact is made
- Tracking of contacts and linkages with other programs, such as Behavioral Health, Employment Training Division (ETD) and Independent Living Skills (ILS)
- Data collection through voluntary demographic forms collected during peer led groups, workshops or events
- Perceived program effectiveness, wellness, and experience in systems will continue to be collected via the WEST Survey

Estimated Number to be reached in FY 23-24
It is estimated that approximately 200 TAY will be served in FY 23-24 based on the previous year's sign-in sheets for the TAY Center and activities, events and workshops.

It is anticipated that Peer Coaching will receive approximately 95 referrals, and roughly a third of these referrals will open to Peer Coaching. It is anticipated that each Peer Coach would carry a caseload of approximately 8-16 young people.

It is expected that each Peer Coach will be able to support all TAY Division programs by providing youth engagement and outreach. Peer Coaches attend program specific meetings and receive referrals for young people with experience across systems.

Peer Coaches represent the TAY Division in the community, and it is estimated that they will provide a minimum of three community presentations/in-services during the next reporting period, as well as table at a minimum of three events.

Peer Coaches will coordinate and facilitate a minimum of 9 workshops or events as well as support other TAY Division activities and community events.

TAY Advocacy and Peer Support Disaster Preparedness and Response
Both HCTAYC and Peer Coaching staff have adapted and modified ways of delivering services and prevention components during the recent global health pandemic. Early intervention, outreach, stigma and discrimination reduction, and youth engagement were delivered both virtually and offered in person when able to do so safely. Participation in the YAB, community policy tables, groups, workshops and community wellness building opportunities continued to meet, both virtually and in person. For example, Peer Coaches partnered with DHHS Public Health and organized three COVID vaccination clinics held at the TAY Division and offered tabling and outreach during each event.

HCTAYC and Peer Coaching will continue to find ways to uplift youth voice and address the needs of transition age youth, such as overcoming a sense of hopelessness, lack of self-efficacy, independent living skills deficit, and economic struggles that impact the social determinants of health during this and future crises.

The global pandemic demonstrated the need for a whole community approach to disaster preparedness. The whole community approach emphasizes that a community can increase resilience through creating working relationships and partnerships before disaster strikes. Youth Leadership development is also a promising practice, shown to build resilience in young people who have experienced disasters, such as hurricane

Katrina[3]. Humboldt County is at risk for disasters as a result of earthquakes, tsunamis, flooding, and violence. In addition to saving lives, disaster preparedness skills training is a method of youth leadership development. HCTAYC is interested in exploring activities that promote these skills. Some ideas might include partnering with local community preparedness groups to facilitate workshops, inviting guest speakers from local emergency management agencies, or creating activities that promote improved personal preparedness such as building a go-bag on a dollar store budget.

TAY Advocacy and Peer Support Stigma and Discrimination Reduction

The TAY Advocacy and Peer Support programs' stigma and discrimination reduction activities are intended to influence program participants as well as professionals and community members who participate in trainings and events facilitated by the program. Activities include trainings for professionals and community members focused on TAY-specific mental health challenges and the engagement of this population, including special populations particularly impacted by stigma and discrimination such as LGBTQ youth, Indigenous Youth, foster youth, and youth experiencing substance misuse and abuse. Trainings take a cultural competence and/or cultural humility approach, with specific youth-developed curriculum that focuses on youth culture. The program's facilitation of events focuses on concepts of behavioral health stigma reduction, outreach and information regarding behavioral health services, and wellness resilience development. The program's focus on youth leadership development addresses stigma and discrimination reduction through advocacy and empowering youth to become leaders. Peer Coaching provides outreach, engagement and linkage to services and to the community. This serves to inform youth of services available to them and supports the reduction of stigma and discrimination toward the systems-involved transition age population. Outreach is provided in multiple ways including referrals for services, the TAY Center, community-wide presentations, and tabling events. Peer Coaches provide regular outreach to the psychiatric hospital, jail, juvenile hall, schools, family resource centers, tribal organizations, and team with other community partners for street outreach to youth experiencing homelessness.

HCTAYC created a pre and post Stigma Discrimination Reduction survey that was integrated into YAB and community-based trainings, measuring learning and change in attitudes. HCTAYC continues to strive to create in the future a community-based stigma and discrimination assessment to be conducted through a survey format, capturing attitudes and beliefs about mental health stigma and discrimination. The impact of the activities is currently measured by post-workshop evaluations and the demographic

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[3] Osofsky, Howard, et al. "Building Resilience after Disasters through the Youth Leadership Program: The Importance of Community and Academic Partnerships on Youth Outcomes." Progress in Community Health Partnerships: Research, Education, and Action, vol. 12 no. 1, 2018, p. 11-21. Project MUSE, doi:10.1353/cpr.2018.0017.

form, which asks questions about effectiveness of the activity and its contribution to wellness.

Integrated Reporting of HCTAYC and Peer Coaching programs FY 21-22
Many young people participate in both Peer Coaching and HCTAYC programs over time and through the course of their personal development. To minimize survey and evaluation fatigue, many of the data collection points have been integrated into voluntary survey tools that are designed to support both programs. The three tools administered in both programs are:

- Wellness, Empowerment and Successful Transitions (WEST) Survey
- Demographics Survey
- Stigma Reduction Survey

While the development of these surveys resulted from youth-driven processes under the umbrella of HCTAYC, all of them were offered to participants in both programs. The latter two were administered during events and activities sponsored by HCTAYC, Peer Coaching, or both programs.

During any given event or year, especially with the recent pandemic, analysis by program yields ineffective results due to small sample sizes. Or, the opposite, duplicating analysis by individual programs results in an overwhelming amount of reporting elements yielding reader fatigue and rendering the reports less impactful. Therefore, we are providing program-integrated analysis and reporting for the above three survey tools.

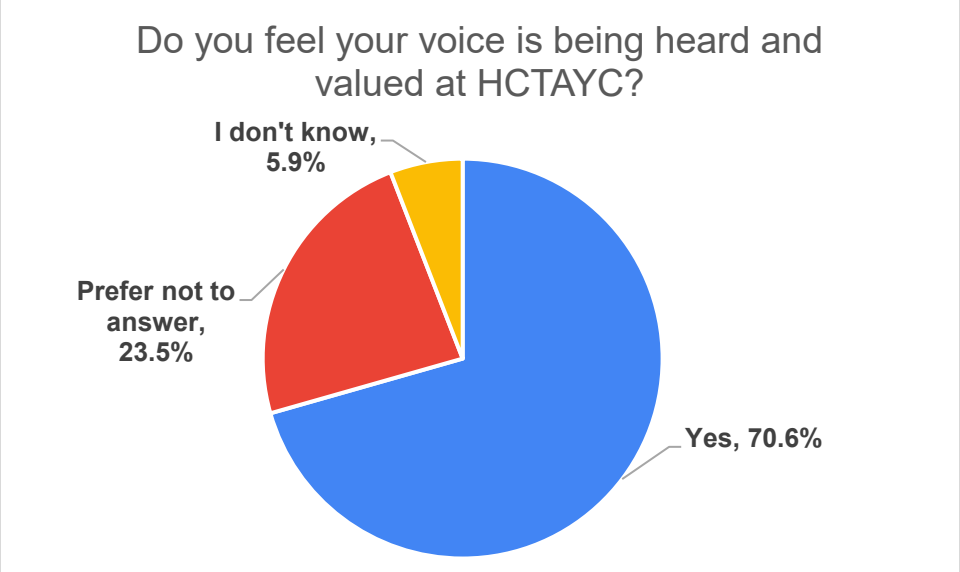
Wellness, Empowerment and Successful Transitions (WEST) Survey Analysis
The WEST Survey was launched in January 2022 after a 3-year long, youth-guided development process. It included 55 questions organized into 3 sections: Skills and motivation growth across SAMHSA's eight wellness domains, perceived helpfulness of programs, and lived experience in systems. Young people who participated in HCTAYC or Peer Coaching programs were prompted to voluntarily complete the survey 3 times a year and were provided consumable incentives for doing so. The goal of this survey was to understand how effectively these programs were listening to the young people they served, providing programs and young people feedback on how their experiences in these programs might have changed over time. Questions were crafted carefully with youth guidance and feedback at every step to mitigate triggers of trauma from revisiting lived experience in systems that may have previously caused harm. There were no required questions other than to provide an email address. The email address acted as an identifier for aggregated baseline and incremental progress comparisons.

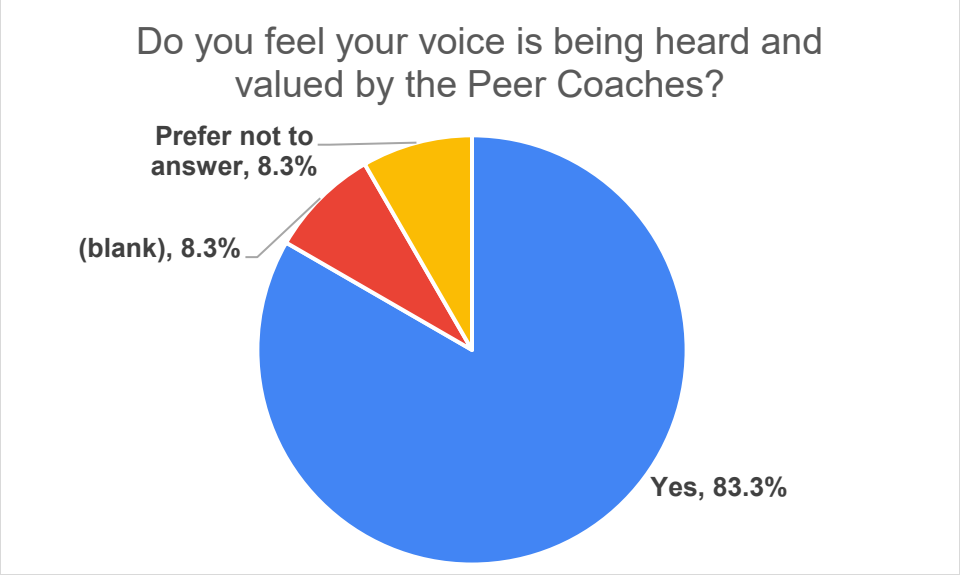
This data collection tool provides a rich data set with numerous possibilities for analysis. However, since it is still within the first year of data collection (launched January 2022),

the volume of responses is low. For the purposes of this report from the data collected to date (24 surveys were submitted). The intent is to get a sense of how the young people served perceive the programs. There is also some preliminary analysis yielding early indicators of program effectiveness i.e., reduced frequency of experience with systems.

Analysis of wellness based on SAMHSA's 8 domains will be conducted at a later date and possibly published under separate cover due to the extensive amount of both quantitative and qualitative data collected. Wellness data can also be available on an individual basis by the young people who request it. Similarly, participants can opt to automatically receive a copy of their responses immediately upon completing the survey to track their own progress.

The most salient request by young people was to include a question that captured whether or not they felt listened to. Results showed that a majority of respondents did in both programs. Yet, indifferent answers such as I Don't Know, Prefer Not to Answer, or skipping the question might be better indicators of not being heard compared to selecting No. No is an option that is indeed offered, however selecting it might require a level of bold self-assertiveness that young people are still developing while participating in these programs.



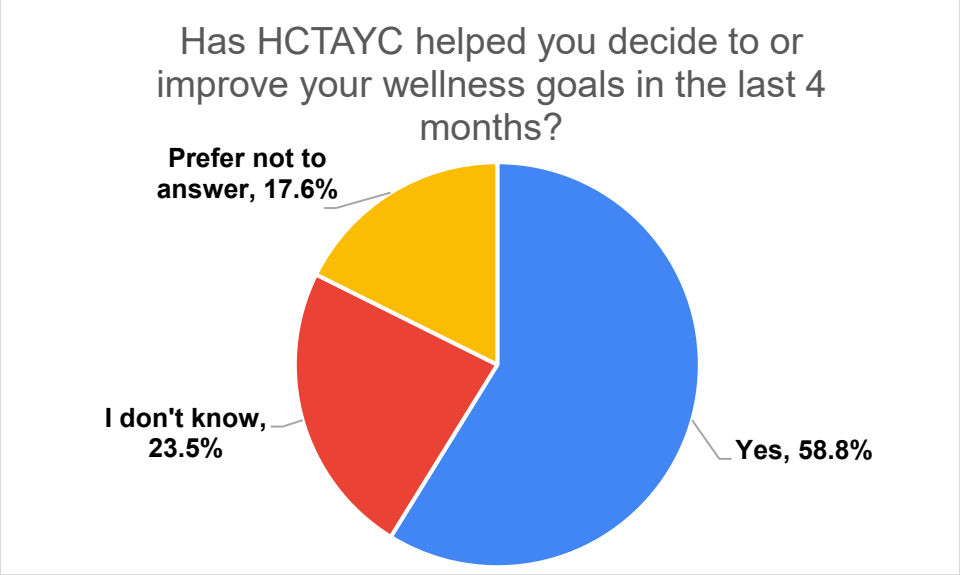


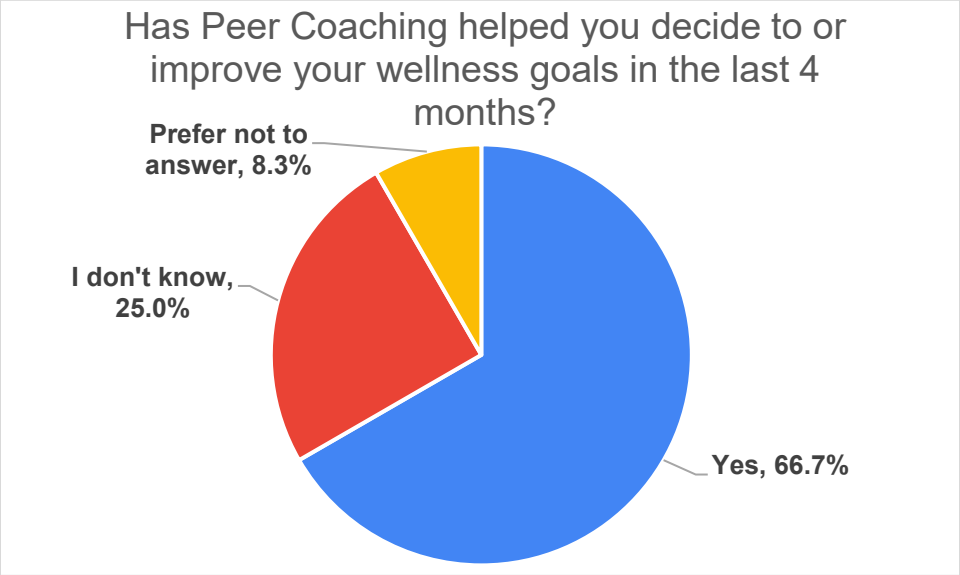
“Health is a state of complete physical, mental, and social well-being, and not merely the absence of disease and infirmity.” — World Health Organization (1946)

HCTAYC and Peer Coaching programs embrace health and wellness as a fundamental objective when engaging and supporting young people. Our services are tailored to help young people develop both skills and motivation in defining and achieving their own individual wellness goals. The WEST Survey helps track how young people perceive interest or progress in their wellness goals over time.

For the current analysis we wanted to get a basic understanding of where program participants are. Future analysis might include comparisons between baseline and incremental responses as well as more detailed insights across the 8 wellness domains.

Again, a majority of survey respondents perceive that the programs help them decide to improve their wellness goals. None of the respondents selected No to this question. Yet, other answers such as I Don’t Know or Prefer Not to Answer may indicate opportunity for program staff to better engage with the participants on where they are in their wellness development.





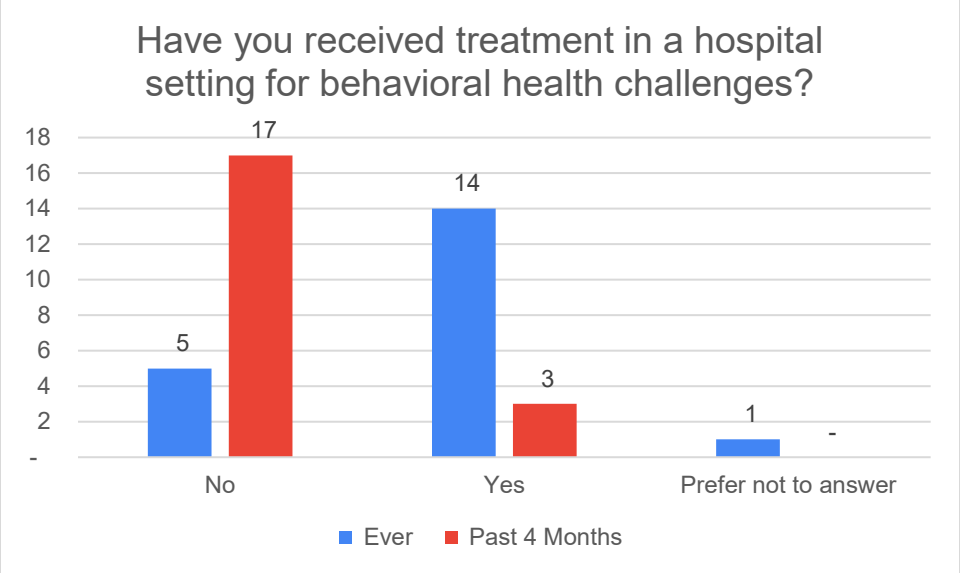
Experience in systems is a consistent evaluation criteria used by the systems themselves. It is known that young people with access and functional needs or members of marginalized communities have more experience with systems of child welfare and foster care, behavioral health, law enforcement, juvenile justice, and homelessness. It is known that within systems, young people are asked to repeat their experiences at a variety of assessment and intake points or interfacing with the hundreds of system personnel they might encounter. It is known that these experience inquiries can create more harm and trauma for the young people. It is important to understand how experience in systems can impact the future of young people or where systems can improve to cause less harm. Data collection can shine light on these impacts or improvements. However, data must be collected in a manner that does not cause additional harm to the young person.

The young people who developed and reviewed the survey helped to create these questions for systems about systems experience. A qualifying question also enabled young people taking the WEST Survey to opt out of questions related to lived experience.

While there is a low volume of responses, it's hard to not be pleased with the results. It appears that HCTAYC and Peer Coaching are supporting young people in positive ways, and there is hope that over time more survey responses will indeed continue to reflect this optimism. If not, they will give input into how to make improvements in the programs that can better meet the needs of the young people served.

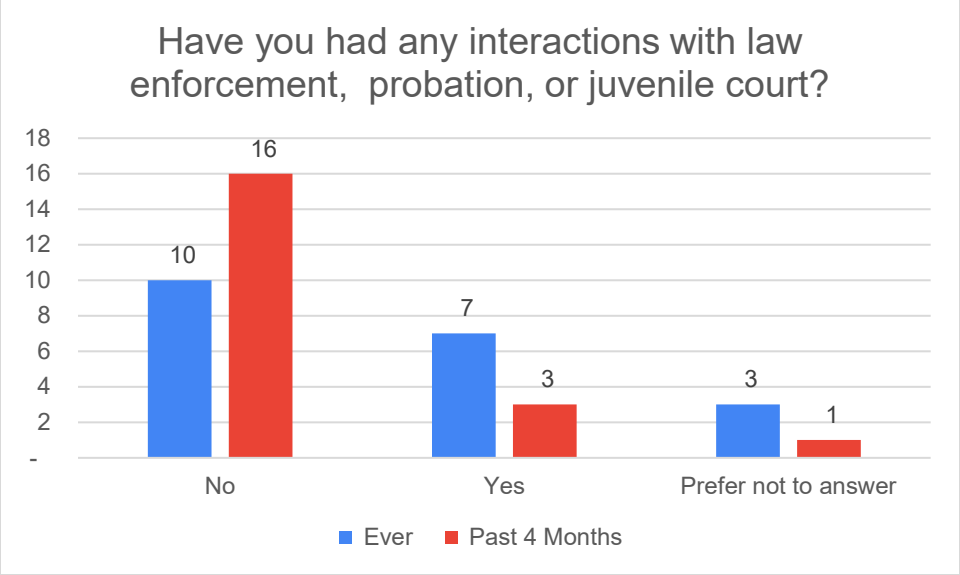
Some of the highlights of the WEST Survey systems experience analysis include:

The percentage of change decreased 78.6% when responding Yes to the question of having ever received treatment in a hospital setting for behavioral health challenges to having received it in the past 4 months.

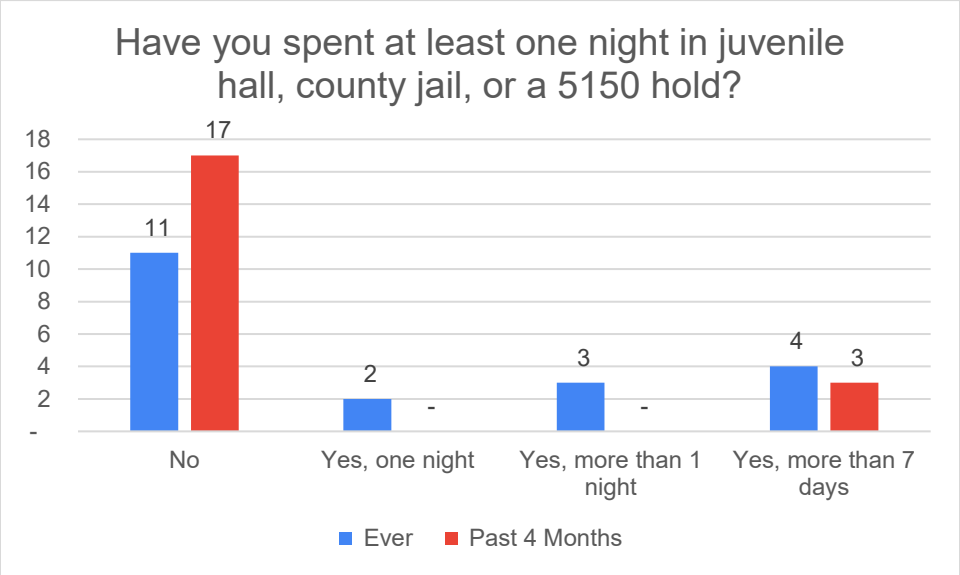


Of the respondents that answered and selected No, there was a 60% increase in the percentage of change between having never had interactions with law enforcement, probation or juvenile court to not having any interactions in the past 4 months.

The percentage of change for responding Yes decreased 57.1% from ever having experience to having experience in the past 4 months.

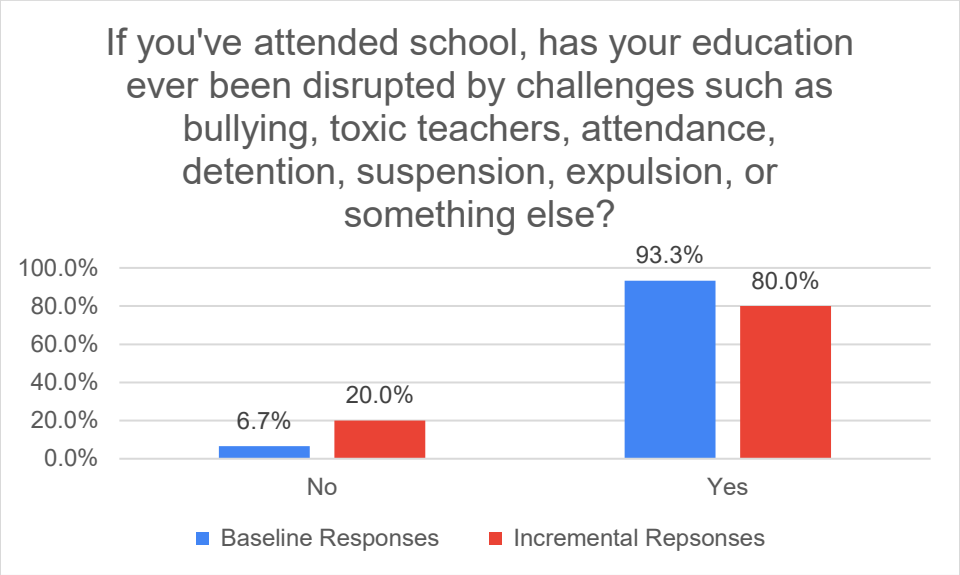


Percentage of change trended in similar ways, increasing 54.5% when responding No and decreasing 66.7% when responding Yes to ever having spent a night in juvenile hall, county jail or on a 5150 hold to having done the same in the past 4 months.



Drop-out and expulsion rates are popular evaluation criteria for young people with lived experience in systems. However, there are many reasons why a young person might have challenges in the current educational system, and additional system experience exacerbates educational challenges. Regardless of the cause, leaving school is disruptive to the young person and can carry stigma and occupational discrimination with it. Understanding how educational disruption is so prolific and impactful to the young people served can help programs plan and offer workshops, individual supports and skills trainings, and advocacy opportunities to help build resilience and reduce stigma.

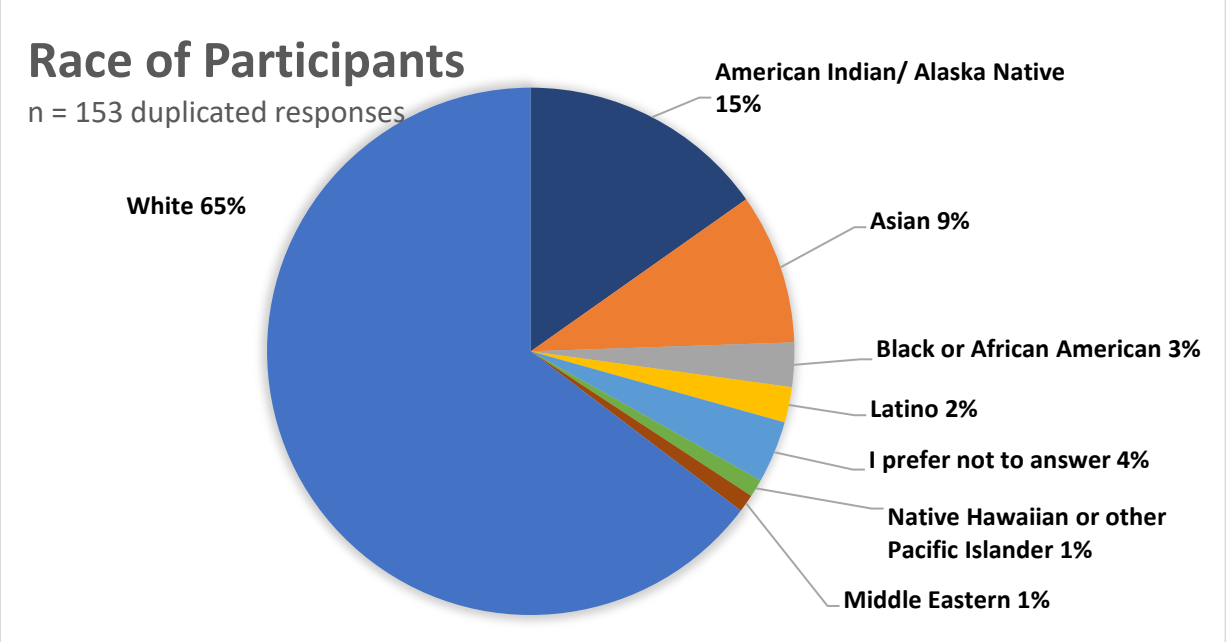
The crux of this data set acknowledges that most of the young people served in HCTAYC and Peer Coaching programs are impacted by a disrupted education. The good news is that those disruptions in program participants decreased by 71.4% when comparing the first survey submitted by unique responders (aggregate baseline) to subsequent surveys submitted by unique responders (incremental responses).



Demographics Survey Analysis

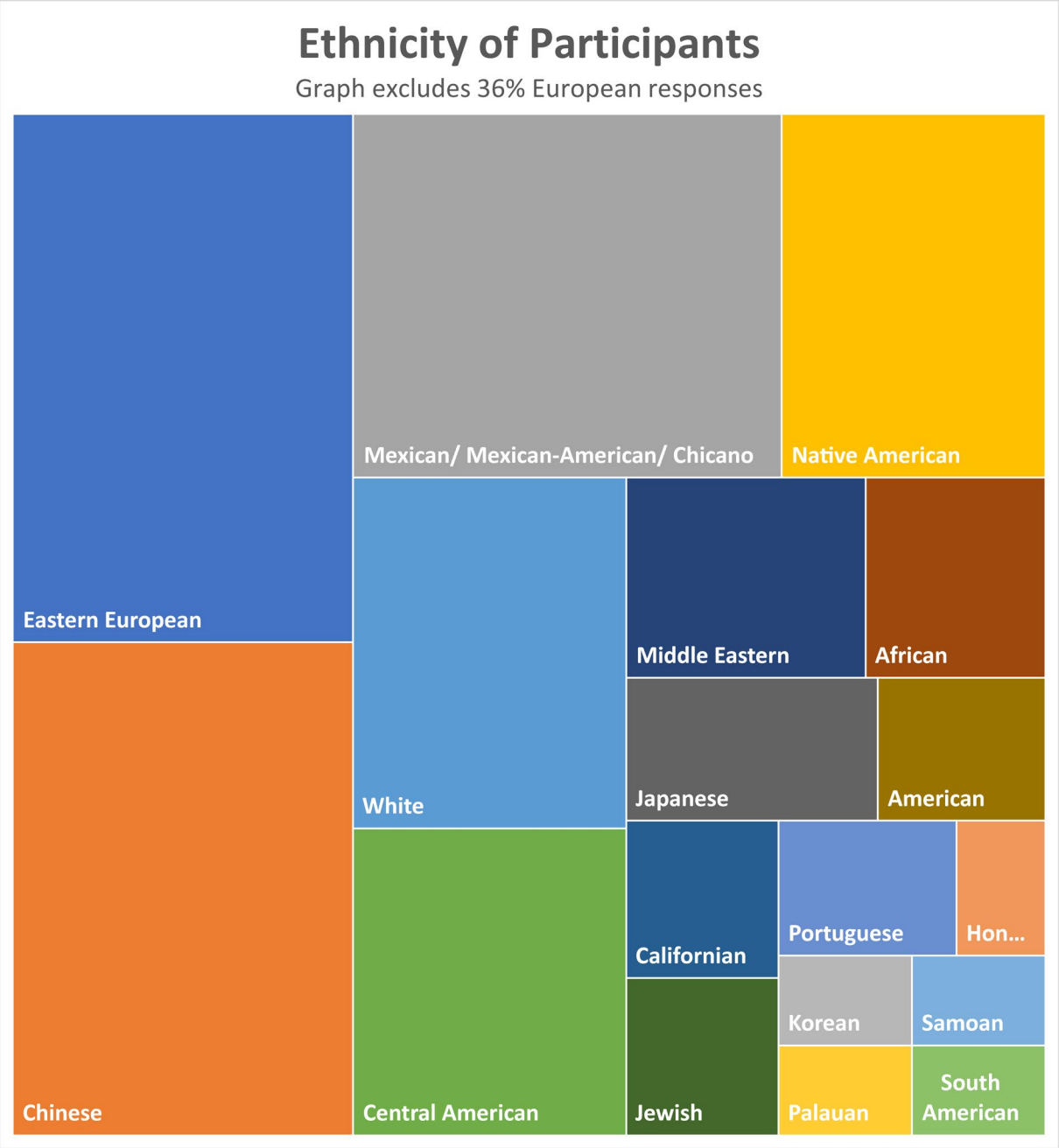
The following charts provide information obtained from 153 demographic survey forms completed by individuals participating in 30 MHSA-funded events or trainings during July 1, 2021, to June 30, 2022. These are duplicated responses as one person could have completed more than one survey having attended multiple events.

Sixty-five percent (65%) of the people who responded to the demographics survey selected White. Fifteen percent (15%) selected American Indian /Alaska Native, representing local tribes including Tolowa, Pomo, Hupa, Karuk, Yurok, and some who selected “American Indian/Alaska Native” but did not list their tribal affiliation. Other tribal regions included Cherokee, Dakota, and Rosebud Sioux. Nine percent (9%) selected Asian. Three percent (3%) selected Black/African American. Two percent (2%) wrote in Latino under other, and4% preferred not to answer. Of the 153 survey responses, 7% selected more than one race.



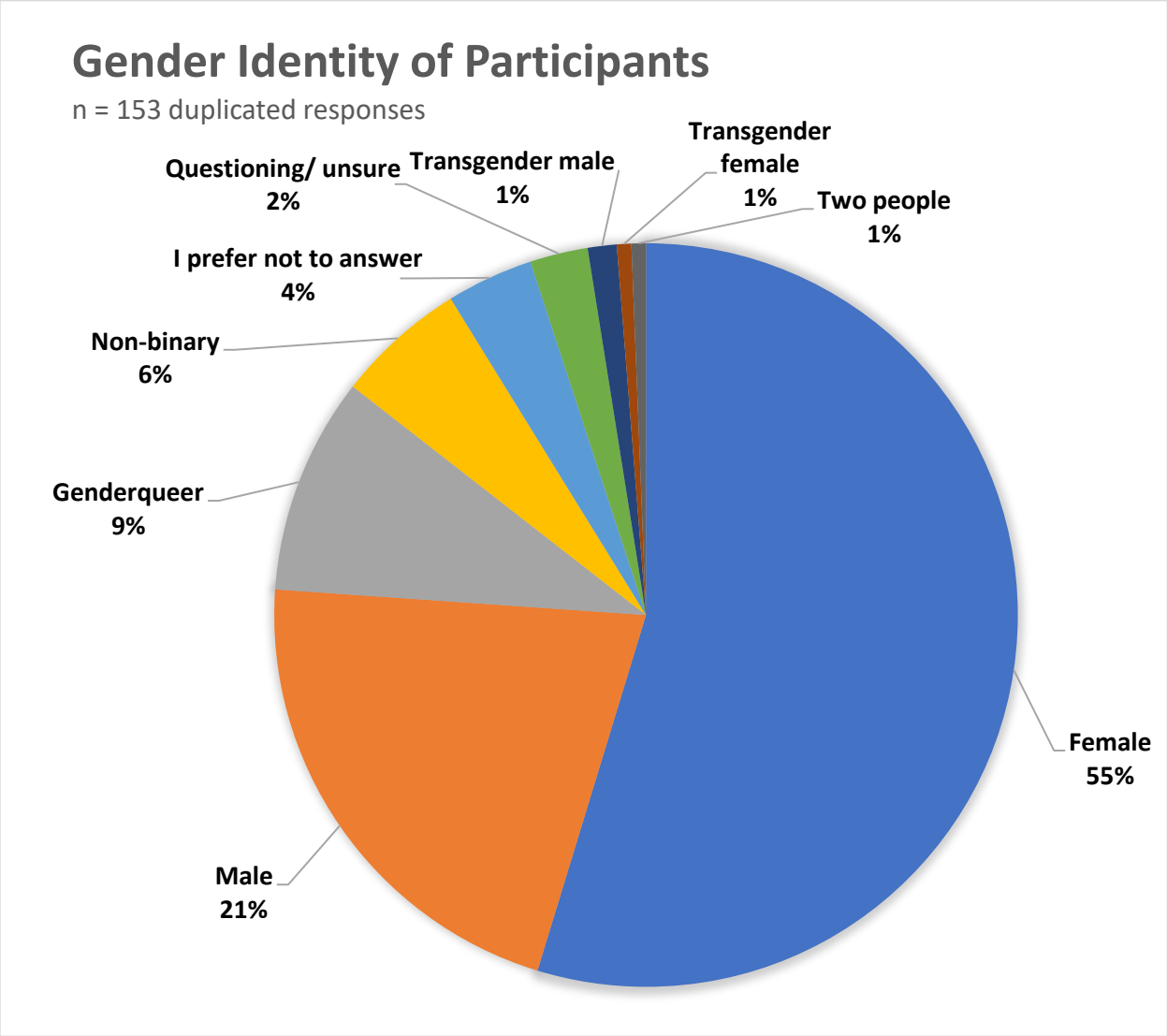
Of the 153 survey respondents, 44% selected more than one ethnicity. Fourteen (14) percent of respondents did not provide their ethnicity. European was the most frequently (36%) selected category. The rest are as follows:

- 9% Eastern European
- 8% Chinese
- 7% Mexican/ Mexican American/ Chicano
- 5% Native American
- 5% White
- 4% Central American
- 2% Middle Eastern
- 2% African
- 2% Japanese
- 1% American
- 1% Californian
- 1% Jewish
- 1% Portuguese
- 1% Honduran
- 1% Korean
- 1% Palauan
- 1% Samoan
- 1% South American

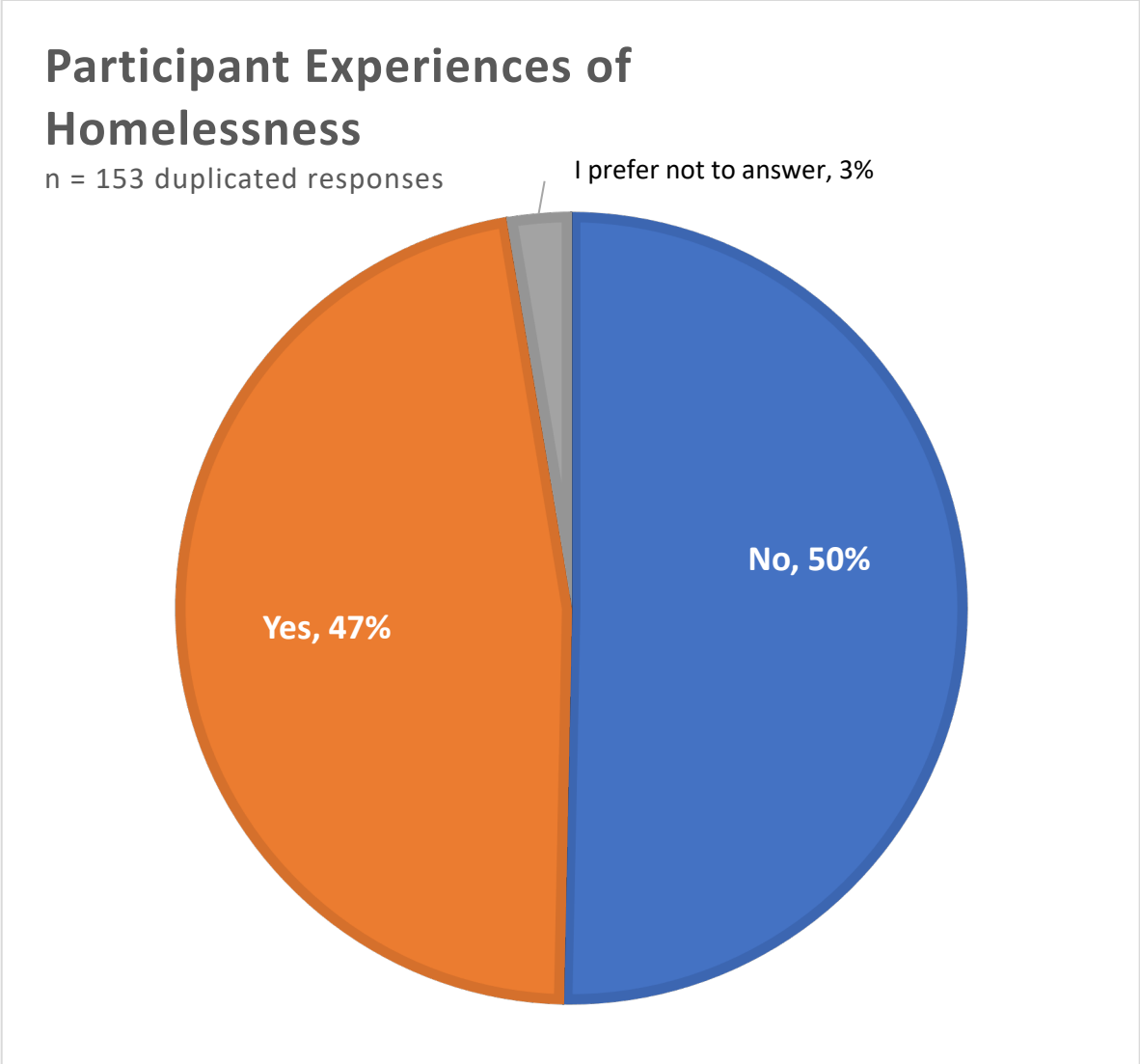


The primary language of participants was roughly 95% English, remaining responses included Spanish, Karuk/Yurok, Portuguese, Palauan, and preferred not to answer. Fifty-nine percent (59%) of the survey participants were within 19-25 years old and 41% within 16-18 years old. However, HCTAYC youth engaged people of all ages in trainings, presentations, community coalitions, and policy recommendation outreach efforts. While 71% of the survey respondents had an assigned birth sex of female, 51% identified as such. Twenty (20%) percent of the survey respondents had an assigned birth sex of male, 21% identified as such. Six participants identified with more than one gender

identity category, and 6 more preferred not to answer. The remaining respondents (20%), identified with a gender category other than female or male, with the genderqueer category (9%) being the most frequently selected.

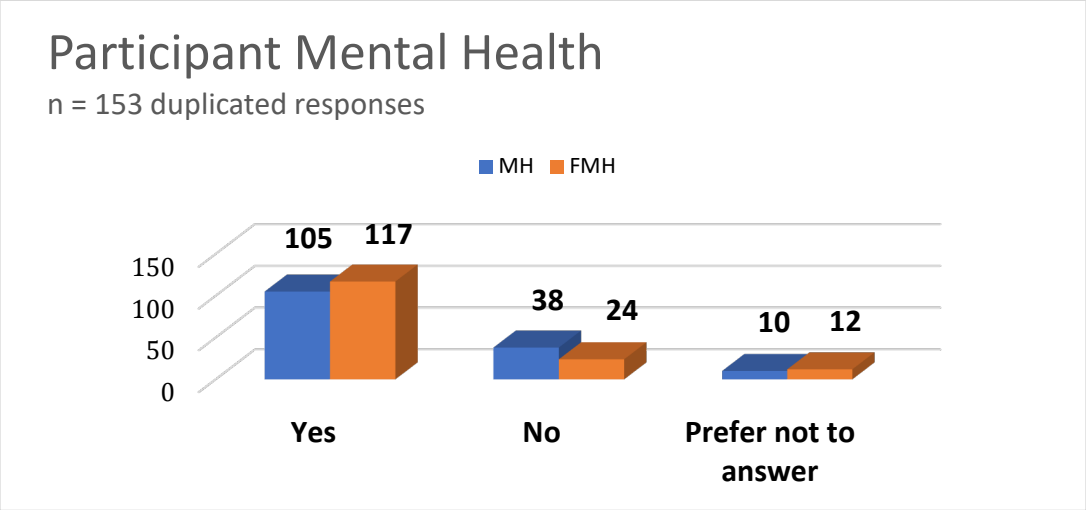


Forty-seven percent (47%) of survey respondents had experience with homelessness, 50% did not, and 3% preferred not to answer.



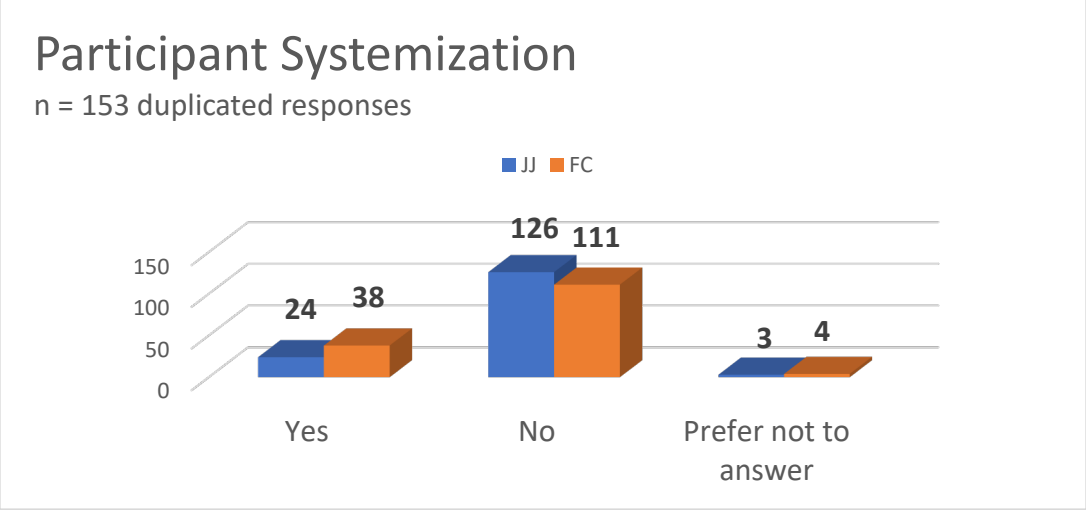
One hundred five (105) survey participants stated they have experienced a personal mental health (MH) condition. Of those, 81% had received a diagnosis. Thirty-eight (38) participants stated they have not experienced a personal mental health condition, while 10 preferred not to answer.

One hundred seventeen (117) stated they have a family member with a mental health (FMH) condition, 24 stated they did not, and 12 preferred not to answer. Seventy-four percent (74%) stated the family member's mental health condition had been diagnosed.



Twenty-four participants reported involvement in the juvenile justice (JJ) system, 126 did not have this involvement, and 3 preferred not to answer.

Thirty-eight (38) participants reported involvement in foster care and/or the child welfare (FC) systems, 111 did not have this involvement, 4 preferred not to answer.



Most of the survey respondents resided in the Eureka area, followed by Arcata, the Eel River Valley, then Northern and Eastern Humboldt.

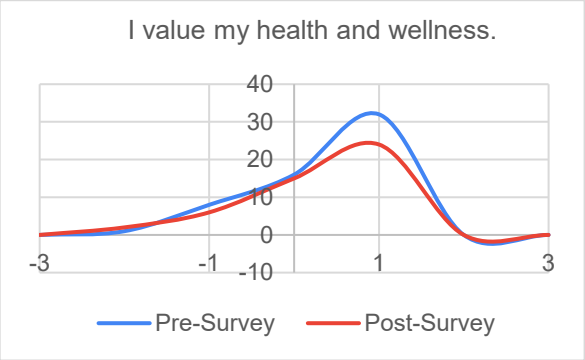
Stigma Discrimination Reduction Survey Analysis

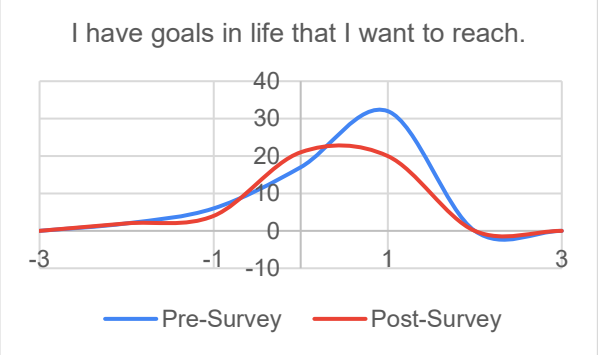
The Stigma Discrimination Reduction Survey is provided electronically at most HCTAYC sponsored events, and some Peer Coach sponsored events. The pre-survey is offered at the beginning of each event and the post-survey at the end. The pre- and post-survey questions are identical.

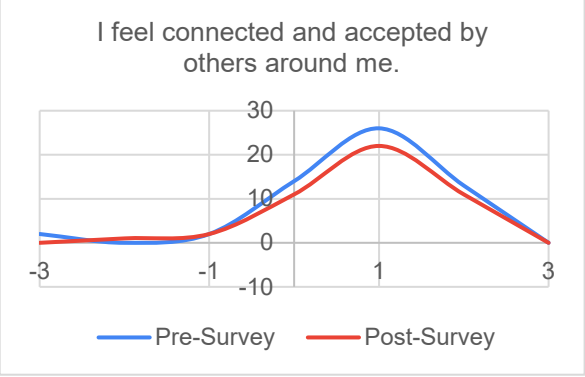
In FY 21-22, the Stigma Discrimination Reduction Survey was offered to participants at 16 different events. A total of 104 surveys were collected, 55% completed a pre-survey, 45% completed a post-survey. Results are not unduplicated. For each question, a 7-point Likert scale was used to collect responses where a raw score of 7 was the most agreeable and a raw score of 1 was the least agreeable response.

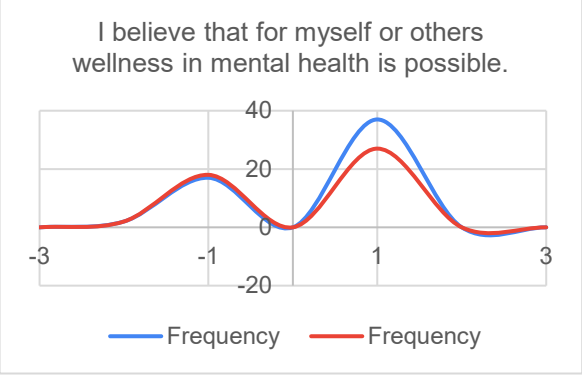
- Fully Agree, 7
- Agree, 6
- Somewhat Agree, 5
- Not Sure, 4
- Somewhat Disagree, 3
- Disagree, 2
- Fully Disagree, 1

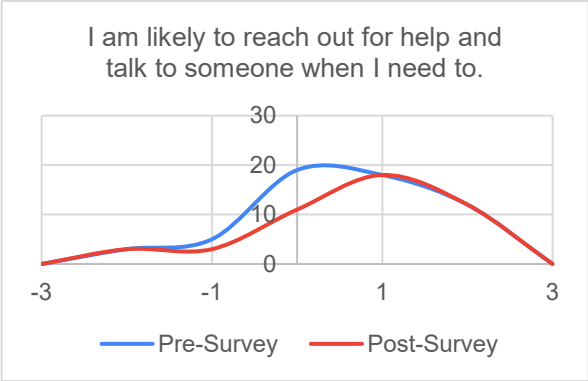
Raw scores were then converted to a normative distribution curve using z-scores. The results are as follows.

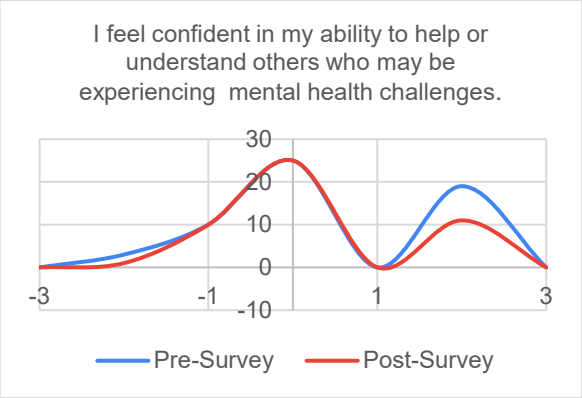


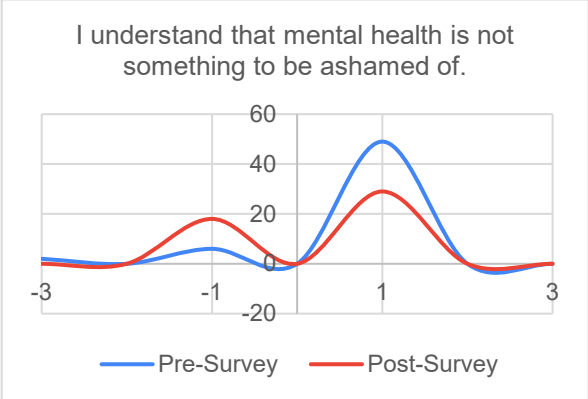


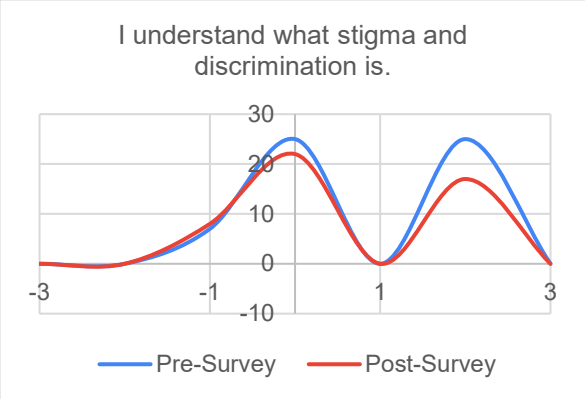


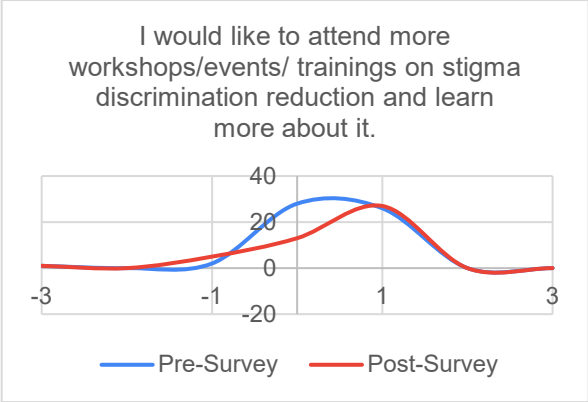












Across the board, there were percentages of change between the pre and post survey responses that moved in a negative direction for multiple questions. There is speculation that this may be more of an indicator of meeting fatigue than a reliable measure of attitudes about stigma. However, the normative distribution didn't indicate any major shifts between standard deviations when comparing pre and post responses. A conclusion we can draw from this analysis is that the majority of responders do skew towards positive attitudes around mental health and wellness which contradict attitudes of discrimination and stigma. The HCTAYC staff plan to re-think the methods for data collection and analysis moving forward to better reflect the good work both programs are making with respect to stigma reducing activities.

TAY Advocacy-HCTAYC Report FY 21-22

Leadership Self-Assessment Survey

Since 2016, HCTAYC young people have been using a Leadership & Wellness Plan document to formalize and track their goals. In FY 20-21, the Leadership Self-Assessment Survey was created to improve engagement during the pandemic. The result also yielded better reliability through consistent response scales. This survey tool is now used to objectively track leadership development of young people participating in HCTAYC.

The survey consists of 24 required questions measuring leadership attitudes and skills. A 5-point Likert scale was used to collect responses where 5 = "I definitely have this [attitude or skill]" and 1 = "I don't have this [attitude or skill]"

Because of the limited number of responses and the volume of questions, a more thorough analysis will be performed at a later time. However, in FY 21-22, 10 Leadership Self-Assessment Surveys were completed by 8 unique (unduplicated) young people. The overall average score across participant groups was **3.9**.

Leadership Tier	Overall Average
Sprout (n=6)	3.8
Sapling (n=3)	4.1
Sequoia (n=1)	4.0

Actual Outcomes for FY 21-22

Consistent youth engagement on the youth advocacy board increased in this period, increasing from an average of 5 consistent members to an average of 8 consistent members. The YAB sustained three topic-specific committees and worked towards the development and execution of committee specific-tasks:

- The LGBTQIA+ & Two-Spirit Leadership Committee successfully finalized and launched our LGBTQIA+ & Two-Spirit Youth Across Systems Policy Recommendations, and related convenings.
- The Multicultural Justice Committee began planning a racial justice speaker series.
- The Substance Dependence and Healing Committee kicked off the development of a youth-driven peer support group.

Each of these committees convened approximately once per month, with average participation in each committee reaching around 4 young people. In addition to the three committees, all-member "Grove" meetings occurred approximately once per month as did

the processing/support/planning “Compost” committee. Young people not consistently engaged tended to attend the Grove and Compost meetings in higher numbers and frequency than they did committee meetings.

The LGBTQIA+ policy recommendations were finalized, and implementation began this reporting period, and then the work of creating a large publication based on the recommendations that were published in the following reporting period began. This reporting period saw several finalization meetings, two release summits (one solely for young people and a second for the entire community), and a great amount of coordination of input from the young people. The youth summit saw the prioritization of the recommendations, and the public release saw agencies and individuals committing to support the implementation of the recommendations and the formation of a workgroup to work towards the implementation of the first recommendation.

Throughout this reporting period, HCTAYC-hosted digital social nights for the YAB focusing on activities identified by young people and staff to experience community during the time of COVID-19. There has been a social event nearly every month of this reporting period, including making mosaics, exploring trans history, creating “moodie” smoothies, multimedia arts, and several critical thinking movie nights.

This reporting period also saw engagement in virtual leadership exchanges with young people from Aoterroa’s national foster youth council, in which everyone shared and learned about one another’s communities as well as the projects that everyone has been working on.

Youth leadership development trainings were provided to the YAB, both consistently and inconsistently engaged. These trainings were: POP SMART event planning, elevator speeches, and curriculum development.

YAB and staff attended several conferences and trainings not facilitated by HCTAYC, including three by Two Feathers Native-American Family Services, California Youth Connection’s Summer Conference & Day at the Capitol, National Summit on Youth Homelessness, National Indian Child Welfare Association, and California Mental Health Advocates for Children and Youth.

Several trainings were provided for the public and youth-serving professionals FY 21-22.

- TRANSforming Organizations:
    - Juvenile Justice (2) - 42 participants
    - TAY - 14 participants
    - CWS (2) - 47 participants
- Listening Deeply: Supporting Transition-Age Youth to Tell Their Stories

    - May is Mental Health Awareness Month / General Public (2) - 37
    - Child Welfare All-Staff Meeting (1) - Over 50 attendees
- POP Smart
    - Youth & Youth-serving Professionals - 14 participants.

In addition, there was a presentation at the United Indian Health Services Youth Substance Use Prevention Conference and development and presentation of a question for the Humboldt County Board of Supervisors candidate forum.

In this reporting period, a lending and zine library for young people at the TAY Center was developed and launched. It is stocked with informational and educational materials regarding mental health, wellness, community organizing, anti-racism, and more.

FY 21-22 saw the transformation of our pre-COVID Wellness Week into a month-long Wellness Series. The Wellness Series was facilitated entirely over video conferencing aside from an in-person workshop at the Juvenile Hall. Workshop supplies and snacks were delivered to youth participants. In total, the Wellness Series consisted of 8 workshops, totaling 24 individual youth participants and an undisclosed number of participants at the Juvenile Hall.

The second digital hybrid Digital Storytelling Retreat occurred during this reporting period. In total there were 8 participants who created digital stories over five total days. Storytellers stayed in the same hotel, but engaged online in their rooms via video conferencing, with staff delivering food, supplies, and supports to rooms individually.

In response to an ongoing need to better address community housing coordination for TAY, HCTAYC created the Humboldt Houseless Youth Support Collaboration (HHYSC). This collaboration launched in January in 2021 and held 11 meetings during this reporting year. Collaboration members have included: HCTAYC and Peer Coaching, YAB members, Redwood Coast Action Agency's YSB and Raven Project programs, Humboldt County Office of Education (HCOE), Family Resource Centers, Host Home Program, CalFresh outreach, DHHS-Home program, Yurok Tribe, Juvenile Probation, Department of Rehab-Young Adult Workforce Development, Project Rebound, DHHS-Policy and Legislative Manager, California Center for Rural Policy (CCRP), Legal Services of Northern California, and Affordable Homeless Housing Alternatives (AHHA).

Relatedly, a collaborative grant proposal was developed to apply for federal funding to expand services supporting unhoused TAY in the community.

The continued advocacy and leadership brought voice to the following policy tables:

- Behavioral Health Board

- Cultural Responsiveness Committee
- Humboldt Community Health Trust
- Humboldt Health Foundation
- Humboldt Housing and Homelessness Commission
- Juvenile Justice Delinquency Prevention Commission
- Juvenile Justice Realignment Meetings
- Multi-agency Juvenile Justice Coordinating Council
- RESPECT Coalition
- Sexual Health Taskforce
- Sorrel Leaf Healing Center

These involvements have materialized into several concrete things, such as guidance of building design and decoration for the Sorrel Leaf Healing Center, adoption of equity measures by boards, development of youth-specific policies, and alignment with ethical principles of stakeholder/youth voice and choice.

Lastly, HCTAYC staff and young people continued to participate in many ongoing meetings with the Juvenile Probation Department, advocating for the needs of youth in the juvenile justice system and the realignment of SB 823 with the Department of Justice. HCTAYC's advocacy piloted peer support programming in the local juvenile hall and led to funding for a full-time peer coach position.

Challenges
COVID-19 has continued to pose challenges for youth recruitment, engagement, and retention on the Youth Advocacy Board. The needs and demands of screening for COVID-19, providing PPE, engaging in extra cleaning, etc. adds a significant amount of time to regular tasks when in-person meetings and gatherings are held. It also poses potential vectors of exposure, increasing staff anxiety.

The YAB continues to struggle with long-time, experienced members transitioning away from the board during the last reporting period in addition to challenges to the health and wellbeing of the young people.

Collaboration with other agencies and entities have also been strained as a result of understaffing and the hiring crisis that is present in human-services and other professional helping agencies including advocacy partners. The balance between having boundaries needed for the program to execute ongoing programming versus responding to emergent needs and opportunities is also significant. A plethora of opportunities as a result of new funding streams has recently come available. Yet, few partners have the capacity to undertake new programs and funding streams for the health and wellbeing of the

community's youth. Recruitment, as a result, through previously relied upon partnerships has been very difficult, requiring more outreach having to be done by staff.

Successes
There were significant success in provision of training during this period, all of which received great feedback.

The convenings and finalization process for the policy recommendations demonstrated a new way of ensuring community engagement and ownership for these recommendations in the future.

There was updating of the programs theory of change and creation of logic models for the program, along with increased aspects of manualization.

Youth engagement and leadership were integral to the planning and adaptation of programming to meet youth needs. There was consistent engagement with YAB members, retaining the majority of those recruited.

Lessons Learned
Staff have learned that consistency and flexibility were necessary to respond to the emerging needs of young people and the realities of the work. There were significantly better responses to in-person activities than solely digital, in terms of youth participation and feedback. In particular, home cooked food continued to serve as a significant incentive.

Digital project management is difficult and requires constant oversight to ensure that things are being tracked and documented. Building in time for planning, check-ins, and retreats is necessary to ensure that the program is in alignment and moving forward in a good relationship.

Formal documents may not necessarily be needed, such as staff wellness plans, to have conversations regarding wellness as those tools can sometimes feel like a barrier.

TAY Peer Support-Peer Coaching Report FY 21-22

Peer Coach Tracker
The Peer Coach Tracker is an administrative tool used solely by staffers to track referrals and case assignments.

Participation was analyzed for the reporting period of July 1, 2021 – June 30, 2022. During that time, Peer Coaching received 95 referrals for individual mentorship, outreach

and engagement to TAY services. Of that, 33 Peer Coaching referrals were open as of June 30, 2022 (includes 3 referrals opened in previous fiscal years). Ninety-two (92) referrals were closed (includes 36 referrals opened in previous fiscal years).

Below is a chart tracking numbers of days from referrals to assigned Peer Coach, days from referral to first attempted contact to young person, and numbers of days from assignment to first attempt at contract. Percentage of change reflects change from previous reporting year, and notes improvement in timeliness of Peer Coach engagement when compared to the previous year.

Average number of days	FY 20-21	FY 21-22	% of change
Referral Date to Date Assigned	6.5	4.7	-28%
Referral Date to First Try Contact Date	14.7	6.5	-56%
Date Assigned to First Try Contact Date	8.3	1.6	-81%

One hundred sixty-seven (167) total unique young people accessed the TAY Center during drop-in hours and/or attended an HCTAYC or Peer Coach organized workshop/event. Of those, 93 were first-time visitors.

- 481 total visits during drop-in hours.
- 144 unique visitors attended drop-in hours, of those, 73 were first-time visitors
- 87 total participants in an HCTAYC/Peer Coach organized workshop/event
- 54 unique visitors attended a workshop or special event, of those, 20 were first time visitors.
- A total of 30 emergency food boxes were distributed.

Participation	FY 19-20	FY 20-21	FY 21-22
Drop-In Hours Visits	1,595	220	481
Drop-in Hours Unique Visitors	203	80	144
Drop-in Hours Unique First Time Visitors	63	26	73
Workshops/Events Visits	147	3	87
Workshops/Events Unique Visitors	64	3	54
Workshops/Events Unique First Time Visitors	6	1	20
Total Unique Visitors	223	82	167

Participation	FY 19-20	FY 20-21	FY 21-22
Total First Time Visitors	69	27	93

Note, the TAY Center was paused due to COVID March 2020 thru December 2021.

Of the 95 referrals received, the Peer Coaching program made 106 referrals to other needed services. The distribution is as follows based on total referrals received:

Referrals to other services	% of Total Referrals Received
Behavioral Health	43.2%
Houselessness Support Services	24.2%
Juvenile Justice Support Services	15.8%
Extended Foster Care or Independent Living Skills	14.7%
HCTAYC	12.6%
First Episode Psychosis	1.1%

The TAY Division implemented a TAY outreach component to Peer Support and TAY Advocacy, doing direct street outreach to homeless youth twice a week. During this reporting period, staff engaged and entered 33 youth into the U.S. Department of Housing and Urban Development (HUD) Homeless Management System (HMIS).

Actual Outcomes for FY 21-22

- Peer coach staffing levels did not remain fully staffed due to 1) staff on leave, 2) COVID-19 related leave.
- All peer coaches completed documentation training linking direct services to electronic medical records.
- Peer coaches continued to support the TAY Center and drop-in hours.
- The TAY Division did a re-visioning process and adjusted TAY Center hours to better meet the population needs, thus increasing 1:1 mentorship capacity for peer support and increasing Peer Coach workshop and event planning and facilitation.
- One peer lead group continued to meet, by individual outreach, Zoom or by in person activity outside.
- Peer Coaches participated in various community presentations and tabling opportunities, including tabling two COVID vaccination clinics.

Trainings Peer Coaches Attended

- Aggression replacement training
- Elevator speech

- Mandated reporter training
- Medical billing and documentation
- Mindfulness
- Peer coach orientation
- POP smart
- SB 803 Peer certification overview
- Strengths finding
- Team building
- Transforming organizations
- Various County annual trainings e.g., ethics, racial diversity, cyber security

Peer Coaches Provided Outreach to (young people, presentation, tabling)

- Betty Chin
- East High School, Fortuna
- Eel River Court and Community School, Fortuna
- Eureka Family Resource Center
- Eureka Rescue Mission
- Food for People, Rio Dell
- Juvenile Probation Services
- Open Door Health Clinic, Willow Creek
- Sempervirens and the Crisis Stabilization Unit
- Street outreach to unhoused young people
- United Congregational Christian Church
- Youth Service Bureau: Raven Project and YSB

Peer Led/Supported Activities, Workshops, Groups and Events

- Back to School Carnival
- Basic Beauty Tips Series
- Elevate and Vibrate Yoga
- Forest Photography
- Get Outside (Hiking workshop)
- Goal Getters
- Halloween Costumes on a Budget
- Harvest Festival
- Hike in the Dunes and Plant Identification
- Holiday cookie activities
- Improv Workshop
- Mommy, Daddy and Me Parenting Skills Group
- Participation in various May is Mental Health Matters Month activities; sign making and walk
- Pencils, Landscape, and Self-Care workshop
- Pour Paint
- Soap and Candle Making Workshop
- Spooky Treats Food Demonstration

- Sushi Making Food Demonstration
- Take a Hike with TAY
- TAY Fall feast community event

In addition, Peer Coaches support HCTAYC and ILS led events, such as HCTAYC's Wellness Series, Digital Stories Retreat, TAY Graduation, Back to School, Tax Preparation, and How to Get a Job workshops.

Challenges
Utilization of the TAY Center continued to be lower than pre-COVID time and peer support work was provided more on a 1:1 basis. With ongoing remote work, daily supervisory check-ins continued to support communication and follow through on assignments. Staffing absences contributed to gaps in communication, delays in planning, and need for increase in supervision oversight and task management. Staffing changes in other TAY Division programs contributed to difficulty in teaming and larger TAY event coordination.

One of the TAY peer led groups, Mommy, Daddy and Me Parenting Skills, was inconsistent this past year, due to inconsistent staffing.

Successes
Peer coach staff remain resilient and focused. Staff have continued to provide direct service, either virtually, by phone or in person, through TAY Center drop-in hours with safety measures in place, and by providing space for young people to connect using virtual platforms or in person. With the re-visioning of the TAY Center and drop-in hours, Peer Coaches have been able to provide an increase in 1:1 services, focusing on individual engagement and mentorship.

Peer Coaches focused on providing the community numerous, fun, creative workshops. Many of these workshops were co-created and facilitated along with a young person.

Lessons Learned
Consistent supervision oversight is needed to ensure outcome tools are gathered. Peer Coach staff need regular and consistent supervision and training opportunities, as well as wellness and team building skill development.

Prevention and Early Intervention: Suicide Prevention

In July 2020, the Humboldt County Department of Health and Human Services, Public Health Branch, Healthy Communities Division - Stigma, Suicide and Violence Prevention (SSVP) Program was renamed the Suicide and Violence Prevention (SVP) Program, as it no longer includes MHSA Stigma and Discrimination Reduction activities.

Program work has continued to integrate projects, streamline processes, and expand community impact to reduce morbidity, mortality and risk behaviors associated with suicide and violence numbers in Humboldt County. The five main SVP projects as identified by PEI Regulations and supported by the MHSA Suicide Prevention are:

Projects

- Humboldt County Suicide Fatality Review (Section 3720. Prevention Program & Section 3730. Suicide Prevention Programs)
- Community Collaboration (Section 3715. Outreach for Increasing Recognition of Early Signs of Mental Illness)
- Prevention and Early Intervention Training (Section 3730. Suicide Prevention Programs)
- Lethal Means Safety (Section 3720. Prevention Program)
- Social Marketing (Section 3715. Outreach for Increasing Recognition of Early Signs of Mental Illness)

Objectives

- Humboldt County Suicide Fatality Review: Conduct suicide fatality reviews to identify trends in local suicide deaths, data-driven suicide prevention and intervention recommendations.
- Community Collaboration: Create a leadership-driven, safety-oriented community committed to reducing suicide and violence.
- Prevention and Early Intervention Training: Increase community capacity to recognize and respond to signs of suicide, violence, and mental health problems through evidence-based community trainings.
- Lethal Means Safety: Develop and promote lethal means safety campaign to educate the community and address the number of suicide and homicide deaths by firearm and to provide safe storage options.
- Social Marketing: Increase awareness of suicide and violence, promote prevention messaging, and encourage positive behavior change in those areas.

Strategies

- Public and targeted information campaigns
- Culturally competent approaches
- Survivor-informed models
- Evidence and practiced based education models and curricula
- Public health model
- Ecological model
- Multisector approach
- Collective impact approach
- Health equity approach
- Zero suicide framework

The Suicide Prevention Program activities meet the SB 1004 priorities of providing suicide prevention programming across the lifespan and targeting the mental health needs of older adults.

Project: Humboldt Suicide Fatality Review (SFR)

The Suicide Fatality Review Team (SFRT) is a multidisciplinary group of professionals who meet to learn about the circumstances leading to suicide deaths and use an innovative approach to develop targeted interventions to prevent suicide in Humboldt County. This group includes sector agency representation from the Humboldt County Department of Health & Human Services (DHHS), Coroner's Office, healthcare, Tribes and community.

The purpose of the SFR is to prevent future suicides in Humboldt County. Based on the data collected, the SFR identifies risk and protective factors for suicide that are unique to Humboldt County and makes recommendations for local policy and practice changes to help reduce suicide risk and promote safety.

The mission of the SFR is to identify gaps in the existing system of suicide care and improve services for people at risk of suicide in Humboldt County. (Section 3720. Prevention Program & Section 3730. Suicide Prevention Programs). Expected outcomes include a reduction in suicide and suicidal behaviors in Humboldt and the development of pathways to suicide care in health, behavioral health, and other community entities for persons at risk and family members.

The SFR process:

- Collects uniform data and accurate statistics on suicide
- Identifies circumstances surrounding suicide deaths that will prevent future suicides
- Promotes collaboration and coordination among participating agencies to address mental illness early in its emergence, including the applicable negative outcomes

listed in Welfare and Institutions Code Section 5840, subdivision (d) that may result from untreated mental illness
- Implements cooperative protocols for the standard review of suicides
- Provides a confidential forum for multiple agencies and disciplines
- Identifies and addresses system and community factors that contribute to suicide

Target Population
Medical and behavioral health providers, healthcare administrators and providers, tribal organizations, county Public and Behavioral Health, Emergency Medical Services, Veteran serving agencies, law enforcement, social services, and subject matter experts.

Key Activities
- Develop SFR protocols, policies, and procedures
- Meet quarterly to review suicides and make recommendations based on findings
- Evaluate local suicidal behavior trends, circumstances, risk and protective factors to strengthen prevention efforts
- Identify targeted systemic changes from data analysis of review meeting recommendations
- Connect technical assistance to target audiences who need training working with healthcare providers, including training content development, guidance, SME, and resources.
- Present findings in conjunction with county epidemiologist that illuminates opportunity for system changes, including providing data to inform decision-making, offering trainings and alignment of shared objectives and deliverables among community partnerships
- Provide technical assistance in the form of sharing process documents and lessons learned to other counties implementing SFR

Outcome Measurements
- Number of SFR meetings held
- Number of participants involved
- Number of suicide death cases reviewed

Expected Outcomes
It was expected that SFR would meet regularly to review two or more suicide deaths at each meeting, reviewing a total of approximately four to eight suicide deaths within the fiscal year.

Actual Outcomes
- 3 SFR meeting held
- 43 participants involved (combined)
- 10 suicide death cases reviewed

Number of Individuals Served (Unduplicated)

- Ten suicide death cases reviewed at the three SFR Meetings
- 43 participants serving 7 agencies at the SFR Meetings

Demographics of Individuals Served

The MHSA PEI Demographic Form is not applicable to this project and is not used as an outcome measurement. Determination of which cases are to be review is solely based on whether the decedent's next-of-kin grants permission.

Projected Outcomes (FY2023-2024)

SFR will meet regularly to review two or more suicide deaths at each meeting, reviewing a total of approximately four to eight suicide deaths in the next fiscal year. SFR will share updated data on local risk factors collected by Humboldt County Sheriff's Office (HCSO) - Coroner's Office using the Suicide Risk Factor Surveillance System (SRFSS), previously called the Suicide Risk Assessment Profile.

Challenges

Reduced staffing and operational changes made quarterly SFR meetings, data analysis, and consistent SFR Core Team meetings difficult.

Successes

The SFR has had numerous successes this year. The Team has successfully adapted to the virtual format started in the prior year. Partnership continued with the HCSO Coroner's Office through their continued use of the Suicide Risk Factor Surveillance System (SRFSS), previously called the Suicide Risk Assessment Profile and collaborative information sharing that have strengthened the SFR and ensured prioritization of this work.

Humboldt County has received recognition at the state level resulting in technical assistance presentations to the state Striving for Zero Learning Collaborative, presentations to multiple counties across California, and co-presenting with national SFR expert to those starting SFR in other states.

Date	Audience
7/21/2021	California Striving for Zero Learning Collaborative, Recording can be accessed here: https://youtu.be/Nw2rajdGbXQ
8/19/2021	Riverside County
8/23/2021	Marin County
8/24/2021	Fresno County
9/8/2021	Los Angeles County

1/26/2022	California Mental Health Services Oversight and Accountability Commission (MHSOAC) Recording can be accessed here: The Suicide Fatality Review Process Webinar - MHSOAC (ca.gov)

Lessons Learned
SFR needs to be adequately staffed with support from Public Health and Behavioral Health leadership in order to be successful. Collaboration with other counties strengthens the efforts.

Project: Humboldt County Suicide Prevention Network
The Humboldt County Suicide Prevention Network (SPN) is comprised of representation from community sectors, county agencies and community partners. The DHHS-Public Health Suicide and Violence Prevention Program serves as the lead agency and collaborates with service providing agencies in multiple sectors, including tribal and community health, clinical behavioral health, social services, hospice, and palliative care. Primary agencies involved volunteers to present information or update the network regularly. SPN also works closely with the local chapter of the American Foundation for Suicide Prevention to help plan the Arcata Out of the Darkness Walk.

The network meets bi-monthly to build relationships and to identify strategies to reduce suicide and suicidal behaviors in our community. The SPN strives to understand and implement the goals of the Zero Suicide framework as well as the needs and goals of the agencies involved.

The SPN collaborates to plan events throughout the year and especially during the month of September in honor of Suicide Prevention Awareness. Anyone is welcome to attend the SPN regularly to provide input or to join during the September events planning time. All efforts will focus on establishing a presence in remote outlying areas of Humboldt County and in tribal communities. Humboldt County PEI staff will continue to act as the backbone agency providing coordination of efforts and guidance on best practices.

In September of 2021, members of SPN started the SPN Steering Committee. Anyone interested was invited to participate. The mission of the Humboldt County SPN Steering Committee is to provide cross-agency backbone to the SPN and to move forward the priorities of the Network. Committee goals include to:

1. Guide the function of the Suicide Prevention Network
2. Elevate the recommendations generated by the Humboldt Suicide Fatality Review Process to the appropriate sector (stakeholder) via the Suicide Prevention Network (to advocate for systematic change in suicide care)
3. Establish task forces to address the four (4) priority areas identified in the BH/Suicide section of the Humboldt Community Health Improvement Plan (CHIP)

Target Population

- Community partners, direct service providers, and prevention specialists.

Key Activities

- Coordinate community-wide activities and events.
- Provide in-service training at each Network meeting to promote evidence and practice-based strategies in suicide safer care
- Foster cross-sector relationship building to increase access and linkage to care for those in crisis and non-crisis situations.
- Promote local, statewide, and national crisis lines, resources, and educational materials to expand on the ability of trainees to increase access and linkage to supports and treatment for persons at risk.
- Improve and integrate suicide prevention resources in the community at large.
- Community education and outreach.
- Training and Workforce Development to increase capability to respond to persons at risk.
- Data collection and surveillance.
- Zero Suicide in Health and Behavioral Health Care Systems.
- Email list-serve
- Leverage resources to broaden the support network for unserved, underserved, and inappropriately served populations.
- Coordinate Network and Steering Workgroup meetings
- Participate in the state-level Striving for Zero Suicide Prevention Learning Collaborative to create a County wide strategic roadmap.

Outcome Measurements

- Number of agencies represented in network
- Number of meetings held annually
- Number of list-serve participants

Expected Outcomes (FY2021-2022)

- Increase number of agencies represented in network by one per year.
- Five meetings held annually
- 300 list serve participants

Actual Outcomes (FY2021-2022)

- 27 agencies represented in network (DHHS counted as one)
- Eleven meetings were held annually
- 420 list serve participants (an increase of 44 from previous fiscal year)

Number of Individuals Served (Unduplicated) (FY2021-2022)
Seventy-one (71) unique participants, representing 27 agencies, attended one or more Suicide Prevention Network meeting in fiscal year 2021-22.

Demographics of Individuals Served
The MHSA PEI Demographic Form is not applicable to this project and is not used as an outcome measurement.

Projected Outcomes (FY2023-2024)

- Increase number of agencies represented in network by one per year.
- Ten meetings held
- 400 list-serve participants

Challenges
Many agencies experience limited funding and frequent staffing changes which results in little capacity to prioritize SPN related tasks outside of the meetings. This has made task or workgroups difficult to cultivate.

Successes
The Suicide Prevention Network continues to maintain good meeting attendance and engagement with Network news shared via the list-serv. In FY21-22, the number of list-serv participants increased by 44, bringing the total to 420, vastly exceeding the goal of 300. The Network has continued to increase visibility in the community using social marketing strategies such as Mailchimp, branding and press releases. Educational or informative presentations take place during each meeting, drawing additional participants. Networking, relationship building, and topic related education continue to be aspects of SPN that bring participants back every other month.

A success in FY21-22 was the start of the SPN Steering Committee which meets during the off months of the larger SPN. This Steering Committee, along with the larger Network, played a significant role in the development of the suicide section of the Humboldt County Community Health Improvement Plan (CHIP). SPN Members participated in the development of the CHIP through:

1) Asset Mapping Activities during the SPN general meetings; Topics included: Postvention & LOSS Teams; Trainings; Lethal Means Safety; and Crisis Response
2) Collaboration during the Live Well Humboldt Suicide and Self Harm Data Workgroup
3) Review and feedback of suicide and self-harm data section of CHIP during SPN Steering Committee meetings

Lessons Learned
While funding and organizational capacity fluctuates, it is vital that a lead agency maintain the administrative functions of the SPN to ensure its continuation over time. Virtual meeting format and tools available foster engagement in collaborative group work. SPN

Steering Committee encourages Network Members to take more ownership of the overall direction of the SPN.

Project: Prevention and Early Intervention Training
The Prevention and Early Intervention Training project incorporates both evidence-based and practice-based trainings. SVP Program staff serve as coordinator, trainer and/or support for trainings offered.

Evidence-based training offerings include:

- Question-Persuade-Refer (QPR) Basic Suicide Prevention Gatekeeper Training
- Be Sensitive Be Brave for Suicide Prevention (BSBB for SP)
- Be Sensitive Be Brave for Mental Health (BSBB for MH)
- LivingWorks Start Training (online basic suicide prevention)

Additionally, the SVP Program has developed a shorter practice-based training module covering the basics of lethal means safety that can be an add on to any basic suicide prevention training.

Trainings take place virtually, allowing for expanded reach and compliance with increased safety measures during the pandemic. A modified, shortened version of the MHSA PEI Demographic Form is used as an outcome measurement to demonstrate the reach and diversity of populations and settings served.

Question-Persuade-Refer (QPR) Suicide Prevention Training
Implemented in September 2009, the Question, Persuade and Refer (QPR) Suicide Prevention Gatekeeper training provides innovative, practical, and proven suicide prevention training that increases knowledge to reduce suicidal behaviors. QPR educates individuals who are strategically positioned to recognize the risk and protective factors present in those who may be at risk of a suicide crisis and how to respond by serving as “gatekeepers”. The key components of this training are *Question* - ask about suicide, *Persuade* - promote the person to seek and accept help, and *Refer* the person to appropriate resources.

Key Activities

- Training participants to recognize the signs of persons in need of behavioral health support.
- Training participants to recognize the signs of persons who are at risk of suicide.
- Promoting wellness, recovery, and resiliency.
- Providing training to diverse groups and populations across multiple settings and professions in order to improve ability to increase access and linkage to care of those in crisis and non-crisis situations.

- Promoting local, statewide and national crisis lines, resources, and educational materials to expand on the ability of trainees increase access and linkage to supports and treatment for persons at risk.
- Improving and integrating suicide prevention resources in the community at large.
- Recognizing other important aspects of suicide prevention including life-promotion and self-care.
- Provide skill-based training so community members will have the knowledge to recognize, signs/symptoms of persons that may be at risk of suicide, respond and intervene.
- Reduce negative attitudes and beliefs about persons experiencing suicidal thoughts and behaviors along with other behavioral health challenges.
- Understand the issue at hand through national, state, and local data; and develop skills to support individuals in safety, wellness, and resilience.

Be Sensitive Be Brave for Suicide Prevention (BSBB for SP)
New to Humboldt in FY21-22, Be Sensitive Be Brave: Suicide Prevention is a culturally responsive workshop on suicide prevention that infuses culture and diversity throughout a foundational workshop in suicide prevention. The workshop teaches community members to act as eyes and ears for suicidal distress and to help connect individuals with appropriate services.

Key Activities
- Teaching how to identify signs of suicide
- Practicing sensitively and confidently asking individuals if they are considering suicide
- Teaching how to connect individuals at risk of suicide with the appropriate resources and community supports
- Teaching to approach suicide prevention in a culturally sensitive manner

Be Sensitive Be Brave for Mental Health & Mental Illness (BSBB: MH)
Also new to Humboldt in FY21-22, Be Sensitive Be Brave for Mental Health is a culturally responsive workshop. BSBB for MH infuses culture and diversity throughout a foundational workshop on mental health and mental illness. The workshop prepares community members to help friends and loved ones during times of distress.

Key Activities
- Teaching how to identify when you or someone you know is in mental distress
- Practicing being sensitive and brave in helping others
- Increasing awareness of mental health resources
- Teaching how to prevent mental illness by using a recipe for mental health
- Building cultural sensitivity around mental illness
- Increasing community responsiveness and decrease stigma

Target Population
All trainings will be targeted to medical providers, direct service providers, first responders and general community members.

Outcome Measurements (FY21-22)

- Number of trainings
- Number of participants
- Number of MHSA PEI Demographic Forms submitted

Expected Outcomes (FY21-22)
Four trainings were expected be held in fiscal year 2021/2022, serving a total of 80 or more individuals.

Actual Outcomes (FY21-22)

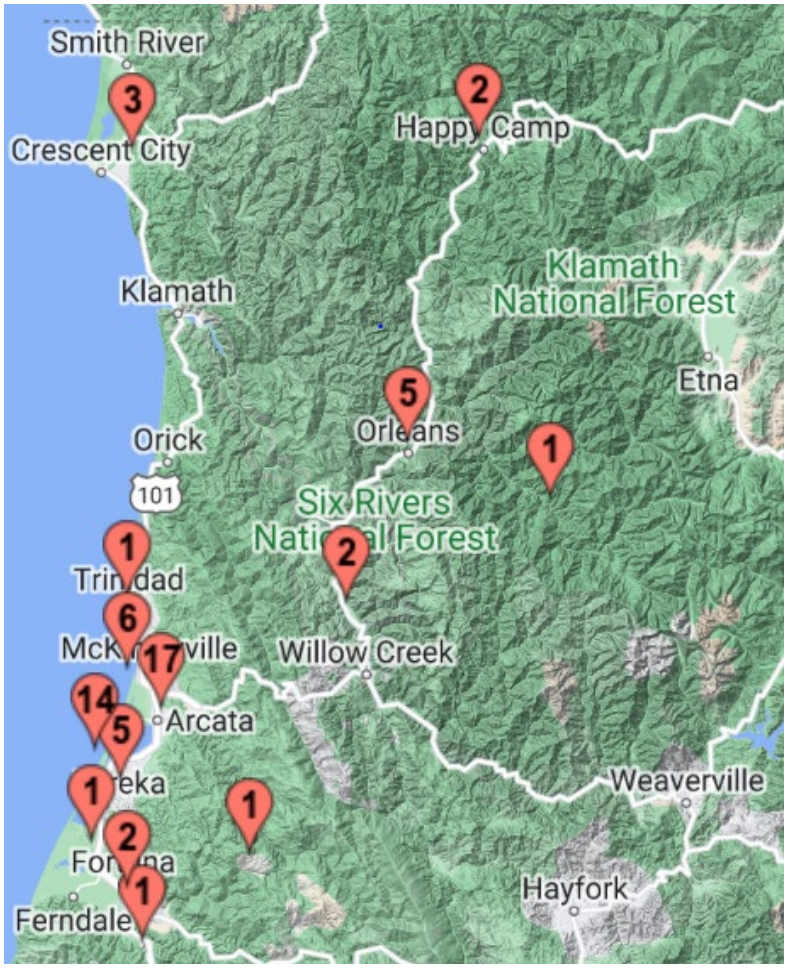
- Eight trainings were held, excluding the self-paced LivingWorks Start Training
- 309 participants total
- Sixty-seven (67) modified, shortened MHSA PEI Demographic Forms were submitted; an increase of 23 from the prior fiscal year

Training	# of Trainings	Individuals Served
QPR or QPR + Lethal Means Safety	3	89
BSBB for Suicide Prevention	1	36
BSBB for Mental Health & Metal Illness	1	55
Other (Know the Signs, LMS, or Gun Shop Project)	3	74
LivingWorks Start (online, self-paced)	n/a	55
TOTAL	8	309

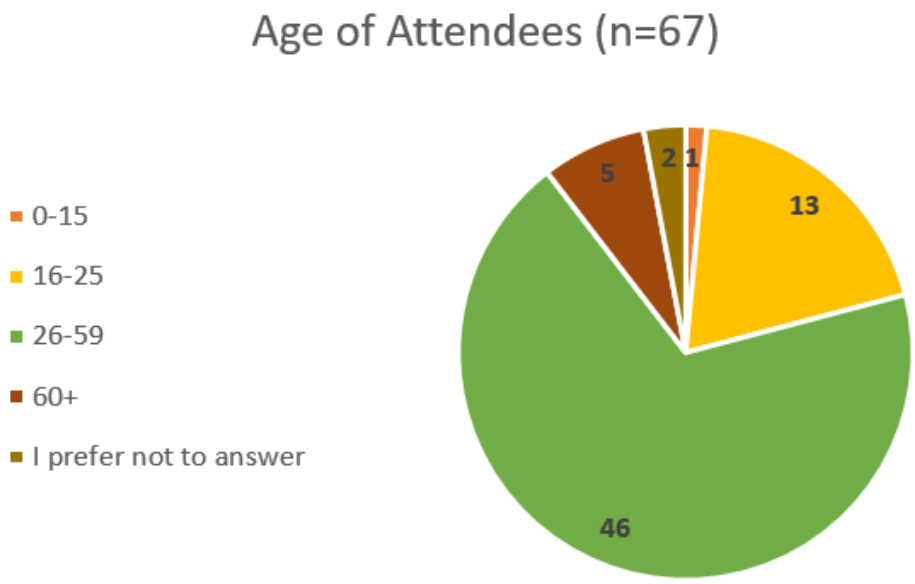
Number of Individuals Served (FY21-22)
In FY 2021/22, eight trainings were held, in addition to the ongoing self-paced LivingWorks Start training, with 309 total individuals served.

Demographics of Individuals Served
Demographic information comes from attendees at QPR &/or LivingWorks Start trainings who complete a demographic form. In Fiscal Year 21/22, 47% (67/144) attendees completed an electronic demographic form.

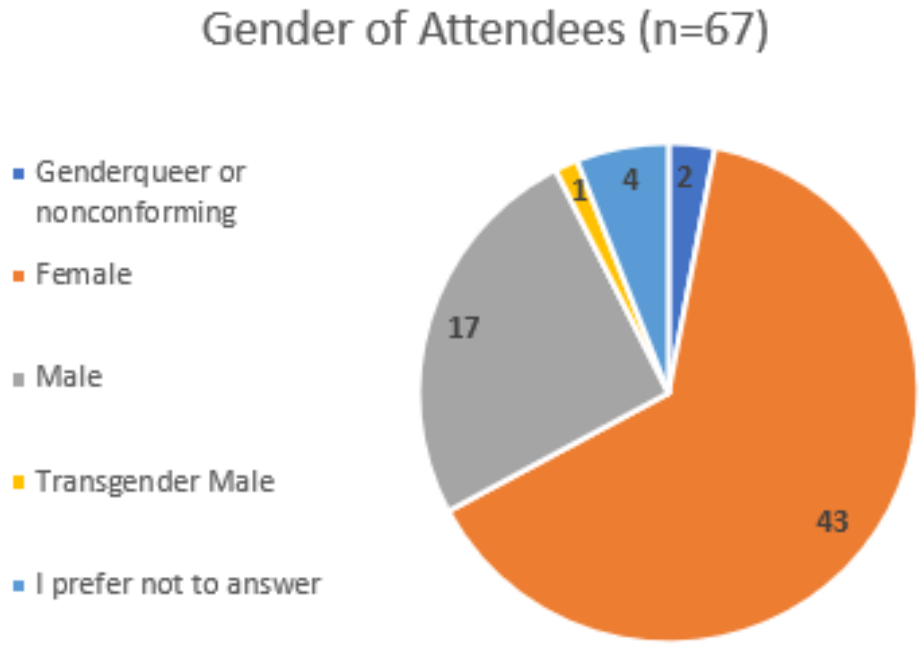
Zip Code of Training Attendees:



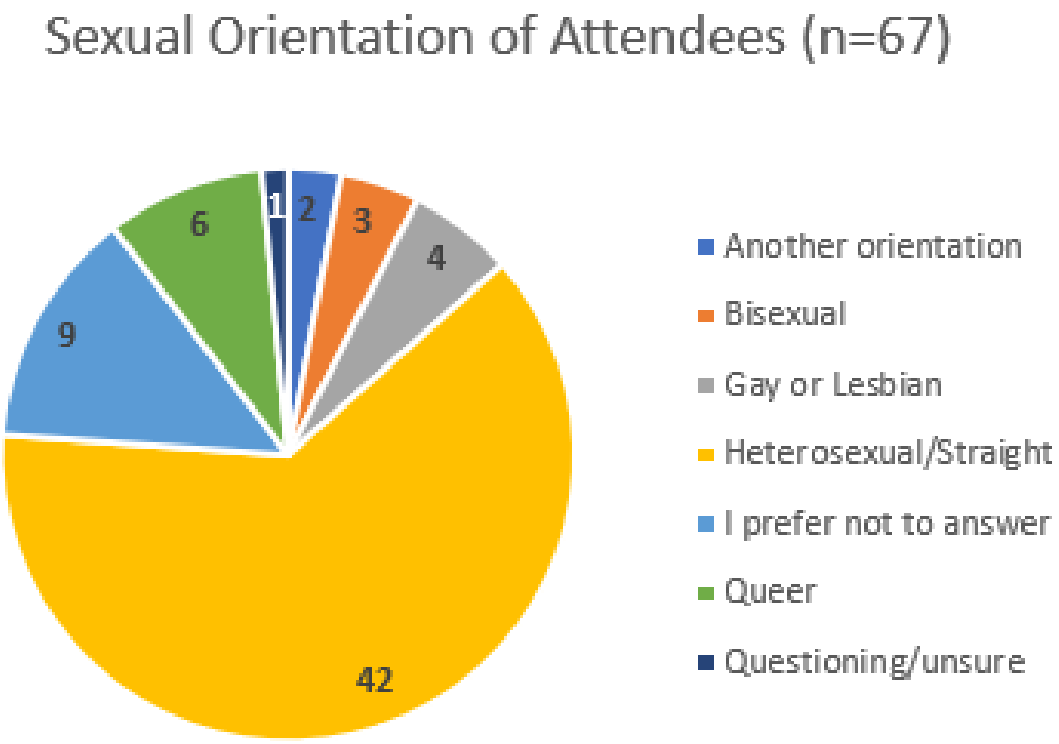
The image above shows local zip codes of training attendees. In Fiscal Year 21/22, out of the 67 completed demographic forms, 17 participants lived within zip code 95521; 14 within zip code 95501; six (6) within 95519; five (5) each within 95503 and 95556; four (4) preferred not to answer; zip codes: 95540, 95546, and 96039 each had two (2) participants; and one (1) participant lived in each of the following zip codes: 94203, 95549, 95551, 95562, 95570, 95667, 96031.



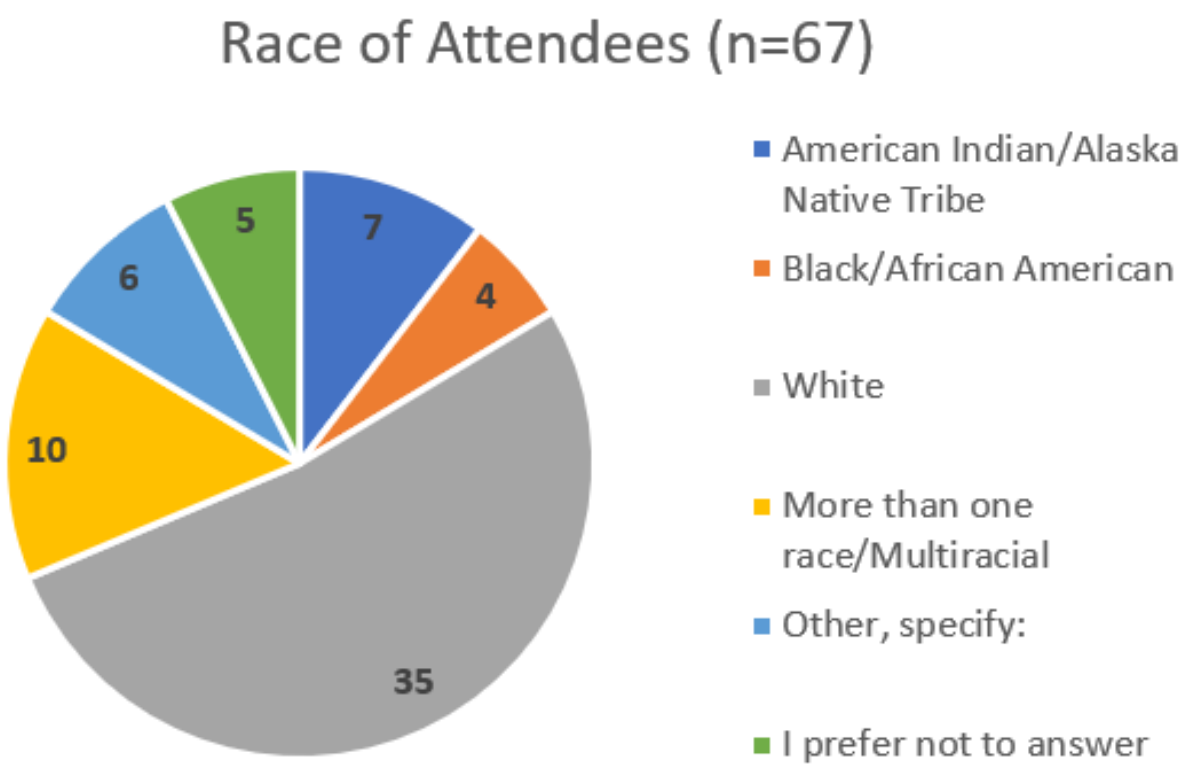
The image above shows the age of training attendees. In fiscal year 21/22, out of the 67 responses, one (1) attendee in trainings was age 0-15, thirteen (13) were ages 16-26, 46 attendees were ages 26-59, five (5) attendees were age 60+, and two (2) preferred not to answer.



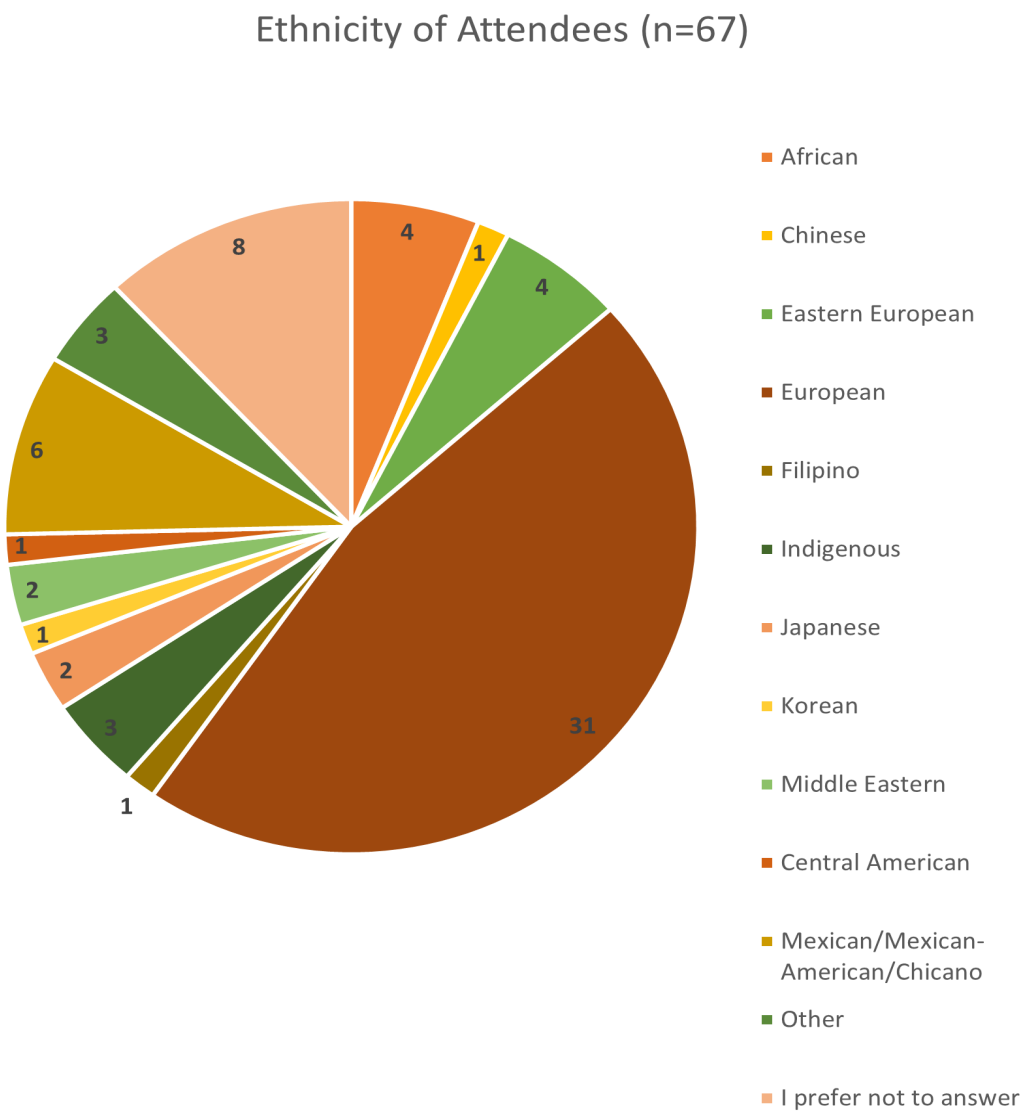
The image above shows the gender of training attendees. Out of 67 responses in fiscal year 21/22, 43 training attendees were female, 17 were male, four (4) preferred not to answer, two (2) were genderqueer or nonconforming, and one (1) was transgender male



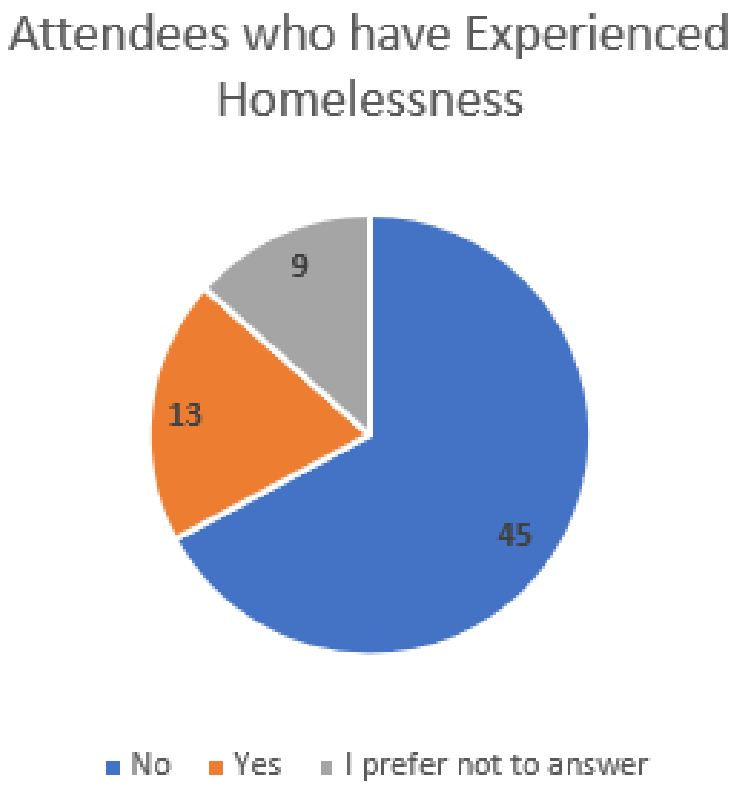
The image above shows the sexual orientation of training attendees. Out of 67 responses in fiscal year 21/22, 42 training attendees were heterosexual/straight, nine (9) preferred not to answer, six (6) were queer, four (4) were gay or lesbian, three (3) were bisexual, two (2) were another orientation not specified, and one (1) was questioning/unsure.



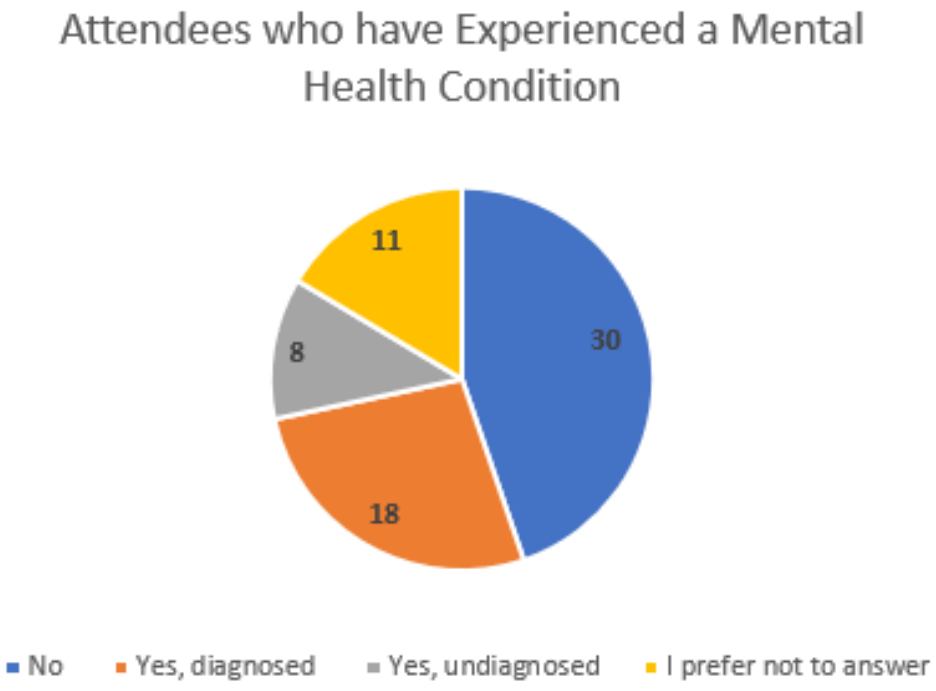
The image above shows the race of training attendees in fiscal year 21/22. Thirty-five (35) attendees were White, ten (10) were more than one race/Multiracial, seven (7) were American Indian / Alaska Native Tribe, six (6) were Other (not specified), five (5) preferred not to answer.



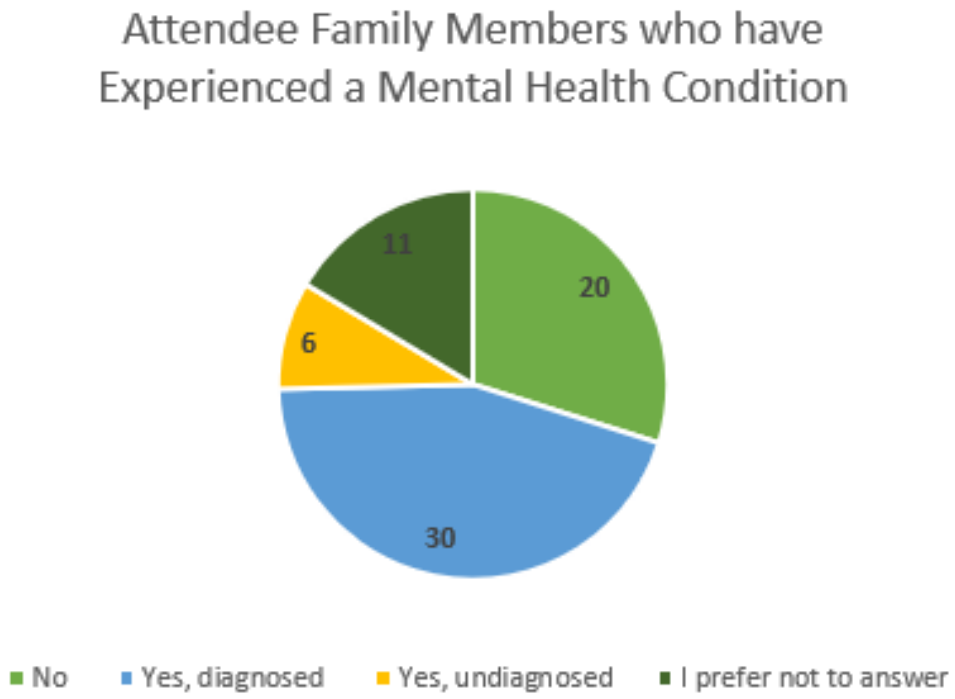
The image above shows the ethnicity of training attendees in fiscal year 21/22. Thirty-one (31) attendees in trainings were European, eight (8) preferred not to answer, six (6) were Mexican/Mexican-American/Chicano, four (4) were African, four (4) were Eastern European, three (3) were Indigenous, three (3) where Other (not specified), two (2) were Japanese, two (2) were Middle Eastern, one (1) was Chinese, one (1) was Filipino, one (1) was Korean, and one (1) was Central American.



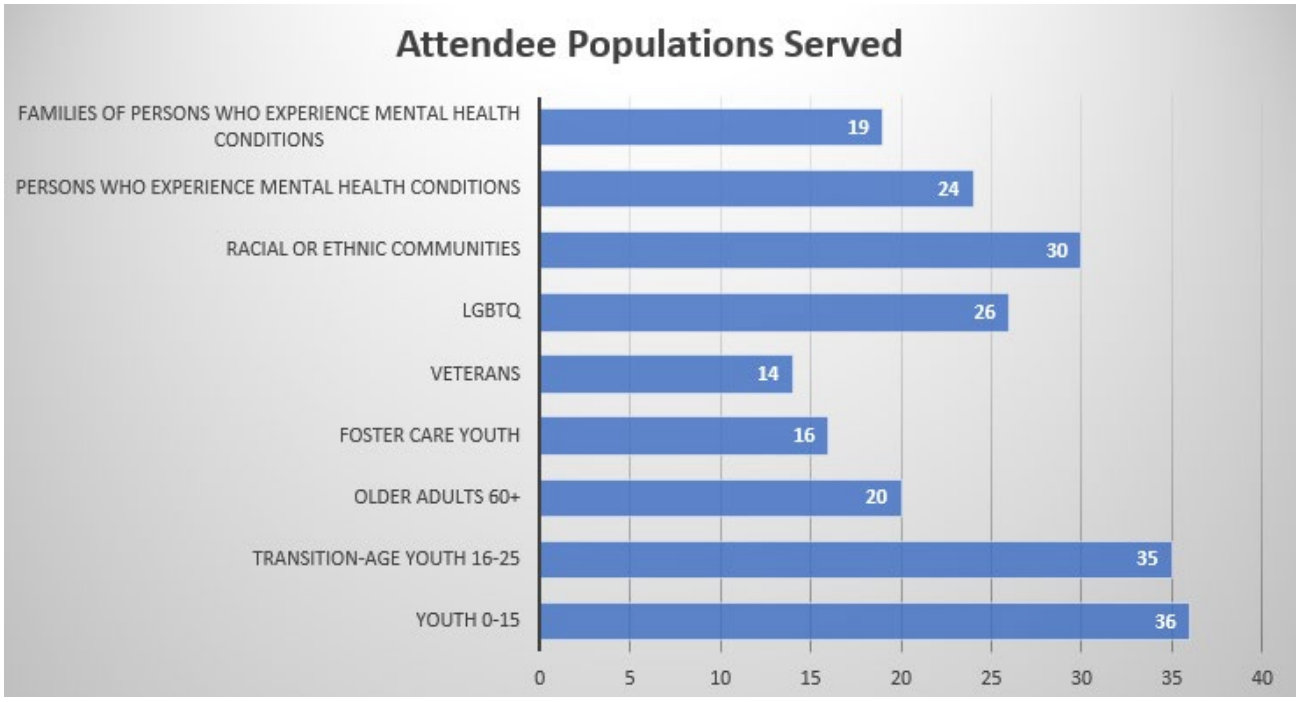
The image above shows that in fiscal year 21/22, training attendees were asked if they had ever experienced homelessness. Forty-five (45) training attendees had not experienced homelessness, 13 attendees had, and nine (9) preferred not to answer.



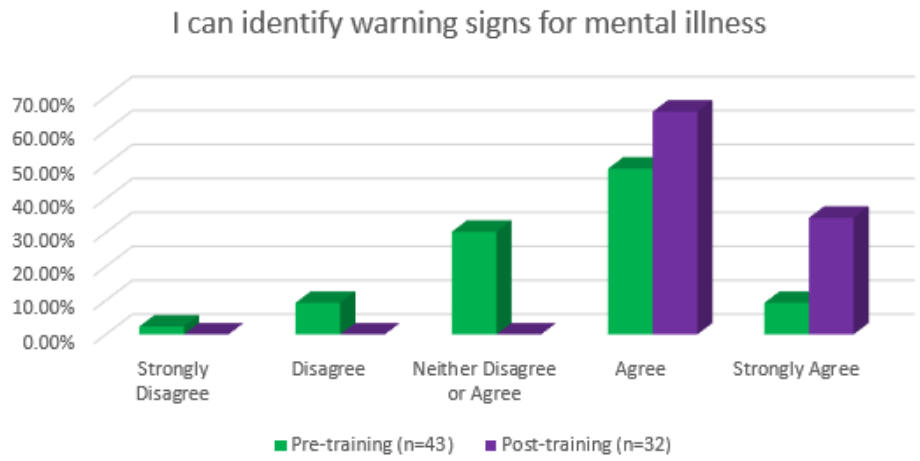
The image above shows that in fiscal year 21/22, training attendees were asked if they had ever experienced a mental health condition. Thirty (30) answered no, 18 answered Yes, diagnosed, eight (8) answered Yes, undiagnosed and 11 preferred not to answer.



The image above shows that in fiscal year 21/22, training attendees were asked if they had a family member with a mental health condition. Twenty (20) answered *no*, 30 answered *Yes*, diagnosed, six (6) answered *Yes, undiagnosed* and 11 *preferred not to answer*.

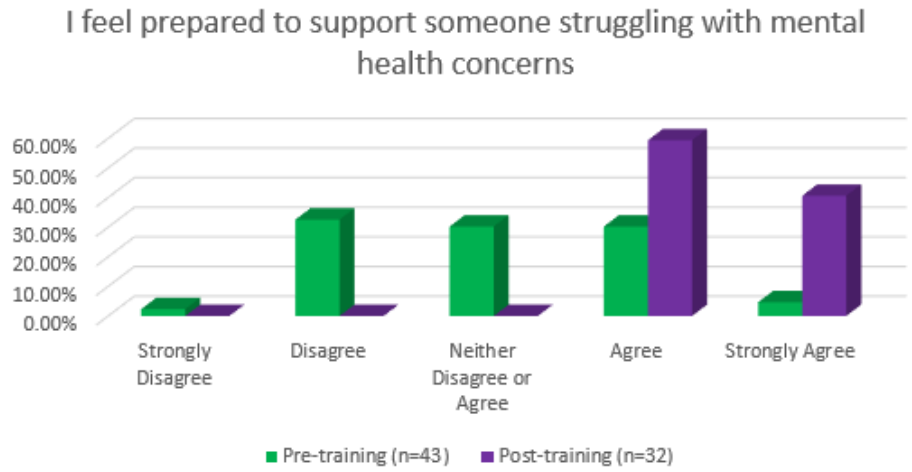


The image above shows that in fiscal year 21/22, the populations served by training attendees were as follows: 36 served youth 0-15; 35 served transition aged youth (TAY) 16-25 years old; 20 served older adults; 16 served foster care youth; 14 served Veterans; 26 served LGBTQ; 30 served racial or ethnic communities; 24 served persons who experience mental health conditions, and 19 served family members of persons who experience mental health conditions.

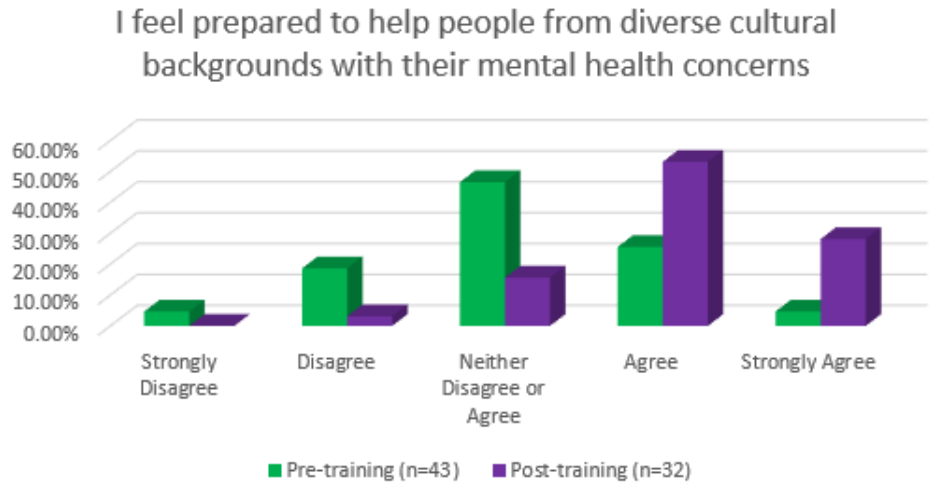


The image above shows the attendees of the Be Sensitive Be Brave (BSBB) for Mental Health & Mental Illness Training's Pre- and Post-Training responses to the statement, I can identify warning signs for mental illness. There were 11 participants who did the pre-

training survey but failed to complete the post. Of the 32 participants who completed both the pre and the post survey, nearly 66% *agreed* with this statement after the training compared with 49% before the training. 34% *strongly agreed* with this statement comparted with only 9% before the training.



The image above shows the attendees of the Be Sensitive Be Brave (BSBB) for Mental Health & Mental Illness Training's Pre- and Post-Training responses to the statement, I feel prepared to support someone struggling with mental health concerns. There were 11 participants who did the pre-training survey but failed to complete the post. Of the 32 participants who completed both the pre and the post survey, nearly 59% *agreed* with this statement after the training compared with 30% before the training. 40% *strongly agreed* with this statement comparted with only 5% before the training.



The image above shows the attendees of the Be Sensitive Be Brave (BSBB) for Mental Health & Mental Illness Training's Pre- and Post-Training responses to the statement, I feel prepared to help people from diverse cultural backgrounds with their mental health

concerns. There were 11 participants who did the pre-training survey but failed to complete the post. Of the 32 participants who completed both the pre and the post survey, 16% *neither disagreed nor agreed* after the training compared with 47% pre training. 53% *agreed* with this statement after the training compared with 26% before the training. 28% *strongly agreed* with this statement comparted with only 5% before the training.

Projected Outcomes (FY2023-2024)
Four trainings will be held, serving 80 or more people, total.

Challenges
Trainer capacity was a challenge this year as several staff positions in the SVP Program were open for many months.

Consistent data collection remains a challenge in virtual trainings. When data collection happens towards the end of a training, there is little we can do to motivate participants to complete post-training surveys. Merging MHSA data collection efforts with those of outside trainers when applicable (Be Sensitive Be Brave (BSBB) Trainings) was also a challenge.

Additionally, attendance is often difficult to predict in virtual trainings where registration is free. On average this year, trainings saw a 65% attendance rate when compared with registration.

Successes
QPR has reached many diverse settings in the community and has been expanded to include lethal means safety content. LivingWorks Start has showed positive learning outcomes from participants.

The inclusion of the Be Sensitive Be Brave (BSBB) trainings have not only added variety to our menu of training offerings but they also teach a culturally responsive framework that can be transferred and applied in multiple scenarios. Prioritization to apply a culturally diverse and inclusive lens to prevention is very much in line with the shift to make suicide prevention and mental health care more equitable across populations.

Lessons Learned
Allowing for over-registration during training promotion will account for the no shows. Factoring additional time during the training to allow participants time to complete post-training data collection will increase survey compliance. Recruiting outside trainers to bring variety and subject matter expertise draws in more participants and reduces the stress on staff to learn additional curriculum.

LivingWorks Start Training - Online Basic Suicide Prevention
In times of heightened isolation and anxiety, people's thoughts of suicide can increase. It is essential that people have effective skills to keep each other safe, even if it is from afar.

LivingWorks, the company known for creating the Applied Suicide Intervention Skills Training (ASIST), released their online basic suicide prevention training called LivingWorks START. Beginning spring 2020, this online training is offered in Humboldt County at no charge.

Start is 90-minute program that lets trainees learn suicide prevention skills even while working from home or practicing social distancing. The benefits of LivingWorks START Training are:

- Works on any computer, smartphone, or tablet, and it includes simulations, practice, and other skills-building activities.
- Applies learned skills via phone, text, and other remote methods.
- Recognizes when friends, family members, co-workers, and neighbors are struggling and takes meaningful actions to keep them safe.
- Trainees report feeling more confident and prepared to help someone, even during work-from-home and social distancing.

Like all of LivingWorks' core programs, LivingWorks START is evidence-based. Third-party evaluations of LivingWorks Start confirmed:

- Improves trainee skills and knowledge
- Improves trainee readiness and confidence
- Safe and effective for trainees as young as 15 years old
- Meets SAMHSA's Tier III evidence-based training criteria
- Based on best practices in online curriculum development

Target Population
LivingWorks Start training is targeted towards DHHS staff, employers seeking to improve workforce ability to recognize signs and symptoms of suicide and/or potentially serious mental illness, social services agencies, shelter and homeless services, tribal leaders, educators, elder care agencies and skilled nursing facilities, general community members, department of veteran's affairs, medical and behavioral health care staff, law enforcement/first responders and others living or working in Humboldt County.

Key Activities

- Learn to recognize when others are struggling and connect them to help
- Learn the TASC model of Tune In, Ask about suicide, State the seriousness, and Connect to help
- Practice TASC skills in a variety of dynamic interactive learning simulations
- Learn how to keep a loved one safe, even when helping remotely

- Develop a personalized resource list using the Connect application that can be accessed at any time and easily shared with others

Outcome Measurements (for FY21/22)

- Number of licenses issued
- Number of trainings completed
- Number of MHSA PEI Demographic Forms submitted

Expected Outcomes (for FY21/22)

- 200 licenses issued
- 100 trainings completed
- 100 MHSA PEI Demographic Forms submitted

Actual Outcomes (for FY21/22)

- 88 licenses issued
- 55 trainings completed
- 55 MHSA PEI Demographic Forms submitted
- 54 Post Course Survey's completed

Number of Individuals Served

In FY 2021/22, 88 Start trainings licenses were issued, 55 trainings were completed with 55 individuals submitting MHSA PEI Demographic forms and 54 completing a Post Course Survey

Demographics of Individuals Served

Demographic information comes from individuals who were issued a license and completed a demographic form. In Fiscal Year 21/22, 63% (55/88) of individuals issued a license completed a demographic form.

Projected Outcomes (FY2023-2024)

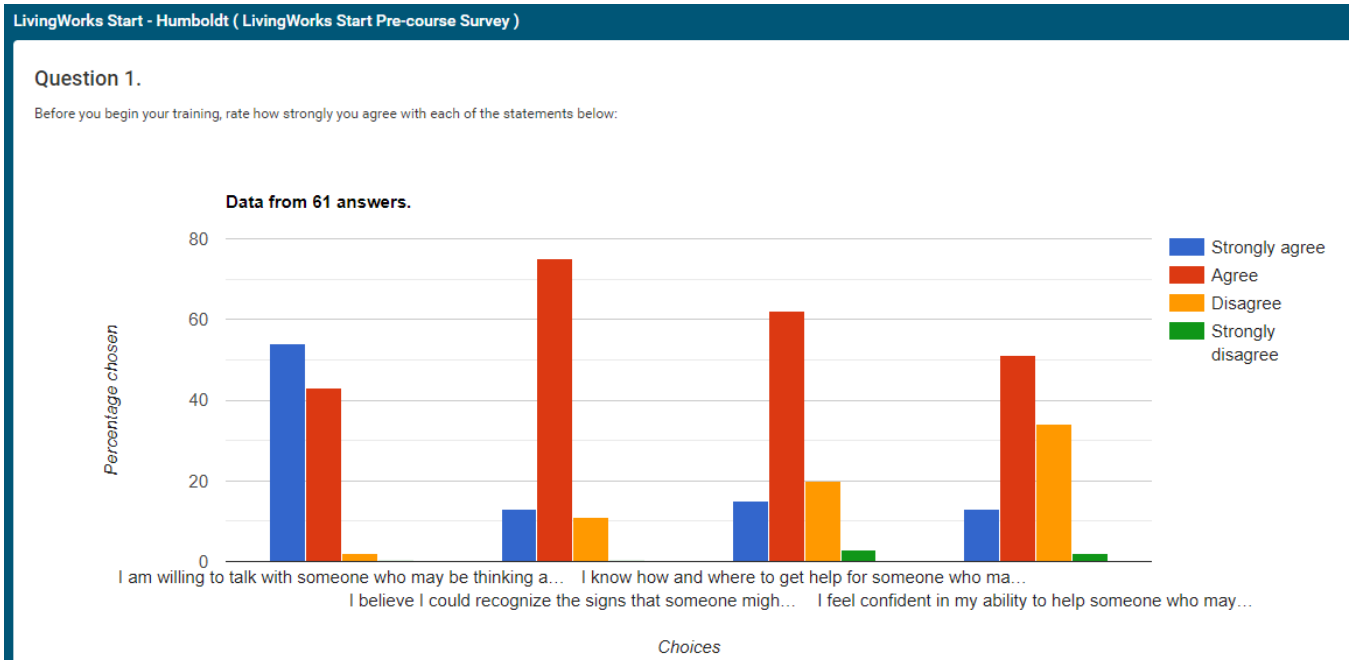
- 100 licenses issued
- 75 trainings completed
- 75 Post course Survey's completed

Challenges

This online training opportunity has presented unforeseen challenges in promotion, license management and participant engagement. Training completion rates are lower than expected which is common in online training. Humboldt County has been over saturated with training licenses due to multiple agencies purchasing bulk licenses from LivingWorks and AB1808 passing at the state level to provide free LivingWorks Start training for school staff and students.

Successes

The LivingWorks Start training increases participant readiness to support someone at risk of suicide. Course survey data is described below.



In Question 1, (image above), participants were asked, prior to the training, how strongly they agreed with each of the following statements:

1. I am willing to talk with someone who may be thinking about suicide.
2. I believe I could recognize the signs that someone might be thinking about suicide.
3. I know how and where to get help for someone who may be thinking about suicide.
4. I feel confident in my ability to help someone who may be thinking about suicide.

Question 2.

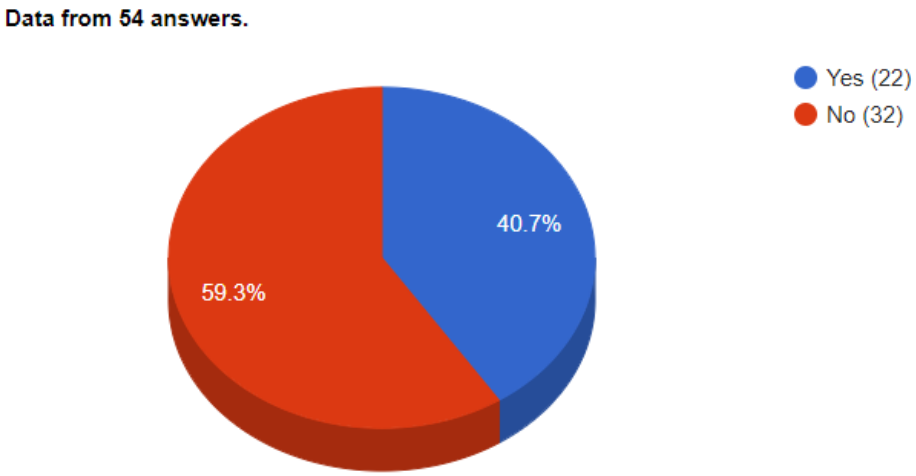
Now that you have completed LivingWorks Start, rate how strongly you agree with each of the statements below:

In Question 2, (image above), after completing the training to the training, participants were asked how strongly they agreed with the same four statements:

1. I am willing to talk with someone who may be thinking about suicide.
2. I believe I could recognize the signs that someone might be thinking about suicide.
3. I know how and where to get help for someone who may be thinking about suicide.
4. I feel confident in my ability to help someone who may be thinking about suicide.

Question 5.

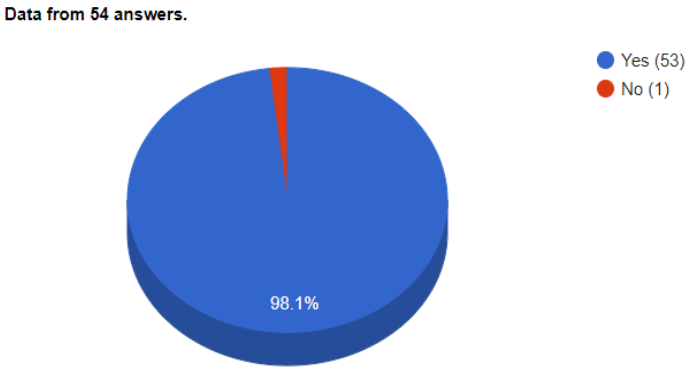
I already have someone in mind that I could use my new skills with.



In Question 5 (image above), Livingworks Start participants were asked if they had someone in mind that they could use their new skills with. Out of 54 responses, 41% (22) answered yes; 59% (32) answered no.

Question 6.

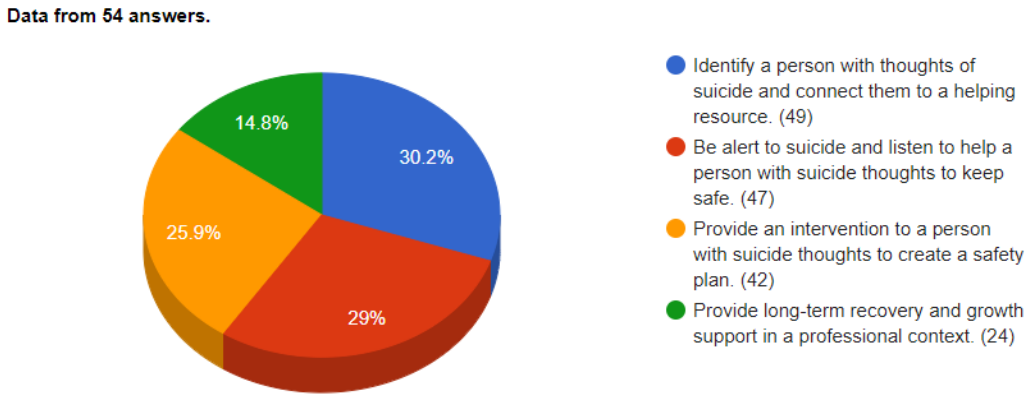
Having taken LivingWorks Start, if I were struggling with thoughts of suicide myself, I know how to use the resources provided to me to get help. (If your answer is no, remember that you can always find details of crisis and safety resources by visiting connect.livingworks.net and clicking on the "Find Safety" button.)



In Question 6 (image above), LivingWorks Start participants were asked, if they were struggling with thoughts of suicide themselves, do they know how to use the resources provided to them to get help. Out of 54 responses, 98% (53) answered yes, and one person answered no.

Question 7.

The role I would like to play in suicide prevention is:(check all that apply)



In Question 7 (image above), participants were asked what role they'd like to play in suicide prevention, multiple answers permitted. Out of 54 responses:

- 30% (49) indicated they would like to identify a person with thoughts of suicide and connect them to a helping resource.

- 29% (47) indicated they would like to be alerted to suicide and listen to help a person with suicide thoughts to keep safe.
- Nearly 26% (42) indicated they would like to provide an intervention to a person with suicide thoughts to create a safety plan.
- Nearly 15% (24) indicated they would like to provide long-term recovery and growth support in a professional context.

LivingWorks Start Participant Feedback
Participant feedback points to additional successes. The following statements are direct quotes from LivingWorks Start participants from FY21-22 when asked for feedback about their favorite parts of the training:

1. There have been past conversations where I needed this and didn't have it. I have always had access to resources but knowing that I can have such a simple conversation and connect people and how to do it is really encouraging and helpful.
2. I have never been trained to interact through text. Seeing as how this is a common way to communicate these days, I found it useful enjoyed the variety of situations where a person could find themselves with thoughts of suicide. It looks different for everyone so it is important to be familiar with the different ways signs can manifest.
3. The emphasis on reflecting suicidal thoughts as "serious" was new to me, despite many hours of prior training. Thank you
4. The videos were really insightful, and it gave clear and helpful steps for helping someone in crisis.

Lessons Learned
Promotion of LivingWorks Start must be consistent and ongoing throughout the fiscal year. Collaboration is needed with community partners to coordinate resources and promotional activities so that efforts are not duplicative or confusing to the community.

Project: Lethal Means Safety
In Humboldt County, between the years of 2005-2018, 47% of all suicide deaths involved a firearm; 26% were due to hanging; and 20% due to poisoning (Vital Statistics via Humboldt County Public Health Epidemiologist). Putting time and distance between a person thinking about suicide and a potentially lethal means may save a life. Reducing access to lethal means is an integral part of a comprehensive suicide prevention plan. Providing safe storage options and lethal means safety education are the priorities of this project. Lethal Means Safety Project includes the following key activities:

- Keep It Safe Campaign
- Lethal Means Safety Training
- Gun Shop Project
- Keep It Safe Lockbox Distribution Program

Key Activities

- The Keep It Safe Campaign includes public health education around means safety that is targeted towards all audiences. The Campaign includes public service announcements, social media messaging and an educational brochure that reaches expanded audiences on the topic of safe storage of potentially dangerous items. The target audience includes all housed community members. Keep it Safe is about preventable injury. The Keep It Safe Brochure is a guide to start a conversation with Humboldt County residents about protecting their loved ones from common items found in homes that could be dangerous such as: medications, alcohol, firearms, cannabis products and anything else that can be used to get high, harm or kill oneself. The brochure is distributed in local community service agencies including medical and behavioral health care settings.
- Lethal Means Safety Training consists of practice-based training modules that can accompany any suicide prevention training or be provided independently to those with previous baseline knowledge.
    - The target population is anyone who takes a suicide prevention training, interacts with high-risk groups, and/or those who provide direct services including: medical and behavioral health care providers, community members, social workers, tribal leaders, law enforcement and first responders, firearms retailers, trainers and range owners, and pharmacists.
    - This practice-based training module involves data around lethal means; firearms suicide; overdose; safety planning; harm reduction strategies for increasing safety and reducing risk; resources to learn more or seek help; and instructions on how to utilize the Public Health Lockbox Program for self or clients served
- The Gun Shop Project is a partnership between Humboldt County Public Health and local gun retailers, trainers, and range owners. There were 285 firearm deaths in Humboldt between 2005-2019. The majority (76%) of those firearm deaths were suicides (Humboldt County Public Health Epidemiologist). Reaching the firearms community with suicide prevention education and resources requires partnership with leaders imbedded in that community. This project reflects that partnership in that local firearms retailers, trainers, and range owners are the ones sharing lethal means safety education and resources with the firearms community. Already experts in safe firearm storage, they also offer pistol lockboxes provided through the Lockbox Distribution Program and consultation on safe storage options. They provide mental health and suicide prevention resources with lockbox distribution. Many of them have taken suicide prevention training with program staff and now, firearm safety instructors are including basic suicide prevention education in their classes. Educating gun owners about the relationship between firearm access and suicide gives gun owners themselves the knowledge that allows them to make informed decisions about safe storage that could potentially save lives.
- The Public Health Keep It Safe Lockbox Distribution Program is an expansion of the overall Keep It Safe Campaign previously known as Lock Up Your Lethals.

    - The Lockbox Distribution Program has been distributing lockboxes in the community through partnership with a variety of local agencies. In 2020, Keep it Safe partnered with various firearm retailers, range owners, and gun safety trainers to expand the Lockbox Program.
    - The goal is to decrease the number of overdose or firearm related deaths and the number of accidental injury or overdose related ER visits in Humboldt County by providing education, resources, and a way to safely store medications, cannabis and/or firearms.
    - Public Health's Keep It Safe Lockbox Program provides lockboxes, free of charge, to community members who need them most. The lockboxes can safely store up to two handguns. These boxes can also be used to lock up medications or cannabis.
- Know the Signs is a statewide suicide prevention social marketing campaign built on three key messages: Know the signs, find the words, and reach out. This campaign is intended to educate Californians how to recognize the warning signs of suicide, how to find the words to have a direct conversation with someone in crisis and where to find professional help and resources.
    - Know the Signs is part of the Take Action for Mental Health Campaign funded by Mental Health Services Act (MHSA) (Prop. 63.) and administered by the California Mental Health Services Authority (CalMHSA).
    - A suicide prevention training and slide desk built around the Know the Signs messaging and campaign has been developed by the state. It is considered a suicide prevention gatekeeper training and can be used in ways similar to QPR.

Outcomes Measured (FY21/22)

- Number of Keep It Safe brochures distributed
- Number of Lethal Means Safety - Training Modules offered
- Number of participants in attendance at Lethal Means Safety Training
- Number of lockboxes distributed
- Number of Lockbox Data Collection Forms completed
- Number of educational resources provided with lockboxes

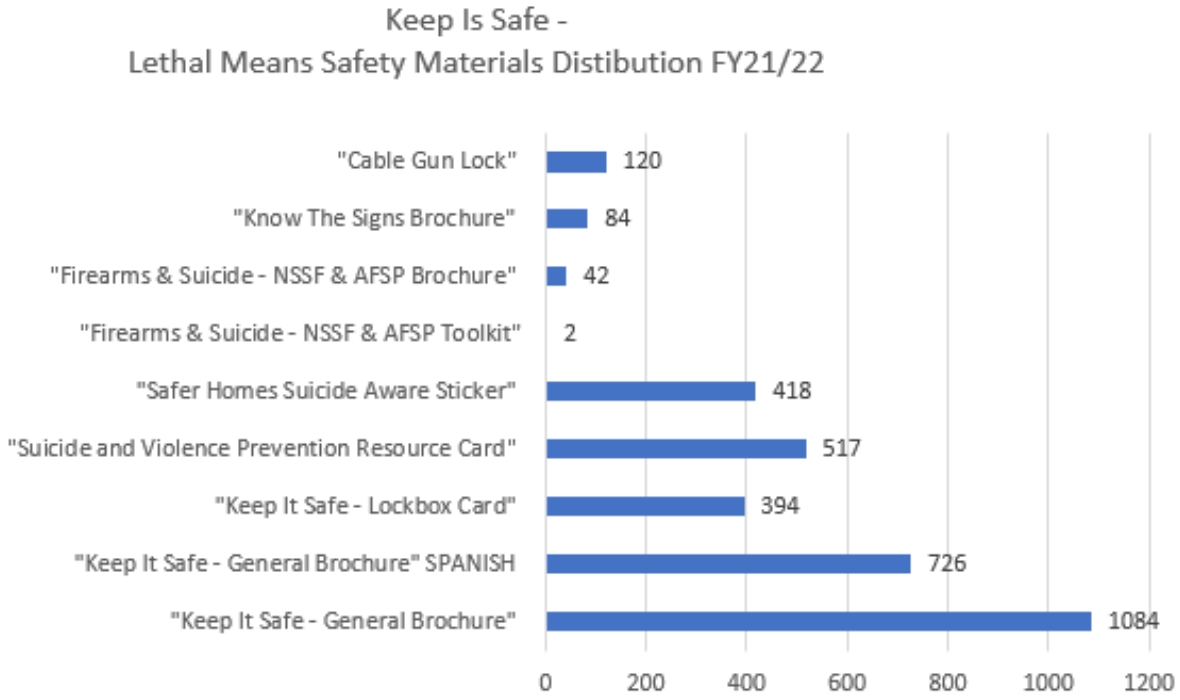
Expected Outcomes (FY21/22)

- 1,000 Keep It Safe brochures distributed throughout the county.
- Two Lethal Means Safety trainings with 15 or more participants
- 650 lockboxes distributed
- 650 Lockbox Data Collection Forms completed
- 650 educational resources provided

Actual Outcomes (FY21/22)

- 1,810 Keep It Safe brochures distributed

- Six Lethal Means Safety Training Modules &/or Keep It Safe presentations offered
- 123 Lethal Means Safety Training & or presentation participants
- 708 lockboxes distributed
- 658 Lockbox Data Collection Forms completed
- 3,267 educational resources provided as part of the Keep It Safe Campaign, including Know the Signs Brochure, Firearms & Suicide – NSSF & AFSP Brochure, Firearms & Suicide – NSSF & AFSP Toolkit, Safer Homes Suicide Aware Sticker, Suicide and Violence Prevention Resource Card, Keep It Safe Lockbox Card, and the Keep Is Safe general brochure in English and Spanish
- 120 cable gun locks distributed

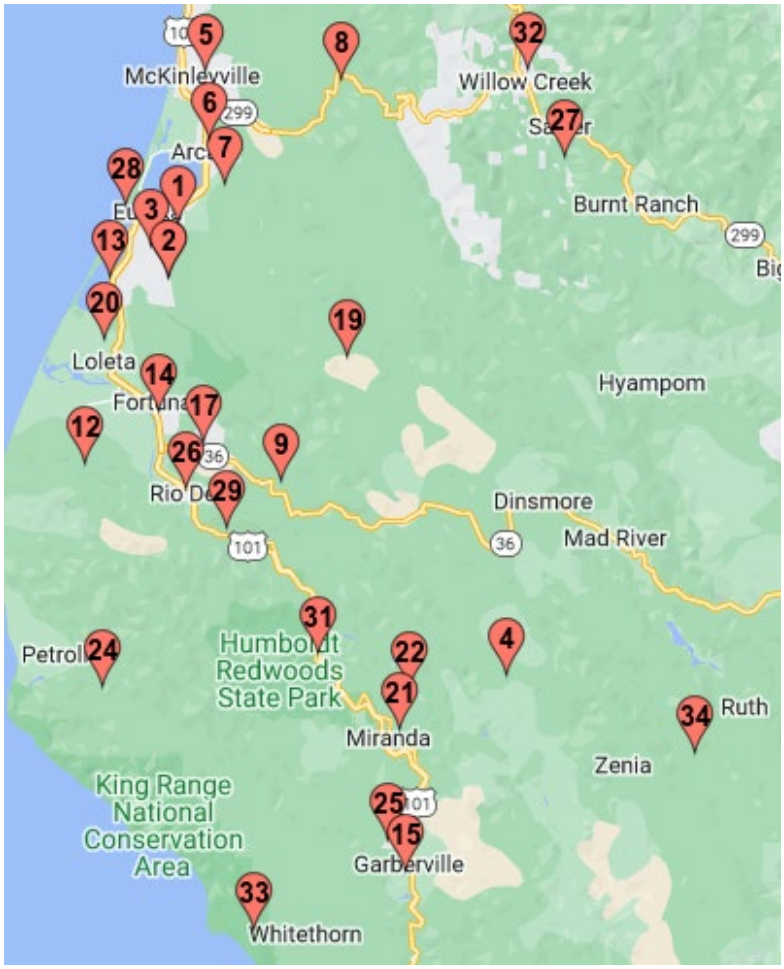


Demographics of Individuals Served

Demographic responses for recipient zip code, firearm in home, and children/teens in the home are from the 658 Lockbox Data Collection Forms completed by lockbox recipients.

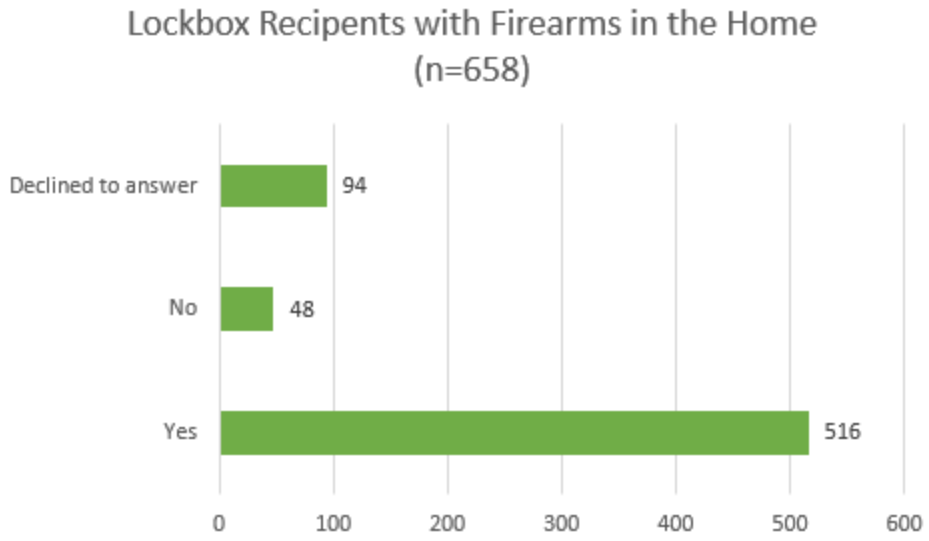
Zip Codes of Lockbox Recipients

In fiscal year 21/22, 180 lockboxes were distributed to recipients living in zip code 95501, 121 were in zip code 95503, 87 were in zip code 95519, 78 were in zip code 95521, 17 were in zip code 95540, 15 were in zip code 95570, 11 were in zip code 95562, and 103 were in other zip codes including: 95546, 95536.



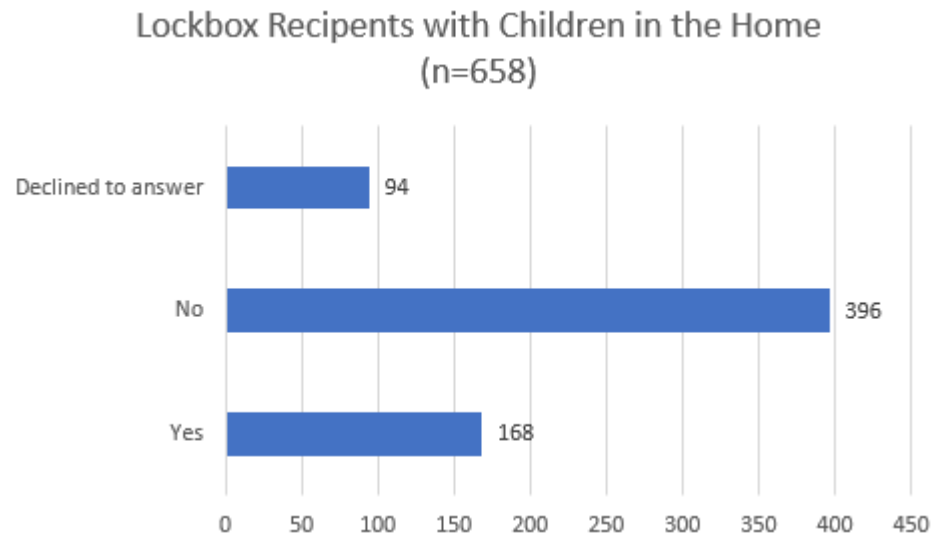
Firearms in the Home

Of the 658 lockbox recipients who completed a Lockbox Data Collection Form, 516 of them answered yes to having firearms in their home. Forty-eight said no, and 94 declined to answer.



Children in the Home

Of the 658 lockbox recipients who completed a Lockbox Data Collection Form, when asked “Are there children or teens in your home (anyone under 18 years old) ”?, 168 responded yes, 396 responded no, and 94 declined to answer.



Projected Outcomes (FY2023-2024)

- 1,000 Keep It Safe brochures distributed throughout the county.
- Two Lethal Means Safety trainings with 30 or more participants total
- 650 lockboxes distributed
- 650 Lockbox Data Collection Forms completed
- 650 educational resources provided

Challenges
Even with great success in the distribution of lockboxes in the County, more resources are needed to meet the high demand in our community. With the purchase of additional lockboxes, there is great potential for continued expansion with community partner outreach.

Successes
Collaboration with firearm retailers was a remarkable opportunity to provide safe storage options and educational resources widely to our community. Additionally, education was provided to firearm retail staff on suicide prevention strategies to recognize risk for suicide. At the time of firearm purchase, firearm retail staff connected with customers about suicide prevention. They were able to have life-saving conversations, give safe storage options and provide educational resources. Firearm safety instructors have embedded suicide prevention education in their classes. The Lockbox Distribution Program expanded to include additional community partner agencies acting as distributors, increasing the reach of the project.

Lessons Learned
It has been essential to working with community partners to widely distribute lockboxes throughout the County. This has enabled distribution to reach diverse target populations of firearms owners.

Project: Social Marketing
This is a continuing suicide prevention social marketing campaign targeting all ages and all Humboldt County residents. It includes a web-based campaign and efforts to combat multiple stigmas and encourage self-acceptance for individual with behavioral illness. It addresses the negative outcomes of suicide and prolonged suffering.

Community-wide prevention efforts are designed to educate the broader community on how to identify the signs of behavioral illness; how to access resources for early detection and treatment; and to reduce mental illness stigma and discrimination. Humboldt County will continue to coordinate local community-wide prevention activities in the areas of suicide prevention, stigma and discrimination reduction, and increased access for unserved/underserved populations.

Target Population
- All Humboldt County residents will be reached with the social marketing efforts, with a focus on direct service providers.

Key Activities

- Promote local, state, and national resources through media and awareness month campaigns
- Develop educational materials, media, infographics, brochures, resource lists, cards, etc.
- Distribute educational materials and resources at community events
- Promote Humboldt County DHHS webpage
- Develop, promote, and maintain Humboldt County DHHS Public Health Suicide and Violence Prevention Program Website
- Coordinate awareness month events with community partners

Communication Channels

- The Email messaging distribution list maintained educational connections made with training participants, direct service providers and the general community. Email content shared included state resources and other social marketing initiatives, promoted local PEI activities (including awareness months) and highlighted resources for behavioral health and suicide prevention.
- Public Service Announcements (PSAs) promoted social marketing campaigns and program objectives through local radio stations. PSA content included local state and national public health campaigns, such as Take Action for Mental Health, Know the Signs, lethal means safety, awareness month resources and messaging.
- The new SVP program website integrates Suicide and Violence Prevention programing. The main page has been published with child pages still in development. Content consists of programmatic activities, population specific resources, training promotion and public health information. Additionally, SVP content is disseminated though the main DHHS webpage and various social media platforms.
- Press releases for Suicide Awareness month were created to share community partner events and educational resources.

Marketing Content

- Media Campaigns and Toolkits: SVP strategies continued to promote statewide and local campaigns including “Know the Signs” and “Take Action for Mental Health”
- Keep It Safe Campaign: This campaign has expanded outreach to audiences on the topic of safe storage of potentially dangerous items. The target audience is any and everyone in the community living in homes. Keep it Safe is about starting a conversation with Humboldt County residents about protecting loved ones from preventable injury. Keep It Safe addresses common items found in homes that could be dangerous such as medications, alcohol, firearms, and anything else that can be used to get high.
- Awareness Months: SVP will continue to collaborate with community partners on awareness month campaigns throughout the year. The intention will be to raise

awareness on mental health, suicide prevention, and their intersection with various health disparities. Collaborative campaigns will include Suicide Prevention Month, Mental Health Month, Sexual Assault and Child Abuse, Domestic Violence Awareness Months

Outcome Measurements
The social marketing strategy or media platform will dictate the type of measurements used for each outcome.

- Number of annual page views for DHHS SVP Program website
- Audience reached by radio PSAs (estimated)
- Number of emails opened

Expected Outcomes FY21/22

- 1000 people through the DHHS Webpage
- 60,000 through radio PSAs
- 2,000 emails opened

Actual Outcomes FY21/22

- 845 annual page views for DHHS SVP Program website
- Eleven different radio PSAs were aired, totaling 820 “radio spots”
- 5,174 emails opened

Projected Outcomes (FY2023-2024)

- 600 people through the DHHS Webpage
- 60,000 through radio PSAs
- 3,000 emails opened

Challenges
It is challenging to measure the reach and demographics of some social marketing activities. For example, radio stations provide their total audience and number of radio spots, but no data on how many people are listening during the time of the public service announcements. It is difficult to conclusively determine the total reach (contacts) by all campaign activities each year, though there is strong data to suggest that thousands were exposed to SVP program social marketing. The firewall that many agencies use prevented some from receiving educational emails sent through bulk listserv. Despite this, the average open rate was 29.4% compared with the average for government being 25.5%. Note, email open rate was calculated by dividing the number of unique emails opened by the number of emails sent – after deducting the number of bounces.

Successes
It has been helpful to use State and National messaging campaigns that have already been tested for efficacy. Using the Mailchimp landing page as an access point for

subscribing to the email list and sharing information on program topics has increased community awareness and engagement. The variety of topics covered in educational emails through Mailchimp was high. Forty-nine (49) education or resource focused emails were sent to an average of 365 recipients each time. A press release in honor of September as Suicide Prevention Month was also released and can be found here: https://humboldtgov.org/CivicAlerts.aspx?AID=4204

Lessons Learned
The SVP program learned to better utilize the DHHS' social media platforms to share education and resource information as well as, to communicate with listserv members how to avoid firewall issues preventing them from receiving emails.

Prevention & Early Intervention: Parent Partners

The Parent Partner Program's vision is to provide support, encouragement, and hope to parents/caregivers who are feeling overwhelmed as they find themselves involved with a challenging and complex child or adult-serving system. It is an early intervention program and provides access and linkage to treatment. It meets the SB 1004 priorities of addressing childhood trauma prevention and early intervention and assists in the early identification of mental health symptoms and disorders. Parent Partners develop and maintain a practice to increase opportunities for parents/caregivers to receive peer-based support services as they encounter county child and adult-serving systems through strategic self-disclosure of their lived experiences as parents of a youth or family member with emotional, mental health or substance abuse needs. Parent Partners provide support as a peer, rather than an expert in the field, and help to create conditions for parents/caregivers to feel empowered and confident as they navigate these county systems, making decisions that are best for their family and determining their course of action based on their families' needs and goals. Parent Partners model effective personal interactions while supporting the development, reconnection and strengthening of natural supports for families. They serve as a mentor to improve parents/caregivers' confidence and ability to self-advocate for and effectively manage the services and supports for their own family. They empower families to identify their own future vision of what their family can be, what they need most to achieve this future, and how they can use their strengths and culture to get those needs met. The services of Parent Partners can contribute to meeting the need for additional services and supports for school age children.

The Parent Partner Program currently employs three full-time staff to provide supportive services to parents/caregivers involved in the DHHS systems of Child Welfare, and Behavioral Health, along with the Probation Dept. and Humboldt County Office of Education. In addition to on-going trainings, two Parent Partners have begun the process of becoming certified Medi-Cal Peer Support Specialists.

As part of the Parent Partner program structure, a Parent Partner III position is used to take on more responsibility for training and mentoring staff. There are currently recruitment efforts happening to fill this position to support this important program. There is also one vacant full-time and one vacant half-time Parent Partner I/II positions. The County continues to contract with a part-time Family Liaison/Mentor with lived experience and dedicated involvement in the National Alliance on Mental Illness (NAMI), who teaches Parent Partners "NAMI Basics" and "Family to Family" curriculum to enhance and develop various types of skills and co-facilitate both the peer support groups and the Family Advisory Board.

Target Population:
The target population includes any parent or caregiver of a youth or adult involved in a child or adult-serving system such as a Children's or Adult Behavioral Health programs or Child Welfare Services. In addition, these services will impact the well-being of families which may include children and other natural supports.

Key Activities:
Parent Partners offer assistance in navigating the DHHS systems, collaborative linkages with community resources, building natural supports, and identifying needs, strengths, skills, and goals to promote family wellness. Parent Partners are often members of Child and Family Teams serving youth with intensive needs. Parent Partners build alliances with other departments and agencies including Probation and Child Welfare Services to assist parents/caregivers whose children have been placed out of county or are currently in programs like probation's New Horizons program or a Short-Term Residential Treatment Program (STRTP). Parent Partners coordinate with the Children's Mobile Response Team so that families with children in crisis are quickly offered support and resources. In addition, Parent Partners are co-facilitators at the County's Family Advisory Board meetings and several NAMI peer support groups offered throughout the county. They are available to parents/caregivers of children or adults receiving services within the Adult Behavioral Health system by being available to families and staff during visitation hours at the Sempervirens Psychiatric Health Facility. Finally, Parent Partners may help staff the DHHS Warm Line bringing their peer-based expertise to support community members seeking services or supports.

Expected Outcomes:
The Parent Partner Program reaches out through meetings, referrals, and support groups to an average of ten people per week. Outreach efforts are done primarily at Sempervirens (SV), Family Resource Centers, the Jefferson Community Center, and directly to families and caregivers in the community. Parent Partners are expected to attend various meetings within the DHHS system to provide the critical perspective of those with lived experience.

Parent Partners are expected to complete an opening, annual, and closing Parent Support Tool (PST) for each parent/caregiver served. Expected outcomes via the PST include:

1. An increase in the presence of the family's support system
2. An increase in the acceptance of the family's support system
3. An increase in the ability to be heard by service providers
4. An increase in the ability to cope with stress
5. A decrease in the impact of transitions

How Outcomes are Measured:
The current outcome tool is the Parent Support Tool (PST). The PST should be completed at the beginning, annually, and at the end of services. The PST measures presence of the family's support system, acceptance of the family's support system, ability to be heard by service providers, coping with stress, transitions, impact, and timing. In addition to the use of the PST data from the CANS (Child and Adolescent Needs and Strengths), a state mandated reporting tool used with our children and families, is included. While Parent Partners are not currently responsible for completing the CANS most of the cases that they are involved with should have a CANS attached to it. Currently there are 46 paired samples for children and youth served by a Parent Partners with both an initial and follow up CANS. Data shows no change in the overall number of actionable needs from initial to follow up CANS.

Estimated Number to be reached in FY 2023-2024:
For the next year an estimated 90 new parents/caregivers will be reached either through a referral for services or attendance at a support group. The expectation is that all current and new cases will have a PST completed at the beginning, annually, and at the time of closure to services.

Report for Fiscal Year 2021-2022

Unduplicated Number of Individuals Served:
For FY 21/22 the Parent Partners served 92 unduplicated parents with 60 new referrals. Overall, 92 unduplicated families received services from a parent partner.

Demographics of individuals served:

- 17 completed voluntary demographic forms
- AGE: Fifteen clients indicated ages 26-59, 2 clients were age 60+.
- RACE/ETHNICITY: 12 White; 1 Black; 4 American Indian or Native American
- SEXUAL ORIENTATION: 15 heterosexual/straight; 1 Bisexual; 1 preferred not to answer about sexual orientation
- LANGUAGE: English was primary language for all

- HOUSING: 12 have been homeless or lived on the streets; 5 answered no
- MENTAL ILLNESS: 14 have been diagnosed with mental illness; 1 preferred not to answer; 2 indicated No
- 14 have family members with diagnosed mental illness; 2 have family members with undiagnosed mental illness; 1 didn't answer

Actual Outcomes for Fiscal Year 2021-2022

At intake, the Parent Support Tool showed:

- 46% report the Presence of the Family Support System "some of the time" and 23% report the Presence of the Family Support System as "very present"
- 33% "feel accepted about many things" about their family support system and 25% "feel accepted by all things" about their family support system
- 33% feel that they are "likely to have some disagreements" with service providers while 46% feel "they will likely be understood and appreciated" by service providers
- 70% report that they have multiple stressors in their life
- 54% will be facing 1-3 transitions and decisions within the next 60 days
- 84% of parents were given a score between 9-12, indicating the need for a moderate level of support

There were not enough matched pairs to make for significant data analysis. Of the matched pairs analyzed all showed improvements in one or more PST categories including a positive decrease in their overall total score from intake.

Parent Partners complete Medi-Cal billing for those parents that they serve that are eligible. Most parents/families served are eligible for Medi-Cal. However, in some limited cases Parent Partners do offer short term non-billable services to parents and families that may not have current Medi-Cal. The table below lists billing data taken from our Electronic Health Record system for the reporting period.

PARENT PARTNER SERVICES FY21/22	#
Number of Individuals Receiving Services	92
Total Number of Services Provided	619
Total Number of Minutes Provided	45,821
Average Number of Minutes Per Service	74
Average Number of Services Per Client	7

Challenges:

The COVID-19 pandemic continued to create many challenges in the last fiscal year. Staff have had to continue to adapt services to maintain social distancing, such as meeting remotely with parents or offering groups remotely/hybrid or in different settings. There continue to be no supervisor for this program and several senior staff have left the team.

However, the current Parent Partners have been able to meet the needs of the majority of referrals.

Successes:
During this current year the number of parents served has increased, and despite the staffing challenges, an experienced and dedicated Parent Partner team continues to exist. Parent Partners have applied for state certification as Medi-Cal Peer Support Specialist which will add another layer to their skill set and create more flexibility in their ability to bill for services. Parent Partners have developed a comprehensive on-boarding document full of resources and tools for peer-based services. These resources have already been invaluable in supporting our newest Parent Partner as they start their journey as a peer.

Lessons Learned:
Staff continue to come up with innovative ways to support one other and provide high-quality services to families. Despite not having a supervisor for this program for many years, staff have adjusted and taken on more leadership roles and ownership of the program. With access to quality training and professional experience development, staff have continued to overcome many obstacles that the pandemic and staffing challenges have wrought. Parent Partners continue to be an integral part of the Specialty Mental Health Services that Humboldt County provides. The goal is to increase the staffing levels on this team and make this important service even more available in the community.

Prevention & Early Intervention: School Climate Transformation - Multi Tiered System of Support – MTSS

Increasing the recognition of early signs of the mental health needs of children in a school setting has been an identified need of the MHSA Community Program Planning Process (CPPP) for years. It remains as an identified need through the current time, with the CPPP of the prior Three-Year Plan showing that increasing support for school age youth, and providing more behavioral health supports in schools, are priorities for the community. This input led to DHHS-Behavioral Health and the Humboldt County Office of Education (HCOE) developing a shared plan to address the need, and enter into a Memorandum of Understanding (MOU) to continue to develop a Multi-Tiered System of Support (MTSS) Coalition to implement the Positive Behavior Interventions and Supports (PBIS) framework of evidence-based practice. This partnership has been in place since 2016. The only change in the support provided since the beginning is that MHSA now supports a position that is shared between DHHS-Behavioral Health and HCOE. This position, the Prevention and Intervention Specialist, is responsible for the management, on site coaching, development, coordination of services, professional development, technical assistance, MTSS, PBIS, Social Emotional Learning (SEL), Restorative Practices, Universal Design for Learning (UDL) and other practices promoting inclusive and

equitable learning opportunities for all students in Humboldt County. The position serves as project manager; establishes and implements district services and technical assistance across these frameworks; coordinates and facilitates various county communities, staff development and leadership activities; and provides leadership in the design, implementation, and maintenance of innovative practices that support student achievement. The MTSS Program is a prevention and early intervention program that will impact the identification of early signs of emotional disturbance (mental health needs) in children and youth, while promoting social-emotional wellness for all students. It meets the SB 1004 priorities of childhood trauma prevention and early intervention, youth engagement and outreach targeting secondary school youth, and provides early identification of mental health symptoms and disorders.

MTSS is a framework to support schools in identifying and utilizing evidence-based practices and data-based decision making to enhance student academic, social-emotional and behavioral outcomes. Research shows that when a child experiences behavioral and/or emotional difficulties in the school environment they also suffer academically. MTSS is a framework that aligns and coordinates evidence-based practices and incorporates School Wide Positive Behavior Interventions and Supports (PBIS) to create systemic change aimed at positively influencing social and academic competencies for all students. Additionally, the framework includes responsive and effective social-emotional learning, and inclusive practices for all student groups.
Schools utilizing a multi-tiered framework responsive to student needs through early systematic intervention have fewer discipline referrals, decreased special education referrals, decreased suspensions and expulsions, and show higher academic achievement scores.

MTSS offers the potential to create needed systematic change through intentional design and redesign of services and supports that quickly identify and match the needs of all students in general education contexts.

The following core components are key aspects of MTSS frameworks:

1. High quality, inclusive academic instruction promoting comprehensive assessment systems, teaming, universal academic supports, and intensified interventions and supports focused on early intervention and prevention.
2. Systemic and sustainable change. MTSS principles promote continuous improvement processes at all levels of the system (district, school site, and grade/course levels). Collaborative restructuring efforts identify key initiatives, collect, analyze, review data, implement supports and strategies based on data and then refine as necessary to sustain effective processes.
3. Integrated data system. District and site staff collaborate to create an integrated data collection system for continuous systemic improvement.

4. Inclusive behavioral instruction. District and school staff collaboratively select and implement schoolwide, classroom, and research-based positive behavioral supports for achieving important social and learning outcomes.
5. Social-emotional learning (SEL) for all students using evidence-based methods.
6. Universal design for learning (UDL) – structural, multi-modal, instructional practices promoting learning for all students. UDL learning environments are inclusive environments for students with a vast array of learning differences.
7. Family and community engagement to build trusting family and community partnerships.
8. Inclusive policy structure and practice by building strong district/school relationships with the coordination and alignment of multi-initiatives through district policy frameworks.

Target Population

One of the strengths of the MTSS framework is that it includes all student groups and moves to improve social-emotional, behavioral, and academic outcomes. The Tiered System is a comprehensive approach to identify needs early and intervene with effective interventions targeting student need. The tiers include academic, behavioral, and social-emotional learning. Tier One (Universal) represents the intervention/instruction for all students. Tier One strengthens the systematic delivery of behavioral and social emotional learning and promotes the use of universal screening across these important three instructional domains. With a robust Tier One, universal screeners are identified by districts and school site teams to determine students with the need for intervention. This methodology provides systematic early intervention across the domains and promotes response to intervention. Tier Two interventions are less intensive, small group interventions for students needing a little extra. Research demonstrates that effective Tier Two interventions are conducted with a small, targeted group with the goal of reversing the difficulty and returning the child into the Universal whole-group instruction. Tier two interventions reduce the numbers of students needing intensive individualized interventions. The need for special education or intensive mental health intervention is reduced when preventative early interventions are implemented. Tier Three interventions are intensive and individualized. These interventions require more time and resources. A larger need for Tier Three interventions exists when Tier One and Tier Two are not established with fidelity.

MTSS, PBIS, and SEL are equitable practices that include all student groups. The practice is trauma-informed and considers the whole-child. Student mental health, outcomes (across academic, behavioral, and social emotional), wellness, inclusion, and attendance are all interventions targeted to ALL student groups.

Key Activities

Key activities include technical assistance, teaming, and coaching. Explicit training in restorative practice/justice, classroom and behavior management, effective school

teaming, inclusive discipline practices, trauma-informed instruction, cultural competency, threat assessment and crisis response, and aspects of wellness (student and staff). The MTSS domains that support the areas of integrated instruction are:

– administrative leadership, integrated educational framework, family and community engagement, and inclusive policy structure and practice. Activities to strengthen these domains are many – examples are working with a team on establishing inclusive discipline policies or working with administrators to support comprehensive strategies and leadership strategies. These are elements of lasting system change. Lasting change requires technical assistance and coaching to support transformative practice. Meaningful data sharing, administrative leadership, and teaming with staff participation are the primary elements of lasting systematic change. Engagement with districts will guide and support these important elements.

Outcomes to be measured

Outcomes may include student discipline, disproportionality of student groups, student attendance, office discipline referrals, suspension and expulsion, referrals to special education and/or mental health, academic performance, rates of student inclusion, and opportunity and rate of community engagement.

Outcome measures

Fidelity Measures: District and school site teams will conduct fidelity measures and make inclusive data-based decisions based on these tools. Some of the measures include Fidelity Integrity Assessment (FIA – a district and site-based tool for MTSS implementation), The Tiered Fidelity Inventory (TFI – a site-based Team assessment to measure the implementation of PBIS/SEL), The Self-Assessment Survey (SAS – a site-based survey of all school personnel to measure the perceptions and priorities of PBIS/SEL implementation. These measures often occur two times an academic year to guide intervention practices.

Behavioral Data: The School-Wide Information System (SWIS, pbisapps.org) is the gold standard tool to guide and support PBIS implementation. Student behavior is tracked and defined as “minor vs. major” behaviors (often differentiated by classroom managed or office managed behaviors). SWIS provides instantaneous rich data that informs whole school, select groups, or individual need. Interventions are effective when data driven, and SWIS provides a tool to inform interventions and effectiveness. Additionally SWIS is a powerful tool to identify disproportionality of specific student groups. The Prevention and Intervention Specialist will provide facilitation, technical assistance and training of SWIS.

Existing Data Sources: Local and state resources (i.e., the CA Dashboard, the Healthy Kids Survey, and school data base systems) are pre-existing measures that will reflect the

impact of transformative system practice. Attendance, referrals, suspensions, disproportionality, and community engagement are data sources that will be examined. MTSS is endorsed by the CA Department of Education, and the CA Department of Special Education, as an evidence-based framework designed to respond to indicators of student need statewide (Differentiated Assistance, DA, Comprehensive Support and Improvement, CSI, Performance Indicator Review – PIR, and Disproportionality – DisPro). Additionally, the CA Department of Education endorses the examination of exclusive disciplinary practices (suspension and expulsions) and the promotion of inclusive disciplinary practices (Restorative Practices, and school wide PBIS) to reduce lasting maladaptive behaviors in our communities and decrease involvement in the juvenile justice system (that increases likelihood of adult incarceration).

Estimated numbers to be reached

With the CA MTSS Initiative there is a slogan that states, “equity in education, ALL means ALL.” And this underscores that all student groups are reached by comprehensive systematic practices. Data sources and analysis of these sources will demonstrate the reduction of intensive individualized intervention leading to special education referrals, mental health referrals, chronic absenteeism, and exclusive discipline actions. Students in need of intensive individualized interventions will be identified and served and will have the opportunity for pre-referral interventions to promote success and inclusion. Culturally responsive community engagement will strengthen our educational and greater community integration – supporting robust avenues of engagement.

Report for Fiscal Year 2021-2022

There are approximately 17,608 students enrolled in Humboldt County public schools.

- 55% are White
- 20% are Hispanic/Latino
- 9% are American Indian/Alaska Native
- 10% are Other
- 4% are Asian/Pacific Islander
- 1% are African American
- 1% Unknown
- 7% are English Language Learners
- 59% are Free and Reduced Lunch eligible students
- 15% are Chronically Absent

MTSS Key Activities include technical assistance; training in Restorative Practices, PBIS fidelity measures and analysis, team building, Inclusive Discipline Practices (Restorative Conferencing as alternative to suspension/expulsion); training in Inclusion and Universal Design for Learning (UDL), stakeholder meetings, DHHS/Educational Leadership

activities and steering committee for Humboldt Bridges to Success; and planning for Phase Two and the establishment of Prevention and Intervention Services at HCOE.

Outcomes are measured by CA Dashboard, EdData, SWIS (School Wide Information System), Special Education Referrals, Office Discipline Referrals, Chronic Absenteeism, Suspension/Expulsion, Staff and Community Surveys and Fidelity Measures of Implementation. These will all be highlighted by individual districts for Phase Two of scaling up MTSS efforts.

Activities Supported by PEI Funding 2021-22
Was this past school year a typical year?

As many can attest, from the beginning of school closures in March of 2020 - and for many local districts until the Spring of 2021 this has been an exceptionally challenging year for students, school staff, families, and the community at large. Never in our recent history have schools been so challenged to meet social emotional and academic needs.

A silver lining of the pandemic for all of civilization has been technology, and the educational system was among the benefactors of the ability to remain connected. Of course, the challenge was immense – from connectivity to chronic absenteeism to simply not participating and having the computer camera off. All of these challenges potentially indicate a myriad of conditions – inequity, poverty, or potential mental health concerns. Schools locally and across the country witnessed an increase of student risk from non-participation to suicidality. The American Academy of Pediatrics reported suicidal ideation 1.6 times higher in March and July of 2020 compared the same months a year prior (published 2020). The authors say that hospital visitations were reduced during COVID, so the number is likely an underestimation.

During the 2020-21 academic year the Humboldt County Office of Education established a new department – Prevention and Intervention Services. The department consists of a director and two Prevention and Intervention Specialists. One of the Prevention and Intervention Specialists is a shared position with the Department of Health and Human Services. The onboarding process of a new department during distance participation, while interesting was highly successful. At the beginning of the 2021 academic year the department welcomed a third Prevention and Intervention Specialist for Early Childhood Mental Health, as well as the Nutrition Department. The growing department is a testament to the organizational commitment to student wellness.

Below is a summary of the new Prevention and Intervention Department:

Prevention and Intervention Services
Summary of Activities 2020-2021

Brief History

In 2015 the Humboldt COE moved to systemically support the 31 rural school districts with the establishment of the Northern CA MTSS Coalition (Multi-Tiered System of Support). Preceding CA MTSS (SUMS) by a year – the statewide initiative between California Department of Education, the SWIFT Center/University of Kansas, Orange County Department of Education, and Butte County Office of Education – the Coalition was informed by best practice intervention with the vision of providing districts tools and assistance toward improving the outcomes for all student groups. Humboldt County is challenged, tied with Mendocino County, with the highest rate in the state of Adverse Childhood Experiences (ACEs) per capita, some districts have special education rates double the state average, in addition to high suicide and homicide rates. These and other social challenges reside in the majesty and vibrant beauty that is the North Coast of CA.

In 2016 HCOE assumed the lead for Region 1 of the CA MTSS (SUMS) and became a leader for technical assistance with the scaling-up of MTSS. MTSS is a framework organizing behavioral, academic, and social-emotional instruction and intervention. As the state recognizes – systemic change promoting responsive and effective early intervention in equitable and inclusive learning environments, not only improves student outcomes, but embraces the whole-child and ultimately improves quality of life for the individual as well as the community at large.

In response to district need and state and national recommendations, HCOE established Prevention and Intervention Services to work across departments within the organization, as well as leveraging resources with local community agencies, native entities, and statewide partnerships – all to strengthen and align the organizational ability to best serve districts, students, and their families.

Integrated mental health services, effective academic instruction, PBIS (Positive Behavior Intervention and Supports), inclusive discipline practices/Restorative Practices, Social-Emotional Learning, UDL (Universal Design for Learning), anti-racism support, and Inclusion are the drivers of our collaborative efforts. Below is a summary of collaborative activities that HCOE has engaged to support local districts with the shifting educational priorities and initiatives.

Current Activities

In the 2020-21 academic year, HCOE in partnership with the Department of Health and Human Services (DHHS) and Project Cal-Well committed to strengthen and increase the organizational capacity to assist districts with the scaling-up of Multi-Tiered System of Support (MTSS) fidelity of implementation. The Prevention and Intervention Department (P&I) was established in academic year 2020-21 – with 3 FTE team members – a Coordinator of the department and two certificated Prevention and Intervention Specialists. This increased capacity created an opportunity for districts to engage in training, coaching, and technical assistance for continuous improvement of school climate transformation.

With a focus to become a regional leader and resource in the north state, staff have partnered with state leadership to build capacity. HCOE has partnered this year with the Placer County Office of Education/CA PBIS Coalition to adopt an established research-based scope and sequence of PBIS district implementation support. The P&I Department has completed tier one of the “trainer of trainer” model (ToT), and engaged three districts with training for PBIS Tier 1 implementation. Additional districts will move through Tier 1 training next year, as the cohorts from this academic year will move into the Tier two scope and sequence.

The P&I Department is also in partnership with the Placer County SELPA and working closely with three local districts with coaching and district support for implementation of Universal Design for Learning (UDL). Other additional capacity building activities include: coaching one of the 20 awarded districts in California that was awarded the Phase 2 grant to support district-wide training in CA MTSS with Orange County Department of Education; both specialists trained as School Wide Information System (SWIS) facilitators; both specialists becoming licensed trainers with the International Institute for Restorative Practices (IIRP); and working with Sacramento Department of Education and CalHOPE by scaling-up district support to scale-up Social Emotional Support Learning (SEL). District SEL “champions” are receiving stipends to build implementation and sustainability plans for the implementation of SEL and participate in the Community of Practice (CoP) with the important focus on adult SEL as well. The P&I Department launched this year the North Coast Service Providers Consortium (NCSP) with the focus of building relationships with county agencies, tribal entities, and school personnel with the goal of better understanding resources and services available for children and families in our rural county. The SEL regional support also includes a North State SEL CoP that consists of COE leaders who meet monthly to share resources and strategies for district support in rural California.

Other priorities of the P&I department include exploring sustainable models of mental health access for all students, suicide prevention and postvention, systematizing and coordinating crisis response for districts, and building international learning opportunities for tribal students and families (in partnership with a university in Taiwan).

Prevention and Intervention Services – HCOE – Primary Initiatives 2021-22

Positive Behavior Intervention and Supports – PBIS – PBIS, the most widely researched and endorsed behavioral education framework is a nationally recognized practice to support student outcomes.

Some exciting changes for the 2021-22 with PBIS is, given the expanded FTE capacity for technical assistance and coaching, that the P&I Department has engaged cohorts of districts to do a “deep dive” of PBIS implementation. In the 2022-23 year staff will be embarking with the fourth cohort of PBIS training/implementation. Each cohort participates in a state endorsed scope and sequence lead by Placer COE and the CA PBIS Coalition (CPC). An additional advancement of this important evidence-based framework promoting mentally healthy school communities is that HCOE has become a technical assistance (TA) center for CA PBIS for Region 1 (Sonoma, Lake, Mendocino, Humboldt, and Del-Norte). Additionally, the P&I Department sits on the executive committee of the CPC. This not only promotes improvement of cross county collaboration, but it brings resources to the department to further the systematic efforts to improve and increase PBIS implementation.

California Multi-tiered System of Support (CAMTSS) (see definition below) in partnership with Placer COE is leading the CA Integrated Supports Project (ISP) which is part of CAMTSS. The primary target of this initiative is to integrate social emotional learning (SEL) into the tiered interventions of PBIS and to integrate SEL into systematic supports. Humboldt County is one of six counties statewide engaged in this work.

Universal Design for Learning – UDL – UDL is an equitable and inclusive educational practice that promotes access to learning for all student groups. With a focus on multi-modal instruction and expression of competency, it promotes the curriculum that teaches across the spectrum of learners opposed to the traditional approach of teaching to the average and then providing modifications for those who excel or struggle. Prevention and Intervention Services, in partnership with the Humboldt/Del Norte SELPA, and the Placer County SELPA, are providing training, technical assistance, and direct coaching to teachers.

Supported by Educator Effectiveness Funds to provide stipends for teachers, HCOE in partnership with the Humboldt Del-Norte SELPA and Placer County SELPA has launched a multi-year project – the Humboldt County UDL Consortium. The goal is to create well trained champion teachers implementing UDL in their classrooms. Participating districts target partnerships between special education and general education teachers – and with TA and Coaching – create model classrooms in Humboldt County. This network approach is to create a collaborative of highly trained teachers that in turn become UDL coaches for additional teachers engaging in the process over the next five years. Curriculum being used is Open Access training which is an evidence-based curriculum endorsed by the state of CA.

Social Emotional Learning – SEL – An increasingly endorsed and recognized domain of education is social emotional learning. Research indicates adult SEL is an essential practice to equip teachers to best serve their students. In partnership with Sacramento COE Community of Practice - CoP (CalHOPE/FEMA SEL initiative), the North State SEL CoP (a consortium of rural CA COE leaders), and local districts (the Humboldt County SEL CoP), HCOE is leading district champions of SEL with technical assistance and support as districts work to scale-up the implementation of social emotional learning. The vision is to promote staff, student, and community wellness by promoting "mentally healthy" learning environments. HCOE has lead districts through training experiences that address COVID related anxiety and community impact, the importance of self-care, student intervention approaches, equity in education, and universal screening for mental health needs.

CalHOPE has new components as it enters Phase Two of this work, and is continuing to provide universal supports for all districts. Three school sites have been identified to be "focal schools". This initiative, under the direction of CA Department of Education and Sacramento COE, are leading the scope and requirements of this work to improve SEL. The identified schools are Captain John Continuation School (Klamath Trinity Joint Unified School District (KTJUSD)), Peninsula School, and Miranda Junior High (Southern Humboldt Joint Unified School District (SHJUSD)). These schools will be supported with TA and fiscal support through CalHOPE. Staff and teams from local districts participating in CalHOPE are also being underwritten to attend the CA PBIS Conference in Oct. 2022.

CA MTSS – HCOE continues to work closely with the CAMTSS. Humboldt remains the Region 1 lead for CA MTSS and provides TA and Coaching at regional coaches meetings (this activity brings revenue into the department and makes Humboldt COE among 18 lead agencies for MTSS support in the state). In this past year CA MTSS has

launched Phase 3 of district support. While continuing to support all phases of the initiative, Phase 3 is furthering the targeted intent of Phase 2B.

Phase 2B, like Phase 3, incentivizes districts to participate in the CAMTSS Pathway Course Modules. Currently South Bay School District, and Loleta School District are participating in the Pathway Course. Teachers and school personnel receive stipends to participate in the Pathway Course. Originally four other local districts applied and rescinded their awards because administration and teams felt that the ask was too much – that 90% of the district staff would participate in the modules – which averages 40-60 hours of rigorous online training. CAMTSS in response to this common statewide response changed their expectations and districts appear more willing to consider engagement in this professional development opportunity.

Restorative Practices – RP – in 2022 HCOE increased their team to four certified trainers with the International Institute for Restorative Practices (IIRP) and is the lead COE in the newly established Restorative Educators Network (REN). In 2022 REN became a recognized group by the CA Department of Education and is housed on the web platform CA Educators Together. This growing network, in partnership with HCOE, Butte COE, and Orange County Department of Education, has had a presence at conferences and continues to work to bring restorative practices to CA public schools and agencies. Conference presentations have occurred at the Association of Positive Behavioral Support (APBS), the Professional Learning Institute (PLI/CAMTSS/OCDE), and the CA PBIS Coalition Conference (CPC).

HCOE has trained hundreds of educators in Humboldt County in Restorative Practices and continues to partner with National Chung Cheng University in Taiwan to advance the global movement of Restorative Practice in Education. IIRP trainings include Introduction to Restorative Practices/How to Run Circles Effectively, and Restorative Conferencing (an inclusive discipline practice in place or in lieu of suspension/expulsion). Additionally, the Prevention and Intervention Department provides abbreviated district trainings, as well as onsite coaching and support to districts. Active partnerships exist with neighboring Del-Norte COE, and Juvenile Hall/Probation. The Restorative Educators Network (REN) was launched this summer to support Restorative Practices in education nationwide.

In the first two months of the 2022-23 academic year RP training to six local school districts was provided, there will be support for the administrative team of local high school district administrators, training to Juvenile Hall staff will be provided, an IIRP two-day training for all educators at the Sequoia Conference Center/HCOE was offered, and quarterly statewide REN zoom meetings have been presented and calendared.

Of significant import is the passing of ***AB-2598 Pupil rights, restorative justice practice***. This states that:

(a) "the department shall develop evidence-based best practices for restorative justice practice implementation on a school campus and make these best practices available on the department's internet website for use by local educational agencies to implement restorative justice practices as part of efforts to improve campus culture and climate. In developing best practices, the department shall consult with all of the following to identify best practices for effective evidence-based restorative practices in elementary and secondary schools:

1. School-based restorative justice practitioners
2. Educators from public schools serving kindergarten and grades 1 to 12, inclusive.
3. Pupils from public schools serving kindergarten and grades 1 to 12, inclusive.
4. Community partners or community members.
5. Non-profit and public entities.

(b) When developing best practices pursuant to subdivision (a), the department is encouraged to, to the extent feasible, take into account resources and best practices that have been identified or developed as part of aligned efforts, including, but not limited to, the Scaling UP MTSS (SUMS) Initiative, the California Community Schools Partnership Program, and resources developed by the department in support of social emotional learning.

(c) For purposes of this section, local educational agency" means school district, county office of education, or charter school.

The above law, effective "on or before June 1, 2024, is a strong affirmation of the ongoing efforts of HCOE in partnership with DHHS and local LEAs, Community Based Organizations (CBOs), and statewide partners, that Humboldt County is a leader in the state of CA with the advancement of Restorative Practices and Restorative Justice.

Integrated Mental Health Services – In partnership with the Department of Health and Human Services, the Humboldt/Del-Norte SELPA, and local district leaders, HCOE is engaged in the important work of establishing integrated mental health access for all students. This collaborative shared vision has developed over years of collaborative partnership, and the current grant funded Humboldt Bridges to Success program. The advisory committee is exploring sustainable funding models and working to a model of Integrated Systems Framework (ISF) to promote integrated mental health for the students of Humboldt County.

Student Behavioral Health Incentive Program (SBHIP) provides information on a new $389 million statewide initiative administered by the California Department of Health Care Services (DHCS) to allow school districts to partner with county behavioral health and Medi-Cal managed care plans to expand access to school-based mental health services. 2021-22 marks the beginning of the assessment period for SBHIP. Community partners are providing input and include:

- Department of Health and Human Services, Behavior Health Branch
- Department of Health and Human Services, Public Health Branch
- Two Feathers Native American Family Services
- Cal-Poly Humboldt Social Work Department
- Humboldt/Del-Norte SELPA
- Humboldt Independent Practice
- Partnership Health Plan, managed care plan.
- Three LEAs
    - Court and Community School
    - Southern Humboldt Joint Unified School District
    - Peninsula School District

The objectives of SBHIP are to break down silos and increase access to school-based mental health for all students in Humboldt County. The Prevention and Intervention Department is leading this effort for the COE in deep engaged partnership with community agencies and Partnership MCP. Additionally, DHHS/HCOE are partnering to create a new position – a Braided Funding Analyst – which will be dedicated to creating and identifying sustainable funding models and practices to support school-based mental health.

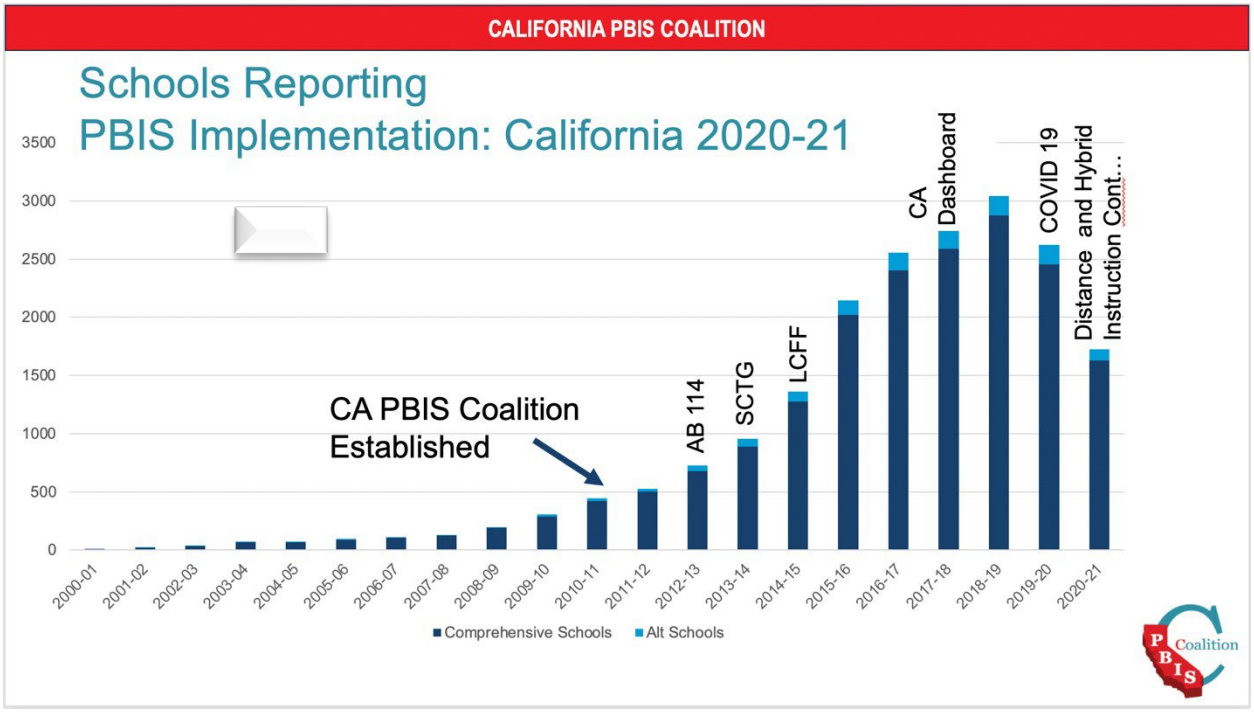
District Engagement Highlight – Court and Community School

PBIS/MTSS in Humboldt County

HCOE has built its capacity, over the past six years, with the partnership and support of DHHS and the Prevention and Early Intervention (PEI) funding support. At first fiscal support helped create the Northern CA MTSS Coalition, and then when the Prevention and Intervention Department was launched in 2020, the joint funding of 1.0 FTE Prevention and Intervention Specialist. With a department that includes two P&I Specialists, an Early Childhood Mental Health Specialist, a School Safety Director, and the Foster and Homeless Youth Team – the department is growing to match the significant need of our county.

2020-21 began Phase Two of PBIS/MTSS in Humboldt County, in part by a strengthened commitment to provide districts with the support necessary to truly scale-up fidelity across these important educational frameworks.

In the fall of 2020-21 the Humboldt County Office of Education initiated a cross-county collaborative effort with the Placer County Office of Education and affiliation with the California PBIS Coalition. Under the direction of Michael Lombardo, PCOE/CAPBIS is the state leader for assisting districts with PBIS implementation. The graph below depicts the growth of PBIS in CA (implementation by school).



The goal of partnering with the CA PBIS Coalition is for HCOE to become a technical assistance center for the North State of California. As part of this effort, the Prevention and Intervention Team identified an initial first cohort (South Bay School District), a second cohort (Freshwater School District and Cutten/Ridgewood School District), a third cohort (Southern Humboldt Joint Unified School District), and our newest 2022-23 Cohort (Peninsula and Trinidad School Districts) to work toward PBIS with a “deep dive” of PBIS implementation and fidelity. The CA PBIS Coalition and Placer COE have established a scope and sequence training sequence for district and site level teams. This requires a Commitment and Readiness Agreement between a district/school site and the COE to assure that the participating district is prepared to move through the three-year training series. Each year consists of four one-day trainings (year one focuses on Tier 1 universal interventions, year two focuses on Tier 2 focused group interventions, and year three on Tier 3 highly individualized intensive interventions). This systematic stepwise evidenced-based approach to systematic change will afford the county the opportunity with local demonstration schools to model implementation

and have outcome data to illustrate the importance of systems change that supports equitable educational learning for all student groups.

For this 2021-22 Annual Report, a district highlight will illustrate the level of support provided by HCOE and the P&I Department – a deep dive:

Court and Community Schools (including Eel River Community School and Eureka Resource Center Community School).

This LEA is comprised of a high number of high-risk students, many in need of special education, and/or mental health intervention. Great efforts have been made by this district over the past years to engage in many initiatives of school climate transformation. The district has engaged in SUMS CAMTSS, PBIS, restorative practice trainings, and numerous professional development opportunities focusing on trauma-informed practices.

Below are some data points for the Court and Community Schools (CCS):

Indicator	Average Pre-Pandemic	2020-21
Chronic Absenteeism	50.4%	80.1%
Suspensions	11.0%	2.0%
Expulsions	0%	0%
Graduation Rate	52.7%	51.1%
Drop Out Rate	33.7%	36.2%

In addition to the data presented above, of the entire enrollment of CCS: 95% qualify for free and reduced lunch, 5% or English Language Learners, 4% qualify as Foster Youth, and 36% experienced homelessness.

2020-21 schools were in session, but it was not a typical year. COVID protocols, staffing, and student adjustment were all challenges, as was the increased need for mental health interventions in the schools. As a nation the CDC reports that more than a third (37%) of high school students reported they expressed poor mental health during the pandemic, and 44% reported they persistently felt sad and hopeless during the past year (CDC Data March 2022). And while the pandemic highlighted the importance of mental health and positive school environments, the need for mental health was on the rise pre-pandemic. From 2009 to 2019 there were marked increase of students reporting persistent feelings of sadness and hopelessness (26.1% to 36.7%), seriously considered attempting suicide (13.8% to 18.8%), made a suicide plan (10.9% to 15.7%), attempted suicide (6.3% to 8.9%), and were injured in a suicide attempt (1.9% to 2.5%).

And while the pandemic has registered even more need – the trend was already indicating acute mental health needs for youth.

CCS has engaged the following initiatives to improve student outcomes and support staff and the community:

- PBIS – technical assistance and professional development with positive behavior interventions and supports to improve school climate and teach and reinforce prosocial and pro-academic behaviors.

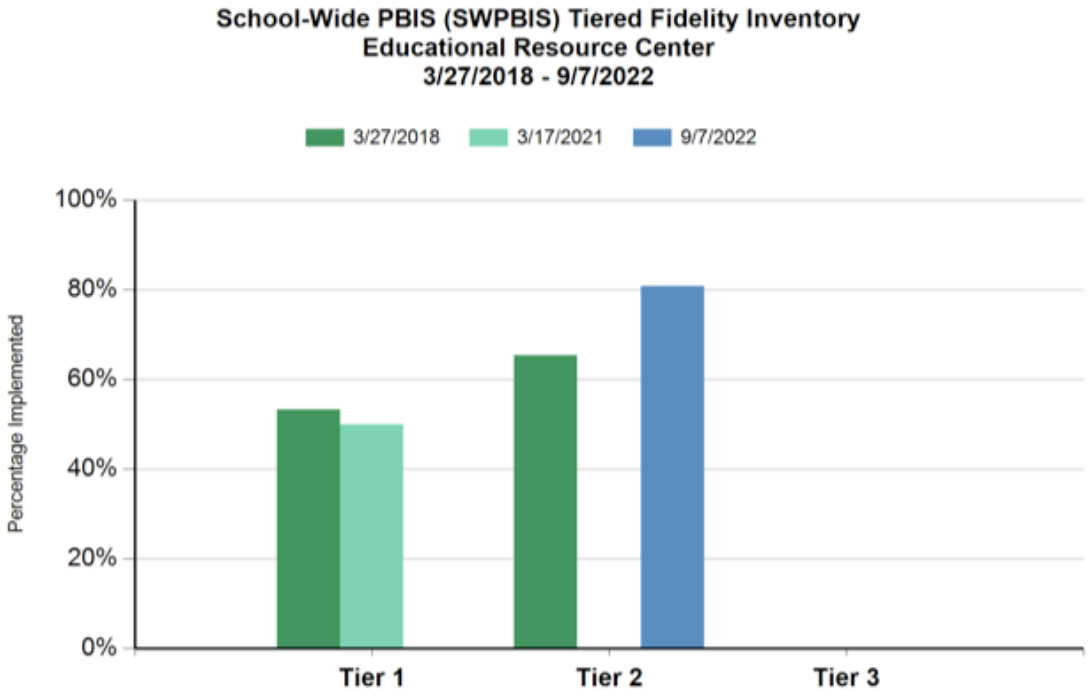
- SBHIP – CCS is an identified LEA participating in the Student Behavioral Incentive Program (SBHIP) to improve school-based mental health access.

- CA Community Schools Partnership Program CCSPP – to improve integrated support services, family and community engagement, collaborative leadership, and extended learning time opportunities.

- Restorative Practices – CCS has engaged in professional development in RP, as well as trauma informed practices to build community, connection, and restore problems before they become acute.

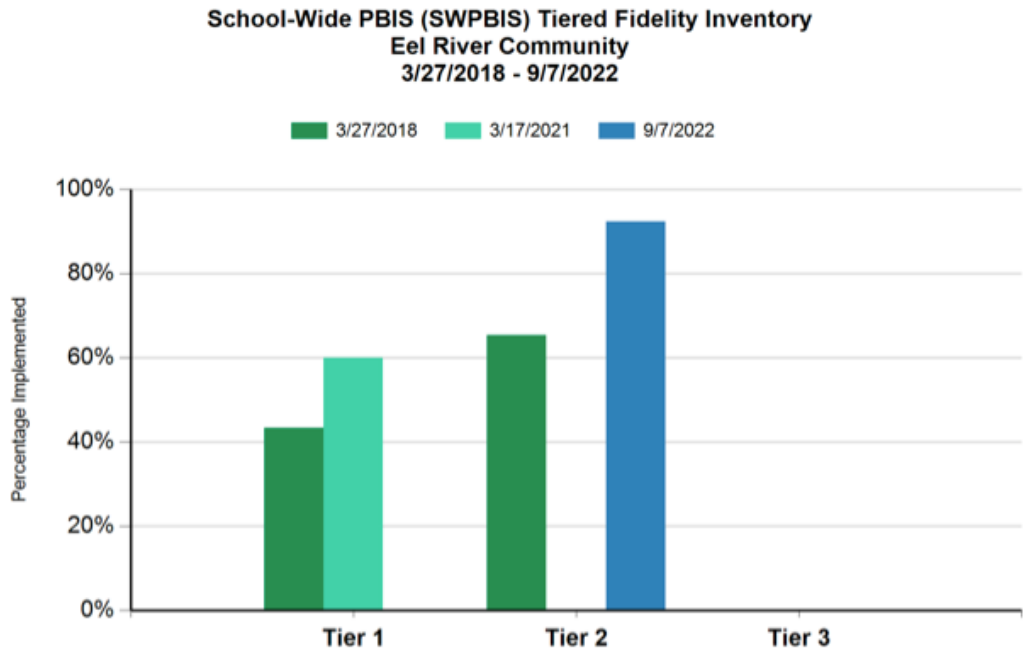
PBIS is a multi-tiered framework that coordinates and identifies supportive interventions and strategies for students. The Tiered Fidelity Inventory TFI Link is a fidelity measure that functions as a roadmap for coordinated implementation. Please see CCS TFI Scores for ERC and Eel River School Sites below:

Educational Resource Center
Eureka, California



Date Completed	Tier 1	Tier 2	Tier 3
3/27/2018	53%	65%	NA
3/17/2021	50%	NA	NA
9/7/2022	NA	81%	NA

Eel River Community
Fortuna, California



Date Completed	Tier 1	Tier 2	Tier 3
3/27/2018	43%	65%	NA
3/17/2021	60%	NA	NA
9/7/2022	NA	92%	NA

As indicated with technical assistance, coaching and support, CCS has shown a marked increase of the fidelity of implementation of PBIS. As evidenced of the decrease of suspension and the absence of expulsions (as seen in the table on page 126), CCS is putting preventative and proactive strategies in place to create opportunities for inclusive discipline practices.

Lessons learned for 2021-22

With the work with PBIS, RP, SEL and SBHIP – what is clear is that more than ever the need for positive school environments requires access to social emotional learning and school-based mental health supports. This is a priority of CA which requires collaboration, vision, and especially in rural CA – shared responsibility to deliver support that is impactful and lasting. The P&I Department and HCOE are grateful for the collaborative opportunities ahead and are committed to pursue sustainable funding models to increase collective capacity to improve and increase county capacity to offer mental health support to all student groups. The support and partnership with DHHS

and the support provided through PEI funding has greatly improved our ability to expand and improve the support that can be provided to local school districts. There is great hope for future collaborations for many years to come.

Prevention and Early Intervention: Local Implementation Agreements

In response to stakeholder input about the value of providing mini-grants to local communities, Prevention and Early Intervention dollars have been used for Local Implementation Agreements beginning in January 2019. Proposals are required to meet the guidelines, definitions and reporting requirements of the MHSA Prevention and Early Intervention Regulations, including having a focus on at least one of the following categories:

•Early Intervention
•Outreach for Increasing Recognition of Early Signs of Mental Illness
•Prevention
•Access and Linkage to Treatment
•Stigma and Discrimination
•Suicide Prevention

Local Implementation Agreements can address any of the SB 1004 priorities, depending upon what is approved for funding in any given year. Past projects have focused on culturally competent and linguistically appropriate prevention and intervention; strategies focusing on the mental health needs of older adults; youth outreach and engagement; and suicide prevention programming.

Four projects were selected for funding in Fiscal Year 2022-2023 and a brief description is below. These projects will conclude in June 2023 and reports on the activities will be provided at that time.

Bear River Band of the Rohnerville Rancheria, *Bear River Neurofeedback.* Bear River will purchase the necessary equipment to provide neurofeedback as a psychotherapy service to the tribal members it serves. This project meets the SB 1004 priority of providing culturally competent prevention and early intervention services.

Changing Tides Family Services, *Attachment Vitamins—Addressing Attachment, Stress and Trauma in Early Childhood.* Changing Tides will provide an intervention group known as Attachment Vitamins to help caregivers of children aged birth to five years learn about child development and the impact of stress and trauma, reflect on the child's experiences and possible meanings of the child's behaviors, and promote secure attachment and safe socialization practices. This project meets the SB 1004 priority of childhood trauma prevention and early intervention.

First 5 Humboldt, *Early Childhood Mental Health Prevention and Early Intervention through Evidence-Based Parenting Education.* First 5 Family Support Navigators will be trained to provide parent education and support programs through the Triple P-Positive Parenting Program® and the Parents as Teachers® programs. This project meets the SB 1004 priority of childhood trauma prevention and early intervention.

McKinleyville Community Collaborative DBA McKinleyville Family Resource Center (McKFRC), *Humboldt Mental Health First Aid.* McKFRC will have additional staff trained as instructors in Teen, Youth, and Adult Mental Health First Aid training in Spanish and English and will then host five Mental Health First Aid trainings. This project meets the SB 1004 priorities of culturally competent and linguistically appropriate prevention and intervention and early identification of mental health symptoms and disorders.

Local Implementation Agreements are expected to continue to be supported by PEI during the period of the 2023-2026 Three-Year Plan.

Prevention and Early Intervention Assigned Funds: North Valley Suicide Prevention Hotline (NVSPH)

The NVSPH is administered through California Mental Health Services Authority (CalMHSA), a Joint Powers Authority created to jointly develop and fund mental health services and education programs for its Member County and Partner Counties. CalMHSA administers NVSPH on behalf of counties that are participating in and funding the program. NVSPH serves as the primary 24/7 suicide prevention hotline, accredited by the American Association of Suicidology for these counties, including Humboldt, and answers calls through its participation in the National Suicide Prevention Lifeline. NVSPH also maintains a hotline website and provides outreach and technical assistance to counties that are participating and funding the program. The NVSPH meets the SB 1004 priority of suicide prevention programming.

In fiscal year 2021-2022, there were a total of 406 calls to the hotline from Humboldt County. Of these there were 238 incoming calls; 42 moderate or higher lethality calls; 9 active rescue calls; 42 callers requiring follow-up; and 168 follow-ups placed. Seven referrals were made to Humboldt County Behavioral Health. Caller concerns were mental health 34%; social issues 25%; health care/physical needs 11%, basic needs 19%, sexual orientation 1%, abuse/violence 7%, and COVID-19 2%. For suicidal call content, 41% were past attempt/ideation; 38% suicidal desire; 18% suicidal intent; and 3% imminently lethal caller. Fifty-four percent of callers were female, 39% male, 6% unknown. One percent of the callers were transgender. For 88% of callers race was unknown; 5% were Native American, 2% were White, 3% were Hispanic/Latino, 1%

were Asian American, 1% were African American/Black. One percent were ages 5-14; 22% ages 15-24; 27% ages 25-34; 8% ages 35-44; 9% ages 45-54; 13% ages 55-64; 13% ages 65-74; 6% unknown; 1% 75-84.

As of February 2023, the NVSPH stopped all operations and is no longer in service. In discussions with CalMHSA, it was advised to not find a replacement for the NVSPH since the 988 line already covers all of California. When the 2024 MHSA Annual Update is drafted, it shall only reflect data provided by the NVSPH for the first half of FY 2022-2023. Funding intended for the NVSPH will remain under the Unspent Funds section of the PEI budget.

Prevention & Early Intervention: New Initiatives

NEW: Latinx Liaison

The Behavioral Health Cultural Responsiveness Committee (BHCRC) devoted three monthly meetings to the topic of providing behavioral health services to Hispanic/Latino/Spanish-speaking community members. These meetings were attended by BH staff and community members interested in this topic. The primary barriers identified over these three months, included the lack of culturally proficient staff to work with the Hispanic/Latino/Spanish-speaking community, the lack of awareness by the community about behavioral health services that exist locally and that lack of understanding about service providers that were available to the community. In response to these identified barriers and needs, the BHCRC recommended that Behavioral Health recruit, hire, and train a Spanish-speaking, culturally proficient individual to provide outreach and act as a liaison to Hispanic/Latino/Spanish speaking communities within Humboldt County and to increase their understanding of services and providers available while helping to link them to these needed services and supports.

NEW: Early Childhood Treatment Certification

The HIFECMH (Humboldt Infant-Family and Early Childhood Mental Health) Certificate Training Program was developed to address the serious gap in our systems' capacity to address the social and emotional (mental health) needs of our young children and their families. Between 10 and 16 percent of young children (22 percent of children in poverty) experience diagnosable mental health conditions. Promotion, prevention, and treatment of mental health conditions for young children takes a unique skill set that is not embedded in our educational systems. Many providers lack the knowledge, skills, and confidence in their capacity to promote social and emotional wellness (mental health) in the population that they serve and can lack the understanding of the critical need to intervene and treat mental health issues in young children. It is critical, in this

time of development, to understand how to work in partnership with families so that children can access appropriate intervention and treatment for early recovery. Humboldt County lacks a workforce qualified to address this need.

The HIFECMH Certificate Training Program is a three-year training program, aligned with the CA Center for Infant-family and Early Childhood Mental Health, that has been designed to address this critical need to train and support a qualified infant-family and early childhood workforce. The program brings together a cohort of up to 24 practitioners, from all child and family serving systems, to share a collective understanding of how their roles will promote mental health. The training grounds practitioners with tools to identify children at risk for mental illness and gives them the capacity to offer families developmentally and culturally appropriate referrals, assessments, and interventions. Many of the HIFECMH training courses are open to community enrollment as stand-alone training courses. By allowing community enrollment, local practitioners can access the most current knowledge and research from local, state, and national experts in the field of IFECMH (Infant Family Early Childhood Mental Health), it promotes. These professional relationships facilitate on-going learning, ease navigating referrals and connections that make complicated systems more accessible to families. Additionally, many of the providers who participate in the full cohort program are eligible for the California state-level endorsement in Infant-family and Early Childhood Mental Health. MHSA (Mental Health Services Act) funding will support up to 24 individuals within the cohort to get this certification in three years.

The third year of this training program will be tailored to provide the additional training and support needed for licensed clinicians to be endorsed as Specialists in Infant-Family and Early Childhood Mental Health. This will include more intensive training targeted to the treatment level of mental health services and additional hours in reflective practice needed for support in this process. For the full cohort, additional hours of reflective practice support will be in place to support them with an endorsement at the state level as a Reflective Practice Facilitator. The program director will strategically work toward alignment with this program with the local college and university to provide future stability, integration, and sustainability.

NEW: Warm Line

Early in the COVID-19 Pandemic, Humboldt County Behavioral Health became aware of an increasingly unsettled community, impacted by COVID related anxiety, depression and distress. Staff worked with County Information Systems to develop a county run “warm line” in order to provide non-emergency mental health counseling and support. This warm line is available to the community regardless of insurance type or association with County Behavioral Health. The goal is to assist individuals with any immediate distress they are experiencing and then connect them to community resources that may help them on a longer term a basis, as needed. While COVID concerns are changing over time, there still seems to be an ongoing need for this level

of community support. The intent of the warm line is anyone feeling emotional distress, that doesn't rise to the level of a mental health crisis, has a number to call to get support and linked to needed resources. It is meant to augment other services available and is an opportunity for earlier intervention that can prevent more acute, intense crisis experiences.

NEW: Prevention and Early Intervention Assigned Funds – CalMHSA Statewide PEI Program

The Department of Health and Human Services Behavioral Health (DHHS BH) will participate over the next three years in the Statewide Prevention and Early Intervention (PEI) Program. By contributing to this effort, Humboldt County's Behavioral Health branch will aid in stigma and discrimination reduction (SDR), will improve access and support of mental health services, will develop local and statewide capacity building support along with new outreach materials for counties, and will improve outreach to community stakeholders. PEI funded programs will promote mental health and wellness, suicide prevention, and health equity throughout communities, with additional focus on diverse and/or historically underserved communities.

Towards reaching the above goals, the contribution of MHSA PEI funding will ensure that CalMHSA will provide the following resources/support while new services are implemented:

- Technical Assistance: suicide prevention expertise, support with regional/local specific webinars, distribution of physical materials, training opportunities for the Learning Collaborative.
- Directing Change: a program/film contest tailored for students that provides financial support to encourage and kick start participation.
- Social Marketing – Take Action: a new statewide PEI Campaign that uses best practices in messaging to increase help seeking, reduce stigma and discrimination, and identifies resources for increasing wellbeing.
- Evaluation – RAND: an independent evaluator that provides consultation and evaluation services to PEI program along with optimization to best practices.

Workforce Education and Training (WET)

Over the years, local Humboldt County MHSA Workforce Education and Training (WET) funding has provided staff development opportunities that promote wellness, recovery, and resilience, culturally competent service delivery, meaningful inclusion of clients and family members, an integrated service experience for clients and their family members, community collaboration, and employment of clients and family members within the behavioral health system. During the next years local WET dollars will be used for Training and Technical Assistance through support of the Relias E-Learning platform and to provide matching funds for the Department of Health Care Access and Information (HCAI--formerly the Office of Statewide Health Planning and Development) Regional Partnership Grants.

Relias E-Learning. Behavioral Health initially contracted with Relias Learning, LLC, in April 2016. Staff have access to the Relias catalog of courses, written by industry experts and accredited through international and state accrediting bodies. Local trainings are created and uploaded to Relias as well. Built in tracking, testing and reporting tools save time and ensure that mandatory training requirements are met. Relias improves new hire orientation as an entire collection of training specific to staff roles can be assigned.

Health Care Access and Information (HCAI) Regional Partnership. DHHS Behavioral Health participates in the statewide WET 2020-2025 Plan through the Behavioral Health Regional Partnership project, coordinated by HCAI. Humboldt County is a member of the Superior Region and collaborated with the other counties in the Region to develop an application to secure HCAI Behavioral Health Program funds. The Superior Region priorities are to provide scholarships and/or stipends for peer specialists, graduate education stipends for Clinical Master and Doctoral program participants, loan repayments for qualified masters/doctoral graduates who commit to working in the public mental health system for a set period of time, and the development and implementation of retention strategies. In Humboldt County the CPPP showed overwhelming support for retention strategies to support the behavioral health workforce, and Behavioral Health leadership has identified the loan repayment program as a priority. It had been anticipated that the HCAI programs would begin in the Fall of 2020, but due to contracting delays experienced in the Superior Region the first loan repayment awards were not approved until September 2022. A first round for peer scholarships should be approved by the end of 2022, as well as a second round for loan repayment awards.

Medi-Cal Peer Support Specialist Certification. Behavioral Health will participate with CalMHSA, which has established a Medi-Cal Peer Support Specialist Certification

program, as required by Behavioral Health information notice 21-041. The program is intended to certify up to 10 Peers through a series of trainings. CalMHSA will act as the certifying entity, responsible for the certification, examination, and enforcement of professional standards for Medi-Cal Peer Support Specialists in California.

County Compliance Certification

This page will contain the County Compliance Certification that will be obtained after the Board of Supervisors approval.

Fiscal Accountability Certification

Enclosure 1

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: Humboldt County

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

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Emi Botzler-Rodgers, LMFT	Name: Cheryl Dillingham
Telephone Number: 707-268-2990	Telephone Number: 707-476-2452
E-mail: ebotzler-rodgers@co.humboldt.ca.us	E-mail: cdillingham@co.humboldt.ca.us
Local Mental Health Mailing Address: Humboldt County DHHS-Behavioral Health 720 Wood Street Eureka CA 95501	

I hereby certify that the Three-Year Program and Expenditure Plan, Annual Update or Annual Revenue and Expenditure Report is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for counties in future years.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached update/revenue and expenditure report is true and correct to the best of my knowledge.

Emi Botzler-Rodgers LMFT	Botzler-Rodgers, Emi (Digitally signed by Botzler-Rodgers, Emi Date: 2023.04.05 08:26:53 -07'00')	4/5/2023
Local Mental Health Director (PRINT)	Signature	Date

I hereby certify that for the fiscal year ended June 30, 2022, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated August 28, 2022 for the fiscal year ended June 30, 2020. I further certify that for the fiscal year ended June 30, 2022, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

I declare under penalty of perjury under the laws of this state that the foregoing, and if there is a revenue and expenditure report attached, is true and correct to the best of my knowledge.

County Auditor-Controller	Dillingham, Cheryl (Digitally signed by Dillingham, Cheryl Date: 2023.04.05 08:36:22 -07'00')	4/5/2023
County Auditor Controller / City Financial Officer (PRINT)	Signature	Date

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

MHSA Funding Summaries

FY 2023-2024 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan Funding Summary

County: HUMBOLDT

Date: 05/31/2023

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2023/24 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	105,380	1,396,784	1,161,085	0	0	
2. Estimated New FY2023/24 Funding	8,984,898	2,246,224	591,112			
3. Transfer in FY2023/24[a/]	(71,651)			71,651		
4. Access Local Prudent Reserve in FY2023/24	0					0
5. Estimated Available Funding for FY2023/24	9,018,627	3,643,008	1,752,197	71,651	0	
B. Estimated FY2023-24 MHSA Expenditures	8,913,574	2,055,834	461,254	71,651	0	
C. Estimated FY2024/25 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	105,053	1,587,174	1,290,943	0	0	
2. Estimated New FY2024/25 Funding	9,436,377	2,359,094	620,814			
3. Transfer in FY2024/25[a/]	(74,940)			74,940		
4. Access Local Prudent Reserve in FY2024/25						
5. Estimated Available Funding for FY2024/25	9,466,491	3,946,268	1,911,757	74,940	0	
D. Estimated FY2024/25 Expenditures	9,180,981	2,109,781	475,092	74,940	0	
E. Estimated FY2025/26 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	285,509	1,836,487	1,436,665	0	0	
2. Estimated New FY2025/26 Funding	9,436,377	2,359,094	620,814			
3. Transfer in FY2025/26[a/]	(78,393)			78,393		
4. Access Local Prudent Reserve in FY2025/26						
5. Estimated Available Funding for FY2025/26	9,643,493	4,195,581	2,057,479	78,393	0	
F. Estimated FY2025/26 Expenditures	9,456,411	2,160,696	489,344	78,939	0	
G. Estimated FY2025/26 Unspent Fund Balance	187,083	2,034,885	1,568,135	0	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2023	1,439,391
2. Contributions to the Local Prudent Reserve in FY 2023/24	
3. Distributions from the Local Prudent Reserve in FY 2023/24	0
4. Estimated Local Prudent Reserve Balance on June 30, 2024	1,439,391
5. Contributions to the Local Prudent Reserve in FY 2024/25	
6. Distributions from the Local Prudent Reserve in FY 2024/25	
7. Estimated Local Prudent Reserve Balance on June 30, 2025	1,439,391
8. Contributions to the Local Prudent Reserve in FY 2025/26	
9. Distributions from the Local Prudent Reserve in FY 2025/26	
10. Estimated Local Prudent Reserve Balance on June 30, 2026	1,439,391

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

FY 2023-2024 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: HUMBOLDT Date: 05/31/2023

	Fiscal Year 2023-24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Comprehensive Community Treatment (CC	11,972,470	7,734,598	3,529,964	707,908		
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. Regional Services	366,044	161,253	204,791			
2. Older Adults	115,462	75,879	39,583			
3. Crisis Residential Treatment	1,809,156	792,410	1,016,746			
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration	161,886	149,434	12,451			
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	14,425,017	8,913,574	4,803,535	707,908	0	0
FSP Programs as Percent of Total	134.3%					

FY 2023-2024 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: HUMBOLDT Date: 05/31/2023

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Comprehensive Community Treatment (CC	12,331,644	7,966,636	3,635,863	729,145		
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. Regional Services	377,025	166,090	210,935			
2. Older Adults	118,926	78,155	40,771			
3. Crisis Residential Treatment	1,863,431	816,183	1,047,248			
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration	166,742	153,917	12,825			
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	14,857,767	9,180,981	4,947,641	729,145	0	0
FSP Programs as Percent of Total	134.3%					

FY 2023-2024 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: HUMBOLDT Date: 05/31/2023

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Comprehensive Community Treatment (CC	12,701,593	8,205,635	3,744,939	751,020		
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. Regional Services	388,336	171,073	217,263			0
2. Older Adults	122,493	80,500	41,994			0
3. Crisis Residential Treatment	1,919,334	840,668	1,078,665			0
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration	171,744	158,535	13,210			
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	15,303,500	9,456,411	5,096,070	751,020	0	0
FSP Programs as Percent of Total	134.3%					

FY 2023-2024 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: HUMBOLDT

Date: 05/31/2023

	Fiscal Year 2023-24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Hope Center	453,001	338,586	114,415			
2. TAY Advocacy and Peer Support	512,598	354,841	157,757			
3. Parent Partnership Program	445,432	311,216	134,216			
4. School Climate Curriculum/MTSS	84,222	84,222				
5. Local Implementation Agreements	120,000	120,000				
6. Latinx Liaison	88,641	88,641				
7. Early Childhood Treatment Certification	118,250	118,250				
8. Warm Line	99,158	99,158				
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. Suicide Prevention	300,375	300,375				
12.	0	0				
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	150,696	150,696				
PEI Assigned Funds	89,849	89,849				
Total PEI Program Estimated Expenditures	2,462,222	2,055,834	406,388	0	0	0

FY 2023-2024 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: HUMBOLDT

Date: 05/31/2023

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Hope Center	466,591	348,743	117,848			
2. TAY Advocacy and Peer Support	527,976	365,487	162,489			
3. Parent Partnership Program	458,794	320,552	138,242			
4. School Climate Curriculum/MTSS	86,749	86,749				
5. Local Implementation Agreements	120,000	120,000				
6. Latinx Liaison	91,300	91,300				
7. Early Childhood Treatment Certification	118,250	118,250				
8. Warm Line	102,132	102,132				
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. Suicide Prevention	306,986	306,986				
12.						
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	155,217	155,217				
PEI Assigned Funds	94,364	94,364				
Total PEI Program Estimated Expenditures	2,528,360	2,109,781	418,579	0	0	0

FY 2023-2024 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: HUMBOLDT

Date: 05/31/2023

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Hope Center	480,588	359,205	121,383			
2. TAY Advocacy and Peer Support	543,815	376,451	167,364			
3. Parent Partnership Program	472,559	330,169	142,390			
4. School Climate Curriculum/MTSS	89,352	89,352				
5. Local Implementation Agreements	120,000	120,000				
6. Latinx Liaison	94,039	94,039				
7. Early Childhood Treatment Certification	118,250	118,250				
8. Warm Line	105,196	105,196				
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. Suicide Prevention	313,796	313,796				
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	159,874	159,874				
PEI Assigned Funds	94,364	94,364				
Total PEI Program Estimated Expenditures	2,591,833	2,160,696	431,137	0	0	0

FY 2023-2024 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: HUMBOLDT

Date: 05/31/2023

	Fiscal Year 2023-24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Residential Engagement and Support Team	419,322	419,322				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	41,932	41,932				
Total INN Program Estimated Expenditures	461,254	461,254	0	0	0	0

FY 2023-2024 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: HUMBOLDT

Date: 05/31/2023

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Residential Engagement and Support Team	464,225	431,902	32,323			
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	43,190	43,190				
Total INN Program Estimated Expenditures	507,415	475,092	32,323	0	0	0

FY 2023-2024 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: HUMBOLDT

Date: 05/31/2023

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Residential Engagement and Support Team	517,586	444,859	72,728			
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	44,486	44,486				
Total INN Program Estimated Expenditures	562,072	489,344	72,728	0	0	0

FY 2023-2024 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: HUMBOLDT

Date: 05/31/2023

	Fiscal Year 2023-24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training and Technical Assistance	65,779	65,779				
2. HCAI Regional Partnerships	5,872	5,872				
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	0					
Total WET Program Estimated Expenditures	71,651	71,651	0	0	0	0

FY 2023-2024 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: HUMBOLDT

Date: 05/31/2023

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training and Technical Assistance	69,068	69,068				
2. HCAI Regional Partnerships	5,872	5,872				
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	0					
Total WET Program Estimated Expenditures	74,940	74,940	0	0	0	0

FY 2023-2024 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: HUMBOLDT

Date: 05/31/2023

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training and Technical Assistance	72,521	72,521				
2. HCAI Regional Partnerships	5,872	5,872				
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	0					
Total WET Program Estimated Expenditures	78,393	78,393	0	0	0	0

FY 2020/21 Through FY 2022/23 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: HUMBOLDT

Date: 05/31/2023

	Fiscal Year 2023-24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11.						
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	0	0	0	0	0	0

FY 2020/21 Through FY 2022/23 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: HUMBOLDT

Date: 05/31/2023

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11.						
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	0	0	0	0	0	0

FY 2020/21 Through FY 2022/23 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: HUMBOLDT

Date: 05/31/2023

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11.	0	0				
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	0	0	0	0	0	0