Mental Health Services Act
Annual Update
FY 2024-25

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Letter from the Behavioral Health Director

Dear Valued Community Members,

This Mental Health Services Act (MHSA) Annual Update, covering fiscal year 2024-2025, comes at a time of great legislative and fiscal uncertainty. As you may already be aware, Behavioral Health relies on sales tax revenue, vehicle license fees and personal income taxes to fund services. The MHSA is funded by personal income tax revenue. With the passing of Proposition 1, this year, during the California primary election, California voters approved various changes to take place within County Behavioral Health across the state, related to MHSA funding.

Some administrative changes will go into effect on January 1st, 2025, while other, more substantive changes will go live on July 1st, 2026. These changes include, a new housing category, renaming the MHSA to the Behavioral Health Services Act (BHSA), a 5% reduction in overall MHSA/BHSA funding across the state, new reporting requirements, and an overall restructure on MHSA/BHSA funding categories. There are many details still being finalized, and so it is still difficult to know what local impacts Proposition 1 will have on existing MHSA-funded programs. Behavioral Health Administration is working diligently with multiple partners across the State on understanding the potential impacts of these changes and waiting on the State to release clean-up language that gives a more accurate representation of what these changes will actually look like and require.

We very much appreciate the community and our partners who have participated and given input into the MHSA community stakeholder process. The commitment and partnership of community members, service providers and stakeholders has been incredibly valuable. Although there are still many unknowns, we will continue to update the community and our partners as further details are made available to counties. Please reach out to Oliver Gonzalez, MHSA Program Manager, via phone at 707-441-3770, toll free at 1-866-320-8911, or through email at mhsacomments@co.humboldt.ca.us with any questions or comments.

Best Regards,

Emi Botzler-Rodgers, LMFT
Behavioral Health Director

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. Due to its reliance in tax revenue, MHSA funding is volatile in nature and subject to change yearly. County Behavioral Health will plan accordingly to prioritize existing infrastructure, programs, and client needs while also using stakeholder feedback to keep informed on local priorities.

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 Annual Update 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 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 2024-2025 Annual Update and associated MHSA information was sent via email to stakeholder groups and individuals to provide an opportunity for input.

Community meetings with stakeholders were held either by using the Zoom virtual platform, in person, or as a hybrid of in-person and Zoom. Materials were provided to attendees via email and shared on the screen during the virtual/hybrid meetings and shared via PowerPoint with people attending the in-person meetings. The materials included:

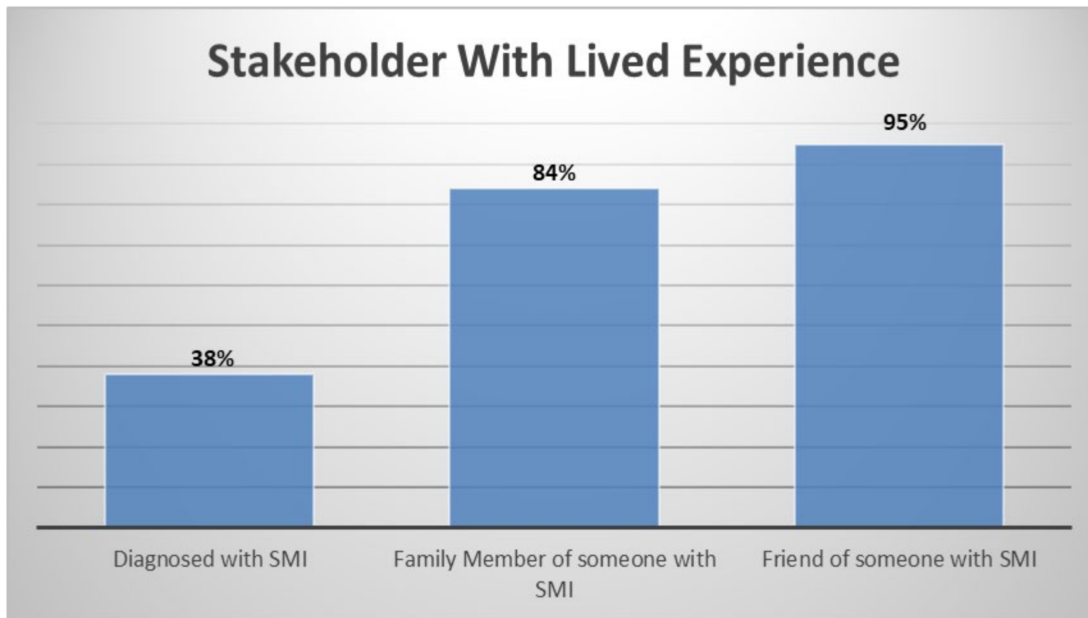
- Draft MHSA 2024-2025 Annual Update, including a draft budget.
- MHSA Fundamental Concepts handout.
- BH services QR Code with link.
- MHSA Information Form handout.
- MHSA Current Programs handout.
- Services Provided by DHHS Behavioral Health handout.
- Definitions of Serious Mental Illness and Serious Emotional Disturbance handout.
- PowerPoint presentation including information on all MHSA components.
- Summary of Governor Newsom's Transformation of Mental Health Services.
- 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.

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. This draft document will be revised based on that input, as appropriate. The stakeholder meeting report was prepared and presented to Behavioral Health Administration for consideration of changes to programs based on the input. This draft document will be 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 24th, 2024.

Stakeholders attending community meetings were invited to complete the demographic questionnaire. During the months of November 2023 through February 2024 a total of eleven stakeholder meetings were held with a total of 110 individuals attending. Of the 110 individuals that attended, 37 (39%) of them filled out the demographic questionnaire.

Individuals with lived experience of a serious mental illness (SMI) and their family members are recognized as a vital voice in the MHSA CPPP. As seen in the chart below, 38% identified as having a serious mental illness, and 84% identified as a family member of someone with a serious mental illness. In addition, 95% of those attending the stakeholder meetings said they were a friend of someone with a serious mental illness.

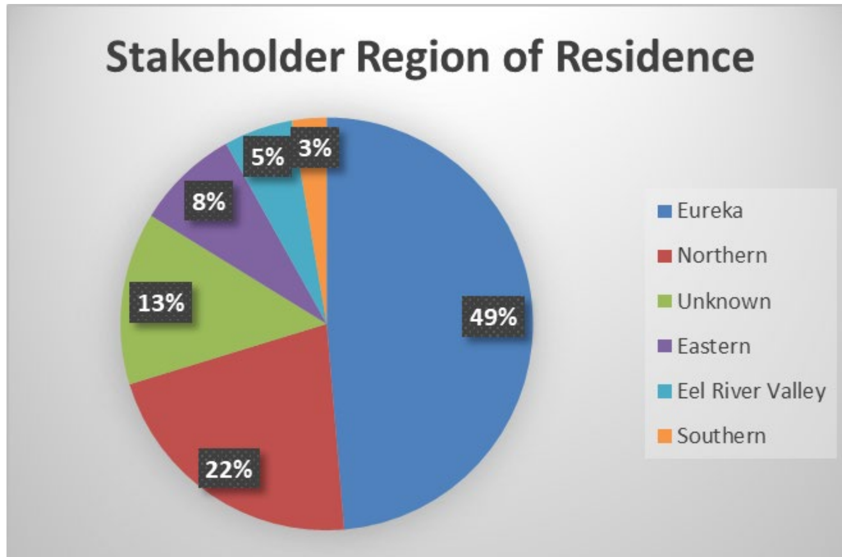


Additional life experiences have been identified as important voices for the CPPP. Sexual orientation and gender identity, homelessness, experience with the justice system, experience with Child Welfare, and those whose primary language is not English have life experiences or conditions that can result in challenges to successful mental health access and treatment. Outreach efforts included people with these experiences:

- 24% identified as LGBTQ
- 35% had Child Welfare experience
- 38% had justice system experience
- 43% identified as having experience with homelessness

We did not receive any demographic forms that reported folks had military experience

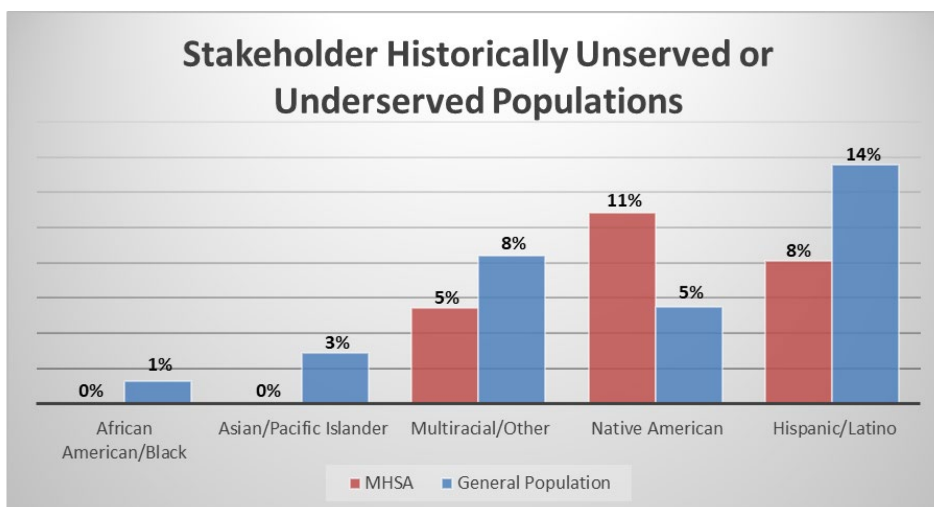
nor utilized a primary language that was not English.
Another priority for representation in the planning process is regional. Most of the MHSA stakeholders attending meetings lived in regions close to the Humboldt Bay: Eureka at 49% and Northern Humboldt at 22%, while 13% did not respond to the question or indicated they lived in another region outside of Humboldt County, 8% resided in Eastern Humboldt, 5% in the Eel River Valley, and 3% in Southern Humboldt.



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

- 5% were Multiracial/Other, compared to 8% of the general population.
- 11% were Native American, compared to 5% of the general population.
- 8% were Hispanic/Latino, compared to 14% of the general population.

Unfortunately, there were no participants who identified as African American/Black nor Asian/Pacific Islander.



The stakeholder meetings included representation from agencies that provided services. The process included individuals from mental health services (17%), education (10%), “other” (9%), social services (7%), community family resource center (7%), non-profit foundation (4%), law enforcement (1%), and 19% are unknown or preferred not to answer the question.

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, a total of 50 responses were provided as input into the Draft 2024-2025 Annual Update. An analysis of all input shows that the top priorities identified by respondents were as follows:

- Expand/increase access to services. Five stakeholder groups and 1 comment form talked about the need to expand services and supports. Comments included to increase outreach; employ more psychiatrists and counselors; provide more programs for juveniles; expand Sempervirens and the Crisis Stabilization Unit; expand services to Southern and Eastern Humboldt; expand peer support; and accept private insurance for services.
- Workforce Support. This need was mentioned at three stakeholder meetings and in one comment form. Comments mentioned included training and support for those working with the 0-8 population; train clinicians in more modalities that are not just focused in Cognitive Behavioral Therapy; providing clinical experience and education for Cal Poly Humboldt graduates; more funds for professional development; improving county’s ability to host trainings without relying on outside help.
- Continuity of care for clients released from Sempervirens, Crisis Stabilization Unit, and the jail, plus other transition services. This need was mentioned at one stakeholder meeting. Ideas include the need for a day treatment center, step-down unit, giving a warm hand-off, increasing residential housing options, expanding services to support and ensure clients released from SV and CSU do not struggle, and more board and care facilities.
- Increased support for school aged children and youth. Three stakeholder meetings and two comments forms indicated the need for increased support for youth, both TAY and those not yet TAY. Support for first break psychosis, crisis support, and strengthening the continuity of care for families was included.
- Services for early childhood. Two stakeholder groups focused on this theme, which included the need for expanding FSP services to serve children, parent education, improving childcare options for when parents need to be involved in service delivery, expanding times in which services are conducted, offering more services that are in-person, and adding trainings.
- Housing and services for those experiencing homelessness. Three stakeholder groups and two comment forms indicated the need for more supportive housing, more supportive services for those who are not housed, increased funding for

emergency housing in areas that could use additional support, and working with rental companies to overcome barriers for achieving housing.

- Support groups and peer support. Two stakeholder groups mentioned the need for more peer support and DHHS sponsored trainings with paid facilitators that anyone with mental illness could attend; and paying peers to tell their stories.
- Law enforcement partnerships. One stakeholder group mentioned the need for a strengthened partnership between law enforcement and mental health, including providing clarification about policies; providing a pocket-sized resource list; increased community collaborations; and providing more training for law enforcement on working with the mentally ill.
- Transportation for clients. Two groups spoke about the need for transportation for clients and community members to get to services and supports. People in Southern Humboldt, Eel River Valley, Eastern Humboldt, and Northern Humboldt expressed a great need for transportation expansion to access services offered only in Eureka.
- Increased support for the seriously mentally ill. Three stakeholder groups mentioned the need for more assertive care treatments; expansion of Comprehensive Client Treatment (CCT); having more case managers and other paraprofessionals; and providing occupational support, supported employment and sheltered work.
- Clarity about Mental Health Services. Four groups and three comment forms stated there needs to be more clarity about navigation of and access to mental health systems. They expressed uncertainty on what services are available and how to access them.
- Hope Center improvements. One group indicated the need to improve/expand the facility and programs of the Hope Center. Ideas included relocating the facility to a more accessible part of town, such as downtown, far from Sempervirens and the Crisis Stabilization Unit; providing more classes and activities; getting a larger facility; providing a full-service kitchen with work programs; along with the need for more staffing to run the Warm Line.
- Bilingual and Culturally Competent Services. This need was mentioned at three stakeholder meetings and two comment forms. A meeting attendee pointed out that we need to have more SUD services. There was one person that pointed out that it might be more culturally appropriate to join other events where people are rather than creating new ones. Folks in Eastern Humboldt mentioned the great need they have on services in general, but especially those that represent them the best.
- More mental health counselors at schools and additional school supports. This need was mentioned at three stakeholder meetings.
- Substance Use Disorder Services. One group and one comment form spoke about the need for additional substance use disorder services, to include youth under age 18 who have co-occurring substance use and mental health issues, creating services and infrastructure that are more inclusive, and to process referrals that are dual diagnosis.

The programs proposed to be supported, contingent upon the availability of funds, in this Annual Update will address many of these identified priorities. The CPPP Report can be found on the Humboldt County website, MHSA section, 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: Archive Center • Mental Health Services Act Documents (humboldtgov.org)

30-Day Comment Period and Public Hearing

In accordance with MHSA regulations, the 2024-2025 Annual Update was made available for public review and comment for a 30-day period from April 24th through May 23rd, 2024.The Behavioral Health Board (BHB) conducted a Public Hearing on the Annual Update at its May 23rd, 2024 meeting. The 2024-2025 Annual Update 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.
- An email to recipients on local organizational e-mail distribution lists.
- An email to people who requested a copy.
- Announcements in local media about the Annual Update'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 six attendees of the Public Hearing filled out a demographic survey, with two containing additional comments.

Public Hearing Information

The BHB conducted a Public Hearing on the 2024-2025 Annual Update at their regular meeting on May 23rd, 2024, 12:15-2:15pm. 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 23 people in attendance at the Public Hearing.

Public Comment Summary

One written comment/recommendation was provided for the Annual Update through email to the MHSA Comment Email during the 30-day public comment period. There were 9 comments on the Annual Update that were made orally during the Public Hearing and two were made via the voluntary demographic form. 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 Annual Update as a result of the 30-Day Public Comment period and Public Hearing.

1. In one email, one person recommended the following: 1) Utilize MHSA-WET funding to provide Wellness Recovery Action Planning (WRAP) certifications to Hope Center staff. WRAP is designed to help individuals with mental health challenges take control of their own wellness and recovery journey by developing personalized plans. The proposal included cost estimates for 16 staff and their travel, which totaled at around $58,400. The proposal also includes an alternative, which is to contract with Advocates for Human Potential. Advocates for Human Potential can certify staff and charge a flat rate between $15,000-$20,000 and would not require staff to travel, making this the more affordable option.
Response: The recommendation and its proposal were shared with BH Leadership for consideration. This type of training is something that would be part of Hope Center operating costs. However, further discussions with the Hope Center staff will occur to gather more details and strategize about WRAP training for staff in general.

2. A member of the Behavioral Health Board had the following question: can training developed by BH be made available to volunteers? Currently, volunteers only receive mandatory trainings required of all County staff. However, trainings outside of the required trainings are not offered to volunteers.
Response: This is something that will be shared with BH leadership to see if it can be considered under MHSA.

3. Comment/recommendation by BHB member: recent meeting attended also highlighted the need for provider retention. County should develop a premedical taskforce to develop a pipeline for high schoolers and or pre-med level student to funnel people into critical roles that are needed in the community.

4. One of the BHB members requested a comparison slide on stakeholder demographics with Humboldt's general population during the Public Hearing presentation.
Response: A presentation slide was discussed at a later part of the presentation that contained the requested information. Aside from this, members were directed to the stakeholder report which covers in greater details.

5. A BHB member noticed that under the demographics section for stakeholders, there was no data on Asian/Pacific Islander. How do we get more information to Tongan

along with other Asian/Pacific Islander communities? They are often missed or not represented in available data, and it would be great to improve this if possible.
Response: I do not have specific points of contact for this demographic. The BHB member has some points of contact and agreed to share with the MHSA coordinator to use for outreach. MHSA will consider more focused in outreach to these communities in next CPPP.

6. A BHB member asked the following: when will the Annual Update go to the Board of Supervisors for approval?
Response: Currently, we are aiming for the plan to go to BOS on June 25th, 2024.

7. A BHB member asked the following: Will PEI LIA funding opportunities be available again?
Response: Yes, the opportunities will open again in the fall (around December) and close in February 2025. There will be communications going out to the community about when the application period opens.

8. A member of the Board of Supervisors and a Behavioral Health Board member recommended engagement with the Karuk Tribe for the Eastern Humboldt region. The MHSA Coordinator will coordinate with BH leadership to identify best points of contact.

9. A community member also made a public comment on adjusting the stakeholder demographic gender identity question. It currently has "transgender" listed as a gender and a community member disagreed with it being considered a gender.
Response: More research will be done on this subject and other stakeholders will be contacted, such as Queer Humboldt, to gather more input on the potential need to change how the question is presented.

The following are comments made on the stakeholder comments form during the Public Hearing:

1. It was recommended to emphasize under program categories which programs focus on dual diagnosis (e.g., behavioral health and substance use disorder).

2. A recommendation was made on adjusting the stakeholder demographic gender identity question. It currently has "transgender" listed as a gender and a community member disagreed with it being considered a gender. Please see the response on #9.

Complaints and Grievances

The MHSA program manager will address any complaints, disputes or grievances from the general public about MHSA program planning. If there is a complaint, dispute, and/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 at MHSA Program Manager, DHHS Behavioral Health, 720 Wood St. Eureka CA 95501, or by email at 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, unless there are factors outside of departmental control, in which case a reasonable timeframe will be set and communicated to the complainant.

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 2024-2025 Annual Update and Three-Year Plan for 2023-2026 will provide information directly from stakeholders. This Capacity Assessment uses information from prior MHSA CPPPs, including the 2023-2026 Three-Year Plan.
2. Updated annually, the Behavioral 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 2023 BHCCP is located here: https://humboldtgov.org/DocumentCenter/View/123436/DHHS---Behavioral-Health-Cultural-Competence-Plan-2023
3. The DHHS Workforce Survey, conducted in September-October 2023, 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 most recent NACT and supporting documentation was submitted August 26, 2022 and found to be in compliance.

5. Employee Services was contacted in order to obtain a vacancy report within Behavioral Health. As of September 2023, Behavioral Health has a 25% 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 per request, showing beneficiary and provider locations. NACT includes information on provider language capacity and availability of Language Line services. Humboldt County's NACT also included the American Indian health facilities in the county. DHCS' evaluation of the 2022 NACT submission resulted in a pass designation, which means that DHHS Behavioral Health is in compliance with the network adequacy certification requirements and standards. Another NACT is due to DHCS in the Fall of 2023 pending release of an updated Behavioral Health Information Notice. As of March 2023, DHHS Behavioral Health is producing the monthly 274 production file, which 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.

The Behavioral Health Cultural Responsiveness Committee (BHCRC) is a strength in the agency. BHCRC facilitates projects to gather data and address issues surrounding diversity. 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.

- 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. Organizational providers are required to provide cultural competence training to their staff annually, which QI monitors.
- Update to contracts with local interpreters and interpreter list.
- 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).
- Offering Cultural Awareness Training, through NEOGOV and monitoring for compliance with the training requirement.
- The DHHS trainings on Common Racial Equity Terms and Implicit Bias were launched and are 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.
- Implementation of CalAIM Documentation Redesign, No Wrong Door, and Payment Reform: Documentation Redesign reduces the documentation burden on direct services staff and allows them to focus more on the quality of direct care. The No Wrong Door initiative describes the method of coordinating between providers to ensure all Humboldt County Medi-Cal beneficiaries get quick access to services in the appropriate delivery of care system (Mental Health Plan, Managed Care Plan or Drug Medi-Cal Organized Delivery System); Payment Reform was implemented in July 2023, with billing methods changing to a Fee-For-Service model.
- 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 reviews key services utilization data on a quarterly basis. Review of this data includes evaluating the needs of key service utilizers. DHHS-BH is paying

particular attention to details as they relate to racial disparities, which informs programmatic decision making.

- Suicide Prevention Initiative: DHHS BH is working with consultants through Community Connections Psychological Associates on impacting death by suicide of clients in our community. This task force analyzes improvement needs in our system of care and will implement necessary change where those needs are indicated. Goals include the integration of a formalized risk screening and/or assessment tool into our EHR SmartCare for use across all DHHS-BH programs including Crisis, Outpatient, and Forensic units as well as identifying and implementing suicide prevention training for all BH staff who interact with BH clients and the public.

Behavioral Health is working with Humboldt Area Foundation and Stepping Stone Consulting as a component of a DHHS contract with these organizations.
The purpose of the BH component of 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 equity advances 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) 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 2022 through September 2023, a combined total of 209 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 Community Program Planning Process (CPPP) for the recently passed 2023-2026 Three-Year Plan and prior Annual Updates for FY 2022-2023 and FY 2024-2025 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 2023-2026 Three-Year Plan, and it was one of the top five priorities for the Annual Update for 2022-2023 and for 2024-2025. For the 2024-2025 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; and expansion of culturally responsive services to Native American communities within the Eastern Humboldt region.
- Stakeholders completing the Community Survey for the 2023-2026 Three-Year Plan ranked this as 10 among all priorities and indicated that racial/ethnic populations are among those not adequately served by current MHSA programs. These racial/ethnic populations included, but were not limited to, 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 2023. 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.
- Eighteen percent of those with Medi-Cal were multiracial, and 26% used DHHS-Behavioral Health services.
- Six percent of those with Medi-Cal had a primary language that was not English, and 23% used DHHS-Behavioral Health services.
- Nine percent of those with Medi-Cal were children aged 0-5, and 2% used DHHS-Behavioral Health Services.
- Thirteen percent of those with Medi-Cal were Older Adults 60+, and 12% 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. Language accessibility is mainly done through use of the Language Line, which may explain why there are a greater number of people whose primary language is not English accessing more DHHS-Behavioral Health services. 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. The mental health needs of very young, especially preverbal children are still not well understood nor are the symptoms that could indicate a need for treatment. As for older adults 60+, there could also be transportation difficulties, not enough case managers and/or clinicians to provide services, and potential barriers caused by the COVID-19 pandemic.

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 September-October 2023 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 Annual Update.

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 260 youth, from 0-15 years old, that would be eligible for FSP during the 22/23 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 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 298 clients could be served annually as FSPs. The age groups anticipated to be served are:
TAY: 11
Adults: 231
Older Adults: 56

During fiscal year 2022-2023, there were 286 unduplicated clients served by the program. Based on the Revenue and Expense Report (RER), which outlines a total cost of $7,420,997 in MHSA funds, the average cost per client is estimated at $25,947.54.

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.

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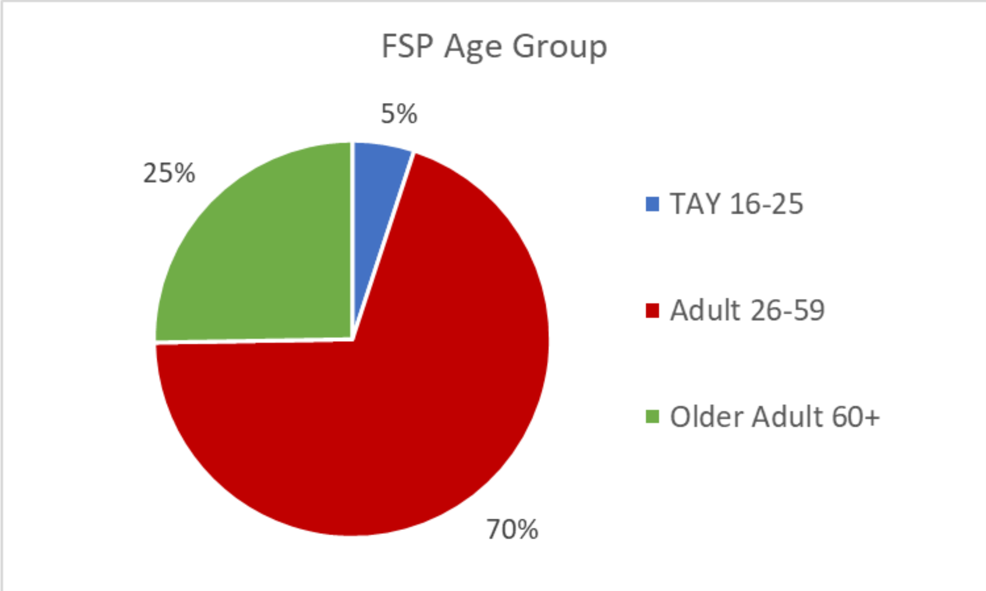
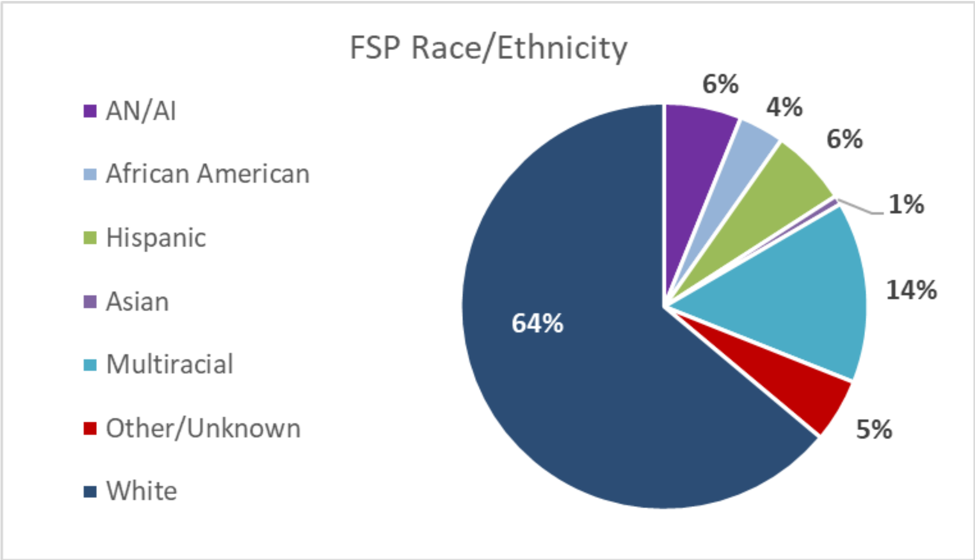
There were 277 Full-Service Partners (FSPs) enrolled for the period July 1, 2022, through June 30, 2023 with a unique client count of 286. Five percent of FSPs were ages 16-26, 70% were ages 26-59, and 25% were age 60+. While enrollment as an FSP is assessed for children under the age of 16 who meet 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, 2022, through June 30, 2023, the percentage of FSPs who identified as White was 64%; the percentage who identified as American Indian/Alaska Native was 6%; the percentage who identified as African American was 4%; the percentage who identified as Hispanic/Latino was 6%; the percentage who identified as Multiracial was 14%; 1% identified as Asian and 5% were Other/Unknown.



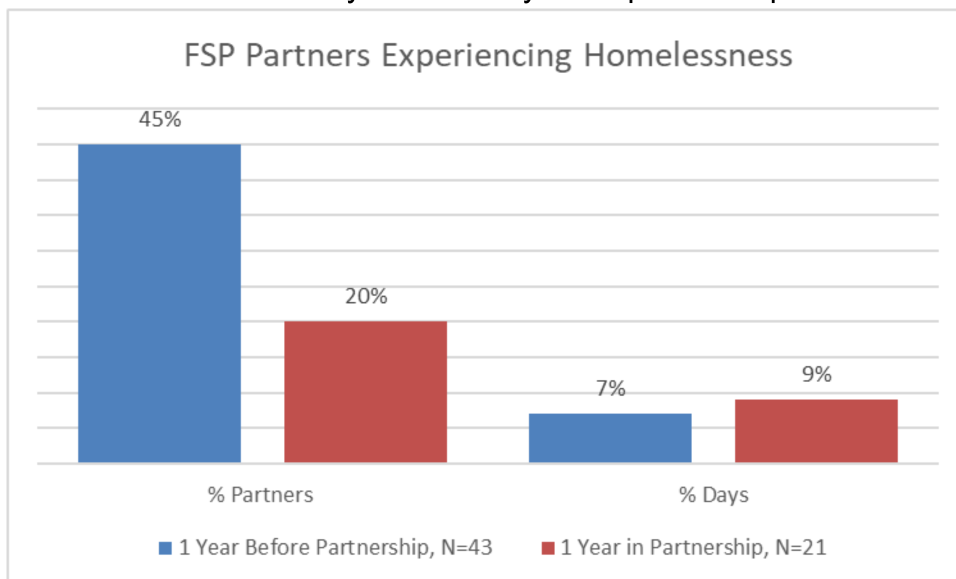
Forty-one percent of FSP clients for the period July 1, 2022, through June 30, 2023, were female and 58% were male.

FSPs exit a Partnership due to a variety of reasons. During the period July 1, 2022, through June 30, 2023, 43 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	21%	0%	24%	17%
Target Criteria	2	5%	25%	0%	17%
Not Located	8	19%	50%	18%	0%
Moved	6	14%	0%	18%	0%
Deceased	8	19%	0%	15%	50%
Discontinue	2	5%	25%	0%	17%
Serving Jail	6	14%	0%	18%	0%
Institution	2	5%	0%	6%	0%
Total Discharged	43		4	33	6

HOMELESSNESS

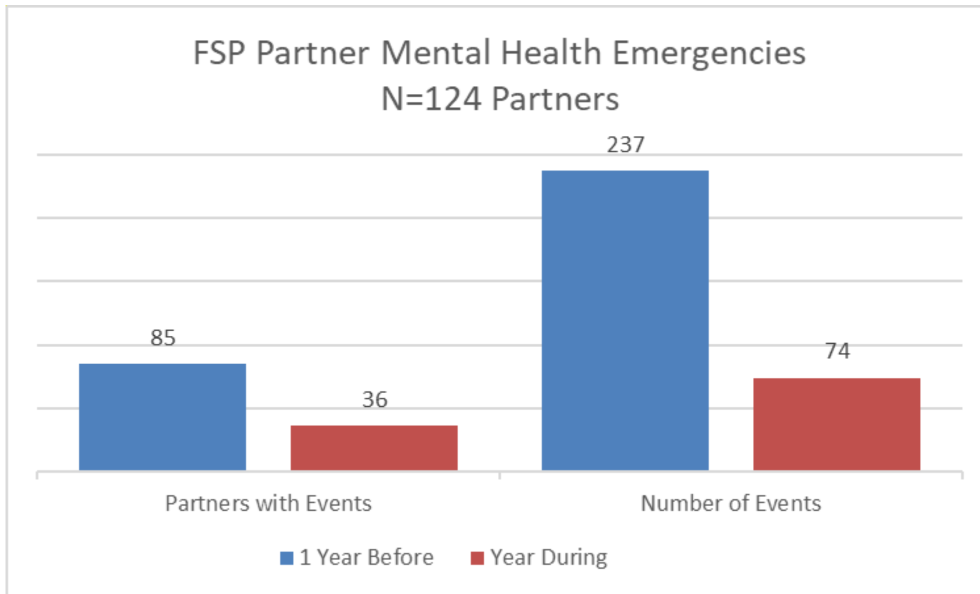
For the 124 who enrolled in an FSP, 43 experienced 9,516 days of homelessness in the year prior to enrollment. In the most recent year in the FSP, 21 partners experienced 3,282 days of homelessness. This represents 45% of partners experiencing 7% of homelessness days one year before the partnership, and 20% of partners experiencing 9% of homelessness days after one year in partnership.



Mental Health Emergency

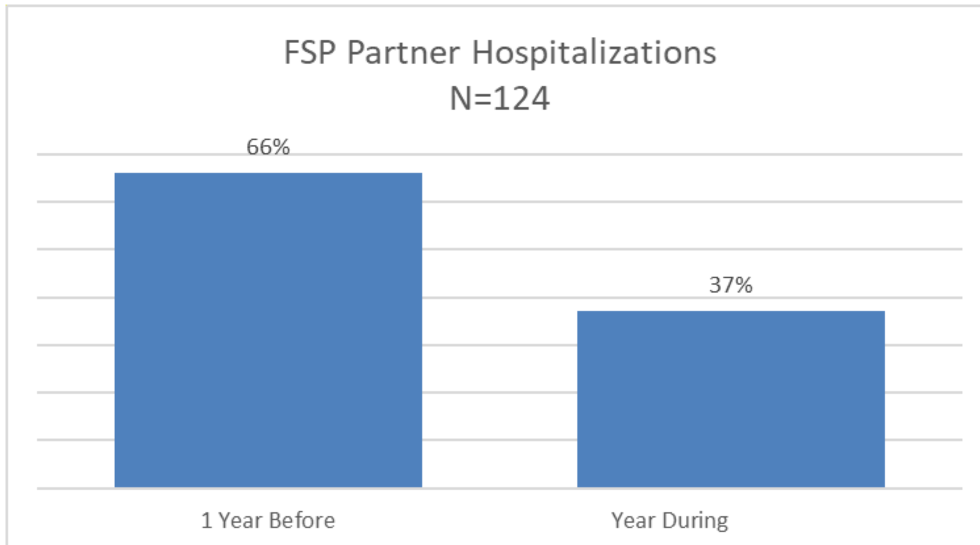
Of the 124 Full-Service Partners enrolled in FSP there were 36 (29%) who participated at least one year in the program. Of these 124, 85 (69%) experienced 237 mental health emergencies in the year prior to enrollment as an FSP. In the most recent year during

enrollment, 36 (29%) experienced 74 mental health emergencies, a decrease of 163 events.



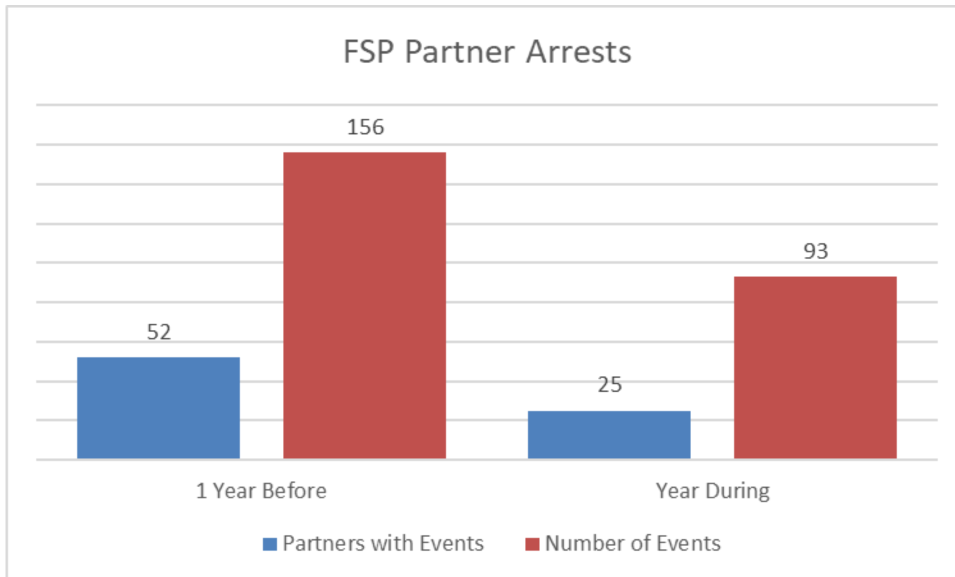
HOSPITALIZATION

Of the 124 Full-Service Partners who participated at least one year in the program, 82 (66%) experienced psychiatric hospitalization in the year prior to enrollment as an FSP. In the most recent year during enrollment 46 (37%) experienced psychiatric hospitalizations.



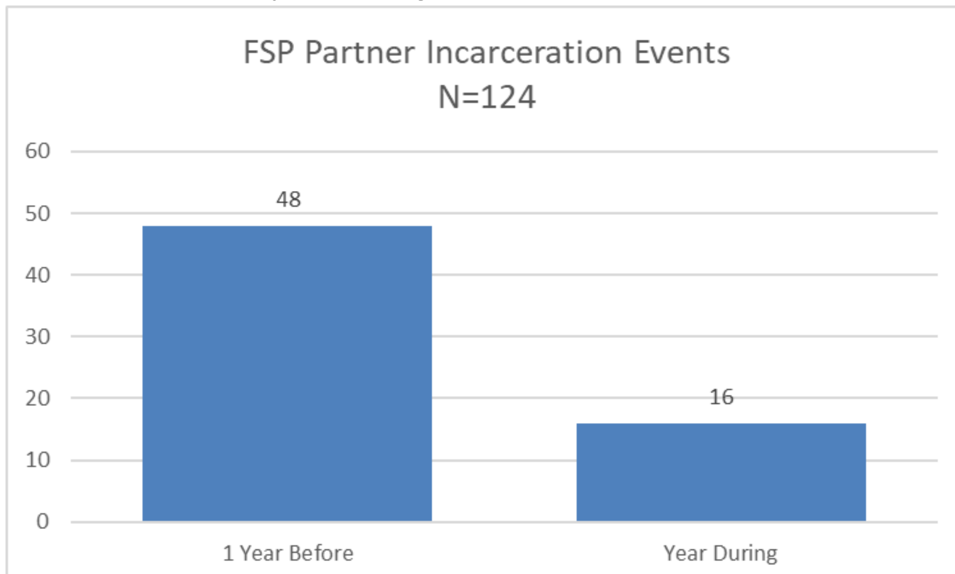
ARRESTS

Of the 124 Full-Service Partners who served at least one year in the program, 52 (42%) experienced 156 arrests in the year prior to enrollment. In the most recent year during enrollment 25 (20%) partners experienced 93 arrests.



INCARCERATION

Among the 124 Full-Service Partners who served at least one year in the program there were 48 incarceration events for 3,398 days in the year prior to enrollment as a Partner. In the most recent year during enrollment there were 16 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, McKinleyville, 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

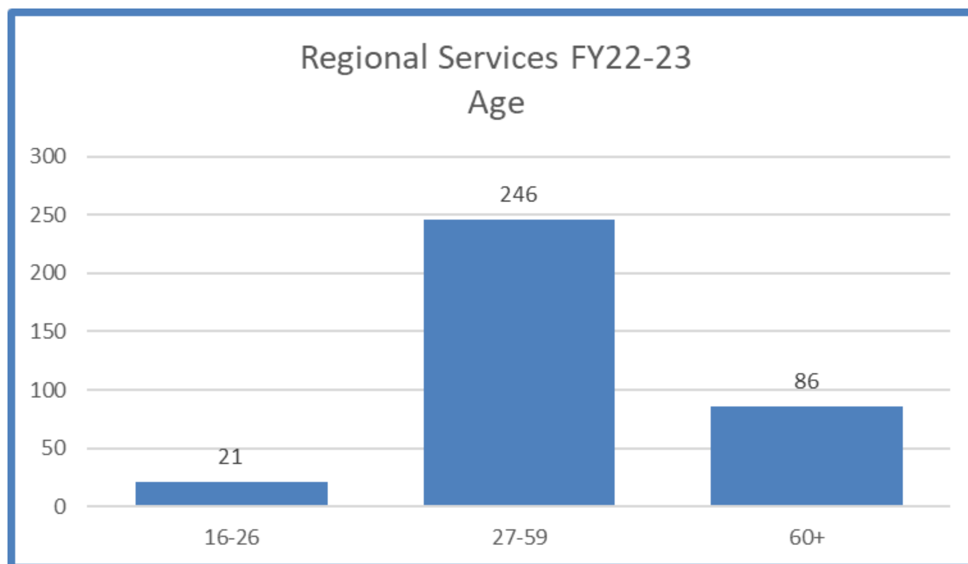
are made to substance use disorder (SUD) services as needed. Staff attend community meetings/outreach events to provide education to other community providers about County services and to engage new client referrals.

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.

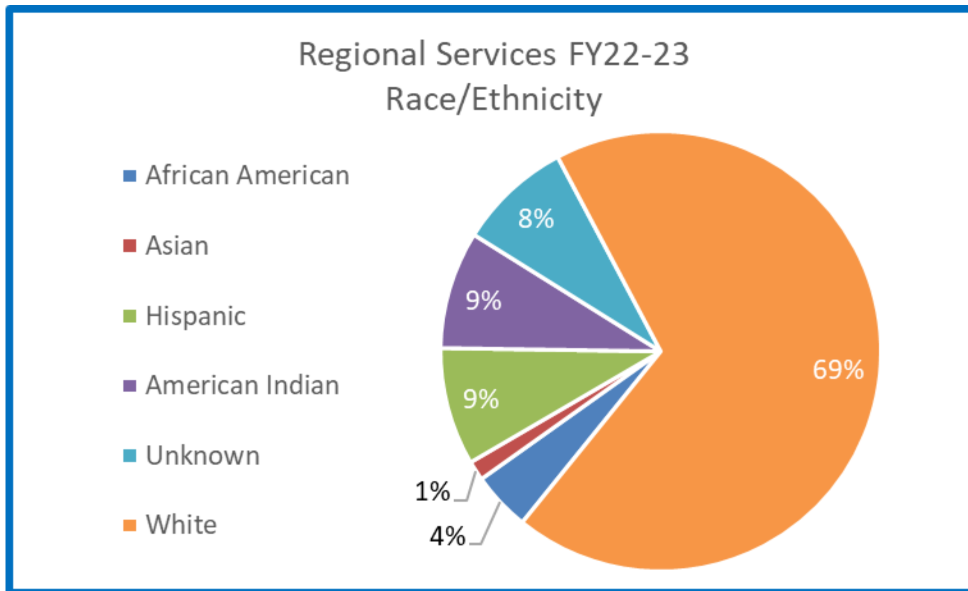
During fiscal year 2022-2023, there were 353 unduplicated clients served by the program. Based on the Revenue and Expense Report (RER), which outlines a total cost of $38,129 in MHSA funds, the average cost per client is estimated at $108.01.

Report for Fiscal Year 2022-2023

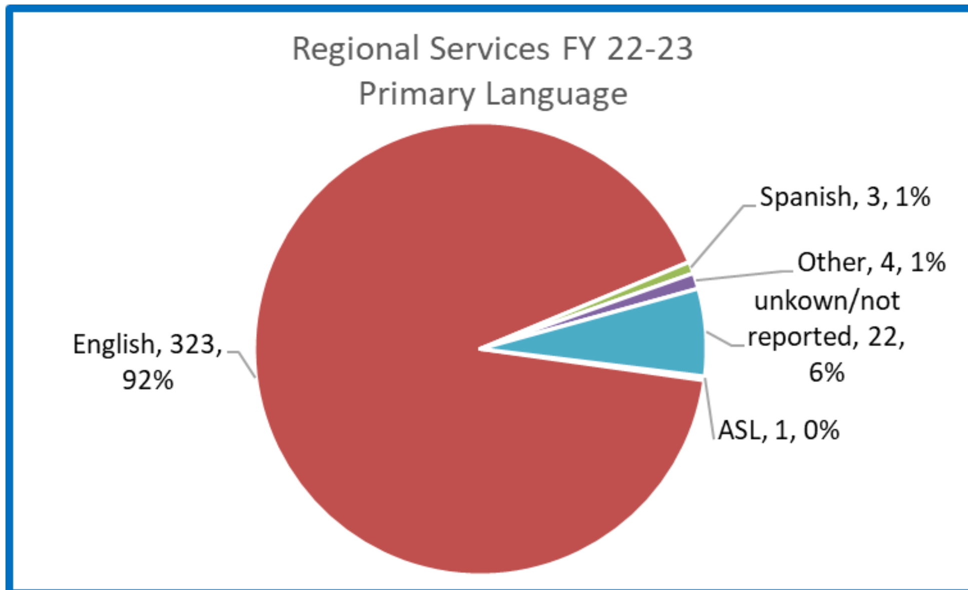
Among the 353 participants served in FY 22/23, 21 (6%) were among the 16-26 age group, 246 (70%) were among the 27-59 age group, and 86 (24%) were among the 60+ group.



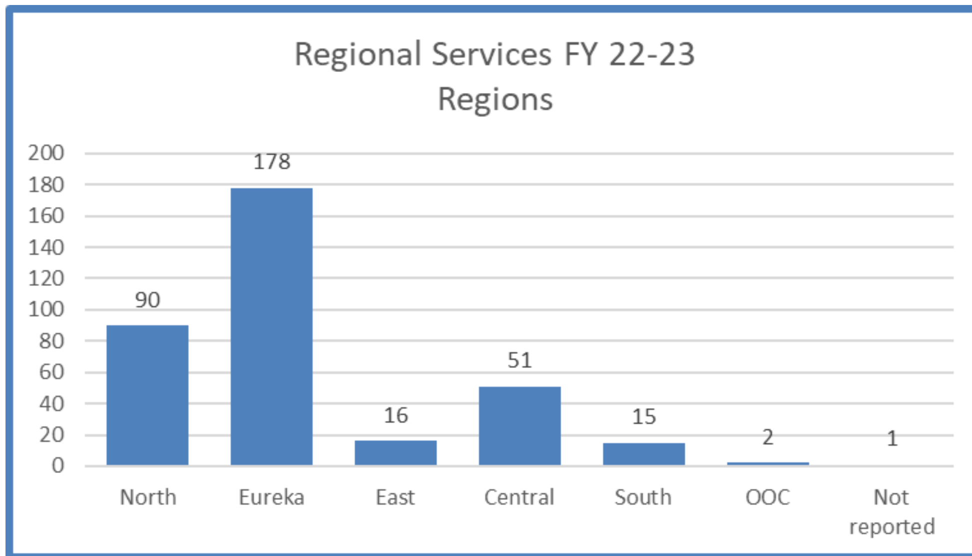
Of the 353 participants served in the Regional Services Program for FY 22/23, 15 (4%) were African American, 5 (1%) were Asian, 30 (8%) were Hispanic, 30 (8%) were American Indian, 238 (67%) were White, and 29 (8%) are Unknown.



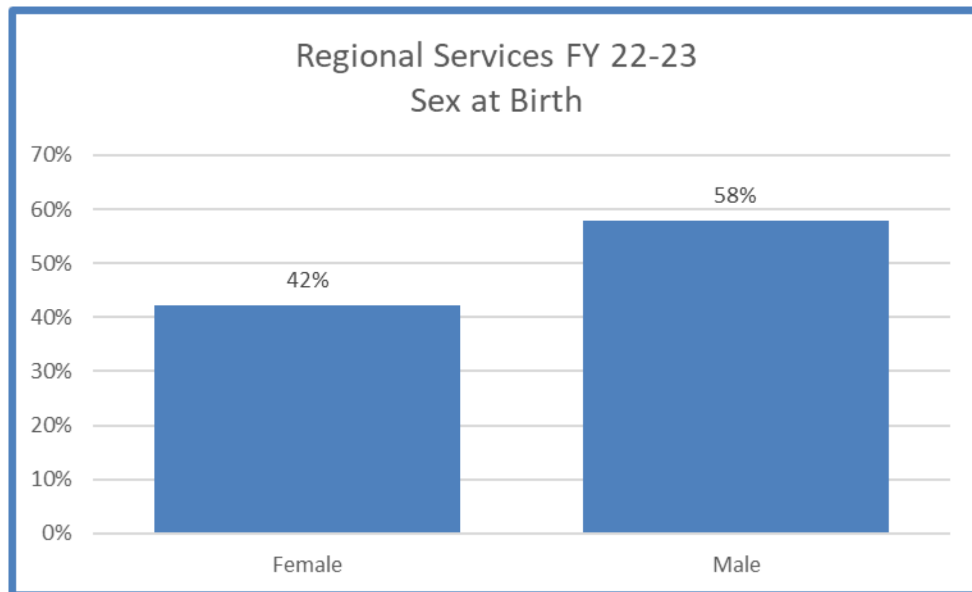
Out of the 353 participants served in the Regional Services Program for FY 22/23, 323 (92%) listed English as their primary language, 1 (<1%) listed ASL, 3 (1%) listed Spanish, 4 (1%) listed the Other category, 22 (6%) did not report their primary language.



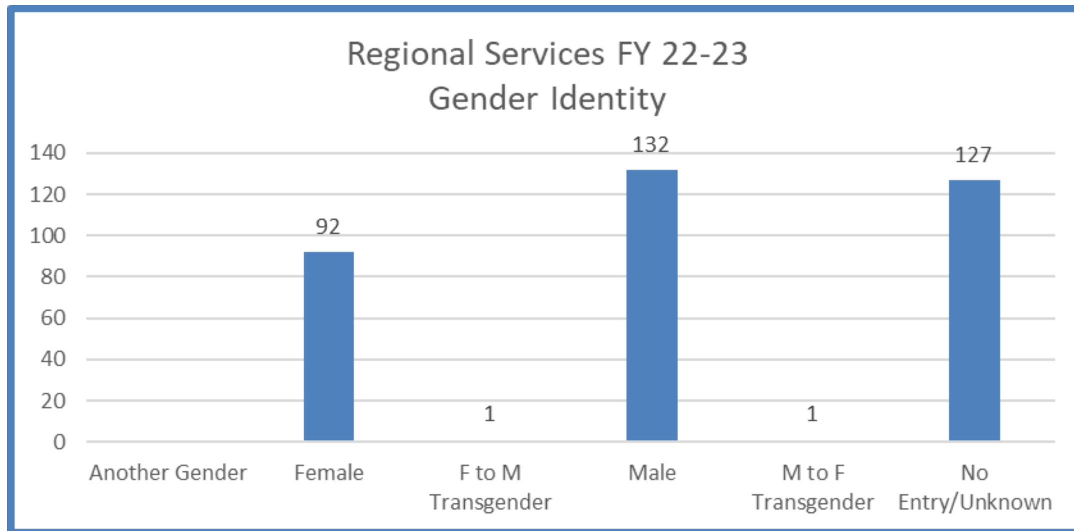
Among the 353 Regional Services participants for FY 22/23, 90 (25%) were from Northern Humboldt, 187 (50%) were from Eureka, 16 (5%) were from Eastern Humboldt, 51 (14%) were from Central Humboldt, 15 (4%) were from Southern Humboldt, 2 (1%) were from Out of County, and 1 (<1%) of the participants did not report the region they live in.



Out of the 353 individuals served by Regional Services in FY 22-23, 149 (42%) identified as female and 204 (58%) identified as male.



Out of the 353 Regional Services participants, 92 (26%) identified as Female, 1 (<1%) from Female to Male Transgender, 132 (37%) as Male, 1 (<1%) from Male to Female Transgender and 127 (36%) 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 150-160 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.

During fiscal year 2022-2023, there were 137 unduplicated clients served by the program. Based on the Revenue and Expense Report (RER), which outlines a total cost of $31,223 in MHSA funds, the average cost per client is estimated at $227.91.

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.

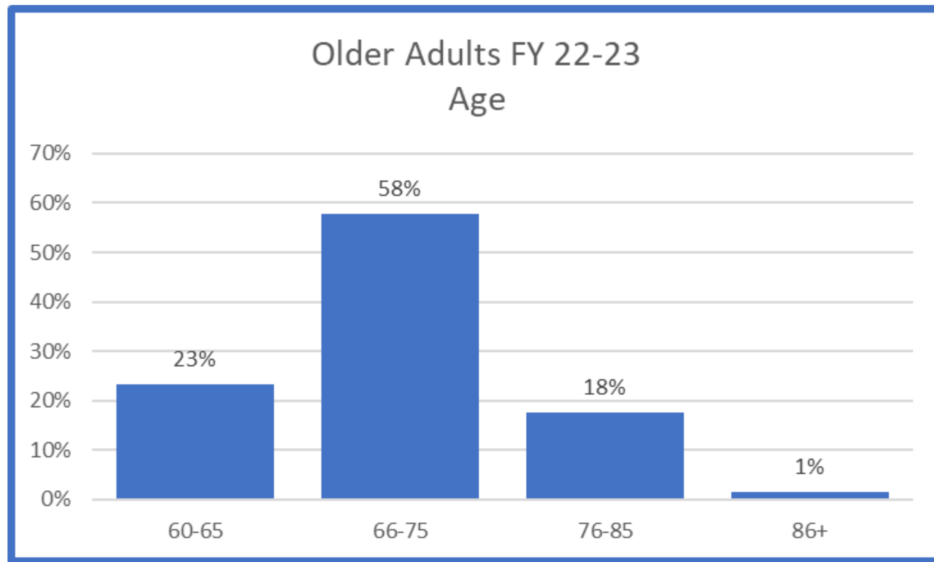
Report for Fiscal Year 2022-2023

Outreach, Prevention and Education

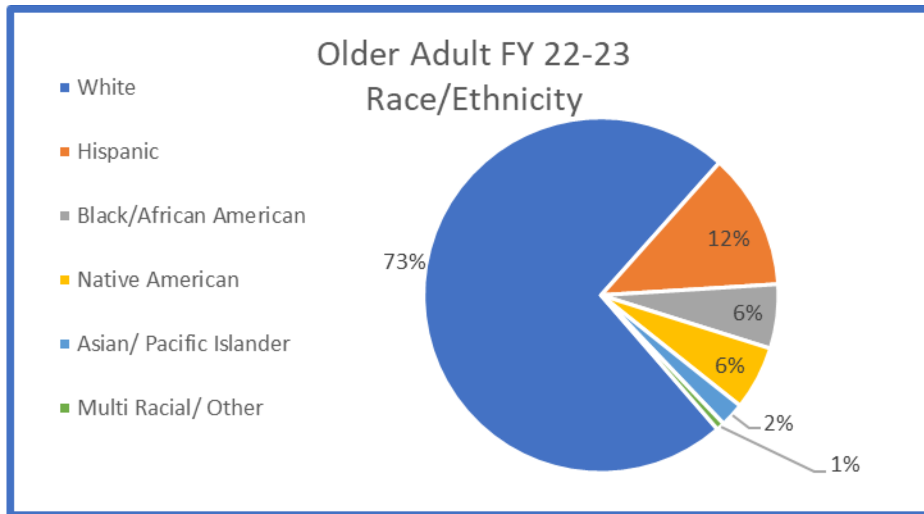
During Fiscal Year 22/23 a total of 137 individuals were contacted by the Behavioral Health Clinician assigned to the Older Adults program, primarily through outreach, prevention and education activities.

Descriptive statistics for participants in the Outreach, Prevention and Education component of the Older Adult program for FY 22/23 are discussed below.

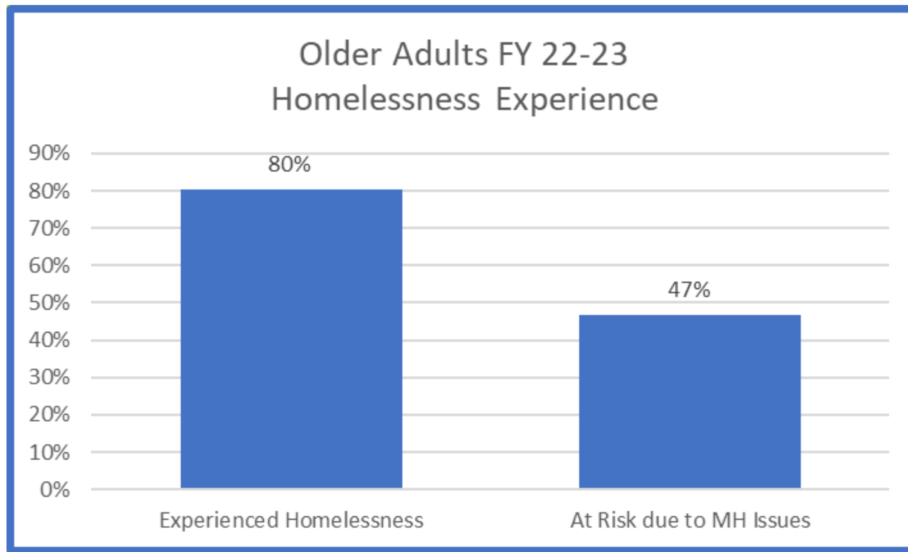
Fifty-three (39%) of the participants were male, 84 (61%) were female. Thirty-two (23%) were age 60-65, 79 (58%) between ages 66-75, 24 (18%) between ages 76-85 and 2 (1%) were 86+.



Among the 137 Older Adults served in FY22/23, 100 (73%) were White, 8 (6%) were African American, 8 (6%) were Native American, 3 (2%) was Asian, and 1 (1%) was Multiracial or other and 17 (12%) of the participants were Hispanic.

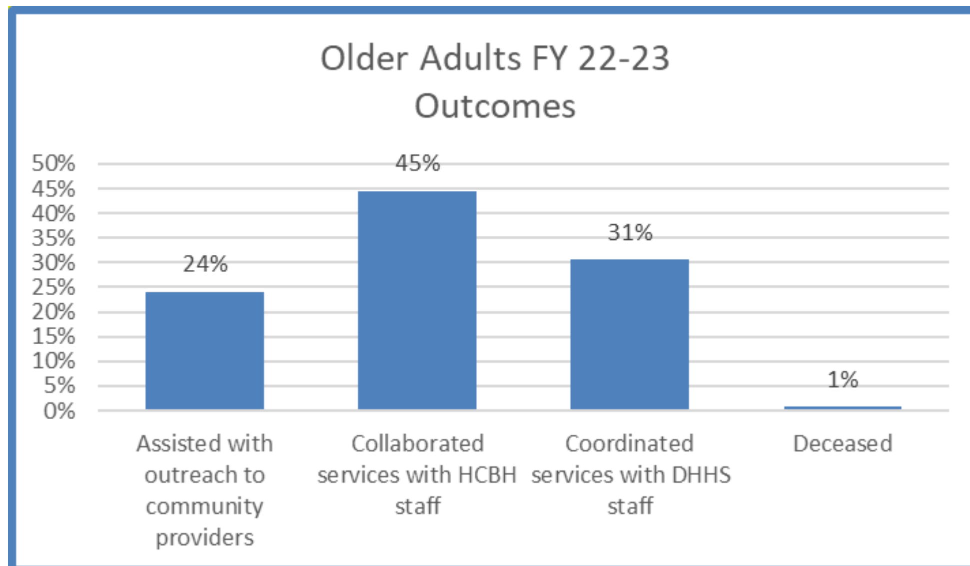


Of the 137 participants in the Older Adult program in FY22/23 110 (80%) self-identified as having experienced homelessness at some time and 64 (47%) expressed feeling at risk of homelessness due to mental health issues.



Outcomes

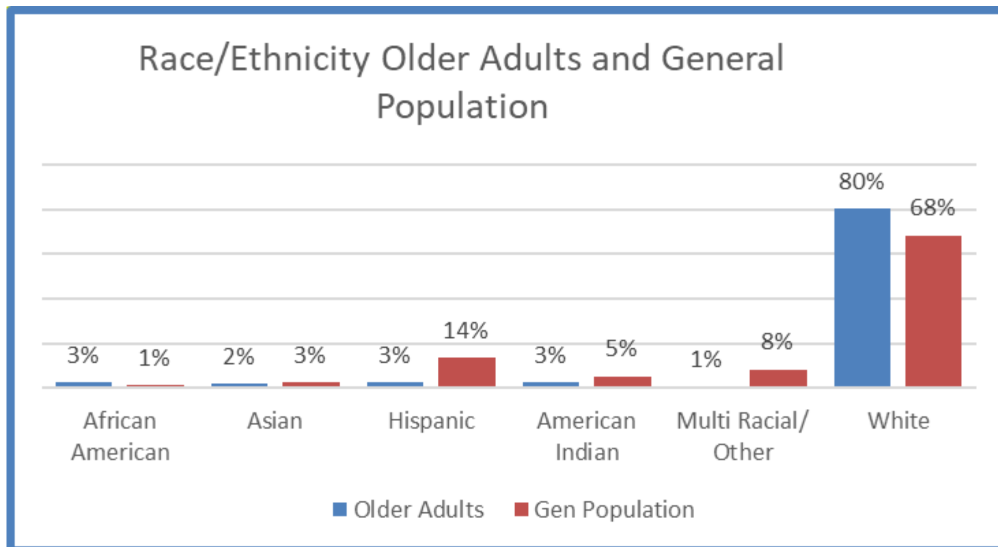
For these 137 Older Adult participants 33 (24%) were assisted with outreach to a community provider; for 42 (31%) services were coordinated with DHHS staff; for 61 (45%) collaboration with Behavioral Health staff was implemented and one client was deceased.



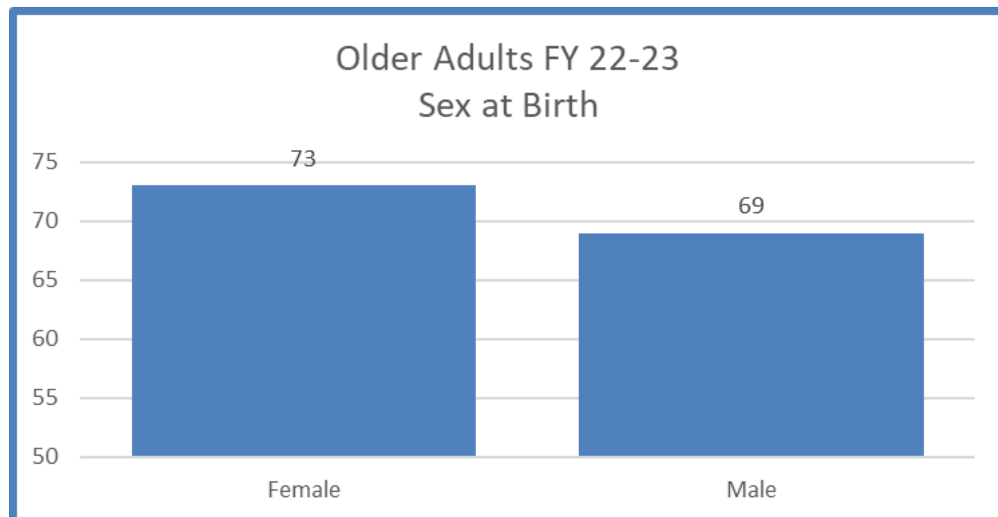
Mental Health Services to Clients

In addition to contacts made through outreach, prevention and education, 142 individuals were provided services as clients of Behavioral Health for Fiscal Year 2022-2023. Of these, 80% 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

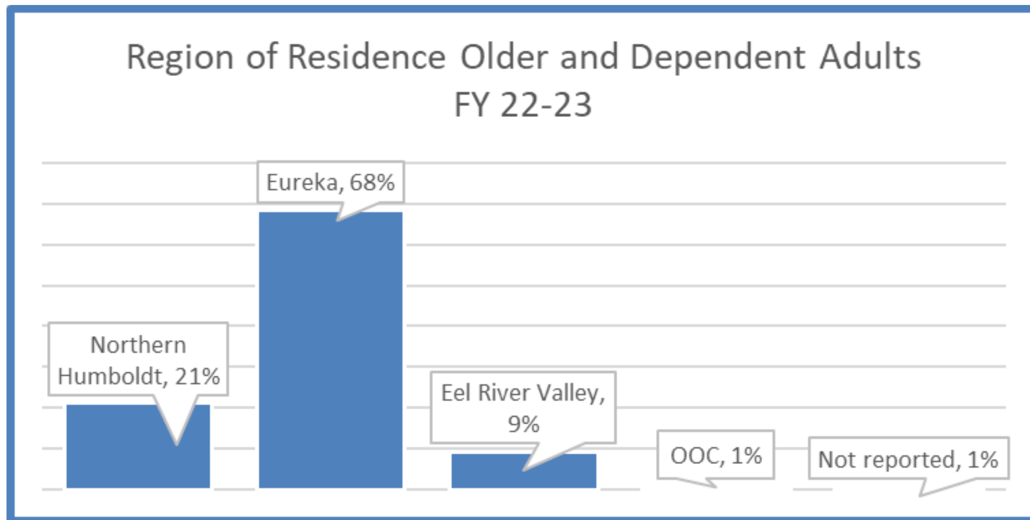
1% of the general population; 2% were Asian, compared to 3% of the general population; and 1% were Multi Racial/Other compared to 8% of the general population.



Sixty-nine (49%) of the participants were male, 73 (51%) were female.



Sixty-eight of those served reside in Eureka, 21% in Northern Humboldt, 9% in Eel River Valley, 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 fall or early winter 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

Since services have not started with this program, cost per client estimates cannot be provided at this time.

NEW Community Services & Supports: Crisis Alternative Response of Eureka (CARE)

Crisis Alternative Response of Eureka (CARE) is a partnership and collaboration effort between the County of Humboldt, city municipalities, and other organizations meant to improve systems and to create the depth and agility needed to provide the best support possible for those in crisis. This program will support Humboldt County Behavioral Health's ability to implement 24-hour Mobile Crisis Benefit Services. CARE will be a

new program and MHSA funding will be utilized to contribute to the operational costs of one clinician and one case manager during the first year.. The program serves as General System Development (GSD) and Outreach and Engagement (O&E).

The goal of mobile crisis response services is to provide person and family-centered care that can de-escalate and resolve a crisis before more restrictive interventions become necessary. Services are provided in the community, including in individuals' homes, streets, and other public and private spaces. The focus is on voluntary services that are provided, whenever possible, outside of an emergency department and without the presence of law enforcement. CARE will work with adults, older adults, transition-age youth, and children experiencing or at risk of experiencing a crisis within the City of Eureka.

CARE will assist individuals in crisis, assess the need for and provide referrals to other community services, and reduce unnecessary hospitalizations and arrests. For the three objectives listed below, data collected in the first year of the program's implementation will be used as the baseline measure to evaluate outcomes:

1. Assist Individuals in Crisis – City of Eureka will collect data on the number of individuals in crisis served by the program in the first year of operation.
2. Assess the need for and provide referrals to other community services – the program will collect data designed to access the referral needs of individuals in crisis, as well as the type and number of referrals provided in the first year.
3. Reduce Unnecessary Psychiatric Hospitalization and Arrests – the program will collect data on the number of individuals in crisis, hospitalized in a psychiatric facility and/or arrested in the first year.

As part of the mobile crisis response intervention, team members initiate a crisis planning process that can help the individual prevent future crises. This process may include the development or modification of a safety plan. When appropriate, telephonic, or in-person follow-up services are provided to determine whether the individual was connected to referrals and if their needs were met. The MHSA Annual Report for fiscal year 2025-2026 will contain a report on activities conducted and data gathered by the program during fiscal year 2024-2025.

NEW Community Services & Supports: Tribal Support

With stakeholder input in mind, DHHS Behavioral Health has supported local tribal organizations in the past to expand and/or develop coordinated systems of care. The 2024-2025 Annual Update has allocated CSS funding for a local tribal organization to increase access and linkage to treatment, by becoming an organizational provider. CSS funding can be used to support infrastructure development via its General System Development (GSD) category.

An organizational provider contracts with DHHS Behavioral Health to provide Medi-Cal billable behavioral health services within the community. CSS funding will assist infrastructure development so a local tribe has the resources needed to become an organizational provider for DHHS Behavioral Health. A similar support was done through the MHSA 2019/2020 Annual Update, when Two Feathers Native American Family Services received funding to develop a program and create infrastructure to increase access and linkage to treatment that was a component of a coordinated system of care that serves youth and their families. Two Feathers also leveraged existing tribal resources with MHSA funding to expand culturally responsive services and became DHHS Behavioral Health's first tribal organization to be an organizational provider.

To access how DHHS Behavioral Health has supported local tribal organizations, please see page 103 of the MHSA 2019/2020 Annual Update; where MHSA funding was utilized to support Two Feathers Native American Family Services in the development of the Making Relatives Program.

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 position is filled and active recruitment is happening to fill all remaining vacancies for this program.

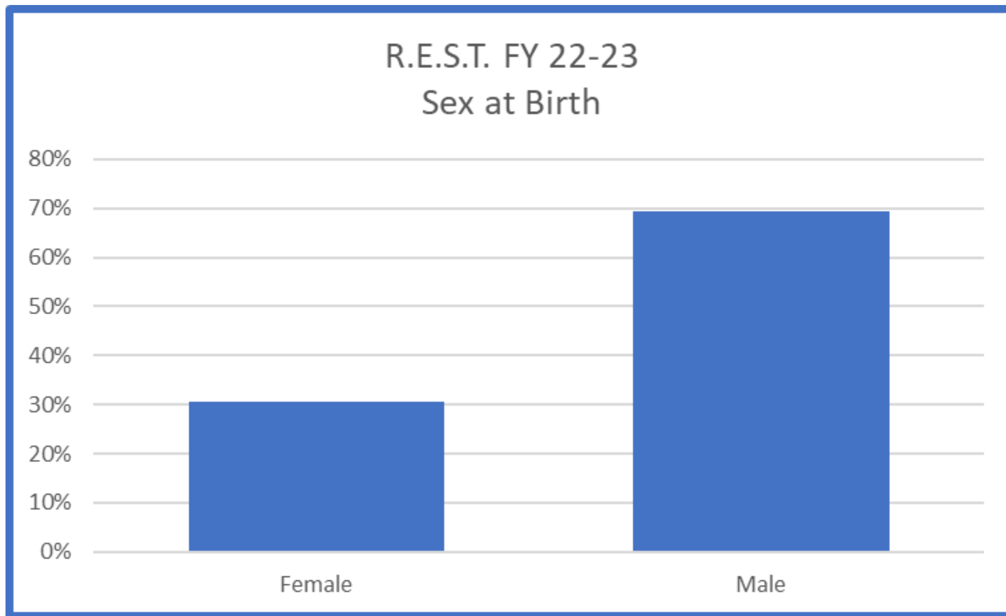
The full proposal for the REST project can be found in the MHSA Annual Update for 2021-2022, available on the County website at Annual Update.

During fiscal year 2022-2023, there were 59 unduplicated clients served by the program. Based on the Revenue and Expense Report (RER), which outlines a total cost of $170,106.59 in MHSA funds, the average cost per client is estimated at $2,883.16.

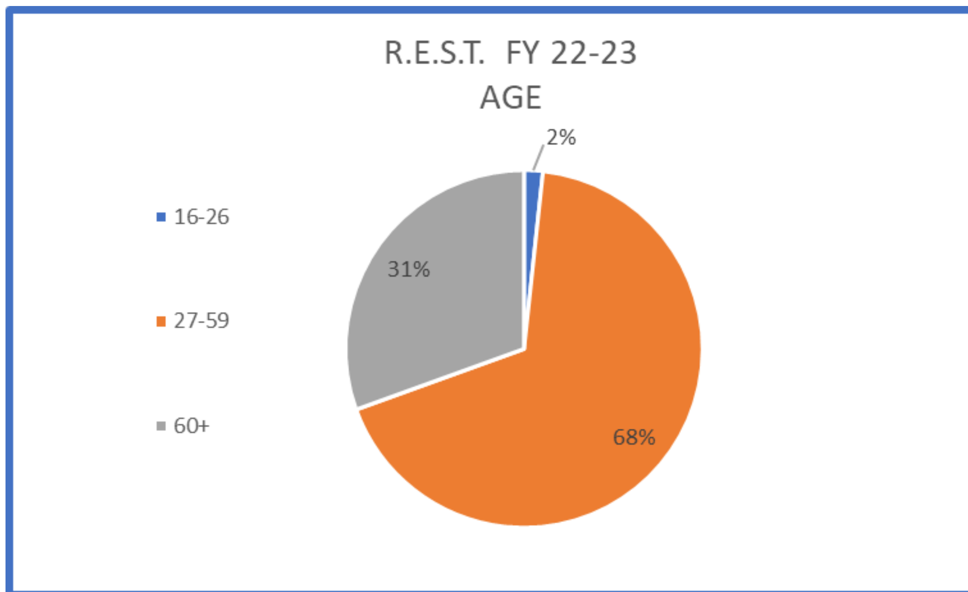
Annual Report FY 2022-2023

For fiscal year 2022/23, REST worked with a total of 59 participants.

As shown on the graph below, in fiscal year 2022/23 30% (18) of the clients supported by the program reported their sex at birth to be female and 70% (41) were male.

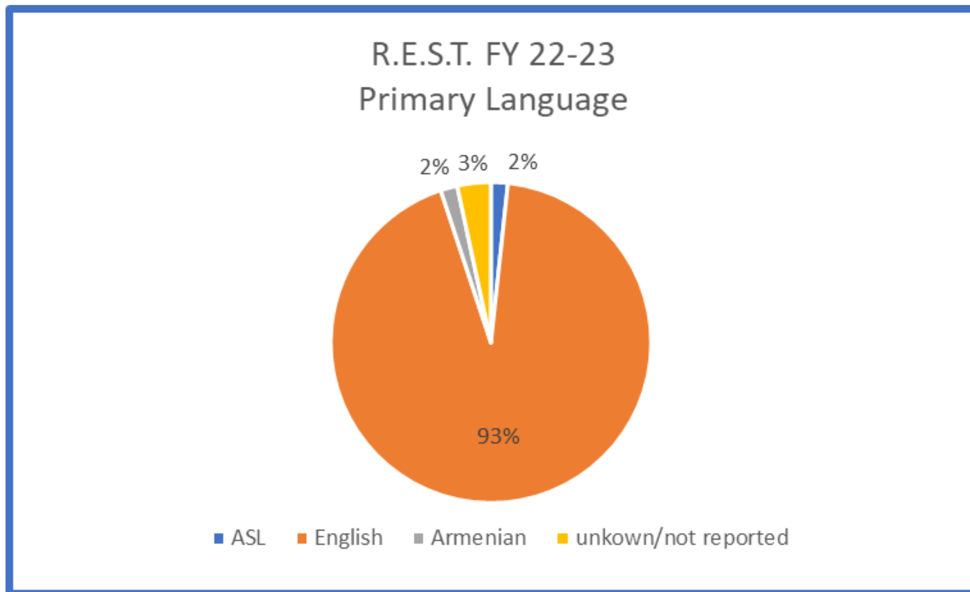


As seen on the graph below, in fiscal year 2022/23 2% (1) of the participants were within the 16-26 TAY age group, 68% (41) of participants were within the 27-59 adult age group, and 31% (18) were within the 60+ older adults age group.

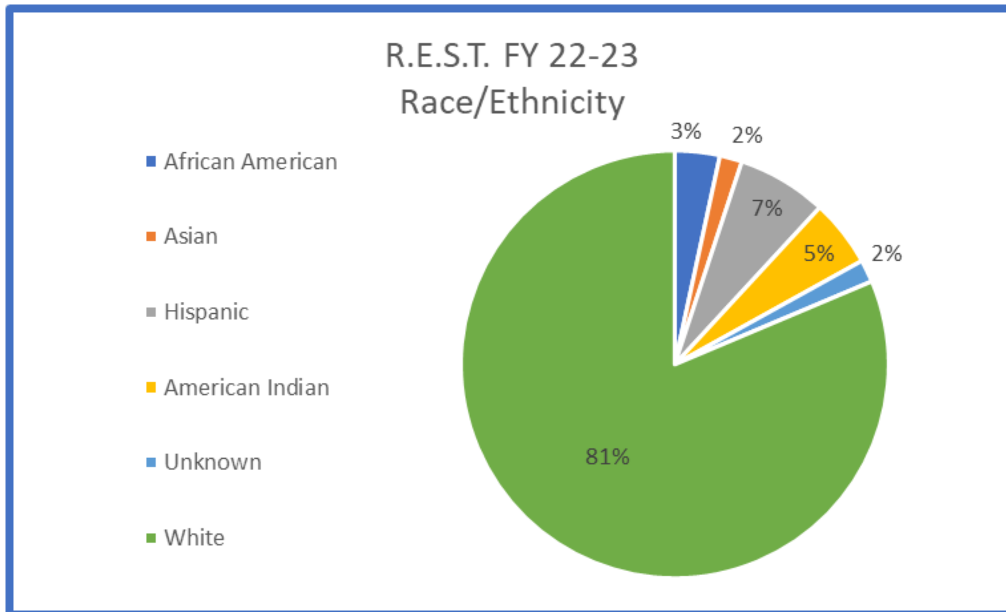


As seen on the graph below, in fiscal year 2022/23 2% (1) of the participants utilized Armenian as a primary language, 3% (2) preferred not to answer, 2% (1) utilized

American Sign Language (ASL), and 93% (55) utilized English as their primary language.

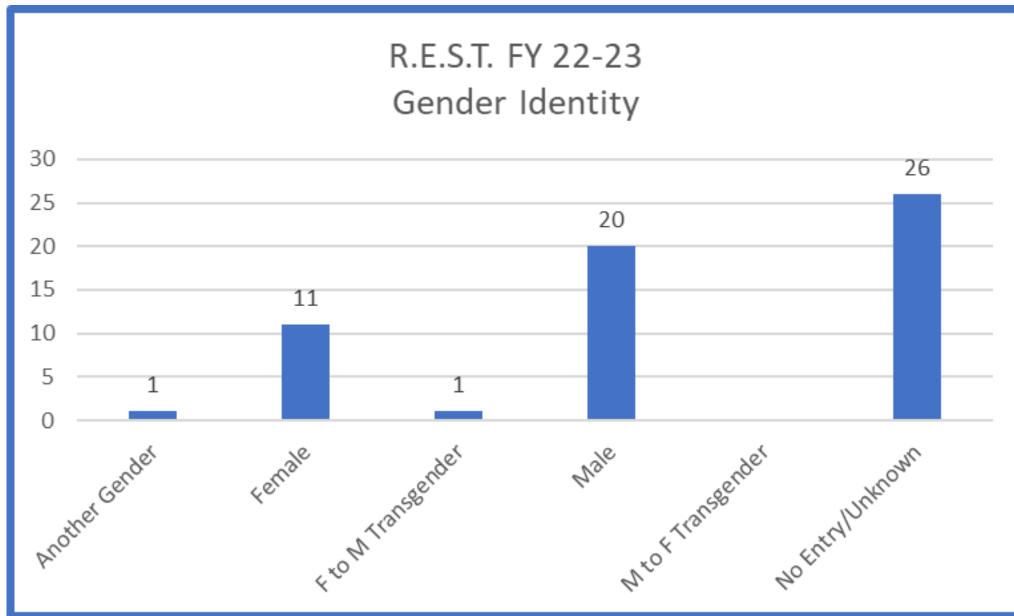


As seen on the graph below, in fiscal year 2022/23 3% (2) of REST participants reported African American as their race/ethnicity, 2% (1) as Asian, 7% (4) as Hispanic, 5% (3) as American Indian, 2% (1) preferred not to answer, and 81% (48) reported White as their race/ethnicity.

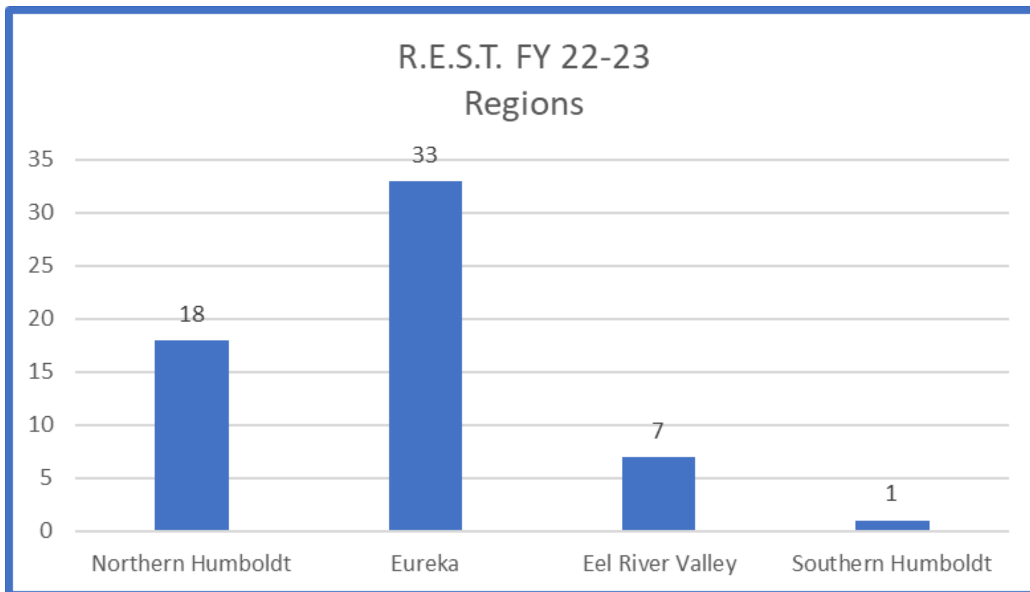


As seen on the graph below, in fiscal year 2022/23 1 (2%) participant identified as another gender identity, 11 (19%) identified as female, 1 (2%) as female to male

transgender (no one identified as male to female transgender), 20 (34%) as male, and 26 (44%) preferred not to answer.



As seen on the graph below, in fiscal year 2022/23 18 (31%) of REST participants are from the Northern Humboldt region, 33 (56%) are from the Eureka region, 7 (12%) from the Eel River Valley region, and 1 (2%) from the Southern Humboldt region.



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 (SDR), 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. Below is a table showing current PEI programs along with their corresponding service category:

PEI Program	Service Category
Hope Center	SDR, Access and linkage to services, Prevention, Early Intervention
Transition-Age Youth Advocacy & Peer Support	Prevention, Early Intervention, SDR, Recognizing early signs of mental illness, Access and linkage to services
Suicide Prevention	Suicide Prevention
Parent Partners	Early Intervention, Access and linkage to services
School Climate Transformation MTSS	Prevention, Early Intervention, Recognizing early signs of mental illness
Local Implementation Agreements	**Vary depending on approved programs**
Latinx Liaison Position	SDR, Access and linkage to services
Early Childhood Treatment Certification	Prevention, Early Intervention, increasing the recognition of early signs of mental illness
Warm Line	Early Intervention, Access and Linkage to Services
Assigned Funds—CalMHSA PEI Program	Recognizing early signs of mental illness

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 Humboldt PEI programs are for suicide prevention)	• Suicide Prevention • Suicide Prevention Hotline • Warm Line • 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 Program

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 III position along with Peer Coach I and II positions. Due to 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. Currently, the Peer Coach III has passed the test and earned their certification. 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 II'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.

The Hope Center strives to accomplish the following:
Access and Linkage to services--

- Build on the dimensions of wellness.
- Incorporate recovery pathways.
- Validate strengths and honor the person.
- Build sustainable living skills.
- Build community engagement through tabling events and other outreach efforts.
- Promote self-advocacy.
- Keep Hope Center a safe location for all participants.
- 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.

Link community members to services through use of the Warm Line.*Hope Center Peer Coaches meet with the client directly when needed and call together to check on referral status.

Stigma and Discrimination Reduction--

- Reduce stigma and discrimination within the system of care and the broader community.
- Break the stigma of "us and them."

Access and Linkage to Services
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.
- New: maintenance of the Warm Line (for more details go to page 160 of the 2024-2025 Annual Update).

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 evaluations 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.

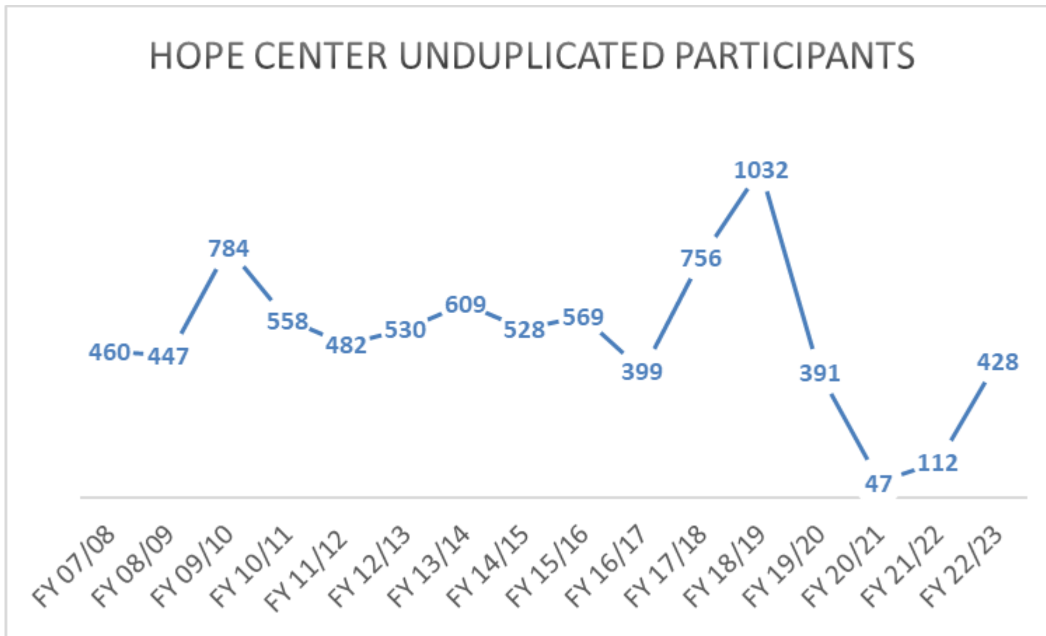
The methods and activities used to change attitudes, knowledge, and/or behavior regarding being diagnosed with a mental illness, having a mental illness and/or seeking mental health services is addressed in the following ways. The Hope Center participant does not need to be a mental health client and 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;

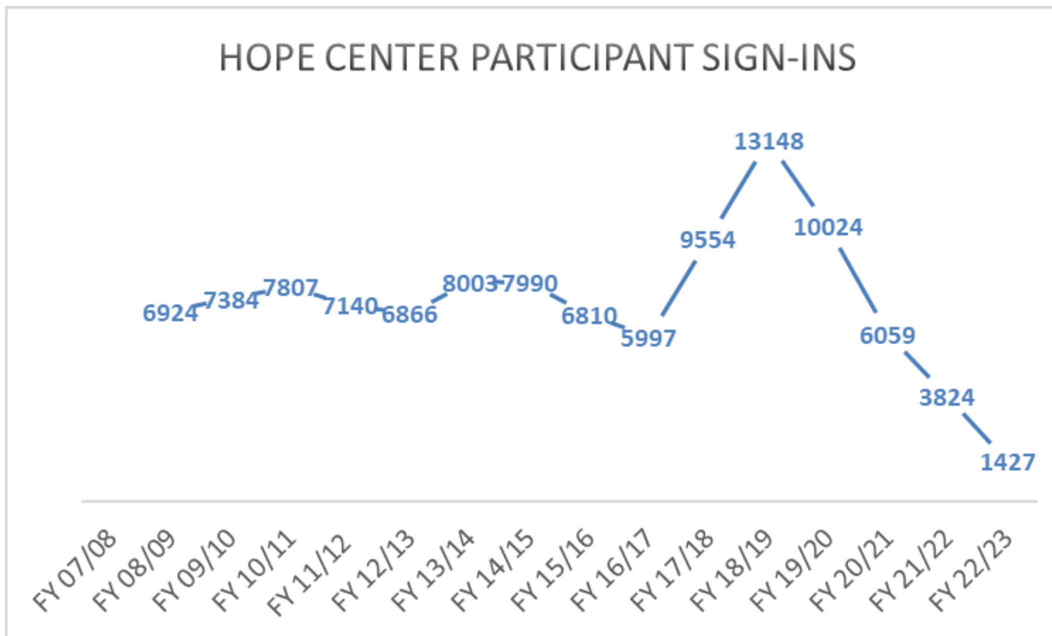
participation and advocacy at the local Behavioral Health Board. The classes and environment of the Hope Center have been one of the most important community efforts to date in reducing stigma and discrimination in Humboldt County.

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.

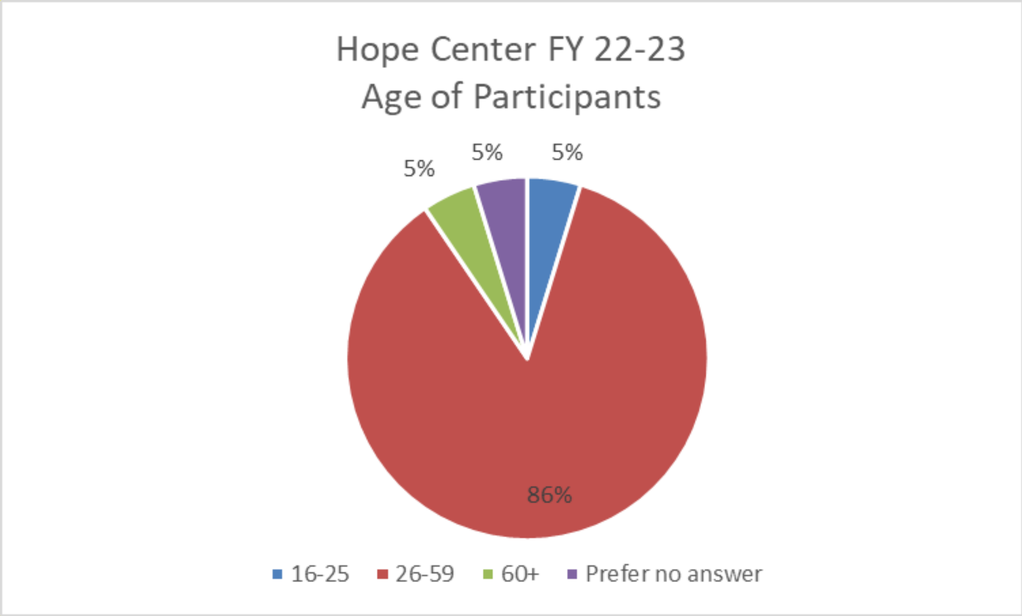
Cost Per Client Estimates
Data includes a recorded total of 428~ unduplicated participants for FY 2022-2023. were recorded. Based on the Revenue and Expense Report (RER), which outlines a total cost of $394,295.05 in MHSA funds, the average cost per client is estimated at $921.25. The number of duplicated participants was 1,427 for FY 2022-2023 which includes individual peer support engagement on site, in Zoom meetings, and in-person with social distancing, and masking. Additionally, hybrid classes have been added.

Below is the report for the Hope Center for Fiscal Year 2022-2023:
During Fiscal Year 2022-2023 the Hope Center interfaced with 428 unduplicated individuals. There was 1,427 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. Please note there was a period of time due to staffing error that data wasn't collected. Furthermore, the system has now gone paperless, which is keeping better track of data. The current data only goes back to December 2022.

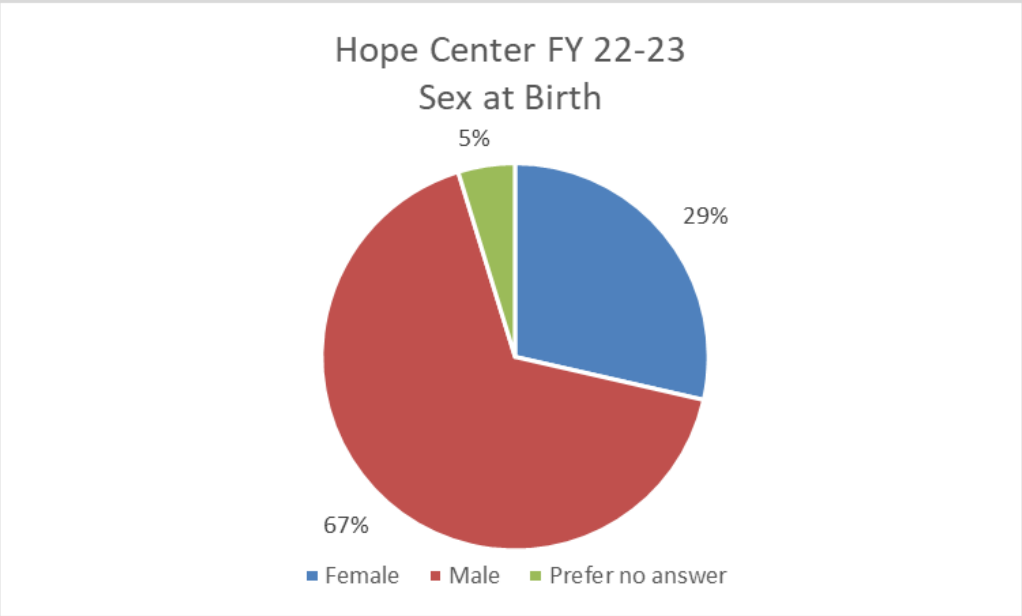




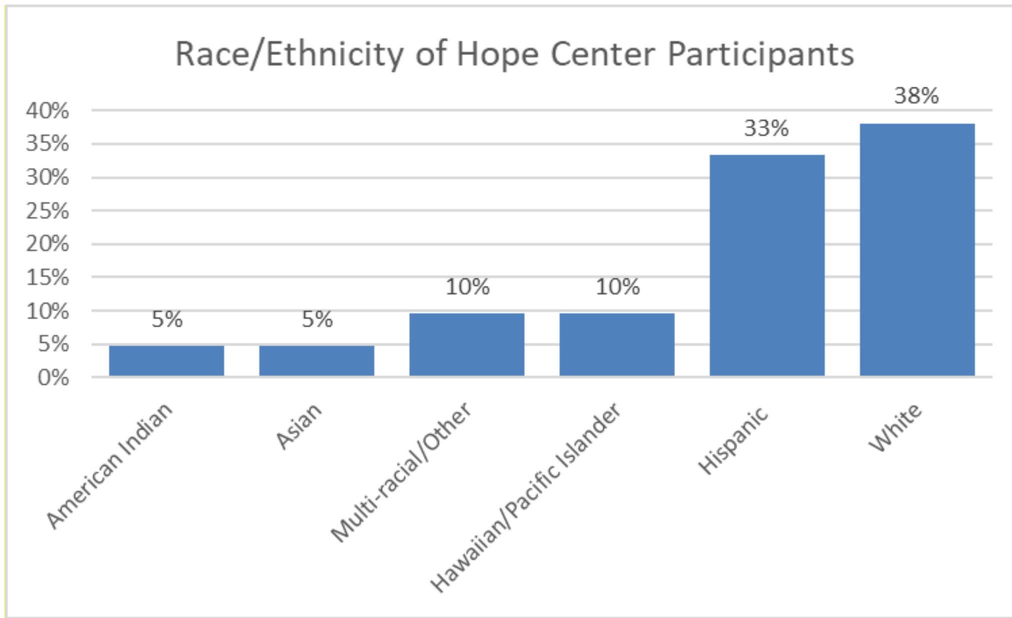
Demographic Data. Of the 428 Hope Center participants, 21 (5%) completed demographic forms. Demographic data is presented in the charts below.
Of those who responded, 5% of participants were ages 16-26, 86% of participants were ages 26-59, and 5% were age 60+. 5% percent did not answer this question.



Of those who responded, 29% were female, 67% male, 5% did not answer this question.

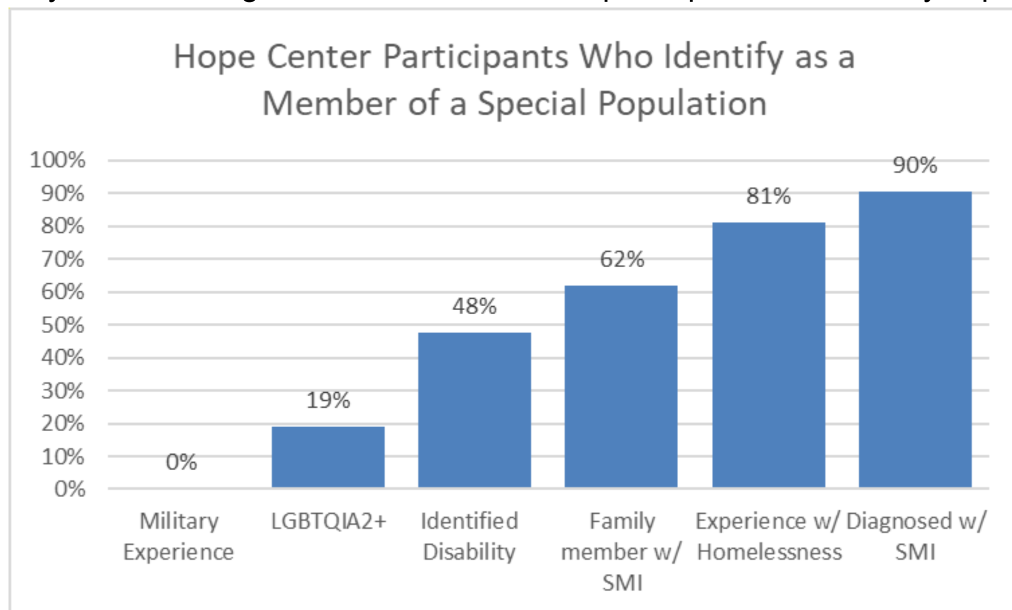


Of those that responded, 38% were White, 10% were Multiracial/Other, 33% were Hispanic/Latinx, 5% were American Indian, and 5% were Asian. 13% did not answer this question.



90% percent of the Hope Center participants who completed the form, spoke English as their primary language. Five percent spoke Spanish and 5% preferred not to answer.

19% identified as LGBTQ, 81% had experience with homelessness, 48% identified as having a disability, 90% had been diagnosed with a serious mental illness (SMI), 62% had a family member diagnosed with SMI, and no participants had military experience.



Prevention and Early Intervention (PEI): Transition-Age Youth (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 (ETD), CalFresh, Medi-Cal, Substance Use Disorder (SUD) services, and collaborates with community partners such as Juvenile Probation and Family Resource Centers.

TAY Access and Linkage to Services activities 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 EFC Unit.
- HCTAYC staff and Youth Advocacy Board (YAB).
- Peer Coaches who serve across the TAY Division.
- A Vocational Counselor from DHHS Employment Training Division (ETD).
- Linkage and referrals to intensive case coordination services as needed.

*Peer coaches attend a weekly TAY BH case consult with a clinical team and are able to ask for updates/status of waitlist for referrals they made. For referrals outside of TAY BH, peer coaches meet with the client directly and call together to check the referral status.

TAY Stigma and Discrimination Reduction (SDR) efforts are accomplished through the following activities:

- TAY Advocacy
- Peer Coaching Program
- Survey Development

**Please note that activities conducted by TAY include both access and linkage to services and SDR efforts. For more specifics on SDR efforts, please go to page 64 of the 2024-2025 Annual Update.

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 CWS, youth who opted into the EFC program, those experiencing behavioral health needs, those experiencing issues with substance use, parenting TAY and youth seeking employment.

TAY Advocacy—HCTAYC
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.

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), and Youth Law Center (YLC). 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.

Key Activities

The TAY Advocacy Program/HCTAYC consists of a shared Supervising Mental Health Clinician, three Youth Organizers, a dedicated peer coach 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 LGBTQIA+ and two-spirit 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].

During fiscal year 2022-2023, there were 200 unduplicated clients served by the program. Based on the Revenue and Expense Report (RER), which outlines a total cost of $389,550 in MHSA funds, the average cost per client is estimated at $1,947.75.

Expected Outcomes for Fiscal Year 2024-2025 (FY 24-25):

- Gather comprehensive outcomes data to report on leadership development as well as outcomes related to the specific PEI domains for Youth Leadership Development.
- The YAB will plan and facilitate activities for May is Mental Health Awareness Month.
- 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.
- Facilitate at least three (3) positive-youth development, stigma-discrimination reduction, or youth engagement trainings for youth-serving professionals.

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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

- 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 questionnaire created by HCTAYC to meet the outcomes domains of the PEI funding source.

The WEST Survey examines socio-emotional development factors along the 8 dimensions of wellness identified by SAMHSA. It also utilizes self-reporting data to assess, over time, the impact of programming on protective factors as well as PEI outcome domains such as suicidality, hospitalizations, education, contact with law enforcement, social relationships, and holistic health and wellbeing. The program is currently in the process of determining how to establish validity and reliability of the self-reporting tool.

Standardized, yet voluntary and confidential, demographic data is collected via a self-report survey during peer-led groups, workshops, or events. Collection of this data has historically been coordinated with DHHS-BH MHSA staff.

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

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

Estimated Number to be reached in FY 24-25

The program is estimated to maintain or exceed 6-12 consistent Youth Advocacy Board members each year. During FY 22-23, the YAB's structure was altered, merging all committees into the central board which meets weekly. Inconsistent participation volumes are more difficult to gauge, but will be measured based upon referrals, outreach, and attendance at committees. It is estimated that FY 24-25 will bring perhaps 133 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 the 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.

Roll out of goals and projects from the previously established Alcohol and Other Drugs, also referred to as SUD, policy recommendations will continue including a youth-driven peer support group for substance dependence and healing. The belief is that this group will reach 10-15 youth during FY 24-25.

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 4 to 8 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.

Wellness programming is expected to reach approximately 20-30 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 mentoring* 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. Peer Coaches:
    a. Believe young people can grow, making them unique in their ability to relate, provide support, and model self-advocacy, recovery, and self-care skills.

b. Build relationships with young people in ways that create validation, inspire hope, and support program participants through empowerment and trust.
c. Build mutuality in their relationships with young people, creating a relationship built on respect, compassion, and reciprocity. Through this unique relationship, young people can build self-determination, self-esteem, and gain skills necessary for transition into adulthood.
d. 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. Can assist young people in building their relational capacity by supporting them when accessing social, vocational, or educational opportunities.

2. *Outreach and engagement* opportunities are provided to young people by linkage to services and to the community. This aids in informing 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 in-services, presentations, and tabling events in the community. Peer Coaches:
    a. Provide 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. 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. Peer Coaches:

    a. Assist young people in navigating the systems, help with referrals to services and support them in appointments, activities, and supporting documents.
    b. 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. Peer Coaches:
    a. 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 WEST Survey.
- Participate in community advocacy settings, including the homelessness reduction collaborative Support HCTAYC in wellness programming activities.
- Support HCTAYC in wellness programming activities.

The expected outcomes for FY 24-25 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 eligible 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, including during drop-in hours.
- 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.
- Support youth with system navigation and advocacy needs.

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 BH, ETD and 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 24-25

It is estimated that approximately 200 TAY will be served in FY 24-25 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. 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 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 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 LGBTQIA+ two-spirit 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 Stigma Discrimination Reduction (SDR) survey for participants in MHSA supported activities, mostly young people. Integrated into YAB, community-based trainings, and Peer Coach supported events, the survey helps gauge learning and attitudes about stigma. The survey is administered post-workshop or activity along with the demographic form. It includes questions about effectiveness of the activity and its contribution to wellness and general perceptions of stigma. HCTAYC envisions developing, 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.

Integrated Reporting of HCTAYC and Peer Coaching programs FY 22-23

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:

- WEST Survey
- Demographics Survey

- SDR 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.

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: Perception of skills and motivation across SAMHSA's eight wellness domains, perceived helpfulness of programs, and lived experience in systems. Young People (YP) 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 using this survey is to gain insight into how HCTAYC programs might be perceived by the young people HCTAYC serves. Questions have been carefully crafted with youth guidance and response at every step to mitigate triggers of trauma from revisiting lived experience in systems that may have previously caused harm. There are no required questions other than to provide an email address. The email address acts as an identifier for baseline and subsequent response comparisons.

Fifty-nine (59) WEST Surveys have been completed since its inception in January 2020. Of those, 10 responders completed more than 1 survey allowing for comparative analysis. However, this data set is still too small to draw any clinical conclusions. Instead, comparisons can be used to help program and YPs see how perceptions have trended over time.

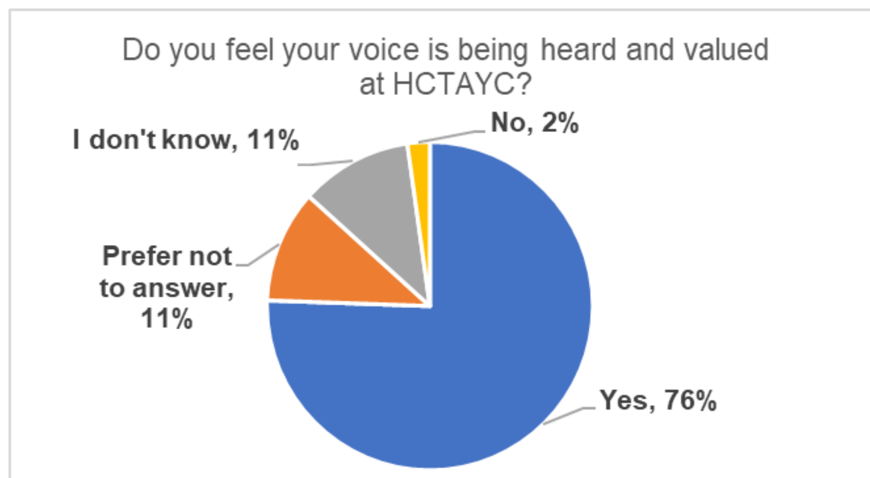
Reponses	Total
Single Entry	24
Baseline (1st individual response)	**10**
Incremental (Responses dated between Baseline and Last)	15
Last (Most recent individual response)	**10**
Grand Total	**59**

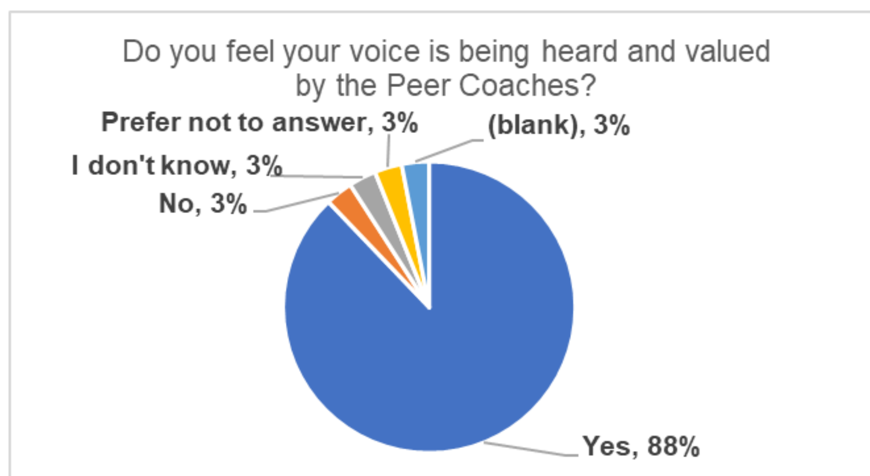
There were 23 unique responders who participated in HCTAYC and 20 in Peer Coaching programs. Fourteen (14) of these YPs participated in both programs.

Analysis of wellness based on SAMHSA's 8 domains can be conducted under separate cover due to the extensive amount of both quantitative and qualitative data collected. However, information can be accessed at any time to assist in planning wellness

activities and events. Wellness data is also available automatically on an individual basis for responders who opt in enabling goal tracking and planning with or without TAY staff support.

The most salient request by young people was to include a question that captured whether or not they felt listened to. Results showed that most 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 in addition to selecting “No.”





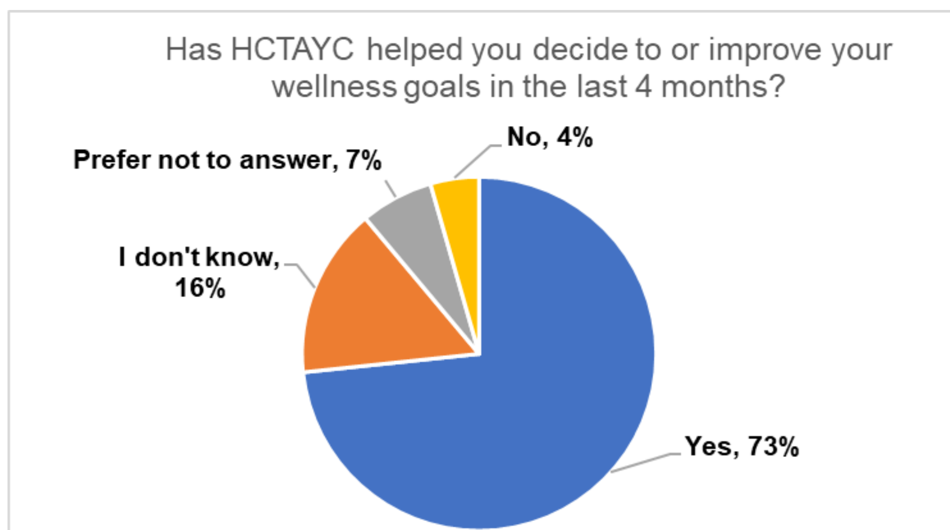
“Health is a state of complete physical, mental, and social well-being, and not merely the absence of disease and infirmity.” — World Health Organization (1946)

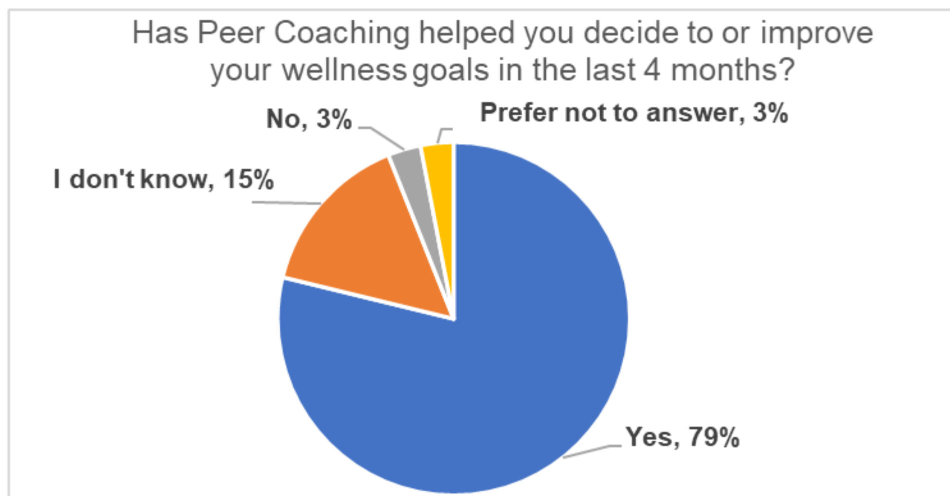
HCTAYC and Peer Coaching programs embrace health and wellness as a fundamental objective when engaging and supporting young people. HCTAYC services are tailored to help young people develop both skills and motivation in defining and achieving their

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 subsequent responses as well as more detailed insights across the 8 wellness domains.

Again, most survey respondents perceive that the programs help them decide to improve their wellness goals. In addition to answering "No", 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 criterion used by the systems themselves. It is known that young people with access and functional needs or

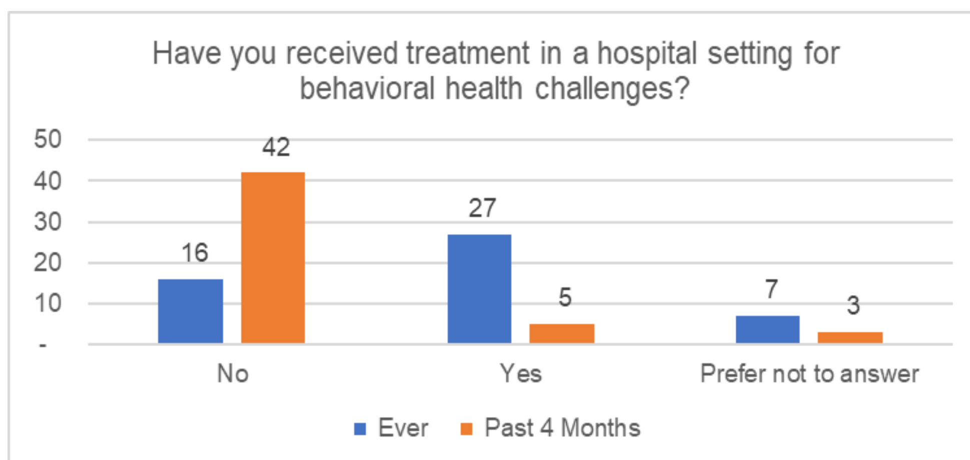
members of marginalized communities have more experience with systems of child welfare and foster care, behavioral health, law enforcement, juvenile justice, and homelessness. It is known that within systems, young people are asked to repeat their experiences at a variety of assessment and intake points 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.

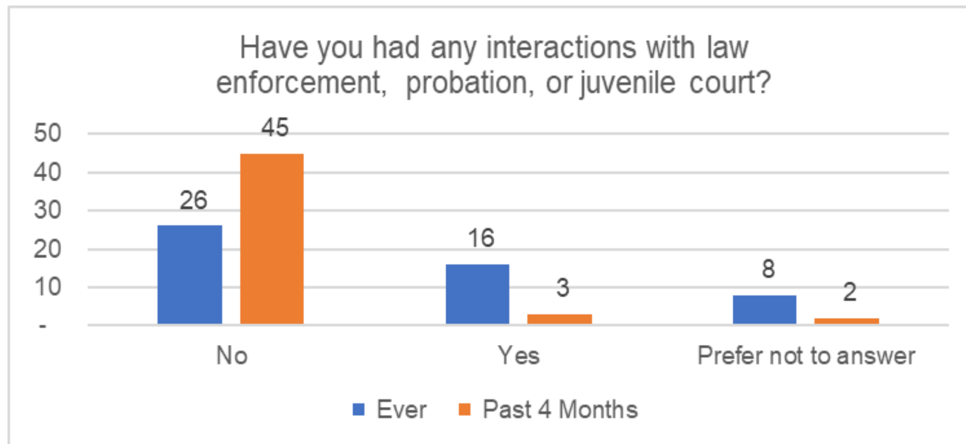
While there is a low volume of responses, it’s hard to not be pleased with the results. It appears that HCTAYC and Peer Coaching are supporting young people in positive ways, and there is hope that over time more survey responses will indeed continue to reflect this optimism. If not, they will give input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

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

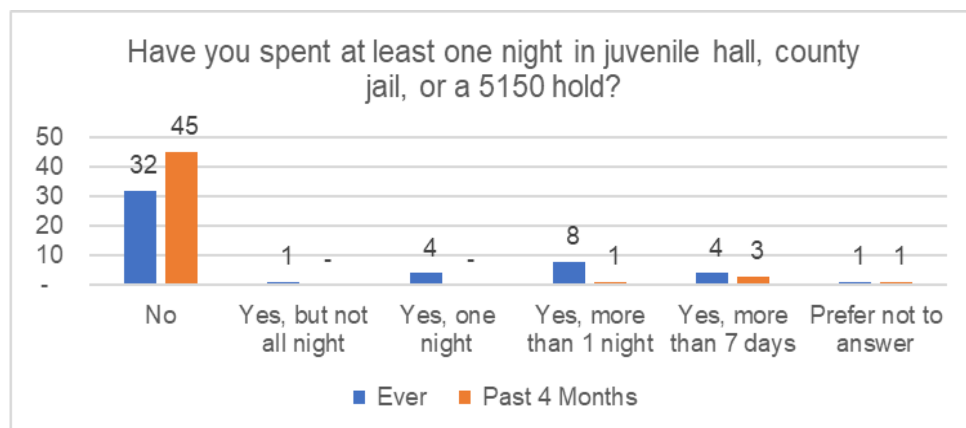
The percentage of change decreased 81.5% when responding “Yes” to the question of having ever received treatment in a hospital setting for behavioral health challenges to having received it in the past 4 months.



Of the respondents that answered and selected “No,” there was a 73.1% increase in the percentage of change between having ever 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 81.3% from ever having experience to having experience in the past 4 months.

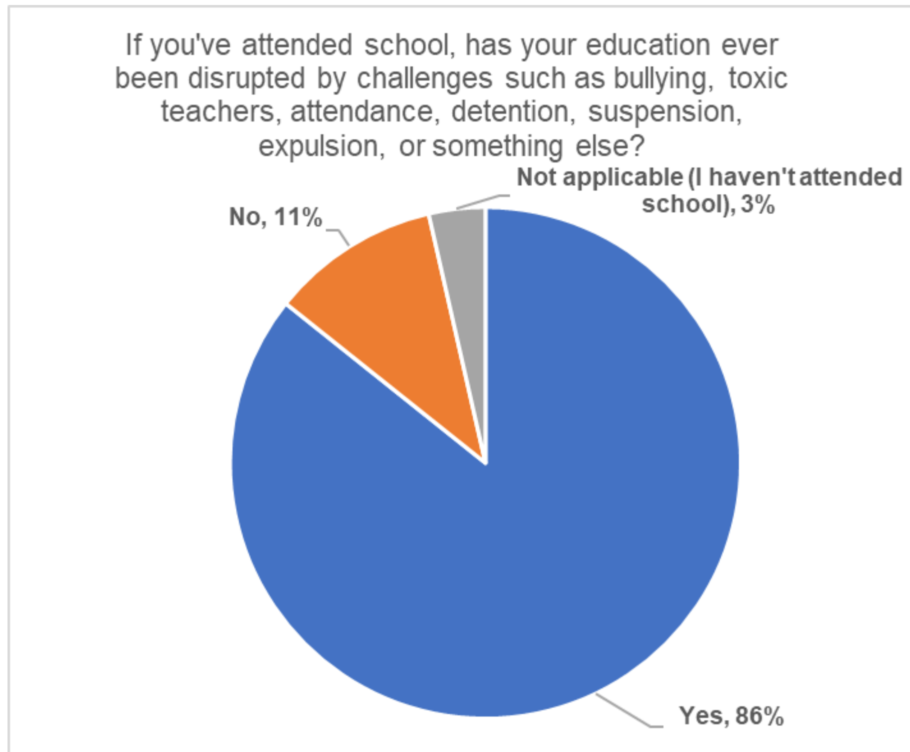


Percentage of change trended in similar ways, increasing 40.6% when responding “No” and decreasing 75.0% when responding “Yes” to ever having spent at least one night in juvenile hall, county jail or on a 5150 hold to having done the same in the past 4 months.

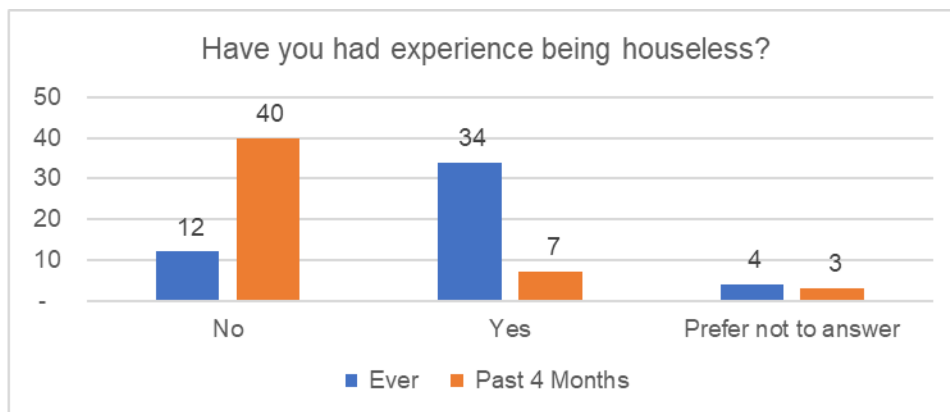


Drop-out and expulsion rates are popular evaluation criteria for young people with lived experience in systems. However, there are many reasons why a young person might have challenges in the current educational system, and additional system experience exacerbates educational challenges. Regardless of the cause, leaving school is disruptive to the young person and can carry stigma and occupational discrimination with it. Most, of the young people HCTAYC serves (86% of responses) have experienced disruptions in their education. Understanding how educational disruption is

so prolific and impactful to program participants can help programs plan and offer workshops, individual supports/skills trainings, and advocacy opportunities to help build resilience and reduce stigma.

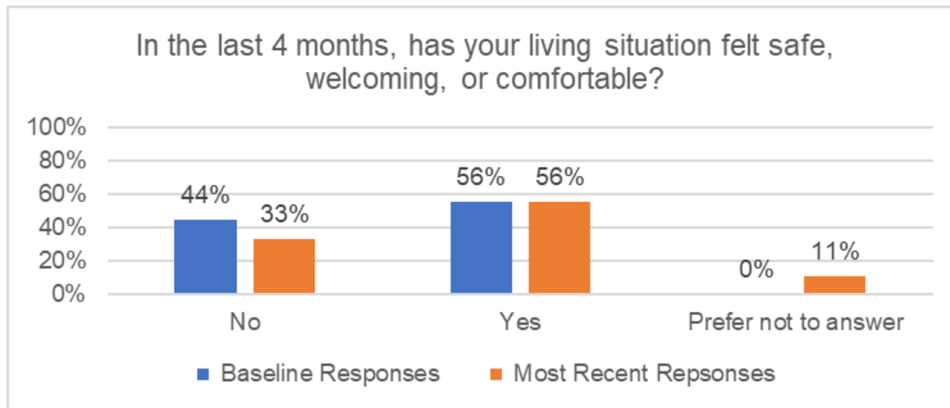


Homelessness is a complex challenge that is pervasive throughout Humboldt County. Sixty-eight (68%) of WEST Survey responders have experienced it at some time in their past.



Youth in HCTAYC programs prefer to use the term houseless instead of homeless. They comment that a sense of home can come from within or being part of a larger community regardless of housing status. Home is where the heart is, so to speak, from

the perspective of the young people who participate in HCTAYC and Peer Coach programs. It's possibly an adaptive perception considering the prevalence of houselessness experienced by program participants. Even when housed, however, living situations can still feel precariously fragile lacking senses of safety, being welcome or comfortable.

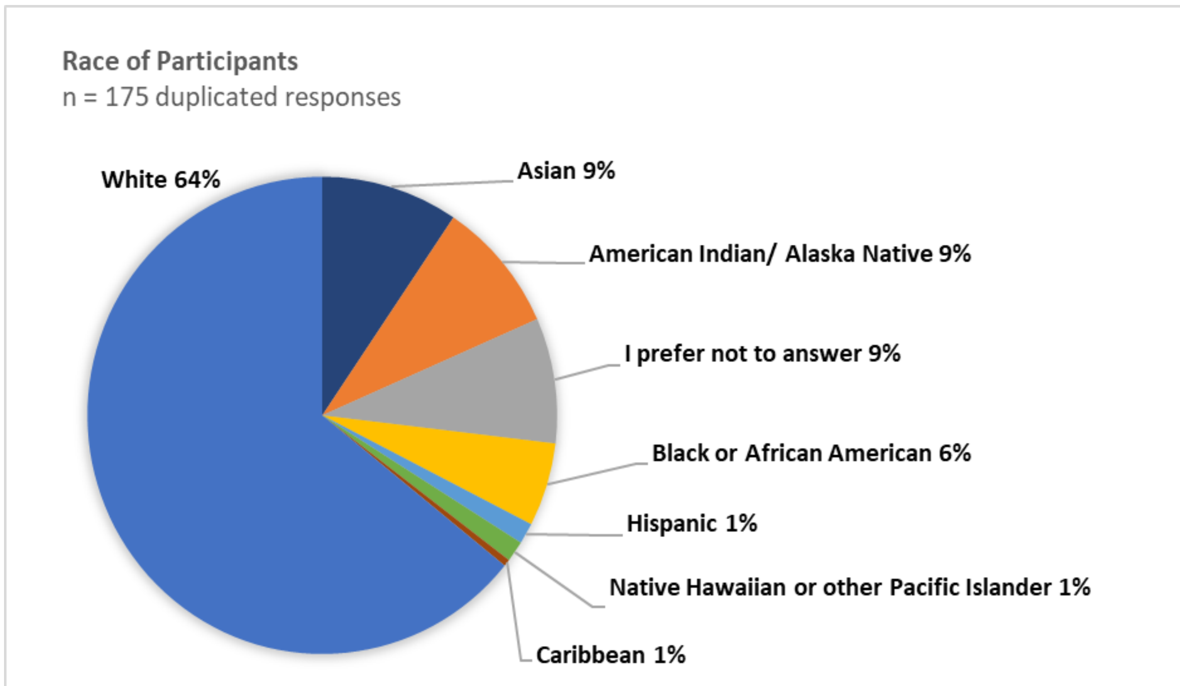


In the chart above, people were asked if their living situation felt safe, welcoming, and comfortable. At first, 44% of respondents said "No" but when asked again after 4 months, 33% of respondents said "No." Initially, 56% of respondents said "Yes" and stayed the same after 4 months. For initial responses, no one selected "prefer not to answer." Eleven percent of respondents preferred not to answer the question when asked again.

Demographics Survey Analysis

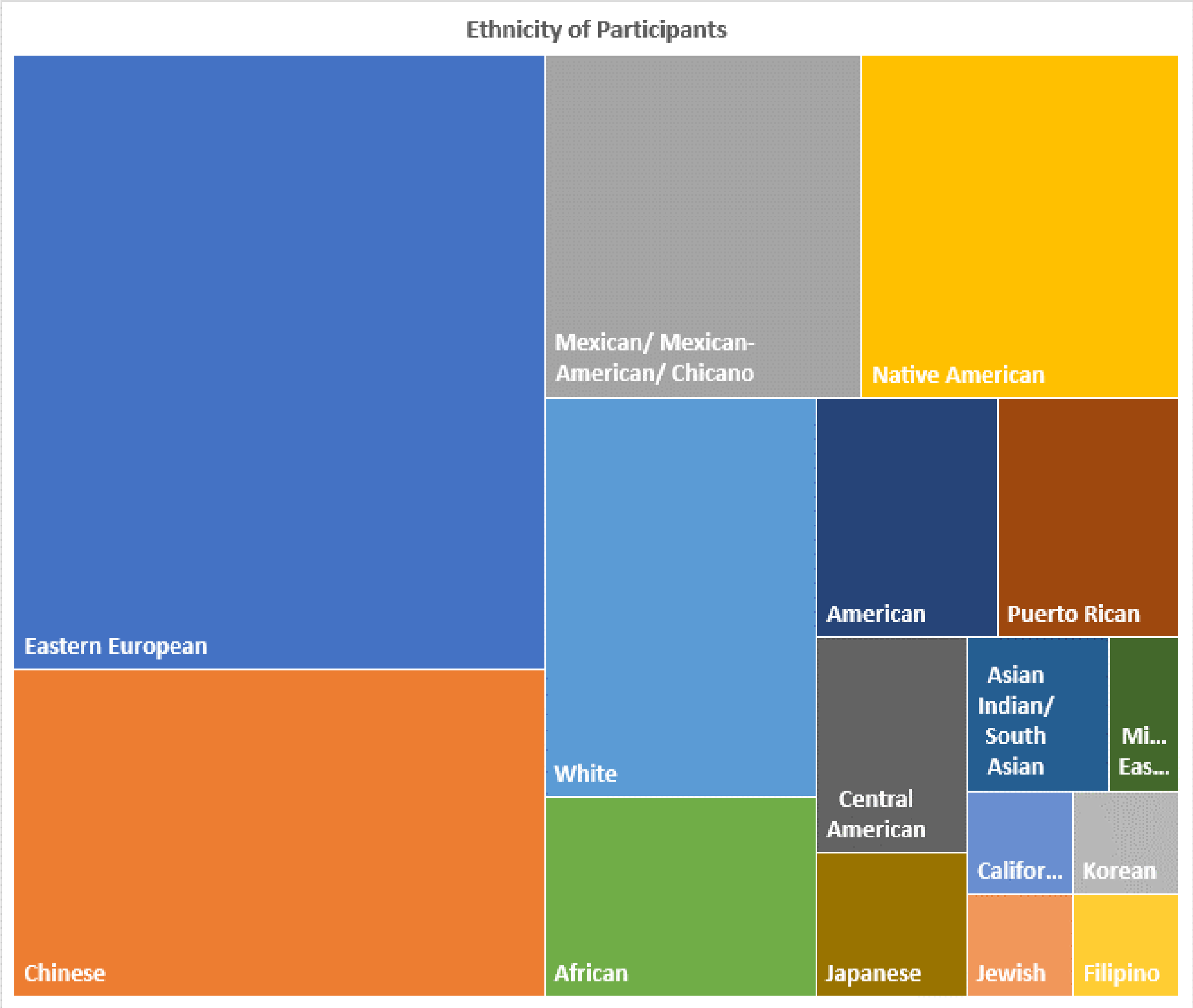
The following charts provide information obtained from 175 demographic survey forms completed by individuals participating in 31 MHSA-funded events or trainings during July 1, 2022, to June 30, 2023. These are duplicated responses as one person could have completed more than one survey having attended multiple events.

Sixty-four percent (64%) of the people who responded to the demographics survey selected White. Nine percent (9%) selected Asian. Nine percent (9%) selected American Indian /Alaska Native, representing local tribes including Yurok, Wiyot, Bear River, and some who selected "American Indian/Alaska Native" but did not list their tribal affiliation. Other tribal regions included Cherokee and Choctaw. Six percent (6%) selected Black/African American. One percent (1%) selected Native Hawaiian or other Pacific Islander. One percent (1%) wrote in Hispanic under other, less than 1%, Caribbean, and 9% preferred not to answer. Of the 175 survey responses, 22% selected more than one race.



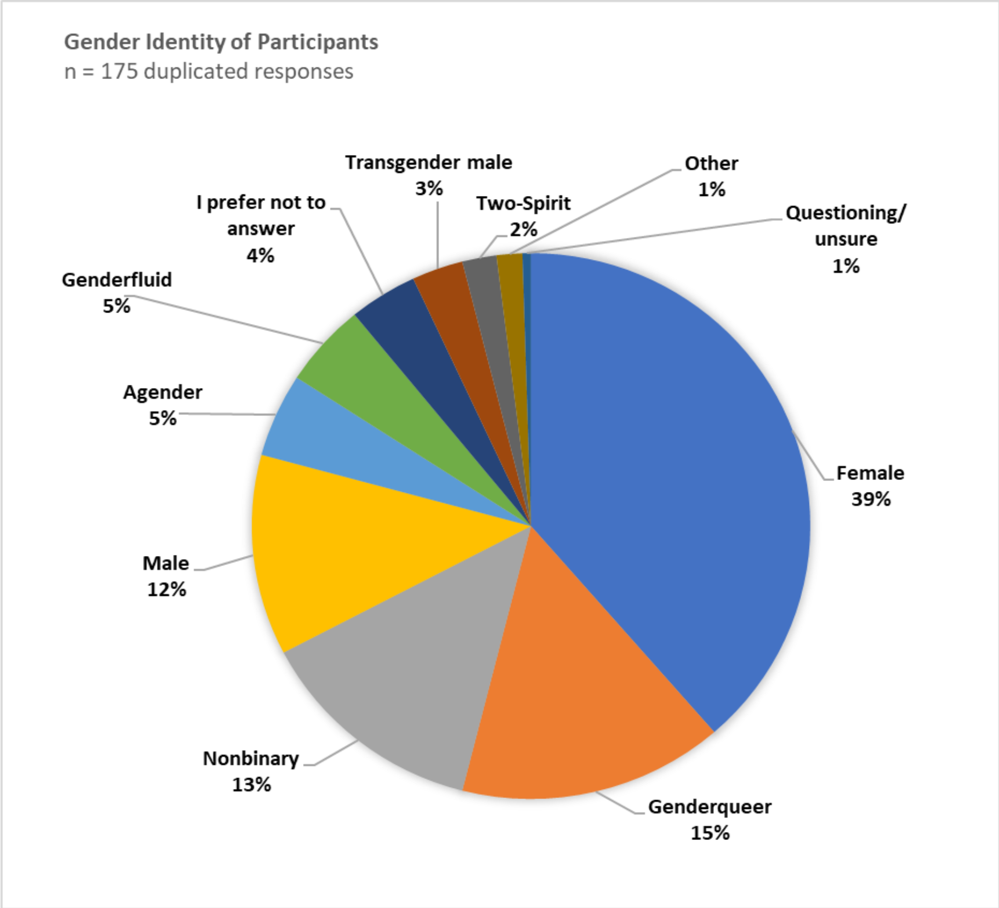
Of the 175 survey respondents, 18% selected more than one ethnicity. Twenty-two percent (22%) of respondents did not provide their ethnicity. European was the most frequently (40%) selected category. The rest are as follows:

- 18% Eastern European
- 9% Chinese
- 6% Mexican/ Mexican American/ Chicano
- 6% Native American
- 6% White
- 3% African
- 2% American
- 2% Puerto Rican
- 2% Central American
- 2% Japanese
- 1% Middle Eastern
- 1% Californian
- 1% Jewish
- 1% Korean
- 1% Filipino



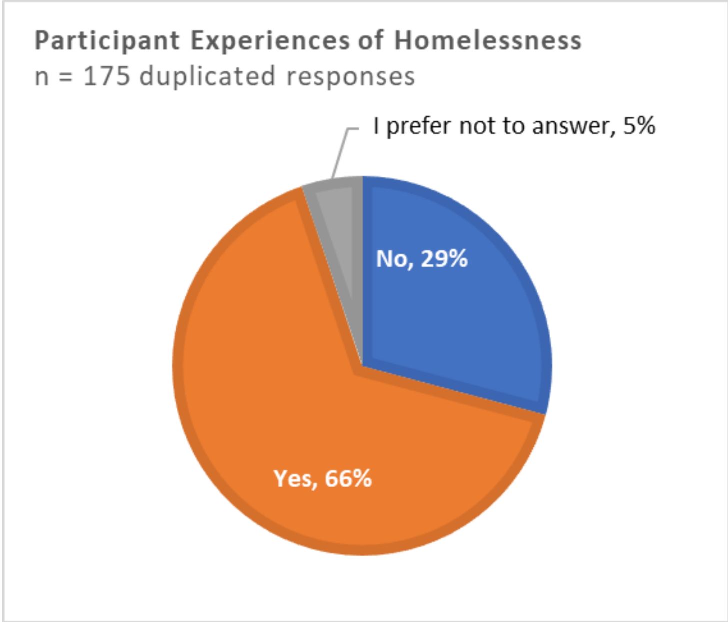
The primary language of participants was roughly 94% English. Remaining responses included Spanish (4%) and preferred not to answer (2%). Two percent (2%) reported being bilingual.

Forty-five percent (45%) of the survey participants were within 19-25 years old and 27% within 16-18 years old. However, HCTAYC youth engaged people of all ages in trainings, presentations, community coalitions, and policy recommendation outreach efforts.



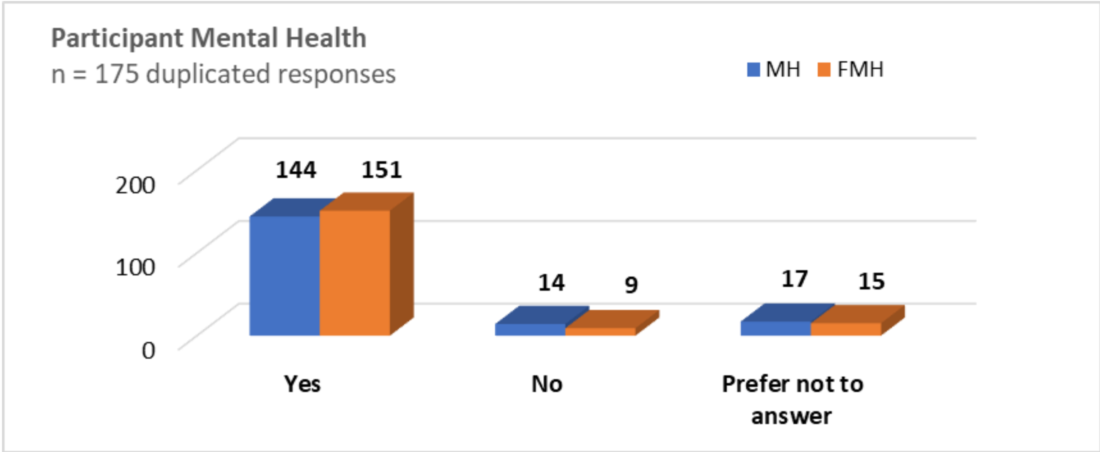
While 73% of the survey respondents had an assigned birth sex of female, 39% identified female as their gender identity. Fourteen (14%) percent of the survey respondents had an assigned birth sex of male, 12% identified male as their gender identity. Forty-six percent (46%), identified with a gender category other than female or male, with the genderqueer category (15%) being the most frequently selected. Nineteen participants identified with more than one gender identity category, and 8 preferred not to answer.

Sixty-six percent (66%) of survey respondents had experience with homelessness, 29% did not, and 5% preferred not to answer.



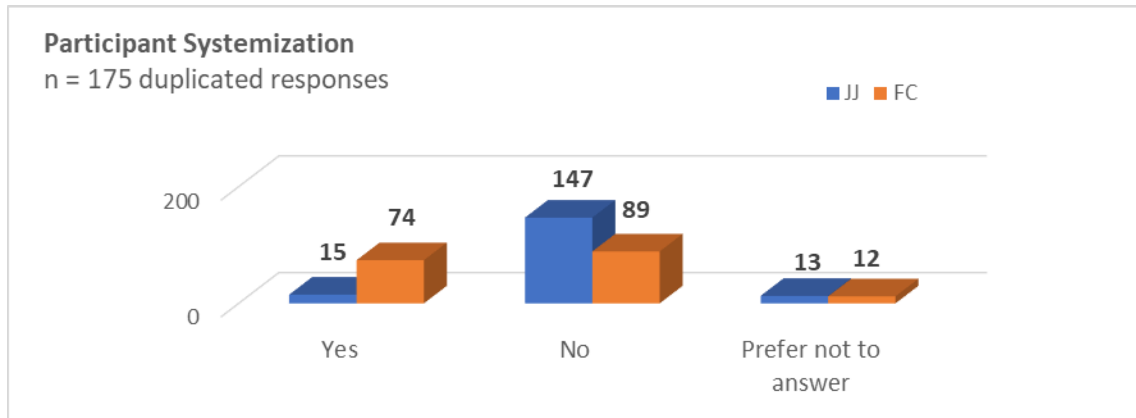
One hundred forty-four (144) survey participants stated they have experienced a personal mental health (MH) condition. Of those, 91% had received a diagnosis. Fourteen (14) participants stated they have not experienced a personal mental health condition, while 17 preferred not to answer.

One hundred fifty-one (151) stated they have a family member with a mental health (FMH) condition, 9 stated they did not, and 15 preferred not to answer. Eighty-one (81%) stated the family member's mental health condition had been diagnosed.

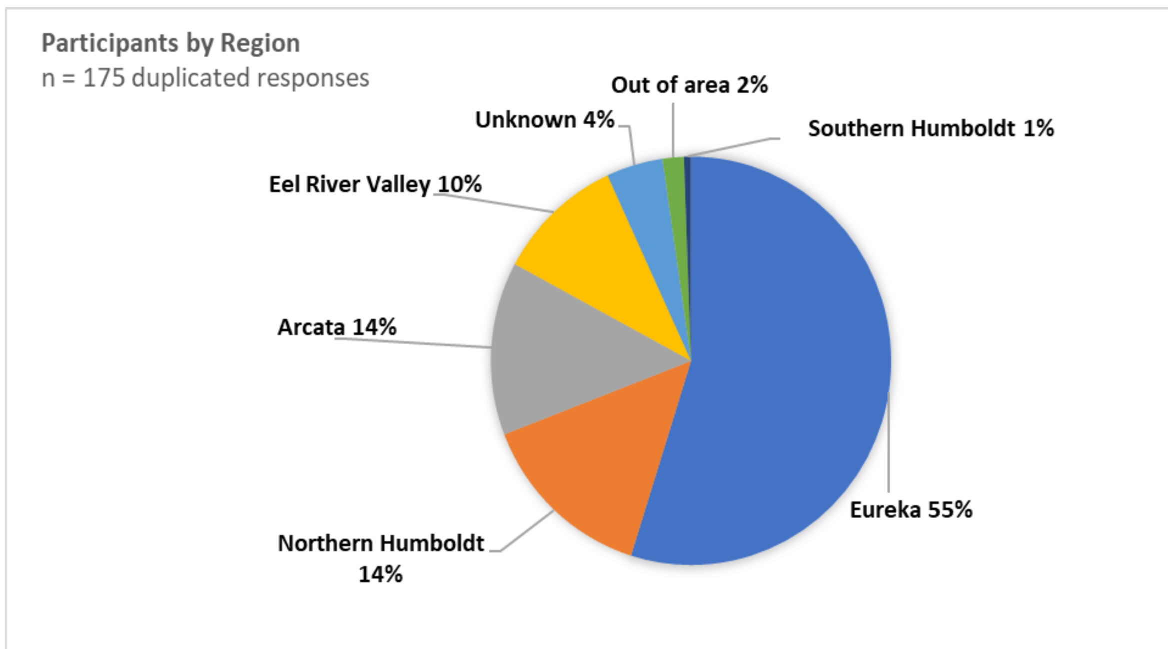


Fifteen (15) participants reported involvement in the juvenile justice (JJ) system, 147 did not have this involvement, and 13 preferred not to answer.

Seventy-four (74) participants reported involvement in foster care and/or the child welfare (FC) systems, 89 did not have this involvement, 12 preferred not to answer.



A little over half of the survey respondents resided in the Eureka area, followed by Northern Humboldt (including 1 response from Del Norte), Arcata, Eel River Valley, and Southern Humboldt. Six percent (6%) were unknown or reported zip codes from out of the area.



Stigma Discrimination Reduction (SDR) Survey Analysis

The SDR Survey is provided electronically at most HCTAYC sponsored events, and some Peer Coach sponsored events either electronically or on paper. In FY 22-23, the survey was offered to participants at 15 different events. A total of 136 surveys were collected. Results are not unduplicated, for example, one youth may complete a survey at each event they attended during the reporting year.

I understand that mental health is not something to be ashamed of.

Response	FY 20-21	FY 21-22	FY 22-23
Fully Agree	69%	78%	74%
Agree	31%	21%	19%
Somewhat Agree	0%	1%	3%
Not sure	0%	0%	1%
Somewhat Disagree	0%	0%	0%
Disagree	0%	0%	0%
Did Not Answer	0%	0%	2%

I understand what stigma and discrimination is.

Response	FY 20-21	FY 21-22	FY 22-23
Fully Agree	69%	39%	63%
Agree	31%	47%	17%
Somewhat Agree	0%	14%	14%
Not Sure	0%	0%	1%
Somewhat Disagree	0%	0%	0%
Disagree	0%	0%	2%
Did Not Answer	0%	0%	3%

A conclusion that can be drawn from the above analysis is that most responders do skew towards positive attitudes around mental health and wellness which contradict attitudes of discrimination and stigma. Moving forward and pending staffing capacity, HCTAYC staff plans to monitor and reevaluate data collection and analysis strategies to better reflect the good work both programs are making with respect to stigma reducing activities.

TAY Advocacy-HCTAYC Report FY 2022-2023

Leadership Self-Assessment Survey

Since 2016, HCTAYC young people have been using a Leadership & Wellness Plan document to formalize and track their goals and have been utilizing a Leadership Self-Assessment Scale to gauge the development of their leadership qualities and skills over time. 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 is used to collect responses where 5 = "I definitely have this [attitude or skill]" and 1 = "I don't have this [attitude or skill]".

Due to staffing capacity challenges, Leadership Self-Assessment data was inconsistently collected in FY 22-23. Therefore, no reportable results are available. The program is devising mitigation strategies to prevent this from happening in future reporting periods.

Actual Outcomes for FY 2022-2023

Consistent youth engagement on the youth advocacy board remained relatively stable at 7 members. The YAB sustained two topic-specific committees and worked towards the development and execution of committee specific-tasks:

- The LGBTQIA+ & Two-Spirit Leadership Committee successfully finalized and launched LGBTQIA+ & Two-Spirit Youth Across Systems Policy Recommendations, and related convenings.
- The Substance Dependence and Healing Committee continued the development of a youth-driven peer-support group which is anticipated to launch during the current reporting period.

Each of these committees convened approximately once per month, with an average of 4 young people (YP) participants in each committee. In addition to the two 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, averaging 6 participants.

The LGBTQIA+ policy recommendations implementation continued this reporting period. This reporting period saw the creation of a working group that led to the drafting of a structure document for the implementation of recommendation one. This workgroup met 14 times during the reporting period averaging 10 participants. It also saw the presentation of the recommendations to DHHS Leadership, as well as at the annual CAPCC Roundtable attended by over 50 individuals from a broad range of organizations, as well as the facilitation of a youth experiences panel which featured three YAB members. This reporting period also included a comprehensive assessment of schools' on-books policy and procedure regarding access to gender neutral restrooms.

Throughout this reporting period, HCTAYC hosted socials for the YAB focusing on activities identified by young people and staff to experience community outside of the

work of advocacy. There has been a social event nearly every month of this reporting period, including art, educational documentaries, and wellness activities.

Youth leadership development trainings were provided to the YAB, both consistently and inconsistently engaged. These trainings were: Facilitation Skills, Curriculum Development, Art as Empowerment, Movement Building, Coalition Building, and Financial Wellness.

YAB and staff attended several conferences and trainings not facilitated by HCTAYC, including two by Two Feathers Native-American Family Services, National Summit on Youth Homelessness, National Indian Child Welfare Association, Penny Lane Centers' EDGY, the Statewide Youth Leader Summit, California Mental Health Advocates for Children and Youth, and four trainings by UC Davis Northern Training Academy.

HCTAYC provided the TRANSforming Organizations training to county behavioral health. HCTAYC and TAY Behavioral Health provided the Transition to Independence Process (TIP) training series to three QMS staff and four future site-based trainers. HCTAYC provided a Committing to Youth Engagement Training to the Humboldt Housing and Homelessness Coalition's Executive Committee, which consists of approximately 12 individuals, and provided the training to six School-Based Health Center staff.

FY 22-23 saw the second iteration of the month-long Wellness Series. The Wellness Series was facilitated in a hybrid manner. Workshop supplies and snacks were delivered to youth participants, or they received them in-person at the site the workshop occurred. The Wellness Series consisted of 10 workshops not including the Kickoff or Closing, totaling 25 unduplicated youth participants.

For this reporting period, HCTAYC's annual digital storytelling retreat resumed its normal structure, with 8 storytellers traveling with staff to the Bay Area to work at Story Center. Each day consisted of information workshops training the young people on how to use the video equipment plus independent time for them to work on their stories. Additionally, team-builder activities occurred in the evenings, introducing the young people to different cultural and artistic activities.

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 9 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, another collaborative grant proposal was developed to apply for federal funding to expand services supporting unhoused TAY in the community. HCTAYC continues working collaboratively with TAY Division program management and DHHS Administration to develop a housing program with at least one FTE position. Internally, TAY, HOME and DHHS Financial Services continue to evaluate possible braided funding sources and program feasibility. These efforts have involved a comprehensive design process including multiple opportunities for youth and staff feedback.

HCTAYC's continued advocacy and leadership invited the voices to the following policy tables:

- Behavioral Health Board
- CAPCC
- Cultural Responsiveness Committee
- DHHS Equity Committee
- FFPSA Cross-System Collaborative
- FFPSA Site Collaborative
- Humboldt Community Health Trust
- Humboldt Health Foundation
- Humboldt Housing and Homelessness Commission
- Juvenile Justice Delinquency Prevention Commission
- Multi-agency Juvenile Justice Coordinating Council
- QPI Workgroup
- RESPECT Coalition
- SB2083 SOC Working Group
- Sexual Health Taskforce
- Sorrel Leaf Healing Center
- Statewide TAY Linkages Workgroup
- Suicide Prevention Network
- Youth MAT Workgroup

HCTAYC's advocacy led to the establishment of a peer position in the Juvenile Hall, with the staff person starting in the FY 23-24 reporting period.

During this reporting period, the YAB and staff developed a new curriculum, the first in a planned three-module series. The training, “Lifting the Blanket: Transforming Substance Dependency and Healing with Young People”, integrates a focus on narrative and storytelling as means of getting youth-serving professionals to adequately support young people with substance dependency/dual diagnosis through a positive-youth development framework over the course of two hours.

Lastly, HCTAYC finalized and published a revised Theory of Change as well as Logic Models for each component of the program.

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 despite the reduction in risk.

The YAB struggled to expand its pool of members because of ZOOM fatigue and engagement challenges. Discussing and devising remedies are planned for the following reporting period.

Collaboration with other agencies and entities were strained due to understaffing and the hiring crisis that is present in human-services and other professional helping agencies including advocacy partners. Balancing the needs within division boundaries to maintain programming versus responding to emergent needs and even opportunities was also significant. New funding streams are now available from State and Federal agencies to address the health and wellbeing of the community’s youth. However, few partners have the capacity to undertake new projects or the mandates required to use these funding streams. In addition, recruitment of more staff has been difficult, even when leveraging partnerships with local organizations. Due the severe staffing shortage, current staff have been conducting outreach efforts despite them already having a full workload. These situations were compounded throughout the reporting period due to increases in staffing shortages throughout DHHS.

Cross-training and sustaining staff engagement and leadership to ensure that outcomes tools such as the SDR Survey and LSA has proven to be a challenge, with changes in the processes not being remembered or these measures being inconsistently administered. Additionally, tracking and documentation regarding leadership and wellness goals is ineffective and inconsistent and must be reevaluated.

Emergent system needs have led to an overwhelming number of meetings that program staff attend. Increased meeting demands limited the efficacy of staff to thoroughly execute core program objectives. The number of meetings will be evaluated/assessed.

Despite the HCTAYC analyst FTE increasing from .5 to 1.0 FTE, staffing capacity challenges across the behavioral health branch resulted in a large portion of the assigned analyst's time being redirected and therefore impacted data tracking projects.

Successes

The Humboldt Housing & Homeless Coalition (HHHC) Executive Committee agreed to partner with HCTAYC to create a youth action board and committed two positions on the committee for youth members.

The implementation process of the latest round of policy recommendations has successfully created a framework for a county-wide oversight body.

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.

HCTAYC was able to host a first year MSW intern from Cal Poly Humboldt. The intern was able to support and help develop two youth-led workshops, participate in a curriculum development retreat, participate in the policy recommendation working group and complete a mini research project on gender inclusive restrooms in schools across Humboldt County. In addition, the intern was trained to staff the TAY Center drop-in and supported participation and attendance in many workshops and events within the TAY Division.

HCTAYC increased program engagement through returning to in-person conferences, resumed the digital storytelling trip, and created more in-person workshops and trainings for youth participation.

HCTAYC completed a contractor evaluation form as a tool to better evaluate the effectiveness and use of outside collaborators and contractors and to ensure HCTAYC values are maintained. HCTAYC aims to implement the evaluation by the end of 2023.

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 post-pandemic work. There were significantly better responses to in-person activities than solely digital with respect

to youth participation and feedback. Notably, providing home-cooked food served as a significant incentive. Because of this increased engagement, YAB meetings moved fully back to in-person during this reporting period.

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. This requires a point-person to ensure that these things are moving forward. Staff accountability for outcomes tracking is necessary as well as continued, focused supervision to ensure that staff remain accountable.

In-person activities created closer relationships and increased engagement of young people as they are better able to provide peer support.

The program must remain flexible regarding the structure of the YAB. Being able to evolve to meet the level of engagement, number of members, and pivot from ongoing projects or structures helps create and maintain momentum.

Strategies to ensure monitoring and tracking leadership and wellness goal completion is needed. Methods to increase accountability or create and maintain central tracking systems are to be explored.

TAY Peer Support-Peer Coaching Report FY 22-23

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, 2022 – June 30, 2023. During that time, Peer Coaching received 98 referrals for individual mentorship, outreach and engagement to TAY services. Eighty-seven (87) referrals were closed (includes 29 referrals opened in previous fiscal years) during FY 22-23 and in total, 128 referrals were managed in FY 22-23 including 29 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.

Average number of days	FY 20-21	FY 21-22	FY 22-23
Referral Date to Date Assigned	6.5	4.7	2.7
Referral Date to First Try Contact Date	14.7	6.5	12.5
Date Assigned to First Try Contact Date	8.3	1.6	10.2

Of the 98 referrals received, the Peer Coaching program made 138 referrals to other needed services. The distribution is as follows based on total referrals received:

- Behavioral Health, 51%
- Houseless Support Services 28%
- EFC or ILS 24%
- Juvenile Justices Support Services 20%
- HCTAYC 11%
- TAY First Episode Psychosis 4%
- Other (e.g., Employment, SUD) 2%

TAY Center Sign-In Sheets

From July 1, 2022 to June 30, 2023, TAY served 211 total unique young people via drop-in or a Peer Coach supported event/workshop. Of those, 118 were first time visitors.

- 618 total visits during drop-in hours.
- 181 unique visitors attended drop-in hours, of those, 96 were first-time visitors.
- 162 total participants in a Peer Coach supported workshop/ event.
- 71 unique visitors attended a Peer Coach supported workshop/ event, of those, 43 were first time visitors.
- A total of 31 emergency food boxes were distributed.

Participation	FY 19-20	FY 20-21	FY 21-22	FY 22-23
Drop-In Hours Visits	1,595	220	481	618
Drop-in Hours Unique Visitors	203	80	144	181
Drop-in Hours Unique First Time Visitors	63	26	73	96
Workshops/Events Visits	147	3	87	162
Workshops/Events Unique Visitors	64	3	54	71

Participation	FY 19-20	FY 20-21	FY 21-22	FY 22-23
Workshops/Events Unique First Time Visitors	6	1	20	43
Total Unique Visitors	**223**	**82**	**167**	**211**
Total First Time Visitors	**69**	**27**	**93**	**118**

Drop-in was paused in accordance with the county's COVID response efforts from March 2020 thru December 2021, when it resumed 3 days a week.

Drop-in Visit Type	Number of Visits (duplicated YPs)
Dropping-in for Drop-in	544
Peer Coaching	22
Behavioral Health	18
HCTAYC	14
ILS/ EFC	12
Other (unspecified)	2
HOME/Housing	2
Bathroom	2
TAY Tour	1
Charter School	1
Humboldt Workforce Coalition	1
Teen Court	1

Drop-in visit type reporting began March 2023.

In addition to a referral process for peer support and peer engagement in the drop-in space, Peer Support and HCTAYC staffers utilize the Department of Housing and Urban Development (HUD) Homeless Management System (HMIS). During this reporting period, 42 houseless youth were engaged and logged in HMIS.

Outreach, Tabling, and In-Service

Peer Coaches and HCTAYC Staff facilitated 50 street outreach, tabling events and TAY in-service presentations in FY 22-23. Street outreach was performed in McKinleyville, Arcata, Eureka, and Fortuna.

Actual Outcomes for FY 22-23

- Peer coach staffing levels did not remain fully staffed due to staff on leave.

- Onboarded two new Peer Coach staff and one Peer Coach intern.
- 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.
- Peer Coaches maintained consistent caseloads for individual mentorship.
- Peer Coaches were crossed trained to support all TAY Division programs.
- Peer Coaches provided monthly workshops and supported integrated TAY Division programming.
- Peer Coaches participated in various community presentations and tabling opportunities.

Peer Led/Supported Activities, Workshops, Groups and Events

Peer coaches facilitated, co-facilitated or supported by staffing and providing transportation for 24 workshops or events during FY 22-23.

- Integrated TAY programs rafting trip
- Blueberry picking and cooking demo
- Grounding yoga
- Integrated TAY programs BBQ
- Integrated TAY programs back to school
- HCTAYC wellness series
- Pumpkin patch and trunk or treat
- Costumes on a budget
- Spooky movie and Halloween treats
- From you to youth closing drive
- Integrated TAY fall feast
- Solstice crafting workshop
- Holiday baking workshop
- Love the Skin you're in
- Date yourself
- Mystery food box cooking challenge
- Look fly on low supply
- Community partner sunset kayak trip
- Mosaic art
- Mental health walk sign making
- Participation in take-action for mental health walk
- Participation and tabling at wellness and connection community BBQ
- Headwater’s hike for mental health
- Integrated TAY programs TAY graduation

Challenges
TAY Division program staffing fluctuated during the reporting year, putting a strain on the HCTAYC and Peer Support program. Peer Support often stepped in to fill the need for case management to young people when on a waitlist for behavioral health services or not opened to services. Peer Support also heavily supported the ILS program by coordination of activities and outreach efforts. CWS ILS/EFC supervisor was on leave for many months of the reporting period and returned as a half time employee. This led to lack of authentic TAY program integration and HCTAYC/Peer Support supervisor capacity maxed out to support the integrated divisions' needs. In addition, Peer Support staffing levels varied throughout the reporting year, making individual Peer Coach caseloads exceed ideal levels.

Peer Coaches need regular and consistent supervision and support. Daily morning check-ins with the supervisor continued to provide real time support and feedback, build communication and allow for assignment of tasks and assignments. This took place in addition to weekly individual and group supervision time.

Cross-training staff to support data collection efforts continued to be a challenge. There were inconsistent uses of the SDR and WEST Survey, with changes in the processes not being remembered or these measures being inconsistently administered. Additionally, there were challenges with tracking and documentation of outreach, tabling and presentations.

Successes
HCTAYC provided advocacy to the Humboldt County Juvenile Probation Division's Department of Juvenile Justice realignment plan. This included the "secure youth track" for young people who would have otherwise been sent out of the county. With that advocacy, a pilot program for peer support within the juvenile hall and New Horizons program started in October 2022. The peer coach assigned to this program provided 4-8 hours of peer support weekly within the juvenile hall, providing 1:1 mentorship, co-facilitation of groups (ILS skills groups, social skills building, and journaling activity), consultation and coaching with correctional staff. The success of this pilot program led to a formal MOU between DHHS and the Probation Department in February 2023 for a full time, fully funded peer coach position assigned to the behavioral health unit working within the juvenile hall. The full-time peer coach position is taking full effect in August of 2023.

The TAY Advocacy Program/HCTAYC and Peer Support supervisor was able to team with a family resource center workforce development program and host a Peer Coach intern work experience placement for 12 weeks. The intern was able to train on how to

run the TAY Center drop-in, complete referrals, updated a resource binder and facilitated an 8-week journal and art project activity in the drop-in space.

Peer Coaching staffers stepped up for drop-in and supported new YP and new to TAY staffers as well as gaps in staffing at times.

Lessons Learned
Staffing fluctuations can impact the peer coach team by increasing caseloads at times. An extra help peer coach has been able to backfill a leave of absence staff which has allowed for consistent staffing of the drop-in center.

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

The six main Suicide and Violence Prevention 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, Outreach, and Tabling (Section 3715. Outreach for Increasing Recognition of Early Signs of Mental Illness)
- Postvention (Section 3730. Suicide Prevention Programs)

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 and practice-based/promising practice 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 and Educational Outreach: Increase awareness of suicide and violence, promote prevention messaging, and encourage positive behavior change in those areas.
- Postvention: Offer resources and materials to support survivors of suicide loss, decrease stigma about talking about suicide, and increase local capacity to offer grief support.

Strategies
- Public and targeted information campaigns
- Culturally responsive approaches
- Survivor-informed models
- Evidence and practiced based education models and curricula
- Public health model
- Socio-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.

During fiscal year 2022-2023, there were roughly 1,628 clients served by the program across its various projects. Based on the Revenue and Expense Report (RER), which outlines a total cost of $209,828 in MHSA funds, the average cost per client is estimated at $128.89.

Project: Humboldt Suicide Fatality Review (SFR)

The Suicide Fatality Review (SFR) Team 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), the Coroner's Office, behavioral healthcare, healthcare, Tribes, and the 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 their 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 illuminate opportunities for system changes, including providing data to inform decision-

making, offering training 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 (for FY2022-2023)

- Three SFR meetings held.
- Forty-seven participants involved (combined).
- Seven suicide death cases reviewed.
- One Annual Report.

Number of Individuals Served (Unduplicated)

- Seven (7) suicide death cases were reviewed at the three (3) SFR Meetings.
- Forty-seven (47) participants serving 10 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 reviewed is solely based on whether the decedent's next-of-kin grants permission.

Projected Outcomes (FY2024-2025)

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). An annual report will be shared each fiscal year that details latest risk factor data and recommendations.

Challenges

Case review during SFR meetings requires permission from the decedent's legal next of kin. Low return rates of completed Consent to Release Information forms limited the

number of cases that could be reviewed in SFR Team Meetings. Reduced staffing and operational changes have made data analysis difficult.

Successes

The success of the SFR in FY22/23 was that the first annual report was completed and shared with the public. The report detailed local risk factor data collected from the partnership between Public Health and the Humboldt County Sheriff's Office (HCSO) Coroner's Office through their continued use of the Suicide Risk Factor Surveillance System (SRFSS), as well as data on recommendations for system improvements and best practices to improve suicide care in Humboldt County. The Humboldt County Suicide Fatality Review (SFR) Annual Report 2022 can be found here in English, and here in Spanish.

As the first county in California to establish a formal review of suicide death, Humboldt County has received recognition at the state level. In addition to the six (6) technical assistance presentations to the state Striving for Zero Learning Collaborative and to multiple counties across California in FY21/22, SVP also provided the following three (3) SFR presentations during FY22/23:

Date	SFR Presentation Audience
4/4/2023	Humboldt County Board of Supervisors
4/13/2023	Humboldt County Suicide Prevention Network
5/18/2023	RANCHO Peer Learning Session featuring the following counties: Glenn, Lake, Trinity, Modoc, Shasta, Del Norte, Siskiyou, and Lassen; as well as eight participants from California Department of Public Health (CDPH).

Lessons Learned

We have learned that the formal SFR review team is a group that can offer details about the case, risk and protective factors present, and agency policy and procedures that either supported or hindered quality care. The recommendations for actions based on overall (de-identified) data, including local risk factor trends, are being made by local subject matter experts and those working directly with individuals at risk. It is also important to have groups like the Humboldt Suicide Prevention Network (SPN) review trends in risk factors and make recommendations on actions that can be applied to targeted communities in culturally appropriate ways, and actions that can be taken to minimize suicide risk for others in the future.

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 volunteered to present information or update the network regularly.

The network meets bi-monthly to build relationships and to identify strategies to reduce suicide and suicidal behaviors in the community. SPN collaborates to plan events throughout the year and especially during the month of September in honor of Suicide Prevention Awareness. 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. Anyone is welcome to attend the SPN regularly to provide input or to join during the September events planning time. All efforts 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 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 a cross-agency backbone to the SPN and to move forward the priorities of the Network. SPN Steering 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/subcommittees to address the four (4) priority areas identified in the BH/Suicide section of the Humboldt Community Health Improvement Plan (CHIP).

In FY22/23, three (3) SPN Subcommittees were created:

1. Training & Education
   Purpose: To ensure suicide prevention trainings are accessible to the community.
2. Lethal Means Safety
   Purpose: To prevent suicide in Humboldt County by providing residents with education and tools to increase lethal means safety.
3. Youth Suicide Prevention
   Purpose: Meet the unique needs of Humboldt County youth (12-25) to prevent suicide.

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 support 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 the 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

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

Actual Outcomes (FY2022-2023)

- Thirty-three (33) agencies represented in network (DHHS counted as one)
- Twenty-seven (27) meetings were held annually (includes SPN Subcommittee meetings)
- Four hundred forty-seven (447) list serve participants (an increase of 27 from previous fiscal year)

Number of Unduplicated Individuals Served (FY2022-2023)

Seventy-six (76) unique participants, representing 33 agencies, attended one or more Suicide Prevention Network meeting in fiscal year 2022-23 (an increase of 5 unique participants from FY21/22)

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 (FY2024-2025)

- Increase number of agencies represented in network by one per year.
- Ten meetings to be held.
- Five hundred (500) 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 FY22-23, the number of list-serv participants increased by 27, bringing the total to 447, 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.

In FY22-23 was the formation of three subcommittees based on priority areas identified in the suicide section of the Humboldt County Community Health Improvement Plan (CHIP) 2022-2027. The three subcommittees include Lethal Means Safety, Youth Suicide Prevention, and Training and Education. These subcommittees are addressing gaps in services and strengthening local suicide prevention efforts through cross-organization collaboration, assessing needs of high-risk populations, and increasing capacity for the network to provide trainings and education on suicide prevention.

In FY 22-23, there were twenty-seven (27) total SPN meetings, fourteen (14) of which were subcommittee meetings. Examples of actions taken as a result of the formation of the three (3) subcommittees included:

1. Specific and measurable goals set for each subcommittee to guide suicide prevention efforts and allow for evaluation.
2. Partnership with local gun shops to develop lethal means safety public service announcements.
3. Fourteen (14) youth-serving professionals trained to give the American Foundation for Suicide Prevention's "It's Real: Teens and Mental Health" presentation.

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. Having subcommittees to support the overall goal of the SPN and focus on specific priority areas has increased opportunity for other agencies to take leadership roles and mobilize suicide prevention efforts. The subcommittees have also increased the number of meetings being held quarterly, expanding participation options for members who have less flexibility in their schedule.

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 coordinators, trainers, 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)

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 adopted 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 the 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 to increase access and linkage to support 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)

Offered in Humboldt since 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)

Offered in Humboldt since 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 decreasing stigma.

Target Population

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

Outcome Measurements (FY2022-2023)

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

Expected Outcomes (FY2022-2023)

Four trainings were expected to be held in fiscal year 2022/2023, serving a total of 80 or more individuals.

Actual Outcomes (FY2022-2023)

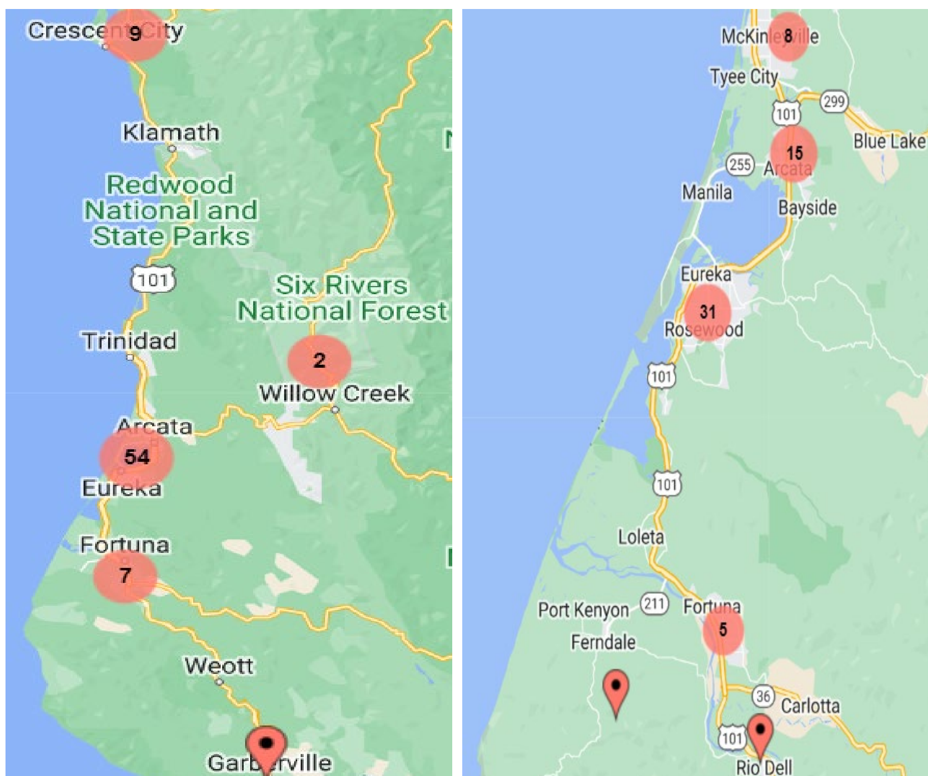
- Eleven (11) trainings were held.
- Three hundred twenty-two (322) participants in total.
- Eighty-three (83) modified, shortened MHSA PEI Demographic Forms were submitted; an increase of 16 from the prior fiscal year.
- Sixty-three (63) BSBB training specific demographic forms were submitted.

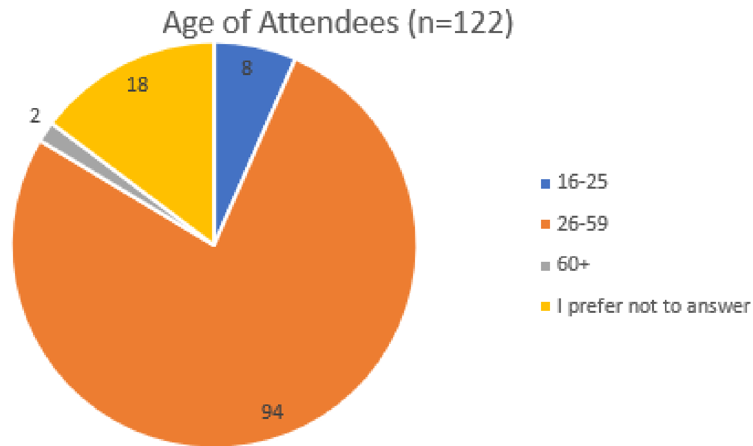
Training	# of Trainings	Individuals Served
QPR or QPR + Lethal Means Safety	8	168
BSBB for Suicide Prevention	1	42
BSBB for Mental Health & Metal Illness	1	35
Other (Youth Suicide Prevention, Know the Signs, LMS (as a stand-alone), or Gun Shop Project)	1	77
TOTAL	11	322

Number of Individuals Served (FY22-23)
In FY 2022/23, eleven (11) trainings were held, with 322 total individuals served. This is an increase of 13 individuals served from the previous fiscal year.

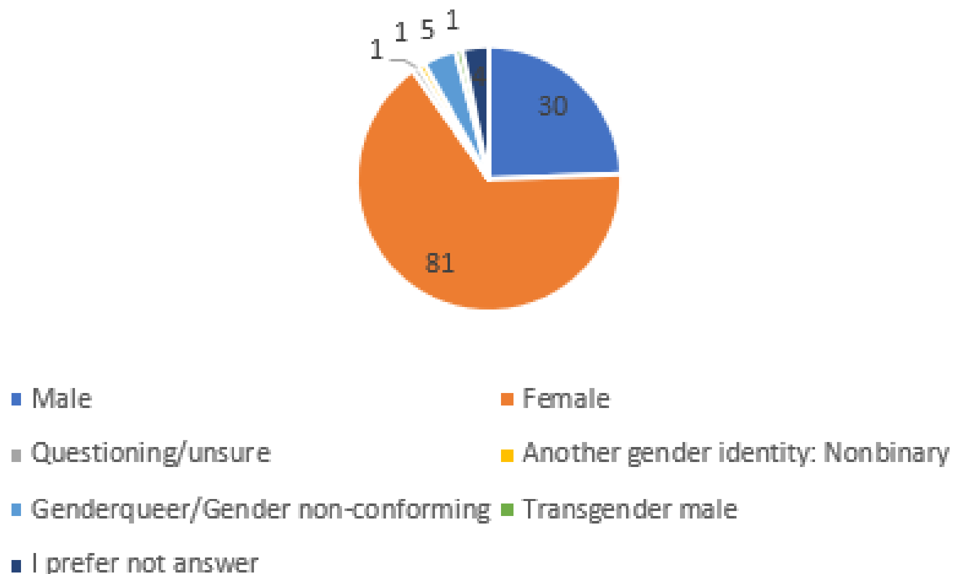
Demographics of Individuals Served
Demographic information comes from attendees at QPR, QPR + Lethal Means Safety, BSBB or other trainings who submitted complete electronic information. In Fiscal Year 22/23, 39% (125/322) of attendees completed an electronic demographic form. Note, some participants didn't answer all questions or weren't asked all questions; therefore, not all data shows 125 responses.

Zip Code of Training Attendees
The images below show the zip codes of training attendees. The first image shows the area from Crescent City to Garberville and the second image zooms in on the more populous Humboldt Bay region. In Fiscal Year 22/23, out of the 78 completed demographic forms, 16 participants lived within zip code 95501 and 13 within 95503 (Eureka); 15 within zip code 95521 (Arcata); eight (8) within 95519 (McKinleyville); nine (9) within 95531 (Crescent City); five (5) within 95540 (Fortuna); two (2) within 95546 (Hoopa); one each in zip codes 95536, 95537, 95542, 95562 and 95564; five (5) preferred not to answer or lived outside the Humboldt/Del Norte area.

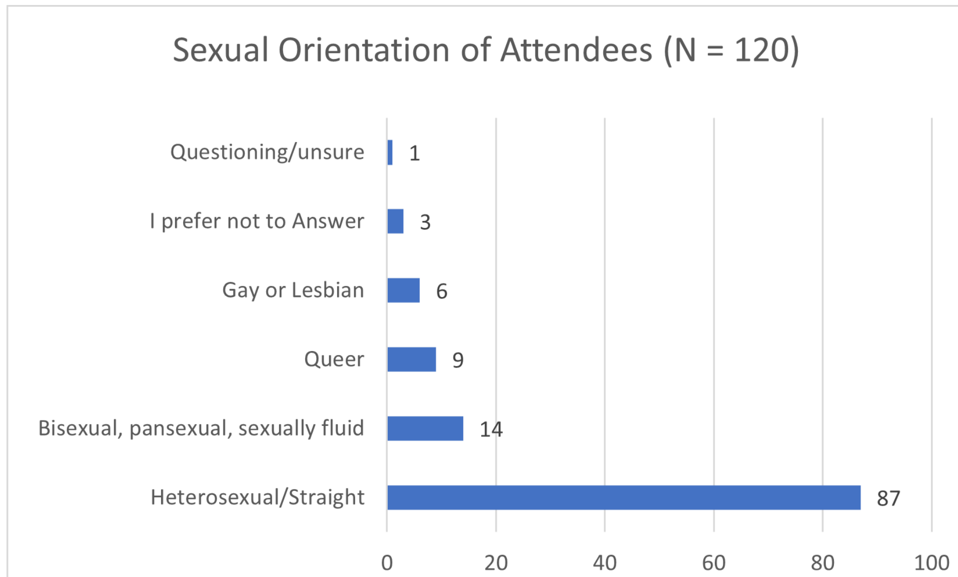




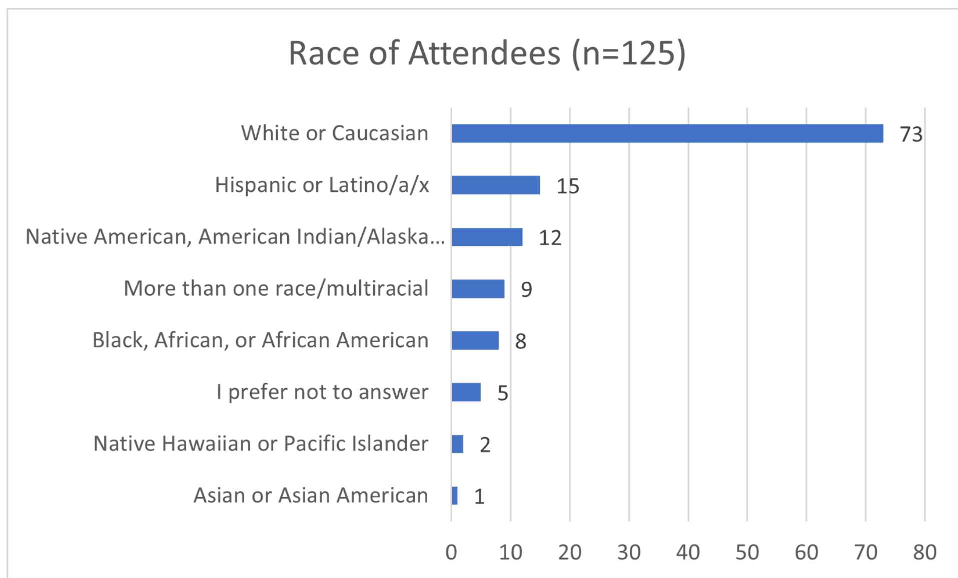
The chart above shows the age of training attendees. In fiscal year 22/23, out of the 122 responses, eight (8) attendees in trainings were ages 16-25, ninety-four (94) attendees were ages 26-59, two (2) attendees in trainings were sixty or older (60+), and eighteen (18) preferred not to answer.



The chart above shows the gender of training attendees. Out of 123 responses in fiscal year 22/23, 81 training attendees were female, 30 were male, five (5) were Genderqueer/Gender non-conforming, four (4) preferred not to answer, one was nonbinary, one was Transgender male, and one preferred not to answer.

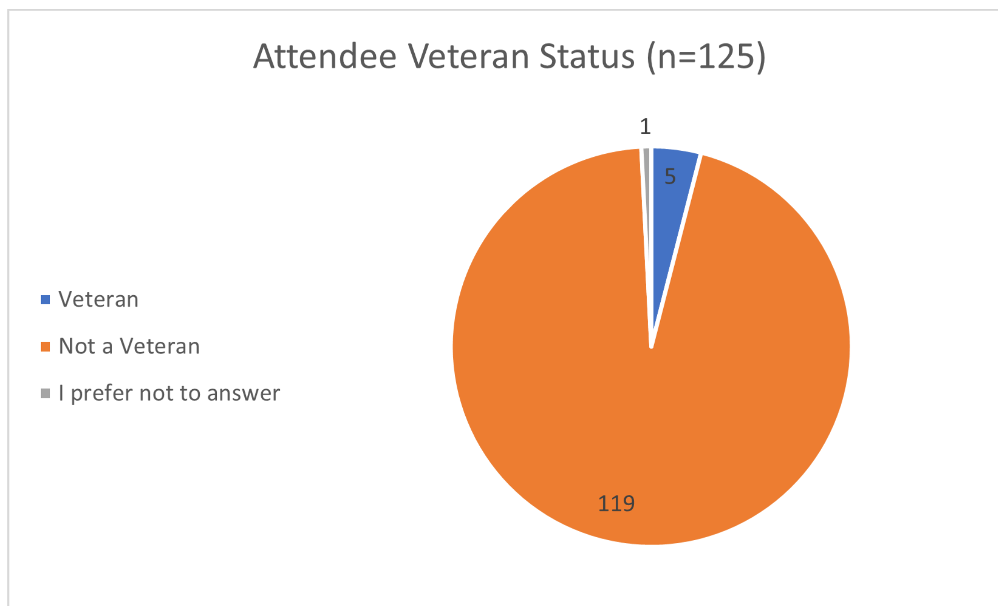


The chart above shows the sexual orientation of training attendees. Out of 120 responses in fiscal year 22/23, 87 training attendees were heterosexual/straight, 14 were bisexual, pansexual, or sexually fluid, nine (9) were queer, six (6) were gay or lesbian, three (3) preferred not to answer, and one (1) was questioning/unsure.

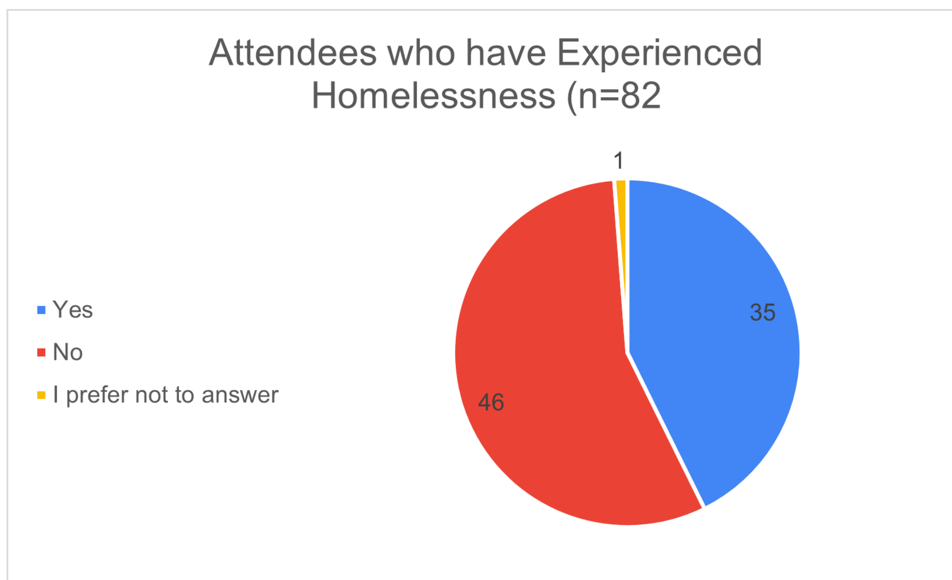


The chart above shows the race of training attendees in fiscal year 22/23. Seventy-three (73) attendees were White or Caucasian, fifteen (15) were Hispanic or Latino/a/x, twelve (12) were Native American, American Indian/Alaska Native or Indigenous, nine (9) were more than one race/multiracial, eight (8) were Black, African, or African American, three

(5) preferred not to answer, two (2) were Native Hawaiian or Pacific Islander, and one (1) was Asian or Asian American.

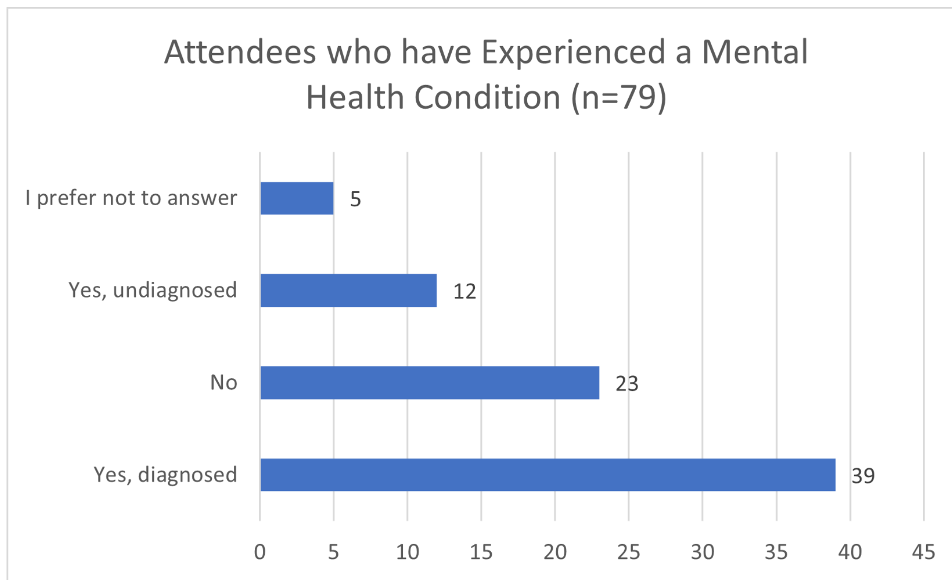


The chart above shows the Veteran status of training attendees in fiscal year 22/23. One hundred and nineteen (119) had never served in the military, five (5) had previously served in the military, and one (1) preferred not to answer.

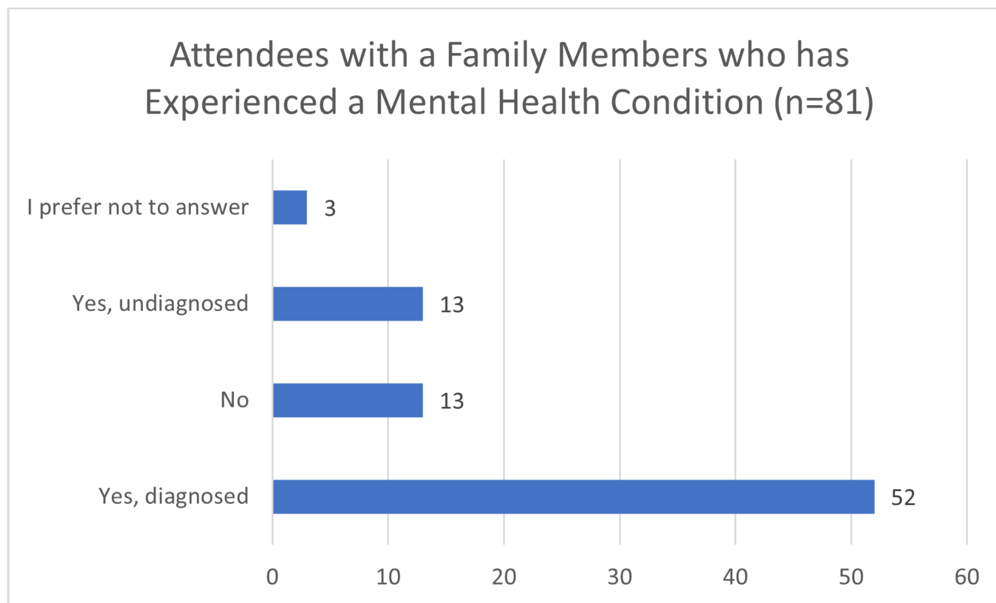


The chart above shows that in fiscal year 22/23, 82 training attendees were asked if they had ever been homeless, lived on the streets, in a shelter, or couch surfed. Thirty-

five (35) attendees had, forty-six (46) attendees had not, and one (1) preferred not to answer.

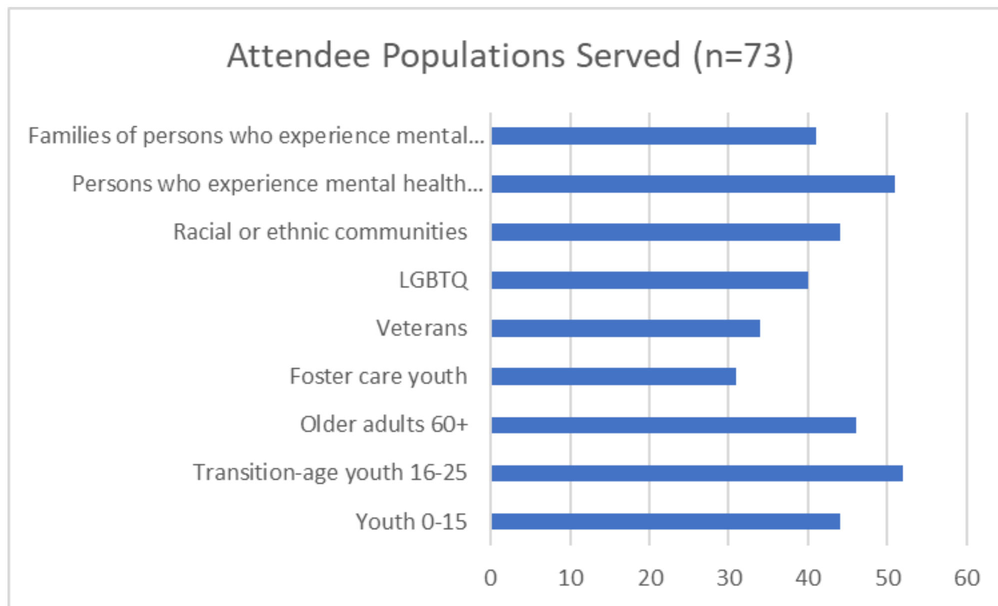


The chart above shows that in fiscal year 22/23, seventy-nine (79) training attendees were asked if they had ever experienced a mental health condition. Five preferred not to answer, twelve (12) answered "yes, undiagnosed", twenty-three (23) answered "no", and thirty-nine (39) answered "yes, diagnosed."

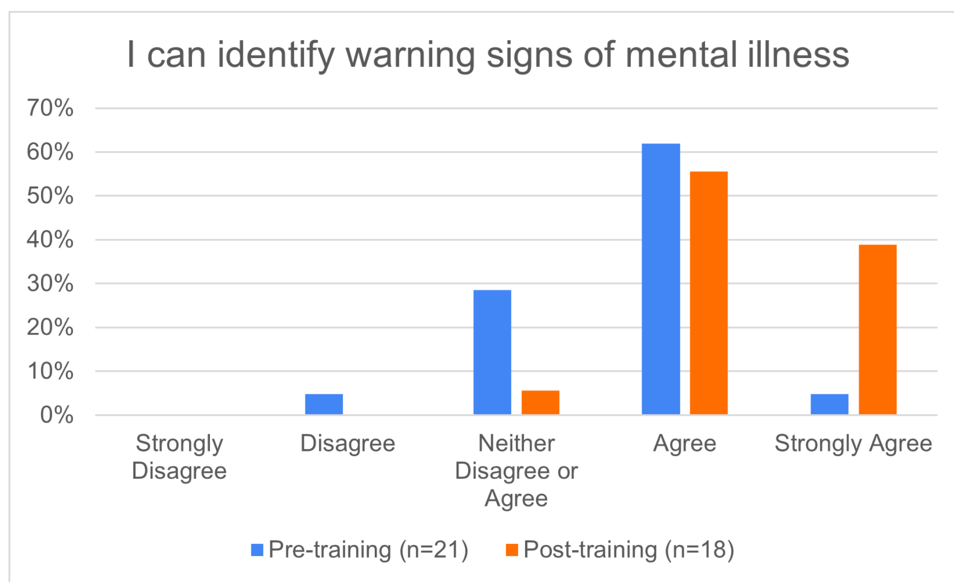


The chart above shows that in fiscal year 22/23, Eighty-one (81) training attendees were asked if they had a family member with a mental health condition. Three (3) preferred

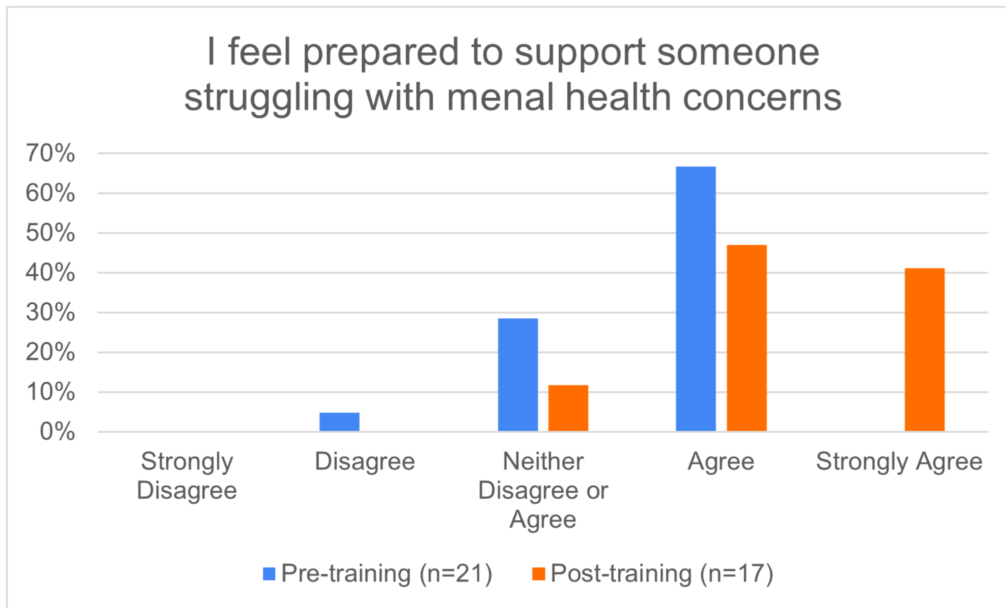
not to answer, thirteen (13) answered “yes, undiagnosed,” thirteen (13) answered “no,” and fifty-two (52) answered “yes, diagnosed.”



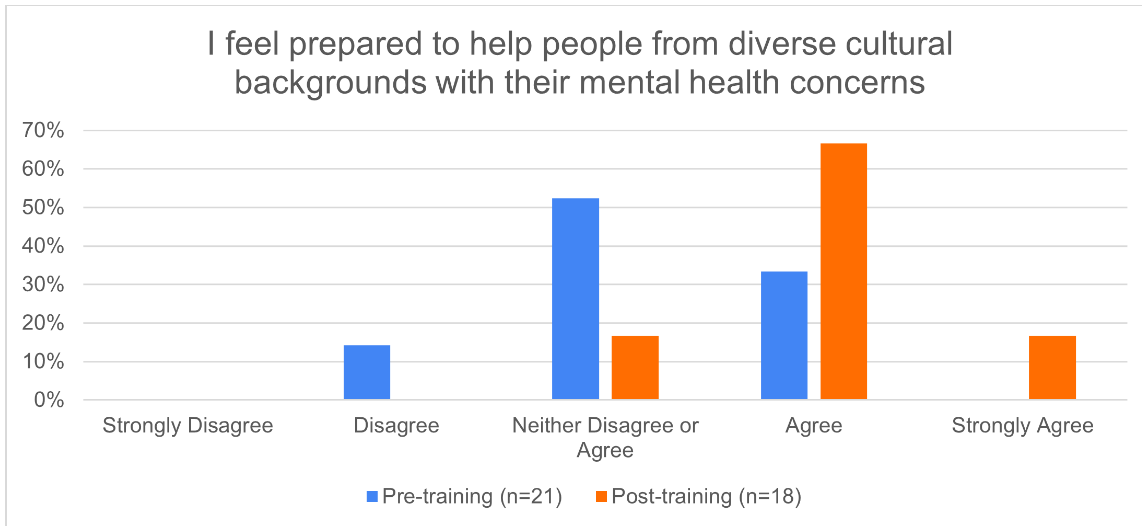
The chart above shows that in fiscal year 22/23, the populations served by training attendees were as follows: 44 served youth 0-15; 52 served transition aged youth (TAY) 16-25 years old; 46 served older adults; 31 served foster care youth; 34 served veterans; 40 served LGBTQ; 44 served racial or ethnic communities; 51 served persons who experience mental health conditions, and 41 served family members of persons who experience mental health conditions.



The chart 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 three (3) participants who did the pre-training survey but failed to complete the post. Of the 18 participants who completed both the pre and the post survey, 56% *agreed* with this statement after the training and 39% *strongly agreed* with this statement comparted with only 5% before the training.



The chart 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 four (4) participants who answered this question in the pre-training survey but failed to answer it in the post. Of the 17 participants who completed both the pre and the post survey, nearly 47% *agreed* with this statement after the training and 41% *strongly agreed* with this statement comparted with 0% strongly agreeing before the training.



The chart 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 three (3) participants who answered this question in the pre-training survey but failed to answer it in the post. Of the 18 participants who completed both the pre and the post survey, 67% *agreed* with this statement after the training compared with 33% before the training. 17% *strongly agreed* with this statement comparted with zero before the training.

Projected Outcomes (FY2024-2025)
Eight to ten trainings will be held, serving 300 or more people, total.

Challenges (FY2022/2023)
Periodic turnover of staff creates program gaps. SVP Trainers were new in their roles this year. They needed time to build their subject matter expertise before increasing the frequency and type of trainings offered.

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) remains a challenge.

Additionally, attendance is often difficult to predict in virtual trainings where registration is free. On average this year, trainings saw a 60% attendance rate when compared with registration. This is a 5% decrease in attendance across all trainings when compared with last fiscal year's attendance rate.

Successes

QPR has reached many diverse settings in the community including service providers, retailers, and educators. QPR has been expanded to include lethal means safety content.

The inclusion of the Be Sensitive Be Brave (BSBB) trainings have not only added variety the program's 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

We resumed offering some trainings in-person which, historically, has offered us better return on data collection efforts and has typically resulted in better attendance rates. We learned that the current preference for virtual suicide prevention trainings is 30-90 minutes and have prioritized offering a variety of training lengths for participants to choose what works best for them. We also learned that recruiting outside trainers to bring variety and subject matter expertise draws in more participants and reduces the stress on staff to learn additional curriculum.

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
- Know the Signs Campaign

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 groups at high risk for injury or suicide, 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.
  - 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 (FY2022/2023)

- 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.

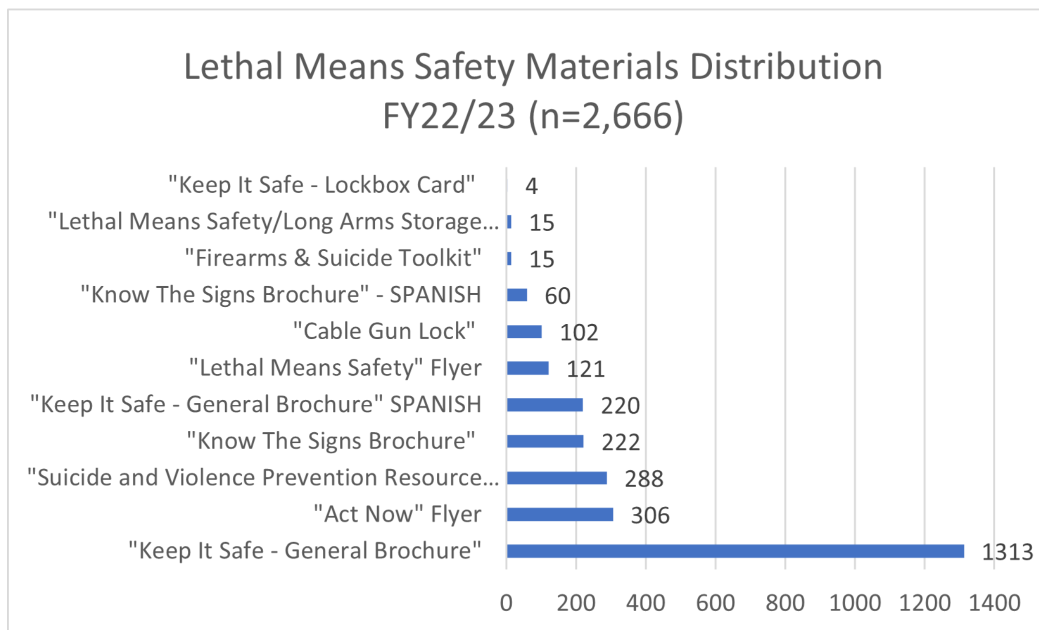
Expected Outcomes (FY2022/2023)

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

Actual Outcomes (FY2022/2023)

- One thousand three hundred and thirteen (1,313) Keep It Safe brochures distributed.

- Three (3) Lethal Means Safety Training Modules &/or Keep It Safe presentations offered.
- Thirty-four (34) Lethal Means Safety Training & or presentation participants.
- Eight hundred fifty-nine (859) lockboxes distributed.
- Six hundred thirty-four (634) Lockbox Data Collection Forms completed.
- Two thousand six hundred sixty-six (2,666) 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 Clipboard Flyer, Suicide and Violence Prevention Resource Card, Keep It Safe Lockbox Card, and the Keep Is Safe general brochure in English and Spanish, and new this year, the Lethal Means Safety-Long Arms Storage Flyer in English and Spanish and the Act Now Flyer.
- One hundred and two (102) cable gun locks distributed.

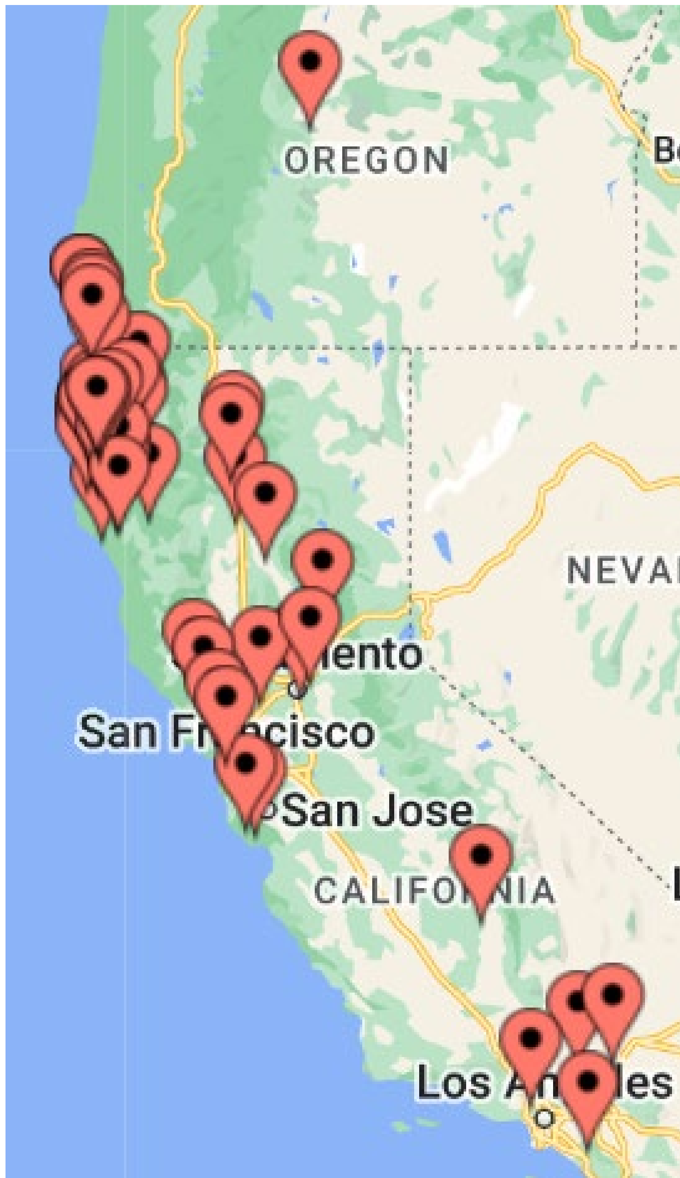


Demographics of Individuals Served

Demographic responses for recipients are from the 634 Lockbox Data Collection Forms completed by lockbox recipients.

Zip Codes of Lockbox Recipients

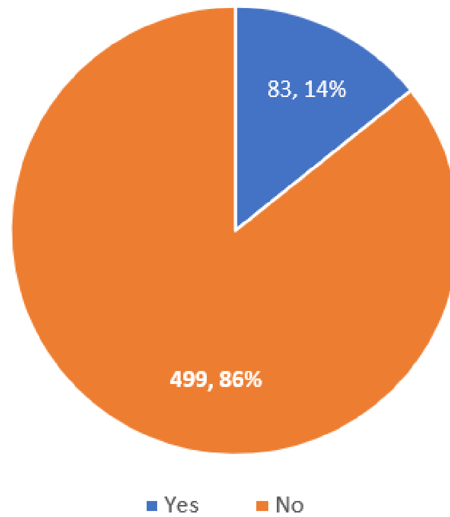
In fiscal year 22/23, 244 lockboxes were distributed to recipients living in Eureka (zip codes 95501, 95502, and 95503), 89 in McKinleyville (zip code 95519), 76 in Arcata (zip codes 95521 and 95518), 55 in Fortuna (zip code 95540), 24 in Hoopa (zip code 95546), 18 in Crescent City (zip code 95531), 12 in Ferndale/Petrolia (zip code 95536), 11 in Trinidad (zip code 95570), and 104 were in other zip codes.



Zipcode	City/Town	Qty
95518	Arcata	2
95521	Arcata	74
95524	Bayside	6
95542	Benbow	3
95525	Blue Lake	5
95526	Bridgeville	2
95528	Carlotta	1
95531	Crescent City	18
95534	Cutten	1
95501	Eureka	117
95502	Eureka	7
95503	Eureka	120
95536	Ferndale/Petrolia	12
95537	Fields Landing	2
95538	Fort Dick	1
95540	Fortuna	55
95546	Hoopa	24
95547	Hydesville	3
95548	Klamath/Requa	9
95549	Kneeland	2
95551	Loleta	6
95519	McKinleyville	89
95553	Miranda	4
95554	Myers Flat	1
95556	Orleans	2
95560	Redway	6
95562	Rio Dell	5
95563	Salyer	1
95564	Samoa	1
95565	Scotia	2
95567	Smith River	1
95570	Trinidad	11
95589	Whitethorn	4
95573	Willow Creek	6
95595	Zenia	2
Other	Out of Area	26

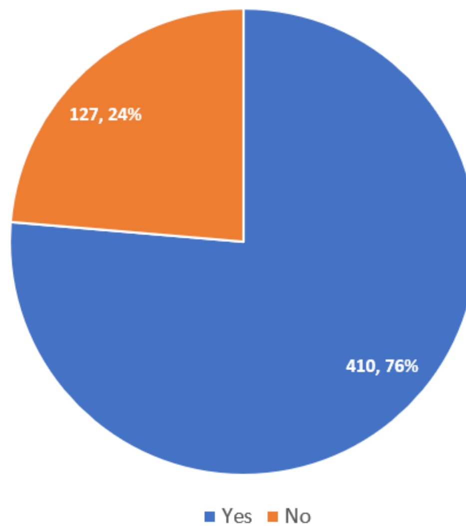
Served in the Military

Of the 634 lockbox recipients who completed a Lockbox Data Collection Form, 83 of them answered yes to serving in the military presently or in the past, 499 said no, and 52 declined to answer.



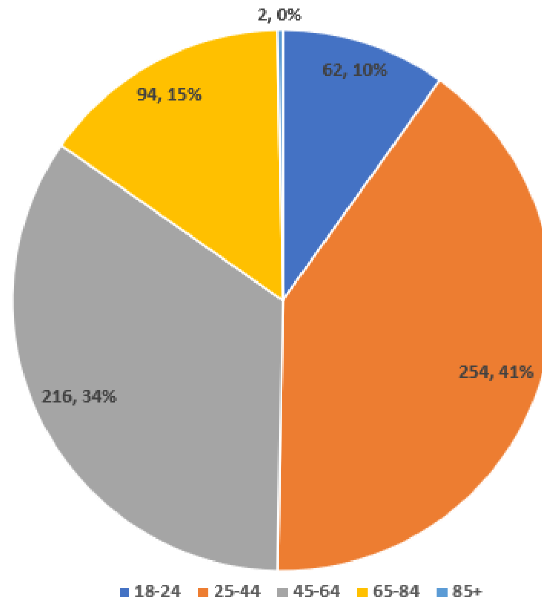
<u>Firearms in the Home</u>

Of the 634 lockbox recipients who completed a Lockbox Data Collection Form, 410 of them answered yes to having firearms in their homes, 127 said no, and 97 declined to answer.



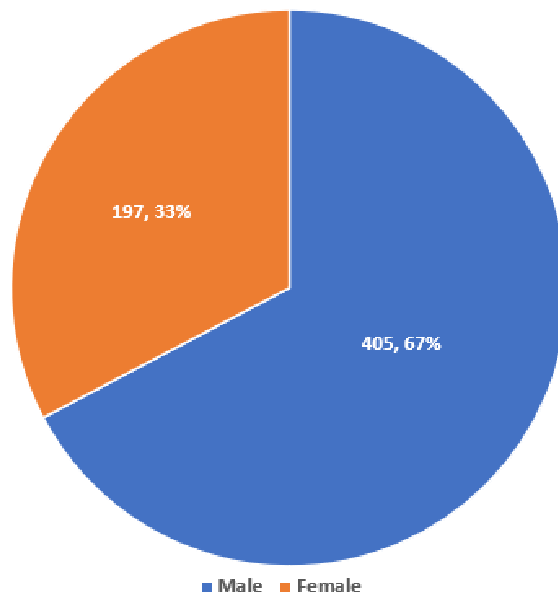
<u>Age Range</u>

Of the 634 lockbox recipients who completed a Lockbox Data Collection Form, two (2) of them were 85+ years of age, 94 were between 65-84, 216 were between 45-64, 254 were between 25-44, 62 were between 18-24, and 6 declined to answer.



Sex

Of the 634 lockbox recipients who completed a Lockbox Data Collection Form, 405 of them were male, 197 were female, and 32 declined to answer.



Projected Outcomes (FY2024-2025)

- 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

While the program has provided many safe storage lockboxes and educational materials, the demand is high in the County and additional funding is needed in order to provide the appropriate number and type of safe storage options for the community.

Successes

Collaboration with firearm retailers continues to be a successful way to provide safe storage options and educational resources widely to the community. 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 continued to include suicide prevention education in their classes, one has even worked with the program to develop an advanced course for clinicians seeking to improve their safety planning efforts through expanding their knowledge of firearm safety and the firearm culture. The Lockbox Distribution Program expanded to include additional non-firearm retail, community partner agencies acting as distributors, increasing the reach of the project.

The SVP Program provided backbone support for the Lethal Means Safety subcommittee of the larger Suicide Prevention Network. This new endeavor has expanded the Keep It Safe campaign efforts and increased the number of partner agencies who are Lockbox Distributors on behalf of the campaign. Additionally, new lethal means safety educational materials were created and are easily accessible on the program website under Lethal Means Safety. Goals, objectives, and measures were developed by the coalition subcommittee that align with those in the Community Health Improvement Plan and with the state strategic plan for suicide prevention, Striving for Zero. Lethal Means Safety subcommittee members even attended outreach events together.

Lessons Learned

Opening the Keep It Safe campaign to be a cross-agency safe storage effort has fostered a sense of shared vision and support for a variety of individuals and organizations. The efforts to align the lethal means safety work with the work of partner agencies allowed expansion of the program.

Project: Social Marketing and Educational Outreach

Social marketing is a continuing suicide prevention 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.

Educational Outreach and tabling activities provide the opportunity to educate, connect, and share suicide prevention resources throughout Humboldt County. Being present at Farmers Markets, Health Fairs, and other community events allows the program broaden its reach to populations that wouldn't normally be contacted and raises awareness of services available for behavioral health and suicide prevention. Distributing educational brochures, event flyers, and training opportunities reduces stigma around mental illness and increases visibility of early signs of suicidal behavior.

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, outreach, and tabling efforts.

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 FY2022/2023

- One thousand (1,000) people through the DHHS Webpage.
- Sixty thousand (60,000) through radio PSAs.
- Two thousand (2,000) emails opened.

Actual Outcomes FY2022/2023

- One thousand three hundred seventy-six (1,376) annual page views for DHHS SVP Program website.
- Six (6) different radio PSAs were aired, totaling 1,344 “radio spots.”

- Forty-two (42) educational or resource focused emails sent via MailChimp; an average of 127 unique opens per email sent; 12,586 total emails opened.
- Eighteen (18) Educational Outreach events.

Projected Outcomes (FY2024-2025)

- Fifteen hundred (1,500) annual page views for the DHHS SVP Program website.
- Sixty thousand (60,000) people reached through radio PSAs.
- Six (6) or more radio PSAs.
- Twelve thousand (12,000) total emails opened.
- Twenty (20) Educational Outreach events.

Challenges

It remains a challenge 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 35%; an increase of 6% from the previous year and, an increase from the average for government which is 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

The Suicide Prevention Network (SPN) coalition began sharing organizational flyers and messaging that was included in social marketing efforts. It was also still beneficial 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. Materials that promote the Mailchimp landing page were developed and used during Educational Outreach which increased the bulk mailer audience and the overall coalition engagement. The variety of topics covered in educational emails through Mailchimp was high. Forty-two (42) education or resource focused emails were sent to an average of 376 recipients each time. A press release in honor of September as Suicide Prevention Month was also released. Staff capacity allowing for the SVP Team to provide educational outreach at eighteen (18) different events/locations broadening the reach of suicide prevention messaging and resource sharing. The approximate number of encounters at those events was 879 people.

Lessons Learned

Educational Outreach is a great way to reduce mental health stigma, increase suicide awareness and to increase visibility about suicide prevention efforts. Discussions with community members led to interest in trainings, resource sharing, and interest in safe storage solutions for potentially lethal items.

Project: Postvention

Studies show that those who have recently lost someone to suicide are at an increased risk of dying by suicide themselves. Postvention are the interventions that take place after a suicide. Postvention includes the care provided to those left behind and is considered an integral part of a robust suicide prevention program. In FY22/23, SVP brought subject matter experts to several coalition meetings to initiate the project. Expansion of support services following a suicide loss emerged as strategy under the overarching goal to *improve suicide related services and supports* within the county's CHIP. Coalition members determined what activities would be prioritized, including providing resources and care packages for loss survivors.

"WeCare" boxes were created by the Suicide Prevention Network to offer support and comfort to suicide loss survivors in Humboldt County. The boxes contain materials on grief after a suicide loss, local resources available for support, self-care items such as candles and tea, and hand stitched heart cushions. By providing these boxes to loss survivors, there is communication that the community is there to support them through their grieving process.

Target Population

Humboldt County residents who have lost someone to suicide and professionals who support them.

Key Activities

- Distribute Survivors of Suicide Loss (SOSL) "WeCare" boxes to newly bereaved.
- Develop resources specific to SOSL.
- Coordinate training opportunities to increase capacity of local care providers and interested community members to offer suicide specific grief support services.

Expected Outcomes (FY2022/2023)

None, this was a new project in FY22/23.

Actual Outcomes (FY2022/2023)

- Ten (10) Survivors of Suicide Loss (SOSL) "WeCare" boxes were provided to Humboldt County Sheriff's Office (HCSO) - Coroner's Office for distribution to suicide loss survivors as applicable.

- One (1) Training was provided by local subject matter expert to increase capacity for offering grief support.

Projected Outcomes (FY2023/2024)

- Ten (10) SOSL “WeCare” boxes to HCSO – Coroner's Office for distribution.
- Twenty (20) SOSL “WeCare” boxes distributed to grieving community members as applicable, provided during various Educational Outreach events.
- One (1) Grief Support Capacity Building training serving ten (10) or more participants.

Lessons Learned

Through postvention efforts, postvention planning during coalition meetings, and educational outreach, it is evident that the community is grieving. There is a gap in services for those who are seeking professional and informal support while working through their grief. While training traditional service providers is a priority, having peer-led, community-driven support groups increases accessibility to support and encourages more people to engage with grief related help-seeking.

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.

Access and Linkage to Treatment:
Parent Partners offer assistance to clients and their families in navigating 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.

Parent Partners staff have weekly supervision where they discuss referrals with their supervisor. Parent Partners staff are co-located with many of the programs that they may be referring to, so they can follow up directly with program staff when needed.

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 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.

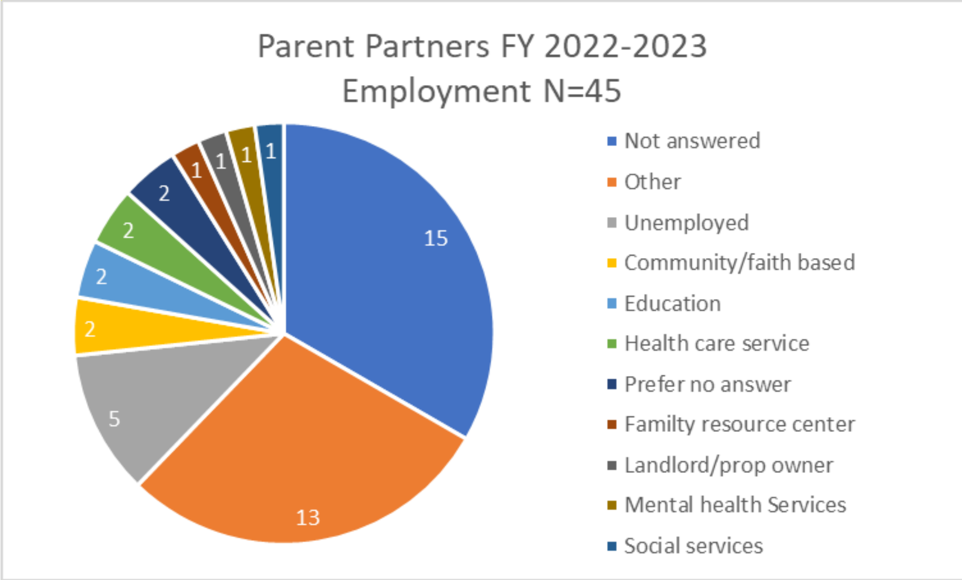
Estimated Number to be reached in FY 2024-2025:
For the next year an estimated 80 new parents/caregivers will be reached either through a referral for services or attendance at a support group. The expectation is that all current and new cases will have a PST completed at the beginning, annually, and at the time of closure to services.

Report for Fiscal Year 2022-2023

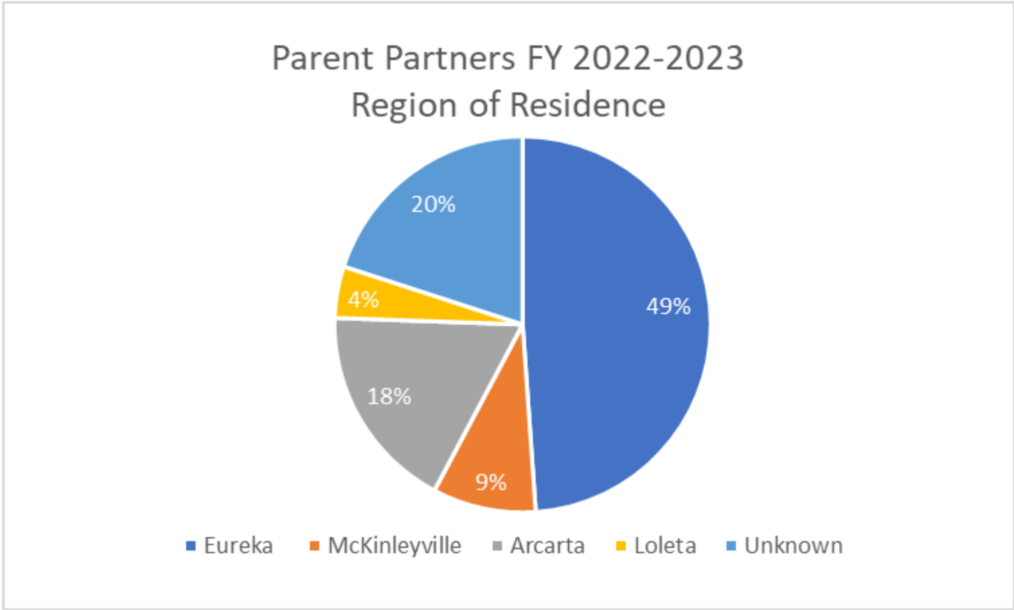
Unduplicated Number of Individuals Served:
For FY 22/23 the Parent Partners served 77 unduplicated parents with 56 new referrals. Overall, 77 unduplicated families received services from a parent partner. Based on the Revenue and Expense Report (RER), which outlines a total cost of $358,632.77 in MHSA funds, the average cost per client is estimated at $4,657.57.

Demographics of individuals served:

- 45 completed voluntary demographic forms.
- AGE: 26 clients indicated ages 26-59, 19 clients were age 60+.
- RACE/ETHNICITY: 34 White; 2 Hispanic, 1 Black; 4 American Indian or Native American, and 3 Multi-racial.
- SEX AT BIRTH: 30 Female; 12 Male, 2 Prefer no answer, 1 did not answer the question.
- GENDER IDENTITY: 29 Female; 12 Male, 2 Prefer no answer, 2 did not answer the question.
- SEXUAL ORIENTATION: 35 heterosexual/straight; 6 Bisexual; 2 Questioning, 1 Other/Unknown, 1 preferred not to answer about sexual orientation.
- LANGUAGE: English was primary language for 44 Clients and one Spanish individual.
- Fifteen individuals have preexisting non mental health disability.
- VETERANS: 3 individuals were Veterans
- HOUSING: 13 have been homeless or lived on the streets; 31 answered no and 1 did not answer.
- MENTAL ILLNESS: 24 have been diagnosed with mental illness; 3 with undiagnosed mental illness, 2 preferred not to answer; 16 indicated No
- FAMILY w/ Mental ILLNESS: 37 have family members with diagnosed mental illness; 2 have family members with undiagnosed mental illness.
- EMPLOYMENT: Individuals come from a variety of employment back grounds. 15 individuals did not answer the question and 13 individuals selected Other. Those which selected Other include 3 Clerk/Retail Sales, 1 Engineer, 1 Findings Department Personnel, 1 Forester, 5 Retirees and 3 Stay at Home Moms.



- REGION of RESIDENCE: Twenty-two (22) Eureka, 8 Arcata, 4 McKinleyville, 2 Loleta and 9 were Unknown.



Actual Outcomes for Fiscal Year 2022-2023

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 the Electronic Health Record system for the reporting period.

PARENT PARTNER SERVICES FY22/23	#
Number of Individuals Receiving Services	77
Total Number of Services Provided	630
Total Number of Minutes Provided	53,221
Average Number of Minutes Per Service	84
Average Number of Services Per Client	9

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 the 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 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 they entered into a Memorandum of Understanding 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 for the future, contingent upon the continuing availability of MHSA funding, is that MHSA will continue to support 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 and other 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 is currently serving 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 systemic 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, multimodal, 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 needs. 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.

School Based Mental Health Initiatives

The California Student Mental Health Implementation Guide (a collaborative document by the California Department of Education, the Mental Health Services Oversight and Accountability Commission, the California School Based Health Alliance, CalMHSA, and the California Mental Health Services Act) is “intended to support local education agencies (LEAs) and county behavioral health departments as they seek to partner to deliver comprehensive, high-quality school mental health services.” The document

identifies the following school initiatives as aligned with comprehensive school based mental health and health care initiatives.

- Multi-Tiered System of Support (MTSS)
- Positive Behavior Interventions and Supports (PBIS)
- Social Emotional Learning (SEL)
- Community Schools
- Trauma-informed classrooms and practices
- Suicide prevention policies in schools
- Restorative practice/justice

The work and focus of the Prevention and Intervention Department at HCOE, supported by PEI funds, provides opportunities for technical assistance, training, and ongoing support to local school districts for these mental health initiatives.

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 four MTSS domains that support the three areas of integrated instruction are:
1) Administrative Leadership
2) Integrated Educational Framework
3) Family and Community Engagement
4) Inclusive Policy Structure and Practice

Activities to strengthen these four domains are extensive. 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
<u>Fidelity Measures</u>: 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 the whole school, select groups, or individual needs. 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 Humboldt County 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 educational and greater community integration – supporting robust avenues of engagement.

Report for Fiscal Year 2022-23, DataQuest California Department of Education

There are approximately 17,573 students enrolled in Humboldt County public schools.

- White - 55%
- Hispanic - 21%
- Two or More Races - 9.9%

- Native - 8.9%
- Asian - 3.1%
- African American- 1.1%
- Pacific Islander - 0.5%
- Filipino -0.5%
- Not Reported - 1.3%
- Free/Reduced - 60.9%
- English Language Learners - 7.3%
- Free and Reduced Lunch eligible students - 60.9%
- 30.9% are Chronically Absent (21-22, 22-23 data isn't available yet)

In addition, in 2022-23 Humboldt had 1,304 homeless youth, 320 TK-12th grade Foster Youth and 234 0-5 Foster Youth.

Based on the Revenue and Expense Report (RER), which outlines a total cost of $78,573 in MHSA funds, the average cost per student is $4.47.

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.

Historical Highlights:

<u>How Covid impacted education</u>

From the beginning of school closures in March of 2020, and for many local districts until the Spring of 2021, it has been an exceptionally challenging time for students, school staff, families, and the community at large. Never in 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 potentially indicating 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 Prevention and Intervention Department:

In 2015 the Humboldt COE moved to systemically support 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 California.

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 being 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 program's

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 the program's collaborative efforts. Attached is a summary of collaborative activities that HCOE has engaged to support local districts with the shifting educational priorities and initiatives.

<u>Current Activities</u>

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 this 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, we 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 are trained as School Wide Information System (SWIS) facilitators, both specialists are becoming licensed trainers with the International Institute for Restorative Practices (IIRP), and we are 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 includes 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 we will be embarking with our 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 systematic efforts to improve and increase PBIS implementation.

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 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 led 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.

We are in the second year of Phase Two (CalHOPE 2.0) of this work, and while continuing to provide universal supports for all districts, we identified three school sites 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 (KTJUSD), Freshwater Elementary School (Freshwater School District), and Miranda Junior High (SHJUSD). These schools will be supported with TA and fiscal support through CalHOPE 2.0. Staff and teams from local districts participating in CalHOPE are also being underwritten to attend the CA PBIS Conference in Oct. 2022. Kelvin, a data collection service, is offered through CalHOPE 3.0 funding to all California schools at no cost. Kelvin will allow school districts to get almost immediate survey results of students, parents, and staff's perspectives. A major emphasis continues to be on building adults' wellbeing and mental health. Professional development offerings include the Humboldt County SEL CoP, which shares turnkey activities and evidence-based social and emotional learning opportunities.

CA MTSS – HCOE continues to work closely with the CAMTSS. We remain the Region 1 lead for CA MTSS and provide TA and Coaching to regional coach's 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 we continue supporting 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 for 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 training includes 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 training, as well as onsite coaching and support to districts. Active partnerships exist with neighboring Del-Norte COE, and Juvenile Hall/Probation. REN, which was launched this summer to support Restorative Practices in education nationwide.

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

In the Spring of 2023, two Restorative Practices training for administrators were offered at one of the high school districts. The purpose was for participants to learn key components of RP while focusing on inclusive discipline practices in place or in lieu of suspension/expulsion.

CA-Integrated Supports Project (CA-ISP) - HCOE is participating in the Partner Entity Grant awarded through the California Department of Education, CA-ISP. The purpose of the grant is to provide funding for high-quality, professional learning to educators in

SEL; trauma-informed practices; and culturally relevant, affirming, and sustaining practices, all in a manner that aligns with CA MTSS. HCOE is one of the PBIS Regional Technical Assistance Centers supporting in the delivery of this project. CA-ISP is designed to enhance CA MTSS which features a continuum of support for inclusive academic, behavior and Social Emotional Learning (SEL)/mental health instruction and interventions. CA-ISP utilizes 14 modules through 5 domains: Identity, Supportive Environment, Voice, Situational Appropriateness, and Data for Equity/Implicit Bias**.** HCOE currently has three schools participating in CA-ISP and outreach continues to bring in more schools into the project.

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) the link 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, County Behavior Health
- 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 – this position will be dedicated to creating and identifying sustainable funding models and practices to support school-based mental health.

District Engagement Highlight – Freshwater School District

PBIS/MTSS in Humboldt County

HCOE has built the 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 the 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 with 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 the 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 Humboldt 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:

Freshwater School District
According to the 2022 CA Dashboard Freshwater has an enrollment of 244 students. 41. 8% are socioeconomically disadvantaged, 1.6% are English Learners and 0% are Foster Youth. 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 training, technical assistance and coaching supporting various state initiatives such as; CAMTSS, PBIS, Restorative Practices, and Universal Design for Learning (UDL). As well as numerous professional development opportunities focusing on trauma-informed practices and student belonging.

Data presents a need to scale-up support:

Below are data points for the Freshwater School District. Indicator data for FY 2022-23 have yet to be released.

Indicator	2021-22
Chronic Absenteeism	3.4 %
Suspensions	0.4%
Expulsions	0%

In addition to the data presented above, in 2022-23, of the entire enrollment of Freshwater: 41.4% qualify for free and reduced lunch, 1% are English Language Learners, 0% qualify as Foster Youth, and 0.7% experienced homelessness.

Freshwater has engaged in 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. Freshwater engaged in PBIS Tier I and Tier II training and have been supported with PBIS coaching and technical assistance by the Prevention and Intervention team at HCOE. In May of 2023 Freshwater applied and received PBIS Silver Recognition. They met the criteria for Silver Recognition for their PBIS implementation awarded by CA PBIS. Qualifying criteria included scoring 70% or higher on the Tiered Fidelity Inventory (TFI, the gold standard fidelity measure for PBIS) and a corresponding low percentage of students receiving Major Office Discipline Referrals. Freshwater received 83% on the TFI. In addition 86% of students received 0-1 Major Office Discipline referrals, 10% received 2-5 Major Office Discipline Referrals and 3.8% received 6 or more Major Office Discipline Referrals. The Silver Implementation Recognition Freshwater received is an indication of the solid Tier One (Universal) supports they have in place to strengthen the systematic delivery of behavioral and

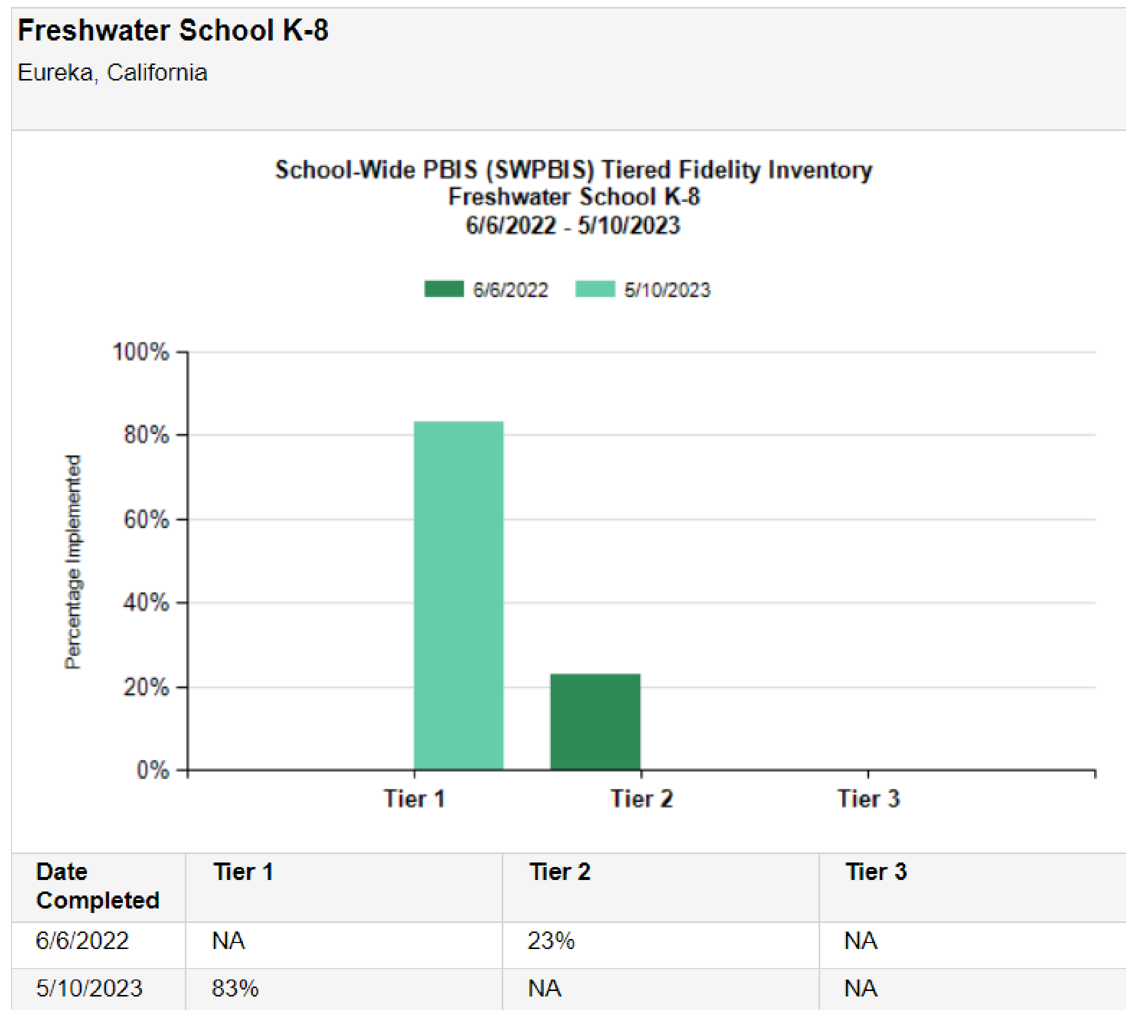
social emotional learning for all students. Freshwater has a robust universal screening process in place to determine when students may benefit from Tier Two (small identified group) interventions and they have a consistent monitoring system to determine when students are ready to return to Universal whole-group instruction.

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

- Universal Design for Learning (UDL) - through Educator Effectiveness Funds Freshwater engaged in a UDL cohort that was led by the Prevention and Early Intervention Team at HCOE and in partnership with Placer County Selpa and Humboldt-Del Norte SELPA. This is a three-year grant which Freshwater joined in 2021-22. 2 teachers from Freshwater have had the opportunity to be trained in UDL and receive TA support with UDL implementation at their site. It is currently moving into year 2 where participants will move into a coaching role at their site, helping to train staff in UDL and supporting teachers with implementing UDL.

- Social-Emotional Learning SEL -Freshwater has partnered with HCOE's Prevention & Intervention department as a "focal school" for a two-year grant through CalHOPE. Freshwater has developed a SEL leadership team, which meet monthly with the charge of supporting and guiding transformative social and emotional learning in their students, staff, and school community. Their SEL leadership team has been working closely with the P & I team for technical assistance, as well as providing on-going coaching support. Freshwater School has focused on building trust and community within their classrooms to better support their students. Another focus has been on providing adult well-being and connection as a staff. The SEL leadership team participates in a monthly Humboldt County SEL CoP to continue exploring resources and networking with other local educators.

SWPBIS TFI 2.1 - Scale - Freshwater School K-8



Date Completed	Tier 1	Tier 2	Tier 3
6/6/2022	NA	23%	NA
5/10/2023	83%	NA	NA

As indicated with technical assistance, coaching and support, Freshwater has shown a marked increase of the fidelity of implementation of PBIS. As evidenced of the decrease of suspension and the absence of expulsions, Freshwater is putting preventative and proactive strategies in place to create opportunities for inclusive discipline practices.

<u>Lessons learned for 2021-22:</u>

With the work with PBIS, RP, SEL and SBHIP – what is clear is that more than ever the need for positive school environments require 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 to offer mental health support to all student groups. The support and partnership we have with DHHS and the support provided through PEI funding support has greatly improved the ability to expand

and improve the support we can provide to local school districts. We look forward to future collaborations for many years to come.

Prevention and Early Intervention: Local Implementation Agreements

In response to stakeholder input, in January 2019 DHHS-BH created a system in the form of Local Implementation Agreements that utilizes Prevention and Early Intervention dollars to allow local organizations to submit a project proposal with the goal of receiving funding through a professional service agreement. 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.

During fiscal year 2022-2023, a total of 72 unduplicated clients were served by projects funded in-part by LIAs. Based on the Revenue and Expense Report (RER), which outlines a total cost of $73,420.70 in MHSA funds, the average cost per client is estimated at $1,019.73.

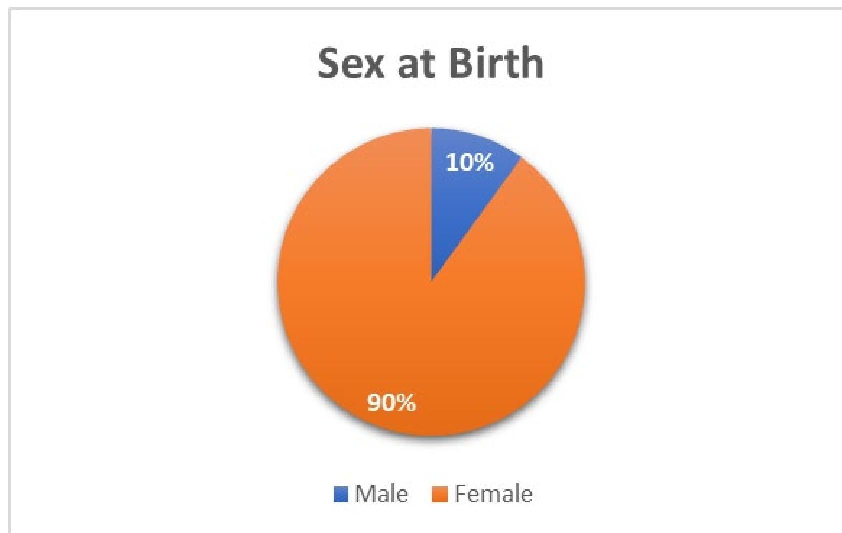
LIA Project Reports for FY 2022-2023

In fiscal year 2022-2023, four local organizations received a Local Implementation Agreement. Below is a brief description of the projects along with their corresponding data:

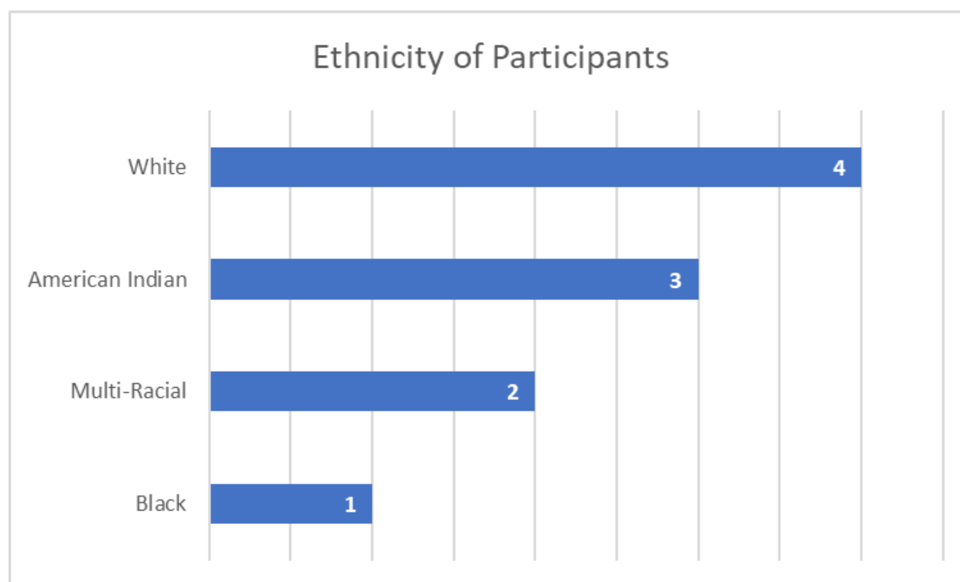
Bear River Band of the Rohnerville Rancheria, *Bear River Neurofeedback*

Bear River purchased equipment and trained two of their Social Workers to provide neurofeedback as a psychotherapy service to the tribal members it serves. Neurofeedback sessions took place within Bear River's social services office located at the Rancheria. This project met the SB 1004 priority of providing culturally competent prevention and early intervention services.

Bear River provided neurofeedback psychotherapy services to a total of 10 individuals, of whom all were within the range of 26-59, all spoke English as their primary language, and identified as heterosexual/straight. Out of the 10 individuals served, 4 stated to have a disability, 2 identified as veterans, 6 had experienced homelessness, 6 experienced a mental health condition, and 8 reported to have a family member that experienced a mental health condition.



As shown on the graph above, of the ten participants that received neurofeedback, 1 (10%) reported male to be their sex at birth and 9 (90%) reported to be female.



As shown on the graph above, 4 participants reported their ethnicity to be White, 3 as American Indian, 2 as Multi-Racial, and 1 as Black.

Since neurofeedback is a form of psychotherapy, most of the participants received mental health treatment within Bear River's system. There was one participant that was referred to outside care for counseling services. Participants were asked after every session a series of questions about how they felt. Before the next session started, participants were asked a series of questions about what they experienced within the first 24 hours after the last session. By checking in with participants about their pre- and post-treatment symptoms, it ensured proper calibration of neurofeedback equipment.

Staff training on equipment use took longer than anticipated. It started with a 40-hour training and then continued with weekly supervision. In the end, it took several months before staff felt confident in providing neurofeedback services to community members. However, now that staff are fully trained and have the necessary equipment available, Bear River plans on continuing neurofeedback service delivery to their community for years to come.

Changing Tides Family Services, *Attachment Vitamins—Addressing Attachment, Stress and Trauma in Early Childhood*

Changing Tides provided 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. The activities of the Attachment Vitamins series took place at the Jefferson Community Center Classroom and childcare spaces in Eureka, California. Changing Tides Family Services partnered with the center to provide an inclusive experience where families could come, learn together, receive childcare and a meal each week as part of the multi-week series. This project met the SB 1004 priority of childhood trauma prevention and early intervention. In total, 6 unduplicated individuals attended meetings, but only 4 filled out demographic forms.

Out of the 4 participants that filled demographic forms, 2 reported to be female and 2 were male. Two reported their ethnicity to be white while one identified as American Indian/Alaskan Native, and one identified as Hispanic/Latino. Three participants were between ages 26-59 years, and one was 60+. All participants were English speaking and from around Humboldt County, including Eureka, Samoa, and Trinidad.

Participants were provided with pre- and post-assessments to establish both a baseline starting point for parents and/or caregivers understanding and skill levels, as well as to document any improvements, changes or increases in capacity based on the participation in the series. The packet included basic demographic information, an

intake assessment, Emotion Regulation Questionnaire (ERQ), Parenting Sense of Competency Scale (PSOCS), Kessler Psychological Distress Scale (KPDS), Parent Reflective Functioning Questionnaire (PRFQ), and a Parent ACES screening. Based on responses obtained through the pre and post assessments, most participants gained an awareness of the impacts of trauma and lived experiences for their children and how it affects their behavior, while also gaining an understanding of how to develop protective factors to mitigate issues. The parents and caregivers also increased their personal awareness around how their behaviors and lived experiences can impact development and attachment of their children.

It should be noted that none of the participants were referred to mental health services through their attendance of the multi-week series. This was due to multiple participants already receiving services prior to participating in the Attachment Vitamins series.

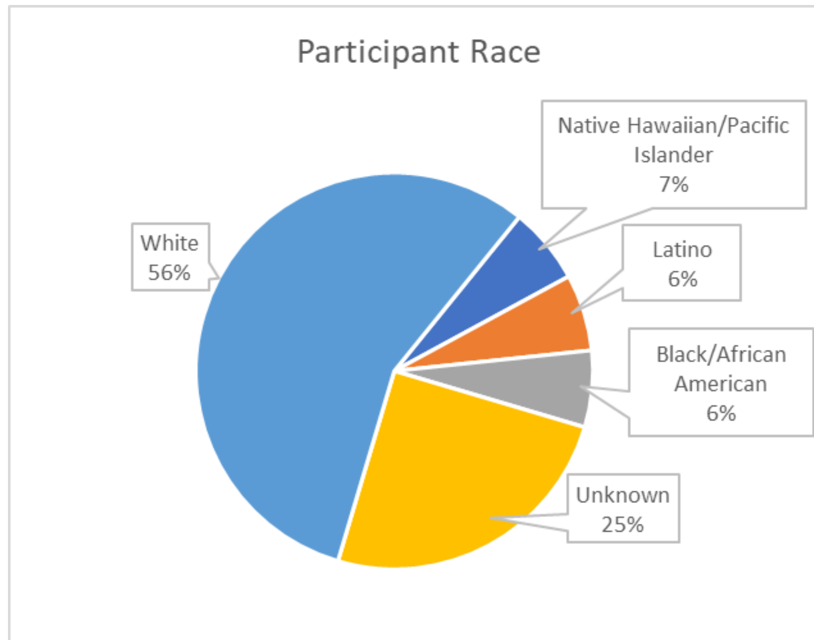
Changing Tides Family Services plans on offering more Attachment Vitamins opportunities for the community in the future. The agency is thinking of potentially offering a series in partnership with an inpatient rehab/treatment facility or to offer a virtual series to reach outlying areas or those without access to transportation. There is interest in engaging in conversations with Tribal Wellness Courts, Humboldt Superior Wellness Court, local school districts and community school coordinators, and Betty Chin's Center to see if the Attachment Vitamins series could strengthen and support their models and communities.

First 5 Humboldt, *Early Childhood Mental Health Prevention and Early Intervention through Evidence-Based Parenting Education*

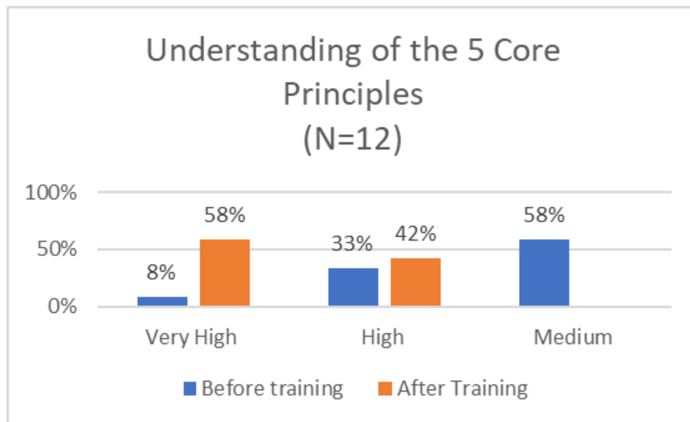
First 5 Humboldt trained 3 Family Support Navigators to provide parent education and support programs through the Triple P-Positive Parenting Program® (Positive Parenting Program) and the Parents as Teachers® programs, which are evidence-based parenting education practices. First 5 Humboldt has infused the teachings of the Parents as Teachers training in the work their Family Support Navigators conduct with families. This project met the SB 1004 priority of childhood trauma prevention and early intervention.

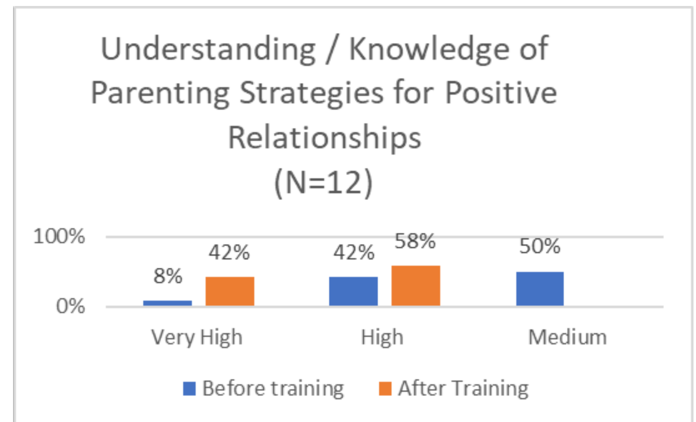
Triple P Series

The Triple P Series, which consisted of 3 sessions, was done at the Jefferson Center in Eureka, which made the series more accessible to parents via their "playgroup" room and provided a full dinner and desert to families. A total of 27 attendees participated in the Triple P Series. The unduplicated count is 19 participants.

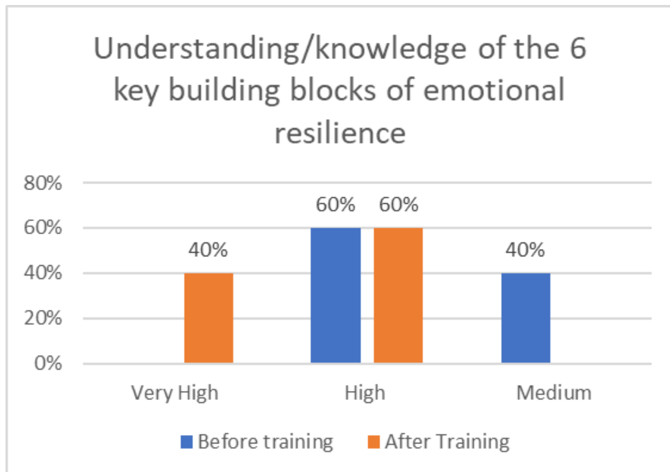


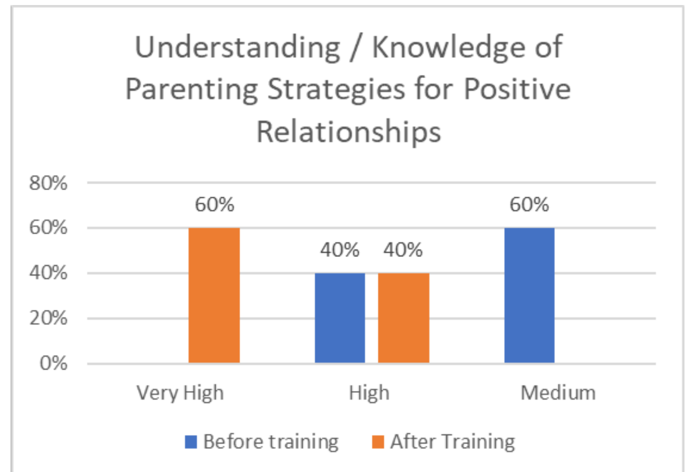
As shown in the graph above, 56% of participants reported to be White, 7% as Native Hawaiian/Pacific Islander, 6% Latino, 6% Black/African American, and 25% were unknown.



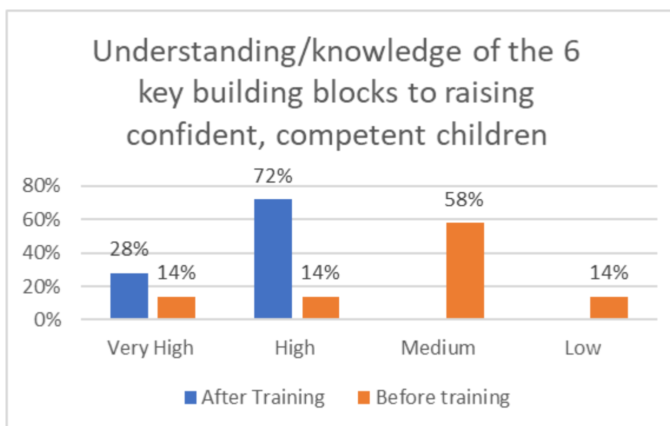


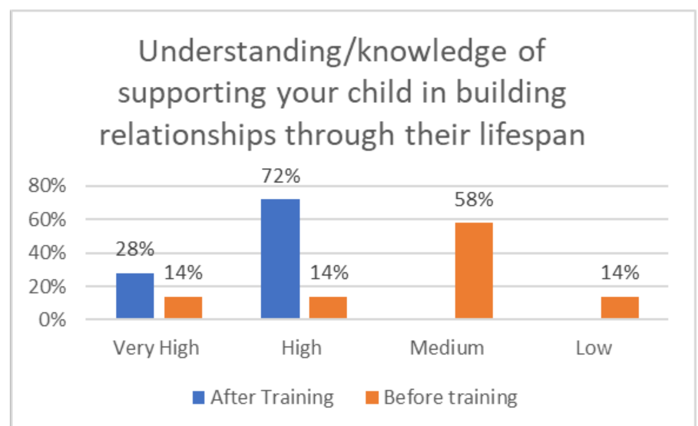
Evaluation surveys were distributed before and after each of the Triple P session. Attendees were asked about their understanding of the 5 core principles. Before the training, Eight percent rated their understanding as “very high,” 33% as “high,” and 58% as “medium.” After the training, 58% rated their understanding as “very high” and 42% as “high.” Attendees were also asked about their understanding of parenting strategies for positive relationships. Before the training, 8% of attendees rated their understanding as “very high,” 42% as “high,” and 50% as “medium.” After the training, 42% rated their knowledge as “very high” and 58% as “high.”



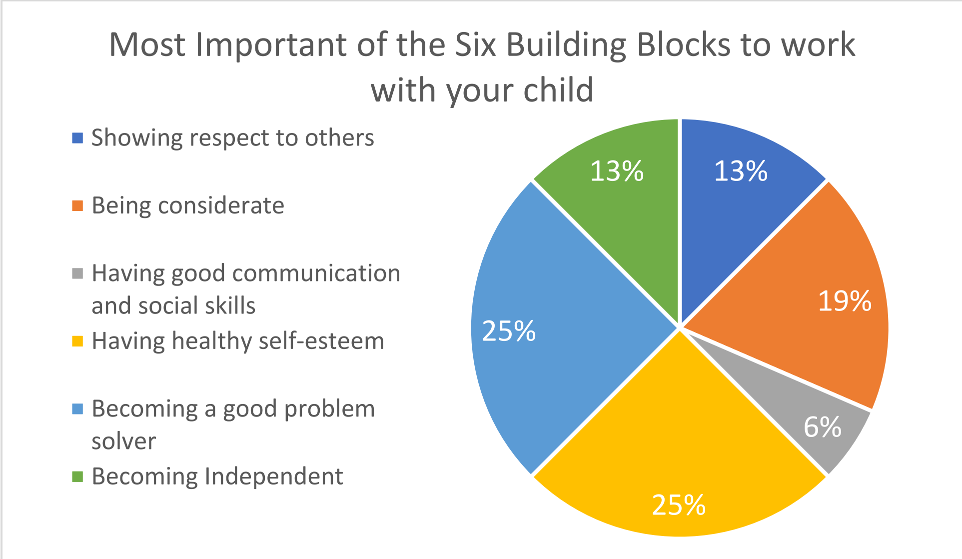


Participants were asked about their understanding of the 6 key building blocks of emotional resilience before and after the training. The chart above shows that before the training, 60% rated their understanding as “high” and 40% as “medium.” After the training, 40% rated their understanding of the 6 key building blocks as “very high” and 60% as “high.” Participants were also asked about their understanding of parenting strategies for positive relationships before and after the training series. Before the trainings, 40% of participants rated their understanding as “high” and 60% as “medium.” After the training, 60% rated their understanding as “very high” and 40% as “high.”

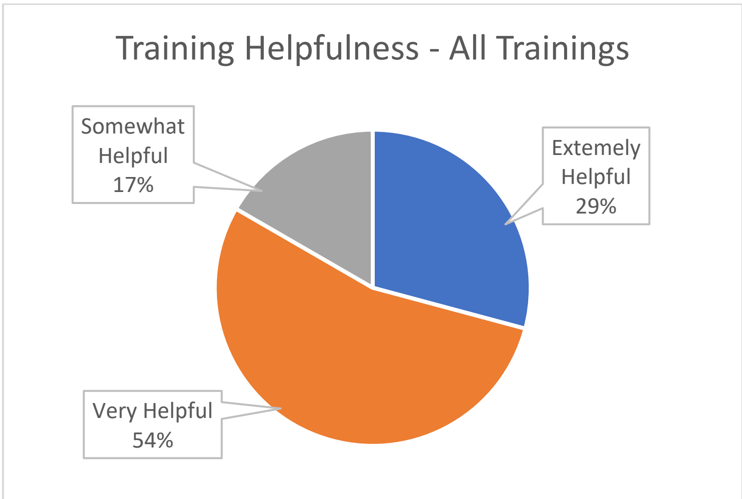




Participants were asked about their understanding of the 6 key building blocks to raising confident, competent children before and after the training series. Before the series, 14% rated their understanding as “very high,” 14% as “high,” 58% as “medium,” and 14% as “low.” After the training series, 25% rated their understanding as “very high” and 72% rated as “high.” Participants were also asked about their understanding in how to support their child in building relationships through their lifespan before and after the training series. Their responses were identical to the 6 key building blocks to raising confident, competent children.



Participants were asked to grade which of the six building blocks is the most important for their children. Thirteen percent graded “showing respect to others” as the most important for their child, 19% chose “being considerate,” 6% chose “having good communication and social skills,” 25% chose “having healthy self-esteem,” 25% chose “becoming a good problem solver,” and 13% chose “becoming independent.”



All participants were asked about the helpfulness of the trainings. In total, 29% found the trainings to be “extremely helpful,” 54% found them “very helpful,” and 17% found the trainings to be “somewhat helpful.”

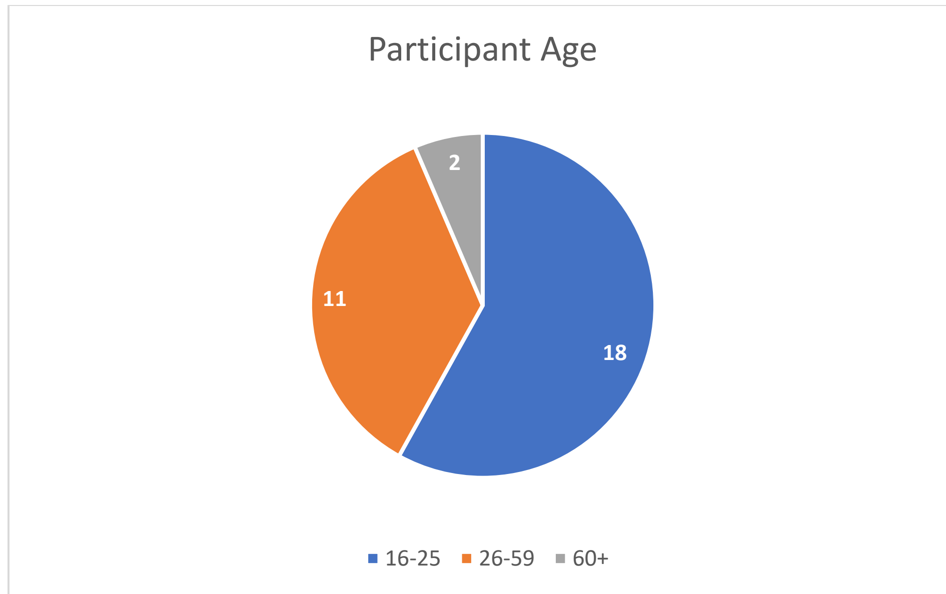
Outcomes demonstrate that the program:
Reduces problem behavior in children.
Improves parents’ wellbeing and parenting skills.

Decreases rates of child abuse.
Reduces foster care placements.
Decreases hospitalizations from child abuse-related injuries.
Is correlated with reduced behavior and emotional challenges where the model is widely available.
Results in parents reporting less stress, fewer feelings of depression and less harsh discipline.
Is cost effective when used throughout a community because of cost savings related to child abuse and neglect.

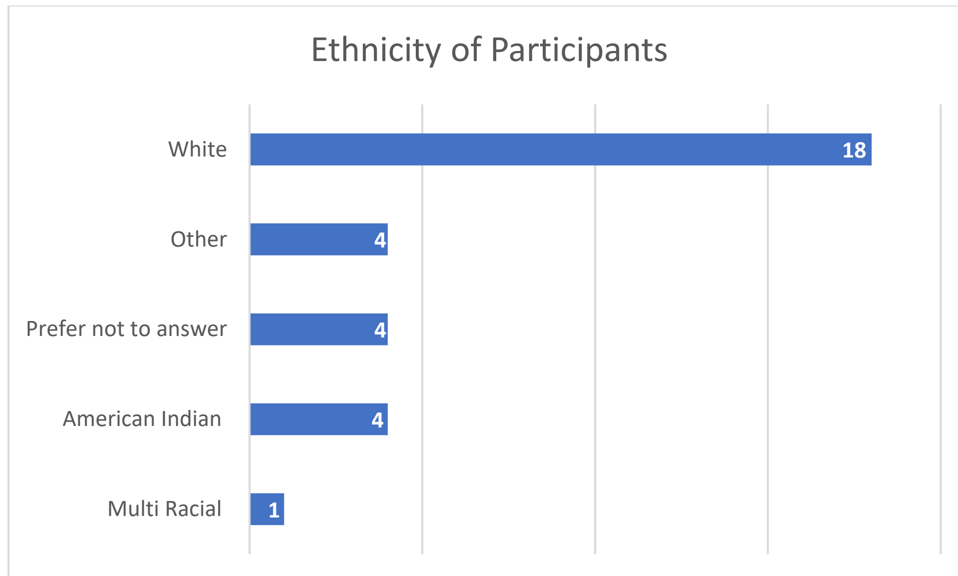
No referrals were made to behavioral health treatment, although a participant received a referral to playgroups and to a Frist 5 Humboldt Family Support Navigator.

With staff trained on Triple P and Parents as Teachers, First 5 Humboldt will continue providing services to community members. First 5 Humboldt will seek to expand the availability of these two trainings through other funding sources. The next phase would be to train staff in Level 3: Discussion Groups, which plans to pursue other levels of training too. First 5 Humboldt is committed to lifting up and expanding these models in Humboldt County and having them consistently available to parents and service providers.

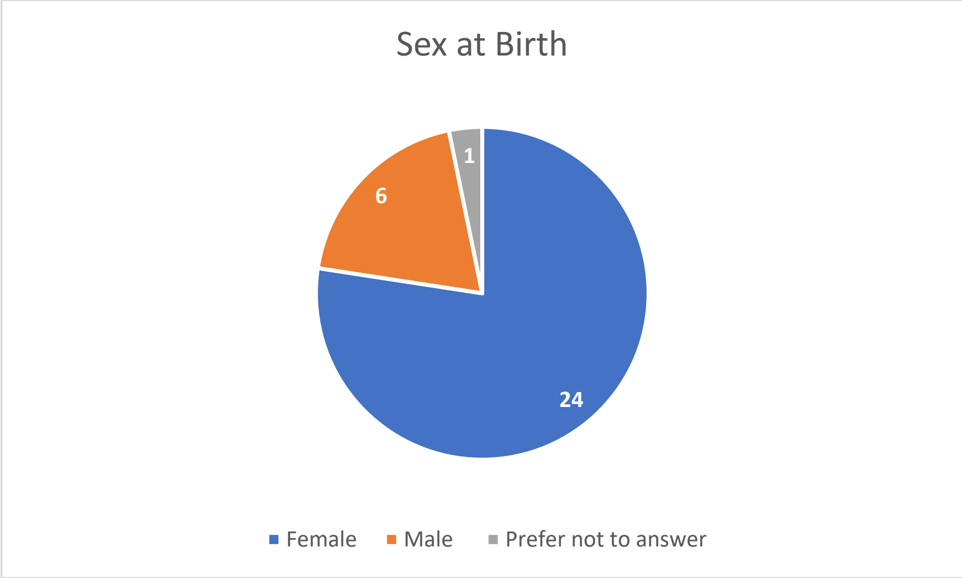
McKinleyville Community Collaborative DBA McKinleyville Family Resource Center (McKFRC), *Humboldt Mental Health First Aid*
McKFRC trained four additional staff as instructors in Teen, Youth, and Adult Mental Health First Aid training in Spanish and English hosted five Mental Health First Aid trainings. There was one adult session, two youth sessions in English, and two sessions in Spanish. It should be noted that the two Spanish sessions did not have any participants. This project met the SB 1004 priorities of culturally competent and linguistically appropriate prevention and intervention and early identification of mental health symptoms and disorders. In total, 37 people attended the Mental Health First Aid Trainings, with only 31 completing the voluntary demographics survey.



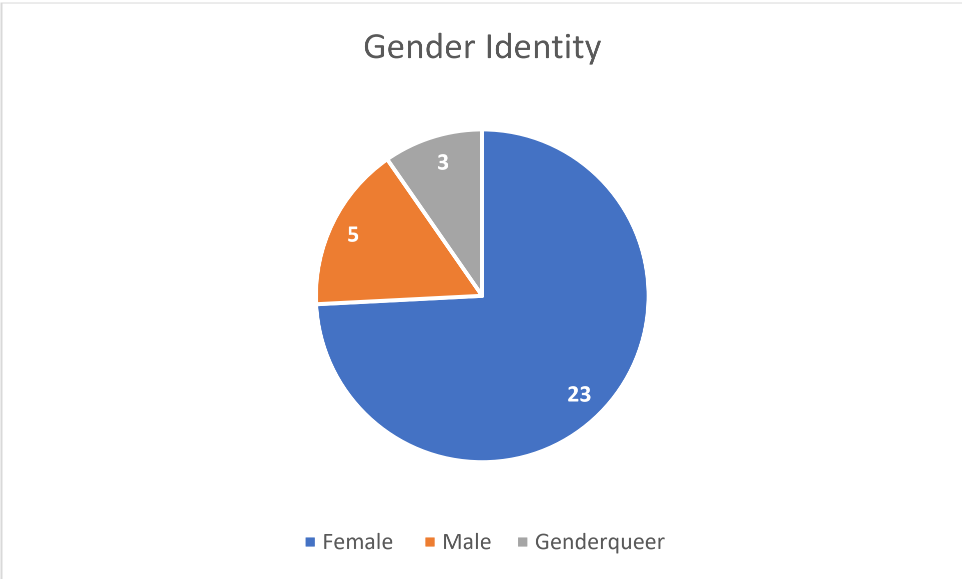
Out of the 31 participants that completed the demographic survey, 18 (58%) were within the TAY 16-25 age group, 11 (35%) were within the Adult 26-59 age group, and 2 (7%) were within the Older Adult 60+ age group.



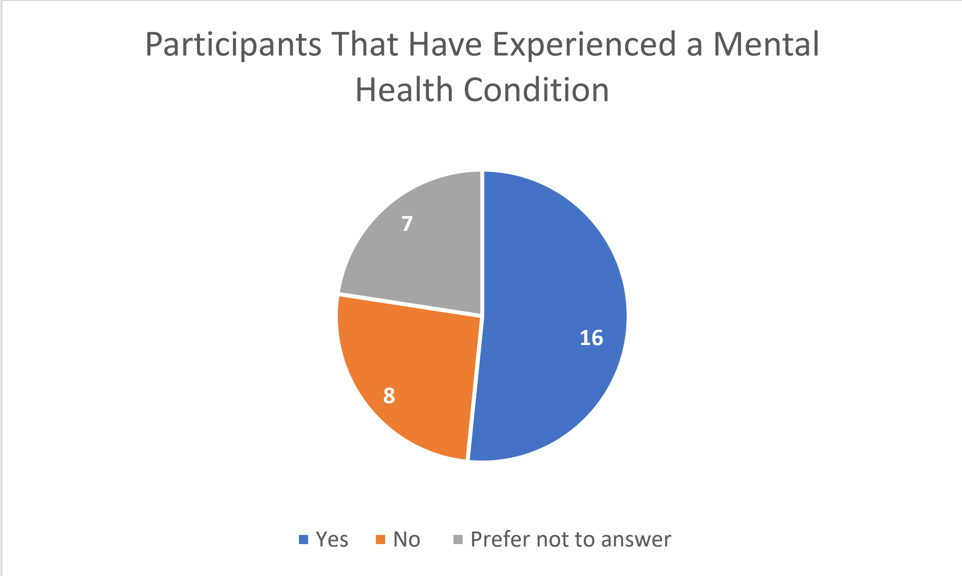
Out of the 31 participants that completed the demographic survey, 18 (58%) were White, 4 (13%) marked as "other," 4 (13%) preferred not to answer, 4 (13%) identified as American Indian, and 1 (3%) participant identified as multi racial.



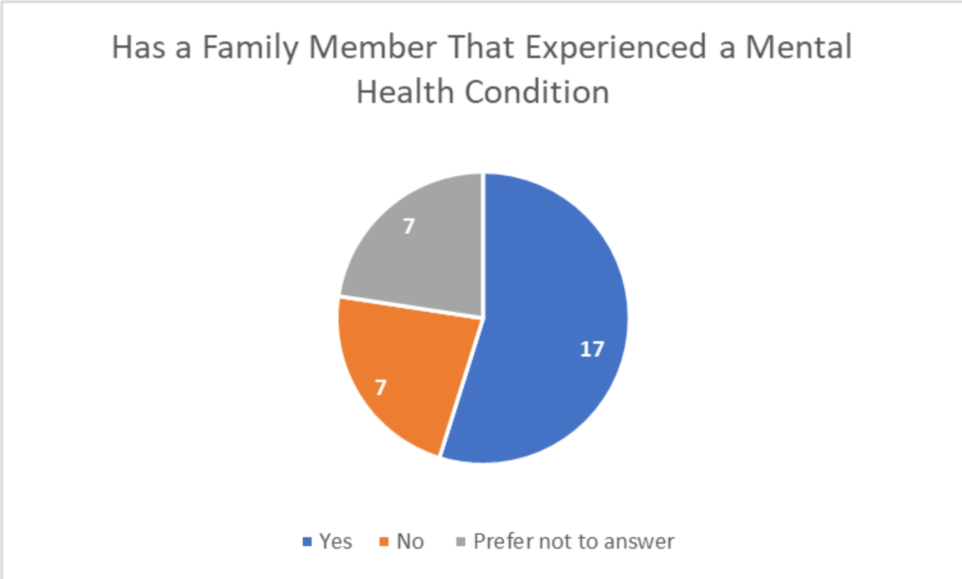
Out of the 31 participants that completed the demographic survey, 24 (77%) reported their sex at birth to be female, 6 (19%) reported their sex at birth to be male, and 1 (3%) did not answer the question.



Out of the 31 participants that completed the demographic survey, 23 (74%) identified as female, 5 (16%) identified as male, and 3 (10%) identified as genderqueer.



Sixteen (52%) participants identified as experiencing a mental health condition, 8 (26%) had not experienced a mental health condition, and 7 (23%) participants preferred not to answer.



Seventeen (55%) of survey respondents reported having a family member with a mental health condition, 7 (23%) did not have a family member with a mental health condition, and 7 (23%) preferred not to answer.

As for other demographics, all survey respondents identified English as their primary language, 1 participant identified as a veteran, and none had experienced

homelessness. Due to the nature of this project, participants were not referred to behavioral health service providers.

Out of the 4 staff trained, 2 staff were trained as teen Mental Health Frist Aid Instructors and 2 bi-lingual staff were trained in both Youth and Adult Mental Health First Aid. As for language capacity, 1 monolingual English speaker was trained to deliver Adult Mental Health First Aid and 1 monolingual English speaker was trained to deliver Youth Mental Health First Aid. These trainings were received online and delivered by Mental Health First Aid USA.

Since more McKFRC staff are now able to conduct Mental Health First Aid training, there are plans to offer Adult and Youth Mental Health First Aid in English and Spanish at The Center in Fall of 2023. McKFRC will continue to collaborate with school districts and is prepared to offer teen Mental Health First Aid if the schools would like to bring the content to their students.

Approved LIA Projects for FY 2023-2024

Five projects were selected for funding in Fiscal Year 2023-2024 and a brief description of each project is below. These projects will conclude in June 2024 and reports on the activities will be provided in the 2025/26 Annual Update.

Bear River Band of Rohnerville Rancheria, *Mental Health Outreach and Awareness in Native Communities*.

The Bear River Band will host a total of 4 outreach events meant to provide community members with learning opportunities on mental health and resources. The first event will be used to collect trends/perceptions people have in regard to mental health needs, which will then be utilized to dictate how the other three events will be organized. This project meets the SB 1004 priority of providing culturally competent prevention and early intervention services.

Humboldt Independence Practice Association (IPA), *Mental Health Prevention through Student Empowerment Groups*

Humboldt IPA will expand their Empowerment Groups to 6 new school sites throughout Humboldt County. These Empowerment Groups are mentorship groups for middle schools and high school students. Group goals include: encouraging emotional health and wellness, developing peer to peer support among student participants, fostering a deeper connection to the community, lowering absenteeism rates in schools, promoting leadership skills, supporting students in their transition to adulthood, fostering resiliency, and instilling self-confidence and self-worth. Student participants will be able to identify

and request topics based on the needs and interests of the group. This project meets the SB 1004 priority of childhood trauma prevention and early intervention.

Queer Humboldt, *Rural 2S/LGBTQIA+ Youth Prevention and Early Intervention Project*
Queer Humboldt will fill a new position called Rural Queer Youth Outreach Coordinator. The Rural Queer Youth Outreach Coordinator will provide outreach and linkage to services to communities located in the Eastern area of Humboldt County. At the time of the project proposal, Queer Humboldt had already identified someone for this position. This project meets the SB 1004 priority of culturally competent and linguistically appropriate prevention and intervention.

Redwood Community Action Agency (RCAA), *SOARing to Stability YSB (Parents and Children in Transition and Youth Services Bureau Programs)*
RCAA will implement SSI/SSDI Outreach, Access, and Recovery (SOAR) Case Management services, educate the community on SOAR's success in Humboldt, build connections with the regional and state SOAR work and training groups, and recruit, employ, and train a SOAR Case Manager. The Case Manager's main role will be to help people apply for SSI/SSDI funding with the logic that having stable income promotes better mental health/boost protective factors and prevent the occurrence of mental illness. This project aims to serve the targeted population through RCAA's Adult and Family Services, Youth Service Bureau Programs, and Energy Services Division. This project meets the SB 1004 priorities of 1) childhood trauma prevention and early intervention 2) culturally competent and linguistically appropriate prevention and intervention.

Redwood Rural Health Center (RRHC), *Comprehensive Training Supporting Trauma Informed Approaches to Early Intervention and Prevention of Suicide and Other Mental Health Crisis*
RRHC will offer Question, Persuade, Refer (QPR), Adverse Childhood Experiences (ACES), and training through Gabriella Grant Consulting Inc. to expand integrated intervention and treatment strategies. Through these trainings, RRHC's goal is to provide better quality support to Southern Humboldt. This project meets the SB 1004 priorities of 1) childhood trauma prevention and early intervention, 2) early psychosis and mood disorder detection and intervention and mood disorder and suicide prevention programming that occurs across the lifespan, 3) early identification programming of mental health symptoms and disorders.

LIA Projects for FY 2024-2025

Contingent upon available funding, Local Implementation Agreements (LIAs) will continue to be supported by PEI during the period of the 2023-2026 Three-Year Plan and Annual Update. The application period for LIAs opened on December 2023 and closed on February 2024. A total of 11 applications from local organizations were received, with 6 receiving approval from BH Administration. The six approved organizations can be found below along with a brief summary of the project they will be carrying for fiscal year 2024-2025:

Bear River Band of the Rohnerville Rancheria: Mental Health Outreach and Awareness in Native Communities Series 2

The Bear River Band will host 4 outreach events specifically tailored to engage the Tribal youth and their families. The first event will serve as an introduction and discussion about Mental Health within the Bear River tribal youth community and help connect people to tribal Social Services. The first event will help gather information that would then be used to design and implement the topics of the other 3 events. Each event will include printed educational information that participants can take home with them. Food will be provided as well as activities to bring engagement to the events, and mental health swag to decrease the stigma of mental illness. It is projected that roughly 40 participants will attend each event for a total of 160 participants.

Centro del Pueblo Movimiento Indígena Migrante: Sembrando Esperanza: La Campaña de Medios y Alcance Para Prevenir el Suicidio Juvenil (English translation: Cultivating Hope: A Campaing of Efforts and Outreach to Prevent Juvenile Suicide)

Centro del Pueblo Will expand their Sembrando Esperanza program, which focuses on Latinx and Indigenous youth suicide prevention efforts. Efforts include: a bilingual awareness social media campaign, a Spanish podcast, presentations and workshops across the county to inform folks about early intervention, suicide prevention, linkage to services, and stigma and discrimination reduction. These activities will be expanded to various regions of Humboldt County through LIA funding, which will also provide help in covering equipment costs to create a new media platform.

First 5 Humboldt: Early Childhood Mental Health Prevention and Early Intervention through Evidence Based Parent Education and Home Visiting

With LIA funding, First 5 Humboldt will train and certify 4 of their Family Support Navigators in Family Spirit, an evidence-based home visiting intervention program. Once training is done, First 5 Humboldt intends to begin offering this new program to families throughout Humboldt County in conjunction with local partners (e.g. UIHS, K’ima:w, Open Door). Through this new service delivery, First 5 Humboldt is aiming to serve 64 families within FY 24-25.

Mattole Valley Resource Center (MVRC): Mental Health Awareness Program

MVRC will expand services from their Mental Health Awareness Program, which focuses on recreational assistance and community building through classes, trainings, and outreach efforts. LIA funding will be used to cover outreach efforts as the organization seeks to expand their program throughout other regions of Humboldt County.

Northern United—Humboldt Charter Schools: Building Bridges to Wellness: Comprehensive Mental Health Support for Student Success

LIA funding will be utilized to cover costs associated with supplies and training two additional staff in evidence-based student mental health supporting practices such as Charter Strong and Social Emotional Learning (SEL) restorative practice interventions. The program will focus on students facing high mental health needs, as identified through a needs assessment survey. The needs assessment survey highlights concerns related to depression, anxiety, isolation, and behaviors impacting the learning environment. The training and supplies covered through LIAs will help equip staff to respond to their population's needs.

Southern Humboldt Family Resource Center: Parent Project – Changing Destructive Adolescent Behavior

The Southern Humboldt Family Resource Center is aiming to host two 10-week sessions of The Parent Project during the 2024-2025 academic school year (starts in September). The Parent Project has been offered in Northern Humboldt for multiple years and has proven to be successful. The organization is looking to expand this service delivery into the Southern Humboldt region. LIA funding will be used to cover material expenses, transportation, and childcare during sessions.

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.

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. Moving forward, Humboldt's call volume will be done through the 988 line. The data being reported in this section spans July 2022 through the end of December 2022.

From July 2022 through December 2022, there were a total of 263 calls to the hotline from Humboldt County. Of these, there were 175 incoming calls; 18 moderate or higher lethality calls; 9 active rescue calls; 32 callers requiring follow-up; and 88 follow-ups placed. Five referrals were made to Humboldt County Behavioral Health. Caller concerns were mental health 36%; social issues 23%; basic needs 17%, health care/physical needs 12%, abuse/violence 10%, homicidal ideation 1%, and sexual orientation 1%.

For suicidal call content, 40% were past attempt/ideation; 35% suicidal desire; 19% suicidal intent; and 6% imminently lethal caller. Fifty-six percent of callers were female, 48% male, 6% unknown. One of the callers identified as transgender. For 99% of callers race was unknown; 1% were Native American/Alaskan Native. One percent were ages 5-14; 13% ages 15-24; 18% ages 25-34; 9% ages 35-44; 17% ages 45-54; 9% ages 55-64; 7% ages 65-74; 2% 75-84; 1% 85+; and 6% unknown.

Prevention and Early Intervention: Latinx Liaison Position

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. This position will advance efforts in access and linkage to services and stigma discrimination reduction through its outreach efforts and coordination with Behavioral Health programs.

The 2023-2026 Three-Year Plan, that was passed by the Board of Supervisors on June 27th, 2023, along with this Annual Update, include a budget item for the development and implementation of the Latinx Liaison position. DHHS-Behavioral Health leadership is working with the MHSA Coordinator on identifying the appropriate job description with the intent of engaging in recruitment efforts.

Since this position is not filled at the time of this report, a cost per client estimate cannot be provided.

Prevention and Early Intervention: Early Childhood Treatment Certification

Infant-Family and Early Childhood Mental Health (IFECMH) 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. Given the nature of this program, it focuses on Prevention, Early Intervention, and increasing the recognition of early signs of mental illness. MHSA funding will support up to 24 individuals within the cohort to get this certification in three years.

The IFECMH Certificate Training Program, which the McKinleyville Community Collaborative will house, is a three-year training program aligned with the CA Center for Infant-family and Early Childhood Mental Health. It is designed to address the 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 IFECMH 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. 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.

The third year of this 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 training series 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 McKinleyville Community Collaborative program director will strategically work toward aligning the certification with the local college and polytechnic university to provide future stability, integration, and sustainability.

Given the nature of this program, it does not serve clients directly. Due to this, a cost per client cannot be estimated. However, since this program is new, the 2025-2026 Annual Update will include an updated report that reflects the numbers of local professionals certified in IFECMH.

Prevention and Early Intervention: Warm Line

During 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" to provide non-emergency mental health 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 basis, as needed. The Warm Line will focus on access and linkage to treatment efforts. While COVID-19 concerns are changing over time, there still seems to be an ongoing need for this level of community support beyond COVID-19. The Hope Center operates this warm line and will be linking callers to services when needed. This warm line will augment other services available and provides opportunity for earlier intervention that can prevent more acute, intense crisis experiences.

Since this is a newly implemented program, there is no data available to report on and therefore not possible to estimate a cost per client. The 2025-2026 Annual Update will include demographical data, access and linkage to treatment strategies, and a cost per client estimate.

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. This joint effort will help in increasing the recognition of early signs of mental illness. 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 provides 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. There is a growing need to provide staff with consultation and training opportunities. The 2024-2025 Annual Update has allocated funding in the budget to offer such opportunities to staff and to help expand equity work across

Humboldt County Behavioral Health and to ensure that culturally responsive engagement is prioritized. Additionally, Humboldt County Behavioral Health, with stakeholder input, has identified a greater need to improve local recruitment and retention strategies within its workforce. MHSA WET funding will also be used to offer local recruitment and retention strategies at the local level outside of the Superior Region Partnership.

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-June 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, sign-on bonuses for folks that apply for specific job openings that have been identified as hard-to-fill, and the development and implementation of recruitment and 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 third round of Loan Repayment will be approved in mid-2023 along with a first round of Graduate Stipends.

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.

Consultation and Trainings. Behavioral Health will continue its consultation work with Stepping Stone Consulting in order to continue the branch wide equity work and to offer more robust cultural coaching opportunities to staff. County Behavioral Health will also consider contracting with other appropriate consultants to specifically address culturally responsive engagement within the community, as needed. Behavioral Health will allocate funding to cover trainings that will help expand equity work efforts; a list of trainings funded during fiscal year 2024-2025 will be provided in the 2025-2026 Annual Update.

County Compliance Certification

This page is a placeholder and 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

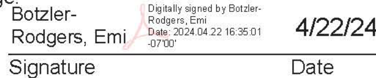
- ☐ Three-Year Program and Expenditure Plan
- ■ Annual Update
- ☐ Annual Revenue and Expenditure Report

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
Local Mental Health Director (PRINT)

Botzler-Rodgers, Emi


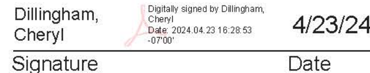
Signature

4/22/24
Date

I hereby certify that for the fiscal year ended June 30, 2023, 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 8/23/2023 for the fiscal year ended June 30, 2021. I further certify that for the fiscal year ended June 30, 2023, 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.

Cheryl Dillingham
County Auditor Controller / City Financial Officer (PRINT)

Dillingham, Cheryl


Signature

4/23/24
Date

[1] Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)
Three-Year Program and Expenditure Plan, Annual Update, and RER Certification (07/22/2013)

MHSA Funding Summaries

FY 2024/25 MHSA Annual Update Funding Summary

County: HUMBOLDT

Date: 06/5/2024

	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 2024/25 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	2,200,930	1,872,779	1,383,300	0	0	
2. Estimated New FY2024/25 Funding	6,419,047	1,604,762	422,306			
3. Transfer in FY2024/25[a/]	(344,940)			344,940		
4. Access Local Prudent Reserve in FY2024/25						
5. Estimated Available Funding for FY2024/25	8,275,037	3,477,541	1,805,606	344,940	0	
B. Estimated FY 2024/25 Expenditures	8,266,956	2,125,629	475,092	344,940	0	
C. Estimated FY 2024/25 Unspent Fund Balance	8,112	1,375,912	1,330,515	0	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2024	1,239,391
2. Contributions to the Local Prudent Reserve in FY 2024/25	
3. Distributions from the Local Prudent Reserve in FY 2024/25	
4. Estimated Local Prudent Reserve Balance on June 30, 2025	1,239,391

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 2024/25 MHSA Annual Update Community Services and Supports (CSS) Funding

County: HUMBOLDT Date: 06/6/2024

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 (CCT)	11,129,196	6,764,188	3,635,863	729,145		
Non-FSP Programs						
1. Regional Services	377,025	166,090	210,935			
2. Older and Dependent Adults Expansion	118,926	78,155	40,771			
3. Crisis Residential Treatment	1,839,658	792,410	1,047,248			
4. Crisis Alternative Response of Eureka (CARE)	225,000	225,000				
5. Tribal Support	87,165	87,165				
CSS Administration	166,742	153,917	12,825			
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	13,943,712	8,266,926	4,947,641	729,145	0	0
FSP Programs as Percent of Total	79.8%					

FY 2024/25 MHSA Annual Update Prevention and Early Intervention (PEI) Funding

County: HUMBOLDT Date: 06/5/2024

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	490,591	372,743	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	92,292	92,292				
5. Local Implementation Agreements	120,000	120,000				
6. Latinx Liaison	91,300	77,605	13,695			
7. Early Childhood Treatment Certification	118,250	118,250				
8. Warm Line	102,132	102,132				
PEI Programs - Early Intervention						
1. Suicide Prevention	306,986	306,986				
PEI Administration	155,217	155,217				
PEI Assigned Funds	94,364	94,364				
Total PEI Program Estimated Expenditures	2,557,903	2,125,629	432,274	0	0	0

FY 2024/25 MHSA Annual Update Innovation (INN) Funding

County: HUMBOLDT Date: 06/5/2024

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 (REST)	464,225	431,902	32,323			
INN Administration	43,190	43,190				
Total INN Program Estimated Expenditures	507,415	475,092	32,323	0	0	0

FY 2024/25 MHSA Annual Update Workforce, Education, and Training (WET) Funding

County: HUMBOLDT Date: 06/5/2024

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. Relias E-Learning	69,068	69,068				
2. HCAI Regional Partnerships	5,872	5,872				
3. Tribal and Equity Consultation	120,000	120,000				
4. Personnel Training and Incentives	150,000	150,000				
WET Administration	0					
Total WET Program Estimated Expenditures	344,940	344,940	0	0	0	0

FY 2024/25 MHSA Annual Update Capital Facilities/Technological Needs (CFTN) Funding

County: HUMBOLDT Date: 06/5/2024

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					
CFTN Programs - Technological Needs Projects						
3.	0	0				
4.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	0	0	0	0	0	0