Humboldt County Department of Health & Human Services
People helping people live better lives

Mental Health Services Act

Annual Update

Fiscal Year 2018/2019

Including

Three Year PEI Evaluation and Annual Innovation Project Reports

Contents

County Compliance Certification

The County Compliance Certification will be completed after Board of Supervisors approval of the Annual Update.

Community Planning and Local Review Process

Background

Humboldt County Department of Health and Human Services is a consolidated organization, integrating Mental Health, Public Health and Social Services. Since its consolidation in 1999, Humboldt County Department of Health and Human Services has been engaged in true system transformation and redesign.

To ensure the most effective use of resources, avoid duplication of effort, and maximize the leveraging of ongoing efforts and community strengths, Mental Health Services Act programming is developed and delivered with consideration of the common goals of other Humboldt County Department of Health and Human Services initiatives, using the transformation strategies and vision that have guided planning and service delivery in Humboldt County for nearly two decades.

It is through these transformational strategies that the Humboldt County Department of Health and Human Services has planned and implemented its Mental Health Services Act (MHSA) programming. Humboldt County's approved Three Year Plan for 2017-2020 sets forth the approved programs for Community Services and Supports, Prevention and Early Intervention, Workforce Education and Training, and Information Technology components.

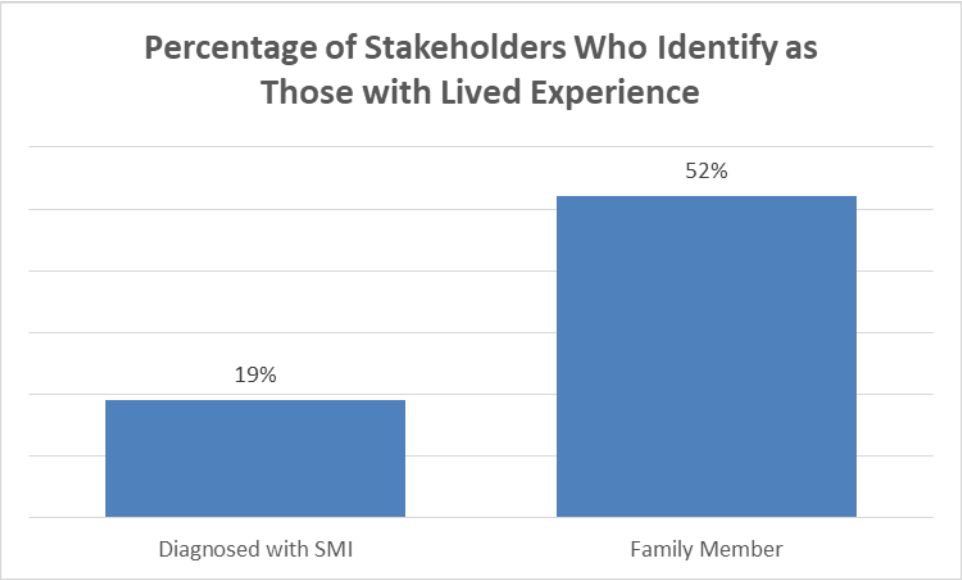
Methods for obtaining stakeholder input for the 2018-2019 Annual Update occurred using the same processes that have been used in prior Three Year Plan and Annual Updates. These included:

- Holding regional stakeholder meetings and other stakeholder groups
- Input and comments sent to the Mental Health Services Act email address, received by the Mental Health Services Act voice mail, or written comments obtained at stakeholder meetings.
- Distribution of the Draft 2018-19 Annual Update and associated MHSA information via email to stakeholder groups and individuals.

Stakeholders

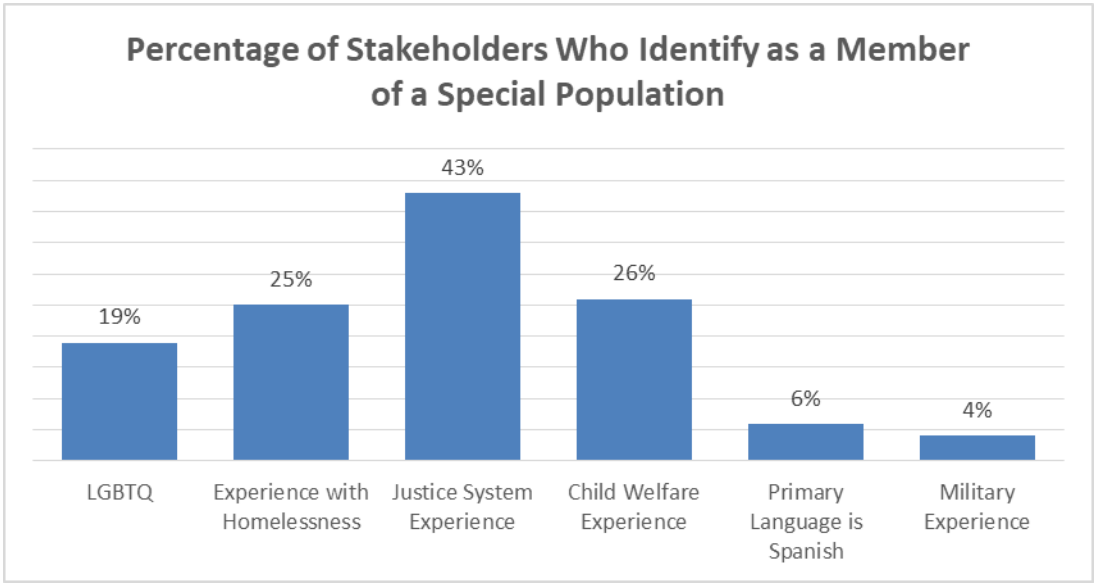
DHHS began collecting stakeholder demographic information in 2008. Between 2008 and January 2019 the majority of MHSA stakeholders participating in community planning activities completed a demographic questionnaire. Demographic information about participants in the stakeholder process from 2008 through January 2019 are presented in the charts below.

Individuals with lived experience with a mental illness are recognized as a vital voice in the MHSA planning process. During the prior years and current stakeholder processes, 19% of people participating identified as having a mental illness, and 52% identified as a family member of someone with a mental illness, as shown in the following chart.

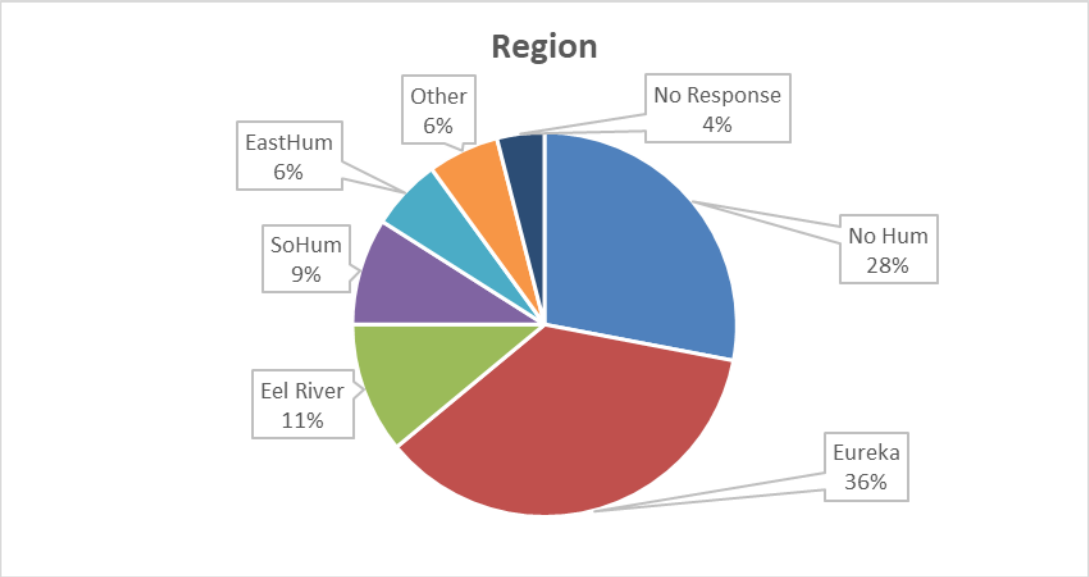


Additional life experiences have been identified as valuable voices for the planning process so they are also monitored for inclusion. Sexual orientation, homelessness, justice system experience, Child Welfare experience, those whose primary language is Spanish, and military experience are all life experiences that may result in challenges to successful mental health treatment. The chart below illustrates how outreach efforts have included people with these life experiences:

- 19% identified as LGBTQ,
- 25% identified as having experience with homelessness,
- 43% had justice system experience,
- 26% had Child Welfare experience,
- 6% stated their primary language is Spanish, and
- 4% had military experience.

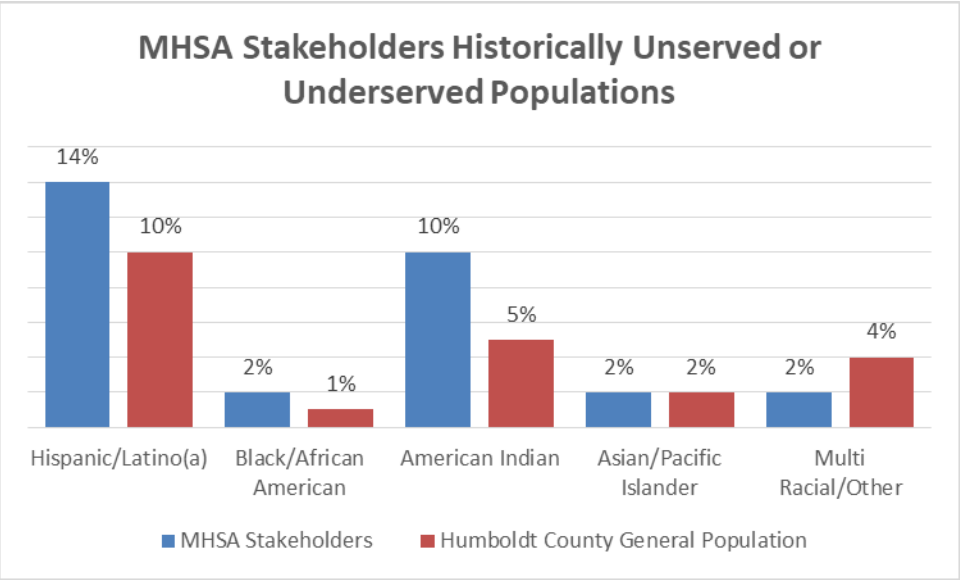


Another priority for representation in the planning process is regional. More than half of the MHSA stakeholders in the processes live in regions close to Humboldt Bay, Northern Humboldt at 28% and Eureka at 36%, while 11% live in the Eel River Valley, 6% in Eastern Humboldt and 9% in Southern Humboldt. Ten percent either did not respond to the question or indicated they lived in another region. This is shown in the chart below.

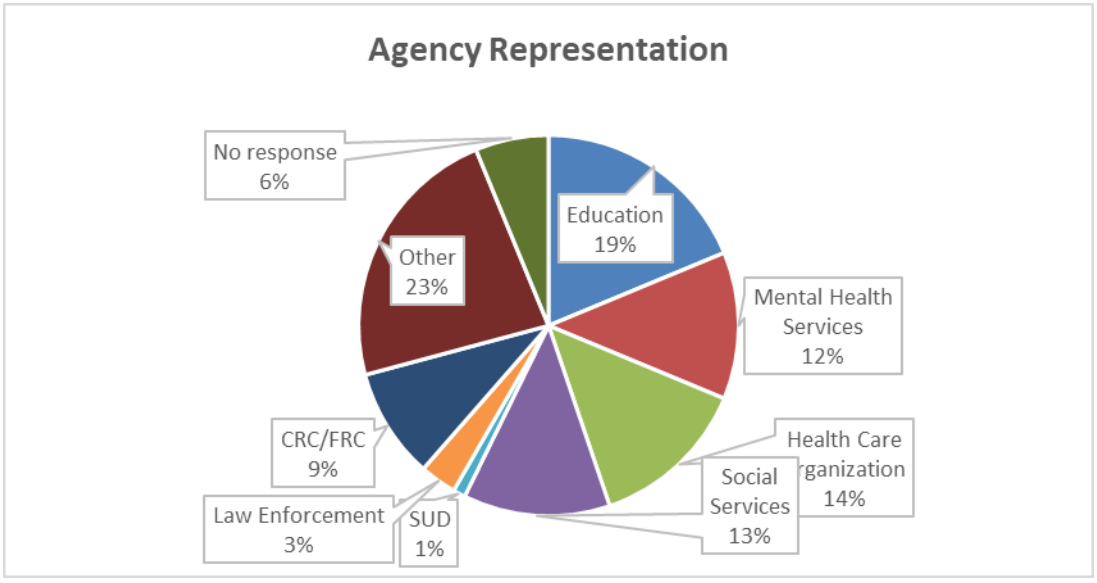


Participants in the stakeholder process reflected the racial and ethnic diversity of Humboldt County:

- 14% were Hispanic/Latino(a), compared to 10% of the Humboldt County general population.
- 2% were Black/African American, compared to 1% of the County general population.
- 10% were American Indian, compared to 5% of the County general population.
- 2% were Asian/Pacific Islander, compared to 2% of the County general population.
- 2% were Multiracial/Other, compared to 4% of the County general population.



The planning process included representation from agencies that provide services. The process has included individuals from education (19%), mental health services (12%), health care organizations (14%), social services (13%), law enforcement (3%), community and family resource centers (9%), Substance Use Disorder Services (1%) and other (23%). This is shown on the chart below.



MHSA Community Planning Process Stakeholder Materials

Most MHSA support materials were available in both English and Spanish, and a Spanish language interpreter was available for stakeholder meetings at which Spanish-speaking individuals were expected to attend. Materials provided to attendees included:

- Draft MHSA Annual Update for 2018/19
- Draft MHSA Budget for 2018/19
- MHSA Fundamental Concepts handout
- MHSA Info Form handout

- MHSA Current Programs handout
- MHSA Comment Form for written comments. This form includes an MHSA comment line phone number and email address for alternate methods of providing input
- Anonymous MHSA Demographic Questionnaire

Public Comment and Public Hearing

There was a 30-day Public Comment period from April 6-May 9 for the Annual Update 2018/19, which includes the PEI Three Year Evaluation Report and Innovation Annual Report. The Public Hearing was facilitated by the Humboldt County Behavioral Health Board on May 9, 2019.

Copies of the Annual Update 2018/19 for the Public Comment Period were made available to stakeholders through the following methods:

- The Humboldt County Department of Health and Human Services, Mental Health Services Act website
- Print format, with comment boxes located at:
    - Humboldt County Department of Health and Human Services (DHHS) Professional Building, 507 F Street, Eureka CA, 95501;
    - DHHS Mental Health, 720 Wood Street, Eureka CA, 95501;
    - DHHS Children Youth and Family Services, 1711 Third St. Eureka CA 95501;
    - Garberville Office, 727 Cedar St. Garberville CA, 95560;
    - Willow Creek Office, 77 Walnut Way, Willow Creek CA, 95573;
    - The Hope Center 2933 H Street Eureka CA, 95501
- An informational flyer was sent to stakeholders participating in the stakeholder process regarding the Update's availability, including information about where to obtain it, where to make comments, and where/when the public hearing was held
- Informational flyers were e-mailed to recipients on local e-mail distribution lists including family/community resource centers, organizational providers, Northern California Association of Nonprofits and Latino Net
- Plans were e-mailed or mailed to all persons requesting a copy
- Press releases were sent to all local media with the Update's availability, where to obtain it, where to make comments, and where/when the public hearing was held
- The Mental Health Director and the MHSA Program Manager announced the Update's availability at DHHS staff meetings, community-based organizations and partner agencies in various meetings ,including where to obtain it, where to make comments, and where/when the public hearing was held.

During the public review period, comments from stakeholders were received from written comments forms left in comment boxes and from written comment forms at the public hearing. If there had been a complaint, dispute or grievance from the general public about MHSA program planning the MHSA Issue Resolution Policy and Procedure would have been used as follows. The issue is forwarded to the MHSA Program Manager (MHSA-PM) or designee through either US Postal Service mail: MHSA Program Manager, DHHS Mental Health, 720 Wood St. Eureka CA 95501; telephone or voice mail: (707) 441-3770; or email MHSAcomments@co.humboldt.ca.us. Issues are recorded at time of receipt by the MHSA-PM in the MHSA Issue Resolution Log and forwarded to the Program Lead of the program involved. Once a resolution is decided upon by the associated Program Lead the MHSA-PM contacts the originator of the issue to notify them of the resolution. Issues are followed up on within five working days. Resolution of the issue will be enacted within 30 days from receipt of issue. During the public review period, no complaints, disputes or grievances were received.

Public Comment Summary. Written comments were provided on the Annual Update through comment forms left in comment boxes and comment forms at the Public Hearing. The substantive comments are summarized below, and following each is the DHHS response.

1. Summary: Several people wrote about the value of the Hope Center and its recovery and wellness activities, and advocated for a larger facility.

   Response: Adequate facilities have been challenging to find. Staff are working on identifying alternative facilities, both in terms of housing the Hope Center and also in terms of taking some of the activities of the HOPE Center into the community. There are efforts being made to obtain space in locations that community members who access Hope Center already are or even reside.

2. Summary: There is a need for more facilities, such as Board and Care, secure locked facilities, and skilled nursing facilities, and to house those who need Board and Care.

   Response: There is a lack of local resources. DHHS is currently drafting a Request for Proposals to release in an effort to increase local placement and treatment opportunities within our community. There are also a number of opportunities via State MHSA funds to increase housing in our community.

3. Summary: Support prevention efforts for the 0-8 Mental Health Collaborative, including monies for child care providers to be trained.

   Response: DHHS Mental Health partners in multiple ways with First 5 Humboldt and the 0-8 Mental Health Collaborative to support community education, workforce development and training opportunities.

Humboldt County Demographics

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 134,623 spread over 3,573 square miles, or 37.7 persons per square mile. 49% of residents live within the incorporated areas while over half of residents live in the outlying rural areas of the County. Eureka is the largest community in the County and is the County seat of government. The County is home to 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.

Race and Ethnicity	Number	Percentage
Native American	6,961	5%
Asian/Pacific Islander	3,186	2%
African American/Black	1,393	1%
White/Caucasian	103,958	77%
Hispanic/Latino	13,211	10%
Multiracial/Other	5,914	4%
Total population	134,623	100%

Residents who are foreign born are approximately 5.5% of the population. Approximately half of those who are foreign born are naturalized citizens. In addition, approximately half of those foreign born are from Latin America.

Foreign Born Population by Region of Birth	Number	Percentage
Europe	1,330	18%
Asia	2,002	27%
Africa	22	<1%
Oceana	178	3%
Latin America	3,423	47%
North America	385	5%
Total	7,340	100%

Residents who do not speak English at home are 8% of the population. Of those who do not speak English at home, 36% (4% of total population) do not speak English "very well."

Language	Number	Percentage	Number speaking less than "very well"	Percentage speaking less than "very well"
Spanish	6,904	5%	4,294	3%
Other Indo-European	2,586	2%	577	<1%
Asian/Pacific Islander	1,726	1%	856	<1%
Total	11,216	8%	5,727	4%

Of the residents who are 25 years and older, 90% are high school graduates and 26% have a bachelor's degree or higher. Approximately 1% of residents are grandparents who are responsible for their grandchildren.

The median family income is $40,830. The median income for male full-time workers is $42,014 and for female full-time workers is $34,652.

The source for data on these pages is the United States 2010 Census at this website: http://www.census.gov/2010census.

Community Services & Supports: ROSE/Mobile Outreach

The Humboldt County DHHS Mobile Outreach program, also known as Rural Outreach Services Enterprise (ROSE), is dedicated to providing services to people in outlying communities, including individuals with severe mental illness or serious emotional disturbance, and to those who are experiencing homelessness or are at risk of homelessness. It is an integrated response with Social Services, Mental Health and Public Health partnering to serve individuals with a variety of physical, behavioral, and social needs as well as providing prevention and education activities. This integrated response reduces the stigma associated with accessing behavioral health and other services, as visitors to the service could be coming in to access anything that is offered. ROSE/Mobile Outreach uses RVs that travel to community sites such as Family Resource/ Community Resource Centers, clinics, tribal offices and volunteer fire departments on a set schedule. Employment services and immunization clinics can be scheduled as needed. Services on these vehicles are often available for special community events as well. Outreach staff on board the vehicles are skilled at engagement of persons in distress and provide access to county mental health services immediately or over time as desired by visitors. Clinical staff occasionally travel with the RV to provide immediate “on board” services, including assessments. If a visitor becomes open to services, regular appointments with clinicians and case managers are scheduled at sites accessible to clients, including home visits.

Because providing on-going services from the RV is usually not possible, as some communities are visited monthly and open clients typically require at least weekly contact, ROSE/Mobile Outreach has clinical staff that travel in 4WD vehicles to visit clients on a regular basis. DHHS has implemented Regional Services, and now has clinical staff stationed on a permanent basis in Southern Humboldt (Garberville) and Eastern Humboldt (Hoopa.)

ROSE/Mobile Outreach staff provide a variety of social, mental health and public health services and/or referrals to Humboldt County residents living in rural communities. During regularly scheduled visits (weather permitting), ROSE/Mobile Outreach staff members are able to provide eligible residents with services they may not be able to access otherwise due to transportation, financial or health-related difficulties. Services are available in Spanish and English.

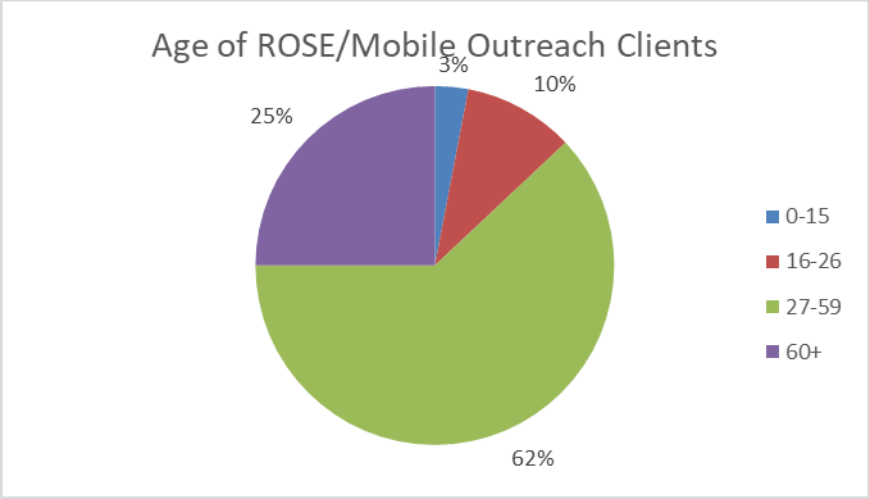
People living in outlying areas who require ongoing mental health services, including medication support, counseling and case management, are served by ROSE/Mobile Outreach staff members. Clients who are homeless are provided transportation to their mental health appointments by ROSE/Mobile Outreach. ROSE/Mobile Outreach services reach people with mental illness who are experiencing homelessness at multiple locations in the County, including free meal sites and homeless encampments. Staff provide mental health and social services as well as substance abuse services and emergency food and supplies.

While the MHSA component of this program provides mental health assessments and services, other DHHS services are available, such as CalFresh, Medi-Cal, Transportation Assistance Program, Car seat program, Well-Child Dental Varnish Program, and Fresh Produce and Supplemental Food Program. The diversity of services available reduces

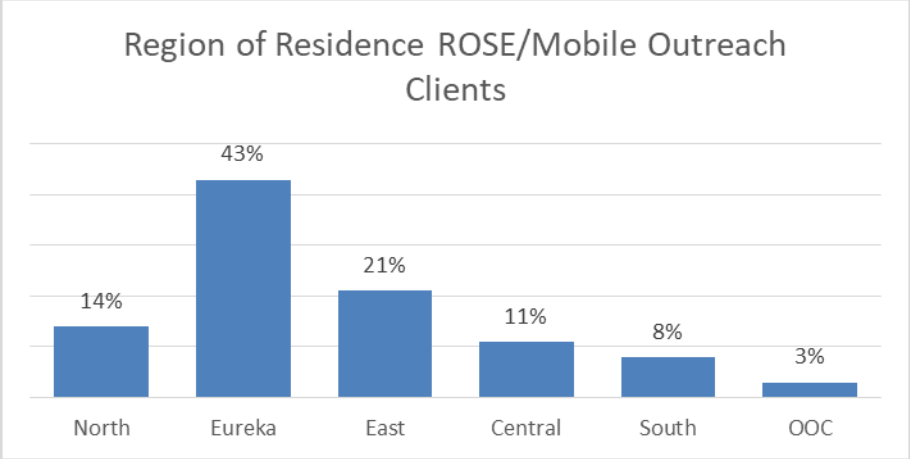
the stigma some might experience if the RVs only provided mental health services. This program continues to reach the unserved and underserved populations in rural, remote, and outlying geographic areas of the county.

Data Report

From July 2016 through June 2018 the program served 121 unduplicated mental health clients. ROSE/Mobile Outreach provides services to people of all ages. Between July 2017 through June 2018 3% of those served were children, 10% were transition age youth, 62% were adults, and 25% were older adults.

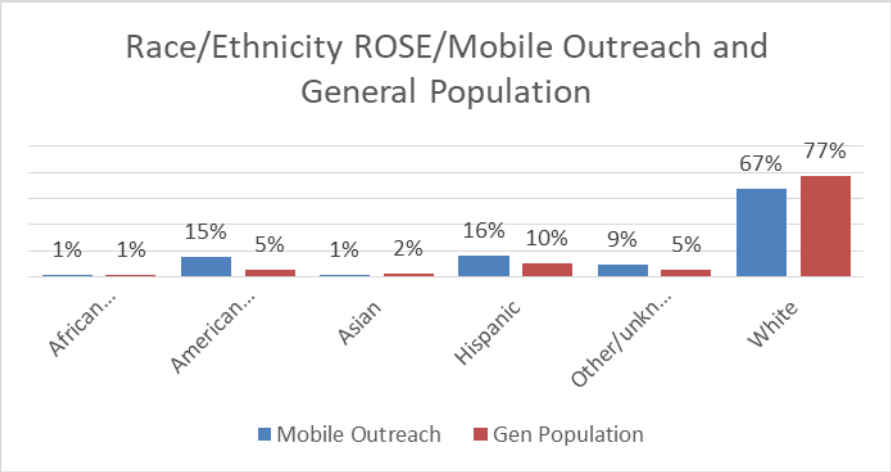


Clients are served throughout the region, with 43% served in Eureka, 8% in Southern Humboldt, 21% in Eastern Humboldt, 14% in Northern Humboldt, 11% in the Central region, and 3% out-of-county.

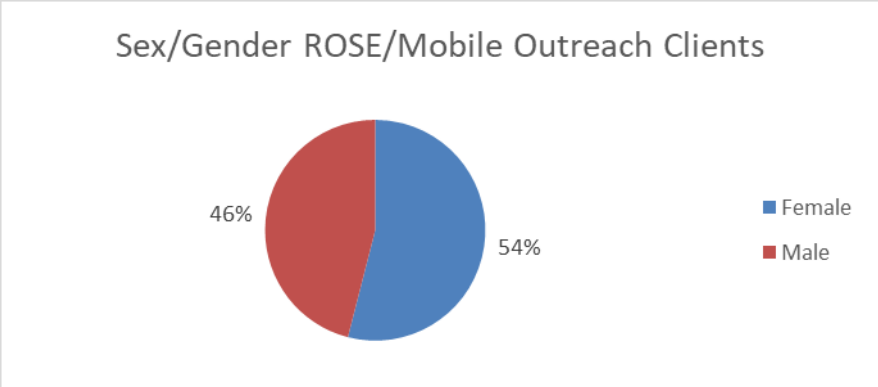


Clients served through ROSE/Mobile Outreach generally reflect the racial and ethnic diversity of the County. The percentage of ROSE/Mobile Outreach clients who identify as White/Caucasian is 67%, and 77% for the general population. The percentage of clients who identify as American Indian is 15%, and 5% for the general population. The percentage of clients who identify as Black/African American is 1%, and 1% for the general population. Clients who identify as Asian/Pacific Islanders is 1%, and 2% for the

general population. The percentage of clients who identify as Hispanic/Latino(a) is 16%, and 10% for the general population.



54% of clients served are female, and 46% are male.



New for 2018-19
This year (FY 2018-19) the project will add Community Integration events to benefit formerly homeless persons with serious mental illness and to build connections with community resources for similar clients in the outlying areas. ROSE/Mobile Outreach staff have placed more than 100 Chronically Homeless people with serious mental illness into permanent housing and continue to provide supportive services to these clients so that they maintain their housing. Housing is provided in all areas of the County.

ROSE/Mobile Outreach learned that one of the major issues for these newly housed people, some having been homeless for more than a decade, was finding activities to fill their time and to build new relationships. The program has sponsored two fishing trips that were well attended and thoroughly enjoyed by clients. Transportation for clients in outlying areas is provided, as well as food during events. Where there are multiple clients in or near one of the multifamily buildings used for housing, ROSE/Mobile Outreach hosts events at the site to include any residents interested in attending to build community identity. These events include pot-lucks, group meal preparation and cooking instruction, game nights, birthday parties, Tai Chi, yoga, ice cream socials and more.

The Mobile Outreach RVs help to bring events to outlying areas. ROSE/Mobile Outreach has hosted Healthy Living workshops with staff from Public Health and IHSS registration and employment fairs, to help clients find caregivers or to enroll to become a caregiver to others. ROSE/Mobile Outreach assisted the Karuk and Yurok Tribes in offering two weeks of summer activities including guitar lessons, dancing, wrestling, arts & crafts for clients and tribal members to aid in re-establishing community connections.

ROSE/Mobile Outreach will continue these events as both community integration and outreach to others experiencing serious mental illness has been the result. ROSE/Mobile Outreach intends to have at least weekly events in different areas of the County that will include hikes in parks and on easy community trails, visits to tide pools at area beaches, more fishing, thrift store shopping outings, group attendance at art and music festivals, volunteer days at community clean-ups, and more.

A total of 60 clients are estimated to be served during the fiscal year.

The map on the next page shows locations of services for ROSE/Mobile Outreach.

Humboldt County Department of Health & Human Services

Mobile Outreach

People helping people live better lives

Serving the following communities:

- Carlotta
- Eureka
- Fortuna
- Garberville
- Hoopa
- Loleta
- Manila
- McKinleyville
- Orick
- Orleans
- Phillipsville
- Redway
- Rio Dell
- Weitchpec
- Willow Creek

Community Services and Supports: Telemedicine

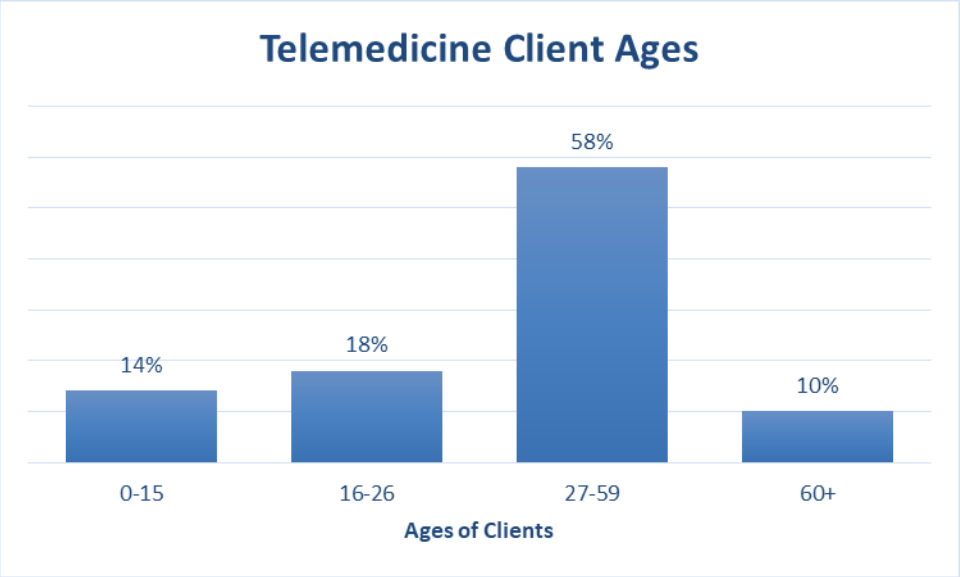
In 2006 the Department initiated an Outpatient Telemedicine Medication Services Expansion in Garberville, and was expanded to Willow Creek in 2011. Using video conferencing equipment, the expansion offered psychiatric services and medication support from a provider located at the main clinic in Eureka to people with serious mental illnesses who reside in remote rural areas of Humboldt County. This allowed clients to receive services at locations closer to where they live, eliminating burdensome travel that is often a barrier to receiving services. As the map below shows, distances are great in the county and there are few highways.

These telemedicine services worked well for clients living in Eastern and Southern Humboldt. However, due to a psychiatrist shortage in the past few years, telemedicine clients have been incorporated into the adult clinic in Eureka. In addition, video conferencing equipment needed to be updated, and bandwidth increased for better connectivity. This new, upgraded data-line went live for both Willow Creek (Eastern Humboldt) and Garberville (Southern Humboldt) at the end of August, 2018. However, staffing issues have impeded resuming telemedicine services at this time. In Garberville, telemedicine services are expected to resume in early 2019. A psychiatric nurse continues to work one and a half days per week to provide outreach and support to adult

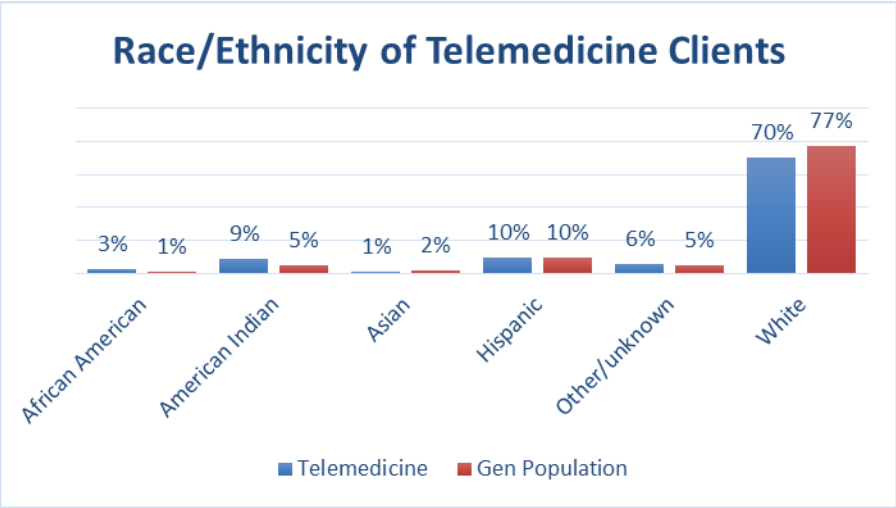
and child clients living in the area.

Data Report
From July 2016 through June 2018 the program served an average of 125 unduplicated clients per month for a total of 3,014 unique individuals during the two year period.

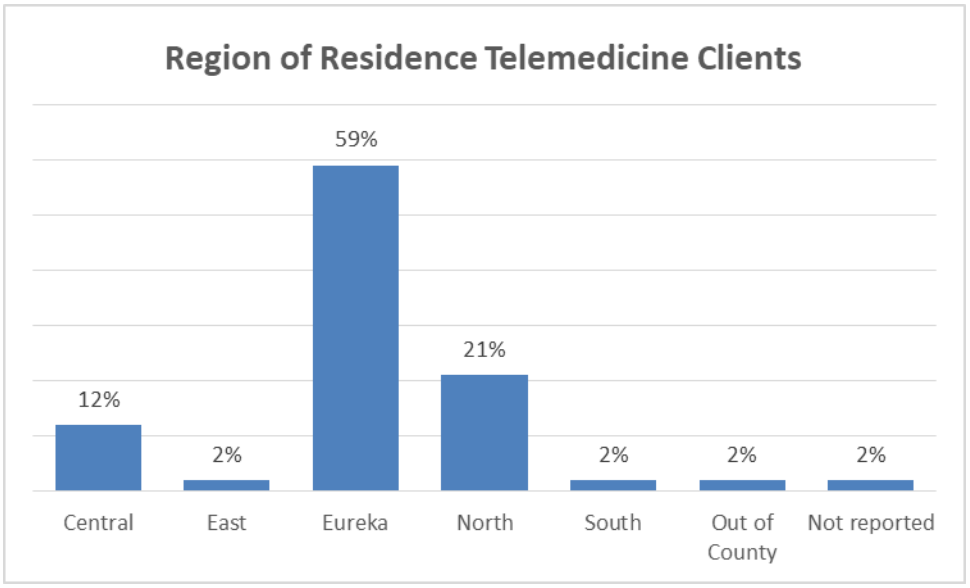
The telemedicine program serves people of all ages. During the two year period, 14% were children ages 0-15, 18% were ages 16-26, 58% were ages 27-59, and 10% were age 60+. 47% are female and 53% are male.



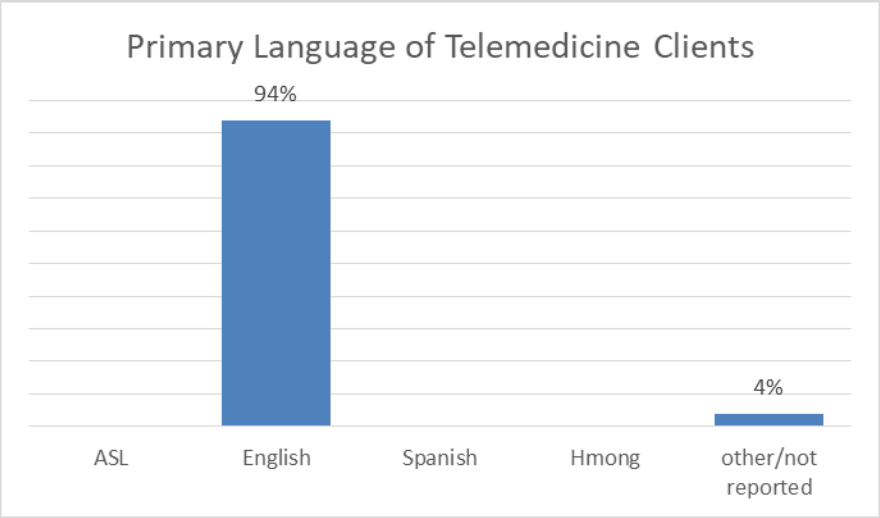
The percentage of telemedicine clients who identify as White/Caucasian is 70%, as compared to 77% of the general population. The percentage of telemedicine clients who identify as Black/African American is 3% and 1% for the general population. Telemedicine clients who identify as Asian/Pacific Islander is 1% and 2% for the general population. The percentage of telemedicine clients who identify as American Indian is 9% and 5% for the general population. The percentage of telemedicine clients who identify as Hispanic/Latino is 10%, and 10% for the general population. The percentage of telemedicine clients who identify as other racial/ethnic makeup or for whom no information is available is 6%, and 5% for the general population.



59% of clients served live in the Eureka area. 21% live in the Northern region of Humboldt County, 12% live in the Central region, 2% in the Southern region, and 2% in the Eastern region. 2% reside out-of-county. Region of residence was not reported for the remaining 2% of telemedicine clients served.



The primary language for telemedicine clients is English, at 94%. Spanish, Hmong and American Sign Language are all less than 1% each. Primary language spoken was not reported for the remaining clients served by telemedicine.



An estimated 1,500 clients will be served during the fiscal year.

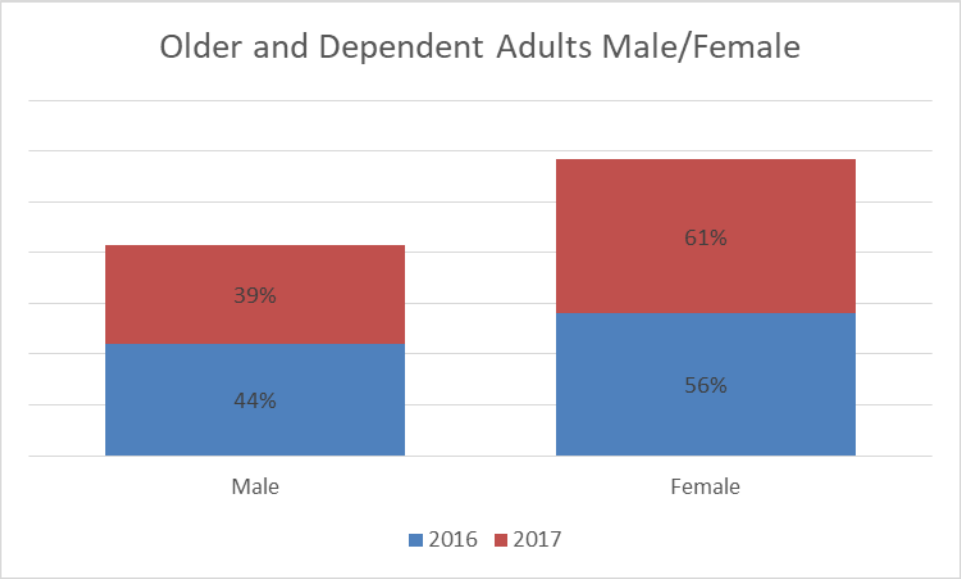
Community Services & Supports: Older Adults and Dependent Adults

Prior to 2007, the DHHS Older Adults and Dependent Adults program included mental health clinicians that were co-located with Adult Protective Services. Beginning in 2007, the program expanded to create an interdisciplinary team including Social Services social workers, Public Health nurses, a psychiatrist, Mental Health clinicians and case managers as a result of the inclusion of an MHSA clinician in order to holistically serve this vulnerable, underserved population. The team conducts multi-disciplinary team meetings, provides case management planning, investigates suspected abuse and neglect, and provides linkage to the full range of services. Mental health staff remove barriers to access and provide mental health screening and assessment services, consultation, education, and wellness/recovery focused clinical services and supports.

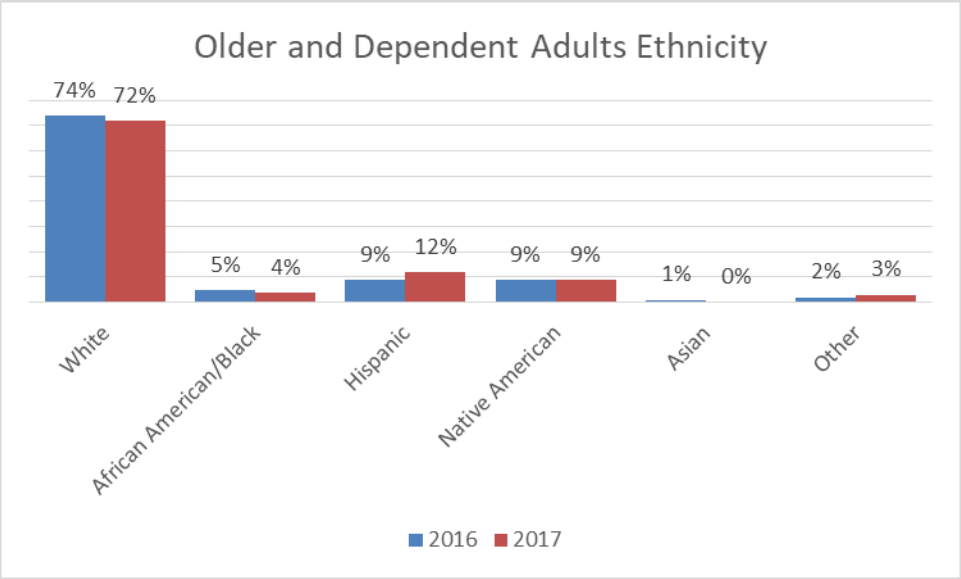
Outreach, Prevention and Education

During calendar year 2016 a total of 88 individuals were contacted by the Mental Health Clinician assigned to the program, and in 2017 a total of 158 individuals were contacted, primarily through outreach, prevention and education activities. The Clinician is contacted by Adult Protective Services, In Home Supportive Services, or community services such as Open Door Community Clinic, local hospitals or PACE. If a mental health need is identified for an older or dependent adult, the Clinician then assists the client in navigating the MH system and identifies appropriate referrals to offer specialized support to the client. Many of these clients are reaching out for the first time. This program strives to reduce the stigma of mental health labels by offering individualized care, education, intervention and connections to services in the community.

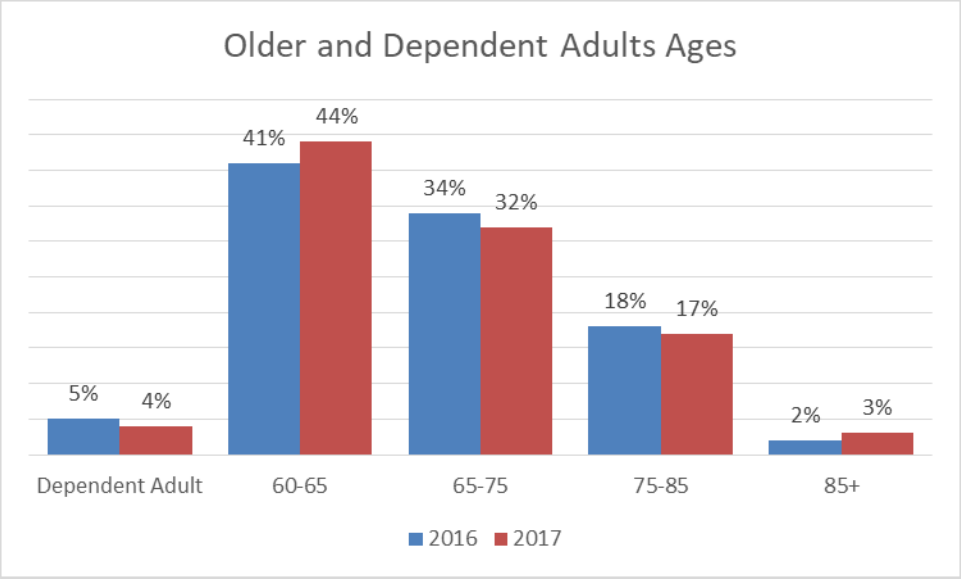
The charts below show some demographics of the individuals served through outreach, prevention and education for calendar years 2016 and 2017. In 2016 44% were male and 56% were female. In 2017 39% were male and 61% were female.



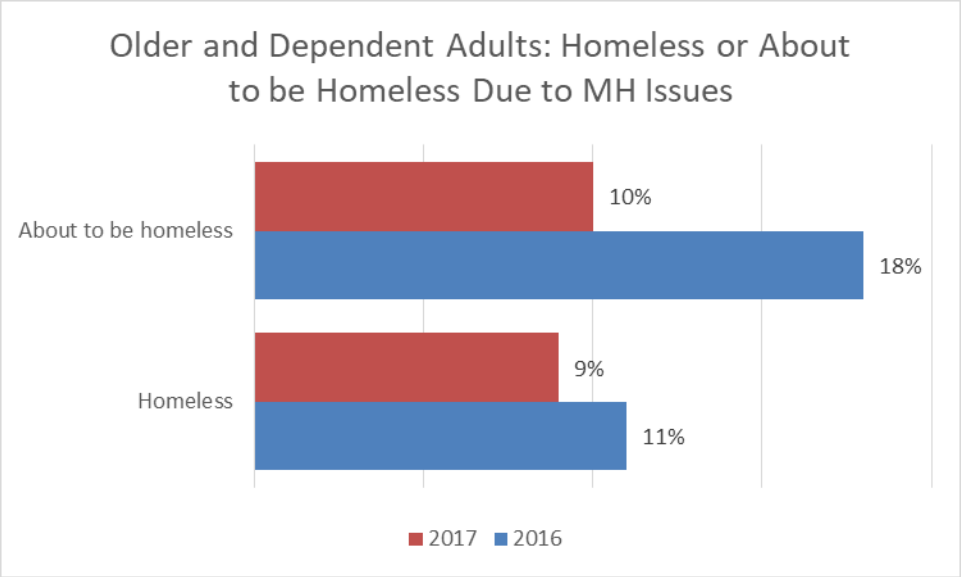
In 2016 74% were White, 5% were African American, 9% were Hispanic, 9% were Native American, 1% were Asian and 2% were Other. In 2017 72% were White, 4% were African American, 12% were Hispanic, 9% were Native American, and 3% identified as other.



In 2016, 5% identified as Dependent Adults, 41% between ages 60-65, 34% between ages 65-75, 18% between ages 75-85, and 2% over age 85. In 2017, 4% identified as Dependent Adults, 44% between ages 60-65, 32% between ages 65-75, 17% between ages 75-85, and 3% over age 85.



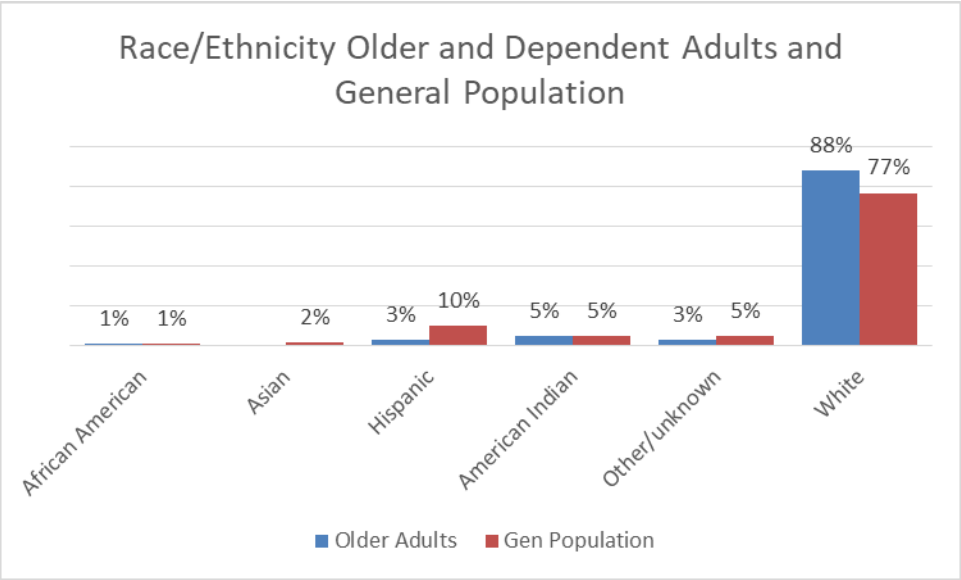
In 2016, 11% self-identified as homeless and 18% were about to be homeless due to mental health issues. In 2017, 9% self-identified as homeless and 10% were about to be homeless due to mental health issues.



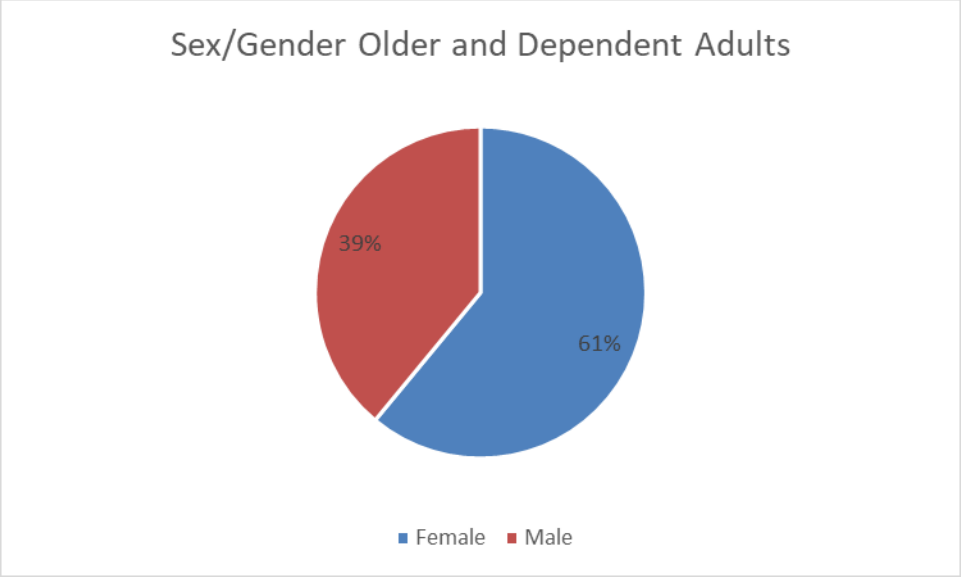
An estimated 123 clients will be served through outreach and education during the fiscal year.

Mental Health Services to Clients

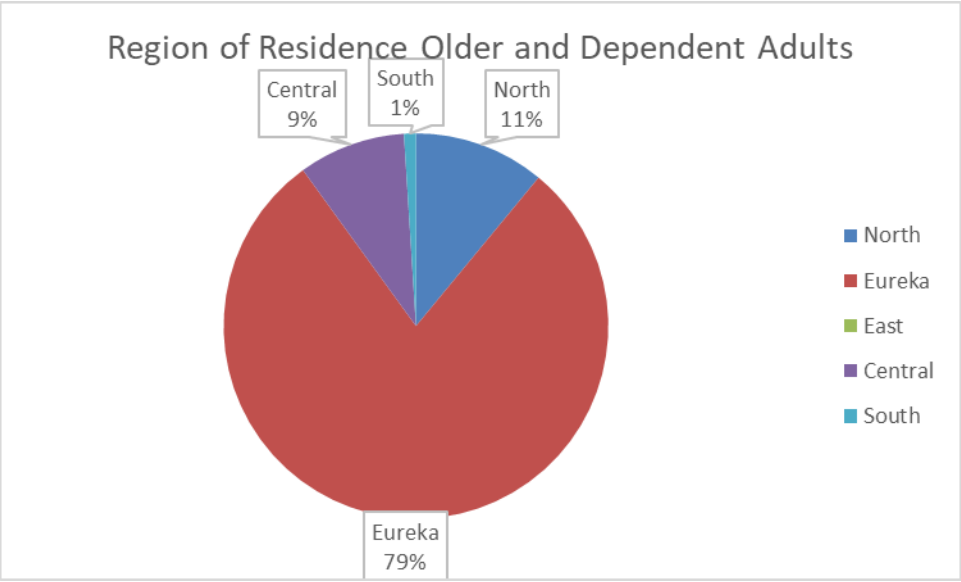
In addition to contacts made through outreach, prevention and education, 133 individuals were provided services as clients of Mental Health for fiscal years 2016/17 and 2017/18. Of these, 88% were White, compared to 77% of the general population; 5% were American Indian, the same as the general population; 3% were Hispanic compared to 10% of the general population; 1% were African American, the same as the general population; and 3% were Other/Unknown. No Asian individuals were served, compared to 2% of the general population.



Sixty-one percent of clients served were female, and 39% male.



Seventy-nine percent of those served reside in Eureka, 11% in Northern Humboldt, 9% in Central Humboldt, 1% in Southern Humboldt, and none in Eastern Humboldt.



An estimated 65 clients will be served through mental health services in the fiscal year.

Community Services & Supports: Full Service Partnership/ Comprehensive Community Treatment

Full Service Partnerships offer a range of services and supports to persons impacted by severe mental illness. These services include medication management, crisis intervention, case management, peer support, family involvement, and education and treatment for co-occurring disorders such as substance abuse. It also provides for non-mental health services such as food and housing. The term “Full Service Partners” (FSP) 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.

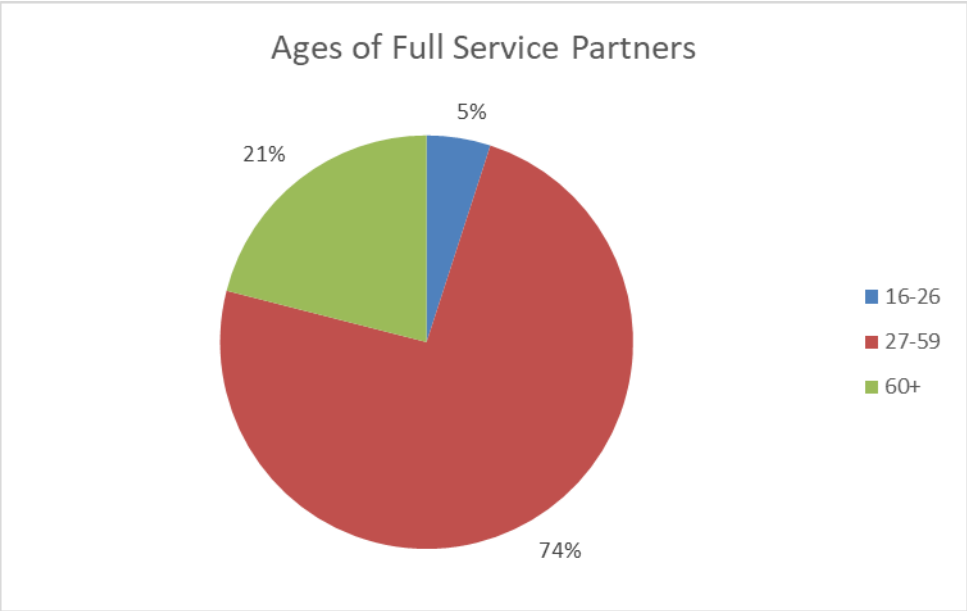
Within the scope of this intensive program, Partners are provided 24 hour, seven days a week crisis response service. The Crisis Response Unit provides this crisis response around the clock. When a Partner in crisis needs acute care treatment, they are able to access Sempervirens Hospital, Humboldt County’s 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 programs including Children and Family Services, Transition Age Youth Division, ROSE/Mobile Outreach, and Older and Dependent Adults programs. However, partners are primarily served through the Comprehensive Community Treatment (CCT) program. Modeled after the evidence-based program Assertive Community Treatment (ACT), CCT provides intensive mental 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 restrictive facilities.

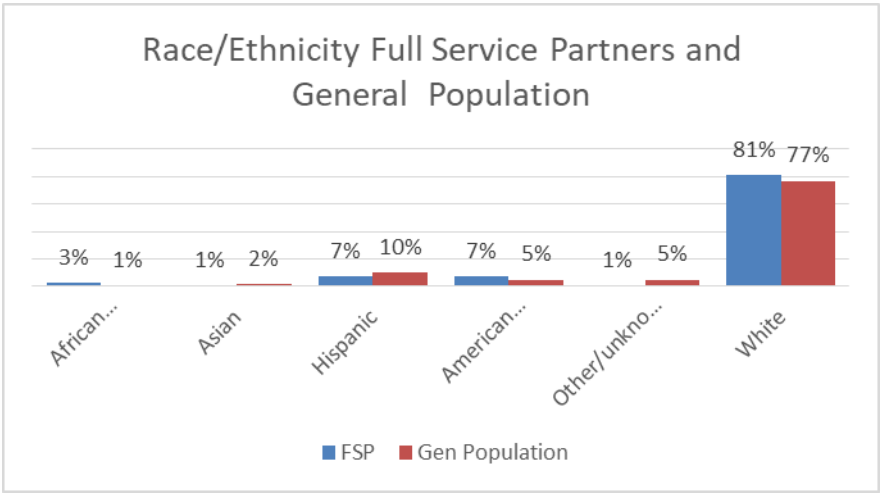
Data Report

From September 2007 through June 2018, a total of 406 mental health clients have enrolled as FSPs.

As the next chart shows, for the period July 1, 2016 through June 30, 2018, 5% of FSPs were ages 16-26, 74% were ages 27-59, and 21% 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.



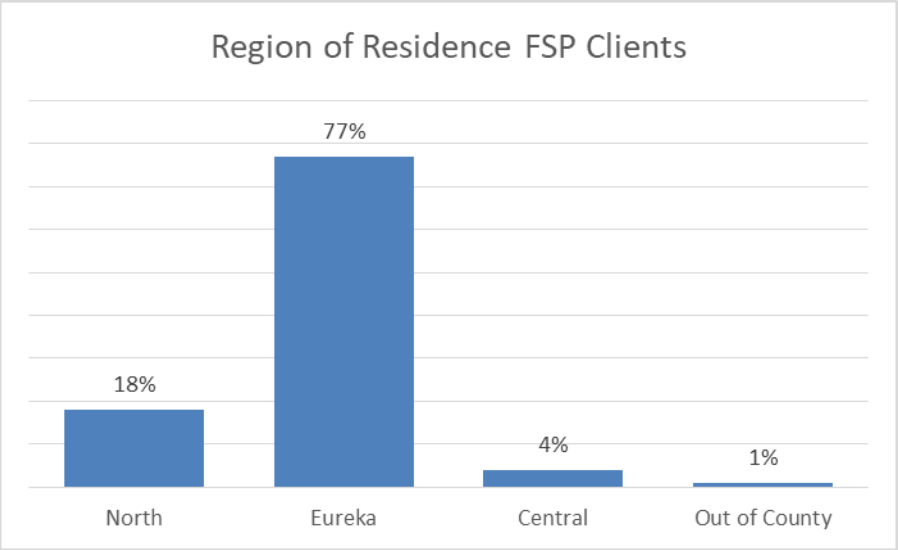
As the chart below shows, for the period July 1, 2016 through June 30, 2018, the percentage of FSPs who identify as White is 81%, compared to 77% for the general population. The percentage of FSPs who identify as Black/African American is 3%, compared to 1% for the general population. The percentage of FSPs who identify as Asian/Pacific Islander is 1%, compared to 2% for the general population. FSPs who identify as American Indian is 7%, compared to 5% for the general population. Hispanic/Latino(a) FSPs are 7%, compared to 10% for the general population. FSPs who identify as other/unknown are 1%, compared to 5% of the general population.



Ninety-eight percent of FSPs speak English as their primary language. One person's primary language was Spanish, one was American Sign Language, and the others were unknown.

Forty percent of FSP clients for the period July 1, 2016 through June 30, 2018 were female and 60% were male.

Seventy-seven percent of FSPs resided in Eureka, 18% in the Northern Humboldt region, 4% in the Central region, and 1% resided out of county.



FSPs exit a Partnership due to a variety of reasons. During the period July 1, 2016 through June 30, 2018, 43 FSPs were discharged from the program for the following reasons.

Discharge Reason	Percentage All FSP	Percentage TAY	Percentage Adult	Percentage 60+
Met Goals	42%	20%	52%	22%
Deceased	16%	20%	14%	22%
Moved Out of County	14%	20%	14%	11%
No Longer Met Criteria	12%	0%	7%	33%
Discontinued	9%	20%	7%	11%
Serving Jail	5%	20%	3%	0%
Not located	2%	0%	3%	0%

Of the 43 FSPs discharged during the specified time period, 29 had completed at least one year of the program; 22 had completed at least two years of the program, 15 had completed at least three years, 14 had completed at least four years, and 9 had completed at least five years. The average length of stay in the program during this period was 501 days for Transition Age Youth, 1,038 days for Adults ages 26-59, and 1,478 for Adults age 60+. During the reporting period of fiscal years 2016/17 and 2017/18, 153 Partners had completed two years of the partnership. The following is data for these 153 Partners.

An estimated 200 clients with be served as FSPs in the fiscal year.

Homelessness
Of the 153 Partners, 31 (20%) experienced 6,353 days of homelessness in the year prior to enrollment; 14 (9%) experienced 1,249 days of homelessness in the first year of enrollment, and this same number (14) experienced 819 days of homelessness during the second year. This is a decrease in homelessness of 11% for these 153 Partners, and an 87% decrease in homelessness-days.

Mental Health Emergency
For the 153 Partners who completed two years in an FSP, 95 (62%) experienced 270 mental health emergency events in the year prior to enrollment; during the first year as a Partner, 13 (8%) experienced 18 mental health emergencies, a decrease of 93% for such events. Eighty-six percent fewer Partners experienced a mental health emergency in the second year of Partnership.

Hospitalization
Of the 153 Partners completing two years in an FSP during this reporting period, 73 (48%) experienced hospitalization in the year prior to enrollment. Fifty-six (37%) experienced hospitalization during the first year of enrollment, a 23% decrease. For the second year, 48 (31%) experienced hospitalization, a 34% reduction from the pre-Partnership level.

Arrests
Of the 153 Partners in this reporting period, 44 (29%) were arrested at some time in the year prior to enrollment in an FSP, with 0 arrested in the first year completed and 6 arrested in the second year, an 86% decrease in arrested Partners. This represents 110 total arrests in the year prior to FSP enrollment down to 10 in the second year, a 91% decrease over the period.

Incarceration
For the 153 Partners, 22 (14%) were incarcerated in the year prior to FSP enrollment, with 4 (2.6%) incarcerated in the first year, a decrease of 81% from the pre-enrollment year. Six (4%) of the 153 were incarcerated in the second year, up 50%, for an overall decrease of 73%**.**

Innovation: Rapid Re-housing

Purpose

The purpose of the Rapid Rehousing Innovation Project is to increase the quality of services, including better outcomes for adults with severe mental illness who are homeless. While this Innovation Project will increase access to services, especially for underserved groups, and promote interagency collaboration, the community planning process identified the need to increase the quality of services and better outcomes as the priority purpose. The Innovation Project has two components: Rapid Re-housing (RRH) and Mobile Intervention Services Team (MIST).

RRH uses the "Housing First" approach to provide housing, peer support and supportive services for individuals with a diagnosis of severe mental illness who are homeless. "Housing First" is a proven strategy for ending all types of homelessness. As described by the United States Interagency Council on Homelessness, Housing First offers immediate access to permanent affordable or supportive housing without requirements of sobriety, income or completion of treatment. Humboldt County continues to make changes to existing rapid rehousing practices used in larger urban areas to demonstrate effectiveness on a smaller scale in rural areas. The RRH component is linked to the efforts of MIST, which combines law enforcement officers and mental health workers in street level interventions for persons experiencing homelessness with mental illness.

Background

Humboldt County has been designated as a community of high need by the Department of Housing and Urban Development (HUD) due to the large number of people who are chronically homeless relative to size of population. HUD considers chronically homeless to be currently homeless and homeless for more than a year, or to have four episodes of homelessness in the past three years. In the last Point in Time Count of homeless persons (2017) 759 people who experienced homelessness were counted on the night of February 27.

Like most areas in California, Humboldt County has a housing shortage. This is most acute in the availability of decent, affordable housing for persons receiving SSI. DHHS is working with local developers to provide more housing for our clients. This began with the early MHSA Capital money and resulted in 15 new studios that opened to clients during Fiscal Year 16-17. The participant portion of rent is limited to less than 30% of income, making long term tenancy possible. Nearly all first tenants came directly from the streets through the RRH/MIST pathway. Nine of the first 15 are still stably housed. Several clients were able to obtain Section 8 certificates and moved into other housing. A couple of evictions happened, but the clients are still being served in interim housing with the goal of trying again in another unit. This project has kept these units filled by maintaining a Coordinated Entry System (CES) and drawing eligible persons – Chronically Homeless with serious mental illness – as units become available.

A housing project in Eureka developed by City of Eureka and partnering with Danco Properties provided DHHS with 15 new apartments (out of 50 total) for RRH participants. Clients began occupying the units in April 2017 and 13 of the 15 are still housed there. Staff are on- site almost every day to provide supportive services to

clients. They also arrange recreational and volunteer opportunities open to all residents to assist community integration and to reduce stigma. Peer Specialists have been used throughout the project and are very central to the successes achieved so far.

In the works, and fully funded, is another 50-unit apartment building with community space for tenants. This development has assigned 25 of the units to this Innovation project and occupancy should begin in summer of 2019. A fourth project about to begin construction is a 30 unit project in Rio Dell. This project will be 29 individual small homes with all utilities and amenities that are fully ADA compliant. Community space for events, supportive services and recreation is available on site. Most of these units will be reserved for participants in this project.

DHHS is planning to make the most of the coming No Place Like Home (NPLH) funding for County Mental Health clients, including participants coming through the RRH/MIST pathway.

Community-wide planning and monitoring of this project includes but is not limited to, Humboldt Housing and Homeless Coalition, Eureka City Council, Eureka Police Department, Humboldt County Board of Supervisors, Humboldt County Health & Human Services, and the Community Planning Process.

Multiple funding sources assist in financial assistance to clients, such as for deposits, rental assistance, moving costs, maintenance and repair and any other needs to assure that clients remain stably housed. Sources include City of Eureka, Humboldt County, Housing and Urban Development, MHSA, Partnership Health and St. Joseph Health System/Providence and private contributions.

Less Utilization of Costly and Restrictive Services

In Humboldt County, there were a number of clients not connected with outpatient services or peer support. The planning process for RRH concluded this was in large part due to homelessness. Permanent supportive housing continues to be the best strategy for clients who are homeless and experience an increase of:

- Seven and thirty day re-admittance rates to psychiatric crisis and hospital services
- Utilization of local emergency departments for psychiatric crises
- Community based contacts with law enforcement and incarceration
- Utilization of higher levels of restricted residential placements

The community has committed to increasing the supply of Permanent Supportive Housing (PSH) and preliminary data demonstrates its effectiveness. Data is collected on consumer use of psychiatric crisis center and psychiatric hospital during the period of one year prior to placement in PSH and comparing the number of same use during the year after being housed. There was a 62% reduction in use of these services by participants in the project. The project is requesting data now from law enforcement entities and local emergency departments and anticipates a similar reduction in visits and calls for service and incarceration.

Stigma and Discrimination

This Innovation Project addresses the stigma in the community that individuals who are

homeless and have a mental illness, ". . . all want to be homeless" as was articulated in the "Focus Strategies, 2014," City of Eureka Homeless Policy Paper. Another source of debate is whether the people living outdoors in Eureka are simply seeking an alternative lifestyle "off the grid" and would "refuse to move indoors even if housing were available." The achievements in housing cited above clearly disprove these assertions.

Project Description

The growing unmet need and increased utilization of costly and restrictive crisis services has led Humboldt County to the conclusion that a change in practice is necessary and timely.

RRH/MIST is addressing the following issues for individuals who are homeless and have a severe mental illness:

- Ineffective or nonexistent engagement, including people with pets
- Suspicion or fear of outreach workers and law enforcement
- Discrimination, even amongst the homeless services community and other homeless persons
- Increasing dependence on higher levels of care and restrictive settings such as psychiatric crisis and hospital services, emergency departments, and incarceration

These issues are being addressed by the development and evaluation of the following approaches:

- Using peer support in a new way and in a new setting
- Exploring innovative approaches to engaging homeless persons with serious mental illness who have a pet
- Collaborating with local homelessness service agencies to implement a community wide Housing First model
- Partnering with law enforcement to identify and engage individuals who are homeless and have a severe mental illness.

Peer Support

Peer support has proven to not only reduce the internalized stigma for clients, but has also had a de-stigmatizing effect for co-workers and community members. With the passing of MHSA, Humboldt County Department of Health and Human Services (DHHS) Mental Health (MH) programs have explicitly included elements of recovery, wellness, and resiliency-focused peer support. Peers have been active part of service provision teams in mobile outreach and inpatient and outpatient programs. The Hope Center, a peer-run empowerment center, has been supporting clients in their recovery goals since it opened in 2008. DHHS MH's 2010 Innovation Plan focused on the development of transition age youth (TAY) peer support specialists in the integrated TAY Division. In 2014, DHHS adopted the three tier classification of Peer Coach I, II, and III. For the first time at DHHS, these job descriptions explicitly recognize the value of lived experience in a service delivery team and provide a career ladder for Peer Coaches.

The community planning process determined that the infusion of peer support has shown success in engaging hard to engage clients, and that peer support has been successful at shifting community attitudes and beliefs through modeling resilience and recovery. Thus far in this Innovation Project, six Peer Coaches have been added to the outreach

and engagement and housing retention team. They have been very successful in achieving goals for client success and have demonstrated the high value of peer support throughout the mental health system. Peers have been integrated into other programs of MH, including Comprehensive Community Treatment and the psychiatric hospital.

Pets

This Project has identified successful practices for engagement of homeless individuals who have a pet to help them retain housing.

- Work with individuals to have the pet get all vaccines, permits, and spayed or neutered,
- Work with individuals' physicians in attaining a prescription for a companion animal,
- Coach individuals on how to approach landlords when they have a pet.

This Innovation project has helped other service providers incorporate pets into their services for clients in common by coaching, experience and provision of crates and kennels to shelters that house clients.

Rapid Rehousing

Initially the conversion of a local long-term transitional housing model for families—the Multiple Assistance Center (MAC) -- to a short-term rapid rehousing model that is inclusive of individuals with a severe mental illness (SMI) required an innovative approach unique to this community. The MAC served as a short-term (30 days) housing program for many homeless adults, including persons with serious mental illness, to safely reside while looking for housing. Direct diversion into housing with rental assistance was available to participants who were able to accomplish this. Innovation funds were used to support participants with serious mental illness. This was a crucial component during 2015-2016, because a very large homeless encampment near the City of Eureka was evacuated. Many of the residents in this camp had SMI and had experienced long periods of homelessness. Fortunately, several sources of funding came together to support this effort and over a hundred persons with SMI were housed through the MIST/MAC system. Most individuals were able to maintain stable housing. The persons that had the most difficulty were persons with co-occurring SMI and Substance Use Disorders (SUD).

In 2017 the management of the facility that was the MAC shifted to Waterfront Recovery Services (WRS). WRS provides substance use disorder treatment and includes medically supervised detoxification and residential SUD treatment for persons that are dually diagnosed. Because community partners substantially increased the financial support of these services, DHHS was able to shift more of the Innovation funds to the MIST part of the project and add staff. Peer Coaches, a Clinician, Case Managers, and Community Health Outreach workers were added to increase access to mental health services, especially engagement and assessment. Persons experiencing homelessness that also have SMI are referred directly to the Housing Unit for permanent housing depending on their level of need, with the most vulnerable placed into Permanent Supported Housing.

Partnering with Law Enforcement--MIST

The most successful component of the Innovation Project, the Mobile Intervention Services Team (MIST), is the collaborative effort to successfully engage homeless individuals who have a severe mental illness and have frequent contact with law enforcement. MIST maintains a registry of the 25 highest utilizers of emergency services including Emergency Department visits, hospitalizations, calls for service, psychiatric hospitalization and crisis intervention. To date, the RRH/MIST pathway has linked 116 unique individuals to permanent or temporary housing. Key activities are:

- Outreach and Engagement. Outreach and engagement occurs through the MIST partnership with law enforcement, emergency departments, psychiatric emergency services and hospitals as well as other community partners. For the period of January 2015-September 2017 DHHS MIST staff contacted 419 individuals. During this same period, Eureka Police Department (EPD) contacted 1,134 individuals. Two hundred twenty nine individuals were contacted by both EPD and DHHS. This resulted in a total of 1,324 unduplicated individuals contacted. Most individuals are contacted more than once. For the time period, there were 4,248 contacts, with an average contact per individual of 10.1 times, the median being two contacts per individual, and a range of 1-182 contacts. It is estimated that approximately 1,000 individuals will be contacted by either MIST or EPD in the fiscal year.
- Types of contacts made were follow-up (62%), outreach (22%), 8% EPD ride-along, other (7%), and Crisis Stabilization Unit/Sempervirens (1%).
- At first contact, 89% of clients were reported as homeless or threatened with eviction. 12% were self-reported as having a history of violence or as being on probation, which was a barrier to stable housing. 42% self-reported as being a veteran or having a disability at any point of contact with MIST.
- Housing First Model. Staff assist participants in locating and securing housing as quickly as possible using a "Housing First" approach. Participants have a housing assessment to determine the appropriate level of housing and any ongoing needs for supportive services to remain housed. Through other funds, financial assistance is also available for deposits and in some cases on-going rental assistance. The housing placements range from private market apartments and efficiencies, subsidized housing, Section 8 subsidy, shared housing and for those most vulnerable with a history of chronic homelessness, Permanent Supportive Housing. Maintenance and repair services for persons with symptoms of severe mental illness, such as hoarding and property destruction during episodes, are provided to keep them housed. This aspect of some mental illnesses is often the reason for their homelessness.
- Permanent Supportive Housing. Humboldt Housing and Homeless Coalition (HHHC) has taken every opportunity from HUD to increase the community's stock of Permanent Supportive Housing (PSH). When funded by HUD, this housing option requires the occupant to be low-income, disabled and chronically homeless. Briefly, PSH allows the participant to choose where he or she wishes to live so long as the rent is in line with Fair Market Rent for the area. The occupant's share of the rent is limited to no more than 30% of his/her income and the HUD-funded agency pays the balance. The housing unit is in the client's

name and allows him/her to develop a good rental history. The participant is offered a full range of supportive services and chooses what he or she would like to participate in as recovery is client-driven. PSH can be funded by other sources, not just HUD, and DHHS Mental Health has a collaborative agreement for 15 units of PSH using the MHSA Housing Program that opened in Fall 2016. Known as Arcata Bay Crossing (ABC), this development has 42 housing units total, including the 15 set aside for homeless people with serious mental illness.

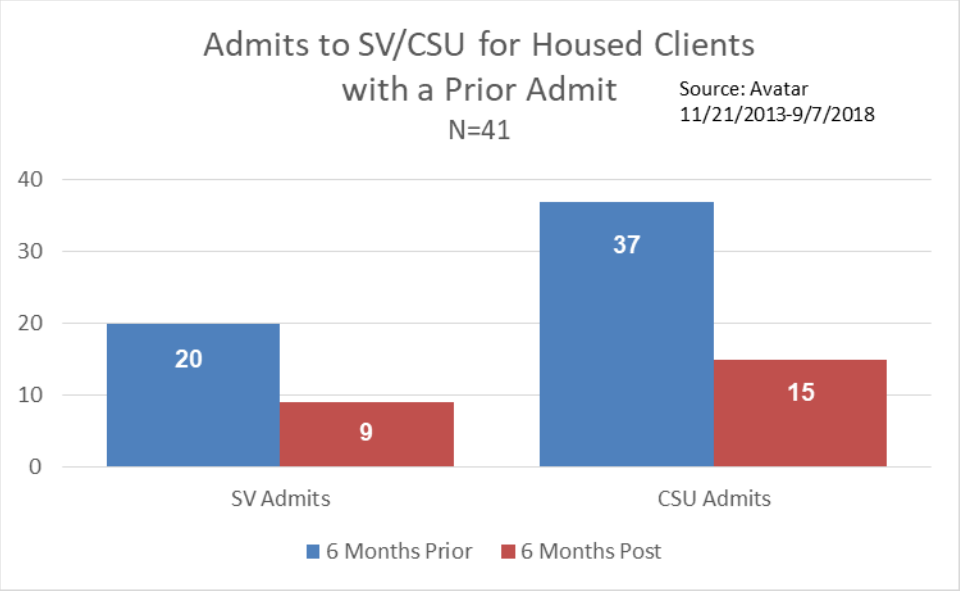
- Peer Support and Linkages. Peer support services includes linkages to services such as:
    - Full Service Partnership enrollment
    - Outpatient mental health counseling
    - Case management
    - Medication support
    - Medi-Cal enrollment
    - Substance Use Disorder services
    - Primary care physician
    - Housing
    - Bus vouchers
    - CalFresh enrollment
    - Transitional Age Youth Division services, which provides mental health, social services, public health, Peer Partner support, advocacy and educational opportunities in an age appropriate, peer driven setting
    - The Hope Center, a peer run empowerment center that provides a safe, welcoming environment based on recovery self-help principles
- DHHS Mobile Outreach Vehicles, which provide services to people in extremely rural outlying communities and to those who are experiencing homelessness. The program uses RVs that travel to community sites such as family resource centers, clinics, tribal offices, volunteer fire departments, free meal sites, and homeless encampments. Social services, mental health and public health services and/or referrals are provided. These services are available in Spanish and English and may not be accessible otherwise due to transportation, financial or health-related difficulties. Mental health services include ongoing counseling, alcohol and substance abuse and case management.
- Transportation Assistance Program provides a non-refundable bus ticket to a pre-determined destination or gas money and daily meal allowance for each day of travel for those who wish to travel out of the area where they have family and/or friends willing to offer support and assistance
- Community Corrections Resource Center (CCRC) is a multidisciplinary center that provides jail custody and community based services to County Probation Department offenders under AB109. DHHS services include development of transitional discharge plans, mental health assessments, counseling, medication management, alcohol and drug counseling, employment, education and housing assistance.

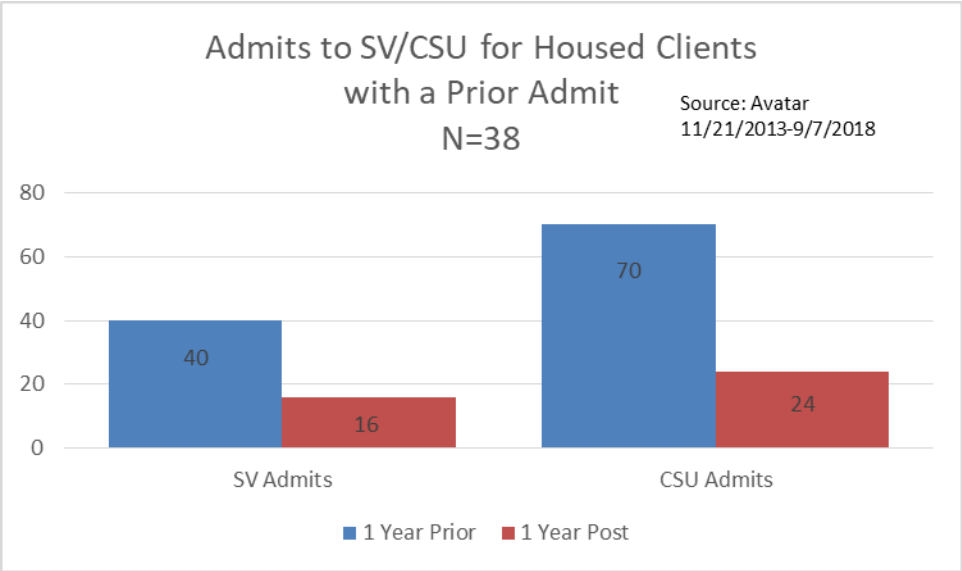
Project Outcomes

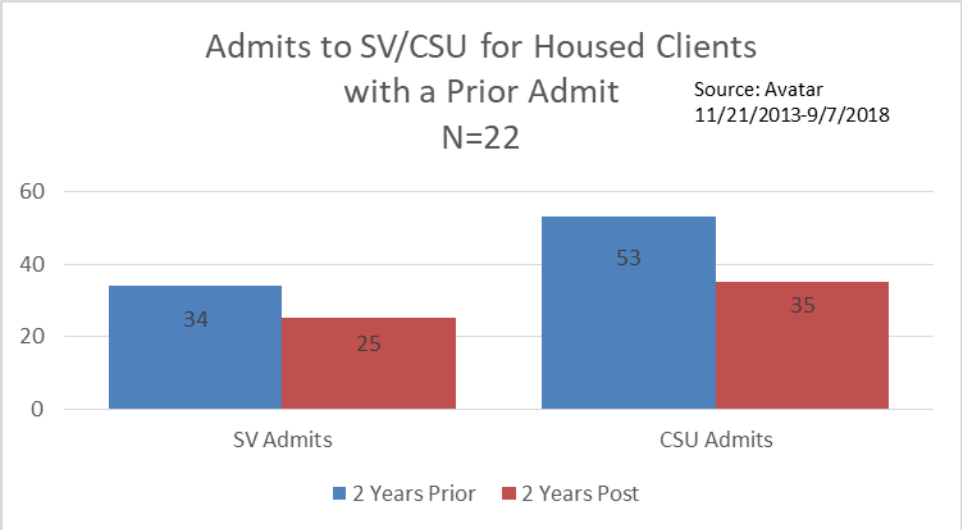
The following outcomes continue to be monitored through the implementation team to identify best practices, which will be reported in a final Innovation Report at the end of the Project. Housing outcomes are monitored using the Homeless Management Information System (HMIS) developed by Bowman and through Avatar, the Mental Health electronic medical record. For those clients who are also Full Service Partners, outcomes are also monitored through the Department of Health Care Services Data Collection and Reporting System.

- Increase in residential stability
- Increase in achieving educational goals
- Increase in achieving vocational goals
- Reduce psychiatric hospitalizations
- Reduce psychiatric emergency visits
- Reduce arrests
- Reduce incarcerations

For the period November 21, 2013 through September 7, 2018, a review of Sempervirens (SV, the psychiatric hospital) and Crisis Stabilization Unit (CSU) admissions were reviewed for RRN/MIST clients. These data show a reduction in admissions for both SV and CSU clients at six months prior to being housed and six months after being housed; at one year prior to being housed and one year after being housed; and at two years before and after being housed.







Project Timeline for Remaining Years

Year	Activities
Fiscal Year 2018/2019	Continue project and evaluation plan. Monitor client outcomes.
Fiscal Year 2019/2020	Continue project and evaluation plan. Monitor client outcomes.
Fiscal Year 2020/2021	Determine efficacy of project and if feasible transition successful project elements to alternative funding. Develop the final report.

Prevention & Early Intervention: Hope Center

The Hope Center serves unserved and underserved populations including transition age youth, adults and older adults who have Mental Health challenges and their family members. The Center meets the need in the community to provide a safe, welcoming environment based on the dimensions of wellness, and the resources necessary for people with and without a mental health diagnosis and their families to be empowered in their choices to be self-sufficient.

The Hope Center is peer driven with a full time Peer Coach III who oversees the Center and two full time and one full time Peer Coach I staff. Staff supervision and consultation is provided by a Senior Program Manager. Peer coaches are trained as Certified Peer Support Specialists through RI International. The Peer Coach III has additional training through the California Association of Mental Health Peer-Run Organizations (CAMHPRO) and the California Association of Social Rehabilitation Agencies (CASRA) as a train the trainer in the Superior Region Provider Core Competency Training. The supervisor of the peers has gone through a Peer Supervisor Training through RI International.

Two Peer Coaches are teaching “My Wellness My Doctor and Me,” classes that teach how to communicate with your doctor and be prepared for visits. There are role playing and discussions on symptoms and side effects. Another class is “Well,” a 16 session class where participants can drop in to any session. It covers many topics such as the pathways of recovery, conflict resolution, substance challenges, social wellness, self-esteem, budgeting and goal setting.

In 2018 the Hope Center created an Advisory Board made up of four participants, one volunteer and two staff. The Board’s job is to be a voice for the Center and give input to staff. Members meet once a month and Board members serve for one year.

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 peer staff and volunteers to people with a mental health diagnosis.

Hope Center Goals:

- Build on the dimensions of wellness
- Incorporate recovery pathways
- Validate strengths and honor the person
- Build sustainable living skills
- Community engagement
- Promote self-advocacy
- Keep Hope Center a safe location for all participants
- Reduce stigma and discrimination within the system of care and the broader community
- Encourage individuals to find their personal strengths and identify their personal recovery goals
- Break the stigma of the us and them

Hope Center Continuing Projects

- Activities, art shows and events
- Healthy Harvest (fresh fruits and vegetables for participants to supplement their diet)
- Support classes
- Education classes
- Cultural competency awareness
- Volunteer program
- Hope ambassadors (participants who know and talk about the recovery pathways)
- Direct access to a clinician who uses the recovery pathways and dimensions of wellness in their interactions with participants
- Wellness Recovery Action Plan facilitation
- Teach interns about the Peer empowerment model and use of the recovery language to use in their future work.
- May is Mental Health Matters Month coordination
- Health and Nutrition education

Hope Center has consistent and active members of the community who contribute services such as outreach, education, and coordination of special events.

Some special events over the past year include:

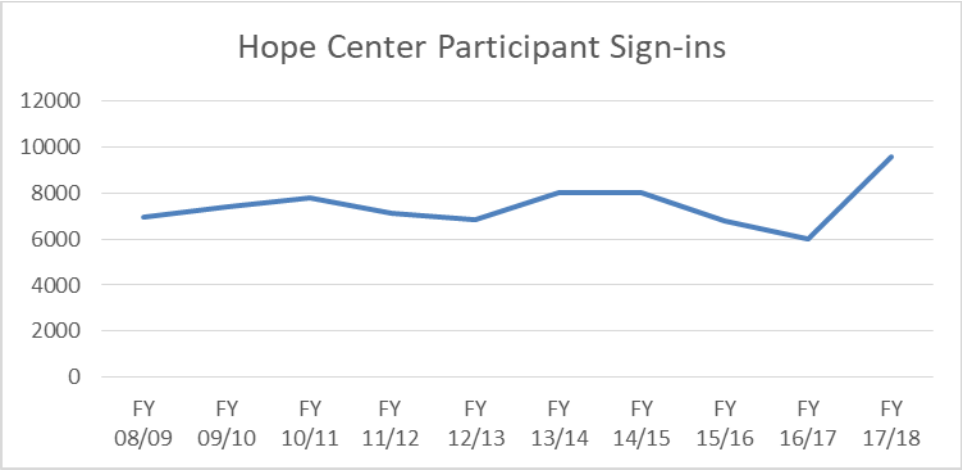
- Gratitude Party
- Pastels on the Plaza
- Out of Darkness Walk for Suicide Prevention
- Pizza parties to celebrate millstones
- Art show
- Bowling
- Tour of Loleta Cheese Factory
- Arcata Pool
- Roller Derby
- Redwood Races
- Costume parties
- Nature Walks/ Beach walks
- Boat tours on the Humboldt Bay
- Community Concerts
- Movies at the theater
- Roller Skating
- Baseball games with local Humboldt team
- Picnics with outlying communities
- Football Homecoming game at HSU
- Camping Retreat
- Day out to the Zoo
- Wellness center visits
- Community holiday outings (Truckers Parade)
- Each Mind Matters Presentation
- May's Mental Health BBQ
- Concert by the Bay

- Mental Health Matters Walk
- ACCESS Meeting and Luncheon (empowerment workshop)
- Freshwater Picnic
- Road Trip to Ukiah Memorial Project
- Trip to the city to see museums
- Local museums tours
- Trip to the capital for Mental Health Matters Day
- Peer conferences and trainings
- Kayaking in the community
- Community gardens

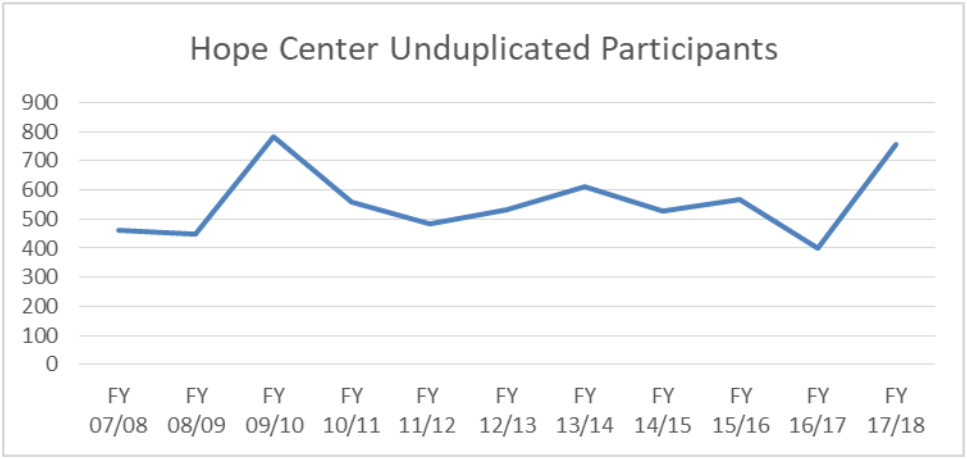
Hope Center offers classes, workshops and education. Some of these have included:

- Reading Circle
- BP magazine
- Positive start
- Mindfulness Monday
- Well Wednesday
- Nutrition class
- Cooking class
- Talk it out Thursday
- Women's healing quilting class
- Men's meeting
- Quilting / beading class
- Feel good Friday
- Walking class
- Gardening class
- Watercolor
- Tasty Tuesday
- Bike and pedestrian safety
- Bingo
- Art
- Games
- Coloring
- Wii
- Welcome to Aging
- Budgeting: it's all about the change (workshop)
- WELL Support (for all the parking lot questions in class)
- Karaoke

Participant sign in sheets show a range of 7,000 to 9,500 sign-ins over the past ten years, with an average of approximately 7,400, as shown in the chart below.



As shown in the chart below, the Hope Center serves an average of over 550 unduplicated participants per year, with a range of 450 to nearly 800. It is estimated that approximately 500 individuals will be served during the fiscal year.



Hope Center participants had this to say: “The Hope Center is like being with family. I feel like I can be myself and that I belong somewhere;” “Hope Center is a life saver for me.”

The Hope Center works with other partners to coordinate May is Mental Health Matters Month activities. A Peer Coach III serves as co-chair of the planning committee, made up of multi-disciplinary agency representatives and community groups. May is Mental Health Matters Month activities include a wide range of activities such as:

- Community BBQ’s
- Art shows
- Zumba
- Movie screenings
- Presentations by the Seeds of Change

- County Board of Supervisors Proclamation
- Community walk that culminates in a rally with speakers

Prevention & Early Intervention: Suicide Prevention

Healthy Communities Suicide Prevention strategies work to prevent suicide as a consequence of mental illness, improve access and linkage to treatment especially for those populations that are underserved or unserved. Strategies include:

- Public and targeted information campaigns
- A community suicide prevention network
- Culturally specific approaches
- Survivor-informed models
- Training and education

All activities meet an evidence based, promising practice, or practice based evidence standard. It is housed within the DHHS Public Health Branch, Healthy Communities Division. According to MHSA PEI Regulations this category of programs does not focus on or have intended outcomes for specific individuals at risk of or with serious mental illness. There are four projects in the Suicide Prevention Program:

- Suicide Prevention Training: Applied Suicide Intervention Skills Training (ASIST)
- Question~Persuade~Refer (QPR) Suicide Prevention Training
- Humboldt County Suicide Prevention Network
- Capacity Building Assistance

The narrative for Suicide Prevention includes the information for the Three Year PEI Evaluation Report.

Project Name: Suicide Prevention Training: Applied Suicide Intervention Skills Training (ASIST)

ASIST is a continuing suicide prevention project for Transitional Age Youth, Adults and Older Adults. It is a public and targeted information campaign and targeted education and training. It addresses the negative outcomes of suicide and prolonged suffering.

ASIST is a two-day interactive workshop in suicide first aid. ASIST teaches participants to recognize when someone may have thoughts of suicide and work with them to create a plan that will support their immediate safety. Humboldt County has prioritized training as a method to increase system and community capacity to respond to persons at risk. ASIST training teams are multidisciplinary and include public health educators, mental health clinicians, social workers, juvenile probation staff, tribal agency representatives, and law enforcement.

ASIST is open to and intended for anyone 16 years and older. Participants include: school personnel, health and behavioral health care providers, first responders, faith community, front line workers, and concerned community members.

Both Probation and Humboldt State University Counseling and Psychology Department require ASIST training for staff and students.

Goal: Through skill-based training, increase the ability of Humboldt county residents to recognize persons at risk of suicide, provide support, and link to additional services

Objectives:

1. Reduce the risk of suicide through prevention and intervention trainings
2. Promote early identification of mental illness and signs of suicidal behavior
3. Increase participants awareness of local, state and national resources

Outcome Measures:

1. ASIST evaluation
2. Number of people trained
3. Demographic forms that demonstrate the diversity of participants and settings
4. Provide skill-based training so community members will have the knowledge to recognize signs/symptoms of persons that may be at risk of suicide and respond with positive intervention
5. Reduce negative attitudes and beliefs about persons experiencing suicidal thoughts and behaviors and other mental health challenges

Implementation Success. The ASIST training team is multidisciplinary. Trainers are employed in multiple settings which increases the reach and diversity of the settings and participants. There were six ASIST trainings in Fiscal Year 16/17 and six in Fiscal Year 17/18. The goal is to have six ASIST trainings in 18/19.

Key Activities

Key activities will support outcomes around improved support for persons at risk of mental health crisis and suicide by:

- Training participants to recognize the signs of persons in need of mental health support
- Training participants to recognize the signs of persons who are at risk of suicide
- Providing training to diverse groups and populations across multiple settings and professions in order to expand capacity to increase access and linkage to care for those in crisis and non-crisis situations
- Promoting local, statewide and national crisis lines, resources, and educational materials, including “Know the Signs” and “Each Mind Matters,” to expand on the ability of trainees to increase access and linkage to supports and treatment for persons at risk
- Understanding ways personal and societal attitudes affect views on suicide and interventions
- Providing guidance and suicide first-aid to a person at risk in ways that meet their individual safety needs
- Identifying the key elements of an effective suicide safety plan and the actions required to implement it
- Improving and integrating suicide prevention resources in the community at large
- Recognizing other important aspects of suicide prevention including life-promotion and self-care.

OUTCOMES	FY 2016-2017 N=	FY 2017-2018 N=
Number of participants	94	152
Participants who reported increased knowledge with recognizing warning signs, and behaviors associated with suicidality (0-5 scale)	74	115
Pre and Post Evaluation Results	% Increase 16/17	% Increase 17/18
If a person's words and/or behaviors suggest the possibility of suicide, I would ask directly if he/she is thinking about suicide	40%	37%
If someone told me they were thinking of suicide, I would do an intervention	35%	30%
I feel prepared to help a person at risk of suicide	47%	56%
I feel confident I could help a person at risk of suicide	46%	52%
I can identify the places or people where I should refer others at risk of suicide	15%	N/A
I have easy access to the educational resource materials I need to learn about helping a person at risk	15%	N/A
I feel comfortable discussing suicide with others	27%	N/A

Project Name: Question~Persuade~Refer (QPR) Suicide Prevention Training

This is a continuing suicide prevention project serving Transitional Age Youth, Adults and Older Adults. The project is targeted education and training addressing the negative outcomes of suicide and prolonged suffering.

Question, Persuade and Refer (QPR) was implemented in September 2009. QPR provides innovative, practical, and proven suicide prevention training that reduces suicidal behaviors by training individuals to serve as "gatekeepers" those who are strategically positioned to recognize the warning signs suicide crisis and how to respond by - Question: Ask about suicide, Persuade and promote the person to seek and accept help, and Refer the person to appropriate resources. QPR training has been tailored to multiple settings and professions—education, crisis workers, first responders, foster parents, social workers, medical providers, faith community, etc. Peer educators, teachers, parents, coaches, caseworkers, police officers, first responders, medical providers, faith community, and the general population have participated in QPR training.

Goal: Through skill-based training, increase the ability of Humboldt county residents to recognize persons at risk of suicide, provide support, and link to additional services.

Objectives:

1. Increase participants knowledge of signs of suicide risk;
2. Increase participants ability to intervene and link persons at risk to community and system based resources.

Outcome Measures:

1. QPR pre and post survey
2. Number of people trained
3. Demographic forms that demonstrate the diversity of populations and settings
4. 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
5. Reduce negative attitudes and beliefs about persons experiencing suicidal thoughts and behaviors along with other mental health challenges

Implementation Success: QPR training has been successfully integrated into a variety of settings. The goal was to have six QPR trainings in Fiscal Year 16/17 and six in Fiscal Year 17/18. This goal was exceeded. The goal for 18/19 is six QPR trainings.

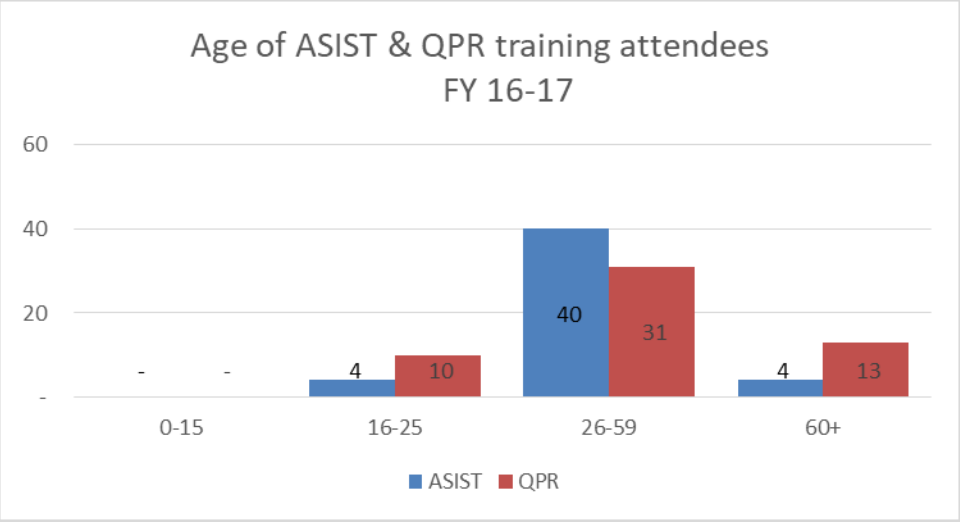
Key Activities: Key activities will support outcomes around improved mental health education and early identification skills by:

- Training participants to recognize the signs of persons in need of mental 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 expand capacity to increase access and linkage to care of those in crisis and non-crisis situations
- Promoting local, statewide and national crisis lines, resources, and educational materials to expand on the ability of trainees increase access and linkage to supports and treatment for persons at risk
- Improving and integrating suicide prevention resources in the community at large
- Recognizing other important aspects of suicide prevention including life-promotion and self-care

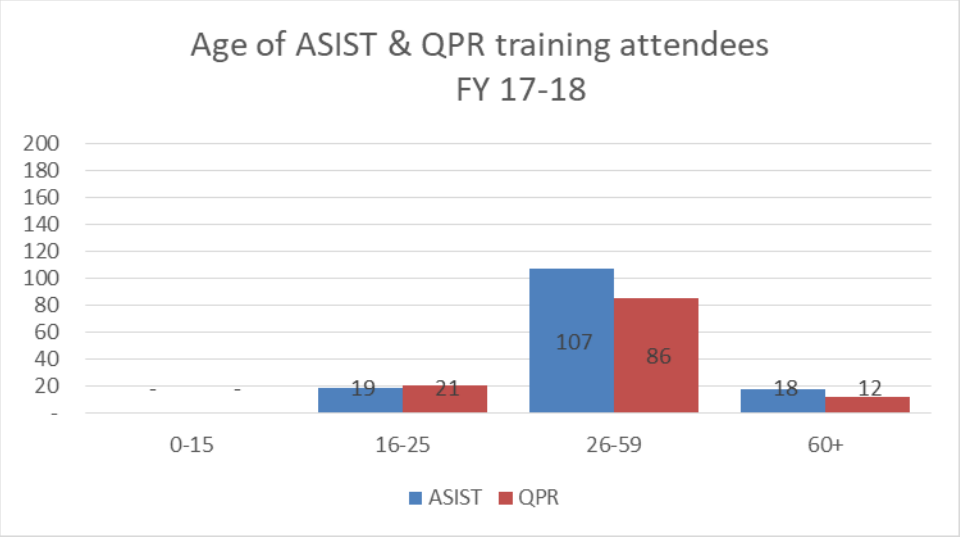
OUTCOMES	FY 2016-2017 N=	FY 2017-2018 N=
Number of Trainings	7	10
Number of participants	62	150
Participants who reported increased knowledge with recognizing warning signs, and behaviors associated with suicidality (0-3 scale)	52	119
Pre and Post Evaluation	% Increase 16/17	% Increase 17/18
• Knowledge of facts about suicide prevention	42%	56%
• Knowledge of warning signs of suicide	26%	31%
• How to ask someone about suicide	58%	59%
• How to persuade someone to get help	46%	50%
• How to get help for someone	32%	59%
• Information about local, state, and national resources for help with suicide	48%	81%
• Do you feel that asking someone about suicide is appropriate?	22%	21%
• Do you feel likely to ask someone about suicide?	26%	24%
• Rate your level of understanding about suicide and suicide prevention	31%	51%

Demographic Information, ASIST and QPR Trainings
Demographic information comes from attendees at trainings who complete a demographic form. In Fiscal Year 16/17, 66% of attendees completed a demographic form, and 34% declined completing a demographic form. In Fiscal Year 17/18, 88% completed a demographic form, and 12% declined completing a demographic form.

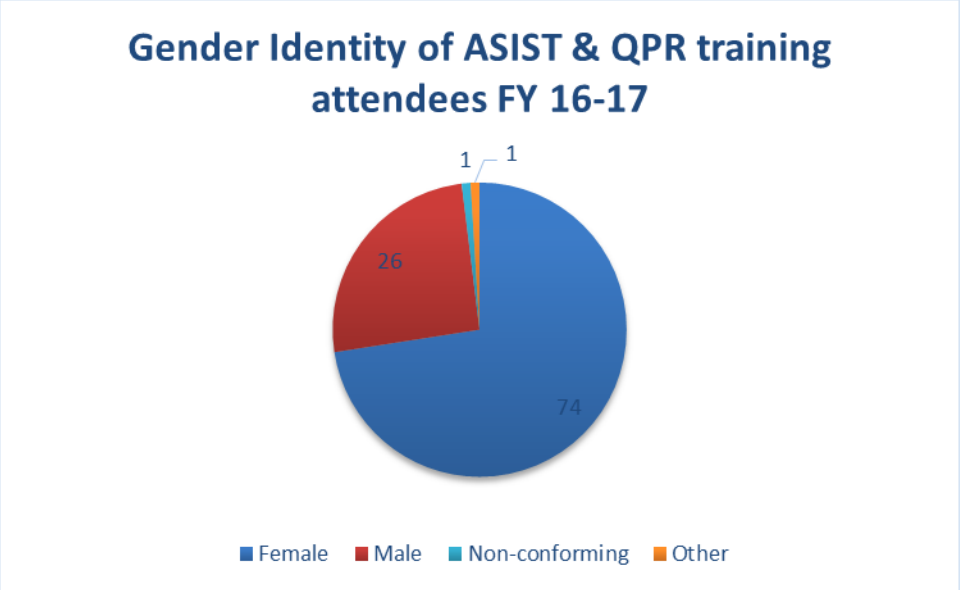
In Fiscal Year 16/17, 14 attendees at ASIST and QPR trainings were ages 16-25, 71 attendees were ages 26-59, and 17 attendees were age 60+.



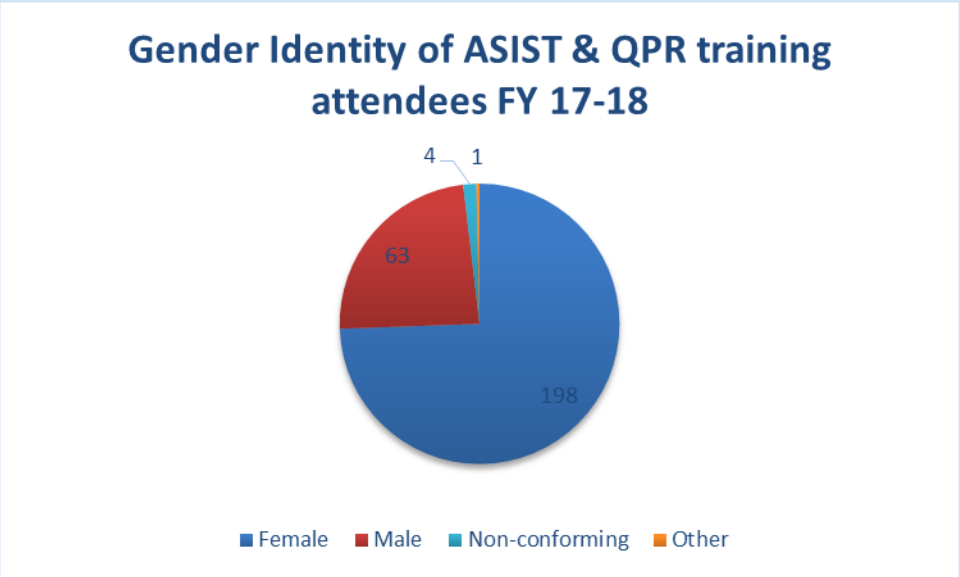
In Fiscal Year 17/18, 40 attendees at ASIST and QPR trainings were ages 16-25, 193 attendees were ages 26-59, and 30 attendees were age 60+.



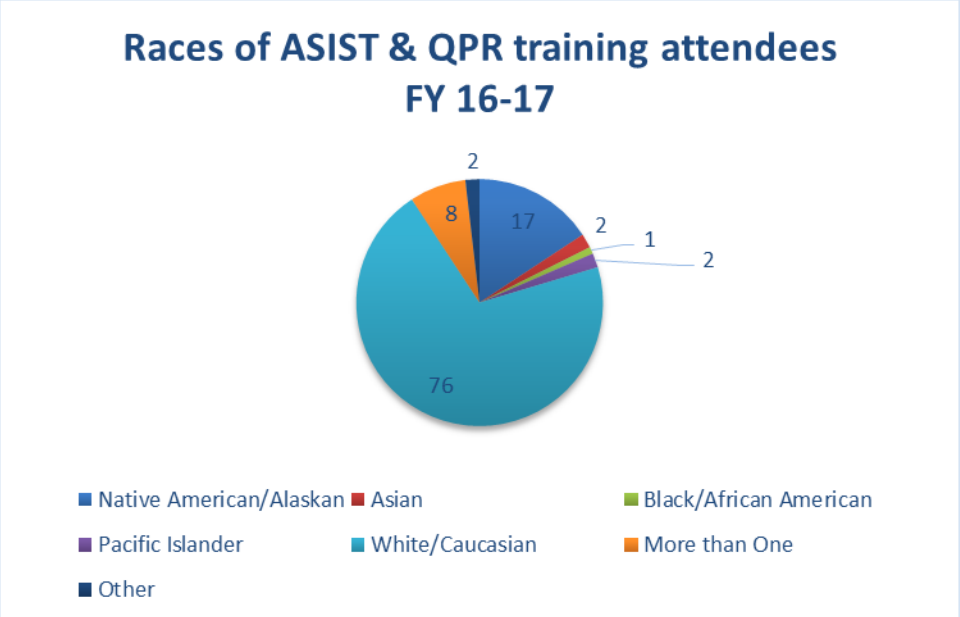
In Fiscal Year 16/17, 74 attendees at ASIST and QPR trainings were female, 26 attendees were male, one attendee was gender non-conforming, and one was Other.



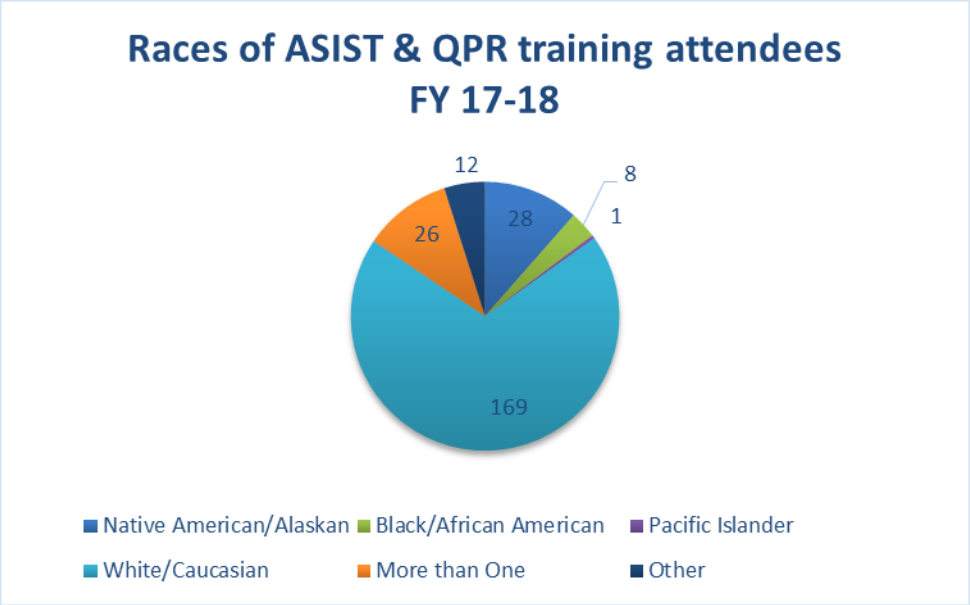
In Fiscal Year 17/18, 198 attendees at ASIST and QPR trainings were female, 63 were male, 4 were gender non-conforming, and one was Other.



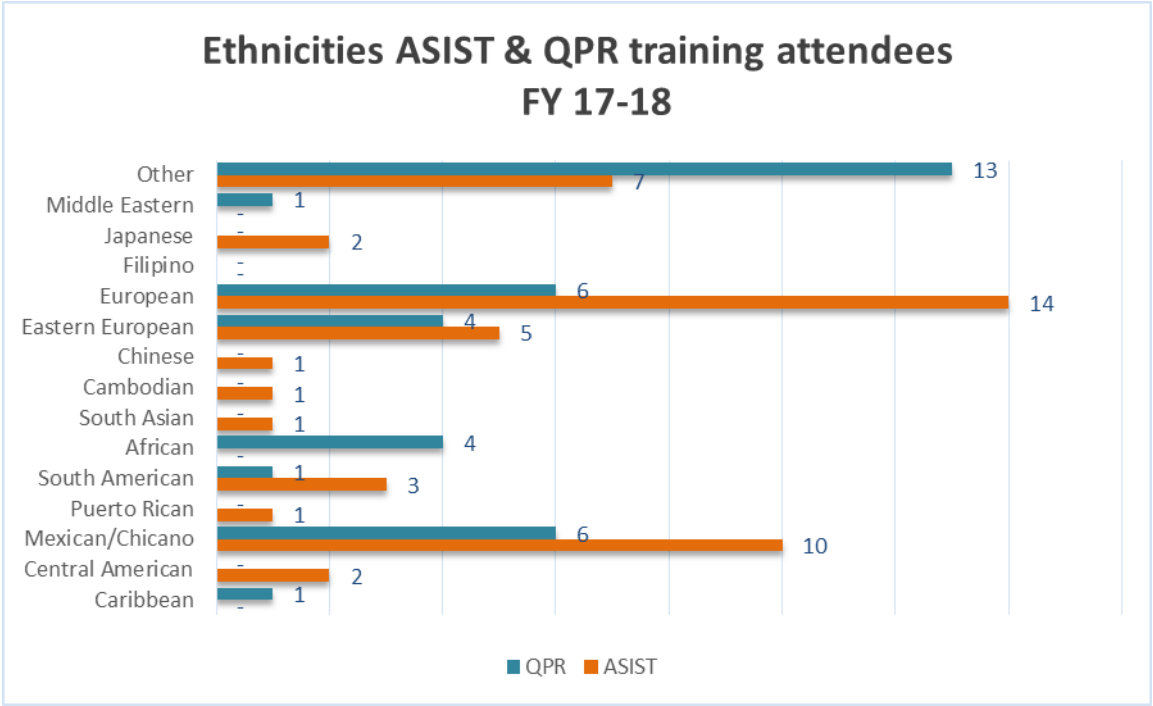
In fiscal year 16/17, 76 attendees at ASIST and QPR trainings were White, 17 were Native American, 8 were Multi-racial, 7 were Hispanic/Latino, 2 were Asian, 2 were Other, 2 were Pacific Islander, and one was Black/African American.



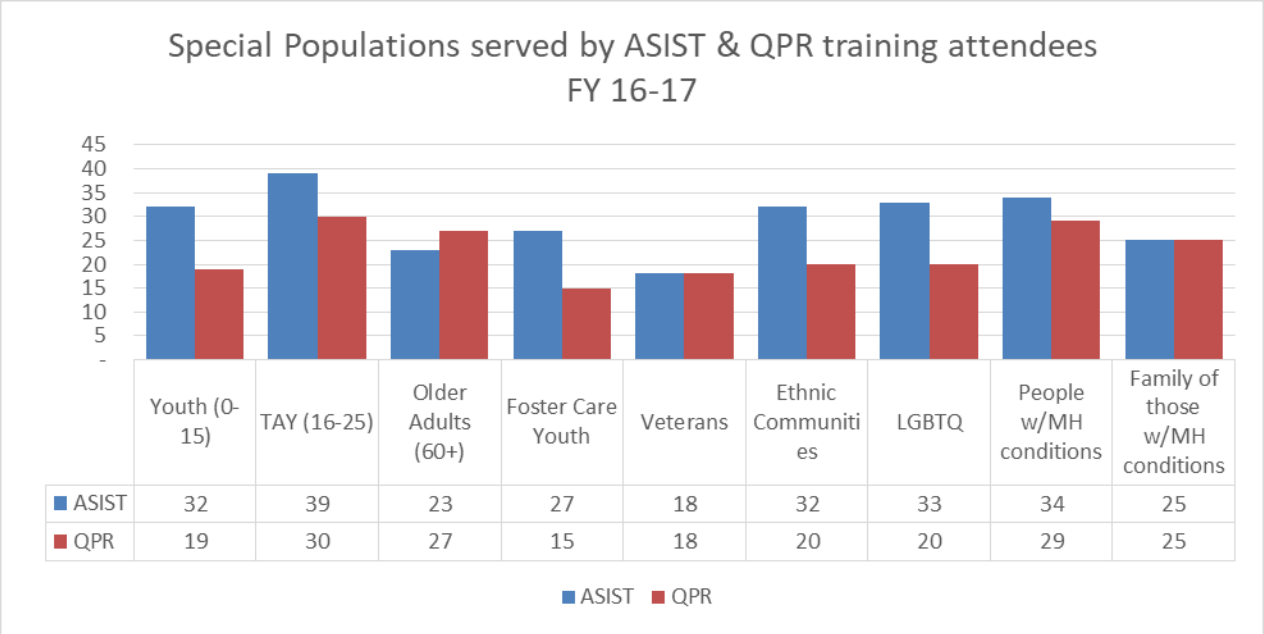
In fiscal year 17/18, 169 attendees at ASIST and QPR trainings were White, 28 were Native American, 26 were Multi-racial, 12 were Other, 8 were Black/African American, and one was Pacific Islander.



In fiscal year 17/18, demographic forms began to capture ethnicities of ASIST & QPR attendees. For those answering the question, 1 was Caribbean, 2 were Central American, 16 were Mexican/Chicano, 1 was Puerto Rican, 4 were South American, 4 were African, 1 was South Asian, 1 was Cambodian, 1 was Chinese, 9 were Eastern European, 20 were European, 2 were Japanese, 1 was Middle Eastern, and 20 were Other.

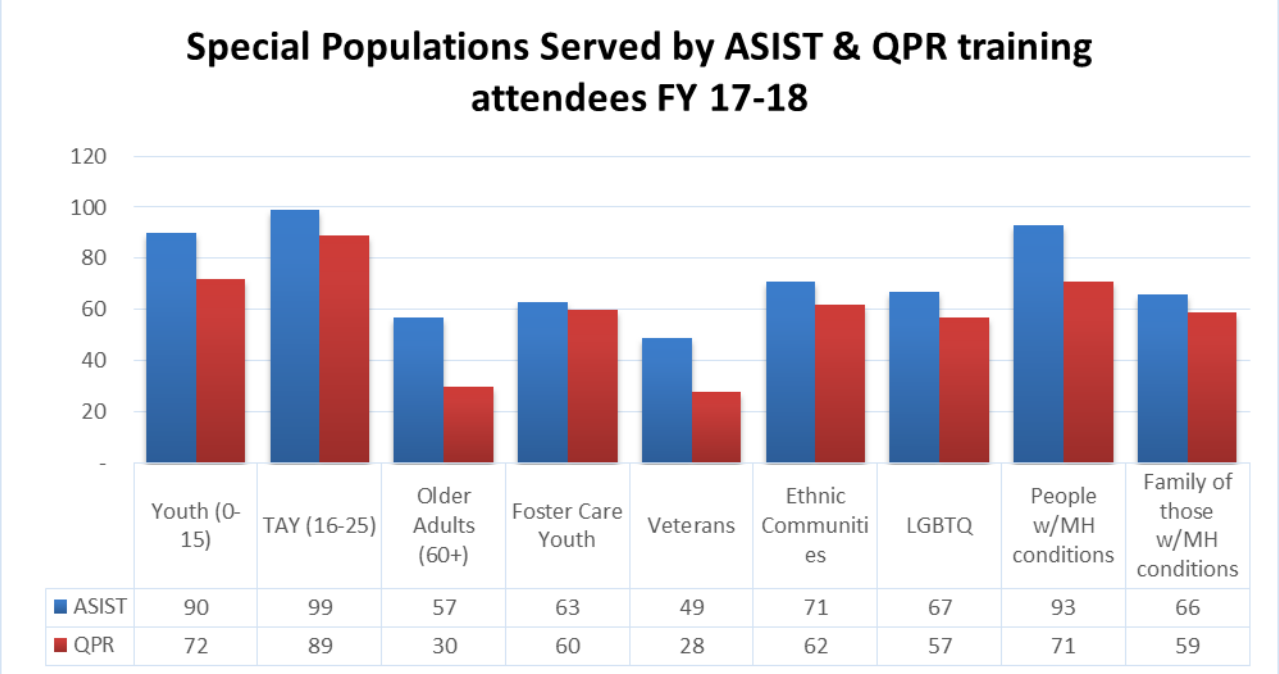


When looking at the populations served by the attendees at ASIST and QPR trainings In fiscal year 16/17, 51 were youth ages 0-15, 69 were TAY, 50 were Older Adults, 42 were Foster Care Youth, 36 were Veterans, 52 were from Ethnic Communities, 53 were LGBTQ, 63 were people with a mental health condition, and 50 were family members of those with a mental health condition.



	Youth (0-15)	TAY (16-25)	Older Adults (60+)	Foster Care Youth	Veterans	Ethnic Communities	LGBTQ	People w/MH conditions	Family of those w/MH conditions
ASIST	32	39	23	27	18	32	33	34	25
QPR	19	30	27	15	18	20	20	29	25

When looking at the populations served by the attendees at ASIST and QPR attendees in fiscal year 17/18, 162 of the population were youth 0-15, 188 were TAY, 87 were Older Adults, 123 were Foster Care Youth, 77 were Veterans, 133 were ethnic communities, 124 were LGBTQ, 164 were people were a mental health condition, and 125 were family members of those with a mental health condition.



	Youth (0-15)	TAY (16-25)	Older Adults (60+)	Foster Care Youth	Veterans	Ethnic Communities	LGBTQ	People w/MH conditions	Family of those w/MH conditions
ASIST	90	99	57	63	49	71	67	93	66
QPR	72	89	30	60	28	62	57	71	59

Project Name: Humboldt County Suicide Prevention Network

This is a continuing suicide prevention project that also addresses stigma and discrimination reduction. It serves all age groups. It is a public and targeted information campaign, a network, a capacity building project, a social marketing campaign, targeted education and training. It is an effort to combat multiple stigmas that have been shown to discourage individuals from seeking mental health services, and an effort to encourage self-acceptance for individuals with a mental illness. It addresses the negative outcomes of suicide and prolonged suffering. The activities target all Humboldt County residents.

The Humboldt County Suicide Prevention Network (SPN), which is comprised of representative community sectors from county agencies, community partners, first responders, medical and behavioral health, schools, people with lived experience and family members, will collaborate to address key community and data driven priority areas: Community Education and Outreach; Training/Workforce Development & Building Organizational Capacity; Data and Surveillance; and Zero Suicide. All efforts will focus on establishing a presence in remote outlying areas of Humboldt County and in tribal communities. Humboldt County PEI staff will continue to act as the backbone agency providing coordination of efforts and guidance on best practices.

Goal: Increase awareness and intervention of community to mobilize support for those affected by suicide.

Objectives:

1. Community Education and Outreach
2. Training and Workforce Development to Increase Capacity to respond to persons at risk
3. Data collection and surveillance
4. Zero Suicide in Health and Behavioral Health Care Systems

Outcome Measures:

1. Sign-in forms – number of participants
2. Number of agencies involved with Network
3. Number of annual meetings

Implementation Success: The SPN continues to expand its reach and diversify its membership. Sharing of resources, increase in collaborative projects and events is a key component.

There were six Network meetings in Fiscal Year 16/17 and six meetings in Fiscal Year 17/18. The goal is to have six Network meetings in 18/19.

Key Activities:

- Coordinate community-wide activities and events
- Conduct a minimum of six Suicide Prevention Network meetings
- Provide in-service training at each Network meeting to expand capacity to increase access and linkage to care of 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 increase access and linkage to supports and treatment for persons at risk
- Improve and integrate suicide prevention resources in the community at large

OUTCOMES	FY 2016-2017 N=	FY 2017-2018 N=
Number of participants	112	115
Number of agencies represented	13	14
Number of meetings	6	6

Project Name: Capacity Building Assistance

This is a continuing suicide prevention project that also addresses stigma and discrimination reduction. It targets all age groups. It is a public and targeted information campaign, builds capacity, provides targeted education and training, includes a web-based campaign, is culturally specific, includes efforts to combat multiple stigmas that have been shown to discourage individuals from seeking mental health services, and efforts to encourage self-acceptance for individuals with a mental illness. It addresses the negative outcomes of suicide, prolonged suffering, and school failure or dropout.

Capacity Building Assistance (CBA) is designed to support and strengthen community partners including community-based organizations, educational institutions, and health and behavioral healthcare organizations, leverage resources, to broaden the support network for unserved, underserved, and inappropriately served populations. CBA is a tailored service to meet the needs of each recipient organization. Target settings include:

- Health and Behavioral Health care
- Educational Institutions
- Workplace
- Probation
- Peer support programs
- Faith community

Goal: Systems will increase their capacity to respond effectively along a continuum of care for persons at risk.

Objectives:
1. Training and Workforce Development
2. Improve resource and referral linkages
3. Systems will increase their capacity to respond effectively along a continuum of care for persons at risk

Outcome Measures:
1. Demographic forms that demonstrate the diversity of populations and settings
2. Number of agencies/schools that address systems chance (trainings, Policy, protocol and procedures, etc.)
3. 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

Implementation Success: Tailored trainings are developed using evidenced-based materials. Schools and community agencies who received tailored trainings have expressed appreciation for addressing actual conditions in the workplace.

The goal was to have six settings/agencies participating in CBA in Fiscal Year 16/17 and six in Fiscal Year 17/18. This is the goal for 18/19 as well.

Key Activities:

- Training and Workforce Development – Trainings utilizing evidence based, promising practice, or practice based evidence model. Staff will provide efforts to expand community's capacity for suicide prevention trainings through consultation, "Train-the-Trainers", and coordination of multi-disciplinary training teams. Training teams include public health educators, mental health clinicians, social workers, tribal community agency representatives, and law enforcement. In addition, tailored training for specific settings and populations is developed in coordination with requesting agencies, schools, and settings. Trainings are designed using tools from statewide partners and other evidenced-based materials.
- Systems Change – Staff will provide support to community partners representing multi-sector settings including education, primary care, behavioral health, and social services to assess capacity to develop and evaluate internal policies and procedures to address continuum of care for persons at risk such as a Zero Suicide approach.

OUTCOMES	FY 2016-2017 N=	FY 2017-2018 N=
Number of participants involved in Capacity Building Assistance including tailored trainings:	944	1140
Number of agencies that have developed policies, protocols, procedures to identify persons at risk of suicide and mental health crisis (system change)	6	7
Number of trainings provided	37	33

Prevention & Early Intervention: Stigma and Discrimination Reduction

Humboldt County Public Health, Healthy Communities Prevention and Early Intervention strategies fall under Stigma and Discrimination. These strategies provide activities that increase awareness of attitudes, beliefs, perceptions, stereotypes and discrimination related to undiagnosed and diagnosed mental illness or to seeking mental health services. The strategies work to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and family members. Strategies include social marketing campaigns, enhancing the voices of people with lived experiences, targeted education and training, anti-stigma advocacy support for statewide web-based campaigns. There are five projects for Stigma and Discrimination Reduction.

Mental Health First Aid (Adult and Youth)
Directing Change
Social Marketing
Speaker's Bureau
Direct Contact Approaches

The narrative for Stigma and Discrimination Reduction includes the information for the Three Year PEI Evaluation Report.

Project Name: Mental Health First Aid (Adult and Youth)

This a continuing stigma and discrimination reduction project for adults providing targeted education and training. It addresses the negative outcome of prolonged suffering.

To support MHSA PEI goals, Mental Health First Aid (MHFA) training focuses on mental illness stigma reduction, and on community education to intervene earlier in mental health crisis. The Healthy Communities PEI strategies under Humboldt County DHHS's Stigma and Discrimination Reduction Program provide training to providers, individuals, and other caregivers who live and/or work in Humboldt County on Mental Health First Aid Certification and Youth Mental Health Aid Certification. The purpose of these training activities is to both help expand the reach of individuals who have the knowledge and skills to respond to or prevent a mental health crisis in the community, and to reduce the stigma associated with mental illness.

This project responds to the need to enhance supports available to individuals before, during, and after crisis, and expand the reach of mental health services to non-mental health staff through the provision of suicide prevention and intervention strategies as well as Mental Health First Aid to non-mental health staff.

MHFA trainings are offered throughout the community. In the past, 5 to 7 trainings have been offered per year. Staff have been certified to provide both the adult and youth versions of MHFA. The type of trainings, locations, and frequency depend on the demand for the trainings and on county data related to targeted groups that work with at risk populations.

The program improves timely access to services for underserved populations. A wide array of community members are trained in identifying signs/symptoms and responding, including skills on connecting individual to services.

- Outreach for Increasing Recognition of Early Signs of Mental Illness
- Stigma and Discrimination Reduction

Mental Health First Aid (MHFA) is an evidenced based training that:

- Increases understanding of mental health and substance use disorders
- Increases knowledge about signs and symptoms of issues such as depression, anxiety, psychosis, and substance abuse
- Reduces negative attitudes and beliefs about people with symptoms of mental health disorders
- Increases skills for responding to people with signs of mental illness and connecting individual to services
- Increases knowledge of resources available

Mental Health First Aid and Youth Mental Health First Aid Certifications

- Both Mental Health First Aid and Youth Mental Health First Aid are eight-hour courses designed to teach individuals in the community how to help someone who is developing a mental health problem or experiencing a mental health crisis. Trainees are taught about the signs and symptoms of mental illness, including anxiety, depression, psychosis, and substance use.
- Youth Mental Health First Aid is especially designed to teach parents, family members, caregivers, teachers, school staff, peers, neighbors, providers, and other individuals how to help adolescents (ages 12–18) experiencing mental health or substance use problems, or are in mental health crisis situations. The training covers health challenges for youth, offers information on adolescent development, and includes a 5-step action plan to help young people both in crisis and non-crisis situations.

Providers, consumers, family members and other community members who may be in a position to recognize and respond to early signs and symptoms of mental illness. These include: school staff, font-line workers in health and human service agencies, community health advocates/Promotores, family members, business owners, community, faith community, first responders, probation staff, librarians, and others.

Goal: Targeted Education and Training aims to expand the reach of the mental health system through the training of individuals who have the knowledge and skills to respond to or prevent a mental health crisis in the community.

Objectives:

1. Expand the reach of mental health services
2. Promote early identification of mental illness.

Outcome Measures:

1. MHFA evaluation
2. Demographic forms that demonstrate the diversity of populations and settings
3. Increase knowledge of mental health signs and symptoms and reduced negative attitudes and beliefs about persons experiencing mental health challenges.

Implementation Success: MHFA and YMHFA have been well received in Humboldt County. The majority of participants indicate they feel better prepared and have a greater understanding of mental health challenges, recovery, and how to help someone.

The goal was to provide six trainings in fiscal year 16/17 and six in fiscal year 17/18. The goal was exceeded, as shown in the Outcomes table below. The goal for 18/19 is to have six trainings.

Key activities will support outcomes around improved mental health education and early identification skills by:

- Training community and family members to recognize the signs of persons in need of mental health support
- Training community and family members to recognize the signs of persons who are at risk of suicide and those who are at risk of developing a mental illness
- Promoting wellness, recovery, and resiliency
- Training and working with families and caregivers in order to develop plans and strategies that are tailored to their family member's need
- Training participants to address the specific needs of certain populations, including youth
- Offering trainings to an intentionally diverse group of community members, family members, and partners, to ensure that persons are trained across a variety of populations in order to meet the needs of 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 broaden base of support for persons at risk

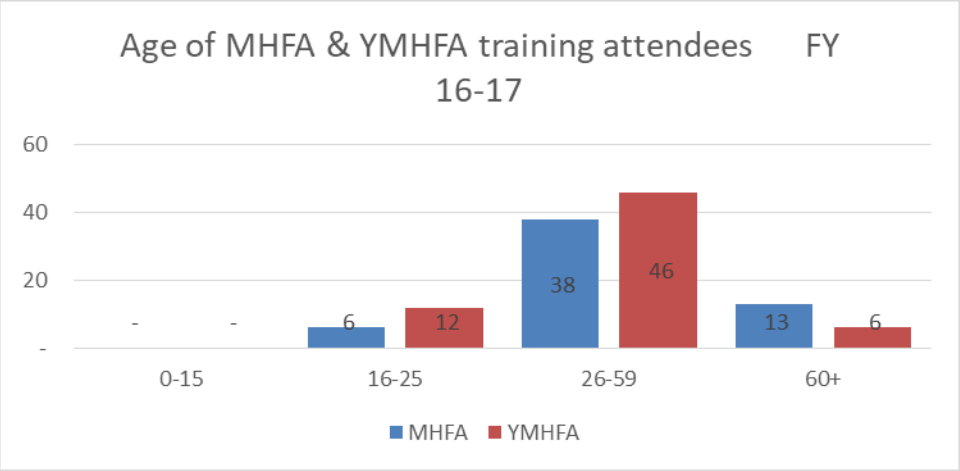
OUTCOMES	FY 2016-2017 N=	FY 2017-2018 N=
Number of Adult and Youth MHFA trainings	8	9
Number of community members that participated in Adult MHFA trainings	85	159
Number of community members that participated in Youth MHFA trainings	81	45
Total number of participants	166	184
Participants who reported gaining knowledge in the following categories about mental illness signs and symptoms (1=strongly disagree; 5=strongly agree. Number equals participants indicating greater than 3 on scale of 0-5)	FY 2016-2017 N=	FY 2017-2018 N=
Recognize that someone may be experiencing a mental health problem or crisis	146	179
Reach out to a person who may be dealing with a mental health challenge	143	177
Offer a distressed person basic "first aid" level information and reassurance about mental health problems	141	177
Assist a person who may be dealing with a mental health problem or crisis to seek professional help	141	174

OUTCOMES	FY 2016-2017 N=	FY 2017-2018 N=
Assist a person who may be dealing with a mental health problem or crisis to connect with appropriate community, peer and personal supports	140	174
Be aware of my own views and feelings about mental health problems and disorders	144	176

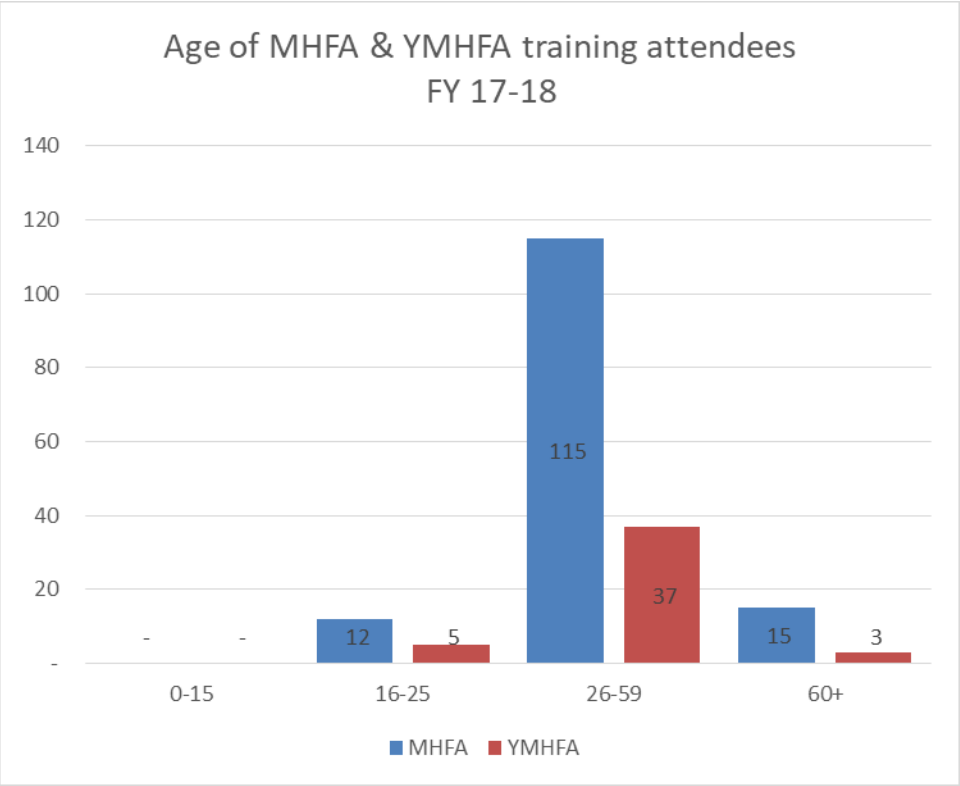
Demographic Information for Mental Health First Aid and Youth Mental Health First Aid

Demographic information comes from attendees at trainings who complete a demographic form. In Fiscal Year 16/17, 71% of attendees completed a demographic form, and 29% declined completing a demographic form. In Fiscal Year 17/18, 90% completed a demographic form, and 10% declined completing a demographic form.

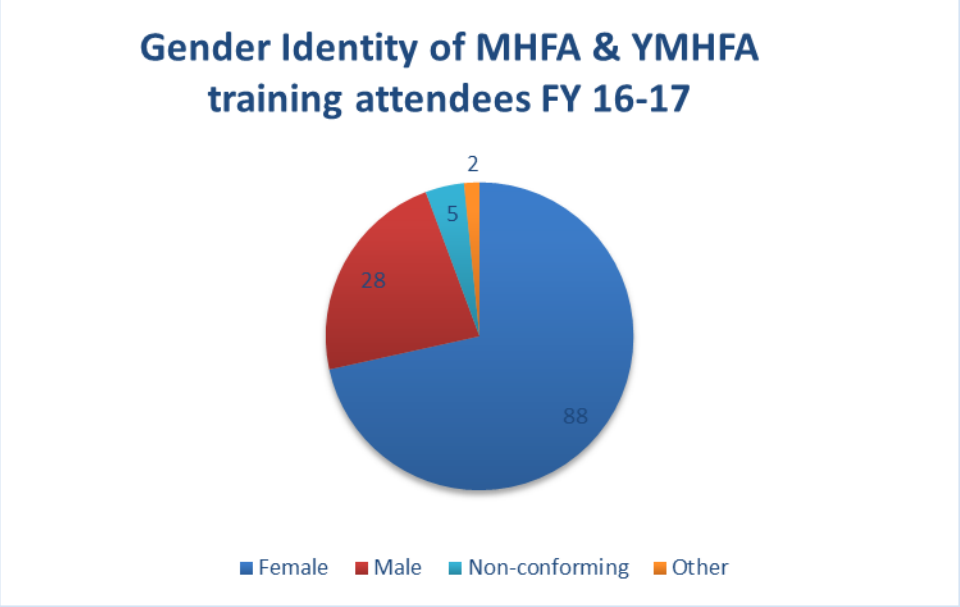
In Fiscal Year 16/17, 18 attendees were ages 16-25, 84 were ages 26-59, and 19 were age 60+.



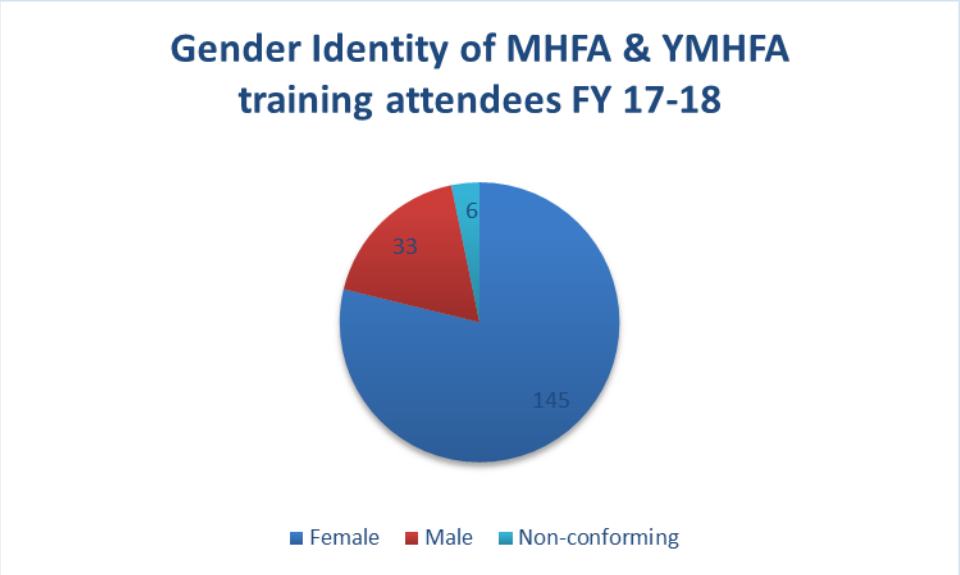
In Fiscal Year 17/18, 17 attendees were ages 16-25, 152 were ages 26-59, and 18 were age 60+.



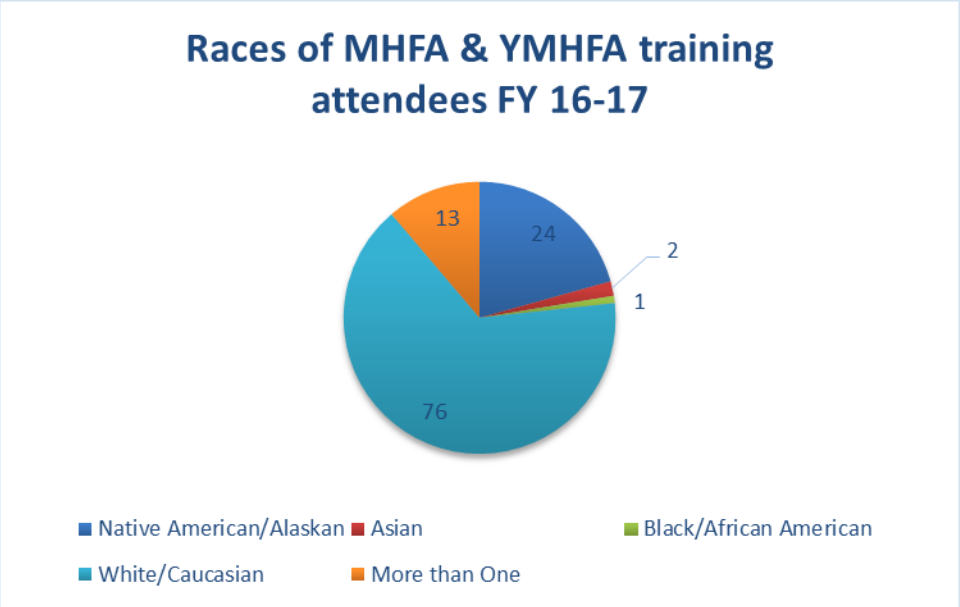
In Fiscal Year 16/17, 88 attendees were female, 28 were male, 5 were gender non-conforming, and 2 were Other.



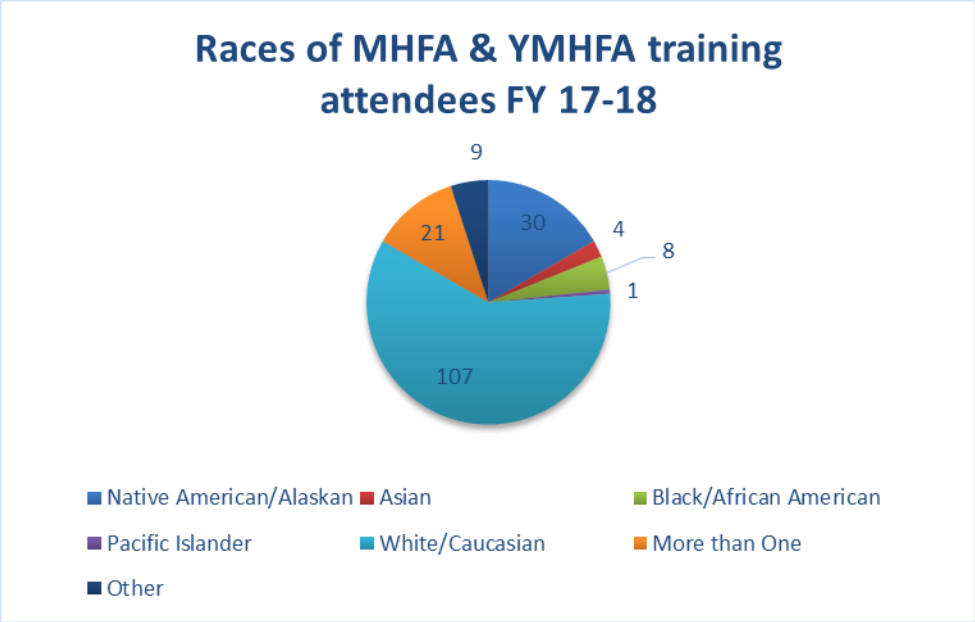
In Fiscal Year 17/18, 145 training attendees were female, 33 were male, and 6 were gender non-conforming.



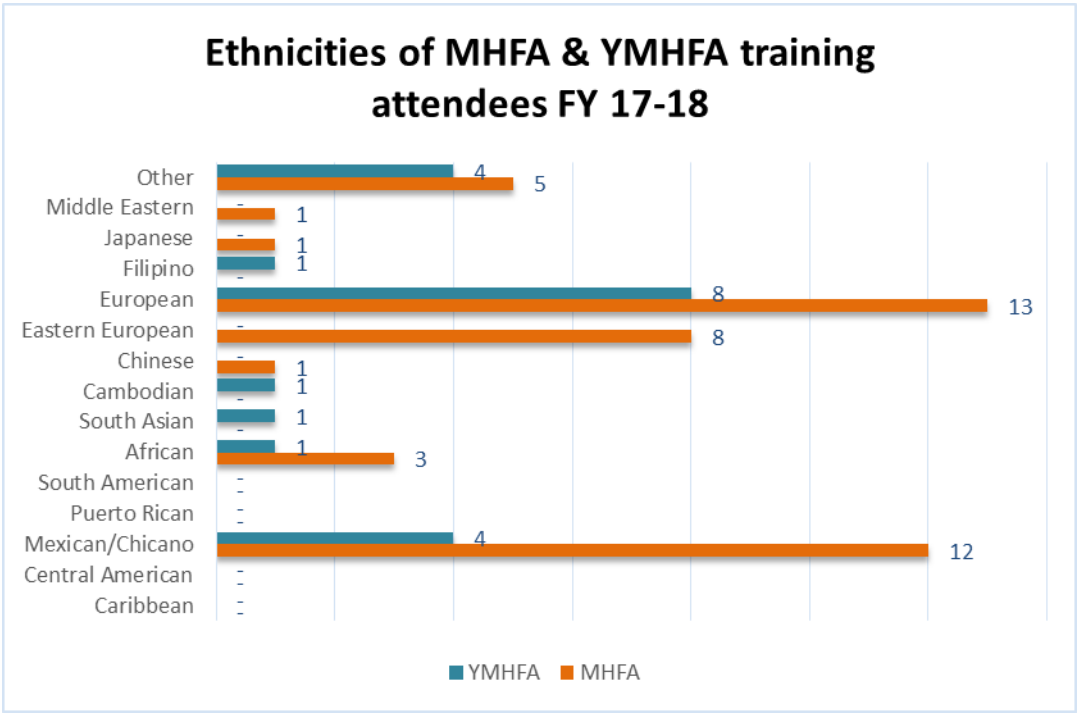
In Fiscal Year 16/17, 76 attendees were White, 24 were Native American, 13 were Multi-racial, 2 were Asian, and one was Black/African American.



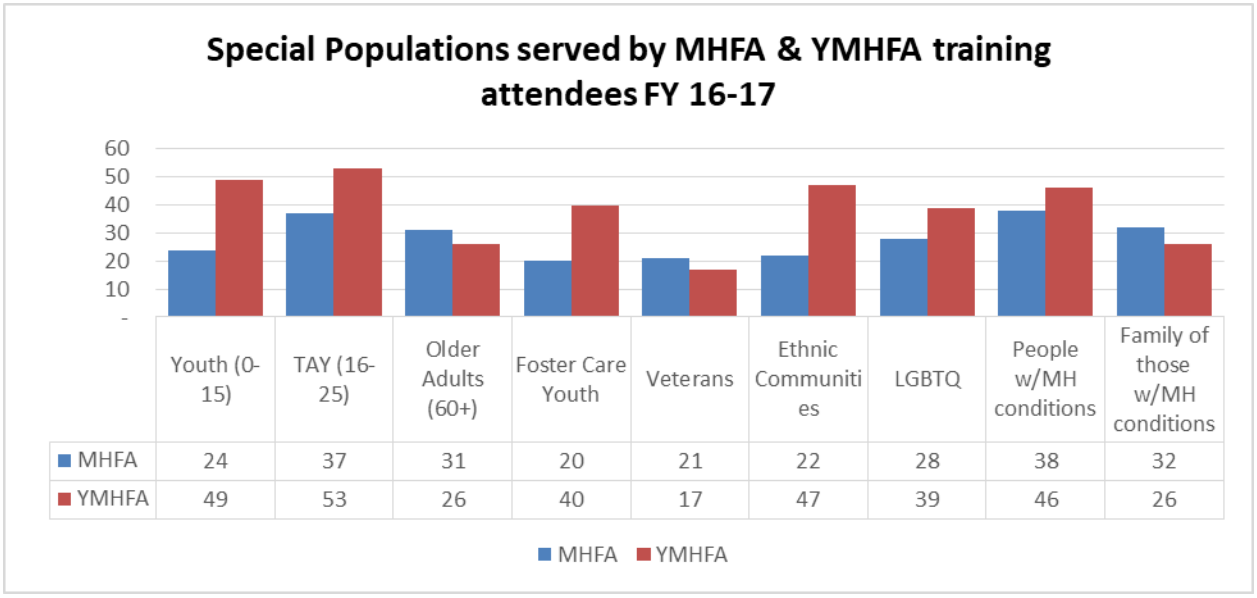
In Fiscal Year 17/18, 107 attendees were White, 30 were Native American, 21 were Multi-racial, 9 were Other, 8 were Black/African American, 4 were Asian, and one was Pacific Islander.



In fiscal year 17/18, demographic forms began to capture ethnicities of MHFA and YMHFA training attendees. For those answering the question, 16 were Mexican/Chicano, 4 were African, 1 was South Asian, 1 was Cambodian, 1 was Chinese, 8 were Eastern European, 21 were European, 1 was Filipino, 1 was Japanese, 1 was Middle Eastern, and 9 were Other.

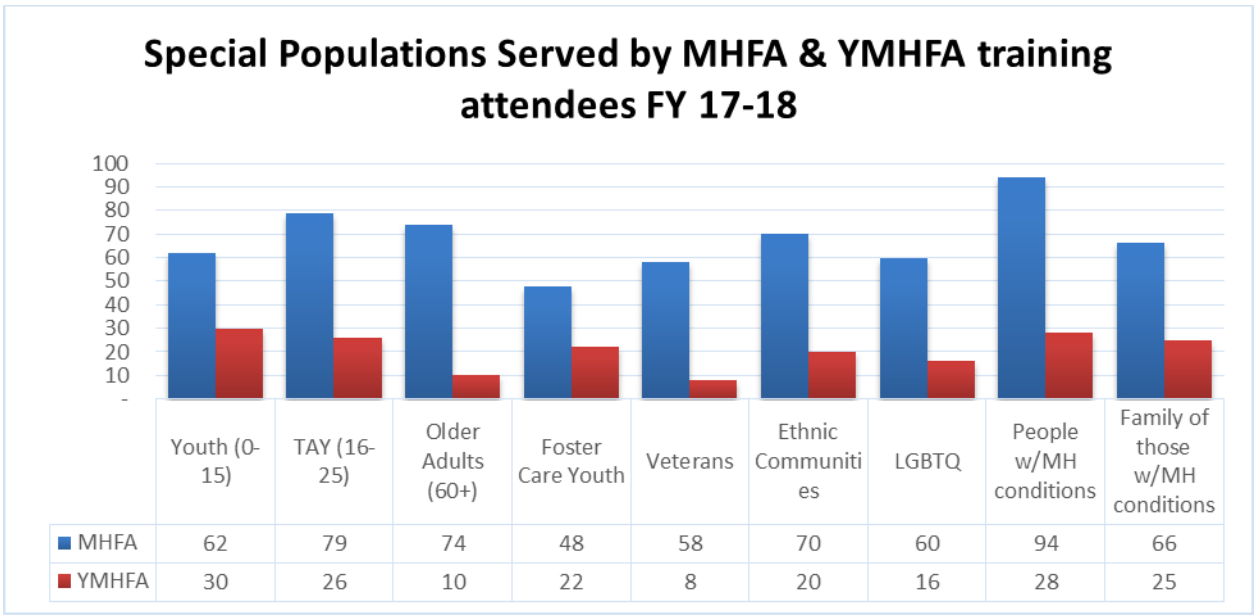


When looking at the populations served by the attendees at MHFA and YMHFA trainings in Fiscal Year 16/17, 73 were youth ages 0-15, 90 were TAY ages 16-25, 57 were Older Adults, 60 were Foster Care Youth, 38 were Veterans, 69 were Ethnic Communities, 67 were LGBTQ, 84 were people with mental health conditions, and 58 were family of those with mental health conditions.



	Youth (0-15)	TAY (16-25)	Older Adults (60+)	Foster Care Youth	Veterans	Ethnic Communities	LGBTQ	People w/MH conditions	Family of those w/MH conditions
MHFA	24	37	31	20	21	22	28	38	32
YMHFA	49	53	26	40	17	47	39	46	26

When looking at the populations served by the attendees at MHFA and YMHFA trainings in Fiscal Year 17/18, 92 were youth ages 0-15, 105 were TAY ages 16-25, 84 were Older Adults, 70 were Foster Care Youth, 66 were Veterans, 90 were Ethnic Communities, 76 were LGBTQ, 122 were people with mental health conditions, and 91 were family members of people with mental health conditions.



	Youth (0-15)	TAY (16-25)	Older Adults (60+)	Foster Care Youth	Veterans	Ethnic Communities	LGBTQ	People w/MH conditions	Family of those w/MH conditions
MHFA	62	79	74	48	58	70	60	94	66
YMHFA	30	26	10	22	8	20	16	28	25

Project Name: Directing Change

This is a continuing project for children and transitional age youth. It is culturally specific social marketing campaign, builds capacity, and provides targeted education and training. It is an effort to combat multiple stigmas that have been shown to discourage individuals from seeking mental health services and to encourage acceptance for individuals with a mental illness. It addresses the negative outcome of prolonged suffering. The target population is adolescents, transitional age youth and school personnel.

Directing Change is a statewide student film contest for youth in grades 7 through 12, as well as those attending a college at any University of California campus. The contest is designed to raise awareness around suicide prevention and reducing stigma and discrimination related to mental illness. A vital component of creating the films requires that students learn about safe messaging related to suicide and mental health, and to incorporate these messages into their submissions. Filmmakers must also structure their content to acknowledge Mental Health Services Act (MHSA), California Mental Health Services Authority (CalMHSA) and the "Know the Signs" campaign.

Humboldt County has become a leader statewide in the creative execution of the Directing Change Youth Film Contest with previous county youth award winners. Program staff will continue to promote the film contest in new schools and alternative/diverse youth settings. Staff works closely with the Humboldt County Transitional Age Youth Collaborative (HCTAYC) staff to plan and execute a years' worth of outreach and activities around supporting youth to become engaged in talking about mental health stigma reduction and suicide prevention. As part of May is Mental Health Matters Month, staff coordinate an evening Red Carpet event to screen films produced. Youth who created films introduce their film at the event.

Goal: Engage youth and adults in suicide prevention and mental health promotion.

Objectives:

1. Promote Statewide contest
2. Provide support for film development and community viewing

Outcome Measures:

1. # of people reached through presentations and film viewings
2. # of informational packets distributed
3. # of films submitted
4. # of people attending the Red Carpet event
5. # of exposures that will happen in theaters
6. # of new youth-serving and/or schools will participate

Implementation Success: Recognition for the Directing Change film contest continues to grow. We are working with schools to incorporate this into curriculum.

There were ten film submissions in FY 16/17 and three new schools/youth groups integrating the Directing Change curriculum. There were ten film submissions in FY 17/18 and three new schools integrating the curriculum. For 18/19, the goal is to show

the Directing Change PSA at ten trainings.

Key Activities:

- Engage adolescents, transitional age youth and adults in creating and viewing films
- Promoting Statewide Directing Change Film Contest to schools and youth groups throughout Humboldt County through community presentations
- Promote local, State, and National resources to broaden support for persons at risk and general community members through distribution of informational/educational resource packets
- Utilize Directing Change films to raise awareness around mental health, suicide, and cultural considerations in various targeted and community formats, i.e., trainings, community events.
- Coordinate local Red Carpet event for Humboldt County residents to view local Directing Change films
- Contract with local theaters to screen Directing Change films during key awareness months (September and May)

OUTCOMES	FY 2016- 2017 N=	FY 2017-2018 N=
Number of youth who participated overall	43	39
Number of films submitted	15	15
# of times DC films shown in movie theaters (Mill Creek and Broadway)	2,240	N/A
# presentations to promote DC	16	11
Estimated # of impressions	6,363	N/A
# of attendees at the Red Carpet event	75	100
Number of participating youth-serving entities Schools	3	3
Youth organizations	1	4

Project Name: Social Marketing

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

Community-wide prevention efforts are designed to educate the broader community on how to identify the signs of mental 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.

Media Campaigns & Toolkits – Healthy Communities Suicide Prevention strategies continue to promote statewide and local campaigns (e.g. purchasing bus ads, print ads,

radio ads, and TV spots) including “Know the Signs,” “Each Mind Matters”, ”Sana Mente,”and “Directing Change” and toolkits including Making Headlines-A Guide to working with the media about suicide prevention, Smartphone app MY3, Culture and Community: Suicide Prevention Resources for Native Americans, Training Resource Guide for Suicide Prevention in Primary Care Settings.

Lock Up Your Lethals – county staff will continue to partner with the Suicide Prevention Network to develop and distribute “Lock Up Your Lethals” educational materials on environmental strategies for safety on reducing access to lethal means through safe storage of firearms and medications and will design a campaign to partner with local gun shops, shooting ranges, and law enforcement to provide suicide prevention materials with a goal of decreasing the number of suicides by firearms.

Awareness Months – Healthy Communities PEI will continue to collaborate with community partners on awareness month campaigns throughout the year with the intention of raising awareness on suicide prevention and its intersection with various health disparities. Events include: May is Mental Health Matters Month, Suicide Prevention Month including the Humboldt County American Foundation for Suicide Prevention Community Walk, Sexual Assault and Child Abuse Awareness Month, and Domestic Violence Awareness Month. Staff will coordinate community efforts and events.

ReFrame Your Brain Poster Contest – Healthy Communities PEI will continue its annual poster contest, inviting all residents of Humboldt County to submit posters with messages of support, hope and recovery. Through participation, participants engage with the topic of mental health (their own or in support of those who live with mental health problems.) Through displays of the posters created and the process of community voting, individuals learn that people with mental health challenges face stigma, that mental health problems can be treated and that community support is important to creating a community that is safe and supportive for all. In FY 16-17, 7 posters were entered. In FY 17-18, 20 posters were entered. In FY 17-18, nearly 200 community members voted on the results of the contest.

Goal: Influence attitudes, beliefs, behaviors of individuals and communities around mental health and suicide through promotion of local, statewide, and national suicide prevention and mental health awareness information, campaigns and toolkits.

Objectives:
1. Reach 2000 Humboldt County residents with EMM and KTS campaign information
2. Design and distribute educational materials through media and events

Outcome Measures:
1. Count of campaign materials distributed/disseminated
2. Frequency of Humboldt County residents exposed to campaign messages

Implementation Challenges and Successes:
Challenges: Measuring specific outcomes for social marketing campaigns. Statewide RAND evaluations show EMM campaigns are associated with more adults using behavioral health services.

Success: It has been helpful to use State and National messaging campaigns that have already been tested for efficacy. For ReFrame Your Brain, printing postcards to raise awareness of contest locally was very helpful. The contest was also posted on Eventbrite.com so community members who weren't able to connect with us via email or word of mouth knew about the contest. People were allowed to vote electronically, which increased community participation and made the contest more accessible. Expanding upon the marketing for this effort in FY 18-19 is planned.

There were 5000 exposures to all aspects of social marketing in both fiscal years. For the next fiscal year, it is expected that at least 5,000 exposures to social marketing will occur.

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: Humboldt County Suicide Prevention Webpage
- Coordinate Awareness Month events with community partners

OUTCOMES	FY 2016-2017 N=	FY 2017-2018 N=
Number of estimated views for Each Mind Matters (bus ads, coasters, coffee sleeves, movie theaters)	37,000	N/A
Number of estimated views for Know The Signs (bus ads, coasters, coffee sleeves, movie theaters)	4,750	4,500
Number of estimated event attendees at community events (tabling at fairs and other events)	9,515	9,550

Project Name: Speakers Bureau

This is a continuing stigma and discrimination reduction and suicide prevention project for transitional age youth, adults and older adults. It is a public and targeted information campaign, capacity building, speakers bureau. It includes efforts to combat multiple stigmas and to encourage self-acceptance for individuals with a mental illness. It addresses the negative outcomes of suicide and prolonged suffering.

Seeds of Change Speaker's Collective: The Seeds of Change is a group of individuals with lived experience related to a mental health challenges. Speakers have experienced stigma and discrimination and use storytelling to increase awareness about mental health, hope and recovery. Speakers develop their stories and perspectives in order to share with community groups and service providers. Healthy Communities stigma and discrimination reduction efforts helped create and has provided technical and capacity building assistance to the "Seeds of Change" speakers' collective such as assisting with agendas, coordinating speaking engagements, providing educational materials and skill development trainings. The target population for speakers' presentations include

employers, landlords, elected officials, school personnel, behavioral and medical providers, community members, law enforcement, and first responders.

Goal: Reduce the stigma and discrimination associated with having a mental health diagnosis/challenge by replacing misconceptions with stories of recovery.

Objectives:
1. Educate community members on the experience of mental health
2. Reduce stigma and discrimination
3. Build resiliency and recovery through leadership opportunities

Outcome Measures:
1. Demographic forms
2. # of participants trained
3. # of presentations offered
4. # of new speakers

Implementation Challenge: Supporting the growth and sustainability of the Speaker's Collective. Other mediums, such as, Digital Stories, are being used as a way to bring in lived experience to community events and trainings when no speakers are available. The goal was to have four speakers' events in FY 16/17 and four in FY 17/18. This goal was not met, as there were three in 16/17 and two in 17/18. The goal for 18/19 is for two speakers events.

Key Activities:
- Provide technical assistance, skill building trainings for speakers, and collaborate with speakers to provide training opportunities.
- Coordinate culturally appropriate trainings for groups that work with diverse and underserved/un-served populations such as monolingual Spanish speakers, LGBTQ, TAY, and Native and Tribal communities.
- Promote Seeds of Change events through community outreach and advertising activities in local media.

OUTCOMES	FY 2016-2017	FY 2017-2018
# of events	3	2
# of participants	47	44
# of new speakers trained to present their stories	0	0

Project Name: Direct Contact Approaches

This is a continuing stigma and discrimination reduction and suicide prevention project for transitional age youth, adults and older adults with lived experience, including survivors of suicide loss. It is a community program that includes underserved populations (LGBTQ, Native American, Latino and women.) It includes efforts to combat to combat multiple stigmas and to encourage self-acceptance for individuals with a mental illness. It addresses the negative outcomes of suicide, prolonged suffering and homelessness.

Artistic solutions is a locally developed strategy that provides groups for persons with

lived experience to express themselves through artwork. Guided art exercises incorporate a variety of media including pastels, collage, quilting, sculpture and more. Groups are topic focused and the art work is the expression of the topic such stigma and discrimination reduction, suicide, family violence, alcohol and other drugs, adverse childhood experience, trauma, resiliency and recovery. Staff facilitates discussions and supports participants in sharing their experiences through peer support. Art projects developed by consumers are shared at community events to raise awareness of mental health challenges and reduce stigma and discrimination.

Goal: Provide persons with lived experience ongoing support, connection to peers, increase network of supports, opportunities for creative expression, and reduce negative impact of stigma.

Objectives:
1. Increase peer to peer support for persons with lived experience
2. Support creative expression

Outcome Measures:
1. Attendance at scheduled workshops
2. Number of individuals who actively participate in Artistic Solutions project at outreach events (PRIDE, Health Fairs, etc.) by creating quilt square messages
3. Number of contacts at outreach events
4. Number of educational quilts created
5. Number of locations at which quilts are displayed

Implementation Challenges and Successes:
Success: Artistic Solutions groups are held at the Peer run Hope Center. Groups provide a safe, supportive environment for persons with severe mental illness.
Challenge: Participants are not required to fill out a pre/post survey and a demographic form. Tracking data comes from sign-in sheets.
The goal was to have 80 workshops in FY 16/17 and 80 in FY 17/18. This goal was exceeded, as show in the Outcomes table below. The goal for 18/19 is 80 workshops.

Key Activities:
- Coordinate, plan and facilitate support groups for persons with lived experience
- Provide consumers with ongoing opportunities for self-expression to combat stigma, increase peer support, and broaden network of support
- Create art for use at community events to raise awareness around suicide prevention, mental health challenges and stigma reduction

OUTCOMES	FY 2016-2017	FY 2017-2018
# of Workshops	82	87
# of participants (may be duplicated)	419	456
# of quilt squares produced	125	39
# of Quilts produced	6	10
# of events/locations where Quilts are displayed	6	5

Prevention & Early Intervention: TAY Advocacy and Peer Support

Target Population

TAY (Transition Age Youth) Advocacy and Peer Support MHSA Program serves youth and young adults ages 16-26 years old. The Humboldt County DHHS Transition Age Youth (TAY) Division consists of co-located DHHS services, including Behavioral Health, Extended Foster Care (EFC), Independent Living Skills (ILS), the Humboldt County Transition Age Youth Collaboration (HCTAYC), and TAY Peer Coaches. In addition, the TAY Division utilizes supports and services from DHHS departments including Public Health, Employment Training Division, CalFresh, Medi-Cal, Alcohol and Other Drug services, and collaborates with community partners such as Juvenile Probation and Family Resource Centers.

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

- A behavioral health team providing specialty mental health services (individual and family therapy, case management, and referrals for psychiatric services), including a supervisor, clinicians, and case managers
- A substance abuse counselor from the Adolescent Treatment Program
- Child Welfare Services (CWS) Independent Living Skills (ILS) program serving youth ages 16 to 21
- CWS Extended Foster Care unit
- HCTAYC staff and a Youth Advisory Board
- Peer Coaches who serve across the TAY Division
- A Vocational Counselor from the DHHS Employment Training Division
- Public Health Nursing, which assists with health care needs
- Linkage and referrals to Wraparound Services as needed

This narrative includes the information for the Three Year PEI Evaluation Report.

Needs/problems addressed by TAY Advocacy

The MHSA 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 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, named the Humboldt County Transition Age Youth Collaboration (HCTAYC), launched in 2008. Program collaborators have changed over time and currently consist of: youth 16-26, DHHS, California Youth Connection, Youth In Mind, and Youth MOVE National. 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, regulation, 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 transition age youth 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 CANS. 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.

This is a prevention program which, along with TAY Peer Coaches, address components of: early intervention, outreach, stigma and discrimination reduction, and outreach for increasing the recognition of early signs of mental illness. 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.

TAY Advocacy Activities

The TAY Advocacy Program/HCTAYC consists of: a shared Supervising Mental Health Clinician, three Youth Organizers, and Youth Advisory Board that provides input and brings a youth voice to program development. The HCTAYC Youth Advisory Board is trained extensively in facilitation, public speaking, and leadership. HCTAYC's areas of focus for systems improvement include: mental 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.

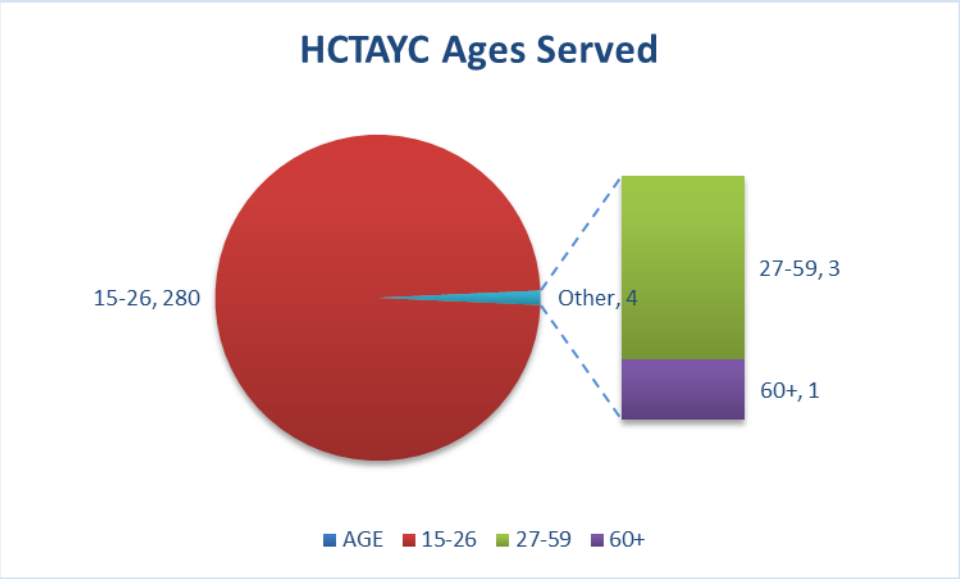
1. **Trainings** for professionals and community members focus on TAY-specific behavioral health challenges and the engagement of this population, including special populations particularly impacted by stigma and discrimination such as LGBTQ youth,

indigenous youth, foster youth, and youth experiencing substance misuse and abuse. Trainings take a cultural competence and/or cultural humility approach, with specific youth-developed curriculum that focuses on youth culture, including youth in decision making tables, communicating with youth, serving transgender and gender diverse youth, serving deaf and hard of hearing youth, LGBTQ foster care rights, sexual health, crisis intervention, and serving youth with substance misuse and abuse challenges. The facilitation of **events** focuses on concepts of mental health stigma reduction, outreach and information regarding mental health services, and wellness resilience development. These events occur in multiple formats, all of which are youth-driven, including HCTAYC's annual wellness week, National Children's Mental Health Awareness Day activities, critical thinking movie nights, and participation in the state-wide Directing Change Mental Health Awareness PSA Contest.

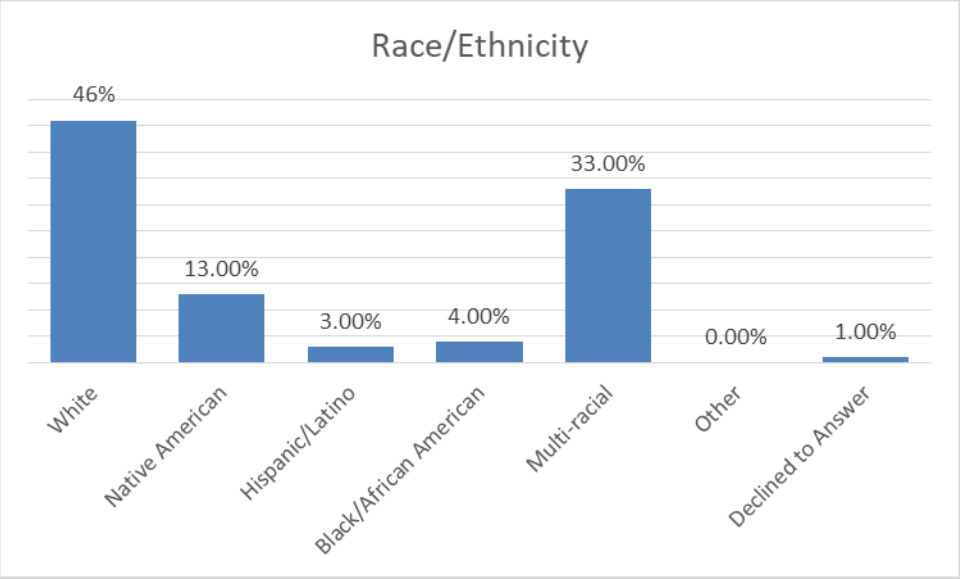
2. **Advocacy** is operationalized through two means, through systems change and individual advocacy. Systems advocacy is enacted through youth organizers supporting the youth advisory board to attend and participate in policy setting or decision making tables or correspondence. This includes participation at local policy tables such as the Behavioral Health Board, statewide opportunities such as MHSOAC Innovations Events or legislative hearings, and national tables such as SAMHSA's LGBTQIA2-S Workgroup. Individual advocacy occurs when HCTAYC Youth Organizers support TAY youth in self-advocacy during their own care coordination and participating in advocacy to amplify the youth's wishes and assisting youth in preparing speaking points for their wraparound meeting and then attending the meeting 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, to prevent the emergence of mental health conditions or reduce prolonged suffering and progression. This development is the transference of skills to, and the continual support and supervision of, youth advisory board 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. 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 three day retreat. The format of the youth advisory board, with multiple affinity-based committees, allows members to develop connections with peers with similar lived experiences, while also receiving consistent support and guidance from HCTAYC youth organizers. Youth exercise autonomy through identifying program priorities, modifying program function, and by driving content creation. Youth exercise competence via the provision of trainings, engaging in advocacy, and successfully planning events. Additionally, extensive studies have demonstrated that youth leadership programming increases self-efficacy - which is an important indicator for the reduction of harmful actions such as self-harm and suicide.

Data Report. From July 2016 through June 2018 HCTAYC has facilitated or provided advocacy, education and outreach training at events resulting in 408 sign-ins. Of those who signed in, there were 99 recorded unique visitors. Among these visitors, 284 (67% of sign-ins) completed demographic forms

HCTAYC provides trainings to people of all ages with targeted focus on transition age youth. Between July 2016-June 2018 the program's participants who disclosed their ages were almost all between ages 15-26, with only three people ages 27-59 and one age 60+.

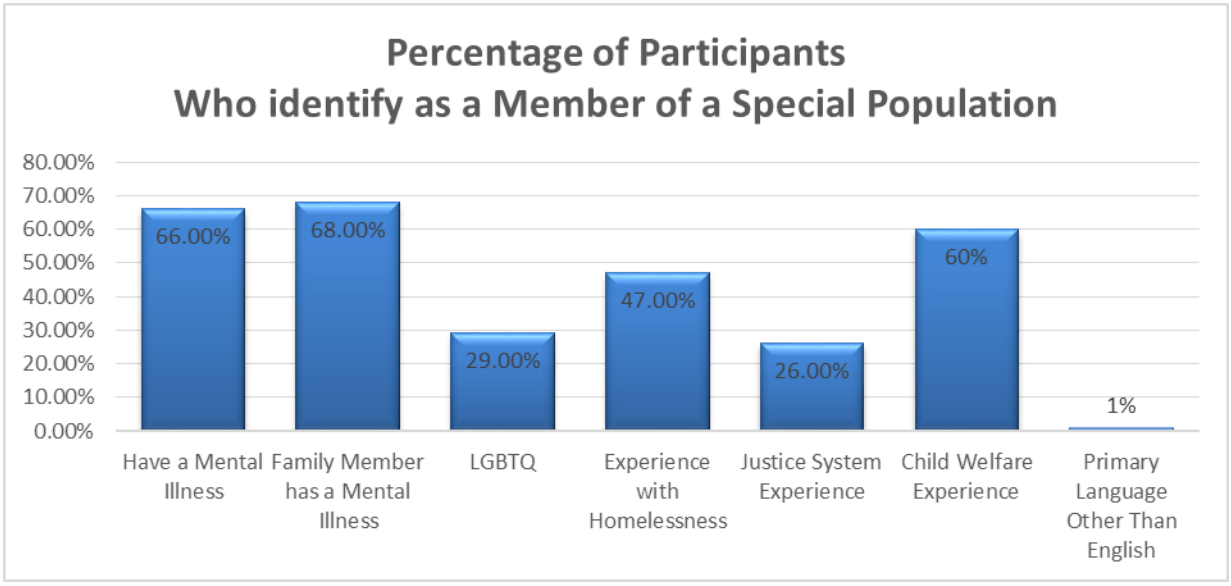


As the chart below shows the percentage of HCTAYC participants who identify as White is 46%. Those who identify as Native American is 13%. Those who identify as Hispanic/Latino(a) is 3%. Those who identify as Black/African American is 4%.Those who identify as Multi-racial is 33%. Those who declined to answer is 1%.



As shown in the chart below, 66% identified as having a mental illness, 68% identified as being a family member of someone with a mental illness, 29% identified as LGBTQ, 1% as having a language other than English as their primary language, 47% with having experience with homelessness, 26% with having experience with the justice system, and 60% with having experience with Child Welfare. These are all life experiences that are

impacted by stigma and discrimination that can result in challenges to successful mental health access and treatment. This chart illustrates how efforts to include people with these unique life experiences is resulting in their participation in HCTAYC. HCTAYC will continue to expand and further their goals in order to meet the needs of youth and young adults in Humboldt County.



TAY Advocacy Targeting and Outcomes

Need for services are assessed through targeting system involved youth, with an integrated self-selection referral system and application process utilizing ongoing collaborative relationships with other parts of the TAY system of care.
Training outcomes are collected and measured through a combined MHSA Demographic and Evaluation Form that is standardized in DHHS PEI Programs. Additionally, number of individuals trained is collected through sign-in sheets.

Youth Leadership Development Programming outcomes are collected through a proprietary leadership and wellness self-assessment and plan and is completed by program participants quarterly.

TAY Advocacy Accomplishments and Awards

Below is a partial list of HCTAYC's fiscal year 2016-2018 accomplishments.

2016

4th Annual Wellness Week
Sponsored Bills & Testified
Foster Youth Bill of Rights - Passed
Foster Youth Medication - Passed
Ended YIM Contract
Attended Conferences
8th Annual Digital Stories
Directing Change - Won 3rd & 5th in State
Updated Theory of Change
Founding Youth Organizer becomes State Foster Ombuds

New TAY Building Planning
AOD Policy Recommendations
TAY Job Ladder Improvement
    WEX
    Part-Time Peer Coaches
Strategic Planning

2017

Started Manualization Process
Restructured & Expanded Youth Advisory Board (YAB)
Presented & Implemented AOD Recs
YAB Member named Youth Advocate of the Year by Young Minds
Started Youth Substance Misuse & Abuse Training for Professionals
2nd Youth Photography Retreat
Youth Organizer Elected to CMHACY Board
Provided Over 7 Trainings on Youth Issues and Policy
Launched YAB Committees
2nd Annual Directing Change Red Carpet
9th Annual Digital Storytelling Trip
5th Annual Wellness Week

2018

Hosted Native Youth Heritage Day
Planning for a local Cultural Exchange
HCTAYC Shook Up MHSOAC Innovations Summit
YAB Members on CMHACY Policy Panels
YAB Member on Panel at Adolescent Mental Wellness Conference @ Stanford
2nd Place and Honorable Mention in Directing Change!
Hosted a YAB Retreat in Fort Bragg
Presented 5 Community Trainings
Hosted Public Speaking Training
Youth Organizer awarded Advocate of the Year by Young Minds
10th Digital Story Trip
6th Annual Wellness Week

TAY Peer Support Activities

The integration of peer coaches within the TAY Division is a prevention program with components of early intervention and access and linkage to treatment. The TAY Peer Support 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 rotating quarterly between each of the Division's programs (HCTAYC, Behavioral Health, Independent Living Skills, and the Drop-in 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 provides: mentoring,

instill hope, empower and help young people build self-esteem, and assist in system navigation and self-advocacy. Peer Coaches have the capacity to engage with young people through shared lived experiences, making them unique in their ability to relate, provide support, and model: self-advocacy, recovery and self-care skills. Peer coaches build relationships with young people in ways that create validation, inspire hope, and support program participants through empowerment and trust. Peer coaches build mutuality in their relationships with young people, creating a relationship built on respect, compassion, and reciprocity. Through this unique relationship, young people are able to build self-determination, self-esteem and gain skills necessary for transition into adulthood. Relationship building is done by providing individual meetings both at the TAY Center and in the community, utilizing shared experiences, in vivo role modeling and teaching, and exploring strengths and needs of the young person from the Transition to Independence Process (TIP) model. Peer coaches are able to assist young people in building their relational capacity by supporting them when accessing social, vocational, or educational opportunities.

2. **Outreach and engagement** is provided both to young people for linkage to services and to the community to inform them of services available to transition age youth and to support the reduction of stigma and discrimination toward the systems-involved transition age population. Outreach is provided in multiple ways, from referrals for services, new youth to enter the TAY Center drop-in space, community-wide presentations and tabling events. Peer coaches provide regular outreach to the psychiatric hospital, jail and juvenile hall, to schools, family resources centers, tribal organizations and team with other community partners for street outreach to youth experiencing homelessness. Over all, 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.
3. **Linkage** to resources support interagency needs, such as increased youth engagement across programs, improved linkage of needed services, stigma reduction, greater understanding of lived experiences, increased advocacy, improved relationship with providers, and the ability to show staff and youth recovery is possible. Peer coaches assist young people with referrals to services and support them in appointments or activities. Peer coaches often serve as a bridge between the young person and services, providing warm hand offs from psychiatric hospitalizations, incarceration or walk-ins to service providers, activities, or other resources.
4. **Activity coordination** is done to provide transition age skill development opportunities for young people. Peer coaches collaborate or take the lead in 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 space, where young people can access service providers, computers, linkage the CalFresh and food resources, clothing closet and hygiene supplies, to workshops on self-care, healthy relationships, wellness, and life skills.

TAY Advocacy Targeting and Outcomes

Need for peer coach services are assessed through targeting system involved youth, with an integrated self and community based referral system. Between August 2017-June 2018, 80 referrals were made for TAY Peer Coaching, including referrals from

HCTAYC, Independent Living Skills, Behavioral Health, Probation, Schools, and youth experiencing homelessness.

Access to the TAY drop-in space and selected events and workshops are collected by sign-in sheets. Comprehensive data collection and outcomes have been challenging to achieve due to staffing capacity, consistent program oversight, and is identified as an area of growth needed within the peer coach advocacy component of DHHS PEI programs.

One future goal of TAY peer coaches is to link documentation of services for youth involved in behavioral health services into an electronic medical records system. Peer coach outcomes would then be tracked by linkage to the overall case plan. Currently, a tracking sheet is used to monitor referrals to support engagement and linkage to treatment. In addition, peer coaches attend a weekly case consultation with the behavioral health unit in which staff are able to communicate referral needs, progress made towards engagement and progress of treatment.

Data for sign-in sheets for drop-in and selected events and workshops began in November 2017 through June of 2018. Of the data collected, 297 duplicated youth participated in TAY services and of the 297, 158 were unduplicated young people.

TAY Peer Support Accomplishments and Awards, August 2017-June 2018
Presented to Adult Probation November 11/2017 (15 probation officers)
Presented to Juvenile Probation 11/2017 (15 probation officers)
Presented to Von Humboldt School 11/2017 (15 students)
Presented to Eureka Resource School (ERC) 10/17 (25 students)
Presented to HCOE 9/2017 (150 people)
Tabled at Day of Hope 10/2017 (250 people)
Tabled at HACHR Overdose Awareness day 9/2017 (100 people)
Presented to Zoe Barnum School 2017 (5 admin staff)
Presented to Adult Probation July 2018 (15 probation officers)
Facilitated three group activities in the Regional Facility between 2017-2018
Tabled at MAY is Mental Health Matters Month in Eureka and Willow Creek May 2018

Training Peer Coaches Attended:
Housing First
ASIST-Suicide Prevention
INaps conference
Naloxone Training
ADA and Media Compliance Training
Boundaries
Brief crisis response
Mental Health First Aid-2018
#Foster Smart presented by YTP
Professionalism, burnout and boundaries, facilitated by CYC staff, April 2018
TIP-Transition to Independence Process
Medical Billing and Documentation
Mandated Reporting

Peer Coaches Provided Outreach to:
Juvenile Hall
Humboldt County Correctional Facility-Jail
Sempervirens and the Crisis Stabilization Unit
Eureka Resource Center-ERC school
Street outreach-Arcata, Eureka, Fair Haven
Willow Creek, Hoopa
Raven Project
Eureka Family Resource Center

Workshops, Groups and Events Lead by Peer Coaches
Dress to Impress-how to dress professionally
Self-Care Skills
Yoga and stigma reduction awareness for MMHMM
Hiking and wellness
Stones that Heal wellness
Sugar Scrubs and Self-Care
Fitness Friday
Support with Mommy and Me Group
Role-play group
Healthy Relationships
Sewing skills
Cooking demonstrations

It is estimated that approximately 150 TAY will be served in Fiscal Year 18/19.

Prevention & Early Intervention: Parent Partners

The Parent Partner Unit aims to build peer-based alliances to support families as they encounter mental health and other County systems. Peer partners build alliances with child-serving systems through strategic self-disclosure of their lived experiences as parents of a youth with emotional, behavioral, mental health or substance abuse needs. Parent partners provide support as a peer rather than an expert in the field. They create conditions for parents/caregivers to feel empowered and confident as they navigate county systems making decisions that are best for their family and to determine their course of action.

This narrative includes the information for the Three Year PEI Evaluation Report.

Parent Partners offer assistance in navigating the DHHS system, linking parents/caregivers with community resources, building natural supports and helping parents/caregivers identify their personal wellness goals to promote self-care. Parent Partners are often members of Wraparound Teams serving youth with intensive needs. Sometimes, they are early responders by request of DHHS staff to offer various types and levels of support to parents at risk of having a child removed from their care. Parent Partners build relationships with other departments and agencies including Probation to assist parents/caregivers whose children have been placed out of county or are currently in programs like New Horizons Regional Facility or a foster care facility. Parent Partners are co-facilitators at the County's Family Advisory Board meetings and several NAMI peer support groups offered in the county. They are available to parents/caregivers of children receiving services within the Adult Mental Health system by being visible to families and staff during visitation hours at the Sempervirens Psychiatric Health Facility. Parent Partners reach out to approximately 45 people per week. This outreach is done primarily at Sempervirens, Family Resource Centers, and directly to families and caregivers in the community.

The Parent Partner Unit employs three Full Time and one Part Time staff to provide strategic services to parents/caregivers involved in the DHHS system-Public Health, Child Welfare, Probation, and Mental Health programs. The most senior PPSP staff member completed certification as a Parent Peer Support Partner Coach through the National Wraparound Implementation Center (NWIC). Another of our Parent Partners is in the process of becoming a certified coach with guidance from the Family Involvement Center of Arizona and will complete certification by the end of 2018. Two of our Parent Partners have been credentialed by the National Federation of Families for Children's Mental Health as Certified Parent Support Providers (CPSP). The CPSP credential is to ensure that people employed in this field meet consistent and high standards of performance when helping other parents who have children experiencing social, emotional or behavioral health challenges. Certification promotes ethical practice within the workforce so parents with experience in successfully helping their own children can support parents in their unique journey to make decisions that are best for themselves and their children without judgement, bias, or stigmatization.

DHHS added a Parent Partner III position to take on more responsibility for training and mentoring staff. We are also currently in the process of interviewing for two vacant Full Time Parent Partner positions to grow our team. The County has also contracted with a

Part Time Mentor with lived experience and dedicated involvement in NAMI who teaches Parent Partners “NAMI Basics” and “Family to Family” curriculum to enhance and develop various types of skills.

During Fiscal Year 2016-17, 61 parents/caregivers were served by Parent Partners. During Fiscal year 2017-18, 27 parents/caregivers were served. Of those served in 17/18, 16 (59%) were age 60+, one (4%) person was age 16-25, and 10 (37%) were ages 26-59. Nineteen (70%) stated their ethnicity was White, one (4%) was American Indian, four (15%) were Multi-racial, one (4%) was Other, and two (7%) preferred not to answer. One person’s primary language was Spanish, for the rest it was English. One person stated sexual preference as gay/lesbian and one was questioning. Three preferred not to answer, and 23 (85%) were heterosexual. Eight (30%) were male and 19 (70%) female. Eight (30%) stated they had been homeless at one time. Eleven (41%) had experienced a mental health condition and 25 (93%) had a family member with a mental health condition.

It is estimated that approximately 30 parents/caregivers will be served in Fiscal Year 18/19.

Prevention & Early Intervention: Local Implementation Agreements

During the period of grant funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) for the Humboldt County Children's Mental Health System of Care Expansion, an opportunity was available for community-based organizations, governmental partners, and DHHS to partner in improving the health of children, youth, young adults and families. Over three years during the SAMHSA funding, 51 "Humboldt BRIDGES Partnership Agreements" were awarded to 28 organizations to address the System of Care goals, including building trauma informed systems, family driven/youth guided, infant and child mental health, cultural and linguistic competence, partnerships, and increasing integration, among others. These agreements supported projects that arose from the community and its stakeholders and focused on the needs, issues and concerns that community members felt were most pressing in their communities. Almost one million dollars was awarded through these Partnership Agreements.

During the years that these Agreements were provided, Humboldt BRIDGES partners, including over 50 agencies, community groups and organizations, provided continuous feedback as to the value of the Partnership Agreements. At monthly Central Team meetings of Humboldt BRIDGES, at Educational Leadership meetings with DHHS and Humboldt County Office of Education and local school districts, and at quarterly Humboldt Network of Family Resource Centers meetings, stakeholders reiterated over and again the value of the grants in their focus on the needs and concerns identified by the community itself, and the desire to continue to fund locally developed projects.

In response to this stakeholder input, Prevention and Early Intervention dollars will be used for PEI Local Implementation Agreements beginning in fiscal year 2018-19. The Local Implementation Agreements and the process for soliciting proposals is modeled on the BRIDGES. Proposals are required to meet the guidelines, definitions and reporting requirements of the Prevention and Early Intervention Regulations. Following those Regulations, funded projects will focus on at least one of the following:

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

Projects for fiscal year 2018-19 will begin by January 1, 2019 and will go through June 2019. For the succeeding fiscal year it is anticipated that projects will be able to begin by July 1, 2019 and run for a full year.

As of the writing of this Annual Update, four projects have been approved for funding.

- Dispelling Stigma: Hoarding Education, Treatment and Prevention Conference
- Childhood Early Mental Health Prevention and Intervention Program
- Social, Emotional, Mental Health Student Engagement
- Expansion of MInD-I Project

Prevention & Early Intervention: School Climate Curriculum Plan/MTSS

Background

Increasing the recognition of early signs of emotional disturbance or mental illness for children in a school setting was an identified need of the MHSA Community Planning Process. In fiscal year 2014-15 the suspension rate in Humboldt County schools was 6.1, almost twice the State rate of 3.8. Following the identification of this need, a stakeholder process occurred that included surveying school superintendents, administrators, teachers, counselors and gathering information through various community stakeholder groups and from DHHS staff. This led to DHHS and the County Superintendent of Humboldt County Office 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) curriculum.

MTSS is a framework used to support schools in 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. Schools utilizing a multi-tiered framework responsive to student needs through early systematic intervention - have less discipline referrals, suspensions, and expulsions and show higher academic achievement scores.

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

The following core components are key aspects of MTSS frameworks:

1. High-quality, inclusive academic instruction promoting comprehensive assessment systems, teaming, universal academic supports, and intensified interventions and supports focused on early intervention and prevention.
2. Systemic and sustainable change. MTSS principles promote continuous improvement processes at all levels of the system (district, school site, and grade/course levels). Collaborative restructuring efforts identify key initiatives, collect, analyze, review data, implement supports and strategies based on data are then refined as necessary to sustain effective processes.
3. Integrated data system. District and site staff collaborate to create an integrated data collection system for continuous systemic improvement.
4. Inclusive behavioral instruction. District and school staff collaboratively select and implement schoolwide, classroom, and research-based positive behavioral supports for achieving important social and learning outcomes.
5. Social-emotional learning (SEL) for all students using evidence-based methods.
6. Universal design for learning (UDL) – structural, multi-modal, instructional practices promoting learning for all students. UDL learning environments are inclusive environments for students with a vast array of learning differences.

7. Family and community engagement to build trusting family and community partnerships.
8. Inclusive policy structure and practice by building strong district/school relationships with the coordination and alignment of multi-initiatives through district policy frameworks.

2016-17 School Year Program Description:
In school year 2016-17, twenty-two Humboldt County schools were a part of the MTSS Coalition. Schools partnering with the HCOE Northern CA MTSS Coalition represent districts/sites that have participated in the two-day PBIS Summer Institute and receive ongoing consultation, and technical assistance provided through the HCOE. Additionally, these schools have access to Professional Learning Communities (PLCs) to strengthen implementation and build capacity through a county supported network. PLCs support site-based teams and coaches.

It is important to note that the Northern CA MTSS coalition supports districts who are not partnered in the coalition by providing “ala carte” services, and professional development opportunities including but not limited to:
• Check-in Check-out (CICO) Trainings – a tier two intervention to support students
• Classified Staff Trainings
• School Wide Information System (SWIS) Certified Facilitators
• Restorative Practices Training and Facilitation
• Trauma Informed Practices and PBIS
• PBIS in Alternative School Settings Training (Juvenile Hall/Community School)
• Common Area Supervision Trainings
• Classroom Management Trainings
• Fidelity Checking and Consultation
• Bus Driver Training
• Positive Behavior Intervention and Supports
• Social Emotional Learning
• Mindfulness
• Fidelity Measure Implementation, Analysis and Action Planning

Activities Supported by PEI Funding:
County-Wide Professional Development:
The 2016 MTSS Coalition Summer Institute Cohort 2 was a two-day professional development experience for Coalition teams. Teams participated in the two-day institute providing training and technical assistance to support initial implementation of PBIS.
Sites included:
• HCOE Court and Community Schools in Partnership with Probation (Juvenile Hall and Regional Facility) – Educational Resource Center (ERC), Eel River Community School, New Horizons, and VonHumboldt Juvenile Hall School.
• Blue Lake School District
• Northern Humboldt Unified High School District – Arcata High School, McKinleyville High School, and Pacific Coast Charter School
• Trinidad School District
• Arcata Elementary School District – Arcata Elementary School and Sunny Brae Middle School

• Loleta Elementary School
• Pacific Union School District

2017 SHIFT Symposium (Toward School Climate Transformation in Rural California)
This two-day regional conference at HCOE's Sequoia Conference Center included national and regional presenters focused on school climate, equity, intervention and cultural competencies. Topics included – equity, PBIS, trauma informed education and intervention, restorative practices, mindfulness, universal design for learning, inclusion, cultural education, social-emotional learning, MTSS in rural California, technology, dramatic arts education, and data-based decision making. Keynote speakers included Dr. Mark Katz and Jessica Pettitt.
The event was filled to capacity with 150 attendees.

National Conference and Training Professional Development:
PBIS National Leadership Forum, Chicago, Il. (October 26th and 27th, 2016)
2 Attendees

International Institute for Restorative Practices – Final Trainer of Trainer for Restorative Conferencing, Bethlehem, PA. (September 14th-16th, 2016).
2 Attendees that are currently licensed trainers of Restorative Practices for the International Institute of Restorative Practices – IIRP.

Over 100 educators and community agency members have participated in 2-day professional development opportunities in Restorative Practices because of this funding support to establish licensed trainers in Humboldt County. Restorative Practices is a practice the builds community, reduces bullying, is trauma informed, and explores alternative and inclusive discipline practices.

CA PBIS Coalition Conference, Sacramento, CA. (September 22nd) This state-wide conference provides professional development to educators and agency participants toward PBIS implementation.
3 Attendees

APBS (Association of Positive Behavior Supports) National Conference, Denver, CO. (March 1-4, 2017) National Conference on PBIS, Trauma Informed Practice, and MTSS.
2 Attendees

Northwest PBIS Spring Conference, Portland, OR. (February 22nd-24th, 2017) This regional PBIS conference provided professional development and training for participants.
8 participants.

Direct Support/Materials:
Educational materials, curriculum, training materials (for PBIS and Restorative Practices), and the establishment of an MTSS lending library were supported through this valuable underwriting.

2017-18 School Year Program Description:
In school year 2017-18, twenty-four Humboldt County schools were a part of the MTSS Coalition. Schools partnering with the HCOE Northern CA MTSS Coalition represent districts/sites that receive ongoing consultation, and technical assistance provided through HCOE. Additionally, these schools have access to Professional Learning Communities (PLCs) and Coaches Meetings to strengthen implementation and build capacity through a county supported network. PLCs and Coaches Meetings support site-based teams and coaches.

It is important to note that the Northern CA MTSS coalition supports districts who are not partnered in the coalition by providing “ala carte” services, and professional development opportunities including but not limited to:
• Check-in Check-out (CICO) Trainings – a tier two intervention to support students
• Classified Staff Trainings
• School Wide Information System (SWIS) Certified Facilitators
• Restorative Practices Training and Facilitation
• Trauma Informed Practices and PBIS
• PBIS in Alternative School Settings Training (Juvenile Hall/Community School)
• Common Area Supervision Trainings
• Classroom Management Trainings
• Fidelity Checking and Consultation
• Bus Driver Training
• Positive Behavior Intervention and Supports
• Social Emotional Learning
• Mindfulness
• Fidelity Measure Implementation, Analysis and Action Planning

Activities Supported by PEI Funding:
County-Wide Professional Development:
The 2017-18 MTSS Coalition Summer Institute Cohort 2 was a two-day professional development experience for Coalition teams. Teams participated in the two-day institute providing training and technical assistance to support initial implementation of PBIS.
Sites included:
• Garfield Elementary School
• Redwood Preparatory Charter School

National Conference and Training Professional Development:
2017 MTSS Coalition Institute: Cohort 3 (Q1)
2018 SHIFT Symposium: School Climate Summit (Q4) (Cancelled)
2017 Northern CA MTSS Coalition Coaches Retreat (Q2)
2017-18 Children's Mental Health PLC (Q1-Q4)

Staff Development to Support Capacity Building and Scale
PBIS Leadership Forum, Chicago, IL Q1 September 26-29
IIRP World Conference (International Institute for Restorative Practices), Bethlehem, PA Q2 October 22-26
California PBIS Coalition Conference, Sacramento, CA Q1 Oct 11 -12

Association for Positive Behavior Support (APBS), San Diego, CA Q3 March 2018

Direct Support/Materials:
Educational materials, curriculum, training materials (for PBIS and Restorative Practices), and the establishment of an MTSS lending library were supported through this valuable underwriting.

2018-19 School Year Proposed Program Description:
In school year 2018-19, approximately eleven additional school sites will join the Northern CA MTSS Coalition, bringing the number of participating schools to thirty-one. Continuing and new schools partnering with the HCOE Northern CA MTSS Coalition represent districts/sites that will receive ongoing consultation, and technical assistance provided through HCOE. Additionally, these schools will have access to Coaches Meetings to strengthen implementation and build internal capacity through a county supported network.

The Northern CA MTSS coalition plans to continue its support efforts to districts who are not partnered in the coalition by providing “ala carte” services, and professional development opportunities including but not limited to:
• Check-in Check-out (CICO) Trainings – a tier two intervention to support students
• Classified Staff Trainings
• School Wide Information System (SWIS) Certified Facilitators
• Restorative Practices Training and Facilitation
• Trauma Informed Practices and PBIS
• PBIS in Alternative School Settings Training (Juvenile Hall/Community School)
• Common Area Supervision Trainings
• Classroom Management Trainings
• Fidelity Checking and Consultation
• Bus Driver Training
• Positive Behavior Intervention and Supports
• Social Emotional Learning
• Mindfulness
• Fidelity Measure Implementation, Analysis and Action Planning

Activities Supported by PEI Funding:
District Team Site Visits to Model PBIS/MTSS Schools in Northern CA. Recognized by California PBIS Coalition for excellence in implementation. Dates TBD.

IIRP World Conference (International Institute for Restorative Practices) Detroit, MI Q2 October 24-26 2 Participants
California PBIS Coalition Conference, Sacramento, CA Q1 September 24-26 2018
10 Participants

Direct Support/Materials:

Educational materials, curriculum, training materials (for PBIS and Restorative Practices), and the establishment of an MTSS lending library were supported through

this valuable underwriting, as well as an underwriting for 26 school sites coalition yearly dues.

The PEI support of the Northern CA MTSS Coalition has provided training and support for hundreds of educators in Humboldt County in a myriad of domains of school climate transformation and multi-tiered interventions targeting all student groups in Humboldt County. Universal interventions focused on prevention and early intervention for all student groups to improve academic, behavioral, and social-emotional outcomes is an evidence-based approach to align learning initiatives and state mandates to improve the mental health outcomes of students. This occurs through system change, improved responsiveness, improved discipline practices, community building, social emotional learning, trauma informed practices and cultural and community engagement. The training, technical assistance, coaching, teaming, and shift in practice afforded by preventative interventions will ultimately impact the intensive needs of our community by building mentally healthy learning environments and practices in our local schools, and build and strengthen collaborative efforts between agencies, tribal entities, and the community at large.

Example of Data Being Collected for Year End Reporting:

The following data example is from South Fortuna Elementary School. South Fortuna Elementary School is located in Fortuna, CA. They have approximately 340 students, K-4th. Approximately 89% of their population is considered Socioeconomically Disadvantaged, 40% English Learners, and less than 1% Foster Youth.

2015/16 versus 2016/17 Suspension Rates: The table below shows that total suspensions went from 29 to 23 in one year, with a suspension rate going from 4.5% to 3.8%, and percent of students suspended with multiple suspensions going from 41.2% to 14.3%.

Name	Cumulative Enrollment	Total Suspensions	Unduplicated Count of Students Suspended	Suspension Rate	Percent of Students Suspended with One Suspension	Percent of Students Suspended with Multiple Suspensions
South Fortuna Elementary 2015-16	382	29	17	4.5%	58.8%	41.2%
South Fortuna Elementary 2016-17	370	23	14	3.8%	85.7%	14.3%

California Assessment of Student Performance and Progress (CAASPP). These charts describe achievement in English Language Arts/Literacy and Mathematics.

2015 English Language Arts/Literacy

Overall Achievement

	3rd Grade	4th Grade
Number of Students Enrolled	78	71
Number of Students Tested	75	70
Number of Students With Scores	75	70
Mean Scale Score	**2341.1**	**2398.2**
Standard Exceeded: Level 4	4 %	1 %
Standard Met: Level 3	4 %	16 %
Standard Nearly Met: Level 2	27 %	26 %
Standard Not Met: Level 1	65 %	57 %

2016 English Language Arts/Literacy

Overall Achievement

	3rd Grade	4th Grade
# of Students Enrolled	49	74
# of Students Tested	48	73
# of Students With Scores	48	73
Mean Scale Score	**2371.5**	**2395.4**
Standard Exceeded: Level 4	0 %	5 %
Standard Met: Level 3	15 %	10 %
Standard Nearly Met: Level 2	46 %	23 %
Standard Not Met: Level 1	40 %	62 %

2017 English Language Arts/Literacy

Overall Achievement

	3rd Grade	4th Grade
# of Students Enrolled	67	47
# of Students Tested	63	46
# of Students With Scores	63	46
Mean Scale Score	**2365.3**	**2421.3**
Standard Exceeded: Level 4	4.76 %	4.35 %
Standard Met: Level 3	9.52 %	19.57 %
Standard Nearly Met: Level 2	31.75 %	28.26 %
Standard Not Met: Level 1	53.97 %	47.83 %

2015 Mathematics

Overall Achievement

	3rd Grade	4th Grade
Number of Students Enrolled	78	71
Number of Students Tested	76	70
Number of Students With Scores	76	69
Mean Scale Score	**2360.5**	**2393.7**
Standard Exceeded: Level 4	0 %	0 %
Standard Met: Level 3	13 %	12 %
Standard Nearly Met: Level 2	24 %	33 %
Standard Not Met: Level 1	63 %	55 %

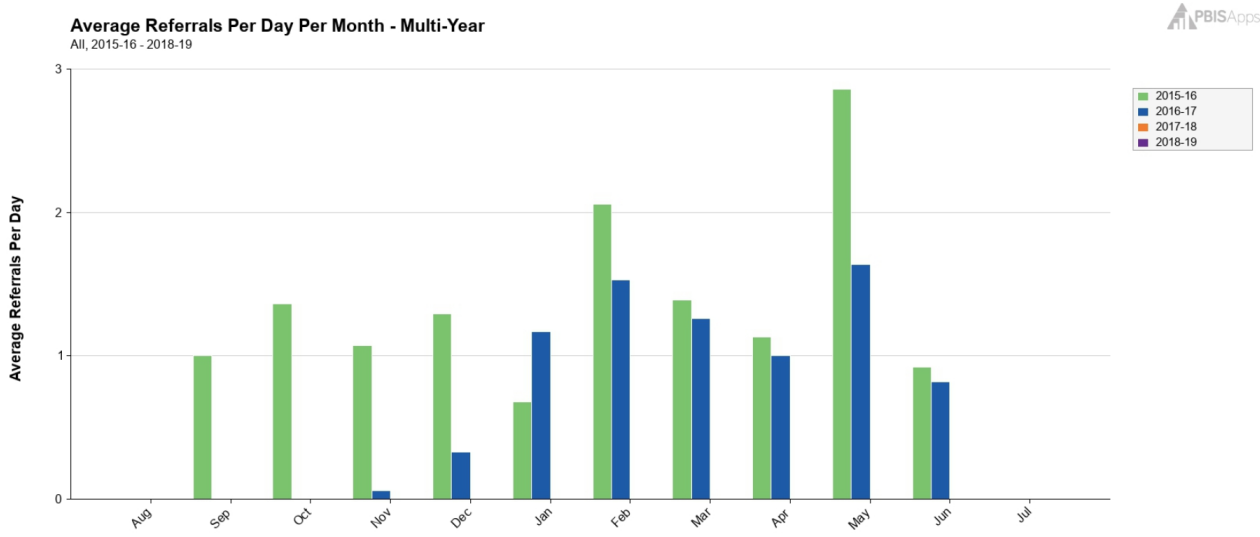
Overall Achievement

	3rd Grade	4th Grade
# of Students Enrolled	49	74
# of Students Tested	48	73
# of Students With Scores	48	72
Mean Scale Score	**2368.1**	**2398.7**
Standard Exceeded: Level 4	0 %	0 %
Standard Met: Level 3	4 %	6 %
Standard Nearly Met: Level 2	38 %	40 %
Standard Not Met: Level 1	58 %	54 %

2017 Mathematics

Overall Achievement

	3rd Grade	4th Grade
# of Students Enrolled	67	47
# of Students Tested	64	46
# of Students With Scores	64	46
Mean Scale Score	**2376.6**	**2425.2**
Standard Exceeded: Level 4	1.56 %	4.35 %
Standard Met: Level 3	12.50 %	6.52 %
Standard Nearly Met: Level 2	34.38 %	45.65 %
Standard Not Met: Level 1	51.56 %	43.48 %



2015/16

Suspension/Expulsion

	Days	Events	Students Contrib...	Days Per 100 Stu...	Events Per 100 S...
In-School Suspension	1.5	2	2	0.45	0.60
Out-of-School Suspension	44.0	28	17	13.21	8.41
Expulsion	0.0	0	0	0.00	0.00
Totals:	45.5	30	19	13.66	9.01

2016/17

Suspension/Expulsion

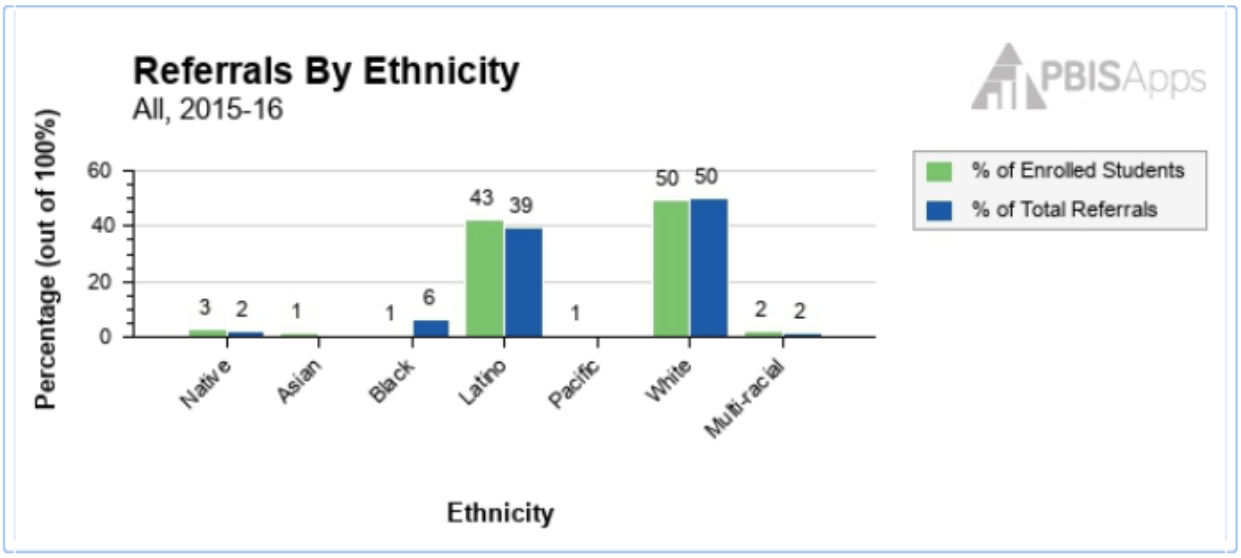
	Days	Events	Students Contrib...	Days Per 100 Stu...	Events Per 100 S...
In-School Suspension	3.5	4	4	0.00	0.00
Out-of-School Suspension	11.0	6	6	0.00	0.00
Expulsion	0.0	0	0	0.00	0.00
Totals:	14.5	10	10	0.00	0.00

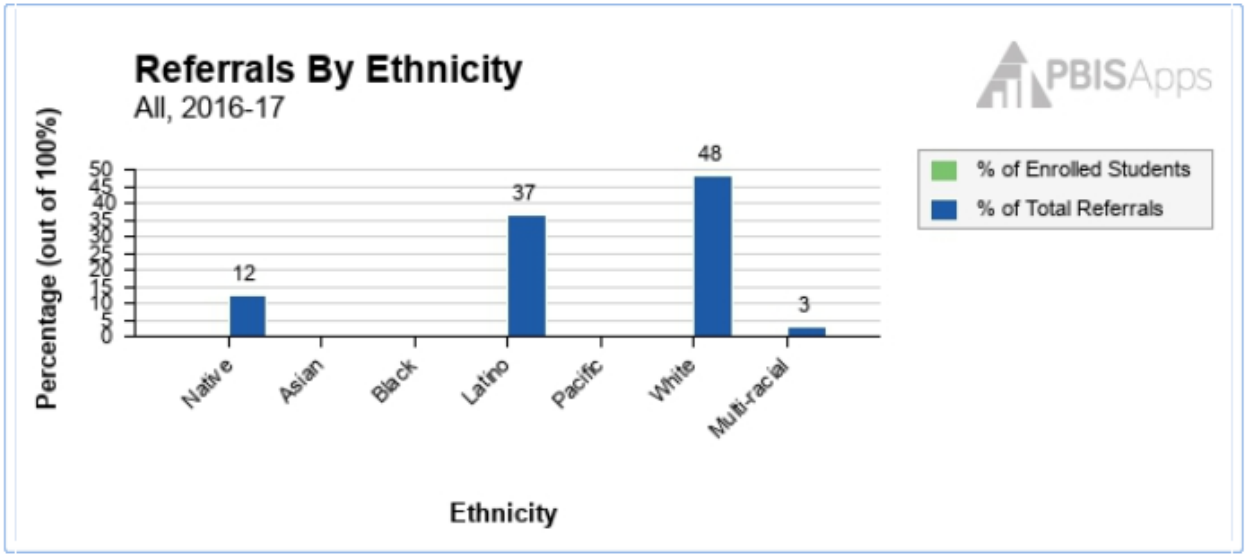
2017/18

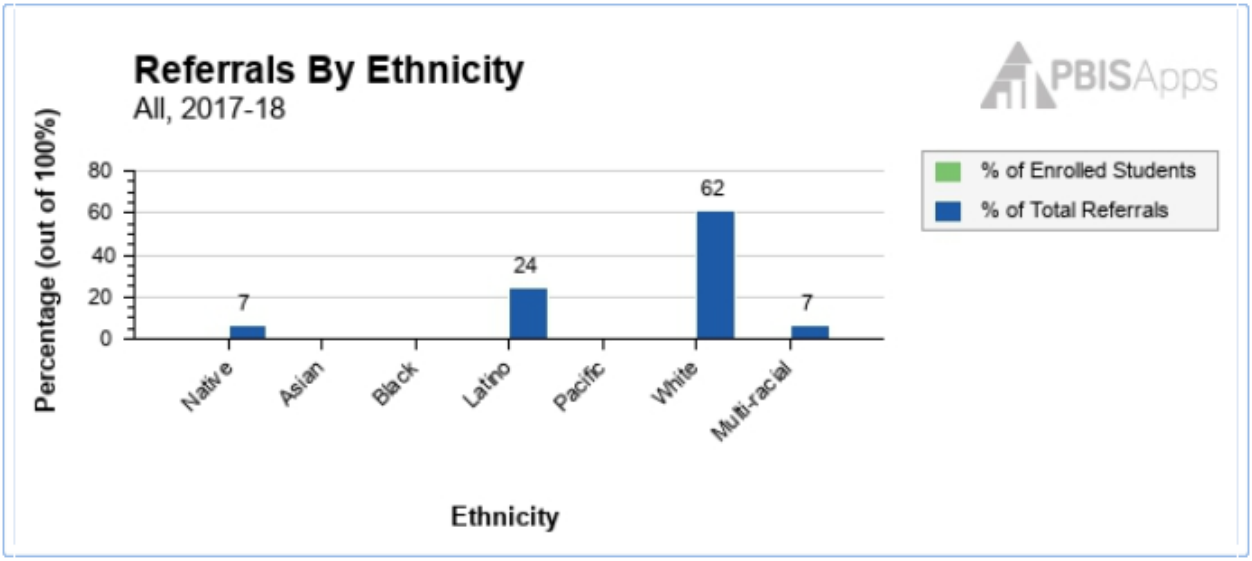
Suspension/Expulsion

	Days	Events	Students Contrib...	Days Per 100 Stu...	Events Per 100 S...
In-School Suspension	1.0	1	1	0.00	0.00
Out-of-School Suspension	11.0	4	4	0.00	0.00
Expulsion	0.0	0	0	0.00	0.00
Totals:	12.0	5	5	0.00	0.00

Office Discipline Referral Data:






Referrals By Ethnicity
All, 2017-18
PBISApps
Percentage (out of 100%)
80
60
40
20
0
7
24
62
7
Native
Asian
Black
Latino
Pacific
White
Multi-racial
Ethnicity
% of Enrolled Students
% of Total Referrals

Prevention and Early Intervention: Making Relatives Program

Big Lagoon Rancheria, Trinidad Rancheria, Two Feathers Native American Family Services and the Bear River Band of the Rohnerville Rancheria will come together in a consortium to create a continuum of care that is a community informed, culturally grounded, systematized approach to tribal mental health. This continuum of care will include a range of supports for mental wellness and suicide prevention, in an early intervention and family supportive cultural framework for tribal youth. Included in this approach will be the development of an indigenous mental health curriculum that seeks to meet the needs of the local tribal communities of Humboldt County. To this end, a major goal of this project will be to support the development of qualities of whole and gifted individuals in local tribal communities, defined as individuals that are strong in their human, natural world and spiritual relationships.[1]

This model program aims to prepare youth and their families to be ready to connect and re-connect to cultural and community relationships. By addressing current mental health gaps in tribal communities through a culturally-based home and community system of care for Native youth and their families, the treatment approach will address the complex and individualized needs of Native youth. The program will borrow from multiple cultural traditions (e.g., different local tribal customs- Yurok/Hupa/Tolowa/ Karuk/Wiyot/Mattole and western approaches) and take a holistic approach that seeks to positively impact multiple layers (individual, family, institutional, tribal, structural) of a child's life. Research and evaluation of our program will be a strong component. Research[2] shows that evaluation on the efficacy of tribally based mental health programming is severely lacking. Accordingly, the prototype project will be evaluated and then systematized for replication.

The project's theory of change assumes that by having flexibility of services provided by a smaller network of tribally based community partners, staff can focus on building long term relationships with at-risk Native youth and families that will include supports such as transportation, crisis response and stabilization. By providing these services from a Native community based non-profit that employs local tribal people, the distrust of Native families will be lessened and engagement will increase. Through the relationships and supports built, the program can support Native youth and their families' participation in mental health services and cultural programming. Research in Native Mental Health as well as personal experiences of consortium members working in Humboldt County for over 20 years point to access to cultural and therapeutic interventions as a major barrier to treatment success for Native youth. This is an important gap in tribal mental health services that must be prioritized because continuing research supports Native American cultural practices and community support as positive interventions that improve self-esteem, school performance, reduce suicidality and substance abuse, and increase overall resilient adaptation in adverse situations.[3]

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[1] Lara-Cooper, K. (2014). K'winya'ya: nma'awhiniw: Creating a Space for Indigenous Knowledge in the Classroom. Journal of American Indian Education, 53:1, 3-22.

[2] Pomerville, A., Burrage, R.L., & Gone, J.P. (2016). Empirical findings from psychotherapy research with Indigenous populations: A systematic review. *Journal of Consulting and Clinical Psychology,* 84(12), 1023-1038; Gone, J.P. (2015). Reconciling evidence-based practice and cultural competence in mental health services: Introduction to a special issue." *Transcultural Psychiatry, 52*(2), 139-149.

[3] Chandler, M. J., & Lalonde, C. (1998). Cultural continuity as a hedge against suicide in Canada's First Nations. *Transcultural Psychiatry, 35*, 191-219 Whitbeck, L. B., McMorris, B. J., Hoyt, D.R., Stubben, J. D., & LaFramboise, T. (220). Perceived

Specific strategies will include restoring relationships by bringing meaning back to the idea of "being a good relative." This "Making Relatives" approach will assist youth through the creation of a team of relatives including family, community members, and professional service providers that mentor, model and support the youth and families in the achievement of wellness. With innovative components grounded in the western system of care "Wraparound," this team will work with youth and families to reconnect to traditional cultural values and practices, including locally informed tribal child rearing and wellness practices and traditional life skills. An intensive in-home program that utilizes trained lay tribal staff that go into the family's home (similar to grandparents, aunties, uncles) to model and coach parenting and life and identity skills; connect youth and families to cultural activities and events in the community (thereby expanding the family's community supports); connect the family to educational supports, psychoeducation on conceptualization of tribal mental health views that are more contextual and strength based, linkage to medical and behavioral health community based services; and providing crisis response.

This project will create a consortium of tribal partners that leverages existing tribal resources with additional funding into a coordinated system of care for youth and their families. By solidifying the consortium through the development of a charter with program policies and procedures, the newly developed organization can provide services to the larger Native American community, filling in many of the current gaps in services, while maintaining strong partnerships with the County and United Indian Health Services. Currently the three tribal partners creating the consortium have a diverse range of services and expertise that, when combined as a consortium, will create a stronger coordinated service system and allow for joint applications for further funding that can help fulfill this vision.

The program will be expanded and sustained through evaluation of the process and service outcomes. In addition, Two Feathers Native American Services will take steps to become an organizational provider with DHHS Mental Health, translating traditional wellness practices into Medi-Cal billable services as appropriate under the specialty mental health services waiver.

Mental Health Services Act funding will be provided for the first year of the program, which covers parts of fiscal years 2018-19 and 2019/2020, focused on developing the consortium and the culturally based program, and establishing a foundation for the Making Relatives Program. In years two and three, the Making Relatives Program will be implemented and evaluated. Subsequent years will be funded through Medi-Cal reimbursement based on Two Feathers becoming an organization provider and other funding sources will be sought as needed.

discrimination, traditional practices and depressive symptoms among American Indians in the upper Midwest, *Journal of Health and Social Behavior, 43*, 400-418; Zimmerman, M. A., Ramirez-Valles, J., Washienko, K. M., Walter, B., & Dyer, S. (1996). The development of a measure of enculturation for Native American youth. *American Journal of Community Psychology*, *24*, 295-310; Teresa D LaFromboise., et al. (2006). Family, community, and school influences on resilience among American Indian adolescents in the upper Midwest. Journal of Community Psychology 34.2: 193-209.

Workforce Education and Training

Over the years, 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 mental health system. Some of these opportunities have included:

- Milestones of Recovery Scale (MORS), an evaluation tool for tracking the process of recovery for individuals with a mental illness.
- The Transition to Independence Process (TIP) Model, an evidence-supported practice based on published studies that demonstrate improvements in real-life outcomes for youth and young adults with emotional and/or behavioral difficulties. The TIP Model is used in the Transition Age Youth Division of DHHS.
- The Integrated Dual Diagnosis and Treatment (IDDT) model, an evidence-based practice that improves the quality of life for people with co-occurring severe mental illness and substance use disorders by combining substance abuse services with mental health services.
- Peer support staff and volunteers have attended workshops, conferences and visited out of county wellness centers.

Over the next two years, WET funding will be used to continue to provide these staff development opportunities as follows:

- The contract with Relias E-Learning will be continued. Mental 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.
- Mental Health will work with the North Coast Equity Alliance, a local non-profit organization, to create customized trainings around the topic of race relations and bias. These will be local, in-person trainings for staff. DHHS Mental Health has a state mandate for annual cultural competence training, and in the past online trainings, such as those available from Relias, have been used. Exclusive use of online training for cultural competence is not advised due to the potentially sensitive nature of issues that may arise at the level of direct services. Customized in-person trainings from the North Coast Equity Alliance will provide the opportunity for peer learning and for staff to discuss their experiences and cultural considerations with trained facilitators and subject matter experts.
- Mental Health will continue the training process to implement and support high-fidelity Wraparound within Children's Mental Health. Topics to be covered are:
    - Coordinating the work of system partners and developing the Wraparound Team as part of the process
    - Emphasis on Access, Voice and Ownership to achieve positive outcomes

- Basic principles; similarity to Humboldt Practice Model and Katie A. services
- Creating alternative ways to organize systems to provide help
- Four key elements, high fidelity Wraparound, quality practice
- Four phases of Wraparound
- High Fidelity Wraparound in Humboldt County; focus on youth eligible for Katie A.; provided by Juvenile Probation, Children and Family Services (TAY, Regional Facility/New Horizon), Child Welfare Services

Information Technology

Continued and Completed Projects

Adding Gender Field to Client Demographic Screens. In October 2017 Humboldt County Mental Health added a custom field in our electronic health record (Avatar) client demographic screens and a new line on the paper Client Information Sheet for client gender identity. Documenting client gender in Avatar will help improve client and staff interaction and cultural compliance within DHHS Mental Health and our community. Adding a gender field will also improve data collection and help our Cultural Competence Committee make data driven decisions in choosing future projects.

Milestones of Recovery Scale (MORS) is a recovery based evaluation tool for adults. It helps identify where an individual is in his or her process of recovery and evaluate when the client is ready to take on, create, or maintain a community role until they are independent of staff support.

Roll out of the MORS began in 2014 and this effort will continue into upcoming fiscal years to assist program direct services staff and clients with monitoring progress in treatment and to assist with treatment decisions and measure readiness for discharge.

Going forward, we will continue to generate MORS reports for all adult outpatient programs and add trainings to assist clinical staff in using MORS to make informed treatment decisions.

Data Collection for Homeless Population. In April 2016 DHHS Mental Health began collecting housing data for clients, specifically the Crisis Stabilization Unit to assess admission and readmission rates, frequency of visits, and making referrals for those clients that report being homeless. Currently, stakeholders are meeting regularly to improve the standardization of collection of this data in Avatar. This project will continue into the next fiscal year.

Creating Updating Substance Use Disorders Forms In Avatar. One of the continued projects is to update the existing 3026 AOD Treatment Plan Avatar form to include diagnosis and primary counselor as well as updating the 3002 AOD Assessment form to assist physician's documentation of when the client history and diagnosis was reviewed.

New Projects

AVATAR Disclosure Management and Release Restriction Alerts: In 2017 Humboldt County Mental Health Medical Records department started using client alerts associated to our Avatar Disclosure Management form to protect client privacy and prevent accidental disclosure of records. For example, an alert can be added to a client's electronic chart when they request that records are not to be disclosed or are revoking an existing consent to release information.

Until 2018 all request for records and disclosures were documented on a Microsoft Excel spreadsheet on the computer network assessable only to Medical Records staff. Disclosure Management in Avatar allows for the documenting of record requests and disclosures, and gives every user access to this information. It also provides special handling instructions before releasing client information. Another important benefit of Disclosure Management includes being able to provide clients with a printed record of disclosures more easily.

As of August 13, 2018, after two months of set up, testing and practice by the Medical Records unit, Disclosure Management is being used exclusively to document requests and disclosures of existing client records.

Health Information Exchange and Summary of Care Documents: Beginning August 30, 2018 with the help of a local health information exchange, North Coast Health Improvement and Information Network (NCHIIN), DHHS Mental Health began receiving emergency care summaries from local hospitals for clients being admitted to Sempervirens Psychiatric Health Facility and the Crisis Stabilization Unit. The Emergency Department Care Summaries include client's emergency department visits and labs within past 90 days, allergies recorded at the hospital, primary care provider, case manager, and a list of diagnostic imaging.

Next steps for the NCHIIN health information exchange in 2018-2019 will be working on providing mental health care summaries to the client's primary care providers to improve coordination of care and client follow up.

PSC-35: In 2018 California Department of Health Care Services began requiring the reporting of two children functional assessment tools; the Pediatric Symptoms Checklist (PSC-35) and the Child and Adolescents Needs and Strengths (CANS). Although our organization has been collecting CANS data for some time, the PSC-35 was new to us and was not completed in electronic form because questions are answered by the child's parent or guardian.

To gather this data our IS Application Development staff created a new electronic form in Avatar for the PCS-35 containing thirty-five questions about child's emotional and physical symptoms. After the parent or guardian complete the paper form, Medical Records and other support staff enter this data into Avatar which will then calculate the child's PSC-35 score. Results collected in Avatar will be compiled to be reported out to California Department of Health Care Services.

FUTURE PLANS

Medication Reconciliation: Avatar includes the functionality to pull in prescribed medications from Order Connect the e-prescribing service used by Humboldt County Mental Health. Medication Reconciliation will allow staff to maintain a client medication list more efficiently for all inpatient and outpatient programs.

Some testing has been done, and it is promising, but there's more work ahead in 2018-

2019 to format the imported medication data, developing workflows for inpatient and outpatient services, and ensure adequate staff training.

CANS form in Avatar: Currently the Child and Adolescent Needs and Strengths functional assessment tool is completed by staff on paper or in an Adobe Acrobat form on their computer. Because it is a periodic screening required by California Department of Health Care Services, the form will be recreated in Avatar to help increase the completion rate of the CANS.

Fiscal Accountability Certification

This page is a placeholder for the County Fiscal Accountability Certification.

FY 2018-19 Mental Health Services Act Annual Update
Funding Summary

County: HUMBOLDT Date: 5/23/19

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2018-19 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	1,109,076	1,393,650	534,157	185,760	0	
2. Estimated New FY 2018-19 Funding	4,737,849	1,261,187	331,891			
3. Transfer in FY 2018-19 [a/]	(20,384)				9,500	10,884
4. Access Local Prudent Reserve in FY 2018-19						
5. Estimated Available Funding for FY 2018-19	5,826,541	2,654,837	866,048	185,760	9,500	
B. Estimated FY 2018-19 MHSA Expenditures	4,694,400	1,794,770	435,637	98,150	9,500	
G. Estimated FY 2018-19 Unspent Fund Balance	1,132,141	860,067	430,411	87,610	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2018	1,428,508
2. Contributions to the Local Prudent Reserve in FY 2018-19	10,884
3. Distributions from the Local Prudent Reserve in FY 2018-19	
4. Estimated Local Prudent Reserve Balance on June 30, 2019	1,439,391

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

FY 2018-19 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding

County: HUMBOLDT Date: 5/23/19

	Fiscal Year 2018-19					
	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	4,659,969	3,333,192	1,291,720			35,057
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. RURAL OUTREACH SERVICES ENTERPRISE (ROSE)	1,472,603	917,314	166,314		32,624	356,351
2. MHSA Telemedicine	186,062	144,870	40,793		399	
3. OLDER AND DEPENDENT ADULT EXPANSION	96,232	96,232				
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
CSS Administration	202,792	202,792				
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	6,617,658	4,694,400	1,498,827	0	33,023	391,408
FSP Programs as Percent of Total	70.4%					

FY 2018-19 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: HUMBOLDT Date: 5/23/19

	Fiscal Year 2018-19					
	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	274,701	274,701				
2. Stigma & Discrimination Reduction	168,630	168,630				
3. TAY Advocacy and Peer Support	423,468	423,468				
4. Parent Partnership Program	244,406	244,406				
5. School Climate Curriculum	86,872	86,872				
6. Local Implementation Agreements	110,000	110,000				
7. Making Relatives Program	87,165	87,165				
8.	0					
9.	0					
10.						
PEI Programs - Early Intervention						
11. Suicide Prevention	258,090	258,090				
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	141,438	141,438				
PEI Assigned Funds						
Total PEI Program Estimated Expenditures	1,794,770	1,794,770	0	0	0	0

FY 2018-19 Mental Health Services Act Annual Update
Innovations (INN) Funding

County: HUMBOLDT Date: 5/23/19

	Fiscal Year 2018-19					
	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. Rapid Re-Housing for Individuals with a Severe Mental Illness	640,809	396,034	244,775			
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	39,603	39,603				
Total INN Program Estimated Expenditures	680,412	435,637	244,775	0	0	0

FY 2018-19 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Funding

County: HUMBOLDT Date: 5/23/19

	Fiscal Year 2018-19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training and Technical Assistance	98,150	98,150				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	0					
Total WET Program Estimated Expenditures	98,150	98,150	0	0	0	0

FY 2018-19 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Funding

County: HUMBOLDT Date: 5/23/19

	Fiscal Year 2018-19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11. Integrated Clinical and Administrative Information System		9,500				
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	0	9,500	0	0	0	0