Mental Health Services Act

Annual Update

Fiscal Year 2019/2020

Contents

MHSA COUNTY COMPLIANCE CERTIFICATION

County: Humboldt

Local Mental Health Director	Program Lead
Name: Emi Botzler-Rodgers, MFT	Name: Cathy Rigby
Telephone Number: 707-268-2990	Telephone Number: 707-268-2990
E-mail: ebotzler-rodgers@co.humboldt.ca.us	E-mail: crigby@co.humboldt.ca.us
County Mental Health Mailing Address:	Humboldt County DHHS-Behavioral Health 720 Wood St. Eureka, CA 95501

I hereby certify that I am the official responsible for the administration of county mental health services in and for said county and that the County has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this annual update, including stakeholder participation and nonsupplantation requirements.

This annual update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft annual update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on _____.

Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant.

All documents in the attached annual update are true and correct.

Emi Botzler-Rodgers MFT
Local Mental Health Director/Designee (PRINT)

EBR, MFT 9/21/2020
Signature Date

County: Humboldt

Date: _____

Community Planning and Local Review Process

Background

Humboldt County Department of Health and Human Services is a consolidated organization, integrating Behavioral 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. This document, the Annual Update for 2019-2020, provides reports from MHSA programs for the 2018-2019 fiscal year and updates the 2017-2020 Three Year Plan with information on program changes and additions.

Stakeholder input for both the Annual Update 2019-2020 and the Three Year Plan for Fiscal Years 2020-2023 was obtained during the same stakeholder process. Methods for obtaining stakeholder input were:

- Holding regional stakeholder meetings and meetings with other stakeholder groups as requested. Sixteen meetings were held from November 2019-January 2020 and a total of 191 stakeholders were present.
- 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 2019-2020 Annual Update and associated MHSA information via email to stakeholder groups and individuals and posting on the County website.
- The Humboldt County MHSA Three Year Program and Expenditure Plan Community Participation and feedback Survey (Community Survey) was available online and in paper format. This survey was focused on gathering input for the Three Year Plan for 2020-2023.

Stakeholders at community meetings

Stakeholder Materials

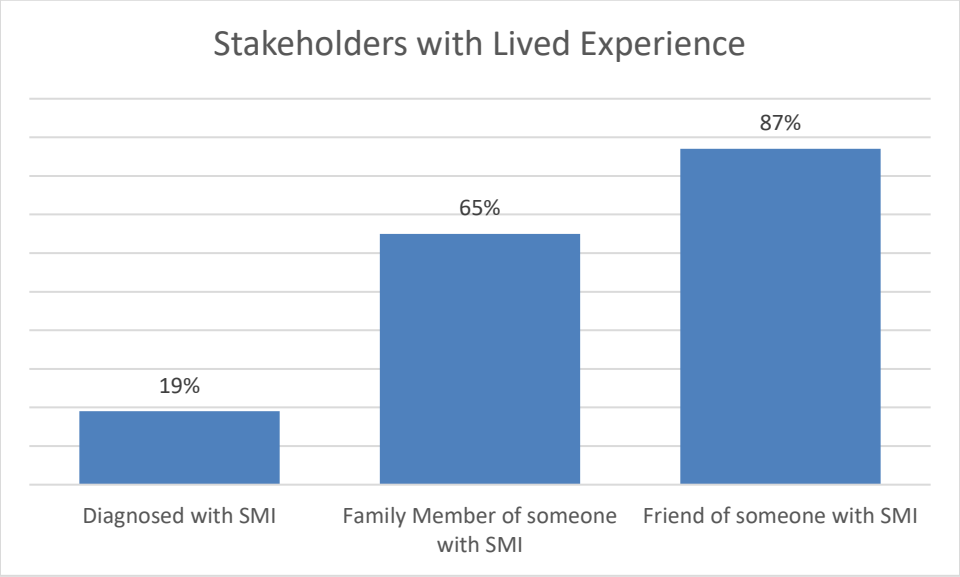
Most MHSA support materials were available in both English and Spanish. Materials provided to attendees included:

- Draft MHSA Annual Update for 2019-2020

- Draft MHSA Budget for 2019-2020
- MHSA Fundamental Concepts handout
- MHSA Info Form handout
- MHSA Current Programs handout
- Mental Health Services provided by the County
- Definitions of Serious Mental Illness and Serious Emotional Disturbance
- 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
- Paper copy of the Community Survey

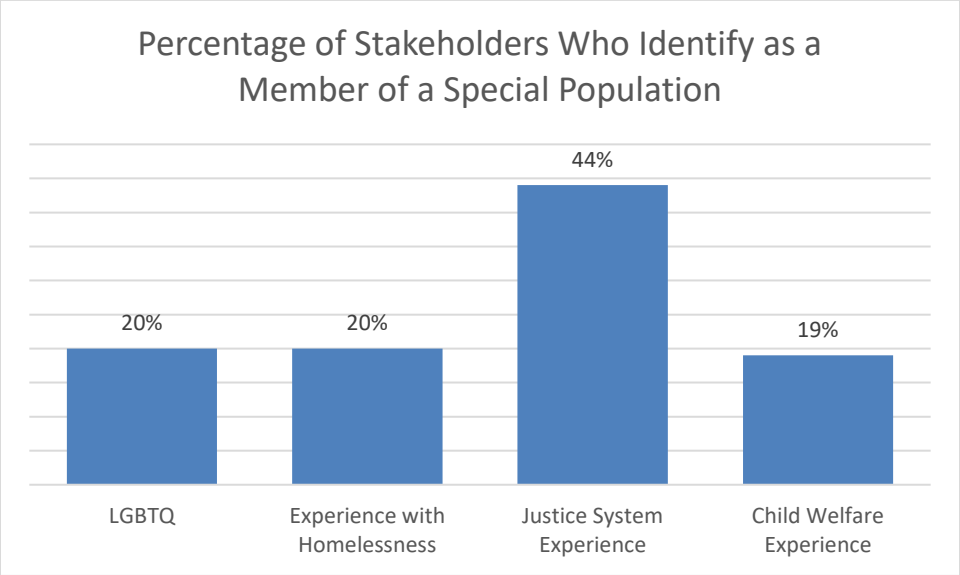
Stakeholders attending community meetings were invited to complete the demographic questionnaire. For the current stakeholder process, 85 individuals, 45% of those attending the meetings, completed a demographic form. The results are presented in the charts below.

Individuals with lived experience with a mental illness are recognized as a vital voice in the MHSA planning process. In this stakeholder process, 19% of people participating identified as having a mental illness, 65% identified as a family member of someone with a mental illness, and 87% identified as a friend of someone with a serious mental illness, as shown in the following chart.

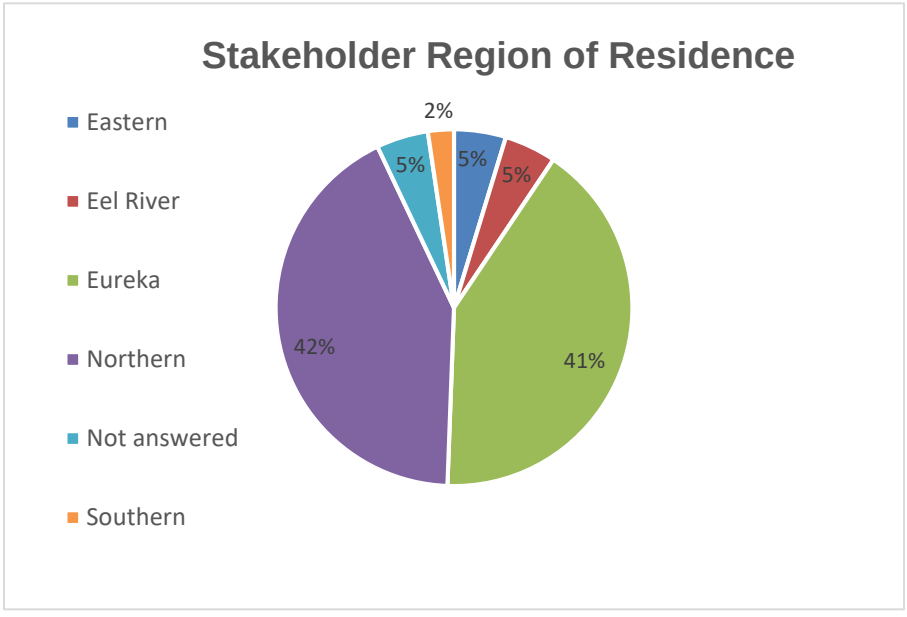


Additional life experiences have been identified as valuable voices for the planning process so they are also monitored for inclusion. Sexual orientation, experience with homelessness, justice system experience, Child Welfare experience, and those whose primary language is other than English are all 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:

- 20% identified as LGBTQ,
- 20% identified as having experience with homelessness,
- 44% had justice system experience,
- 19% had Child Welfare experience
- Only two stakeholders stated their primary language was other than English. These languages were Korean and Spanish.

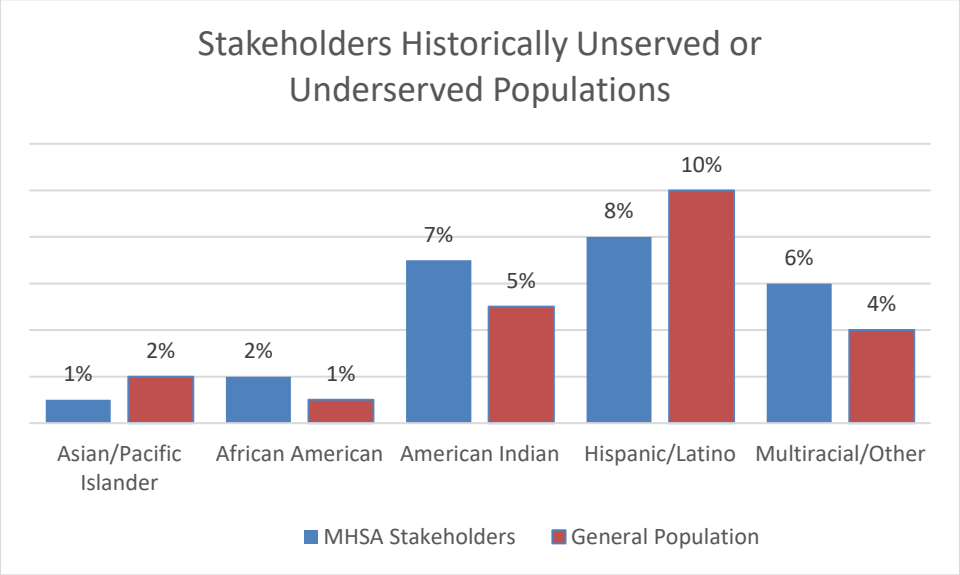


Another priority for representation in the planning process is regional. More than half of the MHSA stakeholders attending meetings live in regions close to Humboldt Bay, Northern Humboldt at 42% and Eureka at 41%, while 5% live in the Eel River Valley, 5% in Eastern Humboldt and 2% in Southern Humboldt. Five percent either did not respond to the question or indicated they lived in another region. This is shown in the chart below.

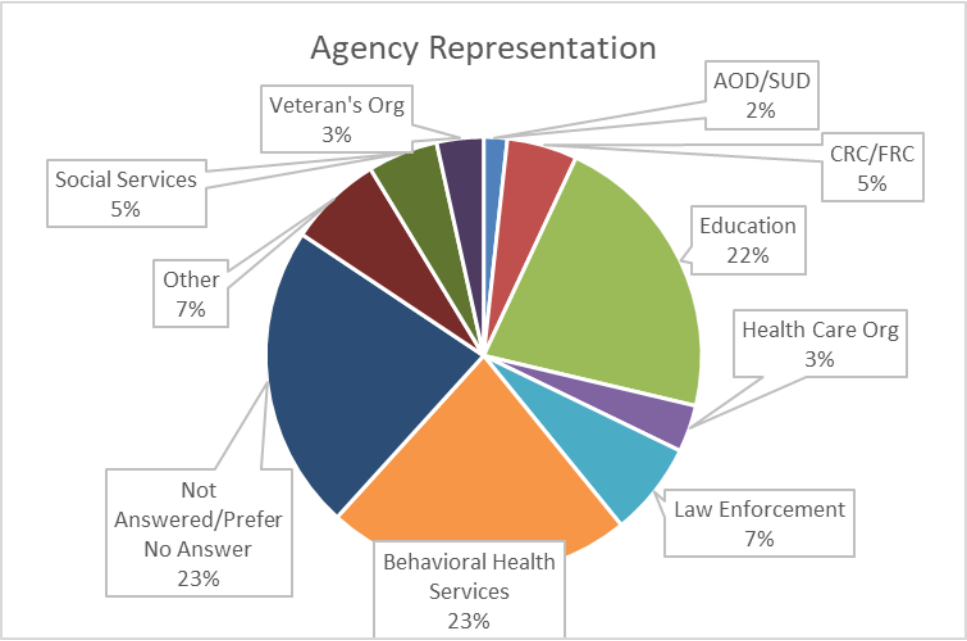


Participants in the stakeholder meetings came from different racial and ethnic categories.

- One percent were Asian/Pacific Islander, compared to 2% of the County general population.
- Two percent were Black/African American, compared to 1% of the County general population.
- Seven percent were American Indian, compared to 5% of the County general population.
- Eight percent were Hispanic/Latino(a), compared to 10% of the Humboldt County general population.
- 6% were Multiracial/Other, compared to 4% of the County general population.



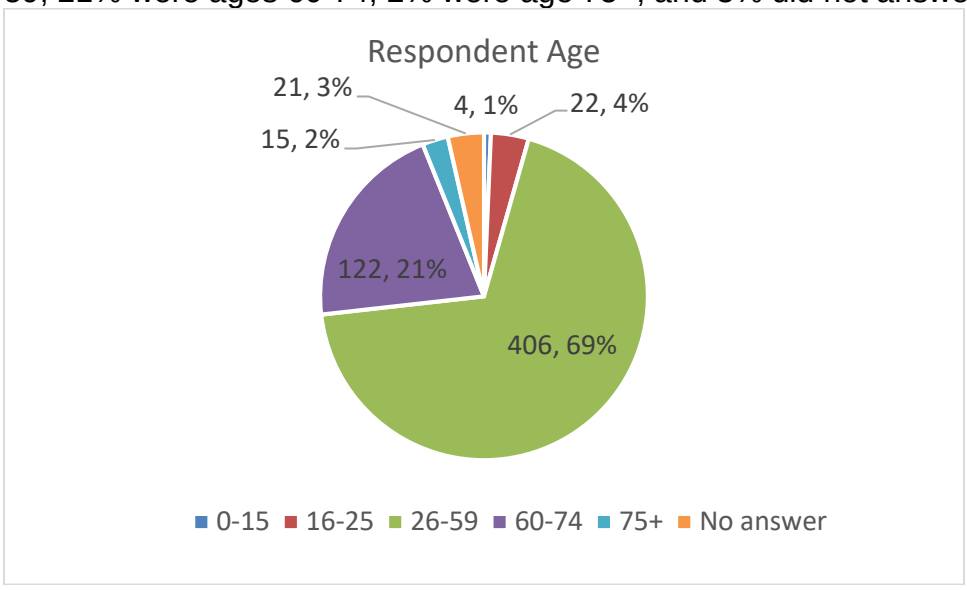
The stakeholder meetings included representation from agencies that provide services. The process has included individuals from education (22%), mental health services (23%), health care organizations (3%), social services (5%), law enforcement (7%), community and family resource centers (5%), Substance Use Disorder Services (2%), Veteran's organization (3%) and other (7%). Twenty-three percent did not answer/preferred not to answer the question. This is shown on the chart below.



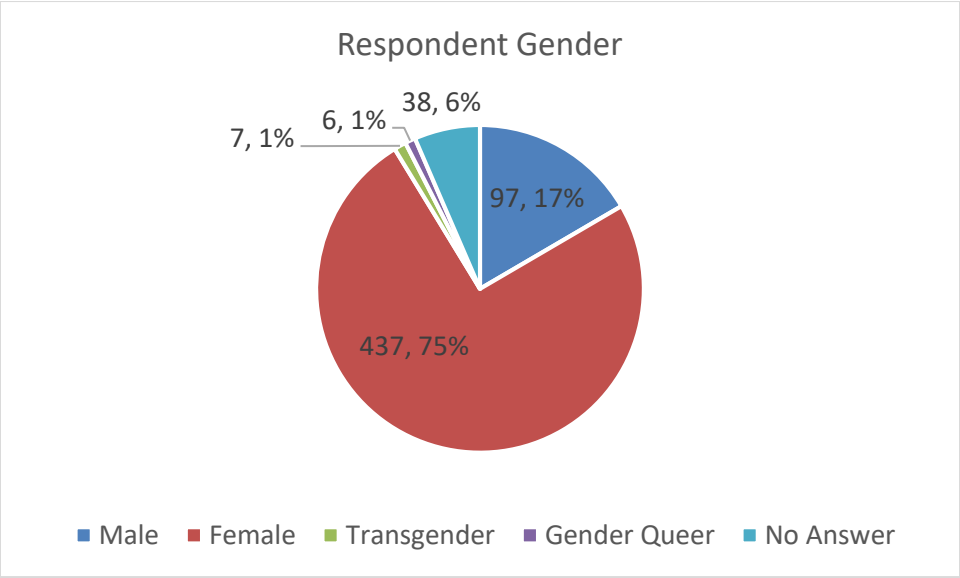
Stakeholders completing the Community Survey

Google Forms was used to create a community survey, available online and in paper format. Between the paper copies and the online survey a total of 597 responses were received. Of the responses, 472 people, 81%, stated it was their first time providing input and information for the MHSA process. For 111 people, 19%, it was not the first time they had provided input into the MHSA process. Though this survey was intended to gather input for the Three Year Plan, the demographics of those participating are presented below.

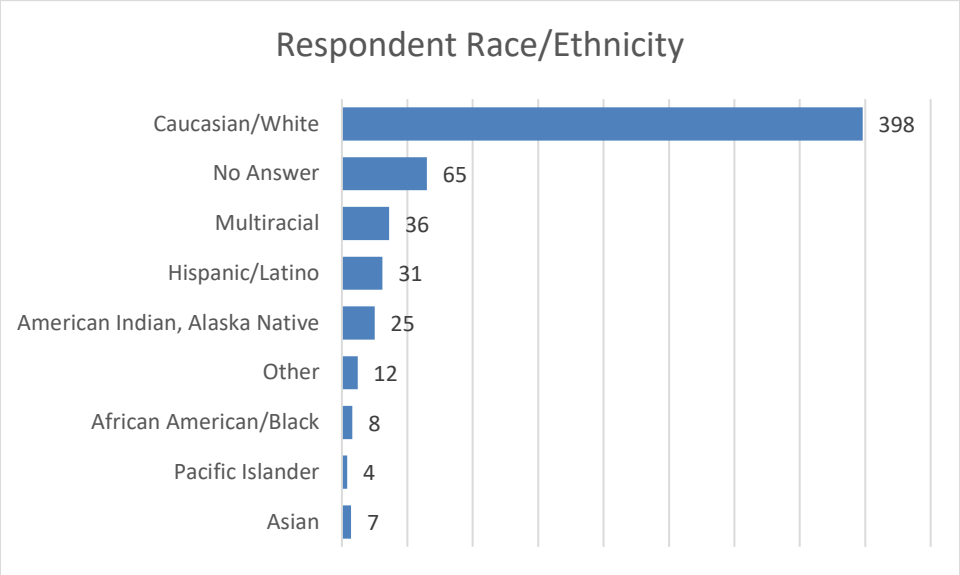
One percent of respondents were ages 0-15, 4% were ages 16-25, 69% were ages 26-59, 21% were ages 60-74, 2% were age 75+, and 3% did not answer.



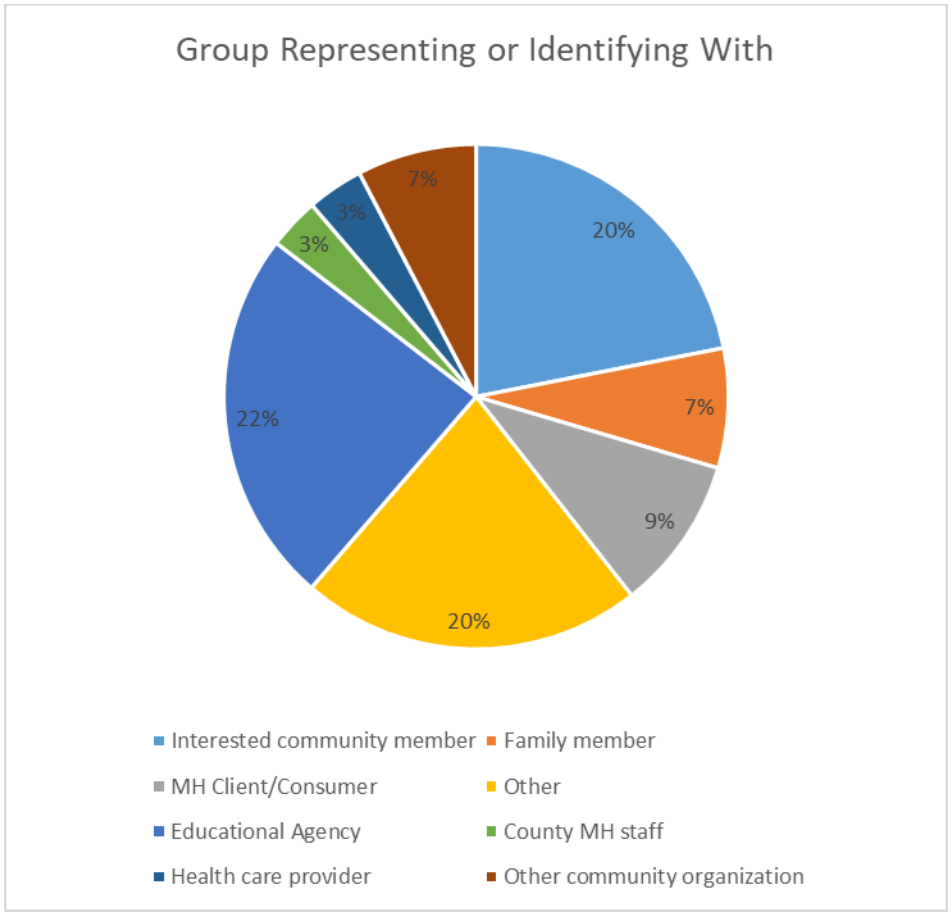
Seventeen respondents were male, 75% female, 1% transgender, 1% gender queer, and 6% did not answer.



398 respondents, 69%, were Caucasian/White; 36 respondents, 5%, were Multiracial; 31 respondents, 5%, were Hispanic/Latino; 25 respondents, 4%, were American Indian/Alaska Native; 12 respondents, 2%, were Other; 8 respondents, 2%, were African American/Black; 4 respondents, 1%, were Pacific Islander; and 7 respondents, 1%, were Asian. 65 respondents, 11%, did not answer.



When asked what group they represented or identified with, 20% of respondents were interested community members; 22% were from educational agencies; 7% from other community organizations; 7% were family members; 9% were mental health clients/consumers; 3% were health care providers, 3% were County Mental Health Staff, and 20% were Other, as represented in the chart below.


Group Representing or Identifying With
20%
7%
9%
20%
22%
3%
3%
7%
Interested community member
Family member
MH Client/Consumer
Other
Educational Agency
County MH staff
Health care provider
Other community organization

Public Comment and Public Hearing

The Annual Update 2019-2020 was made available for public review and comment for a 30-day period, July 28-August 27, 2020. Copies of the Annual Update were available to stakeholders through the following methods:

- The Humboldt County Department of Health and Human Services, MHSA webpage.
- Emails sent to stakeholders participating in the stakeholder process.
- Emails to recipients on local organizational e-mail distribution lists.
- Announcements in local media with the Annual Update's availability, where to obtain it, where to make comments, and where/when/how the public hearing was to be held.

No written comments were received on the Annual Update during the public comment period.

The Behavioral Health Board (BHB) conducted a Public Hearing for the Annual Update 2019-2020 and Three Year Plan 2020-2023 at their regular meeting on August 27, 2020, 12:15-2:15 pm. Due to the current COVID-19 situation, this meeting was conducted via WebEx. There were 36 people in attendance at the Public Hearing. There were no written comments provided and the Annual Update programs have not been changed as a result of the comment period and public hearing.

Complaints and Grievances

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 be followed. The issue would be forwarded to the MHSA Program Manager (MHSA-PM) or designee through either US Postal Service mail: MHSA Program Manager, DHHS Behavioral Health, 720 Wood St. Eureka CA 95501; telephone or voice mail: (707) 441-3770; or email MHSAcomments@co.humboldt.ca.us. Issues are be recorded at time of receipt by the MHSA-PM in the DHHS-BH Client Concerns Log and forwarded to the Program Lead of the program involved. Once a resolution is decided upon by the associated Program Lead the MHSA-PM contact sthe originator of the issue to notify them of the resolution. Issues are followed up on within five working days. Resolution of the issue is enacted within 30 days from receipt of issue.

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 135,558 spread over 3,567 square miles, or 37.7 persons per square mile. Forty-nine percent of residents live around the Humboldt Bay area, while the other half live in the outlying rural areas of the county. The county's residents include those from eight federally recognized American Indian Tribes: Yurok, Karuk, Hupa, Wiyot, Cher-Ae Heights Indian Community of Trinidad Rancheria, Bear River Band of Rohnerville Rancheria, Blue Lake Rancheria and Big Lagoon Rancheria.

Humboldt County is often discussed in terms of five regions: Eureka, Northern Humboldt, Eastern Humboldt, Southern Humboldt and the Eel River Valley. Eureka is the largest city and the county seat of government, and there are several small communities right outside the city limits that are included in this region. Northern Humboldt includes the cities of Arcata and Blue Lake, the unincorporated town of McKinleyville, the Blue Lake Rancheria, Trinidad Rancheria, and Big Lagoon Rancheria, as well as other smaller communities. Eastern Humboldt includes the unincorporated towns of Willow Creek and Hoopa, the Hupa Reservation, and other smaller communities. Southern Humboldt includes the unincorporated towns of Garberville and Redway, and many other smaller communities. The Eel River Valley includes the cities of Fortuna, Ferndale and Rio Dell, the Bear River Band of Rohnerville Rancheria and the Wiyot Tribe, as well as other smaller communities. While the headquarters of the Yurok and Karuk Tribes are in neighboring counties, many tribal members live in Humboldt County.

Five percent of the population is under the age of 5, 19% under the age of 18, 63% are ages 18-64, 18% are age 65 and older. Females are 50% of the population and males are 50%.

Seventy-four percent of the population is White; 1% is Black/African American; 6% American Indian/Alaska Native; 3% Asian; .3% Native Hawaiian and Other Pacific Islander; 6% Two or more Races; and 12% Hispanic or Latino. Residents who are foreign born are approximately 5.4% of the population.

Residents speaking a language other than English at home are 11.8% of the population. The majority of these speak Spanish (7.6%). Of those speaking a language other than English at home, 4.5% speak English less than "very well." For Spanish speakers, 3.2% speak English less than "very well."

The median household income is $45,528 with 20.3% living in poverty. Ninety percent are high school graduates, and 30% have a bachelor's degree or higher.

The demographic information provided is from the U.S. Census American Community Survey, estimates for 2018, unless otherwise noted.

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, Behavioral Health and Public Health partnering to serve individuals with a variety of physical, mental, and social needs as well as providing prevention and education activities. This integrated response reduces the stigma associated with accessing mental health and other services, as visitors to the service could be coming 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 and Regional MH staff. As the program has matured and with the addition of permanent Regional staff, there has been less need of the RV for regular MH services. Clients who are homeless are provided transportation to their mental health appointments by ROSE/Mobile Outreach/Regional. ROSE/Mobile Outreach/Regional 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.

In 2018-19 the project added 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 multiple 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 hosted events at the site to include any residents interested in attending to build community identity. Events include pot-lucks, group meal preparation and cooking instruction, game nights, birthday parties, Tai Chi, yoga, ice cream socials and more. Peers are very involved to help build and sustain recovery communities in housing developments and in outlying areas. Interested persons are invited to Peer Specialist training opportunities when possible to learn skills that may assist their neighbors.

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.

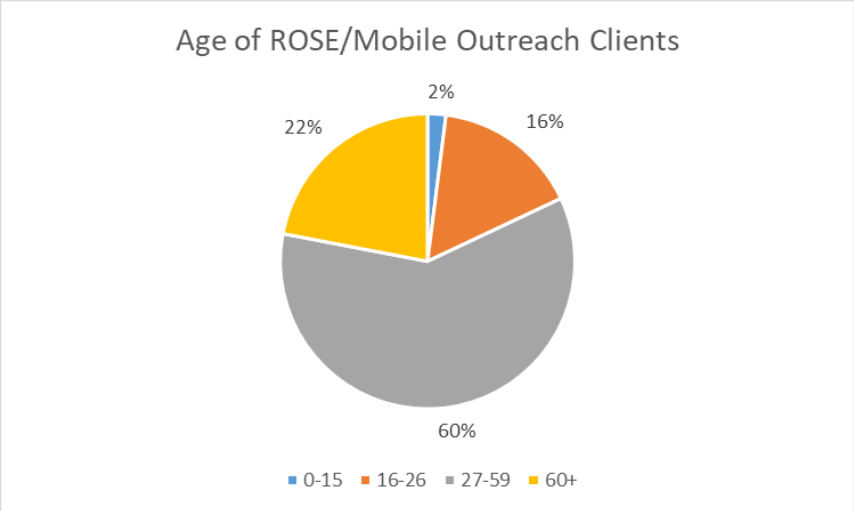
Since some mental health services have been shifted to a regional delivery approach the ROSE RV has been used to develop and provide daylong “service fairs” with a focus to a specific need identified by staff and the community. The RV is also used to support Community Integration projects designed for clients with Serious Mental Illness (SMI) that the Housing, Outreach and Mobile Engagement (HOME) staff has housed. These services help clients learn about resources in the community, volunteer and paid work opportunities, free and low-cost activities that are available to them, exposure to new hobbies and recreation and a mechanism to meet new friends in a supportive manner.

Both of these strategies have been very successful. Service Fairs have focused on topics such as Healthy Foods and preparation, how to provide or receive In Home Supportive Services (IHSS), resolution of child support issues, veteran services and summer activities for youth in outlying areas. Community Integration projects have included multiple fishing trips, easy walks in town, easy hikes in surrounding forests, visits to local thrift stores, visits to zoo, visits to local animal shelters and rescues and trips to fly kites at the beach. All of these are popular with clients and have resulted in clients now working as volunteers at the library, senior lunch site and animal rescue site. Several clients have adopted pets.

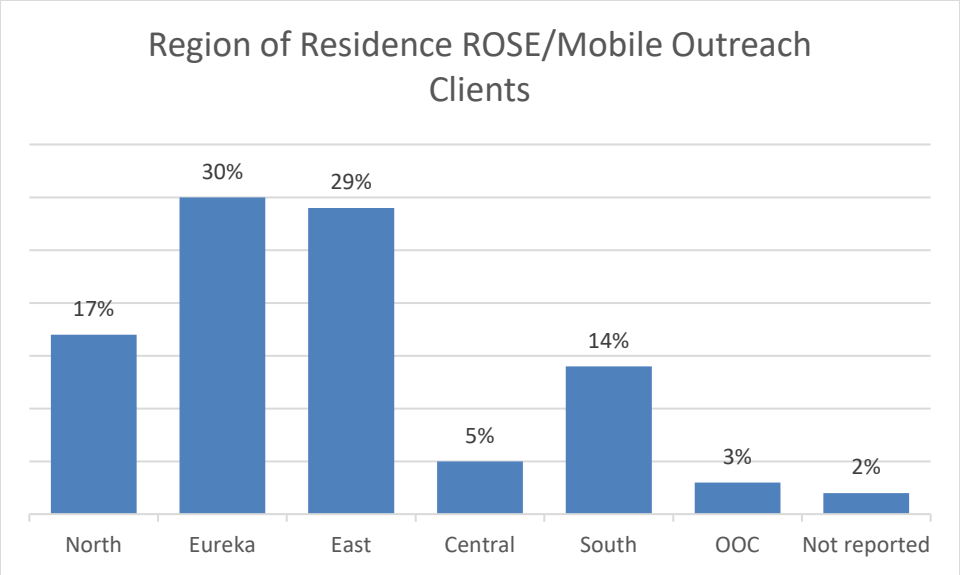
A total of 100 clients are estimated to be served during the fiscal year.

Data Report

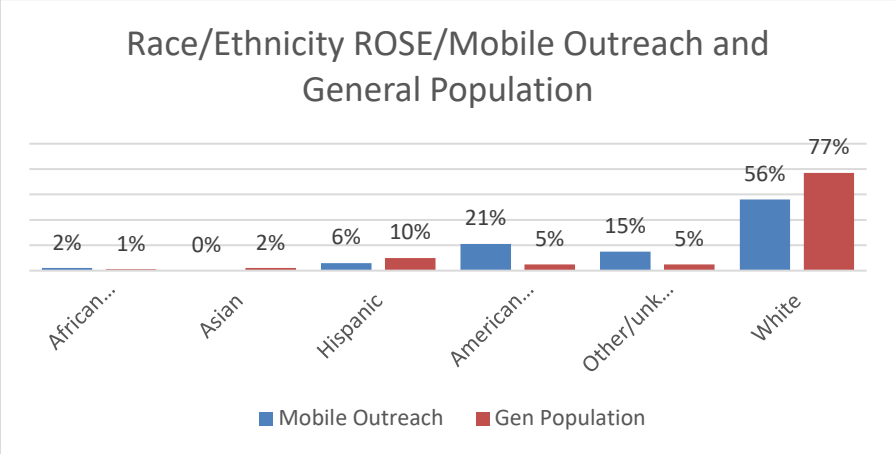
From July 2018 through June 2019 the program served 100 unduplicated mental health clients. ROSE/Mobile Outreach provides services to people of all ages. Between July 2018 through June 2019 2% of those served were children, 16% were transition age youth, 60% were adults, and 22% were older adults.



Clients are served throughout the region, with 30% served in Eureka, 14% in Southern Humboldt, 29% in Eastern Humboldt, 17% in Northern Humboldt, 5% in the Central region, and 3% out-of-county. For 2% the residence region was not reported.



The percentage of ROSE/Mobile Outreach clients who identify as White/Caucasian is 56%, and 77% for the general population. The percentage of clients who identify as American Indian is 21%, and 5% for the general population. The percentage of clients who identify as Black/African American is 2%, and 1% for the general population. Clients who identify as Asian/Pacific Islanders is 0%, and 2% for the general population. The percentage of clients who identify as Hispanic/Latino(a) is 6%, and 10% for the general population.



50% of clients served are female, and 50% are male.

Community Integration Report
For residents who the program has helped to obtain housing, the activities organized help prevent isolation, creating social linkages and integration into the community through positive, fun activities.

In the past year, staff has organized fishing trips, a visit to the Sequoia Park Zoo, a visit to Humboldt Botanical Garden, a group outing to Samoa beach for kite flying, transportation to a film presentation, and participation in Food for People sponsored

cooking classes.

Program staff have worked collaboratively with different community partners including Jefferson (Westside) Community Center and Public Health Healthy Communities program. At the Jefferson Community Center, staff worked with clients to revitalize, plant, maintain and harvest vegetables in three garden beds. Garden activities have included a demonstration of food preparation techniques with vegetables harvested from the site. Working with Public Health's Healthy Communities program, a dozen clients were provided a budget shopping tour at the WINCO store.

Staff helps housed clients eat healthy on a limited budget by organizing weekly appointments and transportation to the Food Bank.

H.O.M.E./Mobile Outreach staff dedicates a large portion of staff time to providing outreach services to residents of outlying communities. Each month, ten communities are visited, helping link people with Public Health, Behavioral Health and Social Services programs. This year staff were very active in assisting SSI recipients in these communities to apply for CalFresh. Staff attend the annual health fair in Hoopa where they worked with In Home Supportive Services to help Hoopa residents apply to become caregivers and care recipients.

In 2019, the program organized special outreach events targeting both young and more elderly residents.

In Orleans, staff worked collaboratively with K'ima:w Medical Center staff and provided families with installation instruction and 13 new child safety seats.

In 2019, staff organized four events aimed at linking older adults with essential services. Older adults in the communities of Weitchpec, Trinidad, Redway and Shelter Cove were provided the opportunity to meet with DHHS staff from IHSS, APS, Public Health Adult Health, the Veterans Services Office, Humboldt County Programs for Recovery and the Public Guardian. From outside DHHS, staff were joined by Area 1 Agency on Aging's HICAP program, PACE, the Southern Humboldt Community Health District and the Senior Living Solutions program.

Community Services and Supports: Telemedicine

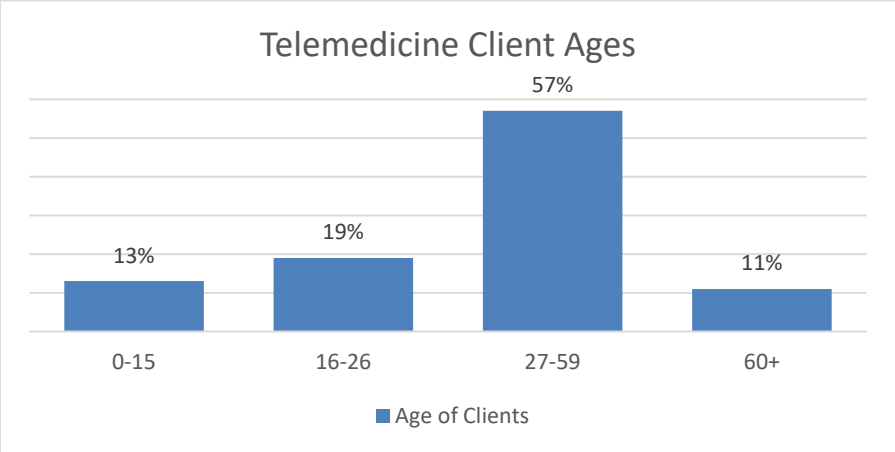
In 2006 the Department initiated an Outpatient Telemedicine Medication Services Expansion in Garberville, and was expanded to Willow Creek in 2011. Using video conferencing equipment, the expansion offered psychiatric services and medication support from a provider located at the main clinic in Eureka to people with serious mental illnesses residing 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 was scheduled to go live for both Willow Creek (Eastern Humboldt) and Garberville (Southern Humboldt) at the end of August, 2018. However, due to delays in connectivity, telemedicine services in Garberville did not resume until June 2019. In Willow Creek, DHHS Facilities and Information Services are still working on improved connectivity and services are expected to begin by the end of

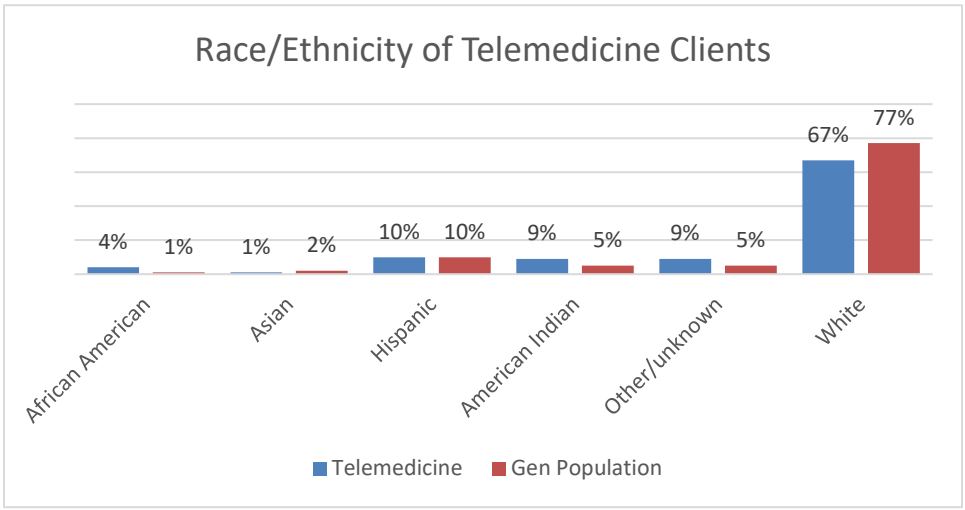
the fiscal year. In the meantime, telemedicine clients are still incorporated into the adult clinic in Eureka, receiving services.

Data Report
From July 2018 through June 2019 the program served an average of 173 unduplicated clients per month for a total of 2,076 unique individuals during the one year period.

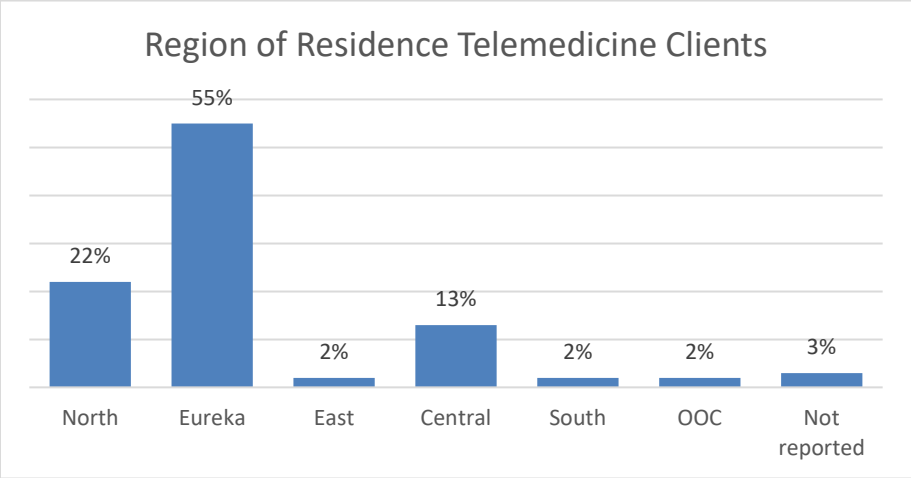
The telemedicine program serves people of all ages. During the one year period, 13% were children ages 0-15, 19% were ages 16-26, 57% were ages 27-59, and 11% were age 60+. Forty-six percent were female and 54% were male.



The percentage of telemedicine clients who identify as White/Caucasian is 67%, as compared to 77% of the general population. The percentage of telemedicine clients who identify as Black/African American is 4% 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 9%, and 5% for the general population.



Fifty-five percent of clients served live in the Eureka area. 22% live in the Northern region of Humboldt County, 13% 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 3% of telemedicine clients served.



The primary language for telemedicine clients is English, at 91%. Other languages, including Spanish, are all less than 1% each. Primary language spoken was not reported for 7% of clients served by telemedicine.

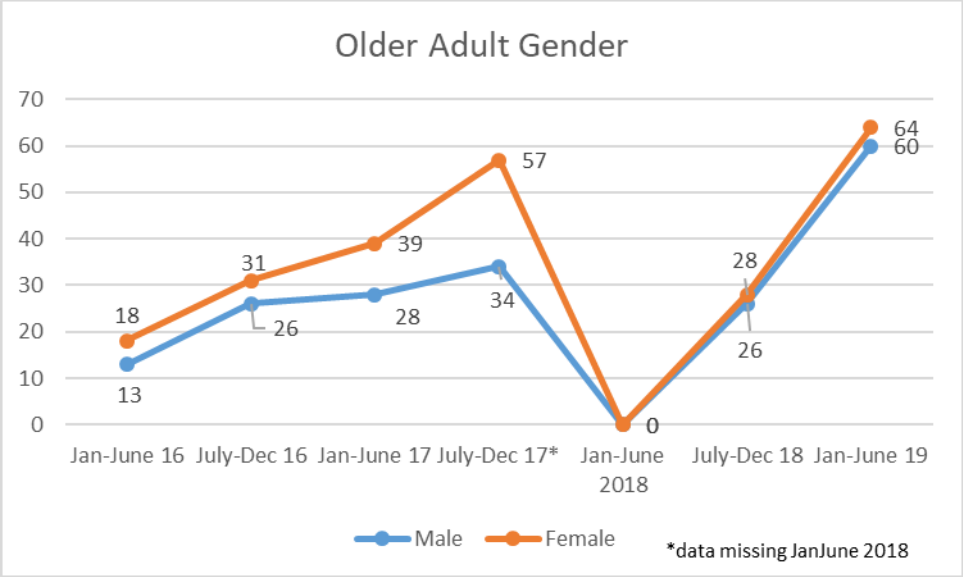
An estimated 2,060 clients will be served during the next fiscal year, with 270 age 0-15, 390 ages 16-25, 1,180 ages 26-59, and 220 ages 60+..

Community Services & Supports: Older Adults and Dependent Adults

Prior to 2007, the DHHS Older Adults and Dependent Adults program included behavioral 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, Behavioral 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. Behavioral Health staff remove barriers to access and provide mental health screening and assessment services, consultation, education, and wellness/recovery focused clinical services and supports. The program has two components: Outreach, prevention and education activities, and mental health services to clients.

Outreach, Prevention and Education

Data collection has been developing as the program evolves and grows. Data since January 2016 are now available and the growth is evident in this graph (data for January to June 2018 are missing).



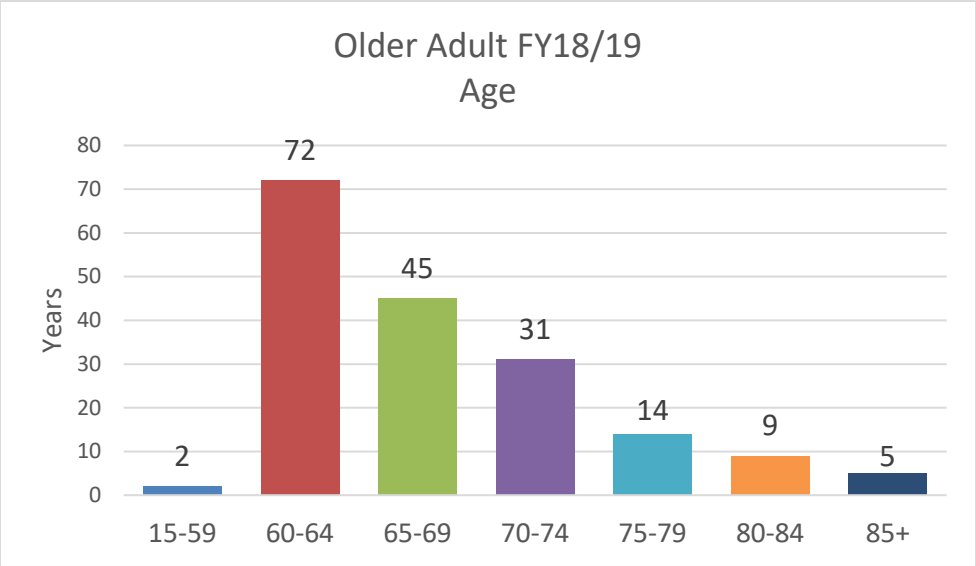
During fiscal year 18/19 a total of 178 individuals were contacted by the Behavioral Health Clinician assigned to the Older and Dependent Adults program, primarily through outreach, prevention and education activities. The Clinician is contacted by Adult Protective Services, In Home Supportive Services, 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 personalized care, education, intervention and connections to services in the community.

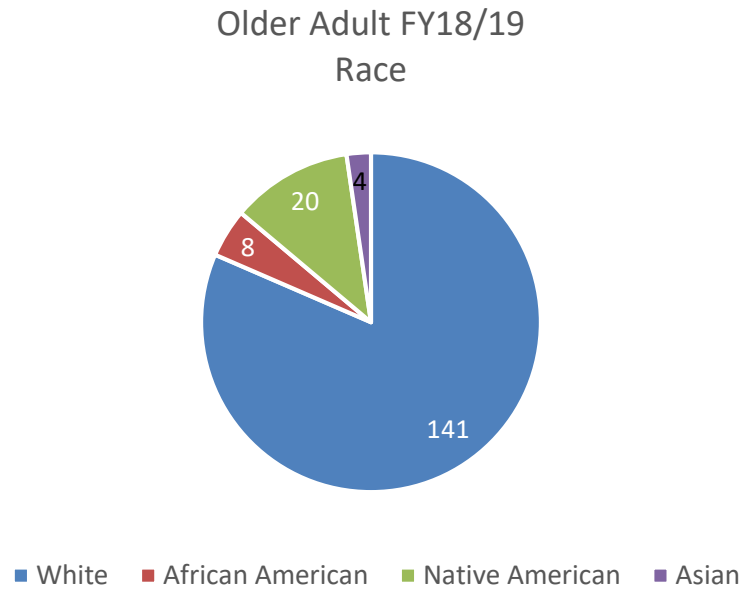
Descriptive statistics for participants in the Older and Dependent Adult program for FY

18/19 are discussed below.

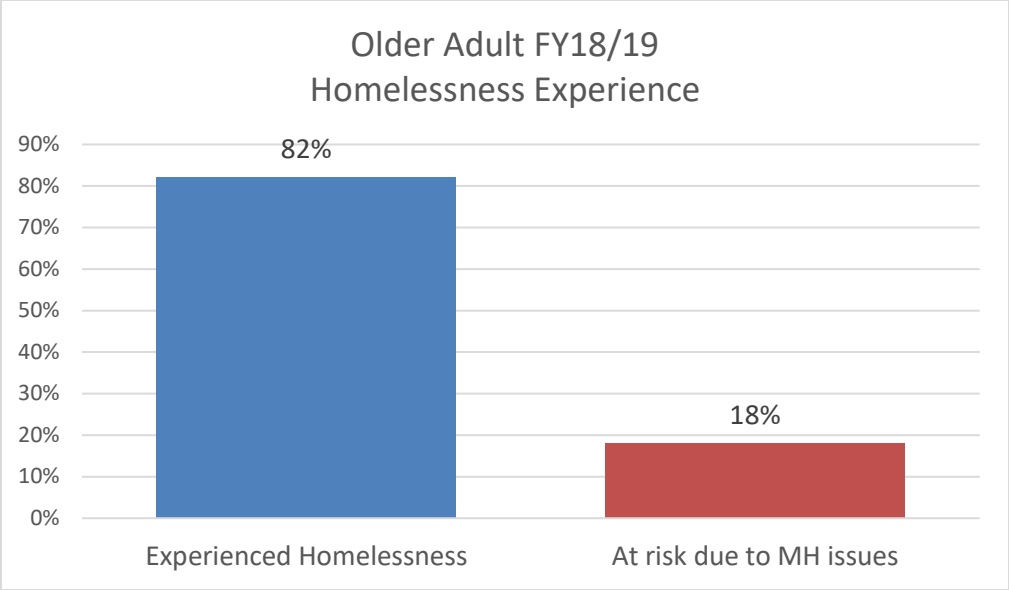
Eighty-six (48%) of the participants were male and 92 (52%) were female. Two participants identified themselves as under 60 years of age and the oldest is 91 years old. Seventy-two (40%) were ages 60-64, 45 (25%) between ages 65-69, 31 (17%) between ages 70-74, 14 (8%) between, 9 (5%) between 80-84 and 5 (3%) over age 85.



Among the 178 Older Adults served in FY18/19, 141 (79%) were White, 8 (4%) were African American, 20 (11%) were Native American, 2 (2%) were Asian and 5 (3%) were Multi Racial/Other. Thirty-one (17%) of the participants were Hispanic.

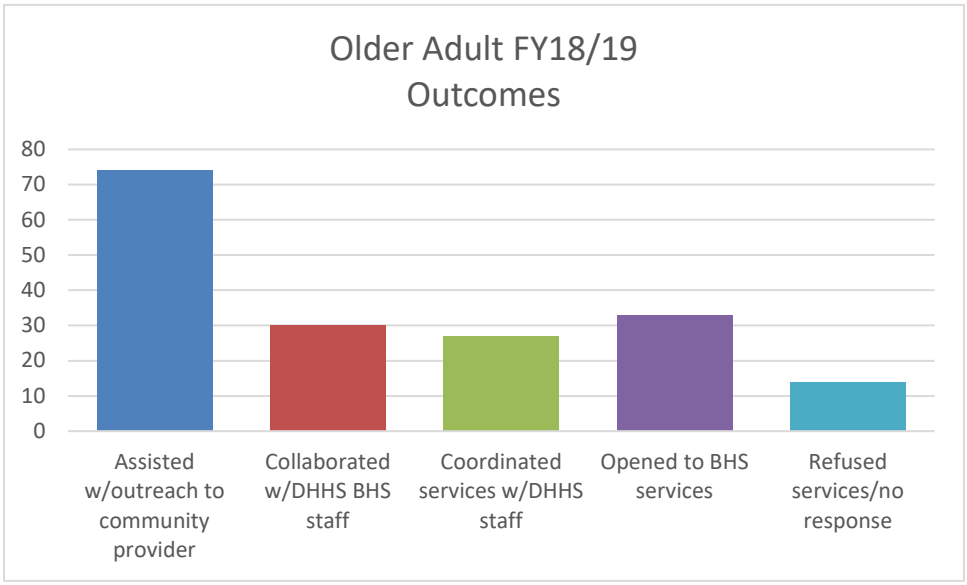


Of the 178 participants in the Older Adult program in FY18/19 146 (82%) self-identified as having experienced homelessness at some time and 32 (18%) expressed feeling at risk of homelessness due to mental health issues.



Outcomes

For these 178 Older Adult participants 14 (8%) refused services or did not respond to outreach efforts by the Behavioral Health Clinician (at least three attempts at contact were made). Seventy-four (42%) were handed off to a community provider, 33 (19%) were provided services by DHHS Behavioral Health Services (BHS), 27 (15%) were referred to other DHHS programs, and 30 (17%) were provided services in collaboration with DHHS BHS staff.

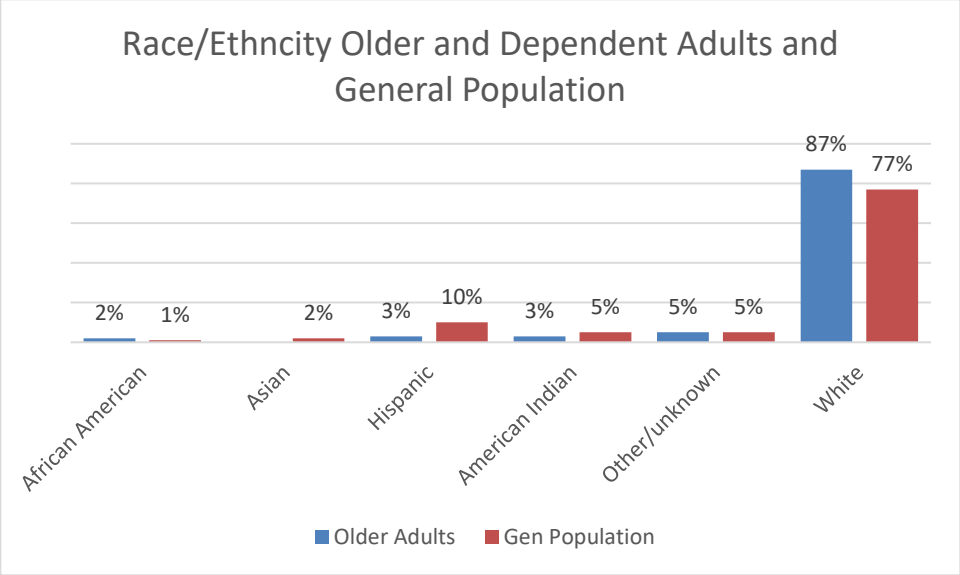


An estimated 150 individuals will be contacted through outreach, prevention and education during FY 19/20.

Mental Health Services to Clients

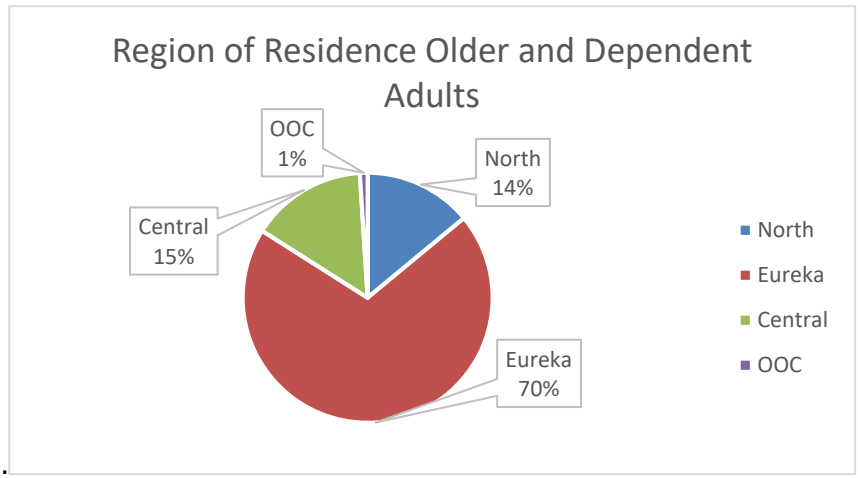
In addition to contacts made through outreach, prevention and education, 151 individuals were provided services as clients of Behavioral Health for fiscal years 2018/2019. Of

these, 87% were White, compared to 77% of the general population; 3% were American Indian, compared to 5% of the general population; 3% were Hispanic compared to 10% of the general population; 2% were African American, compared to 1% of the general population; and 5% were Other/Unknown. No Asian individuals were served, compared to 2% of the general population.



Sixty-two percent of clients served were female, and 38% male.

Seventy percent of those served reside in Eureka, 14% in Northern Humboldt, 15% in Central Humboldt, and none in Eastern or Southern Humboldt. One percent reside out-of-county (OOC).



An estimated 100 clients will be served in the fiscal year

Community Services & Supports: Full Service Partnership

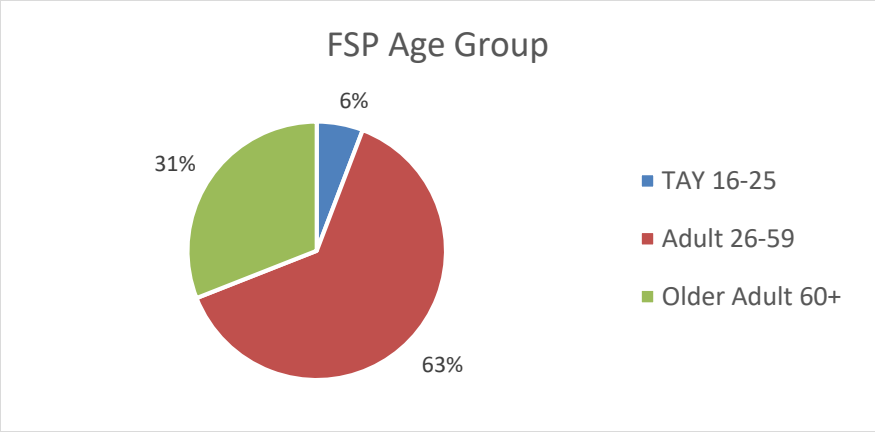
Full Service Partnerships offer a range of services and supports to persons impacted by severe mental illness. These services include medication management, crisis intervention, case management, peer support, family involvement, and education and treatment for co-occurring disorders such as substance 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 through the Crisis Response Unit. 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.

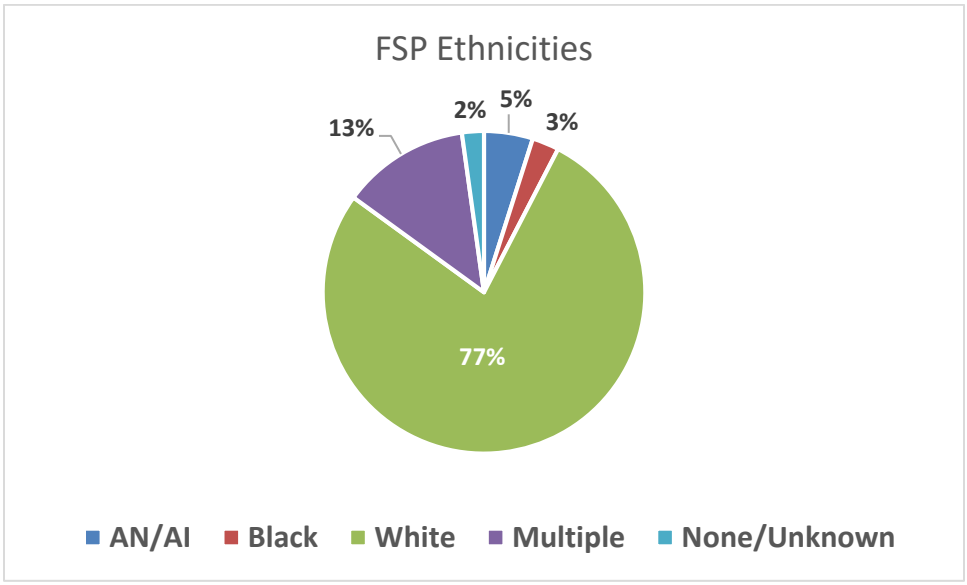
Partners are served through various DHHS programs including Children and Family Services, Transition Age Youth Division, ROSE/Mobile Outreach, and Older and Dependent Adults programs. However, partners are primarily served through the Comprehensive Community Treatment (CCT) program. Modeled after the 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 Data for FSP is from the California Dept. of Health Care Services Data Collection and Reporting (DCR) System.

There were 226 FSPs enrolled for the period July 1, 2018 through June 30, 2019. Among these 226, 194 (86%) completed one year of an FSP and 158 (70%) completed two years. Six percent of FSPs were ages 16-25, 63% were ages 26-59, and 31% 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, 2018 through June 30, 2019, the percentage of FSPs who identify as White is 77%, 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. There were no FSPs who identified as Asian/Pacific Islander, compared to 2% for the general population. FSPs who identify as American Indian/Alaska Native is 5%, compared to 5% for the general population. No FSPs identified as Hispanic/Latino(a), compared to 10% for the general population. FSPs who identify as multiple races were 13%, compared to 10% of the general population. Race/ethnicity was unknown or not recorded for 2% of FSPs.



Ninety-seven percent of FSPs speak English as their primary language. One person's primary language was Spanish, one's was Armenian, and three reported American Sign Language. For two people the primary language was not reported.

Forty-three percent of FSP clients for the period July 1, 2018 through June 30, 2019 were female and 57% were male.

FSPs exit a Partnership due to a variety of reasons. During the period July 1, 2018 through June 30, 2019, 37 FSPs were discharged from the program for the following

reasons.

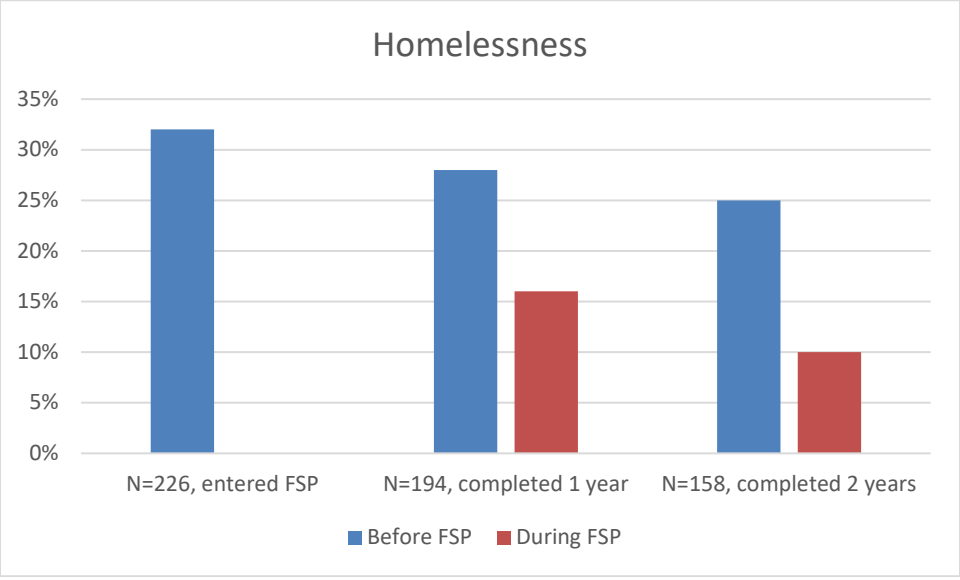
Discharge Reason	Percentage All FSP	Percentage TAY	Percentage Adult	Percentage 60+
Met Goals	59%	0%	30%	30%
Deceased	14%	0%	8%	5%
Moved Out of County	11%	0%	8%	3%
No Longer Met Criteria	3%	0%	3%	0%
Discontinued	3%	0%	3%	0%
Serving Prison	3%	0%	3%	0%
Not located	8%	3%	5%	0%

Of the 37 FSPs discharged during the specified time period, 27 had completed at least one year of the program; 23 had completed at least two years of the program, 17 had completed at least three years, 12 had completed at least four years, and 12 had completed at least five years. The average length of stay in the program during this period was 147 days for Transition Age Youth, 1,121 days for Adults ages 26-59, and 2,156 for Adults age 60+.

An estimated 215 clients with be served as FSPs in the fiscal year, with an estimated 21 TAY, 42 Older Adult, and 152 Adults.

HOMELESSNESS

For the 226 who enrolled in an FSP, 73 (32%) had experienced 15,122 days of homelessness in the year prior to enrollment.

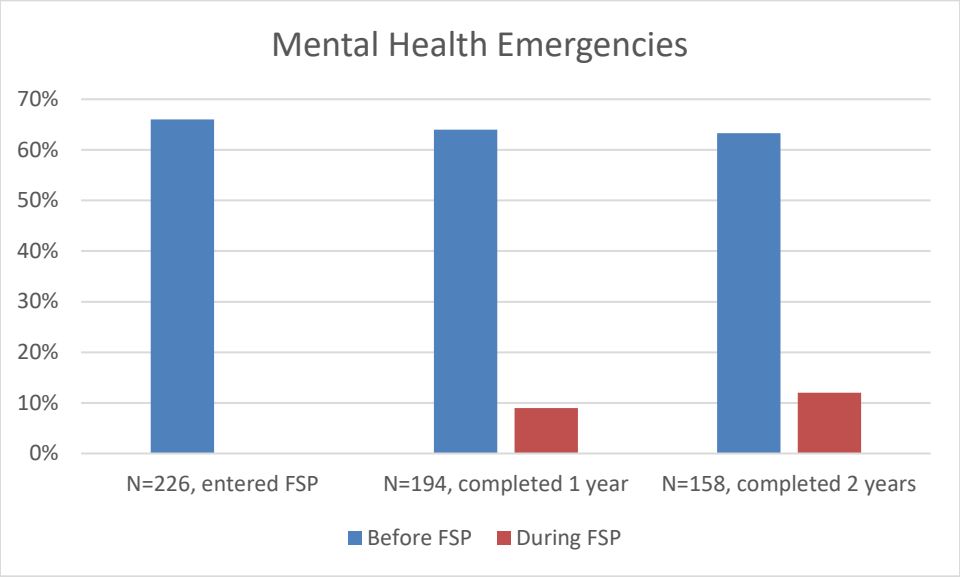


Of the 194 Partners who remained in a partnership for one year, 54 (28%) experienced

10,944 days of homelessness in the previous year and 30 (16%) experienced 5,489 days of homelessness in the first year of enrollment, a decrease of 44% in experienced homelessness and a 50% reduction in homelessness days. Of the 158 Partners who remained enrolled for two years, 39 (25%) had experienced 7,807 days of homelessness in the year prior to the Partnership and 16 (10%) experienced 2,015 days of homelessness during the second year, representing a decrease of 60% in experienced homelessness for a reduction in homelessness days of 74% from the year prior to enrollment in an FSP.

MENTAL HEALTH EMERGENCY

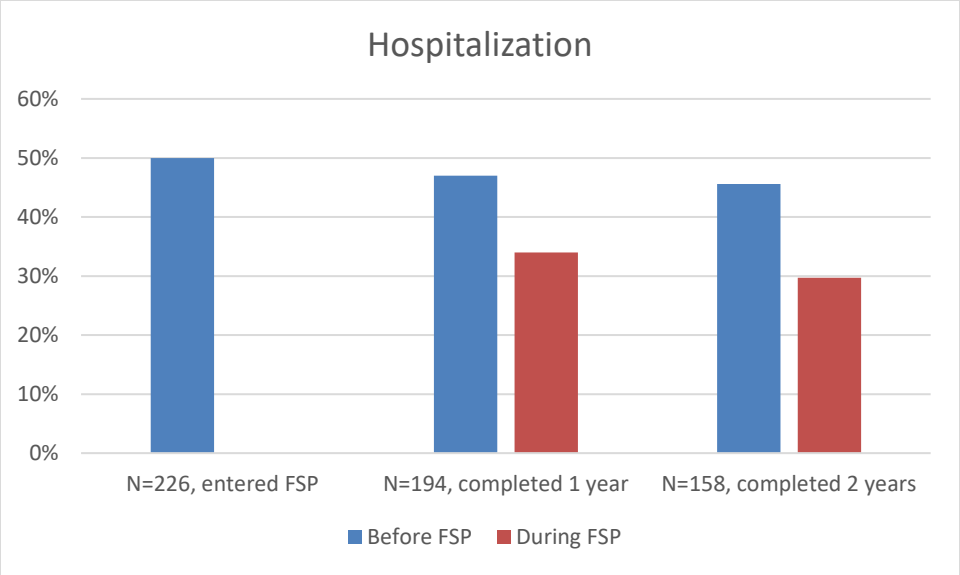
For the 226 Full Service Partners enrolled in an BH program, 150 (66%) experienced mental health emergencies in the year prior to enrollment.



For 194 Partners who completed one year in an FSP, 125 (64%) experienced 377 mental health emergency events in the year prior to enrollment; during the first year as a Partner, 18 (9%) experienced 52 mental health emergencies, a decrease of 86% such events. For the 158 Partners in the second year there were 19 (12%) mental health emergencies, a decrease of 81% from prior to FSP enrollment.

HOSPITALIZATION

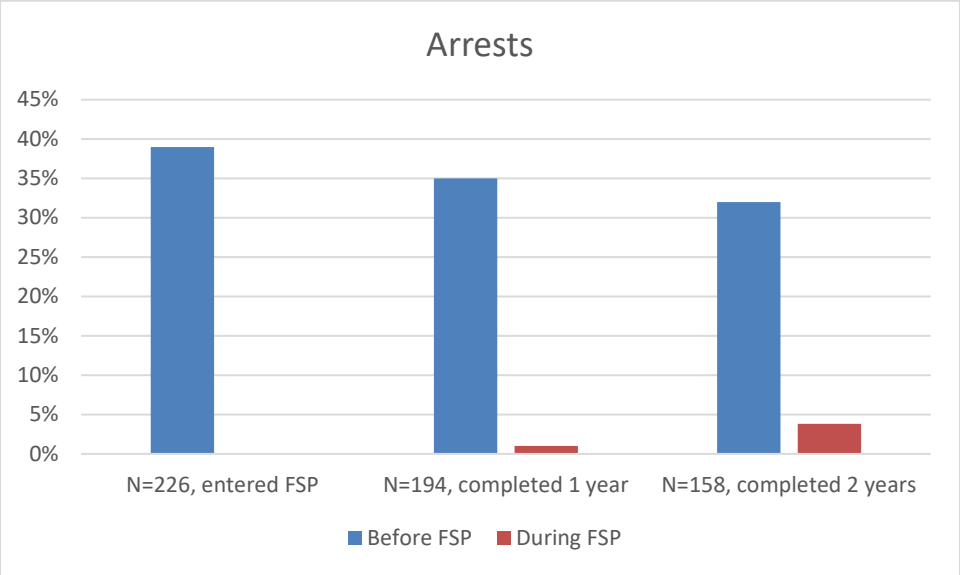
For the 226 Full Service Partners enrolled in an BH program, 113 (50%) experienced hospitalization in the year prior to enrollment.



Of the 194 Partners completing one year in an FSP during this reporting period, 91 (47%) experienced hospitalization in the year prior to enrollment. Sixty-five (34%) experienced hospitalization during the first year of enrollment, a 29% decrease. For the second year there were 47 (30%) out of the 158 Partners who experienced hospitalization, compared to 72 (46%) before FSP enrollment, a 35% reduction in hospitalizations.

ARRESTS

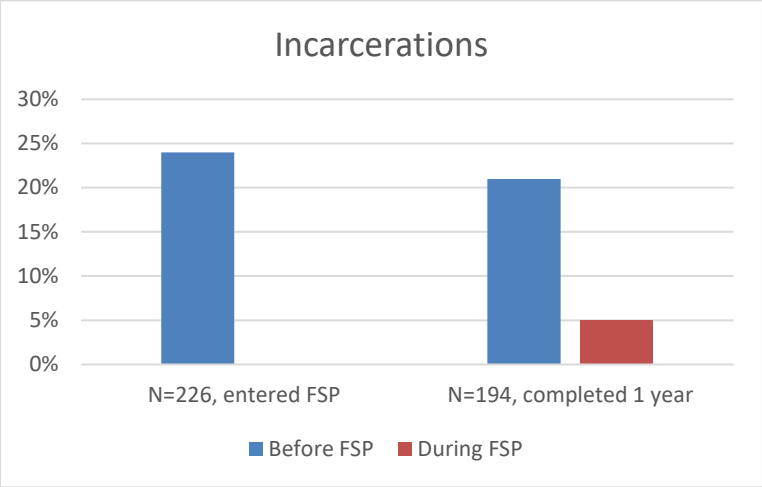
For the 226 Full Service Partners enrolled in an BH program, 89 (39%) were arrested in the year prior to enrollment.



Of the 194 Partners completing one year in an FSP during this reporting period, 68 (35%) were arrested at some time in the year prior to enrollment in an FSP and 3 (1%) were arrested in the first FSP year completed, a 96% decrease in arrests. In the second year, 50 (32%) of the 158 second-year partners had been arrested prior to FSP enrollment and 6 (3.8%) were arrested during the second year, an 88% decrease.

INCARCERATION

For the 226 Full Service Partners enrolled in an BH program, 55 (24%) experienced incarceration in the year prior to enrollment.



Of the 194 Partners completing one year in an FSP during this reporting period 40 (21%) were incarcerated in the year prior to FSP enrollment and 9 (5%) were incarcerated during the first year, a decrease of 78% from the pre-enrollment year. Numbers for the second year of partnership are inconsistent for this measure.

Community Services and Supports: Sub-Acute Transitional Mental Health, Specialty Mental Health and/or Social Rehabilitation Services

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

This program will provide mental health treatment in a residential setting to DHHS-MH referred clients. It will assist individuals who are stepping down from higher levels of care to effectively integrate back into the community. Many or most of the clients will be on a Lanterman Petris Short (LPS) Conservatorship. The program will assist to reduce and prevent homelessness, involvement in the criminal justice system, acute psychiatric hospital admissions and length of stays and admission/re-admission to Institute for Mental Disease (IMD) and Mental Health Rehabilitation Center (MHRC) facilities.

Services will be provided 24 hours/day, seven days per week. Types of services include those in the following categories:

- Sub-Acute Transitional Mental Health Services, including provision of personal living quarters and laundry facilities; provision of continuous observation, assessment, supervision and support; provision of three nutritional meals and snacks in between meals, assistance with tasks of daily living.

- Specialty Mental Health Services, including medically necessary skill-based interventions; counseling; assistance with skill development.

- Social Rehabilitation Services, including written case plans; crisis management; life skills education; maintaining housing.

- Discharge Planning and Coordination Services

The Request for Proposals was issued on January 2020, and proposals are due March 13, 2020. It is anticipated that a proposal will be selected for funding by the end of the Fiscal Year, and that services will begin in FY 2020-2021.

Innovation: Housing, Outreach and Mobile Engagement (HOME) (formerly Rapid Re-housing)

Purpose
The purpose of the HOME Innovation Project is to increase the quality of services, including better outcomes for adults with severe mental illness who are experiencing homelessness. While this Innovation Project is increasing access to services, especially for underserved groups, and promoting 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: Housing, Outreach and Mobile Engagement (HOME) and Mobile Intervention Services Team (MIST).

HOME uses a "Housing First" approach to support clients in obtaining housing. "Housing First" is a proven strategy for ending chronic 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 Housing First practices used in larger urban areas to demonstrate effectiveness on a smaller scale in rural areas. HOME includes outreach and engagement efforts during street level interventions for persons with mental illness who are experiencing homelessness.

The Mobile Intervention Services Team (MIST) is the collaborative effort to successfully engage homeless individuals who have severe mental illnesses and have frequent contact with law enforcement. MIST is discussed later in this section.

To date, the HOME/MIST pathway has linked 166 unique individuals to permanent or temporary housing.

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 (2019) 1,470 people who experienced homelessness were counted on the night of January 23rd.

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 make more affordable housing available for our clients. This began with the early MHSA Housing Program funding and resulted in 15 new studio apartments during Fiscal Year 16-17. The tenant portion of rent is limited to 30% of income, making long term tenancy possible. Nearly all of the initial tenants came directly from the streets through the HOME/MIST pathway. A majority of the initial tenants remain at the same property. Several have obtained Section 8 certificates and moved into other housing. Some have received notices, but most of those have

obtained housing at other properties. As units become available, MHSA eligible clients are supported through the application process and occupancy rates are very high.

Increases in Affordable Housing
A newly developed housing project resulted from a partnership with City of Eureka and a local developer included 15 new subsidized apartments (out of 50 total) for eligible HOME/MIST clients. Clients began occupying the units in April 2017 and occupancy rates have remained very high.

In construction is another 50-unit apartment building with community and meeting space for tenants. This project is fully funded including No Place Like Home (NPLH) funding for 19 of the units. This development has a total of 25 units for eligible HOME/MIST clients. Occupancy should begin in Spring of 2020. A fourth project also under construction is a 25 unit project in Rio Dell. This project will be individual small homes with all utilities and amenities that are fully ADA compliant for eligible HOME/MIST clients.

Community-wide planning and monitoring for projects includes but is not limited to, Humboldt Housing and Homeless Coalition, local city councils, local police departments, Humboldt County Board of Supervisors, Humboldt County Health & Human Services, Humboldt County Behavioral Health Board and the MHSA Community Planning Process.

Multiple funding sources are brought together to ensure financial assistance to tenants such as for deposits, rental assistance, moving costs, damages and other housing related to support housing stability. Sources include City of Eureka, Humboldt County, Housing and Urban Development, MHSA, Partnership Health and St. Joseph Health System/Providence and private contributions.

For all projects, mental health support staff provide services on-site. There are also resident services staff on site. In addition to clinical services, recreational and volunteer opportunities open to all residents to assist community integration and to reduce stigma are provided. All projects also include community spaces for events, supportive services and recreation.

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 HOME 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 high incidence 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 client use of the local crisis services unit and psychiatric hospital during the period

to and after obtaining housing. 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.

HOME/MIST is addressing the following issues for individuals who are experiencing homelessness and have a severe mental illness diagnosis:

- 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 experiencing homelessness and have a severe mental illness diagnosis. These are MIST activities.

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) Behavioral Health (BH) 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 MHSA 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 behavioral health system.

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.
- Coach individuals on how to care for pets in housing.

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.

Minor Changes

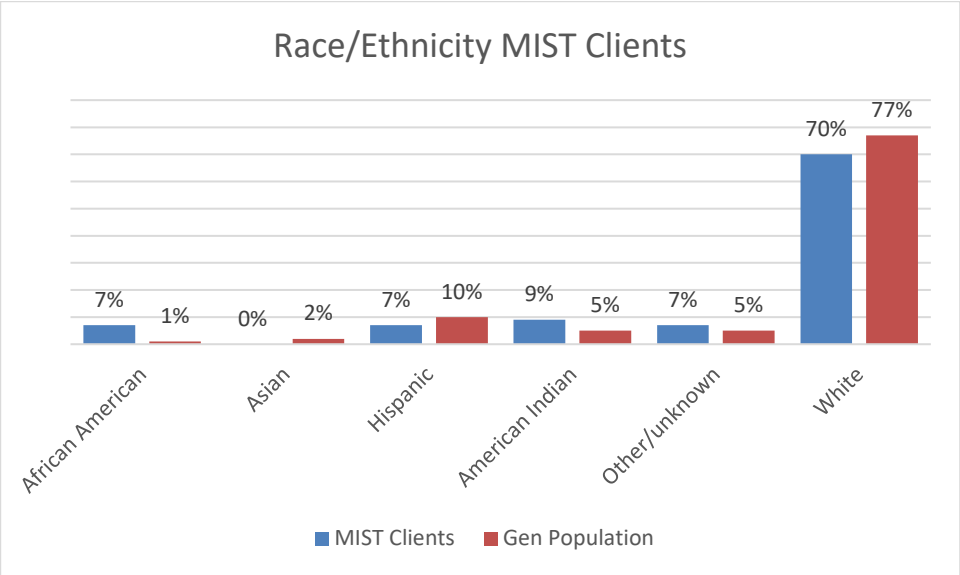
Initially the conversion of a local long-term transitional housing model for families—the Multiple Assistance Center (MAC) -- to a short-term rapid rehousing model that is inclusive of individuals with a severe mental illness diagnosis, required an innovative approach unique to this community. The MAC 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. Innovation funds were used to support participants with serious mental illness with several other sources of funding to support the larger effort and over a hundred persons with a serious mental illness diagnosis obtained housing through the HOME/MIST/MAC project.

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 substance use disorder 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 HOME/MIST part of the project which resulted in an increase of support staff. Additional Peer Coaches, a Clinician, Case Managers, and Community Health Outreach Workers were added to increase access to behavioral health services, especially engagement and assessment. Persons experiencing homelessness that also have a serious mental illness diagnosis are supported in directly obtaining housing.

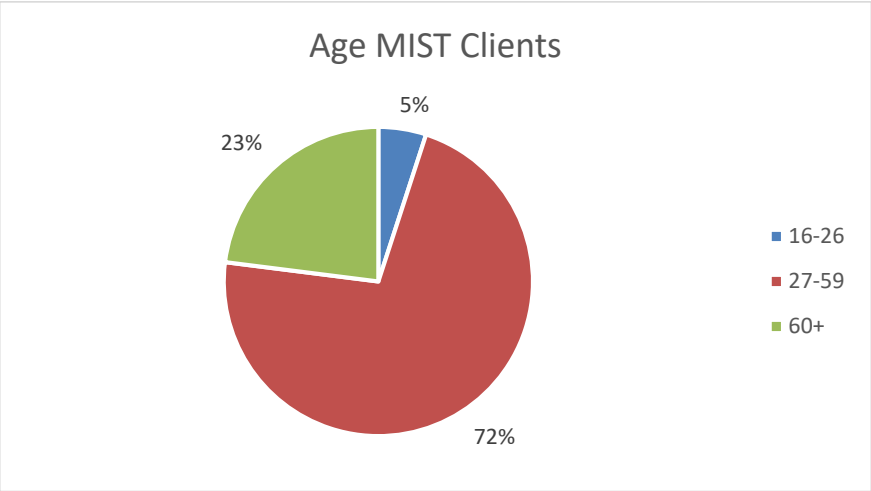
The initial name of the Innovation Project was “Rapid-Rehousing.” As the project has moved forwarded and evolved, implementation team members including program staff, recognized that the title “Rapid-Rehousing” did not include the outreach and engagement components or the range of housing program approaches such as permanent supportive housing. Thus the Project has been renamed Housing, Outreach and Mobile Engagement (HOME).

Mobile Intervention Services Team (MIST)--Partnering with Law Enforcement
MIST maintains a registry of the highest utilizers of emergency services including Emergency Department visits, hospitalizations, calls for service, psychiatric hospitalization and crisis intervention. Referrals are made by the Eureka Police Department (EPD), Arcata Police Department (APD), and the Humboldt County Sheriff’s Office (HCSO).. Key activities are:

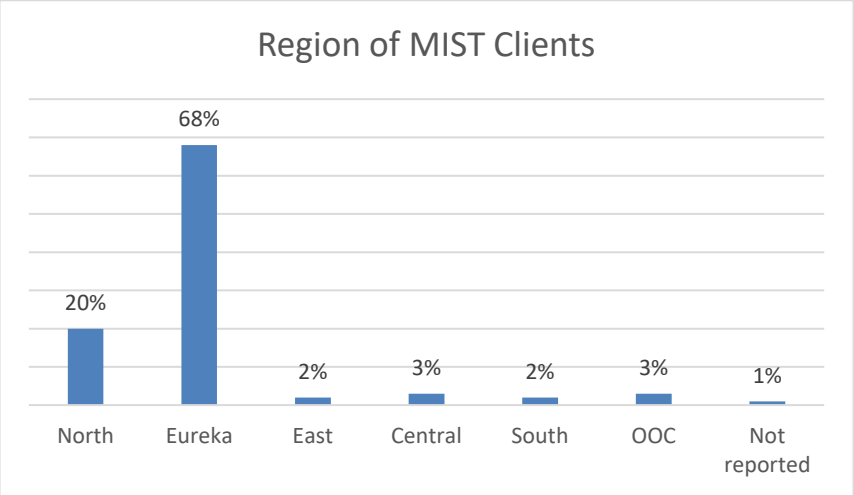
- Outreach and Engagement. Outreach and engagement occur through the MIST partnership with law enforcement, emergency departments, psychiatric emergency services and hospitals as well as other community partners. MIST staff partner with law enforcement officers to ride along on a weekly schedule to make initial contact with the individuals identified by the law enforcement agencies. During the past year there were 1,608 encounters by MIST staff with 92 individuals who then became clients. The average number of encounters per clients was 17, and 15 clients accounted for 62% of the total encounters.
- MIST client data for 2018/19 shows the following:
  Seven percent of MIST clients were African American, as compared to 1% of the general population. There were no clients who were Asian, as compared to 2% of the general population. Seven percent of clients were Hispanic, as compared to 10% of the general population. Nine percent of clients were American Indian, as compared to 5% of the general population. Seventy percent of clients were White, as compared to 77% of the general population. Seven percent of clients were Other/Unknown, as compared to 5% of the general population.



Five percent of MIST clients were ages 16-26, 72% were ages 27-59, and 23% were age 60+.



Forty-three percent of MIST clients were female, and 57% were male. 68% of MIST clients "resided" in Eureka, 20% in the Northern Humboldt region, and the remaining 12% in other regions of the county, out of county (OOC), or not reported.



- In the last year, MIST expanded its service area from Eureka to Arcata and is starting an expansion in the outlying areas of the county. In FY 18-19, MIST received 47 referrals from EPD and 6 referrals form APD. The partnership with HCSO is still in the early development phase and a protocol for receiving referrals is still being established.
- MIST staff consists of a Behavioral Health Clinician, two Behavioral Health Case Managers, three Peer Coaches, and a Community Health Outreach Worker. MIST staff engage in outreach activities each day in an effort to make proactive frequent contacts with the individuals referred to MIST. Sometimes it can take months or even years to engage individuals in services.

- MIST staff review the census on the Crisis Stabilization Unit (CSU) and Sempervirens (SV) Psychiatric Health Facility each day so that they can collaborate on the clients' discharge plans. Staff also review jail bookings each day and work closely with the Behavioral Health staff based in the jail to support clients with developing plans for release. MIST staff visit clients during their stays on CSU, SV, and jail to gain a better understanding of the circumstances leading them to be there and to support them with developing plans to reduce their future visits.
- Once MIST staff have built rapport with the referred individuals they assist them in obtaining a mental health assessment and develop a plan to assist them in achieving their goals. Often the primary goal is to obtain housing.
- MIST clients have extreme difficulty obtaining housing due to the complex nature of experiencing severe mental illnesses, high rates of substance use disorders, and involvement in the criminal justice system.
- 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.
- 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 Behavioral 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

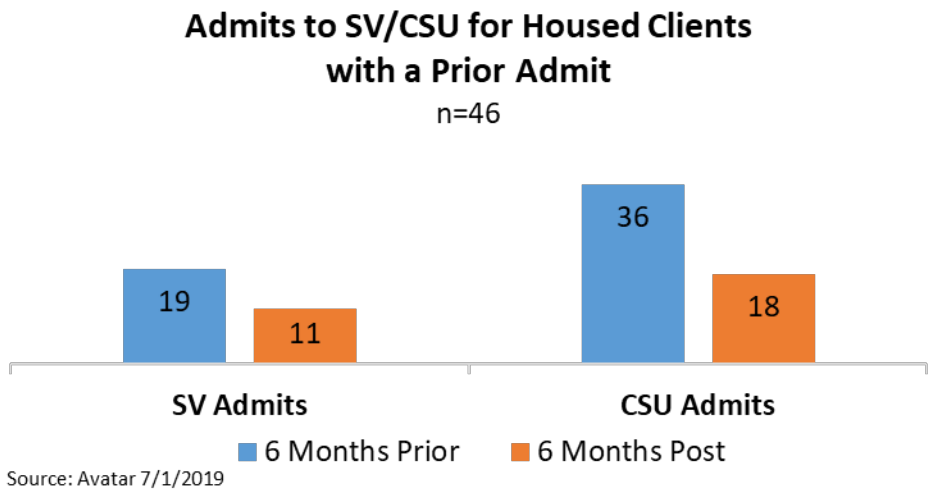
Project Outcomes

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. For those clients who are also Full Service Partners, outcomes may also be monitored through the Department of Health Care Services Data Collection and Reporting System.

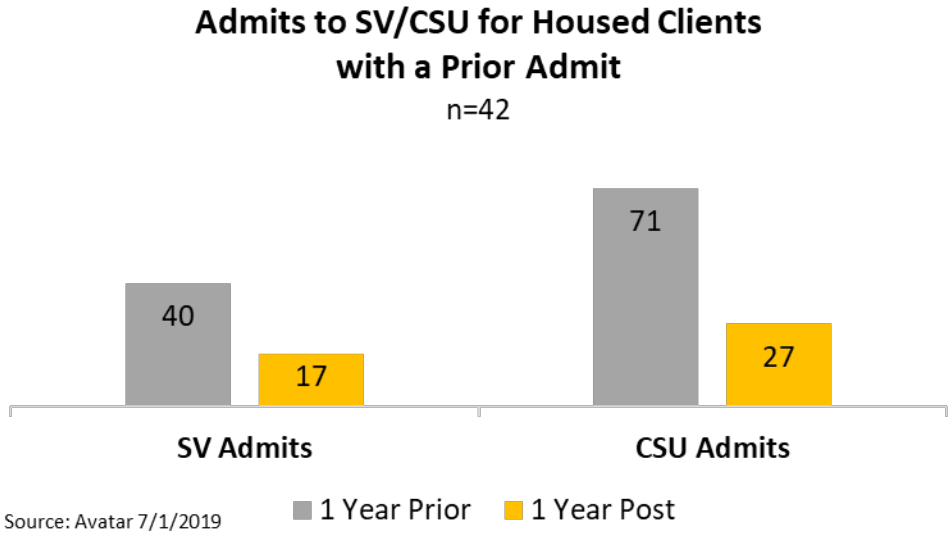
- Increase in residential stability
- Increase in achieving educational goals
- Increase in achieving vocational goals
- Reduce psychiatric hospitalizations
- Reduce psychiatric emergency visits
- Reduce arrests
- Reduce incarcerations

Some initial program outcomes are depicted below.

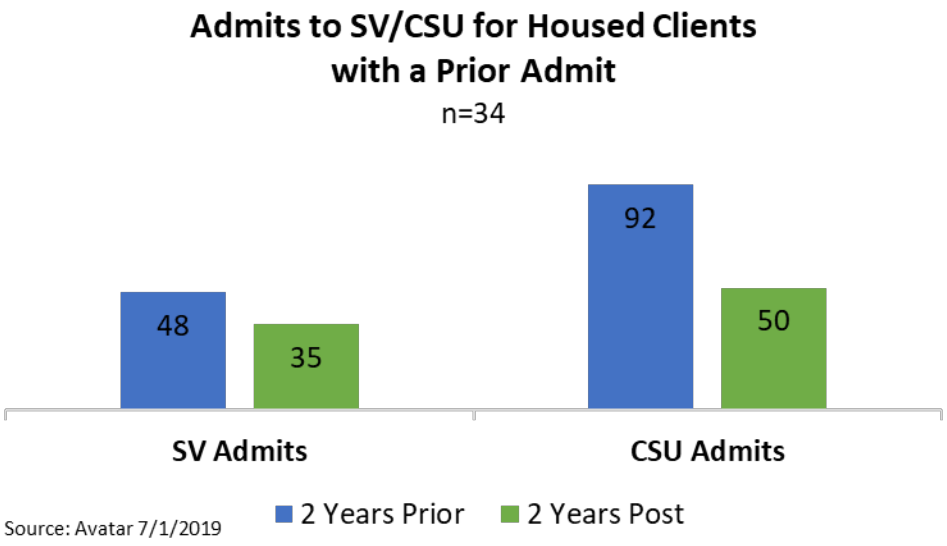
Admissions to Sempervirens (SV, the psychiatric hospital) and the Crisis Support Unit (CSU) declined six months after obtaining housing for homeless individuals who had admissions prior to obtaining housing. For SV, it was 42%. For CSU, it was 50%.



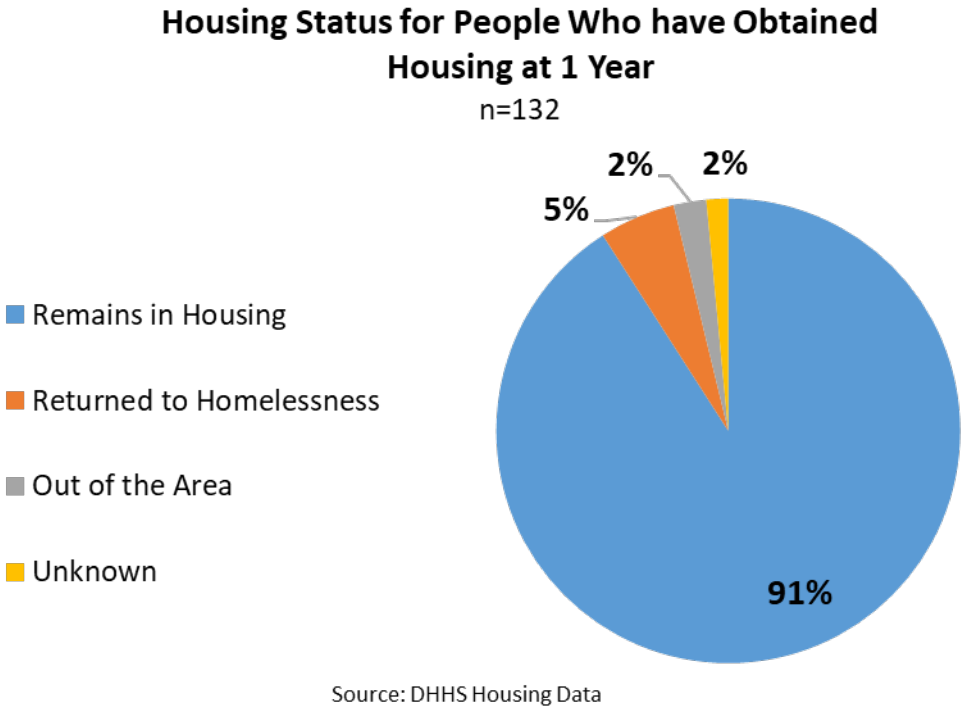
Admissions to SV and CSU declined one year after obtaining housing for homeless individuals who had admissions prior to obtaining housing. For SV, it was 58%. For CSU it was 62%.

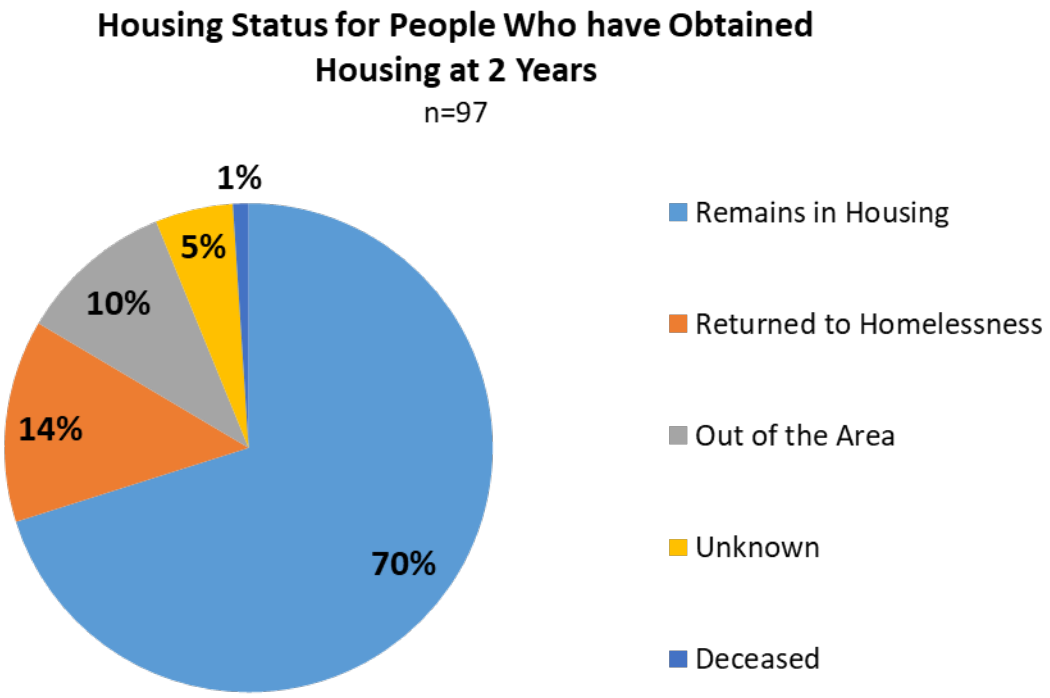


Admissions to SV and CSU declined two years after obtaining housing for homeless individuals who had admissions prior to obtaining housing. For SV, it was 27%. For CSU it was 46%.



At one year after obtaining housing, 91% remained in housing, 5% returned to homelessness, 2% are now out of the area, and 2% are unknown. At two years after obtaining housing, 70% remained in housing, 14% returned to homelessness, 10% are now out of the area, 5% are unknown, and 1% are deceased.





Source: DHHS Housing Data

Project Timeline for Remaining Years

Year	Activities
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 of transition age youth, adults and older adults who have behavioral 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 from SAMHSA, 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 provides prevention activities that reduce stigma and discrimination and provide access and linkage to treatment. These activities contribute to the reduction of all seven of the negative outcomes that may result from untreated mental illness.

The Hope Center is peer driven with a full time Peer Coach III who oversees the Center, three full time Peer Coach staff, two part time Peer Coach staff, and one volunteer. There are two to three Work Experience workers at the Center as well. Consultation is provided by a Senior Program Manager. The majority of the Peer Coaches are trained as Certified Peer Support Specialists through Recovery Innovations (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. The Peer Coach III is leading cross-training of other staff so everyone is able to do the work in the absence of one of the staff. Three staff and one volunteer have completed the Hearing Voices Network Facilitators Training.

Hope Center goals are to:

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

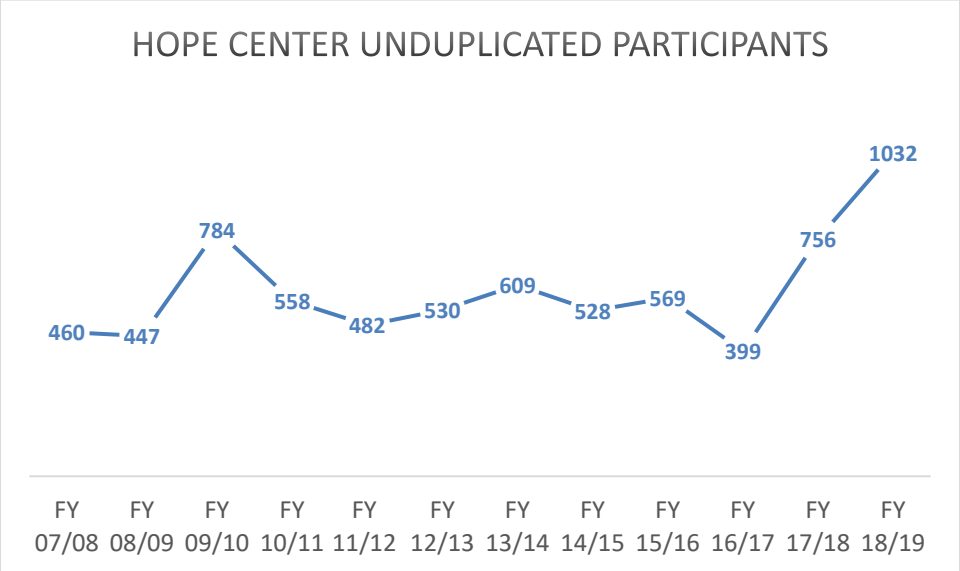
The Center works from the recovery pathways: Hope, Choice, Empowerment, Recovery Environment, Spirituality (purpose/meaning). The Center provides many resources including classes, self-advocacy education, peer support, system navigation, and linkage to services in the community. Outreach efforts are made by Hope Center peer staff and volunteers to people with a mental health diagnosis. 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

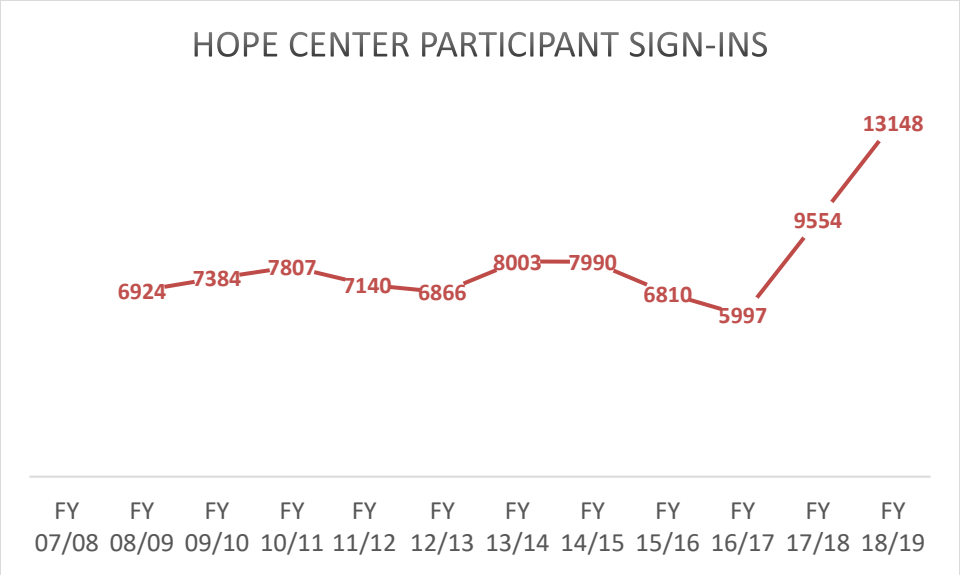
session. It covers many topics such as the pathways of recovery, conflict resolution, substance challenges, social wellness, self-esteem, budgeting and goal setting. In 2018 the Hope Center created an Advisory Board made up of four participants, one volunteer and two staff. The Board's job is to be a voice for the Center and give input to staff. Members meet once a month and Board members serve for one year. One of the Advisory Board members also sits on the Humboldt County Behavioral Health Board. The Hope Center has consistent and active members of the community who contribute services such as outreach, education, and coordination of special events.

Hope Center Continuing Projects include:

- Peer workforce training for the current and future workforce
- Leadership training
- Healthy Harvest--fresh fruits and vegetables for participants to supplement their diet
- Cultural inclusion
- Supporting the Hope Center Advisory Board
- 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
- Teaching interns about the Peer Empowerment model and use of the recovery language to use in their future work.
- May is Mental Health Matters Month participation
- Hope Center offers classes, workshops and education that focus on individuality, mindfulness, nutrition, resilience, fun, building skills, wellness, building community, facing challenges, and building confidence

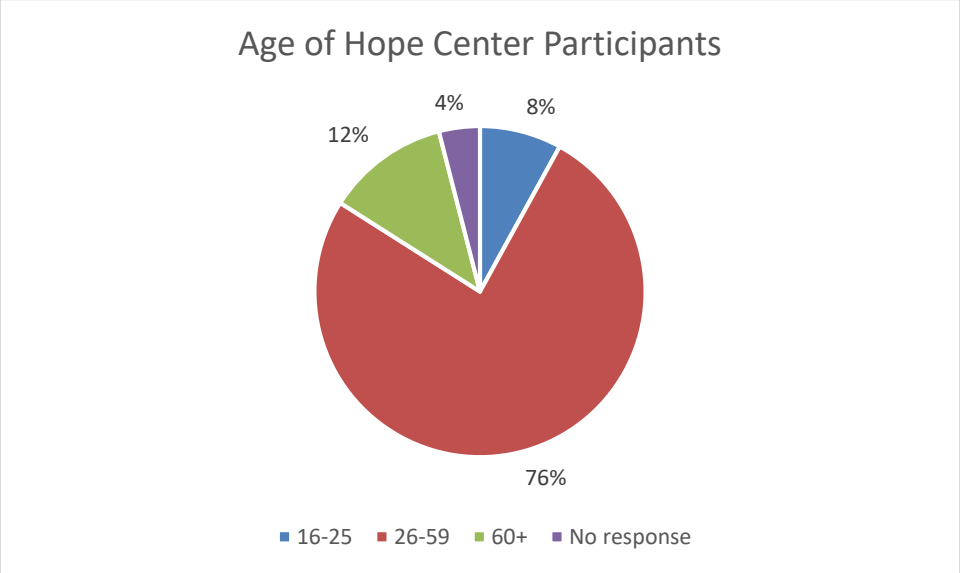
During fiscal year 2018-2019 the Hope Center interfaced with 1,032 unduplicated individuals. There were 13,148 sign-ins to the program. The charts below show the increase over time. In addition, there were three volunteers in the program who put in 566 volunteer hours. It is estimated that in the next fiscal year over 1000 individuals will participate.





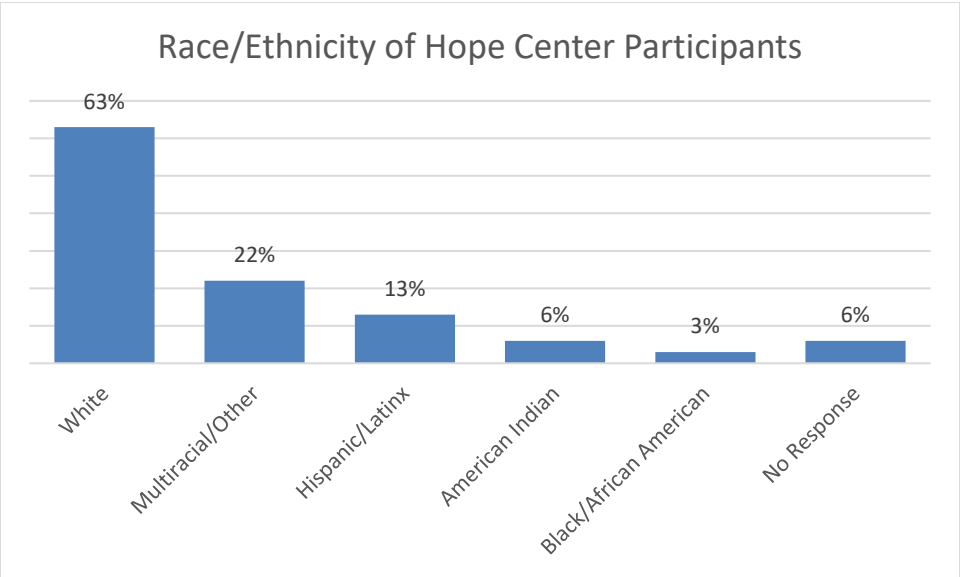
Demographic Data. Of the 1,032 Hope Center participants, 374 (36%) completed demographic forms. Demographic data is presented in the charts below.

Eight percent of participants were ages 16-25, 76% of participants were ages 26-59, and 12% were age 60+. Four percent did not respond to the question.



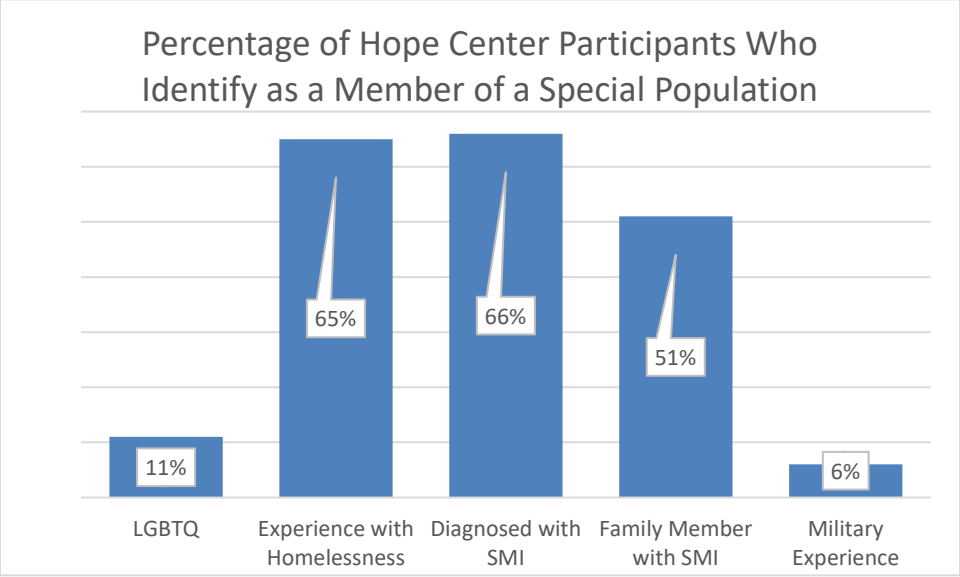
Forty-two percent of Hope Center participants were female, 51% male, and 6% did not respond to the question. Four participants reported their gender as Other.

Sixty-three percent of Hope Center participants were White, 22% were Multiracial/Other, 13% were Hispanic/Latinx, 6% were American Indian, and 3% were Black/African American. There were two Asian/Pacific Islander participants, less than 1%. Six percent did not respond to the question.



Ninety-six percent of Hope Center participants speak English as their primary language, and 3% did not respond to the question. Three participants reported that Spanish is their primary language.

Eleven percent identified as LGBTQ, 65% has experience with homelessness, 66% had been diagnosed with a serious mental illness (SMI), 51% has a family member diagnosed with SMI, and 6% had military experience.



Prevention and 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 including policy, protocol, procedure development for system working with people at risk for suicide
- Humboldt Suicide Fatality Review (SFR)

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.

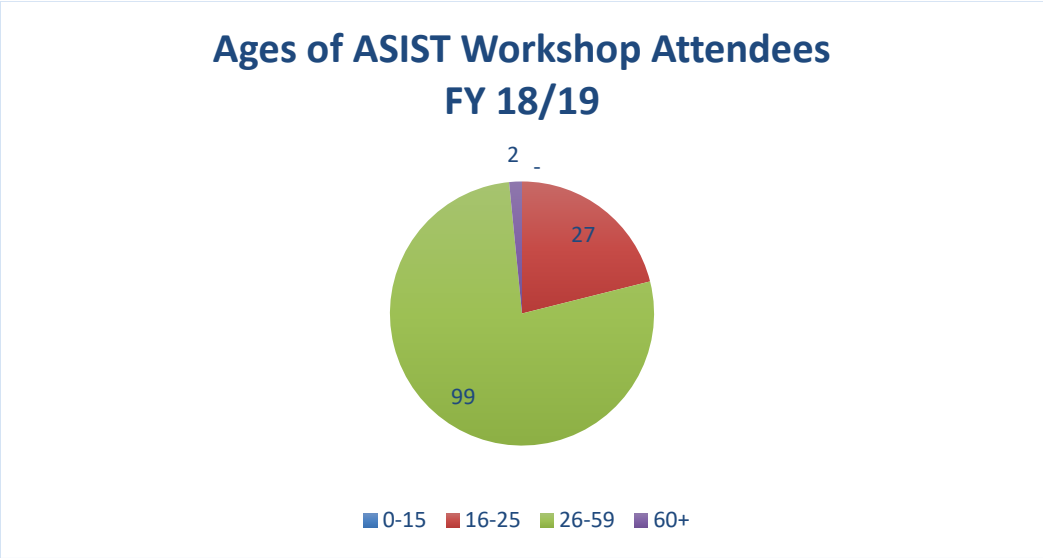
ASIST is a two-day interactive workshop in suicide first aid. ASIST teaches participants to recognize when someone may have thoughts of suicide and work with them to create a plan that will support their immediate safety. Humboldt County has prioritized training as a method to increase system and community 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.

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

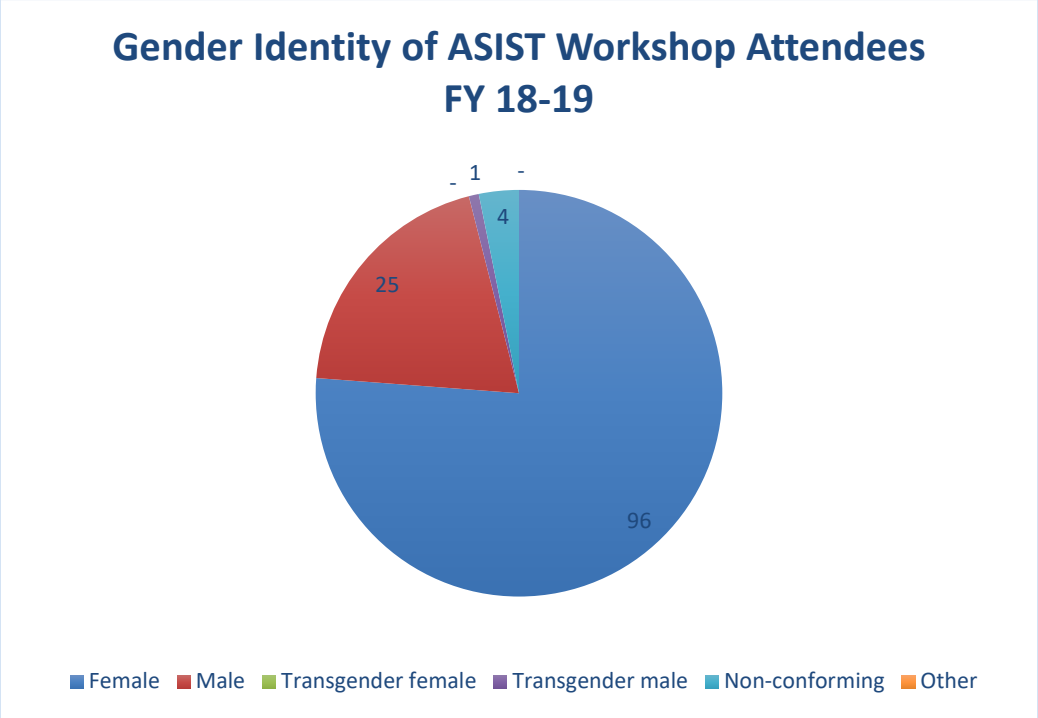
Unduplicated Number of Individuals Served: In FY 2018/19 159 individuals attended ASIST. Seven ASIST Workshops were held.

Demographics of individuals served: Demographic information comes from attendees at trainings who complete a demographic form. In Fiscal Year 18/19, 80.5% of attendees (128) completed a demographic form, and 19.5% (31 attendees) declined completing a demographic form.

In Fiscal Year 18/19, 27 attendees at ASIST workshops were ages 16-25, 99 attendees were ages 26-59, and two attendees were age 60+.

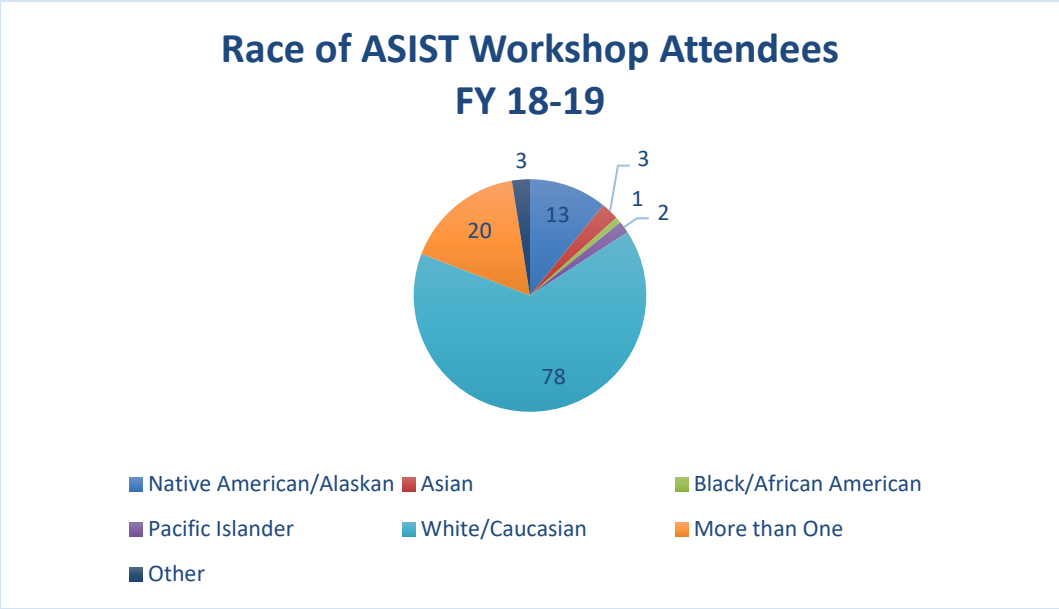


In Fiscal Year 18/19, 96 attendees at ASIST workshops were female, 25 attendees were male, one attendee was transgender male, and four were gender non-conforming.

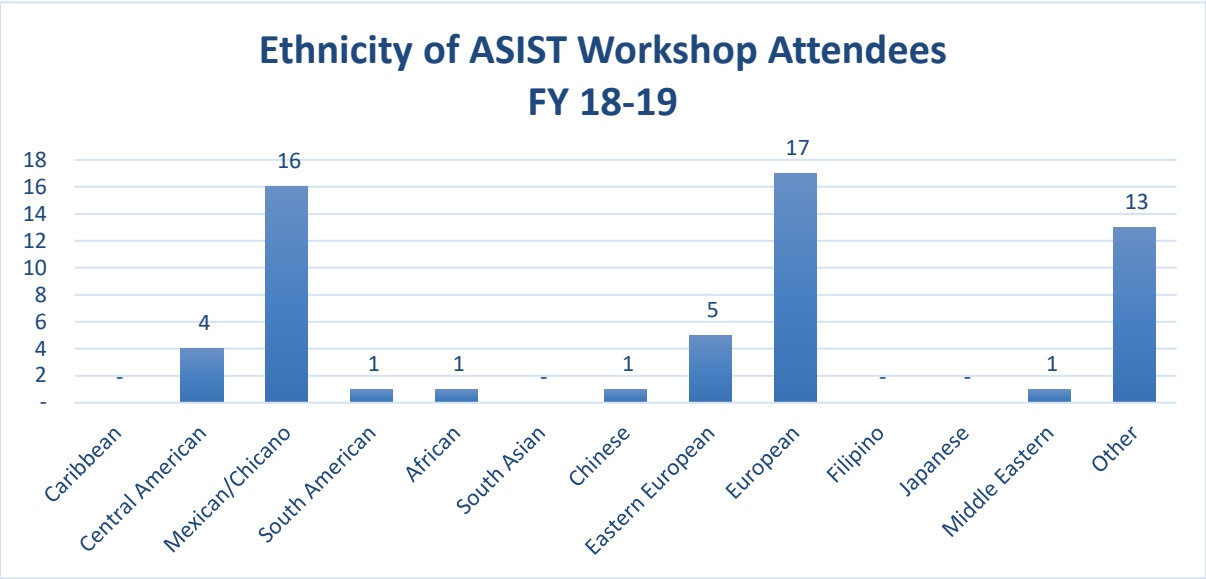


In fiscal year 18/19, 78 attendees at ASIST workshops were White, 13 were Native American, 20 were Multi-racial (More than One), three were Asian, one was

Black/African American, two were Pacific Islander, and three marked Other. Twenty-six participants indicated their ethnicity was Hispanic/Latino.

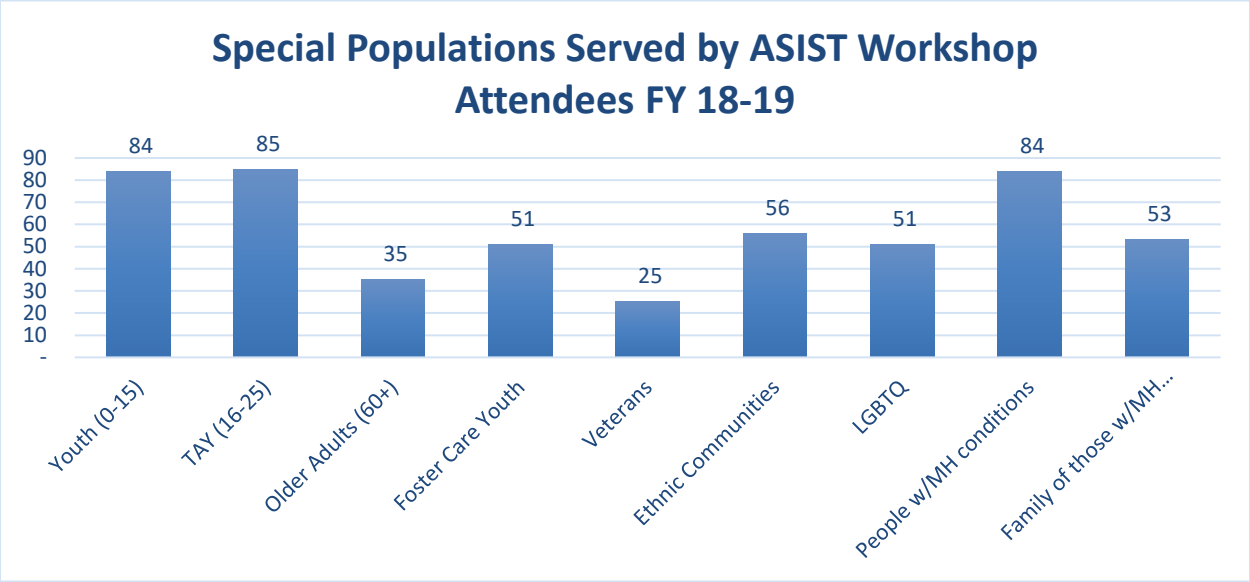


In fiscal year 17/18, demographic forms began to capture ethnicities of ASIST workshop attendees. In FY 18/19, for those answering the question: four were Central American, 16 were Mexican/Chicano, one was South American, one was African, one was Chinese, five were Eastern European, 17 were European, one was Middle Eastern, and 13 marked Other.



When looking at the populations served by the attendees at ASIST, in fiscal year 18/19,

84 served youth ages 0-15, 85 served TAY, 35 served Older Adults, 51 served Foster Care Youth, 25 served Veterans, 56 served Ethnic Communities, 51 served LGBTQ, 84 served people with a mental health condition, and 53 served family members of those with a mental health condition.



Key Activities

Key activities will support outcomes (see below) around improved support for persons at risk of mental health crisis and suicide by giving participants the resources and skills they need to:

- Recognize the signs of persons in need of mental health support
- 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
- Promote 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
- Provide guidance and suicide first-aid to a person at risk in ways that meet their individual safety needs
- Identify the key elements of an effective suicide safety plan and the actions required to implement it
- Improve and integrate suicide prevention resources in the community at large through training and electronic media dissemination
- Recognize other important aspects of suicide prevention including life-promotion and self-care.

OUTCOMES	FY 2018-2019 N=
Number of participants	159
Participants who reported increased knowledge with recognizing warning signs, and behaviors associated with suicidality (0-5 scale)	123
Number of ASIST workshops	7
Pre and Post Evaluation Results	% Increase
If a person's words and/or behaviors suggest the possibility of suicide, I would ask directly if he/she is thinking about suicide	44%
If someone told me they were thinking of suicide, I would do an intervention	40%
I feel prepared to help a person at risk of suicide	65%
I feel confident I could help a person at risk of suicide	63%
I can identify the places or people where I should refer others at risk of suicide	N/A
I have easy access to the educational resource materials I need to learn about helping a person at risk	N/A
I feel comfortable discussing suicide with others	N/A

How Outcome are Measured:

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

Estimated Number to be reached in FY 2019/2020: 120 individuals will complete ASIST workshops in 2019/2020.

Successes. Participants consistently report that ASIST is a powerful, meaningful workshop experience. Trainings consistently fill and have a waitlist, due to positive reputation of this training in our community. Effective partnerships with the Humboldt County Office of Education continues to offset facility costs for our program (and participants), while making ASIST available to community educators.

Challenges: ASIST Trainings are valuable to our community, but are very resource-intensive to produce, as they require up to four trainers, two full days and a training facility with two training rooms. In FY 2019/2020, the PEI program will be losing trainers (due to job changes) and community partnering support (due to sunset of grant funding.) It is likely the cost of ASIST to participants will increase from $30 in FY 19/20.

Because ASIST workshops are two full days long, it can be challenging for participants from outlying areas to attend, due to long commute times, family obligations, etc. It is challenging to bring the training to outlying rural areas for the same reasons.

Lessons Learned: Utilizing technology-based solutions (MailChimp, Eventbrite) to promote and register participants for ASIST has streamlined program staff administrative work for ASIST workshops.

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.

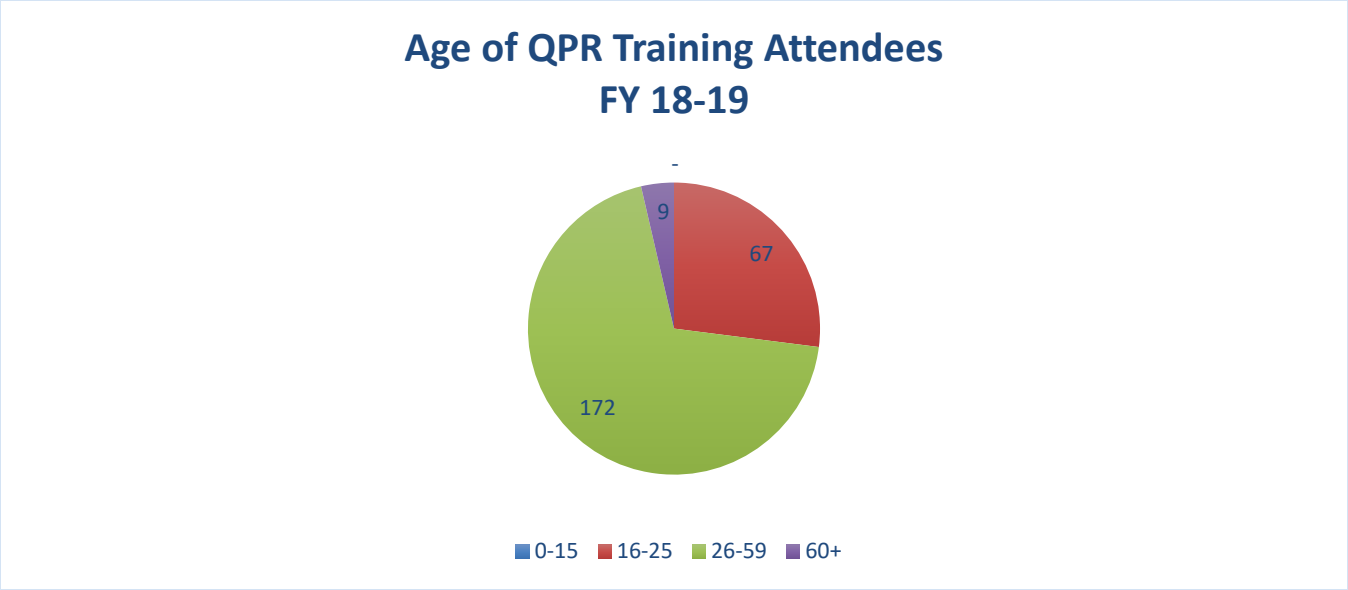
Question, Persuade and Refer (QPR) was implemented in September 2009. QPR provides innovative, practical, and proven suicide prevention training that reduces suicidal behaviors by training individuals to serve as “gatekeepers” those who are strategically positioned to recognize the warning signs suicide 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.

Target Population. 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. With every tailored training a specific resource list for that system and/or population is developed.

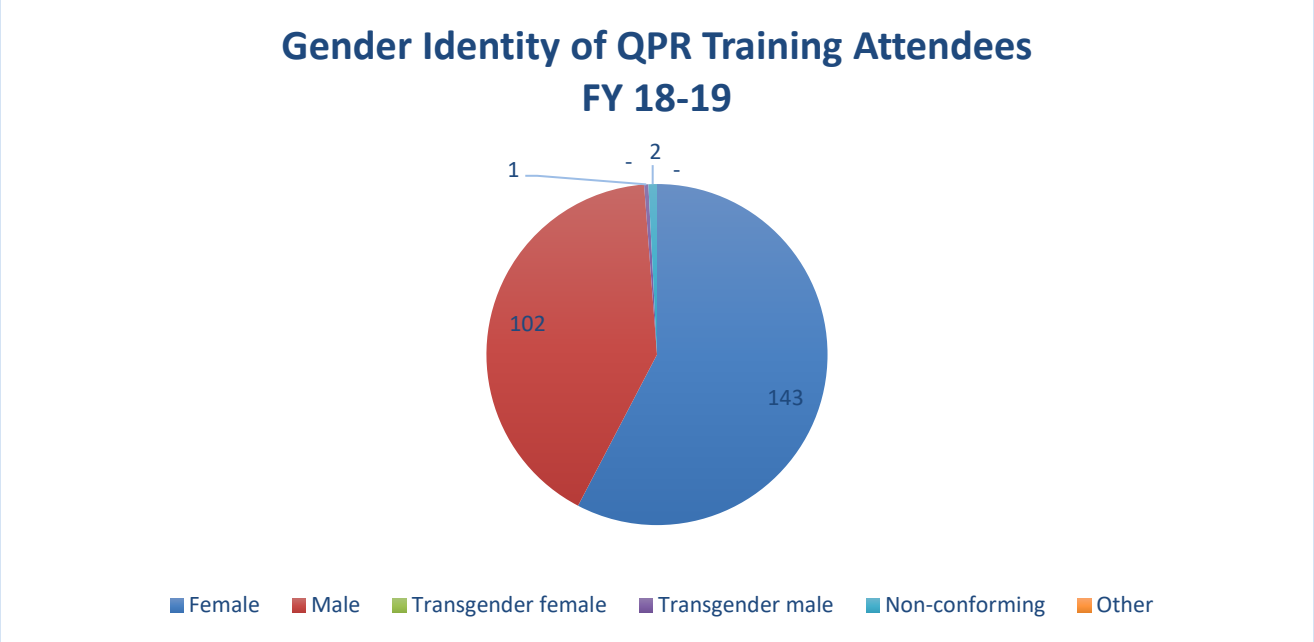
Unduplicated Number of Individuals Served. In FY 2018/19, 459 individuals attended QPR. Nineteen QPR trainings were held.

Demographics of individuals served: Demographic information comes from attendees at trainings who complete a demographic form. In Fiscal Year 18/19, 53% of attendees completed a demographic form, and 47% declined completing or did not receive a demographic form. (See challenges)

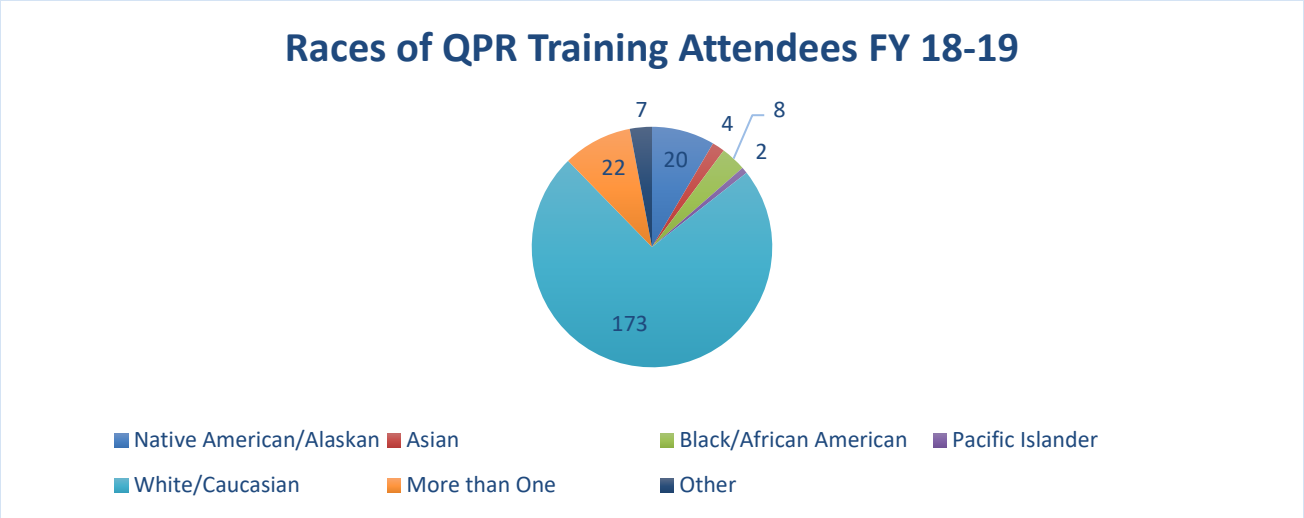
In Fiscal Year 18/19, 67 attendees at QPR trainings were ages 16-25, 172 attendees were ages 26-59, and nine attendees were age 60+.



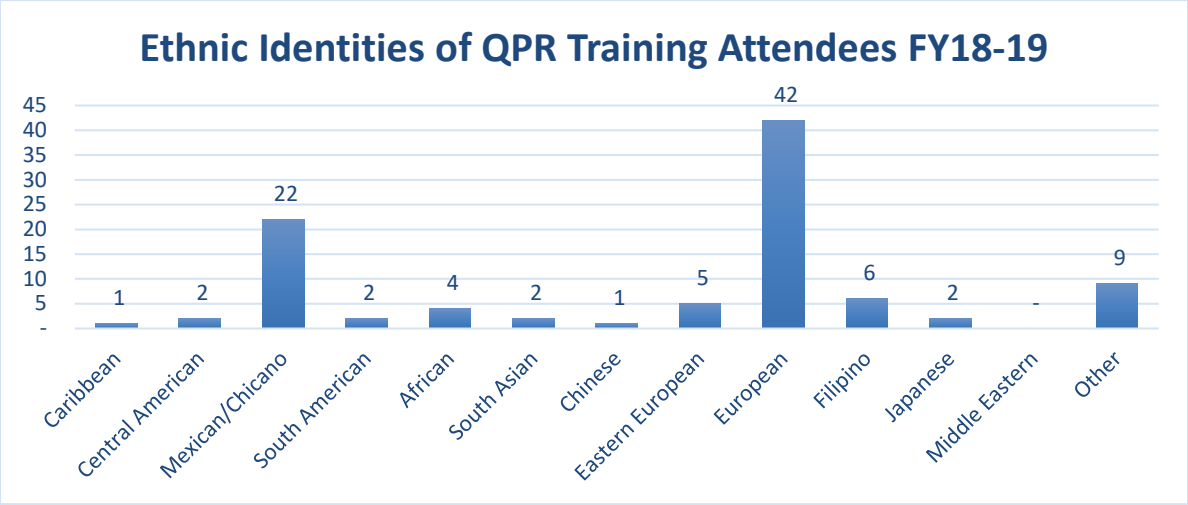
In Fiscal Year 18/19, 143 attendees at QPR trainings were female, 102 attendees were male, one attendee was transgender male and two were gender non-conforming.



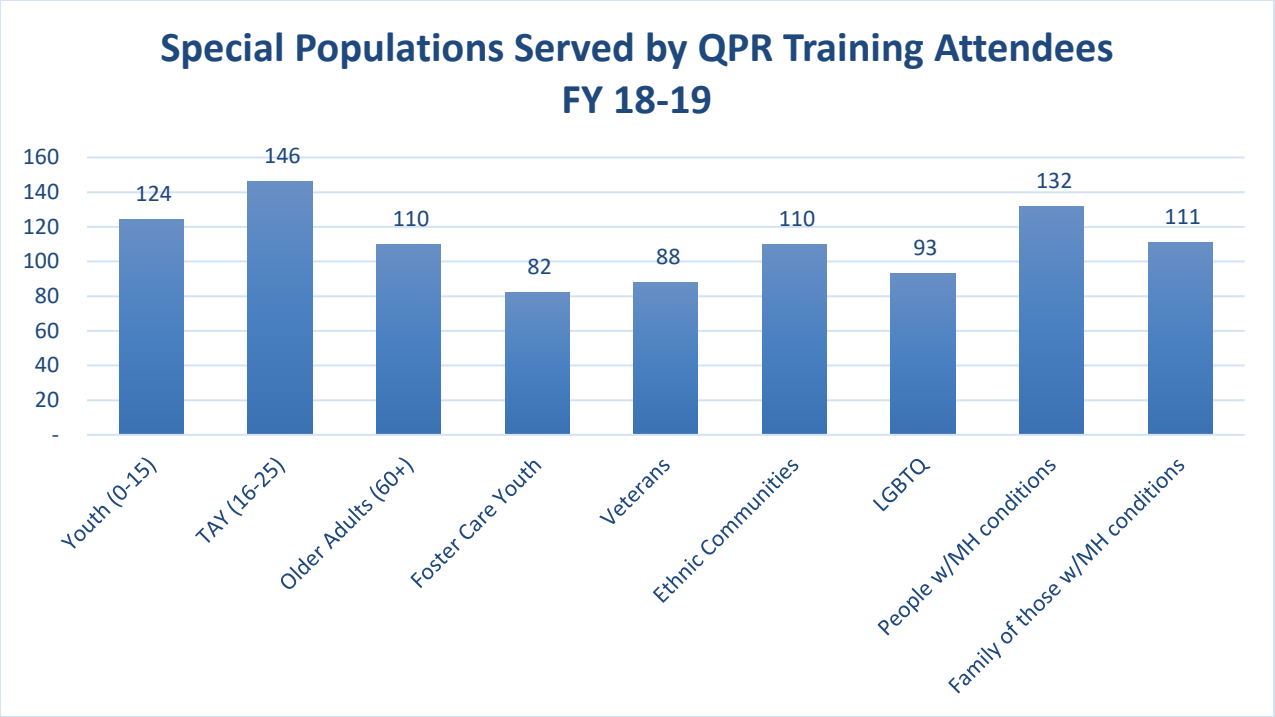
In fiscal year 18/19, 173 attendees at QPR trainings were White, 20 were Native American, 22 were Multi-racial (More than One), four were Asian, seven were Other, two were Pacific Islander and eight were Black/African American. Thirty-one participants were Hispanic/ Latino.



In fiscal year 18/19, demographic forms began to capture ethnicities of QPR training attendees. For those answering the question: one was Caribbean, two were Central American, 22 were Mexican/Chicano, two were South American, four were African, two were South Asian, one was Chinese, five were Eastern European, 42 were European, two were Japanese and nine marked Other.



When looking at the populations served by the QPR attendees in fiscal year 18/19, 124 served youth 0-15, 146 served transition aged youth (TAY), 110 served Older Adults, 82 served Foster Care Youth, 88 served Veterans, 110 served ethnic communities, 93 served LGBTQ, 132 served people with mental health conditions, and 125 served family members of those with a mental health condition.



Key Activities:

- 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

Expected Outcomes: For FY 18/19 the expected outcomes were 6 QPR trainings.

Actual Outcomes for Fiscal Year 2018-2019:

OUTCOMES	FY 2018-2019 N=
Number of Trainings	19
Number of participants	470
Participants who reported increased overall knowledge with recognizing warning signs, and behaviors associated with suicidality (0-3 scale)	272
Pre and Post Evaluation	% Increase 18/19
• Knowledge of facts about suicide prevention	54%

OUTCOMES	FY 2018-2019 N=
• Knowledge of warning signs of suicide	35%
• How to ask someone about suicide	53%
• How to persuade someone to get help	43%
• How to get help for someone	43%
• Information about local, state, and national resources for help with suicide	70%
• Do you feel that asking someone about suicide is appropriate?	23%
• Do you feel likely to ask someone about suicide?	29%
• Rate your level of understanding about suicide and suicide prevention	46%

How Outcomes are Measured:

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 behavioral health challenges

Estimated Number to be reached in FY 2019/2020: We estimate providing 15 QPR trainings reaching 250 people

Challenges: It can be challenging to meet community demand for QPR trainings with our limited staff.

Successes: QPR is a training we have tailored to multiple settings.

Lessons Learned: To increase sustainability, we are providing technical support for community members who are interested in becoming QPR trainers.

Project Name: Humboldt County Suicide Prevention Network

This is a continuing suicide prevention project that also addresses stigma and discrimination reduction. 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 behavioral 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), 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.

Target Population: All age groups of Humboldt County Residents

Unduplicated Number of Individuals Served: One hundred and twelve participants, representing 13 agencies, attended Suicide Prevention Network meetings in 2018-19. Six meetings were held.

Demographics of individuals served: Demographic forms were not administered during Suicide Prevention Network meetings.

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

Expected Outcomes:

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 Mental Health Care Systems

Actual Outcomes for Fiscal Year 2018-2019:

OUTCOMES	FY 2018-2019 N=
Number of participants	112
Number of agencies represented	13
Number of meetings	6

How Outcomes are Measured:

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

Estimated Number to be reached in FY 2019/2020: It is estimated in FY 19/20, that over 100 individuals from 15 organizations will attend Suicide Prevention Network Meetings. Six meetings will be held.

Challenges: One of the key partners supporting the Suicide Prevention Network recently

ended their suicide prevention grant. Their funding and staff support may be less available in the future.

Successes: The Suicide Prevention Network continues to expand. We have implemented ways to increase visibility in the community through outreach using MailChimp. At least twice monthly information is compiled and sent out to our list on local and National training opportunities, the latest information from the field, etc.

Quote from participant: *"I heard about this meeting through a training and decided to attend. At my first (SPN) meeting I heard a presentation about Zero Suicide. I went back to my clinic and started looking into what our system has in place for people at risk for suicide. I found out that at our eleven clinic sites we have no standardized way of screening and care. I decided to move forward with implementing Zero Suicide". Assistant Director of Nursing, Open Door Health Centers*

Lessons Learned: Giving agencies time for discussion and sharing during the SPN meeting allows for helpful brainstorming.

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.

Target Population: 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

Unduplicated Number of Individuals Served: N/A Data from trainings listed in table are included elsewhere in report under QPR or Behavioral Health

Demographics of individuals served: N/A Data from trainings listed in table are included elsewhere in report under QPR or Behavioral Health

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, mental 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.

Expected Outcomes: Six settings in 17/18

Actual Outcomes for Fiscal Year 2018-2019:

OUTCOMES	FY 2018-2019 N=
Number of participants involved in Capacity Building Assistance including tailored trainings:	135
Number of agencies that have developed policies, protocols, procedures to identify persons at risk of suicide and mental health crisis (system change)	2 School Districts Coroner's Office Humboldt Bay Fire The CENTER
Number of trainings provided	8

How Outcomes are Measured:

1. Demographic forms that demonstrate the diversity of populations and settings—the demo forms were provided during tailored trainings developed specifically for the settings where CBA occurred
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

Estimated Number to be reached in FY 2019/2020: One hundred and thirty five individuals, two agencies, and six tailored trainings.

Challenges: Capacity Building Assistance is so varied depending on the setting and agencies involved. We found that CBA support is labor intensive.

Successes: The CBA provided built relationships and provided the structure necessary to incorporate pathways to suicide care.

Lessons Learned: We will scale down our efforts from 6 to 3 settings/agencies for FY 19/20.

Project Name: Humboldt Suicide Fatality Review

Public Health partnered with the Coroner's office to implement a Suicide Fatality Review (SFR) of all adult suicides of Humboldt County residents. In December 2018, Dr. Kimberley Repp trained the Coroner's office, Public Health, Social Services, Behavioral Health, Hospitals, Health Clinics, Primary Care providers, Substance Use Disorder programs, First responders, and other interested community members in how to develop and implement a Suicide Fatality Review. To date, one SFR has been held.

Target Population: Humboldt County Residents

Unduplicated Number of Individuals Served:

- Number who attended SFR training session held on Dec. 4, 2018 with Dr. Kimberly Repp*:* 92
- Number of local agencies represented at Dr. Repp Training: 30
- Number of deaths reviewed in retrospective review (2013-18): 191
- Number of deaths reviewed in first SFR: The number of deaths reviewed in the May 13, 2019 SFR was two.
- Number of participants in first SFR: There were 10 participants serving 8 agencies

The table below shows the risk factor data from the Suicide Consolidated Risk Assessment Profile form 2013-2018.

FREQUENCY OF RESULTS--HUMBOLDT COUNTY SUICIDE CONSOLIDATED RISK ASSESSMENT PROFILE

At time of incident:	% Yes
Current mental health problem	56.0%
Depressed mood	51.8%
Physical health problem	38.7%
Family relationship stress	35.1%
Disclosed intent to commit suicide	32.5%
Other substance abuse problem	30.4%
Current mental health treatment	26.7%
Alcohol problem	26.7%
Intimate partner problem	23.0%
Social isolation	19.4%
Financial problem	14.7%
Criminal legal problem	11.5%
Other relationship problem	10.5%
Job problem	9.4%
Eviction/loss of home	9.4%
Other addiction	7.3%
Anniversary of traumatic event	4.2%
Non-criminal legal problem	2.6%
School problem	2.1%

In the last 30 days	
Perpetrator of interpersonal violence	6.8%
Victim of interpersonal violence	2.6%

In the last 5 years	
Death of friend/family member	10.5%
Suicide of friend/family member	2.6%

At any time	
Suicidal thoughts or plans	44.0%
Mental health diagnosis	34.6%
Suicide attempt	23.6%
Suicide of friend/family member	4.7%
Nonfatal self-directed violence	4.2%
Abused as a child	3.1%

	% Yes
Crisis in past 2 weeks	77.5%
If yes, type of crisis:	
CRISIS: Mental health	46.1%
CRISIS: Physical health	25.1%
CRISIS: Family relationship stress	20.9%
CRISIS: Intimate partner problem	19.4%
CRISIS: Alcohol problem	19.0%
CRISIS: Substance abuse	17.8%
CRISIS: Other relationship problem	8.9%
CRISIS: Financial problem	8.4%
CRISIS: Job problem	5.8%
CRISIS: Eviction/loss of home	5.8%
CRISIS: Criminal legal problem	5.2%
CRISIS: Death of friend/family member	4.2%
CRISIS: Other addiction	3.7%
CRISIS: School problem	1.6%
CRISIS: Non-criminal legal problem	1.6%
CRISIS: Suicide of friend/family member	1.1%

decedent left a note	37.2%	
% of 2013-2018 suicides reviewed	86.4%	n=191

For questions, please contact:
Ron Largusa MSPH
Epidemiologist, County of Humboldt DHHS-Public Health
(707) 268-2187
rlargusa@co.humboldt.ca.us

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

Demographics of individuals served: Demographic forms were not utilized during SFR due to time constraints.

Key Activities:

1. Develop SFR protocols, policies and procedures
2. Meet quarterly to review suicides and make recommendations based on findings
3. Evaluate local suicidal behavior trends, circumstances, risk and protective factors to strengthen prevention efforts

Expected Outcomes:

1. Reduce suicide and suicidal behaviors in Humboldt
2. Develop pathways to suicide care in health, mental health and other community entities for persons at risk and family members.

Actual Outcomes for Fiscal Year 2018-2019:

- Coordinated county-wide Suicide Fatality Review training.
- Partnered with the Coroner's office to develop a SFR process
- Implemented one SFR

How Outcomes are Measured:

- # of SFR meetings held
- # of participants involved
- # of suicide deaths reviewed
- Key findings and follow-up actions

Estimated Number to be reached in FY 2019/2020: SFR will meet quarterly to review 2-3 suicide deaths. It is estimated that SFR will review approximately 8-12 suicide deaths in FY 2019/2020.

Challenges: Lack of information, technical support and financial resources have made development of a robust county SFR model difficult. Staff are researching and designing SFR program materials that will capture the information necessary in order to make informed, action-oriented decisions to inform prevention, intervention and postvention efforts. Access to HIPAA protected information from Humboldt County DHHS Behavioral Health, even with a signed Release of Information from next of kin, has been problematic.

Successes: The partnership with the Coroner's office has been extremely beneficial.

Prevention & Early Intervention: Stigma and Discrimination Reduction

Humboldt County Public Health, Healthy Communities Prevention and Early Intervention strategies fall under Stigma and Discrimination Reduction. 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, and anti-stigma advocacy support for statewide web-based campaigns. There are five projects for Public Health Stigma and Discrimination Reduction, which are reported in this section. It is important to note that other PEI programs, the Hope Center and TAY Advocacy and Peer Support Programs, are also Stigma and Discrimination Reduction programs, and are discussed in other sections of this Annual Update. The Public Health Stigma and Discrimination Reduction Programs are:

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

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

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, five to seven 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

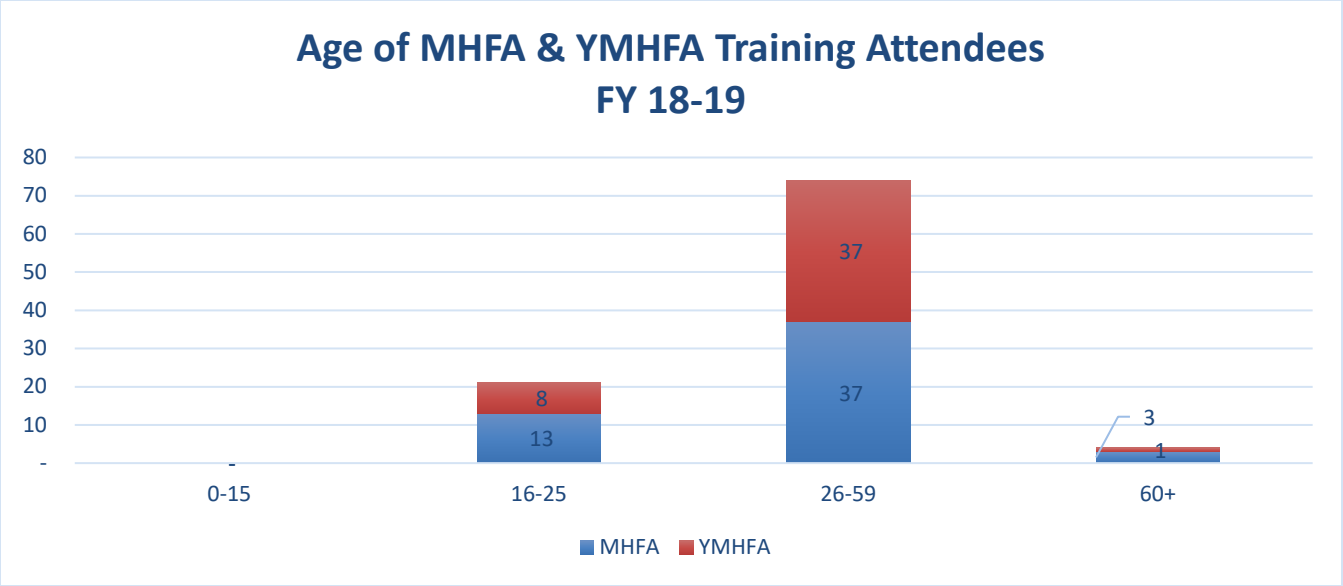
- Both Mental Health First Aid and Youth Mental Health First Aid are eight-hour courses designed to teach individuals in the community how to help someone who is developing a mental health problem or experiencing a mental health crisis. Trainees are taught about the signs and symptoms of mental illness, 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 five-step action plan to help young people both in crisis and non-crisis situations.

Target Population: 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.

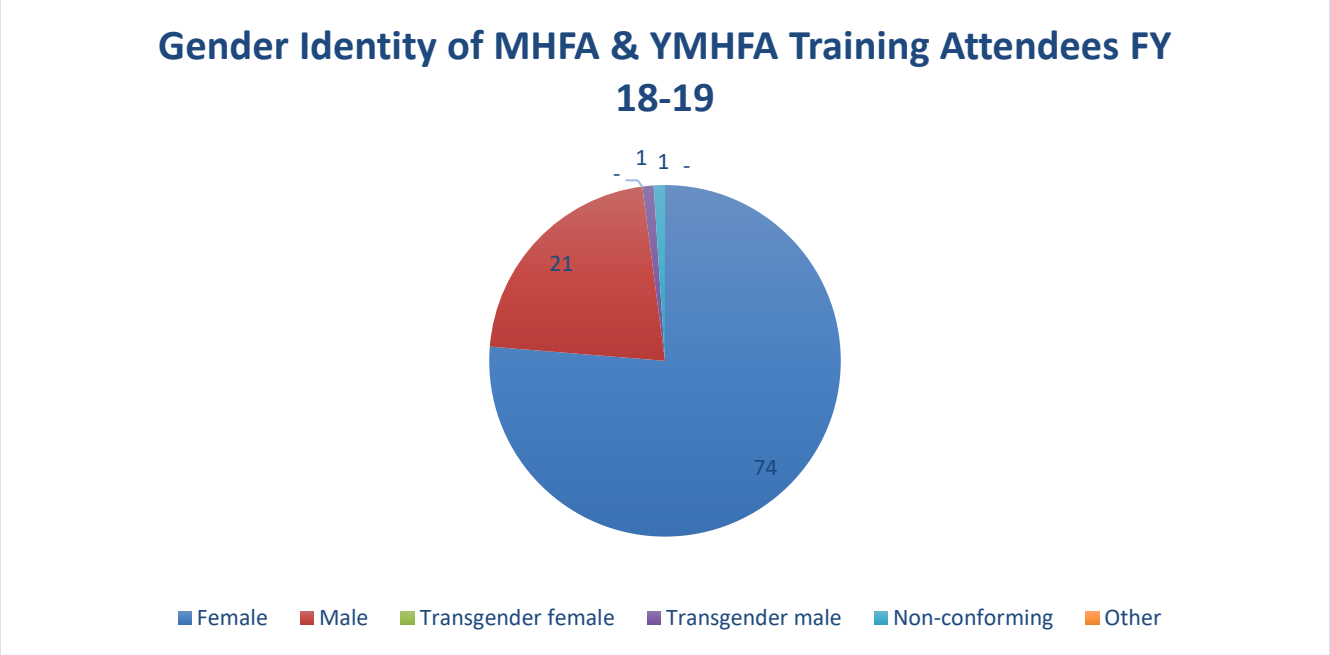
Unduplicated Number of Individuals Served:
In FY 2018-19, a total of 135 individuals attended eight trainings. Seventy-four individuals attended four Mental Health First Aid trainings. Sixty-one individuals attended four Youth Mental Health First Aid trainings.

Demographics of individuals served:
Demographic information comes from attendees at trainings who complete a demographic form. In Fiscal Year 18/19, 74% of attendees completed a demographic form, and 26% declined completing a demographic form.

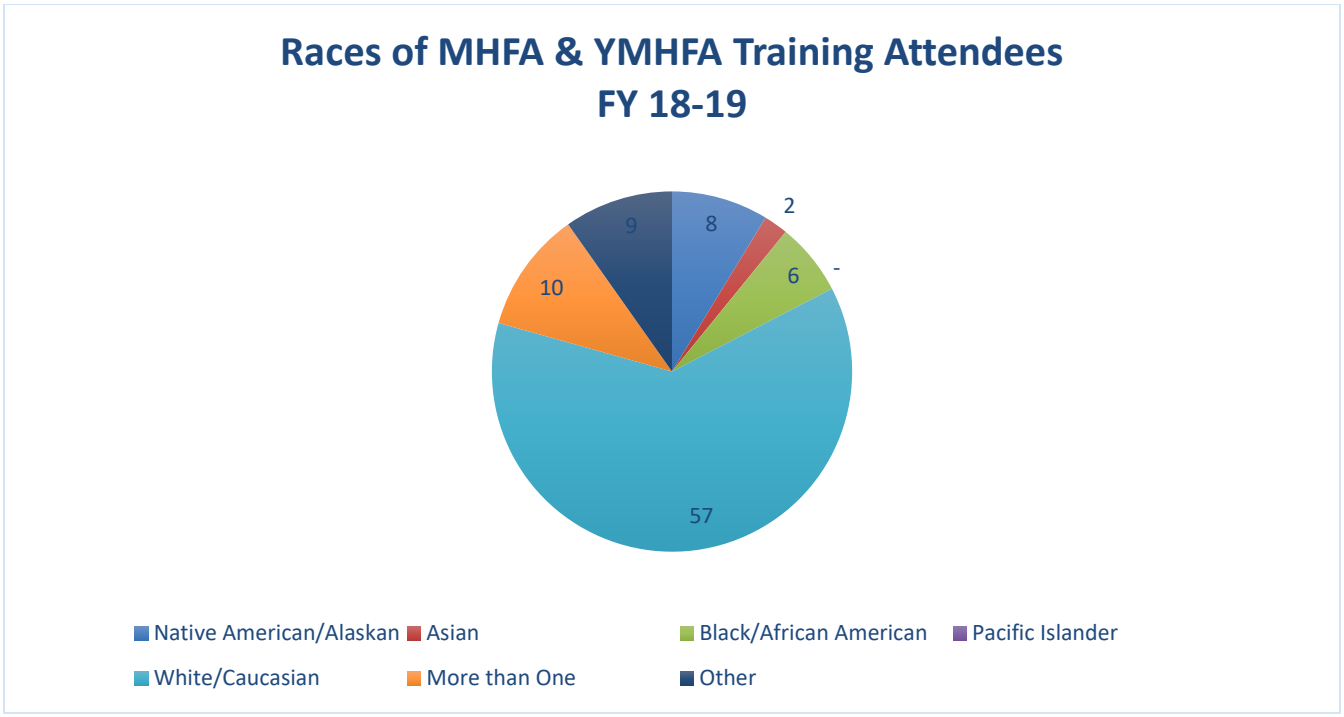
In Fiscal Year 18/19, 21 attendees were ages 16-25, 74 were ages 26-59, and four were age 60+.



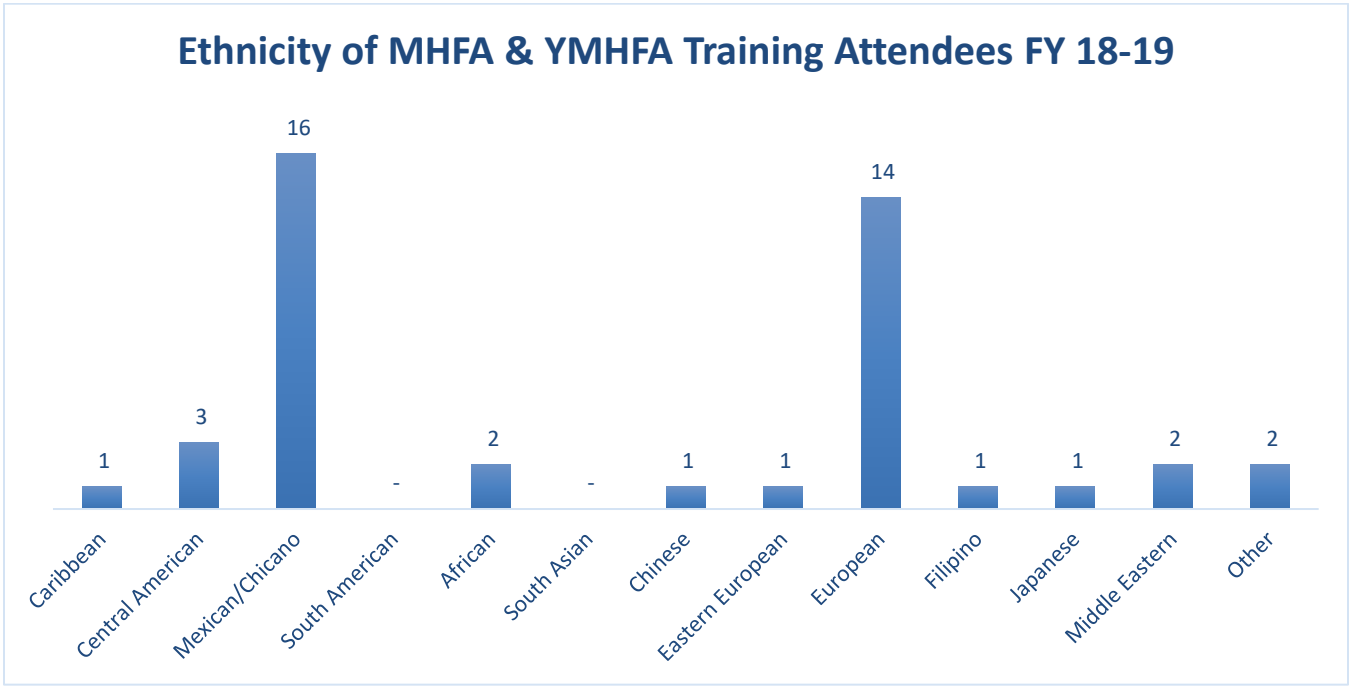
In Fiscal Year 18/19, 74 attendees were female, 21 were male, one was transgender male and one was gender non-conforming.



In Fiscal Year 18/19, 57 attendees were White, eight were Native American, 10 were More than One (Multi-racial), two were Asian, six were Black/African American and nine were Other. Twenty-six participants indicated their ethnicity was Hispanic/Latino.

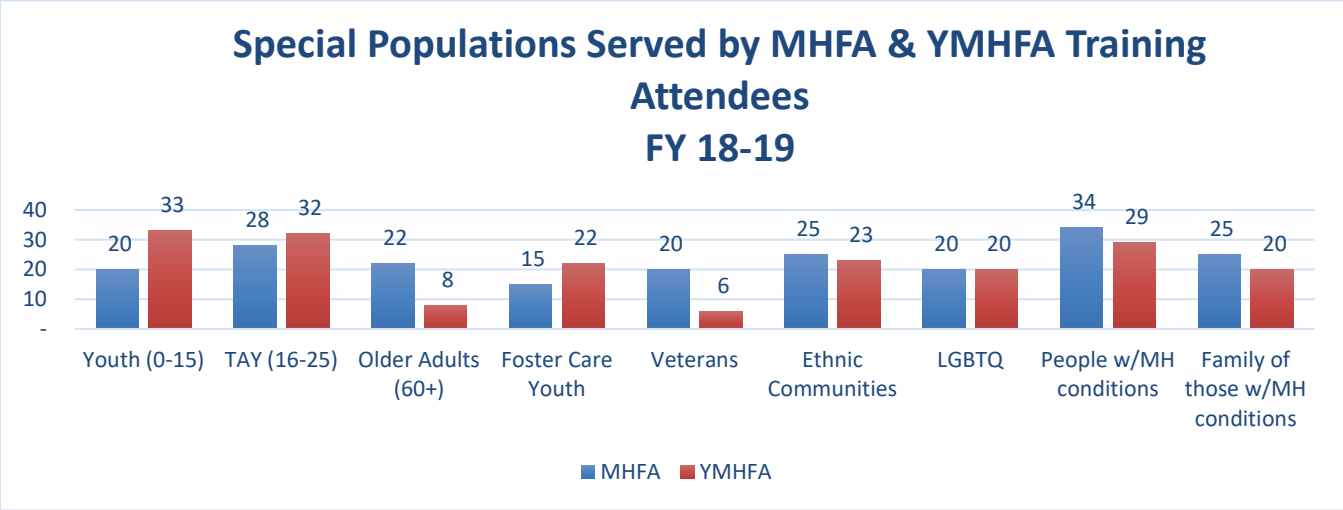


Key Activities: In fiscal year 17/18, demographic forms began to capture ethnicities of MHFA and YMHFA training attendees. For those answering the question in FY 18/19, 16 were Mexican/Chicano, 14 were European, three were Central American, two were African, two were Middle Eastern, one was Chinese, one was Caribbean, one was Filipino, one was Japanese, one was Middle Eastern, and two marked Other.



When looking at the populations served by the attendees at MHFA and YMHFA trainings

in Fiscal Year 18/19, 53 served youth ages 0-15, 60 served transition-aged youth (TAY) ages 16-25, 30 served Older Adults, 37 served Foster Care Youth, 26 served Veterans, 78 served Ethnic Communities, 40 served LGBTQ, 63 served people with mental health conditions and 45 served family members of people with mental health conditions.



Learning Objectives:

- 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

Expected Outcomes:

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 Mental Health Care Systems

Actual Outcomes for Fiscal Year 2018-2019:

OUTCOMES	FY 2018-2019 N =
Number of Adult and Youth MHFA trainings	8
Number of community members that participated in Adult MHFA trainings	74
Number of community members that participated in Youth MHFA trainings	61
Total number of participants	135
Participants who reported gaining knowledge in the following categories about mental illness signs and symptoms (scale of 1-5: 1=strongly disagree; 5=strongly agree). Number equals participants indicating greater than 3	FY 2018-2019 % of participants
Recognize that someone may be experiencing a mental health problem or crisis	97%
Reach out to a person who may be dealing with a mental health challenge	95%
Offer a distressed person basic “first aid” level information and reassurance about mental health problems	95%
Assist a person who may be dealing with a mental health problem or crisis to seek professional help	95%
Assist a person who may be dealing with a mental health problem or crisis to connect with appropriate community, peer and personal supports	94%
Be aware of my own views and feelings about mental health problems and disorders	97%

How Outcomes are Measured:

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

Number to be reached in FY 2019/2020: One hundred twenty individuals to be trained in MHFA or YMHFA in FY 19-20.

Challenges: The biggest challenge is capacity to offer enough trainings to meet community requests. There are a number of reasons for this: 1. We have a small training team. 2. People who are trained move on to other positions and are no longer able to train.

Successes: We have a great partnership with Humboldt County Office of Education and work with them to offer trainings to educational staff throughout Humboldt County. Both Youth and Adult MHFA are a great basic training for community.

Lessons Learned: It can be difficult to anticipate participant show rates when our team isn’t in charge of the registration process for YMHFA or MHFA.

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.

The target population is 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.

Directing Change is promoted as a resource during other suicide prevent and mental health awareness trainings including QPR, mental health 101, high school and other community presentations. Directing Change was promoted as an opportunity for engagement and as a resource at 16 trainings/ presentations to 430 individuals.

Our program also delivered stand-alone Directing Change presentations using the films, for students interested in participating and educators interested in the presentation for their students. The Directing Change films and film contest were the primary focus of presentation at 4 presentations for 96 individuals (81 students and 15 educators). In addition, in 3 separate presentations (not included previously), the team reviewed film storyboards for 76 students.

Demographics of individuals served: Directing Change presentations are almost exclusively made to students and educators, in presentations that are one hour or less in duration. Our program does not administer the form to students under age 18, or in shorter presentations where it isn't feasible. Directing Change presentations were delivered to students at the following high schools:

- Eureka High School (30 students- Directing Change presentation + storyboarding)
- Fortuna High School (46 students- Directing Change presentations + storyboarding)

Directing Change films were submitted from the following high schools:

- Eureka High School
- Fortuna High School

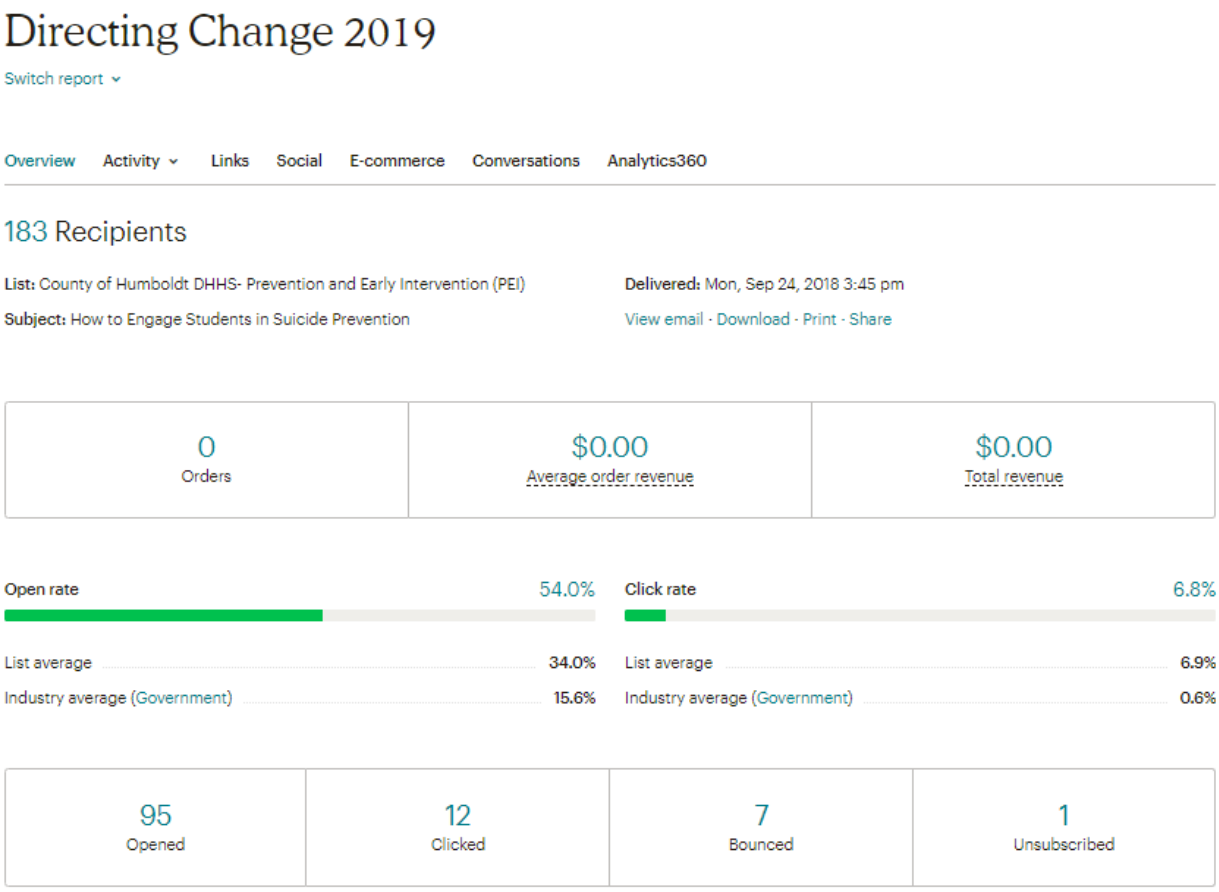
- McKinleyville High School

Expected Outcomes:

- 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.

Actual Outcomes for Fiscal Year 2018-2019:

OUTCOMES	FY 2018- 2019 N=
Number of youth leaders/ local educators who received DC promotional emails sent	183
Number of youth who participated overall	79
Number of films submitted	8
# presentations to promote DC (including only DC- directed)	7
Estimated # of impressions	94
Number of participating youth-serving entities Schools	5
Youth organizations	1



How Outcomes are Measured:

1. # of people reached through presentations and film viewings
2. # of informational packets distributed
3. # of films submitted
4. # of new youth-serving and/or schools will participate

Number to be reached in FY 2019/2020: 150

Challenges: Many of the classes and students who participated in Directing Change did not submit their films to the statewide contest. This year, program staff were not able to have a red carpet ceremony due to staff shortages.

Successes: Directing Change films are part of the core curriculum in grades 7 to 12. The project team has designed classroom presentations using the Statewide films. The films provide students with opportunities for students to discuss and learn about suicide prevention, stigma and discrimination reduction and raise awareness.

Lessons Learned: There is limited staff capacity to reach all the schools in Humboldt County. To address this, the team developed a curriculum for educators so they can use the films in their classrooms. This builds capacity with educators and within school systems.

In addition, the team is relying more on email as a tool to reach out to educators instead

of “promotional packets” used in the past. This does not seem to have impacted the number of educators and classrooms who wish to be involved in Directing Change, and allows project staff to be more strategic in its outreach.

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. print ads, radio ads) 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.

E-Mailing List—Healthy Communities PEI will maintain educational connections made with training participants and with individuals in the community through an email list. Emails will share state content and other social marketing initiatives, promote local PEI activities (including awareness months) and highlight resources for mental health and suicide prevention. Emails will be sent approximately twice per month.

Radio/PSA campaigns—Healthy Communities PEI also promotes its social marketing campaigns and promotes program objectives (such as promoting help-seeking) through radio public service announcements. The focus of radio ads include: Each Mind Matters and Know the Signs content, Lock Up your Lethals information, awareness month resources and messaging and ads targeting stigma and help-seeking.

DHHS Website: Healthy Communities PEI will post key resource and content to the program DHHS webpage, promote this content, and track analytics throughout the course of the focal year.

Target Population: All Humboldt County Residents

Unduplicated Number of Individuals Served: See outcome section for numbers of individuals served.

Demographics of individuals served: Demographic information is not currently collected through social marketing campaigns.

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

Expected Outcomes: 5,000 exposures to social marketing will occur.

Actual Outcomes for Fiscal Year 2018-2019:

OUTCOMES	FY 2018-2019 N=
Number of unique page views for DHHS Suicide Prevention program webpage	250
Number of unique page views for DHHS Stigma and Discrimination Reduction program webpage	63
Number of ReFrame Your Brain Poster Contest Entries	29
Number of Reframe Your Brain Poster Contest votes	193
Audience reached by radio PSAs (estimated)	61,000
Number of Email list emails opened	1,602
Number of estimated event attendees at community events (tabling at fairs and other events)	350
TOTAL SOCIAL MARKETING EXPOSURES	**63,487**

ReFrame Your Brain Poster Contest: In FY 18-19, 29 participants entered for the ReFrame Your Brain Poster Contest and nearly 200 community members voted on the results of the contest. The posters were displayed during May is Mental Health Matters month at the Eureka Public Library and voting was completed electronically via Survey monkey. In addition to votes, voters also had the opportunity to share comments and feedback about the contest. Here are a few of their comments:

"All of the posters are wonderful, picking a favorite was not easy. No one should feel like they did not win because WOW they went through a lot to get where they are and to enter this contest. THANK YOU for opening up and putting these out for the world to see!!!"

"This contest was effective in broadening my horizon about mental illness. I tend to ignore it, or signs of it in others, or even that it could be useful to think about it. I began to feel how important it is to not stigmatize mental illness. Thank you."

"Awesome work artists! Thank you for reminding us what of what is possible by pursuing these passions despite the risks and fears."

Radio PSAs

84 ads per month on three FM stations (KRED 92.3, KFMI 96.3, KKHB 105.5)	Approximately 61,000 listeners each week across all three stations. (based on national radio listener trends)
120 ads per month across two FM stations (KWPT 100.3, KSLG 93.1)	Approximately 61,000 listeners each week across all three stations. (based on national radio listener trends)

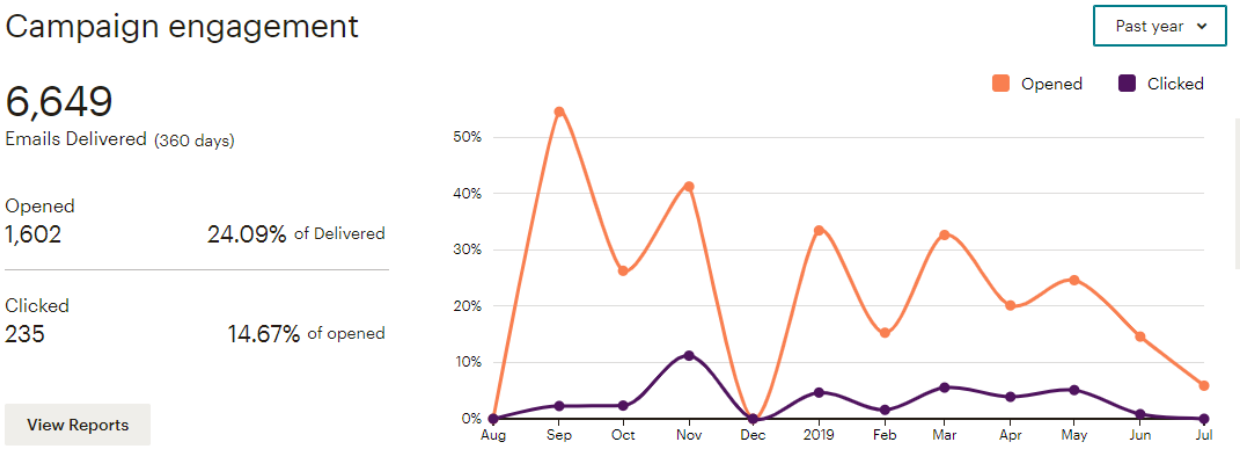
DHHS Website analytics report:

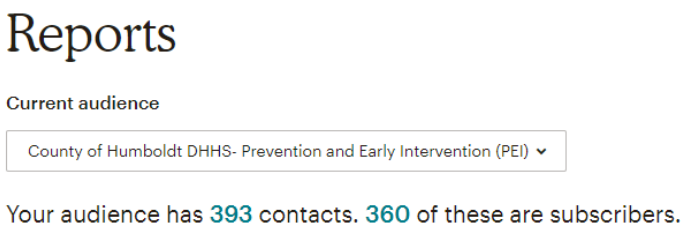
DHHS Website - Suicide Prevention & Stigma Reduction Page Analytics

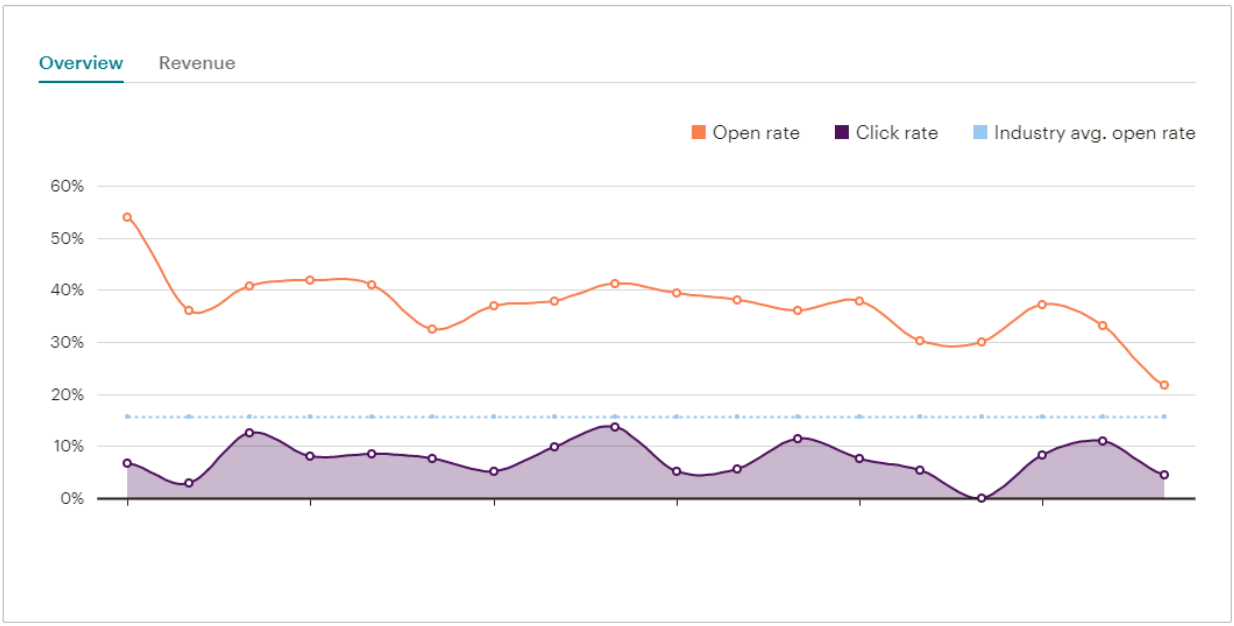
FY 2018-2019 (7/1/2018 - 6/30/2019)

URL	Page Views	Unique Page Views
https://humboldtgov.org/2047/Suicide-Prevention-Program	292	251
https://humboldtgov.org/2096/Suicide-Prevention-Resources	339	250
https://humboldtgov.org/2074/Suicide-Prevention-Training	268	222
https://humboldtgov.org/2095/Reducing-Access-to-Lethal-Means	46	39
https://humboldtgov.org/2075/Technical-Support-and-Capacity	29	27
https://humboldtgov.org/2048/Stigma-and-Discrimination-Reduction-Prog	77	63

Email Lists: Two email lists were created in 2019: one focusing on mental health topics in general, and another focused on suicide prevention activities. At the completion of FY 2018-2019, the PEI email list had 393 contacts and the Suicide Prevention Network (SPN) email list had 404 contacts, for a grand total of 797 contacts. A total of 6,649 emails were sent, with an average "open rate" of 24.09%, which is above industry standard for government generated email lists.





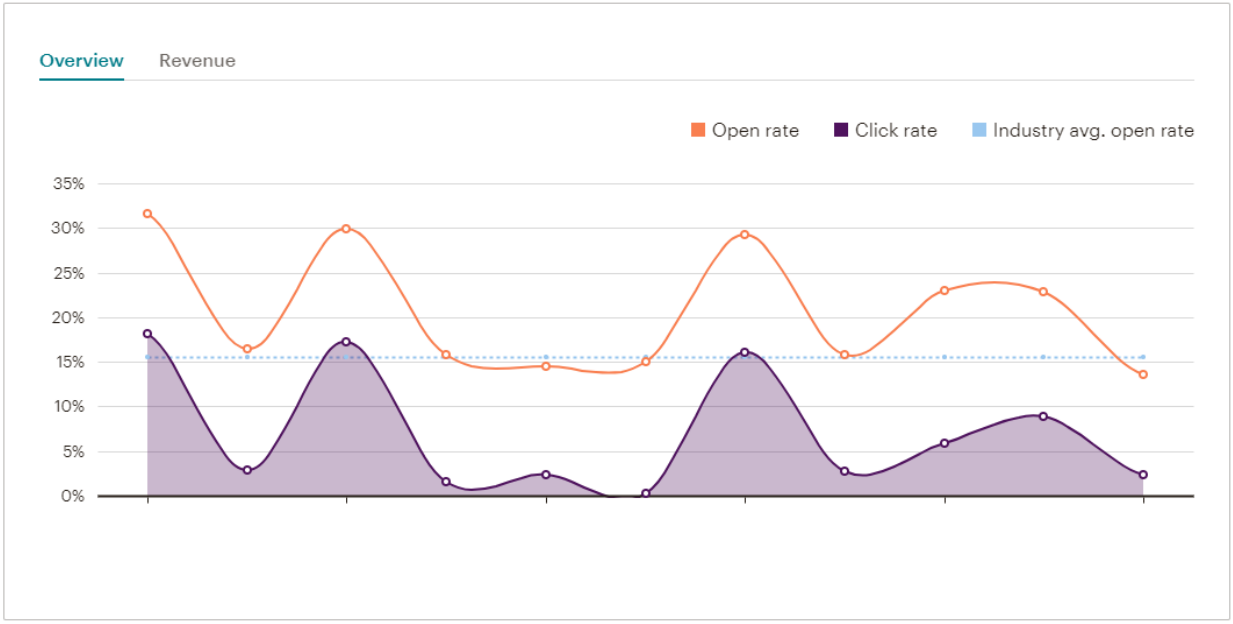


Reports

Current audience

Suicide Prevention Network

Your audience has 404 contacts. 378 of these are subscribers.



How Outcomes are Measured: Outcomes are measured according to the marketing/media platform used.

Number to be reached in FY 2019/2020: In FY 2018/19, Healthy Communities PEI will

reach:

- 250 people through the ReFrame Your Brain Poster Contest
- 350 people through the DHHS Webpage (SDR & SP program pages unduplicated views combined)
- 61,000 though radio PSAs
- Grow email list audience to over 800 (combined) and report over 2,000 emails opened.
- Reach over 100 community members through tabling efforts at health fairs, etc.

Challenges: It is challenging to measuring the reach/ demographics of some social marketing activities. For example, radio stations provide their total audience, but no data on how many people re listening during the time of our public service announcements. It is difficult to conclusively determine the total reach (contacts) by all campaign activities in a given year, though we have strong data to suggest that thousands were exposed to PEI social marketing. Statewide RAND evaluations show EMM campaigns are associated with more adults using mental health services.

Some community members reported that electronic voting wasn't as accessible to their community. Plans for next year's contest are to include opportunities for in-person voting.

Successes: 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.

Lessons Learned: Our team has begun to design local toolkits for targeted populations.

Project Name: Speakers Bureau

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.

Target Population: The target population for speakers' presentations include employers, landlords, elected officials, school personnel, mental and medical providers, community members, law enforcement, and first responders.

Unduplicated Number of Individuals Served: None.

Demographics of individuals served: None.

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.

Actual Outcomes for Fiscal Year 2018-2019:

OUTCOMES	FY 2018-2019
# of events	0
# of participants	2
# of new speakers trained to present their stories	0

How Outcomes are Measured:

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

Number to be reached in FY 2019/2020: The Seeds of Understanding is no longer part of the Public Health work plan, though limited support will be provided.

Challenges: Supporting the growth and sustainability of the Speaker's Collective has been an ongoing challenge. Currently there are only two semi-active members. With limited staff and additional work the Healthy Communities Team has taken on, there is no longer the capacity to support the Speaker's Collective like in previous years. In FY 19/20 the program is utilizing diverse ways to highlight voices of persons with lived experience. Other mediums, such as, Digital Stories previously created, are being used as a way to bring in lived experience to community events and trainings when no speakers are available.

Successes: Project staff met with Speaker's Collective representatives and strategized ways they could take this on through PEI monies channeled to the HOPE Center. The HOPE Center is a peer support center for persons with lived experience.

Project Name: Direct Contact Approaches

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 as 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.

Target Population: 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).

Unduplicated Number of Individuals Served: Not collected.

Demographics of individuals served: Demographics forms are not collected.

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

Expected Outcomes: The goal for 18/19 is 80 workshops.

Actual Outcomes for Fiscal Year 2018-2019:

OUTCOMES	FY 2018-2019
# of Workshops	111
# of participants (may be duplicated)	537
# of Quilts produced	12
# of events/locations where Quilts are displayed	5

How Outcomes are Measured:

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

Number to be reached in FY 2019/2020: 535

Challenges: Participants are not required to fill out a pre/post survey and a demographic form. Tracking data comes from sign-in sheets.

Successes: Artistic Solutions groups are held at the Peer run Hope Center, Healthy Mom's, a Substance Use Disorder treatment program and HumWORKS. In FY18/19, a new group in Hoopa, Native Wellness, was successfully implemented. Groups provide a safe, supportive environment for persons with severe mental illness.

Prevention & Early Intervention: TAY Advocacy and Peer Support

There are two components to this Prevention and Early Intervention Program: TAY Advocacy, through the Humboldt County Transition Age Youth Collaboration (HCTAYC), and TAY Peer Coaches. Both components serve youth and young adults ages 16-26 years old, and both components are a part of the Humboldt County DHHS Transition Age Youth (TAY) Division. The TAY Division consists of co-located DHHS services, including Behavioral Health, Extended Foster Care (EFC), Independent Living Skills (ILS), HCTAYC and TAY Peer Coaches. In addition, the TAY Division utilizes supports and services from DHHS departments including 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 mental 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

TAY Advocacy--HCTAYC

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

The TAY Advocacy Program, 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

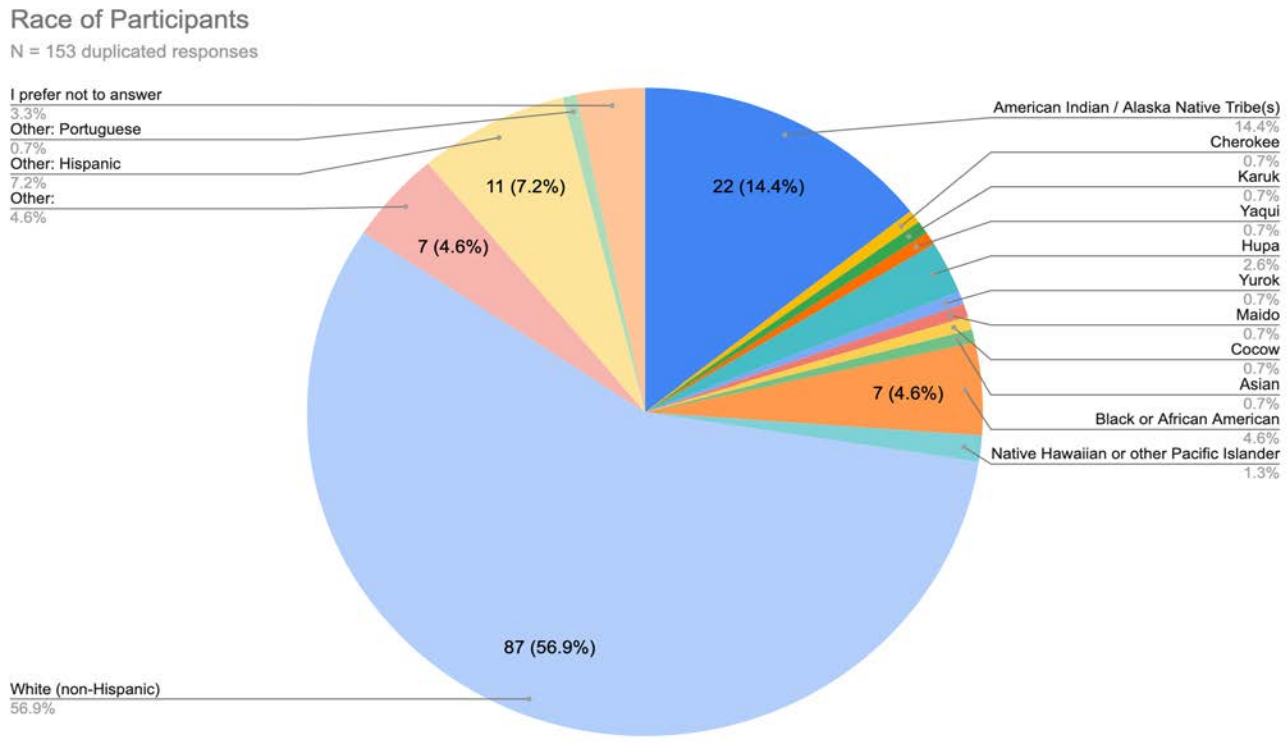
of developing a severe mental illness. The program directly impacts the TAY system of care, making it more responsive to young people's needs, resulting in these larger system outcomes. It also directly impacts the lives of system-impacted youth at-risk of, or struggling with, mental health challenges through the development of resilience and self-efficacy via leadership development. It is the result of this advocacy program that needed systems and services such as the creation of the aforementioned TAY Division in 2012 have come to fruition. This advocacy has also contributed to the passage of legislation and state policy, including the Foster Care Bill of Rights, Foster Care Psychotropic Medication Management, and the California Department of Social Services implementation of 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.

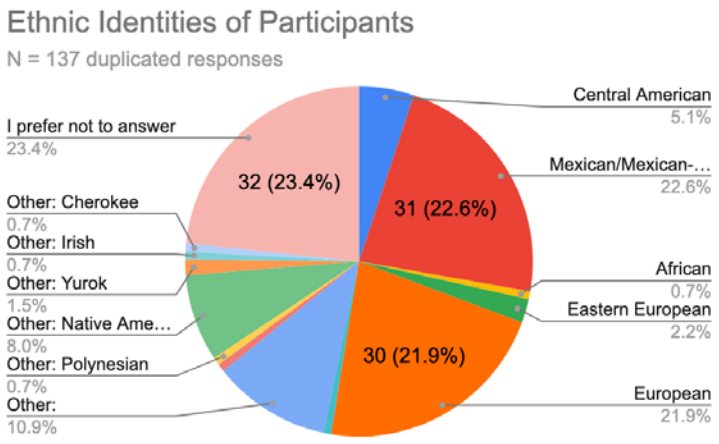
This is a prevention program which, along with TAY Peer Coaches, address components of: early intervention, outreach, stigma and discrimination reduction, and outreach for increasing the recognition of early signs of mental illness. As a rural, poverty-stricken community, access and knowledge regarding 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.

Demographics of individuals served: During 2018-19 HCTAYC served 88 unique individuals according to sign-in sheet records collected at many activities, trainings, and events. However, not all participants sign-in during these activities and not all activities had sign-in sheets due to logistical constraints or staff error. It is estimated that HCTAYC has served at least 115 unique individuals in the reporting period. The following charts provide information obtained from demographic forms completed by individuals participating in HCTAYC activities. Note that these are duplicated, not unduplicated, responses.

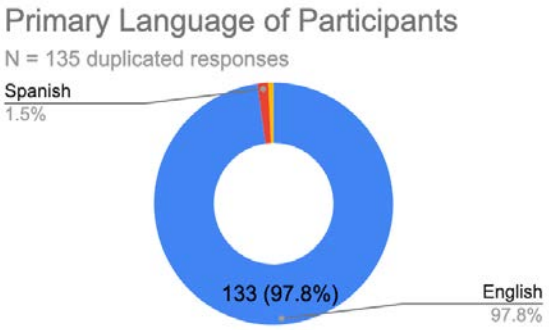
Almost 57% of participants were White, non-Hispanic. Fourteen percent were American Indian/Alaska Native, representing Cherokee, Karuk, Yaqui, Hupa, Yurok, Maido, Cocow tribes. Almost 5% were Black/African American, and 1% were Native Hawaiian or Pacific Islander. Hispanic/Latinx participants were almost 8%, less than 1% were Asian, 4% were other, and 3% preferred not to answer.



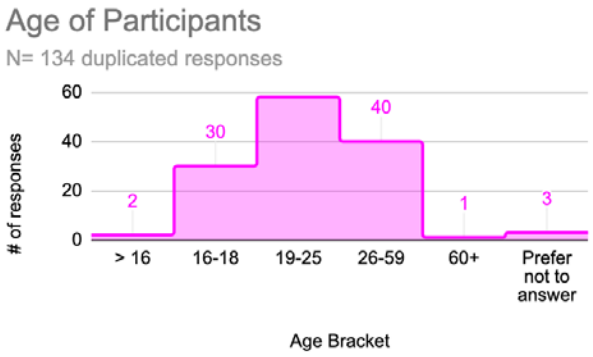
Twenty-two percent of participants indicated their ethnicity as Mexican/Mexican American. Almost 22% of participants indicated their ethnic identity as European. Ten percent indicated Other, without specifying the category. Five percent said Central American, 2% said Eastern European, and less than 1% said African, Irish, Polynesian, Yurok, Irish or other Native American.



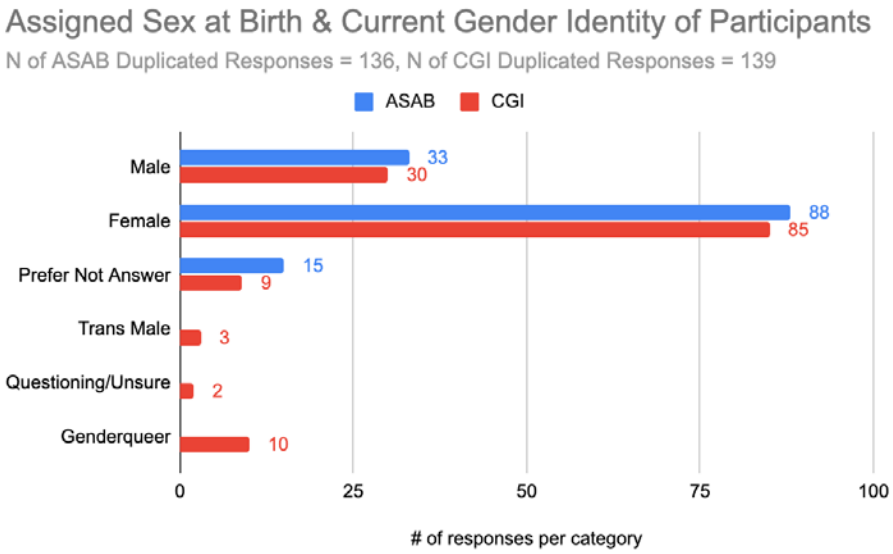
The primary language of participants was 98% English, 1% Spanish, and the rest Other or no response.



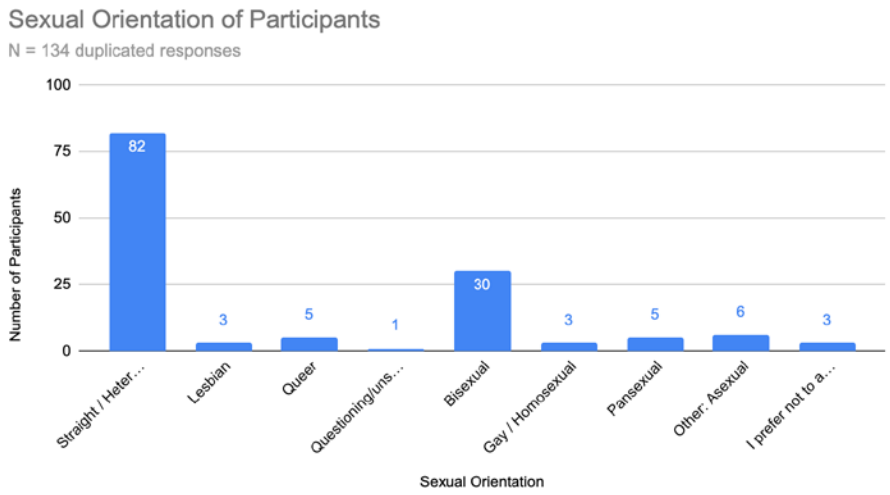
Two participants were age 16, 30 were ages 16-18, 58 were ages 19-25, 40 were age 26-59, one was 60+, and one preferred not to answer.



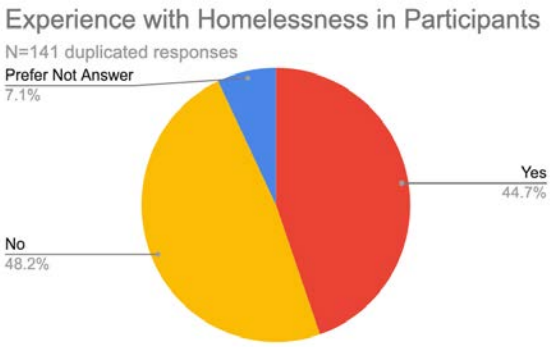
Thirty-three participants stated their assigned sex at birth was male; 88 stated female, and 15 preferred no answer. Their current gender identity was 30 male; 85 female; 9 prefer not to answer; 3 transmale; 2 questioning/unsure, and 10 genderqueer.



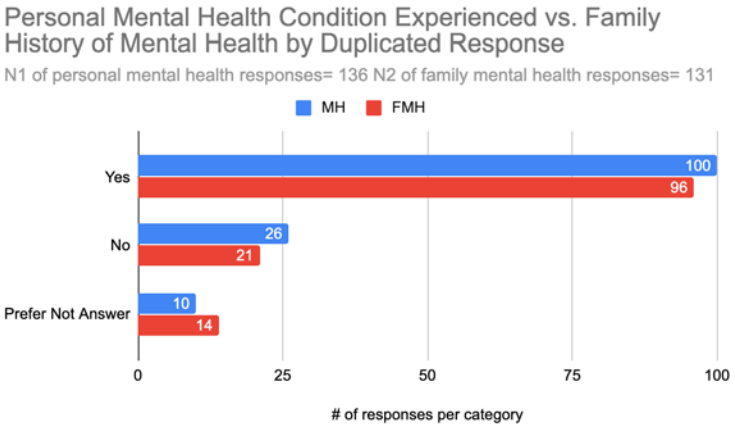
Eighty-two participants stated they are straight/heterosexual, 47 stated LGBTQ/Other, and 3 preferred not to answer.



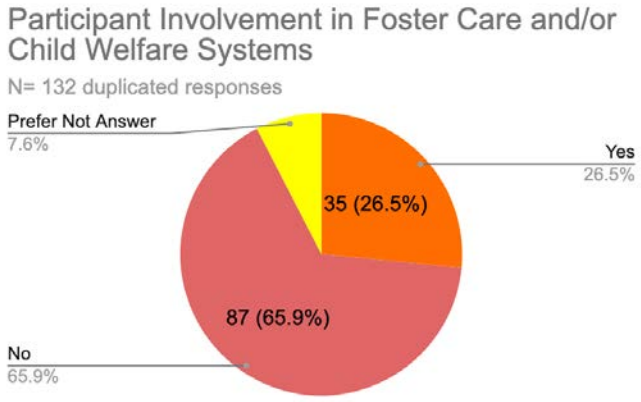
Forty-five percent had experience with homelessness, 48% did not, and 7% preferred not to answer.

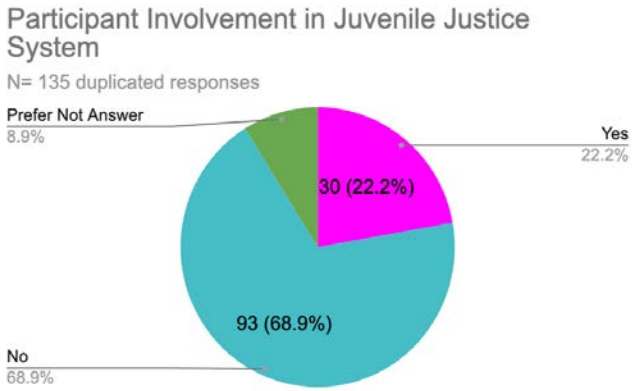


One hundred participants stated they had a personal mental health condition, 26 stated they did not, while 10 preferred not to answer. Ninety-six stated they have a family member with a mental health condition, 21 stated they did not, and 14 preferred not to answer.



Almost 27% reported involvement in foster care and/or the child welfare systems, 66% did not have this involvement, and 7% preferred not to answer. Twenty-two percent reported involvement in the juvenile justice system, 69% did not have this involvement, and 9% preferred not to answer.





The majority of participants resided in the Eureka area, followed by McKinleyville, Arcata and Fortuna.

Key Activities. The TAY Advocacy Program/HCTAYC consists of: a shared Supervising Behavioral 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 mental health challenges and the engagement of this population. This includes special populations particularly impacted by stigma and discrimination such as: LGBTQ youth, indigenous youth, foster youth, 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. This focus includes: 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, participation in the state-wide Directing Change Mental Health Awareness PSA Contest, and a cross-country leadership exchange with youth from New York City.
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, decision making tables, and 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. This is also done through participating in advocacy to amplify the youth's wishes, assisting youth in preparing speaking points for their wraparound meeting, and attending said 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. These three components aid 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 attend a 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.

Expected Outcomes:
The program's expectation was to have more comprehensive outcomes data gathered that reported on leadership development as well as outcomes related to the specific PEI domains for Youth Leadership Development data. The Youth Advisory Board committees were expected to facilitate at least one completely youth-driven project. The program scheduled at least three youth-leadership development trainings for HCTAYC members and the general transition-age youth community.

HCTAYC expected to complete the implementation of our Alcohol and Other Drugs Policy Recommendations. Additionally, the program expected to begin the creation of LGBTQ+ Cross-Systems Policy Recommendations, and planned on continuing participation in various advocacy and policy setting tables at the local, state, and national level.

Actual Outcomes for Fiscal Year 2018-2019:
Due to staffing limitations the data for Leadership Development in this timeframe is not yet accessible for analysis or report. Whilst the PEI domain specific data gathering tool is in the process of being developed through a youth-informed process. Staffing limitations have caused the timeline for the development of this measurement tool to be extended beyond the scope of this annual update. However, the size of consistently engaged Youth Advisory Board members has grown over this reporting period to an average of 15 active members; an increase from an average of eight members from 2017-2018. Currently the Youth Advisory Board participants have almost doubled from previous years. Four youth-leadership develop trainings were provided to youth people: Focus Group Facilitation, Local Policy Campaign Development, YAB Orientation & Professional Development, and Basic Youth Leadership Skills Intensive.

The Committee-led projects' development fell within this reporting period, with three activities successfully planned. Planned were: Woke As Friends LGBTQ+ Cultural Art and Identity Exploration Workshop Series, the TAYvivor community development challenge, and Take Charge Mental Health Rights & History workshops. However, the execution of these activities falls into the next reporting period.

Significant progress has been made regarding the implementation of the AOD Policy Recommendations, assisting in the selection of screening & assessment tools for transition age youth, identifying outpatient youth SUD treatment space and structure, and assisting in the creation of a youth-SUD prevention activity guide. Complete implementation of the policy recommendations r was not completed, however.

Data gathering for the LGBTQ+ Policy recommendations began, and thus far four youth focus groups, one adult partner focus group, and three individual interviews with administration have occurred.

Additionally, the HCTAYC Lead Youth Organizer testified before the California Assembly Committee on Human Services regarding the implementation of Presumptive Transfer for

Foster Youth Mental Health and advocated for more resources for rural communities so that young people do not have to be transferred to another county. We have maintained our participation in the various policy setting tables and committees at a local, state, and national level.

How Outcomes are Measured:
Outcomes are measured in multiple ways. Youth Leadership Development data is collected through individual Leadership and Wellness plans, and a Leadership Skills self-assessment with a more intensive assessment tool in the process of being developed.

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

Estimated Number to be reached in FY 2019/2020:
The program estimates to maintain or exceed 15 consistent Youth Advisory Board members, with the facilitation of at least 3 committee-created projects. Additionally, the program estimates accomplishing at least three more policy goals identified in the AOD Policy Recommendations and the completion and formalization of the LGBTQ+ Cross-Systems Policy Recommendations. It is hoped to provide at least one youth-driven training to professionals, as well as complete the development of one training curriculum. Four to six youth leadership development trainings to youth in Humboldt County are estimated to be provided. It is expected that consistent membership of the current policy setting tables will be maintained, as well as adding to tables regarding equity or other topics that intersect with the upcoming set of policy recommendations.

In terms of outreach for recognizing the early signs of mental illness, the HCTAYC will provide outreach to youth and young adults with experience in the Juvenile Justice, Foster Care, Behavioral Health and Homelessness Services systems. The program will also reach out to staff members who work with young people in these systems as well as some community members. Settings may include the TAY Center, RAVEN Project, Jefferson Community Center, Office of Education, and others. It is difficult to estimate the potential number that could be in the population because this information is kept in disparate information systems.

Challenges:
Challenges during this reporting period exist mostly as a result of staffing shortages, both within the HCTAYC program as well as the Human Services field in general. During this reporting period the previous youth organizer left the organization, and both the program peer coach and supervisor went on extended leaves at various points. The increased number of YAB members and projects were difficult for the sole remaining Youth Organizer to handle single-handedly. As a result several goals related to program development were unable to be met, particularly regarding the development and implementation of more intensive outcome measures.

Successes:
The development & implementation of a cross-country youth leadership exchange in New York City. Implementation of some elements of the AOD Policy Recommendations and the start of the LGBTQ+ Policy Recommendations process. The beginning of

development of a PEI assessment tool. Increased number of youth at the highest level of participation on the Youth Advisory Board, from one at the beginning of reporting time to five.

Lessons Learned:
YAB needs significantly less handholding than given previously in planning youth-driven activities. They are showcasing well developed leadership skills. Data collection needs to be consistent and timely to work. It's not possible for one staff person to do the job of many, but it is possible to keep the core of the program running.

TAY Peer Support

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 focuses on mentoring, instilling hope, empowering and helping young people build self-esteem, and assisting in system navigation and self-advocacy. Peer Coaches have the capacity to engage with young people through shared lived experiences. This makes 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, teaching, and exploring the 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 to young people by linkage to services and to the community. This serves to inform them of services available to transition age youth and supports the reduction of stigma and discrimination toward the systems-involved transition age population. Outreach is provided in multiple ways including referrals for services, the TAY Center drop-in space, community-wide presentations, and tabling events. Peer Coaches provide regular outreach to the psychiatric hospital, jail, juvenile hall, schools, family resource centers, tribal organizations, and team with other community partners for street outreach to youth experiencing homelessness. Overall, peer coaching contributes to participant engagement with care, increased effectiveness

of services, reduced barriers to services and supports, improved outcomes, reduced hospitalization or incarceration, and increased support for educational and vocational success.

3. Linkage to resources available through multiple agencies helps to support increased youth engagement across programs, improve access to needed services, stigma reduction, greater understanding of lived experiences, increased advocacy, improved relationship with providers, and the ability to show staff and youth that recovery is possible. Peer Coaches 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.

Target Population: Humboldt County Youth ages 16-26 who have or are experiencing homelessness, interaction with the juvenile justice system and/or Child welfare systems, youth who opted into the Extended Foster Care program, those experiencing mental health needs, those experiencing issues with Substance use and youth seeking employment.

Unduplicated Number of Individuals Served: There were 1,911 sign ins for TAY activities from September 2018-June 2019), and of those, 448 are Unique, Unduplicated clients.

Demographics of individuals served:
There were 87 responses to the voluntary and confidential questionnaires at TAY.

- Fifty-seven percent or 50 people answered Yes to the question of having ever been homeless, on the streets, in a shelter or couch surfing. 34%, or 30 people responded No, while 7 preferred not to answer or did not answer the question.
- Of the 87 responses, 59%, or 51 people, have a diagnosed mental health experience, and the same 51 people have a family member with a diagnosed mental health experience.
- Five percent have an undiagnosed experience, 21% have no mental health experience, while 14% preferred not to answer or did not answer. 2% report both a diagnosed and undiagnosed experience.
- Sixty-six percent of the total respondents have a family member with a diagnosed mental health experience, 13% do not, 14% preferred not to answer and 6% did not answer.

Demographics:

- Of the 87 workshop questionnaire responses, 79 were in the 16-25 year old age range.
- Thirty-eight percent were 16-18 years old, 53% are 19-25 years old, and 8% were people 26 years or older.
- Twelve of the 87 respondents, 14%, identified as American Indian including members of the following Tribes: Hupa, Choctaw, Blackfoot, Yokut Sioux, Mono, Yurok, Karuk, Wiyot, Bear River, Mattole and Yaqui.
- Eighteen people checked their ethnic identity as Hispanic including Mexican-American, Central American, Latinx and Puerto Rican. Non-Hispanic attendees include Chinese, Asian, and Japanese, as well as 10 who preferred not to answer. 3 of the 87 people speak a language other than English, primarily Spanish.
- Twenty-two responses indicated the presence of a disability. Included are 11 Vision, 3 with Hearing, 8 with a Mental/Learning disability, 3 Physical, 1 chronic, and 3 have an Other or Not specified disability. 3 responses were specifically No, and the remaining were not answered or the person preferred not to answer.
- Nineteen indicated they are not Veterans, while 68 did not answer.
- Regarding Sexual Orientation: 69% identify as Heterosexual/Straight, 2% Gay/Lesbian, 6% Queer, 10% Bisexual; 7% Prefer not to answer/Did not answer and 6% Chose Other.
- Sex assigned at birth, 57 were female and 24 were male, while 2 preferred no answer and 4 were left blank.
- Current gender identity: 51 female, 21 Male, 2 Genderqueer, 2 Transgender Male, 5 Other, and 6 not answered.

Key Activities:

TAY Peer Support Accomplishments and Awards
Presented to Adult Probation
Presented to Juvenile Probation
Presented to Eureka Resource School (ERC)
Presented to HCOE
Presented to Adult Probation
Facilitated three group activities in the Regional Facility
Tabled at MAY is Mental Health Matters Month in Eureka

Training Peer Coaches Attended:
Housing First
ASIST-Suicide Prevention
ADA and Media Compliance Training
Mental Health First Aid
TIP-Transition to Independence Process
Medical Billing and Documentation
Mandated Reporting
CSEC Training
Compassion Fatigue and Burnout-webinar

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
Teen Court
Adult Probation

Workshops, Groups and Events Lead by Peer Coaches
Self-Care Skills
Strategic story telling
Pour your art out
TAY Baby shower
Pumpkin patch field trip and carving
Cooking making/decorating
Scavenger Hunt for local resources
Ropes for Hope
Holiday craft/present making
Hiking and wellness
Fitness Friday
Mommy and Me Group
Role-play group
Healthy Relationships
Cooking demonstrations

Expected Outcomes:
The expected outcomes for 2018/19 were to fully staff all peer coach roles and have peer coach trained or/training with each area of the TAY Division (ILS, BH, HCTAYC, DROP-IN, Lead). It was expected that the peer coaches would be doing medical billing connecting direct service of TAY youth open to Behavioral Health and possible other outcome measurement tools. It was expected to continue and expand outreach and information to needed populations. It was expected that peer coaches would support youth and engage in activities at TAY and relationship building while waiting to receive or be connected to other needed services or require a lower need for care.

Actual Outcomes for Fiscal Year 2018-2019: As of May 2019, all peer coach positions are filled and it is projected that this staff will continue employment throughout the coming year. All peer coaches have completed documentation training linking direct services to electronic medical records. Peer coaches have planned and managed pro-social activities and events monthly.

How Outcomes are Measured:
Access to the TAY drop-in space and selected events and workshops are collected by sign-in sheets. Tracking sheets of referral assignments have been kept but need improvement including tracking date referral is received, assigned and when first contact is made. Some information also overlaps with other programs (BH, employment, ILS)

and these contacts and linkages are currently not being tracked.

Estimated Number to be reached in FY 2019/2020:
It is estimated that approximately 150 TAY (New, unique participants) will be served in Fiscal Year19/20.

Challenges:
Outcome measurements, the overlap of services/tracking of these services and the overlap primarily with the mental health team, and reminding peer staff to use sign in sheets and demographic forms.

Prevention & Early Intervention: Parent Partners

The Parent Partner Program's vision is to provide support, encouragement, and hope to parents/caregivers who are feeling overwhelmed as they find themselves involved with a challenging and complex child-serving system. Parent partners develop and maintain a practice to increase opportunities for parents/caregivers to receive peer based support services as they encounter these county 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 and help to create conditions for parents/caregivers to feel empowered and confident as they navigate these county systems, making decisions that are best for their family and determining their course of action based on their families' needs and goals. Parent Partners model effective personal interactions while supporting the development, reconnection and strengthening of natural supports for families. They serve as a mentor to improve parents/caregivers' confidence and ability to self-advocate for and effectively manage the services and supports for their own family. They empower families to identify their own future vision of what their family can be, what they need most to achieve this future, and how they can use their strengths and culture to get those needs met.

The Parent Partner Program employs three full-time and one part-time staff to provide supportive services to parents/caregivers involved in the DHHS system-Public Health, Child Welfare, Probation, and Behavioral Health, along with Humboldt County Office of Education. The most senior Parent Partner completed certification as a Parent Partner Coach through a National Wraparound Implementation Center Affiliate (NWIC), the Family Involvement Center of Arizona. The Certified Parent Partner Coach has also been credentialed by the National Federation of Families for Children's Mental Health as a Certified Parent Support Provider (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 their families without judgement, bias, or stigmatization.

DHHS added a Parent Partner III position to take on more responsibility for training and mentoring staff. This position is currently filled by the Certified Parent Partner Coach. The Certified Parent Partner III Coach attends quality review meetings to represent the family voice with in DHHS policy and program development and implementation activities. We have two vacant full-time and one vacant half-time Parent Partner I/II positions. The County continues to contract with a Part Time Mentor with lived experience and dedicated involvement in the National Alliance on Mental Illness (NAMI), who teaches Parent Partners "NAMI Basics" and "Family to Family" curriculum to enhance and develop various types of skills and co-facilitate both the peer support groups and the Family Advisory Board.

Target Population:
The target population includes any parent or caregiver of a youth involved in a child-serving system such as a Children's Behavioral Health program or Child Welfare

Services. In addition, these services will impact the well-being of families which may include children and other natural supports.

Unduplicated Number of Individuals Served:
Our current Parent Support Tool (PST) and referral process does not currently capture this number accurately. For the next fiscal year we will be updating our PST to more accurately reflect this number. Based upon individuals served from our prior two fiscal years we estimate that we served forty-four unduplicated individuals.

Demographics of individuals served:
During Fiscal Year 2018-19, we had staff changes and transitions affecting the program's expansion efforts. Six new parents/caregivers were added to the overall caseload in FY 18/19. The collected demographic forms (N=4) provided the following data: 50% of the participants have a stated age range of 26-59, the remaining 50% have a stated age of 60+. 75% of the participants state White as their race and the remaining 25% preferred not to answer. 75% of the participants stated they are not Latino or Hispanic and the remaining 25% preferred not to answer. 100% of participants state English is their primary language. 100% of participants stated their sexual orientation is heterosexual. When asked if the participants have a disability, 50% responded no and the remaining 50% stated they have a chronic health condition. 50% of the participants stated veteran status, the remaining 50% did not. 75% of participants marked male as the assigned gender at birth and 25% failed to mark a response. 100% of participants marked male as their current gender identity. When asked if participants have ever been homeless, 75% answered yes, while the remaining 25% answered no. In response to the question, have you ever experienced a mental health challenge: 50% responded no, 25% stated yes-undiagnosed, the remaining 25% stated yes-diagnosed. 100% of participants have a family member with a diagnosed mental health condition. The final question asked about the participant's job or role: 100% marked other with a handwritten specification: 25% wrote dada, 25% wrote self-employed, 25% wrote retired military and the final 25% wrote natural resource consultant.

Key Activities:
Parent Partners offer assistance in navigating the DHHS system, collaborative linkages with community resources, building natural supports and identifying their needs, strengths, skills, and goals to promote their family wellness. Parent Partners are often members of Child and Family Teams serving youth with intensive needs. Parent Partners build alliances with other departments and agencies including Probation and Child Welfare Services to assist parents/caregivers whose children have been placed out of county or are currently in programs like 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 Behavioral Health system by being visible to families and staff during visitation hours at the Sempervirens Psychiatric Health Facility. The Parent Partner Program reached out to approximately 30 people per week this last year. These outreach efforts were done primarily at Sempervirens, Family Resource Centers, the Jefferson Community Center, and directly to families and caregivers in the community.

Expected Outcomes:
Parent Partners are expected to attend various meetings within the DHHS system in order to provide the critical perspective of those with lived experience.

Parent Partners are expected to complete an opening, annual and closing Parent Support Tool (PST) for each parent/caregiver served. Expected outcomes via the PST include an increase in the presence of the family's support system; an increase in the acceptance of the family's support system; an increase in the ability to be heard by service providers; an increase in the ability to cope with stress; and finally a decrease in the impact of transitions.

Parent Partners are expected to provide outreach to about thirty people/week through outreach efforts at places such as Family Resource Centers, meetings and hospitals.

Actual Outcomes for Fiscal Year 2018-2019:
Parent Partners currently attend approximately eleven DHHS or community based meetings per month to bring the voice of families and those with lived experience to the decision making process.

We have had no matched pairs of the Parent Support Tool so we are unable to quantify outcomes at this time.

The Parent Partner Program reached out to approximately thirty people per week this last year. These outreach efforts were done primarily at Sempervirens, Family Resource Centers, the Jefferson Community Center, and directly to families and caregivers in the community.

How Outcomes are Measured:
Our current outcome tool is the Parent Support Tool (PST). The PST should be completed at the beginning, annually and end of services. The PST measures: presence of the family's support system; acceptance of the family's support system; ability to be heard by service providers; coping with stress; transitions, impact and timing.

Estimated Number to be reached in FY 2019/2020:
For the next fiscal year an estimated 40 additional parents/caregivers will be reached, and the expectation is that all current and new cases will have a PST completed annually and at the time of closure to services.

Challenges:
As a newer program connected to the Children's and Families Services there were some growing pains and implementation challenges in FY 18/19. There were many staffing challenges that impacted the program including supervision and management changes as well as internal staffing challenges and transitions. The completion of documentation in our electronic health record, the Parent Support tool and referral tracking system have been inconsistent and underutilized. While the Parent Partners have been providing important services to many parents and caregivers, there is unfortunately little data to support the work that they have been doing.

Successes:
The Parent Partners have been instrumental in supporting parents in some of the most difficult and contentious cases that involve complex service delivery with Child Welfare Services. They have attended numerous Child and Family Team meetings to support parents and caregivers as well as internal DHHS meetings. For example, Parent Partners have been regularly attending the DHHS Cultural Competency Committee meeting and meetings run by our Quality Assurance unit bringing their unique voice to the table. Finally, Parent Partners have been significantly involved in the implementation of a system wide efforts to reduce secondary stress among staff. Parent Partners have been involved in the development of trainings educating staff about secondary traumatic stress and helped with the roll-out of these trainings to staff.

Lessons Learned:
Some of the lessons learned include a better understanding of the level of support the Parent Partners need in order to complete timely and accurate documentation and outcomes. The program will be evaluating the Parent Support Tool to see that it meets the needs of the program as well as the delivery of usable data that will inform the work.

Prevention & Early Intervention: Local Implementation Agreements

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

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

For the period January-June, 2019, four projects were approved for funding. Unfortunately, of these four projects only one was completed during the project period due to contracting issues with the other organizations that were approved for funding. Results of this project are set forth below.

Dispelling Stigma: Hoarding Education, Treatment and Prevention. There were four components to this project, facilitated by the Area 1 Agency on Aging (A1AA).

- A one day conference *Dispelling Stigma: Hoarding Education, Treatment and Prevention*. This conference was attended by 105 people. Humboldt Access recorded the conference and it was broadcast during one week in April on the Humboldt Access channel. Each of the four segments were shown eight times during that week. A1AA put the recordings on their website along with presenter materials, so the information is available at any time to those who are interested.
- The formation of the Northcoast Hoarding Task Force. Two meetings were held before the end of the grant project period. It is too early to tell if it is successful or will continue, but initial interest appears good.
- Free support group for people who hoard. There is an average of 9-10 people attending this group.
- Free support group for family and friends of people who have cluttering/hoarding issues. There is an average of 3-4 people attending this group.

Feedback from the groups received by the time the grant project ended has been positive, with attendees feeling supported and finding tools to address the issues.

Demographic information from the conference, Task Force and support groups indicates that 4% were ages 16-25, 54% were 26-59, and 42% were age 60+. Approximately 79% were White, 7% Multiracial, 5% American Indian, 4% Other, 2% Asian, with the remaining categories being less than 1%. Those with Hispanic/Latino ethnic identity were 11%. All but one person stated English was their primary language. Seventy-seven percent were heterosexual,15% reported LGBTQ, and 8% did not answer. Ninety-one percent were female and 9% male. Nineteen percent reported being homeless at some time. Forty-nine percent reporting experiencing a mental health condition, and 71%

reported a family member with a mental health condition.

The next period of funding for the Local Implementation Agreements is September 2019-June 2020. Four grant applications were approved for funding and contracts have been executed with the applying agencies. These proposals are summarized below.

Bear River Youth Suicide Prevention Program. The Bear River Band of the Rohnerville Rancheria Social Services will hire a consultant to conduct a three-day intensive peer-counseling program for Bear River youth that focuses on suicide and related issues, such as depression, trauma, violence and substance abuse. The program will take place in February 2020 and will serve 25 people, including 20 youth, two Bear River social workers, and at least three Bear River community members. The program is called Native H.O.P.E. (Helping Our People Endure).

Families Thriving Together – An Individualized, Therapeutic Parenting Program.
This project partners a local therapist with a First 5 Humboldt/HCOE Child and Family Support Specialist. They will develop and implement an intensive therapeutic parenting program based on Infant-Family and Early Childhood Mental Health (IFECMH) best practices to utilize the research-based Family Strengthening Protective Factors as a framework. The program will be offered at The Gathering Place, a trauma-responsive therapeutic environment.

Community Mental Health Project. This project of Making Headway Wellness Center (MHWC) has two goals: to increase mental health services in Spanish and English and to increase domestic violence services in Humboldt County. MHWC will provide individual, family and group therapy in both English and Spanish, using TRD – a trauma-informed and trauma-responsive practice that focuses on supporting individuals who have experienced emotional and physical trauma. This will help break the financial barrier that limits access to services for the Spanish-speaking community. Increasing domestic violence services will be achieved through using grant funding to offset the financial burden for those who are charged with domestic violence and court-ordered to participate in group psychotherapy.

Hospitality and Volunteering Program Coordinator. McKinleyville Community Collaborative Family Resource Center will send three people to Mental Health First Aid (MHFA) Training of Trainers with the intent of serving two target populations: monolingual Spanish speakers and Native American youth in contact with the juvenile justice system. MHFA is a training that focuses on increasing awareness of mental health symptoms, decreasing stigma related to mental health treatment, and providing strategies for community members to assist each other in accessing mental health support. Two of the attendees will be bilingual English-Spanish.

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.

Activities Supported by PEI Funding 2018-19:
In school year 2018-19, approximately eleven additional school sites joined 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.

MTSS Coalition/CA MTSS participating School Districts/ Include (note: other districts are supported by coalition as well):

- Arcata Elementary School District
- Alder Grove Charter
- Cutten Ridgewood School District
- Eureka City Schools
- Blue Lake School District
- Big Lagoon School District
- Trinidad School District
- Southern Humboldt Unified School District
- Ferndale School District
- Freshwater School District
- Fuente Nueva Charter
- Garfield School District
- Loleta Elementary School District
- Jacoby Creek School District
- Rio Dell School District
- Fortuna Elementary School District
- Fieldbrook Elementary School District
- McKinleyville Unified School District
- Pacific Union School District
- Northern Humboldt Unified High School District
- KIamath Trinity School District
- Redwood Preparatory School District
- South Bay School District

Activities Supported by PEI Funding:
IIRP World Conference (International Institute for Restorative Practices) Detroit, MI Q2 October 24-26 2 Participants – Presentation, “Implementation in Rural California”.

California PBIS Coalition Conference, Sacramento, CA Q1 September 24-26, 2018 2 participants presented, “The Northern CA MTSS Coalition, Rural Implementation Behind the Redwood Curtain”.

- Ten Participants representing 9 local school districts were funded to attend the CA PBIS Coalition Conference.

District Team Site Visits to Model PBIS/MTSS Schools in Northern CA. Recognized by California PBIS Coalition for excellence in implementation. March 7th, and May 2nd, 2019.

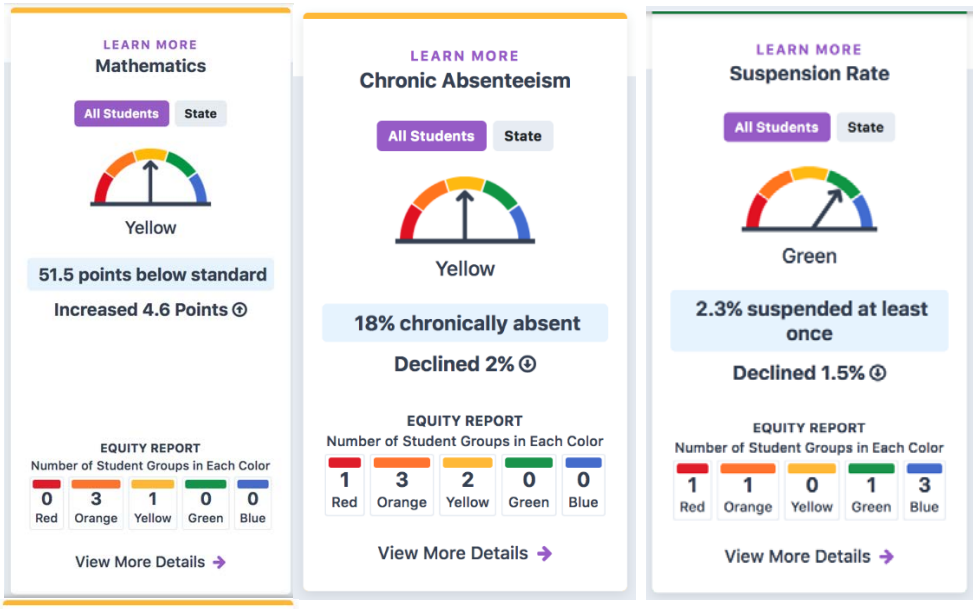
- Valuable collaboration between HCOE and PCOE (Placer County Office of Education) with coordinating support by the CA PBIS Coalition.
- Opportunity for Districts and local agency (probation) teams to benefit from visiting model recognized PBIS school-sites.
- Participating districts – Blue Lake (4 participants with admin representation), Freshwater (4 participants with admin representation), Trinidad (3 participants with admin representation), McKinleyville Elementary School District (6 participants with admin representation), Redwood Preparatory Charter (1 admin), and Court and Community School/Juvenile Hall (5 participants with admin representation).
- This opportunity was reported as very beneficial by teams and hosting sites that the model is being replicated so other local districts will have the option to participate during the 19-20 fiscal year.

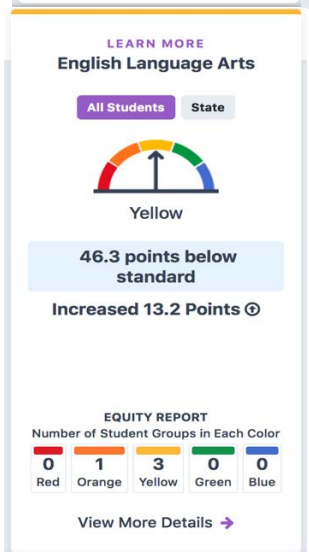
Direct Support/Materials:
Educational materials, curriculum, training materials (for PBIS and Restorative Practices Trainings), and the establishment of an MTSS lending library were supported through this valuable underwriting, as well as the support of 28 school sites' coalition yearly dues. Additional materials include essential snacks for coaches PLC's (Professional Learning Community) which are always appreciated and a draw and the end of a long day.

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 behavioral 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.

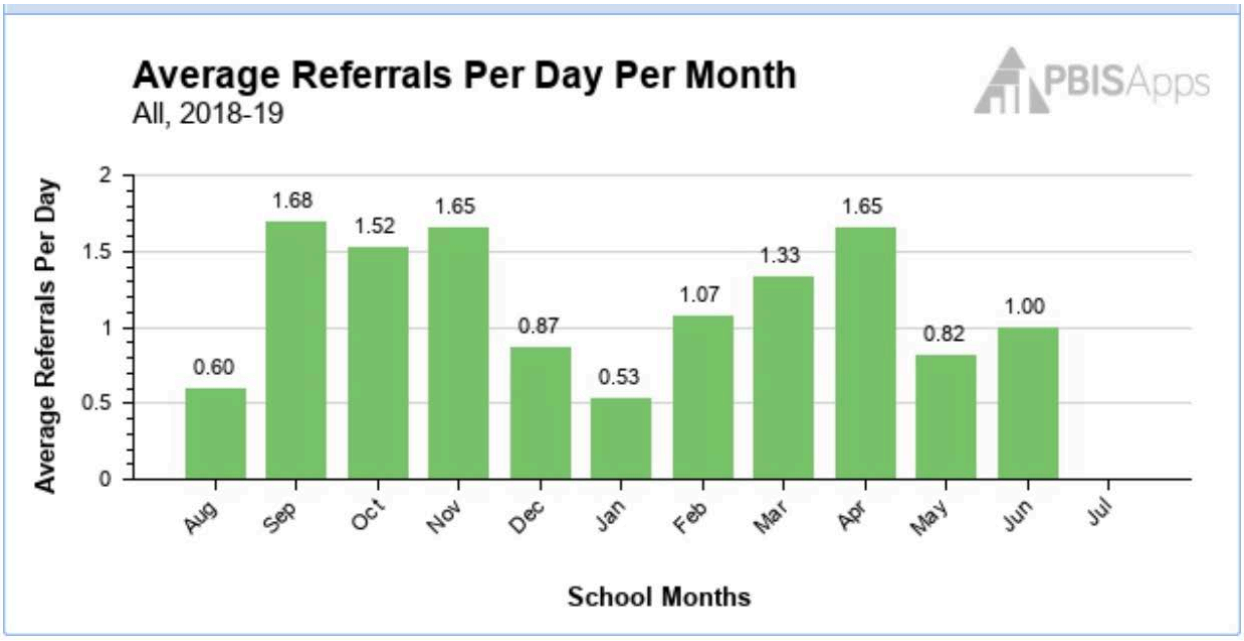
The data images below represent a continuation of the case study of Fortuna Elementary School from year 17-18 annual report. We see continued improvement in all targeted areas on the CA Dashboard (CDE - https://www.caschooldashboard.org/reports/12768026007876/2018)

Demographics of South Fortuna Elementary School:





School-Wide Information System Data Below (SWIS) – note the low average rate of referrals with the trend decreasing as the year progressed.



For an overview of MTSS on the California Department of Education Website - https://www.cde.ca.gov/ci/cr/ri/index.asp

Making Relatives Program

Big Lagoon Rancheria, Trinidad Rancheria, Two Feathers Native American Family Services and the Bear River Band of the Rohnerville Rancheria plan to 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.

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 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 mental health community based services; and providing crisis response.

This project will leverage 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 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 is in the process of becoming an organizational provider with DHHS Behavioral Health, translating traditional wellness practices into Medi-Cal billable services as appropriate under the specialty mental health services waiver. This process should be completed by January 2020.

MHSA funding is provided for the first year of the program, focused on developing the consortium and culturally based program. To date funding has supported consultant services for planning, implementation and evaluation, and clinical policies have been developed for review.

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

The NVSPH is administered through California Mental Health Services Authority (CalMHSA), a Joint Powers Authority created to jointly develop and fund mental health services and education program for its Member County and Partner Counties. CalMHSA will administer NVSPH on behalf of counties that are participating in and funding the program. It will serve as the primary suicide prevention hotline for these counties, including Humboldt County. As funding allows, NVSPH will operate a 24/7 suicide prevention hotline accredited by the American Association of Suicidology and will continue to answer calls through its participation in the National Suicide Prevention Lifeline. NVSPH will also maintain its hotline website and will provide outreach and technical assistance to counties that are participating and funding the program.

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 behavioral health system. During fiscal year 2018-19 WET activities were planned to include a contract with Relias E-Learning, Racial Equity training, and Wraparound training.

- Relias E-Learning. Behavioral Health initially contracted with Relias Learning, LLC, in April 2016. Staff have access to the Relias catalog of courses, written by industry experts and accredited through international and state accrediting bodies. Local trainings are created and uploaded to Relias as well. Built in tracking, testing and reporting tools save time and ensure that mandatory training requirements are met. Relias improves new hire orientation as an entire collection of training specific to staff roles can be assigned. In Fiscal Year 18/19:
    - Staff had access to a total of 813 trainings.
    - Humboldt County Behavioral Health developed and loaded 272 custom trainings. Many were agency Policy & Procedures (P&Ps) Behavioral Health has implemented the assignment of P&Ps through Relias to automate this process and have an accounting of completions.
    - Relias was relied heavily on for tracking of in-services at Sempervirens.
    - Other additions to Relias included Chart Review Training, Cultural Competency Training, Onboarding for Staff, Onboarding for Supervisors, Multidisciplinary Treatment Planning Training for Sempervirens, Scheduling Calendar Trainings and Trauma Informed Care. Additionally, the DHHS-MH Medical Director created trainings for Morbidity & Mortality review and other trainings targeted for Behavioral Health medical staff.
    - Relias was used to assign and track important Behavioral Health communications in the form of QI Bulletins. QI Bulletins are notices related to business practices changes or other important information.
    - Staff enrolled in a total of 11,186 courses, completing 4,898 (44%) of them.
- Behavioral Health planned to 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 would be local, in-person trainings for Behavioral Health staff. A team from the Mental Health Cultural Competence Committee met with the trainers from the Equity Alliance and discussed an outline for the training. Shortly after this meeting, the team learned that DHHS Administration was interested in bringing racial equity training to all DHHS staff. The Mental Health team was advised to put on hold the planning for Behavioral Health staff alone. Since that time the DHHS leadership team developed a plan for leadership to meet with the Equity Alliance over a period of two months and determine next steps. Should this process result in training, WET funds may be used to cover some of the costs.
- Behavioral Health had planned to continue the training process to implement and support High Fidelity Wraparound within Children's Behavioral Health. Shortly after

the beginning of the fiscal year, however, the decision was made to discontinue the High Fidelity Wraparound training due to challenges with staffing and supporting the program long term. Key positions could not be filled, staff were unable to get certified to coach the model, and there were challenges with filling case manager positions and retaining staff in those positions. Though High Fidelity Wraparound is no longer used, Intensive Care Coordination continues to be offered to youth and families.

For Fiscal Year 2019-2020, WET activities will include the following.

- The contract with Relias E-Learning will be continued, and the number of user licenses will be increased. All available 375 licenses are currently being used, and with staff increases projected in FY 19/20 the number will be increased.
- Local training and coaching, such as:
    - Two to four hours per month of cultural coaching for staff with White Bison/Red Road Curriculum
    - Assisted Outpatient Treatment training
    - Cultural Training
    - Training for new Case Managers
    - Training for Comprehensive Community Treatment Personal Service Coordinators
    - Dialectical Behavioral Therapy training
    - Secondary Trauma training
    - Purchase of training Webinars and DVDs
- Out of County travel for staff education, such as:
    - Beyond the Bench
    - American Group Psychotherapy Conference
    - 33rd Annual APNA Conference
    - 18th Annual Psychopharmacology Conference Breaking Barriers 4th Annual Interagency Symposium

Continued and Completed Projects

Milestones of Recovery Scale (MORS)

The MORS is a recovery based evaluation tool for adults that 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, including staff training and reports made available to all outpatient services, and 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.

In April 2019 a new MORS widget was added to the client chart in the electronic health record (Avatar). In the Avatar Chart Summary, the MORS widget provides clinicians a list a client's MORS scores and a color coded bar graph displaying MORS milestones over time.

Data Collection for Homeless Population. Since April 2016 DHHS Behavioral 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.

During 2018 stakeholders met to develop a consistent, reliable, historical and reportable system for tracking homelessness within Avatar. As a result, in the upcoming year existing definitions will be updated with more detail to document client homeless status in the admissions form. It is also the goal to utilize an additional existing field to document homeless status at discharge to improve documentation of chronic homelessness of clients over time.

Health Information Exchange (HIE) and Summary of Care Documents: Since August 30, 2018 DHHS Behavioral Health has received emergency department care summaries from local hospitals for clients being admitted to Sempervirens Psychiatric Health Facility and the Crisis Stabilization Unit (CSU). This is possible with the help of a local health information exchange, North Coast Health Improvement and Information Network (NCHIIN).

The NCHIIN 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. Between August 2018 and June 2019, staff at Sempervirens and CSU has received over 382 care summaries from local hospitals to improve care coordination for clients receiving mental health services.

In November 2018 the HIE capabilities expanded to further improve continuity of care when DHHS Behavioral Health began sending mental health summaries to local hospitals and primary care providers as the client presents to the hospital for

emergency services or seen by their primary care provider for follow up.

CANS and PSC-35: In 2018 California Department of Health Care Services began requiring the collection and reporting of two child functional assessment tools; the Pediatric Symptoms Checklist (PSC-35) and the Child and Adolescents Needs and Strengths (CANS).

CANS and PSC-35 results collected in Avatar were compiled and reported out to California Department of Health Care Services beginning March 1, 2019 and since then DHHS Behavioral Health has successfully submitted 1,496 child functional assessment records to the state.

Currently work is being done to utilize the behavior health analytics platform Objective Arts for developing reports and dashboards to assist clinical staff with timely completion of the CANS as well as provide a wider program and organization level overview for supervisors and managers.

Enclosure 1

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: Humboldt ☐ Annual Update

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Emi Botzler-Rodgers MFT	Name: Karen Paz Dominguez
Telephone Number: 707-268-2990	Telephone Number: 707-476-2470
E-mail: ebotzler-rodgers@co.humboldt.ca.us	E-mail: kpazdominguez@co.humboldt.ca.us
Local Mental Health Mailing Address: Humboldt County DHHS-Behavioral Health 720 Wood St. Eureka CA 95501	

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

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

Emi Botzler-Rodgers MFT
Local Mental Health Director (PRINT)

Signature: Emi Botzler-Rodgers MFT Date: 8/27/2020

I hereby certify that for the fiscal year ended June 30, 2020, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated June 6, 2019 for the fiscal year ended June 30, 2018. I further certify that for the fiscal year ended June 30, 2020, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

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

Karen Paz Dominguez
County Auditor Controller / City Financial Officer (PRINT)

Signature: Karen Paz Dominguez Date: 9/17/2020

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

FY 2019-20 Mental Health Services Act Annual Update Funding Summary

County Humboldt

Date: 5/06/20

	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 2019-20 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	514,932	1,115,832	348,090	65,015	0	
2. Estimated New FY 2019-20 Funding	5,293,300	1,323,325	348,243			
3. Transfer in FY 2019-20 [a/]						0
4. Access Local Prudent Reserve in FY 2019-20						0
5. Estimated Available Funding for FY 2019-20	5,808,232	2,439,157	696,333	65,015	0	
B. Estimated FY 2019-20 MHSA Expenditures	4,995,195	1,872,013	501,017	65,015	0	
C. Estimated FY 2019-20 Unspent Fund Balance	813,037	567,144	195,316	0	0	

D. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2019	1,439,391
2. Contributions to the Local Prudent Reserve in FY 2019-20	0
3. Distributions from the Local Prudent Reserve in FY 2019-20	0
4. Estimated Local Prudent Reserve Balance on June 30, 2020	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 2019-20 Mental Health Services Act Annual Update

Community Services and Supports (CSS) Funding

County: Humboldt Date:05/06/20

Fiscal Year 2019-20

	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	5,094,971	3,479,192	1,583,386			32,393
2. Adult Residential Treatment Services	1,000,000	500,000	500,000			
Non-FSP Programs						
1. RURAL OUTREACH SERVICES ENTERPRISE (ROSE)/Mobile Outreach	976,218	662,486	281,108		32,624	
2. MHSA Telemedicine	218,361	144,870	73,092		399	
3. OLDER AND DEPENDENT ADULT EXPANSION	95,836	60,951	34,885			
CSS Administration	231,610	147,696	83,914			
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	7,616,996	4,995,195	2,556,385	0	33,023	32,393
FSP Programs as Percent of Total	80.0%					

FY 2019-20 Mental Health Services Act Annual Update

Prevention and Early Intervention (PEI) Funding

County: Humboldt Date:05/06/20

Fiscal Year 2019-20

	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	295,791	274,701	21,090			
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	94,100	94,100				
6. Local Implementation Agreements	110,000	110,000				
7. Making Relatives Program	43,583	43,583				
PEI Programs - Early Intervention						
1. Suicide Prevention	258,090	258,090				
PEI Administration	241,410	241,410				
PEI Assigned Funds	13,625	13,625				
Total PEI Program Estimated Expenditures	1,893,103	1,872,013	21,090	0	0	0

FY 2019-20 Mental Health Services Act Annual Update

Innovations (INN) Funding

County: Humboldt Date:05/06/20

Fiscal Year 2019-20

	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. Housing, Outreach and Mobile Engagement (HOME) (formerly Rapid Re-Housing)	1,252,513	379,943	167,379		244,691	460,500
INN Administration	189,179	121,074	68,104			
Total INN Program Estimated Expenditures	1,441,691	501,017	235,483	0	244,691	460,500

FY 2019-20 Mental Health Services Act Annual Update

Workforce, Education and Training (WET) Funding

County: Humboldt Date:05/06/20

Fiscal Year 2019-20

	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	**Estimated WET Funding**	**Estimated Medi-Cal FFP**	**Estimated 1991 Realignment**	**Estimated Behavioral Health Subaccount**	**Estimated Other Funding**
WET Programs 1. Training and Technical Assistance	65,015	65,015				
WET Administration	0					
Total WET Program Estimated Expenditures	65,015	65,015	0	0	0	0

FY 2019-20 Mental Health Services Act Annual Update

Capital Facilities/Technological Needs (CFTN) Funding

County: Humboldt Date:05/06/20

Fiscal Year 2019-20

	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					
CFTN Programs - Technological Needs Projects						
8. Integrated Clinical and Administrative Information System		0				
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	0	0	0	0	0	0

Prudent Reserve Certification

State of California
Health and Human Services Agency

Department of Health Care Services

MENTAL HEALTH SERVICES ACT
PRUDENT RESERVE ASSESSMENT/REASSESSMENT

County/City: HUMBOLDT

Fiscal Year: 2018-19

Local Mental Health Director

Name: Emi Botzler-Rodgers

Telephone: (707) 268-2990

Email: EBotzler-Rodgers@co.humboldt.ca.us

I hereby certify[1] under penalty of perjury, under the laws of the State of California, that the Prudent Reserve assessment/reassessment is accurate to the best of my knowledge and was completed in accordance with California Code of Regulations, Title 9, section 3420.20 (b).

Emi Botzler-Rodgers		4/19/19
Local Mental Health Director (PRINT NAME)	Signature	Date

[1] Welfare and Institutions Code section 5892 (b)(2)

DHCS 1819 (02/19)

Calculation of PR level

County of Humboldt
DHHS - Mental Health, Financial Services

Calculation of maximum Prudent Reserve Level
FY 2018-19

29,260,481	Jul/2013 - Jun/2018 all components
22,237,965	76%
4,447,593	**5 year average per DHCS**
1,439,391.20	current PR balance
32%	PR % of 5 year average
28,314.50	(Over) / Under 33% limit