Mental Health Services Act

Annual Update 2021-2022

Contents

Introduction

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

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

MHSA Plans identify services across the age span, with age groups identified as children (0-16 years), transition age youth/TAY (16-25 years), adults (26-59 years) and older adults (60 years and older). Originally, MHSA plans needed to identify programs according to these five (5) MHSA components: Community Services & Supports (CSS); Prevention & Early Intervention (PEI); Innovations (INN); Workforce, Education & Training (WET); and Capital Facilities & Technological Needs (CFTN). In years after Fiscal Year (FY) 2007-08, programs for CFTN programs were not required, but could be supported as needed. Descriptions of these components and their programs are described in their respective sections in this document. The most recent data (FY 2019/2020) for programs funded by Humboldt County MHSA during the last year of the prior Three Year Plan (FY 2019/2020) are reported in an Appendix to this document. Data for FY 2020-2021 will not be available until the end of FY 2020-2021.

This document was informed by stakeholder input and feedback received during the stakeholder meeting component of the Community Program Planning Process (CPPP).

Following a section about Humboldt County's demographics and characteristics, the process and results of the CPPP will be shared.

Humboldt County Demographics and Characteristics

Humboldt County is located on the coast of northwestern California, 225 miles north of San Francisco and 70 miles south of the Oregon border. The County is rural in nature, with a population of 135,558 spread over 3,567 square miles, or 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.

Stakeholder Meetings

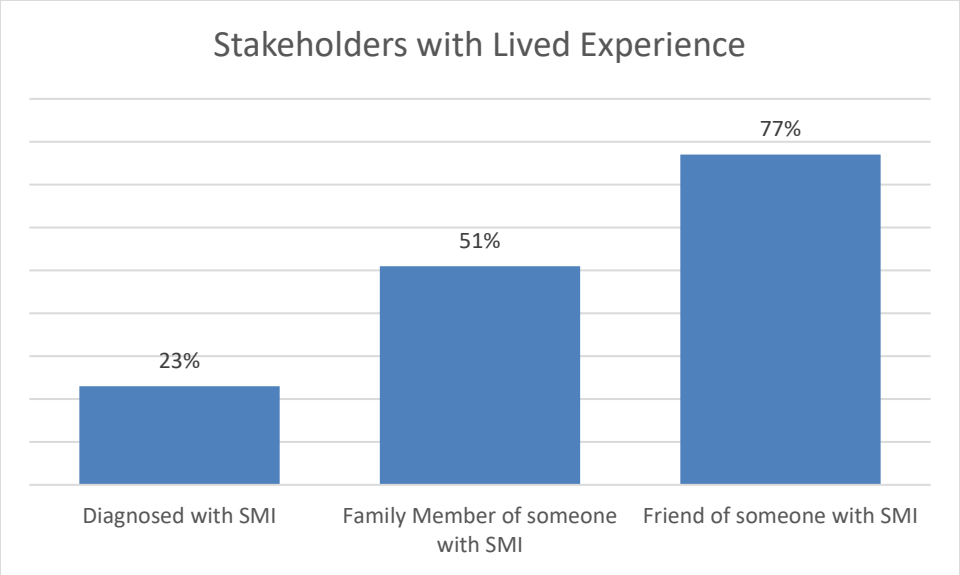
The Community Program Planning Process (CPPP) has three components: stakeholder meetings, the 30 day public comment period, and the public hearing. During the stakeholder meeting component, stakeholders provided input by attending a stakeholder meeting and providing verbal comments; by sending comments to the MHSA email address; by leaving a message on the MHSA voice mail; by providing written comments using the MHSA Comment Form; and by using the "Chat" function on the Zoom platform to make a written comment. The Draft 2021-2022 Annual Update and associated MHSA information was also sent via email to stakeholder groups and individuals to provide an opportunity to provide input.

Due to the COVID-19 restrictions community meetings with stakeholders were held using the Zoom virtual platform. Materials were provided to attendees via email and were shared on the screen during the virtual meeting. The materials included:

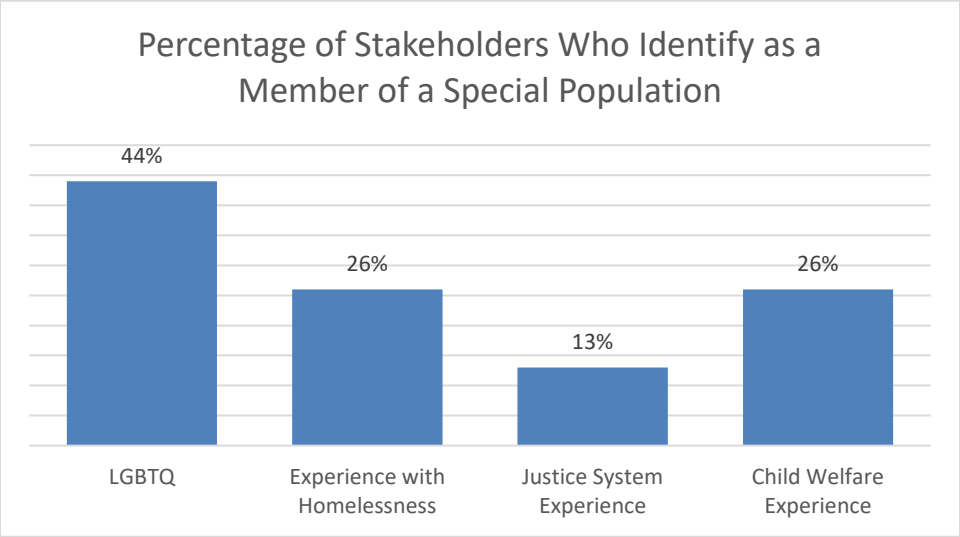
- Draft MHSA Annual Update for 2021-2022, including the draft budget for 2021-2022
- MHSA Fundamental Concepts handout
- MHSA Information Form handout
- MHSA Current Programs handout
- Services provided by DHHS Behavioral Health handout
- Definitions of Serious Mental Illness and Serious Emotional Disturbance handout
- The MHSA demographic questionnaire and MHSA Comment Form were provided to meeting participants via a link during the meeting.

A total of ten meetings were held during the stakeholder meeting component. Six of the meetings were regional, for Northern Humboldt, Southern Humboldt, Eastern Humboldt (two meetings), Eureka and Eel River Valley. Four meetings were held with community groups and organizations. A total of 100 individuals attended these meetings. Attendees were invited to complete the demographic questionnaire, and 39% did so. The results from the demographic questionnaire are presented below.

Individuals with lived experience of a serious mental illness (SMI) and their family members are recognized as a vital voice in the MHSA CPP. As seen in the chart below, 23% identified as having a mental illness, and 51% identified as a family member of someone with a mental illness. In addition, 77% of those attending the stakeholder meetings said they were a friend of someone with a SMI.

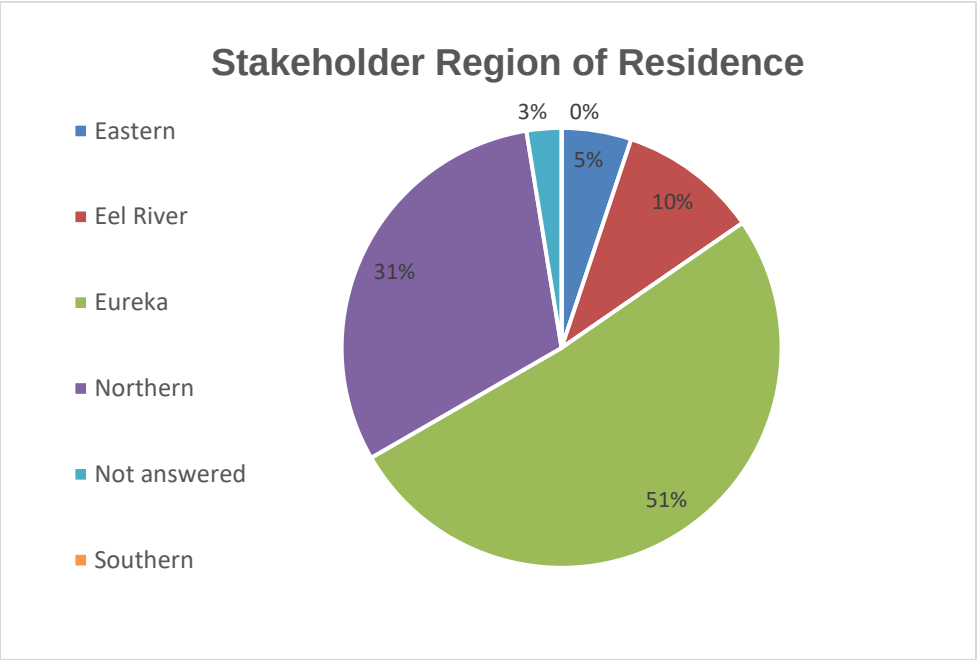


Additional life experiences have been identified as important voices for the CPP. Sexual orientation and gender identity, homelessness, experience with the justice system, experience with Child Welfare, and those whose primary language is not English have life experiences or conditions that can result in challenges to successful mental health access and treatment. The chart below illustrates the inclusion of people with these life experiences in the CPP. Forty-four percent identified as LGBTQ; 26% identified as having experience with homelessness; 13% had justice system experience; and 26% had Child Welfare experience. Because only two stakeholders stated their primary language was a language other than English this is not indicated on the chart.

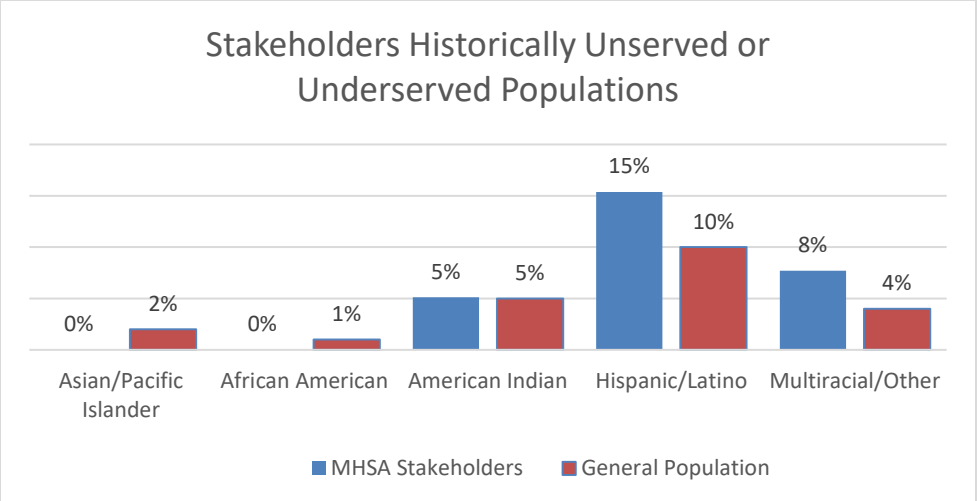


In these stakeholder meetings, 31% of participants resided in the Northern Humboldt region, which includes Arcata, Blue Lake, McKinleyville, and areas north, and 51% of

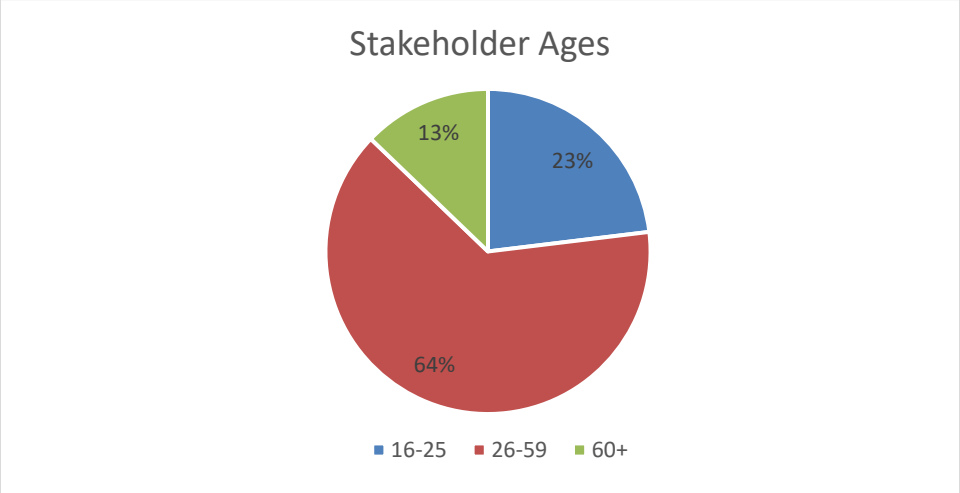
participants resided in Eureka. Three percent of participants resided in Eastern Humboldt, which includes Hoopa and Willow Creek; 10% in the Eel River Valley, which includes Fortuna, Ferndale, Scotia and Rio Dell. No Southern Humboldt stakeholders, which includes Redway, Petrolia and Garberville, submitted a demographic form. Three percent preferred not to answer.



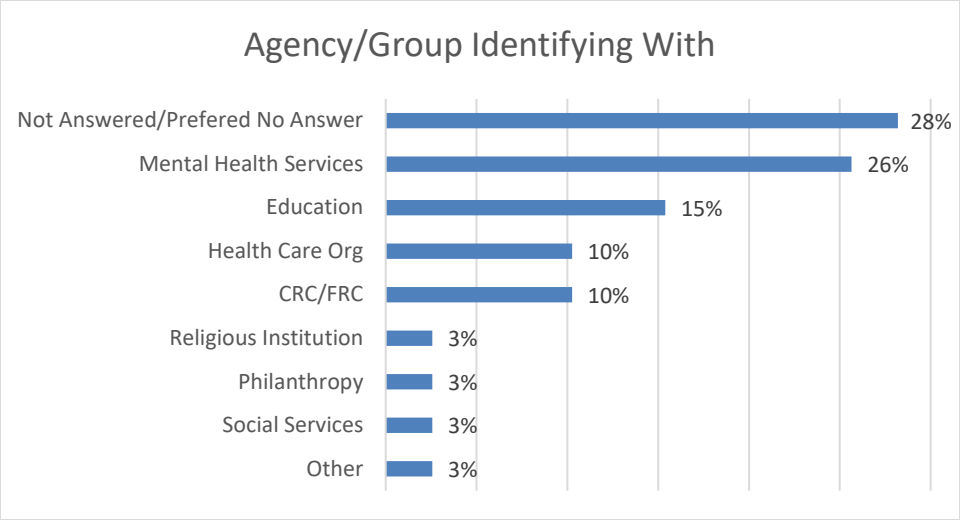
Efforts are made to reach participants that reflect the racial and ethnic diversity of Humboldt County. Of those attending stakeholder meetings, 15% were Hispanic/Latino as compared to 10% of the Humboldt County general population. Eight percent were Multiracial/Other as compared to 4% of the County general population. Five percent were American Indian, as compared to 5% of the County general population. No Black/African or Asian/Pacific Islander provided stakeholders demographics, as compared to 1% of the general population for Black/African and 2% for Asian/Pacific Islander.



Twenty-three percent of those completing the demographic form were ages 16-25; 64% were ages 26-59, and 13% were age 60+.



The chart below illustrates the representation from community agencies participating in the stakeholder meetings. It shows that the process included individuals from mental health services, 26%; education, 15%; health care organizations, 10%; social services, 3%; Community and Family Resource Centers (CRC/FRC), 10%; Religious Institutions 3%, Philanthropy, 3% and Other, 3%. Twenty-six percent provided no response.



After the stakeholder meetings were completed, the notes from each meeting, the Comment Forms received at each meeting, and the comment received from the MHSA Email were reviewed. This review resulted in a grouping of comments and input by the overall themes of the services and supports that community stakeholders would like to see more of, or changes within. The top five overall themes are presented below. Programs and services identified in this Update, in the MHSA Three Year Plan, or available through other DHHS programs that support these priorities are also indicated.

- Bilingual and culturally competent services: Provide better training; healthy cultural activities and services validating the knowledge and experience of tribes; education, outreach and programs with more Spanish-speaking clinicians and services to the Spanish-speaking community.
    - The Workforce Education and Training (WET) component of the MHSA Plan includes two subcomponents: Training and Technical Assistance and the Office of Statewide Health Planning and Development (OSHPD) Regional Partnership. The Training and Technical Assistance component includes a contract with the Relias E-Learning system, whose large catalog of trainings includes several focused on working with cultural communities. Staff are encouraged to take these trainings. The OSHPD Regional Partnership component includes providing graduate education stipends for Clinical Masters and Doctoral program participants. Targeting these stipends for participants from diverse cultures is a priority. Humboldt County Behavioral Health will be participating in the Regional Partnership as soon as it is implemented.
- Expand/increase access to services: Expand services to areas outside of Eureka; expand services for those who are not County Behavioral Health clients; more clinicians, community health outreach workers, and certified peer support staff.

    - The Regional Services Program expands services to Eastern and Southern Humboldt through Behavioral Health clinicians, case managers and peer support. Currently these services are for County Behavioral Health clients.
- Services for those experiencing homelessness: Housing support for those who are not Behavioral Health clients; housing assistance for those experiencing homelessness who need mental health services.
    - Humboldt County DHHS is a partner with several organizations and groups that focus on providing housing and services for those experiencing homelessness. These organizations include the Humboldt Housing and Homeless Coalition, local city councils, local police departments and Humboldt County Board of Supervisors, to name a few. DHHS has a Housing and Assistance Coordinator who coordinates housing assistance programs, including No Place Like Home grants. The Housing, Outreach and Mobile Engagement (HOME) program, formerly funded by MHSA Innovation funds, continues to engage individuals experiencing homelessness and connect them with housing and behavioral health services.
- Increased evaluation of MHSA programs: Statistics that evaluate program effectiveness; evaluation tools.
    - Data for the Comprehensive Community Treatment/Full Service Partnership Program can be accessed through the State's Data Collection and Reporting (DCR) system. Other local MHSA programs collect and report data on numbers served and demographic information. Tools for evaluating program effectiveness are not available statewide, and each county must develop its own system if resources are available. Larger counties have been able to develop evaluation systems or contract out evaluation services to a third party because they have the resources to do so, but most small counties, including Humboldt, have not been able to develop these systems.
- Hope Center improvements: A bigger facility with more space for activities.
    - Behavioral Health recognizes this need. Adequate facilities have been challenging to find, and in the current economic climate there are insufficient funds for a different facility.

The full stakeholder meeting report is available on the Mental Health Service Act webpage on the County website at https://humboldtgov.org/430/Mental-Health-Services-Act-MHSA.

30-Day Public Review and Comment Period and Public Hearing

In accordance with MHSA regulations, the Annual Update for FY 2021-2022 was available for public review and comment for a 30-day period from April 26-May 27, 2021. At the end of the 30-Day Public Review the Behavioral Health Board (BHB) conducted a Public Hearing on the Annual Update on May 27, 2021. The input received is discussed below.

30-Day Public Comment. A total of five emails to the MHSA Comments mailbox were received during the 30-day period. No comments were made via telephone or by mail. The list below summarizes the five comments. Behavioral Health responses are also indicated.

- One commenter requested additional information about the REST proposal. Response: The REST proposal was sent to the individual.
- One commenter stated that until they learned about Mental Health workers going on calls with the police department they were unaware of increased mental health services. Response: The commenter was thanked for their comment.
- One commenter voiced support of more MHSA funding going to three sectors:
    - Building more very low income housing and pairing with Danco and other organizations to do that. Response: Through its housing program, DHHS continues to work with community partners, including Danco, to build more housing.
    - More funding for rent deposits, rental assistance, and other expenses related to getting housing. Response: The proposed REST project would address this need and will be an addition to the funding already available through the Comprehensive Community Treatment and HOME programs.
    - More support teams to help keep people housed once they are housed. Response: The proposed REST project would address this need and will be an addition to the support already available through the Comprehensive Community Treatment and HOME programs.
- One commenter praised the investment into HOME and the focus on Housing First principles, and stated that MHSA needs to invest more into financial recovery for patients, providing guidance on how to apply for an apartment, set up a bank account, etc. Response: The HOME program and the Comprehensive Community Treatment/Full Service Partnership provide guidance to clients on these topics. The proposed REST project will also contribute to addressing this need if the proposal is approved.
- One commenter stated the two most important pieces of the MHSA plan are HCTAYC and Hope Center. They do not support AOT and do not want any MHSA funding going to support that non-voluntary program. Response: At this time MHSA funding is not proposed for AOT implementation.

Public Hearing. The Behavioral Health Board (BHB) facilitated a public hearing on the MHSA Annual Update at their regular meeting on May 27, 2021. A total of 26 people attended: Six BHB members, sixteen DHHS staff members and four community members. A summary of the comments, with Behavioral Health responses, is below.

- Does the BHB have a role in providing feedback into the plan before it goes to the Board of Supervisors (BOS)? Will they have time as the BHB to review and make recommendations? Response: Section 5848(b) of the Mental Health Services Act states: "The mental health board established pursuant to Section 5604 shall conduct a public hearing on the draft three-year program and expenditure plan and annual updates at the close of the 30–day comment period required by subdivision (a). Each adopted three-year program and expenditure plan and update shall include any substantive written recommendations for revisions. The adopted three-year program and expenditure plan or update shall summarize and analyze the recommended revisions. The mental health board shall review the adopted plan or update and make recommendations to the county mental health department for revisions."
- There is never enough funding provided for mental health in general. MHSA only goes so far. Believes strongly we need to provide services to those with greatest need even if it cost more initially because in the long run it will cost the community less. Response: By law no more than 75% of MHSA funds can go to the Community Services and Support (CSS) category. CSS are direct services programs that serve unserved and underserved populations with the greatest need. By law at least 51% of CSS funds must be allocated to Full Service Partnerships. In Humboldt County, 87% of CSS funding is for Full Service Partnerships. Full Service Partnership are those individuals with the highest need for services and the most intensive outpatient services available. MHSA funds are going to those with the highest need.
- Concerned with homelessness for children and youth. Increase outreach to the homeless. Response: If a child under the age of 16 is homeless they are offered behavioral health services, including case management, and the family is assisted with making connections to community resources. TAY Advocacy and Peer Support provides services and support for transition age youth experiencing homelessness. The proposed REST project will increase supports for adults experiencing homelessness.
- What is the long term follow up for those with serious mental illness (SMI)? Are there programs that provide life skills development that would allow an individual in recovery or pursuing recovery to be able to be independent? Things like finance, budgeting, rent assistance, and is there clear linkage to programs that might provide this. Response: Comprehensive Community Treatment/Full Service Partnership, the HOME program, and the proposed REST proposal can all address these needs. There are also components of this type of support within HCTAYC and the HOPE Center, both of which are

funded by MHSA.

- Prioritize budget and services to SMI even if it costs more. Response: By law no more than 75% of MHSA funds can go to the Community Services and Support (CSS) category. CSS are direct services programs that serve unserved and underserved populations with the greatest need. By law a minimum of 51% of CSS funds must be allocated to Full Service Partnerships. In Humboldt County, 87% of CSS funding is for Full Service Partnerships. There is also a specific requirement that 20% of MHSA funds are spent on prevention and early intervention. Humboldt County complies with the regulations regarding MHSA spending.
- Need to look at those most in need. Look at Laura's Law. Evaluate current programs and weigh their effectiveness against the potential effectiveness of Laura's Law. BHB recommends the BOS opt-in to Laura's Law. Consider funding the mandate through AB109, General Fund and/or MHSA. Response: The County is planning to recommend implementing a pilot program of Laura's Law. The funding for this has not yet been determined.
- Concerned with the increase in pediatric SMI in ER and parents don't know where to go. Also concerned about the burden put on local systems of care because our mental health services are insufficient. SMI patients in hospitals are taking up space that could be used for physical health and is affecting patient care. SMI patients are staying too long taking up much needed beds. Response: There are county wide and statewide bed shortages for those individuals experiencing mental health crises. This has impacted County Behavioral Health (BH), Emergency Departments and Law Enforcement. County Behavioral Health is working diligently with community partners and providers to support these individuals with limited resources. COVID has also impacted this and contributed to these challenges. BH will continue to work at the local and state levels on solutions to this on-going crisis.
- BHB should send a letter to the BOS and together advocate to the State to increase funding to State mental health services, especially in light of the current budget surplus. The State should bear the burden of increasing and improving funds for mental health services. Response: Behavioral Health agrees that the BHB and the Board of Supervisors should advocate to increase funding for mental health services.
- Expressed support for Laura's Law as well and its potential to save lives. Response: The County is planning to recommend implementing a pilot program of Laura's Law.
- Had services like the ones supported by MHSA been available to them when they experienced SMI as a child then their life could have been very different. They support the programs that are making a difference.

Complaints and Grievances

If there is a complaint, dispute or grievance from the general public about MHSA program planning the MHSA Issue Resolution Policy and Procedure will be followed.

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

Behavioral Health Capacity Assessment

This draft MHSA Annual Update for FY 2021-2022 is being presented at a time of continuing fiscal uncertainty due to COVID-19. Humboldt County Behavioral Health relies on sales tax revenue, vehicle license fees and personal income taxes to fund services. MHSA is funded by personal income tax revenue. All projections for this revenue source for the next two years suggest continuing decreases. This Annual Update has been developed based on current revenue estimates, which show sharp decreases by FY 2022-2023. The analysis of needed reductions will continue to be a part of the MHSA Annual Update process. As plans are made to adjust due to the decrease in revenues, it is also anticipated that there will be an increased demand in services as more Humboldt County residents become eligible for Medi-Cal due to the global economic downturn.

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

1. The MHSA Community Program Planning Process (CPPP) for gathering community input into the Three Year Plan for 2020-2023 and for this Annual Update provides information directly from stakeholders about needs, including those from diverse populations. The findings from the CPPP for this Annual Update will be discussed in the prior section of this Update.
2. Updated annually, the Mental Health Cultural Competence Plan (MHCCP) provides data on the racially and ethnically diverse populations served, bilingual proficiency in threshold languages, and percentages of diverse cultural, racial/ethnic and linguistic groups represented among direct service providers, as compared to the population needing services and the total population being served. The MHCCP provides the most relevant and pertinent information on the topic of racial/ethnic/linguistic capacity. The 2020 MHCCP is located here:

https://humboldtgov.org/DocumentCenter/View/70542/Behavioral-Health---Cultural-Competency-Plan---Updated-2020?bidId=

3. The Network Adequacy Certification Tool (NACT) and other required documentation report on standards of time, distance and timely access requirements with which the Mental Health Plan must comply. Network Certification provides assurances of adequate capacity and services and demonstrates that the Mental Health Plan offers an appropriate range of services that is adequate for the anticipated number of beneficiaries for the service areas, and maintains a network of providers that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of beneficiaries in the service area. The NACT tool has been submitted quarterly since its inception in April 2018. Beginning in 2020, the NACT and supporting documentation are to be submitted annually no later than April 1.
4. Office of Statewide Health Planning and Development (OSHPD) Workforce Assessment Survey. Required by OSHPD every two to five years, this assessment provides data on the number of public behavioral health system employees, the types of positions, race/ethnicity, and language spoken. The last two OSHPD Workforce Needs Assessments were prepared and submitted in April 2020 and Fall 2018.

System Strengths

Network Adequacy (NACT) documents the federal standards of time, distance and timely access requirements with which the Mental Health Plan must comply. Time and distance standards are up to 60 miles and 90 minute drive from the beneficiary's place of residence to the provider's site. Timely access requires the Plan to meet State standards, taking into account the urgency of the need. The standards are documented with Geographic Access Maps showing beneficiary and provider locations. NACT includes information on language capacity for Russian, Spanish, Tagalog, Vietnamese, American Sign Language, and whether Language Line is available. Humboldt County's NACT also included the American Indian health facilities in the county. The NACT submitted in April 2020 indicates that DHHS Behavioral Health is meeting the required standards. Another NACT will not be submitted until April 2021.

The Behavioral Health Cultural Responsiveness Committee (BHCRC) is a strength in the agency. BHCRC facilitates projects to gather data and address issues surrounding diversity. The Welcoming Environments project focuses on increasing the sense of welcoming to diverse populations in Behavioral Health locations where clients are served. The Latino Outreach project will provide outreach to the Latino population to inform them about services available. The Workforce Demographic Survey gathers information about the diversity of the workforce that is not available through the Employee Services database. A project to update the Client Information Form will increase the number of choices for ethnicity. BHCRC oversees and approves the development of the annual Cultural Competence Plan.

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

- Updating the progress notes in the Electronic Health Record to expand the categories to capture the use of interpretation services. Choices for mode of interpretation now include whether a bilingual practitioner provided the service. Prior to this change, mode of interpretation included client's choice of interpreter, on-site interpreter, or Language Line, and missed those instances where a bilingual practitioner provided a service.
- A continuing contract with Language Line services to ensure services are available in a client's preferred language. Training on using the Language Line is required annually for all staff.
- Maintenance of contractual relationships with organizational providers, including Two Feathers Native American Family Services, which serve diverse populations, and ensuring that organizational providers receive cultural competence training annually.
- Update and maintenance of the local interpreter list, which provides information about the interpreters who have contracted with Behavioral Health to provide live interpretation for clients requesting this service.
- Maintenance of the Behavioral Health Cultural Responsiveness Resource Page, available on the DHHS Intranet, which provides links to resources, trainings, and other information for staff. The Resource List that is a part of this Webpage is updated quarterly.
- Maintenance of the Relias E-Learning contract, which provides cultural competence as well as many other online trainings for staff. This contract is supported by MHSA Workforce, Education and Training (WET).
- Development of cultural competence training, which is offered either in an in-person setting or through Relias, and monitoring to assess compliance with the training requirements.

System Limitations

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

whichever is lower. Though there is currently no threshold language, DHHS Behavioral Health remains committed to providing services to clients in their preferred languages through the use of the Language Line, or through providing a local interpreter if one is available in the client's preferred language.

The MHSA CPPP for the Three Year Plan 2020-2023 provided information on diverse populations. For the priority category Providing Bilingual and Culturally Competent Services:

- Stakeholders at community meetings ranked this as number 13 among all priorities.
- Stakeholders completing the Community Survey ranked this as 13 among all priorities and indicated that racial/ethnic populations are among those not adequately served by current MHSA programs. These racial/ethnic populations included the African American, Asian, Latino, Native American and Pacific Islander communities.

In the MHCCP, an analysis of disparities for those in Humboldt County with Medi-Cal versus those that are served by DHHS Behavioral Health was performed for calendar year 2018. This was a simple descriptive analysis about disparities in each population served by Behavioral Health. Disparities were found in serving Asian/Pacific Islanders and Hispanic/Latino populations.

- Three percent of those with Medi-Cal were Asian Pacific Islander, and 1% used DHHS-Behavioral Health services.
- Thirteen percent of those with Medi-Cal were Hispanic/Latino, and 9% used DHHS-Behavioral Health services.

There could be many reasons that these Medi-Cal populations do not use DHHS Behavioral Health services. Asian/Pacific Islanders may not use County services because of levels of acculturation within their communities, or because there are no providers speaking their languages. Hispanic/Latino populations may not use DHHS Behavioral Health services due to levels of acculturation, cultural beliefs about behavioral health issues and origins, lack of knowledge about available services, or because of the scarcity of providers speaking Spanish.

In addition to looking at disparities among Medi-Cal beneficiaries and their use of Behavioral Health services, the MHCCP reported on the data available for the Behavioral Health workforce. The August 2019 DHHS Employee Services database showed that Whites are overrepresented in the workforce, and other racial/ethnic categories, except Asian/Pacific Islander, are underrepresented as compared to Medi-Cal client utilization. Data from the voluntary Workforce Demographic Survey conducted in September 2019 also showed racial/ethnic disparities in the workforce as compared to client utilization for Native Americans and African Americans. Finally, a survey conducted by the Quality Improvement Unit indicated a disparity in the workforce as compared to Hispanic/Latino clients. Detailed information is available in the MHCCP.

The last Office of Statewide Health Planning and Development (OSHPD) Workforce Assessment Survey was submitted in April 2020. This survey requested NACT data and did not ask questions about workforce race/ethnicity. The OSHPD Workforce Assessment Survey completed in the Fall of 2018 focused on data from July 1, 2016-June 30, 2017. This assessment incudes data on the number of public behavioral health system employees, the types of positions, race/ethnicity, and language spoken. The assessment showed that there is a disparity between the race/ethnicity of clients served and the workforce for Hispanic/Latino and Black/African American populations.

While DHHS Behavioral Health does face challenges in serving diverse racial/ethnic populations, its continuing attention to the issue to make improvements; the continuing contract with Language Line to ensure that behavioral health services are provided in a client's preferred language; the continuing development and monitoring of staff training; and the consistent updating of cultural competence resources all contribute to the conclusion that the agency will have the capacity to implement MHSA programs, subject to the financial and funding limitations facing California and the nation as a whole over the next few years.

Community Services and Supports (CSS) Component

Seventy-six percent (75%) of MHSA funds received by counties must be allocated for the CSS component. MHSA funds may only be used to pay for those portions of the behavioral health programs/services for which there is no other source of funding available. CSS programs serve individuals affected by moderate to severe mental illness and their families. These services must be community based, recovery-oriented and culturally competent. Funding can only be used for voluntary services and no less than 50% must be allocated to Full Service Partnerships (FSPs). The remaining funds in the CSS component are for General System Development programs that provide a less-intensive level of mental health treatment and supportive services, and counties may develop and operate Outreach and Engagement Programs to identify unserved individuals in order to engage them and, when appropriate, their families. The following pages describe the CSS programs that were approved in the Three Year Plan and that will continue to be supported, contingent upon the availability of MHSA revenue.

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

Full Service Partnerships (FSP) offer a range of services and supports to persons impacted by severe mental illness. FSP services provide a “whatever it takes” level of services, also referred to as “wraparound” services, to support the most severely mentally ill clients and their families, twenty-four hours a day, seven days a week. These wraparound services include treatment, crisis intervention, medication management, case management, peer support, transportation, housing, crisis intervention, family education, vocational training and employment services, education and treatment for co-occurring disorders, as well as socialization and recreational activities, based upon the individual’s needs and goals to obtain successful treatment outcomes. It also provides for non-behavioral health services such as food and housing. The term “Full Service Partnership” refers to the commitment on the part of the client, the family, and their service providers to determine the needs of the client and family and to work together to support the client in their recovery. FSP addresses the priorities of the CPPP to increase support for the seriously mentally ill.

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

Partners are served through various DHHS Behavioral Health programs including Children and Family Services Transition Age Youth Division, Housing, Outreach and Mobile Engagement (HOME), and Older and Dependent Adults programs. However, Full Service Partners are primarily served through the Comprehensive Community Treatment (CCT) program. Modeled after the evidence- based program Assertive

Community Treatment, CCT provides intensive behavioral health services and community supports to assist clients in their recovery. These include access to housing, medical, educational, social, vocational, rehabilitative, or other needed community services for those with serious mental illness who are at-risk for psychiatric hospitalization, incarceration, homelessness, or placement in more restrictive facilities.

Children 0-16 who meet FSP eligibility have their service needs addressed by a variety of outpatient Behavioral Health services but are not currently enrolled as FSPs. These services include Assessment, Individual/Family Therapy, Targeted Case Management, Intensive Care Coordination, Intensive Home Based Services, Therapeutic Behavioral Services, Medication Evaluation, Medication Support, Parent Partner/Peer Coaching, and Mobile Crisis services. Additionally, Children's Behavioral Health staff work regularly with other community agencies to hold Child & Family Team meetings to help with coordination of services, assessing client/family needs & strengths, and monitor service plans and progress.

An estimated 225 clients will be served annually as FSPs. The age groups expected to be served are:
TAY: 13
Adults: 143
Older Adults: 69

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

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

Data from Fiscal Year 2019-2020 is included in the Appendix.

Community Services and Supports: Regional Services

DHHS-Behavioral Health Regional Services falls under General System Development (GSD) and Outreach and Engagement (O&E). As GSD, Regional Services focuses on the stabilization, management, and reduction of psychiatric symptoms; on the restoration and maintenance of functioning; on the improvement of interpersonal effectiveness; and on the development and maintenance of healthy support systems for clients. As O&E, Regional Services reaches out and engages adults living in all areas of Humboldt County including Eureka, Fortuna to Garberville, McKinleyville to Orick, and Willow Creek to Orleans—that have a scarcity of behavioral health services and provides services to them as needed. This meets the need to increase and expand behavioral health services.

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

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

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

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

Contingent upon funding availability, MHSA CSS funding will continue to support a proportion of the salary costs for Regional staff. It is estimated that three to five individuals ages18-25, thirty to forty individuals ages 26-59, and fifteen to twenty individuals age 60+ will be reached annually. Outcomes will be measured by the number of clients reached and the program aims to complete 50 new client assessments per year. Regional Services was not supported by MHSA in the prior Three Year Plan so there is no report available for this Annual Update.

Community Services & Supports: Older Adults and Dependent Adults

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

Outreach, Prevention and Education

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

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

Outcomes to be tracked include the following:

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

Contingent upon the availability of MHSA funding, an estimated 150 individuals will be contacted through outreach, prevention and education during fiscal year 2021-2022. A report for Fiscal Year 2019-2020 is provided in the Appendix.

Behavioral Health Services to Clients

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

Client Outcomes:

- Reduced mental health symptoms

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

A report for Fiscal Year 2019-2020 is provided in the Appendix.

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

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

Contingent upon the continuing availability of MHSA funds, this program will provide crisis residential treatment to DHHS-BH referred clients. It will assist individuals who are stepping down from higher levels of care to effectively integrate back into the community. Many 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.

Behavioral Health received three proposals in response to the RFP. Through analysis and interviews with the proposers the RFP selection committee is in the process of selecting a proposal for a Crisis Residential Treatment Facility. The proposal will be submitted to the Board of Supervisors for approval to fund. After that approval, Behavioral Health will enter into contract negotiations with the proposer for the provision of this service.

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

In addition to referrals from Sempervirens, clients can be referred from other programs such as CalWORKs, County Probation, and local housing resources such as shelters. While a resident at the Crisis Residential facility the client will be linked to various programs within DHHS such as the HOME program or Social Services programs, as well as other community and natural resources such as physical health care.

Outcome Measures will be tracked through the State Data Collection and Reporting (DCR) system for those clients who meet criteria for Full-Service Partnerships. Additional outcome measures including re-hospitalization rates and reduction in Administrative Bed Days for individuals waiting to be discharged will be tracked by the Behavioral Health Administrative Analyst.

NEW: Community Services and Supports: Housing Support

In September 2020 Behavioral Health received a small amount of funds from the California Housing Finance Agency (CalHFA) as accrued interest from the MHSA Housing Program. Per statute these funds must be used to provide housing assistance to individuals eligible for MHSA services and supports. Over the next year these funds will be used to provide housing assistance such as rental assistance, security deposits, utility deposits, move-in assistance and utility payments. This is a new CSS Program in fiscal year 2021-2022 and was not included in the Three Year Plan for 2020-2023 as the existence of the funding was unknown at the time of the preparation of the Three Year Plan.

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

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

The hope with this project is to expand on current efforts of the county regarding the overarching goal of improving housing stability. This goal has been a jointly identified need by various county agencies, including Humboldt County Department of Health and Human Services HOME program, Arcata House Partnership, Eureka City Council and HUD to name a few. Currently these efforts exist to find permanent supportive housing for homeless and unsheltered individuals in our county. REST provides a missing competent within this continuum by helping individuals remained housed while assisting in transition to HUD programs.

We believe that this project will work in complement to our HOME program in that HOME is a very time limited program whose unique service is to get individuals housed initially and then to achieve a degree of stability. We have seen that this "stability" goal needs to be individualized in order to promote a successful transition, with the three-month mark as an indicator of progress and assessment if referral is appropriate. Once the individual is ready to be referred from HOME to REST, we will continue to work cooperatively with HOME service providers to ensure a successful transition. REST will continue to provide many of the same Housing First interventions and techniques but hopefully with a reduced frequency as an indicator of the client's stability.

We believe this to be an innovative and necessary approach for our community as it is an identified gap in our continuum of care that does not exist within the various county agencies providing services to individuals experiencing homelessness. HOME has the capability to refer clients to our Full Service Partnership program, called Comprehensive Community Treatment (CCT). REST will provide a secondary option for referrals as REST will be for those individuals who do not meet the criteria for FSP or are resistant to County Behavioral Health services. REST will utilize Housing First principles, which have been identified as a best practice approach for working with this population.

PRIMARY PROBLEM

In its prior Innovation project, Rapid Re-housing (later renamed Housing, Outreach and Mobile Engagement--HOME), Humboldt County achieved some success in developing a system for finding housing for homeless individuals using the Housing First model. Some case management and peer support services are available after an individual becomes housed, but HOME is primarily focused on getting people into housing.

Keeping many of these individuals housed is often challenging due to their behavioral health issues, even though every effort is made to connect them with behavioral health services. The Humboldt community wants to see individuals housed and remain housed, not back out on the streets. Data supporting the need for REST is discussed below.

Experiencing homelessness with mental illness. During the 2019 Point in Time Count, 1702 people were observed as experiencing homelessness in Humboldt County. Of these, 337 reported having a diagnosis of severe mental illness and 454 reported being homeless for at least one year. In the Coordinated Entry system, a database used by housing programs to identify and prioritize individuals eligible for housing services, there are 302 people (as of 6/30/2020) who identify as chronically homeless (literally homeless for at least one year). Of those, 227 identify as having a mental health disability.

Discharge to homelessness or unstable housing after psychiatric hospitalization or stay in crisis stabilization. Humboldt County has a 26 bed psychiatric facility, Sempervirens (SV), and a Crisis Stabilization Unit (CSU) that will accommodate four people at a time. Currently, when a consumer is discharged from SV or CSU the practice is to assign a clinician and give them a medication appointment. If the consumer is homeless or housing unstable this is not sufficient support. Data from Fiscal Year 2019-2020 shows that of 100 encounters for those experiencing homelessness who were admitted and then discharged from SV or CSU, the average number of days before being readmitted was 31.8 days. The days before readmission ranged from 0-246.

Full Service Partners Experiencing Homelessness. The Data Collection and Reporting (DCR) System of the Department of Health Care Services (DHCS) shows that in Fiscal Year 2019-2020 nineteen partners experienced homelessness at some point during the year. Thirty-nine had experienced homelessness one year before the partnership, so entering a partnership reduced those experiences, though twenty partners still experienced homelessness. The DCR also shows that twenty partners were in an emergency shelter at some point in time one year before partnership, and fourteen were in emergency shelter at some point during the most recent year in the partnership.

Returning to homelessness after being housed. Data from the HOME Program includes housing status for people who have obtained housing through the program. From January 2015-June 2020 HOME has supported 224 individuals to obtain housing. At one year post-housing, of 165 consumers, 88% (145) remained in housing, 7% (12) had returned to homelessness, 3% (5) were out of the area, and 2% (3) were unknown. At two years post-housing, of 140 consumers, 66% (92) remained in housing, 16% (22) had returned to homelessness, 11% (15) were out of the area, 4% (6) were unknown, and 3% (4) were deceased. While it is positive that 66% remain in housing after two years, it is concerning that 16% had returned to the experience of homelessness.

HOME data includes the “move out reasons” for consumers who were housed by the program. Of 138 consumers, 30% were asked to leave and 17% were evicted, almost always because they, or their guests, were being too disruptive, These disruptions can be attributed to mental health symptoms that are still present with many of our clients. In the Housing First model, many clients are still symptomatic as Behavioral Health staff slowly begins to engage them in services. We also have discovered individuals who are housed allow long-term guests in their dwelling, which many times is a violation of their rental agreements, particularly if these guests are themselves disruptive. During this critical time, it is important to have sufficient oversight and assistance from Behavioral Health to ensure appointments are kept and negative behaviors are mitigated.

Behavioral Health staff experiences. The problem of keeping people housed is an ongoing topic at staff meetings, including among Case Managers, Outpatient Referral Assignment team members, and the Older Adults team, where strategies for keeping people from getting evicted from local assisted living facility requires considerable time and attention. Many times our Case Management resources are spread thin as we try to assist those who have been recently housed. This topic also takes up considerable amount of time during staff meetings and other clinical support briefings, in an effort to ensure this basic need continues for our most fragile clients.

In summary, the problems indicating the need for a solution are:

- In the 2019 Point in Time Count of those experiencing homelessness, 337 people reported having a diagnosis of severe mental illness
- The Coordinated Entry system shows 302 people who are chronically homeless, and of those, 227 people identify as having a mental health disability
- In Fiscal Year 2019-2020 44 individuals experiencing homeless were served by Humboldt County Behavioral Health either through SV, CSU or case management services
- In Fiscal Year 2019-2020 30 individuals experiencing homelessness were admitted to and then discharged from SV or CSU. Of these individuals, the average number of days before being readmitted to SV or CSU was 31.8
- Consumers discharged from Sempervirens are assigned a clinician and given a medication appointment, but are not provided with wraparound services and supports
- Full Service Partners can experience homelessness even with the support of the partnership. This is being addressed by working with local hotels to create partnerships in housing. Our FSP program is working on managing client placed in these temporary shelters on the weekend and other non-transitional work hours to ensure stability and treatment compliance.
- HOME data shows that 16% of consumers returned to homelessness within two years of being housed
- HOME “move out” data shows that almost 50% were either asked to leave or were evicted because of disruptive behavior

With this proposed Innovation Project, Resident Engagement and Support Team (REST),
Humboldt County is interested in finding solutions to these problems. HOME led to a positive increase in the sheltering of our chronically homeless and unhoused consumers. As a side effect to this we see an increased need for services to address the problematic circumstances related to maintaining housing. Lessons learned from HOME are:

- Peer coaches increase engagement of clients and help them to achieve their goals. This success contributed to the inclusion of peer support in the REST proposal.
- Innovative approaches to engage homeless persons with a pet can be successful and shared with other service providers
- Collaborating with local homelessness service agencies to implement a community-wide Housing First model can lead to increases in affordable housing
- Partnering with law enforcement to identify/engage individuals experiencing homelessness is a successful strategy
- These approaches lead to decreased utilization of costly and restrictive services

The successful practices of HOME are being continued with Social Services funding.

The Housing First model was a new practice for our community, and we believe that REST will be an extension of this new community practice, focusing on the maintenance of housing for our consumers.

We hope to learn how ongoing case management and peer support impacts whole person care, housing stabilization and physical health outcomes. We intend to support consumers in their journey to stable housing, from shelter to transitional housing to supportive housing and then HUD housing.

REST has been prioritized for several reasons.

- Community members place housing and supportive services as a priority. In the stakeholder process for the MHSA 2020-2023 Three Year Plan, over 700 responses in surveys and stakeholder meetings ranked providing more housing and supportive services as one of the top priorities for MHSA support. Other top priorities were providing supportive services and a continuity of care to individuals after discharge from the psychiatric hospital (Sempervirens), the Crisis Stabilization Unit (CSU), and jail; increasing support for the seriously mentally ill by providing more case managers and other paraprofessionals; and increasing and expanding mental health services by the addition of more mental health professionals. Many of those discharged from Sempervirens, the CSU, and jail are homeless and seriously mentally ill. Stakeholders ranked serving persons experiencing homelessness as the number one population not being adequately served by current MHSA programs, and many participants in stakeholder meetings spoke about inadequate case management services and the need for more case managers and services.

- In stakeholder meetings for the MHSA 2021-2022 Annual Update, stakeholders continued to place addressing homelessness as a top priority, with this need being discussed at four meetings and in one written comment provided during the process. Comments included providing services and supports to address the difficulty of keeping clients housed due to mental health issues.
- During the 30 day public comment period and in the public hearing for the 2021-2022 Annual Update, participants continued to emphasize the need to provide additional services and supports for those experiencing homelessness or at risk of homelessness. Commenters suggested increased funding for rent deposits, rental assistance and other expenses related to obtaining housing; more support teams to help keep people housed, and additional support for finance, budgeting and other assistance to help foster independence once housed. REST will address these needs.
- HOME program outcomes for housing status for people who have obtained housing, at two years post obtaining housing, show that 14% have returned to homelessness. While this percentage is a positive one, and shows success for HOME, REST hopes to decrease the percentage for not only those stepping down from the HOME program, but for other individuals who are recently housed and engaging in the Behavioral Health system.
- Finally, the critical nature of the housing and homelessness crisis in Humboldt County, across California, and in the nation warrants providing additional supportive services to keep people housed after housing is found for them.

REST will be a component of the Humboldt Housing and Homeless Coalition (HHHC). HHHC is a Continuum of Care comprised of several organizations, service providers, developers, government agencies and leaders, faith-based organizations and community members dedicated to ending homelessness.

The HHHC was established in 2004 and includes service providers, local government agencies, advocates and others who are interested in helping people move out of homelessness. The group does not have a staff and is not officially incorporated or organized. The county provides some administrative support, but most projects are accomplished by volunteers.

Members of the HHHC work together on specific issues (policy, input into the general plan, working with law enforcement, etc.). The HHHC is sometimes asked to provide input on issues to the local jurisdictions. Any public statements must be agreed upon by the whole membership.

The HHHC shares ideas, coordinates services, increases communication and helps identify service gaps within our communities. HHHC administers the Point-in-Time Count, the Homeless Management Information System, and provides several training opportunities throughout the year.

Partner agencies are Arcata House Partnership; Eureka Veterans Clinic; Food for People; Housing Authority of the City of Eureka and County of Humboldt; Housing Humboldt; Humboldt County Department of Health and Human Services; Humboldt County Office of Education, Foster & Homeless Youth Services; North Coast AIDS Project; North Coast Veterans Resource Center; Open Door Community Health Centers Mobile Health Services; Redwood Community Action Agency; Youth Service Bureau; and Rural Community Housing Development Corporation.
Humboldt County has long prioritized resolution for the homeless and under sheltered individuals in our County. REST will increase access to mental health services to underserved groups and will apply a promising community driven practice that has been successful in non-mental health contexts. Much research has shown the effectiveness of Housing First at getting people into housing, and part of its effectiveness has been the case management services that are provided once people are housed. We believe that supportive services through case management and peer support is the next step for ensuring that the efforts of finding housing for individuals will result in those individuals staying housed, and that these supportive services will enhance the individuals' recovery and their re-integration into the community. We want to test this hypothesis through the REST project.

PROPOSED PROJECT

A) Brief narrative overview description of the proposed project.

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

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

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

The ongoing case management services in the "Post-Housing" Housing First model as implemented in our community through REST will allow us to better understand the

needs of our consumers once housing has been secured. We hope to have a seamless transition of Case Management services for our consumers once they are housed to allow them to fully engage in needed Outpatient Behavioral Health Services at a pace that is consumer driven and client centered. This will be measured in the length of time between housing and Behavioral Health treatment initiation by the consumer, as well as statistics related to housing of consumers at points in time such as after 6 months, one year, 18 months and two years.
With this better understanding comes more preventive measures we can take for consumers when we identify them in our community. With this in mind, another goal is to continue to refine the services we offer to consumers once housed to ensure these services follow the principles of the Housing First model and fidelity to the Housing First practice. During this time of "Post-Housing" service, emphasis is placed on a Harm Reduction and Recovery Oriented approaches, Individualized and Person Driven supports, and Social and Community Re-integration. This will be measured by consumer perception surveys of treatment they receive and monitoring of treatment service adherence.

B) Identify which of the three project general requirements specified the project will implement.

This project will apply a promising community driven practice or approach that has been successful in a non-mental health context or non-mental health setting. Research has shown that Housing First has been successful in a non-mental health context. The principle of ensuring individuals are housed is the initial and most important priority in Housing First. The practice indicates that consumers treatment adherence is limited when they are focused on the acquisition of basic needs. Housing First indicates that a person cannot reasonably be expected to attend weekly appointments when they are unhoused. Our HOME program has worked diligently in our community to follow the Housing First guidelines to fidelity. This Innovation plan will be enhancement of the work they have done following Housing First.

C) Why the selected approach is appropriate.

This Innovation project will be drawing from the Housing First approach that is outside the mental health field. Much research has shown the effectiveness of Housing First in getting people into housing. Part of the effectiveness of Housing First has been the case management services that are provided once people are housed.

D) Estimate the number of individuals expected to be served annually and how you arrived at this number.

It is estimated that REST will serve a minimum of 100 individuals annually. The number was determined from an analysis of all data gathered for the description of the primary

problem, the number of current clients open to mental health services minus those who are FSPs, and an estimate of those who may services but are not yet open to them.

RESEARCH ON INN COMPONENT

REST will be testing the Housing First model in a rural, not urban, setting. It will not be offering county-owned housing, as there is none in Humboldt County, but will instead help connect consumers to existing rental housing and then provide the supports they need to remain housed. Case Management services and Peer support will be comprehensive to include those services that are part of a Behavioral Health Treatment Plan and those that may fall outside of this to ensure that ongoing medical necessity is not a barrier to getting critical services that maintain housing.

The MHSOAC website has descriptive information about approved Innovation projects in FY 17/18 and 18/19, and a Program Search tool. These search tools were used with the keywords housing; Housing First; case management; peers; and life skills. As a result of this search, brief descriptions of thirteen projects from other counties were reviewed. Of those, the three described below are existing programs with elements of what we are proposing.

The San Joaquin County *Progressive Housing* project is an adaptation of the Housing First model for individuals who are homeless and have serious mental illness. The project offers a system of housing with four levels of service at each of the houses and examines an individual's development through the recovery process. REST will not offer a system of housing as in the San Joaquin project but similarly will work with individuals to secure housing and provide supports that will assist them in their recovery. There may be learning from the San Joaquin project that will inform REST.

The *Intensive Case Management/Full-Service Partnership to Outpatient Transition Support* Innovation Project of San Francisco MHSA seeks to implement a peer linkage team to provide support for consumers transitioning from intensive case management or full-service partnerships to outpatient services. In REST, Case Managers and Peer support staff will provide support to the identified populations—those being discharged from SV and CSU, those stepping down from FSP or HOME services, and those already in Adult Outpatient Services--to link them with housing, outpatient services, and other supports to help them maintain housing once secured. REST is focused on a Post-Housing First model, while the San Francisco project does not reference this practice.

Merced County's *Housing Supportive Services Program* serves individual adults who are experiencing homelessness, at-risk of being homeless, couch surfing, or those who have already been placed in a housing program. The Program's team works with the consumer to link them to services, provide life skills and educational training, advocate

for the consumer, and support their growth towards meeting housing goals. There may be learning from this project that will inform REST.

The Google search engine was used to locate web-based literature and program information. Search terms included case management, Housing First, homeless, homelessness, housing, trauma, and trauma-informed. A total of 24 articles were reviewed during this search. Several of these articles were available on Medline (PubMed) and were peer-reviewed in major journals. The research indicates that there have been numerous random controlled trials demonstrating the effectiveness and cost-effectiveness of Pathways to Housing First. In one study, the At Home-Chez-soi (AH-CS) study, Housing First was found to be successful, most especially regarding the primary outcome of enabling people with a mental illness who are homeless to find and maintain stable housing for an extended period of time Can J Psychiatry. 2015 Nov; 60(11): 465–466). Another article referenced the research on AH-CS and concluded that Housing First can be successfully adapted to different contexts and for different populations without losing its fidelity, and that people receiving Housing First achieved superior housing outcomes and showed more rapid improvements in community functioning and quality of life than those receiving treatment as usual. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4679127/ The AH-CS study was conducted in five Canadian cities, and other referenced studies were conducted in urban areas, so the REST project will provide information on the practice in a rural area.

Research on Mental Health America's The Village in southern California showed an excellent recovery model system. While Humboldt County does not have the resources to support a Village-type facility and program, we will strive to keep the recovery principles in the forefront of the REST project.

LEARNING GOALS/PROJECT AIMS

Six learning questions have been developed for REST.

1. How effective is ongoing case management and peer support for those discharged from SV or CSU, or exiting from a Full Service Partnership (FSP) or HOME services, to maintain housing?

We hypothesize that well-trained Case Managers and Peers will increase engagement of consumers in appointment-based outpatient care. The length of time between referral to first kept appointment and overall appointment compliance rate will be the data we collect to answer this question using the Electronic Health Record (Avatar), reports from the DHCS Data Collection and Reporting (DCR) System, reports from the HOME database, and reports from Activate Care. Activate Care is a nationally recognized provider of community care coordination and referral management technology with which Behavioral Health participates.

2. Will increased case management and peer support services facilitate recovery as indicated by a reduction in the number of emergency service episodes?

We hypothesize that consistent and consumer driven interventions by our REST team will promote successful outcomes leading to appropriate and sustained transitions to lower levels of care and reduced need for emergency psychiatric care. Reports from Avatar and MORS reports will help to answer this question.

3. Will educating landlords about recovery increase the number of landlords who accept our consumers as tenants?
We hypothesize that our education efforts with local landlords will lead to increased capacity for housing as well as forbearance for consumers as they actively engage in treatment services. These efforts will lead to clients remaining housed throughout duration of REST. Data will be gathered from Avatar, the HOME database, and baseline data with housing units available and currently occupied. A survey with local landlords will also be conducted annually.

4. Will REST help us learn what services and supports are most utilized by newly housed individuals?
We hypothesize that by using consumer driven treatment approaches that are individualized for the consumer that clients will maintain treatment compliance. Data will be gathered from consumers through the Consumer Perception Survey required by the State and through a targeted consumer survey for REST participants. The overall appointment compliance rate will come from Avatar. A client survey and/or focus group will also be conducted to get their perceptions.

5. Will REST services contribute to improved physical health outcomes for consumers served? We hypothesize that our efforts to ensure long term housing stability will contribute to the overall physical health of our clients. We will have some baseline measures for this and utilize data on physical health appointments and contacts as well as emergency room and Urgent Care appointments. This data will be obtained from the North Coast Health Improvement and Information Network (NCHIIN) Health Information Exchange (HIE).

6. How long do consumers remain housed?
We hypothesize that given the interventions that the REST program proposes we will see a much higher rate of consumers remaining housed. Length of time in housing will be the data we collect for this. We will also do comparative analysis with data we have already collected from the HOME program.

The ongoing case management services in the “Post-Housing” Housing First model as implemented in our community through REST will allow us to better understand the needs of our consumers once housing has been secured. We want to have a seamless transition for our consumers once they are housed to allow them to fully engage in Outpatient Behavioral Health Services at some point in time. This will be measured in the length of time between housing and Behavioral Health treatment initiation by the

consumer, as well as statistics related to housing of consumers at points in time such as after 6 months, one year, 18 months and two years.

With this better understanding comes more preventive measures we can take for consumers when we identify them in our community. With this in mind, another goal is to continue to refine the services we offer to consumers once housed to ensure these services follow the principles of the Housing First model and fidelity to the Housing First practice. During this time of "Post-Housing" service, emphasis is placed on a Harm Reduction and Recovery Oriented approaches, Individualized and Person Driven supports, and Social and Community Re-integration. This will be measured by consumer perception surveys of treatment they receive and monitoring of treatment service adherence.

EVALUATION OR LEARNING PLAN

Goal 1: To have a seamless transition for consumers once they are housed to allow them to fully engage in Outpatient Behavioral Health Services at some point in time. This will be measured in the length of time between housing and behavioral health treatment initiation by the consumer, as well as statistics related to housing of consumers at points in time such as after one year, 18 months and two years.

Goal 2: To continue to refine the services we offer to consumers once housed to ensure these services follow the principles of the Housing First model and fidelity to the Housing First practice. During this time of "Post-Housing" service, emphasis is placed on a Harm Reduction and Recovery Oriented approaches, Individualized and Person Driven supports, and Social and Community Re-integration. This will be measured by consumer perception surveys of treatment they receive and monitoring of treatment service adherence.

Goal 3: Improve housing stability for community residents as a component of the Humboldt Housing and Homeless Coalition (HHHC) Continuum of Care.

Learning Question	**Sources of Data**	**Data Collection Strategy**
1. How effective is ongoing case management and peer support for those discharged from SV or CSU, or exiting from a Full Service Partnership (FSP) or HOME services, to maintain housing?	Avatar EHR DCR HOME housing database Activate Care	Avatar reports DCR reports HOME dashboards Activate Care
2. Will increased case management and peer support services facilitate recovery as indicated by a	Avatar EHR MORS	Avatar Reports MORS Reports

reduction in the number of emergency service episodes?		
3. Will educating landlords about recovery increase the number of landlords who accept our consumers as tenants?	Avatar EHR Baseline data with housing units available and currently occupied HOME database	Clients remaining housed Survey with landlords HOME dashboard
4. Will REST help us learn what services and supports are most utilized by newly housed individuals?	Consumers Avatar EHR Consumer survey and/or focus group	Consumer perception surveys Targeted Consumer survey for REST services Show Rate and Appointment Compliance rate Consumer survey/focus group
5. Will REST services contribute to improved physical health outcomes for consumers served?	NCHIIN HIE data	Physical health appointments and contacts Emergency room visits Urgent care appointments.
6. How long do consumers remain housed?	HOME database	Length of time in housing

CONTRACTING

Humboldt County DHHS-Behavioral Health is in the process of analyzing impacts to its budget over the next several years and is looking at all ways to minimize spending. One possibility that has been discussed is to contract out this project to a qualified agency. No decision has been made and until then it is the intention of Behavioral Health to implement REST.

COMMUNITY PROGRAM PLANNING

In the stakeholder process for the MHSA 2020-2023 Three Year Plan, over 700 responses in surveys and stakeholder meetings ranked providing more housing and supportive services as one of the top priorities for MHSA support. Other top priorities were providing supportive services and a continuity of care to individuals after discharge from the psychiatric hospital (Sempervirens), the Crisis Stabilization Unit (CSU), and jail; increasing support for the seriously mentally ill by providing more case managers and other paraprofessionals; and increasing and expanding mental health services by the addition of more mental health professionals. Many of those discharged from Sempervirens, the CSU, and jail are homeless and seriously mentally ill. Stakeholders ranked serving persons experiencing homelessness as the number one population not being adequately served by current MHSA programs, and many participants in

stakeholder meetings spoke about inadequate case management services and the need for more case managers and services.

In stakeholder meetings for the MHSA 2021-2022 Annual Update, stakeholders continued to place addressing homelessness as a top priority, with this need being discussed at four meetings and in one written comment provided during the process. Comments included providing services and supports to address the difficulty of keeping clients housed due to mental health issues.
It is because of this community input that REST has been developed. It will address the top priorities expressed by stakeholders.

MHSA GENERAL STANDARDS

A) Community Collaboration will be an integral part of REST. We will be working with landlords; the developers of low barrier housing projects; the owners and managers of current housing projects; North Coast Health Improvement and Information Network (NCHIIN); Humboldt Independent Practice Association (IPA); justice and diversion programs; law enforcement though the activities of the Mobile Intervention Services Team; the Regional Services “ride-alongs” with law enforcement; National Alliance for the Mentally Ill (NAMI); and the Family Advisory Board, to name just a few of the agencies, organizations, businesses and community groups with which we will collaborate.
B) Cultural Competency. Humboldt County Behavioral Health is committed to the provision of culturally responsive/competent services that are effective, equitable, understandable, respectful and responsive to diverse cultural beliefs and practices, including beliefs about health and behavioral health. Behavioral Health services are delivered in a consumer’s preferred language and with consideration of the individual’s or family’s culture. The Cultural Competence Plan, updated annually, sets forth this commitment and provides detailed information on the programs and activities of the agency. There are policies and procedures focusing on cultural responsiveness/competence; disparities in service delivery are identified annually; the Cultural Responsiveness Committee undertakes projects to further cultural responsiveness; and Behavioral Health participates in the DHHS Racial Equity Steering Committee. In addition, all Behavioral Health staff are required to complete one cultural responsiveness training annually. As a program of Behavioral Health, REST will be covered by this commitment.
C) Consumer-Driven. The stakeholder process for the Three Year Plan for 2020-2023 clearly identified the need for a program and services such as those to be provided by REST. REST will be driven by Housing First principles, where engagement in services is not a prerequisite to housing. In REST, as with all other Behavioral Health services, the concurrent documentation strategy is used, with provider staff working with consumers during assessment, service planning and intervention sessions to complete as much related documentation as possible, including working collaboratively on the treatment plan. Because REST includes two Peer Coaches

their voice will also be a factor in the services provided. In addition, REST has built consumer surveys into the project to ensure consumer voice.

D) Family-Driven. The target population for REST is adults over the age of 18, so this General Standard does not apply.
E) Wellness, Recovery, and Resilience-Focused. Wellness, recovery and resilience are built into the client services provided by Behavioral Health. Consumers are encouraged and supported to live, work and participate fully in their communities. REST will promote concepts key to recovery for mental illness, such as hope, personal empowerment, respect, social connections and self-determination.
F) Integrated Service Experience for Consumers and Families. Services provided through REST will be from Behavioral Health programs—Sempervirens, Crisis Stabilization Unit, HOME and FSP. Consumers will not have to navigate through multiple agencies to get their needs met. In addition, it will be the role of the Case Managers and Peer Coaches to assist consumers in coordinating services to provide an integrated service experience.

CULTURAL COMPETENCE AND STAKEHOLDER INVOLVEMENT IN EVALUATION

The evaluation will be conducted with sensitivity and awareness of consumer diversity related to culture, language and other diverse identities. Key stakeholders will be involved in evaluation though their participation in program meetings, data provision, development of surveys, and consumers will provide input through the consumer perception survey and through the targeted survey developed specifically for REST.

INNOVATION PROJECT SUSTAINABILITY AND CONTINUITY OF CARE

The County will evaluate the REST plan at several intervals to ensure it is providing the services outlined. Knowing that keeping individuals housed is a community priority and one that promotes positive treatment outcomes for Behavioral Health Consumers, we expect that this project would continue past the Innovation timeframe to continue to be supported by other funding. We will constantly evaluate if there are any elements that are not effective or are redundant with other services and eliminate those if necessary.

Individuals with serious mental illness will receive services from this project. When the project has ended they will continue to receive services through Medi-Cal billing and Realignment funding.

COMMUNICATION AND DISSEMINATION PLAN

The final report for the Innovation project will be posted to the County website on the MHSA webpage. The general community will be informed via a press release issued by the DHHS Communications Group. The press release will summarize the findings of the project and provide the web address of the full report. Stakeholders who have been more closely involved with the implementation of the project will be informed via email of the findings and the location of the final report. These stakeholders will be asked to share the findings and final report with others.

TIMELINE

Subject to review of MHSOAC the hoped for start date is July 1, 2021 and end date June 30, 2026. The REST project will be five years.

Timeframe	Activities
July 2021	Recruitment, hiring and Training of REST staff and/or contracting with outside agency
October 2021	Identification and recruitment of participants; Annual Innovation Report due (June 30)
January 2022	Develop surveys; identify baseline data
April 2022	Conduct surveys and enter data
July 2022	Data Pull and analysis
October 2022	Annual Innovation Report due (June 30)
January 2023	Share Report with stakeholders
April 2023	Conduct surveys and enter data
July 2023	Data pull and analysis
October 2023	Annual Innovation Report due (June 30)
January 2024	Share Report with stakeholders
April 2024	Conduct surveys and enter data
July 2024	Data Pull and analysis
October2024	Annual Innovation Report due (June 30)
January 2025	Share Report with stakeholders
April 2025	Conduct surveys and enter data
July 2025	Data Pull and analysis
October 2025	Annual Innovation Report due June 30)
January 2026	Share Report with stakeholders
April 2026	Conduct surveys and enter data
June 30, 2026	Project end date; Data Pull and analysis
December 2026	Final Report due

BUDGET NARRATIVE

This project is anticipated to begin in July 2021 and end in June 2026 for a total of five years.

Salaries and Benefits. The total for Salary expenses for the five years are $1,185,478 and $977,215 for benefits. This includes:

- $1,148,567 for direct services project staff salaries and $949,117 for benefits over the five years. Personnel include:
  - 1.0 FTE Program Coordinator
  - 2.0 FTE Mental Health Case Managers
  - 2.0 FTE Peer Coaches I/II

- $23,710 for administration staff salaries and $16,883 for benefits over the five years. Administration includes:
    - .02 FTE Program Manager
    - .05 FTE Administrative Analyst I/II

- $13,201 for evaluation salaries and $11,215 for benefits over the five years. Evaluation personnel is .05 FTE Administrative Analyst I/II.

Operating Costs. $66,150 for operating costs over the five years. In the first year this includes the expenses of laptops and cell phones for direct services project staff. In every year operating costs include Activate Care licenses, cell phone charges, and rental assistance for clients in the REST program.

Indirect Costs. $222,884 (10%)

Medi-Cal Federal Financial Participation: $834,132 estimated.

The total amount of MHSA Innovation funds being requested for this project is $1,617,598 over the five year period. With the estimate of FFP included the total is $2,451,730.

REST Appendix

https://www.healio.com/psychiatry/journals/psycann/2015-3-45-3/%7Becb767d3-41bc-4772-a2b2-27a1f9a1e629%7D/case-management-a-new-approach Talisman N, Kaltman S, Davis K, Sidel S, Akil M, Alter C. Case Management: A New Approach. *Psychiatr Ann.* 2015; 45: 134-138. doi: 10.3928/00485713-20150304-08.

https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.51.11.1410 Ziguras SJ, Stuart GW. A meta-analysis of the effectiveness of mental health case management over 20 years. Psychiatr Serv. 2000;51(11): 1410-1421. Doi 10.1176/appi.ps 51.11.1410.

https://www.ncbi.nlm.nih.gov/pubmed/17631513 Burns T, Catty J, Dash M, Roberts C, Lockwood A, Marshall M. Use of intensive case management to reduce time in hospital in people with severe mental illness: systematic review and meta-regression. *BMJ*. 2007;335(7615):336. doi:10.1136/bmj.39251.599259.55.

https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD000381.pub3/pdf/CDSR/CD000381/CD000381.pdf Life skills programmes for chronic mental illnesses Tungpunkom P, Maayan N, Soares-Weiser K. Life skills programmes for chronic mental illnesses. *Cochrane Database Syst Rev*. 2012;1:CD000381. Published 2012 Jan 18. doi:10.1002/14651858.CD000381.pub3.

https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD000381.pub3/pdf/CDSR/CD000381/CD000381.pdf Housing First Intensive Case Management Toolkit

https://www.youtube.com/watch?edufilter=NULL&t=1909s&v=tGq_Lq1KEBE Rapid Re-Housing: Case Management and Services, National Alliance to End Homelessness, funded by CDSS and California Housing and Community Development.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4679126/https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4679126/ Putting Housing First: The Evidence and Impact. Paula N Goering, RN, PHD and David L. Streiner, PhD. Can J Psychiatry. 2015 Nov; 60(11): 465–466.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3221290/ The At Home/Chez Soi trial protocol: a pragmatic, multi-site, randomized controlled trial of a Housing First intervention for homeless individuals with mental illness in five Canadian Cities. Paula N Goering, David L Streiner, Carol Adair, Tim Aubry, Jayne Barker, Jino Distasio, Stephan W Hwang, Janina Komaroff, Eric Latimer, Julian Somers, and Denise M Zabkiewicz.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4679127/ Housing First for People With Severe Mental Illness Who are Homeless: A Review of the Research and Findings From the At Home-Chez soi Demonstration Project. Tim Aubry, PHD, Geoffrey Nelson, PHD, and Sam Tsemberis, PhD.

https://www.youtube.com/watch?edufilter=NULL&v=5nys6iebjHw The Housing First approach to homelessness, Lloyd Pendleton.

https://www.youtube.com/watch?edufilter=NULL&v=HsFHV-McdPoHousing First TED talk by Sam Tsemberis, founder of Pathways to Housing, New York City.

https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/case-management

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2852027/ Patterns of Recovery from Severe Mental Illness: A Pilot Study of Outcomes. Leonard Miller, Timothy T. Brown, David Pilon, Richard M Scheffler, and Monica Davis. Community Mental Health J. 2010 Apr; 46(2): 177–187.

www.Mhala.org Mental Health America of Los Angeles

https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00047 A New Approach to Mental Health Care, Imported from Abroad. Rob Waters. Health Affairs, Vol. 39, NO. 3, March 2020.

http://www.traumacenter.org/products/pdf_files/shelter_from_storm.pdf Shelter from the Storm: Trauma-Informed Care in Homelessness Services Settings. Elizabeth K. Hopper, Ellen L. Bassuk, and Jeffrey Olivet. The Open Health Services and Policy Journal, 2009, 2,131-151.

https://muse.jhu.edu/article/190543 Homeless, Mentally Ill and Addicted: The Need for Abuse and Trauma Services. Richard C. Christensen, Candace C. Hodgkins, Lorrie Garces, Kathleen L. Estllund, M. Davis Miller, Reginald Touchton. Journal of Health Care for the Poor and Underserved, Volume 16, Number 4, November 2005, pp. 615-622.
https://www.feantsa.org/download/feantsa_traumaandhomelessness03073471219052946810738.pdf Recognising the Link Between Trauma and Homelessness, European Federation of National Organisations Working with the Homeless (FEANTSA), January 27, 2017.

https://www.ncbi.nlm.nih.gov/pubmed/28067944Intensive case management for severe mental illness. Dieterich M, Irving CB, Bergman H, Khokhar MA, Park B, Marshall M.

https://www.ncbi.nlm.nih.gov/pubmed/21983904 Case management for moderate-need patients and recovery: what can we learn from experimental and quasi-experimental studies? Latimer E., Rabouin D.

https://www.ncbi.nlm.nih.gov/pubmed/27687900 Effectiveness of case management interventions for frequent users of healthcare services: a scoping review. Hudon C, Chouinard MC, Lambert M, Dufour I, Krieg C. 2016Sept. 29

https://www.ncbi.nlm.nih.gov/pubmed/11324744 / Case management and quality of life: assessing treatment and outcomes for clients with chronic and persistent mental illness. Jinnett K, Alexander JA, Ullman E. April 2001.

https://www.ncbi.nlm.nih.gov/pubmed/32271769 The effectiveness of case management interventions for the homeless, vulnerably housed and persons with lived experience: A systemic review. Ponka D, Agbata E, Kendall C, Stergiopoulos V, Mendonca O, Magwood O, Saad A, Larson B, Sun AH, Arya N, Hannigan T, Thavorn K, Andermann A, Tugwell P, Pottie K

https://pubmed.ncbi.nlm.nih.gov/28414579/?from_term=Housing+First&from_pos=2 Cherner RA, Aubry T, Sylvestre J, Boyd R, Pettey D. Housing First for Adults with Problematic Substance Use. *J Dual Diagn*. 2017;13(3):219-229. doi:10.1080/15504263.2017.1319586.

Prevention & Early Intervention (PEI) Component

Nineteen percent (20%) of MHSA funds received by counties must be allocated for PEI services, designed to prevent mental illnesses from becoming severe and disabling. PEI services focus on preventing the onset of mental health issues and/or providing early intervention treatment and referral services. MHSA regulations require PEI plans to include at least one program focused on delivering services for the following service categories: 1) Prevention, 2) Early intervention, 3) Stigma and discrimination reduction, 4) Recognizing early signs of mental illness, and 5) Promoting greater access and linkage to treatment. Suicide prevention programs also fit within the PEI component. At least fifty-one percent (51%) of PEI funds must be allocated for serving individuals who are 25 years old or younger. Programs that serve parents, caregivers or family members with the goal of addressing children and youth at risk of or with early onset of a mental illness can be counted as serving children and youth. The following pages describe the PEI programs and services that reflect the themes and priority areas identified in the CPPP. The continuing implementation of these programs is contingent upon continuing availability of MHSA funding.

Prevention and Early Intervention: Hope Center

The Hope Center serves unserved and underserved populations of transition age youth, adults and older adults who have behavioral health challenges 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 the Substance Abuse Mental Health Services Administration (SAMHSA), and the resources necessary for people with and without a behavioral health diagnosis and their families to be empowered in their choices to be self-sufficient. The Hope Center provides prevention and early intervention activities that reduce stigma and discrimination and provide access and linkage to treatment. These activities contribute to the reduction of the negative outcomes that may result from untreated behavioral illness.

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

The Hope Center has a full time Peer Coach III who oversees the Center, three full time Peer Coach staff, and three part time Peer Coach staff. There are two Work Experience workers at the Center as well. Consultation is provided by a Senior Program Manager. All 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 Behavioral 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. During the next fiscal year, peers will participate in the RI International Health Living Through Self-Management Facilitator Training, which teaches students how to facilitate the Healthy Living 7 week curriculum for program participants.

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 “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 behavioral 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. 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
- Classes, workshops, and education that focus on individuality, mindfulness, nutrition, resilience, fun, building skills, wellness, building community, facing challenges, and building confidence
- Counseling services are available when needed

Since the program began in Fiscal Year 2007-08, there was an increase over time in the number of unduplicated participants, from 460 at the beginning to 1,032 in FY 2018-19. The duplicated number of sign-ins to the program increased from 6,924 to 13,148. Unfortunately, due to the COVID-19 pandemic, the numbers of participants and sign-ins decreased significantly in Fiscal Year 2019-2020. A report for FY 2019-2020 is included in the Appendix.

Plans for the next year, contingent upon available MHSA funding, include hosting the CAMHPRO conference in March 2021, Zoom classes, monthly wellness center meetings and peer calls.

Hope Center activities contribute to the reduction of negative outcomes that can result from untreated mental illness. Besides basic process evaluation that includes numbers reached and events held, the program will measure increases in participants' knowledge, awareness, attitudes and beliefs towards recovery and wellness and any increase in social connections they may experience. This will be measured through training/class evaluations and surveys offered on a periodic basis. In addition, program staff will use a newly developed form with participants, when indicated, to identify if a participant has had past symptoms of mental illness, whether or not they were treated for these symptoms, and to what service/program a participant may have been referred.

Hope Center Stigma and Discrimination Reduction.
The Hope Center is one of the central programs that Humboldt County Behavioral Health has for furthering the efforts of stigma and discrimination reduction with adults. As discussed earlier in this section, the Hope Center is peer led, and peer support is an evidence based practice. Over the years of operation the Hope Center has

provided a location for individuals in the community that offers a variety of services and programs without the need of becoming a formal mental health client. These services and programs have been branded as “classes” as they are intended to assist individuals in the community with education on a variety of topics, with the goal of allowing all participants to gain a level of self-sufficiency and self-reliance. The program is intended to influence those living with a mental illness, those who have not been diagnosed with a mental illness but who are experiencing some symptoms that are of concern, and community members who may want to participate in classes or events that are of interest to them.

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

Besides basic process evaluation that includes numbers reached and events held, the program will measure increases in participants’ knowledge, awareness, attitudes and beliefs towards recovery and wellness and any increase in social connections they may experience. This will be measured through training/class evaluations and surveys offered on a periodic basis. Fidelity to the evidence-based peer support practice is ensured through the certification process of Recovery Innovations (RI) International. All Peer Coaches are trained as Certified Peer Support Specialists through RI International. The Peer Coach III has additional training through the California Association of Behavioral 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 also gone through a Peer Supervisor Training through RI International.

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, 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, Substance Use Disorder services, and collaborates with community partners such as Juvenile Probation and Family Resource Centers.

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

- A behavioral health team providing specialty behavioral 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 Advocacy Board (YAB)
- 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 intensive case coordination 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, addresses components of: early intervention, 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.

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

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

1. **Trainings** 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 behavioral health stigma reduction, outreach and information regarding behavioral health services, and wellness resilience development. These events occur in multiple formats, all of which are youth-driven, including HCTAYC's annual Wellness Week, National Children's Mental Health Awareness Day activities, critical thinking movie nights, participation in the Youth Opioid Response campaign, and a cross-country leadership exchange with youth from New York City.
2. **Advocacy** is operationalized through two means, systems change and individual advocacy. Systems advocacy is enacted through youth organizers supporting the YAB to attend and participate in policy setting, decision making tables, and correspondence. This includes participation at local 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 case planning meetings, and attending said meetings to support the youth's desired outcome.
3. **Youth Leadership Development** is perhaps the most transformative element of the HCTAYC program, consciously targeting the three base psychological needs identified in self-determination theory: autonomy, competence, and relatedness. These three components aid to prevent the emergence of behavioral health conditions or reduce prolonged suffering and progression. This development is the transference of skills to, and the continual support and supervision of, YAB members. By creating a system of tiered levels of leadership, board members are given the opportunity to experience, develop, and practice leadership skills in a gradual progression of intensity, while emphasizing increased peer engagement and relationship building. 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 YAB, 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. As board members plan their transition from active membership they put together an accumulative leadership portfolio demonstrating their strengths and successes as youth leaders. 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:

- Gather comprehensive outcomes data to report on leadership development as well as outcomes related to the specific PEI domains for Youth Leadership. Development.
- YAB committees will facilitate at least one completely youth-driven project per year.
- Facilitate at least three youth-leadership development trainings for HCTAYC members and the general transition-age youth community per year.
- Create and implement policy recommendations for Substance Use Disorder treatment and LGBTQ+ Cross-Systems.
- Participate in various advocacy and policy setting tables at the local, state, and national level.
- Create a partnership with the Public Health Youth Opioid Response campaign.

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 is 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 2021-2022:

The program estimates to maintain or exceed 10-15 consistent Youth Advocacy Board members. During this new reporting period thus far, the Youth Advocacy Board structure has shifted to a single campaign model, moving away from the committee-driven structure of the previous reporting period. This campaign is still in the process of being planned currently, and as a result it is difficult to estimate the outcomes of that campaign. Additionally, the program plans to move towards closing out the focus on the AOD policy recommendations. The completion and formalization of the LGBTQ+ Cross-Systems Policy Recommendations is also one of the primary objectives of this reporting period. 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. An attempt to execute a digital storytelling training is planned for this reporting period as well, which is a new approach to legacy programming for HCTAYC. Due to the ongoing developments of the COVID-19 pandemic, much of our planned programming is still in question and subject to shift.

In terms of outreach for recognizing the early signs of mental illness, 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. HCTAYC hopes to implement a pre/post survey for events, workshops and trainings to address stigma and discrimination reduction and measure learning and change in attitudes around mental illness.

TAY Peer Support

The integration of Peer Coaches within the TAY Division is a prevention program with components of early intervention, access and linkage to treatment, stigma and discrimination reduction, and outreach for increasing recognition of early signs of mental illness. The TAY Peer 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 in navigating the systems, help 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 with 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.

Key Activities:

- Outreach and presentations to local agencies and organizations

- Facilitation of group activities
- Tabling at events
- Attending training to increase skills
- Workshop, group and event facilitation
- Mentorship

Expected Outcomes:
The expected outcomes for 2021-2022 are:

- Ensure cross-training of Peer Coaches in each area of the TAY Division (ILS, BH, HCTAYC, DROP-IN).
- Peer Coaches will be doing Medi-Cal billing through direct service to TAY youth open to Behavioral Health and possible other outcome measurement tools.
- Continue and expand outreach and information to needed populations.
- Continue to support youth and engage in activities at TAY and relationship building while youth are waiting to receive or to be connected to other needed services.

How Outcomes are Measured:

- Access to the TAY drop-in space and selected events and workshops are measured by sign-in sheets.
- Tracking sheets of referral assignments, including date referral is received, assigned and when first contact is made.
- Tracking of contacts and linkages with other programs, such as Behavioral Health, Employment and ILS.

Estimated Number to be reached in FY 2021/2022:
It is estimated that approximately 125 TAY (New, unique participants) will be served in Fiscal Year 21/22 based on the previous year's sign-in sheets for the TAY Center and activities, events and workshops. COVID-19 may reduce the TAY Center drop-in hours and impact this estimated number of young people served.

TAY Advocacy and Peer Support Disaster Preparedness and Response
Both HCTAYC and Peer Support staff have adapted and modified ways of delivering services and prevention components with the current worldwide health pandemic. Early intervention, outreach, stigma and discrimination reduction, and youth engagement are being delivered virtually utilizing multiple web and other platforms. Participation in the YAB, community policy tables, groups, workshops and community wellness building opportunities continue to meet, now in a virtual setting. Not knowing what gathering in larger groups may look like in the future, HCTAYC and Peer Support will continue to be creative and find ways to uplift youth voice and address the needs of transition age youth, such as overcoming a sense of hopelessness, lack of self-efficacy, independent living skills deficit, and economic struggles that will continue to impact the social determinants of health during this crisis.

TAY Advocacy and Peer Support Stigma and Discrimination Reduction. The TAY Advocacy and Peer Support program's stigma and discrimination reduction activities are intended to influence the TAY involved in the program and the professional and community members who participate in trainings and events facilitated by the program. Activities include trainings for professionals and community members focused on TAY-specific mental health challenges and the engagement of this population, including special populations particularly impacted by stigma and discrimination such as LGBTQ youth, Indigenous Youth, foster youth, and youth experiencing substance misuse and abuse. Trainings take a cultural competence and/or cultural humility approach, with specific youth-developed curriculum that focuses on youth culture. The program's facilitation of events focuses on concepts of behavioral health stigma reduction, outreach and information regarding behavioral health services, and wellness resilience development. The program's focus on youth leadership development addresses stigma and discrimination reduction through advocacy and empowering youth to become leaders. Peer support provides outreach, engagement and linkage to services and to the community. This serves to inform youth of services available to them and supports the reduction of stigma and discrimination toward the systems-involved transition age population. Outreach is provided in multiple ways including referrals for services, the TAY Center 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.

The impact of the activities is currently measured by post-workshop evaluations and the demographic form, which asks questions about effectiveness of the activity and its contribution to wellness. For the future, a community-based stigma and discrimination assessment will be conducted through a survey format, capturing attitudes and beliefs about mental health stigma and discrimination. In addition, the program is considering a pre/post survey at events, workshops and trainings to measure learning and change in attitudes.

Prevention and Early Intervention: Suicide Prevention

Beginning in 2019, three formerly separate programs of the Humboldt County Department of Health and Human Services, Public Health Branch, Healthy Communities Division--Stigma and Discrimination Reduction, Suicide Prevention and Family Violence Prevention--combined to create the Stigma, Suicide and Violence Prevention (SSVP) Program. As of June 2020, the SSVP program will no longer include Stigma and Discrimination Reduction activities.

This merging aligned with U.S. Center for Disease Control and Prevention (Wilkins, 2014) and California Department of Public Health (CDPH)[i] recommendations about preventing suicide and violence. Both agencies published reports stating that these

public health problems share significant risk and protective factors, and require a coordinated, multi-sector approach. Throughout 2020, work has integrated projects, streamlined processes and expanded community impact to reduce morbidity, mortality and risk behaviors associated suicide and violence numbers in Humboldt County.

The five main SSVP projects supported by the Suicide Prevention program are:

Projects as Identified by PEI Regulations

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

Objectives

- Humboldt County Suicide Fatality Review: Conduct suicide fatality reviews to identify data-driven suicide prevention recommendations.
- Community Collaboration: Create a leadership-driven, safety-oriented community committed to reducing stigma, suicide and violence.
- Prevention and Early Intervention Training: Increase community capacity to recognize and respond to signs of suicide, violence and mental health problems through community trainings such Question-Persuade-Refer (QPR) and LivingWorks' Start.
- Lethal Means Safety: Develop and promote firearms safety campaign to educate community and address majority number of suicide and homicide deaths by firearm.
- Social Marketing: Increase awareness of suicide, violence and stigma, promote prevention messaging and encourage positive behavior change in those areas.

Strategies

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

- Health equity approach
- Zero suicide framework

Throughout this section, the MHSA PEI Demographic Form is used as an outcome measurement to demonstrate the reach and diversity of populations and settings served.

Project: Humboldt Suicide Fatality Review (SFR)

The Suicide Fatality Review Team (SFRT) is a multidisciplinary group of professionals who meet quarterly to learn more about the circumstances leading to suicide deaths in Humboldt. This group includes the Humboldt County Department of Health & Human Services (DHHS), Coroner's Office, health care professionals, and representatives from community agencies.

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

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

The SFR process:

- Collects uniform data and accurate statistics on suicide.
- Identifies circumstances surrounding suicide deaths that will prevent future suicides.
- Promotes collaboration and coordination among participating agencies to address mental illness early in its emergence, including the applicable negative outcomes listed in Welfare and Institutions Code Section 5840, subdivision (d) that may result from untreated mental illness.
- Implements cooperative protocols for the standard review of suicides.
- Provides a confidential forum for multiple agencies and disciplines.
- Identifies and addresses system and community factors that contribute to suicide.

Target Population

Medical providers, healthcare administrators, and county leadership.

Key Activities

- Develop SFR protocols, policies and procedures.

- Meet quarterly to review suicides and make recommendations based on findings.
- Evaluate local suicidal behavior trends, circumstances, risk and protective factors to strengthen prevention efforts.
- Educational presentations for Humboldt County medical and behavioral healthcare organizations. These presentations will familiarize stakeholders with the SFR and determine contacts for future involvement.
- Identify targeted systemic changes from data analysis of review meeting recommendations.
- Provide technical assistance to target audiences who need training working with healthcare providers, including training content development, guidance, SME, and resources.
- Present findings in conjunction with county epidemiologist that illuminates opportunity for system changes, including providing data to inform decision-making, offering trainings and alignment of shared objectives and deliverables among community partnerships.

Outcome Measurements

- Number of SFR meetings held
- Number of participants involved
- Number of suicide death cases reviewed
- Annual report completed and presented to County Board of Supervisors
- Progress on County-Wide ordinance mandated Suicide Fatality Review

Outcome Estimates in FY2021-2022

SFR will meet quarterly to review 2-3 suicide deaths. It is estimated that SFR will review approximately 6-12 suicide deaths over the next year.

Project: Prevention and Early Intervention Training

The Prevention and Early Intervention Training project incorporates both evidence-based and practice-based trainings. SSVP Program staff serve as coordinator, trainer and/or support for the offered trainings. The Suicide Prevention staff coordinates and facilitates the following trainings.

- Evidence-based
    - Question-Persuade-Refer (QPR) Basic Suicide Prevention Gatekeeper Training
    - LivingWorks Start Training (online basic suicide prevention)

Question-Persuade-Refer (QPR) Suicide Prevention Training

Implemented in September 2009, the Question, Persuade and Refer (QPR) Suicide Prevention Gatekeeper training provides innovative, practical, and proven suicide prevention training that increases knowledge to reduce suicidal behaviors. QPR educates individuals who are strategically positioned to recognize the risk and

protective factors present in those who may be at risk of a suicide crisis and how to respond by serving as “gatekeepers”. The key components of this training are *Question* - ask about suicide, *Persuade* - promote the person to seek and accept help, and *Refer* the person to appropriate resources.

Target Population
QPR trainings will be targeted to medical providers, direct service providers and first responders.

Key Activities
- Training participants to recognize the signs of persons in need of behavioral health support.
- Training participants to recognize the signs of persons who are at risk of suicide.
- Promoting wellness, recovery, and resiliency.
- Providing training to diverse groups and populations across multiple settings and professions in order to improve ability to increase access and linkage to care of those in crisis and non-crisis situations.
- Promoting local, statewide and national crisis lines, resources, and educational materials to expand on the ability of trainees increase access and linkage to supports and treatment for persons at risk.
- Improving and integrating suicide prevention resources in the community at large.
- Recognizing other important aspects of suicide prevention including life-promotion and self-care.
- Provide skill-based training so community members will have the knowledge to recognize, signs/symptoms of persons that may be at risk of suicide, respond and intervene.
- Reduce negative attitudes and beliefs about persons experiencing suicidal thoughts and behaviors along with other behavioral health challenges.

Outcome Measurements
- Number of trainings
- Number of participants
- Number of MHSA PEI Demographic Forms submitted
- Number of participants who reported increased in overall knowledge of suicide and suicide prevention (0-3 scale)

Outcome Estimates (FY 2021-2022)
Four trainings will be held, serving 20 people per training.

LivingWorks Start Training - Online Basic Suicide Prevention
In times of heightened isolation and anxiety, people’s thoughts of suicide can increase. Now more than ever, it is essential that people have effective skills to keep each other

safe, even if it is from afar. To this end, the SSVP Program will share an online alternative to basic suicide prevention training to our community.

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

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

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

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

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

Target Population

- DHHS Staff
- Employers seeking to improve workforce ability to recognize signs and symptoms of suicide and/or potentially serious mental illness
- Social Services Agencies
- Shelter & Homeless Services
- Tribal Leaders
- Educators
- Elder Care Agencies & SNF’s
- General Community Members
- Department of Veterans Affairs
- Medical & Behavioral Health Care Staff
- Law Enforcement/First Responders

Key Activities

- Learn to recognize when others are struggling and connect them to help

- Learn the TASC model of Tune In, Ask about suicide, State the seriousness, and Connect to help
- Practice TASC skills in a variety of dynamic interactive learning simulations
- Learn how to keep a loved one safe, even when helping remotely
- Develop a personalized resource list using the Connect application that can be accessed at any time and easily shared with others

Outcome Measurements

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

Outcome Estimates for FY 2021-2022

- 600 licenses issued
- 400 accounts created
- 400 trainings completed
- 400 MHSA PEI Demographic Forms submitted

Practice-based Prevention Training

In addition to the evidence-based trainings, the SSVP Program has developed a series of shorter practice-based training modules. These training modules cover topics such as for Lethal Means Safety and Domestic Violence and Mental Health 101:

- Lethal Means Safety: add-on or stand-alone training module that teaches participants about environmental safety (see additional details in Lethal Means Safety project section).

Key Activities

- Understand the issue at hand through national, state, and local data; recognize language and actions that perpetuate stigma; and develop skills to support individuals in safety, wellness, and resilience.

Project: Humboldt County Suicide Prevention Network

This continuing suicide prevention project also addresses stigma and discrimination reduction. The Humboldt County Suicide Prevention Network (SPN) is comprised of representation from community sectors, county agencies and community partners. DHHS-Public Health collaborates with service providing agencies in multiple sectors, including tribal and community health, clinical behavioral health, social services, hospice and palliative care. Primary agencies involved volunteer to present information or update the network regularly. SPN also works closely with the local chapter of the American Foundation for Suicide Prevention to help plan the Arcata Out of the Darkness Walk.

The network meets bi-monthly to build relationships and to identify strategies to reduced suicide and suicidal behaviors in our community. The SPN strives to understand and

implement the goals of the Zero Suicide framework as well as the needs and goals of the agencies involved.

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

Target Population

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

Key Activities

- Coordinate community-wide activities and events.
- Provide in-service training at each Network meeting to expand ability 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.
- Community education and outreach.
- Training and Workforce Development to increase capability to respond to persons at risk.
- Data collection and surveillance .
- Zero Suicide in Health and Behavioral Health Care Systems.
- Email list-serve.
- Leverage resources to broaden the support network for unserved, underserved, and inappropriately served populations.

Outcome Measurements

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

Outcome Estimates (FY2021-2022)

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

SSVP goes beyond providing targeted education and training to enable individuals, organizations, systems to strengthen their ability to perform effectively in addressing problems focusing on stigma, suicide and violence prevention on the community level.

Targeted outreach and education supports and strengthens community partners who most need it. These include community-based organizations, educational institutions, and behavioral healthcare and health organizations via outreach for increasing recognition of early signs of mental illness and / or suicide and providing them with the hands-on skills they need to effectively intervene and refer.

Project: Lethal Means Safety

Lethal Means Safety initially consisted of the Lock Up Your Lethals campaign, which was a brochure. It now consists of:

- Keep It Safe, a public health educational campaign for any and all audiences.
- Lethal Means Safety, a practice-based training module that can accompany any suicide prevention training or be provided independently to those with previous baseline knowledge.
- Gun Shop Project, a new and growing collaboration between Humboldt County Public Health and local gun retailers, trainers, and range owners. This project includes a Lockbox Distribution Program.
- Nationwide 45% of people who die by suicide saw their primary care provider within the last 30 days. In Humboldt County the findings are more stark: about a third {29% (55/191)} of the people who died by suicide had a known date of their last health care visit. Of those, 51% (28/55) had a healthcare visit less than 10 days before their death. (2013-2018 Retrospective Study). Based this data, the Lethal Means Safety Project, through provider outreach will encourage discussion means safety and promotion of lockbox distribution program.

Key Activities

- Keep It Safe
    - Keep It Safe is a revision of the previous Lock Up Your Lethals campaign. The new Keep It Safe is a brochure was developed with the goal of reaching expanded audiences on the topic of safe storage of potentially dangerous items. The target audience are all housed community members. Keep it Safe is about starting a conversation with Humboldt County residents about protecting their loved ones from preventable injury.
    - Similar to the Lock Up Your Lethal campaign, Keep It Safe addresses common items found in homes that could be dangerous such as: medications, alcohol, firearms, cannabis products and anything else that can be used to get high or harm oneself. The Keep It Safe campaign brochure will be distributed in local community service agencies including medical and behavioral health care settings.
- Lethal Means Safety – Training Module
    - Lethal Means Safety – Training Module, is an add-on or stand-alone training module that teaches participants about environmental safety. The

target population is anyone who takes a suicide prevention training and/or those who provide direct services. Over FY2020-2023, the populations to be targeted with Lethal Means Safety as an add-on or stand-alone presentation will include medical and behavioral health care providers, social workers, tribal leaders, law enforcement and first responders, firearms retailers, trainers and range owners, and pharmacists.
    - This practice-based presentation will involve:
        - data around lethal means, overdose, and suicide
        - safety planning
        - harm reduction strategies for increasing safety and reducing risk
        - resources to learn more or seek help
        - instructions on how to utilize the Public Health Lockbox Program for self or clients served
- Gun Shop Project
    - The Gun Shop Project is a new and growing collaboration between Humboldt County Public Health and local gun retailers, trainers, and range owners. During FY2020—2023 this project will involve local firearms retailers sharing lethal means safety information with customers. They will discuss safe firearm storage, offer pistol lockboxes, and include mental health and suicide prevention resources with lockbox distribution.

Outcomes Measured

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

Outcome Estimates (FY2021-2022)

- 13,000 Keep It Safe brochures distributed throughout the county.
- Two Lethal Means Safety trainings with 15 or more participants
- 600 lockboxes distributed, 600 Lockbox Data Collection Forms completed and 600 educational resources provided.

Project: Social Marketing

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

Community-wide prevention efforts are designed to educate the broader community on how to identify the signs of behavioral illness; how to access resources for early

detection and treatment; and to reduce behavioral illness stigma and discrimination. Humboldt County will continue to coordinate local community-wide prevention activities in the areas of suicide prevention, stigma and discrimination reduction, and increased access for unserved/underserved populations.

Target Population

- All Humboldt County residents will be reached with the social marketing efforts.

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
- Coordinate Awareness Month events with community partners

Communication Channels

- Email Messaging
    - Distribution List: will maintain educational connections made with training participants and with individuals in the community through an email list.
    - Content: Emails will share state content and other social marketing initiatives, promote local PEI activities (including awareness months) and highlight resources for behavioral health and suicide prevention.
- Public Service Announcements (PSAs)
    - PSAs will promote social marketing campaigns and program objectives through local radio stations. PSA content will include local state and national public health campaigns. Each Mind Matters, Know the Signs, Lock Up your Lethals information, awareness month resources and messaging and ads targeting stigma and help-seeking.
- Website
    - The new SSVP program website is in development. It will integrate former Suicide Prevention, SDR and Violence Prevention programing. Content will consist of programmatic activities, population specific resources, training promotion and public health information. Additionally, SSVP content will be disseminated though the DHHS webpage.

Marketing Content

- Media Campaigns & Toolkits
    - SSVP strategies continue to promote statewide and local campaigns (e.g. print ads, radio ads) including “Know the Signs” and “Each Mind Matters.” Additionally 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 will be promoted.

- Keep It Safe Campaign (previously Lock Up Your Lethals)
    - The new Keep It Safe brochure was developed with the goal of reaching expanded audiences on the topic of safe storage of potentially dangerous items. The target audience is any and everyone in the community living in homes. Keep it Safe is about starting a conversation with Humboldt County residents about protection our loved ones from preventable injury. Keep It Safe addresses common items found in homes that could be dangerous such as medications, alcohol, firearms, and anything else that can be used to get high. Keep it Safe evolved from the Lock Up Your Lethals campaign to also include cannabis products.
- Awareness Months
    - SSVP will continue to collaborate with community partners on awareness month campaigns throughout the year. The intention will be to raise awareness on suicide prevention and its intersection with various health disparities.
    - Collaborative campaigns will include:
        - Suicide Prevention Month, including the local chapter of the American Foundation for Suicide Prevention Community Walk
        - Sexual Assault and Child Abuse Awareness Month
        - Domestic Violence Awareness Month

Outcome Measurements

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

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

Outcome Estimates for FY2021-2022

- 5,000 exposures to social marketing
- 300 people through the DHHS Webpage
- 20,000 though radio PSAs
- Grow email list audience to over 300 and report over 600 emails opened.

Prevention & Early Intervention: Parent Partners

The Parent Partner Program's vision is to provide support, encouragement, and hope to parents/caregivers who are feeling overwhelmed as they find themselves involved with a challenging and complex child or adult-serving system. It is an early intervention program and provides access and linkage to treatment. Parent Partners develop and maintain a practice to increase opportunities for parents/caregivers to receive peer based support services as they encounter county child and adult-serving systems through strategic self-disclosure of their lived experiences as parents of a youth or

family member with emotional, mental health or substance abuse needs. Parent Partners provide support as a peer rather than an expert in the field and help to create conditions for parents/caregivers to feel empowered and confident as they navigate these county systems, making decisions that are best for their family and determining their course of action based on their families' needs and goals. Parent Partners model effective personal interactions while supporting the development, reconnection and strengthening of natural supports for families. They serve as a mentor to improve parents/caregivers' confidence and ability to self-advocate for and effectively manage the services and supports for their own family. They empower families to identify their own future vision of what their family can be, what they need most to achieve this future, and how they can use their strengths and culture to get those needs met. The services of Parent Partners can contribute to meeting the need for additional services and supports for school age children. The Parent Partner Program will continue to be supported contingent upon continuing availability of MHSA funding.

The Parent Partner Program employs three full-time staff to provide supportive services to parents/caregivers involved in the DHHS systems-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 Behavioral 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 mental 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 within DHHS policy and program development and implementation activities. There are 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 or adult involved in a child or adult-serving system such as a Children's or Adult 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.

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 coordinate with the Children's Mobile Response Team so that families that have children in crisis are quickly offered support and resources. In addition, Parent Partners are co-facilitators at the County's Family Advisory Board meetings and several NAMI peer support groups offered in the county. They are available to parents/caregivers of children or adults receiving services within the Adult Behavioral Health system by being available to families and staff during visitation hours at the Sempervirens Psychiatric Health Facility. Parent Partners may help staff the DHHS Warm Line bringing their peer-based expertise to support community members seeking services.

Expected Outcomes:

The Parent Partner Program reaches out, through meetings, referrals and support groups, to an average 30 people per week. Outreach efforts are done primarily at Sempervirens, Family Resource Centers, the Jefferson Community Center, and directly to families and caregivers in the community. Parent Partners are expected to attend various meetings within the DHHS system 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.

How Outcomes are Measured:

The 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 2021-2022:

For the next year an estimated 100 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.

Prevention & Early Intervention: School Climate Curriculum Plan/MTSS

Increasing the recognition of early signs of emotional disturbance or behavioral illness for children in a school setting has been an identified need of the MHSA Community Program Planning Process (CPPP) for years. It remains as an identified need through the current time, with the CPPP of the Three Year Plan showing that increasing support for school age youth, and providing more behavioral health supports in schools, are priorities for the community. This input led to DHHS-Behavioral Health and the Humboldt County Office of Education (HCOE) developing a shared plan to address the need, and they entered into a Memorandum of Understanding to continue to develop a Multi-Tiered System of Support (MTSS) Coalition to implement the Positive Behavior Interventions and Supports (PBIS) curriculum. This partnership has been in place since 2016. The only change in the support provided for the future, contingent upon the continuing availability of MHSA funding, is that MHSA will support a position that is shared between DHHS-Behavioral Health and HCOE. This position, the Prevention and Intervention Specialist, will be responsible for the management, development, coordination of services, professional development, technical assistance and other MTSS, PBIS, Social Emotional Learning (SEL) programs/services and related projects. The position will serve as the lead administrator for a project team; will establish and implement district services and technical assistance across these frameworks; will coordinate and facilitate various county communities, staff development and leadership activities; and will provide leadership in the design, implementation, and maintenance of innovative practices that support student achievement. The MTSS Program is a prevention and early intervention program that will impact the identification of early signs of emotional disturbance in children and youth.

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

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

The following core components are key aspects of MTSS frameworks:

1. High-quality, inclusive academic instruction promoting comprehensive assessment systems, teaming, universal academic supports, and intensified interventions and supports focused on early intervention and prevention.
2. Systemic and sustainable change. MTSS principles promote continuous improvement processes at all levels of the system (district, school site, and grade/course levels). Collaborative restructuring efforts identify key initiatives, collect, analyze, review data, implement supports and strategies based on data and then 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.

Target Population

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

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

Key Activities

Key activities include technical assistance, teaming, and coaching. Explicit training in restorative practice/justice, classroom and behavior management, effective school teaming, inclusive discipline practices, trauma-informed instruction, cultural competency, threat assessment and crisis response, and aspects of wellness (student and staff). The MTSS domains that support the three areas of integrated instruction are – administrative leadership, integrated educational framework, family and community engagement, and inclusive policy structure and practice. Activities to strengthen these domains are many – examples are working with a team on establishing inclusive discipline policies or working with administrators to support comprehensive strategies and leadership strategies. These are elements of lasting system change. Lasting change requires technical assistance and coaching to support transformative practice. Meaningful data sharing, administrative leadership, and teaming with staff participation are the primary elements of lasting systematic change. Engagement with districts will guide and support these important elements.

Outcomes to be measured

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

Outcome measures

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

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

Prevention and Intervention Specialist will provide facilitation, technical assistance and training of SWIS.
Existing Data Sources: Local and state resources (i.e. the CA Dashboard, the Healthy Kids Survey, and school data base systems) are pre-existing measures that will reflect the impact of transformative system practice. Attendance, referrals, suspensions, disproportionality, and community engagement are data sources that will be examined. MTSS is endorsed by the CA Department of Education, and the CA Department of Special Education, as an evidence-based framework designed to respond to indicators of student need statewide (Differentiated Assistance, DA, Comprehensive Support and Improvement, CSI, Performance Indicator Review – PIR, and Disproportionality – DisPro). Additionally the CA Department of Education endorses the examination of exclusive disciplinary practices (suspension and expulsions) and the promotion of inclusive disciplinary practices (Restorative Practices, and school-wide PBIS) to reduce lasting maladaptive behaviors in our communities and decrease involvement in the juvenile justice system (that increases likelihood of adult incarceration).

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

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 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

Successful projects are:

- Stigma and Discrimination Reduction, through the conference *Dispelling Stigma: Hoarding Education, Treatment and Prevention*, the formation of the Northcoast Hoarding Task Force, free support groups for people who hoard, and free support groups for family and friends of people who have cluttering/hoarding issues.
- Suicide Prevention, through the Bear River Band of the Rohnerville Rancheria's three-day intensive peer counseling program for Bear River youth.
- Early Intervention, through the development and implementation of an intensive therapeutic parenting program for the parents of children ages 0-5.
- Access and Linkage to Treatment and Early Intervention, though the provision of trauma focused services in Spanish and increasing access to domestic violence counseling services.
- Stigma and Discrimination Reduction and Access and Linkage to Treatment, though a Mental Health First Aid Train the Trainers, with the intent of serving monolingual Spanish speakers and Native American youth.

Local Implementation projects will continue to be funded contingent upon the continuing availability of MHSA funds. These small projects can potentially address many of the priorities that were identified in the CPPP, as have the prior funded projects. Requests for Application for the next round of projects are planned to be distributed in January 2021.

Prevention and Early Intervention Assigned Funds: North Valley Suicide Prevention Hotline

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, local Humboldt County MHSA Workforce Education and Training (WET) funding has provided staff development opportunities that promote wellness, recovery, and resilience, culturally competent service delivery, meaningful inclusion of clients and family members, an integrated service experience for clients and their family members, community collaboration, and employment of clients and family members within the behavioral health system. During the next year, contingent upon the continuing availability of MHSA funding, local WET dollars will be used for Training and Technical Assistance through support of the Relias E-Learning platform and to provide matching funds for the Office of Statewide Health Planning and Development (OSHPD) Regional Partnership Grants. A report on WET activities for FY 2019-2020 is found in the Appendix.

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.

OSHPD Regional Partnership. DHHS Behavioral Health will participate in the statewide WET 2020-2025 Plan through the Regional Partnership project, coordinated by OSHPD. Humboldt County is a member of the Superior Region and collaborated with the other counties in the Region to develop an application to secure OSHPD WET funds. The Superior Region priorities are to provide scholarships and/or stipends for peer specialists, graduate education stipends for Clinical Master and Doctoral program participants, loan repayments for qualified masters/doctoral graduates who commit to working in the public mental health system for a set period of time, and the development and implementation of retention strategies. In Humboldt County the CPPP showed overwhelming support for retention strategies to support the behavioral health workforce, and Behavioral Health leadership has identified the loan repayment program as a priority. It had been anticipated that the OSHPD programs would begin in the Fall of 2020, but due to contracting delays experienced in the Superior Region the estimated time for beginning the OSHPD programs is now Spring 2021.

MHSA Funding Summary

The budget presented in this Annual Update indicates a 2% reduction across the board for Fiscal Year 2021-22 as compared to Fiscal Year 2020-2021. This reduction was set forth in the Three Year Plan for 2020-2023 and is consistent with a MHSA revenue decline as projected by an economic expert who has been advising the California Association of Behavioral Health Directors over the past several years. Any changes in fiscal conditions will trigger a reassessment of programs and services to be provided. Although the MHSA programs may indicate a budgeted amount at this time, there may be a change in the budget for a program due to increased or decreased cost of services or increased or decreased revenues. In other instances, expenditures may change due to any number of factors, including but not limited to a change to the services identified for the project, project demand, or lack of provider(s). Additionally, the State Legislature has been re-evaluating the MHSA. Key requirements may be modified within the Annual Update period. Should these changes occur, this Update will be modified and updated through the CPPP or through an additional stakeholder process in between the Annual Updates, if needed.

FY 2021-22 MHSA Annual Update Funding Summary

County: Humboldt County Date 03/25/2021

	A	B	C	D	E	F
	CSS	**PEI**	**INN**	**WET**	**CFTN**	**Prudent Reserve**
A. Estimated FY 2021-22 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	780,422	578,350	622,486			
2. Estimated New FY 2021-22 Funding	5,592,295	1,398,074	367,914			
3. Transfer in FY 2021-22 a/	(54,563)			54,563		
4. Access Local Prudent Reserve in FY 2021-22						
5. Estimated Available Funding for FY 2021-21	6,134,009	1,776,381	723,784	54,563	0	
B. Estimated FY 2021-22 MHSA Expenditures	5,816,860	1,592,315	444,448	54,563	0	
G. Estimated FY 2020-21 Unspent Fund Balance	501,294	384,109	545,952	0	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2020	1,439,391
2. Contributions to the Local Prudent Reserve in FY 2020-21	
3. Distributions from the Local Prudent Reserve in FY 2020-21	(200,000)
4. Estimated Local Prudent Reserve Balance on June 30, 2021	1,239,391

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

FY 2021-22 MHSA Annual Update Community Services and Supports (CSS) Funding

County: Humboldt County Date 03/25/2021

	A	B	C	D	E	F
	Est. Total Mental Health Expenditures	**Est. CSS Funding**	**Est. Medi-Cal FFP**	**Est. 1991 Realignment**	**Est. Behavioral Health Subaccount**	**Est. Other Funding**
FSP Programs						
1. Comprehensive Community Treatment	7,310,343	4,518,676	2,760,570			31,097
Non-FSP Programs						
1. Regional Services	138,199	125,635	12,564			
2. Older Adults and Dependent Adults	99,292	65,802	33,489			
3. Sub-Acute Transitional Behavioral Health, Specialty Behavioral Health and/or Social Rehabilitation Services	960,000	480,000	480,000			
4. Housing Support	21,743	21,743				
CSS Administration	618,501	605,004	13,497			
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	9,148,078	5,816,860	3,300,121	0	0	31,097
FSP Programs as Percent of Total	79.9%					

FY 2021-22 MHSA Annual Update Prevention and Early Intervention (PEI) Funding

County: Humboldt County Date 03/25/2021

	A	B	C	D	E	F
	Est. Total Mental Health Expenditures	Est. PEI Funding	Est. Medi-Cal FFP	Est. 1991 Realignment	Est. Behavioral Health Subaccount	Est. Other Funding
PEI Programs - Prevention						
1. Hope Center	283,491	263,713	19,778			
2. TAY Advocacy and Peer Support	435,646	388,229	29,117			18,300
3. Parent Partners	332,552	309,351	23,201			
4. Local Implementation Agreements	105,600	105,600				
5. School Climate Curriculum Plan/MTSS	86,400	86,400				
PEI Programs - Early Intervention						
1. Suicide Prevention	192,000	192,000				
PEI Administration	231,754	231,754				
PEI Assigned Funds	15,268	15,268				
Total PEI Program Estimated Expenditures	1,682,712	1,592,315	72,097	0	0	18,300

FY 2021-22 MHSA Annual Update Innovations (INN) Funding

County: Humboldt County Date 03/25/2021

	A	B	C	D	E	F
	Est. Total Mental Health Expenditures	Est. INN Funding	Est. Medi-Cal FFP	Est. 1991 Realignment	Est. Behavioral Health Subaccount	Est. Other Funding
INN Programs						
1. Resident Engagement and Support Team (REST)	436,367	404,044	32,323			
INN Administration	40,404	40,404				
Total INN Program Estimated Expenditures	476,771	444,448	32,323	0	0	0

FY 2021-22 MHSA Annual Update Workforce, Education and Training (WET) Funding

County: Humboldt County Date 03/25/2021

	A	B	C	D	E	F
	Est. Total Mental Health Expenditures	Est. WET Funding	Est. Medi-Cal FFP	Est. 1991 Realignment	Est. Behavioral Health Subaccount	Est. Other Funding
WET Programs 1. Training and Technical Assistance	54,563	54,563				
WET Administration	0					
Total WET Program Estimated Expenditures	54,563	54,563	0	0	0	0

FY 2021-22 MHSA Annual Update Capital Facilities/Technological Needs (CFTN) Funding

County: Humboldt County Date 03/25/2021

	A	B	C	D	E	F
	Est. Total Mental Health Expenditures	Est. CFTN Funding	Est. Medi-Cal FFP	Est. 1991 Realignment	Est. Behavioral Health Subaccount	Est. Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
2.	0					
CFTN Programs - Technological Needs Projects						
3.						
4.	0					
5.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	0	0	0	0	0	0

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)

Botzler-Rodgers, Emi Digitally signed by Botzler-Rodgers, Emi Date: 2021.06.15 15:18:07 -07'00' 06/15/2021
Signature Date

County: Humboldt

Date: _____

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.

Botzler-Rodgers, Emi Digitally signed by Botzler-Rodgers, Emi Date: 2021.04.28 07:31:19 -07'00'

Signature Date

Emi Botzler-Rodgers MFT

Local Mental Health Director (PRINT)

I hereby certify that for the fiscal year ended June 30, 2021, 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 9/25/2020 for the fiscal year ended June 30, 2019. I further certify that for the fiscal year ended June 30, 2021, 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 6/4/2021 Date

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

Appendix

Fiscal Year 2019-2020
Program Reports

Contents

Introduction

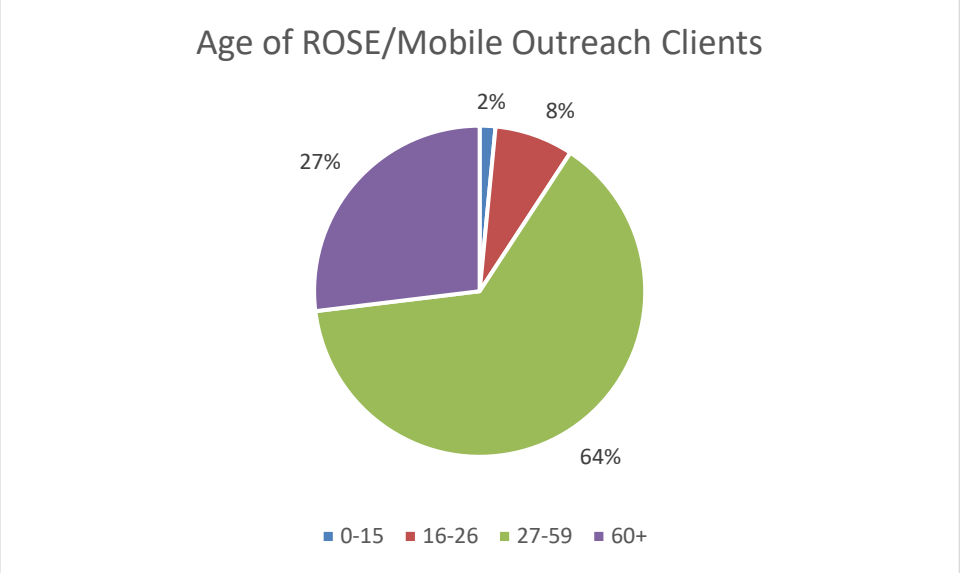
This Appendix provides a report for the MHSA programs that were funded in the last Fiscal Year of the 2017-2020 Three Year Plan, which was Fiscal Year 2019-2020. Data for 2019-2020 is the last Fiscal Year data available as of the preparation of this Annual Update for 2021-2022. Some of the programs presented in this report did not continue to receive MHSA funding in the 2020-2023 Three Year Plan, so this will be the final reporting on the services that were provided. Other programs presented in this report will continue to be funded by MHSA in the next three years, so reports on their activities will be provided in subsequent Annual Updates.

Programs that will no longer be funded by MHSA in the 2020-2023 Three Year Plan are the Community Services and Supports programs ROSE/Mobile Outreach and Telemedicine. These programs continue with other funding sources. The HOME Innovation project ended as it reached its regulatory limit of five years. HOME services continue with other funding sources. The Stigma and Discrimination Reduction (SDR) Program that was implemented by the Healthy Communities Division of DHHS Public Health will no longer continue as originally designed. Instead, Healthy Communities has incorporated some of the aspects of their SDR Program into Suicide Prevention. Other SDR activities will be implemented by the TAY Advocacy and Peer Support and Hope Center Programs.

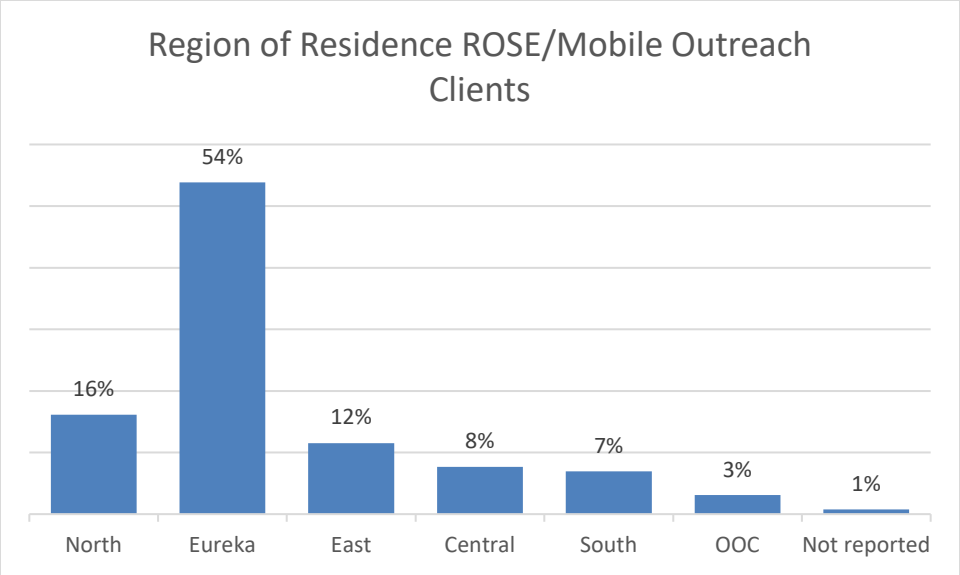
Community Services & Supports: ROSE/Mobile Outreach

The Mobile Outreach program, which was originally known as Rural Outreach Services Enterprise (ROSE), was integrated into the Housing, Outreach and Mobile Engagement (HOME) Program in Fiscal Year 2019-2020. HOME includes outreach services and housing support services throughout Humboldt County. The mission of HOME outreach services is to connect communities throughout the county with DHHS services so residents who do not live in Eureka can access Behavioral Health, Public Health or Social Services programs. Staff work on board a mobile engagement vehicle, a converted RV which acts as a rolling office space and visits communities located throughout the county. Some services, such as counseling, may require an appointment, others can be provided right at the program vehicle. Community sites such as Family Resource/ Community Resource Centers, clinics, tribal offices and volunteer fire departments are visited on a set schedule.

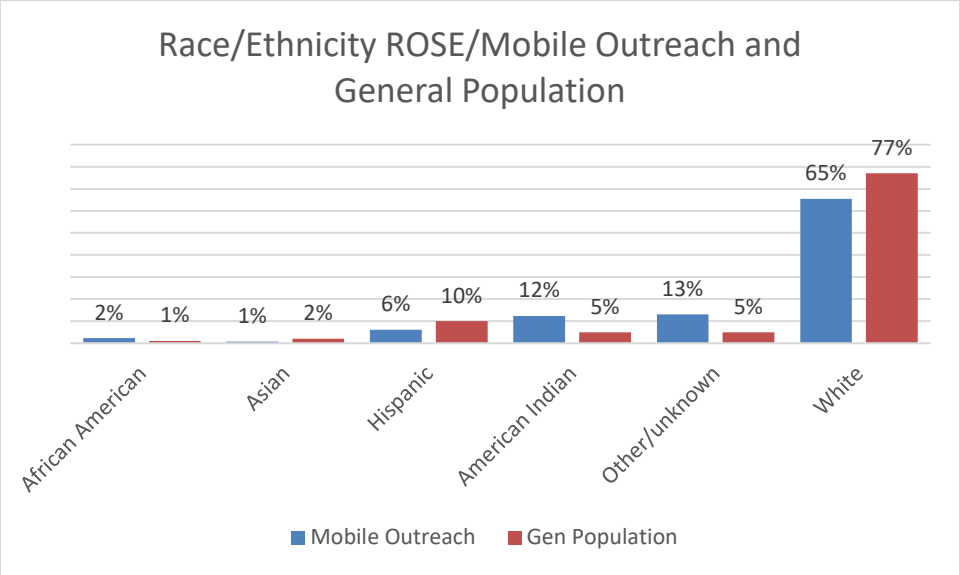
From July 2019 through June 2020 the program served 130 unduplicated behavioral health clients. Two percent of those served were children, 8% were transition age youth, 64% were adults, and 27% were older adults.



Clients were served throughout the region, with 54% served in Eureka, 7% in Southern Humboldt, 12% in Eastern Humboldt, 16% in Northern Humboldt, 8% in the Central region, and 3% out-of-county. For 1% the residence region was not reported.



The percentage of ROSE/Mobile Outreach clients who identify as White/Caucasian was 65%, and 77% for the general population. The percentage of clients who identify as American Indian is 12%, 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 1%, and 2% for the general population. The percentage of clients who identify as Hispanic/Latino(a) is 6%, and 10% for the general population.

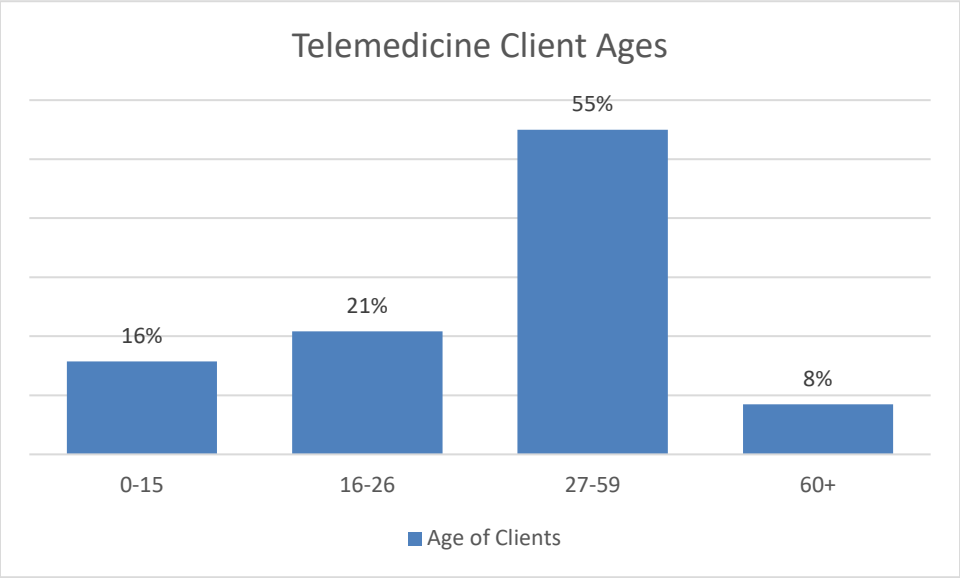


The services and outreach provided through ROSE/Mobile Outreach will continue to be provided through the outreach component of HOME, funded by sources other than MHSA.

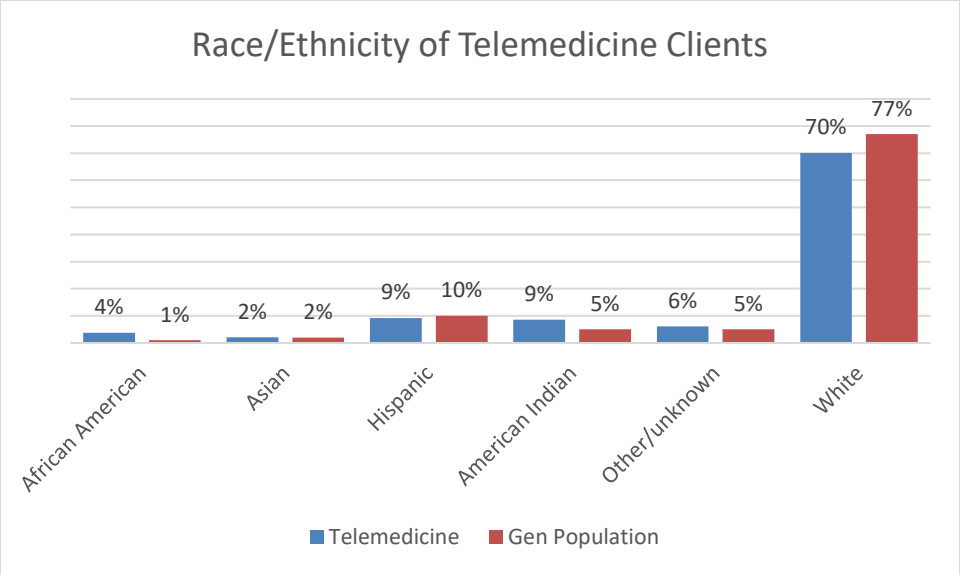
Community Services and Supports: Telemedicine

From July 2019 through June 2020 the program served an average of 96 unduplicated clients per month for a total of 1,158 unique individuals during the time.

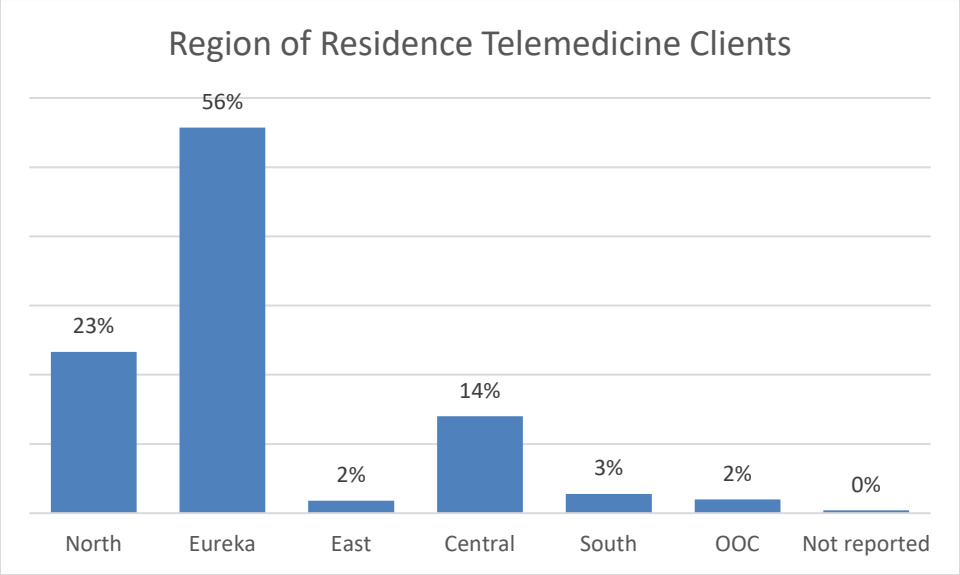
The telemedicine program served people of all ages. During the year 16% were children ages 0-15, 21% were ages 16-26, 55% were ages 27-59, and 8% were age 60+. Fifty percent were female and 50% were male.



The percentage of telemedicine clients who identify as White/Caucasian was 70%, 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 2% 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 9%, and 10% for the general population. The percentage of telemedicine clients who identify as other racial/ethnic makeup or for whom no information is available is 6%, and 5% for the general population.



Fifty-six percent of clients served lived in the Eureka area. 23% lived in the Northern region of Humboldt County, 14% lived in the Central region, 3% in the Southern region, and 2% in the Eastern region. Two percent resided out-of-county.



The primary language for telemedicine clients is English, at 95%. Spanish was the primary language for 1% of telemedicine clients. Other languages were all less than 1% each.

Telemedicine services will continue to be provided by Behavioral Health but will be funded by sources other than MHSA.

Community Services & Supports: Older Adults and Dependent Adults

The program has two components: Outreach, prevention and education activities, and mental health services to clients.

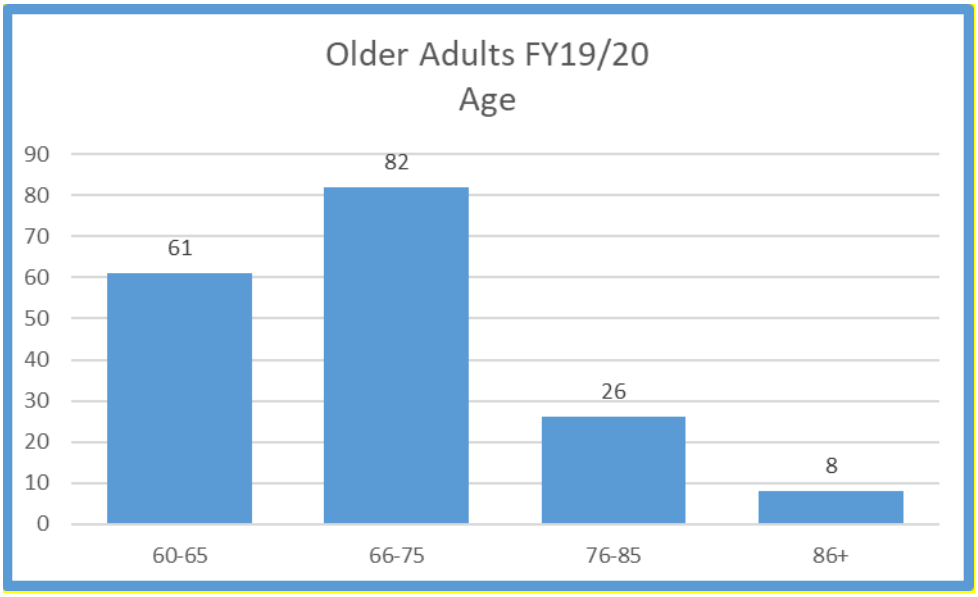
Outreach, Prevention and Education

During Fiscal Year 19/20 a total of 177 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.

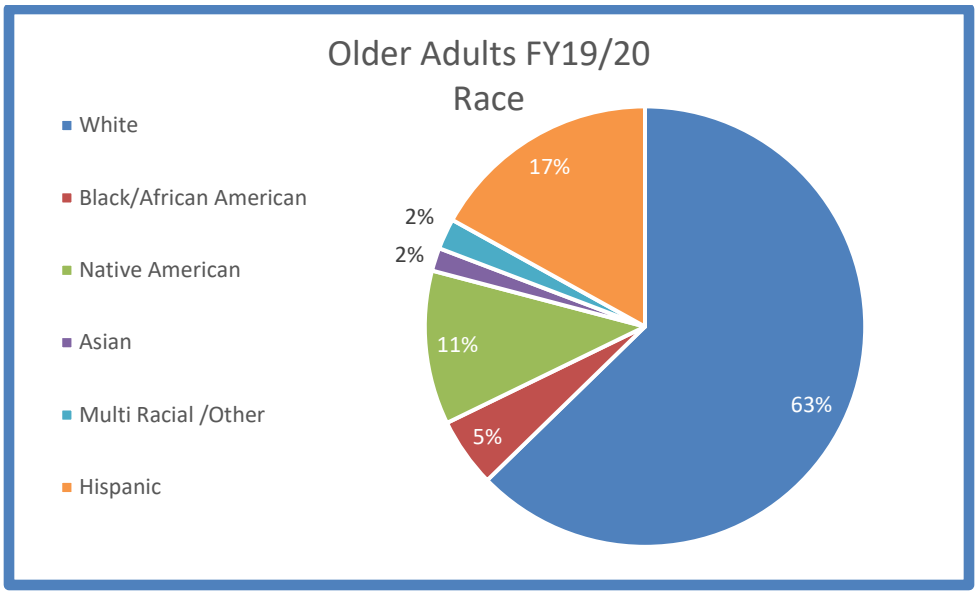
Many of these clients are reaching out for the first time. This program strives to reduce the stigma of mental health labels by offering personalized care, education, intervention and connections to services in the community.

Descriptive statistics for participants in the Older and Dependent Adult program for FY 19/20 are discussed below.

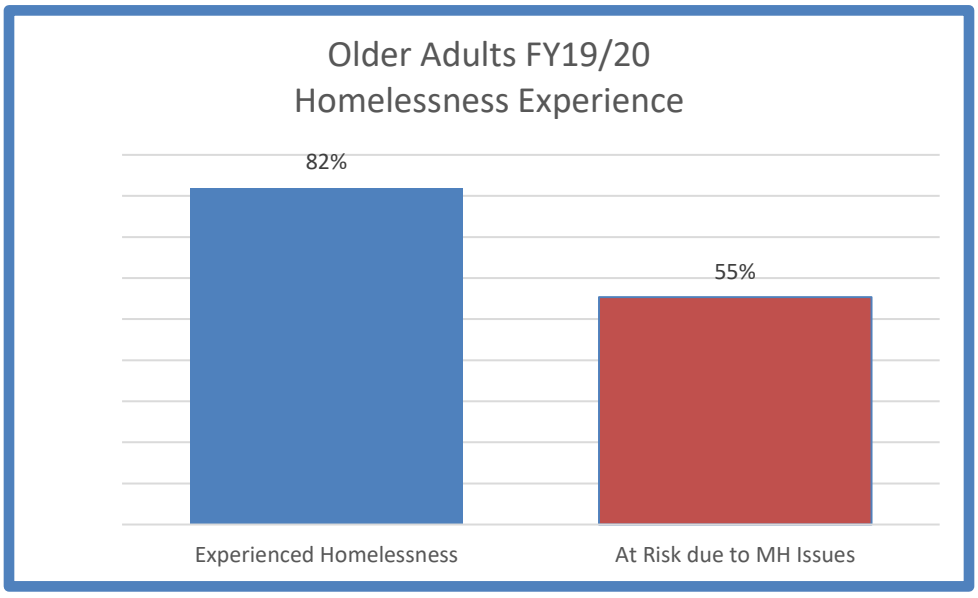
Ninety-seven (55%) of the participants were male and 80 (45%) were female. Sixty-one (34%) were ages 60-65, 82 (46%) between ages 66-75, 26 (15%) between ages 76-85, and 8 (5%) age 86+.



Among the 177 Older Adults served in FY19/20, 111 (63%) were White, 9 (5%) were African American, 20 (11%) were Native American, 3 (2%) were Asian and 4 (2%) were Multi Racial/Other. Thirty (17%) of the participants were Hispanic.

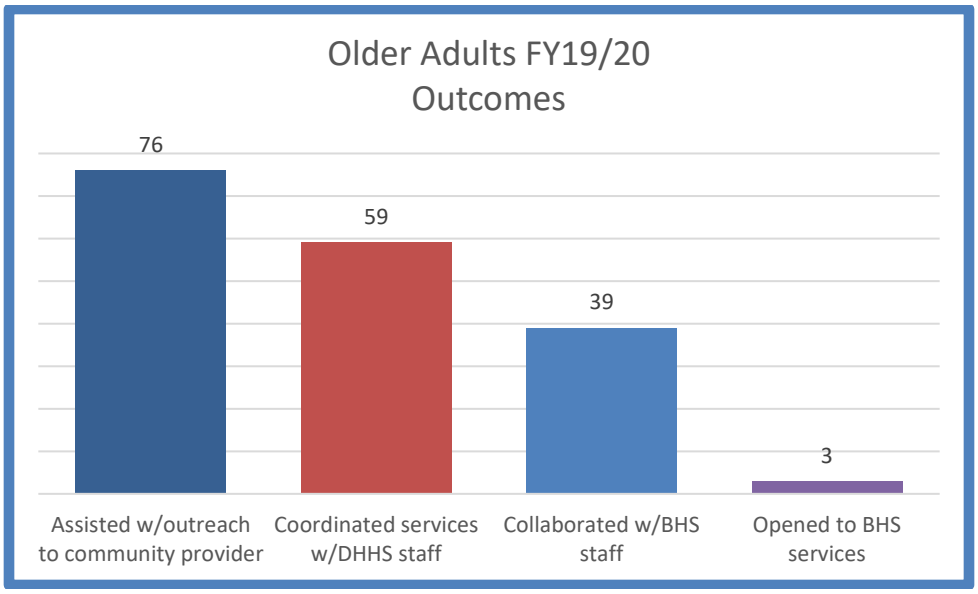


Of the 177 participants in the Older Adult program in FY19/20 145 (82%) self-identified as having experienced homelessness at some time and 98 (55%) expressed feeling at risk of homelessness due to mental health issues.



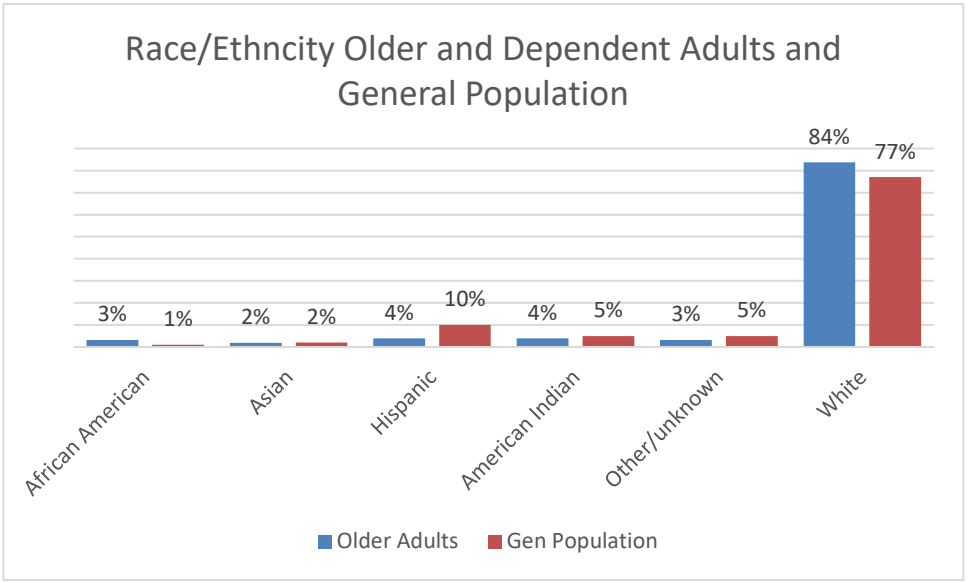
Outcomes

For these 177 Older Adult participants 76 (43%) were assisted with outreach to a community provider; for 59 (33%) services were coordinated with DHHS staff; for 39 (22%) collaboration with Behavioral Health staff was implemented; and 3 participants were opened to Behavioral Health services.



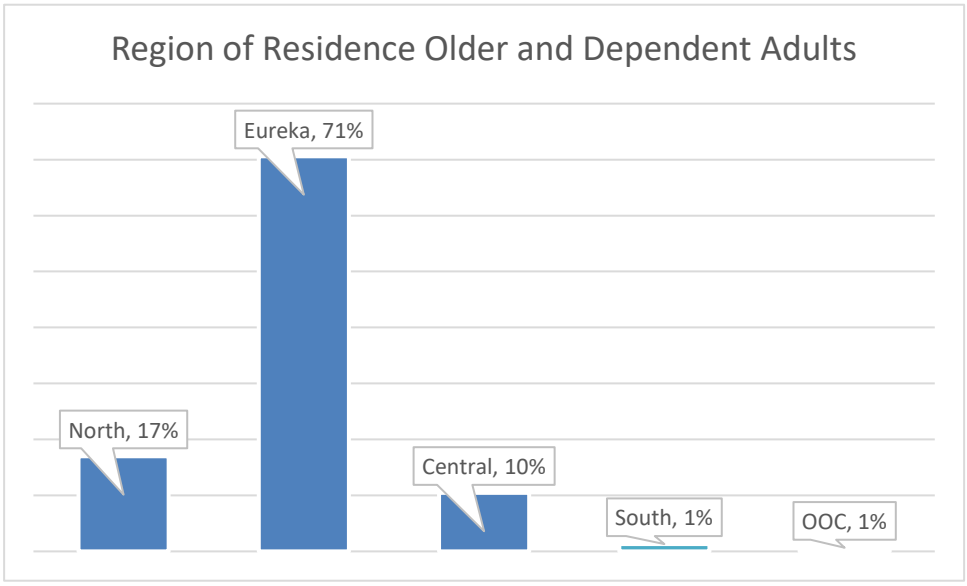
Mental Health Services to Clients

In addition to contacts made through outreach, prevention and education, 153 individuals were provided services as clients of Behavioral Health for Fiscal Year 2019-2020. Of these, 84% were White, compared to 77% of the general population; 4% were American Indian, compared to 5% of the general population; 4% were Hispanic compared to 10% of the general population; 3% were African American, compared to 1% of the general population; 2% were Asian, compared to 2% of the general population; and 3% were Other/Unknown.



Fifty-nine percent of clients served were female, and 41% male.

Seventy-one percent of those served reside in Eureka, 17% in Northern Humboldt, 10% in Central Humboldt, 1% in Southern Humboldt, and none in Eastern Humboldt. One percent reside out-of-county (OOC).

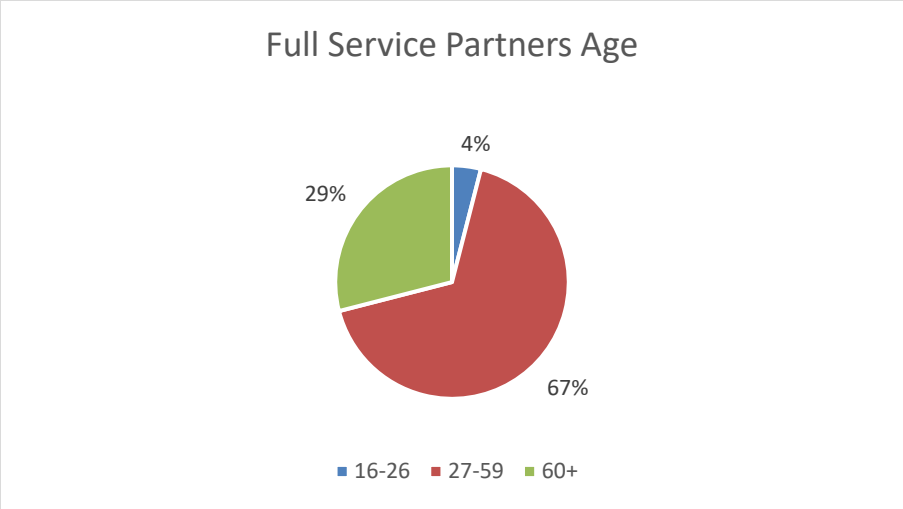


.

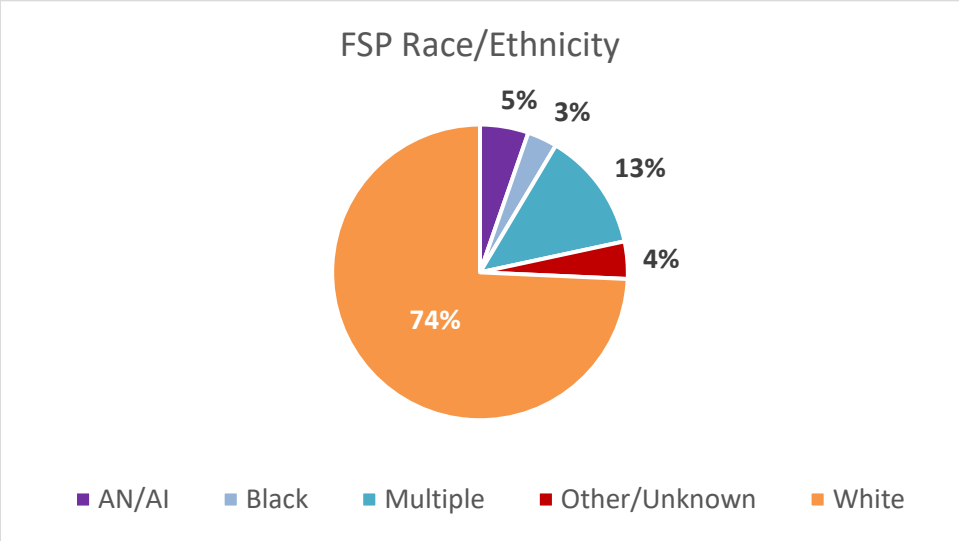
Community Services & Supports: Full Service Partnership

Data for the Comprehensive Community Treatment/Full Service Partnership Program is from the California Dept. of Health Care Services Data Collection and Reporting (DCR) System.

There were 245 Full Service Partners (FSPs) enrolled for the period July 1, 2019 through June 30, 2020. Four percent of FSPs were ages 16-25, 67% were ages 26-59, and 29% 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, 2019 through June 30, 2020, the percentage of FSPs who identified as White was 74%; the percentage who identified as American Indian/Alaska Native was 5%; th epercentage who identified as African American was 3%; the percentage who identified as Multiracila was 13%; and 4% were Other Unknown.



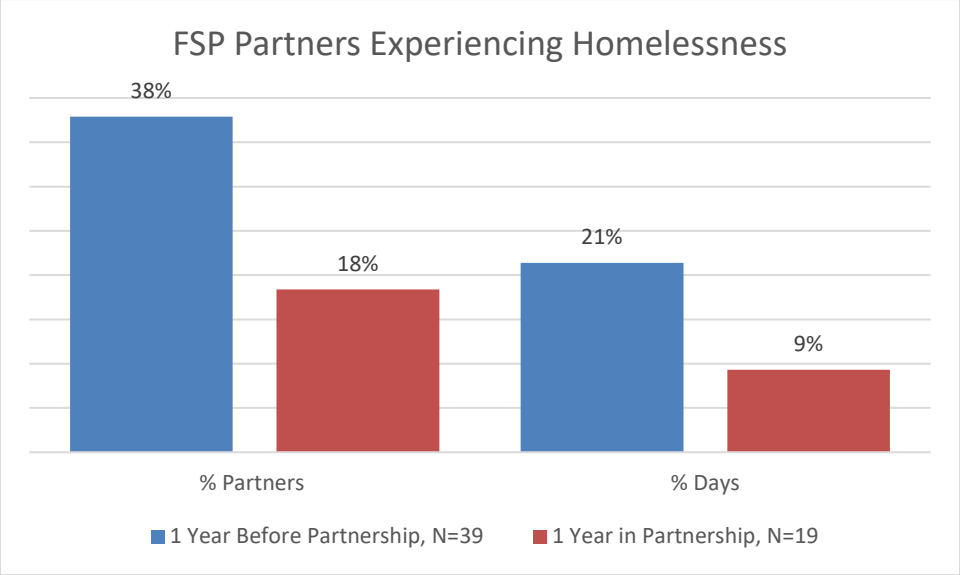
Forty-one percent of FSP clients for the period July 1, 2019 through June 30, 2020 were female and 58% were male.

FSPs exit a Partnership due to a variety of reasons. During the period July 1, 2019 through June 30, 2020, 43 FSPs were discharged from the program for the following reasons.

Discharge Reason	# Discharged	Percentage ALL FSP	Percentage TAY	Percentage Adult	Percentage 60+
Met Goals	13	30%	0%	26%	44%
Target Criteria	6	14%	25%	13%	13%
Not Located	6	14%	0%	22%	6%
Moved	6	14%	25%	13%	13%
Deceased	5	12%	0%	9%	19%
Discontinue	4	9%	0%	13%	6%
Serving Jail	2	5%	50%	0%	0%
Institution	1	2%	0%	4%	0%

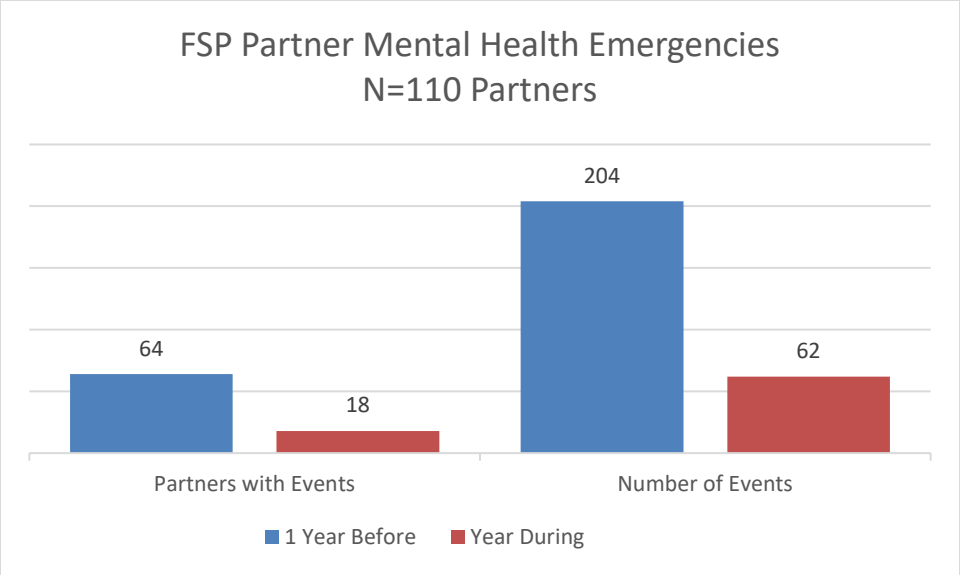
HOMELESSNESS

For the 245 who enrolled in an FSP, 39 experienced 8,030 days of homelessness in the year prior to enrollment. In the most recent year in the FSP, 19 partners experienced 3,513 days of homelessness. This represents 38% of partners experiencing 21% of homelessness days one year before the partnership, and 18% of partners experiencing 9% of homelessness days after one year in partnership.



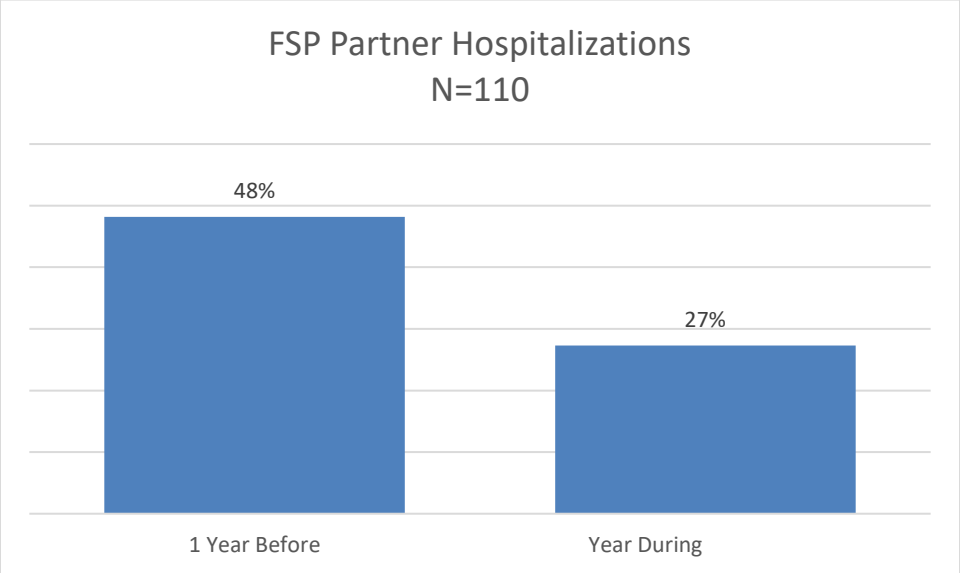
MENTAL HEALTH EMERGENCY

Of the 245 Full Service Partners enrolled in FSP there were 110 (45%) who served at least one year in the program. Of these 110, 64 (58%) experienced 204 mental health emergencies in the year prior to enrollment as an FSP. In the most recent year during enrollment, 18 (16%) experienced 62 mental health emergencies, a decrease of 142 events.



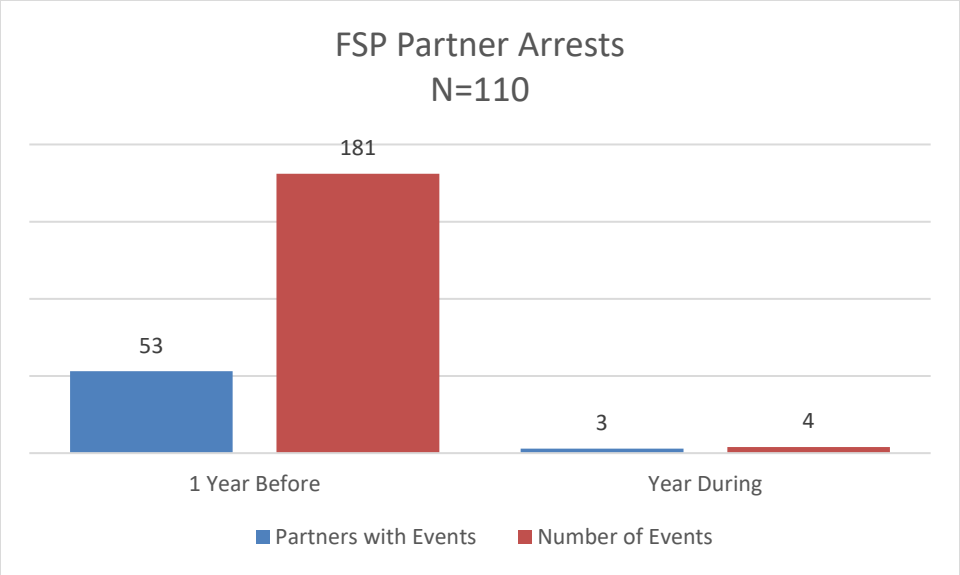
HOSPITALIZATION

Of the 110 Full Service Partners who served at least one year in the program, 53 (48%) experienced psychiatric hospitalization in the year prior to enrollment as an FSP. In the most recent year during enrollment 30 (27%) experienced psychiatric hospitalizations.



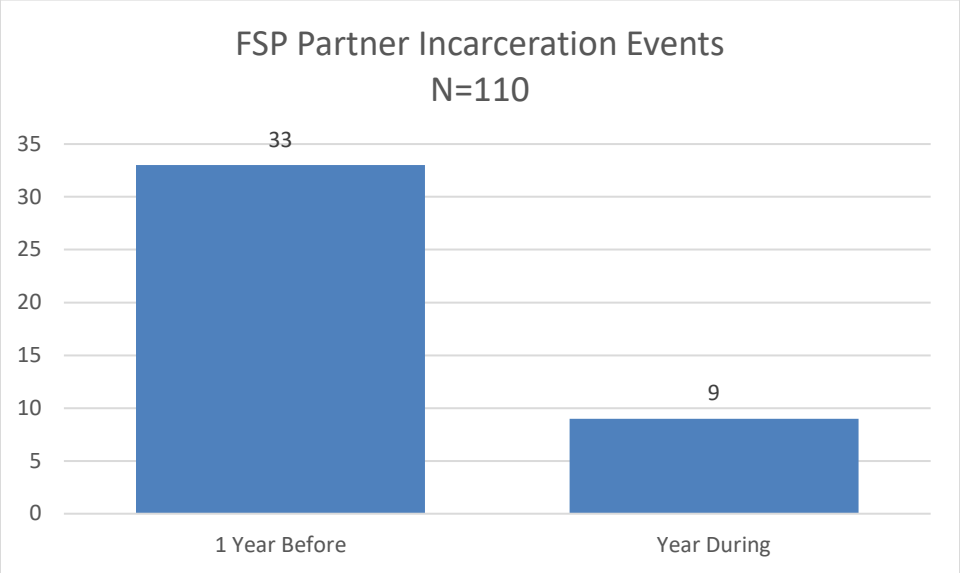
ARRESTS

Of the 110 Full Service Partners who served at least one year in the program, 53 (48%) experienced 181 arrests in the year prior to enrollment. In the most recent year during enrollment three partners experienced 4 arrests.



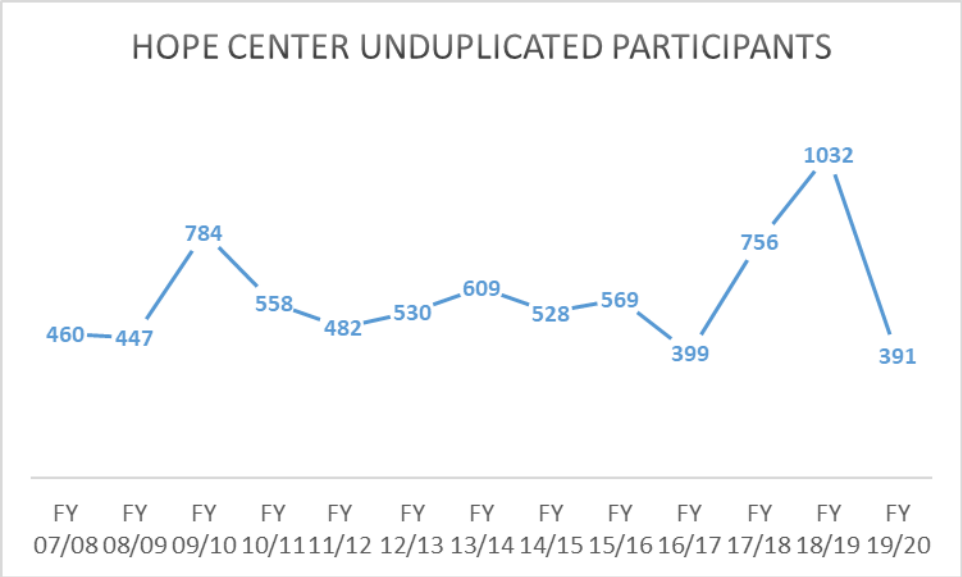
INCARCERATION

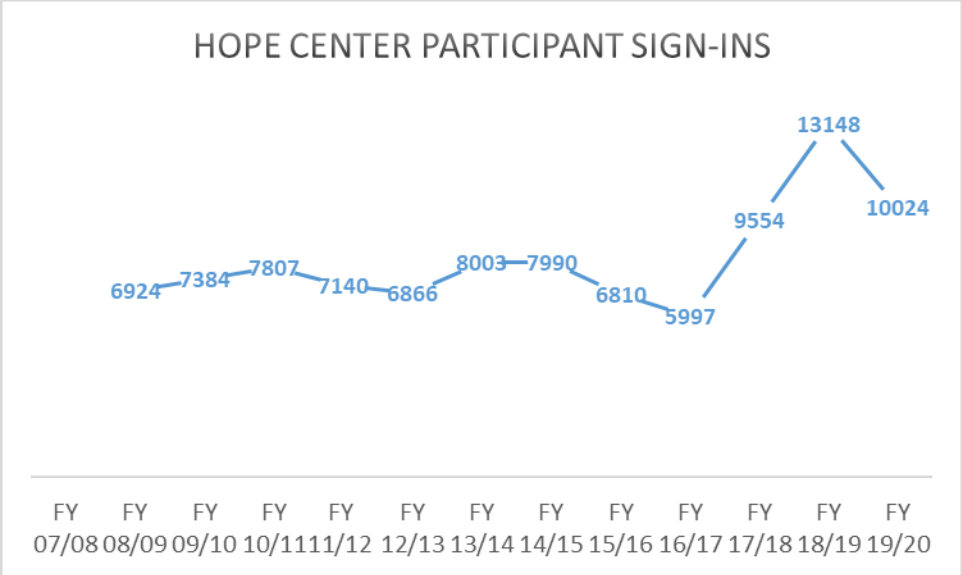
Among the 110 Full Service Partners who served at least one year in the program there were 33 incarceration events for 2,486 days in the year prior to enrollment as a Partner. In the most recent year during enrollment there were 9 incarceration events.



Prevention & Early Intervention: Hope Center

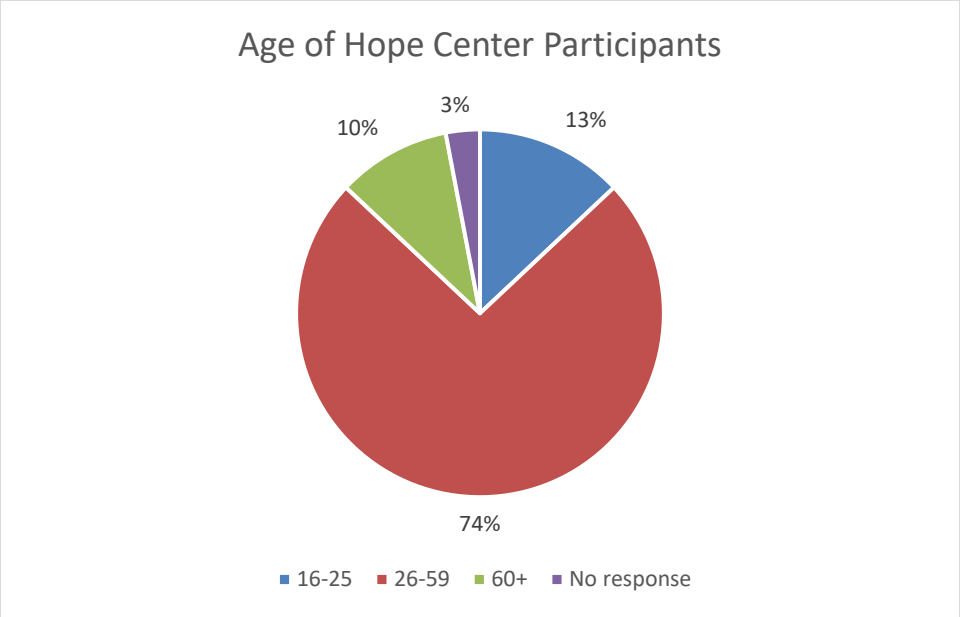
During Fiscal Year 2019-2020 the Hope Center interfaced with 391 unduplicated individuals. There were 10,024 sign-ins to the program. These number are reduced due to COVID-19 pandemic, which caused the closing of the Center. There were three volunteers in the program who put in 327 volunteer hours.





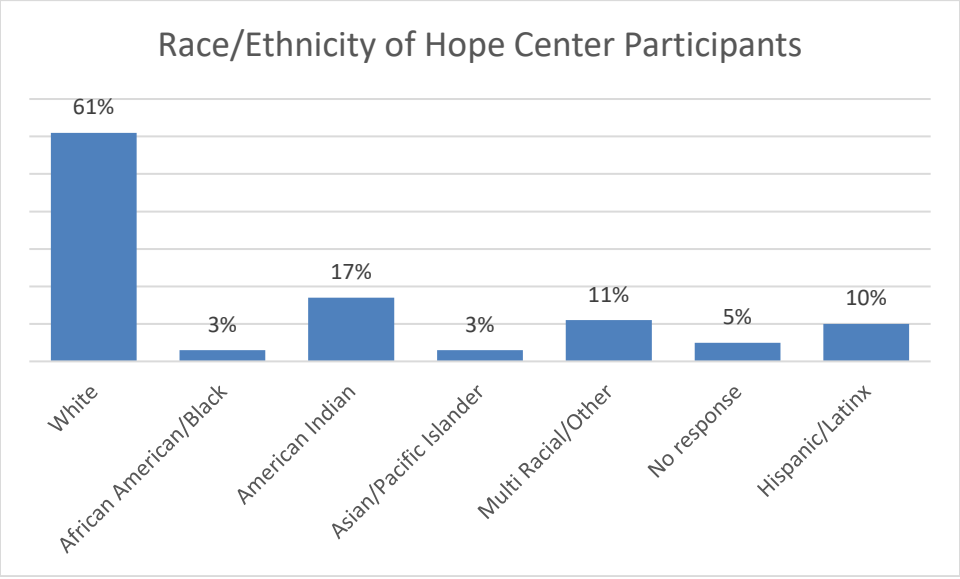
Demographic Data. Of the 391 Hope Center participants, 79 (20%) completed demographic forms. Demographic data is presented in the charts below.

Thirteen percent of participants were ages 16-25, 74% of participants were ages 26-59, and 10% were age 60+. Three percent did not respond to the question.



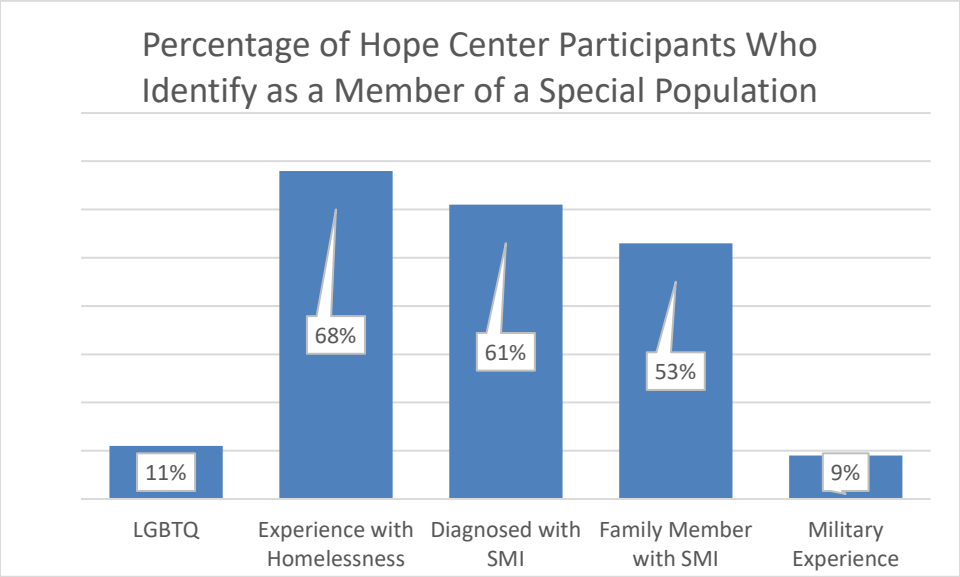
Forty-two percent of Hope Center participants were female, 54% male, one person said "Other" and two people did not respond to the question.

Sixty-one percent of Hope Center participants were White, 11% were Multiracial/Other, 10% were Hispanic/Latinx, 17% were American Indian, 3% were Asian/Pacific Islander, and 3% were Black/African American. Five percent did not respond to the question.



Ninety-seven percent of Hope Center participants spoke English as their primary language, and 3% did not respond to the question.

Eleven percent identified as LGBTQ, 68% had experience with homelessness, 61% had been diagnosed with a serious mental illness (SMI), 53% had a family member diagnosed with SMI, and 9% had military experience.



Prevention and Early Intervention: Suicide Prevention

Throughout this report, we use the MHSA PEI Demographic Form as an outcome measurement to demonstrate the reach and diversity of populations and settings served.

Project: Prevention and Early Intervention Training

The Prevention and Early Intervention Training project incorporates Suicide Prevention and Stigma and Discrimination Reduction (SDR) supported trainings. SSVP Program staff serve as coordinator, trainer and/or support for the offered trainings. Beginning in FY20-21, the online basic suicide prevention training, LivingWorks Start will offered to DHHS staff and community members. The Suicide Prevention staff coordinated and facilitated the following evidence-based training: LivingWorks Applied Suicide Intervention Skills Training (ASIST) and Question-Persuade-Refer (QPR) Basic Suicide Prevention Gatekeeper Training.

LivingWorks Applied Suicide Intervention Skills Training (ASIST)

ASIST is a continuing suicide prevention targeted education and training project for Transitional Age Youth, Adults and Older Adults. 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. ASIST training teams are multidisciplinary. Teams have included public health educators, behavioral health

clinicians, social workers, juvenile probation staff, tribal agency representatives, and law enforcement.

Target Population
ASIST is provided to anyone 18 years and older. Participants include school personnel, health and behavioral health care providers, first responders, faith community, front line workers, and concerned community members. ASIST is offered to diverse groups and populations across multiple settings and professions in order to improve workforce ability to increase access and linkage to care for those in crisis and non-crisis situations.

Key Activities
Activities in the two-day ASIST workshop include:

- Learning how to recognize the signs of persons in need of mental/behavioral health support
- Learning how to identify the risk and protective factors in persons who may be thinking of suicide
- Skills based practice using an intervention model, role-play scenarios, video, and group discussion
- Understanding ways personal and societal attitudes affect views on suicide and interventions
- Learning how to provide guidance and suicide first-aid to a person at risk in ways that meet their individual safety needs
- Identifying the key elements of an effective suicide safety plan and the actions required to implement it
- Improving and integrating suicide prevention resources in the community at large through training and electronic media dissemination
- Understanding the significance of other important aspects of suicide prevention including life-promotion and self-care
- Reducing negative attitudes and beliefs about persons experiencing suicidal thoughts and behaviors and other mental/behavioral health challenges
- Promotion of 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

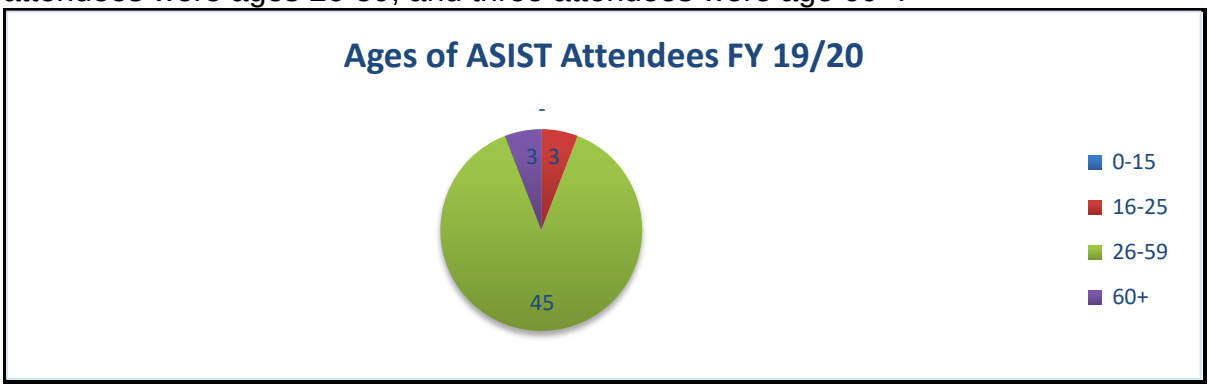
Number of Individuals Served
In FY2019-20, fifty-two individuals attended ASIST. Two ASIST Workshops were held in September and November 2019. Subsequent trainings scheduled for the fiscal year were canceled due to the COVID-19 pandemic and insufficient number of trainers available from the trainer pool.

Demographics of Individuals Served

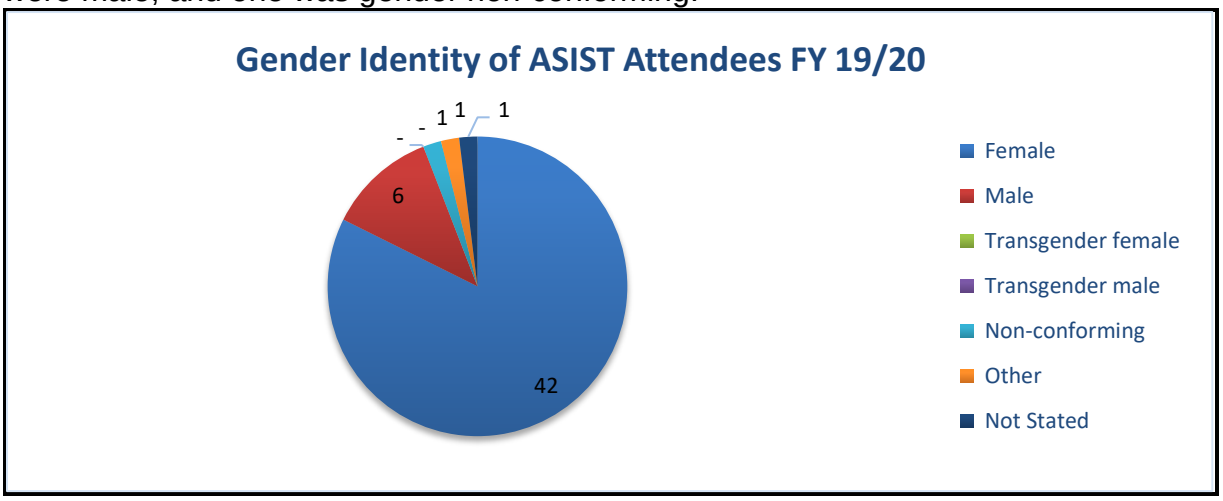
Demographic information comes from attendees at trainings who complete a demographic form. In FY 2019-20, 98% of attendees (51) completed a demographic form, and 2% (1 attendee) declined completing a demographic form.

In FY 2019-20, three attendees at ASIST workshops were ages 16-25, forty-five

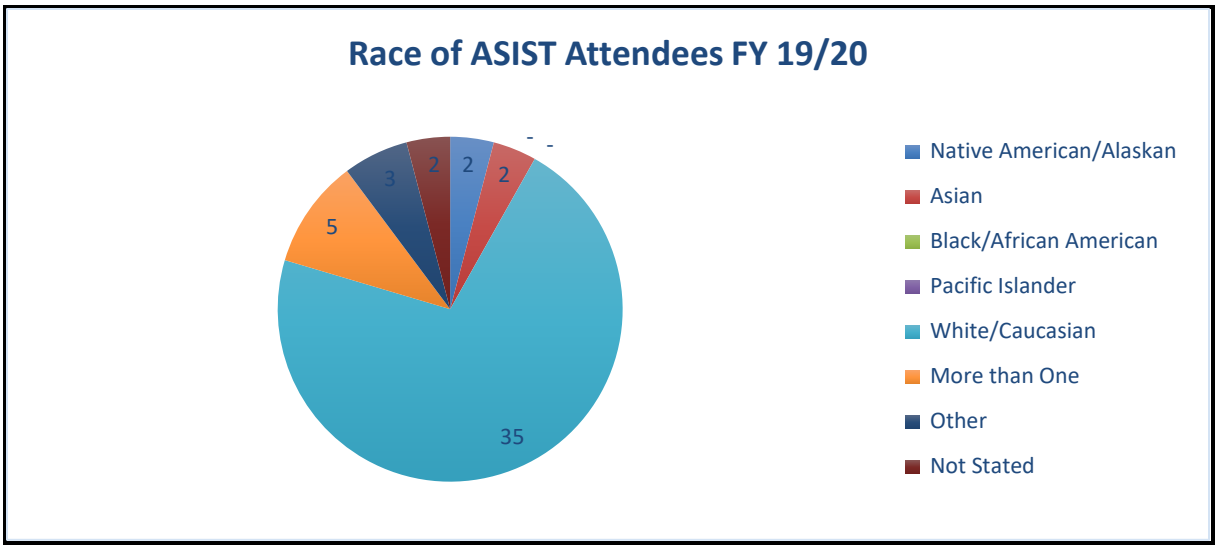
attendees were ages 26-59, and three attendees were age 60+.



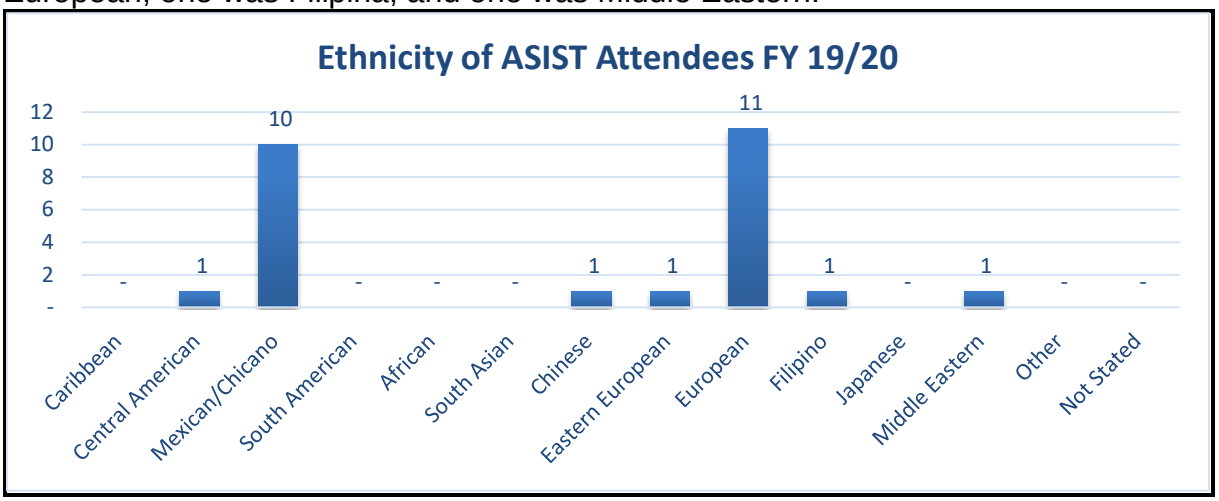
In FY 2019-20, forty-two attendees at ASIST workshops were female, six attendees were male, and one was gender non-conforming.



In FY 2019-20, thirty-five attendees at ASIST workshops were White, two were Native American, five were multi-racial (More than One), two were Asian, and three marked Other. Eleven participants indicated their ethnicity was Hispanic/Latino.

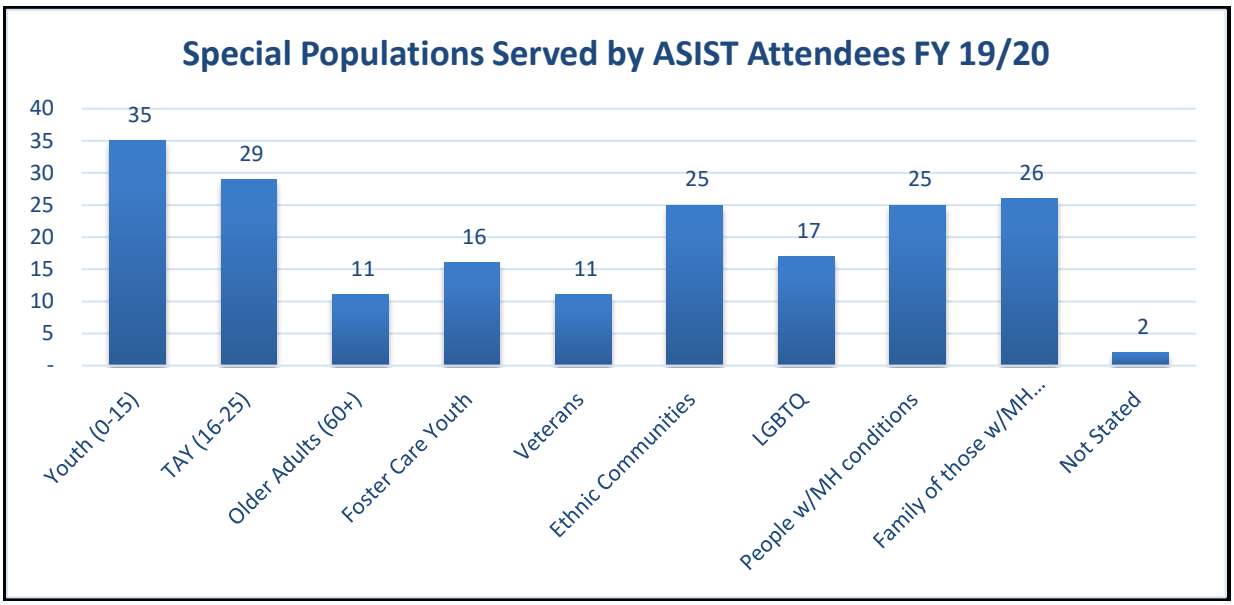


In FY 2019-20, for those answering the question: one was were Central American, ten were Mexican/Chicano, one was Chinese, one was Eastern European, eleven were European, one was Filipina, and one was Middle Eastern.



In FY 2019-20, the populations served by the attendees at ASIST, 35 served youth ages 0-15, 29 served TAY, 11 served Older Adults, 16 served Foster Care Youth, 11 served Veterans, 25 served Ethnic Communities, 17 served LGBTQ, 25 served people with a mental health condition, and 26 served family members of those with a mental

health condition.



Outcome Measurements

- Number of workshops
- Number of participants
- Number of MHSA PEI Demographic Forms submitted
- Post training feedback form
- Number of participants who reported increased knowledge with recognizing warning signs, and behaviors associated with suicidality

Actual Outcomes (FY2019-2020)

OUTCOMES	FY 2019-2020 N=
Participants who reported increased knowledge with recognizing warning signs, and behaviors associated with suicidality (0-5 scale)	53
Number of ASIST workshops	2
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	25%
If someone told me they were thinking of suicide, I would do an intervention	25%
I feel prepared to help a person at risk of suicide	67%
I feel confident I could help a person at risk of suicide	33%
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

Challenges
The COIVID- 19 pandemic has compounded previously existing challenges of a reduction in the Humboldt County trainer pool capacity (due to staffing and community partner funding changes) and resource-intensive production requirements (four trainers, two full days and a training facility with two training rooms).

Successes
Despite major challenges, program staff continued to deliver a meaningful workshop experience for participants. Trainings consistently filled and effective community partnerships were used to maximize resources. Partnerships with United Indian Health Services (UIHS) and the Humboldt County Office of Education continued to support training efforts.

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

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

Target Population
QPR trainings are open to anyone aged 15 and older. Audiences include educators, peer educators, parents, caseworkers, first responders, crisis workers, foster parents, social workers, medical providers, faith community members and general community members.

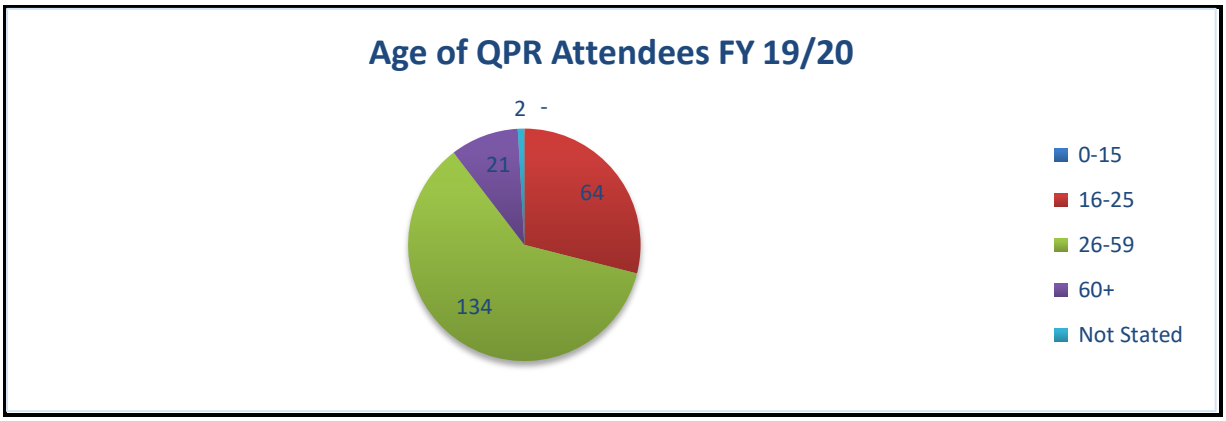
Key Activities
- Training participants to recognize the signs of persons in need of behavioral health support
- Training participants to recognize the signs of persons who are at risk of suicide
- Promoting wellness, recovery, and resiliency
- Providing training to diverse groups and populations across multiple settings and professions in order to improve ability to increase access and linkage to care of those in crisis and non-crisis situations
- Promoting local, statewide and national crisis lines, resources, and educational materials to expand on the ability of trainees increase access and linkage to supports and treatment for persons at risk

- Improving and integrating suicide prevention resources in the community at large
- Recognizing other important aspects of suicide prevention including life-promotion and self-care
- Provide skill-based training so community members will have the knowledge to recognize, signs/symptoms of persons that may be at risk of suicide, respond and intervene
- Reduce negative attitudes and beliefs about persons experiencing suicidal thoughts and behaviors along with other behavioral health challenges

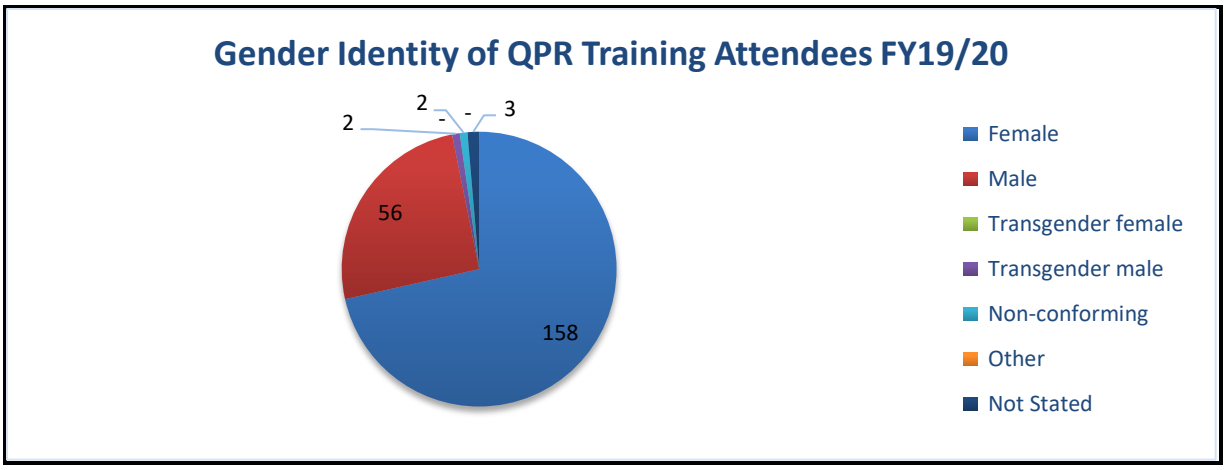
Number of Individuals Served
In FY 2019/20, ten QPR trainings were held with 258 individuals in attendance.

Demographics of Individuals Served
Demographic information comes from attendees at trainings who complete a demographic form. In Fiscal Year 19/20, 85.7% (221) of attendees completed a demographic form, and 14.3% (37) declined completing or did not receive a demographic form.

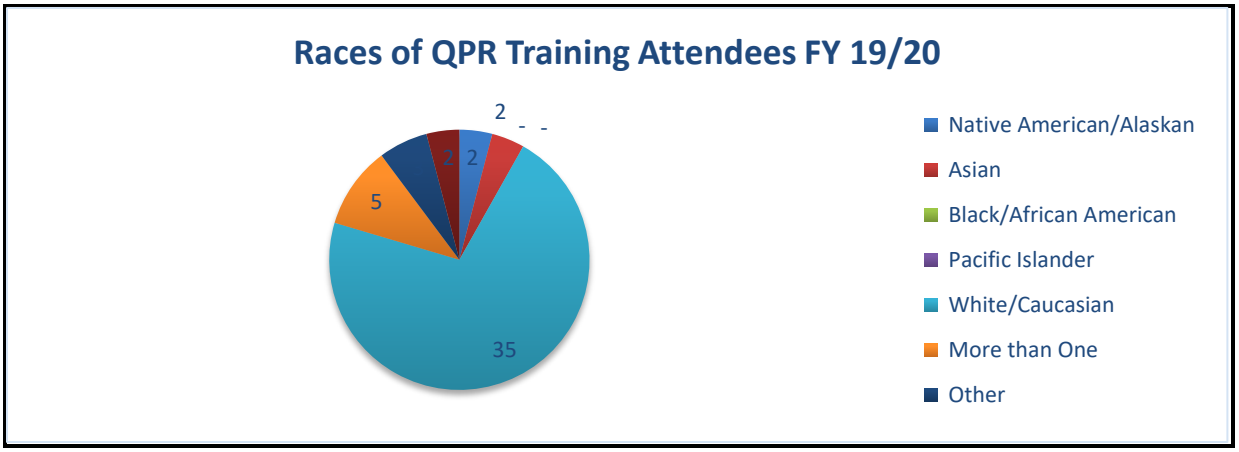
In Fiscal Year 19/20, 64 attendees at QPR trainings were ages 16-25, 134 attendees were ages 26-59, and 21 attendees were age 60+.



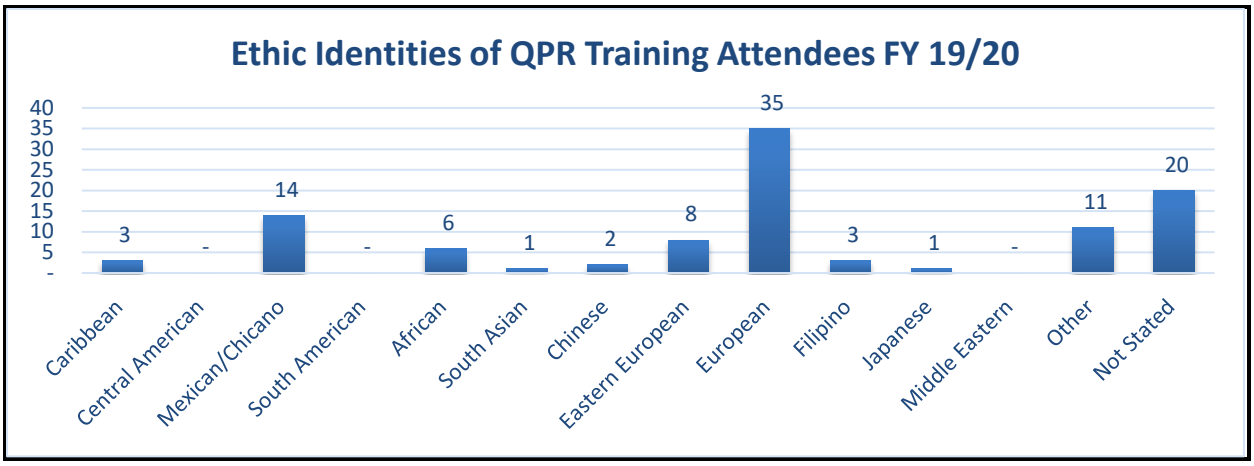
In Fiscal Year 19/20, 158 attendees at QPR trainings were female, 56 attendees were male, two attendee was transgender male and two were gender non-conforming.



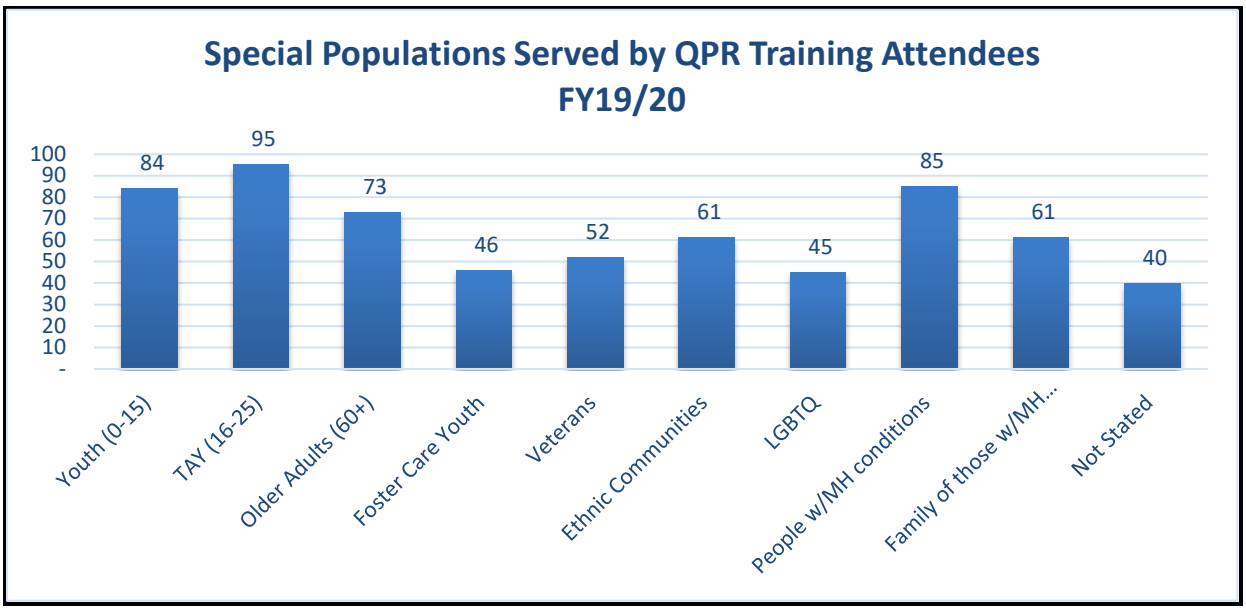
In fiscal year 19/20, 35 attendees at QPR trainings were White, two were Native American, five were multi-racial (More than One), two were Asian, three were Other. Twenty-two participants were Hispanic/ Latino.



In fiscal year 19/20, three attendees at QPR training attendees were Caribbean, two were Central American, 14 were Mexican/Chicano, six were African, one was South Asian, two were Chinese, eight were Eastern European, 35 were European, three were Filipino, one was were Japanese and eleven marked Other.



The populations served by the QPR attendees in fiscal year 19/20 were, 84 served youth 0-15, 95 served transition aged youth (TAY), 73 served Older Adults, 46 served Foster Care Youth, 52 served Veterans, 61 served ethnic communities, 45 served LGBTQ, 85 served people with mental health conditions, and 61 served family members of those with a mental health condition.



Outcome Measurements

- Number of trainings
- Number of participants
- Number of MHSA PEI Demographic Forms submitted
- Number of participants who reported increased in overall knowledge of suicide and suicide prevention (0-3 scale)

Actual Outcomes (FY2019-2020)

OUTCOMES	FY 2018-2019 N=
Number of Trainings	10
Number of Participants	230
Participants who reported increased overall knowledge with recognizing warning signs and behaviors associated with suicidality (0-3 scale)	141
Pre and Post Evaluation Results	% increase
Knowledge of facts about suicide prevention	50%
Knowledge of warning signs of suicide	50%
How to ask someone about suicide	50%
How to persuade someone to get help	50%
How to get help for someone	50%
Information about local, state, and national resources for help with suicide	50%
I feel comfortable discussing suicide with others	50%
Do you feel that asking someone about suicide is appropriate?	50%
Do you feel likely to ask someone about suicide?	50%
Rate your level of understanding about suicide and suicide prevention	NA

Challenges
It has been extremely challenging to meet community demand for QPR trainings due to COVID-19, reduced staff and transition to virtual training modalities.

Successes
QPR has reached many diverse settings in our community, and has been expanded to include lethal means safety content. The SSVP Program purchased a bundle of training licenses for LivingWorks Start Online Suicide Prevention Training to widely distribute throughout Humboldt County beginning in fiscal year 2020/2021.

Lessons Learned
Program training offerings have shifted from relying heavily on resources to provide in person opportunities with limited capacity to using virtual platforms to increase our reach and impact of suicide prevention education in our community.

LivingWorks Start Training - Online Basic Suicide Prevention
In times of heightened isolation and anxiety, people's thoughts of suicide can increase. Now more than ever, it is essential that we have effective skills to keep each other safe, even if it is from afar. To this end, the Stigma, Suicide, and Violence Prevention (SSVP) Program will share an online alternative to basic suicide prevention training in our community.

LivingWorks, the company known for creating the Applied Suicide Intervention Skills Training (ASIST), released their online basic suicide prevention training called LivingWorks START. Beginning spring 2020, the MHSA PEI funds were used to cover

the licensing fee and offering this online training in Humboldt County at no charge (valued at $30/person).

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

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

Like all of LivingWorks' core programs, LivingWorks Start is evidence-based. Here's what third-party evaluations of LivingWorks Start confirmed:

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

Target Population

- DHHS Staff
- Employers seeking to improve workforce ability to recognize signs and symptoms of suicide and/or potentially serious mental illness
- Social Services Agencies
- Shelter & Homeless Services
- Tribal Leaders
- Educators
- Elder Care Agencies & SNF’s
- General Community Members
- Department of Veterans Affairs
- Medical & Behavioral Health Care Staff
- Law Enforcement/First Responders

Key Activities

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

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

Outcome Measurements

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

Outcome Estimates for FY 2020-2023

- 650 licenses issued
- 400 accounts created
- 120 trainings completed
- 120 MHSA PEI Demographic Forms submitted

Project: Humboldt County Suicide Prevention Network

This continuing suicide prevention project also addresses stigma and discrimination reduction. The Humboldt County Suicide Prevention Network (SPN) is comprised of representation from community sectors, county agencies and community partners. DHHS-Public Health collaborates with service providing agencies in multiple sectors, including tribal and community health, clinical behavioral health, social services, hospice and palliative care. Primary agencies involved volunteer to present information or update the network regularly. SPN also works closely with the local chapter of the American Foundation for Suicide Prevention to help plan the Arcata Out of the Darkness Walk.

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

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

Target Population

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

Key Activities

- Coordinate community-wide activities and events

- Provide in-service training at each Network meeting to expand ability 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
- Community education and outreach
- Training and Workforce Development to increase capability to respond to persons at risk
- Data collection and surveillance
- Zero Suicide in Health and Behavioral Health Care Systems
- Email list-serve

Number of Individuals Served
Thirty-four unique participants, representing 20 agencies, attended Suicide Prevention Network meetings in fiscal year 2019-20.

Demographics of Individuals Served
Demographic forms are not administered during Suicide Prevention Network meetings.

Actual Outcomes (FY2019-2020)
- 20 agencies represented in network
- six meetings held annually
- 364 list serve participants

Challenges
One of the key partners supporting the Suicide Prevention Network has seen a reduction in funding and staff support for SPN due to the close of their suicide prevention grant. Additionally, many agencies are facing funding and staffing changes due to the COVID-19 pandemic which results in very limited capacity to prioritize SPN related tasks outside of the meetings.

Successes
The Suicide Prevention Network continues to expand in its meeting attendance. Through the use of Mailchimp, the Network has increased visibility in the community. Up to two emails go out monthly to a list of over 350 contacts on topics such as education, trainings, and evidence-based strategies for suicide prevention and intervention. The Network has rebranded with a new logo, mission statement and description that are shared via Mailchimp landing page. Educational or informative presentations take place during each meeting, drawing additional participants. Networking, relationship building and topic related education continue to be aspects of SPN that bring participants back every other month.

Lessons Learned

While funding and organizational capacity fluctuates, it is vital that a lead agency maintain the administrative functions of the SPN to ensure its continuation over time.

Project: Increased, Targeted Community Education and Outreach (formerly Capacity Building Assistance)
Increased, Targeted Community Education and Outreach goes beyond providing targeted education and training to enable individuals, organizations, systems to strengthen their ability to perform effectively in addressing problems focusing on stigma, suicide and violence prevention on the community level.

Targeted outreach and education supports and strengthens community partners who most need it. These include community-based organizations, educational institutions, and behavioral healthcare and health organizations via outreach for increasing recognition of early signs of mental illness and / or suicide and providing them with the hands-on skills they need to effectively intervene and refer:

Target Population
Organizational settings include:

- Health and Behavioral Health care providers
- Educational Institutions
- Workplace
- Peer support programs
- Faith communities

Key Activities

- Leverage resources to broaden the support network for unserved, underserved, and inappropriately served populations.
- Technical Assistance
    - Policy and Systems Level Change such as consultation on Zero Suicide Framework Implementation or leveraging local data to drive institutional change
- Workforce Development
    - Increase community trainer pool for PEI Training project offerings.
    - Supporting organizational staff in cultivating “in-house trainers” for basic suicide prevention or providing educators with the *Directing Change in the Classroom* Curriculum so they themselves can offer it to their students
    - Staff will provide efforts to expand community’s capability for suicide prevention trainings through consultation, “Train-the-Trainers”, and coordination of multi-disciplinary training teams. Training teams include public health educators, behavioral health clinicians, social workers, tribal community agency representatives, and law enforcement. In addition, tailored training for specific settings and populations are developed in coordination with requesting agencies, schools, and settings. Trainings

are designed using tools from statewide partners and other evidenced-based materials.

- Systems Change
    - Staff will provide support to community partners representing multi-sector settings including education, primary care, behavioral health, community-based and social services. The support will aid in the assessment of their capacity to develop and evaluate internal policies and procedures to address continuum of care Zero Suicide approach, Connecting the Dots framework or other.

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.

Outcome Measurements
Number of organizations or agencies served annually

Actual Outcomes (FY2019-20)
The number of organizations or agencies served during fiscal year 2019-20 was twelve, with 200 individuals. Organizations served include, K'ima:w Medical Center, Changing Tides Family Services, Two Feather Native American Family Services and Open Door Community Health Centers. This data includes Stigma and Discrimination Reduction Directing Change programming.

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
Working collaboratively to support an organization in meeting their training needs is a great way to network and build relationships in the community.

Project: Humboldt Suicide Fatality Review (SFR)
The Suicide Fatality Review Team (SFRT) is a multidisciplinary group of professionals who meet quarterly to learn more about the circumstances leading to suicide deaths in Humboldt. This group includes the Humboldt County Department of Health & Human Services (DHHS), Coroner's Office, health care professionals, and representatives from community agencies.

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

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

The SFR process:

- Collect uniform data and accurate statistics on suicide.
- Identify circumstances surrounding suicide deaths that will prevent future suicides.
- Promote collaboration and coordination among participating agencies to address mental illness early in its emergence, including the applicable negative outcomes listed in Welfare and Institutions Code Section 5840, subdivision (d) that may result from untreated mental illness.
- Implement cooperative protocols for the standard review of suicides.
- Provide a confidential forum for multiple agencies and disciplines.
- Identify and address system and community factors that contribute to suicide.

Target Population
Medical providers, healthcare administrators, and county leadership.

Key Activities

- Develop SFR protocols, policies and procedures
- Meet quarterly to review suicides and make recommendations based on findings
- Evaluate local suicidal behavior trends, circumstances, risk and protective factors to strengthen prevention efforts
- Educational presentation for Humboldt County medical and behavioral healthcare organizations. These presentations will familiarize stakeholders with the SFR and determine contacts for future involvement.
- Identify targeted systemic changes from data analysis of review meeting recommendations.
- Provide technical assistance to target audiences who need training working with healthcare providers, including training content development, guidance, SME, and resources.
- Present findings in conjunction with county epidemiologist that illuminates opportunity for system changes, including providing data to inform decision-making, offering trainings and alignment of shared objectives and deliverables among community partnerships.

Number of Individuals Served

- Three suicide death cases reviewed at September SFR Meeting
- Four suicide death cases reviewed at December SFR Meeting
- 10 participants serving 6 agencies/departments in September SFR Meeting
- 13 participants serving 9 agencies/departments in December SFR Meeting

The Suicide Consolidated Risk Assessment Profile (SCRAP) form continued to be used by the coroner's office throughout fiscal year 2019/20. However due to COVID-19 pandemic staff changes, data analysis was unable to be completed by the reporting deadline.

Demographics of Individuals Served
Demographic forms were not utilized during SFR due to time constraints.

Outcome Measurements
- Number of SFR meetings held
- Number of participants involved
- Number of suicide death cases reviewed
- Key findings and follow-up actions

Actual Outcomes (FY2019-2020)
- 2 SFR meetings held
- 23 participants involved
- 7 suicide death cases reviewed
- Key findings and follow-up actions
    - Preliminary participant recommendation themes include: screening, training, outreach, expanding services, follow-up, provider engagement, policy and recommended standards of care.

Challenges
Staff adapted to staffing and operational changes due to COVID-19, including transitioning to virtual meeting format, completing case reviews, and a reduction in core team staff.

Successes
The partnership with the Coroner's office has been extremely beneficial. While adapting to staffing changes, program staff have restructured the data methods and collection process for capturing recommendations from participants. The SFR is HIPAA compliant and has streamlined the release of information process and outreach to next of kin. Staff have created promotional materials, including a brochure explaining the process, purpose and mission of the SFR. The SFR has garnered public media attention in print, online, and press releases.

Project: Lethal Means Safety
Lethal Means Safety initially consisted of the Lock Up Your Lethals campaign which was a brochure (see Lock Up Your Lethals / Keep It Safe section). It now consists of:

- Keep It Safe, a public health educational campaign for any and all audiences
- Lethal Means Safety, a practice-based training module that can accompany any suicide prevention training or be provided independently to those with previous baseline knowledge
- Gun Shop Project, a new and growing collaboration between Humboldt County Public Health and local gun retailers, trainers, and range owners. This project includes a Lockbox Distribution Program.
- Nationwide 45% of people who die by suicide saw their primary care provider within the last 30 days. In Humboldt County the findings are more stark: about a third {29% (55/191)} of the people who died by suicide had a known date of their last health care visit. Of those, 51% (28/55) had a healthcare visit less than 10 days before their death. (2013-2018 Retrospective Study. Based this data, the Lethal Means Safety Project, through provider outreach will encourage discussion of means safety and promotion of lockbox distribution program.

Key Activities

- Keep It Safe
    - Keep It Safe is a revision of the previous Lock Up Your Lethals campaign. The new Keep It Safe is a brochure was developed with the goal of reaching expanded audiences on the topic of safe storage of potentially dangerous items. The target audience are all housed community members. Keep it Safe is about starting a conversation with Humboldt County residents about protecting their loved ones from preventable injury.
    - Similar to the Lock Up Your Lethal campaign, Keep It Safe addresses common items found in homes that could be dangerous such as: medications, alcohol, firearms, cannabis products and anything else that can be used to get high or harm oneself. The Keep It Safe campaign brochure will be distributed in local community service agencies including, medical and behavioral health care setting.
- Lethal Means Safety – Training Module
    - Lethal Means Safety – Training Module, is an add-on or stand-alone training module that teaches participants about environmental safety. The target population is anyone who takes a suicide prevention training and/or those who provide direct services. Over the FY2020-2021, the populations to be targeted with Lethal Means Safety presentation will include: medical and behavioral health care providers, social workers, tribal leaders, law enforcement and first responders, firearms retailers, trainers and range owners, and pharmacists.
    - This practice-based presentation will involve:
        - data around lethal means, overdose, and suicide
        - safety planning
        - harm reduction strategies for increasing safety and reducing risk

        - resources to learn more or seek help
        - instructions on how to utilize the Public Health Lockbox Program for self or clients served
- Gun Shop Project
    - The Gun Shop Project is a new and growing collaboration between Humboldt County Public Health and local gun retailers, trainers, and range owners. During FY2020-21, this project will involve local firearms retailers sharing lethal means safety information with customers. They will discuss safe firearm storage, offer pistol lockboxes, and include mental health and suicide prevention resources with lockbox distribution.

Outcome Measurements

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

Prevention & Early Intervention: Stigma and Discrimination Reduction

Due to funding reallocation, the SSVP Program will no longer offer many components of the Stigma and Discrimination Reduction program. Beginning in fiscal year 2020/2021, activities have been descoped from the SSVP program entirely or absorbed into the suicide prevention activities.

Project: Prevention and Early Intervention Training

The Prevention and Early Intervention Training project incorporates Suicide Prevention and Stigma and Discrimination Reduction (SDR) supported trainings. SSVP Program staff serve as coordinator, trainer and/or support for the offered trainings. The SDR staff coordinates and facilitates the evidence-based trainings Adult Mental Health First Aid Training and Youth Mental Health First Aid Training and the practiced-based Mental Health 101 Training.

Adult/Youth Mental Health First Aid Training

This a continuing stigma and discrimination reduction project for adults providing targeted education and training. The Mental Health First Aid (MHFA) training focuses on mental illness stigma reduction, and on community education to intervene earlier in behavioral health crisis.

The SSVP Program delivers training to providers, individuals, and other caregivers who live and/or work in Humboldt County. 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 behavioral health crisis in the community, and to reduce the stigma associated with behavioral illness.

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

Mental Health First Aid and Youth Mental Health First Aid are each eight-hour courses designed to teach individuals in the community how to help someone who is developing a behavioral health problem or experiencing a behavioral health crisis. Trainees are taught about the signs and symptoms of behavioral illness, including anxiety, depression, suicide, psychosis, and substance use.

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

- Increases understanding of behavioral 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 behavioral health disorders
- Increases skills for responding to people with signs of behavioral illness and connecting individual to services
- Increases knowledge of resources available

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 behavioral health or substance use problems, or are in behavioral 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.

MHFA trainings are offered throughout the community. 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.

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 behavioral illness. Includes: 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.

Key Activities

- Training community and family members to recognize the signs of persons in need of behavioral health support, who are at risk of suicide and those who are at risk of developing a behavioral 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

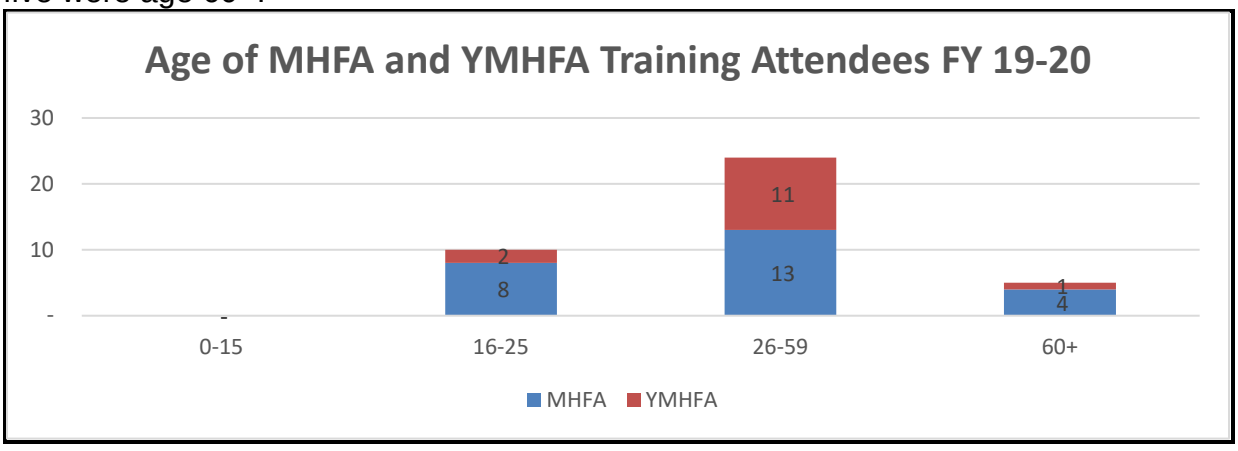
Number of Individuals Served

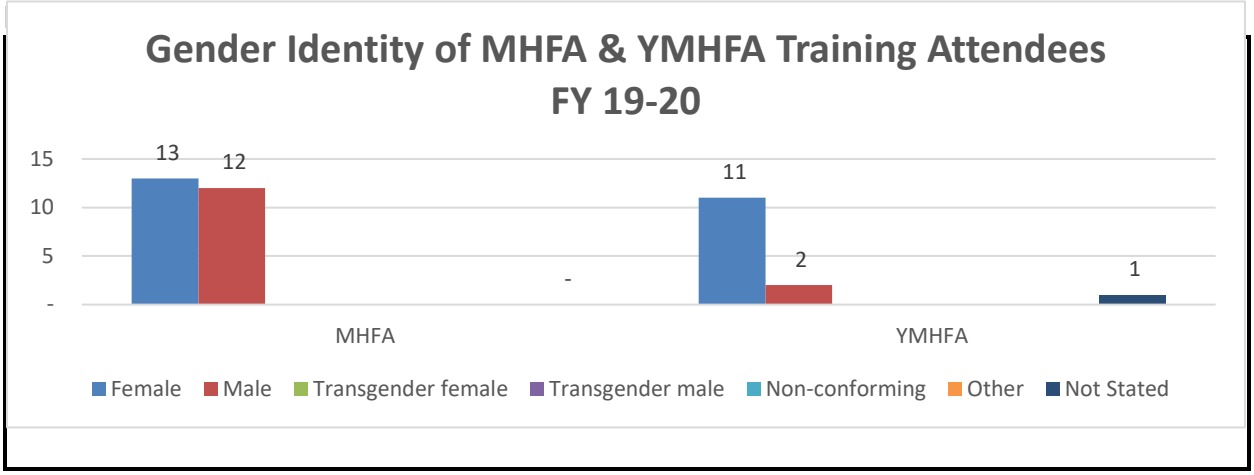
In FY 2019-20, forty-four individuals attended two Mental Health First Aid and Youth Mental Health trainings. Subsequent trainings scheduled for the fiscal year were canceled due to the COVID-19 pandemic and insufficient number of trainers available from the trainer pool.

Demographics of Individuals Served

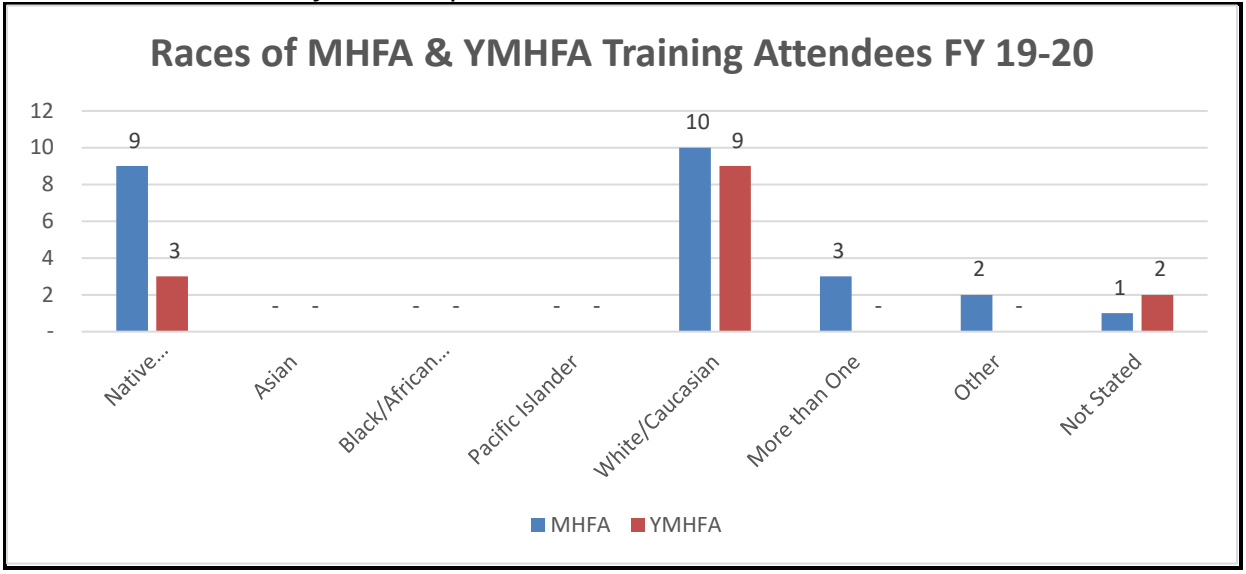
Demographic information comes from attendees at trainings who complete a demographic form. In Fiscal Year 19/20, 88.6% (39) of attendees completed a demographic form, and 11.4% (5) declined completing a demographic form.

In Fiscal Year 19/20, ten attendees were ages 16-25, twenty-four were ages 26-59, and five were age 60+.

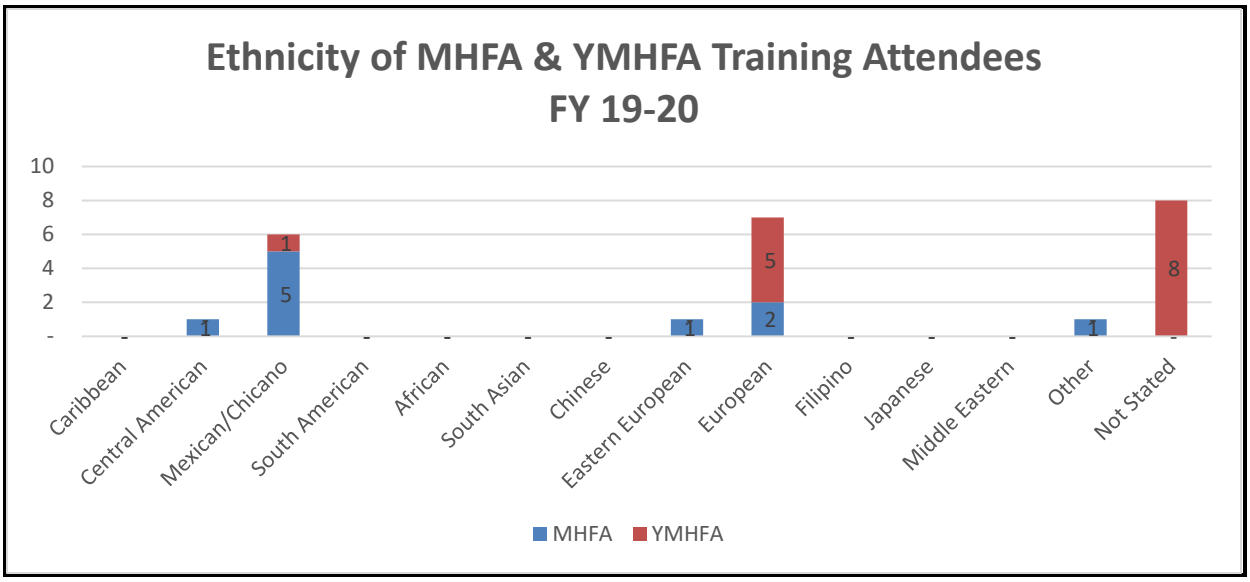




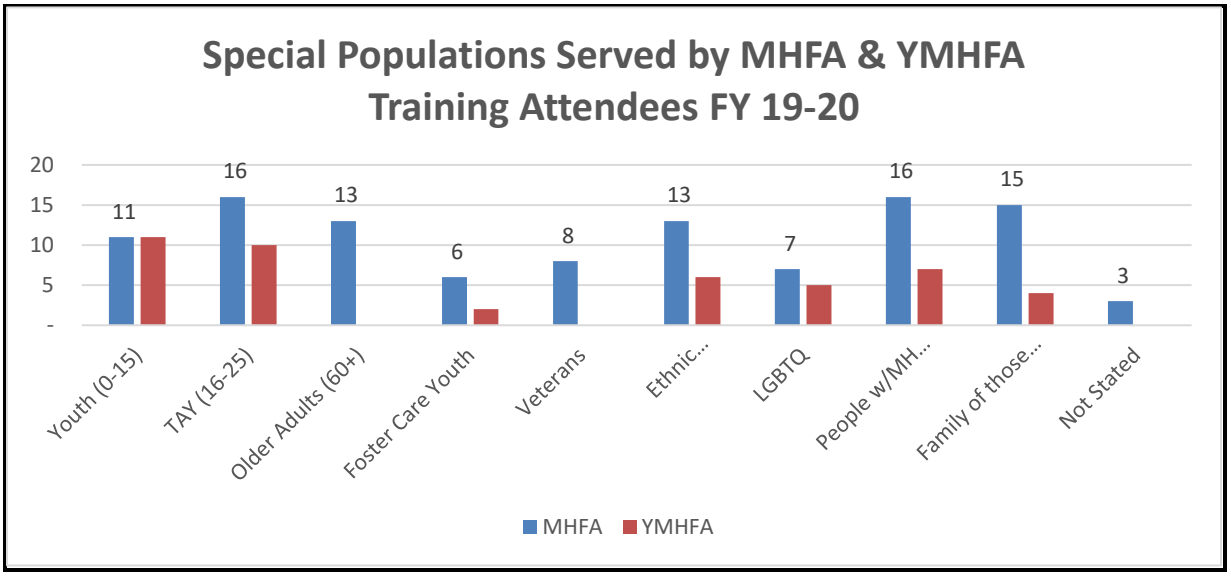
In Fiscal Year 19/20, nineteen attendees were White, twelve were Native American, three were More than One (multi-racial), and two were Other. Eight participants indicated their ethnicity was Hispanic/Latino.



In fiscal year 19/20, one was Central American, six were Mexican/Chicano, one was Eastern European seven were European, and one marked Other.



In fiscal year 19/20, the special populations served by the attendees at the MHFA and YMFA trainings were, twenty-two served youth ages 0-15, twenty-six served transition-aged youth (TAY) ages 16-25, thirteen served Older Adults, eight served Foster Care Youth, eight served Veterans, nineteen served Ethnic Communities, twelve served LGBTQ, twenty-three served people with mental health conditions and nineteen served family members of people with mental health conditions.



Outcome Measurements

- MHFA and YMHFA evaluation forms
- Demographic forms
- Number of Adult and Youth MHFA trainings
- Number of community members that participated in Adult MHFA trainings
- Number of community members that participated in Youth MHFA trainings

- Total number of participants
- Number of participants who reported
    - Increase knowledge of behavioral health signs and symptoms and reduced negative attitudes and beliefs about persons experiencing behavioral health challenges

Actual Outcomes (FY2019-2020)

- One Adult and one Youth MHFA training
- 28 community members that participated in Adult MHFA trainings
- 16 community members that participated in Youth MHFA trainings
- 44 total participants

Challenges

The biggest challenge is capacity to offer enough trainings to meet community requests. One reason being, we have a small training team and 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 is not in charge of the registration process for YMHFA or MHFA.

Project: Increased, Targeted Community Education and Outreach (formerly Directing Change)

Youth Serving Providers

The implementation of district level policy in response to AB2246/EC215 has resulted in greater demand for school presentations on the topics of mental/behavioral health and suicide prevention. In an effort to meet the demand, the Stigma and Discrimination Reduction Program, with support of the Suicide Prevention Program, will offer increased education and outreach targeting schools serving grades 7-12 in Humboldt County. The SDP and SP programs will share curriculum teachers can use to start conversations about mental/behavioral health and suicide prevention, share resources, and promote the Statewide Directing Change Film Contest. The curriculum uses the informational slides, Directing Change films, guided discussion with questions for the students, as well as options for supplemental activities.

The Directing Change films previously mentioned are part of 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 films are designed to raise awareness around suicide prevention and reduce stigma and discrimination related to mental/behavioral illness. Directing Change is a culturally specific social marketing campaign that provides

targeted education and training to youth. It seeks to combat multiple stigmas that have been shown to discourage individuals from seeking mental/behavioral health services. It also aims to encourage acceptance for individuals with a mental/behavioral illness and addresses the negative outcome of prolonged suffering.

Target Population
The target audience for this project for is anyone working with 7th-12th grade youth in a group or classroom setting (educators, administrators, afterschool programs, etc.).

Key Activities

- Engage adolescents, transitional age youth and adults in creating and viewing films
- Promote local Reframe Your Brain Poster Contest and Statewide Directing Change Film Contest to schools and youth groups throughout Humboldt County through classroom 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 behavioral health, suicide, and cultural considerations in various targeted and community formats, i.e., trainings, community events.

Demographics of Individuals Serve
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 is not feasible. Directing Change presentations were delivered to students, teachers and administrators at local high schools.

Outcome Measurements
The number of youth-serving sites across the county who utilize this service will be the outcome measure.

Actual Outcomes (FY2019-2020)
Eight youth-serving sites across the county who utilized this service, with 155 individuals, during fiscal year 2019-20. Youth serving sites services include Northern United Humboldt Charter Schools (Eureka and Arcata sites), Redwood Preparatory Charter, Fortuna High School and Eureka High School. This data includes Suicide Prevention programming.

Challenges
Many of the classes and students who participated in Directing Change did not submit their films to the statewide contest.

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. Staff transitioned from student classroom presentations to teacher presentations to increase capacity for facilitation opportunities. The films provide students with opportunities for students to discuss and learn about suicide prevention, stigma and discrimination reduction and positive mental health 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: 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 Behavioral illness. It addresses the negative outcomes of suicide and prolonged suffering.

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

Target Population
- All Humboldt County residents will be reached with the social marketing efforts.

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
- Coordinate Awareness Month events with community partners

Communication Channels
- Email Messaging
    - Distribution List: maintained educational connections made with training participants and with individuals in the community through an email list.

    - Content: Emails shared state content and other social marketing initiatives, promote local PEI activities (including awareness months) and highlight resources for behavioral health and suicide prevention.
- Public Service Announcements (PSAs)
    - PSAs promoted social marketing campaigns and program objectives through local radio stations. PSA content included local state and national public health campaigns. Each Mind Matters, Know the Signs, Lock Up your Lethals information, awareness month resources and messaging and ads targeting stigma and help-seeking.
- Website
    - The new SSVP program website is in development. It will integrate former Suicide Prevention and Violence Prevention programing. Due to funding reallocations, the SDR content will not be included in further content development. Content will consist of programmatic activities, population specific resources, training promotion and public health information. Additionally, SSVP content will be disseminated though the DHHS webpage.

<u>Marketing Content</u>

- Media Campaigns and Toolkits
    - SSVP 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.
- Keep It Safe Campaign (previously Lock Up Your Lethals)
    - The new Keep It Safe brochure was developed with the goal of reaching expanded audiences on the topic of safe storage of potentially dangerous items. The target audience is any and everyone in the community living in homes. Keep it Safe is about starting a conversation with Humboldt County residents about protection our loved ones from preventable injury. Similar to the Lock Up Your Lethal campaign, Keep It Safe addresses common items found in homes that could be dangerous such as: medications, alcohol, firearms, and anything else that can be used to get high. Keep it Safe evolved from the Lock Up Your Lethals campaign to also include cannabis products.
- Awareness Months
    - SSVP will continued to collaborate with community partners on awareness month campaigns throughout the year. The intention was to raise awareness on suicide prevention and its intersection with various health disparities. Staff coordinated community efforts and events.
    - Events will include:

        - May is Mental Health Matters Month (due to the COIVD-19 pandemic, this was not executed by the SSVP team).
        - Suicide Prevention Month: including the local chapter of the American Foundation for Suicide Prevention Community Walk
        - Sexual Assault and Child Abuse Awareness Month
        - Domestic Violence Awareness Month
- ReFrame Your Brain Poster Contest
    - SSVP began 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 behavioral health (their own or in support of those who live with behavioral health problems.) Online platforms were utilized to promote the contest, which expanded our reach to the outskirts of our rural county. Digital entries, online voting, and virtual art shows allowed the contest to reach higher numbers of community members with messages of hope and recovery. Due to the COVID-19 pandemic, the contest was not completed. Beginning in fiscal year 2020-21 this contest will no longer be housed within the SSVP program.

Demographics of Individuals Served
Demographic information is not currently collected through social marketing campaigns.

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

- Number of annual page views for DHHS SSVP Program website
- Number of ReFrame Your Brain Poster Contest Entries
- Audience reached by radio PSAs (estimated)
- Number of Email list emails opened

Actual Outcomes (FY2019-2020)

- 869 annual page views for DHHS SSVP Program website
- Eleven ReFrame Your Brain Poster Contest Entries
- 61,000 people reached by radio PSAs (estimated)
- 1,602 Email list emails opened

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)

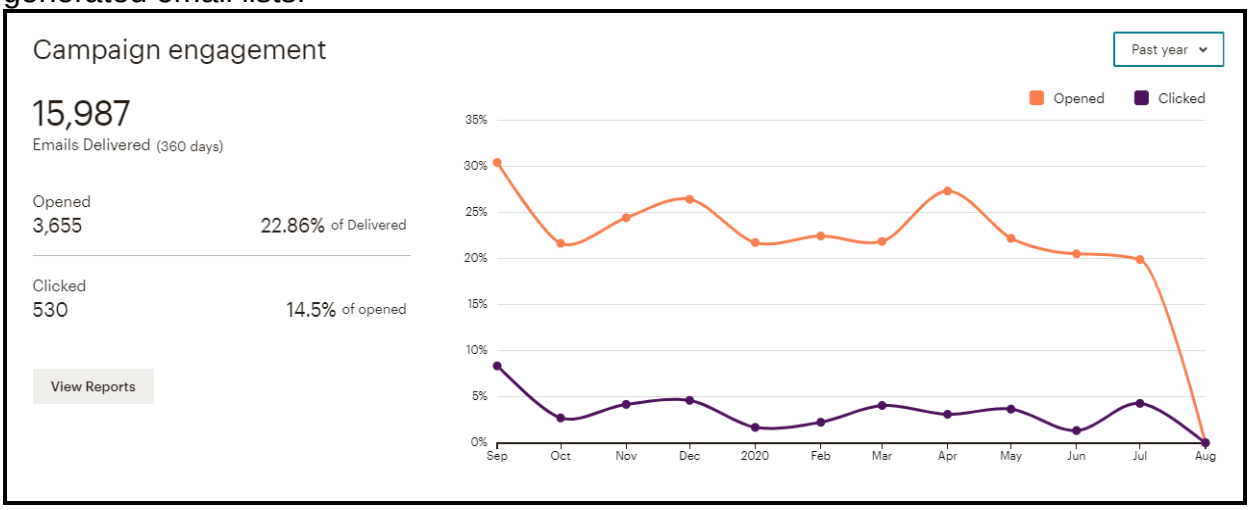
DHHS Website Analytics

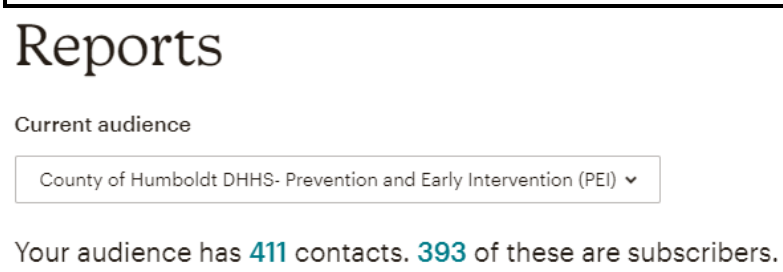
DHHS Website - Suicide Prevention & Stigma Reduction Page Analytics

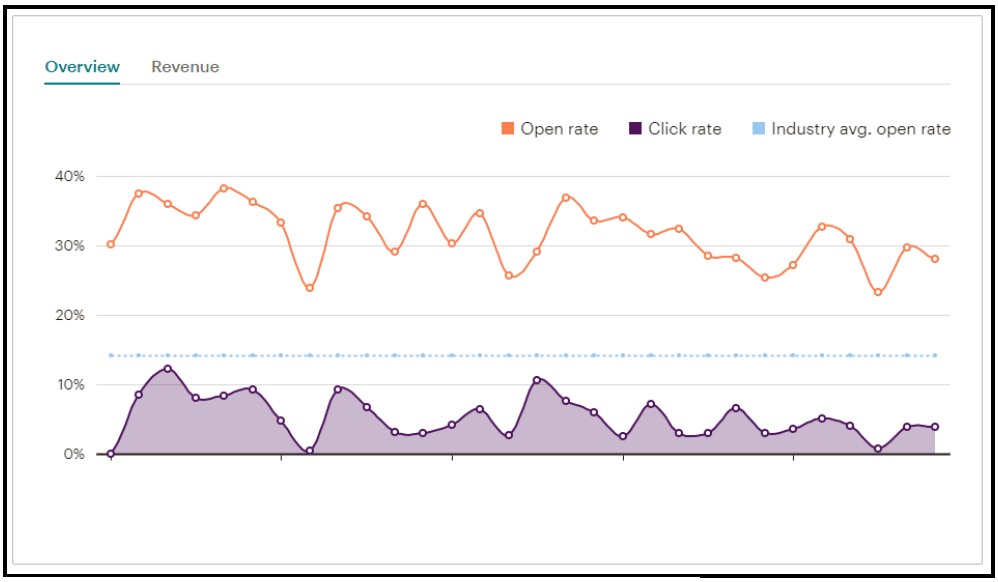
FY 2019-2020 (7/1/2019 - 6/30/2020)

URL	Page Views	Unique Page Views
https://humboldtgov.org/2047/Suicide-Prevention-Program	869	725
https://humboldtgov.org/2096/Suicide-Prevention-Resources	303	220
https://humboldtgov.org/2074/Suicide-Prevention-Training	231	192
https://humboldtgov.org/2095/Reducing-Access-to-Lethal-Means	88	60
https://humboldtgov.org/2075/Technical-Support-and-Capacity	41	35
https://humboldtgov.org/2048/Stigma-and-Discrimination-Reduction-Prog	67	58

Email Lists: Two email lists were utilized during the FY 2019-2020: one focusing on mental health topics in general, and another focused on suicide prevention activities. At the completion of FY 2019-2020, the PEI email list had 411 contacts and the Suicide Prevention Network (SPN) email list had 363 contacts, for a grand total of 774 contacts. A total of 18,053 emails were successfully delivered, which is three times the number of email sent in the previous fiscal year and far exceeds our expected outcomes. Emails had an average "open rate" of 27.31%, which is above industry standard for government generated email lists.





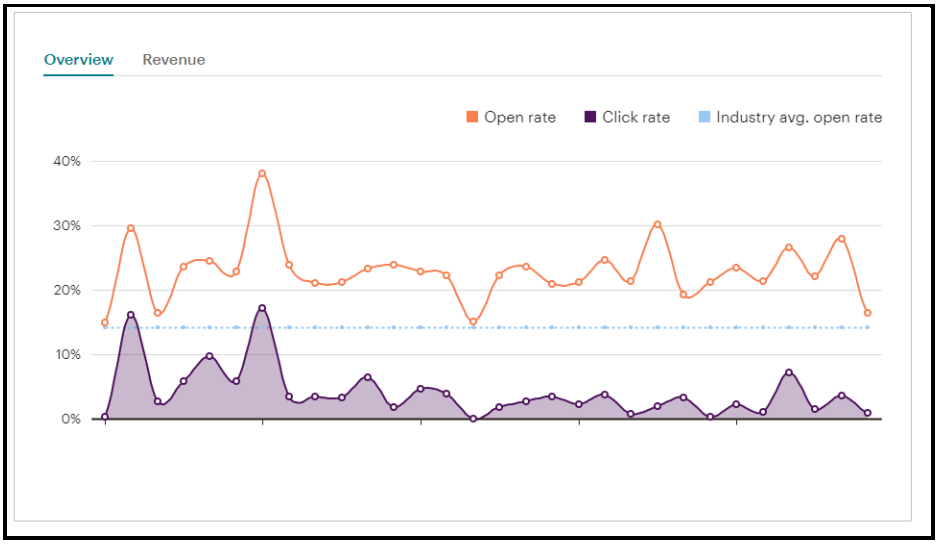


Reports

Current audience

Suicide Prevention Network

Your audience has 363 contacts. 343 of these are subscribers.



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 are 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 SSVP program social marketing. Statewide RAND evaluations show EMM campaigns are associated with more adults using mental health services.

Successes
It has been helpful to use State and National messaging campaigns that have already been tested for efficacy.

Lessons Learned
The SSVP program has designed local social media toolkits for targeted populations. Email messaging through social marketing platforms such as Mailchimp, has streamlined our process and improved data analytics on engagement.

Project: Artistic Solutions
Artistic Solutions is a locally developed project based on the direct contact approach model that provides groups for people 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 artwork 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 behavioral health challenges and reduce stigma and discrimination.

Target Population
Transitional age youth, adults and older adults with lived experience, including survivors of suicide loss. This community program includes underserved people, including LGBTQ, Native American, Latino and women populations.

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

Number of Individuals Served: Not collected.

Demographics of Individuals Served: Demographics forms are not collected.

Outcome Measurements
- Number of workshops held
- Number of workshop participants
- Number of display locations and/or outreach events

Actual Outcomes (FY2019-2020)
Due to the COVID-19 pandemic, access to data on actual outcomes is unavailable at this time.

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

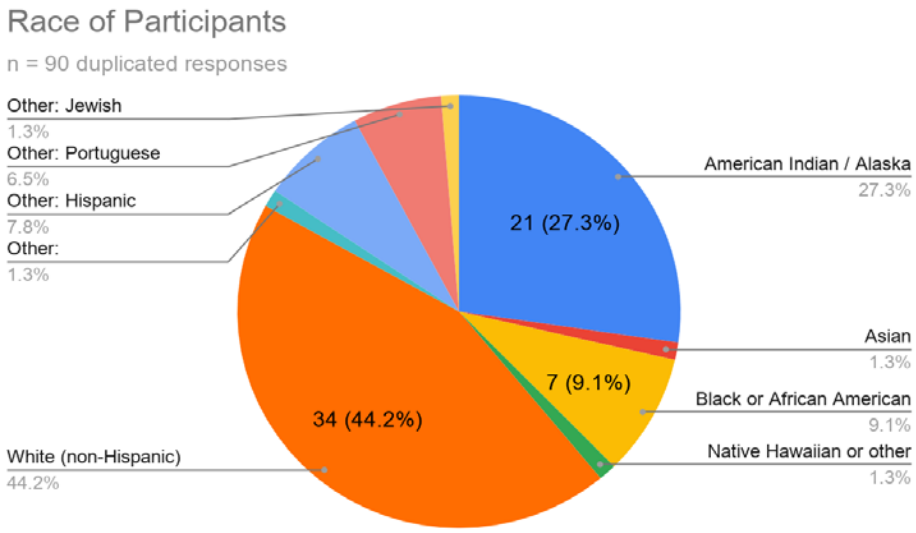
Successes
Artistic Solutions groups are held at the peer run Hope Center, Healthy Mom's, a Substance Use Disorder treatment program, HumWORKS and Hoopa Native Wellness. Groups provide a safe, supportive environment for persons with severe mental illness.

Prevention & Early Intervention: TAY Advocacy and Peer Support

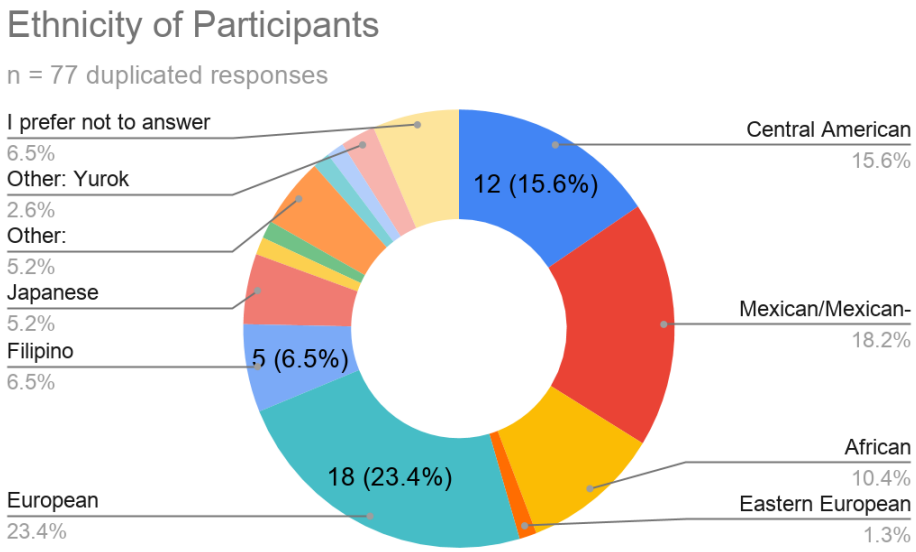
There are two components to this Prevention and Early Intervention Program: TAY Advocacy, through the Humboldt County Transition Age Youth Collaboration (HCTAYC), and TAY Peer Coaches. Both components serve youth and young adults ages 16-26 years old, and both components are a part of the Humboldt County DHHS Transition-Age Youth (TAY) Division.

TAY Advocacy-HCTAYC
During 2019-2020 HCTAYC served 28 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, COVID-19 digital platforms, or staff error. It is estimated that HCTAYC has served at least 45 unique individuals in the reporting period. The following charts provide information obtained from demographic forms completed by individuals participating in HCTAYC activities. These are duplicated, not unduplicated, responses.

Forty-four percent of participants were White, non-Hispanic; 27% were American Indian/Alaska Native, representing Yaqui, Yurok, Bear River, Wiyot, and Sioux tribes. Nine percent were Black/African American. Hispanic/Latinx participants were almost 8%, 1% were Asian, 1% were Native Hawaiian or other Pacific Islander, and 8% were other.



Roughly 18% of participants indicated their ethnicity as Mexican/Mexican American. 10% African. Over 23% of participants indicated their ethnic identity as European. Five percent indicated Other, without specifying the category, similarly for Japanese. Nearly 16 percent said Central American, nearly 7% said Filipino, nearly 3% said Yurok, roughly 1% said Eastern European.

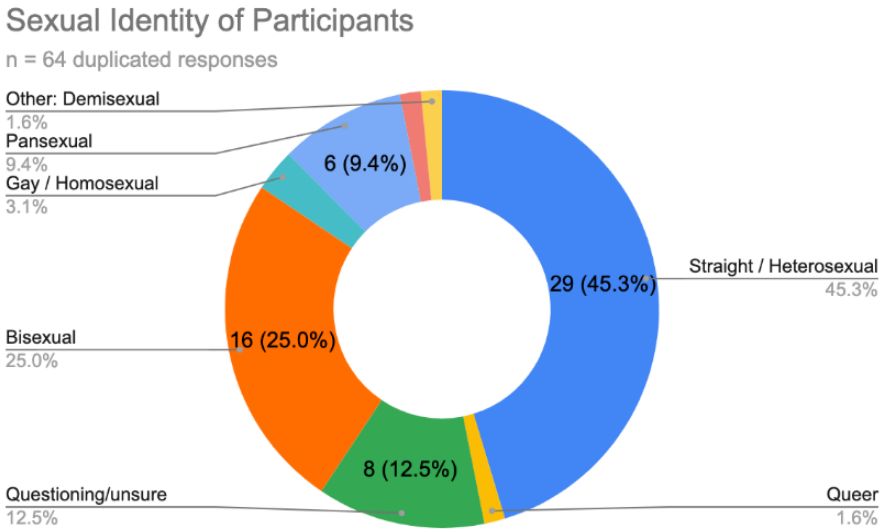


The primary language of participants was roughly 97% English, with the rest of responses evenly divided between Spanish and Hmong.

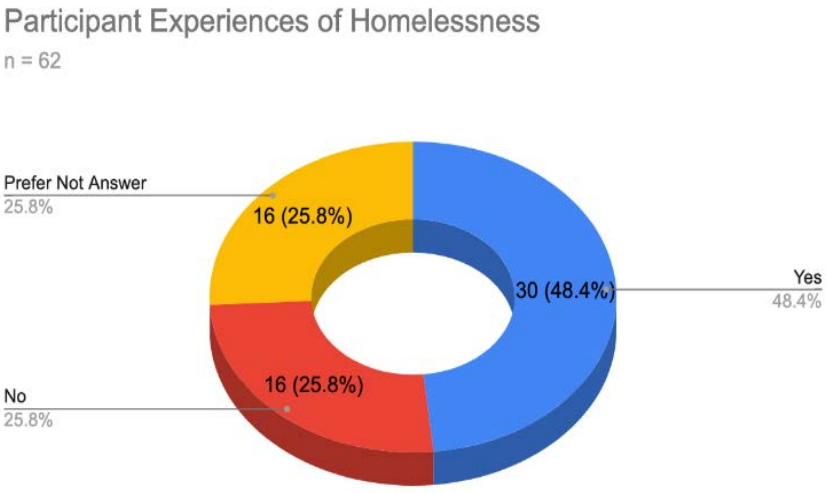
One participant was age 16 or younger, 22 were ages 16-18, and 38 were ages 19-25.

Fourteen participants stated their assigned sex at birth was male; 42 stated female, and 16 preferred not to answer. Their current gender identities were 14 male; 29 female; 2 prefer not to answer; 5 trans male; 9 questioning/unsure, 1 trans female, 1 genderqueer, and 1 other.

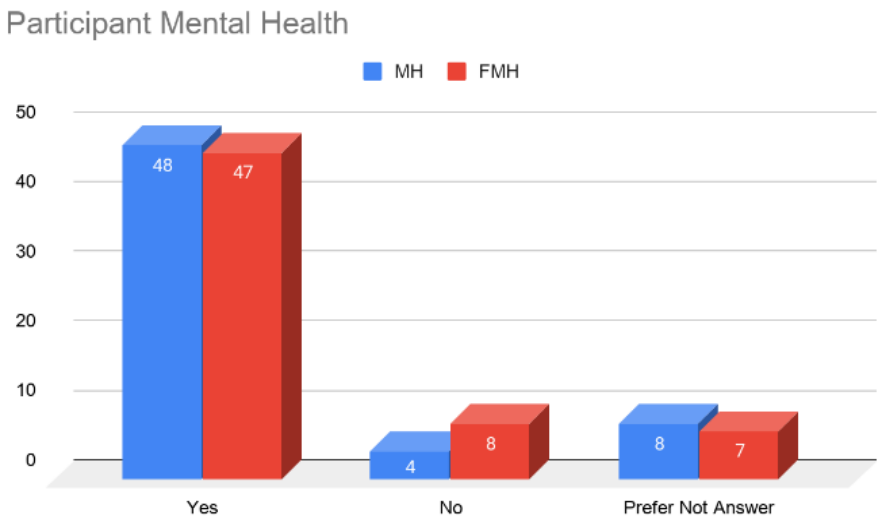
45.3% identified as straight / heterosexual 35% bisexual, 9.4% pansexual, 3.1% gay/homosexual, 12.5% questions/unsure, one participant chose queer, and one other participant chose demisexual.



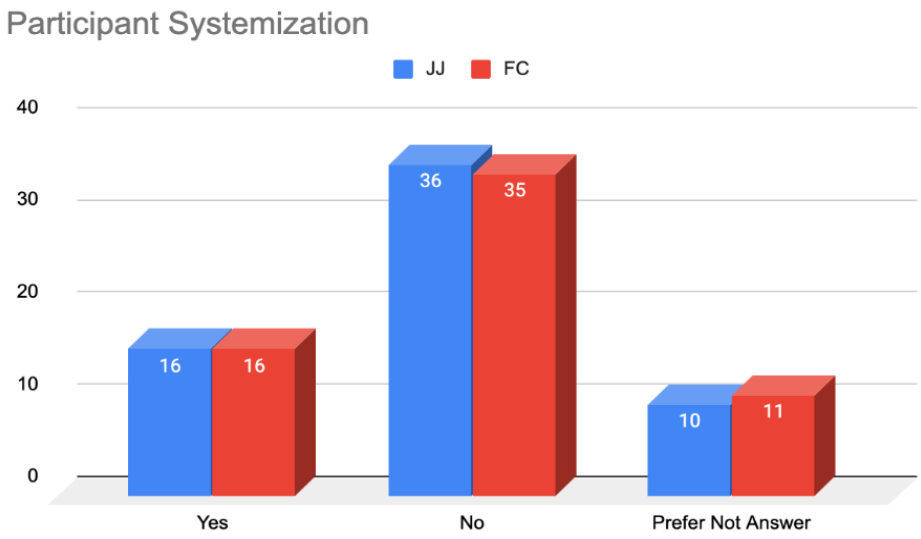
Forty-eight percent had experience with homelessness, 26% did not, and 26% preferred not to answer.



48 participants stated they had a personal mental health condition, 4 stated they did not, while 8 preferred not to answer. 47 stated they have a family member with a mental health condition,8 stated they did not, and 7 preferred not to answer.



Sixteen participants reported involvement in foster care and/or the child welfare systems, 35 did not have this involvement, and 11 preferred not to answer. 16 participants reported involvement in the juvenile justice system, 36 did not have this involvement, and 10 preferred not to answer.



The majority of participants resided in the McKinleyville area, followed by Eureka, and distantly Arcata and Fortuna. A few residents resided in Ferndale, Willow Creek or Hoopa, and Garberville / Redway.

Actual Outcomes for Fiscal Year 2019-2020:

Foremost the youth participants voted to change the name of the Youth Board to Youth Advocacy Board from Youth Advisory Board.

Due to staffing limitations and the COVID-19 pandemic, the data for Leadership Development in this timeframe is not yet accessible for analysis or report. 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 once again.

The size of consistently involved YAB members has decreased somewhat during this period as a result of the COVID-19 pandemic, to roughly ten consistent participants. Five youth-leadership develop trainings were provided to youth people: Focus Group Facilitation, Local Policy Campaign Development, YAB Orientation & Professional Development, Youth Professional Wellness, Youth-Driven Curriculum Develop, and Youth Leadership Qualities Intensive.

The Committee-led projects' execution fell within this reporting period, with two activities successfully executed. Planned were Woke As Friends LGBTQ+ Cultural Art and Identity Exploration Workshop Series, the TAYvivor community development challenge. Additionally, several other youth-lead workshops were planned during this period, but due to difficulties of coordination and the COVID-19 pandemic, these were unable to successfully occur.

Continued progress has been made regarding the implementation of the AOD Policy Recommendations, including the shift of outpatient youth SUD treatment space, structure, and significant improvements related to its staffing and supervision. Additionally, HCTAYC has led a regional youth substance use prevention campaign and provided a significant amount of work in this endeavor within this reporting period with the campaign launching during the next reporting period. YAB members and HCTAYC staff have also participated in the creation of a community council for the accountable communities for health initiative and provided leadership and guidance regarding the creation of mini-grants for community organizations working on issues of substance misuse/abuse prevention. Complete implementation of the policy recommendations has still not been completed, however, HCTAYC is beginning to scale back focus on this topic as other campaigns and initiatives require attention.

Data gathering for the LGBTQ+ Policy recommendations continued through this reporting period, with over 15 individual interviews and focus groups occurring, with the end of this process estimated to conclude sometime during the next reporting period leading to the subsequent creation and beginning of the implementation of the policy recommendations.

Challenges:
In March of 2020, COVID-19 required HCTAYC to shift its operational practices to remote platforms. Youth Advocacy Board meetings moved to Zoom. Trainings and retreats went virtual. Data gathering for the LBGTQ+ Policy Recommendations slowed

down as staff explored creative ways to continue to gather data and hold focus groups. An increased focus on virtual project management and collaboration has been the focus of this period, shifting key work dynamics and operational procedures that have required significant effort on the part of program staff. The pandemic has also provided challenges to the engagement and retainment of youth leaders and relationship consistency with partners. Prior to the pandemic, Humboldt County was impacted by several public safety power shut-offs that contributed to resource scarcity and instability for young people and staff. A significant amount of staffing time was invested in responding to these crises and trying to support young people in disaster response and preparedness. Another challenge to this period was the lead youth organizer beginning graduate school.

Successes:
HCTAYC has proven to be incredibly resilient in weathering these crises. Staff have been formidable in their ability to pinpoint youth needs and provide individualized support to them, providing the development of significant problems for the youth participants of the program. Adaptation to the needs of the pandemic have been successful in being implemented, with digital platforms being easily adopted by staff and youth. Implementation of youth organizer specializations has led to an increase in efficiency and accomplishments.

Lessons Learned:
The previous structure, especially when down some members of the YAB, stretched the capacity of the staff and youth too thin. Data collection needs to be consistent and timely to work and is difficult to prioritize when there are too many ongoing projects and disasters. Having multiple, specialized staff makes it easier to accomplish core programming but new staff take a considerable amount of time and effort to onboard to a level of competence needed for such a complex and storied program.

TAY Peer Support

Demographics and Unduplicated Number of Individuals Served:
There were 1,742 young people that participated in 199 drop-in or workshop events from July 1, 2019 to June 30, 2020. Of those, 223 were unique participants during July 1, 2019 to June 30, 2020. There were 53 referrals for peer coaching during the reporting year for individual mentorship. Each of these 53 referrals were assigned a peer coach who provided outreach and offered individual mentorship.

There is no voluntary confidential demographic information available for TAY peer support for this reporting period. For the first six months of the reporting period, the assigned shared supervisor was on leave and a temporary supervisor was assigned. Analyst assignments for this reporting year changed hands a few times and tracking, knowledge of program needs, and data collection were lost. Few peer run workshops were held between January 2020-June 2020 due to COVID-19, and for those workshops that did occur, only two demographic forms were returned.

Actual Outcomes for Fiscal Year 2019-2020: Peer coach staffing levels did not remain fully staffed due to: 1) staff going out on leave, 2) COVID-19 related leave.

March 2020-June 2020, staffing consisted of one lead peer coach III position and two full time peer coach II positions. All peer coaches have completed documentation training linking direct services to electronic medical records. Peer coaches have planned and managed pro-social activities. Peer coaches have continued to provide individual mentorship through engagement in the drop-in TAY Center or by referral.

Training Peer Coaches Attended:

- TIP-Transition to Independence Process
- Medical billing and documentation
- Certified Peer support specialist certification through Recovery International (RI)
- Strength building workshop

Peer Coaches Provided Outreach to:

- Juvenile and Adult Probation Services: Juvenile Hall and Humboldt County Correctional Facility-Jail
- Sempervirens and the Crisis Stabilization Unit
- Eureka Resource Center-ERC school
- Street outreach
- Eureka Family Resource Center
- Teen Court

Peer Led/Supported Activities, Workshops, Groups and Events

- Mommy and Me Parenting Skills Group
- Role Play Group
- TAY rafting trip
- “Work it Wednesday” workshop
- “The power of your story” workshop
- TAY BBQ
- Food demonstrations
- Cookie decorating and community building
- Suicide prevention sign making
- Improvisation workshop
- Self-care workshops
- Fall Decorating, including build your own caramel apple, pumpkin patch, and Halloween party
- Hand washing demonstration
- TAY Fall feast community event
- Cider making demonstration
- Holiday craft making
- Holiday decorating
- Holiday youth variety talent show
- Acrylic paint workshop
- Take a hike workshop
- The mask you wear workshop-cancelled due to COVID
- Tie-Dye workshop-Canceled due to COVID

Challenges:
Supervision of peer coaches was split this reporting year as the assigned supervisor was out on leave. Being unfamiliar with MHSA TAY peer support reporting needs, unique challenges to supervising a peer team, and the pandemic all impacted outcome collection. A change in analysts assigned to this program also occurred this reporting period, and lack of knowledge of reporting needs, and inconsistent oversight of data collected and tracked also contributed to challenges with reporting, especially with gathering, tracking and analyzing demographic information.

Successes:
Peer coach staff have remained resilient and focused despite the pandemic that changed so much of their work. Staff have continued to provide direct service, either virtually, by phone or in person, run a drop-in center with safety measures in place, and provide space for young people to connect using virtual platforms. Staff have been creative in outreach and presentations, giving virtual tours of TAY while sharing about the programs and services.

One of the TAY peer led groups, Mommy and Me Parenting Skills, has continued attendance by staff preparing and delivering a hot meal and activity packet to each family twice a month, with follow up check-ins by phone.

The TAY peer support lead staff facilitates a morning check-in every day for the other peer staff. This was done in person and then by video conferencing because of COVID-19. During this time, they review how the day before went, what goals and assignments they have for that day, and how others can support them in their work. This regular supportive peer to peer meeting allows staff to build positive relationships and communication skills with one another, thus translates to improved delivery of services and linkage to services for TAY young people.

Lessons Learned:
Consistent supervision oversight is needed to ensure outcome tools are gathered. Peer coach staff need regular and consistent supervision and training opportunities. The need for digitized demographic forms may benefit data collection while work is being done remotely.

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. The target population includes any parent or caregiver of a youth involved in a child-serving system such as a Children's Mental 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:

For FY 19/20 the Parent Partners served 33 unduplicated parents. There were 47 total referrals with 33 of these receiving services.

Demographics of individuals served:

- 26 completed demographic forms
- AGE: 22 indicated ages 26-59; 4 people were ages 16-25
- RACE/ETHNICITY: 19 White; 1 Asian; 4 preferred not to answer about race; 2 Multi-racial; 1 Hispanic
- SEXUAL ORIENTATION: 24 heterosexual/straight; 1 Bisexual; 1 no answer about sexual orientation
- LANGUAGE: English is primary language for all
- HOUSING: 20 have been homeless or lived on the streets; one didn't answer; 4 answered no
- MENTAL ILLNESS: 13 have been diagnosed with mental illness; 4 said undiagnosed mental illness; 4 didn't answer; 5 indicated No
- 17 have family members with diagnosed mental illness; 5 have family member with undiagnosed mental illness; 2 said no; 1 didn't answer

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 Mental 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.

Actual Outcomes for Fiscal Year 2019-2020

At intake:

- 53% report the Presence of the Family Support System "some of the time"
- 53% also "feel accepted about many things" in regard to their family support system.
- 40% feel that they are "likely to have some disagreements" with service providers while 53% feel "they will likely be understood and appreciated".
- 94% report that they have multiple stressors in their life.
- 87% will be facing 1-3 transitions and decisions within the next 60 days.
- 73% percent of parents were given a score between 9-12 indicating the need for a moderate level of support.

While the number of Parent Support Tools collected increased this year there were not enough matched pairs to make for significant data analysis. Of the matched pairs analyzed all showed improvements in one or more PST categories including a positive decrease in their overall total score from intake.

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

PARENT PARTNER SERVICES	#
Number of Individuals Receiving Services	33
Total Number of Services Provided	384
Total Number of Minutes Provided	27890
Average Number of Minutes Per Service	73
Average Number of Services Per Client	9

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 and provides a total score. In addition to the use of the PST we would like to begin using data from the CANS (Child and Adolescent Needs and Strengths), a state mandated reporting tool used with our children and families that we have begun implementing into our Behavioral Health programs. While Parent Partners are not currently responsible for completing the CANS most of the cases that they are involved with should have a CANS attached to it. As our CANS completion rates increase this data should become available to provide further analysis and support for the Parent Partner program.

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 and 19/20. 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 for the first half of FY 19/20. The second half of FY 19/20 we had better business practices in place to both support staff in documenting their services and capturing outcomes. As of the writing of this report we have also added a full-time supervisor to support this program which will enable better day-to-day support of staff and more accurate documentation and data gathering.

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. As a testament to their success we have had inquiries from our Child Welfare colleagues about the possibility of Parent Partners joining a special program designed to support parents struggling with substance use issues and parenting children 0-5 years old. This fiscal year all of the Parent Partners completed the RI Consulting Peer Support and Recovery Training Peer Employment Training and the Advanced Peer Practices Training. Parent Partners also have been on the front lines of responding to the COVID Pandemic in our community. They have continued to support our most vulnerable families through both tele-health and in-person services. Parent Partners continue to regularly attend meetings run by our Quality Assurance unit bringing their unique voice to the table.

Lessons Learned:
The most important lesson learned this fiscal year is the importance of consistent support and training for staff. The Parent Partners have a vital role to play in our System of Care and have proven themselves to be a talented group that can work with a variety of challenging family situations. Because of our internal staffing challenges and changes we have not been able to fully amplify these talents and strengths in order to grow the Parent Partner program. With the recent addition of an experienced supervisor to the team we are hopeful that staff will feel more supported and thus able to spend more of their time serving parents in our community. In addition, our staff have reported positive experiences with the RI Consulting trainings. As we grow our program we recognize the need for consistent on-boarding of staff through a shared training approach and clear policies. We are hopeful that our positive experience with these trainings will allow for us to better build our Parent Partner capacity.

Prevention & Early Intervention: Local Implementation Agreements

During Fiscal Year 2019-2020 four Local Implementation Agreements were funded. A description of these funded projects is provided below.

Bear River Band of the Rohnerville Rancheria, Bear River Youth Suicide Prevention Program.
Bear River Social Services hired a consultant to conduct a four-day intensive peer-counseling program for Bear River youth that focused on suicide and related issues, such as depression, trauma, violence, and substance abuse. The program is called Native H.O.P.E. (Helping Our People Endure). The program took place in February 2020. A total of 32 Native youth were served by the program and there were 21 adults who participated during the four days. Seven of the adults were parents and 14 served as trainers. Survey results from the project indicated an increase in knowledge on the risk factors that contribute to suicide, how to maintain healthy relationships, how to use

personal sources of strength, how to identify unhealthy cycles and break them, and how to help others.

Making Headway Center, Community Mental Health Project
Making Headway Center provided individual, family and group psychotherapy in both Spanish and English to community members. They provided these services to more than 55 individuals and family members that had not received mental health services in the past. They were also able to provide over 1,000 individual and group hours of service without a fee for these individuals. The ability to provide services in both Spanish and English increased their referrals from collaborative agencies and medical providers.

McKinleyville Community Collaborative Family Resource Center (MFRC), Hospitality and Volunteering Program Coordinator
MFRC sent three people to Mental Health First Aid (MHFA) Training of Trainers to become certified trainers. Two of these individuals are fluent in Spanish. Between these three new trainers, three trainings have been conducted that included 56 people, 55 of whom become certified MHSFA first-aiders. Two of the new trainers are now pursuing additional certifications to address the Latino and Native American communities.

First 5 Humboldt (in partnership with The Gathering Place), Families Thriving Together – An Individualized, Therapeutic Parenting Program.
This project partnered a local therapist with a First 5 Humboldt/Humboldt County Office of Education Child and Family Support Specialist to 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 was offered at The Gathering Place, a trauma-responsive therapeutic environment created by the local therapist. Unfortunately, due to the COVID-10 shelter-in-place the project was able to complete only Phase 1 of the project, which focused on the desired outcome of the participating parents gaining a deeper understanding of themselves and their children. Phase 1 also included the development of a Toolkit with resources for understanding trauma and interventions that can be used, and this Toolkit was completed.

Prevention & Early Intervention: School Climate Curriculum Plan/Multi-Tiered System of Support (MTSS)

There are approximately 18,100 students enrolled in Humboldt County public schools.

- 57% are White
- 19% are Hispanic/Latino
- 9% are American Indian/Alaska Native
- 9% are Other
- 4% are Asian/Pacific Islander
- 1% are African American
- 1% Unknown
- 7% are English Language Learners

- 58% are Free and Reduced Lunch eligible students
- 15.7% are Chronically Absent

MTSS Key Activities include technical assistance; training in Restorative Practices, PBIS fidelity measures and analysis, team building, Inclusive Discipline Practices (Restorative Conferencing as alternative to suspension/expulsion); training in Inclusion and Universal Design for Learning (UDL), stakeholders meetings, DHHS/Educational Leadership activities and steering committee for Humboldt Bridges to Success; and planning for Phase Two and the establishment of Prevention and Intervention Services at HCOE.

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

Activities Supported by PEI Funding 2019-20:
In school year 2019-20, the Northern CA MTSS Coalition had thirty-one participating schools. The HCOE Northern CA MTSS Coalition is comprised of districts/sites that will have access to ongoing consultation, and technical assistance provided through HCOE.

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

Northwest PBIS Network Conference – 18th Annual, Tacoma, WA Q3 - February 26-28, 2020

Theme: PBIS for ALL Students.

- Six Participants representing 3 local school districts were funded to attend the Northwest PBIS Network Conference.

A year of catastrophic events: CA PBIS Coalition Conference, Sacramento, Oct. 28-29, and District Team Site Visits to Model PBIS/MTSS Schools, Spring 2020:

As we can all attest, 2019-20, and into the current (2020-21) academic year has held a host of challenges, especially when it comes to travel for professional development opportunities. The Northern CA MTSS Coalition had arranged to sponsor two district leadership teams to the CA PBIS Coalition Conference in Sacramento – and due to the periodic PSPS (Public Safety Power Shutoff) by Pacific Gas and Electric – both teams opted to not attend the conference. It was an unfortunate missed opportunity but a dynamic that forced the teams to prioritize serving their communities and managing the crisis. Many districts forged ahead while providing instruction and services despite the power outages. In addition, there were road closures due to wildfires. Participation was also decreased with that additional factor.

The second half of the year and COVID-19. Fortunately, we had full participation to the Northwest PBIS Conference in Tacoma, WA. This event occurred when concern of the virus had not yet impacted the United States to the degree that soon followed, although several travelers expressed concern upon return. That was how quickly the information landscape was occurring. All travelers were safe, but within weeks districts moved from in-person instruction to distance learning.

The final professional development opportunity impacted by the year's events were the planned site visits to model PBIS sites. District teams have found great benefit by the opportunity to visit model sites and meet with district leadership teams at sites that have been identified by the CA PBIS Coalition as implementing PBIS to a high degree of fidelity. Unfortunately COVID-19 disrupted this ability to move forward with spring 2020 site visits by local district leadership teams.

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.

District Engagement Highlight

Deliberate system change requires administrative leadership, active teaming, and staff and community engagement. Additionally, to truly scale-up MTSS efforts policy must be reviewed and modified. There are indicators such as Differentiated Assistance (DA), Comprehensive Support and Improvement (CSI), Performance Indicator Review (PIR), and Significant Disproportionality (Sig Dis), that inform school districts of areas of improvement in a multitude of areas by the examination of school data. The continuous improvement process engages school teams, personnel, families and stakeholders to drive system change. MTSS is a framework to coordinate change efforts across behavioral, academic and social-emotional domains. The following brief district example highlights the importance of MTSS in these change efforts and how data impacts decisions around system improvement. The example will use the Significant Disproportionality indicator to highlight the necessary district work that is captured in an MTSS framework.

<u>Southern Humboldt Unified School District</u>

Southern Humboldt was identified as being in disproportionate for discipline for a series of academic school years, (2015-16, 2016-17 and 2017-18) and was identified as “Sig Dis” again in 2019-20. The data that is used to indicate Sig Dis is the prior academic year (2018-19).

Significant Disproportionality differs from Disproportionality in the following way: *Disproportionality* “is the overrepresentation of a particular racial or ethnic group in one of four areas: special education in general, special education within a specific disability category; disciplinary action; or more restrictive educational environments. *Significant Disproportionality* is defined as a district identified as being disproportionate for three consecutive years in the same area.

In response to being notified of Sig Dis status by the CA Department of Education in June 2019, the district identified a leadership team and attended a mandatory training to begin to develop the Comprehensive Early Intervening Services (CCEIS) plan.

Similar to the aforementioned disruption of professional development referred to earlier in this summary report, the initial stakeholder meetings were thwarted by the PSPS rolling power outages. Instead phone interviews were conducted with stakeholders and focus group members (the Northern CA MTSS Coalition participated in the interviews). Qualitative and quantitative data were collected from multiple sources and analyzed. Part of the analysis included the identification of root causes and a plan was drafted with stakeholder input.

Highlights of the CCEIS Plan: data and root cause analysis; plan for improvement (areas of focus, review of policies, practices and procedures, action plan, budget); implementation, evaluation and sustaining strategies.

Current indicator was Sig Dis for discipline of white children with disabilities.

- White students make up 75% of the overall student population and account for 72% of the special education population.
    - Students with disabilities account for 30.4% of suspensions
    - General education students' suspension rate at 11.2%

- Suspensions of White students with disabilities fell into these categories:
    - Disruption and Defiance (accounting for 22.8% of total suspensions),
    - Caused, Attempted or Threatened Physical Injury (19.2% of suspensions),
    - Possession of a Controlled Substance (15.2% of suspensions),
    - Used Force or Violence (7.6% of suspensions),
    - Assault on a School Employee (7.6% of suspensions),
    - Causing Serious Physical Injury to Another Person (5% of total suspensions),
    - Bullying (4% of suspensions),
    - Obscene Acts (4% of suspensions),
    - Harassment (3% of suspensions),
    - Weapons (2% of suspensions),
    - Theft (2% of suspensions),
    - Sexual Harassment (1% of suspensions),
    - Property Damage (1% of suspensions)

- Total suspensions for the district during the 2017-18 school year was 248.
    - Students with disabilities accounted for 47.5% of the total suspensions.
    - Total days out of school for students with disabilities due to these suspensions were 267.
    - Students who were Socio-Economically Disadvantaged were suspended at a rate of 15% compared to 4.8% for students who were not Socio-Economically Disadvantaged.

- Data show that
    - 38.1% of the suspensions for students with disabilities occurred at Miranda Junior High,

        - Of the total Miranda Junior High suspensions, 51% of those were for students with disabilities.
    - 27.9% at Agnes J. Johnson Elementary,
    - 22.8% at Redway Elementary,
    - 11% at South Fork High School.

- Students with disabilities who were also identified as
    - Homeless/McKinney-Vento had a suspension rate of 80%,
    - Foster Youth at 100%, and
    - Socio-Economically Disadvantaged had a suspension rate of 35.4%.

- Chronic absenteeism across the district was 26.8%,
    - at South Fork High School the rate was 30%,
    - at Miranda Junior High School the rate was 32.9%, and
    - at Whitethorn Elementary School the rate was 42.6%.

- Data from the 2017-2018 academic year show 33 students who are White, disabled, and chronically absent. Of these 51% of them have been suspended.

- Breaking it down further,
    - 56% of the male students in this cohort have been suspended,
    - 85.7% of the students who were also classified as homeless were suspended, and
    - 65.2% of the students who were also classified as socioeconomically disadvantaged were suspended.

- White Students with Disabilities are chronically absent at a rate of 36.8% compared to White students in general education at a rate of 27.9%.

- Chronic absenteeism for:
    - Socio-Economically Disadvantaged students was 29.6%,
    - Homeless/McKinney-Vento it was 42.4% and
    - Foster Youth 31.3%
- Teacher turnover
    - in the 17-18 school year was 16.8%;
    - in 18-19 it was 24%; and again
    - in 19-20 it was 24%.
    - Administrative turnover was complete in the 17-18 school year, with all schools having new principals as well as a new District Superintendent.
- Humboldt County has California's highest Adverse Childhood Experiences (ACEs) rate
    - 30.8% of adults report experiencing four or more ACEs (versus 13% statewide and a national rate of three or more ACEs of 11%.)

- This is of particular importance because children who have experienced high levels of adversity often exhibit behaviors that are disruptive to the school environment.

The data set above illustrates the qualitative and quantitative data analyzed.

The Root Causes, 2018-19

Using Improvement Science methods, the leadership team identified the following root causes contributing to the district Sig Dis.

- Lack of consistency in discipline policies, procedures and practices.
- Socioeconomic demographics
- Chronic absenteeism
- Lack of Data Management
- Inconsistent MTSS and prereferral interventions
- Lack of parent engagement

While the district has engaged in professional development and initial implementation of MTSS/PBIS over the past years, there is a need for deeper engagement in system change and this was evident in the root cause analysis.

While MTSS is identified as a root cause – it is important to note that in a comprehensive MTSS framework resides discipline policies and practice, chronic absenteeism, data management toward meaningful and responsive interventions, and parent engagement.

Comprehensive implementation of MTSS requires not only technical assistance and training, but administrative leadership, investment in on-site coaching, data collection and analysis, and a committed team to lead the transformative efforts.

Phase One – MTSS in Humboldt County.

In part through PEI funding support, the Humboldt County Office of Education has engaged districts with strong training opportunities in MTSS – including PBIS, Restorative Practices and Social Emotional Learning. Districts and site level teams have moved to coordinate and implement evidence-based practices to scale-up these efforts. The educational landscape has changed exponentially since the inception of the Northern CA MTSS Coalition teams have been afforded that opportunity to develop a strong understanding of the elements of these transformative practices. The fidelity of implementation varies from site to site, and there is a myriad of measures to gauge implementation.

To move into a stronger degree of fidelity and system change efforts – improvement needs increased resource of support.

Phase Two – MTSS in Humboldt County.

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

With great appreciation for the collaborative partnership between the Department of Health and Human Services and the Humboldt County Office of Education, a new department has been developed at the Humboldt County Office of Education. The Prevention and Intervention Services is a department that is part of the School Support division at HCOE. Capacity to help districts in the past year has shifted from .6 FTE to 3 FTE. Prevention and Intervention Services, during phase two, will coordinate MTSS effort with districts in Humboldt County. As the Southern Humboldt Unified School District Sig Dis example indicates, districts are engaged in MTSS, but efforts to strengthen the fidelity of implementation is greatly needed to improve academic, behavioral and social emotional outcomes for all student groups.

The Prevention and Intervention Team will provide technical assistance and leverage resources and support efforts across HCOE's departments as well as with a strong spirit of collaboration with agencies, tribal entities and other important community partnerships. This is largely due to the collaborative opportunity between the Department of Health and Human Services and the Humboldt County Office of Education. MTSS is a framework that promotes responsive and systematic interventions for all student groups and will continue to move toward the establishment of strong mental health and wellness interventions embedded in our educational settings.

Lessons Learned:
The movement to focus on scaling-up implementation with an identified number of districts that are ready to engage with intensive teaming and the furthering of the change effort. The goal is to create model schools in Humboldt County. Narrowing the focus of support will provide robust data and outcomes to evaluate the effect of MTSS efforts with select districts. This opportunity will continue to offer districts intensive technical assistance and support. For districts that may not be ready – readiness professional development activities and teaming will be provided by HCOE and leveraged resources.

The Prevention and Intervention Department will collaborate and coordinate efforts addressing; crisis response and threat assessment, suicide prevention, service providers consortium, and collaborative efforts with tribal entities. Many lessons have been learned since the Phase One (2015-2020) of the support offered to local districts with the Northern CA MTSS Coalition, and with the increase of capacity we will see robust training and technical assistance to help districts scale-up their transformative efforts.

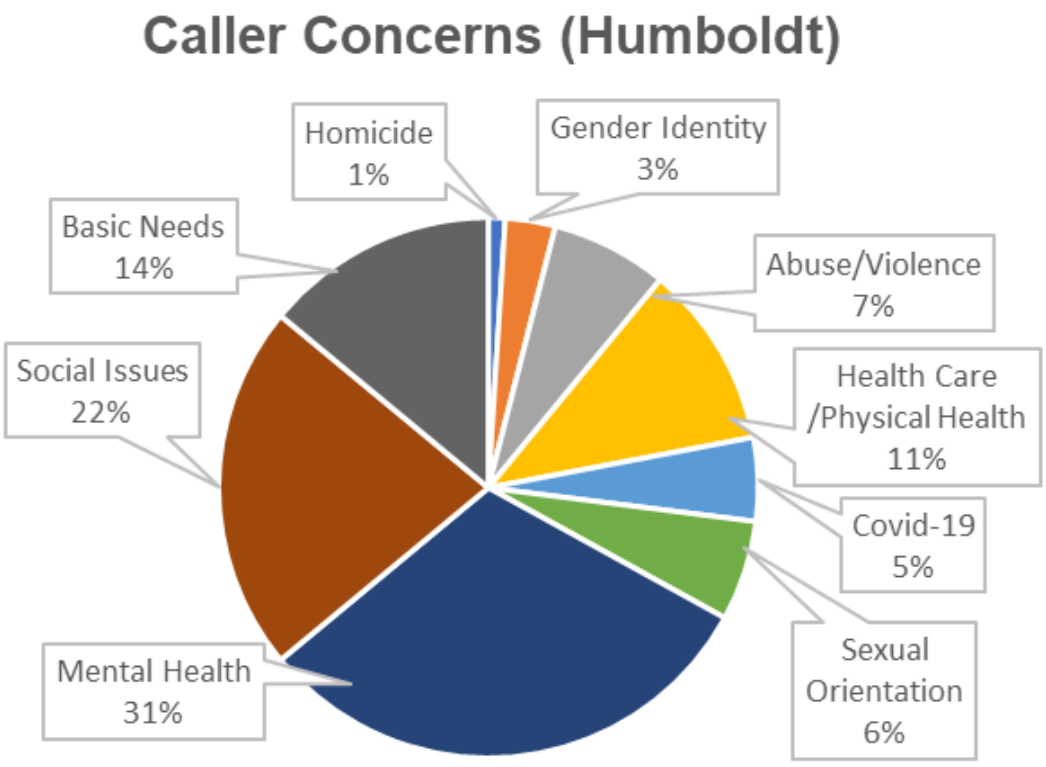
Prevention and Early Intervention Assigned Funds: North Valley Suicide Prevention Hotline (NVSPH)

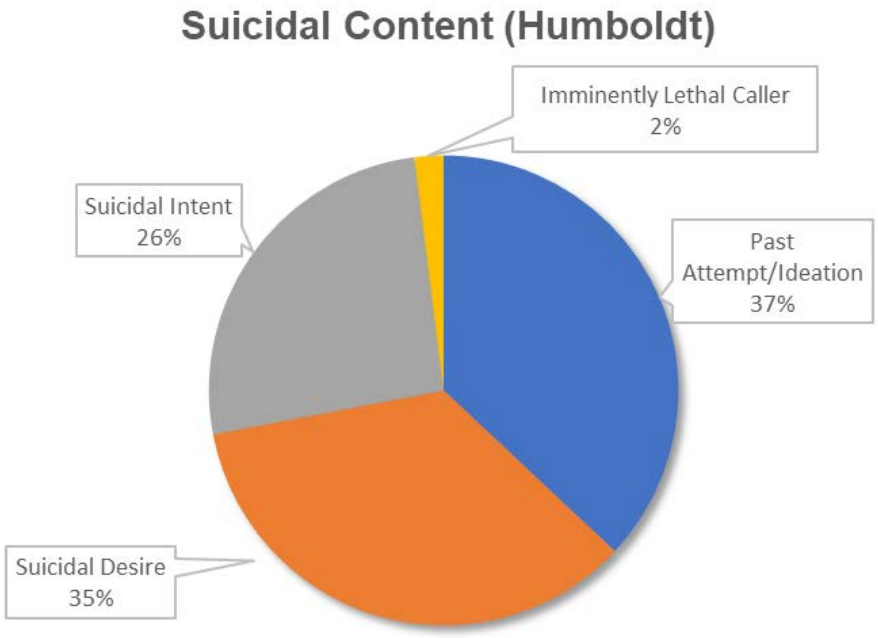
The NVSPH is administered through California Mental Health Services Authority (CalMHSA), a Joint Powers Authority created to jointly develop and fund mental health services and education program for its Member County and Partner Counties. CalMHSA administers NVSPH on behalf of counties that are participating in and funding the program. It serves as the primary suicide prevention hotline for these counties, including Humboldt County. NVSPH operates a 24/7 suicide prevention hotline accredited by the American Association of Suicidology and answers calls through its participation in the National Suicide Prevention Lifeline. A report for Fiscal Year 2019-2020 follows.

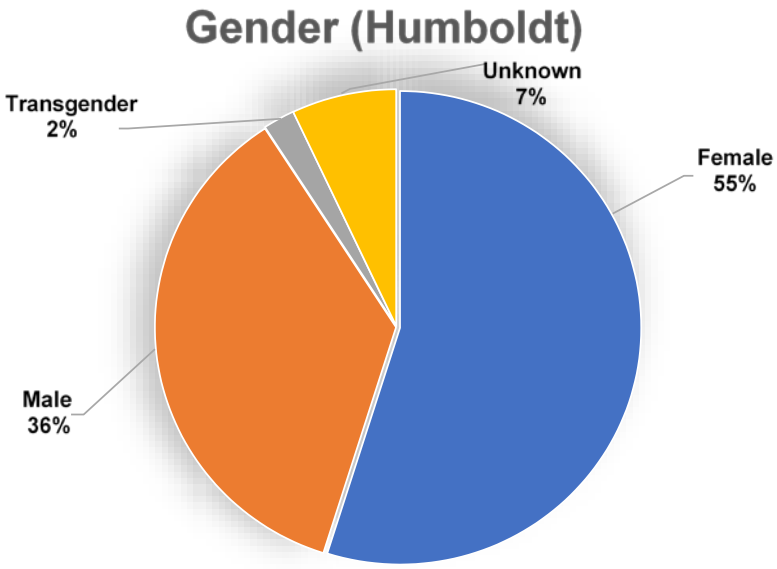
- There were 324 callers to the Hotline during the Fiscal Year.
- Seven were Active Rescue callers. Active Rescues are initiated to secure the immediate safety of a caller at risk if, in spite of the crisis line counselor's best efforts to engage the at-risk caller's cooperation, they remain unwilling and/or unable to take actions likely to prevent their suicide, or they remain at imminent risk/danger to themselves or others.
- Forty-one were Moderate or Higher Lethality calls.
- Cost Avoidance
    - Most crisis line callers have few healthcare options and resources; therefore, when individuals escalate into imminent lethality, costs for emergency services or other limited resources are usually covered by the county.

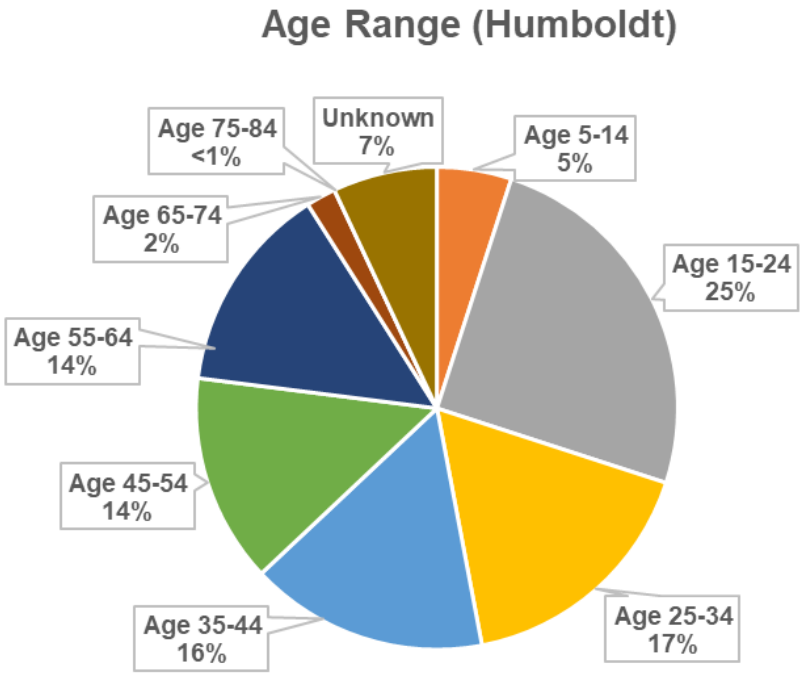
Emergency Services*	**Costs to System**
Ambulance Transport	$590
Law Enforcement/In-Person Crisis Intervention	$6/minute MediCal = $360/hr
Psychiatric Admission	$1,000 - $1,800/day

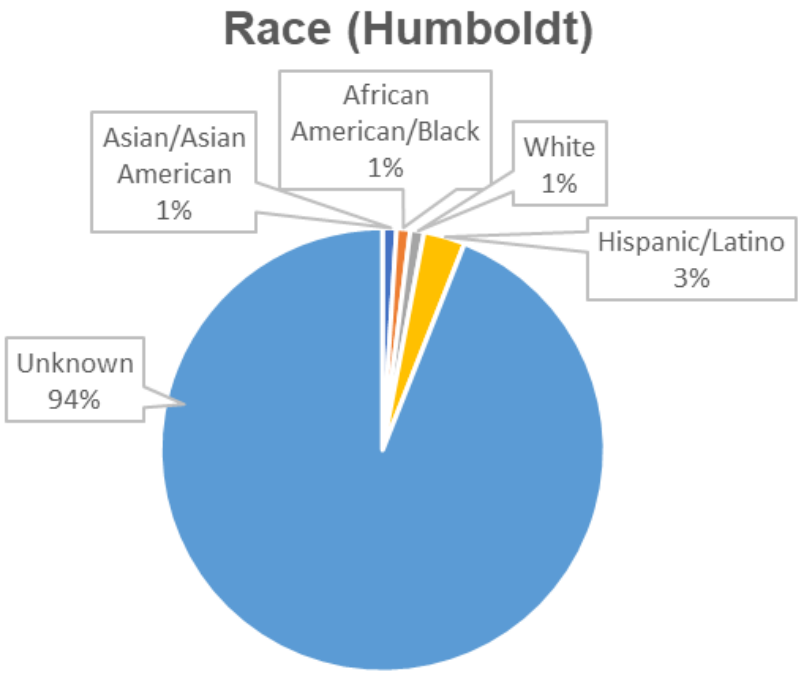
    - With access to critical crisis lines like NVSPH, callers at moderate or high lethality can avoid costly psychiatric hospital stays (or more serious consequences) as they are able to receive immediate support and deescalate from emotional crises before the situation turns into an emergency.


Caller Concerns (Humboldt)
Homicide 1%
Gender Identity 3%
Basic Needs 14%
Abuse/Violence 7%
Social Issues 22%
Health Care /Physical Health 11%
Covid-19 5%
Sexual Orientation 6%
Mental Health 31%


Suicidal Content (Humboldt)
Imminently Lethal Caller 2%
Suicidal Intent 26%
Past Attempt/Ideation 37%
Suicidal Desire 35%


Gender (Humboldt)
Unknown
7%
Transgender
2%
Female
55%
Male
36%


Age Range (Humboldt)
Age 75-84
<1%
Unknown
7%
Age 5-14
5%
Age 65-74
2%
Age 15-24
25%
Age 55-64
14%
Age 45-54
14%
Age 35-44
16%
Age 25-34
17%


Race (Humboldt)
African American/Black 1%
Asian/Asian American 1%
White 1%
Hispanic/Latino 3%
Unknown 94%

Workforce Education and Training

During Fiscal Year 2019-20 WET activities included the continuation of the contract with Relias E-Learning and the provision of local training and coaching.

- Staff had access to 1,370 courses in the Relias course catalog.
- 307 staff completed 517 courses. Those 517 courses accounted for 2,657 credit hours of training.
- Humboldt County Behavioral Health developed and uploaded and additional 166 custom trainings to Relias, bringing the total of custom trainings on Relias to 438.
- The tracking of in-services at Sempervirens continues in Relias. Relias also tracks outpatient in-services such as Outpatient Documentation training, CPR and Crisis Prevention Institute training.
- Significant additions to Relias in the last year have been FAQ 2020, the Scheduling Calendar Handbook, and updated training for Access to Services and RAS Log.
- Relias continues to be 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. In Fiscal Year 2019-2020 over 30 QI Bulletins have been published and are available for reference in Relias.

In addition to Relias, WET funds supported the three-day Transition to Independence Process (TIP) trainings for the Transition Age Youth Division and Nonviolent Crisis Intervention trainings for direct services staff.

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

Purpose
The purpose of the HOME Innovation Project was to increase the quality of services, including better outcomes for adults with severe mental illness who are experiencing homelessness. While this Innovation Project was increasing access to services, especially for underserved groups, and promoting interagency collaboration, the original community planning process identified the need to increase the quality of services and better outcomes as the priority purpose. The Innovation Project had two components: Housing, Outreach and Mobile Engagement (HOME) and Mobile Intervention Services Team (MIST).

HOME used 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 continued to make changes to existing Housing First practices used in larger urban areas to demonstrate effectiveness on a smaller scale in rural areas. HOME included outreach and engagement efforts during street level interventions for persons with mental illness who are experiencing homelessness.

The Mobile Intervention Services Team (MIST) was 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.

As of the end of the project, the HOME/MIST pathway had 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 continues to work 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.

Another 50-unit apartment building with community and meeting space for tenants was 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 began 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 included but was 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 were 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 included 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 provided services on-site. There were 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 were provided. All projects also included 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 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 addressed 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 led Humboldt County to the conclusion that a change in practice was necessary and timely.

HOME/MIST addressed the following issues for individuals experiencing homelessness with 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 were 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. The 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 original 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. Six Peer Coaches were 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 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 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

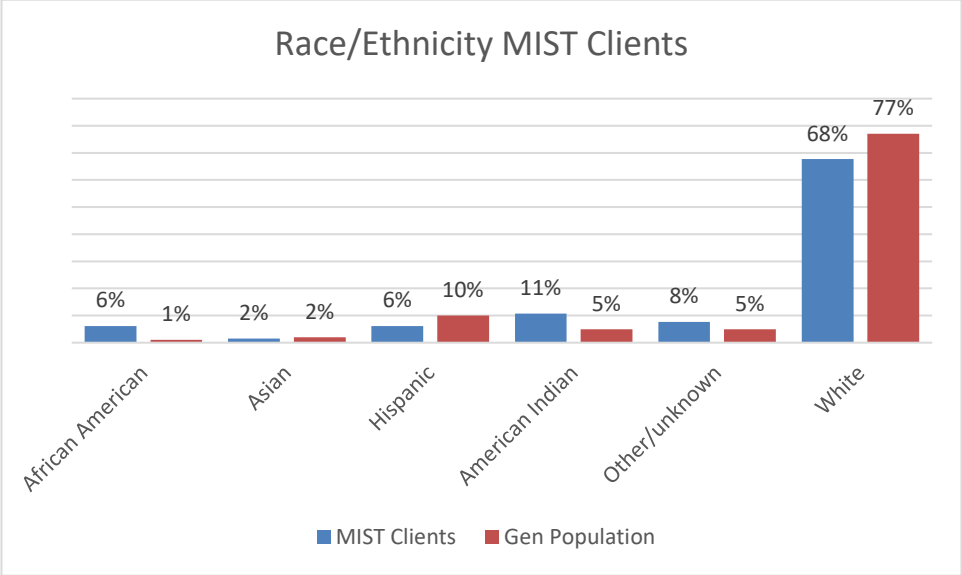
Initially the conversion of a local long-term transitional housing model for families—the Multiple Assistance Center (MAC) -- to a short-term rapid rehousing model that is inclusive of individuals with a severe mental illness diagnosis, required an innovative approach unique to this community. The MAC 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 were supported in directly obtaining housing.

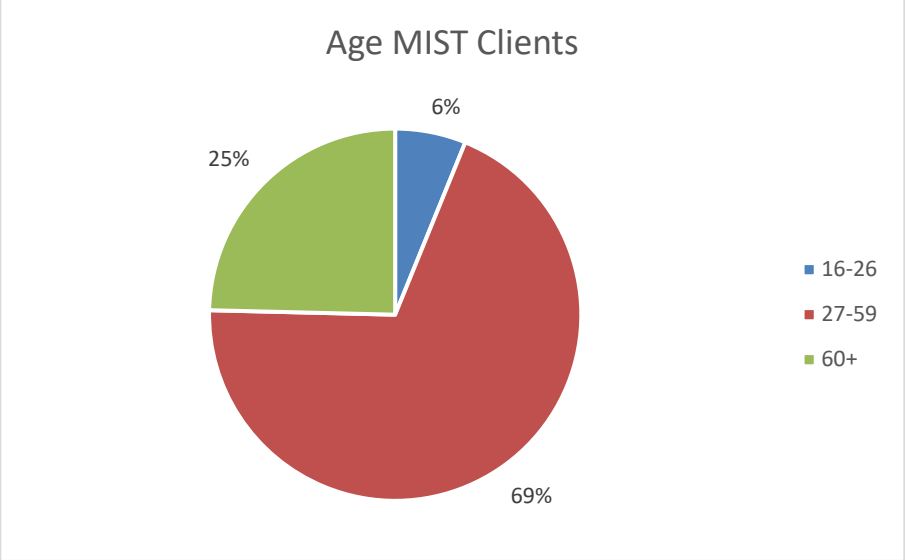
The initial name of the Innovation Project was “Rapid-Rehousing.” As the project moved forwarded and evolved, implementation team members including program staff recognized that the title “Rapid-Rehousing” did not include the outreach and engagement components or the range of housing program approaches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

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

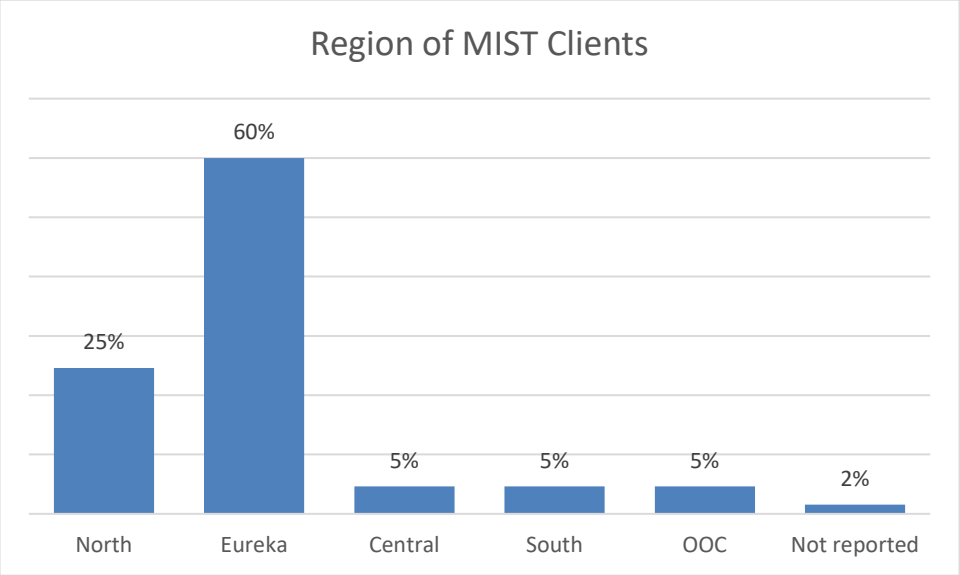
- Outreach and Engagement. Outreach and engagement occured through the MIST partnership with law enforcement, emergency departments, psychiatric emergency services and hospitals as well as other community partners. MIST staff partnered with law enforcement officers to ride along on a weekly schedule to make initial contact with the individuals identified by the law enforcement agencies. During 2019-2020 there were 915 encounters by MIST staff with 65 individuals who then became clients. The average number of encounters per clients was 14, and 15 clients accounted for 71% of the total encounters.
- MIST client data for 2019/20 showed the following:
  Six percent of MIST clients were African American, as compared to 1% of the general population. Two percent of MIST clients were Asian, as compared to 2% of the general population. Six percent of clients were Hispanic, as compared to 10% of the general population. Eleven percent of clients were American Indian, as compared to 5% of the general population. Sixty-eight percent of clients were White, as compared to 77% of the general population. Eight percent of clients were Other/Unknown, as compared to 5% of the general population.



Six percent of MIST clients were ages 16-26, 69% were ages 27-59, and 25% were age 60+.



Fifty-four percent of MIST clients were female, and 46% were male. 60% of MIST clients “resided” in Eureka, 25% in the Northern Humboldt region, and the remaining 15% in other regions of the county, out of county (OOC), or not reported.



- In 2018 MIST expanded its service area from Eureka to Arcata and began an expansion in the outlying areas of the county in 2019.
- MIST staff engaged 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 reviewed the census on the Crisis Stabilization Unit (CSU) and Sempervirens (SV) Psychiatric Health Facility each day so that they could collaborate on the clients' discharge plans. Staff also reviewed jail bookings each day and worked closely with the Behavioral Health staff based in the jail to support clients with developing plans for release. MIST staff visited 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 built rapport with the referred individuals they assisted them in obtaining a mental health assessment and developed a plan to assist them in achieving their goals. Often the primary goal was to obtain housing.
- MIST clients had 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.

HOME staff assisted participants in locating and securing housing as quickly as possible using a "Housing First" approach. Participants had 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 was also available for deposits and in some cases on-going rental assistance. The housing placements ranged 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, were provided to keep them housed. This aspect of some mental illnesses is often the reason for their homelessness.

Humboldt Housing and Homeless Coalition (HHHC) took 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; and the Hope Center.

The HOME Fact Sheet provides program information and program outcomes. Those interested in a copy of the Fact Sheet should send an email to mhsacomments@co.humboldt.ca.us and the Fact Sheet will be provided.