AGENDA ITEM NO.
C25

COUNTY OF HUMBOLDT

For the meeting of: July 31, 2018

Date: June 20, 2018

To: Board of Supervisors

From: Connie Beck, Director
Department of Health and Human Services

Subject: Mental Health Services Act Three-Year Program and Expenditure Plan

RECOMMENDATION:

That the Board of Supervisors adopt the attached Mental Health Services Act Three-Year Program and Expenditure Plan for fiscal years 2017-2018 through 2019-2020.

SOURCE OF FUNDING:

Mental Health Fund

DISCUSSION:

Proposition 63 was passed by the California voters in November 2004 and enacted into law on January 1, 2005. Now known as the Mental Health Services Act (MHSA), this legislation places a one percent (1%) tax on individuals with a personal income above one million dollars ($1,000,000.00).

The attached MHSA Three-Year Program and Expenditure Plan has been developed with the participation of stakeholders in accordance with the Community Planning Process (CPP) set forth in Section 5848 of the California Welfare and Institutions Code and Section 3300 of Title 9 of the California Code of Regulations. The draft MHSA Three-Year Plan was circulated to representatives of stakeholder interests and any interested party for thirty (30) days in preparation for the public hearing held by the Humboldt County Behavioral Health Board on June 21, 2018.

The process for obtaining stakeholder input for the attached MHSA Three-Year Plan utilized the same methods that were used for prior MHSA Three-Year Plan updates. Fourteen (14) stakeholder meetings were held, including meetings with groups representing the five (5) regions of Humboldt County and nine (9)

Prepared by Samantha Anderson, Administrative Analyst I CAO Approval

REVIEW:
Auditor County Counsel Sim Human Resources Other

TYPE OF ITEM:
X Consent
Departmental
Public Hearing
Other

PREVIOUS ACTION/REFERRAL:
Board Order No. C-26
Meeting of: 06/23/15

BOARD OF SUPERVISORS, COUNTY OF HUMBOLDT
Upon motion of Supervisor Fennell Seconded by Supervisor Wilson
Ayes Fennell, Wilson, Sundberg, Bass
Nays
Abstain
Absent Bohn

and carried by those members present, the Board hereby approves the recommended action contained in this Board report.

Dated: 7/31/18
By:
Kathy Hayes, Clerk of the Board

meetings with other community stakeholder groups. Input and comments were sent to the MHSA email address, left on the MHSA voice mail or written on forms at the stakeholder meetings.

The CPP for the attached MHSA Three-Year Plan had two components, MHSA education and collecting input from stakeholders. MHSA education included the following areas of planning; mental health policy, program planning, implementation, monitoring, quality improvement, evaluation and budget allocations. such education also included the MHSA core concepts of community collaboration, cultural competence, client wellness, recovery and resilience and an integrated service experience for clients and their families.

In addition to the continuing Prevention and Early Intervention (PEI) programs, which include Rapid Re-Housing, Hope Center, Transition Age Youth Advocacy and Peer Support, Parent Partners, Suicide Prevention and Stigma and Discrimination Reduction through twenty-four (24) hour crisis support and community education, there are two (2) new PEI programs proposed to be funded as part of the attached MHSA Three-Year Plan: Implementation Agreements and Making Relatives.

On July 10, 2017, Governor Brown signed into law Assembly Bill 114. This bill amended certain sections of the California Welfare and Institution Code related to the reversion of MHSA funds. Pursuant to California Welfare and Institutions Code Section 5892.1, funds subject to reversion as of July 1, 2017 are deemed to have been reverted and reallocated to the county of origin for the purposes for which they were originally allocated. By July 1, 2018 counties are required to have a plan to spend those funds by July 1, 2020. The Assembly Bill 114 plan is included in the attached MHSA Three-Year Plan.

The attached MHSA Three-Year Plan was posted to the County of Humboldt's website on May 15, 2018 and the Board of Supervisors should adopt the plan within ninety (90) days of the posting. Once the attached MHSA Three-Year Plan has been adopted by the Board of Supervisors, it will be sent to the California Department of Health Care Services and the Mental Health Services Oversight and Accountability Committee.

FINANCIAL IMPACT:

Pursuant to California Welfare and Institutions Code Section 5892, MHSA component funding is distributed to counties on a monthly basis based on actual tax receipt collections. Each county is responsible for ensuring that twenty percent (20%) of the funds distributed from the Mental Health Services Fund is allocated for PEI programs. In addition, counties are required to utilize five percent (5%) of such funding for Innovative programs and the balance of such funding must be allocated for Community Service and Support (CSS) programs. Transfers of CSS funds for capital facilities and technological and human resource needs are limited to twenty percent (20%) of the average amount of funds allocated to a county for the previous five (5) years.

The attached MHSA Three-Year Plan includes worksheets which set forth the estimated MHSA funding that will be received by the County of Humboldt for fiscal years 2017-2018 through 2019-2020. Allocation of the MHSA funding reflected in these worksheets is consistent with the applicable requirements set forth in the above-referenced provisions of the California Welfare and Institutions Code. Revenue estimates are based on recommendations by the California Department of Health Care Services and the California Behavioral Health Directors Association. Estimated expenditures are based on calculations included in the approved fiscal year 2017-2018 and fiscal year 2018-2019 budgets for DHHS – Mental Health Administration budget unit 1170-424 and DHHS – Mental Health Services Act budget unit 1170-477; FY 2017-18 projected MHSA expenditures are $6,465,554; FY 2018-19 budgeted MHSA expenditure is $7,046,893. Adoption of the attached MHSA Three-Year Plan will not impact the Humboldt County General Fund.

The recommended action supports the Board of Supervisors' Strategic Framework by ensuring opportunities

for improved safety and health, protecting vulnerable populations, supporting self-reliance of citizens and providing community-appropriate levels of service.

OTHER AGENCY INVOLVEMENT:

The California Department of Health Care Services
The Mental Health Services Oversight and Accountability Commission

ALTERNATIVES TO STAFF RECOMMENDATIONS:

The Board could choose not to adopt the attached MHSA Three-Year Program and Expenditure Plan. However, this alternative is not recommended since it would result in noncompliance with Section 5847 of the California Welfare and Institutions Code.

ATTACHMENTS:

1. Mental Health Services Act Three-Year Program and Expenditure Plan for Fiscal Years 2017-2018 through 2019-2020

Mental Health Services Act

Three-Year Plan

Fiscal Years 2017/2018, 2018/2019 and 2019/2020

Table of Contents

MHSA COUNTY COMPLIANCE CERTIFICATION

County/City: Humboldt

☒ Three-Year Program and Expenditure Plan
☐ Annual Update

Local Mental Health Director	Program Lead
Name: Emi Botzler-Rodgers, MFT	Name: Cathy Rigby
Telephone Number: 707 268-2990	Telephone Number: 707 268-3450
E-mail: ebotzler-rodgers@co.humboldt.ca.us	E-mail: crigby@co.humboldt.ca.us
Local Mental Health Mailing Address:	Humboldt County DHHS-Mental Health 720 Wood Street Eureka, Ca 95501

I hereby certify that I am the official responsible for the administration of county/city mental health services in and for said county/city and that the County/City has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this Three-Year Program and Expenditure Plan or Annual Update, including stakeholder participation and nonsupplantation requirements.

This Three-Year Program and Expenditure Plan or 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 Three-Year Program and Expenditure Plan or 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 (PRINT)

Signature

7/2/18
Date

Community Planning and Local Review Process

Background

It is helpful to the understanding of Mental Health Services Act to be aware of some of the background of Humboldt County Department of Health and Human Services.

Humboldt County Department of Health and Human Services is a consolidated and integrated Health and Human Services Agency under the State's Integrated Services Initiative (AB 315 Berg) and includes Mental Health, Public Health and Social Services. Since its consolidation in 1999, Humboldt County Department of Health and Human Services has been engaged in true system transformation and redesign through numerous key strategies, including but not limited to:

- Establishing consolidated administrative support infrastructures;
- Establishing consolidated program support infrastructures;
- Developing governmental "rapid cycle" change management processes;
- Importing or developing evidence based practices and other outcome based approaches to services;
- Developing integrated, co-located and decentralized services concurrently;
- Establishing client and cultural inclusion structures/processes that will advise the Department in terms of policy and programming;
- Focusing on quality improvement and systems accountability in terms of outcomes linked to improved individual and family recovery and self-sufficiency, as well as improved community health;
- Working with State Health and Human Services Agency to reduce or eliminate barriers that impede effective service delivery at the County level.
- Using a "3 x 5" approach to program design which spans:
  -Three service strategies: Universal, Selective and Indicated, and
  -Five target populations: Children, Youth and Families, Transition Age Youth, Adults, Older Adults, and Community

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

It is through AB315 and these transformational strategies that the Humboldt County Department of Health and Human Services has planned and implemented its Mental Health Services Act (MHSA) programming. Humboldt County's approved Community Services and Supports Plans, Workforce Education and Training Work Plans, Capital Facilities and Information Technology Needs Plan, Prevention and Early Intervention Plan, and Innovation Plan were developed and are being implemented with cross-departmental integration aimed at the delivery of holistic and transformational programs.

Methods for obtaining stakeholder input for the 2017-2020 MHSA Plan Update occurred

as follows. This is the same process that has been used in prior Three Year Plan Updates.

- Fourteen stakeholder meetings were held, including groups in five regions of the County and nine meetings with other community stakeholder groups.
- Input and comments were sent to the Mental Health Services Act email address, left on the Mental Health Services Act voice mail, or written on comment forms at stakeholder meetings.
- The Draft Three Year Plan and associated MHSA information was distributed via email to 828 individuals representing the medical community, the education community, law enforcement, DHHS staff and community-based organizations.

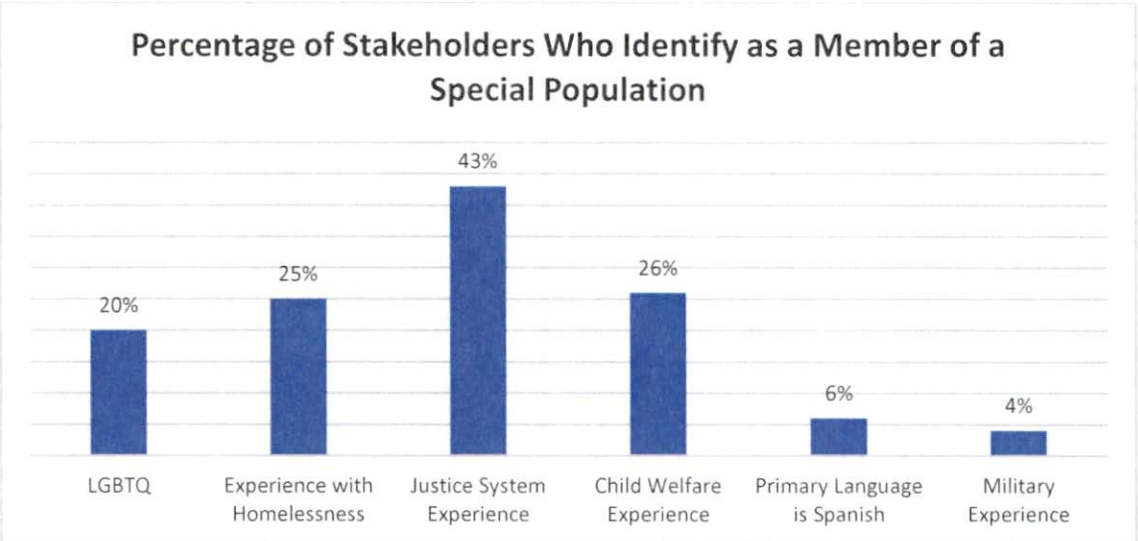
Stakeholders

DHHS began collecting stakeholder demographic information in 2008. Between 2008 and the end of the planning process for the current update, the majority of MHSA stakeholders participating in community planning activities completed a demographic questionnaire. Demographic information about participants in the stakeholder process from 2008 through the present are found in the charts below.

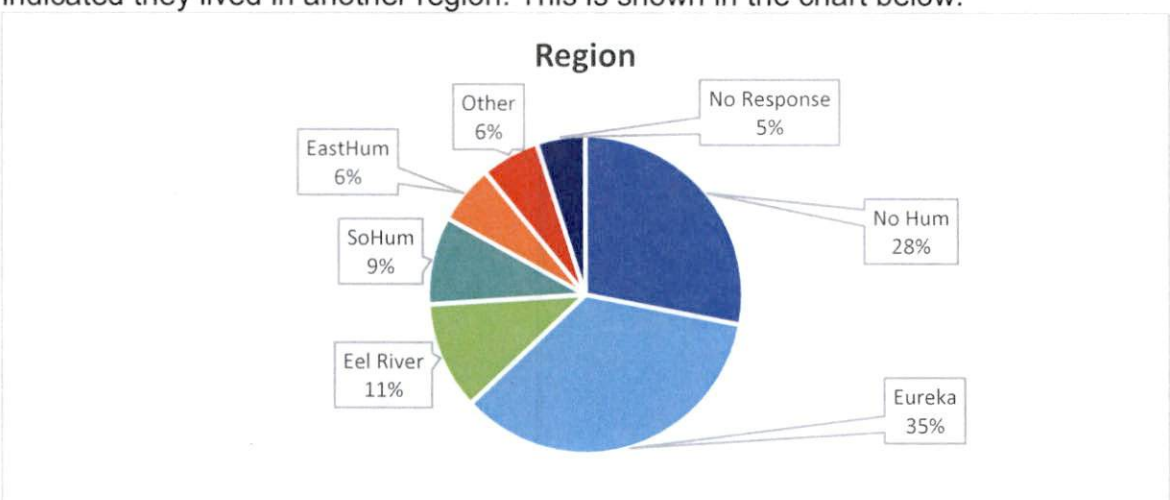
Individuals with lived experience with a mental illness are recognized as a vital voice in the MHSA planning process. During the stakeholder process, 19% of people participating have identified as having a mental illness, and 50% have identified as a family member of someone with a mental illness. This is shown in the chart below.

Additional life experiences have been identified as necessary voices for the planning process, so they too are monitored for inclusion. Sexual orientation, homelessness, justice system experience, Child Welfare experience, those whose primary language is Spanish and military experience are all life experiences or conditions that can result in challenges to successful mental health treatment. The chart below illustrates how outreach efforts have included people with these life experiences. 20% identified as LGBTQ. 25% identified as having experience with homelessness. 43% had justice system experience. 26% had Child Welfare experience. 6% stated their primary

language is Spanish. 4% had military experience. This is shown in the chart below.

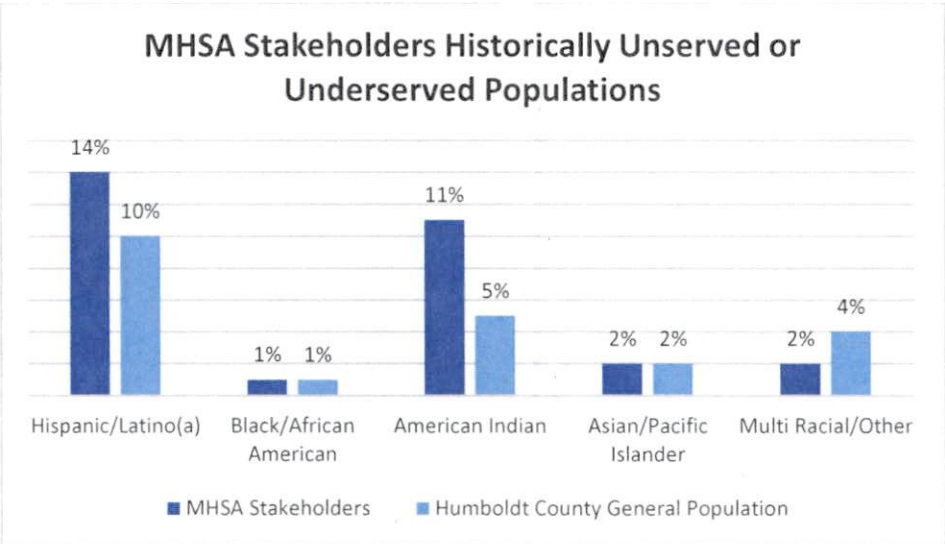


Another priority for representation in the planning process is regional. More than half of the MHSA stakeholders live in regions close to Humboldt Bay, Northern Humboldt at 28% and Eureka at 35%, while 11% live in the Eel River Valley, 6% in Eastern Humboldt and 9% in Southern Humboldt. 11% either did not respond to the question or indicated they lived in another region. This is shown in the chart below.

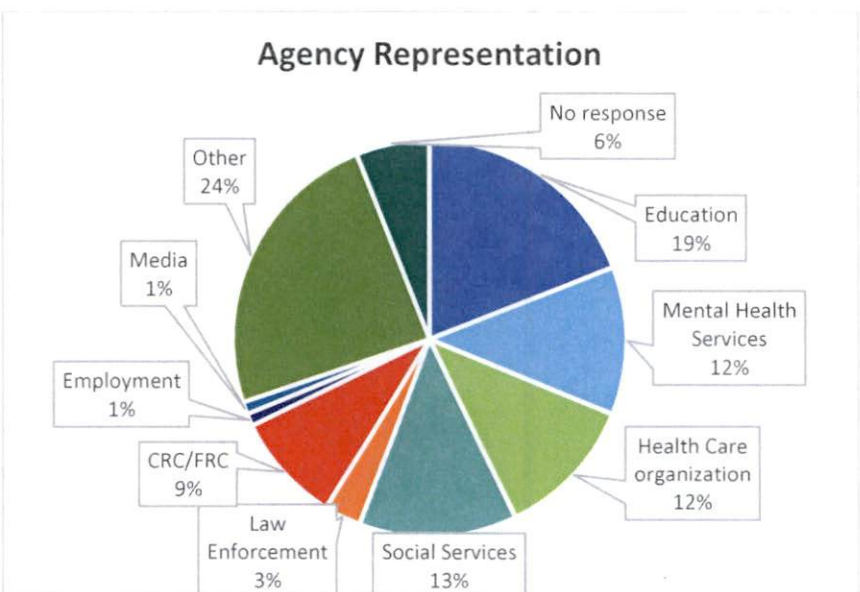


Participants in the stakeholder process reflect the racial and ethnic diversity of Humboldt County. Progress is continuing in efforts to increase the participation of individuals who identify as a race and/or ethnicity that has traditionally experienced disparities in mental health services. The chart below reflects the participation in the MHSA planning process since 2008. 14% are Hispanic/Latino(a) as compared to 10% of the Humboldt County general population. 1% are Black/African American as compared to 1% of the County general population. 11% are American Indian as compared to 5% of the County general population. 2% are Asian/Pacific Islander as

compared to 2% of the County general population. 4% are Multiracial/Other as compared to 4% of the County general population.



The planning process includes representation from agencies that provide services to MHSA clients. The process has included individuals from education (19%), mental health services (12%), health care organizations (12%), social services (13%), law enforcement (3%), community and family resource centers (9%), employment (1%), media (1%) and other (24%). This is shown on the chart below.



MHSA Community Planning Process Stakeholder Materials

MHSA materials were available in both English and Spanish, and a Spanish language interpreter was used for one meeting at which a number of Spanish-speaking individuals attended. Materials provided to attendees included:

- Draft MHSA Three Year Plan for 2017-2020
- Draft MHSA Budget for 2017-2020
- MHSA Fundamental Concepts handout
- MHSA Info Form handout
- MHSA Current Programs handout
- MHSA Comment Form for written comments. This form includes an MHSA comment line phone number and email address for alternate methods of providing input
- Anonymous MHSA Demographic Questionnaire
- MHSA Budget slides
- Educational Power Point presentation that includes MHSA background, definitions, regulations, component and local program funding percentages and funding amounts.

Public Comment and Public Hearing

There was a 30-day Public Comment period from May 21-June 20, 2018. During this time copies of the MHSA Three-Year Plan were made available through the following methods:

- Electronic format: the Humboldt County Department of Health and Human Services, Mental Health Services Act website
- Print format: Humboldt County Department of Health and Human Services (DHHS) Professional Building, 507 F Street, Eureka CA, 95501; DHHS Mental Health, 720 Wood Street, Eureka CA, 95501; DHHS Children Youth and Family Services, 1711 Third St. Eureka CA 95501; Garberville Office, 727 Cedar St. Garberville CA, 95560; Willow Creek Office, 77 Walnut Way, Willow Creek CA, 95573; and The Hope Center 2933 H Street Eureka CA, 95501
- An informational flyer was sent to stakeholders participating in the stakeholder process regarding the Plan's availability, including where to obtain it, where to make comments, and where/when the public hearing will be held
- Informational flyers were distributed and posted at public library branches
- Informational flyers were e-mailed to recipients on local e-mail distribution lists including family/community resource centers, organizational providers, LatinoNet, NorCAN, Senior Resource Center, Suicide Prevention Network, 0-8 Mental Health Collaborative, NAMI Humboldt
- Plans were e-mailed or mailed to all persons who requested a copy
- A press release was sent to thirteen local media outlets announcing the Plan's availability, including where to obtain it, where to make comments, and where/when the public hearing will be held
- The Mental Health Director and the Mental Health Services Act Coordinator announced to Department of Health and Human Services staff, community-based organizations and partner agencies in various meetings the Plan's availability including where to obtain it, where to make comments, and where/when the public hearing would be held.

During the 30 day public comment period, comments were received via e-mail, from comment boxes, and from phone calls. Comments included requests for more resources for preschoolers and very young children, more trained psychiatric nurses, bigger facilities, more guidance counselors in schools, and more data on programs, budget, and how programs are working. At the public hearing, comments focused on the same topics as the 30 day comment period, with the addition of adding programs for dually diagnosed clients, supported employment, first episode psychosis, expanded mobile crisis support, and forensic treatment. All written and verbal comments were summarized and reviewed by Mental Health leadership. No substantive changes were made to the Plan as a result.

What's New in the 2017-2020 Three Year Plan. Two new Prevention and Early Intervention (PEI) programs will be funded. Implementation Agreements and Making Relatives. These are discussed in the PEI sections of the Plan.

Humboldt County Demographics

Humboldt County is located on the coast of northwestern California, 225 miles north of San Francisco and 70 miles south of the Oregon border. Neighboring counties are Del Norte, Siskiyou, Trinity and Mendocino. The County is rural in nature, with a population of 134,623 spread over 3,573 square miles, or 37.7 persons per square mile. 49% of residents live within the incorporated areas while over half of residents live in the outlying rural areas of the County. Eureka is the largest community in the County, and is the county seat of government. The County is home to eight federally recognized American Indian Tribes including the Yurok, Karuk, Hupa, Wiyot, Cher-Ae Heights Indian Community of Trinidad Rancheria, Bear River Band of Rohnerville Rancheria, Blue Lake Rancheria and Big Lagoon Rancheria.

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

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

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

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

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

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

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

Data Source: http://www.census.gov/2010census/

Community Services & Supports: ROSE/Mobile Outreach

The Humboldt County DHHS Mobile Outreach program is dedicated to providing services to people in outlying communities and to those who are experiencing homelessness. Rural Outreach Services Enterprise (ROSE) is the MHSA component of this program. The DHHS Mobile Outreach Program is an integrated response with Social Services, Mental Health and Public Health as a mobile outreach program for individuals with a variety of physical, behavioral, and social needs as well as prevention and education activities, thereby reducing the stigma associated with accessing behavioral health services. The MHSA Community Services and Support (CSS) component of this integrated program serves individuals with severe mental illness or serious emotional disturbance including people who are homeless and at-risk of homelessness.

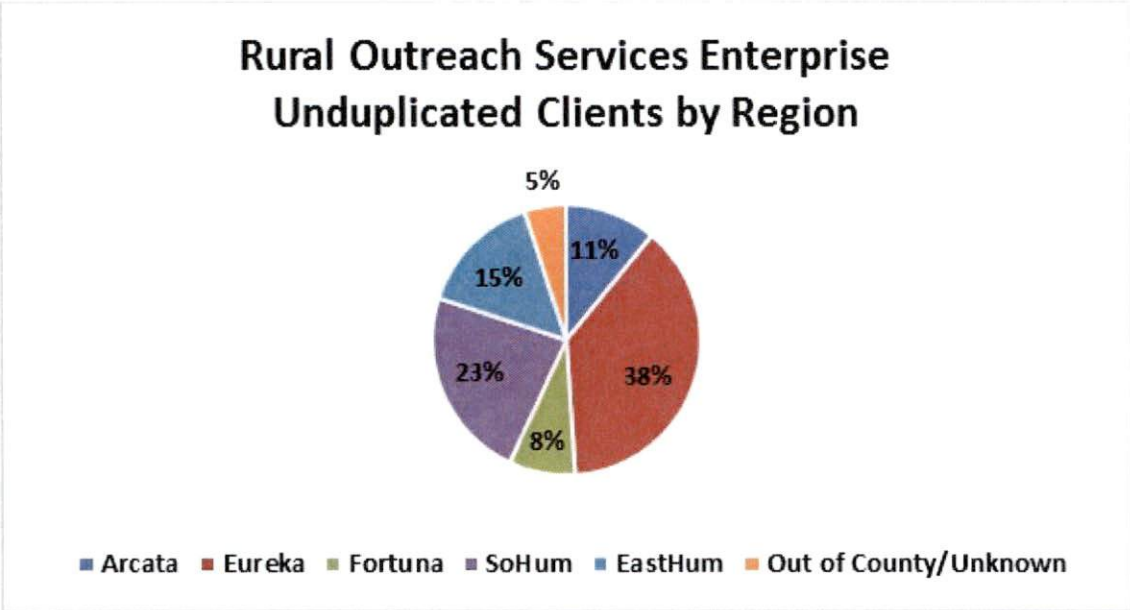
The program uses RVs that travel to community sites such as Family Resource/ Community Resource Centers, clinics, tribal offices and volunteer fire departments on a set schedule. Employment services and immunization clinics can be scheduled as needed. Services on these vehicles are often available for special community events as well. Stigma associated with seeking mental health services in small communities can be overcome by offering a wide variety of services from these units as visitors could be coming in to access anything offered. Outreach staff onboard the vehicles are skilled at engagement of persons in distress and provide access to County mental health services immediately or over time as desired by visitors. Clinical staff travel with the RV on some trips for immediate "on board" services including assessments. If a visitor becomes open to services, regular appointments with clinicians and case managers are scheduled at sites accessible to clients, including home visits. Providing on-going services from the RV is usually not possible since some communities are visited monthly and open clients typically require at least weekly contact. DHHS Mobile Outreach has clinical staff that travel in 4WD vehicles to visit clients on a regular basis. DHHS is currently implementing Regional Services and now has clinical staff stationed on a permanent basis in Southern Humboldt (Garberville) and East County (Weitchpec and Hoopa).

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

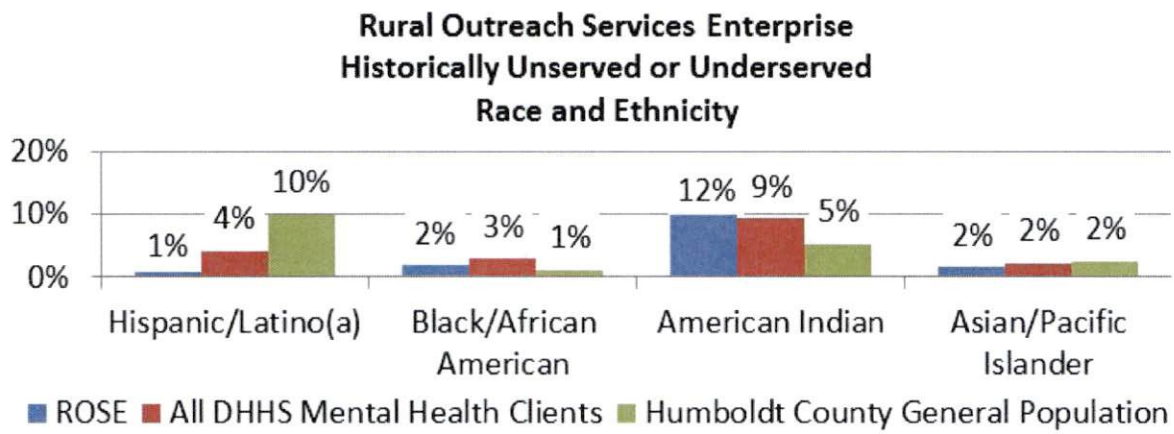
People living in outlying areas who require ongoing mental health services, including medication support, counseling and case management, are served by Mobile Outreach staff members. Clients who are homeless are provided transportation to their mental health appointments by Mobile Outreach. Mobile outreach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

While the MHSA component of this program provides mental health assessments and services, other DHHS services are available, such as CalFresh, Medi-Cal, Transportation Assistance Program, Car seat program, Well-Child Dental Varnish Program, and Fresh Produce and Supplemental Food Program. The diversity of services available reduces the stigma some might experience if the RVs only provided mental health services. This program continues to reach the unserved and underserved populations in rural, remote, and outlying geographic areas of the county.

From July 2007 through June 2016 the program has served an average of 250 unduplicated mental health clients per year for a total of 1,996 unique individuals. ROSE provides services to people of all ages. Between July 2007 and June 2016, 7% of those served were children, 15% were transition age youth, 71% were adults, and 7% were older adults.

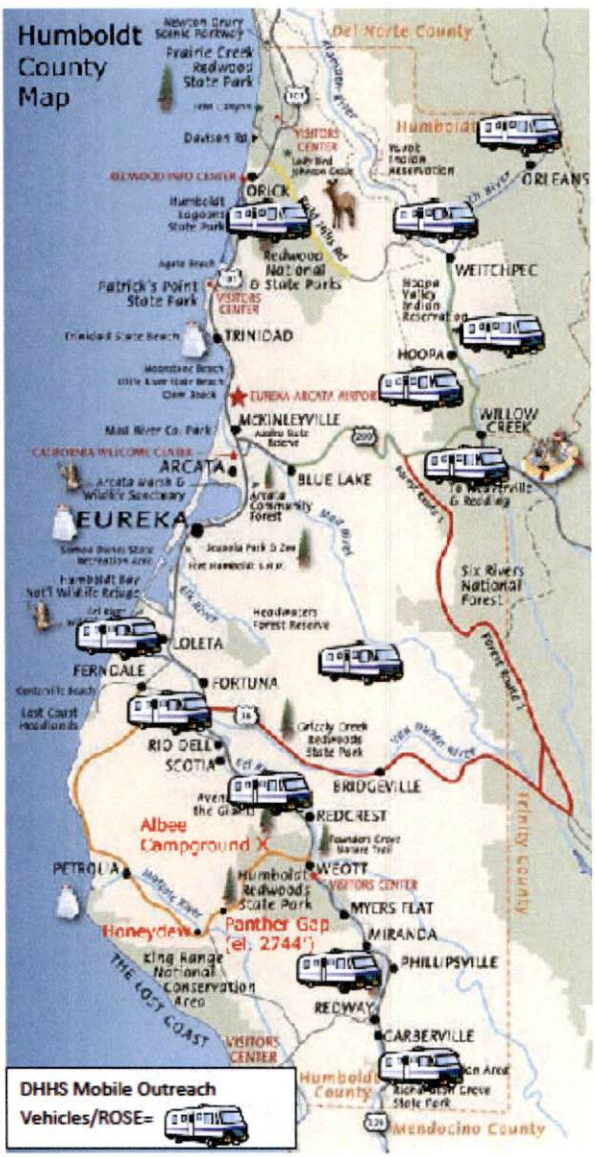


As the chart above indicates, clients are served throughout the region, with 38% served in Eureka, 23% in Southern Humboldt, 15% in Eastern Humboldt, 11% in Arcata, 8% in Fortuna, and 5% out-of-county/unknown.



Clients served through ROSE generally reflect the racial and ethnic diversity of the County. As the chart above indicates, the percentage of ROSE clients who identify as White/Caucasian is 77%, overall mental health client utilization is 78% and 77% for the general population. The percentage of ROSE clients who identify as American Indian is 12%, overall mental health client utilization is 9%, and 5% for the general population. The percentage of ROSE clients who identify as Black/African American is 2%, overall mental health client utilization is 3%, and 1% for the general population. ROSE clients who identify as Asian/Pacific Islanders is 2%, overall mental health client utilization is 2%, and 2% for the general population. There is a disparity for the percentage of ROSE clients who identify as Hispanic/Latino(a) which is 1%, overall mental health client utilization is 4%, and 10% for the general population.

The map below shows locations of services for Mobile Outreach.



Humboldt County Department of Health & Human Services

Mobile Outreach

People helping people live better lives

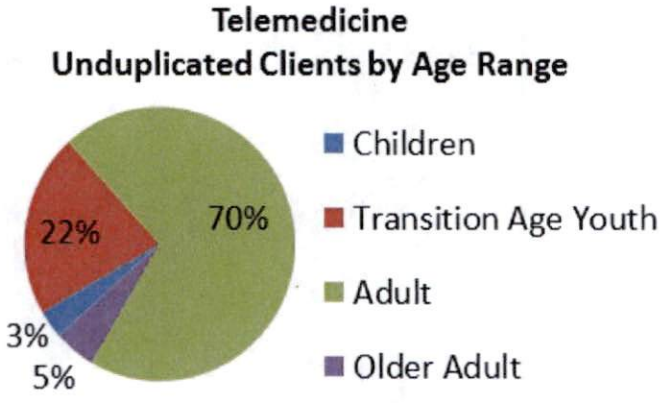
Serving the following communities:

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

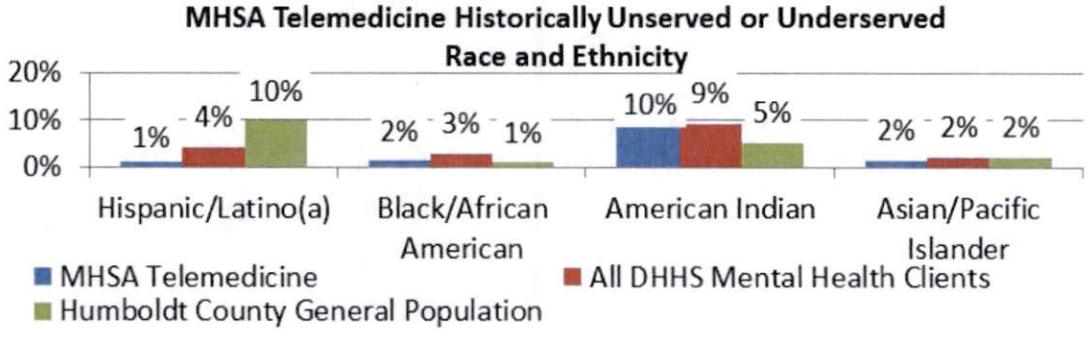
Community Services and Supports: Telemedicine

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

In the past couple of years, due to a psychiatrist shortage, the telemedicine clients have been incorporated into the adult clinic in Eureka. Video conferencing equipment is currently being updated and a project is ongoing to expand bandwidth for better connectivity in Willow Creek. In Garberville, a psychiatric nurse works one and a half days to provide outreach and support to adult and child clients living in the area.



From July 2007 through June 2014 the program has served an average of 26 unduplicated clients per month and 77 unduplicated mental health clients per year for a total of 622 unique individuals. As the chart above illustrates, this program provides services to people of all ages. 70% are adults, 22% transition age youth, 5% older adults and 3% children.



Clients served through the program reflect the racial and ethnic diversity of Humboldt County. As the chart above shows, the percentage of clients who identify as White/Caucasian is 82%, overall mental health client utilization is 78% and 77% for the general population. The percentage of MHSA telemedicine who identify as Black/African American is 2%, overall mental health client utilization is 3%, and 1% for the general population. Clients who identify as Asian/Pacific Islanders is 2%, overall mental health client utilization is 2%, and 2% for the general population. The percentage of clients who identify as American Indian is 10%, overall mental health client utilization is 9%, and 5% for the general population. There is a notable disparity for the percentage of clients who identify as Hispanic/Latino a) which is 1%, overall mental health client utilization is 4%, and 10% for the general population.

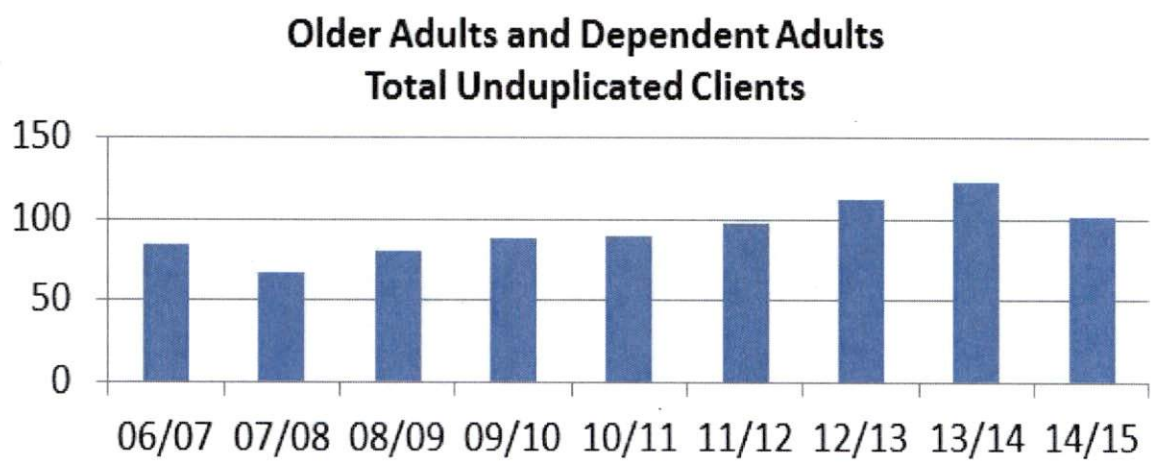
Efforts continue to increase the participation of individuals who identify as a race and or ethnicity traditionally experiencing disparities in mental health services. By reducing barriers and outreaching to ethnically diverse areas, the program contributed to the increase of services to previously unserved and underserved mental health clients who

identify as American Indians. The Cultural Competency Committee has identified specific service strategies to be implemented to address the system wide disparities for Hispanic/Latino(a) clients, specifically non- proficient English speakers.

Community Services & Supports: Older Adults and Dependent Adults

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

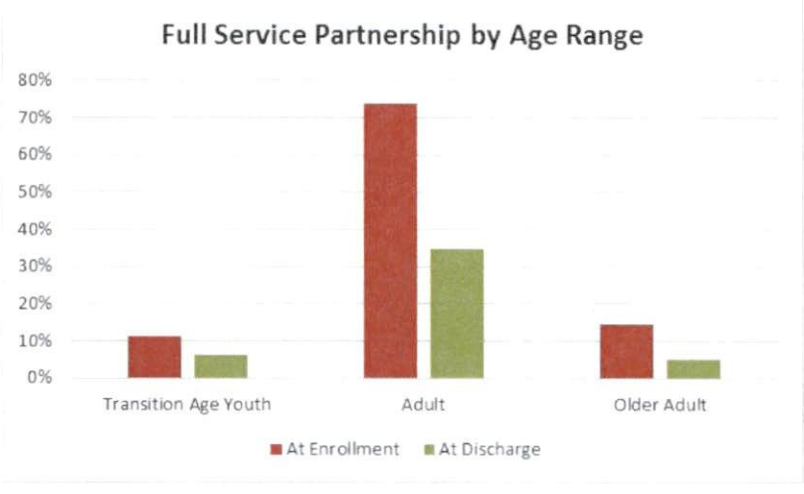
The chart below shows the total unduplicated clients for the program from 2006-2015. The range has been from approximately 80-130 clients over these years, with the greatest number in fiscal year 2013-2014. Data is not available after 2015.



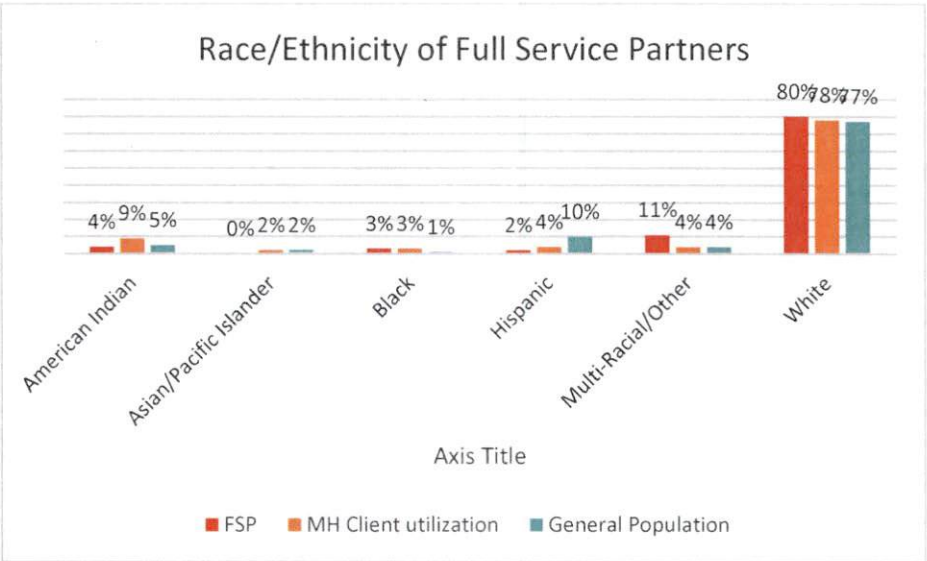
Community Services & Supports: Full Service Partnership

Full Service Partnerships (FSP) offer a range of services and supports to persons impacted by severe mental illness. These services include medication management, crisis intervention, case management, peer support, family involvement, and education and treatment for co-occurring disorders such as substance abuse. It also provides for non-mental health services such as food and housing. The term "Full Service Partners" 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. From September 2007 through June 2016, a total of 326 mental health clients have enrolled as "Partners."

As of June 2016, 282 (87%) individuals completed at least one year as an FSP, 195 (60%) completed at least two years, 152 (47%) completed at least three years, and 123 (38%) completed at least four years.



The majority of FSPs are adults and older adults. As the chart above shows, at enrollment,11% are between the ages of 15 and 25 years old, 72% are between ages 26-60, and 17% over age 60. At discharge these percentages go down, indicating aging within the group. While enrollment as an FSP is assessed for all children who meet the FSP eligibility requirements, to date the full spectrum of services have been provided through alternate programs and funding sources.



As the chart above shows, the percentage of clients who identify as White/Caucasian is 80%, overall mental health client utilization is 78% and 77% for the general population. The percentage of Partners who identify as Black/African American is 3%, overall mental health client utilization is 3%, and 1% for the general population. There are no current Partners who identify as Asian/Pacific Islander, though overall mental health client utilization is 2% and the general population is 2%. Partners who identify as American Indian is 4%, overall mental health client utilization is 9%, and 5% for the general population. Hispanic/Latino(a) Partners are 2%, overall mental health client utilization is 4%, and 10% for the general population. Partners who identify as multi-racial/other are 11%, overall mental health client utilization is 4%, and 4% of the general population.

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

Partners are served through various DHHS programs including Children and Family Services, Transition Age Youth Division, Rural Outreach Services Enterprise, and Older and Dependent Adults programs. However, partners are primarily served through the Comprehensive Community Treatment (CCT) program. Modeled after the evidence-based program Assertive Community Treatment (ACT), CCT provides intensive mental health services and community supports to assist clients in their recovery. These include access to housing, medical, educational, social, vocational, rehabilitative, or other needed community services for those with serious mental illness who are at-risk for psychiatric hospitalization, incarceration, homelessness, or placement in restrictive facilities.

In June 2011, the Dual Recovery Program (DRP) was introduced to better address the treatment needs of people with co-occurring severe and persistent mental illness and a secondary diagnosis of a substance abuse disorder. Modeled after the evidence-based program Integrated Dual Diagnosis Treatment (IDDT), DRP uses an integrated dual diagnosis treatment approach for clients needing both substance abuse and mental health services. The program uses the principles and practices of IDDT as the foundation, and provides motivational-based treatment designed to engage participants in the recovery process. Individualized case planning and time unlimited services are key features of DRP. An important goal of DRP is the reduction of negative consequences related to substance abuse. Many clients of mental health services who struggle with substance abuse are not ready to endorse abstinence early on in their treatment and may even lack the motivation to reduce their use of substances. However, significant gains in treatment can be made in the early stages of treatment by focusing treatment on reducing the negative consequences of substance use, an approach often referred to as harm reduction. At the heart of this approach, the emphasis is on protecting clients from the most severe consequences of their substance use while developing a therapeutic alliance that can motivate clients to more actively address their substance abuse, endorse abstinence from substances, and create a plan to address relapses.

As the table below shows, Partners are referred to an FSP program from within DHHS and various community partners.

Referred By:	**Percentage**
Acute Psychiatric	3%
Self or Family Member	1%
Jail/Law Enforcement	3%
DHHS Mental Health	74%
Substance Abuse Agency	2%
Social Services Agency	2%
Other	15%

Partners exit a Partnership due to a variety of reasons.

Discharge Reason	**Percentage**
Met Goals	28%
Moved Out of County	11%
No Longer Met Criteria	9%

Discharge Reason	Percentage
Chose to Discontinue	23%
Institutionalized	2%
Could Not be Located	4%
Incarcerated	4%
Deceased	19%

Full Service Partnership programs lead to dramatic improvements in decreased use of emergency shelters, homelessness days, psychiatric crisis admits, arrests, and days spent incarcerated. For Partners in FSP for 4 years the following has been found:

- Homelessness Days Down 88%
- Emergency Shelter Days Down 95%
- Psychiatric Crisis Admits Down 94%
- Arrests Down 100%
- Incarceration Days Down 100%

Innovation: Rapid Re-housing

Purpose

The purpose of this Innovation Project is to increase the quality of services, including better outcomes for adults with a severe mental illness who are homeless. While this Innovation Project will increase access to services, especially for underserved groups and promote interagency collaboration, the community planning process identified the need to increase the quality of services and better outcomes as the priority purpose.

This Rapid Re-Housing Project uses the "Housing First" approach to provide housing, peer support and supportive services for individuals with a diagnosis of severe mental illness who are homeless. "Housing First" is a proven strategy for ending all types of homelessness. As described by the United States Interagency Council on Homelessness, Housing First offers immediate access to permanent affordable or supportive housing without requirements of sobriety, income or completion of treatment. Humboldt County continues to make changes to existing rapid rehousing practices used in larger urban areas to demonstrate effectiveness on a smaller scale in rural areas. The housing component linked to the efforts of the Mobile Intervention and Services Team (MIST), which combines law enforcement officers and mental health workers in street level interventions for persons experiencing homelessness with mental illness, is proving to be the most successful component of this Innovation Project. To date, the MIST/Rapid Re-housing pathway provides permanent supportive housing to over 100 formerly homeless persons with severe mental illness. Clinicians, peers and case managers assigned to MIST provide outreach and engagement services to homeless individuals living on the street.

Background

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

Humboldt County has been designated as a community of high need by 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 3three years. In the last Point in Time Count of homeless persons (2017) 759 people who experienced homelessness were counted on the night of February 27. That was a reduction from the 1,180 homeless people counted in 2015. One possible explanation of the reduction is that the County's efforts at reducing homelessness are having a positive effect. Other explanations include slightly fewer volunteers conducting the count and wide dispersal of homeless persons following closure of the large encampment in Palco Marsh. This

Innovation project focuses on identification and service provision to homeless persons with severe mental illness, with a goal to provide clients stability in permanent supportive housing. Multiple funding sources assist in financial assistance to clients such as deposits, rental assistance, moving costs, maintenance and repair and any other needs to assure that clients remain stably housed. Sources include City of Eureka, Humboldt County, Housing and Urban Development, MHSA, Partnership Health and St. Joseph Health System/Providence and private contributions.

Like most areas in California, Humboldt County has a housing shortage. This is most acute in the availability of decent, affordable housing for persons receiving SSI. DHHS is working with local developers to provide more housing for our clients. This began with the early MHSA Capital money and resulted in 15 new studios for consumers that opened to clients during FY 16-17. Participant portion of rent is limited to less than 30% of income, making long term tenancy possible. Nearly all first tenants came directly from the streets through the MIST/Rapid Re-housing pathway with persistent and severe mental illness. Nine of the first 15 are still stably housed over a year later. Several clients were able to obtain Section 8 certificates and moved into other housing. A couple of evictions happened but the clients are still being served in interim housing with the goal of trying again in another unit.

A housing project in Eureka developed by City of Eureka/Danco Properties provided DHHS with 15 new apartments (out of 50) for participants in this project. Clients began occupying the units in April 2017 and 13 of the 15 are still housed there. Staff are on-site almost every day to provide supportive services to clients. They also arrange recreational and volunteer opportunities open to all residents to assist community integration and to reduce stigma. Peer Specialists have been used throughout the project and are very central to the successes achieved so far.

In the works and fully funded is another 50-unit apartment building with community space for tenants. This development has assigned 25 of the units to this Innovation project and occupancy should begin in Fall 2018. A fourth project in the planning stages is a 30 to 40-unit project in southern Humboldt area. Most of these units will be reserved for participants in this project. DHHS is planning to make the most of the coming No Place LIke Home funding for County Mental Health clients, including participants coming through the MIST/RRH pathway.

Over Utilization of Costly and Restrictive Services

In Humboldt County, there are a number of clients who are not connecting with outpatient services or peer support. The planning process concluded this is in large part due to homelessness. Permanent supportive housing continues to be a current unmet service need for clients who are homeless that is resulting in increased:

- 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

Stigma and Discrimination

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

Project Description

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

This Innovation Project is addressing the following issues:

- Ineffective or nonexistent engagement of individuals who are homeless and have a severe mental illness, including those with pets
- Individuals who are homeless and have a severe mental illness are often suspicious or fearful of outreach workers and law enforcement
- Individuals who are homeless and have a severe mental illness continue to experience discrimination even amongst the homeless services community and other homeless persons
- The increasing dependence on higher levels of care and restrictive settings such as psychiatric crisis and hospital services, emergency departments, and incarceration

Through the development and evaluation of the following approaches:

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

Peer Support

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

these job descriptions explicitly recognize the value of lived experience in a service delivery team and provide a career ladder for Peer Coaches. The community planning process determined that thus far the infusion of peer support has shown success in engaging hard to engage clients. Further, that peer support has been successful at shifting community attitudes and beliefs through modeling resilience and recovery. The planning process articulated a confidence that the innovative approach of peer support will prove successful for engaging and housing individuals who are homeless and have a severe mental illness. Thus far, in this Innovation Project six Peer Coaches have been added to the outreach and engagement and housing retention team. They have been very successful in achieving goals for client success and have demonstrated the high value of peer support throughout the mental health system. Peers have been integrated into multiple programs of the Branch, including CCT and the hospital.

Pets

Thus far, this Project has identified a few successful practices for engagement of homeless individuals who have a pet as well as retention of housing.

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

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

Rapid Rehousing

As a small county health and human services agency, DHHS has successfully partnered with community organizations to address the unique needs of our special populations in Humboldt. Initially, for this Project, the conversion of a local long-term transitional housing model for families to a short-term rapid rehousing model that is inclusive of individuals with a severe mental illness required an innovative approach unique to this community. The large facility served as a short-term (30 days) housing program for many homeless adults, including persons with serious mental illness, to safely reside while looking for housing. Direct diversion into housing with rental assistance was available to participants who were able to accomplish this. Innovation funds were used to support participants with serious mental illness.

MAC Changes

A large part of the previous year INN project was use of the Multiple Assistance Center (MAC) to house homeless persons with SMI for a short term while Permanent Supportive Housing units were sought for them. This was a crucial component during 2015-2016 because a very large homeless encampment near the City of Eureka was evacuated. Many of the residents in this camp had SMI and had experienced long periods of homelessness. Fortunately, several sources of funding came together to support this effort and we were able to house over a hundred persons with SMI through the MIST/MAC system.

Most individuals were able to maintain stable housing. The persons that had the most difficulty were persons with co-occurring SMI and Substance Use Disorders. We have reconfigured MAC by adding SUD treatment to the Case Management services still offered there and have included medically supervised detoxification and residential SUD treatment for persons that are dually diagnosed. Community partners have substantially increased the financial support of the project so DHHS was able to shift more of the INN funds to the MIST part of the project and add staff: Peer Coaches, Clinician, Case Managers, Community Health Outreach workers to increase access to MH services especially engagement and assessment. The individuals with dual diagnoses will be placed into the MAC. Persons experiencing homelessness that also have SMI are referred directly to our Housing unit for permanent housing depending on their level of need with the most vulnerable placed into Permanent Supported Housing.

Partnering with Law Enforcement

The most successful component of this Project, the Mobile Intervention Services Team (MIST), is the collaborative effort to successfully engage homeless individuals who have a severe mental illness and have frequent contact with law enforcement. Thus far this Innovation Project has designed, developed, and piloted DHHS Mental Health staff partnering with local law enforcement officers. MIST maintains a registry of the 25 highest utilizers of emergency services including Emergency Department visits, hospitalizations, calls for service, psychiatric hospitalization and crisis intervention.

Key Activities

- Outreach and Engagement. Outreach and engagement occurs through the MIST partnership with law enforcement, emergency departments, psychiatric emergency services and hospitals as well as other community partners.

- Housing First Model. Staff assist participants in locating and securing housing as quickly as possible using a "Housing First" approach. Participants have a housing assessment to determine the appropriate level of housing for the individuals with serious mental illness and any ongoing needs for supportive services to remain housed. Through other funds, financial assistance is also available for deposits and in some cases on-going rental assistance. The housing placements range from private market apartments and efficiencies, subsidized housing, Section 8 subsidy, shared housing and for those most vulnerable with a history of chronic homelessness, Permanent Supportive Housing. Maintenance and repair services for persons with symptoms of severe mental illness such as hoarding and property destruction during episodes are provided to keep them housed. This aspect of some mental illnesses is often the reason for their homelessness.

- Permanent Supportive Housing. Humboldt Housing and Homeless Coalition (HHHC) has taken every opportunity from HUD to increase the community's stock of Permanent Supportive Housing (PSH). When funded by HUD, this housing option requires the occupant to be low-income, disabled and chronically homeless. Briefly, PSH allows the participant to choose where he or she wishes to live so long as the

rent is in line with Fair Market Rent for the area. The occupant's share of the rent is limited to no more than 30% of his/her income and the HUD-funded agency pays the balance. The housing unit is in the client's name and allows him/her to develop a good rental history. The participant is offered a full range of supportive services and chooses what he or she would like to participate in as recovery is client-driven. PSH can be funded by other sources, not just HUD, and DHHS Mental Health has a collaborative agreement for 15 units of PSH using the MHSA Housing Program that opened in Fall 2016. Known as Arcata Bay Crossing (ABC), this development has 42 housing units total, including the 15 set aside for homeless people with serious mental illness.

The success of our MHSA Housing Program came to attention of a local building developer who approached DHHS with an offer to provide our Mental Health clients with 15 units of brand new housing in their development in Eureka known as the Lodge. We were able to house 15 persons over the age of 55 with SMI in this project beginning March 2017 and all but two have maintained stability there. The same developer has a project that is funded breaking ground early in 2018. There will be 50 units and 25 are set aside for DHHS MH clients that are homeless and have serious mental illness. Another project in planning stages is for persons over 55 and/or disabled. Persons disabled by mental illness will have access to some of these units. We anticipate that the funds available through NPLH will help us and the developer leverage funding to build more PSH units.

- 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
    - Alcohol and other drug services
    - Primary care physician
    - Housing
    - Bus vouchers
    - CalFresh enrollment
    - Transitional Age Youth Division, which provides mental health, social services, public health, Peer Partner support, advocacy and educational opportunities in an age appropriate, peer driven setting
    - The Hope Center, a peer run empowerment center that provides a safe, welcoming environment based on recovery self-help principles
    - DHHS Mobile Outreach Vehicles, which provide services to people in extremely rural outlying communities and to those who are experiencing homelessness. The program uses RVs that travel to community sites such as family resource centers, clinics, tribal offices, volunteer fire departments, free meal sites, and homeless encampments. Social services, mental health and public health services and/or referrals are

provided. These services are available in Spanish and

- English and may not be accessible otherwise due to transportation, financial or health-related difficulties. Mental health services include ongoing counseling, alcohol and substance abuse and case management.
- Transportation Assistance Program provides a non-refundable bus ticket to a pre-determined destination or gas money and daily meal allowance for each day of travel for those who wish to travel out of the area where they have family and/or friends willing to offer support and · assistance
- Community Corrections Resource Center (CCRC) is a multidisciplinary center that provides jail custody and community based services to County Probation Department offenders under AB109. DHHS services include development of transitional discharge plans, mental health assessments, counseling, medication management, alcohol and drug counseling, employment, education and housing assistance.

Project Outcomes

The following will continue to be monitored through the implementation team to identify best practices, which will be reported in a final Innovation Report at the end of the Project. Client outcomes will be monitored quarterly through the DHCS Data Collection and Reporting data base for Full Service Partners. They include but are not limited to increasing residential stability, increasing educational goals, and increasing vocational goals. At the same time, desired outcomes are reducing psychiatric hospitalizations, reducing psychiatric emergency visits, reducing arrests, and reducing incarcerations.

The project timeline is below.

	Rapid Re-housing Project Timeline
	Activities
Fiscal Year 2014/2015	Planning and preparation of MHSA Innovation Plan
Fiscal Year 2015/2016	Transition the MAC from long-term to rapid re-housing model, develop staffing positions and job duties, recruit and train personnel, outreach and engage initial client participants, and implement project and evaluation plan.
Fiscal Year 2016/2017	Continue project and evaluation plan. Monitor client outcomes.
Fiscal Year 2017/2018	Continue project and evaluation plan. Monitor client outcomes.
Fiscal Year 2018/2019	Continue project and evaluation plan. Monitor client outcomes.

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

Prevention & Early Intervention: Hope Center

The Hope Center serves unserved and underserved populations including transition age youth, adults and older adults who have a severe mental illness and their family members. It provides a safe, welcoming environment based on recovery self-help principles and the resources necessary for people with a mental health diagnosis and their families to be empowered in their efforts to be self-sufficient. The Hope Center is client/family member run with a full time Peer Coach III who oversees the Center and two full time and one part time Peer Coach II staff. Staff supervision and consultation is provided by a Senior Program Manager. Two Peer Coaches are trained and provide Wellness Recovery Action Plan (WRAP) development training. The Center provides recovery services including self-advocacy education, peer support, system navigation, and linkage to services. Outreach efforts are made by Hope Center peer staff and volunteers to people with a mental health diagnosis.

Hope Center Goals:

- Build socialization skills
- Build sustainable living skills
- Community engagement
- Promote self-advocacy
- Keep Hope Center a safe location for all participants
- Reduce stigma and discrimination within the system of care and the broader community
- Encourage individuals to find their personal strengths and identify their personal recovery goals

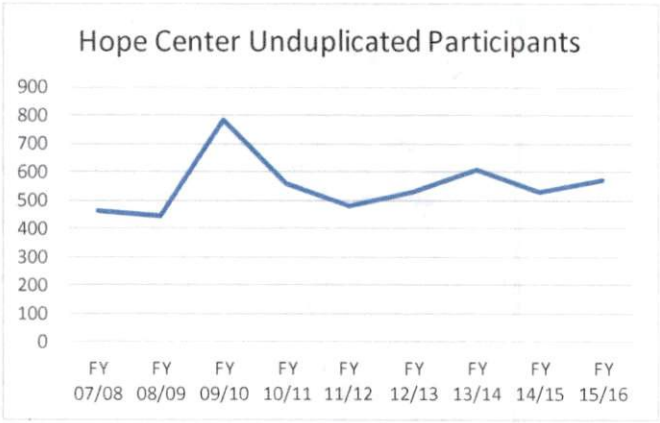
Hope Center Continuing Projects

- Activities, art shows and events
- Healthy Harvest – Cal Fresh grant
- Support groups
- Supportive Employment Project
- Wellness Recovery Action Plan facilitation
- Hope Center peer support group at the psychiatric hospital

- May is Mental Health Month coordination

Participant sign in sheets show a range of 7000 to 8200 sign ins over the past eight years, with an average of approximately 7000, as shown in the chart below.

As shown in the chart below, the Hope Center serves an average of over 500 unduplicated participants per year, with a range of 450 to nearly 800.



A Hope Center participant had this to say: "The Hope Center is like being with family. I feel like I can be myself and that I belong somewhere."

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

- Community BBQ's
- Art shows
- Zumba
- Movie screenings
- Presentations by the Seeds of Understanding
- County Board of Supervisors Proclamation

- Community walk that culminates in a rally with speakers

Volunteers at the Hope Center are consistent and active members of the community who contribute services such as outreach, education, and coordination of special events. Some special events over the past year include:

- Art Sale
- Each Mind Matters Presentation
- Bird Walk
- May's Mental Health BBQ
- Car Show
- Ice Cream Social
- Concert by the Bay
- Mental Health Walk
- Open Mic
- Movie Night at Sequoia Park
- MHSA Meeting and Luncheon
- Dell'Arte Mash-Up Bash Pageant
- Freshwater Picnic
- Redwood Park Walk
- Headwaters Walk
- Supportive Employment
- Cruz Car
- Road Trip to Ukiah Memorial Project

Prevention & Early Intervention in Public Health

Prevention and Early Intervention (PEI) strategies in Public Health are designed to reduce the stigma associated with mental illness, to prevent mental illness from becoming severe and disabling and to improve timely access to services—in particular to traditionally unserved, underserved, or inappropriately served communities. Mental Health Services Act Three-Year Integrated Program for Fiscal Years 2017/18 - 2019/20 outlines the implementation of the following PEI strategies. All activities meet an evidence based, promising practice, or practice based evidence standard. It is housed within DHHS Public Health Healthy Communities Division and uses a public health approach following the Spectrum of Prevention model. The Program works to build capacity in the community to support a coordinated continuum of care across systems. The program achieves this through enhancing partnerships with health care, education, mental health providers, first responders, probation, Tribes, youth serving providers, faith communities, and Family Resource Centers.

In October of 2015 new PEI regulations require an expansion of demographics collected to include age, race, ethnicity, primary language, gender assigned at birth, current gender identity, sexual orientation, veteran's status, and disabilities. PEI programs are now required to collect the demographic information for both individuals who receive early intervention services, and the individuals for whom training and education are provided. Additionally the new regulations imposed requirements to better track access and linkage services. The new PEI requirements have been challenging to implement in terms of data collection systems and current workflows. CalMHSA is working on developing outcome measures for SDR and SP programs that will provide comparable data across the state. The Humboldt County PEI programs are open and responsive to the changes. PEI programs will continue to work closely with CalMHSA to implement these requirements.

Community Education, Outreach and Engagement – Community-wide prevention efforts are designed to educate the broader community on how to identify the signs of mental illness; how to access resources for early detection and treatment; and to reduce mental illness stigma and discrimination. In FY 2017/20 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.

Capacity Building Assistance – Capacity Building Assistance (CBA) is designed to support and strengthen community partners including community-based organizations, educational institutions, and health and behavioral healthcare organizations, leverage resources, and broaden the support network for unserved, underserved, and inappropriately served population. Capacity building assistance is not one size-fits-all. CBA is a tailored service to meet the needs of each recipient organization.

Evaluation & Outcomes for PEI Programs. The PEI programs of Healthy Communities are currently writing their five year strategic plans following the Strategic Prevention Framework, which will incorporate outcomes in accordance with MHSA

regulations. The Suicide Prevention outcome measures will include pre and post surveys for QPR and other suicide prevention trainings and presentations. The ASIST evaluation, demographic forms and participant counts will be collected. Educational materials will be distributed. Stigma and Discrimination Reduction will use the evaluation forms from Mental Health First Aid and Youth Mental Health First Aid. Becoming Brave will have a pre and post survey related to evaluating self-stigma. All other events will measure participant counts and will provide educational materials.

Prevention & Early Intervention: Suicide Prevention

The County will continue to regionally promote 24 hour crisis support, suicide prevention materials, and continue to fund suicide prevention trainings for mental health providers, community partners, and the general public in Humboldt County. Trainings are provided by the County and a multi-disciplinary training team made up of community partners across all sectors. Trainings, workshops and other activities will include:

Community Education, Outreach and Engagement:

Question, Persuade and Refer (QPR) was implemented in September 2009. This training is a brief educational program designed to teach "gatekeepers"--those who are strategically positioned to recognize and refer someone at risk of suicide (e.g., parents, friends, neighbors, teachers, coaches, caseworkers, police officers)--the warning signs of a suicide crisis and how to respond by - Question: Ask about suicide; Persuade and promote the person to seek and accept help; and Refer the person to appropriate resources.

Applied Suicide Intervention Skills Training (ASIST) – An evidence-based model for suicide prevention is a two-day course designed to train individuals over 16 years old—regardless of prior experience or training—who want to be able to provide "suicide first aid." The ASIST model teaches effective intervention skills while helping build suicide prevention networks in the community. Those trained in the model will have the ability to recognize and review risk, and to intervene to prevent the immediate risk of suicide.

Tailored Trainings - Tailored Suicide Prevention Trainings 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 evidence-based materials.

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

Community Coalitions and Partners – The Suicide Prevention program will continue to have a presence on community coalitions in order to provide suicide prevention materials, resources, and support. Coalitions include:

- Humboldt County Office of Education (HCOE), in order to provide trainings and model policy to implement AB2246 in the County's school districts;
- Humboldt County Behavioral Health Board,

- Child Abuse Prevention Coordinating Council to help plan the annual summit
- Domestic Violence Coordinating Council to assist with the countywide "Safety and Accountability Assessment"
- Humboldt Pregnancy and Postpartum Support Network
- Allies for Substance Abuse and Prevention
- RxSafe Humboldt to address the opioid epidemic and the intersection of substance abuse and suicide
- LatinoNet
- American Foundation for Suicide Prevention in Humboldt County

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

DHHS Suicide Prevention Webpage – Staff support the maintenance of current resources, trainings, and information.

Suicide Prevention Month – Program staff will continue to lead the coordination of community events and efforts to raise awareness around suicide prevention including proclamations and presentations before the County Board of Supervisors, American Foundation of Suicide Prevention Community "Out of the Darkness" walk, tabling at the Humboldt County LGBTQ Pride Festival, trainings, and film screenings.

Capacity Building Assistance:

Training and Workforce Development - Trainings utilizing evidence based, promising practice, or practice based evidence model. Staff will provide efforts to expand community's capacity for suicide prevention trainings through consultation, "Train-the-Trainers", and coordination of multi-disciplinary training teams. Training teams include public health educators, mental health clinicians, social workers, tribal community agency representatives, and law enforcement.

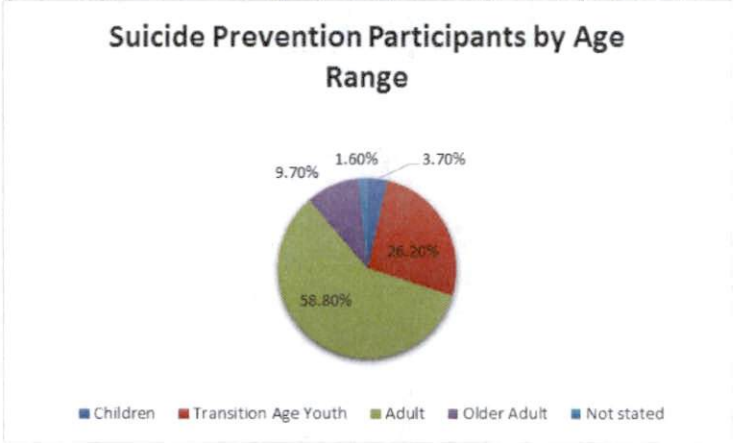
Systems Change - Staff will provide support to community partners representing multi-sector settings including education, primary care, behavioral health, and social services to assess capacity develop and evaluate internal policies and procedures to address continuum of care for persons at risk such as a Zero Suicide approach.

Suicide Prevention Report

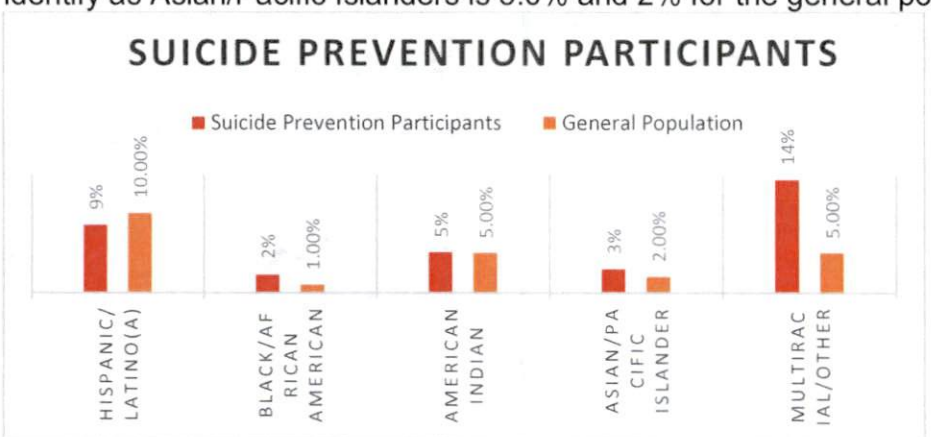
Between November 2009 and June 2016, there were 38 events with 2,233 participants sponsored by the Suicide Prevention Program. These included speaker events, technical assistance meetings, local hospital grand rounds, building community capacity events, and tabling at community events such the Festejando Nuestra Salud (Latino

Health Fair), the K'ima:w Tribal Health Fair, the St Joseph's Health Fair and the Humboldt Pride Festival. In addition there were 187 suicide prevention trainings with 3,501 participants for a total of 5,734 participants. Of those 2,861 or 49% completed demographic forms.

The Suicide Prevention Program provides trainings to people of all ages. As shown in the chart below, between November 2009 and June 2016 of the 2,752 total Program participants with Demographic forms collected, there were 102 (3.7%) children, 722 (26.2%) transition age youth, 1617 (58.8%) adults, and 266 (9.7%) older adults.

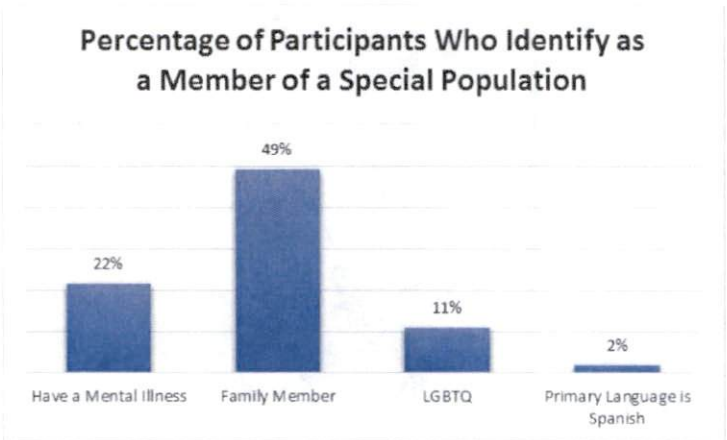


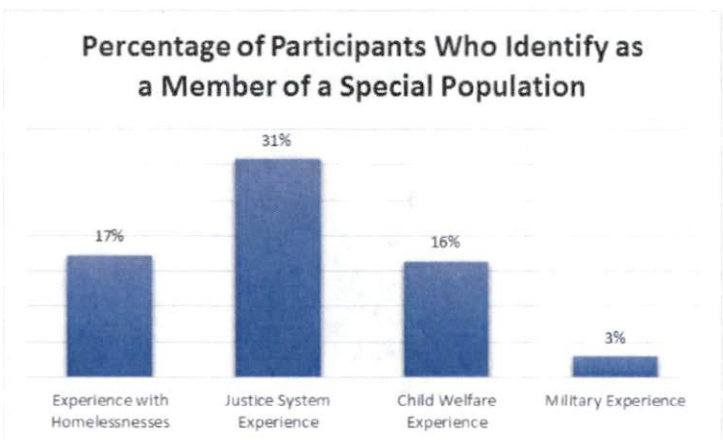
As shown in the chart below, participants reflect the racial and ethnic diversity of Humboldt County with an emphasis on those populations that are historically underserved, underserved or inappropriately served. The percentage of Suicide Prevention participants who identify as Hispanic/Latino(a) is 8.5%, and 10% for the general population. The percentage of participants who identify as White/Caucasian is 66.9% and 77% for the general population. The percentage who identify as Black/African American is 2.3% and 1% for the general population. The percentage who identify as American Indian is 5.1% and 5% for the general population. Participants who identify as Asian/Pacific Islanders is 3.0% and 2% for the general population.



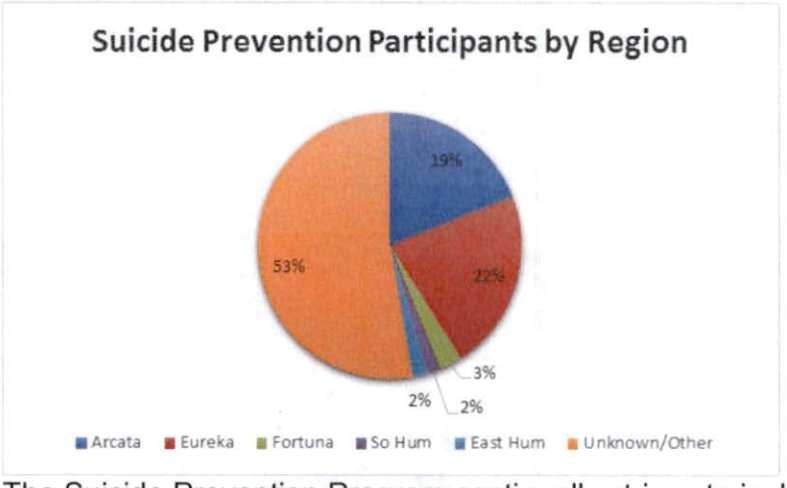
Life experiences where there is extensive evidence that disparities exist in the areas of access, quality, and outcomes in mental health service provision are also monitored for

participation. Sexual orientation, gender identity, homelessness, incarceration, former foster youth, are all life experiences where the impact of stigma and discrimination can result in challenges to successful mental health access and treatment. The charts below shows that 22% stated they had a mental illness. 49% stated they are a family member of someone with a mental illness. 11% stated they are LGBTQ. 2% stated their primary language is Spanish. 17% have experience with homelessness. 31% have experience with the justice system. 16% have experience with the Child Welfare system. 3% have military experience.

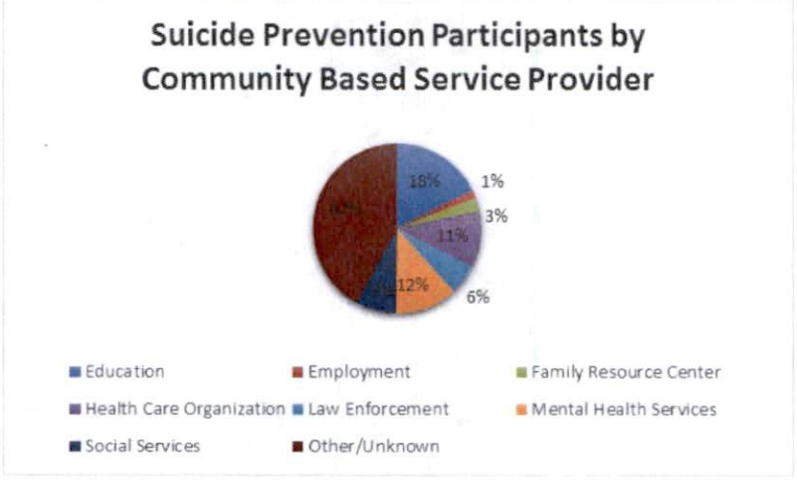




Another priority for representation in Suicide Prevention activities is regional. As shown in the chart below, half of County residents live in the Arcata (19%) and Eureka (22%) regions close to Humboldt Bay while the other half lives in the southern (2%), eastern (2%) and Fortuna (3%) regions of the County. 53% are unknown/other region. To date activities have been focused in the Arcata and Eureka regions of the County and staff is focusing on increasing activities in other regions.



The Suicide Prevention Program continually strives to include representation from diverse community based service providers. As shown in the chart below, individuals have participated from education (18%), employment (1%), Family Resource Centers (3%), mental health services (12%), health care organizations (11%), social services (7%), and law enforcement (6%). 42% are other/unknown.



Trainings

Question, Persuade and Refer (QPR) Between September 2009 and June 2016, there have been 130 QPR trainings with 2,540 participants and 1,861 completed an evaluation. QPR is customizable and staff have made this training useful to a range of populations from high school students to law enforcement.

Applied Suicide Intervention Skills Training (ASIST) Between September 2011 and June 2016 there were 31 ASIST trainings with 535 participants and 227, or 42.4%, completed a CalMHSA evaluation.

The table below shows the results from the pre-and post evaluations for the ASIST training, overall showing an increase in attendees feeling their capacity to help someone who has thoughts of suicide.

Results of ASIST Pre and Post Evaluation	Percent Increase in Capacity to Help
If a person's words or behaviors suggest the possibility of suicide, I would ask directly if they are thinking about suicide	34%
If someone told me he or she were thinking of suicide, I would do a suicide intervention	29%
I feel prepared to help a person at risk of suicide	47%
I feel confident I could help a person at-risk of suicide	44%
I can identify the places or people where I should refer others at risk of suicide	30%
I have easy access to the educational resource materials I need to learn about helping a person at risk of suicide	29%
I feel comfortable discussing suicide with others	39%

Prevention & Early Intervention: Stigma and Discrimination Reduction

The PEI Stigma and Discrimination Reduction Program provides activities that increase awareness of attitudes, beliefs, perceptions, stereotypes and discrimination related to undiagnosed and diagnosed mental illness or to seeking mental health services. The program works to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and family members. The Program intends to influence all community members in Humboldt County. The Program includes social marketing campaigns, enhancing the voices of people with lived experiences, targeted education and training, anti-stigma advocacy support for statewide web-based campaigns.

Community Education, Outreach and Engagement:

Mental Health First Aid / Youth Mental Health First Aid – Mental Health First Aid is an evidence-based 8-hour training that provides a general overview and basic skills to identify, understand, and respond to mental health and substance use issues. Mental Health First Aid provides information to identify symptoms, risk factors, and warning signs for depression, anxiety, and suicide. Participants gain a better understanding of psychotic disorders and substance abuse and learn how to implement the five step Mental Health First Aid action plan. To date 161 people have participated in 10 trainings; these demographics and participation numbers are tracked as Suicide Prevention. Youth Mental Health First Aid Training (YMHFA), tracked as Stigma and Discrimination Reduction, was launched in January of 2016 and to date 4 trainings have been held with a total of 77 attendees.

Tailored Trainings - Tailored Stigma Reduction Trainings 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 evidence-based materials.

Becoming Brave - A new training to Humboldt County, Becoming Brave is based on Honest, Open, Proud. This training guides those living with mental health disorders through the story they have been telling themselves about their mental health, in order to discern helpful and hurtful self-attitudes, and analyze the pros and cons of disclosing in different settings to different people. The training guides participants to draft their own story into a format that discloses not only the pain of mental health challenges but also the internal and external resources they have discovered and use to live their lives. A contractor will provide the training and program staff will be trained to lead this training on an ongoing basis. This will provide a safe place for our community to discuss mental health, and will be an avenue to introduce our community to the power of their own story.

Peer and Consumer Voices – Staff will continue to support and promote the voices of people with lived experiences through art, dialogue, speakers' collectives, and digital story telling.

- "Seeds of Change" speakers collective - The Program will continue to assist the

Seeds of Understanding with their goals. This spring and summer will be the launch of a refreshed recruitment of membership.

- "Reframe Your Brain" poster contest - annual art contest to promote creative expression of stigma-busting messages and issues related to mental health and wellness.
- "Artistic Solutions" – using artistic medium to express lived experiences.

May is Mental Health Matters Month - The Stigma and Discrimination Reduction Program will continue to assist in the coordination of the May is Mental Health Matters Month planning committee. Multi-disciplinary agency representatives and community groups work to coordinate events, activities, and outreach. Humboldt County's May celebration is among the most active in the state, and includes movie screenings, presentations by the "Seeds of Change" members, three mental health barbeques, a family mental wellness skate, a County Board of Supervisors Proclamation, and a walk that culminates in a rally with speakers. The Program engages in community outreach and has provided education and awareness information at local health fairs and community events. The program has increased its visibility and is highly valued by organizers of these events.

Capacity Building Assistance

Capacity building assistance in Stigma and Discrimination Reduction is not one size-fits-all. CBA is a tailored service to meet the needs of each recipient organization. Stigma's CBA in this reporting period will reflect a shift to five-year strategic planning and building capacity and infrastructure in the Seeds program (by implementing EBPs) and work with the Center in McKinleyville's implementation plan to incorporate equity in client service delivery, which is directly related to stigma and discrimination reduction.

The bulk of SDR's numbers traditionally come from the Seeds of Understanding presentations. The shift in prioritizing presentations has been deliberate. SDR, Healthy Communities, Public Health has pulled back in order to restructure the program and ensure quality. We have shifted focus from quantity to quality. There are specific parameters for how to reduce stigma in public speaking.

Collaborative Efforts

Media Campaigns & Toolkits - The Suicide Prevention Program continues to promote statewide and local campaigns (e.g. purchasing bus ads, print ads, radio ads, and TV spots) including "Know the Signs,""Each Mind Matters,""Sana Mente,"and "Directing Change" and toolkits including Making Headlines-A Guide to working with the media about suicide prevention, Smartphone app MY3, Culture and Community: Suicide Prevention Resources for Native Americans, Training Resource Guide for Suicide Prevention in Primary Care Settings.

Directing Change - Humboldt County has become a leader statewide in the creative execution of the Directing Change Youth Film Contest with previous county youth award winners. Program staff will continue to promote the film contest in new

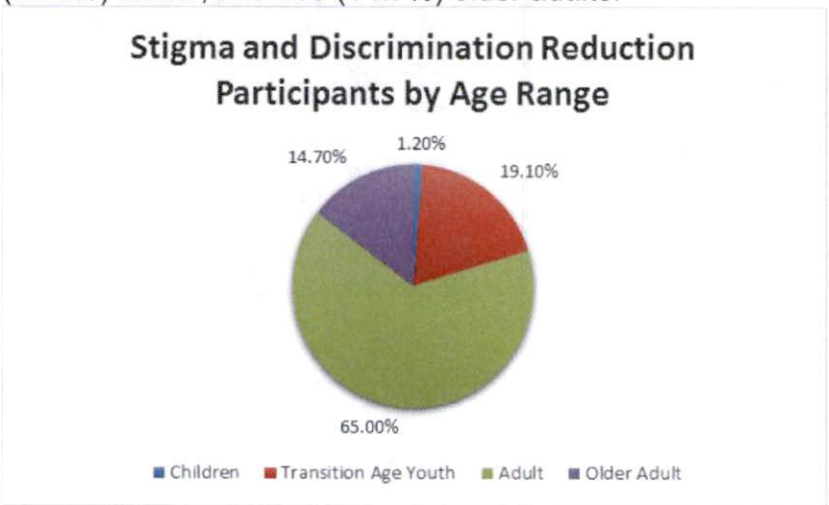
schools and alternative/diverse youth settings. Staff work closely with the Humboldt County Transitional Age Youth Collaborative (HCTAYC) staff to plan and execute a years' worth of outreach and activities around supporting youth to become engaged in talking about mental health stigma reduction and suicide prevention. Youth are provided support around safe messaging and film development through workshops.

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

Stigma and Discrimination Reduction Report

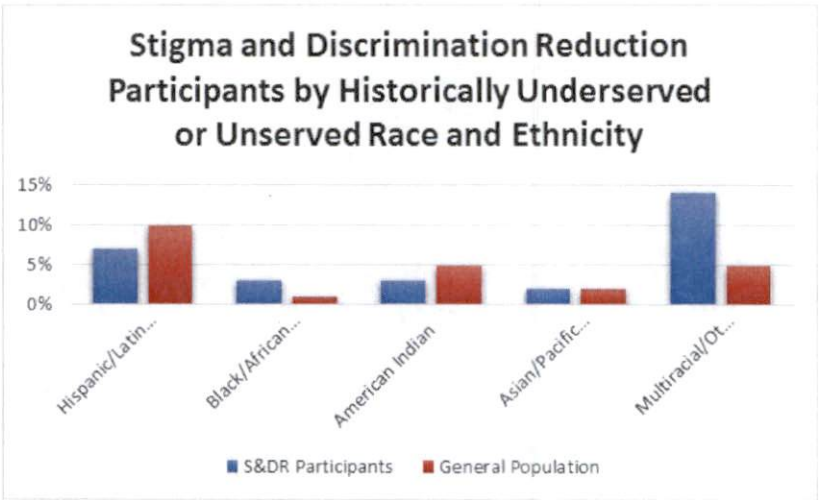
Between February 2010 and June 2016 there were 150 events including tabling at community events, peer-driven planning meetings, trainings, and presentations with a total of 5,508 participants. Of those 2,081 or 37.7% completed demographic forms.

As the chart below illustrates, the Stigma and Discrimination Reduction Program provides trainings to people of all ages. Between February 2010 and June 2016 the Program's participants were 24 (1.2%) children, 398 (19.1%) transition age youth, 1,352 (65.0%) adults, and 305 (14.7%) older adults.

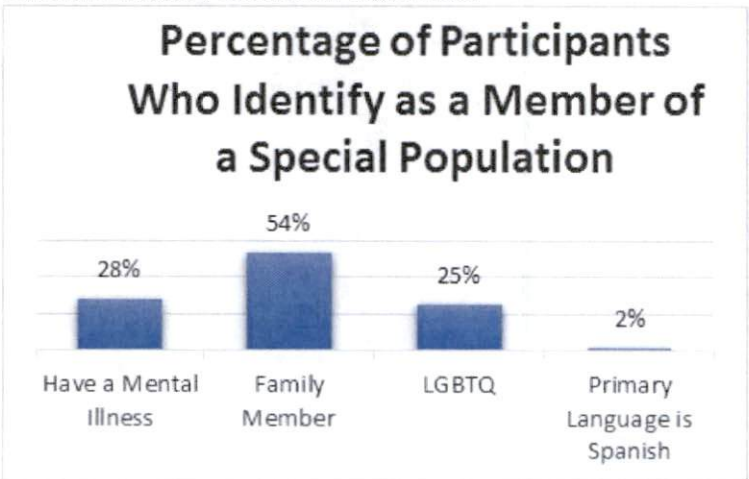


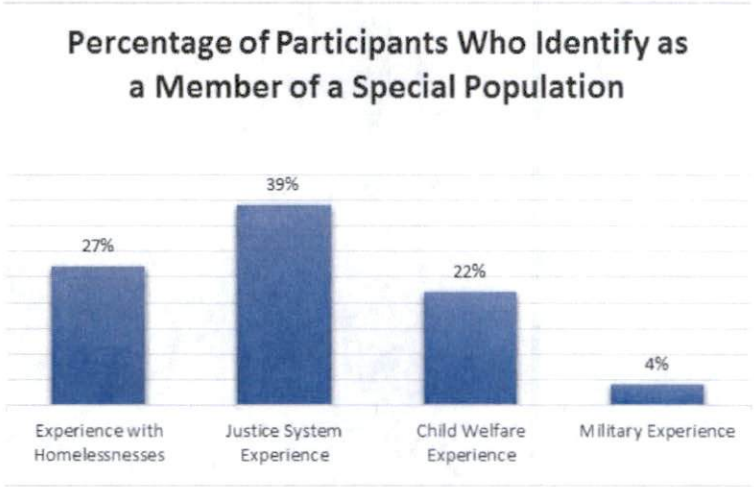
As the chart below shows, participants reflect the racial and ethnic diversity of Humboldt County with an emphasis on those populations that are historically unserved, underserved and inappropriately served. The percentage of Stigma and Discrimination Reduction participants who identify as Hispanic/Latino(a) is 6.5%, and 10% for the general population. The percentage of participants who identify as White/Caucasian is 71.8% and 77% for the general population. The percentage who identify as Black/African American is 2.7% and 1% for the general population. The percentage who identify as American Indian is 3.3% and 5% for the general population. Participants who

identify as Asian/Pacific Islanders is 1.7% and 2% for the general population.

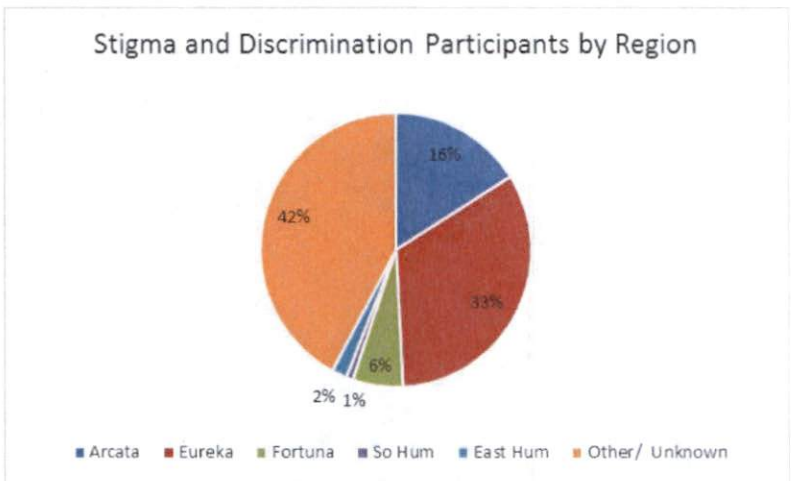


Life experiences where there is extensive evidence that disparities exist in the areas of access, quality, and outcomes in mental health service provision are also monitored for participation. As shown in the charts below, 28% identified as having a mental illness, 54% identified as being a family member of someone with a mental illness, 25% identified as LGBTQ, 2% as having Spanish as their primary language, 27% have experience with homelessness, 39% have experience with the justice system, 22% have experience with Child Welfare, and 4% have military experience. These are all life experiences that are impacted by stigma and discrimination that can result in challenges to successful mental health access and treatment. Outreach efforts to include people with these unique life experiences is resulting in their participation in Stigma and Discrimination Reduction activities.

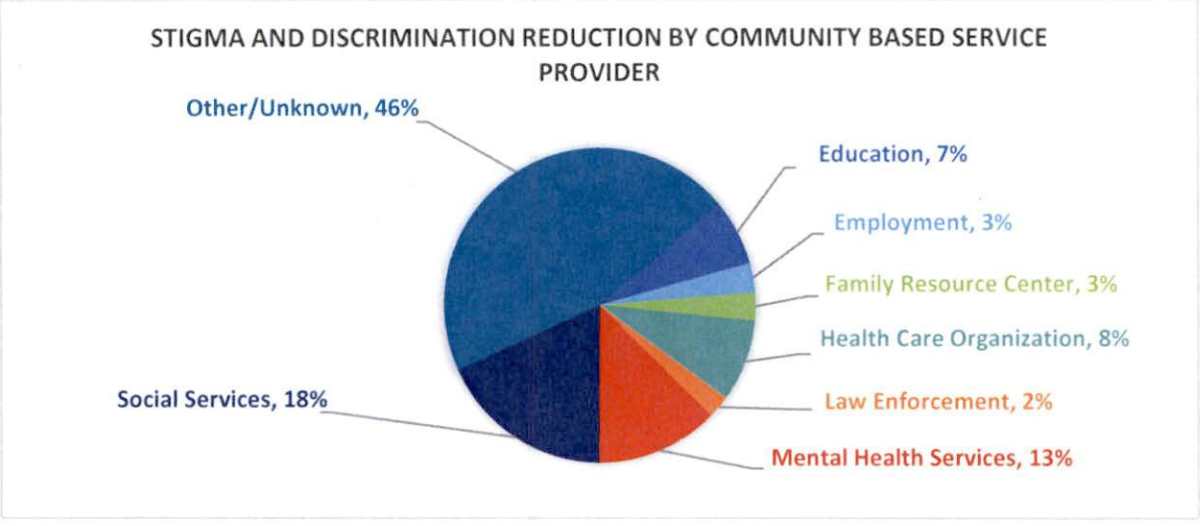




Another priority for representation in Stigma and Discrimination Reduction activities is regional. As shown in the chart below, approximately half of residents live in the Arcata (16%) and Eureka (33%) regions close to Humboldt Bay while the other half lives in the southern (1%), eastern (2%) and Fortuna (6%) regions of the County. 42% are other/unknown. To date activities have been focused in the Arcata and Eureka regions of the County and there is a need to engage with and provide Stigma and Discrimination Reduction activities to residents in the southern and eastern regions of the County.



The Stigma and Discrimination Reduction Program continually strives to include representation from diverse Community based service providers. As the chart below shows, individuals have participated from education (18%), employment (3%), mental health services (13%), Family Resource Centers (3%), health care organizations (8%), social services, and law enforcement. Individuals such as housing staff, media and faith based organizations were not significantly reached. The program will do targeted outreach to these representatives for future activities.


STIGMA AND DISCRIMINATION REDUCTION BY COMMUNITY BASED SERVICE PROVIDER
Other/Unknown, 46%
Education, 7%
Employment, 3%
Family Resource Center, 3%
Health Care Organization, 8%
Law Enforcement, 2%
Mental Health Services, 13%
Social Services, 18%

Prevention & Early Intervention: TAY Advocacy and Peer Support

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

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

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

The Mental Health Services Act (MHSA) and TAY Division

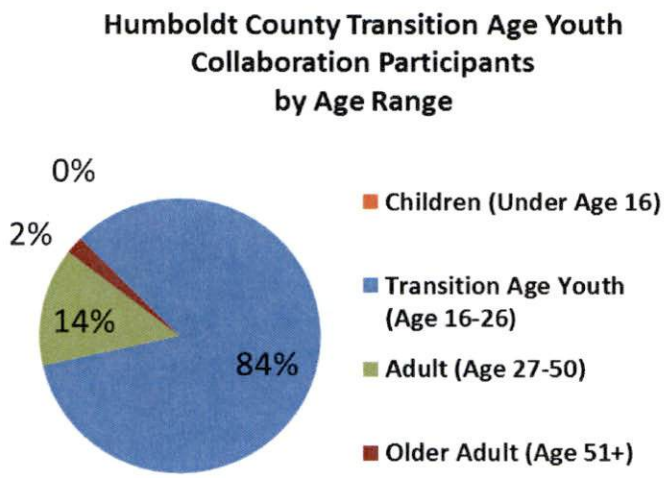
The MHSA elements of the TAY Division are rooted in the 2004/2005 MHSA Stakeholder process where a significant need was identified to address poor outcomes for unserved and underserved youth with a severe mental illness or whose risk of developing a severe mental illness is significantly higher than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

TAY Advocacy, Education, Outreach and Peer Support launched in 2008 and is the MHSA Prevention and Early Intervention (PEI) component of the TAY Division. It brings together youth, DHHS, California Youth Connection, and the Y.O.U.T.H. Training Project (YTP) to improve the services youth receive as they transition into adulthood and become independent. The purpose is to cultivate 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 and to improve access and linkage to treatment. HCTAYC directly impacts the transition age youth system of care making it more responsive to young people's needs. It fosters youth development, youth advocacy, 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. HCTAYC provides training to youth, staff, and community partners related to more effectively engage youth and develop youth informed approaches.

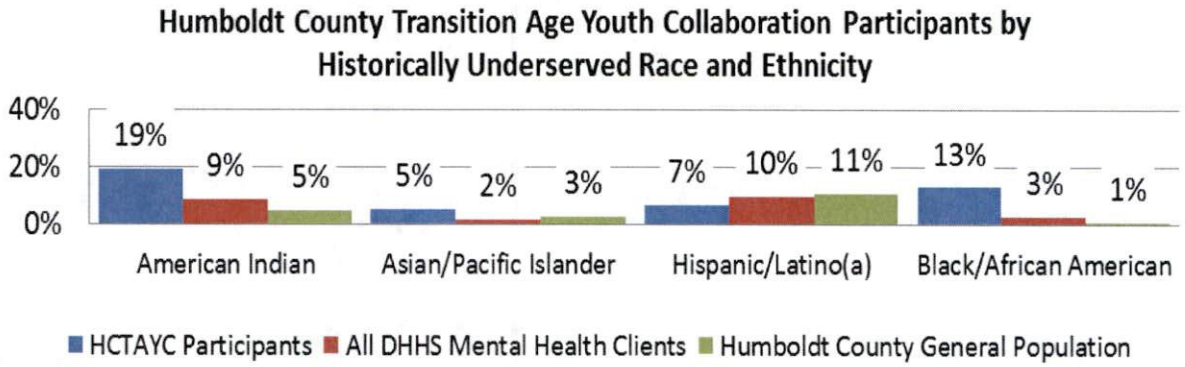
HCTAYC is made up of a Youth Advisory Board that provides input and brings a youth voice to program development. The HCTAYC Youth Advisory Board is trained extensively in facilitation, public speaking, and leadership. HCTAYC's areas of focus for systems improvement include: mental health, homelessness, foster care, juvenile justice, alcohol and drug abuse, transitional housing, employment services, and many other services for transition age youth.

From 2014 through 2016 HCTAYC has facilitated or provided advocacy, education and outreach training at events resulting in 700 sign-ins, an average of 233 per year. Of those who signed in, there were 317 recorded unique visitors. Among these visitors, 538 (75% of sign-ins) completed demographic forms

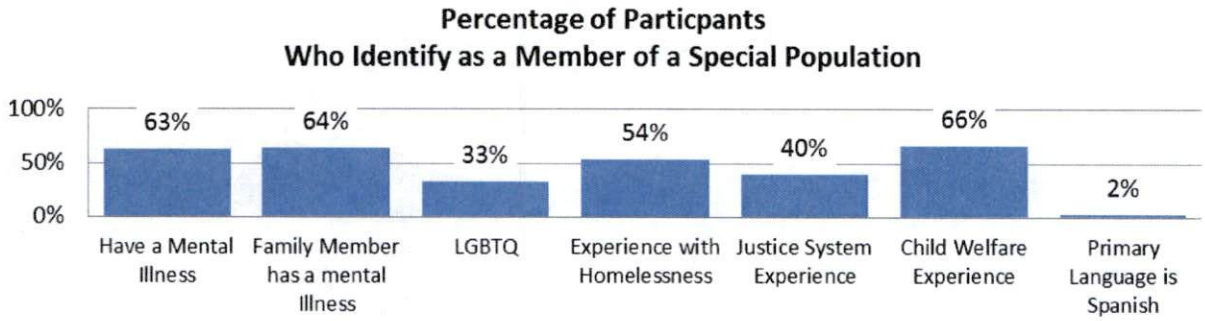
As the chart below illustrates, HCTAYC provides trainings to people of all ages with targeted focus on transition age youth. Between January 2014 and December 2016 the program's participants who disclosed their age were 84% transition age youth, 14% adults, 2% older adults, and 0% children.



HCTAYC participants reflect the racial and ethnic diversity of Humboldt County with an emphasis on those populations that are historically underserved or unserved. As the chart below shows, the percentage of HCTAYC participants who identify as Hispanic/Latino(a) is 7%, overall Mental Health client utilization is 10%, and 11% for the general population. The percentage of HCTAYC participants who identify as White/Caucasian is 53%, overall Mental Health client utilization is 66% and 76% for the general population. The percentage who identify as Black/African American is 13%, overall Mental Health client utilization is 3%, and 1% for the general population. The percentage who identify as American Indian is 19%, overall Mental Health client utilization is 9%, and 5% for the general population. HCTAYC participants who identify as Asian/Pacific Islanders is 5%, overall Mental Health client utilization is 2%, and 3% for the general population.



As shown in the chart below, 63% identified as having a mental illness, 64% identified as being a family member of someone with a mental illness, 33% identified as LGBTQ, 2% as having Spanish as their primary language, 54% have experience with homelessness, 40% have experience with the justice system, and 66% have experience with Child Welfare. These are all life experiences that are impacted by stigma and discrimination that can result in challenges to successful mental health access and treatment. This chart illustrates how efforts to include people with these unique life experiences is resulting in their participation in HCTAYC. HCTAYC will continue to expand and further their goals in order to meet the needs of youth and young adults in Humboldt County.

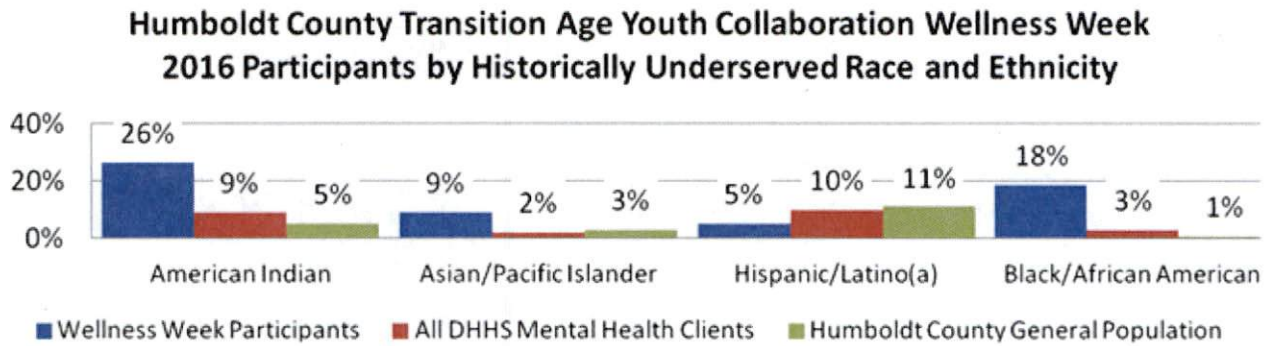


Wellness Week 2016

HCTAYC planned, organized and sponsored its fourth annual Wellness Week in September 2016 with 37 unique participants. It is a five day event specifically for youth ages 16-26 with experience in homelessness, mental health, foster care or juvenile justice.

Activities are youth driven and encourage and empower participants to develop and maintain their wellness goals. Many Wellness Week participants are also members of historically unserved or underserved populations as the chart below illustrates. 26% of Wellness Week participants were American Indian, compared to 9% of all DHHS Mental Health clients and 5% of the Humboldt County general population. 9% of all Wellness

Week participants were Asian/Pacific Islander, compared to 2% of all DHHS Mental Health clients and 3% of the Humboldt County general population. 5% of all Wellness Week participants were Hispanic/Latino(a), compared to 10% of all DHHS Mental Health clients and 11% of the Humboldt County general population. 18% of all Wellness Week participants were Black/African American, compared to 3% of all DHHS Mental Health clients and 1% of the Humboldt County general population.



Accomplishments and Awards

Below is a partial list of HCTAYC's fiscal year 2016/2017 accomplishments:

- Participated in YTP Winter Leadership Institute
- HCTAYC Youth Organizer Participated in California Reducing Disparities Project LGBTQ Stakeholder Workgroup
- HCTAYC YAB Met with California Congress members regarding Mental Health
- HCTAYC Co-Sponsored and Passed the Update to the Foster Youth Bill of Rights AB1067
- Held 2 Curriculum Development Retreats, Developed Deaf Culture Curriculum
- Held a Youth Photography Retreat
- Participated in the Foster Youth Museum
- Participated in YTP Youth Wellness Retreats
- Co-Facilitated Directing Change Workshops, 3 HCTAYC videos created 'in 2016, 4 created in 2017
- Attended UACF Conference
- Attended CMHAYC Conference
- Youth Organizer elected to CMHAYC Board
- HCTAYC Youth Organizer Keynote at HSU MSW Colloquium
- Facilitated Public Speaking Policy Training
- Attended Beyond the Bench Conference
- Provided Over 7 Community Trainings on Youth Issues and Policy
- Trained AFACTR AmeriCorps
- Hosted Youth Advisory Board Leadership Retreat
- Facilitated Local Directing Change & National Children's Mental Health Awareness Day Red Carpet Event
- Hosted 3 Digital Storytelling Kickbacks

- Held Focus Group Facilitation Workshop
- HCTAYC YAB Supported Foster Care Psychotropic Medications Bills and Testimony
- Developed Youth Lead Policy Recommendations for Humboldt County AOD Services
- Attended and presented at NICWA Conference
- Restructured & Expanded Youth Advisory Board

Below is a partial list of HCTAYC's fiscal year 2016/2017 Youth Advisory Board's many awards, recognitions, and accomplishments:

- HCTAYC YAB Directing Change Through the Lens of Culture Suicide Prevention - 3rd Place
- HCTAYC YAB Youth Advocate of the Year from Young Minds Advocacy Project
- Participated in the Foster Youth Educational Summit in Sacramento

TAY Division and Peer Support Goals

The DHHS TAY Division was formally launched in 2011. It was envisioned with HCTAYC and staff from child and adult serving programs throughout DHHS. The environment at the TAY Division is youth-informed, meaning that youth have a strong influence in the way it is set up, including the physical area, especially the common areas, and service delivery. TAY Division work going forward:

- **Transition to Independence Model (TIP)**

The TAY Division utilizes the TIP model. This gives staff and community partners a common language, approach, and tools to engage with youth. TIP was chosen through a youth-informed process in 2011, and training began in February of 2012. Expansion and training will continue to further integrate the TIP model.

- **Youth Leadership and Advocacy**

The TAY Division will continue to:

- Facilitate access for youth to participate in mental health policy and program improvement initiatives locally and statewide as equal partners at decision-making tables;
- Encourage youth participation in statewide and national conferences and trainings.

Prevention & Early Intervention: Parent Partners

The Parent Partner Unit employs three Full Time and one Part Time staff who serve parents via referrals from the DHHS-Public Health, Child Welfare, Probation, DHHS-Mental Health departments. Staff aim to build peer-based alliances by sharing their lived experience as a parent of a youth with mental health issues rather than an expert of the field. They offer assistance in navigating the DHHS system, linking parents with community resources, building natural supports and helping parents identify their personal wellness goals to promote self-care. Our Parent Partners are often members of Wraparound Teams serving youth with intensive needs and early responders by request of Child Welfare Services to offer support to parents at risk of having a child removed from their care. Parent Partners have also teamed with Probation to assist parents whose children have been placed out of county or are in New Horizons Regional Facility to encourage positive outcomes as the youth transitions home. Parent Partners are in attendance at the County's Family Advisory Board and are co-facilitators of several NAMI peer support groups offered in the county. They also make themselves available to parents within the Adult Mental Health system who have children by being visible to families and staff during visitation hours on our Sempervirens Psychiatric Health Facility.

The most senior staff member has recently completed certification as a Parent Peer Support Partner coach through the National Wraparound Implementation Center (NWIC). Another of our staff is in process of becoming a certified coach with guidance from the Family Involvement Center of Arizona and will complete certification in February 2018. We will soon be adding a Parent Partner III position that will take on more responsibility for training and mentoring staff. We are also currently in the process of interviewing for two vacant Full Time Parent Partner positions to grow our team. The County has also contracted with a Part Time mentor with lived experience and dedicated involvement in NAMI who teaches Parent Partners "NAMI Basics" and "Family to Family" curriculum to enhance their skills.

Prevention & Early Intervention: Local Implementation Agreements

Over the past three years, grant funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) for the Humboldt County Children's Mental Health System of Care Expansion created an opportunity for community-based organizations, governmental partners, and the Humboldt County Department of Health and Human Services (DHHS) to partner in improving the health of our children, youth, young adults and families. This funding was designed to strengthen the Children's Mental Health System of Care in Humboldt County. Over those three years, 51 "Humboldt BRIDGES Partnership Agreements" were awarded to 28 organizations to address the System of Care goals, including building trauma informed systems, family driven/youth guided, infant and child mental health, cultural and linguistic competence, partnerships, and increasing integration, among others. Embedding the core System of Care values of family-driven, youth guided, culturally respectful, and community/home/school-based services, was critically important in the work of these partnership agreements and will be a major focus of any future agreements awarded. These previously awarded agreements supported projects that arose from the community and its stakeholders and focused on the needs, issues and concerns that community members felt were most pressing in their communities. Almost one million dollars was awarded through these Partnership Agreements.

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

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

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

Prevention & Early Intervention: School Climate Curriculum Plan

Background

Increasing the recognition of early signs of emotional disturbance or mental illness for children in a school setting was an identified need of the Community Planning Process. In fiscal year 2014-15 the suspension rate in Humboldt County schools was 6.1, almost twice the State rate of 3.8. Following the identification of this need, a stakeholder process occurred that included surveying school superintendents, administrators, teachers, counselors and gathering information through various community stakeholder groups and from DHHS staff. This led to DHHS and the County Superintendent developing a shared plan to address the need. The School Climate Curriculum Plan engages and trains school personnel in ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness or serious emotional disturbance.

Program Description

Initially, three evidence based practice (EBP) curriculums were identified.

- Positive Behavioral Intervention Supports (PBIS) is a framework for assisting school personnel in adopting and organizing evidence-based behavioral interventions into an integrated continuum that enhances academic and social behavior outcomes for all students. PBIS is not a packaged curriculum or scripted intervention. It is a prevention-oriented way for school personnel to (a) organize evidence-based practices, (b) improve their implementation of those practices, and (c) maximize academic and social behavior outcomes for students. PBIS supports the success of all students[1].
- Second Step students learn self-regulation and executive-function skills that help them pay attention, remember directions, control their behavior, and develop social-emotional skills including making friends, managing emotions, and solving problems. Students also learn how to navigate adolescence with communication, coping, and decision-making skills that help them make good choices and avoid pitfalls like peer pressure, substance abuse, and bullying[2].
- Restorative Justice is a philosophy, set of principles and practices that help adults and young people in schools to understand and respond to conflict. Restorative practices have successfully strengthened communities in schools, taught adults and students to take responsibility, changed classroom dynamics and improved school safety[3].

In 2017, DHHS and Humboldt County Office of Education (HCOE) entered into a Memorandum of Understanding to continue to develop a Multi-Tiered System of Support (MTSS) Coalition to implement the PBIS curriculum. Activities to date have included:

[1] https://www.pbis.org/school/swpbis-for-beginners/pbis-faqs

[2] http://www.cfchildren.org/second-step

[3] http://www.rjtica.org/

- A two-day PBIS training by a nationally respected PBIS trainer, Nancy Franklin, for a cohort of fifteen schools throughout Humboldt County. Each school sent a team of eight people including administration, educators, staff and community stakeholders.
- PBIS "Best Behavior" resources were provided for fifteen schools.
- The two MTSS Coordinators attended National PBIS Leadership Forum in Chicago, where they attended workshops with a wide-array of training resources.
- The two MTSS Coordinators were trained in Facilitating Restorative Conferences
- The two MTSS Coordinators facilitated a restorative conference for Eureka City Schools to address gang violence in the school
- The two MTSS Coordinators were trained to become School-Wide Information System (SWIS) Facilitators. The role of the SWIS Facilitator is to assist sites with building and training teams to manage PBIS data.
- The two MTSS Coordinators hold MTSS meetings on the second Wednesday of every month to share resources and training in school climate subjects with school districts.
- Planning has begun to bring Nancy Franklin back to Humboldt County to visit each cohort site to provide on-site coaching and consultation.

Outcomes

Indicators focused on early awareness of mental illness also address emotional wellness through a three-tiered system of prevention and support. This approach addresses a spectrum of behavioral health needs of all students, including acknowledging typical behaviors based on the development of children, providing more specialized attention to those who exhibit particular behaviors and finally by focusing on addressing the needs of students who are most challenging. Data collection mechanisms will be developed with the support of the trainers and consultants.

- Positive Behavioral Interventions and Support (PBIS) has been shown to achieve the following outcomes:
- Better classroom management practices with less discipline issues and more instructional minutes
- Maximized academic engagement and achievement for all students
- Less reactive, aversive, dangerous and exclusionary practices
- More engaging, responsive, preventive and productive environments
- A continuum of services available for students learning and emotional needs
- Improved interagency, community, parental and school interdependence

Additional outcomes related to PBIS and Restorative Justice include:

- Increased understanding by students, of school-wide behavioral expectations
- Decreased number of office referrals
- Decreased number of suspensions
- Decreased impulsive and aggressive behavior
- Increased social competence
- Steps are taken to repair harm
- Victims and offenders are restored to contributing members of society

Prevention and Early Intervention: Making Relatives Program

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

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

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

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

[2] Pomerville, A., Burrage, R.L., & Gone, J.P. (2016). Empirical findings from psychotherapy research with Indigenous populations: A systematic review. *Journal of Consulting and Clinical Psychology, 84*(12), 1023-1038; Gone, J.P.

(2015). Reconciling evidence-based practice and cultural competence in mental health services: Introduction to a special issue." *Transcultural Psychiatry, 52*(2), 139-149,

continuing research supports Native American cultural practices and community support as positive interventions that improve self-esteem, school performance, reduce suicidality and substance abuse, and increase overall resilient adaptation in adverse situations.[3]

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

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

[3] Chandler, M. J., & Lalonde, C. (1998). Cultural continuity as a hedge against suicide in Canada's First Nations. *Transcultural Psychiatry, 35* 191-219; Whitbeck, L. B., McMorris, B. J., Hoyt, D. R., Stubben, J. D., & LaFromboise, T. (2002). Perceived discrimination, traditional practices, and depressive smptoms among American Indians in the upper Midwest. *Journal of Health and Social Behavior, 43,* 400-418; Zimmerman, M. A., Ramirez-Valles, J., Washienko, K. M., Walter, B., & Dyer, S. (1996). The development of a measure of enculturation for Native American youth. *American Journal of Community Psychology, 24,* 295-310. Teresa D LaFromboise., et al. 2006. Family, community, and school influences on resilience among American Indian adolescents in the upper Midwest. Journal of Community Psychology 34.2: 193-209

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

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

Workforce Education and Training

Workforce Education and Training (WET) provides staff development opportunities that promote wellness, recovery, and resilience, culturally competent service delivery, meaningful inclusion of clients and family members, an integrated service experience for clients and their family members, community collaboration and employment of clients and family members within the mental health system. Examples include:

- Milestones of Recovery Scale (MORS) which is an effective evaluation tool for tracking the process of recovery for individuals with a mental illness. It provides easy to use data that allows staff, supervisors and administrators to see how individual programs and agencies are performing. It focuses on the here and now, providing a snapshot of an individual's progress toward recovery. It can help staff tailor services to fit each individual's needs, assign individuals to the right level of care and create "flow" through a mental health system. It quantifies the stages of an individual's recovery using milestones that range from extreme risk to advanced recovery and everywhere in between. It is rooted in the principles of psychiatric rehabilitation and defines recovery as a process beyond symptom reduction, client compliance and service utilization. It operates from a perspective that meaningful roles and relationships are the driving forces behind achieving recovery and leading a fuller life.

- The Transition to Independence Process (TIP) Model is an evidence-supported practice based on published studies that demonstrate improvements in real-life outcomes for youth and young adults with emotional and/or behavioral difficulties (EBD). The TIP Model prepares youth and young adults with EBD for their movement into adult roles through an individualized process, engaging them in their own futures planning process, as well as providing developmentally-appropriate and appealing supports and services. It engages TAY in a process that facilitates their movement towards greater self-sufficiency and successful achievement of their goals. Young people are encouraged to explore their interests and futures as related to each of the transition domains: employment and career, education, living situation, personal effectiveness and wellbeing, and community-life functioning.

- Parent-Child Interaction Therapy (PCIT) is an empirically-supported treatment for young children with emotional and behavioral disorders that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns.

- The Integrated Dual Disorder Treatment (IDDT) model is an evidence-based practice that improves the quality of life for people with co-occurring severe mental illness and substance use disorders by combining substance abuse services with mental health services. It helps people address both disorders at the same time—in the same service organization by the same team of treatment providers. IDDT emphasizes that individuals achieve big changes like sobriety, symptom management, and an increase in independent living via a series of small, overlapping, incremental changes that occur over time. Therefore, IDDT takes a

stages-of-change approach to treatment, which is individualized to address the unique circumstances of each person's life. IDDT is multidisciplinary and combines pharmacological (medication), psychological, educational, and social interventions to address the needs of consumers and their family members. IDDT also promotes consumer and family involvement in service delivery, stable housing as a necessary condition for recovery, and employment as an expectation for many.

- Peer support staff and volunteers attend workshops, conferences and visit out of county wellness centers.

WET funding will continue to be used consistent with the previously approved WET Plan for Training and Technical Assistance.

Information Technology

Perceptive Document Scanning and Indexing Implementation. In 2016 Humboldt County Mental Health upgraded our document imaging from ScerIS to Perceptive scanning. The update allowed for users to view scanned client records within Avatar and scan documents into the client records more easily and 'on-the-fly'.

After extensive Perceptive planning, which began in 2015, training began the later part of November 2016. Hands-on scanning and indexing training for Medical Records and clinical training occurred the last week of November. An email went out to all Avatar users announcing the go-live date of Dec. 1 which contained the training handout on how to view scanned documents in Avatar.

As of June 2017 the project was completed and ScerIS was taken offline. The implementation of Perceptive has improved practitioner access to client scanned records.

ICD and DSM Coding Updates. At DHHS Mental Health and across the country there were big diagnostic code changes in 2015 through 2017. Allowing for greater diagnostic specificity the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and the International Statistical Classification of Diseases (ICD) were updated. ICD-9 transitioned into ICD 10, then later codes were updated or discontinued, and most recent DSM-IV updated to DSM 5.

These updates in ICD and DSM coding required testing, training, updating of reports, and sending out notices to our staff and Org Providers. For Mental Health there was preparation up until October 1, 2015 when Medi-Cal required all claims to have ICD 10 codes. One year later in 2016 some ICD 10 codes were replaced or discontinued altogether. In 2017 DHCS required a shift from the use of DSM-IV to DSM-5 diagnostic criteria and all clinical documentation needed to reflect the DSM-5 diagnostic criteria for all mental health and substance use disordered diagnosis.

We updated our diagnosis form for Org Providers to include the most common DSM-5 diagnosis. We continue to update our diagnosis error reports for ICD 10 and DSM 5 errors. On April 17 the diagnosis pull forward feature was disabled in the Diagnosis Form to prevent entering outdated codes by program staff. Our plans are to continue updating outdated DSM-IV primary diagnosis to DSM 5 for clients with open episodes.

Restricted Charts. In 2016 we updated our restricted chart policy to allow users emergency access to charts. This improved clinician, nurse and doctor access to client charts in a timely manner for scheduling and treatment. Instead of having Medical Records unlocking blocked charts upon request and blocking again weekly, users are now given a warning they are opening a restricted chart and prompted to enter a reason for accessing the client record. As part of our new policy, the charts opened by users and reasons for accessing are reviewed weekly by Medical Records staff and any suspicious activity will be reported to the Compliance Officer for investigation.

EHR Security. Beginning 2015 the EHR Security Team started meeting quarterly to provide comprehensive system security oversight and monitoring of access to client information to ensure privacy protections and

regulatory compliance. The team consist of our DHHS Administration Assistant Director, Information Services Supervisor, DHHS Compliance and Privacy Director, Mental Health Compliance Officer, IS Security Analyst, QI Coordinator, and Medical Records Manager. The EHR Security Team reviews security audits of the EHR system setup, usage, and activity. The EHR Security Team also develops and monitors multiple reports of user access in Avatar to insure privacy and compliance.

Error Correction Team Process, Reports and Dashboards: Since 2014 the Medical Records Analyst has continually run weekly and monthly reports to ensure that all Avatar clinical charting errors are identified, processed, and corrected in a unified and timely manner. These documentation error reports include missing or outdated diagnosis, incorrect service duration, and duplicate services entries among others.

These weekly and monthly reports are presented on an Error Correction Dashboard which provides a comprehensive view of completed and outstanding EHR chart corrections needed. The Medical Records Analyst also compiles and distributes to management and program staff a comprehensive weekly status report of outstanding chart corrections. The Error Correction Team play a vital part in insuring charting and billing integrity and help facilitate problem resolution for staff via email and the phone.

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

Roll out of the MORS in 2014 was to establish benchmarks for program accountability and develop a forum for continued improvement of an organization's treatment modalities with feed-back from staff and clients. MORS became part of the Quality Improvement outpatient work plan for 2015-2016 fiscal year.

This effort will continue for the next fiscal years to assist program direct services staff and clients with monitoring progress in treatment and to assist with treatment decisions and measure readiness for discharge. Going forward, we will continue to generate MORS reports for all adult outpatient programs and add trainings to assist clinical staff in using MORS to make informed treatment decisions.

Data collection for homeless population. In April 2016 DHHS Mental Health began collecting housing data for clients, specifically CSU to assess admission and readmission rates and frequency and making referrals for those clients that report being homeless.

FUTURE PLANS

Adding Gender Field to Client Demographic Screens. In 2017 DHHS Mental Health will add a custom field in Avatar client demographic screens for gender. As part of the gender field roll out the Client Information Sheet will be updated with an added line for gender so clients will be able document their gender identity. This will help improve client and staff interaction and cultural compliance within DHHS Mental Health and our community. Adding a gender field will also improve data collection and help our Cultural

Competence Committee make data driven decisions in choosing future projects.

Creating New and Updating Substance Use Disorders Forms In Avatar. One of the first projects underway in 2016-2017 was to build a new Avatar form that models our 3025 Stay Review Form. This form currently is only a paper form and is required to be completed every five to six months. Currently it is difficult to track due dates any place within the EMR. The lack of clients having an up to date 3025 Stay Review Form is one of the main cause for disallowances in our Substance Use Disorder (SUD department.

To meet Medi-Cal documentation requirements we will be updating the existing 3026 AOD Treatment Plan Avatar form to include diagnosis and primary counselor as well as updating the 3002 AOD Assessment form to assist physician's document when the client history and diagnosis was reviewed.

MHSA funding for Information Technology will be provided in Fiscal Year 2017-18. After this, the project will be funded from other sources.

Assembly Bill (AB) 114 Plan

AB 114 became effective July 10, 2017. The bill amended certain Welfare and Institution Code (WIC) Sections related to the reversion of MHSA funds.

AB 114 implemented provisions concerning funds subject to reversion as of July 1, 2017. Funds subject to reversion as of July 1, 2017, are deemed to have been reverted and reallocated to the county of origin for the purposes for which they were originally allocated (WIC Section 5892.1(a)). Funds that could be subject to reversion as of July 1, 2017, were distributed to counties from Fiscal Year (FY) 2005/2006 through FY 2014-15. By July 1, 2018, counties are required to have a plan to spend those funds by July 1, 2020 (WIC Section 5892.1(c)).

AB 114 requires that counties develop a plan to spend AB 114 reallocated funds and post to the county's website, sending a link to the Department of Health Care Services (DHCS). Humboldt County's Plan to spend AB 114 funds is included with its Three Year Plan, as the Three Year Plan will be posted to the county's website by July 1, 2018. The county Board of Supervisors will then adopt the plan within 90 days of the posting to the county's website. Within 30 days of adoption by the Board of Supervisors the final plan will be submitted to DHCS and the Mental Health Services Oversight and Accountability Commission.

The table below shows AB 114 MHSA Funds Subject to Reversion by Fiscal Year by MHSA Component.

Humboldt	CSS	PEI	INN	WET	CFTN	Total
FY 2005-06	-					-
FY 2006-07	-			$185,760		$185,760
FY 2007-08	-				$59,132	$59,132
FY 2008-09	-	-	$258,495			$258,495
FY 2009-10	-	-	$20,579			$20,579
FY 2010-11	-	$25,898	$197,871			$223,769
FY 2011-12	-	-	-			-
FY 2012-13	-	-	$57,212			$57,212
FY 2013-14	-	-	-			-
FY 2014-15	-		-			-
Total	-	$25,898	$534,157	$185,760	$59,132	$804,947

$- No Funds Subject to Reversion

Shaded area: ARER expenditure data is not complete

Humboldt County plans to spend reallocated funds as follows:

CSS (Community Services and Supports) – No funds subject to reversion or reallocation.

INN (Innovation) – Reallocated funds from past years will be used prior to July 1, 2020 for activities consistent with the current Innovation Plan, Rapid Re-housing, that is approved by the MHSOAC. The Rapid Re-housing program is described in the MHSA Three Year Plan, and was subject to stakeholder input during the Three Year Plan Update process.

PEI (Prevention and Early Intervention) - Reallocated funds from past years will be used prior to July 1, 2020 for activities consistent with approved PEI programs. PEI programs are described in the MHSA Three Year Plan, and were subject to stakeholder input during the Three Year Plan Update process.

Workforce Education and Training (WET) - Reallocated funds from past years will be used prior to July 1, 2020 for activities consistent with the previously approved WET plan for Training and Technical Assistance. WET is described in the MHSA Three Year Plan, and were subject to stakeholder input during the Three Year Plan Update process.

Capital Facilities and Technology (CFTN)- Reallocated funds from past years will be used prior to July 1, 2020 for activities consistent with approved CFTN programs. These activities are described in the MHSA Three Year Plan, and were subject to stakeholder input during the Three Year Plan Update process.

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: Humboldt

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

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

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

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

Emi Botzler-Rodgers
Local Mental Health Director (PRINT)

Signature

6/29/18
Date

I hereby certify that for the fiscal year ended June 30, 2018, 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 03/21/18 for the fiscal year ended June 30, 2017. I further certify that for the fiscal year ended June 30, 2018, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

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

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

Signature

7/6/18
Date

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

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Funding Summary

County: HUMBOLDT

Date: 6/14/18

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2017/18 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	999,031	1,608,949	629,104	207,567	57,581	
2. Estimated New FY2017/18 Funding	4,766,447	1,268,799	362,963			
3. Transfer in FY2017/18[a/]	(269,158)				0	269,158
4. Access Local Prudent Reserve in FY2017/18						0
5. Estimated Available Funding for FY2017/18	5,496,320	2,877,748	992,067	207,567	57,581	
B. Estimated FY2017-18 MHSA Expenditures	4,372,524	1,556,982	457,910	21,807	56,331	
C. Estimated FY2018/19 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	1,123,796	1,320,766	534,157	185,760	1,250	
2. Estimated New FY2018/19 Funding	4,737,849	1,261,187	331,891			
3. Transfer in FY2018/19[a/]	(500,000)				0	500,000
4. Access Local Prudent Reserve in FY2018/19						0
5. Estimated Available Funding for FY2018/19	5,361,645	2,581,953	866,048	185,760	1,250	
D. Estimated FY2018-19 Expenditures	4,694,491	1,794,770	435,637	120,745	1,250	
E. Estimated FY2019/20 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	667,154	787,183	430,410	65,015	0	
2. Estimated New FY2019/20 Funding	4,500,956	1,198,127	315,297			
3. Transfer in FY2019/20[a/]	(500,000)				0	500,000
4. Access Local Prudent Reserve in FY2019/20						0
5. Estimated Available Funding for FY2019/20	4,668,110	1,985,310	745,707	65,015	0	
F. Estimated FY2019/20 Expenditures	4,519,725	1,611,411	430,410	65,015	0	
G. Estimated FY2019/20 Unspent Fund Balance	148,385	373,899	315,297	0	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2017	1,168,816
2. Contributions to the Local Prudent Reserve in FY 2017/18	269,158
3. Distributions from the Local Prudent Reserve in FY 2017/18	0
4. Estimated Local Prudent Reserve Balance on June 30, 2018	1,437,974
5. Contributions to the Local Prudent Reserve in FY 2018/19	500,000
6. Distributions from the Local Prudent Reserve in FY 2018/19	0
7. Estimated Local Prudent Reserve Balance on June 30, 2019	1,937,974
8. Contributions to the Local Prudent Reserve in FY 2019/20	500,000
9. Distributions from the Local Prudent Reserve in FY 2019/20	0
10. Estimated Local Prudent Reserve Balance on June 30, 2020	2,437,974

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 2017-18 Through FY 2019/20 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: HUMBOLDT

Date: 6/14/18

	Fiscal Year 2017/18					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Comprehensive Community Treatment (CCT	4,535,203	3,208,426	1,291,720			35,057
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. Rural Outreach Services Enterprise (ROSE)	1,472,603	917,314	166,314		32,624	356,351
2. MHSA Telemedicine	113,626	72,434	40,793		399	
3. Older and Dependent Adults Expansion	2,123	2,123				
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration	172,227	172,227				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	6,295,782	4,372,524	1,498,827	0	33,023	391,408
FSP Programs as Percent of Total	103.7%					

FY 2017-18 Through FY 2019/20 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: HUMBOLDT

Date: 6/14/18

	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Comprehensive Community Treatment (CCT	4,659,969	3,333,192	1,291,720			35,057
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. Rural Outreach Services Enterprise (ROSE)	1,472,603	917,314	166,314		32,624	356,351
2. MHSA Telemedicine	186,062	144,870	40,793		399	
3. Older and Dependent Adults Expansion	96,323	96,323				
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration	202,792	202,792				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	6,617,749	4,694,491	1,498,827	0	33,023	391,408
FSP Programs as Percent of Total	99.3%					

FY 2017-18 Through FY 2019/20 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: HUMBOLDT Date: 6/14/18

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Comprehensive Community Treatment (CCT	4,659,969	3,333,192	1,291,720			35,057
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. Rural Outreach Services Enterprise (ROSE)	1,422,603	867,314	166,314		32,624	356,351
2. MHSA Telemedicine	186,062	144,870	40,793		399	
3. Older and Dependent Adults Expansion	2,123	2,123				
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration	172,226	172,226				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	6,442,983	4,519,725	1,498,827	0	33,023	391,408
FSP Programs as Percent of Total	103.1%					

FY 2017-18 Through FY 2019/20 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: HUMBOLDT Date: 6/14/18

	Fiscal Year 2017/18					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Hope Center	266,700	266,700				
2. Stigma and Discrimination Reduction	168,630	168,630				
3. TAY Advocacy and Peer Support	411,134	411,134				
4. Parent Partnership Program	237,288	237,288				
5. School Climate Curriculum	86,872	86,872				
6.						
7.	0					
8.	0					
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. Suicide Prevention	258,090	258,090				
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	128,268	128,268				
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	1,556,982	1,556,982	0	0	0	0

FY 2017-18 Through FY 2019/20 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: HUMBOLDT Date: 6/14/18

	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Hope Center	274,701	274,701				
2. Stigma and Discrimination Reduction	168,630	168,630				
3. TAY Advocacy and Peer Support	423,468	423,468				
4. Parent Partnership Program	244,406	244,406				
5. School Climate Curriculum	86,872	86,872				
6. Local Implementation agreements	110,000	110,000				
7. Making Relatives Program	87,165	87,165				
8.	0					
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. Suicide Prevention	258,090	258,090				
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	141,438	141,438				
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	1,794,770	1,794,770	0	0	0	0

FY 2017-18 Through FY 2019/20 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: HUMBOLDT Date: 6/14/18

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Hope Center	274,701	274,701				
2. Stigma and Discrimination Reduction	168,630	168,630				
3. TAY Advocacy and Peer Support	423,468	423,468				
4. Parent Partnership Program	244,406	244,406				
5. School Climate Curriculum	0					
6. Local Implementation agreements	110,000	110,000				
7. Making Relatives Program	0					
8.	0					
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. Suicide Prevention	258,090	258,090				
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	132,116	132,116				
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	1,611,411	1,611,411	0	0	0	0

FY 2017-18 Through FY 2019/20 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: HUMBOLDT

Date: 6/14/18

	Fiscal Year 2017/18					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Rapid Re-housing for individuals with a Seve	718,844	416,282	182,631			119,931
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	41,628	41,628				
Total INN Program Estimated Expenditures	760,472	457,910	182,631	0	0	119,931

FY 2017-18 Through FY 2019/20 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: HUMBOLDT Date: 6/14/18

	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Rapid Re-housing for individuals with a Seve	640,809	396,034	244,775			
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	39,603	39,603				
Total INN Program Estimated Expenditures	680,412	435,637	244,775	0	0	0

FY 2017-18 Through FY 2019/20 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: HUMBOLDT Date: 6/14/18

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Rapid Re-housing for individuals with a Seve	626,051	391,282	234,769			
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	39,128	39,128				
Total INN Program Estimated Expenditures	665,179	430,410	234,769	0	0	0

FY 2017-18 Through FY 2019/20 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: HUMBOLDT Date: 6/14/18

	Fiscal Year 2017/18					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training and Technical Assistance	21,807	21,807				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	0					
Total WET Program Estimated Expenditures	21,807	21,807	0	0	0	0

FY 2017-18 Through FY 2019/20 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: HUMBOLDT Date: 6/14/18

	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training and Technical Assistance	120,745	120,745				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	0					
Total WET Program Estimated Expenditures	120,745	120,745	0	0	0	0

FY 2017-18 Through FY 2019/20 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: HUMBOLDT Date: 6/14/18

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training and Technical Assistance	65,015	65,015				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	0					
Total WET Program Estimated Expenditures	65,015	65,015	0	0	0	0

FY 2017-18 Through FY 2019/20 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: HUMBOLDT Date: 6/14/18

	Fiscal Year 2017/18					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11. Integrated Clinical and Administrative Inforr	56,331	56,331				
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	56,331	56,331	0	0	0	0

FY 2017-18 Through FY 2019/20 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: HUMBOLDT Date: 6/14/18

	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11. Integrated Clinical and Administrative Inforr	1,250	1,250				
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	1,250	1,250	0	0	0	0

FY 2017-18 Through FY 2019/20 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: HUMBOLDT

Date: 6/14/18

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11. Integrated Clinical and Administrative Inforr	0	0				
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	0	0	0	0	0	0