Mental Health Services Act
Annual Update
FY 2025-2026

Contents

Letter from the Behavioral Health Director

Dear Valued Community Members,

This Mental Health Services Act (MHSA) Annual Update, covering fiscal year 2025-2026, comes at a time of great legislative and fiscal changes. As you may already be aware, Behavioral Health relies on sales tax revenue, vehicle license fees and personal income taxes to fund services. The MHSA is funded by personal income tax revenue. With the passing of Proposition 1, in March 2024, during the California primary election, California voters approved various changes to take place within County Behavioral Health across the state, related to MHSA funding.

Some administrative changes went into effect on January 1st, 2025, while other, more substantive changes will go live on July 1st, 2026. These changes include, a new housing category, renaming the MHSA to the Behavioral Health Services Act (BHSA), a 5% reduction in overall MHSA/BHSA funding across the state, new reporting requirements, and an overall restructure on MHSA/BHSA funding categories. There are many details still being finalized, and so it is still difficult to know all local impacts Proposition 1 will have on existing MHSA-funded programs. However, some changes are already determined, such as the name change which will go into effect starting July 1, 2026, as the 2026-2029 BHSA Integrated Plan. Behavioral Health Administration is working diligently with multiple partners across the State on understanding the potential impacts of these changes and waiting on the State to release clean-up language that gives a more accurate representation of what these changes will actually look like and require.

We very much appreciate the community and our partners who have participated and given input into the MHSA community stakeholder process throughout its 20 years of existence. The commitment and partnership of community members, service providers and other partners has been incredibly valuable. Although there are still many unknowns, we will continue to update the community and our partners as we prepare for these changes. Please reach out to Oliver Gonzalez, MHSA/BHSA Program Manager, via phone at 707-441-3770, toll free at 1-866-320-8911, or through email at mhsacomments@co.humboldt.ca.us with any questions or comments.

Best Regards,

Emi Botzler-Rodgers, LMFT
Behavioral Health Director

Introduction

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

The MHSA created a dedicated funding source by imposing a 1% tax on California residents with personal incomes greater than one million dollars. MHSA funds are accumulated by the State before being redistributed to each behavioral health jurisdiction (all 58 counties, and 2 cities) according to their population size and other factors. To receive MHSA funds, jurisdictions must produce and locally approve a stakeholder-informed plan describing how funds will be utilized. These MHSA program and expenditure plans are required in three-year cycles, with annual updates required in the interim years. Due to its reliance in tax revenue, MHSA funding is volatile in nature and subject to change yearly. County Behavioral Health will plan accordingly to prioritize existing infrastructure, programs, and client needs while also using stakeholder feedback to keep informed on local priorities.

MHSA Plans identify services across the age span, with age groups identified as children (0-16 years), transition age youth/TAY (16-26 years), adults (26-59 years) and older adults (60 years and older). Originally, MHSA plans needed to identify programs according to these five (5) MHSA components: Community Services & Supports (CSS); Prevention & Early Intervention (PEI); Innovations (INN); Workforce, Education & Training (WET); and Capital Facilities & Technological Needs (CFTN). In years after Fiscal Year (FY) 2007-08, programs for CFTN programs were not required, but could be supported as needed. Descriptions of these components and their programs are described in their respective sections in this document.

This document will be informed by stakeholder input and feedback received during the stakeholder meeting component of the Community Program Planning Process (CPPP). Following a section about Humboldt County's demographics and characteristics, the process, and results of the CPPP will be presented in the Annual Update after its completion.

Humboldt County Demographics and Characteristics

Humboldt County is located on the coast of northwestern California, 225 miles north of San Francisco and 70 miles south of the Oregon border. The County is rural in nature, with a population of 135,558 spread over 3,567 square miles, or 38 persons per square mile. Forty-nine percent of residents live around the Humboldt Bay area, while the other half live in the outlying rural areas of the county. The county's residents include those from eight federally recognized American Indian Tribes: Yurok, Karuk, Hupa, Wiyot, Cher-Ae Heights Indian Community of Trinidad Rancheria, Bear River Band of Rohnerville Rancheria, Blue Lake Rancheria and Big Lagoon Rancheria.

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

Sixteen percent of the population is ages 0-15; 15% are ages 16-26; 44% are ages 25-59; and 25% are age 60+. Females are 51% of the population and males are 49%. Residents speaking a language other than English at home are 12% of the population. The majority of these speak Spanish (8%). Of those speaking any language other than English at home, 29% speak English less than "very well." For Spanish speakers, 18% speak English less than "very well." Residents who are foreign born are approximately 5.4% of the population. (Data from the American Community Survey, estimates for 2021).

Sixty-eight percent of the population is White; 1% is Black/African American; 5% American Indian/Alaska Native; 3% Asian/Pacific Islander; 8% Multiracial; and 14% Hispanic or Latino (U.S. Census 2020.)

Stakeholder Meetings

The Community Program Planning Process (CPPP) has three components: stakeholder meetings, the 30-day public comment period, and the public hearing. During the stakeholder meeting component, stakeholders provide input by attending a stakeholder meeting and providing verbal comments; by sending comments to the MHSA email address; by leaving a message on the MHSA voice mail; by providing written comments using the MHSA Comment Form; and by using the "Chat" function on the Zoom platform to make a written comment. The Draft 2025-2026 Annual Update and associated MHSA information will be sent via email to stakeholder groups and individuals to provide an opportunity for input.

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

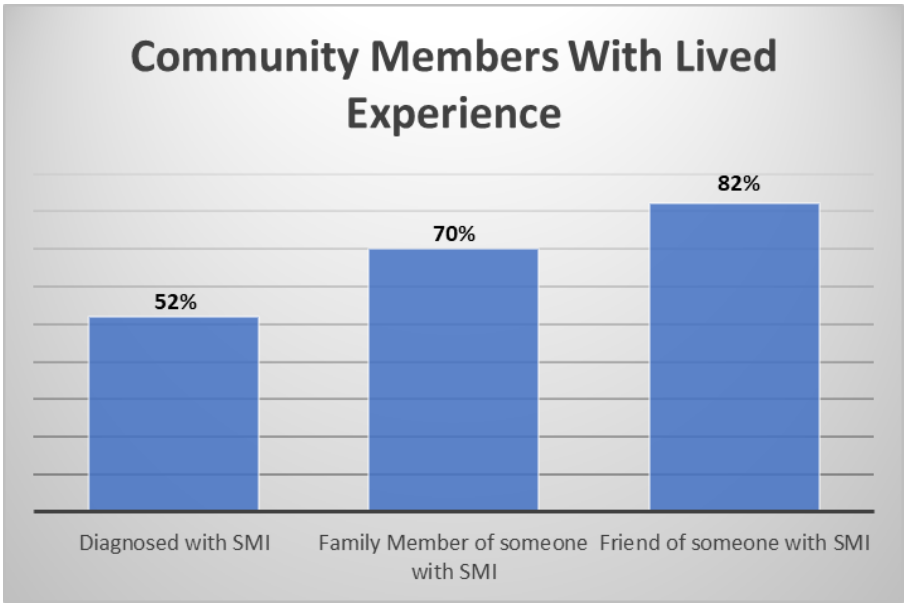
- Draft MHSA 2025-2026 Annual Update, including a draft budget.
- MHSA Fundamental Concepts handout.
- BH services QR Code with link.
- MHSA Information Form handout.
- MHSA Current Programs handout.
- Services Provided by DHHS Behavioral Health handout.
- Definitions of Serious Mental Illness and Serious Emotional Disturbance handout.
- PowerPoint presentation including information on all MHSA components.
- Summary of Governor Newsom's Transformation of Mental Health Services.
- The MHSA demographic questionnaire and MHSA Comment Form will be provided to meeting participants via a link during the meeting for those attending virtually and in paper format for those attending in person.

After the stakeholder meetings are completed, the notes from each meeting, the Comment Forms received at each meeting, and the comments received from the MHSA email and phone line will be reviewed. A stakeholder meeting report will be prepared and presented to Behavioral Health Administration for consideration of changes to programs based on the input received. This draft document will be revised based on that input, as appropriate. The stakeholder meeting report will be prepared and presented to Behavioral Health Administration for consideration of changes to programs based on the input. This draft document will be revised based on that input, as appropriate. The stakeholder

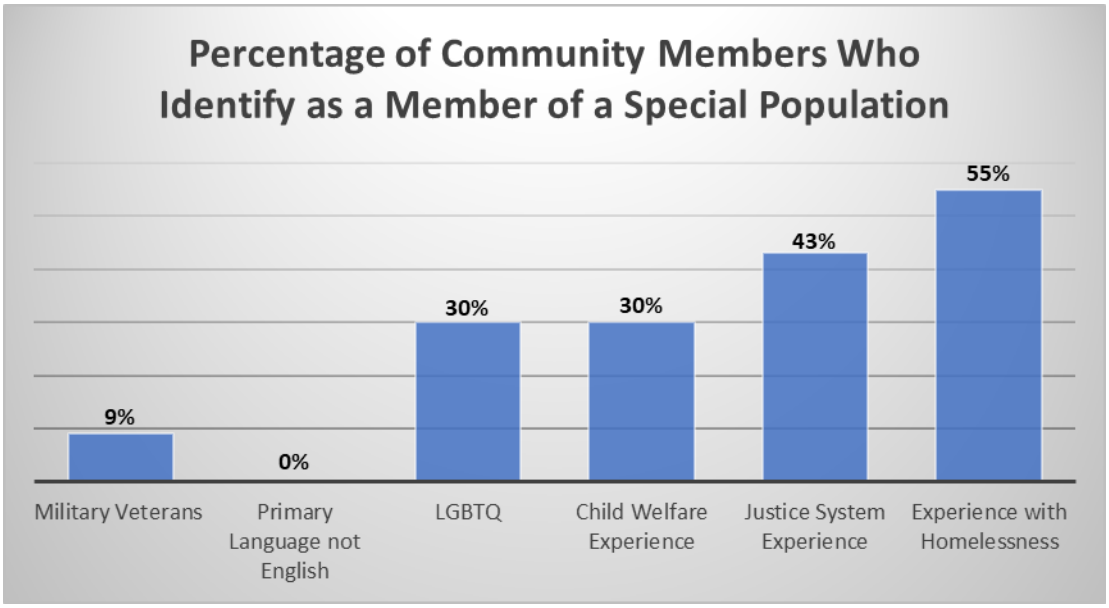
meeting report will be posted into the Mental Health Services Act webpage on the County website when ready. Below there is a summary of the demographics of participants along with a summary of the stakeholder process.

Community members attending meetings were asked to complete a MHSA demographic form. Completion of the form was voluntary, and responses were anonymous. A total of 56 individuals, 49% of those attending, completed a demographic form at the community meetings.

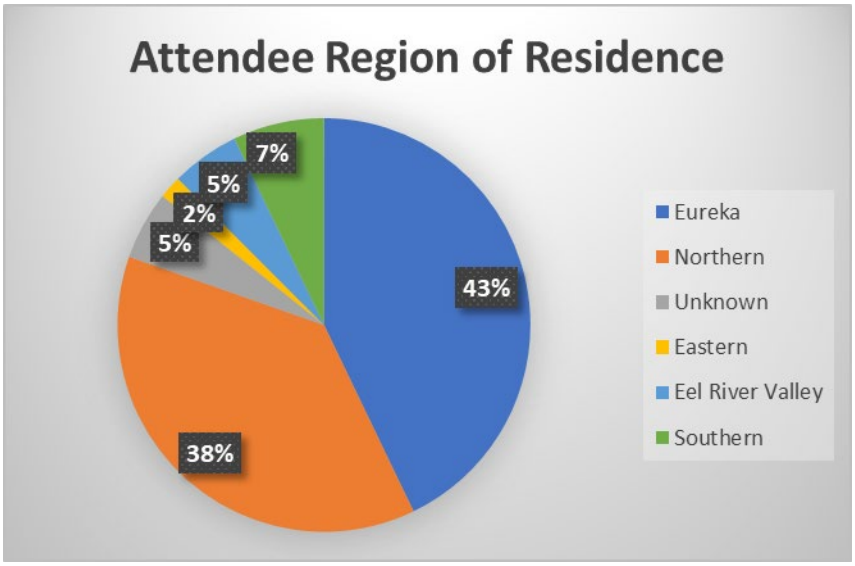
Individuals with lived experience of a serious mental illness (SMI) and their family members are recognized as a vital voice in the MHSA CPPP. As seen in the chart below, 52% identified as having a serious mental illness, and 70% identified as a family member of someone with a serious mental illness. In addition, 82% of those attending the community meetings said they were a friend of someone with a serious mental illness.



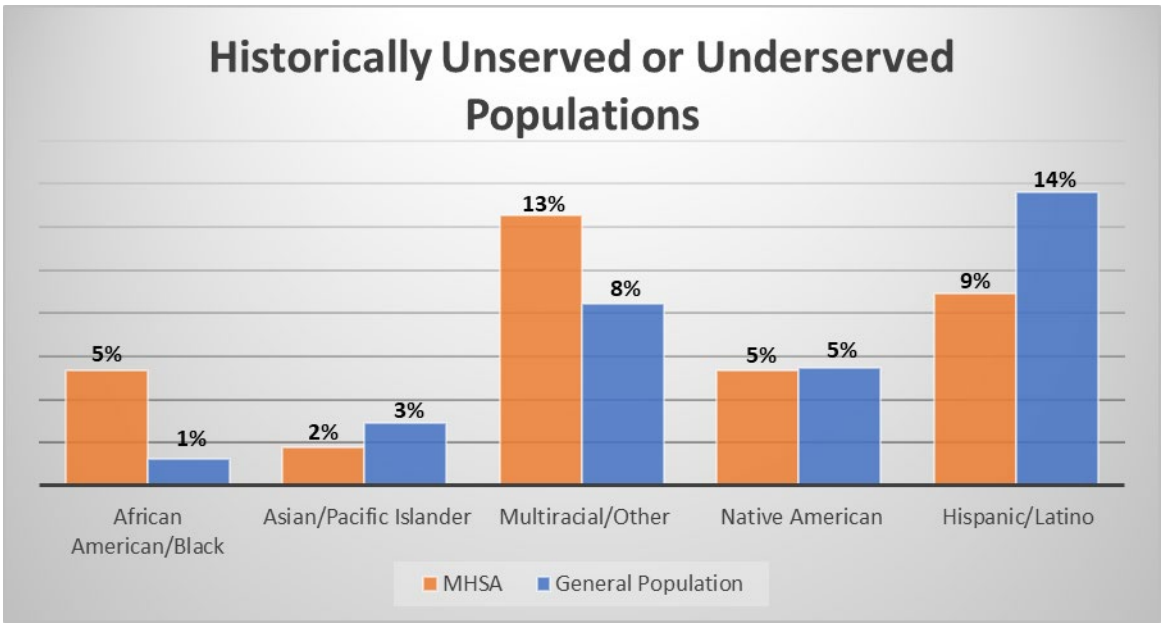
Additional life experiences have been identified as important voices for the CPPP. Sexual orientation and gender identity, homelessness, experience with the justice system, experience with Child Welfare, and those whose primary language is not English have life experiences or conditions that can result in challenges to successful mental health access and treatment. The chart below illustrates the inclusion of people with these life experiences in the CPPP. Nine percent identified as a military veteran; 30% percent identified as LGBTQ; 30% had Child Welfare experience; 43% had justice system experience; and 55% identified as having experience with homelessness. None of the demographic forms reported that folks utilized a primary language that was not English.



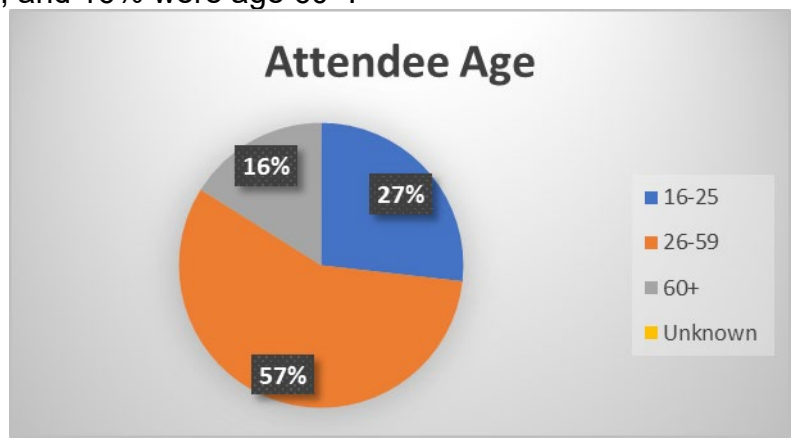
In this CPPP, 43% of meeting participants resided in Eureka, 38% in Northern Humboldt, 5% did not fill answer the question, 2% resided in Eastern Humboldt, 5% resided in Eel River Valley, and 7% resided in Southern Humboldt.



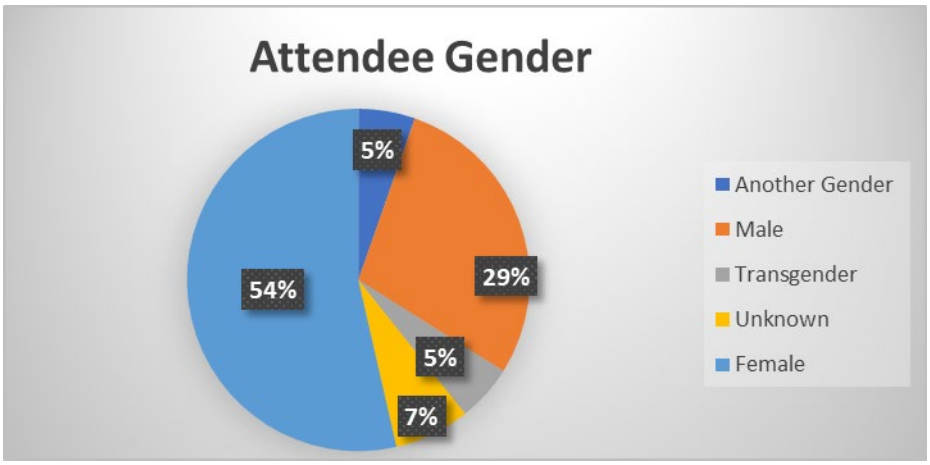
Efforts are made to reach participants that reflect the racial and ethnic diversity of Humboldt County. Of those attending the community meetings, 5% were African American/Black as compared to 1% of the general population. Two percent were Asian/Pacific Islander as compared to 3% of the general population. Thirteen percent were Multiracial/Other as compared to 8% of the general population. Five percent were Native American, as compared to 5% of the general population. Nine percent were Hispanic/Latino as compared to 14% of the general population.



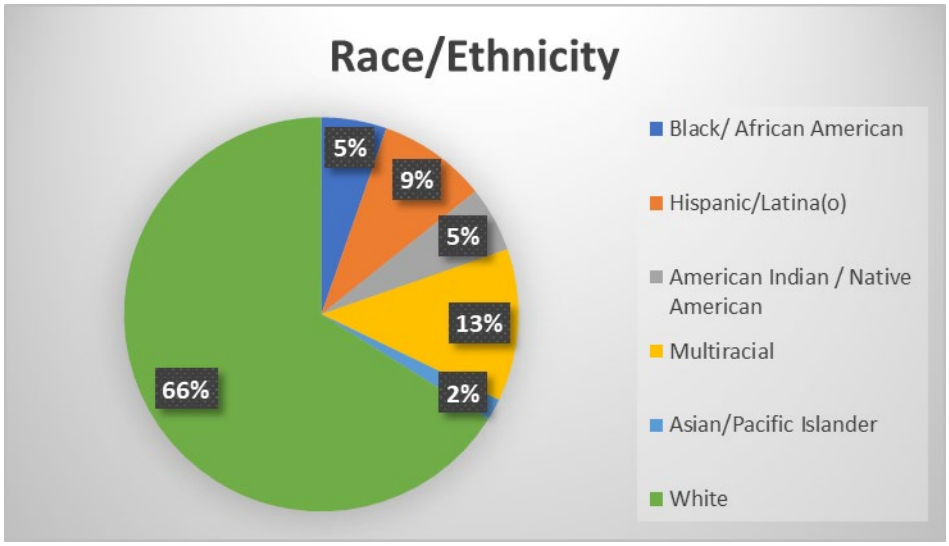
Twenty-seven percent of those completing the demographic form were ages 16-25; 57% were ages 26-59, and 16% were age 60+.



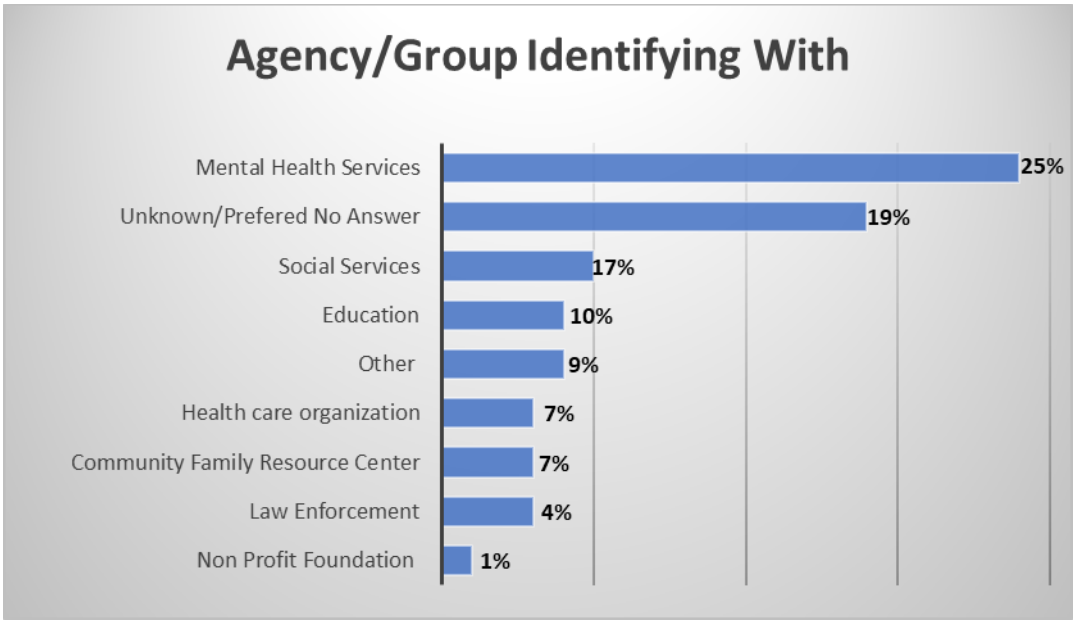
The chart below shows attendee gender. Five percent reported as another gender, 29% reported as male, 5% reported as transgender, 7% did not respond to the question, and 54% reported to be female.



With regards to race/ethnicity, the graph below shows that 5% of attendees were Black/African American, 9% were Hispanic/Latino(a), 5% were American Indian/Native American, 13% identified as multiracial, 2% were Asian/Pacific Islander, and 66% identified as White.



The chart below illustrates the representation from community agencies participating in the community meetings. It shows that the process included individuals from mental health services at 25%; social services, 17%; education, 10%; other, 9%; health care organization, 7%; Community and Family Resource Centers (CRC/FRC), 7%; law enforcement, 4%; Non-Profit Foundation, 1%; and 19% provided no response.



Summary of Findings from the Community Program Planning Process (CPPP)
Between the input from community stakeholder meetings, comments made through the MHSA Phone Line and MHSA Comments Email, a total of 56 responses were provided as input into the Draft 2025-2026 Annual Update. An analysis of all input shows that the top priorities identified by respondents were as follows:

- Expand/increase access to services. This need was mentioned at eight meetings and 7 comment forms talked about the need to expand services and supports. Comments included to increase outreach; provide more programs for juveniles; expand Sempervirens and the Crisis Stabilization Unit; expand services to Southern and Eastern Humboldt; and expand peer support. *Some of this work is being done in the following areas: HEPI program, addition of the Crisis Alternative Response of Eureka (CARE) program, the opening of Hyperion, Regional Services for locations outside of Eureka, Mobile Response Team, Local Implementation Agreements for the SoHum Family Resource Center, and peer support services offered by Parent Partners, Hope Center, and HCTAYC.
- Workforce Support. This need was mentioned at four meetings and in seven comment forms. Comments mentioned included training and support for those working with the 0-8 population; providing clinical experience and education for Cal Poly Humboldt graduates; more funds for professional development; continue work with cultural coaches; and to expand internship opportunities within the TAY population that do not require a CA driver's license. *Some of this work is being done in the following areas: through county partnership with the McKinleyville Community Collaborative via the Early Childhood Treatment Certification Program, ongoing collaboration with Cal Polys' Social Work department, work with Stepping Stone Consulting and Kauffman and Associates.
- Continuity of care for clients released from Sempervirens, Crisis Stabilization Unit, and the jail, plus other transition services. This need was mentioned at three

meetings and two comments. Ideas include the need for a day treatment center, step-down unit, giving a warm hand-off, increasing residential housing options, expanding services to support and ensure clients released from SV and CSU do not struggle, and more board and care facilities across the county. Some of this work is being done in the following areas: Hyperion and the Light House, CCRC, discharge planner at SV.

- Increased support for school aged children and youth. This was mentioned at three meetings and seven comment forms. Individuals indicated the need for increased support for youth, both TAY and those not yet TAY. Support for first episode psychosis, crisis support, and strengthening the continuity of care for families was voiced. Folks expressed great support on the inclusion of the HEPI program. *Some of this work is being done in the following areas: the addition of the HEPI program within the MHSA 2025-2026 Annual Update, HCTAYC and TAY, the Early Childhood Treatment Certification Program, Local Implementation Agreements with schools, Parent Partners, MTSS and Bridges to Wellness, Children's Behavioral Health Clinic, Children's Mobile Response team, Adolescent Treatment Program, and New Horizons.
- Services for early childhood. This was mentioned at two meetings and three comment forms. This included the need for expanding parent education, improving childcare options for when parents need to be involved in service delivery, expanding times in which services are conducted, offering more services that are in-person, and adding trainings. *Some of this work is being done in the following areas: Org Provider sites, TAY/HCTAYC/HEPI (when working with pregnant and parenting young people and their families), Children's Behavioral Health Clinic (which includes CBH Clinic, Med Support Clinic, Child Welfare Behavioral Health, Children's Mobile Response Team (CMRT), Parent Partners, Humboldt Bridges to Wellness, Case Management), the Early Childhood Treatment Certification Program, the Healthy Moms program, and there are staff/clinicians that live in outlying areas to provide services locally. Additionally, Children's Behavioral health has a clinician focused on early childhood services within the Humboldt Bridges to Wellness (HBTW) team who gets all of their referrals from HCOE/Special Beginnings. This clinician focuses on 0-5 year olds and works extensively with each young person's family when working on a case.
- Housing and services for those experiencing homelessness. One community meeting indicated the need for more supportive housing and more supportive services for those who are not housed. *Some of this work is being done in the following areas: through the HOME program, REST, MIST, and CARE.
- Support groups and peer support. Four meetings mentioned the need for more peer support across all services, including, but not limited to TAY, HCTAYC, Hope Center, Parent Partners, etc. *Peer support services are conducted in various outlets including TAY, Hope Center, Parent Partners, and MIST.(they are embedded throughout our programs)
- Law enforcement partnerships. One meeting mentioned the need for a strengthened partnership between law enforcement and mental health, including providing clarification about services and how to better refer people to services. *Some of this work is being done in the following areas: provide services in a number of correctional facilities including Community Corrections Resource Center

(CCRC), which is a program that supports transitioning from incarceration to community. In addition work is done in the following programs: New Horizons Program, Juvenal Hall, and BH clinicians at the Humboldt County Correctional Facility.

- Transportation for clients. Three groups and two comments mentioned the need for transportation for clients and community members to get to services and supports. People in Southern Humboldt, Eel River Valley, Eastern Humboldt, and Northern Humboldt expressed a great need for transportation expansion to access services offered only in Eureka. Additionally, the TAY population and Black Humboldt underscored the need to fund bus passes or easier/accessible forms of transportation for folks to access recreational centers, work, and other areas that could help ease folk's mental state. *Some of this work is being done in the following areas: Regional Services, Mobile Outreach, Children's Mobile Response Team, MIST, community partners through LIA funding, Garberville Behavioral Health Outpatient, and Willow Creek Behavioral Health Outpatient.
- Increased support for the seriously mentally ill. Six meetings and one comment mentioned the need for more assertive care treatments; expansion of Comprehensive Client Treatment (CCT) "whatever it takes approach" to other services; having more case managers and other paraprofessionals; providing occupational support, and supported employment; and providing more support groups for clients/patients and their families. *Some of this work is being done in the following areas: the CCT program, HCTAYC, Hope Center, Parent Partners, Local Implementation Agreement partnerships. We have more intensive programs such as CCT where case management is the primary intervention and we have case manager throughout most of our programs, including REST.
- Clarity about Mental Health Services. Three groups and two comment forms stated there needs to be more clarity about navigation of and access to mental health systems. They expressed uncertainty on what services are available and how to access them; along with the need to improve website postings, maximizing the use of social media, and publicizing more clearly when a new program opens. Folks expressed frustration not knowing that Hyperion had opened in late 2024. *Some of this work is being done in the following areas: the DHHS Media Team uses social media platforms (e.g., Facebook, Instagram, and X), they publish a quarterly newsletter that often highlights programs, and they issue news releases through the county website and via local news outlets. In addition, the Behavioral Health Board is meeting space open to the public where updates are shared and programs (i.e., the Hope Center, HCTAYC) conduct outreach/tabling events.
- Hope Center improvements. One group indicated the need to improve/expand the facility and programs of the Hope Center. Ideas included relocating the facility to a more accessible part of town, such as downtown, far from Sempervirens and the Crisis Stabilization Unit; providing more classes and activities; getting a larger facility; providing a full-service kitchen with work programs; along with the need for more staffing to run the Warm Line. *Since the Hope Center is located on county property, rent and costs are controlled effectively. Additionally, due to coming BHSA adjustments, an expansion to this program may not be possible for the time being.

- Bilingual and Culturally Competent Services. This need was mentioned at four meetings and on five comment forms. A meeting attendee pointed out that there needs to be more SUD services. Folks in Eastern Humboldt mentioned the great need they have on services in general, but especially those that represent them the best. People liked the idea of working with the Yurok Tribe; so much so that the folks at Hoopa also showed interest in wanting to work with the County more. Some folks expressed the need for more LGBTQIA+ specific services and resources. *Some of this work is being done in the following areas: consultation with Stepping Stone, Kauffman and Associates, discussions with the Yurok Tribe, having Two Feathers as an organizational provider, Local Implementation Agreements with culturally responsive organizations (e.g., Queer Humboldt and Centro Del Pueblo), the Latinx Liaison position, Parent Partners, the Cultural Responsiveness Committee, Equity Plan, and HCTAYC.
- More mental health counselors at schools and additional school supports. This need was mentioned at one meeting, with folks highlighting the need for more clear ways to access behavioral health services. *Some of this work is being done in the following areas: through MTSS and our partnership with the Humboldt County Office of Education (HCOE) and the Bridges to Wellness program.
- Substance Use Disorder Services. One group and one comment form spoke about the need for additional substance use disorder services, having more outreach to SUD communities, and to collect more input from SUD advocates/representative groups when possible. *Although current MHSA-funded programs do not directly work with SUD clients, other programs do. Examples include: Healthy Moms, Humboldt County Programs for Recovery (HCPR), Dual Recovery Program, among others (family wellness court).
- Comments regarding BHSA/Prop. 1: This was mentioned at 3 community meetings. Folks expressed concern of the new changes and would like to be updated as soon as more information becomes available. *Behavioral Health Administration is consistently monitoring changes and will share with community as more information becomes available.

The CPPP Report from last year's plan can be found on the Humboldt County website, MHSA section, at Mental Health Services Act (MHSA) | Humboldt County, CA - Official Website (humboldtgov.org) and provides details of the input received during the CPPP. Archived documents, including, but not limited to, previous Three-Year Plans, CPPP reports, and Annual Updates can be found at: Archive Center • Mental Health Services Act Documents (humboldtgov.org)

30-Day Comment Period and Public Hearing

In accordance with MHSA regulations, the 2025-2026 Annual Update will be made available for public review and comment for a 30-day period. The Behavioral Health Board (BHB) will conduct a Public Hearing on the Annual Update in one of their regularly

scheduled meetings. The 2025-2026 Annual Update was be available to stakeholders through the following methods:

- The Humboldt County Department of Health and Human Services, MHSA webpage.
- An informational email sent to stakeholders who participated in the stakeholder process.
- An email to recipients on local organizational e-mail distribution lists.
- An email to people who requested a copy.
- Announcements in local media about the Annual Update's availability, where to obtain it, where to make comments, and where/when/how the Public Hearing was to be held.

One written comment was received via e-mail to the MHSA Email Comment address and seven attendees of the Public Hearing filled out a demographic survey, with six containing additional comments.

Public Hearing Information

The BHB conducted a Public Hearing on the 2025-2026 Annual Update at their regular meeting on May 22nd, 2025, 12:15-2:15pm. The meeting was conducted in a hybrid format. Community members had the opportunity to attend the meeting either in person or via Zoom. There were 23 people in attendance at the Public Hearing.

Public Comment Summary

One written comment/recommendation was provided for the Annual Update through email to the MHSA Comment Email during the 30-day public comment period. There were 4 comments on the Annual Update that were made orally during the Public Hearing and 6 were made via the voluntary demographic form. The comments are summarized below and following each is the Behavioral Health response for those that had questions. No substantive comments were received that would cause changes to the draft 2025-2026 Annual Update as a result of the 30-Day Public Comment period and Public Hearing.

<u>Email</u>:

1. In the email received, one person from Queer Humboldt expressed their support of the 2025-2026 Annual Update. The email respectfully urged Humboldt County Behavioral Health Administration and the Behavioral Health Board to ensure that MHSA funding continues to sustain essential therapeutic programs that are critical to the well-being, safety, and resilience of Humboldt's diverse community.

<u>Comments/Questions Made Orally During the Public Hearing</u>:

1. One attendee advocated to keep the new HEPI program when transitions to the BHSA format begin.

2. Question: This is the last year of the MHSA framework. How will this change be communicated to community members as many are still unaware of the changes?
Answer: Details are still flowing out slowly from the state to counties. New policy manuals are slowly being provided to counties but are experiencing constant revisions; with the latest draft anticipated to receive a state revision around July or August. The MHSA Program Manager, along with BH leadership, is working to understand all the changes and planning to host community meetings to educate/inform community members and programs on the new BHSA regulatory requirements.

3. An attendee supported the need for the HEPI program to continue receiving MHSA and BHSA funding. They underscored that HEPI has the potential to be effective in upstream treatment and it should be prioritized.

4. An attendee advocated for funding to train staff on working with neurodivergent populations; especially when it comes to identifying symptoms and diagnosing folks. Another attendee pointed out that the organization called the Redwood Coast Start Project focuses on this type of work and proceeded to share a point of contact for folks to have.

Comment Forms:
1. Looking forward to seeing how SUD will be added to the mix in the future. There is never enough funding for these services compared to community needs. Hoping TAY's HEPI Program can be sustained as funds shift around. Early Intervention for young adults experiencing psychosis is a very important item.
2. Love Healthy Moms. They help me learn the skills and tools to stay sober.
3. No comments beyond good luck with the new BHSA requirements!
4. Peer coaches are a huge prevention service that saves the county a lot of money. They deserve to be paid more and not asked to do jobs outside of their scope.
5. Programs to continue support: Hope Center, HEPI, REST. Thank you.
6. Really grateful for the mental health awareness and support there is in our community. As a mental and addition nurse, I'm thankful for the support and help there is for our people. Happy to be a part of our community and helping others.

Complaints and Grievances
The MHSA program manager will address any complaints, disputes or grievances from the general public about MHSA program planning. If there is a complaint, dispute, and/or grievance about an MHSA program, the MHSA Issue Resolution Policy and Procedure will be followed. This procedure is as follows: the issue is forwarded to the MHSA Program Manager (MHSA-PM) or designee through either US Postal Service mail at MHSA Program Manager, DHHS Behavioral Health, 720 Wood St. Eureka CA 95501, or by email at MHSAcomments@co.humboldt.ca.us. Issues will be recorded at time of receipt in the

DHHS-BH Client Concerns Log and forwarded to the Program Lead of the program involved. Once a resolution is decided upon by the Program Lead the MHSA-PM will contact the originator of the issue to notify them of the resolution. Issues will be followed up on within five working days. Resolution of the issue will be enacted within 30 days from receipt of issue, unless there are factors outside of departmental control, in which case a reasonable timeframe will be set and communicated to the complainant.

Behavioral Health Capacity Assessment

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

1. The MHSA Community Program Planning Process (CPPP) for gathering community input into the 2024-2025 Annual Update and 2025-2026 Annual Update will provide information directly from stakeholders. This Capacity Assessment also uses information from prior MHSA CPPPs, including the 2023-2026 Three-Year Plan.
2. Updated annually, the Behavioral Health Cultural Competence Plan (BHCCP) provides data on the racially and ethnically diverse populations served, bilingual proficiency in threshold languages, and percentages of diverse cultural, racial/ethnic and linguistic groups represented among direct service providers, as compared to the population needing services and the total population being served. The BHCCP provides the most relevant and pertinent information on the topic of racial/ethnic/linguistic capacity. The 2023 BHCCP is located here: https://humboldtgov.org/DocumentCenter/View/123436/DHHS---Behavioral-Health-Cultural-Competence-Plan-2023
3. The DHHS Workforce Survey, conducted in September-October 2023, provides information about the demographics of the workforce.
4. The Network Adequacy Certification Tool (NACT) and other required documentation report on standards of time, distance, and timely access requirements with which the Mental Health Plan must comply. Network Certification provides assurances of adequate capacity and services and demonstrates that the Mental Health Plan offers an appropriate range of services that is adequate for the anticipated number of beneficiaries for the service areas and maintains a network of providers that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of beneficiaries in the service area. There have been two NACT submissions since the last update to this report: November 1, 2023 and August 1, 2024. DHHS BH received an assessment of initial findings following the November 2023 submission in May 2024, which included a request to reassess timely access and submit additional data. A final report has not been issued, yet

the initial assessment of the network certification shows DHHS BH is meeting geographic access time or distance standards, and all Provider to Beneficiary ratios in fiscal year 2023-24.

5. Employee Services was contacted in order to obtain a vacancy report within Behavioral Health. As of September 2024, Behavioral Health has a 33% vacancy rate in the Mental Health Clinician job category.
6. The County Behavioral Health Directors Association (CBHDA) hosts state-wide meetings for MHSA Program Managers and Ethnic Services Managers. These meetings give counties the ability to communicate with each other by asking program questions, sharing updates, and providing guidance with program development. The CBHDA site also provides statewide reports, learning tools, and insight on how to implement MHSA programs.

System Strengths

The Network Adequacy Certification Tool (NACT) documents the federal standards of time, distance, and timely access requirements with which the Mental Health Plan must comply. Time and distance standards are up to 60 miles and 90-minute drive from the beneficiary's place of residence to the provider's site. Timely access requires the Plan to meet State standards, taking into account the urgency of the need. The standards are documented with Geographic Access Maps provided by DHCS per request, showing beneficiary and provider locations. NACT includes information on provider language capacity and availability of Language Line services. Humboldt County's NACT also included the American Indian health facilities in the county. DHHS BH submitted a NACT on August 1, 2024. This is the last time DHCS requires the tool to be used by Mental Health Plans. It will be replaced by the monthly submission of 274 production files, an Electronic Data Interchange for submitting network provider and capacity information.

The Behavioral Health Cultural Responsiveness Committee (BHCRC) is a strength in the agency. BHCRC facilitates projects to gather data and address issues surrounding diversity. BHCRC oversees and approves the development of the annual Cultural Competence Plan.

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

- A continuing contract with Language Line services to ensure services are available in a client's preferred language. Training on using the Language Line is required annually for all staff.
- Maintenance of the contractual relationship with organizational provider Two Feathers Native American Family Services, which serve diverse populations. Organizational providers are required to provide cultural competence training to their staff annually, which QI monitors.

- Update to contracts with local interpreters and interpreter list.
- Maintenance of the Behavioral Health Cultural Responsiveness Resource Page, available on the DHHS Intranet and on the county website, which provides links to resources, trainings, and other information for staff. The Resource List that is a part of this Webpage is updated quarterly.
- Maintenance of the Relias E-Learning contract, which provides cultural competence as well as many other online trainings for staff. This contract is supported by MHSA Workforce, Education and Training (WET).
- Offering Cultural Awareness Training, through NEOGOV and monitoring for compliance with the training requirement.
- The DHHS trainings on Common Racial Equity Terms and Implicit Bias were launched and are required by all DHHS staff.
- Roll-out California Advancing and Innovating Medi-Cal (CalAIM) plans for transforming and strengthening Medi-Cal to offer people services that are more equitable for diverse populations, coordinated, and follow a person-centered approach.
- Implementation of CalAIM Documentation Redesign, No Wrong Door, and Payment Reform: Documentation Redesign reduces the documentation burden on direct services staff and allows them to focus more on the quality of direct care. The No Wrong Door initiative describes the method of coordinating between providers to ensure all Humboldt County Medi-Cal beneficiaries get quick access to services in the appropriate delivery of care system (Mental Health Plan, Managed Care Plan or Drug Medi-Cal Organized Delivery System); Payment Reform was implemented in July 2023, with billing methods changing to a Fee-For-Service model.
- As part of CalAIM and the Behavioral Health Quality Improvement Plan (BHQIP) BH has joined with CalMHSA to implement three Performance Improvement Projects (PIPs) associated with three Healthcare Effectiveness Data and Information Set (HEDIS) measures (Follow-Up After Emergency Department Visit for Substance Use (FUA), Follow-Up After Emergency Department Visit for Mental Illness (FUM), and Pharmacotherapy for Opioid Use Disorder (POD)). All three focus on removing racial disparities and seek to implement interventions to improve upon health outcomes for beneficiaries as it relates to BH emergency department follow up and opioid treatment follow through.
- BH reviews key services utilization data on a quarterly basis. Review of this data includes evaluating the needs of key service utilizers. DHHS-BH is paying particular attention to details as they relate to racial disparities, which informs programmatic decision making.
- Suicide Prevention Initiative: DHHS BH is working with consultants through Community Connections Psychological Associates on impacting death by suicide of clients in our community. This task force analyzes improvement needs in our system of care and will implement necessary change where those needs are indicated. Goals include the integration of a formalized risk screening and/or assessment tool into our EHR SmartCare for use across all DHHS-BH programs

including Crisis, Outpatient, and Forensic units as well as identifying and implementing suicide prevention training for all BH staff who interact with BH clients and the public.

Behavioral Health is working with Humboldt Area Foundation and Stepping Stone Consulting as a component of a DHHS contract with these organizations.
The purpose of the BH component of this work is to build upon the initiatives already underway in BH to further advance racial equity at all levels of the department. The desired outcomes include coaching, support and consultation to BH leadership, as well as managers and teams, to support staff in advancing racial equity across programs, learn about staff experiences and perspectives and what is needed to help them adapt to new and emerging commitments to racial equity advances to BH policy and practice and provide training around facilitating conversations about race and racism in the workplace, among other things.

Three new policies and procedures were developed in 2021 that focus on racial and cultural equity. The foundational policy's purpose is "To set forth the intention of Humboldt County Behavioral Health (BH) to work to advance racial and cultural equity by dismantling systemic (institutional) and structural racism and structural inequality, and to set the foundation for all actions and decisions made by BH and its staff in this regard." A second policy's purpose is "To ensure that all Behavioral Health policies, procedures and forms will be developed and reviewed with a conscious consideration to advance racial and cultural equity and dismantle systemic (institutional) and structural racism and structural inequality." A Policy, Procedure and Form Review Tool was developed and is in use to implement this policy. The Ethnic Services Manager (ESM) reviews all new policies, existing policies that are due for review, and documents using the Tool to identify language that could be changed or added to advance racial and cultural equity. From September 2023 through September 2024, a combined total of 249 Behavioral Health policies, procedures, and documents received ESM review. The purpose of the third policy is "to ensure that Behavioral Health budgets are developed and reviewed with a conscious consideration to advance racial and cultural equity and dismantle systemic (institutional) and structural racism and structural inequality." An existing Budget Planning Questionnaire was modified to implement this policy. The revised Budget Questionnaire was used during the budget cycle in early 2022.

System Limitations
The sources listed below give a picture of the limitations faced in serving diverse racial/ethnic populations in Humboldt County, which is a remote, rural county located on the North Coast of California. There are few culturally and linguistically diverse staff in the agency, and it is difficult to hire staff due to behavioral health staff shortages, which is true throughout California as well as the nation. It should be noted that for several years

Humboldt County's threshold language was Spanish, and it was a limitation of the system that there were few providers who were bilingual in both Spanish and English. Recent data from the California Department of Health Care Services, Research and Analytic Studies Division, however, indicates that Humboldt County has had no threshold language since January 2015. Threshold language is defined as 3,000 Medi-Cal beneficiaries or 5 percent of each county's total Medi-Cal Beneficiary population, whichever is lower. Though there is currently no threshold language, DHHS Behavioral Health remains committed to providing services to clients in their preferred languages through the use of the Language Line, or through providing a local interpreter if one is available in the client's preferred language.

The MHSA Community Program Planning Process (CPPP) for the recently passed 2023-2026 Three-Year Plan and prior Annual Update for FY 2024-2025 provided information on diverse populations. For the priority category Providing Bilingual and Culturally Responsive Services:

- Stakeholders at community meetings ranked this as number 13 among all priorities for the 2023-2026 Three-Year Plan, and it was one of the top five priorities for the Annual Update for 2022-2023 and for 2024-2025. For the 2024-2025 Annual Update, comments included providing better training; healthy cultural activities and services validating the knowledge and experience of tribes; and education, outreach and programs with more Spanish-speaking clinicians and services to the Spanish-speaking community; and expansion of culturally responsive services to Native American communities within the Eastern Humboldt region.
- Stakeholders completing the Community Survey for the 2023-2026 Three-Year Plan ranked this as 10 among all priorities and indicated that racial/ethnic populations are among those not adequately served by current MHSA programs. These racial/ethnic populations included, but were not limited to, the African American, Asian, Latino, Native American and Pacific Islander communities.

In the Behavioral Health Cultural Competence Plan (BHCCP), an analysis of disparities for those in Humboldt County with Medi-Cal versus those that are served by DHHS Behavioral Health was performed for calendar year 2023. This was a simple descriptive analysis about disparities in each population served by Behavioral Health. Disparities were found in serving Asian/Pacific Islanders, multiracial populations, for people whose primary language was not English, and for children ages 0-5.

- Three percent of those with Medi-Cal were Asian Pacific Islander, and 1% used DHHS-Behavioral Health services.
- Eighteen percent of those with Medi-Cal were multiracial, and 26% used DHHS-Behavioral Health services.
- Six percent of those with Medi-Cal had a primary language that was not English, and 23% used DHHS-Behavioral Health services.

- Nine percent of those with Medi-Cal were children aged 0-5, and 2% used DHHS-Behavioral Health Services.
- Thirteen percent of those with Medi-Cal were Older Adults 60+, and 12% used DHHS-Behavioral Health Services.

There could be many reasons that these Medi-Cal populations do not use DHHS Behavioral Health services. Asian/Pacific Islanders may not use County services because of levels of acculturation within their communities, or because there are no providers speaking their languages. For people whose primary language is not English, they may not use DHHS Behavioral Health services due to levels of acculturation, cultural beliefs about behavioral health issues and origins, lack of knowledge about available services, or because of the scarcity of providers that can speak their language. Language accessibility is mainly done through use of the Language Line, which may explain why there are a greater number of people whose primary language is not English accessing more DHHS-Behavioral Health services. These reasons may be applicable to the multiracial population as well. Children 0-5 may not utilize DHHS Behavioral Health services due to their family's cultural beliefs, conflicts in parent work schedule, parental figures not having enough knowledge of Behavioral Health services, and perhaps parental figures not realizing their child may qualify for, or even need, Behavioral Health services. The mental health needs of very young, especially preverbal children are still not well understood nor are the symptoms that could indicate a need for treatment. As for older adults 60+, there could also be transportation difficulties, not enough case managers and/or clinicians to provide services, and potential barriers caused by the COVID-19 pandemic.

In addition to looking at disparities among Medi-Cal beneficiaries and their use of Behavioral Health services, the BHCCP reported on the data available for the Behavioral Health workforce. The September 2022 DHHS Employee Services database showed that Whites are overrepresented in the workforce, and Multiracial and Native Americans are underrepresented in the workforce, as compared to Medi-Cal client utilization. Data from the DHHS Workforce Demographic Survey conducted in September-October 2023 also showed racial/ethnic disparities in the workforce as compared to client utilization for all categories other than White. Detailed information is available in the BHCCP.

While DHHS Behavioral Health does face challenges in serving diverse racial/ethnic populations, there are continued efforts to address issues to make improvements. These efforts include continuing to contract with the Language Line to ensure that behavioral health services are provided in a client's preferred language, the continuing development and monitoring of staff training, the work with Humboldt Area Foundation and Stepping Stone Consulting, and the consistent updating of cultural competence resources, all of which contribute to the conclusion that the agency will have the capacity to implement MHSA programs that serve the community.

Community Services and Supports (CSS) Component

Seventy-six percent (76%) of MHSA funds received by counties must be allocated for the CSS component. MHSA funds may only be used to pay for those portions of the behavioral health programs/services for which there is no other source of funding available. CSS programs serve individuals affected by moderate to severe mental illness and their families. These services must be community based, recovery-oriented and culturally competent. Funding can only be used for voluntary services and no less than 50% must be allocated to Full-Service Partnerships (FSPs). The remaining funds in the CSS component are for General System Development programs that provide a less-intensive level of mental health treatment and supportive services, and counties may develop and operate Outreach and Engagement Programs to identify unserved individuals in order to engage them and, when appropriate, their families. The following pages describe the CSS programs that are planned to be included in the Annual Update.

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

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

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

discharge planning needs in order to support the FSP client's return to the community and to avoid re-hospitalization.

Partners are served through various DHHS Behavioral Health programs including Children and Family Services Transition Age Youth Division, Housing, Outreach and Mobile Engagement (HOME), and Older Adults programs. However, Full-Service Partners are primarily served through the Comprehensive Community Treatment (CCT) program. Inspired by the evidence-based program Assertive Community Treatment, CCT provides intensive behavioral health services and community supports to assist clients in their recovery. These include access to housing, medical, educational, social, vocational, rehabilitative, or other needed community services for those with serious mental illness who are at-risk for psychiatric hospitalization, incarceration, homelessness, or placement in more restrictive facilities.

Children's Behavioral Health has identified 277 youth, from 0-15 years old, that would be eligible for FSP during the 23/24 fiscal year. While youth up to age 21 have previously been enrolled in FSP, due to staffing constraints and an inability to meet the 24/7 availability of staff, these currently eligible youth have not been enrolled in FSP but are eligible to receive full behavioral health service array. These services include Assessment, Individual/Family Therapy, Targeted Case Management, Intensive Care Coordination, Intensive Home-Based Services, Therapeutic Behavioral Services, Medication Evaluation, Medication Support, Parent Partner/Peer Coaching, and Mobile Crisis services. In addition, staff anticipate being able to offer Therapeutic Foster Care and an in-county Short Term Residential Treatment Program during the current fiscal year, through a local organizational provider. The mobile crisis services for youth are limited due to staffing issues, but Humboldt County does maintain a 24-hour hotline to triage crisis calls and this service is available to anyone experiencing a crisis situation. Staff work closely with local Emergency Rooms to coordinate care for youth that go there due to a behavioral health crisis. For current and former foster youth and caregivers, there is coordination with the Family Urgent Response System (FURS) which can respond 24/7 if there are urgent needs that require in-person response. Additionally, in order to meet Family First Prevention Services Act (FFPSA) requirements, the intent is to contract with an Organizational Provider in the next year to provide Wraparound services. The intent is to build capacity within this contract to provide High Fidelity Wraparound services to FSP eligible youth, including 24/7 availability.

An estimated 300 clients could be served annually as FSPs. The age groups anticipated to be served are:
TAY: 11
Adults: 233
Older Adults: 56

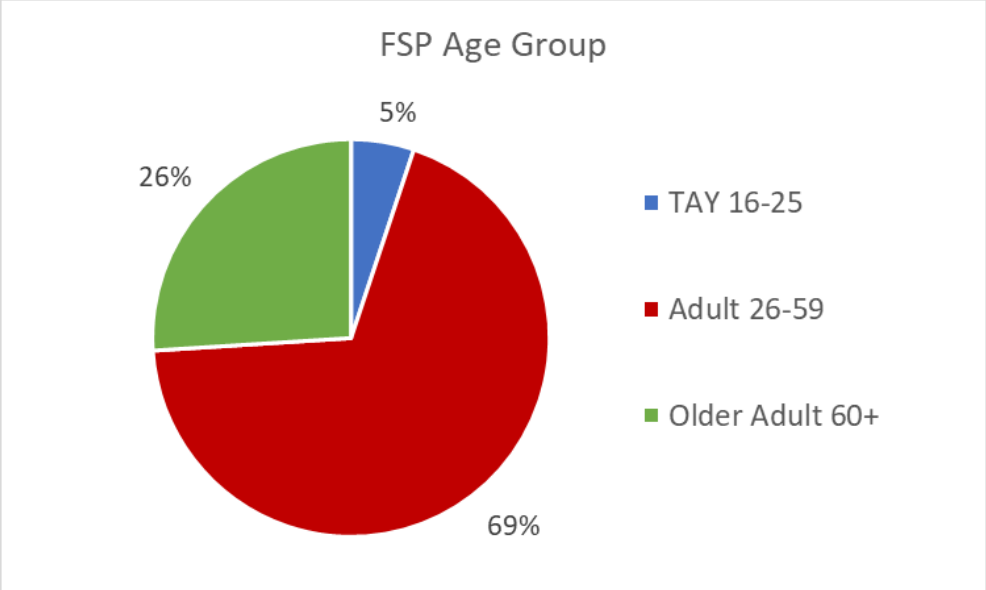
During fiscal year 2023-2024, there were 273 unduplicated clients served by the program. Based on last year's Revenue and Expense Report (RER), which outlines a total cost of $7,338,165.18 in MHSA funds, the average cost per client is estimated at $26,879.73.

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

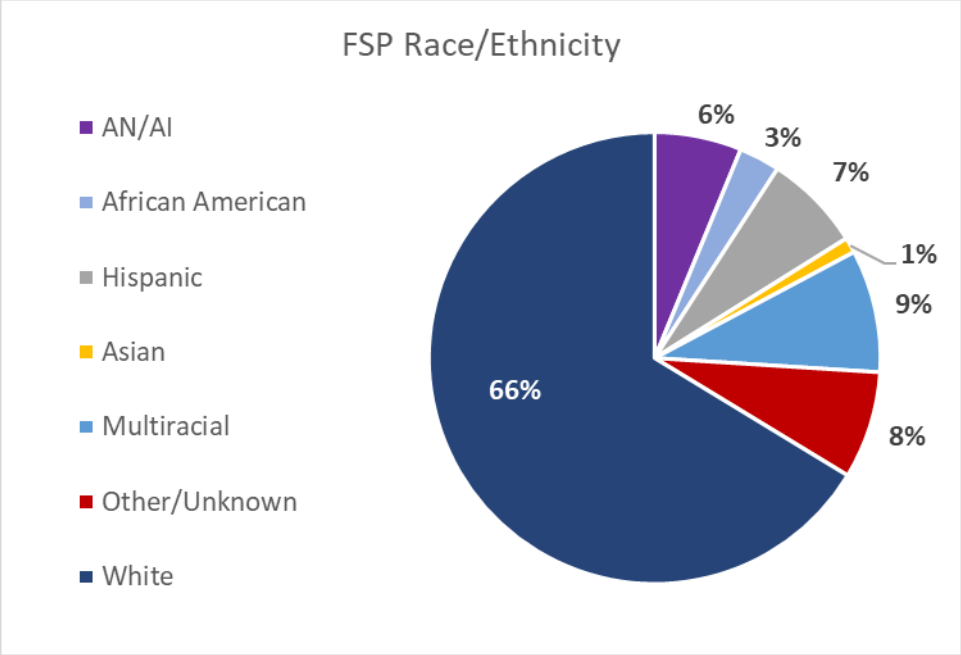
- Decrease in homelessness days.
- Decrease in behavioral health emergencies.
- Decrease in psychiatric hospitalizations.
- Decrease in arrests.
- Decrease in incarcerations.

Report for FY 2023-2024

There were 33 new Full-Service Partners (FSPs) enrolled for the period July 1, 2023, through June 30, 2024 with a unique client count of 273 Partners Served. Fourteen or Five percent of FSPs were ages 16-26, 69% were ages 26-59, and 26% were age 60+. While enrollment as an FSP is assessed for children under the age of 16 who meet the FSP eligibility requirements, to date the full spectrum of services have been provided through alternate programs and funding sources other than MHSA FSP funding, as described above.



As the chart below shows, for the period July 1, 2023, through June 30, 2024, the percentage of FSPs who identified as White was 66%; the percentage who identified as American Indian/Alaska Native was 6%; the percentage who identified as African American was 3%; the percentage who identified as Hispanic/Latino was 7%; the percentage who identified as Multiracial was 9%; 1% identified as Asian and 8% were Other/Unknown.



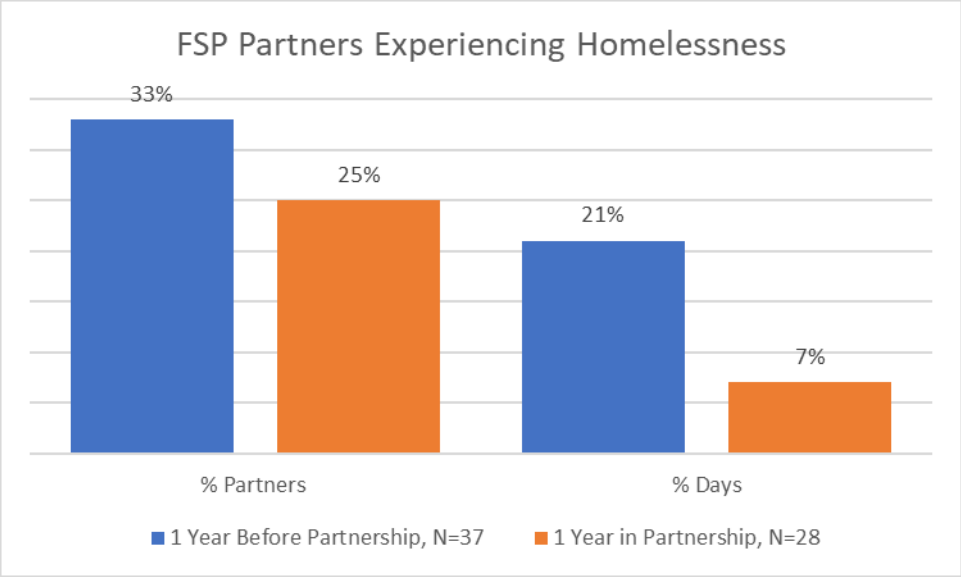
Forty-three percent of FSP clients for the period July 1, 2023, through June 30, 2024, were female, 56% were male and less than 1% where unknown or preferred not to answer.

FSPs exit a Partnership due to a variety of reasons. During the period July 1, 2023, through June 30, 2024, 44 FSPs were discharged from the program for the following reasons.

Discharge Reason	# Discharged	Percentage ALL FSP	Percentage TAY	Percentage Adult	Percentage 60+
Met Goals	13	30%	17%	35%	22%
Not Located	7	16%	50%	10%	11%
Deceased	5	11%	0%	10%	22%
Target Criteria	5	11%	33%	7%	11%
Moved	5	11%	0%	10%	22%
Serving Prison	3	7%	0%	10%	0%
Institution	4	9%	0%	14%	0%
Discontinue	2	5%	0%	3%	11%
Total Discharged	44		6	29	9

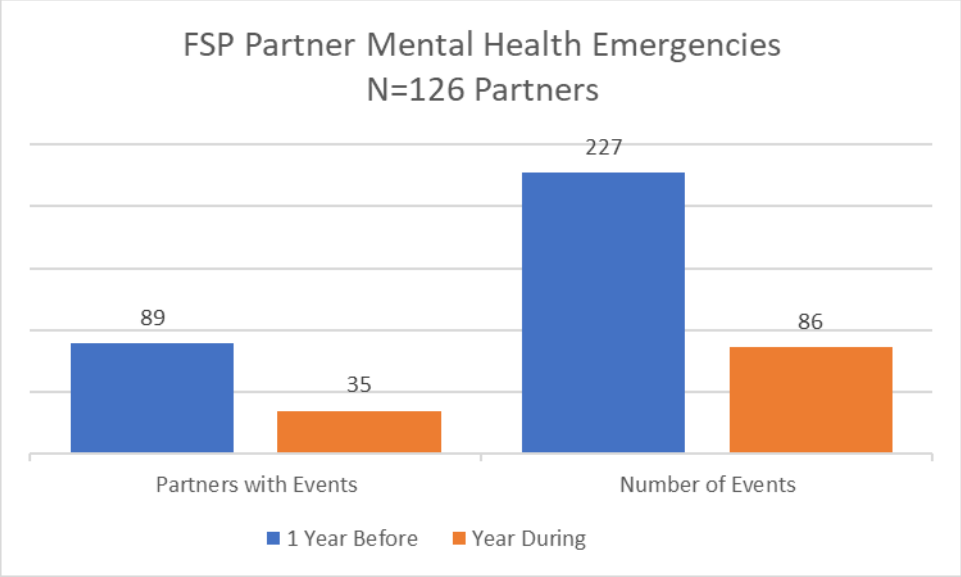
HOMELESSNESS

For the 114 Partners in an FSP with Residential needs, 37 experienced 8,648 days of homelessness in the year prior to enrollment. In the most recent year in the FSP, 28 partners experienced 3,042 days of homelessness. This represents 33% of partners experiencing 21% of homelessness days one year before the partnership, and 25% of partners experiencing 7% of homelessness days after one year in partnership.



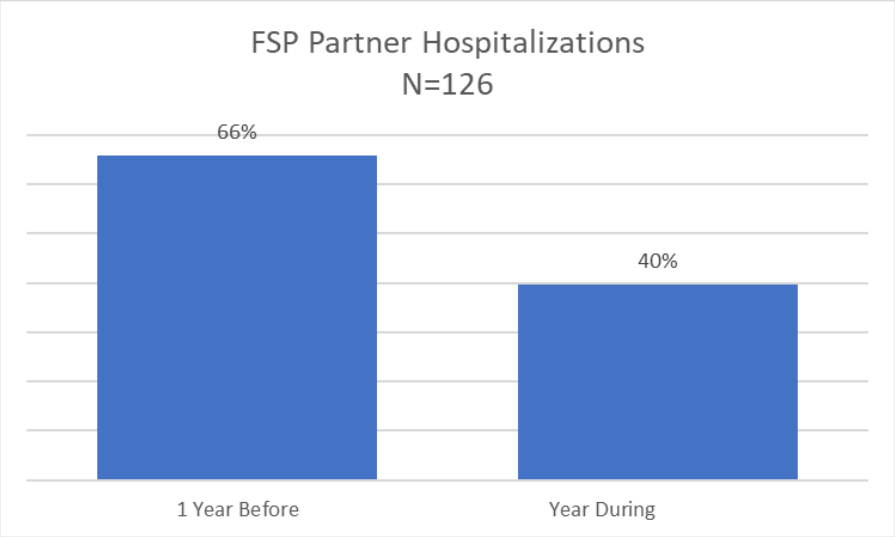
Mental Health Emergency

Of the 126 Full-Service Partners enrolled in FSP there were 35 (28%) who participated at least one year in the program. Of these 127, 89 (70%) experienced 227 mental health emergencies in the year prior to enrollment as an FSP. In the most recent year during enrollment, 35 (28%) experienced 86 mental health emergencies, a decrease of 141 events.



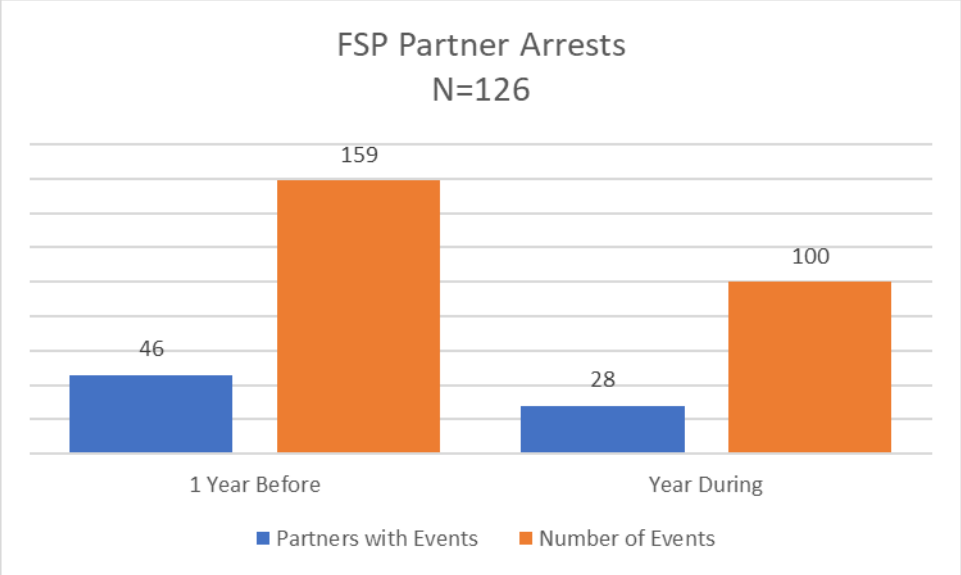
HOSPITALIZATION

Of the 126 Full-Service Partners who participated at least one year in the program, 83 (66%) experienced psychiatric hospitalization in the year prior to enrollment as an FSP. In the most recent year during enrollment 50 (40%) experienced psychiatric hospitalizations.



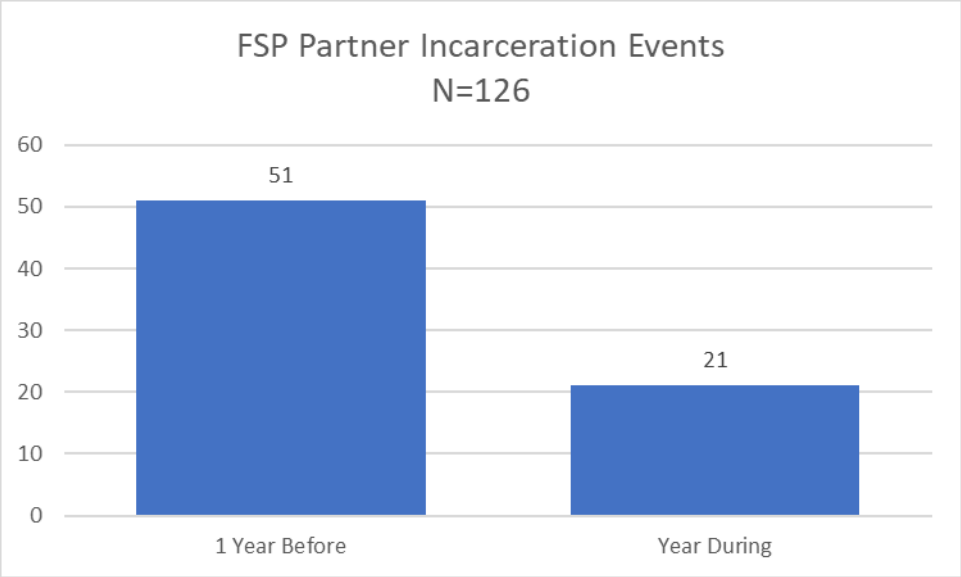
ARRESTS

Of the 126 Full-Service Partners who served at least one year in the program, 46 (36%) experienced 159 arrests in the year prior to enrollment. In the most recent year during enrollment 28 (22%) partners experienced 100 arrests.



INCARCERATION

Among the 126 Full-Service Partners who served at least one year in the program, there were 51 incarceration events for 3,876 days in the year prior to enrollment as a Partner. In the most recent year during enrollment there were 21 incarceration events.



Community Services and Supports: Regional Services

DHHS-Behavioral Health Regional Services falls under General System Development (GSD) and Outreach and Engagement (O&E). As GSD, Regional Services focuses on the stabilization, management, and reduction of psychiatric symptoms; on the restoration and maintenance of functioning; on the improvement of interpersonal effectiveness; and on the

development and maintenance of healthy support systems for clients. As O&E, Regional Services reaches out and engages adults living in all areas of Humboldt County including Eureka, Fortuna to Garberville, McKinleyville to Orick, and Willow Creek to Orleans—that have a scarcity of behavioral health services and provides services to them as needed. This meets the need to increase and expand behavioral health services.

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

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

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

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

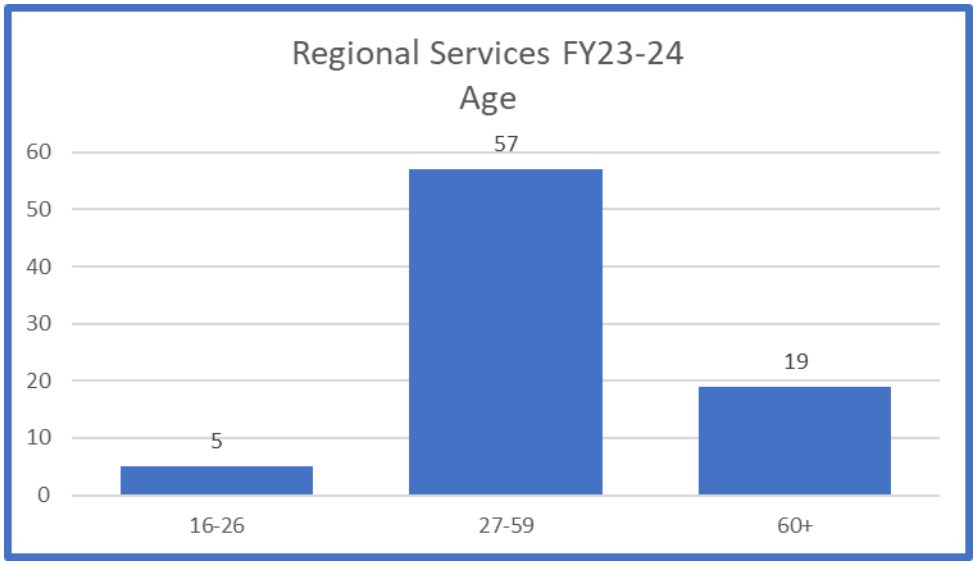
MHSA CSS funding will continue to support a proportion of the salary costs for Regional Services staff. Outcomes will be measured by the number of clients reached and the program aims to complete 50 new client assessments per year.

During fiscal year 2023-2024, there were 81 unduplicated clients served by the program. Based on last year's Revenue and Expense Report (RER), which outlines a total cost of $188,768.72 in MHSA funds, the average cost per client is estimated at $2,330.48.

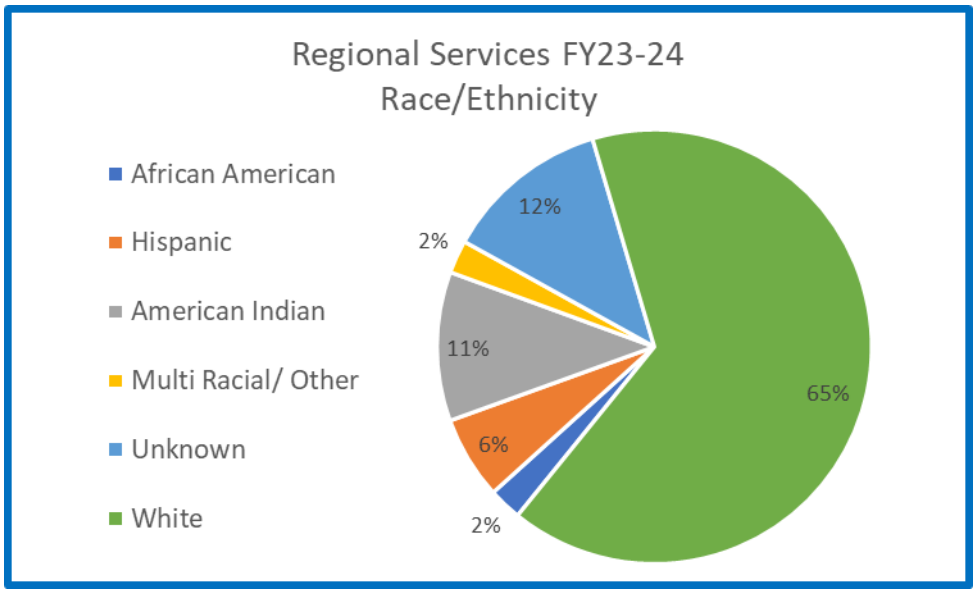
Report for Fiscal Year 2023-2024

There was a total of 81 unduplicated participants served for FY 2023-2024. It should be noted that this figure is smaller than the one presented in last year's MHSA 2023-2024 Annual Update due to housing navigation services being outsourced to Social Services.

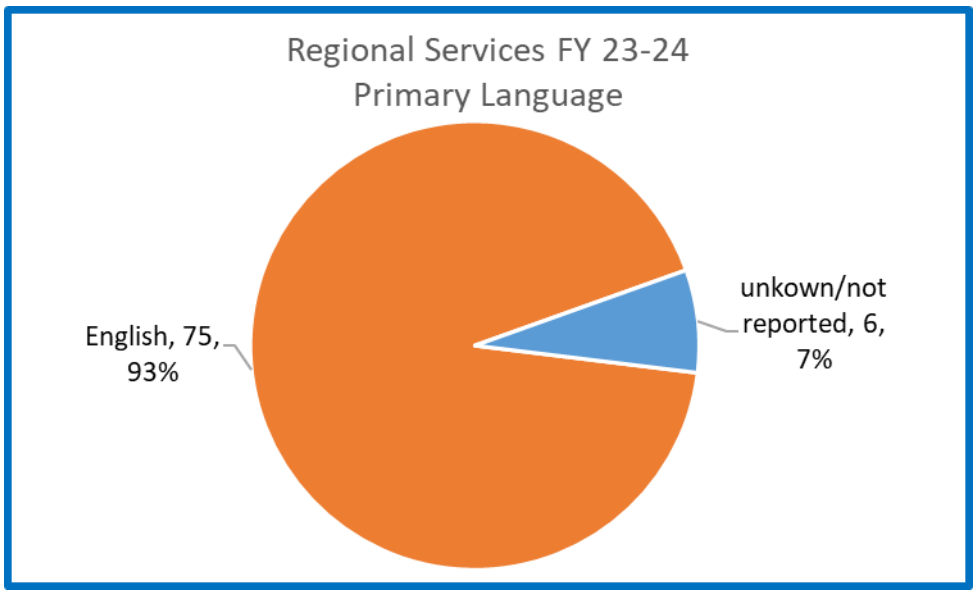
Among the 81 participants served in FY 23/24, 5 (6%) were among the 16-26 age group, 257 (70%) were among the 27-59 age group, and 19 (23%) were among the 60+ group.



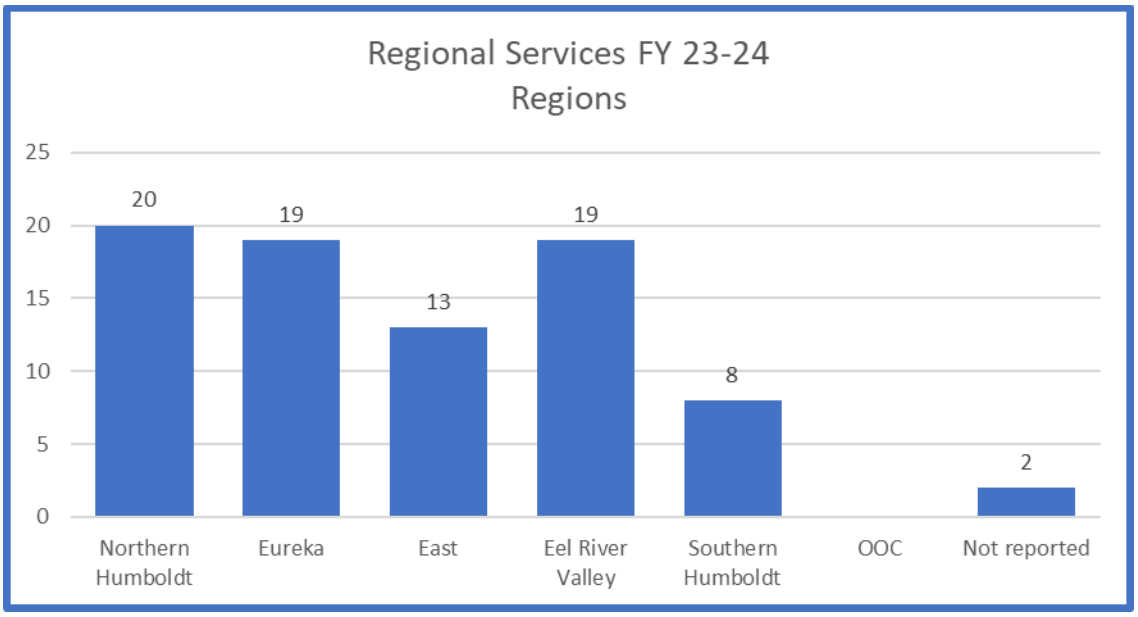
Of the 81 participants served in the Regional Services Program for FY 23/24, 2 (2%) were African American, 5 (6%) were Hispanic, 9 (11) were American Indian, 53 (65%) were White, 2 (2%) are Other and 10 (12%) are Unknown.



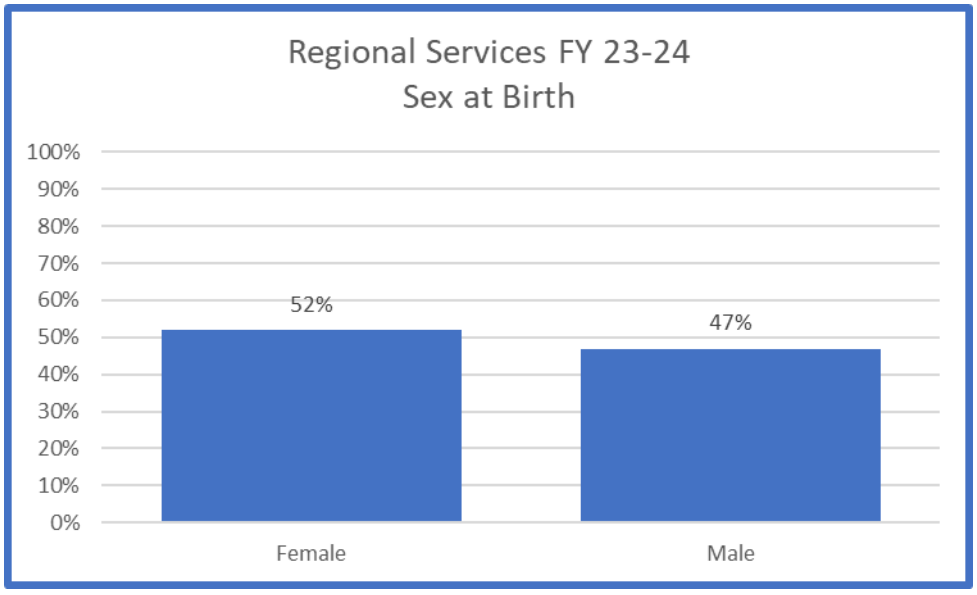
Out of the 81 participants served in the Regional Services Program for FY 23/24, 75 (93%) listed English as their primary language, 6 (7%) are Unknown or did not report their primary language.



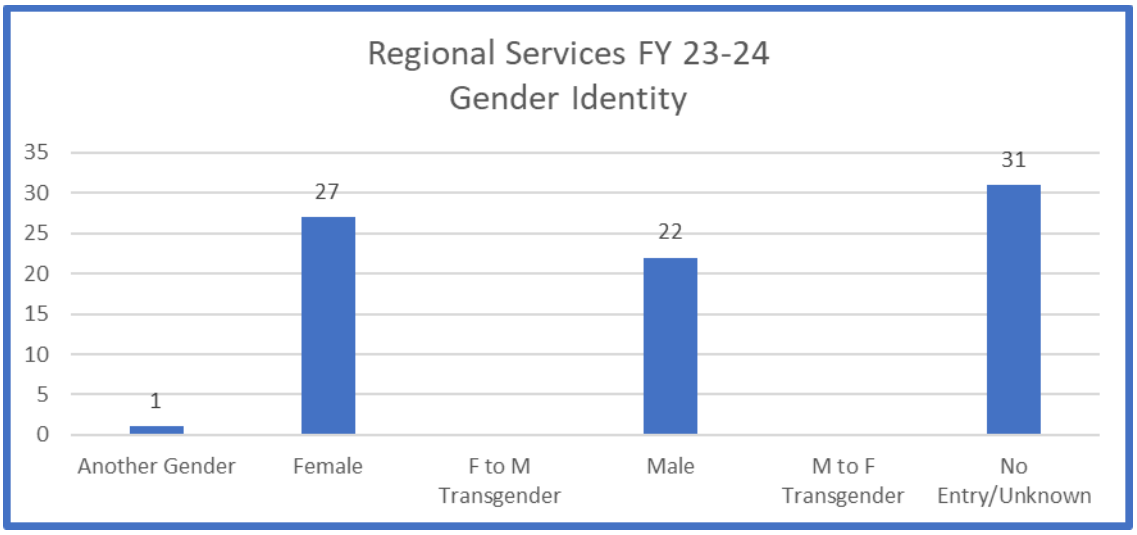
Among the 81 Regional Services participants for FY 23/24, 20 (25%) were from Northern Humboldt, 19 (23%) were from Eureka, 13 (16%) were from Eastern Humboldt, 19 (23%) were from Central Humboldt, 8 (10%) were from Southern Humboldt, and 2 (2%) of the participants did not report the region they live in.



Out of the 81 individuals served by Regional Services in FY 23-24, 42 (52%) identified as female and 47 (47%) identified as male and 1 (1%) were Unknown.



Out of the 353 Regional Services participants, 27 (33%) identified as Female, 22 (27%) as Male, and 31 (38%) did not enter gender identity.



Community Services & Supports: Older Adults

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

Outreach, Prevention and Education

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

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

Outcomes that are tracked include the following:

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

An estimated 120-150 individuals will be contacted through outreach, prevention and education during fiscal year 2023-2024. With the definition of Older Adults being lowered to the age of 60, there is potential for the number of individuals contacted to increase.

During fiscal year 2023-2024, there were 124 unduplicated clients served by the program. Based on last year's Revenue and Expense Report (RER), which outlines a total cost of $166,441.76 in MHSA funds, the average cost per client is estimated at $1,342.27.

Behavioral Health Services to Clients

In addition to contacts made through outreach, prevention and education, older adults are provided services as clients of DHHS Behavioral Health. An estimated 125 clients will be served over the next year. Clients will receive a variety of services that can include Psychiatry, Medication Support, Group Treatment, Individual Therapy, and Intensive Case Management.

Client Outcomes that are tracked:

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

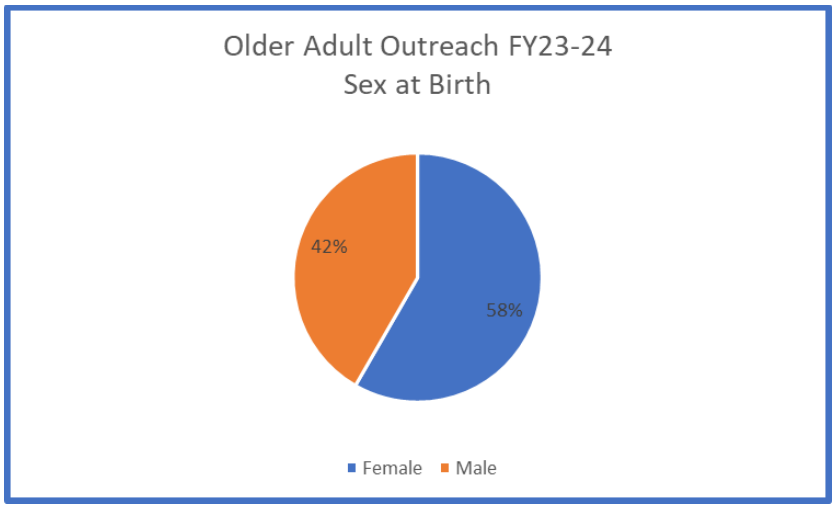
Report for Fiscal Year 2023-2024

Outreach, Prevention and Education

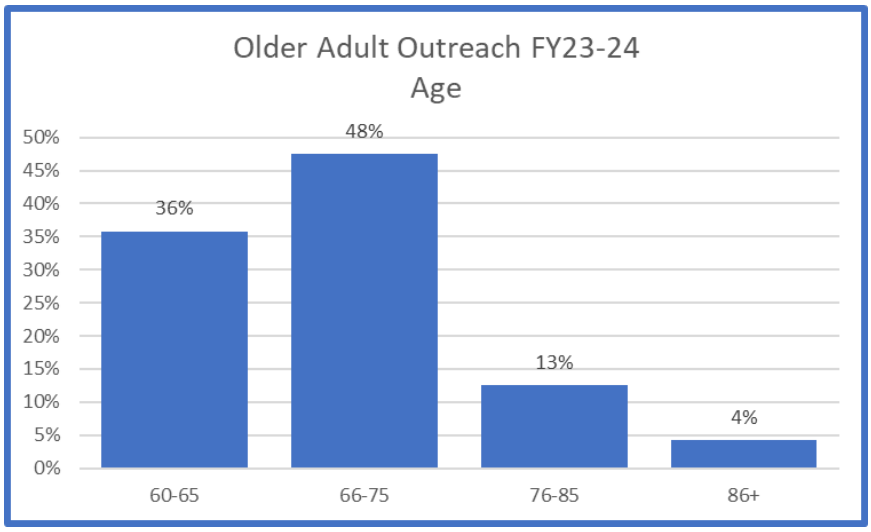
During Fiscal Year 23/24 a total of 120 individuals were contacted by the Behavioral Health Clinician assigned to the Older Adults program, primarily through outreach, prevention and education activities.

Descriptive statistics for participants in the Outreach, Prevention and Education component of the Older Adult program for FY 23/24 are discussed below.

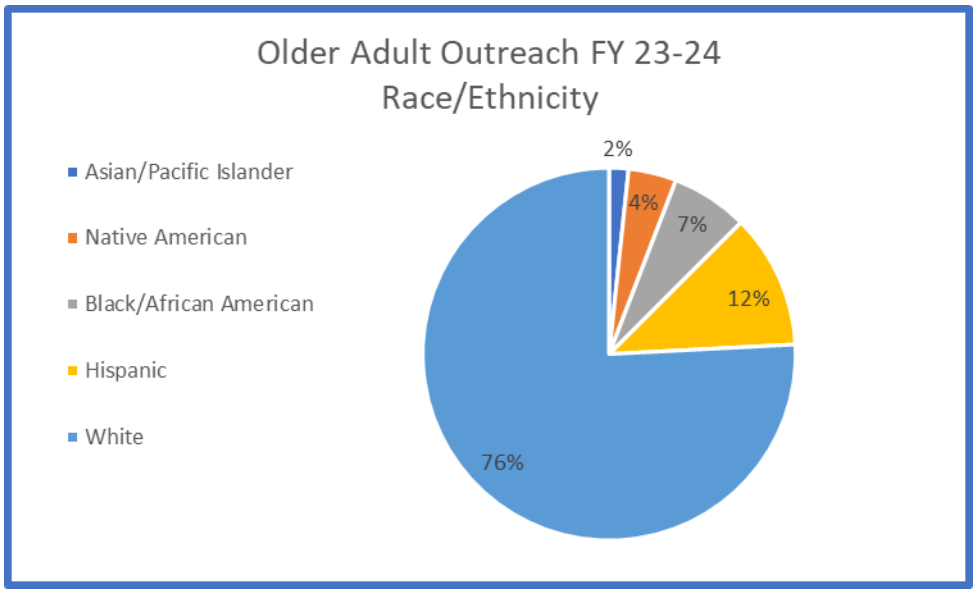
As shown in the graph below, fifty (42%) of the participants were male, 70 (58%) were female.



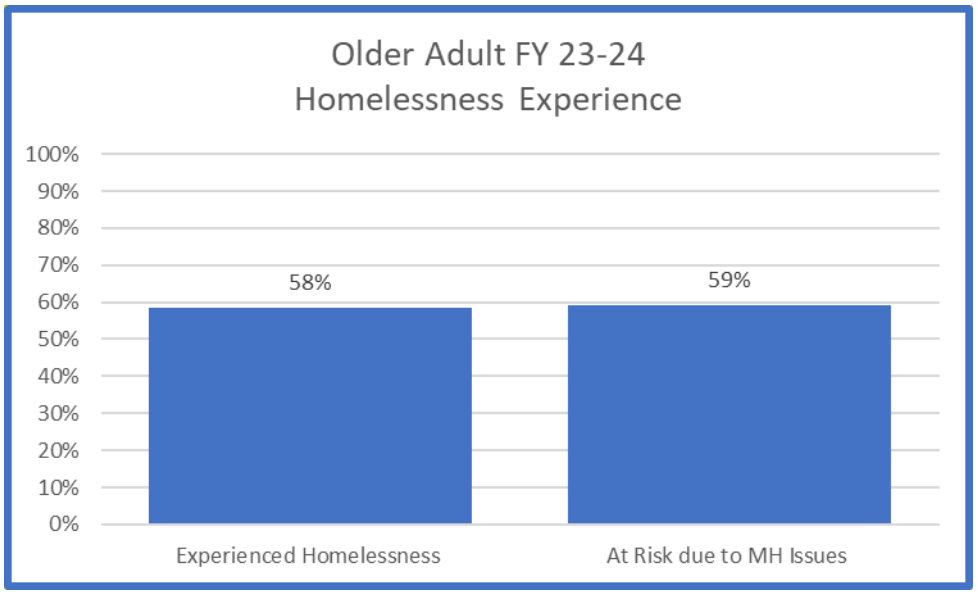
Twenty-Five (36%) were age 60-65, 57 (48%) between ages 66-75, 15 (13%) between ages 76-85 and 5 (4) were 86+.



Among the 120 Older Adults served in FY23/24, 91 (76%) were White, 8 (7%) were African American, 5 (4%) were Native American, 2 (2%) was Asian, and 14 (12%) of the participants were Hispanic.

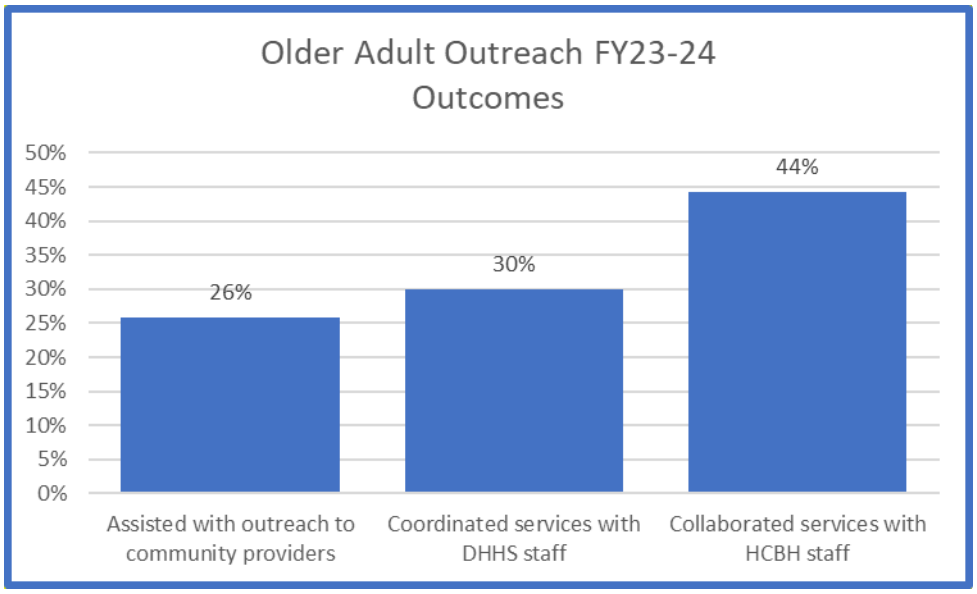


Of the 120 participants in the Older Adult program in FY23/24 70 (58%) self-identified as having experienced homelessness at some time and 71 (59%) expressed feeling at risk of homelessness due to mental health issues.



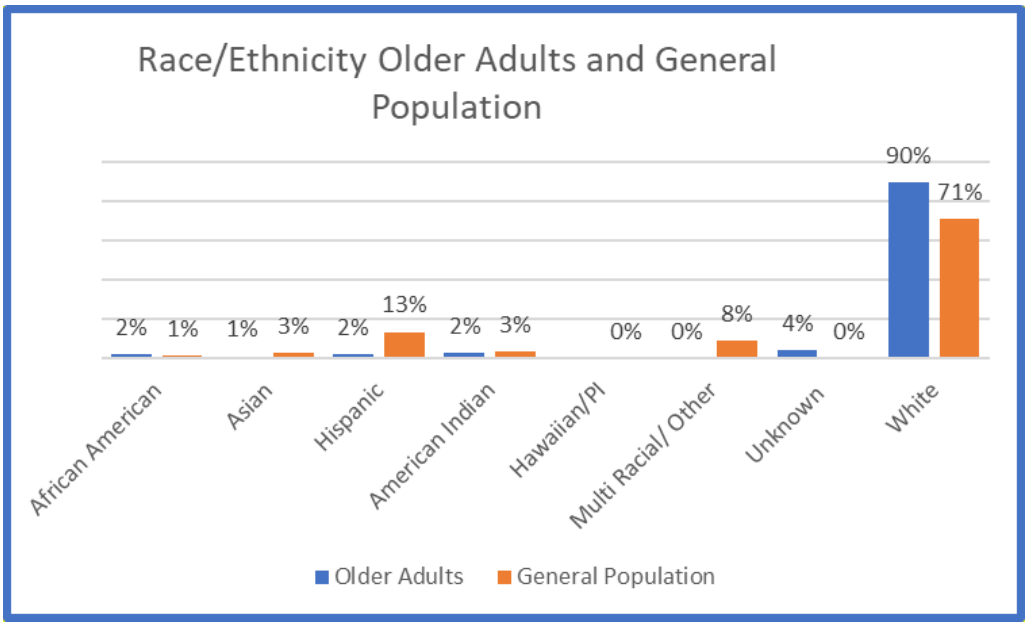
Outcomes

For these 120 Older Adult participants 31 (26%) were assisted with outreach to a community provider; for 36 (30%) services were coordinated with DHHS staff; for 53 (44%) collaboration with Behavioral Health staff was implemented.

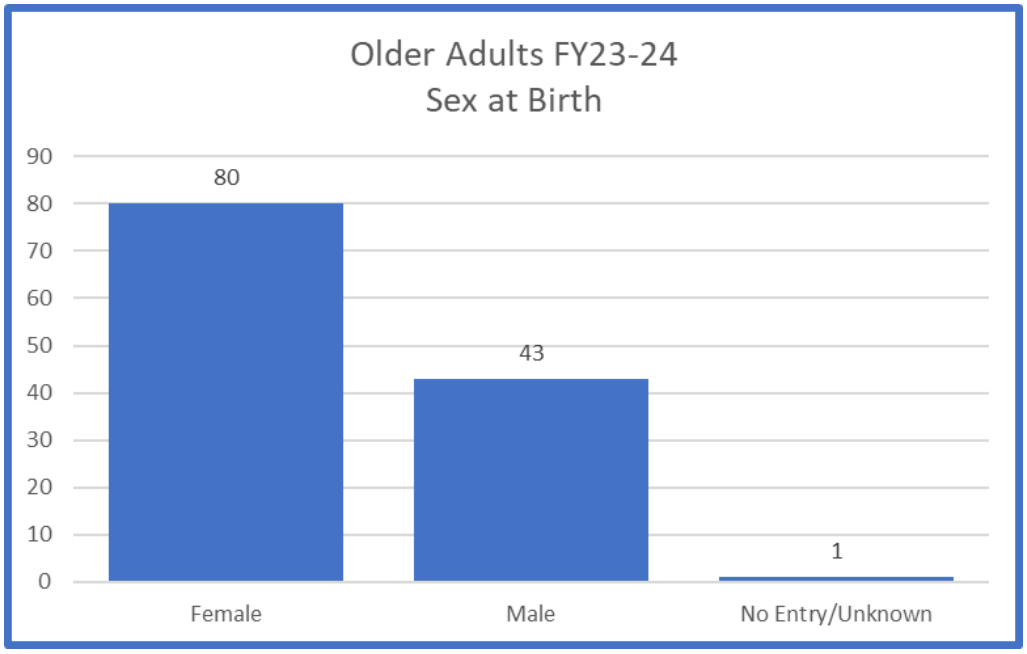


Mental Health Services to Clients

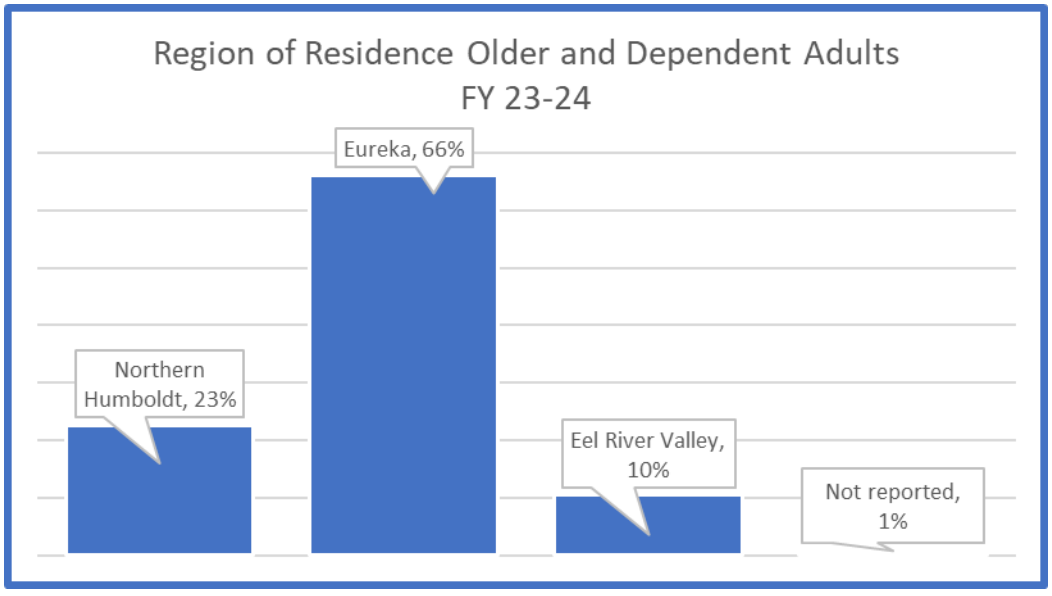
In addition to contacts made through outreach, prevention and education, 124 individuals were provided services as clients of Behavioral Health for Fiscal Year 2023-2024. Of these, 90% were White, compared to 71% of the general population; 2% were American Indian, compared to 3% of the general population; 2% were Hispanic compared to 13% of the general population; 2% were African American, compared to 1% of the general population; 1% were Asian, compared to 3% of the general population; and 0% were Multi Racial/Other compared to 8% of the general population.



Forty-Three (35%) of the participants were male, 80 (65%) were female, 1 (1%) were unknown.



Sixty-six of those served reside in Eureka, 23% in Northern Humboldt, 10% in Eel River Valley, and 1% not reported.



Community Services and Supports: Crisis Residential Treatment (Hyperion)

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

Behavioral Health received three proposals in response to the RFP. Through analysis and interviews with the proposers the RFP selection committee selected Willow Glen as the successful proposer. Willow Glen is working to establish a Crisis Residential Treatment (CRT) program in our community. As of October 2022, Willow Glen has been able to acquire a property in Eureka and is currently working on remodeling efforts and additional planning. The hope is to have the CRT in operation by late fall or early winter of 2023.

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

While a resident at the Crisis Residential Treatment facility, the client will be linked to various programs within DHHS such as the HOME program or Social Services programs, as well as other community and natural resources such as physical health care.

In addition to referrals from Psychiatric Health Facilities, clients can be referred from other programs such as CalWORKs, County Probation, and local housing resources such as shelters.

The program will assist to reduce and prevent homelessness, involvement in the criminal justice system, acute psychiatric hospital admissions and length of stays and admission/re-admission to Institute for Mental Disease (IMD) and Mental Health Rehabilitation Center (MHRC) facilities. This program should benefit individuals on our Lanterman Petris Short (LPS) Conservatorship as well as clients involved in the Assisted Outpatient Treatment Program (AOT).

Outcome Measures will be tracked through the State Data Collection and Reporting (DCR) system for those clients who meet criteria for Full-Service Partnerships. Outcome measures include:

- Psychiatric hospitalizations
- Incarcerations,
- Housing status, including number of nights homeless if applicable,
- Law Enforcement contacts, including probation/parole status if applicable,
- LPS status, including tracking those who are able to get off of LPS,
- Starting or stopping schooling and/or employment
- Starting or stopping Substance Use Disorder Treatment
- Currently enrolled with a Primary Care Provider
- Number of children in Child Welfare system

Since services started around October 2024, cost per client estimates cannot be provided at this time.

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

Crisis Alternative Response of Eureka (CARE) is a partnership and collaboration effort between the County of Humboldt, city municipalities, and other organizations meant to improve systems and to create the depth and agility needed to provide the best support possible for those in crisis. This program will support Humboldt County Behavioral Health's ability to implement 24-hour Mobile Crisis Benefit Services. CARE will be a new program and MHSA funding will be utilized to contribute to the operational costs of one clinician and one case manager during the first year. The program serves as General System Development (GSD) and Outreach and Engagement (O&E).

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

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

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

As part of the mobile crisis response intervention, team members initiate a crisis planning process that can help the individual prevent future crises. This process may include the development or modification of a safety plan. When appropriate, telephonic, or in-person follow-up services are provided to determine whether the individual was connected to referrals and if their needs were met.

Community Services & Supports: Tribal Support

DHHS Behavioral Health has supported local tribal organizations in the past to expand and/or develop coordinated systems of care. The 2024-2025 Annual Update allocated CSS funding for a local tribal organization to increase access and linkage to treatment, by becoming an organizational provider or establishing a collaborative partnership. The 2025/2026 Annual Update carries over this funding for the same purpose.

A similar support was done through the MHSA 2019/2020 Annual Update, when Two Feathers Native American Family Services received funding to develop a program and create infrastructure to increase access and linkage to treatment that was a component of a coordinated system of care that serves youth and their families. Two Feathers also leveraged existing tribal resources with MHSA funding to expand culturally responsive services and became DHHS Behavioral Health's first tribal organization to be an organizational provider.

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

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

The Resident Engagement and Support Team (REST) project applies a promising community driven practice or approach that has been successful in a non-mental health context or setting for those experience mental health challenges. This approach is Housing First. The project's primary purpose is to increase access to mental health

services to underserved groups. These groups are homeless individuals or those who are at risk of becoming homeless.

This project will expand on current efforts of the county regarding the overarching goal of improving housing stability. This goal has been a jointly identified need by various county agencies, including Humboldt County Department of Health and Human Services HOME program, Arcata House Partnership, Eureka City Council and the Department of Housing and Urban Development (HUD) to name a few. Currently these efforts exist to find permanent supportive housing for homeless and unsheltered individuals in the county. REST addresses a missing component within this continuum by helping individuals remain housed while assisting in transition them to HUD programs.

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

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

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

REST was approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC) on June 24, 2021, and by the Humboldt County Board of Supervisors on August 10, 2021. Services for consumers were expected to begin by January 2022. However, hiring Case Managers for the program has proven to be challenging. Limited services began in July of 2022. Currently one position is filled and active recruitment is happening to fill all remaining vacancies for this program.

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

During fiscal year 2023-2024, there were 63 unduplicated clients served by the program. Based on last year's Revenue and Expense Report (RER), which outlines a total cost of $266,430.95 in MHSA funds, the average cost per client is estimated at $4,229.06.

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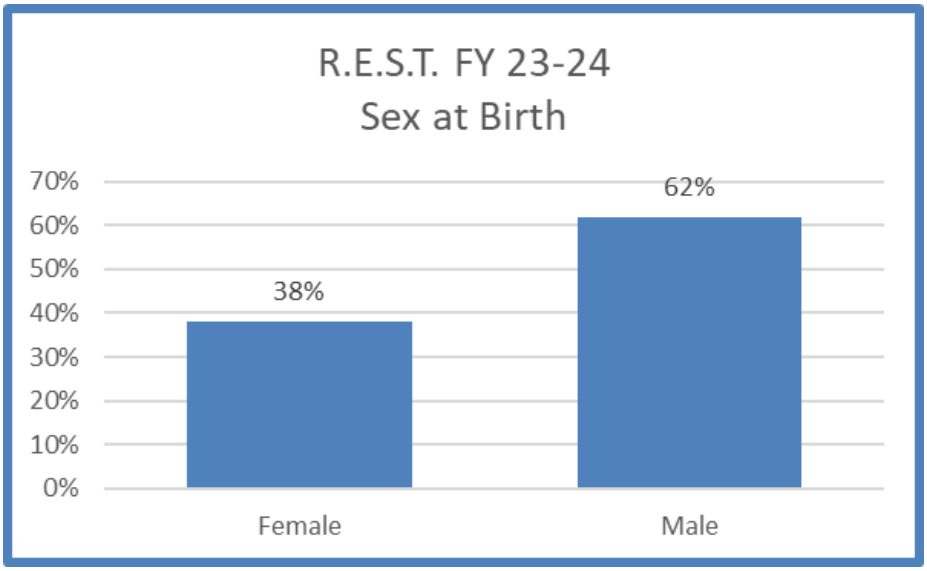
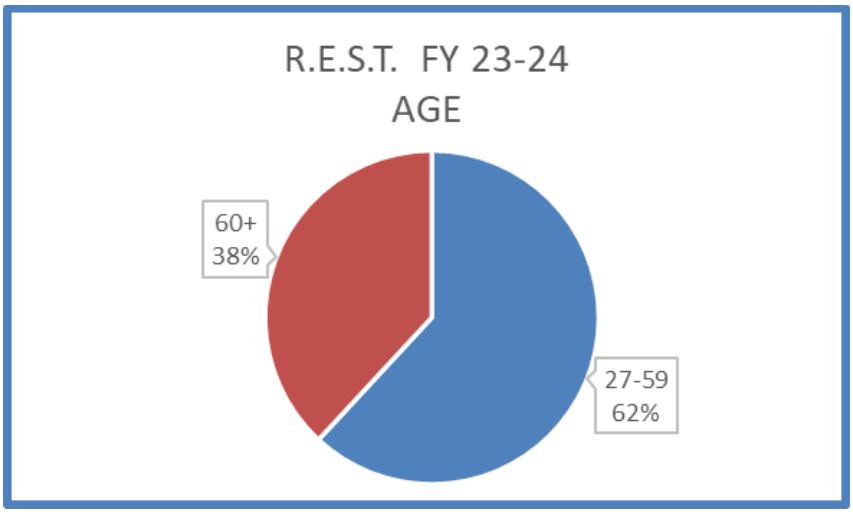
For fiscal year 2023-24, REST worked with a total of 63 participants.

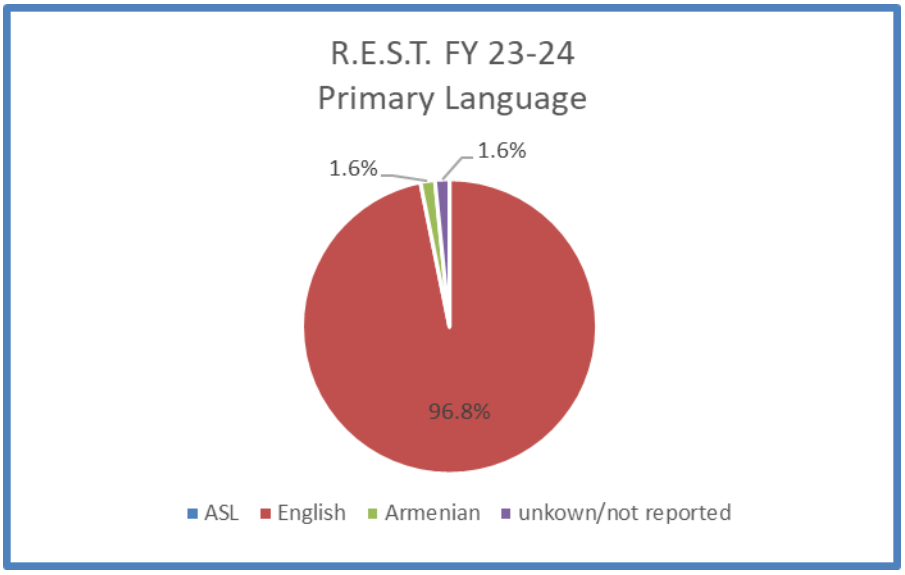
As shown on the graph below, in fiscal year 2023-24 38% (24) of the clients supported by the program reported their sex at birth to be female and 62% (39) were male.



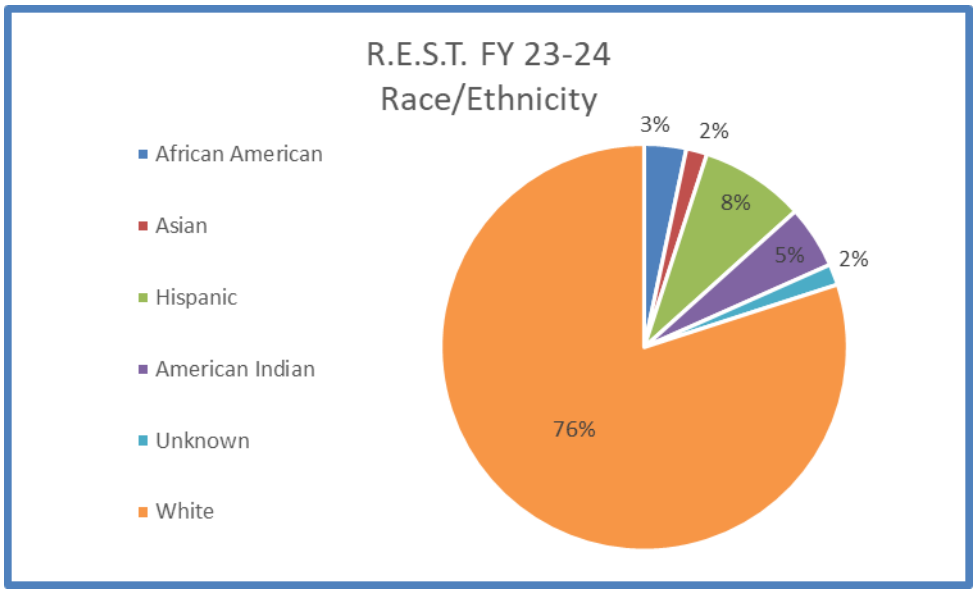
As seen on the graph below, in fiscal year 2023-24, 62% (39) of participants were within the 27-59 adult age group, and 38% (24) were within the 60+ older adults age group.



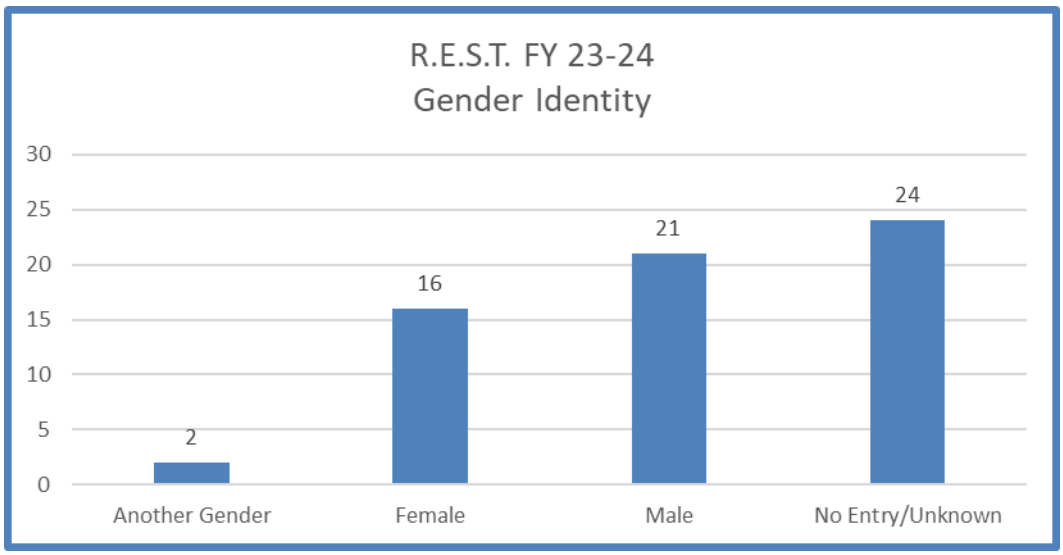
As seen on the graph below, in fiscal year 2023-24 2% (1) of the participants utilized Armenian as a primary language, 2% (1) preferred not to answer, and 96.8% (61) utilized English as their primary language.



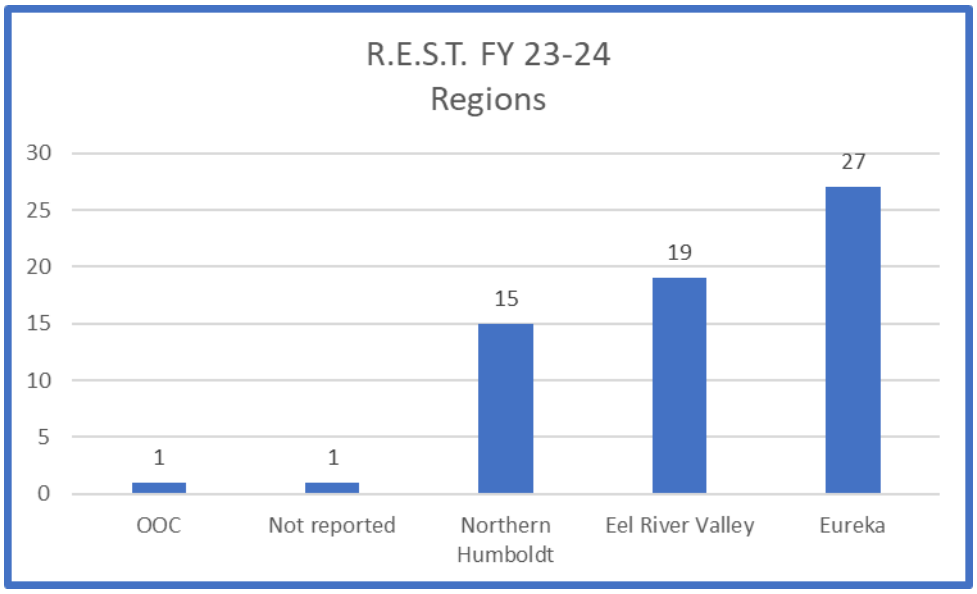
As seen on the graph below, in fiscal year 2023-24 3% (2) of REST participants reported African American as their race/ethnicity, 2% (1) as Asian, 8% (5) as Hispanic, 5% (3) as American Indian, 2% (1) preferred not to answer, and 76% (48) reported White as their race/ethnicity.



As seen on the graph below, in fiscal year 2023-24 2 (3%) participant identified as another gender identity, 16 (25%) identified as female, 21 (33%) as male, and 24 (38%) preferred not to answer.



As seen on the graph below, in fiscal year 2023-24 15 (24%) of REST participants are from the Northern Humboldt region, 27 (43%) are from the Eureka region, 19 (30%) from the Eel River Valley region, 1 (2%) from Out of County and 1 (2%) are Unknown or preferred not to answer.



Prevention & Early Intervention (PEI) Component

Nineteen percent (19%) of MHSA funds received by counties must be allocated for PEI services, designed to prevent mental illnesses from becoming severe and disabling. PEI services focus on preventing the onset of mental health issues and/or providing early intervention treatment and referral services. MHSA regulations require PEI plans to include at least one program focused on delivering services for the following service categories: 1) Prevention, 2) Early intervention, 3) Stigma and discrimination reduction (SDR), 4) Recognizing early signs of mental illness, and 5) Promoting greater access and linkage to treatment. Suicide prevention programs also fit within the PEI component. Below is a table showing current PEI programs along with their corresponding service category:

PEI Program	Service Category
Hope Center	SDR, Access and Linkage to services, Prevention, Early Intervention
Transition-Age Youth Advocacy & Peer Support	Prevention, Early Intervention, SDR, Recognizing early signs of mental illness, Access and linkage to services
Suicide Prevention	Suicide Prevention
Parent Partners	Early Intervention, Access and Linkage to services
School Climate Transformation MTSS	Prevention, Early Intervention, Recognizing early signs of mental illness
Local Implementation Agreements	**Vary depending on approved programs**
Latinx Liaison Position	SDR, Access and linkage to services

Early Childhood Treatment Certification	Prevention, Early Intervention, increasing the recognition of early signs of mental illness
Warm Line	Early Intervention, Access and Linkage to Services
Assigned Funds—CalMHSA PEI Program	Recognizing early signs of mental illness
NEW: Humboldt Early Psychosis Intervention Program (HEPI)	Early Intervention, Access and Linkage to Services

Per the requirements of SB 1004, as listed in the chart below under the column SB 1004 Priorities, the programs in the five service categories listed above should focus on six priorities. Humboldt County's PEI programs include the six priorities, as indicated in the table below. Because in most cases more than one PEI program addresses each of the priorities, determining the share of PEI funding that is received by each priority is difficult. An estimate is 17% for childhood trauma prevention and early intervention; 13% for suicide prevention; 14% for youth outreach and engagement; 17% for culturally competent and linguistically appropriate prevention and intervention; 8% for older adults; and 31% for early identification programming. The PEI programs are supported by stakeholder engagement and contribution. Themes from stakeholders over the past years include increasing bilingual and culturally competent services; focusing on early childhood mental health, including trauma prevention and early intervention; and increasing support for school age and transition age youth. It should be noted that Humboldt Behavioral Health has an Early Psychosis program meeting the priority of early psychosis and mood disorder detection and intervention that is not funded by MHSA, and the Older Adults program, funded by MHSA CSS dollars, includes an outreach, education and engagement component that fits under the priority of strategies targeting the mental health needs of older adults.

SB 1004 Priorities	**Humboldt PEI Programs**
Childhood trauma prevention and early intervention	• Parent Partners • Local Implementation Agreements • MTSS • Early Childhood Treatment Cert. • HEPI
Early psychosis, mood disorder detection, intervention and suicide prevention programming that occurs across the	• Suicide Prevention • Warm Line

lifespan (Note: all Humboldt PEI programs are for suicide prevention)	• CalMHSA PEI Program • HEPI
Youth outreach and engagement strategies that target secondary school and transition age youth and youth not in college, with a priority on partnership with college mental health programs	• TAY Advocacy and Peer Support • MTSS • CalMHSA PEI Program
Culturally competent and linguistically appropriate prevention and intervention	• Hope Center • Local Implementation Agreements • Embedded in all PEI programs • Latinx Liaison • CalMHSA PEI Program
Strategies targeting the mental health needs of older adults	• Suicide Prevention • Suicide Prevention Hotline • CalMHSA PEI Program
Early identification programming of mental health symptoms and disorders	• Hope Center • TAY Advocacy and Peer Support • Parent Partners • MTSS • Warm Line

At least fifty-one percent (51%) of PEI funds must be allocated for serving individuals who are 25 years old or younger. Programs that serve parents, caregivers or family members with the goal of addressing children and youth at risk of or with early onset of a mental illness can be counted as serving children and youth. The following pages describe the PEI programs and services that reflect the themes and priority areas identified in the CPPP.

Prevention and Early Intervention: Hope Center

The Hope Center serves unserved and underserved populations of transition age youth, adults and older adults who have behavioral health challenges as well as their family members. The Center meets the need in the community to provide a safe, welcoming environment based on the dimensions of wellness from the Substance Abuse Mental Health Services Administration (SAMHSA), and the resources necessary for people with and without a behavioral health diagnosis and their families to be empowered in their

choices to be self-sufficient. The Hope Center provides prevention and early intervention activities that reduce stigma and discrimination and provide access and linkage to treatment. Hope Center activities are culturally responsive and linguistically appropriate and help provide early identification of mental health symptoms and disorders, meeting the SB 1004 priorities. These activities contribute to the reduction of the negative outcomes that may result from untreated behavioral health challenges and illness.

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

The Hope Center has a Peer Coach lll position along with Peer Coach I and II positions. Due to legislation changes, all Peer Support staff have the opportunity to be certified through CalMHSA as Peer Support Specialists. Many of them are completing their education and training requirements for this certification already. Once this is done, they will take the Peer Certification test administered by CalMHSA. Currently, the Peer Coach III has passed the test and earned their certification. This certification will allow for Medi-Cal to be billed for the service of Peer Support creating an additional funding mechanism to help sustain peer programs, including the HOPE Center. In addition to this, two of Hope Center Peer Coach ll's have completed the Wellness Recovery Action Plan (WRAP) training. This is an evidence-based practice that emphasizes recovery and resiliency for those consumers who at times struggle with their stability.

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

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

- Encourage individuals to find their personal strengths and identify their personal recovery goals.
- Develop a more sustainable hybrid setup, to allow access to all who want to participate.
- Link community members to services through use of the Warm Line.

*Hope Center Peer Coaches meet with the client directly when needed and call together to check on referral status. *

Stigma and Discrimination Reduction--

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

Access and Linkage to Services

The Center works from the recovery pathways: Hope, Choice, Empowerment, Recovery Environment, Spirituality (purpose/meaning). The Center provides many resources including classes, self-advocacy education, peer support, system navigation, and linkage to services in the community. Outreach efforts are made by Hope Center peers to people with a behavioral health diagnosis. The Hope Center has been slowly returning to in person services while maintaining a Zoom community. Hybrid classes will be added to our calendar in the following year. Hope Center has introduced Recovery Innovations “My Wellness plan” course to the curriculum as well as a reading club focused on individuals’ experiences with mental health. The Center has created a stronger community connection by tabling at local events. In 2018 the Hope Center created an Advisory Board made up of four participants and a staff member. Unfortunately, the Advisory Board was unable to sustain during the coronavirus outbreak, but staff are working diligently to support participants in re-establishing this Advisory Board. The Advisory Board’s job is to be a voice for the Center and give input to staff. Participants meet once a month to discuss topics of concern, ideas, and thoughts about Mental Health and the role of the Center in the community. The Hope Center has consistent and active members of the community who contribute services such as outreach, education, and coordination of special events.

Hope Center continuing projects include:

- Peer workforce training for the current and future workforce.
- Zoom and Hybrid (in person and online simultaneously) meetings and classes.
- Leadership training.
- Healthy Harvest--fresh fruits and vegetables for participants to supplement their diet.
- Work towards Cultural inclusion.
- The Hope Center Advisory Board.

- Hope ambassadors (participants who know and talk about the recovery pathways).
- Training staff on Wellness Recovery Action Plan facilitation.
- Teaching interns about Peer Empowerment and use of the recovery language in their future work.
- May is Mental Health Matters Month participation.
- Classes, workshops, and education that focus on individuality, mindfulness, nutrition, resilience, fun, building skills, wellness, building community, facing challenges, and building confidence.
- One on one Peer Support as needed.
- Maintenance of the Warm Line

Plans for the next year include training and reintroduction of WRAP, in-person services, Zoom and hybrid classes, monthly wellness center meetings, Peer support services and community outreach.

Hope Center activities contribute to the reduction of negative outcomes that can result from untreated mental illness. Besides basic process evaluations that includes numbers reached and events held, the program will measure increases in participants' knowledge, awareness, attitudes and beliefs towards recovery and wellness and any increase in social connections they may experience. This will be measured through training/class evaluations and surveys offered on a periodic basis. In addition, program staff will use a newly developing form with participants, when indicated, to identify if a participant has had past symptoms of mental illness, whether they were treated for these symptoms, and to what service/program a participant may have been referred.

Hope Center Stigma and Discrimination Reduction

The Hope Center is one of the central programs that Humboldt County Behavioral Health has for furthering the efforts of stigma and discrimination reduction with adults. As discussed earlier in this section, the Hope Center is peer led, and peer support is an evidence-based practice. Over the years of operation, the Hope Center has provided a location for individuals in the community that offers a variety of services and programs without the need of becoming a formal mental health client. These services and programs have been identified as "classes" as they are intended to assist individuals in the community with education on a variety of topics and have the goal of allowing all participants to gain a level of self-sufficiency and self-reliance. The program is intended to influence those living with a mental illness, those who have not been diagnosed with a mental illness but who are experiencing some symptoms that are challenging, and community members who may want to participate in classes or events that are of interest to them.

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

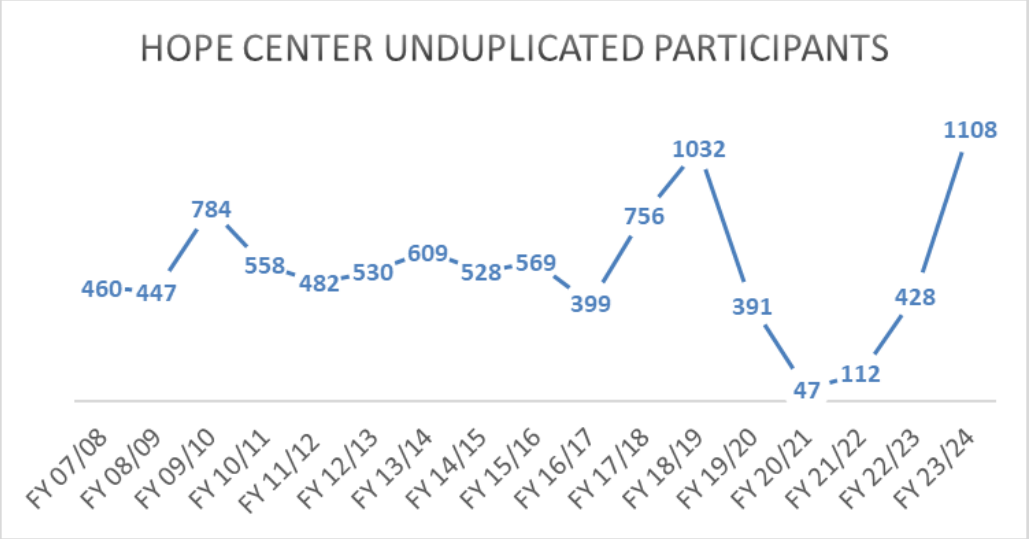
Fidelity to the evidence-based peer support practice is ensured through the certification process of Recovery Innovations (RI) International. All Peer Coaches are trained as Certified Peer Support Specialists through RI International.

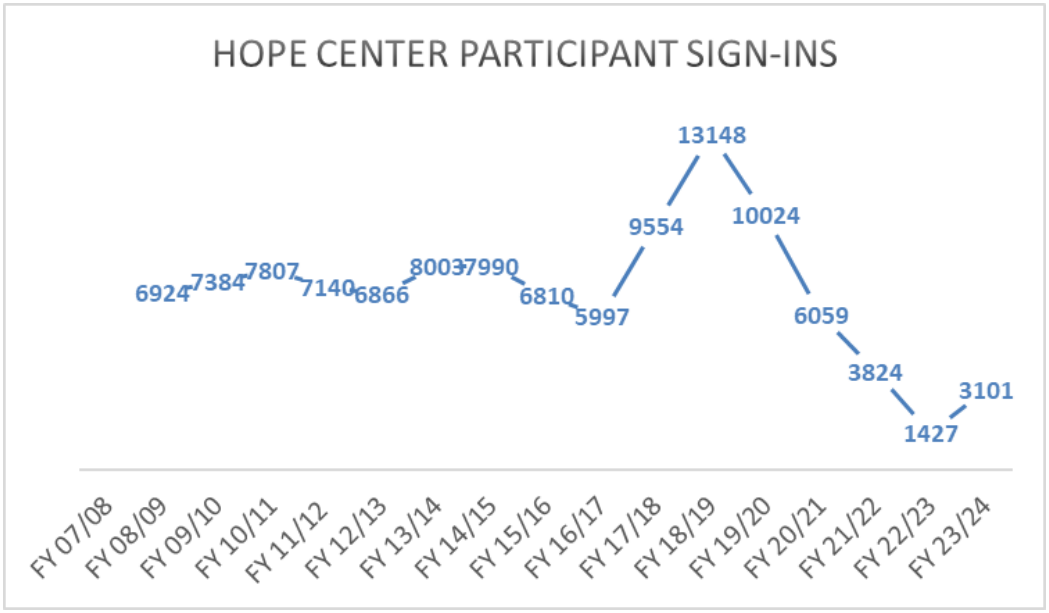
Cost Per Client Estimates

Data includes a recorded total of 1,108~ unduplicated participants for FY 2023-2024. were recorded. Based the 2023-2024 Revenue and Expense Report (RER), which outlines a total cost of $446,821.99 in MHSA funds, the average cost per unduplicated client is estimated at $403.27. The number of duplicated participants was 1,427 for FY 2023-2024 which includes individual peer support engagement on site, in Zoom meetings, and in-person with social distancing, and masking. Additionally, hybrid classes have been added.

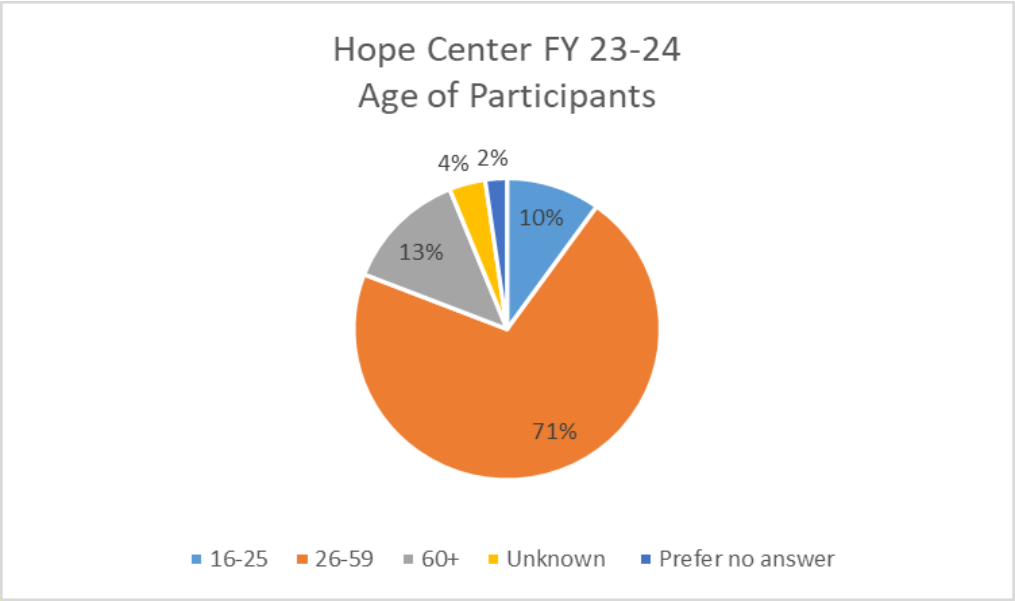
Hope Center report for Fiscal Year 2023-2024:

During Fiscal Year 2023-2024 the Hope Center interfaced with 1,108 unduplicated individuals. There were 3,101 sign-ins (duplicated) to the program. Comparing the unduplicated participant count with prior years, there is a large spike in attendance. There were no volunteer hours for this fiscal year, but Hope Center is developing the volunteer process to include volunteer hours in the near future.

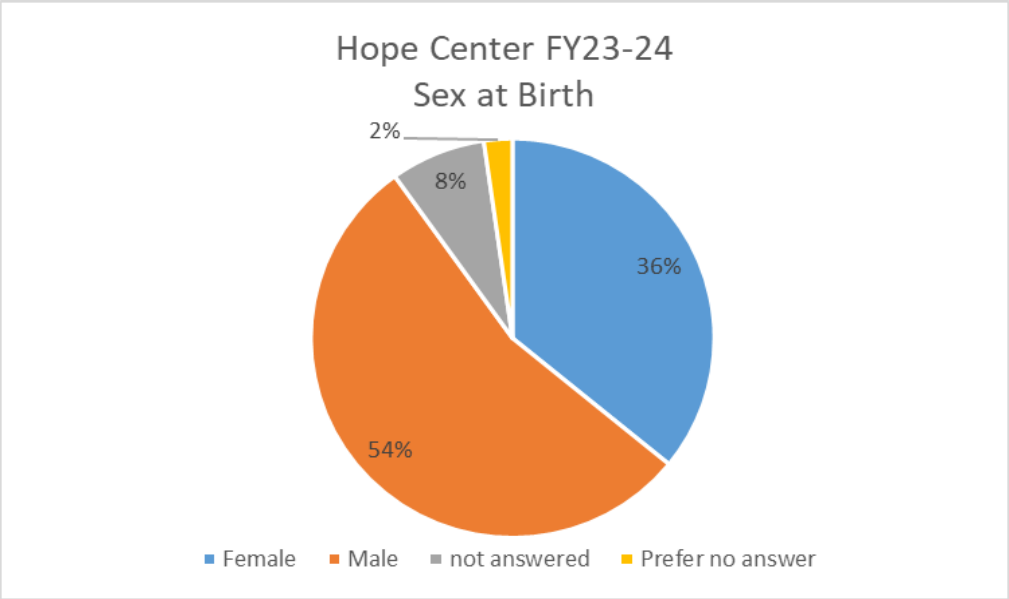




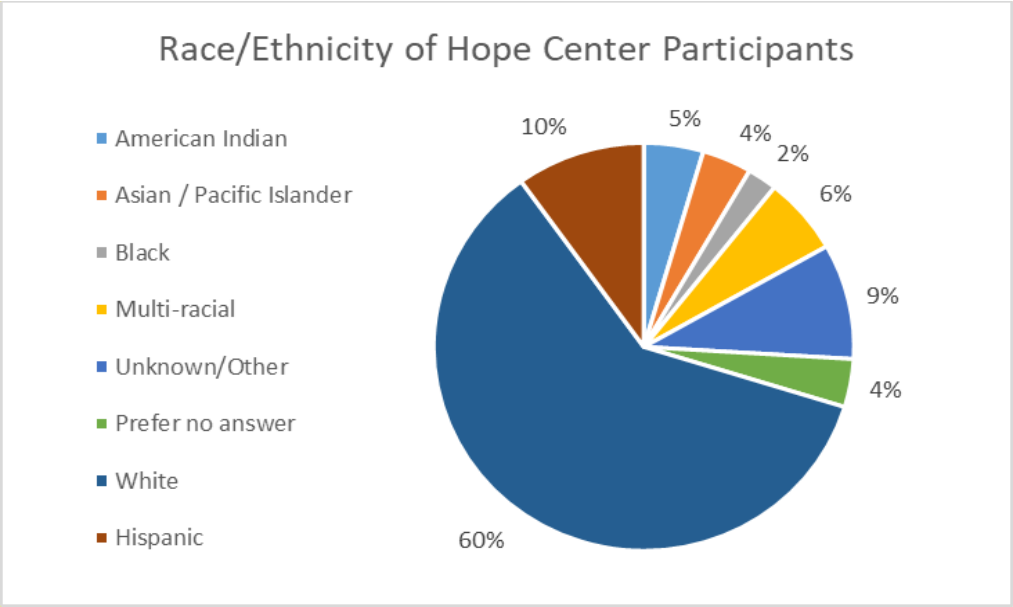
Demographic Data. Of the 1,108 Hope Center participants, 131 (12%) completed demographic forms. Demographic data is presented in the charts below. Of those who responded, 10% of participants were ages 16-26, 71% of participants were ages 26-59, and 13% were age 60+. Four percent were Unknown and 2% Preferred not to answer this question.



Of those who responded, 36% were female, 54% male, 8% did not answer this question and 2% Preferred no Answer.

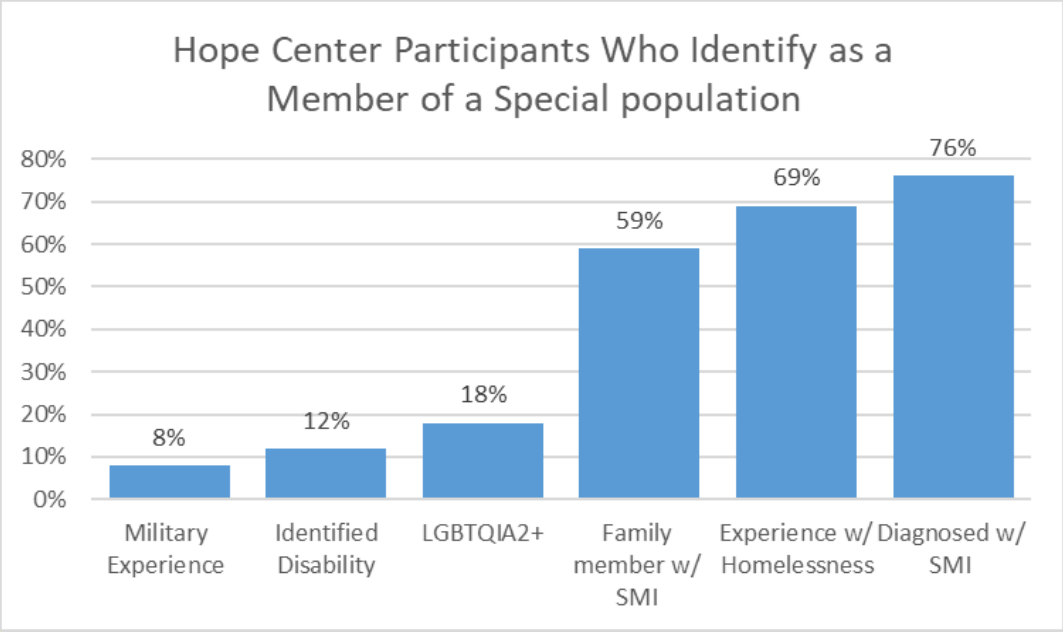


Of those that responded, 60% were White, 6% were Multiracial, 9% Unknown/Other, 10% were Hispanic/Latinx, 5% were American Indian, 2% were Black, and 4% were Asian. 4% did not answer this question.



89% percent of the Hope Center participants who completed the form spoke English as their primary language. Five percent spoke Spanish and 6% are Other/Unknown.

18% identified as LGBTQIA2+, 69% had experience with homelessness, 12% identified as having a disability, 76% had been diagnosed with a serious mental illness (SMI), 59% had a family member diagnosed with SMI, and no participants had military experience.



Prevention and Early Intervention (PEI): Transition-Age Youth (TAY) Advocacy and Peer Support

There are two components to this **Prevention and Early Intervention Program: Transition-Age Youth (TAY) Advocacy**, through the Humboldt County Transition-Age Youth Collaboration (HCTAYC), and **Peer Support** through TAY Peer Coaching services. Both components span the access and linkages aspects of PEI, as well as stigma-discrimination reduction, and serve youth and young adults ages 16-26. TAY Advocacy and Peer Support are a part of the Humboldt County DHHS TAY Division.

The TAY Division consists of co-located DHHS services at the TAY Center, including Behavioral Health (BH), Extended Foster Care (EFC), Independent Living Skills (ILS), HCTAYC and TAY Peer Coaches. In addition, the TAY Division utilizes supports and services from DHHS departments including Employment Training Division (ETD), CalFresh, Medi-Cal, Substance Use Disorder (SUD) services, and collaborates with community partners such as Juvenile Probation and Family Resource Centers.

TAY Access and Linkage to Services activities include but are not limited to:

- ●A behavioral health team providing specialty mental health services (individual and family therapy, case management, and referrals for psychiatric services), including a supervisor, clinicians, and case managers.
- ●Linkage and referrals to Adolescent Treatment Program and other substance use disorder services[1].
- ●Child Welfare Services (CWS) Independent Living Skills (ILS) program serving youth ages 16 to 21.
- ●CWS EFC Unit.
- ●HCTAYC staff and Youth Advocacy Board (YAB).
- ●Peer Coaches who serve across the TAY Division.
- ●A Vocational Counselor from DHHS Employment Training Division (ETD).
- ●Linkage and referrals to intensive case coordination services as needed.

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

- ●TAY Advocacy
- ●Peer Coaching Program
- ●Survey Development

[1] Peer coaches attend a weekly TAY Behavioral Health case consultation with the clinical team and can ask for updates/status of the waitlist for referrals they made. For referrals outside of TAY BH, peer coaches meet with the client directly and call together to check the referral status.

Target Population

Both HCTAYC and Peer Coaching programs serve Humboldt County youth ages 16-26 who have or are experiencing homelessness, current or historic interaction with the juvenile justice system and/or CWS, youth who opted into the EFC program, those experiencing behavioral health needs, those experiencing issues with substance use, parenting TAY and youth seeking employment.

TAY Advocacy—HCTAYC

TAY Advocacy is a prevention program which, along with TAY Peer Coaches, addresses components of early intervention, stigma and discrimination reduction, and outreach for increasing the recognition of early signs of mental illness. The TAY Advocacy and Peer Support activities meet the SB 1004 priority of youth outreach and engagement targeting transition-age youth and the priority of early identification of mental health symptoms and disorders.

As a rural, poverty-stricken community, access and knowledge regarding the aforementioned subjects, particularly for systems-impacted youth are limited. There is a significant need to address the hopelessness, lack of self-efficacy, and significant independent living skill deficit that exacerbate existing social determinants of health.

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

The TAY Advocacy Program, HCTAYC, launched in 2008. Program collaborators have changed over time and currently consist of youth ages 16-26, DHHS, California Youth Connection (CYC), National Network for Youth (NN4Y), and Youth Law Center (YLC). HCTAYC works to improve the services youth receive as they transition into adulthood and become independent.

HCTAYC fosters positive youth development, youth advocacy and leadership, community engagement, and promotes youth wellness. HCTAYC provides a youth voice that informs system policy, regulations, and practice at the local, state, and national levels with the purpose of cultivating better outcomes for unserved and underserved youth with a severe mental illness or who are at a significantly higher than average risk of developing a severe mental illness. The program directly impacts the TAY system of care, making it more responsive to young people’s needs, resulting in the improvement of these larger system outcomes. It also directly impacts the lives of system-impacted youth at-risk of, or

struggling with, mental health challenges through the development of resilience and self-efficacy via leadership development.

It is the result of this advocacy program that needed systems and services, such as the creation of the aforementioned TAY Division in 2012, have come to fruition. This advocacy has also contributed to the passage of legislation and state policy, including updates to the Foster Care Bill of Rights, Foster Care Psychotropic Medication Management Bills, creation of the MHSA Youth Innovation Project, the California Department of Social Services' implementation of the Child and Adolescent Needs and Strengths (CANS) tool, shifts to the language of the Behavioral Health Services Act from Prevention and Early Intervention to only Early Intervention, and greater consideration of youth in extended foster care in the child welfare rate reform process. These policies have all significantly contributed to the statewide transition-age youth system of care's ability to best serve youth.

Large-scale impacts of system change at local, state, or national levels, particularly policy advocacy, are difficult to measure as they are collaborative and span multiple years without the possibility of before or after impact evaluations that measure efficacy and attitudinal change of a large, disparate populace. However, measurable data can be obtained from program operationalization through public awareness events directed at youth and community members; trainings provided to staff and community partners on effectively engaging youth and developing youth-informed approaches; and leadership development opportunities provided to youth participants.

Key Activities

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

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

1. Trainings take a cultural competence and/or cultural humility approach. Each training is uniquely developed within the context of youth-adult partnership, with young people taking the lead of developing curriculum with staff support. Training focuses on youth culture and the ways in which systems impact youth wellness, as well as developing specific knowledge, skills, and attitudes of participants. Events focus on concepts of behavioral health stigma reduction, outreach and information regarding behavioral health services, and wellness resilience development. These events occur in multiple formats, all of which are youth driven.

    a. Trainings for professionals and community members focus on TAY-specific mental health challenges, other challenges/barriers/and strengths with this

population, and the engagement of this population. This includes special populations particularly impacted by stigma and discrimination such as LGBTQIA+ and two-spirit youth, Indigenous Youth, foster youth, juvenile justice youth, homeless youth, and youth experiencing substance-use related issues.

2. Advocacy is operationalized through two means; *systems change* and *individual advocacy*.

    a. *Systems change* is enacted through youth organizers supporting the YAB to attend and participate in policy setting, decision making tables, and correspondence. This includes participation at local, state, and national policy tables and related coalitions or collaboratives, letters of support/opposition, and direct communication with policy makers/legislators.

    b. *Individual advocacy* occurs when HCTAYC Youth Organizers and/or Peer Coaches support young people in self-advocacy during their own care coordination. This is also done through participating in advocacy to amplify the youth's wishes, assisting youth in preparing speaking points for their case planning meetings, and attending said meetings to support the youth's desired outcome.

3. Youth Leadership Development is perhaps the most transformative element of the HCTAYC program, consciously targeting the three base psychological needs identified in self-determination theory: autonomy, competence, and relatedness. These three components aid to prevent the emergence of behavioral health conditions or reduce prolonged suffering and progression.

    a. This development is the transference of skills to, and the continual support and supervision of, YAB members. By creating a system of tiered levels of leadership, board members are given the opportunity to experience, develop, and practice leadership skills in a gradual progression of intensity, while emphasizing increased peer engagement and relationship building.

    b. Participants receive periodic training on different elements of leadership and topical education on advocacy topics. Higher-level leaders go through a multi-week orientation process and attend a three-day retreat.

    c. The format of the YAB, with multiple affinity-based committees, allows members to develop *relatedness* with peers with similar lived experiences, while also receiving consistent support and guidance from HCTAYC youth organizers.

    d. Youth exercise *autonomy* through identifying program priorities, modifying program function, and by driving content creation.

    e. Youth exercise *competence* via the provision of trainings, engaging in advocacy, and successfully planning events. As board members plan their

transition from active membership, they put together an accumulative leadership portfolio demonstrating their strengths and successes as youth leaders.

f. Additionally, extensive studies have demonstrated that youth leadership programming increases self-efficacy[2] - which is an important indicator for the reduction of harmful actions such as self-harm and suicide[3].

During fiscal year 2023-2024, there were 295 unduplicated clients served by the program. Based on last year's Revenue and Expense Report (RER), which outlines a total cost of $428,419.44 in MHSA funds, the average cost per client is estimated at $1,452,.27.

Expected Outcomes for Fiscal Year 2025-2026 (FY 25-26):

- Gather comprehensive outcomes data to report on leadership development as well as outcomes related to the specific PEI domains for Youth Leadership Development.

- The YAB will plan and facilitate activities for May is Mental Health Awareness Month when possible.

- Young people 16-26 with lived experience in the foster care, juvenile justice, behavioral health, and homelessness services systems will be empowered to share their voice in meaningful ways to drive systems change.

- Attempt to facilitate at least two (2) youth-leadership development trainings for HCTAYC members and the general transition-age youth community.

- Identification of new local policy priority and/or re-evaluation of implementation of previous rounds of policy recommendations.

- Attempt to facilitate at least two (2) positive-youth development, stigma-discrimination reduction, or youth engagement trainings for youth-serving professionals.

- Participate in advocacy and policy setting tables at the local, state, and national level as able and relevant to youth issues and needs.

- One (1) creative leadership retreat or intensive workshop per year, as able.

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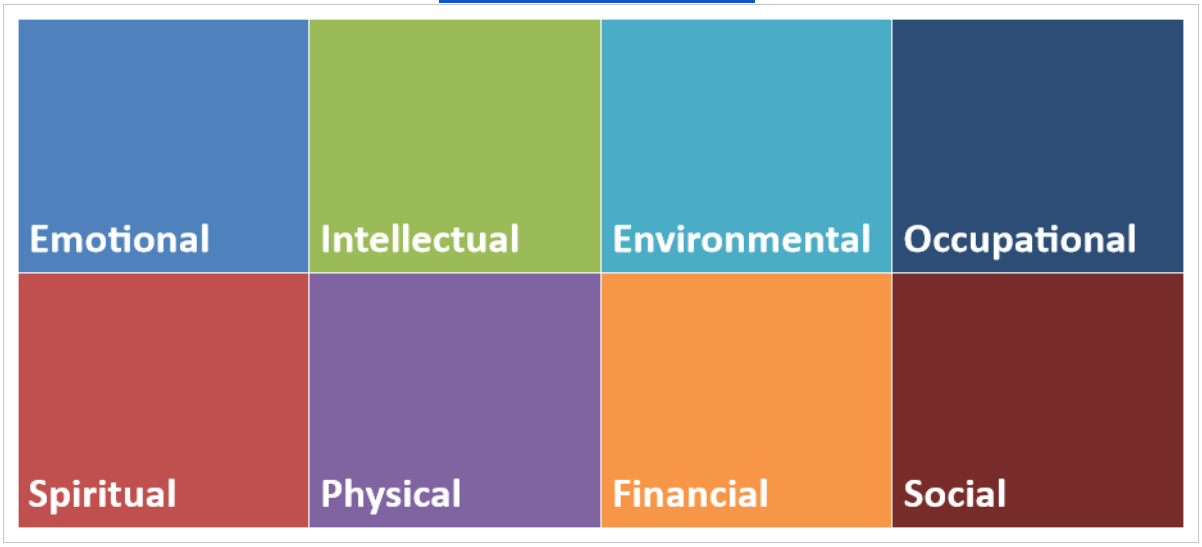
[2] Perreault, D., Cohen, L.R. & Blanchard, C.M. (2016). Fostering transformational leadership among young adults: a basic psychological needs approach. *International Journal of Adolescence and Youth*, *21*(3), 341-355. DOI: 10.1080/02673843.2015.1083451

[3] Han, J., Wong, I., Christensen, H., et al. (2022). Resilience to suicidal behavior in young adults: a cross-sectional study. *Scientific Reports, 12*, 11419. https://doi.org/10.1038/s41598-022-15468-0

- Maintenance of homeless youth action committee and youth participation in Homeless and Housing Continuum of Care (CoC).

- Comprehensive wellness programming focusing on the eight (8) domains of wellness identified by SAMHSA.



How Outcomes are Measured

Outcomes are measured in multiple ways, depending upon the element of the program.

Youth leadership development and wellness skills data are collected through individual leadership plans, a Leadership Skills Self-Assessment, and the Wellness Empowerment & Successful Transitions (WEST) Survey– a strengths-based, youth-adult partnership-developed questionnaire created by HCTAYC to meet the outcomes domains of the PEI funding source.

The WEST Survey examines socio-emotional development factors along the 8 dimensions of wellness identified by SAMHSA. It utilizes self-reporting data to assess, over time, the impact of programming on protective factors as well as PEI outcome domains such as suicidality, hospitalizations, education, contact with law enforcement, social relationships, and holistic health and wellbeing. The program, as per the writing of this report, is pausing utilization of the WEST Survey temporarily to revise the tool to better measure the impacts of programs utilizing youth input and trends identified in the current data set.

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

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

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

The program plans to provide outreach via tabling at various events which will include educational and informational resources regarding services and supports available to transition-age youth, advocacy, and information regarding the recognition of early signs of mental illness and social determinants that contribute to such.

Estimated Number to be reached in 2025-2026 (FY 25-26)

The program is estimated to maintain or exceed 10-15 consistent Youth Advocacy Board members when possible.

May is Mental Health Matters Programming is estimated to reach 10-15 youth participants in a workshop setting.

At least two leadership development trainings to youth in Humboldt County are estimated to be provided to a total of 20-30 young people. At least two youth-driven trainings to professionals will occur, with participation at each training ranging from 12-35 participants.

It is expected that advocacy at local, statewide, and national policy setting tables will reach at minimum the participants of those policy setting tables. Membership of tables range from 7 - 30 participants each, with multiple meetings per month.

It is estimated that there will be engagement of 4 to 8 youth in a creative leadership retreat or intensive workshop per year, when feasible.

It is estimated that at least two young people will be supported to participate in Homeless and Housing Continuum of Care (CoC) executive activities, and approximately 5-10 others will be engaged to support/inform that participation.

There are plans to table at two (2) events, reaching approximately 40-75 individuals.

Wellness programming is expected to reach approximately 20-30 young people.

TAY Peer Support—Peer Coaching Program

The integration of Peer Coaches within the TAY Division is a peer support prevention program with components of early intervention, access and linkage to treatment, stigma and discrimination reduction, and outreach for increasing recognition of early signs of mental illness. The TAY Peer Coaching program consists of a shared Supervising Mental Health Clinician and five (5)[4] full-time Peer Coaches. Peer Coaches are an integral part of

[4] One (1) peer coach position is currently frozen and unable to be recruited and filled, leaving the program with four (4) full-time positions.

the multidisciplinary team at the TAY Division, and support each of the Division's programs (HCTAYC, Behavioral Health, Independent Living Skills, and the TAY Center).

Peer Coaches operate from the lens of empowerment and recovery and integrate into the division in four main ways: 1. relationship building and mentoring, 2. outreach and engagement, 3. linkage to resources, and 4. activity coordination.

1. *Relationship building and mentoring* is done by Peer Coaches using their personal lived experiences to connect with young people ages 16-26 and focuses on mentoring, instilling hope, empowering, and helping young people build self-esteem, and assisting in system navigation and self-advocacy. Peer Coaches have the capacity to engage with young people through shared lived experiences. Peer Coaches:

    a. Believe young people can grow in the same ways they have been able to, making them unique in their ability to relate, provide support, and model self-advocacy, recovery, and self-care skills.

    b. Build relationships with young people in ways that create validation, inspire hope, and support program participants through empowerment and trust.

    c. Build mutuality in their relationships with young people, creating a relationship built on respect, compassion, and reciprocity. Through this

unique relationship, young people can build self-determination, self-esteem, and gain skills necessary for transition into adulthood.

d. Approach this work from a youth-adult partnership model that allows young people to drive the services and support the goals they need. Relationship building is done by providing individual meetings both at the TAY Center and in the community, utilizing shared experiences, in-vivo role modeling, teaching, and exploring the strengths and needs of the young person from the Transition to Independence Process (TIP) model.

e. Can assist young people in building their relational capacity by supporting them when accessing social, vocational, or educational opportunities.

2. *Outreach and engagement* opportunities are provided to young people by linkage to services and to the community. This aids in informing them of services available to transition-age youth and supports the reduction of stigma and discrimination toward the systems-involved transition-age population. Outreach is provided in multiple ways including referrals for services, the TAY Center, community-wide in-services, presentations, and tabling events in the community.

   Peer Coaches:

   a. Provide outreach to the psychiatric hospital, jail, juvenile hall, schools, family resource centers, tribal organizations, and team with other community partners for tabling and street outreach to youth experiencing homelessness. Overall, peer coaching contributes to participant engagement with care, increased effectiveness of services, reduced barriers to services and supports, improved outcomes, reduced hospitalization or incarceration, and increased support for educational and vocational success. .
   b. Are the primary staff that oversee the TAY Center and drop-in hours.

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

   Peer Coaches:

   a. Assist young people in navigating systems, help with referrals to services and support them in appointments, activities, and supporting documents.

   b. Often serve as a bridge between the young person and services, providing warm hand offs from psychiatric hospitalizations, incarceration, or walk-ins to service providers, activities, or other resources.

4. *Activity coordination* is done to provide young people skill development opportunities, wellness and self-care, and community building skills for young people.

   Peer Coaches:

   a. Collaborate on and mostly lead many TAY Division workshops and events, often in response to youth requests and identified needs.

   b. Activity coordination varies from regular oversight of the TAY Center drop-in hours, where young people can access service providers, computers, linkage with CalFresh and food resources, clothing closet and hygiene supplies, to facilitating workshops on self-care, healthy relationships, wellness, and life skills.

Key Activities

- Mentorship
- Outreach and engagement to youth, local agencies, and organizations, providing in-services about TAY programs.
- Tabling events.
- Linkage and system navigation to resources/services.
- Facilitate peer lead group activities.
- Coordinate and facilitate workshop and events.
- Attend trainings to increase skill development.
- Gather comprehensive outcomes data for peer coaching through sign-in sheets, demographics, assignment tracking sheet and WEST Survey.
- Participate in community advocacy settings, including the homelessness reduction collaborative Support HCTAYC in wellness programming activities.
- Support HCTAYC in wellness programming activities.

The expected outcomes for 2025-2026 (FY 25-26) are:

- Staff the TAY Center drop-in hours.
- Provide individual mentorship to assigned caseloads from the referral process.
- Ensure cross-training of Peer Coaches in each area of the TAY Division (ILS, BH, HCTAYC).

  Bill Medi-Cal through direct service to eligible TAY youth, utilizing an electronic health record system.

- Provide outreach and information to needed populations by providing presentations, tabling, street outreach, and collaborating with other youth-serving agencies.
- Facilitate and engage youth in wellness & resiliency-building activities.
- Build supportive relationships while youth are waiting to receive or to be connected to other needed services.
- Support youth with system navigation and advocacy needs.

How Outcomes are Measured

- Access to the TAY Center, drop-in hours and selected events and workshops are measured by sign-in sheets.
- Tracking referrals for individual Peer Coach mentorship, including management of caseloads, date referral is received, assigned and when first contact is made.
- Tracking of contacts and linkages with other programs, such as BH, ETD and ILS
- Data collection through voluntary demographic forms collected during peer led groups, workshops, or events.
- Perceived program effectiveness, wellness, and experience in systems will continue to be collected via the WEST Survey.

Estimated Number to be reached in 2025-2026 (FY 25-26):

It is estimated that approximately 300 TAY will be served in FY 25-26 based on the previous year's sign-in sheets for the TAY Center and activities, events, and workshops.

It is anticipated that Peer Coaching will receive approximately 95 referrals. It is anticipated that each Peer Coach would carry a caseload of approximately 8-16 young people.

Peer Coaches represent the TAY Division in the community, and it is estimated that they will provide a minimum of three community presentations/in-services during the next reporting period, as well as table a minimum of three events reaching approximately 40-90 individuals.

Peer Coaches will coordinate and facilitate a minimum of seven (7) workshops or events as well as support other TAY Division activities and community events.

TAY Advocacy and Peer Support Stigma and Discrimination Reduction

The TAY Advocacy and Peer Support programs' stigma and discrimination reduction activities are intended to influence program participants as well as professionals and community members who participate in trainings and events facilitated by the program.

Activities include trainings for professionals and community members focused on TAY-specific mental health challenges and the engagement of this population, including special populations particularly impacted by stigma and discrimination such as LGBTQIA+ two-spirit youth, Indigenous Youth, foster youth, and youth experiencing substance misuse and abuse. Trainings take a cultural competence and/or cultural humility approach, with specific youth-developed curriculum that focuses on youth culture.

The program's facilitation of events focuses on concepts of behavioral health stigma reduction, outreach and information regarding behavioral health services, and wellness resilience development. The program's focus on youth leadership development addresses stigma and discrimination reduction through advocacy and empowering youth to become leaders. Peer Coaching provides outreach, engagement, and linkage to services and to the community. This serves to inform youth of services available to them and supports the reduction of stigma and discrimination toward the systems-involved transition-age population.

Outreach is provided in multiple ways including referrals for services, the TAY Center, community-wide presentations, and tabling events. Peer Coaches provide regular outreach to the psychiatric hospital, jail, juvenile hall, schools, family resource centers, tribal organizations, and team with other community partners for street outreach to youth experiencing homelessness.

HCTAYC created a Stigma Discrimination Reduction (SDR) survey for participants in MHSA supported activities, mostly young people. Integrated into YAB, community-based trainings, and Peer Coach supported events, the survey helps gauge learning and attitudes about stigma. The survey is administered post-workshop or activity along with the demographic form. It includes questions about effectiveness of the activity and its contribution to wellness and general perceptions of stigma.

Integrated Reporting of HCTAYC and Peer Coaching programs FY 23-24

Many young people participate in both Peer Coaching and HCTAYC programs over time and through the course of their personal development. To minimize survey and evaluation fatigue, many of the data collection points have been integrated into voluntary survey tools that are designed to support both programs. The three tools administered in both programs are:

- WEST Survey
- Demographics Survey
- SDR Survey

While the development of these surveys resulted from youth-driven processes under the umbrella of HCTAYC, all of them were offered to participants in both programs. The latter two were administered during events and activities sponsored by HCTAYC, Peer Coaching, or both programs.

Wellness, Empowerment, and Successful Transitions (WEST) Survey Analysis

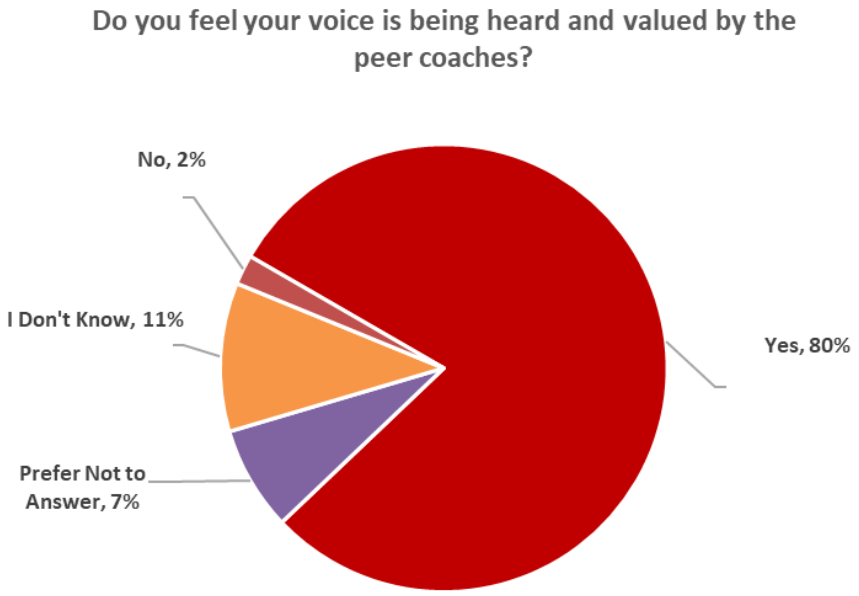
The WEST Survey was launched in January 2022 after a 3-year long, youth-guided development process. It included 55 questions organized into 3 sections: Perception of skills and motivation across SAMHSA's eight wellness domains, perceived helpfulness of programs, and lived experience in systems. Young People (YP) who participated in HCTAYC or Peer Coaching programs were prompted to voluntarily complete the survey 3 times a year and were provided consumable incentives for doing so.

The goal of using this survey is to gain insight into how HCTAYC programs might be perceived by the young people HCTAYC serves. Questions have been carefully crafted with youth guidance and response at every step to mitigate triggers of trauma from revisiting lived experience in systems that may have previously caused harm. There are no required questions other than to provide an email address. The email address acts as an identifier for baseline and subsequent response comparisons.

One hundred twenty-five (125) WEST Surveys have been completed since its inception in January 2022. Of those, 26 responders completed more than 1 survey allowing for comparative analysis. However, this data set is still too small to draw any clinical conclusions. Instead, comparisons can be used to help program and YPs see how perceptions have trended over time.

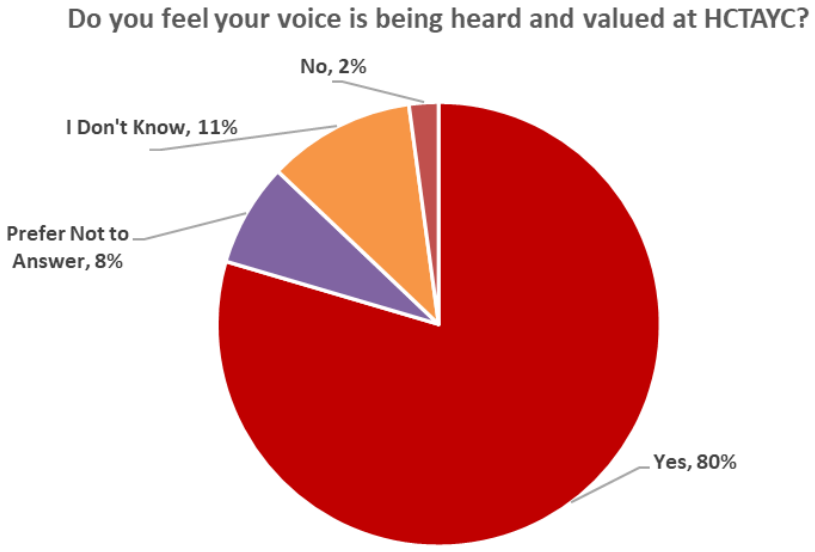
Reponses	Total
Single Entry	35
Baseline (1st individual response)	**26**
Incremental (Responses dated between Baseline and Last)	38
Last (Most recent individual response)	**26**
Grand Total	**125**

There were 38 unique responders who participated in HCTAYC and 40 in Peer Coaching programs. Twenty-seven (27) of these YPs participated in both programs.



Analysis of wellness based on SAMHSA's 8 domains can be conducted under separate cover due to the extensive amount of both quantitative and qualitative data collected. However, information can be accessed at any time to assist in planning wellness activities and events. Wellness data is also available automatically on an individual basis for responders who opt in enabling goal tracking and planning with or without TAY staff support.

The most salient request by young people was to include a question that captured whether they felt listened to. Results showed that most respondents did in both programs. Yet, indifferent answers such as "I Don't Know," "Prefer Not to Answer," or skipping the question might be better indicators of not being heard in addition to selecting "No."



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

HCTAYC and Peer Coaching programs embrace health and wellness as a fundamental objective when engaging and supporting young people. HCTAYC services are tailored to help young people develop both skills and motivation in defining and achieving their own individual wellness goals. The WEST Survey helps track how young people perceive interest or progress in their wellness goals over time.

For the current analysis we wanted to get a basic understanding of where program participants are. Future analysis might include comparisons between baseline and subsequent responses as well as more detailed insights across the 8 wellness domains.

Seventy-seven percent (77%) of survey respondents perceive that the programs help them decide to improve their wellness goals. In addition to 4% answering “No”, 12% answered as “I Don’t Know” and 6% “Prefer Not to Answer,” which may indicate opportunity for program staff to better engage with the participants on where they are in their wellness development. Additionally, when asked if Peer Coaching helped with deciding and/or improving wellness goals in the past 4 months, 73% said yes, 5% preferred not to answer, 21% were unsure, and 1% said “no.”

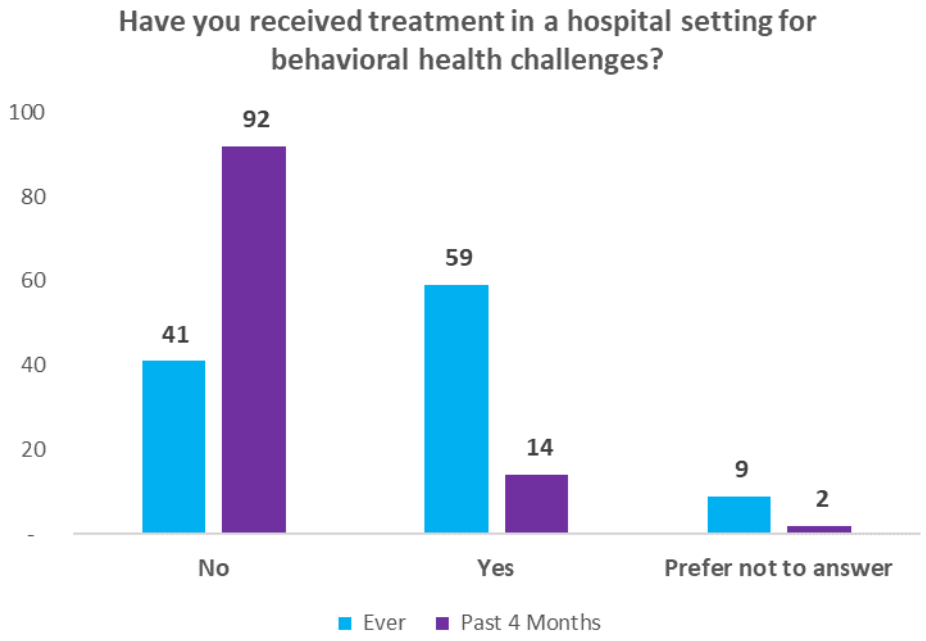
Experience in systems is a consistent evaluation criterion used by the systems themselves. It is known that young people with access and functional needs or members of marginalized communities have more experience with systems of child welfare and foster care, behavioral health, law enforcement, juvenile justice, and homelessness. It is known that within systems, young people are asked to repeat their experiences at a variety of assessment and intake points or interfacing with the hundreds of system personnel they might encounter. It is known that these experience inquiries can create more harm and trauma for the young people. It is important to understand how experience in systems can impact the future of young people or where systems can improve to cause less harm. Data collection can shine light on these impacts or improvements. However, data must be collected in a manner that does not cause additional harm to the young person.

The young people who developed and reviewed the survey helped to create these questions for systems about systems experience. A qualifying question also enabled young people taking the WEST Survey to opt out of questions related to lived experience.

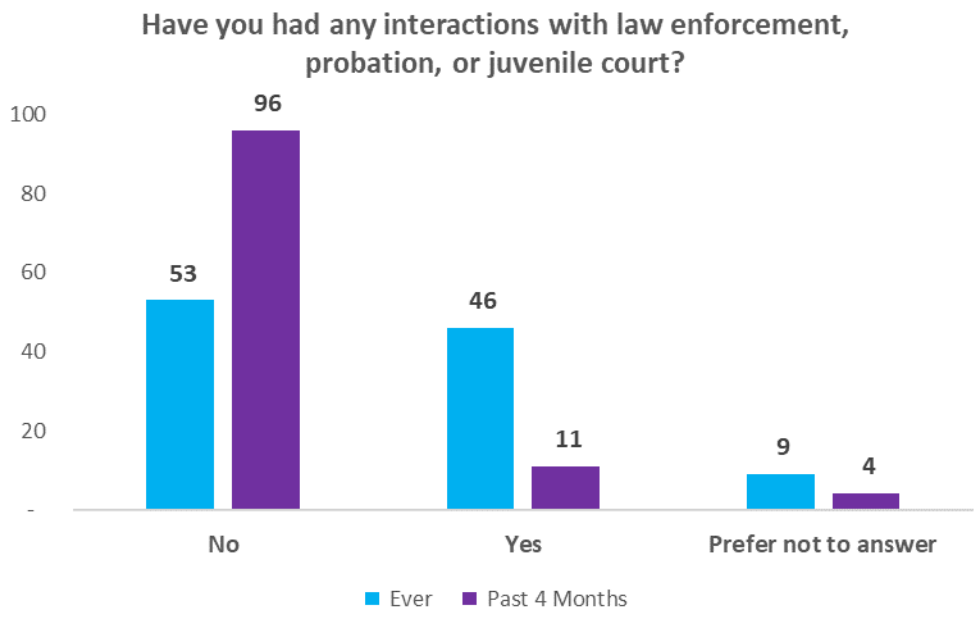
While there is a low volume of responses, it's hard to not be pleased with the results. It appears that HCTAYC and Peer Coaching are supporting young people in positive ways, and there is hope that over time more survey responses will indeed continue to reflect this optimism. If not, they will give input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

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

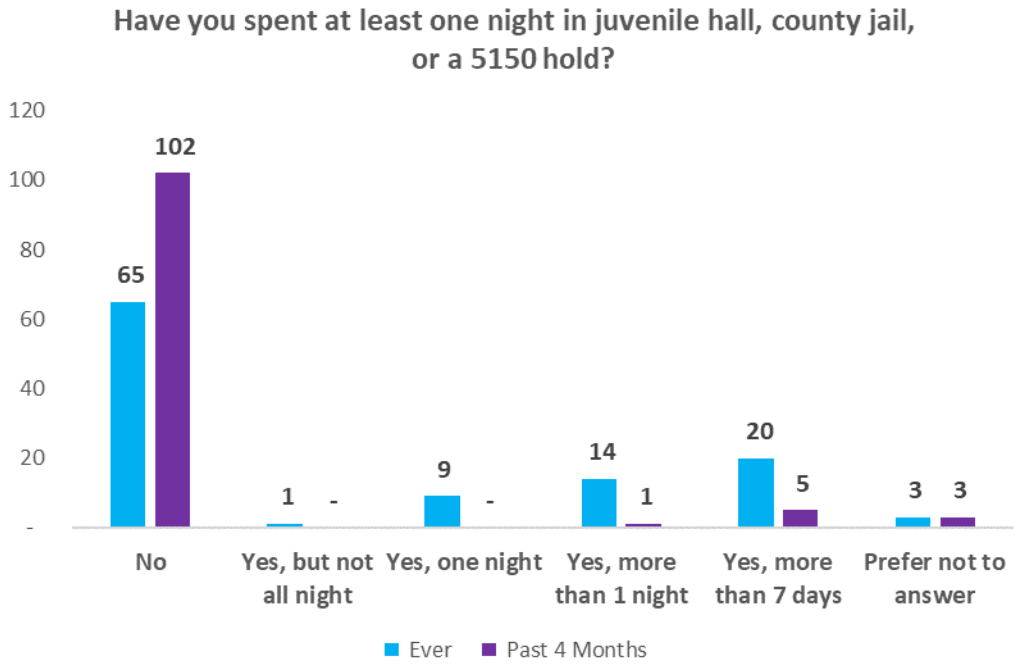
The percentage of change decreased 76% when responding "Yes" to the question of having ever received treatment in a hospital setting for behavioral health challenges to having received it in the past 4 months.



Of the respondents that answered and selected "No," there was an 81% increase in the percentage of change between having ever had interactions with law enforcement, probation, or juvenile court to not having any interactions in the past 4 months. The percentage of change for responding "Yes" decreased 76% from ever having experience to having experience in the past 4 months.

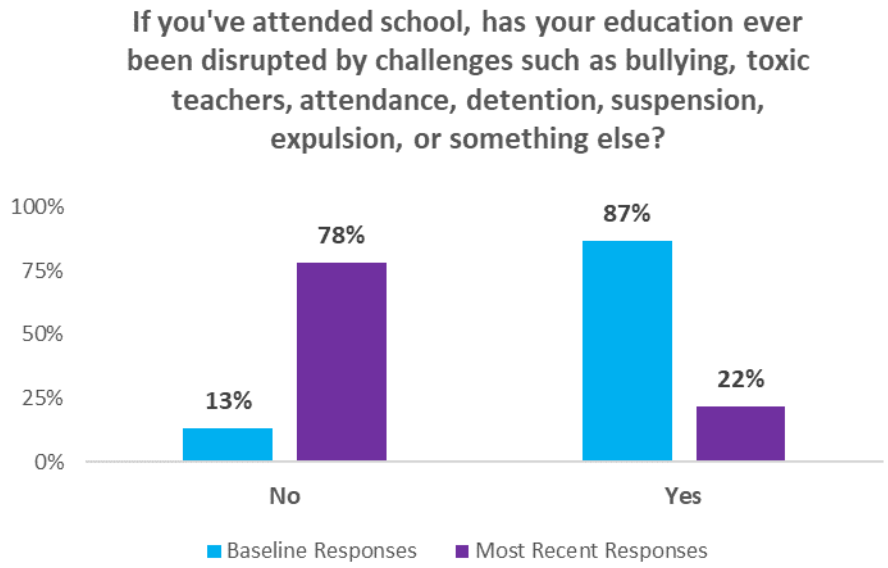


Percentage of change trended in similar ways, increasing 57% when responding “No” and decreasing 86.0% when responding “Yes” to ever having spent at least one night in juvenile hall, county jail or on a 5150 hold to having done the same in the past 4 months.

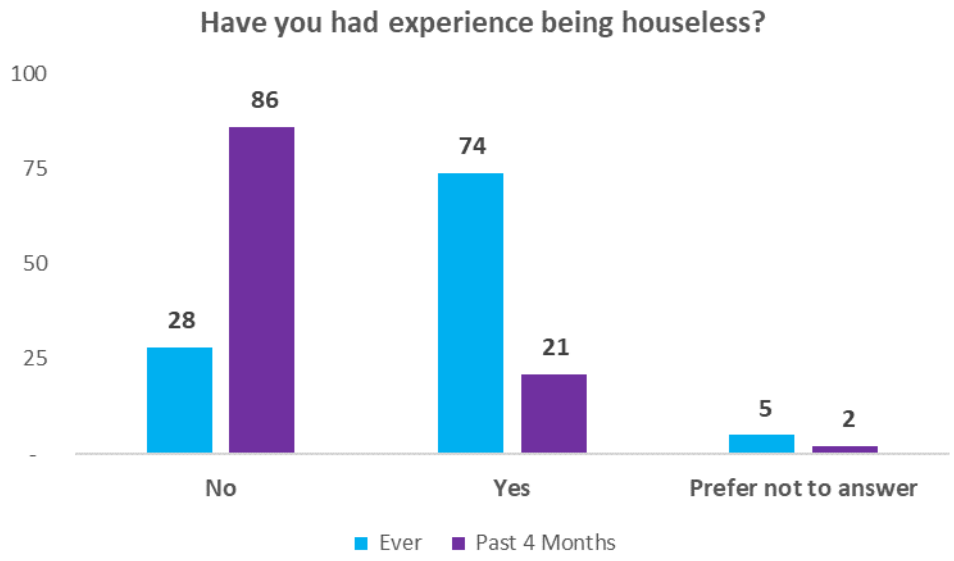


Drop-out and expulsion rates are popular evaluation criteria for young people with lived experience in systems. However, there are many reasons why a young person might have challenges in the current educational system, and additional system experience exacerbates educational challenges. Regardless of the cause, leaving school is disruptive

to the young person and can carry stigma and occupational discrimination with it. Most of the young people HCTAYC serves (89% of responses) have experienced disruptions in their education. Understanding how educational disruption is so prolific and impactful to program participants can help programs plan and offer workshops, individual supports/skills trainings, and advocacy opportunities to help build resilience and reduce stigma.

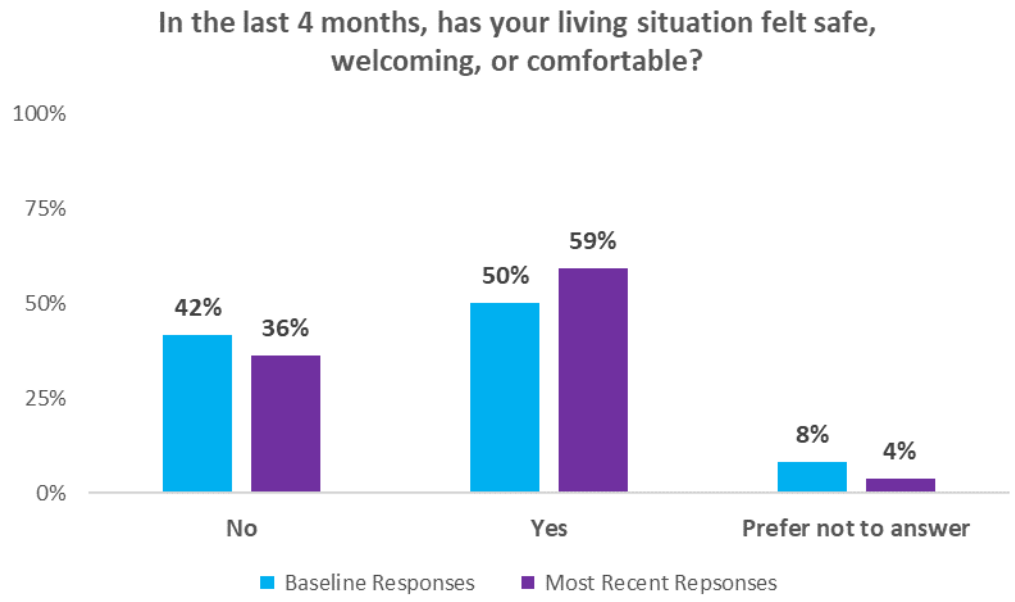


Homelessness is a complex challenge that is pervasive throughout Humboldt County. Seventy-four (74%) of WEST Survey responders have experienced it at some time in their past.



Youth in HCTAYC programs prefer to use the term houseless instead of homeless. They comment that a sense of home can come from within or being part of a larger community

regardless of housing status. Home is where the heart is, so to speak, from the perspective of the young people who participate in HCTAYC and Peer Coach programs. It's possibly an adaptive perception considering the prevalence of houselessness experienced by program participants. Even when housed, however, living situations can still feel precariously fragile, lacking senses of safety, being welcome, or comfort.

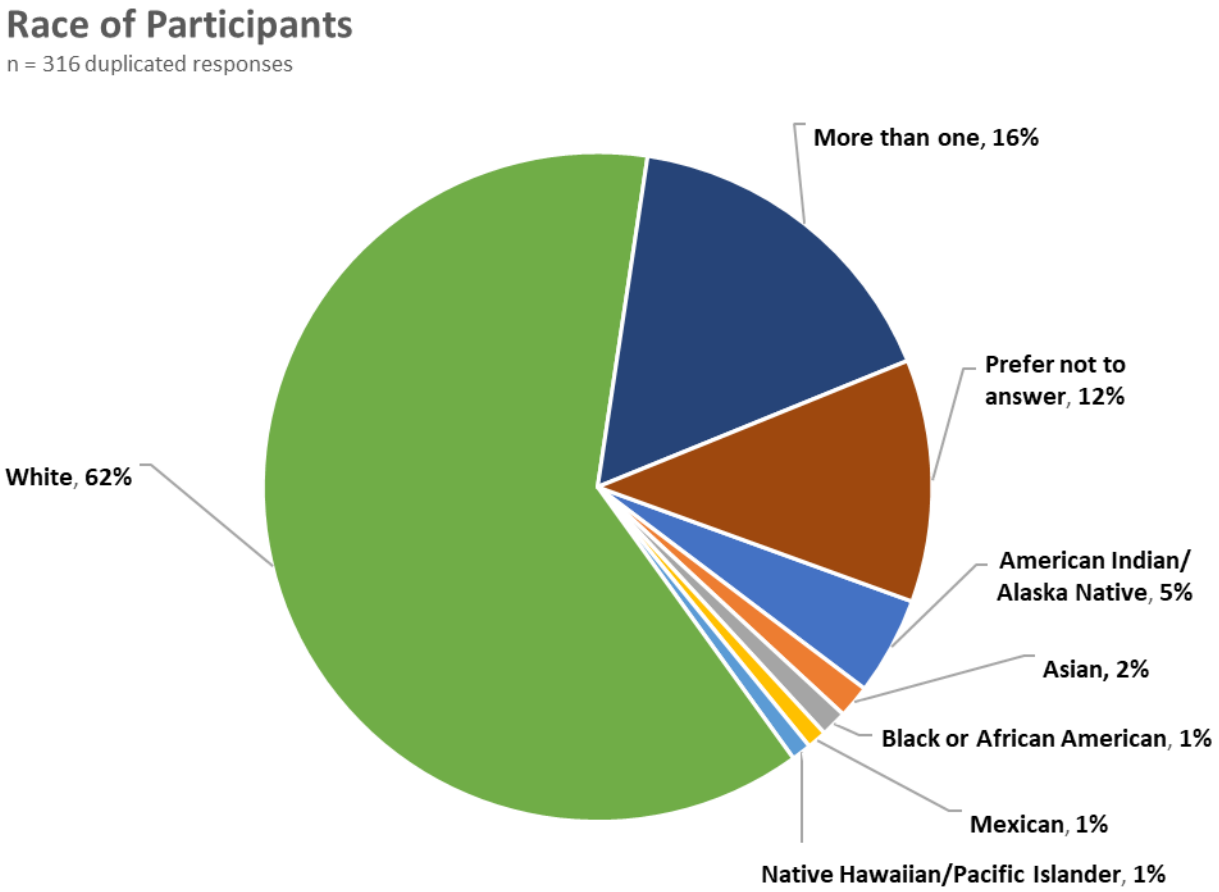


In the chart above, people were asked if their living situation felt safe, welcoming, and comfortable. At first, 42% of respondents said "No" but when asked again after 4 months, 36% of respondents said "No." Initially, 50% of respondents said "Yes", with such occurrences increasing to 59% after 4 months. For initial responses, two respondents selected "prefer not to answer." One respondent preferred not to answer the question when asked again 4 months later.

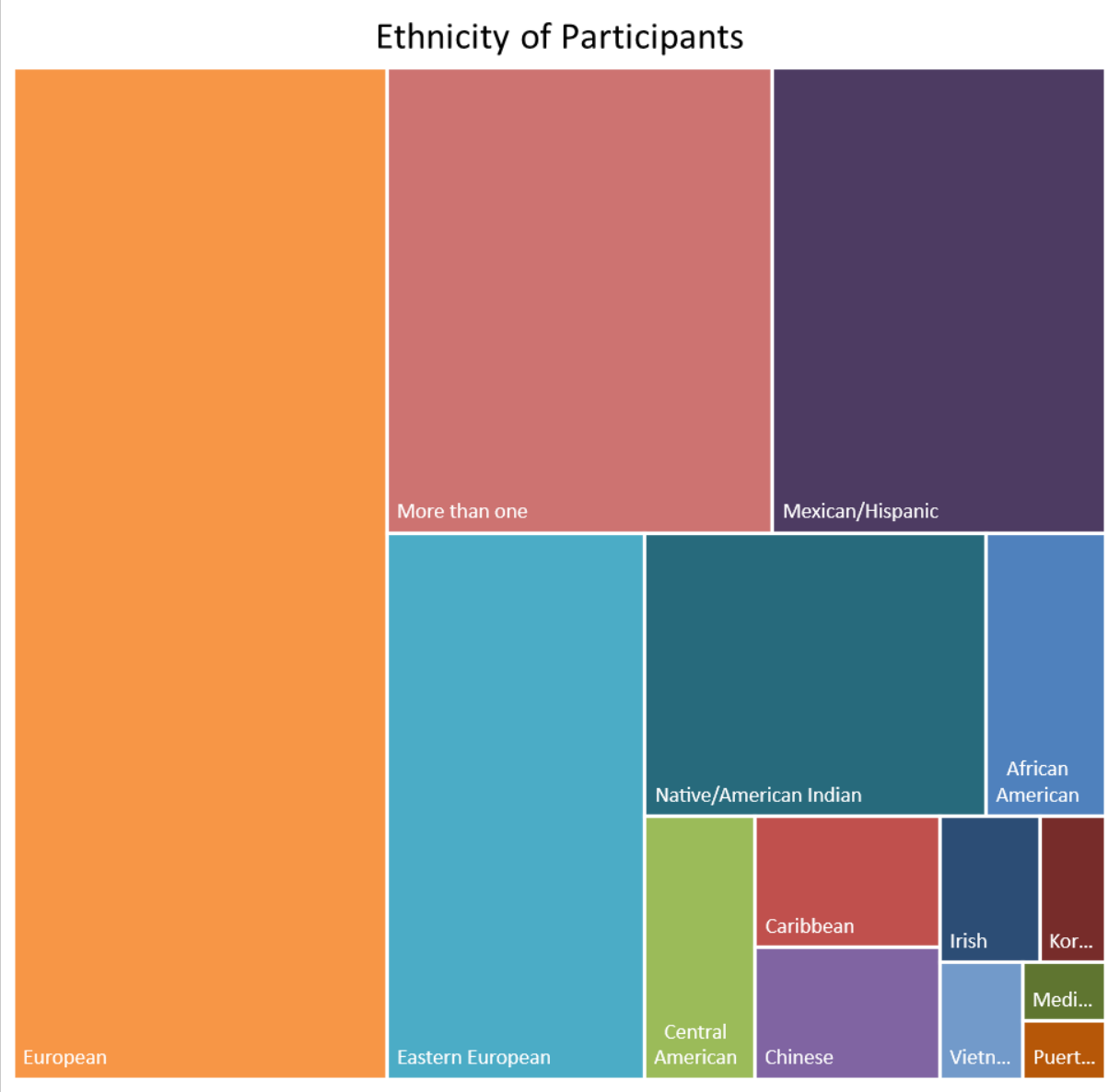
Demographics Survey Analysis

The following charts provide information obtained from 316 demographic survey forms completed by individuals participating in 39 MHSA-funded events or trainings during July 1, 2023, to June 30, 2024. These are duplicated responses as one person could have completed more than one survey having attended multiple events.

Sixty-two percent (62%) of the people who responded to the demographics survey selected White. Two percent (2%) selected Asian. Five percent (5%) selected American Indian /Alaska Native, representing local tribes including Yurok, Wailaki/Mattole, and Cherokee, and some who selected "American Indian/Alaska Native" but did not list their tribal affiliation. One percent (1%) selected Black/African American. One percent (1%) selected Native Hawaiian or other Pacific Islander. One percent (1%) wrote in Mexican under other, and 12% preferred not to answer. Of the 316 survey responses, 16% selected more than one race.

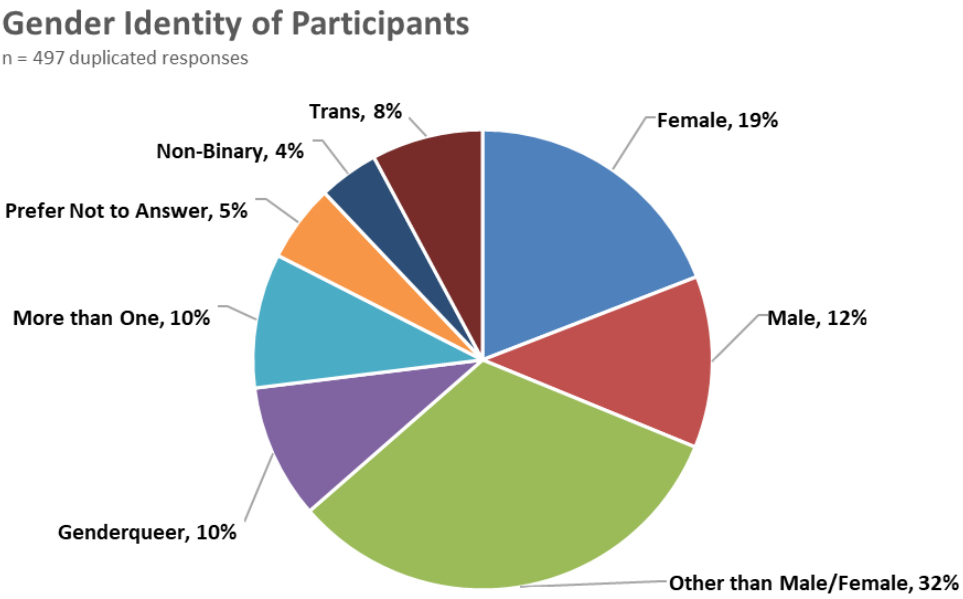


As seen in the chart below, of the 316 survey respondents, 12% selected more than one ethnicity. Twenty-eight percent (28%) of respondents did not provide their ethnicity. European was the most frequently (25%) selected category. Ten percent were Mexican, Hispanic, Chicano, 9% Eastern European, 6% Native/American Indian, 2% African American, 2% Caribbean, 2% Central American, 2% Chinese, 1% Irish, 1% Korean, 1% Vietnamese, less than 1% were Mediterranean and Puerto Rican.



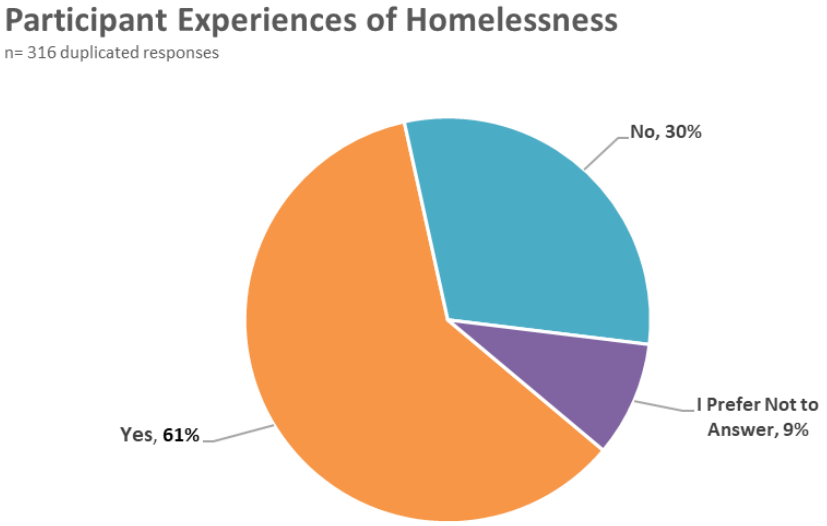
The primary language of participants was roughly 96% English. Three percent (3%) of remaining responses preferred not to answer and one percent (1%) reported being bilingual.

Fifty-nine percent (59%) of the survey participants were within 19-25 years old and 21% within 16-18 years old. However, HCTAYC youth engaged people of all ages in trainings, presentations, community coalitions, and policy recommendation outreach efforts.

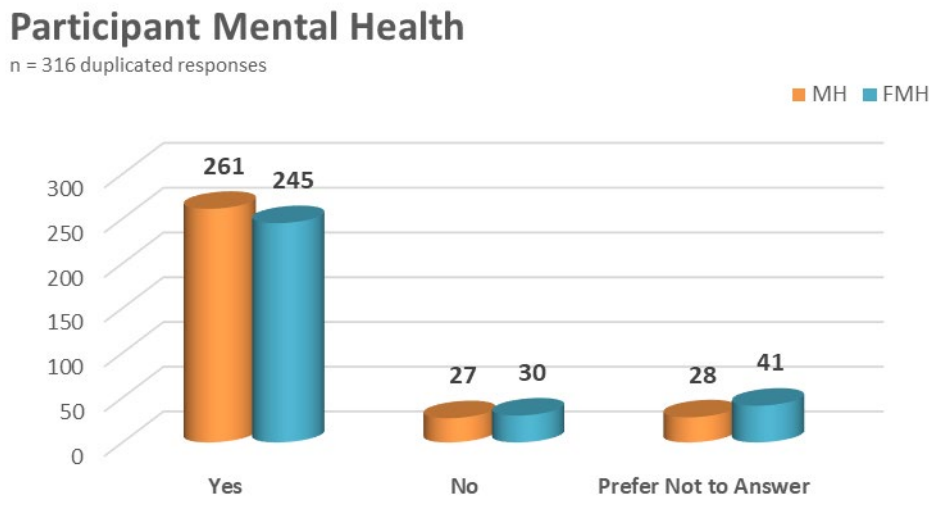


While 56% of the survey respondents had an assigned birth sex of female, 19% identified female as their gender identity. Twenty-three (23%) percent of the survey respondents had an assigned birth sex of male, 12% identified male as their gender identity. Thirty-two percent (32%) identified as other than female or male and genderqueer and more than one were recorded at 10% each. Regarding gender identity, more than one identifier was allowable per response. Because of this, 497 data points were collected pertaining to gender identity from 316 respondents.

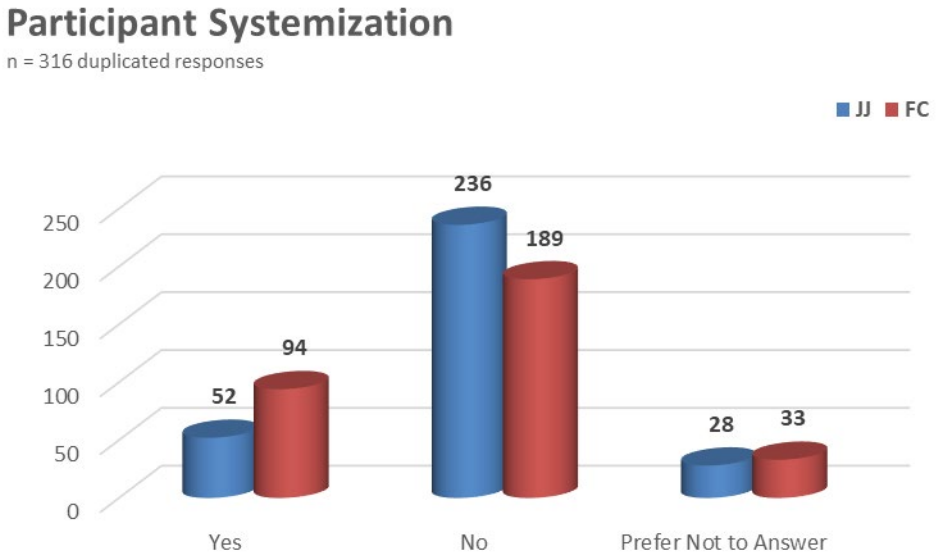
Sixty-one percent (61%) of survey respondents had experience with homelessness, 30% did not, and 9% preferred not to answer.



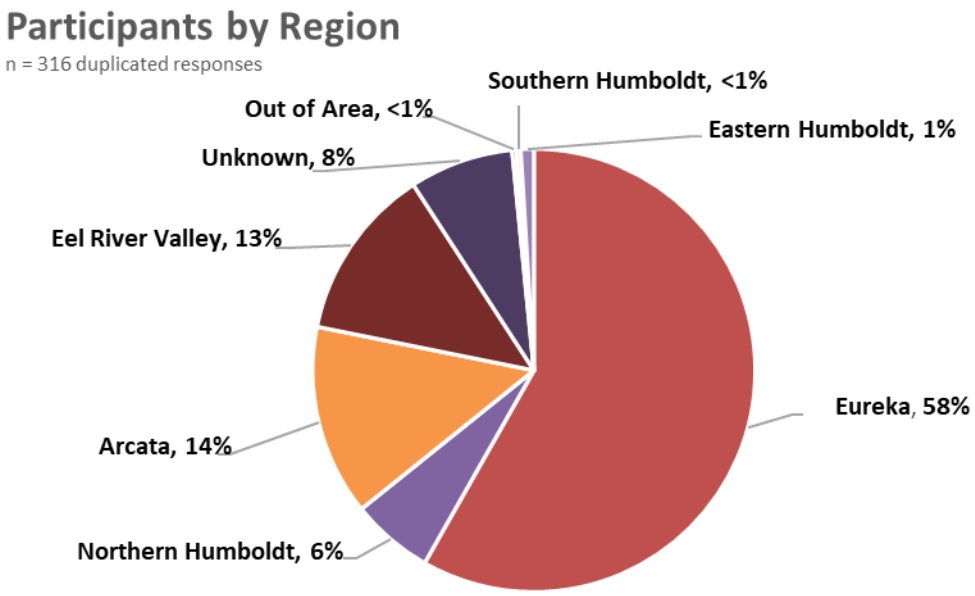
Two hundred sixty-one (261) survey participants stated they have experienced a personal mental health (MH) condition. Of those, 92% had received a diagnosis. Twenty-seven (27) participants stated they have not experienced a personal mental health condition, while 28 preferred not to answer. Two hundred forty-five (245) stated they have a family member with a mental health (FMH) condition, 30 stated they did not, and 41 preferred not to answer. Two hundred twelve (67%) stated the family member's mental health condition had been diagnosed.



Fifty-two (52) participants reported involvement in the juvenile justice (JJ) system, 236 did not have this involvement, and 28 preferred not to answer. Ninety-four (94) participants reported involvement in foster care and/or the child welfare (FC) systems, 189 did not have this involvement, 33 preferred not to answer.



A little over half (58%) of survey respondents resided in the Eureka area, followed by Arcata (14%), Fortuna (8%), and McKinleyville (6%). Other respondents reported residing in Rio Dell, Willow Creek, Ferndale, Blue Lake, Alderpoint, and Loleta. The small percentage of remaining respondents reported living either outside of Humboldt County (i.e., Crescent City), or out of state.



Stigma Discrimination Reduction (SDR) Survey Analysis

The SDR Survey is provided electronically at most HCTAYC sponsored events, and some Peer Coach sponsored events either electronically or on paper. In FY 23-24, the survey was offered to participants at 15 different events. A total of 136 surveys were collected and results are not unduplicated. For example, one youth may complete a survey at each event they attend during the reporting year.

I believe that for myself and others, wellness in mental health is possible.

Response	FY 20-21	FY 21-22	FY 22-23	FY 23-24
Fully Agree	59%	50%	57%	66%
Agree	38%	29%	20%	22%
Somewhat Agree	3%	8%	10%	6%

Response	FY 20-21	FY 21-22	FY 22-23	FY 23-24
Not sure	0%	10%	10%	6%
Somewhat Disagree	0%	4%	1%	0%
Disagree	0%	0%	1%	0%
Fully Disagree	0%	0%	2%	0%

I understand what stigma and discrimination are.

Response	FY 20-21	FY 21-22	FY 22-23	FY 23-24
Fully Agree	69%	40%	64%	69%
Agree	31%	45%	15%	23%
Somewhat Agree	0%	14%	14%	3%
Not Sure	0%	0%	1%	5%
Somewhat Disagree	0%	0%	0%	0%
Disagree	0%	0%	2%	0%
Fully Disagree	0%	0%	0%	0%

I wish to attend more workshops/events/trainings on Stigma Discrimination Reduction and learn more about it.

Response	FY 20-21	FY 21-22	FY 22-23	FY 23-24
Fully Agree	65%	51%	69%	69%
Agree	28%	24%	18%	22%
Somewhat Agree	7%	15%	4%	5%
Not Sure	0%	7%	6%	3%
Somewhat Disagree	0%	0%	0%	2%
Disagree	0%	1%	1%	0%
Fully Disagree	0%	1%	0%	0%
No Response	0%	1%	1%	0%

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

TAY Advocacy-HCTAYC Report FY 2023-2024
Leadership Self-Assessment Survey

Since 2016, HCTAYC young people have been using a Leadership & Wellness Plan document to formalize and track their goals and have been utilizing a Leadership Self-Assessment Scale to gauge the development of their leadership qualities and skills over time. The result also yielded better reliability through consistent response scales. This survey tool is now used to objectively track leadership development of young people participating in HCTAYC.

The survey consists of 24 required questions measuring leadership attitudes and skills. A 5-point Likert scale is used to collect responses where 5 = “I definitely have this [attitude or skill]” and 1 = “I don’t have this [attitude or skill]”.

Due to a low amount of young people at the Sapling & Sequoia levels of participation, Leadership Self-Assessment data was very limited in FY 23-24. Therefore, no reportable results are available. The program is devising mitigation strategies to prevent this from happening in future reporting periods, once again expanding the LSA to all levels of participation.

Actual Outcomes for FY 2023-2024

Engagement of young people on the youth advocacy board increased greatly during this reporting period, reaching an average of 15 consistently engaged members at various levels of participation from a low of 5 during the first part of the reporting period.
Near the beginning of the period, the Youth Advisory Board (YAB) had relatively low participation and voted to move from a committee-based model to a general meeting model that included all members at once to better focus energy and time. This was done as there was a feeling that such few members could not sustain the momentum needed for committees to be successful with completing their projects. Additionally, the YAB decided to no longer be a chapter of Youth MOVE National due to the high requirement of participation and the requirement of rebranding.

Youth organizers prioritized providing individual support and engagement to youth members, creating a new engagement tracking sheet and prioritizing time during staff meetings to collaborate on how to best support program participants. The intention of this work was to increase the consistency of member participation and bolster their capacity This resulted in over 250 recorded individual meetings by 3 staff across 21 participants lasting an average of 1.5 hours. Of staff, only two members were able to consistently prioritize this tracking, those that met most frequently with the participants. It is estimated an additional 50-75 individual meetings with young people occurred with the other three staff. Topics of these individual sessions ranged from preparing for upcoming meetings and trainings to support around self-advocacy, systems-navigation, crisis, and basic needs.

The board continued with the monthly “Grove Meeting” each month of the reporting period and then there were a total 24 weekly general meetings for a total of 35 convenings of the Youth Advocacy Board averaging 9 members.
This period of meetings accomplished the following:

- Provided feedback to Alianza for Youth Justice’s Positive Youth Justice Initiative structure and training.

- Learned about & strategized around the impact of Proposition 1.
- Created & Visioned Homelessness Continuum of Care Youth Action Committee.
- Reviewed and identified potential model statutes regarding youth homelessness.
- Engaged in MHSA Plan stakeholder process.
- Met with State Senator Mike McGuire.
- Collaborated with Planned Parenthood staff around training and outreach.
- Worked to create an alternate, youth-friendly informational flyer for the Adolescent Treatment Program.
- Discussed issues and barriers to accessing appropriate medication with Medi-Cal.
- Met with representative from Youth MOVE National.
- Learned about the impact of medicalization and origins of mental health field.
- Strategized around Homelessness Point-in-Time Count outreach.
- Visioned and planned around Family First Prevention Services Act Funding.
- Learned about & visioned around Lethal Means Prevention for TAY Center.
- Gave feedback on TAY Center Community Agreement Violation Consequences Process.
- Planned for HCTAYC's 16th Anniversary Celebration.
- Discussed improving engagement and outreach for public health, employment, and Planned Parenthood collaborative workshops/drop-in times.
- Discussed and provided peer support regarding on-campus protests and personal experiences/experiences of other young people.
- Identified needed leadership development trainings.
- Identified effective incentives for outcomes tracking.
- Advised division regarding adding a parent partner position to first-episode psychosis team.
- Visioned the Foster Youth Initiative and future TAY Housing Voucher screening/applicant review process.
- Voted to return to Committee-based Structure starting FY 24/25 due to high participation.

The dissolution of committees saw the creation of a “reading group” that focused on reviewing and tailoring the SMART Recovery manual to be culturally appropriate for the community and age-range. This workgroup of 4-6 young people met six (6) times during this reporting period.

The LGBTQIA+ policy recommendations implementation continued this reporting period. The oversight body is anticipated to formally launch in the next reporting period. This includes a youth-focused event that drew the participation of seventeen (17) 2-S & LGBTQIA+ young people.

Youth leadership development trainings were provided to the YAB and other TAY participants, both consistently and inconsistently engaged. These trainings were: Recruitment Action Plan (RAP) Outreach, Purpose, Outcomes, Process (POP), Specific, Measurable, Attainable, Relevant, Time-Bound (SMART) Event Planning, Leadership & Facilitation Skills, Charting Skills, Curriculum Development, and Power Mapping and Movement Building.

YAB and staff attended several conferences and trainings not facilitated by HCTAYC, including: the National Summit on Youth Homelessness, National Indian Child Welfare Association, California Statewide Indian Child Welfare Association, Financial Wellness, Alternatives to Suicide, Ending Poverty in California, California Mental Health Advocates for Children and Youth, FFPSA Motivational Interviewing, and two trainings by UC Davis Northern Training Academy.

HCTAYC and TAY Behavioral Health provided the Transition to Independence Process (TIP) training series to three QMS staff and four future site-based trainers. HCTAYC provided a Lifting the Blanket: Transforming Substance Dependency & Healing with Young People training to 12 people at the beginning of the reporting period and presented the curriculum at the CMHACY conference to an audience of over 30 individuals.

FY 23-24 saw the return to the original format of our multiple-award winning Wellness Week. The week saw 11 activities spread across five days, touching each of SAMHSA’s eight (8) dimensions of wellness. There was a total of 35 unduplicated youth participants, with each activity averaging 12 participants and lasting an average of 1.5 hours.

Two large-scale events occurred during this reporting period which did much to contribute to the program’s visibility and impact in the community. The first of these events was a screening of the digital stories created during the last reporting period. The event was attended by over 40 participants and included a showing of each story created, with an opportunity for the young person who created it to introduce the story and a panel of some of the youth creators following the screening. The second of these large events was a

celebration of HCTAYC's 16th anniversary. This consisted of three activities, the first of which was a dance and dinner attended by over 20 youth, the second of which was the Power Mapping and Movement Building training covered above, and the third was a community celebration that covered HCTAYC's history and the distribution of awards recognizing the work and legacy of change makers in Humboldt County. The Celebration was attended by over 60 participants.

For this reporting period, HCTAYC's annual digital storytelling retreat was replaced by the first "Creative Leadership Retreat". This activity saw 8 young people with lived experience travel to the Bay Area to experiment with different forms of creative expression and its application to amplifying their voices and the voices of other young people with lived experience. Participants learned group aerial dance, improv, poetry, videography, sketch-creation, and speech making. Participants created a shared video which utilizes a group-created poem that will be shown in the next reporting period and is in the development of a planned showcase event.

The program maintained the Humboldt Houseless Youth Support Collaboration (HHYSC). This collaboration held 9 meetings during this reporting year. Collaboration members have included: HCTAYC and Peer Coaching, YAB members, Redwood Coast Action Agency's YSB and Raven Project programs, Humboldt County Office of Education (HCOE), Family Resource Centers, CalFresh outreach, DHHS-Home program, Yurok Tribe, Juvenile Probation, Department of Rehab-Young Adult Workforce Development, Project Rebound, DHHS-Policy and Legislative Manager,), Legal Services of Northern California, Affordable Homeless Housing Alternatives (AHHA), Open Door Mobile Unit, Planned Parenthood Northern California, Aegis, Southern Humboldt Family Resource Center, Disaster Case Management (DCM), Juvenile Justice Delinquency Prevention Commission (JJDPC), Fortuna Advocates Services, Humboldt Housing and Homelessness Coalition (HHHC), and Partnership Health Plan.
This reporting period saw the continued development of the division's homelessness assistance services, in particular the progression of partnership with the HOME Program to secure a housing navigator position for TAY and further development of youth-driven measures such as gap analysis.

HCTAYC's continued advocacy and leadership brought the voices and experiences of young people to the following policy tables:

- Behavioral Health Board
- BHB SUD Committee
- Board of Supervisors
- CAPCC
- Cultural Responsiveness Committee
- DHHS Equity Committee
- Dishgamu Land Trust
- FFPSA Cross-System Collaborative
- FFPSA Site Collaborative
- Humboldt Community Health Trust
- Humboldt Health Foundation
- Humboldt Housing & Homelessness Commission
- Humboldt Housing & Homelessness Commission Executive Committee
- Juvenile Justice Delinquency Prevention Commission
- Multi-agency Juvenile Justice Coordinating Council
- QPI Workgroup
- Redwood Coast Mental Health Symposium
- RESPECT Coalition
- SB2083 SOC Working Group
- State & Federal Senator & Representatives Offices
- Sexual Health Taskforce
- Sorrel Leaf Healing Center Board & Committees
- CALSWEC Training Logic Model Workgroup
- Suicide Prevention Network
- Warming Center Workgroup
- Youth MAT Workgroup

During this reporting period, the YAB and staff began the development of “Removing the Blanket: Transforming Substance Dependence & Healing for Young People”, a compliment to the curriculum developed the following reporting period continuing the theme of youth-driven and strengths-based support & treatment.

Challenges

This reporting period has been a time of reflection for the program. The program has reviewed the budget priorities in preparation of changes due to the passage of Prop 1.

During the start of this reporting period there was a high number of youth cancellations and inconsistent engagement because of things going on in the young people’s lives and the lack of support that they received from systems. This led to a low period of activity in the Youth Advocacy Board and very low numbers of engagement in workshops, educational opportunities, and meetings. Shifts to staff’s process of engagement and recruitment bolstered numbers of participants and engagement by the end of the reporting period.

Low engagement and only having more senior members of the YAB completing the LSA resulted in a lack of meaningful data. The following reporting period this tool will be once again used with all members. Additionally, tracking and documentation regarding leadership and wellness goals continues to be ineffective and inconsistent and must be reevaluated.

Successes

This reporting period ended with the largest youth advocacy board in the history of the program.

Two new large community events launched in this reporting period, the Digital Storytelling Screening and Sweet 16 Anniversary Celebration. These included the Board of Supervisors recognizing the anniversary, and the attendance of administration and elected officials at both events.

Our innovative programming to replace Digital Storytelling was a success, with the participants reporting that the Creative Leadership Retreat had a huge positive impact on their wellness and sense of connectedness and meaning. Peer support relationships were created and strengthened, and creative coping skills have provided avenues for those young people to become better advocates, themselves.

Our presentation of “Lifting the Blanket” at the CMHACY conference was praised as being the only actual youth-driven and youth-created programming to happen at the conference, and our youth presenters were recognized for their excellence, insight, and skill at creating meaningful and interesting curriculum.

Three new site-based trainers for the Transition to Independence Process Model were certified within the program, increasing the ability to support the Center/division and larger community to better serve TAY.

This reporting period saw the finalization of an independent, county-wide oversight body in alignment with recommendation 1 of our 2-S & LGBTQIA+ Policy Recommendations, securing a private partner and community leaders to actualize the body with support from our program. The name of this oversight body is yet to be determined.

This reporting period saw the maintenance of current staffing levels and increase in effective teaming and planning, including the hiring of a replacement analyst in a youth-driven hiring process.

The program maintained consistent engagement with both the Behavioral Health Board, Humboldt Housing and Homelessness Coalition (HHHC), and the Juvenile Justice and Delinquency Prevention Commission (JJDPC) with young people with relevant lived experience.

The resurrection of the traditional structure of Wellness Week saw great turnout, including successful partnering with Project Rebound to provide programming within Juvenile Hall.

Lessons Learned

The program has seen the success of shifting prioritization to individual time with members and bolstering recruitment efforts in being able to expand and maintain the youth advocacy board. Through a targeted onboarding process and consistent 1:1's with Youth Organizers and Peer Coaches, as well as focused teaming, the program is better able to understand the needs and challenges of young people and remain on the same page as to how the program will ultimately support and engage them.

The program's organizing structure and media dissemination proved its ability to turn out large crowds for impactful, youth-centered events. With previous screenings of Digital Stories being virtual/hybrid, the in-person success of the screening proved the program's interest to the public and ability to disseminate stigma-reduction messaging. Additionally, the turnout for the Sweet 16 series of activities demonstrated the positive impact of having youth-only and then blended events with a shared, coherent theme.
Digital project management continues to pose barriers, in particular changes to the management software and the centralization of documents in another system makes using both difficult. The program must shift to ensuring that shared tools have low barriers to access and use, are structured around the fiscal year, have a clear usage case, and track only needed information. Building in time for planning, check-ins, and retreats is necessary to ensure that the program is in alignment and moving forward in a good relationship. This requires a point-person to ensure that these things are moving forward.

Less structured events with more time for relationship building allow young people to experience less crisis during emotionally activating programming and allows for the creation of stronger peer-support relationships.

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

TAY Peer Support-Peer Coaching Report 2023-2024 (FY 23-24)

Peer Coach Tracker

The Peer Coach Tracker is an administrative tool used solely by staffers to track referrals and case assignments.

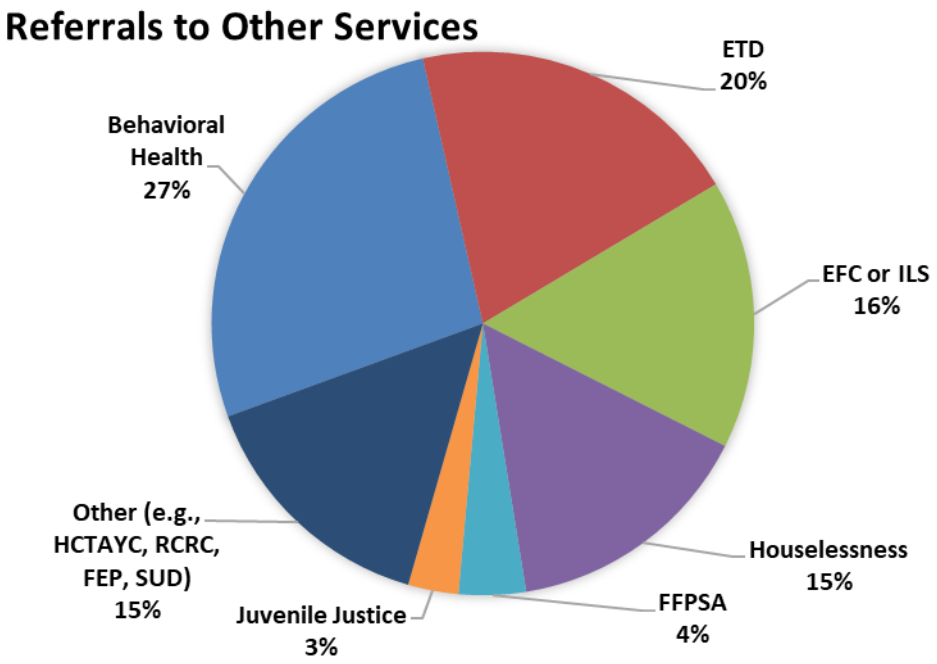
Participation was analyzed for the reporting period of July 1, 2023 – June 30, 2024. During that time, Peer Coaching received ninety-two (92) referrals for individual mentorship, outreach and engagement to TAY services. Eighty-five (85) referrals were closed (including thirty-five (35) referrals opened in previous fiscal years) during FY 23-24 and in total, 122 referrals were managed in FY 23-24.

Below is a chart tracking numbers of days from referrals to assigned Peer Coach, days from referral to first attempted contact to young person, and numbers of days from assignment to first attempt at contract.

Average Number of Days	FY 20-21	FY 21-22	FY 22-23	FY 23-24
Referral Date-to-Date Assigned	6.5	4.7	2.7	3.9
Referral Date to First Try Contact Date	14.7	6.5	12.5	11
Date Assigned to First Try Contact Date	8.3	1.6	10.2	6.6

Of the 92 referrals received, the Peer Coaching program made 179 referrals to other needed services. The distribution is as follows based on total referrals received:

- Behavioral Health, 27%, ETD 20%, EFC or ILS 16%, Houselessness 15%, FFPSA 4%, Juvenile Justice 3%, and Other (e.g., HCTAYC, RCRC, FEP, SUD) 15%.



TAY Center Sign-In Sheets

- From July 1, 2023, to June 30, 2024, TAY served 275 total unique young people via drop-in or a Peer Coach supported event/workshop. Of those, 173 were first time visitors.
- 1,270 total visits during drop-in hours.
- 275 unique visitors attended drop-in hours, of those, 154 were first-time visitors.
- 293 total participants in a Peer Coach supported workshop/ event.
- 100 unique visitors attended a Peer Coach supported workshop/ event, of those, 19 were first time visitors.
- A total of 10 emergency food boxes were distributed.

Participation	FY 19-20	FY 20-21	FY 21-22	FY 22-23	FY 23-24
Drop-In Hours Visit	1,595	220	481	618	1,270
Drop-In Hours Unique Visitors	203	80	144	181	275

Participation	FY 19-20	FY 20-21	FY 21-22	FY 22-23	FY 23-24
Drop-In Hours Unique First Time Visitors	63	26	73	96	154
Workshops/Events Visits	147	3	87	162	293
Workshops/Events Unique Visitors	64	3	54	71	100
Workshops/Events Unique First Time Visitors	6	1	20	43	19
Total Unique Visitors	**223**	**82**	**167**	**211**	**295**
Total First Time Visitors	**69**	**27**	**93**	**118**	**173**

Drop-in was paused in accordance with the county's COVID response efforts from March 2020 thru December 2021, when it resumed 3 days a week. Drop-in visit type reporting began March 2023.

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

Outreach, Tabling, and In-Service

Peer Coaches and HCTAYC Staff facilitated 35 street outreach, tabling events and TAY in-service presentations in FY 23-4.

Actual Outcomes for 2023-2024 (FY 23-24)

- Peer Coaches staffed the TAY Center and drop-in hours. Peer Coaches started two ongoing structured drop-in activities, "connected crafting" weekly and "Stitch Fix" monthly. See above for TAY Center drop-in data.

- Peer Coaches maintained consistent caseloads for individual mentorship. See above for Peer Coach tracking of how many referrals received.
- Peer Coaches were cross trained to support all TAY Division programs.
- Peer Coaches participated in various community presentations and tabling opportunities. See above for outreach, tabling, and presentation data.
- Peer Coaches provided monthly workshops and supported integrated TAY Division programming.
- Peer Coaches built supportive relationships with youth while waiting to receive or to be connected to other needed services.
- Peer Coaches supported youth with system navigation and advocacy needs.

Peer Led/Supported Activities, Workshops, Groups and Events

Peer coaches facilitated, co-facilitated, or supported by staffing and providing transportation for 25 workshops or events during FY 23-24.

Integrated TAY Rafting Trip	Stitch Witch	Sign Making for MHAM
D.O.S.E of Happiness	Integrated TAY Fall Feast	MHAM Walk
Integrated TAY BBQ	Stirring the Pot	MHAM BBQ
HCTAYC Wellness Week	Dim Sumbody Say Dumplings	Garden to Table
HCOE Back to School Fair	Stitch Witch Part 2	Love is Love
Puzzle Making	Nails on a budget	TAY Graduation
Scary Life Skills	Date Yourself Part 2	Coffee Time w/ a Peer Coach
Costumes on a Budget	Community Hike	

Challenges

TAY Division program staffing fluctuated during the reporting year, putting a strain on the HCTAYC and Peer Support program. The Peer Support program was down one full time Peer Coach for the entire reporting period, who was out on leave and then resigned. When able to fill the position, hiring freezes due to fiscal constraints paused the process. Peer Support heavily supported the ILS program by coordination of activities and outreach efforts. CWS ILS/EFC supervisor was at half time and then out on leave impacting TAY program integration and HCTAYC/Peer Support supervisor capacity to support the integrated divisions' needs.

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

Cross-training staff to support data collection efforts continued to be a challenge. There were inconsistent uses of the SDR and WEST Survey, with changes in the processes not being practiced or inconsistently administered.

Humboldt County Behavioral Health took on a new electronic health record (EHR) system. EHR implementation processes posed challenges and created additional time constraints for staff.

Successes

The Peer Support program increased their outreach, tabling, and in-service presentations this reporting year, reaching a broad number of geographic and demographic audiences.

The TAY Center drop-in space visits, both unique and duplicated youth, increased significantly this year. Peer Coach staff were able to increase engagement and did this by creating semi-structured drop-in activities and offering home like meals.

Despite being understaffed by one Peer Coach Position, the Peer Support program coordinated, facilitated or supported 25 workshops/events. The peer support program received and managed 92 referrals, similar to previous years.

Peer Coaching staffers supported drop-in, new YP and new to TAY staffers. There was excellent teaming, and program cross training. Peer Coaches felt supported with daily check in's, and weekly individual and group supervision from their supervisor and regular check-ins with the lead Peer Coach staff.

The Peer Support staff coordinated and attended many events and activities for May is Mental Health Awareness Month. They were active and visible in the community and worked to reduce stigma discrimination around mental health.

Peer Support staff were able to be trained in the TAY Division TIP (Transition to Independence Process) training, with one staff and the shared supervisor becoming certified site-based trainers in the TIP model.

One Peer Coach has been assigned to support the Humboldt Early Psychosis Intervention Program (HEPI) programming that is operating at TAY. and the Peer Coach is receiving extended training in first episode psychosis.

Peer Coach staff participated in gathering data for the Point and Time (PIT) count.

Two Peer Coach staff attended the N.A.P.S. (The National Association of Peer Supporters) conference.

Lessons Learned

Staffing fluctuations can impact the peer coach team by impacting caseloads and other assigned tasks. . Peer Coach staff have worked on balancing the work they do, including within the peer role, both with young people and with other staff.

Consistent supervision oversight is important to ensure outcome tools are gathered. Peer Coach staff need regular and consistent supervision and training opportunities, as well as wellness and team building skill development time built into their schedules.

The Peer Coach staffing team is fully committed to this work. One staff member was asked if they were interested in applying for a case management position and they responded with “I love my job and the work I get to do as a peer.”

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[1] Dominique Perreault, Lori R. Cohen & Céline M. Blanchard (2016) Fostering transformational leadership among young adults: a basic psychological needs approach, International Journal of Adolescence and Youth, 21:3, 341-355, DOI: 10.1080/02673843.2015.1083451

[2] Han, J., Wong, I., Christensen, H. et al. Resilience to suicidal behavior in young adults: a cross-sectional study. Sci Rep 12, 11419 (2022). https://doi.org/10.1038/s41598-022-15468-0

Prevention and Early Intervention: Suicide Prevention

The six main Suicide and Violence Prevention projects as identified by PEI Regulations and supported by the MHSA Suicide Prevention are:

Projects

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

Objectives

- Humboldt County Suicide Fatality Review: Conduct suicide fatality reviews to identify trends in local suicide deaths, data-driven suicide prevention, and intervention recommendations.
- Community Collaboration: Create a leadership-driven, safety-oriented community committed to reducing suicide and violence.
- Prevention and Early Intervention Training: Increase community capacity to recognize and respond to signs of suicide, violence, and mental health problems through evidence-based and practice-based/promising practice community trainings.
- Lethal Means Safety: Develop and promote lethal means safety campaign to educate the community and address the number of suicide and homicide deaths by firearm and to provide safe storage options.
- Social Marketing and Educational Outreach: Increase awareness of suicide and violence, promote prevention messaging, and encourage positive behavior change in those areas.
- Postvention: Offer resources and materials to support survivors of suicide loss, decrease stigma about talking about suicide, and increase local capacity to offer grief support.

Strategies

- Public and targeted information campaigns
- Culturally responsive approaches
- Survivor-informed models
- Evidence and practiced based education models and curricula
- Public health model
- Socio-Ecological Model
- Multisector approach
- Collective impact approach
- Health equity approach
- Zero suicide framework

The Suicide Prevention Program activities meet the SB 1004 priorities of providing suicide prevention programming across the lifespan and targeting the mental health needs of older adults.

During fiscal year 2023-2024, there were roughly 1,501 clients served by the program across its various projects. Based on the 2023-2024 Revenue and Expense Report (RER), which outlines a total cost of $300,375 in MHSA funds, the average cost per client is estimated at $200.12.

Project: Humboldt Suicide Fatality Review (SFR)

The Suicide Fatality Review (SFR) Team is a multidisciplinary group of professionals who met to learn about the circumstances leading to suicide deaths and use an innovative

approach to develop targeted interventions to prevent suicide in Humboldt County. This group includes sector agency representation from the Humboldt County Department of Health & Human Services (DHHS), the Coroner's Office, behavioral healthcare, healthcare, Tribes, and the community.

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

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

For historical knowledge of the project, and for project-related resources, please see the Humboldt County Suicide Fatality Review (SFR) Annual Report 2022, which can be found here in English, and here in Spanish.

The SFR process

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

Target Population

Medical and behavioral health providers, healthcare administrators and providers, tribal organizations, county Public and Behavioral Health, Emergency Medical Services, Veteran serving agencies, law enforcement, social services, and subject matter experts.

Key Activities

- Develop SFR protocols, policies, and procedures.
- Meet quarterly to review suicides and make recommendations based on findings.

- Evaluate local suicidal behavior trends, circumstances, risk and protective factors to strengthen prevention efforts.
- Identify targeted systemic changes from data analysis of review meeting recommendations.
- Connect technical assistance to target audiences who need training working with healthcare providers, including training content development, guidance, SME, and resources.
- Present findings in conjunction with county epidemiologist that illuminate opportunities for system changes, including providing data to inform decision-making, offering training and alignment of shared objectives and deliverables among community partnerships.
- Provide technical assistance in the form of sharing process documents and lessons learned to other counties implementing SFR.

Outcome Measurements

- Number of SFR meetings held.
- Number of participants involved.
- Number of suicide death cases reviewed.

The measures listed above remain in effect for the reporting period of FY 2023-2024, which is reflected in this 2025-2026 Annual Update. However, there are new measures future MHSA plans will reflect, which include:

- Percentage of cases with Suicide Risk Factor Surveillance System (SRFSS) data analysis.
- Number of cases reviewed by the SFR PH Core Team.
- Number of reports that include risk factor data.

Expected Outcomes (FY2023/2024)

It was expected that SFR would meet regularly to review two or more suicide deaths at each meeting, reviewing a total of approximately four to eight suicide deaths within the fiscal year.

Actual Outcomes (for FY2023-2024)

- Two SFR meetings held.
- Twenty-three participants involved (combined).
- Five suicide death cases reviewed.

Number of Individuals Served (Unduplicated)

- Five (5) suicide death cases were reviewed at the two (2) SFR Meetings.
- Twenty-three (23) participants serving 10 agencies at the SFR Meetings.

Demographics of Individuals Served

The MHSA PEI Demographic Form is not applicable to this project and is not used as an outcome measurement. Determination of which cases are to be reviewed is solely based on whether the decedent's next-of-kin grants permission.

Projected Outcomes (FY2025-2026)
SFR has paused meeting as multi-disciplinary cross-sector Team to review suicide death cases. SFR Public Health (PH) Core Team and Humboldt County Sheriff's Office (HCSO) - Coroners will continue to collaborate on the Suicide Risk Factor Surveillance System (SRFSS). SFR PH Core Team will share updated data on local risk factors collected by the Coroner's Office, using an updated SRFSS, in conjunction with an annual Humboldt Suicide Mortality Report.

- SRFSS data analysis of 70% of suicide cases.
- Twenty (20) or more cases reviewed by SFR Public Health Core Team.
- Updated de-identified risk factor data shared in one (1) report, annually.

Challenges
Reduced staffing and operational changes continued to make data analysis difficult. The multi-disciplinary SFR Team meetings were paused in November 2023. This decision was made to enable a thorough analysis of the data collected thus far. It also provided the SFR Public Health Core Team the opportunity to collaborate with community partners to identify gaps in data and collection methods.

Successes
The goal was met by reviewing five cases during SFR Team Meetings. Information was also collected on formal suicide death review team processes that have informed the project and many others across the state. Additionally, a quality improvement project was implemented in November 2023 surrounding the Suicide Risk Factor Surveillance System (SRFSS).

Lessons Learned
It was found that the formal Multi-Disciplinary SFR review team offers detailed insights into cases, identifying risk and protective factors, as well as the agency policies and procedures that impact outcomes. However, full participation of the multi-disciplinary team was hampered by legal restrictions related to consent and the logistical challenges of coordinating multiple agency schedules for the significant time commitment required. Given that the review process can be traumatizing for team members, it is essential to continue this pause to thoroughly analyze the lessons learned over the past five years. This will enable the program to refine its process and proceed with a thoughtful, trauma-informed approach, ensuring collection of the necessary information for the community's suicide prevention efforts.

While this process is re-evaluated, the program will continue to collaborate with the Coroner's Office to collect SRFSS information and monitor suicide cases. Additionally, the potential use of state and national-level syndromic surveillance systems is promising, as these systems may provide invaluable risk factor and demographic data for all of Humboldt's decedents, not just those for whom here is a SRFSS data or signed consent forms to review.

The recommendations for actions based on de-identified data, including local risk factor trends, were made by local subject matter experts and those working directly with individuals at risk of suicide. The Suicide Prevention Program has recognized the importance of groups like the local suicide prevention coalition, in reviewing risk factor trends and making recommendations on actions tailored to specific communities in culturally appropriate ways, and measures that can minimize suicide risk for others in the future.

Project: Humboldt County Suicide Prevention Network

The Humboldt County Suicide Prevention Network (SPN) is comprised of representation from community sectors, county agencies, and community partners. The DHHS-Public Health Suicide and Violence Prevention Program serves as the lead agency and collaborates with service-providing agencies in multiple sectors, including tribal and community health, clinical behavioral health, social services, hospice, and palliative care. Primary agencies involved volunteered to present information or update the network regularly.

The network meets bi-monthly to build relationships and to identify strategies to reduce suicide and suicidal behaviors in the community. SPN collaborates to plan events throughout the year and especially during the month of September in honor of Suicide Prevention Awareness. SPN also works closely with the local chapter of the American Foundation for Suicide Prevention to help plan the Arcata Out of the Darkness Walk. Anyone is welcome to attend the SPN regularly to provide input or to join during the September events planning time. All efforts focus on establishing a presence in remote outlying areas of Humboldt County and in tribal communities. Humboldt County PEI staff will continue to act as the backbone agency providing coordination of efforts and guidance on best practices.

In September 2021, members of SPN started the SPN Steering Committee. Anyone interested was invited to participate. The mission of the Humboldt County SPN Steering Committee is to provide a cross-agency backbone to the SPN and to move forward the priorities of the Network. SPN Steering Committee goals include to:

1. Guide the function of the Suicide Prevention Network.

2. Elevate the recommendations generated by the Humboldt Suicide Fatality Review Process to the appropriate sector (stakeholder) via the Suicide Prevention Network (to advocate for systematic change in suicide care).
3. Establish task forces/subcommittees to address the four (4) priority areas identified in the BH/Suicide section of the Humboldt Community Health Improvement Plan (CHIP).

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

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

Target Population

- Community partners, direct service providers, Survivors of Suicide Loss and those with lived experience, and prevention specialists.

Key Activities

- Coordinate community-wide activities and events.
- Provide in-service training at each Network meeting to promote evidence and practice-based strategies in suicide safer care.
- Foster cross-sector relationship building to increase access and linkage to care for those in crisis and non-crisis situations.
- Promote local, statewide, and national crisis lines, resources, and educational materials to expand on the ability of trainees to increase access and linkage to support and treatment for persons at risk.
- Improve and integrate suicide prevention resources in the community at large.
- Community education and outreach.
- Training and Workforce Development to increase the capability to respond to persons at risk.
- Data collection and surveillance.
- Zero Suicide in Health and Behavioral Health Care Systems.
- Email list-serve.
- Leverage resources to broaden the support network for unserved, underserved, and inappropriately served populations.
- Coordinate Network and Steering Workgroup meetings.
- Participate in the state-level Striving for Zero Suicide Prevention Learning Collaborative to create a County wide strategic roadmap.

Outcome Measurements

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

Expected Outcomes (for FY2023-24)

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

Actual Outcomes (FY2023-2024)

- Thirty-seven (37) agencies represented in network (DHHS SSB, PH & BH counted as one) – an increase of 4 agencies from the previous fiscal year; there were two community members who attended.
- Twenty-seven (27) meetings were held annually (includes SPN Steering & Subcommittee meetings).
- Four hundred forty- five (445) list serve participants.

Number of Unduplicated Individuals Served (FY2023-2024)

Eighty-eight (88) unique participants, representing 37 agencies, attended one or more Suicide Prevention Network meeting in fiscal year 2023-24 (an increase of 12 unique participants from FY22/23).

Demographics of Individuals Served

The MHSA PEI Demographic Form is not applicable to this project and is not used as an outcome measurement.

Projected Outcomes (FY2025-2026)

- Increase number of agencies represented in network by one per year.
- Ten meetings to be held.
- Five hundred (500) list-serve participants.

Challenges

New leadership in the coalition was a priority in FY23-24 and while the coalition did get there, it took a few months of leadership change as prospective members trialed the role of chair or co-chair before it was settled. Many agencies experience limited funding and frequent staffing changes which results in little capacity to invest in SPN leadership roles or work on related tasks outside of the meetings. The SVP Program maintained the role of administrative backbone during this time to ensure continuation of baseline coalition activities and support coalition members with limited time.

Successes

The Suicide Prevention Network continues to maintain good meeting attendance and engagement with Network news shared via the list-serv. In FY23-24, the average number of list-serv participants was 445, exceeding the goal of 300. The Network has continued to increase visibility in the community using social marketing strategies such as Mailchimp, branding and press releases.

The Suicide Prevention Network's strong base of community partnership has allowed space for new leadership to emerge. The coalition has elected a new chairperson from long-standing Tribal partner agency, United Indian Health Services, to lead SPN and SPN Steering Committee meetings. The subcommittees have also seen leadership change; the Lethal Means Safety Subcommittee has a community member holding the position of co-chair and the Youth Suicide Prevention Subcommittee has a new chair. These changes encourage fresh perspectives, new ideas, and reflects the collective ownership across organizations and the community in moving the coalition efforts forward.

In-person meetings were re-established in FY 24-25, with the goal of holding one per quarter. The network expressed the desire to have opportunities to network and connect in person, so we made a goal of holding meetings in each region of the county to create a space for all partners to have the chance to see each other and benefit from the connection in-person meetings provide. The first meeting was hosted by United Indian Health Services at their facility in Arcata, attendees benefited from a presentation on services offered, a tour of the grounds, and time to network.

The Suicide Prevention Network's subcommittees, based on priority areas identified in the suicide section of the Humboldt County Community Health Improvement Plan (CHIP) 2022-2027, Lethal Means Safety, Youth Suicide Prevention, and Training and Education have continued to thrive since being established last year. These subcommittees are addressing gaps in services and strengthening local suicide prevention efforts through cross-organization collaboration, assessing needs of high-risk populations, and increasing capacity for the network to provide trainings and education on suicide prevention. The three subcommittees formed in FY22-23 based on priority areas identified in the suicide section of the Humboldt County Community Health Improvement Plan (CHIP) 2022-2027 continued to meet in FY23-24. The three subcommittees include Lethal Means Safety, Youth Suicide Prevention, and Training and Education. These subcommittees are addressing gaps in services and strengthening local suicide prevention efforts through cross-organization collaboration, assessing needs of high-risk populations, and increasing capacity for the network to provide trainings and education on suicide prevention.

In FY 23-24, there were twenty-seven (27) total SPN meetings, 21 of which were subcommittee meetings. Notable accomplishments include the Lethal Means Safety Subcommittee partnering with a local CCW trainer to create a training "Let's Talk Gun

Safety" which focuses on the intersection of mental health and firearm safety. The Youth Suicide Prevention Subcommittee is amplifying youth voices by eliciting feedback directly from youth on trainings and educational materials. The Training and Education Subcommittee has continued to offer a space for cross-organization collaboration, which has led to partnering on outreach efforts and co-facilitating trainings.

Lessons Learned

While organizational capacity continues to fluctuate, it is important to encourage shared ownership of the SPN's goals and mission from community partners and organizations to ensure its sustainability over time. Having new leadership is one way to encourage collective buy-in and reflect the many voices that make up the coalition, which in turn helps avoid any one organization carrying the responsibility of maintaining the functions of the entire network. Having subcommittees to support the overall goal of the SPN and focus on specific priority areas has increased opportunity for other agencies to take leadership roles and mobilize suicide prevention efforts. The subcommittees have also increased the number of meetings being held quarterly, expanding participation options for members who have less flexibility in their schedule.

Project: Prevention and Early Intervention Training

The Prevention and Early Intervention Training project incorporates both evidence-based and practice-based trainings. SVP Program staff serve as coordinators, trainers, and/or support for trainings offered.

Evidence-based training offerings include:

- Question-Persuade-Refer (QPR) Basic Suicide Prevention Gatekeeper Training
- Be Sensitive Be Brave for Suicide Prevention (BSBB for SP)

Additionally, the SVP Program has developed a shorter practice-based training module covering the basics of lethal means safety that can be an add-on to any basic suicide prevention training. SVP also partners with Eureka VA to provide administrative support to the VA specific suicide prevention training, VA SAVE.

Trainings take place virtually or in-person. A modified, shortened version of the MHSA PEI Demographic Form is used as an outcome measurement to demonstrate the reach and diversity of populations and settings served.

Question-Persuade-Refer (QPR) Suicide Prevention Training

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

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

Key Activities

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

Be Sensitive Be Brave for Suicide Prevention (BSBB for SP)

Be Sensitive Be Brave for Suicide Prevention was first offered in Humboldt during FY21-22. It is a culturally responsive workshop on suicide prevention that infuses culture and diversity throughout a foundational workshop in suicide prevention. The workshop teaches community members to act as eyes and ears for suicidal distress and to help connect individuals with appropriate services.

Key Activities

- Teaching how to identify signs of suicide.
- Practicing sensitively and confidently asking individuals if they are considering suicide.
- Teaching how to connect individuals at risk of suicide with the appropriate resources and community supports.
- Teaching to approach suicide prevention in a culturally sensitive manner.

During FY23/24, SVP staff attended the virtual BSBB Academy. Prior to this, the program was contracting with outside trainers to provide this valuable training. SVP continued to offer the established QPR while building their capacity to offer the BSBB training in FY24/25.

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

Outcome Measurements (FY2023-2024)
- Number of trainings.
- Number of participants.
- Number of MHSA PEI Demographic Forms submitted.

Expected Outcomes (FY2023-2024)
Four trainings were expected to be held in fiscal year 2023-2024 serving a total of 80 or more individuals.

Actual Outcomes (FY2023-2024)
- Nineteen (19) trainings were held.
- Two hundred fifty-seven (257) participants in total.
- One hundred fifty-nine (159) modified, shortened MHSA PEI Demographic Forms were submitted; an increase from 39% to 62% from the prior fiscal year.

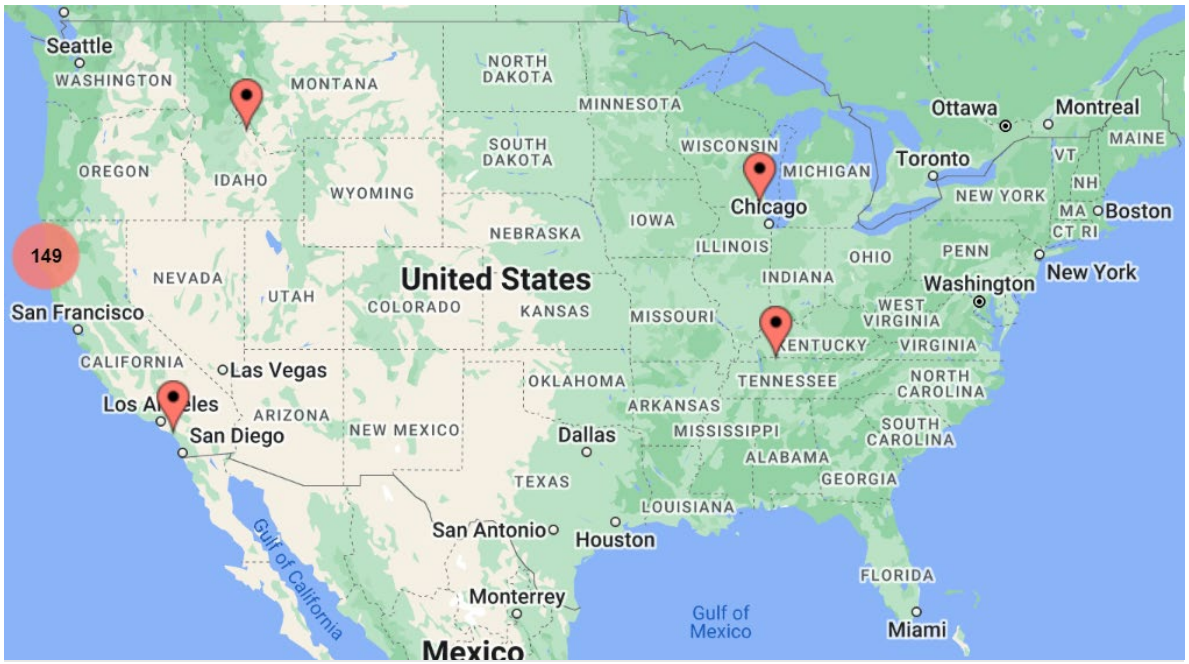
Training	# of Trainings	Individuals Served
QPR or QPR + Lethal Means Safety	19	240
Other (Youth Suicide Prevention, VA SAVE, LMS (as a stand-alone), or Gun Shop Project)	2	17
TOTAL	21	257

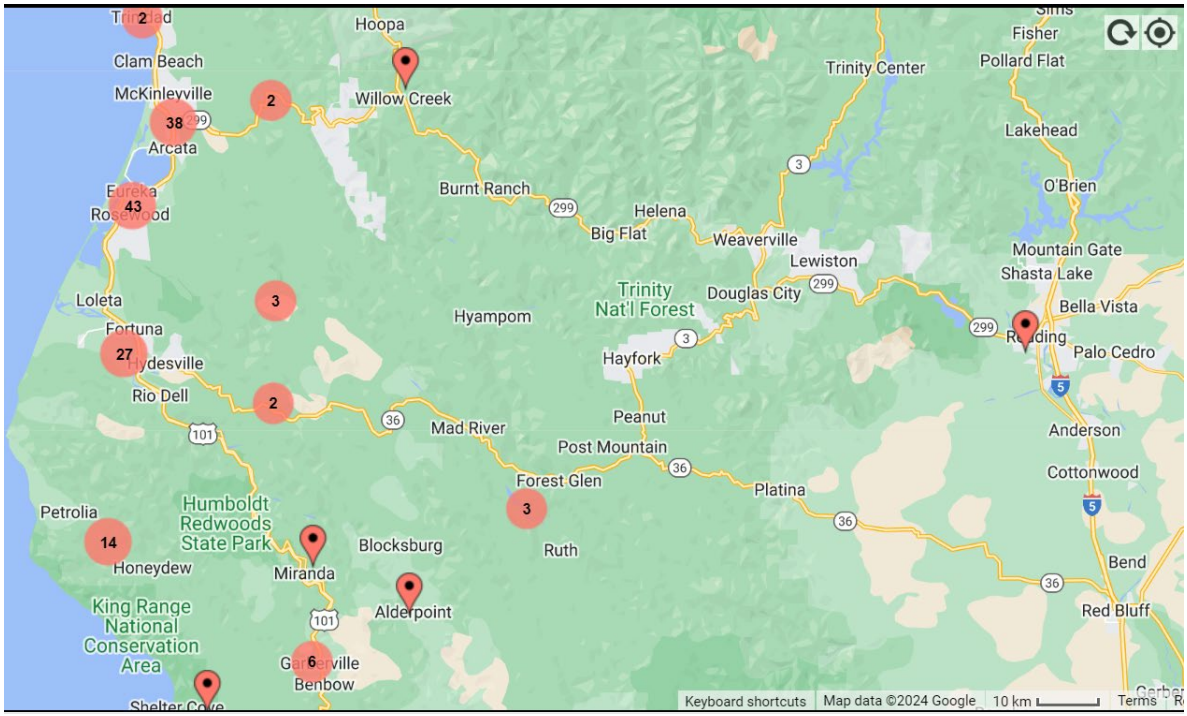
Number of Individuals Served (FY 2023-2024)
In FY 2023/24, twenty-one (21) trainings were held, with 257 total individuals served. This is a decrease of 65 individuals served from the previous fiscal year.

Demographics of Individuals Served
Demographic information comes from attendees at QPR, QPR + Lethal Means Safety, BSBB or other trainings who submitted complete electronic information. In Fiscal Year 2023/24, 60% (159) of attendees completed an electronic demographic form.

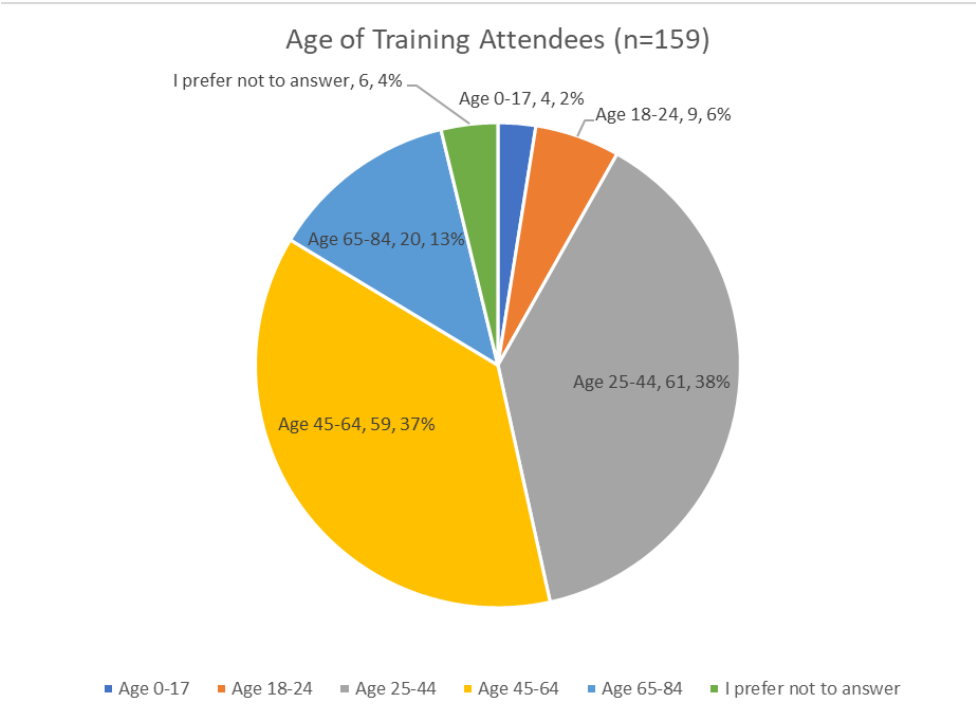
Zip Code of Training Attendees

The images below show the zip codes of training attendees. The first image shows the map of the United States and the second image zooms in on the Northern California region. In Fiscal Year 23/24, out of the 153 completed demographic forms, 41 participants lived within zip codes 95501, 95502 and 95503 (Eureka); 23 within zip code 95521 (Arcata); 15 within 95519 (McKinleyville) and Fortuna (95540); twelve (12) within 95558 (Petrolia); 8 within 95536 (Loleta) three (3) each within the zip codes: 95531 (Crescent City), Mad River (95552), Redway (95560), Kneeland (95549), Garberville (95542) and Rio Dell (95562); two each in Blue Lake (95525), Honeydew (95545), and Trinidad (95570) one each in zip codes 37043, 60003, 83467, 92672, 95470, 95511, 95526, 95528, 95534, 95551, 95553, 95564, 95573, 95589 & 96001.

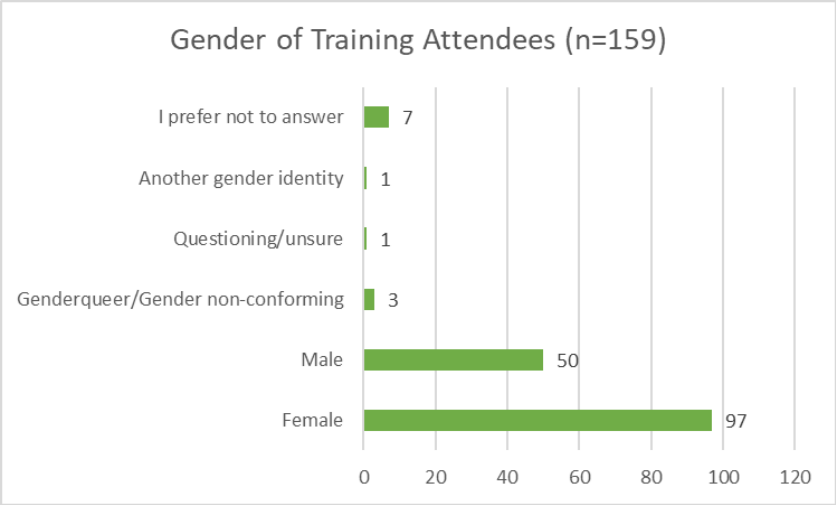




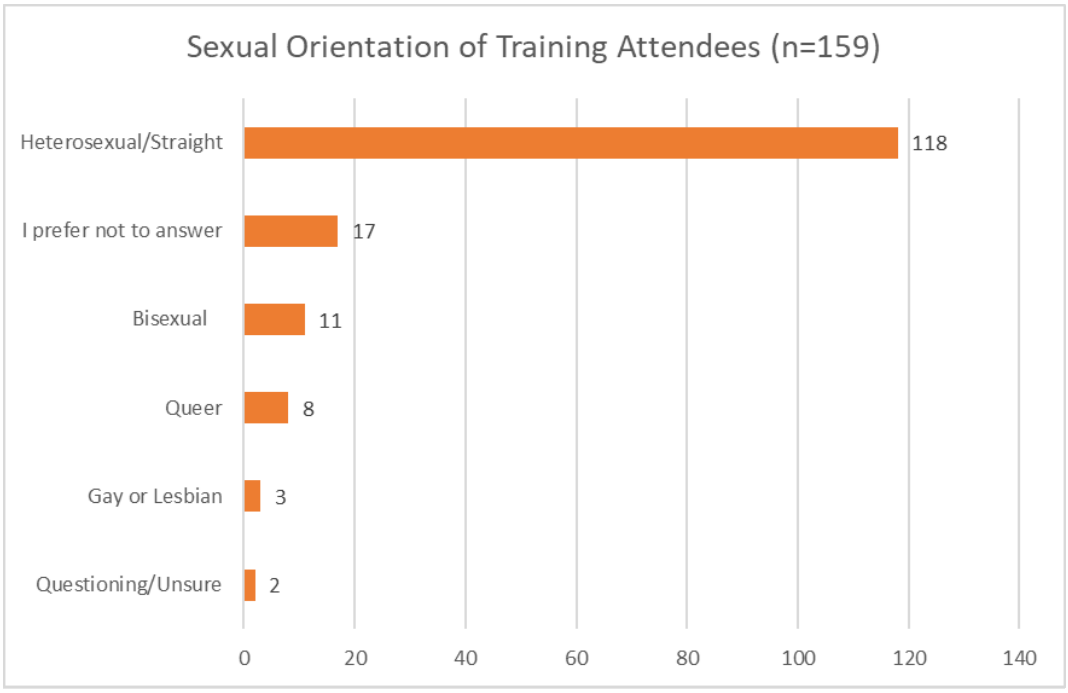
The chart below shows the age of training attendees. In fiscal year 23/24, out of the 159 responses, four (4) attendees (2%) were ages 0-17, nine (9) attendees (6%) were ages 18-24, sixty-on (61) attendees (38%) were ages 25-44, fifty-nine (59) attendees (37%) were ages 45-64, twenty (20) attendees (13%) were ages 65-84, and six (6) attendees (4%) preferred not to answer.



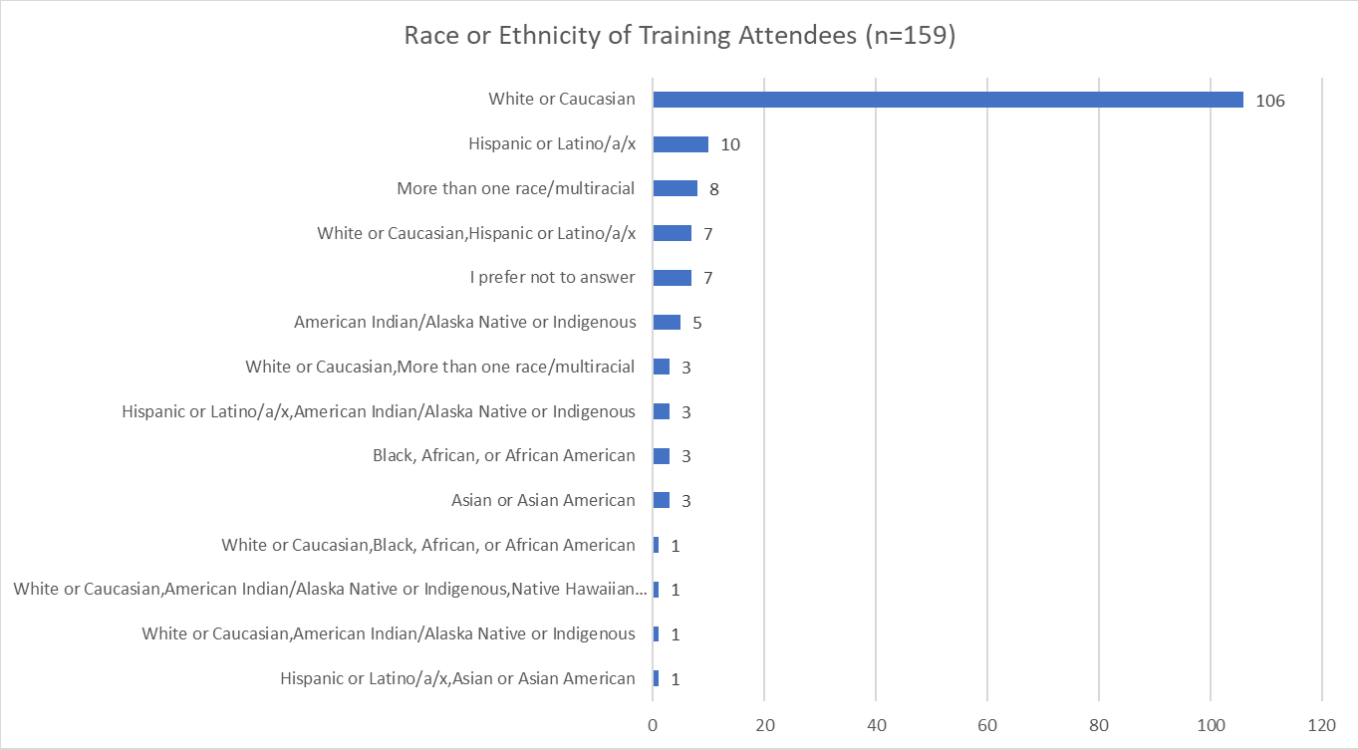
The chart below shows the gender of the training attendees in FY23/24. Out of 159 responses, 97 were female, 50 were male, 3 were genderqueer/gender non-confirming, 1 was questioning/unsure, 1 was another gender identity, and 7 preferred not to answer. Note: selections with zero responses are not reflected in the chart.



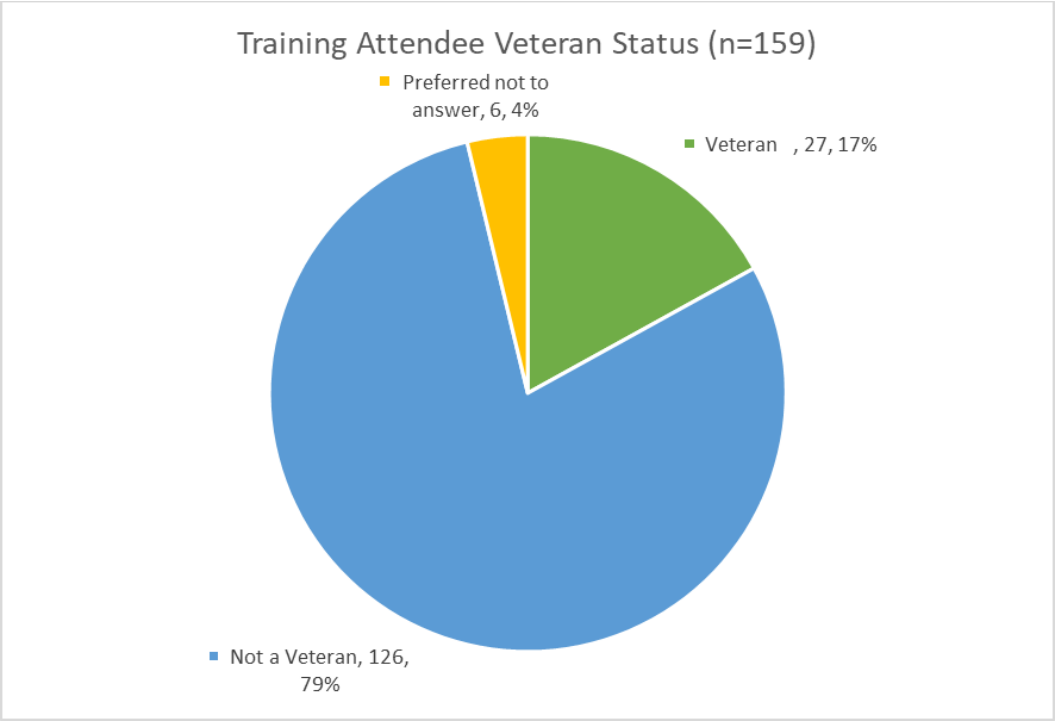
The chart below shows the sexual orientation of training attendees. Out of 159 responses in fiscal year 2023-2024, 118 training attendees were heterosexual/straight, 17 preferred not to answer, 11 were bisexual, eight (8) were queer, three (3) were gay or lesbian, and two (2) were questioning/unsure.



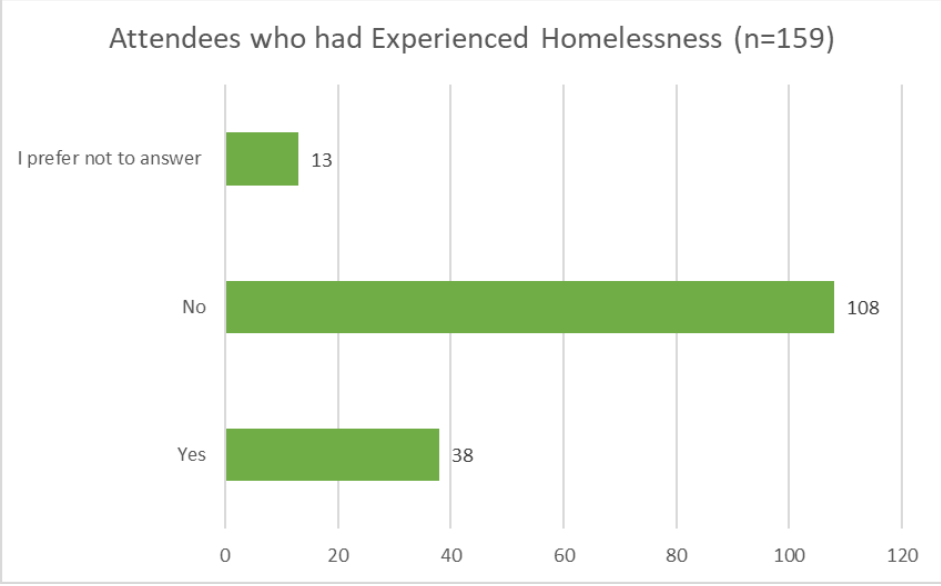
The chart below shows the race or ethnicity of training attendees. Out of 159 responses, 106 were White or Caucasian; ten (10) were Hispanic or Latino/a/x; eight (8) were more than one race/multiracial; seven (7) were both White or Caucasian, and Hispanic or Latino/a/x; seven (7) preferred not to answer; five (5) were American Indian/Alaska Native or Indigenous; three (3) were both White or Caucasian and more than one race/multiracial; three (3) were both Hispanic or Latino/a/x, and American Indian/Alaska Native or Indigenous; three (3) were Black, African, or African American; three (3) were Asian or Asian American; one (1) was both White or Caucasian, and Black, African, or African American; one(1) was White or Caucasian, American Indian/Alaska Native or Indigenous, and Native Hawaiian or Pacific Islander; one (1) was both White or Caucasian, and American Indian/Alaska Native or Indigenous; one (1) was both Hispanic or Latino/a/x, and Asian or Asian American.



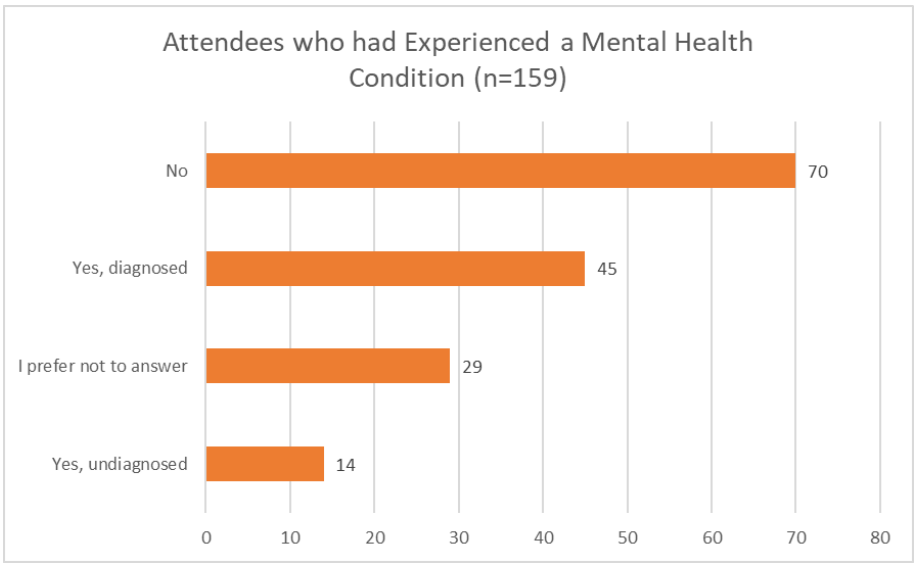
The chart below shows the veteran status of the 159 training attendees in fiscal year 23/24 who were asked if they had ever served in the U.S. Armed Forces. One Hundred twenty-six (126), or 79%, were not Veterans. Twenty-seven (27), or 17%, were Veterans, and six (6), or 4% choose not to answer.



The chart below shows that in fiscal year 23/24, 159 training attendees were asked if they had ever been homeless, lived on the streets, in a shelter, or couch surfed. 38 attendees had, 108 had not, and 13 preferred not to answer.



The chart below shows that in fiscal year 23/24, 159 training attendees where asked if they had ever experienced a mental health condition. Seventy (70) attendees answered “No”, 45 answered “Yes, diagnosed”, 29 preferred not to answer, and 14 answered “Yes, undiagnosed.”



The chart above shows that in fiscal year 23/24, 159 training attendees were asked if they had a family member with a mental health condition. Forty-seven (47) answered “No”, 67 answered “Yes, diagnosed”, 23 preferred not to answer, and 22 answered “Yes, undiagnosed”.

Projected Outcomes (FY2025-2026)

Four to six trainings will be held, serving 60 or more people, total. Braided funding that supports trainings will expire in fiscal year 2025 which may decrease the program capacity to offer trainings.

Challenges (FY2023/204)
The implementation of a new curriculum, "Be Sensitive Be Brave for Suicide Prevention" (BSBB), into the SVP training offerings required staff time to learn and become comfortable with the new material. The time needed to build subject matter expertise caused a delay in delivering the training to the community.

Visibility of training offerings continues to be a work in progress. Staff are regularly considering new ways to make trainings more accessible to the community and to simplify the request process. A new request form was implemented in FY 23-24 using the platform Qualtrics Experience Management, allowing community members to digitally submit a request form that is emailed directly to the SVP team inbox, rather than having to print a physical document and email it to the team. While this new process is quicker for those requesting trainings, there was a learning curve and technical difficulties that delayed response times to scheduling trainings. Staff continue to explore ways to lower barriers and increase the visibility of available suicide prevention trainings.

Successes
Teaming with other community entities, such as the Eureka VA, to provide specialized trainings like VA SAVE has broadened the spectrum of individuals who can benefit from these services. Jointly conducting these sessions with community allies promotes a unified strategy for suicide prevention, merging resources and skills to achieve shared objectives instead of isolated efforts.

QPR remains an effective tool for engaging a variety of community environments, including service providers, retail workers, and educators. The program has been enhanced to cover topics such as lethal means safety and comprehensive safety planning upon request. Its flexibility to be delivered both virtually and face-to-face makes it highly adaptable to the unique training needs of our community, which includes rural and remote areas.

The introduction of the Be Sensitive Be Brave (BSBB) training has not only diversified the range of our training programs but also imparts a culturally responsive approach applicable in various scenarios. This emphasis on cultural diversity and inclusion in prevention efforts aligns with the broader movement towards making suicide prevention and mental health services more equitable for all populations.

On average this year, trainings saw a 78% attendance rate when compared with registration. This is a 18% increase in attendance across all trainings when compared with last fiscal year’s attendance rate.

Lessons Learned

Implementing a new training curriculum, collaborating with community partners, and altering the way trainings are requested has ultimately improved the quality and efficiency of the suicide prevention trainings being offered. The program learned that having more training options, such as "Be Sensitive Be Brave" and QPR with Lethal Means Safety and Safety Planning, casts a wider net for participation in the community. Keeping trainings available in both virtual and in-person formats also ensures that the accessibility needs of different organizations and community members are being considered. Lastly, partnering with outside organizations on trainings reduces the workload on staff and provides the opportunity to cover more topics around suicide prevention without staff having to learn additional curricula.

The program resumed offering some in-person training sessions, which historically have provided a better return on data collection efforts and typically resulted in higher attendance rates. The program learned that the current preference for virtual suicide prevention training is 30-90 minutes, which pushed the program to prioritize offering various training lengths for participants to choose what works best for them. The program also discovered that recruiting external trainers to bring diversity and subject matter expertise attracts more participants and alleviates the stress on staff to learn additional curricula.

Project: Lethal Means Safety

In Humboldt County, between the years of 2010-2020, there were 216 firearm deaths, of which 74% were suicides. 44% of all suicide deaths in the same period of time involved a firearm; 29% were due to hanging; and 19% due to poisoning (Vital Statistics via Humboldt County Public Health Epidemiologist). Putting time and distance between a person thinking about suicide and a potentially lethal means may save a life. Lockboxes provide the added protection of a physical and psychological barrier, the option of transferring keys to a trusted individual, and the option of transferring the firearm altogether in accordance with California's Safe Harbor Law (PC 27882). Reducing access to lethal means is an integral part of a comprehensive suicide prevention plan. Providing safe storage options and lethal means safety education are the priorities of this project. Lethal Means Safety Project includes the following key activities:

- Keep It Safe Campaign
- Lethal Means Safety Training
- Gun Shop Project
- Keep It Safe Lockbox Distribution Program
- Know the Signs Campaign

<u>Key Activities</u>

- The Keep It Safe Campaign includes public health education around means safety that is targeted towards all audiences. The Campaign includes public service

announcements, social media messaging and an educational brochure that reaches expanded audiences on the topic of safe storage of potentially dangerous items. The target audience includes all housed community members. Keep it Safe is about preventable injury. The Keep It Safe Brochure is a guide to start a conversation with Humboldt County residents about protecting their loved ones from common items found in homes that could be dangerous such as: medications, alcohol, firearms, cannabis products and anything else that can be used to get high, harm or kill oneself. The brochure is distributed in local community service agencies including medical and behavioral health care settings.

- Lethal Means Safety Training consists of practice-based training modules that can accompany any suicide prevention training or be provided independently to those with previous baseline knowledge.
    - The target population is anyone who takes a suicide prevention training, interacts with groups at high risk for injury or suicide, and/or those who provide direct services including medical and behavioral health care providers, community members, social workers, tribal leaders, law enforcement and first responders, firearms retailers, trainers and range owners, and pharmacists.
    - This practice-based training module involves data around lethal means; firearms suicide; overdose; safety planning; harm reduction strategies for increasing safety and reducing risk; resources to learn more or seek help; and instructions on how to utilize the Public Health Lockbox Program for self or clients served.
- The Gun Shop Project is a partnership between Humboldt County Public Health and local gun retailers, trainers, and range owners. There were 216 firearm deaths in Humboldt between 2010-2020. The majority (74%) of those firearm deaths were suicides (Humboldt County Public Health Epidemiologist). Reaching the firearms community with suicide prevention education and resources requires partnership with leaders imbedded in that community. This project reflects that partnership in that local firearms retailers, trainers, and range owners are the ones sharing lethal means safety education and resources with the firearms community. Already experts in safe firearm storage, they also offer pistol lockboxes provided through the Keep it Safe Lockbox Distribution Program and consultation on safe storage options. They provide mental health and suicide prevention resources with lockbox distribution. Many of them have taken suicide prevention training with program staff and now, firearm safety instructors are including basic suicide prevention education in their classes, including concealed carry permit classes, for which SVP recently produced a 1-hour mental health curriculum. Educating gun owners about the relationship between firearm access and suicide gives gun owners themselves the knowledge that allows them to make informed decisions about safe storage that could potentially save lives. SVP has also partnered with a local firearms instructor to offer a basic firearms safety and secure storage class to clinicians and service providers who may work in situations where firearms may be present, as well as the general public.

- The Public Health Keep It Safe Lockbox Distribution Program is an expansion of the overall Keep It Safe Campaign.
    - The Lockbox Distribution Program has been distributing lockboxes in the community through partnership with a variety of local agencies. In 2020, Keep it Safe partnered with various firearm retailers, range owners, and gun safety trainers to expand the Lockbox Program.
    - The goal is to decrease the number of overdose or firearm related deaths and the number of accidental injury or overdose related ER visits in Humboldt County by providing education, resources, and a way to safely store medications, cannabis and/or firearms.

Public Health's Keep It Safe Lockbox Program provides lockboxes, free of charge, to community members who need them most. The lockboxes can safely store up to two handguns. These boxes can also be used to lock up medications or cannabis.

Outcomes Measured (FY2023/2024)

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

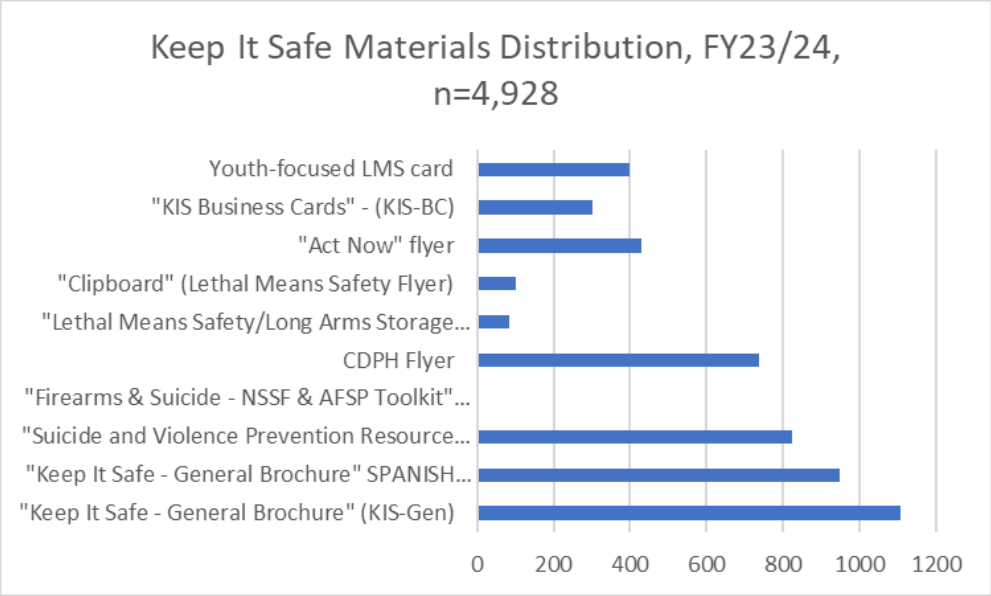
Expected Outcomes (FY2023/2024)

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

Actual Outcomes (FY2023/2024)

- One thousand and eighty (1,080) Keep It Safe brochures distributed.
- Three (3) Lethal Means Safety Training Modules &/or Keep It Safe presentations offered.
- 41 Lethal Means Safety Training & or presentation participants.
- 1,958) lockboxes distributed.
- (727) Lockbox Data Collection Forms completed.
- 4,928 educational resources provided as part of the Keep It Safe Campaign, including Know the Signs Brochure, Firearms & Suicide – NSSF & AFSP Brochure, Firearms & Suicide – NSSF & AFSP Toolkit, Safer Homes Clipboard Flyer, Suicide and Violence Prevention Resource Card, Keep It Safe Lockbox Card, and the Keep Is Safe general brochure in English and Spanish, and new

this year, the Lethal Means Safety-Long Arms Storage Flyer in English and Spanish and the Act Now Flyer.



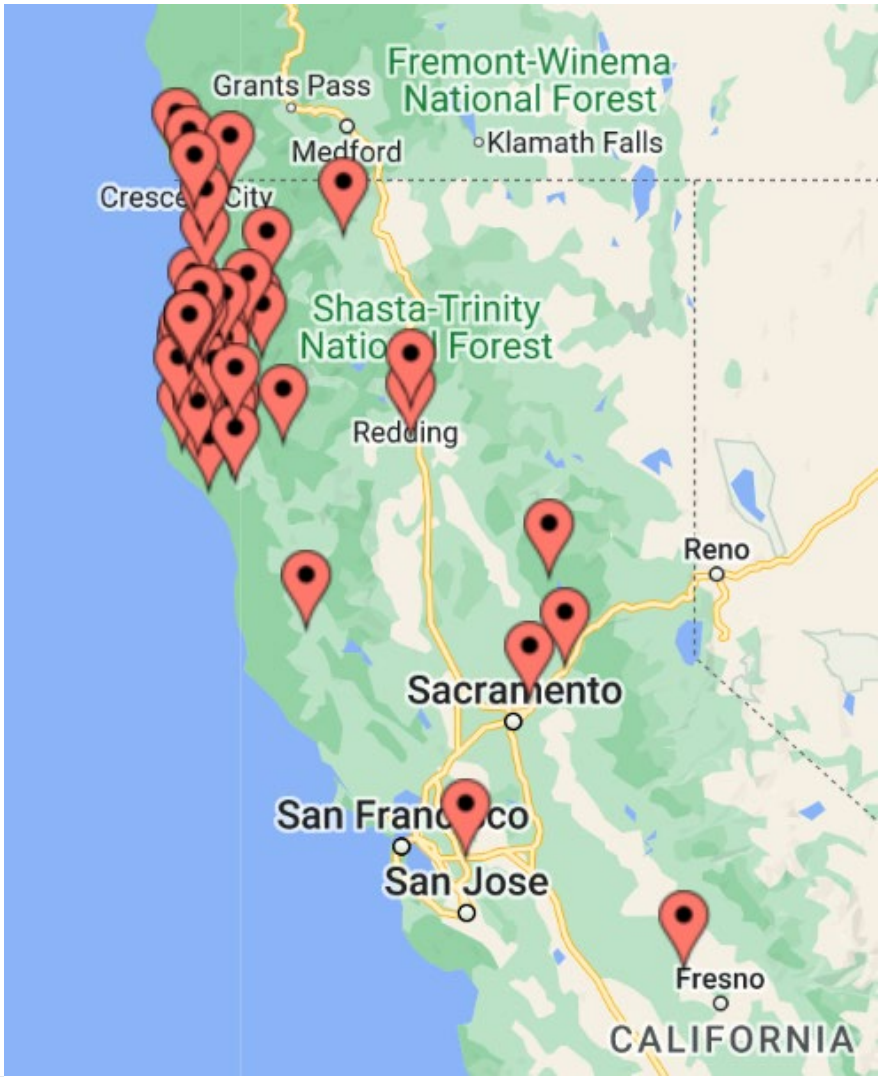
Demographics of Individuals Served

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

Zip Codes of Lockbox Recipients

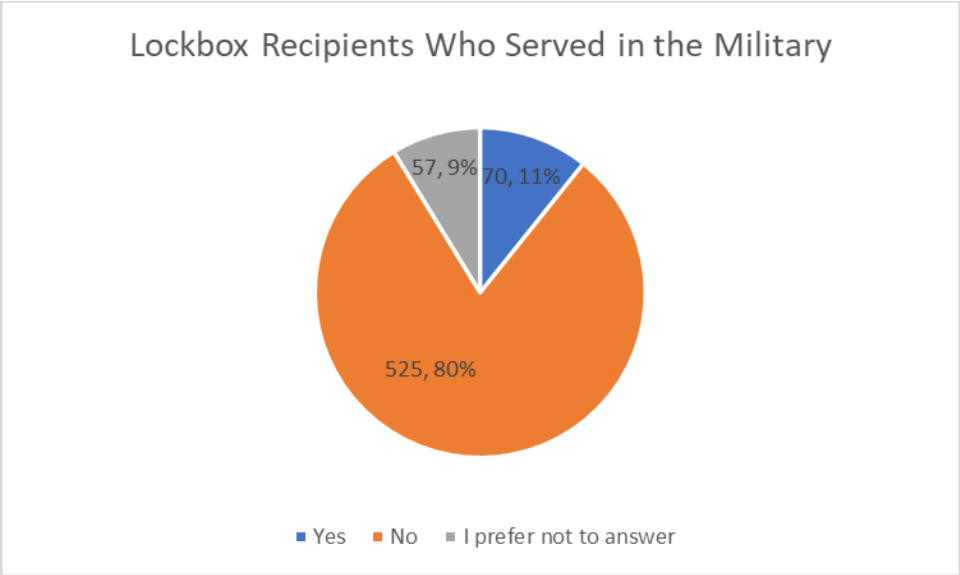
In fiscal year 23/24, 202 lockbox data collections forms were completed by lockbox recipients living in Eureka (zip codes 95501, 95502, and 95503), 103 in Fortuna (zip code 95540), 78 in Arcata (zip codes 95521 and 95518), 53 in McKinleyville (zip code 95519), 49 in Hoopa (zip code 95546), 20 in Rio Dell (zip code 95562) and 131 were in other zip codes.

City/Town	Lockboxes
Eureka	202
Fortuna	103
Arcata	78
McKinleyville	53
Hoopa	49
Rio Dell	20
Loleta	14
Carlotta	12
Blue Lake	8
Hydesville	8
Petrolia	8
Trinidad	8
Bridgeville	7
Ferndale	7
Crescent City	6
Klamath	6
Bayside	4
Kneeland	4
Mad River	4
Salyer	4
Redcrest	4
Willow Creek	4
Fields Landing	3
Garberville	3
Scotia	3
Gasquet	2
Korbel	2
Redway	2
Smith River	2
Cutten	1
Honeydew	1
Miranda	1
Myers Flat	1
Orick	1
Orleans	1



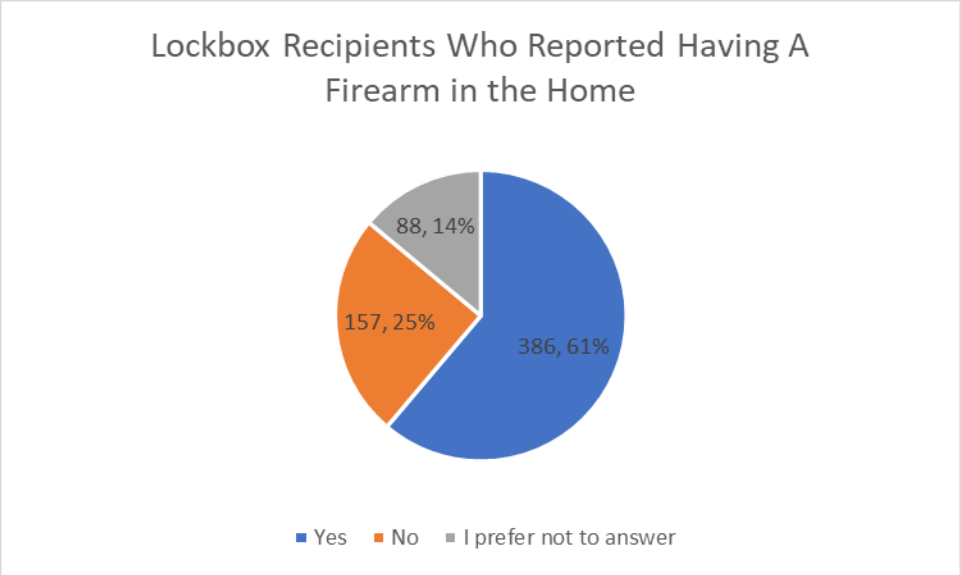
Served in the Military

The graph below shows that out of the 711 lockbox recipients who completed a Lockbox Data Collection Form, 70 of them answered yes to serving in the military presently or in the past, 525 said no, and 57 declined to answer.



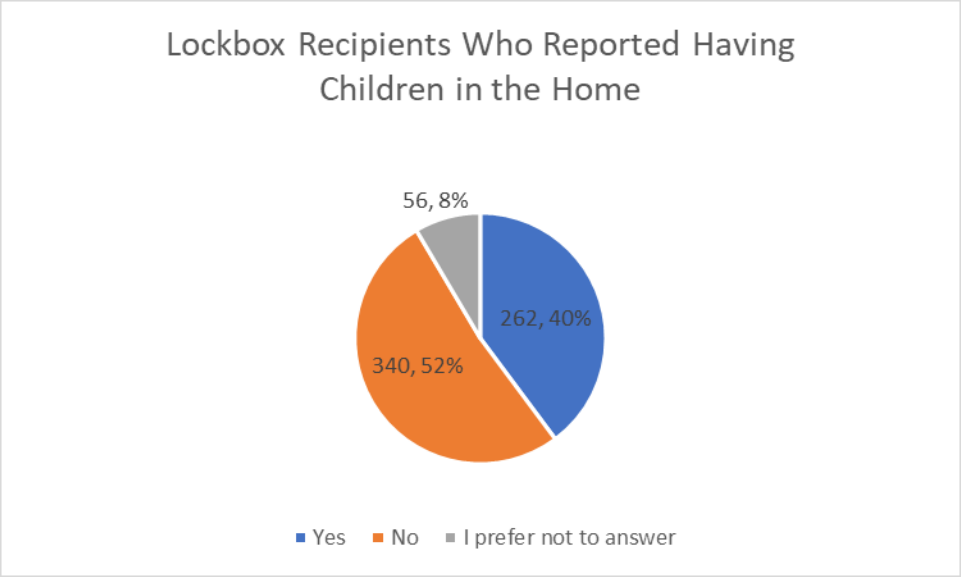
Firearms in the Home

The graph below shows that out of the 711 lockbox recipients who completed a Lockbox Data Collection Form, 386 (61%) of them answered yes to having firearms in their homes, 157 (25%) said no, and 88 (14%) declined to answer.



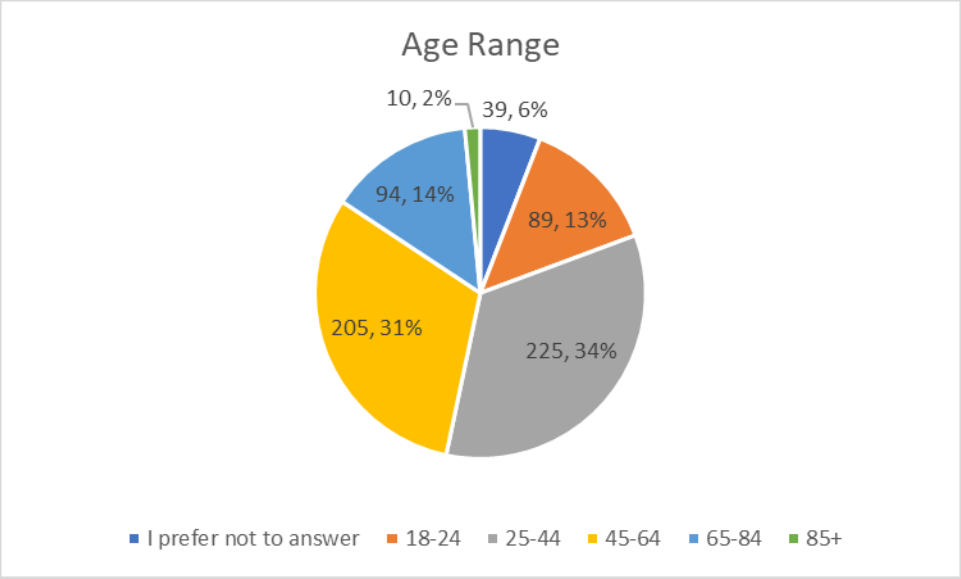
Children in the Home

The graph below shows that out of the out of 711 lockbox recipients who returned a lockbox data collection form, 262 (40%) answered yes to whether they have children in the home, 340 (52%) said no, and 56 (8%) declined to answer.



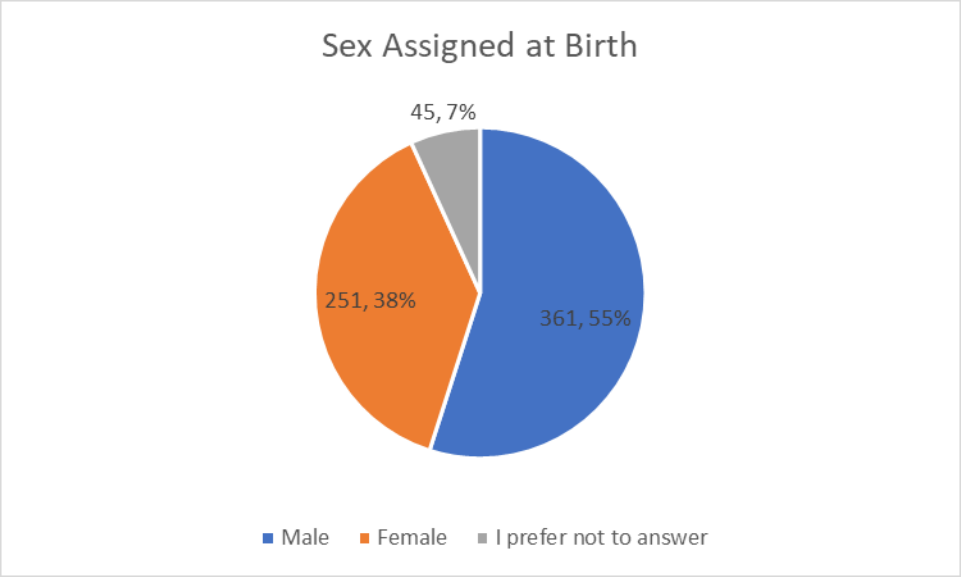
Age Range

The graph below shows that out of the 711 lockbox recipients who completed a Lockbox Data Collection Form, 10 (2%) of them were 85+ years of age, 94 (14%) were between 65-84, 205 (31%) were between 45-64, 225 (34%) were between 25-44, 89 (13%) were between 18-24, and 39 (6%) declined to answer.



Sex

The graph below shows that out of the 711 lockbox recipients who completed a Lockbox Data Collection Form, 361 (55%) of them were male, 251 (38%) were female, and 45 (7%) declined to answer.



Projected Outcomes (FY2024-2025)

- 1,000 Keep It Safe brochures distributed throughout the county.
- Two Lethal Means Safety trainings with 30 or more participants total.
- 650 lockboxes distributed.
- 450 Lockbox Data Collection Forms completed.
- 650 educational resources provided.

Challenges

While the program has provided many safe storage lockboxes and educational materials, many of the community-serving agencies we provided with lockboxes are likely still holding large numbers of supplies. The program was able to obtain a large number of lockboxes for the last fiscal year, which led to the program pushing out higher-than-average numbers to our community partners. While this is a success, the program must now wait for those partners to distribute the lockboxes among the people they serve before we can get survey data back from their final recipients. This is why, although the numbers for lockbox distribution are higher in FY23-24 than they were in past FY, the percentage of lockbox data collection forms received has dropped. For this reason, and the simple fact that when distribution happens through many channels, it is not possible to ensure 100% survey response, the projected outcome for lockbox data collection forms received for FY 24/25 was adjusted, down to 450 from 650.

Successes

Collaboration with firearm retailers continues to be a successful way to provide safe storage options and educational resources widely to the community. At the time of firearm purchase, firearm retail staff connected with customers about suicide prevention. They were able to have life-saving conversations, give safe storage options and provide

educational resources. Firearm safety instructors have continued to include suicide prevention education in their classes, one has even worked with the program to develop an advanced course for clinicians seeking to improve their safety planning efforts through expanding their knowledge of firearm safety and the firearm culture. The Lockbox Distribution Program expanded to include additional non-firearm retail, community partner agencies acting as distributors, increasing the reach of the project. The SVP Program now works with 96 total partners to distribute lockboxes throughout Humboldt County.

SVP was invited by a local concealed carry permit instructor to design a curriculum to meet the need created by a new (1/1/2024) law requiring all applicants for permits to carry a concealed weapon (CCW) to undertake 1 hour of mental health training. This training was designed to draw connections between the importance of mental health and the responsibility of gun ownership and includes significant information about suicide prevention. This information includes how to recognize suicide warning signs and clues, why safe and secure firearm storage is essential for suicide prevention, resources for having conversations about firearm security, and information about how to obtain secure storage devices for handguns from the Keep it Safe program.

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

Lessons Learned

Opening the Keep It Safe campaign to be a cross-agency safe storage effort has fostered a sense of shared vision and support for a variety of individuals and organizations. The efforts to align the lethal means safety work with the work of partner agencies allowed expansion of the program. SVP also learned that work with various partner agencies will proceed at differing rates, and the program must adjust its expectations about receiving feedback through the lockbox data collection form when working with community-serving agencies who do not distribute lockboxes with the same volume and regularity as the Gun Shop Project partners.

Project: Social Marketing and Educational Outreach

The ongoing social marketing campaign in Humboldt County aims to prevent suicide for residents of all ages. This initiative encompasses an online campaign and strives to

reduce stigmas, promote self-acceptance, and support individuals with behavioral health issues, addressing the adverse impacts of suicide and prolonged suffering.

Through educational outreach and tabling activities, the campaign seeks to inform, connect, and disseminate suicide prevention resources across Humboldt County. By participating in Farmers Markets, Health Fairs, and various community events, the program expands its reach to otherwise underserved populations, highlighting available behavioral health and suicide prevention services. The distribution of educational materials, event flyers, and training opportunities helps diminish mental illness stigma and enhances the recognition of early suicidal behavior signs.

Community-wide prevention initiatives are structured to educate the general public on identifying behavioral illness symptoms, accessing early detection and treatment resources, and reducing the stigma and discrimination associated with mental illness. Humboldt County will persist in coordinating local prevention activities focused on suicide prevention, stigma reduction, and improving access for underserved communities.

Target Population

- All Humboldt County residents will be reached with the social marketing, outreach, and tabling efforts.

Key Activities

- Promote local, state, and national resources through media and awareness month campaigns.
- Develop educational materials, media, infographics, brochures, resource lists, cards, etc.
- Distribute educational materials and resources at community events.
- Promote Humboldt County DHHS webpage.
- Develop, promote, and maintain Humboldt County DHHS Public Health Suicide and Violence Prevention Program Website.
- Coordinate awareness month events with community partners.

Communication Channels

- The Email messaging distribution list maintained educational connections made with training participants, direct service providers and the general community. Email content shared included state resources and other social marketing initiatives, promoted local PEI activities (including awareness months) and highlighted resources for behavioral health and suicide prevention.
- Public Service Announcements (PSAs) promoted social marketing campaigns and program objectives through local radio stations. PSA content included local state and national public health campaigns, such as Take Action for Mental Health, Know the Signs, lethal means safety, awareness month resources and messaging.

- The new SVP program website integrates Suicide and Violence Prevention programing. The main page has been published with sub-pages still in development. Content consists of programmatic activities, population specific resources, training promotion and public health information. Additionally, SVP content is disseminated though the main DHHS webpage and various social media platforms.
- Press releases for Suicide Awareness month were created to share community partner events and educational resources.

Marketing Content

- Media Campaigns and Toolkits: SVP strategies continued to promote statewide and local campaigns including “Know the Signs,” “Take Action for Mental Health,” and “Never A Bother.”
- Keep It Safe Campaign: This campaign has expanded outreach to audiences on the topic of safe storage of potentially dangerous items. The target audience is any and everyone in the community. Keep it Safe is about starting a conversation with Humboldt County residents about protecting loved ones from preventable injury. Keep It Safe addresses common items found in homes that could be dangerous such as medications, alcohol, firearms, and anything else that can be used to get high.
- Awareness Months: SVP will continue to collaborate with community partners on awareness month campaigns throughout the year. The intention will be to raise awareness on mental health, suicide prevention, and their intersection with various health disparities. Collaborative campaigns will include Suicide Prevention Month, Mental Health Month, Sexual Assault and Child Abuse, Domestic Violence Awareness Months

Outcome Measurements

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

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

Expected Outcomes FY2023/2024

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

Actual Outcomes (FY23/24)

- One thousand four hundred eighty-four (1,484) annual page views for DHHS SVP Program website.
- Six (6) different radio PSAs were aired, totaling 1,268 “radio spots.”

- Eighteen (18) educational or resource focused emails sent via MailChimp; an average of 168 unique opens per email sent; 6,345 total emails opened. Forty-seven percent (47%) of email subscribers are highly engaged and often open and click emails.
- Thirty-three (33) Educational Outreach events.
- Two (2) Media News Releases
- One (1) News Interview (Redwood News)

Projected Outcomes (FY2025-2026)

- One thousand five hundred (1,500) annual page views for the DHHS SVP Program website.
- Six thousand (6,000) total emails opened.
- Twenty (20) Educational Outreach events.
- One (1) or more Media News Release

Challenges

It remains a challenge to measure the reach and demographics of some social marketing activities. For example, radio stations provide their total audience and number of radio spots, but no data on how many people are listening during the time of the public service announcements. It is difficult to conclusively determine the total reach (contacts) by all campaign activities each year, though there is strong data to suggest that thousands were exposed to SVP program social marketing.

Due to projected decreases in staff capacity with the end of in-kind funding, SVP will shift to quarterly educational emails sent via Mailchimp. We have also paused radio PSAs in an effort to redirect funds towards more immediate program needs.

Successes

Despite the firewall that prevents many agencies from engaging with educational emails sent through bulk listserv, the average email open rate was 46%; an increase of 17% from the two years prior and, and nearly double the average for government which is 25.5%. Note, email open rate was calculated by dividing the number of unique emails opened by the number of emails sent – after deducting the number of bounces.

Using the Mailchimp landing page as an access point for subscribing to the email list and sharing information on program topics has increased community awareness and engagement. Materials that promote the Mailchimp landing page and listserv enrollment were used widely during Educational Outreach which increased the bulk mailer audience and the overall coalition engagement. A press release highlighting SVP Program winning the state ‘Striving for Zero, Suicide Prevention Excellence Awarded’ for work with local firearm retailers was released and picked up by local news such as Redheaded Blackbelt (click here to view), and Redwood News. A press release in honor of September as Suicide Prevention Month was also released. Staff capacity allowing for the SVP Team to

provide educational outreach at thirty-three (33) different events/locations broadening the reach of suicide prevention messaging and resource sharing. The approximate number of encounters at those events was 1,612 people.

Lessons Learned

Engaging in educational outreach is an effective approach to diminish the stigma around mental health, raise awareness about suicide, and highlight prevention initiatives. Conversations with locals sparked enthusiasm for training opportunities, sharing resources, and finding secure storage options for potentially dangerous items. Nearly doubling the educational outreach this year led to new and strengthened partnerships.

The program learned that it is important to estimate the number of youth who are engaging in the materials and discussion during educational outreach events. SVP will track those numbers moving forward.

Project: Postvention

Studies show that those who have recently lost someone to suicide are at an increased risk of dying by suicide themselves. Postvention are the interventions that take place after a suicide. Postvention includes the care provided to those left behind and is considered an integral part of a robust suicide prevention program. Coalition members determined what activities would be prioritized, including providing resources and care packages for loss survivors.

In FY 23/24, the Suicide Prevention Network (SPN) carried out those determined priority activities and held a postvention event where the community was invited to participate in the creation of “We Care” boxes. These boxes offer support and comfort to suicide loss survivors in Humboldt County, containing materials on grief after a suicide loss, local resources available for support, self-care items such as candles and tea, and hand stitched heart cushions. The SPN made it a goal to hold these events in different locations throughout the county, to ensure these boxes are accessible to those living in more rural areas. The first event took place at a family resource center in Southern Humboldt, which also acts as a hub for distribution of the boxes. The community was invited to help assemble the “We Care” boxes, engage in grounding exercises, and enjoy art activities. Fifty-two (52) boxes were made and have since been distributed to survivors of suicide loss.

Three staff members attended a grief support facilitator training, specifically geared toward supporting survivors of suicide loss. Since those who lose someone to suicide are at an increased risk of dying by suicide themselves, it is imperative that creating spaces for grieving and connecting be created. Using the skills learned, staff intend to offer drop-

in grief support groups open to anyone who is grieving a suicide loss around the county, bridging the gap in resources available to the newly bereaved.

Target Population

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

Key Activities

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

Outcome Measurements (FY2023/2024)

- Number of SOSL “We Care” boxes distributed.
- Number of Grief Support Trainings offered.

Expected Outcomes (FY2023/2024)

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

Actual Outcomes (FY2023/2024)

- Fifty-two (52) Survivors of Suicide Loss (SOSL) “We Care” boxes were assembled and distributed through the Southern Humboldt Family Resource Center and the Humboldt County Community Wellness Center
- Three (3) staff members attended a grief support group facilitator training.
- Twelve (12) hours of locally contracted Veteran Peer2Peer Project Development for Grief Support Group Facilitator Training

Projected Outcomes (FY2025/2026)

- Ten (10) SOSL “We Care” boxes to HCSO – Coroner's Office for distribution.
- Twenty (20) SOSL “We Care” boxes distributed to Community-serving agencies and/or directly to grieving community members as applicable, provided during various Educational Outreach events.
- One (1) Grief Support Capacity Building training serving ten (10) or more participants.
- One (1) 4-6 week session of drop-in grief support groups, open to anyone who is grieving a suicide loss around the county

Lessons Learned

Engaging the Suicide Prevention Network (SPN) in postvention activities, such as setting up We Care box events, has contributed to the project's funding and staffing needs. Hosting a We Care box assembly event in Southern Humboldt was possible due to collaboration with community partners, and there are plans to replicate similar events across the county. Although some staff members are trained to lead grief groups, additional resources are needed to adequately support the community.

Through postvention efforts, coalition meeting planning, and educational outreach, it has become apparent that there is a lack of services for those seeking both professional and informal support during their grieving process. While training traditional service providers is important, peer-led, community-focused support groups enhance accessibility and encourage more individuals to seek grief-related assistance.

SVP discovered that partnering with a local clinical expert in complex grief significantly enhanced the ability to meet community needs in postvention. The collaborating clinician, together with Eureka Veterans Affairs, a peer-led curriculum for grief support groups was developed. Veterans face suicide rates that can be up to six times greater than those of non-Veterans. The Veteran-Peer-led grief support model aligns with best practices and exemplifies a community-based participatory approach, where Veterans, as partners, contribute their expertise and share in decision-making and ownership.

Prevention & Early Intervention: Parent Partners

The Parent Partner Program's vision is to provide support, encouragement, assistance and hope to parents/caregivers who are feeling overwhelmed as they find themselves involved with a challenging _ child or adult-serving system. It is an early intervention program and provides access and linkage to treatment and other needed services. It meets the SB 1004 priorities of addressing childhood trauma prevention and early intervention in that it empowers caregivers to grow their knowledge, skill and confidence in caring for others with complex needs, resolve challenges to family well-being, and to successfully navigate complex helping systems. _Parent Partners develop and maintain a practice to _ provide peer-based support services to parents and other care givers as they encounter county child and adult-serving systems. Using strategic self-disclosure of their lived experiences as parents of a youth or family member with emotional, mental health or substance abuse needs, Parent Partners provide support as a peer, rather than an expert in the field. They help to create conditions for parents/caregivers to feel empowered and confident as they navigate these county systems, making decisions that are best for their family and determining their course of action based on their families' needs and goals. Parent Partners model effective personal interactions while supporting the development, reconnection and strengthening of natural supports for families. They serve as a mentor to improve parents/caregivers' confidence and ability to self-advocate for and effectively

manage the services and supports for their own family. They assist families to connect with community resources to increase their safety, stability and well-being. They empower families to identify their own future vision of what their family can be, what they need most to achieve this future, and how they can use their strengths and culture to get those needs met. The services of Parent Partners can contribute to meeting the need for additional services and supports for school age children.

The Parent Partner Program currently employs two full-time staff to provide supportive services to parents/caregivers involved in the DHHS systems of Child Welfare, and Behavioral Health, along with the Probation Dept. and Humboldt County Office of Education. In addition to on-going trainings, both Parent Partners have begun the process of becoming certified Medi-Cal Peer Support Specialists.

As part of the Parent Partner program structure, a Parent Partner III position is used to take on more responsibility for training and mentoring staff. There are currently recruitment efforts happening to fill this position to support this important program. The County continues to contract with a part-time Family Liaison/Mentor with lived experience and dedicated involvement in the National Alliance on Mental Illness (NAMI), who teaches Parent Partners “NAMI Basics” and “Family to Family” curriculum to enhance and develop peer coaching skills.

Target Population:
The target population includes any parent or caregiver of a youth or adult involved in a child or adult-serving system such as a Children’s or Adult Behavioral Health programs and Child Welfare Services .In addition, these services will impact the well-being of families which may include additional children and other natural supports.

Access and Linkage to Treatment:
Parent Partners offer assistance to clients and their families in navigating DHHS systems, linking them with community resources, building natural supports, and identifying needs, strengths, skills, and goals to promote family wellness. They support parents and other care providers to become confident and effective self-advocates in contexts that include dependency court and school systems. Parent Partners are often members of Child and Family Teams serving youth with intensive needs. Parent Partners build alliances with other departments and agencies including Probation and Child Welfare Services to assist parents/caregivers whose children have been made dependents of the juvenile court, or are currently in programs like probation’s New Horizons program, or may be placed out of county in a Short-Term Residential Treatment Program (STRTP). Parent Partners coordinate with the Children’s Mobile Response Team so that families with children in crisis are quickly offered support and resources. In addition, Parent Partners are co-facilitators at the County’s Family Advisory Board meetings and several NAMI peer support groups offered throughout the county. They are available to parents/caregivers of

children or adults receiving services within the Adult Behavioral Health system by being available to families and staff during visitation hours at the Sempervirens Psychiatric Health Facility. Finally, Parent Partners may help staff the DHHS Warm Line bringing their peer-based expertise to support community members seeking services or supports.

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

Expected Outcomes:
The Parent Partner Program reaches out through meetings, referrals, and support groups to an average of ten people per week. Outreach efforts are done primarily at Sempervirens (SV), Family Resource Centers, the Jefferson Community Center, and directly to families and caregivers in the community. Parent Partners are expected to attend various meetings within the DHHS system to provide the critical perspective of those with lived experience.

Parent Partners are expected to complete an opening, annual, and closing Parent Support Tool (PST) for each parent/caregiver served. Expected outcomes via the PST include:

1. An increase in the presence of the family's support system.
2. An increase in the acceptance of the family's support system.
3. An increase in the ability to be heard by service providers.
4. An increase in the ability to cope with stress.
5. A decrease in the impact of transitions.

How Outcomes are Measured:
The current outcome tool is the Parent Support Tool (PST). The PST should be completed at the beginning, annually, and at the end of services. The PST measures presence of the family's support system, acceptance of the family's support system, ability to be heard by service providers, coping with stress, transitions, impact, and timing. In addition to the use of the PST data from the CANS (Child and Adolescent Needs and Strengths), a state mandated reporting tool used with children and families, is included. While Parent Partners are not currently responsible for completing the CANS most of the cases that they are involved with should have a CANS attached to it. Currently there are 46 paired samples for children and youth served by a Parent Partners with both an initial and follow up CANS. Data shows no change in the overall number of actionable needs from initial to follow up CANS.

Estimated Number to be reached in FY 2025-2026:

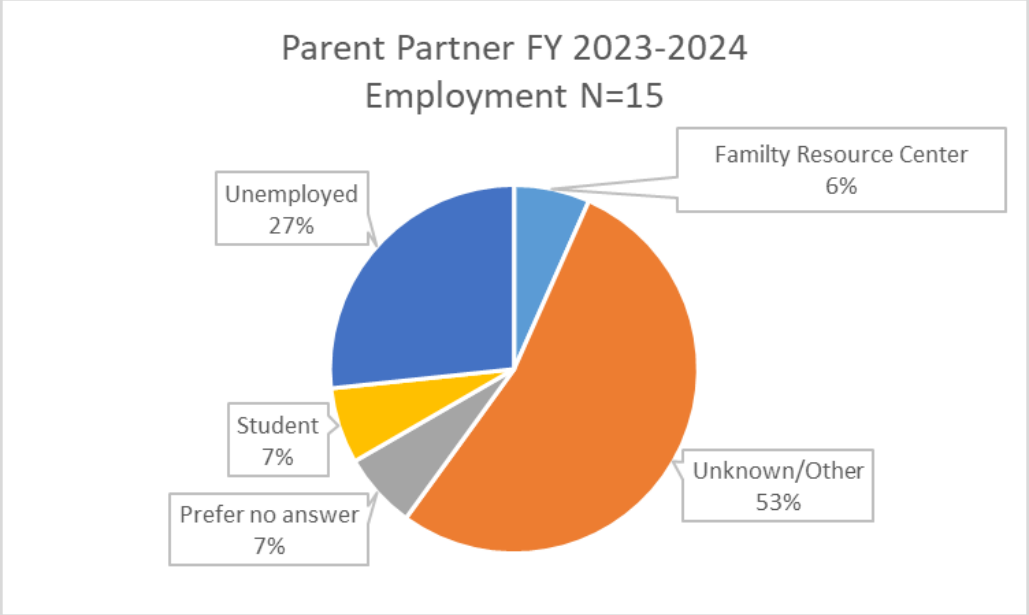
For the next year an estimated 70 new parents/caregivers will be reached either through a referral for services or attendance at a support group. The expectation is that all current and new cases will have a PST completed at the beginning, annually, and at the time of closure to services.

Report for Fiscal Year 2023-2024

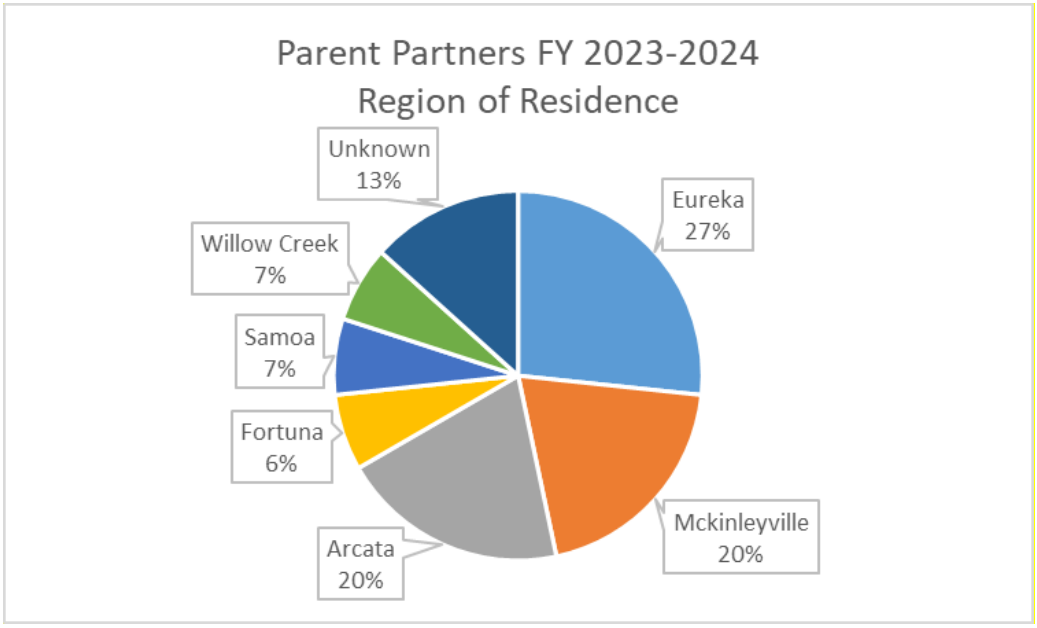
Unduplicated Number of Individuals Served:
For FY 23/24 the Parent Partners served 68 unduplicated families with 39 new referrals. Based on the 2023-2024 Revenue and Expense Report (RER), which outlines a total cost of $363,354.43 in MHSA funds, the average cost per client is estimated at $5,343.45.

Demographics of individuals served:

- 15 completed voluntary demographic forms.
- AGE: 12 clients indicated ages 26-59, 3 clients were age 60+.
- RACE/ETHNICITY: 9 White; 4 American Indian or Native American, 1 Multi-racial and I Prefer no answer.
- SEX AT BIRTH: 11 Female; 3 Male and 1 Not Answered.
- GENDER IDENTITY: 12 Female; 3 Male.
- SEXUAL ORIENTATION: 13 heterosexual/straight; 1 Bisexual; 1 preferred not to answer about sexual orientation.
- LANGUAGE: English was primary language for all 15 Clients.
- NON-MENTAL HEALTH DISABILITY: Two individuals have a preexisting non mental health disability.
- VETERANS: No clients were Veterans
- HOUSING: 10 have been homeless or lived on the streets; 5 answered no.
- MENTAL ILLNESS: 10 have been diagnosed with mental illness; 2 with undiagnosed mental illness, 1 preferred not to answer; 2 indicated No
- FAMILY w/ Mental ILLNESS: 12 have family members with diagnosed mental illness; 1 preferred not to answer; 2 indicated No.
- EMPLOYMENT: One Family Resources Center, 4 Unemployed, 1 Student, 1 Prefer no answer, 8 Unknown/Other.



- REGION of RESIDENCE: Four (27%) Eureka, 3 (20%) Arcata, 3 (20%) McKinleyville, 1 (6%) Fortuna, 1 (6%) Samoa, 1 (6%) Willow Creek, and 2 were Unknown.



Actual Outcomes for Fiscal Year 2023-2024

At intake, the Parent Support Tool showed:

- 47% report the Presence of the Family Support System “some of the time” and 41% report the Presence of the Family Support System as “very present.”

- 12% “feel accepted about many things” about their family support system,29% “feel accepted by all things” about their family support system and 59% feel judged by a variety of things” about their family support system.
- 24% feel that they are “likely to have some disagreements” with service providers while 47% feel “they will likely be understood and appreciated” by service providers. 29% feel “they are likely to be misunderstood” by service providers.
- 88% report that they have multiple stressors in their life.
- 41% will be facing 1-3 transitions and decisions within the next 60 days and 18% report 4 or more transitions.
- 59% of parents were given a score between 9-12, indicating the need for a moderate level of support and 29% were given a score between 5-8 indicating a need for intensive support.

There were not enough matched pairs to make for significant data analysis. Of the matched pairs analyzed all showed improvements in one or more PST categories including a positive decrease in their overall total score from intake.

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

PARENT PARTNER SERVICES FY23/24	#
Number of Individuals Receiving Services	68
Total Number of Services Provided	401
Total Number of Face to Face Minutes Provided	21,421
Average Number of Face to Face Minutes Per Service	53
Average Number of Services Per Client	6

Challenges:
In July 2023, Humboldt County Behavioral Health transitioned to using a new electronic health record, which required restructuring of previous data related reports to accommodate this change. As a result, data reporting between fiscal years 22/23 and 23/24 presents reliability issues between common reporting outcomes and changes to the reporting for service minutes. Service minutes is reported as Face-to-Face minutes only, whereas previous years reported this as Total minutes which included documentation and travel time.

Successes:
Despite the staffing challenges, an experienced and dedicated Parent Partner team continues to exist. Parent Partners have applied for state certification as Medi-Cal Peer

Support Specialists which will add another layer to their skill set and create more flexibility in their ability to bill for services. Parent Partners have developed a comprehensive on-boarding document full of resources and tools for peer-based services. These resources have already been invaluable in supporting the newest Parent Partners as they start their journey as a peer.

Lessons Learned:
Staff continue to come up with innovative ways to support one other and provide high-quality services to families with access to quality training and professional experience development, staff have continued to overcome the obstacles that staffing challenges have wrought. Parent Partners continue to be an integral part of the Specialty Mental Health Services that Humboldt County provides. The goal is to increase the staffing levels on this team and make this important service even more available in the community.

Prevention & Early Intervention: School Climate Transformation - Multi Tiered System of Support – MTSS

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

needs) in children and youth, while promoting social-emotional wellness for all students. It meets the SB 1004 priorities of childhood trauma prevention and early intervention, youth engagement and outreach targeting secondary school youth, and provides early identification of mental health symptoms and disorders.

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

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

The following core components are key aspects of MTSS frameworks:

1. High quality, inclusive academic instruction promoting comprehensive assessment systems, teaming, universal academic supports, and intensified interventions and supports focused on early intervention and prevention.

2. Systemic and sustainable change. MTSS principles promote continuous improvement processes at all levels of the system (district, school site, and grade/course levels). Collaborative restructuring efforts identify key initiatives, collect, analyze, review data, implement supports and strategies based on data and then refine as necessary to sustain effective processes.

3. Integrated data system. District and site staff collaborate to create an integrated data collection system for continuous systemic improvement.

4. Inclusive behavioral instruction. District and school staff collaboratively select and implement schoolwide, classroom, and research-based positive behavioral supports for achieving important social and learning outcomes.

5. Social-emotional learning (SEL) and transformational trauma informed mental health for all students using evidence-based methods.

6. Universal design for learning (UDL) – structural, multimodal, instructional practices promoting learning for all students. UDL learning environments are inclusive environments for students with a vast array of learning differences.

7. Family and community engagement to build trusting family and community partnerships.

8. Inclusive policy structure and practice by building strong district/school relationships with the coordination and alignment of multi-initiatives through district policy frameworks.

Target Population

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

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

School Based Mental Health Initiatives

The California Student Mental Health Implementation Guide LINK (a collaborative document by the California Department of Education, the Mental Health Services

Oversight and Accountability Commission, the California School Based Health Alliance, CalMHSA, and the California Mental Health Services Act) is “intended to support local education agencies (LEAs) and county behavioral health departments as they seek to partner to deliver comprehensive, high-quality school mental health services.” The document identifies the following school initiatives as aligned with comprehensive school based mental health and health care initiatives.

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

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

Key Activities

Key activities include technical assistance, teaming, and coaching. Explicit training in restorative practice/justice, classroom and behavior management, effective school teaming, inclusive discipline practices, trauma-informed instruction, cultural competency, threat assessment and crisis response, and aspects of wellness (student and staff). The MTSS domains that support the three areas of integrated instruction are:

- Administrative leadership, integrated educational framework, family and community engagement, and inclusive policy structure and practice.

Activities to strengthen these domains are many. Examples include working with a team on establishing inclusive discipline policies or working with administrators to support comprehensive strategies and leadership strategies. These are elements of lasting system change. Lasting change requires technical assistance and coaching to support transformative practice. Meaningful data sharing, administrative leadership, and teaming with staff participation are the primary elements of lasting systematic change. Engagement with districts will guide and support these important elements.

Outcomes to be measured

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

Outcome measures

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

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

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

Estimated numbers to be reached

With the CA MTSS Initiative there is a slogan that states, “equity in education, ALL means ALL.” And this underscores that all student groups are reached by comprehensive systematic practices. Data sources and analysis of these sources will demonstrate the reduction of intensive individualized intervention leading to special education referrals, mental health referrals, chronic absenteeism, and exclusive discipline actions. Students in need of intensive individualized interventions will be identified and served and will have the opportunity for pre-referral interventions to

promote success and inclusion. Culturally responsive community engagement will strengthen our educational and greater community integration – supporting robust avenues of engagement.

Below is the report component for fiscal year 2023-24, DataQuest California Department of Education:

There are approximately 17,355 students enrolled in Humboldt County public schools.

- White - 53.7%
- Hispanic - 21.3%
- Two or More Races - 10.6%
- Native - 8.7%
- Asian - 3%
- African American - 1%
- Pacific Islander - 0.5%
- Filipino -0.2%
- Not Reported - 1%
- English Language Learners - 7%
- Free and Reduced Lunch eligible students - 61.9%
- 31.1% are Chronically Absent (22-23, 23-24 data isn't available yet).

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

Based on the 2023-2024 Revenue and Expense Report (RER), which outlines a total cost of $103,240.98 in MHSA funds, the average cost per student is $5.95.

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

Outcomes are measured by CA Dashboard, EdData, SWIS (School Wide Information System), Special Education Referrals, Office Discipline Referrals, Chronic Absenteeism, Suspension/Expulsion, Staff and Community Surveys and Fidelity Measures of

Implementation. These will all be highlighted by individual districts for Phase Two of scaling-up MTSS efforts.

Historical Highlights:

How Covid impacted education

From the beginning of school closures in March of 2020 - and for many local districts until the Spring of 2021 this has been an exceptionally challenging year for students, school staff, families, and the community at large. Never in our recent history have schools been so challenged to meet social-emotional and academic needs.

A silver lining of the pandemic for all of civilization has been technology, and the educational system was among the benefactors of the ability to remain connected. Of course, the challenge was immense – from connectivity to chronic absenteeism to simply not participating and having the computer camera off. All potentially indicating a myriad of conditions – inequity, poverty, or potential mental health concerns. Schools locally and across the country witnessed an increase of student risk from non-participation to suicidality. The American Academy of Pediatrics reported suicidal ideation 1.6 times higher in March and July of 2020 compared the same months a year prior (published 2020). The authors say that hospital visitations were reduced during COVID, so the number is likely an underestimation.

During the 2020-21 academic year the Humboldt County Office of Education established a new department – Prevention and Intervention Services. The department consists of a director and two Prevention and Intervention Specialists. One of the Prevention and Intervention Specialists is a shared position with the Department of Health and Human Services. The onboarding process of a new department during distance participation, while interesting, was highly successful. At the beginning of the 2021 academic year the department welcomed a third Prevention and Intervention Specialist for Early Childhood Mental Health, as well as the Nutrition Department. The growing department is a testament to the organizational commitment to student wellness.

Below is a summary of the Prevention and Intervention Department:

In 2015 the Humboldt COE moved to systemically support our 31 rural school districts with the establishment of the Northern CA MTSS Coalition (Multi-Tiered System of Support). Preceding CA MTSS (SUMS) by a year – the statewide initiative between California Department of Education, the SWIFT Center/University of Kansas, Orange County Department of Education, and Butte County Office of Education – the Coalition was informed by best practice intervention with the vision of providing districts tools and assistance toward improving the outcomes for all student groups. Humboldt County is challenged, tied with Mendocino County, with the highest rate in the state of Adverse Childhood Experiences (ACEs) per capita, some districts have special education rates double the state average, in addition to high suicide and homicide rates. These and other social challenges reside in the majesty and vibrant beauty that is the North Coast of California.

In 2016 HCOE assumed the lead for Region 1 of the CA MTSS (SUMS) and became a leader for technical assistance with the scaling-up of MTSS. MTSS being a framework organizing behavioral, academic, and social-emotional instruction and intervention. As the state recognizes – systemic change promoting responsive and effective early intervention in equitable and inclusive learning environments, not only improves student outcomes, but embraces the whole-child and ultimately improves quality of life for the individual as well as the community at large.

In response to district need and state and national recommendations, HCOE established Prevention and Intervention Services to work across departments within the organization, as well as leveraging resources with local community agencies, native entities, and statewide partnerships – all to strengthen and align the organizational ability to best serve districts, students, and their families.

Integrated mental health services, effective academic instruction, PBIS (Positive Behavior Intervention and Supports), inclusive discipline practices/Restorative Practices, Social-Emotional Learning, UDL (Universal Design for Learning), anti-racism support, and Inclusion are the drivers of the collaborative efforts. Attached is a summary of collaborative activities that HCOE has engaged to support local districts with the shifting educational priorities and initiatives.

Current Activities

In the 2020-21 academic year, HCOE in partnership with the Department of Health and Human Services (DHHS) and Project Cal-Well committed to strengthen and increase the organizational capacity to assist districts with the scaling-up of Multi-Tiered System of Support (MTSS) fidelity of implementation. The Prevention and

Intervention Department (P&I) was established this academic year (2020-21) – with 3 FTE team members – a Coordinator of the department and two certificated Prevention and Intervention Specialists. This increased capacity created an opportunity for districts to engage in training, coaching, and technical assistance for continuous improvement of school climate transformation.

With a focus to become a regional leader and resource in the north state, we have partnered with state leadership to build capacity. HCOE has partnered this year with the Placer County Office of Education/CA PBIS Coalition to adopt an established research- based scope and sequence of PBIS district implementation support. The P&I Department has completed tier one of the trainer of trainer model (ToT), and engaged three districts with training for PBIS Tier 1 implementation. Additional districts will move through tier 1 training next year, as the cohorts from this academic year will move into the tier two scope and sequence.

The P&I Department is also in partnership with the Placer County SELPA and working closely with three local districts with coaching and district support for implementation of Universal Design for Learning (UDL). Other additional capacity building activities include; coaching one of the 20 awarded districts in California that was awarded the Phase 2 grant to support district-wide training in CA MTSS with Orange County Department of Education, both specialists are trained as School Wide Information System (SWIS) facilitators, both specialists are becoming licensed trainers with the International Institute for Restorative Practices (IIRP), and we are working with Sacramento Department of Education and CalHOPE by scaling-up district support to scale-up Social Emotional Support Learning (SEL). District SEL “champions” are receiving stipends to build implementation and sustainability plans for the implementation of SEL and participate in the Community of Practice (CoP) with the important focus on adult SEL as well. The P&I Department launched this year the North Coast Service Providers Consortium (NCSP) with the focus of building relationships with county agencies, tribal entities, and school personnel with the goal of better understanding resources and services available for children and families in our rural county. The SEL regional support also includes a North State SEL CoP that consists of COE leaders who meet monthly to share resources and strategies for district support in rural California.

Other priorities of the P&I department include exploring sustainable models of mental health access for all students, suicide prevention and postvention, systematizing and coordinating crisis response for districts, and building international learning opportunities for tribal students and families (in partnership with a university in Taiwan).

Prevention and Intervention Services – HCOE – Primary Initiatives 2023-24

Positive Behavior Intervention and Supports – PBIS – PBIS, the most widely researched and endorsed behavioral education framework is a nationally recognized practice to support student outcomes.

Some exciting changes for the 2024-25 year with PBIS is, given the expanded FTE capacity (with the addition of a dedicated 1.0 FTE Prevention and Intervention Specialist) for technical assistance and coaching, that the P&I Department has engaged cohorts of districts to do a "deep dive" of PBIS implementation. In the 2024-25 year we will be embarking with our fifth cohort of PBIS training/implementation. Each cohort participates in a state endorsed scope and sequence led by Placer COE and the CA PBIS Coalition (CPC). An additional advancement of this important evidence-based framework promoting mentally healthy school communities, is that HCOE has become a technical assistance (TA) center for CA PBIS for Region 1 (Sonoma, Lake, Mendocino, Humboldt, and Del-Norte). Additionally, the P&I Department sits on the executive committee of the CPC. This not only promotes improvement of cross county collaboration, but it brings resources to the department to further program systematic efforts to improve and increase PBIS implementation.

CAMTSS (see definition below) in partnership with Placer COE is leading the CA Integrated Supports Project (ISP) which is part of CAMTSS. The primary target of this initiative is to integrate social emotional learning (SEL) into the tiered interventions of PBIS and to integrate SEL into systematic supports. Humboldt County is one of six counties statewide engaged in this work.

Universal Design for Learning – UDL – UDL is an equitable and inclusive educational practice that promotes access to learning for all student groups. With a focus on multi-modal instruction and expression of competency, it promotes the curriculum that teaches across the spectrum of learners opposed to the traditional approach of teaching to the average and then providing modifications for those who excel or struggle.

Prevention and Intervention Services, in partnership with the Humboldt/Del Norte SELPA, and the Placer County SELPA, are providing training, technical assistance, and direct coaching to teachers.

Supported by Educator Effectiveness Funds to provide stipends for teachers, HCOE in partnership with the Humboldt Del-Norte SELPA and Placer County SELPA has launched a multi-year project – the Humboldt County UDL Consortium. The goal is to create well trained champion teachers implementing UDL in their classrooms. Participating districts target partnerships between special education and general education teachers – and with TA and Coaching – create model classrooms in Humboldt County. This network approach is to create a collaborative of highly trained teachers that in turn become UDL coaches for additional teachers engaging the process over the next five years. Curriculum being used is Open Access training which is an evidence-based curriculum endorsed by the state of CA.

Social Emotional Learning – SEL – An increasingly endorsed and recognized domain of education is social emotional learning. Research indicates adult SEL is an essential practice to equip teachers to best serve their students. In partnership with Sacramento COE Community of Practice - CoP (CalHOPE/FEMA SEL initiative), the North State SEL CoP (a consortium of rural CA COE leaders), and local districts (the Humboldt County SEL CoP). HCOE is leading district champions of SEL with technical assistance and support as districts work to scale-up the implementation of social emotional learning. The vision is to promote staff, student, and community wellness by promoting “mentally healthy” learning environments. HCOE has led districts through training experiences that address COVID related anxiety and community impact, the importance of self-care, student intervention approaches, equity in education, and universal screening for mental health needs.

The program has completed the CalHOPE 2.0 as well as the first year of CalHOPE 3.0 is currently beginning the second and final year of CalHOPE 3.0 and continues to support the previously identified “focal schools” from Phase Two (CalHOPE 2.0). This initiative, under the direction of CA Department of Education and Sacramento COE, is leading the scope and requirements of this work to improve SEL. The identified schools are Captain John Continuation School (KTJUSD), Freshwater Elementary School (Freshwater School District), and Miranda Junior High (SHJUSD). These schools were supported with TA and fiscal support through CalHOPE 2.0. Several staff members from local districts participating in CalHOPE were invited to attend the CA PBIS Conference in Oct. 2023 (for the second consecutive year). Kelvin, a data collection service, is offered through CalHOPE 3.0 funding to all California schools at no cost. Kelvin will allow school districts to get almost immediate survey results of students, parents, and staff’s perspectives. A success of the CalHOPE efforts included Klamath-Trinity Joint School District implementing Kelvin to collect major stakeholders’ perspectives. A major emphasis continues to be on building adults’ wellbeing and mental health. Professional development offerings include the Humboldt County SEL

CoP, which shares turnkey activities and evidence-based social and emotional learning opportunities.

HCOE hosted the Redwood Coast Mental Health Symposium in May 2024, which was largely attended by local community members and agencies, highlighting the importance of well-being and mental health, specifically including SEL. This was a collaborative effort with DHHS, UIHS, Two Feathers, Centro de Pueblo, and the Humboldt-Suicide Prevention Network.

CA MTSS – HCOE continues to work closely with the CAMTSS. We remain the Region 1 lead for CA MTSS and provide TA and Coaching to regional coach's meetings (this activity brings revenue into the department and makes Humboldt COE among 18 lead agencies for MTSS support in the state. In the past year CA MTSS has launched Phase 3 of district support. While we continue supporting all phases of the initiative, Phase 3 is furthering the targeted intent of Phase 2B.

Phase 2B, like Phase 3, incentivizes districts to participate in the CAMTSS Pathway Course Modules. Currently South Bay School District, and Loleta School District are participating in the Pathway Course. Teachers and school personnel receive stipends to participate in the Pathway Course. Originally, other local districts applied and rescinded their awards because administration and teams felt that the ask was too much – that 90% of the district staff would participate in the modules – which averages 40-60 hours of rigorous online training. CAMTSS in response to this common statewide response changed their expectations and districts appear more willing to consider engagement in this professional development opportunity.

Restorative Practices – RP – in 2022 HCOE increased their team to four certified trainers with the International Institute for Restorative Practices (IIRP) and is the lead COE in the newly established Restorative Educators Network (REN). In 2022 REN became a recognized group by the CA Department of Education and is housed on the web platform CA Educators Together. This growing network, in partnership with HCOE, Butte COE, and Orange County Department of Education, has had a presence at conferences and continues to work to bring restorative practices to CA public schools and agencies. Conference presentations have occurred at the Association of Positive Behavioral Support (APBS), the Professional Learning Institute (PLI/CAMTSS/OCDE), and the CA PBIS Coalition Conference (CPC).

HCOE has trained hundreds of educators in Humboldt County in Restorative Practices and continues to partner with National Chung Cheng University in Taiwan to advance the global movement of Restorative Practice in Education. IIRP training includes

Introduction to Restorative Practices/How to Run Circles Effectively, and Restorative Conferencing (an inclusive discipline practice in place or in lieu of Suspension/expulsion). Additionally, the Prevention and Intervention Department provides abbreviated district training, as well as onsite coaching and support to districts. Active partnerships exist with neighboring Del-Norte COE, and Juvenile Hall/Probation. REN, which was launched this summer to support Restorative Practices in education nationwide.

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

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

CA-Integrated Supports Project (CA-ISP) - HCOE is participating in the Partner Entity Grant awarded through the California Department of Education, CA-ISP. The purpose of the grant is to provide funding for high-quality, professional learning to educators in SEL; trauma-informed practices; and culturally relevant, affirming, and sustaining practices, all in a manner that aligns with CA MTSS. HCOE is one of the PBIS Regional Technical Assistance Centers supporting in the delivery of this project. CA-ISP is designed to enhance CA MTSS which features a continuum of support for inclusive academic, behavior and SEL/mental health instruction and interventions. CA-ISP utilizes 14 modules through 5 domains: Identity, Supportive Environment, Voice, Situational Appropriateness, and Data for Equity/Implicit Bias**.** HCOE currently engages three school districts within Humboldt County, and two districts in neighboring counties with this work. Humboldt COE continues to be the lead county in Region One providing technical assistance and coaching for the CA-ISP.

Integrated Mental Health Services – In partnership with the Department of Health and Human Services, the Humboldt/Del-Norte SELPA, and local district leaders, HCOE is engaged in the important work of establishing integrated mental health access for all students. This collaborative shared vision has developed over years of collaborative partnership, and the current grant funded Humboldt Bridges to Success program. The advisory committee is exploring sustainable funding models and working to a model

of Integrated Systems Framework (ISF) to promote integrated mental health for the students of Humboldt County.

Student Behavioral Health Incentive Program (SBHIP) the link provides information on a new $389 million statewide initiative administered by the California Department of Health Care Services (DHCS) to allow school districts to partner with county behavioral health and Medi-Cal managed care plans to expand access to school-based mental health services. 2021-22 Marks the beginning of the assessment period for SBHIP. Community partners are providing input and include:

- Department of Health and Human Services, County Behavioral Health
- Department of Health and Human Services, Public Health Branch
- Two Feathers Native American Family Services
- Cal-Poly Humboldt Social Work Department
- Humboldt/Del-Norte SELPA
- Humboldt Independent Practice
- Partnership Health Plan, managed care plan.
- Three LEAs
    - Court and Community School
    - Southern Humboldt Joint Unified School District
    - Peninsula School District

The objectives of SBHIP are to break down silos and increase access to school-based mental health for all students in Humboldt County. The Prevention and Intervention Department is leading this effort for the COE in deep engaged partnership with community agencies and Partnership MCP. Additionally, DHHS/HCOE are partnering to create a new position – a Braided Funding Analyst – this position will be dedicated to creating and identifying sustainable funding models and practices to support school-based mental health. Providing mental health training to schools has been an area of focus and both Be Sensitive, Be Brave for Mental Health and Youth Mental Health First Aid have been offered on a monthly basis throughout the 2023-24 school year.

Humboldt Bridges to Success Transferring to Humboldt Bridges to Wellness

Humboldt Bridges to Success, which was funded via the Mental Health Student Services Act (MHSSA) grant, ended in June of 2024. HCOE Prevention and Intervention is working closely with DHHS Children's Behavioral Health to continue this collaborative work - as a reimagined program, Humboldt Bridges to Wellness. Grant funding has been secured by HCOE to fund and hire Holistic Wellness Coaches (formerly called Student Service Navigators), and collaborative funding models are being explored to expand the clinical services for school based mental health support. The Department of Health Care Services (DHCS) and the Children and Youth Behavioral Health Initiative are engaging a statewide mental health support program with a significant funding opportunity with the Multi-Payer Fee Schedule where school

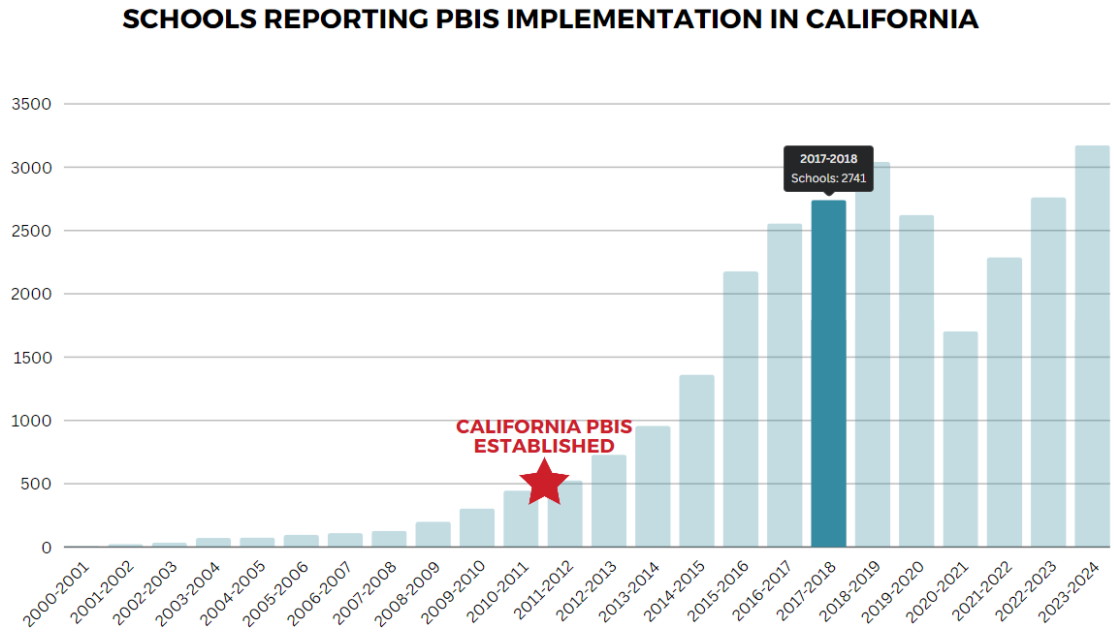
providers will be able to bill Medi-Cal as well as private insurance to provide an opportunity for sustainable funding.

PBIS/MTSS in Humboldt County

HCOE has built the capacity, over the past six years, with the partnership and support of DHHS and the Prevention and Early Intervention (PEI) funding support. At first fiscal support helped create the Northern CA MTSS Coalition, and then when the Prevention and Intervention Department was launched in 2020, the joint funding of 1.0 FTE Prevention and Intervention Specialist. With a department that includes two P&I Specialists, an Early Childhood Mental Health Specialist, a School Safety Director, and the Foster and Homeless Youth Team – the department is growing to match the significant need of the county.

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

In the fall of 2020-21 the Humboldt County Office of Education initiated a cross-county collaborative effort with the Placer County Office of Education with affiliation with the California PBIS Coalition. Under the direction of Michael Lombardo, PCOE/CAPBIS is the state leader for assisting districts with PBIS implementation. The graph below depicts the growth of PBIS in CA (implementation by school).



The goal of partnering with the CA PBIS Coalition is for HCOE to become a technical assistance center for the North State of California. As part of this effort, the Prevention and Intervention Team identified an initial first cohort (South Bay School District), a second cohort (Freshwater School District and Cutten/Ridgewood School District), a third cohort (Southern Humboldt Joint Unified School District), a 4th cohort (Peninsula and Trinidad School Districts) and a 5th cohort (Eureka City Schools District and Scotia Elementary School District) to work toward PBIS with a “deep dive” of PBIS implementation and fidelity. The CA PBIS Coalition and Placer COE have established a scope and sequence training sequence for district and site level teams. This requires a Commitment and Readiness Agreement between a district/school site and the COE to assure that the participating district is prepared to move through the three-year training series. Each year consists of four one-day trainings (year one focuses on Tier 1 universal interventions, year two focuses on Tier 2 focused group interventions, and year three on Tier 3 highly individualized intensive interventions). This systematic stepwise evidenced-based approach to systematic change will afford our county the opportunity with local demonstration schools to model implementation and have outcome data to illustrate the importance of systems change that supports equitable educational learning for all student groups. Freshwater School District, who was trained and coached in Tier 1 and Tier 2 PBIS implementation, has received the CA PBIS Gold Implementation Award.

For this 2023-24 Annual Report, a district highlight will illustrate the level of support provided by HCOE and the P&I Department – a deep dive:

Southern Humboldt Joint Unified School District

According to the 2023 CA Dashboard Southern Humboldt Joint Unified School District has an enrollment of 708 students. 66.8% are socioeconomically disadvantaged, 7.3% are English Learners and 0.6% are Foster Youth. Great efforts have been made by this district over the past years to engage in many initiatives of school climate transformation. The district has engaged in training, technical assistance and coaching supporting various state initiatives such as; CAMTSS, PBIS, Restorative Practices, and Social Emotional Learning (SEL). As well as numerous professional development opportunities focusing on trauma-informed practices and student belonging.

<u>Data presents a need to scale-up support:</u>

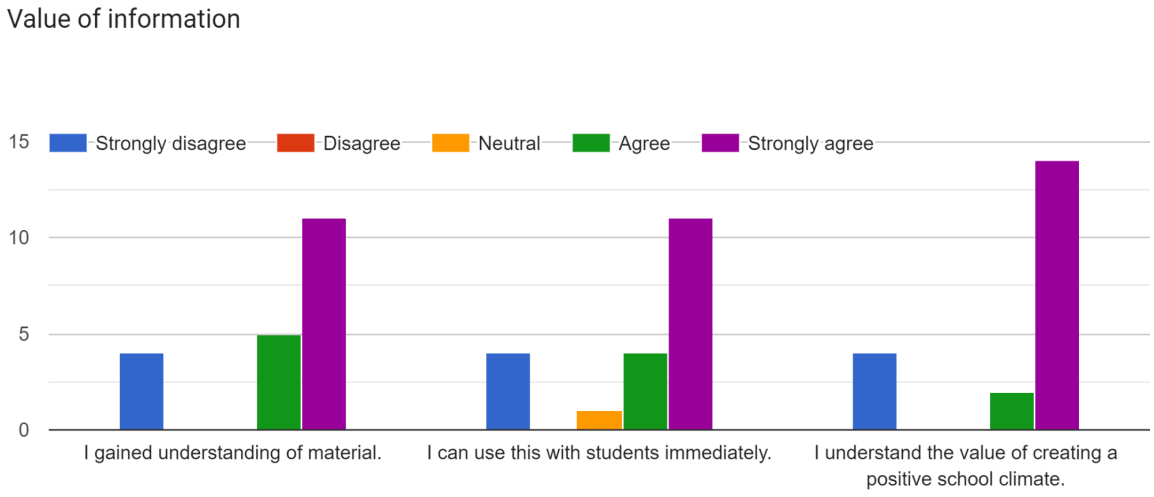
Below are data points for the Southern Humboldt Joint Union School District (SHJUSD).

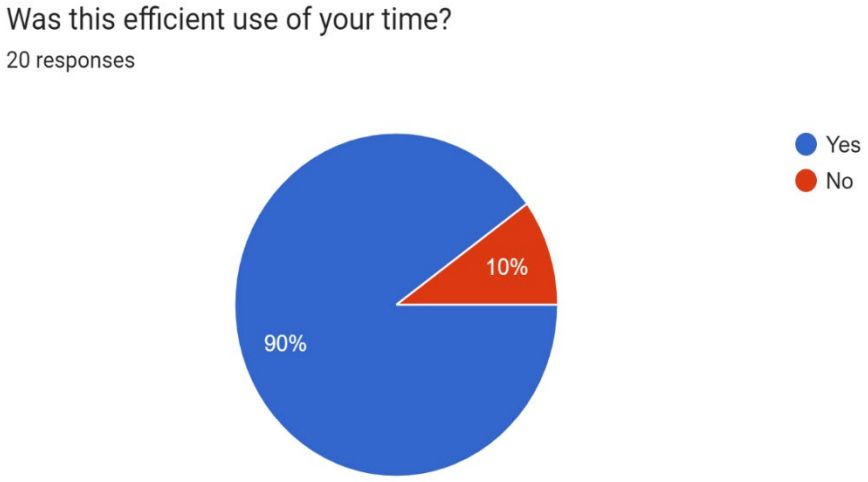
Indicator	2022-23
Chronic Absenteeism	53.2%
Suspension Rate	7.1%
Expulsion Rate	0%

In addition to the data presented above, in 2023/24, of the entire enrollment of Southern Humboldt JUSD: 69.6% qualify for free and reduced lunch (23/24), 7% are English Language Learners, 2.9% qualify as Foster Youth, and 10% experienced homelessness.

Southern Humboldt Joint Unified School District has engaged in the following initiatives to improve student outcomes and support staff and the community.

- Districtwide Pre-Service Professional Learning Opportunity- Four full trainings of professional development were offered, and paid, to all district employees at the beginning of August 2024, prior to the start of the school year. This training was focused on supporting positive school climate, with an emphasis on CAMTSS, including all three Whole Child Domains, academic, behavioral, and SEL. Three days of this training was facilitated by a P & I Specialist. Approximately 30 staff members attended.





- PBIS – technical assistance and professional development with positive behavior interventions and supports to improve school climate and teach and reinforce prosocial and pro-academic behaviors. Southern Humboldt JUSD has completed PBIS Tier I training with additional support provided including coaching and technical assistance by the Prevention and Intervention team at HCOE. While they are continuing to develop and strengthen their Tier I universal supports district wide, one of their schools, Miranda Junior High, has quickly implemented a solid Tier I infrastructure and are making significant progress and efforts in their PBIS team and system.
- Restorative Practices – Southern Humboldt Unified School District participated in a Restorative Circles training in May 2024. There were over 75 participants that moved through the training which was focused on building community and creating a sense of belonging.
- Restorative Educators Network (REN). In collaboration with Humboldt COE, Butte County COE and Orange County Department of Education, the Restorative Educators Network was formed in 2021. The purpose is to bring together a community of educators across the state, dedicated to promoting restorative practices within their educational settings. REN provides a space for educators to collectively share ways to create more equitable and inclusive learning environments and address conflicts in a constructive way.
- Social-Emotional Learning (SEL) -Miranda Junior High has partnered with HCOE's Prevention & Intervention department as a "focal school" for a 2 year grant through CalHOPE. Miranda Junior High has developed a SEL leadership team, which met monthly with the charge of supporting and guiding transformative social and emotional learning in their students, staff, and school community. Their SEL leadership team has been working closely with the P & I team for technical assistance, as well as providing on-going coaching support.

Technical assistance by the P & I team was provided on a monthly basis at the SEL Leadership meetings, including training on building relationships, connecting with students and colleagues, CASEL's five competencies of SEL, and team development. All of Miranda Junior High's staff participated in a monthly Humboldt County SEL CoP to continue exploring resources and networking with other local educators.

- Mental Health- Southern Humboldt JUSD has been trained in Be Sensitive, Be Brave for Mental Health (BSBB). BSBB is a mental health training focused on cultural differences and the potential impacts of culture on mental health. This training supports educators and community helpers to be better trained to recognize signs and symptoms of mental health struggles, as well as the differences between everyday stress and mental health conditions.

Lessons learned from 2023-24

With the work with PBIS, RP, SEL and SBHIP – what is clear is that more than ever the need for positive school environments require access to social emotional learning and school-based mental health supports. This is a priority of CA which requires collaboration, vision, and especially in rural CA – shared responsibility to deliver support that is impactful and lasting. The P&I Department and HCOE are grateful for the collaborative opportunities ahead and are committed to pursue sustainable funding models to increase our collective capacity to improve and increase our county capacity to offer mental health support to all student groups. The support and partnership we have with DHHS and the support provided through PEI funding support has greatly improved our ability to expand and improve the support we can provide our local school districts. We look forward to future collaborations for many years to come.

Prevention and Early Intervention: Local Implementation Agreements

In response to stakeholder input, in January 2019 DHHS-BH created a system in the form of Local Implementation Agreements that utilizes Prevention and Early Intervention dollars to allow local organizations to submit a project proposal with the goal of receiving funding through a professional service agreement. Proposals are required to meet the guidelines, definitions and reporting requirements of the MHSA Prevention and Early Intervention Regulations, including having a focus on at least one of the following categories:

•Early Intervention
•Outreach for Increasing Recognition of Early Signs of Mental Illness
•Prevention
•Access and Linkage to Treatment

•Stigma and Discrimination
•Suicide Prevention

Local Implementation Agreements can address any of the SB 1004 priorities, depending upon what is approved for funding in any given year. Past projects have focused on culturally competent and linguistically appropriate prevention and intervention; strategies focusing on the mental health needs of older adults; youth outreach and engagement; and suicide prevention programming.

During fiscal year 2023-2024, a total of 769 unduplicated clients were served by projects funded in-part by LIAs. Based on the 2023-2024 Revenue and Expense Report (RER), which outlines a total cost of $111,195.47 in MHSA funds, the average cost per client is estimated at $144.60.

LIA Project Reports for FY 2023-2024
In fiscal year 2023-2024, five local organizations received a Local Implementation Agreement. Below is a brief description of the projects along with their corresponding data and project outcomes:

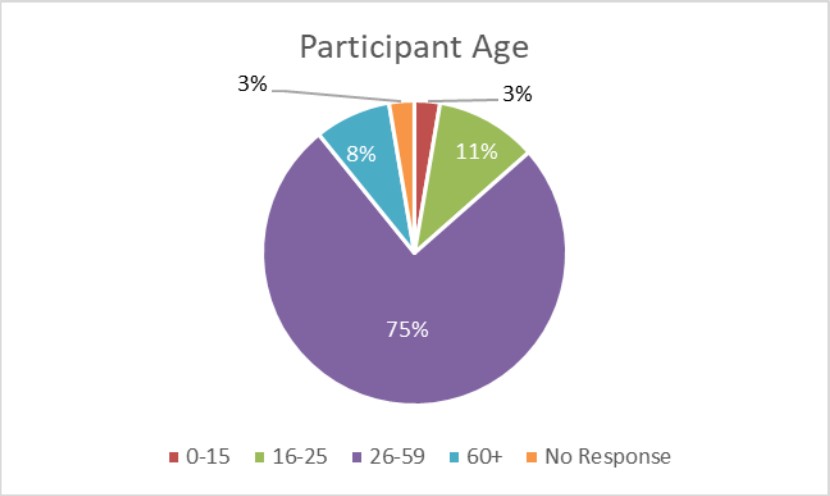
Bear River Band of Rohnerville Rancheria, *Mental Health Outreach and Awareness in Native Communities*.
The Bear River Band hosted a total of 4 outreach events meant to provide community members with learning opportunities on mental health and resources. This project meets the SB 1004 priority of providing culturally competent prevention and early intervention services.

All activities for the project took place at the Bear River Tish-Non-Community Center in the form of resiliency events. The first event was used to collect trends/perceptions people have in regard to mental health needs, which then was utilized to dictate how the other three events were organized. In total, 37 people attended the outreach events. The four resiliency events were:

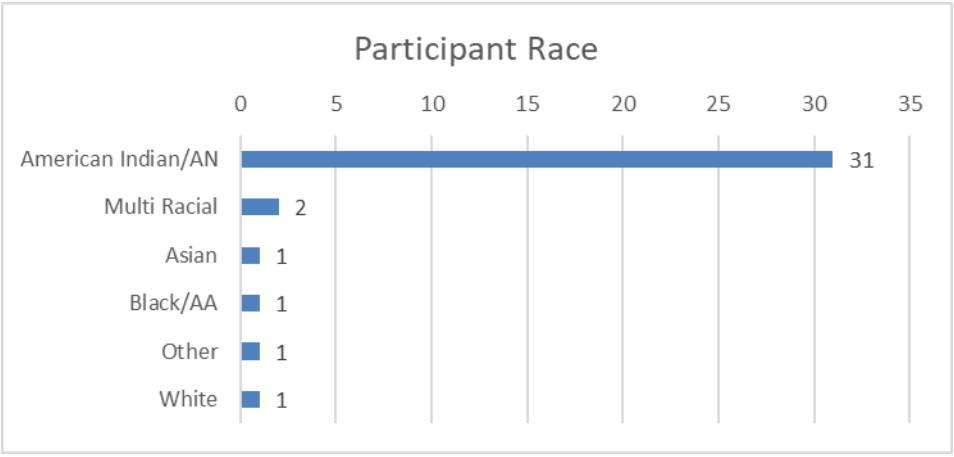
1) A kickoff event: used to capture community input for the next three events.
2) NarCan: the communal nature of the event was important to boosting mental health, as was the subject matter in that opioid death prevention is important to maintaining a strong and resilient community.
3) Grief
4) Suicide Prevention

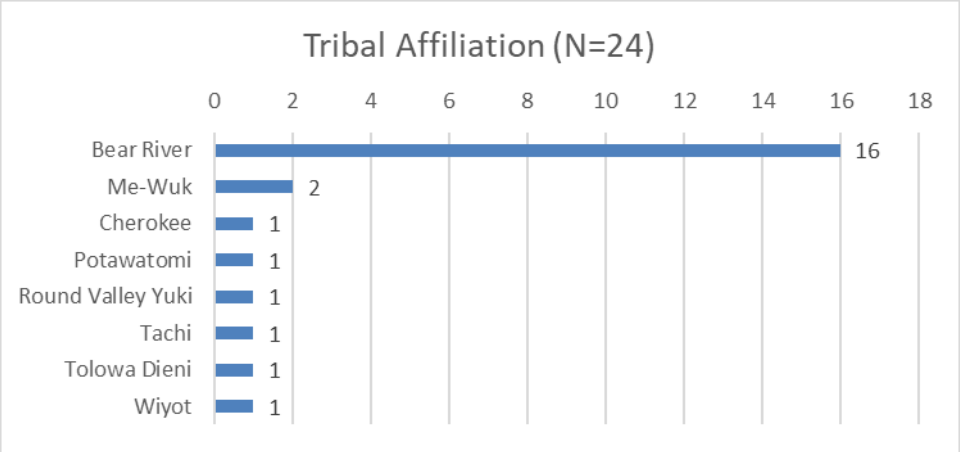
Demographics

As shown on the graph below, out of the 37 people that attended the events, 3% reported being between ages 0-15, 11% between 16-25 years of age, 75% between 26-59, 8% as 60+, and 3% of people did not provide their age group.

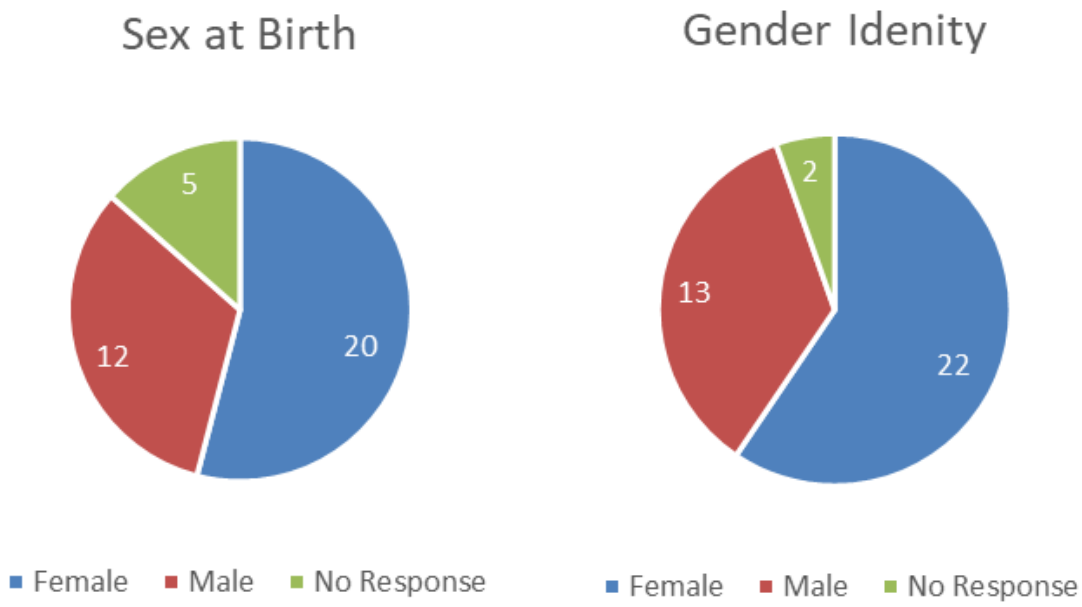


When it comes to participant race, 31 attendees identified as being American Indian/Native American, 2 as multi-racial, 1 as Asian, 1 as Black/African American, 1 as other, and 1 as White. Out of the 31 attendees that identified as American Indian/Native American, 24 shared their tribal affiliation. 16 identified an affiliation with Bear River, 2 with Me-Wuk, 1 with Cherokee, 1 with Potawatomi, 1 with Round Valley Yuki, 1 with Tachi, 1 with Tolowa Dieni, and 1 with Wiyot.

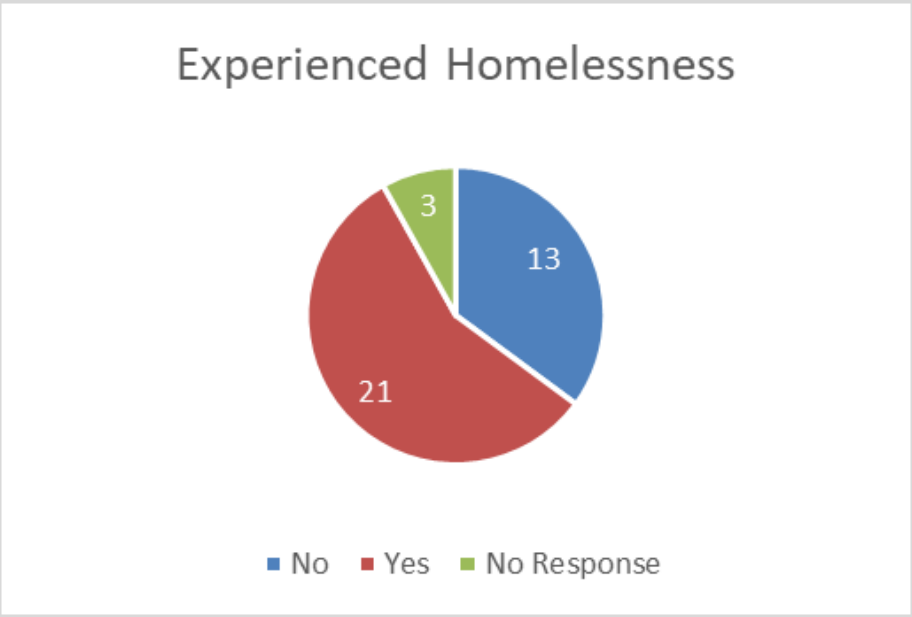




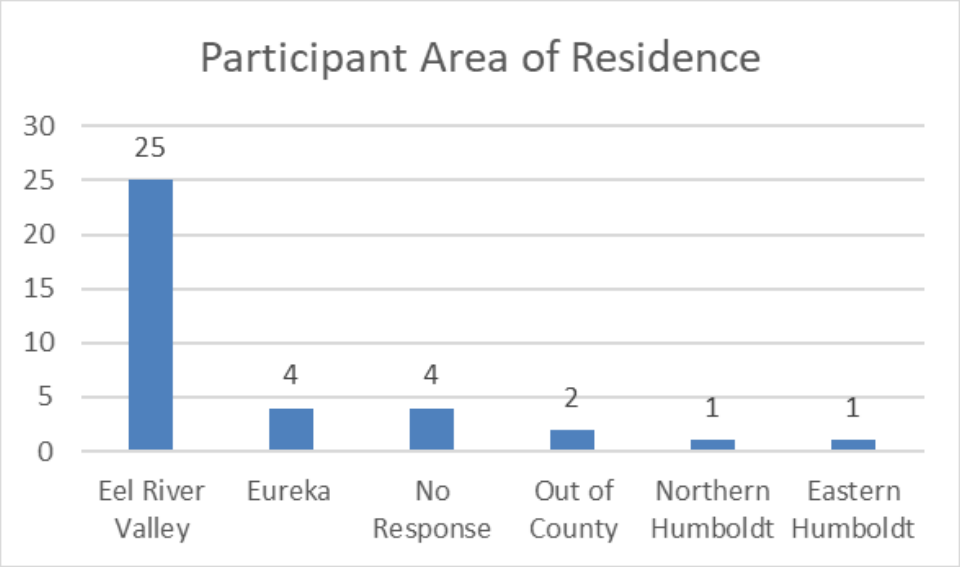
Out of the 37 event attendees, 20 reported their sex at birth as female, 12 as male, and 5 did not respond to the question. When it comes to gender identity, 22 identified as female, 13 as male, and 2 preferred not to answer to the question. For sexual orientation, 4 participants identified as being bisexual, 26 as heterosexual/straight, and 7 prefered not to answer.



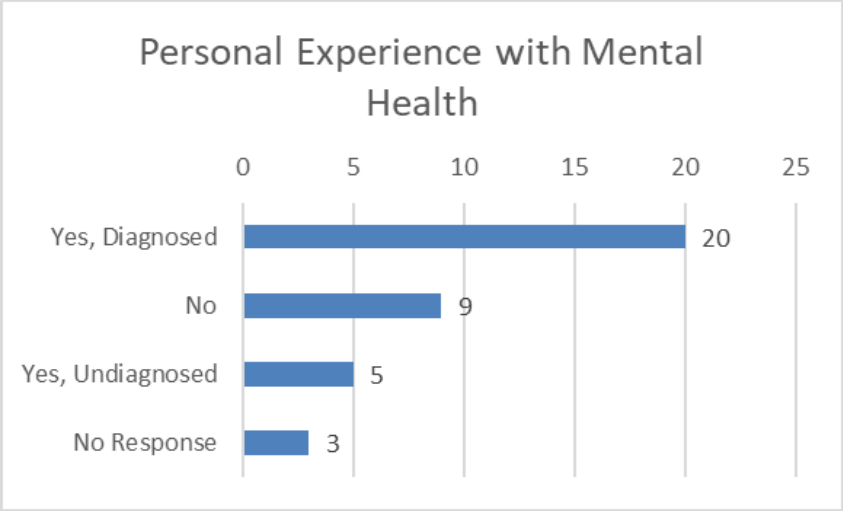
As for homelessness, 13 of the participants reported to not have experienced homelessness, 21 did experience homelessness, and 3 participants did not respond.



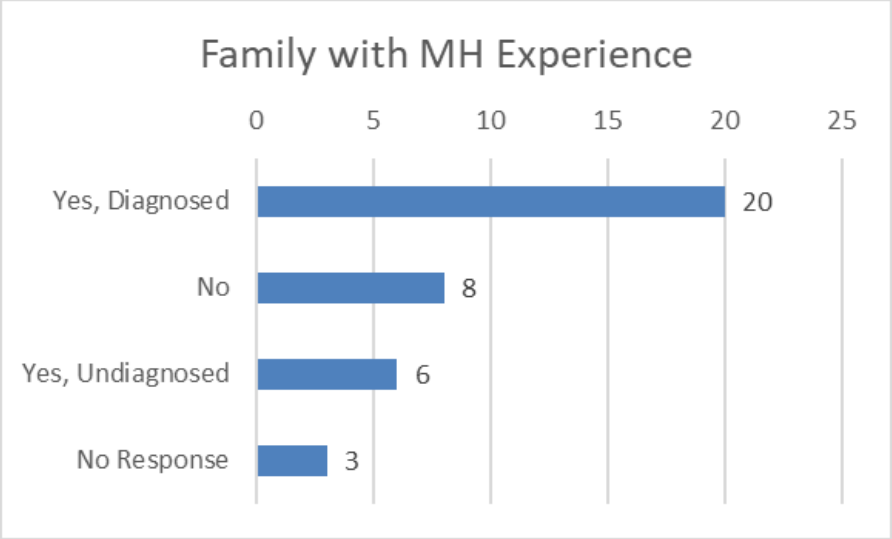
When it comes to area of residence, 25 of the participants were from the Eel River Valley area, 4 were from Eureka, 4 did not respond, 2 were from outside Humboldt County, 1 was from Northern Humboldt, and 1 attendee was from Eastern Humboldt.



Out of the 37 event attendees, 20 reported to having been diagnosed with a mental health condition, 9 did not have experience with mental health, 5 did report experience with mental health but were undiagnosed, and 3 people did not respond.



As for family members, 20 of the event attendees reported on having a family member with mental health experience, 8 did not have family with mental health experience, 6 reported having family with an undiagnosed mental health experience, and 3 did not respond to the question.



It should be noted that all event participants reported to having English as their primary language and that one attendee reported to being a U.S. veteran.

Lessons Learned

People felt that the events were informative, and the Tribe believes using multi-media presentations works well, as evidenced by one of the events having an hour-plus long video that captured the attention of participants. The Tribe also utilized LIA funding to purchase food for cultural reasons, and prizes to encourage participation really helped

and brought in more people. The Grief event was the most talked about event that seemed to have the biggest impact on participants--since strategies and the processes of grief isn't a well talked about subject.

As for challenges, Bear River faced difficulty obtaining age-appropriate speakers to capture the attention of younger participants. As noted in the age demographics, only 3% of participants identified as being between ages 0-15.

Building a community response network for Tribal communities is very important. When a community suffers with mental health disparities, having a community response is crucial. Future activities include: teaching tribal members how to respond to mental health crisis and providing information regarding neurofeedback treatment in order to bring tools to our youth who are suffering with mental health.

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

Humboldt IPA, through its School Based Wellness Center (SBWC), expanded its Empowerment Groups, which are mentorship groups, to middle schools and high schools throughout Humboldt County by training additional Peer Educators. Group goals included: encouraging emotional health and wellness, developing peer to peer support among student participants, fostering a deeper connection to community, lowering absenteeism rates, promoting leadership skills, supporting students in their transition to adulthood, fostering resiliency, and instilling self-confidence and self-worth. Student participants had the ability to identify and request topics based on the needs and interests of the group. This project meets the SB 1004 priority of childhood trauma prevention and early intervention. SBWC offered five groups:

1. La Mariposa (the butterfly): Focused on engaging Latinx participants.
2. The Young Men's Council: Focused on youth identifying as male.
3. Pride Group: Focused on LGBTQIA and Two Spirit youth and allies.
4. Girls Group: Focused on youth identifying as female.
5. Black Students Union/Multicultural Group: Focused on BIPOC youth.

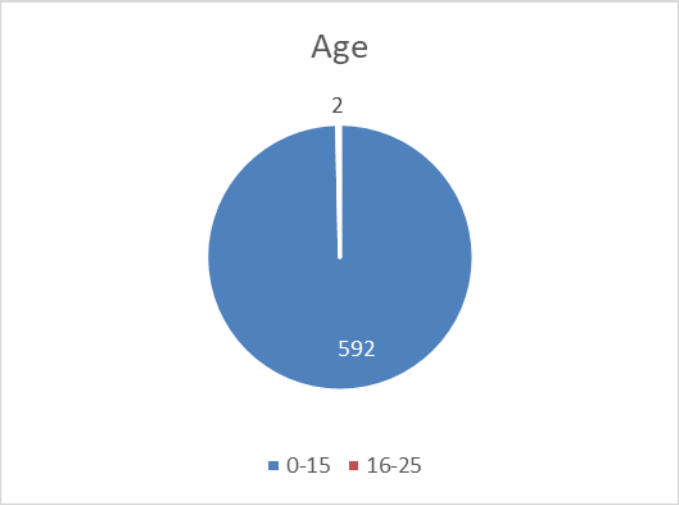
Empowerment Group goals include encouraging emotional health and wellness, developing peer to peer support among student participants, fostering a deeper connection to community, lowering absenteeism rates, promoting leadership skills, supporting students in their transition to adulthood, fostering resiliency, and instilling self-confidence and self-worth. In the 2022/2023 School Year, the IPA had 24 Groups, and with the help of Local Implementation Agreement funding, the IPA expanded to 36 Empowerment Groups across Humboldt County in the 2023/2024 School Year. In total, the IPA had 594 students participate in Empowerment Groups, 6 active Peer Educators, and made 148 referrals to mental health treatment.

With regards to setting, the IPA' Empowerment Groups took place on the following school campuses: Arcata High School, Blue Lake Union Elementary School, McKinleyville Middle School, Pacific Union Elementary School, Peninsula Union Elementary School, Sunny Brae Middle School, Redwood Coast, Montessori, Zane Middle School, Zoe Barnum High School, The Juvenile Hall, McKinleyville High School, and Fortuna High School. However, Peer Educators were only available to the following campuses: Arcata High School, Sunny Brae Middle School, Pacific Union Elementary School, and Peninsula Union Elementary School.

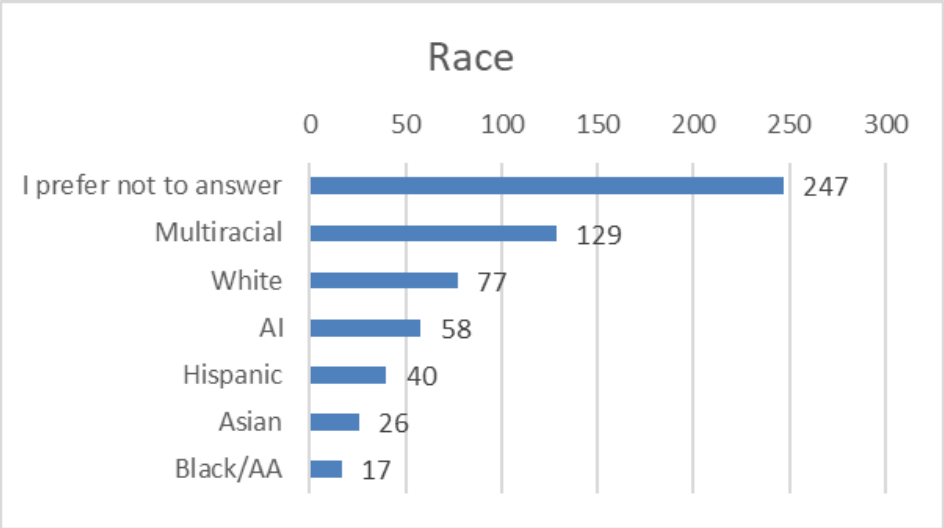
Demographics

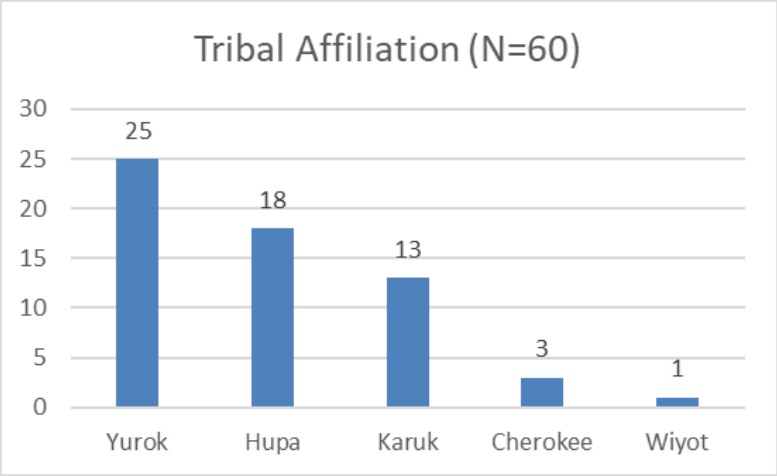
The IPA utilized surveys from their Empowerment Groups and Peer Educators. The IPA measured the following domains for their Peer Educators: self-confidence and positive self-image, ability to manage difficult emotions, emotional and mental wellness, conflict resolution, and developing healthy relationships.

Out of the 594 students that participated in Empowerment Groups, 594 were between ages 0-15 and 2 were between ages 16-25.

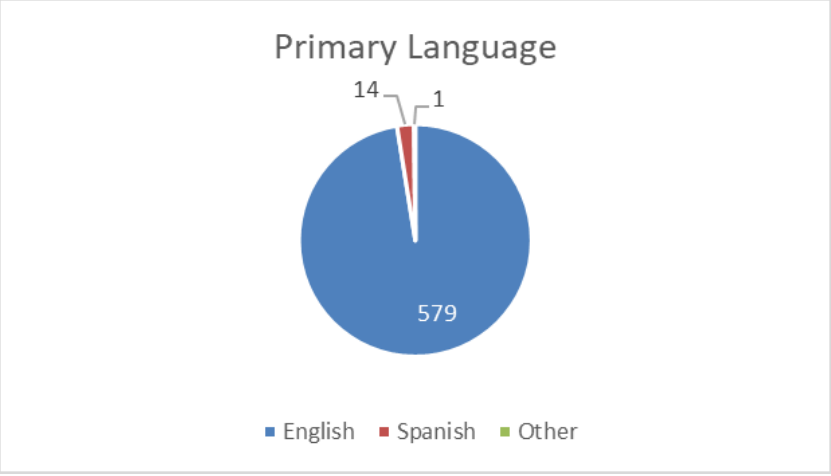


As seen in the chart below, when it comes to race, 247 of the participants preferred not to answer, 129 identified as multiracial, 77 identified as White, 58 identified as American Indian, 40 identified as Hispanic, 26 identified as Asian, and 17 identified as Black/African American.

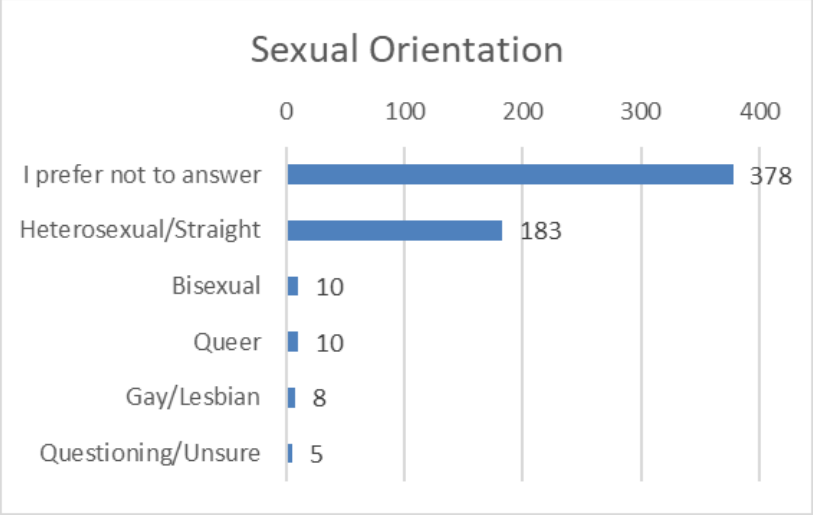




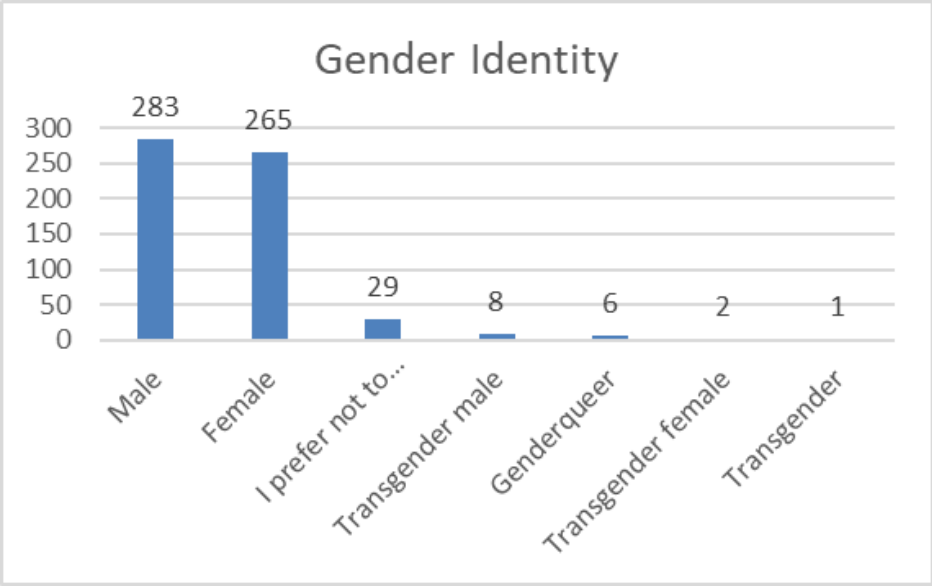
Aside from this, sixty students identified being affiliated with a tribe: 25 identified with the Yurok tribe, 18 with Hupa, 13 with Karuk, 3 with Cherokee, and 1 with the Wiyot tribe.

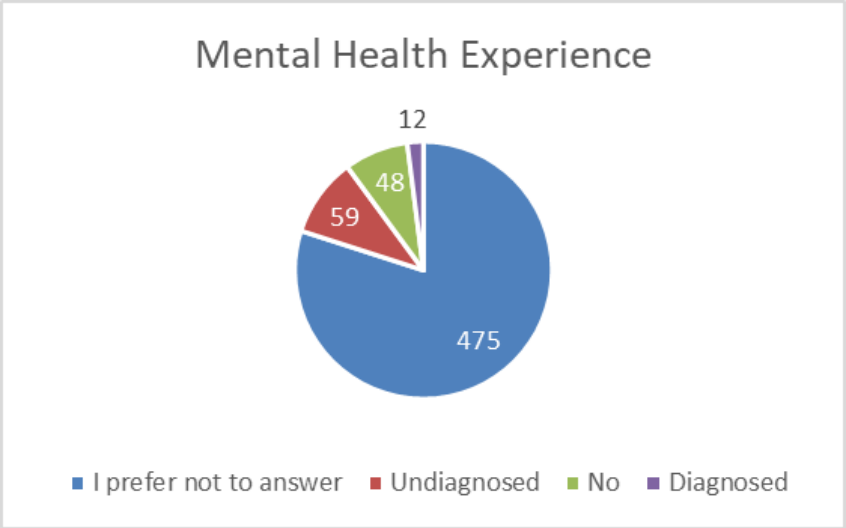


As seen in the chart above, out of the 594 students, 579 identified English as their primary language, 14 identified Spanish, and 1 student identified their primary language as “other.”

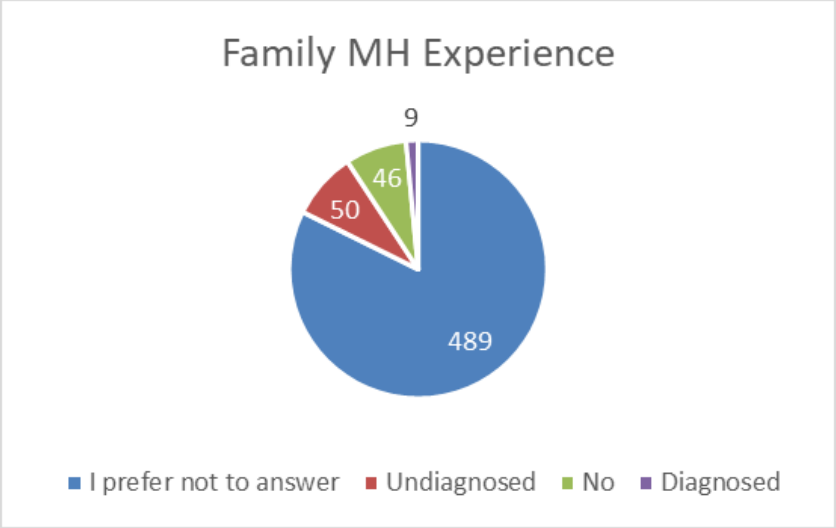


As for sexual orientation, 378 of participants preferred not to answer, 183 identified as heterosexual/straight, 10 as bisexual, 10 as queer, 8 as gay/lesbian, and 5 as questioning/unsure. As seen in the chart below, when it comes to gender identity, 283 participants identified as male, 265 as female, 29 preferred not to answer, 8 as transgender male, 6 as genderqueer, 2 as transgender female, and 2 as transgender (unspecified).

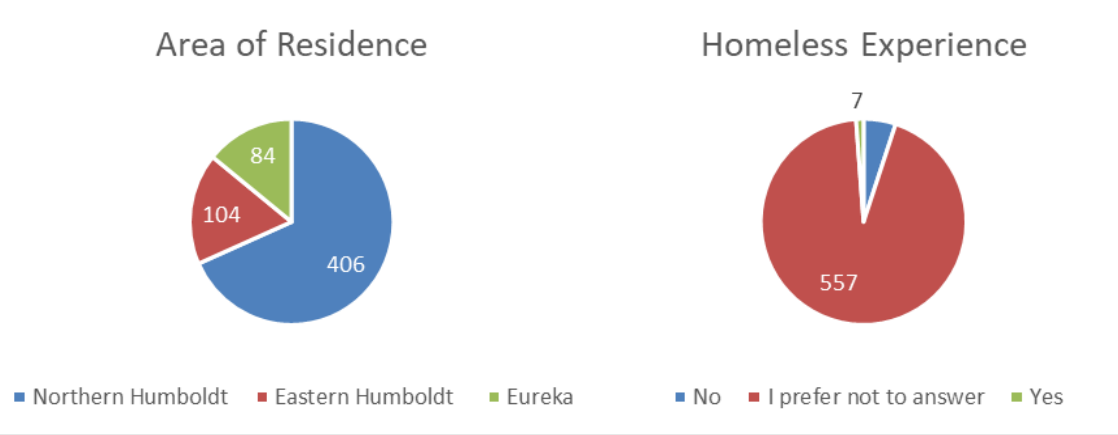




For mental health experience, 475 of participants preferred not to answer, 59 reported experiencing an undiagnosed mental health condition, 48 reported not having a mental health condition, and 12 reported having a diagnosed mental health condition. Additionally, participants were asked about their family experience.



Four hundred eighty-nine (489) of the participants preferred not to answer, 50 reported having family with an undiagnosed mental health condition, 46 reported not having family with a mental health condition, and 9 reported having family with a diagnosed mental health condition.



As shown in the graph above, 406 identified Northern Humboldt County (e.g. Trinidad and McKinleyville) as their area of residence, 104 lived in Eastern Humboldt (e.g. Willow Creek), and 84 lived in the Eureka area. As for homelessness, 7 participants identified experiencing homelessness.

Outcomes

The IPA's Empowerment Groups expanded through this initiative and served 220 more students. Peer Educators reported in their pre and post surveys that they felt an increased sense of confidence after being a Peer Educator. They also reported that their ability to manage conflicts, promote emotional wellbeing, and manage their own emotions increased. Throughout the school year, the Peer Educators had several opportunities for additional training through the IPA's program. The training focused on building confidence, managing conflicts, promoting emotional and physical wellness, and more. These trainings aided in the development of the Peer Educators, and they utilized the tools from these trainings in their work.

Peer Educators understood their role as co-facilitators of the Empowerment Groups. They helped the IPA recruit more students to the groups, and towards the middle of the school year there was a noticeable difference in attendance for the groups that had the support of a Peer Educator when compared to groups that did not. Peer Educators met with the Group Leads (Youth Intervention Specialists) to prepare groups each week. These preparation sessions helped create a clear plan of action, but also gave the Peer Educator the opportunity to express their recommendations for the groups. For example, Peer Educators would write the open-ended questions that would be asked for the activity, they would explore what questions they felt would resonate with the youth, and which ones would not. Their input and life experience was incredibly valuable to each group. Students that were group participants shared that they looked up to the Peer Educators, and some expressed that they hoped they could become a Peer Educator in the following school year.

Funding this program is a challenge. The IPA ended up adding two additional Peer Educators in the middle of the school year, and this took them past their goal of 4.

Additionally, some Peer Educators struggled with developing their skillset. For example, there was a Peer Educator that stayed supporting the group through developing the ice breaker activities for several months past their initial goal of fully leading a group. The Youth Intervention Specialist troubleshot these circumstances and supported the Peer Educators in their goal advancement.

In the future, the IPA would like to continue to expand the Peer Educator Program and further develop their training. Ideally every Empowerment Group would have a Youth Peer Educator.

Queer Humboldt, *Rural 2S/LGBTQIA+ Youth Prevention and Early Intervention Project*
With Local Implementation Agreement funding, Queer Humboldt increased protective factors and access to mental health supports/services for youth (under 21 years of age) who live in rural local settings and are Two-Spirit/Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual and all those who belong under the queer umbrella (2S/LGBTQIA+). Funding supported the creation of a new position, the Rural Queer Youth Outreach Coordinator (RQYOC). This project meets the SB 1004 priority of culturally competent and linguistically appropriate prevention and intervention services.

Queer Humboldt's Rural 2S/LGBTQIA+ Youth Prevention and Early Intervention Project directly served over 100 individuals who participated in 50 activities at four primary sites: Hoopa Valley High School, Garberville Library, the Gene Lucas Community Center in Fortuna, and iL Tuq Cultural Center (also in Hoopa). The purpose of each activity was to screen for mental health early intervention, facilitate early intervention referrals, and reduce negative feelings/attitudes/beliefs/perceptions/stereotypes and discrimination as they relate to mental illness and being members of the 2S/LGBTQIA+ community. The following programs were created:

Hoopa Valley High School: This program consisted of youth engagement activities to promote peer connection and understanding of sexual orientation and gender diversity among youth (mostly Native youth) and occurred at weekly lunch and after-school gatherings hosted by the Rural Queer Youth Outreach Coordinator (RQYOC). Each meeting provided mentorship and group discussions to build protective factors and connect students with existing supports in their community. Activities incorporated mental health screening, suicide prevention and interventions, along with referrals and "warm handoffs" as needed. Some of the topics covered included substance use, gender identity and expression, community interactions, school climate, self-care, and positive self-growth techniques. Program youth practiced skills for interrupting bias, increasing resilience, engaging in positive social involvement, and creating safe spaces. They received information and support for accessing mental health resources,

mentorship, tutoring, homework support, and mental health strategies for coping with stress. They also participated in art resilience-building projects, played culturally based games, and built social connections in a substance-free, wellness-focused environment. Organic conversations during these gatherings facilitated open discussions and sharing, which assisted in assessing youth for emerging mental health concerns.

Garberville Library: Queer Humboldt collaborated with the library, as a community partner organization, in developing an accessible and affirming program for 2S/LGBTQIA+ youth via weekly gatherings in a safe, inclusive space where program youth and their supportive adults could access resources and reduce barriers to mental health. The RQYOC integrated conversations about mental health and associated stigmas, resilience building, suicide prevention and capacity building to support youth while everyone participated in youth-centered art and craft activities. Queer Humboldt also provided library staff with information about early intervention services available to Southern Humboldt families and youth, which may help decrease adverse childhood experiences locally. Activities incorporated mental health screening and suicide prevention strategies, while simultaneously engaging directly with families of 2S/LGBTQIA+ youth to increase familial support.

Gene Lucas Community Center in Fortuna: Queer Humboldt worked in partnership with Two Feathers Native American Family Services (TFNAFS) to provide a twice-monthly, substance-free, all-ages safe space for five months. Initial meetings focused on discussions with program youth about barriers to health they experienced as local queer youth. In subsequent meetings, the RQYOC and TFNAFS mentor supported youth in planning solutions to those barriers. The project educated youth and program implementers about the early signs of mental illness, provided support to increase access to early intervention services, and facilitated youth-centered activities promoting mental health resilience. Youth practiced skills for interrupting bias, increasing resilience, engaging in positive social involvement, and creating safe spaces. The ongoing interactions assisted the RQYOC in assessing youth for emerging mental health concerns. This program had a special focus on fostering youth leadership and peer-to-peer support.

iL Tuq Cultural Center: Queer Humboldt established a weekly community gathering at the iL Tuq Cultural Center in Hoopa in response to input and requests from high school youth and community members. Scheduled on Sundays to allow for greater participation, these gatherings included Native youth, parents, family members, cultural leaders, and elders. Examples of weekly activities include cooking, practicing traditional art, making tea, and playing games. The RQYOC facilitated conversations addressing experiences of being 2S/LGBTQIA+ youth in that Native community and fostered systems of support for improving mental health outcomes. Tribal elders shared culturally relevant practices and conversations that gave those in attendance tools for responding to early signs of mental illness. These culturally-centered, substance-free, resilience-building activities included discussions on early signs of mental illness, increasing community awareness, reducing the stigma associated with mental illness, and decreasing instances of discrimination in medical and community settings. Sunday

gatherings at iL Tuq provided the RQYOC with opportunities to work directly with families and community members of 2S/LGBTQIA+ Native youth, aligning with early intervention and prevention research to bridge the capacity for supportive adults to resource youth.

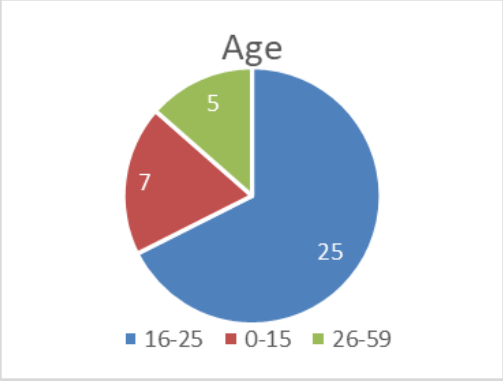
*Through the above-described programs, ten youths were referred to mental health treatment. *

In addition to the above regularly-convening activities, the RQYOC and Queer Humboldt provided training at the Two-Spirit Teachings Conference and the Red Road Healing Circle Summit, to Hoopa Valley High School staff, and to Blue Lake Rancheria tribal leaders. The RQYOC facilitated youth, community members', and program implementers' attendance and participation at the Two-Spirit Drag and Poetry Show and the Bay Area American Indian Two-Spirits Powwow. Additionally, program youth were present to accept the Humboldt County Board of Supervisors proclamation declaring Two-Spirit Awareness and Celebration Day at the Humboldt County Courthouse on the Spring Equinox. Cal Poly College Corp interns received mentoring in protective factors and access to mental health supports/services. All of these activities were implemented either to educate the community and supportive adults about the mental health supports they can offer to 2S/LGBTQIA+ youth, or to engage with and encourage youth via activities to promote mental health resilience.

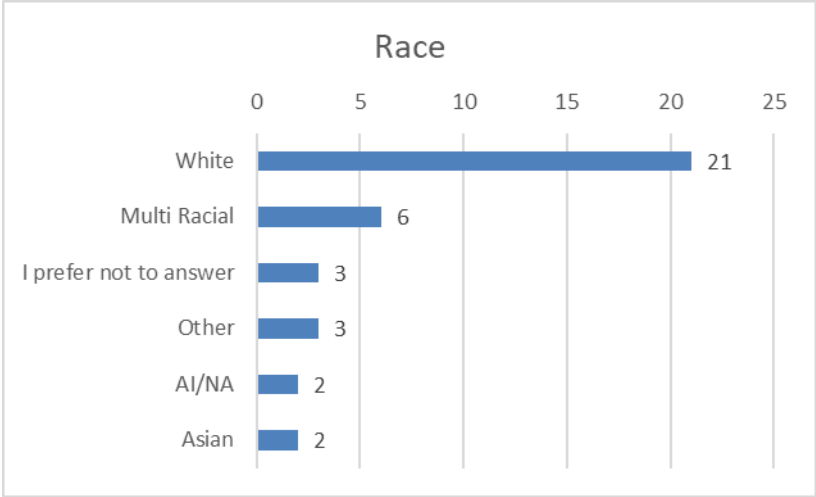
Demographics

Out of the 100 individuals the RQYOC interacted with, 37 filled out the demographic survey. Out of the 37, people reported having a mental/learning disability, having a vision disability, having a physical/mobility disability, and reported having a chronic health condition. Paper versions of the PEI demographic forms and a displayed QR code for accessing a virtual version of the demographic form were displayed in visible locations and made available to all participants to gather demographic information. Sign-In sheets were placed alongside the PEI forms and the RQYOC documented the exact number of attendees, activities at each event, and recorded comments and reactions from community leaders in their documentation.

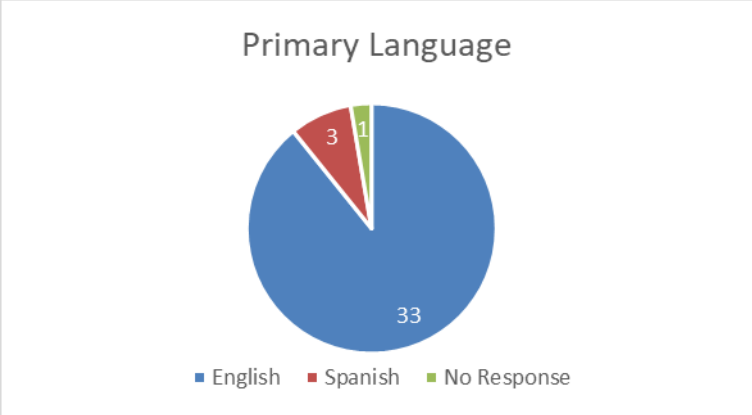
As shown in the graph below, 25 of the survey respondents shared they were between ages 16-25, 7 reported being between ages 0-15, and 5 reported being between ages 26-59.



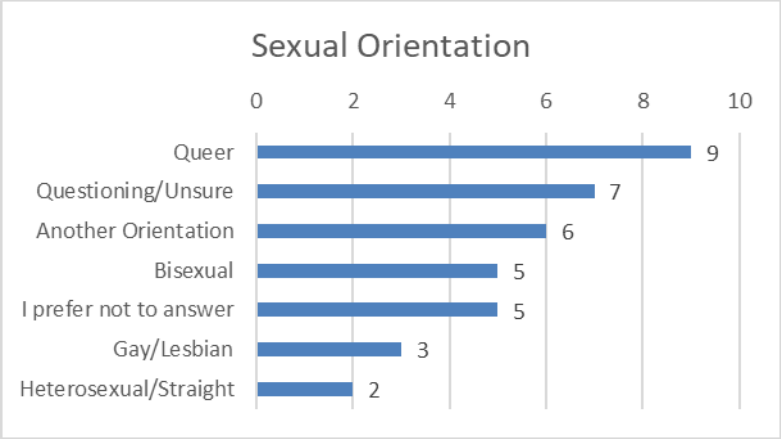
When it comes to race, 21 respondents identified as White, 6 as multiracial, 3 preferred not to answer, 3 identified as “other,” 2 identified as American Indian/Native American, and 2 identified as Asian. The two folks that identified as American Indian/Native American identified with the Cherokee tribe.

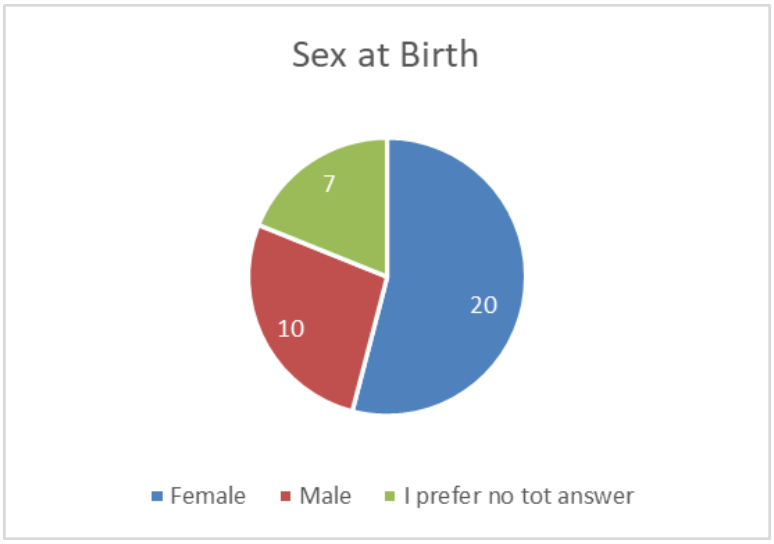


For primary language shown below, 33 of the survey respondents mentioned English was their primary language, 3 shared their primary language to be Spanish, and 1 person did not respond to the question.

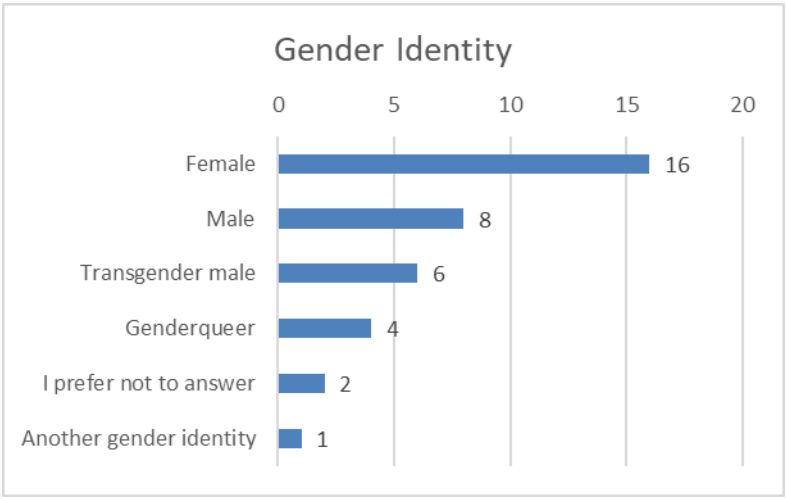


For sexual orientation, 9 respondents identified as queer, 7 as questioning/unsure, 5 as bisexual, 5 preferred not to answer, 3 as gay/lesbian, and 2 people identified as heterosexual/straight.

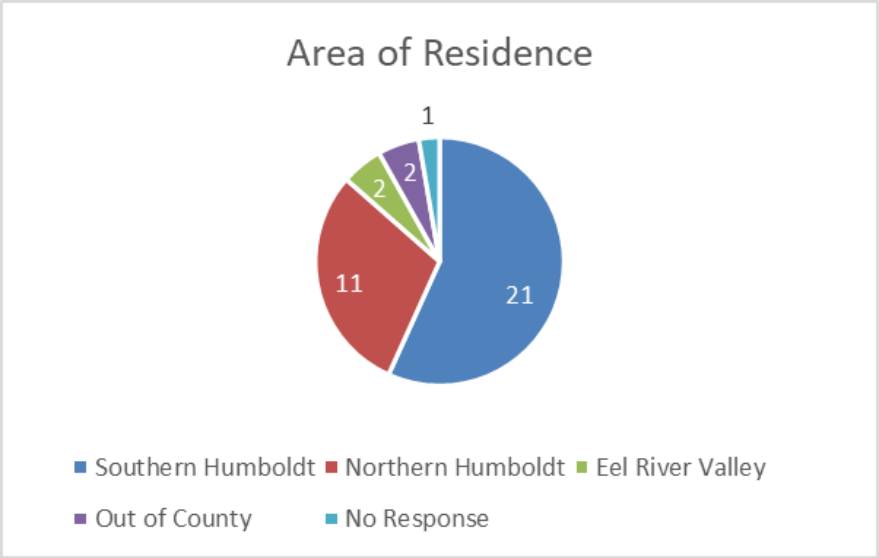




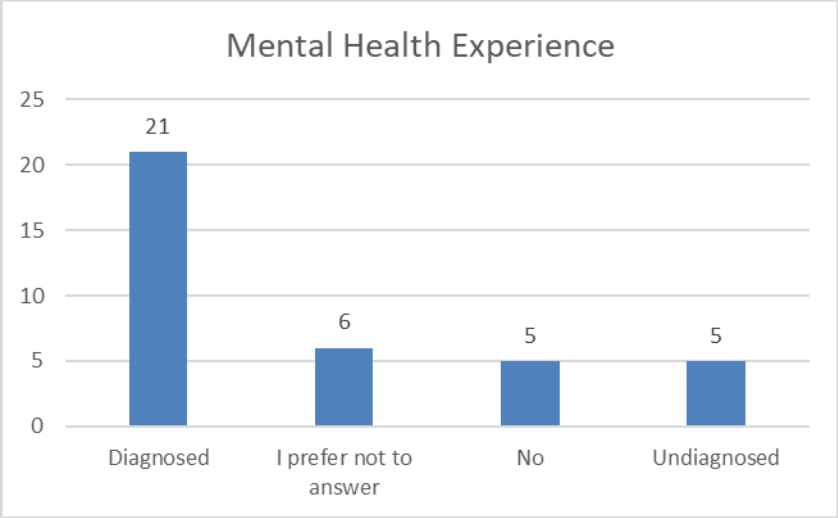
As seen in chart above, when it comes to sex at birth, 20 of the survey respondents identified as female, 10 as male, and 7 preferred not to answer.



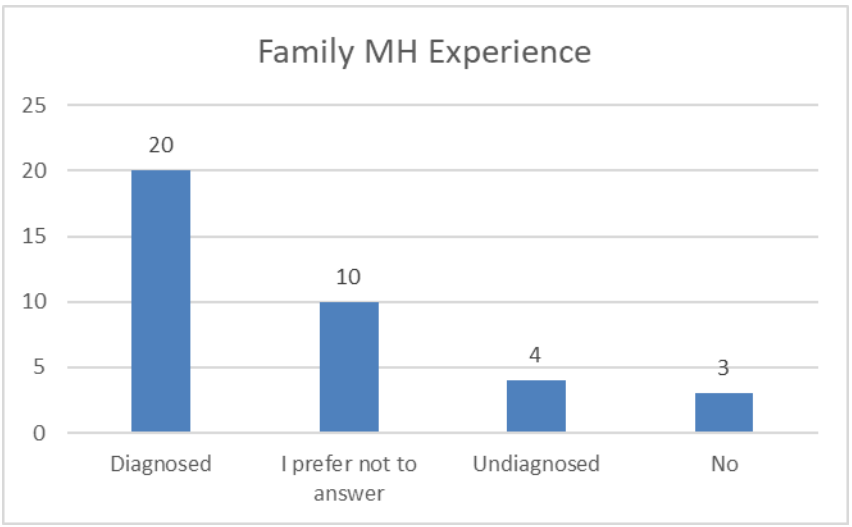
For gender identity, 16 identified as female, 8 identified as male, 6 identified as transgender male, 4 as genderqueer, 2 respondents preferred not to answer, and 1 person identified as “another gender identity.”



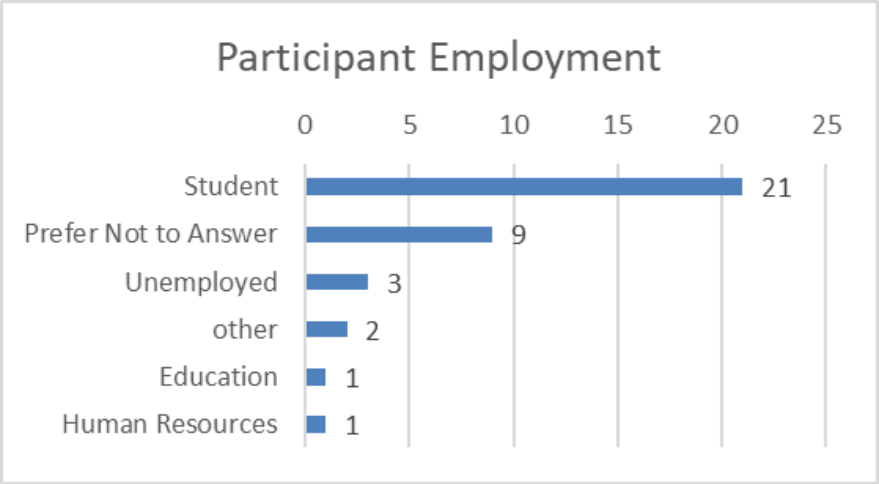
For area of residence, 21 participants reported living in Southern Humboldt (e.g. Garberville), 11 from Northern Humboldt (e.g. McKinleyville, Trinidad), 2 from the Eel River Valley (e.g. Fortuna), 2 were from outside of Humboldt, and 1 person did not respond to the question. As is seen in the pie chart below, when it comes to experiencing homelessness, 24 participants mentioned they have not experienced homelessness, 11 answered yes, and 2 preferred not to answer.



When it comes to mental health experience, 21 of the survey respondents shared they have been diagnosed with a mental health condition, 6 preferred not to answer, 5 said no, and 5 reported having an undiagnosed mental health condition. Additionally, out of the 37 survey respondents, 20 shared they had at least a family member with a mental health condition, 10 preferred not to answer, 4 reported having at least one family member with an undiagnosed mental health condition, and 3 said no.



For employment, 21 of the respondents identified as being students, 9 preferred not to answer, 3 identified as unemployed, 2 as “other,” 1 in education, and 1 person identified being in the human resources sector.



Outcomes

The Early Intervention component of the program engaged 75 adult program implementers from Hoopa Valley High, Middle, and Elementary Schools, Blue Lake Rancheria, Northern California Indian Development Council, the Garberville Library, the Gene Lucas Community Center, Hoopa Tribal Education, Hoopa courts, and Hupa elders and culture keepers through various activities and trainings. By building relationships with representatives from these local youth-serving entities, the RQYOC facilitated greater awareness and access to support services for youth in rurally isolated regions of Humboldt County that have historically had limited access to services. The project activities consisted of early intervention measures and activities and engaged more than the anticipated 10 youths with early intervention services; over 70 youth attended the various programs, with many participating week after week.

The Prevention component of the program provided resilience tools to more than 50 youth, increasing culturally based protective factors and decreasing risk factors for developing serious mental illness for 2S/LGBTQIA+ youth. Over 35 adult program implementers from rural community organizations were also equipped with tools to develop and implement 2S/LGBTQIA+ inclusive practices, and collaboration with Native program implementers and organizations increased access for Native 2S/LGBTQIA+ youth to culturally relevant options for prevention supports and services. Family member participation was a key component of prevention activities, and the RQYOC thoughtfully engaged multiple family members to increase their familial support for their 2S/LGBTQIA+ youth.

Through trainings and engagement activities, over 100 people increased their awareness of how to recognize and respond to early indicators of mental illness among 2S/LGBTQIA+ youth, and how to enhance culturally relevant protective factors while decreasing adverse childhood experiences for 2S/LGBTQIA+ youth. Multiple conversations that took place during events allowed the RQYOC and other Queer Humboldt team members to learn from youth and rural youth program implementers about early signs of mental illness. Tribal leaders and cultural leaders also provided guidance on culturally relevant practices for responding to early signs of mental illness.

At nearly every meeting of program participants at Hoopa Valley High School, the Gene Lucas Community Center, and the iL Tuq Cultural Center, youth listening sessions were embedded into the discussions by the RQYOC, with over 30 youth participants during the Local Implementation Agreement funding period.

Queer Humboldt also tabled at the Hoopa Rainbow Extravaganza (estimated engagement of 125 people), Southern Humboldt's Pride event at Mateel Community Center in Redway (estimated engagement of 120 people), and Ferndale Pride (estimated engagement of 150 people) using wellness campaign materials, direct conversation, and educational publications to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes, and discrimination related to being diagnosed with mental illness, living with mental illness, seeking mental health treatment services, and being members of the 2S/LGBTQIA+ community, all to reduce stigma and discrimination.

Training for Hoopa Valley High School staff and Blue Lake Rancheria Administrators included discussions and collaboration on suicide prevention and healing opportunities for youth. Additionally, interactions between the RQYOC and families and caring community members of 2S/LGBTQIA+ youth purposefully addressed bridging capacity for supporting youth in alignment with suicide prevention strategies and engaging in suicide prevention activities at home, school, and in community settings. More than 35 adults engaged in suicide prevention-focused activities and discussions.

Overall, project outcomes included engaging more people than anticipated. Early intervention and prevention activities and trainings were initially targeted at project youth, youth-supporting adults, and youth-serving entities. However, Queer Humboldt successfully included many more individuals and a variety of organizations to amplify the benefits of these services. Additionally, more family members than expected were engaged in the direct services, likely due to Queer Humboldt's efforts to emphasize the impact of allyship for 2S/LGBTQIA+ youth and the larger community as ongoing regular services continued.

Queer Humboldt found that community leaders in both Eastern and Southern Humboldt County were eager collaborators and excited about the project's availability in their communities. As the project concluded, it was clear that the collaborators wanted to continue these activities to provide safe spaces and bring people together.

Project youth increased their resilience, built stronger relationships, attended and participated in events that brought them queer joy, and gained tools to strengthen their identities as 2S/LGBTQIA+ community members. Most importantly, 2S/LGBTQIA+ youth living in rural communities experienced increased access to supportive resources, activities, and adult mentors, and gained reduced barriers to mental health care.

What worked best

Consistent, frequent contact with all participants, especially youth, resulted in strong, trusting relationships. This approach also allowed the RQYOC to more effectively identify if project youth needed a referral to mental health services. Combining youth-centered activities with training and open, organic discussion provided project youth with parallel engagement experiences, facilitating easier communication.

Ensuring that loved ones, parents, elders, and youth-supporting adults were welcomed and encouraged to participate in youth-centered gatherings allowed everyone to grow and strengthen their relationships with each other. It also helped adults recognize that others in their community might be experiencing similar challenges as they navigate growth and learning around mental health and the 2S/LGBTQIA+ youth they love.

Challenges

Working with trusted local leaders in the rural communities of Humboldt was crucial for accessing community engagement. The biggest challenge was that these leaders were often very busy and had limited capacity. Queer Humboldt navigated this by collaborating with multiple individuals across regions to overcome these individual capacity challenges, fostering robust and diverse relationships within the rural outlying communities of Humboldt County.

It was also tough to gather individual demographic data. Despite personal verbal encouragement and requests to participants to complete either the paper or digital form, it was optional for participants to provide demographic data and not all participants chose to provide that information.

Plans for future project development

Queer Humboldt's ongoing relationships in all of the regions where this project took place will allow for continued collaboration and coordination of services with these communities and community partners. Queer Humboldt will continue to seek grant funding to build these programs and will offer online resources for individuals who live far from community centers where resources are more readily available.

Redwood Community Action Agency (RCAA), *SOARing to Stability YSB (Parents and Children in Transition and Youth Services Bureau Programs)*

Through use of Local Implementation Agreement funding, RCAA implemented SSI/SSDI Outreach, Access, and Recovery (SOAR) Case Management services, educated the community on SOAR's success in Humboldt, built connections with the regional and state SOAR work and training groups, and recruited, employed, and trained a dynamic service provider to fill the role of a SOAR Case Manager. The Case Manager trained a team member of RCAA's Community Services Division and served the targeted population through RCAA's Adult and Family Services and Youth Services Bureau programs, and the Energy Services Division programs.

The foundation of the SOAR model is rich and rooted in Social Security Administration (SSA) and Substance Abuse and Mental Health Services Administration (SAMHSA)

projects and is now established in all states across the Country. This specialized service delivery process promotes recovery and wellness, through increased access to Social Security disability benefits and a stable income for eligible individuals who are experiencing or at risk of houselessness, have a serious mental illness, medical impairment, and/or a co-occurring substance use disorder, with completing and submitting quality applications to the Social Security Administration on behalf of these vulnerable people. During the duration of this project, there were 5 unduplicated referrals for SOAR services, with 3 eligible individuals being provided extensive SOAR services. This project meets the SB 1004 priorities of 1) childhood trauma prevention and early intervention 2) culturally competent and linguistically appropriate prevention and intervention.

For community education, the following were utilized: online provider group meetings (local, state, and national), SOAR Technical Assistance portal and work group forums (national), local houseless provider groups, HUMCO Coordinated Entry System administrators/workgroups/meetings, HHHC meeting, HUMCO COC, RCAA Board of Directors meetings, local NAMI forum, meetings with local medical and psychiatric providers, Veterans services provider groups, Nations Finest providers, collaborative meetings with many HUMCO DHHS programs and staff, Sempervirens medical records staff, landlords, property management firms, Housing Authority staff members, Jared Huffman's local office staff, local disability advocacy organizations and staff members, Kaiser Permanente (Oregon sites), and other local providers and community members that were interested in the SOAR model and services.

Outcomes:

The methods used to measure the outcomes of this project were:

- Direct client feedback about their experience with the SOAR process, including challenges and successes.
- Direct feedback from the assigned SSA Technical Assistance personnel in New York, who provided excellent feedback, was accessible and knowledgeable, and supported the SOAR Case Worker many times during this project. Ironically enough, the TA staff in New York had spent their honeymoon in Humboldt County many years ago, and they reported that they were very impressed that RCAA had finally brought SOAR work to our community. They reported that they love Humboldt and keep up on the happenings here, especially regarding the vulnerable populations here and the support provided. This was a wonderful professional experience for both the SOAR Case Worker and their Manager, as this connection was invaluable to the piloting process and the person really cares about our community, despite their geographical distance of more than 3500 miles away.
- Community provider feedback about their experience in learning and receiving education from us about the SOAR model and ability to pilot a hybrid model of this

service in Humboldt County through this project.

There were many SOAR model education opportunities RCAA was able to provide to a variety of community provider groups and individuals. This education proved to be successful in RCAA's project goal to educate others about the efficacy, successes, challenges, and process of the SOAR model for disability advocacy created by SAMHSA and the SSA.

Due to the challenge of recruiting, hiring and training a qualified applicant for the new SOAR Case Worker position, RCAA was unable to start the project until early October 2023. The SOAR model requires extensive training through SAMHSA as well as internal agency trainings, prior to starting the direct work with clients, which began in late October 2023.

Due to the limited funding that this project allowed for implementation of the SOAR work, RCAA anticipated a larger client group that was served. The typical caseload for a first-time and full-time SOAR worker is an average of 2-3 clients that are actively receiving disability advocacy services. This project allowed for approximately a .40FTE SOAR position, in which RCAA was able to serve 3 individuals during this project's timeline.

This project allowed for 2 complete, accurate, and quality applications for permanent disability benefits through the SSA for 2 of the 3 individuals served. Unfortunately, due to the nature of this project and the process with the SSA, these completed applications were submitted for processing, and the outcomes of these applications have not yet been reported to RCAA or the client's served as of the date of this report. The SOAR Case Worker's processes with these applications have been shifted to the Manager for any final steps with SSA for these 2 applications, as this project's timeline is complete.

What worked best:
All clients reported that they felt more comfortable working with the SOAR Case Worker on this process, rather than an attorney or a "government" employee.

People reported being satisfied with the services and supports they received through the SOAR Case Worker and felt like they were able to build a positive rapport and trusting relationship with the SOAR Case Worker, especially as they were the assigned "Authorized Representative" with their SSA disability advocacy process.

Community provider groups and individuals that were provided education about the SOAR model and process were highly satisfied. The main feedback and questions from local community providers is how they can get the funding to implement SOAR services. Additionally, many local providers were excited to hear that there is a lengthy and in-depth

training process through SAMHSA that is required, prior to someone registering to be a SOAR Case Worker and have access to the SSA's Online Application Tracking (OAT) portal, and also to be a sanctioned "Authorized Representative" with an individual's disability application process. Educating local providers on SOAR logistics was successful and promoted a deeper need for this service delivery.

Challenges:

When it comes to challenges for this project, 66.6% of clients faced challenges accessing medical and psychiatric records. This was largely due to providers going out of business, medical records being destroyed due to the legal retention period ending.

Another challenge found through this project's timeline is that due to the part-time nature of this project's funding for the personnel costs associated, RCAA was unable to serve as many clients as originally anticipated.

An unforeseen challenge RCAA discovered was that due to the lack of SOAR education within the local medical system, it made it difficult to interact with providers in the beginning. The education piece of this project made a significant impact in building trust and relationships with local providers, which was used to move the work forward.

Another challenge RCAA encountered through this process is that many local medical providers were unclear as to what the SOAR Medical Summary Report (MSR) was when they were presented with it for an MD signature. This challenge was exceptionally beneficial, as the local medical provider group held high value in RCAA's SOAR process with them, that they established and assigned a staff member to be an official liaison between their large medical provider group to directly interface with the SOAR Case Worker, to ensure that there is a timely response and completed MD signature on the client's individual MSR reports.

Future Project Plans

Due to the amazing process of piloting this SOAR project here in Humboldt County, it is a pleasure to announce that RCAA was able to solidify a liaison to directly interface with the medical providers system in Humboldt County.

With the demonstrated success gained through this project, RCAA was able to propose to a local funding source the need to add a SOAR Case Worker position to one of RCAA's core programs serving adults and their households that are houseless and typically struggling with 1 or more permanent disabilities. This position became officialized on July 1, 2024, and RCAA has filled this new position with a qualified staff member from one of the Family Services programs.

It is RCAA's intention to build SOAR services into the other Adult and Family Services programs, as these programs serve individuals and their households and families with minor children that may be experiencing houselessness, complex trauma, disability impact, poly substance use/dependencies, institutionalization, incarceration, family separation and discord, involvement with Child Welfare Services and Adult Protective Services.

Additionally, RCAA intends to continue educating community providers and partners, funders, and the general public about SOAR services and the incredibly positive impact this model and service can have directly on the individuals who require and deserve disability advocacy. Additionally, RCAA stresses the SOAR impact on the community including how it can reduce the challenges with the heavy utilizer populations and increase self-sustainability for people who gain permanent income through disability benefits. As SOAR services increase locally, RCAA anticipates Humboldt County will experience a decrease in the high level of services and supports that disabled populations require to sustain a healthy lifestyle.

This impact is and will continue to be profound to Humboldt and RCAA's hope is to keep the momentum alive and promote SOAR services county wide.

Redwood Rural Health Center (RRHC), *Comprehensive Training Supporting Trauma Informed Approaches to Early Intervention and Prevention of Suicide and Other Mental Health Crisis*

With Local Implementation Agreement funding, RRHC expanded its training offerings to its staff. Additional trainings that were provided to RRHC staff are: Question, Persuade, Refer (QPR), Adverse Childhood Experiences (ACE's), and Trauma Informed Services training. Through this expansion of training offerings, RRHC aimed to provide better quality support to the Southern Humboldt region. This project meets the SB 1004 priorities of 1) childhood trauma prevention and early intervention, 2) early psychosis and mood disorder detection and intervention and mood disorder and suicide prevention programming that occurs across the lifespan, 3) early identification programming of mental health symptoms and disorders.

The following attendance was collected for each training:

- QPR Training (9/26/2023): 22 team members attended.
- ACE's Training (3/7/2024): 28 team members attended.
- Trauma Informed Services Training (5/29/2024): 30 team members attended.

Given the nature of these trainings and since they were offered to existing RRHC staff, demographics were not collected. However, team members included front-desk staff,

direct services providers, department and service coordinators, and other staff who have direct contact with clients and patients of Redwoods Rural Health Center.

Additionally, since an expansion of RRHC staff trainings was the focus of this project, clients/patients were not directly referred to mental health treatment. However, it is hoped that due to the trainings, effective referrals to mental health services were made by staff who attended the trainings.

The original intention was to provide pre and post surveys to all team member attendees. However, what actually occurred were in-depth conversations about the topics discussed immediately following the trainings and then further revisited during team meetings in all departments. RRHC also evaluated the success of the trainings through the repeat attendance. Overall, 80 team members attended, with 35 unduplicated attendees. These trainings were not mandatory for all team members, and so the repeated interest in the subjects indicated that the training was in fact needed and appreciated.

To ensure that team members could be fully present and to promote collaborative and personal open conversations, trainings were held off-site in the community. This allowed staff to be away from the pressures of their work-duties and attend with full-focus on the topics covered in the trainings. The locations included The Civic Club, the Benbow KOA, and the Healy Senior Center. Not only were the trainings provided for informational and professional development, RRHC also used the opportunity for team building.

Project Outcomes:

The primary outcome is that the trainings were able to occur and that so many team members were able to attend and be fully present. Because RRHC cannot bill for trainings of this nature, most of the time they are not possible at this scale. Funding allowed RRHC to gather a wide range of team members from multiple departments to participate, which created the secondary beneficial opportunity for staff to interact and work collaboratively with team members outside of their immediate departments. Initially, RRHC had anticipated being able to incorporate more staff and to provide a wider range of trainings, but during the grant period, all departments experienced a significant staffing turnover, and shortages made scheduling and full attendance less possible than what was hoped for.

Lessons Learned:

All team members agreed that for such difficult and personal topics, it worked best to hold the trainings offsite and away from all distractions. It also worked well to have the trainings held as an “all-staff” rather than by departments so that each modality and department could learn from and provide their own expertise, experience, and impressions as conversations rather than in memos or follow-up meetings.

While the off-site locations were ideal for staff participation, there were issues with the tech and internet that caused some disruption to the trainings. Also as earlier explained, during the grant period, all departments experienced a significant staffing turnover, and shortages made scheduling and full attendance less possible than what RRHC had hoped for.

These trainings were intended to provide staff with opportunity to develop their skills and obtain information that would allow them to support Redwoods Rural Health Center clients and patients as well as each other and other persons outside of the health center direct circle. As RRHC implements a new electronic health record, EPIC, it is expected that the increased skills staff gained from these trainings will impact the development of new workflow and patient/client interactions, and that they will have an improved focus or navigation of services for persons with mental health conditions and heightened awareness of those in need of immediate mental health support. Due to the success of the trainings, RRHC will continue to seek funding which will allow these kinds of opportunities for staff to gather and learn together.

LIA Projects during FY 2024-2025

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

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

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

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

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

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

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

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

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

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

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

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

The Southern Humboldt Family Resource Center is aiming to host two 10-week sessions of The Parent Project during the 2024-2025 academic school year (starts in September). The Parent Project has been offered in Northern Humboldt for multiple

years and has proven to be successful. The organization is looking to expand this service delivery into the Southern Humboldt region. LIA funding will be used to cover material expenses, transportation, and childcare during sessions.

LIA Projects for FY 2025-2026

Contingent upon available funding, Local Implementation Agreements (LIAs) will continue to be supported by PEI during the period of the 2023-2026 Three-Year Plan and Annual Update. The application period for LIAs opened on February 2025 and closed on March 2025. A total of 18 applications from local organizations were received, with 6 receiving approval from BH Administration. The six approved organizations can be found below along with a brief summary of the project they will be carrying for fiscal year 2025-2026:

Black Humboldt: Community Wellness and Cultural Healing Initiative

Black Humboldt will provide culturally responsive mental health support and healing spaces for BIPOC folk in Humboldt via cultural exchange groups, affinity spaces, art therapy, and mental health access and linkage events/workshops. Through these events, Black Humboldt aims to offer opportunities for personal and professional networking, resource sharing, and joy-centered community engagement. The project is also intersectional in nature, meaning it is inclusive to folks who are 2S/LGBTQIA+, disabled, experienced poverty or incarceration, unhoused, youth, and elders.

First 5 Humboldt: Expanding Developmental Screening in First 5 Playgroups

First 5 Humboldt will expand and support developmental screenings for young children ages zero to five in Humboldt County using evidence based developmental screening materials and methods. First 5 will contract with an Infant-Family and Early Childhood Mental Health (IFECMH) specialist to offer Facilitating Attuned Interactions (FAN) training. FAN is a nationally recognized training model focused on improving the communication skills of professionals who serve families, with the goals of strengthening the provider-parent relationship and parent-child relationship. The FAN training will serve at least 20 people who work with families and young children, including First 5 Humboldt staff, Playgroup leaders, and additional local providers as space allows.

Fortuna Union High School District (FUHSD): Fortuna Union High School District Annual Community Resource Faris and Guides

FUHSD will implement two annual Community Resource Fairs at Fortuna High School to provide students, parents, and staff with access to essential local mental health and community services. Since Fortuna High is a centralized location, it would provide accessibility for all students in the district. The first event will take place in the Fall as

part of Back-to-School Night, and aims to provide parents and guardians with access to local agencies and organizations that offer mental health support, housing, assistance, educational resources, and other essential services. The second fair will take place in the spring and will focus on students and staff during school hours to ensure maximum participation and engagement. Since one of these events will take place in the evening, FUHSD will provide dinner for people that attend.

Humboldt Senior Resource Center: Increasing Treatment Modalities for Humboldt County Older Adults

The Humboldt Senior Resource Center will expand its access to mental health care for older adults by training its clinicians in the application of Neurofeedback. The training will strengthen the capacity to provide early intervention and prevention for conditions such as depression, anxiety, cognitive decline, and trauma-related symptoms.

Redwood Community Action Agency (RCAA): Breathing and Tapping Our Way to Wellness

RCAA will train its Case Workers and leadership staff (a total of 13 staff) in Breathwork and Emotional Freedom Techniques (tapping) facilitation practices. Once trained, staff will provide education and training to participants within the RCAA ecosystem. This project is tied to the holistic case management framework and aims to relieve stress and promote relaxation, reduce anxiety, and to identify, explore, resolve limiting thinking and habits of behavior, and appropriately work towards healing the effects of trauma.

Southern Humboldt Family Resource Center: Southern Humboldt Parent Project, Loving Solutions, and Parent Support Groups

The Southern Humboldt Family Resource Center will host and facilitate three 10-week sessions of The Parent Project, Loving Solutions, Positive Parenting Program in Spanish, and 10 monthly Parenting Support Groups in the 2025-2026 academic school year. This project requires a lot of time and resources, and Southern Humboldt presents barriers to participation, such as expensive materials, transportation to class location, childcare during class time, and time commitment/duration of class time. LIA funding will remove and ease these barriers for families by covering the cost of the educational materials, providing childcare for parents with younger children who have no other childcare option and providing a meal during the weekly two-hour class and monthly support group.

Prevention and Early Intervention: Latinx Liaison Position

The Behavioral Health Cultural Responsiveness Committee (BHCRC) devoted three monthly meetings to the topic of providing behavioral health services to Hispanic/Latino/Spanish-speaking community members. These meetings were

attended by BH staff and community members interested in this topic. The primary barriers identified over these three months, included the lack of culturally proficient staff to work with the Hispanic/Latino/Spanish-speaking community, the lack of awareness by the community about behavioral health services that exist locally and that lack of understanding about service providers that were available to the community. In response to these identified barriers and needs, the BHCRC recommended that Behavioral Health recruit, hire, and train a Spanish-speaking, culturally proficient individual to provide outreach and act as a liaison to Hispanic/Latino/Spanish speaking communities within Humboldt County and to increase their understanding of services and providers available while helping to link them to these needed services and supports. This position will advance efforts in access and linkage to services and stigma discrimination reduction through its outreach efforts and coordination with Behavioral Health programs.

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

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

Prevention and Early Intervention: Early Childhood Treatment Certification

Infant-Family and Early Childhood Mental Health (IFECMH) Certificate Training Program was developed to address the serious gap in our systems' capacity to address the social and emotional (mental health) needs of our young children and their families. Between 10 and 16 percent of young children (22 percent of children in poverty) experience diagnosable mental health conditions. Promotion, prevention, and treatment of mental health conditions for young children takes a unique skill set that is not embedded in our educational systems. Many providers lack the knowledge, skills, and confidence in their capacity to promote social and emotional wellness (mental health) in the population that they serve and can lack the understanding of the critical need to intervene and treat mental health issues in young children. It is critical, in this time of development, to understand how to work in partnership with families so that children can access appropriate intervention and treatment for early recovery. Humboldt County lacks a workforce qualified to address this need. Given the nature of this program, it focuses on Prevention, Early Intervention, and increasing the recognition of early signs

of mental illness. MHSA funding will support up to 24 individuals within the cohort to get this certification in three years.

The IFECMH Certificate Training Program, which the McKinleyville Community Collaborative will house, is a three-year training program aligned with the CA Center for Infant-family and Early Childhood Mental Health. It is designed to address the critical need to train and support a qualified infant-family and early childhood workforce. The program brings together a cohort of up to 24 practitioners, from all child and family serving systems, to share a collective understanding of how their roles will promote mental health.

The training grounds practitioners with tools to identify children at risk for mental illness and gives them the capacity to offer families developmentally and culturally appropriate referrals, assessments, and interventions. Many of the IFECMH training courses are open to community enrollment as stand-alone training courses. By allowing community enrollment, local practitioners can access the most current knowledge and research from local, state, and national experts in the field of IFECMH. These professional relationships facilitate on-going learning, ease navigating referrals and connections that make complicated systems more accessible to families. Additionally, many of the providers who participate in the full cohort program are eligible for the California state-level endorsement in Infant-family and Early Childhood Mental Health.

The third year of this program will be tailored to provide the additional training and support needed for licensed clinicians to be endorsed as Specialists in Infant-Family and Early Childhood Mental Health. This training series will include more intensive training targeted to the treatment level of mental health services and additional hours in reflective practice needed for support in this process. For the full cohort, additional hours of reflective practice support will be in place to support them with an endorsement at the state level as a Reflective Practice Facilitator. The McKinleyville Community Collaborative program director will strategically work toward aligning the certification with the local college and polytechnic university to provide future stability, integration, and sustainability.

Given the nature of this program, it does not serve clients directly. Due to this, a cost per client cannot be estimated.

Below is an update on the 17 requirements followed by the program:

1. Ensuring EFECMH Certificate Training Program promotional materials are prepared and distributed to community partners, student population and public.

- Promotional materials were developed in English and Spanish.
- Promotion occurred through the distribution of the 0 to 8 Mental Health Collaborative Newsletter to over 300 local children and family service providers. Materials were distributed at the 0 to 8 Mental Health Collaborative Leadership Team. Regular attendance at these meetings covers many local child and family serving agencies and Cal Poly Humboldt faculty.

- The Director of IFEMCH Training, tabled at two events to promote the training program including the Family Resource Center Round Table Event and the NAMI (National Alliance of Mental Illness) Humboldt tabling event.

2. Conducting, compiling, and producing an IFECMH Certificate Training Program community needs assessment and program evaluation.

The Director of IFECMH Training is working closely with the Redwood Institute of Social Research (RISR) to ensure that the program is aligned with the CA Endorsement for Infant-Family and Early Childhood Mental Health. In this fiscal year, RISR has supported the development of a logic model and developed a program evaluation plan that is being used to assess the training and program.

3. Creating a comprehensive training plan that aligns with the California IFECMH Endorsement process.

The training plan is aligned with the *California Compendium of Training Guidelines, Personnel Competencies, and Professional Endorsement Criteria for Infant-Family and Early Childhood Mental Health.*

4. Identifying and recruiting presenters, facilitators, and instructors to provide training to participants in the IFECMH Certificate Training Program and contracting for services.

Date:	Hours of Training:	Required or Optional	Training Title:	Presenter/Facilitator:	Number of Participants:
December/January	1	Required	Introduction to the Humboldt Infant Family and Early Childhood Mental Health Cohort	Beth Heavilin and Angie Lua	32
February 23, 2024	9	Required	Introduction to Infant-Family and Early Childhood Mental Health (3 sessions)	Beth Heavilin	23
January-June	8	Optional	Book Club -Beyond Behaviors (Exploring the work of Mona Delahooke)	Janet Skillings	2 groups at 4 sessions
March 22, 2024	6	Required	Introduction to Reflective Practice (2 sessions)	Jennifer Gonzalves and Beth Heavilin	21
April 10 & 11	13		Facilitating Attuned iNteractions (FAN)	Meg Walkley & Beth Heavilin	20
April 26, 2024	3	Required	Utilizing the Diversity Informed Tenets in Early Childhood Mental Health	Sharrone Blanck	21
May 24, 2024	3	Required	Topic: Early Social and Emotional Development (Infant-Toddler and Preschool Development)	Dr. Robin Kissinger	22

Date:	Hours of Training:	Required or Optional	Training Title:	Presenter/Facilitator:	Number of Participants:
June 10, 11, 12 & 13	**28**	**Optional**	**Certified Infant Massage Educator Training** ***(This training has an additional fee. Scholarships will be available.)***	**Beth Heavilin**	9
June 21, 2024	**7**	**Required cohort 9-12**	**Perinatal Mental Health Conference**	**Dr. Kristie Brandt** **Dr. Carrie Griffin** **Panel -Perinatal Providers** **Panel-Doula Providers**	**69**
July 26, 2024	**3**	**Required**	**Sharing a Common Framework around Family-Centered Services (Parenting, Caregiving, Family Functioning and Parent-Child Relationships)**	**TouchPoints Introduction**	**27**
Sept. 13 & 27	**6**	**Optional**	**Attachment Vitamins**	**Virtual Module**	**TBD**

Total Training hours offered (to be offered) for the Foundational Cohort: 86
Duplicated count of training participants: 292 (This number does not include September's optional training. It is anticipated that 12 practitioners will participate.)

5. Identifying and recruiting student participants for the IFECMH Certificate Training Program.

Multiple sessions to introduce the program were offered to interested professionals both in person and on Zoom. The training program was filled at its maximum with 24 practitioners. The 24 participants in the cohort come from multiple child and family serving perspectives and agencies.

6. Identifying and booking a facility at which to conduct the IFECMH Certificate Training Program.

The Center in McKinleyville has been housing all the training and reflective practice groups, with the exception of the Perinatal Mental Health Conference that was located at the Humboldt County Office of Education in the Sequoia Center.

7. Mentoring and supporting student participants in the IFECMH Certificate Training Program.

Please see Training Chart under requirement number 4.

8. Providing food and beverages for participants in the IFECMH Certificate Training Program.

Light snacks and beverages were available for participants at all training sessions. The Perinatal Mental Health Conference included a catered breakfast and lunch.

9. Coordinating with the Mental Health Collaborative on planning a Children's Mental Health Summit to meet requirements for IFECMH State level endorsements.
The 0 to 8 Mental Health Collaborative Leadership Team worked together to offer the Perinatal Mental Health Conference to the larger community.

10. Implementing a Children's Mental Health Summit that fulfils requirements for IFECMH State level endorsements.
Trainings at the Perinatal Mental Health Conference aligned with the *California Compendium of Training Guidelines, Personnel Competencies, and Professional Endorsement Criteria for Infant-Family and Early Childhood Mental Health.*

11. Facilitating the provision of monthly training services that align with the California IFECMH Endorsement process.
Please see training chart requirement number 4.

12. Translating and interpreting training materials to support Spanish speaking participants, as needed.
The promotional materials were in Spanish, but no providers who were monolingual Spanish speakers joined the cohort or needed translation and interpretation services.

13. Facilitating the provision of two (2) hours of reflective practice services per month, for each participant individually or in small groups.
The Director, achieved her Reflective Practice Mentor Level Endorsement so that the hours participants accrued in reflective practice can be used by any discipline to achieve state level endorsement.

Reflective Practice groups (a maximum of 8 participants per group) all 24 cohort members are assigned to a group. There are a total of 4 reflective practice groups that meet monthly. For the Foundational year groups started in April, and will go until November (9 reflective practice opportunities, totaling 18 hours of reflective practice hours). The CA Endorsement in IFECMH requires a minimum of 12 hours of reflective practice facilitation for a transdisciplinary infant-family and early childhood mental health provider. Reflective Practice will continue into the Advanced Year.
The Director has been mentoring one participant to work towards Reflective Practice Endorsement by the state of CA.

April to November 2024	**2 hour sessions**	**Required by all cohort members**	**Lead Reflective Practice Facilitator: Beth Heavilin**	**23 participants**	**Total hours to be completed with 4**

					reflective practice groups: 72

14. Supporting the completion of the California IFECMH Endorsement process by working with participants individually or in small groups.
Ongoing conversations and support for the IFEMCH Endorsement process have been available. The first formal meeting to discuss the Endorsement process will be in September 2024.

15. Planning and facilitating monthly 0 to 8 Mental Health Collaborative Leadership Team meetings and workgroups to support the IFECMH Certification Training Program.
Monthly 0 to 8 Mental Health Collaborative Leadership Team meetings have been facilitated with the exception of July 2024. There is a workgroup for the work plan and for the newsletter. There was a focused work group for the Perinatal Mental Health Conference.

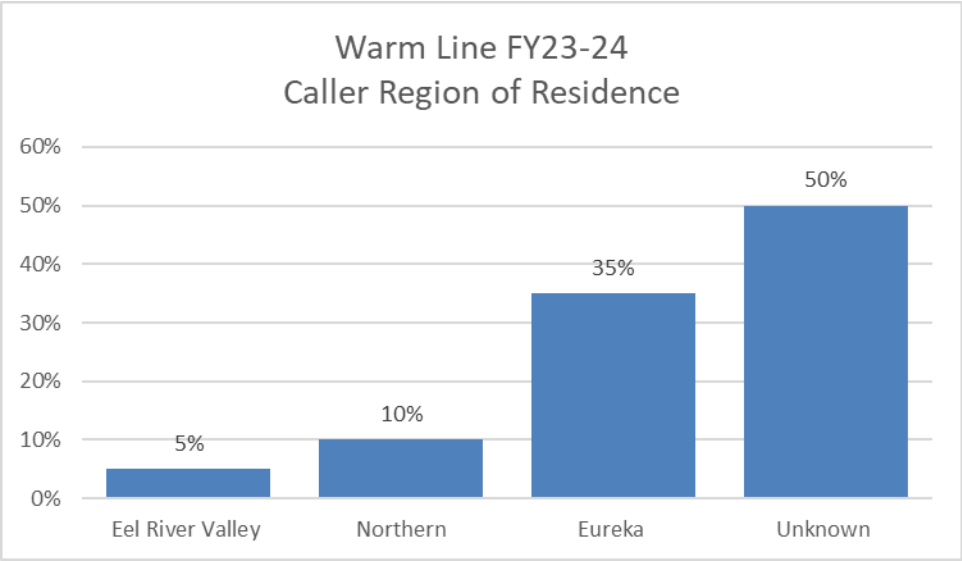
16. Publishing and distributing quarterly 0 to 8 Mental Health Collaborative Newsletter to build system cohesion.
The 0 to 8 Mental Health Collaborative Newsletter has been published on a quarterly basis. Please see the home page of our website for the Summer edition of the newsletter: https://0to8mhc.org/
17. Assessing professional development in order to ensure the provision of ethically responsive interventions in mentoring others to become reflective facilitators in accordance with IFECMH best practices and state level guidelines and competencies.
The Director was invited to be one of two participants in the Napa Infant-Parent Mental Health Fellowship Program, Reflective Supervision and Mentoring Academy. In this program, participants are getting training and reflective practice support for their work providing reflective facilitation and mentoring. In addition, this program allows participants to access to monthly training with experts in the field of Infant Mental Health. This is the first training cohort to be phase one certified in the Neurosequential Model of Therapeutics - Early Childhood with Dr. Bruce Perry.

Prevention and Early Intervention: Warm Line

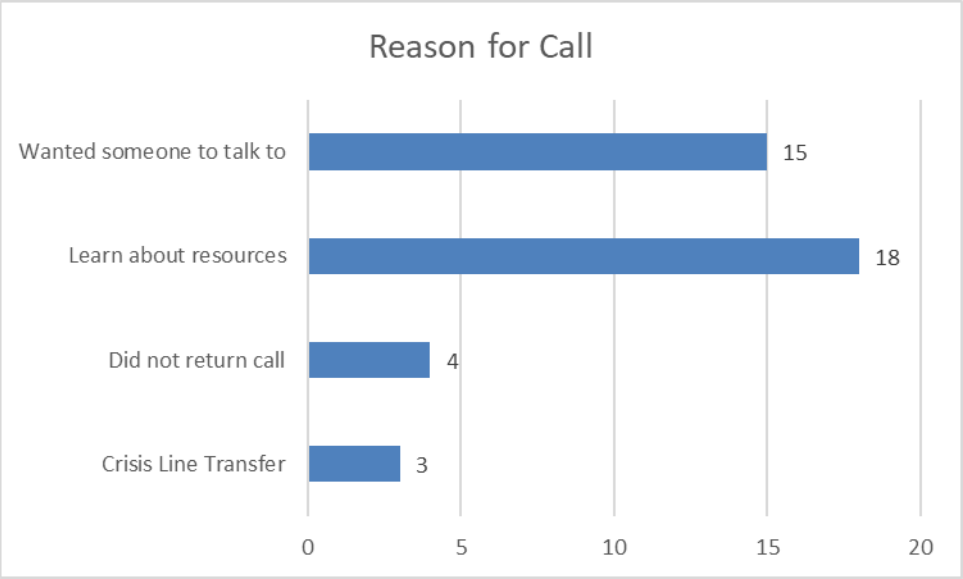
During the COVID-19 Pandemic, Humboldt County Behavioral Health became aware of an increasingly unsettled community, impacted by COVID related anxiety, depression, and distress. Staff worked with County Information Systems to develop a county run "warm line" to provide non-emergency mental health support. This Warm Line is available to the community regardless of insurance type or association with County

Behavioral Health. The goal is to assist individuals with any immediate distress they are experiencing and then connect them to community resources that may help them on a longer-term basis, as needed. The Warm Line will focus on access and linkage to treatment efforts. While COVID-19 concerns are changing over time, there still seems to be an ongoing need for this level of community support beyond COVID-19. The Hope Center operates this warm line and will be linking callers to services when needed. This warm line will augment other services available and provides opportunity for earlier intervention that can prevent more acute, intense crisis experiences.

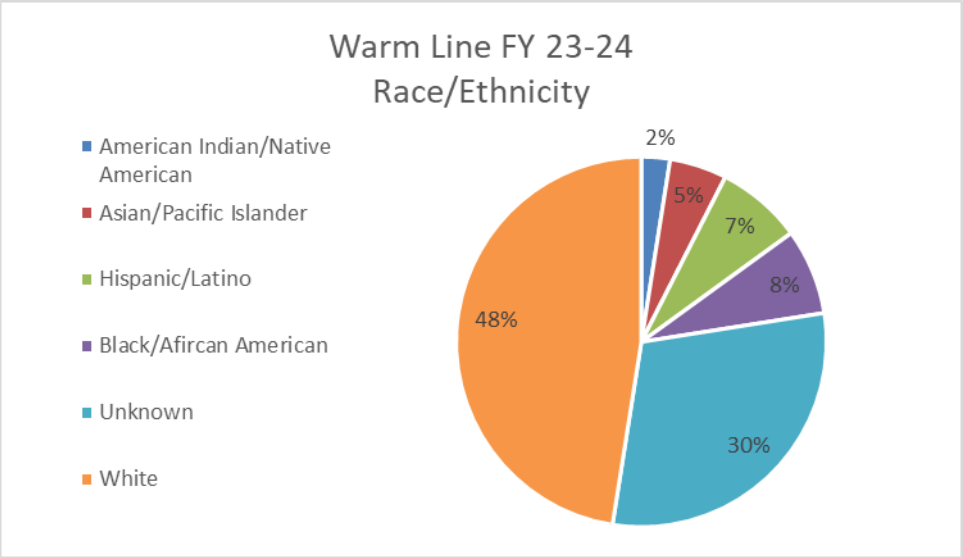
Warm Line report for Fiscal Year 2023-2024:
During Fiscal Year 2023-2024 the Warm Line received a total of 40 calls. The 2023-2024 Revenue and Expense Report outlines a total cost of $1,535.18; this is an average cost of $38.38 per client. Out of the 40 calls, 5% originated from Eel River Valley, 10% from Northern Humboldt, 35% from Eureka, and 50% of callers preferred not to answer.



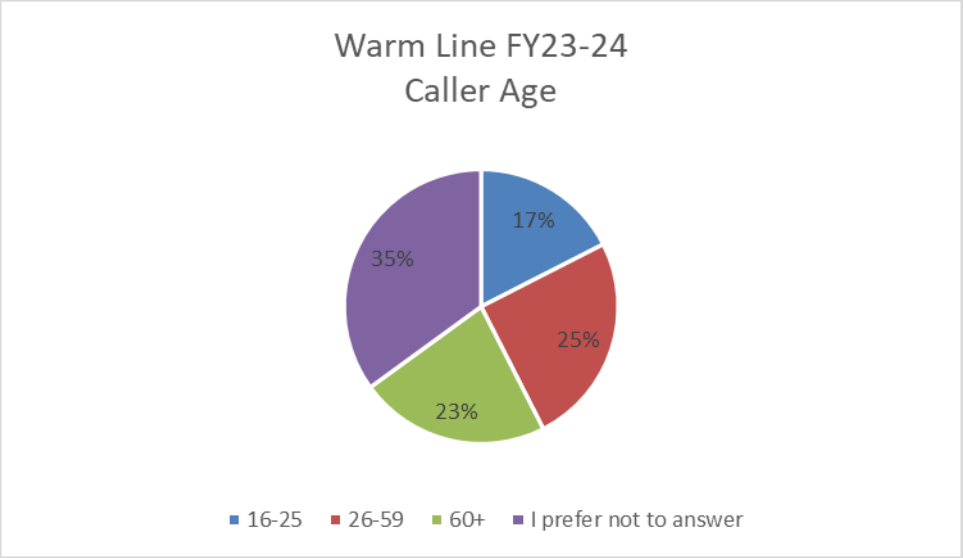
Out of the 40 calls, 15 were done because the caller wanted someone to talk to, 18 were regarding learning about resources, 4 left a message but did not return the follow-up call, and 3 were transferred to the Crisis Line.



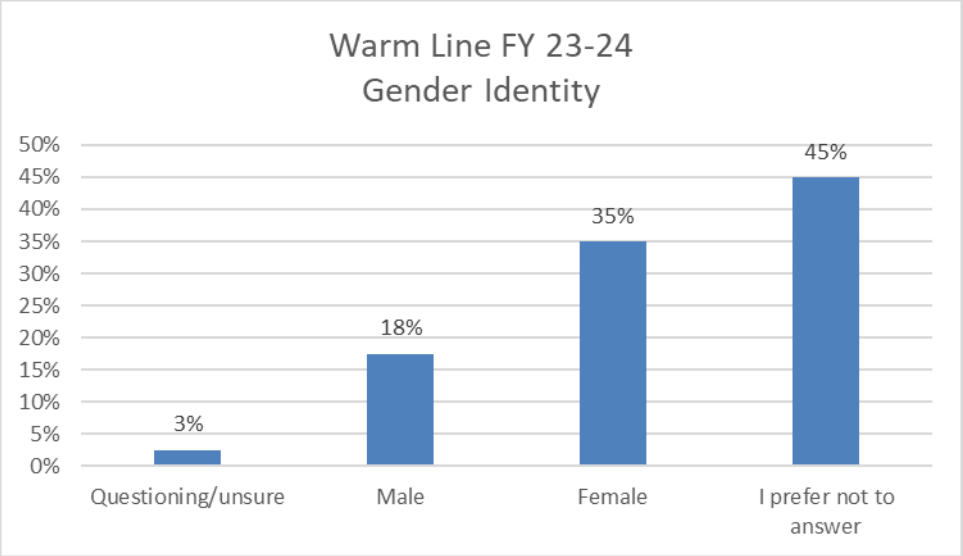
For race and ethnicity, 48% of callers identified as White, 2% as American Indian/Native American, 5% as Asian/Pacific Islander, 7% as Hispanic/Latino, 8% and Black/African American, and 30% did not respond to the question.



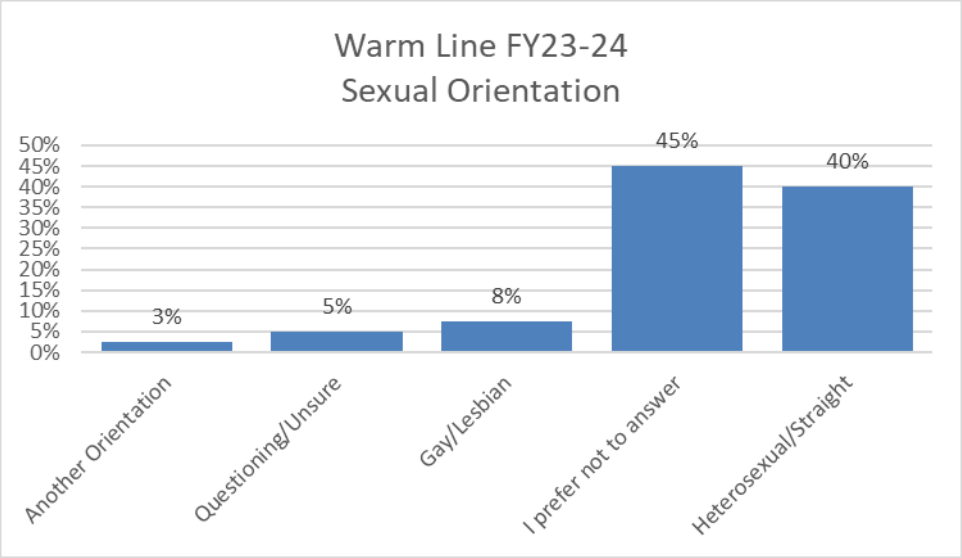
For caller age, 17% identified being between ages 16-25, 25% were between ages 26-59, 22% were 60+, and 35% preferred not to answer.



For gender identity, 3% of callers were questioning/unsure, 18% identified as male, 35% as female, and 45% preferred not to answer.



For sexual orientation, 3% identified as having another orientation, 5% were questioning/unsure, 8% identified as gay/lesbian, 45% preferred not to answer, and 40% identified as heterosexual/straight.



Prevention and Early Intervention: Assigned Funds – CalMHSA Statewide PEI Program

The Department of Health and Human Services Behavioral Health (DHHS BH) will participate over the next three years in the Statewide Prevention and Early Intervention (PEI) Program. By contributing to this effort, Humboldt County's Behavioral Health branch will aid in stigma and discrimination reduction (SDR), will improve access and support of mental health services, will develop local and statewide capacity building support along with new outreach materials for counties, and will improve outreach to community stakeholders. This joint effort will help in increasing the recognition of early signs of mental illness. PEI funded programs will promote mental health and wellness, suicide prevention, and health equity throughout communities, with additional focus on diverse and/or historically underserved communities.

Towards reaching the above goals, the contribution of MHSA PEI funding will ensure that CalMHSA provides the following resources/support while new services are implemented:

- Technical Assistance: suicide prevention expertise, support with regional/local specific webinars, distribution of physical materials, training opportunities for the Learning Collaborative.
- Directing Change: a program/film contest tailored for students that provides financial support to encourage and kick start participation.
- Social Marketing – Take Action: a new statewide PEI Campaign that uses best practices in messaging to increase help seeking, reduce stigma and discrimination, and identifies resources for increasing wellbeing.

- Evaluation – RAND: an independent evaluator that provides consultation and evaluation services to PEI program along with optimization to best practices.

NEW Prevention and Early Intervention: Humboldt Early Psychosis Intervention Program (HEPI)

The Humboldt Early Psychosis Intervention program (HEPI) is embedded within the Transitional Age Youth Behavioral Health program (TAY-BH). Youth meeting the HEPI criteria are offered group therapy, individual therapy, family support services, peer support services, medication referrals with ongoing support, and case management services. The focus of HEPI is to help young people remain with their families and/or in their community at the highest level of independence possible while maintaining and increasing their capacity for learning and enhancing self-sufficiency. Behavioral Health services, which include peer coaching, are integrated with support and programming provided by Child Welfare Services (CWS) social workers, CalWORKS case managers and Housing, Outreach & Mobile Engagement (HOME) program coordinators. HEPI is an early intervention program that satifies the following SB 1004 priorities: chilhood trauma prevention and early intervention; early psychosis, mood disorder detection, intervention and suicide prevention programming that occurs across the lifespan.

In 2023, TAY leadership began working with Epi-Cal to identify barriers and strategically plan for better implementation of the HEPI program. TAY has met monthly with Epi-Cal, attended each quarterly learning collaborative meeting, and has begun training staff in Coordinated Specialty Care (CSC). Further, to address the unique barriers rural counties are facing, Humboldt County DHHS leadership, along with leadership from Siskiyou County, met for an additional session with Epi-Cal in order to discuss specific needs related to First Episode Psychosis (FEP) for rural counties.

HEPI staff use the following Evidenced Based Practices (EBP's): Coordinated Specialty Care (CSC), The Transition to Independence (TIP) Model, Cognitive Behavioral Therapy for psychosis (CBTp) and Eye Movement Desensitization and Reprocessing (EMDR). Each of these EBP's has outcome tools attached to them that tmonitor progress and provide outcome data in a number of life domains.

Workforce Education and Training (WET)

Over the years, local Humboldt County MHSA Workforce Education and Training (WET) funding has provided staff development opportunities that promote wellness, recovery, and resilience, culturally competent service delivery, meaningful inclusion of clients and family members, an integrated service experience for clients and their family members, community collaboration, and employment of clients and family members within the behavioral health system. During the next years local WET dollars will be used for

Training and Technical Assistance through support of the Relias E-Learning platform and to provide matching funds for the Department of Health Care Access and Information (HCAI--formerly the Office of Statewide Health Planning and Development) Regional Partnership Grants. There is a growing need to provide staff with consultation and training opportunities.

The 2025-2026 Annual Update has allocated funding in the budget to offer such opportunities to staff and to help expand equity work across Humboldt County Behavioral Health and to ensure that culturally responsive engagement is prioritized. Additionally, Humboldt County Behavioral Health, with stakeholder input, has identified a greater need to improve local recruitment and retention strategies within its workforce. MHSA WET funding may be used as needed to offer local recruitment and retention strategies at the local level outside of the Superior Region Partnership.

Relias E-Learning. Behavioral Health initially contracted with Relias Learning, LLC, in April 2016. Staff have access to the Relias catalog of courses, written by industry experts and accredited through international and state accrediting bodies. Local trainings are created and uploaded to Relias as well. Built in tracking, testing and reporting tools save time and ensure that mandatory training requirements are met. Relias improves new hire orientation as an entire collection of training specific to staff roles can be assigned.

Health Care Access and Information (HCAI) Regional Partnership. DHHS Behavioral Health participates in the statewide WET 2020-June 2025 Plan through the Behavioral Health Regional Partnership project, coordinated by HCAI. Humboldt County is a member of the Superior Region and collaborated with the other counties in the Region to develop an application to secure HCAI Behavioral Health Program funds. The Superior Region priorities are to provide scholarships and/or stipends for peer specialists, graduate education stipends for Clinical Master and Doctoral program participants, loan repayments for qualified masters/doctoral graduates who commit to working in the public mental health system for a set period of time, sign-on bonuses for folks that apply for specific job openings that have been identified as hard-to-fill, and the development and implementation of recruitment and retention strategies. In Humboldt County the CPPP showed overwhelming support for retention strategies to support the behavioral health workforce, and Behavioral Health leadership has identified the loan repayment program as a priority. It had been anticipated that the HCAI programs would begin in the Fall of 2020, but due to contracting delays experienced in the Superior Region the first loan repayment awards were not approved until September 2022. A second round was done in 2023 and a third round of Loan Repayment was conducted in 2024.

Medi-Cal Peer Support Specialist Certification. Behavioral Health will participate with CalMHSA, which has established a Medi-Cal Peer Support Specialist Certification program, as required by Behavioral Health information notice 21-041. The program is intended to certify up to 10 Peers through a series of trainings. CalMHSA will act as the certifying entity, responsible for the certification, examination, and enforcement of professional standards for Medi-Cal Peer Support Specialists in California.

Consultation and Trainings. Behavioral Health will continue its consultation work with Stepping Stone Consulting in order to continue the branch wide equity work and to offer more robust cultural coaching opportunities to staff. County Behavioral Health will also consider contracting with other appropriate consultants to specifically address culturally responsive engagement within the community, as needed. Behavioral Health may allocate funding to cover trainings that will help expand equity work efforts; a list of any trainings funded under this section will be listed in future reports.

County Compliance Certification

This page was intentionally left blank as a placeholder for when the county compliance certification is ready.

Fiscal Accountability Certification

Enclosure 1

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: Humboldt County

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

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Emi Botzler-Rodgers, LMFT	Name: Mychal Evenson
Telephone Number: 707-268-2990	Telephone Number: 707-476-2353
E-mail: ebotzler-rodgers@co.humboldt.ca.us	E-mail: mevenson3@co.humboldt.ca.us
Local Mental Health Mailing Address: Humboldt County DHHS-Behavioral Health 720 Wood Street Eureka, CA 95501	

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

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

Emi Botzler-Rodgers LMFT	Botzler-Rodgers, Emi (Digitally signed by Botzler-Rodgers, Emi Date: 2025.03.13 17:02:01 -07'00')	3/13/25
Local Mental Health Director (PRINT)	Signature	Date

I hereby certify that for the fiscal year ended June 30, 2024, 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 2/14/2025 for the fiscal year ended June 30, 2023. I further certify that for the fiscal year ended June 30, 2024, 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.

Mychal Evenson	Evenson, Mychal (Digitally signed by Evenson, Mychal Date: 2025.03.14 16:05:07 -07'00')	3/14/2025
County Auditor Controller / City Financial Officer (PRINT)	Signature	Date

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

Three-Year Program and Expenditure Plan, Annual Update, and RER Certification (07/22/2013)

MHSA Funding Summaries

FY 2025/26 MHSA Annual Update Funding Summary

County: HUMBOLDT Date: 11/8/2024

	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2025/26 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	3,352,791	1,779,498	1,453,544	0	0	
2. Estimated New FY2025/26 Funding	5,177,154	1,294,288	340,602			
3. Transfer in FY2025/26[a/]	(218,393)			218,393		
4. Access Local Prudent Reserve in FY2025/26	0					0
5. Estimated Available Funding for FY2025/26	8,311,551	3,073,786	1,794,146	218,393	0	
B. Estimated FY 2025/26 Expenditures	8,166,371	2,399,731	489,344	218,393	0	
C. Estimated FY 2025/26 Unspent Fund Balance	145,181	674,055	1,304,802	0	0	

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

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

FY 2025/26 MHSA Annual Update Community Services and Supports (CSS) Funding

County: HUMBOLDT Date: 11/8/2024

Fiscal Year 2025-26	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)	10,400,051	6,764,188	3,635,863			
Non-FSP Programs						
1. Regional Services	382,008	171,073	210,935			
2. Older Adults	121,270	80,500	40,771			
3. Crisis Residential Treatment	1,839,658	792,410	1,047,248			
4. Crisis Alternative Response of Eureka (CARE)	112,500	112,500				
5. Tribal Support	87,165	87,165				
CSS Administration	171,360	158,535	12,825			
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	13,117,011	8,166,371	4,947,641	0	0	0
FSP Programs as Percent of Total	79.3%					

FY 2025/26 MHSA Annual Update Prevention and Early Intervention (PEI) Funding

County: HUMBOLDT Date: 11/8/2024

Fiscal Year 2025-26	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	477,053	359,205	117,848			
2. TAY Advocacy and Peer Support	527,976	365,487	162,489			
3. Parent Partnership Program	468,411	330,169	138,242			
4. School Climate Curriculum/MTSS	89,352	89,352				
5. Local Implementation Agreements	120,000	120,000				
6. Latinx Liaison	107,734	94,039	13,695			
7. Early Childhood Treatment Certification	118,250	118,250				
8. Warm Line	105,196	105,196				
PEI Programs - Early Intervention						
1. Suicide Prevention	313,796	313,796				
2. Humboldt Early Psychosis Intervention Program (HEPI)	325,000	250,000	75,000			
PEI Administration	159,874	159,874				
PEI Assigned Funds	94,364	94,364				
Total PEI Program Estimated Expenditures	2,907,005	2,399,731	507,274	0	0	0

FY 2025/26 MHSA Annual Update Innovation (INN) Funding

County: HUMBOLDT

Date: 11/8/2024

Fiscal Year 2025-26	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Residential Engagement and Support Team (REST)	622,802	444,859	177,943			
INN Administration	44,486	44,486				
Total INN Program Estimated Expenditures	667,288	489,344	177,943	0	0	0

FY 2025/26 MHSA Annual Update Workforce, Education, and Training (WET) Funding

County: HUMBOLDT

Date: 11/8/2024

Fiscal Year 2025-26	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Relias E-Learning	72,521	72,521				
2. HCAI Regional Partnerships	5,872	5,872				
3. Tribal and Equity Consultation	70,000	70,000				
4. Personnel Training and Incentives	70,000	70,000				
WET Administration	0					
Total WET Program Estimated Expenditures	218,393	218,393	0	0	0	0

FY 2025/26 MHSA Annual Update Capital Facilities/Technological Needs (CFTN) Funding

County: HUMBOLDT

Date: 11/8/2024

Fiscal Year 2025-26	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
2.	0					
CFTN Programs - Technological Needs Projects						
3.	0	0				
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	0	0	0	0	0	0