Mental Health Services Act

Annual Update 2022-2023

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Introduction

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

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

MHSA Plans identify services across the age span, with age groups identified as children (0-16 years), transition age youth/TAY (16-25 years), adults (26-59 years) and older adults (60 years and older). Originally, MHSA plans needed to identify programs according to these five (5) MHSA components: Community Services & Supports (CSS); Prevention & Early Intervention (PEI); Innovations (INN); Workforce, Education & Training (WET); and Capital Facilities & Technological Needs (CFTN). In years after Fiscal Year (FY) 2007-08, programs for CFTN programs were not required, but could be supported as needed. Descriptions of these components and their programs are described in their respective sections in this document.

This document was informed by stakeholder input and feedback received during the stakeholder meeting component of the Community Program Planning Process (CPPP). Following a section about Humboldt County's demographics and characteristics, the process and results of the CPPP to date is shared.

Humboldt County Demographics and Characteristics

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

Seventeen percent of the population is ages 0-15; 16% are ages 16-25; 48% are ages 25-59; and 20% 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 (7%). Of those speaking a language other than English at home, 29% speak English less than "very well." For Spanish speakers, 17% speak English less than "very well." Residents who are foreign born are approximately 5.3% of the population. (Data from the American Community Survey, estimates for 2019).

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 provided input by attending a stakeholder meeting and providing verbal comments; by sending comments to the MHSA email address; by leaving a message on the MHSA voice mail; by providing written comments using the MHSA Comment Form; and by using the "Chat" function on the Zoom platform to make a written comment. The Draft 2022-2023 Annual Update and associated MHSA information was also sent via email to stakeholder groups and individuals to provide an opportunity to provide input.

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

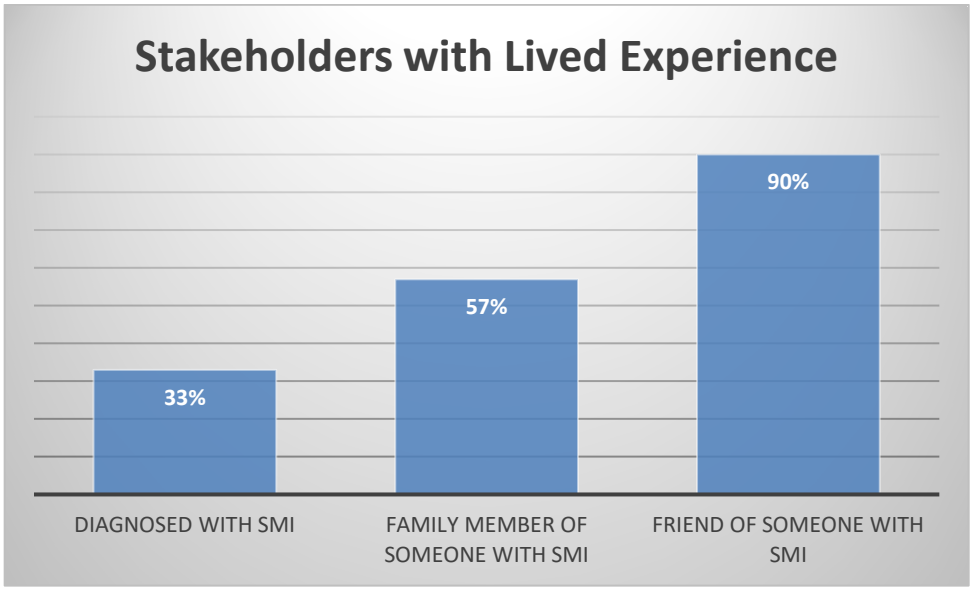
- Draft MHSA Annual Update for 2022-2023, including the draft budget for 2022-2023
- PowerPoint presentation including information on all MHSA components

- The MHSA demographic questionnaire and MHSA Comment Form were provided to meeting participants via a link during the meeting.

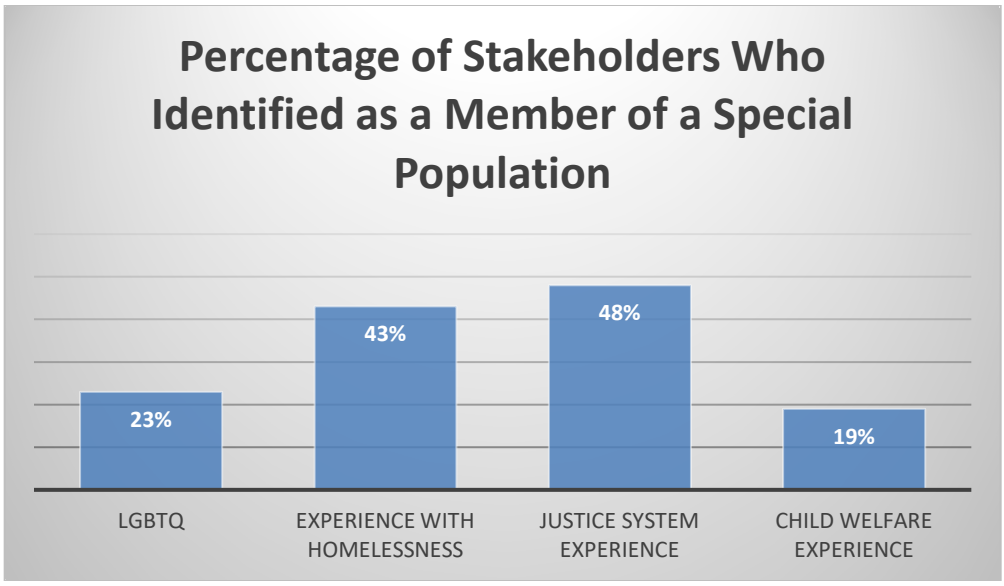
A total of 72 individuals attended one of ten stakeholder meetings and/or provided input via email for the Draft Annual Update 2022-2023.

Stakeholder Demographics at Meetings
Stakeholders attending meetings were asked to complete a MHSA demographic form. Completion of the form was voluntary, and responses were anonymous. A total of 22 individuals, 31% of those attending, completed a demographic form at the stakeholder meetings.

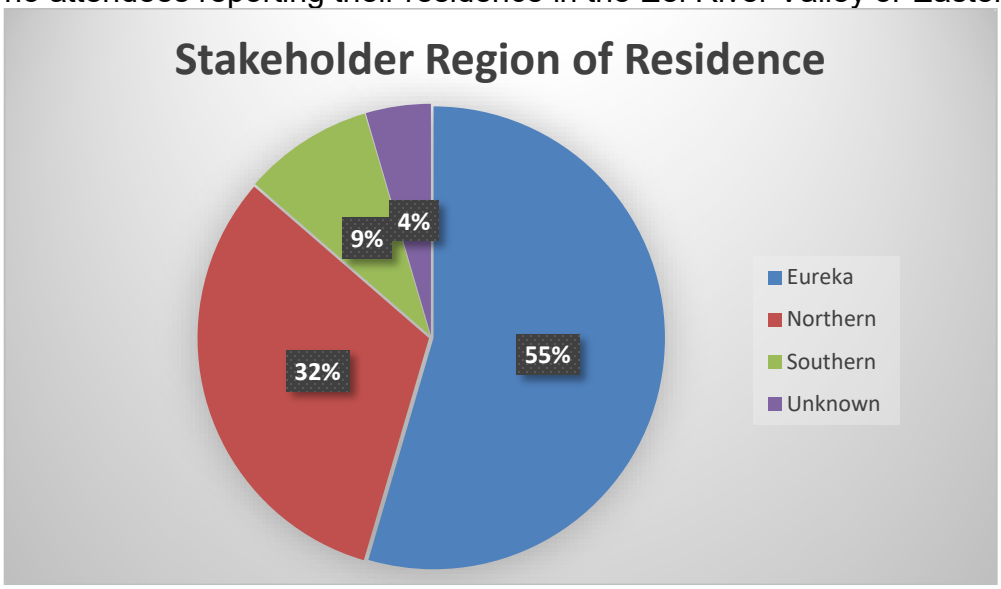
Individuals with lived experience of a serious mental illness (SMI) and their family members are recognized as a vital voice in the MHSA CPP. As seen in the chart below, 33% identified as having a mental illness, and 57% identified as a family member of someone with a mental illness. In addition, 90% of those attending the stakeholder meetings said they were a friend of someone with a SMI.



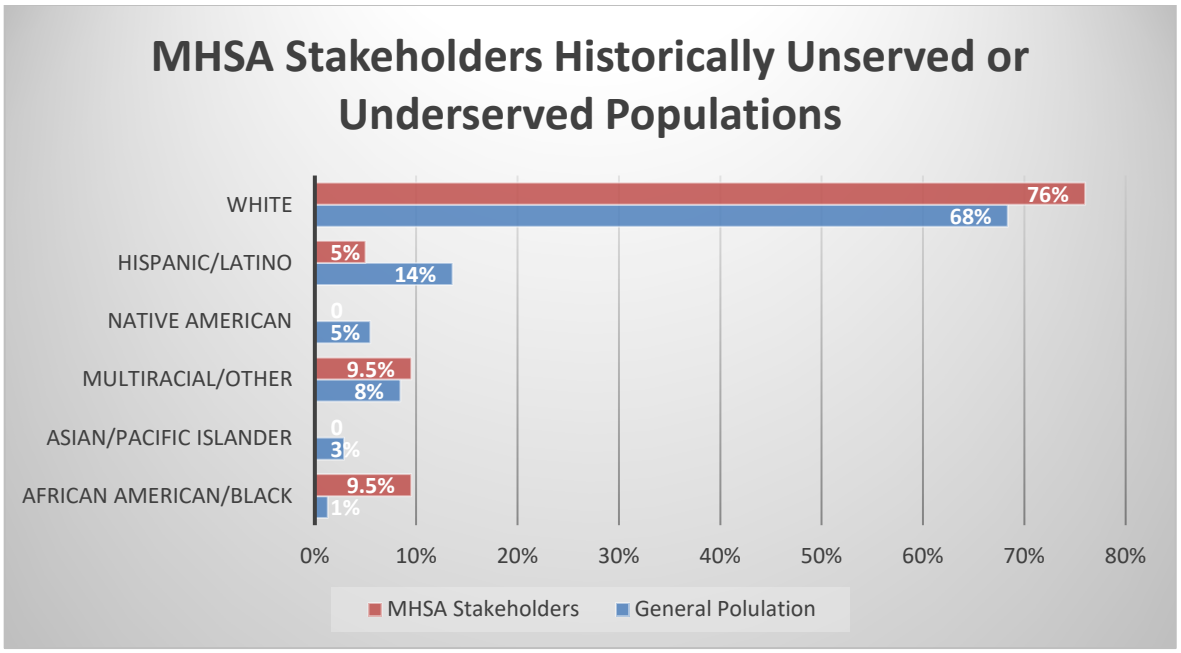
Additional life experiences have been identified as important voices for the CPP. Sexual orientation and gender identity, homelessness, experience with the justice system, experience with Child Welfare, and those whose primary language is not English have life experiences or conditions that can result in challenges to successful mental health access and treatment. The chart below illustrates the inclusion of people with these life experiences in the CPP. Twenty-three percent identified as LGBTQ; 43% identified as having experience with homelessness; 48% had justice system experience; and 19% had Child Welfare experience. Because only one stakeholder stated their primary language was a language other than English this is not indicated on the chart.



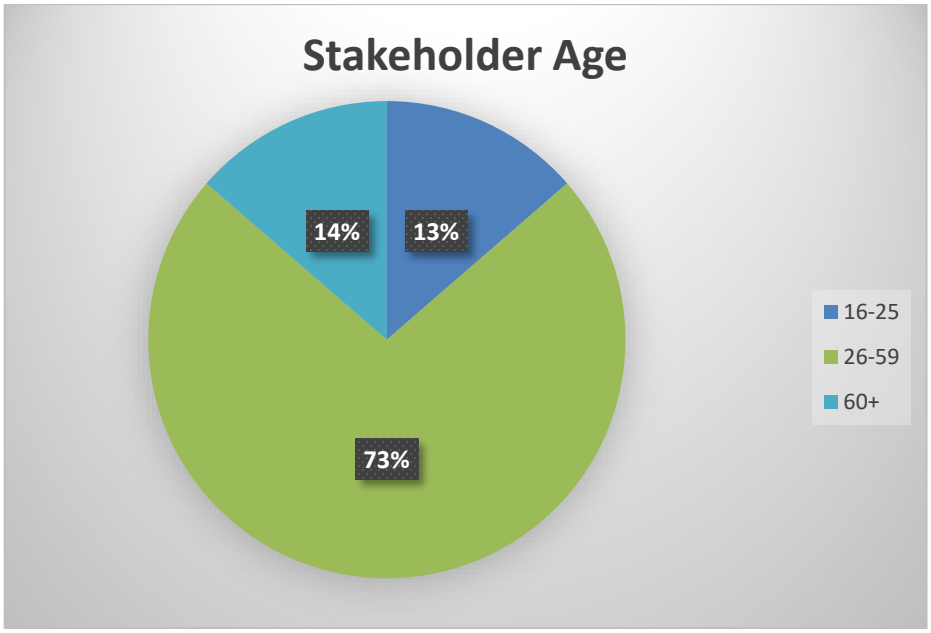
In these stakeholder meetings, 32% of participants resided in the Northern Humboldt region, which includes Arcata, Blue Lake, McKinleyville, and areas north, and 55% of participants resided in Eureka. Nine percent resided in Southern Humboldt, which includes Redway, Petrolia and Garberville. Four percent provided no answer. There were no attendees reporting their residence in the Eel River Valley or Eastern Humboldt.



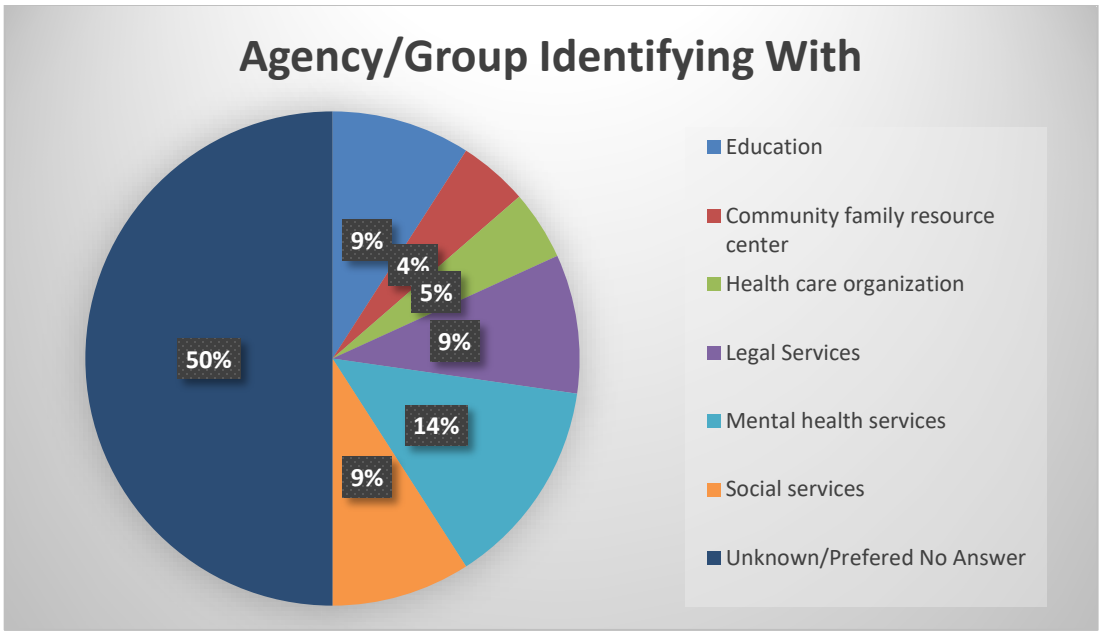
Efforts are made to reach participants that reflect the racial and ethnic diversity of Humboldt County. Of those attending stakeholder meetings, 5% were Hispanic/Latino as compared to 14% of the Humboldt County general population; 9.5% were Multiracial/Other as compared to 8% of the County general population; and 9.5% were Black/African as compared to 1% of the general population. There were no Native American or Asian/Pacific Islander stakeholders completing the demographic form.



Thirteen percent of those completing the demographic form were ages 16-25; 73% were ages 26-59, and 14% were age 60+.



The chart below illustrates the representation from community agencies participating in the stakeholder meetings. It shows that the process included individuals from mental health services, 14%; education, 9%; health care organizations, 5%; social services, 9%; Community and Family Resource Centers (CRC/FRC), 4%; Legal Services, 9%. Fifty percent provided no response.



After the stakeholder meetings were completed, the notes from each meeting, the Comment Forms received at each meeting, and the comments received from the MHSA Email and phone line were reviewed. A stakeholder meeting report was prepared and presented to Behavioral Health Administration for consideration of changes to programs based on the input. The draft document was modified based on that input. These modifications were an updated budget for Fiscal Year 2022-2023 that accounts for the improved projection of MHSA funds for the next year, and the addition of a proposed new Innovation project, Semi-Statewide Enterprise Health Record project, discussed further in this Annual Update. The stakeholder meeting report was posted to the Mental Health Services Act webpage on the County website.

30-Day Public Review and Comment Period and Public Hearing

In accordance with MHSA regulations, the Annual Update for FY 2022-2023 was available for public review and comment for a 30-day period from May 25 through June 23. The Behavioral Health Board (BHB) conducted a Public Hearing on the Annual Update at its June 23, 2022 meeting. There was one substantive comment received--that there was insufficient input from the Eastern Humboldt region. During the next planning process additional outreach will be made to this region.

Complaints and Grievances

If there is a complaint, dispute or grievance from the general public about MHSA program planning the MHSA Issue Resolution Policy and Procedure will be followed. This procedure is as follows. The issue is forwarded to the MHSA Program Manager (MHSA-PM) or designee through either US Postal Service mail: MHSA Program Manager, DHHS Behavioral Health, 720 Wood St. Eureka CA 95501, or email MHSAcomments@co.humboldt.ca.us. Issues will be recorded at time of receipt in the DHHS-BH Client Concerns Log and forwarded to the Program Lead of the program involved. Once a resolution is decided upon by the Program Lead the MHSA-PM will contact the originator of the issue to notify them of the resolution. Issues will be followed

up on within five working days. Resolution of the issue will be enacted within 30 days from receipt of issue.

Behavioral Health Capacity Assessment

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

1. The MHSA Community Program Planning Process (CPPP) for gathering community input into the Three Year Plan for 2020-2023, the Annual Update for 2021-2022, and the Annual Update for 2022-2023 provides information directly from stakeholders about needs, including those from diverse populations.
2. Updated annually, the Mental Health Cultural Competence Plan (MHCCP) provides data on the racially and ethnically diverse populations served, bilingual proficiency in threshold languages, and percentages of diverse cultural, racial/ethnic and linguistic groups represented among direct service providers, as compared to the population needing services and the total population being served. The MHCCP provides the most relevant and pertinent information on the topic of racial/ethnic/linguistic capacity. The 2021 MHCCP is located here: https://humboldtgov.org/DocumentCenter/View/70542/Behavioral-Health---Cultural-Competency-Plan---Updated-2021?bidId=
3. DHHS Workforce Survey, conducted in August-September 2021, 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. The most recent NACT and supporting documentation was submitted July 1, 2021.

System Strengths

Network Adequacy (NACT) documents the federal standards of time, distance and timely access requirements with which the Mental Health Plan must comply. Time and distance standards are up to 60 miles and 90 minute drive from the beneficiary's place of residence to the provider's site. Timely access requires the Plan to meet State standards, taking into account the urgency of the need. The standards are documented with Geographic Access Maps showing beneficiary and provider locations. NACT includes information on language capacity for Russian, Spanish, Tagalog, Vietnamese, American Sign Language, and whether Language Line is available. Humboldt County's NACT also

included the American Indian health facilities in the county. Results from the NACT submitted in July 2021 have not yet been received. The results from the 2020 NACT indicated that DHHS Behavioral Health is meeting the required standards. Another NACT will not be submitted until July 2022.

The Behavioral Health Cultural Responsiveness Committee (BHCRC) is a strength in the agency. BHCRC facilitates projects to gather data and address issues surrounding diversity. During the past year the Latino Outreach project was restarted and will provide outreach to the Latino population to inform them about services available. The Client Information Form was modified to increase the number of choices for ethnicity and to add choices for gender identity and sexual orientation. BHCRC oversees and approves the development of the annual Cultural Competence Plan.

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

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

System Limitations

The sources listed give a picture of the limitations faced in serving diverse racial/ethnic populations in Humboldt County, which is a remote, rural county located on the North

Coast of California. There are few culturally and linguistically diverse staff in the agency, and it is difficult to hire staff due to severe behavioral health staff shortages, which is true throughout California as well as the nation. It should be noted that for several years Humboldt County's threshold language was Spanish, and it was a limitation of the system that there were few providers who were bilingual in both Spanish and English. Recent data from the California Department of Health Care Services, Research and Analytic Studies Division, however, indicates that Humboldt County has had no threshold language since January 2015. Threshold language is defined as 3,000 Medi-Cal beneficiaries or 5 percent of each county's total Medi-Cal Beneficiary population, whichever is lower. Though there is currently no threshold language, DHHS Behavioral Health remains committed to providing services to clients in their preferred languages through the use of the Language Line, or through providing a local interpreter if one is available in the client's preferred language.

The MHSA CPPP for the Three Year Plan 2020-2023, the Annual Update 2021-2022 and the Annual Update 2022-2023 provided information on diverse populations. For the priority category Providing Bilingual and Culturally Competent Services:

- Stakeholders at community meetings ranked this as number 13 among all priorities for the Three Year Plan. It was one of the top five priorities for the Annual Update 2021-2022, and one of the top seven priorities in the CPPP for the Annual Update 2022-2023. For the Annual Update comments included providing better training; healthy cultural activities and services validating the knowledge and experience of tribes; adult immigrant counseling; and education, outreach and programs with more Spanish-speaking clinicians and services to the Spanish-speaking community.
- Stakeholders completing the Community Survey for the Three Year Plan ranked this as 13 among all priorities and indicated that racial/ethnic populations are among those not adequately served by current MHSA programs. These racial/ethnic populations included the African American, Asian, Latino, Native American and Pacific Islander communities.

In the MHCCP, an analysis of disparities for those in Humboldt County with Medi-Cal versus those that are served by DHHS Behavioral Health was performed for calendar year 2019. This was a simple descriptive analysis about differences in each population served by Behavioral Health. Differences were found in serving Asian/Pacific Islanders, Multiracial/Other, and Hispanic/Latino populations.

- Three percent of those with Medi-Cal were Asian Pacific Islander, and 1% used DHHS-Behavioral Health services.
- Sixteen percent of those with Medi-Cal were Multiracial/Other, and 13% used DHHS-Behavioral Health services.
- Thirteen percent of those with Medi-Cal were Hispanic/Latino, and 9% used DHHS-Behavioral Health services.

There could be many reasons that these Medi-Cal populations do not use DHHS Behavioral Health services. Asian/Pacific Islanders may not use County services because of levels of acculturation within their communities, or because there are no providers speaking their languages. Hispanic/Latino populations may not use DHHS Behavioral

Health services due to levels of acculturation, cultural beliefs about behavioral health issues and origins, lack of knowledge about available services, or because of the scarcity of providers speaking Spanish.

In addition to looking at disparities among Medi-Cal beneficiaries and their use of Behavioral Health services, the MHCCP reported on the data available for the Behavioral Health workforce. The September 2021 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 August-September 2021 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 MHCCP.

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

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

Community Services and Supports (CSS) Component

Seventy-six percent (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 were approved in the Three Year Plan and that will continue to be supported, contingent upon the availability of MHSA revenue.

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

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

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

Partners are served through various DHHS Behavioral Health programs including Children and Family Services Transition Age Youth Division, Housing, Outreach and Mobile Engagement (HOME), and Older and Dependent Adults programs. However, Full Service Partners are primarily served through the Comprehensive Community Treatment (CCT) program. Modeled after the evidence- based program Assertive Community Treatment, CCT provides intensive behavioral health services and community supports to assist clients in their recovery. These include access to housing, medical, educational, social, vocational, rehabilitative, or other needed community services for those with

serious mental illness who are at-risk for psychiatric hospitalization, incarceration, homelessness, or placement in more restrictive facilities.

Children's Behavioral Health has identified 252 youth, from 0-15 years old, that would be eligible for FSP during the 20/21 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 our 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, we anticipate we will also be able to offer Therapeutic Foster Care and an in-county Short Term Residential Treatment Program during the current fiscal year. Our 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. Our staff work closely with our local Emergency Rooms to coordinate care for youth that visit them due to a behavioral health crisis. For current and former foster youth and caregivers, we also coordinate with our Family Urgent Response System (FURS) which can respond 24/7 if there urgent needs that require in-person response. Additionally, in order to meet FFPSA requirements, our intent is to contract with an Organizational Provider in the next year to provide Wraparound services. We anticipate building into this contract the capacity to provide High Fidelity Wraparound services to FSP eligible youth, including 24/7 availability.

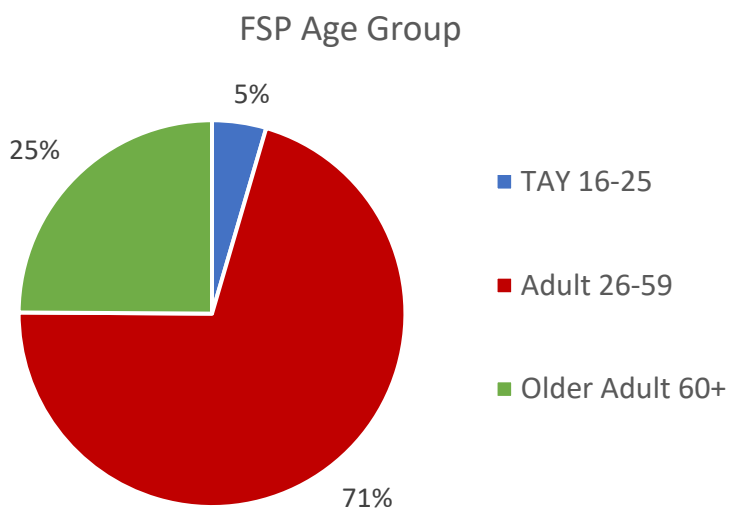
An estimated 225 clients will be served annually as FSPs. The age groups expected to be served are:
TAY: 13
Adults: 143
Older Adults: 69

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

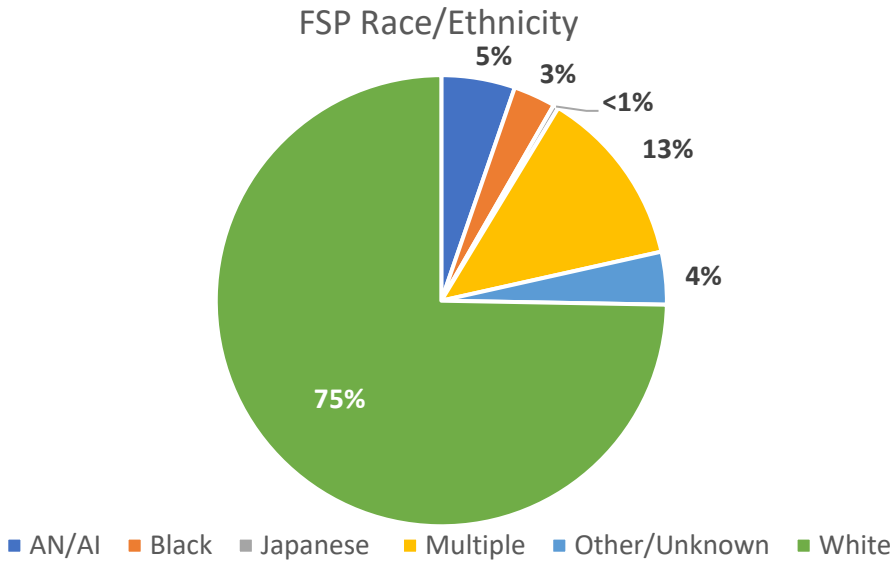
- Decrease in homelessness days
- Decrease in behavioral health emergencies
- Decrease in psychiatric hospitalizations
- Decrease in arrests
- Decrease in incarcerations

Report for FY 2020-2021

There were 265 Full Service Partners (FSPs) enrolled for the period July 1, 2020 through June 30, 2021. Five percent of FSPs were ages 16-25, 71% were ages 26-59, and 25% were age 60+. While enrollment as an FSP is assessed for children under the age of 16 who meet the FSP eligibility requirements, to date the full spectrum of services have been provided through alternate programs and funding sources other than MHSA FSP funding.



As the chart below shows, for the period July 1, 2020 through June 30, 2021, the percentage of FSPs who identified as White was 75%; the percentage who identified as American Indian/Alaska Native was 5%; the percentage who identified as African American was 3%; the percentage who identified as Multiracial was 13%; Less that 1% identified as Japanese and 4% were Other/Unknown.



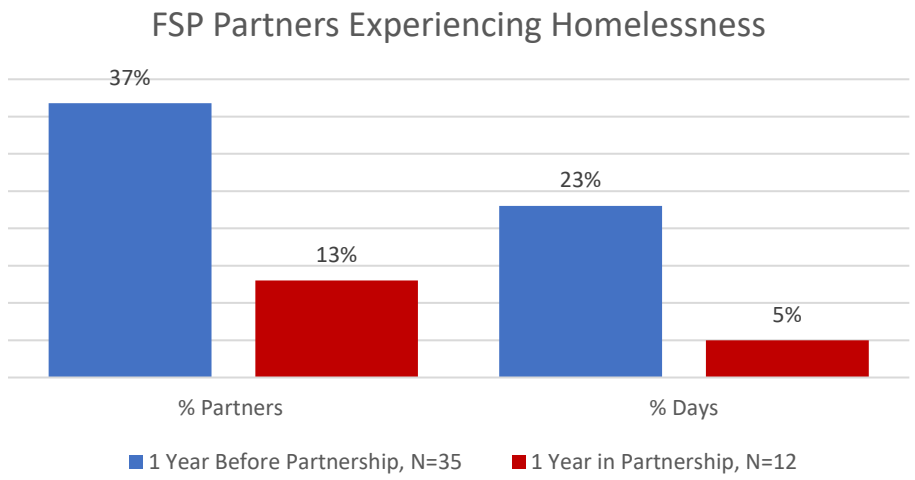
Forty-two percent of FSP clients for the period July 1, 2020 through June 30, 2021 were female and 58% were male.

FSPs exit a Partnership due to a variety of reasons. During the period July 1, 2020 through June 30, 2021, 49 FSPs were discharged from the program for the following reasons.

Discharge Reason	# Discharged	Percentage ALL FSP	Percentage TAY	Percentage Adult	Percentage 60+
Met Goals	20	41%	10%	55%	35%
Target Criteria	3	6%	0%	67%	33%
Not Located	7	14%	14%	86%	0%
Moved	5	10%	0%	60%	40%
Deceased	5	10%	0%	60%	40%
Discontinue	4	8%	50%	50%	0%
Serving Jail	1	2%	0%	100%	0%
Institution	4	8%	0%	100%	0%

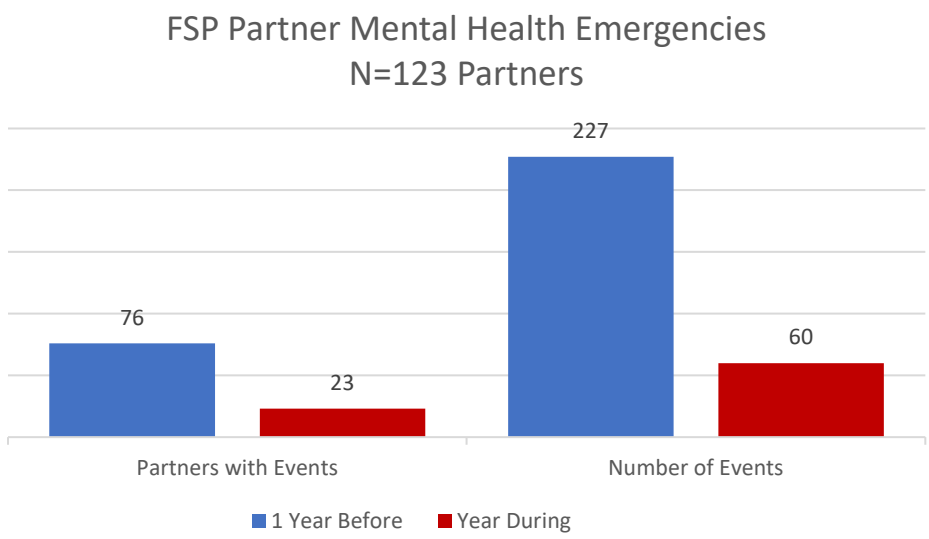
HOMELESSNESS

For the 123 who enrolled in an FSP, 35 experienced 7,945 days of homelessness in the year prior to enrollment. In the most recent year in the FSP, 12 partners experienced 1,733 days of homelessness. This represents 37% of partners experiencing 23% of homelessness days one year before the partnership, and 13% of partners experiencing 5% of homelessness days after one year in partnership.



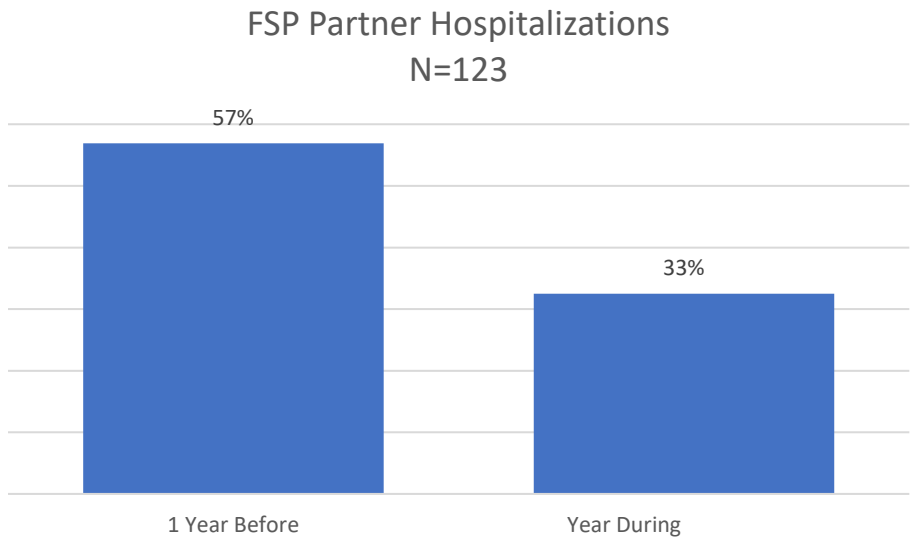
MENTAL HEALTH EMERGENCY

Of the 123 Full Service Partners enrolled in FSP there were 23 (19%) who participated at least one year in the program. Of these 123, 76 (62%) experienced 227 mental health emergencies in the year prior to enrollment as an FSP. In the most recent year during enrollment, 23 (19%) experienced 60 mental health emergencies, a decrease of 167 events.



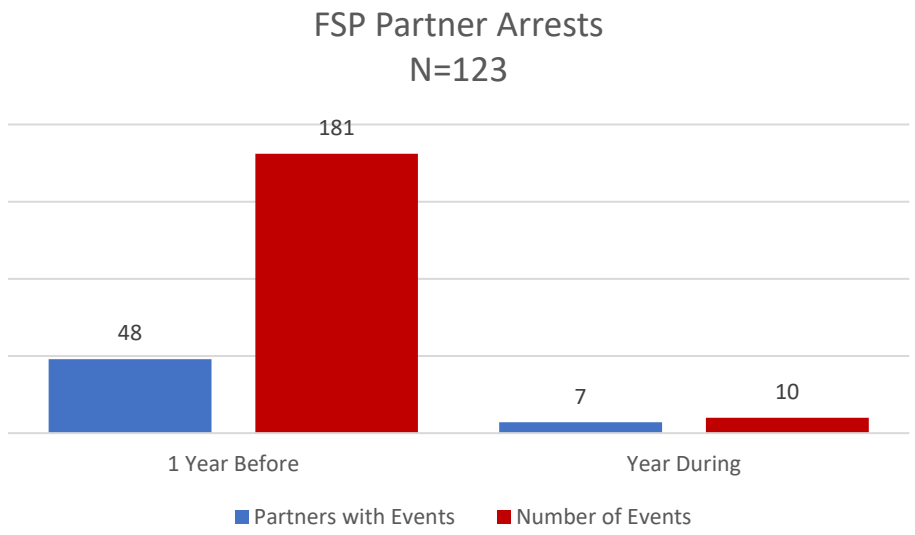
HOSPITALIZATION

Of the 123 Full Service Partners who participated at least one year in the program, 70 (57%) experienced psychiatric hospitalization in the year prior to enrollment as an FSP. In the most recent year during enrollment 40 (33%) experienced psychiatric hospitalizations.



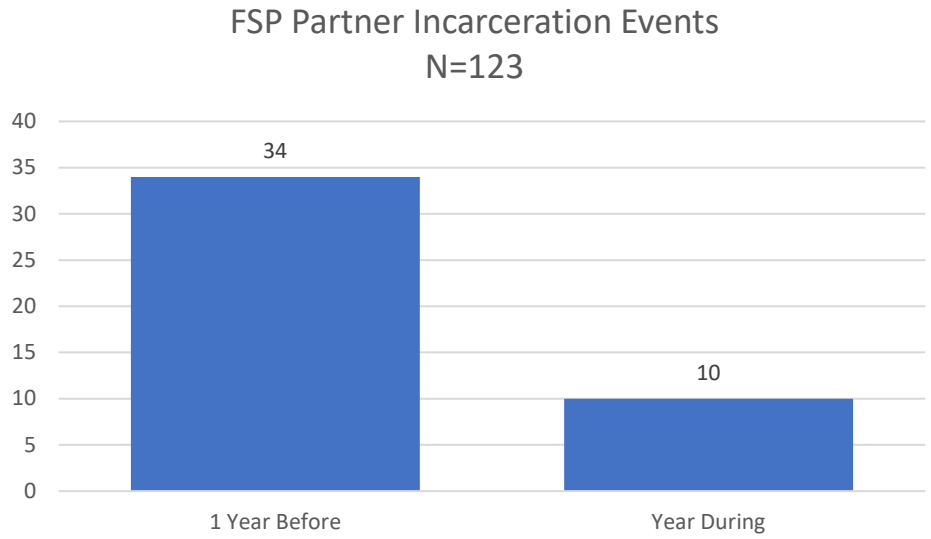
ARRESTS

Of the 123 Full Service Partners who served at least one year in the program, 48 (39%) experienced 181 arrests in the year prior to enrollment. In the most recent year during enrollment seven partners experienced 10 arrests.



INCARCERATION

Among the 123 Full Service Partners who served at least one year in the program there were 34 incarceration events for 2,474 days in the year prior to enrollment as a Partner. In the most recent year during enrollment there were 10 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 Behavioral Health Plan Contract, including guidelines for target population and services provided. Consumers seeking services must meet medical necessity criteria, have a qualifying DSM-5 diagnosis, meet functional impairment criteria, and meet intervention related criteria in order to receive ongoing Specialty Mental Health Services.

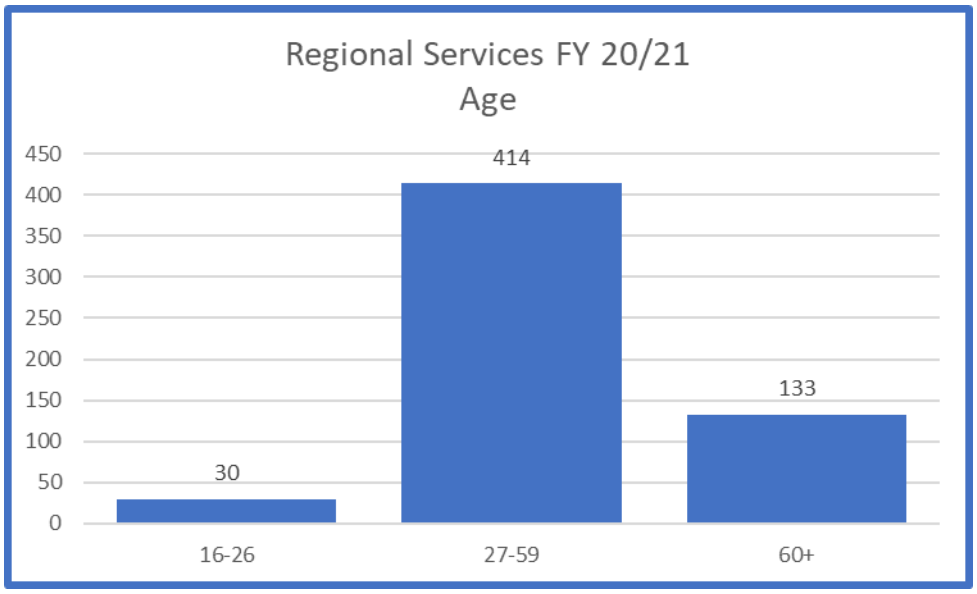
Regional Services receives referrals from other programs within DHHS as well as from many community providers. These community providers include multiple tribes, K'ima:w Medical Center on the Hupa Reservation, United Indian Health Services, Willow Creek Community Health Center, Willow Creek Community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

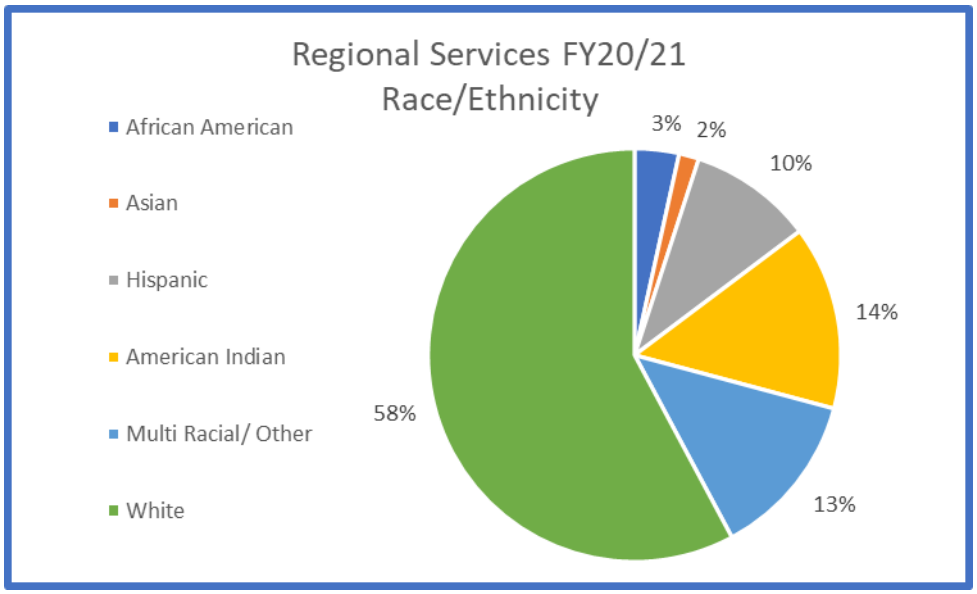
Clients can be met in their homes or in different community sites. Regional Services staff utilize offices in Eureka, Garberville, Willow Creek, and Weitchpec. Staff have also developed close working relationships with many community partners that allow them to utilize office space as needed in other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

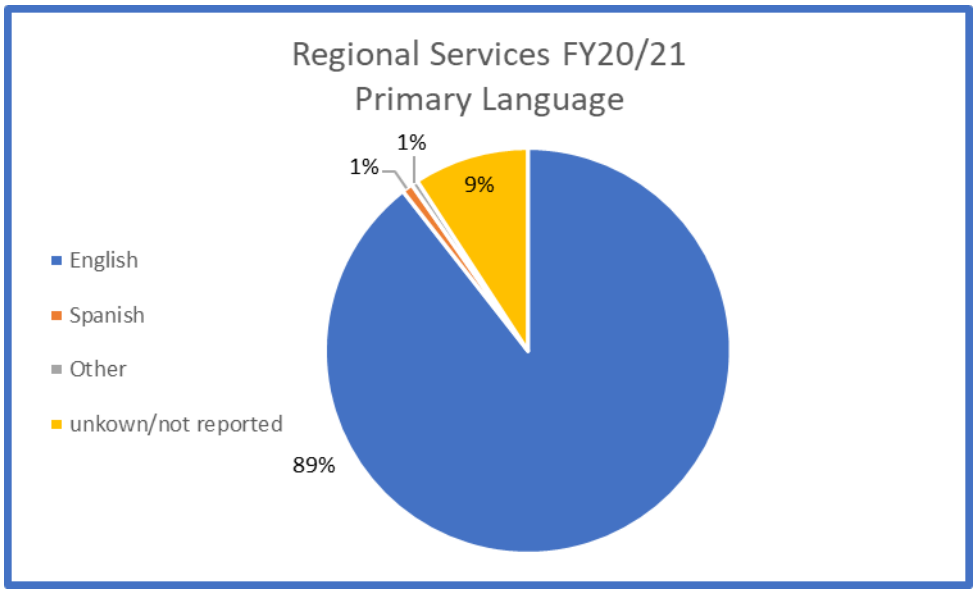
Regional Services includes Behavioral Health Clinicians, Case Managers and Community Health Outreach Workers. Staff provide outreach in the community to individuals in need of services and work to link individuals with appropriate services. Behavioral Health Clinicians screen and assess individuals requesting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

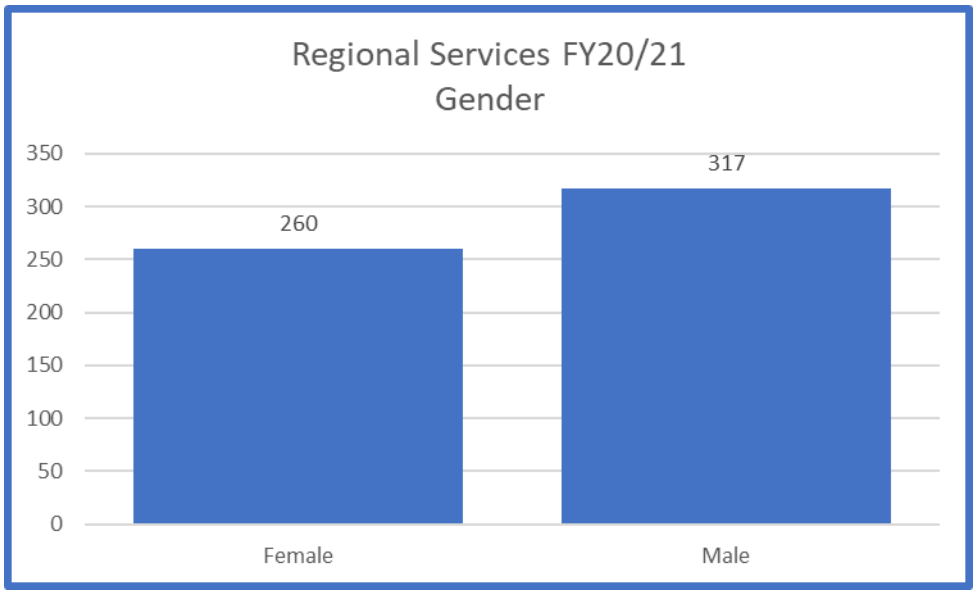
MHSA CSS funding will continue to support a proportion of the salary costs for Regional staff. Outcomes will be measured by the number of clients reached and the program aims to complete 50 new client assessments per year.

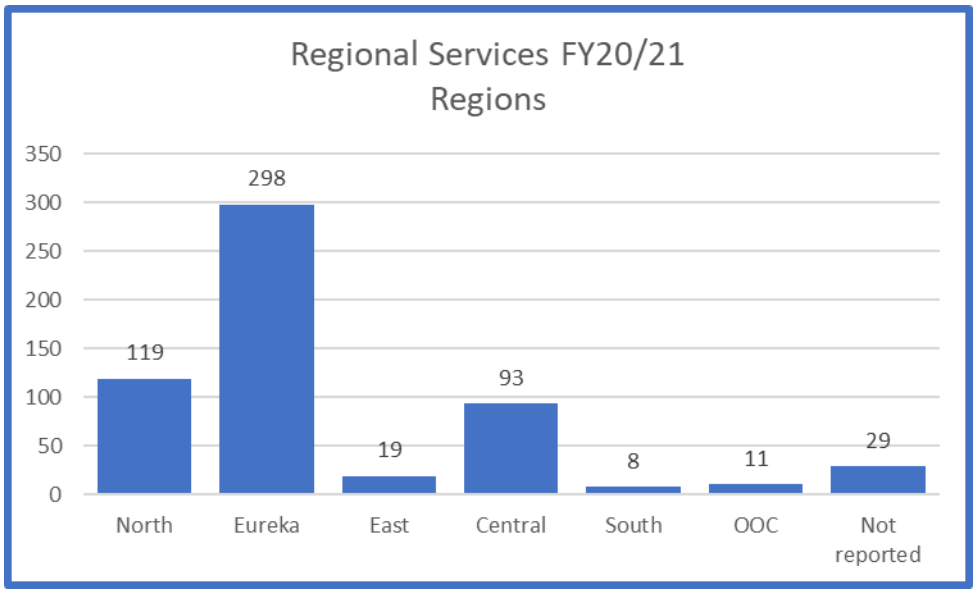
Report for Fiscal Year 2020-2021


Regional Services FY 20/21
Age
450
400
350
300
250
200
150
100
50
0
414
133
30
16-26
27-59
60+


Regional Services FY20/21
Race/Ethnicity
African American
Asian
Hispanic
American Indian
Multi Racial/ Other
White
3%
2%
10%
14%
13%
58%


Regional Services FY20/21
Primary Language
1%
1%
9%
English
Spanish
Other
unkown/not reported
89%


Regional Services FY20/21
Gender
350
300
250
200
150
100
50
0
260
317
Female
Male



Community Services & Supports: Older Adults and Dependent Adults

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

Outreach, Prevention and Education

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

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

Outcomes to be tracked include the following:

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

An estimated 150 individuals will be contacted through outreach, prevention and education during fiscal year 2022-2023.

Behavioral Health Services to Clients

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

Client Outcomes:

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

Report for Fiscal Year 2020-2021

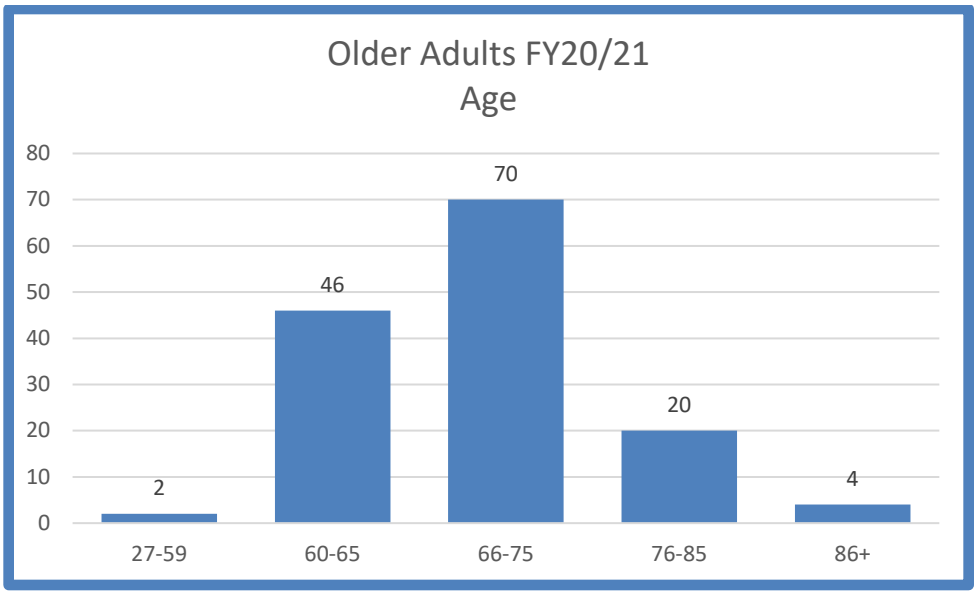
Outreach, Prevention and Education

During Fiscal Year 20/21 a total of 142 individuals were contacted by the Behavioral Health Clinician assigned to the Older and Dependent Adults program, primarily through outreach, prevention and education activities. The Clinician is contacted by Adult Protective Services, In Home Supportive Services, or community services such as Open Door Community Clinic, local hospitals or PACE. If a mental health need is identified for an older or dependent adult, the Clinician then assists the client in navigating the MH system and identifies appropriate referrals to offer specialized support to the client.

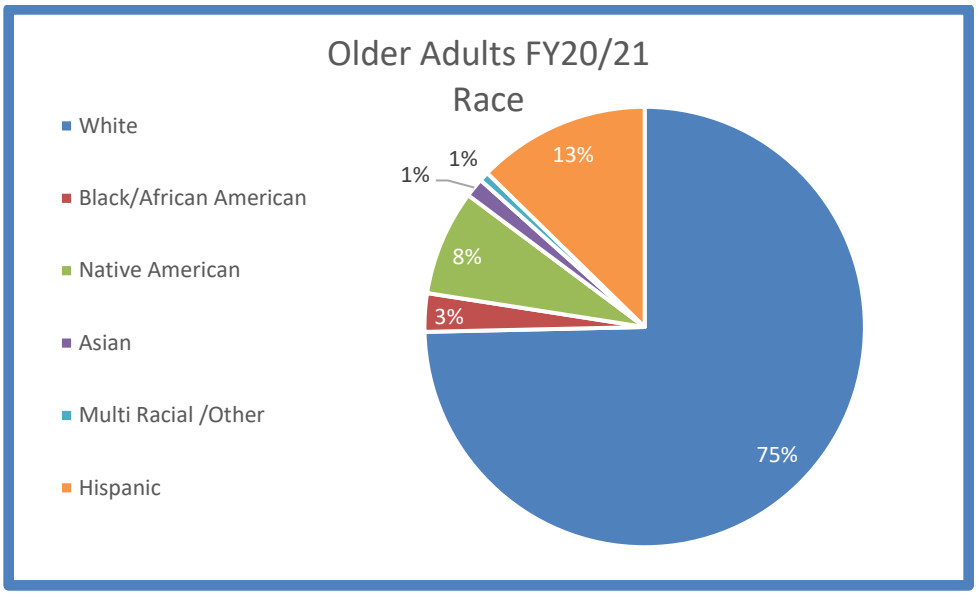
Many of these clients are reaching out for the first time. This program strives to reduce the stigma of mental health labels by offering personalized care, education, intervention and connections to services in the community.

Descriptive statistics for participants in the Older and Dependent Adult program for FY 20/21 are discussed below.

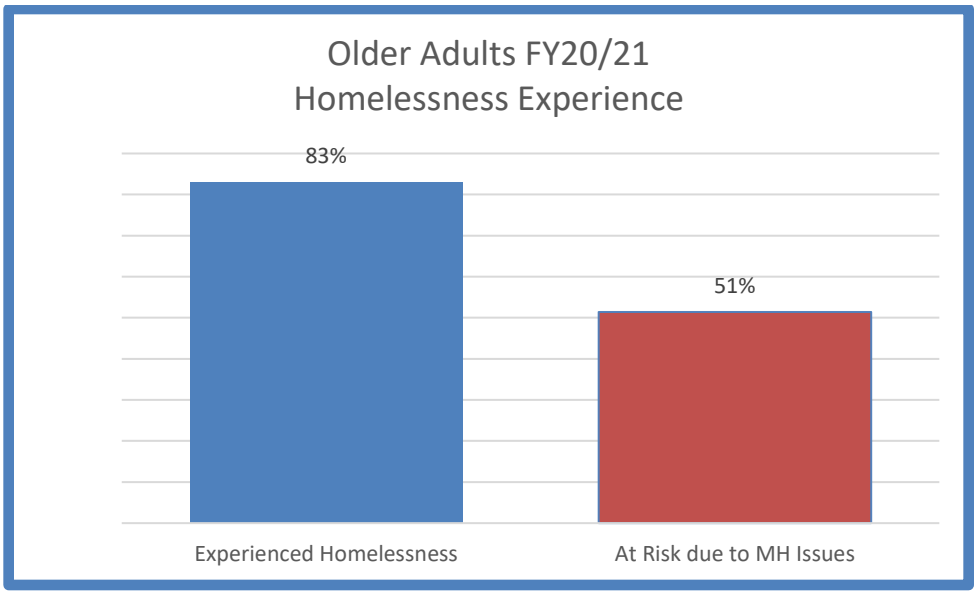
Seventy-One (50%) of the participants were male and 71 (50%) were female. Two (1%) were age 27-59, 46 (32%) were ages 60-65, 70 (49%) between ages 66-75, 20 (14%) between ages 76-85, and 4 (3%) age 86+.



Among the 142 Older Adults served in FY20/21, 106 (75%) were White, 4 (3%) were African American, 11 (8%) were Native American, 2 (1%) were Asian and 1 (1%) were Multi Racial/Other. Eighteen (13%) of the participants were Hispanic.

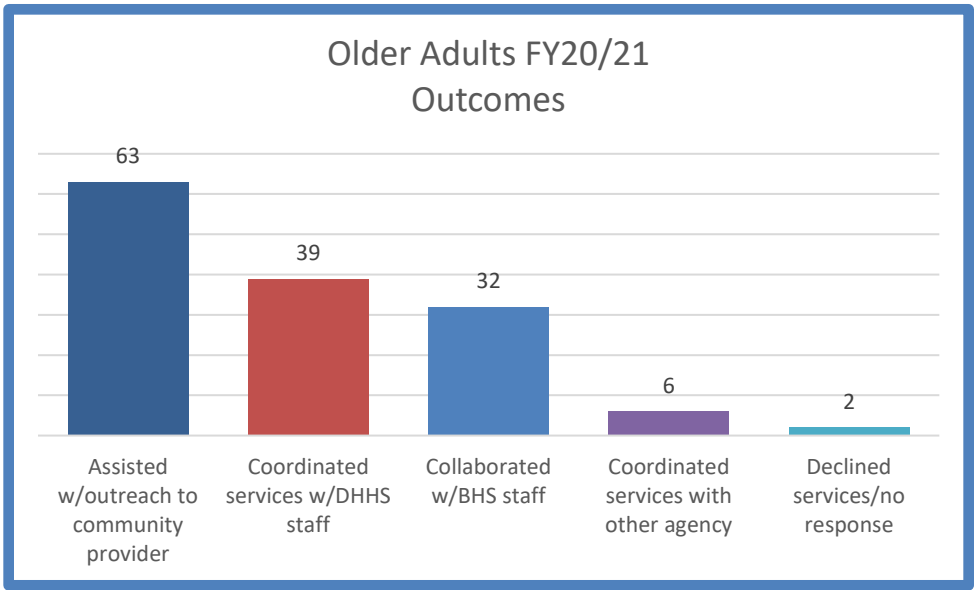


Of the 142 participants in the Older Adult program in FY20/21 118 (83%) self-identified as having experienced homelessness at some time and 73 (51%) expressed feeling at risk of homelessness due to mental health issues.



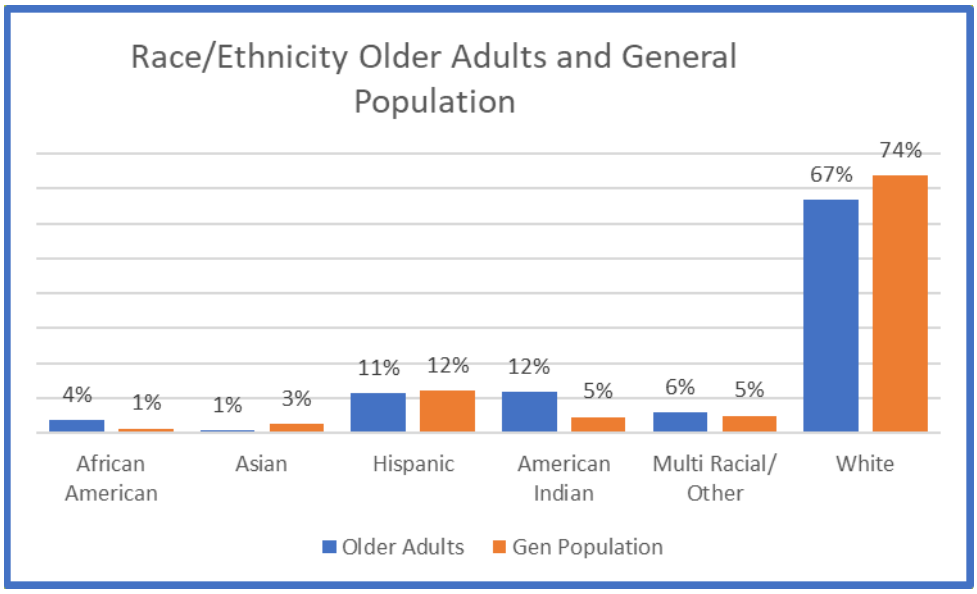
Outcomes

For these 142 Older Adult participants 63 (44%) were assisted with outreach to a community provider; for 39 (27%) services were coordinated with DHHS staff; for 32 (23%) collaboration with Behavioral Health staff was implemented; 6 coordinated services with another agency and 2 participants declined services.



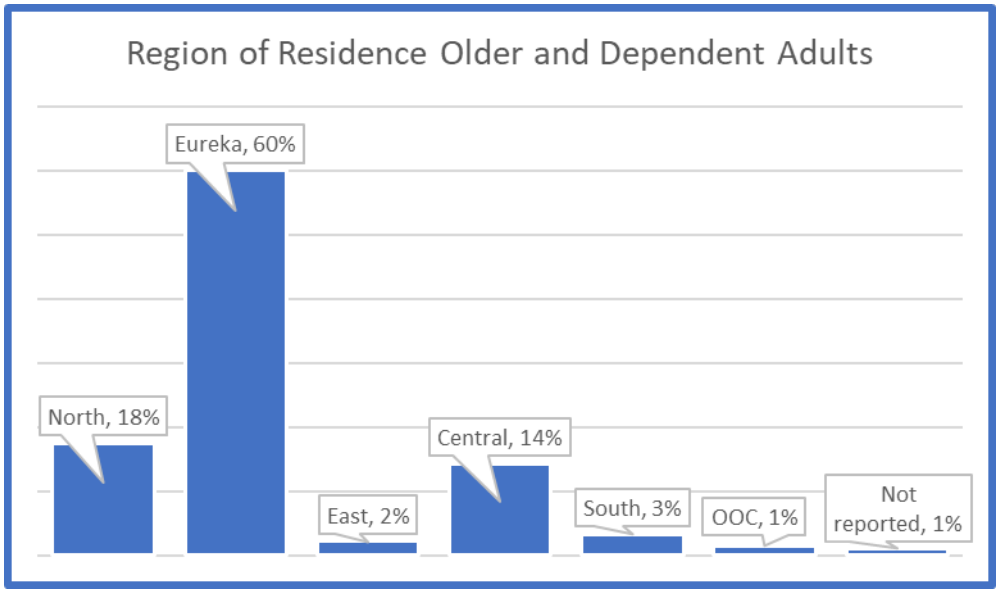
Mental Health Services to Clients

In addition to contacts made through outreach, prevention and education, 273 individuals were provided services as clients of Behavioral Health for Fiscal Year 2020-2021. Of these, 67% were White, compared to 74% of the general population; 12% were American Indian, compared to 5% of the general population; 11% were Hispanic compared to 12% of the general population; 4% were African American, compared to 1% of the general population; 1% were Asian, compared to 3% of the general population; and 6% were Multi Racial/Other.



Forty-seven percent of clients served were female, and 53% male.

Sixty percent of those served reside in Eureka, 18% in Northern Humboldt, 14% in Central Humboldt, 3% in Southern Humboldt, and 2% in Eastern Humboldt. One percent reside out-of-county (OOC) and 1% not reported.



Community Services and Supports: Crisis Residential Treatment

(formerly Sub-Acute Transitional Behavioral Health, Specialty Behavioral Health and/or Social Rehabilitation Services)

Based on input from stakeholders over the past several years, including in the CPPP for the Three Year Plan 2020-2023, in FY 2019-2020 Humboldt County Behavioral Health (DHHS-BH) sent out a Request for Proposals for qualified behavioral health treatment facilities to provide sub-acute transitional behavioral health, specialty behavioral health

and/or social rehabilitation services to eligible DHHS-BH clients as part of a long-term adult residential treatment and/or supportive living program.

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 will help establish a Crisis Residential Treatment Program in our community. The current challenge is finding a location for the program. Willow Glen and BH staff are working hard on identifying and securing this location. It is estimated that services to clients will begin in late 2022.

Crisis Residential Treatment is a Medi-Cal billable service that allows eligible Medi-Cal beneficiaries to receive immediate housing and treatment for those stepping down from an Acute Psychiatric Hospitalization and/or in danger of their symptoms worsening that would require emergency Psychiatric Hospitalization. Crisis Residential allows for a stay up to 90 days. During that time 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 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. We anticipate that this program will benefit individuals on our Lanterman Petris Short (LPS) Conservatorship as well as clients involved in our soon to be established 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. Additional outcome measures including re-hospitalization rates and reduction in Administrative Bed Days for individuals waiting to be discharged from psychiatric facilities and will be tracked by the Behavioral Health Administrative Analyst.

Community Services and Supports: Housing Support

In September 2020 Behavioral Health received a small amount of funds from the California Housing Finance Agency (CalHFA) as accrued interest from the MHSA Housing Program. Per statute these funds were used to provide housing assistance to individuals eligible for MHSA services and supports. These funds were used in 2020-2021 to provide assistance such as rental assistance, security deposits, utility deposits, move-in assistance and utility payments. The funds were fully expended during the fiscal year.

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

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

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 HUD to name a few. Currently these efforts exist to find permanent supportive housing for homeless and unsheltered individuals in our county. REST provides a missing competent within this continuum by helping individuals remained housed while assisting in transition to HUD programs.

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 will be at risk of homelessness or be homeless, and may include:

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

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

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, a delay in hiring Case Managers for the program has moved out the starting date, which is now expected by the beginning of the new fiscal year.

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

NEW Innovation: CalMHSA Semi-Statewide Enterprise Health Record

Humboldt County Behavioral Health (BH) is proposing to allocate Innovation funds to participate in a Semi-Statewide Enterprise Health Record Initiative spearheaded by the California Mental Health Services Authority (CalMHSA). CalMHSA, a Joint Powers Authority (JPA) operating on behalf of California counties, is utilizing its unique position to launch a Request for Proposals (RFP) to engage Electronic Health Record (EHR) vendors to create a tool that meets California-specific enterprise needs. With the rapidly increasing complexity of the Drug Medi-Cal Organized Delivery System, participation in a regional network under the upcoming California Advancing and Innovating Medi-Cal (CalAIM) transformations mark this as a crucial time to update our Health Information Technology to meet the challenges ahead.

Until now, Behavioral Health Plans (BHPs) have had a limited number of options from which to choose when seeking to implement a new EHR. The majority of EHR vendors develop products to meet the needs of the much larger physical health care market, while the few national vendors that cater to the behavioral health market have been disincentivized from operating in California by the many unique aspects of the California behavioral health landscape. This has resulted in the majority of county BHPs largely dissatisfied with their current EHRs, yet with few viable choices when it comes to implementing new solutions. The pervasive difficulties of configuring the existing EHRs to meet the everchanging California requirements, collecting and reporting on meaningful outcomes for all of the county behavioral health services (including MHSA-funded activities), and providing direct service staff and the clients they serve with tools that enhance rather than hinder care have been difficult and costly to tackle on an individual county basis.

This project is an opportunity for counties to take a substantial leap forward with regard to EHRs. CalAIM changes target documentation redesign, payment reform and data exchange requirements, bringing California BHP requirements into greater alignment with national physical healthcare standards, thereby creating a lower-barrier entry to EHR vendors seeking to serve California. At the same time, the COVID-19 pandemic has increased the demand for behavioral health services, has disproportionately impacted communities of color, and has factored into the staggering workforce shortages faced by counties throughout California. BHPs need to foundationally revamp their primary service tool to meet the challenges and opportunities of this moment. BHPs, in partnership with CalMHSA, are positioned to do that through the Semi-Statewide Enterprise Health Record initiative.

The target population for this Semi-Statewide Enterprise Health Record Project includes all individuals who turn to or are referred to the BHP for intervention. This population includes all consumers who are identified with a diagnosis that meets the criteria for substance use disorder(s), those who may have a co-occurring substance use disorder, Serious Mental Illness (SMI), and are Seriously Emotionally Disturbed (SED). This population also includes those who are in need of mental health or substance use treatment who have not been formally diagnosed. The target population includes those with Medi-Cal as well as those who are indigent and underserved or may have an inability to pay.

Humboldt County's participation in this project will address some of the needs and themes expressed by community stakeholders during the last several years. In the community program planning process for the 2020-2023 Three Year Plan the top-ranking theme was to expand and increase mental health services and access to services. The third-ranking theme was to increase support for the behavioral health workforce. EHRs have been identified as a source of burnout and dissatisfaction among healthcare direct service staff, including in Humboldt County. EHRs, which were first and foremost designed as billing engines, have not evolved to prioritize the user experience of either the providers or recipients of care. The impact of this design issue is telling – an estimated 40% of a healthcare staff person's workday is currently spent in documenting encounters, instead of providing direct client care. This 40% estimate does not even consider the full breadth of the BHP workforce, which relies on a wide diversity of provider types, not just direct service providers, needed to respond to the population. Participation in this project is anticipated to increase direct mental health services by decreasing the time a provider spends in documenting encounters, and to increase workforce satisfaction with their jobs. Optimizing EHR platforms used by providers to meet their daily workflow needs can enhance their working conditions, increase efficiencies, and reduce burnout. This increased efficiency translates into more time to meet the needs of Humboldt County residents with serious behavioral health challenges, while improving overall client care and increasing provider retention. In addition, this project will increase the efficiency and effectiveness of local data exchange, including through the Health Information Exchange, that is critical to support care of mental health patients in the Emergency Departments and with other service providers.

Increasing bilingual and culturally competent services was also among the top needs identified in the 2020-2023 Three Year Plan. One of the foundations of providing such services is having accurate data on what populations are underserved or unserved. This data has been difficult to obtain in the current EHR. A key aim of the Semi-Statewide EHR Program is to improve the accuracy, uniformity, and completeness of data collection, which impacts the understanding of the populations treated and their care outcomes. Outcomes beyond standard Medi-Cal demographic categories will be collected to better support diversity, equity and inclusion work. Differential outcomes by race/ethnicity, age, and other meaningful variables will be available. Additionally, to the extent that the Semi-Statewide EHR is adopted across multiple counties, there will be unprecedented access to regional and/or statewide comparisons and benchmarking. This information will be available for decision making on all levels and will support the efforts of the Humboldt County Behavioral Health Cultural Responsiveness Committee (BHCRC) in recommending system improvements to reach underserved communities. This body contributes to Cultural Competency Plans/updates, sets the annual training agenda, and continues to improve the ability to identify and provide (or refer) clients to culturally specific programs.

CalMHSA plans to partner with 20+ California Counties that are collectively responsible for over half of the state's Medi-Cal beneficiaries. CalMHSA will develop and submit an Innovation Project proposal to the Mental Health Services Oversight and Accountability Commission (MHSOAC) for their approval before any activities for this project will begin. When the MHSOAC approves the project, Humboldt County plans to join by entering into a Participation Agreement (PA) with CalMHSA. The PA cost is priced by county size and funds the EHR Request for Proposal (RFP) development and EHR vendor selection

process. Concurrently, Humboldt County will work with CalMHSA to prepare the county for transition to both a new EHR vendor and the future CalAIM requirements. CalMHSA will work with Humboldt developing transitional strategies to support billing and cost reporting activities to bridge operations in advance of payment reform. In addition, CalMHSA will leverage national expertise on counties' behalf to design efficient and robust data collection strategies.

The allocation of Innovation funds for this project will be a one-time expenditure for fiscal year 2022-2023. The funds are available because of the delay in spending on the REST Innovation project due to challenges in hiring staff, as discussed in the prior section. The expenditure of funds for this project will ensure Innovation funds are not reverted and preserve them for the very positive impacts of the CalMHSA Semi-Statewide EHR project on the community, clients and service providers.

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, 4) Recognizing early signs of mental illness, and 5) Promoting greater access and linkage to treatment. Suicide prevention programs also fit within the PEI component. At least fifty-one percent (51%) of PEI funds must be allocated for serving individuals who are 25 years old or younger. Programs that serve parents, caregivers or family members with the goal of addressing children and youth at risk of or with early onset of a mental illness can be counted as serving children and youth. The following pages describe the PEI programs and services that reflect the themes and priority areas identified in the CPPP. The continuing implementation of these programs is contingent upon continuing availability of MHSA funding.

Prevention and Early Intervention: Hope Center

The Hope Center serves unserved and underserved populations of transition age youth, adults and older adults who have behavioral health challenges 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. 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 full time Peer Coach III who oversees the Center, three full time Peer Coach II and two part time Peer Coach I. All Peer Coaches are trained as Certified Peer Support Specialists through Recovery Innovations (RI) International. The Peer Coach III has additional training through the California Association of Behavioral Health Peer-Run Organizations (CAMHPRO) and the California Association of Social Rehabilitation Agencies (CASRA) as a train the trainer in the Superior Region Provider Core Competency Training. The Peer Coach III is leading cross-training of other staff, so everyone is able to do the work in the absence of one of the staff. During the next fiscal

year the Hope Center will be getting the Peer Coach III re-certified for Wellness Recovery Action Plan (WRAP) facilitation as well as two Full time Peer coaches to be certified in WRAP facilitation.

Hope Center goals are to:

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

The Center works from the recovery pathways: Hope, Choice, Empowerment, Recovery Environment, Spirituality (purpose/meaning). The Center provides many resources including classes, self-advocacy education, peer support, system navigation, and linkage to services in the community. Outreach efforts are made by Hope Center peer staff to people with a behavioral health diagnosis. Due to the Novel Coronavirus the Hope Center incorporated WRAP’s Wellness Guide to Overcoming Isolation During COVID-19, which focuses on overcoming feelings of isolation and loneliness through building connections with oneself and others. It is designed for self-exploration about being connected and help one discover ways to take action and create positive changes for themselves and safely connect back with community. This was done as a class and has now integrated into a one-on-one peer support activity. In 2018 the Hope Center created an Advisory Meeting made up of four participants and a staff member. The Meeting’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 the Center. 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
- Cultural inclusion
- Supporting the Hope Center Advisory Meeting
- Hope ambassadors (participants who know and talk about the recovery pathways)
- Wellness Recovery Action Plan facilitation
- Teaching interns about the Peer Empowerment model and use of the recovery language to use in their future work.

- May is Mental Health Matters Month participation
- Classes, workshops, and education that focus on individuality, mindfulness, nutrition, resilience, fun, building skills, wellness, building community, facing challenges, and building confidence
- Counseling services are available when needed

Unfortunately due to the pandemic, and a lack of available staff who were supporting other programs in need, the data was not maintained well. A total of 47 unduplicated participants for FY 2020-21 were recorded. The number of duplicated participants is 6,012 for FY 2020-21 which includes individual peer support on site, in Zoom meetings, in-person with social distancing, masking and limited space Zoom as well as recently added hybrid classes.

Plans for the next year are contingent upon available MHSA funding and include training and reintroduction of WRAP, in-person, Zoom and hybrid classes, monthly wellness center meetings, peer calls and community outreach.

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

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

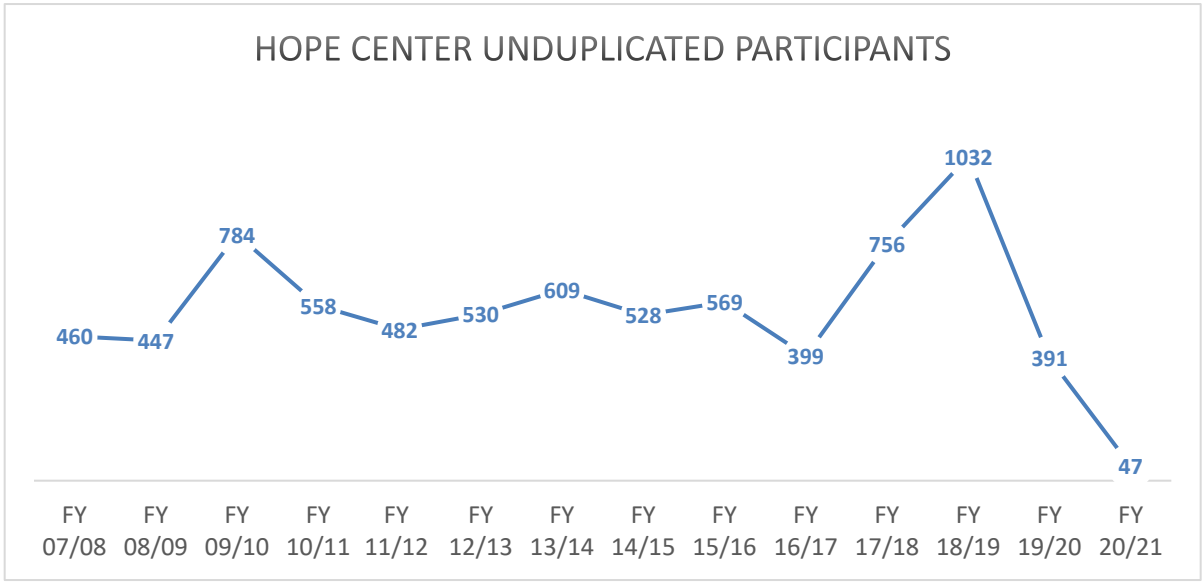
The methods and activities used to change attitudes, knowledge, and/or behavior regarding being diagnosed with mental illness, having mental illness and/or seeking mental health services is addressed in the following ways. The Hope Center participant does not need to be a mental health client and there is no requirement to self-disclose a diagnosis or any other mental health symptom to participate. The classes are focused on the areas of coping skills, symptom management, and reducing functional impairments, but there are other classes designed to promote activities of daily living including

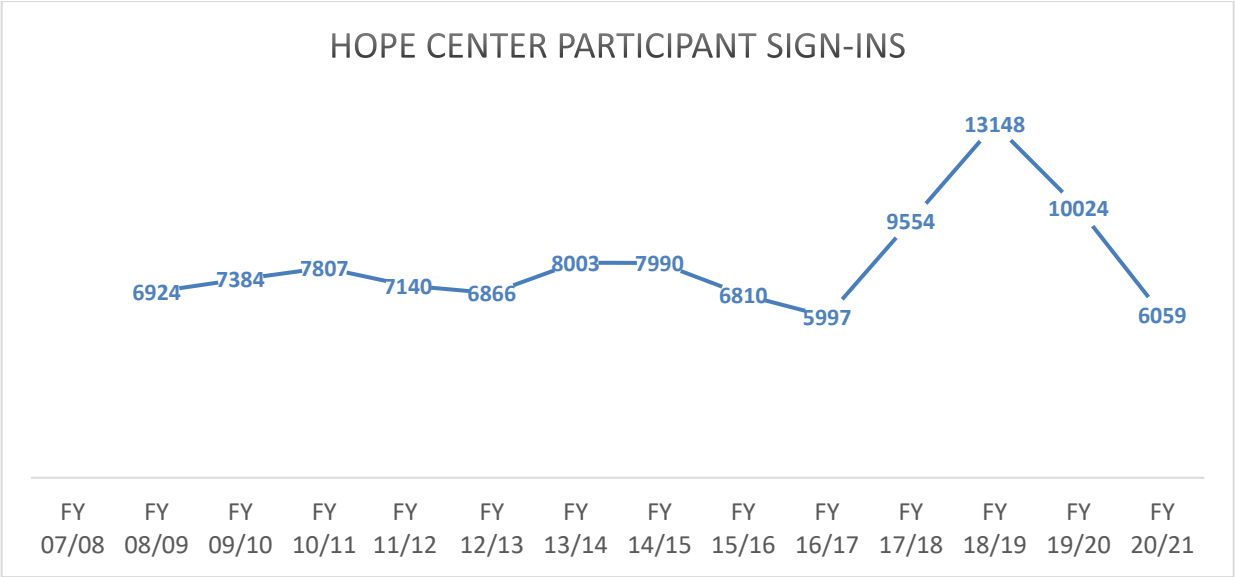
budgeting, gardening, and smoking cessation. When participants are not engaged in classes, they are involved in an environment whose primary aim is promoting inclusion and acceptance. Participants are empowered to make decisions for themselves and the program to further ensure that the community has a venue where stigma and discrimination reduction is prioritized. Events that have been coordinated from the Hope Center with this purpose in mind include yearly Arts Alive nights, where participant art is shown at an actual art gallery; May Is Mental Health Month Community Walk; Quarterly Community BBQ's; as well as participation and advocacy on the local Behavioral Health Board. The classes and environment of the Hope Center have been one of the most important community efforts to date in reducing stigma and discrimination in Humboldt County.

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

Below is the report for the Hope Center for Fiscal Year 2020-2021

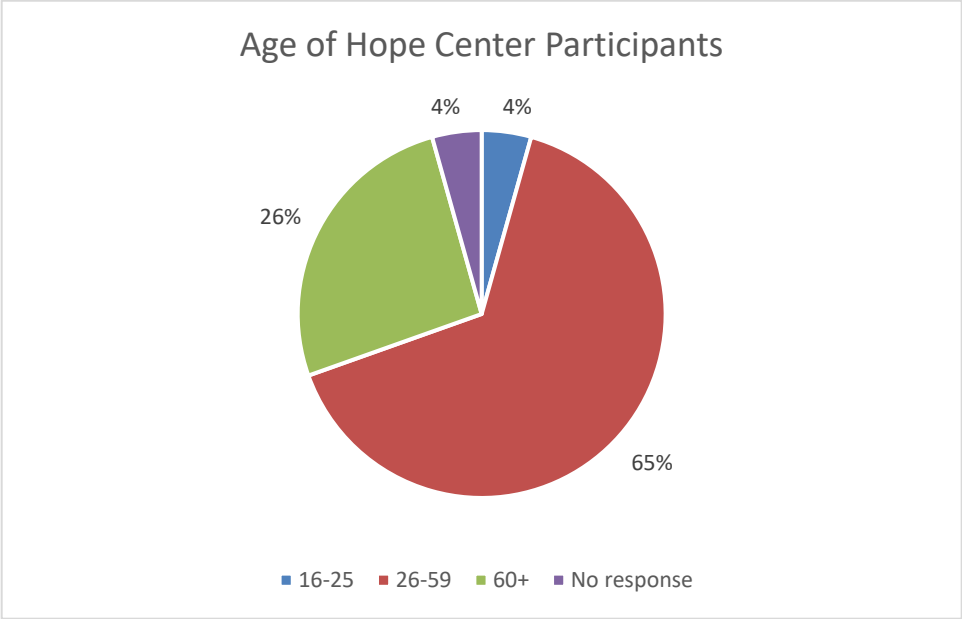
During Fiscal Year 2020-2021 the Hope Center interfaced with 47 unduplicated individuals. There were 6,012 sign-ins to the program. These number are reduced due to COVID-19 pandemic, which caused the closing of the Center. There were no volunteer hours due to the COVID-19 pandemic.



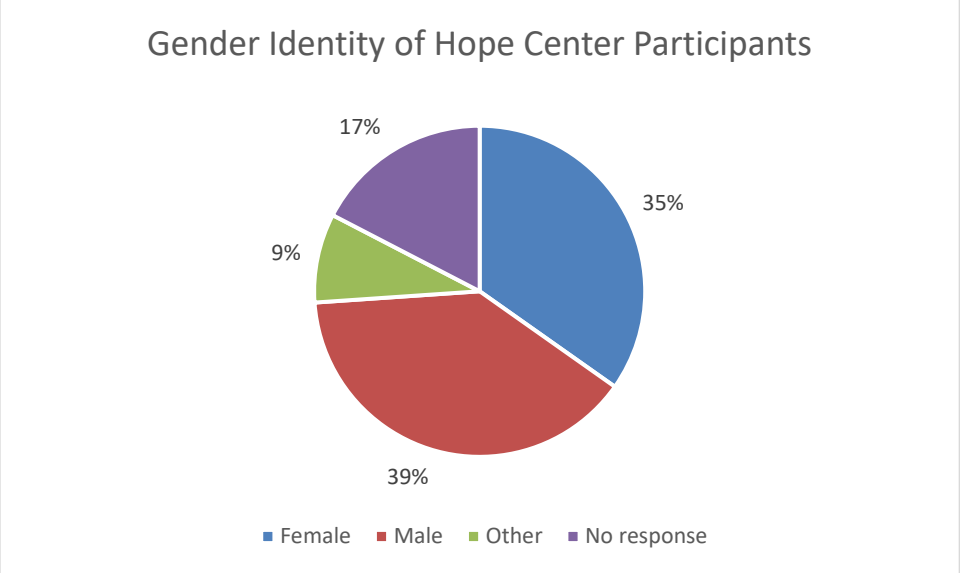


Demographic Data. Of the 47 Hope Center participants, 23 (49%) completed demographic forms. Demographic data is presented in the charts below.

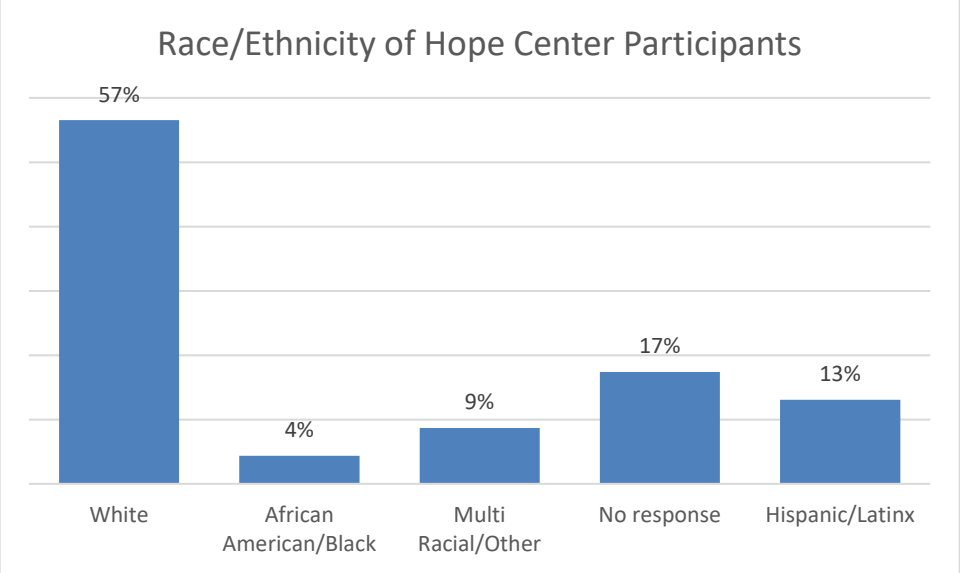
4% of participants were ages 16-25, 65% of participants were ages 26-59, and 26% were age 60+. 4% percent did not respond to the question.



35% of Hope Center participants were female, 39% male, 9% other and 17% did not respond to the question.

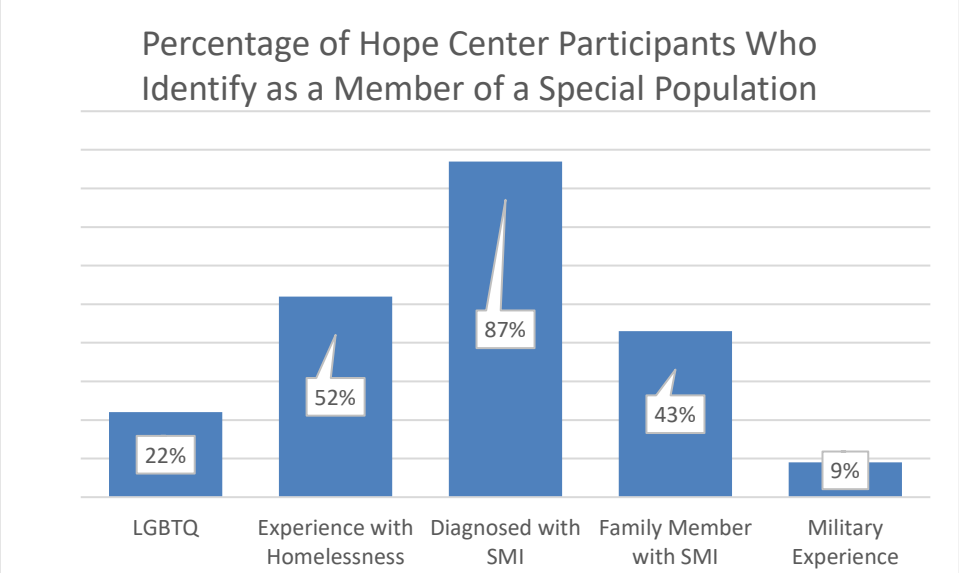


57% of Hope Center participants were White, 9% were Multiracial/Other, 13% were Hispanic/Latinx, 0% were American Indian, 0% were Asian/Pacific Islander, and 4% were Black/African American. 17% did not respond to the question.



87% percent of Hope Center participants spoke English as their primary language.

22% identified as LGBTQ, 52% had experience with homelessness, 87% had been diagnosed with a serious mental illness (SMI), 43% had a family member diagnosed with SMI, and 9% had military experience.



Prevention & Early Intervention: TAY Advocacy and Peer Support

There are two components to this Prevention and Early Intervention Program: TAY Advocacy, through the Humboldt County Transition Age Youth Collaboration (HCTAYC), and TAY Peer Coaches. Both components serve youth and young adults ages 16-26, and both components are a part of the Humboldt County DHHS Transition Age Youth (TAY) Division. The TAY Division consists of co-located DHHS services, including Behavioral Health (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 Public Health, Employment Training Division, CalFresh, Medi-Cal, Substance Use Disorder services, and collaborates with community partners such as Juvenile Probation and Family Resource Centers.

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

- A behavioral health team providing specialty behavioral health services (individual and family therapy, case management, and referrals for psychiatric services), including a supervisor, clinicians, and case managers
- Linkage and referrals to Adolescent Treatment Program and other Substance Use Disorder services
- Child Welfare Services (CWS) Independent Living Skills (ILS) program serving youth ages 16 to 21
- CWS Extended Foster Care Unit
- HCTAYC staff and a Youth Advocacy Board (YAB)
- Peer Coaches who serve across the TAY Division
- A Vocational Counselor from the DHHS Employment Training Division
- Linkage and Referrals to Public Health Nursing
- Linkage and referrals to intensive case coordination services as needed

TAY Advocacy—HCTAYC

The TAY Advocacy elements of the TAY Division are rooted in the 2004/2005 MHSA Stakeholder process, where a significant need was identified to address poor outcomes

for unserved and underserved youth with a severe mental illness or whose risk of developing a severe mental illness is significantly higher than average. A modest initial MHSA Community Services and Supports investment fostered a TAY Advocacy work plan that led to a community-wide mapping of “what was working well, what needed improvement, and what were the gaps” for TAY throughout DHHS and the broader community.

The TAY Advocacy Program, named the Humboldt County Transition Age Youth Collaboration (HCTAYC), launched in 2008. Program collaborators have changed over time and currently consist of youth 16-26, DHHS, California Youth Connection, Youth In Mind, and Youth MOVE National. HCTAYC works to improve the services youth receive as they transition into adulthood and become independent.

HCTAYC fosters positive youth development, youth advocacy and leadership, community engagement, and promotes youth wellness. HCTAYC provides a youth voice that informs system policy, regulation, and practice at the local, state, and national levels with the purpose of cultivating better outcomes for unserved and underserved youth with a severe mental illness or who are at a significantly higher than average risk of developing a severe mental illness. The program directly impacts the TAY system of care, making it more responsive to young people’s needs, resulting in these larger system outcomes. It also directly impacts the lives of system-impacted youth at-risk of, or struggling with, mental health challenges through the development of resilience and self-efficacy via leadership development. It is the result of this advocacy program that needed systems and services such as the creation of the aforementioned TAY Division in 2012 have come to fruition. This advocacy has also contributed to the passage of legislation and state policy, including the Foster Care Bill of Rights, Foster Care Psychotropic Medication Management, and the California Department of Social Services implementation of CANS. These policies have all significantly contributed to the statewide transition-age youth system of care’s ability to best serve youth.

It is evident that there is a significant need for the creation of a youth-positive environment so that youth may participate as fully engaged participants in society, shaping their lives and fostering collective wellness. Large-scale impacts of system change at local, state, or national levels, particularly policy advocacy, are difficult to measure as they are collaborative and span multiple years without the possibility of before or after impact evaluations that measure efficacy and attitudinal change. However, measurable data can be obtained from program operationalization through public awareness events directed at youth and community members; trainings provided to staff and community partners on effectively engaging youth and developing youth-informed approaches; and leadership development opportunities provided to youth participants.

This is a prevention program which, along with TAY Peer Coaches, addresses components of: early intervention, stigma and discrimination reduction, and outreach for increasing the recognition of early signs of mental illness. As a rural, poverty-stricken community, access and knowledge regarding the aforementioned subjects, particularly for systems-impacted youth are limited. There is a significant need to address the hopelessness, lack of self-efficacy, and significant independent living skill deficit that

exacerbate existing social determinants of health.

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

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

1. **Trainings** for professionals and community members focus on TAY-specific mental health challenges and the engagement of this population. This includes special populations particularly impacted by stigma and discrimination such as LGBTQ youth, Indigenous Youth, foster youth, juvenile justice youth, homeless youth, and youth experiencing substance use related issues. Trainings take a cultural competence and/or cultural humility approach, with specific youth-developed curriculum that focuses on youth culture and the ways in which systems impact youth wellness. The facilitation of **events** focuses on concepts of behavioral health stigma reduction, outreach and information regarding behavioral health services, and wellness resilience development. These events occur in multiple formats, all of which are youth-driven.

2. **Advocacy** is operationalized through two means, systems change and individual advocacy. Systems advocacy is enacted through youth organizers supporting the YAB to attend and participate in policy setting, decision making tables, and correspondence. This includes participation at local, state, and national policy tables and related coalitions or collaboratives. Individual advocacy occurs when HCTAYC Youth Organizers support TAY youth in self-advocacy during their own care coordination. This is also done through participating in advocacy to amplify the youth's wishes, assisting youth in preparing speaking points for their case planning meetings, and attending said meetings to support the youth's desired outcome.

3. **Youth Leadership Development** is perhaps the most transformative element of the HCTAYC program, consciously targeting the three base psychological needs identified in self-determination theory: autonomy, competence, and relatedness. These three components aid to prevent the emergence of behavioral health conditions or reduce prolonged suffering and progression. This development is the transference of skills to, and the continual support and supervision of, YAB members. By creating a system of tiered levels of leadership, board members are given the opportunity to experience, develop, and practice leadership skills in a gradual progression of intensity, while emphasizing increased peer engagement and relationship building. Participants receive periodic trainings on different elements of leadership and topical education on advocacy topics. Higher-level leaders go through a multi-week orientation process and attend a three-day retreat. The format of the YAB, with multiple affinity-based committees, allows members to develop connections with peers with similar lived experiences, while also receiving consistent support and guidance from HCTAYC youth organizers. Youth exercise autonomy through identifying

program priorities, modifying program function, and by driving content creation. Youth exercise competence via the provision of trainings, engaging in advocacy, and successfully planning events. As board members plan their transition from active membership they put together an accumulative leadership portfolio demonstrating their strengths and successes as youth leaders. Additionally, extensive studies have demonstrated that youth leadership programming increases self-efficacy - which is an important indicator for the reduction of harmful actions such as self-harm and suicide.

Expected Outcomes:

- Gather comprehensive outcomes data to report on leadership development as well as outcomes related to the specific PEI domains for Youth Leadership Development.
- YAB committees will facilitate at least one completely youth-driven project per year.
- Facilitate at least three youth-leadership development trainings for HCTAYC members and the general transition-age youth community per year.
- Implement policy recommendations for Substance Use Disorder treatment and LGBTQ+ Cross-Systems.

- Participate in various advocacy and policy setting tables at the local, state, and national level.

How Outcomes are Measured:

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

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

Estimated Number to be reached in FY 2022-2023:

The program estimates to maintain or exceed 5-10 consistent Youth Advocacy Board members. During this new reporting period, the YAB readopted a committee structure to better align their work with their individual lived experience, with some members returning to the board after absence due to the more specialized nature of the committees. Inconsistent participants are difficult to gauge in number, but will be measured based upon referrals, outreach, and attendance at committees. We estimate the 2022-2023 fiscal year to bring perhaps 15 engagements that do not result in consistent membership.

Additionally, the program plans to continue towards closing out the focus on the AOD policy recommendations. The implementation of Drug Medi-Cal has provided new and additional opportunities to interface with other programs, youth, and the public. HCTAYC's anticipated participation in a regional harm reduction campaign will contribute to achieving this goal. We anticipate presenting 10-15 times to the public, including individual organizational engagements, large digital or hybrid events, and individual engagements with decision makers.

It is hoped to provide at least one youth-driven training to professionals, as well as complete the development of one training curriculum. Four to six youth leadership development trainings to youth in Humboldt County are estimated to be provided. It is expected that consistent membership of the current policy setting tables will be maintained, as well as adding to tables regarding equity or other topics that intersect with the upcoming set of policy recommendations. A digital storytelling training is planned for this reporting period as well, building on our successful hybrid retreat which occurred during the last reporting period. We estimate to engage 8 youth, and present at least two times to the public on the created stories. Ongoing developments of the COVID-19 pandemic has caused us to shift our work and its implementation with the majority of activities occurring in a digital format. This brings with it both benefits and deficits in terms of tracking attendance, gauging engagement, and collecting demographic and pre/post survey data.

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

TAY Peer Support

The integration of Peer Coaches within the TAY Division is a prevention program with components of early intervention, access and linkage to treatment, stigma and discrimination reduction, and outreach for increasing recognition of early signs of mental illness. The TAY Peer Support program consists of a shared Supervising Mental Health Clinician and five full-time Peer Coaches. Peer Coaches are an integral part of the multidisciplinary team at the TAY Division, and support each of the Division's programs (HCTAYC, Behavioral Health, Independent Living Skills, and the Drop-in Center).

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

1. **Relationship building and mentoring** is done by Peer Coaches using their personal lived experiences to connect with young people ages 16-26 and focuses on mentoring, instilling hope, empowering and helping young people build self-esteem, and assisting in system navigation and self-advocacy. Peer Coaches have the capacity to engage with young people through shared lived experiences. Peer Coaches believe young people have the ability to grow. This makes them unique in their ability to relate, provide support, and model self-advocacy, recovery, and self-care skills. Peer Coaches build relationships with young people in ways that create validation, inspire hope, and support program participants through empowerment and trust. Peer Coaches build mutuality in their relationships with young people, creating a relationship built on respect, compassion, and reciprocity. Through this unique relationship, young people are able to build self-

determination, self-esteem, and gain skills necessary for transition into adulthood. Peer Coaches 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. Peer Coaches are able to assist young people in building their relational capacity by supporting them when accessing social, vocational, or educational opportunities.

2. **Outreach and engagement** is provided to young people by linkage to services and to the community. This serves to inform them of services available to transition age youth and supports the reduction of stigma and discrimination toward the systems-involved transition age population. Outreach is provided in multiple ways including referrals for services, the TAY Center drop-in space, community-wide presentations, and tabling events. Peer Coaches provide regular outreach to the psychiatric hospital, jail, juvenile hall, schools, family resource centers, tribal organizations, and team with other community partners for street outreach to youth experiencing homelessness. Overall, peer coaching contributes to participant engagement with care, increased effectiveness of services, reduced barriers to services and supports, improved outcomes, reduced hospitalization or incarceration, and increased support for educational and vocational success.

3. **Linkage to resources** available through multiple agencies helps to support increased youth engagement across programs, improve access to needed services, stigma reduction, greater understanding of lived experiences, increased advocacy, improved relationship with providers, and the ability to show staff and youth that recovery is possible. Peer Coaches assist young people in navigating the systems, help with referrals to services and support them in appointments or activities. Peer Coaches often serve as a bridge between the young person and services, providing warm hand offs from psychiatric hospitalizations, incarceration, or walk-ins to service providers, activities, or other resources.

4. **Activity coordination** is done to provide transition age skill development opportunities for young people. Peer Coaches collaborate or take the lead in many TAY Division workshops and events, often in response to youth requests and identified needs. Activity coordination varies from regular oversight of the TAY Center drop-in space, where young people can access service providers, computers, linkage with CalFresh and food resources, clothing closet and hygiene supplies, to workshops on self-care, healthy relationships, wellness, and life skills.

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

Key Activities:

- Outreach and presentations to local agencies and organizations

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

Expected Outcomes:

The expected outcomes for 2022-2023 are:

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

How Outcomes are Measured:

- Access to the TAY drop-in space and selected events and workshops are measured by sign-in sheets.
- Tracking sheets of referrals, assignments, including date referral is received, assigned and when first contact is made.
- Tracking of contacts and linkages with other programs, such as Behavioral Health, Employment and ILS.
- Data collection through demographic forms collected during peer led groups, workshops or events.
- Data entry into the HUD HMIS data system for youth experiencing homelessness.

Estimated Number to be reached in FY 2022/2023:
It is estimated that approximately 200 TAY will be served in Fiscal Year 22/23 based on the previous year's sign-in sheets for the TAY Center and activities, events and workshops. COVID-19 may reduce the TAY Center drop-in hours and impact this estimated number of young people served. It can also be estimated that this number may increase when COVID-19 restrictions are lifted, increasing open hours for the TAY Center and increasing need for services as people work towards recovery from the pandemic.

TAY Advocacy and Peer Support Disaster Preparedness and Response
Both HCTAYC and Peer Support staff have adapted and modified ways of delivering services and prevention components with the current worldwide health pandemic. Early intervention, outreach, stigma and discrimination reduction, and youth engagement are being delivered both virtually and offered in person when able to do so safely. Participation in the YAB, community policy tables, groups, workshops and community wellness building opportunities continue to meet, primarily in a virtual setting. Not knowing what gathering in larger groups may look like in the future, HCTAYC and Peer Support

will continue to be creative and find ways to uplift youth voice and address the needs of transition age youth, such as overcoming a sense of hopelessness, lack of self-efficacy, independent living skills deficit, and economic struggles that will continue to impact the social determinants of health during this crisis. We have already found success with hybrid and socially distanced activities prior to the rise of the delta variant of COVID-19, and are hopeful to be able to get to a point of safety to do so again.

TAY Advocacy and Peer Support Stigma and Discrimination Reduction

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

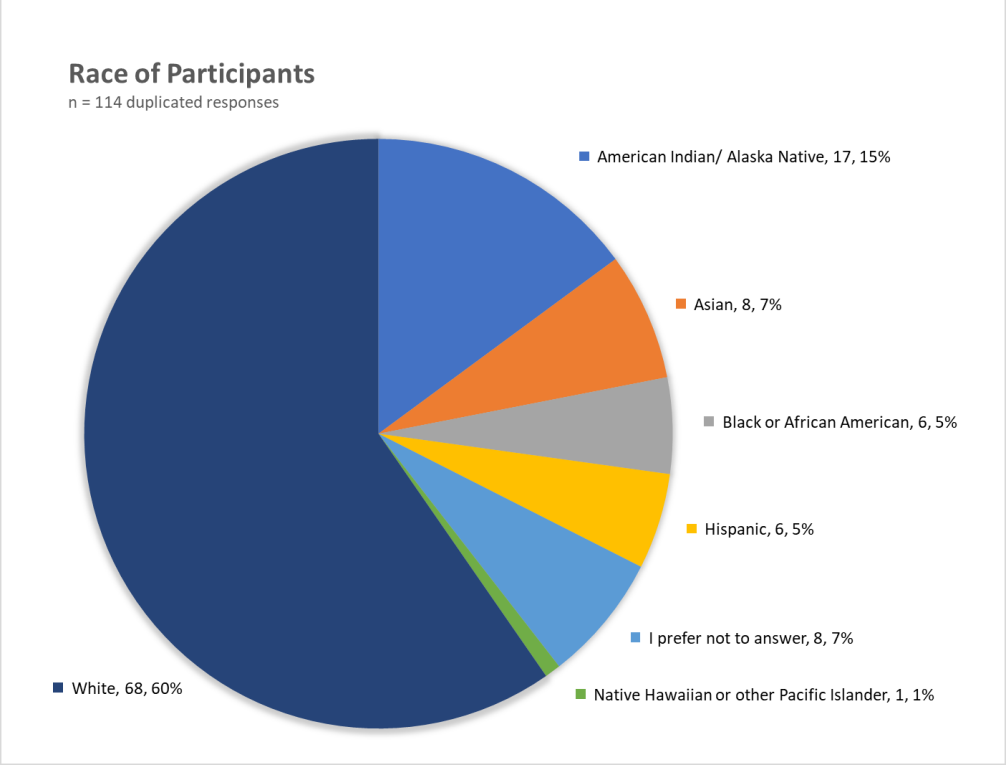
HCTAYC created a pre and post Stigma Discrimination Reduction survey that was integrated into YAB and community-based trainings, measuring learning and change in attitudes. HCTAYC continues to strive to create in the future a community-based stigma and discrimination assessment to be conducted through a survey format, capturing attitudes and beliefs about mental health stigma and discrimination. The impact of the activities is currently measured by post-workshop evaluations and the demographic form, which asks questions about effectiveness of the activity and its contribution to wellness.

Report for Fiscal Year 2020-2021

TAY Advocacy-HCTAYC

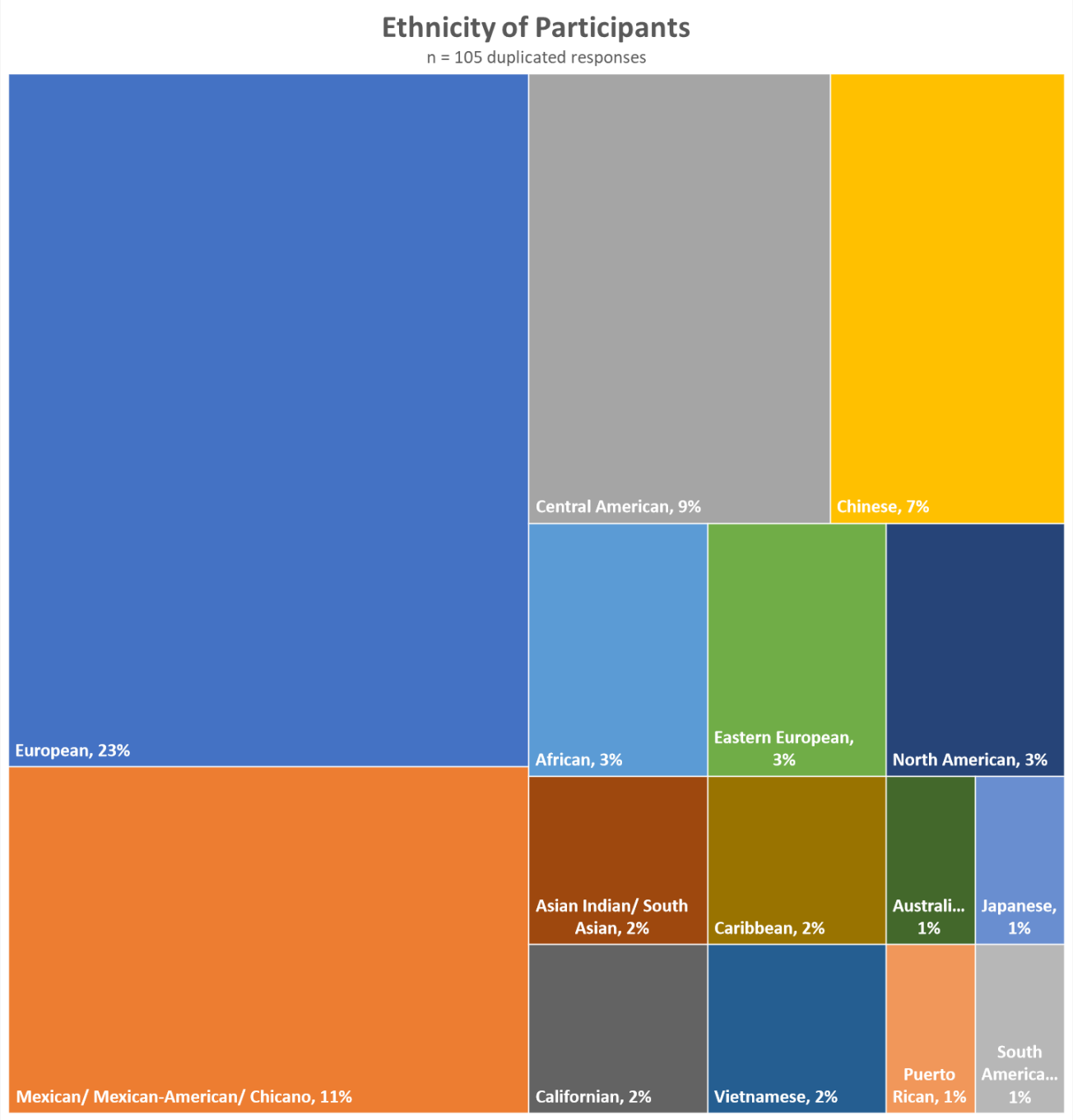
During 2020-2021 HCTAYC provided activities, trainings and events, however sign-in sheets were not recorded due to logistical constraints, COVID-19 digital platforms, or staff error. The following charts provide information obtained from 98 demographic forms completed by individuals participating in HCTAYC activities. These are duplicated, not unduplicated, responses.

Sixty percent of the people who responded to the demographics survey selected White, non-Hispanic; 15% selected American Indian/Alaska Native, representing local tribes as well as Cherokee, Maidu/Konkow and Tu'un Saavi. Seven percent selected Asian. Five percent selected Black/African American. Five percent selected Hispanic/Latinx. And, 7% preferred not to answer. Of the 98 survey responses, 15.3% selected more than one race.



Five percent of the respondents selected more than one ethnicity. Thirty percent of respondents did not provide their ethnicity. Of those that did:

- 23% selected European
- 11% selected Mexican/ Mexican-American/Chicano
- 9% selected Central American
- 7% selected Chinese
- 3% selected African, Eastern European, or North American
- 2% selected Asian Indian/ South Asian, Californian, Caribbean, or Vietnamese
- 1% selected Australian, Japanese, Puerto Rican, or South American



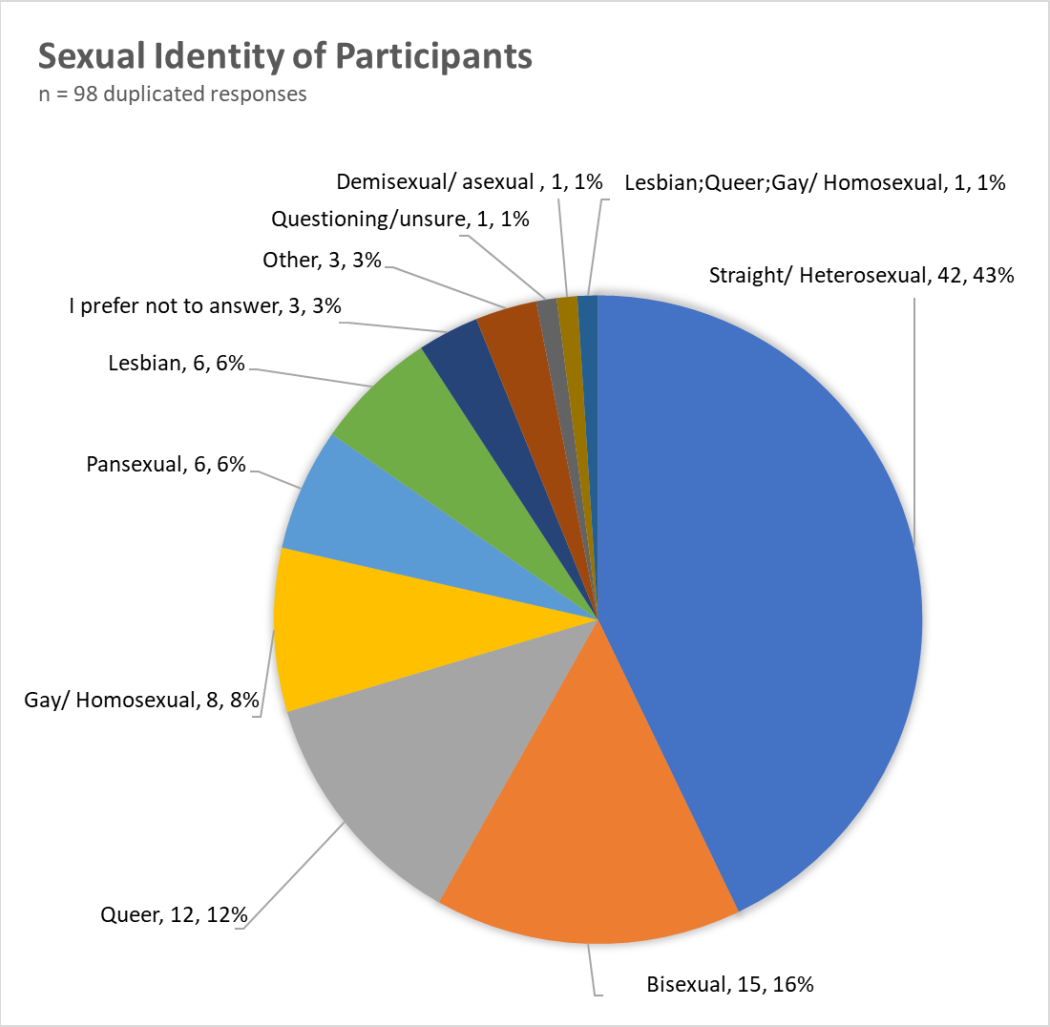
The primary language of participants was roughly 95% English, with the rest of responses included Spanish, Hmong, and preferred not to answer.

Almost two-thirds of the participants were within 19-25 years old and roughly one-third within 16-18 years old. However, HCTAYC youth engaged people of all ages in trainings, presentations, community coalitions, and policy recommendation outreach efforts.

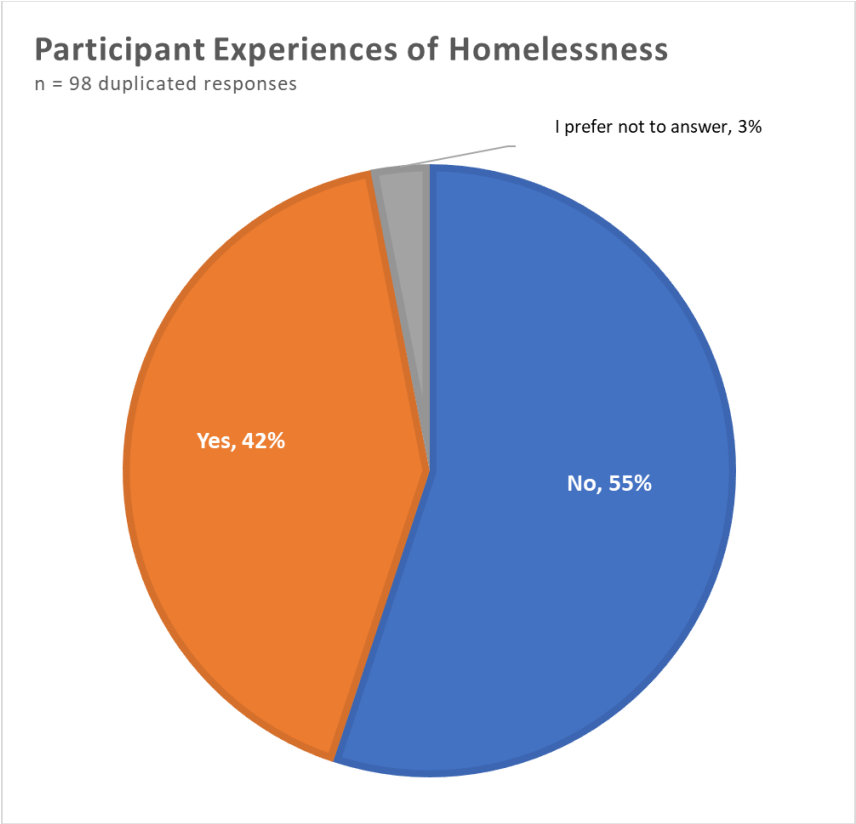
Sixty-seven participants stated their assigned sex at birth was female; 27 stated male, and 6 preferred not to answer. Their current gender identities were 48% female; 28% male; 11% wrote in non-binary, 8% genderqueer, 3% trans male; 2% prefer not to

answer; 1% questioning/unsure.

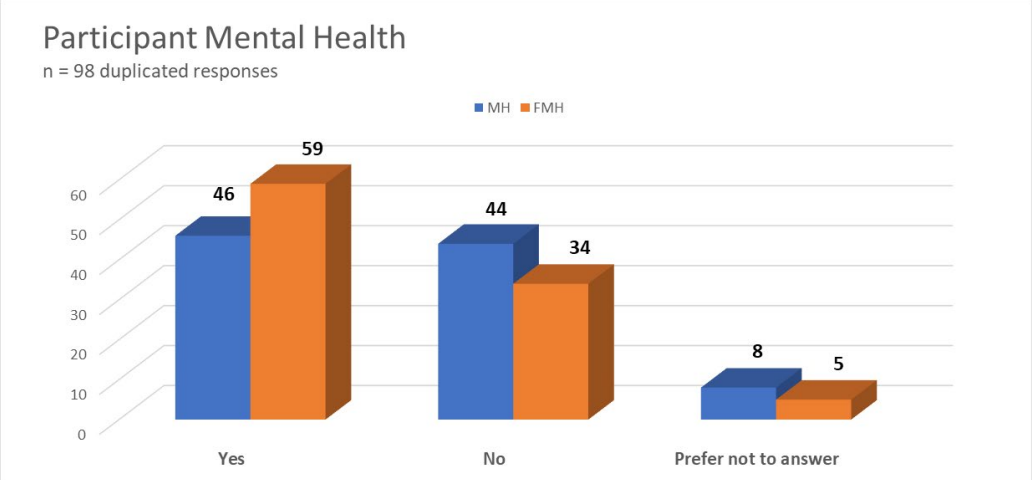
43% identified as straight / heterosexual 15% bisexual, 12% queer, 8% gay/homosexual, 6% lesbian or pansexual, 3% chose other or prefer not to answer, and 1% chose demisexual/asexual, questioning/unsure, or more than one orientation.



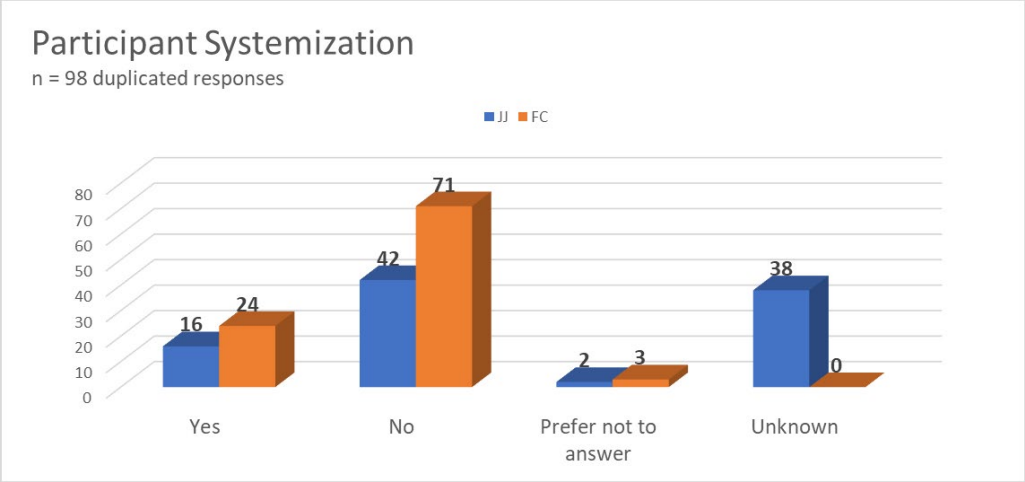
Forty-two percent had experience with homelessness, 55% did not, and 3% preferred not to answer.



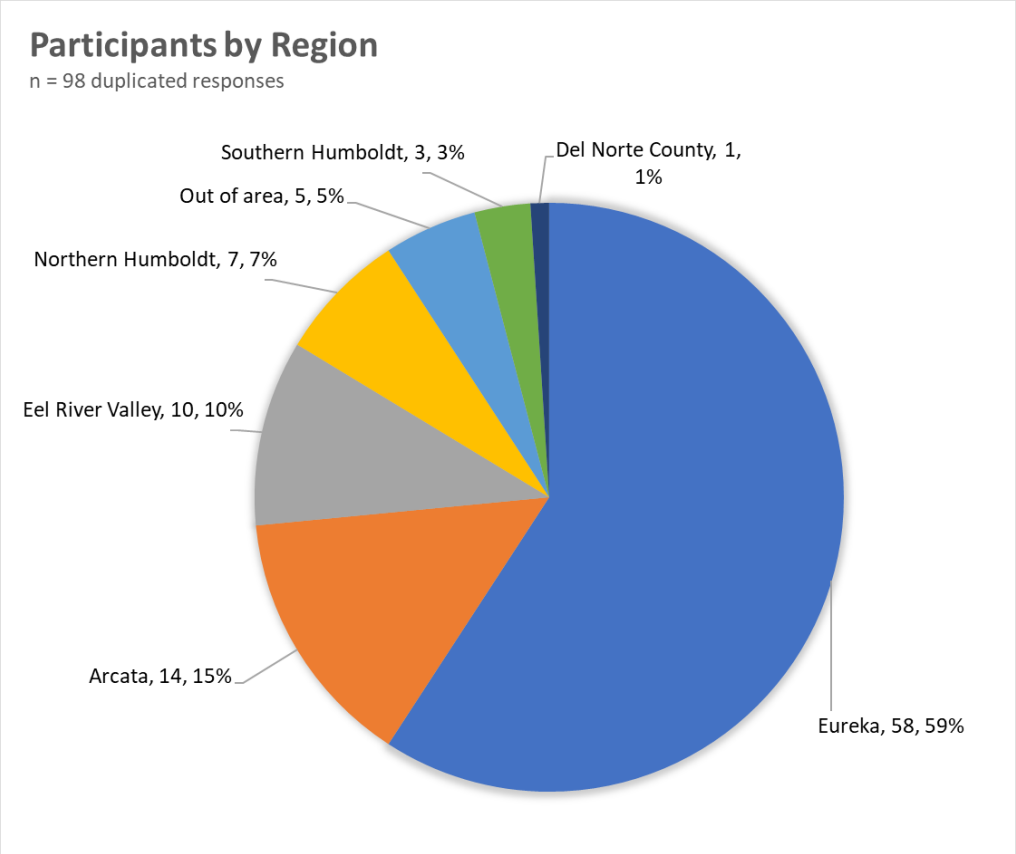
46 participants stated they had a personal mental health condition, 44 stated they did not, while 8 preferred not to answer. Fifty-nine stated they have a family member with a mental health condition,34 stated they did not, and 5 preferred not to answer.



Twenty-four participants reported involvement in foster care and/or the child welfare systems, 71 did not have this involvement, and 0 preferred not to answer. Sixteen participants reported involvement in the juvenile justice system, 42 did not have this involvement, 2 selected preferred not to answer, and 38 did not answer question.

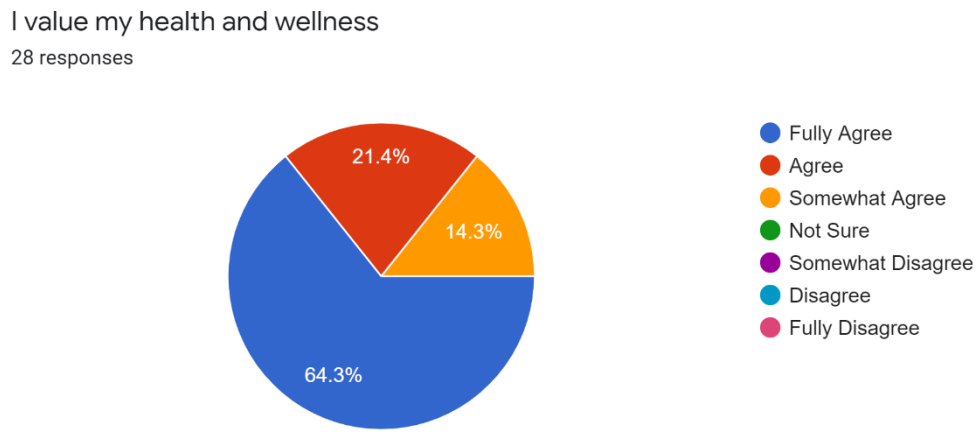


The majority of participants resided in the Eureka area, followed by Arcata, the Eel River Valley, and Northern Humboldt.

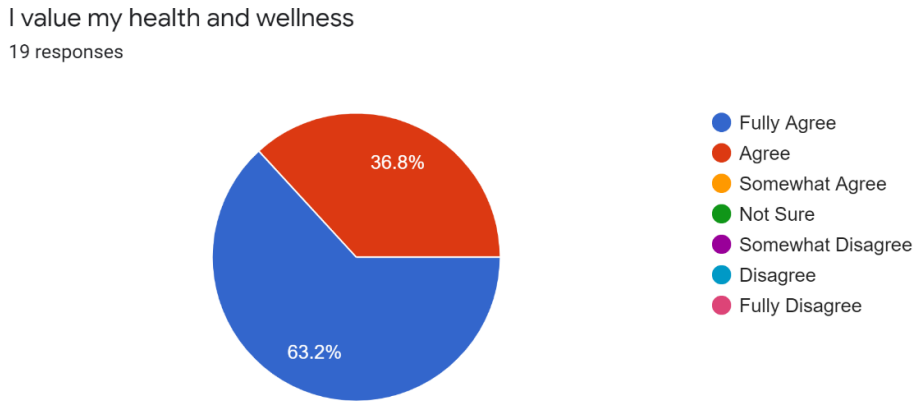


For the **stigma and discrimination reduction** activities, HCTAYC collected 47 responses to a pre and post Stigma Discrimination Reduction survey, measuring learning and change in attitudes around mental health. Following the pre/post questions and comparisons.

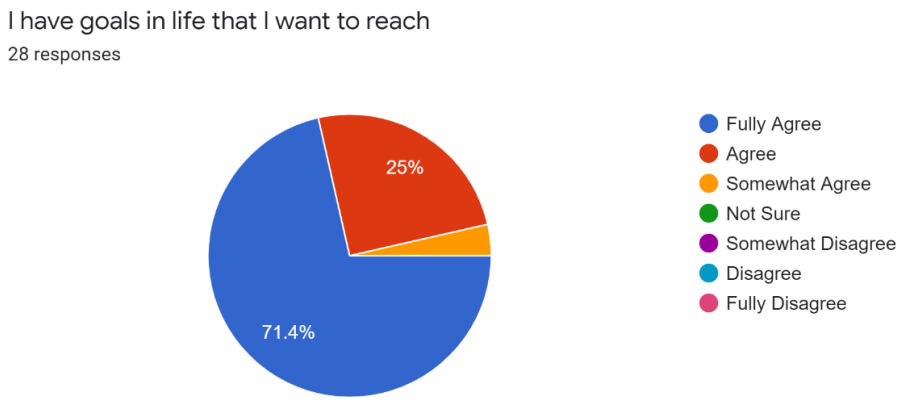
Pre-survey: 64.4% said they fully agree that they value their health and wellness, 21.4% said they agree, and 14.3% said they somewhat agree.



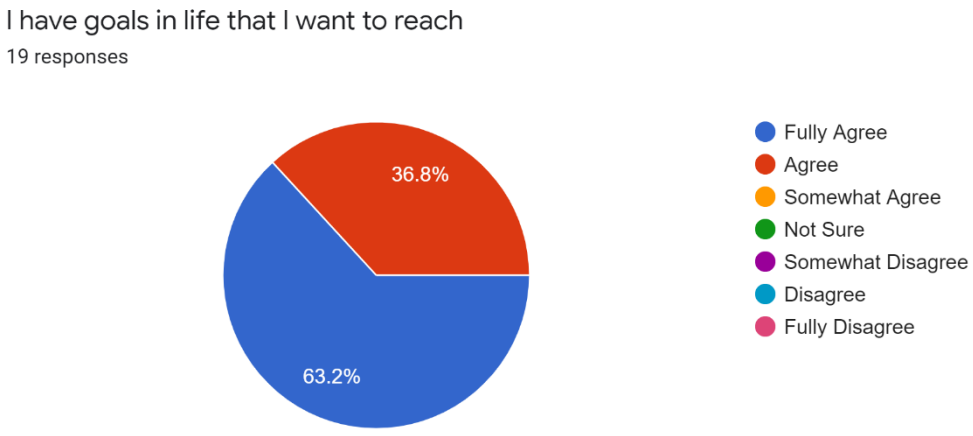
Post survey: 63.2% said they fully agree, and 36.8% said they agree.



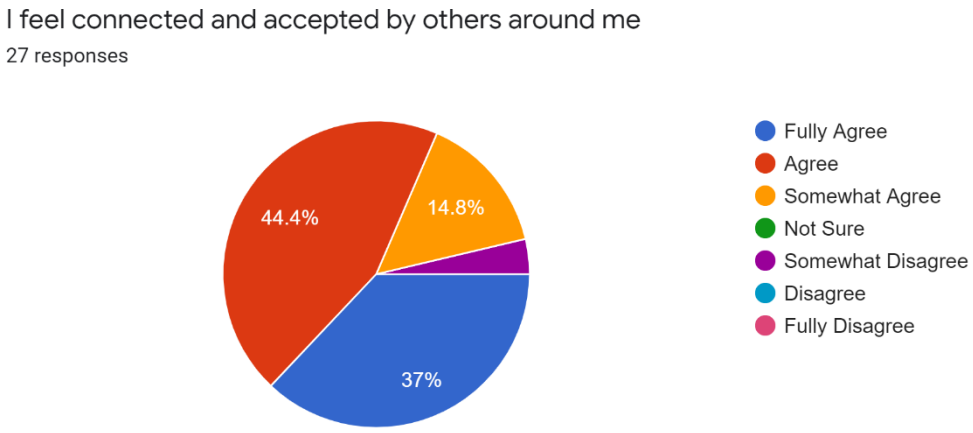
Pre-survey: 71.4% fully agree they have goals in life that they want to reach; 25% agree; 3.6% somewhat agree.



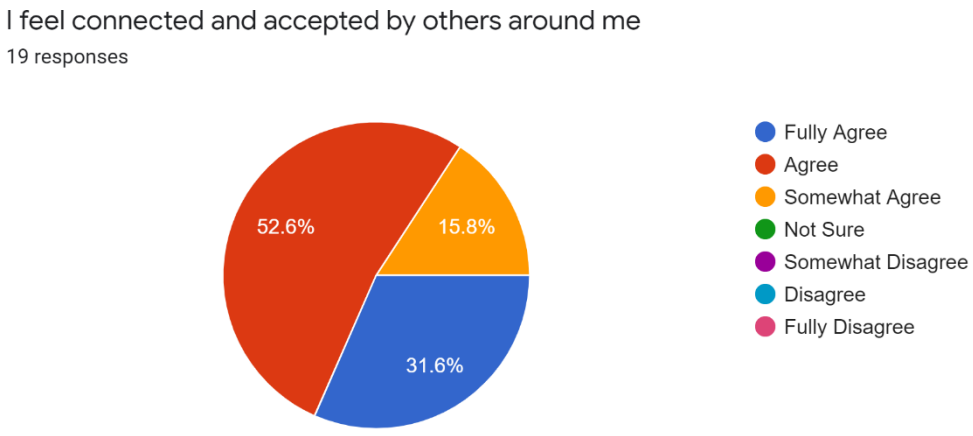
Post survey: 63.2% fully agree, 36.8% agree.



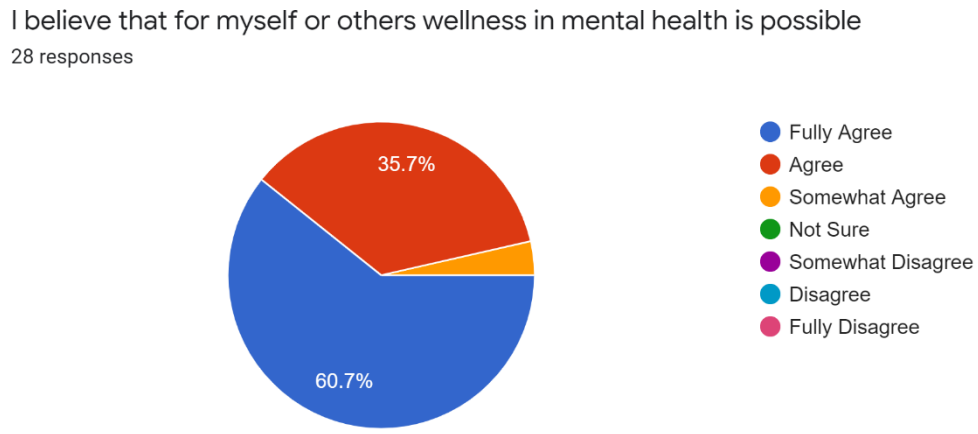
Pre survey: 37% fully agree they feel connected and accepted by others; 44.4% agree; 14.8% somewhat agree; 3.8% somewhat disagree.



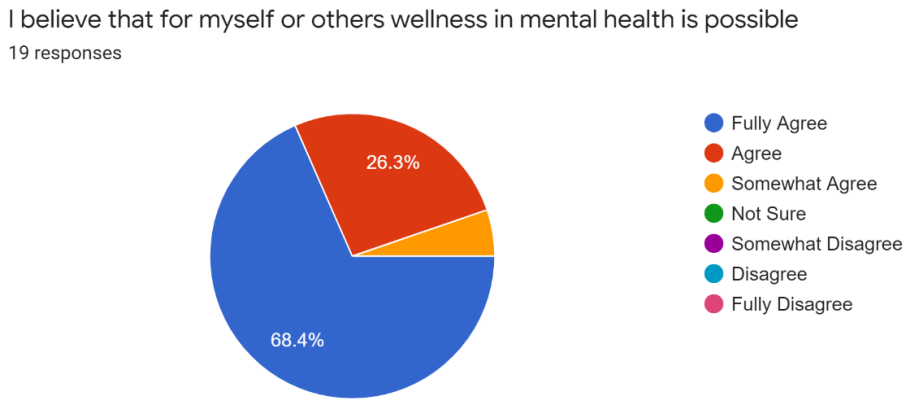
Post survey: 31.6% fully agree;52.6% agree;15.8% somewhat agree.



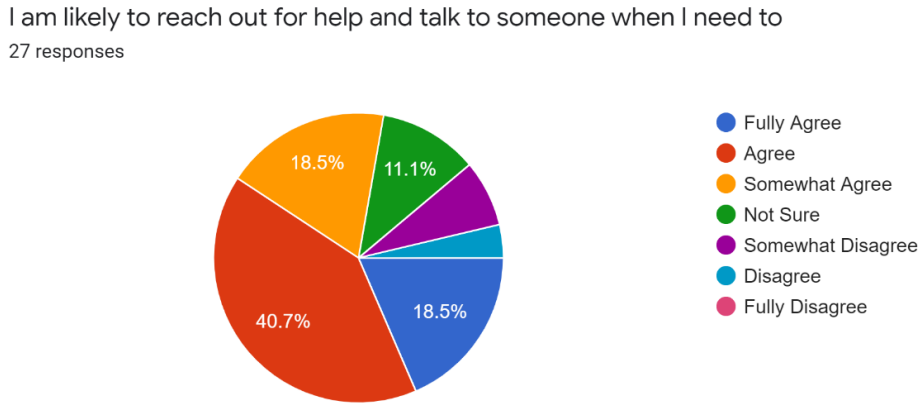
Pre-survey: 60.7% fully agree that for themselves or others wellness in mental health is possible; 35.7% agree; 3.6% somewhat agree.



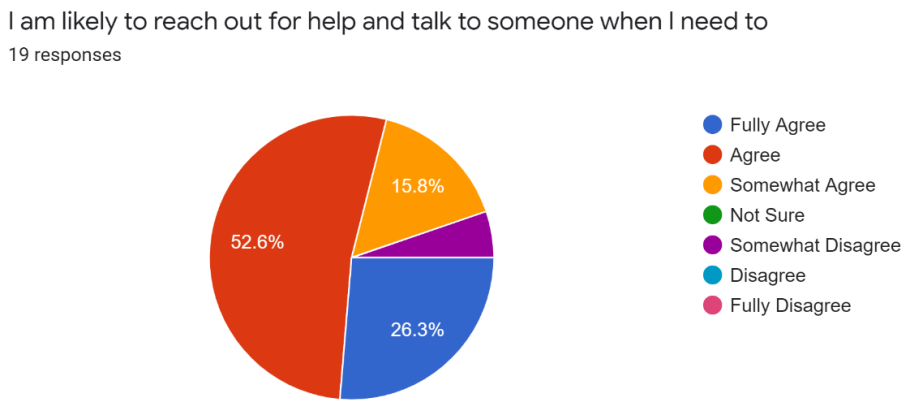
Post survey: 68.4% fully agree; 26.3% agree; 5.3% somewhat agree.



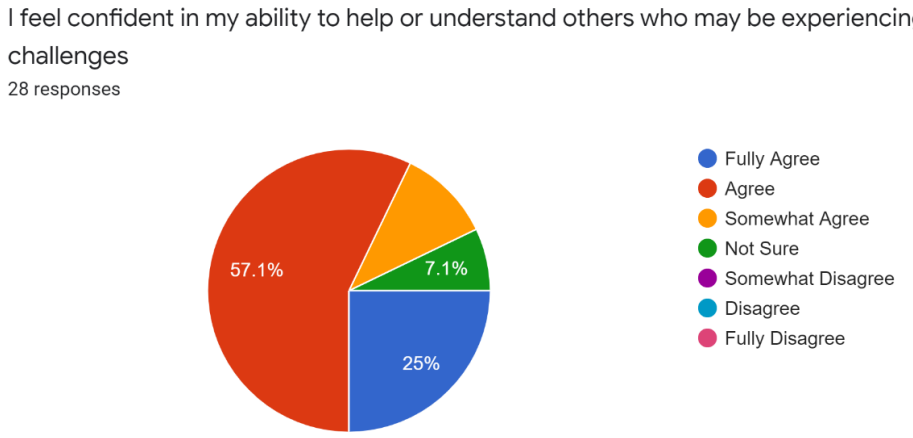
Pre survey: 18.5% fully agree they are likely to reach out for help and talk to someone when they need to; 40.7% agree;18.5% somewhat agree; 11.1% are not sure.



Post survey: 26.3% fully agree; 52.6% agree;15.8% somewhat agree; 5.3% somewhat disagree.



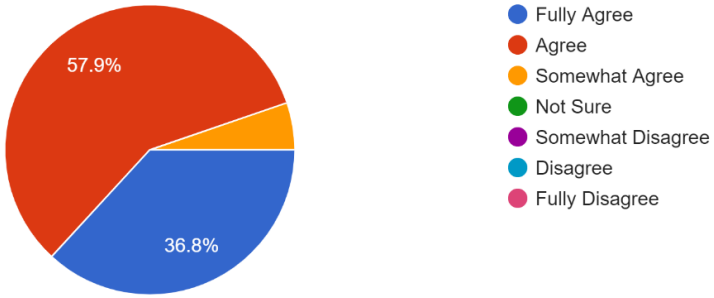
Pre survey:25% fully agree they are confident in their ability to help or understand others who may be experiencing mental health challenges; 57.1% agree; 10.8% somewhat agree, 7.1% are not sure.



Post: 36.8% fully agree; 57.9% agree; 5.3% somewhat agree.

I feel confident in my ability to help or understand others who may be experiencing mental health challenges

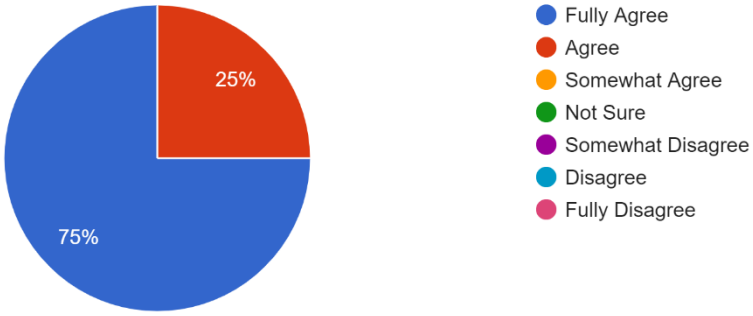
19 responses



Pre-survey: 75% fully agree they understand that mental health challenges are not something to be ashamed of; 25% agree.

I understand that mental health challenges are not something to be ashamed of

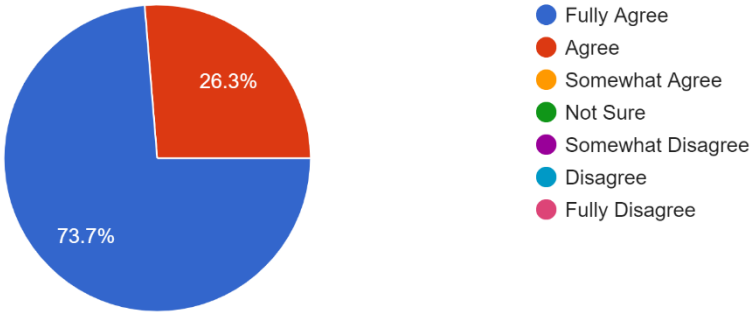
28 responses



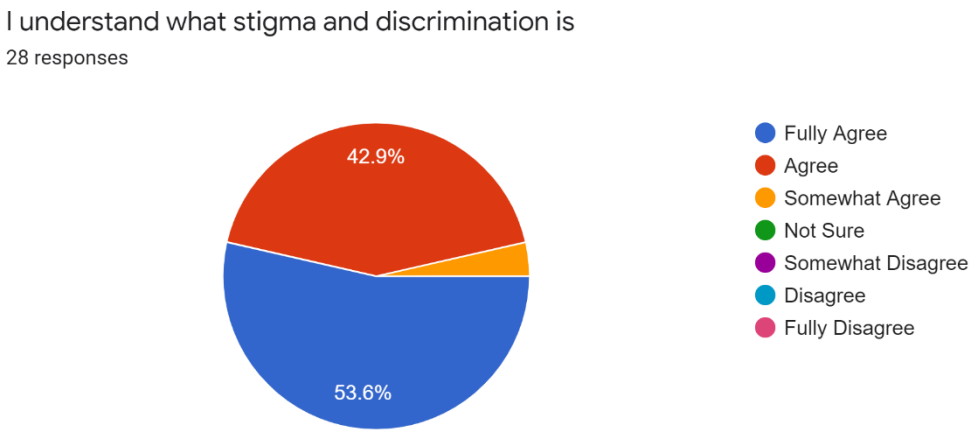
Post survey: 73.7% fully agree; 26.3% agree.

I understand that mental health is not something to be ashamed of

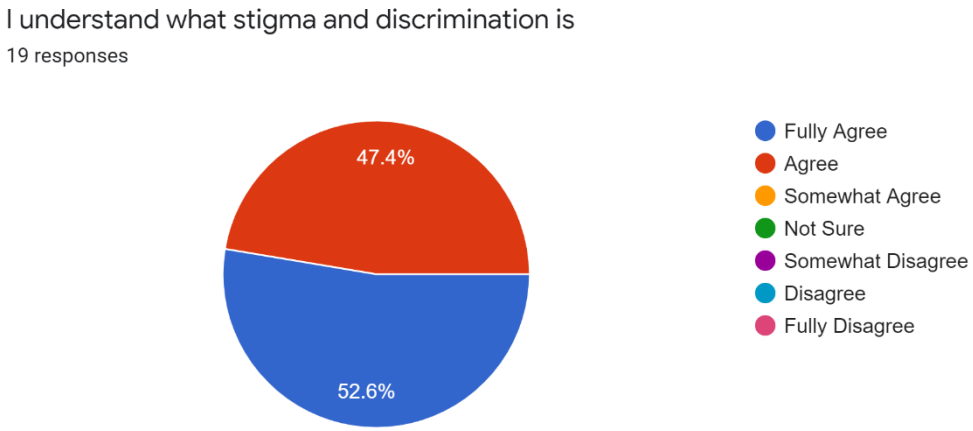
19 responses



Pre-survey: 53.6% fully agree they understand what stigma and discrimination is;42.9% agree; 3.5% somewhat agree.



Post survey: 52.6% fully agree; 47.4% agree.



Actual Outcomes for Fiscal Year 2020-2021:

Due to staffing limitations and the COVID-19 pandemic, the data for Leadership Development in this timeframe is not yet accessible for analysis or report. The PEI domain specific data gathering tool is in the process of being developed through a youth-informed process. Staffing limitations have caused the timeline for the development of this measurement tool to be extended beyond the scope of this annual update once again. However, the PEI domain specific data tool is nearly complete and should be piloted and adopted during the next reporting period.

The size of consistently involved YAB members has decreased significantly during this period as a result of the COVID-19 pandemic, to roughly five consistent participants. Five youth-leadership development trainings were provided to young people: Introductory Leadership Skills, Facilitation, World Cafe Facilitation, Wellness & Nutrition, and Stakeholder Participation. During May is Mental Health Matters Month we also hosted a

workshop entitled “Find Your Way” addressing finding purpose and meaning in life.

Trainings were also provided to community members and youth-serving professions in multiple sessions. These trainings included: Transition to Independence Process (TIP) Model Modules, TRANSforming Organizations, Introduction to Systems of Care Framework, and Listening Deeply: Supporting Transition-Age Youth to tell their stories. HCTAYC and the YAB also presented at the CMHACY conference with a training called Take Charge: Know Your History. Know Your Rights. Know Your Power.

During this reporting period, HCTAYC-hosted digital social nights focusing on activities identified by the young people and staff to experience community during the time of COVID-19. There have been approximately 7 socials, including painting by numbers, pride nights, suncatcher creation, ABO Comix, and several critical thinking movie nights.

Complete implementation of the AOD policy recommendations has still not been completed, however, HCTAYC is beginning to scale back focus on this topic as other initiatives require attention. We still maintain our involvement in relevant policy & advocacy tables. In particular, we devoted specific attention to the Humboldt Allies for Substance Abuse Prevention (ASAP) and Humboldt County Behavioral Health Board (BHB). For ASAP, HCTAYC YAB attempted to shift their work plan to exclude punitive prevention methods. For BHB, it focused on attempting to assist the board in shifting its practice and facilitation method to be more welcoming of stakeholder participation, with a specific focus on youth. This involved the creation of specific recommendations for each of these advocacy bodies, and a significant amount of time preparing them and working to get them implemented.

Data gathering for the LGBTQ+ Policy recommendations continued through this reporting period, adjusting to the COVID-19 pandemic data gathering included a digital survey for the first time, receiving 44 respondents, and three additional interviews focusing on understanding issues pertinent to health care. For the first time this reporting period saw us engage in the piloting of a community drafting process, engaging individuals and organizations in refining the draft recommendations before they are published. This process has continued into the next reporting period.

Our first digital hybrid Digital Storytelling Retreat occurred during this reporting period. In total we have six youth participants who created digital stories over four total days. Storytellers stayed in the same hotel, but engaged online in their rooms, with staff delivering food, supplies, and supports to rooms individually. It was incredibly successful and has created a framework for other organizations to do similar work.

During this period, HCTAYC staff and youth founded the Humboldt Houseless Youth Support Collaboration to leverage collective community energy and engage in resource sharing to better serve and document youth impacted by homelessness. This includes overseeing the implementation of grant funding, and utilization of the HMIS data system that is essential to assisting youth to gain access to HUD services. HCTAYC staff and youth have engaged in street outreach as a result, distributing supplies and information to young people on the streets or in other locations.

Significantly, the state realigned a significant portion of juvenile justice services to

counties. HCTAYC staff and young people have been deeply involved in the subsequent meetings and planning to develop a plan to best serve young people that would have formerly been served by the Department of Juvenile Justice.

Challenges:

COVID-19 has continued to pose challenges for youth recruitment, engagement, and retention on the Youth Advocacy Board. Morale and team building are difficult, as is managing program tasks in a virtual setting. Stress put upon other systems has intensified, and HCTAYC staff have had to shift priorities multiple times. Additionally, during the course of this reporting period, several key leaders of the YAB transitioned away from the board. While their success is our success, we have not been able to fill those gaps.

Successes:

HCTAYC has proven to be incredibly resilient in weathering these crises. Staff have been formidable in their ability to pinpoint youth needs and provide individualized support to them. Remaining members of the YAB have proven to be incredibly strong leaders, managing multiple projects with staff support.

Lessons Learned:

Digital project management requires consistent usage of the tracking platforms, including documentation, assignment, and prioritization. It is even more important in times of crisis to provide guidance and structure to staff and youth. It is also necessary to cultivate collective wellness to support engagement, prioritizing the things that would happen naturally if time was spent physically together when digitally together.

TAY Peer Support

Demographics and Unduplicated Number of Individuals Served:

There were 223 young people that participated in 93 drop-in or workshop events from July 1, 2020 to June 30, 2021. Of those, 82 were unique participants. We had 27 new young people visit drop-in or workshop events with 18% of those occurring in June 2021. Reasons might have included increased street outreach efforts, vaccine availability for young people, and the state's changing guidance for operating during the pandemic all happening in June.

There were 84 new referrals for peer coaching during the reporting year for individual mentorship. Each of these 84 referrals were assigned a peer coach who provided outreach and offered individual mentorship. In addition, there were 8 active participants in the peer coaching program from referrals submitted in previous years. The average time from assigned date to first try contact date was 8 days.

Because the pandemic impacted the ability for young people to participate in available drop-in hours, emergency food distribution was coordinated by peer coaches providing linkages to CalFresh. One hundred emergency food boxes were distributed to young people during the reporting period.

There is no voluntary confidential demographic information available for TAY peer support for this reporting period. Peer Coaches were unable to fulfil this reporting need due to constraints of COVID.

The TAY Division implemented a TAY Outreach component to Peer Support and TAY Advocacy, doing direct street outreach for homeless youth twice a week. During this reporting period, staff engaged and entered 33 youth into the U.S. Department of Urban Development (HUD) Homeless Management System (HMIS).

Actual Outcomes for Fiscal Year 2020-2021

Peer coach staffing levels did not remain fully staffed due to: 1) staff on leave, 2) COVID-19 related leave. All peer coaches have completed documentation training linking direct services to electronic medical records. Peer coaches managed staffing the TAY Center, with reduced hours due to COVID-19. Peer coaches have continued to provide individual mentorship through engagement in the drop-in TAY Center or by referral. One peer lead group continued to meet, by individual outreach, Zoom or by in person activity outside. Peer Coaches continued to support TAY Division workshops and events. Peer Coaches participated in various community presentations.

Training Peer Coaches Attended:

- TIP-Transition to Independence Process
- Medical billing and documentation
- Strength building workshops
- Boundaries training
- Peer Coach purpose, vision and values workshop
- Other various agency required trainings

Peer Coaches Provided Outreach to:

- Juvenile and Adult Probation Services: Juvenile Hall and Humboldt County Correctional Facility-Jail
- Sempervirens and the Crisis Stabilization Unit
- Street outreach
- Eureka Family Resource Center
- Youth Service Bureau: Raven Project and YSB

Peer Led/Supported Activities, Workshops, Groups and Events

- Mommy, Daddy and Me Parenting Skills Group
- TAY Fall feast community event
- Holiday cookie activities
- Acrylic paint workshops

- Mindfulness workshop
- Back to school workshop
- Virtual Pumpkin Carving Contest
- Gardening workshop
- Budgeting Workshop
- Tax Prep Workshop
- Tie Dye Workshop
- Virtual TAY Center Drop-in hours during shelter in place

Challenges:

COVID-19 continued to pose challenges both with supervision and ability to perform scheduled activities. Daily check-ins for supervision were needed to support communication and follow through on assignments. The TAY Center reopened with reduced hours during this reporting period, contributing to a decline in youth attending compared to previous years. Staff were not able to gather virtual sign-in sheets and demographic forms, finding it challenging to manage a virtual space and gather digital forms simultaneously.

Successes:

Peer coach staff have remained resilient and focused. Staff have continued to provide direct service, either virtually, by phone or in person, run a drop-in center with safety measures in place, and provide space for young people to connect using virtual platforms or in person. Staff have been creative in outreach and presentations, giving virtual tours of TAY while sharing about the programs and services. With reduced TAY Center hours Peer Coach staff were able to spend more time on individual engagement and mentorship and help fill low staffing gaps in case management. Peer Coaches were able to team and bond well during this past year.

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

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

Lessons Learned:

Consistent supervision oversight is needed to ensure outcome tools are gathered. Peer Coach staff need regular and consistent supervision and training opportunities. Staff need regular reminders and training on how to gather data through sign- in sheets and

demographics forms.

Prevention and Early Intervention: Suicide Prevention

In July 2020, the Humboldt County Department of Health and Human Services, Public Health Branch, Healthy Communities Division - Stigma, Suicide and Violence Prevention (SSVP) Program was renamed the Suicide and Violence Prevention (SVP) Program, as it no longer includes MHSA Stigma and Discrimination Reduction activities.

Program work has continued to integrate projects, streamline processes, and expand community impact to reduce morbidity, mortality and risk behaviors associated suicide and violence numbers in Humboldt County. The five main SVP 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 (Section 3715. Outreach for Increasing Recognition of Early Signs of Mental Illness)

Objectives

- Humboldt County Suicide Fatality Review: Conduct suicide fatality reviews to identify trends in local suicide deaths and data-driven suicide prevention 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 community trainings such Question-Persuade-Refer (QPR) and LivingWorks Start.
- Lethal Means Safety: Develop and promote lethal means safety campaign to educate community and address majority number of suicide and homicide deaths by firearm and to provide safe storage options.
- Social Marketing: Increase awareness of suicide and violence, promote prevention messaging, and encourage positive behavior change in those areas.

Strategies

- Public and targeted information campaigns
- Culturally competent approaches
- Survivor-informed models

- Evidence and practiced based education models and curricula
- Public health model
- Ecological model
- Multisector approach
- Collective impact approach
- Health equity approach
- Zero suicide framework

Project: Humboldt Suicide Fatality Review (SFR)

The Suicide Fatality Review Team (SFRT) is a multidisciplinary group of professionals who meet 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), Coroner's Office, healthcare, Tribes and 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 family members.

The SFR process:

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

Target Population

Medical 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.
- Provide educational presentations for Humboldt County medical and behavioral healthcare organizations. These presentations will familiarize stakeholders with the SFR and determine contacts for future involvement.
- Identify targeted systemic changes from data analysis of review meeting recommendations.
- Provide technical assistance to target audiences who need training working with healthcare providers, including training content development, guidance, SME, and resources.
- Present findings in conjunction with county epidemiologist that illuminates opportunity for system changes, including providing data to inform decision-making, offering trainings and alignment of shared objectives and deliverables among community partnerships.
- 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
- Note: the following measurements were removed due to changes in program needs.
    - Annual report completed and presented to County Board of Supervisors
    - Progress on County-Wide ordinance mandated Suicide Fatality Review

Expected Outcomes

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. These expected outcomes, like many other program activities in Public Health, were severely impacted by the COVID pandemic during the fiscal year 2020-21.

Actual Outcomes

- 1 SFR meeting held
- 11 participants involved
- 2 suicide death cases reviewed
- Note: Key findings and follow-up actions were not included due to the small number of meetings held.

Number of Individuals Served (Unduplicated)

- Two suicide death cases reviewed at the SFR Meeting
- 11 participants serving 5 agencies at the SFR Meeting

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 (FY2022-2023)
SFR will meet regularly to review two or more suicide deaths at each meeting, reviewing a total of approximately four to eight suicide deaths in the next fiscal year.

Challenges
Reduced staffing and operational changes due to the pandemic made quarterly SFR meetings, transition to virtual meeting format, completion of case reviews, and consistent SFR Core Team meetings difficult.

Successes
The SFR has had numerous great successes this year. A quality improvement project was completed to identify administrative structure, create a database tracking system, formalize materials, and increase readiness for SFR Team Members, and solidify the SFR Core Team membership and responsibilities. Partnership continued with the HCSO Coroner's Office through their continued use of the Suicide Risk Assessment Profile and collaborative information sharing that have strengthened the SFR and ensured prioritization of this work.

Humboldt County has received recognition at the state level resulting in technical assistance presentations to the state Striving for Zero Learning Collaborative, presentations to multiple counties across California, and co-presenting with national SFR expert to those starting SFR in other states. Additionally, procedural improvements have streamlined work to increase efficiency, including the use of project management tools, and the creation of secure file sharing systems and procedural guides. Continued relationship building with local organizations has prioritized SFR work and increased a sense of responsibility among SFR Team Members. Participating organizations have received support through orientations and resources, with the identification of six point of contacts to coordinate work with the SFR team.

Lessons Learned
Allocating time for quality improvement is vital to refining the SFR process. Sector representation within team membership is a way to increase equity and ensure a wide breadth of voices and expertise is included. It has been essential to identify Team Member roles to ensure readiness and success during SFR Team Meetings. The administration of the SFR would benefit from more dedicated staff time. Administrative and Public Health leadership have recognized the importance of buy-in from all DHHS branches in order to most effectively achieve desired outcomes from the suicide fatality review as a quality improvement process.

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 volunteer to present information or update the network

regularly. SPN also works closely with the local chapter of the American Foundation for Suicide Prevention to help plan the Arcata Out of the Darkness Walk.

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

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

Target Population

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

Key Activities

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

- Increase number of agencies represented in network by one per year.

- Five meetings held annually
- 300 list serve participants

Actual Outcomes
- 34 agencies represented in network
- Seven meetings were held annually
- 376 list serve participants

Number of Individuals Served (Unduplicated)
Eighty-two unique participants, representing 34 agencies, attended Suicide Prevention Network meetings in fiscal year 2020-21.

Demographics of Individuals Served (tables)
The MHSA PEI Demographic Form is not applicable to this project and is not used as an outcome measurement.

Projected Outcomes (FY2022-2023)
- Increase number of agencies represented in network by one per year.
- Five meetings held
- 300 list-serve participants

Challenges
Many agencies are experiencing continued funding and staffing changes which results in limited capacity to prioritize SPN related tasks outside of the meetings.

Successes
The Suicide Prevention Network continues to expand in its meeting attendance. This year the number of organizations represented in the Network increased by fourteen, vastly exceeding the goal of increasing agencies represented in the network by one per year. The Network has continued to increase visibility in the community through the use of social marketing strategies such as Mailchimp, branding and press releases. Educational or informative presentations take place during each meeting, drawing additional participants. Networking, relationship building, and topic related education continue to be aspects of SPN that bring participants back every other month.

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

Project: 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 coordinator, trainer and/or support for trainings offered.

Evidence-based training offerings include Question-Persuade-Refer (QPR) Basic Suicide Prevention Gatekeeper Training and LivingWorks Start Training (online basic suicide prevention). Additionally, the SVP Program has developed a series of shorter practice-based training modules covering topics related to mental health and suicide prevention.

Over the past year training offerings have shifted from an in-person to virtual format, allowing for expanded reach and compliance with increased safety measures during the pandemic. Throughout this section, the MHSA PEI Demographic Form is used as an outcome measurement to demonstrate the reach and diversity of populations and settings served.

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

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

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

Outcome Measurements
- Number of trainings
- Number of participants
- Number of MHSA PEI Demographic Forms submitted

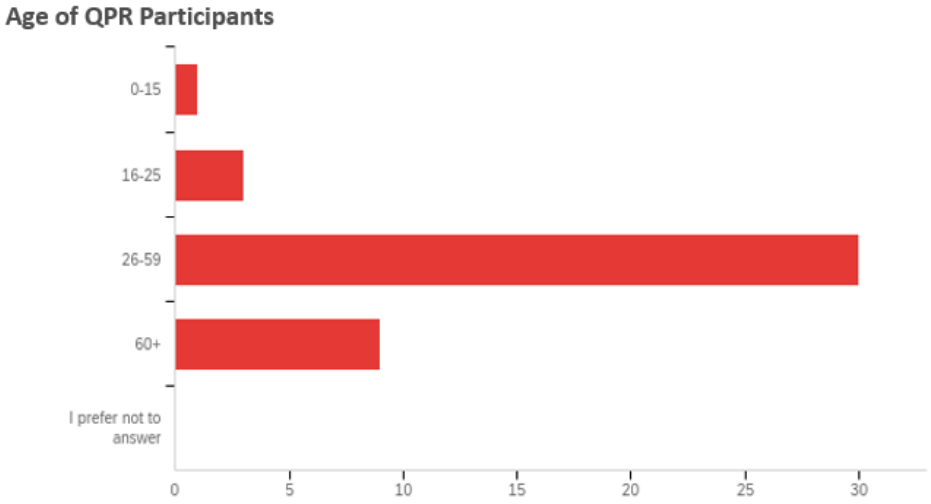
Expected Outcomes
Four trainings were expected be held in fiscal year 2020/2021, serving 20 people per training.

Actual Outcomes
- Five trainings were held
- Eighty-eight participants
- Forty-four MHSA PEI Demographic Forms were submitted

Number of Individuals Served
In FY 2020/21, five QPR trainings were held with 88 individual participants.

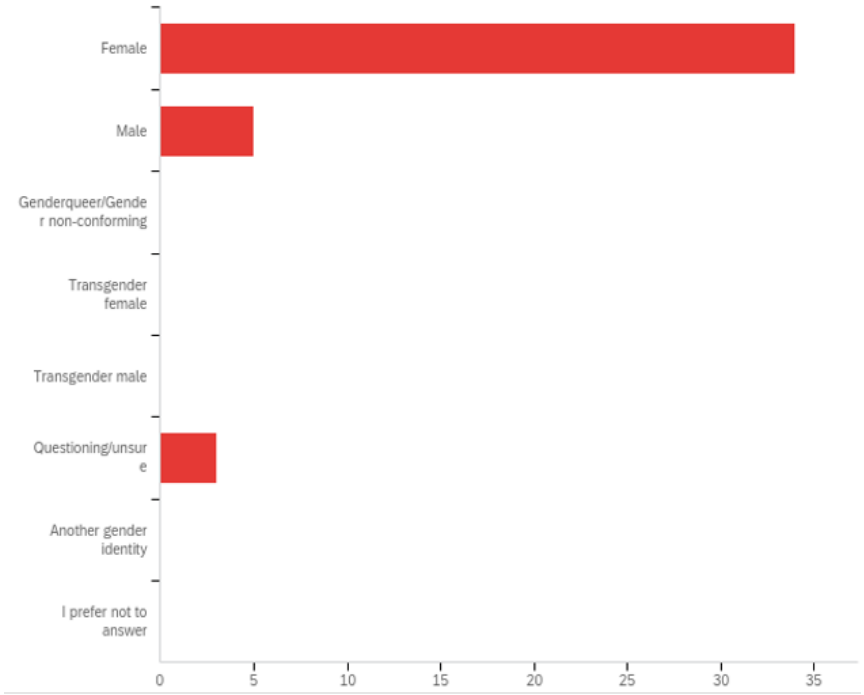
Demographics of Individuals Served
Demographic information comes from attendees at trainings who complete a demographic form. In Fiscal Year 20/21, 50% (44) attendees completed an electronic demographic form, and 50% (44) declined completing or did not receive a demographic form.

In Fiscal Year 20/21, out of the 44 completed demographic forms, one attendee at QPR trainings was 0-15, three were ages 16-25, 30 attendees were ages 26-59, and nine attendees were age 60+.



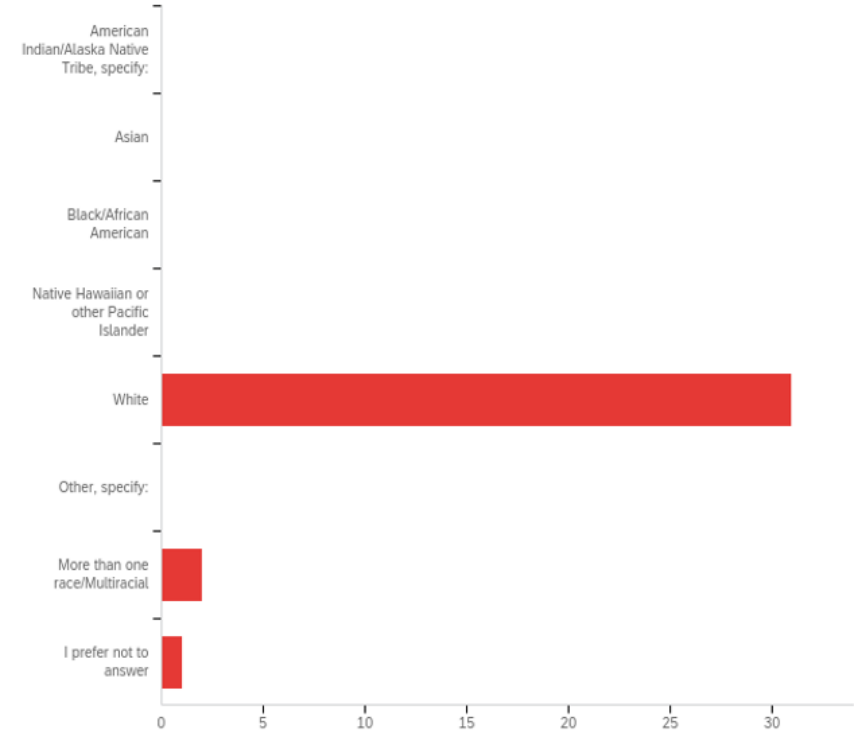
In Fiscal Year 20/21, 34 attendees at QPR trainings were female, five attendees were male, and three were questioning/unsure.

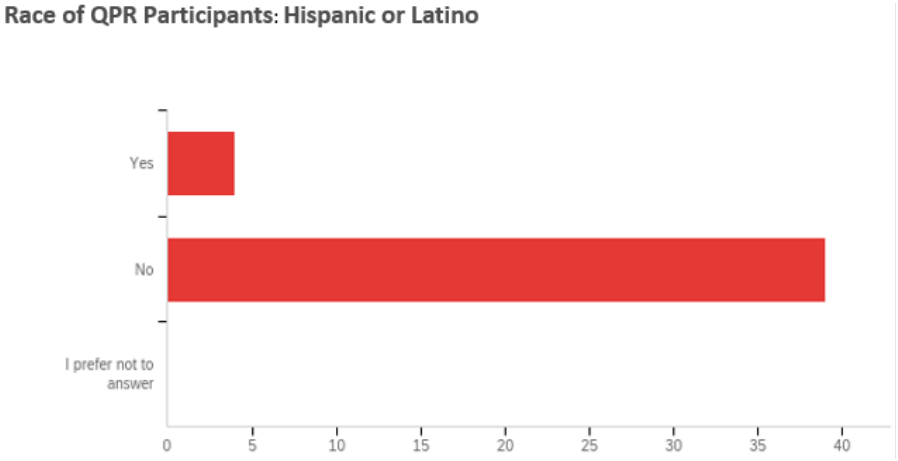
Gender Identity of QPR Participants



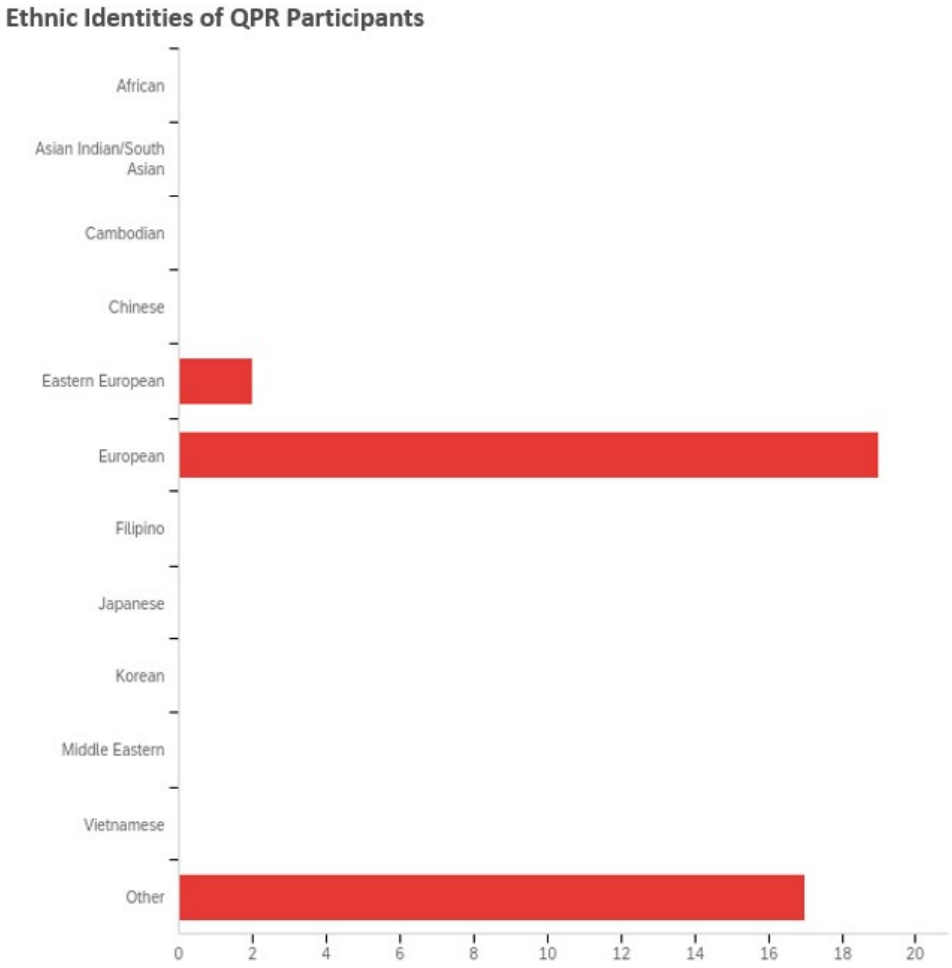
In fiscal year 20/21, 31 attendees at QPR trainings were White, two were more than one race/Multiracial, and four were Hispanic/ Latino.

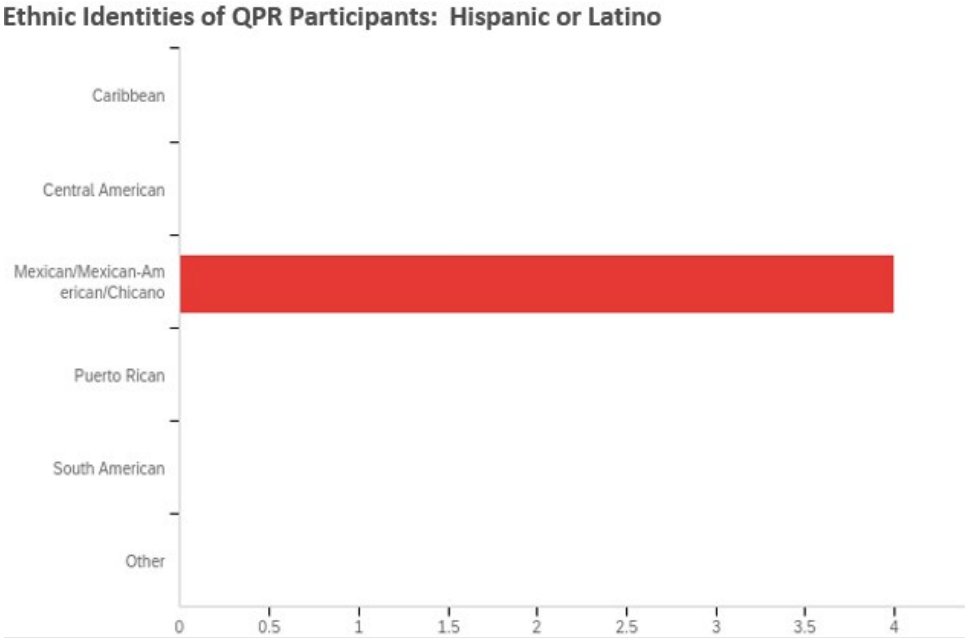
Race of QPR Participants



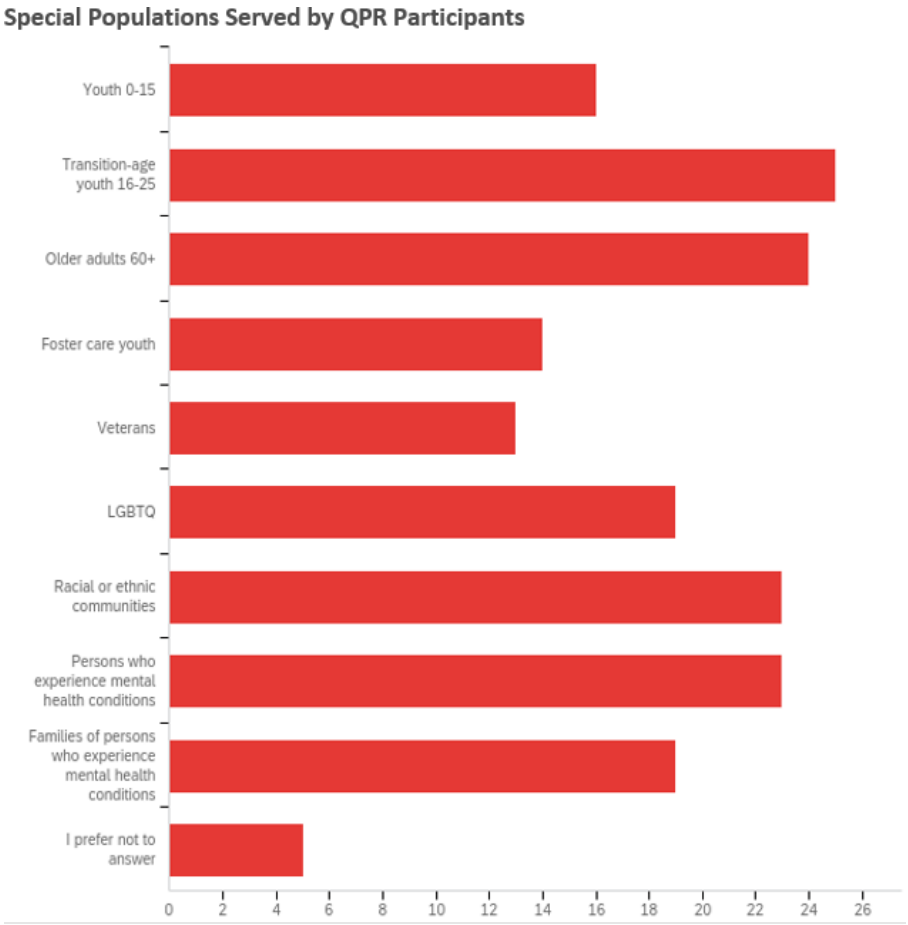


In fiscal year 20/21, four attendees at QPR training attendees were Mexican/Mexican-American/Chicano, two were Eastern European, 19 were European, and 17 marked Other.





The populations served by the QPR attendees in fiscal year 20/21 were, 16 served youth 0-15, 25 served transition aged youth (TAY), 24 served Older Adults, 14 served Foster Care Youth, 13 served Veterans, 23 served ethnic communities, 19 served LGBTQ, 23 served people experiencing mental health conditions, and 19 served family members of people experiencing a mental health condition.



Projected Outcomes (FY2022-2023)
Three trainings will be held, serving 15 people per training.

Challenges
It has been challenging to hold QPR trainings due to the pandemic and reduced program staff. Due to nature of virtual training settings it is harder to get demographic forms and training surveys completed. Competing virtual training opportunities outside of our community have limited attendance. Additionally, participants accessing online materials after trainings has been difficult.

Successes
QPR has reached many diverse settings in our community and has been expanded to include lethal means safety content. Offering the training virtually has allowed us to continue the training project through times where in-person training is unsafe due to the pandemic.

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

LivingWorks Start Training - Online Basic Suicide Prevention

In times of heightened isolation and anxiety, people's thoughts of suicide can increase. Now more than ever, it is essential that people have effective skills to keep each other safe, even if it is from afar. To this end, the SSVP Program will share an online alternative to basic suicide prevention training to our community.

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

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

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

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

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

Target Population

LivingWorks Start training is targeted towards DHHS staff, employers seeking to improve workforce ability to recognize signs and symptoms of suicide and/or potentially serious mental illness, social services agencies, shelter and homeless services, tribal leaders, educators, elder care agencies and SNF's, general community members, department of veteran's affairs, medical and behavioral health care staff, law enforcement/first responders and others living or working in Humboldt County.

Key Activities

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

Outcome Measurements

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

Expected Outcomes

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

Actual Outcomes

- 323 licenses issued
- 162 trainings completed
- 210 MHSA PEI Demographic Forms submitted
- Note: the number of forms submitted exceeds the number of trainings completed. When licenses were issued, every participant was required to complete a demographic form prior to gaining access to the training. 48 participants completed the form but did not fully complete the training.

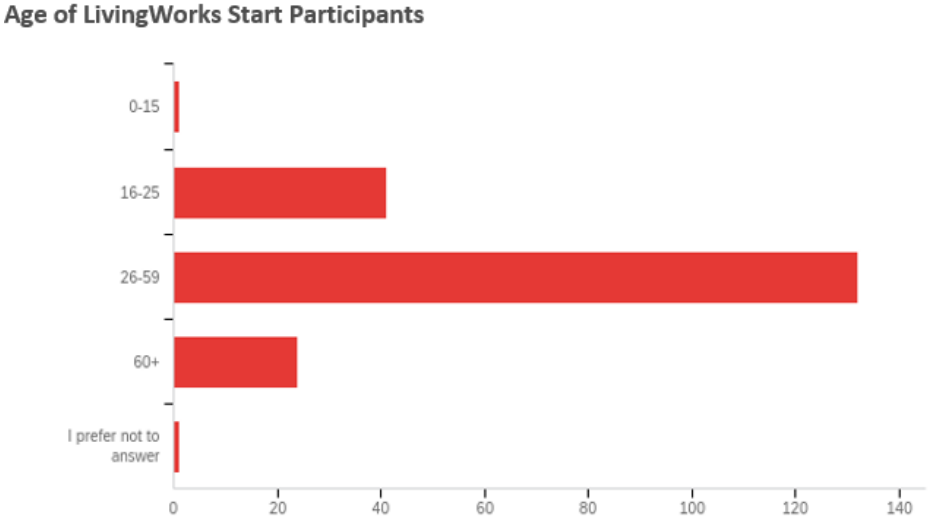
Number of Individuals Served

In FY 2020/21, 323 Start trainings licenses were issued, 162 trainings were completed with 210 individuals submitting MHSA PEI Demographic forms.

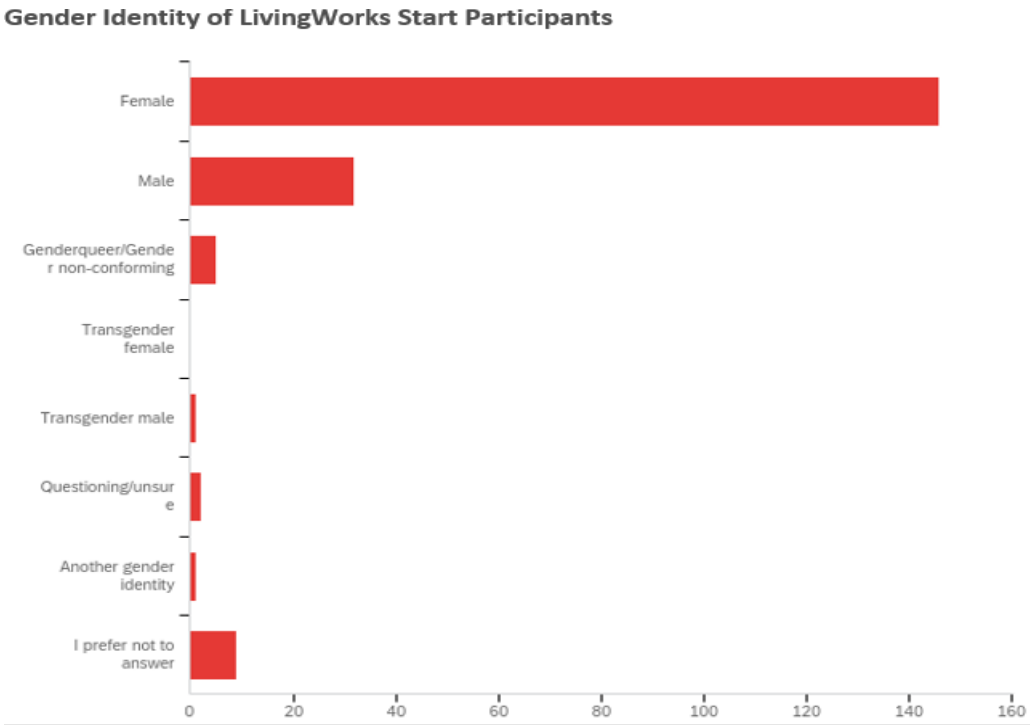
Demographics of Individuals Served

Demographic information comes from individuals who were issued a license and completed a demographic form. In Fiscal Year 20/21, 65% (210) of individuals issued a license completed a demographic form, and 35% (113) did not complete a form. Every participant who was issued a license, was required to complete a demographic form prior to gaining access to the training.

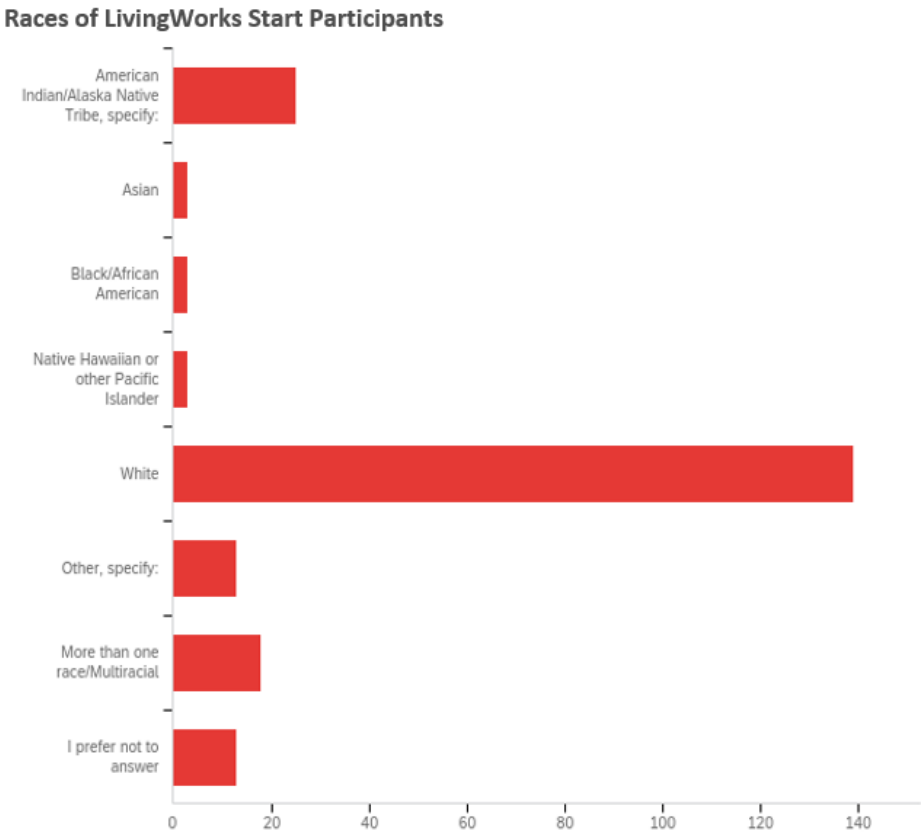
In Fiscal Year 20/21, one training participant was 0-15, 41 were ages 16-25, 132 participants were ages 26-59, 24 participants were age 60+ and one preferred not to answer.

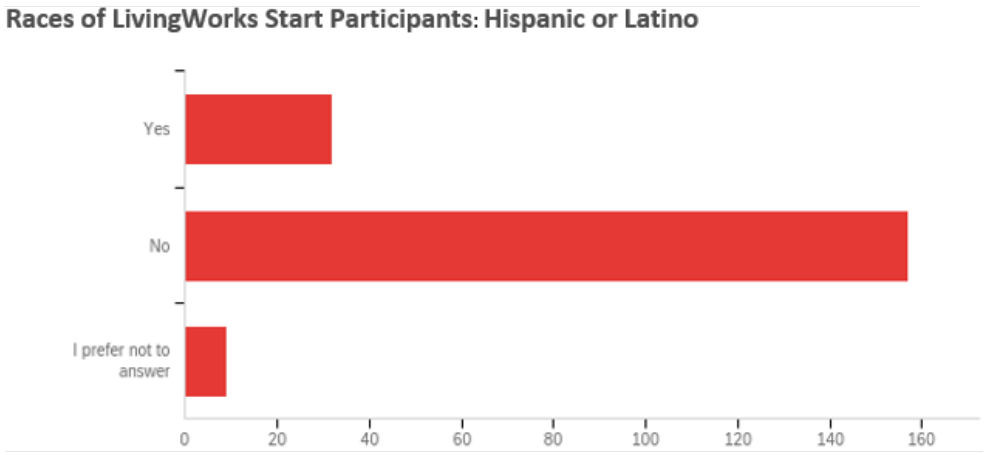


In Fiscal Year 20/21, 146 training participants were female, 32 participants were male, 5 were genderqueer/gender non-conforming, one was transgender male, two were questioning/unsure, one was another gender identity and nine preferred not to answer.



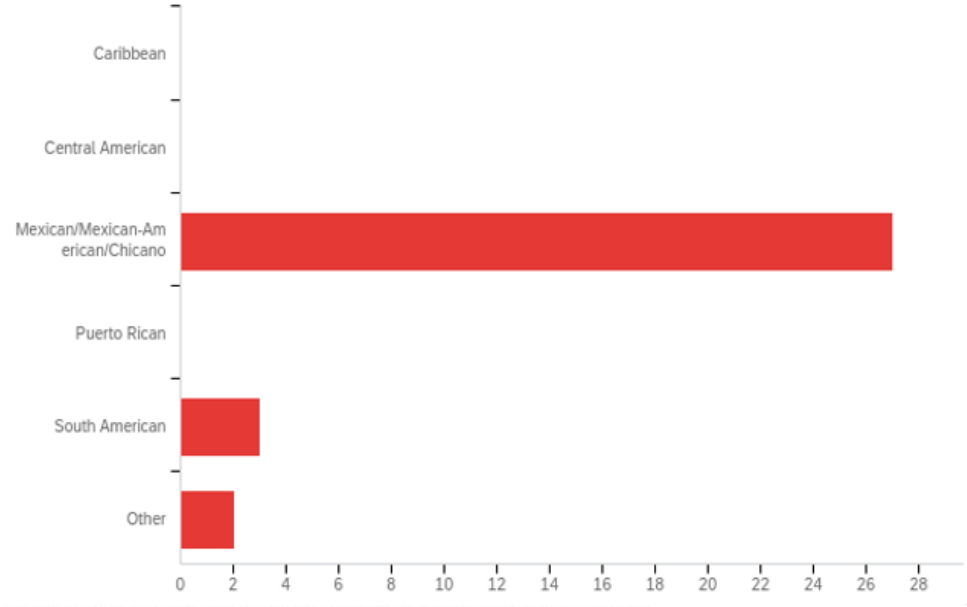
In fiscal year 20/21, 25 training participants were American Indian/Alaska Native Tribe, three were Asian, three were Black/African American, 32 were Hispanic or Latino, three were Native Hawaiian or Other Pacific Islander, 139 were White, 13 response Other, 18 were more than one race/Multiracial and 13 preferred not to answer.



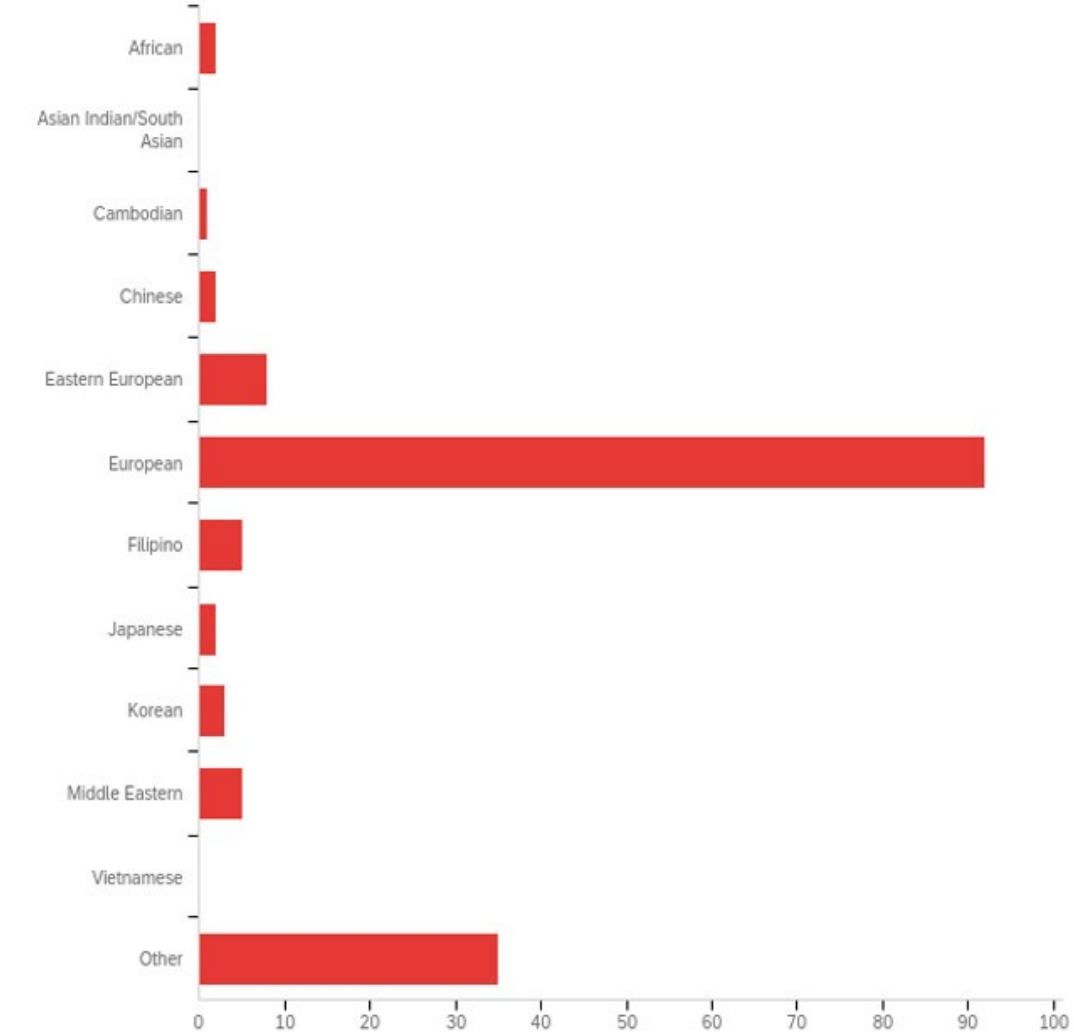


In fiscal year 20/21, 27 training participants that marked Hispanic or Latino were Mexican/Mexican-American/Chicano, three were South American, two marked other. Additionally, for participants that did not mark Hispanic or Latino, two were African, one was Cambodian, two were Chinese, eight were, Eastern European, 92 were European, five were Filipino, two were Japanese, three were Korean, five were Middle Eastern, and 35 marked Other.

Ethnic Identities of LivingWorks Start Participants: Hispanic or Latino

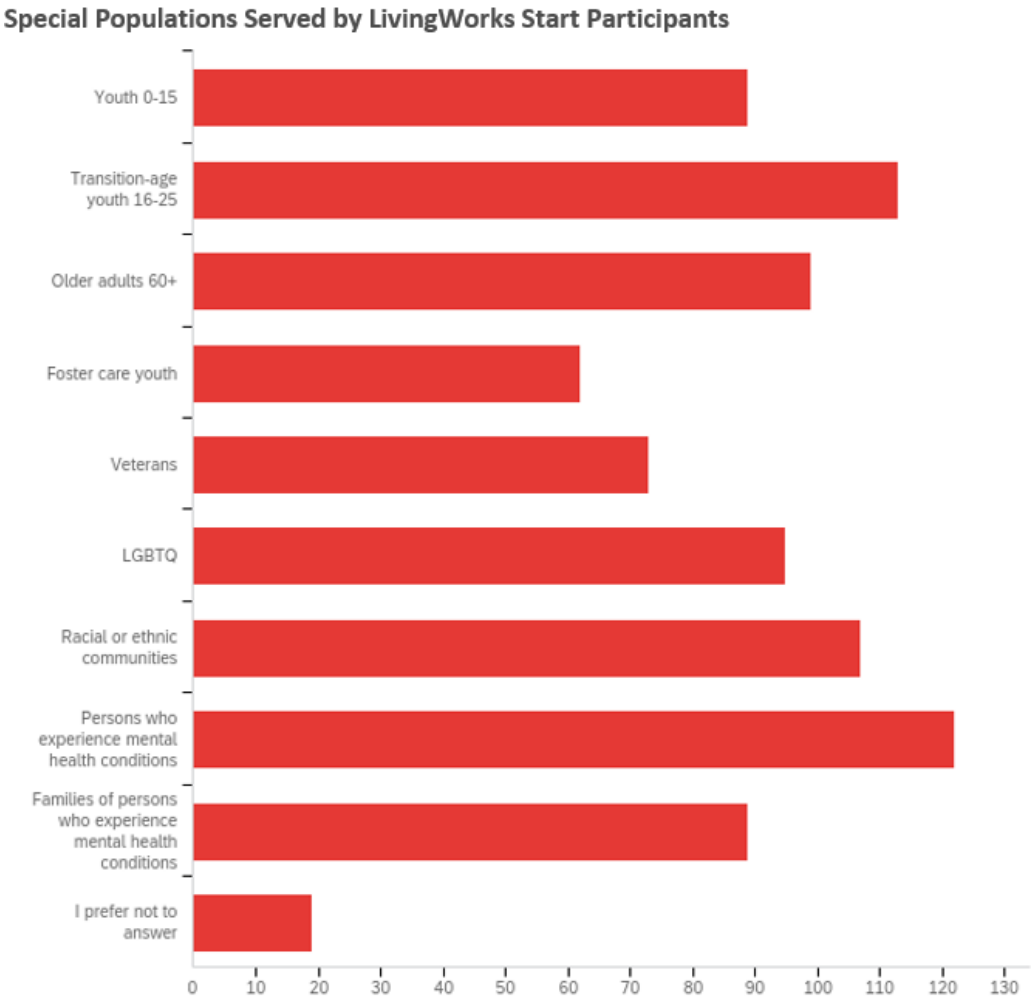


Ethnic Identities of LivingWorks Start Participants



The populations served by the participants in fiscal year 20/21 were, 89 served youth 0-

15, 113 served transition aged youth (TAY), 99 served Older Adults, 62 served Foster Care Youth, 73 served Veterans, 107 served ethnic communities, 95 served LGBTQ, 112 served people who experience mental health conditions, 89 served family members of people experiencing mental health conditions and 19 preferred not to answer.



Projected Outcomes (FY2022-2023)

- 200 licenses issued
- 100 trainings completed
- 100 MHSA PEI Demographic Forms submitted

Challenges

This online training opportunity has presented unforeseen challenges in promotion, license management and participant engagement. Training completion rates are lower than expected and staff time for administrative tasks is higher. The market in Humboldt County has been over saturated with training licenses due to multiple agencies purchasing bulk licenses from LivingWorks and AB1808 passing at the state level to provide training for school staff and students.

Successes

The LivingWorks Start training has been widely promoted to Humboldt County residents, through social marketing campaigns and targeted organizational outreach. Eventbrite has been used to give people interested in the training more information and register for a license. The training also allows us to offer immediate access to a training in situations staffing limitations present a barrier to providing live, virtual trainings.

Lessons Learned
Collaboration is needed with community partners to coordinate resources and promotional activities.

Project: Lethal Means Safety
In Humboldt County, between the years of 2005-2018, 47% of all suicide deaths involved a firearm; 26% were due to hanging; and 20% 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. 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

Key Activities

- 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 high risk groups, 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 285 firearm deaths in Humboldt between 2005-2019. The majority (76%) 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 our 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 our program staff and now, firearm safety instructors are including basic suicide prevention education in their classes. 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.
- The Public Health Keep It Safe Lockbox Distribution Program is an expansion of the overall Keep It Safe Campaign previously known as Lock Up Your Lethals.
    - 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

- 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

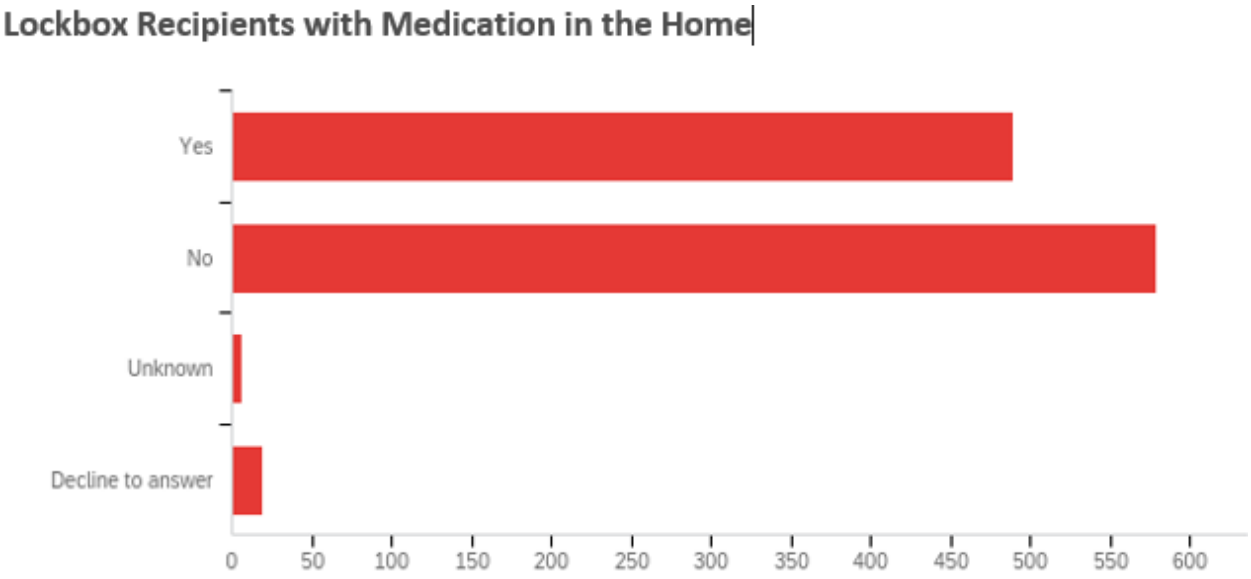
- 1,000 Keep It Safe brochures distributed throughout the county.
- Two Lethal Means Safety trainings with 15 or more participants
- 650 lockboxes distributed
- 650 Lockbox Data Collection Forms completed
- 650 educational resources provided

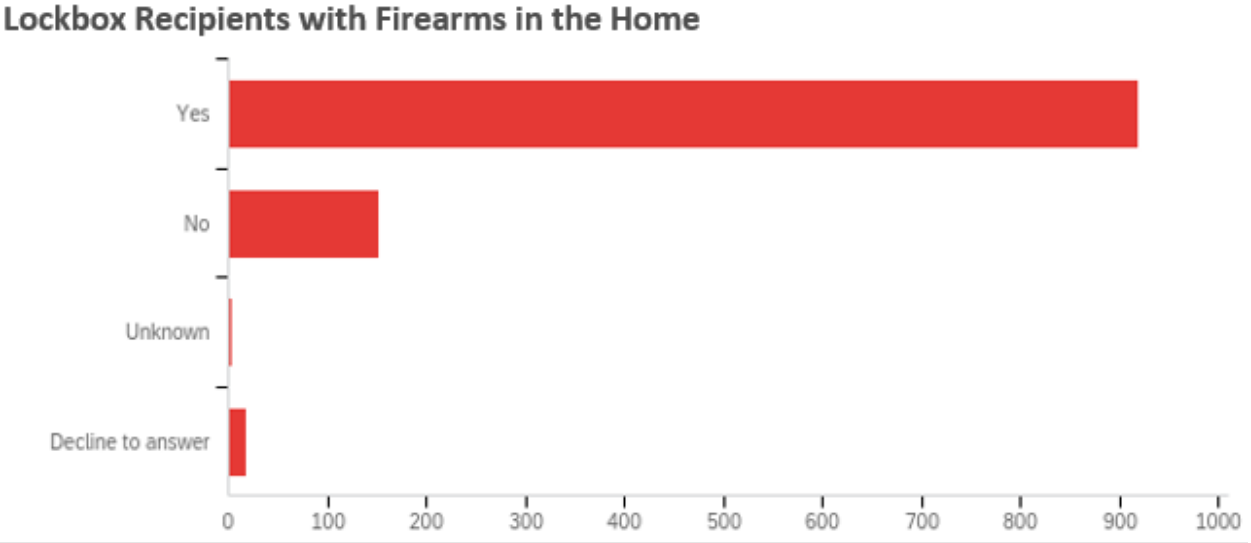
Actual Outcomes

- 2800 Keep It Safe brochures distributed
- Four Lethal Means Safety Training Modules offered
- 68 Lethal Means Safety Training participants
- 2121 lockboxes distributed
- 1109 Lockbox Data Collection Forms completed
- 3850 educational resources provided with lockboxes (3000 Lockbox cards and 850 suicide prevention resource cards) Note: Public Health's Substance Use Prevention Program also distributes lockbox cards to community partners when appropriate.

Demographics of Individuals Served

Demographic responses for zip codes, medication in home and firearm in home are from the 1109 Lockbox Data Collection Forms completed by lockbox recipients.





Projected Outcomes (FY2022-2023)

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

Challenges

Even with great success in the distribution of lockboxes in the County, more resources are needed to meet the high demand in our community. With the purchase of additional lockboxes, there is great potential for continued expansion with community partner outreach.

Successes

Collaboration with firearm retailers was a remarkable opportunity to provide safe storage options and educational resources widely to our community. Additionally, education was

provided to firearm retail staff on suicide prevention strategies to recognize risk for suicide. 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.

Lessons Learned
It has been essential to working with community partners to widely distribute lockboxes throughout the County. This has enabled distribution to reach diverse target populations of firearms owners.

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

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

Target Population
- All Humboldt County residents will be reached with the social marketing efforts, with a focus on direct service providers.

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 Each Mind Matters, 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 child 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.
- 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” and “Each Mind Matters.”
- 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 living in homes. Keep it Safe is about starting a conversation with Humboldt County residents about protection our loved ones from preventable injury. Keep It Safe addresses common items found in homes that could be dangerous such as medications, alcohol, firearms, and anything else that can be used to get high.
- 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

- 1000 people through the DHHS Webpage
- 60,000 through radio PSAs
- 2,000 emails opened

Actual Outcomes

- 1,226 annual page views for DHHS SVP Program website
- Radio PSAs were not aired
- 3,086 emails opened

Projected Outcomes (FY2022-2023)

- 300 people through the DHHS Webpage
- 60,000 through radio PSAs
- 1,000 emails opened

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

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

Lessons Learned
The SVP program has redesigned the program to increase access to local resources and sees further expansion of content to be useful in community education efforts. Email messaging through social marketing platforms such as Mailchimp, has streamlined our process and improved data analytics on engagement.

Prevention & Early Intervention: Parent Partners

The Parent Partner Program's vision is to provide support, encouragement, and hope to parents/caregivers who are feeling overwhelmed as they find themselves involved with a challenging and complex child or adult-serving system. It is an early intervention program and provides access and linkage to treatment. Parent Partners develop and maintain a practice to increase opportunities for parents/caregivers to receive peer based support services as they encounter county child and adult-serving systems through strategic self-disclosure of their lived experiences as parents of a youth or family member with emotional, mental health or substance abuse needs. Parent Partners provide support as a peer, rather than an expert in the field, and help to create conditions for parents/caregivers to feel empowered and confident as they navigate these county systems, making decisions that are best for their family and determining their course of action based on their families' needs and goals. Parent Partners model effective personal interactions while supporting the development, reconnection and strengthening of natural supports for families. They serve as a mentor to improve parents/caregivers' confidence and ability to self-advocate for and effectively manage the services and supports for their own family. They empower families to identify their own future vision of what their family can be, what they need most to achieve this future, and how they can use their strengths and culture to get those needs met. The services of Parent Partners can contribute to meeting the need for additional services and supports for school age children. The Parent Partner Program will continue to be supported contingent upon continuing availability of MHSA funding.

The Parent Partner Program employs three full-time staff to provide supportive services to parents/caregivers involved in the DHHS systems-Public Health, Child Welfare, Probation, and Behavioral Health, along with Humboldt County Office of Education. The most senior Parent Partner completed certification as a Parent Partner Coach through a National Wraparound Implementation Center Affiliate (NWIC), the Family Involvement

Center of Arizona. The Certified Parent Partner Coach has also been credentialed by the National Federation of Families for Children's Behavioral Health as a Certified Parent Support Provider (CPSP). The CPSP credential is to ensure that people employed in this field meet consistent and high standards of performance when helping other parents who have children experiencing social, emotional or behavioral health challenges. Certification promotes ethical practice within the workforce so parents with experience in successfully helping their own children can support parents in their unique journey to make decisions that are best for their families without judgement, bias, or stigmatization.

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

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

Key Activities:
Parent Partners offer assistance in navigating the DHHS system, collaborative linkages with community resources, building natural supports and identifying their needs, strengths, skills, and goals to promote their family wellness. Parent Partners are often members of Child and Family Teams serving youth with intensive needs. Parent Partners build alliances with other departments and agencies including Probation and Child Welfare Services to assist parents/caregivers whose children have been placed out of county or are currently in programs like New Horizons Regional Facility or a foster care facility. Parent Partners coordinate with the Children's Mobile Response Team so that families that have children in crisis are quickly offered support and resources. In addition, Parent Partners are co-facilitators at the County's Family Advisory Board meetings and several NAMI peer support groups offered in the county. They are available to parents/caregivers of children or adults receiving services within the Adult Behavioral Health system by being available to families and staff during visitation hours at the Sempervirens Psychiatric Health Facility. Parent Partners may help staff the DHHS Warm Line bringing their peer-based expertise to support community members seeking services.

Expected Outcomes:
The Parent Partner Program reaches out, through meetings, referrals and support groups, to an average of ten people per week. Outreach efforts are done primarily at Sempervirens, Family Resource Centers, the Jefferson Community Center, and directly to

families and caregivers in the community. Parent Partners are expected to attend various meetings within the DHHS system in order to provide the critical perspective of those with lived experience.

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

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

Estimated Number to be reached in FY 2022-2023:
For the next year an estimated 80 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 annually and at the time of closure to services.

The Parent Partner Program's vision is to provide support, encouragement, and hope to parents/caregivers who are feeling overwhelmed as they find themselves involved with a challenging and complex child-serving system. The target population includes any parent or caregiver of a youth involved in a child-serving system such as a Children's Mental Health program or Child Welfare Services. In addition, these services will impact the well-being of families which may include children and other natural supports.

Report for Fiscal Year 2020-2021

Unduplicated Number of Individuals Served:
For FY 20/21 the Parent Partners served 52 unduplicated parents. There were 17 new referrals with 16 of these receiving services.

Demographics of individuals served:

- 12 completed demographic forms
- AGE: All 12 indicated ages 26-59
- RACE/ETHNICITY: 10 White; 1 Black; 1 preferred not to answer about race; 1 Hispanic
- SEXUAL ORIENTATION: 9 heterosexual/straight; 2 Bisexual; 1 no answer about sexual orientation
- LANGUAGE: English is primary language for all
- HOUSING: 7 have been homeless or lived on the streets; one didn't answer; 4 answered no
- MENTAL ILLNESS: 5 have been diagnosed with mental illness; 3 said undiagnosed mental illness; 1 didn't answer; 3 indicated No
- 10 have family members with diagnosed mental illness; 2 didn't answer

Key Activities:
Parent Partners offer assistance in navigating the DHHS system, collaborative linkages with community resources, building natural supports and identifying their needs, strengths, skills, and goals to promote their family wellness. Parent Partners are often members of Child and Family Teams serving youth with intensive needs. Parent Partners build alliances with other departments and agencies including Probation and Child Welfare Services to assist parents/caregivers whose children have been placed out of county or are currently in programs like New Horizons Regional Facility or a foster care setting. Parent Partners are co-facilitators at the County's Family Advisory Board meetings and several NAMI peer support groups offered in the county. They are available to parents/caregivers of children receiving services within the Adult Mental Health system by being visible to families and staff during visitation hours at the Sempervirens Psychiatric Health Facility. The Parent Partner Program reached out to approximately 30 people per week this last year. These outreach efforts were done primarily at Sempervirens, Family Resource Centers, the Jefferson Community Center, and directly to families and caregivers in the community.

Actual Outcomes for Fiscal Year 2020-2021
At intake, the Parent Support Tool showed:

- 39% report the Presence of the Family Support System "some of the time" and 39% report the Presence of the Family Support System "very present"
- 23% "feel accepted about many things" about their family support system and 38% "feel accepted by all things" about their family support system
- 27% feel that they are "likely to have some disagreements" with service providers while 46% feel "they will likely be understood and appreciated" by service providers
- 96% report that they have multiple stressors in their life
- 77% will be facing 1-3 transitions and decisions within the next 60 days
- 54% of parents were given a score between 9-12, indicating the need for a moderate level of support

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

Parent Partners complete Medi-Cal billing for those parents that they serve that are eligible. Most parents/families 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 our Electronic Health Record system for the reporting period.

PARENT PARTNER SERVICES FY20/21	#
Number of Individuals Receiving Services	52
Total Number of Services Provided	500
Total Number of Minutes Provided	34,519
Average Number of Minutes Per Service	69
Average Number of Services Per Client	10

How Outcomes are Measured:
Our current outcome tool is the Parent Support Tool (PST). The PST should be completed at the

beginning, annually and end of services. The PST measures: presence of the family's support system; acceptance of the family's support system; ability to be heard by service providers; coping with stress; transitions, impact and timing and provides a total score. In addition to the use of the PST we would like to begin using data from the CANS (Child and Adolescent Needs and Strengths), a state mandated reporting tool used with our children and families that we have begun implementing into our Behavioral Health programs. While Parent Partners are not currently responsible for completing the CANS most of the cases that they are involved with should have a CANS attached to it. As our CANS completion rates increase this data should become available to provide further analysis and support for the Parent Partner program.

Challenges:
The COVID-19 pandemic has created many challenges in the last fiscal year. Staff have had to adapt services to maintain social distancing, such as meeting remotely with parents, offering groups remotely or in different settings. While our core group of Parent Partners has remained steady the supervisor for this program left the position. This change created an extra challenge in terms of supporting the training and day to day management of the program. We are currently recruiting for a new supervisor.

Successes:
Despite the challenges of COVID, and the loss of a supervisor, there have been many successes. Our team is more seasoned and has demonstrated an increase in direct billable service enhancing the sustainability and growth potential of the program. Staff are much more adept at Medi-Cal billing and can provide services to both our Children's and Adult's programs. Because staff are more adept at documentation, we are also better able to measure our services which further adds to the sustainability and accountability of this program. Finally, staff have availed themselves of many remote learning opportunities and continue to build their service delivery skills.

Lessons Learned:
While the pandemic has stressed many aspects of our system of care our staff have adjusted. With the proper support and training staff have shown they can continue to deliver high-quality services while continuing their own professional development under these challenging circumstances. We are fortunate to have a seasoned and well-trained group of Parent Partners that were able to quickly adjust to the new challenges of work during a pandemic. We will continue our recruitment efforts for a dedicated supervisor for this group as this is a crucial component if we wish to grow this program.

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.

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 systematic change through intentional design and redesign of services and supports that quickly identify and match the needs of all students in general education contexts.

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

Target Population
One of the strengths of the MTSS framework is that it includes all student groups and moves to improve social-emotional, behavioral, and academic outcomes. The Tiered System is a comprehensive approach to identify needs early and intervene with effective interventions targeting student need. The tiers include academic, behavioral, and social-emotional learning. Tier One (Universal) represents the intervention/instruction for all students. Tier One strengthens the systematic delivery of behavioral and social emotional learning and promotes the use of universal screening across these important three instructional domains. With a robust Tier One, universal screeners are identified by districts and school site teams to determine students with the need for intervention. This methodology provides systematic early intervention across the domains and promotes response to intervention. Tier Two interventions are less intensive, small group interventions for students needing a little extra. Research demonstrates that effective Tier Two interventions are conducted with a small, targeted group with the goal of reversing the difficulty and returning the child into the Universal whole-group instruction. Tier two interventions reduce the numbers of students needing intensive individualized interventions. The need for special education or intensive mental health intervention is reduced when preventative early interventions are

implemented. Tier Three interventions are intensive and individualized. These interventions require more time and resources. A larger need for Tier Three interventions exists when Tier One and Tier Two are not established with fidelity.

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

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

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

Outcome measures
Fidelity Measures: District and school site teams will conduct fidelity measures and make inclusive data-based decisions based on these tools. Some of the measures include Fidelity Integrity Assessment (FIA – a district and site-based tool for MTSS implementation), The Tiered Fidelity Inventory (TFI – a site-based Team assessment to measure the implementation of PBIS/SEL), The Self-Assessment Survey (SAS – a site-based survey of all school personnel to measure the perceptions and priorities of PBIS/SEL implementation. These measures often occur two times an academic year to guide intervention practices.
Behavioral Data: The School-Wide Information System (SWIS, pbisapps.org) is the gold standard tool to guide and support PBIS implementation. Student behavior is tracked and defined as “minor vs. major” behaviors (often differentiated by classroom managed or office managed behaviors). SWIS provides instantaneous rich data that informs whole school, select groups, or individual need. Interventions are effective when data driven, and SWIS provides a tool to inform interventions and effectiveness. Additionally

SWIS is a powerful tool to identify disproportionality of specific student groups. The Prevention and Intervention Specialist will provide facilitation, technical assistance and training of SWIS.

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

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

Below is the report component for fiscal year 2020-2021

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

- 57% are White
- 19% are Hispanic/Latino
- 9% are American Indian/Alaska Native
- 9% are Other
- 4% are Asian/Pacific Islander
- 1% are African American
- 1% Unknown
- 7% are English Language Learners
- 58% are Free and Reduced Lunch eligible students
- 15.7% are Chronically Absent

MTSS Key Activities include technical assistance; training in Restorative Practices, PBIS fidelity measures and analysis, team building, Inclusive Discipline Practices (Restorative Conferencing as alternative to suspension/expulsion); training in Inclusion and Universal Design for Learning (UDL), 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.

Activities Supported by PEI Funding 2020-21

<u>The Continuation of the COVID-19 Pandemic:</u>

As we can all attest, 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 years 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 new Prevention and Intervention Department.

Prevention and Intervention Services
Summary of Activities
2020-2021

Brief History

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 CA.

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 our 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 our 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 includes 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

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. Prevention and Intervention Services in partnership with the CA PBIS Coalition and Placer COE is establishing a technical assistance center for the

North State to support the rural districts of Humboldt County and neighboring counties in Region 1 and 2. Currently we are working with identified districts to scale-up implementation fidelity with a vision to engage all districts served by HCOE.

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. The vision is to establish UDL classrooms that will then model the practice and mentor other teachers, building sustainable capacity to foster the pedagogical shift of practice.

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 lead 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.

CA MTSS – HCOE continues to work closely with the CA MTSS Initiative, as the Region 1 Lead and within Humboldt County. In this past year CA MTSS has launched Phase 2B of district support. Of approximately 20 grantees of Phase 2B, Prevention and Intervention Services is working with the South Bay School District with professional development, technical assistance, and coaching. 90% of district staff will engage in training modules over an 18-month period as Prevention and Intervention Specialists will meet regularly with School Leadership Teams and the District Leadership Team with the vision of scaling-up the implementation of MTSS (social emotional, academic, and behavioral learning).

Restorative Practices – RP – HCOE supports three certified trainers with the International Institute for Restorative Practices (IIRP) and is the lead COE in the newly established Restorative Educators Network (REN). HCOE has trained over 600 regional educators in Restorative Practices and has partnered with National Chung Cheng University in Taiwan to advance the global movement of Restorative Practice in Education. IIRP trainings include 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 trainings, 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.

The North Coast Service Providers Consortium – NCSP – The NCSP was fortuitous byproduct of the COVID pandemic. In partnership with the Yurok Tribal Behavioral Health Task Force and the Department of Health and Human Services – the inception of this collaborative consortium was developed. The NCSP consists of service providers and educators representing local districts, non-public agencies (NPAs), tribal entities, probation, and the Department of Health and Human Services. The NCSP meets quarterly (only virtually at this point) with the main goal to deepen cross organizational understanding, while building social capital and relationships. As past crisis response efforts attest – the better understanding agencies have of the services they provide and the authentic power of relationship – access and coordination to intervention is improved. The vision of this consortium is to tighten the net of services and best serve students and promote community health.

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.

District Engagement Highlights

Prior District Engagement in Humboldt County
In school year 2019-20, the Northern CA MTSS Coalition had thirty-one participating schools. The HCOE Northern CA MTSS Coalition is comprised of districts/sites that will have access to ongoing consultation, and technical assistance provided through HCOE.

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

- Arcata Elementary School District
- Alder Grove Charter
- Cutten Ridgewood School District
- Eureka City Schools
- Blue Lake School District
- Big Lagoon School District
- Trinidad School District
- Southern Humboldt Unified School District
- Ferndale School District
- Freshwater School District

- Fuente Nueva Charter
- Garfield School District
- Loleta Elementary School District
- Jacoby Creek School District
- Rio Dell School District
- Fortuna Elementary School District
- Fieldbrook Elementary School District
- McKinleyville Unified School District
- Pacific Union School District
- Northern Humboldt Unified High School District
- Klamath Trinity School District
- Redwood Preparatory School District
- South Bay School District

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

Below is a brief snapshot of direct district and community engagement over the 2020-21 academic year. The list is not exhaustive but highlights some of the activities supporting our local districts focusing on student wellness and mental health.

Jul-Dec 2020

Brief Description of Trainings Provided	MH Staff	School Staff
8/20 SEL District Training (Freshwater SD) – Adult and Student Social Emotional Wellness	2	28
9/22 Admin Meeting, Southern Humboldt SD – SEL – SEL and Covid Self-Care	1	6
9/28 SEL District Training Trinidad SD - Adult and Student Social Emotional Wellness	1	22
10/19 SEL District Training South Bay SD – Adult and Student Social Emotional Wellness	2	33
10/21 & 10/22 PBIS Training – Court and Community School	2	18
10/30 North Coast Service Providers Consortium – MH in Schools and Community in the time of COVID-19	26	15

Brief Description of Trainings Provided	MH Staff	School Staff
11/2 SEL District Training, Fuente Nueva Charter – Adult and Student Social Emotional Wellness	2	17
11/6 SEL District Training, Northern United Charter – Adult and Student Social Emotional Wellness	2	12
11/12 Check-In, Check-Out Community training for Native American MH Providers	6	4
11/12 & 11/19 PBIS Training with Court and Community Schools	2	18
11/30 PBIS Training (Day 1) - South Bay School District	2	12
TOTAL	**48**	**159**

Jan-Mar 2021

Brief Description of Trainings Provided	MH Staff	School Staff
1/3 SEL District Training – Arcata School District – Adult and Student Social Emotional Wellness	3	34
1/11 Restorative Practice as a MH & SEL tool, Coastal Grove Charter	1	13
1/19 Restorative Practice as a MH & SEL tool, Northern Humboldt Unified HS District, PD Day	2	23
1/25 PBIS (Day 2) South Bay District	2	12
1/29 North Coast Service Providers Consortium – MH in Schools – Student Engagement and Wellness	15	16
2/6 CalSOAP Tutor Training – Trauma and MH and Learning	0	22
3/1 PBIS (Day 3) South Bay District	2	12
3/3 Roundtable Presentation for Humboldt County MH providers – Family Resource Center and Child Welfare Organized – MTSS and Multi-Tiered School-Based MH intervention	35	40
3/3 SEL District Training – Rio Dell District – Adult and Student Wellness	0	28
3/17 PBIS Training with Court and Community Schools	2	18
3/26 Positive Behavioral Interventions, Trauma Informed Care, and MH in the Schools. Southern Humboldt District	3	32
TOTAL	**65**	**250**

Apr-Jun 2021

Brief Description of Trainings Provided	MH Staff	School Staff
4/5 PBIS (Day 4) South Bay District	2	12
4/9 PBIS (Day 1) Freshwater and Cutten/Ridgewood Districts	2	22
4/23 Trauma Informed Classroom Management	0	16
Southern Humboldt District (Middle School Certificated and Classified personnel)		
4/26 Universal Design for Learning Training – (included Northern Humboldt Unified HS District Staff)	0	10
5/12 Mental Health Awareness Month – Student Engagement – Healthy Relationships and Interpersonal Wellness – NHUHSD	0	18

4/27, 4/28, 5/18 & 5/19 Equity Series – Making a Difference in Kids Lives – Race, Belonging, and Special Education. Partnership with HSU and WestEd.	4	22
4/30 North Coast Service Providers Consortium – Adult Social Emotional Learning	18	25
5/3 PBIS (Day 2) Freshwater and Cutten/Ridgewood Districts	2	14
5/10 Universal Design for Learning Training – (included Northern Humboldt Unified HS District Staff)	0	10
5/14 PBIS (Day 3) Freshwater and Cutten/Ridgewood Districts	2	14
5/28 PBIS (Day 4) Freshwater and Cutten/Ridgewood Districts	2	14
5/25, 5/26, 6/1 & 6/2 Restorative Practices for Educators/Running Circles Effectively – Del Norte School District	2	18
6/3 & 6/4 Restorative Practices for Educators/Running Circles Effectively – Juvenile Hall/Probation – Humboldt County Probation	3	12
5/27 Countywide SEL Community of Practice	9	41
6/24 Countywide SEL Community of Practice	12	38

Phase One – PBIS/MTSS in Humboldt County.

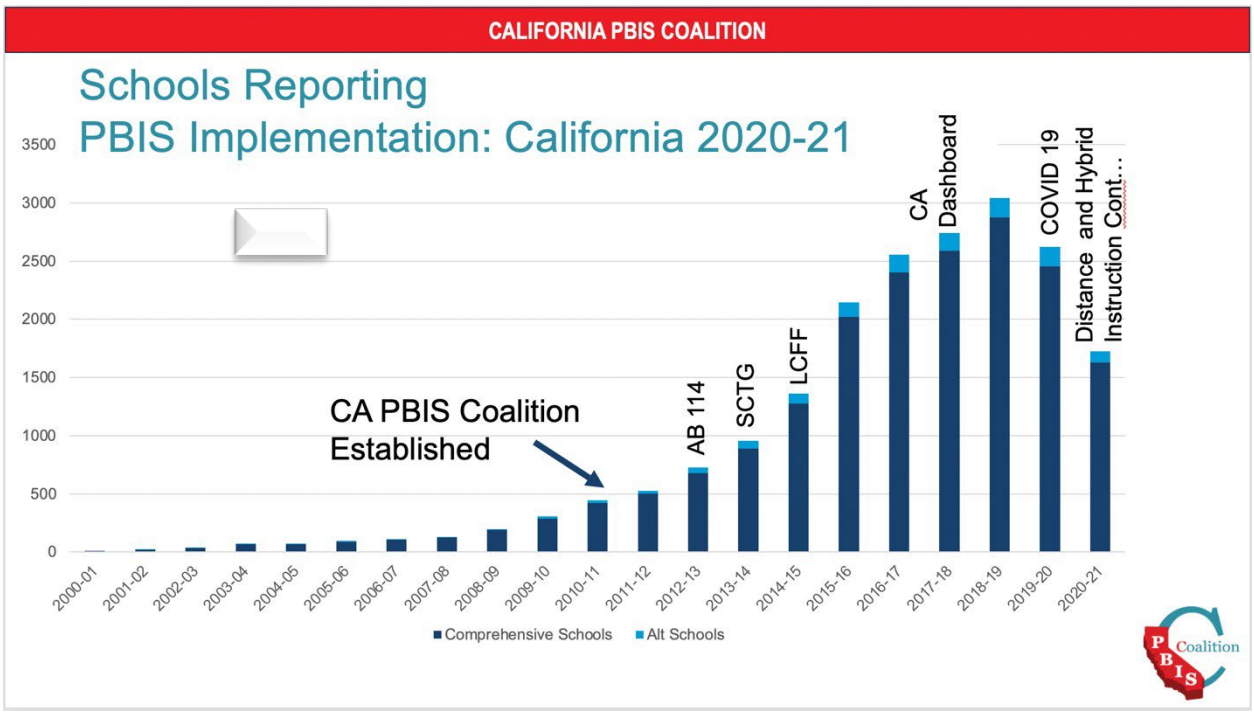
In part through PEI funding support, the Humboldt County Office of Education has engaged districts with strong training opportunities in MTSS – including PBIS, Restorative Practices and Social Emotional Learning. Districts and site level teams have moved to coordinate and implement evidence-based practices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

To move into a stronger degree of fidelity and system change efforts – improvement needs increased resource of support. This is one of the primary factors that shaped the need and vision of Prevention and Interventions Services at HCOE.

Phase Two – PBIS/MTSS in Humboldt 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) and a third cohort (Southern Humboldt Joint Unified 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.

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

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

2020-21 afforded many opportunities for growth as a department, as an organization, and a community. A silver lining of the pandemic is that technology is used to an unprecedented degree. Virtual meeting platforms became a norm, and while tiresome at times, the benefit was the ability to meet quickly and efficiently without the need to travel. The team could meet a district an hour to the south in the morning, and moments later meet with a district in the far northeastern part of the county. We were also able to meet with two districts simultaneously which was not even a consideration pre- pandemic. This concept not only brought school teams together but occurred regionally and across the state. The Yurok Behavioral Health Task Force, the North Coast Services Providers Consortium, the regional and state communities of practice for SEL, and trainings and technical assistance were all done virtually. And while there are many reasons that people need to gather in person, during this time, much was gained by our ability to work effectively on virtual platforms. We will never return to how it was, though we all hope that the pendulum swings in the right direction, we will always know the new horizons of possibility to remain connected in a myriad of ways.

Prevention & Early Intervention: Local Implementation Agreements

In response to stakeholder input about the value of providing mini-grants to local communities, Prevention and Early Intervention dollars were used for Local Implementation Agreements beginning in January 2019. Proposals 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

Three projects were selected for funding in early 2021 and work began on them in April 2021. These projects concluded in March 2022. Projects funded were:

Bear River Band of the Rohnerville Rancheria, Seeking Safety for Community Wellness. Bear River Social Services provided evidence-based Seeking Safety groups and individual sessions to members of the Bear River Band of the Rohnerville Rancheria

Tribe living in the service area of Humboldt County. Participation was open to youth ages 14 and up and their families. A total of four individuals were served during the project period. All were female Bear River tribal members between the ages of 26-29. The Tribe had hoped to reach more individuals during the project period, but the pandemic reduced the numbers who may have otherwise participated. The GAD7 and PHQ9 were administered at the beginning and the end of the grant period, and results showed a reduction in both anxiety (13% reduction) and depression (33% reduction).

Two Feathers Native American Family Services, Cultural Coordinator.
Funding was used to hire a part-time Cultural Coordinator to assist in the development and implementation of cultural programming through facilitating weekly cultural groups and activities. By the end of the grant period a total of 38 different activities/events were held for adults, youth and very young children and their parents/guardians. The events were held either virtually or in person. The numbers provided below are duplicated as many attended more than one event. The majority of participants are Native American.
Children 0-5 and their families: 48
Youth: 1,272
Adults: 294
All Ages: 466

The project shed light upon the mental health services gap for native children ages 0-5 and their families, and as a result Two Feathers will be starting a 0-5 playgroup for this population.

Humboldt Independent Practice Association, Mental Health Prevention through Student Empowerment Groups. This grant provided funding to bring student empowerment groups to two additional Middle School sites and one to Juvenile Hall. In addition, seven new empowerment groups were added at the three existing school sites, with 258 students reached at these three sites. Sixty-two youth were referred to mental health services on school campus and 63 youth were referred to mental health services in the community. Topics discussed at groups were substance use, healthy relationships, consent, bullying, mental health, systemic racism and more. One of the new groups established was the Pride group at two Middle Schools, which served 40 unduplicated students.

Local Implementation projects will continue to be funded in 2022-2023 Requests for Application for the next round of projects were distributed in Spring 2022 and decisions about funding will be made by the beginning of June.

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

The NVSPH is administered through California Mental Health Services Authority (CalMHSA), a Joint Powers Authority created to jointly develop and fund mental health services and education program for its Member County and Partner Counties.

CalMHSA administers NVSPH on behalf of counties that are participating in and funding the program. NVSPH serves as the primary 24/7 suicide prevention hotline, accredited by the American Association of Suicidology for these counties, including Humboldt, and answers calls through its participation in the National Suicide Prevention Lifeline. NVSPH also maintains a hotline website and provides outreach and technical assistance to counties that are participating and funding the program.

In fiscal year 2020-2021, there were a total of 405 calls to the hotline from Humboldt County. Of these there were 257 incoming calls; 48 moderate or higher lethality calls; 3 active rescue calls; 3 imminently lethal callers deescalated; 47 callers requiring follow-up; and 148 follow-ups placed. Ten referrals were made to Humboldt County Behavioral Health. Caller concerns were mental health 30%; social issues 22%; health care/physical needs 15%, basic needs 14%, sexual orientation 7%, abuse/violence 7%, and COVID 19 5%. For suicidal concern, 46% were past attempt/ideation; 35% suicidal desire; 17% suicidal intent; and 2% imminently lethal caller. Fifty-one percent of callers were female, 43% male, 6% unknown. One caller was transgender. For 84% of callers race was unknown; 9% were Native American, 6% were White, and there was one Latino/a and one African American. Ten percent were ages 5-14; 15% ages 15-24; 21% ages 25-34; 10% ages 35-44; 7% ages 45-54; 13% ages 55-64; 19% ages 65-74; 6% unknown.

Workforce Education and Training

Over the years, local Humboldt County MHSA Workforce Education and Training (WET) funding has provided staff development opportunities that promote wellness, recovery, and resilience, culturally competent service delivery, meaningful inclusion of clients and family members, an integrated service experience for clients and their family members, community collaboration, and employment of clients and family members within the behavioral health system. During the next year, contingent upon the continuing availability of MHSA funding, local WET dollars will be used for Training and Technical Assistance through support of the Relias E-Learning platform and to provide matching funds for the Department of Health Care Access and Information (HCAI--formerly the Office of Statewide Health Planning and Development) Regional Partnership Grants.

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.

HCAI Regional Partnership. DHHS Behavioral Health will participate in the statewide WET 2020-2025 Plan through the 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 WET funds. The Superior Region priorities are to provide scholarships and/or stipends for peer specialists, graduate education stipends for Clinical Master and Doctoral program participants, loan repayments for qualified masters/doctoral graduates who commit to working in the public mental health system for a set period of time, and the development and implementation of retention strategies. In Humboldt County the CPPP showed overwhelming support for retention strategies to support the behavioral health workforce, and Behavioral Health leadership has identified the loan repayment program as a priority. It had been anticipated that the HCAI programs would begin in the Fall of 2020, but due to contracting delays experienced in the Superior Region the estimated time for beginning the HCAI programs is now July 2022.

FY 2022-23 MHSA Annual Update Funding Summary

County: Humboldt County Date 5/10/22

	A	B	C	D	E	F
	Community Services and Supports	**Prevention and Early Intervention**	**Innovation**	**Workforce Education and Training**	**Capital Facilities & Technological Needs**	**Prudent Reserve**
A. Estimated FY 2022-23 Funding						
1. Est. Unspent Funds from Prior Fiscal Years	850,152	1,167,754	1,593,191			
2. Est. New FY 2022-23 Funding	8,061,828	2,015,457	530,383			
3. Transfer in FY 2022-23 [a/]	(54,563)			54,563		
4. Access Local Prudent Reserve in FY 22-23						
5. Est. Available Funding for FY 22-23	8,857,416	3,183,211	2,123,574	54,563	0	
B. Est. FY 2022-23 MHSA Expenditures	7,870,217	1,797,123	1,035,765	54,563	0	
G. Est. FY 2022-23 Unspent Fund Balance	987,200	1,386,088	1,087,810	0	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2022	1,239,391
2. Contributions to the Local Prudent Reserve in FY 2022-23	
3. Distributions from the Local Prudent Reserve in FY 2022-23	
4. Estimated Local Prudent Reserve Balance on June 30, 2023	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 2022-23 MHSA Annual Update Community Services and Supports (CSS) Funding

County: Humboldt County Date 5/10/22

	A	B	C	D	E	F
	Est. Total Mental Health Expenditures	**Est. CSS Funding**	**Est. Medi-Cal FFP**	**Est. 1991 Realignment**	**Est. Behavioral Health Subaccount**	**Est. Other Funding**
FSP Programs						
1. Comprehensive Community Treatment	10,617,539	7,161,665	3,268,485			187,389
Non-FSP Programs						
1. Regional Services	244,811	5,300	56,495			183,016
2. Older Adults and Dependent Adults	106,908	70,258	36,651			
3. Crisis Residential Treatment (formerly Sub-Acute Transitional Behavioral Health, Specialty Behavioral Health and/or Social Rehabilitation Services)	1,000,000	500,000	500,000			
4. Housing Support	0	0				
CSS Administration	144,523	132,994	11,529			
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Est. Expenditures	12,113,782	7,870,217	3,873,160	0	0	370,405
FSP Programs as Percent of Total	87.6%					

FY 2022-23 MHSA Annual Update Prevention and Early Intervention (PEI) Funding

County: Humboldt County Date 5/10/22

	A	B	C	D	E	F
	Est. Total Mental Health Expenditures	**Est. PEI Funding**	**Est. Medi-Cal FFP**	**Est. 1991 Realignment**	**Est. Behavioral Health Subaccount**	**Est. Other Funding**
PEI Programs - Prevention						
1. Hope Center	408,626	302,686	105,940			
2. TAY Advocacy and Peer Support	581,718	417,346	146,071			18,300
3. Parent Partners	479,343	355,069	124,274			
4. School Climate Transformation/MTSS (formerly School Climate Curriculum Plan/MTSS)	99,169	99,169				
5. Local Implementation Agreements	121,206	121,206				
PEI Programs - Early Intervention						
1. Suicide Prevention	220,375	220,375				
PEI Administration	266,004	266,004				
PEI Assigned Funds	15,268	15,268				
Total PEI Program Est. Expenditures	2,191,709	1,797,123	376,286	0	0	18,300

FY 2022-23 MHSA Annual Update Innovations (INN) Funding

County: Humboldt County Date 5/10/22

	A	B	C	D	E	F
	Est. Total Mental Health Expenditures	**Est. INN Funding**	**Est. Medi-Cal FFP**	**Est. 1991 Realignment**	**Est. Behavioral Health Subaccount**	**Est. Other Funding**
INN Programs 1. Resident Engagement and Support Team (REST)	465,913	388,261	77,652			
2. CalMHSA Semi-Statewide Enterprise Health Record	608,678	608,678				
INN Administration	38,826	38,826				
Total INN Program Est. Expenditures	1,113,417	1,035,765	77,652	0	0	0

FY 2022-23 MHSA Annual Update Workforce, Education and Training (WET) Funding

County: Humboldt County Date 5/10/22

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

FY 2022-23 MHSA Annual Update Capital Facilities/Technological Needs (CFTN) Funding

County: Humboldt County Date 5/10/22

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

County Compliance Certification

This page will contain the County Compliance Certification that will be obtained after the Board of Supervisors approval.

Fiscal Accountability Certification

Enclosure 1

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: Humboldt ☑ Annual Update

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

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

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

Botzler-Rodgers, Emi — Digitally signed by Botzler-Rodgers, Emi Date: 2022.07.01 13:56:27 -07'00'

Signature Date

Emi Botzler-Rodgers MFT

Local Mental Health Director (PRINT)

I hereby certify that for the fiscal year ended June 30, 2022, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated 9/25/20 for the fiscal year ended June 30, 2019. I further certify that for the fiscal year ended June 30, 2022, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

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

Cheryl Dillingham 7/1/2022

Signature Date

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

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