2026 - 2029 Integrated Plan

Humboldt County

The Behavioral Health Services Act (BHSA) requires counties to submit three-year Integrated Plans (IPs) for Behavioral Health Services and Outcomes. For related policy information, refer to 3.A. Purpose of the Integrated Plan .

General Information

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to 3.A. General Information .

General Information

County, City, Joint Powers, or Joint Submission
County

Entity Name
Humboldt County

Behavioral Health Agency Name
Humboldt County Department of Health and Human Services

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County Behavioral Health System Overview

Please provide the city/county behavioral health system (inclusive of mental health and substance use disorder) information listed throughout this section. The purpose of this section is to provide a high-level overview of the city/county behavioral health system's populations served, technological infrastructure, and services provided. This information is intended to support city/county planning and transparency for stakeholders. The Department of Health Care Services recognizes that some information provided in this section is subject to change over the course of the Integrated Plan (IP) period. All data should be based on FY preceding the year plan development begins (i.e., for 2026-2029 IP, data from FY 2023-2024 should be used).

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to 3.E.2 General Requirements.

Populations Served by County Behavioral Health System

Includes individuals that have been served through the county Medi-Cal Behavioral Health Delivery System and individuals served through other county behavioral health programs. Population-level behavioral health measures, including for untreated behavioral health conditions, are covered in the Statewide Behavioral Health Goals section and County Population-Level Behavioral Health Measure Workbook.For related policy information, refer to 2.B.3 Eligible Populations and 3.A.2 Contents of the Integrated Plan.

Children and Youth

In the table below, please report the number of children and youth (under 21) served by the county behavioral health system who meet the criteria listed in each row.**Counts may be duplicated as individuals may be included in more than one category**.

Criteria	**Number of Children and Youth Under Age 21**
Received Medi-Cal Specialty Mental Health Services (SMHS)	1381
Received at least one substance use disorder (SUD) individual-level prevention and/or early intervention service	0
Received Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services	35
Received mental health (MH) and SUD services from the mental health plan (MHP) and DMC county or DMC-ODS plan	31

Criteria	Number of Children and Youth Under Age 21
Accessed the Early Psychosis Intervention Plus Program, pursuant to Welfare and Institutions Code Part 3.4 (commencing with section 5835), Coordinated Specialty Care, or other similar evidence-based practices and community-defined evidence practices for early psychosis and mood disorder detection and intervention programs	34
Were chronically homeless or experiencing homelessness or at risk of homelessness	32
Were in the juvenile justice system	316
Have reentered the community from a youth correctional facility	68
Were served by the Mental Health Plan and had an open child welfare case	128
Were served by the DMC County or DMC-ODS plan and had an open child welfare case	0

Criteria	Number of Children and Youth Under Age 21
Have received acute psychiatric care	108

Adults and Older Adults

In the table below, please report the number of adults and older adults (21 and older) served by the county behavioral health system who meet the criteria listed in each row.**Counts may be duplicated as individuals may be included in more than one category**.

Criteria	Number of Adults and Older Adults
Were dual-eligible Medicare and Medicaid members	563
Received Medi-Cal SMHS	2802
Received DMC or DMC-ODS services	509
Received MH and SUD services from the MHP and DMC county or DMC-ODS plan	107
Were chronically homeless, or experiencing homelessness, or at risk of homelessness	498

Criteria	Number of Adults and Older Adults
Experienced unsheltered homelessness	185
Moved from unsheltered homelessness to being sheltered (emergency shelter, transitional housing, or permanent housing)	0
Of the total number of those who moved from unsheltered homelessness to being sheltered, how many transitioned into permanent housing	0
Were in the justice system (on parole or probation and not currently incarcerated)	2046
Were incarcerated (including state prison and jail)	0
Reentered the community from state prison or county jail	0
Received acute psychiatric services	373

Input the number of persons in designated and approved facilities who were

Admitted or detained for 72-hour evaluation and treatment rate

291

Admitted for 14-day and 30-day periods of intensive treatment
425

Admitted for 180-day post certification intensive treatment
0

Please report the total population enrolled in Department of State Hospital (DSH) Lanterman-Petris-Short (LPS) Act programs
<11*

Please report the total population enrolled in DSH community solution projects (e.g., community-based restoration and diversion programs)
32

Of the data reported in this section, are there any areas where the county would like to provide additional context for DHCS's understanding?
No

Please describe the local data used during the planning process
The local data that was utilized was a mixture of data gathered from Humboldt County Probation, Children's Behavioral Health, Quality Improvement.

If desired, provide documentation on the local data used during the planning process

Local CARE Act Implementation

Identify the specific service components within your 3-year Integrated Plan that will support CARE participants. Explain how the county will ensure these individuals receive priority access and specialized coordination within the broader behavioral health continuum, including housing if appropriate.
Individuals in CARE Court (CC) can be enrolled as a Full Service Partnership participant. CC participants have a case manager, a clinical and psychiatric providers assigned to them. This team works with the participant to link them to appropriate services as indicated. Additionally, individuals participating in CC who are also struggling with housing insecurity will receive priority status in behavioral health funded Permanent Supported Housing and other housing options. Humboldt County has a specific program called HOME, whose primary focus is to help individuals experiencing housing insecurity into housing options. Our CC staff work closely with HOME to take advantage of all housing opportunities for CC participants.

Describe how CARE referral pathways will be integrated into existing referral and service pathways within the county behavioral health system.

CC participants will have access to all needed programs that they qualify for in BH. Existing referral processes in SmartCare (SC) called Care Coordination will be accessed to make, track and report all referrals to needed services. All referrals are reviewed and processed in a regularly held meeting called OPRA.

Describe the process for identifying and redirecting individuals who are potentially eligible for CARE to alternative pathways when a formal petition is not required or appropriate. For individuals redirected from CARE, describe how the county will confirm and document successful connection to services.

All CC petitions that do not qualify for CC will be referred to the appropriate level of care that is needed. This starts with the establishment of an Access appointment. This appointment will be treated as a new beneficiary establishing care for the first time if they are not currently open to BH services. These referrals to Access are tracked in the TADT reporting to DHCS for timely access to needed services. All referrals to Access are tracked in SC for follow up, referral and other data tracking mandates.

County Behavioral Health Technical Infrastructure

Cities submitting their Integrated Plan independently from their counties do not have to complete this section. For related policy information, refer to 6.C.1 Promoting Access to Care Through Efficient Use of State and County Resources Introduction .

Does the county behavioral health system use an Electronic Health Record (EHR)?

Yes

Please select which of the following EHRs the county uses

SmartCare

County participates in a Qualified Health Information Organization (QHIO)?

Yes

Please select which QHIO the county participates in
Connex
SacValley MedShare

Application Programming Interface Information

Counties are required to implement Application Programming Interfaces (API) in accordance with Behavioral Health Information Notice (BHIN) 22-068 and federal law.

Please provide the link to the county's API endpoint on the county behavioral health plan's website
https://humboldtgov.org/3373/Resource-Documents-for-Partners-and-Comm (click 'For Partners' tab, scroll down to s

Does the county wish to disclose any implementation challenges or concerns with these requirements?
No

Counties are required to meet admission, discharge, and transfer data sharing requirements as outlined in the attachments to BHINs 23-056 , 23-057 , and 24-016 . Does the county wish to disclose any implementation challenges or concerns with these requirements?
No

County Behavioral Health System Service Delivery Landscape

Cities submitting their Integrated Plan independently from their counties do not have to complete this section. For related policy information, refer to 6.C.1 Promoting Access to Care Through Efficient Use of State and County Resources Introduction .

Substance Abuse and Mental Health Services Administration (SAMHSA) Projects for Assistance in Transition from Homelessness (PATH) Grant

Will the county participate in SAMHSA's PATH Grant during the Integrated Plan period?

Yes

Please select all services the county behavioral health system plans to provide under the PATH grant
Outreach services

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?
Yes

Please describe these challenges or concerns
People with mental illness tend to be the most adamant about not having any mental health issues or concerns. It is not an easy topic to bring up and it requires a lot of engagement to get to the point of broaching the topic.

Community Mental Health Services Block Grant (MHBG)

Will the county behavioral health system participate in any MHBG set-asides during the Integrated Plan period?
Yes

Please select all set asides that the county behavioral health system plans to participate in under the MHBG
Children's System of Care Set-Aside
Discretionary/Base Allocation
Dual Diagnosis Set-Aside
First Episode Psychosis Set-Aside

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?
No

Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG)

Will the county behavioral health system participate in any SUBG set asides during the

Integrated Plan period?
Yes

Please select all set-asides that the county behavioral health system participates in under SUBG
Adolescent/Youth Set-Aside
Perinatal Set-Aside
Discretionary

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?
No

Opioid Settlement Funds (OSF)

Will the county behavioral health system have planned expenditures for OSF during the Integrated Plan period?
Yes

Please check all set asides the county behavioral health system participates in under OSF Exhibit E
Address The Needs of Criminal Justice-Involved Persons
Connect People Who Need Help to The Help They Need (Connections to Care)
Leadership, Planning, and Coordination
Prevent Misuse of Opioids
Prevent Over-Prescribing and Ensure Appropriate Prescribing and Dispensing of Opioids
Prevent Overdose Deaths and Other Harms (Harm Reduction)
Support People in Treatment and Recovery
Treat Opioid Use Disorder (OUD)

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?
No

Bronzan-McCorquodale Act

The county behavioral health system is mandated to provide the following community mental health services as described in the Bronzan-McCorquodale Act (BMA).
a. Case Management
b. Comprehensive Evaluation and Assessment
c. Group Services
d. Individual Service Plan
e. Medication Education and Management
f. Pre-crisis and Crisis Services
g. Rehabilitation and Support Services
h. Residential Services
i. Services for Homeless Persons
j. Twenty-four-hour Treatment Services
k. Vocational Rehabilitation

In addition, BMA funds may be used for the specific services identified in the list below.
Select all services that are funded with BMA funds:
Community Health Worker Services (CHW)
Coordinated Specialty Care for First Episode Psychosis (CSC for FEP)
Other Programs and Services

Please describe
Most services provided with 1991 realignment (Bronzan-McCorquodale Act) are currently for providing SMH to clients both in acute crisis and residential facilities along with Medication Services.

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?
No

Public Safety Realignment (2011 Realignment)

The county behavioral health system is required to provide the following services which may be funded under the Public Safety Realignment (2011 Realignment)
a. Drug Courts

b. Medi-Cal Specialty Mental Health Services, including Early Periodic Screening Diagnostic Treatment (EPSDT)
c. Regular and Perinatal Drug Medi-Cal Services
d. Regular and Perinatal DMC Organized Delivery System Services, including EPSDT
e. Regular and Perinatal Non-Drug Medi-Cal Services

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?
Yes

Please describe these challenges or concerns
With continued increased costs and need, providing additional services is challenging without additional funding.

Medi-Cal Specialty Mental Health Services (SMHS)

The county behavioral health system is mandated to provide the following services under SMHS authority (no action required).
a. Adult Residential Treatment Services
b. Crisis Intervention
c. Crisis Residential Treatment Services
d. Crisis Stabilization
e. Day Rehabilitation
f. Day Treatment Intensive
g. Mental Health Services
h. Medication Support Services
i. Mobile Crisis Services
j. Psychiatric Health Facility Services
k. Psychiatric Inpatient Hospital Services
l. Targeted Case Management
m. Functional Family Therapy for individuals under the age of 21
n. High Fidelity Wraparound for individuals under the age of 21
o. Intensive Care Coordination for individuals under the age of 21
p. Intensive Home-based Services for individuals under the age of 21
q. Multisystemic Therapy for individuals under the age of 21
r. Parent-Child Interaction Therapy for individuals under the age of 21

s. Therapeutic Behavioral Services for individuals under the age of 21
t. Therapeutic Foster Care for individuals under the age of 21
u. All Other Medically Necessary SMHS for individuals under the age of 21

Has the county behavioral health system opted to provide the specific Medi-Cal SMHS identified in the list below as of June 30, 2026?
CSC for FEP
Peer Support Services

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?
No

Drug Medi-Cal (DMC)/Drug Medi-Cal Organized Delivery System (DMC-ODS)

Select which of the following services the county behavioral health system participates in DMC-ODS Program

Drug Medi-Cal Organized Delivery System (DMC-ODS)
The county behavioral health system is mandated to provide the following services as a part of the DMC-ODS Program (DHCS currently follows the guidance set forth in the American Society of Addiction Medicine (ASAM) Criteria, 3rd Edition). (no action required)
a. Care Coordination Services
b. Clinician Consultation
c. Outpatient Treatment Services (ASAM Level 1)
d. Intensive Outpatient Treatment Services (ASAM Level 2.1)
e. Medications for Addiction Treatment (MAT), Including Narcotics Treatment Program (NTP) Services
f. Mobile Crisis Services
g. Recovery Services
h. Residential Treatment services (ASAM Levels 3.1, 3.3., 3.5)
i. Traditional Healers and Natural Helpers
j. Withdrawal Management Services
k. All Other Medically Necessary Services for individuals under age 21 for individuals under age 21

l. Early Intervention for individuals under age 21

Has the county behavioral health system opted to provide the specific Medi-Cal SUD services identified in the list below as of June 30, 2026?
Peer Support Services
Recovery Incentives Program (Contingency Management)

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?
No

Other Programs and Services

Please list any other programs and services the county behavioral health system provides through other federal grants or other county mental health and SUD programs

Program or service
Family Wellness Court: For Families that have Family Dependency cases in Humboldt County.
Superior Court: If the client is a Yurok Tribal member, the case will be presided over by two judges—a tribal court judge and a state court judge—and operates under California state law, Federal law, and Yurok tribal law. If they are not a tribal member, the case will be presided over by a state court judge—and will operate under California state law and Federal law.

Dual Recovery Program: DRP is for adults who are dually diagnosed with a severe and persistent mental illness and a secondary diagnosis of a moderate to severe substance abuse disorder. DRP provides motivational-based treatment designed to engage participants in the recovery process so participants can reach and maintain recovery goals in order to lead safe, healthy lives.

Care Transitions

Has the county implemented the state-mandated Transition of Care Tool for Medi-Cal Mental Health Services **(Adult and Youth)?**

Yes

Does the county's Memorandum of Understanding include a description of the system used to transition a member's care between the member's mental health plan and their managed care plan based upon the member's health condition?

Yes

Statewide Behavioral Health Goals

All fields must be completed unless marked as optional. You don't need to finish everything at once-your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to, please see 3.E.6 Statewide behavioral health goals

Population-Level Behavioral Health Measures

The statewide behavioral health goals and associated population-level behavioral health measures must be used in the county Behavioral Health Services Act (BHSA) planning process and should inform resource planning and implementation of targeted interventions to improve outcomes for the fiscal year(s) being addressed in the IP. For more information on the statewide behavioral health goals, please see the Policy Manual Chapter 2, Section C.

Please review your county's status on each population-level behavioral health measure, including the primary measures and supplemental measures for each of the 14 goals. All measures are publicly available, and counties are able to review their status by accessing the measures via DHCS-provided instructions and the County Population-Level Behavioral Health Measure Workbook.

As part of this review, counties are required to evaluate disparities related to the six priority statewide behavioral health goals. Counties are encouraged to use their existing tools, methods, and systems to support this analysis and may also incorporate local data sources to strengthen their evaluation.

Please note that several Phase 1 measures include demographic stratifications – such as race, sex, age, and spoken language – which are included in the prompts below. Counties may also use local data to conduct additional analyses beyond these demographic categories.

For related policy information, refer to E.6.1 Population-level Behavioral Health Measures.

Mark page as complete

Priority statewide behavioral health goals for improvement

Counties are required to address the six priority statewide behavioral health goals in this section. Cities should utilize data that corresponds to the county they are located within. As such, the City of Berkeley should use data from Alameda County and Tri-City should use data from Los Angeles County. For related policy information, refer to E.6.2 Primary and Supplemental Measures.

Access to care: Primary measures

Specialty Mental Health Services (SMHS) Penetration Rates for Adults and Children & Youth (DHCS), FY 2023

How does your county status compare to the statewide rate?

For adults/older adults
Above

For children/youth
Above

What disparities did you identify across demographic groups or special populations?
Age
Race or Ethnicity
Sex

Non-Specialty Mental Health Services (NSMHS) Penetration Rates for Adults and Children & Youth (DHCS), FY 2023

How does your county status compare to the statewide rate?

For adults/older adults
Above

For children/youth
Above

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Drug Medi-Cal (DMC) Penetration Rates for Adults and Children & Youth (DHCS), FY 2022 - 2023

How does your county status compare to the statewide rate?

For adults/older adults
Not Applicable

For children/youth
Not Applicable

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Drug Medi-Cal Organized Delivery System (DMC-ODS) Penetration Rates for Adults and Children & Youth (DHCS), FY 2022 - 2023

How does your county status compare to the statewide rate?

For adults/older adults
Above

For children/youth
Same

What disparities did you identify across demographic groups or special populations?
Race or Ethnicity

Access to care: Supplemental Measures

Initiation of Substance Use Disorder Treatment (IET-INI) (DHCS), FY 2023

How does your county status compare to the statewide rate?
Below

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Access to care: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
Humboldt County generally exceeds statewide averages in behavioral health service penetration for adults, older adults, and youth, but disparities remain across several subpopulations. Adults consistently access services at higher rates than the state, including 2.4% for DMC-ODS versus 1.6% statewide, 18.2% for NSMHS versus 9.7%, and 4.5% for SMHS compared to 3.4%. Youth also show above or equal penetration, such as 16.5% for NSMHS compared to 14.6%. Despite this overall strength, certain groups are underserved. Young children (ages 3–5, as low as 2–9.8%) and older adults (65+, 3.8%) have lower service use than other age groups. Gender patterns vary, with females accessing services at higher rates in NSMHS but slightly lower than males in SMHS. Racial and ethnic disparities are most evident, as Hispanic and Asian/Pacific Islander populations show consistently lower penetration (e.g., Hispanic adults 3%, Asian/Pacific Islander adults 1.6% in SMHS) compared to White and Other groups. Language adds further barriers, with Spanish-speaking adults (12.2%) and youth (5.1%) accessing care at lower levels.

Access to care: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may increase your county's level of access to care. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships, or initiatives the county is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes
Humboldt County generally performs above the statewide average in overall behavioral health service

penetration; however, disparities persist across specific age, racial/ethnic, and language groups, and opportunities remain to improve timely linkage following crisis encounters. In FY 2023, Humboldt County exceeded statewide averages for Specialty Mental Health Services (SMHS) penetration among adults (4.5% compared to 3.4% statewide) and children/youth (6.6% compared to 4.2% statewide). Non-Specialty Mental Health Services (NSMHS) penetration also exceeded statewide averages for adults (18.2% compared to 9.7% statewide) and youth (16.5% compared to 14.6% statewide). For DMC-ODS, adult penetration (2.4%) exceeded the state median (1.6%), while youth penetration was comparable to the state (.3%). Despite this overall strength, disparity analysis identified underserved subpopulations. Young children ages 3–5 access services at significantly lower rates (as low as 2–2.8%) compared to older youth. Older adults (65+) also demonstrate lower penetration rates (3.8% in SMHS and 13.1% in NSMHS). Racial and ethnic disparities are evident, with Hispanic adults (3%) and Asian/Pacific Islander adults (1.6%) accessing SMHS at lower rates than White and other groups. Spanish-speaking members also access care at lower rates than English-speaking members. In addition, the County's Initiation of Substance Use Disorder Treatment (IET-IN) rate (34.1%) is slightly below the statewide median (34.3%), indicating opportunity to strengthen timely engagement in treatment following identification of substance use disorder. The County's state-mandated Performance Improvement Project (PIP) for Follow-Up After Emergency Department Visit for Substance Use (FUA) identified a pre-baseline rate of 42.26% in 2024, further highlighting the need to improve post-crisis linkage to ongoing care.

Beginning July 1, 2026, Humboldt County will strengthen and implement several strategies to improve equitable access to care and address identified gaps. Humboldt County will expand current PIP efforts aimed at increasing 30-day follow-up after emergency department visits for substance use disorder by integrating outreach protocols into clinical workflows, strengthening collaboration between emergency departments and behavioral health providers, and increasing coordination with care managers. Health Information Exchange (HIE) functionality, integrated into the SmartCare electronic health record system through partnership with SacValley MedShare and CalMHSA, will support real-time notification of emergency department encounters and hospitalizations, enabling more timely outreach and reducing delays in follow-up care. These efforts are intended to improve FUA and IET performance while reducing repeat emergency department utilization.

To address disparities among underserved communities, Humboldt County plans to expand peer support capacity across both adult and youth systems of care. Peer staff conduct proactive outreach following emergency department encounters, assist with navigation into ongoing services, and serve as culturally responsive points of contact for individuals who may face barriers related to language, stigma, or system complexity. Youth-focused peers and family partners serve as early engagement contacts to support children and adolescents entering services. In the substance use disorder system, the Humboldt County is exploring additional peer staffing to strengthen engagement and retention in treatment.

To address low penetration among young children, Humboldt County is in the early stages of implementing Parent-Child Interaction Therapy (PCIT), an evidence-based practice designed for children ages 2–7 and

their caregivers. Over the next 18 months, the County will train staff and potentially contracted providers in PCIT, begin accepting referrals, and work toward certification in the model. Expanding PCIT capacity is expected to increase engagement among young children and families while improving clinical outcomes.

Humboldt County will also continue strengthening referral pathways and cross-system coordination through ongoing collaboration with Open Door Community Health Centers, United Indian Health Services, Child Welfare Services, and Probation. These efforts aim to promote awareness of available behavioral health services, streamline non-crisis referral pathways, and reduce reliance on emergency department access. Crisis and stabilization capacity will be further optimized through effective use of psychiatric swing beds to maximize minor bed availability and through continued utilization of the 12-bed Crisis Stabilization Unit as part of the Crisis Triage Center funded through BHCIP Round 5 funding to meet both adult and youth needs. Improving stabilization capacity supports smoother transitions into outpatient services and reduces prolonged emergency department boarding.

All access strategies will be implemented with an equity-focused lens. Humboldt County will continue to monitor penetration rates, IET, FUA, and related measures annually and will use continuous quality improvement processes to refine outreach, workforce deployment, and referral coordination efforts. While the County exceeds statewide averages in overall penetration, these targeted strategies beginning July 1, 2026 are designed to improve equitable, timely, and sustained access to behavioral health services across all populations.

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Please identify the category or categories of funding that the county is using to address the access to care goal

BHSA Behavioral Health Services and Supports (BHSS)
BHSA Full Services Partnership (FSP)
BHSA Housing Interventions
1991 Realignment
2011 Realignment
State General Fund
Federal Financial Participation (SMHS, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System (DMC/DMC-ODS)
Substance Abuse and Mental Health Services Administration(SAMHSA) Projects for Assistance in Transition from Homelessness(PATH)
Community Mental Health Block Grant (MHBG)
Substance Use Block Grant (SUBG)

Homelessness: Primary measures

People Experiencing Homelessness Point-in-Time Count (Rate per 10,000 people by Continuum of Care Region) (HUD), 2024

How does your county status compare to the PIT Count Rate out of every 10,000 people by Continuum of Care region?
Above

What disparities did you identify across demographic groups or special populations?
Age
Gender
Race or Ethnicity

Homeless Student Enrollment by Dwelling Type, California Department of Education (CDE), 2023 - 2024

How does your county status compare to the statewide rate?
Above

What disparities did you identify across demographic groups or special populations?
Gender
Race or Ethnicity
Spoken Language
Other

Please describe other
Migrant and student with disability.

Homelessness: Supplemental Measures

PIT Count Rate of People Experience Homelessness with Severe Mental Illness, (Rate per 10,000 people by Continuum of Care Region) (HUD), 2024

How does your county status compare to the PIT Count Rate out of every 10,000 people by Continuum of Care region?

Above

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

PIT Count Rate of People Experience Homelessness with Chronic Substance Abuse, (Rate per 10,000 people by Continuum of Care Region) (HUD), 2024

How does your county status compare to the PIT Count Rate out of every 10,000 people by Continuum of Care region?
Above

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

People Experiencing Homelessness Who Accessed Services from a Continuum of Care (CoC) Rate (BCSH), 2023 (This measure will increase as people access services.)

How does your local CoC's rate compare to the average rate across all CoCs?
Above

What disparities did you identify across demographic groups or special populations?
Age
Race or Ethnicity
Sex

Homelessness: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
Humboldt County's homelessness data demonstrate both elevated overall rates compared to statewide benchmarks and significant disparities across age, gender, race/ethnicity, and special student populations. The primary measure used for this analysis was the 2024 Point-in-Time (PIT) count rate per 10,000 residents (HUD). Humboldt County's PIT rate was 117, substantially above the statewide rate of 47, indicating a disproportionate local burden of homelessness. Supplemental measures included PIT rates among individuals experiencing homelessness with Severe Mental Illness (SMI) and Chronic Substance Use, as well

as homeless student enrollment data from the California Department of Education (2023–2024), and Continuum of Care (CoC) service access rates (2023).

Age-based disparities are evident in the PIT data. Adults ages 35–44 experience the highest rate of homelessness (247), representing the largest disparity among age groups. Individuals ages 45 and older also demonstrate elevated rates (108), while young adults ages 18–34 have a rate of 115. Youth ages 0–18 show a lower rate (57) relative to adults; however, student homelessness data indicate heightened vulnerability among specific youth subgroups. English Learners (13.2%), migrant students (33.3%), and students with disabilities (10%) experience homelessness at rates substantially above overall student rates. These data suggest that while PIT counts show adult concentration, youth homelessness is disproportionately concentrated among linguistically diverse and educationally vulnerable populations.

Gender disparities are pronounced. PIT data indicate that males experience homelessness at nearly twice the rate of females (156 compared to 78). Among homeless students, non-binary students experience the highest rates (11.7%), followed by females (8.3%) and males (7.6%), indicating differing gender patterns between adult and youth populations.

Racial and ethnic disparities are the most significant and persistent. PIT data show that American Indian/Alaska Native individuals experience the highest rate of homelessness (318), nearly three times the rate of White individuals (120) and substantially higher than the statewide PIT benchmark. Native Hawaiian/Pacific Islander individuals (172) and Black individuals (158) also experience disproportionately high rates. While Hispanic/Latino (59) and Asian (46) individuals show lower PIT rates relative to other racial/ethnic groups, student-level data reveal disparities among Pacific Islander students (17.95%), American Indian/Alaska Native students (17.1%), African American students (9.4%), and Hispanic/Latino students (9.5%) compared to White students (5.8%) and Asian students (3.5%). These patterns indicate intersectional disparities that differ by age and educational status.

Behavioral health-related homelessness disparities are also substantial. The PIT rate of individuals experiencing homelessness with Severe Mental Illness (SMI) in Humboldt County is 31 compared to the statewide rate of 11. Similarly, the PIT rate of individuals experiencing homelessness with chronic substance use is 36 compared to the statewide rate of 11. These data demonstrate that individuals with significant behavioral health conditions are overrepresented within the homeless population at rates nearly three times the statewide benchmark.

Finally, although Humboldt County's Continuum of Care (CoC) service access rate (192) exceeds the statewide rate (91) and median (83), indicating strong engagement among identified individuals, disparities within access remain. Age data show higher service engagement among adults ages 35–54 (325–327) compared to individuals 65+ (69), and racial data indicate higher service utilization among Black (649), American Indian/Alaska Native (416), and Native Hawaiian/Pacific Islander (319) individuals compared to Asian/Pacific Islander individuals (46). These variations likely reflect underlying population need but may

also indicate differences in service access, system touchpoints, or outreach effectiveness.

Overall, the data demonstrate that homelessness in Humboldt County disproportionately affects American Indian/Alaska Native communities, Native Hawaiian/Pacific Islander communities, Black residents, adult males, adults ages 35–44, individuals with severe mental illness or chronic substance use disorders, English learners, migrant students, and students with disabilities. These disparities were identified using HUD PIT count data (2024), California Department of Education homeless student enrollment data (2023–2024), and CoC service access data (2023). Together, these measures provide a comprehensive view of both prevalence and service engagement disparities across the continuum.

Homelessness: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's level of homelessness in the population experiencing severe mental illness, severe SUD, or co-occurring conditions. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships, or initiatives the county is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)

Humboldt County's 2024 Point-in-Time (PIT) count rate of 117 per 10,000 residents is substantially above the statewide rate of 47, indicating a significant local housing instability challenge. Disparity analysis shows pronounced inequities across demographic groups. Adults ages 35–44 experience the highest rates (247), followed by individuals 45 and older (108) and young adults 18–34 (115), while youth ages 0–18 experience a rate of 57. Males are disproportionately affected (156 compared to 78 for females). Racial and ethnic disparities are particularly significant, with American Indian/Alaska Native individuals experiencing the highest rate (318), followed by Native Hawaiian/Pacific Islander (172), Black (158), and White (120) populations. Hispanic/Latino (59) and Asian (46) populations experience lower rates relative to other groups, though disparities remain evident when compared proportionally to population size. Among students, homelessness rates exceed statewide medians, with Humboldt reporting 8% compared to the statewide median of 4.6%. English learners (13.2%), migrant students (33.3%), and students with disabilities (10%) are disproportionately impacted. Supplemental measures further demonstrate elevated need, with the PIT rate of individuals experiencing homelessness with Severe Mental Illness (SMI) at 31 compared to the state rate of 11, and chronic substance use-related homelessness at 36 compared to the state rate of 11. While Humboldt's Continuum of Care (CoC) service access rate (192) exceeds statewide averages (91) and median rates (83), indicating strong service engagement among those identified, the overall scale of homelessness and the severity of behavioral health co-occurrence underscore the need for continued system-level intervention.

Beginning July 1, 2026, Humboldt County will strengthen and expand collaborative housing partnerships to address homelessness among individuals with behavioral health conditions. While housing services are not directly administered under Behavioral Health, the County maintains an established and ongoing partnership with the Housing, Outreach, and Mobile Engagement (HOME) program to coordinate housing resources and prioritize referrals for individuals experiencing homelessness who are engaged in behavioral health services. Behavioral Health routinely refers eligible individuals to HOME and participates in collaborative planning to align housing resources with behavioral health treatment needs. The County will continue strengthening coordination through the established Tenant Selection Team participation to ensure individuals with high behavioral health acuity are prioritized appropriately.

The Resident Engagement and Support Team (REST) program supports housing retention by assisting individuals who are currently housed but at risk of losing housing due to behavioral health instability. Beginning July 1, 2026, REST will continue to focus on stabilization, connection to services, and proactive engagement to prevent returns to homelessness. For youth and transitional age youth (TAY), the County's TAY Division deploys peers and case managers to connect young people to housing and supportive resources, working closely with Child Welfare Services (CWS) to support housing stability among system-involved youth. These services are intended to address the elevated homelessness rates among young adults and youth with intersecting system involvement.

Additionally, individuals involved in CARE Court or involved in the Diversion program have prioritized housing access through coordinated collaboration between Behavioral Health, HOME, and the Tenant Selection Team. These structured pathways ensure that individuals with serious behavioral health conditions who are justice-involved or at risk of institutionalization are connected to available housing as part of a broader stabilization plan. By aligning housing prioritization with Diversion and treatment pathways, Humboldt County aims to reduce cycling between homelessness, emergency services, and justice involvement.

Humboldt County will continue monitoring PIT trends, CoC service access rates, and subgroup disparities annually, with particular attention to American Indian/Alaska Native communities, Native Hawaiian/Pacific Islander populations, Black residents, males, English learners, migrant students, and individuals with co-occurring severe mental illness or substance use disorders. Through strengthened partnerships with HOME, expanded retention efforts through REST, youth-focused outreach via the TAY division, and prioritized pathways for CARE Court and Diversion participants, Humboldt County seeks to reduce homelessness among individuals with behavioral health needs and improve housing stability outcomes.

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Please identify the category or categories of funding that the county is using to address the homelessness goal

BHSA BHSS
BHSA FSP
BHSA Housing Interventions
1991 Realignment
2011 Realignment
State General Fund
Federal Financial Participation (SMHS, DMC/DMC-ODS)
SAMHSA PATH
MHBG
SUBG

Institutionalization

Per 42 CFR 435.1010, an institution is "an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor." Institutional settings are intended for individuals with conditions including, but not limited to, behavioral health conditions.
Care provided in inpatient and residential (i.e., institutional) settings can be clinically appropriate and is part of the care continuum. Here, institutionalization refers to individuals residing in these settings longer than clinically appropriate. Therefore, the goal is not to reduce stays in institutional settings to zero. The focus of this goal is on reducing stays in institutional settings that provide a Level of Care that is not – or is no longer – the least restrictive environment. (no action)

Institutionalization: Primary Measures

Inpatient administrative days (DHCS) rate, FY 2023

How does your county status compare to the statewide rate/average?

For adults/older adults
Above

For children/youth
Not Applicable

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Institutionalization: Supplemental Measures

Involuntary Detention Rates, FY 2021 - 2022

How does your county status compare to the statewide rate/average?

14-day involuntary detention rates per 10,000
Above

30-day involuntary detention rates per 10,000
Above

180-day post-certification involuntary detention rates per 10,000
Same

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Conservatorships, FY 2021 - 2022

How does your county status compare to the statewide rate/average?

Temporary Conservatorships
Above

Permanent Conservatorships
Above

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

SMHS Crisis Service Utilization (Crisis Intervention, Crisis Residential Treatment Services, and Crisis Stabilization) (DHCS), FY 2023
Increasing access to crisis services may reduce or prevent unnecessary admissions to institutional facilities

How does your county status compare to the statewide rate/average?

Crisis Intervention

For adults/older adults
Below

For children/youth
Above

Crisis Residential Treatment Services

For adults/older adults
Not Applicable

For children/youth
Not Applicable

Crisis Stabilization

For adults/older adults
Below

For children/youth
Not Applicable

What disparities did you identify across demographic groups or special populations?
Age
Gender
Race or Ethnicity
Sex

Institutionalization: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
Humboldt County's institutionalization data indicate elevated utilization across multiple measures when compared to statewide benchmarks, suggesting systemic gaps in step-down capacity and community-based alternatives. The primary measure used for this analysis was the FY 2023 Inpatient Administrative Days rate (DHCS), supplemented by FY 2021–2022 Involuntary Detention Rates, Conservatorship Rates, and FY 2023 SMHS Crisis Service Utilization data.

The County's inpatient administrative days rate was 48.6, which exceeds both the statewide rate (25.6) and statewide median (34.9). Elevated administrative days typically reflect delays in discharge due to limited step-down placement options or insufficient community-based supports. While disaggregated demographic data were not available for inpatient administrative days, the magnitude of the difference relative to statewide benchmarks indicates structural barriers affecting individuals requiring higher levels of care.

Involuntary detention rates further demonstrate elevated institutional involvement. The 14-day involuntary detention rate per 10,000 was 17.8 in Humboldt County compared to the statewide rate of 10.2 and median of 9.6. The 30-day involuntary detention rate was 2.0 compared to the statewide rate and median of 0.9. These figures indicate that individuals in Humboldt County are detained involuntarily at significantly higher rates than statewide averages. While demographic breakdowns were not available for detention rates, the elevated overall rates suggest disproportionate impact among individuals with severe behavioral health acuity, including those with co-occurring disorders and limited community supports.

Conservatorship rates show the most pronounced disparity relative to statewide figures. Temporary conservatorships were 2.0 compared to the statewide rate of 0.7 and median of 0.8. Permanent conservatorships were 15.1 compared to the statewide rate of 2.8 and median of 3.1. This indicates that

Humboldt County's permanent conservatorship rate is more than five times the statewide rate. Elevated conservatorship utilization suggests significant clinical acuity and limited availability of intermediate levels of care such as Mental Health Rehabilitation Centers (MHRCs) or other structured step-down placements.

Crisis service utilization data provide insight into demographic disparities within the continuum preceding institutionalization. For crisis intervention services (FY 2023), adult minutes per beneficiary were 214.4, slightly below the statewide rate (240.1) but above the statewide median (205.4), indicating moderate engagement. However, youth crisis intervention utilization was significantly elevated at 487.1 minutes per beneficiary, well above both the statewide median (225.6) and statewide rate (266.8). Age disparities are evident, with youth ages 12–17 averaging 375 minutes and transitional age youth (18–20) averaging 252 minutes. Among adults, the 34–44 age group averaged 226 minutes, indicating higher crisis intensity in this cohort.

Racial and ethnic disparities are also present within crisis intervention utilization. Adult crisis minutes per beneficiary were highest among American Indian/Alaska Native individuals (236 minutes), followed by Hispanic (202), White (199), Asian/Pacific Islander (190), and Black (185) individuals. Among youth, American Indian/Alaska Native youth averaged 426 minutes, Hispanic youth 333 minutes, and White youth 291 minutes, with other groups suppressed or lower. These data indicate disproportionately high crisis intensity among American Indian/Alaska Native youth and adults, and elevated utilization among Hispanic youth relative to other populations. Gender differences are also evident, with adult females averaging 230 minutes compared to 196 minutes for adult males, and youth males averaging 346 minutes compared to 323 minutes for youth females.

Taken together, the data demonstrate that Humboldt County experiences elevated institutional involvement relative to statewide averages, particularly in inpatient administrative days, involuntary detention, and permanent conservatorships. Within the crisis continuum, disparities are most pronounced among youth (particularly ages 12–17), adults ages 34–44, American Indian/Alaska Native individuals, Hispanic youth, and females in adult crisis utilization. While disaggregated data are not available for all institutional measures, the combined inpatient, detention, conservatorship, and crisis utilization data suggest that high-acuity individuals—particularly youth and American Indian/Alaska Native community members—are disproportionately impacted within the institutional continuum.

These findings were derived from DHCS Inpatient Administrative Days data (FY 2023), DHCS Involuntary Detention and Conservatorship data (FY 2021–2022), and DHCS SMHS Crisis Service Utilization data (FY 2023). Continued monitoring and expanded demographic reporting will be necessary to further refine disparity identification and target system improvements.

Institutionalization: Cross-Measure Questions

What additional local data do you have on the current status of institutionalization in your county? (Example: utilization of Mental Health Rehabilitation Center or Skilled Nursing Facility-Special Treatment Programs)
N/A

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Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's rate of institutionalization. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the count is implementing (e.g., enhancing crisis response services targeting a sub-population in which data demonstrates they have poorer outcomes)
Humboldt County's data indicate elevated rates of institutional utilization compared to statewide benchmarks, particularly for adults. In FY 2023, the County's inpatient administrative days rate was 48.6, which is significantly above both the statewide rate (25.6) and statewide median (34.9). Supplemental measures further demonstrate elevated institutional involvement. Fourteen-day involuntary detention rates per 10,000 were 17.8 in Humboldt County compared to the statewide rate of 10.2 and median of 9.6. Thirty-day involuntary detention rates were 2.0 compared to the statewide rate and median of 0.9. Temporary conservatorships were 2.0 compared to the statewide rate of 0.7, and permanent conservatorships were 15.1 compared to the statewide rate of 2.8 and median of 3.1. These data indicate a higher reliance on involuntary detention and conservatorship relative to statewide averages. Crisis service utilization data provide additional context. For adults, crisis intervention minutes per beneficiary (214.4) were slightly below the statewide rate (240.1) but above the statewide median (205.4), suggesting moderate crisis service engagement. However, youth crisis intervention minutes (487.1) were substantially above both the statewide median (225.6) and statewide rate (266.8), indicating significant youth crisis intensity. Age disparities in crisis intervention utilization show elevated minutes among youth ages 12–17 (375) and 18–20 (252), and among adults ages 34–44 (226). Racial and ethnic differences in crisis intervention minutes also exist, with higher utilization among American Indian/Alaska Native and Hispanic youth compared to other groups. Although demographic disparities data are limited for inpatient administrative days and conservatorships, the elevated system-wide institutional measures suggest structural gaps in step-down and community-based capacity.

Beginning July 1, 2026, Humboldt County will strengthen strategies designed to reduce institutionalization and improve timely transitions to the least restrictive level of care. A primary focus is improving step-down

placement options for conserved individuals who experience prolonged inpatient stays due to limited Mental Health Rehabilitation Center (MHRC) acceptance and placement barriers. Humboldt County is actively exploring expanded partnerships and placement pathways with facilities such as Windsor, Willow Glen (Lighthouse), and other MHRC to increase access to appropriate step-down care. Efforts include developing strategies to improve clinical readiness documentation, strengthening discharge planning processes, and identifying system barriers that limit acceptance to subacute facilities.

To address gaps within the behavioral health continuum of care, Humboldt County is expanding crisis and residential capacity. Humboldt County currently contracts with providers who operate crisis residential beds and is expanding youth crisis residential capacity through contracts with Sorrel Leaf, which will include 12 youth crisis residential beds. The BHCIP Round 5 funded Crisis Triage Center includes both residential and dual-diagnosis beds, improving stabilization capacity and reducing reliance on inpatient psychiatric hospitalization when appropriate to do so. This Crisis Triage Center will add 43 beds to the crisis continuum within Humboldt County. Increasing crisis residential and stabilization capacity is intended to divert individuals from inpatient admission when clinically appropriate and to facilitate faster discharge for individuals stepping down from acute settings.

Diversion strategies are also being strengthened. CARE Court pathways and jail-based behavioral health services provide early identification, stabilization, and referral options to reduce cycling between jail, hospitalization, and conservatorship. Individuals who meet criteria for higher levels of care may be referred to conservatorship or Department of State Hospitals placement when clinically necessary, but the County's goal is to increase access to community-based alternatives prior to reaching that threshold. By aligning diversion, stabilization, and housing pathways, the County aims to reduce prolonged institutional stays.

Additionally, Humboldt County is constructing a new psychiatric hospital made possible through Proposition 1 dollars, which will modernize inpatient capacity and improve care environments for minors and adults requiring acute psychiatric services. While inpatient capacity remains necessary for individuals with significant acuity, Humboldt County's long-term strategy emphasizes strengthening crisis intervention, crisis residential, and step-down services to reduce administrative days and conservatorship reliance.

Through expanded MHRC partnerships, increased crisis residential capacity, diversion initiatives, and improved discharge coordination, Humboldt County seeks to reduce unnecessary institutionalization and improve access to timely, least restrictive care beginning July 1, 2026. The County will continue monitoring inpatient administrative days, involuntary detention rates, conservatorships, and crisis utilization metrics to assess progress and refine system improvements over time.

File Upload

Please identify the category or categories of funding that the county is using to address the institutionalization goal
BHSA BHSS
BHSA FSP
BHSA Housing Interventions
1991 Realignment
2011 Realignment
State General Fund
Federal Financial Participation (SMHS, DMC/DMC-ODS)
SAMHSA PATH
MHBG
SUBG

Justice-Involvement: Primary Measures

Arrests: Adult and Juvenile Rates (Department of Justice), Statistical Year 2023

How does your county status compare to the statewide rate/average?

For adults/older adults
Above

For juveniles
Above

What disparities did you identify across demographic groups or special populations?
Age
Race or Ethnicity
Sex

Justice-Involvement: Supplemental Measures

Adult Recidivism Conviction Rate (California Department of Corrections and Rehabilitation (CDCR)), FY 2019 - 2020

How does your county status compare to the statewide rate/average?
Above

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Incompetent to Stand Trial (IST) Count (Department of State Hospitals(DSH)), FY 2023
Note: The IST count includes all programs funded by DSH, including, state hospital, Jail Based Competency Treatment (JBCT), waitlist, community inpatient facilities, conditional release, community-based restoration and diversion programs. However, this count excludes county-funded programs. As such, individuals with Felony IST designations who are court-ordered to county-funded programs are not included in this count.

How does your county status compare to the statewide rate/average?
Above

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Justice-Involvement: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
Humboldt County's justice involvement data demonstrate elevated rates compared to statewide benchmarks and significant disparities across age, race/ethnicity, and gender. The primary measure used for this analysis was Adult and Juvenile Arrest Rates (DOJ, Statistical Year 2023), supplemented by Adult Recidivism Conviction Rates (CDCR, FY 2019–2020) and Incompetent to Stand Trial (IST) counts (Department of State Hospitals, FY 2023).

Adult arrest rates in Humboldt County were 4,627 compared to the statewide median of 2,646, indicating substantially higher justice involvement among adults. Juvenile arrest rates were also above the statewide median, with Humboldt reporting 432 compared to the statewide median of 395. These data demonstrate elevated justice system entry at both adult and youth levels.

Age disparities are evident within adult arrest data. The overall adult rate (4,627) is exceeded significantly among individuals ages 30–39 (10,919) and 20–29 (5,422), indicating disproportionate arrest involvement

among young and early middle-aged adults. These age cohorts represent the highest concentration of justice system contact and may overlap with individuals experiencing untreated behavioral health conditions, housing instability, or substance use disorders.

Racial and ethnic disparities are pronounced. The overall 2024 arrest rate was 4,007, with Black individuals experiencing a rate of 14,008, more than three times the overall rate. White individuals also exceeded the benchmark at 4,093. Although full statewide racial comparisons were not provided in the dataset, the magnitude of difference relative to the county overall rate indicates substantial racial disparity in justice involvement. These findings are consistent with broader statewide and national trends showing disproportionate justice system impact among Black individuals.

Gender disparities are also significant. Among adults, males experienced an arrest rate of 7,233 compared to the overall rate of 4,627, indicating substantially higher justice involvement among adult males. Among youth, males experienced a rate of 611 compared to the overall juvenile rate of 432, again demonstrating disproportionate involvement among male youth. These data indicate that justice involvement is heavily concentrated among males across age groups.

Supplemental measures further demonstrate elevated system involvement among individuals with behavioral health needs. The adult recidivism conviction rate was 45.2%, above the statewide median of 39.6%, indicating a higher likelihood of reoffending among individuals released from custody. The Incompetent to Stand Trial (IST) count was 36 compared to the statewide median of 18, indicating that Humboldt County's IST population is approximately double the statewide benchmark. Elevated IST counts suggest a significant intersection between serious mental illness and justice system involvement, particularly among individuals requiring restoration services.

Taken together, the data indicate that justice involvement in Humboldt County disproportionately affects adults ages 20–39, Black individuals, White individuals relative to county overall rates, and males across both adult and youth populations. Elevated recidivism and IST counts further suggest that individuals with significant behavioral health needs are overrepresented within the justice system continuum. These disparities were identified using DOJ arrest data (Statistical Year 2023), CDCR recidivism data (FY 2019–2020), and Department of State Hospitals IST data (FY 2023). Continued disaggregation of behavioral health-related justice data will support more targeted intervention strategies moving forward.

Justice-Involvement: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's level of justice-involvement for those living with significant behavioral health needs. In your response, please describe how you plan to address measures where your status is below the statewide

average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the count is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)

Humboldt County's justice involvement indicators exceed statewide benchmarks across multiple measures, demonstrating the need for strengthened diversion, treatment engagement, and reentry coordination strategies. In Statistical Year 2023, adult arrest rates were 4,627 compared to the statewide median of 2,646. Juvenile arrest rates were also above the statewide median, with Humboldt reporting 432 compared to the state median of 395. Age disparities are evident within adult arrest data, with individuals ages 30–39 (10,919) and 20–29 (5,422) exceeding the overall adult rate benchmark, indicating disproportionate justice involvement among young and middle-aged adults. Racial disparities are also pronounced. The overall 2024 arrest rate was 4,007, with Black individuals (14,008) and White individuals (4,093) exceeding the overall benchmark. Gender disparities are significant, with adult males exceeding the overall rate (7,233 compared to 4,627), and among youth, males (611) exceeding the overall juvenile rate (432). Supplemental measures further reflect elevated system involvement. The adult recidivism conviction rate (FY 2019–2020) was 45.2%, above the statewide median of 39.6%. The Incompetent to Stand Trial (IST) count (FY 2023) was 36, double the statewide median of 18, indicating a substantial intersection between behavioral health acuity and criminal justice involvement.

Beginning July 1, 2026, Humboldt County will strengthen diversion, evidence-based practice implementation, and reentry coordination to reduce justice system involvement among individuals with behavioral health needs. A key strategy is the early-stage implementation of Functional Family Therapy (FFT) and Multisystemic Therapy (MST), evidence-based practices targeted toward youth involved in or at risk of involvement in the juvenile justice system. Humboldt County will train staff and potentially contracted providers in FFT and MST, begin accepting referrals, and work toward certification in these models. These practices are designed to improve youth and family engagement, address behavioral drivers of justice involvement, and reduce recidivism among system-involved youth.

CARE Court and diversion pathways will continue to serve as upstream interventions for individuals whose justice involvement is driven by untreated serious behavioral health conditions. By connecting eligible individuals to structured treatment plans, housing pathways, and coordinated supervision, Humboldt County aims to reduce arrests, recidivism, and prolonged system involvement. The County will also strengthen collaboration between Behavioral Health and the jail system through expanded in-reach services. Jail-based behavioral health staff will assist incarcerated individuals in developing discharge plans prior to release, facilitating linkage to outpatient services, medication continuity, and community supports. These efforts may include connection to housing-related supports through Medi-Cal Managed Care Plan (MCP) Community Supports and Enhanced Care Management, thereby addressing one of the primary drivers of recidivism.

Given the elevated Incompetent to Stand Trial (IST) counts and recidivism rates, Humboldt County will continue aligning crisis stabilization, step-down placement, and diversion pathways to reduce the number of individuals cycling between behavioral health crises and justice involvement. Through expanded implementation of evidence-based youth interventions, strengthened jail in-reach and reentry coordination, continued CARE Court and diversion programming, and cross-system collaboration with housing and outpatient providers, Humboldt County seeks to reduce justice involvement among individuals with behavioral health needs beginning July 1, 2026. Ongoing monitoring of arrest rates, recidivism, IST counts, and demographic disparities will inform continuous quality improvement efforts.

File Upload

Please identify the category or categories of funding that the county is nusing to address the justice-involvement goal

BHSA BHSS
BHSA FSP
BHSA Housing Interventions
1991 Realignment
2011 Realignment
State General Fund
Federal Financial Participation (SMHS, DMC/DMC-ODS)
SAMHSA PATH
MHBG
SUBG

Removal Of Children from Home: Primary Measures

Children in Foster Care (Child Welfare Indicators Project (CWIP)), as of January 2025

How does your county status compare to the statewide rate?

Above

What disparities did you identify across demographic groups or special populations?

Age

Removal Of Children from Home: Supplemental Measures

Open Child Welfare Cases SMHS Penetration Rates (DHCS), 2022

How does your county status compare to the statewide rate?
Below

What disparities did you identify across demographic groups or special populations?
Age
Race or Ethnicity
Sex

Child Maltreatment Substantiations (CWIP), 2022

How does your county status compare to the statewide rate?
Above

What disparities did you identify across demographic groups or special populations?
Age
Race or Ethnicity
Sex

Removal Of Children from Home: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
Humboldt County's removal and child welfare data indicate elevated rates compared to statewide benchmarks and significant disparities across age and race/ethnicity. The primary measure used for this analysis was Children in Foster Care (Child Welfare Indicators Project, CWIP) as of January 2025, supplemented by Open Child Welfare Cases SMHS Penetration Rates (DHCS, 2022) and Child Maltreatment Substantiation Rates (CWIP, 2022).

As of January 2025, Humboldt County's foster care rate was 878 compared to the statewide median of 484, indicating substantially higher removal prevalence. Age disparities are pronounced, with infants and toddlers disproportionately represented. Children under age 1 have a rate of 1,459 and children ages 1–2 have a rate of 1,311, both significantly exceeding the overall county benchmark of 878. These data indicate

that the highest concentration of removals occurs among the youngest children. Gender distribution at sex assigned at birth is nearly evenly split (male 684; female 656), and no meaningful disparity is observed by sex in removal rates.

Open Child Welfare Case SMHS penetration data reveal disparities in behavioral health service engagement among child welfare-involved youth. Humboldt County's penetration rate of 26.4% is below the statewide median of 39.5%, indicating that children involved in child welfare locally are accessing specialty mental health services at lower rates than statewide peers. Age-based differences are evident: children ages 6–11 (41.1%) and 18–20 (38.1%) show higher service penetration, while younger children ages 3–5 (20.7%) and children ages 0–2 and 12–17 (1%) demonstrate markedly lower service engagement. These patterns suggest that very young children, despite experiencing high removal and substantiation rates, are not accessing specialty mental health services at comparable levels.

Racial and ethnic disparities are significant in both substantiation and service data. Child maltreatment substantiation rates show that Native American children experience the highest rate (36), substantially exceeding the overall county rate (8.5) and the statewide median (6.5). White children also exceed the statewide median at 10.1. Latino children (3.3), Asian/Pacific Islander children, and Black children are reported at lower rates in this dataset; however, Native American children are disproportionately impacted at a magnitude far exceeding other groups. Within SMHS penetration for open child welfare cases, Hispanic children demonstrate higher service penetration (39.4%) compared to the county average (26.4%), while other racial categories show lower or comparable penetration levels. These findings indicate disparities in both child welfare involvement and behavioral health access among specific racial and ethnic groups.

Child maltreatment substantiation data further reinforce age disparities. Children ages 1–2 have the highest substantiation rate (14.1), followed by ages 3–5 (9.3), 6–10 (8.0), and 11–15 (7.3). Rates decline significantly among older youth and infants in this dataset. These patterns demonstrate that early childhood remains the highest-risk period for substantiated maltreatment and removal.

Taken together, the data indicate that removal and maltreatment in Humboldt County disproportionately affect infants and toddlers (ages 0–2), Native American children, and very young children overall. Additionally, although gender disparities are minimal in foster care counts, disparities exist in service penetration, with younger children less likely to access specialty mental health services despite elevated removal and substantiation rates. These disparities were identified using CWIP Foster Care data (January 2025), CWIP Maltreatment Substantiation data (2022), and DHCS SMHS penetration data for open child welfare cases (2022). Continued disaggregation and cross-system data sharing between Behavioral Health and Child Welfare will be critical to refining disparity identification and targeting prevention efforts.

Removal Of Children from Home: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may increase your county's level of access to care. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships, or initiatives the county is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes

Humboldt County's data indicate elevated rates of child removal and maltreatment compared to statewide benchmarks, alongside disparities across age and race/ethnicity. As of January 2025, the Children in Foster Care rate was 878 compared to the statewide median of 484, indicating substantially higher placement prevalence locally. Age disparities are pronounced among very young children. Children under age 1 (1,459) and ages 1–2 (1,311) exceed the overall foster care benchmark, indicating disproportionate removal among infants and toddlers. Gender distribution at sex assigned at birth is nearly evenly split (male 684; female 656), with no significant disparity identified in removal rates by sex.

Supplemental measures further highlight system challenges. Open Child Welfare Case SMHS penetration rates (2022) were below the statewide median, with Humboldt at 26.4% compared to the state median of 39.5%, indicating that children involved in child welfare are accessing specialty mental health services at lower rates than the statewide benchmark. Age breakdowns show higher penetration among children ages 6–11 (41.1%) and 18–20 (38.1%), while younger children ages 3–5 (20.7%) and 0–2 and 12–17 populations (1%) demonstrate lower service engagement. Racial and ethnic differences are also evident within SMHS penetration: Hispanic children show a penetration rate of 39.4% compared to the overall 26.4%, while other racial groups show lower or comparable rates. Gender penetration differences are modest, with males at 31.5% and females at 30.5% compared to the overall rate of 26.4%.

Child maltreatment substantiation rates (CWIP, 2022) are also above the statewide median, with Humboldt at 8.5 compared to the state median of 6.5. Age disparities again show higher substantiation rates among very young children, particularly ages 1–2 (14.1) and 3–5 (9.3), with lower rates among older youth. Racial disparities are substantial. Native American children experience the highest substantiation rate (36), followed by White children (10.1), while Latino children (3.3), Asian/Pacific Islander, and Black children report lower rates in this dataset. These patterns indicate disproportionate system involvement among Native American children and very young children.

Beginning July 1, 2026, Humboldt County will strengthen collaboration between Behavioral Health (BH) and Child Welfare Services (CWS) to reduce removals and preserve placement stability. A key strategy includes the continued expansion and integration of evidence-based practices (EBPs) that serve child welfare-involved youth and families, with the goal of stabilizing behavioral health needs early and reducing

placement disruption. EBPs will be deployed in coordination with CWS to support families at risk of removal and to promote reunification when appropriate.

CWS is increasing its utilization of the Child and Adolescent Needs and Strengths (CANS) assessment tool, using CANS data to inform case planning, child and family team meetings, and service coordination. Behavioral Health and CWS are strengthening collaboration around shared cases to ensure timely communication when children enter the behavioral health system. By aligning assessment, treatment planning, and child welfare case management, the County aims to improve service matching, address behavioral health drivers of removal, and preserve family placements whenever safely possible.

Through strengthened CANS-informed case planning, expanded EBP implementation, and enhanced BH–CWS coordination, Humboldt County seeks to reduce child removals, increase appropriate mental health service penetration among open child welfare cases, and address disparities affecting very young children and Native American youth beginning July 1, 2026. Ongoing monitoring of foster care rates, maltreatment substantiations, and SMHS penetration for child welfare-involved youth will guide continuous quality improvement efforts.

File Upload

Please identify the category or categories of funding that the county is nusing to address the removal of children from home goal

BHSA BHSS
BHSA FSP
BHSA Housing Interventions
1991 Realignment
2011 Realignment
State General Fund
Federal Financial Participation (SMHS, DMC/DMC-ODS)
SAMHSA PATH
MHBG
SUBG

Untreated Behavioral Health Conditions: Primary Measures

Follow-Up After Emergency Department Visits for Substance Use (FUA-30), 2022

How does your county status compare to the statewide rate/average?

For the full population measured
Above

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Follow-Up After Emergency Department Visits for Mental Illness (FUM-30), 2022

How does your county status compare to the statewide rate/average?

For the full population measured
Below

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Untreated Behavioral Health Conditions: Supplemental Measures

Adults that needed help for emotional/mental health problems or use of alcohol/drugs who had no visits for mental/drug/alcohol issues in past year(CHIS), 2023

How does your county status compare to the statewide rate?

For the full population measured
Below

What disparities did you identify across demographic groups or special populations?
Age
Race or Ethnicity
Sex

Untreated Behavioral Health Conditions: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis

Humboldt County's untreated behavioral health condition data reflect disparities across age, race/ethnicity, and gender, despite relative strengths in certain follow-up measures. The primary measures used for this analysis were Follow-Up After Emergency Department Visits for Substance Use (FUA-30, 2022), Follow-Up After Emergency Department Visits for Mental Illness (FUM-30, 2022), and the California Health Interview Survey (CHIS, 2023) indicator measuring adults who needed help for emotional/mental health problems or alcohol/drug use but had no visits for these issues in the past year.

For FUA-30 (2022), Humboldt County achieved a rate of 36.8%, exceeding both the MY22 Minimum Performance Level (21.2%) and the statewide rate (28.8%), indicating comparatively strong follow-up after substance use-related emergency department visits. However, FUM-30 (2022) performance was 34.7%, which is below both the MY22 Minimum Performance Level (54.5%) and the statewide rate (38.2%). This suggests a disparity in follow-up between substance use and mental health-related ED visits, with individuals presenting for mental health crises less likely to receive timely outpatient follow-up.

The CHIS 2023 unmet need measure indicates that 42.3% of Humboldt County adults who reported needing help for emotional/mental health problems or alcohol/drug use had no visits for those concerns in the past year. Although this rate is below the statewide median (50.5%) and mean (48.4%), it represents a substantial proportion of residents experiencing untreated behavioral health conditions. Age disparities are evident. Adults ages 25–64 report the highest rate of untreated need (44.3%), exceeding the county average. Adults age 65+ report 37.1%, and young adults ages 18–24 report 29.3%. These findings indicate that working-age adults are most likely to experience unmet behavioral health need.

Racial and ethnic disparities are pronounced. American Indian/Alaska Native (AI/AN) individuals report the highest rate of untreated need at 66.7%, substantially exceeding the county average (42.3%) and all other racial/ethnic groups in the dataset. White individuals report a rate of 40.6%, near the county average, while Latina individuals report 34.1%. Within the Latina population, gender variation is noted, with Latina females reporting higher unmet need compared to Latino males in the dataset provided. These data indicate significant inequities in access to or engagement with behavioral health services among AI/AN community members.

Gender disparities are also present. Males report a higher rate of untreated need (45.3%) compared to females (38.7%), indicating that adult males are more likely to experience behavioral health concerns without receiving services. This aligns with patterns observed in justice involvement and arrest data, suggesting cross-system overlap among males experiencing untreated behavioral health conditions.

While disaggregated data were not available for all demographic categories within the FUA and FUM measures, the combination of ED follow-up metrics and CHIS unmet need data suggests that untreated behavioral health conditions disproportionately affect working-age adults (25–64), American Indian/Alaska Native individuals, and males. Additionally, the gap between FUA and FUM performance indicates that individuals presenting with mental health crises may face greater barriers to follow-up care than those

presenting with substance use crises.

These disparities were identified using DHCS FUA-30 and FUM-30 performance data (2022) and CHIS 2023 unmet need survey data. Continued disaggregation of follow-up and outpatient engagement measures by race/ethnicity, age, and gender will further refine understanding of inequities and inform targeted outreach and engagement strategies.

Untreated Behavioral Health Conditions: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's level of untreated behavioral health conditions. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the count is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)

Humboldt County's data on untreated behavioral health conditions reflect both strengths in post-crisis follow-up and ongoing disparities in access to outpatient behavioral health care. For Follow-Up After Emergency Department Visits for Substance Use (FUA-30, 2022), Humboldt County achieved a rate of 36.8%, exceeding the MY22 Minimum Performance Level (21.2%) and the statewide rate (28.8%), indicating relatively strong short-term follow-up after substance use-related emergency department visits. However, for Follow-Up After Emergency Department Visits for Mental Illness (FUM-30, 2022), Humboldt County's rate of 34.7% was below both the MY22 Minimum Performance Level (54.5%) and the statewide rate (38.2%), indicating a gap in timely mental health follow-up after ED visits.

Supplemental data from the California Health Interview Survey (CHIS, 2023) further highlight unmet need. In 2023, 42.3% of Humboldt County adults who reported needing help for emotional/mental health problems or alcohol/drug use had no visits for these issues in the past year. Although this rate is below the statewide median (50.5%) and mean (48.4%), it still represents a substantial proportion of residents experiencing untreated conditions. Age disparities are present, with adults ages 25–64 reporting the highest rate of unmet need (44.3%), compared to 18–24 year-olds (29.3%) and adults age 65+ (37.1%). Racial and ethnic disparities are significant. American Indian/Alaska Native individuals report the highest rate of untreated need (66.7%), substantially exceeding the county average (42.3%). White individuals report a rate of 40.6%, while Latina individuals report 34.1%. Gender disparities are also evident, with males reporting higher untreated need (45.3%) compared to females (38.7%).

Beginning July 1, 2026, Humboldt County will strengthen cross-system referral pathways and early intervention strategies to reduce untreated behavioral health conditions. The County continues to expand

collaboration with local law enforcement and the Mobile Response Team (MRT) and the Mobile Intervention & Services Team (MIST), which provides crisis response and referral pathways for individuals not currently engaged in services. Law enforcement partnerships support diversion from arrest into treatment and allow referrals of individuals exhibiting untreated mental illness directly into behavioral health services. The jail system also plays a critical role in identifying individuals with untreated mental illness and facilitating referrals to outpatient behavioral health services upon release, helping to reduce gaps in care continuity.

The County will continue implementing its Performance Improvement Project (PIP) focused on improving follow-up after emergency department visits, particularly targeting mental health follow-up rates (FUM-30), where performance currently lags behind state benchmarks. Enhanced outreach protocols, coordination with emergency departments, and use of Health Information Exchange (HIE) alerts will strengthen linkage from acute settings to outpatient treatment.

Community-based stigma reduction and engagement efforts are also central to addressing untreated conditions. Humboldt County partners with the Behavioral Health Board (BHB) to promote public awareness and reduce stigma associated with mental health and substance use treatment. Collaboration with NAMI and community leaders such as Lea Nagy supports ongoing peer-led support groups, family education, and mentoring and coaching of peers. These efforts help reduce barriers related to stigma and mistrust and increase voluntary service engagement.

The Crisis Intervention Team (CIT) training further strengthens early identification and diversion of individuals experiencing untreated behavioral health crises. By equipping law enforcement and first responders with behavioral health-informed response skills, CIT supports safe de-escalation and connection to services rather than arrest or hospitalization. CARE Court provides an additional pathway for individuals with serious untreated behavioral health conditions, allowing family members, providers, or community members to petition the court to connect individuals to structured treatment plans and coordinated services when voluntary engagement has not occurred.

Through strengthened Emergency Department (ED) follow-up processes, expanded cross-system referral pathways, stigma reduction initiatives, CIT training, jail in-reach coordination, and CARE Court implementation, Humboldt County aims to reduce the proportion of residents experiencing untreated behavioral health conditions beginning July 1, 2026. Ongoing monitoring of FUA, FUM, CHIS unmet need indicators, and demographic disparities will guide continuous quality improvement and equity-focused interventions.

File Upload

Please identify the category or categories of funding that the county is using to address the untreated behavioral health conditions goal

BHSA BHSS
BHSA FSP
BHSA Housing Interventions
1991 Realignment
2011 Realignment
State General Fund
Federal Financial Participation (SMHS, DMC/DMC-ODS)
SAMHSA PATH
MHBG
SUBG

Additional statewide behavioral health goals for improvement

Please review your county's status on the remaining eight statewide behavioral health goals using the primary measure(s) to compare your county to the statewide status and review the supplemental measure(s) for additional insights in the County Performance Workbook. These measures should inform the overall strategy and where relevant, be incorporated into the planning around the six priority goals.

In the next section, the county will select AT LEAST one goal from below for which your county is performing below the statewide rate/average on the primary measure(s) to improve on as a priority for the county.

For related policy information, refer to E.6.2 Primary and Supplemental Measures .

Care Experience: Primary Measures

Perception of Cultural Appropriateness/Quality Domain Score (Consumer Perception Survey (CPS)), 2024

How does your county status compare to the statewide rate/average?

For adults/older adults
Below

For children/youth
Above

Quality Domain Score (Treatment Perception Survey (TPS)), 2024

How does your county status compare to the statewide rate/average?

For adults/older adults
Same

For children/youth
Below

Engagement In School: Primary Measures

Twelfth Graders who Graduated High School on Time (Kids Count), 2022

How does your county status compare to the statewide rate/average?
Above

Engagement In School: Supplemental Measures

Meaningful Participation at School (California Health Kids Survey (CHKS)), 2023

How does your county status compare to the statewide rate/average?
Below

Student Chronic Absenteeism Rate (Data Quest), 2022

How does your county status compare to the statewide rate/average?
Above

Engagement In Work: Primary Measures

Unemployment Rate (California Employment Development Department (CA EDD)), 2023

How does your county status compare to the statewide rate/average?
Below

Engagement In Work: Supplemental Measures

Unable to Work Due to Mental Problems (California Health Interview Survey (CHIS)), 2023

How does your county status compare to the statewide rate/average?
Above

Overdoses: Primary Measures

All Drug-Related Overdose Deaths (California Department of Public Health (CDPH)), 2022

How does your county status compare to the statewide rate/average?

For the full population measured
Above

For adults/older adults
Above

For children/youth
Below

Overdoses: Supplemental Measures

All-Drug Related Overdose Emergency Department Visits (CDPH), 2022

How does your county status compare to the statewide rate/average?

For the full population measured
Above

For adults/older adults
Above

For children/youth
Below

Prevention And Treatment of Co-Occurring Physical Health Conditions: Primary Measures

Adults' Access to Preventive/Ambulatory Health Service & Child and Adolescent Well-Care Visits (DHCS), 2022

How does your county status compare to the statewide rate/average?

For adults (specific to Adults' Access to Preventive/Ambulatory Health Service)
Same

For children/youth (specific to Child and Adolescent Well-Care Visits)
Below

Prevention And Treatment of Co-Occurring Physical Health Conditions: Supplemental Measures

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications & Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing (DHCS), 2022

How does your county status compare to the statewide rate/average?

For adults/older adults (specific to Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications)
Below

For children/youth (specific to Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing)
Below

Quality Of Life: Primary Measures

Perception of Functioning Domain Score (CPS), 2024

How does your county status compare to the statewide rate/average?

For the full population measured
Above

For adults/older adults
Above

For children/youth
Below

Quality Of Life: Supplemental Measures

Poor Mental Health Days Reported (Behavioral Risk Factor Surveillance System (BRFSS)), 2024

How does your county status compare to the statewide rate/average?

For the full population measured
Above

Social Connection: Primary Measures

Perception of Social Connectedness Domain Score (CPS), 2024

How does your county status compare to the statewide rate/average?

For the full population measured
Above

For adults/older adults
Above

For children/youth
Above

Social Connection: Supplemental Measures

Caring Adult Relationships at School (CHKS), 2023

How does your county status compare to the statewide rate/average?
Above

Suicides: Primary Measures

Suicide Deaths, 2022

How does your county status compare to the statewide rate/average?

For the full population measured
Above

Suicides: Supplemental Measures

Non-Fatal Emergency Department Visits Due to Self-Harm, 2022

How does your county status compare to the statewide rate/average?

For the full population measured
Above

For adults/older adults
Below

For children/youth
Above

County-selected statewide population behavioral health goals

For related policy information, refer to 3.E.6 Statewide Behavioral Health Goals .

Based on your county's performance or inequities identified, select at least one additional goal to improve on as a priority for the county for which your county is performing below the statewide rate/average on the primary measure(s). For each county-selected goal, provide the information requested below.
Suicides

Suicides

Please describe why this goal was selected
Humboldt County selected Suicides as its additional Behavioral Health Services Act (BHSA) goal based on local data demonstrating both elevated suicide mortality rates and significant disparities across demographic groups, as well as system-level indicators showing high levels of behavioral health crisis activity in the community.

Analysis of the most recent available data shows that Humboldt County experiences substantially higher suicide death rates than the statewide average, with a rate of 28.3 deaths per 100,000 residents in 2022. Suicide deaths are disproportionately concentrated among men and middle-aged adults, particularly individuals ages 45–64 and 25–44, suggesting that working-age adults face elevated suicide risk and may not be engaging with behavioral health services prior to fatal outcomes.

In addition to mortality data, Humboldt County also experiences high levels of non-fatal emergency department (ED) visits due to self-harm, which serve as an important early indicator of suicide risk and behavioral health crises. The county's ED visit rate of 159.2 per 100,000 residents exceeds statewide averages and reveals significant disparities among youth and young adults, particularly individuals ages 10–24, who experience the highest rates of crisis-related ED visits. Disparities are also present among American Indian and Alaska Native residents, whose ED visit rate is more than double the county average, highlighting the need for culturally responsive prevention and engagement strategies.

These data indicate that suicide-related outcomes affect multiple priority populations in Humboldt County and that both upstream prevention efforts and crisis response improvements are necessary to reduce suicide risk and improve behavioral health outcomes.

Additionally, changes to the Behavioral Health Services Act (BHSA) Early Intervention structure will negatively impact funding available for Humboldt County's existing Suicide Prevention program, creating additional urgency to prioritize suicide prevention efforts within the county's planning framework. Because these funding changes may limit the scale of current prevention activities, the county identified Suicide Prevention as a priority goal in order to maintain focus on reducing suicide risk, strengthening early intervention strategies, and improving coordination between crisis services, hospitals, and community-based supports.

By selecting Suicide Prevention as a BHSA goal, Humboldt County intends to focus on reducing suicide deaths, addressing disparities among high-risk populations, and strengthening early identification and intervention systems to better respond to behavioral health crises across the county.

What disparities did you identify across demographic groups or priority populations among the Additional Statewide Behavioral Health Goals? For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis

Humboldt County selected Suicide Prevention as its additional Behavioral Health Services Act (BHSA) goal and reviewed county performance using two related measures: (1) suicide deaths and (2) non-fatal emergency department (ED) visits due to self-harm. Together, these measures help identify both fatal outcomes and earlier crisis indicators across demographic groups.

Analysis of the most recent available data (2022) demonstrates that Humboldt County experiences both elevated suicide mortality and significant disparities across demographic and priority populations.

Measure 1: Suicide Deaths (Rate per 100,000 population)

Humboldt County's suicide death rate in 2022 was 28.3 deaths per 100,000 residents, substantially higher than statewide averages and placing Humboldt among counties with the highest suicide mortality rates. Examination of demographic breakdowns reveals disparities across sex and age groups.

Sex Disparities: Suicide mortality disproportionately impacts men, whose death rate (38.7 per 100,000) substantially exceeds the countywide rate. This indicates that suicide deaths are concentrated among men in Humboldt County and suggests that males are less likely to engage with behavioral health services prior to fatal outcomes.

Age Disparities: Higher suicide death rates were observed among middle-aged adults, particularly residents aged 45–64 (36.3 per 100,000) and 25–44 (32.3 per 100,000), both exceeding the countywide rate. This pattern indicates increased suicide risk among working-age adults, suggesting potential contributing factors such as economic stress, substance use, social isolation, and untreated behavioral health conditions.

Race and Ethnicity Considerations: Available data show suicide mortality rates primarily among White residents; however, several demographic categories had suppressed or unavailable rates due to small population denominators. As a result, disparities among smaller racial and ethnic groups cannot be reliably quantified in this dataset, though national and statewide data indicate that rural and Native communities may experience elevated suicide risk.

Measure 2: Non-Fatal Emergency Department Visits Due to Self-Harm (Rate per 100,000 population)

Non-fatal ED visits due to self-harm are an important early indicator of suicide risk and behavioral health crisis activity. Humboldt County's rate in 2022 was 159.2 visits per 100,000 residents, exceeding statewide averages and demonstrating high levels of crisis presentation within the county.

Disparities are more pronounced within this measure and highlight populations experiencing elevated crisis risk prior to fatal outcomes.

Age Disparities

The most significant disparities occur among youth and young adults:

Ages 15–19: 475.4 visits per 100,000

Ages 10–14: 298.5 per 100,000

Ages 20–24: 217.2 per 100,000

These rates are substantially higher than the county average and demonstrate that adolescents and young adults experience disproportionately high levels of crisis and self-harm behaviors. Rates decline significantly among older adults, indicating that behavioral health crises requiring ED care are concentrated among younger populations.

Race and Ethnicity Disparities: A substantial disparity is observed among American Indian and Alaska Native residents, who experience 344.1 ED visits per 100,000, more than double the county average and significantly higher than rates observed among White and Hispanic populations. This indicates a disproportionate crisis burden among Native populations and highlights the need for culturally responsive and community-driven prevention approaches.

Sex Disparities: Unlike suicide deaths, non-fatal ED visits due to self-harm occur more frequently among females, whose rate (187.6 per 100,000) exceeds both the countywide average and the rate among males (99.8 per 100,000). This suggests that females are more likely to present for emergency care following self-harm, while males experience higher fatality rates.

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may improve your county's level of Suicides and refer to any data that was used to make this decision (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)
Beginning July 1, 2026, Humboldt County will strengthen and implement a coordinated set of programs, partnerships, and system improvements intended to reduce suicide deaths and suicide-related crises, consistent with the county's selection of Suicide as its Behavioral Health Services Act (BHSA) additional goal. Planned actions are informed by county and statewide data demonstrating that Humboldt experiences suicide mortality rates significantly higher than statewide averages, alongside elevated rates of non-fatal ED visits due to self-harm among youth and certain priority populations.

County data analysis indicates that suicide deaths in Humboldt are disproportionately concentrated among middle-aged adults and men, while non-fatal self-harm ED visits occur at much higher rates among youth, young adults, females, and American Indian/Alaska Native residents. These findings highlight both upstream prevention needs among youth and crisis response and engagement needs among adults experiencing behavioral health crises. The county's planned activities beginning in FY 2026–27 are designed to address both fatal outcomes and earlier crisis indicators.

Humboldt County will strengthen post–emergency department follow-up and care transition processes for individuals presenting with mental health crises or self-harm. Humboldt County will work with local hospitals and emergency departments to improve real-time or near-real-time notification and referral processes, standardize outreach protocols following discharge, and ensure timely connection to behavioral health services, crisis supports, peer services, or residential treatment as appropriate. These improvements aim to reduce repeat crisis events and support individuals during critical periods following ED encounters, which data show occur at disproportionately high rates among adolescents and young adults.

Humboldt County will also strengthen cross-sector collaboration with hospitals and other partners to improve suicide prevention and crisis response workflows. These partnerships will support consistent discharge planning, referral pathways, and shared strategies for engaging individuals at elevated suicide risk. Enhanced coordination between hospitals, crisis services, and outpatient behavioral health programs will help ensure that individuals presenting in crisis are connected to ongoing care and community-based supports.

In addition, Humboldt County will strengthen local suicide-related data tracking and monitoring to better identify emerging trends and priority populations requiring targeted interventions. Improved data monitoring will support ongoing quality improvement and enable the county to adjust strategies in response to local needs, particularly in communities or demographic groups where data may currently be limited due to small population sizes.

Equity-focused prevention and engagement strategies will also be strengthened as part of implementation. County analysis shows disproportionately high self-harm ED visit rates among American Indian and Alaska Native residents and elevated crisis rates among adolescents. Beginning in FY 2026–27, Humboldt County will align suicide prevention activities with its Behavioral Health Equity efforts, including collaboration with community partners and culturally responsive approaches designed to improve access and engagement for communities experiencing the greatest disparities.

Finally, Humboldt County will leverage existing quality improvement infrastructure to support suicide prevention efforts, including workflow improvements, staff training, and coordination across service systems to ensure individuals at risk are more effectively identified and engaged in care. Performance improvement approaches previously used to improve follow-up after emergency department encounters will inform suicide prevention workflows and outreach strategies moving forward.

Collectively, these efforts are intended to reduce suicide risk by strengthening early intervention, improving transitions from crisis care to ongoing services, and ensuring interventions are responsive to the populations experiencing the highest burden of suicide-related outcomes. By targeting both upstream crisis indicators among youth and downstream fatal outcomes among adults, these initiatives are expected to improve county performance on suicide-related measures and reduce disparities across priority populations.

Please identify the category or categories of funding that the county is using to address this goal

BHSA BHSS
BHSA FSP
BHSA Housing Interventions
1991 Realignment
2011 Realignment
State General Fund
Federal Financial Participation (SMHS, DMC/DMC-ODS)
SAMHSA PATH
MHBG
SUBG

Community Planning Process

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For more information on this section, please see 3.B Community Planning Process .

Stakeholder Engagement

For related policy information, refer to 3.B.1 Stakeholder involvement

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Please indicate the type of engagement used to obtain input on the planning process

County outreach through social media
County outreach through traditional media (e.g., television, radio, newspaper)
Key informant interviews with subject matter experts
Meeting(s) with county
Public e-mail inbox submission
Survey participation
Training, education, and outreach related to community planning
County outreach through townhall meetings

Include date(s) of stakeholder engagement for each type of engagement

Type of engagement
Survey participation

Date
12/10/2025

Type of engagement
County outreach through social media

Date
12/10/2025

Type of engagement
Training, education, and outreach related to community planning

Date
12/10/2025

Type of engagement
Key informant interviews with subject matter experts

Date
12/10/2025

Type of engagement
County outreach through traditional media (e.g., television, radio, newspaper)

Date
12/10/2025

Type of engagement
Meeting(s) with county

Date
12/10/2025

Type of engagement
Public e-mail inbox submission

Date
12/10/2025

Type of engagement
County outreach through townhall meetings

Date
1/15/2026

Please list specific stakeholder organizations that were engaged in the planning process. Please do not include specific names of individuals
Promotores, First 5 Humboldt, Providence, St. Joseph Hospital, United Indian Health Services (UIHS), Blue Lake Community Resource Center, Mattole Valley Resource Center, Partnership Health Plan, Bear River Band of Rohnerville Rancheria, Changing Tides, Fortuna Union Highschool District, McKinleyville Family Resource Center, Redwoods Rural Health Center, Southern Humboldt Community Healthcare District, Behavioral Health Board, Nation's Finest, Family Advisory Board, Humboldt County Office of Education (HCOE), Hope Center, Redwood Coast Regional Center, Humboldt County Child Welfare, Humboldt County Public Health, Yurok Tribe, Wiyot Tribe, Karuk Tribe, SUD-Dual Recovery Committee, Youth Advisory Board (YAB), the National Alliance of Mental Illness (NAMI), Humboldt Probation (youth and adult), Cal Poly Humboldt, Two Feathers Family Services, Tri County Independent Living

What are the five most populous cities in counties with a population greater than 200,000 (Cities submitting IP independently are not required to collaborate with other cities) (Population and Housing Estimates for Cities, Counties, and the State)

	City name
1	Eureka
2	Fortuna
3	Garberville
4	Willow Creek
5	Blue Lake

Were you able to engage all required stakeholders/groups in the planning process?
No

If not, which required stakeholder/groups were you unable to engage in the planning process?
Labor representative organizations
Disability insurers

Disability insurers
Attempted but did not receive a response

Labor representative organizations
Attempted but did not receive a response

Please describe and provide documentation (such as meeting minutes) to support how diverse stakeholder viewpoints were incorporated into the development of the Integrated Plan, including any community-identified strengths, needs, and priorities
Humboldt County incorporated diverse stakeholder viewpoints into the development of the Integrated Plan through its Community Program Planning Process (CPPP), which included community meetings, demographic surveys, key informant interviews, written comment forms, a community survey, email and phone input, and opportunities for public comment. Between December 2025 and March 2026, the County hosted five regional meetings across Humboldt County. Input from these meetings was documented through meeting notes, flip chart recordings, comment forms, demographic surveys, and public comment records, which serve as supporting documentation for stakeholder engagement in the planning process.

Community feedback was analyzed through review of meeting notes, written comment forms, survey responses, and other public input. Themes were identified and used to inform planning priorities. Community-identified strengths included strong partnerships with local organizations, existing peer support services, and collaborative efforts with schools, tribes, and community-based organizations. Community members also identified several key needs and priorities, including expanded access to mental health services in rural areas; stronger workforce recruitment, retention, and training; improved continuity of care for individuals transitioning from crisis services, hospitals, and the justice system; increased services for youth, transition-age youth, and early childhood populations; expanded culturally responsive services for historically underserved communities, including African American, Hmong, Hispanic/Latino, and LGBTQ+ communities; increased peer support opportunities; improved transportation access; expanded housing and supportive services for individuals experiencing homelessness; stronger partnerships with law enforcement and community organizations; and improved public awareness of available behavioral health services.

Consistent with BHSA CPPP requirements, the County also considered stakeholder categories that were not directly represented during the planning process, including labor representative organizations and disability insurers. The County conducted targeted outreach to representatives from these groups through

direct email outreach and phone calls. Documentation of these efforts, including outreach emails, call logs, and the stakeholder contact list, is maintained as part of the County's CPPP documentation. Although direct responses were not received from these groups during this planning cycle, their perspectives were considered in the development of the Integrated Plan through related community and system feedback.

Labor representative organizations were considered through the County's review of workforce-related feedback received during the CPPP, including community and system concerns regarding recruitment, retention, workforce shortages, training needs, staff capacity, geographic access, and the ability of the behavioral health workforce to meet community needs. These themes informed plan priorities related to workforce development, service access, culturally responsive care, and sustainability of behavioral health services. The County will continue outreach to labor representative organizations in future Annual Updates and CPPP activities to obtain more direct input on workforce implementation, staff impacts, and service delivery considerations.

Disability insurers were considered through the County's review of feedback related to access to care, coordination across health systems, continuity of care, navigation of available services, and the need to align behavioral health services with other health coverage and payer systems. These considerations are consistent with the BHSA's emphasis on cross-system coordination and efficient use of public and non-BHSA resources. While disability insurers did not provide direct comments during this planning cycle, the County considered their role in the broader behavioral health system when developing priorities related to access, care coordination, transition planning, and linkage to appropriate services and coverage. The County will continue targeted outreach to disability insurers in future planning cycles and will document any responses received and how their feedback is incorporated.

All stakeholder input received during the CPPP was reviewed by Behavioral Health leadership and considered in relation to BHSA requirements, community-identified needs, available funding, existing service capacity, and the County's broader behavioral health continuum. The resulting Integrated Plan reflects both direct stakeholder feedback and documented efforts to include required stakeholder groups, including those that did not respond during the initial outreach period.

Upload File
Community Survey and Deographic Survey Results.pdf

Local Health Jurisdiction (LHJ)

Cities submitting their Integrated Plan independently from their counties do not have to complete this section. For related policy information, refer to B.2 Considerations of Other Local Program Planning Processes .

Did the county work with its LHJ on the development of the LHJ's recent Community Health Assessment (CHA) and/or Community Health Improvement Plan (CHIP)? Additional information regarding engagement requirements with other local program planning processes can be found in Policy Manual Chapter 3, Section B.2.3.
Yes

Please describe how the county engaged with LHJs, along with Medi-Cal managed care plans (MCPs), across these three areas in developing the CHA and/or CHIP: collaboration, data-sharing, and stakeholder activities
Humboldt County Behavioral Health had its BHSA Coordinator join the governing board for the local LHJ's CHA/CHIP planning process. Through this engagement, there has been collaboration seen in the form of sharing data, planning behind surveys and community engagement, policy development, and an attempt to align stakeholder activities. Partnership, which is Humboldt County's Managed Care Plan, has been an active member of the LHJ's CHA/CHIP planning process.

Did the county utilize the County-LHJ-MCP Collaboration Tool provided via technical assistance?
Yes

Collaboration

Please select how the county collaborated with the LHJ
Attended key CHA and CHIP meetings as requested.
Served on CHA and CHIP governance structures and/or subcommittees as requested.

Data-Sharing

Data-Sharing to Support the CHA/CHIP

Select Statewide Behavioral Health Goals that were identified for data-sharing to support behavioral health-related focus areas of the CHA and CHIP
Suicides
Quality of Life
Overdoses
Access to Care
Care Experience
Engagement in School

Engagement in Work
Homelessness

Was data shared?
Yes

Data-Sharing from MCPS and LHJs to Support IP development

Select Statewide Behavioral Health Goals that were identified for data-sharing to inform IP development
Access to Care
Care Experience
Engagement in School
Engagement in Work
Homelessness
Institutionalization
Justice Involvement
Overdoses
Prevention of Co-Occurring Physical Health Conditions
Quality of Life
Removal of Children from Home
Social Connection
Suicides
Untreated Behavioral Health (BH) Conditions (e.g., substance use disorder, depression, maternal and child behavioral disorders, other adult mental health conditions)
Other

Please describe
The Live Well Humboldt portal was designed and implemented by the local LHJ as a way of making data accessible to the public. Many of the metrics address in the Live Well Humboldt portal align with the statewide BH goals. There are tools in the portal for community members/organizations to submit their own data, making it easy for MCPs to contribute information as well.

Was data shared?
Yes

Stakeholder Activities

Select which stakeholder activities the county has coordinated for IP development with the LHJ engagement on the CHA/CHIP. Please note that although counties must coordinate stakeholder activities with LHJ CHA/CHIP processes (where feasible), the options below are for illustrative purposes only and are not required forms of stakeholder activity coordination (e.g., counties do not need to conduct each of these activities)

Collaborated with LHJ to identify shared stakeholders that are key for both the IP and CHA/CHIP process.
Collaborated on joint surveys, focus groups, and/or interviews that can be used to inform both the IP and CHA/CHIP.
Coordinated messaging and stakeholder events calendars (e.g., governance meetings) around IP development and CHA/CHIP engagement.

Most Recent Community Health Assessment (CHA), Community Health Improvement Plan (CHIP) or Strategic Plan

Has the county considered either the LHJ's most recent CHA/CHIP or strategic plan in the development of its IP ? Additional information regarding engagement requirements with other local program planning processes can be found in Policy Manual Chapter 3, Section B.2.3

Yes

Provide a brief description of how the county has considered the LHJ's CHA/CHIP or strategic plan when preparing its IP

There are elements from previous CHA/CHIP that were considered, especially around efforts regarding Suicide. Humboldt County Behavioral Health has had partnerships with the LHJ in funding a Suicide Prevention program. However, due to changing state policies and guidelines, this is an effort that cannot continue. As a result, Humboldt County has recognized the importance of focusing on Suicide and selected it as one of the additional goals of focus. This is a decision that was in part made with the review of local data.

Medi-Cal Managed Care Plan (MCP) Community Reinvestment

For related policy information, refer to B.2 Considerations of Other Local Program Planning Processes .

Please list the Managed Care Plans (MCP) the county worked with to inform the MCPs' respective community reinvestment planning and decision-making processes

Partnership Healthplan

Which activities in the MCP Community Reinvestment Plan submissions address needs identified through the Behavioral Health Services Act community planning process and collaboration between the county, MCP, and other stakeholders on the county's Integrated Plan?

Humboldt County collaborated with Partnership HealthPlan of California during the community planning process and through ongoing regional coordination efforts. Activities included reviewing priorities related to Medi-Cal member needs and identifying opportunities to align behavioral health investments. Partnership HealthPlan's Community Reinvestment and population health initiatives support several areas that align with needs identified through Humboldt County's BHSA community planning process, including expanding Enhanced Care Management and Community Supports for individuals experiencing homelessness or complex behavioral health needs, strengthening the behavioral health workforce through provider training and peer workforce development, and supporting community-based programs that improve access to culturally responsive behavioral health services. These efforts complement the County's BHSA strategies to improve access to care, address homelessness, and support recovery for individuals with significant behavioral health needs.

Comment Period and Public Hearing

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to B.3 Public Comment and Updates to the Integrated Plan .

Comment Period and Public Hearing

For related policy information, refer to B.3 Public Comment and Updates to the Integrated Plan .

Confirm that the data is up to date and reflects the correct information for a Draft Plan

Date the draft Integrated Plan (IP) was released for stakeholder comment
4/20/2026

Date the stakeholder comment period closed
5/28/2026

Date of behavioral health board public hearing on draft IP
5/28/2026

Please provide proof of a public posting with information on the public hearing. Please select the county's preferred submission modality
PDF,image,or other document

Please upload the PDF, image, or other file documenting the public posting
BHSA 2026-2029 IP Public Comments News Blast Website post.png
BHSA 2026-2029 IP Public Comments News Blast.png
BHSA Public Comments 2026.pdf
Stakeholder List BHSA Draft 2026-2029 Integrated Plan Posted for Public Comments.pdf
BHSA Draft 2026-2029 Integrated Plan Posted for Public Comments.pdf
Public Comments Social Media posting.jpg

If the county uses an existing landing page or other web-based location to publicly post IPs for comment, please provide a link to the landing page

The public comments period began on 4/20/2026 and concluded after the end of the Public Hearing hosted by Humbo

File Upload

Please select the process by which the draft plan was circulated to stakeholders

Public posting
Email outreach
Other

Attach email

Email of IP Posting.pdf

Please specify the other process the draft plan was circulated to stakeholders

Social media and news outlets were utilized as well.

Please describe stakeholder input in the table below. Please add each stakeholder group into their own row in the table

Stakeholder group that provided feedback

First 5 Humboldt

Summarize the substantive revisions recommended this stakeholder during the comment period

First 5 Humboldt submitted via email a letter advocating for the following:

• Emphasize funding for Prevention and Early Intervention services within the BHSA IP, with a focus on the 0-5 population and their families. They urge Humboldt to maximize use of these dollars to the best of their ability.
• Recognize early childhood as a critical developmental window.
• Invest in primary prevention.
• First 5 Humboldt encourages funding programs that:
o Support parents at risk of substance use.
o Address postpartum depression.
o Prevent family separation.
o Promote healthy parenting and family connections.

Stakeholder group that provided feedback
Humboldt County Office of Education (HCOE)

Summarize the substantive revisions recommended this stakeholder during the comment period
The Humboldt County Office of Education (HCOE) Early Education Department has proposed a three-year pilot project titled Early Childhood Mental Health Support: Pyramid Community Model to address growing behavioral health and social-emotional needs among young children in Humboldt County. The proposal responds to local data showing Humboldt County has one of the highest rates of special education identification in California, with approximately 17% of K–12 students receiving special education services, increasing to approximately 22% when preschool-aged children are included. The proposal also highlights concerns regarding preschool suspensions and expulsions, disparities impacting children of color, and limited access to early childhood behavioral health supports.

Stakeholder group that provided feedback
Community Member (Older Adults)

Summarize the substantive revisions recommended this stakeholder during the comment period
An email was received from a community member wanting to advocate for the Older Adults (60+) population. They recommended for more program information to be come more accessible so that folks can find services easier. Additionally, they advocated for more services specific to this population as they felt that this population does not get the attention they need.

Stakeholder group that provided feedback
Humboldt County Public Defender's Office

Summarize the substantive revisions recommended this stakeholder during the comment period
This group submitted a proposal that requests BHSA funding for four holistic defense teams, each consisting of one social worker and one attorney, to serve criminal and juvenile system-involved individuals through early representation/pretrial, juvenile court, collaborative courts, and conflict counsel services.

Stakeholder group that provided feedback
Nurture Center

Summarize the substantive revisions recommended this stakeholder during the comment period

The Nurture Center, under the MHSA FY 2025-2026 Annual Update, has provided an early childhood treatment certification program under Prevention and Early Intervention. An email was received from one of the lead team members requesting BHSA funds be allocated to support this certification process within the 2026-2029 Integrated Plan. A proposal will be submitted at a later time for consideration.

Please describe any substantive recommendations made by the local behavioral health board that are not included in the final Integrated Plan or update. If no substantive revisions were recommended by stakeholders during the comment period, please input N/A.

Substantive recommendations

N/A

County Behavioral Health Services Care Continuum

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress.

County Behavioral Health Services Care Continuum

The Behavioral Health Care Continuum is composed of two distinct frameworks for substance use disorder and mental health services. These frameworks are used for counties to demonstrate planned expenditures across key service categories in their service continuum. Questions on the Behavioral Health Care Continuum are in the Integrated Plan Budget Template.

Mark section as complete

County Provider Monitoring and Oversight

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to 6.C.2 Securing Medi-Cal Payment .

Medi-Cal Quality Improvement Plans

Cities submitting their Integrated Plan independently from their counties do not have to complete this section or Question 1 under All BHSA Provider Locations.

For Specialty Mental Health Services (SMHS) or for integrated SMHS/Drug Medi-Cal Organized Delivery System (DMC-ODS) contracts under Behavioral Health Administrative Integration, please upload a copy of the county's current Quality Improvement Plan (QIP) for State Fiscal Year (SFY) 2026-2027

QI Work Plan FY 2024-2025 Final.pdf
FY2025-2026 Humboldt County DHHS-BH Outpatient QI Work Plan.pdf

Does the county operate a standalone DMC-ODS program (i.e., a DMC-ODS program that is not under an integrated SMHS/DMC-ODS contract)?

Yes

For standalone DMC-ODS, please upload a copy of the county's current QIP for SFY 2026-2027

DMC-ODS QI Program Work Plan.pdf

Contracted BHSA Provider Locations

As of the date this report is submitted, please provide the total number of contracted Behavioral Health Services Act (BHSA) provider locations offering non-Housing services for SFY 2025-26. I.e., BHSA-funded locations that are (i) not owned or operated by the county, and (ii) offer BHSA services other than Housing Interventions services. (A provider location should be counted if it offers both Housing Interventions and mental health (MH) or substance use disorder services (SUD); provider location that contracts with the county to provide both mental health and substance use disorder services should be counted separately.)

Services Provided	**Number of contracted BHSA provider locations**
Mental Health (MH) services only	0
Substance Use Disorder (SUD) services only	0
Both MH and SUD services	0

Among the county's contracted BHSA provider locations, please identify the number of locations that also participate in the county's Medi-Cal Behavioral Health Delivery System (BHDS) (including SMHS and Drug MC/DMC-ODS) for SFY 2025-26

Services Provided	**Number of Contracted BHSA Provider Locations**
SMHS only	0
DMC/DMC-ODS only	0
Both SMHS and DMC/DMC-ODS systems	0

All BHSA Provider Locations

For related policy information, refer to B.2 Considerations of Other Local Program Planning Processes .

Among the county's BHSA funded SMHS provider locations (county-operated and contracted) that offer services/Levels of Care that may be covered by Medi-Cal MCPs as non-specialty mental health services (NSMHS), what percentage of BHSA funded SMHS providers contract with at least one MCP in the county for the delivery of NSMHS?

0

Please describe the county's plans to enhance rates of MCP contracting starting July 1, 2027, and over the subsequent two years among the BHSA provider locations that are providing services that can/should be reimbursed by Medi-Cal MCPs

Humboldt County does not currently have BHSA-funded provider locations that provide non-specialty mental health services (NSMHS) or non-specialty substance use disorder (SUD) services that can or should be reimbursed by Medi-Cal Managed Care Plans (MCPs). Most BHSA-funded services are operated internally by County Behavioral Health and are delivered through the County's specialty behavioral health system.

Because the County does not currently have BHSA-funded providers delivering services that qualify as NSMHS or non-specialty SUD services, there are no applicable providers from the County currently enhancing MCP contracting rates. However, beginning July 1, 2027, and over the subsequent two years, Humboldt County will review any new BHSA-funded provider agreements to determine whether the provider is delivering services that may be reimbursable by Medi-Cal MCPs. The County will also update its BHSA contract template to include requirements that applicable providers make a good faith effort to seek reimbursement from Medi-Cal MCPs for eligible services, including expectations related to Medi-Cal enrollment, MCP contracting, and documentation of reimbursement efforts when applicable.

If such services are identified, Humboldt County will require the provider to make a good faith effort to seek MCP reimbursement, including exploring MCP contracting, documenting outreach to MCPs, and coordinating with the County to avoid inappropriate use of BHSA funds where Medi-Cal reimbursement may be available.

To maximize resource efficiency, counties must, as of July 1, 2027, require their BHSA providers to (subject to certain exceptions)

a. **Check whether an individual seeking services eligible for BHSA funding is enrolled in Medi-Cal and/or a commercial health plan, and if uninsured, refer the individual for eligibility screening**

b. **Bill the Medi-Cal Behavioral Health Delivery System for covered services for which the provider receives BHSA funding; and**

c. **Make a good faith effort to seek reimbursement from Medi-Cal Managed Care Plans (MCPs) and commercial health plans for covered services for which the provider receives BHSA funding**

Does the county wish to describe implementation challenges or concerns with these requirements?

No

Counties must monitor BHSA-funded providers for compliance with applicable requirements under the Policy Manual, the county's BHSA contract with DHCS, and state law and regulations. Effective SFY 2027-2028, counties must (1) adopt a monitoring schedule that includes periodic site visits and (2) preserve monitoring records, including monitoring reports, county-approved provider Corrective Action Plans (CAPs), and confirmations of CAP resolutions. Counties shall supply these records at any time upon DHCS's request. DHCS encourages counties to adopt the same provider monitoring schedule as under Medi-Cal: annual monitoring with a site visit at least once every three years. For providers that participate in multiple counties' BHSA programs, a county may rely on monitoring performed by another county.

Does the county intend to adopt this recommended monitoring schedule for BHSA-funded providers that:

Also participate in the county's Medi-Cal Behavioral Health Delivery System? (Reminder: Counties may simultaneously monitor for compliance with Medi-Cal and BHSA requirements)

Yes

Do not participate in the county's Medi-Cal Behavioral Health Delivery System?

Yes

Behavioral Health Services Act/Fund Programs

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress.

Behavioral Health Services and Supports (BHSS)

For related policy information, refer to 7.A.1 Behavioral Health Services and Supports Expenditure Guidelines

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General

Please select the specific Behavioral Health Services and Supports (BHSS) that are included in your plan

Adult and Older Adult System of Care (non-FSP)
Early Intervention Programs (EIP)
Outreach and Engagement (O&E)
Workforce, Education and Training (WET)

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program

For each program or service type that is part of the county's BHSS funded Adult and Older Adult System of Care (Non-FSP) program, provide the following information. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.2 Children's, Adult, and Older Adult Systems of Care

Please select the service types provided under Program

Mental health services
Supportive services

Please describe the specific services provided

Hyperion (Crisis Residential Treatment) is a Behavioral Health Services and Supports (BHSS) Adult and Older Adult System of Care (non-Full Service Partnership) program that provides Crisis Residential Treatment (CRT) services to adults and older adults experiencing acute behavioral health crises who require short-term, clinically supervised residential stabilization as an alternative to psychiatric hospitalization, incarceration, or homelessness.

Hyperion delivers Medi-Cal billable Crisis Residential Treatment services for individuals stepping down from acute psychiatric hospitalization or who are at imminent risk of psychiatric hospitalization due to worsening mental health symptoms. Services are provided in a licensed residential setting for up to 90 days and include 24-hour supervision, psychiatric and clinical oversight, medication support, therapeutic interventions, and recovery-oriented skill building designed to stabilize symptoms and support safe transition back to the community.

Clients served by Hyperion are not required to be previously enrolled in county behavioral health services but must have a diagnosed mental illness and meet clinical criteria indicating risk of higher-level care. During their stay, individuals are actively linked to ongoing behavioral health treatment, primary care, housing supports, social services, and community-based resources to promote continuity of care following discharge.

Referrals are accepted from Psychiatric Health Facilities, hospitals, probation, CalWORKs, shelters, and other county and community partners. The program prioritizes individuals at risk of homelessness, justice system involvement, institutionalization, or Lanterman-Petris-Short (LPS) conservatorship and supports individuals involved in Assisted Outpatient Treatment (AOT) when clinically appropriate.

Through short-term residential stabilization and coordinated discharge planning, Hyperion reduces avoidable psychiatric hospital admissions and lengths of stay, supports community reintegration, and advances BHSA goals related to access to care, reduction of institutionalization, and housing stability.

Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below

Plan Period by FY	**Projected Number of Individuals Served**

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	234
FY 2027 – 2028	234
FY 2028 – 2029	234

Please describe any data or assumptions the county used to project the number of individuals served through the Adult and Older Adult System of Care

Hyperion is a 10 bed Facility that is open 365 days a year. Individuals who are accepted to Hyperion average a length of stay of 14 days. Given a 90% occupancy rate the average number of consumers we would serve is 234.

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program

For each program or service type that is part of the county's BHSS funded Adult and Older Adult System of Care (Non-FSP) program, provide the following information. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.2 Children's, Adult, and Older Adult Systems of Care

Please select the service types provided under Program

Mental health services
Supportive services

Please describe the specific services provided

The Older Adults Program is a Behavioral Health Services and Supports (BHSS) Adult and Older Adult System of Care (non-FSP) program that provides outreach, engagement, and specialty mental health services to adults age 60 and older. The program prioritizes older adults who are unserved or underserved, including individuals experiencing social isolation, functional decline, housing instability, or barriers to accessing behavioral health care.

The program delivers outreach, engagement, prevention, and education services to identify older adults with unmet behavioral health needs and to reduce stigma associated with seeking care. Referrals are commonly received from Adult Protective Services, In-Home Supportive Services, community health clinics,

hospitals, PACE programs, and other community-based organizations. When a behavioral health need is identified, program staff assist individuals with navigation of the behavioral health system and linkage to appropriate specialty mental health, medical, social service, and community supports.

In addition to outreach and engagement activities, the Older Adults Program provides direct specialty mental health services to eligible clients who meet medical necessity criteria. Services include psychiatric services, medication support, individual and group therapy, intensive case management, and coordination with internal and external providers. Services are delivered in community settings and clinical locations to promote accessibility, continuity of care, and stabilization.

Through its combined outreach and service delivery model, the Older Adults Program improves access to care, increases coordination across systems serving older adults, supports symptom reduction and coping skills, and reduces the risk of crisis, homelessness, and institutionalization.

Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below

Plan Period by FY	**Projected Number of Individuals Served**
FY 2026 – 2027	120
FY 2027 – 2028	120
FY 2028 – 2029	120

Please describe any data or assumptions the county used to project the number of individuals served through the Adult and Older Adult System of Care

Projections are based on historical utilization data from the Older Adults Program. During FY 2023–2024, the program contacted approximately 120 older adults through outreach, prevention, and education activities and provided specialty mental health services to approximately 124 unduplicated clients. Humboldt County assumes stable service capacity, continued referral volume from community partners, and sustained demand for behavioral health services among adults age 60 and older. Projections also account for the lowered age threshold for older adults and the high prevalence of housing instability and access barriers within this population, supporting consistent annual service levels throughout the plan period.

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program

For each program or service type that is part of the county's BHSS funded Adult and Older Adult System of Care (Non-FSP) program, provide the following information. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.2 Children's, Adult, and Older Adult Systems of Care

Please select the service types provided under Program

Mental health services
Supportive services

Please describe the specific services provided

The Resident Engagement and Support Team (REST) program provides housing stabilization and engagement services to adults with behavioral health conditions who are experiencing homelessness or are at risk of homelessness and do not meet the level of care required for a Full-Service Partnership (FSP). REST operates within the county's Adult Outpatient System of Care and focuses on supporting individuals in maintaining housing stability and strengthening connections to behavioral health and community-based services. This program started out as an Innovation (INN) under the Mental Health Services Act (MHSA) in 10/01/2021 and is scheduled to term out of INN funding on 10/1/2026. Due to this, there are encumbered MHSA-INN funds in the Integrated Plan budget to account for this with the intent of utilizing BHSS Adult and Older Adult System of Care funding to support the program moving forward.

The program utilizes a Housing First–informed approach and provides field-based case management and peer support services. REST staff work with individuals transitioning from higher levels of care, including inpatient or crisis stabilization services, individuals stepping down from Full-Service Partnership programs, and adults currently receiving outpatient behavioral health services who are at risk of losing housing.

Services may include care coordination, connection to mental health and physical health services, coordination with housing providers and landlords, support with activities of daily living, development of daily structure and routines, linkage to community resources, and support in building coping skills that promote long-term stability. Staff also collaborate with family members, service providers, and housing partners to address barriers to housing retention.

Through these services, REST aims to improve housing stability, increase engagement in outpatient behavioral health treatment, and reduce the risk of homelessness and higher levels of system involvement among individuals with behavioral health needs.

Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	70
FY 2027 – 2028	70
FY 2028 – 2029	70

Please describe any data or assumptions the county used to project the number of individuals served through the Adult and Older Adult System of Care

The projected number of individuals served was estimated using historical utilization data from the Resident Engagement and Support Team (REST) program, which served 63 unduplicated individuals during fiscal year 2023–2024. The projections assume similar service demand and program capacity during the FY 2026–2029 plan period. Projections also assume continued demand for housing stabilization services among individuals transitioning from higher levels of care, including crisis stabilization services, inpatient settings, or step-down from more intensive behavioral health programs. Based on these factors, the county anticipates serving approximately 70 individuals annually during the FY 2026–2029 plan period.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3 , but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs .

Program or service name

Program Removed

Please select which of the three EI components are included as part of the program or service

Outreach
Access and Linkage: Screenings
Access and Linkage: Referrals

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs

Yes

Please select the EBPs and CDEPs that apply

Cognitive Behavioral Therapy (CBT) for Psychosis
Eye Movement Desensitization and Reprocessing (EMDR)

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
EMDR

Please describe intended outcomes of the program or service

Program Removed

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2

No

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	39
FY 2027 – 2028	42
FY 2028 – 2029	45

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Program Removed

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3 , but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs .

Program or service name
Hope Center

Please select which of the three EI components are included as part of the program or service
Outreach
Access and Linkage: Screenings
Access and Linkage: Assessments
Access and Linkage: Referrals
Access and Linkage: Other

Please specify "other" type of Access and Linkage
Peer-led navigation and warm handoff support, including accompaniment during calls to behavioral health providers, follow-up on referral status, assistance understanding service options, and linkage to community-based supports that address early behavioral health risk factors (e.g., housing instability, social isolation, food insecurity).

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs
No

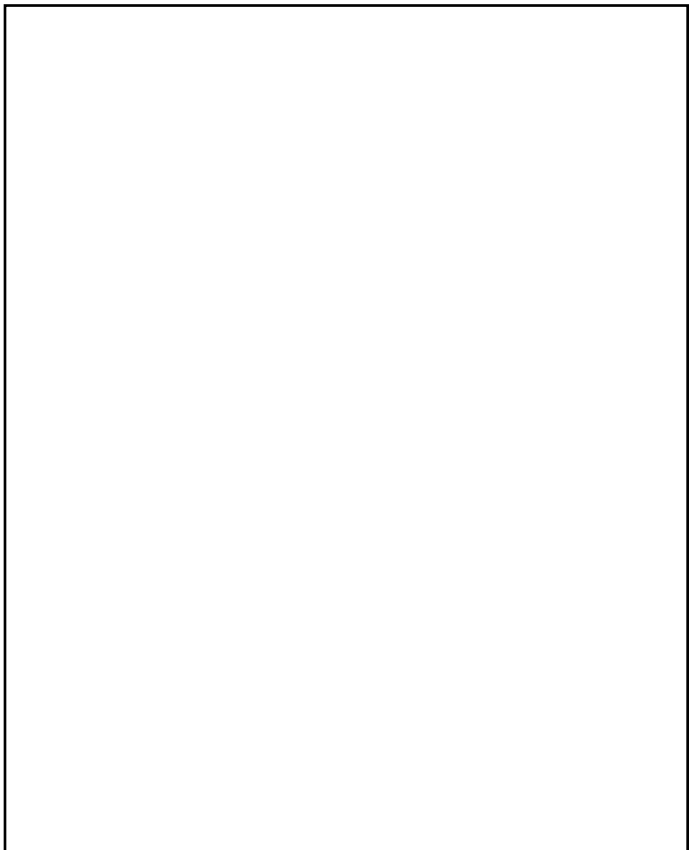
Please describe intended outcomes of the program or service
The intended outcomes of the Hope Center – Early Intervention Peer Support and Linkage Program are to identify individuals experiencing early signs of mental health or substance use challenges, reduce barriers to accessing care, and prevent the escalation of behavioral health needs. Outcomes include increased early identification of behavioral health risk factors; improved participant knowledge of available behavioral health and community resources; increased successful referrals and warm handoffs to appropriate levels of care; reduced stigma associated with help-seeking; and strengthened protective factors such as social connection, self-efficacy, and engagement in wellness-oriented activities. The program aims to support timely access to services and reduce the likelihood of crisis-level intervention through early engagement and peer-driven support.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
Yes

Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program

Additional priority name	Description
Peer-Led Early Identification and Navigation for At-Risk Individuals	Humboldt County included this priority to address gaps in early identification and engagement for individuals who may not yet meet diagnostic criteria but are experiencing early behavioral health symptoms, functional challenges, or known risk factors such as trauma exposure, housing instability, or social isolation. Peer-led engagement increases trust, reduces stigma, and supports earlier connection to appropriate services, particularly for underserved populations. Program effectiveness will be assessed using the following metrics: Number of individuals engaged through peer-led

outreach and early identification activities; Number and percentage of participants receiving screening or brief assessment; Number of referrals made to behavioral health or supportive services; Percentage of referrals resulting in successful linkage or completed warm handoff; Participant-reported increases in knowledge of services and willingness to seek help; Reduction in reported barriers to accessing care; Participant satisfaction with peer support and navigation services.



Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	1100
FY 2027 – 2028	1150
FY 2028 – 2029	1200

Please describe any data or assumptions the county used to project the number of individuals served through EI programs

The projected number of individuals served is based on historical Hope Center utilization data and adjusted to reflect Early Intervention–allowable activities under BHSA. During FY 2023–2024, the Hope Center served approximately 1,108 unduplicated individuals through peer engagement, outreach, and linkage activities. Projections assume a stable level of community demand for early identification and navigation services, with modest annual growth driven by expanded outreach, increased peer certification capacity, hybrid service delivery options, and improved referral pathways. Estimates reflect unduplicated individuals receiving EI-eligible services, including outreach, screening, brief assessment, and access and linkage, and exclude individuals receiving ongoing treatment services.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3 , but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs .

Program or service name

Latinx Liaison

Please select which of the three EI components are included as part of the program or service

Outreach
Access and Linkage: Referrals
Access and Linkage: Other

Please specify "other" type of Access and Linkage

The Latinx Liaison provides culturally and linguistically responsive engagement, navigation, and access support for Hispanic/Latino/Spanish-speaking community members who may be experiencing early signs of behavioral health distress or who face risk factors associated with unmet mental health or substance use needs. Through trusted, community-based outreach and relationship-building, the Liaison supports early identification of needs, increases understanding of available behavioral health services, and facilitates timely access and warm linkage to appropriate programs and supports. This role reduces cultural, linguistic, and system navigation barriers that often delay care, helping individuals connect to services earlier and before needs escalate to crisis or higher levels of intervention.

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs

No

Please describe intended outcomes of the program or service

The intended outcomes of the Latinx Liaison program are to improve early identification of behavioral health needs among Hispanic/Latino/Spanish-speaking community members, increase timely access and linkage to appropriate behavioral health and supportive services, and reduce delays in care caused by cultural, linguistic, and systemic barriers. By engaging individuals at earlier stages of need and increasing awareness of available services, the program aims to prevent the escalation of untreated behavioral health concerns to crisis, emergency, or higher levels of care. Additional outcomes include increased engagement of underserved populations in the behavioral health system and improved equity in access to services.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2

No

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	75
FY 2027 – 2028	100
FY 2028 – 2029	125

Please describe any data or assumptions the county used to project the number of individuals served through EI programs

Projections are based on the anticipated implementation of a dedicated Spanish-speaking Latinx Liaison position focused on culturally and linguistically responsive outreach, engagement, and access and linkage to behavioral health services. Because the position was not filled at the time of reporting, estimates reflect conservative assumptions regarding start-up, onboarding, and initial community engagement in the first year, with increased reach in subsequent years as community awareness, trust, and coordination with Behavioral Health programs expand. Counts represent unique individuals engaged through outreach, education, navigation, and linkage activities consistent with Early Intervention indicated prevention and case identification.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3 , but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs .

Program or service name

Positive School Climate, Multi-Tiered System of Support (MTSS)

Please select which of the three EI components are included as part of the program or service

Access and Linkage: Screenings
Access and Linkage: Assessments
Access and Linkage: Referrals

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs

No

Please describe intended outcomes of the program or service

Through comprehensive school climate transformation grounded in Multi-Tiered System of Supports (MTSS), Positive Behavioral Interventions and Supports (PBIS), Universal Design for Learning (UDL), and Restorative Practices (RP), schools can expect measurable improvements across multiple indicators of student well-being and success. These data-driven interventions, guided by behavioral data systems such as the School Wide Information System (SWIS), enable educators to identify patterns, target supports precisely, and monitor progress with precision. These integrated frameworks demonstrably reduce office discipline referrals by addressing behavioral concerns proactively and restoratively, while simultaneously improving attendance and reducing chronic absenteeism—a considerable concern in Humboldt County—by creating environments where students feel safe, valued, and engaged. As students experience consistent opportunities to learn and practice prosocial behaviors within supportive, culturally responsive communities, academic outcomes improve alongside social-emotional development, creating upward spirals of competence and confidence. Perhaps most significantly, these preventative approaches reduce the number of students requiring referrals to special education or intensive Tier 3 interventions, including mental health services, by ensuring that universal supports are robust enough to meet diverse needs and that early intervention catches struggles before they become entrenched. This shift represents not only improved outcomes for individual students but also more equitable, sustainable use of limited educational and mental health resources across the community.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2

Yes

Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program

Additional priority name	Description
Positive Behavioral Interventions and Supports (PBIS)	PBIS explicitly teaches and reinforces prosocial behaviors—like conflict resolution, emotional regulation, and positive peer interactions—that are core protective factors for mental health, while creating predictable, safe environments that reduce anxiety and behavioral dysregulation.
Universal Design for Learning (UDL)	UDL removes barriers to engagement and success by honoring diverse learning needs, which builds self-efficacy, reduces frustration, and prevents the learned helplessness that often precedes depression and anxiety.

Restorative Practices (RP)	Restorative Practices represent a transformative approach to building inclusive school communities by centering equity of voice and repairing harm through dialogue rather than exclusion. When students violate school expectations, restorative approaches create opportunities for those who caused harm to understand its impact, make meaningful amends to those affected, and develop the social-emotional skills needed to make different choices—turning disciplinary moments into powerful learning experiences rather than punitive dead-ends.

Social Emotional Learning (SEL)	Helps children and adults manage emotions, set goals, build positive relationships, and make responsible decisions. It improves academic performance, increases school attendance, reduces behavioral issues, and enhances long-term, life-long skills.

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	**Projected Number of Individuals Served**
FY 2026 – 2027	1387
FY 2027 – 2028	2420
FY 2028 – 2029	3725

Please describe any data or assumptions the county used to project the number of individuals served through EI programs

Enrollment data from 24/25 was used along with projections of additional schools that have been reaching out for support with PBIS.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3 , but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs .

Program or service name

Parent Partners

Please select which of the three EI components are included as part of the program or service

Outreach
Access and Linkage: Referrals
Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs

No

Please describe intended outcomes of the program or service

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

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

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2

No

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	63
FY 2027 – 2028	66
FY 2028 – 2029	68

Please describe any data or assumptions the county used to project the number of individuals served through EI programs

Forecasts for number of clients served were calculated using historical data and assumes similar staffing levels reach projected totals.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3 , but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs .

Program or service name

Transition-Age Youth (TAY) Advocacy and Peer Support

Please select which of the three EI components are included as part of the program or service

Outreach
Access and Linkage: Referrals
Access and Linkage: Other

Please specify "other" type of Access and Linkage

Youth Leadership Development: Youth Leadership Development is perhaps the core component of the HCTAYC program, 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. 1) This development is the transference of skills to, and the continual support and supervision of, Youth Advocacy Board (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. 2) Participants receive training on different elements of leadership and education on advocacy topics. Higher-level leaders go through a more intensive orientation process. 3) The format of the YAB, with multiple affinity-based committees, allows members to develop relatedness with peers with similar lived experiences, while also receiving consistent support and guidance from HCTAYC youth organizers (staff). 4) Youth exercise autonomy through identifying program priorities, modifying program function, and by driving content creation. 5) 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. 6) 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.

Advocacy: Advocacy is operationalized through two means; systems change and individual advocacy. Systems change is enacted through youth organizers (staff) supporting the YAB to attend and participate in policy setting, decision making tables, and correspondence. This includes participation at local, state, and national policy tables and related coalitions or collaboratives, letters of support/opposition, and direct communication with policy makers/legislators. Individual advocacy occurs when HCTAYC Youth Organizers and/or Peer Coaches support young people in self-advocacy during their own care coordination. This is also done through participating in advocacy to amplify the youth's wishes, assisting youth in preparing speaking points for their case planning meetings, and attending said meetings to support the youth's desired outcome.

Trainings and Events: Trainings take a cultural competence and/or cultural humility approach. Each training is uniquely developed within the context of youth-adult partnership, with young people taking the lead of developing curriculum with staff support. Training focuses on youth culture and the ways in which systems impact youth wellness, as well as developing specific knowledge, skills, and attitudes of participants. Events focus on concepts of behavioral health stigma reduction, outreach and information regarding behavioral health services, and wellness resilience development. These events occur in multiple formats, all of which are youth driven. Trainings for professionals and community members focus on TAY-specific mental health challenges, other challenges/barriers/and strengths with this population, and the engagement of this population. This includes special populations particularly impacted by stigma and discrimination such as LGBTQIA+ and two-spirit youth, Indigenous Youth, foster youth, juvenile justice youth, homeless youth, and youth experiencing substance-use related issues.

Activity coordination: Activity coordination is done to provide young people skill development opportunities, wellness and self-care, and community building skills for young people. Peer Coaches lead monthly workshops and events, often in response to youth requests and identified needs. Activity coordination varies from regular oversight of the TAY Center drop-in hours, where young people can access

service providers, computers, linkage with CalFresh and food resources, clothing closet and hygiene supplies, to facilitating workshops on self-care, healthy relationships, wellness, and life skills.

Relationship building and mentoring: 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 can grow in the same ways they have been able to, making them unique in their ability to relate, provide support, and model self-advocacy, recovery, and self-care skills. Build relationships with young people in ways that create validation, inspire hope, and support program participants through empowerment and trust. Build mutuality in their relationships with young people, creating a relationship built on respect, compassion, and reciprocity. Through this unique relationship, young people can build self-determination, self-esteem, and gain skills necessary for transition into adulthood. 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. Can assist young people in building their relational capacity by supporting them when accessing social, vocational, or educational opportunities.

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs
No

Please describe intended outcomes of the program or service
HCTAYC: Young people 16-26 with lived experience in the foster care, juvenile justice, behavioral health, and homelessness services systems will be empowered to share their voice in meaningful ways to drive systems change as part of the Youth Advocacy Board (YAB). YAB will consist of 10-15 members.
Gather comprehensive outcomes data to report on leadership development as well as outcomes related to the specific PEI domains for Youth Leadership Development.
Facilitate two (2) youth-leadership development trainings for HCTAYC members and the general transition-age youth community.
Participate in advocacy and policy tables at the local, state, and national level relevant to youth issues and needs. Identify local policy advocacy needs.
Facilitate two (2) positive-youth development, stigma-discrimination reduction, or youth engagement trainings for youth-serving professionals.
Attend one (1) conference focused on the system of care for TAY.
Facilitate one (1) creative leadership retreat or intensive workshop for the transition-age youth community.

Maintain participation in the HUD YHDP homeless youth action committee and youth participation in the Homeless and Housing Continuum of Care (CoC).
Provide comprehensive wellness programming focusing on the eight (8) domains of wellness identified by SAMHSA.

Peer Support: Staff the TAY drop-in Center offering outreach, engagement and linkage to resources and referrals.
Provide individual mentorship to assigned caseloads from the referral process.
Provide outreach and information to needed populations by providing presentations, tabling, street outreach, and collaborating with other youth-serving agencies.
Facilitate and engage youth in wellness, stigma reduction and resiliency-building activities.
Build supportive relationships while youth are waiting to receive or to be connected to other needed services.
Support youth with system navigation, advocacy needs and referrals.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
No

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	**Projected Number of Individuals Served**
FY 2026 – 2027	423
FY 2027 – 2028	490
FY 2028 – 2029	557

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
A linear regression model was generated using the last 5 years of data. Since fiscal year 2020-2021, the number of unique individuals visiting and integrating with TAY has been on the upswing. Number model predications see this trend continuing, with an average increase of 67 unique individuals visiting and interacting with TAY each fiscal year.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3 , but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs .

Program or service name
Warm Line

Please select which of the three EI components are included as part of the program or service
Outreach
Access and Linkage: Screenings
Access and Linkage: Referrals
Access and Linkage: Other

Please specify "other" type of Access and Linkage
The Warm Line provides real-time emotional support, navigation, and care coordination for individuals experiencing early signs of mental health or substance use–related distress. Services include brief problem identification, normalization of distress, motivational support, and warm handoffs to appropriate community-based behavioral health, social service, and prevention resources. The Warm Line supports case identification and early engagement by helping callers clarify needs and facilitating timely access to care before conditions escalate to crisis or require higher levels of intervention.

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs
No

Please describe intended outcomes of the program or service
The intended outcomes of the Warm Line are to increase early identification of behavioral health needs, reduce barriers to accessing services, and improve timely linkage to appropriate community-based behavioral health and supportive resources. The program aims to support individuals experiencing early signs of mental health or substance use–related distress before conditions escalate to crisis, emergency department utilization, or higher levels of care. Additional outcomes include increased awareness of

available services, improved care navigation, and enhanced engagement among individuals who may not otherwise seek formal behavioral health supports.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
No

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	50
FY 2027 – 2028	60
FY 2028 – 2029	70

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Projections are based on historical Warm Line utilization data from Fiscal Year 2023–2024, during which the program served 40 individuals. The county assumed modest annual increases in utilization reflecting continued community need for low-threshold early intervention supports, gradual increases in program awareness, and stable staffing and operating capacity. Projections do not assume expansion of service hours or scope and are intended to reflect conservative; achievable estimates aligned with the Warm Line's role as an Early Intervention access and linkage resource.

Coordinated Specialty Care for First Episode Psychosis (CSC) program

For related policy information, refer to 7.A.7.5.1 Coordinated Specialty Care for First Episode Psychosis .

Please provide the following information on the county's Coordinated Specialty Care for First Episode Psychosis (CSC) program

CSC program name

Humboldt Early Psychosis Intervention (HEPI) Program

CSC program description

The Humboldt Early Psychosis Intervention program (HEPI) is embedded within the Transitional Age Youth Behavioral Health program (TAY-BH). Youth meeting the HEPI criteria are offered group therapy, individual therapy, family support services, peer support services, medication referrals with ongoing support, and case management services. The focus of HEPI is to help young people remain with their families and/or in their community at the highest level of independence possible while maintaining and increasing their capacity for learning and enhancing self-sufficiency. Behavioral Health services, which include peer coaching, are integrated with support and programming provided by Child Welfare Services (CWS) social workers, CalWORKS case managers and Housing, Outreach & Mobile Engagement (HOME) program coordinators.

In 2023, TAY leadership began working with Epi-Cal to identify barriers and strategically plan for better implementation of the HEPI program. TAY has met monthly with Epi-Cal, attended each quarterly learning collaborative meeting, and has begun training staff in Coordinated Specialty Care (CSC). Further, to address the unique barriers rural counties are facing, Humboldt County DHHS leadership, along with leadership from Siskiyou County, met for an additional session with Epi-Cal in order to discuss specific needs related to First Episode Psychosis (FEP) for rural counties.

HEPI staff use the following Evidenced Based Practices (EBP's): Coordinated Specialty Care (CSC), The Transition to Independence Process (TIP) Model, Cognitive Behavioral Therapy for psychosis (CBTp) and Eye Movement Desensitization and Reprocessing (EMDR). Each of these EBP's has outcome tools attached to them that tmonitor progress and provide outcome data in a number of life domains.

DHCS will provide counties with information to complete the estimated fields for eligible population and practitioners/teams needed for CSC. The estimated numbers of teams/practitioners reflect the numbers needed to reach the entire eligible population (i.e., achieve a 100 percent penetration rate), and DHCS recognizes that counties will generally not be able to reach the entire eligible population. These projections are not binding and are for planning purposes. In future guidance, DHCS will provide more information on the number of teams counties must implement to demonstrate compliance with BHSA CSC requirements

Please review the total estimated number of individuals who may be eligible for CSC (based on the Service Criteria in the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Evidence Based Practice (EBP) Policy Guide and the Policy Manual Chapter 7, Section A.7.5). Please input the estimates provided to the county in the table below.

CSC Eligible Population	**Estimates**
Number of Medi-Cal Enrolled Individuals	26
Number of Uninsured Individuals	<11*

CSC Practitioners and Teams Needed	**Estimates**
Number of Practitioners Needed to Serve Total Eligible Population	4.25
Number of Teams Needed to Serve Total Eligible Population	1

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for BHSS, please provide the total number of teams and Full-Time Equivalents (FTEs) (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTE) to provide CSC over this Integrated Plan period, by fiscal year.

County Actuals	**FY 26-27**	**FY 27-28**	**FY 28-29**

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	1	2	2
Total Number of Teams	1	1	1

Will the county's CSC program be supplemented with other (non-BHSA) funding source(s)?
Yes

Please list the other funding source(s)
Mental Health Block Grant

Outreach and Engagement (O&E) Program

For each program or activity that is part of the county's standalone O&E programs provide the following information. If the county provides more than one program or activity, use the "Add" button. For related policy information, refer to 7.A.3 Outreach and Engagement .

Program or activity name
Regional Services

Please describe the program or activity
Regional Services is a Behavioral Health Services and Supports (BHSS) program with an Outreach and Engagement (O&E) function that delivers community-based specialty mental health services to adults and older adults living in geographically isolated and underserved areas of Humboldt County. The program prioritizes individuals who experience barriers to accessing care due to rural location, transportation limitations, service scarcity, or risk of untreated behavioral health conditions.

Regional Services provides mobile and office-based behavioral health services across Northern, Central, Southern, and Eastern Humboldt County, including Eureka, McKinleyville, Garberville, Willow Creek, Weitchpec, and surrounding rural communities. Services are delivered in clients' homes, community

settings, partner locations, and County Behavioral Health offices to ensure timely access to care.

Program staff include Behavioral Health Clinicians, Case Managers, and Substance Use Disorder (SUD) Counselors who conduct outreach, screening, and assessment; provide ongoing individual therapy; deliver case management and rehabilitation services; and facilitate linkage to specialty mental health, substance use disorder treatment, medical care, housing supports, and other community-based resources. Services are provided to individuals who meet specialty mental health medical necessity criteria and are delivered in accordance with the County Mental Health Plan and applicable clinical and documentation standards.

Regional Services maintains strong partnerships with Tribal health programs, community health centers, hospitals, social services, senior centers, law enforcement, and community-based organizations to identify individuals in need of care, reduce service gaps, and improve continuity of services. Through its outreach and engagement activities, the program improves access to behavioral health services, supports stabilization and recovery, and reduces the risk of crisis, hospitalization, and institutionalization among rural and underserved populations.

Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below

Plan Period by FY	**Projected Number of Individuals Served**
FY 2026 – 2027	85
FY 2027 – 2028	90
FY 2028 – 2029	95

Please describe any data or assumptions the county used to project the number of individuals served through O&E programs

Projections are based on historical utilization data from the Regional Services program, which served 81 unduplicated individuals during FY 2023–2024. Humboldt assumed modest annual growth reflecting stabilization of staffing levels, continued outreach to rural and underserved communities, and sustained demand for mobile and community-based behavioral health services in areas with limited access to care. Incremental increases in projected individuals served account for improved referral pathways with community partners, increased engagement activities, and continued prioritization of individuals at risk of untreated behavioral health conditions, crisis, or institutionalization.

County Workforce, Education, and Training (WET) Program

As described in the Policy Manual, WET activities should supplement, but not duplicate, funding available through other state-administered workforce initiatives, including the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative administered by the Department of Health Care Access and Information (HCAI). Counties should prioritize available BH-CONNECT and other state-administered workforce programs whenever possible. Responses in this section should address the county's WET program. Other workforce efforts should be addressed in the Workforce Strategy section of the Integrated Plan (IP).
For each program or activity that is part of the county's overall WET program, provide the following information. If the county provides more than one program or activity type, use the "Add" button. For related policy information, refer to 7.A.4 Workforce Education and Training .

Program or activity name
Relias E-Learning

Please select which of the following categories the activity falls under
Workforce Recruitment, Development, Training, and Retention

Please describe efforts to address disparities in the Behavioral Health workforce.
Additional information regarding diversity of the behavioral health workforce can found in Policy Manual Chapter 7, Section A.4.9
Humboldt County 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.

This activity also supports the Humboldt's broader efforts to address workforce disparities by ensuring staff have access to consistent training that can strengthen cultural responsiveness, equity-informed practice, and readiness to serve diverse racial, ethnic, linguistic, geographic, and lived-experience communities. This training infrastructure supports other workforce initiatives aimed at improving recruitment, retention, and diversity within the Behavioral Health workforce.

County Workforce, Education, and Training (WET) Program

As described in the Policy Manual, WET activities should supplement, but not duplicate, funding available through other state-administered workforce initiatives, including the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative administered by the Department of Health Care Access and Information (HCAI). Counties should prioritize available BH-CONNECT and other state-administered workforce programs whenever possible. Responses in this section should address the county's WET program. Other workforce efforts should be addressed in the Workforce Strategy section of the Integrated Plan (IP).
For each program or activity that is part of the county's overall WET program, provide the following information. If the county provides more than one program or activity type, use the "Add" button.
For related policy information, refer to 7.A.4 Workforce Education and Training .

Program or activity name
Peer Certification

Please select which of the following categories the activity falls under
Professional Licensing and/or Certification Testing and Fees

Please describe efforts to address disparities in the Behavioral Health workforce.
Additional information regarding diversity of the behavioral health workforce can found in Policy Manual Chapter 7, Section A.4.9
Peer Certification: Humboldt County Behavioral Health will use BHSA WET funds to support county behavioral health peer staff in obtaining and maintaining Medi-Cal Peer Support Specialist Certification through CalMHSA. Funds may be used for certification-related costs such as required training, application fees, examination fees, renewal fees, and other allowable costs necessary to prepare for, obtain, or maintain certification. This activity supports development and retention of staff with lived experience and strengthens Humboldt's ability to provide culturally responsive, recovery-oriented peer support services within the behavioral health delivery system.

County Workforce, Education, and Training (WET) Program

As described in the Policy Manual, WET activities should supplement, but not duplicate, funding available through other state-administered workforce initiatives, including the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce

initiative administered by the Department of Health Care Access and Information (HCAI). Counties should prioritize available BH-CONNECT and other state-administered workforce programs whenever possible. Responses in this section should address the county's WET program. Other workforce efforts should be addressed in the Workforce Strategy section of the Integrated Plan (IP).
For each program or activity that is part of the county's overall WET program, provide the following information. If the county provides more than one program or activity type, use the "Add" button. For related policy information, refer to 7.A.4 Workforce Education and Training .

Program or activity name
Consultation and Training

Please select which of the following categories the activity falls under
Workforce Recruitment, Development, Training, and Retention

Please describe efforts to address disparities in the Behavioral Health workforce.
Additional information regarding diversity of the behavioral health workforce can found in Policy Manual Chapter 7, Section A.4.9
Consultation and Training: Behavioral Health will continue its consultation work with Stepping Stone Consulting in order to continue the branch wide equity work and to offer more robust cultural coaching opportunities to staff. County Behavioral Health will also consider contracting with other appropriate consultants and training providers to specifically address culturally responsive engagement within the community, as needed. For instance, WET funding will also be utilized to cover costs associated in the implementation of a Transgender, Gender Diverse, or Intersex (TGI) training that is required as part of DHCS's Behavioral Health Information Notice (BHIN) 25-019.

Full Service Partnership Program

DHCS will provide counties with information to complete the estimated fields for eligible population and practitioners/teams needed for each EBP. The estimated numbers of teams/practitioners reflect the numbers needed to reach the entire eligible population (i.e., achieve a 100 percent penetration rate), and DHCS recognizes that counties will generally not be able to reach the entire eligible population, in consideration of BHSA funding availability. These projections are not binding and are for planning purposes only. In future guidance, DHCS will provide more information on the number of teams counties must implement to demonstrate compliance with BHSA FSP requirements. For related policy information, refer to 7.B.3 Full Service Partnership Program Requirements and 7.B.4 Full Service Partnership Levels of Care

Please review the total estimated number of individuals who may be eligible for each of the following Full Service Partnership (FSP) services (consistent with the Service Criteria in the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Evidence-Based Practice (EBP) Policy Guide , the Policy Manual Chapter 7, Section B , and forthcoming High Fidelity Wraparound (HFW) Medi-Cal Guidance): Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT), Full Service Partnership (FSP) Intensive Case Management (ICM), HFW and Individual Placement and Support (IPS) Model of Supported Employment). Please input the estimates provided to the county in the table below

Total Adult FSP Eligible Population	**Estimates**
Number of Medi-Cal Enrolled Individuals	595
Number of Uninsured Individuals	65
Number of Total FSP Eligible Individuals with Some Justice-System Involvement	272

Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT) Eligible Population

Please input the estimates provided to the county in the table below

ACT Eligible Population	**Estimates**
Number of Medi-Cal Enrolled Individuals	105

ACT Eligible Population	Estimates
Number of Uninsured Individuals	12

FACT Eligible Population (ACT with Justice-System Involvement)	Estimates
Number of Medi-Cal Enrolled Individuals	53
Number of Uninsured Individuals	6

ACT/FACT Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	20
Number of Teams Needed to Serve Total Eligible Population	<11*

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and Full-Time Equivalents (FTEs) (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTEs) to provide ACT and FACT over this Integrated Plan period, by fiscal year. DHCS will provide further guidance and Technical Assistance (TA) to assist counties with completing these fields.

County Actuals	FY 26-27	FY 27-28	FY 28-29

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	0	0	0
Total Number of Teams	0	0	0

Full Service Partnership (FSP) Intensive Case Management (ICM) Eligible Population

Please input the estimates provided to the county in the table below

FSP ICM Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	437
Number of Uninsured Individuals	47

FSP ICM Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	20

FSP ICM Practitioners and Teams Needed	Estimates
Number of Teams Needed to Serve Total Eligible Population	4

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and FTEs (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTEs) to provide FSP ICM over this Integrated Plan period, by fiscal year. DHCS will provide further guidance and TA to assist counties with completing these fields.

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	17	17	17
Total Number of Teams	1	1	1

High Fidelity Wraparound (HFW) Eligible Population

Please input the estimates provided to the county in the table below

HFW Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	220

HFW Eligible Population	Estimates
Number of Uninsured Individuals	15

HFW Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	82
Number of Teams Needed to Serve Total Eligible Population	4

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and FTEs (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTE) to provide HFW over this Integrated Plan period, by fiscal year. DHCS will provide further guidance and TA to assist counties with completing these fields.

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	4	5	5
Total Number of Teams	1	1	1

Individual Placement and Support (IPS) Eligible Population

Please input the estimates provided to the county in the table below

IPS Eligible Population	**Estimates**
Number of Medi-Cal Enrolled Individuals	657
Number of Uninsured Individuals	75

IPS Practitioners and Teams Needed	**Estimates**
Number of Practitioners Needed to Serve Total Eligible Population	47.5
Number of Teams Needed to Serve Total Eligible Population	19

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and FTEs (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTE) to provide IPS over this Integrated Plan period, by fiscal year.

County Actuals	**FY 26-27**	**FY 27-28**	**FY 28-29**
Total Number of Practitioners	0	0	0

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Teams	0	0	0

Full Service Partnership (FSP) Program Overview

Please provide the following information about the county's BHSA FSP program

Will any of the estimated number of practitioners the county plans to utilize (provided above) be responsible for providing more than one EBP?
No

Please describe how the county is employing a whole-person, trauma-informed approach, in partnership with families or an individual's natural supports
Humboldt County's Full-Service Partnership (FSP) model uses a "whatever it takes"/wraparound approach that is community-based, whole-person, trauma-informed, recovery-focused, and delivered in partnership with families or an individual's natural supports, consistent with BHSA FSP requirements.

The County's Comprehensive Community Treatment (CCT) approach provides individualized, team-based supports that include treatment, crisis intervention, medication management, case management, peer support, transportation assistance, family education, connection to vocational/employment supports, co-occurring supports, and socialization/recreational activities based on the individual's goals and needs.

In addition, the County integrates care across settings and systems by providing 24/7 crisis response through the Crisis Stabilization Unit and coordinating with Sempervirens Psychiatric Health Facility on discharge planning to support community return and reduce rehospitalization.

Please describe the county's efforts to reduce disparities among FSP participants
Humboldt County monitors disparities and access patterns among FSP participants using demographic and outcomes data (via DHCS Data Collection and Reporting). For example, the County tracks race/ethnicity and gender distribution of participants and uses those data to inform outreach, engagement, and service design (e.g., ensuring the model is equipped to serve a diverse population and reduce barriers to participation).

The County's FSP service array also addresses key disparity drivers (e.g., homelessness, crisis utilization, hospitalization, and justice involvement) through intensive, community-based supports, including linkages to housing/food resources and other whole-person supports that are often critical for underserved populations.

Select which goals the county is hoping to support based on the county's allocation of FSP funding

Access to care
Homelessness
Institutionalization
Justice involvement
Untreated behavioral health conditions
Overdoses
Social connection
Quality of life
Prevention of co-occurring physical health conditions
Suicides
Care experience

Please describe what actions or activities the county behavioral health system is doing to provide ongoing engagement services to individuals receiving FSP ICM

Humboldt County provides ongoing engagement for FSP participants through intensive, team-based CCT services (inspired by ACT) that maintain participant involvement in care and recovery.

BHSA requires counties to provide ongoing engagement services to maintain continued treatment, which may include peer support, transportation, consumer-operated/recovery-oriented services, and services that support maintaining housing. Humboldt's FSP model reflects these elements through 24/7 crisis response access, coordinated discharge planning with inpatient psychiatric services, ongoing case management and medication support, transportation supports, and linkages to housing and other community resources to sustain stability and engagement.

Ongoing engagement services is a required component of ACT, FACT, IPS, and HFW. Please describe any ongoing engagement services the county behavioral health system will provide beyond what is required of the EBP

In addition to engagement embedded within the required high-intensity models, Humboldt County's FSP approach includes enhanced wraparound engagement supports such as family education and involvement, assistance with accessing food/housing and other community resources, socialization and recreational activities, and linkage to vocational/education supports, tailored to individual goals and needs.

The County also strengthens continuity and engagement during transitions by coordinating with inpatient psychiatric care to support discharge planning and reduce re-hospitalization, and by ensuring participants have access to 24/7 crisis response through the Crisis Stabilization Unit.

Please describe how the county will comply with the required FSP levels of care (e.g., transition FSP ICM teams to ACT, stand up new ACT teams and/or stand up new FSP ICM teams, etc.)

Under BHSA, counties are required to provide standardized FSP levels of care aligned with evidence-based or community-defined practices, including ACT, FACT, or FSP ICM, unless an approved exemption is granted. Humboldt County qualifies as a small county and plans to formally request an ACT exemption based on workforce limitations, geographic dispersion, and challenges in sustaining ACT fidelity at scale. In lieu of ACT, the County will continue to operate FSP ICM teams that meet BHSA requirements for intensity, accessibility, and ongoing engagement. Humboldt County's FSP model is delivered through the Comprehensive Community Treatment (CCT) program, which is inspired by the ACT model and provides high-intensity, community-based, multidisciplinary services to individuals at risk of hospitalization, incarceration, homelessness, or placement in more restrictive settings.

These FSP ICM teams provide individualized, recovery-oriented services including case management, medication support, crisis intervention, peer support, transportation, coordination with inpatient psychiatric facilities, and linkage to housing, employment, and other community supports, consistent with BHSA FSP requirements.

Please indicate whether the county FSP program will include any of the following optional and allowable services

N/A

Primary substance use disorder (SUD) FSPs

No

Outreach activities related to enrolling individuals living with significant behavioral health needs in an FSP (activities that fall under assertive field-based initiation of substance use disorder treatment services will be captured separately in the next section)

No

Other recovery-oriented services
Yes

Please describe the other recovery-oriented services the county's FSP program will include
We have a specialized Dual Recovery program that individuals with an SUD diagnosis are eligible to attend. This program offers group and individual services to our FSP participants.

If there are other services not described above that the county FSP program will include, please list them here. For team-based services, please include number of teams. If no additional FSP services, use "N/A"
N/A

What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible children and youth in the development of the county's FSP program (e.g., review data, engage with stakeholders, analyze research, etc.) who are:

In, or at-risk of being in, the juvenile justice system
Humboldt is currently reviewing our policies and procedures around Children and Youth FSP programs with the goal of opening our FSP program to this population. Humboldt has some collaborative contact with the TAY Program, which runs their own advisory board; issues and concerns are lifted through administration.

To inform this review, Humboldt considered TAY/HCTAYC youth engagement data, including survey information from youth and young adults participating in MHSA-funded events and trainings. HCTAYC demographic information was obtained from 221 demographic surveys completed by individuals participating in 40-MHSA-funded events or trainings between July 1, 2024, and June 30, 2025. Out of the youth that participated in this survey, fifty-five percent (55%) reported experiences with homelessness, thirty-four percent (34%) had not, and twenty percent (20%) reported past involvement in the juvenile justice system.

Community input was also considered through ongoing collaboration with the TAY Program, Youth Advocacy Board, Family Advisory Board, DHHS Administration, Humboldt County office of Education (HCOE), and other community partners involved in BHSA planning. Through MHSA/BHSA outreach efforts, Humboldt's broader community planning process also includes youth with lived experience, families, providers, public safety partners including juvenile justice agencies, local education agencies, child welfare, Tribal partners, and community-based organizations serving culturally and linguistically diverse communities.

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)
Humboldt is currently reviewing policies and procedures around Children and Youth FSP programs with the goal of opening the FSP program to this population.

To inform this review, Humboldt considered MHSA/BHSA community engagement data and HCTAYC youth engagement information. In the 2025-2026 MHSA planning process, 30% of participants identified as LGBTQ, and the broader 2023 community survey included respondents who identified as gender queer, transgender, and another gender identity. Humboldt's Cultural Competence Plan also notes that HCTAYC has developed policy recommendations for LGBTQI+ and Two-Spirit Transition Age Youth, including recommendations related to safe and affirming youth-serving environments, specialized mental health and substance use services, outreach and access, and peer professionals who reflect the diversity of LGBTQI+ and Two-Spirit youth.

Community input was also considered through ongoing collaboration with the TAY Program, Youth Advocacy Board, Family Advisory Board, DHHS Administration, HCTAYC, and other community partners involved in BHSA planning.

In the child welfare system
Humboldt is currently reviewing policies and procedures around Children and Youth FSP programs with the goal of opening the FSP program to this population.

To inform this review, Humboldt considered MHSA/BHSA community engagement data and youth input gathered through TAY/HCTAYC activities. In the 2025-2026 MHSA planning process, 30% of participants reported child welfare experience, which included engagement from current and former foster youth, transition age youth, clients, family members, providers, and community-based organizations as participants in the community engagement process. Community input was considered through ongoing collaboration with the TAY Program, Youth Advocacy Board, Family Advisory Board, DHHS Administration, Humboldt County Office of Education, child welfare partners, and other community partners involved in BHSA planning.

What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible adults **in the development of the county's FSP (e.g., review data, engage with stakeholders, analyze research, etc.) who are**

Older adults
We have a specialized program for Older Adults funded through MHSA. This program will refer to FSP as appropriate. CCT staff routinely attend trainings specific to this population.

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)
CCT staff routinely attend trainings to help focus on the specialized needs of this population.

In, or are at risk of being in, the justice system
We have a County Jail Behavior Health program internally. This program will refer to FSP as appropriate. In addition we have a partnership with the Adult Probation department to provide outpatient mental health services. CCT staff routinely attend trainings specific to this population.

Assertive Field-Based Substance Use Disorder (SUD) Questions

For related policy information, refer to 7.B.6 Assertive Field-Based Initiation for Substance Use Disorder Treatment Services

Please describe the county behavioral health system's approach and timeline(s) to support and implement assertive field-based initiation for SUD treatment services program requirements by listing the existing and new programs (as applicable) that the county will leverage to support the assertive field-based SUD program requirements and provide the current funding source, BHSA service expansion, and the expected timeline for meeting programmatic requirements to expand existing programs and/or stand up new initiatives before July 1, 2029. Counties should include programs not funded directly or exclusively by BHSA dollars. Additional information regarding assertive field-based initiation for SUD treatment services can be found in the BHSA Policy Manual Chapter 7, Section B.6.

Existing Programs for Assertive Field-Based SUD Treatment Services

Targeted outreach

Existing programs
Currently our FSP program does not offer Targeted Outreach for Primary SUD individuals.

Program descriptions
N/A

Current funding source
N/A

BHSA changes to existing programs to meet BHSA requirements
N/A

Expected timeline of operation
N/A

Mobile-field based programs

Existing programs
Currently our FSP program does not offer Mobile Field Based programs for Primary SUD individuals.

Program descriptions
N/A

Current funding source
N/A

BHSA changes to existing programs to meet BHSA requirements
N/A

Expected timeline of operation
N/A

Open-access clinics

Existing programs
Currently our FSP program refers to a our local MAT provider through Drug Medi-Cal access points. This clinic is not Open Access and requires pre-authorization from the MCP

Program descriptions
Aegis Treatment Center is a Drug Medi-Cal vendored Outpatient Rehabilitation program located in Eureka CA. providing MAT services to eligible Humboldt County community members.

Current funding source
Drug Medi-Cal

BHSA changes to existing programs to meet BHSA requirements
This is a Community agency and not overseen by County Behavioral Health. We will have discussions with this program about streamlining our referral process. As we are a small county Aegis might not have the capacity or man power to operate an Open-Access Clinic.

Expected timeline of operation
Currently operating, ongoing.

New Programs for Assertive Field-Based SUD Treatment Services

Targeted outreach

New programs
Currently our FSP program employs Peer Support Specialists who conduct Outreach for individuals with mental health concerns. We will expand this program to include Primary SUD outreach. We already employ these individuals to community sites where this type SUD concerns might be most prevalent.

Program descriptions
Humboldt County's Full-Service Partnership (FSP) model utilizes a "whatever it takes"/wraparound approach that is community-based, whole-person, trauma-informed, recovery-focused, and delivered in partnership with families or an individual's natural supports, consistent with BHSA FSP requirements.

The County's Comprehensive Community Treatment (CCT) approach provides individualized, team-based supports that include treatment, crisis intervention, medication management, case management, peer support, transportation assistance, family education, connection to vocational/employment supports, co-occurring behavioral health services, and socialization/recreational activities based on the individual's goals and needs.

Targeted outreach efforts are informed by local data sources to identify and engage priority populations, including individuals experiencing homelessness, justice involvement, and those at risk of institutionalization. Humboldt County utilizes data from sources such as the Homeless Management Information System (HMIS), Point-in-Time (PIT) Count, behavioral health access and utilization data, crisis response encounters, and referrals from community partners to identify areas of high need and individuals who may benefit from SUD services. Humboldt County collaborates with local partners including community-based organizations, law enforcement, homeless service providers, and healthcare providers to share information and coordinate outreach efforts.

Mobile field-based staff, including Peer Support Specialists, clinicians, and case managers, conduct outreach in community settings such as encampments, shelters, and other high-need locations identified through these data sources. Outreach efforts are designed to provide immediate engagement and facilitate rapid access to Medication-Assisted Treatment (MAT) and other SUD services. This includes:

-Conducting in-field screening and engagement to identify individuals in need of SUD services
-Providing direct, same-day linkage to MAT providers through warm handoffs and coordination with Drug Medi-Cal providers
-Accompanying individuals to intake appointments and facilitating same-day or next-day access when available
-Coordinating transportation and providing in-person support to ensure successful connection to care
-Maintaining ongoing engagement to support retention in MAT and other SUD treatment services

Through these coordinated, data-informed outreach strategies, Humboldt County ensures that individuals from priority populations are identified and connected to timely, appropriate SUD treatment services in alignment with BHSA requirements.

Planned funding
Medi-Cal/Realignment/BHSA

Planned operations
Expand job duties for current Peer Support Specialist. Look to recruit additional Peers.

Expected timeline of implementation
7/1/2026

Mobile-field based programs

New programs
Currently our FSP program is primarily operated as a field based program. We will expand the acceptance into the program to include those with Co-Morbid Mental Health and SUD dx with the primary dx of SUD.

Program descriptions
Humboldt County's Full-Service Partnership (FSP) model utilizes a "whatever it takes"/wraparound approach that is community-based, whole-person, trauma-informed, recovery-focused, and delivered in partnership with families or an individual's natural supports, consistent with BHSA FSP requirements.

The County's Comprehensive Community Treatment (CCT) approach provides individualized, team-based supports that include treatment, crisis intervention, medication management, case management, peer support, transportation assistance, family education, connection to vocational/employment supports, co-occurring behavioral health services, and socialization/recreational activities based on the individual's goals and needs.

Field-based staff (including clinicians, case managers, and peers) conduct outreach and engagement in community settings such as homes, shelters, encampments, and other locations where individuals reside. These teams provide real-time assessment, motivational engagement, and coordination of care, including:

-Direct, same-day linkage to MAT providers through warm handoffs and coordination with Drug Medi-Cal providers
-Accompaniment to MAT appointments and facilitation of immediate intake when available
-Coordination of transportation and in-field support to ensure individuals successfully access services
-Ongoing engagement and follow-up to support retention in MAT and SUD treatment services
-Support with medication adherence, including coordination with prescribing providers and pharmacies

In addition, staff assist individuals with overcoming barriers to care by supporting access to telehealth services when appropriate, providing in-person support during virtual appointments, providing transportation to individuals, being present during appointments should individuals need the additional support, and ensuring individuals are connected to the full continuum of behavioral health and SUD services available within Humboldt County.

Planned funding
Medi-Cal/Realignment/BHSA

Planned operations
Expand criteria for acceptance into the CCT/FSP program.

Expected timeline of implementation
7/1/2026

Open-access clinics

New programs
We will work with Community Providers to expand referral pathways to their program to include more rapid access to MAT.

Program descriptions
Aegis Treatment Center is a Drug Medi-Cal/private insurance/self-pay outpatient provider offering Medication-Assisted Treatment (MAT) services in Humboldt County. Aegis Treatment Centers provides MAT for individuals living with Opioid Use Disorder, combining FDA-approved medications with counseling and supportive services to help individuals achieve stability, recovery, and improved quality of life. The County will partner with Aegis and other SUD providers to support rapid access to MAT through same-day or next-day appointments, streamlined intake processes, and prioritized referrals from behavioral health and field-based teams. Where full open-access clinic capacity is not feasible, the County will implement coordinated alternatives to ensure timely entry into treatment consistent with BHSA requirements.

Planned funding
Drug Medi-Cal

Planned operations
Humboldt County does not currently operate a county-run open-access SUD clinic; however, the County will ensure rapid access to MAT and other SUD services through coordinated provider partnerships and alternative access pathways. This includes establishing prioritized same-day or next-day access with Drug Medi-Cal providers, utilizing field-based teams to directly connect individuals to treatment, and implementing expedited intake and drop-in scheduling where feasible. In rural areas where full open-access clinic capacity is limited, the County will ensure functional equivalents to open-access through warm handoffs, transportation support, and direct linkage to MAT providers to prevent delays in treatment access.

Expected timeline of implementation
7/1/2026

Medications for Addiction Treatment (MAT) Details
Please describe the county's approach to enabling access to same-day medications for addiction treatment (MAT) to meet the estimated population needs before July 1, 2029.

Describe how the county will assess the gap between current county MAT resources (including programs and providers) and MAT resources that can meet estimated needs
Humboldt County will assess the gap between current MAT capacity and community need by reviewing local utilization data, provider capacity, and referral patterns across the behavioral health system. The County will evaluate access to existing Drug Medi-Cal MAT providers, including Aegis Treatment Center, by examining factors such as wait times for appointments, referral pathways, and barriers to same-day treatment initiation. This analysis will also incorporate information from field-based programs, including the County's Full Service Partnership (FSP) Comprehensive Community Treatment (CCT) teams, crisis

services, and community partners that frequently encounter individuals with substance use disorders. Humboldt County will use this information to identify service gaps, streamline referral processes, and improve coordination with MAT providers to support more rapid access to treatment. Progress will be monitored through ongoing data review and collaboration with providers to ensure the County continues to expand timely access to MAT services before July 1, 2029.

Select the following practices the county will implement to ensure same day access to MAT

Contract directly with MAT providers in the County
Enter into referral agreements with other MAT providers including providers whose services are covered by Medi-Cal MCPs and/or Fee-For-Service (FFS) Medi-Cal
Leverage telehealth model(s)
Partner with neighboring counties
Contract with MAT providers in other counties

Please provide the names of the neighboring counties the county will partner with

Del Norte, Trinity, Mendocino, Sonoma, Butte, Sacramento

Please provide the names of other counties the contracted MAT providers are located in

Del Norte, Trinity, Mendocino, Sonoma, Butte, Sacramento

What forms of MAT will the county provide utilizing the strategies selected above?

Other

Please specify other forms of MAT

Aegis Treatment Center is a Drug Medi-Cal vendored Outpatient Rehabilitation program located in Eureka CA., providing MAT services to eligible Humboldt County community members. This agency provides support in the form of Buprenorphine, and Methadone.

Housing Interventions

Planning

For related policy information, refer to 7.C.3 Program priorities and 7.C.4 Eligible and priority populations

System Gaps

Please identify the biggest gaps facing individuals experiencing homelessness and at risk of homelessness with a behavioral health condition who are Behavioral Health Services Act (BHSA) eligible in the county. Please use the following definitions to inform your response: No gap – resources and connectivity available; Small gap – some resources available but limited connectivity; Medium gap – minimal resources and limited connectivity available; Large gap – limited or no resources and connectivity available; Not applicable – county does not have setting and does not consider there to be a gap. Counties should refer to their local Continuum of Care (CoC) Housing Inventory Count (HIC) to inform responses to this question.

Supportive housing
Large gap

Apartments, including master-lease apartments
Large gap

Single and multi-family homes
Large gap

Housing in mobile home communities
Large gap

(Permanent) Single room occupancy units
Large gap

(Interim) Single room occupancy units
Large gap

Accessory dwelling units, including junior accessory dwelling units
Large gap

(Permanent) Tiny homes
Large gap

Shared housing
Large gap

(Permanent) Recovery/sober living housing, including recovery-oriented housing
Large gap

(Interim) Recovery/sober living housing, including recovery-oriented housing
Large gap

Assisted living facilities (adult residential facilities, residential facilities for the elderly, and licensed board and care)
Large gap

License-exempt room and board
Large gap

Hotel and Motel stays
Large gap

Non-congregate interim housing models
Large gap

Congregate settings that have only a small number of individuals per room and sufficient common space (does not include behavioral health residential treatment settings)
Large gap

Recuperative Care
Large gap

Short-Term Post-Hospitalization housing
Large gap

(Interim) Tiny homes, emergency sleeping cabins, emergency stabilization units
Large gap

Peer Respite
Large gap

Permanent rental subsidies
Large gap

Housing supportive services
Large gap

What additional non-BHSA resources (e.g., county partnerships, vouchers, data sharing agreements) or funding sources will the county behavioral health system utilize (local, state, and federal) to expand supply and/or increase access to housing for BHSA eligible individuals **?**
Humboldt County will continue to utilize available non-BHSA resources to support and expand housing access for BHSA eligible individuals, including Behavioral Health Bridge Housing funds, Medi-Cal billing where allowable, Medi-Cal Managed Care Plan housing-related Community Supports, Enhanced Care Management, 1991 Realignment, and other state, federal, and local housing resources available through county and community partners. Humboldt will also continue coordinating with homeless services, Coordinated Entry/HMIS partners, HOME, healthcare providers, and community-based housing partners to support referrals, housing navigation, tenancy supports, and connection to available rental assistance or housing resources.

How will BHSA Housing Interventions intersect with those other resources and supports to strengthen or expand the continuum of housing supports available to BHSA eligible individuals?
BHSA Housing Interventions will be coordinated with the resources identified in Question 2 to strengthen the overall housing continuum for BHSA eligible individuals. When a housing need is identified, Humboldt will first coordinate with existing partners and funding sources to determine whether Medi-Cal Community Supports, Enhanced Care Management, Behavioral Health Bridge Housing, Realignment, federal block grants, or other housing resources can appropriately support the individual. BHSA Housing Interventions will then be used to fill gaps, expand access, or provide housing supports that are not otherwise available or covered by another funding source.

What is the county behavioral health system's overall strategy to promote permanent housing placement and retention for individuals receiving BHSA Housing Interventions?
Our placement and retention strategy is to assign responsibility for housing placement and retention, provide tenant education, develop individual service plans, invest in landlord relationships, provide ongoing supportive services and provide additional emergency financial support when necessary to retain housing.

What actions or activities is the county behavioral health system engaging in to connect BHSA eligible individuals to and support permanent supportive housing (PSH) (e.g., rental subsidies for individuals residing in PSH projects, operating subsidies for PSH projects, providing supportive services to individuals in other permanent housing settings, capital development funding for PSH)?

The BH system is helping to guide BHSA eligible individuals through the Coordinated Entry System (CES) which governs tenant selection for most supportive housing in the community, and is participating in regular case conference meetings where decisions about whom to prioritize for supportive housing are made. In addition to the resources that participate in the CES, the County has agreements with with some developers where units have been set aside for supportive housing for BHSA eligible individuals. The BH system is also the lead service provider for two NPLH projects with a combined 33 units, and one MHSA housing project that has 15 units.

Please describe how the county behavioral health system will ensure all Housing Interventions settings provide access to clinical and supportive behavioral health care and housing services

Humboldt County ensures that individuals served through Housing Interventions settings have access to both clinical and supportive behavioral health and housing services through coordinated, multidisciplinary service delivery and cross-department collaboration.

In Permanent Supportive Housing settings, housing stability and service access are supported by on-site or affiliated property managers and resident service coordinators who provide housing-related interventions and facilitate service connections. Most residents placed in Permanent Supportive Housing are active Behavioral Health clients and are connected to ongoing behavioral health services, including assignment to case managers and peer support staff who provide engagement, service coordination, and recovery-oriented support.

Residents are also connected to Humboldt County's Innovation program, the Resident Engagement Support Team (REST), which provides additional case management and engagement services aimed at maintaining housing stability and supporting individuals in navigating behavioral health and community services.

Clinical and crisis support services are available through the county's Mobile Intervention and Services Team (MIST), which engages individuals directly in their home or community settings to provide crisis response, stabilization, and linkage to ongoing care. Additionally, the Housing Outreach and Mobile Engagement (HOME) program within Social Services assists individuals experiencing or at risk of homelessness by linking them to behavioral health services and housing supports.

To ensure appropriate placement and service matching, a multidisciplinary tenant selection committee

reviews referrals and screens applicants to ensure individuals are placed in housing settings that best meet their clinical, supportive service, and housing needs. When individuals are not currently open to behavioral health services, referrals can be made to outreach and engagement teams, including HOME and MIST, to support connection to care.

Through coordination among property management, resident service coordinators, behavioral health case managers, peer staff, crisis teams, outreach programs, and tenant selection processes, Humboldt County ensures Housing Interventions settings consistently provide access to necessary clinical and supportive behavioral health and housing services to promote long-term housing stability and recovery.

Eligible Populations

Please describe how the county behavioral health system will identify, screen, and refer individuals eligible for BHSA Housing Interventions

Humboldt County Behavioral Health identifies, screens, and refers individuals eligible for BHSA Housing Interventions through coordinated screening, referral, and cross-system collaboration processes designed to ensure individuals experiencing homelessness or housing instability are connected to appropriate housing and behavioral health supports.

Individuals accessing Behavioral Health services commonly present with a behavioral health diagnosis and housing instability or homelessness. Eligibility and housing needs are identified during intake and service engagement processes, including screening conducted by Behavioral Health Access staff. As part of service entry, staff utilize the CalMHSA Youth Medi-Cal Screening Tool when youth request services. The screening tool includes housing-related questions such as whether an individual is currently without housing or a safe place to sleep, or has previously experienced homelessness, allowing staff to identify housing needs early and initiate appropriate referrals.

When housing needs are identified, referrals are made to appropriate housing resources, including the county's Housing Interventions programs. For youth experiencing homelessness or housing instability, staff may refer individuals to the Housing Outreach and Mobile Engagement (HOME) program under Social Services and support youth in contacting 2-1-1 and other community resource systems to identify immediate housing options and supports.

Referrals into housing programs may also originate from any Behavioral Health program, including outpatient services, case management programs, crisis teams, and other county-operated or contracted behavioral health services, ensuring multiple entry points into housing supports. Additionally, individuals may be referred through external systems such as the Community Assistance, Recovery and Empowerment (CARE) Court process, further strengthening cross-system identification of individuals in need of housing and behavioral health services.

All referrals for housing placements are reviewed through a multidisciplinary tenant selection committee, which screens applicants to ensure individuals are matched with housing settings appropriate to their clinical, supportive service, and housing needs.

Through coordinated screening, internal and external referral pathways, and centralized tenant selection processes, Humboldt County ensures individuals eligible for BHSA Housing Interventions are effectively identified and linked to appropriate housing and behavioral health supports.

Will the county behavioral health system provide BHSA-funded Housing Interventions to individuals living with a substance use disorder (SUD) only **?**
No

Please indicate why the county behavioral health system will not provide BHSA funded Housing Interventions to individuals living with a SUD only and include data to support
Insufficient resources

Please explain why there are insufficient resources to provide BHSA-funded Housing Interventions to individuals living with an SUD only
Humboldt County faces insufficient available funding to provide BHSA-funded Housing Interventions exclusively for individuals living with a substance use disorder (SUD) diagnosis without co-occurring behavioral health needs.

BHSA Housing Intervention funding does not represent new funding but is primarily a reallocation of existing resources that were previously utilized within Full Service Partnership (FSP) and other behavioral health housing supports. Current fiscal projections indicate that Humboldt County's existing housing costs for individuals with the most significant behavioral health needs already meet or exceed the required BHSA Housing Intervention funding allocation. As a result, available funding must first be prioritized to sustain current housing placements and supports serving individuals experiencing homelessness or housing instability who also have complex behavioral health needs.

Additionally, Humboldt County continues to face funding pressures related to limited housing stock, rising housing costs, and the need to maintain supportive services necessary to ensure housing stability. These fiscal constraints, combined with overall reductions in county allocation under BHSA compared to prior MHSA funding levels, require the county to focus available Housing Intervention funding on maintaining existing housing capacity rather than expanding services to additional populations.

Because available funding is already fully committed to sustaining existing housing interventions and meeting required BHSA funding allocations, Humboldt County does not have sufficient resources to

expand BHSA-funded Housing Interventions to serve individuals living with SUD-only diagnoses.

What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible children and youth in the development of the county's Housing Interventions services (e.g., review data, engage with stakeholders, analyze research, etc.) who are:

In, or at-risk of being in, the juvenile justice system

To consider the needs of youth involved in or at risk of involvement in the juvenile justice system, Humboldt County Behavioral Health engaged in collaborative planning and data-informed advocacy efforts through youth-serving partnerships and homelessness collaborations.

HCTAYC and associated youth advocacy structures regularly engage partners such as Juvenile Probation, youth-serving community organizations, education partners, and behavioral health services through collaborations including the Humboldt Houseless Youth Support Collaboration (HHYSC). These meetings and collaborations focus on identifying service and housing gaps affecting justice-involved and at-risk youth and developing coordinated responses to support stable transitions into housing and services.

Youth leaders and advocacy groups also participated in homelessness planning discussions and stakeholder processes, helping ensure that housing planning efforts incorporate the needs of youth exiting or at risk of entering justice systems, who often experience housing instability.

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)

Humboldt County considered the needs of LGBTQ+ youth through data collection, youth engagement, and targeted advocacy efforts incorporated into community planning and youth leadership activities.

Community Program Planning Process data and program participation data demonstrate that a significant portion of youth accessing services identify as LGBTQIA2+, highlighting the importance of inclusive and affirming housing and services. Youth advocacy groups and program participants have actively worked on LGBTQIA+ policy recommendations and supported youth-focused events and planning activities aimed at improving system responsiveness and reducing disparities for LGBTQ+ youth.

Youth-led engagement efforts and leadership development activities ensure that LGBTQ+ youth voices are incorporated into planning and program development, including discussions related to homelessness and housing stability. These activities inform county approaches to developing housing and supportive services that are safe, inclusive, and responsive to LGBTQ+ youth experiencing housing instability.

In the child welfare system
Humboldt County Behavioral Health considered the needs of youth involved in the child welfare system through ongoing collaboration between Behavioral Health, Child Welfare Services, and Transition-Age Youth programs focused on housing stability and service access.

The TAY Division integrates Behavioral Health services with Extended Foster Care, Independent Living Skills programs, and youth advocacy supports to address housing, service, and transition needs for youth exiting or involved in foster care. Youth advocacy and system planning activities have historically focused on improving outcomes for foster youth and addressing housing and service gaps affecting system-impacted youth transitioning into adulthood.

Ongoing collaboration through youth-serving partnerships and homelessness-focused planning ensures that housing needs of foster youth and youth exiting child welfare systems are incorporated into Housing Interventions planning and service coordination efforts.

What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible adults in the development of the county's Housing Interventions services (e.g., review data, engage with stakeholders, analyze research, etc.) who are

Older adults
To address the needs of older adults eligible for FSP services, Humboldt County Behavioral Health reviewed program utilization data, demographic trends, and community input gathered through the Community Program Planning Process to better understand service and housing needs among older adults experiencing serious behavioral health conditions.

Planning efforts considered the challenges older adults face related to housing stability, access to behavioral health care, physical health needs, and social isolation. Community feedback and program experience indicated the importance of service coordination, housing stability supports, and accessible outpatient and crisis services to help older adults maintain stability in community settings and avoid unnecessary hospitalization or institutional placement.

Behavioral Health programs serving adults and older adults were included in stakeholder discussions and planning efforts to ensure FSP services remain responsive to the needs of older adults requiring intensive community-based behavioral health supports.

In, or are at risk of being in, the justice system
Humboldt County Behavioral Health considered the needs of adults involved in or at risk of involvement in the justice system through analysis of service utilization patterns, crisis service interactions, and stakeholder engagement with justice system and community partners.

Community planning processes and stakeholder discussions identified the need for intensive behavioral health services and housing supports to reduce repeated crisis events, incarceration, and hospitalizations among adults with serious behavioral health needs. Collaboration with justice system partners, crisis response teams, and community service providers informed planning efforts focused on improving diversion opportunities, stabilizing individuals in community settings, and reducing justice system involvement.

These efforts informed FSP planning by emphasizing the importance of intensive, community-based services and housing supports that address the needs of adults experiencing behavioral health challenges who are at risk of justice system involvement.

In underserved communities
Humboldt County conducted extensive community outreach through its Behavioral Health Services Act (BHSA) Community Program Planning Process to engage underserved communities in shaping service priorities, including housing and supportive services. Between December 2025 through March 2026, the county hosted and attended various community meetings across multiple regions of Humboldt County and collected input through surveys, written comments, and public feedback mechanisms. Participants included individuals with lived experience of serious mental illness, family members, people with experience of homelessness, justice system involvement, and members of historically underserved populations including LGBTQ+ individuals and racial/ethnic minority communities. Outreach materials and comment forms were also made available in Spanish to increase accessibility. Community feedback emphasized the need for expanded housing supports, culturally responsive services, and improved access to behavioral health services in rural areas such as Southern, Eastern, and Eel River Valley communities. This engagement process informed the county's understanding of housing and service needs among underserved populations and helped guide planning for housing-related behavioral health services

Local Housing System Engagement

How will the county behavioral health system coordinate with the Continuum of Care (CoC) and receive referrals for Housing Interventions services?
Humboldt County Behavioral Health coordinates closely with the local Continuum of Care (CoC) to support referral pathways and placement processes for individuals eligible for BHSA Housing Intervention services through ongoing collaboration and shared system coordination.

In Humboldt County, the Continuum of Care functions as a collaborative meeting space where housing and service providers coordinate resources, referrals, and housing placements for individuals experiencing homelessness. Representatives from the county's Housing Outreach and Mobile Engagement (HOME) program regularly participate in CoC meetings to coordinate referrals, identify shared clients, and align housing placement opportunities. Information from these meetings is communicated back to Behavioral Health and the tenant selection committee to support coordinated placement decisions.

Referrals for Housing Intervention services originate from multiple entry points, including Behavioral Health outpatient programs, case management services, crisis response teams, and other county-operated or contracted programs. Behavioral Health staff coordinate with housing partners and HOME staff to ensure individuals identified through treatment or outreach programs are referred to appropriate housing resources and considered for placement through the tenant selection process.

The HOME program also plays a central coordination role as an Enhanced Care Management (ECM) provider, supporting collaboration between health, behavioral health, and housing partners to ensure individuals receive both clinical services and housing-related supports. Through these partnerships, Behavioral Health and housing providers coordinate referrals, share information as appropriate, and ensure individuals are connected to the appropriate level of housing and supportive services.

Through regular CoC participation, coordinated referral processes, tenant selection coordination, and collaboration between Behavioral Health and housing programs, Humboldt County ensures Housing Intervention referrals are aligned across systems and individuals are connected to appropriate housing and supportive behavioral health services.

Please describe the county behavioral health system's approach to collaborating with the local CoC, Public Housing Agencies, Medi-Cal managed care plans (MCPs), Enhanced Care Management (ECM) and Community Supports providers, as well as other housing partners, including existing and prospective PSH developers and providers in your community in the implementation of the county's Housing Interventions

Local CoC

Humboldt County Behavioral Health collaborates with the local Continuum of Care (CoC) through regular participation in CoC meetings, which serve as a collaborative forum for housing and service providers to coordinate referrals, housing placements, and service supports for individuals experiencing homelessness. Representatives from the county's Housing Outreach and Mobile Engagement (HOME) program attend CoC meetings and coordinate closely with Behavioral Health and the tenant selection committee to align referrals and housing placement decisions. This coordination allows Behavioral Health and housing partners to identify shared clients, prioritize individuals with behavioral health needs, and ensure referrals into Housing Intervention services are coordinated across systems. Behavioral Health programs also

coordinate directly with housing partners to support referrals and placement processes when individuals receiving behavioral health services are identified as needing housing supports.

Public Housing Agency
Behavioral Health coordinates with local public housing agencies through ongoing collaboration with housing partners and service providers involved in housing placement and stabilization efforts. Public housing resources are incorporated into broader housing planning discussions and placement strategies, with Behavioral Health programs working alongside housing partners to support individuals eligible for housing programs and ensure individuals placed in public housing settings receive ongoing behavioral health and supportive services necessary to maintain housing stability.

MCPs
Humboldt County Behavioral Health collaborates with Medi-Cal Managed Care Plans, including through coordination with Enhanced Care Management and Community Supports services that intersect with housing stabilization efforts. Through this collaboration, Behavioral Health works to ensure individuals eligible for Medi-Cal services are connected to available housing-related supports and health services, reducing service duplication and strengthening care coordination for individuals experiencing homelessness or housing instability. Coordination between Behavioral Health and managed care partners supports continuity of care and service alignment for individuals placed in Housing Intervention settings.

ECM and Community Supports Providers
The county's HOME program functions as an Enhanced Care Management (ECM) provider and plays a central role in coordinating housing referrals, outreach, and engagement services. HOME staff collaborate with Behavioral Health programs, housing partners, and community-based providers to ensure individuals experiencing homelessness or housing instability are connected to housing resources, behavioral health services, and other community supports. Through ECM and Community Supports partnerships, providers coordinate care planning, outreach, and service engagement to support housing placement and long-term housing stability for individuals receiving Housing Intervention services.

Other (e.g., CalWORKS/TANF housing programs, child welfare housing programs, PSH developers and providers, etc.)
Humboldt County Behavioral Health also collaborates with a broad network of housing and social service partners, including programs serving families, individuals involved in child welfare or public assistance systems, and permanent supportive housing providers and developers. Coordination occurs through referral pathways, tenant selection processes, and shared service planning efforts to ensure individuals are matched to appropriate housing resources and supportive services. Behavioral Health works with housing developers, service providers, and county programs to support both existing and prospective permanent supportive housing projects and ensure residents have access to clinical and supportive behavioral health services necessary to maintain housing stability. Collaboration includes coordination among Behavioral

Health programs, Social Services housing programs such as HOME, housing providers and property managers, permanent supportive housing developers, community-based organizations, crisis response teams, outreach providers, and referral and tenant selection processes. These partnerships ensure that individuals eligible for Housing Interventions are identified, referred, placed, and supported through coordinated housing and behavioral health services designed to promote long-term housing stability and recovery.

How will the county behavioral health system work with Homekey+ and supportive housing sites to provide services, funding, and referrals that support and house BHSA eligible individuals?

Humboldt County Behavioral Health works with Homekey+ and other supportive housing sites through coordinated referral processes, contracted service delivery, and ongoing service engagement to ensure BHSA-eligible individuals receive the services and supports necessary to obtain and maintain stable housing.

Supportive housing sites, including permanent supportive housing developed through programs such as Homekey+, receive referrals through coordinated housing and behavioral health referral pathways, including Behavioral Health programs, outreach teams, and housing partners. Individuals identified as eligible for housing and supportive services are referred through established placement processes, including review by tenant selection committees, to ensure appropriate placement within available supportive housing settings.

Behavioral Health is contracted to provide ongoing supportive and clinical services within permanent supportive housing and other supportive housing environments. Individuals placed in these housing settings are connected to case management, peer support, and other behavioral health services designed to support housing stability and recovery. Mobile crisis and behavioral health response services are also available to residents through county-operated crisis response teams, which provide engagement and stabilization services in housing settings when behavioral health needs arise.

Through coordination with supportive housing providers, contracted service delivery, referral processes, and mobile behavioral health services, Humboldt County ensures BHSA-eligible individuals placed in Homekey+ and other supportive housing sites have access to services and supports necessary to maintain housing and achieve long-term stability.

Did the county behavioral health system receive Homeless Housing Assistance and Prevention Grant Program (HHAP) Round 6 funding?

Yes

How will the county coordinate the use of HHAP dollars to support the housing needs of BHSA eligible individuals in your community?

The Transition-Age Youth Division created a referral form for: TAY-HHAP, FYI, THP+ and Community Supports. Staff complete the form, along with the VI-SPDAT, the supervisor team reviews the referrals and makes recommendations to most appropriate program based on eligibility criteria. Appropriate referrals are sent to the HOME program and/or the housing authority for the FYI vouchers. The HOME program has an assigned Peer Coach that works directly with TAY clients and coordinates with TAY staff.

BHSA Housing Interventions Implementation

The following questions are specific to BHSA Housing Interventions funding (no action needed).
For more information, please see 7.C.9 Allowable expenditures and related requirements

Rental Subsidies (Chapter 7. Section C.9.1)

The intent of Housing Interventions is to provide rental subsidies in permanent settings to eligible individuals for as long as needed, or until the individual can be transitioned to an alternative permanent housing situation or rental subsidy source. (no action needed)

Is the county providing this intervention?

Yes

Is the county providing this intervention to chronically homeless individuals?

Yes

How many individuals does the county behavioral health system expect to serve with rental subsidies under BHSA Housing Interventions on an annual basis?

25

How many of these individuals will receive rental subsidies for permanent housing on an annual basis?

25

How many of these individuals will receive rental subsidies for interim housing on an annual basis?
0

What is the county's methodology for estimating total rental subsidies and total number of individuals served in interim and permanent settings on an annual basis?
Behavioral Health fiscal reviews the County's ability to pay subsidies based on current rent costs and past mitigation costs and provides a number of projected households that can be subsidized. This can and is adjusted as necessary.

For which setting types will the county provide rental subsidies?
Non-Time-Limited Permanent Settings: Supportive housing
Non-Time-Limited Permanent Settings: Apartments, including master-lease apartments
Non-Time-Limited Permanent Settings: Single and multi-family homes
Non-Time-Limited Permanent Settings: Housing in mobile home communities
Non-Time-Limited Permanent Settings: Single room occupancy units
Non-Time-Limited Permanent Settings: Accessory dwelling units, including Junior Accessory Dwelling Units
Non-Time-Limited Permanent Settings: Tiny Homes
Non-Time-Limited Permanent Settings: Shared housing
Non-Time-Limited Permanent Settings: Recovery/Sober Living housing, including recovery-oriented housing
Non-Time-Limited Permanent Settings: Assisted living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
Non-Time-Limited Permanent Settings: License-exempt room and board
Non-Time-Limited Permanent Settings: Other settings identified under the Transitional Rent benefit

Will this Housing Intervention accommodate family housing?
Yes

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
Rental subsidies are provided to qualified tenants on a Rapid Rehousing (RRH) basis to address homelessness and housing instability. All rental subsidy payments are issued directly to property owners, property managers, or contracted providers administering BHSA-funded rental assistance, in compliance with BHSA Housing Intervention requirements.

Subsidies are administered through formal lease agreements between the tenant and property owner, with Humboldt County or contracted provider coordinating payment processes. Property owners and managers

are informed of program requirements during the leasing process, including inspection standards, habitability requirements, and applicable rent limits. Subsidy amounts are adjusted as needed based on tenant eligibility and program guidelines, and payments are updated or terminated accordingly when tenants exit the program.

Will the county behavioral health system provide rental assistance through project-based (tied to a particular unit) or tenant-based (tied to the individual) subsidies?
Tenant-based

How will the county behavioral health system identify a portfolio of available units for placing BHSA eligible individuals, including in collaboration with other county partners and as applicable, Flex Pools (e.g., Master Leasing)? Please include partnerships and collaborative efforts your county behavioral health system will engage in
Humboldt County utilizes a coordinated, multi-system approach to identify and maintain a diverse portfolio of housing units for BHSA-eligible individuals. Humboldt County actively partners with the local Continuum of Care (CoC), participates in regular CoC meetings, and engages in coordinated entry processes to identify available housing opportunities and match individuals to appropriate units. Humboldt County is an active participant in the Homeless Management Information System (HMIS), using data to identify individuals experiencing homelessness and to coordinate housing placements and service delivery.

Humboldt County collaborates with a range of partners, including local housing authorities, community-based organizations, homeless service providers, property management companies, and other county departments within DHHS and housing programs (e.g., HOMEKEY and other state- and federally-funded housing initiatives). Through these partnerships, the Humboldt County participates in tenant selection processes, supports shared clients across systems, and coordinates access to available housing resources.

Housing navigation services are utilized to conduct targeted housing searches, engage and recruit private landlords, and assist individuals through the housing application and placement process. Additionally, Humboldt County utilizes master leasing arrangements and flexible housing pool strategies, where available, to increase access to units and provide immediate housing opportunities for individuals with high needs.

Total number of units funded with BHSA Housing Interventions per year
25

Please provide additional details to explain if the county is funding rental subsidies with BHSA Housing Interventions that are not tied to a specific number of units
N/A

Operating Subsidies (Chapter 7, Section C.9.2)

Is the county providing this intervention?
No

Please explain why the county is not providing this intervention
Humboldt County prioritizes BHSA for subsidies and tenant needs since that is the highest need locally.

Landlord Outreach and Mitigation Funds (Chapter 7, Section C.9.4.1)

Is the county providing this intervention?
Yes

Is the county providing this intervention to chronically homeless individuals?
Yes

Anticipated number of individuals served per year
25

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
Funds have been set aside to support landlord engagement and risk mitigation strategies to increase access to housing for BHSA-eligible individuals. Humboldt County provides landlord incentives to encourage participation in housing programs, including payments to offset application fees, background check costs, and to incentivize landlords to offer units to tenants with behavioral health needs. Incentives may also be used to support unit readiness, including minor repairs, accessibility modifications (e.g., ramps, safety features, or habitability improvements), and upgrades necessary to meet housing voucher or program requirements. Incentive amounts typically range from $500 to $2,000 depending on the scope of need, with higher incentives available in situations requiring additional landlord participation, such as holding units while tenant documentation is completed.

In addition, Humboldt County has established mitigation funds to reduce landlord risk and support tenancy stability. These funds may be used to cover tenant-caused damages, address vacancy loss, or resolve issues that could otherwise result in eviction or lease termination. This approach supports landlord

retention and helps prevent individuals from becoming or returning to homelessness. Together, these landlord engagement and mitigation strategies expand the available housing inventory and support long-term housing stability for individuals served under BHSA Housing Interventions.

Total number of units funded with BHSA Housing Interventions per year
25

Please provide additional details to explain if the county is providing landlord outreach and mitigation funds with BHSA Housing Interventions that are not tied to a specific number of units
N/A

Participant Assistance Funds (Chapter 7, Section C.9.4.2)

Is the county providing this intervention?
Yes

Is the county providing this intervention to chronically homeless individuals?
Yes

Anticipated number of individuals served per year
100

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
The interventions are need based and will be used for the following: essential grooming and hygiene needs, community integration, any number of simple personal needs by client, help people mail things, providing support to meet essential needs.

Housing Transition Navigation Services and Tenancy Sustaining Services (Chapter 7, Section C.9.4.3)
Pursuant to Welfare and Institutions (W&I) Code section 5830, subdivision (c)(2) **, BHSA Housing Interventions may not be used for housing services covered by Medi-Cal MCP. Please select Yes only if the county is providing these services to individuals who are not eligible to receive the services through their Medi-Cal MCP (no action needed)**

Is the county providing this intervention?

Yes

Is the county providing this intervention to chronically homeless individuals?
Yes

Anticipated number of individuals served per year
25

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
Navigation services to identify and apply for adequate housing for individuals. Application fees, fees to remove barriers such as outstanding bills or past due rent.

Housing Interventions Outreach and Engagement (Chapter 7, Section C.9.4.4)

Is the county providing this intervention?
Yes

Is the county providing this intervention to chronically homeless individuals?
Yes

Anticipated number of individuals served per year
25

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
The Housing Outreavch and Mobile Engagement (HOME) program provides outreach for BHSA through its Projects for Assistance in Transitioning from Homelessness (PATH) outreach program, which educates community members on Humboldt County Behavioral Health (HCBH) services and provides support for navigation and connection to services. HOME conducts outreach in places where homeless community members can be found all throughout the county and have a weekly schedule for this. The program also educates other service providers and ensure they understand how their shared clients can access services they may be qualified for through HCBH. Additionally, the program uses housing intervention funding to remove barriers to housing like application fees, past debt consolidation where appropriate (i.e., paying outstanding housing fees to Housing Authority or other landlords in order to qualify individuals for another housing opportunity), payments to start utility services, household items, deposits, and accommodations for health needs (such as motility improvement, heating/cooling, shower bars, auto water shut off defices,

etc.).

Capital Development Projects (Chapter 7, Section C.10)

Counties may spend up to 25 percent of BHSA Housing Interventions on capital development projects. Will the county behavioral health system use BHSA Housing Interventions for capital development projects?
No

Please explain why the county is not providing this intervention
There is not enough funding available at this time to explore a capital development project at this time.

Other Housing Interventions

If the county is providing another type of Housing Interventions not listed above, please describe the intervention
No

Is the county providing this intervention to chronically homeless individuals?
Anticipated number of individuals served per year

Continuation of Existing Housing Programs

Please describe if any BHSA Housing Interventions funding will be used to support the continuation of housing programs that are ending (e.g., Behavioral Health Bridge housing)
Not at this time.

Relationship to Housing Services Funded by Medi-Cal Managed Care Plans

For more information, please see 7.C.7 Relationship to Medi-Cal Funded Housing Services

Which of the following housing-related Community Supports is the county behavioral health system an MCP-contracted provider of?
Housing Transition Navigation Services
Housing Deposits

Housing Tenancy and Sustaining Services

For which of the following services does the county behavioral health system plan to become an MCP-contracted provider of?

Housing Transition Navigation Services
No

Housing Deposits
No

Housing Tenancy and Sustaining Services
No

Short-Term Post-Hospitalization Housing
No

Recuperative Care
No

Day Habilitation
No

Transitional Rent
Yes

When does the county behavioral health system plan to become an MCP-contracted provider?
5/1/2026

How will the county behavioral health system identify, confirm eligibility, and refer Medi-Cal members to housing-related Community Supports covered by MCPs **(including Transitional Rent)?**
Behavioral Health staff identify Members in need of housing-related Community Supports through engaging the Member in inpatient and/or outpatient county behavioral health services.

Staff confirm the client is enrolled in Medi-Cal. If the client is not currently enrolled in Medi-Cal, Behavioral

Health staff assist the person to apply and work with county Social Services eligibility workers to confirm enrollment. The county's no-wrong-door approach includes the Housing Outreach and Mobile Engagement (HOME) Unit. If the client comes through the HOME unit, HOME staff will confirm Medi-Cal enrollment or assist the person with applying.

The HOME unit is contracted with the MCP as a Community Supports provider of the "housing trio" to serve county Behavioral Health clients. Behavioral Health, Social Services and HOME staff are embedded into the county's integrated Department of Health & Human Services. If the person does not qualify for specialty mental health services, county Behavioral Health or HOME staff will refer the person to the MCP for housing-related community supports and/or mild/moderate mental health benefits. Mild/moderate mental health and specialty mental health referrals are monitored by an electronic closed loop referral system between the MCP and county Behavioral Health.

Please describe coordination efforts and ongoing processes to ensure the county behavioral health contracted provider network for Housing Interventions is known and shared with MCPs serving your county

The County will share its contracted Housing Interventions provider network with the county's single MCP via email to the MCP's Regional Director and Director of Enhanced Health Services who coordinates contracting for the Transitional Rent benefit. The County's single MCP lists their contracted provider network for CalAIM Community Supports Housing Trio on their public-facing website. The MCP and County Behavioral Health participate in ongoing quarterly MOU meetings where CalAIM Housing Intervention utilization and referral data is presented and discussed.

Does the county behavioral health system track which of its contracted housing providers are also contracted by MCPs for housing-related Community Supports (provided in questions #1 and #2 above)?

No

What processes does the county behavioral health system have in place to ensure Medi-Cal members living with significant behavioral health conditions do not experience gaps in service once any of the MCP housing services are exhausted, to the extent resources are available?

The county behavioral health and HOME Unit help the person collect necessary documents, apply for a section 8 HUD housing voucher with the Housing Authority, apply for SSI and/or connect the person to Education and Training resources when employment is identified as a viable option for long-term housing sustainability. For those who are enrolled in FSP, BHSA Housing Interventions may be the best option for ongoing rent and housing sustaining services after the CalAIM benefits are exhausted.

Flexible Housing Subsidy Pools

Flexible Housing Subsidy Pools ("Flex Pools") are an effective model to streamline and simplify administering rental assistance and related housing supports. DHCS released the Flex Pools TA Resource Guide that describes this model in more detail linked here: Flexible Housing Subsidy Pools - Technical Assistance Resource . Please reference the TA Resource Guide for descriptions of the Flex Pool model and roles referenced below including the Lead Entity, Operator, and Funder.

For related policy information, refer to 7.C.8 Flexible Housing Subsidy Pools .

Is there an operating Flex Pool (or elements of a Flex Pool, which includes (1) coordinating and braiding funding streams, (2) serving as a fiscal intermediary, (3) identifying, securing, and supporting a portfolio of units for participants, and/or (4) coordinating with providers of housing supportive services) in the county (please refer to DHCS' Flex Pools TA Resource Guide)?
Yes

Is the county behavioral health system participating in or planning to participate in the Flex Pool?
Yes

What role does the county behavioral health system have or plan to have in the Flex Pool?
Operator
Housing Supportive Services Provider

What organization is serving as the Operator?
Housing Outreach and Mobile Engagement (HOME), a program under DHHS Social Services

Does the county plan to administer some or all Housing Interventions funds through or in coordination with the Flex Pool?
Yes

Which Housing Interventions does the county plan to administer through or in coordination with the Flex Pool?

Rental Subsidies
Landlord Outreach and Mitigation Funds
Participant Assistance Funds
Housing Transition Navigation Services and Tenancy and Sustaining Services

Please describe any other roles and functions the county behavioral health system plans to take to support the operations or launch and scaling of a Flex Pool in addition to those described above

None.

Behavioral Health Services Fund: Innovative Behavioral Health Pilot and Projects

For each innovative program or pilot provide the following information. If the county provides more than one program, use the "Add additional program" button. For related policy information, refer to 7.A.6 Innovative Behavioral Health Pilots and Projects .

Does the county's plan include the development of innovative programs or pilots?

No

Workforce Strategy

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For more information on this section, please see 6.C.2 Securing Medi-Cal Payment.

Maintain an Adequate Network of Qualified and Culturally Responsive Providers

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The county must ensure its county-operated and county-contracted behavioral health workforce is well-supported and culturally and linguistically responsive with the population to be served. Through existing Medi-Cal oversight processes, the Department of Health Care Services (DHCS) will assess whether the county:

Maintains and monitors **a network of providers that is sufficient to provide adequate access to services and supports for individuals with behavioral health needs; and**

Meets federal and state standards **for timely access to care and services, considering the urgency of the need for services.**

The county must ensure **that Behavioral Health Services Act (BHSA)-funded providers are qualified to deliver services, comply with nondiscrimination requirements, and deliver services in a culturally competent manner. Effective FY 2027-2028, DHCS encourages counties to require their BHSA providers to comply with the same standards as Medi-Cal providers in these areas (i.e. requiring the same standards regardless of whether a given service is reimbursed under BHSA or Medi-Cal), as described in the Policy Manual.**

Does the county intend to adopt this recommended approach for BHSA-funded providers that also participate in the county's Medi-Cal Behavioral Health Delivery System?
Yes

Does the county intend to adopt this recommended approach for BHSA-funded providers that do not participate in the county's Medi-Cal Behavioral Health Delivery System?
Yes

Build Workforce to Address Statewide Behavioral Health Goals

For related policy information, refer to 3.A.2 Contents of Integrated Plan and 7.A.4 Workforce Education and Training

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Assess Workforce Gaps

What is the overall vacancy rate for permanent clinical/direct service behavioral health positions in the county (including county-operated providers)?
31

Upload any data source(s) used to determine vacancy rate

For county behavioral health (including county-operated providers), please select the five positions with the greatest vacancy rates
Licensed Clinical Social Worker
Licensed Marriage and Family Therapist
Licensed Psychologist
Psychiatric Technician (PT)
Substance Use Disorder Counselor

Please describe any other key workforce gaps in the county
Beyond the positions with the highest vacancy rates mentioned in the prior section, Humboldt County continues to experience structural workforce gaps that have impacted behavioral health's system capacity. As a rural county, recruitment and retention challenges are particularly pronounced for specialized clinical and medical roles, including psychiatrists, nurse practitioners, substance use disorder counselors, case managers, peer support staff, and other prescribing professionals.

Additional workforce gaps exist among peer and rehabilitation support roles, such as Medi-Cal Certified Peer Support Specialists. These positions are essential for engagement, recovery support, and culturally responsive services but remain limited due to workforce shortages, certification barriers, and insufficient

training opportunities locally. Humboldt County also faces ongoing challenges recruiting substance use disorder counselors and dual-diagnosis providers, which affects the county's ability to provide integrated behavioral health treatment for individuals with co-occurring mental health and substance use conditions.

Humboldt County's geographic isolation and large service area create workforce pressures related to service access and workforce distribution, particularly for field-based and community outreach services. Recruiting staff who are able to travel across rural communities, deliver home-based care, and provide crisis response services remains difficult. Addressing these gaps will require continued investment in workforce development, training pipelines, and retention strategies to ensure the county can meet the increasing demand for behavioral health services under the Behavioral Health Services Act (BHSA) and other state-wide initiatives.

How does the county expect workforce needs to shift over the next three fiscal years given new and forthcoming requirements, including implementation of new evidence-based practices under Behavioral Health Transformation (BHT) and Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT)?

Over the next three fiscal years, Humboldt County anticipates that its behavioral health workforce needs will shift in response to statewide system reforms, including Behavioral Health Transformation (BHT) and the BH-CONNECT demonstration, both of which expand required services, evidence-based practices (EBPs), and accountability for outcomes. These initiatives are designed to increase access to community-based behavioral health services and strengthen the workforce needed to deliver them across the Medi-Cal system.

Humboldt County expects increased demand for specialized clinical and multidisciplinary team roles as new EBPs are implemented. Under BH-CONNECT and related reforms, counties are expected to deliver practices such as Coordinated Specialty Care for first-episode psychosis and several family-based youth interventions. These models require team-based staffing structures, including psychiatrists or prescribing providers, licensed clinicians, case managers, employment specialists, and peer providers. As a result, counties will likely see continued demand for licensed clinicians (LCSWs, LMFTs, psychologists), psychiatric prescribers, and staff trained in specialized evidence-based treatment models.

Workforce needs are expected to shift toward community-based and recovery-oriented roles. State reforms emphasize services delivered outside of institutional settings and closer to where people live, including outreach, community transition services, and housing-related supports. This shift will increase the need for peer support specialists, community health workers, rehabilitation specialists, and field-based clinicians who can engage individuals experiencing homelessness, justice involvement, or serious behavioral health conditions in community settings.

Humboldt County anticipates growing workforce needs related to substance use disorder treatment and

integrated care. Behavioral Health Transformation expands funding and programmatic emphasis on services addressing both mental health and substance use conditions. This will likely increase demand for Substance Use Disorder counselors, dual-diagnosis clinicians, and providers trained in medications for addiction treatment (MAT), particularly as counties expand access to SUD services within the broader behavioral health continuum.

Overall, workforce needs are expected to increase due to shifts toward team-based, community-based, and specialized clinical roles, with a growing emphasis on peer and community health workforce positions, integrated mental health and substance use treatment, and training in evidence-based models required under BHT and BH-CONNECT.

Address Workforce Gaps

If the county is planning to leverage the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative to address workforce gaps including for FSP and CSC for FEP, such as through applying for and/or encouraging providers to apply for the following BH-CONNECT workforce programs, please specify below.

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Scholarship Program?
No

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Student Loan Payment Program?
No

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Recruitment and Retention Program?
No

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Community-Based Provider Training Program?
No

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Residency Program?

No

Please describe any other efforts underway or planned in the county to address workforce gaps aside from those already described above under Behavioral Health Services Act Workforce, Education, and Training

In addition to efforts described under the Behavioral Health Services Act (BHSA) Workforce, Education, and Training (WET) section, Humboldt County Behavioral Health (BH) is advancing several complementary initiatives to address workforce gaps through a racial and cultural equity lens. As outlined in the 2025 Cultural Competence Plan, workforce development is embedded as a core strategic priority across the department.

First, BH is implementing its Behavioral Health Equity Plan (2025–2028), which includes two workforce development strategies focused on strengthening internal equity work, improving hiring, recruitment, and retention practices, and preparing staff in supervisory and leadership roles. This work aligns with the broader DHHS Racial Equity Strategic Plan and includes structured training and coaching for all staff, development of internal racial equity coaching capacity, and intentional efforts to improve the experiences of Black, Indigenous, and People of Color (BIPOC) staff.

Second, BH has strengthened internal infrastructure to advance culturally responsive hiring and retention. The Ethnic Services Manager (ESM) reviews policies, procedures, and budget development processes to ensure conscious consideration of racial and cultural equity. Between September 2024 and September 2025, over 200 policies, procedures, and forms received equity-focused review. Budget planning tools were also revised to ensure workforce investments are evaluated for their impact on equity and representation.

Third, BH continues to invest in building a multicultural and multilingual workforce. This includes:
- Providing bilingual pay differentials for qualified staff.
- Utilizing contract interpreters and a 24-hour Language Line.
- Incorporating a Latinx Liaison position to strengthen outreach and engagement with Spanish-speaking communities.
- Partnering with culturally responsive providers such as Two Feathers Native American Family Services and United Indian Health Services to expand culturally responsive service capacity.

Fourth, BH is deepening Tribal engagement through partnership with Kauffman & Associates, Inc., which facilitated Tribal Engagement Sessions in 2025. Recommendations from these sessions include cross-training opportunities, collaborative staffing models, formalized communication agreements (MOUs/MOAs), and support for Tribal behavioral health initiatives.

Finally, the department continues to support system-wide cultural competence through annual cultural competence training requirements, racial equity trainings, leadership coaching, and equity-focused management meetings. The Cultural Responsiveness Committee (CRC) and Racial Equity Steering Committee further reinforce accountability and staff engagement in equity work.
Collectively, these efforts reflect a multi-pronged approach to addressing workforce gaps by strengthening recruitment, retention, equity work, bilingual services, Tribal partnerships, and culturally responsive organizational practices beyond the BHSA WET framework.

Budget and Prudent Reserve

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For more information on this section, please see 6.B.3 Local Prudent Reserve .

Budget and Prudent Reserve

Download and complete the budget template using the button below before starting this section

Please upload the completed budget template
Integrated-Plan-Budget-Template_v3 (final 5.28.26).xlsx

Please indicate how the county plans to spend the amount over the maximum allowed prudent reserve limit for each component if the county indicated they would allocate excess prudent reserve funds to a given Behavioral Health Services Act component in Table Nine of the budget template

Behavioral Health Services and Supports (BHSS)
N/A

Full Service Partnership (FSP)
N/A

Housing Interventions
N/A

Enter date of last prudent reserve assessment
5/5/2026

Please describe how the use of excess prudent reserve funds drawn down from the local prudent reserve aligns with the goals of the Integrated Plan

BHSS
N/A

FSP
N/A

Housing Interventions
N/A

Plan Approval and Compliance

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For more information on this section, please see 3.A.1 Reporting Period

Behavioral health director certification

Download and complete the behavioral health director certification template using the button below before starting this section

Please upload the completed Behavioral health director certification template
BH Director Certification - Signed.pdf

County administrator or designee certification

Download and complete the county administrator or designee certification template using the button below before starting this section

Please upload the completed County administrator or designee certification template
CAO Certification - Signed.pdf

Board of supervisor certification

For final submission, download and complete the board of supervisor certification template using the button below before starting this section

Please upload the completed Board of supervisor certification template
Board of Supervisors Certification.pdf
Confirm that the data is up to date and reflects the correct information for a Draft Plan

Requests

Assertive Community Treatment (ACT)

For counties seeking an exemption to the requirement to include ACT in the county's FSP program

Please select which FSP exemptions criteria the county meets
Limited workforce (e.g. qualified providers)

Please provide justification for this FSP exemption request
Humboldt County is a small rural county with limited numbers of professionals to staff positions adequately under current program guidelines and would be further challenging with the implementation of ACT. Humboldt County currently operates at a 27% Vacancy rate for LPHA positions which has been a steady number since the end of the Pandemic. Humboldt County also operates other 24-Hour programs where staffing levels are a chronic concern causing program closures from time to time. Qualified staff willing to work evening and night shifts in current 24-hour programs also present financial challenges to recruit and retain these types of staff, both front line and supervisory staff.

Due to workforce shortages, the County must rely on locum/contract staff to operate existing services, resulting in significantly higher personnel costs. This reliance demonstrates the County's inability to recruit and retain sufficient qualified staff to meet 24-hour service demands. Expansion to ACT/FACT models would require additional staffing capacity that is not currently attainable.

Supporting Data

Please upload supporting data
Humboldt County Vacancy Counts.xlsx

Please select the data source
County workforce data

Forensic Assertive Community Treatment (FACT)

For counties seeking an exemption to the requirement to include FACT in the county's FSP program

Please select which FSP exemptions criteria the county meets
Limited workforce (e.g. qualified providers)

Please provide justification for this FSP exemption request
Humboldt County is a small rural county with limited numbers of professionals to staff positions adequately under current program guidelines and would be further challenging with the implementation of FACT. Humboldt County currently operates at a 27% Vacancy rate for LPHA positions which has been a steady number since the end of the Pandemic. Humboldt County also operates other 24-Hour programs where staffing levels are a chronic concern causing program closures from time to time. Qualified staff willing to work evening and night shifts in current 24-hour programs also present financial challenges to recruit and retain these types of staff, both front line and supervisory staff.

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Supporting Data

Please upload supporting data
Humboldt County Vacancy Counts.xlsx

Please select the data source
County workforce data

Individual Placement and Support (IPS) Supported Employment

For counties seeking an exemption to the requirement to include IPS in the county's FSP program

Please select which FSP exemptions criteria the county meets
Limited workforce (e.g. qualified providers)
Other hardships

Please provide justification for this FSP exemption request
Humboldt County is a small, rural county with a population under 200,000 and a limited behavioral health workforce, which presents significant challenges to implementing the Individual Placement and Support (IPS) model with fidelity. While the County experiences persistent vacancy rates among Licensed Practitioner of the Healing Arts (LPHA) and related clinical staff (27% as mentioned in the ACT and FACT exemption requests), IPS implementation requires an additional specialized workforce, including trained employment specialists and supervisors capable of maintaining IPS fidelity standards. Recruitment and retention of these positions is particularly challenging in Humboldt's rural labor market.

Additionally, Humboldt County has a limited employer base, with approximately 3,178 employer establishments, and a local economy largely driven by seasonal industries such as tourism, agriculture, and natural resources. These conditions limit the availability of stable, competitive employment opportunities required under IPS. Furthermore, the County's rural geography and transportation barriers—characterized by long travel distances between communities and reliance on personal vehicles—create challenges for consistent employer engagement and rapid job placement. Collectively, these structural and economic factors prevent Humboldt County from implementing IPS at the scale and fidelity required under current program guidelines.

Supporting Data

Please upload supporting data
Humboldt Census Data.pdf

Please select the data source
County demographic data

Supporting Data

Please upload supporting data
Humboldt County Vacancy Counts.xlsx

Please select the data source
County workforce data

Data Suppression Notice:
Values marked with "*" have been suppressed per DHCS de-identification standards. Counts between 1–10 are displayed as "<11*"