Community Planning Process Report

For the

Mental Health Services Act

Annual Update 2019-2020

and

Three Year Plan 2020-2023

Introduction

This document reports the results of the Community Planning Process (CPP) for the Humboldt County Mental Health Services Act (MHSA) Annual Update for 2019-2020 and the Three Year Plan for 2020-2023. The document is organized as follows.

1. Summary of Findings
2. CPP Summary
3. Stakeholder Demographics
    a. Stakeholder Meetings
    b. Community Survey
4. Stakeholder Meeting Themes
5. Community Survey Themes
6. MHSA Funding Availability
7. Next Steps

This report provides information to Behavioral Health leadership in determining whether the draft Annual Update for 2019-2020 should be revised, and in determining what MHSA programs and services will be supported for the next three years in the Three Year Plan for 2020-2023. In its deliberations, leadership should consider the requirements for implementing Welfare and Institutions Code Section 5840.7 enacted by Senate Bill 1004. This Section establishes priorities for County use of Prevention and Early Intervention (PEI) funding. Counties can choose to focus on other priorities, and if so will need to describe why these programs are included and the metrics by which their effectiveness will be measured. The priorities for Section 5840.7 are:

- Childhood trauma prevention and early intervention
- Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the lifespan
- Youth outreach and engagement strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs
- Culturally competent and linguistically appropriate prevention and intervention
- Strategies targeting the mental health needs of older adults
- Early identification programming of mental health symptoms and disorders

In addition, leadership will need to take into account that a new Innovation project will need to be developed and approved within the next fiscal year. A new project will need a budget allocation of not more than 5% of the total MHSA budget, and the funds will come from the Community Services and Supports category of MHSA.

This report will be posted to the County's website. Those who provided input into the CPP, and others, can be assured that their input was recorded.

Summary of Findings

A total of 793 responses were provided by community members as input into the Draft Annual Update 2019-2020 and the yet-to-be-written Three Year Plan 2020-2023. Stakeholders providing input resided in communities throughout Humboldt County. The top priorities identified by respondents were:

- Increase and expand mental health services: To more communities in Humboldt County; have more doctors, counselors, and other mental health professionals; have more programs; provide services and supports to all who need it.
- Workforce support: Recruit, retain and train the workforce---the mental health workforce as well as those who may encounter people needing mental health services. Law enforcement, child care providers, and teachers are included as part of the workforce.
- Services and supports for early childhood: Therapeutic environments, trauma informed environments, parent education, home visiting, playgroups, support for the 0-8 Mental Health Collaborative, and attention for extreme behaviors in young children.
- Continuity of care for clients released from Sempervirens (SV), Crisis Stabilization Unit (CSU), Jail, and other transition services: Providing discharge plans, warm handoffs, transitional housing/placements.
- Increase support for school age youth: Both transition age youth (TAY) and those not yet TAY. Support for first break psychosis, crisis support, and strengthening the continuity of care for families.
- Housing and support for those experiencing homelessness: Supportive housing and other services.
- At schools, provide more mental health counselors and other mental health supports.
- Increase support for the seriously mentally ill: Those with anosognosia (lack of insight into illness); more assertive care treatments; expansion of Comprehensive Client Treatment (CCT); more case managers and other paraprofessionals; occupational support, supported employment and sheltered work.

The top five populations that respondents felt were unserved/underserved by current MHSA programs are:

- Persons experiencing homelessness
- School age children
- Transition age youth
- Children 0-5
- Those released from jail or who are on probation

The top challenges to receiving mental health services were: 1) lack of appointments, 2) transportation, and 3) the locations of services. These identified challenges reinforce the theme of expanding and increasing access to services.

Community Planning Process (CPP) Summary

The CPP for the 2019-2020 MHSA Annual Update and the 2020-2023 Three Year Plan began in November 2019. Input was gathered in three ways: 1) stakeholder meetings, 2) comments to the MHSA Comment Email and to the MHSA Comment Phone Line, and 3) results from the Community Participation and Feedback Survey (Community Survey).

Stakeholder Meetings. The MHSA Program Manager contacted community groups and organizations to ask for agenda time at their regularly scheduled meetings, or to request their assistance in setting up a special meeting to gather stakeholder input. During the months of November 2019 through January 2020 a total of sixteen stakeholder meetings were held with a total of 191 individuals attending. For the regularly scheduled meetings of groups, at which MHSA was an agenda item, publicity about the meeting was provided by the group hosting the meeting. For the two specially scheduled community meetings, DHHS Media issued a news release to fourteen media outlets. Attachment 1 is a list of the meetings, groups, dates and number attending.

Attendees at the meetings received a packet of information about MHSA. This information included the Draft 2019-2020 Annual Update; summary of 2019-2020 MHSA programs currently funded; MHSA fundamental concepts; MHSA information sheet; Mental Health Services provided by the County; definitions of Serious Mental Illness and Serious Emotional Disturbance; MHSA Comment Form; MHSA demographic form; and a paper copy of the Community Survey. The summary of current programs, fundamental concepts, information sheet, comment form, demographic form and Community Survey were also available in Spanish. Attachment 2 contains the English versions of the information that was provided. The draft Annual Update is found in Attachment 3. There were no Spanish-speaking-only individuals at the stakeholder meetings.

At each stakeholder meeting, the MHSA Program Manager presented the information and participants were invited to ask questions and provide input. The input was recorded in notes or on flip charts. Participants in these meetings could also provide written comments on the MHSA Comment Form in addition to providing verbal input. Seventeen written comment forms were collected from meeting participants during the stakeholder process.

MHSA Comment Email. Four stakeholders provided input through an email to the MHSA Comment Email address and one stakeholder left a message on the MHSA Comment Phone Line.

Community Survey. Google Forms was used to create a community survey, available online and in paper format. Between the paper copies and the online responses a total of 597 responses were received. Of the responses, 472 people, 81%, stated it was their first time providing input and information for the CPP. For 111 people, 19%, it was not the first time they had provided input. The documents in Attachment 2 include a copy of the paper survey.

Information about the community survey's availability was provided through several means.

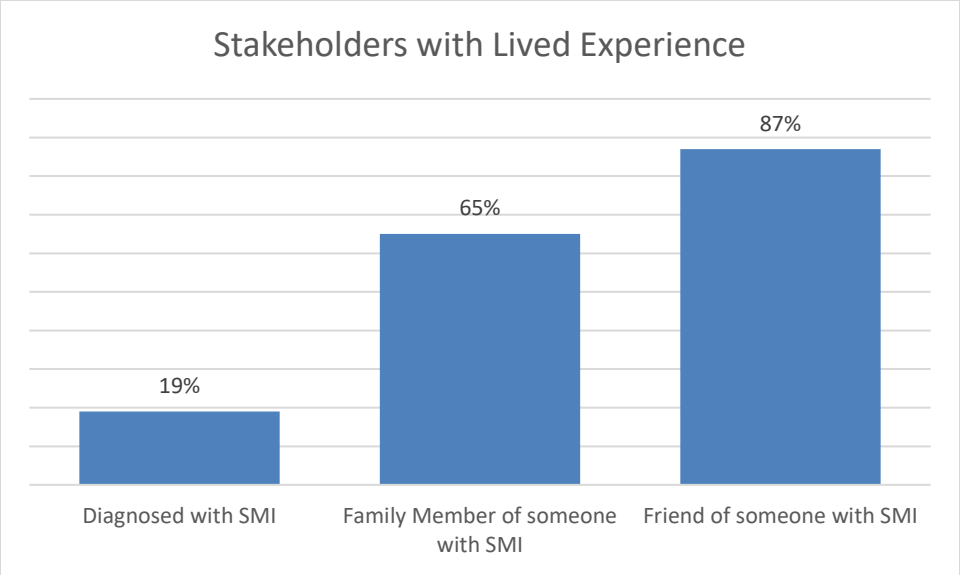
- A news release was prepared by DHHS Media and submitted on November 18 to fourteen local media outlets.
- The information was posted to the DHHS Facebook page, and First 5 Humboldt posted to their Facebook page.
- The County of Humboldt published the information on its website on November 18 and again on January 6.
- The January 2020 e-Newsletter of the County included a reminder about the community survey's availability.
- Links to the survey were provided via email to over 1,000 DHHS staff; to over 200 members of the 0-8 Mental Health Collaborative; to the 100+ Promotores distribution list; to the Northern California Association of Nonprofits (NorCAN) distribution list of over 1,000. Many other groups with smaller distribution lists were also provided with the link and shared with their distribution lists.
- All groups with which a stakeholder meeting was held received paper copies of the community survey and were asked to make the survey available to their constituents.

Between the 191 individuals attending meetings, five providing input through MHSA Email Comments and MHSA Phone Comments, and 597 responses to the Community Survey, a total of 793 responses were provided as input into the Draft Annual Update and the Three Year Plan.

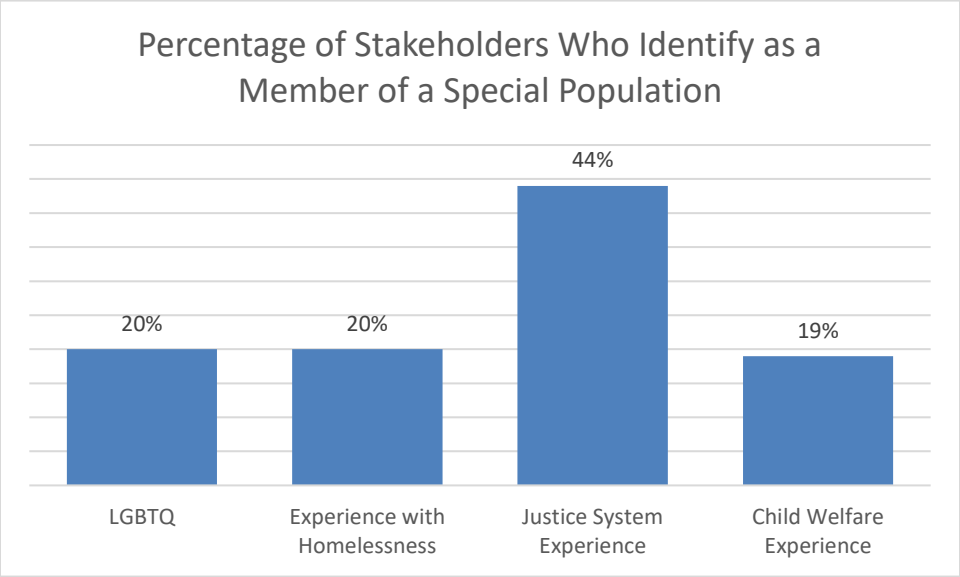
Stakeholder Demographics

Stakeholder Demographics from meetings. Stakeholders attending meetings were asked to complete a MHSA demographic form. Completion of the form was voluntary, and responses were anonymous. A total of 85 individuals, 45% of those attending, completed a demographic form at the stakeholder meetings.

Individuals with lived experience of a serious mental illness (SMI) and their family members are recognized as a vital voice in the MHSA CPP. As seen in the chart below, 19% identified as having a mental illness, and 65% identified as a family member of someone with a mental illness. In addition, 87% of those attending the stakeholder meetings said they were a friend of someone with a SMI.

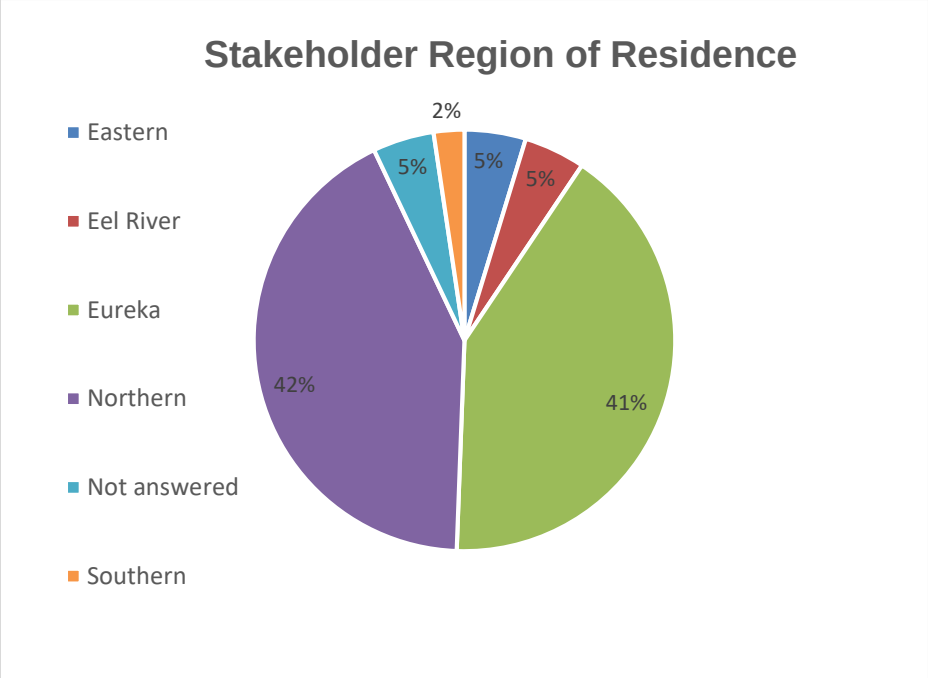


Additional life experiences have been identified as important voices for the CPP. Sexual orientation and gender identity, homelessness, experience with the justice system, experience with Child Welfare, and those whose primary language is not English have life experiences or conditions that can result in challenges to successful mental health access and treatment. The chart below illustrates the inclusion of people with these life experiences in the CPP. Twenty percent identified as LGBTQ; 20% identified as having experience with homelessness; 44% had justice system experience; and 19% had Child Welfare experience. Two stakeholders stated their primary language was a language other than English.

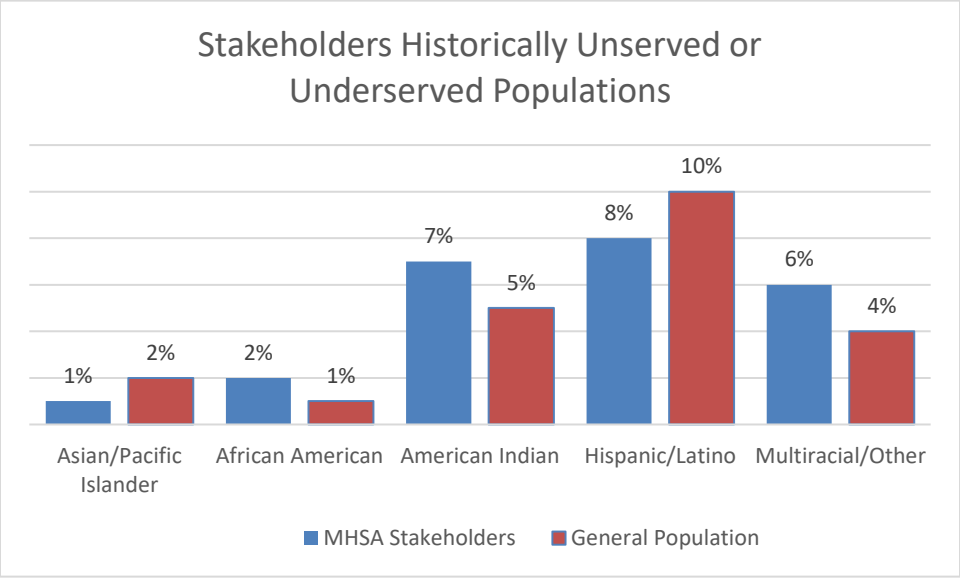


In this CPP, 42% of participants resided in the Northern Humboldt region, which includes Arcata, Blue Lake, McKinleyville, and areas north, and 41% of participants resided in Eureka. Five percent of participants resided in Eastern Humboldt, which includes Hoopa and Willow Creek; 5% in the Eel River Valley, which includes Fortuna, Ferndale, Scotia and Rio Dell; and 2%

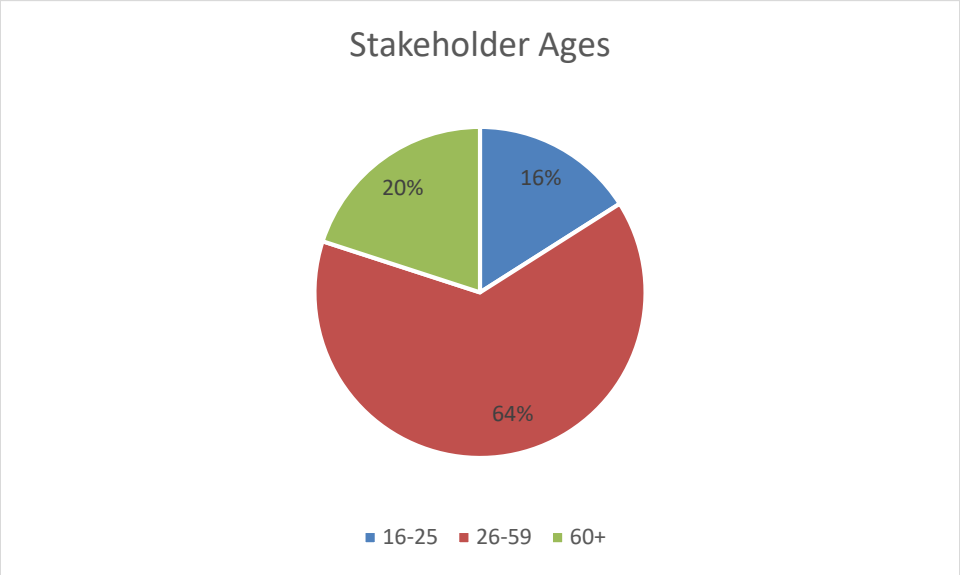
resided in Southern Humboldt, which includes Redway, Petrolia and Garberville.



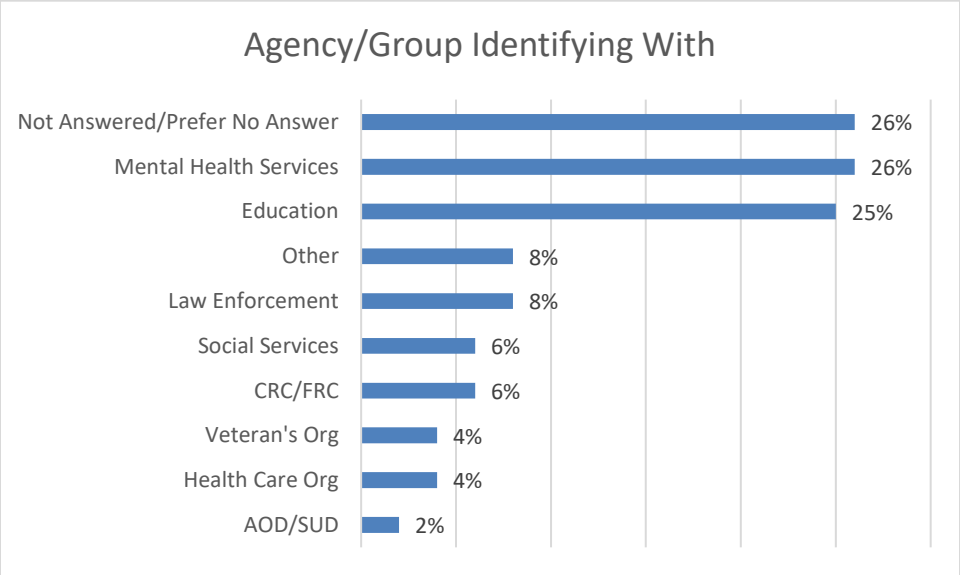
Efforts are made to reach participants that reflect the racial and ethnic diversity of Humboldt County. Of those attending stakeholder meetings, 8% were Hispanic/Latino as compared to 10% of the Humboldt County general population. Two percent were Black/African American, as compared to 1% of the general population. Seven percent were American Indian, as compared to 5% of the County general population. 1% were Asian/Pacific Islander as compared to 2% of the general population. Six percent were Multiracial/Other as compared to 4% of the County general population.



Sixteen percent of those completing the demographic form were ages 16-25; 64% were ages 26-59, and 20% were age 60+.

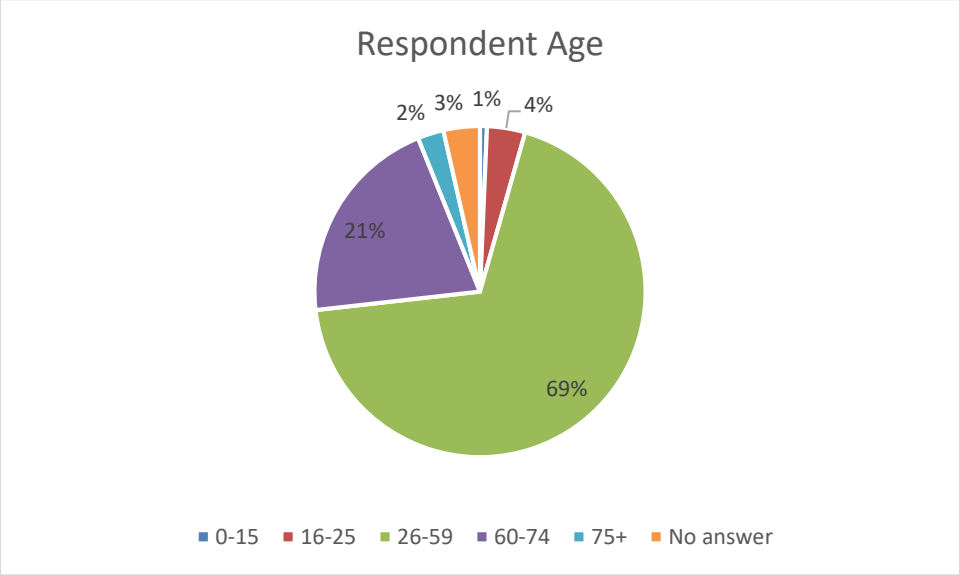


The chart below illustrates the representation from community agencies participating in the stakeholder meetings. It shows that the process included individuals from mental health services, 26%; education, 25%; health care organizations, 4%; social services, 6%; Substance Use Disorder Services, 2%, Community and Family Resource Centers (CRC/FRC), 6%; Other 8%; law enforcement 8%; veterans organizations 4%; and 26% provided no response. Some respondents checked more than one category, so the total is more than 100%.

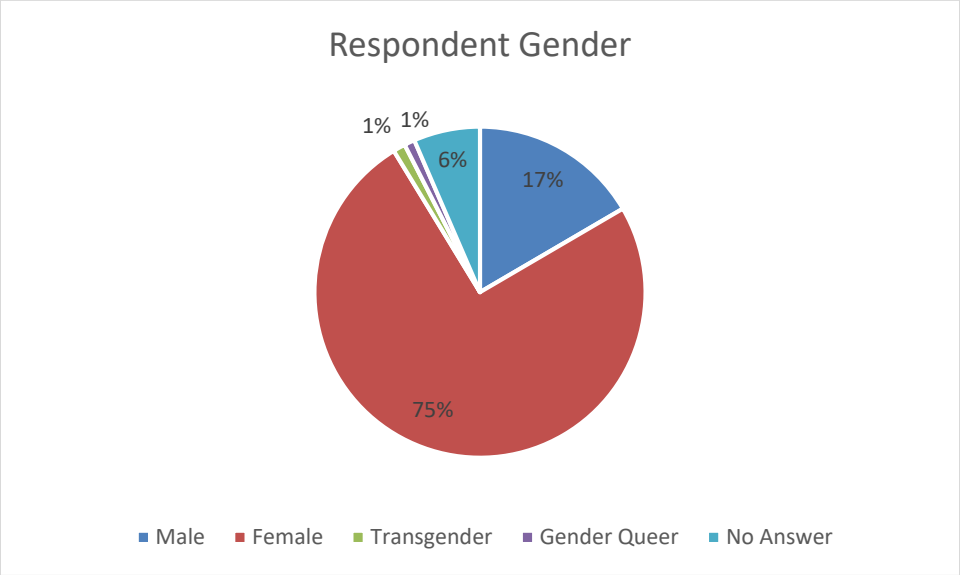


<u>Stakeholder demographics from Community Survey</u>. Community members completing the survey either online or in paper format were asked to provide demographic information.

One percent of respondents were ages 0-15, 4% were ages 16-25, 69% were ages 26-59, 21% were ages 60-74, 2% were age 75+, and 3% did not answer.

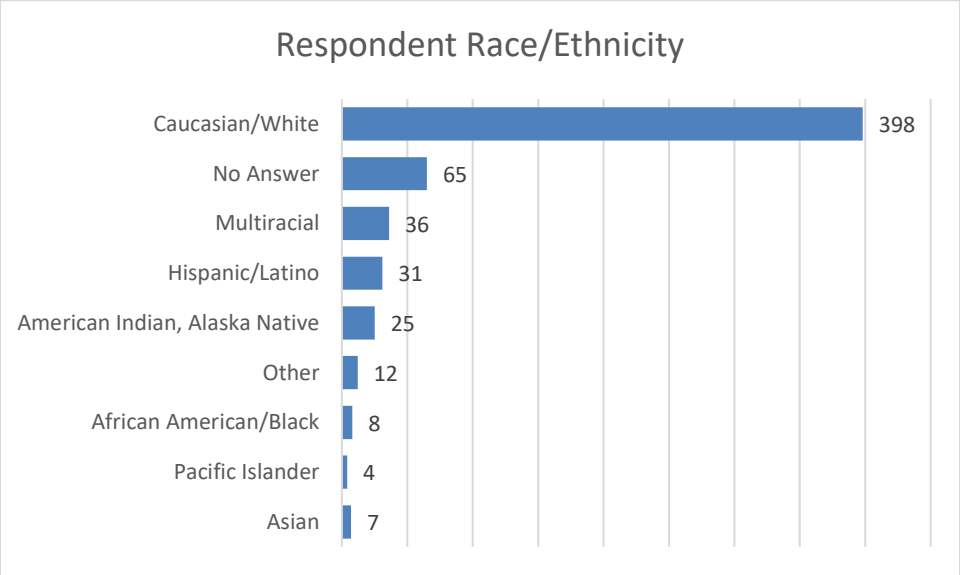


Seventeen percent of respondents were male, 75% female, 1% transgender, 1% gender queer, and 6% did not answer.

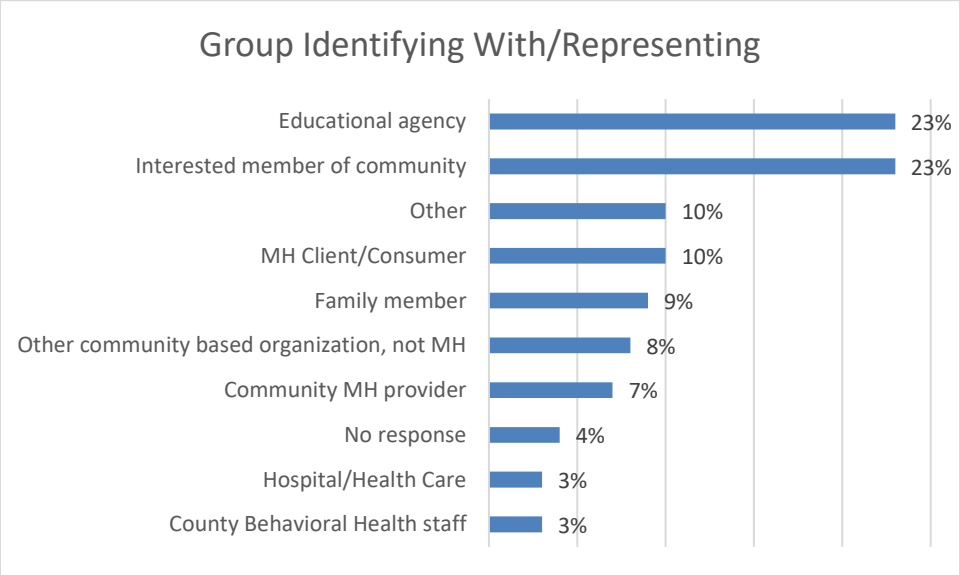


398 respondents, 69%, were Caucasian/White; 36 respondents, 5%, were Multiracial; 31 respondents, 5%, were Hispanic/Latino; 25 respondents, 4%, were American Indian/Alaska Native; 12 respondents, 2%, were Other; 8 respondents, 2%, were African American/Black; 4

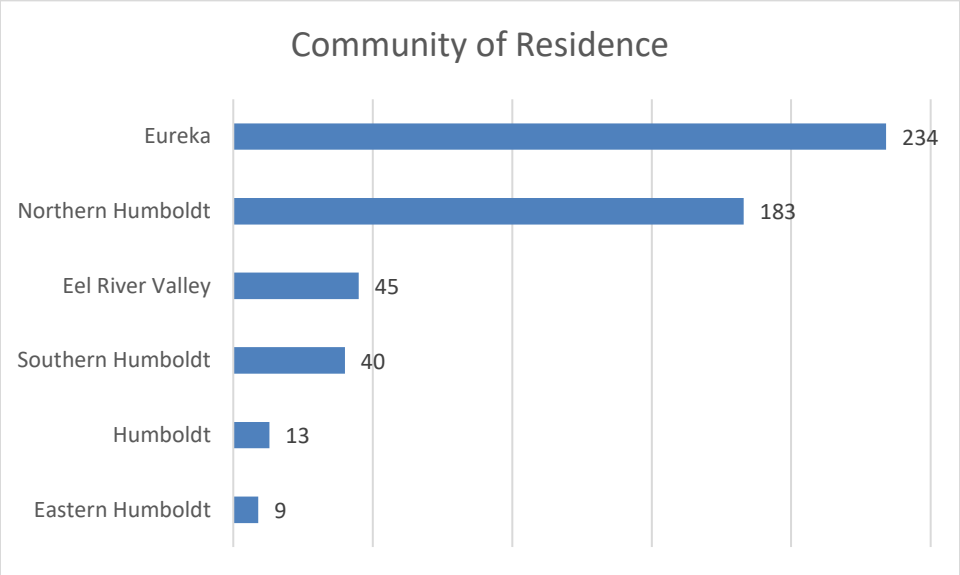
respondents, 1%, were Pacific Islander; and 7 respondents, 1%, were Asian. 65 respondents, 11%, did not answer.



Survey respondents were asked to identify the group that they primarily identify with or represent. Twenty-three percent indicated educational agency; 23% indicated an interested member of the community; 10% indicated Other; 10% indicated mental health client/consumer; 9% indicated family member of a client/consumer; 8% indicated another community based organization, not mental health; 7% indicated a community mental health provider; 4% made no response; 3% indicated hospital/health care; and 3% indicated County Behavioral Health staff. In the Other category, the primary responses were faith community, law enforcement, homeless/housing services, NAMI, Substance Use Disorder services, and Veteran Services.



Survey respondents were asked to identify the city or community in which they reside. The majority of respondents resided in the Humboldt Bay area—Eureka, Arcata and McKinleyville—417 respondents. The Eel River Valley, including Fortuna, Rio Dell, and Ferndale, had 45 respondents, followed by Southern Humboldt, including Redway, Garberville, and Petrolia, at 40 respondents. Thirteen people responded "Humboldt" as their community of residence. There were nine respondents from Hoopa, Weitchpec and Willow Creek in Eastern Humboldt.



CPP Themes

Themes from stakeholder meetings. After the stakeholder meetings were completed, the notes from each meeting, the Comment Forms received at each meeting, and the comments received from the MHSA Email and Phone Line were reviewed. This review resulted in a grouping of comments and input by the overall themes of the services and supports that community stakeholders would like to see more of, or changes within.

The table below shows the ranking of themes from the sixteen stakeholder meetings, the five comments received from the MHSA Comment Email and MHSA Phone Line, and the seventeen comment forms received at the stakeholder meetings. Comments in the Other category on comment forms were services for older adults, programs for obesity, and appreciation for the information.

Ranking by Totals for meetings and comments

Themes	# meetings at which mentioned	Email and phone	Comment Forms	Totals
Expand/increase access to services	6	2	3	11
Workforce support	9			9
Continuity of care for clients released from SV, CSU, Jail; Other transition services	7		1	8
Increase support for youth	4		4	8
Services for early childhood (0-5)	4		2	6
Housing & Services for those experiencing homelessness	4		1	5
Support groups and peer support	4			4
Law enforcement partnerships	3		1	4
Transportation for clients	2		1	3
Increase support for seriously mentally ill	3			3
Clarity about MH services provided	3			3
Hope Center improvements	3			3
Bilingual & Culturally Competent Services	2			2
Mental Health Counselors at schools	2			2
Substance Use Disorder Services	2			2
Other			4	4

For a breakdown of the community meetings at which the input was received, the number of comments from the MHSA Comment Email or Phone Line, and the Comment Forms received, see Attachment 4. For the notes from each community stakeholder meeting, see Attachment 5. Below is a brief summary of each theme.

Expand/increase access to services. Six stakeholder groups talked about the need to expand services and supports, and email/comment forms also focused on this theme. Comments included to increase outreach, employ more psychiatrists and counselors, provide more programs for juveniles, expand Sempervirens and the Crisis Stabilization Unit, and provide more residential care teams and services.

Workforce Support. This need was mentioned at nine stakeholder meetings. Training and support for those working with the 0-8 population; providing clinical experience and education for Humboldt State University graduates; more funds for professional development; flexible schedules for staff—all were comments relating to this theme.

Continuity of care for clients released from Sempervirens, Crisis Stabilization Unit, and the jail, plus other transition services. This need was mentioned at seven stakeholder meetings and in

one comment form. Ideas include the need for a day treatment center, step-down unit, giving a warm hand-off, increasing residential housing options, and more board and care facilities.

Increased support for school aged children and youth. Four stakeholder meetings, and four comments forms, indicated the need for increased support for youth, both TAY and those not yet TAY. Support for first break psychosis, crisis support, and strengthening the continuity of care for families was included.

Services for early childhood. Four stakeholder groups and two comment forms focused on this theme, which included the need for therapeutic nurseries and preschools, trauma centers and trauma informed environments, parent education, home visiting, playgroups, support for the 0-8 Mental Health Collaborative, and attention for extreme behaviors in children K-3rd grade.

Housing and services for those experiencing homelessness. Attendees at four meetings, and one comment form, indicated the need for more supportive housing, more supportive services for those who are not housed, and working with rental companies to overcome barriers for achieving housing.

Support groups and peer support. Attendees at four meetings spoke about the need for more support groups--DHHS sponsored with paid facilitators that anyone with mental illness could attend; paying peers to tell their stories; and expanding Mother/Woman groups.

Law enforcement partnerships. Attendees at three meetings, and one Comment Form, spoke about the need for a strengthened partnership between law enforcement and mental health, including providing clarification about policies; providing a pocket-sized resource list; increased community collaborations; and providing more training for law enforcement on working with the mentally ill.

Transportation for clients. Two groups, and one Comment Form, spoke about the need for transportation for clients and community members to get to services and supports. Transportation to the Hope Center was specifically mentioned.

Increased support for the seriously mentally ill. Attendees at three groups spoke about providing increased services and support for those with anosognosia (lack of insight into illness); more assertive care treatments; expansion of Comprehensive Client Treatment (CCT); having more case managers and other paraprofessionals; and providing occupational support, supported employment and sheltered work.

Clarity about Mental Health Services. Three groups stated there needs to be more clarity about navigation of and access to mental health systems.

Hope Center improvements. Three groups indicated the need to improve/expand the facility and programs of the Hope Center. Ideas included relocating the facility to a more accessible part of town, such as downtown, far from Sempervirens and the Crisis Stabilization Unit; providing more classes and activities; getting a larger facility; and providing a full-service kitchen with work programs.

Bilingual and Culturally Competent Services. This need was mentioned at two stakeholder meetings. Staff at K'ima:W Medical Center in Hoopa felt MHSA funds should be provided to the

organization to hire staff and provide services in order to be truly culturally competent. Tribal Social Services Directors stated all MHSA funds should go to tribes.

More mental health counselors at schools and additional school supports. This need was mentioned at two stakeholder meetings.

Substance Use Disorder Services. Two groups spoke about the need for additional substance use disorder services, and to include youth under age 18 who have co-occurring substance use and mental health issues.

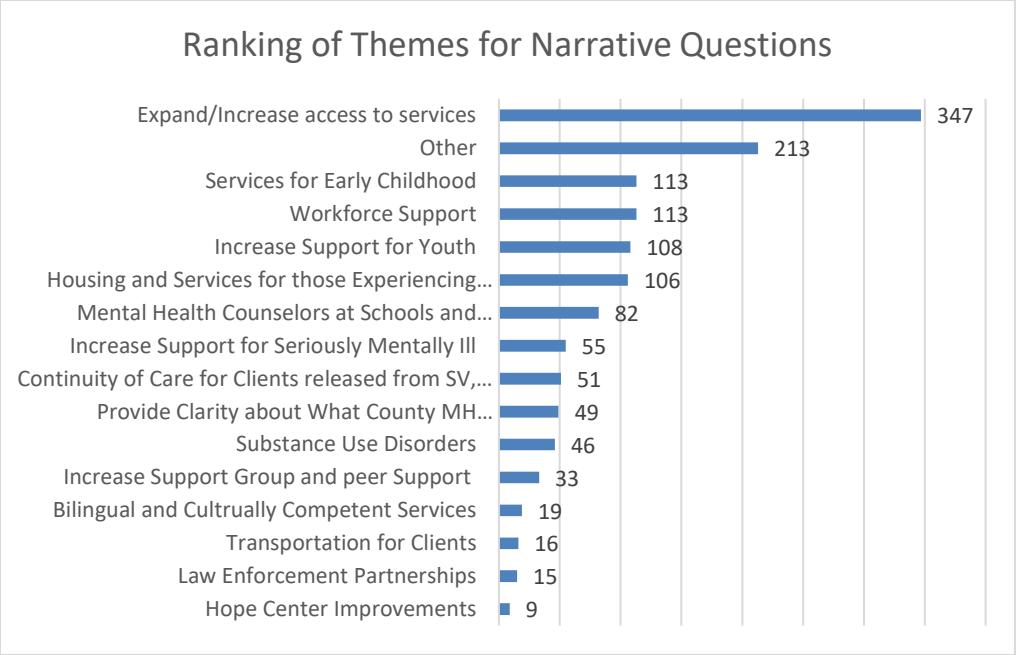
Expand Sempervirens and Crisis Stabilization Unit using MHSA Capital funds. This idea was brought up at one stakeholder meeting.

Community Survey Themes.

The online community survey had eighteen questions, with most questions allowing respondents to write in a narrative response. There were a very large number of narrative comments that were analyzed—70 pages--and for purposes of continuity, the responses were organized into the same themes identified in the stakeholder meetings. Many of the comments contained more than one theme, and it was challenging to organize this much information. All of the comments are found in Attachment 6.

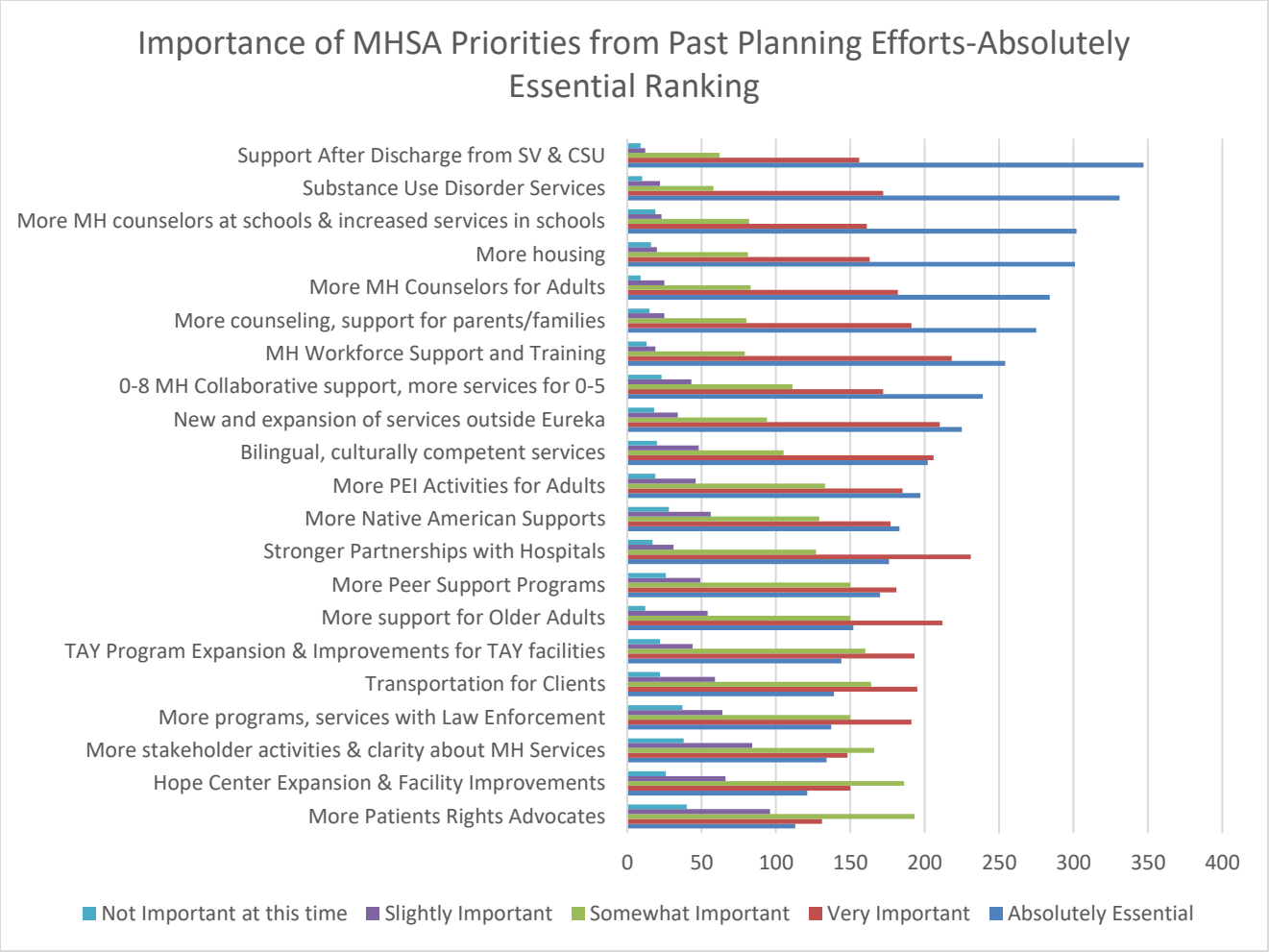
Four of the survey questions (questions 3, 9, 10 and 18, as numbered in the online version of the survey) are grouped together in the chart below to show the overall survey respondent priorities by theme. The top six are: 1) Expand/increase access to services, 2) Other, 3) Services for early childhood, 4) Workforce support, 5) Increase support for youth, and 6) Housing and services for those experiencing homelessness.

The top six priorities that surfaced in Other were: 1) Ensure MH staff accountability and change agency practices, 2) increase community based work focused on primary prevention, such as events, addressing poverty, helping people gain life skills, 3) include alternative therapies, such as art, nature, yoga and meditation as part of the therapeutic process, 4) increase collaboration and coordination with other agencies, 5) support more suicide prevention programs, Zero Suicide, and Suicide Fatality Review, and 6) more prevention and early intervention supports.

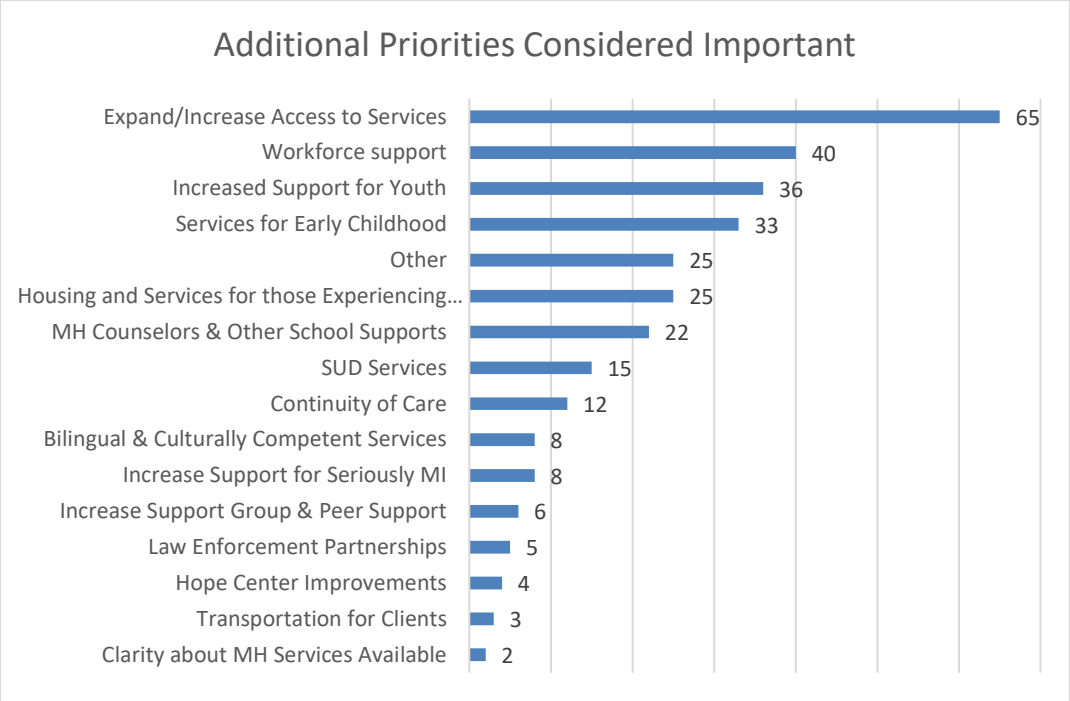


The remainder of this section reports results by each question.

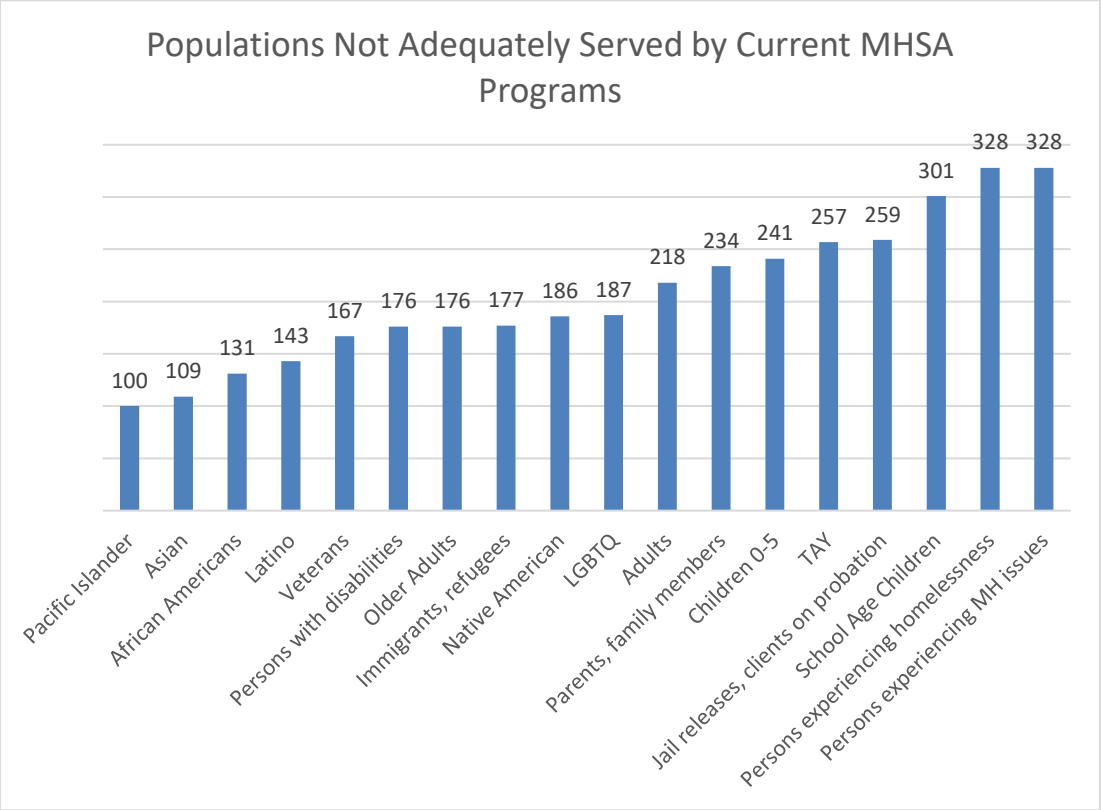
<u>Rate the level of importance of MHSA priorities from past planning efforts.</u> Ratings were "Absolutely Essential," "Very important," "Somewhat important," "Slightly important," and "Not important at this time." As the chart below shows, the top five priorities for "Absolutely Essential" are Support after Discharge from SV & CSU; Substance Use Disorder Services; More MH Counselors at schools and increased services in schools; More housing; More MH Counselors for Adults.



What additional priorities not listed above are important? The top priorities for this question are 1) Expand/Increase Access to Services, 2) Workforce Support, 3) Increased Support for Youth, 4) Services for Early Childhood (0-5), and 5) Other. The top three priorities that were listed in Other were: 1) more suicide prevention programs, Suicide Fatality Review, and Zero Suicide, 2) more community based work focused on primary prevention, such as events, addressing poverty, helping people gain life skills, and 3) increasing collaboration and coordination with other agencies. As stated earlier, answers to this question were also analyzed with the other narrative questions, as shown in the chart on page 15.

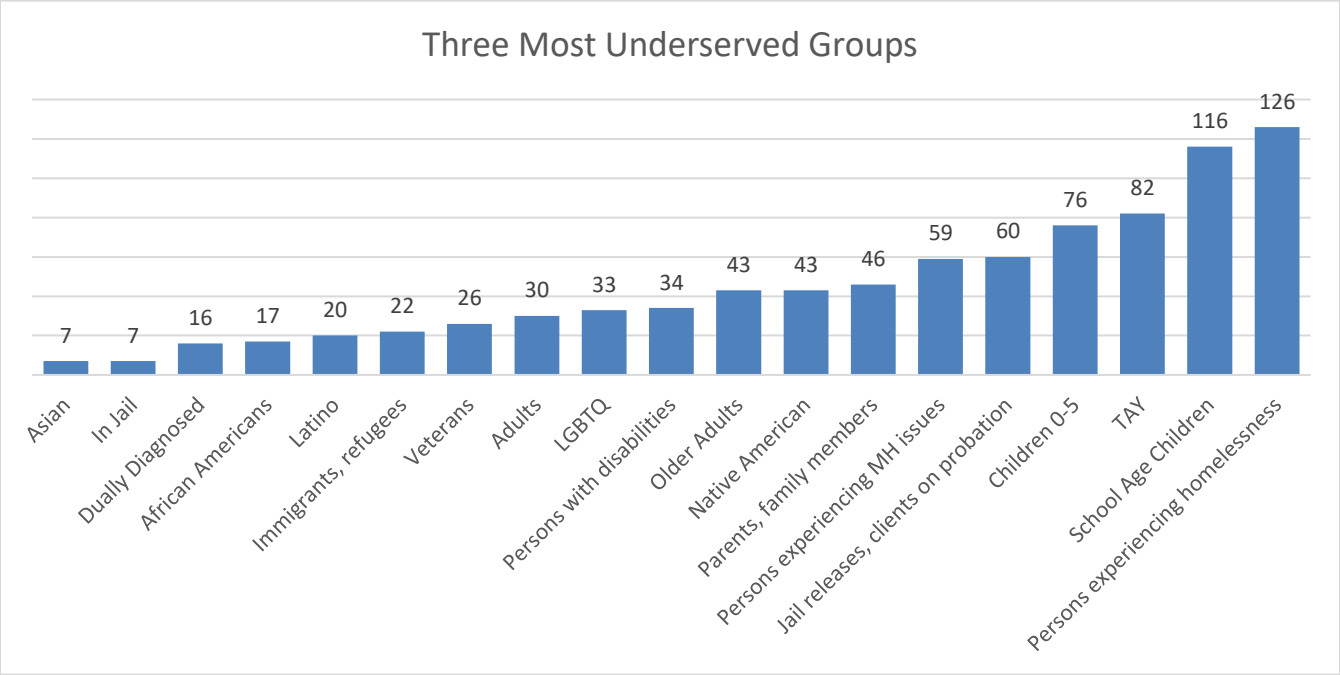


<u>What populations/groups are not being served adequately by current MHSA programs?</u>
The top five groups, as indicated in the chart below, are persons experiencing mental health issues; persons experiencing homelessness; school age children; those released from jail and clients on probation; and transition age youth (TAY).

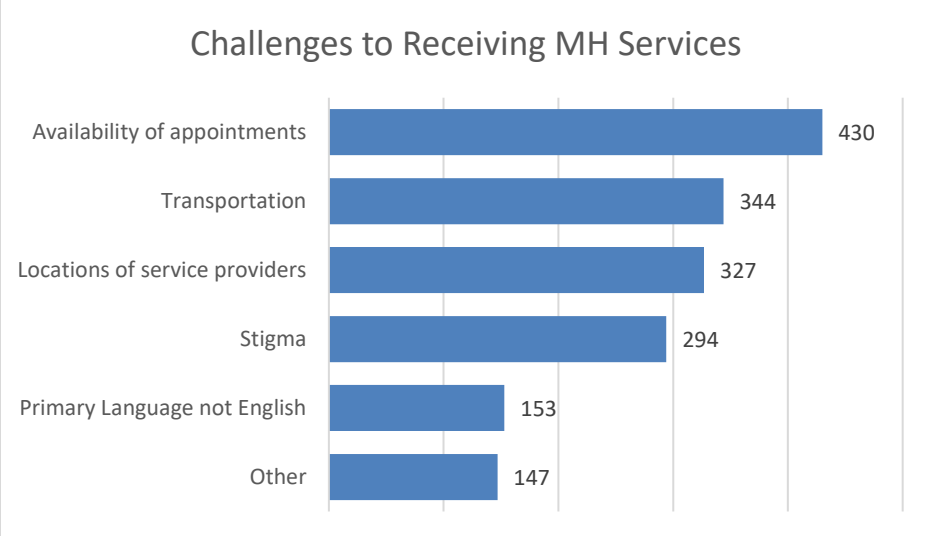


If you checked Other, describe. The top four responses in Other were: 1) those who are dually diagnosed with mental illness and substance use disorders, 2) those who are currently in jail, 3) those living in remote rural areas, and 4) foster families and youth.

Who are your top three underserved/unserved groups? The chart below depicts the responses to this question, and adds in the top two responses from the Other category of question 5, the dually diagnosed and those who are jail. The top five groups were: 1) persons experiencing homelessness, 2) school age children, 3) TAY, 4) children ages 0-5, and 5) jail releases and those on probation.

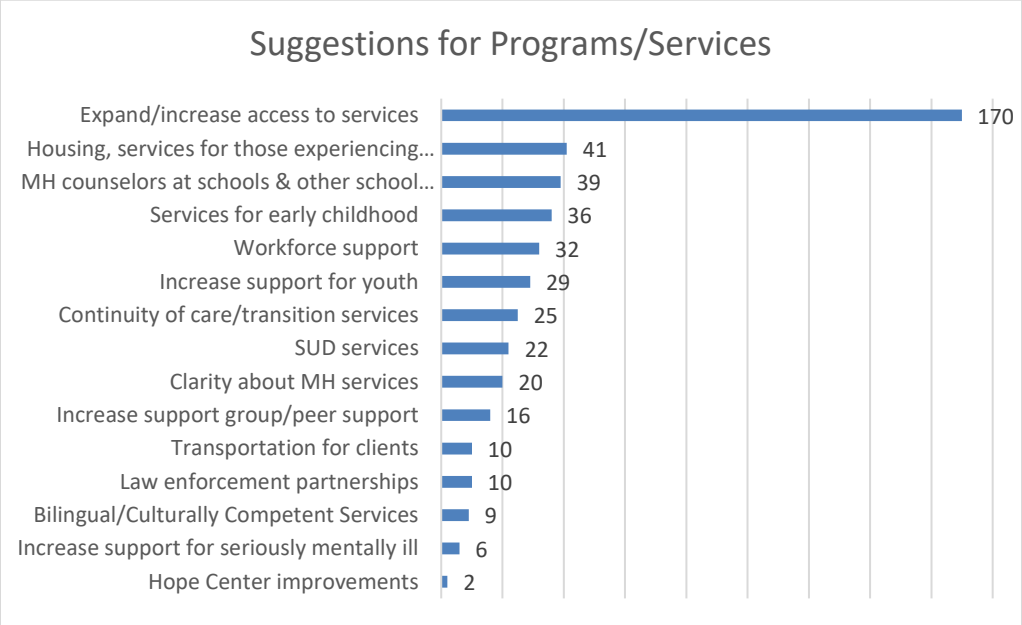


What issues make it most challenging for consumers and their families to receive mental health services? The results are depicted in the chart below.

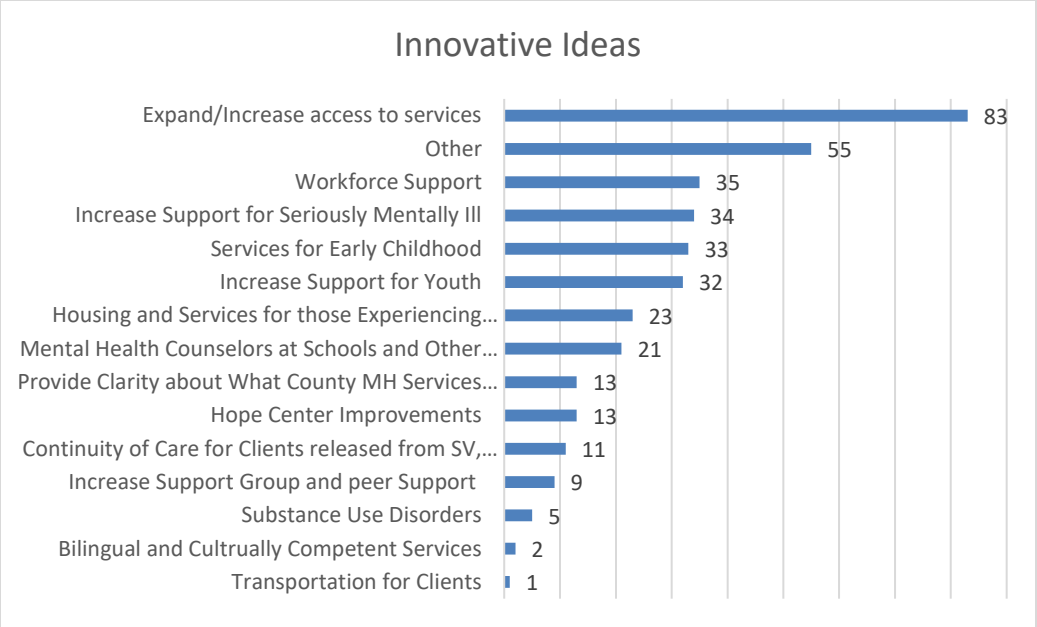


If you checked Other, please describe. The top four responses in Other were: 1) too few providers of services, 2) cost of services and lack of insurance, 3) mental health staff accountability and changing agency practices, and 4) lack of clarity about services available and how to access them.

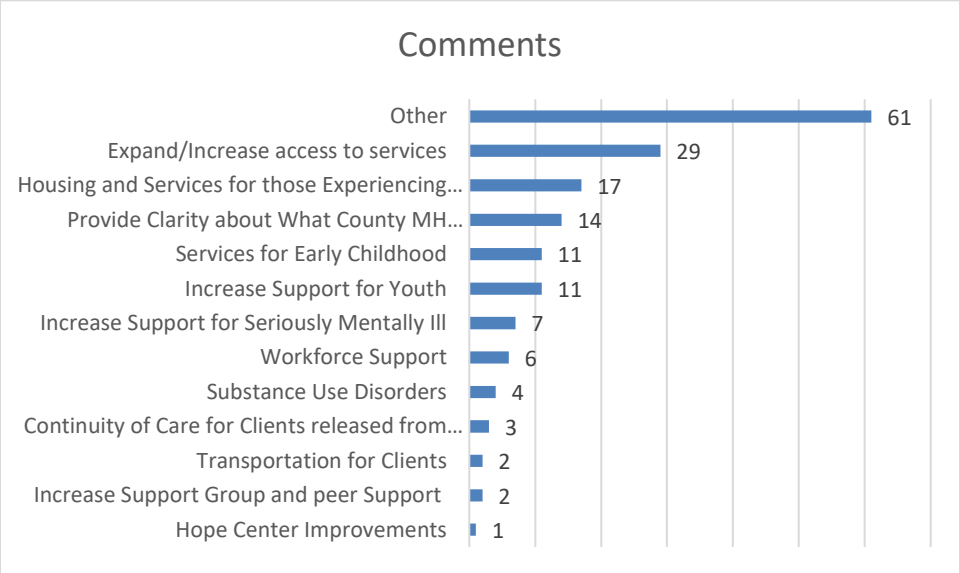
What are your suggestions for programs/services that would enhance wellness and recovery and better meet the needs of your community? As stated before, answers to this question were also analyzed with other narrative questions and the results are on the chart on page 15. Expanding/increasing access to services was the top suggestion, surpassing the next four priorities of housing and services for those experiencing homelessness, mental health counselors and other school supports, services for early childhood, and workforce support.



What innovative ideas could improve or transform the County MH system? The top six priorities were: 1) Expand/increase access to services, 2) Other, 3) Workforce Support, 4) Increase support for seriously mentally ill, 5) Services for early childhood, and 6) increase support for youth. For the category Other, the top priorities were: 1) mental health staff accountability and changing agency practices, 2) more community based work focused on primary prevention, such as events, addressing poverty, helping people gain life skills, 3) increasing collaboration and coordination with other agencies, and 4) more suicide prevention programs. Answers to this question were analyzed with other narrative question, as seen in the chart on page 15.



Other comments. Other comments made by respondents are categorized by the same themes, as depicted below. In the other category, the primary type of comment was expressing appreciation for making the survey available. The responses for this question are included in the analysis of all narrative themes, as depicted on page 15.



MHSA Funding Availability

The draft budget prepared by Mental Health Fiscal on 10/10/19 indicates that there will be an estimated $550,598 unspent fund balance by the end of FY 2019/2020. This draft budget is a part of the draft Annual Update for 2019/2020, which is found in Attachment 2. The projected unspent fund balance is broken down by category:

- Community Services and Supports, $0
- Prevention and Early Intervention, $496,968

- Innovation, $0
- Workforce Education and Training, $53,630

Per Mental Health Fiscal, there are no revised budget numbers as of the date of this report. As the FY 2020-21 budget is prepared, FY 2019-20 projected unspent balances will be updated. As of the writing of this report, no budget has been developed for FY 2020-2021 or subsequent years.

Next Steps

This report will be reviewed by DHHS and Behavioral Health Administration. This review may result in making changes to the Annual Update for 2019-2020. Administration decisions will dictate the content of the Three Year Plan 2020-2023, and the Plan will be written based upon those decisions. The Annual Update and Three Year Plan will be posted on the County's website and available through other methods for review and comment for a 30-day public comment period. Comments made during this period may be incorporated into the documents. Immediately after the comment period there will be a public hearing, facilitated by the Humboldt County Behavioral Health Board. The documents will then go to the Humboldt County Board of Supervisors for approval, and after Board approval they will be submitted to the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission. Final versions of the documents will be posted to the County website.

Attachment 1
Stakeholder Meetings

Attachment 1

MHSA Annual Update 2019-2020 and Three Year Plan 2020-2023
Stakeholder Meetings

Date	Group	Location	Time	# attending
11/4/19	Hupa Family Resource Center Network	Hupa FRC	12-1:00	6
11/21/19	Behavioral Health Board	Rohner Park, Fortuna	12:15-2:15	8
11/22/19	Eastern Humboldt Services Group	K'ima:W Medical Center	10:00-12:00	12
12/4/19	Southern Humboldt Working Together	Redway Family Resource Center	12:00-1:30	7
12/9/19	DHHS/Education Leadership Group	Humboldt County Office of Education	1:30-3:00	16
12/9/19	0-8 MH Collaborative	Humboldt County Office of Education	3:00-4:30	16
12/10/19	Family Advisory Board	Humboldt Plaza	12:00-1:30	6
12/17/19	Hope Center participants	Hope Center	1:00-1:20	20
1/7/20	Youth Advisory Board	TAY Center	4:00-5:00	10
1/8/20	NAMI Humboldt	Large Mezzanine, Professional Building	5:30-7:30	11
1/9/20	First 5 Humboldt	First 5 Office	10:00-11:00	11

Attachment 1

1/9/20	CIT Review Group	Correctional Facility Administration	1:30-3:00	15
1/10/20	Tribal Social Services Directors	Two Feathers Native American Services	10:30-12:00	5
1/14/20	Eureka Community	Jefferson Center	12-1:30	22
1/23/20	Behavioral Health Board Meeting	Large Mezzanine, Professional Building	1:15-2:15	18
1/24/20	Northern Humboldt Region	Blue Lake Family Resource Center	12-1:30	8
	16 Stakeholder Meetings			191 Attendees

Attachment 2
Meeting Materials

Mental Health Services Act

This stakeholder questionnaire is voluntary and anonymous! The purpose is to gather the demographic information of the people who are participating in our stakeholder process to ensure we are reaching people from different backgrounds and all regions in Humboldt County.

What is your age?

☐0-15 ☐26-59
☐16-25 ☐60+

What is your Ethnicity/Race?
(Please check one or more)

☐Black/ African American
☐American Indian/ Native American
☐ Tribe(s) _____
☐Alaskan Native
☐Asian
☐Pacific Islander
☐Hispanic/Latina(o)
☐Middle Eastern/Arab
☐White/ Euro American (non-Hispanic)
☐Other _____

What is your Primary Language?

☐English
☐Spanish
☐Hmong
☐Other _____

What is your gender identity?

☐ Female
☐Male
☐Transgender
☐Other _____

What is your sexual orientation?

☐Straight ☐ Bisexual
☐Lesbian ☐Queer
☐ Gay ☐Other_____

What is your zip code? _____

Have you ever served in the military?

☐Yes ☐No

Are you an employee of Humboldt County Health and Human Services?

☐Yes ☐No

Do you represent a community based service provider?

☐Education
☐Mental health services
☐Health care organization
☐Social services
☐Alcohol and other drugs services
☐Veteran's organization
☐Law enforcement
☐Community family resource center
☐Employment
☐Media
☐ Other (explain) _____

Have you been diagnosed with a serious mental illness?

☐ Yes ☐ No

Has someone in your family been diagnosed with a serious mental illness or serious emotional disturbance?

☐ Yes ☐ No

Are you a friend of someone who has been diagnosed with a mental health condition?

☐Yes ☐No

Have you ever experienced homelessness?

☐ Yes ☐ No

Have you or your family ever been involved in the juvenile or adult justice system?

☐Yes ☐No

Have you or your family ever been involved in the child welfare system?

☐Yes ☐No

If you would like to comment on any of the above items, you can do so on the back of this page. We appreciate any feedback that you have.

Thank You

Mental Health Services Act Comment Form

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

<u>You do not need to include your name to provide a comment!</u>

Please complete the MHSA Comment Form. You can:

1) Give it to Cathy Rigby, MHSA Coordinator, if you are at a meeting with her

2) Mail it to Cathy at DHHS, 930 6th Street, Eureka CA 95501

3) Call 707-441-3770, or toll free 866-320-8911 to leave a comment

4) Send an email to mhsacomments@co.humboldt.ca.us

Thank You!

Mental Health Services Act

The Mental Health Services Act (MHSA) was approved by voters in 2004 and enacted into law on January 1, 2005. It places a 1% tax on Californians with a personal income above 1 million dollars.

The MHSA is intended to:

- Expand best-practices and recovery-focused mental health programs that demonstrate their effectiveness for people with serious mental illness
- Reduce the long-term negative impacts on individuals, families, and state and local budgets resulting from untreated mental illness
- Prevent mental illness from becoming severe and disabling.

DHHS Mental Health provides recovery focused, integrated services to the community through programs and service settings. These services are funded through many different funding sources. Services and supports that are funded by the MHSA are those presented in the Three Year Plan and Annual Update, and include:

- Mobile Outreach
- Telemedicine
- Older and Dependent Adults
- Full Service Partnership
- Adult Residential Treatment Services
- Housing, Outreach and Mobile Engagement
- Hope Wellness Center
- Suicide Prevention
- Workforce Education and Training
- Stigma and discrimination reduction
- Transition Age Youth Advocacy and Peer Support
- Local Implementation Agreements
- Parent Partners
- Making Relatives Program
- School Climate Curriculum Plan

MHSA Comment Email: mhsacomments@co.humboldt.ca.us, MHSA Comment Phone Numbers: (707) 441-3770, or toll free (866) 320-8911 to leave a message.

Mental Health Services Act

Fundamental Concepts

Community collaboration: the process by which various stakeholders, including groups of individuals or families, citizens, agencies, organizations, and businesses work together to share information and resources in order to accomplish a shared vision. Collaboration allows for shared leadership, decisions, ownership, vision, and responsibility. The goal of community collaboration is to bring members of the community together in an atmosphere of support to systematically solve existing and emerging problems that could not easily be solved by one group alone.

Cultural competence: a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers, family member providers, and professionals that enables that system, agency or those professionals, consumer providers, and family member providers to work effectively in cross-cultural situations. Cultural competence includes language competence and views cultural and language competent programs and services as methods for elimination of racial and ethnic mental health disparities.

Client and family driven: Adult clients and families of children and youth identify their needs and preferences which lead to the services and supports that will be most effective for them. Their needs and preferences drive the policy and financing decisions that affect them. Adult services are client-centered and child and youth services are family driven; with providers working in full partnership with the clients and families they serve to develop individualized, comprehensive service plans.

Wellness focus, which includes the concepts of recovery and resilience: Recovery refers to the process in which people who are diagnosed with a mental illness are able to live, work, learn, and participate fully in their communities. For some individuals, recovery means recovering certain aspects of their lives and the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or elimination of symptoms. Focusing on recovery in service planning encourages and supports hope. Resilience refers to the personal qualities of optimism and hope, and the personal traits of good problem solving skills that lead individuals to live, work and learn with a sense of mastery and competence.

Integrated service experiences for clients and their families throughout their interactions with the mental health system: This means that services are "seamless" to clients and that clients do not have to negotiate multiple agencies and funding sources to get critical needs met and to move towards recovery and develop resiliency. Services are delivered, or at a minimum, coordinated through a single agency or a system of care. The integrated service experience centers on the individual/family, uses a strength-based approach, and includes multi-agency programs and joint planning to best address the individual/family's needs using the full range of community-based treatment, case management, and interagency system components required by children/transition age youth/adults/older adults. Integrated service experiences include attention to people of all ages who have a mental illness and who also have co-occurring disorders, including substance use problems and other chronic health conditions or disabilities. With a full range of integrated services to treat the whole person, the goals of self-sufficiency for older adults and adults and safe family living for children and youth can be reached for those who may have otherwise faced homelessness, frequent and avoidable emergency medical care or hospitalization, incarceration, out-of-home placement, or dependence on the state for years to come.

What is a “serious” mental illness?

A mental disorder that is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time.

• And the person has a mental disorder as identified in the Diagnostic and Statistical Manual of Mental Disorders, other than a substance use disorder or developmental disorder or acquired traumatic brain injury.

• And as a result of the mental disorder, the person has substantial functional impairments or symptoms, or a psychiatric history demonstrating that without

treatment there is an imminent risk of decompensation to having substantial impairments or symptoms.

• And as a result of a mental functional impairment and circumstances, the person is likely to become so disabled as to require public assistance, services, or entitlements.

California Welfare and Intuitions Code Section 5600.3

What is a “serious” emotional disturbance?

Minors under the age of 18 years who have a mental disorder as identified in the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms.

And as a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:

•The child is at risk of removal from home or has already been removed from the home.

•The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

And/or the child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

California Welfare and Intuitions Code Section 5600.3

Mental Health Services*

1. **24-hour Crisis Services**

   If you are experiencing a psychiatric emergency, help is available 24 hours a day.

2. **Adult Behavioral Health Services**

   Programs and services that promote behavioral health and wellness for adults and older adults including therapy, case management, telemedicine, Comprehensive Community Treatment/Full Service Partnership, Mobile Outreach, housing and homelessness services, and medication support.

3. **Behavioral Health Board**

   The Humboldt County Behavioral Health Board meets monthly to discuss and evaluate the community's behavioral health needs and priorities.

4. **Children's Mental Health Services**

   The Children and Family Services Program provides assessment, therapy, case management, psychological services, and medication services. Parent Partners are available to support families as they encounter mental health and other County systems. Outpatient counseling for youth between the ages of 12 and 19 with substance abuse issues is also available.

5. **Community Corrections Resource Center**

   The Humboldt County Community Corrections Resource Center provides support and services to those leaving the criminal justice system, helping them to successfully rejoin the community.

6. **County Mental Health Triage Services**

   The Children's Mobile Response Team provides short-term mental health crisis intervention and support to children and their families. The Adult's Mobile Response Team assists individuals in gaining access to effective outpatient and crisis services in the least restrictive manner possible. Humboldt Bridges to Success staff work with staff at local public schools to provide short=term, school-based mental health intervention and support to students who are in crisis or at risk of crisis.

7. **Crisis Stabilization Unit**

   Crisis Stabilization Unit (CSU) is an outpatient program that provides crisis intervention and stabilization services to individuals in need of immediate crisis services.

8. **Hope Center**

   The Hope Center is a safe, positive environment where clients learn to live the best life possible - personally, socially, mentally and emotionally. It is a place to relax, create, socialize, play games, learn new skills and maximize your potential.

*Items in red font are funded in part by the Mental Health Services Act

Mental Health Services*

9. Mental Health Quality Improvement

Mental Health Quality Improvement monitors services that are provided throughout Humboldt County's Mental Health Plan—including contracted providers—to ensure that state contracts and state and federal regulations are met.

10. Mental Health Services Act (MHSA)

The Mental Health Services Act (MHSA) provides funding to counties to expand and develop innovative and integrated mental health services for children, youth, adults, and older adults.

11. Patients' Rights Advocacy Services

These services ensure the rights of mental health consumers are known and observed.

12. Sempervirens Psychiatric Health Facility

Sempervirens (SV) offers a locked facility for clients who have serious and persistent mental illness and need acute psychiatric care.

13. Substance Use Disorder Treatment Services

Substance Use Disorder (SUD) Treatment Services assist individuals who are experiencing substance use problems that are impacting their physical health, interpersonal relationships or causing employment or legal issues. Services include Healthy Moms and Family Wellness Court.

14. HumWORKS

HumWORKs provides behavioral health services to CalWORKs Welfare-to-Work participants, supporting those experiences barriers to work, such as mental health symptoms, domestic violence and/or substance use issues.

15. Transition Age Youth Programs

These programs serve youth and young adults ages 16-26, creating environments where young people thrive at home, school, work and in their community. Programs include the Humboldt County Transition-Age Youth Collaboration, Independent Living Skills program, counseling services and employment training.

*Items in red font are funded in part by the Mental Health Services Act

Mental Health Services Act

Current Programs 2019/2020

Estimated Funding: $7,419,615

Community Services and Supports (CSS)

CSS are the programs that serve unserved and underserved populations, with an emphasis on eliminating disparity in access and improving mental health outcomes for racial/ethnic populations and other unserved and underserved populations. Estimated funding: $4,995,195. Program: $4,847,499; Administration $147,696

ROSE/Mobile Outreach is dedicated to providing services to people in outlying communities and to those who are experiencing homelessness. It is an integrated response within Social Services, Mental Health and Public Health as a outreach program for people with a variety of physical, behavioral and social needs, as well as prevention and education activities. Estimated: $662,486

Outpatient Medication Services Expansion through Telemedicine provides medication support to people with a serious mental illness residing in remote rural areas through video conferencing equipment. Estimated: $144,870

Older Adults and Dependent Adults Program Expansion provides in-home services to disabled adults, at-risk adults and older adults. Services include outreach, education, assessment and treatment for older and dependent adults with mental health challenges who are at risk of abuse or neglect, or who are in need of support services to remain in their home. Estimated: $60,951

Full Service Partnership provides intensive community services and supports (e.g. housing, medical, educational, social, vocational, rehabilitative, and other needed community services) as defined by the client/partner to decrease hospitalization and achieve recovery. Estimated: $3,479,192

Adult Residential Treatment Services will provide mental health treatment in a residential setting to DHHS-Mental Health referred clients. The Request for Proposals for this program will be sent out during Fiscal Year 2019-2020. Estimated: $500,000

Innovation (INN)

The goal of this component is to develop and implement promising practices designed to increase access to services by underserved groups, increase the quality of services, improve outcomes, and to promote interagency collaboration. Estimated funding: $501,017. Program: $379,943; INN Administration: $121,074

Housing, Outreach and Mobile Engagement (HOME) increases the quality of services, including better outcomes, for adults with a severe mental illness who are homeless. The program uses the "Housing First" approach to provide outreach and engagement, housing, peer support and supportive services. This program was formerly known as "Rapid Re-housing." Estimated: $379,943

Prevention and Early Intervention (PEI)

This component supports the design of programs to prevent mental illnesses from becoming severe and disabling. Estimated funding: $1,858,388. Program: $1,616,978; PEI Administration: $241,410

The Hope Center provides a safe, welcoming environment based on recovery self-help principles and resources for people with mental health challenges to be self-sufficient. The Hope Center is client run and includes peer-to-peer education and support, system navigation, and linkage to services. Estimated: $274,701

Suicide Prevention Program provides community education, outreach and engagement, and capacity building assistance around suicide prevention. Trainings such as Question, Persuade and Refer (QPR) and Applied Suicide Intervention Skills Training (ASIST) are provided along with collaboration with the Humboldt County Suicide Prevention Network and other community coalitions. Estimated: $258,090

Stigma and Discrimination Reduction provides activities that increase awareness of attitudes, beliefs, perceptions, stereotypes and discrimination related to undiagnosed and diagnosed mental illness or to seeking mental health services. The Program includes social marketing campaigns, targeted education and training, and anti-stigma advocacy support for statewide web-based campaigns. Estimated: $168,630

Transition Age Youth (TAY) Advocacy and Peer Support provides activities for youth and young adults ages 16-26 that are responsive to their needs, fostering youth development, advocacy, community engagement, and promoting youth wellness. Estimated: $423,468

Parent Partners aim to build peer-based alliances by sharing lived experience as a parent of a youth with mental health issues. They offer assistance in navigating the DHHS system, linking parents with community resources, building natural supports and helping parents identify their personal wellness goals. Estimated: $244,406

Local Implementation Agreements provide an opportunity for community-based organizations to apply for funding for projects that meet the PEI guidelines. These projects are focused on early intervention, outreach for increasing the recognition of early signs of mental illness, prevention, access and linkage to treatment, stigma and discrimination reduction, and suicide prevention. Estimated: $110,000

School Climate Curriculum Plan provides funding to the Humboldt County Office of Education to develop a Multi-Tiered System of Support Coalition that will implement the Positive Behavioral Intervention Supports framework. The framework assists school personnel in adopting and organizing evidence-based behavioral interventions into an integrated continuum that enhances academic and social behavior outcomes for all students. Estimated: $94,100

Making Relatives Program will bring together a tribal consortium to create a continuum of care that includes a range of supports for mental wellness and suicide prevention in a cultural framework for tribal youth. Estimated: $43,583

Workforce Education and Training (WET)

This component provides staff development opportunities that promote wellness, recovery, resilience, culturally competent service delivery, meaningful inclusion of clients and family members, integrated service experience, community collaboration and employment of clients and family members within the mental health system. Estimated funding: $65,015

Information Technology

This component addresses the infrastructure to support implementation of the CSS and PEI programs, including to improve or replace existing technology systems and for capital projects. Estimated funding: $0

Avatar Electronic Health Record (EHR) System and associated technological supports such as Perceptive Document Scanning have been implemented in past years.

Humboldt County
Mental Health Services Act Three Year Program and Expenditure Plan
Community Participation and Feedback Survey

Survey Instructions: The Mental Health Services Act (MHSA) of Humboldt County wants your ideas on how to strengthen its mental health programs to better serve you and your community. What would you like to see included as part of the work over the next three years, considering limited resources? Also, what are some new or innovative ideas you'd like Humboldt County to consider?

This survey is part of a larger community planning process that also includes community meetings throughout Humboldt County from November 2019 to January 2020. If you would like information about these meetings, or if you want to receive further information about the planning process, please send an email to MHSAComments@co.humboldt.ca.us or call (707) 441-3770 with your name and contact information.

You can complete this survey online by going to this link: https://forms.gle/A8nZZq46otS3CGgZA Your answers when completing the survey online are automatically recorded. If you are completing the survey on paper, you can:

- Mail it to Cathy Rigby, Program Manager, DHHS, 930 6th St. Eureka CA 95501
- Return it to Cathy in person if you are in a meeting with her
- Scan the completed survey and email it to MHSAComments@co.humboldt.ca.us

The survey takes about 10 minutes to complete. All questions are optional, and you can leave questions blank if you do not want to respond. This survey is anonymous.

Thank you for your help with this effort!

1. Is this your first time providing input and information for our MHSA Community Planning Process?
   - Yes
   - No

2. The priorities listed on the next page come from prior MHSA community planning activities. Please mark the level of importance on each of these previously identified priorities, and then add priorities you think should be explored. The priorities were those that community members felt were important at the time. Priorities are expected to change over time.

(Note: MH = Mental Health; TAY = Transition Age Youth, ages 16-25)

Key: 1=Not important at this time; 2=Slightly Important; 3=Somewhat Important; 4=Very Important; 5=Absolutely Essential

Priority	**1**	**2**	**3**	**4**	**5**
New services and expansion of MH outreach/ services to regions outside of Eureka					
Bilingual, culturally competent MH services					
Substance Use Disorder Services					
MH workforce support and training					
More MH counselors at schools & increased services in a school setting					
More housing					
0-8 MH Collaborative support, and services for early childhood					
More counseling and support for parents/families					
TAY program expansion and improvements for TAY facilities					
More MH counselors for adults					
More programs, services with law enforcement					
Transportation for clients					
More support for older adults (ages 60+)					
Provide more stakeholder activities and clarity about MH services provided by County MH					
More Native American supports					
Hope Center program expansion and facility improvements					
More Patients' Rights Advocates					
More prevention and early intervention activities for adults					
Support after discharge from Sempervirens and Crisis Support Unit					
Stronger partnerships with hospitals					
More peer support programs					
Additional priority: Describe					
Additional priority: Describe					
Additional priority: Describe					

Comments:

3. Are there any populations or groups of people whom you believe are not being adequately served by the current MHSA programs in Humboldt County? Please check all that apply.

- Children 0-5
- School Age Children
- Transition Age Youth-TAY (ages 16-25)
- Adults
- Older Adults (ages 60+)
- Lesbian, Gay, Bisexual, Transgender, Queer, Questioning (LGBTQQ) people
- Veterans
- Jail releases and clients on probation
- Parents/family members
- Persons with disabilities
- Persons experiencing MH issues
- Persons experiencing homelessness
- Immigrants and refugees
- African American community
- Asian community
- Latino community
- Native American community
- Pacific Islander community
- Other population(s), please specify: _____
  _____

4. Based on your answers in question 3, please identify who you feel are the three most underserved groups

- _____
- _____
- _____

5. What issues make it more challenging for consumers and their families to receive MH services? Check all that apply.

- Lack of transportation
- Limited availability of appointments
- Locations of clinics or service providers
- Services not provided in a consumer's primary language
- Stigma around mental illness in your community
- Other, please specify: _____
  _____

6. What are your suggestions for programs or services that would enhance wellness and recovery and better meet the needs of your community? _____
_____
_____
_____

_____

7. What innovative ideas could improve or transform our County MH system? These ideas should fall into one of the categories below.

a. A new MH practice or approach to the MH system, including prevention and early intervention.

b. A change to an existing MH practice or approach, including adapting it to a new setting, community or population.

c. Adapting a promising community-driven practice that has been successful in non-mental health settings, and applying it to the MH system.

_____

_____

_____

Please tell us about yourself.

8. My **Age Group** is
- 0-15
- 16-25
- 26-59
- 60+
- 75+
- Prefer not to answer

9. My **Gender** is:
- Male
- Female
- Transgender
- Gender queer
- Another gender identity
- Prefer not to answer

10. I primarily reside in this **City or Community**: _____

11. My **Race/Ethnicity** is:
- African American or Black
- American Indian or Alaska Native
- Asian
- Caucasian or White
- Hispanic or Latino
- Native Hawaiian or Other Pacific Islander
- More than one Race/Ethnicity
- Prefer not to answer
- Other: _____

12. Which of the following **Groups** do you primarily identify with or represent? Please choose only one group.

- MH client/consumer
- Family member of a MH consumer
- An interested member of the community
- Educational agency
- Community-based MH provider
- Homeless community/Housing services
- County Behavioral Health staff
- Faith-based organization
- Substance use disorder service provider
- Hospital or healthcare provider
- Law enforcement
- NAMI
- Veteran or Veteran Services
- Other community based organization—not MH provider
- Prefer not to answer
- Other: _____

13. Use the space below, or the back of this page, for any additional comments you would like to give us. Thank you for your time!

Attachment 3
Draft Annual Update
2019-2020

Mental Health Services Act

Annual Update

Fiscal Year 2019/2020

Contents

County Compliance Certification

This page will contain the County Compliance Certification that will be obtained after the Public Comment and Public Hearing Process is completed.

Community Planning and Local Review Process

Background

Humboldt County Department of Health and Human Services is a consolidated organization, integrating Behavioral Health, Public Health and Social Services. Since its consolidation in 1999, Humboldt County Department of Health and Human Services has been engaged in true system transformation and redesign.

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

It is through these transformational strategies that the Humboldt County Department of Health and Human Services has planned and implemented its Mental Health Services Act (MHSA) programming. Humboldt County's approved Three Year Plan for 2017-2020 sets forth the approved programs for Community Services and Supports, Prevention and Early Intervention, Workforce Education and Training, and Information Technology components. This document, the Annual Update for 2019-2020, provides reports from MHSA programs for the 2018-2019 fiscal year and updates the 2017-2020 Three Year Plan with information on program changes and additions.

Stakeholder input for both the Annual Update 2019-2020 and the Three Year Plan for Fiscal Years 2020-2023 was obtained during the same stakeholder process. Methods for obtaining stakeholder input were:

- Holding regional stakeholder meetings and meetings with other stakeholder groups as requested. Sixteen meetings were held from November 2019-January 2020 and a total of 191 stakeholders were present.
- Input and comments sent to the Mental Health Services Act email address, received by the Mental Health Services Act voice mail, or written comments obtained at stakeholder meetings.
- Distribution of the Draft 2019-2020 Annual Update and associated MHSA information via email to stakeholder groups and individuals, and posting on the County website.
- The Humboldt County MHSA Three Year Program and Expenditure Plan Community Participation and feedback Survey (Community Survey) was available online and in paper format. This survey was focused on gathering input for the Three Year Plan for 2020-2023.

Stakeholders at community meetings

Stakeholder Materials

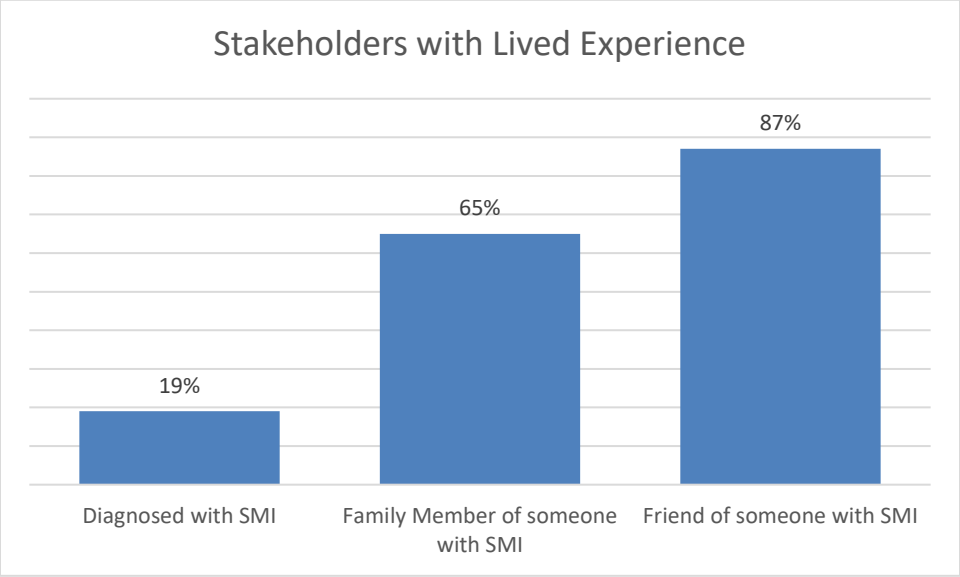
Most MHSA support materials were available in both English and Spanish. Materials provided to attendees included:

- Draft MHSA Annual Update for 2019-2020

- Draft MHSA Budget for 2019-2020
- MHSA Fundamental Concepts handout
- MHSA Info Form handout
- MHSA Current Programs handout
- Behavioral Health Services provided by the County
- Definitions of Serious Mental Illness and Serious Emotional Disturbance
- MHSA Comment Form for written comments. This form includes an MHSA comment line phone number and email address for alternate methods of providing input
- Anonymous MHSA Demographic Questionnaire
- Paper copy of the Community Survey

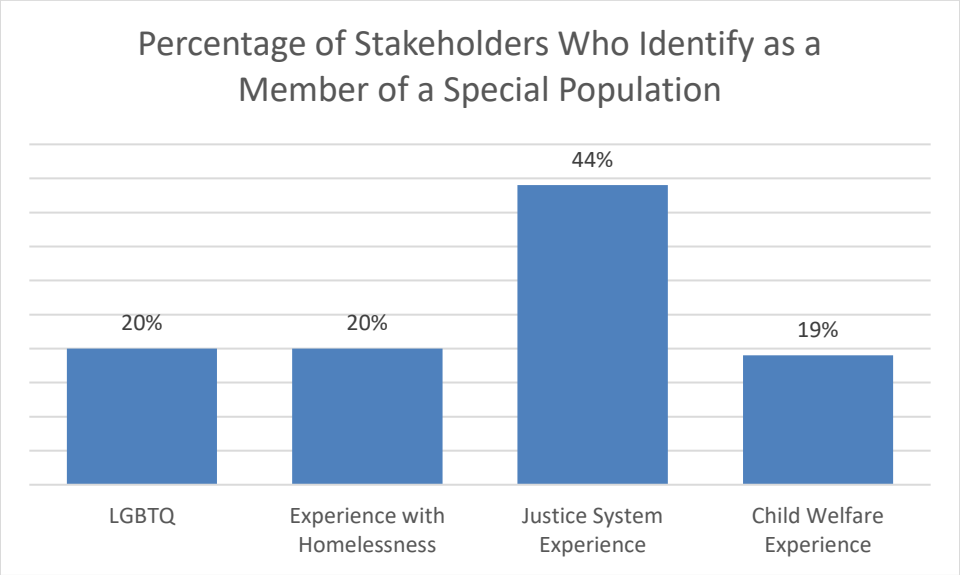
Stakeholders attending community meetings were invited to complete the demographic questionnaire. For the current stakeholder process, 85 individuals, 45% of those attending the meetings, completed a demographic form. The results are presented in the charts below.

Individuals with lived experience with a mental illness are recognized as a vital voice in the MHSA planning process. In this stakeholder process, 19% of people participating identified as having a mental illness, 65% identified as a family member of someone with a mental illness, and 87% identified as a friend of someone with a serious mental illness, as shown in the following chart.

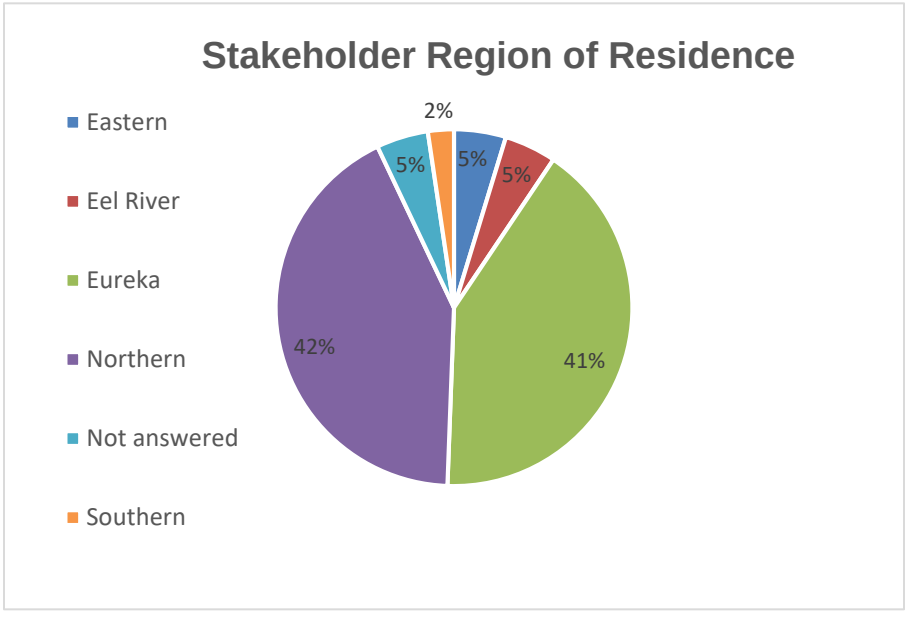


Additional life experiences have been identified as valuable voices for the planning process so they are also monitored for inclusion. Sexual orientation, experience with homelessness, justice system experience, Child Welfare experience, and those whose primary language is other than English are all life experiences that may result in challenges to successful behavioral health treatment. The chart below illustrates how outreach efforts have included people with these life experiences:

- 20% identified as LGBTQ,
- 20% identified as having experience with homelessness,
- 44% had justice system experience,
- 19% had Child Welfare experience
- Only two stakeholders stated their primary language was other than English. These languages were Korean and Spanish.

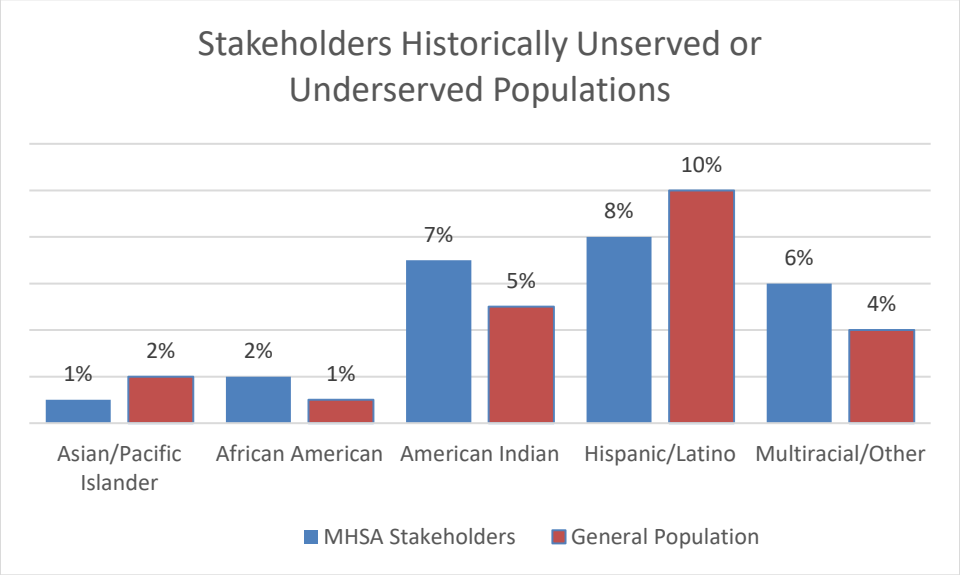


Another priority for representation in the planning process is regional. More than half of the MHSA stakeholders attending meetings live in regions close to Humboldt Bay, Northern Humboldt at 42% and Eureka at 41%, while 5% live in the Eel River Valley, 5% in Eastern Humboldt and 2% in Southern Humboldt. Five percent either did not respond to the question or indicated they lived in another region. This is shown in the chart below.

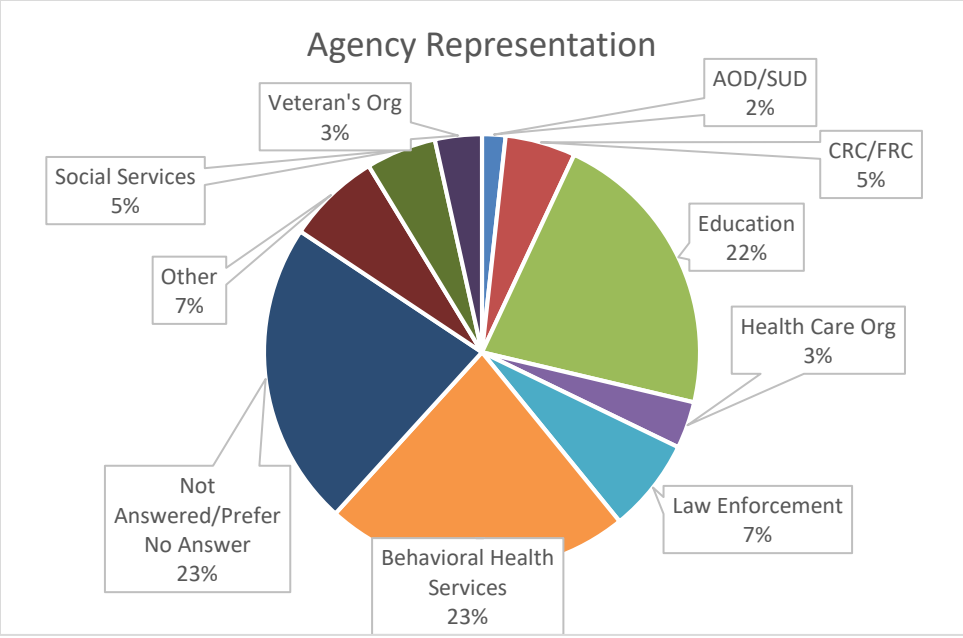


Participants in the stakeholder meetings came from different racial and ethnic categories.

- One percent were Asian/Pacific Islander, compared to 2% of the County general population.
- Two percent were Black/African American, compared to 1% of the County general population.
- Seven percent were American Indian, compared to 5% of the County general population.
- Eight percent were Hispanic/Latino(a), compared to 10% of the Humboldt County general population.
- 6% were Multiracial/Other, compared to 4% of the County general population.



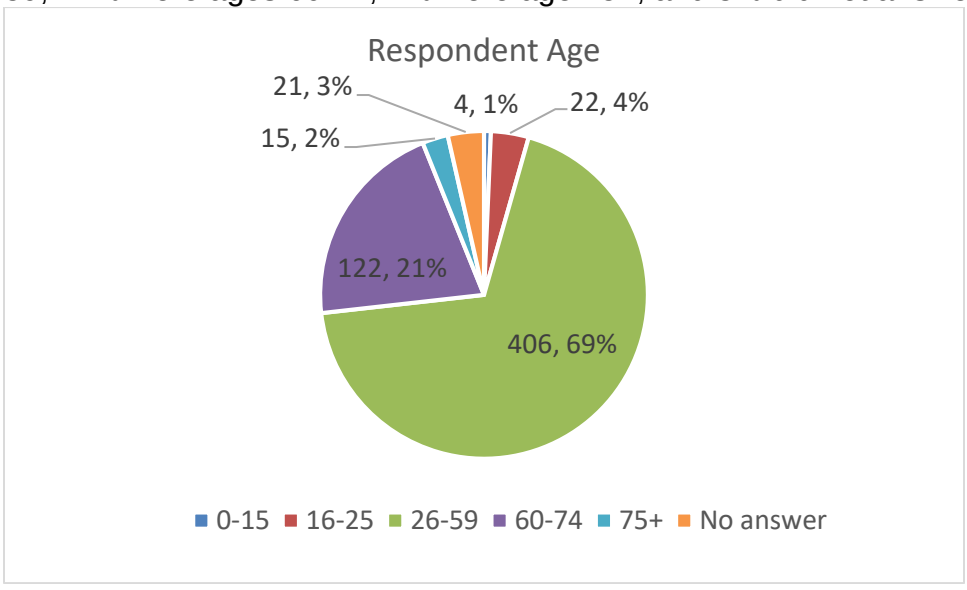
The stakeholder meetings included representation from agencies that provide services. The process has included individuals from education (22%), behavioral health services (23%), health care organizations (3%), social services (5%), law enforcement (7%), community and family resource centers (5%), Substance Use Disorder Services (2%), Veteran's organization (3%) and other (7%). Twenty-three percent did not answer/preferred not to answer the question. This is shown on the chart below.



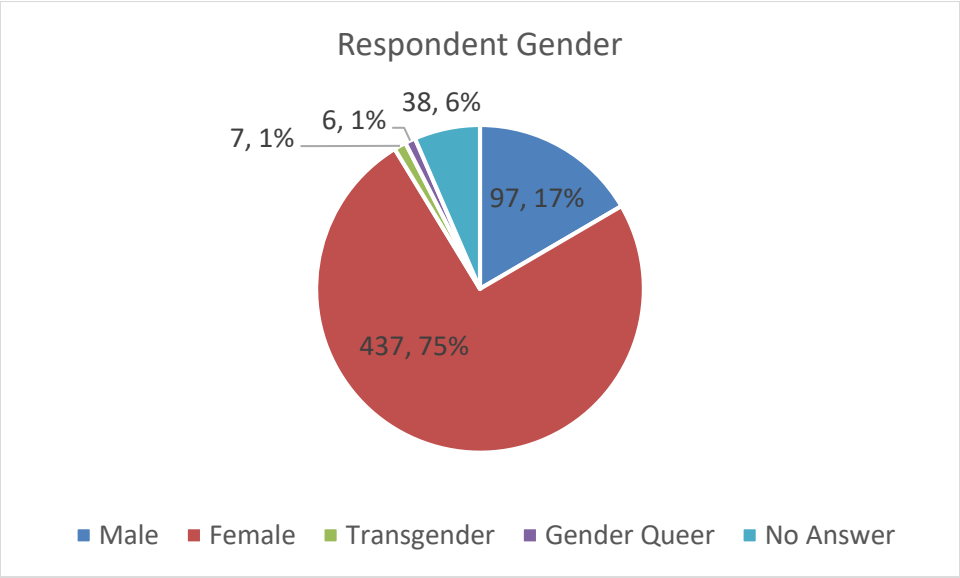
Stakeholders completing the Community Survey

Google Forms was used to create a community survey, available online and in paper format. Between the paper copies and the online survey a total of 597 responses were received. Of the responses, 472 people, 81%, stated it was their first time providing input and information for the MHSA process. For 111 people, 19%, it was not the first time they had provided input into the MHSA process. Though this survey was intended to gather input for the Three Year Plan, the demographics of those participating are presented below.

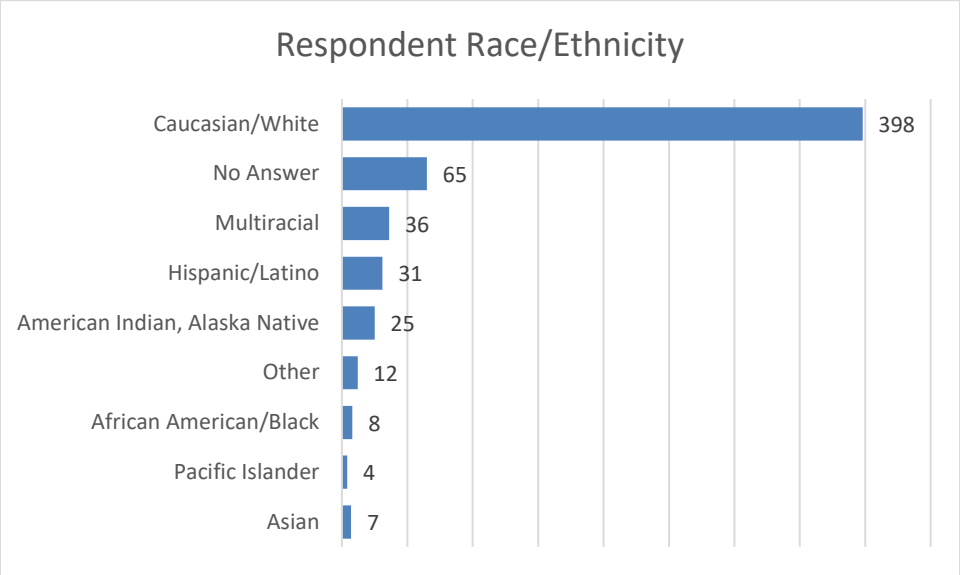
One percent of respondents were ages 0-15, 4% were ages 16-25, 69% were ages 26-59, 21% were ages 60-74, 2% were age 75+, and 3% did not answer.



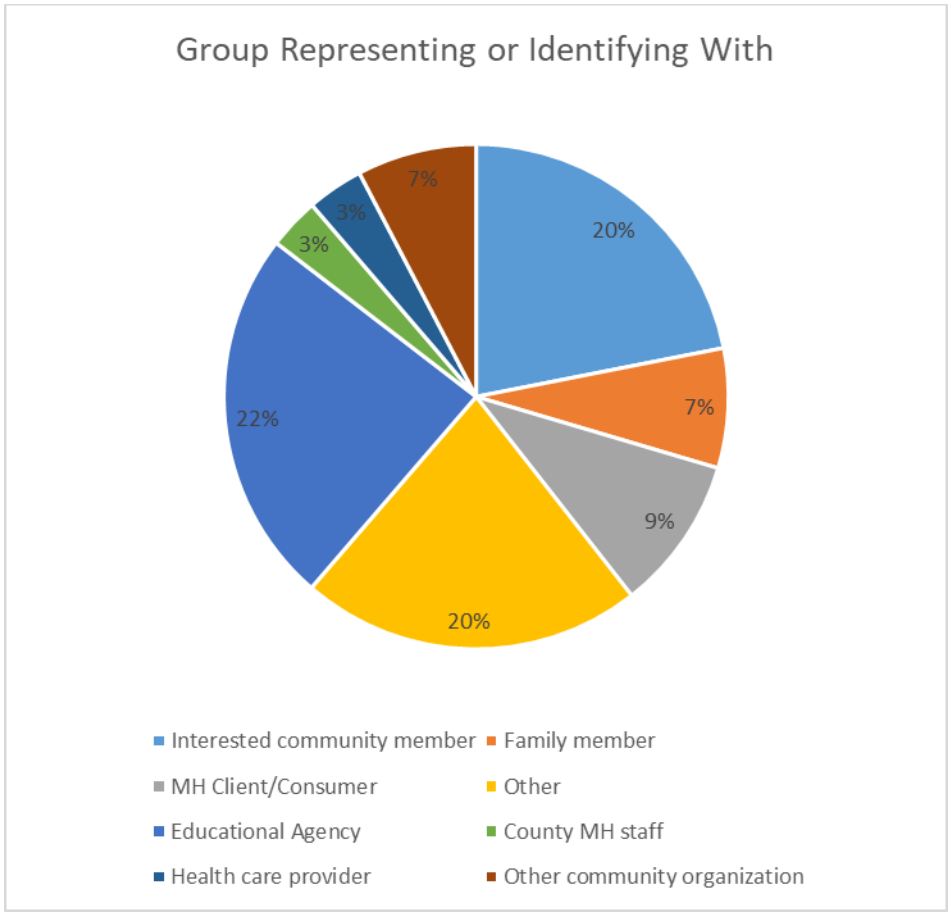
Seventeen respondents were male, 75% female, 1% transgender, 1% gender queer, and 6% did not answer.



398 respondents, 69%, were Caucasian/White; 36 respondents, 5%, were Multiracial; 31 respondents, 5%, were Hispanic/Latino; 25 respondents, 4%, were American Indian/Alaska Native; 12 respondents, 2%, were Other; 8 respondents, 2%, were African American/Black; 4 respondents, 1%, were Pacific Islander; and 7 respondents, 1%, were Asian. 65 respondents, 11%, did not answer.



When asked what group they represented or identified with, 20% of respondents were interested community members; 22% were from educational agencies; 7% from other community organizations; 7% were family members; 9% were behavioral health clients/consumers; 3% were health care providers, 3% were County Behavioral Health Staff, and 20% were Other, as represented in the chart below.


Group Representing or Identifying With
20%
7%
9%
20%
22%
3%
3%
7%
Interested community member
Family member
MH Client/Consumer
Other
Educational Agency
County MH staff
Health care provider
Other community organization

Public Comment and Public Hearing

The 30-day Public Comment period for the Annual Update 2019-2020 and Three Year Plan for Fiscal Years 2020-2023 will be _____.

Copies of the Annual Update 2019-2020 and the Three Year Plan for Fiscal Years 2020-2023 for the Public Comment Period will be made available to stakeholders through the following methods:

- The Humboldt County Department of Health and Human Services, Mental Health Services Act website
- Print format:
    - Humboldt County Department of Health and Human Services (DHHS) Professional Building, 507 F Street, Eureka CA, 95501;
    - DHHS Behavioral Health, 720 Wood Street, Eureka CA, 95501;
    - DHHS Children Youth and Family Services, 1711 Third St. Eureka CA 95501;
    - Garberville Office, 727 Cedar St. Garberville CA, 95560;
    - Willow Creek Office, 77 Walnut Way, Willow Creek CA, 95573;
    - The Hope Center 2933 H Street Eureka CA, 95501
- An informational flyer will be sent to stakeholders participating in the stakeholder process regarding the Update and Three Year Plan availability, including information about where to obtain them, where to make comments, and where/when the public hearing will be held
- Informational flyers will be e-mailed to recipients on local e-mail distribution lists
- The Update and Plan will be e-mailed or mailed to all persons who request a copy
- Announcements will appear in local media with the Update and Plan's availability, where to obtain it, where to make comments, and where/when the public hearing will be held
- The availability of the document and how to provide input will be publicized by DHHS, which may include communications from DHHS Media, staff announcements, and or sharing the information in community meetings or other forums.

During the public review period, comments from stakeholders will be received in a variety of ways, including e-mail, comment boxes, phone calls, and at the public hearing. Should there be a complaint, dispute or grievance from the general public about MHSA program planning the MHSA Issue Resolution Policy and Procedure will be followed. The issue will be forwarded to the MHSA Program Manager (MHSA-PM) or designee through either US Postal Service mail: MHSA Program Manager, DHHS Behavioral Health, 720 Wood St. Eureka CA 95501; telephone or voice mail: (707) 441-3770; or email MHSAcomments@co.humboldt.ca.us. Issues will be recorded at time of receipt by the MHSA-PM in the DHHS-MH Client Concerns Log and forwarded to the Program Lead of the program involved. Once a resolution is decided upon by the associated Program Lead the MHSA-PM will contact the originator of the issue to notify them of the resolution. Issues will be followed up on within five working days. Resolution of the issue will be enacted within 30 days from receipt of issue.

What's New: Changes made to the Annual Update as a result of the public comment period or public hearing will be included in this section.

Humboldt County Demographics

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

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

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

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

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

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

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

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

The source for data on these pages is the United States 2010 Census at this website: http://www.census.gov/2010census.

Community Services & Supports: ROSE/Mobile Outreach

The Humboldt County DHHS Mobile Outreach program, also known as Rural Outreach Services Enterprise (ROSE), is dedicated to providing services to people in outlying communities, including individuals with severe mental illness or serious emotional disturbance, and to those who are experiencing homelessness or are at risk of homelessness. It is an integrated response with Social Services, Behavioral Health and Public Health partnering to serve individuals with a variety of physical, behavioral, and social needs as well as providing prevention and education activities. This integrated response reduces the stigma associated with accessing behavioral health and other services, as visitors to the service could be coming in to access anything that is offered. ROSE/Mobile Outreach uses RVs that travel to community sites such as Family Resource/ Community Resource Centers, clinics, tribal offices and volunteer fire departments on a set schedule. Employment services and immunization clinics can be scheduled as needed. Services on these vehicles are often available for special community events as well. Outreach staff on board the vehicles are skilled at engagement of persons in distress and provide access to county behavioral health services immediately or over time as desired by visitors. Clinical staff occasionally travel with the RV to provide immediate “on board” services, including assessments. If a visitor becomes open to services, regular appointments with clinicians and case managers are scheduled at sites accessible to clients, including home visits.

Because providing on-going services from the RV is usually not possible, as some communities are visited monthly and open clients typically require at least weekly contact, ROSE/Mobile Outreach has clinical staff that travel in 4WD vehicles to visit clients on a regular basis. DHHS has implemented Regional Services, and now has clinical staff stationed on a permanent basis in Southern Humboldt (Garberville) and Eastern Humboldt (Hoopa.)

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

People living in outlying areas who require ongoing behavioral health services, including medication support, counseling and case management, are served by ROSE/Mobile Outreach staff members and Regional MH staff. As the program has matured and with the addition of permanent Regional staff, there has been less need of the RV for regular MH services. Clients who are homeless are provided transportation to their behavioral health appointments by ROSE/Mobile Outreach/Regional. ROSE/Mobile Outreach/Regional services reach people with mental illness who are experiencing homelessness at multiple locations in the County, including free meal sites and homeless encampments. Staff provide behavioral health and social services as well as substance abuse services and emergency food and supplies.

While the MHSA component of this program provides behavioral health assessments and services, other DHHS services are available, such as CalFresh, Medi-Cal,

Transportation Assistance Program, Car seat program, Well-Child Dental Varnish Program, and Fresh Produce and Supplemental Food Program. The diversity of services available reduces the stigma some might experience if the RVs only provided behavioral health services. This program continues to reach the unserved and underserved populations in rural, remote, and outlying geographic areas of the county.

In 2018-19 the project added Community Integration events to benefit formerly homeless persons with serious mental illness and to build connections with community resources for similar clients in the outlying areas. ROSE/Mobile Outreach staff have placed more than 100 Chronically Homeless people with serious mental illness into permanent housing and continue to provide supportive services to these clients so that they maintain their housing. Housing is provided in all areas of the County.

ROSE/Mobile Outreach learned that one of the major issues for these newly housed people, some having been homeless for more than a decade, was finding activities to fill their time and to build new relationships. The program has sponsored multiple fishing trips that were well attended and thoroughly enjoyed by clients. Transportation for clients in outlying areas is provided, as well as food during events. Where there are multiple clients in or near one of the multifamily buildings used for housing, ROSE/Mobile Outreach hosted events at the site to include any residents interested in attending to build community identity. Events include pot-lucks, group meal preparation and cooking instruction, game nights, birthday parties, Tai Chi, yoga, ice cream socials and more. Peers are very involved to help build and sustain recovery communities in housing developments and in outlying areas. Interested persons are invited to Peer Specialist training opportunities when possible to learn skills that may assist their neighbors.

The Mobile Outreach RVs help to bring events to outlying areas. ROSE/Mobile Outreach has hosted Healthy Living workshops with staff from Public Health and IHSS registration and employment fairs, to help clients find caregivers or to enroll to become a caregiver to others. ROSE/Mobile Outreach assisted the Karuk and Yurok Tribes in offering two weeks of summer activities including guitar lessons, dancing, wrestling, arts & crafts for clients and tribal members to aid in re-establishing community connections.

ROSE/Mobile Outreach will continue these events as both community integration and outreach to others experiencing serious mental illness has been the result. ROSE/Mobile Outreach intends to have at least weekly events in different areas of the County that will include hikes in parks and on easy community trails, visits to tide pools at area beaches, more fishing, thrift store shopping outings, group attendance at art and music festivals, volunteer days at community clean-ups, and more.

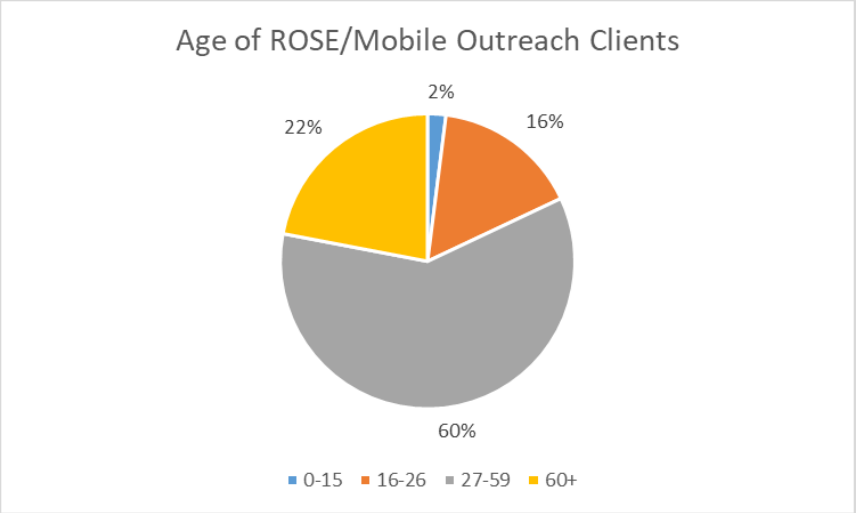
Since some behavioral health services have been shifted to a regional delivery approach the ROSE RV has been used to develop and provide daylong “service fairs” with a focus to a specific need identified by staff and the community. The RV is also used to support Community Integration projects designed for clients with Serious Mental Illness (SMI) that the Housing, Outreach and Mobile Engagement (HOME) staff has housed. These services help clients learn about resources in the community, volunteer and paid work opportunities, free and low-cost activities that are available to them, exposure to new hobbies and recreation and a mechanism to meet new friends in a supportive manner.

Both of these strategies have been very successful. Service Fairs have focused on topics such as Healthy Foods and preparation, how to provide or receive In Home Supportive Services (IHSS), resolution of child support issues, veteran services and summer activities for youth in outlying areas. Community Integration projects have included multiple fishing trips, easy walks in town, easy hikes in surrounding forests, visits to local thrift stores, visits to zoo, visits to local animal shelters and rescues and trips to fly kites at the beach. All of these are popular with clients and have resulted in clients now working as volunteers at the library, senior lunch site and animal rescue site. Several clients have adopted pets.

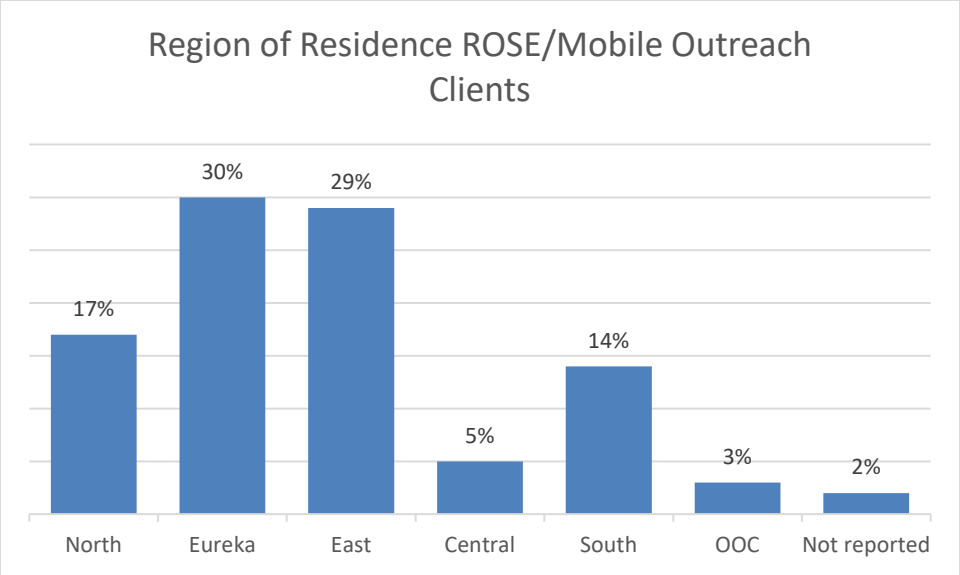
A total of 100 clients are estimated to be served during the fiscal year.

Data Report

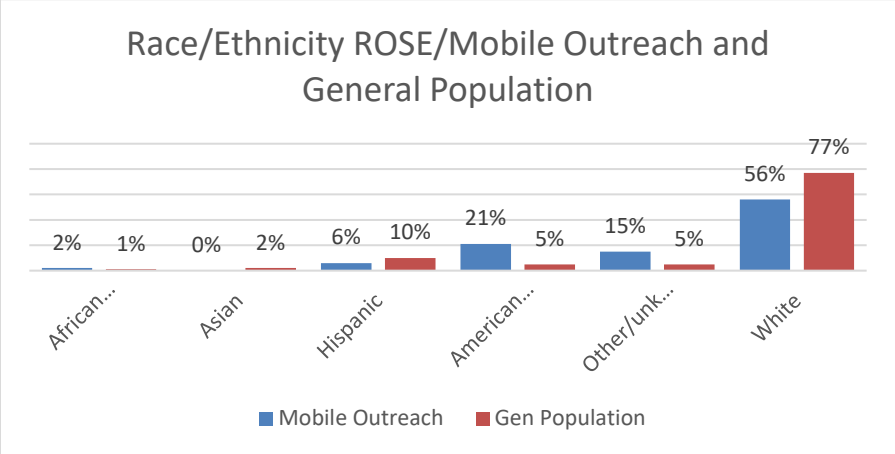
From July 2018 through June 2019 the program served 100 unduplicated behavioral health clients. ROSE/Mobile Outreach provides services to people of all ages. Between July 2018 through June 2019 2% of those served were children, 16% were transition age youth, 60% were adults, and 22% were older adults.



Clients are served throughout the region, with 30% served in Eureka, 14% in Southern Humboldt, 29% in Eastern Humboldt, 17% in Northern Humboldt, 5% in the Central region, and 3% out-of-county. For 2% the residence region was not reported.



The percentage of ROSE/Mobile Outreach clients who identify as White/Caucasian is 56%, and 77% for the general population. The percentage of clients who identify as American Indian is 21%, and 5% for the general population. The percentage of clients who identify as Black/African American is 2%, and 1% for the general population. Clients who identify as Asian/Pacific Islanders is 0%, and 2% for the general population. The percentage of clients who identify as Hispanic/Latino(a) is 6%, and 10% for the general population.



50% of clients served are female, and 50% are male.

Community Integration Report
For residents who the program has helped to obtain housing, the activities organized help prevent isolation, creating social linkages and integration into the community through positive, fun activities.

In the past year, staff has organized fishing trips, a visit to the Sequoia Park Zoo, a visit to Humboldt Botanical Garden, a group outing to Samoa beach for kite flying, transportation to a film presentation, and participation in Food for People sponsored

cooking classes.

Program staff have worked collaboratively with different community partners including Jefferson (Westside) Community Center and Public Health Healthy Communities program. At the Jefferson Community Center, staff worked with clients to revitalize, plant, maintain and harvest vegetables in three garden beds. Garden activities have included a demonstration of food preparation techniques with vegetables harvested from the site. Working with Public Health's Healthy Communities program, a dozen clients were provided a budget shopping tour at the WINCO store.

Staff helps housed clients eat healthy on a limited budget by organizing weekly appointments and transportation to the Food Bank.

H.O.M.E./Mobile Outreach staff dedicates a large portion of staff time to providing outreach services to residents of outlying communities. Each month, ten communities are visited, helping link people with Public Health, Behavioral Health and Social Services programs. This year staff were very active in assisting SSI recipients in these communities to apply for CalFresh. Staff attend the annual health fair in Hoopa where they worked with In Home Supportive Services to help Hoopa residents apply to become caregivers and care recipients.

In 2019, the program organized special outreach events targeting both young and more elderly residents.

In Orleans, staff worked collaboratively with K'ima:w Medical Center staff and provided families with installation instruction and 13 new child safety seats.

In 2019, staff organized four events aimed at linking older adults with essential services. Older adults in the communities of Weitchpec, Trinidad, Redway and Shelter Cove were provided the opportunity to meet with DHHS staff from IHSS, APS, Public Health Adult Health, the Veterans Services Office, Humboldt County Programs for Recovery and the Public Guardian. From outside DHHS, staff were joined by Area 1 Agency on Aging's HICAP program, PACE, the Southern Humboldt Community Health District and the Senior Living Solutions program.

Community Services and Supports: Telemedicine

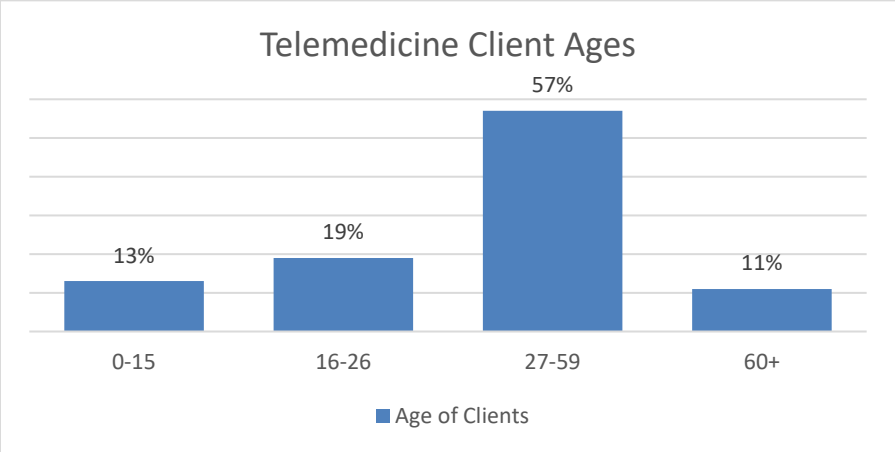
In 2006 the Department initiated an Outpatient Telemedicine Medication Services Expansion in Garberville, and was expanded to Willow Creek in 2011. Using video conferencing equipment, the expansion offered psychiatric services and medication support from a provider located at the main clinic in Eureka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

These telemedicine services worked well for clients living in Eastern and Southern Humboldt. However, due to a psychiatrist shortage in the past few years, telemedicine clients have been incorporated into the adult clinic in Eureka. In addition, video conferencing equipment needed to be updated, and bandwidth increased for better connectivity. This new, upgraded data-line was scheduled to go live for both Willow Creek (Eastern Humboldt) and Garberville (Southern Humboldt) at the end of August, 2018. However, due to delays in connectivity, telemedicine services in Garberville did not resume until June 2019. In Willow Creek, DHHS Facilities and Information Services are still working on improved connectivity and services are expected to begin by the end of

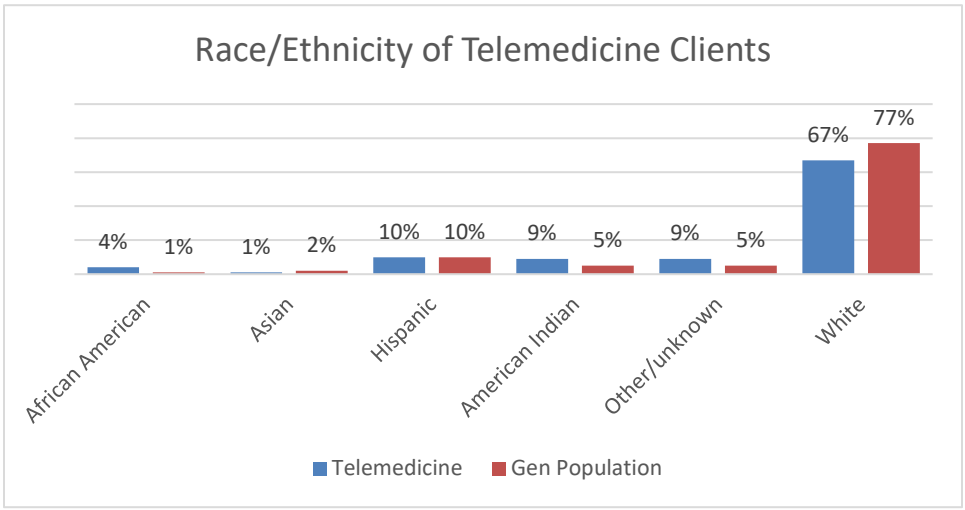
the fiscal year. In the meantime, telemedicine clients are still incorporated into the adult clinic in Eureka, receiving services.

Data Report
From July 2018 through June 2019 the program served an average of 173 unduplicated clients per month for a total of 2,076 unique individuals during the one year period.

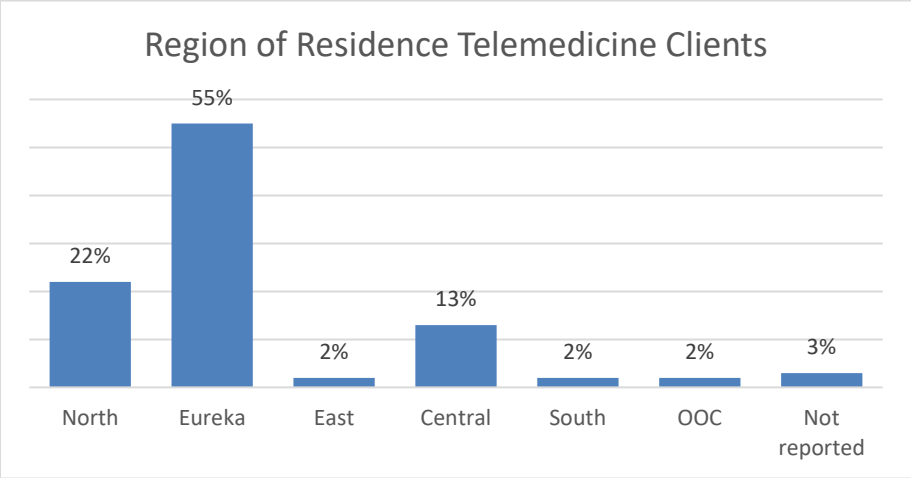
The telemedicine program serves people of all ages. During the one year period, 13% were children ages 0-15, 19% were ages 16-26, 57% were ages 27-59, and 11% were age 60+. Forty-six percent were female and 54% were male.



The percentage of telemedicine clients who identify as White/Caucasian is 67%, as compared to 77% of the general population. The percentage of telemedicine clients who identify as Black/African American is 4% and 1% for the general population. Telemedicine clients who identify as Asian/Pacific Islander is 1% and 2% for the general population. The percentage of telemedicine clients who identify as American Indian is 9% and 5% for the general population. The percentage of telemedicine clients who identify as Hispanic/Latino is 10%, and 10% for the general population. The percentage of telemedicine clients who identify as other racial/ethnic makeup or for whom no information is available is 9%, and 5% for the general population.



Fifty-five percent of clients served live in the Eureka area. 22% live in the Northern region of Humboldt County, 13% live in the Central region, 2% in the Southern region, and 2% in the Eastern region. 2% reside out-of-county. Region of residence was not reported for the remaining 3% of telemedicine clients served.



The primary language for telemedicine clients is English, at 91%. Other languages, including Spanish, are all less than 1% each. Primary language spoken was not reported for 7% of clients served by telemedicine.

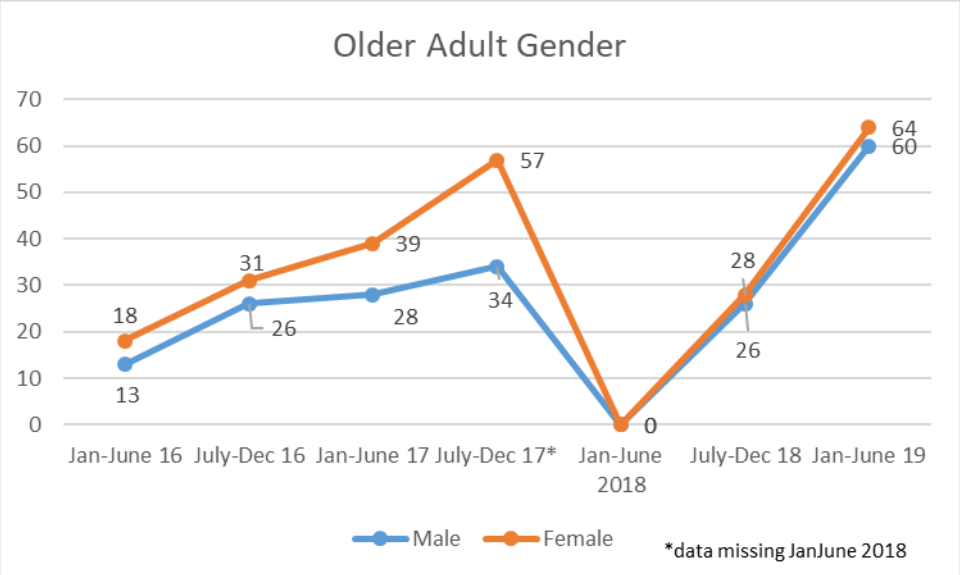
An estimated 2,060 clients will be served during the next fiscal year, with 270 age 0-15, 390 ages 16-25, 1,180 ages 26-59, and 220 ages 60+..

Community Services & Supports: Older Adults and Dependent Adults

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

Outreach, Prevention and Education

Data collection has been developing as the program evolves and grows. Data since January 2016 are now available and the growth is evident in this graph (data for January to June 2018 are missing).



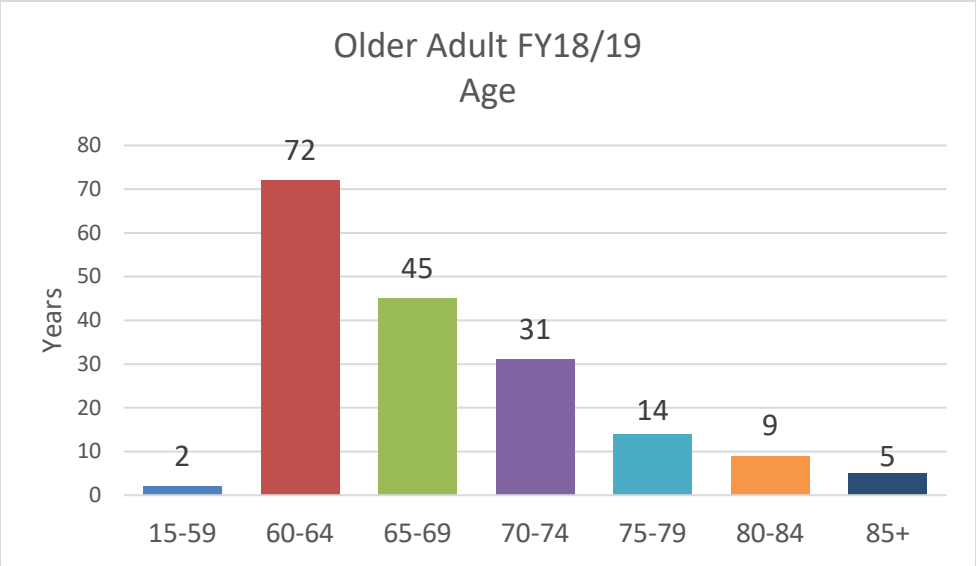
During fiscal year 18/19 a total of 178 individuals were contacted by the Behavioral Health Clinician assigned to the Older and Dependent Adults program, primarily through outreach, prevention and education activities. The Clinician is contacted by Adult Protective Services, In Home Supportive Services, or community services such as Open Door Community Clinic, local hospitals or PACE. If a behavioral health need is identified for an older or dependent adult, the Clinician then assists the client in navigating the MH system and identifies appropriate referrals to offer specialized support to the client.

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

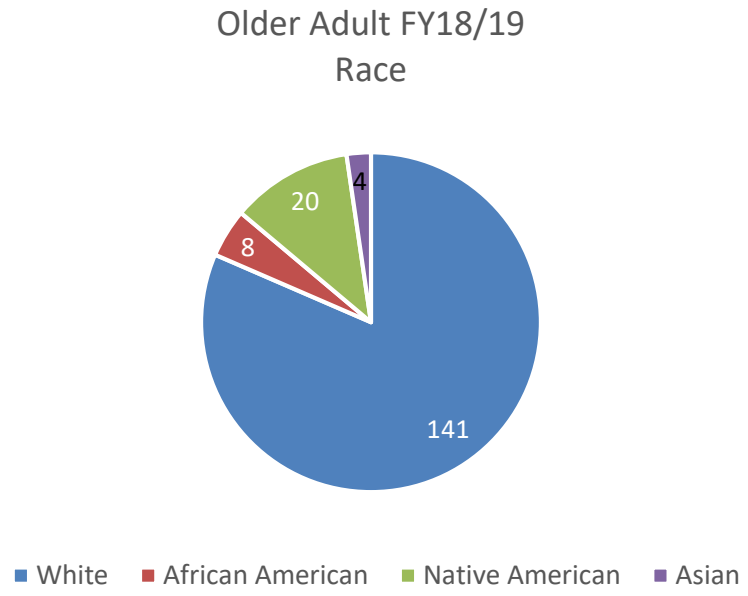
Descriptive statistics for participants in the Older and Dependent Adult program for FY

18/19 are discussed below.

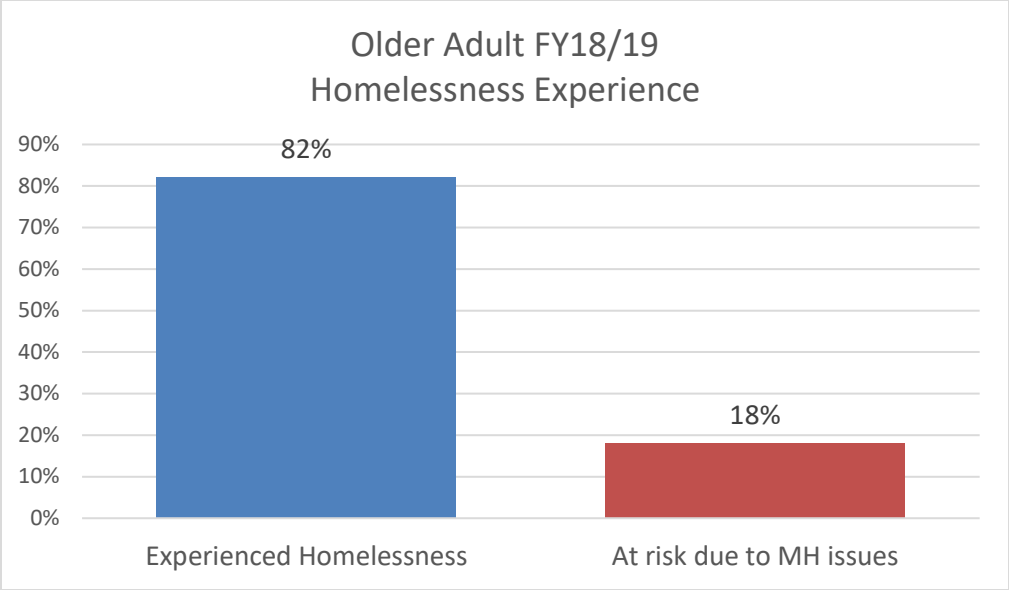
Eighty-six (48%) of the participants were male and 92 (52%) were female. Two participants identified themselves as under 60 years of age and the oldest is 91 years old. Seventy-two (40%) were ages 60-64, 45 (25%) between ages 65-69, 31 (17%) between ages 70-74, 14 (8%) between, 9 (5%) between 80-84 and 5 (3%) over age 85.



Among the 178 Older Adults served in FY18/19, 141 (79%) were White, 8 (4%) were African American, 20 (11%) were Native American, 2 (2%) were Asian and 5 (3%) were Multi Racial/Other. Thirty-one (17%) of the participants were Hispanic.

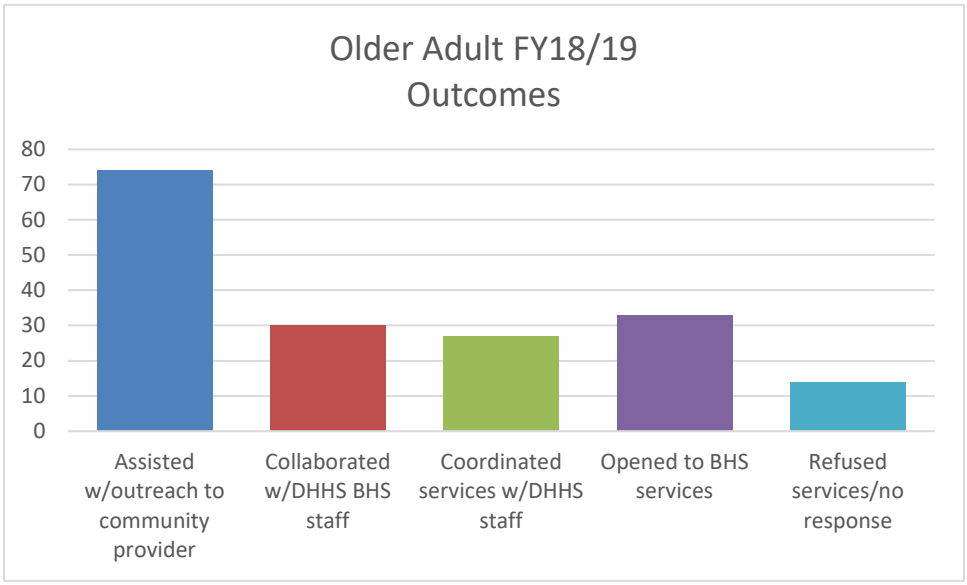


Of the 178 participants in the Older Adult program in FY18/19 146 (82%) self-identified as having experienced homelessness at some time and 32 (18%) expressed feeling at risk of homelessness due to behavioral health issues.



Outcomes

For these 178 Older Adult participants 14 (8%) refused services or did not respond to outreach efforts by the Behavioral Health Clinician (at least three attempts at contact were made). Seventy-four (42%) were handed off to a community provider, 33 (19%) were provided services by DHHS Behavioral Health Services (BHS), 27 (15%) were referred to other DHHS programs, and 30 (17%) were provided services in collaboration with DHHS BHS staff.

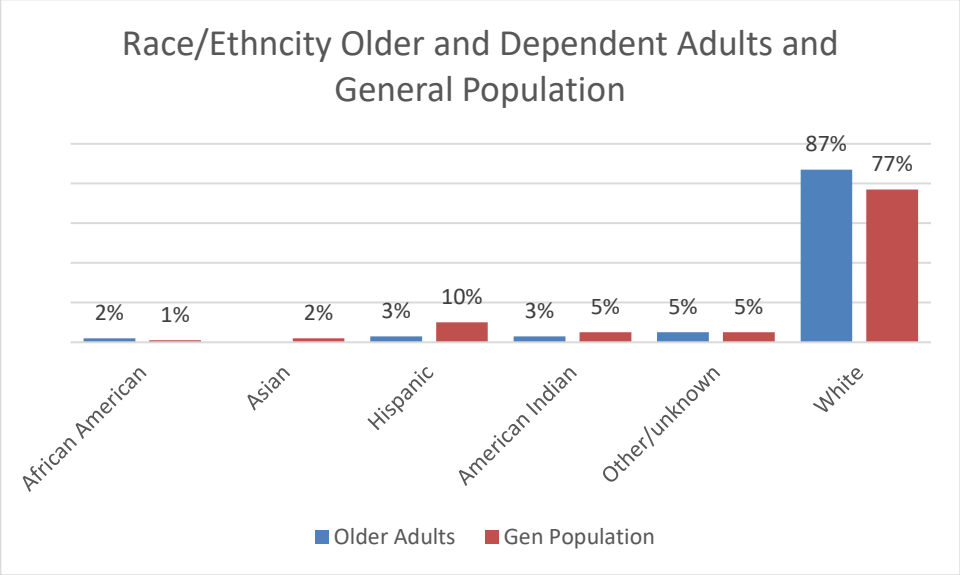


An estimated 150 individuals will be contacted through outreach, prevention and education during FY 19/20.

Behavioral Health Services to Clients

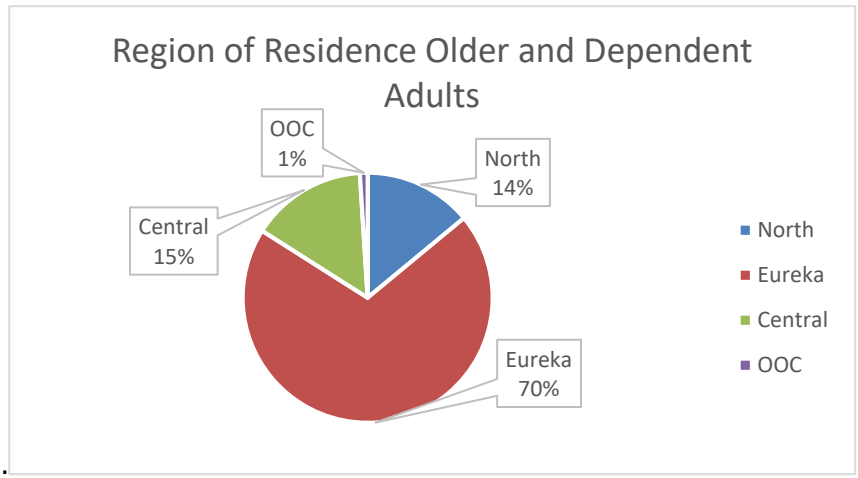
In addition to contacts made through outreach, prevention and education, 151 individuals were provided services as clients of Behavioral Health for fiscal years 2018/2019. Of

these, 87% were White, compared to 77% of the general population; 3% were American Indian, compared to 5% of the general population; 3% were Hispanic compared to 10% of the general population; 2% were African American, compared to 1% of the general population; and 5% were Other/Unknown. No Asian individuals were served, compared to 2% of the general population.



Sixty-two percent of clients served were female, and 38% male.

Seventy percent of those served reside in Eureka, 14% in Northern Humboldt, 15% in Central Humboldt, and none in Eastern or Southern Humboldt. One percent reside out-of-county (OOC).



An estimated 100 clients will be served in the fiscal year

Community Services & Supports: Full Service Partnership

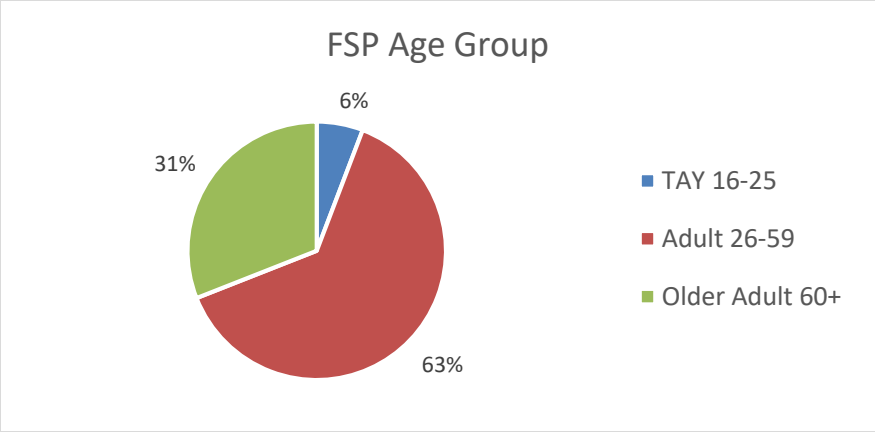
Full Service Partnerships offer a range of services and supports to persons impacted by severe mental illness. These services include medication management, crisis intervention, case management, peer support, family involvement, and education and treatment for co-occurring disorders such as substance abuse. It also provides for non-behavioral health services such as food and housing. The term “Full Service Partners” (FSP) refers to the commitment on the part of the client, the family, and their service providers to determine the needs of the client and family and to work together to support the client in their recovery.

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

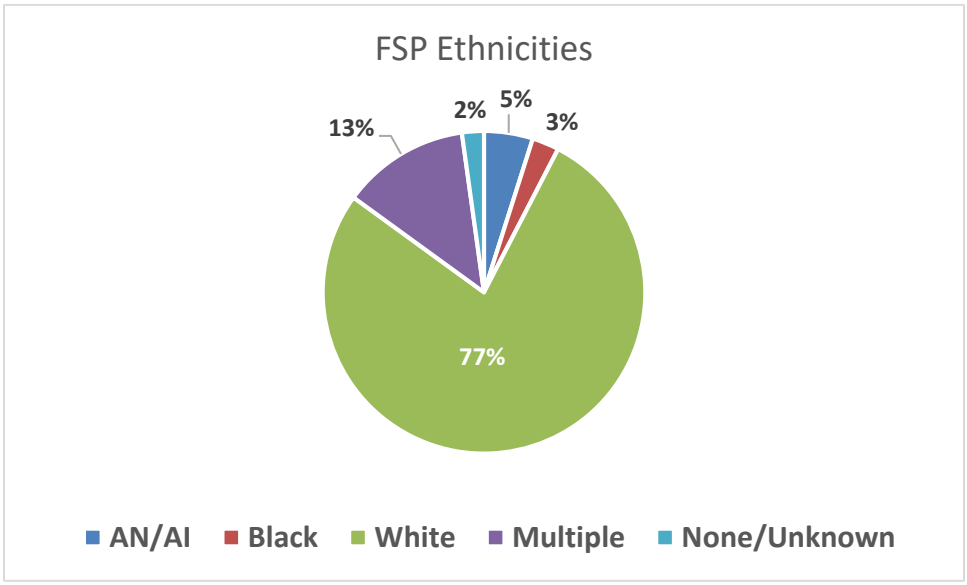
Partners are served through various DHHS programs including Children and Family Services, Transition Age Youth Division, ROSE/Mobile Outreach, and Older and Dependent Adults programs. However, partners are primarily served through the Comprehensive Community Treatment (CCT) program. Modeled after the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

Data Report Data for FSP is from the California Dept. of Health Care Services Data Collection and Reporting (DCR) System.

There were 226 FSPs enrolled for the period July 1, 2018 through June 30, 2019. Among these 226, 194 (86%) completed one year of an FSP and 158 (70%) completed two years. Six percent of FSPs were ages 16-25, 63% were ages 26-59, and 31% were age 60+. While enrollment as an FSP is assessed for children under the age of 16 who meet the FSP eligibility requirements, to date the full spectrum of services have been provided through alternate programs and funding sources other than MHSA FSP funding.



As the chart below shows, for the period July 1, 2018 through June 30, 2019, the percentage of FSPs who identify as White is 77%, compared to 77% for the general population. The percentage of FSPs who identify as Black/African American is 3%, compared to 1% for the general population. There were no FSPs who identified as Asian/Pacific Islander, compared to 2% for the general population. FSPs who identify as American Indian/Alaska Native is 5%, compared to 5% for the general population. No FSPs identified as Hispanic/Latino(a), compared to 10% for the general population. FSPs who identify as multiple races were 13%, compared to 10% of the general population. Race/ethnicity was unknown or not recorded for 2% of FSPs.



Ninety-seven percent of FSPs speak English as their primary language. One person's primary language was Spanish, one's was Armenian, and three reported American Sign Language. For two people the primary language was not reported.

Forty-three percent of FSP clients for the period July 1, 2018 through June 30, 2019 were female and 57% were male.

FSPs exit a Partnership due to a variety of reasons. During the period July 1, 2018 through June 30, 2019, 37 FSPs were discharged from the program for the following

reasons.

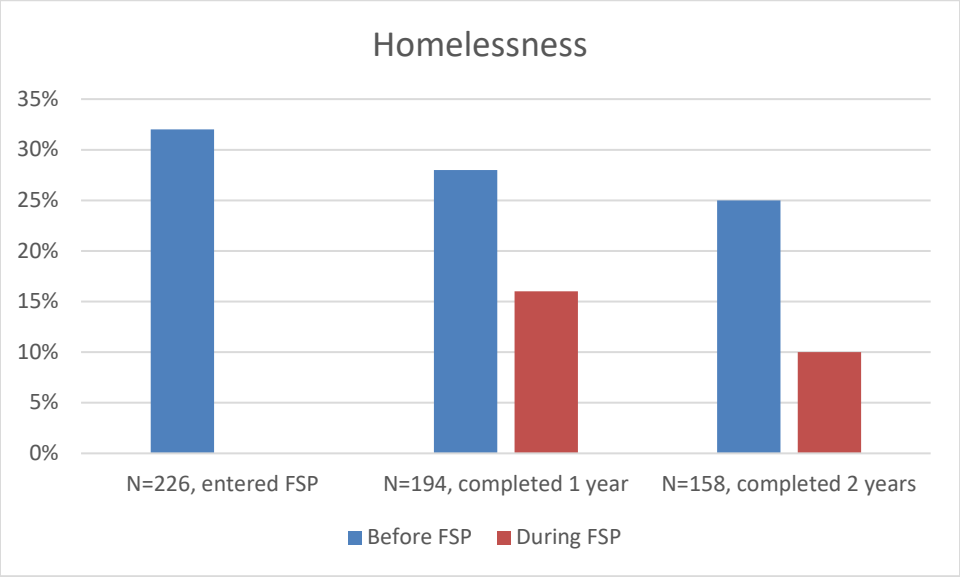
Discharge Reason	Percentage All FSP	Percentage TAY	Percentage Adult	Percentage 60+
Met Goals	59%	0%	30%	30%
Deceased	14%	0%	8%	5%
Moved Out of County	11%	0%	8%	3%
No Longer Met Criteria	3%	0%	3%	0%
Discontinued	3%	0%	3%	0%
Serving Prison	3%	0%	3%	0%
Not located	8%	3%	5%	0%

Of the 37 FSPs discharged during the specified time period, 27 had completed at least one year of the program; 23 had completed at least two years of the program, 17 had completed at least three years, 12 had completed at least four years, and 12 had completed at least five years. The average length of stay in the program during this period was 147 days for Transition Age Youth, 1,121 days for Adults ages 26-59, and 2,156 for Adults age 60+.

An estimated 215 clients with be served as FSPs in the fiscal year, with an estimated 21 TAY, 42 Older Adult, and 152 Adults.

HOMELESSNESS

For the 226 who enrolled in an FSP, 73 (32%) had experienced 15,122 days of homelessness in the year prior to enrollment.

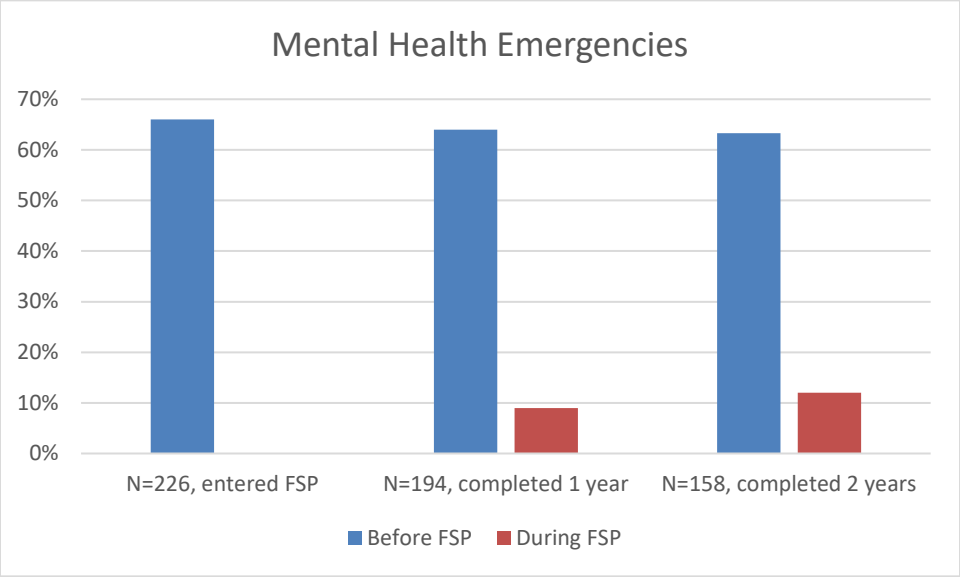


Of the 194 Partners who remained in a partnership for one year, 54 (28%) experienced

10,944 days of homelessness in the previous year and 30 (16%) experienced 5,489 days of homelessness in the first year of enrollment, a decrease of 44% in experienced homelessness and a 50% reduction in homelessness days. Of the 158 Partners who remained enrolled for two years, 39 (25%) had experienced 7,807 days of homelessness in the year prior to the Partnership and 16 (10%) experienced 2,015 days of homelessness during the second year, representing a decrease of 60% in experienced homelessness for a reduction in homelessness days of 74% from the year prior to enrollment in an FSP.

BEHAVIORAL HEALTH EMERGENCY

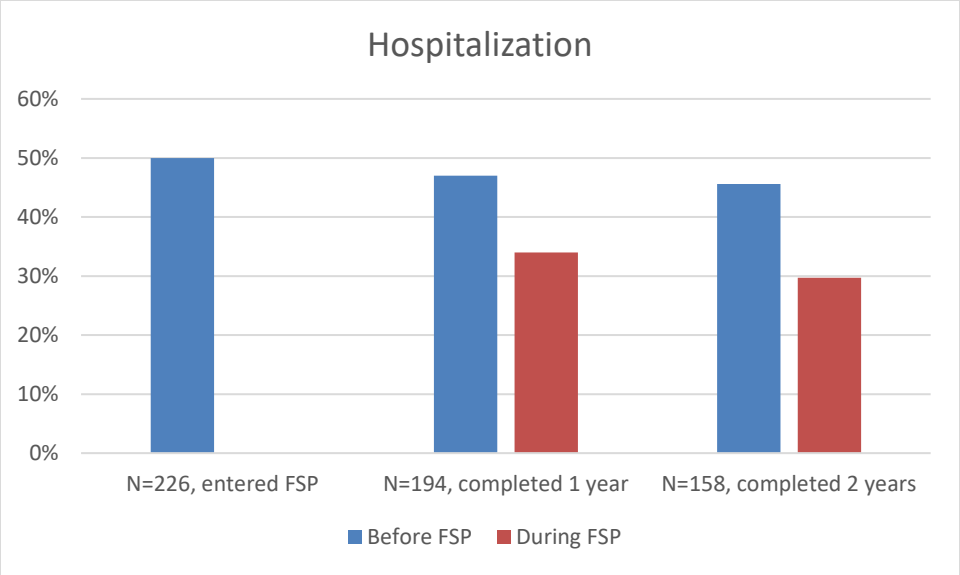
For the 226 Full Service Partners enrolled in an BH program, 150 (66%) experienced behavioral health emergencies in the year prior to enrollment.



For 194 Partners who completed one year in an FSP, 125 (64%) experienced 377 behavioral health emergency events in the year prior to enrollment; during the first year as a Partner, 18 (9%) experienced 52 behavioral health emergencies, a decrease of 86% such events. For the 158 Partners in the second year there were 19 (12%) behavioral health emergencies, a decrease of 81% from prior to FSP enrollment.

HOSPITALIZATION

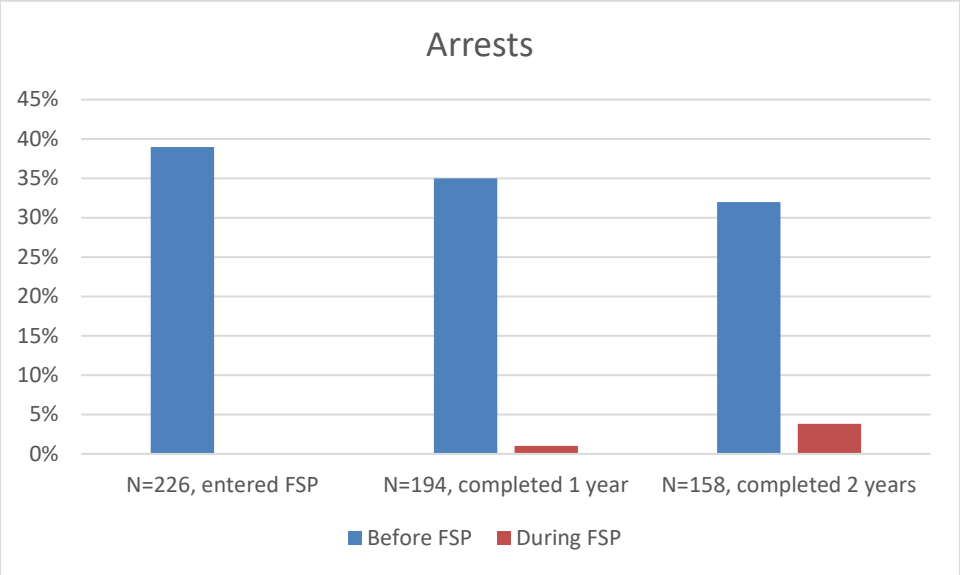
For the 226 Full Service Partners enrolled in an BH program, 113 (50%) experienced hospitalization in the year prior to enrollment.



Of the 194 Partners completing one year in an FSP during this reporting period, 91 (47%) experienced hospitalization in the year prior to enrollment. Sixty-five (34%) experienced hospitalization during the first year of enrollment, a 29% decrease. For the second year there were 47 (30%) out of the 158 Partners who experienced hospitalization, compared to 72 (46%) before FSP enrollment, a 35% reduction in hospitalizations.

ARRESTS

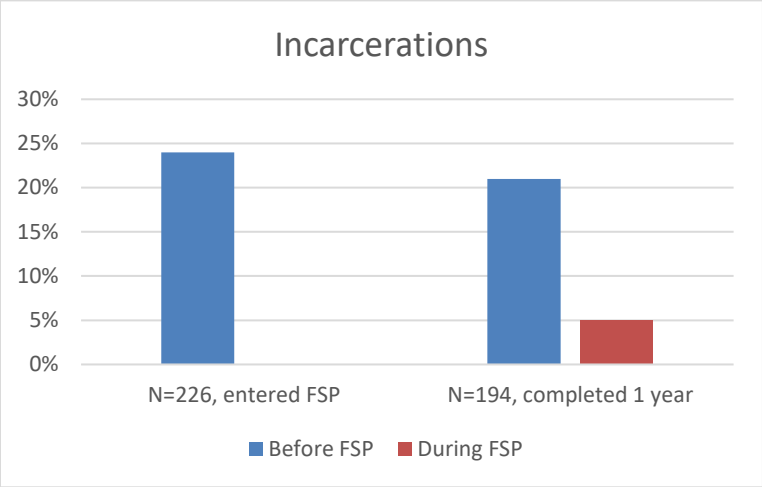
For the 226 Full Service Partners enrolled in an BH program, 89 (39%) were arrested in the year prior to enrollment.



Of the 194 Partners completing one year in an FSP during this reporting period, 68 (35%) were arrested at some time in the year prior to enrollment in an FSP and 3 (1%) were arrested in the first FSP year completed, a 96% decrease in arrests. In the second year, 50 (32%) of the 158 second-year partners had been arrested prior to FSP enrollment and 6 (3.8%) were arrested during the second year, an 88% decrease.

INCARCERATION

For the 226 Full Service Partners enrolled in an BH program, 55 (24%) experienced incarceration in the year prior to enrollment.



Of the 194 Partners completing one year in an FSP during this reporting period 40 (21%) were incarcerated in the year prior to FSP enrollment and 9 (5%) were incarcerated during the first year, a decrease of 78% from the pre-enrollment year. Numbers for the second year of partnership are inconsistent for this measure.

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

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

This program will provide behavioral health treatment in a residential setting to DHHS-MH referred clients. It will assist individuals who are stepping down from higher levels of care to effectively integrate back into the community. Many or most of the clients will be on a Lanterman Petris Short (LPS) Conservatorship. The program will assist to reduce and prevent homelessness, involvement in the criminal justice system, acute psychiatric hospital admissions and length of stays and admission/re-admission to Institute for Mental Disease (IMD) and Mental Health Rehabilitation Center (MHRC) facilities.

Services will be provided 24 hours/day, seven days per week. Types of services include those in the following categories:

- Sub-Acute Transitional Mental Health Services, including provision of personal living quarters and laundry facilities; provision of continuous observation, assessment, supervision and support; provision of three nutritional meals and snacks in between meals, assistance with tasks of daily living.

- Specialty Mental Health Services, including medically necessary skill-based interventions; counseling; assistance with skill development.

- Social Rehabilitation Services, including written case plans; crisis management; life skills education; maintaining housing.

- Discharge Planning and Coordination Services

The Request for Proposals was issued on January 2020, and proposals are due March 13, 2020. It is anticipated that a proposal will be selected for funding by the end of the Fiscal Year, and that services will begin in FY 2020-2021.

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

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

HOME uses a "Housing First" approach to support clients in obtaining housing. "Housing First" is a proven strategy for ending chronic homelessness. As described by the United States Interagency Council on Homelessness, Housing First offers immediate access to permanent affordable or supportive housing without requirements of sobriety, income or completion of treatment. Humboldt County continues to make changes to existing Housing First practices used in larger urban areas to demonstrate effectiveness on a smaller scale in rural areas. HOME includes outreach and engagement efforts during street level interventions for persons with mental illness who are experiencing homelessness.

The Mobile Intervention Services Team (MIST) is the collaborative effort to successfully engage homeless individuals who have severe mental illnesses and have frequent contact with law enforcement. MIST is discussed later in this section.

To date, the HOME/MIST pathway has linked 166 unique individuals to permanent or temporary housing.

Background
Humboldt County has been designated as a community of high need by the Department of Housing and Urban Development (HUD) due to the large number of people who are chronically homeless relative to size of population. HUD considers chronically homeless to be currently homeless and homeless for more than a year, or to have four episodes of homelessness in the past three years. In the last Point in Time Count of homeless persons (2019) 1,470 people who experienced homelessness were counted on the night of January 23rd.

Like most areas in California, Humboldt County has a housing shortage. This is most acute in the availability of decent, affordable housing for persons receiving SSI. DHHS is working with local developers to make more affordable housing available for our clients. This began with the early MHSA Housing Program funding and resulted in 15 new studio apartments during Fiscal Year 16-17. The tenant portion of rent is limited to 30% of income, making long term tenancy possible. Nearly all of the initial tenants came directly from the streets through the HOME/MIST pathway. A majority of the initial tenants remain at the same property. Several have obtained Section 8 certificates and moved into other housing. Some have received notices, but most of those have

obtained housing at other properties. As units become available, MHSA eligible clients are supported through the application process and occupancy rates are very high.

Increases in Affordable Housing
A newly developed housing project resulted from a partnership with City of Eureka and a local developer included 15 new subsidized apartments (out of 50 total) for eligible HOME/MIST clients. Clients began occupying the units in April 2017 and occupancy rates have remained very high.

In construction is another 50-unit apartment building with community and meeting space for tenants. This project is fully funded including No Place Like Home (NPLH) funding for 19 of the units. This development has a total of 25 units for eligible HOME/MIST clients. Occupancy should begin in Spring of 2020. A fourth project also under construction is a 25 unit project in Rio Dell. This project will be individual small homes with all utilities and amenities that are fully ADA compliant for eligible HOME/MIST clients.

Community-wide planning and monitoring for projects includes but is not limited to, Humboldt Housing and Homeless Coalition, local city councils, local police departments, Humboldt County Board of Supervisors, Humboldt County Health & Human Services, Humboldt County Behavioral Health Board and the MHSA Community Planning Process.

Multiple funding sources are brought together to ensure financial assistance to tenants such as for deposits, rental assistance, moving costs, damages and other housing related to support housing stability. Sources include City of Eureka, Humboldt County, Housing and Urban Development, MHSA, Partnership Health and St. Joseph Health System/Providence and private contributions.

For all projects, Behavioral health support staff provide services on-site. There are also resident services staff on site. In addition to clinical services, recreational and volunteer opportunities open to all residents to assist community integration and to reduce stigma are provided. All projects also include community spaces for events, supportive services and recreation.

Less Utilization of Costly and Restrictive Services
In Humboldt County, there were a number of clients not connected with outpatient services or peer support. The planning process for HOME concluded this was in large part due to homelessness. Permanent supportive housing continues to be the best strategy for clients who are homeless and experience high incidence of:

- Seven and thirty day re-admittance rates to psychiatric crisis and hospital services
- Utilization of local emergency departments for psychiatric crises
- Community based contacts with law enforcement and incarceration
- Utilization of higher levels of restricted residential placements

The community has committed to increasing the supply of Permanent Supportive Housing (PSH) and preliminary data demonstrates its effectiveness. Data is collected on client use of the local crisis services unit and psychiatric hospital during the period

to and after obtaining housing. There was a 62% reduction in use of these services by participants in the project. The project is requesting data now from law enforcement entities and local emergency departments and anticipates a similar reduction in visits and calls for service and incarceration.

Stigma and Discrimination

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

Project Description

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

HOME/MIST is addressing the following issues for individuals who are experiencing homelessness and have a severe mental illness diagnosis:

- Ineffective or nonexistent engagement, including people with pets
- Suspicion or fear of outreach workers and law enforcement
- Discrimination, even amongst the homeless services community and other homeless persons
- Increasing dependence on higher levels of care and restrictive settings such as psychiatric crisis and hospital services, emergency departments, and incarceration

These issues are being addressed by the development and evaluation of the following approaches:

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

Peer Support

Peer support has proven to not only reduce the internalized stigma for clients, but has also had a de-stigmatizing effect for co-workers and community members. With the passing of MHSA, Humboldt County Department of Health and Human Services (DHHS) Behavioral Health (MH) programs have explicitly included elements of recovery, wellness, and resiliency-focused peer support. Peers have been active part of service provision teams in mobile outreach and inpatient and outpatient programs. The Hope Center, a peer-run empowerment center, has been supporting clients in their recovery goals since it opened in 2008. DHHS MHSA 2010 Innovation Plan focused on the development of transition age youth (TAY) peer support specialists in the integrated TAY

Division. In 2014, DHHS adopted the three tier classification of Peer Coach I, II, and III. For the first time at DHHS, these job descriptions explicitly recognize the value of lived experience in a service delivery team and provide a career ladder for Peer Coaches.

The community planning process determined that the infusion of peer support has shown success in engaging hard to engage clients, and that peer support has been successful at shifting community attitudes and beliefs through modeling resilience and recovery. Thus far in this Innovation Project, six Peer Coaches have been added to the outreach and engagement and housing retention team. They have been very successful in achieving goals for client success and have demonstrated the high value of peer support throughout the behavioral health system.

Pets

This Project has identified successful practices for engagement of homeless individuals who have a pet to help them retain housing.

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

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

Minor Changes

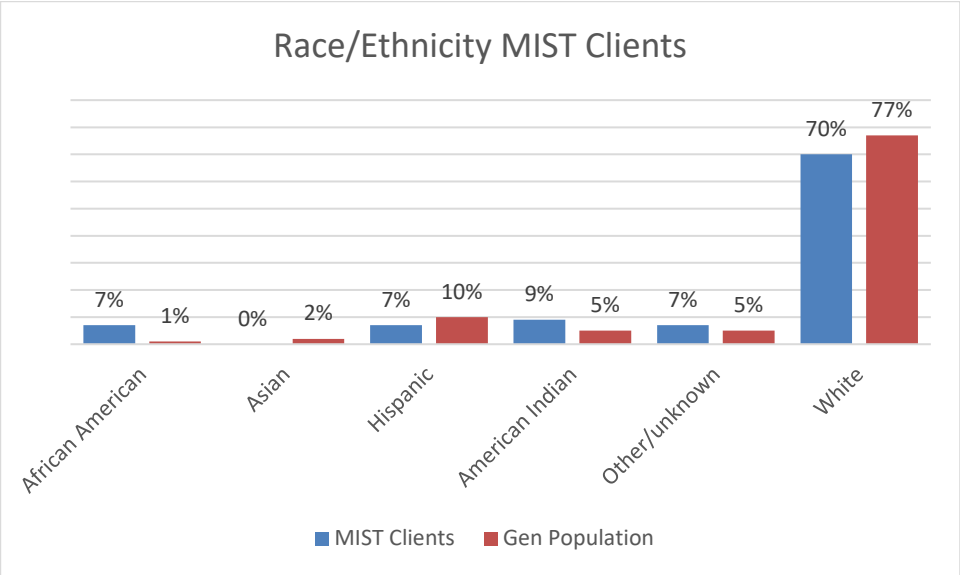
Initially the conversion of a local long-term transitional housing model for families—the Multiple Assistance Center (MAC) -- to a short-term rapid rehousing model that is inclusive of individuals with a severe mental illness diagnosis, required an innovative approach unique to this community. The MAC served as a short-term (30 days) housing program for many homeless adults, including persons with serious mental illness, to safely reside while looking for housing. Direct diversion into housing with rental assistance was available to participants. Innovation funds were used to support participants with serious mental illness with several other sources of funding to support the larger effort and over a hundred persons with a serious mental illness diagnosis obtained housing through the HOME/MIST/MAC project.

In 2017 the management of the facility that was the MAC shifted to Waterfront Recovery Services (WRS). WRS provides substance use disorder treatment and includes medically supervised detoxification and residential substance use disorder treatment for persons that are dually diagnosed. Because community partners substantially increased the financial support of these services, DHHS was able to shift more of the Innovation funds to the HOME/MIST part of the project which resulted in an increase of support staff. Additional Peer Coaches, a Clinician, Case Managers, and Community Health Outreach Workers were added to increase access to behavioral health services, especially engagement and assessment. Persons experiencing homelessness that also have a serious mental illness diagnosis are supported in directly obtaining housing.

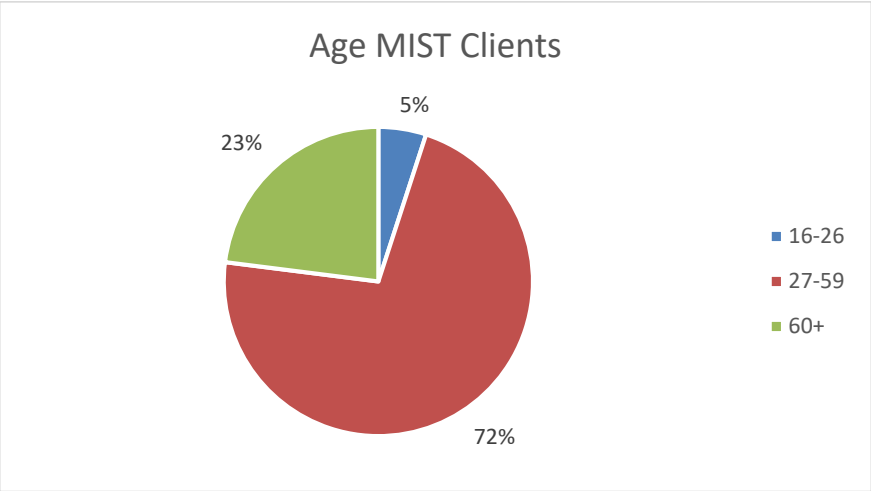
The initial name of the Innovation Project was “Rapid-Rehousing.” As the project has moved forwarded and evolved, implementation team members including program staff, recognized that the title “Rapid-Rehousing” did not include the outreach and engagement components or the range of housing program approaches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

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

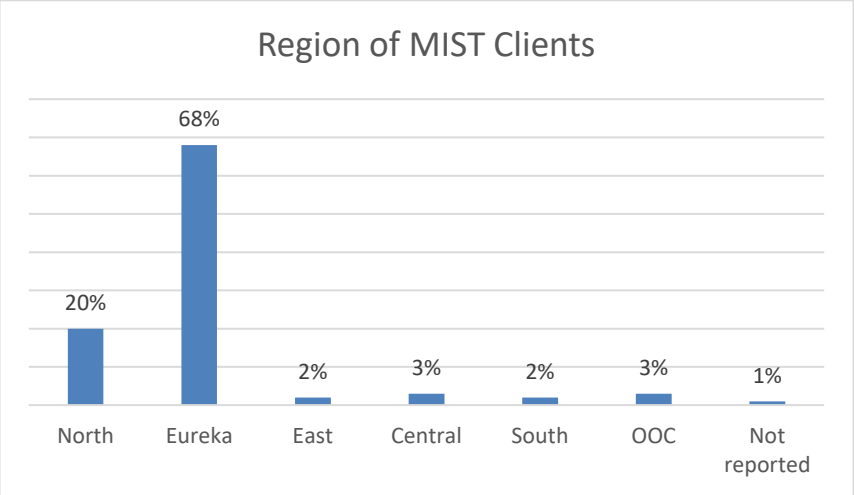
- Outreach and Engagement. Outreach and engagement occur through the MIST partnership with law enforcement, emergency departments, psychiatric emergency services and hospitals as well as other community partners. MIST staff partner with law enforcement officers to ride along on a weekly schedule to make initial contact with the individuals identified by the law enforcement agencies. During the past year there were 1,608 encounters by MIST staff with 92 individuals who then became clients. The average number of encounters per clients was 17, and 15 clients accounted for 62% of the total encounters.
- MIST client data for 2018/19 shows the following:
  Seven percent of MIST clients were African American, as compared to 1% of the general population. There were no clients who were Asian, as compared to 2% of the general population. Seven percent of clients were Hispanic, as compared to 10% of the general population. Nine percent of clients were American Indian, as compared to 5% of the general population. Seventy percent of clients were White, as compared to 77% of the general population. Seven percent of clients were Other/Unknown, as compared to 5% of the general population.



Five percent of MIST clients were ages 16-26, 72% were ages 27-59, and 23% were age 60+.



Forty-three percent of MIST clients were female, and 57% were male. 68% of MIST clients "resided" in Eureka, 20% in the Northern Humboldt region, and the remaining 12% in other regions of the county, out of county (OOC), or not reported.



- In the last year, MIST expanded its service area from Eureka to Arcata and is starting an expansion in the outlying areas of the county. In FY 18-19, MIST received 47 referrals from EPD and 6 referrals form APD. The partnership with HCSO is still in the early development phase and a protocol for receiving referrals is still being established.
- MIST staff consists of a Behavioral Health Clinician, two Behavioral Health Case Managers, three Peer Coaches, and a Community Health Outreach Worker. MIST staff engage in outreach activities each day in an effort to make proactive frequent contacts with the individuals referred to MIST. Sometimes it can take months or even years to engage individuals in services.

- MIST staff review the census on the Crisis Stabilization Unit (CSU) and Sempervirens (SV) Psychiatric Health Facility each day so that they can collaborate on the clients' discharge plans. Staff also review jail bookings each day and work closely with the Behavioral Health staff based in the jail to support clients with developing plans for release. MIST staff visit clients during their stays on CSU, SV, and jail to gain a better understanding of the circumstances leading them to be there and to support them with developing plans to reduce their future visits.
- Once MIST staff have built rapport with the referred individuals they assist them in obtaining a behavioral health assessment and develop a plan to assist them in achieving their goals. Often the primary goal is to obtain housing.
- MIST clients have extreme difficulty obtaining housing due to the complex nature of experiencing severe mental illnesses, high rates of substance use disorders, and involvement in the criminal justice system.
- Staff assist participants in locating and securing housing as quickly as possible using a "Housing First" approach. Participants have a housing assessment to determine the appropriate level of housing and any ongoing needs for supportive services to remain housed. Through other funds, financial assistance is also available for deposits and in some cases on-going rental assistance. The housing placements range from private market apartments and efficiencies, subsidized housing, Section 8 subsidy, shared housing and for those most vulnerable with a history of chronic homelessness, Permanent Supportive Housing. Maintenance and repair services for persons with symptoms of severe mental illness, such as hoarding and property destruction during episodes, are provided to keep them housed. This aspect of some mental illnesses is often the reason for their homelessness.
- Humboldt Housing and Homeless Coalition (HHHC) has taken every opportunity from HUD to increase the community's stock of Permanent Supportive Housing (PSH). When funded by HUD, this housing option requires the occupant to be low-income, disabled and chronically homeless. Briefly, PSH allows the participant to choose where he or she wishes to live so long as the rent is in line with Fair Market Rent for the area. The occupant's share of the rent is limited to no more than 30% of his/her income and the HUD-funded agency pays the balance. The housing unit is in the client's name and allows him/her to develop a good rental history. The participant is offered a full range of supportive services and chooses what he or she would like to participate in as recovery is client-driven. PSH can be funded by other sources, not just HUD, and DHHS Behavioral Health has a collaborative agreement for 15 units of PSH using the MHSA Housing Program that opened in Fall 2016. Known as Arcata Bay Crossing (ABC), this development has 42 housing units total, including the 15 set aside for homeless people with serious mental illness.
- Peer Support and Linkages. Peer support services includes linkages to services such as:
    - Full Service Partnership enrollment
    - Outpatient mental health counseling

- Case management
- Medication support
- Medi-Cal enrollment
- Substance Use Disorder services
- Primary care physician
- Housing
- Bus vouchers
- CalFresh enrollment
- Transitional Age Youth Division services, which provides behavioral health, social services, public health, Peer Partner support, advocacy and educational opportunities in an age appropriate, peer driven setting
- The Hope Center, a peer run empowerment center that provides a safe, welcoming environment based on recovery self-help principles

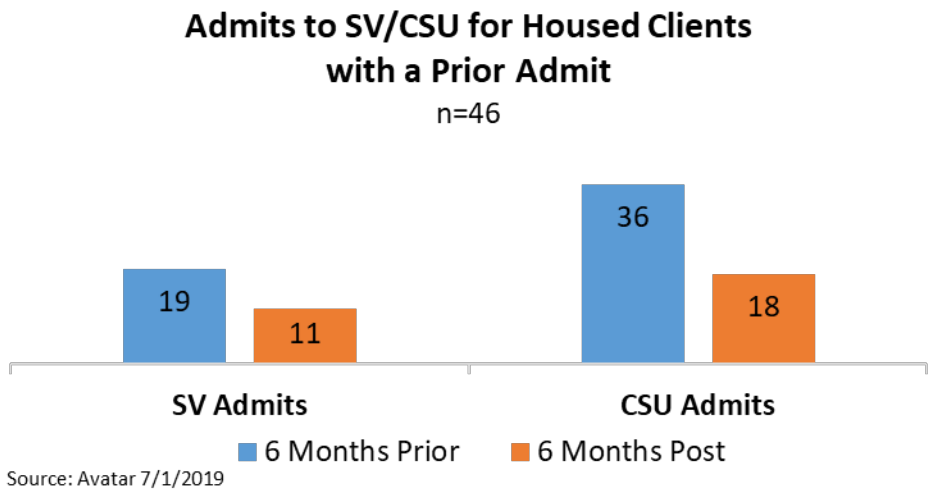
Project Outcomes

The following outcomes continue to be monitored through the implementation team to identify best practices, which will be reported in a final Innovation Report at the end of the Project. For those clients who are also Full Service Partners, outcomes may also be monitored through the Department of Health Care Services Data Collection and Reporting System.

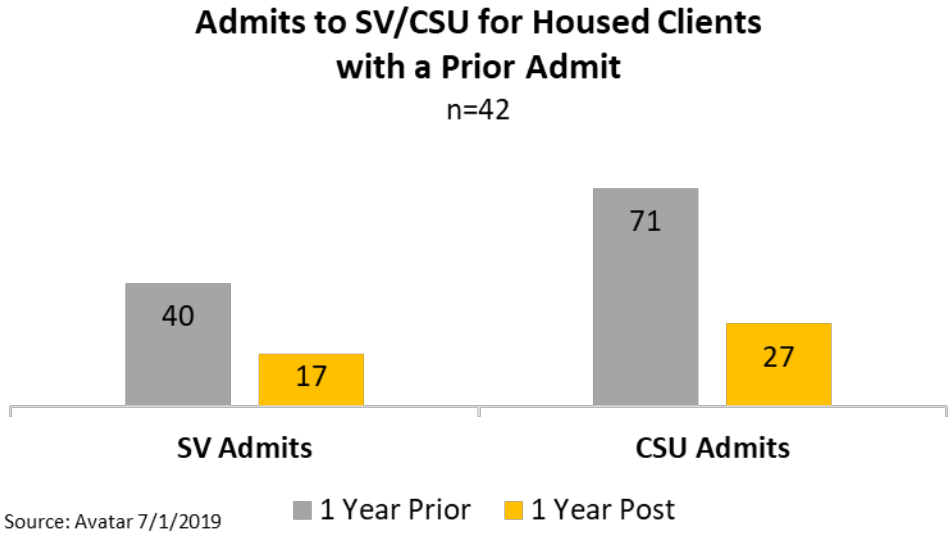
- Increase in residential stability
- Increase in achieving educational goals
- Increase in achieving vocational goals
- Reduce psychiatric hospitalizations
- Reduce psychiatric emergency visits
- Reduce arrests
- Reduce incarcerations

Some initial program outcomes are depicted below.

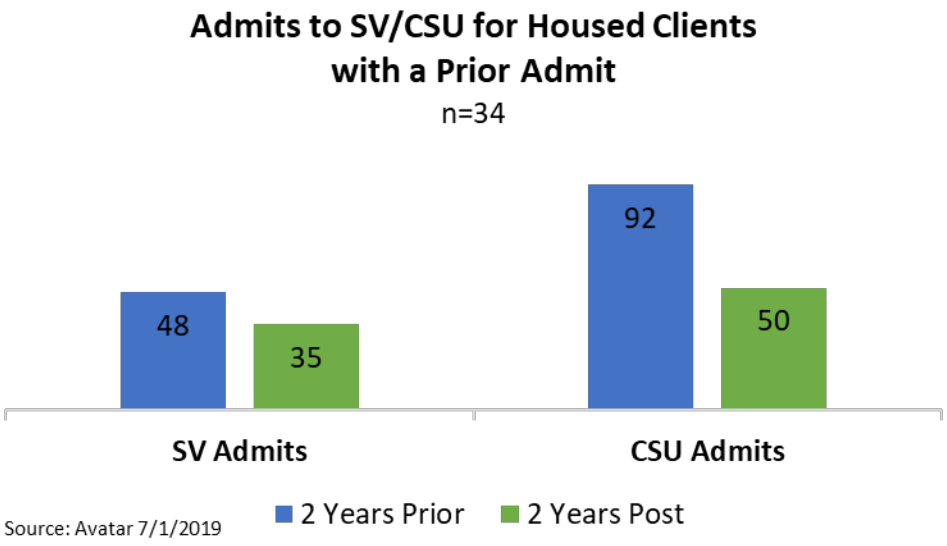
Admissions to Sempervirens (SV, the psychiatric hospital) and the Crisis Support Unit (CSU) declined six months after obtaining housing for homeless individuals who had admissions prior to obtaining housing. For SV, it was 42%. For CSU, it was 50%.



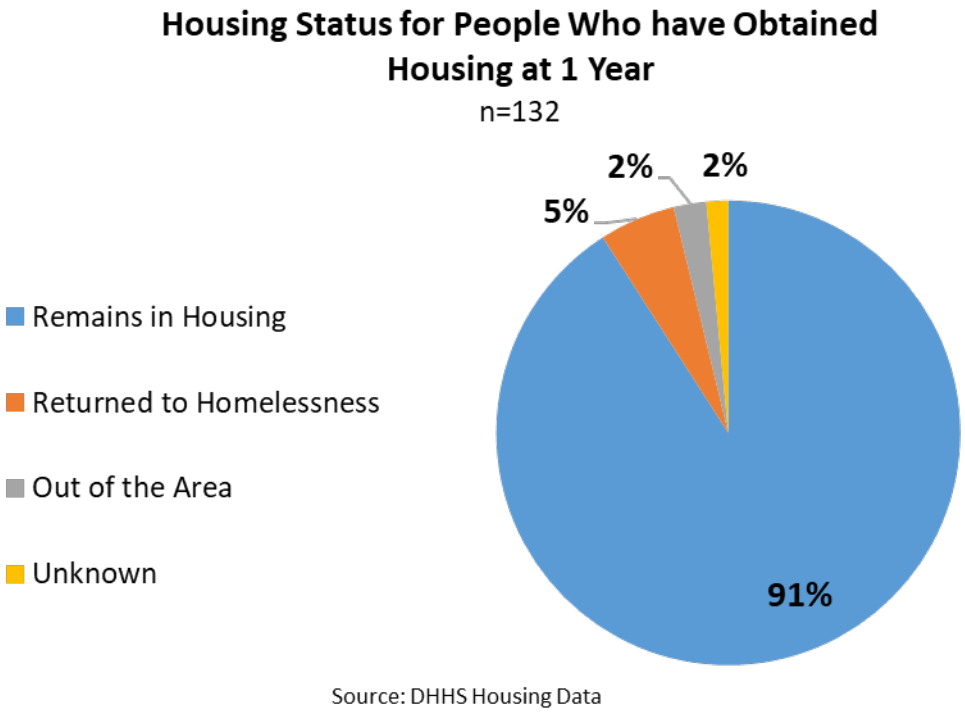
Admissions to SV and CSU declined one year after obtaining housing for homeless individuals who had admissions prior to obtaining housing. For SV, it was 58%. For CSU it was 62%.

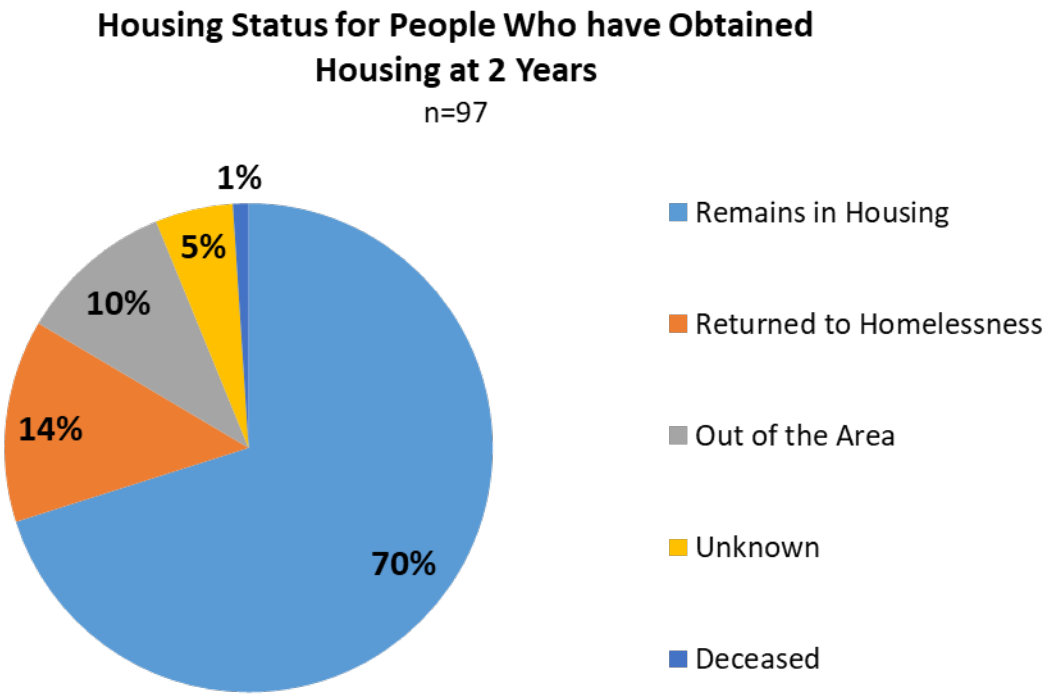


Admissions to SV and CSU declined two years after obtaining housing for homeless individuals who had admissions prior to obtaining housing. For SV, it was 27%. For CSU it was 46%.



At one year after obtaining housing, 91% remained in housing, 5% returned to homelessness, 2% are now out of the area, and 2% are unknown. At two years after obtaining housing, 70% remained in housing, 14% returned to homelessness, 10% are now out of the area, 5% are unknown, and 1% are deceased.





Source: DHHS Housing Data

Project Timeline for Remaining Years

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

Prevention & Early Intervention: Hope Center

The Hope Center serves unserved and underserved populations of transition age youth, adults and older adults who have behavioral health challenges and their family members. The Center meets the need in the community to provide a safe, welcoming environment based on the dimensions of wellness from SAMHSA, and the resources necessary for people with and without a behavioral health diagnosis and their families to be empowered in their choices to be self-sufficient. The Hope Center provides prevention activities that reduce stigma and discrimination and provide access and linkage to treatment. These activities contribute to the reduction of all seven of the negative outcomes that may result from untreated mental illness.

The Hope Center is peer driven with a full time Peer Coach III who oversees the Center, three full time Peer Coach staff, two part time Peer Coach staff, and one volunteer. There are two to three Work Experience workers at the Center as well. Consultation is provided by a Senior Program Manager. The majority of the Peer Coaches are trained as Certified Peer Support Specialists through Recovery Innovations (RI) International. The Peer Coach III has additional training through the California Association of Mental Health Peer-Run Organizations (CAMHPRO) and the California Association of Social Rehabilitation Agencies (CASRA) as a Train- the- Trainer in the Superior Region Provider Core Competency Training. The supervisor of the peers has gone through a Peer Supervisor Training through RI International. The Peer Coach III is leading cross-training of other staff so everyone is able to do the work in the absence of one of the staff. Three staff and one volunteer have completed the Hearing Voices Network Facilitators Training.

Hope Center goals are to:

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

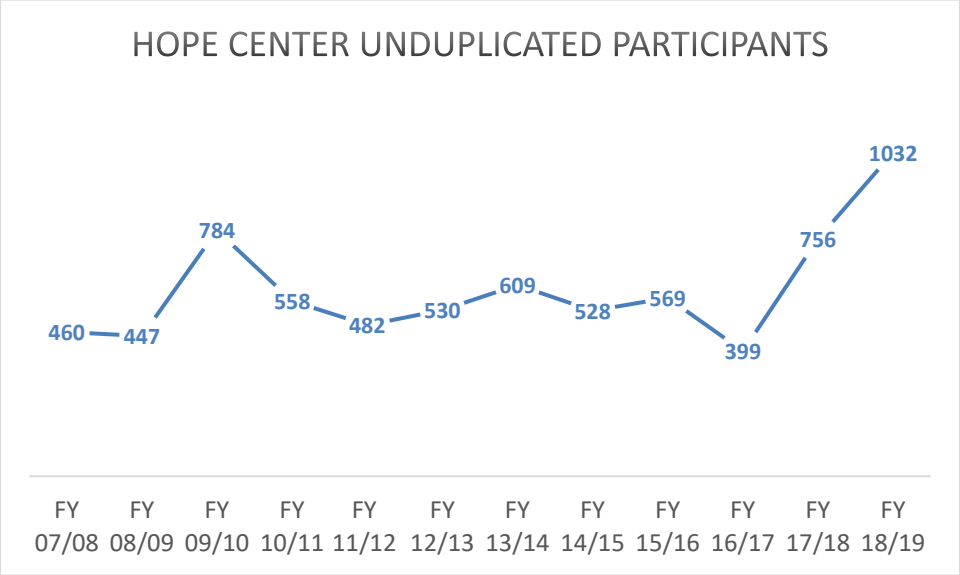
The Center works from the recovery pathways: Hope, Choice, Empowerment, Recovery Environment, Spirituality (purpose/meaning). The Center provides many resources including classes, self-advocacy education, peer support, system navigation, and linkage to services in the community. Outreach efforts are made by Hope Center peer staff and volunteers to people with a behavioral health diagnosis. Two Peer Coaches are teaching “My Wellness My Doctor and Me” classes that teach how to communicate with your doctor and be prepared for visits. There are role playing and discussions on symptoms and side effects. Another class is “Well,” a 16 session class where participants can drop

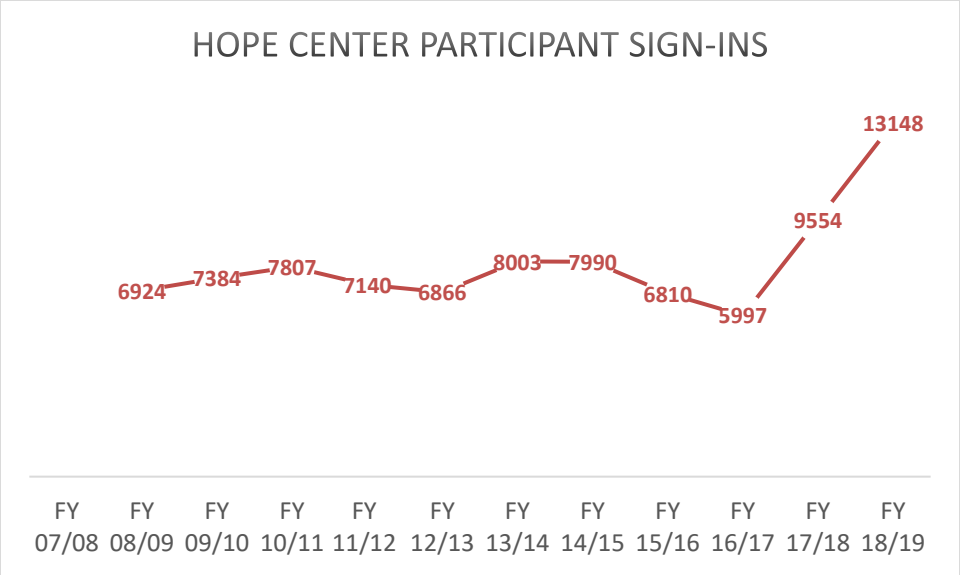
in to any session. It covers many topics such as the pathways of recovery, conflict resolution, substance challenges, social wellness, self-esteem, budgeting and goal setting. In 2018 the Hope Center created an Advisory Board made up of four participants, one volunteer and two staff. The Board's job is to be a voice for the Center and give input to staff. Members meet once a month and Board members serve for one year. One of the Advisory Board members also sits on the Humboldt County Behavioral Health Board. The Hope Center has consistent and active members of the community who contribute services such as outreach, education, and coordination of special events.

Hope Center Continuing Projects include:

- Peer workforce training for the current and future workforce
- Leadership training
- Healthy Harvest--fresh fruits and vegetables for participants to supplement their diet
- Cultural inclusion
- Supporting the Hope Center Advisory Board
- Hope ambassadors (participants who know and talk about the recovery pathways)
- Direct access to a clinician who uses the recovery pathways and dimensions of wellness in their interactions with participants
- Wellness Recovery Action Plan facilitation
- Teaching interns about the Peer Empowerment model and use of the recovery language to use in their future work.
- May is Mental Health Matters Month participation
- Hope Center offers classes, workshops and education that focus on individuality, mindfulness, nutrition, resilience, fun, building skills, wellness, building community, facing challenges, and building confidence

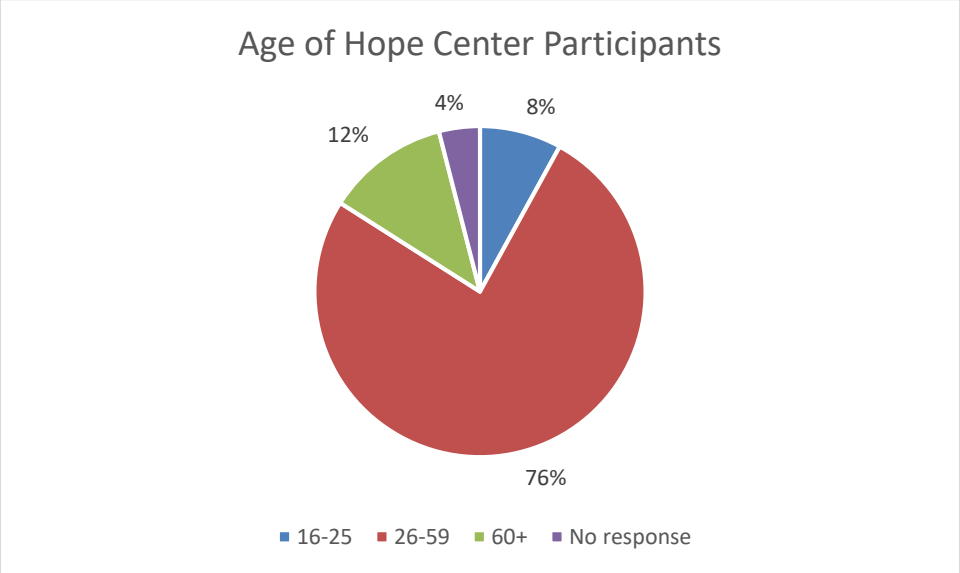
During fiscal year 2018-2019 the Hope Center interfaced with 1,032 unduplicated individuals. There were 13,148 sign-ins to the program. The charts below show the increase over time. In addition, there were three volunteers in the program who put in 566 volunteer hours. It is estimated that in the next fiscal year over 1000 individuals will participate.





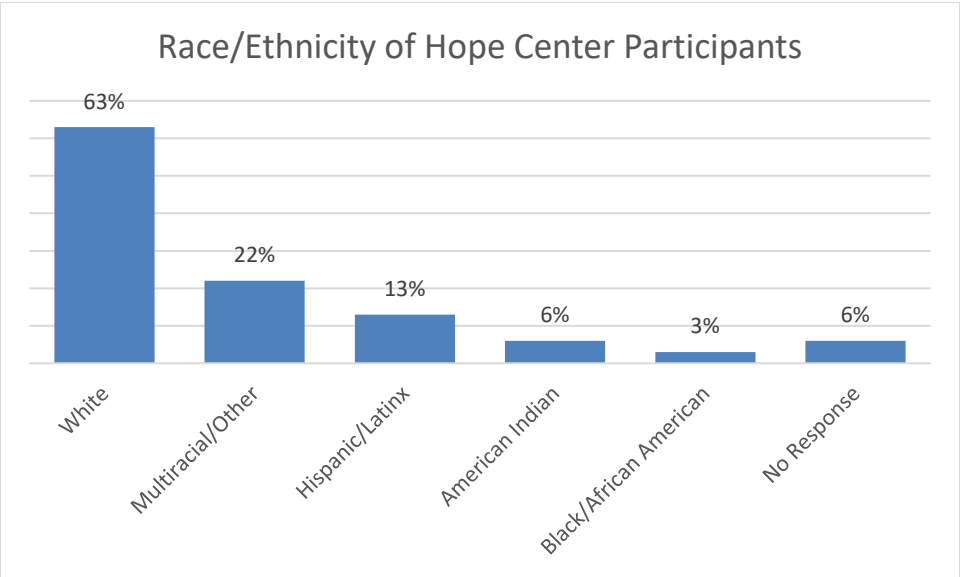
Demographic Data. Of the 1,032 Hope Center participants, 374 (36%) completed demographic forms. Demographic data is presented in the charts below.

Eight percent of participants were ages 16-25, 76% of participants were ages 26-59, and 12% were age 60+. Four percent did not respond to the question.



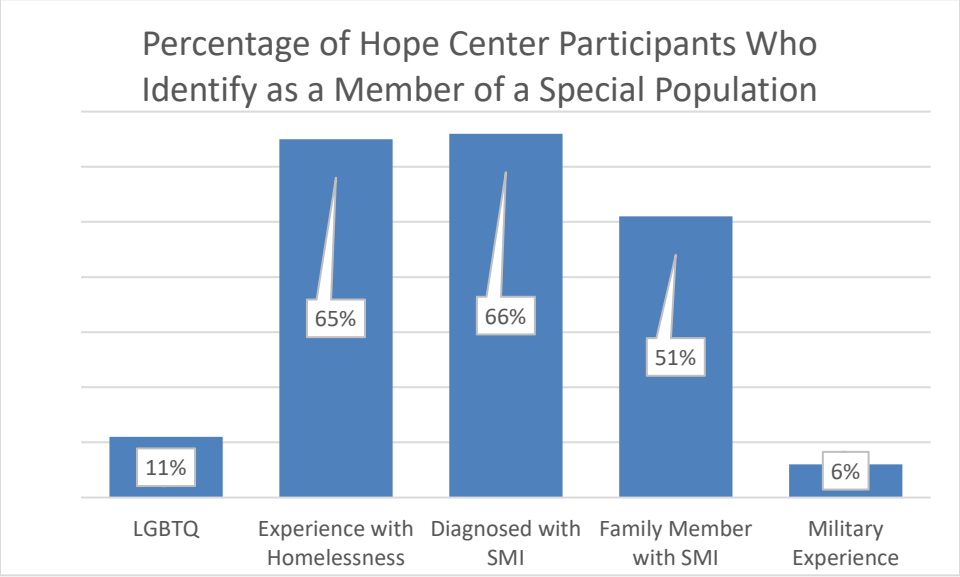
Forty-two percent of Hope Center participants were female, 51% male, and 6% did not respond to the question. Four participants reported their gender as Other.

Sixty-three percent of Hope Center participants were White, 22% were Multiracial/Other, 13% were Hispanic/Latinx, 6% were American Indian, and 3% were Black/African American. There were two Asian/Pacific Islander participants, less than 1%. Six percent did not respond to the question.



Ninety-six percent of Hope Center participants speak English as their primary language, and 3% did not respond to the question. Three participants reported that Spanish is their primary language.

Eleven percent identified as LGBTQ, 65% has experience with homelessness, 66% had been diagnosed with a serious mental illness (SMI), 51% has a family member diagnosed with SMI, and 6% had military experience.



Prevention and Early Intervention: Suicide Prevention

Healthy Communities Suicide Prevention strategies work to prevent suicide as a consequence of mental illness, improve access and linkage to treatment especially for those populations that are underserved or unserved. Strategies include:

- Public and targeted information campaigns
- A community suicide prevention network
- Culturally specific approaches
- Survivor-informed models
- Training and education

All activities meet an evidence based, promising practice, or practice based evidence standard. It is housed within the DHHS Public Health Branch, Healthy Communities Division. According to MHSA PEI Regulations this category of programs does not focus on or have intended outcomes for specific individuals at risk of or with serious mental illness. There are four projects in the Suicide Prevention Program:

- Suicide Prevention Training: Applied Suicide Intervention Skills Training (ASIST)
- Question~Persuade~Refer (QPR) Suicide Prevention Training
- Humboldt County Suicide Prevention Network
- Capacity Building Assistance including policy, protocol, procedure development for system working with people at risk for suicide
- Humboldt Suicide Fatality Review (SFR)

Project Name: Suicide Prevention Training: Applied Suicide Intervention Skills Training (ASIST)

ASIST is a continuing suicide prevention project for Transitional Age Youth, Adults and Older Adults. It is a public and targeted information campaign and targeted education and training. It addresses the negative outcomes of suicide and prolonged suffering.

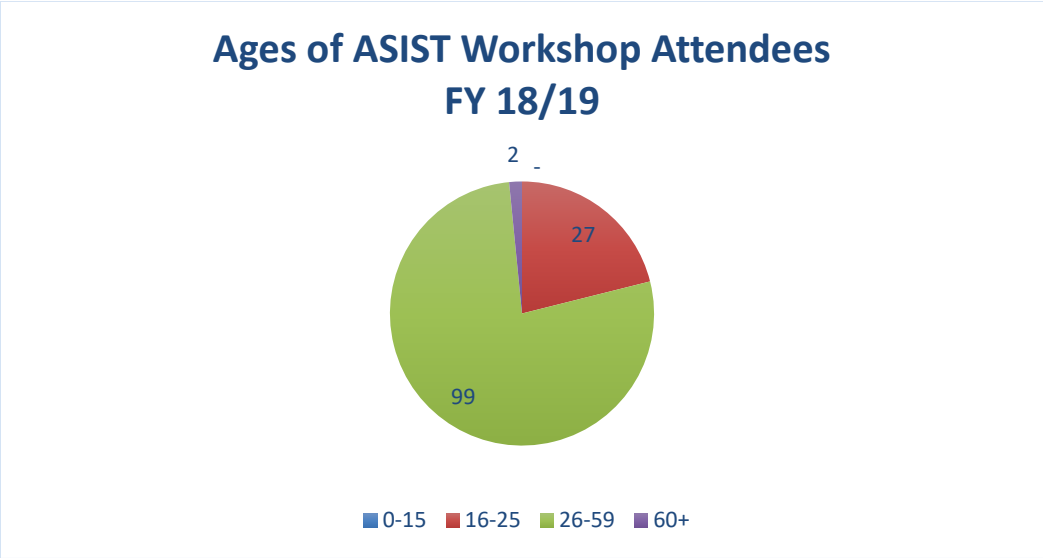
ASIST is a two-day interactive workshop in suicide first aid. ASIST teaches participants to recognize when someone may have thoughts of suicide and work with them to create a plan that will support their immediate safety. Humboldt County has prioritized training as a method to increase system and community capacity to respond to persons at risk. ASIST training teams are multidisciplinary and include public health educators, behavioral health clinicians, social workers, juvenile probation staff, tribal agency representatives, and law enforcement.

Target Population: ASIST is open to and intended for anyone 16 years and older. Participants include: school personnel, health and behavioral health care providers, first responders, faith community, front line workers, and concerned community members.

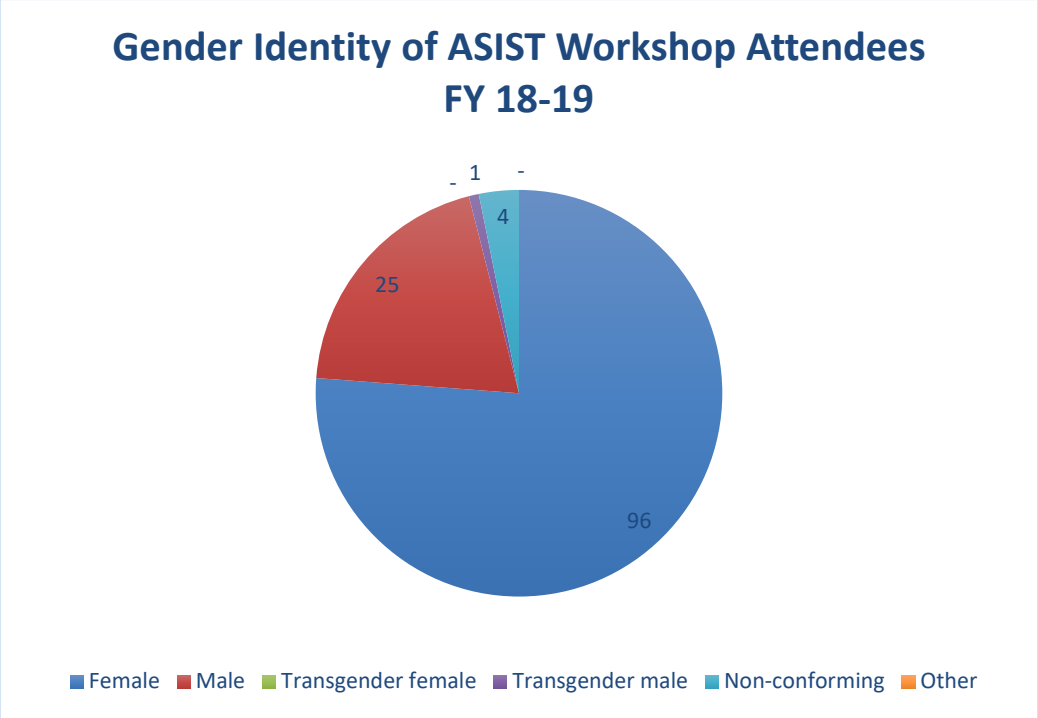
Unduplicated Number of Individuals Served: In FY 2018/19 159 individuals attended ASIST. Seven ASIST Workshops were held.

Demographics of individuals served: Demographic information comes from attendees at trainings who complete a demographic form. In Fiscal Year 18/19, 80.5% of attendees (128) completed a demographic form, and 19.5% (31 attendees) declined completing a demographic form.

In Fiscal Year 18/19, 27 attendees at ASIST workshops were ages 16-25, 99 attendees were ages 26-59, and two attendees were age 60+.

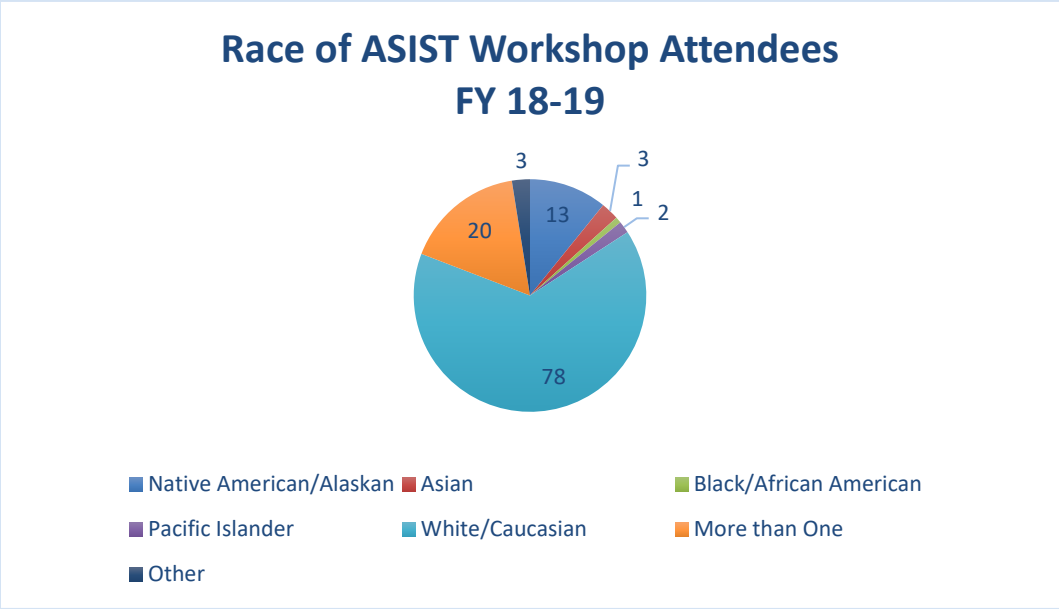


In Fiscal Year 18/19, 96 attendees at ASIST workshops were female, 25 attendees were male, one attendee was transgender male, and four were gender non-conforming.

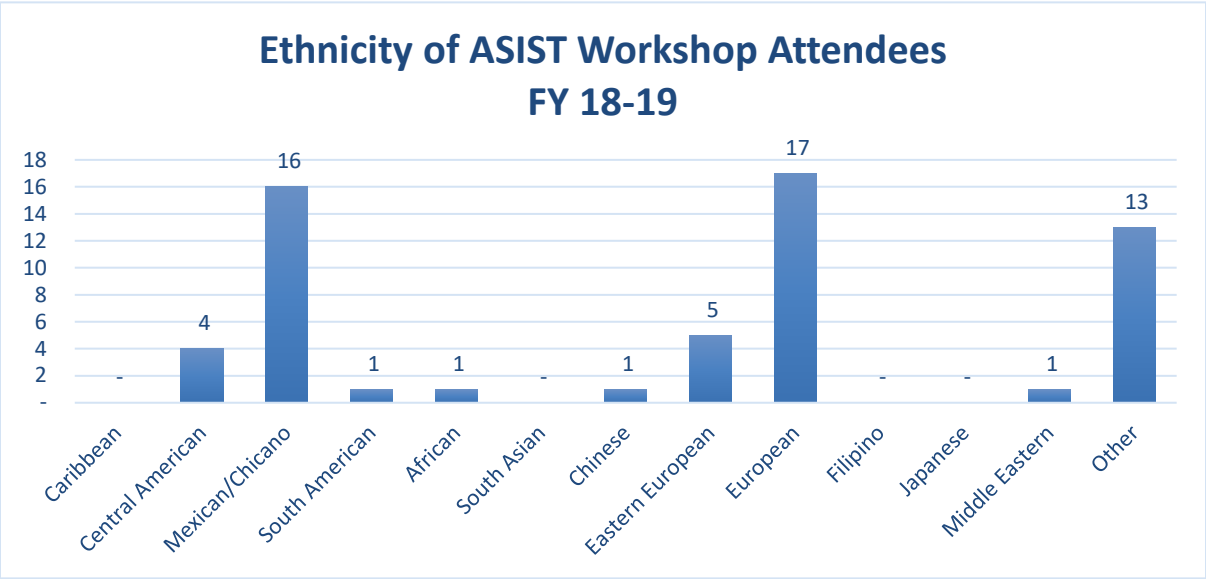


In fiscal year 18/19, 78 attendees at ASIST workshops were White, 13 were Native American, 20 were Multi-racial (More than One), three were Asian, one was

Black/African American, two were Pacific Islander, and three marked Other. Twenty-six participants indicated their ethnicity was Hispanic/Latino.

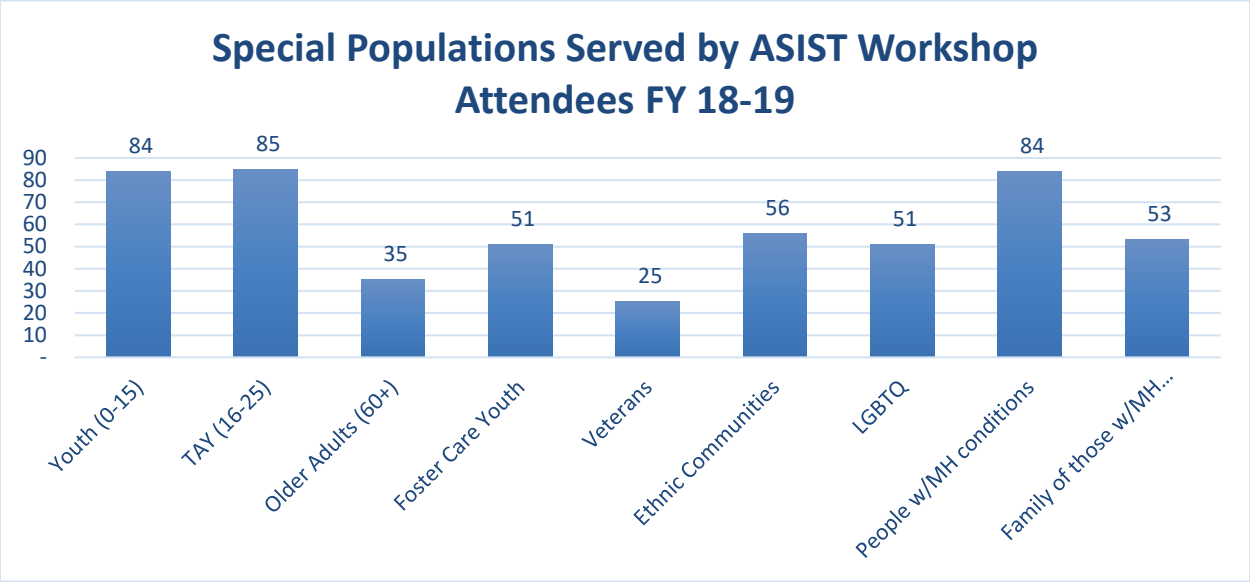


In fiscal year 17/18, demographic forms began to capture ethnicities of ASIST workshop attendees. In FY 18/19, for those answering the question: four were Central American, 16 were Mexican/Chicano, one was South American, one was African, one was Chinese, five were Eastern European, 17 were European, one was Middle Eastern, and 13 marked Other.



When looking at the populations served by the attendees at ASIST, in fiscal year 18/19,

84 served youth ages 0-15, 85 served TAY, 35 served Older Adults, 51 served Foster Care Youth, 25 served Veterans, 56 served Ethnic Communities, 51 served LGBTQ, 84 served people with a behavioral health condition, and 53 served family members of those with a behavioral health condition.



Key Activities

Key activities will support outcomes (see below) around improved support for persons at risk of behavioral health crisis and suicide by giving participants the resources and skills they need to:

- Recognize the signs of persons in need of behavioral health support
- Recognize the signs of persons who are at risk of suicide
- Providing training to diverse groups and populations across multiple settings and professions in order to expand capacity to increase access and linkage to care for those in crisis and non-crisis situations
- Promote local, statewide and national crisis lines, resources, and educational materials, including “Know the Signs” and “Each Mind Matters,” to expand on the ability of trainees to increase access and linkage to supports and treatment for persons at risk
- Understanding ways personal and societal attitudes affect views on suicide and interventions
- Provide guidance and suicide first-aid to a person at risk in ways that meet their individual safety needs
- Identify the key elements of an effective suicide safety plan and the actions required to implement it
- Improve and integrate suicide prevention resources in the community at large through training and electronic media dissemination
- Recognize other important aspects of suicide prevention including life-promotion and self-care.

OUTCOMES	FY 2018-2019 N=
Number of participants	159
Participants who reported increased knowledge with recognizing warning signs, and behaviors associated with suicidality (0-5 scale)	123
Number of ASIST workshops	7
Pre and Post Evaluation Results	% Increase
If a person's words and/or behaviors suggest the possibility of suicide, I would ask directly if he/she is thinking about suicide	44%
If someone told me they were thinking of suicide, I would do an intervention	40%
I feel prepared to help a person at risk of suicide	65%
I feel confident I could help a person at risk of suicide	63%
I can identify the places or people where I should refer others at risk of suicide	N/A
I have easy access to the educational resource materials I need to learn about helping a person at risk	N/A
I feel comfortable discussing suicide with others	N/A

How Outcome are Measured:

1. ASIST evaluation
2. Number of people trained
3. Demographic forms that demonstrate the diversity of participants and settings
4. Provide skill-based training so community members will have the knowledge to recognize signs/symptoms of persons that may be at risk of suicide and respond with positive intervention
5. Reduce negative attitudes and beliefs about persons experiencing suicidal thoughts and behaviors and other behavioral health challenges

Estimated Number to be reached in FY 2019/2020: 120 individuals will complete ASIST workshops in 2019/2020.

Successes. Participants consistently report that ASIST is a powerful, meaningful workshop experience. Trainings consistently fill and have a waitlist, due to positive reputation of this training in our community. Effective partnerships with the Humboldt County Office of Education continues to offset facility costs for our program (and participants), while making ASIST available to community educators.

Challenges: ASIST Trainings are valuable to our community, but are very resource-intensive to produce, as they require up to four trainers, two full days and a training facility with two training rooms. In FY 2019/2020, the PEI program will be losing trainers (due to job changes) and community partnering support (due to sunset of grant funding.) It is likely the cost of ASIST to participants will increase from $30 in FY 19/20.

Because ASIST workshops are two full days long, it can be challenging for participants from outlying areas to attend, due to long commute times, family obligations, etc. It is challenging to bring the training to outlying rural areas for the same reasons.

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

Project Name: Question~Persuade~Refer (QPR) Suicide Prevention Training

This is a continuing suicide prevention project serving Transitional Age Youth, Adults and Older Adults. The project is targeted education and training addressing the negative outcomes of suicide and prolonged suffering.

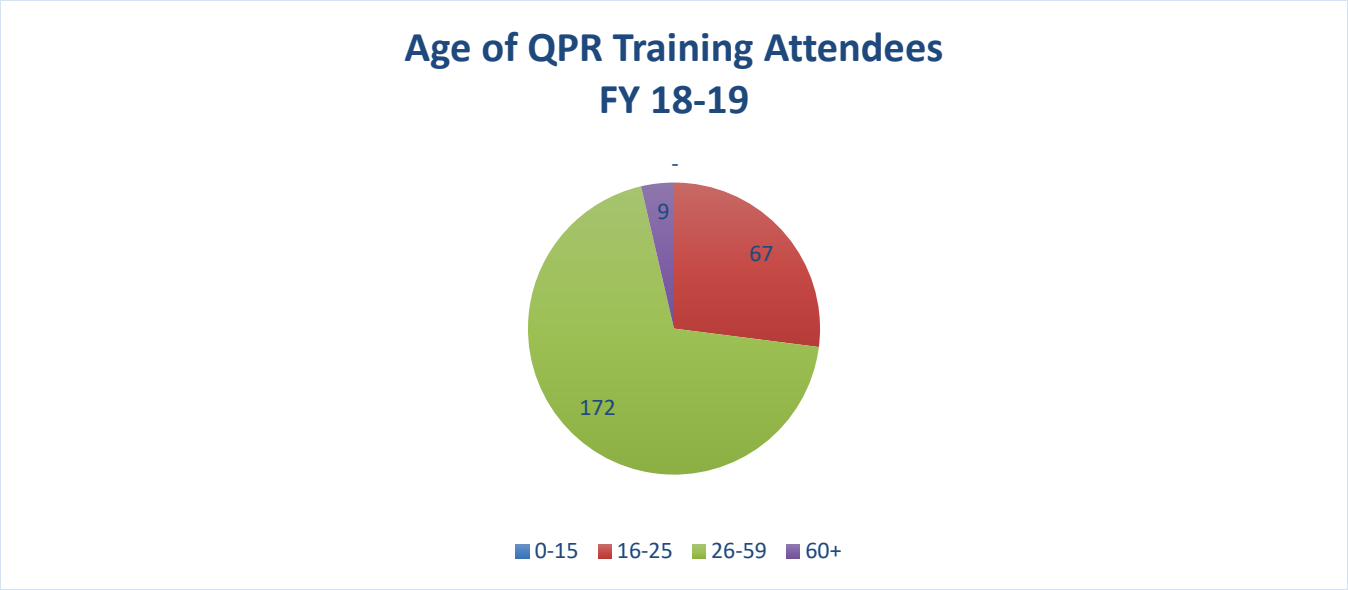
Question, Persuade and Refer (QPR) was implemented in September 2009. QPR provides innovative, practical, and proven suicide prevention training that reduces suicidal behaviors by training individuals to serve as “gatekeepers” those who are strategically positioned to recognize the warning signs suicide crisis and how to respond by - Question: Ask about suicide, Persuade and promote the person to seek and accept help, and Refer the person to appropriate resources.

Target Population. QPR training has been tailored to multiple settings and professions—education, crisis workers, first responders, foster parents, social workers, medical providers, faith community, etc. Peer educators, teachers, parents, coaches, caseworkers, police officers, first responders, medical providers, faith community, and the general population have participated in QPR training. With every tailored training a specific resource list for that system and/or population is developed.

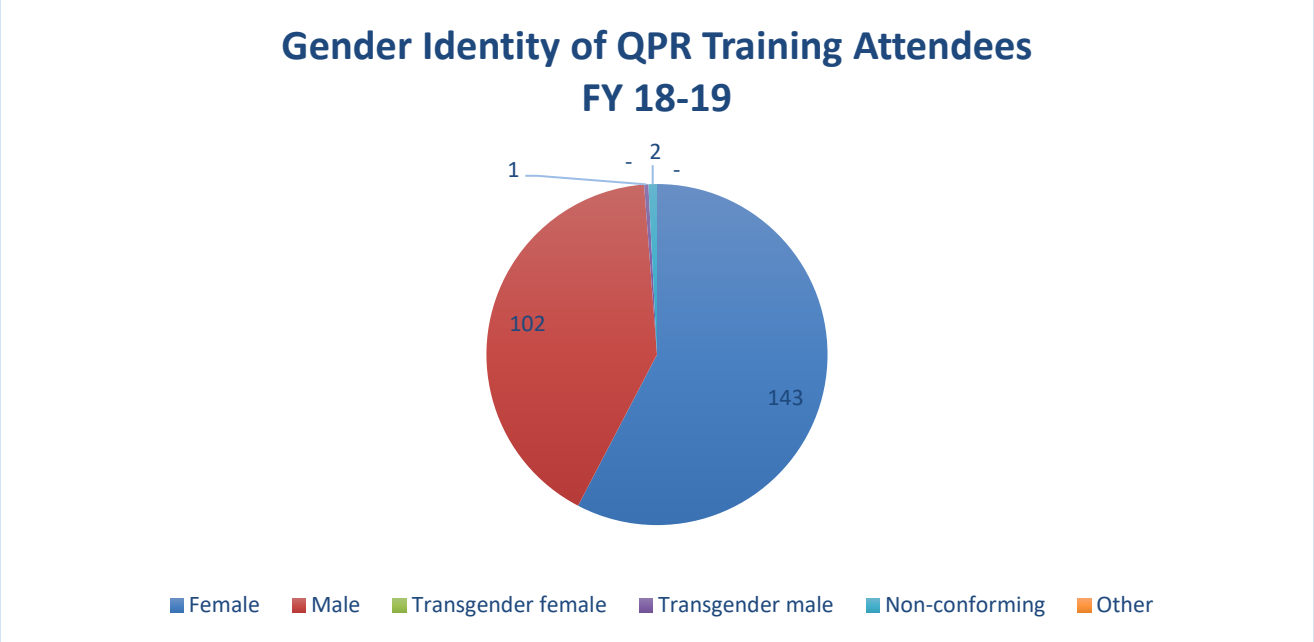
Unduplicated Number of Individuals Served. In FY 2018/19, 459 individuals attended QPR. Nineteen QPR trainings were held.

Demographics of individuals served: Demographic information comes from attendees at trainings who complete a demographic form. In Fiscal Year 18/19, 53% of attendees completed a demographic form, and 47% declined completing or did not receive a demographic form. (See challenges)

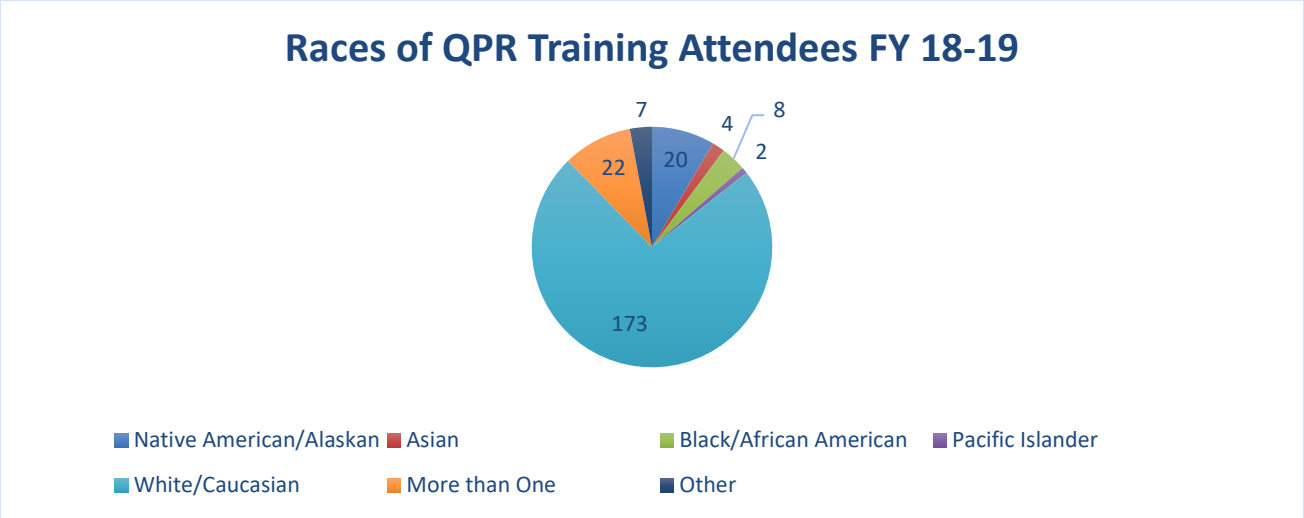
In Fiscal Year 18/19, 67 attendees at QPR trainings were ages 16-25, 172 attendees were ages 26-59, and nine attendees were age 60+.



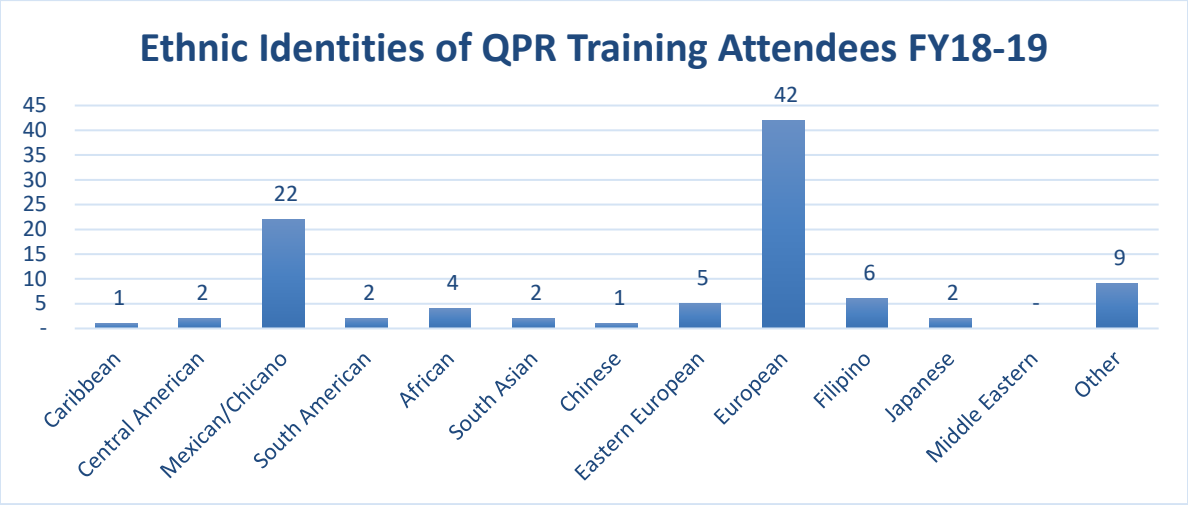
In Fiscal Year 18/19, 143 attendees at QPR trainings were female, 102 attendees were male, one attendee was transgender male and two were gender non-conforming.



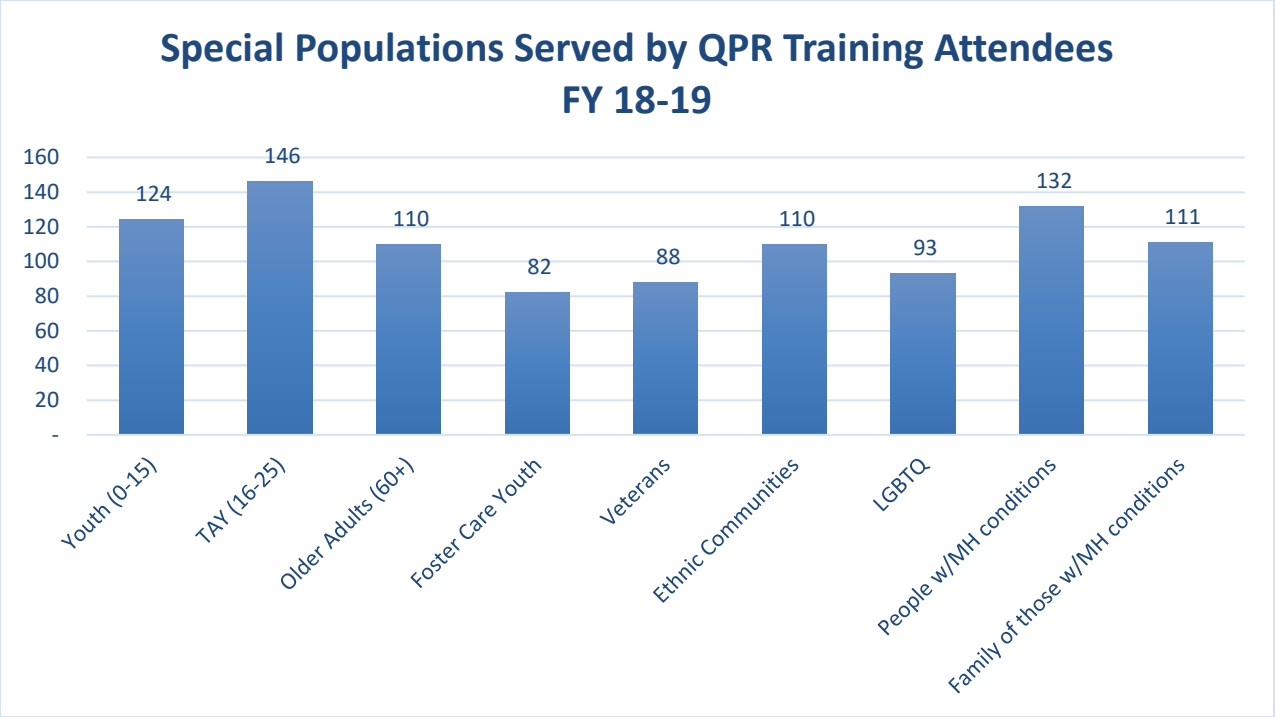
In fiscal year 18/19, 173 attendees at QPR trainings were White, 20 were Native American, 22 were Multi-racial (More than One), four were Asian, seven were Other, two were Pacific Islander and eight were Black/African American. Thirty-one participants were Hispanic/ Latino.



In fiscal year 18/19, demographic forms began to capture ethnicities of QPR training attendees. For those answering the question: one was Caribbean, two were Central American, 22 were Mexican/Chicano, two were South American, four were African, two were South Asian, one was Chinese, five were Eastern European, 42 were European, two were Japanese and nine marked Other.



When looking at the populations served by the QPR attendees in fiscal year 18/19, 124 served youth 0-15, 146 served transition aged youth (TAY), 110 served Older Adults, 82 served Foster Care Youth, 88 served Veterans, 110 served ethnic communities, 93 served LGBTQ, 132 served people with behavioral health conditions, and 125 served family members of those with a behavioral health condition.



Key Activities:

- Training participants to recognize the signs of persons in need of behavioral health support
- Training participants to recognize the signs of persons who are at risk of suicide
- Promoting wellness, recovery, and resiliency
- Providing training to diverse groups and populations across multiple settings and professions in order to expand capacity to increase access and linkage to care of those in crisis and non-crisis situations
- Promoting local, statewide and national crisis lines, resources, and educational materials to expand on the ability of trainees increase access and linkage to supports and treatment for persons at risk
- Improving and integrating suicide prevention resources in the community at large
- Recognizing other important aspects of suicide prevention including life-promotion and self-care

Expected Outcomes: For FY 18/19 the expected outcomes were 6 QPR trainings.

Actual Outcomes for Fiscal Year 2018-2019:

OUTCOMES	FY 2018-2019 N=
Number of Trainings	19
Number of participants	470
Participants who reported increased overall knowledge with recognizing warning signs, and behaviors associated with suicidality (0-3 scale)	272
Pre and Post Evaluation	% Increase 18/19
• Knowledge of facts about suicide prevention	54%

OUTCOMES	FY 2018-2019 N=
• Knowledge of warning signs of suicide	35%
• How to ask someone about suicide	53%
• How to persuade someone to get help	43%
• How to get help for someone	43%
• Information about local, state, and national resources for help with suicide	70%
• Do you feel that asking someone about suicide is appropriate?	23%
• Do you feel likely to ask someone about suicide?	29%
• Rate your level of understanding about suicide and suicide prevention	46%

How Outcomes are Measured:

1. QPR pre and post survey
2. Number of people trained
3. Demographic forms that demonstrate the diversity of populations and settings
4. Provide skill-based training so community members will have the knowledge to recognize, signs/symptoms of persons that may be at risk of suicide, respond and intervene
5. Reduce negative attitudes and beliefs about persons experiencing suicidal thoughts and behaviors along with other behavioral health challenges

Estimated Number to be reached in FY 2019/2020: We estimate providing 15 QPR trainings reaching 250 people

Challenges: It can be challenging to meet community demand for QPR trainings with our limited staff.

Successes: QPR is a training we have tailored to multiple settings.

Lessons Learned: To increase sustainability, we are providing technical support for community members who are interested in becoming QPR trainers.

Project Name: Humboldt County Suicide Prevention Network

This is a continuing suicide prevention project that also addresses stigma and discrimination reduction. It is a public and targeted information campaign, a network, a capacity building project, a social marketing campaign, targeted education and training. It is an effort to combat multiple stigmas that have been shown to discourage individuals from seeking behavioral health services, and an effort to encourage self-acceptance for individuals with a mental illness. It addresses the negative outcomes of suicide and prolonged suffering. The activities target all Humboldt County residents.

The Humboldt County Suicide Prevention Network (SPN), is comprised of representative community sectors from county agencies, community partners, first responders, medical and behavioral health, schools, people with lived experience and family members, will collaborate to address key community and data driven priority areas: Community

Education and Outreach; Training/Workforce Development & Building Organizational Capacity; Data and Surveillance; and Zero Suicide. All efforts will focus on establishing a presence in remote outlying areas of Humboldt County and in tribal communities. Humboldt County PEI staff will continue to act as the backbone agency providing coordination of efforts and guidance on best practices.

Target Population: All age groups of Humboldt County Residents

Unduplicated Number of Individuals Served: One hundred and twelve participants, representing 13 agencies, attended Suicide Prevention Network meetings in 2018-19. Six meetings were held.

Demographics of individuals served: Demographic forms were not administered during Suicide Prevention Network meetings.

Key Activities:

- Coordinate community-wide activities and events
- Conduct a minimum of six Suicide Prevention Network meetings
- Provide in-service training at each Network meeting to expand capacity to increase access and linkage to care of those in crisis and non-crisis situations
- Promote local, statewide and national crisis lines, resources, and educational materials to expand on the ability of trainees increase access and linkage to supports and treatment for persons at risk
- Improve and integrate suicide prevention resources in the community at large

Expected Outcomes:

1. Community Education and Outreach
2. Training and Workforce Development to Increase Capacity to respond to persons at risk
3. Data collection and surveillance
4. Zero Suicide in Health and Behavioral Health Care Systems

Actual Outcomes for Fiscal Year 2018-2019:

OUTCOMES	FY 2018-2019 N=
Number of participants	112
Number of agencies represented	13
Number of meetings	6

How Outcomes are Measured:

1. Sign-in forms – number of participants
2. Number of agencies involved with Network
3. Number of annual meetings

Estimated Number to be reached in FY 2019/2020: It is estimated in FY 19/20, that over 100 individuals from 15 organizations will attend Suicide Prevention Network Meetings. Six meetings will be held.

Challenges: One of the key partners supporting the Suicide Prevention Network recently

ended their suicide prevention grant. Their funding and staff support may be less available in the future.

Successes: The Suicide Prevention Network continues to expand. We have implemented ways to increase visibility in the community through outreach using MailChimp. At least twice monthly information is compiled and sent out to our list on local and National training opportunities, the latest information from the field, etc.

Quote from participant: *"I heard about this meeting through a training and decided to attend. At my first (SPN) meeting I heard a presentation about Zero Suicide. I went back to my clinic and started looking into what our system has in place for people at risk for suicide. I found out that at our eleven clinic sites we have no standardized way of screening and care. I decided to move forward with implementing Zero Suicide". Assistant Director of Nursing, Open Door Health Centers*

Lessons Learned: Giving agencies time for discussion and sharing during the SPN meeting allows for helpful brainstorming.

Project Name: Capacity Building Assistance

This is a continuing suicide prevention project that also addresses stigma and discrimination reduction. It targets all age groups. It is a public and targeted information campaign, builds capacity, provides targeted education and training, includes a web-based campaign, is culturally specific, includes efforts to combat multiple stigmas that have been shown to discourage individuals from seeking behavioral health services, and efforts to encourage self-acceptance for individuals with a mental illness. It addresses the negative outcomes of suicide, prolonged suffering, and school failure or dropout.

Capacity Building Assistance (CBA) is designed to support and strengthen community partners including community-based organizations, educational institutions, and health and behavioral healthcare organizations, leverage resources, to broaden the support network for unserved, underserved, and inappropriately served populations.

Target Population: CBA is a tailored service to meet the needs of each recipient organization. Target settings include:

- Health and Behavioral Health care
- Educational Institutions
- Workplace
- Probation
- Peer support programs
- Faith community

Unduplicated Number of Individuals Served: N/A Data from trainings listed in table are included elsewhere in report under QPR or Behavioral Health

Demographics of individuals served: N/A Data from trainings listed in table are included elsewhere in report under QPR or Behavioral Health

Key Activities:

- Training and Workforce Development – Trainings utilizing evidence based, promising practice, or practice based evidence model. Staff will provide efforts to expand community's capacity for suicide prevention trainings through consultation, "Train-the-Trainers", and coordination of multi-disciplinary training teams. Training teams include public health educators, behavioral health clinicians, social workers, tribal community agency representatives, and law enforcement. In addition, tailored training for specific settings and populations is developed in coordination with requesting agencies, schools, and settings. Trainings are designed using tools from statewide partners and other evidenced-based materials.
- Systems Change – Staff will provide support to community partners representing multi-sector settings including education, primary care, behavioral health, and social services to assess capacity to develop and evaluate internal policies and procedures to address continuum of care for persons at risk such as a Zero Suicide approach.

Expected Outcomes: Six settings in 17/18

Actual Outcomes for Fiscal Year 2018-2019:

OUTCOMES	FY 2018-2019 N=
Number of participants involved in Capacity Building Assistance including tailored trainings:	135
Number of agencies that have developed policies, protocols, procedures to identify persons at risk of suicide and behavioral health crisis (system change)	2 School Districts Coroner's Office Humboldt Bay Fire The CENTER
Number of trainings provided	8

How Outcomes are Measured:

1. Demographic forms that demonstrate the diversity of populations and settings—the demo forms were provided during tailored trainings developed specifically for the settings where CBA occurred
2. Number of agencies/schools that address systems chance (trainings, Policy, protocol and procedures, etc.)
3. Provide skill-based training so community members will have the knowledge to recognize, signs/symptoms of persons that may be at risk of suicide, respond and intervene

Estimated Number to be reached in FY 2019/2020: One hundred and thirty five individuals, two agencies, and six tailored trainings.

Challenges: Capacity Building Assistance is so varied depending on the setting and agencies involved. We found that CBA support is labor intensive.

Successes: The CBA provided built relationships and provided the structure necessary to incorporate pathways to suicide care.

Lessons Learned: We will scale down our efforts from 6 to 3 settings/agencies for FY 19/20.

Project Name: Humboldt Suicide Fatality Review

Public Health partnered with the Coroner's office to implement a Suicide Fatality Review (SFR) of all adult suicides of Humboldt County residents. In December 2018, Dr. Kimberley Repp trained the Coroner's office, Public Health, Social Services, Behavioral Health, Hospitals, Health Clinics, Primary Care providers, Substance Use Disorder programs, First responders, and other interested community members in how to develop and implement a Suicide Fatality Review. To date, one SFR has been held.

Target Population: Humboldt County Residents

Unduplicated Number of Individuals Served:

- Number who attended SFR training session held on Dec. 4, 2018 with Dr. Kimberly Repp*:* 92
- Number of local agencies represented at Dr. Repp Training: 30
- Number of deaths reviewed in retrospective review (2013-18): 191
- Number of deaths reviewed in first SFR: The number of deaths reviewed in the May 13, 2019 SFR was two.
- Number of participants in first SFR: There were 10 participants serving 8 agencies

The table below shows the risk factor data from the Suicide Consolidated Risk Assessment Profile form 2013-2018.

FREQUENCY OF RESULTS--HUMBOLDT COUNTY SUICIDE CONSOLIDATED RISK ASSESSMENT PROFILE

At time of incident:	% Yes
Current mental health problem	56.0%
Depressed mood	51.8%
Physical health problem	38.7%
Family relationship stress	35.1%
Disclosed intent to commit suicide	32.5%
Other substance abuse problem	30.4%
Current mental health treatment	26.7%
Alcohol problem	26.7%
Intimate partner problem	23.0%
Social isolation	19.4%
Financial problem	14.7%
Criminal legal problem	11.5%
Other relationship problem	10.5%
Job problem	9.4%
Eviction/loss of home	9.4%
Other addiction	7.3%
Anniversary of traumatic event	4.2%
Non-criminal legal problem	2.6%
School problem	2.1%

In the last 30 days	
Perpetrator of interpersonal violence	6.8%
Victim of interpersonal violence	2.6%

In the last 5 years	
Death of friend/family member	10.5%
Suicide of friend/family member	2.6%

At any time	
Suicidal thoughts or plans	44.0%
Mental health diagnosis	34.6%
Suicide attempt	23.6%
Suicide of friend/family member	4.7%
Nonfatal self-directed violence	4.2%
Abused as a child	3.1%

	% Yes
Crisis in past 2 weeks	77.5%
If yes, type of crisis:	
CRISIS: Mental health	46.1%
CRISIS: Physical health	25.1%
CRISIS: Family relationship stress	20.9%
CRISIS: Intimate partner problem	19.4%
CRISIS: Alcohol problem	19.0%
CRISIS: Substance abuse	17.8%
CRISIS: Other relationship problem	8.9%
CRISIS: Financial problem	8.4%
CRISIS: Job problem	5.8%
CRISIS: Eviction/loss of home	5.8%
CRISIS: Criminal legal problem	5.2%
CRISIS: Death of friend/family member	4.2%
CRISIS: Other addiction	3.7%
CRISIS: School problem	1.6%
CRISIS: Non-criminal legal problem	1.6%
CRISIS: Suicide of friend/family member	1.1%

decedent left a note	37.2%	
% of 2013-2018 suicides reviewed	86.4%	n=191

For questions, please contact:
Ron Largusa MSPH
Epidemiologist, County of Humboldt DHHS-Public Health
(707) 268-2187
rlargusa@co.humboldt.ca.us

Humboldt County Department of Health & Human Services
People helping people live better lives

Demographics of individuals served: Demographic forms were not utilized during SFR due to time constraints.

Key Activities:

1. Develop SFR protocols, policies and procedures
2. Meet quarterly to review suicides and make recommendations based on findings
3. Evaluate local suicidal behavior trends, circumstances, risk and protective factors to strengthen prevention efforts

Expected Outcomes:

1. Reduce suicide and suicidal behaviors in Humboldt
2. Develop pathways to suicide care in health, behavioral health and other community entities for persons at risk and family members.

Actual Outcomes for Fiscal Year 2018-2019:

- Coordinated county-wide Suicide Fatality Review training.
- Partnered with the Coroner's office to develop a SFR process
- Implemented one SFR

How Outcomes are Measured:

- # of SFR meetings held
- # of participants involved
- # of suicide deaths reviewed
- Key findings and follow-up actions

Estimated Number to be reached in FY 2019/2020: SFR will meet quarterly to review 2-3 suicide deaths. It is estimated that SFR will review approximately 8-12 suicide deaths in FY 2019/2020.

Challenges: Lack of information, technical support and financial resources have made development of a robust county SFR model difficult. Staff are researching and designing SFR program materials that will capture the information necessary in order to make informed, action-oriented decisions to inform prevention, intervention and postvention efforts. Access to HIPAA protected information from Humboldt County DHHS Behavioral health, even with a signed Release of Information from next of kin, has been problematic.

Successes: The partnership with the Coroner's office has been extremely beneficial.

Prevention & Early Intervention: Stigma and Discrimination Reduction

Humboldt County Public Health, Healthy Communities Prevention and Early Intervention strategies fall under Stigma and Discrimination Reduction. These strategies provide activities that increase awareness of attitudes, beliefs, perceptions, stereotypes and discrimination related to undiagnosed and diagnosed mental illness or to seeking behavioral health services. The strategies work to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and family members. Strategies include social marketing campaigns, enhancing the voices of people with lived experiences, targeted education and training, and anti-stigma advocacy support for statewide web-based campaigns. There are five projects for Public Health Stigma and Discrimination Reduction, which are reported in this section. It is important to note that other PEI programs, the Hope Center and TAY Advocacy and Peer Support Programs, are also Stigma and Discrimination Reduction programs, and are discussed in other sections of this Annual Update. The Public Health Stigma and Discrimination Reduction Programs are:

- Mental Health First Aid (Adult and Youth)
- Directing Change
- Social Marketing
- Speaker's Bureau
- Direct Contact Approaches

Project Name: Mental Health First Aid (Adult and Youth) Training

This a continuing stigma and discrimination reduction project for adults providing targeted education and training. It addresses the negative outcome of prolonged suffering.

To support MHSA PEI goals, Mental Health First Aid (MHFA) training focuses on mental illness stigma reduction, and on community education to intervene earlier in behavioral health crisis. The Healthy Communities PEI strategies under Humboldt County DHHS's Stigma and Discrimination Reduction Program provide training to providers, individuals, and other caregivers who live and/or work in Humboldt County on Mental Health First Aid Certification and Youth Mental Health Aid Certification. The purpose of these training activities is to both help expand the reach of individuals who have the knowledge and skills to respond to or prevent a behavioral health crisis in the community, and to reduce the stigma associated with mental illness.

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

MHFA trainings are offered throughout the community. In the past, five to seven trainings have been offered per year. Staff have been certified to provide both the adult and youth versions of MHFA. The type of trainings, locations, and frequency depend on the demand for the trainings and on county data related to targeted groups that work with at risk populations.

The program improves timely access to services for underserved populations. A wide

array of community members are trained in identifying signs/symptoms and responding, including skills on connecting individual to services.

- Outreach for Increasing Recognition of Early Signs of Mental Illness
- Stigma and Discrimination Reduction

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

- Increases understanding of behavioral health and substance use disorders
- Increases knowledge about signs and symptoms of issues such as depression, anxiety, psychosis, and substance abuse
- Reduces negative attitudes and beliefs about people with symptoms of behavioral health disorders
- Increases skills for responding to people with signs of mental illness and connecting individual to services
- Increases knowledge of resources available

Mental Health First Aid and Youth Mental Health First Aid Certifications

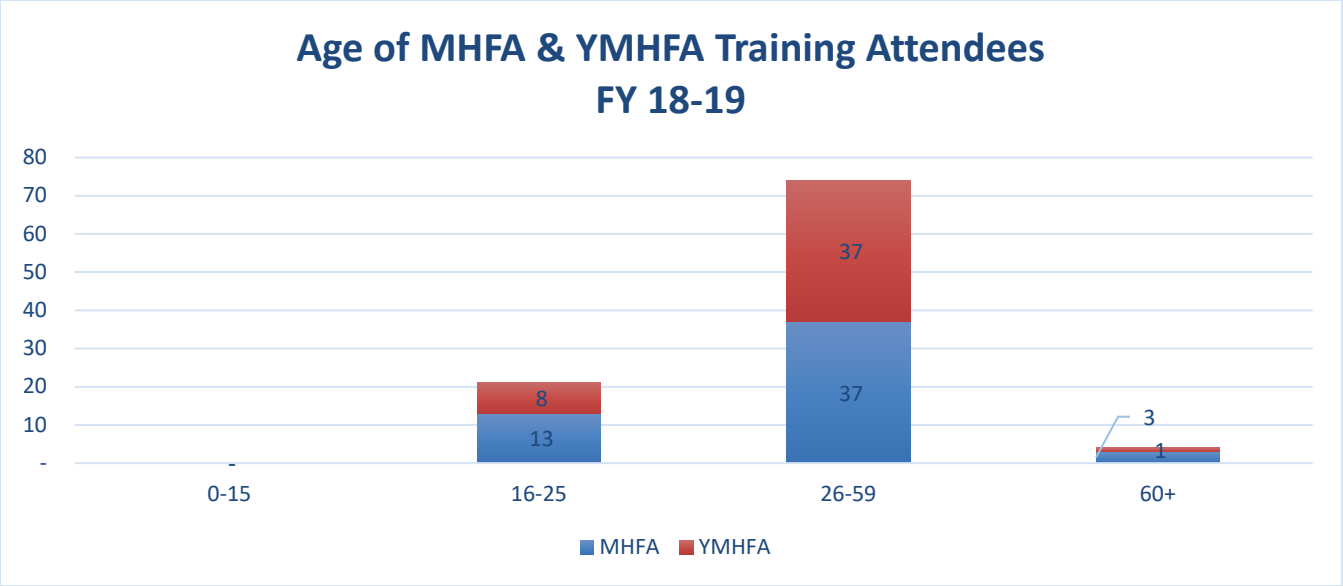
- Both Mental Health First Aid and Youth Mental Health First Aid are eight-hour courses designed to teach individuals in the community how to help someone who is developing a behavioral health problem or experiencing a behavioral health crisis. Trainees are taught about the signs and symptoms of mental illness, including anxiety, depression, psychosis, and substance use.
- Youth Mental Health First Aid is especially designed to teach parents, family members, caregivers, teachers, school staff, peers, neighbors, providers, and other individuals how to help adolescents (ages 12–18) experiencing behavioral health or substance use problems, or are in behavioral health crisis situations. The training covers health challenges for youth, offers information on adolescent development, and includes a five-step action plan to help young people both in crisis and non-crisis situations.

Target Population: Providers, consumers, family members and other community members who may be in a position to recognize and respond to early signs and symptoms of mental illness. These include: school staff, font-line workers in health and human service agencies, community health advocates/Promotores, family members, business owners, community, faith community, first responders, probation staff, librarians, and others.

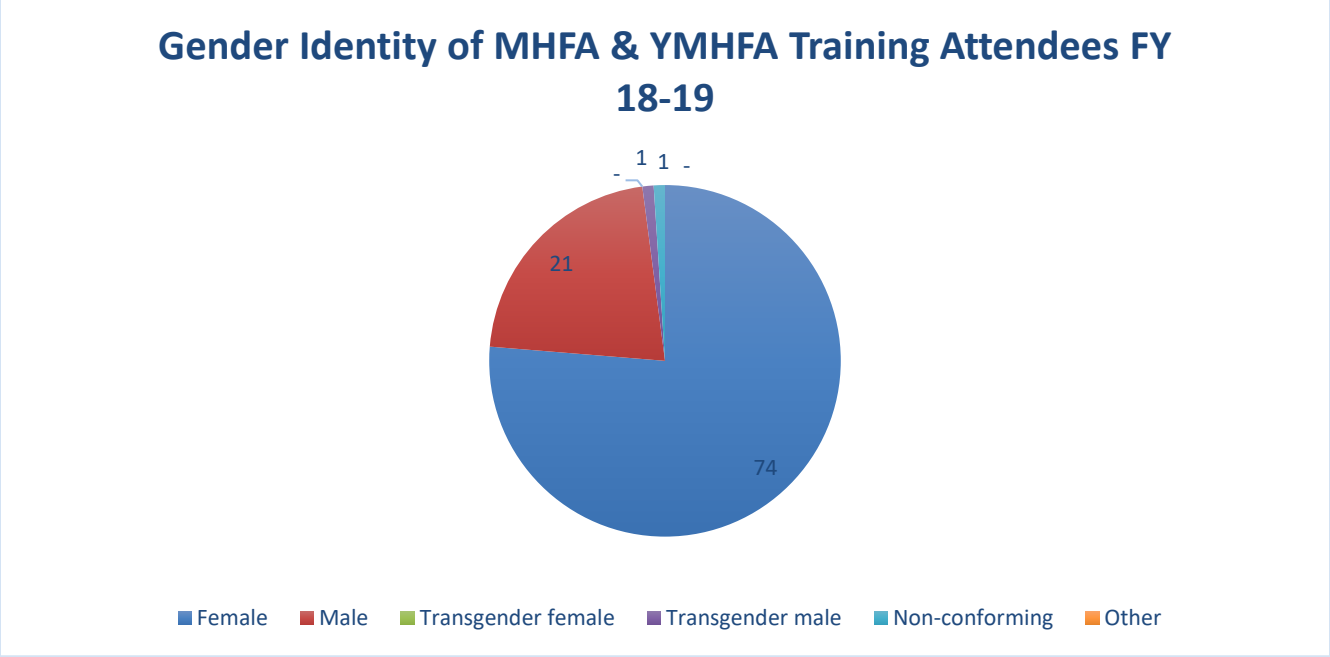
Unduplicated Number of Individuals Served:
In FY 2018-19, a total of 135 individuals attended eight trainings. Seventy-four individuals attended four Mental Health First Aid trainings. Sixty-one individuals attended four Youth Mental Health First Aid trainings.

Demographics of individuals served:
Demographic information comes from attendees at trainings who complete a demographic form. In Fiscal Year 18/19, 74% of attendees completed a demographic form, and 26% declined completing a demographic form.

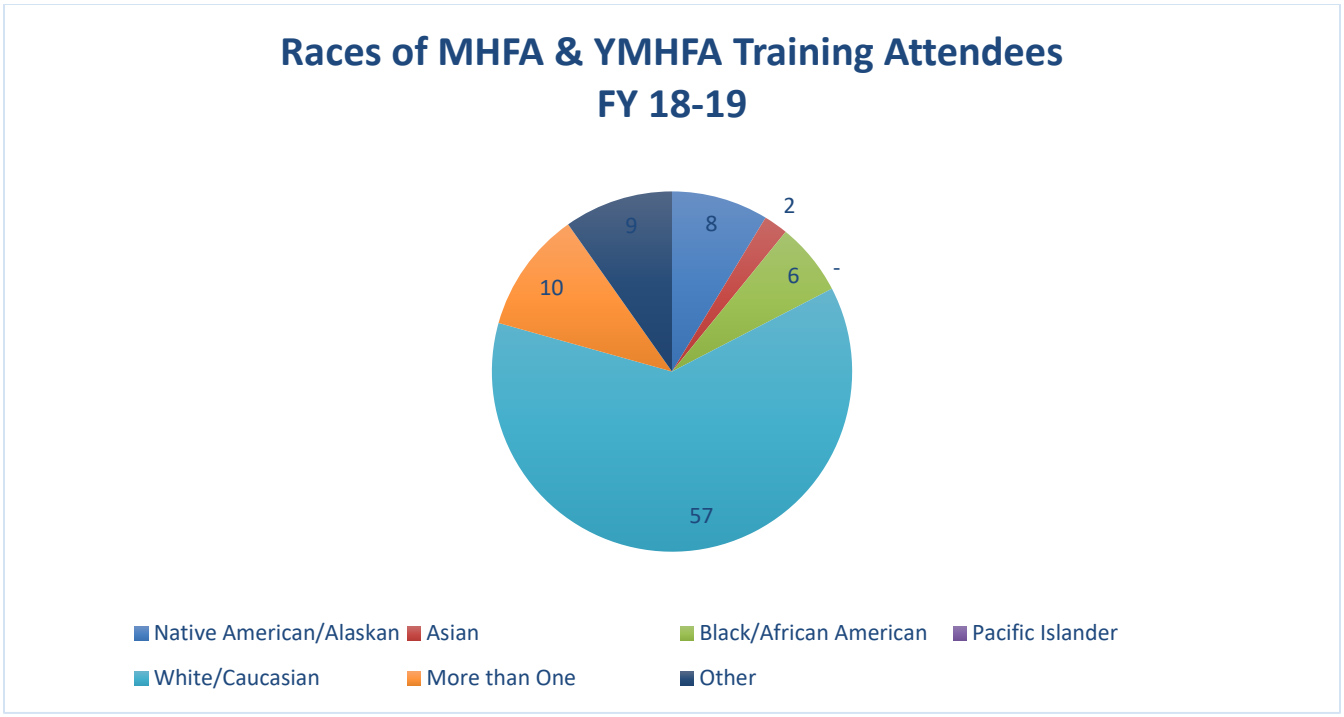
In Fiscal Year 18/19, 21 attendees were ages 16-25, 74 were ages 26-59, and four were age 60+.



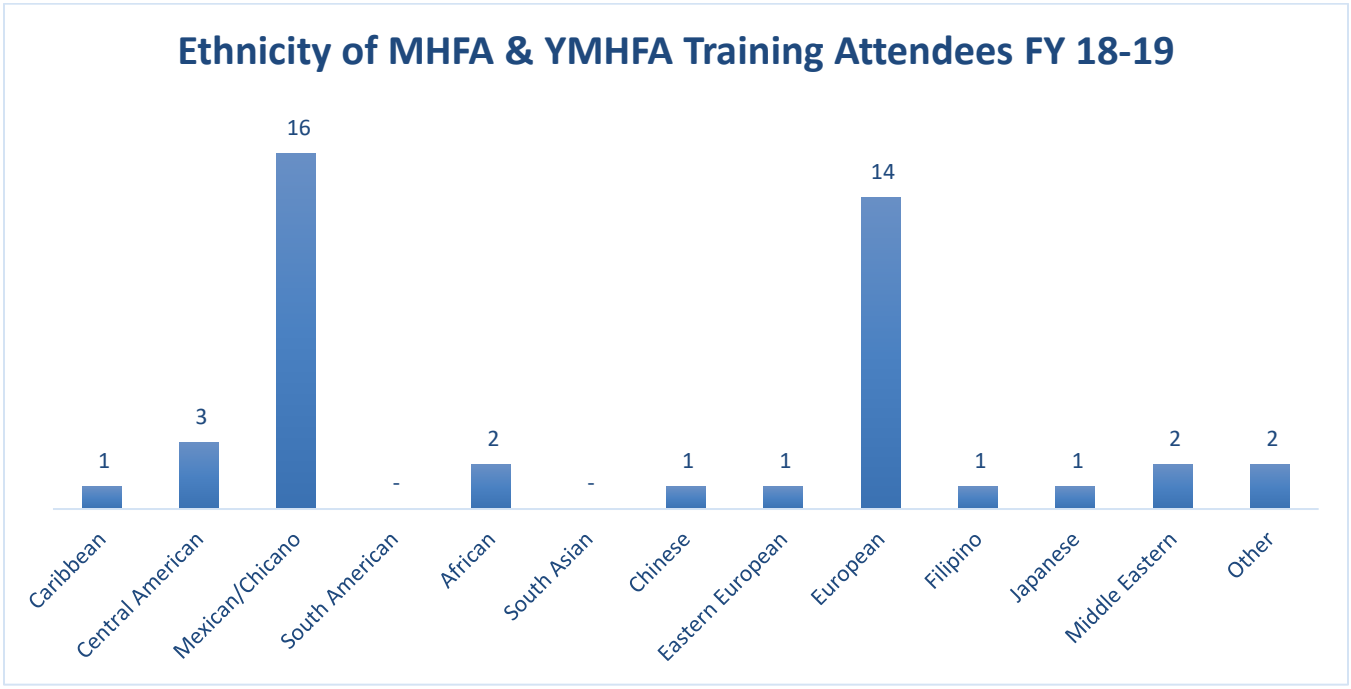
In Fiscal Year 18/19, 74 attendees were female, 21 were male, one was transgender male and one was gender non-conforming.



In Fiscal Year 18/19, 57 attendees were White, eight were Native American, 10 were More than One (Multi-racial), two were Asian, six were Black/African American and nine were Other. Twenty-six participants indicated their ethnicity was Hispanic/Latino.

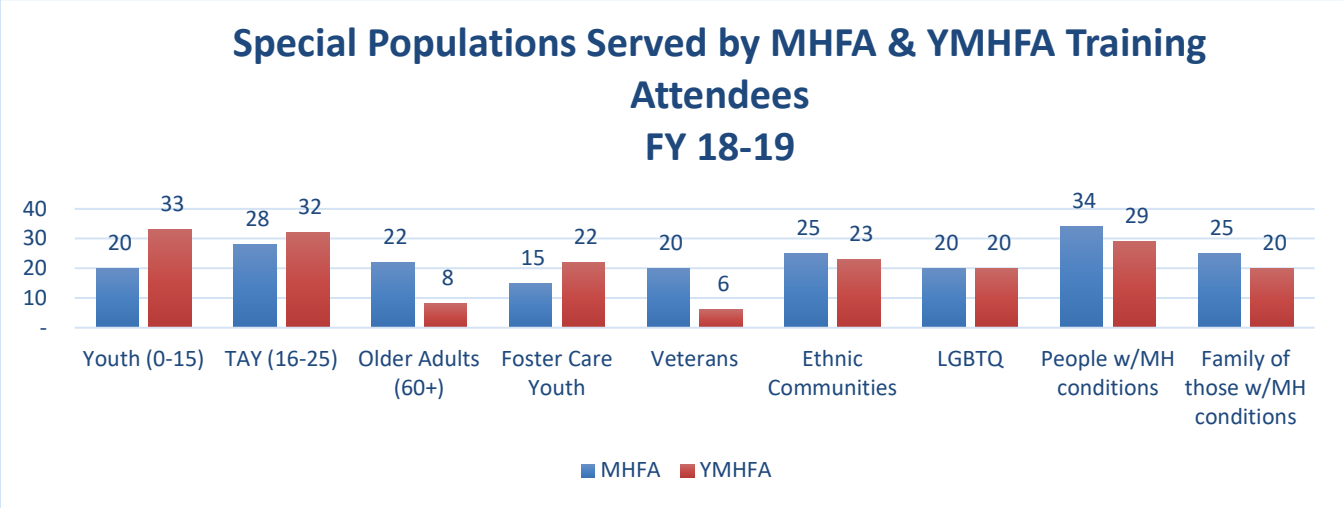


Key Activities: In fiscal year 17/18, demographic forms began to capture ethnicities of MHFA and YMHFA training attendees. For those answering the question in FY 18/19, 16 were Mexican/Chicano, 14 were European, three were Central American, two were African, two were Middle Eastern, one was Chinese, one was Caribbean, one was Filipino, one was Japanese, one was Middle Eastern, and two marked Other.



When looking at the populations served by the attendees at MHFA and YMHFA trainings

in Fiscal Year 18/19, 53 served youth ages 0-15, 60 served transition-aged youth (TAY) ages 16-25, 30 served Older Adults, 37 served Foster Care Youth, 26 served Veterans, 78 served Ethnic Communities, 40 served LGBTQ, 63 served people with behavioral health conditions and 45 served family members of people with behavioral health conditions.



Learning Objectives:

- Training community and family members to recognize the signs of persons in need of behavioral health support
- Training community and family members to recognize the signs of persons who are at risk of suicide and those who are at risk of developing a mental illness
- Promoting wellness, recovery, and resiliency
- Training and working with families and caregivers in order to develop plans and strategies that are tailored to their family member's need
- Training participants to address the specific needs of certain populations, including youth
- Offering trainings to an intentionally diverse group of community members, family members, and partners, to ensure that persons are trained across a variety of populations in order to meet the needs of those in crisis and non-crisis situations
- Promote local, statewide and national crisis lines, resources, and educational materials to expand on the ability of trainees to broaden base of support for persons at risk

Expected Outcomes:

1. Community Education and Outreach
2. Training and Workforce Development to Increase Capacity to respond to persons at risk
3. .Data collection and surveillance
4. .Zero Suicide in Health and Behavioral Health Care Systems

Actual Outcomes for Fiscal Year 2018-2019:

OUTCOMES	FY 2018-2019 N =
Number of Adult and Youth MHFA trainings	8
Number of community members that participated in Adult MHFA trainings	74
Number of community members that participated in Youth MHFA trainings	61
Total number of participants	135
Participants who reported gaining knowledge in the following categories about mental illness signs and symptoms (scale of 1-5: 1=strongly disagree; 5=strongly agree). Number equals participants indicating greater than 3	FY 2018-2019 % of participants
Recognize that someone may be experiencing a mental health problem or crisis	97%
Reach out to a person who may be dealing with a mental health challenge	95%
Offer a distressed person basic “first aid” level information and reassurance about mental health problems	95%
Assist a person who may be dealing with a mental health problem or crisis to seek professional help	95%
Assist a person who may be dealing with a mental health problem or crisis to connect with appropriate community, peer and personal supports	94%
Be aware of my own views and feelings about mental health problems and disorders	97%

How Outcomes are Measured:

1. MHFA evaluation
2. Demographic forms that demonstrate the diversity of populations and settings
3. Increase knowledge of behavioral health signs and symptoms and reduced negative attitudes and beliefs about persons experiencing behavioral health challenges

Number to be reached in FY 2019/2020: One hundred twenty individuals to be trained in MHFA or YMHFA in FY 19-20.

Challenges: The biggest challenge is capacity to offer enough trainings to meet community requests. There are a number of reasons for this: 1. We have a small training team. 2. People who are trained move on to other positions and are no longer able to train.

Successes: We have a great partnership with Humboldt County Office of Education and work with them to offer trainings to educational staff throughout Humboldt County. Both Youth and Adult MHFA are a great basic training for community.

Lessons Learned: It can be difficult to anticipate participant show rates when our team isn’t in charge of the registration process for YMHFA or MHFA.

Project Name: Directing Change

This is a continuing project for children and transitional age youth. It is culturally specific social marketing campaign, builds capacity, and provides targeted education and training. It is an effort to combat multiple stigmas that have been shown to discourage individuals from seeking behavioral health services and to encourage acceptance for individuals with a mental illness. It addresses the negative outcome of prolonged suffering. The target population is adolescents, transitional age youth and school personnel.

Directing Change is a statewide student film contest for youth in grades 7 through 12, as well as those attending a college at any University of California campus. The contest is designed to raise awareness around suicide prevention and reducing stigma and discrimination related to mental illness. A vital component of creating the films requires that students learn about safe messaging related to suicide and behavioral health, and to incorporate these messages into their submissions. Filmmakers must also structure their content to acknowledge Mental Health Services Act (MHSA), California Mental Health Services Authority (CalMHSA) and the “Know the Signs” campaign.

The target population is providers, consumers, family members and other community members who may be in a position to recognize and respond to early signs and symptoms of mental illness. These include: school staff, font-line workers in health and human service agencies, community health advocates/Promotores, family members, business owners, community, faith community, first responders, probation staff, librarians, and others.

Directing Change is promoted as a resource during other suicide prevent and behavioral health awareness trainings including QPR, behavioral health 101, high school and other community presentations. Directing Change was promoted as an opportunity for engagement and as a resource at 16 trainings/ presentations to 430 individuals.

Our program also delivered stand-alone Directing Change presentations using the films, for students interested in participating and educators interested in the presentation for their students. The Directing Change films and film contest were the primary focus of presentation at 4 presentations for 96 individuals (81 students and 15 educators). In addition, in 3 separate presentations (not included previously), the team reviewed film storyboards for 76 students.

Demographics of individuals served: Directing Change presentations are almost exclusively made to students and educators, in presentations that are one hour or less in duration. Our program does not administer the form to students under age 18, or in shorter presentations where it isn’t feasible. Directing Change presentations were delivered to students at the following high schools:

- Eureka High School (30 students- Directing Change presentation + storyboarding)
- Fortuna High School (46 students- Directing Change presentations + storyboarding)

Directing Change films were submitted from the following high schools:

- Eureka High School

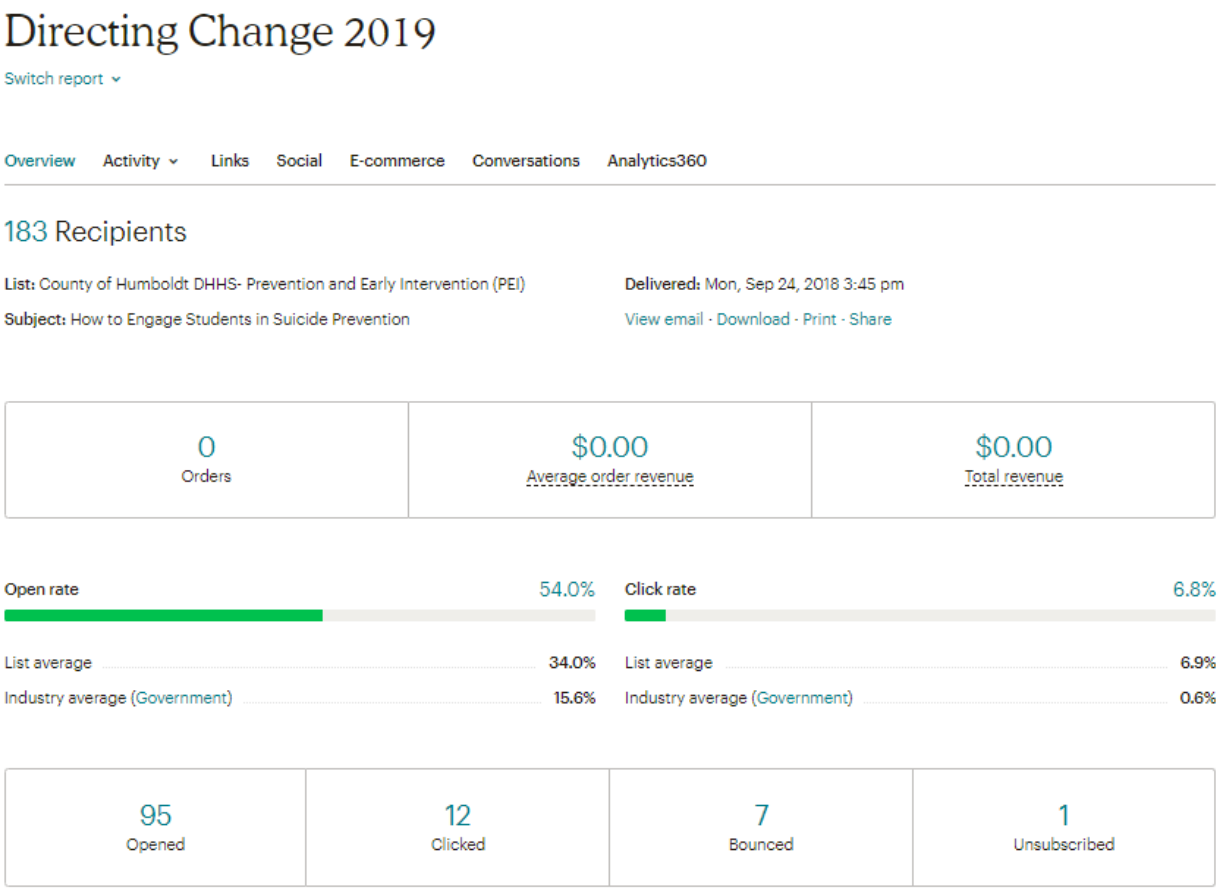
- Fortuna High School
- McKinleyville High School

Expected Outcomes:

- Engage adolescents, transitional age youth and adults in creating and viewing films
- Promoting Statewide Directing Change Film Contest to schools and youth groups throughout Humboldt County through community presentations
- Promote local, State, and National resources to broaden support for persons at risk and general community members through distribution of informational/educational resource packets
- Utilize Directing Change films to raise awareness around behavioral health, suicide, and cultural considerations in various targeted and community formats, i.e., trainings, community events.

Actual Outcomes for Fiscal Year 2018-2019:

OUTCOMES	FY 2018- 2019 N=
Number of youth leaders/ local educators who received DC promotional emails sent	183
Number of youth who participated overall	79
Number of films submitted	8
# presentations to promote DC (including only DC- directed)	7
Estimated # of impressions	94
Number of participating youth-serving entities Schools	5
Youth organizations	1



How Outcomes are Measured:

1. # of people reached through presentations and film viewings
2. # of informational packets distributed
3. # of films submitted
4. # of new youth-serving and/or schools will participate

Number to be reached in FY 2019/2020: 150

Challenges: Many of the classes and students who participated in Directing Change did not submit their films to the statewide contest. This year, program staff were not able to have a red carpet ceremony due to staff shortages.

Successes: Directing Change films are part of the core curriculum in grades 7 to 12. The project team has designed classroom presentations using the Statewide films. The films provide students with opportunities for students to discuss and learn about suicide prevention, stigma and discrimination reduction and raise awareness.

Lessons Learned: There is limited staff capacity to reach all the schools in Humboldt County. To address this, the team developed a curriculum for educators so they can use the films in their classrooms. This builds capacity with educators and within school systems.

In addition, the team is relying more on email as a tool to reach out to educators instead

of “promotional packets” used in the past. This does not seem to have impacted the number of educators and classrooms who wish to be involved in Directing Change, and allows project staff to be more strategic in its outreach.

Project Name: Social Marketing

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

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

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

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

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

ReFrame Your Brain Poster Contest – Healthy Communities PEI will continue its annual poster contest, inviting all residents of Humboldt County to submit posters with messages of support, hope and recovery. Through participation, participants engage with the topic of behavioral health (their own or in support of those who live with behavioral health problems.) Through displays of the posters created and the process of community voting, individuals learn that people with behavioral health challenges face stigma, that behavioral health problems can be treated and that community support is important to

creating a community that is safe and supportive for all.

E-Mailing List—Healthy Communities PEI will maintain educational connections made with training participants and with individuals in the community through an email list. Emails will share state content and other social marketing initiatives, promote local PEI activities (including awareness months) and highlight resources for behavioral health and suicide prevention. Emails will be sent approximately twice per month.

Radio/PSA campaigns—Healthy Communities PEI also promotes its social marketing campaigns and promotes program objectives (such as promoting help-seeking) through radio public service announcements. The focus of radio ads include: Each Mind Matters and Know the Signs content, Lock Up your Lethals information, awareness month resources and messaging and ads targeting stigma and help-seeking.

DHHS Website: Healthy Communities PEI will post key resource and content to the program DHHS webpage, promote this content, and track analytics throughout the course of the focal year.

Target Population: All Humboldt County Residents

Unduplicated Number of Individuals Served: See outcome section for numbers of individuals served.

Demographics of individuals served: Demographic information is not currently collected through social marketing campaigns.

Key Activities:

- Promote local, state, and National resources through media and awareness month campaigns
- Develop educational materials, media, infographics, brochures, resource lists, cards, etc.
- Distribute educational materials and resources at community events
- Promote Humboldt County DHHS webpage: Humboldt County Suicide Prevention Webpage
- Coordinate Awareness Month events with community partners

Expected Outcomes: 5,000 exposures to social marketing will occur.

Actual Outcomes for Fiscal Year 2018-2019:

OUTCOMES	FY 2018-2019 N=
Number of unique page views for DHHS Suicide Prevention program webpage	250
Number of unique page views for DHHS Stigma and Discrimination Reduction program webpage	63
Number of ReFrame Your Brain Poster Contest Entries	29
Number of Reframe Your Brain Poster Contest votes	193
Audience reached by radio PSAs (estimated)	61,000
Number of Email list emails opened	1,602
Number of estimated event attendees at community events (tabling at fairs and other events)	350
TOTAL SOCIAL MARKETING EXPOSURES	**63,487**

ReFrame Your Brain Poster Contest: In FY 18-19, 29 participants entered for the ReFrame Your Brain Poster Contest and nearly 200 community members voted on the results of the contest. The posters were displayed during May is Mental Health Matters month at the Eureka Public Library and voting was completed electronically via Survey monkey. In addition to votes, voters also had the opportunity to share comments and feedback about the contest. Here are a few of their comments:

"All of the posters are wonderful, picking a favorite was not easy. No one should feel like they did not win because WOW they went through a lot to get where they are and to enter this contest. THANK YOU for opening up and putting these out for the world to see!!!"

"This contest was effective in broadening my horizon about mental illness. I tend to ignore it, or signs of it in others, or even that it could be useful to think about it. I began to feel how important it is to not stigmatize mental illness. Thank you."

"Awesome work artists! Thank you for reminding us what of what is possible by pursuing these passions despite the risks and fears."

Radio PSAs

84 ads per month on three FM stations (KRED 92.3, KFMI 96.3, KKHB 105.5)	Approximately 61,000 listeners each week across all three stations. (based on national radio listener trends)
120 ads per month across two FM stations (KWPT 100.3, KSLG 93.1)	Approximately 61,000 listeners each week across all three stations. (based on national radio listener trends)

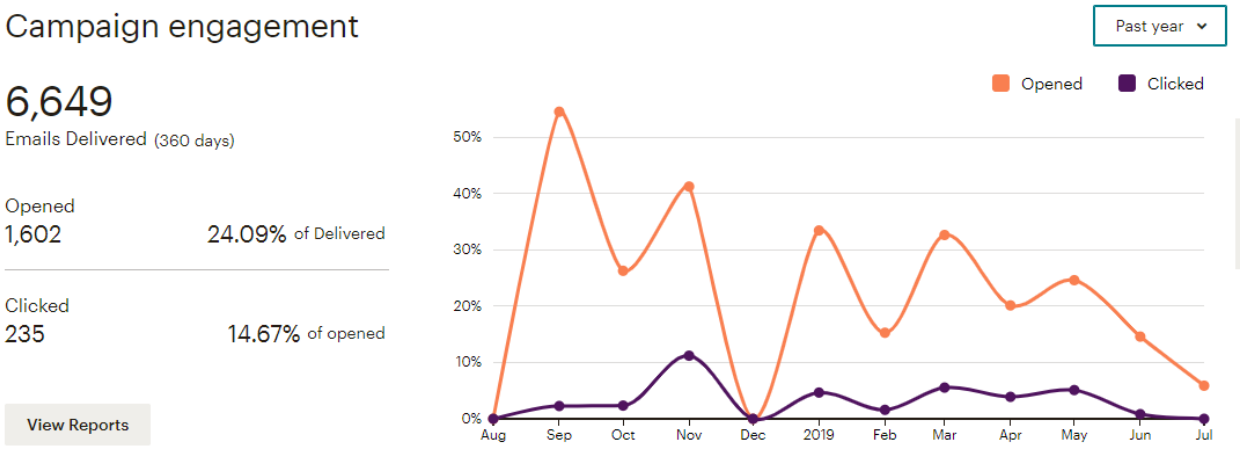
DHHS Website analytics report:

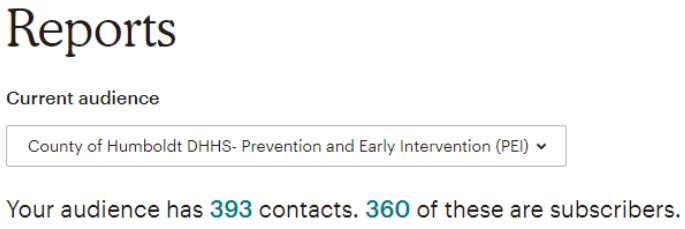
DHHS Website - Suicide Prevention & Stigma Reduction Page Analytics

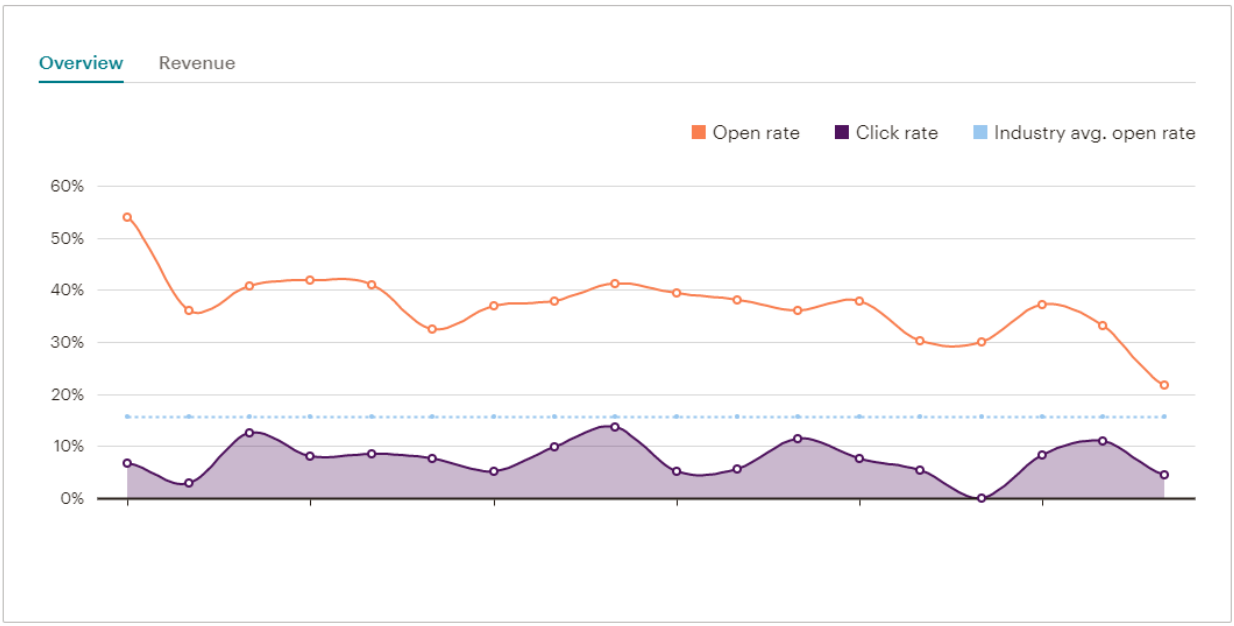
FY 2018-2019 (7/1/2018 - 6/30/2019)

URL	Page Views	Unique Page Views
https://humboldtgov.org/2047/Suicide-Prevention-Program	292	251
https://humboldtgov.org/2096/Suicide-Prevention-Resources	339	250
https://humboldtgov.org/2074/Suicide-Prevention-Training	268	222
https://humboldtgov.org/2095/Reducing-Access-to-Lethal-Means	46	39
https://humboldtgov.org/2075/Technical-Support-and-Capacity	29	27
https://humboldtgov.org/2048/Stigma-and-Discrimination-Reduction-Prog	77	63

Email Lists: Two email lists were created in 2019: one focusing on behavioral health topics in general, and another focused on suicide prevention activities. At the completion of FY 2018-2019, the PEI email list had 393 contacts and the Suicide Prevention Network (SPN) email list had 404 contacts, for a grand total of 797 contacts. A total of 6,649 emails were sent, with an average "open rate" of 24.09%, which is above industry standard for government generated email lists.





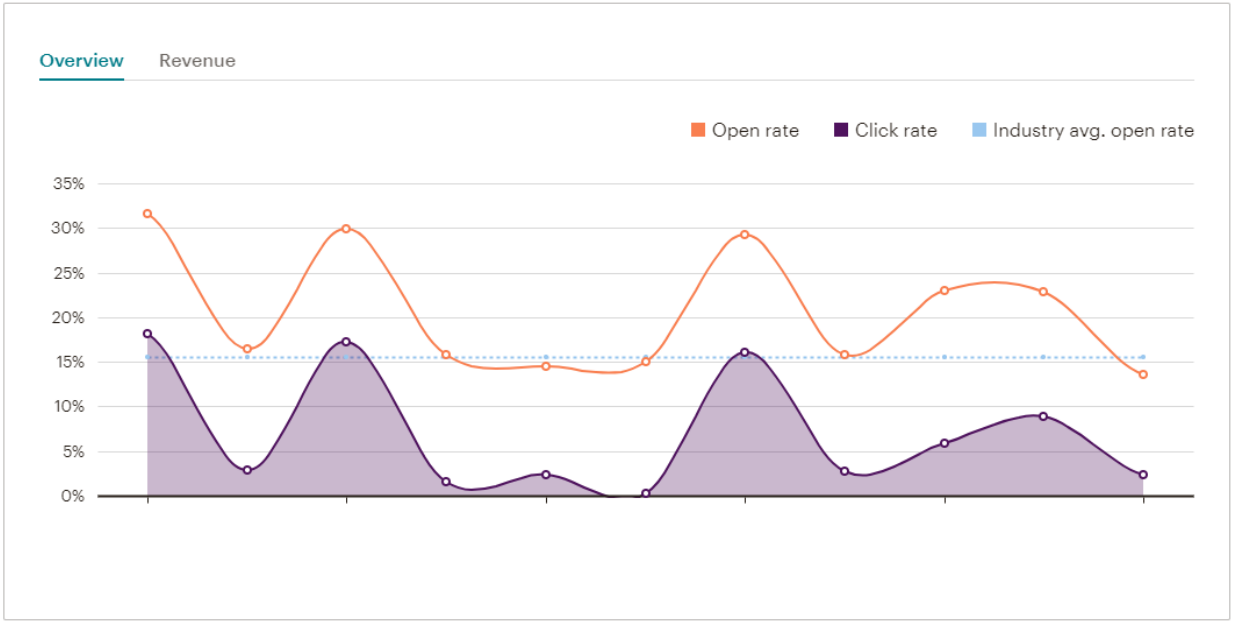


Reports

Current audience

Suicide Prevention Network

Your audience has 404 contacts. 378 of these are subscribers.



How Outcomes are Measured: Outcomes are measured according to the marketing/media platform used.

Number to be reached in FY 2019/2020: In FY 2018/19, Healthy Communities PEI will

reach:

- 250 people through the ReFrame Your Brain Poster Contest
- 350 people through the DHHS Webpage (SDR & SP program pages unduplicated views combined)
- 61,000 though radio PSAs
- Grow email list audience to over 800 (combined) and report over 2,000 emails opened.
- Reach over 100 community members through tabling efforts at health fairs, etc.

Challenges: It is challenging to measuring the reach/ demographics of some social marketing activities. For example, radio stations provide their total audience, but no data on how many people re listening during the time of our public service announcements. It is difficult to conclusively determine the total reach (contacts) by all campaign activities in a given year, though we have strong data to suggest that thousands were exposed to PEI social marketing. Statewide RAND evaluations show EMM campaigns are associated with more adults using behavioral health services.

Some community members reported that electronic voting wasn't as accessible to their community. Plans for next year's contest are to include opportunities for in-person voting.

Successes: It has been helpful to use State and National messaging campaigns that have already been tested for efficacy. For ReFrame Your Brain, printing postcards to raise awareness of contest locally was very helpful. The contest was also posted on Eventbrite.com so community members who weren't able to connect with us via email or word of mouth knew about the contest. People were allowed to vote electronically, which increased community participation and made the contest more accessible.

Lessons Learned: Our team has begun to design local toolkits for targeted populations.

Project Name: Speakers Bureau

Seeds of Change Speaker's Collective: The Seeds of Change is a group of individuals with lived experience related to a behavioral health challenges. Speakers have experienced stigma and discrimination and use storytelling to increase awareness about behavioral health, hope and recovery. Speakers develop their stories and perspectives in order to share with community groups and service providers. Healthy Communities stigma and discrimination reduction efforts helped create and has provided technical and capacity building assistance to the "Seeds of Change" speakers' collective such as assisting with agendas, coordinating speaking engagements, providing educational materials and skill development trainings.

Target Population: The target population for speakers' presentations include employers, landlords, elected officials, school personnel, behavioral and medical providers, community members, law enforcement, and first responders.

Unduplicated Number of Individuals Served: None.

Demographics of individuals served: None.

Key Activities:

- Provide technical assistance, skill building trainings for speakers, and collaborate with speakers to provide training opportunities.
- Coordinate culturally appropriate trainings for groups that work with diverse and underserved/un-served populations such as monolingual Spanish speakers, LGBTQ, TAY, and Native and Tribal communities.
- Promote Seeds of Change events through community outreach and advertising activities in local media.

Actual Outcomes for Fiscal Year 2018-2019:

OUTCOMES	FY 2018-2019
# of events	0
# of participants	2
# of new speakers trained to present their stories	0

How Outcomes are Measured:

1. Demographic forms
2. # of participants trained
3. # of presentations offered
4. # of new speakers

Number to be reached in FY 2019/2020: The Seeds of Understanding is no longer part of the Public Health work plan, though limited support will be provided.

Challenges: Supporting the growth and sustainability of the Speaker's Collective has been an ongoing challenge. Currently there are only two semi-active members. With limited staff and additional work the Healthy Communities Team has taken on, there is no longer the capacity to support the Speaker's Collective like in previous years. In FY 19/20 the program is utilizing diverse ways to highlight voices of persons with lived experience. Other mediums, such as, Digital Stories previously created, are being used as a way to bring in lived experience to community events and trainings when no speakers are available.

Successes: Project staff met with Speaker's Collective representatives and strategized ways they could take this on through PEI monies channeled to the HOPE Center. The HOPE Center is a peer support center for persons with lived experience.

Project Name: Direct Contact Approaches

Artistic Solutions is a locally developed strategy that provides groups for persons with lived experience to express themselves through artwork. Guided art exercises incorporate a variety of media including pastels, collage, quilting, sculpture and more.

Groups are topic focused and the art work is the expression of the topic such as stigma and discrimination reduction, suicide, family violence, alcohol and other drugs, adverse childhood experience, trauma, resiliency and recovery. Staff facilitates discussions and supports participants in sharing their experiences through peer support. Art projects developed by consumers are shared at community events to raise awareness of behavioral health challenges and reduce stigma and discrimination.

Target Population: transitional age youth, adults and older adults with lived experience, including survivors of suicide loss. It is a community program that includes underserved populations (LGBTQ, Native American, Latino and women).

Unduplicated Number of Individuals Served: Not collected.

Demographics of individuals served: Demographics forms are not collected.

Key Activities:

- Coordinate, plan and facilitate support groups for persons with lived experience
- Provide consumers with ongoing opportunities for self-expression to combat stigma, increase peer support, and broaden network of support
- Create art for use at community events to raise awareness around suicide prevention, behavioral health challenges and stigma reduction

Expected Outcomes: The goal for 18/19 is 80 workshops.

Actual Outcomes for Fiscal Year 2018-2019:

OUTCOMES	FY 2018-2019
# of Workshops	111
# of participants (may be duplicated)	537
# of Quilts produced	12
# of events/locations where Quilts are displayed	5

How Outcomes are Measured:

1. Attendance at scheduled workshops
2. Number of individuals who actively participate in Artistic Solutions project at outreach events (PRIDE, Health Fairs, etc.) by creating quilt square messages
3. Number of contacts at outreach events
4. Number of educational quilts created
5. Number of locations at which quilts are displayed

Number to be reached in FY 2019/2020: 535

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

Successes: Artistic Solutions groups are held at the Peer run Hope Center, Healthy Mom's, a Substance Use Disorder treatment program and HumWORKS. In FY18/19, a new group in Hoopa, Native Wellness, was successfully implemented. Groups provide a safe, supportive environment for persons with severe mental illness.

Prevention & Early Intervention: TAY Advocacy and Peer Support

There are two components to this Prevention and Early Intervention Program: TAY Advocacy, through the Humboldt County Transition Age Youth Collaboration (HCTAYC), and TAY Peer Coaches. Both components serve youth and young adults ages 16-26 years old, and both components are a part of the Humboldt County DHHS Transition Age Youth (TAY) Division. The TAY Division consists of co-located DHHS services, including Behavioral Health, Extended Foster Care (EFC), Independent Living Skills (ILS), HCTAYC and TAY Peer Coaches. In addition, the TAY Division utilizes supports and services from DHHS departments including Public Health, Employment Training Division, CalFresh, Medi-Cal, Alcohol and Other Drug services, and collaborates with community partners such as Juvenile Probation and Family Resource Centers.

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

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

TAY Advocacy--HCTAYC

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

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

HCTAYC fosters positive youth development, youth advocacy and leadership, community engagement, and promotes youth wellness. HCTAYC provides a youth voice that informs system policy, regulation, and practice at the local, state, and national levels with the purpose of cultivating better outcomes for unserved and underserved youth with a severe mental illness or who are at a significantly higher than average risk

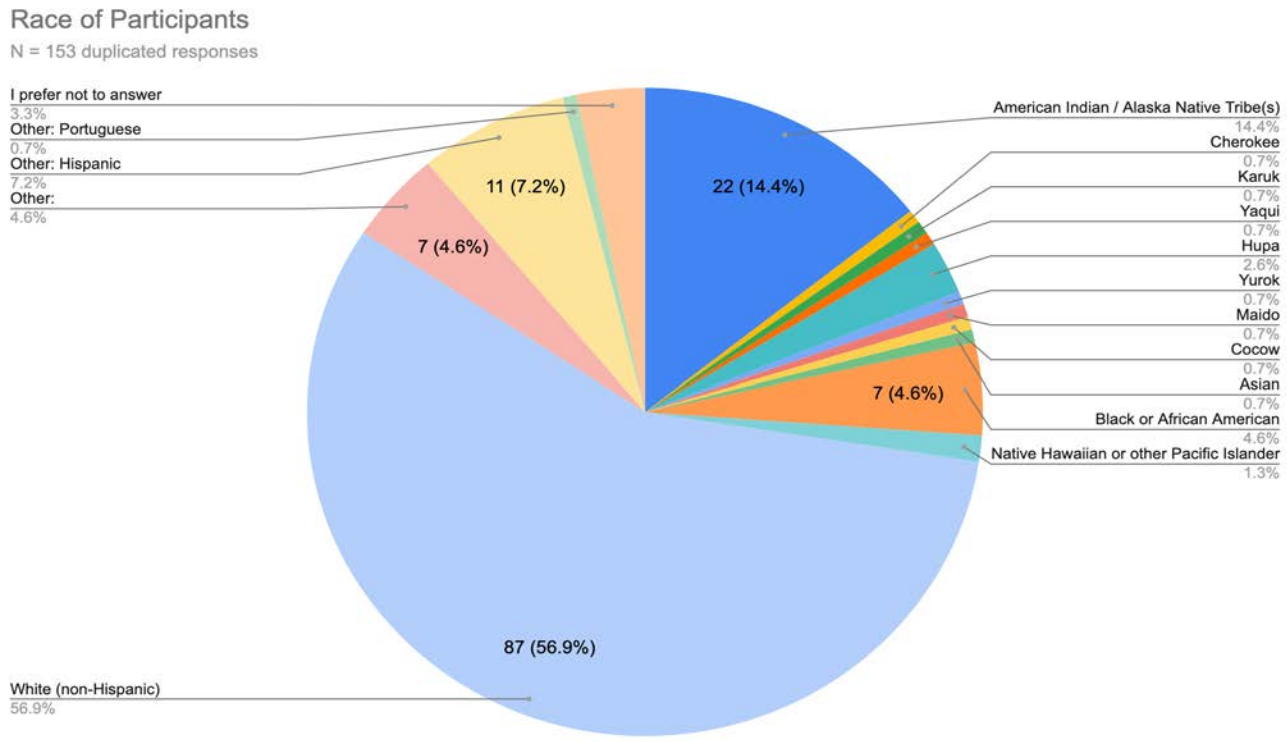
of developing a severe mental illness. The program directly impacts the TAY system of care, making it more responsive to young people's needs, resulting in these larger system outcomes. It also directly impacts the lives of system-impacted youth at-risk of, or struggling with, behavioral health challenges through the development of resilience and self-efficacy via leadership development. It is the result of this advocacy program that needed systems and services such as the creation of the aforementioned TAY Division in 2012 have come to fruition. This advocacy has also contributed to the passage of legislation and state policy, including the Foster Care Bill of Rights, Foster Care Psychotropic Medication Management, and the California Department of Social Services implementation of CANS. These policies have all significantly contributed to the statewide transition age youth system of care's ability to best serve youth.

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

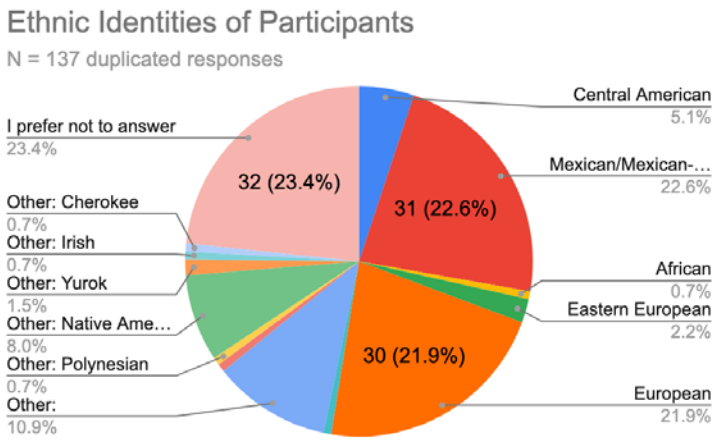
This is a prevention program which, along with TAY Peer Coaches, address components of: early intervention, outreach, stigma and discrimination reduction, and outreach for increasing the recognition of early signs of mental illness. As a rural, poverty-stricken community, access and knowledge regarding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

Demographics of individuals served: During 2018-19 HCTAYC served 88 unique individuals according to sign-in sheet records collected at many activities, trainings, and events. However, not all participants sign-in during these activities and not all activities had sign-in sheets due to logistical constraints or staff error. It is estimated that HCTAYC has served at least 115 unique individuals in the reporting period. The following charts provide information obtained from demographic forms completed by individuals participating in HCTAYC activities. Note that these are duplicated, not unduplicated, responses.

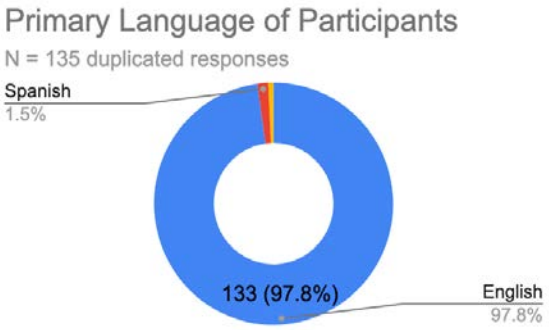
Almost 57% of participants were White, non-Hispanic. Fourteen percent were American Indian/Alaska Native, representing Cherokee, Karuk, Yaqui, Hupa, Yurok, Maido, Cocow tribes. Almost 5% were Black/African American, and 1% were Native Hawaiian or Pacific Islander. Hispanic/Latinx participants were almost 8%, less than 1% were Asian, 4% were other, and 3% preferred not to answer.



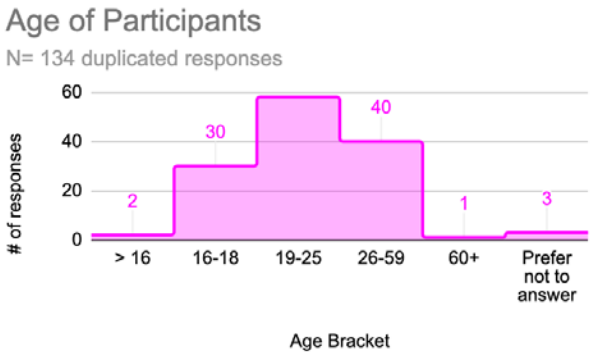
Twenty-two percent of participants indicated their ethnicity as Mexican/Mexican American. Almost 22% of participants indicated their ethnic identity as European. Ten percent indicated Other, without specifying the category. Five percent said Central American, 2% said Eastern European, and less than 1% said African, Irish, Polynesian, Yurok, Irish or other Native American.



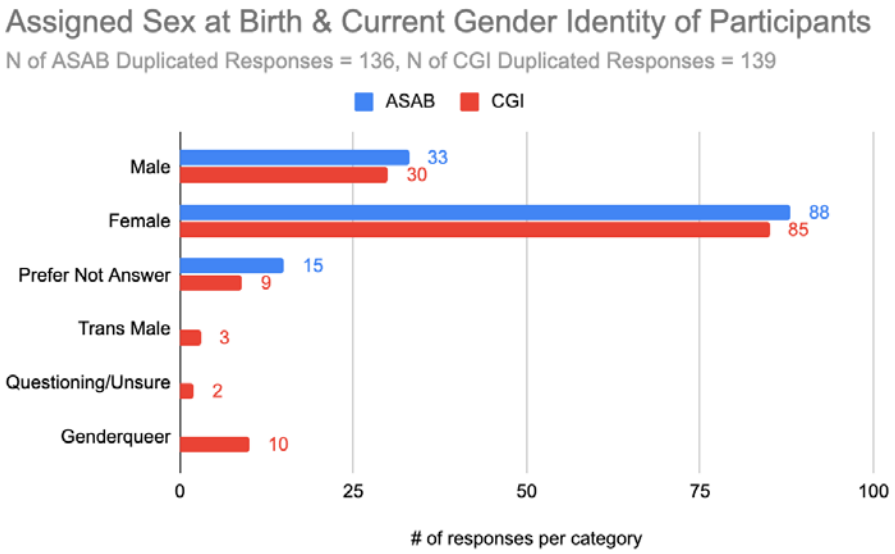
The primary language of participants was 98% English, 1% Spanish, and the rest Other or no response.



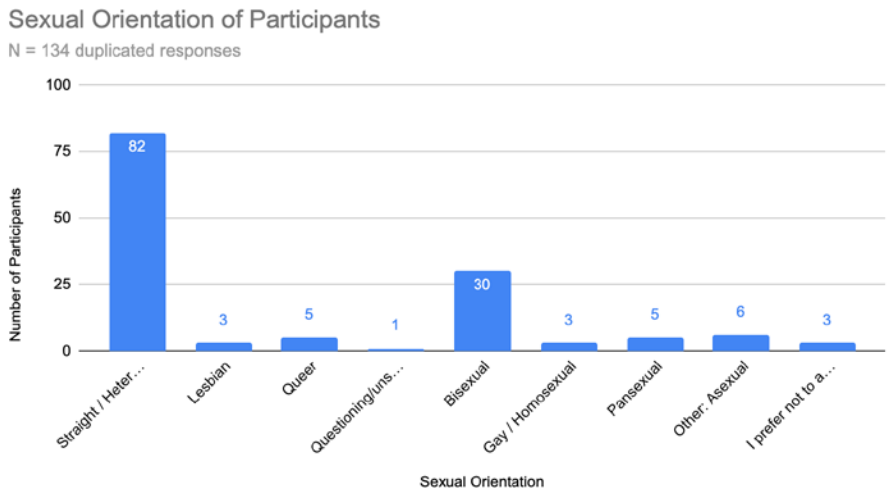
Two participants were age 16, 30 were ages 16-18, 58 were ages 19-25, 40 were age 26-59, one was 60+, and one preferred not to answer.



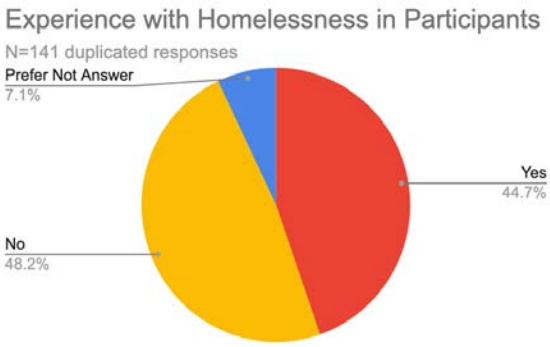
Thirty-three participants stated their assigned sex at birth was male; 88 stated female, and 15 preferred no answer. Their current gender identity was 30 male; 85 female; 9 prefer not to answer; 3 transmale; 2 questioning/unsure, and 10 genderqueer.



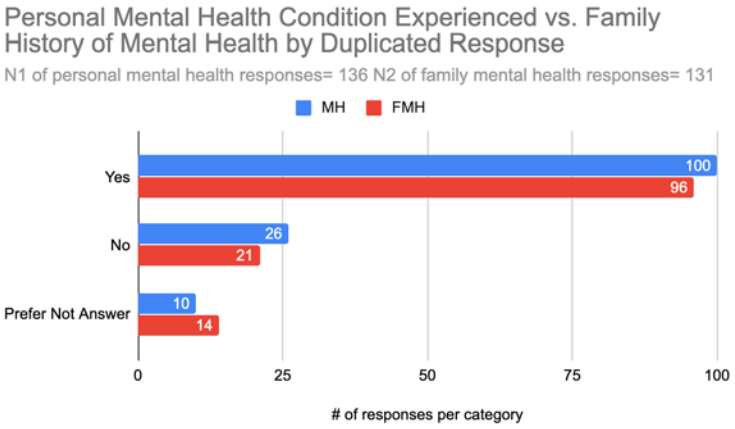
Eighty-two participants stated they are straight/heterosexual, 47 stated LGBTQ/Other, and 3 preferred not to answer.



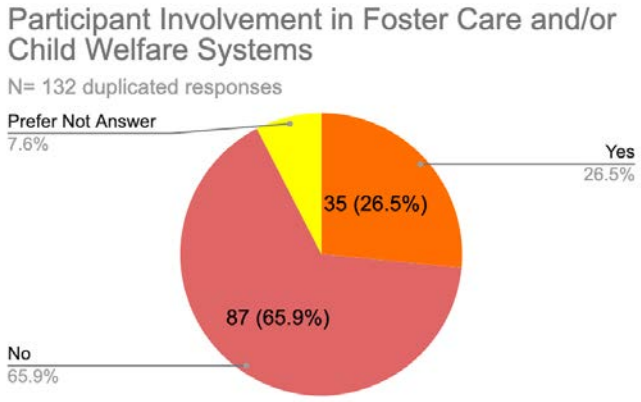
Forty-five percent had experience with homelessness, 48% did not, and 7% preferred not to answer.

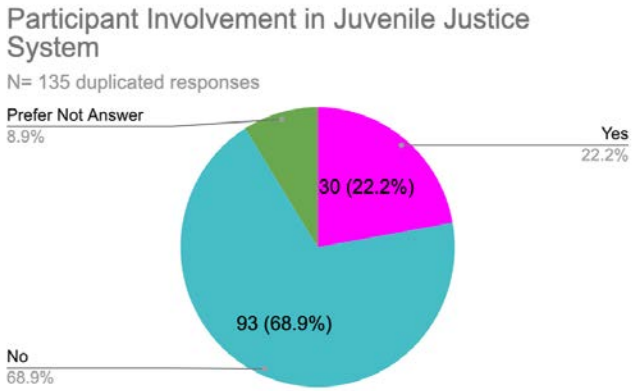


One hundred participants stated they had a personal behavioral health condition, 26 stated they did not, while 10 preferred not to answer. Ninety-six stated they have a family member with a behavioral health condition, 21 stated they did not, and 14 preferred not to answer.



Almost 27% reported involvement in foster care and/or the child welfare systems, 66% did not have this involvement, and 7% preferred not to answer. Twenty-two percent reported involvement in the juvenile justice system, 69% did not have this involvement, and 9% preferred not to answer.





The majority of participants resided in the Eureka area, followed by McKinleyville, Arcata and Fortuna.

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

There are three major components of HCTAYC Program Activities: 1. Trainings and

Events; 2. Advocacy; and 3. Youth Leadership Development.

1. **Trainings** for professionals and community members focus on TAY-specific behavioral health challenges and the engagement of this population. This includes special populations particularly impacted by stigma and discrimination such as: LGBTQ youth, indigenous youth, foster youth, and youth experiencing substance misuse and abuse. Trainings take a cultural competence and/or cultural humility approach, with specific youth-developed curriculum that focuses on youth culture. This focus includes: youth in decision making tables, communicating with youth, serving transgender and gender diverse youth, serving deaf and hard of hearing youth, LGBTQ foster care rights, sexual health, crisis intervention, and serving youth with substance misuse and abuse challenges. The facilitation of **events** focuses on concepts of behavioral health stigma reduction, outreach and information regarding behavioral health services, and wellness resilience development. These events occur in multiple formats, all of which are youth-driven, including HCTAYC's annual Wellness Week, National Children's Mental Health Awareness Day activities, critical thinking movie nights, participation in the state-wide Directing Change Mental Health Awareness PSA Contest, and a cross-country leadership exchange with youth from New York City.
2. **Advocacy** is operationalized through two means, through systems change and individual advocacy. Systems advocacy is enacted through youth organizers supporting the Youth Advisory Board to attend and participate in policy setting, decision making tables, and correspondence. This includes participation at local policy tables such as the Behavioral Health Board, statewide opportunities such as MHSOAC Innovations Events or legislative hearings, and national tables such as SAMHSA's LGBTQIA2-S Workgroup. Individual advocacy occurs when HCTAYC Youth Organizers support TAY youth in self-advocacy during their own care coordination. This is also done through participating in advocacy to amplify the youth's wishes, assisting youth in preparing speaking points for their wraparound meeting, and attending said meeting to support the youth's desired outcome.
3. **Youth Leadership Development** is perhaps the most transformative element of the HCTAYC program, consciously targeting the three base psychological needs identified in self-determination theory: autonomy, competence, and relatedness. These three components aid to prevent the emergence of mental health conditions or reduce prolonged suffering and progression. This development is the transference of skills to, and the continual support and supervision of, youth advisory board members. By creating a system of tiered levels of leadership, board members are given the opportunity to experience, develop, and practice leadership skills in a gradual progression of intensity, while emphasizing increased peer engagement and relationship building. Participants receive periodic trainings on different elements of leadership and topical education on advocacy topics. Higher-level leaders go through a multi-week orientation process and attend a three day retreat. The format of the Youth Advisory Board, with multiple affinity-based committees, allows members to develop connections with peers with similar lived experiences, while also receiving consistent support and guidance from HCTAYC youth organizers. Youth exercise autonomy through identifying program priorities, modifying program function, and by driving content creation. Youth exercise competence via the provision of trainings, engaging in advocacy, and successfully planning events. Additionally, extensive

studies have demonstrated that youth leadership programming increases self-efficacy - which is an important indicator for the reduction of harmful actions such as self-harm and suicide.

Expected Outcomes:
The program's expectation was to have more comprehensive outcomes data gathered that reported on leadership development as well as outcomes related to the specific PEI domains for Youth Leadership Development data. The Youth Advisory Board committees were expected to facilitate at least one completely youth-driven project. The program scheduled at least three youth-leadership development trainings for HCTAYC members and the general transition-age youth community.

HCTAYC expected to complete the implementation of our Alcohol and Other Drugs Policy Recommendations. Additionally, the program expected to begin the creation of LGBTQ+ Cross-Systems Policy Recommendations, and planned on continuing participation in various advocacy and policy setting tables at the local, state, and national level.

Actual Outcomes for Fiscal Year 2018-2019:
Due to staffing limitations the data for Leadership Development in this timeframe is not yet accessible for analysis or report. Whilst the PEI domain specific data gathering tool is in the process of being developed through a youth-informed process. Staffing limitations have caused the timeline for the development of this measurement tool to be extended beyond the scope of this annual update. However, the size of consistently engaged Youth Advisory Board members has grown over this reporting period to an average of 15 active members; an increase from an average of eight members from 2017-2018. Currently the Youth Advisory Board participants have almost doubled from previous years. Four youth-leadership develop trainings were provided to youth people: Focus Group Facilitation, Local Policy Campaign Development, YAB Orientation & Professional Development, and Basic Youth Leadership Skills Intensive.

The Committee-led projects' development fell within this reporting period, with three activities successfully planned. Planned were: Woke As Friends LGBTQ+ Cultural Art and Identity Exploration Workshop Series, the TAYvivor community development challenge, and Take Charge Mental Health Rights & History workshops. However, the execution of these activities falls into the next reporting period.

Significant progress has been made regarding the implementation of the AOD Policy Recommendations, assisting in the selection of screening & assessment tools for transition age youth, identifying outpatient youth SUD treatment space and structure, and assisting in the creation of a youth-SUD prevention activity guide. Complete implementation of the policy recommendations r was not completed, however.

Data gathering for the LGBTQ+ Policy recommendations began, and thus far four youth focus groups, one adult partner focus group, and three individual interviews with administration have occurred.

Additionally, the HCTAYC Lead Youth Organizer testified before the California Assembly Committee on Human Services regarding the implementation of Presumptive Transfer for

Foster Youth Mental Health and advocated for more resources for rural communities so that young people do not have to be transferred to another county. We have maintained our participation in the various policy setting tables and committees at a local, state, and national level.

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

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

Estimated Number to be reached in FY 2019/2020:
The program estimates to maintain or exceed 15 consistent Youth Advisory Board members, with the facilitation of at least 3 committee-created projects. Additionally, the program estimates accomplishing at least three more policy goals identified in the AOD Policy Recommendations and the completion and formalization of the LGBTQ+ Cross-Systems Policy Recommendations. It is hoped to provide at least one youth-driven training to professionals, as well as complete the development of one training curriculum. Four to six youth leadership development trainings to youth in Humboldt County are estimated to be provided. It is expected that consistent membership of the current policy setting tables will be maintained, as well as adding to tables regarding equity or other topics that intersect with the upcoming set of policy recommendations.

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

Challenges:
Challenges during this reporting period exist mostly as a result of staffing shortages, both within the HCTAYC program as well as the Human Services field in general. During this reporting period the previous youth organizer left the organization, and both the program peer coach and supervisor went on extended leaves at various points. The increased number of YAB members and projects were difficult for the sole remaining Youth Organizer to handle single-handedly. As a result several goals related to program development were unable to be met, particularly regarding the development and implementation of more intensive outcome measures.

Successes:
The development & implementation of a cross-country youth leadership exchange in New York City. Implementation of some elements of the AOD Policy Recommendations and the start of the LGBTQ+ Policy Recommendations process. The beginning of

development of a PEI assessment tool. Increased number of youth at the highest level of participation on the Youth Advisory Board, from one at the beginning of reporting time to five.

Lessons Learned:
YAB needs significantly less handholding than given previously in planning youth-driven activities. They are showcasing well developed leadership skills. Data collection needs to be consistent and timely to work. It's not possible for one staff person to do the job of many, but it is possible to keep the core of the program running.

TAY Peer Support

The integration of peer coaches within the TAY Division is a prevention program with components of early intervention and access and linkage to treatment. The TAY Peer Support program consists of: a shared Supervising Behavioral Health Clinician and five full-time peer coaches. Peer coaches are an integral part of the multidisciplinary team at the TAY Division, and rotating quarterly between each of the Division's programs (HCTAYC, Behavioral Health, Independent Living Skills, and the Drop-in Center). Peer coaches operate from the lens of empowerment and recovery and integrate into the division in four main ways: 1. relationship building and mentoring, 2. outreach and engagement, 3. linkage to resources and 4. activity coordination.

1. Relationship building and mentoring is done by Peer Coaches using their personal lived experiences to connect with young people ages 16-26 and focuses on mentoring, instilling hope, empowering and helping young people build self-esteem, and assisting in system navigation and self-advocacy. Peer Coaches have the capacity to engage with young people through shared lived experiences. This makes them unique in their ability to relate, provide support, and model self-advocacy, recovery, and self-care skills. Peer Coaches build relationships with young people in ways that create validation, inspire hope, and support program participants through empowerment and trust. Peer Coaches build mutuality in their relationships with young people, creating a relationship built on respect, compassion, and reciprocity. Through this unique relationship, young people are able to build self-determination, self-esteem, and gain skills necessary for transition into adulthood. Relationship building is done by providing individual meetings both at the TAY Center and in the community, utilizing shared experiences, in-vivo role modeling, teaching, and exploring the strengths and needs of the young person from the Transition to Independence Process (TIP) model. Peer Coaches are able to assist young people in building their relational capacity by supporting them when accessing social, vocational, or educational opportunities.

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

of services, reduced barriers to services and supports, improved outcomes, reduced hospitalization or incarceration, and increased support for educational and vocational success.

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

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

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

Unduplicated Number of Individuals Served: There were 1,911 sign ins for TAY activities from September 2018-June 2019), and of those, 448 are Unique, Unduplicated clients.

Demographics of individuals served:
There were 87 responses to the voluntary and confidential questionnaires at TAY.

- Fifty-seven percent or 50 people answered Yes to the question of having ever been homeless, on the streets, in a shelter or couch surfing. 34%, or 30 people responded No, while 7 preferred not to answer or did not answer the question.
- Of the 87 responses, 59%, or 51 people, have a diagnosed behavioral health experience, and the same 51 people have a family member with a diagnosed behavioral health experience.
- Five percent have an undiagnosed experience, 21% have no behavioral health experience, while 14% preferred not to answer or did not answer. 2% report both a diagnosed and undiagnosed experience.
- Sixty-six percent of the total respondents have a family member with a diagnosed behavioral health experience, 13% do not, 14% preferred not to answer and 6% did not answer.

Demographics:

- Of the 87 workshop questionnaire responses, 79 were in the 16-25 year old age range.
- Thirty-eight percent were 16-18 years old, 53% are 19-25 years old, and 8% were people 26 years or older.
- Twelve of the 87 respondents, 14%, identified as American Indian including members of the following Tribes: Hupa, Choctaw, Blackfoot, Yokut Sioux, Mono, Yurok, Karuk, Wiyot, Bear River, Mattole and Yaqui.
- Eighteen people checked their ethnic identity as Hispanic including Mexican-American, Central American, Latinx and Puerto Rican. Non-Hispanic attendees include Chinese, Asian, and Japanese, as well as 10 who preferred not to answer. 3 of the 87 people speak a language other than English, primarily Spanish.
- Twenty-two responses indicated the presence of a disability. Included are 11 Vision, 3 with Hearing, 8 with a Mental/Learning disability, 3 Physical, 1 chronic, and 3 have an Other or Not specified disability. 3 responses were specifically No, and the remaining were not answered or the person preferred not to answer.
- Nineteen indicated they are not Veterans, while 68 did not answer.
- Regarding Sexual Orientation: 69% identify as Heterosexual/Straight, 2% Gay/Lesbian, 6% Queer, 10% Bisexual; 7% Prefer not to answer/Did not answer and 6% Chose Other.
- Sex assigned at birth, 57 were female and 24 were male, while 2 preferred no answer and 4 were left blank.
- Current gender identity: 51 female, 21 Male, 2 Genderqueer, 2 Transgender Male, 5 Other, and 6 not answered.

Key Activities:

TAY Peer Support Accomplishments and Awards
Presented to Adult Probation
Presented to Juvenile Probation
Presented to Eureka Resource School (ERC)
Presented to HCOE
Presented to Adult Probation
Facilitated three group activities in the Regional Facility
Tabled at MAY is Mental Health Matters Month in Eureka

Training Peer Coaches Attended:
Housing First
ASIST-Suicide Prevention
ADA and Media Compliance Training
Mental Health First Aid
TIP-Transition to Independence Process
Medical Billing and Documentation
Mandated Reporting
CSEC Training
Compassion Fatigue and Burnout-webinar

Peer Coaches Provided Outreach to:

Juvenile Hall
Humboldt County Correctional Facility-Jail
Sempervirens and the Crisis Stabilization Unit
Eureka Resource Center-ERC school
Street outreach-Arcata, Eureka, Fair Haven
Willow Creek, Hoopa
Raven Project
Eureka Family Resource Center
Teen Court
Adult Probation

Workshops, Groups and Events Lead by Peer Coaches
Self-Care Skills
Strategic story telling
Pour your art out
TAY Baby shower
Pumpkin patch field trip and carving
Cooking making/decorating
Scavenger Hunt for local resources
Ropes for Hope
Holiday craft/present making
Hiking and wellness
Fitness Friday
Mommy and Me Group
Role-play group
Healthy Relationships
Cooking demonstrations

Expected Outcomes:
The expected outcomes for 2018/19 were to fully staff all peer coach roles and have peer coach trained or/training with each area of the TAY Division (ILS, BH, HCTAYC, DROP-IN, Lead). It was expected that the peer coaches would be doing medical billing connecting direct service of TAY youth open to Behavioral Health and possible other outcome measurement tools. It was expected to continue and expand outreach and information to needed populations. It was expected that peer coaches would support youth and engage in activities at TAY and relationship building while waiting to receive or be connected to other needed services or require a lower need for care.

Actual Outcomes for Fiscal Year 2018-2019: As of May 2019, all peer coach positions are filled and it is projected that this staff will continue employment throughout the coming year. All peer coaches have completed documentation training linking direct services to electronic medical records. Peer coaches have planned and managed pro-social activities and events monthly.

How Outcomes are Measured:
Access to the TAY drop-in space and selected events and workshops are collected by sign-in sheets. Tracking sheets of referral assignments have been kept but need improvement including tracking date referral is received, assigned and when first contact is made. Some information also overlaps with other programs (BH, employment, ILS)

and these contacts and linkages are currently not being tracked.

Estimated Number to be reached in FY 2019/2020:
It is estimated that approximately 150 TAY (New, unique participants) will be served in Fiscal Year19/20.

Challenges:
Outcome measurements, the overlap of services/tracking of these services and the overlap primarily with the behavioral health team, and reminding peer staff to use sign in sheets and demographic forms.

Prevention & Early Intervention: Parent Partners

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

The Parent Partner Program employs three full-time and one part-time staff to provide supportive services to parents/caregivers involved in the DHHS system-Public Health, Child Welfare, Probation, and Behavioral Health, along with Humboldt County Office of Education. The most senior Parent Partner completed certification as a Parent Partner Coach through a National Wraparound Implementation Center Affiliate (NWIC), the Family Involvement Center of Arizona. The Certified Parent Partner Coach has also been credentialed by the National Federation of Families for Children's Mental Health as a Certified Parent Support Provider (CPSP). The CPSP credential is to ensure that people employed in this field meet consistent and high standards of performance when helping other parents who have children experiencing social, emotional or behavioral health challenges. Certification promotes ethical practice within the workforce so parents with experience in successfully helping their own children can support parents in their unique journey to make decisions that are best for their families without judgement, bias, or stigmatization.

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

Target Population:
The target population includes any parent or caregiver of a youth involved in a child-serving system such as a Children's Behavioral Health program or Child Welfare

Services. In addition, these services will impact the well-being of families which may include children and other natural supports.

Unduplicated Number of Individuals Served:
Our current Parent Support Tool (PST) and referral process does not currently capture this number accurately. For the next fiscal year we will be updating our PST to more accurately reflect this number. Based upon individuals served from our prior two fiscal years we estimate that we served forty-four unduplicated individuals.

Demographics of individuals served:
During Fiscal Year 2018-19, we had staff changes and transitions affecting the program's expansion efforts. Six new parents/caregivers were added to the overall caseload in FY 18/19. The collected demographic forms (N=4) provided the following data: 50% of the participants have a stated age range of 26-59, the remaining 50% have a stated age of 60+. 75% of the participants state White as their race and the remaining 25% preferred not to answer. 75% of the participants stated they are not Latino or Hispanic and the remaining 25% preferred not to answer. 100% of participants state English is their primary language. 100% of participants stated their sexual orientation is heterosexual. When asked if the participants have a disability, 50% responded no and the remaining 50% stated they have a chronic health condition. 50% of the participants stated veteran status, the remaining 50% did not. 75% of participants marked male as the assigned gender at birth and 25% failed to mark a response. 100% of participants marked male as their current gender identity. When asked if participants have ever been homeless, 75% answered yes, while the remaining 25% answered no. In response to the question, have you ever experienced a behavioral health challenge: 50% responded no, 25% stated yes-undiagnosed, the remaining 25% stated yes-diagnosed. 100% of participants have a family member with a diagnosed mental health condition. The final question asked about the participant's job or role: 100% marked other with a handwritten specification: 25% wrote dada, 25% wrote self-employed, 25% wrote retired military and the final 25% wrote natural resource consultant.

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

Expected Outcomes:
Parent Partners are expected to attend various meetings within the DHHS system in order to provide the critical perspective of those with lived experience.

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

Parent Partners are expected to provide outreach to about thirty people/week through outreach efforts at places such as Family Resource Centers, meetings and hospitals.

Actual Outcomes for Fiscal Year 2018-2019:
Parent Partners currently attend approximately eleven DHHS or community based meetings per month to bring the voice of families and those with lived experience to the decision making process.

We have had no matched pairs of the Parent Support Tool so we are unable to quantify outcomes at this time.

The Parent Partner Program reached out to approximately thirty people per week this last year. These outreach efforts were done primarily at Sempervirens, Family Resource Centers, the Jefferson Community Center, and directly to families and caregivers in the community.

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

Estimated Number to be reached in FY 2019/2020:
For the next fiscal year an estimated 40 additional parents/caregivers will be reached, and the expectation is that all current and new cases will have a PST completed annually and at the time of closure to services.

Challenges:
As a newer program connected to the Children's and Families Services there were some growing pains and implementation challenges in FY 18/19. There were many staffing challenges that impacted the program including supervision and management changes as well as internal staffing challenges and transitions. The completion of documentation in our electronic health record, the Parent Support tool and referral tracking system have been inconsistent and underutilized. While the Parent Partners have been providing important services to many parents and caregivers, there is unfortunately little data to support the work that they have been doing.

Successes:
The Parent Partners have been instrumental in supporting parents in some of the most difficult and contentious cases that involve complex service delivery with Child Welfare Services. They have attended numerous Child and Family Team meetings to support parents and caregivers as well as internal DHHS meetings. For example, Parent Partners have been regularly attending the DHHS Cultural Competency Committee meeting and meetings run by our Quality Assurance unit bringing their unique voice to the table. Finally, Parent Partners have been significantly involved in the implementation of a system wide efforts to reduce secondary stress among staff. Parent Partners have been involved in the development of trainings educating staff about secondary traumatic stress and helped with the roll-out of these trainings to staff.

Lessons Learned:
Some of the lessons learned include a better understanding of the level of support the Parent Partners need in order to complete timely and accurate documentation and outcomes. The program will be evaluating the Parent Support Tool to see that it meets the needs of the program as well as the delivery of usable data that will inform the work.

Prevention & Early Intervention: Local Implementation Agreements

In response to stakeholder input about the value of providing mini-grants to local communities, Prevention and Early Intervention dollars were used for PEI Local Implementation Agreements, beginning in January 2019. Proposals were required to meet the guidelines, definitions and reporting requirements of the MHSA Prevention and Early Intervention Regulations, including having a focus on at least one of the following categories:

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

For the period January-June, 2019, four projects were approved for funding. Unfortunately, of these four projects only one was completed during the project period due to contracting issues with the other organizations that were approved for funding. Results of this project are set forth below.

Dispelling Stigma: Hoarding Education, Treatment and Prevention. There were four components to this project, facilitated by the Area 1 Agency on Aging (A1AA).

- A one day conference *Dispelling Stigma: Hoarding Education, Treatment and Prevention*. This conference was attended by 105 people. Humboldt Access recorded the conference and it was broadcast during one week in April on the Humboldt Access channel. Each of the four segments were shown eight times during that week. A1AA put the recordings on their website along with presenter materials, so the information is available at any time to those who are interested.
- The formation of the Northcoast Hoarding Task Force. Two meetings were held before the end of the grant project period. It is too early to tell if it is successful or will continue, but initial interest appears good.
- Free support group for people who hoard. There is an average of 9-10 people attending this group.
- Free support group for family and friends of people who have cluttering/hoarding issues. There is an average of 3-4 people attending this group.

Feedback from the groups received by the time the grant project ended has been positive, with attendees feeling supported and finding tools to address the issues.

Demographic information from the conference, Task Force and support groups indicates that 4% were ages 16-25, 54% were 26-59, and 42% were age 60+. Approximately 79% were White, 7% Multiracial, 5% American Indian, 4% Other, 2% Asian, with the remaining categories being less than 1%. Those with Hispanic/Latino ethnic identity were 11%. All but one person stated English was their primary language. Seventy-seven percent were heterosexual,15% reported LGBTQ, and 8% did not answer. Ninety-one percent were female and 9% male. Nineteen percent reported being homeless at some time. Forty-nine percent reporting experiencing a behavioral health condition, and 71%

reported a family member with a behavioral health condition.

The next period of funding for the Local Implementation Agreements is September 2019-June 2020. Four grant applications were approved for funding and contracts have been executed with the applying agencies. These proposals are summarized below.

Bear River Youth Suicide Prevention Program. The Bear River Band of the Rohnerville Rancheria Social Services will hire a consultant to conduct a three-day intensive peer-counseling program for Bear River youth that focuses on suicide and related issues, such as depression, trauma, violence and substance abuse. The program will take place in February 2020 and will serve 25 people, including 20 youth, two Bear River social workers, and at least three Bear River community members. The program is called Native H.O.P.E. (Helping Our People Endure).

Families Thriving Together – An Individualized, Therapeutic Parenting Program.
This project partners a local therapist with a First 5 Humboldt/HCOE Child and Family Support Specialist. They will develop and implement an intensive therapeutic parenting program based on Infant-Family and Early Childhood Mental Health (IFECMH) best practices to utilize the research-based Family Strengthening Protective Factors as a framework. The program will be offered at The Gathering Place, a trauma-responsive therapeutic environment.

Community Mental Health Project. This project of Making Headway Wellness Center (MHWC) has two goals: to increase behavioral health services in Spanish and English and to increase domestic violence services in Humboldt County. MHWC will provide individual, family and group therapy in both English and Spanish, using TRD – a trauma-informed and trauma-responsive practice that focuses on supporting individuals who have experienced emotional and physical trauma. This will help break the financial barrier that limits access to services for the Spanish-speaking community. Increasing domestic violence services will be achieved through using grant funding to offset the financial burden for those who are charged with domestic violence and court-ordered to participate in group psychotherapy.

Hospitality and Volunteering Program Coordinator. McKinleyville Community Collaborative Family Resource Center will send three people to Mental Health First Aid (MHFA) Training of Trainers with the intent of serving two target populations: monolingual Spanish speakers and Native American youth in contact with the juvenile justice system. MHFA is a training that focuses on increasing awareness of behavioral health symptoms, decreasing stigma related to behavioral health treatment, and providing strategies for community members to assist each other in accessing behavioral health support. Two of the attendees will be bilingual English-Spanish.

Prevention & Early Intervention: School Climate Curriculum Plan/MTSS

Background

Increasing the recognition of early signs of emotional disturbance or mental illness for children in a school setting was an identified need of the MHSA Community Planning Process. In fiscal year 2014-15 the suspension rate in Humboldt County schools was 6.1, almost twice the State rate of 3.8. Following the identification of this need, a stakeholder process occurred that included surveying school superintendents, administrators, teachers, counselors and gathering information through various community stakeholder groups and from DHHS staff. This led to DHHS and the County Superintendent of Humboldt County Office Education (HCOE) developing a shared plan to address the need, and they entered into a Memorandum of Understanding to continue to develop a Multi-Tiered System of Support (MTSS) Coalition to implement the Positive Behavior Interventions and Supports (PBIS) curriculum.

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

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

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

7. Family and community engagement to build trusting family and community partnerships.
8. Inclusive policy structure and practice by building strong district/school relationships with the coordination and alignment of multi-initiatives through district policy frameworks.

Activities Supported by PEI Funding 2018-19:
In school year 2018-19, approximately eleven additional school sites joined the Northern CA MTSS Coalition, bringing the number of participating schools to thirty-one. Continuing and new schools partnering with the HCOE Northern CA MTSS Coalition represent districts/sites that will receive ongoing consultation, and technical assistance provided through HCOE. Additionally, these schools will have access to Coaches Meetings to strengthen implementation and build internal capacity through a county supported network.

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

- Arcata Elementary School District
- Alder Grove Charter
- Cutten Ridgewood School District
- Eureka City Schools
- Blue Lake School District
- Big Lagoon School District
- Trinidad School District
- Southern Humboldt Unified School District
- Ferndale School District
- Freshwater School District
- Fuente Nueva Charter
- Garfield School District
- Loleta Elementary School District
- Jacoby Creek School District
- Rio Dell School District
- Fortuna Elementary School District
- Fieldbrook Elementary School District
- McKinleyville Unified School District
- Pacific Union School District
- Northern Humboldt Unified High School District
- KIamath Trinity School District
- Redwood Preparatory School District
- South Bay School District

Activities Supported by PEI Funding:
IIRP World Conference (International Institute for Restorative Practices) Detroit, MI Q2 October 24-26 2 Participants – Presentation, “Implementation in Rural California”.

California PBIS Coalition Conference, Sacramento, CA Q1 September 24-26, 2018 2 participants presented, “The Northern CA MTSS Coalition, Rural Implementation Behind the Redwood Curtain”.

- Ten Participants representing 9 local school districts were funded to attend the CA PBIS Coalition Conference.

District Team Site Visits to Model PBIS/MTSS Schools in Northern CA. Recognized by California PBIS Coalition for excellence in implementation. March 7th, and May 2nd, 2019.

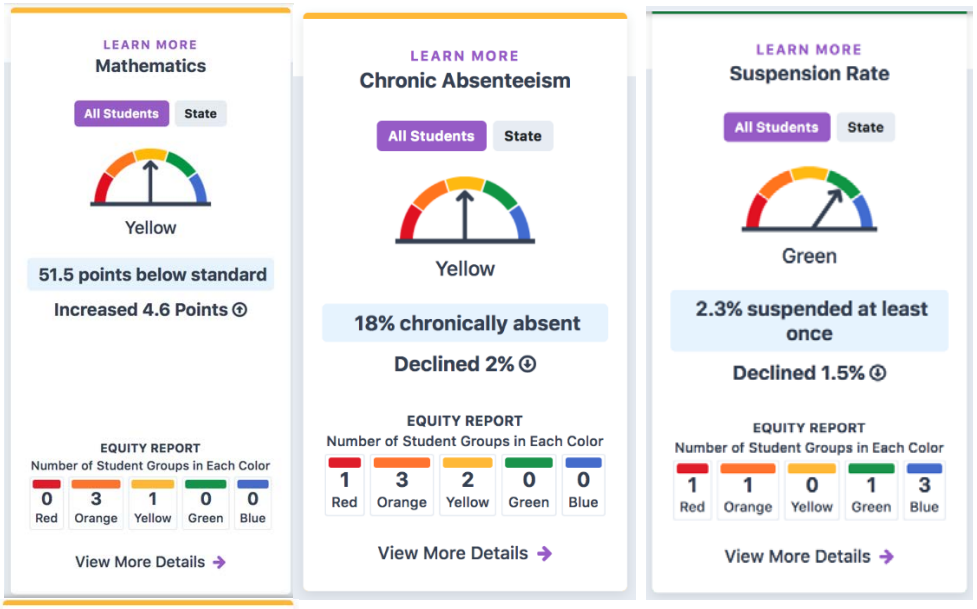
- Valuable collaboration between HCOE and PCOE (Placer County Office of Education) with coordinating support by the CA PBIS Coalition.
- Opportunity for Districts and local agency (probation) teams to benefit from visiting model recognized PBIS school-sites.
- Participating districts – Blue Lake (4 participants with admin representation), Freshwater (4 participants with admin representation), Trinidad (3 participants with admin representation), McKinleyville Elementary School District (6 participants with admin representation), Redwood Preparatory Charter (1 admin), and Court and Community School/Juvenile Hall (5 participants with admin representation).
- This opportunity was reported as very beneficial by teams and hosting sites that the model is being replicated so other local districts will have the option to participate during the 19-20 fiscal year.

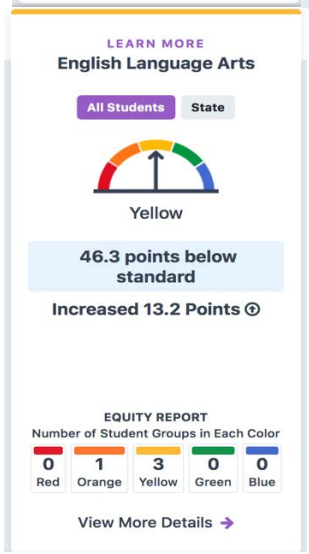
Direct Support/Materials:
Educational materials, curriculum, training materials (for PBIS and Restorative Practices Trainings), and the establishment of an MTSS lending library were supported through this valuable underwriting, as well as the support of 28 school sites' coalition yearly dues. Additional materials include essential snacks for coaches PLC's (Professional Learning Community) which are always appreciated and a draw and the end of a long day.

The PEI support of the Northern CA MTSS Coalition has provided training and support for hundreds of educators in Humboldt County in a myriad of domains of school climate transformation and multi-tiered interventions targeting all student groups in Humboldt County. Universal interventions focused on prevention and early intervention for all student groups to improve academic, behavioral, and social-emotional outcomes is an evidence-based approach to align learning initiatives and state mandates to improve the behavioral health outcomes of students. This occurs through system change, improved responsiveness, improved discipline practices, community building, social emotional learning, trauma informed practices and cultural and community engagement. The training, technical assistance, coaching, teaming, and shift in practice afforded by preventative interventions will ultimately impact the intensive needs of our community by building mentally healthy learning environments and practices in our local schools, and build and strengthen collaborative efforts between agencies, tribal entities, and the community at large.

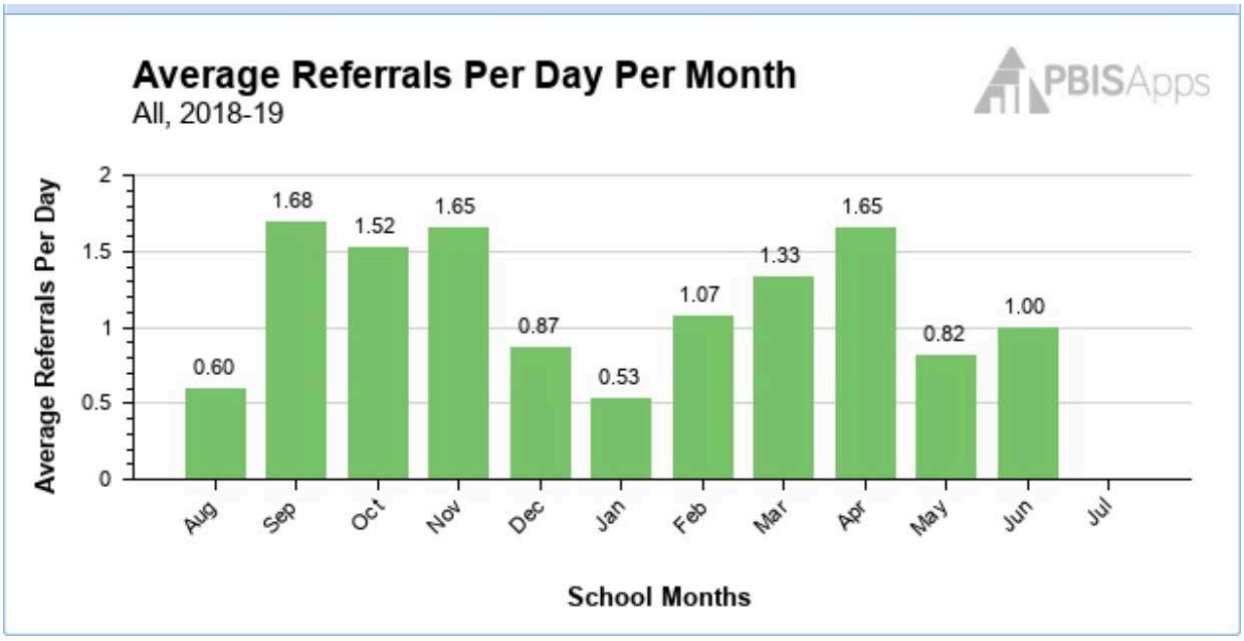
The data images below represent a continuation of the case study of Fortuna Elementary School from year 17-18 annual report. We see continued improvement in all targeted areas on the CA Dashboard (CDE - https://www.caschooldashboard.org/reports/12768026007876/2018)

Demographics of South Fortuna Elementary School:





School-Wide Information System Data Below (SWIS) – note the low average rate of referrals with the trend decreasing as the year progressed.



For an overview of MTSS on the California Department of Education Website - https://www.cde.ca.gov/ci/cr/ri/index.asp

Making Relatives Program

Big Lagoon Rancheria, Trinidad Rancheria, Two Feathers Native American Family Services and the Bear River Band of the Rohnerville Rancheria plan to come together in a consortium to create a continuum of care that is a community informed, culturally grounded, systematized approach to tribal behavioral health. This continuum of care will include a range of supports for mental wellness and suicide prevention, in an early intervention and family supportive cultural framework for tribal youth. Included in this approach will be the development of an indigenous behavioral health curriculum that seeks to meet the needs of the local tribal communities of Humboldt County.

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

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

The program will be expanded and sustained through evaluation of the process and service outcomes. In addition, Two Feathers Native American Services is in the process of becoming an organizational provider with DHHS Behavioral Health, translating traditional wellness practices into Medi-Cal billable services as appropriate under the specialty behavioral health services waiver. This process should be completed by January 2020.

MHSA funding is provided for the first year of the program, focused on developing the consortium and culturally based program. To date funding has supported consultant services for planning, implementation and evaluation, and clinical policies have been developed for review.

Workforce Education and Training

Over the years, MHSA Workforce Education and Training (WET) funding has provided staff development opportunities that promote wellness, recovery, and resilience, culturally competent service delivery, meaningful inclusion of clients and family members, an integrated service experience for clients and their family members, community collaboration, and employment of clients and family members within the behavioral health system. During fiscal year 2018-19 WET activities were planned to include a contract with Relias E-Learning, Racial Equity training, and Wraparound training.

- Relias E-Learning. Behavioral Health initially contracted with Relias Learning, LLC, in April 2016. Staff have access to the Relias catalog of courses, written by industry experts and accredited through international and state accrediting bodies. Local trainings are created and uploaded to Relias as well. Built in tracking, testing and reporting tools save time and ensure that mandatory training requirements are met. Relias improves new hire orientation as an entire collection of training specific to staff roles can be assigned. In Fiscal Year 18/19:
    - Staff had access to a total of 813 trainings.
    - Humboldt County Behavioral Health developed and loaded 272 custom trainings. Many were agency Policy & Procedures (P&Ps) Behavioral Health has implemented the assignment of P&Ps through Relias to automate this process and have an accounting of completions.
    - Relias was relied heavily on for tracking of in-services at Sempervirens.
    - Other additions to Relias included Chart Review Training, Cultural Competency Training, Onboarding for Staff, Onboarding for Supervisors, Multidisciplinary Treatment Planning Training for Sempervirens, Scheduling Calendar Trainings and Trauma Informed Care. Additionally, the DHHS-MH Medical Director created trainings for Morbidity & Mortality review and other trainings targeted for Behavioral Health medical staff.
    - Relias was used to assign and track important Behavioral Health communications in the form of QI Bulletins. QI Bulletins are notices related to business practices changes or other important information.
    - Staff enrolled in a total of 11,186 courses, completing 4,898 (44%) of them.
- Behavioral Health planned to work with the North Coast Equity Alliance, a local non-profit organization, to create customized trainings around the topic of race relations and bias. These would be local, in-person trainings for Behavioral Health staff. A team from the Behavioral Health Cultural Competence Committee met with the trainers from the Equity Alliance and discussed an outline for the training. Shortly after this meeting, the team learned that DHHS Administration was interested in bringing racial equity training to all DHHS staff. The Behavioral Health team was advised to put on hold the planning for Behavioral Health staff alone. Since that time the DHHS leadership team developed a plan for leadership to meet with the Equity Alliance over a period of two months and determine next steps. Should this process result in training, WET funds may be used to cover some of the costs.
- Behavioral Health had planned to continue the training process to implement and support High Fidelity Wraparound within Children's Behavioral Health. Shortly after

the beginning of the fiscal year, however, the decision was made to discontinue the High Fidelity Wraparound training due to challenges with staffing and supporting the program long term. Key positions could not be filled, staff were unable to get certified to coach the model, and there were challenges with filling case manager positions and retaining staff in those positions. Though High Fidelity Wraparound is no longer used, Intensive Care Coordination continues to be offered to youth and families.

For Fiscal Year 2019-2020, WET activities will include the following.

- The contract with Relias E-Learning will be continued, and the number of user licenses will be increased. All available 375 licenses are currently being used, and with staff increases projected in FY 19/20 the number will be increased.
- Local training and coaching, such as:
    - Two to four hours per month of cultural coaching for staff with White Bison/Red Road Curriculum
    - Assisted Outpatient Treatment training
    - Cultural Training
    - Training for new Case Managers
    - Training for Comprehensive Community Treatment Personal Service Coordinators
    - Dialectical Behavioral Therapy training
    - Secondary Trauma training
    - Purchase of training Webinars and DVDs
- Out of County travel for staff education, such as:
    - Beyond the Bench
    - American Group Psychotherapy Conference
    - 33rd Annual APNA Conference
    - 18th Annual Psychopharmacology Conference Breaking Barriers 4th Annual Interagency Symposium

Continued and Completed Projects

Milestones of Recovery Scale (MORS)

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

Roll out of the MORS began in 2014, including staff training and reports made available to all outpatient services, and will continue into upcoming fiscal years to assist program direct services staff and clients with monitoring progress in treatment and to assist with treatment decisions and measure readiness for discharge.

In April 2019 a new MORS widget was added to the client chart in the electronic health record (Avatar). In the Avatar Chart Summary, the MORS widget provides clinicians a list a client's MORS scores and a color coded bar graph displaying MORS milestones over time.

Data Collection for Homeless Population. Since April 2016 DHHS Behavioral Health began collecting housing data for clients, specifically the Crisis Stabilization Unit, to assess admission and readmission rates, frequency of visits, and making referrals for those clients that report being homeless.

During 2018 stakeholders met to develop a consistent, reliable, historical and reportable system for tracking homelessness within Avatar. As a result, in the upcoming year existing definitions will be updated with more detail to document client homeless status in the admissions form. It is also the goal to utilize an additional existing field to document homeless status at discharge to improve documentation of chronic homelessness of clients over time.

Health Information Exchange (HIE) and Summary of Care Documents: Since August 30, 2018 DHHS Behavioral Health has received emergency department care summaries from local hospitals for clients being admitted to Sempervirens Psychiatric Health Facility and the Crisis Stabilization Unit (CSU). This is possible with the help of a local health information exchange, North Coast Health Improvement and Information Network (NCHIIN).

The NCHIIN Emergency Department Care Summaries include client's emergency department visits and labs within past 90 days, allergies recorded at the hospital, primary care provider, case manager, and a list of diagnostic imaging. Between August 2018 and June 2019, staff at Sempervirens and CSU has received over 382 care summaries from local hospitals to improve care coordination for clients receiving behavioral health services.

In November 2018 the HIE capabilities expanded to further improve continuity of care when DHHS Behavioral Health began sending behavioral health summaries to local hospitals and primary care providers as the client presents to the hospital for

emergency services or seen by their primary care provider for follow up.

CANS and PSC-35: In 2018 California Department of Health Care Services began requiring the collection and reporting of two child functional assessment tools; the Pediatric Symptoms Checklist (PSC-35) and the Child and Adolescents Needs and Strengths (CANS).

CANS and PSC-35 results collected in Avatar were compiled and reported out to California Department of Health Care Services beginning March 1, 2019 and since then DHHS Behavioral Health have successfully submitted 1,496 child functional assessment records to the state.

Currently work is being done to utilize the behavior health analytics platform Objective Arts for developing reports and dashboards to assist clinical staff with timely completion of the CANS as well as provide a wider program and organization level overview for supervisors and managers.

Fiscal Accountability Certification

Placeholder for County Compliance Certification” needs to appear

FY 2019-20 Mental Health Services Act Annual Update
Funding Summary

County: HUMBOLDT Date: 5/6/20

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2019-20 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	514,932	1,115,832	348,090	65,015	0	
2. Estimated New FY 2019-20 Funding	5,293,300	1,323,325	348,243			
3. Transfer in FY 2019-20 [a/]						0
4. Access Local Prudent Reserve in FY 2019-20						0
5. Estimated Available Funding for FY 2019-20	5,808,232	2,439,157	696,333	65,015	0	
B. Estimated FY 2019-20 MHSA Expenditures	4,995,195	1,858,388	501,017	65,015	0	
G. Estimated FY 2019-20 Unspent Fund Balance	813,037	580,769	195,316	0	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2019	1,439,391
2. Contributions to the Local Prudent Reserve in FY 2019-20	0
3. Distributions from the Local Prudent Reserve in FY 2019-20	0
4. Estimated Local Prudent Reserve Balance on June 30, 2020	1,439,391

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

FY 2019-20 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding

County: HUMBOLDT Date: 5/6/20

	Fiscal Year 2019-20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Comprehensive Community Treatment	5,094,971	3,479,192	1,583,386			32,393
2. Adult Residential Treatment Services	1,000,000	500,000	500,000			
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. RURAL OUTREACH SERVICES ENTERPRISE (ROSE)/Mobile Outreach	976,218	662,486	281,108		32,624	
2. MHSA Telemedicine	218,361	144,870	73,092		399	
3. OLDER AND DEPENDENT ADULT EXPANSION	95,836	60,951	34,885			
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
CSS Administration	231,610	147,696	83,914			
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	7,616,996	4,995,195	2,556,385	0	33,023	32,393
FSP Programs as Percent of Total	80.0%					

FY 2019-20 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: HUMBOLDT Date: 5/6/20

	Fiscal Year 2019-20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Hope Center	295,791	274,701	21,090			
2. Stigma & Discrimination Reduction	168,630	168,630				
3. TAY Advocacy and Peer Support	423,468	423,468				
4. Parent Partnership Program	244,406	244,406				
5. School Climate Curriculum	94,100	94,100				
6. Local Implementation Agreements	110,000	110,000				
7. Making Relatives Program	43,583	43,583				
8.	0					
9.	0					
10.						
PEI Programs - Early Intervention						
11. Suicide Prevention	258,090	258,090				
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	241,410	241,410				
PEI Assigned Funds						
Total PEI Program Estimated Expenditures	1,879,478	1,858,388	21,090	0	0	0

FY 2019-20 Mental Health Services Act Annual Update
Innovations (INN) Funding

County: HUMBOLDT Date: 5/6/20

	Fiscal Year 2019-20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Housing, Outreach and Mobile Engagement (HOME) (formerly Rapid Re-Housing)	1,252,513	379,943	167,379		244,691	460,500
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	189,179	121,074	68,104			
Total INN Program Estimated Expenditures	1,441,691	501,017	235,483	0	244,691	460,500

FY 2019-20 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Funding

County: HUMBOLDT Date: 5/6/20

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

FY 2019-20 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Funding

County: HUMBOLDT Date: 5/6/20

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

State of California
Health and Human Services Agency

Department of Health Care Services

MENTAL HEALTH SERVICES ACT
PRUDENT RESERVE ASSESSMENT/REASSESSMENT

County/City: HUMBOLDT

Fiscal Year: 2018-19

Local Mental Health Director

Name: Emi Botzler-Rodgers

Telephone: (707) 268-2990

Email: EBotzler-Rodgers@co.humboldt.ca.us

I hereby certify[1] under penalty of perjury, under the laws of the State of California, that the Prudent Reserve assessment/reassessment is accurate to the best of my knowledge and was completed in accordance with California Code of Regulations, Title 9, section 3420.20 (b).

Emi Botzler-Rodgers — Local Mental Health Director (PRINT NAME)

Signature

4/19/19 — Date

[1] Welfare and Institutions Code section 5892 (b)(2)

County of Humboldt
DHHS - Mental Health, Financial Services

Calculation of maximum Prudent Reserve Level
FY 2018-19

29,260,481	Jul/2013 - Jun/2018 all components
22,237,965	76%
4,447,593	**5 year average per DHCS**
1,439,391.20	current PR balance
32%	PR % of 5 year average
28,314.50	(Over) / Under 33% limit

Attachment 4
Stakeholder Meeting Themes

Stakeholder Meeting Themes

More funding, support and improvements needed for:

Theme	Community Meeting	Phone, Email, Form
Expand/increase access to services * Streamline * Increase outreach programs * Tele-Doc for mental health * More counselors, more psychiatrists * More residential care teams and services * More programs for juveniles * Expand SV and CSU for more beds * CSU for minors in a different location * Provide MH services to people with disabilities	CIT Review Group Eureka Community Family Advisory Board Youth Advisory Board Tribal Directors Northern Humboldt	Phone Email Comment Forms
Workforce support * 0-8 population * Clinical experience and education for HSU graduates * More funds for professional development * Flexible schedules for staff * Better retention strategies * Career advancement support to build skilled workforce in Corrections, LE and medical * Support to get clinicians to work in jail * Use WET for teacher and faculty training to recognize mental illness symptoms	0-8 MH Collaborative First 5 Humboldt CIT Review Group Northern Humboldt NAMI Eureka Community Tribal Directors Youth Advisory Board Behavioral Health Board	
Continuity of care for clients released from SV, CSU and jail, and other transition services * Warm hand off * Include residential housing options to increase flow in system of care * Day treatment center needed * Step down unit * Include family to extent possible--outreach, provide lots of information on first diagnosis * County needs to run new residential program, not contract it out * More Board and Cares needed, and County should develop them	CIT Review Group Behavioral Health Board Family Advisory Board NAMI Tribal Directors Southern Humboldt Northern Humboldt	Comment Form

Increase support for youth * Not yet TAY age * TAY * Curriculum for students to know how to determine for themselves if they need help * First break support * Crisis support for children and families * Strengthen continuity of care for families	Eureka Community NAMI Northern Humboldt Youth Advisory Board	Comment Forms
Services for early childhood * Therapeutic nurseries and preschools *Trauma centers, trauma informed environments * Parent education, home visiting, playgroups, infant, early childhood & family education, Nurse Family Partnership could all be supported * 0-8 Collaborative at risk of folding *Extreme behaviors in children K-3rd grade; need attention *Ger more data on # of children with SED, and # of children without SED but in need of services to pursuade support of early childhood	0-8 MH Collaborative DHHS/Education Leadership Group First 5 Humboldt Northern Humboldt	Comment Forms
Housing and Services for those experiencing homelessness * Build more supportive housing * More support services * Work with rental companies to overcome barriers for people	Behavioral Health Board NAMI Tribal Directors Northern Humboldt	Comment Form
Support groups and peer support * Expand Mother/Woman groups * Pay peers to tell their stories * DHHS sponsored with paid facilitators *Anyone with MI could attend, not just "depression" group	Eureka Community Family Advisory Board Hope Center Behavioral Health Board	
Law enforcement partnerships * List of services for LE; pocket sized resource/flow chart * Clarification of policies * More training for LE on working with mentally ill *Increase community collaborations	CIT Review Group Tribal Directors Northern Humboldt	Comment Form
Transportation for clients	Hope Center Tribal Directors	Comment Form

Increase support for seriously mentally ill * Those with anosognosia (lack of insight into illness) * More assertive care treatments * Expansion of CCT * More case managers and other paraprofessionals *Occupational support, supported employment, sheltered work	Behavioral Health Board NAMI Eastern Humboldt County Services	
Provide clarity about what County MH services are provided * Clarity about navigation of and access to the systems	0-8 MH Collaborative Eureka Community Tribal Directors	
Hope Center improvements * Relocate facility to more accessible part of town, downtown, far from SV and CSU *More activities, more classes * Full-service kitchen work programs * Improve facility, make it larger	Behavioral Health Board Family Advisory Board Hope Center participants	
Bilingual and Culturally Competent Services * Funds should be given to K'ima:W to hire staff and provide services to be culturally competent * All MHSA funds should be given to tribes as they are the outlying communties	Eastern Humboldt County Services Tribal Social Services Directors	
Mental Health Counselors at schools	Eureka Community Youth Advisory Board	Comment Form
Substance Use Disorder Services * Include youth under age 18 with co-occurring SUD and MH issues	Family Advisory Board Tribal Directors	
Expand SV & CSU using Capital funds	Northern Humboldt	

Positive Program Comments

What	Community/Group
Felt TAY was a great service model for those in foster and youth service; wish TAY was in more cities	Northern Humboldt

Critical/Negative Comments

What	Community/Group
Mobile Outreach: People want clarity about what is provided; no services are provided, just outreach	Tribal SS Directors
Outreach from County isn't effective--too limited	Eastern Humboldt County

Local MH Crisis line was not answered over Christmas	Eureka Community meeting
A lot of money is being spent on Parent Partner Program and a small number are being served	Eureka Community meeting
MHSA funds need to be better prioritized	Eureka Community meeting
No Place Like Home takes money from client services, and the County is too controlling of NPLH dollars	Family Advisory Board
No MHSA investment in early years. ACES grants are not sustainable	First 5 Humboldt

Attachment 5

Notes from Stakeholder Meetings and MHSA Comment Email/Phone Line

Attachment 5
Notes from Stakeholder Meetings and MHSA Comment Email/Phone Line

Hupa FRC Network
November 4, 2019

- Participants provided no feedback after presentation

Behavioral Health Board
November 21, 2019

- Would like to have a stakeholder meeting with flip charts, go into subgroups, write up people's thoughts on the flip charts, have people move around
- V. Price will take community surveys out wherever he goes
- Idea: go to free meal to do surveys. Contact Brian Olson
- Tim Ash: Board needs to digest the information. Come back in January to get their comments

---

Eastern Humboldt County Services
November 22, 2019

- Services and funding provided should reflect the head count of people living in the region
- How do you submit a proposal for MHSA dollars?
- Give them the funding, let them hire the staff, provide the services. The outreach from the County isn't effective. Not that County staff aren't doing a good job, but it is too limited.
- Use paraprofessionals, don't always have to have clinicians. First 5 Humboldt Measure S money is an example of using paraprofessionals
- Would like TAY to come out to Hoopa. Jet will see about having YAB come out and speak
- Any information on training that people could attend: send flyers to Shannon Wilhite or to dori.marshall@kimaw.org

---

Southern Humboldt Working Together
December 4, 2019

shwt@googlegroups.com is the email group for Southern Humboldt Working Together (SHWT). They are trying to get SHWT back to a non-profit status. There is a Facebook page, but hasn't been updated in a while.

Input:

- More services are needed in the jail
- There needs to be training and outreach about housing first concepts. [Note: Laurel Johnson contacted Robert Ward about doing a presentation. Robert said he would be happy to do one, but didn't know that it would help with NIMBYism]
- How does MHSA work with NAMI? Responded that NAMI provides input into the MHSA Annual Updates and Three Year Plans, and have a meeting scheduled with them in January
- Needs to be some work done in helping people apply for SSDi
- Julia would like to help with getting the word out more about the community survey. [After the meeting I sent her the press release so she could contact KMUD.]

Attachment 5
Notes from Stakeholder Meetings and MHSA Comment Email/Phone Line

---

DHHS/Education Leadership Group
12/9/19

No one provided any input after the presentation. However, the presentation about Humboldt Bridges to Success provided some information about needs that can be used:

- 155 referrals to Bridges this year
- Out in Hoopa, the Navigator (Christy Colegrove) has such a long standing relationship with families in the community that she hasn't made any referrals to the program. Instead, kids come to see her and she is able to connect them to services/supports without a formal referral to the program. The number she's connected with isn't included in the referral count
- The majority of referral have been for children kindergarten-3rd grade
- Referral have been for really extreme behaviors
- Past trauma is a big issue
- Also an uptick in referrals for foster youth

0-8 Mental Health Collaborative
December 9, 2019

- Slots for 0-8 MH Collaborative trainings are filled right away. This shows the need for trainings that impact workforce development and retention
- County MH has problems with staff being inexperienced. They are "green." HSU isn't providing clinical experience or education
- There is a struggle with finding staff who are willing to stay. They aren't allowed to have alternative schedules, have flexibility.
- Some counties can pay differential pay to those with 0-5 expertise. That isn't possible here.
- We need better retention strategies
- There is new legislation regarding universal screening for ACES—how will this affect MHSA? And if people are screened, and then there are no services to which to refer them?
- Need therapeutic nurseries and preschools. Partnership between several agencies could make this happen.
- A trauma center is needed
- MHSA was supposed to fill in gaps in the mental health system. There should be a continuum of care, starting with nursery/preschool, all the way through age groups
- Need trauma informed environments everywhere
- Need to make it clearer how to navigate the systems, what do services do? How can we make this easier for people to understand? 211 was supposed to do this.
- The 0-8 Collaborative is at risk of folding. It needs funding to continue.

Family Advisory Board
December 10, 2019

- Need a support group for people—MH clients and others in the community who could benefit. Anyone with a mental illness could attend—not just a "depression support group" or any other

specific diagnosis. Needs to be DHHS-sponsored with paid facilitators. A peer support specialist would be a good choice to facilitate the group. Note: members of the group thought there could be a group similar to this at the Jefferson Center already, but even if there is more are needed.

- Need a Hope Center-like place in downtown Eureka or someplace that is far from the campus where SV and CSU are.
- We need a CSU for minors in a different location. There are big issues when a minor comes to the CSU, as no adults can then be on the unit. Causes a backlog.
- There are issues with getting rentals because of the practices of the company Real Property Management.
- No Place Like Home takes money from client services.
- The County is too controlling of NPLH $.
- Need a place, a step down unit, or transitional housing, or transitional shelter, for people to stay upon discharge from SV. A place to be for a while to stabilize. Families often can't handle it. Phoenix AZ has a model that is really good.
- Need substance use disorder treatment for youth under age 18 with co-occurring SUD and mental health issues
- Need family focused services. When someone on CSU or SV, need way to outreach to families—a visit, phone call, face-to-face meeting. Staff need to do this. Need a systematic way to give and get generic information, a family/patient system to share. Questions regarding when an ROI is needed. Need outreach to parents of young children when mental health issues are first identified, need to provide a flood of information on first diagnosis.

Hope Center Community Meeting
December 17, 2019

- Transportation: need to be sure to continue the transportation on MWF; transportation is critical to reducing social isolation.
- Need to have support groups for people who no longer have their biological families
- Need to have more classes:
    - Exercise/physical activity/ways for people to be active
    - Nutrition
    - Job preparation
    - Classes that help people integrate into the community
- Need 12 step no smoking programs
- Need to focus on environmental justice, the environment itself
- Don't want to be served in the older adults program; want to continue to come to the Hope Center [It was explained that participant could continue to come to the Hope Center even if being served in Older Adults program]
- Need a bigger building
- Case managers need to be available more than once a month to clients. Some programs have policies that a client can ask for assistance from a case manager only one time per month
- How much money is unexpended from the MHSA budget? [I do not know the answer to the question and said I did not know]

Attachment 5
Notes from Stakeholder Meetings and MHSA Comment Email/Phone Line

---

HCTAYC Youth Advisory Board
01/07/2020

- There was no participation from this group in the community survey as of the date of this meeting. A few filled out the form and returned during the meeting
- Access to timely service from time of enrollment to counselor or front line staff
    - Stakeholders claimed time from as little as a month to four months to access a counselor after a traumatic incident
    - More counselors are needed
- Questions about access to homeless services potentially funded by MHSA
- Need services focused on services to queer community
- Need for crisis intervention counselors in school
    - They feel it is deficient
- Concerns about VA services and how it handles individuals with preexisting conditions that are exacerbated by military service, but not created by their military service. VA won't treat them, because they say the conditions weren't created by the military service.

NAMI Humboldt
January 8, 2020

- Regarding the Adult Residential program that is new in the Annual Update for 19-20: This needs to be for people who are not on conservatorship. Why isn't County running this program themselves instead of contracting it out? We need more Board and Cares, and the County should develop/run them.
- There are so many layers of administration. Too many requirements.
- There needs to be more funding for CCT. There's not enough now.
- We need more housing.
- WET dollars should be used for teachers and faculty training to recognize mental illness symptoms. There should be a curriculum for them.
- There should be a curriculum for students as well. They need to know how to determine for themselves whether they need help. A guide should be developed for students that includes symptoms of mental illness/distress, services available. [Some conversation about whether or not HSU has a program on campus that does this.]
- Having a job, having work—this provides structure and is good for people. Supported employment opportunities should be provided for people, like what the Regional Center has for developmentally disabled people.
- Have something like Welfare to Work for mental health clients/consumers.
- Need to focus on "first break" both for consumers and family members. Family could also include faculty, staff and the workforce. Everyone needs to be educated.
- There needs to be contact between the family and staff (when someone gets admitted to CSU or SV) to give connection to the family as to what is going on with their loved one. Hire someone to focus exclusively on SV and CSU. Their sole job would be to develop rapport and connect to the family.
- SV doesn't give medications when someone leaves. Then they have trouble getting their meds out in the community. Meds should be given to people before they leave SV.

- There should be a structured follow up process for those leaving SV, CSU.
- Parents/family members need to be really educated on symptoms and the long term prognosis when a loved one is hospitalized and diagnosed. Tell the truth about it, the full truth.
- There should be a post treatment step down facility, a plan, a 3 day place to stay that has education and support. Not a hospital. Family can be/is involved at this stage.
- Reference to [and it was read aloud] a comment made on the community survey.
- Need to have Laura's Law here, but also something that isn't as strict as Laura's Law.
- There needs to be more help for those who have no insight into their illness. There is a lack of treatment for those without insight.
- There are a lot of issues with the County not doing its job.
- Need assisted outpatient treatment.
- There are not enough case managers for outpatient treatment.
- A new mental health diversion law—Humboldt County is going to apply for the money in the future.
- Need to bring back the day treatment center. There was art therapy, counseling, a psychiatrist was available. This is evidence based.
- A lot of people don't fit in at the Hope Center, so need a day treatment center.
- Need step down treatment of all kinds.
- Need more crisis appointments with a doctor to do a medication adjustment. People need to have meds when they need them and not have to wait for an appointment.
- There needs to be a walk in clinic that can serve people when they need it.
- We need alternative housing types, and safe parking, and camping
- Jail releases need just as much help as those leaving SV. They need step down treatment as well.
- Need to have structured release from hospital and jail.
- Need aftercare., like having home health/public health nurses visit people after release.

First 5 Humboldt
January 9, 2020

- There is no adequate investment by MHSA in the early years. Other counties in the State make this investment, but Humboldt does not.
- ACES grants, which First 5 does in partnership with DHHS, are not sustainable. These are small amounts of money. This is not adequate investment in the early years.
- Prevention is critical. We need to "turn off the tap" to reduce the need for secondary and tertiary services.
- Child care workers and early education providers are now feeling unable to address the increasing needs of the very young. Those working in the profession are leaving, or are under a lot of stress. The issues children are presenting are serious. There is a lot of acting out. What do you do when using "consequences" for behavior modification doesn't work?
- In other counties, MHSA dollars contributed to funding the Nurse Family Partnership program.
- Funds are needed to support parent education, home visiting, infant, early childhood and family education.
- Playgroups could be supported by these funds.
- WET funds could be used to support the 0-5 workforce.
- Home visiting support is needed.

- When children are in foster care they and their foster families receive a lot of support and funding. If those children are adopted, though, all that support ends. Continuing support needs to be provided to those adopting children. Otherwise it discourages adoption.
- Need to get data on the number of children ages 0-8 with SED. That would give a picture of the need, and then maybe DHHS would be more likely to provide MHSA support.
- Is there a survey that could be done to find out the number of young children who don't have a SED diagnosis, but who have the need for services?
- DHHS could consider a split in the MHSA funding, with a certain portion going to true, primary prevention, prevention that happens before symptoms occur. Carve out a portion for just primary prevention.

CIT Monthly Review Meeting
01/09/2020

- Development on what or how police need in order to handle MH clients
- Need list of services law enforcement can use
- Clarification of policies with law enforcement (LE)
- Creation of a pocket size and standard size flow chart for officers
- Training for law enforcement in dealing with mental health clients and staff
- Access to services is inadequate
    - Streamline service to speed access
    - More outreach programs to assist LE community efforts
    - More programs for juvenile clients
- Expanding Access teams for getting into system of care
    - Opening access to care
    - More residential care teams and services
    - Jail support and resources for people coming out of jail but still needing care
    - More resources in the jail
    - AOD step down for LE
    - Finding funds and allocation to facilitate a step-down unit
- Limited space at SV; they are regularly in overflow
    - Expanding bed space for SV
- Communication for shared system of coordinated care
    - So Open Door could work more efficiently with MH/SV
    - Clear HIPAA Regulations
    - Struggles in outpatient med support
    - Nurture PHD relationships to attract a full spectrum of qualified medical staff
    - Lack of coordination presents risk to families in the long term
- Expand CSU beds
    - Ongoing Project
- Create robust residential program to help system of care flow
- Target career advancement support to build greater pool of skilled medical labor in various roles
    - Particularly in Correction and LE related systems that would overlap with MH clients
    - Find clinicians to work in corrections

- E Range is a relatively new service to the community that is providing residential services to VA clients
    - Providing care to VETs in from homeless services to residential care
    - Brochure provided

Tribal Social Services Directors
01/10/2020

Procedural Notes:

- The County needs to do its due diligence in dealing with sovereign nations as each is independent of the other
- Notices need to be sent to individual sovereign tribes so they can choose who to send as representatives

MHSA Programs Feedback

- Stakeholders present were looking for an account of unencumbered monies
- They would like to see an estimate of funds per program per year in next 3yr plan
- Rose/Mobile Outreach
    - Need outcomes in how Native Americans are being served
    - Clarification on how it affects Sovereign Tribes
    - They feel the program details are vague
    - How or what counts as service and what services are actually provided on the bus is not clear
    - Bus does not come out to Bear River or Trinidad Rancheria
    - They do not like that mobile outreach only provides referrals into Eureka. No actual services are provided on the bus
    - Need for community access and engagement
    - No consistent service and the community wants it
    - They feel access to community services are critical for Native Americans
- Telemedicine
    - Clarification into what this program provides
    - Considered ineffective for most except those who are high functioning MH Clients
    - Not culturally appropriate
    - Missing equipment and broken infrastructure
    - Facilities not up and running or properly staffed
- Not clear on how Native Americans are identified in med records and data. [Cathy explained Client Information Forms are completed by clients, so self-identification]
- They want data outcomes or reports to reflect areas served with respect to Native American Populations / More focused reports with Native American information

General Program Comments

- Services need to be located on tribal lands
- MH clinicians need to be on site
- Too hard to access the mental health network for rural populations
- Roadmap to services is not effective

- Streamline intake services
- Need to offer services through MH. MH refers people to tribal services once they find out someone is Native American. MH should be providing the services if a person wants them
- Services not reflective of tribal needs
- Tribes would like direct line into MH services, someone specific to call when they have need
- Tribal Council wants participation and relationship building from MH Administration
- Tribal Communities are the outlying communities of Humboldt County. MH is not effectively serving Tribes and Sovereign Nations
- More collaboration with health services and tribal services to build future plans to build bridges for multi-agency collaboration
- Flow of services after discharge from jail. Need discharge, step down plans
- Community leaders would like data outcomes on housing and M.I.S.T programs
    - How Data in these programs reflects service to Tribal peoples
    - Potentially a tribal outcomes report for Native American community
    - Trinidad MIST program not effective [Could not get clarification on "Trinidad MIST program"]
- Lack of housing for Native Americans in CWS reunification efforts creates instability in homes and challenges for the MH and CWS services that serve them
- Requested funding sources to create better housing options
- Zack Brown, Trinidad Rancheria, presented description of multi-agency project to see a residential in-patient service with transitional housing built in, on Tribal lands or in collaboration with tribes, to serve the area needs
    - It would build or house a tribal rehab center
    - Create tiered system for services with transitional stages
    - Partnership in creating community based efforts
    - Create a committee with MH Admin, United Indian Health Services, County efforts, Tribal Directors.
- Will County accept proposals for MHSA funding?

Eureka Community Meeting
January 14, 2020

- The local MH Crisis Line was not answered over Christmas. Humboldt 211 tied the line several times and it was not answered. They had some people call who were experiencing suicidal ideation. They had to then connect the people with a national hotline. 211 Director stated that if provided additional training, she would have her staff answer the Crisis Line for MH. She is staffed 24/7/365.
- Another person in the room has had the same experience with the Line not being answered. He says 8-12 unhoused people over the past several months have reported calling the line and it wasn't answered.
- Mother/Woman support groups are very beneficial to those attending. 211 Director, who helps organize the groups, has tried to get someone from MH to come and talk to groups, but no one will agree to come unless they are paid to do so.

Attachment 5

Notes from Stakeholder Meetings and MHSA Comment Email/Phone Line

- Mother/Woman groups should be expanded. There needs to be more of them. The current groups are full.
- Younger youth, not yet TAY age, need to be supported. Could unexpended MHSA funds be used for this? TAY also needs more support.
- People should be paid stipends for sharing their stories. Stories from peers are powerful and need to be shared with the community.
- The counselors who are in schools—this is a good thing, and needs to be continued. More are needed though.
- Mental health services should be provided to people with disabilities.
- Don't use the word "handicapped." When describing parking, use the term "accessible parking."
- Parent Partner Program: This is a lot of money to spend for the number of people served by the program. Should re-evaluate the need for this.
- In the handout for MHSA Current Programs, include the number of people served by the program to make it easier to understand. Also include, if available, the # of services provided.
- People are really unclear about how to access MH services. How do all the pieces interact? Need a roadmap of the system. Need a better way to navigate.
- Counselors aren't available, can't get on lists.
- Access to counselors takes a long time
- North American Counseling Services is a new group in town that will hopefully increase the amount of counseling available.
- Need a "Tele-Doc" for mental health just like for physical health
- Need more psychiatrists.
- MHSA funds need to be better prioritized.
- MHSA funds should support more support groups. National Institute of Mental Health statistics show that support groups are a good strategy.
- Peer support provided by support groups is good, but counselors are needed as well.
- More funding should go to professional development for those working in the system, or encountering those with mental health needs. More money for training of staff should be available, so that people can attend trainings. Example of how DHHS would not allow interested staff to attend the Hoarding conference unless they paid their own way. Maybe there are grants available for training that could be accessed.
- More dollars need to go towards prevention, especially for the very young.

Behavioral Health Board
01/23/2020

- Increased support for seriously ill clients
- More assertive care treatments
- Better continuity of care for clients released from jail or corrections
    - Better flow of care after release from SV and jail more of a "warm hand off" type of support to better navigate the mental health system
    - Expansion of CCT
    - More case managers

- More case managers adult outpatient seems overwhelmed
    - Create opportunity for occupational support
- Larger Hope Center
    - More activities
    - Public trainings to educate public of mental health concerns
    - Create a semi full-service kitchen work programs
    - Improve the facility
    - Relocate the facility within better bus routes
    - Or relocate bus routes
- Build more supportive housing
    - Increase availability of funds to build/renovate/repurpose housing in the area
- Increase support to homeless support services
- More transition services for those that need it
- Better occupational support services to the community

Northern Humboldt – Blue Lake FRC
01/24/2020

- Help finding sheltered work for MH Clients
    - It gives people a sense of purpose and worth
    - Could help with flow out of jail/corrections and SV
- Fund expansion of capital project to expand SV/CSU
- Fund immediate crisis support for children
    - Support for families of children with immediate crisis
        - Especially when out of county relocation is required
    - They feel there is not even a place to refer people to
    - Strengthen continuity of care for families in crisis situations
- Improve staffing efforts
- Training staff/clinicians to be ready to support clients
    - Quality of care/staff behavior concerns
    - Find more community clinicians and case managers
- Improve homeless support
- Mobile outreach support to Blue Lake community
- Create and or increase residential mental health support services
- Decentralize services back into the local communities and rural areas
    - Increase access for those that can't get to and from Eureka
- More Law Enforcement support and partnership for community support
- Support services in schools for kids whose parents/guardians may need mental health services
    - Secondary Trauma Support
    - Train school staff to recognize signs in a child that could show that services are needed
- Tay has been very important service for youth and foster system that should be expanded into rural regions
    - Expand TAY services by creating more centers throughout Humboldt

Attachment 5
Notes from Stakeholder Meetings and MHSA Comment Email/Phone Line

MHSA Comment Email and Phone Line

- More outreach needs to be done, and there needs to be alternative treatment available so people won't have to put poisons into their body.
- She is a disabled person who is concerned about the abuse perpetuated by the medical community on patients, including mental abuse. She said there was a radio show on KMUD that evening from 7-8, a call in show called Politically Correct Week in Review with Paul Encimer, where the focus was going to be on medical abuse. Said "if you care, which you probably don't, you can listen" to learn what people really experience. She had a counselor but the counselor stopped seeing her.
- The MHSA Older Adults position is currently halftime. It offers outreach and education to the over 60 year old population in the entire Humboldt County region. This county is vast and resources are limited. During 2019, referrals were received for over 180 individuals requesting services. Much of what the job entails is increasing access to underserved groups and offering a resource to address mental health needs. Referrals are primarily received from APS, IHSS, and other HCMH programs. Many of the referrals are complex and often require involving greater levels of services (hoarding, grave disability, homelessness, severe medical issues). Often, MDT's are held for these referrals and extensive follow through is essential which usually includes additional referrals to outside agencies. There is a great need to partner with the outside agencies to promote interagency collaboration and to offer advocacy, interventions, education, and outreach. The need is greater than this half time position can manage especially as the 60 plus population continues to expand. Please consider expanding this part time position to a full time opportunity.
- I would like to say through my experience patients need more advocacy. It's too easy for doctors to manipulate patients with no recourse for the patient. My psyc doctor mistreated me. And now that my mind is back to normal I'll report it. But he has already moved on to another state.
- I attended the Behavioral health Board meeting on the 23rd of January, 2020. The most impressive portion of the board meeting for me, was the presentation by Julie Przepiora, regarding the necessity of Trauma Informed Care(TIC). I have noticed that this was lacking in my experience with the mental health system and Believe it is imperative to implement this into the system Throughout Humboldt county hospitals and services.

Attachment 6
Community Survey Themes

Expand/Increase Access to Services
More public depression management and similar self help technique education-somewhat important
I absolutely believe that more mental health services should be handled for people in the jail, otherwise we are just going in circles. There are many people that I do substance abuse assessments for that have mental health challenges, trauma, PTSD, yet there is not help. We are treating substance abuse, but not mental health.
More mental health providers in the community
Average people cant get help. Only the really bad ones. The people that could lead relatively normal lives with help are left in the cold
More mental health psychiatrists for both adults and children (absolutely essential), housing programs/assistance for mental health patients (very important), wellness activities (somewhat important), medication assistance/funding (absolutely essential), substance use treatment facility that accepts minors (absolutely ESSENTIAL)
A larger county facility with more bed space.
Increase group outpatient options for community members. Creation of intensive outpatient program for daily outpatient support rather than relying on prolonged hospitalization
Therapists and group therapy for those on MediCal but not members of CCT or conserved.
collaboration with churches and/or ministries that are serving the mentally ill/homeless, such as the eureka rescue mission, Remi Vista, and the other one I can't think of.
Affordable care is a 5, essential.
More mh counseling in southern Humboldt that takes medical insurance
Housing, SUD, MH services (counseling and medication), and active participation w community partners. Outreach to disadvantaged communities (not just Eureka focused efforts).
This county needs to have funding to help expand the emergency services at SV so that dangerous clients and youth can be housed separately so that the facility does not go into diversion. The facility also needs more beds and more staff.
Access to early diagnoses. Absolutely essential!
Therapists at support groups not just the lady who thinks she knows about mental health
I think there needs to be a quicker in and out for patient that don't need to be committed but are in a time of crisis it's absolutely essential. Easier access for care givers to speak with doctors/nurses is absolutely essential
Counseling services at County MH Rather than just medication management
We need more MH services across the board
Please don't forget Southern Humboldt :)
Find a way to get TMS (Transcranial Magnetic stimulation) or ECT (Electro Convulsive Therapy) therapies in Humboldt County
If the Hope Center is able to expand, consider placing Hope Center activities at a new Day Center located near Old Town: Very Important Provide mental health clinicians in the field and where at risk populations are located (i.e. St. Vincent de Paul) for easier access to assessment and support services: Absolutely Essential
Absolutely essential: services designed to facilitate connection and reduce isolation for people of all ages
Expanding options for tele-medicine with MH providers due to limited access for rural populations
Specialized family and caregiver support for trauma impacted families.
Need more early intervention services for parenting adults with ACES
People can't get in to counseling. We also do not have adequate face to face psychiatric access, many people don't like telephone-video psychiatric care

Expand/Increase Access to Services
Psycho education support for the community; understanding how to support community members with mental health issues as a fellow community member; ongoing mental health services to avoid crisis level needs and after crisis ongoing treatment to prevent recurring crisis
Partnerships with/financial support of those organizations doing vital work in outlying communities, particularly when funded county positions/programs are not filled.
counselor that addresses Post Partum Depression and is embedded with Nursing programs.
Clients need a case manager to assist on an ongoing basis.
More access to mid-level Mental Health Treatment including 1:1 counseling with Clinicians
Medical care available to all- currently being told doctors are not accepting new patients. It's incredibly difficult EVEN WITH FULL COVERAGE insurance to find a doctor/therapist/counselor. Waiting periods are 3-6 months to get appts. Unacceptable.
Most children need mental health support and parents also.
There aren't enough psychiatrists here. So people with chronic mental health disorders have to go to their doctor or more likely a nurse practitioner to have a prescription written for them for an anti-depressant. Some of these medications have potentially severe side effects like suicidal thoughts, but there is no one monitoring these patients after they get their medications. I speak from personal experience on this. If someone has a biochemical disorder causing debilitating anxiety or depression, mental health counselors can only help so much if it is medical treatment that they need for the disorder. These people are often on their own to self-medicate with drugs and alcohol because there are no psychiatrists available to help them locally. The few that are here only take private insurance, so if you only have mediCal you have no access to psychiatric care.
Early intervention, parent & professionals MH support needed.
When people are having severe mental problems in rural areas, we, as a community, feel very unprepared for how to handle the situation.
Seems like housing is most important. Then psychiatric care, substance abuse treatment, and counseling, including life skills/job coaching, on the job training opportunities and support.
Outreach in rural communities. And long term commitments to get out of Eureka and serve rural communities to build relationships and not just "check-in" for an hour between staff meetings in your Eureka office.
I would like to see more outreach to get regular service providers in the area (Willow Creek, Hoopa, Orleans). If anyone wants services for themselves or family members, they would have to find providers out town, which isn't always possible because of hours of operations and online options aren't covered by insurance.
Teens in Southern Humboldt and the far Northern Humboldt areas (Hoopa, Willow Creek) need more services!!!
More supports and MH services in very rural portions of the county: Absolutely essential.
Dual diagnosis treatment (substance abuse and mental illness address together) = absolutely essential
Support families dealing with mental health issues
Prior to housing we should have many day centers for washing and sitting getting mail and haircuts and laundry and doctor visits
We need accessible Mental Health resources which take Medi-Cal insurance. A majority of people in Humboldt county are on Medi-Cal as their primary insurance but forgo mental health or medical treatment because they can't find a facility that will take them.
Support for early childhood educators and their programs and families, more counselors for young adults and older adults in which insurance will cover, more suicide prevention programs.
The county needs to increase the mental health services provided to the prisoners in the county jail
Mental Health is a huge issue across ages and generations. We need as many service options for as many people as possible to help break the cycle and address underlying issues.
increase capacity of local MH facility
More board & care and other supportive congregate housing facilities
Ensure that there is accessible counseling for low income families (rank: Essential)

Expand/Increase Access to Services
I understand that there are NO facilities in Humboldt County. where children can stay even temporarily, when there is a need for MH treatment. The children's recovery will be enhanced by their parent's proximity and ability to visit and reassure, and the parents will be relieved to have the opportunity to check on their children. Keep Humboldt County dollars in Humboldt County.
More Classes
more out of the box non billable services Leadership training for the community Look at what shasta co is doing the have an 8 day training leadership institute for the community
transitory systemart worka group money class
Free low cost therapy/counseling training to law enforcement housing crisis
Family Resource Center
integrated physical medical care with MH DR Clear Concise transportation information on all client options streamline grievance procedures make bad employees accountable and keep records
Evidence based supported employment
Specifically sober transitional living where families are allowed--5; inpatient treatment where families are allowed--5; community consent to coordinate easier. Very difficult to find MH providers for people that are not MediCal or Partnership. Many support staff fall into this group. We need to care for people who do the caring
Services centered in areas where the population and needed is Day Center would be helpful Do not support telemedicine prefer 1 on 1 contact
Adults on to one counseling very important as MH Patients cant see psychotherapist outside county mental health
more urgent need MH Services, something between SV and regular MH Support Expansion Semper Virens
No barriers to receiving care. Expand services, hire more people, decentralize service locations, meet people where they are, do home visits, help them make a safety plan if SV doesn't have room, don't just deny them services (we know the denial of services by MH has contributed to deaths by suicide - don't close the door on people who are asking for help, find an alternative service and offer it)
In Southern Humboldt it is essential for the unhoused to have a day center and eventually some type of camp, where they can shower, wash clothes, receive referrals, use the internet and have a hot meal. This is a community wide issue - it effects all of our health & safety.
More positive projects like the Jefferson Center to engage people and make them feel useful. More facilities like Napa for those who are dangerous to self and others. More beds locally for minors with severe issues since this problem seems to be rising by leaps and bounds. Offer more hands up not hand outs
More mental health professionals available for timely appointments
Wellness centers outside of Eureka, with transportations (shuttle) to wellness centers
More providers, more appointments and more locations. Creation of satellite sites throughout the county to increase access. More psychiatrists so people having sever mental health symptoms don't have to wait 3 months to be seen for a medication consultation. A center devoted to minor children and young adults who require hospitalization and overnight treatment. More services to address eating disorders.
More availability when people are ready to participate in services

Expand/Increase Access to Services
More providers
Increased field nursing and home visits
More doctors and counselors
The county needs to divert funding to expand mental health. Not just a new program with a cute ackronym, but build out Semper Virens. Make room for more beds and staffing. We have outgrow our current facilities, and it makes staff unpleasant and keeps everyone from reaching the desired goal.
if we cannot get service providers locally can we utilize more telehealth,
More MH workers to meet the needs of poverty and addiction problems in our 0-5 families. More MH workers for outreach in our homeless communities. More housing for our shelter deprived people that would have MH services built in.
More and longer services.
Locations set up for services in tribal communities for screening and prevention as well as support groups after a diagnosis to discuss things such as the dangers of alcohol and drug use, especially marijuana, combined with prescription drugs
Just having a program and resources for all levels of MH
More people to help others
Mobile MH to rural area's such as Bridgeville, Whitethorn, Shelter Cove, Whale Gulch
There needs to be more programs with availability, programs that are can work with people with dual diagnosis, closer to central social services, more partnerships with non profits who directly work with those experiencing mental health issues (st. Vincent de Paul, betty Kwan Chinn day center, eureka rescue mission)
More family counseling opportunities, local child psychiatrist
More recovery services for mentally ill/drug addicted in addition to long term in home support. We need services for children 0-3 for behavioral support
A mental health crisis response team that can be dispatched in lieu of law enforcement. (See CAHOOTS in Eugene, OR.) Could we start trying to organize something like that here?
Provide low cost therapy appointments
More availability for appointments/services, education, campaign to reduce stigma
Additional clinicians
Mental health response team that responds to mental health crises instead of armed cops
Pop-up or temporary intake stations on Broadway, Old Town, and marsh areas. Faster and more aggressive intervention in keeping elders in homes. A better liaison with courts and probation departments.
More therapists, more free and low cost detox services, more housing
Mental health hospitals
peer support training; outreach to homeless (partner w law enforcement), more local services (not just in Eureka)
Adult case management should be given to all people who go to sv, for at least 4 to 6 months after dc. Hope center should have programming that helps ppl get to appointments and supports all ranges of functioning, not just the most needyAll adult system administration above tay, should be shuffled off to other departments. Im sure they work hard, but they dont care about clients and it shows in the programming and staff training. All line staff should have training 4 times a year. Not from drug companies or from programming spokespeople...we're here to sell you our latest "evidenced based blablabla."
Very large rehab center for long stays if necessary.
A compassionate proactive approach. Outreach to all the nooks and crannies of this County. I've lived in many varied places in this country, this lovely place has many struggling people.
More prevention/education around resources available in our community, more beds in a better staffed acute care facility (SV), local residential/inpatient care for those under 18, better reimbursement rates for providers who work in this community so that they can afford to be seeing those who need care

Expand/Increase Access to Services
More services, more counselors, more after hours availability, more long term care and treatment options
Mobile clinics? Regular events/screenings/offerings at host locations?
More services needed overall but, before adding additional services in Eureka, etc. consider new services in SoHum, Willow Creek, Hoopa, etc.
good medication/psychiatric backup for outlying communities' few professional and intermittent volunteer MH workers
More qualified good staff, central location, outreach programs and add to the places clinicians go to for services, schools, church's, community centers, resource centers etc.
Every city needs a mental health clinic. Patients that just need a med adjustment have once place to go in humboldt county and they are booked out for weeks and that doesn't work to care for patients
More services and treatment in the jail. More case management. More mental health doctors.
more case managers, easier access to SUD detox and residential Tx.
Availability increases & cost reductions
more psychologist for counseling
Providing support and mental health consultation to early childcare providers
More crisis and early intervention capacity. Changing what qualifies as â€˜crisis' - some folks may be in crisis without thoughts of harming oneself or others. How do people get critically needed services before they get to that point?
More consumer webinars of MHSA and access California YouTube not just educated but also in power us consumers to make three wise and effective decisions in voiceing our concerns
Access to services in Southern Humboldt.
MH treatment facilities for teens
Restructure some existing Mental Health programs to provide adequate services. Reduce the number of hoops clients must jump through in order to receive services. If someone is having a mental health crisis, a 15 page intake packet is a huge barrier to services.
More pediatric mental health services. Sempervirens is not suitable or safe for children. There is no where for kids to be treated for MH crises, and very few MH providers for children with outpatient needs.
We need more Mental Health providers throughout the County.
Adequate staffing for existing services needs to happened before new services are added
Assisted Outpatient Treatment, Mental Health Courts
prevention
We need more mental health case managers who can help.camilies access services and navifate the dhhs system
invent programs to specifically help middle class not struggle so hard
More clinicians More education to providers in the community
Robust trauma responsive support for pregnant and parenting folks who have been impacted by ACEs. Supporting current Infant-Family and Early Childhood Mental Health and Trauma Responsive training efforts to continue to build a qualified workforce.
more out of Eureka services
Cal-AIM would be a good start.
Treatment programs that address dual diagnosis, in-county residential treatment for youth
Agency offices in places like Fortuna. Having Clinicians who are available to only see Fortuna children at schools.
provide services where people naturally go for supports
On the ground mental health outreach at homeless camps, law enforcement able to make referrals to MH services in lieu of arrest
Increased access to care
More counselors for low income and help with transportation

Expand/Increase Access to Services
Reach out and expand services to more rural locations. Train more individuals, hire more individuals. Reach out t o the university to get people interested in positions working with social services.
A community friendly accessible center that is a resource for navigating services to support mental health.
a wellness center for outpatients that isn't at the clark complex,more beds at sempervirens and staff at sempervirens that interacts with the clients instead of hiding behind a lucite cage at the nursing station where they ignore the clients,their as our population has increased the staff morale leaves a lot to be desired,its very disturbing
home visits, MEV providing counseling in outlying communities.
training, more staff
Free counseling, for anyone who needs it. Cost keeps me from being able to attend regular meetings. This community needs help and needs the help to be EASILY ACCESSABLE. Why would someone in crisis, want to make 50 phone calls to only be told "not accepting new patients." That person is not going to make another call after that, they will just feel hopeless.
access to MH services for all adults and children who need it
More money towards hiring and training clinicians and smaller case loads so individuals with mental health issues can receive the help they need consistently and over time. Six weeks and six appointments for a child to recover from neglect and sexual abuse that has occurred over several years? Really?!
Funding for support and outreach.
Family Wellness Center with an emphasis on providing trauma responsive services and informed by the principles of the MHSA
more community based supports to build resiliency and connection such as play groups and family resource centers
Law enforcement & school professionals trained in trauma-informed practices, psych first aide, etc.; strengthened partnerships b/n schools, MH service providers, law enforcement and medical facilities; proper support and training for MH workers to prevent burnout and turnover; programs and services offered and focused on early intervention.
More programs around early intervention and prevention.
More of the parenting classes
Round the clock services, satellite offices, bilingual staff
A program to mentor in new private counselors.
Prevention and early intervention services. More thorough screening of parents to be and new patients. Education series with information, resources, and destigmatization strategies.
Early intervention, education and support for families
Having counselors and programs in very rural areas.
Home visiting for all pregnant families. Supports for pregnancy and postpartum mood and anxiety disorders. A clinic that serves families during pregnancy until there young children to access therapeutic services. These are true Prevention and Early Intervention activities.
Primary prevention - connecting communities within themselves; Parent and Peer partners to support each other
We need help (more service providers, group settings, etc.) within our community, which is very small. Many people who need help can't get to Eureka or the towns around it. In any case, they need to be persuaded somehow to seek help, no matter where it is offered. Stigma is a big issue in a small community. How can people who badly need help be persuaded to seek it?
Caseworkers/social workers/outreach to people that need help navigation of available services. And just housing and mental health care, incl. SA treatment. (dual diagnosis)
Psychiatry (for prescriptions) and counseling services for families (myself, my s.o., and 2 children all need those services in our area). Both children are autistic and need mh services.
Early intervention prior to full crisis.
Adolescent inpatient support services.

Expand/Increase Access to Services
Remove the opt out for parents when children/families have been recommended for counseling by teachers and/or mental health staff. All foster youth/homeless should have a counselor through 26 years of age. Any family with CPS report records needs family counseling on an on-going basis. The court ordered requirement is a short term hoop that they jump through. It needs to be long term counseling for life change.
Wrap around Wellness Centers on school campuses. A physical place on campus to house community service providers.Social workers and school counselors can work together to provide cohesive support plans and schedules.
A wellness clinic and a place for recovery in Hoopa.
Bus like the Blood mobile to go out to clients
Community awareness of the impact of ACEs & a two-generation approach to Mental Health.
mobile services to outlying areas
More counseling centers that are low cost and grant based for clients, or if medical is the primary funder a lower case load for MH providers. Open to licensed staff to serve the clientele they want as long as it is community based.
Local center locations to drop in when MH issues flare. Consistent Drug Awareness and Substance Abuse Counselors on call - Tough Job!!!!!!
More access to services in our location. I feel like our community would be able to change the stigma.
Timeliness. Inadequate providers in high schools.
Outreach to rural areas. Some of our most remote areas are some of the most in need.
More mental health care providers, support groups for parents/family, earlier outreach in school.
Reduce case loads to enable staff to provide necessary help long term without so much burn out. Train volunteers to assist with support. Longevity in this challenging field would be increased if more positive results of lives actually transformed were seen.
Early intervention
More child providers, better phsy doctors.
limit income barrier, offer more choices in mental health providers and give ut information through schools so parents know where to go to get help.
Fund the ones you have, train your staff better, hire more staff, and address waste in a top-down manner (freeze raises on bosses, always pay staff a living wage plus).
Offer services in schools, churches and community locations health gyms that families, seniors or homeless could access easily. Information or groups in the same locations.
There is such a lack of doctors and mental health services - patients should be able to receive a broad spectrum of services as early on as possible when diagnosed.
More services...counselors, psychiatrists, primary care physicians, etc
More treatment options, cheaper treatment options
mobile clinic services, high school-based services
spend more of the MHSA funds on the most severely ill patients rather than the least ill; don't spend any county money on things like birthday parties for SV until the actual services for patients are being provided
Better and earlier detection of M. I., thus a need for high school and university faculty and staff to recognize the symptoms.
An increase in providers that accept a variety of insurance plans, but also an increase of school based providers.
More services outside eureka
MH counseling and MFT therapy available in my community: Petrolia/Honeydew.
Multicultural approach group setting- educational/therapeutic programs for siblings/extended family. Social skill therapeutic group for individuals with disabilities. Development of peer support groups with inclusive multicultural perspective.
more outreach in isolated rural communities

Expand/Increase Access to Services
More trauma-informed mindfulness based programs available through wellness/health centers, family resources, and in schools
local psychologist in rural ares
awareness, outreach, stop the stigma, have a referal specialist who can help match the right therapist with clients, HAVE INSURANCE COVER YOGA AND MEDITATION classes, as well as other wellness programs, teach holistic health care.
Counselors for rural schools that can meet in the school on a weekly or biweekly time for sessions.
Every foster child should have a regular checkup with a LCSW whether they are problematic or not
Local access to well trained MH counselors
Day centers
Housing, adequate local services
We currently do not have any existing mental health structure to treat a large portion of the community, not just individuals who choose to seek help on their own. Obtaining mental health help is a battle in this area, it means calling dozens of practitioners and asking if they accept new patients or insurance. It means being put on a long waiting list, sometimes being told that it will be over 12 months before the possibility of an opening even occurs and then never getting follow up. We need a large number of facilities with a large number of practitioners which will accept all types of insurance.
Accessible (good) health care providers
A new mental health facility in Eureka as Sempervirins gets full and can not Accommodat patients.
more service in gbv
Mental Health walk-in office in the Old Town area.
Free public transit, at home/with family social work and therapy
Extended hours for counseling and crisis intervention ad prevention
More walk-in services with peer counselors and providers that are not judgmental or condescending.
Eating Disorder supports
The research is out there, there are proven tracks to take to reduce the storms and encourage folks to get help when they need it. We need more mental health services in general in this community.
Level One adult MH clients need to receive individual therapy weekly
We need more housing for the mentally ill, like board and cares.
Service providers that are housed in locations where the clients go regularly. For example, MH counselors that provide services to children at the schools that they attend.
more access in the city of residence
More specialists available and accessible programs where clients feel supported.
More qualified counselors available for mental health needs
Qualified persons and adequate training to deal with mental illness, drug addiction, family violence, teen pregnancy, rape
Bring in house jail mental health standards into the modern age. Having more in area providers.
more drop in services to manage crisis for adult children and families , more training for para professionals to assist minors and families before they are in crisis or need MH services
Mobile clinics? Telehealth?
more locations and easier access to them
client lead programs
Services- more housing, locally, such as SNF, Board and Care, TRTF's.

Expand/Increase Access to Services
Entice counselors and psychologists to move to this area
Some of the Cannabis money streaming into the county can be used for Mental Health Services. 1. An adequate building that represents health (720 Wood Street is a substandard facility). 2. More clinicians, so the work load is manageable and the staff burnout rate reduces. 3. A systemic change of promoting health within the system. Windows in the buildings, garden space, beauty. 4. Staff appreciation 5. Group and Individual meeting rooms that promote mental health. (improve lighting, remove clutter, old ratty posters, old ratty furniture). 6. Staff restorative rooms to process secondary trauma.
Consideration of protective factors, esp. for children i.e. arts, outdoor activities, music, drama, immersed in nature, sing-a-longs, karaoke, religion and church activities. Emphasis on Adverse Childhood Experiences (ACE's) resolution. Collaboration with other community resources. As a greater and more comprehensive integration of all a person's health care needs I encourage the purchase of acreage for development of a patient-centered medical home (PCMH). Continue to address the issue and complexities of dual-diagnosis or co-occurring disorders.
more wrap around svs for people coming out of jail; full services for immigrants/refugees regardless of policies; service provider offices in remote areas.
bigger wellness center, training for staff that peers are not providers they are supporters, continuity of care, community stakeholder training
Eureka needs a homeless shelter. How many people have to die before we receive a shelter? The winter in Eureka is cold enough to kill us. And we are dying, we are hungry, we are scared, Homeless women, alone out there. need safe housing it could be done. please help us.
Therapeutic child care centers More services for children under 5 and their parents/caregiver more services for foster youth Partnership between MH and HCOE or DNCS
Decentralize services bring to outlying community structure programs around specific community / cultural needs
restore day treatment center. HOPE is not enough. It is warehousing. My brother made great progress in day treatment center
enhanced cognitive behavior therapy, supported employment, supported housing
Hire more psychiatrists/work on keeping the ones we have. Crisis residential facility to provide ongoing care after folks are discharged from SV
Possibly have a MH network that can connect the community to access their MH doctor or info/make-change & access MH info with artificial intelligence
Make therapy counseling more readily available for veterans and youth. the va needs people who are more caring about vets lives after the military. including getting help for conditions the military exacerbates ie non PTSD ailments
Have services available in this area
in patient treatment facilities / low barrier transitional housing
CMH does one to one counseling
Counselors available @ ST. Vincent's de Paul & the Mission(where people are) Expansion or relocation of SV Day Health Centers Where people can walk in if they are experiencing a mental health challenge
I don't know enough to say, but recruiting more professionals in the mental health field would seem to be a high priority.
Wellness centers are great at being a place for support groups, classes, and activities that promote mental wellness and social support. Having an ideal space is essential. Our current wellness center is overcrowded and many are no longer attending due to its overcapacity issues.

Expand/Increase Access to Services
More offices throughout the county to meet. Not 8-5 M-F
Recognition of mental health as important as physical health in the workplace
The trauma-informed care models that have been previewed at the last two conferences sponsored by the California Surgeon General at the County Office of Education should be implemented here. The models were developed in the Bay Area and Southern California and have been significantly successful. It is stupid to present these models repeatedly and then take zero action to provide any aspect of them in our community that is so desperately in need of this type of care! I have a homeless child in my preschool who was physically bloodied in June by her angry father, who is a three-time convicted criminal on probation out of Sonoma County and the DAs office could not even manage to do a CAST interview of this 3-yr-old for 4 months! she was NEVER referred for ANY therapy despite showing signs of needing it, and the father remains free, continuing to terrorize this little girl months afterwards because the court system cannot manage to put together a timely court date! So now this child continues to suffer, as does her entire family. I work with another child who was born drug addicted, abandoned by his drug-addicted mother at age 7, whose father is in and out of jail for drug related charges, and who suffers from severe mental health issues, but who only receives talk-therapy, which doesn't work for him. He does not receive trauma-informed care at all and receives very little cognitive-behavioral care, which is what he needs. This model of care requires child psychiatrists to be recruited into Humboldt County, which may require absolute magic.
I don't have the answer, just more funding, more retention, more compassion
Prevention!!!!! And early intervention!!
More programs around early intervention
A mental health crisis response team that can be dispatched in lieu of law enforcement. (See CAHOOTS in Eugene, OR.) Could we start trying to organize something like that here?
Recruiting more therapists to the area. We have so many t hd at need help and can't find it or afford it.
education & continuing support for MH/Social Service/Education providers around trauma informed care, ACES, & fostering resiliency. Comprehensive services addressing family health, wellness, & social services needs provided in the school setting.
1) Mental health response team that responds to mental health crises instead of armed cops. 2) Housing first. 3) Programs that are NOT based on income. People who need help will need the help regardless of how much they make on paper.
b and c - we to reach people where they are, where they live, and communicate in their language(s); community focused efforts could be self sustaining and more relevant to local needs - too much MH infrastructure in focused in Eureka
Stop hiring therapist that are forced to work there to pay off loans or intern bonuses. Hire people who want to work there. Make the MH team part of the community, out on the streets, at playgroups, school events. People need the relationship so they can use the service
I thought the county was working with Dr. Bruce Perry's neuro-sequential model of therapy/education. Is this still a path for social services? It was inspiring to think that LEOs, teachers, health workers, juvenile courts, etc. were synchronizing their approach with best practices in mental health. Guest speakers or events at schools, play groups and senior centers in Southern Humboldt could help spread awareness of services and work to de-stigmatize seeking help with mental health. Education about ACES is absolutely paramount, too.
We need a larger facility. Is there a way to negotiate the General Hospital as the new MH locked facility?
The potential of video conferencing with providers. It has proven successful in other parts of the country.
Healthy cross agency collaboration and support, intensive identification, intervention and prevention services for all families.
A, with a new and larger SV and Crisis Units.
to open up some of the trainings provided to county personal to staff of agencies that contract with the County. Such as Changing Tide Family Services, Betty Chinn. It would not cost anything but would increase the knowledge of their staff. The UC Davis trainings that SSB staff attend are really good and others could benefit. Employment within the community. Something like the Helping Humboldt training program.

Expand/Increase Access to Services
Having more doctors available, and in person doctors instead of telehealth
I would like to see a MH Residential Living Center much like a Senior Living Center. I think it would help give MH folks the ability to have a stable living environment.
As I mentioned, we need a trauma-informed theraputic preschool with wraparound services to serve children and families with high ACES and for children who have experienced trauma and are exhibiting very challenging behaviors.
a&b: The Bridges to Success program seems to be great start at addressing some of the issues for the population of children 5 and under. Currently though, referrals can not be made by private care providers. Opening up the referral process to all serving this population could benefit children. Also expanding these services or creating new services to provide consultation services to early childcare providers would better serve families, allow for more children to be served and help increase the capacity of this workforce in serving these children in a beneficial manner.
As stated above, from personal experience, it took me three rejections from hospitals and ending up at a police station in order to get critically needed mental health help. I was rejected because I didn't have thoughts of harming myself or others, but was experiencing severe hallucinations and delusions after a traumatic experience. If we had centers people could go for help without having to â€˜qualify' in certain ways, many people would be better off in our community.
A center to provide adequate services for these individuals
prevention and early intervention
Adapt programs to be able to serve at least some of clients current needs before referring them to an alternate program/ not working with clients who do not meet criteria. Conduct extensive staff workplace satisfaction studies to reduce identify/ reduce the cause of rapid employee turnover at the current MH programs.
Prevention and early intervetion
More MH services offered for minors in schools, hospitals, outpatient settings
A safe place where people could go when they are in a MH crisis, aside from Sempervirons. This place should be staffed with experienced, compassionate MH providers that people can actually talk to in person when experiencing a crisis.
The DHHS HOME program is already going out into the community and meeting people where they are at, but this typically only consists of case managers and peer support staff. The HOME program should also include clinicians in their team (probably 3) that can go out with the staff to locations such as St. Vincent de Paul, Eureka Rescue Mission, etc.), to help connect with folks experiencing mental health challenges that require a higher level of skill than what can be provided by case managers and other support staff.
INVEST IN AND SUPPORT YOUR PROVIDERS WELLNESS!
Including Mental Health Services, Public Health, Social Services with other home visiting services. Truly innovate and create a team or pod as opposed to having to refer to each other
this question is difficult to easily answer. I think when there is an innovative new practice, or community driven one, county MH limits success with rules about grants being OTO. Hard to build on innovation while chasing funds.
Supporting mental health services that Native American providers (Two Feathers, UIHS, Tribes) are making available that first supports identity of the client and includes more traditional mental health services. Community mental health activities that builds community responsiveness and connection around mental health (opposite of isolation that happens for individuals).
as our population has increased the amount of beds haven't increased,same as in the 70s
Embed counselors in home visiting programs
Adding a new division to help support parents with difficult teen youth.
Make more beds available at SV, Crestwood etc. Because there are 10 beds avail, doesn't mean there are only 10 people experiencing a need for mental health help.

Expand/Increase Access to Services
Not sure if this exactly addresses the question, but I think it is critical for children in the foster care system to receive MH supports/services--I know in theory, each foster care child is supposed to be able to receive a MH assessment, but I also know that this does not happen in actuality.
funding mental health clinicians to work in the homes of families with children who have diagnosed mental health disorders.
See the above mentioned idea about a Family Wellness Center. Ideally, a collaborative entity which would also serve as an internship location for HSU students, as a research facility, as a workforce training facility and as an incubator for best and promising practices with an emphasis on serving pregnant women and their families and those ages 0-5.
Increased availability of counseling and streamlined referrals would greatly improve the system for indigent and needy children and parents.
Money to hire more psychiatrists. These other options don't fix the biggest problem, which is no psychiatrists available for those who need one.
Streamline application process, accept all insurance or sliding scale
I believe we should take the services that places like Remi Vista and Changing Tides supply and provide it for families that have insurance other than Medi-Cal (while still providing services to low-income families). Also, we should start to adopt more tele-health services for MH.
Make MH affordable/easier/convenient to access
after hours wellness groups, play groups.
C. Adapting group session, home visiting, and therapeutic sessions (art, etc)
Providing employers and local community members with incentives to help those in need. In small, rural towns the people who need help often aren't hired for work or accepted as tenants because they might have a reputation with poor "life" skills- taking your trash to the dump, having the police called for various reasons, so those individuals and families are pushed further into isolation. If there were incentives, either financial or a variety of mental health programs/counselors as supports, that could really help.
Sorry I don't really know. Finding ways to attract more highly qualified practitioners, and making use of proven best practices.
Integration of complimentary care into mental health care services. For example yoga, meditation, art therapy, movement such as Ti Chi, etc. These classes could provide a brief educational component then the actual activity. Sort of a no risk way to access services for those who may need care but do not "believe in" it or whatever other reason for not accessing services.
More training in trauma informed care, services at natural access points as described earlier (IFECMH support for 0-5 kids/parents at playgroups, libraries), have MH folks at the libraries (in particular Eureka, Arcata, Southern Humboldt-maybe others)
Mobile mental health clinics targeting the homeless
I've mentioned the idea of a Wellness Center a few times... I also think a MH mobile response team would be very beneficial to schools and the broader community. We also need an SV type placement for high school age youth who are experiencing suicidal thoughts.
Rural offices/substations
Mobile services, web based services for people who have a hard time leaving their homes or do not have transportation. Having access to the internet or a mobile health service can be a powerful tool to bring counseling services to people who are home bound. This includes the elderly, mothers caring for young children, children in school and even support groups. Duo, Facetime, Skype can all bring a real person to a person's home for less expensive delivery of many types of health services. Our lack of providers in this area could also be helped by the use of technology.
Harm reduction. Housing programs/permanent supportive housing in blended communities. Expand Sempervirens by about 600%, as a start.

Expand/Increase Access to Services
Schools really do not have mental health providers on staff. It would be great to get more mental health provider on sites to offer group or class information on basic or proactive practices for students. Or offer information to school staff in our area.
An all-in-one setting would be ideal. Also, creating partnerships with large facilities, such as Stanford, UCSF, etc for access to interns
Support existing "coming of age" traditions (like the tribal events, bat/bar mitzvahs, quincenera), and develop a new one for people who do not have a faith-based/existing culturally-based event. Use these to help teens develop agency, grit and perseverance towards life goals.
I think that the current Humboldt County DHHS MHB administrators don't understand enough about patients with psychiatric illness to be competent to administer MHSA (or any other public MH funds). I would love to see a fully staffed CCT, CMs for every patient, patients to be given their first month supply of meds when they leave SV etc. etc. and I would love to see the administrators treat their staff humanely. I would love Humboldt County to spend more money on service providers and less money on administrators who aren't willing/able to pitch in and provide services. I would love for Humboldt County DHHS to view mental health care as what it is: MEDICAL care (psychiatric care) realize that when they don't administrate it well, people suffer.
C.). Training educational staff more thoroughly to recognize symptoms and have A SMOOTHLY WORKING PROCEDURE FOR GETTING HELP TO STUDENTS WHO NEED IT.
I am a nutrition professional. Many things contribute to positive mental health, but I have often wondered what would happen if a nutrition/neutraceutical approach was included in county mental health services. For example, if mental health professionals received training about how diet (sugar consumption, amino acids, B vitamins, alcohol consumption, junk vs. real food) affects mental health and incorporated this into all county mental health services, this could make a difference. Assigning health coaches/nutrition coaches to mental health clients could make a huge difference in outcomes. In fact, I've wondered about helping to create a collaborative intervention trial model with a group of sempirvirens patients, or recovering addicts to add a nutritionist coach and nutriceutical supplementation plan to their team and plan to see if we can reduce addiction recidivism and reduce hospitalization/symptoms. I've seen first hand how addiction, anxiety, depression, and other mental health issues can be related to poor gut health, nutrient deficiencies, and poor diets. If this sounds like something you'd like to discuss further, I'd be happy to connect: Amanda Malachesky, 707-629-3533.
More caseworkers available to anyone (and education around what they do) so that all folks can have assistance in accessing all the resources available to them.
Day centers
Have case workers available to help parents take kids to doctor/dentist/eye appointments and to sign up for preschool and kindergarten.
In regards to MH practice or approach, training therapists working in children's mental health to utilize the Neurosequential Model, which crosses over with several theories already being used by local therapists, I think would treat the effects of trauma. Also, children's mental health needs to work with the whole family system, not just the "identified client." Often the parents/caregivers have their own stuff they need to work through. Ultimately, taking a wraparound approach to work with the entire family and providing parenting support to families through parent partners (Spanish speaking too please!) would be extremely beneficial.
Train the locals and PAY them enough money to survive. Individuals and families need money and a job brings in money. Put these people to work helping each other. Stop giving the sheriff and the deputies money to harass and criminalize the homeless. Make it easier to get a cannabis license. Get rid of the Department of Fish and Wildlife and the Waterboards stranglehold on the permit process. This seriously impacting the economy and creating mental health issues for all the individuals and families that are in Humboldt county. Do this NOW. Another study is not going to help...

Expand/Increase Access to Services
Although this probably doesn't fall into any of the three categories may I suggest that there needs to be a reorganization of DHHS. There are far too many or too great a per cent age of employees in administration and not â€œin the trenchesâ€. The hands-on employees should be trusted to do the right thing and some of those in the upper echelon should be treating patients.
more education about prevention and early intervention; more cross-cultural opportunities for services, including clients with disabilities and children.
Help people with housing and wrap around case management
I think a lot of people needing services in our community fall through the cracks because they are on the edge of qualifying for services. We need to expand our service capacity to include those with slightly larger incomes or who on paper appear to have more supports, but in actuality have no way of accessing those supports.
meeting the disabled more
Depression prevention
prevention
support for the 0-8 Collabrative
Have a MH network that uses a virtual AI system to access records/make or change appointments and provide info re MH and how it works/other info
A new mental health hospital for somewhat long term stays. make therapy more affordable, professional therapy accepted my medical
Access to public supported facilities and buildings for housing and activities, reconvert building to MH Housing use
Available and safe place, less telemed more 1 0n 1, less psychotropic prescription more other practices
(more funding (staff) facilities)
Needs for Mental Health Services among children esp and other ages are growing. We need to expand services to meet the growing need.
More staffing to meet the high demands of consumers.
Start finding funds to aid outlying communities.
It's time to invest in the fucture of MH as it's destroying our Communties
We need many more MH providers throughout the county to deal with the current needs of the community. The number of providers that are needed simply don't exist right now. A longer term goal needs to be focused on parenting supports so we can raise kids with better self-esteem and resiliency to deal with the world around them which would reduce the need for MH services down the road. A culture of participation trophy's and "protection" from natural consequences has taken away the sense of identity and earned self-worth that is so vital for kids as they go out into the world. We aren't doing them any favors by "protecting" them from the experiences they need to learn and develop. This has resulted in so many young adults that lack basic social skills and an ability to deal with the world around them.
I have to drive to eureka for mh services and don't have time to drive up as often as medical insurance requires. There is no mh counselors in my areas
Need longterm, residential housing with case management, supportive services fri adults with mental health and substance abuse issues
Do to many contributing factors we are behind in offing folks the help that they need. I hope that the new funding will help to catch up.
As a consumer in the county mental health system it was a failure for me and my family and I had to go outside the county services for proper care. Even outside the county services Mental health services are sorely lacking for children and adults. Primary health providers are ill-equipped and uneducated about proper medication management of this population.

Expand/Increase Access to Services
Humboldt County needs to do more to support children and their families regarding mental health services. There are no emergency MH services for minors, they are literally kept in the same vicinity as adult patients and that is highly inappropriate and dangerous. There are also very few counselors, psychologists, and psychiatrists to treat children in humboldt county. We need a separate office for children's MH services, or much more money thrown into expanding the children's & YSB departments. EPD, HCSO, & St. Joseph's Hospital should be a part of these plans as well.
I'm hopeful that we will see the development of a DHHS led Day Center for those experiencing homelessness, with wrap-around services that focus on housing assistance, substance use disorder, mental health challenges, and living skills to help better transition people from living on the streets to being placed into housing.I've also seen to many times when DHHS has placed clients into housing, but then do not seem to have resources to help furnish the unit, and people end up sleeping on the floor. We cannot expect that simply putting someone into a unit will be all it takes for them to be successfully housed. Not only do they need supportive services, but they need bedding, cookware, etc, to help make a house a home.
The state of healthcare in this county overall is tragic. It is very important to remember that a big part of what people here need help recovering from is abuse by medical professionals and bureaucrats. This entire county is mentally unwell, from top to bottom. The horribly sadistic bureaucrats are damaging people's lives all day long without any remorse. This county is run by psychopaths who are incapable of empathy. If you want to establish mental health in Humboldt County, don't put the onus on just the people on the street. All Humboldt County staff should have to be trained in deescalation, recognizing trauma, and showing compassion. Why is it that I get along fine with the Sherriff's Dept staff, but medical professionals assault me? Training. The medical staff here in Humboldt always only escalates tensions in my experience. They're very unqualified for their clientele. It makes every medical facility turn into nothing but a fascist detention center staffed by blind automata, not human beings. Medical care in this country does NOT have patient wellness as priority one. Nope, priority one is profit. And patient wellness isn't even on the list. Turn the Humboldt County medical staff into human beings through sensitivity training or don't even bother claiming to care about mental health here.
There is a huge need for more expansive mental health services.
A counselor who is trained and available for women with Post Partum Depression
Increased funding and services for all populations is critically needed. Services have come a long way and there is still a need for increased awareness, funding, support, and access to quality care.
Find ways to invite clients back with access to care when needed (which requires additional trained personnel). A patient in crisis is often left "high and dry" because there are not enough personnel to provide help.
Rural areas are experiencing real increased needs for MH services. A local community Family Resource Center in Petrolia is responding to these needs very well, but FRCs need additional funding.
SoHum has too few MH services and providers
It all takes $$, don't know where you're going to get it, but it's definitely needed.

Expand/Increase Access to Services
Train the locals and PAY them enough money to survive. Individuals and families need money and a job brings in money. Put these people to work helping each other. Stop giving the sheriff and the deputies money to harass and criminalize the homeless. Make it easier to get a cannabis license. Get rid of the Department of Fish and Wildlife and the Waterboards stranglehold on the permit process. This seriously impacting the economy and creating mental health issues for all the individuals and families that are in Humboldt county. Do this NOW. Another study is not going to help...Hire and train locals ONLY to do this important work. Do not import any more people. Meaningful work has been shown to improve mental health. There are not enough good paying jobs. Supporting the Cannabis farming network and decreasing the fears related to police harassment will improve mental health. There is plenty of housing for all the homeless taking advantage of empty buildings that can be taken over by the government using eminent domain laws.Please learn to identify with all Humans, especially the poor. 25% of the residents of Humboldt county live in poverty. Poverty leads to all sorts of mental health issues. Poverty is the main cause of Alcoholism, drug addiction and Crime. Eliminate poverty and there will be way fewer mental Health problems, less Alcoholism , drug addiction and Crime. This will save us all lots of Money. DUH.When people have meaningful work and are well payed they make better life choices. One of these choices is the choice to improve the diet for themselves and their family. What goes in your body is important. Rich people can buy organic fruits and vegetables, poor people go to Mac-Donalds. The rich and famous have personal chefs. Homeless peolpe dumpster dive. Do you get the point I am trying to make? Legalize all drugs and get rid of the medical insurance corporations that are destroying the medical professionals from doing their job. Let them do what they are trained to do, administer health care to their patients. These medical professionals were not trained to fill out insurance forms so they can get a paycheck. The insurance companies are sucking the economic life out of the health care system CHANGE THIS NOW...For the love of GOD. Do the right thing now.Thank you.
We cannot continue to enable bad behavior, it is time to do outreach programs for the young about how bad their lives can be if they have a drug dependency , for those already using, we need to identify them early and be sure they get treatment and counseling (Like it or not) as far as the Chronic users, we need mental heath facilities, that is why we don't want chronic drug addicts, they have burned their brains to the point that they are unable to function and need constant care or they force their dysfunctions on communities. And it isn't cute to see, especially when you have young children and families
There are no opportunities for level one MH clients to get individual therapy, even those who recently attempted suicide.
I want to know more about why ACEs are so high in Humboldt. How many people with ACEs are from Humboldt, and how many come here from other places? When I worked at The Job Market by the courthouse, many people on welfare told me how they loved this area because it was so much easier to get 'benefits' than the state where they lived. We just don't have enough tax payers producing enough tax dollars to fund services for the steady influxz of people into this community. How is the County planning on continuing to provide services to more and more people with less and less funding? Our roads are a mess, rent is astronomical with so little low income housing, the schools are far underfunded, public transportation sucks - we need our tax dollars to go to this critical infrastructure. When will this happen?
Provide more follow up for youth services, especially for LGBTQ+ youth.
more time with mental health manager yes 2 years please at doctors office together
It would be nice to have less of a time gap between filing a mental health help and actually getting set up with what they need.
Need more services like Free Meal or Betty Chin Meal Program
please, please start providing one to one psychotherapy for adults
Availability of quality mental health is one of my major concerns we also need programs that "make sense" for people who are experiencing challenges whether it be homelessness or crisis or trauma.

Workforce Support
More robust recruitment to fill hard-to-fill licensed positions
More experienced QUALIFIED doctors to treat emergency patients @ SV. you have a long-standing recruitment and retention problem. Would much higher salary and long term contracts help? Usually the job is overwhelming and the dr's spouses don't find our county an acceptable place to live. Lack of culture and shopping ,etc. What will entice good psych docs to settle here????
Seems like the County Mental Health needs more workforce
SUD treatment on demand very important SUD treatment for adolescents very important Aftercare housing for homeless persons leaving SV/CSU very important Expanded use of Peers in all MH settings very important Improved wages for Peers, Case Managers very important
More mental health psychiatrists for both adults and children (absolutely essential), housing programs/assistance for mental health patients (very important), wellness activities (somewhat important), medication assistance/funding (absolutely essential), substance use treatment facility that accepts minors (absolutely ESSENTIAL)
Trauma informed information for schools and service providers
More competent psychiatrists, especially bilingual and culturally competent psychiatrists - absolutely essential!!
staff training and support very critical. its too expensive to continually replace and hire. staff retention is more efficient then new hires.
Screening for ACES it of utmost importance! Training for all LEO, health workers
Absolutely important to have competent MH professionals here in Humboldt county who care about the patient and work Ethically and empathetic to someone suffering.
Staffing levels are very inadequate
Trauma-informed service/education/workplace training in all agencies
Mental Healthcare needs to change into supportive counseling, not just drugging whoever whenever. This county's medical clinic staff must ALL get training in dealing with traumatized people - to be able to recognize trauma as opposed to insanity. It is *absolutely essential* that this becomes REAL HEALTHCARE orientwd toward patient wellness. As it is, unstable patients are abused at ALL facilities in Humboldt County - bureaucracy, medical, etc. Frankly, the law enforcement officials are better trained at recognizing a traumatic response than any medical professionals I have encountered anywhere in Humboldt. ALL medical clinic staff should be required to do the same training as the law enforcement in deescalation and mediation. As it is, medical clinic staff treat emotional patients as criminals. I was escorted out of SoHum Clinic in Garberville just last week (Weds. 12/4/19) because a doctor refused to give me referrals I needed and I said I wouldn't leave until I got what I needed. The entire staff came out of every corner and escorted me out of the building like a gang of robotic zombies. You want to tell me that's healthcare? That's traumatic abuse. And it's truly terrifying how fascist this country already is that they could all so thoughtlessly do something so cruel to someone disabled by three TBIs and 100 grand mal seizures. It's really like nazism. People in Humboldt do NOT understand cognitive disability. It's ABSURD because it is rampant here.
Psycho education support for the community; understanding how to support community members with mental health issues as a fellow community member; ongoing mental health services to avoid crisis level needs and after crisis ongoing treatment to prevent recurring crisis
more doctors urgently needed as well as staff at sempervirens

Workforce Support
motivational interviewing training for MH staff, Narcan for Law Enforcement and other first responders, we need to address the issue of medical and mental health providers leaving the area, medical monopolies such as St. Joseph's Hospital and Open Door Clinics need more oversight to make sure that practitioners are actually being supervised, patients are being referred out as needed, etc.
Training for police and fire department and EMT on MH. Very important. Wrap around services and services for care MH.
Training and support for providers to screen for ACES and resiliency and to have to counselors/ MH to refer to.
**If there is funding allocated to law enforcement, the focus needs to be directed towards cultivating programs to train law enforcement in psychological first aid, secondary trauma (how it impacts reflexive responses in high-stress situations) and cultural humility/awareness related to this specific region (i.e. Native peoples, homeless/houseless pop., substance users, etc).
Trauma informed Trainings in the emergency services (police, EMT, fire department. Also Trauma informed Trainings in Child Welfare Services. Both Absolutely essential.
Recognize and integrate the science of ACEs into the plans across the lifespan
More training for teachers and school administrators. More academic counselors at the high schools, because often they are the first to notice or be notified of problems.
It is somewhat important that non-Mental Health/county providers (e.g. medical staff, caregivers) are provides some anti-stigma training
Separate high school teacher and student training sessions = absolutely!
More doctors in the area
you have got to give a shit. currently, staff is trained to think of the patients as attention seeking and that the patients cost the agency money instead that they provide the revenue.
Doctors and therapists experienced in working with trauma
provide real, serious therapy for those with need for long-term counseling. People who suffer from ptsd/ borderline personality disorder, etc. are not able to pay for therapy
Transgender and non-binary competent MH services at all levels (peer support, counselors, psychiatrists)
Qualified therapists providing MH services to foster youth not new graduates they don't have the experience for the complex trauma of our foster youth.
Peer workforce training and support with WET and MHSA dollars. Send peers to supported trainings for the National Certification for Peer Support - like WISE U in Sacramento. https://www.wiseup.work/wise-u - Absolutely essential
Mental health training for teachers in the public schools is absolutely essential.
we need more MH providers
pay employees a living wage and give raises 8
More clinicians are needed in the DHHS Mental Health Services. A focus on pstream prevention is essential in Humboldt County
We are missing a huge opportunity in the jail to work with people on SUD, and mental health issues. Also more education to DAs, LE on how to avoid creating more trauma which creates MH issues
Implementation of Laura's law Establish a MH Court Provide Resources (Continuity of care leaving criminal justice system) Prioritize recruitment of MH practitioners and clinicians
High school and university faculty education--5, high school student education--5, Day Treatment Center medically staffed
Increase & expansion/improvements of technology for MH--5; courses in training MH staff on how to use this technology for MH--5

Workforce Support
No barriers to receiving care. Expand services, hire more people, decentralize service locations, meet people where they are, do home visits, help them make a safety plan if SV doesn't have room, don't just deny them services (we know the denial of services by MH has contributed to deaths by suicide - don't close the door on people who are asking for help, find an alternative service and offer it)
See all above. Perhaps a CR program to train and educate people wanting to be in mental health treatment...@ entry level through Psych expert level. Once in program then a bridge to local jobs @ SV after completion of program. We could recruit the best and get a much more qualified staff.
Increased supports and encouragement/ financial incentives for HSU students willing to get their counseling certification.
Not treating mental illness as a crime
We need more therapists, with better sensitivity training. We also need to have housing for humboldt's ever growing homeless population, and services that aren't tied to churches that will demand a certain way of life from those in need.
A well qualified workforce that sticks around. More services for Adults and more prevention focused services.
support staff more, and they will pass this on to consumers.
Support for people to become trained/incentiveised
Trauma informed care and harm-reduction interventions
30 hour work week-working 4 tens schedule so that providers can work longer into the evening and have available time to work with individuals after 5pm. Which will then decrease burn out in providers and increase productivity in working with community.
Training for ALL medical staff in recognizing and treating trauma and cognitive disability. They MUST learn how to STOP furthering the TRAUMA. They all have to learn or they will continue abusing patients.
Robust trauma responsive support for pregnant and parenting folks who have been impacted by ACEs. Supporting current Infant-Family and Early Childhood Mental Health and Trauma Responsive training efforts to continue to build a qualified workforce.
Reach out to LCSWs and ask them to develop a plan. Dr Lynn Lester had some great ideas when I worked with her at Open Door.
a wellness center for outpatients that isn't at the clark complex,more beds at sempervirens and staff at sempervirens that interacts with the clients instead of hiding behind a lucite cage at the nursing station where they ignore the clients,their as our population has increased the staff morale leaves a lot to be desired,its very disturbing
training, more staff
More money towards hiring and training clinicians and smaller case loads so individuals with mental health issues can receive the help they need consistently and over time. Six weeks and six appointments for a child to recover from neglect and sexual abuse that has occurred over several years? Really?!
Support person that can help coordinate services. Training's on helping families and empowering them. Training on better customer service.
Law enforcement & school professionals trained in trauma-informed practices, psych first aide, etc.; strengthened partnerships b/n schools, MH service providers, law enforcement and medical facilities; proper support and training for MH workers to prevent burnout and turnover; programs and services offered and focused on early intervention.
Trauma informed training's
I believe we need more mental health clinicians that are trained in working with children, teens, and families. An increase in services provided to middle class families with various insurances is much needed.
More support for school staff. Mental health days retreats etc. More bodies on campus. We have to support our support team.

Workforce Support
More mental health care providers, support groups for parents/family, earlier outreach in school.
Reduce case loads to enable staff to provide necessary help long term without so much burn out. Train volunteers to assist with support. Longevity in this challenging field would be increased if more positive results of lives actually transformed were seen.
Fund the ones you have, train your staff better, hire more staff, and address waste in a top-down manner (freeze raises on bosses, always pay staff a living wage plus).
Regular follow-up with clients from counselor/therapists, psych nurses, and physicians.
Transdisciplinary training and education in early childhood mental health, increased services for the 0-5 population,
Train the locals and PAY them enough money to survive. Make it easier to get a cannabis license. Get rid of the Department of Fish and Wildlife and the Waterboards stranglehold on the permit process. This seriously impacting the economy and creating mental health issues for all the individuals and families that are in Humboldt county. Do this NOW. Another study is not going to help...
Some of the Cannabis money streaming into the county can be used for Mental Health Services. 1. An adequate building that represents health (720 Wood Street is a substandard facility). 2. More clinicians, so the work load is manageable and the staff burnout rate reduces. 3. A systemic change of promoting health within the system. Windows in the buildings, garden space, beauty. 4. Staff appreciation 5. Group and Individual meeting rooms that promote mental health. (improve lighting, remove clutter, old ratty posters, old ratty furniture). 6. Staff restorative rooms to process secondary trauma.
Educating every single person on trauma and how to not cause more. De stigmatizing is essential for change.
bigger wellness center, training for staff that peers are not providers they are supporters, continuity of care, community stakeholder training
early intervention! work force develepoment, study of toxic stress on MH support force
enhanced cognitive behavior therapy, supported employment, supported housing
Wellness centers are great at being a place for support groups, classes, and activities that promote mental wellness and social support. Having an ideal space is essential. Our current wellness center is overcrowded and many are no longer attending due to its overcapacity issues.
Outside contracting. Find younger people who are perhaps willing to be trained if not fully qualified. County could pay for the licensing if they fulfill certain requirements (e.g. work at least 3 years, take tests...)
Training, intervention, resolution
I don't have the answer, just more funding, more retention, more compassion
Recruiting more therapists to the area. We have so many t hd at need help and can't find it or afford it.
education & continuing support for MH/Social Service/Education providers around trauma informed care, ACES, & fostering resiliency. Comprehensive services addressing family health, wellness, & social services needs provided in the school setting.
Bringing back more "old fashioned" ideas like actual social contact (NOT virtual), how to communicate with others face to face, the concept that used to be a basic tenant of parenting-the theory of natural consequences rather than wrapping kids up in a plastic bubble to protect them from the world. "Protecting" kids from the world around them while their young, only to find out that they aren't the star of the universe when they head out into the world leads to depression.
1) Mental health response team that responds to mental health crises instead of armed cops. 2) Housing first. 3) Programs that are NOT based on income. People who need help will need the help regardless of how much they make on paper.

Workforce Support
All adult system administration above tay, should be shuffled off to other departments. Im sure they work hard, but they dont care about clients and it shows in the programming and staff training. All line staff should have training 4 times a year. Not from drug companies or from programming spokespeople...we're here to sell you our latest "evidenced based blablabla."
Category "c)"... The library offers various free classes that give people in the community something practical to do with their brain [MH], get them to meet others that are not always in their usual circle of friends. This win-win formula might be adapted for programs in the MH system.
All the above, and better diagnoses, so we know what we are doing!
Explore the restorative practice system that local schools implement so MH could immediately connect with those young people in need
Stop hiring therapist that are forced to work there to pay off loans or intern bonuses. Hire people who want to work there. Make the MH team part of the community, out on the streets, at playgroups, school events. People need the relationship so they can use the service
current approach is fine just need a lot more experienced staff.
Targeted case management services with small caseloads to provide longterm support to chronically mentally ill clients, plus supportive housing/residential facilities.
I thought the county was working with Dr. Bruce Perry's neuro-sequential model of therapy/education. Is this still a path for social services? It was inspiring to think that LEOs, teachers, health workers, juvenile courts, etc. were synchronizing their approach with best practices in mental health. Guest speakers or events at schools, play groups and senior centers in Southern Humboldt could help spread awareness of services and work to de-stigmatize seeking help with mental health. Education about ACES is absolutely paramount, too.
Wellbriety training for all contact Don Coyhis
to open up some of the trainings provided to county personal to staff of agencies that contract with the County. Such as Changing Tide Family Services, Betty Chinn. It would not cost anything but would increase the knowledge of their staff. The UC Davis trainings that SSB staff attend are really good and others could benefit. Employment within the community. Something like the Helping Humboldt training program.
More early intervention for at risk children 0-8, A community-driven approach that encompasses the entire family to support all those affected by mental health issues.
workforce training in Mental Health that extends beyond the classical sense of mental health professionals, teachers, ECE providers, nurses, parents etc. Breaking free of the classical clinical model to create a culture/vernacular of mental wellness
trauma-informed systems of care

Workforce Support
(1) Training for all medical staff in recognizing and addressing a traumatized person and deescalating. Learning to treat disabled people with compassion. Having REAL advocates for cognitively disabled people. I was assaulted by an in-house self-proclaimed advocate at RRHC Dental, the office manager Barbara. The nonchalance of the response of the clinic made it clear she's just their bouncer and assaults patients whenever she wants. Not having a third party witness to events is a serious endangerment to all disabled people receiving medical "care" here. Humboldt County healthcare is horribly unsafe for disabled patients generally. (2) There must be some legal recourse for patients who are mistreated by staff or the staff will NEVER stop the abuse. Insurance complaints go NOWHERE. At the least there could be a Medical Abuse line where one who has been abused could get counseling and have an outlet. Personally, I have been dismissed from two clinics and I haven't lived here one year. Literally no one in Humboldt County gives a shit at all about how I've been mistreated and abused by "medical" staff. And even my counselor who claimed to be an Anger Management specialist dropped me when I got upset with her one day. So how am I supposed to get help when I'm supposed to be healed before I can get treatment? No one in Humboldt understands cognitive disability. I get MORE TRAUMATIZED every time I try to get care of any kind here. There absolutely has to be more counseling available. (3) I think a call-in counseling line with people available at will is a much better option than making appointments with people ridiculously far away. I think concentrating care also eases oversight. The counselors won't be able to abuse patients off in some hidden corner. They could be monitored on call or the calls could be recorded and then reviewable if a patient complains.
Increase pay and support for staff so that the good ones don't leave from burnout, educate admin on trauma informed care for STAFF, provide increased evening and weekend hours for the working poor
Normalizing reflective practice support to those serving families impacted by trauma and mental health struggles. Free parenting support to ACEs impacted families when their children are very young to help prevent the continuance of multiple generational trauma.
Money to hire more psychiatrists. These other options don't fix the biggest problem, which is no psychiatrists available for those who need one.
Sorry I don't really know. Finding ways to attract more highly qualified practitioners, and making use of proven best practices.
Drug screen your employees and then send them to classes on customer service and empathy. Then if they pass the Cs/empathy class then send them to a class on ethics. A large percentage of people are undertrained and rude. The strength of your organization is your employees, their knowledge and level of empathy is what has more impact on your level of service that anything else.Also give your employees a raise and fire the ones that can't do the job
More training in trauma informed care, services at natural access points as described earlier (IFECMH support for 0-5 kids/parents at playgroups, libraries), have MH folks at the libraries (in particular Eureka, Arcata, Southern Humboldt-maybe others)
C.). Training educational staff more thoroughly to recognize symptoms and have A SMOOTHLY WORKING PROCEDURE FOR GETTING HELP TO STUDENTS WHO NEED IT.

Workforce Support

Prevention would be a novel thing to try for once. I feel like nothing, as far as crime and mental health crisis, is dealt with until it becomes an emergency. We do not have the facilities or people to implement preventative procedures. The largest group which would benefit from mental health care are the literally thousands of homeless and substance abusers who bounce back and forth from the jail cell to the streets. What's more, the community at large displays animosity towards these two groups, colloquially called tweakers, because they run rampant in search of their vices rather than getting help. Because there is no help. I feel like preventing people from wanting to abuse substances or commit crimes would solve a lot of our problems with Tweakers in this area.

Also, recently HSU got rid of one of its counseling programs. They used to let the grad students in Psychology practice in a guided setting and in return other students would get regular and free mental help, but they have since stopped doing this. They still have CAPS, but you can only get 8 free 0.5 hour sessions per year and you have to call at 8 in the morning to get a first come first serve appointment. This left many students without regular and free counseling. A program that is not run by the campus, but an outside entity, would be nice. I think regular and consistent mental health opportunities are necessary to the absolute CRISIS this county is embroiled in.

I have lived here my entire life. Over the past five years or so everyone I know that has lived here for a long while has said that Eureka has gotten worse. The Drug problems, the crime problems, the general pollution caused by the homeless and needle users. We need to find a way to get these people up on their feet and healing before they get so far gone that they aren't human anymore and they refuse to be helped.

Jobs, housing is needed to give people some hope for a better life.

Less reactive response and more trauma information to our responders

In regards to MH practice or approach, training therapists working in children's mental health to utilize the Neurosequential Model, which crosses over with several theories already being used by local therapists, I think would treat the effects of trauma. Also, children's mental health needs to work with the whole family system, not just the "identified client." Often the parents/caregivers have their own stuff they need to work through. Ultimately, taking a wraparound approach to work with the entire family and providing parenting support to families through parent partners (Spanish speaking too please!) would be extremely beneficial.

Although this probably doesn't fall into any of the three categories may I suggest that there needs to be a reorganization of DHHS. There are far too many or too great a per cent age of employees in administration and not â€œin the trenchesâ€. The hands-on employees should be trusted to do the right thing and some of those in the upper echelon should be treating patients.

Never use peer pressure or browbeat to achieve medication compliance. Some people are afraid of medication and eschew drug use even medication in their lives. Some people have religious intolerance for the "cult of the magic pill or shot"

MHSA dollars need to be used to DIRECTLY benefit consumers by supporting peer activities, community integration, HOPE Center, rental assistance, funds for household emergencies, small grants for generating entrepreneurship of consumers, travel funds for conferences and training.

Workforce Support

The state of healthcare in this county overall is tragic. It is very important to remember that a big part of what people here need help recovering from is abuse by medical professionals and bureaucrats. This entire county is mentally unwell, from top to bottom. The horribly sadistic bureaucrats are damaging people's lives all day long without any remorse. This county is run by psychopaths who are incapable of empathy. If you want to establish mental health in Humboldt County, don't put the onus on just the people on the street. All Humboldt County staff should have to be trained in deescalation, recognizing trauma, and showing compassion. Why is it that I get along fine with the Sherriff's Dept staff, but medical professionals assault me? Training. The medical staff here in Humboldt always only escalates tensions in my experience. They're very unqualified for their clientele. It makes every medical facility turn into nothing but a fascist detention center staffed by blind automata, not human beings. Medical care in this country does NOT have patient wellness as priority one. Nope, priority one is profit. And patient wellness isn't even on the list. Turn the Humboldt County medical staff into human beings through sensitivity training or don't even bother claiming to care about mental health here.

More compassionate & understanding individuals

CWS must work better with the Unit. Staff on the unit must stop telling parents not to pick up their children. There must be a way for MH to deal with MH clients and issues without foisting them off on Probation or CWS. MH must find a way to see children much much much more quickly. Facilitated skills groups for children and parents would be so much more helpful than the therapy 50 minutes.

use your money to get the staff properly educated. re integrate admin into the service providers. get rid of the guards by seeing the patients as people just like yourselves.

Is there a special community wide consent so service providers can coordinate more effectively; more harm reduction community education. Do we have an idea on the community brasses and needs for education?

Continuity of Care from SV, CSU, Jail, and other transitional services

The public health suicide fatality review (5) safety planning and warm hand offs for every SV discharge!!!!!!! (5)

SUD treatment on demand very important
SUD treatment for adolescents very important
Aftercare housing for homeless persons leaving SV/CSU very important
Expanded use of Peers in all MH settings very important
Improved wages for Peers, Case Managers very important

Transitional housing, step down, for those discharged from the hospital with MH issues.

Focus on the most SMI people by connecting with local disability resources for employment and housing and providing Treatment, Housing, AOT, Mental Health Court, Triage centers, Board and Care homes with more support , expanded hospital, support for nurses and MH professionals, bed and psychiatric care providers: Highly important.

Support set up before release of SV!

More emergency beds, more aftercare, permanent supportive housing, mental health support folded in with pcp in a communicative continuum of care

I think it absolutely essential to(1) follow up on a weekly basis with HCMH clients upon discharge to help with ordering/receiving/and making regular meds schedule., and (2) to provide regular talk therapy/counseling sessions, and (3) to provide more on-site crisis psychiatric nurses and physicians.

Dual Diagnosis support
Post release from jail support

Continuity of Care from SV, CSU, Jail, and other transitional services
Implementation of Laura's law Establish a MH Court Provide Resources (Continuity of care leaving criminal justice system) Prioritize recruitment of MH practitioners and clinicians
Transitional housing for patients leaving SV and still are psychotic--5; family support for first break episodes--4; Laura's Law--4; Assisted outpatient treatment--4
Specifically sober transitional living where families are allowed--5; inpatient treatment where families are allowed--5; community consent to coordinate easier. Very difficult to find MH providers for people that are not MediCal or Partnership. Many support staff fall into this group. We need to care for people who do the caring
Jail release referrals/drug rehab--5; jail release referrals MH and housing--5; A large portion of people in jail suffer MH problems. There is no therapy available in jail, counseling or therapist. So these people released to reoffend. Psychoactive drugs are extremely limited in jail exasperating the problem
wrap around services for people release from Sempervirens
All shelters should have counselors available to children who are trained in trauma-informed care. All children referred to child welfare and/or court services for child abuse should also be immediately referred to theraputic services for trauma-informed care that is immediately available to them.
Pop-up or temporary intake stations on Broadway, Old Town, and marsh areas. Faster and more aggressive intervention in keeping elders in homes. A better liaison with courts and probation departments.
Transitional programs aka step down programs
More services and treatment in the jail. More case management. More mental health doctors.
More residential & medicinal follow up. secure and stable access for the rural and transient people.
Drug and alcohol rehab and follow-up services
Wrap around Wellness Centers on school campuses. A physical place on campus to house community service providers.Social workers and school counselors can work together to provide cohesive support plans and schedules.
A better connection with police regarding their observations. Not jail time, but instead addressing the behaviors and possible mental health concerns causing the repeated offenses
Mandatory care post-discharge (follow up appts, counseling)
Some type of check in to insure stability
I think starting at a young age in school we should be discussing MH so that there isn't such stigma associated with it. Students should be able to talk to someone about themselves or someone in their home and get needed help.
Multicultural approach group setting- educational/therapeutic programs for siblings/extended family. Social skill therapeutic group for individuals with disabilities. Development of peer support groups with inclusive multicultural perspective.
Every foster child should have a regular checkup with a LCSW whether they are problematic or not
For the mentally ill, they need group homes where they can be supervised and made to take their medicine. Left on their own, they will stop taking their meds and end up on the street again. That is not safe for them or the rest of the community.
Free public transit, at home/with family social work and therapy
When a person is arrested, seen for a medical aid, or uses the Emergency room and is identified as being on drugs, this should set off an instant referral as well as a court date to see a judge and be referred to a drug program. Quit enabling known drug offenders. You are degrading communities, families and functional peoples lives by doing so.

Continuity of Care from SV, CSU, Jail, and other transitional services
Step-down/step-up facility, expansion of Hope Center
more drop in services to manage crisis for adult children and families , more training for para professionals to assist minors and families before they are in crisis or need MH services
more wrap around svs for people coming out of jail; full services for immigrants/refugees regardless of policies; service provider offices in remote areas.
bigger wellness center, training for staff that peers are not providers they are supporters, continuity of care, community stakeholder training
Mobile MH units like MIST Post release from jail services
restore day treatment center. HOPE is not enough. It is warehousing. My brother made great progress in day treatment center
After care after incarceration, semper virens, and being recently housed
Counselors available @ ST. Vincent's de Paul & the Mission(where people are) Expansion or relocation of SV Day Health Centers Where people can walk in if they are experiencing a mental health challenge
Zero suicide ebp. Caring contacts for SV discharges. Warm hand offs to outpatient care.
Making mental health or substance abuse services mandatory as a condition of parole or probation for people with mental health or substance abuse issues.
I would like to see a MH Residential Living Center much like a Senior Living Center. I think it would help give MH folks the ability to have a stable living environment.
Step down facilities for both Children and Adult after Crisis Services or Inpatient services.
More MH services offered for minors in schools, hospitals, outpatient settings
Full Service Partnership for children's mental health, California Wraparound and/or Nationally accredited wraparound services for all youth with high end mental health needs
Not sure if this exactly addresses the question, but I think it is critical for children in the foster care system to receive MH supports/services--I know in theory, each foster care child is supposed to be able to receive a MH assessment, but I also know that this does not happen in actuality.
Harm reduction. Housing programs/permanent supportive housing in blended communities. Expand Sempervirens by about 600%, as a start.
A stronger focus on MH aftercare for both children/youths and adults.
step-down/step-up - in addition to the classic step-down program that supports people recently discharged from inpatient, the facility is able to step-up individuals from the community that are in crisis and at risk of needing inpatient care if they are not stabilized
We need supportive jobs for mentally ill
This county needs Interagency communication to advance continuum of care including transportation services. More accountability and transparency over government funding
Let's start supporting families to keep young people home
Focus on the jail. No service in the jail other than medication and the types of that are limited. I ask for help and there is no one to help me. Takes two weeks just to get someone to talk to and then they only can give me meds. No therapy or NLP, or other service to help me/others. A lot of people have MH problems here. No referrals either

Increase Support for School Aged Children and Youth
MH services for under 18 including an under 18 MH hospital/emergency placement. Absolutely essential.
Childrens mental health
Youth Crisis Mental Health Services (inpatient)
Tay services should expand and overtake adult services. They understand how and why to provide services. The rest of adult mental health is there to get a paycheck. They have no training from the admin down to the clerical staff. They do not know what they can do to constructively help. Tay s directors do and they communicate that to their staff and they have a coordinated program to deliver meaningful services. Adult services needs that too. Adult services needs to lob off about half its administration overhead.
Home school connection
more direct services for children - absolutely essential
Mental Health and Substance abuse support for teens in Humboldt- absolutely essential
Children's services are needed most
Specialized family and caregiver support for trauma impacted families.
Services to teens; suicide prevention and ethnic studies support in schools
24/7 After hour support for youth that have high end mental health support
local crisis and hospitalization support for youth. therapeutic foster homes. local youth treatment facilities.
children's mental health crisis intervention and local treatment program inpatient, and increased outpatient in the home mental health intervention for children.
We desperately need more people in our schools that have been trained using a developmental model of support to provide the necessary long-term help for children with trauma.
Most children need mental health support and parents also.
The need for funding for parents, children 0-5 and school aged childrenâ€”especially with the Prevention and Early Intervention dollars.
The county needs to specifically address how it will serve families with high ACES scores, including children infants through school age.
need for funding for parents, children 0-5 and school aged childrenâ€”especially with the Prevention and Early Intervention dollars (I would rate all of this as essential)
education and prevention services for youth and teens
Inpatient unit for youth under age 18. Follow up post discharge with those youth. Greater willingness to place when appropriate, as opposed to telling parents to refuse their children so that CWS will respond.
More MH support for school age children- Very Important
Enhance Bridges program to support more school age youth.
more programs and services for youth
Peer support/mentor programs for 10-17 year olds- Absolutely Essential. Mental Wellness programming/activities for youth--created with youth- Absolutely Essential Supports for LGBTQ school age youth & parents- Absolutely Essential
A top priority I see needed for our area youth and families is the longevity and increase in service outreach programs such as Bridges as well as full staffing of the MRT.
It is extremely important to reach out to schools and younger children, as well as teenagers and services for those dealing with addiction.
facilitated groups for MH Dx people. Raven Project collaborartion for their youth
Early Intervention of drug users as well as high school and Jr. High education programs are essential. Stop the pattern before it be starts or before it becomes chronic

Increase Support for School Aged Children and Youth
More follow up programs for children and youth services to help make sure the kids are on track and coming back from their trauma. A lot of kids get some help, but never get the follow up they need to help keep them going.
Automatic long term counseling for all foster youth.
Some additional priorities would include talking to kids about mental health and awareness and and discussing genetic or outside factors of cause.
Substance use Disorder inpatient treatment for youth and parents w/their children Suicide texting crisis line or warm line crisis services for youth
Therapeutic child care centers More services for children under 5 and their parents/caregiver more services for foster youth
help for first break with family focus--5
Transitional housing for patients leaving SV and still are psychotic--5; family support for first break episodes--4; Laura's Law--4; Assisted outpatient treatment--4
Explain diagnosis of children to parents better and better to children
More MH workers to meet the needs of poverty and addiction problems in our 0-5 families. More MH workers for outreach in our homeless communities. More housing for our shelter deprived people that would have MH services built in.
Better support for parents of young children to encourage a return to more active parenting rather than a culture of participation trophy's (teaching resilience)
Address children with risks! We know 12 year olds that need help. Connect them with mental health and medical. The team needs to work together
Growth in 0-8 services and providers, additional space to see these individuals
MH treatment facilities for teens
Making MH services a priority for young children and their families by making them accessible and being flexible to meet the needs of the families. Providing intensive services to young children at school and in the home is crucial to their development. Teachers are struggling and need more support in their classrooms.
More pediatric mental health services. Sempervirens is not suitable or safe for children. There is no where for kids to be treated for MH crises, and very few MH providers for children with outpatient needs.
Agency offices in places like Fortuna. Having Clinicians who are available to only see Fortuna children at schools.
More childhood mental health support.
There is a need for funding for parents, children in the 0-5 age category and school aged children. Prevention and early intervention is key to the health of our children and communities.
More of the parenting classes
I believe we need more mental health clinicians that are trained in working with children, teens, and families. An increase in services provided to middle class families with various insurances is much needed.
Intervention services available in schools for teens
More after school activities for TAY
counseling services on school sites
Timeliness. Inadequate providers in high schools.
Eureka High School (and other schools) need onsite wellness centers and staff.
I recommend more prevention and wellness activities and education at the 10-17 year old age, and an increase in social-emotional education for children and their families. Continuing to build community
Early intervention

Increase Support for School Aged Children and Youth
More access to programs that address substance abuse issues that are geared towards people who work (there are some programs but often they meet during the 8-5 work day). More clinicians in schools (K-12). Later hours at mental health clinics.
I think starting at a young age in school we should be discussing MH so that there isn't such stigma associated with it. Students should be able to talk to someone about themselves or someone in their home and get needed help.
parent/ new family financial/ budgeting classes, young parents grouped with early childhood education programs, TAY volunteer-work experience opportunities
Every foster child should have a regular checkup with a LCSW whether they are problematic or not
More mental health specialists in preschools and k-12
youth counseling
More counselors for children
Increase the amount of counselors available to students and counseling programs in the school setting.
Therapeutic child care centers More services for children under 5 and their parents/caregiver more services for foster youth Partnership between MH and HCOE or DNCS
more 0-5 clinicians and programs
My daughter has been diagnosed with depression and enjoys being around other kids like her but it hasn't been available to her outside of a mental health facility. It also would be helpful to have more supports in the schools, she's mostly been punished at her current school for common mental health behaviors.
Prevention!!!!! And early intervention!!
More programs around early intervention
Bringing back more "old fashioned" ideas like actual social contact (NOT virtual), how to communicate with others face to face, the concept that used to be a basic tenant of parenting-the theory of natural consequences rather than wrapping kids up in a plastic bubble to protect them from the world. "Protecting" kids from the world around them while their young, only to find out that they aren't the star of the universe when they head out into the world leads to depression.
I thought the county was working with Dr. Bruce Perry's neuro-sequential model of therapy/education. Is this still a path for social services? It was inspiring to think that LEOs, teachers, health workers, juvenile courts, etc. were synchronizing their approach with best practices in mental health. Guest speakers or events at schools, play groups and senior centers in Southern Humboldt could help spread awareness of services and work to de-stigmatize seeking help with mental health. Education about ACES is absolutely paramount, too.
As I mentioned, we need a trauma-informed theraputic preschool with wraparound services to serve children and families with high ACES and for children who have experienced trauma and are exhibiting very challenging behaviors.
prevention and early intervention
More early intervention for at risk children 0-8, A community-driven approach that encompasses the entire family to support all those affected by mental health issues.
Early prevention and intervention is key to improving the mental health in our community. Training and support for staff and teachers to be able to support children and families. I believe that bringing MH professionals into the field to the ones who need support would make a bigger impact then having clients come to them. This is especially important for young children.
Prevention and early intervetion
More MH services offered for minors in schools, hospitals, outpatient settings
Social workers in schools working around ACES and teaching faculty, parents and kids how to respond
Full Service Partnership programs for youth in foster re

Increase Support for School Aged Children and Youth
Not sure if this exactly addresses the question, but I think it is critical for children in the foster care system to receive MH supports/services--I know in theory, each foster care child is supposed to be able to receive a MH assessment, but I also know that this does not happen in actuality.
Increased availability of counseling and streamlined referrals would greatly improve the system for indigent and needy children and parents.
preventive services for youth and teens
See answer to #9. In addition, continue to train MH staff on Infant-family and Early Childhood Mental Health to build a quality workforce to serve families who are pregnant and parenting young children. Support the 0 to 8 Mental Health Infant-Family and Early Childhood Mental Health Training Program.
More training in trauma informed care, services at natural access points as described earlier (IFECMH support for 0-5 kids/parents at playgroups, libraries), have MH folks at the libraries (in particular Eureka, Arcata, Southern Humboldt- maybe others)
Wrap around supports for youth and their families across agencies.
I've mentioned the idea of a Wellness Center a few times... I also think a MH mobile response team would be very beneficial to schools and the broader community. We also need an SV type placement for high school age youth who are experiencing suicidal thoughts.
prevention and early intervention,
Eureka High School (and other schools) need onsite wellness centers and staff.
More involvement in schools to help students see the signs and symptoms of mental health crisis prior to turning to self medication or other risky behaviors.
A new approach to MH services by partnering with schools to offer school based mental health services through on campus wellness centers.
Prevention and early intervention for the 0-5 population, embedding MH practitioners into the existing structures that parents use such as schools, childcare, playgroups and medical offices.
Crisis center for youth in county
Early intervention. 0-5 ages and family wellness
Early intervention for children
more education about prevention and early intervention; more cross-cultural opportunities for services, including clients with disabilities and children.
Early intervention and more services for minors so they don't end up on the crisis unit. there needs to be a mental health unit at juvenile hall.
Definitely provide better services earlier on, especially for younger children, and the genetic factors.
support for the 0-8 Collabrative
Preschool and early education are vitally important and state programs have so few resources. Children and families need support. We need more quality teachers and specialists and they need to be compensated for this important work. We are not attracting anyone to this field with these sad conditions and pay. Early prevention could save so much in the long run.
It is a challenge to restore a young person at school when that young person returns to an at risk environment at home
As a consumer in the county mental health system it was a failure for me and my family and I had to go outside the county services for proper care. Even outside the county services Mental health services are sorely lacking for children and adults. Primary health providers are ill-equipped and uneducated about proper medication management of this population.
Humboldt County needs to do more to support children and their families regarding mental health services. There are no emergency MH services for minors, they are literally kept in the same vicinity as adult patients and that is highly inappropriate and dangerous. There are also very few counselors, psychologists, and psychiatrists to treat children in humboldt county. We need a separate office for children's MH services, or much more money thrown into expanding the children's & YSB departments. EPD, HCSO, & St. Joseph's Hospital should be a part of these plans as well.

Increase Support for School Aged Children and Youth
Let's start supporting families to keep young people home
Services are desperately needed for families with private medical insurance. In addition, there is an increasing need for services for youth and teens before the person is in acute crisis.
CWS must work better with the Unit. Staff on the unit must stop telling parents not to pick up their children. There must be a way for MH to deal with MH clients and issues without foisting them off on Probation or CWS. MH must find a way to see children much much much more quickly. Facilitated skills groups for children and parents would be so much more helpful than the therapy 50 minutes.
The ACE's scores in our community/county are the highest in the state (one other county is equally high). We need all the help we can get.
I am not specifically involved or aware of all services provided, but I know from experiences of family and friends, that there is a shortage of mental health other than immediate crisis. I believe we need more follow up mental health services and work hard at early intervention.
increased Humboldt County partnerships with schools will benefit the entire county and help reestablish the importance of the neighborhood school as a prominent community supporter
The number of students coming to school with social emotional challenges is growing at an alarming rate. Schools need support in the efforts to teach students self regulating and problem-solving skills. Families need supports to work on establishing the strong foundation their children need.

Services for Early Childhood
We have very little support for children 0-3 with aggressive behaviors. If they don't have a delay there's not much intervention. This is such a crucial point in time in their lives where the greatest difference can be made. I work with children 0-3 and these kids are falling through the cracks.
Trauma informed care, education about ACES - Living/Parenting with ACES, Collaboration with the Head Start / Early Head Start programs
Begin with babies and young parents. Preventative programs are essential.
more direct services for children - absolutely essential
More clinicians that serve young children and there's a big need for a trauma-informed theraputic preschool to serve children with high ACES.
Absolutely Essential: Services for young children 0-5 years of age and support for child care providers. We all know the importance the first five years play in brain development and how this age set the stage for a child's life. We see many children who struggle in group settings. Addressing these issues before a child enters elementary school is essential to help both them and the rest of the peers they will be attending school with. Failure to address these issues early on has played a role in continued behavior issues in the elementary and middle school settings. Staff in these programs are ill equipped to deal with the types of behavior and trauma they are seeing. This often lead to children and not being able to receive much need child care. This in turn harm the child and prevents parents for finding work. In reality it just delays addressing the issues until later in life when intervention is more costly, less effective and impacts all children's ability to be in an appropriate learning environment.
Mental health services need to be easier to access in a timely manner for families with young children. This is absolutely essential for early intervention.
Children's services are needed most
Early intervention is the most effective use of time and energy in terms of generating social change.
Specialized family and caregiver support for trauma impacted families.
Mental health services for birth to five and increased mental health services for school age children
counselor that addresses Post Partum Depression and is embedded with Nursing programs.

Services for Early Childhood
0-8 Mental health Services and Hope Center treatment resources.
0-5 ages
I believe it is absolutely essential that we look to provide more mental health services for families with young children and MH practitioners who are skilled to work with young children
The need for funding for parents, children 0-5 and school aged childrenâ€”especially with the Prevention and Early Intervention dollars.
The county needs to specifically address how it will serve families with high ACES scores, including children infants through school age.
need for funding for parents, children 0-5 and school aged childrenâ€”especially with the Prevention and Early Intervention dollars (I would rate all of this as essential)
Early intervention, parent & professionals MH support needed.
Support for families with young kids (even prenatally) is absolutely essential to break this cycle of poor physical and mental health. If parents are cared for they can care for their children, and if those children have services we are supporting parents. Please make linguistically and culturally sensitive.
Recognize and integrate the science of ACEs into the plans across the lifespan
Mental health support for early childhood age kids and families (before school, 0-5) through things like playgroups with IFECMH endorsed Specialists at every playgroup every time, perhaps visits to libraries by IFECMH to do "events" with families with young kids. Real prevention and early intervention!
It is extremely important to reach out to schools and younger children, as well as teenagers and services for those dealing with addiction.
I think a systemic approach to reducing poverty ultimately is the real strategy to support mental health. If people can eat, have well-paid work, and an affordable life, a lot of mental health challenges aren't present. So food support, job training, group programs/community-building, increasing the minimum wage, etc. are the kinds of things I think are important. SUpporting children and reducing adverse childhood experiences and trauma before they happen are SUPER important.
Prevention and early intervention activities for young children and their families
More parenting classes for new parents and parents with older kids is absolutely essential
0-5. We can influence a generation if we spend more time with children. They are the future
Support for early childhood educators and their programs and families, more counselors for young adults and older adults in which insurance will cover, more suicide prevention programs.
If we can make an impact earlier, maybe we will need less services later in life.
There should be more affordable housing in this area. # 5
Funding underfunded programs or areas where the funding has been consistently lowered should be priority
Therapeutic child care centers More services for children under 5 and their parents/caregiver more services for foster youth
Explain diagnosis of children to parents better and better to children
More MH workers to meet the needs of poverty and addiction problems in our 0-5 families. More MH workers for outreach in our homeless communities. More housing for our shelter deprived people that would have MH services built in.
More recovery services for mentally ill/drug addicted in addition to long term in home support. We need services for children 0-3 for behavioral support
Better support for parents of young children to encourage a return to more active parenting rather than a culture of participation trophy's (teaching resilience)

Services for Early Childhood
Address children with risks! We know 12 year olds that need help. Connect them with mental health and medical. The team needs to work together
0-8 Mental Health Collaborative and Infant Mental Health trainings.
Trauma-informed theraputic preschool; more clinicians to serve the 0-5 population, clinicians that will see undocumented families (bilingual and for families that do not have medi-cal or insurance)
Providing support and mental health consultation to early childcare providers
Growth in 0-8 services and providers, additional space to see these individuals
Making MH services a priority for young children and their families by making them accessible and being flexible to meet the needs of the families. Providing intensive services to young children at school and in the home is crucial to their development. Teachers are struggling and need more support in their classrooms.
More pediatric mental health services. Sempervirens is not suitable or safe for children. There is no where for kids to be treated for MH crises, and very few MH providers for children with outpatient needs.
Robust trauma responsive support for pregnant and parenting folks who have been impacted by ACEs. Supporting current Infant-Family and Early Childhood Mental Health and Trauma Responsive training efforts to continue to build a qualified workforce.
Agency offices in places like Fortuna. Having Clinicians who are available to only see Fortuna children at schools.
access to MH services for all adults and children who need it
inpatient mental health treatment locally for children.
More childhood mental health support.
There is a need for funding for parents, children in the 0-5 age category and school aged children. Prevention and early intervention is key to the health of our children and communities.
More of the parenting classes
I believe we need more mental health clinicians that are trained in working with children, teens, and families. An increase in services provided to middle class families with various insurances is much needed.
Home visiting for all pregnant families. Supports for pregnancy and postpartum mood and anxiety disorders. A clinic that serves families during pregnancy until there young children to access therapeutic services. These are true Prevention and Early Intervention activities.
Psychiatry (for prescriptions) and counseling services for families (myself, my s.o., and 2 children all need those services in our area). Both children are autistic and need mh services.
Early intervention prior to full crisis.
Invest in resources for 0 to 5 children and their families.
counseling services on school sites
I recommend more prevention and wellness activities and education at the 10-17 year old age, and an increase in social-emotional education for children and their families. Continuing to build community
Early intervention
More access to programs that address substance abuse issues that are geared towards people who work (there are some programs but often they meet during the 8-5 work day). More clinicians in schools (K-12). Later hours at mental health clinics.
I think starting at a young age in school we should be discussing MH so that there isn't such stigma associated with it. Students should be able to talk to someone about themselves or someone in their home and get needed help.

Services for Early Childhood
parent/ new family financial/ budgeting classes, young parents grouped with early childhood education programs, TAY volunteer-work experience opportunities
Every foster child should have a regular checkup with a LCSW whether they are problematic or not
Transdisciplinary training and education in early childhood mental health, increased services for the 0-5 population,
More mental health specialists in preschools and k-12
youth counseling
More counselors for children
Increase the amount of counselors available to students and counseling programs in the school setting.
Parents experiencing moderate mental health issues substance use intervention for school age and TAY
Therapeutic child care centers More services for children under 5 and their parents/caregiver more services for foster youth Partnership between MH and HCOE or DNCS
My daughter has been diagnosed with depression and enjoys being around other kids like her but it hasn't been available to her outside of a mental health facility. It also would be helpful to have more supports in the schools, she's mostly been punished at her current school for common mental health behaviors.
Prevention!!!!! And early intervention!!
More programs around early intervention
Bringing back more "old fashioned" ideas like actual social contact (NOT virtual), how to communicate with others face to face, the concept that used to be a basic tenant of parenting-the theory of natural consequences rather than wrapping kids up in a plastic bubble to protect them from the world. "Protecting" kids from the world around them while their young, only to find out that they aren't the star of the universe when they head out into the world leads to depression.
I thought the county was working with Dr. Bruce Perry's neuro-sequential model of therapy/education. Is this still a path for social services? It was inspiring to think that LEOs, teachers, health workers, juvenile courts, etc. were synchronizing their approach with best practices in mental health. Guest speakers or events at schools, play groups and senior centers in Southern Humboldt could help spread awareness of services and work to de-stigmatize seeking help with mental health. Education about ACES is absolutely paramount, too.
As I mentioned, we need a trauma-informed theraputic preschool with wraparound services to serve children and families with high ACES and for children who have experienced trauma and are exhibiting very challenging behaviors.
a&b: The Bridges to Success program seems to be great start at addressing some of the issues for the population of children 5 and under. Currently though, referrals can not be made by private care providers. Opening up the referral process to all serving this population could benefit children. Also expanding these services or creating new services to provide consultation services to early childcare providers would better serve families, allow for more children to be served and help increase the capacity of this workforce in serving these children in a beneficial manner.
prevention and early intervention
More early intervention for at risk children 0-8, A community-driven approach that encompasses the entire family to support all those affected by mental health issues.

Services for Early Childhood
Early prevention and intervention is key to improving the mental health in our community. Training and support for staff and teachers to be able to support children and families. I believe that bringing MH professionals into the field to the ones who need support would make a bigger impact then having clients come to them. This is especially important for young children.
More MH services offered for minors in schools, hospitals, outpatient settings
Social workers in schools working around ACES and teaching faculty, parents and kids how to respond
Full Service Partnership programs for youth in foster re
Not sure if this exactly addresses the question, but I think it is critical for children in the foster care system to receive MH supports/services--I know in theory, each foster care child is supposed to be able to receive a MH assessment, but I also know that this does not happen in actuality.
Increased availability of counseling and streamlined referrals would greatly improve the system for indigent and needy children and parents.
preventive services for youth and teens
See answer to #9. In addition, continue to train MH staff on Infant-family and Early Childhood Mental Health to build a quality workforce to serve families who are pregnant and parenting young children. Support the 0 to 8 Mental Health Infant-Family and Early Childhood Mental Health Training Program.
More training in trauma informed care, services at natural access points as described earlier (IFECMH support for 0-5 kids/parents at playgroups, libraries), have MH folks at the libraries (in particular Eureka, Arcata, Southern Humboldt-maybe others)
Wrap around supports for youth and their families across agencies.
I've mentioned the idea of a Wellness Center a few times... I also think a MH mobile response team would be very beneficial to schools and the broader community. We also need an SV type placement for high school age youth who are experiencing suicidal thoughts.
prevention and early intervention,
A new approach to MH services by partnering with schools to offer school based mental health services through on campus wellness centers.
A stronger focus on MH aftercare for both children/youths and adults.
Prevention and early intervention for the 0-5 population, embedding MH practitioners into the existing structures that parents use such as schools, childcare, playgroups and medical offices.
Crisis center for youth in county
Early intervention. 0-5 ages and family wellness
Early intervention for children
more education about prevention and early intervention; more cross-cultural opportunities for services, including clients with disabilities and children.
Early intervention and more services for minors so they don't end up on the crisis unit. there needs to be a mental health unit at juvenile hall.
Definitely provide better services earlier on, especially for younger children, and the genetic factors.
support for the 0-8 Collabrative
Preschool and early education are vitally important and state programs have so few resources. Children and families need support. We need more quality teachers and specialists and they need to be compensated for this important work. We are not attracting anyone to this field with these sad conditions and pay. Early prevention could save so much in the long run.
It is a challenge to restore a young person at school when that young person returns to an at risk environment at home

Services for Early Childhood
Humboldt County needs to do more to support children and their families regarding mental health services. There are no emergency MH services for minors, they are literally kept in the same vicinity as adult patients and that is highly inappropriate and dangerous. There are also very few counselors, psychologists, and psychiatrists to treat children in humboldt county. We need a separate office for children's MH services, or much more money thrown into expanding the children's & YSB departments. EPD, HCSO, & St. Joseph's Hospital should be a part of these plans as well.
Services are desperately needed for families with private medical insurance. In addition, there is an increasing need for services for youth and teens before the person is in acute crisis.
CWS must work better with the Unit. Staff on the unit must stop telling parents not to pick up their children. There must be a way for MH to deal with MH clients and issues without foisting them off on Probation or CWS. MH must find a way to see children much much much more quickly. Facilitated skills groups for children and parents would be so much more helpful than the therapy 50 minutes.
Thank you for the opportunity to share my opinion. Please strongly consider the research on pregnancy and infant development while you are deciding how to utilize our communities funding. We need to intervene in these earliest ports- of- entry into a families life in order to avoid adverse childhood experiences and support a family-centered, multi-generational, culturally responsive approach to family services. I do not think that the majority of Early Intervention and Prevention funds should be used to intervene when years of adversity have already impacted the individual.
The ACE's scores in our community/county are the highest in the state (one other county is equally high). We need all the help we can get.
I am not specifically involved or aware of all services provided, but I know from experiences of family and friends, that there is a shortage of mental health other than immediate crisis. I believe we need more follow up mental health services and work hard at early intervention.
increased Humboldt County partnerships with schools will benefit the entire county and help reestablish the importance of the neighborhood school as a prominent community supporter
The number of students coming to school with social emotional challenges is growing at an alarming rate. Schools need support in the efforts to teach students self regulating and problem-solving skills. Families need supports to work on establishing the strong foundation their children need.
Provide more follow up for youth services, especially for LGBTQ+ youth.

Housing and Services for those experiencing homelessness
Emergency housing facilities for TAY. Teens, kicked out of home or runaways, are especially vulnerable for substance abuse and human traffiking. Absolutely essential.
More mental health psychiatrists for both adults and children (absolutely essential), housing programs/assistance for mental health patients (very important), wellness activities (somewhat important), medication assistance/funding (absolutely essential), substance use treatment facility that accepts minors (absolutely ESSENTIAL)
Get people off the streets, into housing and into MH services
Designated camping places. Get them off Broadway. Stop taking their belongings (dignity) and dogs away from them. Dogs are sometimes their only emotional support though its a hard life for the animals...Provide dog friendly assistance. Humboldt Spay Neuter Network, HART and local rescues provide fostering.
Some way to get homeless people needing mental health or substance abuse services into mental health and substance abuse programs.
More help for the homeless. I think it's an absolute necessary.

Housing and Services for those experiencing homelessness
"Supportive Housing" should have on-site case managers that engage dialogue with tenants to determine individual needs & encourage participation in services. People who provide services should reach out to tenants in supportive Housing and introduce counselors & other services to in-need individuals. More on-site activities to prevent the boredom that causes tenants to drink & take drugs out of seer boredom. Consumers need to be an active part of their supportive Housing in working with one another. i.e. Arcata Bay crossing is evicting mentally ill tenants for occasional smoking in their room, while low income people smoke in their room & hide it, an Golden opportunity here to go visit with tenants who need working with to keep their apartments. If someone's disability is making walking a hardship, there has to be accommodations for smokers, so they don't have far to go to reach smoking site. Managers need to be more accommodating and more proactive, not harsh and reactive otherwise we keep homeless going through a revolving door...In then eviction & out. Not right.
More support services for homeless individuals (absolutely most essential)
Absolutely essential: housing or shelter options for people with mild-moderate MH issues, locked facilities for those with serious MH issues
Following up regularly with people on the streets that are self treating with illicit drugs
Housing, SUD, MH services (counseling and medication), and active participation w community partners. Outreach to disadvantaged communities (not just Eureka focused efforts).
Support for Landlords in dealing with tenants with MH who abuse them (the Landlords). Level-Very important.
more housing options for homeless, easier access to detox services for all, diversion programs for SUD clients, more ETD programs accessible to all, ALL ABSOLUTELY ESSENTIAL!
Seems like housing is most important. Then psychiatric care, substance abuse treatment, and counseling, including life skills/job coaching, on the job training opportunities and support.
More housing for mentally ill. More hospitalization care for high-risk people.
More emergency beds, more aftercare, permanent supportive housing, mental health support folded in with pcp in a communicative continuum of care
HOUSING & Job training
Supportive housing for the severely mentally ill
Housing with support like a mom-someone there to be sure meds are consumed appropriately and everyone is home when expected.
provide more housing for mentally ill, TRTF's, board and cares
We need more housing locally for all levels of care
Housing, rapid housing action programs, HUD complaint offices and housing legal services.
Free low cost therapy/counselingtraining to law enforcementhousing crisis
Jail release referrals/drug rehab--5; jail release referrals MH and housing--5; A large portion of people in jail suffer MH problems. There is no therapy available in jail, counseling or therapist. So these people released to reoffend. Psychoactive drugs are extremely limited in jail exasperating the problem
Emphasize outreach to homeless Emphasize SUD Emphasize Housinig
In Southern Humboldt it is essential for the unhoused to have a day center and eventually some type of camp, where they can shower, wash clothes, receive referrals, use the internet and have a hot meal. This is a community wide issue - it effects all of our health & safety.

Housing and Services for those experiencing homelessness
Implement Housing First as a matter of extreme priority.
Work with families of clients and help provide no cost ride services (HTA etc, dial a ride, County vans) to better assist and provide transportation to and from services and HOPE Center. Most MH clients do not drive and have extremely limited income. Current HTA discounts are minimal for disabled applicants and a bit difficult to come by. Access to public bus lines/stops may be difficult or, not feasible. Dial-a-Sheriff is not recommended.
More MH workers to meet the needs of poverty and addiction problems in our 0-5 families. More MH workers for outreach in our homeless communities. More housing for our shelter deprived people that would have MH services built in.
Housing first. Pod communities, mini houses, designated camping with showers and laundry facilities monitored by trained MH workers and LEOs.
All shelters should have counselors available to children who are trained in trauma-informed care. All children referred to child welfare and/or court services for child abuse should also be immediately referred to theraputic services for trauma-informed care that is immediately available to them.
More help for the homeless problem, meaning more out reach and places for them to go for help that will not judge them.
On-site services for homeless & disabled that meet the tenants, in proactive one on one discussion, not plan a meeting then sit & wait then end it because no one comes. Problems, even indoor smoking, should be pro-actively discouraged, not reactive harshness that returns homeless to the street.
More buildings for housing homeless including homeless families and battered women. Housing for 290 registrants and people with criminal records (low barrier housing)
We need more therapists, with better sensitivity training. We also need to have housing for humboldt's ever growing homeless population, and services that aren't tied to churches that will demand a certain way of life from those in need.
Having regular check ins and check ups on people wandering around in the streets
Housing in other states.
Pop-up or temporary intake stations on Broadway, Old Town, and marsh areas. Faster and more aggressive intervention in keeping elders in homes. A better liaison with courts and probation departments.
Housing, affordable housing and more mj counselors in so hum
peer support training; outreach to homeless (partner w law enforcement), more local services (not just in Eureka)
Dual diagnosis treatment. Access to affordable housing
Mobile clinics? Regular events/screenings/offerings at host locations?
Making MH services a priority for young children and their families by making them accessible and being flexible to meet the needs of the families. Providing intensive services to young children at school and in the home is crucial to their development. Teachers are struggling and need more support in their classrooms.
On the ground mental health outreach at homeless camps, law enforcement able to make referrals to MH services in lieu of arrest
Weekly or monthly established visitations to apartment complexes(high risk) places.
There needs to be a creative and successful way to reduce homelessness in Humboldt County.
Caseworkers/social workers/outreach to people that need help navigation of available services. And just housing and mental health care, incl. SA treatment. (dual diagnosis)
community housing and food services.
Group therapy counselling for homeless after housing services provided

Housing and Services for those experiencing homelessness
More affordable housing, and access to jobs
Day centers
Housing, adequate local services
We need more housing for the mentally ill, like board and cares.
Services- more housing, locally, such as SNF, Board and Care, TRTF's.
Housing! Help with Housing. Help with legal services and credit building around housing....
Eureka needs a homeless shelter. How many people have to die before we receive a shelter? The winter in Eureka is cold enough to kill us. And we are dying, we are hungry, we are scared, Homeless women, alone out there. need safe housing it could be done. please help us.
Direct outreach to homeless community
Food and Housing Insecurity
increased services, incentives for housing / land lord relations and increase housing retention, stigma reduction for the community at large
enhanced cognitive behavior therapy, supported employment, supported housing
mentions needing help with housing otherwise doesn't wish to have other contact w/ government program
Shelters Day Center place to stay, hang out
Housing Programs, Support Groups that use harm reduction practices
Community Center and day center safe and accepting place for animal care, training center
focus on homeless youth, art programs, diabetes support in conjunction w mental health, more housing more SUD programs
Counselors available @ ST. Vincent's de Paul & the Mission(where people are) Expansion or relocation of SV Day Health Centers Where people can walk in if they are experiencing a mental health challenge
Expand supportive housing programs to include shared housing with on-site services by MH staff. New larger site for HOPE Center and increased funding from MHSA for Peer staff and services. They need a real kitchen, laundry facilities, showers, phone charging station and lockers.
Housing that includes MH services.
A warm house for those who need a place but not in need of locked in acute care.
Housing Housing Housing...lots of small units for single people...Texas has some good ones...Some cities have had success with providing jobs for folks. Like SWAP only a way to pay rent on temporary transition housing. Some need basic skills like reading and writing. Some though, need permanent care homes found for them. and always drug rehab.
Be more open to memory & other inabilities of mentally ill even the fears of medications, etc. Definitely a new approach to MH system through one on one prevention, and early intervention. Go out and bring metal health services to homeless apartment tenants. Get HSU Sociology students or volunteers to take people out into society to do the things we all enjoy. The mentally ill are judged harshly if they make a mistake and basically hide instead of live. Also item c) above. We aren't keeping the mentally ill housed because there is no compassionate proactive tolerance & outreach. Smoking inside shouldn't be a mortal sin that causes eviction because it stinks and is a fire hazard...kindness encouragement to smoke outside proactively should be the norm in breaking unsafe habits. Punishment creates backlash and stubbornness, which causes larger problems.

Housing and Services for those experiencing homelessness
A - keep those at risk in housing and faster return to housing of those that lose shelter. Much more aggressive stance on preventing homelessness and getting services to those that refuse them. Develop personal relationships to the clients and look at long term follow through. End the unwieldy warehousing of the homeless and those with memory issues in Motel 6, Budget Inn, etc.
Targeted case management services with small caseloads to provide longterm support to chronically mentally ill clients, plus supportive housing/residential facilities.
A place inside a building where patients can be away from the weather and the public.
Offer NFP to all parents at risk and increase access to well organized structured re homeing programs (supportive living) example is Redwood Community Action Agency PACT housing program.
Mobile mental health clinics targeting the homeless
Creating a homeless housing community (tiny houses or shipping container housing) near MH services.
Harm reduction. Housing programs/permanent supportive housing in blended communities. Expand Sempervirens by about 600%, as a start.
mobile vehicles to park and provide services, providing with evening/ night services
A stronger focus on MH aftercare for both children/youths and adults.
Day centers
Jobs, housing is needed to give people some hope for a better life.
More case management and access to housing
Help people with housing and wrap around case management
Direct outreach to homeless community that works permanently not temporary
Housing for the MH like a group home or sober environment that provides support
Inpatient treatment that allows children; actual transitional sober living environments that allow families (outside of Betty's + PACT; actual dual recovery inpatient treatment (outside Waterfront) One that can handle MH behaviors. Transportation to outpatient services that's more supportive than bus transit.
Housing first Boots outside MH for easy drop in
Access to public supported facilities and buildings for housing and activities, reconvert building to MH Housing use
MHSA dollars need to be used to DIRECTLY benefit consumers by supporting peer activities, community integration, HOPE Center, rental assistance, funds for household emergencies, small grants for generating entrepreneurship of consumers, travel funds for conferences and training.
Housing, housing, housing with MH services
Do some serious research on the small pod communities that some cities have employed to get folks off the street FIRST. From there, all else falls in line.
I would like there to be more housing for all levels of care provided locally, especially board and care homes with a small population and a homey feel.
Affordable housing, rent control, change laws that disadvantage tenants in regards to eviction.
We need a safe, warm, permanent shelter for homeless people WANTING to get off the streets.We NEED a MANDATORY MH facility that KEEPS patients until they are NO longer a danger to themselves or the public, like Talmadge was in the 1950s and 60s.
outreach outreach outreach in public places./ I.E. tabling at schools and stores
There needs to be intensive efforts to provide long term housing and support to mentally ill adults

Housing and Services for those experiencing homelessness
I want to know more about why ACEs are so high in Humboldt. How many people with ACEs are from Humboldt, and how many come here from other places? When I worked at The Job Market by the courthouse, many people on welfare told me how they loved this area because it was so much easier to get 'benefits' than the state where they lived. We just don't have enough tax payers producing enough tax dollars to fund services for the steady influxz of people into this community. How is the County planning on continuing to provide services to more and more people with less and less funding? Our roads are a mess, rent is astronomical with so little low income housing, the schools are far underfunded, public transportation sucks - we need our tax dollars to go to this critical infrastructure. When will this happen?
We desperately need more local housing options-board and cares, TRTF's. Our loved one's are housed far away from the support of family, while other counties are reimbursed for care that could be spent locally-a win-win.
Local housing of all levels of care will benefit our county's bottom line and enable families access to our loved ones. The money is available and I believe this is the highest priority.
I feel a twelve step meetings are good the program a people class are good, the hope center is good my primary residence my thought of having my own place to sleep and hang my hat and make the best of it in some time of healthy living in safety
please keep helping people with emergency hygiene and food
Its horrible for the people to be in the elements 24/7. cold rain, no place to sleep, no safe places, women alone, scared, being raped, not reporting it, this goes on against men too! Yes men too! a seasonal shelter is badly needed it hurts me seeing our homeless population.
If a person does not have safe affordable housing they can't be treated effectively. Housing First
Need more services like Free Meal or Betty Chin Meal Program
Availability of quality mental health is one of my major concerns we also need programs that "make sense" for people who are experiencing challenges whether it be homelessness or crisis or trauma.

Support Groups and Peer Support
More public depression management and similar self help technique education-somewhat important
Some activities for lonely
Transportation services for MH clients to get to appointments is essential. Also expansion on peer support and peer workforce support! More culturally appropriate services for minority populations dealing with trauma.
SUD treatment on demand very important SUD treatment for adolescents very important Aftercare housing for homeless persons leaving SV/CSU very important Expanded use of Peers in all MH settings very important Improved wages for Peers, Case Managers very important
Funded peer support for our community. When we learn from each other... we have success.
practical support for drug users such as needle exchanges - housing first programs for homeless population
Peer-based on neighborhood-based supports- when do people just need a friend and/or an advocate and when do they need support from a professional. If we have limited clinicians we need to explore other levels of professionals and/or peers/neighbors that can provide support for those in need.
peer support training; outreach to homeless (partner w law enforcement), more local services (not just in Eureka)
more community based supports to build resiliency and connection such as play groups and family resource centers
Primary prevention - connecting communities within themselves; Parent and Peer partners to support each other

Support Groups and Peer Support
Support at things already going on that are more natural access points-like playgroups, the library (there's a REAL need and lots of folks at libraries in need of help)
Training of trainers for natural leaders to meet people's needs in their communities; so not centralized and institutionalized or necessarily "professionalized" but peer to peer support; not sure exactly what that would look like but I'm thinking MotherWoman- like support groups (but beyond a perinatal focus) at every Family Resource Center throughout the County and more Resource Centers in every neighborhood that have a variety of wellness activities.
More mental health care providers, support groups for parents/family, earlier outreach in school.
focus parent and child supports
Mental health information at parenting play groups. Information sessions on mental health for parents of preschoolers up to highschoolers.
More life skills programs for all. Cooking, shopping, bus riding.
Make programs more affordable for families, and offer transportation to group meetings, or play groups for children.
Bring in house jail mental health standards into the modern age. Having more in area providers.
client lead programs
homeless or disabled MH Patients social rehabilitation
more one on one talks
Sports, youth groups, more church activities, events. Support more mass together events, live concerts, plays, carnivals, races of all types
Wellness centers are great at being a place for support groups, classes, and activities that promote mental wellness and social support. Having an ideal space is essential. Our current wellness center is overcrowded and many are no longer attending due to its overcapacity issues.
Expand supportive housing programs to include shared housing with on-site services by MH staff. New larger site for HOPE Center and increased funding from MHSA for Peer staff and services. They need a real kitchen, laundry facilities, showers, phone charging station and lockers.
Faith Center church has successfully helped people with many mental health issues through their recovery groups, such as women of courage for recovery of sexual abuse. such faith-based recovery groups should be integrated into county mh services.these groups are free to the public and religion is not forced on attendees.
Allowing voulenteers to come into locked facilities to visit residents (peer support) reducing levels of violence within facilities and promoting natural supports within the community
Category "c)"... The library offers various free classes that give people in the community something practical to do with their brain [MH], get them to meet others that are not always in their usual circle of friends. This win-win formula might be adapted for programs in the MH system.
Stop hiring therapist that are forced to work there to pay off loans or intern bonuses. Hire people who want to work there. Make the MH team part of the community, out on the streets, at playgroups, school events. People need the relationship so they can use the service
I thought the county was working with Dr. Bruce Perry's neuro-sequential model of therapy/education. Is this still a path for social services? It was inspiring to think that LEOs, teachers, health workers, juvenile courts, etc. were synchronizing their approach with best practices in mental health. Guest speakers or events at schools, play groups and senior centers in Southern Humboldt could help spread awareness of services and work to de-stigmatize seeking help with mental health. Education about ACES is absolutely paramount, too.
after hours wellness groups, play groups.
Programs for parents, offenders and not, in which adult victims of child abuse speak
MHSA dollars need to be used to DIRECTLY benefit consumers by supporting peer activities, community integration, HOPE Center, rental assistance, funds for household emergencies, small grants for generating entrepreneurship of consumers, travel funds for conferences and training.

Support Groups and Peer Support
We need to have a "client" support group that is open to the community and supported and facilitated by peer support specialists with lived experiences.

Law Enforcement Partnerships
Mental heath department included in law enforcement.
Training for police and fire department and EMT on MH. Very important. Wrap around services and services for care MH.
**If there is funding allocated to law enforcement, the focus needs to be directed towards cultivating programs to train law enforcement in psychological first aid, secondary trauma (how it impacts reflexive responses in high-stress situations) and cultural humility/awareness related to this specific region (i.e. Native peoples, homeless/houseless pop., substance users, etc).
We are missing a huge opportunity in the jail to work with people on SUD, and mental health issues. Also more education to DAs, LE on how to avoid creating more trauma which creates MH issues
Free low cost therapy/counseling training to law enforcement housing crisis
Not treating mental illness as a crime
More collaboration with Police and other service providers
Community resources and Mental health services.
If LE still does not have Narcan we need it now.
Law enforcement & school professionals trained in trauma-informed practices, psych first aide, etc.; strengthened partnerships b/n schools, MH service providers, law enforcement and medical facilities; proper support and training for MH workers to prevent burnout and turnover; programs and services offered and focused on early intervention.
A better connection with police regarding their observations. Not jail time, but instead addressing the behaviors and possible mental health concerns causing the repeated offenses
Law enforcement training for mental illness
Continued education of mental health issues. Crisis interventions. More law enforcement support.
Mobile MH units like MIST Post release from jail services
Laura's Law, Collaborative Courts, MH Diversion, Additional Dual diagnosis facilities, housing (transitional and low income), Social Workers to assist individuals with accessing services

Transportation for Clients
Transportation services for MH clients to get to appointments is essential. Also expansion on peer support and peer workforce support! More culturally appropriate services for minority populations dealing with trauma.
Hope Center transportation needs to remain in place instead of being discontinued as of December 27, 2019. Very important

Transportation for Clients
integrated physical medical care with MH DR Clear Concise transportation information on all client options streamline grievance procedures make bad employees accountable and keep records
Wellness centers outside of Eureka, with transportations (shuttle) to wellness centers
More counselors for low income and help with transportation
services centralized to public transit, a park for kids to play in and food for while waiting at appointments
GAS VOUCHERS TO GET TO EUREKA
Free public transit, at home/with family social work and therapy
Free public transit, at home/with family social work and therapy
More life skills programs for all. Cooking, shopping, bus riding.
Make programs more affordable for families, and offer transportation to group meetings, or play groups for children.
Rides for disabled
Provide transportation and child care if needed
Use of teaming up with Uber for transportation, more group counseling, gas gift cards
This county needs Interagency communication to advance continuum of care including transportation services. More accountability and transparency over government funding
I have a plate in my leg and a bad back when I walk a little ways I fall on my face

Increase Support for Seriously Mentally Ill
Absolutely essential: housing or shelter options for people with mild-moderate MH issues, locked facilities for those with serious MH issues
Create a MH response team that responds to mental health calls instead of the police. Stop sending armed people to deal with someone having a mental health issue.
ABSOLUTELY ESSENTIAL: We need a mental health hospital to house those who are incapable of caring for themselves.
Focus on the most SMI people by connecting with local disability resources for employment and housing and providing Treatment, Housing, AOT, Mental Health Court, Triage centers, Board and Care homes with more support , expanded hospital, support for nurses and MH professionals, bed and psychiatric care providers: Highly important.
When people are having severe mental problems in rural areas, we, as a community, feel very unprepared for how to handle the situation.
More housing for mentally ill. More hospitalization care for high-risk people.
I notice that none of the items include: AOT, Laura's Law, MH DIversion, treatment of acutely psychotic patients at the jail, CCT or more case managers for patients with severe chronic mental illness. To me, these are the services that the lawmakers and tax payers want MHSA funds to prioritize since these are the patients who are the most ill, need the most help, don't realize they need the help (anosagnosia) and are most likely to be homeless and incarcerated due to society's neglect to care for them. To me, county mental health centers exist first to care for these patients, the ones that are too ill and disorganized to be able to stay well in the community and used to be institutionalized at state hospitals
provide real, serious therapy for those with need for long-term counseling. People who suffer from ptsd/ borderline personality disorder, etc. are not able to pay for therapy

Increase Support for Seriously Mentally Ill
More positive projects like the Jefferson Center to engage people and make them feel useful. More facilities like Napa for those who are dangerous to self and others. More beds locally for minors with severe issues since this problem seems to be rising by leaps and bounds. Offer more hands up not hand outs
The county needs to divert funding to expand mental health. Not just a new program with a cute ackronym, but build out Semper Virens. Make room for more beds and staffing. We have outgrow our current facilities, and it makes staff unpleasant and keeps everyone from reaching the desired goal.
Address children with risks! We know 12 year olds that need help. Connect them with mental health and medical. The team needs to work together
spend more of the MHSA funds on the most severely ill patients rather than the least ill; don't spend any county money on things like birthday parties for SV until the actual services for patients are being provided
For the mentally ill, they need group homes where they can be supervised and made to take their medicine. Left on their own, they will stop taking their meds and end up on the street again. That is not safe for them or the rest of the community.
Better understanding of harm reduction, mental health disorders include SUD
Be more open to memory & other inabilities of mentally ill even the fears of medications, etc. Definitely a new approach to MH system through one on one prevention, and early intervention. Go out and bring metal health services to homeless apartment tenants. Get HSU Sociology students or volunteers to take people out into society to do the things we all enjoy. The mentally ill are judged harshly if they make a mistake and basically hide instead of live. Also item c) above. We aren't keeping the mentally ill housed because there is no compassionate proactive tolerance & outreach. Smoking inside shouldn't be a mortal sin that causes eviction because it stinks and is a fire hazard...kindness encouragement to smoke outside proactively should be the norm in breaking unsafe habits. Punishment creates backlash and stubbornness, which causes larger problems.
Prevention!!!!! And early intervention!!
More programs around early intervention
Explore the restorative practice system that local schools implement so MH could immediately connect with those young people in need
Stop hiring therapist that are forced to work there to pay off loans or intern bonuses. Hire people who want to work there. Make the MH team part of the community, out on the streets, at playgroups, school events. People need the relationship so they can use the service
I thought the county was working with Dr. Bruce Perry's neuro-sequential model of therapy/education. Is this still a path for social services? It was inspiring to think that LEOs, teachers, health workers, juvenile courts, etc. were synchronizing their approach with best practices in mental health. Guest speakers or events at schools, play groups and senior centers in Southern Humboldt could help spread awareness of services and work to de-stigmatize seeking help with mental health. Education about ACES is absolutely paramount, too.
A center to provide adequate services for these individuals
prevention and early intervention
Prevention and early intervetion
More MH services offered for minors in schools, hospitals, outpatient settings
A safe place where people could go when they are in a MH crisis, aside from Sempervirons. This place should be staffed with experienced, compassionate MH providers that people can actually talk to in person when experiencing a crisis.
INVEST IN AND SUPPORT YOUR PROVIDERS WELLNESS!

Increase Support for Seriously Mentally Ill
(1) Training for all medical staff in recognizing and addressing a traumatized person and deescalating. Learning to treat disabled people with compassion. Having REAL advocates for cognitively disabled people. I was assaulted by an in-house self-proclaimed advocate at RRHC Dental, the office manager Barbara. The nonchalance of the response of the clinic made it clear she's just their bouncer and assaults patients whenever she wants. Not having a third party witness to events is a serious endangerment to all disabled people receiving medical "care" here. Humboldt County healthcare is horribly unsafe for disabled patients generally. (2) There must be some legal recourse for patients who are mistreated by staff or the staff will NEVER stop the abuse. Insurance complaints go NOWHERE. At the least there could be a Medical Abuse line where one who has been abused could get counseling and have an outlet. Personally, I have been dismissed from two clinics and I haven't lived here one year. Literally no one in Humboldt County gives a shit at all about how I've been mistreated and abused by "medical" staff. And even my counselor who claimed to be an Anger Management specialist dropped me when I got upset with her one day. So how am I supposed to get help when I'm supposed to be healed before I can get treatment? No one in Humboldt understands cognitive disability. I get MORE TRAUMATIZED every time I try to get care of any kind here. There absolutely has to be more counseling available. (3) I think a call-in counseling line with people available at will is a much better option than making appointments with people ridiculously far away. I think concentrating care also eases oversight. The counselors won't be able to abuse patients off in some hidden corner. They could be monitored on call or the calls could be recorded and then reviewable if a patient complains.
Social workers in schools working around ACES and teaching faculty, parents and kids how to respond
Case managers that assist with the social determinants of health. Refer to Maslow's hierarchy when considering providing services to any group.
Supporting mental health services that Native American providers (Two Feathers, UIHS, Tribes) are making available that first supports identity of the client and includes more traditional mental health services. Community mental health activities that builds community responsiveness and connection around mental health (opposite of isolation that happens for individuals).
Full Service Partnership for children's mental health, California Wraparound and/or Nationally accredited wraparound services for all youth with high end mental health needs
Healthier and more holistic approach. We are crisis driven right now.
Make more beds available at SV, Crestwood etc. Because there are 10 beds avail, doesn't mean there are only 10 people experiencing a need for mental health help.
funding mental health clinicians to work in the homes of families with children who have diagnosed mental health disorders.
prevention and early intervention,
Eureka High School (and other schools) need onsite wellness centers and staff.
More involvement in schools to help students see the signs and symptoms of mental health crisis prior to turning to self medication or other risky behaviors.
A new approach to MH services by partnering with schools to offer school based mental health services through on campus wellness centers.
Schools really do not have mental health providers on staff. It would be great to get more mental health provider on sites to offer group or class information on basic or proactive practices for students. Or offer information to school staff in our area.
Client-centered follow-up and "as needed" care from psychiatric nurses and physicians.

Increase Support for Seriously Mentally Ill

I am a nutrition professional. Many things contribute to positive mental health, but I have often wondered what would happen if a nutrition/neutraceutical approach was included in county mental health services. For example, if mental health professionals received training about how diet (sugar consumption, amino acids, B vitamins, alcohol consumption, junk vs. real food) affects mental health and incorporated this into all county mental health services, this could make a difference. Assigning health coaches/nutrition coaches to mental health clients could make a huge difference in outcomes.

In fact, I've wondered about helping to create a collaborative intervention trial model with a group of sempirvirens patients, or recovering addicts to add a nutritionist coach and nutriceutical supplementation plan to their team and plan to see if we can reduce addiction recidivism and reduce hospitalization/symptoms. I've seen first hand how addiction, anxiety, depression, and other mental health issues can be related to poor gut health, nutrient deficiencies, and poor diets.

If this sounds like something you'd like to discuss further, I'd be happy to connect: Amanda Malachesky, 707-629-3533.

Have case workers available to help parents take kids to doctor/dentist/eye appointments and to sign up for preschool and kindergarten.

Prevention would be a novel thing to try for once. I feel like nothing, as far as crime and mental health crisis, is dealt with until it becomes an emergency. We do not have the facilities or people to implement preventative procedures. The largest group which would benefit from mental health care are the literally thousands of homeless and substance abusers who bounce back and forth from the jail cell to the streets. What's more, the community at large displays animosity towards these two groups, colloquially called tweakers, because they run rampant in search of their vices rather than getting help. Because there is no help. I feel like preventing people from wanting to abuse substances or commit crimes would solve a lot of our problems with Tweakers in this area.Also, recently HSU got rid of one of its counseling programs. They used to let the grad students in Psychology practice in a guided setting and in return other students would get regular and free mental help, but they have since stopped doing this. They still have CAPS, but you can only get 8 free 0.5 hour sessions per year and you have to call at 8 in the morning to get a first come first serve appointment. This left many students without regular and free counseling. A program that is not run by the campus, but an outside entity, would be nice. I think regular and consistent mental health opportunities are necessary to the absolute CRISIS this county is embroiled in. I have lived here my entire life. Over the past five years or so everyone I know that has lived here for a long while has said that Eureka has gotten worse. The Drug problems, the crime problems, the general pollution caused by the homeless and needle users. We need to find a way to get these people up on their feet and healing before they get so far gone that they aren't human anymore and they refuse to be helped.

Early intervention and more services for minors so they don't end up on the crisis unit. there needs to be a mental health unit at juvenile hall.

Help people with housing and wrap around case management

support for the 0-8 Collabrative

We need supportive jobs for mentally ill

Inpatient treatment that allows children; actual transitional sober living environments that allow families (outside of Betty's + PACT; actual dual recovery inpatient treatment (outside Waterfront) One that can handle MH behaviors. Transportation to outpatient services that's more supportive than bus transit.

Increase Support for Seriously Mentally Ill

At County Mental Health there is no outside supervision of people with serious mental health conditions. They roam around the neighborhoods being inappropriate. I have witnessed people shooting up in the driveway of the red house next to the parking lot. I have reported it twice and with no response.

Health care providers on high alert for possible suicide victims

I'm hopeful that we will see the development of a DHHS led Day Center for those experiencing homelessness, with wrap-around services that focus on housing assistance, substance use disorder, mental health challenges, and living skills to help better transition people from living on the streets to being placed into housing.

I've also seen to many times when DHHS has placed clients into housing, but then do not seem to have resources to help furnish the unit, and people end up sleeping on the floor. We cannot expect that simply putting someone into a unit will be all it takes for them to be successfully housed. Not only do they need supportive services, but they need bedding, cookware, etc, to help make a house a home.

I just have my own story. My sister started showing signs of MH issues at puberty. She has been in and out of jail, homeless lots of the time, kicked out of every transitional house in the area, refused service from businesses and motels. Law enforcement would take her to Sempervirons and she would stay for a couple/few days and be released. She was diagnosed with bipolar schizophrenia and PTSD and continued to have no where to go. At last in 2019 at age 36 she is finally in a facility in Modesto. My whole family lived with trauma for years trying to get help. Everyone knew the seriousness of her situation as law enforcement and Sempervirons saw her on a regular basis.I work in an Elementary School and hope to not have students/families find themselves in the same situation.

There needs to be intensive efforts to provide long term housing and support to mentally ill adults

We cannot continue to enable bad behavior, it is time to do outreach programs for the young about how bad their lives can be if they have a drug dependency , for those already using, we need to identify them early and be sure they get treatment and counseling (Like it or not) as far as the Chronic users, we need mental heath facilities, that is why we don't want chronic drug addicts, they have burned their brains to the point that they are unable to function and need constant care or they force their dysfunctions on communities. And it isn't cute to see, especially when you have young children and families

I'm manic Depressive and I come in every 6 months for a reevaluation and I am happy w those services, Hope the river project does not close

Provide Clarity and Navigation of Available County Mental Health Services

More public awareness in the community,

Psycho education support for the community; understanding how to support community members with mental health issues as a fellow community member; ongoing mental health services to avoid crisis level needs and after crisis ongoing treatment to prevent recurring crisis

Public small classes on coping with ...depression, loss, divorce

More public awareness through social media, newspaper, TV and hold seminars/information meetings.

All those involved, could have completed list of resources.

Direction connection with afterschool programs

Advocates/ building awareness of mental health

More community activities bringing awareness

Provide Clarity and Navigation of Available County Mental Health Services
Caseworkers/social workers/outreach to people that need help navigation of available services. And just housing and mental health care, incl. SA treatment. (dual diagnosis)
Bus like the Blood mobile to go out to clients
mobile services to outlying areas
Offer services in schools, churches and community locations health gyms that families, seniors or homeless could access easily. Information or groups in the same locations.
Better communication with stakeholders around a client's options, supports, and opportunities for feedback on the effectiveness of services
More options, and a centralized list of what the options are. As a teacher I am still unaware of many resources for my students.
Qualified persons and adequate training to deal with mental illness, drug addiction, family violence, teen pregnancy, rape
Offer support to all seeking mental health services despite the severity of their needs and increase collaboration with other organizations/agencies.
More awareness on mental health topics other than depression/suicide in order to break the stigma around other lesser known mental health issues such as eating disorders or anxiety disorders
Complete openness and timely access, list all services from every different dept. and MHD disclosure, budget and services put on the internet (public) is to bring MHD to legal liability if they do not provide the service and needs as is wanted and required
Better understanding of harm reduction, mental health disorders include SUD
Give Suddenlink/local TV stations a tax break to advertise MH services. More drastic punishment for drug dealers. Pamphlets in hospitals, welfare, social security office, probation office
Availability of information around resources, connect with people
CMH does one to one counseling
I thought the county was working with Dr. Bruce Perry's neuro-sequential model of therapy/education. Is this still a path for social services? It was inspiring to think that LEOs, teachers, health workers, juvenile courts, etc. were synchronizing their approach with best practices in mental health. Guest speakers or events at schools, play groups and senior centers in Southern Humboldt could help spread awareness of services and work to de-stigmatize seeking help with mental health. Education about ACES is absolutely paramount, too.
Better referral system for medi-cal clients and additional navigation through resources
Not sure if this exactly addresses the question, but I think it is critical for children in the foster care system to receive MH supports/services--I know in theory, each foster care child is supposed to be able to receive a MH assessment, but I also know that this does not happen in actuality.
No closed doors around prevention and early intervention. Communities need to know what services are available and how to access them. They also need to know how to create the change they wish to see. Service providers need to be able to assist their clients with this information. We need collaboration amongst service providers with regards to prevention and early intervention strategies.
Inviting and strengthening ties b/n providers - that often overlap, however, lack paralleled training in MH (i.e. school staff, law enforcement, medical staff as well as MH workers & orgs) - by developing relevant programs/trainings
I believe we should take the services that places like Remi Vista and Changing Tides supply and provide it for families that have insurance other than Medi-Cal (while still providing services to low-income families). Also, we should start to adopt more tele-health services for MH.
Make MH affordable/easier/convenient to access

Provide Clarity and Navigation of Available County Mental Health Services
C. Adapting group session, home visiting, and therapeutic sessions (art, etc)
making information in a easier learning environment also parent /guardian support groups
I am a nutrition professional. Many things contribute to positive mental health, but I have often wondered what would happen if a nutrition/neutraceutical approach was included in county mental health services. For example, if mental health professionals received training about how diet (sugar consumption, amino acids, B vitamins, alcohol consumption, junk vs. real food) affects mental health and incorporated this into all county mental health services, this could make a difference. Assigning health coaches/nutrition coaches to mental health clients could make a huge difference in outcomes. In fact, I've wondered about helping to create a collaborative intervention trial model with a group of sempirvirens patients, or recovering addicts to add a nutritionist coach and nutriceutical supplementation plan to their team and plan to see if we can reduce addiction recidivism and reduce hospitalization/symptoms. I've seen first hand how addiction, anxiety, depression, and other mental health issues can be related to poor gut health, nutrient deficiencies, and poor diets. If this sounds like something you'd like to discuss further, I'd be happy to connect: Amanda Malachesky, 707-629-3533.
Have case workers available to help parents take kids to doctor/dentist/eye appointments and to sign up for preschool and kindergarten.
The key is getting family and friends and patients all in same page. Educating everyone and finding ways around HIPPA barriers to ensure continued care and support
The key is getting family and friends and patients all in same page. Educating everyone and finding ways around HIPPA barriers to ensure continued care and support
I do not know what the Hope Center is. That is a problem of public education I presume.
There seems to be so little coordination of agencies that should be working together to offer not just mental health services but the other services that support individuals and families trying to survive to keep themselves mentally healthy-- Changing Tides will help very young children, but ONLY if they are on Medi-Cal; where do they go otherwise? Family Resource Centers have their hands on the purse strings for childcare services during holidays but act as if it is their personal money and there is no fair distribution to help parents needing respite care, or who are homeless and need a place for their kids to go when school is out for the whole family's mental health. The County Office of Education receives McKinney-Vento grant funds to serve homeless preschoolers but will not spend a penny of it on them so these poor little kids are literally out in the cold with no services at ALL, pushing their parents over the edge emotionally. Changing Tides is supposed to be doing outreach to homeless preschoolers because of funding they receive but they not only don't do that, they make it HARDER for the homeless parents that do manage to find out about their funding for homeless preschoolers in childcare-- it is absolutely maddening and all contributes to the very poor mental health in the most vulnerable of our community. It must stop, These agencies have to work together to figure out how to streamline their services in all aspects to make it easier for those the services are intended to help access them.

Provide Clarity and Navigation of Available County Mental Health Services

Don't pretend to provide "supportive housing" for homeless & disabled, if the guidelines of "supportive housing" will not be followed....it causes despair to the homeless who can't get what they want and need and it causes difficulties for family members, who know their mentally ill person needs what services on-site were promised. It doesn't increase hope for families or homeless and it is worse than leaving them alone... to evict them when they have a warm spot then send them back out without nothing to lose faith in humanity. I have heard first hand mental health counselors tell people if "smoking helps calm them down, then smoke."....yet these same people who lack life skills, who might be lost in their own private world of voices etc. get evicted if they forget to go 150' to a smoking area in the cold. Such was our family member and we pleaded with everyone & anyone to stop their eviction and give them the services promised to be on-site, and no one cared. Nothing came of this pleading for our son and for others in the same position and we see the young woman evicted lying on the sidewalk talking to the unknown wrapped in a thin blanket, when she needed medication and support. When hiring management for apts. that "house" mentally ill the management should be well informed of mentally ill problems. Yes rules are made to follow and black & white.. for the safety of other tenants and facilities. but people do not all process "black & white", and that is where we fail people who need more one on one proactive support. Our son & a female tenant at Arcata Bay Crossing are being evicted because an IHHS worker reported to
management a few cigarette butts in their rooms. They must be out by 20th of November. This is the result of Health & Human Services Mental Health services not working one on one with life skills, rules, reminders, drinking issues and support services that were supposed to be "on-site." All Jessica Duke could say was "well he smoked in his room" that is against the rules. A lot of low income people smoke occasionally in their rooms, but they process well enough to hide the evidence, and get to stay. This picture is hurtful and accomplishes nothing to better the life for the mentally ill homeless tenant. So we loose 2 more mentally ill tenants mid November and Health & Human Services doesn't care.

This is extremely important for many people so please go all in and all out to make the changes that are and have obviously been needed for quite a long time. Patients can an do read the verbal and non-verbal actions of employees and doctors. I know some patients get wild and or lie, and say weird stuff but they don't want to have to deal with their situation just like mh providers don't either. Sempervirons employees need to check their egos at the door and be ethical and honest. Also don't force anyone into a 5150 if they are not a 5150.

We have done very little over the last 40 years in the way of making great strides in our care of people with mental health issues. There has been some amazing research done and in small percentages, people have a greater understanding, but it is not wide spread, and it is not funded. Public understanding of the issue and what can be done and how it can be done is still needed. Our public and policy makers need to be informed, stigma erased and changes made! In the meantime, the cost to society is beyond measure.

Learning what and how Trauma affects the individual (Internal/External) is Absolutely important in functioning in the world.

If there are meetings about how to improve services I would like to be invited. Crystal Perez 707 825-2538

When making a referral to MH parents often complain they did not get a call, however when checking into the situation it is often the parent that did not return a call of phone full not taking messages etc. If there were a way to look at the first intake process it might insure clients are getting what they need a little more effective?

Provide Clarity and Navigation of Available County Mental Health Services
I am not specifically involved or aware of all services provided, but I know from experiences of family and friends, that there is a shortage of mental health other than immediate crisis. I believe we need more follow up mental health services and work hard at early intervention.
My main goal is to not only raise awareness for depression and suicide, but also for the less talked about mental illnesses that I've personally watched destroy people and tear apart family bonds.
I feel that a lot of people whom speak other languages other than English do not seek MH Services due to stigma and low education. people are not easily going to produce info that they do need help due to stigma in their culture
Need navigator at SV for families
Is there a special community wide consent so service providers can coordinate more effectively; more harm reduction community education. Do we have an idea on the community brasses and needs for education?
Availability of quality mental health is one of my major concerns we also need programs that "make sense" for people who are experiencing challenges whether it be homelessness or crisis or trauma.

Hope Center Improvements
Hope Center transportation needs to remain in place instead of being discontinued as of December 27, 2019. Very important
If the Hope Center is able to expand, consider placing Hope Center activities at a new Day Center located near Old Town: Very Important Provide mental health clinicians in the field and where at risk populations are located (i.e. St. Vincent de Paul) for easier access to assessment and support services: Absolutely Essential
Allow healing to occur in nature. Hope center needs to expand-maybe relocate in a peaceful natural setting.
A larger building for the Hope Center
Adult case management should be given to all people who go to sv, for at least 4 to 6 months after dc. Hope center should have programming that helps ppl get to appointments and supports all ranges of functioning, not just the most needyAll adult system administration above tay, should be shuffled off to other departments. Im sure they work hard, but they dont care about clients and it shows in the programming and staff training. All line staff should have training 4 times a year. Not from drug companies or from programming spokespeople...we're here to sell you our latest "evidenced based blablabla."
expand and improve the hope center and establish more board and cares, provide Substance Use disorder residential treatment for pregnant moms and moms with children under six years
Expand supportive housing programs to include shared housing with on-site services by MH staff. New larger site for HOPE Center and increased funding from MHSA for Peer staff and services. They need a real kitchen, laundry facilities, showers, phone charging station and lockers.
Increase the size of the Hope Center - get them a building away from the Mental health complex
MHSA dollars need to be used to DIRECTLY benefit consumers by supporting peer activities, community integration, HOPE Center, rental assistance, funds for household emergencies, small grants for generating entrepreneurship of consumers, travel funds for conferences and training.

Bilingual and Culturally Competent Services
Transportation services for MH clients to get to appointments is essential. Also expansion on peer support and peer workforce support! More culturally appropriate services for minority populations dealing with trauma.
More competent psychiatrists, especially bilingual and culturally competent psychiatrists - absolutely essential!!
Intergenerational Trauma for Indigenous Native who have not been told that True Historical trauma that was n is still being inflicted on Native in school and jails n especially the Indigenous Men and women in government prison os USA.
Services to teens; suicide prevention and ethnic studies support in schools
Support for families with young kids (even prenatally) is absolutely essential to break this cycle of poor physical and mental health. If parents are cared for they can care for their children, and if those children have services we are supporting parents. Please make linguistically and culturally sensitive.
More outreach/de-mystifying of services available to minorities. Also more training of staff to recognize, understand, and overcome cultural barriers minorities may have to seeking/accepting needed MH services.
Bilingual mental health services
I believe it is very important to have information available in a persons native language.
Locations set up for services in tribal communities for screening and prevention as well as support groups after a diagnosis to discuss things such as the dangers of alcohol and drug use, especially marijuana, combined with prescription drugs
Train staff to be competent in care for LGBTQ patients
Better communication between the institutions that offer services, resources for helping families understand what services exist and how to participate in these services in a language they understand
Round the clock services, satellite offices, bilingual staff
Cultural competence
In general, having more Spanish speakers in the mental health community would benefit this large population.
Multicultural approach group setting- educational/therapeutic programs for siblings/extended family. Social skill therapeutic group for individuals with disabilities. Development of peer support groups with inclusive multicultural perspective.
Increased outreach/presence of MH staff at cultural events/gatherings, and bi-lingual PSA's to reach minorities.
Making them more culturally accessible
Support existing "coming of age" traditions (like the tribal events, bat/bar mitzvahs, quincenera), and develop a new one for people who do not have a faith-based/existing culturally-based event. Use these to help teens develop agency, grit and perseverance towards life goals.
The healing restorative aspect of being in a natural setting can be capitalized upon here in Hum. Co.

Mental Health Services at Schools and Other School Supports
Housing, SUD, MH services (counseling and medication), and active participation w community partners. Outreach to disadvantaged communities (not just Eureka focused efforts).
Mental health services for birth to five and increased mental health services for school age children
We desperately need more people in our schools that have been trained using a developmental model of support to provide the necessary long-term help for children with trauma.
Enhance Bridges program to support more school age youth.
More training for teachers and school administrators. More academic counselors at the high schools, because often they are the first to notice or be notified of problems.

Mental Health Services at Schools and Other School Supports
I think it is absolutely essential to begin to implement wellness centers on high school campuses that house county services such as health care providers, social workers, counselors, drug/alcohol prevention programs, etc. This would help provide wrap around services and increase access.
We have one full time counselor for all our students (over 1000). There are interns and a part-time counselor from Open-door, but it is not nearly enough to serve all of our students.
Families and children need help and they should be receiving them at school -- since the kids already go there most everyday. Why can't we spend some money to pay the schools to provide some of these services -- since the families and kids already know and trust the schools?
more counseling at school sites
A top priority I see needed for our area youth and families is the longevity and increase in service outreach programs such as Bridges as well as full staffing of the MRT.
It is extremely important to reach out to schools and younger children, as well as teenagers and services for those dealing with addiction.
Mental health counselors should be placed in every school.
More mental health services for the schools- essential!
To reinforce responses already given, I feel it is extremely important that we access increased support in the school setting with MH clinicians and school based counselors, especially training in trauma informed care as well as addressing behavioral concerns.
Outreach at schools for peer counseling of gender identity harassment and social help.
More counselors for children in schools especially in rural area where it is difficult for the children to go into Eureka to meet with a counselor. The students that have to travel to town if they can meet with a counselor would have to miss time in school which is also very important for them. For an hour session it means 3 hours or more of travel time. The counselors need to go to the rural schools where they can meet with several students in a day.
We need school counselors on site- not only a visiting psychologist who does assessments.
Early Intervention of drug users as well as high school and Jr. High education programs are essential. Stop the pattern before it be starts or before it becomes chronic
Support in our elementary schools, trainings for officers, teachers and pediatricians. Centralized list of support services to lower our ACES scores repeatedly being high.
I believe that schools particularly at the middle school level need more additional counseling services and mental health supports due to their developmental period and also the significant trauma that affects our area here in Humboldt County. Schools should have resources for at least one or two full-time counselors on site.
More resources available to schools to assist with student mental health issues. Not just "the school can deal with it" as the resources aren't there for schools either but actual mental health support working WITH schools to support student needs.
ALWAYS on-site counselor and psychologist at every school
SED/SUD programs, school-based mental health services and support, mental health awareness and coping mechanisms for school aged children.
More counseling in schools
More qualified good staff, central location, outreach programs and add to the places clinicians go to for services, schools, church's, community centers, resource centers etc.
Making MH services a priority for young children and their families by making them accessible and being flexible to meet the needs of the families. Providing intensive services to young children at school and in the home is crucial to their development. Teachers are struggling and need more support in their classrooms.
More social workers in schools, more people able to bill medi-@$cal
Agency offices in places like Fortuna. Having Clinicians who are available to only see Fortuna children at schools.
Mental health councilors that come to the site at the preschool level.

Mental Health Services at Schools and Other School Supports
More in schools, more in play groups
Law enforcement & school professionals trained in trauma-informed practices, psych first aide, etc.; strengthened partnerships b/n schools, MH service providers, law enforcement and medical facilities; proper support and training for MH workers to prevent burnout and turnover; programs and services offered and focused on early intervention.
More school-based mental health services, perhaps grant-funded
More support for school staff. Mental health days retreats etc. More bodies on campus. We have to support our support team.
Wrap around Wellness Centers on school campuses. A physical place on campus to house community service providers.Social workers and school counselors can work together to provide cohesive support plans and schedules.
counseling services on school sites
more outreach for students and opportunities to broaden world view
Timeliness. Inadequate providers in high schools.
Eureka High School (and other schools) need onsite wellness centers and staff.
School based mental health services through on campus wellness centers.
Mental health counselors/therapists on school sites, serving students on a regular basis
More access to programs that address substance abuse issues that are geared towards people who work (there are some programs but often they meet during the 8-5 work day). More clinicians in schools (K-12). Later hours at mental health clinics.
limit income barrier, offer more choices in mental health providers and give ut information through schools so parents know where to go to get help.
mobile clinic services, high school-based services
Better and earlier detection of M. I., thus a need for high school and university faculty and staff to recognize the symptoms.
An increase in providers that accept a variety of insurance plans, but also an increase of school based providers.
I would love to see more parenting classes offered at school settings and then the parents would be provided with day care so they are able to attend
meetings at schools without school stigma
More trauma-informed mindfulness based programs available through wellness/health centers, family resources, and in schools
We need a school counselor, desperately. And more access to mental health services in our remote valley (Petrolia).
Counselors for rural schools that can meet in the school on a weekly or biweekly time for sessions.
School districts need regularly scheduled on going mental health personnel; there needs to be intense mental health services in HCCF.
More options, and a centralized list of what the options are. As a teacher I am still unaware of many resources for my students.
more services for students
provide the services for school age children at school -- they are already there and schools are willing to participate
More school funding for these issues
investment in a multilingual physician
More counselors for children
Mental health support in schools and preschools
Increase the amount of counselors available to students and counseling programs in the school setting.
More mental health support personnel in schools
Fund programs and services developed by schools. They best know the needs of their students. Also, work more closely with Family Resource Centers.

Mental Health Services at Schools and Other School Supports
Best and Promising Practices for the Implementation of Zero Suicide in Indian Country, from Zero Suicide in Health and Behavioral Health Care
My daughter has been diagnosed with depression and enjoys being around other kids like her but it hasn't been available to her outside of a mental health facility. It also would be helpful to have more supports in the schools, she's mostly been punished at her current school for common mental health behaviors.
b and c - we to reach people where they are, where they live, and communicate in their language(s); community focused efforts could be self sustaining and more relevant to local needs - too much MH infrastructure in focused in Eureka
community cultural centers for marginalized communities so that they have a natural place to receive support that would be preventative in nature because connection is a mediator for mental health challenges. this would then be a great place to implement peer support programs.
Early prevention and intervention is key to improving the mental health in our community. Training and support for staff and teachers to be able to support children and families. I believe that bringing MH professionals into the field to the ones who need support would make a bigger impact then having clients come to them. This is especially important for young children.
More MH services offered for minors in schools, hospitals, outpatient settings
Social workers in schools working around ACES and teaching faculty, parents and kids how to respond
Supporting mental health services that Native American providers (Two Feathers, UIHS, Tribes) are making available that first supports identity of the client and includes more traditional mental health services. Community mental health activities that builds community responsiveness and connection around mental health (opposite of isolation that happens for individuals).
counseling clinics at all schools, all grade levels.
Culturally appropriate services
Eureka High School (and other schools) need onsite wellness centers and staff.
More involvement in schools to help students see the signs and symptoms of mental health crisis prior to turning to self medication or other risky behaviors.
A new approach to MH services by partnering with schools to offer school based mental health services through on campus wellness centers.
Wellness Centers in every school
Schools really do not have mental health providers on staff. It would be great to get more mental health provider on sites to offer group or class information on basic or proactive practices for students. Or offer information to school staff in our area.
C.). Training educational staff more thoroughly to recognize symptoms and have A SMOOTHLY WORKING PROCEDURE FOR GETTING HELP TO STUDENTS WHO NEED IT.
Better info and services in schools
Prevention and early intervention for the 0-5 population, embedding MH practitioners into the existing structures that parents use such as schools, childcare, playgroups and medical offices.
A new approach. Meeting the people where they are, and making sure services are provided to all area schools to meet the needs of the students to learn the skills necessary to succeed. Provide personnel to schools so teachers and mental health can work together for the whole child.
increased services and partnerships with schools
More mental health personnel providing actual services to students. Not just telling the existing staff at schools what to do.

Substance Use Disorder Services
SUD treatment on demand very important SUD treatment for adolescents very important Aftercare housing for homeless persons leaving SV/CSU very important Expanded use of Peers in all MH settings very important Improved wages for Peers, Case Managers very important
Treatment for disorders and substance abuse in lieu of jail to prevent reoffense
More mental health psychiatrists for both adults and children (absolutely essential), housing programs/assistance for mental health patients (very important), wellness activities (somewhat important), medication assistance/funding (absolutely essential), substance use treatment facility that accepts minors (absolutely ESSENTIAL)
more housing options for homeless, easier access to detox services for all, diversion programs for SUD clients, more ETD programs accessible to all, ALL ABSOLUTELY ESSENTIAL!
Mental Health and Substance abuse support for teens in Humboldt- absolutely essential
More suboxone programs, and more advertising on where people can get the specific mental health services they need
Seems like housing is most important. Then psychiatric care, substance abuse treatment, and counseling, including life skills/job coaching, on the job training opportunities and support.
More substance abuse counseling and prevention programs
It is extremely important to reach out to schools and younger children, as well as teenagers and services for those dealing with addiction.
Dual diagnosis treatment (substance abuse and mental illness address together) = absolutely essential
practical support for drug users such as needle exchanges - housing first programs for homeless population
facilitated groups for MH Dx people. Raven Project collaborartion for their youth
Dual Diagnosis support Post release from jail support
Substance use Disorder inpatient treatment for youth and parents w/their children Suicide texting crisis line or warm line crisis services for youth
Emphasize outreach to homeless Emphasize SUD Emphasize Housinig
SED/SUD programs, school-based mental health services and support, mental health awareness and coping mechanisms for school aged children.
Making mental health or substance abuse services mandatory as a condition of parole or probation for people with mental health or substance abuse issues.
More recovery services for mentally ill/drug addicted in addition to long term in home support. We need services for children 0-3 for behavioral support
Harder attack on drug abuse and the creation of programs to track patients on critical mental health meds to insure that they are regularly filling and TAKING the medicine.
Dual diagnosis treatment. Access to affordable housing
Substance Use support groups (harm reduction approach) where the clients are located (i.e. St. Vincent de Paul).
Treatment programs that address dual diagnosis, in-county residential treatment for youth
Sobering and Detoxification Facilities
More SUD services and after hours support for working families.

Substance Use Disorder Services
We need more Suboxone programs because there is a long waiting list of people that want to sign up, and the very few providers in the area that provide these services are overwhelmed with the amount of patients they have
Caseworkers/social workers/outreach to people that need help navigation of available services. And just housing and mental health care, incl. SA treatment. (dual diagnosis)
Effective and up to date substance abuse programs
Drug and alcohol rehab and follow-up services
Local center locations to drop in when MH issues flare. Consistent Drug Awareness and Substance Abuse Counselors on call - Tough Job!!!!!!
in patient SUD treatment
More access to programs that address substance abuse issues that are geared towards people who work (there are some programs but often they meet during the 8-5 work day). More clinicians in schools (K-12). Later hours at mental health clinics.
Qualified persons and adequate training to deal with mental illness, drug addiction, family violence, teen pregnancy, rape
Consideration of protective factors, esp. for children i.e. arts, outdoor activities, music, drama, immersed in nature, sing-a-longs, karaoke, religion and church activities. Emphasis on Adverse Childhood Experiences (ACE's) resolution. Collaboration with other community resources. As a greater and more comprehensive integration of all a person's health care needs I encourage the purchase of acreage for development of a patient-centered medical home (PCMH). Continue to address the issue and complexities of dual-diagnosis or co-occurring disorders.
Parents experiencing moderate mental health issues substance use intervention for school age and TAY
Need to have more programs for SUD/mental health long waiting list; need follow up after discharge from SV with family included; first break follow up
Better understanding of harm reduction, mental health disorders include SUD
focus on homeless youth, art programs, diabetes support in conjunction w mental health, more housing more SUD programs
Assessment and treatment for co-occurring mental health and SUD simultaneously.
As stated above, from personal experience, it took me three rejections from hospitals and ending up at a police station in order to get critically needed mental health help. I was rejected because I didn't have thoughts of harming myself or others, but was experiencing severe hallucinations and delusions after a traumatic experience. If we had centers people could go for help without having to â€˜qualify' in certain ways, many people would be better off in our community.

Substance Use Disorder Services
Prevention would be a novel thing to try for once. I feel like nothing, as far as crime and mental health crisis, is dealt with until it becomes an emergency. We do not have the facilities or people to implement preventative procedures. The largest group which would benefit from mental health care are the literally thousands of homeless and substance abusers who bounce back and forth from the jail cell to the streets. What's more, the community at large displays animosity towards these two groups, colloquially called tweakers, because they run rampant in search of their vices rather than getting help. Because there is no help. I feel like preventing people from wanting to abuse substances or commit crimes would solve a lot of our problems with Tweakers in this area.Also, recently HSU got rid of one of its counseling programs. They used to let the grad students in Psychology practice in a guided setting and in return other students would get regular and free mental help, but they have since stopped doing this. They still have CAPS, but you can only get 8 free 0.5 hour sessions per year and you have to call at 8 in the morning to get a first come first serve appointment. This left many students without regular and free counseling. A program that is not run by the campus, but an outside entity, would be nice. I think regular and consistent mental health opportunities are necessary to the absolute CRISIS this county is embroiled in. I have lived here my entire life. Over the past five years or so everyone I know that has lived here for a long while has said that Eureka has gotten worse. The Drug problems, the crime problems, the general pollution caused by the homeless and needle users. We need to find a way to get these people up on their feet and healing before they get so far gone that they aren't human anymore and they refuse to be helped.
Early intervention, Drug users usually have mental health issues that bring in Law Enforcement or Fire services, they degrade their health and end up in the ER. When they are identified they need to have a court date that brings them in front of a judge who orders them to attend mental health counsuling to correct their behavior BEFORE it becomes chronic behavior.
Housing for the MH like a group home or sober environment that provides support
People in Humboldt are self medicating. Most have some pretty traumatic issues in the past, and use drugs because they cannot get the mental health services that would be helpful and a smoother path for change in their life and their recovery.
The true homeless, especially families, should be helped above those who are repeat substance abusers.
I'm hopeful that we will see the development of a DHHS led Day Center for those experiencing homelessness, with wrap-around services that focus on housing assistance, substance use disorder, mental health challenges, and living skills to help better transition people from living on the streets to being placed into housing. I've also seen to many times when DHHS has placed clients into housing, but then do not seem to have resources to help furnish the unit, and people end up sleeping on the floor. We cannot expect that simply putting someone into a unit will be all it takes for them to be successfully housed. Not only do they need supportive services, but they need bedding, cookware, etc, to help make a house a home.
We cannot continue to enable bad behavior, it is time to do outreach programs for the young about how bad their lives can be if they have a drug dependency , for those already using, we need to identify them early and be sure they get treatment and counseling (Like it or not) as far as the Chronic users, we need mental heath facilities, that is why we don't want chronic drug addicts, they have burned their brains to the point that they are unable to function and need constant care or they force their dysfunctions on communities. And it isn't cute to see, especially when you have young children and families

Other
The public health suicide fatality review (5) safety planning and warm hand offs for every SV discharge!!!!!!! (5)
Implement a "Zero Suicide" approach for all access points. Absolutely essential
interface with Redwood Coast Regional Center
More inclusive community events (ex. Agricultural work, community gardens, clothing swaps, food drives and cook outs)
Funded, local residential chemical health treatment for persons with developmental disabilities. Also, more MH/Sober homes that also support people with intellectual disabilities.
Suicide Fatality Review - Absolutely essential
Whatever needs to be implemented to track patients and monitor if they stay on their needed mental health meds. There is a very fine line between their rights to refuse their meds and the public's rights to be safe from their behaviors when they are not taking them. Laws need to be looked at and changed.
A mobile program that can deliver food, firewood, and other essential items to consumers homes would be very essential. Appointment reminders and any appointment change notifications is also very essential.
I would like to see an agency or individual bring people together from different agencies. We do a lot of believe we have a lot of resources that are duplicated or available. Perhaps quarterly.
If applicable to the services you provide, food security and other means of allowing one's most basic needs to be met are necessary for one's mental and emotional health. I would say it is a 4 out of 5 on level of importance. People cannot pursue personal growth if they are not getting their most basic needs (i.e food and shelter) met.
Parenting classes are highly recommended.
Suicide Fatality Review
Assessments need to be more than client provided info
More training, counselors, and stronger partnerships to support individuals with intellectual disabilities. (Absolutely essential)
Parent/ Family education programs.
I think a systemic approach to reducing poverty ultimately is the real strategy to support mental health. If people can eat, have well-paid work, and an affordable life, a lot of mental health challenges aren't present. So food support, job training, group programs/community-building, increasing the minimum wage, etc. are the kinds of things I think are important. SUpporting children and reducing adverse childhood experiences and trauma before they happen are SUPER important.
A priority should be the welfare of the community at large, not just the people in need of personal services. Mental health needs are endless but money to spend on them isn't nor should it be. It is more important to create adults who can take care of their own needs first whether their behavior is troubling or not.
Support for early childhood educators and their programs and families, more counselors for young adults and older adults in which insurance will cover, more suicide prevention programs.
Reducing stigma for our most vulnerable.
Can music and nature be utilized as part of the therapeutic process?
Increased collaborations within the community especially among agencies, health care facilities, etc. ABSOLUTELY ESSENTIAL
Budget issues that put pressures on front line staff every year to be able to resolve them by working longer harder faster etc. It would build morale , and demonstrate cooperation teaming support and leadership if those that do not normally provide direct service but are qualified to would rollup their sleeves and join to make things better
Implementation of Laura's law Establish a MH Court Provide Resources (Continuity of care leaving criminal justice system) Prioritize recruitment of MH practitioners and clinicians

Other
Substance use Disorder inpatient treatment for youth and parents w/their children Suicide texting crisis line or warm line crisis services for youth
integrated physical medical care with MH DRClear Concise transportation information on all client optionsstreamline grievance proceduresmake bad employees accountable and keep records
Reduce stigma
Include nature, art as part of therapeutic process
Expand information source for assessment to include more than client information
more prevention activities
Support suicide fatality review
Start really listening to your people, meet them where they are at. Spend more time with listening to their past and how that could be affecting them now.
Art and music programs incorporated into treatment plans; providing mindfulness meditation and yoga options
Less stigma associated with functional mental health issues & treatment
Free classes about basic mental health information.
holding public forums for the purpose of gathering a cross-section of the public to hold discussions on important topics and get to know one another.
caring contacts, safety plans - education and standard process
Continue to offer/promote healthy foods wherever possible as I believe having access to those foods is key to wellness/recovery.
All Nationality tackle this together. Become a real sincere caring n loving from your heart and soul to assist in healing the trauma the government n or president inflicted on Mother Earth.
Less reliance on grant writing, more legislative commitment to permanently fund mental health and wellness programs
Ask yourself what causes MH distress and that's your answer.
Adoption of Laura's Law
Mental health needs to be addressed and meeting the person where there are without adding blame.
Listen
More consumer webinars of MHSA and access California YouTube not just educated but also in power us consumers to make three wise and effective decisions in voiceing our concerns
Assisted Outpatient Treatment, Mental Health Courts
To support these efforts that are being established now through consistent funding. My concern is these programs dissipating once funding runs out.
Better communication between the institutions that offer services, resources for helping families understand what services exist and how to participate in these services in a language they understand
Mindfulness, meditation, yoga
A community friendly accessible center that is a resource for navigating services to support mental health.
a wellness center for outpatients that isn't at the clark complex,more beds at sempervirens and staff at sempervirens that interacts with the clients instead of hiding behind a lucite cage at the nursing station where they ignore the clients,their as our population has increased the staff morale leaves a lot to be desired,its very disturbing
Advocates/ building awareness of mental health
Supporting the Asset Based Community Development model particularly in outlying communities by utilizing available funding to support/expand services being successfully provided in home communities.

Other
home visits, MEV providing counseling in outlying communities.
If client's meet certain criteria it should be required for them to receive services and engage in them instead of being voluntary.
Community resources and Mental health services.
Free counseling, for anyone who needs it. Cost keeps me from being able to attend regular meetings. This community needs help and needs the help to be EASILY ACCESSABLE. Why would someone in crisis, want to make 50 phone calls to only be told "not accepting new patients." That person is not going to make another call after that, they will just feel hopeless.
Weekly or monthly established visitations to apartment complexes(high risk) places.
Support person that can help coordinate services. Training's on helping families and empowering them. Training on better customer service.
Make treatment MANDATORY for mentally ill residents
Due to the limitations of clinicians, have a disclaimer that a client can sign so entities can disclose if they are working with a client. Just so several programs aren't working with the same few, when there is such a need.
More resources easily available, affordable MH services, and less negative stigma.
services centralized to public transit, a park for kids to play in and food for while waiting at appointments
Home visiting for all pregnant families. Supports for pregnancy and postpartum mood and anxiety disorders. A clinic that serves families during pregnancy until there young children to access therapeutic services. These are true Prevention and Early Intervention activities.
Primary prevention - connecting communities within themselves; Parent and Peer partners to support each other
We need help (more service providers, group settings, etc.) within our community, which is very small. Many people who need help can't get to Eureka or the towns around it. In any case, they need to be persuaded somehow to seek help, no matter where it is offered. Stigma is a big issue in a small community. How can people who badly need help be persuaded to seek it?
Mattole resource center practices minimum legal requirements versus best practices. The board of directors of the MRC have by their actions have caused me to shun their organization and question their intentions. I would rather drive to Eureka or Mad river health center in trinity county than Mattole Resource Center.
Integration of complimentary care into mental health care. For example yoga, meditation, art therapy, movement such as Ti Chi, etc. These classes could have a brief educational component then the actual activity. Sort of a no risk way to access services for those who may need care but not "believe in" it or whatever other reason for not accessing services.
We just need more money and earlier start for issues
Dismantle and replace the current corrupt and harmful system.
Remove the opt out for parents when children/families have been recommended for counseling by teachers and/or mental health staff. All foster youth/homeless should have a counselor through 26 years of age. Any family with CPS report records needs family counseling on an on-going basis. The court ordered requirement is a short term hoop that they jump through. It needs to be long term counseling for life change.
SBMH and local resources working together to fill the need for all community members.
Community awareness of the impact of ACEs & a two-generation approach to Mental Health.
Commitments to relationship building
Timeliness. Inadequate providers in high schools.
The more services provided will lower the mental health crisis the State is currently in.
Intervention in the home.
Small teams where a cadre of support services follow a small group rather than a Henry Ford assembly line approach with specialists who only see a person until they move on to another level, etc.
I would love to see more parenting classes offered at school settings and then the parents would be provided with day care so they are able to attend

Other
just give the agency to the TAY department. Allow them to expand their services to include adults, older adults, and inpatient oversight. They have an education and an appropriate ethic. it shows.
awareness, outreach, stop the stigma, have a referal specialist who can help match the right therapist with clients, HAVE INSURANCE COVER YOGA AND MEDITATION classes, as well as other wellness programs, teach holistic health care.
parent/ new family financial/ budgeting classes, young parents grouped with early childhood education programs, TAY volunteer-work experience opportunities
More diverse approaches
Reach out for support throughout other counties and MH regions in California.
Train the locals and PAY them enough money to survive. Make it easier to get a cannabis license. Get rid of the Department of Fish and Wildlife and the Waterboards stranglehold on the permit process. This seriously impacting the economy and creating mental health issues for all the individuals and families that are in Humboldt county. Do this NOW. Another study is not going to help...
Eating Disorder supports
More life skills programs for all. Cooking, shopping, bus riding.
Musical events- concerts, sing-a-longs, drum circles, dancing
What about caring for pets in a supervised setting? Rescue shelters appreciate visitors who keep the waiting pets socialized by affectionate visitors. Other volunteer activities where a group together improve our area could build self esteem.
Offer support to all seeking mental health services despite the severity of their needs and increase collaboration with other organizations/agencies.
Consideration of protective factors, esp. for children i.e. arts, outdoor activities, music, drama, immersed in nature, sing-a-longs, karaoke, religion and church activities. Emphasis on Adverse Childhood Experiences (ACE's) resolution. Collaboration with other community resources. As a greater and more comprehensive integration of all a person's health care needs I encourage the purchase of acreage for development of a patient-centered medical home (PCMH). Continue to address the issue and complexities of dual-diagnosis or co-occurring disorders.
Educating every single person on trauma and how to not cause more. De stigmatizing is essential for change.
religion government and philosophy classes
Therapeutic Classes
more/higher taxes on the wealthy
early intervention! work force develepoment, study of toxic stress on MH support force
Never make medication the issue; never browbeat or intimate to medicate; never use peer pressure to achieve medication compliance
Give Suddenlink/local TV stations a tax break to advertise MH services. More drastic punishment for drug dealers. Pamphlets in hospitals, welfare, social security office, probation office
Sports, youth groups, more church activities, events. Support more mass together events, live concerts, plays, carnivals, races of all types
keep doing what you have to do to obtain funding
Community Interaction Nutrition, Health and Physical Activities/Alternatives Day Centers Afterschool Hours use of gym and facilities, showers, sports
Suicide fatality review, Zero Suicide, more suicide prevention programs
Parenting classes, family education
Volunteering

Other
Eating disorder supports
Zero suicide ebp. Caring contacts for SV discharges. Warm hand offs to outpatient care.
Suicide Prevention: safety plans and follow-up upon release from SV
mandated suicide fatality reviews
Family inclusive counselling sessions with either Dr. and/or case workers. Total exclusion of family in Patient/Dr assessments (as current practices enforce) severely limits the effectiveness of case work and other "facts" about patient behaviors. Patients by practice will either limit the QnA or flat out lie as convenience and avoidance. Better case management (case worker assignments to clients) I currently have an adult son who is a outpatient client, and no case worker is assigned.
Implement Zero Suicide approach
prevention and early intervention
Same as above, include art, music, dance, theater, and alternative healing practices.
Recognition of mental health as important as physical health in the workplace
Best and Promising Practices for the Implementation of Zero Suicide in Indian Country, from Zero Suicide in Health and Behavioral Health Care
The grand jury needs to do a comprehensive review of our county mental health from every step in the process. Every program, all the discharge stats, interview all staff, and investigate what it would take to get things functioning up to the needs of our community.
Teach on cause and effect. You do evil, you suffer. It's nothing personal done by an angry deity, it's the law of the universe.
Change the system that only helps people over a certain age, because there are a lot of guys that need help in their late 20s through their 50s
Be more open to memory & other inabilities of mentally ill even the fears of medications, etc. Definitely a new approach to MH system through one on one prevention, and early intervention. Go out and bring metal health services to homeless apartment tenants. Get HSU Sociology students or volunteers to take people out into society to do the things we all enjoy. The mentally ill are judged harshly if they make a mistake and basically hide instead of live. Also item c) above. We aren't keeping the mentally ill housed because there is no compassionate proactive tolerance & outreach. Smoking inside shouldn't be a mortal sin that causes eviction because it stinks and is a fire hazard...kindness encouragement to smoke outside proactively should be the norm in breaking unsafe habits. Punishment creates backlash and stubbornness, which causes larger problems.
All adult system administration above tay, should be shuffled off to other departments. Im sure they work hard, but they dont care about clients and it shows in the programming and staff training. All line staff should have training 4 times a year. Not from drug companies or from programming spokespeople...we're here to sell you our latest "evidenced based blablabla."
I have yet to hear of an effective MH practice unless you have money. Ethics and empathy are extremely important. Get more psyc doctors with innovative ideas that are careing approaches here in Humboldt.
Implement a true stakeholders committee that meets every quarter minimum. From 10 to 15 people does that accesses Mental Health Services With County Mental Health administration, senior program manager oh, and case managers also on this stakeholders committee
Adapt programs to be able to serve at least some of clients current needs before referring them to an alternate program/ not working with clients who do not meet criteria. Conduct extensive staff workplace satisfaction studies to reduce identify/ reduce the cause of rapid employee turnover at the current MH programs.
INVEST IN AND SUPPORT YOUR PROVIDERS WELLNESS!

Other
(1) Training for all medical staff in recognizing and addressing a traumatized person and deescalating. Learning to treat disabled people with compassion. Having REAL advocates for cognitively disabled people. I was assaulted by an in-house self-proclaimed advocate at RRHC Dental, the office manager Barbara. The nonchalance of the response of the clinic made it clear she's just their bouncer and assaults patients whenever she wants. Not having a third party witness to events is a serious endangerment to all disabled people receiving medical "care" here. Humboldt County healthcare is horribly unsafe for disabled patients generally. (2) There must be some legal recourse for patients who are mistreated by staff or the staff will NEVER stop the abuse. Insurance complaints go NOWHERE. At the least there could be a Medical Abuse line where one who has been abused could get counseling and have an outlet. Personally, I have been dismissed from two clinics and I haven't lived here one year. Literally no one in Humboldt County gives a shit at all about how I've been mistreated and abused by "medical" staff. And even my counselor who claimed to be an Anger Management specialist dropped me when I got upset with her one day. So how am I supposed to get help when I'm supposed to be healed before I can get treatment? No one in Humboldt understands cognitive disability. I get MORE TRAUMATIZED every time I try to get care of any kind here. There absolutely has to be more counseling available. (3) I think a call-in counseling line with people available at will is a much better option than making appointments with people ridiculously far away. I think concentrating care also eases oversight. The counselors won't be able to abuse patients off in some hidden corner. They could be monitored on call or the calls could be recorded and then reviewable if a patient complains.
Community driven
c) Adapting a promising community-driven practice that has been successful in non-mental health settings, and applying it to the MH system. Facilitate events which draw users of services for MHSA input - ask them what they need and how they are able to receive support.
Embed counselors in home visiting programs
Adding a new division to help support parents with difficult teen youth.
Healthier and more holistic approach. We are crisis driven right now.
A - a new MH practice or approach, such as Bruce Perry's approach.
Town meetings
C. sounds good, since each community is different, therefore making sure the needs of a specific area has been captured. Prevention and early intervention is always a must, which could even prevent MH.
A change to an existing MH practice or approach, including adapting it to the setting, community or population of Humboldt county.
I think we need more approaches that involve Holistic Health rather than prescribing pharmaceuticals for every issue
It would be nice to see a more holistic approach in general. It seems that many agencies are pigeon held by "this is how it's always been done" and
Sanctuary Model
1) Domestic violence program for victims that provides counseling and independent living skills.
Mobile services, web based services for people who have a hard time leaving their homes or do not have transportation. Having access to the internet or a mobile health service can be a powerful tool to bring counseling services to people who are home bound. This includes the elderly, mothers caring for young children, children in school and even support groups. Duo, Facetime, Skype can all bring a real person to a person's home for less expensive delivery of many types of health services. Our lack of providers in this area could also be helped by the use of technology.
Dream Centers in Los Angeles and Atlanta have very successful results with their programs. The whole person needs to be treated for full recovery.
Parenting classes!
An all-in-one setting would be ideal. Also, creating partnerships with large facilities, such as Stanford, UCSF, etc for access to interns

Other
I am a nutrition professional. Many things contribute to positive mental health, but I have often wondered what would happen if a nutrition/neutraceutical approach was included in county mental health services. For example, if mental health professionals received training about how diet (sugar consumption, amino acids, B vitamins, alcohol consumption, junk vs. real food) affects mental health and incorporated this into all county mental health services, this could make a difference. Assigning health coaches/nutrition coaches to mental health clients could make a huge difference in outcomes. In fact, I've wondered about helping to create a collaborative intervention trial model with a group of sempirvirens patients, or recovering addicts to add a nutritionist coach and nutriceutical supplementation plan to their team and plan to see if we can reduce addiction recidivism and reduce hospitalization/symptoms. I've seen first hand how addiction, anxiety, depression, and other mental health issues can be related to poor gut health, nutrient deficiencies, and poor diets. If this sounds like something you'd like to discuss further, I'd be happy to connect: Amanda Malachesky, 707-629-3533.
Until there is a reasonable involuntary treatment system, stop wasting resources on the to encourage a change in behavior. Offer services to those who want to change, not just want everyone else to change
Changes need to be made in the existing MH system. This one is not working. My son has been in and out of Sempervirens. He gets on his medication, the voices go away and out the door he goes with no supervision. Within weeks he is back living rough. If he were not mentally ill he would never choose that life style. His whole extended family lives with constant worry about his safety. He trusts no one, and will not take help from anyone. Not when he is not medicated. If he ends up dead, we will never know.... We just worry and wonder, when it rains, when there is a report of a hit and run on Broadway. Was it him? Is this the best America has to offer? Denying family from taking care of him and yet not allowing anyone to take care of him or those most vulnerable with mental illness. The whole system need to be changed!
Implement Laura's law
prevention and early intervention
Adapting a promising community-driven practice that has been successful in non-mental health settings, and applying it to the MH system. - Reach out for community support. Promote community planning processes restlessly.
teaching empathy
take advantage of the healing property of nature and make available excursions to our abundant natural resources or provide a living situation that includes access
Participating in group musical events, singing, drumming, dancing, chanting can elevate one's mood and help a person to feel connected and part of something greater than one's self. Being in nature is enough to create a peaceful attitude.
Better inner agency communication and support. Free, no, or lost MH services for the community similar to Open Door set up with primary focus being MH.
Collaboration and service availability to a broader range of individuals.
Awareness events similar to the Out Of The Darkness walk for mental illnesses such as eating disorders as well as making schools more aware of and accommodating to individuals who struggle with mental illness.
Humboldt County has to update it's ancient approach of Mental Health. Promote feelings of health and wellness from a system of wellness. MH clinicians provide amazing work to clients, support and expand this amazing work. The supervisors create a supported work environment. Provide MH services that are culturally relevant, include art therapy, somatic therapy, mindfulness practices. Provide easier access to Med support. Meeting rooms are very small and often are cramped with people who attend groups.
I think a lot of people needing services in our community fall through the cracks because they are on the edge of qualifying for services. We need to expand our service capacity to include those with slightly larger incomes or who on paper appear to have more supports, but in actuality have no way of accessing those supports.

Other
Laura's Law
B and C and non interfered with patient rights advocate that can do a proper and just job in make the administration and its employees answerable
Never use peer pressure or browbeat to achieve medication compliance. Some people are afraid of medication and eschew drug use even medication in their lives. Some people have religious intolerance for the "cult of the magic pill or shot"
Tax break to local media to do ads for MH services
more integrated programs not necessarily MH based bring in MH to help integrate program such as art based programs
Home visiting
Perhaps this is a step in the right direction. Hopefully so.
We appreciate your endeavors as stressed and limited as it may be. MH staff is doing a great service under most difficult circumstances.
Thank you for asking for input from the community.
I resent your pushing the "race" issue. It's about people who need help. and I have to say as an employee of DHHS, there is a lack of understanding or support to co-workers experiencing issues such as depression. Disgusting isn't it.
Don't pretend to provide "supportive housing" for homeless & disabled, if the guidelines of "supportive housing" will not be followed....it causes despair to the homeless who can't get what they want and need and it causes difficulties for family members, who know their mentally ill person needs what services on-site were promised. It doesn't increase hope for families or homeless and it is worse than leaving them alone... to evict them when they have a warm spot then send them back out without nothing to lose faith in humanity. I have heard first hand mental health counselors tell people if "smoking helps calm them down, then smoke."....yet these same people who lack life skills, who might be lost in their own private world of voices etc. get evicted if they forget to go 150' to a smoking area in the cold. Such was our family member and we pleaded with everyone & anyone to stop their eviction and give them the services promised to be on-site, and no one cared. Nothing came of this pleading for our son and for others in the same position and we see the young woman evicted lying on the sidewalk talking to the unknown wrapped in a thin blanket, when she needed medication and support. When hiring management for apts. that "house" mentally ill the management should be well informed of mentally ill problems. Yes rules are made to follow and black & white.. for the safety of other tenants and facilities. but people do not all process "black & white", and that is where we fail people who need more one on one proactive support. Our son & a female tenant at Arcata Bay Crossing are being evicted because an IHHS worker reported to management a few cigarette butts in their rooms. They must be out by 20th of November. This is the result of Health & Human Services Mental Health services not working one on one with life skills, rules, reminders, drinking issues and support services that were supposed to be "on-site." All Jessica Duke could say was "well he smoked in his room" that is against the rules. A lot of low income people smoke occasionally in their rooms, but they process well enough to hide the evidence, and get to stay. This picture is hurtful and accomplishes nothing to better the life for the mentally ill homeless tenant. So we loose 2 more mentally ill tenants mid November and Health & Human Services doesn't care.
PLEASE MAKE MENTAL HEALTH CARE AFFORDABLE. MY HUSBAND NEEDS HELP
Thank you for your work to make a healthier Humboldt community.
We need many more MH providers throughout the county to deal with the current needs of the community. The number of providers that are needed simply don't exist right now. A longer term goal needs to be focused on parenting supports so we can raise kids with better self-esteem and resiliency to deal with the world around them which would reduce the need for MH services down the road. A culture of participation trophy's and "protection" from natural consequences has taken away the sense of identity and earned self-worth that is so vital for kids as they go out into the world. We aren't doing them any favors by "protecting" them from the experiences they need to learn and develop. This has resulted in so many young adults that lack basic social skills and an ability to deal with the world around them.

Other
Don't let the cops lead this discussion or be a major part of it. They are not mental health experts. A member of this community was killed by a cop in NY when he was having a mental health crisis. The cops here have shot and killed people have mental health crises as well. Let the doctors and the science of effective tactics prevail.
Stop hiding behind procedure, confidentiality, and process. Create something specifically for Humboldt County.
Thank you for this opportunity to gain input from the communities that you serve
My agenda is for Humboldt to be great: I want good people to live here and bad people to leave or get help to be good.
thanks for asking.
I dont believe spending with people trying to get rid of their symptoms is productive. Symptoms will remain, let's help each other thrive with our symptoms. When we learn to hid our symptoms, recovery is hard to attain.
Thank you for listening and for the difficult work you all do.
I'm always praying n together I know n love that healing can n Faith that it will happen if we all pray together
At County Mental Health there is no outside supervision of people with serious mental health conditions. They roam around the neighborhoods being inappropriate. I have witnessed people shooting up in the driveway of the red house next to the parking lot. I have reported it twice and with no response.
These problems are related to a flawed system that puts too much emphasis on materialistic values and too little on spiritual contentment. Also, the process is difficult and scary for persons already feeling marginalized by society.
Thanks for considering input!
Thank you for making a difference!
Thank you for all your hard work to consider MH improvements in Humboldt County.
The state of healthcare in this county overall is tragic. It is very important to remember that a big part of what people here need help recovering from is abuse by medical professionals and bureaucrats. This entire county is mentally unwell, from top to bottom. The horribly sadistic bureaucrats are damaging people's lives all day long without any remorse. This county is run by psychopaths who are incapable of empathy. If you want to establish mental health in Humboldt County, don't put the onus on just the people on the street. All Humboldt County staff should have to be trained in deescalation, recognizing trauma, and showing compassion. Why is it that I get along fine with the Sherriff's Dept staff, but medical professionals assault me? Training. The medical staff here in Humboldt always only escalates tensions in my experience. They're very unqualified for their clientele. It makes every medical facility turn into nothing but a fascist detention center staffed by blind automata, not human beings. Medical care in this country does NOT have patient wellness as priority one. Nope, priority one is profit. And patient wellness isn't even on the list. Turn the Humboldt County medical staff into human beings through sensitivity training or don't even bother claiming to care about mental health here.
Cathy Rigby has done an amazing job making the MHSA and MH services more understandable.
Thanks for having MH available to people like me
I am concerned that Dr Soper at St Joseph's makes significant psych med changes when mental health clients are hospitalized for medical, not psychiatric, reasons without consulting the client's county psychiatrist.
I am thrilled this survey is being done and look forward to hearing about the outcome
Thank you for receiving feedback from this community!
Thanks taking input from the community you serve.
Thanks for your hard work!
Thank you for taking the time to inquire!

Other
Please publish the rate at which the resources are given to the person in need. Example: When you give money to a charity you can find out how much of your $100 given is spent.Is it feeding the hungry people as opposed to charities with an overhead that is so huge that if you give $100 only $20 goes to food and food prep and $80 goes â€œoverheadâ€ which is a scam. If you could make your year budgets publicly available online then the general public would trust the non profits that receives public funding and people would trust them. Instead please remember the Matel foundation and Regge on the River and where did the money go???????????It is called Hippie Economics they take all they can and still want more.
Tell everyone you meet to urge lawmakers to pass laws creating single-payer universal health coverage that includes mental health.
Thank you for your work to help the community.
Things continue to improve! Keep up the great work!
Thank you for this survey. MH is a priority that has been neglected for far too long. Hopefully those in decision positions will plan and implement the very necessary services to MH related clients/patients.
I appreciate everything you do! I only wish there were more of you...
I appreciate all the help and services that are being provided.
Thank you for your efforts to meet this need in our community!
Thank you for conducting this survey!
You guys have a thankless job. Thank you for doing it.
Homeless folks aren't likely to see this survey. Nor are they likely to have the patience to fill it out like this. Without cops involved, and without the associated providers involved, survey the client base and take their criticisms seriously. I've heard too many folks with horror stories about poor care, denied care, and the profound harm caused by such.
Please reflect upon our suggestions! Thank you.
Please spend as much of your money on "on the ground" actual help to people and little on academia.
First as about what results are desired, not just how to do what is being offered
Thank you for asking for input
Thank you for addressing this issue with the public
Thank you for this opportunity, sad to miss the event but I don't want my kiddos being a distraction. Open communication is key, this community is wonderful. Excited to raise my family here â¤ï¸
Thanks for asking
Humboldt tends to react and implement policy they should research and slowly implement new policy and determine if it is working. The constant implementation then realizing it doesn't work here is more harmful than not doing anything. The reactionary mindset needs to change
Thanks for all the work you do.
As one of the locum psychiatrists said back in 2004, "the problem with HCMH is basically administrative," meaning too many bean counters who seem to view their clients as funding units, not people, who are deserving of care and compassion.
Thank you for all the work you do!
Thank you for doing these surveys, I look forward to seeing the progress that occurs because of them.
My main goal is to not only raise awareness for depression and suicide, but also for the less talked about mental illnesses that I've personally watched destroy people and tear apart family bonds.
Appreciate the desire for improvement
I appreciate your work!
This survey needs to be extended for a month as it was not publicized enough to get good input.
MH needs to come up to code on all human services in all demanded human rights and needs services. An independent civilian review committee to monitor all complaints and infractions against all depts., clarity of services and timely access

Other
Thank you for providing this survey, it helps when people come together and provide their input and are serious about wanting to help their community. If anyone is interested on the possible use of artificial intelligence MH Network please let me know.
SV during intake focuses too much on medication compliance and does not allow the patient to just come in and go to bed without being medicated, but they should. Resolution without medication is always preferable as to accept the meds establishes a precendent one may not want in their lives. To pull through a crisis observation without mds would boost morale of patient and some people are afraid of drugs and medication and of being chained to a pill regimen. Focus/overfocus on medication compliance or willingness to accept meds is an unneeded escalation and sorely exacerbates the situation of any patient pursuing religious freedom or healthy choices to be without meds
Availability of quality mental health is one of my major concerns we also need programs that "make sense" for people who are experiencing challenges whether it be homelessness or crisis or trauma.