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

Mental Health Services Act

Three Year Program and Expenditure Plan

FY 2020/21-FY 2022/23

Contents

Letter from the Behavioral Health Director

Dear Valued Community Members,

This Mental Health Services Act (MHSA) Three-Year Plan, covering FY 2020-2023, comes at a time of great fiscal uncertainty. As you may already be aware, Behavioral Health relies on sales tax revenue, vehicle license fees and personal income taxes to fund services. The MHSA is funded by personal income tax revenue. Projections for this revenue source, over the next three years, suggest a significant decrease. The current plan revenue estimates are based on anticipated economic conditions related to COVID-19, but we expect that we'll need to make future adjustments as we get more information on the long-term fiscal impacts of this pandemic. We will use the annual update process to assess and adjust this plan as needed.

Our plan specifically seeks to support the critical mental health services needed in our community, that supplement and enhance programs and services we are mandated to provide through other state and federal funding. It recognizes the importance of providing services and supports across the lifespan and continuum of care. It allows us to invest in prevention and early intervention, our Transition Age Youth, our schools and school climate curriculum, as well as lifting up individuals with lived experience and supporting a recovery model of healing. It gives us opportunity to reduce stigma and discrimination and to educate our community on the importance and opportunities to prevent suicide. It allows us to be creative and innovative in providing services that meet our communities unique cultural and geographic make up and to invest in our local expertise around what is needed to heal our communities. Finally, it supports our efforts around recruitment and retention of a workforce that is invested in our community's health and wellbeing.

We very much appreciate the community and our partners who have participated and given input into the MHSA community stakeholder process. The commitment and partnership of community members, service providers and stakeholders has been amazing. The work ahead of us will undoubtedly be challenging and there are still many unknowns, but together, we can continue to support the health and well being of Humboldt County.

Best Regards,

Emi Botzler-Rodgers, LMFT
Behavioral Health Director

Introduction

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

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

MHSA Plans identify services across the age span, with age groups identified as children (0-16 years), transition age youth/TAY (16-25 years), adults (26-59 years) and older adults (60 years and older). Originally, MHSA plans needed to identify programs according to these five (5) MHSA components: Community Services & Supports (CSS); Prevention & Early Intervention (PEI); Innovations (INN); Workforce, Education & Training (WET); and Capital Facilities & Technological Needs (CFTN). In years after FY 2007-08, programs for CFTN programs were not required, but could be supported as needed. Descriptions of these components and their programs are described in their respective sections in this document. The most recent data (FY 2018/19) for programs currently funded by Humboldt County MHSA are reported in the Annual Update for FY 2019-2020, available on the Humboldt County website at https://humboldtgov.org/Archive.aspx?AMID=60

This document was informed by stakeholder input and feedback received during the Community Program Planning Process (CPPP). Following a section about Humboldt County's demographics and characteristics, the process and results of the CPPP is shared to provide insights on local community needs and perspectives that helped shape the MHSA Plan.

Humboldt County Demographics and Characteristics

Humboldt County is located on the coast of northwestern California, 225 miles north of San Francisco and 70 miles south of the Oregon border. The County is rural in nature, with a population of 135,558 spread over 3,567 square miles, or 37.7 persons per square mile. Forty-nine percent of residents live around the Humboldt Bay area, while the other half live in the outlying rural areas of the county. The county's residents include those from eight federally recognized American Indian Tribes: Yurok, Karuk, Hupa, Wiyot, Cher-Ae Heights Indian Community of Trinidad Rancheria, Bear River Band of Rohnerville Rancheria, Blue Lake Rancheria and Big Lagoon Rancheria.

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

Five percent of the population is under the age of 5, 19% under the age of 18, 63% are ages 18-64, 18% are age 65 and older. Females are 50% of the population and males are 50%.

Seventy-four percent of the population is White; 1% is Black/African American; 6% American Indian/Alaska Native; 3% Asian; .3% Native Hawaiian and Other Pacific Islander; 6% Two or more Races; and 12% Hispanic or Latino. Residents who are foreign born are approximately 5.4% of the population.

Residents speaking a language other than English at home are 11.8% of the population. The majority of these speak Spanish (7.6%). Of those speaking a language other than English at home, 4.5% speak English less than "very well." For Spanish speakers, 3.2% speak English less than "very well."

The median household income is $45,528 with 20.3% living in poverty. Ninety percent are high school graduates, and 30% have a bachelor's degree or higher.

The demographic information provided is from the U.S. Census American Community Survey, estimates for 2018, unless otherwise noted.

Community Program Planning Process (CPPP)

Stakeholder input for both the Annual Update 2019-2020 and this 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 to January 2020.
- Input and comments sent to the MHSA email address, received by the MHSA 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.
- The 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.

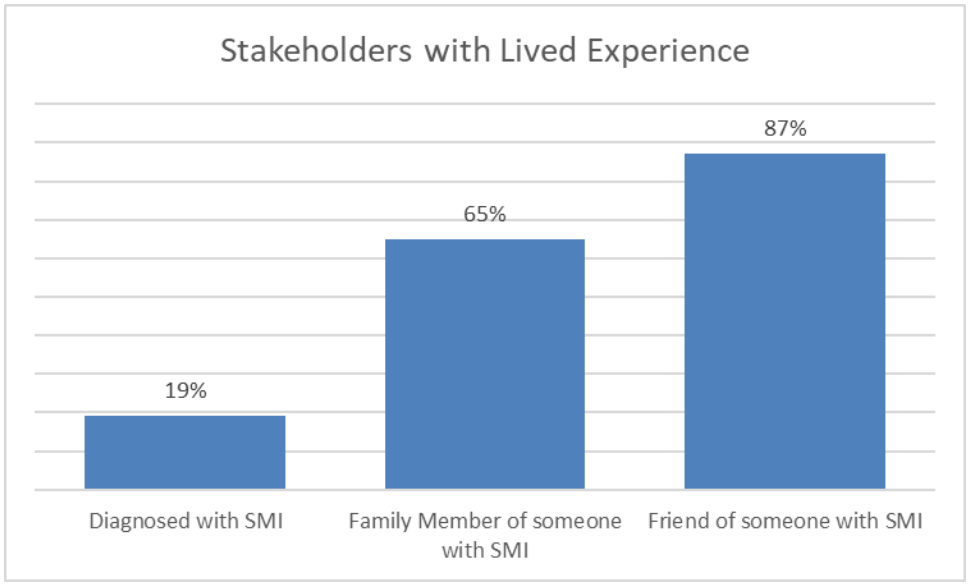
Stakeholders at community meetings

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 Information Form handout
- MHSA Current Programs handout
- Services provided by DHHS Behavioral Health handout
- Definitions of Serious Mental Illness and Serious Emotional Disturbance handout
- MHSA Comment Form for written comments. This form includes a 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 the 191 attending the meetings, completed a demographic form.

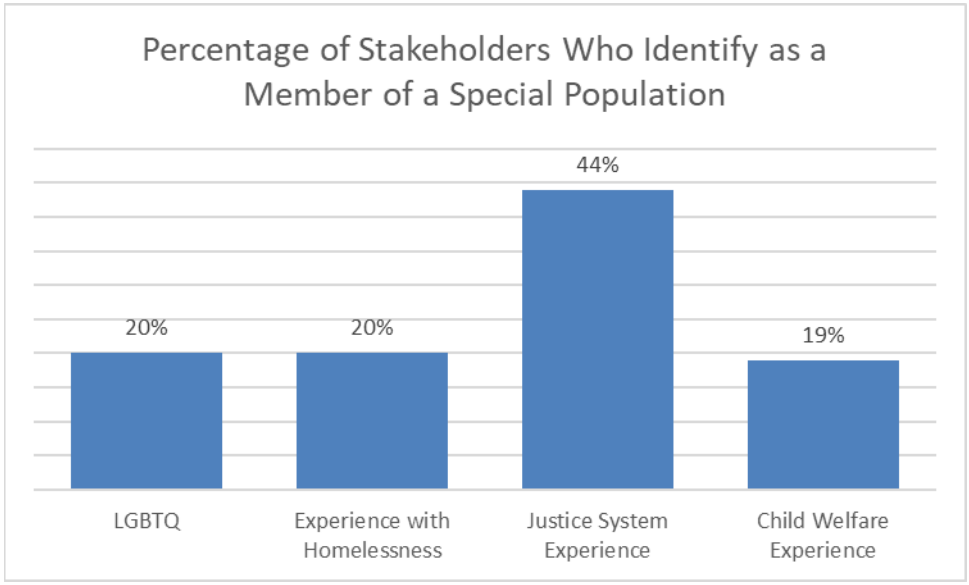
Individuals with lived experience of a mental illness are recognized as a vital voice in the MHSA planning process. In this stakeholder process, 19% of people participating identified as having a serious mental illness (SMI), 65% identified as a family member of someone with a SMI, and 87% identified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



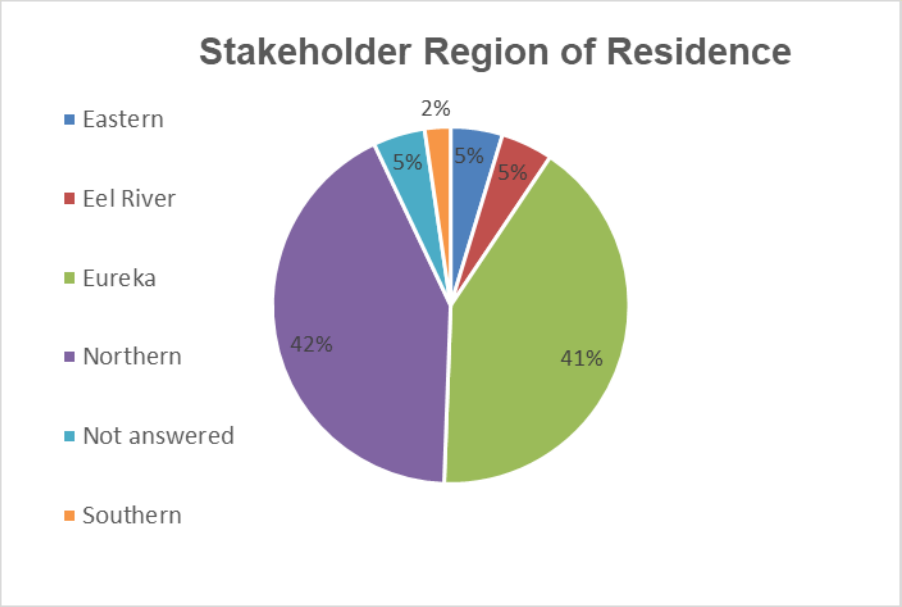
Additional life experiences have been identified as valuable voices for the planning process, so they are also monitored for inclusion. Sexual orientation, experience with homelessness, justice system experience, Child Welfare experience, and having a primary language other than English are all life experiences and conditions that may result in challenges to successful mental health treatment. Outreach efforts 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.

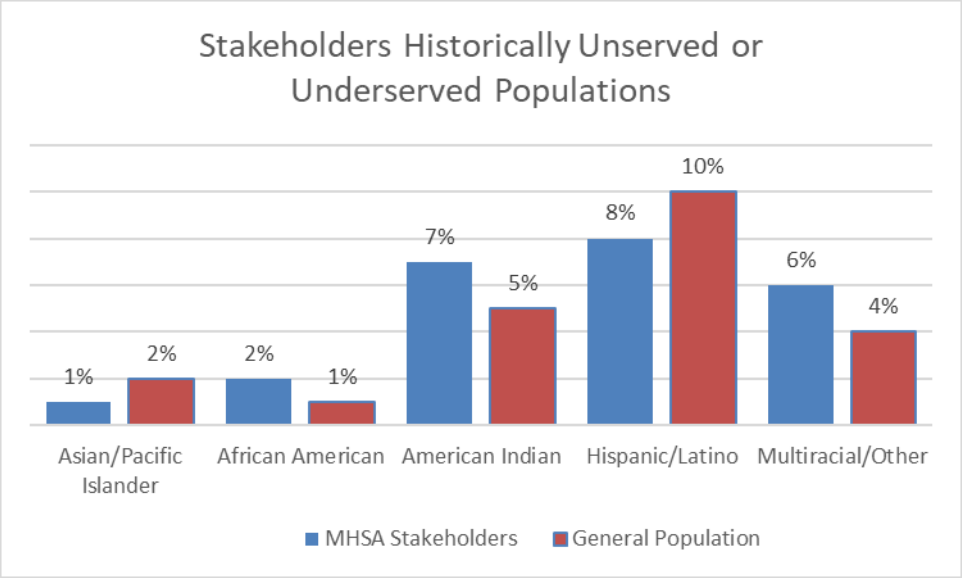


Another priority for representation in the planning process is regional. Most of the MHSA stakeholders attending meetings lived in regions close to Humboldt Bay: Northern Humboldt at 42% and Eureka at 41%, while 5% lived in the Eel River Valley, 5% in Eastern Humboldt and 2% in Southern Humboldt. Five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

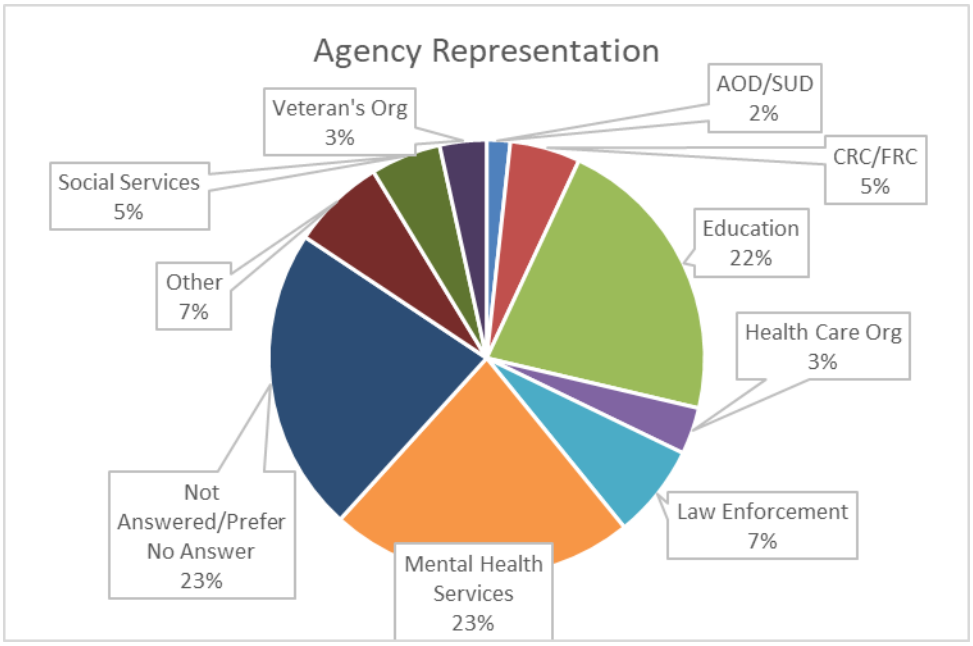


Participants in the stakeholder meetings came from different racial and ethnic categories. Note that percentages for the general population are from the 2010 Census.

- 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 included individuals from education (22%), mental 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 organizations (3%) and other (7%). Twenty-three percent did not answer/preferred not to answer the question.

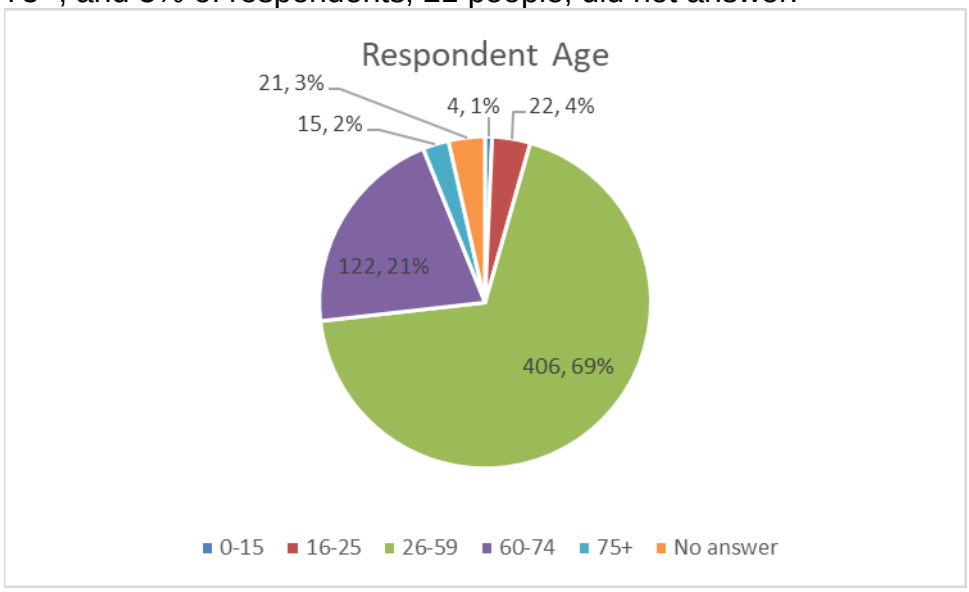


Stakeholders completing the Community Survey

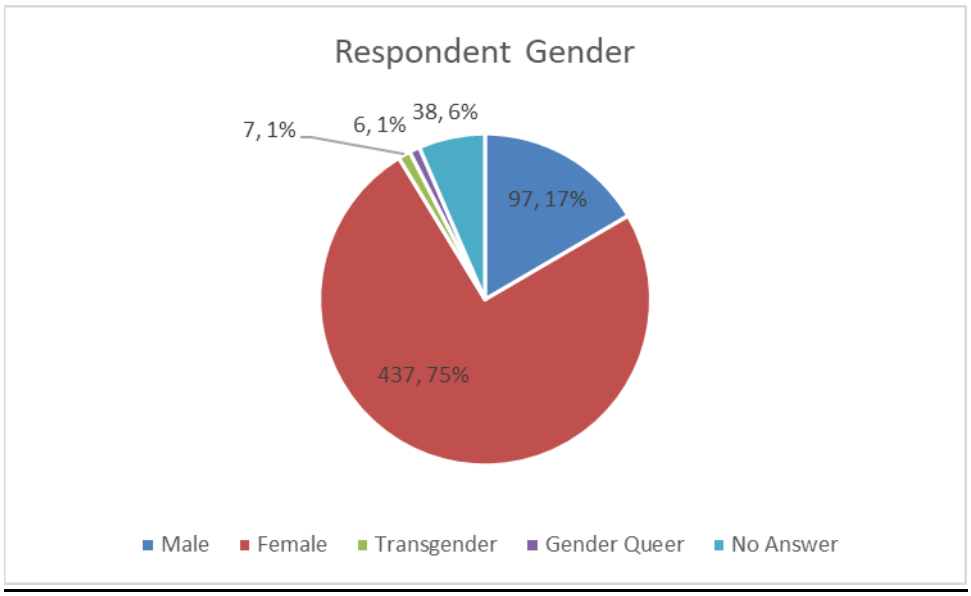
A community survey was developed and was available online and in paper format. Between the paper copies and the online survey a total of 597 responses were received. Of the responses, 472 people, 81%, stated it was their first time providing input and information for the MHSA process. For 111 people, 19%, it was not the first time they had provided input. The demographics of those completing the Community Survey are

presented below.

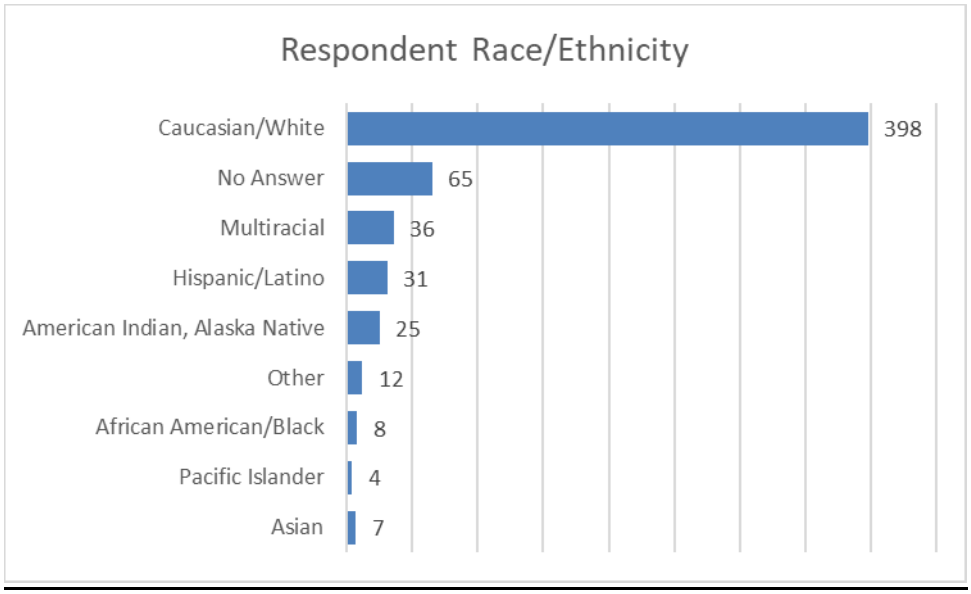
One percent of respondents, four people, were ages 0-15; 4% of respondents, 22 people, were ages 16-25; 69% of respondents, 406 people, were ages 26-59; 21% of respondents, 122 people, were ages 60-74; 2% of respondents, 15 people, were age 75+; and 3% of respondents, 21 people, did not answer.



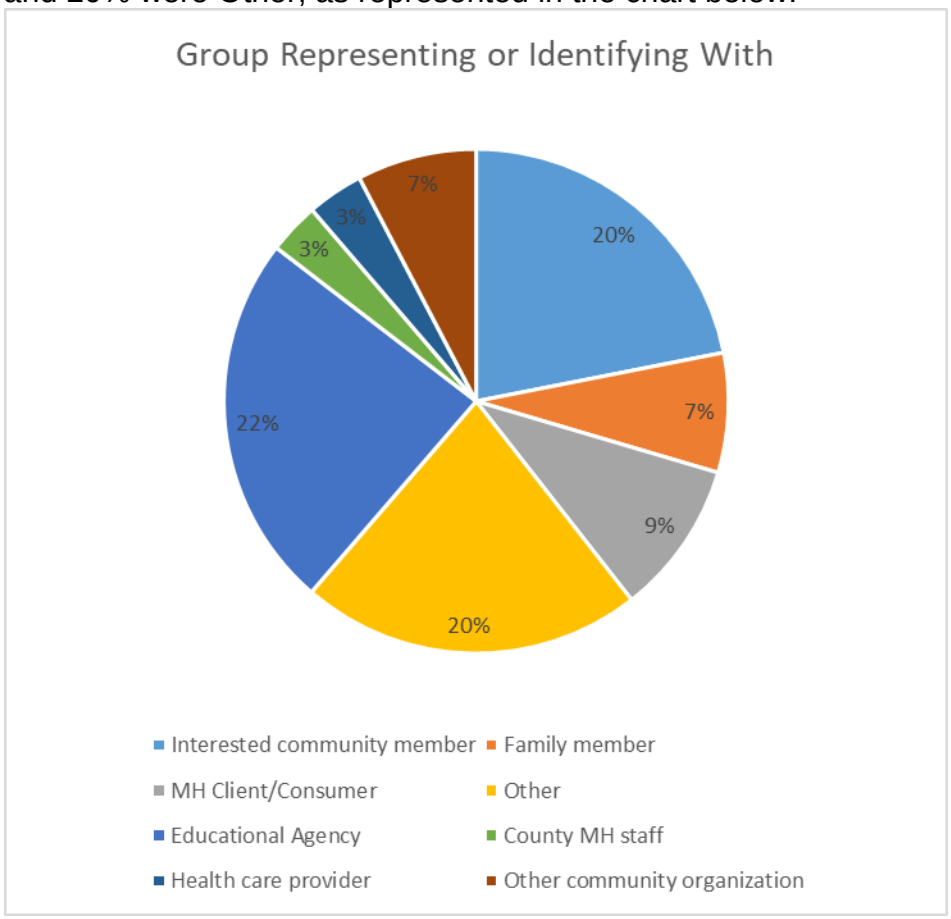
Seventeen percent of respondents, 97 people were male; 75%, 437 people, were female; 1%, 7 people, transgender; 1%, 6 people, gender queer; and 6%, 38 people, did not answer.



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 Mental Health staff, and 20% were Other, as represented in the chart below.



Summary of Findings from the Community Program Planning Process (CPPP)

Between the input from community stakeholder meetings, comments made through the MHSA Phone Line and MHSA Comment Email, and the Community Survey, a total of 793 responses were provided as input into the Draft Annual Update 2019-2020 and the Three Year Plan 2020-2023. An analysis of all input shows that the top priorities identified by respondents were as follows. Programs and services identified in this Plan to support these priorities are also indicated.

- Increase and expand behavioral health services. Some examples of this priority are: Have more services available in more communities in the county; increase the number of psychiatrists, counselors, and other behavioral health professionals; have more programs available; provide individual, one-to-one counseling; provide services and supports to everyone who needs them. The Regional Services Program, which increases outreach and services in outlying communities that are not in the Humboldt Bay area, will address this priority, as will the new Innovation project, which intends to increase the number of case managers and peers.
- Workforce support. Some examples of this priority are: Recruit more providers, retain these providers, and train them---the behavioral health workforce as well as other service providers who may encounter people needing behavioral health services. Law enforcement, childcare providers, and teachers are included as part of the workforce in this perspective. The Workforce Education and Training (WET) component of this Plan addresses this priority by increasing the training available to DHHS-BH staff through Relias E-Learning. In addition, the WET Regional Partnership grants that will be implemented with other counties in the Superior Region will also address this priority.
- Services and supports for early childhood. Some examples of this priority include providing 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. While there is no specific program in this Three Year Plan that addresses this priority outright, DHHS-BH has an existing partnership with First 5 Humboldt through which mini-grants are funded and specifically address Adverse Childhood Experiences (ACEs) for early childhood.
- Continuity of care for clients released from Sempervirens (SV), Crisis Stabilization Unit (CSU), Jail, and other transition services. Examples of the priority are to provide discharge plans, warm handoffs, transitional housing/placements for clients released from the psychiatric hospital, crisis services, the jail, and any other programs where a warm handoff is beneficial. The Sub-Acute Transitional Behavioral Health, Specialty Behavioral Health and/or Social Rehabilitation Services Program, is a Request for Proposals seeking to identify an organization that will address this priority though providing transitional housing and placements for clients needing these services.
- Increase support for school age youth and provide more behavioral health counselors and other behavioral health supports at schools.. Some examples of this priority include providing services and supports for first break psychosis, crisis support, and strengthening the continuity of care for families. The School Climate Curriculum Plan/MTSS Program of this Three Year Plan will contribute to

increasing behavioral health supports at schools. Though not part of this Three Year Plan, DHHS Children's Behavioral Health has received two State MHSA grants through the Mental Health Services Oversight and Accountability Commission (MHSOAC) that focus exclusively on behavioral health supports in schools. One grant, Bridges to Success, has been implemented over the past eighteen months. The MHSOAC has just announced that Humboldt County was chosen for additional funding through the Mental Health Student Services Act.

- Housing and support for those experiencing homelessness. Supportive housing and other services for those who are homeless or at risk of homelessness will be addressed through the Full Service Partnership Program, providing support to clients to help them maintain their housing; through the outreach, engagement and education component of the Older Adult and Dependent Adults Program, connecting older adults with the support they need to stay housed; through the TAY Advocacy and Peer Support Program, which works with TAY to find housing and assist TAY in staying housed; and through the proposed new Innovation project, which plans to work with adults who are homeless or at risk of homelessness. In addition, Humboldt County is a full participant in the No Place Like Home initiative, which is coordinated through DHHS Administration.
- Increase support for the seriously mentally ill. Some examples include providing more services to those with anosognosia (lack of insight into illness); more assertive care treatments; expansion of Comprehensive Community Treatment (CCT); more case managers and other paraprofessionals; occupational support, supported employment and sheltered work. This priority will be addressed through the Full Service Partnership and through the proposed new Innovation project, which will increase case managers and peer coaches for Adult Outpatient clients.

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

- Persons experiencing homelessness. Services and support to this population will be increased through the new Innovation project. In addition, this population is being served by the DHHS participation in the No Place Like Home Initiative.
- School age children. The School Climate Curriculum Plan/MTSS will focus on services to this population, and as discussed above, the two grants from MHSOAC expand services to school age children.
- Transition age youth. The TAY Advocacy and Peer Support Program focuses on this population, and youth still in school will benefit from the programs described for school age children.
- Children 0-5. As discussed above, DHHS-BH has a partnership with First 5 Humboldt to provide mini-grants addressing Adverse Childhood Experiences (ACEs) for the very young child.
- Those released from jail or who are on probation. The new Innovation project can include those who have been released from jail or who are on probation, and the Sub-Acute Transitional Behavioral Health, Specialty Behavioral Health and/or Social Rehabilitation Services Program designed from the RFP award could also include clients from this population. Additionally, a recently awarded grant from the California Department of State Hospitals may impact this population through serving individuals at risk of being or deemed incompetent to stand trial on felony

charges.

The top challenges to receiving behavioral health services were described as the lack of appointments, lack of transportation, and the locations of services. These identified challenges reinforce the priority of expanding and increasing access to services though Regional Services.

The programs proposed to be supported, contingent upon the availability of funds, in this Three Year Plan will address many of these identified priorities. The CPPP Report can be found on the Humboldt County website, MHSA webpage, at https://humboldtgov.org/Archive.aspx?AMID=60 and provides details of the input received during the CPPP.

30-Day Public Review and Comment Period and Public Hearing

In accordance with MHSA regulations, the Annual Update for Fiscal Years 2019-2020 and Three Year Plan for Fiscal Years 2020-2023 was available for public review and comment for a 30-day period, July 28-August 27, 2020. The Annual Update 2019-2020 and the Three Year Plan 2020-2023 were available to stakeholders through the following methods:

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

One written comment was received via e-mail to the MHSA Email Comment address.

Public Hearing Information

The Behavioral Health Board (BHB) conducted a Public Hearing on the Annual Update and Three Year Plan at their regular meeting on August 27, 2020, 12:15-2:15 pm. Due to the current COVID-19 situation, this meeting was conducted via WebEx. There were 36 people in attendance at the Public Hearing.

Public Comment Summary

One written comment was provided for the Three Year Plan through an email to the MHSA Comment Email during the 30-day public comment period. The other comments on the Three Year Plan were made orally at the Public Hearing. The comments are summarized below and following each is the Behavioral Health response. No changes were made to the draft Three Year Plan as a result of the public comment.

1. In the one written comment received, the commenter requested more attention in the Plan to co-occurring disorders once a funding avenue for more specific treatment opens in MHSA.

Response: Regional Services and the Comprehensive Community Treatment/Full Service Partnership programs, funded by MHSA, include individuals with co-occurring disorders. The Dual Recovery Program, which is not funded by MHSA but by other sources, is specifically for individuals who are dually diagnosed.

2. Several people indicated their support for having a MHSA committee to provide ongoing input into planning and implementation.
Response: Behavioral Health has been exploring the establishment of a MHSA Advisory Committee and will continue this exploration with the intent of establishing a committee within the next year.

3. Add a placeholder in the Three Year Plan and earmark funds for Laura's Law implementation should the current bill in the legislature pass.
Response: Should the legislation regarding Laura's Law pass, Behavioral Health will assess the feasibility of implementing the law, including whether there are sufficient funds available. Community input will be gathered through the MHSA Community Program Planning Process and be incorporated in the next Annual Update.

4. The Hope Center is a valuable resource and needs a larger and more attractive facility.
Response: Behavioral Health recognizes this need. Adequate facilities have been challenging to find, and in the current economic climate there are insufficient funds for a different facility.

5. Overall services for sub-acute mental health and better step-down and transitional services are needed. A feasibility study could determine what is needed.
Response: The new program, Sub-Acute Transitional Behavioral Health, Specialty Behavioral Health and/or Social Rehabilitation Services, when started, will help to address this need.

6. Support and training for clients and families for first episode psychosis is needed.
Response: Behavioral Health has a first episode psychosis program that is not funded by MHSA.

7. Three members of the Youth Advisory Board spoke about the value of the Humboldt County Transition Age Youth Collaboration (HCTAYC) and Transition Age Youth (TAY) programs and the positive impact on their lives. One member suggested better advertising of all services provided, including HCTAYC.
Response: Behavioral Health appreciates the positive input about the programs and will share the input with HCTAYC and staff. There are number of ways that services are currently advertised, including using social media. Staff will look at other reasonable options to broaden these advertising opportunities.

8. The continued support and collaboration between the Humboldt County Office of Education and Behavioral Health is very positive.
Response: Behavioral Health appreciates the positive input about this ongoing collaboration to increase mental health services and supports in local schools.

Complaints and Grievances

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

Behavioral Health Capacity Assessment

As a preface to the Behavioral Health Capacity Assessment, it must be stated that this draft MHSA Three Year Plan for Fiscal Year 2020-2023 is being presented at a time of great fiscal uncertainty due to COVID-19. Humboldt County Behavioral Health relies on sales tax revenue, vehicle license fees and personal income taxes to fund services. MHSA is funded by personal income tax revenue. All projections for this revenue source for the next three years suggest significant decreases. This Three Year Plan has been developed based on current revenue estimates, which show sharp decreases by Fiscal Year 2022-2023, but it is anticipated that there will be a need to make future reductions as more is learned about the long-term fiscal impact of COVID-19. The analysis of needed reductions will be a part of the MHSA Annual Update process. As plans are made to adjust due to the decrease in revenues, it is also anticipated that there will be an increased demand in services as more Humboldt County residents become eligible for Medi-Cal due to the global economic downturn.

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

1. The MHSA Community Program Planning Process (CPPP) for gathering community input into this Three Year Plan provides information directly from stakeholders about needs, including those from diverse populations. The findings from the CPPP have been discussed in the prior section of this Plan. The CPPP included sixteen stakeholder meetings as well as a community survey receiving nearly 600 responses.
2. Updated annually, the Mental Health Cultural Competence Plan (MHCCP) provides data on the racially and ethnically diverse populations served, bilingual proficiency in threshold languages, and percentages of diverse cultural, racial/ethnic and linguistic groups represented among direct service providers, as compared to the population needing services and the total population being served. The MHCCP provides the most relevant and pertinent information on the topic of racial/ethnic/linguistic capacity. The 2019 MHCCP is located here: Mental Health Cultural Competence Plan 2019
3. The Network Adequacy Certification Tool (NACT) and other required documentation report on standards of time, distance and timely access requirements with which the Mental Health Plan must comply. Network Certification provides assurances of adequate capacity and services and demonstrates that the Mental Health Plan offers an appropriate range of services that is adequate for the anticipated number of beneficiaries for the service areas, and maintains a network of providers that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of beneficiaries in the service area. The NACT tool has been submitted quarterly

since its inception in April 2018. Beginning in 2020, the NACT and supporting documentation are to be submitted annually no later than April 1.

4. Office of Statewide Health Planning and Development (OSHPD) Workforce Assessment Survey. Required by OSHPD every two to five years, this assessment provides data on the number of public behavioral health system employees, the types of positions, race/ethnicity, and language spoken. The last two OSHPD Workforce Needs Assessments were prepared and submitted in April 2020 and Fall 2018.

System Limitations

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

The MHSA CPPP, presented in the section Community Program Planning Process, provided information on diverse populations. For the priority category Providing Bilingual and Culturally Competent Services:

- Stakeholders at community meetings ranked this as number 13 among all priorities.
- Stakeholders completing the Community Survey ranked this as 13 among all priorities.
- Stakeholders completing the Community Survey indicated that racial/ethnic populations are among those not adequately served by current MHSA programs. These racial/ethnic populations included the African American, Asian, Latino, Native American and Pacific Islander communities.

In the MHCCP, an analysis of disparities for those in Humboldt County with Medi-Cal versus those that are served by DHHS Behavioral Health was performed for calendar year 2017. This was a simple descriptive analysis about disparities in each population served by Behavioral Health and was not an analysis of whether the disparities were statistically significant. With this caveat about definition, disparities were found in serving Native Americans, Asian/Pacific Islanders and Hispanic/Latino populations.

- Eight percent of those with Medi-Cal were Native American, and 7% used DHHS-Behavioral Health services.

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

There could be many reasons that these Medi-Cal populations do not use DHHS Behavioral Health services. Native Americans may use the behavioral health services available to them through their tribes, including United Indian Health Services, which has five locations. There may also be historical negative experiences with social and governmental programs. Asian/Pacific Islanders may not use County services because of levels of acculturation within their communities, or because there are no providers speaking their languages. Hispanic/Latino populations may not use DHHS Behavioral Health services due to levels of acculturation, cultural beliefs about behavioral health issues and origins, lack of knowledge about available services, or because of the scarcity of providers speaking Spanish.

In addition to looking at disparities among Medi-Cal beneficiaries and their use of Behavioral Health services, the MHCCP reported on the data available for the Behavioral Health workforce. The August 2019 DHHS Employee Services database showed that Whites are overrepresented in the workforce, and other racial/ethnic categories, except Asian/Pacific Islander, are underrepresented as compared to Medi-Cal client utilization. Data from the voluntary Workforce Demographic Survey conducted in September 2019 also showed racial/ethnic disparities in the workforce as compared to client utilization for Native Americans and African Americans. Finally, a survey conducted by the Quality Improvement Unit indicated a disparity in the workforce as compared to Hispanic/Latino clients. Detailed information is available in the MHCCP.

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

System Strengths

DHHS Behavioral Health also has strengths and strategies to address the limitations described above.

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

included the American Indian health facilities in the county. The NACT submitted in April 2020 indicates that DHHS Behavioral Health is meeting the required standards.

The Behavioral Health Cultural Responsiveness Committee (BHCRC) is a strength in the agency. BHCRC facilitates projects to gather data and address issues surrounding diversity. The Welcoming Environments project focuses on increasing the sense of welcoming to diverse populations in Behavioral Health locations where clients are served. The Latino Outreach project will provide outreach to the Latino population to inform them about services available. The Workforce Demographic Survey gathers information about the diversity of the workforce that is not available through the Employee Services database. A project to update the Client Information Form will increase the number of choices for ethnicity. BHCRC oversees and approves the development of the annual Cultural Competence Plan.

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

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

While DHHS Behavioral Health does face challenges in serving diverse racial/ethnic populations, its continuing attention to the issue to make improvements; the continuing contract with Language Line to ensure that behavioral health services are provided in a client's preferred language; the continuing development and monitoring of staff training;

and the consistent updating of cultural competence resources all contribute to the conclusion that the agency will have the capacity to implement MHSA programs, subject to the financial and funding limitations facing California and the nation as a whole over the next few years.

Community Services and Supports (CSS) Component

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

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

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

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

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

homelessness, or placement in more restrictive facilities.

Children 0-16 who meet FSP eligibility have their service needs addressed by a variety of outpatient Behavioral Health services but are not currently enrolled as FSPs. These services include Assessment, Individual/Family Therapy, Targeted Case Management, Intensive Care Coordination, Intensive Home Based Services, Therapeutic Behavioral Services, Medication Evaluation, Medication Support, Parent Partner/Peer Coaching, and Mobile Crisis services. Additionally, Children's Behavioral Health staff work regularly with other community agencies to hold Child & Family Team meetings to help with coordination of services, assessing client/family needs & strengths, and monitor service plans and progress.

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

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

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

Community Services and Supports: Regional Services

DHHS-Behavioral Health Regional Services Program falls under General System Development (GSD) and Outreach and Engagement (O&E). As a GSD program, Regional Services focuses, to the maximum extent possible, on the stabilization, management, and reduction of psychiatric symptoms; on the restoration and maintenance of functioning; on the improvement of interpersonal effectiveness; and on the development and maintenance of healthy support systems for clients. As an Outreach and Engagement program, Regional Services reaches out and engages adults living in the outlying areas of Humboldt County--Fortuna to Garberville, McKinleyville to Orick, and Willow Creek to Orleans—that have a scarcity of behavioral health services and provides services to them as needed. This meets the need of increasing and expanding behavioral health services. Priority is given to adults that are at risk of Child Welfare involvement due to their behavioral health and substance use disorders.

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

ongoing Specialty Mental Health Services.

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

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

Regional Services is currently staffed by two Behavioral Health Clinicians, two Behavioral Health Case Managers, two Substance Abuse Counselors, one Community Health Outreach Worker, and one Vocational Assistant. Regional Services staff, primarily the Vocational Assistant and Community Health Outreach Worker, are responsible for providing outreach in the community to individuals in need of services and work to link individuals with appropriate services. The Regional Services Substance Abuse Counselors also provide outreach to engage individuals in individual and/or group Substance Use Disorder (SUD) services. Each Substance Abuse Counselor provides weekly SUD groups as well as individual SUD services. The Regional Services Behavioral Health Clinicians are responsible for screening and assessing individuals requesting access to behavioral health services. The Behavioral Health Clinicians provide ongoing individual therapy as indicated and provide clinical guidance to the teams. The Regional Services Behavioral Health Case Managers work with open DHHS-BH clients to provide case management brokerage and rehabilitation services to connect them with resources and support them with moving forward in their recovery processes. Regional Services staff attend many community meetings/outreach events each month to provide education to other community providers about County services and to engage new client referrals.

Contingent upon MHSA funding availability, MHSA CSS funding will support a proportion of the salary costs for Regional staff. It is estimated that three to five individuals ages18-25, thirty to forty individuals ages 26-59, and fifteen to twenty individuals age 60+ will be reached annually. Outcomes will be measured by the number of clients reached and the program aims to complete 50 new client assessments per year.

Community Services & Supports: Older Adults and Dependent Adults

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

Outreach, Prevention and Education

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

Many of these clients are reaching out for the first time. The program strives to reduce the stigma of behavioral health labels by offering personalized care, education, intervention and connections to services in the community. Data from FY18/19 showed that 82% of those contacted self-identified as having experienced homelessness at some time and 18% expressed feeling at risk of homelessness due to behavioral health issues.

Outcomes to be tracked include the following:

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

Contingent upon the availability of MHSA funding, an estimated 500 individuals will be contacted through outreach, prevention and education during fiscal years 2020-2023.

Behavioral Health Services to Clients

In addition to contacts made through outreach, prevention and education, older and dependent adults are provided services as clients of DHHS Behavioral Health. Contingent upon the availability of MHSA funding, an estimated 300 clients will be served over the next three years. Clients will receive a variety of services that can include Psychiatry, Medication Support, Group Treatment, Individual Therapy, and Intensive Case Management.

Client Outcomes:

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

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

Based on input from stakeholders over the past several years, including in the CPPP for

this Three Year Plan, in fiscal year 2019-2020 Humboldt County Behavioral Health (DHHS-BH) sent out a Request for Proposals for qualified behavioral health treatment facilities to provide sub-acute transitional behavioral health, specialty behavioral health and/or social rehabilitation services to eligible DHHS-BH clients as part of a long-term adult residential treatment and/or supportive living program.

Contingent upon the availability of MHSA funds, this program will provide behavioral health treatment in a residential setting to DHHS-BH referred clients. It will assist individuals who are stepping down from higher levels of care to effectively integrate back into the community. Many 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 may include those in the following categories:

- Sub-Acute Transitional Behavioral Health Services, including provision of personal living quarters and laundry facilities; provision of continuous observation, assessment, supervision and support; provision of three nutritious 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

Outcome Measures will be tracked through the State Data Collection and Reporting (DCR) system for those clients who meet criteria for Full-Service Partnerships. Additional outcome measures including re-hospitalization rates and reduction in Administrative Bed Days for individuals waiting to be discharged will be tracked by the Behavioral Health Administrative Analyst.

The Request for Proposals was issued on January 2020, and proposals were due March 13, 2020. Due to COVID-19 there will be minor delays in selecting an applicant. However, it is anticipated that a proposal will be selected for funding soon and that services will begin in FY 2020-2021.

Innovation (INN) Component: Project in Development

Counties are required to allocate five percent of total MHSA funds to INN projects. INN projects are defined as novel, creative, and/or ingenious behavioral health practices or approaches that are expected to contribute to learning. The INN Component allows counties the opportunity to try out new approaches that can inform current and future behavioral health practices and approaches. INN projects can only be funded on a one-time basis and are time-limited, to no more than three years (for large counties) or five years (small counties).

In August 2015 the Rapid Rehousing Innovation project was approved for Humboldt County. Rapid Rehousing has two components. The housing component, renamed in fiscal year 2019/2020 to Housing, Outreach and Mobile Engagement (HOME), uses a "Housing First" approach to support clients in obtaining housing. "Housing First" is a proven, evidence-based 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 services increase quality, including better outcomes for adults with severe behavioral illness who are experiencing homelessness. HOME includes outreach and engagement efforts during street level interventions for persons with behavioral illness who are experiencing homelessness.

The second component of the Rapid Rehousing Innovation Project was the Mobile Intervention Services Team (MIST). The MIST component of the project was the collaborative effort to successfully engage homeless individuals who have a severe mental illnesses and have frequent contact with law enforcement. To date, the HOME/MIST pathway has linked 166 unique individuals to permanent or temporary housing.

MHSA Innovation projects for small counties are approved for no more than five years, and the five year period for this Innovation project will be over at the end of the July 2020. Per Innovation regulations a final report will be due by the end of January 2021 and will be disseminated to stakeholders. Because stakeholder input from the CPPP clearly shows that housing is a top priority need in the County, the HOME component will continue with other, non-MHSA funding streams related to housing. In the coming years, HOME will work with families, individuals, those with and without disabilities and take referrals from Behavioral Health, Social Services and Public Health programs. Clients currently receiving mental health services will continue to receive these services either through their current HOME clinician or through Behavioral Health. Though the MIST component of the Innovation project was successful, it will not continue to exist as it is currently configured because other funding sources were not identified to continue it. However, current MIST clients are being referred to other programs within Behavioral Health. MIST staff is working to provide warm handoffs to ensure successful transitions to those programs, which include Older Adults, Comprehensive Community Treatment, and Adult Outpatient Case Management.

In response to CPPP input and Humboldt County Behavioral Health data identifying

needs that may be addressed through innovative methods, planning for a future Innovation project has begun. Subject to continuing stakeholder involvement and input, this project will be focused on meeting three of the priorities identified by stakeholders: 1) increasing and expanding behavioral health services, 2) providing continuity of care for clients released from Sempervirens and the Crisis Stabilization Unit through transition services, and 3) housing and support for those experiencing homelessness. As currently envisioned, these priorities will be met through the provision of additional case managers and/or peer coaches housed in the Adult Outpatient Program who will provide transitional and other case management services including helping clients stay housed. Once this new Innovation proposal has been developed it will go through a 30 day Public Comment period before being submitted to the Mental Health Services Oversight and Accountability Commission (MHSOAC) for approval. Only when this approval is received will a new Innovation project begin. As with other programs, the amount of funding available for a new Innovation project is contingent upon continuing MHSA revenue.

Prevention & Early Intervention (PEI) Component

Nineteen percent (19%) of MHSA funds received by counties must be allocated for PEI services, designed to prevent mental illnesses from becoming severe and disabling. PEI services focus on preventing the onset of mental health issues and/or providing early intervention treatment and referral services. MHSA regulations require PEI plans to include at least one program focused on delivering services for the following service categories: 1) Prevention, 2) Early intervention, 3) Stigma and discrimination reduction, 4) Recognizing early signs of mental illness, and 5) Promoting greater access and linkage to treatment. Suicide prevention programs also fit within the PEI component. At least fifty-one percent (51%) of PEI funds must be allocated for serving individuals who are 25 years old or younger. Programs that serve parents, caregivers or family members with the goal of addressing children and youth at risk of or with early onset of a mental illness can be counted as serving children and youth. The following pages describe the proposed PEI funded programs and services that reflect the themes and priority areas identified in the CPPP. The implementation of these programs is contingent upon continuing availability of MHSA funding.

Prevention and Early Intervention: Hope Center

The Hope Center serves unserved and underserved populations of transition age youth, adults and older adults who have behavioral health challenges 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 the Substance Abuse Mental Health Services Administration (SAMHSA), and the resources necessary for people with and without a behavioral health diagnosis and their families to be empowered in their choices to be self-sufficient. The Hope Center provides prevention and early intervention activities that reduce stigma and discrimination and provide access and linkage to treatment. These activities contribute to the reduction of the negative outcomes that may result from untreated behavioral illness.

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

The Hope Center has a full time Peer Coach III who oversees the Center, three full time Peer Coach staff, and three part time Peer Coach staff. There are two Work Experience workers at the Center as well. Consultation is provided by a Senior Program Manager. All Peer Coaches are trained as Certified Peer Support Specialists through Recovery Innovations (RI) International. The Peer Coach III has additional training through the California Association of Behavioral Health Peer-Run Organizations (CAMHPRO) and

the California Association of Social Rehabilitation Agencies (CASRA) as a train the trainer in the Superior Region Provider Core Competency Training. The 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. During the next fiscal year, peers will participate in the RI International Health Living Through Self-Management Facilitator Training, which teaches students how to facilitate the Healthy Living 7 week curriculum for program participants.

Hope Center goals are to:

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

The Center works from the recovery pathways: Hope, Choice, Empowerment, Recovery Environment, Spirituality (purpose/meaning). The Center provides many resources including classes, self-advocacy education, peer support, system navigation, and linkage to services in the community. Outreach efforts are made by Hope Center peer staff 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. 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
- Classes, workshops, and education that focus on individuality, mindfulness, nutrition, resilience, fun, building skills, wellness, building community, facing challenges, and building confidence
- Counseling services are available when needed

Since the program began in Fiscal Year 2007-08, there has been an increase over time in the number of unduplicated participants, from 460 at the beginning to 1,032 in Fiscal Year 2018-19. The duplicated number of sign-ins to the program has increased from 6,924 to 13,148. It is estimated that these numbers will continue to grow over the next three years.

Plans for the next three years, contingent upon available MHSA funding, include: 1) Hosting *Recovery to Practice for Peer Supporters*, a training for all staff, done by International Association of Peer Support (iNAPS), 2) Hosting Pat Deegan, a consultant who researches and trains on the topic of recovery and the empowerment of people in recovery and providers who serve them, and obtaining certification in her CommonGround program.

Hope Center activities contribute to the reduction of negative outcomes that can result from untreated mental illness. Besides basic process evaluation that includes numbers reached and events held, the program will measure increases in participants' knowledge, awareness, attitudes and beliefs towards recovery and wellness and any increase in social connections they may experience. This will be measured through training/class evaluations and surveys offered on a periodic basis. In addition, program staff will use a newly developed form with participants, when indicated, to identify if a participant has had past symptoms of mental illness, whether or not they were treated for these symptoms, and to what service/program a participant may have been referred.

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

The methods and activities used to change attitudes, knowledge, and/or behavior

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

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

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. These components will continue to be supported contingent upon the availability of MHSA funding. Both components serve youth and young adults ages 16-26, and both components are a part of the Humboldt County DHHS Transition Age Youth (TAY) Division. The TAY Division consists of co-located DHHS services, including Behavioral Health, Extended Foster Care (EFC), Independent Living Skills (ILS), HCTAYC and TAY Peer Coaches. In addition, the TAY Division utilizes supports and services from DHHS departments including Public Health, Employment Training Division, CalFresh, Medi-Cal, Substance Use Disorder services, and collaborates with community partners such as Juvenile Probation and Family Resource Centers.

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

- A behavioral health team providing specialty behavioral health services (individual and family therapy, case management, and referrals for psychiatric services), including a supervisor, clinicians, and case managers
- 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 Advocacy Board (YAB)
- 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 intensive case coordination services as needed

TAY Advocacy--HCTAYC

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

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

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

It is evident that there is a significant need for the creation of a youth-positive environment so that youth may participate as fully engaged participants in society,

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

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

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

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

1. **Trainings** for professionals and community members focus on TAY-specific mental health challenges and the engagement of this population. This includes special populations particularly impacted by stigma and discrimination such as LGBTQ youth, Indigenous Youth, foster youth, 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 Youth Opioid Response campaign, and a cross-country leadership exchange with youth from New York City.
2. **Advocacy** is operationalized through two means, systems change and individual advocacy. Systems advocacy is enacted through youth organizers supporting the YAB to attend and participate in policy setting, decision making tables, and

correspondence. This includes participation at local 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 case planning meetings, and attending said meetings to support the youth's desired outcome.

3. **Youth Leadership Development** is perhaps the most transformative element of the HCTAYC program, consciously targeting the three base psychological needs identified in self-determination theory: autonomy, competence, and relatedness. These three components aid to prevent the emergence of behavioral health conditions or reduce prolonged suffering and progression. This development is the transference of skills to, and the continual support and supervision of, YAB members. By creating a system of tiered levels of leadership, board members are given the opportunity to experience, develop, and practice leadership skills in a gradual progression of intensity, while emphasizing increased peer engagement and relationship building. Participants receive periodic trainings on different elements of leadership and topical education on advocacy topics. Higher-level leaders go through a multi-week orientation process and attend a three-day retreat. The format of the YAB, with multiple affinity-based committees, allows members to develop connections with peers with similar lived experiences, while also receiving consistent support and guidance from HCTAYC youth organizers. Youth exercise autonomy through identifying program priorities, modifying program function, and by driving content creation. Youth exercise competence via the provision of trainings, engaging in advocacy, and successfully planning events. As board members plan their transition from active membership they put together an accumulative leadership portfolio demonstrating their strengths and successes as youth leaders. Additionally, extensive studies have demonstrated that youth leadership programming increases self-efficacy - which is an important indicator for the reduction of harmful actions such as self-harm and suicide.

Expected Outcomes:

- Gather comprehensive outcomes data to report on leadership development as well as outcomes related to the specific PEI domains for Youth Leadership. Development.
- YAB committees will facilitate at least one completely youth-driven project per year.
- Facilitate at least three youth-leadership development trainings for HCTAYC members and the general transition-age youth community per year.
- Create and implement policy recommendations for Substance Use Disorder treatment and LGBTQ+ Cross-Systems.
- Participate in various advocacy and policy setting tables at the local, state, and national level.
- Create a partnership with the Public Health Youth Opioid Response campaign.

How Outcomes are Measured:

Outcomes are measured in multiple ways. Youth Leadership Development data is

collected through individual Leadership and Wellness plans, and a Leadership Skills self-assessment with a more intensive assessment tool in the process of being developed.

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

Estimated Number to be reached in FY 2020-2023:
The program's intent is to maintain or exceed 15 consistent YAB members to expand and impact more young people, with the facilitation of at least one committee-created project per year. Additionally, the program estimates accomplishing at least eight more policy goals identified in the SUD Policy Recommendations and the completion and formalization of the LGBTQ+ Cross-Systems Policy Recommendations. It is hoped to provide at least three youth-driven trainings to professionals, as well as complete the development of new training curricula related to the LGBTQ+ policy recommendations. Four to six youth leadership development trainings to youth in Humboldt County are estimated to be provided per year. 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.

TAY Peer Support

The integration of Peer Coaches within the TAY Division is a prevention program with components of early intervention, access and linkage to treatment, stigma and discrimination reduction, and outreach for increasing recognition of early signs of mental illness. The TAY Peer Support program consists of a shared Supervising Mental Health Clinician and five full-time Peer Coaches. Peer Coaches are an integral part of the multidisciplinary team at the TAY Division, and 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 in navigating the systems, help with referrals to services and support them in appointments or activities. Peer Coaches often serve as a bridge between the young person and services, providing warm hand offs from psychiatric hospitalizations, incarceration, or walk-ins to service providers, activities, or other resources.

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

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

Key Activities:

- Outreach and presentations to local agencies and organizations

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

Expected Outcomes:
The expected outcomes for 2020-2023 are:

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

How Outcomes are Measured:

- Access to the TAY drop-in space and selected events and workshops are measured by sign-in sheets.
- Tracking sheets of referral assignments, including date referral is received, assigned and when first contact is made.
- Tracking of contacts and linkages with other programs, such as Behavioral Health, Employment and ILS.

Estimated Number to be reached in FY 2020-2023:
It is estimated that approximately 400 TAY (New, unique participants) will be served over the next three years.

TAY Advocacy and Peer Support Disaster Preparedness and Response
Both HCTAYC and Peer Support staff have adapted and modified ways of delivering services and prevention components with the current worldwide health pandemic. Early intervention, outreach, stigma and discrimination reduction, and youth engagement are being delivered virtually utilizing multiple web and other platforms. Participation in the YAB, community policy tables, groups, workshops and community wellness building opportunities continue to meet, now in a virtual setting. Not knowing what gathering in larger groups may look like in the future, HCTAYC and Peer Support will continue to be creative and find ways to uplift youth voice and address the needs of transition age youth, such as overcoming a sense of hopelessness, lack of self-efficacy, independent living skills deficit, and economic struggles that will continue to impact the social determinants of health during this crisis.

TAY Advocacy and Peer Support Stigma and Discrimination Reduction. The TAY Advocacy and Peer Support program's stigma and discrimination reduction activities are intended to influence the TAY involved in the program and the professional and community members who participate in trainings and events facilitated by the program. Activities include trainings for professionals and community members focused on TAY-

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

The impact of the activities is currently measured by post-workshop evaluations and the demographic form, which asks questions about effectiveness of the activity and its contribution to wellness. For the future, a community-based stigma and discrimination assessment will be conducted through a survey format, capturing attitudes and beliefs about mental health stigma and discrimination. In addition, the program is considering a pre/post survey at events, workshops and trainings to measure learning and change in attitudes.

Prevention and Early Intervention: Suicide Prevention

Beginning in 2019, three formerly separate programs of the Humboldt County Department of Health and Human Services, Public Health Branch, Healthy Communities Division--Stigma and Discrimination Reduction, Suicide Prevention and Family Violence Prevention--combined to create the Stigma, Suicide and Violence Prevention (SSVP) Program. As of June 2020, the SSVP program will no longer include Stigma and Discrimination Reduction activities.

This merging aligned with U.S. Center for Disease Control and Prevention (Wilkins, 2014) and California Department of Public Health (CDPH)[i] recommendations about preventing suicide and violence. Both agencies published reports stating that these public health problems share significant risk and protective factors, and require a coordinated, multi-sector approach. Throughout 2020, work has integrated projects, streamlined processes and expanded community impact to reduce morbidity, mortality and risk behaviors associated suicide and violence numbers in Humboldt County.

The five main SSVP projects supported by the Suicide Prevention program are:

Projects as Identified by PEI Regulations

- Humboldt County Suicide Fatality Review (Section 3720. Prevention Program & Section 3730. Suicide Prevention Programs)

- Community Collaboration (Section 3715. Outreach for Increasing Recognition of Early Signs of Mental Illness)
- Prevention and Early Intervention Training (Section 3730. Suicide Prevention Programs)
- Lethal Means Safety (Section 3720. Prevention Program)
- Social Marketing (Section 3715. Outreach for Increasing Recognition of Early Signs of Mental Illness)

Objectives

- Humboldt County Suicide Fatality Review: Conduct suicide fatality reviews to identify data-driven suicide prevention recommendations.
- Community Collaboration: Create a leadership-driven, safety-oriented community committed to reducing stigma, suicide and violence.
- Prevention and Early Intervention Training: Increase community capacity to recognize and respond to signs of suicide, violence and mental health problems through community trainings such Question-Persuade-Refer (QPR) and LivingWorks' Start.
- Lethal Means Safety: Develop and promote firearms safety campaign to educate community and address majority number of suicide and homicide deaths by firearm.
- Social Marketing: Increase awareness of suicide, violence and stigma, promote prevention messaging and encourage positive behavior change in those areas.

Strategies

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

Throughout this section, the MHSA PEI Demographic Form is used as an outcome measurement to demonstrate the reach and diversity of populations and settings served.

Project: Humboldt Suicide Fatality Review (SFR)

The Suicide Fatality Review Team (SFRT) is a multidisciplinary group of professionals who meet quarterly to learn more about the circumstances leading to suicide deaths in Humboldt. This group includes the Humboldt County Department of Health & Human Services (DHHS), Coroner's Office, health care professionals, and representatives from community agencies.

The purpose of the SFR is to prevent future suicides in Humboldt County. Based on the

data collected, the SFR identifies risk and protective factors for suicide that are unique to Humboldt County and makes recommendations for local policy and practice changes to help reduce suicide risk and promote safety.

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

The SFR process:

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

Target Population
Medical providers, healthcare administrators, and county leadership.

Key Activities

- Develop SFR protocols, policies and procedures.
- Meet quarterly to review suicides and make recommendations based on findings.
- Evaluate local suicidal behavior trends, circumstances, risk and protective factors to strengthen prevention efforts.
- Educational presentations for Humboldt County medical and behavioral healthcare organizations. These presentations will familiarize stakeholders with the SFR and determine contacts for future involvement.
- Identify targeted systemic changes from data analysis of review meeting recommendations.
- Provide technical assistance to target audiences who need training working with healthcare providers, including training content development, guidance, SME, and resources.
- Present findings in conjunction with county epidemiologist that illuminates opportunity for system changes, including providing data to inform decision-making, offering trainings and alignment of shared objectives and deliverables among community partnerships.

Outcome Measurements

- Number of SFR meetings held
- Number of participants involved

- Number of suicide death cases reviewed
- Annual report completed and presented to County Board of Supervisors
- Progress on County-Wide ordinance mandated Suicide Fatality Review

Outcome Estimates in FY2020-2023
SFR will meet quarterly to review 2-3 suicide deaths. It is estimated that SFR will review approximately 20-36 suicide deaths over the next three years.

Project: Prevention and Early Intervention Training
The Prevention and Early Intervention Training project incorporates both evidence-based and practice-based trainings. SSVP Program staff serve as coordinator, trainer and/or support for the offered trainings. The Suicide Prevention staff coordinates and facilitates the following trainings.

- Evidence-based
    - Question-Persuade-Refer (QPR) Basic Suicide Prevention Gatekeeper Training
    - LivingWorks Start Training (online basic suicide prevention)

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

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

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

recognize, signs/symptoms of persons that may be at risk of suicide, respond and intervene.
- Reduce negative attitudes and beliefs about persons experiencing suicidal thoughts and behaviors along with other behavioral health challenges.

Outcome Measurements
- Number of trainings
- Number of participants
- Number of MHSA PEI Demographic Forms submitted
- Number of participants who reported increased in overall knowledge of suicide and suicide prevention (0-3 scale)

Outcome Estimates (FY 2020-2023)
Four trainings will be held per year, serving 20 people per training. This will allow twelve QPR trainings to be held, reaching 240 people over three years.

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

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

START is 90-minute program that lets trainees learn suicide prevention skills even while working from home or practicing social distancing. The benefits of LivingWorks START include:
- Works on any computer, smartphone, or tablet, and it includes simulations, practice, and other skills-building activities.
- Apply learned skills via phone, text, and other remote methods.
- Recognize when friends, family members, co-workers, and neighbors are struggling and take meaningful actions to keep them safe.
- Trainees report feeling more confident and prepared to help someone, even during work-from-home and social distancing.

Like all of LivingWorks' core programs, LivingWorks Start is evidence-based. Third-party evaluations of LivingWorks Start confirmed:
- Improves trainee skills and knowledge
- Improves trainee readiness and confidence
- Safe and effective for trainees as young as 15 years old
- Meets SAMHSA's Tier III evidence-based training criteria
- Based on best practices in online curriculum development

Target Population

- DHHS Staff
- Employers seeking to improve workforce ability to recognize signs and symptoms of suicide and/or potentially serious mental illness
- Social Services Agencies
- Shelter & Homeless Services
- Tribal Leaders
- Educators
- Elder Care Agencies & SNF's
- General Community Members
- Department of Veterans Affairs
- Medical & Behavioral Health Care Staff
- Law Enforcement/First Responders

Key Activities

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

Outcome Measurements

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

Outcome Estimates for FY 2020-2023

- 2,000 licenses issued
- 1,200 accounts created
- 1,200 trainings completed
- 1,200 MHSA PEI Demographic Forms submitted

Practice-based Prevention Training

In addition to the evidence-based trainings, the SSVP Program has developed a series of shorter practice-based training modules. These training modules cover topics such as for Lethal Means Safety and Domestic Violence and Mental Health 101:

- Lethal Means Safety: add-on or stand-alone training module that teaches participants about environmental safety (see additional details in Lethal Means Safety project section).

Key Activities

- Understand the issue at hand through national, state, and local data; recognize language and actions that perpetuate stigma; and develop skills to support individuals in safety, wellness, and resilience.

Project: Humboldt County Suicide Prevention Network

This continuing suicide prevention project also addresses stigma and discrimination reduction. The Humboldt County Suicide Prevention Network (SPN) is comprised of representation from community sectors, county agencies and community partners. DHHS-Public Health collaborates with service providing agencies in multiple sectors, including tribal and community health, clinical behavioral health, social services, hospice and palliative care. Primary agencies involved volunteer to present information or update the network regularly. SPN also works closely with the local chapter of the American Foundation for Suicide Prevention to help plan the Arcata Out of the Darkness Walk. The network meets bi-monthly to build relationships and to identify strategies to reduced suicide and suicidal behaviors in our community. The SPN strives to understand and implement the goals of the Zero Suicide framework as well as the needs and goals of the agencies involved.

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

Target Population

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

Key Activities

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

Outcome Measurements

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

Outcome Estimates (FY2020-2023)

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

SSVP goes beyond providing targeted education and training to enable individuals, organizations, systems to strengthen their ability to perform effectively in addressing problems focusing on stigma, suicide and violence prevention on the community level.

Targeted outreach and education supports and strengthens community partners who most need it. These include community-based organizations, educational institutions, and behavioral healthcare and health organizations via outreach for increasing recognition of early signs of mental illness and / or suicide and providing them with the hands-on skills they need to effectively intervene and refer.

Project: Lethal Means Safety

Lethal Means Safety initially consisted of the Lock Up Your Lethals campaign, which was a brochure. It now consists of:

- Keep It Safe, a public health educational campaign for any and all audiences.
- Lethal Means Safety, a practice-based training module that can accompany any suicide prevention training or be provided independently to those with previous baseline knowledge.
- Gun Shop Project, a new and growing collaboration between Humboldt County Public Health and local gun retailers, trainers, and range owners. This project includes a Lockbox Distribution Program.
- Nationwide 45% of people who die by suicide saw their primary care provider within the last 30 days. In Humboldt County the findings are more stark: about a third {29% (55/191)} of the people who died by suicide had a known date of their last health care visit. Of those, 51% (28/55) had a healthcare visit less than 10 days before their death. (2013-2018 Retrospective Study). Based this data, the Lethal Means Safety Project, through provider outreach will encourage discussion means safety and promotion of lockbox distribution program.

Key Activities

- Keep It Safe
    - Keep It Safe is a revision of the previous Lock Up Your Lethals campaign. The new Keep It Safe is a brochure was developed with the goal of reaching expanded audiences on the topic of safe storage of potentially dangerous items. The target audience are all housed community members. Keep it Safe is about starting a conversation with Humboldt County residents about protecting their loved ones from preventable injury.
    - Similar to the Lock Up Your Lethal campaign, Keep It Safe addresses common items found in homes that could be dangerous such as: medications, alcohol, firearms, cannabis products and anything else that can be used to get high or harm oneself. The Keep It Safe campaign brochure will be distributed in local community service agencies including medical and behavioral health care settings.

- Lethal Means Safety – Training Module
    - Lethal Means Safety – Training Module, is an add-on or stand-alone training module that teaches participants about environmental safety. The target population is anyone who takes a suicide prevention training and/or those who provide direct services. Over FY2020-2023, the populations to be targeted with Lethal Means Safety as an add-on or stand-alone presentation will include medical and behavioral health care providers, social workers, tribal leaders, law enforcement and first responders, firearms retailers, trainers and range owners, and pharmacists.
    - This practice-based presentation will involve:
        - data around lethal means, overdose, and suicide
        - safety planning
        - harm reduction strategies for increasing safety and reducing risk
        - resources to learn more or seek help
        - instructions on how to utilize the Public Health Lockbox Program for self or clients served
- Gun Shop Project
    - The Gun Shop Project is a new and growing collaboration between Humboldt County Public Health and local gun retailers, trainers, and range owners. During FY2020—2023 this project will involve local firearms retailers sharing lethal means safety information with customers. They will discuss safe firearm storage, offer pistol lockboxes, and include mental health and suicide prevention resources with lockbox distribution.

Outcomes Measured

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

Outcome Estimates (FY2020-2023)

- 3,000 Keep It Safe brochures distributed throughout the county.
- Two Lethal Means Safety trainings per year for three years with 15 or more participants each time totaling 6 trainings and 90 participants.
- 2,000 lockboxes distributed, 2,000 Lockbox Data Collection Forms completed and 2,000 educational resources provided.

Project: Social Marketing

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

Community-wide prevention efforts are designed to educate the broader community on

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

Target Population

- All Humboldt County residents will be reached with the social marketing efforts.

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
- Coordinate Awareness Month events with community partners

Communication Channels

- Email Messaging
    - Distribution List: will maintain educational connections made with training participants and with individuals in the community through an email list.
    - Content: 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.
- Public Service Announcements (PSAs)
    - PSAs will promote social marketing campaigns and program objectives through local radio stations. PSA content will include local state and national public health campaigns. Each Mind Matters, Know the Signs, Lock Up your Lethals information, awareness month resources and messaging and ads targeting stigma and help-seeking.
- Website
    - The new SSVP program website is in development. It will integrate former Suicide Prevention, SDR and Violence Prevention programing. Content will consist of programmatic activities, population specific resources, training promotion and public health information. Additionally, SSVP content will be disseminated though the DHHS webpage.

Marketing Content

- Media Campaigns & Toolkits
    - SSVP strategies continue to promote statewide and local campaigns (e.g. print ads, radio ads) including “Know the Signs” and “Each Mind Matters.” Additionally 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 will be promoted.
- Keep It Safe Campaign (previously Lock Up Your Lethals)

- The new Keep It Safe brochure was developed with the goal of reaching expanded audiences on the topic of safe storage of potentially dangerous items. The target audience is any and everyone in the community living in homes. Keep it Safe is about starting a conversation with Humboldt County residents about protection our loved ones from preventable injury. Keep It Safe addresses common items found in homes that could be dangerous such as medications, alcohol, firearms, and anything else that can be used to get high. Keep it Safe evolved from the Lock Up Your Lethals campaign to also include cannabis products.

- Awareness Months
  - SSVP will continue to collaborate with community partners on awareness month campaigns throughout the year. The intention will be to raise awareness on suicide prevention and its intersection with various health disparities.
  - Collaborative campaigns will include:
    - Suicide Prevention Month, including the local chapter of the American Foundation for Suicide Prevention Community Walk
    - Sexual Assault and Child Abuse Awareness Month
    - Domestic Violence Awareness Month

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

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

Outcome Estimates for FY2020-2023

- 5,000 exposures to social marketing will occur per year.
- 1000 people through the DHHS Webpage
- 60,000 though radio PSAs
- Grow email list audience to over 400 and report over 2,000 emails opened.

Prevention & Early Intervention: Parent Partners

The Parent Partner Program's vision is to provide support, encouragement, and hope to parents/caregivers who are feeling overwhelmed as they find themselves involved with a challenging and complex child or adult-serving system. It is an early intervention program and provides access and linkage to treatment. Parent Partners develop and maintain a practice to increase opportunities for parents/caregivers to receive peer based support services as they encounter county child and adult-serving systems through strategic self-disclosure of their lived experiences as parents of a youth or family member with emotional, mental health or substance abuse needs. Parent Partners provide support as a peer rather than an expert in the field and help to create conditions for parents/caregivers to feel empowered and confident as they navigate these county systems, making decisions that are best for their family and determining their course of action based on their families' needs and goals. Parent Partners model effective personal interactions while supporting the development, reconnection and strengthening of natural

supports for families. They serve as a mentor to improve parents/caregivers' confidence and ability to self-advocate for and effectively manage the services and supports for their own family. They empower families to identify their own future vision of what their family can be, what they need most to achieve this future, and how they can use their strengths and culture to get those needs met. The services of Parent Partners can contribute to meeting the need for additional services and supports for school age children. The Parent Partner Program will continue to be supported contingent upon continuing availability of MHSA funding.

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

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

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

Key Activities:
Parent Partners offer assistance in navigating the DHHS system, collaborative linkages with community resources, building natural supports and identifying their needs, strengths, skills, and goals to promote their family wellness. Parent Partners are often members of Child and Family Teams serving youth with intensive needs. Parent Partners build alliances with other departments and agencies including Probation and Child Welfare Services to assist parents/caregivers whose children have been placed out of county or are currently in programs like New Horizons Regional Facility or a foster care

facility. Parent Partners coordinate with the Children's Mobile Response Team so that families that have children in crisis are quickly offered support and resources. In addition, Parent Partners are co-facilitators at the County's Family Advisory Board meetings and several NAMI peer support groups offered in the county. They are available to parents/caregivers of children or adults receiving services within the Adult Behavioral Health system by being available to families and staff during visitation hours at the Sempervirens Psychiatric Health Facility. Parent Partners may help staff the DHHS Warm Line bringing their peer-based expertise to support community members seeking services.

Expected Outcomes:
The Parent Partner Program reached out, through meetings, referrals and support groups, 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. Parent Partners are expected to attend various meetings within the DHHS system in order to provide the critical perspective of those with lived experience.

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

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

Estimated Number to be reached in FY 2020-2023:
For the next three years an estimated 300 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.

Prevention & Early Intervention: Local Implementation Agreements

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

Successful projects are:

- Stigma and Discrimination Reduction, through the conference *Dispelling Stigma: Hoarding Education, Treatment and Prevention*, the formation of the Northcoast Hoarding Task Force, free support groups for people who hoard, and free support groups for family and friends of people who have cluttering/hoarding issues.
- Suicide Prevention, through the Bear River Band of the Rohnerville Rancheria's three-day intensive peer counseling program for Bear River youth.
- Early Intervention, through the development and implementation of an intensive therapeutic parenting program for the parents of children ages 0-5.
- Access and Linkage to Treatment and Early Intervention, though the provision of trauma focused services in Spanish and increasing access to domestic violence counseling services.
- Stigma and Discrimination Reduction and Access and Linkage to Treatment, though a Mental Health First Aid Train the Trainers, with the intent of serving monolingual Spanish speakers and Native American youth.

For the next three years Local Implementation projects will continue to be funded contingent upon the continuing availability of MHSA funds. These small projects can potentially address many of the priorities that were identified in the CPPP, as have the prior funded projects. Requests for Application for the next fiscal year will be distributed once the Three Year Plan is approved. Guidelines will be reviewed each year. Priority target populations may be identified in different years, depending upon stakeholder input regarding needs, but at all times the focus of projects will be on the PEI categories. For the next fiscal year, discussions about focusing the target population on youth has been initiated.

Prevention & Early Intervention: School Climate Curriculum Plan/MTSS

Increasing the recognition of early signs of emotional disturbance or behavioral illness for children in a school setting has been an identified need of the MHSA Community Program Planning Process (CPPP) for years. It remains as an identified need through the current time, with the CPPP of this Three Year Plan showing that increasing support for school age youth, and providing more behavioral health supports in schools, are priorities for the community. This input led to DHHS-Behavioral Health and the Humboldt County Office of Education (HCOE) developing a shared plan to address the need, and they entered into a Memorandum of Understanding to continue to develop a Multi-Tiered System of Support (MTSS) Coalition to implement the Positive Behavior Interventions and Supports (PBIS) curriculum. This partnership has been in place since 2016. The only change in the support provided for the future, contingent upon the continuing availability of MHSA funding, is that MHSA will support a position that is shared between DHHS-Behavioral Health and HCOE. This position, the Prevention and Intervention Specialist, will be responsible for the management, development, coordination of services, professional development, technical assistance and other MTSS, PBIS, Social Emotional Learning (SEL) programs/services and related projects. The position will serve as the lead administrator for a project team; will establish and implement district services and technical assistance across these frameworks; will coordinate and facilitate various

county communities, staff development and leadership activities; and will provide leadership in the design, implementation, and maintenance of innovative practices that support student achievement. The MTSS Program is a prevention and early intervention program that will impact the identification of early signs of emotional disturbance in children and youth.

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

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

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

Target Population
One of the strengths of the MTSS framework is that it includes all student groups and

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

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

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

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

Outcome measures

Fidelity Measures: District and school site teams will conduct fidelity measures and make inclusive data-based decisions based on these tools. Some of the measures include Fidelity Integrity Assessment (FIA – a district and site based tool for MTSS implementation), The Tiered Fidelity Inventory (TFI – a site-based Team assessment to measure the implementation of PBIS/SEL), The Self-Assessment Survey (SAS – a site-based survey of all school personnel to measure the perceptions and priorities of PBIS/SEL implementation. These measures often occur two times an academic year to guide intervention practices.
Behavioral Data: The School-Wide Information System (SWIS, pbisapps.org) is the gold standard tool to guide and support PBIS implementation. Student behavior is tracked and defined as "minor vs. major" behaviors (often differentiated by classroom managed or office managed behaviors). SWIS provides instantaneous rich data that informs whole school, select groups, or individual need. Interventions are effective when data driven, and SWIS provides a tool to inform interventions and effectiveness. Additionally SWIS is a powerful tool to identify disproportionality of specific student groups. The Prevention and Intervention Specialist will provide facilitation, technical assistance and training of SWIS.
Existing Data Sources: Local and state resources (i.e. the CA Dashboard, the Healthy Kids Survey, and school data base systems) are pre-existing measures that will reflect the impact of transformative system practice. Attendance, referrals, suspensions, disproportionality, and community engagement are data sources that will be examined. MTSS is endorsed by the CA Department of Education, and the CA Department of Special Education, as an evidence-based framework designed to respond to indicators of student need statewide (Differentiated Assistance, DA, Comprehensive Support and Improvement, CSI, Performance Indicator Review – PIR, and Disproportionality – DisPro). Additionally the CA Department of Education endorses the examination of exclusive disciplinary practices (suspension and expulsions) and the promotion of inclusive disciplinary practices (Restorative Practices, and school-wide PBIS) to reduce lasting maladaptive behaviors in our communities and decrease involvement in the juvenile justice system (that increases likelihood of adult incarceration).

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

Prevention and Early Intervention Assigned Funds: North Valley Suicide Prevention Hotline

The NVSPH is administered through California Mental Health Services Authority (CalMHSA), a Joint Powers Authority created to jointly develop and fund mental health services and education program for its Member County and Partner Counties. CalMHSA will administer NVSPH on behalf of counties that are participating in and funding the program. It will serve as the primary suicide prevention hotline for these counties, including Humboldt County. As funding allows, NVSPH will operate a 24/7 suicide prevention hotline accredited by the American Association of Suicidology and will continue to answer calls through its participation in the National Suicide Prevention Lifeline. NVSPH will also maintain its hotline website and will provide outreach and technical assistance to counties that are participating and funding the program.

Workforce Education and Training

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

Training and Technical Assistance. 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 the last fiscal year for which data is available:

- Staff had access to a total of 813 trainings.
- DHHS 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, the psychiatric hospital.
- 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-BH 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 practice changes or other important information such as training requirements and new course availability.
- Staff enrolled in a total of 11,186 courses, completing 4,898 (44%) of them.

OSHPD Regional Partnership. DHHS Behavioral Health will participate in the statewide WET 2020-2025 Plan through the Regional Partnership project, coordinated by OSHPD. Humboldt County is a member of the Superior Region and collaborated with the other counties in the Region to develop an application to secure OSHPD WET funds. The Superior Region priorities are to provide scholarships and/or stipends for peer specialists, graduate education stipends for Clinical Master and Doctoral program participants, loan repayments for qualified masters/doctoral graduates who commit to working in the public mental health system for a set period of time, and the development

and implementation of retention strategies. In Humboldt County the CPPP showed overwhelming support for retention strategies to support the behavioral health workforce, and Behavioral Health leadership has identified the loan repayment program as a priority. It is anticipated that the OSHPD programs will begin in the Fall of 2020.

MHSA Funding Summary

This MHSA Three Year Program and Expenditure Plan reflects continued MHSA funding for some previously approved components and has transitioned funding for some prior approved programs to non-MHSA funding. The Making Relatives Program was completed at the end of calendar year 2019, so no additional funding is allocated. One of the outcomes of the Making Relatives Program was the addition of Two Feathers Native American Family Services becoming the first Native American Organizational Provider for specialty mental health services. Funding for Telemedicine, ROSE/Mobile Outreach, HOME and Information Technology was transitioned to non-MHSA funding. The new programs added respond to the community needs as expressed during the Community Program Planning Process. One program new to MHSA is Regional Services, providing outreach, engagement and behavioral health services to community members residing in regions outside of the Eureka area, thus expanding services to more communities in Humboldt County. Another new program is the RFP process for establishing a Sub-Acute Transitional Behavioral Health, Specialty Behavioral Health and/or Social Rehabilitation Services Program, which will meet three of the CPPP priorities: increase and expand behavioral health services; provide continuity of care for clients released from Sempervirens, Crisis Stabilization Unit, or out-of-county placements; and increase support for the seriously mentally ill. The current Innovation project consisting of HOME and MIST, has reached the end of its approved funding period and no additional MHSA funding is allocated for it. HOME will continue to be supported by non-MHSA funds, and MIST will transition its clients to other programs to ensure continuity of services. The required 5% is allocated in the budget for a new Innovation project, which as currently conceived will address some of the needs identified in the CPPP.

In prior years, actual MHSA allocations have exceeded early conservative revenue estimates. During the CPPP, experts were advising counties that total MHSA revenues were expected to increase slightly each year during the course of this Plan. However, as of this writing, the international economic situation is very volatile, as the adverse financial effects of COVID-19 are impacting all aspects of the global economy. The budget presented in this Plan indicates a 2% reduction across the board for Fiscal Year 2021-22 and a 20% reduction in Fiscal Year 2022-23. These reductions are consistent with a MHSA revenue decline as projected by an economic expert who has been advising the California Association of Behavioral Health Directors over the past several years. Changes in fiscal conditions will trigger a reassessment of programs and services to be provided. Although the MHSA projects may indicate a budgeted amount at this time, there may be a change in the budget for a program due to increased or decreased cost of services or increased or decreased revenues. In other instances, expenditures may change due to any number of factors, including but not limited to a change to the services identified for the project, project demand, or lack of provider(s).

Additionally, the State Legislature has been re-evaluating the MHSA. Key requirements may be modified within this 3-Year Plan period. Should these changes occur, this Plan will be modified and updated through the Annual Update process or through conducting an additional stakeholder process in between the Annual Update process, if needed.

FY 2020-2021 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan Funding Summary

County: HUMBOLDT

Date: 7/16/2020

MHSA FUNDS

	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 2020/21 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	729,123	580,768	221,693	0	0	
2. Estimated New FY2020/21 Funding	5,825,307	1,456,327	383,244			
3. Transfer in FY2020/21[a/]	(143,316)			143,316		
4. Access Local Prudent Reserve in FY2020/21	200,000					(200,000)
5. Estimated Available Funding for FY2020/21	6,611,114	2,037,095	604,937	143,316	0	
B. Estimated FY2020-21MHSA Expenditures	6,036,580	1,658,788	249,067	143,316	0	
C. Estimated FY2021/22 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	574,534	378,307	355,870	0	0	
2. Estimated New FY2021/22 Funding	5,592,295	1,398,074	367,914			
3. Transfer in FY2021/22[a/]	(54,563)			54,563		
4. Access Local Prudent Reserve in FY2021/22						
5. Estimated Available Funding for FY2021/22	6,112,266	1,776,381	723,784	54,563	0	
D. Estimated FY2021/22 Expenditures	5,795,117	1,592,315	444,448	54,563	0	
E. Estimated FY2022/23 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	317,149	184,066	279,336	0	0	

	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**
2. Estimated New FY2022/23 Funding	4,473,836	1,118,459	294,331			
3. Transfer in FY2022/23[a/]	(54,563)			54,563		
4. Access Local Prudent Reserve in FY2022/23						
5. Estimated Available Funding for FY2022/23	4,736,421	1,302,525	573,668	54,563	0	
F. Estimated FY2022/23 Expenditures	4,636,094	1,273,246	400,003	54,563	0	
G. Estimated FY2022/23 Unspent Fund Balance	100,328	29,280	173,664	0	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2020	1,439,391
2. Contributions to the Local Prudent Reserve in FY 2020/21	
3. Distributions from the Local Prudent Reserve in FY 2020/21	(200,000)
4. Estimated Local Prudent Reserve Balance on June 30, 2021	1,239,391
5. Contributions to the Local Prudent Reserve in FY 2021/22	
6. Distributions from the Local Prudent Reserve in FY 2021/22	
7. Estimated Local Prudent Reserve Balance on June 30, 2022	1,239,391
8. Contributions to the Local Prudent Reserve in FY 2022/23	
9. Distributions from the Local Prudent Reserve in FY 2022/23	
10. Estimated Local Prudent Reserve Balance on June 30, 2023	1,239,391

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

FY 2020-2021 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: HUMBOLDT Date: 7/16/2020

Fiscal Year 2020/21

	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	**Estimated CSS Funding**	**Estimated Medi-Cal FFP**	**Estimated 1991 Realignment**	**Estimated Behavioral Health Subaccount**	**Estimated Other Funding**
FSP Programs 1. Comprehensive Community Treatment (CCT)	7,614,941	4,706,954	2,875,594			32,393
Non-FSP Programs						
1. Regional Services	143,957	130,870	13,087			
2. Older and Dependent Adults Expansion	103,429	68,544	34,885			
3. SubAcute Transitional Behavioral Health, Specialty Behavioral Health and/or Social Rehabilitation Services	1,000,000	500,000	500,000			
CSS Administration	644,272	630,212	14,060			
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	9,506,599	6,036,580	3,437,626	0	0	32,393
FSP Programs as Percent of Total	126.1%					

Fiscal Year 2021/22

	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	**Estimated CSS Funding**	**Estimated Medi-Cal FFP**	**Estimated 1991 Realignment**	**Estimated Behavioral Health Subaccount**	**Estimated Other Funding**
FSP Programs 1. Comprehensive Community Treatment (CCT)	7,310,343	4,518,676	2,760,570			31,097
Non-FSP Programs						
1. Regional Services	138,199	125,635	12,564			
2. Older and Dependent Adults Expansion	99,292	65,802	33,489			
3. SubAcute Transitional Behavioral Health, Specialty Behavioral Health and/or Social Rehabilitation Services	960,000	480,000	480,000			
CSS Administration	618,501	605,004	13,497			
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	9,126,335	5,795,117	3,300,121	0	0	31,097
FSP Programs as Percent of Total	126.1%					

Fiscal Year 2022/23

	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	**Estimated CSS Funding**	**Estimated Medi-Cal FFP**	**Estimated 1991 Realignment**	**Estimated Behavioral Health Subaccount**	**Estimated Other Funding**
FSP Programs 1. Comprehensive Community Treatment (CCT)	5,848,275	3,614,940	2,208,456			24,878
Non-FSP Programs						
1. Regional Services	110,559	100,508	10,051			0
2. Older and Dependent Adults Expansion	79,433	52,642	26,791			0
3. SubAcute Transitional Behavioral Health, Specialty Behavioral Health and/or Social Rehabilitation Services	768,000	384,000	384,000			0
CSS Administration	494,801	484,003	10,798			
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	7,301,068	4,636,094	2,640,096	0	0	24,878
FSP Programs as Percent of Total	126.1%					

FY 2020-2021 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: HUMBOLDT

Date: 7/16/2020

Fiscal Year 2020/21

	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	**Estimated PEI Funding**	**Estimated Medi-Cal FFP**	**Estimated 1991 Realignment**	**Estimated Behavioral Health Subaccount**	**Estimated Other Funding**
PEI Programs - Prevention						
1. Hope Center	274,701	274,701				
2. TAY Advocacy and Peer Support	423,468	405,168				18,300
3. Parent Partnership Program	322,241	322,241				
4. School Climate Curriculum/MTSS	90,000	90,000				
5. Local Implementation Agreements	110,000	110,000				
PEI Programs - Early Intervention						
1. Suicide Prevention	200,000	200,000				
PEI Administration	241,410	241,410				
PEI Assigned Funds	15,268	15,268				
Total PEI Program Estimated Expenditures	1,677,088	1,658,788	0	0	0	18,300

Fiscal Year 2021/22

	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	283,491	263,713	19,778			
2. TAY Advocacy and Peer Support	435,646	388,229	29,117			18,300
3. Parent Partnership Program	332,552	309,351	23,201			
4. School Climate Curriculum/MTSS	86,400	86,400				
5. Local Implementation Agreements	105,600	105,600				
PEI Programs - Early Intervention						
1. Suicide Prevention	192,000	192,000				
PEI Administration	231,754	231,754				
PEI Assigned Funds	15,268	15,268				
Total PEI Program Estimated Expenditures	1,682,712	1,592,315	72,097	0	0	18,300

Fiscal Year 2022/23

	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	284,810	210,970	73,840			
2. TAY Advocacy and Peer Support	432,647	306,923	107,423			18,300
3. Parent Partnership Program	334,099	247,481	86,618			
4. School Climate Curriculum/MTSS	69,120	69,120				
5. Local Implementation Agreements	84,480	84,480				
PEI Programs - Early Intervention						
1. Suicide Prevention	153,600	153,600				
PEI Administration	185,403	185,403				
PEI Assigned Funds	15,268	15,268				
Total PEI Program Estimated Expenditures	1,559,427	1,273,246	267,881	0	0	18,300

FY 2020-2021 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: HUMBOLDT

Date: 7/16/2020

Fiscal Year 2020/21

	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. INN project in development - Draft budget	210,439	210,439				
INN Administration	38,628	38,628				
Total INN Program Estimated Expenditures	249,067	249,067	0	0	0	0

Fiscal Year 2021/22

	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 INN project in development - Draft budget	436,367	404,044	32,323			
INN Administration	40,404	40,404				
Total INN Program Estimated Expenditures	476,771	444,448	32,323	0	0	0

Fiscal Year 2022/23

	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 INN project in development - Draft budget	436,367	363,639	72,728			
INN Administration	36,364	36,364				
Total INN Program Estimated Expenditures	472,731	400,003	72,728	0	0	0

FY 2020-2021 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: HUMBOLDT

Date: 7/16/2020

Fiscal Year 2020/21

	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	45,781	45,781				
2. OSHPD Regional Partnerships	97,535	97,535				
WET Administration	0					
Total WET Program Estimated Expenditures	143,316	143,316	0	0	0	0

Fiscal Year 2021/22

	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	54,563	54,563				
WET Administration	0					
Total WET Program Estimated Expenditures	54,563	54,563	0	0	0	0

Fiscal Year 2022/23

	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	54,563	54,563				
WET Administration	0					
Total WET Program Estimated Expenditures	54,563	54,563	0	0	0	0

FY 2020-2021 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: HUMBOLDT Date: 7/16/2020

Fiscal Year 2020/21

	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	0					
CFTN Programs - Technological Needs Projects	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	0	0	0	0	0	0

Fiscal Year 2021/22

	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	0					
CFTN Programs - Technological Needs Projects	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	0	0	0	0	0	0

Fiscal Year 2022/23

	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	0					
CFTN Programs - Technological Needs Projects	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	0	0	0	0	0	0

MHSA COUNTY COMPLIANCE CERTIFICATION

County: Humboldt

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

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

This Three Year Plan has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft Three Year Plan was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The Three Year Program and expenditure plan. attached hereto, was adopted by the County Board of Supervisors on October 27, 2020.

Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant.

All documents in the attached Three Year Plan are true and correct.

Emi Botzler-Rodgers MFT
Local Mental Health Director/Designee (PRINT)

EBR MFT 9/21/2020
Signature Date

County: Humboldt

Date: October 27, 2020

Enclosure 1

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: Humboldt ☐ Three Year Plan

Local Mental Health Director	County Auditor-Controller/ City Financial Officer
Name: Emi Botzler-Rodgers MFT	Name: Karen Paz Dominguez
Telephone Number: 707-268-2990	Telephone Number: 707-476-2470
E-mail: ebotzler-rodgers@co.humboldt.ca.us	E-mail: kpazdominguez@co.humboldt.ca.us
Local Mental Health Mailing Address: Humboldt County DHHS-Behavioral Health 720 Wood St. Eureka CA 95501	

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

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

Emi Botzler-Rodgers MFT

Local Mental Health Director (PRINT)

Signature Date 8/27/2020

I hereby certify that for the fiscal year ended June 30, 2020, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIG 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated June 6, 2019 for the fiscal year ended June 30, 2018. I further certify that for the fiscal year ended June 30,2020, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIG section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

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

Karen Paz Dominguez
County Auditor Controller/ City Financial Officer (PRINT)

Signature Date 9/17/2020

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