Mental Health Services Act

Three-Year Plan

Fiscal Years 2014/2015, 2015/2016 and 2016/2017

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Community Planning and Local Review Process

Background

It is helpful to the understanding of Mental Health Services Act programing to be aware of some of the background of Humboldt County Department of Health and Human Services.

Humboldt County Department of Health and Human Services is a consolidated and integrated Health and Human Services Agency under the State's Integrated Services Initiative (AB 315 Berg) and includes Mental Health, Public Health and Social Services. Since its consolidation in 1999, Humboldt County Department of Health and Human Services has been engaged in true system transformation and redesign through numerous key strategies, including but not limited to:

- Establishing consolidated administrative support infrastructures;
- Establishing consolidated program support infrastructures;
- Developing governmental "rapid cycle" change management processes;
- Importing or developing evidence based practices and other outcome based approaches to services;
- Developing integrated, co-located and decentralized services concurrently;
- Establishing client and cultural inclusion structures/processes that will advise the Department in terms of policy and programming;
- Focusing on quality improvement and systems accountability in terms of outcomes linked to improved individual and family recovery and self sufficiency, as well as improved community health;
- Working with State Health and Human Services Agency to reduce or eliminate barriers that impede effective service delivery at the County level.
- Using a "3 x 5" approach to program design which spans:

Three Service Strategies	Five Target Populations
Universal	Children, Youth and Families
Selective	Transition Age Youth
Indicated	Adults
	Older Adults
	Community

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

It is through AB315 and these transformational strategies that the Humboldt County Department of Health and Human Services has planned and implemented its Mental Health Services Act programming. Humboldt County's approved Community Services and Supports Plans, Workforce Education and Training Work Plans, Capital Facilities and Information Technology Needs Plan, Prevention and Early Intervention Plan, and Innovation Plan were developed and are being implemented with cross-departmental integration aimed at the delivery of holistic and transformational programs.

Community planning Process

Methods for obtaining stakeholder input occur in a varity of ways that include but are not limited to:

- Humboldt County Department of Health & Human Services sponsored MHSA education and planning meetings. These are widely advertised meetings inviting people to gather to discuss Mental Health Services Act.

- Humboldt County Department of Health & Human Services participation in community meetings where Mental Health Services Act education and planning are discussed. These are meetings already occurring in the community where a county staff person attends and requests that Mental Health Services Act planning be on the agenda for a specific meeting to focus on MHSA education and input. These are often meetings sponsored by local community-based organizations and associations that represent and/or serve diverse stakeholders. This dramatically increases the number and diversity of individuals providing input.

- To conduct planning where communities are already gathered is an important method of obtaining stakeholder input. It ensures the inclusion of the diversity of stakeholders that represent the demographics of the Humboldt County population.

- Input sent to the Mental Heath Services Act email address, left on the Mental Health Services Act voice mail, left in a Mental Heath Services Act comment box, written on comment forms at stakeholder meetings. This ensures stakeholder's anonymity and input methods that stakeholders are most comfortable with at a time that is most convenient.

The planning process for this Plan was built upon knowledge gained from ongoing input activities and Local Review processes including but not limited to:

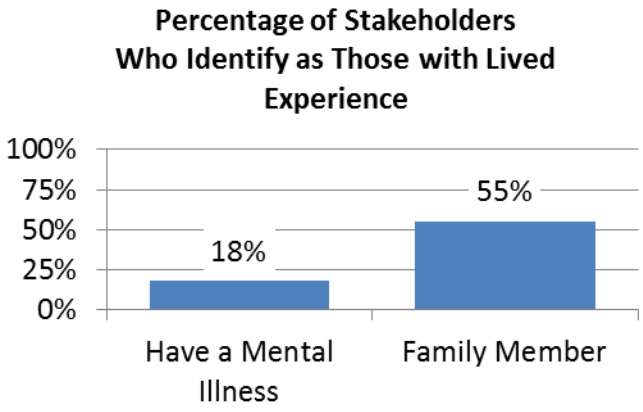
• Department Mission and Vision	• California Partnership for Permanency (CAPP)
• MHSA Prevention and Early Intervention	• Children's System of Care planning
• MHSA Innovation	• MHSA Workforce Education and Training
• Superior Region WET Partnership	• MHSA Annual Updates 2006/2007 to 2013/2014
• Initial 2004/2005 Community Services and Supports planning	
• Humboldt County Transition Age Youth Collaboration HCTAYC Policy Recommendations	
• MHSA Capital Facilities and Information Technology Needs	

Community planning Process

Stakeholders

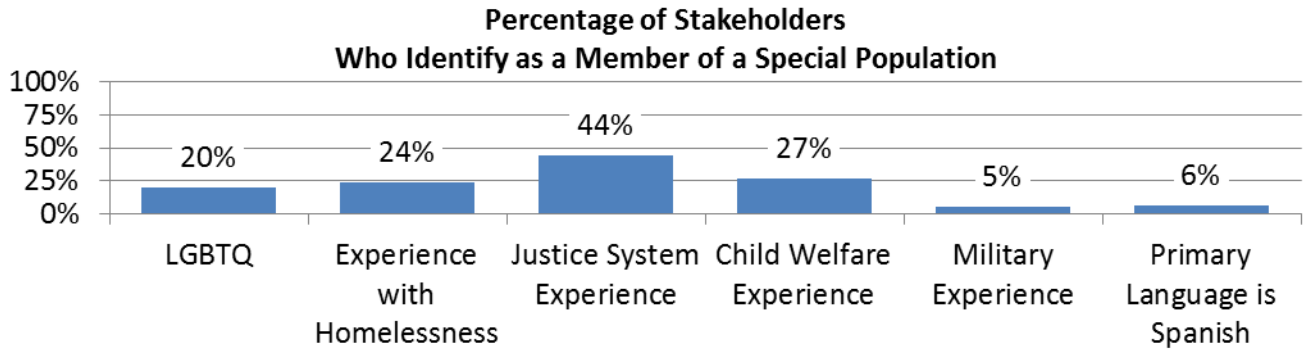
DHHS began collecting stakeholder demographic information in earnest in 2008. Between 2008 and 2014, 458 or 66% of the 690 MHSA stakeholders participating in MHSA CPP activities completed a demographic questionnaire. The MHSA CPP for this Plan included partnering with a local hospital and the local public health branch in 2013 for the Humboldt County Community Health Improvement Plan which included six regional community meetings. In 2014, an additional six regional MHSA planning and education community meetings occurred throughout the County with a total of 127 comments that informed this Plan. The tables and charts below reflect the 165 or 68% of the 243 attendees at these events who completed demographic forms.

Individuals with lived experience with a mental illness and their family members are recognized as a vital voice in the MHSA CPP and efforts continue to ensure and increase their inclusion as the following chart

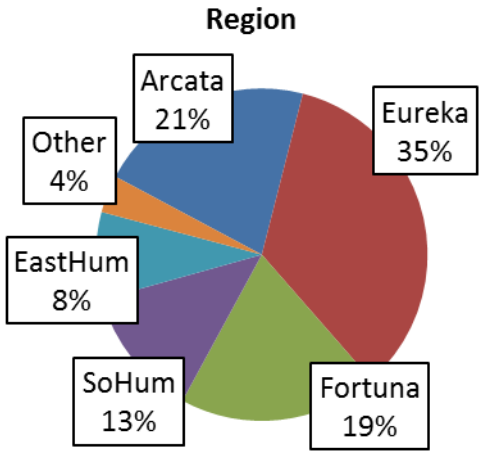


illustrates.

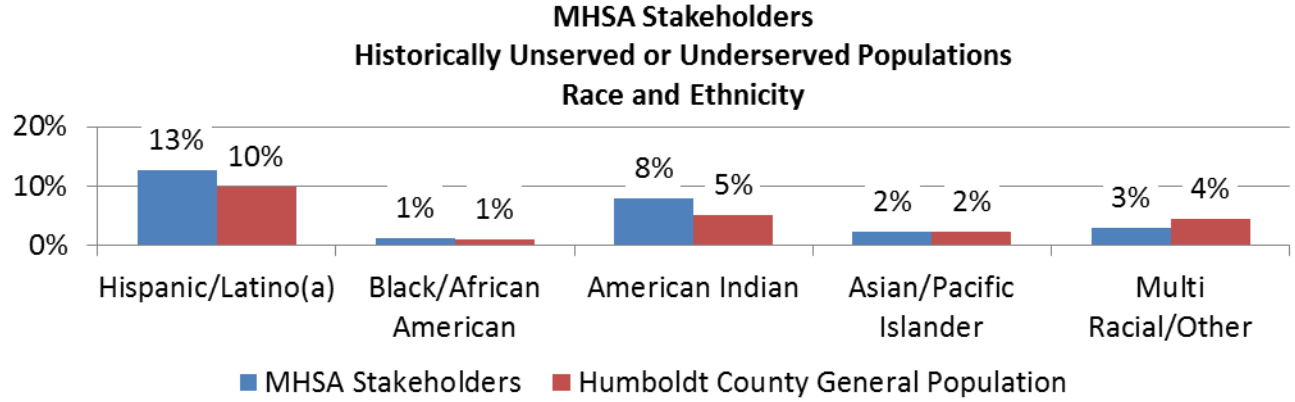
Additional life experiences have been identified, at the local level, as necessary voices for the CPP, so they too are monitored for inclusion. Sexual orientation, gender identity, homelessness, incarceration, former foster youth, veterans, and those whose primary language is Spanish are all life experiences that can result in challenges to successful mental health treatment. The chart below illustrates how outreach efforts to include people with these unique life experiences is resulting in their participation in the CPP.



Another priority for representation in the CPP is regional. Half of County residents live in the Arcata and Eureka regions close to Humboldt Bay while the other half lives in the southern and eastern regions of the County. As this chart reflects, the CPP process for this Plan included diverse regional representation.



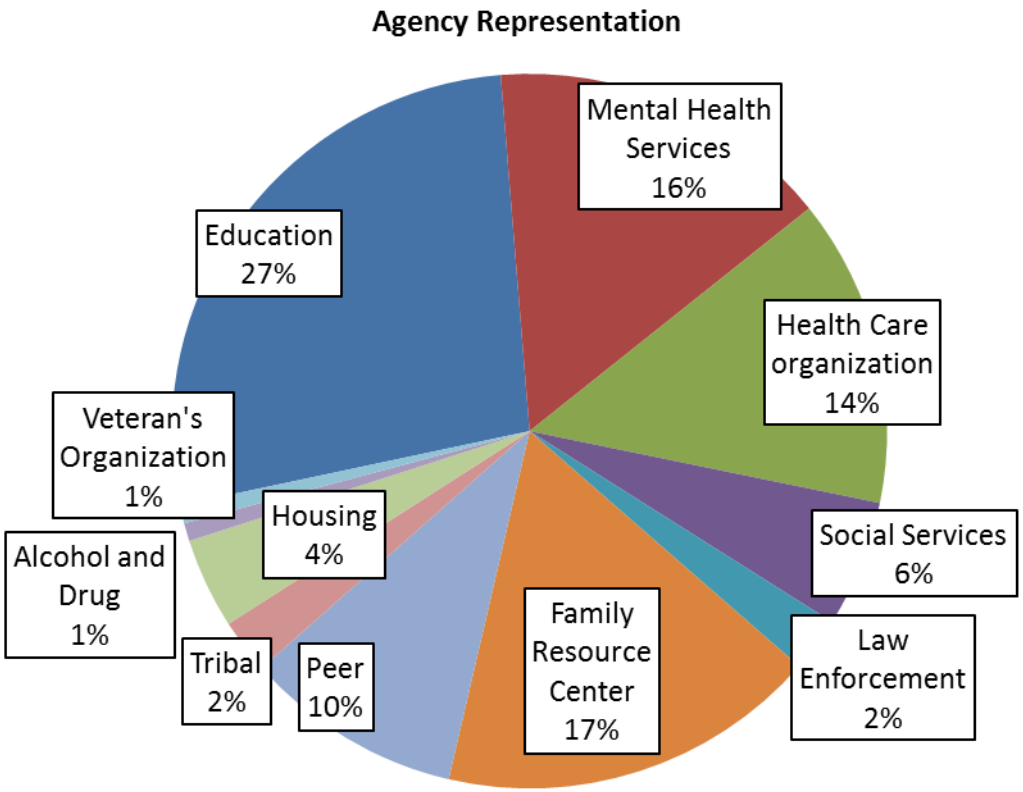
CPP participants for this Plan reflect the racial and ethnic diversity of Humboldt County. Progress is continuing in efforts to increase the participation of individuals who identify as a race and or ethnicity that



Community planning Process

has traditionally experienced disparities in mental health services. As this chart illustrates, the percentage of stakeholder participation for Hispanic/Latino(a)s, Black/African Americans, Asian/Pacific Islanders, and American Indian or Alaska Natives is comparable or greater than that of Humboldt County's general population.

The CPP continually strives to include representation from diverse agencies that provide services to MHSA clients. As the below chart illustrates, the CPP for this Plan included individuals from education, mental health services, health care organization, social services, law enforcement, family resource center, peers, tribal organizations, affordable housing, alcohol and drug services, and veteran's organizations.



Education and Input

The CPP for this Plan had two components, First, MHSA education and second, collecting input from stakeholders. MHSA education included the following areas of planning; mental health policy, program planning, implementation, monitoring, quality improvement, evaluation, and budget allocations. It also included the MHSA core concepts of community collaboration, cultural competence, client driven, wellness, recovery and resilience focused, and an integrated service experience for clients and their families.

MHSA CPP Stakeholder Materials

MHSA materials were available in both English and Spanish and a Spanish language interpreter was utilized. They included:

- MHSA Planning and Core Concepts handout
- MHSA Components and Humboldt County MHSA Program Descriptions handout
- Comment Form for written comments that included an MHSA comment line phone number and email address for alternate methods of providing input
- Anonymous Demographic Questionnaire
- Educational Power Point presentation that included MHSA background, definitions, regulations, component and local program funding percentages and funding amounts.

Public Comment and Public Hearing

There was a 30-day Public Comment period from May 8th through June 9th, 2015 and a Public Hearing on June 10th, 2015 from 11:30 to 1:00 at the Humboldt County Department of Health and Human Services Professional Building located at 507 F Street, Eureka, Ca 95501 (Attachment A)

Copies of the MHSA Three-Year Plan were made available to all stakeholders through the following methods:

- Electronic format: the Humboldt County Department of Health and Human Services, Mental Health Services Act website
- Print format: Humboldt County Department of Health and Human Services (DHHS) Professional Building, 507 F Street, Eureka Ca, 95501; DHHS Mental Health, 720 Wood Street, Eureka Ca, 95501; DHHS Children Youth and Family Services 1711 3rd Street Eureka Ca, 95501; and The Hope Center 2933 H Street Eureka Ca, 95501
- An informational flyer (Attachment B) was sent to stakeholders regarding the Plan's availability, including where to obtain it, where to make comments, and where/when the public hearing would be held.
- Informational flyers were mailed to over 30 locations around the county, including public libraries, health care clinics, tribes, and senior centers
- Informational flyers were e-mailed to recipients on more than 10 local e-mail distribution lists including family/community resource centers, organizational providers, and Latino Net
- Plans are e-mailed or mailed to all persons who request a copy
- Announcements appear in local media with the Plan's availability, including where to obtain it, where to make comments, and where/when the public hearing will be held (Attachment C)
- The Mental Health Director and the Mental Health Services Act Coordinator announced to Department of Health and Human Services staff, community-based organizations and partner agencies in various meetings the Plan's availability including where to obtain it, where to make comments, and where/when the public hearing will be held.

During the public review period, 38 comments from stakeholders were received in a variety of ways, including e-mail, comment boxes, phone calls, and at the public hearing. While some comments received were outside the scope of the Mental Health Services Act Fiscal 3-Year Plan, all of the comments are relevant and important to services provided in the community. All comments were carefully documented and will be used to inform planning and implementation of programs and activities throughout the Humboldt County Department of Health and Human Services. While there was no required "substantive" change to this Plan, during the Public Comment period a stakeholder noted that there should be a brief description of the school climate curriculum evidence based practices rather than just a link to their websites and have since been added to the Plan.

What's New

Included in this Plan is an Innovation Final Report and a new Innovation Project Plan, Rapid Re-Housing. While no programs have been eliminated, Transition Age Youth Adaptation to Peer Support has been transitioned from the Innovation to the Prevention and Early Intervention component.
Other programs and/or services have been transitioned from MHSA to alternative funding:

- Integrated Child Welfare Prevention and Early Intervention Team, formerly the Alternative Response Team (ART)
- Crisis Intervention Services and Training
- Integrated Services and Supports

Humboldt County Demographics

Humboldt County is located on the coast of northwestern California, 225 miles north of San Francisco and 70 miles south of the Oregon border. Neighboring counties are Del Norte, Siskiyou, Trinity and Mendocino. The County is rural in nature; with a population of 134,623 spread over 3,573 square miles, or 37.7 persons per square mile. 49% of residents live within the incorporated areas while over half of residents live in the outlying rural areas of the County. Eureka is the largest community in the County, and is the county seat of government. The County is home to eight federally recognized American Indian Tribes including the 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.

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

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

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

Language Spoken at Home other than English (over 5 years old)			Speak English less than "very well"	
	#	%	#	%
Spanish	6,904	5%	4,294	3%
Other Indo-European	2,586	2%	577	>1%
Asian/Pacific Islander	1,726	1%	856	>1%
Total	11,216	8%	5,727	4%

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

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

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

Data Source: http://www.census.gov/2010census/

Humboldt County Demographics

Rural Outreach Services Enterprise

The Humboldt County DHHS Mobile Outreach program is dedicated to providing services to people in outlying communities and to those who are experiencing homelessness. Rural Outreach Services Enterprise (ROSE) is the MHSA component of this program. The DHHS Mobile Outreach Program is an integrated response with Social Services, Mental Health and Public Health as a mobile outreach program for individuals with a variety of physical, behavioral, and social needs as well as prevention and education activities, thereby reducing the stigma associated with accessing behavioral health services. The MHSA CSS component of this integrated program serves individuals with severe mental illness or serious emotional disturbance including people who are homeless and at-risk of homelessness.

The program uses RVs that travel to community sites such as Family Resource Centers, clinics, tribal offices and volunteer fire departments on a set schedule. Employment services and immunization clinics can be scheduled as needed. Services on these vehicles are often available for special community events as well.

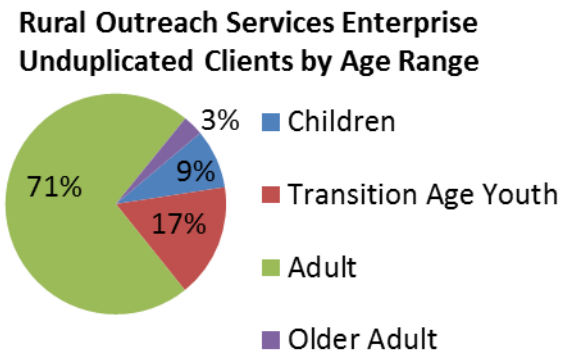
Mobile Outreach staff provide a variety of social, mental health and public health services and/or referrals to Humboldt County residents living in rural communities. During regularly scheduled visits (weather permitting), Mobile Outreach staff members are able to provide eligible residents with services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

People living in outlying areas who require ongoing mental health services, including medication support, counseling and case management, are served by Mobile Outreach staff members. Clients who are homeless are provided transportation to their mental health appointments by Mobile Outreach. Street outreach services reaches people with mental illness who are experiencing homelessness at multiple locations in the county, including free meal sites and homeless encampments. Staff provide mental health and social services as well as substance abuse services and emergency food and supplies.

While the MHSA component of this program provides mental health assessments and services other DHHS services are available as well such as CalFresh, Medi-Cal, Transportation Assistance Program, Car seat program, Well-Child Dental Varnish Program, and Fresh Produce and Supplemental Food Program. The diversity of services available reduces the stigma some might experience if the RVs only provided mental health services. This program continues to reach the unserved and underserved populations in rural, remote, and outlying geographic areas of the county.

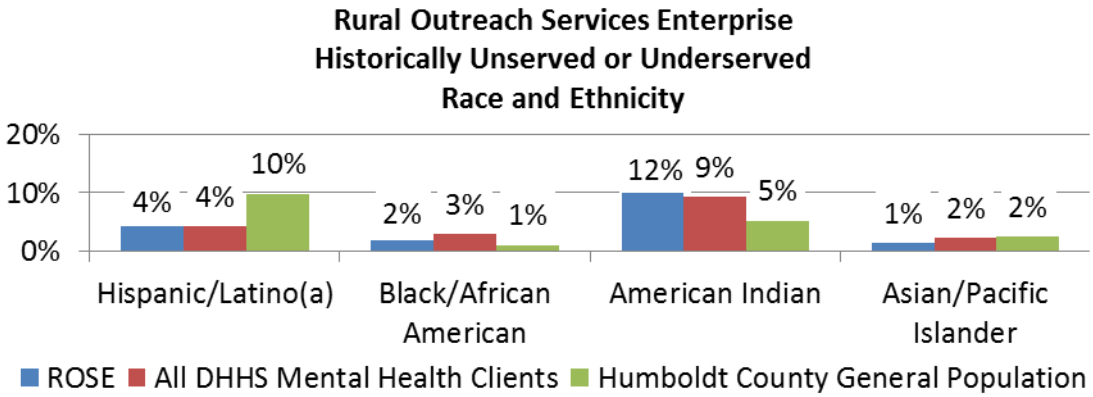
From July 2007 through June 2014 the program has served an average of 72 unduplicated mental health clients per month and 249 unduplicated mental health clients per year for a total of 1,026 unique individuals.

As this chart illustrates, ROSE provides services to people of all ages. Between July 2007 and June 2014 the program has served 89 (6%) children, 171 (17%) transition age youth, 735 (71%) adults, and 31 (3%) older adults.



Clients served through ROSE reflect the racial and ethnic diversity of Humboldt County. The percentage of ROSE clients who identify as White/Caucasian is 75%, overall Mental Health client utilization is 78% and 77% for the general population. The percentage of ROSE clients who identify as Black/African American is 2%, overall Mental Health client utilization is 3%, and 1% for the general population. ROSE clients who identify as Asian/Pacific Islanders is 1%, overall Mental Health client utilization is 2%, and 2% for the general population.

Progress is continuing in efforts to increase the participation of individuals who identify as a race and or ethnicity that has traditionally experienced disparities in mental health services. As this chart illustrates, by reducing barriers and outreaching to ethnically diverse outlying areas, ROSE contributed to the increase of services to previously unserved and underserved mental health clients who identify as American Indians.



The percentage of ROSE clients who identify as American Indian is 12%, overall Mental Health client utilization is 9%, and 5% for the general population. There is a notable disparity for the percentage of ROSE clients who identify as Hispanic/Latino(a) which is 4%, overall Mental Health client utilization is 4%, and 10% for the general population. The Cultural Competency Committee has identified specific service strategies to be implemented in fiscal year 2014/15 to address the system wide disparities for Hispanic/Latino(a) clients, specifically non- proficient English speakers including improved linguistic competency.

"All DHHS Mental Health Clients" data source through out this plan: DHHS EHR for calendar year 2011

Humboldt County Department of Health & Human Services

Mobile Outreach

People helping people live better lives

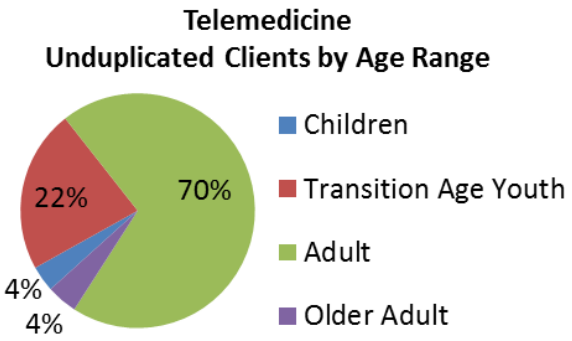
Serving the following communities:

- Carlotta
- Eureka
- Fortuna
- Garberville
- Hoopa
- Loleta
- Manila
- McKinleyville
- Orick
- Orleans
- Phillipsville
- Redway
- Rio Dell
- Weitchpec
- Willow Creek

Community Services and Supports Rural outreach Services Enterprise

Telemedicine

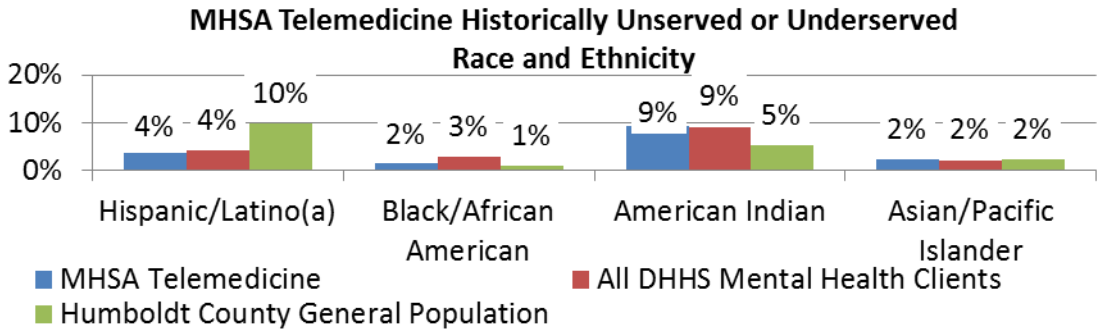
In 2006 the Department initiated an Outpatient Telemedicine Medication Services Expansion in Garberville and in Willow Creek in 2011. This expansion offers psychiatric services and medication support from a provider at located at the main clinic in Eureka to people with a serious mental illness who reside in remote rural areas of the County utilizing video conferencing equipment. It allows clients to receive services at locations that are closer to where they reside eliminating burdensome travel that often is a barrier in receiving services. This program will expand the number of days and hours it is offered as the need increases and providers are available. From July 2007 through June 2014 the program has served an average of 26 unduplicated mental health clients per month and 88 unduplicated mental health clients per year for a total of 307 unique individuals. As this chart illustrates, this program provides services to people of all ages.



Between July 2007 and June 2014 the program has served 11 (4%) children, 69 (22%) transition age youth, 214 (70%) adults, and 13 (4%) older adults.

Clients served through this MHSA telemedicine program reflect the racial and ethnic diversity of Humboldt County. The percentage of clients who identify as White/Caucasian is 81%, overall Mental Health client utilization is 78% and 77% for the general population. The percentage of MHSA telemedicine who identify as Black/African American is 2%, overall Mental Health client utilization is 3%, and 1% for the general population. Clients who identify as Asian/Pacific Islanders is 2%, overall Mental Health client utilization is 2%, and 2% for the general population.

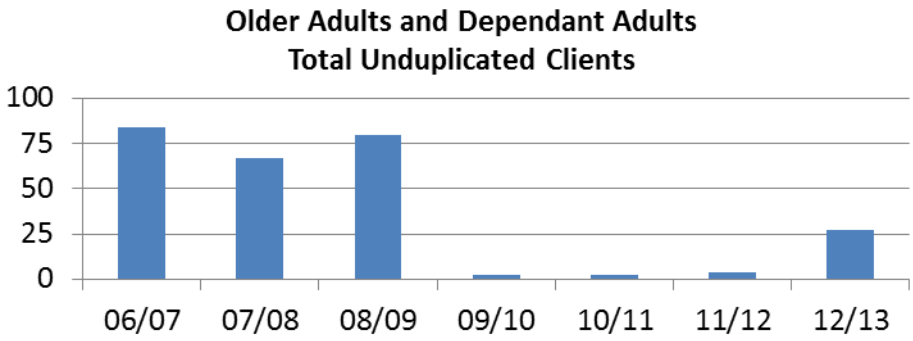
Progress is continuing in efforts to increase the participation of individuals who identify as a race and or ethnicity that has traditionally experienced disparities in mental health services. As this chart illustrates, by reducing barriers and outreaching to ethnically diverse outlying areas, this program contributed to the increase of services to previously unserved and underserved mental health clients who identify as American Indians. The percentage of clients who identify as American Indian is 9%, overall Mental Health client utilization is 9%, and 5% for the general population. There is a notable disparity for the percentage of clients who identify as Hispanic/Latino(a) which is 4%, overall Mental Health client utilization is 4%, and 10% for the general population. The Cultural Competency Committee has identified specific service strategies to be implemented in fiscal year 2014/15 to address the system wide disparities for Hispanic/ Latino(a) clients, specifically non-proficient English speakers.

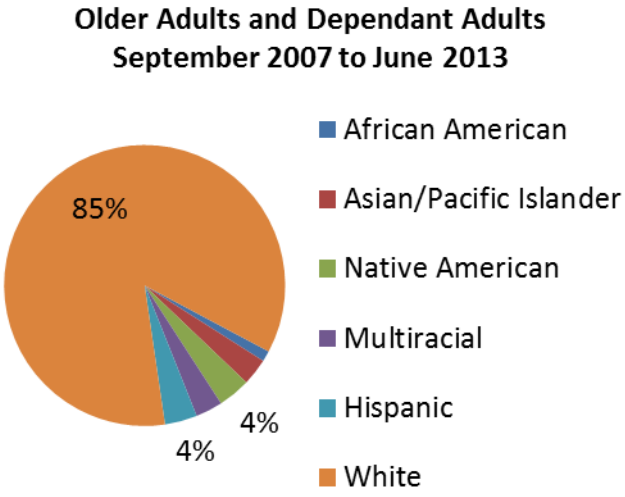


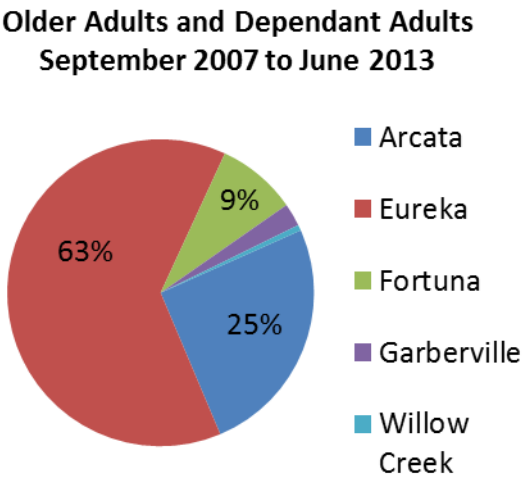
Older Adults and Dependent Adults

Prior to 2007, the DHHS Older Adults and Dependent Adults program included mental health clinicians that were co-located with Adult Protective Services. Beginning in 2007, an interdisciplinary team including Social Services social workers, Public Health nurses, Mental Health clinicians and case managers formed as a result of the inclusion of an MHSA clinician in order to holistically serve this vulnerable and underserved population. The team conducts multi-disciplinary team meetings, provides case management planning, performs investigation into suspected abuse and neglect, and provides linkage to the full range of services. Specifically, mental health staff remove barriers to access and provide mental health screening and assessment services, consultation, education, and wellness/recovery focused clinical services and supports.

The Mental Health positions were not consistently staffed during fiscal years 2009/10 to 2011/12.



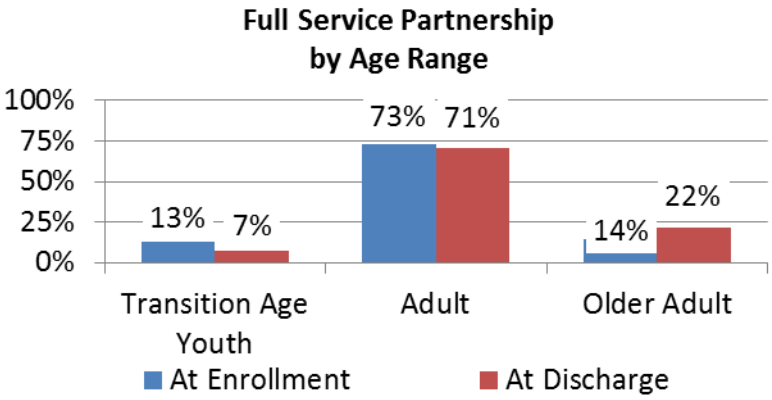




Full Service Partnership

Full Service Partnerships (FSP), offer a range of services and supports to persons impacted by severe mental illness. These services include medication management, crisis intervention, case management, peer support, family involvement, and education and treatment for co-occurring disorders such as substance abuse. It also provides for non mental health services such as food and housing. The term "Full Service Partners" 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. Beginning in September 2007 through February 2015, there has been a total of 255 mental health clients enrolled as "Partners".

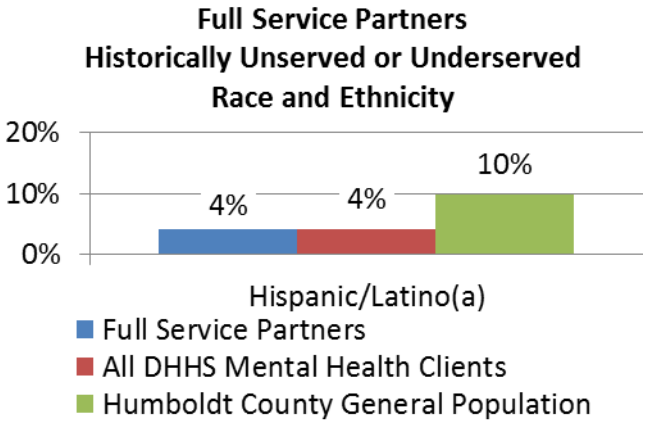
As of February 2015, 201 (79%) individuals completed at least one year as an FSP, 154 (60%) completed at least two years, 114 (45%) completed at least three years, 95 (37%) completed at least four years, and 71 (28%) completed at least five years.



The majority of FSPs are adults and older adults. 13% are between the ages of 15 and 25 years old. While enrollment as an FSP is assessed for all children who meet the FSP eligibility requirements, to date the full spectrum of services have been provided through alternate programs and funding sources.

Full Service Partners reflect the racial and ethnic diversity of Humboldt County. The percentage of clients who identify as White/Caucasian is 84%, overall Mental Health client utilization is 78% and 77% for the general population. The percentage of Partners who identify as Black/African American is 3%, overall Mental Health client utilization is 3%, and 1% for the general population. Partners who identify as Asian/ Pacific Islander is 2%, overall Mental Health client utilization is 2%. Partners who identify as American Indian is 6%, overall Mental Health client utilization is 9%, and 5% for the general population.

Progress continues in efforts to increase the participation of individuals who identify as a race and or ethnicity that has traditionally experienced disparities in mental health services. There is a notable disparity for the percentage of clients who identify as Hispanic/Latino(a) which is 4%, overall Mental Health client utilization is 4%, and 10% for the general population. The Cultural Competency Committee has identified specific service strategies to be implemented in fiscal year 2014/15 to address the system wide disparities for Hispanic/Latino(a) clients, specifically non- proficient English speakers including improved linguistic competency.



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

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

In June 2011, the Dual Recovery Program (DRP) was introduced to better address the treatment needs of people with co-occurring severe and persistent mental illness and a secondary diagnosis of a substance abuse disorder. Modeled after the evidence-based program Integrated Dual Diagnosis Treatment (IDDT), DRP utilizes an integrated dual diagnosis treatment approach for clients needing both substance abuse and mental health services. The program uses the principles and practices of IDDT as the foundation, and provides motivational-based treatment designed to engage participants in the recovery process. Individualized case planning and time unlimited services are key features of DRP. An important goal of DRP is the reduction of negative consequences related to substance abuse. Many clients of mental health services who struggle with substance abuse are not ready to endorse abstinence early on in their treatment and may even lack the motivation to reduce their use of substances. However, significant gains in treatment can be made in the early stages of treatment by focusing treatment on reducing the negative consequences of substance use, an approach often referred to as harm reduction. At the heart of this approach, the emphasis is on protecting clients from the most severe consequences of their substance use while developing a therapeutic alliance that can motivate clients to more actively address their substance abuse, endorse abstinence from substances, and create a plan to address relapses.

As these tables show, Partners are referred to an FSP program from within DHHS and various community partners. Also, partners exit an FSP due to a variety of reasons.

Referred By	Percentage
Acute Psychiatric	4%
Self or Family Member	4%
Jail/Law Enforcement	4%
DHHS Mental Health	70%
Substance Abuse Agency	2%
Social Services Agency	2%
Other	15%

Discharge Reason	Percentage
Met Goals	22%
Moved Out of County	15%
No Longer Met Criteria	11%
Chose to Discontinue	24%
Institution	2%
Could Not Be Located	6%
Incarcerated	3%
Deceased	18%

As the following tables illustrate, Full Service Partnership programs lead to dramatic improvements in increased independent living and decreased use of emergency shelters, homelessness, psychiatric emergency admits, psychiatric hospital stays, arrests, and days spent incarcerated.

Independent Living	Before FSP	Second Year of FSP	% Increase
FSPs N=154	36%	47%	↑ 29%

The number of Partners who were living independently the year prior to entering an FSP program compared to the number of Partners in their second year is up 29%. The

Independent Living	Before FSP	Second Year of FSP	% Increase
Days N=56,210	24%	33%	↑ 37%

number of days Partners were living independently the year prior to entering an FSP program to the number of days for those Partners in their second year is up 37%, the equivalent of over 13 years.

Homelessness	Before FSP	First Year of FSP	% Decrease
FSPs N=201	14%	8%	↓ 41%
Days N=73,365	7%	3%	↓ 60%
Homelessness	**Before FSP**	**Fourth Year of FSP**	**% Decrease**
FSP N=95	7%	5%	↓ 29%
Days N=34,675	4%	<1%	↓ 87%

Independent Living Days
Up 37%

Homelessness Days
Down 87%

Emergency Shelter Days
Down 91%

Psychiatric Crisis Admits
Down 94%

Psychiatric Hospital Admits
Down 62%

Arrests
Down 100%

Incarceration Days
Down 82%

The number of Partners who were homeless the year prior to entering an FSP program is down 41% compared to the number of Partners in their first year and 60% for those in their fourth year. The number of days homeless is down 29% for those in their first year and 87% for those in their fourth year, the equivalent of almost 12 years.

The number of Partners who were in an emergency shelter the year prior to entering an FSP program is down 50% compared to the number of Partners in their first year and 86% for those in their fourth year. The number of days in an emergency shelter is down 54% for those in their first year and 91% for those in their

. . .an increase in time spent living independently equivalent to over 13 years . . . homelessness decrease almost 12 years . . . emergency shelter decrease over eight years . . . psychiatric hospital decrease almost three years . . . incarcerated decrease almost four years . . .

Psychiatric Crisis	Before FSP	First Year of FSP	% Decrease
FSPs N=201	70%	12%	↓ 83%
# of Admits	407	38	↓ 91%
Psychiatric Crisis	**Before FSP**	**Fourth Year of FSP**	**% Decrease**
FSPs N=95	72%	7%	↓ 90%
# of Admits	202	13	↓ 94%
Psychiatric Hospital	**Before FSP**	**First Year of FSP**	**% Decrease**
FSPs N=201	54%	36%	↓ 32%
Psychiatric Hospital	**Before FSP**	**Fourth Year of FSP**	**% Decrease**
FSPs N=95	64%	24%	↓ 62%
Days N=34,765	5%	3%	↓ 47%

fourth year, the equivalent of over eight years. The number of Partners who were admitted for a psychiatric crisis the year prior to entering an FSP program is down 83% compared to the number of Partners in their first year and 90% for those in their fourth year. The number of admits for a psychiatric crisis is down 91% for those in their first year and 94% for those in their fourth year. The number of Partners who were admitted to psychiatric hospital the year prior to entering an FSP program is down 32% compared to the number of Partners in their first year and 62% for those in their fourth year. The number of days in a psychiatric hospital is down 47% for those in their fourth year, the equivalent of almost three years.

Arrested	Before FSP	First Year of FSP	% Decrease
FSPs N=201	26%	1%	↓ 94%
# of Arrests	86	3	↓ 97%
Arrested	**Before FSP**	**Fourth Year of FSP**	**% Decrease**
FSPs N=95	17%	0%	↓ 100%
# of Arrests	32	0	↓ 100%
Incarcerated	**Before FSP**	**First Year of FSP**	**% Decrease**
FSPs N=201	15%	3%	↓ 77%
Days N=73,365	2%	1%	↓ 65%
Incarcerated	**Before FSP**	**Fourth Year of FSP**	**% Decrease**
FSPs N=95	12%	2%	↓ 82%
Days N=34,675	2%	>1%	↓ 82%

The number of Partners who were arrested the year prior to entering an FSP program is down 94% compared to the number of Partners in their first year and 100% for those in their fourth year. The number of arrests is down 97% for those in their first year and 100% for those in their fourth year. The number of Partners who were incarcerated the year prior to entering an FSP program is down 77% compared to the number of Partners in their first year and 82% for those in their fourth year. The number of days spent incarcerated is down 97% for those in their first year and 82% in their fourth year, the equivalent of almost four years.

Rapid Re-housing

Purpose

The purpose of this Innovation Project is to increase the quality of services, including better outcomes for adults with a severe mental illness who are homeless. While this Innovation Project will increase access to services, especially for underserved groups and promote interagency collaboration, the CPP clearly identified the need to increase the quality of services, including better outcomes as the priority purpose.

This Rapid Re-Housing Project will use the "Housing First" approach to provide housing, peer support and supportive services for individuals with a diagnosis of severe mental illness who are homeless. "Housing First" is a proven strategy of ending all types of homelessness. As described by the United States Interagency Council on Homelessness (USICH), Housing First offers immediate access to permanent affordable or supportive housing without requirements of sobriety, income or completion of treatment. Humboldt County will make changes to existing rapid rehousing practices used in larger urban areas to demonstrate effectiveness on a smaller scale in rural areas. The housing component is linked to the efforts of the Mobile Intervention and Services Team (MIST), which combines law enforcement officers and mental health workers in street level interventions for persons experiencing homelessness with mental illness.

Background

A community-wide planning process that included but was not limited to, Humboldt Housing and Homeless Coalition (HHHC), City of Eureka City Council, Eureka Police Department (EPD), Humboldt County Board of Supervisors, Community Homeless Improvement Project (CHIP), Humboldt County Department of Health & Human Services (DHHS) Redwood Community Action Agency (RCAA) and the Mental Health Services Act (MHSA) Community Planning Process (CPP) led to the creation of a rapid rehousing initiative coupled with mobile mental health services.

Humboldt County has been designated as a community of high need by HUD due to the large number of people who are Chronically Homeless (CH) relative to size of population. Briefly, HUD considers CH to be currently homeless and homeless for more than a year, or to have 4 episodes of homelessness in the past 3 years. In the last Point in Time Count of homeless persons (2013) 1,054 homeless people were surveyed. 42% of the survey respondents self-reported having mental health issues; 18% reported having serious mental illness and 17% described themselves as Chronic Substance Abusers. Very similar percentages were reported in the Count of 2011 and it is expected that the 2015 Count completed January 2015 will be consistent.

In addition, as a small rural county, Humboldt struggles with economy of scale challenges which increase costs brought about by the smaller numbers of special need populations. This Innovation Project will result in the design, development, piloting, and evaluation of the inclusion of individuals who are homeless and have a diagnosis of severe mental illness in a county-wide rapid rehousing initiative. It will advance learning on the following issues: expanding options for people struggling with homelessness and severe mental illness, connecting them to community based supports, and reducing the stigma of severe mental illness in a mixed population rapid rehousing facility.

Over Utilization of Costly and Restrictive Services

In Humboldt County, there are a number of clients that are not connecting with outpatient services or peer support. The CPP concluded this is in large part due to homelessness. Permanent supportive housing is a current unmet service need for clients who are homeless that is resulting in increased:

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

Stigma and Discrimination

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

Project Description

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

This Innovation Project will address the following issues:

- Ineffective or nonexistent engagement of individuals who are homeless and have a severe mental illness including those with pets
- Individuals who are homeless and have a severe mental illness are often suspicious or fearful of outreach workers and law enforcement
- A lack of safe consistent shelter is too much of a barrier for individuals who are homeless and have a severe mental illness to engage in mental health services
- Individuals who are homeless and have a severe mental illness continue to experience discrimination even amongst the homeless services community and other homeless persons
- The increasing dependence on higher levels of care and restrictive settings such as psychiatric crisis and hospital services, emergency departments, and incarceration.

Through the development and evaluation of the following approaches:

- Utilizing peer support in a new way and in a new setting
- Exploring innovative approaches to engaging homeless persons with serious mental illness who have a pet
- Collaborating with local homelessness service agencies to implement a rapid rehousing initiative
- Partnering with law enforcement to identify and engage individuals who are homeless and have a severe mental illness.

Peer Support

Peer support has proven to not only reduce the internalized stigma for clients; it has also had a de-stigmatizing effect for co-workers and community members. With the passing of MHSA, Humboldt County Department of Health and Human Services (DHHS) Mental Health (MH) programs have explicitly included elements of recovery, wellness, and resiliency-focused peer support. Peers have been active part of service provision teams in mobile outreach, inpatient and outpatient programs. The Hope Center, a peer-run wellness center has been supporting clients in their recovery goals since it opened in 2008. DHHS MH's 2010 Innovation Plan focused on the development of transition age youth (TAY) peer support specialists in the DHHS integrated TAY Division. In 2014, after many years of hard work DHHS was able to adopt the three tier classification of Peer Coach I, II, and III. For the first time at DHHS, these job descriptions explicitly recognize the value of lived experience in a service delivery team and provide a career ladder for Peer Coaches.

The CPP determined that thus far the infusion of peer support has shown success in engaging hard to engage clients. Further, that peer support has been successful at shifting community attitudes and beliefs through modeling resilience and recovery. The CPP articulated a confidence that the innovative approach of peer support will prove successful for engaging and housing individuals who are homeless and have a severe mental illness.

Pets

Of the homeless individuals with a mental illness that have a pet, a significant percentage will not give up the pet in order to participate in services. While it will not be immediately possible to include sheltering pets at the Multiple Assistance Center, the CPP determined that something should be done in order to successfully engage these individuals in this rapid re-housing project. Therefore, this project will explore approaches to engagement that will also serve to prepare the pet for sheltering such as food and grooming products, vouchers for spaying, neutering, vaccinations, and for short term pet care facilities or "doggie day care". A minimum of 1% of the budget will be allocated as a flex fund that direct service providers can access for this purpose. Direct service providers will be responsible to develop principles for the use and accounting of these funds following all laws, policies and/or regulations. As a result, best practices will be identified and adopted.

Rapid Rehousing

As a small county health and human services agency, DHHS has successfully partnered with community organizations to address the unique needs of our special populations in Humboldt. The planned conversion of a local long-term transitional housing model for families to a short-term rapid rehousing model that is inclusive of individuals with a severe mental illness will require an innovative approach unique to this community. The large facility will serve as a short-term (30 days) housing program for any homeless adult, including persons with serious mental illness, to safely reside while looking for housing. Direct diversion into housing with rental assistance is available to participants who are able to accomplish this. Innovation funds will be used to support participants with serious mental illness.

According to the National Alliance to End Homelessness, rapid rehousing is an intervention designed to help individuals to quickly exit homelessness and return to permanent housing. This community-wide initiative will offer this assistance without preconditions (such as employment, income, absence of criminal record, or sobriety) and the resources and services provided will be tailored to the unique needs of the individual. While the larger community-wide initiative will serve all adults, this Innovation Project will serve those with a severe mental illness.

The Multiple Assistance Center (MAC) was a community-living program for families in transition that combined safe and clean temporary housing with in-depth case management and on-site direct services. Opened in April 2005, the MAC is a year-round, 24-hour staffed facility where families were challenged and supported to move from homelessness toward stability. The MAC provides a hospitable environment where people find respect, dignity, and comprehensive integrated services to assist them in overcoming the challenges of homelessness. Beginning in summer 2015, the MAC will transition from a transitional housing model for families, with stays up to 18 months, to a short-term transitional program (average stay 30 days) for adults as singles or couples while awaiting rapid placement into housing. In addition, the MAC, through this Innovation Project, will also begin to serve people with a severe mental illness as part of a mixed population of residents and participants.

Partnering with Law Enforcement
Another component to the local homelessness issue that merits the attention of this learning opportunity is the collaborative effort required to successfully engage homeless individuals who have a severe mental illness and have frequent contact with law enforcement. This innovation Project will result in the design, development, piloting, and evaluation of DHHS partnering with local law enforcement.

"The Eureka Police Department realizes that in order to effectively reduce the impact on our neighborhoods, the homeless mental health piece must be front and center of any effective solution. The Eureka Police Department, working in collaboration with the Humboldt County Department of Health and Human Services, is elated to explore new and important solutions to this very difficult and resource-intense problem. DHHS, working with EPD in the field, brings the expertise and experience necessary to improve our problem-solving efforts."

~Chief Andrew Mills, Eureka Police Department

Key Activities

- Outreach and Engagement
  Outreach and engagement will occur through the MIST partnership with law enforcement, emergency departments, psychiatric emergency services and hospital as well as other community partners.

- Rapid Re-Housing
  The Multiple Assistance Center (MAC) is a large short -term housing facility that will accommodate up to 80 people. It will serve as a safe place for a mixed adult population of homeless adults, including adults with serious mental illness, while seeking housing. Staff from the MAC, case managers and client support specialists from DHHS Mental Health and other community partners will assist participants in locating and securing housing as quickly as possible using a "Housing First" approach. Participants will have a housing assessment to determine the appropriate level of housing for the individuals with serious mental illness and any ongoing needs for supportive services to remain housed. Financial assistance is also available for deposits and in some cases on-going rental assistance. The housing placements will range from private market apartments and efficiencies, subsidized housing, Section 8 subsidy, shared housing and for those most vulnerable with a history of chronic homelessness, Permanent Supportive Housing.

- Permanent Supportive Housing
  Humboldt Housing and Homeless Coalition (HHHC) has taken every opportunity from HUD to increase the community's stock of Permanent Supportive Housing (PSH). When funded by HUD, this housing option requires the occupant to be low-income, disabled and chronically homeless. Briefly, PSH allows the participant to choose where he or she wishes to live so long as the rent is in line with Fair Market Rent for the area. The occupant's share of the rent is limited to no more than 30% of his/her income and the HUD-funded agency pays the balance. The housing unit is in the client's name and allows him/her to develop a good rental history. The participant is offered a full range of supportive services and chooses what he or she would like to participate in as recovery is client-driven. PSH can be funded by other sources, not just HUD, and DHHS Mental Health has a collaborative agreement for 15 units of PSH using the MHSA Housing Program that will open in Fall 2015. Known as Arcata Bay Crossing (ABC), this development will have 42 housing units total, including the 15 set aside for homeless people with

serious mental illness. Persons entering the MAC that need the level of support provided by PSH will be eligible for placement into ABC.

- Peer Support and Linkages
  Peer support services includes linkages to services such as:
  - Full Service Partnership enrollment
  - Outpatient mental health counseling
  - Case management
  - Medication support
  - Medi-Cal enrollment
  - Alcohol and other drug services
  - Primary care physician
  - Housing
  - Bus vouchers
  - CalFresh enrollment
  - Transitional Age Youth Division which provides mental health, social services, public health, Peer Partner support, advocacy and educational opportunities in an age appropriate, peer driven setting
  - The Hope Center, a peer run wellness center that provides a safe, welcoming environment based on recovery self-help principles
  - DHHS Mobile Outreach Vehicles, which provide services to people in extremely rural outlying communities and to those who are experiencing homelessness. The program uses RVs that travel to community sites such as family resource centers, clinics, tribal offices, volunteer fire departments, free meal sites, and homeless encampments. Social services, mental health and public health services and/or referrals are provided. These services are available in Spanish and English and may not be accessible otherwise due to transportation, financial or health-related difficulties. Mental health services include ongoing counseling, alcohol and substance abuse and case management.
  - Transportation Assistance Program provides a non-refundable bus ticket to a pre-determined destination or gas money and daily meal allowance for each day of travel for those who wish to travel out of the area where they have family and/or friends willing to offer support and assistance, will also be made
  - Community Corrections Resource Center (CCRC) is a multidisciplinary center that provides jail custody and community based services to County Probation Department offenders under AB109. DHHS services include development of transitional discharge plans, mental health assessments, counseling, medication management, alcohol and drug counseling, employment, education and housing assistance.

Project Elements
Elements known to be effective include Housing First model, Rapid Re-Housing model, client determined path to recovery.

Elements that are new include:
- Peer Support in a mixed populations, rapid re-housing environment
- Explore innovative approaches to engaging persons with serious mental illness who have a pet
- Short term housing for mixed populations, including persons with serious mental illness
- Short term housing facility where supportive services are provided by multiple agencies
- On-site presence of law enforcement in casual setting to reduce stigma. There will be a room in the facility for officers to use for writing reports, using phone, and taking a break. Interaction with residents

is encouraged to allow officers to see clients when they are not in crisis and to allow residents to interact with officers when not facing arrest.

Project Outcomes

The following will be monitored quarterly through the implementation team to identify best practices which will be reported annually in MHSA Updates and will culminate in a final Innovation Report at the end of the Project:

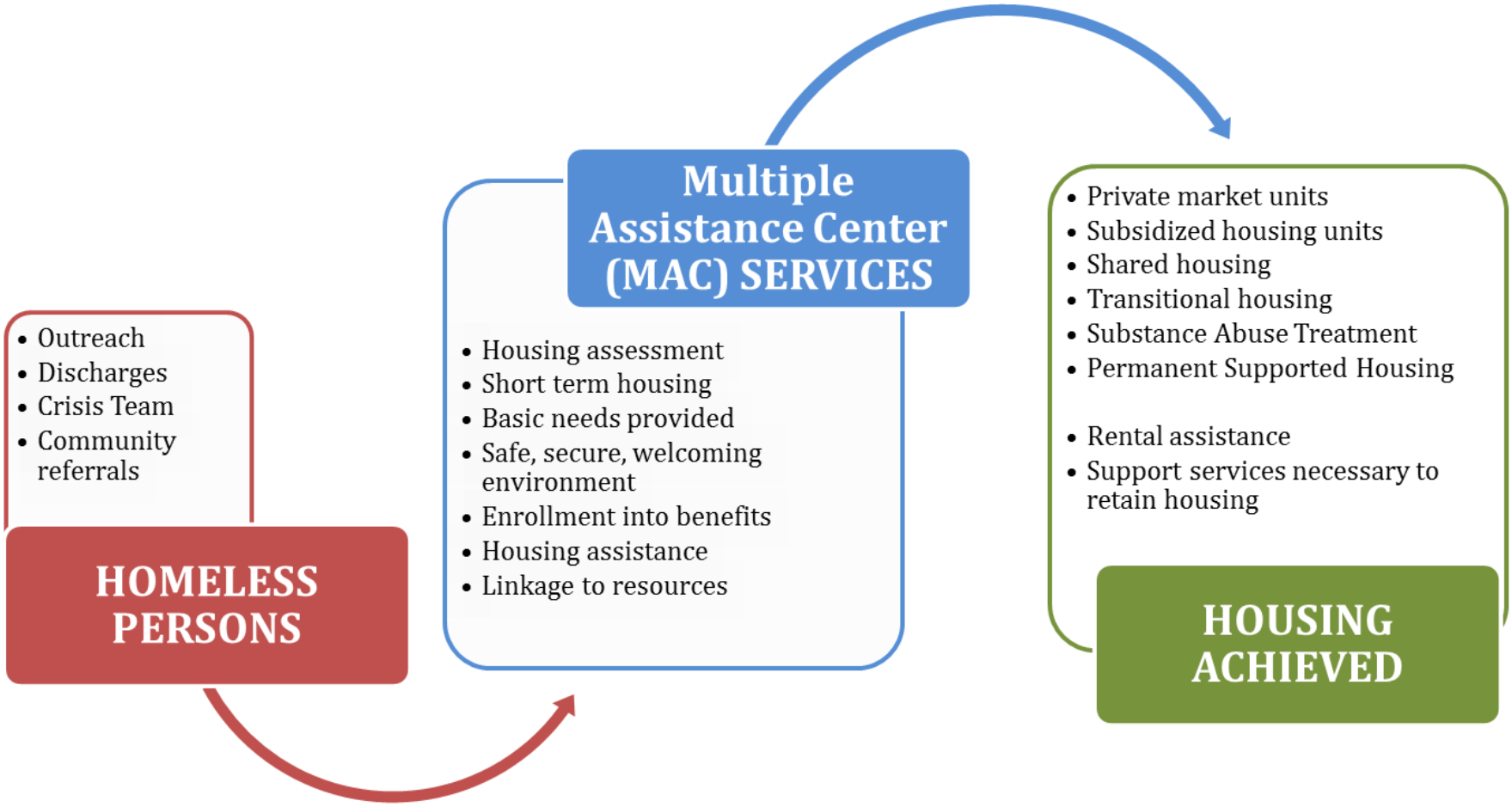
- Utilization of peer support in a new way and in a new setting .
- Exploring innovative approaches to engaging homeless persons with serious mental illness who have a pet
- Collaborating with local homelessness service agencies to implement a rapid rehousing initiative
- Partnering with law enforcement to identify and engage individuals who are homeless and have a severe mental illness.

Client outcomes will be monitored quarterly through the DHCS Data Collection and Reporting data base for Full Service Partners. They include but are not limited to:

Increase	Reduce
Residential Stability	Psychiatric Hospitalizations
Educational Goals	Psychiatric Emergency Visits
Vocational Goals	Arrests
	Incarceration

Project Timeline

Fiscal Year	
2014/2015	Planning and preparation of MHSA Innovation Plan
2015/2016	Transition the MAC from long-term to rapid re-housing model, develop staffing positions and job duties, recruit and train personnel, outreach and engage initial client participants, and implement project and evaluation plan.
2016/2017	Continue project and evaluation plan. Monitor client outcomes.
2017/2018	Continue project and evaluation plan. Monitor client outcomes.
2018/2019	Determine efficacy of project and if feasible transition successful project elements to alternative funding. Develop the final report.



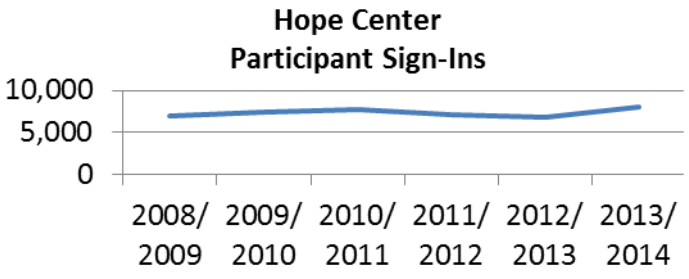
Innovation Rapid Re-housing NEW!
Innovation Rapid Re-housing NEW!

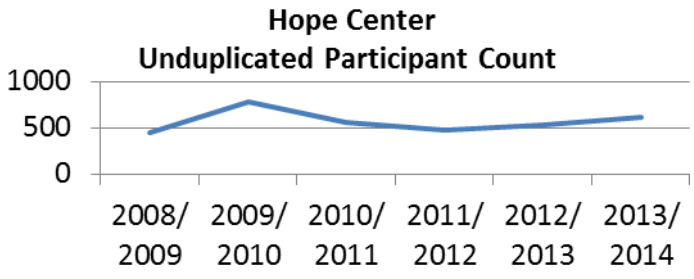
Hope Center

The Hope Center serves unserved and underserved populations including transition age youth, adults and older adults who have a severe mental illness and their family members. It provides a safe, welcoming environment based on recovery self-help principles and the resources necessary for people with a mental health diagnosis and their families to be empowered in their efforts to be self sufficient. The Hope Center is client/family member run with a full time Peer Coach III who oversees the Center and one full time and two part time Peer Coach II staff. Staff supervision and consultation is provided by a Supervising Clinician. Two Peer Coaches are trained and provide Wellness Recovery Action Plan (WRAP) development training. The Center provides recovery services including self advocacy education, peer support, system navigation, and linkage to services. Outreach efforts are made by Hope Center peer staff and volunteers to people with a mental health diagnosis.

Hope Center Goals	Hope Center Continuing Projects
Build socialization skills	Activities, art shows and events
Build sustainable living skills	Healthy Harvest - Cal Fresh grant
Community engagement	Support Groups
Promote self-advocacy	Supportive Employment Project
Keep Hope Center a safe location for all participants	Wellness Recovery Action Plan facilitation
Reduce stigma and discrimination within the system of care and the broader community	Hope Center peer support group at the psychiatric hospital
Encourage individuals to find their personal strengths and identify their personal recovery goals	May is Mental Health Month Coordination

The number of participants shown in the following charts represents the number of sign-ins and unduplicated participants who attended the Hope Center each fiscal year as indicated on daily sign in sheets. The Hope Center services an average of over 500 unduplicated participants per year with an average of over 7000 participants signing in each year.





"With these May is Mental Health Month activities, we have created a greater awareness in our community and created a voice for those who didn't have one."

~Hope Center Peer Coach

The Hope Center coordinates all May is Mental Health Month activities. A Peer Coach III serves as chair of the planning committee which is made up of multi-disciplinary agency representatives and community groups. May is Mental Health Month activities include a wide range of activities such as:

- Community BBQ's
- Art shows
- Zumba
- Movie screenings
- Presentations by the Seeds of Understanding
- County Board of Supervisors Proclamation
- Community walk that culminates in a rally with speakers

Hope Center Special Events in 2014 Partial List	
Art Sale	Each Mind Matters Presentation
Bird Walk	Mays Mental Health BBQ
Car Show	Ice Cream Social
Concert by the Bay	Mental Health Walk
Open Mic	Movie Night at Sequoia Park
MHSA Meeting and Luncheon	Dell' Arte Mash-Up Bash Pageant Blue Lake
Freshwater Picnic	Redwood Park Walk
Headwaters Walk	Supportive Employment
Cruz Car	Road Trip to Ukiah Memorial Project

kudos korner

I want to recognize Kellie Jack, peer specialist at the Hope Center. Efforts to increase mental wellness and decrease the burden of stigma and discrimination for those with a mental illness is a year-round effort, but every May we celebrate Mental Health Month with opportunities to recognize our successes and educate ourselves and the community about recovery and wellness. While there are many people involved in these activities, Kellie's stand-out dedication and leadership made this May such an incredible success! Her commitment to promoting mental wellness and busting destructive myths about mental illness is a benefit to our staff, our clients and our community.

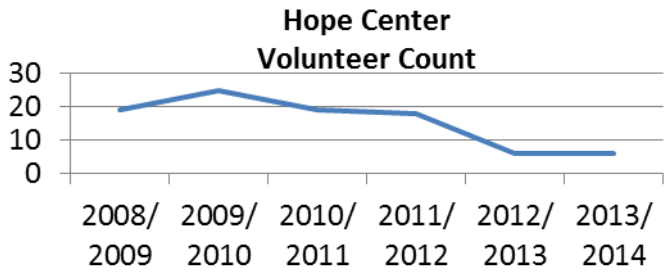
Jaclyn Culleton
Mental Health Services Act program manager

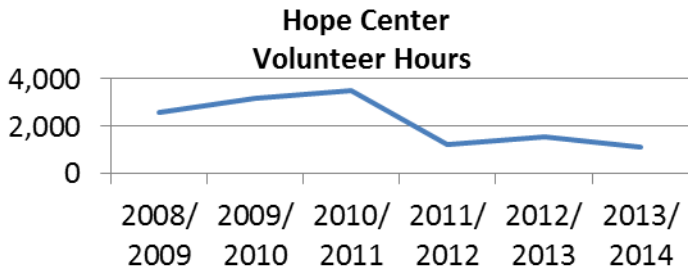
DHHS Newsletter Article June 2014

"The Hope Center is like being with family. I feel like I can be myself and that I belong somewhere."

~Hope Center Participant

Volunteers at the Hope Center are consistent and active members of the community who contribute valuable services such as outreach, education, and coordination of special events. The number of volunteers has decreased since the initial opening of the Hope Center as a result of increased organization, training and guidance provided by Peer Support staff.





Hope Center supports healthy living

by **Val Saunders**, MFT, Supervising Mental Health Clinician

The Hope Center is designed to provide mentally ill adults and their family and friends a safe, positive environment to learn to live the best life possible — personally, socially, mentally and emotionally. The Hope Center hosts Community Recovery in Action meetings for the community every Monday at 1 p.m. During these meetings, participants and staff members come together to discuss changes, challenges, solutions and progress being made in the participants' recovery from mental health issues, as well as to conduct official Hope Center business.

Pictured outside the Hope Center are, from left, Mental Health Aides Jim Woolsey and Jesse Katz, Peer Specialist Kellie Jack and Mental Health Aide Shannon Kirke.

The Hope Center is a peer-run center, with DHHS Mental Health staff members who are peers themselves, which means decisions are made by the center's stakeholders themselves. Examples of these decisions include selecting activities to take place at the Hope Center, such as the quilting group, beading group, art activities, physical activities like swimming and walking, the advocacy group, healthy harvest and gardening.

Healthy living and food choices are supported at the Hope Center, and participation in CalFresh is encouraged. There is a dedicated garden area where we help participants grow and harvest healthy foods. We educate participants, volunteers and staff members by visiting working farms, including apple and other fruit orchards where participants can learn by seeing how food grows and then pick or harvest some of their own. In collaboration with DHHS Public Health and other experienced community volunteers, we offer reading materials and provide classes in economical and healthy food preparation.

Hope Center staff members encourage all participants to suggest activities they are able to offer or would like to participate in. Examples of this include the embroidery group and the games group that are both led by consumers of the center. The Wellness Recovery Action Plan (WRAP) groups have expanded to include a simplified pocket version of WRAP and have also added an individualized WRAP activity for people who have a difficult time participating within a group. A cooking class was held in cooperation with Public Health and led by Colleen Ogle, DHHS Public Health nutritionist from the Community Wellness Center.

We offer a total of five activities every day, plus four hours a day of unstructured drop-in time. We have monthly birthday cakes, special activities with food from licensed kitchens and provide coffee daily. Overall, participation has increased.

We are in the process of establishing a solid volunteer base, as well as promoting the Hope Center to new participants. We are also working on increasing WRAP awareness to the medication support staff's nurses and doctors in an attempt to provide WRAP education to the greater mental health community within Humboldt County. A WRAP group has also been implemented in the Dual Recovery Program.

Observing Mental Health Month

There were many ways to celebrate May is Mental Health Month in Humboldt County this year, including the annual Art for Life sale and reception, the Mental Health Walk and the Hope Center barbecue. Here are a few photos from those events for you to enjoy.

DHHS scrapbook

The Hope Center barbecue took place May 16 at Carson Park in Eureka. Pictured at the grill are Peter Lonely, left, and Jimmie Austin, both DHHS Mental Health case managers with Comprehensive Community Treatment.

A large crowd of Hope Center supporters, staff members and volunteers enjoyed hamburgers and hot dogs and plenty of potluck fare. Various activities were also offered, including game booths and Zumba.

Walkers got the attention of downtown Eureka motorists as they marched from the Hope Center to the Humboldt County Courthouse on May 13. The annual DHHS Mental Health Walk started just after noon. Walkers were greeted a half-hour later at the courthouse by county officials, DHHS employees and community members for a rally, which kicked off with Supervisor Rex Bohn reading a Mental Health Month proclamation issued earlier in the day by the Board of Supervisors. The festivities also included a Zumba session to promote physical activity as a way to improve mental wellness and a series of speakers, including DHHS Mental Health Director Asha George and DHHS Peer Specialist Kellie Jack with the Hope Center.

Many people attended the Art for Life sale and reception on May 2 in the Rainbow Room at DHHS Mental Health's 720 Wood St. facility. DHHS Mental Health Clinician Etta Bergstresser, left, looks at artwork with Jan Ramsey, who oversees the Art for Life Studio. Art for Life is a studio art program developed in 1995 by Ramsey in partnership with DHHS Mental Health. It is designed to help adults with severe mental illness work as serious artists.

On May 13, during the Board of Supervisors' morning session, Supervisor Virginia Bass, center, issued a proclamation recognizing May as Mental Health Month in Humboldt County. Pictured here with Bass receiving the proclamation are Tim Ash, president of NAMI Humboldt and a member of the Humboldt County Behavioral Health Board, and Kellie Jack, DHHS peer specialist at the Hope Center.

DHHS Health Education Specialist Oceana Madrone is a longtime quilter who facilitates the Hope Center's quilting classes. At the barbecue, she helped people create their own quilt squares.

Suicide Prevention

The Purpose of the DHHS Suicide Prevention Program is to prevent suicide as a consequence of mental illness, improve access and linkage to treatment especially for those populations that are underserved or unserved. The Program includes public and targeted information campaigns, a community suicide prevention network, culturally specific approaches, survivor-informed models, and training and education. All activities meet an evidence based, promising practice, or practice based evidence standard. It is housed within the DHHS Public Health Branch and uses a public health approach following the Spectrum of Prevention model. The Program works to build capacity in the community to develop a coordinated response to suicide prevention and early intervention. The program achieves this through enhancing partnerships with health care, education, mental health providers, first responders, probation, Tribes, youth serving providers, faith communities, and Family Resource Centers.

Spectrum of Prevention	
Level	**Definition**
Strengthen Individual Knowledge and Skills	Enhancing an individual's capability of preventing injury or illness and promoting safety
Promote Community Education	Reaching groups of people with information and resources to promote health and safety
Educate Providers	Informing providers who will transmit skills and knowledge to others
Foster Coalitions and Networks	Bringing together groups and individuals for broader goals and greater impact
Change Organizational Practices	Adopting regulations and shaping norms to improve health and safety
Influence Policy and Legislation	Developing strategies to change laws and policies to influence outcomes

Key components include:

- Increasing awareness
- Promoting help-seeking
- Promoting mental health, wellness, and suicide prevention skills

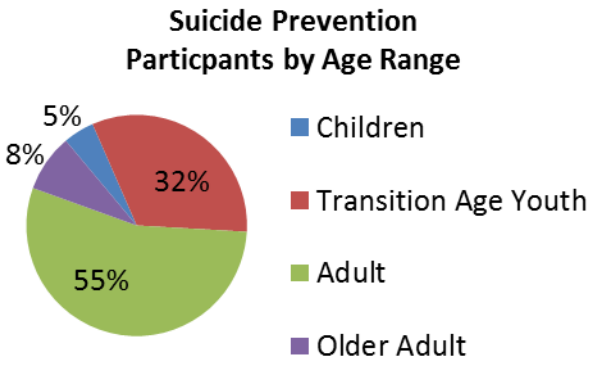
Key activities include:

- Trainings utilizing evidence based, promising practice, or practice based evidence model
- Capacity building support
- Technical assistance to develop policies, protocols and procedures that build a framework for suicide prevention and crisis intervention for agencies and schools
- Reducing access to lethal means through safe storage of firearms and medications

Participants

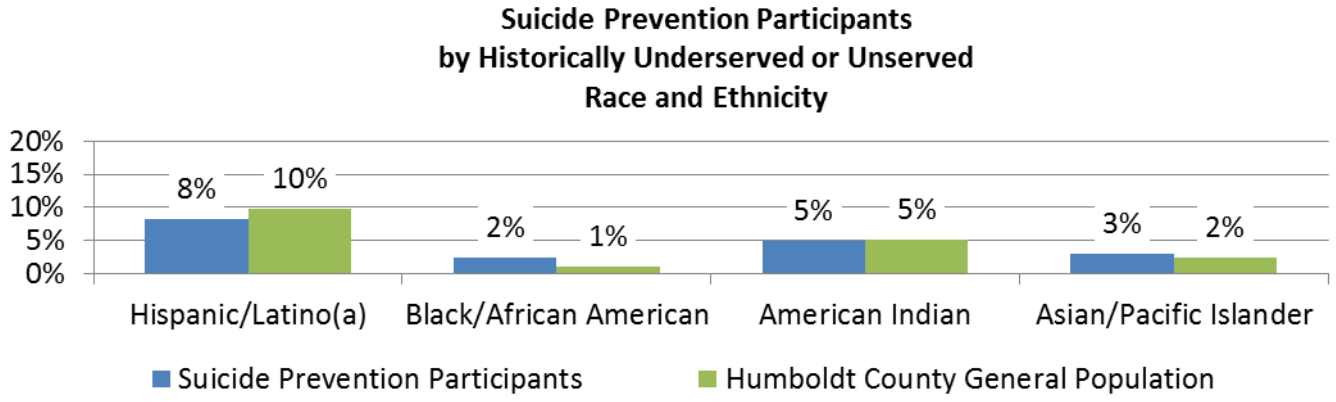
Between November 2009 and June 2014, there were 41 events with 4,257 participants sponsored by the Suicide Prevention Program including speaker events, technical assistance meetings, local hospital grand rounds, or building community capacity events, as well as, community events that suicide prevention staff attended such as tabling at the Festejando Nuestra Salud (Latino Health Fair), the K'ima:w Tribal Health Fair, the St Joseph's Health Fair and the Humboldt Pride Festival. In addition there were 123 suicide

prevention trainings with 2,642 participants for a total of 6,899 participants. Of those 2,315 or 34% completed demographic forms.

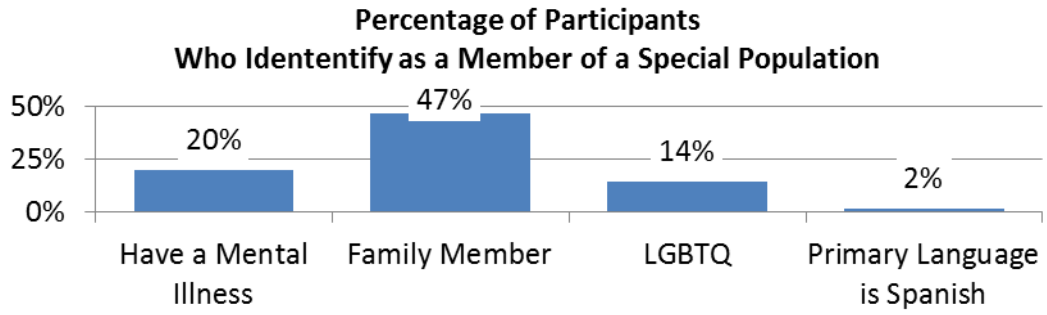


As this chart illustrates, the Suicide Prevention Program provides trainings to people of all ages. Between November 2009 and June 2014 the Program's participants were 105 (5%) children, 747 (32%) transition age youth, 1,256 (54%) adults, and 193 (8%) older adults.

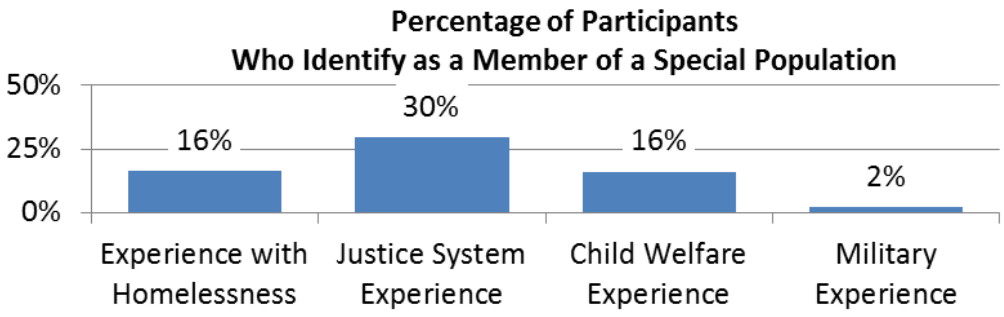
Participants reflect the racial and ethnic diversity of Humboldt County with an emphasis on those populations that are historically underserved, underserved or



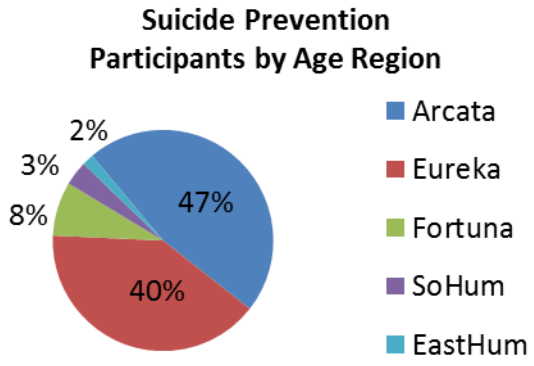
inappropriately served. The percentage of Suicide Prevention participants who identify as Hispanic/Latino (a) is 8%, and 10% for the general population. The percentage of participants who identify as White/ Caucasian is 68% and 77% for the general population. The percentage who identify as Black/African American is 2% and 1% for the general population. The percentage who identify as American Indian is 5% and 5% for the general population. Participants who identify as Asian/Pacific Islanders is 3% and 2% for the general population.



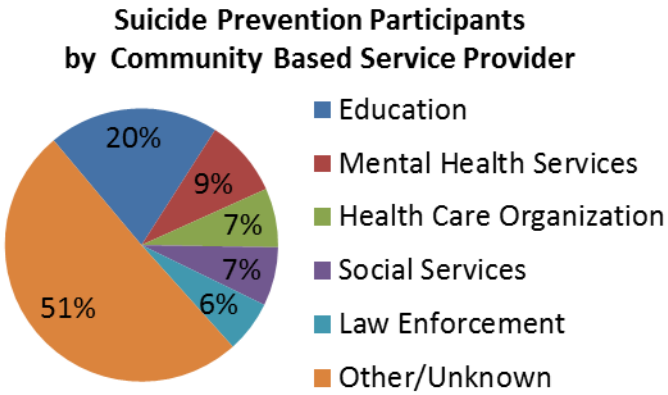
Life experiences where there is extensive evidence that disparities exist in the areas of access, quality, and outcomes in mental health service provision are also monitored for participation. Sexual orientation, gender identity, homelessness,



incarceration, former foster youth, are all life experiences where the impact of stigma and discrimination can result in challenges to successful mental health access and treatment. This chart illustrates how outreach efforts to include people with these unique life experiences is resulting in their participation in Suicide Prevention activities.



Another priority for representation in Suicide Prevention activities is regional. Half of County residents live in the Arcata and Eureka regions close to Humboldt Bay while the other half lives in the southern and eastern regions of the County. As this chart reflects, to date activities have been focused in the Arcata and Eureka regions of the County and there is a need to engage and provide Suicide Prevention activities for residents in the southern and eastern regions of the County.



The Suicide Prevention Program continually strives to include representation from diverse community based service providers. As the chart illustrates, individuals participated from education, mental health services, health care organization, social services, and law enforcement. In addition, 28 representatives from Family Resource Centers and 322 DHHS staff have participated. Individuals such as employers and faith based organizations were not significantly reached. The program will do targeted outreach to these representatives for future suicide prevention trainings.

Trainings

The Suicide Prevention Program provides three training models. Training teams are multidisciplinary and include public health educators, mental health clinicians, social workers, local university staff, tribal community agency representatives, and law enforcement. They include the following:

Question, Persuade, and Refer Pre and Post Evaluation	Percent Increase
Knowledge of Facts concerning Suicide Prevention	↑ 44%
Knowledge of warning signs of suicide	↑ 35%
How to ask someone about suicide	↑ 51%
Persuading someone to get help	↑ 36%
How to get help for someone	↑ 36%
Information about local resources for help with suicide	↑ 55%
Do you feel that asking someone about suicide is appropriate?	↑ 23%
Do you feel likely to ask someone if they are thinking of suicide?	↑ 28%
Rate your level of understanding about suicide & suicide prevention	↑ 41%

Question, Persuade and Refer (QPR) was implemented in September 2009. This training is a brief educational program designed to teach "gatekeepers"--those who are strategically positioned to recognize

and refer someone at risk of suicide (e.g., parents, friends, neighbors, teachers, coaches, caseworkers, police officers)--the warning signs of a suicide crisis and how to respond by - Question: Ask about suicide, Persuade and promote the person to seek and accept help, and Refer the person to appropriate resources. Between September 2009 and June 2014, there have been 93 QPR trainings with 2,508 participants and 1,367 completed and evaluation. QPR is customizable and staff have made this training useful to a range of populations from high school students to law enforcement.

"I truly enjoyed the training. I felt I learned a lot more about suicide intervention and feel I've been equipped with great tools to intervene for someone who is at risk.

~ASIST Training Participant

safeTALK is a half-day alertness workshop that prepares anyone over the age of 15 (e.g., parents, students, teachers, front-line workers and supervisors, police, emergency responders, human resources personnel), regardless of prior experience or training, to become a suicide-alert helper. This is a structured training that provides graduated exposure for practicing actions to approaches and discussing suicide with persons in distress. safeTALK provides skills to challenge attitudes that inhibit open talk about suicide, recognize a person who might be having thoughts of suicide, engage individuals at risk in direct and open talk about suicide, and refer persons at risk to people trained in suicide intervention. The Suicide Prevention Program provided four trainings to 67 participants. While safeTALK remains as an option for training, QPR is more adaptable to specific populations and therefor efforts have been more focused on providing QPR in the community.

ASIST Pre and Post Evaluation	Percent Increase
If a person's words or behaviors suggest the possibility of suicide, I would ask directly if they are thinking about suicide	↑ 33%
If someone told me he or she were thinking of suicide, I would do a suicide intervention	↑ 33%
I feel prepared to help a person at risk of suicide	↑ 50%
I feel confident I could help a person at-risk of suicide	↑ 47%
I can identify the places or people where I should refer others at risk of suicide	↑ 30%
I have easy access to the educational resource materials I need to learn about helping a person at risk of suicide	↑ 30%
I feel comfortable discussing suicide with others	↑ 41%

Applied Suicide Intervention Skills Training (ASIST) was implemented in November 2011 and is a two-day intensive, interactive workshop on suicide first aid. ASIST is applicable for all professions especially those who are in a position to be caregivers. It provides the tools to recognize invitations for help, review the risk of suicide, apply a suicide intervention model, and link a person at risk with appropriate resources. Between September 2011 and June 2014 there were 20 ASIST trainings with 384 participants and 161 or 42%, completed an evaluation. Participants had an overall 38% increase in their knowledge, comfort and confidence in preventing suicide.

Raising Awareness

The Suicide Prevention Program has promoted statewide and local campaigns to increase community awareness and promote help-seeking. Marketing and media outreach efforts include:

- Know The Signs English and Spanish posters, brochures, tent cards have been distributed throughout Humboldt County at all trainings and outreach events.
- An interior and exterior bus ad campaign in both English and Spanish
- A four-page insert has been distributed in community venues
- 2,500 promotional pin buttons were created and distributed at all trainings.
- 6 Directing Change student video contest submissions were submitted since 2013. The videos have been used in presentations in student health and safety classes, suicide prevention trainings, and other presentations.

The following tools or toolkits have been used or shared:

- Making Headlines-A Guide to working with the media about suicide prevention
- Smartphone app MY3 has been incorporated into all trainings and resource materials
- Culture and Community: Suicide Prevention Resources for Native Americans
- Training Resource Guide for Suicide Prevention in Primary Care Settings

The Suicide Prevention Program helps promote access to the Institute on Aging's Friendship Line. It is the nation's only 24-hour toll-free hotline for older and disabled adults. The Friendship Line is both a crisis intervention center and a "warm" line for routine, even daily, phone calls that provide emotional support, medication reminders and well-being check-ins. Trained staff and volunteers make and receive calls to and from individuals who are either in crisis or just in need of a friend. Institute on Aging staff members and volunteers are trained to listen for signs of emotional pain, cognitive decline or medical problems that might otherwise go unnoticed. A program of Institute on Aging's Center for Elderly Suicide Prevention and Grief-Related Services, the Friendship Line is accredited by the American Association of Suicidology.

Friendship Line services include:

- Crisis intervention and referrals
- Well-being telephone check-ins
- Follow-up home visits for supportive counseling and psychotherapy
- Group and individual grief counseling
- Specialized counseling and bereavement support for people who have experienced traumatic loss to suicide or sudden death

The Suicide Prevention Program placed advertisements for the Friendship Line in the Senior Resource Center Newspaper for 11

months in 2013 and 2014. During this time period, There were a total of 1,315 calls for Humboldt County at the Friendship Line. The Program is considering the most effective plan for continued promotion of the Friendship Line.

Program Goals for Training

Additional Program staff will be trained to facilitate programs, including in Spanish, such as: QPR, ASIST, and Safe Talk. The Program will continue to participate in conferences such as the American Association of Suicidology, Tools for Change, and Each Mind Matters.

Increase outreach and participation in suicide prevention trainings for healthcare providers, educators, service providers, congregations, law enforcement, first responders, and neighborhood groups. The program will emphasize efforts in outlying areas. The program will also coordinate culturally appropriate trainings for groups that work with diverse and underserved and unserved populations such as monolingual Spanish speakers, LGBTQ, Youth, Tribal communities. Included in these trainings will be an emphasis on training for DHHS staff.

Continue and expand relationships with the local university and community college and provide trainings in ASIST, QPR and Mental Health First Aid to school staff and students in higher education. Currently all students in the masters of psychology program must complete the two day ASIST training before graduation. Continue to provide technical assistance and participate in the k-12 Student Support Services Personnel Collaborative, attending the quarterly meeting. This will include support in developing guidelines around suicide prevention in the areas of identification, referral, support and postvention.

Program Goals for Raising Awareness

Continue and expand community-wide media campaigns by promoting existing suicide prevention campaigns (e.g. purchasing bus ads, print ads, radio ads, and TV spots) to publicize statewide or national campaigns such as: Each Mind Matters, Sana Mente, Know the Signs, and Directing Change. The Suicide Prevention Program will also continue to collaborate with the Stigma and Discrimination Reduction Program to conduct additional Photovoice and Digital Storytelling workshops. The products from these workshops will be used in trainings and will be displayed throughout the community. Continue to distribute suicide prevention materials to providers, which include brochures, posters and other materials from statewide or national campaigns.

Continue to participate in community events and provide suicide prevention resources to the community at events such as the Humboldt LGBTQ Pride, Festejando Nuestra Salud, the K'ima:w health fair, and the St. Joseph health fair at the Bayshore Mall. In addition, continue to support May is Mental Health Month, Recovery Month, Suicide Prevention Week and Wellness Week by attending planning meetings, promoting month long activities and utilizing translators and interpreters to make activities accessible to Spanish speakers when possible.

Program Goals for Collaboration

The Suicide Prevention program will continue to promote and collaborate with groups such as Humboldt Allies for Substance Abuse Prevention (ASAP), Latino Community Providers Network, Let's Get Healthy Humboldt, Domestic Violence Coordinating Council, and Humboldt Bridges (Children's System of Care) by attending meetings, collaborating on activities, promoting work within the Promotores Committee and sharing updates.

Stigma and Discrimination Reduction

The purpose of the Stigma and Discrimination Reduction Program is to provide direct activities that reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and discrimination related to being diagnosed with a mental illness, having a mental illness, or to seeking mental health services for a mental illness, and to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families.

The Program includes, social marketing campaigns, speakers' bureaus and other direct-contact approaches, targeted education and training, anti-stigma advocacy support for statewide web-based campaigns, efforts to combat multiple stigmas that have been shown to discourage individuals with a mental illness from seeking mental health services, and efforts to encourage self-acceptance for individuals with a mental illness.

All activities meet an evidence based, promising practice, or practice based evidence standard and include improving access and linkage to treatment especially for those populations that are underserved or unserved. It is housed within the DHHS Public Health Branch and uses a public health approach following the Spectrum of Prevention model.

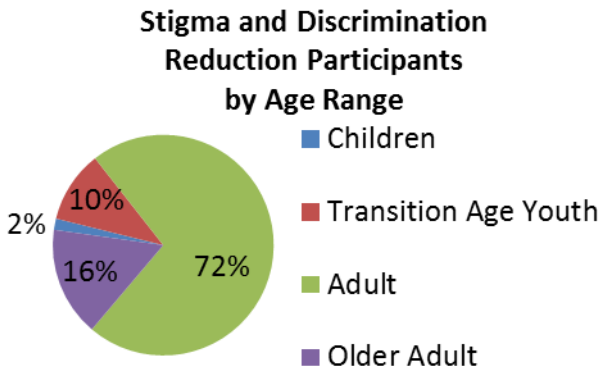
The program provides trainings to service providers, decision-makers and community members who have direct contact with mental health consumers to raise awareness and reduce stigma and discrimination in the community. The program also works to amplify peer/consumer voice and participation in our community by continued facilitation of peer-driven initiatives. The program helped create and supports an ongoing speakers' collective of individuals with lived experience by providing technical support, trainings and opportunities for speaking engagements.

Type of Event	Number of Events	Number of Participants
Trainings for Peer Empowerment and Story Telling	15	247
Speaker Bureau Planning Meetings	9	90
Speaker Bureau Presentations	17	1,271
Speaker Presentations with Films or Digital Stories	15	444
Other Types of Presentations and Tabling	28	1,031

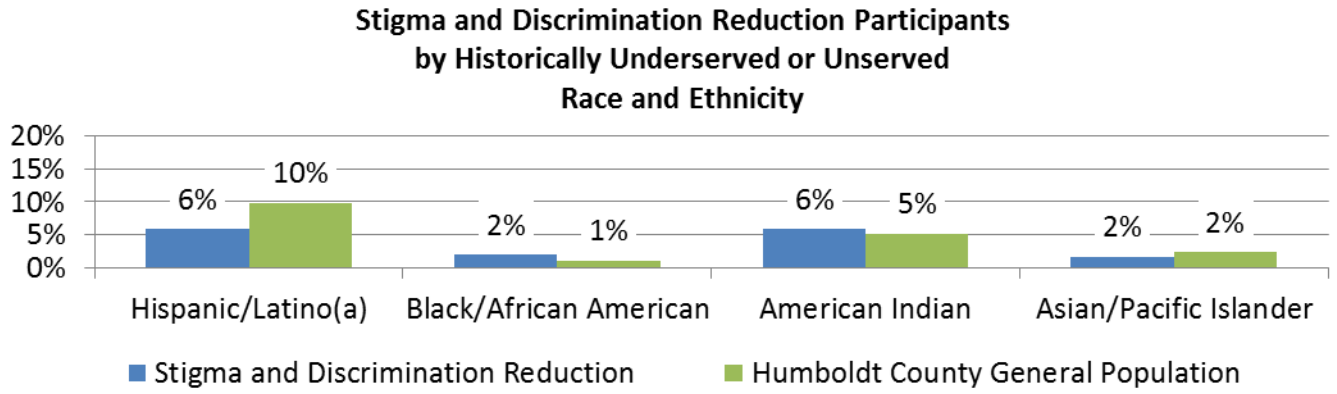
Participants

Between February 2010 and June 2014 there were 84 events including tabling at community events, peer-driven planning meetings, trainings, and presentations with a total of 3,083 participants. Of those 1,111 or 36% completed demographic forms.

As this chart illustrates, the Stigma and Discrimination Reduction Program provides trainings to people of all ages. Between February 2010 and June 2014 the Program's participants were 18 (2%) children, 115 (10%) transition age youth, 783 (70%) adults, and 175 (16%) older adults.

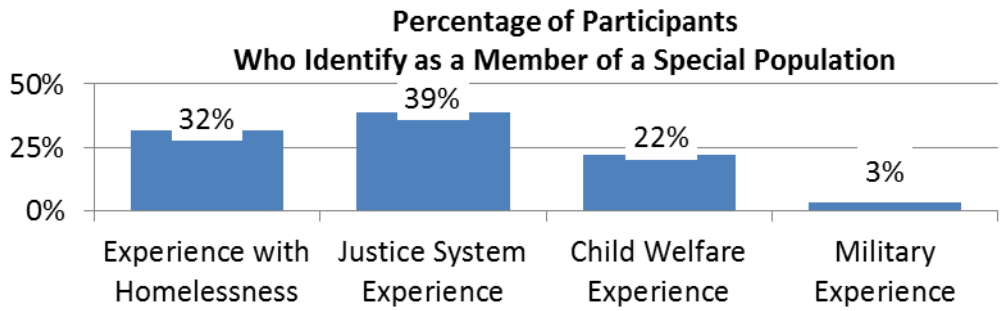


Participants reflect the racial and ethnic diversity of Humboldt County with an emphasis on those populations that are historically unserved, underserved and inappropriately served. The percentage of Stigma and Discrimination Reduction participants who identify as Hispanic/Latino(a) is 6%, and 10% for the

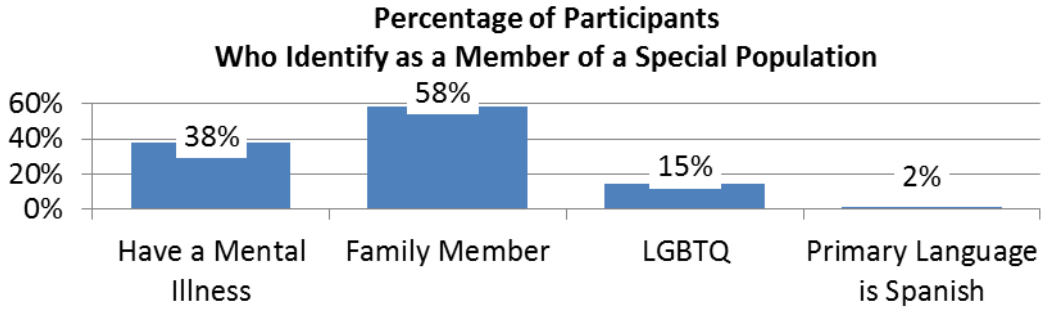


general population. The percentage of participants who identify as White/Caucasian is 72% and 77% for the general population. The percentage who identify as Black/African American is 2% and 1% for the general population. The percentage who identify as American Indian is 6% and 5% for the general population. Participants who identify as Asian/Pacific Islanders is 2% and 2% for the general population.

Life experiences where there is extensive evidence that disparities exist in the areas of access, quality, and outcomes in mental health service provision are also monitored for participation.

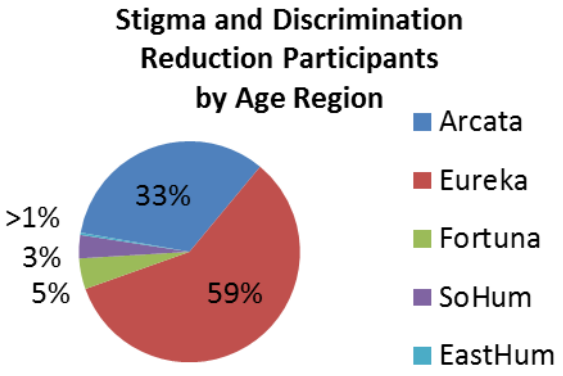


Sexual orientation, gender identity, homelessness, incarceration, former foster youth, are all life experiences that are impacted by stigma and discrimination that can result in challenges to successful mental health access and treatment. This chart illustrates how outreach efforts to include people with these unique life experiences is resulting in their participation in Stigma and Discrimination Reduction activities.

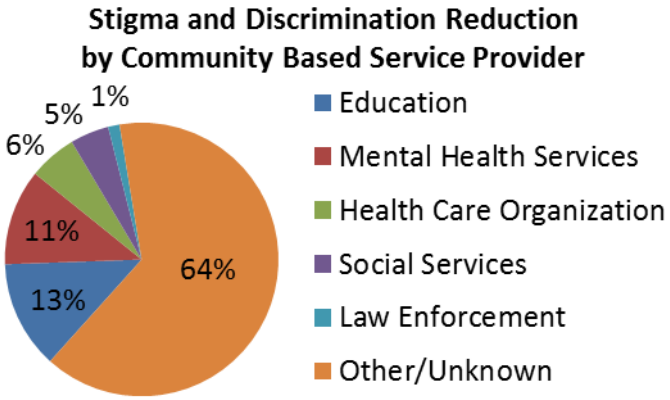


Another priority for representation in Stigma and Discrimination Reduction activities is regional. Half of residents live in the Arcata and Eureka regions close to Humboldt Bay while the other half lives in the southern and eastern regions of the County.

As this chart reflects, to date activities have been focused in the Arcata and Eureka regions of the County and there is a need to engage with and provide Stigma and Discrimination Reduction activities to residents in the southern and eastern regions of the County.



The Stigma and Discrimination Reduction Program continually strives to include representation from diverse Community based service providers. As this chart illustrates, individuals participated from education, mental health services, health care organization, social services, and law enforcement. In addition, 25 representatives from Family Resource Centers and 321 DHHS staff have participated. Individuals such as employers and faith based organizations were not significantly reached. The program will do targeted outreach to these representatives for future activities.



Trainings

Multiple training and presentation models have been used as a part of this Program. Training and presentation teams are multidisciplinary and include community members with lived experience, public health educators and Mental Health and Transition Age Youth Division peer support staff. They include the following:

Artistic solutions is locally developed and provides workshops for people with lived experiences to express themselves through artwork. It is guided art exercises that incorporate a variety of media including pastels, collage, quilting, sculpture and more. Art projects developed by consumers are shared at community events to raise awareness of mental health challenges and reduce stigma and discrimination.

Mental Health First Aid is an evidence-based 8-hour training that provides a general overview and basic skills to identify, understand, and respond to mental health and substance use issues. Mental Health First Aid provides information to identify symptoms, risk factors, and warning signs for depression, anxiety, and suicide. Participants gain a better understanding of psychotic disorders and substance abuse and learn

"Artistic Solutions opens doors that go beyond words and accesses deeper feelings. It explores ideas and feelings that are hard to talk about, like the issue of stigma and the root of stigma. Art can help a person find who they are and to feel strong and secure within themselves. When a person feels power from within and a sense of control over their life, they do not feel the need to have power over others. Art is powerful in the creation and in the viewing, offering community education opportunities, as well as opportunities for personal growth."

~ Stigma and Discrimination Reduction Program staff

how to implement the five step Mental Health First Aid action plan. Mental Health First Aid Training was launched in late 2014 and to date forty-five people have participated in trainings.

Wellness Works is a workplace mental health training program that seeks to increase capacity for employers to respond more appropriately when employees have mental health issues, reduce stigma and social prejudice towards people who have mental health challenges and mental illnesses, and promote mental wellness in the workplace. This training was provided to DHHS management.
Digital Storytelling is a short form of digital media that promotes the value of a story as a means for compassionate community action. Program staff completed train the trainer programs at the Center for Digital Story Telling and provide this training locally to people with lived experience in order to share their personal stories.

Peers Envisioning and Engaging in Recovery Services (PEERS) promotes empowerment, mental health and wellness, and social inclusion. PEERS fights against discrimination and stigma associated with mental illness by providing support and training that enhance the voices of speakers collectives.

In Our Own Voice is a public education program developed by the National Alliance on Mental Illness (NAMI), in which trained consumer speakers share compelling personal stories about living with mental illness and achieving recovery. Presentations change attitudes, assumptions and stereotypes by describing the reality of living with mental illness.

Peer and Consumer Voice
The Program provides various opportunities for those with lived experience to combat stigma and discrimination through art and personal stories.

The Program has coordinated an annual art contest called "Reframe Your Brain". This activity has successfully promoted creative expression of stigma-busting messages and issues related to mental health and wellness. Art submissions have included paintings, digital art creations, as well as poetry. Last year a compilation of visual art and poetry was used to create a calendar. These pieces have been displayed in art shows in local venues and have been produced on social marketing items such as posters, totes and t-shirts/hoodies.
The Program helped create and has supported the "Seeds of Understanding" speakers' collective. The Seeds of Understanding is a group of individuals with lived experience related to stigma and discrimination. Participants use storytelling to overcome their own self-stigma. They develop their stories and perspectives in order to share with community groups and service providers. The Speakers' Collective is moving towards more independence. Participants have written group

agreements and bylaws. They have elected a chair and co-chair. They have taken on the responsibility of scheduling and leading the meetings. The Program provides technical support such as assisting with agendas, coordinating speaking engagements, and providing educational materials and skill development trainings. Membership in the Seeds of Understanding speakers collective has increased to 9 active members who speak at program engagements and trainings monthly and 5 additional speakers who participate annually related to specific topics such as May Is Mental Health Month and Family Violence Awareness Month.

Raising Awareness

The program creates and/or promotes various social marketing campaigns utilizing materials produced as part of the Reframe Your Brain Art Contest as well as from the statewide Each Mind Matters campaign through messaging in local newspapers and on promotional items that are given out at community events such as t-shirts, sweatshirts, tote bags, etc. The Program also coordinated community dialogue events that paired speakers panels from the Seeds of Understanding with a viewing of the PBS documentary "A New State of Mind: Ending the Stigma of Mental Illness". The film campaign was shown in 9 communities in Humboldt including outlying areas such as Scotia and Willow Creek. The film was also aired 5 times followed by an interview with two of the speakers from the Seeds of Understanding on the local PBS station.

The Stigma and Discrimination Reduction Program contributes to May is Mental Health Month planning meetings with multi-disciplinary agency representatives and community groups to coordinate events, activities, and outreach. This committee planned and implemented a wide range of activities such as, movie screenings, presentations by the Seeds of Understanding members, a County Board of Supervisors Proclamation, and a walk that culminates in a rally with speakers. The Program engages in community outreach and has provided outreach, education and awareness information at local health fairs and community events. The program has increased its visibility and is highly valued by organizers of these events.

Program Goals for Training

Additional staff will be trained as trainers for Mental Health First Aid and programs that build leadership and amplify the voice of community members such as Photovoice and Digital Storytelling. The program will also work with community partners to build a network of trainers in programs such as Mental Health First Aid, Coming Out Proud, safeTalk in Spanish, QPR and Digital Storytelling. Continue and expand the diversity of training participants such as employers, landlords, elected officials, and school personnel with an emphasis on outlying areas. The Program will also coordinate culturally appropriate trainings for groups that work with diverse and underserved/un-served populations such as monolingual Spanish speakers, LGBTQ, TAY, and Native and Tribal communities.

Program Goals for Peer and Consumer Voice

The Program will continue to help recruit new members from underserved and unserved populations, provide technical assistance, provide skill building trainings for speakers, and collaborate with speakers to provide training opportunities. The Program will promote the Seeds of Understanding events through community outreach, education and advertising activities in local media.

Program Goals for Raising Awareness

Activities will include continuing the annual Reframe Your Brain Art Contest, promotion of and participation in existing anti-stigma campaigns such as Each Mind Matters, Know the Signs, and Directing Change, coordinating activities such as Photovoice and Brave Faces, and conducting Artistic Solutions groups. Continue to provide educational tables and provide awareness-raising materials at local events and health fairs. Support and participate in local and nationally recognized activities such as May is Mental Health Month, Recovery Month, Suicide Prevention Week and Wellness Week. And continue to provide resources

and materials to service providers, medical providers, and family resources centers. The Program will continue to collaborate with local community groups such as the Perinatal Mood and Anxiety Disorder Task Force, the Latino Community Providers' Network - LatinoNet, and Humboldt Allies for Substance Abuse Prevention (ASAP), and the Suicide Prevention Workgroup.

Adapted Transition Age Youth Peer Support

The MHSA Innovation Project, Adaptation to Peer Transition Age Youth (TAY) launched in earnest in July 2012. It was designed to include the vital engagement of TAY who have lived experience with mental illness and foster care. DHHS wanted to learn how to adapt the peer support utilized in adult mental health services, with an integrated DHHS TAY Division (launched in 2011) that consists of collocated DHHS services including, Behavioral Health, Independent Living Skills (ILS) and the Humboldt County Transition Age Youth Collaboration (HCTAYC).

The essential learning goal was to discover what adaptations were necessary, and if they would improve outcomes for TAY with a severe mental illness, who may be former foster youth and have in the last two years experienced at least one hospitalization and/or psychiatric emergency visit and/or placement at a restrictive level of care, including incarceration. In addition to traditional mental health services, the adapted TAY peer support staff have improved service delivery and increased the success of TAY clients in an integrated, holistic and culturally appropriate environment.

The TAY peer support staff utilizes training they receive including but not limited to:

- DHHS Child Welfare Services all staff Core Training
- Health Insurance Portability and Accountability Act (HIPAA)
- Microsoft Word, Excel, and Outlook
- Educational Advocacy
- Cardiopulmonary resuscitation (CPR)
- Suicide Prevention
- The Transition to Independence Process (TIP) Model is an evidence-supported practice based on published studies that demonstrate improvements in real-life outcomes for youth and young adults with emotional and/or behavioral difficulties (EBD). The TIP Model prepares youth and young adults with EBD for their movement into adult roles through an individualized process, engaging them in their own futures planning process, as well as providing developmentally-appropriate and appealing supports and services. It engages TAY in a process that facilitates their movement towards greater self-sufficiency and successful achievement of their goals. Young people are encouraged to explore their interests and futures as related to each of the transition domains: employment and career, education, living situation, personal effectiveness and wellbeing, and community-life functioning.
- Extended Foster Care Assembly Bill 12 (AB12). AB12, which took effect in 2012, and the subsequent AB212, implement provisions of the Federal Fostering Connections to Success and Increasing Adoptions Act of 2008 to improve outcomes for youth in foster care. A provision of the Federal Fostering Connections to Success law permits states to extend title IV-E assistance to eligible child welfare or

probation youth that remain in foster care up to age 21. AB12 guiding principles are permanency, helping youth transition to lifelong connections, creating a collaborative youth-centered process, working proactively with youth to develop and reach independent living goals, helping youth gain real life experiences with independence and allowing them to learn from their mistakes, and providing a safety net for the most vulnerable youth so they can achieve success living as independent adults.

- Y.O.U.T.H. Training Project (YTP) is a collaboration between current and former foster youth (ages 16-24), child welfare professionals, and youth-serving organizations. YTP empower transition age foster youth, who are experts in navigating the foster care system, to develop and deliver best-practice training for professionals who support transition-age youth.
- Youth In Mind (YIM) is founded and steered by youth affected by the mental health system. Members participate in multiple levels of leadership and advocacy, including member leadership summits, mental health conferences, and local advocacy activities with the purpose of promoting positive change through authentic youth engagement.
- California Youth Connection(CYC) provides the opportunity to gain facilitation skills and apply them by becoming facilitators at conferences, Day at the Capital and Summer Leadership and Policy Conference.
- California Mental Health Advocates for Children and Youth (CMHACY) annual conference where TAY peer support staff, clients and advisory board members both attend and present workshops.
- Beyond the Bench workshops and specialized trainings which are sponsored by the Judicial Council of California, Administrative Office of the Courts (AOC), Center for Families, Children & the Courts (CFCC) and supported by The California Endowment, and Casey Family Programs. Trainings include juvenile dependency, juvenile delinquency, AB12/AB212, family violence, mental health, collaborative justice, child welfare, legal aid and, collaborative court issues through a multidisciplinary approach.

The TAY peer support staff are members of or participate in a diversity of community wide committees including:

- Humboldt County Behavioral Health Board
- Educational Dream Luncheon – An annual retreat with the presidents and administration of both the local university and community college to work together in supporting TAY with foster youth experience and mental health issues to

HCTAYC workshop presented at CMHACY May 2014

Transforming Organizations: Empowering Organizations to Support Trans and Genderqueer Youth - The Humboldt County Transition Age Youth Collaboration (HCTAYC)

Join HCTAYC in an interactive workshop developed by queer youth leaders. We will prepare participants to create safe, inclusive spaces for TRANS and gender-nonconforming youth. Topics covered include: appropriate terminology, addressing TRANS erasure, and identifying, preventing, and intervening in stigma and discrimination. Participants will gain tools to assist TRANS youth to engage in safe and supportive mental health services. Humboldt County's youth system of care will share tips on supporting inclusivity and accessibility from a rural, integrated, mental health transition age youth program.

Presenters:

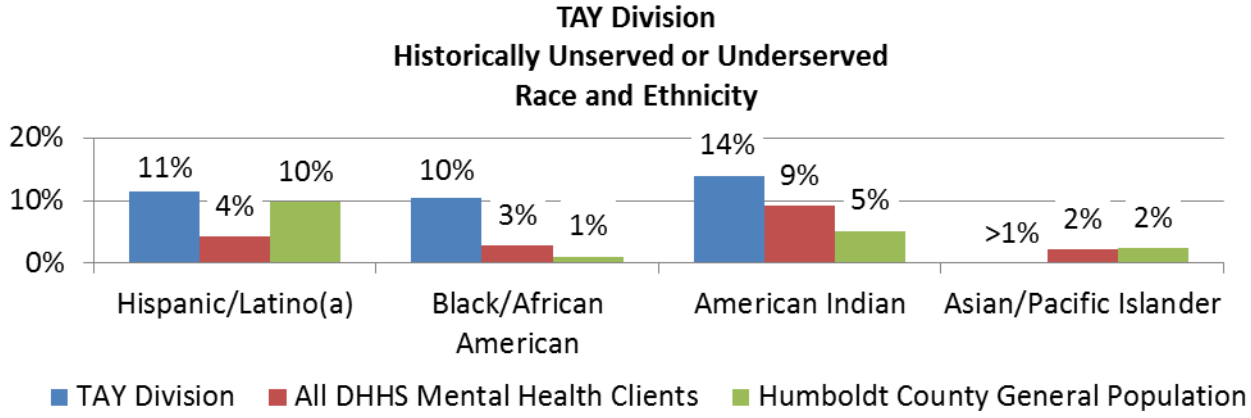
- Rochelle Trochtenberg, Youth Organizer, HCTAYC, member, CMHACY Board of Directors
- Qaiel Peltier; TAY Partner, TAY Division, Humboldt County
- Cole Vanwey, Jade Carlson, La'Vel Carter, Youth Advisory Board Members
- Julie Freitas, Clinical Supervisor, TAY Division, Humboldt County

reach their educational goals.

- Mobile Street Outreach Services
- Juvenile Justice Delinquency Prevention Committee
- Disproportionate Minority Stakeholder and Steering Committee – A Probation Department initiative to reduce disproportionate system impact on minority youth.
- Humboldt Housing and Homeless Coalition
- System of Care Central Team and Core Team
- Youth Transition and Action Team – A team composed of representatives from agencies that serve the TAY population across the county
- Bike Kitchen – A program that teaches youth bike repair skills, and in return you receive a bike
- MHSA planning groups
- Point in Time homeless count
- AB12 workgroup – Extended Foster Care for non-minor dependents
- California Partners for Permanency

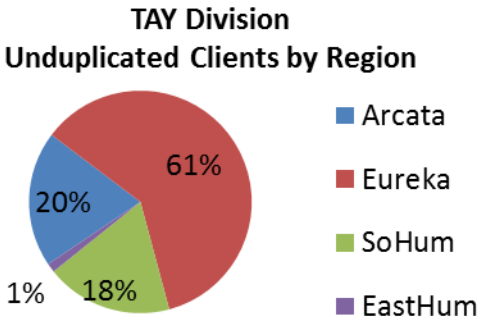
TAY Division Behavioral Health Clients

The TAY peer support staff use a progressive engagement approach which allows youth to take part in activities and services that meet them where they are in their own recovery process. While no youth is obligated, when appropriate, they are encouraged and supported to participate in DHHS Mental Health activities as well as other DHHS service initiatives through Social Services and Public Health. Since July 2012,



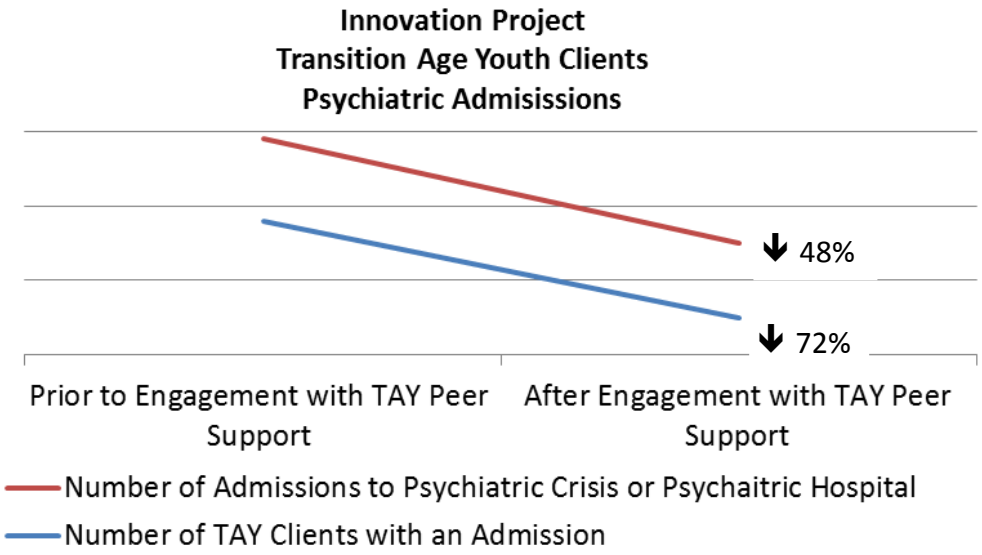
a total of 77 TAY Division clients have been engaged in TAY peer support mental health services.
TAY Division mental health clients reflect the racial and ethnic diversity of Humboldt County with an emphasis on those populations that are historically underserved. The percentage of clients who identify as Hispanic/Latino(a) is 11%, overall Mental Health client utilization is 4%, and 10% for the general population. The percentage of clients who identify as White/Caucasian is 61%, overall Mental Health client utilization is 78% and 77% for the general population. The percentage who identify as Black/African American is 10%, overall Mental Health client utilization is 3%, and 1% for the general population. The percentage who identify as American Indian is 14%, overall Mental Health client utilization is 9%, and 5% for the general population. There is disparity for clients who identify as Asian/Pacific Islanders at >1%, while overall Mental Health client utilization is 2%, and 2% for the general population.

Half of residents live in the Arcata and Eureka regions close to Humboldt Bay while the other half lives in the southern and eastern regions of the County.



Innovation Project Client Outcomes

Between July 2012 and July 2014, of the 77 TAY Division behavioral health clients, a sub-set of 18 were admitted to a psychiatric crisis unit or psychiatric hospital 29 times prior to their engagement with the TAY Division and TAY peer support. Once engaged with TAY peer support, often beginning at the crisis unit or hospital, five of those same clients were admitted a total of 15 times.



Peer Coaches

While this Innovation Project ended in June 2014, the expansion of TAY peer support positions will continue through MHSA PEI as newly reclassified "Peer Coach I/II/III". This Innovation project was not only successful in terms of improved outcomes for TAY clients; it also had an valuable impact at the County level. Peer support has proven to not only reduce the internalized stigma for clients; it has also had a de-stigmatizing effect for co-workers and community members.

With the passing of MHSA, DHHS has explicitly included elements of recovery, wellness, and resiliency-focused peer support. Peers have been an active part of service provision teams for adults and TAY in mobile outreach, inpatient services and outpatient programs. However, peer support staff did not have the recognition of their position reflected in their County job description as there was no "peer" job classification, so they were hired as Vocational Assistants or Mental Health Aides.

It was not until August 2014, after many years of extensive work, that the County adopted the three tier classification of Peer Coach I/II/III and Parent Partner I/II/III. For the first time at DHHS, these job descriptions explicitly recognize the value of lived experience in a service delivery team and provide a career ladder for Peer Coaches and Parent Partners. This work was guided and informed by the voice of people with lived experience as clients, family members and peer support providers. It reflects the value of lived experience in service delivery, as well as in developing training curriculum and policy recommendations.

TAY Advocacy and Peer Support

Humboldt County DHHS Transition Age Youth (TAY) Division serves youth and young adults, ages 16 to 26 years old. The TAY Division consists of collocated DHHS services including, Behavioral Health, Independent Living Skills (ILS) and the Humboldt County Transition Age Youth Collaboration (HCTAYC). In addition, the TAY Division utilizes supports and services from DHHS departments including; public health, employment training, CalFresh, Medi-cal, alcohol and other drug services, and collaborates with community partners such as juvenile probation and family resource centers.

TAY Division co-located services include but not limited to:

- A behavioral health team providing specialty mental health services (individual and family therapy, case management, and psychiatric services), including a supervisor, clinicians, and case managers
- A substance abuse counselor
- Child Welfare Services (CWS) Independent Living Services (ILS) program serving youth ages 16 to 21, including a supervisor, an ILS coordinator, and three social workers who carry Extended Foster Care caseloads
- HCTAYC, including a program manager, two youth organizers, and a Youth Advisory Board
- Four TAY Partner positions (Peer Coaches) who serve across the TAY Division
- A Vocational Counselor from the DHHS Employment Training Division who partners closely with TAY Division
- Public Health Nursing, that assists with health care needs a few times a month at the TAY Division

MHSA and TAY Division

The MHSA elements of the TAY Division are rooted in the 2004/2005 MHSA Stakeholder process where a significant need was identified; 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 - TAY Advocacy workplan 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.

TAY Advocacy, Education, Outreach and Peer Support, launched in 2008, is the MHSA Prevention and Early Intervention (PEI) component of the TAY Division which brings together youth, DHHS, Youth In Mind, California Youth Connection, and the Y.O.U.T.H. Training Project to improve the services youth receive as they transition into adulthood and become independent. The purpose is to improve 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, improve access and linkage to treatment. HCTAYC directly impacts the transition age youth system of care to be more responsive to young people's needs. It fosters youth development, youth advocacy, community engagement, and promotes youth wellness. HCTAYC provides youth voice that informs system policy, regulation, and practice at the local, state, national levels. HCTAYC provides training to youth, staff, and community partners related to more

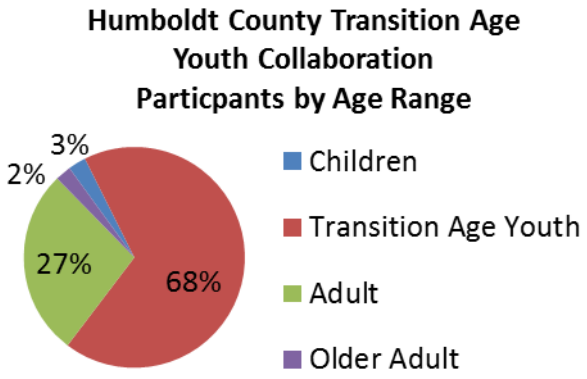
The TAY Division brings the once silo services "scattered across town" to one place, in a culturally appropriate environment for their age and a strict standard of youth driven focus.

~MHSA Community Stakeholder

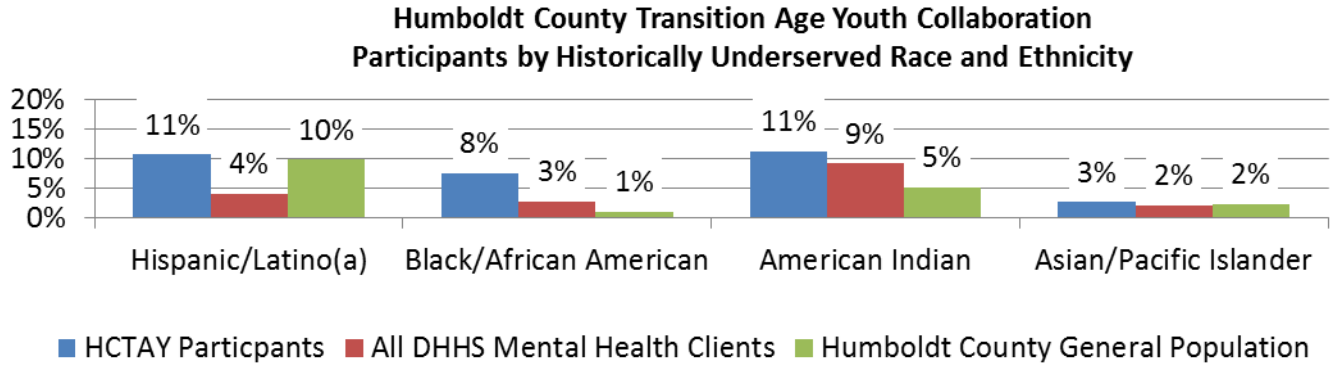
effectively engaging youth and developing youth informed approaches. HCTAYC is made up of a Youth Advisory Board that provides input and program development. The HCTAYC Youth Advisory Board is trained extensively in facilitation, public speaking, and leadership. HCTAYC's areas of focus for systems improvement include: mental health, homelessness, foster care, juvenile justice, alcohol and drug abuse, transitional housing, employment services, and any other services transition age youth use.

TAY Advocacy and Education Participants

From July 2009 through June 2014 the HCTAYC has facilitated or provided advocacy, education and outreach training to 756 individuals with an average of 151 individuals per year. Of those, 737 (95%) completed demographic forms.
As this chart illustrates, HCTAYC provides trainings to people of all ages with targeted focus on transition age youth. Between July 2009 and June 2014 the program's participants were 18 (3%) children, 468 (70%) transition age youth, 189 (28%) adults, and 16 (2%) older adults.

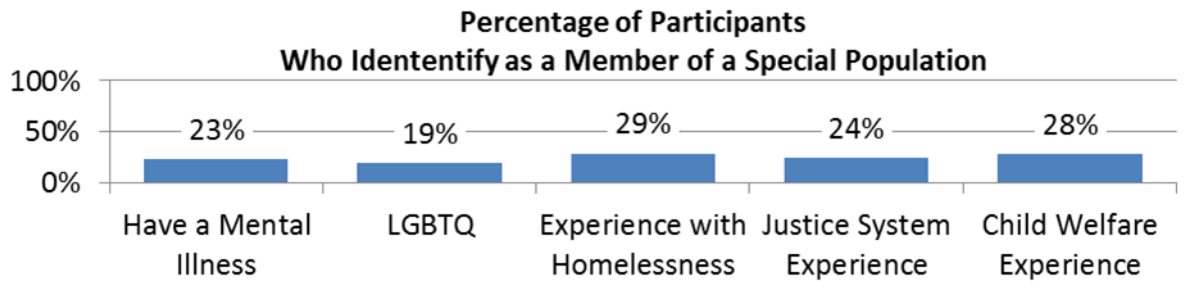


HCTAYC participants reflect the racial and ethnic diversity of Humboldt County with an emphasis on those populations that are historically underserved. The percentage of HCTAYC participants who identify as Hispanic/Latino(a) is 11%, overall Mental Health client utilization is 4%, and 10% for the general population. The percentage of HCTAYC participants who identify as White/Caucasian is 58%, overall Mental Health client utilization is 78%



and 77% for the general population. The percentage who identify as Black/African American is 8%, overall Mental Health client utilization is 3%, and 1% for the general population. The percentage who identify as American Indian is 11%, overall Mental Health client utilization is 9%, and 5% for the general population. HCTAYC participants who identify as Asian/Pacific Islanders is 3%, overall Mental Health client utilization is 2%, and 2% for the general population.

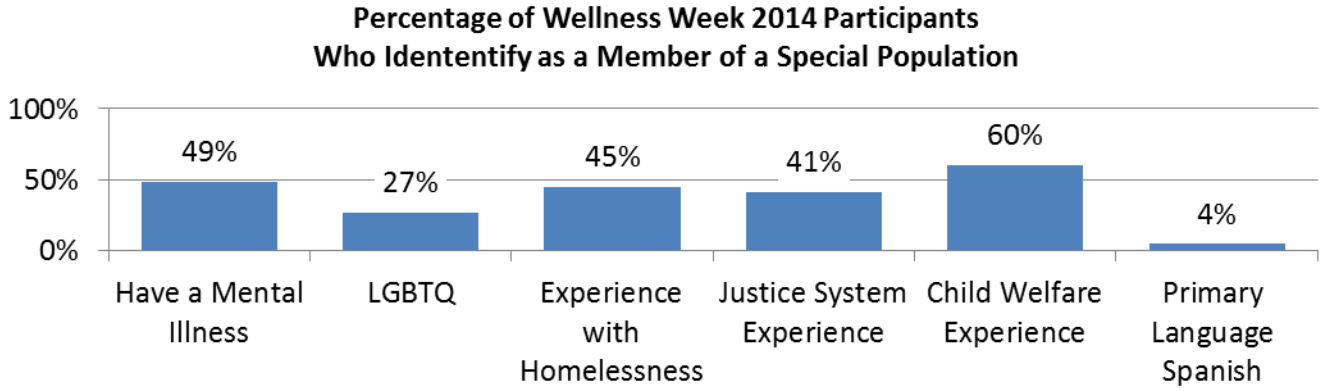
HCTAYC identified life experiences that highly correlate with poor outcomes for youth. Sexual orientation,



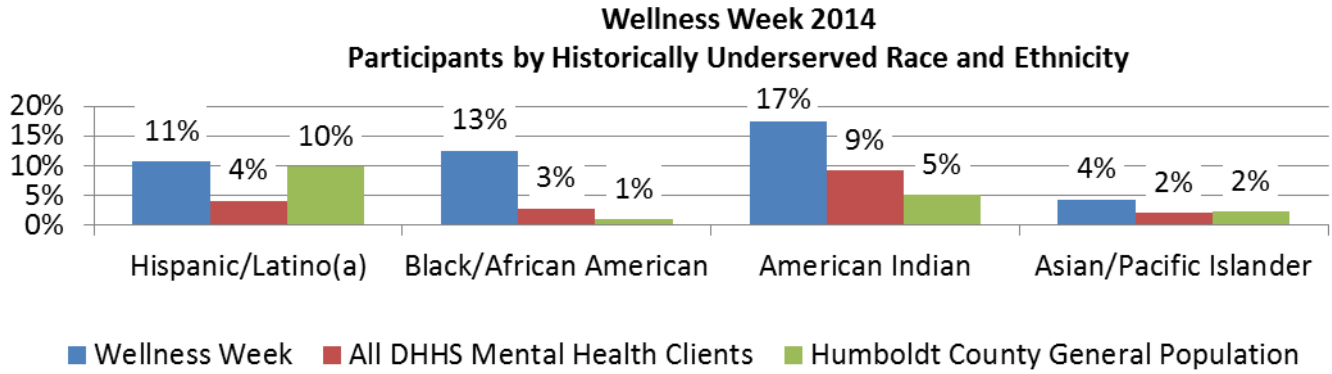
gender identity, homelessness, incarceration, former foster youth, are all life experiences that can result in challenges to successful mental health access and treatment. This chart illustrates how outreach efforts to include people with these unique life experiences is resulting in their participation in HCTAYC.
HCTAYC will continue to expand, and further their goals in order to meet the needs of youth and young adults in Humboldt County.

Wellness Week

HCTAYC planned organized and sponsored its second annual Wellness Week in September 2014 with over 206 participants. It is a five day event specifically for youth ages 16-26 with experience in homelessness, mental health, foster care or juvenile justice.



Activities are youth driven and encourage and empower participants to develop and maintain their wellness goals. Many Wellness Week participants are also members of historically unserved or underserved populations as the chart below illustrates.



"Wellness Week has helped me become a better person, made me more open minded, helped to involve me in my community, and grew my leadership skills in working with other community organizations!" -

~ Youth Advisory Board Member

Accomplishments and Awards

Below is a partial list of HCTAYs fiscal year 2013/2014 accomplishments:

- Domestic Violence/Healthy Relationships Training
- Public Speaking
- May is Mental Health Month Event-Digital Story Kickback
- California Mental Health Association for Children and Youth (CMHACY) Conference: TRANSforming Organizations Curriculum presentation
- Evidence-Based Practice (EBP) Symposium: first stakeholder participants in planning committee

- EBP Symposium: Engagement and Retention Panel Presentation, and TIP Model Presentation
- Presented Juvenile Justice Policy Recommendations to Juvenile Justice and Delinquency Prevention Commission

Below is a partial list of HCTAYs fiscal year 2013/2014 Youth Advisory Board many awards, recognitions, and accomplishments:

- Excellence in Community Communications and Outreach (ECCO) Silver Award- Audience Award: Children, Youth and Young Adults
- ECCO Bronze Award- Strategy Award: partnership development
- HCTAYC TAY Peer Coach recognized in 2014 as SAMHSA Honoree in Leadership for Peer Support during Children's Mental Health Awareness Day, and was part of panel presentation at National Council for Mental Health conference
- Youth Advisory Board Team Leader and Assistant Team Leader were voted onto Humboldt County's Behavioral Health Board in 2014
- Two Youth Advisory Board members received Community Leadership Awards from Humboldt County Behavioral Health Board in recognition of their role in coordinating Wellness Week, and for their excellence in bringing youth voice and expertise to local policy tables in 2014
- Youth Advisory Board Team Leader voted onto Humboldt's Juvenile Justice and Delinquency Prevention Commission in 2014
- HCTAYC lead youth organizer part of CMHACY Policy Panel in 2014 and continues on CMHACY Board

TAY Division and Peer Support Goals

The DHHS TAY Division was formally launched in 2011. It was envisioned with HCTAYC and staff from child and adult serving programs throughout DHHS. The environment at the TAY Division is youth-informed, meaning that youth have a strong influence in the way it is set up, including the physical area especially the common areas, and service delivery. TAY Division Goals include:

- **Transition to Independence Model (TIP)**

The TAY Division utilizes the TIP model. This gives staff and community partners a common language, approach, and tools to engage with youth. TIP was chosen through a youth-informed process in 2011, and training began in February of 2012. Expansion and training will continue to further integrate the TIP model.

- **Youth Leadership and Advocacy**

The TAY Division will continue to facilitate access for youth to participate in mental health policy and program improvement initiatives locally and statewide as equal partners at decision-making tables; Facilitate youth's participation in statewide and national conferences and trainings

such as youth advocacy, policy, outreach, and leadership. Increase the number and diversity of engaged youth, including specific outreach to outlying and remote areas of the County and to Tribal youth; Expand HCTAYC Wellness Week event and related outreach to include more youth from across the county, such as holding workshops in outlying areas of the county; and Expand Digital storytelling, recruitment, preparation, and selection process. Continuation and expansion of TAY-specific stigma reduction campaigns and events as related to mental illness are also planned.

- **Peer Coaches and Parent Partners**

Expansion of TAY peer support, recently reclassified as Peer Coaches I/II/III, will continue as the TAY Division engages additional unserved or underserved youth in Full Service Partnerships. In addition, DHHS will increase the use of effective Parent Partner peer support throughout the child-serving system to promote individual-level engagement and involvement in behavioral health and wellness services and activities. To increase family involvement at the service level, Family Partner positions will be guiding the policy-level Family Voice collaborative currently in development. In this capacity, Family Partners will participate in Wraparound teams and in similar ways that TAY Peer Coaches currently participate in services, family and team meetings, staff training, and outreach and engagement activity.

- **Full Service Partnership**

Full Service Partnerships provide intensive community services and supports, such as peer support, housing, medical, educational, social, vocational, rehabilitative, or other needed community services, as defined by the client, or "Partner", to achieve recovery. While there are TAY Full Services Partners, there is an identified need to both engage more youth with a severe mental illness as Partners and continue to increase the cultural appropriateness of services for the TAY population. The TAY division will focus on youth that have not responded or engaged with traditional mental health services. Many of these youth have experienced adverse childhood experiences and multigenerational risk factors such as, domestic violence, substance abuse, trauma, homelessness and underreported sexual abuse. Key risk factors include homelessness, co-occurring substance abuse, exposure to trauma, repeated school failure, multiple foster care placements, and experiences in the juvenile justice system. The goals of FSP is to support youth and young adults with severe mental illnesses live successfully in the community, prevent out of home care, reduce homelessness, reduce hospitalization.

DHHS employee honored at national behavioral health conference

A peer support specialist with DHHS' Transition Age Youth Division was honored May 6 in Washington, D.C., by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Qaiel Peltier, 23, was recognized by SAMHSA for working to help Humboldt County youth overcome challenges in their lives as they enter adulthood. Qaiel was invited to speak during SAMHSA's National Children's Mental Health Awareness Day kickoff event, which was part of this year's National Council for Behavioral Health Conference.

Qaiel and three other youth from across the nation shared the SAMHSA stage with former U.S. Department of Health and Human Services Secretary Kathleen Sebelius, SAMHSA Administrator Pamela Hyde and New York City Mayor Bill de Blasio, whose daughter, Chiara de Blasio, served as the 2014 honorary chairperson of National Children's Mental Health Awareness Day.

At the conference, Qaiel also co-facilitated a workshop titled "What Really Works for Young Adults," which delved into the unique needs of young adults with mental health or co-occurring conditions and the value of peer support in addressing those needs.

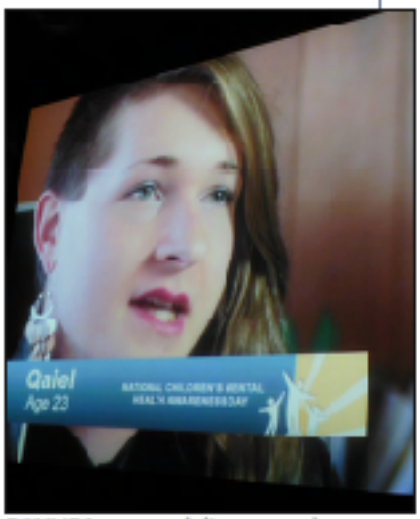
"As California comes to a critical crossroads in terms of implementation of its health and behavioral health systems, the voices of the children, youth and families we serve in shaping the programs the state delivers are essential if government is to have a positive impact," said DHHS Director Phillip R. Crandall. "The phrase 'nothing about us without us' underscores the key role youth and families should play in shaping services and supports toward a future where they can thrive, not just survive."

Qaiel's speech focused on the importance of improving behavioral health services in schools to meet all young people's needs, including gender and sexual minority students. Qaiel also encouraged schools to use positive climate models that focus on policy and training in addressing issues like bullying and discrimination and urged leaders across the nation to include "an authentic youth voice" in decisions that involve services youth receive.

"Young people need to be valued as experts in our own lives and to be given a say in voice and control over the services we receive … and our path to wellness," Qaiel said in an interview.

Growing up, Qaiel experienced significant bullying and discrimination related to sexual orientation and gender expression. This led to depression, eating disorders and other mental health challenges. Finding little help in high school or through traditional mental health services, Qaiel ultimately found support through

DHHS Peer Support Specialist Qaiel Peltier gives a speech during the Substance Abuse and Mental Health Services Administration's National Children's Mental Health Awareness Day launch event on May 6 in Washington, D.C.



SAMHSA representatives came to Humboldt County in April to make a short film about Qaiel, which was shown at the National Children's Mental Health Awareness Day event.

the Humboldt County Transition Age Youth Collaboration (HCTAYC). HCTAYC is a component of DHHS' Transition Age Youth (TAY) Division. The TAY Division, which serves young adults ages 16 to 26, has three main units: TAY Behavioral Health, the Independent Living Skills program and HCTAYC.

"When I got involved with HCTAYC, I was going through a pretty dark time," Qaiel said. "I was pretty hopeless. I needed an outlet. HCTAYC and the TAY Division were that outlet … I don't know where I'd be right now if I hadn't had this to pour my energy into."

Qaiel soon became a member of HCTAYC's Youth Advisory Board. While serving on the advisory board, Qaiel worked with a team of peers to create a curriculum on engaging and supporting transgender and gender-nonconforming youth in mental health services. This curriculum has gone on to be presented by Qaiel and others at state and national conferences. Qaiel also helped create DHHS' Transition Age Youth Behavioral Health Unit, which provides specialty mental health services for young people that focus on gaining employment, housing, education and personal well-being.

"Humboldt County DHHS continues to provide leadership at the state and national levels in the implementation of youth developed and driven services," Crandall said.

Two years ago, Qaiel started working as a peer support specialist for DHHS' TAY Division. As part of the job, Qaiel assists young people who are in crisis, with the goal of engaging them in seeking services and supports at the TAY Division and continues to contribute to workgroups that inform services for young people.

"We use our experiences to help other people," said Qaiel in an interview. "We have a different understanding of what it's like to struggle with your own wellness."

HCTAYC youth organizer Rochelle Trochtenberg nominated Qaiel for the SAMHSA recognition. In her nomination letter she wrote, "Qaiel is open to learning about different perspectives and is constantly striving for professional growth and improvement."

One of Qaiel's interests is the topic of preferred-gender pronouns (PGP) that are inclusive and welcoming for transgender and gender-nonconforming people. Ze (a gender-neutral pronoun that replaces he or she) encourages people to use gender-neutral pronouns when talking to or about hir (a gender-neutral pronoun that replaces him or her) or others who prefer the use of PGPs.

With all of hir talents and skills, who knows what ze will do next?

For more information about the TAY Division, call 476-4944. For more information about HCTAYC, call 476-4922 or visit www.humboldtyouth.org.

Qaiel, second from left, is pictured with former U.S. Department of Health and Human Services Secretary Kathleen Sebelius, center, at the SAMHSA's National Children's Mental Health Awareness Day launch event. Also pictured are other youth from across the nation who were also honored. They are, from left, Sean Campbell, Michelle Vance and Jim Saintgermain.

School Climate Models

Background

Increasing the recognition of early signs of emotional disturbance or mental illness for children in a school setting was an identified need of the CPP, which led to DHHS and County Superintendents development of a shared plan to address this need. This School Climate Curriculum Plan will engage and train school personnel ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness or serious emotional disturbance. Following the identification of this need, a stakeholder process occurred that included surveying school superintendents, administrators, teachers, counselors and gathering information through various community stakeholder groups and from DHHS staff.

Challenges

Through this stakeholder process, several challenges for a collaborative response to behavioral health interventions at school sites were identified:

- DHHS and schools are governed by different rules and regulations and work under varied state and federal initiatives meant to address behavioral issues in students. The application of these rules and regulations make it difficult to coordinate services and to ensure their effectiveness.
- AB114 and Local Control Funding Formula are recent statewide policy changes that have impacted the funding mechanisms and organizational responsibility of providing services within the educational system.
- There are 31 separate school districts in the County serving over 18,000 children in 91 schools all with varying levels of support, need, and positive behavior intervention curriculum implementation.

Program Description

With the needs and challenges in mind, several evidence based practice (EBP) curriculums have been identified:

- Positive Behavioral Intervention Supports (PBIS) is a framework or approach for assisting school personnel in adopting and organizing evidence-based behavioral interventions into an integrated continuum that enhances academic and social behavior outcomes for all students. PBIS is not a packaged curriculum, scripted intervention, or manualized strategy.
  PBIS is a prevention-oriented way for school personnel to (a) organize evidence-based practices, (b) improve their implementation of those practices, and (c) maximize academic and social behavior outcomes for students. PBIS supports the success of all students[1].
- Second Step students learn self-regulation and executive-function skills that help them pay attention, remember directions, control their behavior, and develop social-emotional skills including making friends, managing emotions, and solving problems. Students also learn skills such as how to navigate adolescence with communication, coping, and decision-making skills that help them make good choices and avoid pitfalls, such as peer pressure, substance abuse, and bullying[2].
- Restorative Justice in schools is a philosophy, set of principles and practices that help adults and young people in schools to both understand and respond to conflict. Restorative practices have successfully strengthened communities in schools, taught adults and students to take responsibility, changed classroom dynamics and improved school safety[3].

[1] https://www.pbis.org/school/swpbis-for-beginners/pbis-faqs
[2] http://www.cfchildren.org/second-step
[3] http://www.rjtica.org/

These three models are being considered due to their proven effectiveness in the school environment. Additionally there is already support and acceptance based on the limited exposure and use at schools throughout the County. The intent of the Program is to initiate, expand and sustain these practices. Initially, a few school campuses will be identified, each to implement curriculums. The training and implementation will be tailored to the need. Each campus will receive training and implementation support from certified trainers. Each campus will then have a consultant identified who will be available over the course of the school year to provide on-going implementation coaching and technical assistance as needed. At the end of the first year of this Program, DHHS and education will make recommendations for the continuation of the collaboration and coordination of services for children and families. DHHS and education commit to continue to cultivate strong working relationships and to jointly offer a continuum of care for the children and families served within both systems.

Outcomes

Early awareness of mental illness indicators also address emotional wellness through a three-tiered system of prevention and support. This approach addresses a spectrum of behavioral health needs of all students, including through acknowledging typical behaviors based on the development of children, providing more specialized attention to those who exhibit particular behaviors and finally by focusing on addressing the needs of students who are most challenging. Data collection mechanisms will be developed with the support of the trainers and consultants.

Positive Behavioral Interventions and Support (PBIS) has been shown to achieve the following outcomes:

- Better classroom management practices with less discipline issues and more instructional minutes
- Maximized academic engagement and achievement for all students
- Less reactive, aversive, dangerous and exclusionary practices
- More engaging, responsive, preventive and productive environments
- A continuum of services available for students learning and emotional needs
- Improved interagency, community, parental and school interdependence

Additional outcomes related to PBIS and Second Step and Restorative Justice include:

- Increased understanding by students, of school-wide behavioral expectations
- Decreased number of office referrals
- Decreased number of suspensions
- Decreased impulsive and aggressive behavior
- Increased social competence
- Steps are taken to repair harm
- Victims and offenders are restored to contributing members of society

Leveraging Resources

The MHSA PEI component of this Program includes initial training, curriculum, and consultants for coaching and support. Through a Children's System of Care grant, a mental health consultant will assist education and DHHS in creating a process for triaging children in need of services. This consultant will help increase understanding of regulations informing each system, so that appropriate decisions can be made not only about a child's behavioral health needs, but also regarding the system best equipped and responsible to meet those needs. Additional and on-going resources will be leveraged as a part of this program including the Children's System of Care grant and school counseling initiatives such as AB 114 and the Local Control Funding Formula. Schools will also contribute resources by releasing staff for training, supporting implementation efforts, and making system modifications as recommended by the model.

Workforce Education and Training

Workforce Education and Training (WET) provides 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 mental health system. Examples include:

- Milestones of Recovery Scale (MORS) which is an effective evaluation tool for tracking the process of recovery for individuals with a mental illness. It provides easy to use data that allows staff, supervisors and administrators to see how individual programs and agencies are performing. It focuses on the here and now, providing a snapshot of an individual's progress toward recovery. It can help staff tailor services to fit each individual's needs, assign individuals to the right level of care and create "flow" through a mental health system. It quantifies the stages of an individual's recovery using milestones that range from extreme risk to advanced recovery and everywhere in between. It is rooted in the principles of psychiatric rehabilitation and defines recovery as a process beyond symptom reduction, client compliance and service utilization. It operates from a perspective that meaningful roles and relationships are the driving forces behind achieving recovery and leading a fuller life.

- The Transition to Independence Process (TIP) Model is an evidence-supported practice based on published studies that demonstrate improvements in real-life outcomes for youth and young adults with emotional and/or behavioral difficulties (EBD). The TIP Model prepares youth and young adults with EBD for their movement into adult roles through an individualized process, engaging them in their own futures planning process, as well as providing developmentally-appropriate and appealing supports and services. It engages TAY in a process that facilitates their movement towards greater self-sufficiency and successful achievement of their goals. Young people are encouraged to explore their interests and futures as related to each of the transition domains: employment and career, education, living situation, personal effectiveness and wellbeing, and community-life functioning.

- Parent-Child Interaction Therapy (PCIT) is an empirically-supported treatment for young children with emotional and behavioral disorders that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns.

- The Integrated Dual Disorder Treatment (IDDT) model is an evidence-based practice that improves the quality of life for people with co-occurring severe mental illness and substance use disorders by combining substance abuse services with mental health services. It helps people address both disorders at the same time—in the same service organization by the same team of treatment providers. IDDT emphasizes that individuals achieve big changes like sobriety, symptom management, and an increase in independent living via a series of small, overlapping, incremental changes that occur over time. Therefore, IDDT takes a stages-of-change approach to treatment, which is individualized to address the unique circumstances of each person's life. IDDT is multidisciplinary and combines pharmacological (medication), psychological, educational, and social interventions to address the needs of consumers and their family members. IDDT also promotes consumer and family involvement in service delivery, stable housing as a necessary condition for recovery, and employment as an expectation for many.

- Peer support staff and volunteers attend workshops, conferences and visit out of county wellness centers.

MyAvatar - one-month checkup

by **Amy Cone**, Interim Deputy Director Mental Health

What began in December 2008 is now a reality. DHHS Mental Health undertook a transformative system change that has now been implemented. April 1, 2014, was day one of the new Electronic Health Record (EHR) for DHHS Mental Health. Many congratulations and kudos to staff that made the changeover from all paper charts to a new electronic format. Change is not easy, but it was clear that staff took the challenge and jumped into a new world. The transition was not without challenges, but instead of being mired down by such challenges many staff members became warriors for the cause.

This project is underway, but far from over as new health care standards are set and new requirements are rolled out. When fully functional and exchangeable, the benefits of EHRs offer far more than a paper record can. EHRs

- Improve quality and convenience of patient care
- Increase patient participation in his or her care
- Improve accuracy of diagnoses and health outcomes
- Improve care coordination
- Increase practice efficiencies and cost savings.

The EHR for DHHS Mental Health is called MyAvatar. It is a key ingredient for success under health care reform, with the ability to utilize health information technology to manage the care of patients across the continuum of care and produce actionable data to help improve outcomes and reduce costs.

It has been more than a month since the system was implemented and the MyAvatar support team continues to field questions, conduct maintenance, provide training and offer support as MyAvatar users need it. This core team has been a significant presence in this transition. Increased knowledge of the system by staff members will allow the support team to be utilized less over time. During Go-Live, MyAvatar super-users kept in close communication with the MyAvatar support team to report their unit's needs and concerns. They were pro-active in seeking solutions when problems arose and shared resolutions with their co-workers. For example, staff feedback prompted the rapid creation of the "Chart View" screen by DHHS Information Services as a way of reading or printing any of a client's chart entries from a single screen.

We are already seeing the amount of paper diminishing. Jeanne Albertson, Medical Records manager, reports a significant reduction in the amount of paper being sent to Medical Records for scanning. While there isn't a firm number yet because of the early date, she believes it has decreased by approximately 75 percent.

Val Saunders, supervising mental health clinician said, "As a supervisor, Avatar makes it much easier to see what's going on with our clients, and my staff like it, too."

There is still much to do as we look at implementing the scanning component of MyAvatar, which is called "Perceptive." The project planning for Perceptive began May 1, 2014, and deals with how scanning files into MyAvatar will occur. Later this summer, we will begin the project of including the "Order/Entry" module so that processes within the Psychiatric Health Facility are made even more efficient.

DHHS Newsletter Article June 2014

upcoming ICD changes

by Chloe Secor
Medical Records Manager

Change is coming. The International Classifications of Diseases version 10 (ICD-10) will take effect Oct. 1, 2015. The World Health Organization is behind this change, and is urging the world's health care community to use a common language to describe, categorize and evaluate the effectiveness of health care delivery across the globe. The U.S. lags behind others in implementation to move forward with version 10 of the ICD classification system, in part because it uses the system for payment where the rest of the world does not. One may ask how this impacts DHHS-Mental Health, and the answer is that the change will affect the way service delivery is documented, to how data is gathered and reported, to Information Services' resources and architecture, to processes, policies and procedures and to financial reporting and budgetary needs.

An additional change that comes with ICD-10 will be the change to the clinical and diagnostic nomenclature that is known as Diagnostic and Statistical Manual (DSM) from version 4 to 5. The DSM-4 crosswalks very nicely to the ICD-9, but the same is not true for ICD-10 to the DSM-5, which are not easily cross referenced. This particular change will propose a unique challenge for the technical, clinical documentation and billing worlds. For this implementation we will once again be partnering with our MyAvatar vendor, Netsmart, to utilize a dual coding solution that will assist and support these two complex languages being used diagnostically, statistically and fiscally. This dual coding function will also assist us in having the ability to crosswalk ICD-9 to ICD-10 codes and will support us in a "soft, go live" preparation for the Oct. 1 cutover date. This "soft, go live" is highly recommended to aid in a smooth transition and to prevent any delays in claiming.

Over the next six months, we will prepare for this transition by conducting a readiness assessment and a gap analysis. This will assist in formulating a training plan for the clinical care and business teams to assure that they are fully trained, and ready to address the impending changes. The changes include clinical documentation training to assure that staff learns the new DSM and ICD-10 codes, evaluation of our electronic health record and paper forms to assure that we make the necessary changes to capture DSM and ICD codes accurately and are able to review reports that will be affected by these changes. Once the appropriate changes are identified, we will begin testing these processes to assure that both technical changes and business process function appropriately, and to allow for an uninterrupted revenue cycle. The work being done internally and externally now will assure that our claiming process will be functioning properly come Oct. 1.

In short, the ICD-10 changes are about capturing the specificity and granularity in clinical documentation to capture the risk and severity of illness in our patients, and finally to be reimbursed for the quality health services that are rendered at Humboldt County Mental Health.

DHHS Newsletter Article March 2015

program highlight
permanent supportive housing in Arcata

by Jaclyn Culleton, Program Manager

This past January, construction began on the Arcata Bay Crossing housing project. When completed, it will have a total of 32 units, 15 of which will be reserved for mental health clients who have a diagnosis of severe mental illness and are homeless or at risk of homelessness. Twenty-five of the units will be single room occupancy and six will be double occupancy. A property manager will live on-site in another unit. There will be a laundry room, a community room, a kitchen and a meeting room.

> At its root, homelessness is the result of the inability to afford and maintain housing. Remember that any plan to end homelessness must incorporate an investment in creating affordable housing. This includes supportive housing, which is permanent housing coupled with supportive services.
> -endhomelessness.org/pages/ten-essentials

What is so unique and exciting about this new community-based housing opportunity is that it will be permanent supportive housing. What is permanent supportive housing?

"Permanent" means that residents have the same rights and privileges of tenancy that any other person would have when renting an apartment. Each resident controls access to his or her own unit. Tenants can keep their housing as long as they pay the rent and do not violate the terms of their lease agreement. Tenants cannot be compelled or required to participate in any type of program or services as a condition of their lease agreement. The terms of the lease agreement (e.g. about pets, visitors or use of shared facilities) are the same for all residents with or without a mental health diagnosis or disability.

"Supportive" means that they will continue to receive a range of recovery-oriented services from DHHS Mental Health, including mental health, substance abuse, case management and other assistance designed to help them keep their stable housing. The Mental Health Services Act units at Arcata Bay Crossing will also be affordable. Tenants will pay no more than 30 percent of their income for rent.

Left to right: Arcata House Executive Director Karen "Fox" Olson, DHHS Assistant Director, Programs Barbara LaHaie and Mental Health Director Asha George survey construction progress

The ceremonial groundbreaking took place Feb. 12. The Arcata Bay Crossing housing project is expected to be ready for occupancy by summer 2015.

Placeholder until after Board of Supervisor adoption

MHSA COUNTY COMPLIANCE CERTIFICATION

County/City: Humboldt

☒ Three-Year Program and Expenditure Plan
☐ Annual Update

Local Mental Health Director	Program Lead
Name: Asha George, PhD	Name: Jaclyn Culleton
Telephone Number: 707 268-2990	Telephone Number: 707 268-2932
E-mail: asgeorge@co.humboldt.ca.us	E-mail: jculleton@co.humboldt.ca.us
Local Mental Health Mailing Address:	Humboldt County DHHS-Mental Health 720 Wood Street Eureka, Ca 95501

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

This Three-Year Program and Expenditure Plan or Annual Update 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 Program and Expenditure Plan or Annual Update 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 annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on _____.

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 annual update are true and correct.

Asha George, PhD
Local Mental Health Director (PRINT)

_____
Signature Date

County Certification County Certification County Certification

Placeholder until after Board of Supervisor adoption

Fiscal Accountability Certificate

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: Humboldt

☒ Three-Year Program and Expenditure Plan
☐ Annual Update
☐ Annual Revenue and Expenditure Report

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Asha George, PhD	Name: Joseph Mellett
Telephone Number: 707 268-2990	Telephone Number: 707 476-2452
E-mail: asgeorge@co.humboldt.ca.us	E-mail: jmellett@co.humboldt.ca.us
Local Mental Health Mailing Address: Humboldt County DHHS - Mental Health 720 Wood Street Eureka, Ca 95501	

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

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

Asha George, PhD _____ _____
Local Mental Health Director (PRINT) Signature Date

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

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

Joseph Mellett, CPA _____
County Auditor Controller / City Financial Officer (PRINT) Signature Date

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

Fiscal Accountability Certificate

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Funding Summary

County: HUMBOLDT

Date: 4/30/2015

DRAFT

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2014/15 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	0	1,405,587	972,954	285,188	28,624	
2. Estimated New FY2014/15 Funding	3,433,855	915,695	228,924			
3. Transfer in FY2014/15[a/]	0					
4. Access Local Prudent Reserve in FY2014/15						0
5. Estimated Available Funding for FY2014/15	3,433,855	2,321,282	1,201,878	285,188	28,624	
B. Estimated FY2014/15 MHSA Expenditures	3,344,000	1,183,216	66,660	119,188	28,624	
C. Estimated FY2015/16 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	89,855	1,138,066	1,135,218	166,000	0	
2. Estimated New FY2015/16 Funding	3,433,855	915,695	228,924			
3. Transfer in FY2015/16[a/]	(296,875)				296,875	
4. Access Local Prudent Reserve in FY2015/16						0
5. Estimated Available Funding for FY2015/16	3,226,835	2,053,761	1,364,142	166,000	296,875	
D. Estimated FY2015/16 Expenditures	3,187,660	1,569,065	555,013	116,000	296,875	
E. Estimated FY2016/17 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	39,175	484,696	809,129	50,000	0	
2. Estimated New FY2016/17 Funding	3,605,547	961,479	240,370			
3. Transfer in FY2016/17[a/]	(150,000)				150,000	
4. Access Local Prudent Reserve in FY2016/17						0
5. Estimated Available Funding for FY2016/17	3,494,722	1,446,175	1,049,499	50,000	150,000	
F. Estimated FY2016/17 Expenditures	2,902,600	1,443,925	487,460	50,000	150,000	
G. Estimated FY2016/17 Unspent Fund Balance	592,122	2,250	562,039	0	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2014	1,152,061
2. Contributions to the Local Prudent Reserve in FY 2014/15	0
3. Distributions from the Local Prudent Reserve in FY 2014/15	0
4. Estimated Local Prudent Reserve Balance on June 30, 2015	1,152,061
5. Contributions to the Local Prudent Reserve in FY 2015/16	0
6. Distributions from the Local Prudent Reserve in FY 2015/16	0
7. Estimated Local Prudent Reserve Balance on June 30, 2016	1,152,061
8. Contributions to the Local Prudent Reserve in FY 2016/17	0
9. Distributions from the Local Prudent Reserve in FY 2016/17	0
10. Estimated Local Prudent Reserve Balance on June 30, 2017	1,152,061

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 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: HUMBOLDT

Date: 4/30/15

DRAFT

	Fiscal Year 2014/15					
	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. Full Service Partnership	3,891,187	2,830,000	1,061,187			
Non-FSP Programs						
1. Rural Outreach Service Enterprise	793,908	187,000	413,680		24,215	169,013
2. MHSA Telemedicine	157,227	87,000	70,227			
3. Older and Dependent Adult Expansion	70,494	70,000	494			
CSS Administration	170,000	170,000				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	5,082,816	3,344,000	1,545,588	0	24,215	169,013
FSP Programs as Percent of Total	76.6%					

	Fiscal Year 2015/16					
	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. Full Service Partnership	3,889,466	2,722,160	1,167,306			
Non-FSP Programs						
1. Rural Outreach Service Enterprise	807,598	140,000	455,047		26,637	185,914
2. MHSA Telemedicine	160,750	83,500	77,250			
3. Older and Dependent Adult Expansion	70,543	70,000	543			
CSS Administration	172,000	172,000				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	5,100,357	3,187,660	1,700,146	0	26,637	185,914
FSP Programs as Percent of Total	76.3%					

	Fiscal Year 2016/17					
	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. Full Service Partnership	3,675,671	2,450,000	1,225,671			
Non-FSP Programs						
1. Rural Outreach Service Enterprise	823,579	122,600	477,800		27,969	195,210
2. MHSA Telemedicine	164,112	83,000	81,112			
3. Older and Dependent Adult Expansion	72,570	72,000	570			
CSS Administration	175,000	175,000				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	4,910,932	2,902,600	1,785,153	0	27,969	195,210
FSP Programs as Percent of Total	74.8%					

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: HUMBOLDT Date: 4/30/15

DRAFT

	Fiscal Year 2014/15					
	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. Suicide Prevention	235,600	235,600				
2. Stigma & Discrimination Reduction	153,600	153,600				
3. Hope Center	242,000	242,000				
4. School Climate Models	0	0				
5. TAY Advocacy and Peer Support	434,600	434,600				
PEI Programs - Early Intervention						
PEI Administration	117,416	117,416				
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	1,183,216	1,183,216	0	0	0	0

	Fiscal Year 2015/16					
	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. Suicide Prevention	258,600	258,600				
2. Stigma & Discrimination Reduction	155,600	155,600				
3. Hope Center	249,140	249,140				
4. School Climate Models	115,000	115,000				
5. TAY Advocacy and Peer Support	670,960	670,960				
PEI Programs - Early Intervention						
PEI Administration	119,765	119,765				
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	1,569,065	1,569,065	0	0	0	0

	Fiscal Year 2016/17					
	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. Suicide Prevention	245,800	245,800				
2. Stigma & Discrimination Reduction	160,600	160,600				
3. Hope Center	254,000	254,000				
4. School Climate Models	57,500	57,500				
5. TAY Advocacy and Peer Support	603,865	603,865				
PEI Programs - Early Intervention						
PEI Administration	122,160	122,160				
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	1,443,925	1,443,925	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: HUMBOLDT

Date: 4/30/15

DRAFT

	Fiscal Year 2014/15					
	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. Rapid Re-Housing	65,353	65,353				
INN Administration	5,000	1,307				
Total INN Program Estimated Expenditures	70,353	66,660	0	0	0	0

	Fiscal Year 2015/16					
	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. Rapid Re-Housing	984,026	544,130	282,096			157,800
INN Administration	41,626	10,883				
Total INN Program Estimated Expenditures	1,025,652	555,013	282,096	0	0	157,800

	Fiscal Year 2016/17					
	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. Rapid Re-Housing	1,005,950	477,902	370,248			157,800
INN Administration	36,560	9,558				
Total INN Program Estimated Expenditures	1,042,510	487,460	370,248	0	0	157,800

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: HUMBOLDT

Date: 4/30/15

DRAFT

	Fiscal Year 2014/15					
	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	119,188	119,188				
WET Administration	0					
Total WET Program Estimated Expenditures	119,188	119,188	0	0	0	0

	Fiscal Year 2015/16					
	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	116,000	116,000				
WET Administration	0					
Total WET Program Estimated Expenditures	116,000	116,000	0	0	0	0

	Fiscal Year 2016/17					
	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	50,000	50,000				
WET Administration	0					
Total WET Program Estimated Expenditures	50,000	50,000	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: HUMBOLDT

Date: 4/30/15

DRAFT

	Fiscal Year 2014/15					
	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						
CFTN Programs - Technological Needs Projects						
11. Integrated Clinical and Administrative Information System	28,624	28,624				
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	28,624	28,624	0	0	0	0

	Fiscal Year 2015/16					
	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						
CFTN Programs - Technological Needs Projects						
11. Integrated Clinical and Administrative Information System	433,744	296,875		136,869		
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	433,744	296,875	0	136,869	0	0

	Fiscal Year 2016/17					
	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						
CFTN Programs - Technological Needs Projects						
11. Integrated Clinical and Administrative Information System	252,713	150,000		102,713		
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	252,713	150,000	0	102,713	0	0

Attachment A

Humboldt County
Behavioral Health Board
Mental Health Services Act
Public Hearing Agenda
June 10, 2015

1. Call to Order 11:30

2. Adjustments to the agenda

3. Action Items:
    a) MHSA 3-Year Plan Public Hearing

4. Public comments- three minute limit

5. Adjournment 1:00 pm

Humboldt County Department of Health & Human Services

HUMBOLDT COUNTY
DEPARTMENT of HEALTH & HUMAN SERVICES
PROFESSIONAL BUILDING
MEZZANINE MAIN CONFERENCE ROOM
ATTENDEE ROSTER

MEETING: MHSA Public Hearing 6/10/15

2015 Date Month/Day	Time In	Time Out	Please Print Name	Work-Phone Number	Office Use
	10:45		Jack Barcellos	825-2199	
	11:00		TYRONE McDONALD		
	11:30		Sarah Nelson	441-5565	
	11:30		Kellie Jack	441-3783	
	11:30		Byron Hostler		
	11:30		Jason Wenger		
	11:30		Mariam Lemelson		
	11:30		David Four	839-0591	
	11:30		Ruth Needham	725-4406	
	11:30		Leah Lamathe	845 898	
	11:30		Elijah Zshay	382 1855	
	11:30		Sarah Braun	601-4614	
	11:30		Laurie Ruggles	496-5633	
	11:30		Tim Doty	825-845-	
	11:30		Lea Nagy	845-3233	
			Barbara Lahue		
			Sarah Brown		
	11:30		Jim Woolsey	845-6676	

EVACUATION PROCEDURES: **TAKE THIS SIGN-IN SHEET WITH YOU WHEN EVACUATING**
PRIMARY EVACUATION ROUTE is via of the main stairs by the elevator, to the first floor, and then out the front door to "F" Street. If this route is not useable, then use the SECONDARY EVACUATION ROUTE, go out the door marked "EXIT ", on the 5th street side of the Mezzanine Conference Room, down the stairs and out the door to 5th street. From either exit route, once outside proceed to the County Parking Lot at the corner of 5th and F street and assemble in the center of the Parking Lot.

Attachment B

What do **you** think about the MHSA three-year plan?

Comments welcome:

Now is your chance to view and comment on the Mental Health Services Act

Three-Year Plan and Update

See the documents at the MHSA humboldtgov.org website , then place your comments in an **MHSA Comment Box** at any of the following Humboldt County DHHS locations:

- Professional Building: 507 F St., Eureka
- Children and Family Services: 1711 Third St., Eureka
- Garberville Office: 727 Cedar St., Garberville
- Mental Health: 720 Wood Street, Eureka
- Hope Center: 2933 H St., Eureka
- Willow Creek Office: 77 Walnut Way, Willow Creek

You may also email your comments to:

- mhsacomments@co.humboldt.ca.us

or send them to:

- DHHS Mental Health
  attn: Jaclyn Culleton
  720 Wood St.
  Eureka, CA 95501

Public comments accepted from

May 8 to June 9

Then join DHHS Mental Health for a

Public Hearing on June 10

11:30 – 1:00

At the DHHS "Professional Building"
507 F Street, Eureka, 95501

To request a printed copy of the Three Year Plan or leave a comment, call 707-441-3770 or toll-free 866-320-8911.

The Mental Health Services Act provides opportunities to expand and develop innovative and integrated mental health services.

Humboldt County Department of Health & Human Services

LOST COAST OUTPOST

Please Comment on the County's Mental Health Services Act Plan, Public

ANDREW GOFF / FRIDAY, MAY 8 @ 3:46 P.M. /

Tweet Like 0

EDUCATION , HEALTH

Humboldt County Department of Health and Human Services:

> Starting May 8, community residents are invited to review and comment on the county's Mental Health Services Act (MHSA) three-year plan.
>
> The plan outlines the MHSA programs and expenditures through fiscal year 2016/17. The comment period will be open for 30 days.
>
> The MHSA provides funding to counties to develop and expand innovative and integrated mental health services for children, youth, adults and older adults. The MHSA is funded by Proposition 63, which imposes a 1 percent tax on personal income in excess of $1 million.
>
> Once the open comment period has ended, there will be a public hearing before the plan is sent to the Humboldt County Board of Supervisors for adoption.
>
> The plan can be reviewed online at http://humboldtgov.org/451/Documents-Open-for-Public-Comment.
>
> Comments can be submitted via email at mhsacomments@co.humboldt.ca.us. They can also be sent to DHHS Mental Health, attn: Jaclyn Culleton at 720 Wood St., Eureka, Ca. 95501. Recorded comments can be made by calling 707-441-3770, or toll free 866-320-8911. A printed copy of the three-year plan may also be requested by phone or email.

COMMENTS ENCOURAGED ON COUNTY'S MENTAL HEALTH SERVICES ACT

May 8, 2015 | Kym Kemp | Leave a comment

Press release provided by the Humboldt County Department of Health and Human Services:

Starting May 8, community residents are invited to review and comment on the county's Mental Health Services Act (MHSA) three-year plan.

The plan outlines the MHSA programs and expenditures through fiscal year 2016/17. The comment period will be open for 30 days.

The MHSA provides funding to counties to develop and expand innovative and integrated mental health services for children, youth, adults and older adults. The MHSA is funded by Proposition 63, which imposes a 1 percent tax on personal income in excess of $1 million.

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Humboldt County Department of Health & Human Services

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Monday
JUNE
15
2015

6/16/2015
10:30 AM -2:00 PM
Weitchpec/Mobile Outreach

6/17/2015
1:30 PM -3:00 PM
QI Tools and Techniques

6/17/2015
6:00 PM -8:00 PM
Family Acceptance Project for Families : LGBT

DHHS Calendar

< June 2015 >

Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

- Events and Activities
- Mobile Outreach Schedule
- Training Opportunities
- Vaccination Clinics

DHHS Web Log

MHSA three-year plan ready for public input

Friday, May 08, 2015

The Mental Health Services Act three-year plan is available now for public comment. We're issuing a news release to that effect this afternoon. Check it out.

MHSA three-year plan ready for public comment

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The MHSA provides funding to counties to develop and expand innovative and integrated mental health services for children, youth,

Our Mission: To reduce poverty and connect people and communities to opportunities for health and wellness

Questions or comments about the DHHS Bulletin Board?
Check the Intranet User Guide, or send your feedback to dhhsintranet@co.humboldt.ca.us