Humboldt County Department of Health and Human Services

A Needs Assessment and Recommendations Report for Humboldt County’s Children Mental Health System of Care

Prepared by:
Resource Development Associates
Humboldt County Children’s Mental Health System Assessment

A Needs Assessment and Recommendations Report for Humboldt County’s Children’s Mental Health System of Care

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About Resource Development Associates

Resource Development Associates (RDA) is a consulting firm based in Oakland, California, that serves government and nonprofit organizations throughout California as well as other states. Our mission is to strengthen public and non-profit efforts to promote social and economic justice for vulnerable populations. RDA supports its clients through an integrated approach to planning, grant-writing, organizational development, and evaluation.
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Overview of Humboldt County

Humboldt County is small rural county in Northern California with a total population of 135,116 individuals and 53,036 households. Among county residents, youth and children account for 19.7% (26,712) of the population. Humboldt County’s population is predominately white (81.7%), with significant populations of Latinos (9.8%) and American Indians (5.7%). The median household income in Humboldt County for 2015 was $42,197. About 20% of individuals and 13% of families in the county live below the poverty line. Children make up 22% of individuals who currently live below the poverty line.

In terms of geographic size, Humboldt County covers 4,052 square miles. It has a population density of 33 people per square mile, which is larger than the surrounding counties of Del Norte, Mendocino, and Trinity, but on the lower end of population density for California counties. While more than half of the population lives in three large population centers – of Eureka-Arcata, McKinleyville, and Fortuna – the rest of the population resides in small communities spread throughout the County. Many smaller communities are experience isolation due to the sparse population of the county.

There are also eight federally recognized tribes and a number of reservations Indian Reservations within the county’s boarders, including the Hoopa Valley Reservation, one of the largest reservations in the state as well as a number of tribal communities and reservations. There are only four other counties in the United States that have a greater number of reservations within their borders.

Needs Assessment Background and Purpose

Background

The passage of Assembly Bill (AB) 114 in 2011 realigned the responsibility of providing Education Related Mental Health Services (ERMHS) from county mental health departments to Local Education Agencies (LEA). This has resulted in confusion across the state regarding how agencies work together to ensure they meet the mental health needs of children and their families. Mental health departments, however, retain the responsibility to administer specialty mental health services to low-income residents with Medi-Cal or who are otherwise uninsured. Specialty mental health services are primarily funded through the Early and Periodic Screening, Diagnosis, & Treatment (EPSDT) Medi-Cal benefit for those that meet medical necessity criteria, and through the Mental Health Services Act (MHSA).

Humboldt County’s previous MHSA Three-Year Program and Expenditure Plan includes implementation of a school climate model to address challenges resulting from:

1) Differing sets of rules and regulations that govern the Humboldt County Department of Health and Human Services (DHHS) and the schools.
2) The funding and organizational responsibility changes resulting from AB 114

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Sensing a need to better integrate the efforts of the DHHS, the 31 distinct school districts, and the 91 schools serving over 18,000 children in Humboldt County, education and county mental health leadership formed the DHHS/Education Leadership Group. The DHHS/Education Leadership Group is a workgroup composed of department and education leadership and stakeholders, which includes but is not limited to Department of Health and Human Services-Children and Family Services’ (DHHS-C&FS), Humboldt County Office of Education (HCOE), and representatives from various school districts. The group meets monthly to strengthen the partnership between educational partners and county mental health and better serve children experiencing mental health issues.

Needs Assessment Purpose

In the fall of 2016, DHHS, in partnership with HCOE and the DHHS/Education Leadership Group, contracted with Resource Development Associates (RDA) to conduct a needs assessment of the children’s mental health system of care.

The purpose of the assessment is to:

- Identify the gaps in the current system and who system gaps impact
- Bolster behavioral health services and improve outcomes
- Develop strategies to better integrate DHHS mental health services with school-based mental health
- Increase collaboration among education and mental health partners
- Identify potential funding opportunities
- Foster interagency partnerships and collaborative program development

Below is a timeline of the key activities for the needs assessment.

Humboldt Needs Assessment Timeline and Activities

<table>
<thead>
<tr>
<th>Project Kick Off</th>
<th>System Assessment</th>
<th>Plan Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Launch Meetings</td>
<td>Stakeholder Survey</td>
<td>Planning Summit</td>
</tr>
<tr>
<td>Data Sources Identification</td>
<td>Focus Groups &amp; Interviews</td>
<td>Recommendations &amp; Strategies Development</td>
</tr>
<tr>
<td>Protocols and Materials Development</td>
<td>Policy Analysis</td>
<td></td>
</tr>
<tr>
<td>Finalize Workplan</td>
<td>Data &amp; Documentation Review</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Benchmarking Research</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Initial Assessment Report</td>
<td></td>
</tr>
</tbody>
</table>

October-December 2016 | January -July 2017 | August - September 2017
This assessment is intended to support the county in documenting the current service delivery model, including referral pathways and service availability, while enabling the county, its partners, and stakeholders to clarify and strengthen the model in alignment with governing rules and regulations, information from other jurisdictions, and local expertise.
Assessment Methods

Evaluation Design and Methods

The RDA team designed and conducted a mixed-methods approach to the needs assessment. RDA collaborated with the Education Leadership Committee to identify a series of data collection activities designed to produce a thorough understanding of the system-level needs of children in Humboldt County.

The needs assessment included key informant interviews, town hall meetings, surveys, and an analysis of secondary mental health data and publicly available prevalence data. RDA also conducted an analysis of mental health and education-related policy and funding to assess the current systems alignment with policy requirements as well as to identify any potential opportunities to leverage funding.

Below are the high-level research questions that guide the assessment’s focus on measuring needs in system-level operations, recognizing that the goal is to improve the outcomes of youth and families involved in the mental health system.

Key Informant Interviews

RDA conducted key informant interviews and town hall discussions to gather input from stakeholders about the current children’s system of care. Phone interviews were conducted, lasting approximately 45 to 60 minutes each. Please see the table below for a list of the stakeholders who participated in the key informant interviews.

<table>
<thead>
<tr>
<th>Position/Stakeholder Role</th>
<th>Key Informant Interviews Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHHS Representatives</td>
<td></td>
</tr>
<tr>
<td>1 DHHS Director</td>
<td>Connie Beck</td>
</tr>
<tr>
<td>2 Deputy Director Children’s Mental Health</td>
<td>Emi Rodgers-Botzler</td>
</tr>
<tr>
<td>3 Deputy Director Child Welfare</td>
<td>Michele Stephens</td>
</tr>
</tbody>
</table>
Department of Health and Human Services
Children’s Mental Health System Assessment

<table>
<thead>
<tr>
<th>4</th>
<th>Drug and Alcohol Services Rep./Deputy Director Adult Mental Health</th>
<th>Amanda Winstead</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Social Services Director</td>
<td>Stephanie Weldon</td>
</tr>
</tbody>
</table>

**Education**

<table>
<thead>
<tr>
<th>6</th>
<th>Superintendent of Schools</th>
<th>Chris Hartley</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Director of SELPA at County Office of Education</td>
<td>Mindy Fattig</td>
</tr>
<tr>
<td>8</td>
<td>County Office of Education Foster Youth</td>
<td>Roger Golec &amp; Anna Kanouse-Tempelae</td>
</tr>
<tr>
<td>9</td>
<td>Superintendent of Fortuna Union High School District</td>
<td>Glen Senestraro</td>
</tr>
<tr>
<td>10</td>
<td>Superintendent of McKinleyville Union School District</td>
<td>Jan Schmidt</td>
</tr>
<tr>
<td>11</td>
<td>Northern Humboldt Union High School District Student Services Director</td>
<td>Melanie Susavilla</td>
</tr>
</tbody>
</table>

**Juvenile Probation**

| 12 | Probation Leadership | Bill Damiano Jody Green |

**Community-Based Providers**

<table>
<thead>
<tr>
<th>13</th>
<th>Community Representative</th>
<th>Marianne Pennekamp</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>Mental Health Provider Rep (school-based)</td>
<td>Peter Stoll</td>
</tr>
</tbody>
</table>

**Focus Groups**

Given the number of school districts and the remote location of many of Humboldt County’s communities, RDA held regional town hall meetings with parents, teachers, education stakeholders, and mental health providers. RDA worked with Education and DHHS Leadership groups to implement an outreach and engagement strategy that leveraged local schools to spread the word about the assessment and recruit participants for focus groups.

RDA facilitated twelve focus group discussions with stakeholders to better understand the needs of children in the county. Focus groups ranged from 60 minutes to 90 minutes. Also recognizing that Humboldt has a number of tribal communities, RDA worked with DHHS and Education Leadership partners to provide participation opportunities for tribal members. Please see the table below for the list of focus group participants.

<table>
<thead>
<tr>
<th>Focus Group Type</th>
<th>Region</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent Town Hall Meeting (5)</td>
<td>• Eureka Area</td>
<td>• Eureka UHSD</td>
</tr>
<tr>
<td></td>
<td>• Eastern Region</td>
<td>• Klamath-Trinity Joint UHSD</td>
</tr>
<tr>
<td></td>
<td>• Northern Region</td>
<td>• Northern Humboldt School District</td>
</tr>
<tr>
<td></td>
<td>• Southern Region</td>
<td>• Mattole USD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Southern Humboldt USD</td>
</tr>
<tr>
<td></td>
<td>• Fortuna District</td>
<td>• Fortuna HSD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ferndale</td>
</tr>
<tr>
<td>Teacher/Education Mental Health Provider Town Hall Meetings (5)</td>
<td>• Eureka Area</td>
<td>• Eureka UHSD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• School based behavioral health staff</td>
</tr>
<tr>
<td></td>
<td>• Eastern Region</td>
<td>• Klamath-Trinity Joint UHSD</td>
</tr>
</tbody>
</table>
Surveys

The evaluation team developed surveys for both parents and teachers to assess their experiences with the mental health system. The Education Leadership members in each region disseminated surveys. Parent and teacher surveys were available online and in paper. The survey period lasted 30 days from April 1, 2017, to May 1, 2017. RDA received 25 responses from parents and 99 response from teachers.

Secondary Data

To understand service utilization trends over time, RDA collected secondary data from Humboldt County Mental Health Services. We requested aggregated and de-identified data sets of client demographics and service utilization trends for individuals 18 and under from 2013 to 2016.

We also requested service data from the HCOE Special Education Local Plan Area (SELPA) of utilization of school-based mental health services in 2016. Due to the way services in schools are recorded, HCOE SELPA was only able to provide the number of students served by school district.

Public Data Sources

We collected data from several public data sources to understand regional demographics and mental health prevalence and contributing factors. To obtain this data, we used the following resources:

- The American Community Survey
- California Health Kids Survey
- Youth.gov
- Centers for Disease Control and Prevention
- Behavioral Risk Factor Surveillance System
Limitations

The RDA Team noted several limitations to data collection that emerged during our assessment. While the RDA Team worked closely with DHHS leadership and representatives from various school districts on outreach and engagement of stakeholders, participation of parents in focus groups and the survey was lower than expected. The limited participation does raise concerns that stakeholder participation was not a representative sample of the County’s population. As such, there may be perspective and opinions about the children’s mental health system that were missed.

In similar respect, a central finding of this assessment centered on the impact of limited service availability in the County’s rural outlying communities. We did make attempts to collect data from families in these community by working with school districts on outreach activities, conducting focus groups at high schools in each of the County’s regions, and disseminating an online and paper based survey through schools. However it was difficult to collect data from individuals in these communities due to several factors that include: 1) the distribution many small communities across a large geographic distance; 2) outreach/communication difficulties; 3) distrust/disengagement among parents towards the County; and 4) unawareness or misunderstanding of the needs assessment’s purpose. As such, our data may not provide the full picture of the challenges families in Humboldt County outlying communities experience in accessing mental health services.

Lastly, this assessment did not include of youth or child consumers in our qualitative data collection activities due to privacy and consent concerns. As a small county, it would present a large risk of violating the privacy of consumers by collecting from this group due to low numbers of potential in certain regions of the County. We did collect de-identified and aggregated secondary data of service data that contained no identifiers to assess service utilization levels.
Humboldt County’s Mental Health Profile

Protective Factors

In Humboldt County, there are a variety of protective factors that reduce risks of mental health issues among children and youth. From the assessment, three themes for protective factors emerged:

- Low levels of mental health stigma
- Community connectedness
- School safety

Low Levels of Stigma about Mental Health

Among Humboldt County parents, teachers, and providers there appeared to be low levels of mental health stigma. Most town hall participants felt that mental health issues were generally accepted as a chronic illness that needed to be treated rather than an individual deficit. Most parents felt they could be open with teachers, friends, and providers about their children’s mental health needs. Several commented that this made finding support and services for their children easier.

Community Connectedness

Outside of the Eureka area, Humboldt County is made up of mostly small communities that are often centered on a school district or school. Throughout the assessment process, stakeholders expressed a strong sense of community as parents, providers and teachers create an informal network of support for children and families. Among students surveyed from 2011 to 2013 for the California Health Kids Surveys (CHKS), over two-thirds (69%) of high school students agreed that adults in their neighborhood or communities care about them. Moreover, stakeholders noted that community members are often willing to go out of their way to help each other during times of difficulty and in many cases provide informal linkages to mental health services and other resources.

Parents shared that when they are unable to access mental health services through DHHS in a timely manner, they seek alternative options. This includes seeking informal pathways into the system. As some parents stated, they successfully received services due to knowing the right person and knowing whom to call. For example, a parent shared, “I was able to call someone that referred us to a psychiatrist that quit a few years ago. It was all luck.” Several parents indicated that if it were not for those individual relationships, their children would not have been able to receive the services at the appropriate time.

Tribal providers described a similar network of support within tribal communities. While mental health services are provided through tribal community-based organizations, members of a community will often come to the aid of youth and children struggling with mental health issues to provide support as a community.
School Safety

Compared to students statewide, students in Humboldt County reported higher levels of perceived school safety and connectedness. Seventy percent of students in Humboldt County reported feeling safe or very safe at their schools (compared to 64% statewide). More than half of students (56%) surveyed in Humboldt County reported a high level of overall school connectedness, which was substantially higher than the statewide mark (45%). Additionally, a much larger share of students in Humboldt County reported a high level of agreement that teachers or other adults care for them (44% in Humboldt County compared to 34% statewide). Similarly, a higher share of students mentioned that they have opportunities for meaningful participation in school (19% in Humboldt County compared to 14% statewide).2 These findings indicate that, while Humboldt County children and youth face a number of challenges, schools represent an opportunity to provide support in an environment where students already feel some sense of safety and connectedness. In addition, as discussed below, high levels of connectedness are associated with lower levels of substance use and depression.

Risk Factors

During the assessment, we identified factors present in Humboldt County that increase the risk of mental illness among youth and children. Community members initially identified most risk factors during town hall meetings and focus groups. Then, possible risk factors were confirmed through research of available public or county data on the topic.

High Prevalence of Mental Illness

Among the residents of Humboldt County, there is a high prevalence of mental health issues and other factors that may contribute to increased risk among children and youth of mental illness. To understand the prevalence of mental health issues and factors that put individuals at risk, we collected quantitative and qualitative data during the assessment and reviewed publically available data. In addition to prevalence of mental health issues, we examined other risk factors among children and youth, such as bullying and substance abuse.

The population of Humboldt County has one of the higher rates of mental illness in California. As shown in Figure 1, the rate of serious mental illness in Humboldt County is higher than most counties in the state. In 2014, nearly 20% of adults reported needing help in the last 12 months for mental health or drug/alcohol problems compared to the state average of 16.3%. This finding indicates that Humboldt County, like many other northern rural counties in California, faces increased need for mental health services, which may strain existing systems.

Adverse Childhood Experiences

In addition to high rates of serious mental illness, Humboldt County has one of the highest Adverse Childhood Experience Study (ACES) scores in the state. In Humboldt County, among residents surveyed, 75% reported one or more ACEs; 54% of adults reported two or more ACEs; and 31% of adults reported four or more ACEs. A wide body of research suggests that having a higher number of adverse events in childhood increases the likelihood of future victimization and perpetration of violence. Additionally, higher ACEs scores are linked to chronic health problems, poor quality of life, and early death. A person with four or more ACEs is five times more likely to suffer from depression than an individual with no ACES.

Parents with High ACES Scores

In addition to the challenges that adults with high ACEs scores face, research has found a strong association between high ACEs scores in parents and childhood adversity, such as neglect, homelessness,

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5 Ibid


substance abuse in the home, and prolonged separation from family. Findings from town halls, key informant interviews, and survey data indicate mental health issues affecting the adults in Humboldt County are also affecting their children. While data do not connect mental health issues among parents in Humboldt County to their children, findings indicate that parents and teachers are concerned about the many needs of Humboldt County’s children and youth. Parents and teachers who were surveyed reported anxiety and depression as the top two needs facing youth in the county. Additionally, both groups reported history of trauma and substance use as top issues. Parents also reported concern about bullying and cyber bullying, but that concern did not rise to the top concerns of teachers. As discussed below, some of these concerns, especially substance use, is supported by youth self-reports from the California Healthy Kids Survey (CHKS), but other concerns are more ambiguous in the data.

Marijuana and Alcohol Use

One of the top concerns stated by key informants and survey responders is the share of youth in Humboldt using alcohol or marijuana. These concerns were supported by CHKS survey data. Indeed, much higher shares of students reported marijuana use in Humboldt County compared to the state (25% in Humboldt reported have used marijuana seven or more times in lifetime compared to 15% statewide).

Students that reported being highly connected to their schools were less likely to be frequent users of marijuana; this finding held true in both Humboldt County and statewide. Students reporting a low level of school connectedness were more than twice more likely to report regular marijuana use than those with higher connectedness (41% to 20%). However, even for students with a high level of connectedness, the share of students reporting regular marijuana use was double the statewide average of 10%.

Similar to marijuana use, students in Humboldt County were much more likely to report alcohol use compared to students statewide. When asked, 13% of students in Humboldt reported they drink “until I feel it a lot or get really drunk,” which was almost double the share of students that reported this statewide (7%).

Bullying/Harassment

Despite being a top concern among parents, students in Humboldt County reported slightly lower levels of bullying and harassment compared to students statewide (32% in Humboldt County compared to 34% statewide). However, one in three Humboldt County students reported experience with bullying and harassment, indicating that this may be a factor affecting students.

Youth and Children Client Profile

Mental Health Prevalence among Youth and Children

Data from the California Healthy Kids Survey from 2011-2013 indicates that prevalence rates for mental health indicators is similar to the statewide prevalence rates. The rate of depression among high school students in Humboldt County was similar to that statewide.

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students is a little under one-third (29.6%) of high school students which is slightly lower than the statewide average (30%). Similarly, the percentage of students reporting thoughts about suicide also aligns with the statewide average of 18.5%. However, high school students in Humboldt County have much higher rates of substance use than the statewide average.

Both assessment findings and publically available data indicate mental health issues at school are particularly common. Nearly 45% of Humboldt teachers who participated in the CHKS felt that student mental health issues are a problem at school—compared to 20% of teachers statewide. Of the 109 teachers surveyed, almost one-third (30%) reported they had provided students with mental health services and nearly two-thirds (64%) had worked or taught students with mental health issues. Only six teachers (6%) reported that, to their knowledge, they had not experienced working with or teaching students with mental health issues. Similarly, most parents that answered the survey reported they have used mental health services for their children. Of those that had not used services, most reported their children had not experienced mental health issues or received mental health services. For parents who had children that had experienced mental health service, the most commonly mentioned services were mental health assessment and individual therapy.

Client Demographics

In 2016, 1,203 individual received mental health services through the Humboldt County Children’s Mental Health System and 141 students received school-based mental health services through Education Related Intensive Counseling Services (ERICS).9 No data was available for youth and children who received mental health services through private insurance.

Of the 1,203 youth and children served by the county mental health system, nearly two-thirds (62%) were white, followed by Native America (17%), and African American (5%). An additional 15% of youth and children were classified as unknown or other. It is unclear from the data if Latino student are included as white or listed as other.

For youth and children that received mental health services through DHHS, more than half of the youth and children served were males (55%) and 45% were female. Youth and children that received mental health services through ERICS had a wider split across gender, with males making up 69% of ERICS clients and females accounting for 31%.

| Table 1. DHHS and ERIC clients by gender in 2016 |
|-----------------|-----------------|-----------------|
| Gender          | DHHS (n = 1203) | ERICS (n = 141) |
| Female          | 545 (45%)       | 44 (31%)        |
| Male            | 657 (55%)       | 97 (69%)        |

The most common age group that received mental health services was youth between the ages of 13 to 18. Nearly half (49%) of the youth who received services from DHHS and 60% of ERIC clients fell into this age group. Youth and children ages six to 12 was also largely represented accounting for 43% of DHHS

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9 Due to data limitations it is not known whether the ERICS and County Clients are duplicates.
clients and 40% of ERICS. For DHHS services, the least common age group was clients in the zero to five group (6%) and zero to three group (2%). No individuals in this age group received ERICS services.

Table 2. DHHS and ERICS clients by age group in 2016

<table>
<thead>
<tr>
<th>Age Group</th>
<th>DHHS (n = 1227)</th>
<th>ERICS (n = 141)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-3</td>
<td>25 (2%)</td>
<td>N/A</td>
</tr>
<tr>
<td>0-5</td>
<td>75 (6%)</td>
<td>N/A</td>
</tr>
<tr>
<td>6-12</td>
<td>531 (43%)</td>
<td>57 (40%)</td>
</tr>
<tr>
<td>13-18</td>
<td>596 (49%)</td>
<td>84 (60%)</td>
</tr>
</tbody>
</table>

Regional Distributions of Clients

In 2016, a large portion (40%) of youth and children DHHS clients live in the Humboldt Bay region. Nearly a quarter of youth and children DHHS clients reside in the Eel River Valley (24%) and similar numbers live Northern Humboldt (23%) region. Small portions clients live in the Southern Humboldt and Eastern Humboldt Regions as well as outside of the county. It is expected that the Humboldt Bay, Eel River Valley, and Northern Humboldt regions would represent a large share of DHHS clients as most of the County’s population lives in these three regions and most DHHS services are concentrated there. However, it is important to note that lower representation in a particular region does not imply that there is less of a need for mental health services.

Table 3. Regional distribution of DHHS mental health clients 18 and under in 2016

<table>
<thead>
<tr>
<th>County Region</th>
<th>Percent of Mental Health Clients (n = 1203)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Humboldt Bay</td>
<td>40%</td>
</tr>
<tr>
<td>Eel River Valley</td>
<td>24%</td>
</tr>
<tr>
<td>Northern Humboldt</td>
<td>23%</td>
</tr>
<tr>
<td>Eastern Humboldt</td>
<td>3%</td>
</tr>
<tr>
<td>Southern Humboldt</td>
<td>3%</td>
</tr>
<tr>
<td>Out of County</td>
<td>2%</td>
</tr>
<tr>
<td>Unknown</td>
<td>5%</td>
</tr>
</tbody>
</table>

In the schools, the distribution of students who received ERICS services aligned with the regional distribution of DHHS clients. The school districts in the County’s population centers had a greater number of students who received services through ERICS compared to more rural districts. As depicted in Table 4 more than three-fourths of ERICS students (78%) live in five of the 18 total school districts that reported providing ERICS to students. In 2016, 45 schools provided ERICS to students, however a large share was concentrated in a handful of schools. The top five schools attended by ERICS students account for more than a third of all students in Humboldt County that receive ERICS. Though not depicted, the top schools accounted for 60% of all ERICS students.

Table 4. Top five districts or residence and schools with the highest number of ERICS students in Humboldt County for 2016

<table>
<thead>
<tr>
<th>District of Residence</th>
<th>School of Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Eureka City Unified (28%)</td>
<td>1. Eureka Senior High (9%)</td>
</tr>
</tbody>
</table>
Similar to DHHS data, ERICS data also shows that utilization of school-based mental health services occurs mostly in the County’s population centers. While there is clearly needs in those areas, the lack of or limited service utilization in less populated regions of the County does not necessarily mean there is not a need for mental health services. It is quite possible that the level of mental health needs are at the same levels or higher in those areas, but go unreported due to a lack of services in those regions.

Mental Health System Overview

Humboldt County’s children’s mental health system of care is comprised of variety of programs, services, and supports provided by Humboldt County Mental Health (HCMH) through various public and community-based agencies. Medi-Cal funding for children under 21 is available primarily through Early Periodic Screening, Diagnosis, and Treatment (EPSDT) and are available to all children who meet medical necessity and eligibility requirements. EPDST services are also available to eligible children and youth through child welfare, probation, and children who meet Katie A criteria.

HCMH received $14,992,079 in funding to provide mental health services for children, youth, and transitional aged youth (TAY) programming. The County’s Children’s Mental Health also received funding from the Mental Health Services Act (MHSA) totaling $391,556, which was used primarily to support TAY programs. The remaining funds were sourced from a variety of discrete public funding sources, grants, and inter-department funding transfers.

<table>
<thead>
<tr>
<th>Funding Source</th>
<th>Total</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inter-department Transfers</td>
<td>$1,188,493</td>
<td>8.0%</td>
</tr>
<tr>
<td>Grants</td>
<td>$923,057</td>
<td>6.2%</td>
</tr>
<tr>
<td>Mental Health Service Act</td>
<td>$391,556</td>
<td>2.6%</td>
</tr>
<tr>
<td>Medi-Cal EPSDT</td>
<td>$11,188,908</td>
<td>75.0%</td>
</tr>
<tr>
<td>Other- Federal</td>
<td>$1,012,195</td>
<td>6.8%</td>
</tr>
<tr>
<td>Misc.- Fee, Sundry</td>
<td>$217,870</td>
<td>1.5%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$14,922,079</strong></td>
<td></td>
</tr>
</tbody>
</table>

The County received $11,188,908 in Medi-Cal EPSDT funding for direct mental health services through the county’s mental health programs, community-based mental health providers, and transitional aged youth (TAY) programming. The County Children’s Mental Health also received funding from the Mental Health Services Act (MHSA) totaling $391,556, which was used primarily to support TAY programs. The remaining funds were sourced from a variety of discrete public funding sources, grants, and inter-department funding transfers.
Table 6. Children’s mental health funding by program areas (FY 2016-17)

<table>
<thead>
<tr>
<th>Funding Sources</th>
<th>Total</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children and Families Services</td>
<td>$7,130,363</td>
<td>48%</td>
</tr>
<tr>
<td>Organizational Providers</td>
<td>$5,182,560</td>
<td>35%</td>
</tr>
<tr>
<td>Transitional Aged Youth Programs</td>
<td>$1,636,568</td>
<td>11%</td>
</tr>
<tr>
<td>Juvenile Justice</td>
<td>$712,480</td>
<td>5%</td>
</tr>
<tr>
<td>Community Programs Support</td>
<td>$260,108</td>
<td>2%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$14,922,079</strong></td>
<td></td>
</tr>
</tbody>
</table>

In FY 2016-17, funding in the children’s mental health system was allocated across five different program areas outline in Table 6. HCMH used the majority of mental health funds for children and families services programs run by county providers and community-based mental health services provided contract providers. Eleven percent of funding was dedicated to TAY programs. The remaining was allocated to mental health services in the county juvenile justice program and support for community programs.

Children’s Mental Health Providers

Eligible children and youth can access a variety of preventative, crisis, and outpatient mental health services as well as ancillary services such as case management, referrals, and linkages to other services. The county currently provides services directly through HCMH’s Children and Family Services and contracts with mental health providers to provide additional mental health services to children throughout the community. Table 7 provides a list of county and contract mental health providers in the children’s system of care. In addition to county and community-based providers, HCMH also contracts with five individual providers who provide mental health assessment, treatment, and psychological evaluation services.

Table 7. Humboldt County Mental Health Providers

<table>
<thead>
<tr>
<th>County Mental Health Programs</th>
<th>Contract Mental Health Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Child Welfare Behavioral Health Unit</td>
<td>• Changing Tides Family Services</td>
</tr>
<tr>
<td>• Wraparound Program</td>
<td>• Remi Vista</td>
</tr>
<tr>
<td>• Transitional Aged Youth Office</td>
<td>• Redwood Community Action Agency</td>
</tr>
<tr>
<td>• Juvenile Hall Regional Facility</td>
<td>• Humboldt Family Service Center</td>
</tr>
<tr>
<td>• Children, Youth, and Family Outpatient Clinic</td>
<td></td>
</tr>
<tr>
<td>• County Crisis Stabilization Unit</td>
<td></td>
</tr>
</tbody>
</table>

There is currently no inpatient capacity for youth and children in Humboldt County. Individuals in need of inpatient treatment or hospitalization are referred to contracted inpatient and residential programs outside of Humboldt County. Currently, the closest inpatient provider is located in Santa Rosa, Calif., about a four-hour drive from Eureka.

School Based Mental Health Services

Humboldt County’s public school system also plays a large role in serving the mental health needs of students. School-based mental health services are funded through the Special Education Local Plan Area (SELPA) using AB 114 funding. The Humboldt-Del Norte SELPA uses AB 114 for the area’s ERICS that include...
a range of assessments, group and individual counseling, and crisis intervention services for students with an existing individualized education plan (IEP). In many schools, crisis counselors and support staff are available to all students on a drop-in basis for counseling support and referrals. The SELPA also has memoranda of understanding with several of the local contract providers that students with mental health needs that can be easily referenced.

Private Insurance

Youth and children covered under their parent’s insurance can also access mental health providers through their insurance company’s provider network. Many parents and teachers felt that the current provider network did not have the capacity to serve the mental health needs of families with private insurance. There are currently very few mental health providers in Humboldt County that accept private insurance and those that do have long waitlists. Many providers commented that families with private insurance actually have the lowest level of accessibility and often have to pay out of pocket or travel long distances to get mental health treatment.

Access to Mental Health Services

Access to mental health care services is a crucial aspect of a public mental health system. Based on the Agency for Healthcare Research and Quality’s definition, access to care refers to the “the timely use of personal healthcare services to achieve the best health outcome.”10 Ideally, this means people get the appropriate care they need when they need it, at a convenient location. Common barriers to accessing care include a lack of health insurance or means to pay for it; limited sources of care in convenient locations for patients; a lack of consistent sources of care such as primary care providers; and patient perceptions of need.

Identification of Children with Mental Health Needs

There is a variety of ways that children with mental health needs are identified. By far the most common way of identifying a child in need occurs when a parent or family member notices irregular behavior or moods in their child and calls the county for services. Parents shared a variation of how they noticed a child had a mental health issue. This included behavior changes, personal hygiene, and not having a clue until a crisis arose.

Another common way that children are identified is through their school. Teachers stated they typically could notice when a student is experiencing mental health issues at a relatively early stage as they spend a significant amount of time with them. Typical signs teachers observe as warnings include acting out, abnormal school absence, large gaps in social skills and ability to cope with stressful situations, and

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changes in engagement levels. While school staff generally referred students with most extreme needs, teachers also expressed that families or students often referred themselves and asked for help.

Service providers and key informants reported that referrals to DHHS typically come from community-based organizations, schools, families, health care systems, the Probation Department, and other youth serving systems that includes:

- Child welfare services
- Community based programs and organizations
- Doctor’s office
- Juvenile justice/probation
- Tribal organizations
- First responders (law enforcement, emergency medical services)
- Crisis services providers (suicide prevention, mobile crisis)

**DHHS Access Program**

Children, youth, and their families access mental health service through the County’s Access Program. When a child is identified as needing mental health services, the parents or guardians of the children are told to call the DHHS C&FS Access Program.

The Access line is where families receive:

- Information about mental health services
- Mental health screening to determine the child’s level of care
- Medi-Cal eligibility assessment
- Referral to the appropriate mental health service
- Referrals to ancillary services, supports, and other resources

In order to receive mental health services, parents must first call the C&FS Access line to receive a mental health screening for both Medi-Cal eligibility and medical necessity. If eligible, the parents will receive a referral to a mental health provider. Children served through the county system of care, with few exceptions, must be eligible for Medi-Cal. After medical necessity and eligibility is determined, Access staff will make a referral and schedule a mental health assessment with a provider.  

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11 For families ineligible for Medi-Cal due to having private insurance, the Access Program staff cannot give a referral for services. They will instruct parents to contact their insurance provider to get an authorization for mental health services through their provider network. Given the high volumes of calls Access receives from parents with insurance, they provide parents with the contact information of the major insurance providers in the region as well as a list of providers who accept private insurance.
While the Access line serves as a mechanism to streamline the referral process, there are often delays in connecting eligible families to services. Access identified one reason for these delays is that Access was not keeping up-to-date records of service availability in the children’s system of care. As such, Access staff first had to call each provider to identify available spots for referrals. In 2017, the Access Program implemented an e-form in early 2017 as a way to track program availability in real time. While it is still early to know whether the program has reduced delays, Access staff do feel that the program was showing early impacts in reducing referral times. Participants throughout the county acknowledged that once they gained entry into the mental health system through Access, services typically met the needs of their children.

Access Program Challenges

A challenge about the Access Program that emerged is a varying level of awareness about the program and referral process among parents, teachers, and first responders to mental health crises. During focus groups, mental health providers described how parents would often walk in to their program location or call them to request services for their child or children. When program staff refer them to the Access line, parents often perceive this as being turned away from services. While many parents will follow up and obtain services through the Access process, providers felt that the lack of the awareness about the process create a barrier to entry into the mental health system and contribute to a perception in the community that there are no mental health services for children and youth.

Timely and effective communication between parents and the Access Program staff can be challenging. Parents and teachers described how delays were common between the first contact with the Access staff and the mental health assessment appointment, discouraging many parents from further pursuing services. Phone and email communication to certain parts of the county is limited either due to limited cell reception, outages, and that many families do not possess a landline. If the Access Program staff cannot contact a family after three attempts, the case is closed. As one stakeholder shared, “referrals tend to be too late.” Both parents and community members expressed concern over the waiting time – some families stated they had to wait up to four weeks for a mental health assessment. Contributions to the delay are limited availability of providers, high numbers of requests for services, a lack of follow up, and closed cases after three phone call attempts. Some attributed time delays to the lack of a system in place that can screen, triage, and prioritize appropriately.

Regional Approach to Service Delivery

In response to community feedback about access challenges in rural areas outside of Eureka, the County has taken a regional approach to serving youth and children with mental health needs in their communities. The County has developed a process of placing clinicians in historically underserved regions who provide mental health services to clients a couple days a week. The County also noticed that a barrier to getting into mental health services for many is the phone screening process. In response to this, the County worked with the Access Program to modify the screening process to allow clinicians to do assessments face to face at an individual’s home or school to make them more accessible and increase
the likelihood of completion. This has required a shift in how assessment are conducted and recorded, as most assessments require clinicians enter the information directly into the Medi-Cal reporting system.

**School-based Mental Health Services**

Many Humboldt County schools offer mental health services for students with the mental health issues. While schools are a common means through which mental health issues in children and youth are initially identified, schools also offer a variety of preventative, crisis, and outpatient services to address the varying levels of needs among students. Across the county, parents, teachers, and providers attributed the proximity and relationship schools have with the community as reasons why many students receive mental health services through school. Many acknowledged the crucial role teachers have in identifying and supporting students with mental health needs and their families.

While some schools are able to provide students with the appropriate level of mental health services, such as school staff that carry caseloads, not all schools have access to the same continuum of mental health care. The wide variability of services among schools is especially challenging for the smaller rural schools as they are very limited service availability. Many parents and teachers voiced concern over the limited availability of on-site school services and general mental health services because several communities, especially those farther away from Eureka and Arcata, are reliant on what is available at schools. Additionally, due to the limited accessibility to mental health services, many students were receiving IEPS as an alternative way to receive services. While IEPS may be beneficial for students with adverse mental health issues, many school staff expressed this as a concern because students with mild-moderate needs have the potential of not receiving the appropriate level of services or educational placement, and as a result risk either falling behind academically or not being appropriately served. In fact, some school sites emphasized this mechanism as troublesome because they only had resource classes for students with IEPs and did not have the proper counselors to meet the needs of children with behavioral health IEPs.

Many teachers have to go through the process of finding the parents, calling them, and/or meeting them to consult about authorizing the referral. They reported difficulty in assuring the referral linkage between the parents and child with DHHS as sometimes parents would refuse to sign authorization due to stigma and/or mistrust towards governmental agencies. As a service provider commented, there are many youth who have disorganized families due to intergenerational mental health issues and trauma, making parent engagement challenging. Teachers also expressed how even communicating to parents once they go home is difficult as some families do not have internet or a phone line. Lastly, parents and teachers shared that when a child experiences a crisis they either go to the emergency room or call the Sheriff’s Department for an involuntary psychiatric hold (5150) where typically children may be placed in the county crisis stabilization unit.

Overall, Humboldt community members agreed that an increase of on-site services and general mental health services for schools would benefit students and alleviate barriers to accessing mental health services in the county. As schools often serve as a community center in many of the County’s communities, they also provide an opportunity for teachers, parents, providers, and children and youth to share space.
During focus groups, community members strongly recommended leveraging the unique space that schools provide to situate mental health services and supports.

**Child Welfare and Juvenile Justice Mental Health Services**

Humboldt community members shared that when youth are dual status or are involved with the child welfare system, they typically are able to access mental health services with ease. In fact, many parents across focus groups self-identified as foster parents and shared how easy it is to receive services for their foster children. As a parent stated, “When my foster kid came to live with me she was already hooked up with services. The high school consultant takes her to her appointment so it works nicely. For the most part it works. She is doing well.” Furthermore, parents of justice-system-involved youth expressed how treatment services through the Northern California Regional Facility and linkage to county mental health services through the county’s Probation Department meet the needs of youth with mental health conditions and are easy to access, if needed.
Service Utilization Trends

To understand service utilization trends among youth and children, we reviewed data from county mental health services by clients 18 and under from 2013 to 2016. From our analysis, we identified several utilization trends:

- Utilization of children’s mental health services has grown annually since 2014 while the number of clients served had little change from 2013 to 2015 and decreased in 2016.
- The increases in utilization paired with the little growth in the number of clients served suggest increased level of need and acuity of among consumers.
- Medication support and case management services have limited capacity to absorb growth in need.

The overall trend in the service utilization data shows that service utilization levels have increased annually since 2014. For some types of services, growth has been rather dramatic with a 15% increase in the number of clients and a nearly 30% increase in the units of services.

Over this four-year period, the county provided mental health services to an average of 1,300 youth and children per year. With a population of children and youth estimated at 26,712, the number of clients served by HCMH represents about 5% of that population.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Clients Served</th>
<th>% Change from previous year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>1,304</td>
<td>N/A</td>
</tr>
<tr>
<td>2014</td>
<td>1,329</td>
<td>2%</td>
</tr>
<tr>
<td>2015</td>
<td>1,363</td>
<td>2%</td>
</tr>
<tr>
<td>2016</td>
<td>1,203</td>
<td>-13%</td>
</tr>
</tbody>
</table>

As depicted in Table 8, the number of children served grew steadily from 2013 to 2015 at a rate of two percent (2%) each year. However, that number dropped by nearly 13% in 2016 from 2015 levels. On the other hand, service utilization increased on average from 2014 to 2016 by 15%. This may suggest that the public mental health system is providing services to a smaller client population with a higher level of mental health need.

Service Categories

For youth and children who need mental health services, the children’s mental health system has a varying level of capacity to address each service category. Table 9 provides an overview of the types of services available and the number of providers who provide them.

<table>
<thead>
<tr>
<th>Services</th>
<th># of Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health Assessment</td>
<td>5</td>
</tr>
<tr>
<td>Individual counseling</td>
<td>5</td>
</tr>
<tr>
<td>Service</td>
<td>Count</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Family/group counseling</td>
<td>5</td>
</tr>
<tr>
<td>Case management services</td>
<td>3</td>
</tr>
<tr>
<td>Medication services</td>
<td>2*</td>
</tr>
<tr>
<td>Substance Use Services</td>
<td>2</td>
</tr>
<tr>
<td>Crisis Intervention</td>
<td>1**</td>
</tr>
</tbody>
</table>

The county system of care offers these services through both county and community-based providers. Mental health assessments and individual counseling are the most common types of services available. Parents and teachers who participated in focus groups and surveys suggested that there is a lack of familiarity among families about the types of mental health services available for children and youth. While community members seemed generally aware that mental health services exist, the majority felt they were either hard to get or unsure of where to get them.

**Mental Health Assessment**

Most children and youth who receive services through Humboldt County’s mental health system receive a mental health assessment at intake or their initial visit with a clinician. Generally, a clinician meets with a child or youth, conducts the assessment, and uses it to develop a mental health treatment plan. Currently, all five county and community-based mental health providers offer mental health assessments, as they are an essential part of treatment.

Since 2013, the number of assessments the county has conducted has shown sustained growth of each year. As depicted in Figure 2, 2016 saw 1,234 assessments provided to 843 children and youth, nearly double the number of assessments conducted in 2014 (651). While the children’s mental health system has been able to sustain the increase in need for mental health assessments each year, DHHS should look for a way to address future growth by increased assessment capacity in the near future.

**Individual Counseling Utilization**

The mostly frequently utilized service within the children’s mental health system is individual counseling, which exceeds other service categories in volume of units of service and clients served by wide margins. Nearly all of Humboldt County’s providers and contractors offer individual counseling services. In 2016,

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*Medication management services are also available through primary care providers. The County also offers telemedicine services

**Currently crisis and mobile crisis service are available through the County’s crisis stabilization unit in Eureka. For inpatient crisis services children and youth are admitted Aurora Hospital in Santa Rosa, Ca.
mental health providers delivered 3,152 units of services to 762 clients. On average, clients had 12 visits with a mental health provider.

<table>
<thead>
<tr>
<th>Year</th>
<th>Units of Service</th>
<th># of Clients</th>
<th>Average # of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>9964</td>
<td>861</td>
<td>11.6</td>
</tr>
<tr>
<td>2014</td>
<td>5881</td>
<td>653</td>
<td>9.0</td>
</tr>
<tr>
<td>2015</td>
<td>8667</td>
<td>763</td>
<td>11.4</td>
</tr>
<tr>
<td>2016</td>
<td>9276</td>
<td>762</td>
<td>12.2</td>
</tr>
</tbody>
</table>

4-Year Average | 8447 | 759.8 | 11.0 |

As shown in Table 10, over the period of 2013 to 2016, utilization of individual counseling services fluctuated serving between 861 and 653 clients. Given that this is the most common service provided in the children’s system of care offered by nearly all providers, it is likely that system is able to adjust to periodic changes in utilization levels.

Family and Group Counseling

Family and group counseling is offered by all providers in the county’s children’s mental health system. Out of all the other service categories, family and group counseling has the lowest levels of utilization. As shown in Table 11, the number of clients has increase more the three-fold from 2013 to 2014 going from 99 clients to 345. The increase in clients also seemed to have affected the number of group or family counseling visits clients received each year as the average number dropped from 25.5 to 7.6. Also notable, was in 2016 when the number of client decreased by five, but the units of services dropped by 19% from 2577 to 2095. It is possible that the expansion of Medi-Cal in 2014 will have increased the eligibility, but reduced the number of group and family sessions per episode. Since 2014 however, group and family services have remained relatively stable serving between 335 to 345 clients per year.

<table>
<thead>
<tr>
<th>Year</th>
<th>Units of Service</th>
<th># of Clients</th>
<th>Average # of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>2524</td>
<td>99</td>
<td>25.5</td>
</tr>
<tr>
<td>2014</td>
<td>2615</td>
<td>345</td>
<td>7.6</td>
</tr>
<tr>
<td>2015</td>
<td>2577</td>
<td>340</td>
<td>7.6</td>
</tr>
<tr>
<td>2016</td>
<td>2095</td>
<td>335</td>
<td>6.3</td>
</tr>
</tbody>
</table>

4-Year Average | 2452.8 | 279.8 | 11.7 |
Case Management Services

Case management services are available through the County and Redwood Community Action Agency (RCAA)—although RCAA specifically provides case management to individuals and families experience homelessness. Case management generally includes a range services provided by a case manager that include service coordination, rehabilitation, treatment planning, referrals to ancillary services, collateral, and monitoring.

Case management utilization levels dropped substantially between 2013 and 2015, but rebounded in terms of both clients and units of services in 2016. As depicted in Figure 3, case management levels grew in 2016 from previous years as mental health providers delivered 3,152 units of case management services to 320 children and youth. This increase in utilization represents about a 15% increase in the number of clients and a 33% increase in units of service from 2014-15 levels. This level of rapid growth has the potential to put a large amount stress on the system. This is especially salient for case management services as large caseloads often results in diminishing service quality and effectiveness. While the reasons for the increase are not clear, should growth clients and utilization continue into 2017 and 2018, DHHS should consider expanding case management capacity within the system of care.

Medication Services

Currently, medication services are available through the county’s outpatient clinic in Eureka and telemedicine services. It is also common for primary care providers to provider medication management due to the limited number of licensed psychiatrists in the region. Since 2013, Humboldt County has provided medication services to an average of 356 children and youth clients that constitutes slightly over one-quarter (27%) of the 1,300 youth and children the county provides mental health services to each year. As shown in Figure 4, service utilization and the number of youth and children receiving medication services has dropped from 2013 levels, but does show a trend of growth since 2014.
The growing demand for medication services may be an area of concern for the county mental health system if it continues. Community members strongly articulated that provider shortages and waitlists are barriers to getting treatment and felt that this is particularly an issue with specialists such as psychiatrists. As is the case many rural counties, Humboldt County has a very limited number of licensed psychiatrists and it may be increasingly difficult for the county to provide adequate levels of medication services to continue to meet the demand. The county may want to consider alternative approaches to medication services to increase capacity such as:

- Continue to utilize telemedicine services
- Encourage professionals to work at the top of their licenses
- Explore clinical training opportunities to increase scope of practice existing physicians

Crisis Services

Children and youth experiencing a mental health crisis can access crisis services at the county’s crisis stabilization unit (CSU). Currently, the County CSU has one bed available for children and youth experiencing a mental health crisis. Recently, the CSU has expanded mobile crisis services that offer crisis intervention services and have 5150 capacity. Although the County has taken steps in recent years to expand the crisis capacity within the children’s system of care, the level of services are not adequate for current need. The CSU’s bed is an available bed, but not exclusively dedicated for youth and children and is often used for overflow from the adult system. In instances when the CSU bed is not available, youth and children are sent to the emergency department at the local hospital or to a crisis facility in another County. The limited crisis capacity of the children’s mental health system represents a large gap in mental health services.

Suicide Prevention

Currently, DHHS operates a Suicide Prevention Program, which focuses on promoting help-seeking, improving access, and linking to treatment through a series of evidence-based trainings. Some of the key activities include:

- Suicide prevention 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
- Training utilizing evidence-based promising practices, or practice-based evidence models

According to the DHHS MHSA Annual Update for 2016-17, suicide prevention training and activities are in the Arcata and Eureka regions of the county, and there is a need to engage and provide these activities for residents in the southern and eastern regions of the county. As the suicide prevention program does respond to many of the needs stakeholders discussed, the county could leverage these existing services to reach the southern and eastern regions and help create more preventative protocols and provide education about suicide prevention.
Substance Use Disorder Treatment Services

Currently, there are no substance use disorder (SUD) treatment services available for children and youth through the public mental health system. The only provider of SUD treatment services is the New Horizons Juvenile Regional Facility where children and youth involved with the juvenile justice system can receive SUD assessments and treatment. New Horizon’s SUD services are not available for children and youth not involved with the juvenile justice system. In most cases, youth and children have to go out of county for substance use services. Among county providers, RCAA offers psycho-educational classes that include topics about substance use; however, it is unclear whether this is an ad hoc offering or a regularly scheduled class. For youth and children in need of medication assisted treatment for opioid or alcohol dependency, they will likely need to go to a SUD in the adult system of care or a provider out of county.

Barriers and Gaps in Mental Health Services

The needs assessment identified barriers and gaps that families, youth, and children encounter during their interaction with Humboldt County’s children mental health system of care. Stakeholders provided input during town hall meetings, focus groups, and a community survey. Through our analysis of the data, we identified three categories of barriers:

- **Barriers to accessing mental health care**: Systemic challenges and obstacles that prevent timely access to care when clients need in locations convenient to them
- **Gaps in service delivery**: Services and programs currently unavailable in the current system. Gaps in service also include un/underserved populations and communities
- **Barriers specific to rural community**: System challenges and barriers that result from the rural and isolated geography of certain regions and communities

When families do try to get services, they face multiple barriers. Qualitative findings suggest the largest barriers for families are the availability of services at convenient times and locations, the timeliness of referrals, and the reliability of transportation. Access barriers are often the result of a variety of issues within a mental health system and may require a multi-faceted strategy to address.

Barriers to Accessing Mental Health Care

Capacity of Existing Services

According to findings from the National Comorbidity Survey, the prevalence of mental health disorders with severe impairment or distress among youth 13 to 18 years old is 22%—or one out of every four to five youth. According to the Centers for Disease Control and Prevention, suicide is the third most common cause of death among youth and young people between the ages of 10 to 24. In 2013, 13% of

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high school students had considered suicide and developed a plan and 8% had at least one attempt. Furthermore, youth from low-income households have a higher risk with 21% of children from low-income households experiencing mental health disorders.

The county and school districts are currently providing services to about 1,345 youth and children per year through the county, community, and school-based providers. This accounts for about 5.6% of the 26,712 youth and children residents. Based on national statistics on mental health disorders among youth, this level of service delivery through the public systems is below prevalence levels and may suggest that the system of care in Humboldt does not meet the existing need among community members.

Findings from the needs assessment also point to a need for increased, and more widely dispersed, capacity of the local mental health system. Parents, teachers, and providers agreed that the system does not have sufficient services to meet the many needs of Humboldt County’s children and youth. Only one-third (33%) of survey respondents reported “services are available to meet students’ needs,” while the remaining two-thirds indicated that services were not available or difficult to access. As one teacher reported, “Mental health services at schools are meeting the needs [of] many students, but [the system] is overtaxed because this is the only mental health support they can access in the community.”

Many community members stated that there are not enough mental health providers or services to adequately serve their community. Throughout all activities, there was an emphasis on the fact that the high level of demand exceeds the number of staff and services available to properly respond to the needs of communities across the county. This includes psychiatry, youth specific in-patient services, and on-site school counseling. Some attributed the shortage of mental health providers and services to rural-specific challenges such as recruiting and retaining providers and the capacity to reach secluded communities.

Provider Availability

One contributing factor to the system’s capacity is a shortage of qualified mental health providers. Community stakeholders described how most providers have waitlists and getting into services can often take weeks or months. For psychiatry services, the county system currently only has two psychiatrists that can provide psychopharmacology and medication support services. Most parents described going to their primary care physician or clinic for medication services and consultations. Parents and teachers described similar waitlists and delays to getting services for families or youth who are seeking individual or family therapy with youth typically not seeing a provider for weeks after an initial assessment has been conducted. While this is a larger workforce issue that affects most counties in California, it is worth noting

that any efforts to increase capacity of the system must consider strategies to increase the number of clinical providers.

Additional wait time may be detrimental for children who may not be in crisis but are experiencing severe issues. Focus groups reported that even when a child is suicidal, the wait time could be over two weeks. In fact, many community members said the disjointed process leads them to look for alternative options such as going out of the county to receive services. Overall, community members stated that both the long waitlists and lack of follow-up creates a loss of trust towards the county’s ability to provide services in a timely manner. As a provider stated, “We cannot help them when they are first showing signs. The parents probably will not call back when they’re at a higher level because we already turned them away.”

Service Location

The location of services was regularly mentioned as a barrier for families that live in communities outside of population centers. Throughout the town halls and surveys, stakeholders reported physical service access as an issue. With most services located in Eureka or Arcata, families must travel great distances to receive services that are not available in their immediate area. As one teacher stated, “all the services are in Eureka.” Another teacher stated that if services are offered, “they are only in certain areas, but we can’t go out that far.” It can be a challenge to find ways to provide services in outlying areas with smaller population sizes, leading to some areas with fewer services.

Many consumers identified that mental health services with accessible service hours, located in the communities where they live, would improve their access and service participation. Stakeholders felt efforts should be focused outside Eureka and Arcata, where they felt services were already most easily accessed.

System Navigation

Families discussed that it is difficult to know where to access help when in need, and the process is confusing and disjointed. While there are a variety of strategies in place such as the Access line, parent support groups, and 211 hotline, the persistence and knowledge required to access mental health services combined with rural specific challenges makes it difficult to navigate Humboldt’s mental health system. Community members
expressed it is even more challenging for parents who are looking for services while also experiencing their own mental health challenges. Unaddressed intergenerational mental health issues were a common barrier for many community members. They also expressed that many families experience myriad high stress situations such as financial instability, substance abuse, and intergenerational trauma and mental health issues. Overall, parent engagement and navigation with the mental health system is challenging for many parents due to the lack of support and the multiple steps required to access mental health services.

Challenges with navigating the system can be exacerbated when families are struggling. As one informant stated, “If you are a functioning family with an adult who is able to navigate the system, you can persist and get your child into county mental health services. It takes persistence and tolerance to make sure services are connected. It works well for a narrow segment of the population.” This may mean that services are being provided to those families that are best able to navigate the system rather than to the families that need them the most.

Service Awareness

Across all town halls, stakeholders agreed that better dissemination of information is needed regarding what mental health services are available and how to access them. For example, a key informant stated that it is difficult for school staff to get any information on what services are available, making it difficult to refer families to services when they seek help. Furthermore, a majority of town hall participants, including principals, teachers, community providers, and families, expressed they attended the town halls to find out more about what services are available for their children and students, an indicator of a need for increased dissemination of available services.

Very few surveyed parents reported confidence in knowing where to go to get services for their children and 45% reported that it was “not at all or only a little bit true” that they knew where to get services. At town hall meetings, parents and teachers repeated that it is difficult to get any information on what services are available or how to get services for their children. When families and teachers do not know the array of services available to them, they may overly rely on trying to obtain special education services. This can mean that some students may not receive the most appropriate services for their needs.

Community members identified the development of a well-defined, clearly understood referral process and the dissemination of accessible, updated resources and service directories as an alleviation of this barrier.
Gaps in Service Delivery

Crisis Services

Like many other rural counties, limited crisis services are a large challenge. When children experience a mental health crisis, they often have to travel up to three to four hours away by emergency vehicles to find crisis services. During our key informant interviews and town halls, community stakeholder shared their concern of the growing level of mental health crisis that children experience. Humboldt mental health providers and education stakeholders and teachers alike described seeing more and more young children needing crisis services. While there are some crisis services within the County such as a Suicide Hotline and a limited number of mobile crisis teams in Eureka, crisis services overall are limited.

Teachers and key informants repeatedly reported that a lack of crisis services for children was a challenge. Parents and providers agreed that the lack of crisis services as well as inpatient and residential placement options for kids creates significant barriers to getting adequate treatment for children experiencing mental health crisis. The county's crisis stabilization has two beds available for children and youth experiencing a mental health crisis. If the CSU beds are unavailable, children either go to the emergency department at the local hospital or must be placed out-of-county at either a psychiatric hospital or state hospital.

The lack of available services within the county sends families out of the county for mental health treatment specifically for residential and inpatient treatment. Community members noted that children are often sent out of the county, sometimes as far as San Diego, to receive crisis mental health treatment. This is disruptive for a child because they are separated from their families, community, and academics. One parent described the challenge that out-of-county placement creates for families, “we have to send kids out of the area for crisis mental health treatment. The closest facility is a three-and-a-half-hour drive. This means kids are separated from families at a time when everyone is feeling vulnerable. A lot of parents are reluctant to place their kids there.” Some parents reported having to pay significant out of pocket expenses for out-of-county treatment and the burden it places. Not only does this negatively impact the children in crisis who are now placed miles away from their home, family, and support systems, but also the transport itself has been described by providers as traumatizing.

Underserved Populations

In Humboldt County, many populations were considered underserved or inappropriately served by community members. These populations either demonstrated a higher need of mental health issues or were the most likely populations to not receive mental health services because of stigma, type of service provided, or inability to access services. However, the populations that were listed as underserved varied from town halls and survey findings. Data from town halls and key informant interviews indicated that the most underserved populations were children between six to nine years old; undocumented children; tribal
community members; homeless youth; victims of crime especially in more rural or tribal populated areas; and children with families who are using substances. Survey respondents also mentioned homeless youth and families where there is substance use, but reported that the most underserved group was children experiencing a mental health crisis.

Language

Community members shared concern over non-English speaking communities and their ability to access language appropriate services. They specifically identified the lack of Spanish and Hmong speaking service providers and staff as a concern due the growth of non-English speaking communities in Humboldt County. Furthermore, community members and services providers expressed the need to provide better translation services and bilingual staff throughout the referral process, such as the Access line, as many families are dropped off throughout the process due to language barriers.

Overall, community members suggested the county place more efforts in outreaching more to non-English speaking communities, as there appears to be a lack of visibility of such communities within the mental health system. Most providers and teachers acknowledge that they are constantly engaged in efforts to recruit and hire more Spanish-speaking clinicians and staff, but have not been able to keep up with demand.

Rural Community Challenges

Geographic Distance and Transportation

Given the rural and mountainous geography of the region, the distance between communities is a major barrier for residents in outlying communities. Since most services are concentrated in the Eureka area, transportation to and from mental health appointments can be especially challenging as parents may have to drive over an hour each way. For many families without reliable transportation options, the distance from outlying communities to services make system engagement and service attainment difficult.

Community members were especially concerned about distance to services and transportation needs when a child is experiencing a mental health crisis. In many cases, families choose not to take their child to Eureka during a crisis due to the distance and limited transportation options. As such, they often feel their only option is law enforcement at the time of a crisis.

Limited reliable transportation heightens the impact the county’s geography has on access to services. Throughout all the town halls and surveys, limited transportation options was cited repeatedly as a primary barrier for families and students seeking or maintaining mental health...
services. Public transportation in remote areas is mostly non-existent and at the most infrequent and expensive. Even within population centers such as Eureka and Arcata, youth and children encounter transportation barriers to getting services. Many teachers noted that students often miss appointments because they cannot get reliable transportation.

Overall, stakeholders emphasized the need for more accessible and efficient transportation, especially for outlying communities and the need for the county to explore efforts to decrease the burden of transportation. Specifically, many identified community-based services or satellite sites as possible solutions. The remote geography and limited transportation options points to a need for solutions to mitigate the impact they have on families seeking mental health services for their children. Providing transportation for children to and from appointments offers a potential solution to the issues. This issue could also be address by increasing services at schools or satellite locations near to where families live. As one teacher stated, “with transportation being a challenge for the majority of the families, I am interested in in exploring and bringing in clinicians into school spaces but the County does not work with some schools.”

Distrust of Government Agencies

Perceptions of distrust in the government or government involvement is a common factor that prevents many families from seeking mental health services and support from the County. Humboldt County has a rich history of self-reliant and independent communities and individuals. This history, mixed with an underground economy from the cannabis industry, has resulted in high levels of distrust of government institutions.

Mental Health Stigma

Stigma and mistrust of providers can be a barrier for students and families. A large number of survey respondents (almost half of those surveyed) reported mistrust of mental health providers. This finding indicated that Humboldt County might want to focus effort on reducing stigma and distrust that may prevent families from seeking services for their children.

Privacy

Challenges with privacy and confidentiality can be especially challenging in a rural community. Informants stated that this can be an issue when one wants to receive mental health services without others knowing or report suspected domestic violence or sexual abuse for children in the community. As one teacher stated, “we have services
that are too familiar which is a real problem....It is a small community; I have the sheriff’s home phone number. To have more services, the familiarity can be a hindrance too.”

Communication/ Outreach Methods

Community members voiced that traditional communication methods such as phone calls and emails are a barrier for many families, as many do not have a phone line or home internet access. Families reported having to go to sites outside of their homes to make phone calls and follow up with service providers due to lack of phone access. However, many also voiced a communication disconnect with DHHS as they reported that after three phone call attempts, DHHS closes their cases. However, service providers and teachers also reported challenges contacting families as mistrust and fear exists towards unknown numbers. Overall, stakeholders shared the need to come up with alternative methods to outreach and follow up with hard to reach families in order to assure linkage to mental health services.

“In some parts of the county, not having a phone is a common barrier. Contacting someone by normal means is hard. Being able to follow up is hard. Families don’t get the help they need.”

Mental Health Provider
System Collaboration and Coordination

System coordination and collaboration both within Humboldt County DHHS as well as between behavioral health and local school districts represents both an ongoing opportunity and challenge to improve mental health services for children. In other sectors, such as healthcare, there is a large body of research that supports the effectiveness of collaborative care models to decrease cost, increase service accessibility, and improve quality. While the research base for school mental health is still evolving, it is widely acknowledged among professionals that collaboration is essential to providing school-based mental health services. Despite studies that indicate that when youth do receive mental health services, they receive them in schools, there are a number of challenges that arise including differences in training and philosophical orientation; limited resources; marginalization of mental health services in schools; and confidentiality concerns.

Collaboration between County and School Mental Health Systems

In Humboldt County, key informants indicated that the county has been focusing efforts in the past few years on increasing collaboration internally and externally. Survey data and findings from key informant interviews suggest that some of these efforts are resulting in positive changes in the county.

Collaboration between DHHS Divisions

Within DHHS, key informants reported that in the last five years there has been more collaboration between different departments that serve the same populations. Informants attributed the changes to new leadership that has promoted cross-agency collaboration, a new System of Care Grant, and improvements in the children’s crisis system.

At the leadership level, DHHS has promoted new efforts to work across departments. Specifically, the County’s System of Care Grant has increased partnership efforts between mental health and child welfare agencies. The foster care behavioral health unit is one example of a way DHHs is integrating services. This unit, which has been the most integrated with child welfare, has co-located behavioral health and child welfare staff.

Additionally, DHHS leadership reported that the relationship between the children’s and adult’s mental health system, which has historically been strained due to a lack of crisis services for children, has been improving. In the past, when a child would come in for crisis services, he or she would be placed in the adult system, which would result in challenges transitioning children from the adult crisis system to children’s mental health. Leadership staff reported that in the last year, they have added clinicians that

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16 Challenges to collaboraton
17 What are the challenges to school and mh partnerships
specifically work with children in crisis, which had alleviated the strain between the children’s and adult’s system and has improved handoff after a crisis.

However, despite the increases in collaboration within DHHS there remain challenges. First, much of the collaboration that happens within DHHS has yet to be institutionalized. Staff rely on individual relationships with other agencies, which creates challenges when a staff changes positions or leaves the agency creating the feeling that the newfound collaboration is fragile. Second, for many, at an organizational level it still feels like departments are working within silos. For example, one key informant reported that “mental health services happen in a silo. Children’s services does not talk to the unit that works to stabilize kids, so a child that goes to it because of suicidal ideation does not get linked to services.” This finding indicates a need for a formal system, such as an improved referral process to link children in crisis to services.

Collaboration between DHHS and School Districts

In recent years, collaboration between DHHS and school districts has greatly improved. Key informant and teachers reported that there is more collaboration now than in the past. Survey results indicated that teachers reported there is more coordination as a notable strength. As one teacher reported in the survey, “At our site, involvement through the county has stepped up significantly in the past two years. We have much greater access to support and guidance on how to handle difficult situations.”

Increased collaboration has happened at both the leadership and school district level. At the leadership level, DHHS has held regular leadership meetings to work on improving relationships with school districts. Both education and county members of the DHHS-Education Leadership Committee reported during interviews that the committee has helped leaders from the two system develop shared goals and coordinate efforts.

Unfortunately, key informants reported that while leadership at the School District and DHHS are partnering well, this does not reach middle management and line staff which causes communication barriers on both ends. Key informants reported that while leadership has created a shared vision for partnering, it has not been implemented in ways that affect the larger system. Staff cannot see the changes happening at the district level and may not have access to specific strategies to implement change at individual schools. This may mean that line staff feel they are left without training or resources to implement the leadership’s collaborative vision.
Additionally, several school districts have created multidisciplinary teams to get individuals together from the schools and DHHS departments. Once example is a multidisciplinary team called the STARS board held at a school district to address truancy.

**Family Resource Centers**

An additional positive change in collaboration has occurred as school districts and Family Resource Centers have been able to collaborate to meet the mental health needs of children. Within the county there are approximately 15 FRCs that can work as “go between” linking mental health and school districts. As one teacher reported, “Family resource centers are the people who can help you take the load off.”

Key informants reported that in regions where districts have co-located mental health services at schools and Family Resource Centers (FRC), the partnerships has created stronger collaboration between teachers and mental health providers and increased access for families to get assessment. As one example, in the Northern Region of the county, McKinleyville, the district has formalized their relationship with the local FRC that has created a resource center that partner with mental health staff that are available to assess and treat children.

A main advantage to collaborating with local FRCs is that school districts can refer students, who can be assessed on site. In the past, students needed to come to Eureka for mental health assessments, and many families did not receive services because of the travel to Eureka for assessment. Humboldt has leveraged the Family Resource Centers system who formed partnerships with schools and mental health to allow students to be assessed locally.

**Collaboration Challenges**

Despite recent improvements collaboration and coordination of the County and school mental health systems, there are a number of challenges that hinder collaboration between mental health providers and education providers. These challenges reflect more systemic differences between the two systems rather than an unwillingness to work together. They fall roughly into three categories:

- Funding Silos
- Variation in Mental Health Practices
- Data Sharing Challenges

While these issues in these areas preventing collaboration, they are making it more difficult for providers from each system to work together to serve children and youth.
Funding Silos

One of the challenges that come with limited, siloed funding is that it can create divisions between various entities that serve children. This situation is exacerbated when a child with high levels of need crosses multiple systems. As one informant stated, when there are “Children with high levels of mental health needs, there can be turf wars between child welfare, education and probation, usually around which agency is going to place the child. The most difficult cases are when there are minor child welfare and probation issues that happen concurrently with severe mental health issues.” Several key informants reported that funding silos create tension between schools and County agencies about which funding stream should pay for services. This dynamic can create a negative perception that other entities do not want to provide services for a child because they do not want to pay for them.

Another challenge facing collaboration between school districts and county mental health is a limited knowledge and transparency around funding. School districts are not aware of the amount of funding the County has allocated for school-based services and any limitation that exist in spending allocated funds. This limited knowledge leads to misperceptions that the County should have additional funds for services. For example, Humboldt County receives funding through the Mental Health Services Act (MHSA), but only a small share of this funding can be provided for prevention services at schools. School districts may not be aware of the limitations on County Mental Health and perceive that the County has funds that are not being adequately used in the schools.

As one member of DHHS leadership reported, school districts may feel especially frustrated that the County does not provide enough services for children with lower levels of need. This feeling may be execrated if the district staff are not aware of the County’s limitations on services causing distrust. From the school’s perspective there needs to be a broader effort to help children before they have acute needs. This informant reported that it is an ongoing challenge of how to help “kids more generally that are not rising to a higher level. [We have] struggled a lot around kids who are experiencing trauma. If you have experienced trauma, you need some support, but what does that look like. [We are] working to refine our assessment tool to better look through a trauma-informed lens.” However, despite the sentiments that shared funding streams may be optimal for serving children, departments may be reluctant to dismantle the current system or share funding for fear it will reduce what the limited allocations they have
Variation in Mental Health Practices

The existence of mental health services vary widely among districts. Some schools have strong relationships with FRCs and have school counselors or social workers located at the school site, but many do not. Overall, respondents reported that more school-based mental health services would be necessary to meet the needs at the school. Teachers reported that having the school serve as a hub for services is crucial. As one teacher reported, “Schools are the center of the community; that is where it [services] should be rooted. When it is all over the place, it makes it harder for the families.” Another teacher reported, “Once they go home it is hard to get them back into services. The hub is crucial. It’s a model that is working. Despite the need for services, the current reliance on individual districts incorporating mental health services represents an opportunity to conduct more outreach to districts for partnership opportunities.

Even for school districts with mental health providers, there can be challenges that arise in working with professionals representing different disciplines and training. Research indicates that a common barrier in incorporating mental health services into schools is that there is often limited training in education for mental health staff and limited mental health training for education staff. In many school districts, little time is built in to schedules for interdisciplinary training and teamwork. This situation can create numerous barriers to collaboration.

Challenges with Data Sharing

Informants in Humboldt County reported that one of the challenges in working with mental health staff is limited ability to share information and a reluctance among clinical staff at schools to provide information back to a teacher once a referral has been made. This situation creates tension that clinicians are not willing to collaborate. This indicates an opportunity to work with school staff and clinicians around shared expectations with regards to sharing data. School staff are bound by the Family Educational Rights and Privacy Act (FERPA) and mental health clinicians are covered by Health Insurance Portability and Accountability Act (HIPAA); staff may not understand the differences between confidentiality recommendations, as well as ways to optimally share data.
Culturally Responsive Services

Humboldt County is culturally and racially diverse with eight sovereign tribes, a large Latino and multi-racial community, and a growing Hmong population. As the county becomes more diverse, it is important that the mental health services and approaches to these communities are culturally responsive. Culturally responsive services refer to the ability to be responsive to the needs of individuals and their families as they make choices and plans, which often are based on a framework by their cultural background.

In our listening session with the tribal community, stakeholders shared that county and school-based providers must first focus on building authentic relationships with the tribes for foundation in responsive services. Tribal partners described the need for more culturally responsive services, and acknowledged where the county has made some efforts, but indicated that there is still a long way to go.

Cultural coaches are tribal community members who help social workers by providing culturally responsive training. Some of the cultural coaches suggested working more with psychologists to integrate ceremonies that would support well-being and mental health. Other tribal community members explained that many of their healing interventions could be Medi-Cal billed, but staff and administrators need to be trained in how to bill for these cultural services like brush dancing and ceremonies.

Some suggestions for more successful communication include:

- Engaging tribal liaisons in the beginning of cases with tribal youth
- Creating feedback loops when sharing information about tribal youth
- Acknowledging the role of historical trauma and active listening
- Utilizing the Cultural Coaches for Social Workers and for administrators
- Partnering with the tribes to ask what they need help funding
- Providing tribal ceremonies in the school

Tribal communities shared they find it difficult to build trust when they have to interface with large staff turnover. During our benchmarking interviews, many counties shared their challenges interfacing and
working well with the tribes, especially if their organization has seen a lot of turnover. Siskiyou County explained that they have had the same clinician for years to reach out to their tribal partners.
Recommendations and Strategies

Recommendations and Strategy Development Overview

Based on the assessment findings and stakeholder input, RDA developed an initial set of recommendations and strategies to expand and build upon the children’s mental health system of care. These initial recommendations were developed from data collected during the assessment, as well as best practices and benchmarking research, and were intended to address gaps in the children’s mental health system. The initial recommendations are below, with more detail provided in the following section.

1. Develop governance structures to support collaboration and information between mental health and school providers
2. Continue to strengthen collaboration and partnerships between mental health and school providers
3. Increase access to children’s mental health services
4. Increase co-location of mental health staff at school sites
5. Explore opportunities to expand crisis services
6. Consider alternative solutions to increase medication services providers
7. Explore opportunities to expand alcohol and drug services for youth and children
8. Continue to engage and collaborate with tribal communities to address mental health issues
9. Increase bilingual capacity among providers

Following the completion of the Needs Assessment and Recommendations Report, the DHHS/Education Leadership Committee began a process of prioritizing and refining recommendations as illustrated in Figure 5. In August 2017, the DHHS/Education Leadership Committee convened a strategy planning summit to review needs assessment findings and recommendations. An objective of this meeting was to validate and prioritize recommendations in order to develop a set of strategies and action items as next steps.

**Figure 5. Recommendation and Strategy Development Process**

During the summit, members agreed that all of the recommendations were important and aligned with the needs of children, youth, and families struggling to access mental health services. While all members felt that increased co-location, collaboration, and information sharing are high priorities, there is a need
for a governance structure between providers from different systems to share information and collaborate more formally.

With a refined and prioritized set of strategies, RDA conducted town hall report-back sessions with community members to inform stakeholders of the needs assessment’s findings and recommendations and collect any additional input stakeholders may have on implementing the strategies. An overview of the community input is provided in the final section of this report.

**Recommendations and Strategies**

**Strengthen collaboration through the development of a governance structure**

A major challenge for school and mental health providers is that there are limited processes to collaborate and share information about a particular client they may both serve. As a result, clients receive services from multiple providers in a disjointed manner. This increases the risk of clients receiving duplicative service from multiple systems of care.

A governance structure, such as a universal release of information and a memorandum of understanding (MOU), will allow providers to collaborate and share information around a client’s mental health assessment and treatment planning. This care coordination can support continuous and multi-disciplinary service delivery. A MOU between the school and the mental health providers could include defined roles, confidentiality agreements, and practices for sharing information. These structures could then lead to the creation of clear expectations about necessary releases to share student information that meet the requirements of both groups.

Developing a governance structure that supports and strengthens collaboration emerged as a top priority during the planning meeting. To accomplish effective interagency collaboration, a governance structure should be characterized by formalized processes, mutual buy-in, shared decision-making models, and transparency. Figure 6 illustrates a framework for an approach to governance development between various agencies.
This model may be especially useful for the DHHS/Education Leadership Committee as its four components reflect best practices for inter-agency partnership building, collaboration, and shared accountability:

- **Starting Conditions**: Conditions present at the outset of collaboration are important as they may facilitate or discourage cooperation among stakeholders. Starting conditions set the basic level of trust, conflict, and social capital that become resources or liabilities during collaboration.

- **Facilitative Leadership**: Literature has found that facilitative leadership is essential for bringing stakeholders together and engaging with a collaborative spirit. Facilitation limits intrusion on the management prerogatives of stakeholders and ensures the integrity of the consensus-building process. Such leadership also sets and maintains ground rules, builds trust, facilitates dialogue, and explores mutual gains.

- **Institutional Design**: Institutional design refers to the basic protocols and ground rules for collaboration. Literature suggests that clear ground rules and process transparency are important design features. Overall, institutional design is important because it contributes to procedural legitimacy and trust building.

- **Collaborative Process**: Literature states that the collaborative process is cyclical rather than linear. Due to its non-linear process, a stage model of collaboration is important for calling attention to changing strategies as context changes.

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Developing shared governance across multiple children and youth serving systems can present unique challenges due to the sensitivity of the information involved, privacy laws, and territorial issues among different agencies.\(^{20}\) Given these challenges, efforts to build governance are prone to failure. Research by the Substance Abuse and Mental Health Services Agency (SAMHSA) identified specific organizational characteristics that can bolster governance efforts across different child and youth servicing agencies as outlined below in Table 12.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Description</th>
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<tbody>
<tr>
<td>Membership</td>
<td>- Membership is inclusive and diverse</td>
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<tr>
<td></td>
<td>- Members are reflective of local communities and demographics</td>
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<tr>
<td></td>
<td>- Outreach efforts targets organizations not currently participating</td>
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<tr>
<td>Participation</td>
<td>- Agencies have fiscal and programmatic incentives to participate</td>
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<tr>
<td></td>
<td>- Benefits of participation are clearly defined</td>
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<tr>
<td></td>
<td>- Potential impacts on client outcomes are articulated</td>
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<tr>
<td></td>
<td>- Participation should be formalized without being too prescriptive</td>
</tr>
<tr>
<td>Roles and Responsibilities</td>
<td>- Roles and responsibilities are clearly defined and support interagency</td>
</tr>
<tr>
<td></td>
<td>collaboration and information sharing</td>
</tr>
<tr>
<td></td>
<td>- Formal agreements and budgetary authority define oversight structure</td>
</tr>
<tr>
<td>Decision making</td>
<td>- Decision-making is transparent and democratic</td>
</tr>
<tr>
<td></td>
<td>- Decision making process is based on a shared vision, mission, and theory of</td>
</tr>
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<td></td>
<td>change</td>
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Lastly, research recommends a variety of strategies that human service organizations can take to address barriers to cross-systems governance and collaboration. Based on the collaboration and information sharing challenges identified during the needs assessment, the following strategies were found to be most salient to Humboldt County’s needs:

- Maintain a focus on client need rather than agency differences and “territorial” issues
- Use an evidence base to inform training to ensure effectiveness, inform organizational change, and to inform new practices.
- Actively managing staff morale by ensuring meetings that agency staff do attend are relevant, and having input into sector meeting agendas so that opportunities for sharing understanding are facilitated.
- Collect data to demonstrate the efficacy of particular interagency projects or initiatives as well as having a clear understanding of funding eligibility.


\(^{21}\) Ibid
Department of Health and Human Services  
Children's Mental Health System Assessment

- Develop systems of ongoing contact with families and consumer which can be a source of new ideas, and information about strengths and weaknesses.\(^{22}\)

Continue to strengthen collaboration and partnerships between mental health and school providers

A major finding from the needs assessment was that collaboration and partnership between mental health and school providers posed a variety of organizational, legal, and practice challenges. At the same time, providers felt that more collaboration and partnerships between county and school-based mental health providers were crucial to better serving children, youth, and families struggling with mental health issues. Research suggests the following strategies for strengthening collaboration between mental health workers and schools:\(^{23}\)

- Address roles, responsibilities, and expectations when mental health staff begin working with a school.
- Build in time for interdisciplinary teamwork and training between mental health staff and school faculty and staff.
- Develop lists within the school of existing resources and ensure mental health staff are aware of other mental health agencies in the community for referral
- Establish a multi-disciplinary team within a school to focus on collaborative efforts and lessen “turf” issues
- Agree upon shared outcomes for students such as better attendance or school connectedness
- Encourage community clinicians to have active roles in the schools beyond one-on-one counseling, such as school-wide teams, and find ways to allow time in a clinician’s schedules to allow for collaborative work

Another factor to successful collaboration and partnership involves building synergy between agencies. Synergy involves the ability to combine perspective, resources, and skills of a group of individuals or organizations to create a partnership that is more effective than the sum of the individual parts of each agency.\(^{24}\) The level of synergy in a partnership is reflected in the way partners think about the partnership’s goals, plans, and evaluation; the types of actions the partnership carries out; and the relationship the partnership develops with the broader community. To create synergy, members should ensure the partnership has the necessary resources, stakeholders, group structure, and connections needed to achieve their collective goals. A synergistic partnership should consider the following questions:

- What resources does this partnership need?


• What types of skills, expertise, and information does the partnership need to achieve its goals?
• What types of members does the partnership need?
• How can members coordinate and align efforts at the institutions they represent?
• Does this partnership have the appropriate connections to organizations, communities, and groups?
• What level of involvement is expected for each member?
• What kinds of decision-making power does the partnership have?

Fostering synergy within a partnership can greatly boost the capacity of members to work collectively to achieve their shared goals. However, it is important to note that creating synergy is often a long-term effort that requires building the necessary levels of shared leadership, trust, and continuity of members. It also requires that members take active steps to align priorities, efforts, and resources within their organizations.

Increase Access to Children’s Mental Health Services

Many Northern California counties have similar challenges to Humboldt in that their counties cover a large rural region. This can lead to difficulties when connecting children and families to services because of unawareness of services, transportation, and mental health stigma. To identify effective strategies for reducing barriers to mental health services, RDA spoke to leadership from mental health departments and school-based mental health systems in six similar California counties. These entities included:

• Butte County Office Education
• Del Norte County Children’s Mental Health Provider
• Shasta County Health and Human Services Department, Children’s Services
• Mendocino County Office of Education
• Siskiyou County Behavioral Health Services
• Yolo County Health and Human Services, Child, Youth, and Family Services

Through these discussions and subsequent best practices research, the following strategies emerged for increasing access to mental health services for children, youth, and families.

• **Self-referral to services.** In Del Norte County, the County has contracted with a mental health provider who takes individuals and families who self-refer into their system. If those families do not have Medi-Cal, the contracted provider will call the County and staff will help families fill out the paperwork. This requires a lot of warm hand-offs and phone calls, but the County says this has been a successful strategy in linking their children and families to mental health services.

• **Stigma reduction.** Yolo County has created a Transition Aged Youth (TAY) speakers’ bureau, where youth and young adults with lived experience of mental health issues share their stories of mental health recovery and resources where youth can go get mental health and support. The program is intended to reduce mental health stigma and increase access to services for children and families entering the system.
• **Community liaisons.** Several counties have found it effective to partner with recognized members of diverse communities. In Shasta County, mental health providers utilize community liaisons and defer to them as they are experts in outreach and engagement. These community liaisons play an important role in helping counties navigate complicated cultural differences, and explicitly describing when things aren’t working well and how to focus on solutions.

• **Community partnerships.** Literature on mental health recovery programs emphasizes the role of engaging organizations in outreach that have access to the program’s target population. Community-based organizations, neighborhood or cultural groups, and social service agencies, among others, are beneficial partners in carrying out outreach and marketing. In Mendocino County, the County Office of Education created a specific position, Director of Innovation, Research, Partnership, and Accountability. This position is responsible for building strong community and agency relationships throughout the county and supporting and fostering networking between departments and initiatives to improve children’s physical/mental health.

• **Culturally appropriate and personalized relationships.** Hiring bilingual and bicultural staff is crucial to addressing barriers to success for individuals and families with limited English proficiency. Some staff foster relationships with children and families through home visits, which may not only be more convenient for participants; these visits may also provide a means for a mental health provider or case manager to get to know families and understand their unique circumstances. In Siskiyou County, the children’s psychiatrist conducts targeted outreach in the community by traveling to tribal communities, schools, community events, health fairs, and county fairs.

• **Peer support.** Peer support allows families to receive and provide feedback and guidance on successes and challenges in working with their children in the mental health system. Some counties like Yolo and Shasta, have hired peer and family navigators who either have lived experience of mental health issues or have a loved one with mental health issues, to help families navigate the system. In order to support their children with mental health needs, Shasta County also started a parent engagement group run by drug and alcohol and mental health staff. This has increased families’ participation in their service plan, and these groups give families an opportunity to discuss their own trauma and work on coping skills.

**Increase co-location of mental health staff at school sites**

Given the rural geography of Humboldt County and remoteness of many communities, schools serve multiple roles, often serving as community and resource centers. As one of the largest gaps in the current system of care is the accessibility of mental health services in locations outside of Eureka, schools offer a potential space to identify and serve children and youth with mental health needs. Co-locating clinicians at school sites has potential to increase the accessibility of mental health services and ensure a seamless

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27 ibid
continuation of care between home, school, and clinical settings. Co-located mental health programs can also bolster preventative efforts, provide families with referrals to other resources, and serve as triage location for students in crisis. For families with limited transportation options, co-located programs would also reduce the travel burden on many families to get to mental health services.

Explore opportunities to expand crisis services

The current capacity to provide crisis services for children and youth does not meet the current need. The County should consider pursuing upcoming funding opportunities for crisis services through the SB 82 Triage Funding. The Mental Health Office of Oversight and Accountability Commission is especially interested in funding child, youth, and TAY specific programs that include:

- Drop-in crisis clinics
- Roving school-based clinicians
- Crisis response programs co-located in emergency departments
- Mobile crisis partnerships with law enforcement agencies
- Crisis service partnership with tribal communities

The County may also want to consider applying for SAMHSA system of care grants that support the expansion of mental health services for children with serious emotional disturbances. SAMHSA expects to announce these funding opportunity in December of 2017.

Consider alternative solutions to increase medication services providers

The number of medication service providers is currently limited to two providers. Based on RDA’s assessment, this is well below the number of providers needed to meet the demand and as a result creates stress on the current system. However, it is not realistic to expect that recruitment efforts will result in large increases in number of psychiatrists in Humboldt County or across the region. In order to increase capacity, the County and providers should consider investing in telemedicine services as a way to immediately increase medication services capacity.

Similarly, the assessment found that many families receive psychiatric medication from primary care providers. The County may want to explore offering professional development trainings and other opportunities for primary care providers. This would aim to both: 1) increase the number of primary care providers willing to prescribe psychotropic medications; and 2) ensure providers have the training and knowledge to appropriately prescribe.

Explore options to develop substance use disorder services for youth and children

There is a currently a lack of drug and alcohol treatment services for children and youth struggling with substance use disorders. The County should explore potential funding opportunities and partnerships as ways to provide alcohol and drug treatment services within Humboldt County. The County may want to pursue developing services under the Drug Medi-Cal Bridge to Reform Waiver (DMC Waiver). The DMC Waiver supports counties in setting up publically funded alcohol and drug treatment services by
expanding Medi-Cal eligibility to include drug and alcohol treatment services currently not allowed by Medi-Cal.

Continue to engage and collaborate with Tribal communities to address mental health issues

The County should continue to engage tribal communities to support their efforts to address mental health issues. Based on input collected from the tribal members, the following recommendation were identified:

- Involve tribal leaders early on in needs assessments and strategies working with youth
- Formalize roles between government and tribes
- Take steps to reconcile historical trauma and past disagreements between county and tribal partners
- Support trainings, cultural sensitivity workshops, and integrating initiatives into applications
- Provide culturally responsive services for tribal youth
- Implement trauma-informed practices in Humboldt schools

Increase bilingual capacity among mental health service providers

Members of the Latino community, a population that is growing in Humboldt, shared that it is difficult to access services when there are no bilingual and bicultural staff. At this time, the state is experiencing a workforce shortage of bilingual clinicians and most counties struggle to address this issue. The County should work with providers within the system of care to identify a strategy to recruit and retain bilingual mental health providers. Strategies that have proven effective in other jurisdictions include:

- Providing additional compensation for bilingual staff
- Partnering with clinical training programs to provide internship and other incentives for students
- Investing in translation services
- Increasing the mental health technical language capacity of translators
Community Input and Considerations

Following the needs assessment, the RDA team, with the support of the DHHS and Humboldt County Office of Education, facilitated four report-back town hall meetings. The RDA team held the town hall meetings over a three day period at centralized locations across Humboldt County. As depicted in Table 13 below, a total of 34 community members attended the four meetings. Participant make-up varied at each meeting but included mental health providers, school faculty and staff, and parents.

Table 13. Report Back Meeting Dates, Locations, and Participants

<table>
<thead>
<tr>
<th>Southern Region Town Hall</th>
<th>DHHS/ CBO Providers</th>
<th>Eureka/Central Region Town Hall</th>
<th>Northern Region Town Hall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday, September 25th</td>
<td>Tuesday, September 26th</td>
<td>Tuesday, September 26th</td>
<td>Wednesday, September 27th</td>
</tr>
<tr>
<td>11 people present</td>
<td>3 people present</td>
<td>14 people present</td>
<td>6 people present</td>
</tr>
</tbody>
</table>

The purpose of these town hall meetings was to report on the findings from the needs assessment and strategy planning. These meetings as served as means to validate Humboldt County’s next steps and collect additional considerations or input on how to initiate strategies. During these town halls, community members and stakeholders had the opportunity to provide input to further inform the recommendations and provide feedback. Below are key takeaways and considerations that emerged from these report back town halls.

Key Findings

Across the three town halls, stakeholders largely resonated with the needs assessment findings, recommendations, and strategies. Meeting participants overwhelmingly agreed that the needs assessment accurately portrayed the system-level needs and gaps in Humboldt County. While each of the regions had different priority areas, overall themes emerged during the discussion and are organized by (1) priority areas for the County to address, (2) additional populations, and (3) considerations for the County.

Community Priority Areas

Throughout the town halls, education and mental health stakeholders wanted the County to prioritize the following:

- Develop crisis services and strengthen countywide crisis capacity for children
- Provide de-escalation training for law enforcement agencies/sheriff departments responding to children in crisis
- Expand mental health services and co-locate mental health services in schools
- Increase number of providers available through incentives and work on retaining existing staff
Formalize cross system partnerships to strengthen care coordination through governance

- Leverage relationships with the Family Resource Center to support regional service delivery

**Additional Populations and Needs**

Community stakeholders discussed additional populations to incorporate in implementation, including:

- Early Childhood Ages 0-5
- Children experiencing extreme poverty
- Children who are co-occurring [substances use and mental health issues]

**Considerations for the DHHS/Education Leadership Group**

The following are considerations for the DHHS/Education Leadership Group as they work toward implementation of the recommendations of the needs assessment.

- **Consider building language capacity** for Spanish, Hmong, and Portuguese populations
- **Develop substance use services for youth** through the upcoming Drug- Medi-Cal Waiver process
- **Promote access and linkage of existing services** through region-wide marketing campaigns to promote services
- **Streamline referral process** and allocate mental health point people for teachers
- **Leverage existing relationships and meetings** for coordination of care for children (e.g. SARBS) and include education
- **Sponsor on-going interagency training** for all front line staff serving children
- **Partner with nurse practitioners** who can prescribe psychiatric medication and care to support the provider shortage
- **Outreach to education stakeholders during Mental Health Service Act [MHSA] planning meetings** to share input on children mental health needs.
- **Continue to work on strengthening the partnership between education and mental health**

“There is a lot to celebrate, and there is intention to work hard. Progress is being made. We recognize where we’ve been, where we are, and where we ultimately want to be.”

—Town Hall Participant