Orange County Mental Health Services Act

WELLNESS • RECOVERY • RESILIENCE

Plan Update FY 2018/2019

OC health CARE AGENCY

TABLE OF CONTENTS

Search

TABLE OF CONTENTS

INDIVIDUAL/FAMILY SUPPORT 61

TABLE OF CONTENTS

TABLE OF CONTENTS

MESSAGE FROM THE AGENCY DIRECTOR

This Mental Health Services Act (MHSA) Annual Plan Update for Fiscal Year (FY) 2018-19 represents an opportunity to review our progress to date and re-evaluate our current Three-Year MHSA Plan. In the upcoming year we look to expand our capacity for serving two underserved populations of adults living with mental illness: homeless individuals who are eligible for Whole Person Care services and adults preparing to be discharged from jail. We also seek to extend the success of our Full Service Partnerships by expanding services for youth involved in the Criminal Justice system and for youth living with co-occurring physical and mental illnesses. Through these and other programs, MHSA will continue to transform the Orange County mental health system via the principles of community collaboration, cultural competence, wellness, recovery and resilience, consumer- and family-driven decision-making, integrated service experiences, and increased access for unserved and underserved populations.

The progress made thus far would not have been possible without the support and guidance of groups and entities including the Orange County Board of Supervisors, Mental Health Board, MHSA Steering Committee, Community Action Advisory Committee, advocates for unserved and underserved populations, and the multitude of volunteers, County staff and others who have so graciously given their time and expertise to create the successes achieved over the past 13 years.

Nevertheless, there is still more work to be done. We remain committed to providing safe housing for individuals living with mental illness as we diligently pursue additional funding sources. We are refining our performance outcomes by standardizing measures and emphasizing clinical indicators of success. We have re-organized the Annual Plan Update according to programs' primary service functions rather than their MHSA component to help promote understanding of our system of care. And an external evaluator is in the process of conducting a Needs/Gaps Analysis of mental health care in Orange County and a Cost-Benefit Analysis of select MHSA programs to better inform future planning efforts.

As I review the Annual Plan Update for FY 2018-19, I am pleased with the continued success of many of our programs and excited about the plans to expand our system of care. This was truly a collaborative effort between our outstanding community partners and Behavioral Health Services staff, and demonstrates our dedication to improving the lives of the individuals and family members affected by mental illness here in Orange County.

Sincerely,

Richard Sanchez

Richard Sanchez
Health Care Agency Director

OVERVIEW AND EXECUTIVE SUMMARY

In November 2004, California voters passed Proposition 63, also known as the Mental Health Services Act (MHSA). The Act implemented a 1% state tax on income over $1 million and emphasizes transforming the mental health system to improve the quality of life for individuals living with mental illness and their families. With 13 years of funding, mental health programs have been tailored to meet the needs of diverse clientele in each county in California. As a result, local communities and their residents are experiencing the benefits of expanded and improved mental health services.

Orange County Behavioral Health Services (BHS) has used a comprehensive stakeholder process to develop local MHSA programs that range from prevention services to crisis residential care. Central to the development and implementation of all programs is the focus on community collaboration, cultural competence, consumer- and family-driven services, service integration for consumers and families, prioritization of serving the unserved and underserved, and a focus on wellness, recovery and resilience.

The current array of services, with an annual budget of $218.8 million for FY 2018-19, was developed incrementally, starting with the planning efforts of stakeholders in 2005 and continuing to present day.

The Orange County FY 2018-19 MHSA Annual Plan Update ("Plan Update" or "Update") to the Three-Year Program and Expenditure Plan for Fiscal Years 2017-18 through 2019-20 was approved by the Board of Supervisors in **Update**. This Update increases funding for the Community Services and Supports and the Capital Facilities and Technological Needs components, and maintains but re-distributes funding within the Prevention and Early Intervention and the Workforce Education and Training components.

Budget Review and "True Up" Process

As part of the fiscal review done in preparation for the current Annual Plan Update, BHS engaged in a detailed process of aligning existing program budgets more closely with actual program expenditures from the most recent fiscal year (i.e., FY 2016-17). This budget "true up," which took place during Fall 2017, allowed managers to identify cost savings for programs that could be transferred to cover budget increases and/or implementation costs of other programs within the same component. The most common source of savings was actual or anticipated funds that remained unspent during a program's development and/or implementation phase (e.g., salary savings, reduced number of individuals served, etc.).

MHSA Components and Funding Categories

MHSA funding is broken down into five components that are defined by the Act: Community Services and Supports, Prevention and Early Intervention, Innovation, Workforce Education and Training, and Capital Facilities and Technological Needs. In addition, Community Services and Supports may allocate funds to support MHSA housing. A brief description and the funding level for each of these areas is provided below.

Community Services and Supports Component

Community Services and Supports (CSS) is the largest of all five MHSA components and receives 76% of the Mental Health Services Fund. It supports comprehensive mental health treatment for people of all ages living with serious emotional disturbance (SED) or serious mental illness (SMI). CSS develops and implements promising or proven practices designed to increase underserved groups' access to services, enhance quality of services, improve outcomes and promote interagency collaboration.

Several significant changes to CSS programs were incorporated into the FY 2018-19 Annual Plan Update:

- Peer Mentoring was expanded to support individuals in several new tracks:
  - Individuals of all ages receiving services in County outpatient clinics
  - Homeless adults eligible for Whole Person Care
  - Adults served in the Senate Bill (SB) 82 Triage Grant program that expires June 30, 2018
- Transitional Age Youth (TAY) Full Service Partnerships (FSPs) were expanded to serve additional youth involved in the Criminal Justice system.
- Adult FSPs were expanded to cover increasing housing assistance and residential treatment costs.
- BHS Outreach and Engagement was expanded to fund individuals eligible for Whole Person Care.
- The Children's and TAY/Adult Crisis Assessment Teams (CATs) received increased funding to expand the number of clinicians.
- A new program, Correctional Health Services Jail to Community Re-Entry, was added to provide comprehensive discharge planning and linkage to behavioral health services with the goal of reducing subsequent incarcerations.

The resulting CSS budget for FY 2018-19 is $145,612,490. A full description of each CSS program, including the above changes, is provided in the Community and the Individual/Family Support sections of this Plan.

Prevention and Early Intervention Component

MHSA dedicates 19% of its allocation to Prevention and Early Intervention (PEI), which is intended to prevent mental illness from becoming severe and disabling and to improve timely access for people who are underserved by the mental health system. The component maintained an overall level annual budget of $35,452,761 for FY 2018-19, although funds were transferred from the Training, Assessment and Coordination Services program to the Violence Prevention Education, Crisis Prevention Hotline, Survivor Support Services and Warmline programs to reflect actual program expenditures and/or increase service capacity based on demonstrated need. In addition, the MHSA Steering Committee approved HCA's plan to spend reverted PEI funds, per Assembly Bill (AB) 114, on existing PEI programs during FY 2018-19. A description of each program is provided in the Community and the Individual/Family sections.

Innovation Component

MHSA designates 5% of a County's allocation to the Innovation component, which specifically and exclusively dedicates funds to trying new or modified approaches that contribute to learning rather than expanding service delivery. Projects are time-limited to a maximum of five years and evaluated for effectiveness and consideration for continued funding through an alternative source. All active projects are described in the Community and the Individual/Family Support sections.[1]

In addition, HCA is developing two mental health-focused technology projects aimed at increasing access to services (see the Special Projects section). One proposal is to join the Mental Health Technology Solutions project, a cross-county collaboration initially proposed by Los Angeles and Kern counties and approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC). HCA is also currently working with community stakeholders to develop an integrated application that will harness technology to improve access to housing and other behavioral health resources. The MHSA Steering Committee similarly approved HCA's plan to spend AB 114 reverted INN funds on existing and, if applicable, newly approved projects in the manner that maximally protects funds from reversion.

Workforce Education and Training Component

Workforce Education and Training (WET) is intended to increase the mental health services workforce and to improve staff cultural and linguistic competency. WET maintained a level

[1] *After further research on the remaining Round 3 projects, it was determined that the concepts/ideas presented in the Child Focused Mental Health Training for Religious Leaders; Immigrant Screening and Referrals; and Whole Person Healing Initiative proposals are currently being implemented elsewhere and are unlikely to receive MHSOAC approval.*

annual budget of $5,150,282 for FY 2018-19, although funds were transferred from the Financial Incentives Program and Training and Technical Assistance to Workforce Staffing Support to reflect actual program expenditures. A full description of each program is provided in the BHS System Support section.

Capital Facilities and Technology Needs Component

The Capital Facilities and Technology Needs (CFTN) component funds a wide range of projects necessary to support the service delivery system and is currently funded through CSS. A total of $9.2 million was transferred to Capital Facilities to fund two projects in FY 2018-19: $9 million to purchase a property for Co-Located Services and $200,000 for renovations to a building used for Youth Core Services. In addition, Orange County transferred $3,756,082 to Technological Needs for continued implementation of the BHS Electronic Health Record (EHR). A full description of all projects is provided in the CFTN description within the BHS System Support section.

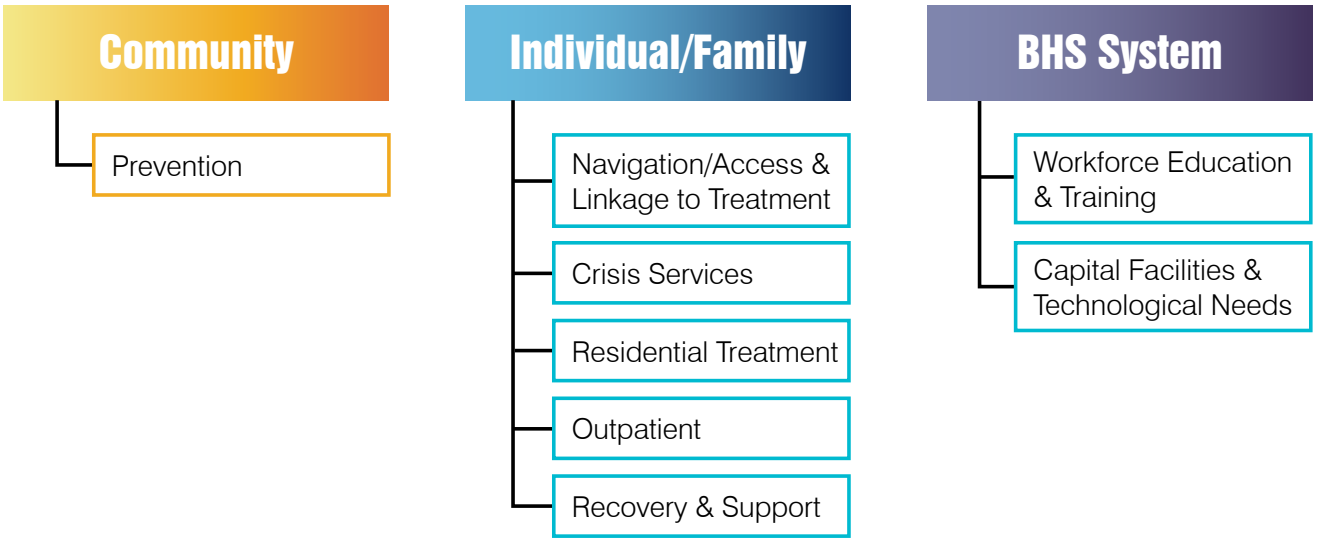
Housing

Under direction from the Board of Supervisors, $20 million was allocated during the FY 2017-18 Community Planning Process to develop permanent supportive housing through the MHSA Special Needs Housing Program. Some funds have already been allocated to several projects in development and will allow Orange County to continue creating permanent housing options for those living with SMI. A description of each project is provided in the Individual/Family Support section of this Plan Update.

Annual Plan Update Re-Organization

Programs were previously organized in the Plan according to their funding component (i.e., CSS, PEI, etc.). However, this structure did not necessarily promote understanding of what the programs did or how they related to each other. To address this limitation, the current Plan Update has been re-organized along two tiers: (1) Support Level, which reflects the program's primary target of intervention/support (i.e., Community, Individual/Family, BHS System) and (2) Service Function, which reflects the primary intent of the services provided (i.e., Prevention, Crisis Services, Outpatient Services, etc.). The Service Functions and the MHSA programs contained within them are described in more detail in this Plan Update. Although some programs span multiple Support Levels (i.e., Individual/Family, Community), they are categorized according to their primary Service Function.

MHSA Plan Organizational Structure



نظرة عامة والملخص التنفيذي (ARABIC)

تم توسيع نطاق شراكات الخدمة الكاملة (FSPs) للشباب في السن الانتقالية (TAY) ليشمل الشباب الآخرين المتورطين في النظام القضائي الجنائي.
تم توسيع نطاق شراكات الخدمة الكاملة للبالغين ليشمل زيادة المساعدات السكنية وتكاليف العلاج بالحجز في مصحة.
تم توسيع نطاق التوعية والمشاركة بشأن BHS لتمويل الأفراد المؤهلين للحصول على رعاية الفرد الكاملة.
تلقت فرق تقييم الأزمات (CATs) للأطفال والشباب في السن الانتقالي (TAY)/البالغين المزيد من التمويل لزيادة عدد الأطباء.
تمت إضافة برنامج جديد، الخدمات الصحية الإصلاحية في السجون لإعادة الانخراط في المجتمع (Correctional Health Services Jail to Community Re-Entry)، لتقديم تخطيط شامل عند إطلاق السراح والتواصل مع خدمات الصحة السلوكية بهدف تقليل احتمالات دخول السجن فيما بعد.
زانية CSS المتوقعة للسنة المالية 2018-2019 بقيمة 145.612.490 دولارًا أمريكيًا. ويرد وصف كامل لكل برنامج من برامج ما في ذلك التغييرات المذكورة أعلاه، في أقسام دعم المجتمع والفرد/الأسرة في هذه الخطة.

لوقاية والتدخل المبكر

، MHSA نسبة 19% من مخصصاته لقطاع الوقاية والتدخل المبكر (PEI)، والذي يهدف إلى منع المرض العقلي من أن يصبح حادًا إلى إعاقة، فضلاً عن تحسين إمكانية وصول الأشخاص المحرومين من نظام الصحة العقلية إلى الخدمات في الوقت المناسب. وقد ذا القطاع على مستوى شامل للميزانية السنوية بلغ 35.452.761 دولارًا أمريكيًا في السنة المالية 2018-2019، وذلك على الرغم يل التمويلات من برنامج التدريب والتقييم والتنسيق (Training, Assessment and Coordination Services program) إلى التوعية عن منع العنف (Violence Prevention Education) والخط الساخن لمنع الأزمات (Crisis Prevention Hotline) ت دعم الناجين (Survivor Support Services) وخط الدعم العاطفي (Warmline)، بحيث تعكس النفقات الفعلية على البرامج يادة قدرة تقديم الخدمات بناءً على الحاجة الواضحة. بالإضافة إلى ذلك، وافقت اللجنة التوجيهية التابعة لـ MHSA على خطة هيئة الصحية (HCA) لإنفاق الأموال المخصصة للوقاية والتدخل المبكر (PEI) المرتجعة، بموجب مشروع قانون الجمعية (AB) رقم على برامج PEI القائمة خلال السنة المالية 2018-2019. ويُقدَّم وصف عن كل برنامج في أقسام دعم المجتمع والفرد/الأسرة.

لابتكار

، MHSA نسبة 5% من مخصصات المقاطعة لقطاع الابتكار، والذي يحدد أوجه إنفاق الأموال بصورة محددة وعلى وجه الحصر بة أساليب تسهم في التعلّم بدلاً من توسيع نطاق تقديم الخدمات. تنحصر مدة المشروعات على خمس سنوات كحد أقصى وتخضع فاعلية والأهمية لاستمرار التمويل من خلال مصدر بديل. وتُوصف جميع المشروعات القائمة في أقسام دعم المجتمع والفرد/الأسرة.[1]

ة إلى ذلك، تطوّر هيئة HCA مشروعين معنيين بالتكنولوجيا المرتكزة على الصحة العقلية، ويهدف المشروعان إلى زيادة إمكانية ، إلى الخدمات (راجع قسم المشروعات الخاصة). ويستهدف أحد المقترحات الانضمام إلى مشروع حلول تكنولوجيا الصحة العقلية Mental Health Technology Solu)، وهو مشروع تعاوني بين المقاطعات اقترحته في البداية مقاطعتا لوس أنجلوس وكيرن، عليه لجنة الرقابة والمساءلة التابعة لخدمات الصحة العقلية (MHSOAC). وتعمل هيئة HCA حاليًا مع أصحاب المصلحة في ، لتطوير تطبيق متكامل يسخّر التكنولوجيا في تحسين فرص الحصول على السكن وغيرها من موارد الصحة السلوكية. وبالمثل، اللجنة التوجيهية التابعة لـ MHSA على خطة HCA لإنفاق أموال قطاع الابتكار (INN) المرتجعة بموجب مشروع قانون الجمعية رقم 114 على المشروعات القائمة و، إن أمكن، المعتمدة حديثًا على النحو الذي يحمي من ارتجاع الأموال بأكبر قدر ممكن.

علم وتدريب القوى العاملة

طاع تعليم وتدريب القوى العاملة (WET) إلى زيادة العاملين في خدمات الصحة العقلية وتحسين الكفاءة الثقافية واللغوية للموظفين. ظ قطاع WET على مستوى ميزانية شاملة بلغ 5,150,282 دولارًا أمريكيًا للسنة المالية 2018-2019، وذلك على الرغم من تحويل ت من برنامج الحوافز المالية (Financial Incentives Program) ودعم التدريب والدعم الفني (Training and Technical Assis) إلى دعم توظيف القوى العاملة (Workforce Staffing Support)، بحيث تعكس النفقات الفعلية على البرامج. ويُقدَّم كامل لكل برنامج في قسم دعم نظام BHS.

براء المزيد من الأبحاث على مشروعات الدورة 3 المتبقية، فقد تقرر أن المفاهيم/الأفكار المطروحة في مقترحات تدريب الصحة العقلية المرتكز الأطفال للقادة الدينيين (Child Focused Mental Health Training for Religious Leaders)، وفحص المهاجرين وإحالتهم (Immigrant Screening and Refe) ومبادرة المداواة الشمولية (Whole Person Healing Initiative) تُنفذ حاليًا في مكان آخر ومن غير المحتمل أن تحصل موافقة لجنة الرقابة والمساءلة التابعة لخدمات الصحة العقلية (MHSOAC).

في نوفمبر عام 2004، أقرّ الناخبون في ولاية كاليفورنيا المقترح 63، المعروف أيضًا باسم قانون خدمات الصحة العقلية (Mental Health Services Act, MHSA). وقد فرض القانون 1% ضريبة ولائية على الدخل الذي يزيد عن مليون دولار أمريكي، وأكد على ضرورة تغيير نظام الصحة العقلية في سبيل تحسين نوعية حياة الأفراد المصابين بأمراض عقلية، وكذلك حياة عائلاتهم. ومع 13 عامًا من التمويل، فقد صُممت برامج الصحة العقلية لتلبية احتياجات مختلف العملاء في كل مقاطعة في كاليفورنيا. ونتيجة لذلك، تنعم المجتمعات المحلية وسكانها بمزايا خدمات الصحة العقلية الموسعة والمحسنة.

استعانت خدمات الصحة السلوكية بمقاطعة أورانج (Orange County Behavioral Health Services, BHS) بعملية شاملة لأصحاب المصلحة، وذلك لتطوير برامج MHSA محلية، والتي تتباين بين الخدمات الوقائية ورعاية الحجز في المصحة في أوقات الأزمات. ومن الأمور المحورية في تطوير وتنفيذ جميع البرامج التركيز على التعاون المجتمعي، والكفاءة الثقافية، والخدمات الموجهة من المريض والأسرة، وتكامل الخدمات للمرضى وأسرهم، وإيلاء الأولوية لخدمة غير المخدومين والمحرومين، والتركيز على الصحة والعافية وسهولة التكيف. وقد تم تطوير مجموعة الخدمات الحالية، مع ميزانية سنوية بلغت 218.9 مليون دولار للسنة المالية 2018-2019، بصورة تدريجية، حيث بدأت بجهود التخطيط التي يبذلها أصحاب المصلحة واستمرت إلى يومنا هذا.

وصدّق مجلس المشرفين (Board of Supervisors) على التحديث السنوي لخطة MHSA في مقاطعة أورانج للسنة المالية 2018-2019 ("تحديث الخطة" أو "التحديث") إلى برنامج الثلاث سنوات وخطة الإنفاق للسنوات المالية 2017-2018 حتى 2019-2020 في MONTH 2018. ويسهم هذا التحديث في زيادة التمويل المخصص لعنصري الخدمات والمساعدات المجتمعية ومرافق رأس المال والاحتياجات التقنية، ويظل تمويل عنصري الوقاية والتدخل المبكر وتعليم وتدريب القوى العاملة دون تغيير، غير أنه يُعاد توزيعه.

مراجعة الميزانية وعملية "التصحيح"

كجزء من عملية المراجعة المالية التي أُجريت تحضيرًا للتحديث السنوي الحالي للخطة، شاركت خدمات الصحة السلوكية (BHS) في عملية مفصلة لمواءمة ميزانيات البرامج الحالية على نحو أوثق مع نفقات البرامج الفعلية من آخر سنة مالية (مثلاً، السنة المالية 2016-2017). وقد أتاحت عملية "تصحيح" الميزانية تلك، التي تمت في خريف 2017، للمديرين تحديد وفورات التكاليف في البرامج التي يمكن تحويلها لتغطية الزيادات في الميزانية و/أو تكاليف تنفيذ البرامج الأخرى ضمن العنصر ذاته. وكان مصدر الوفورات الأكثر شيوعًا هي التمويلات الفعلية أو المتوقعة التي ظلت غير مصروفة خلال مرحلة تطوير البرنامج و/أو تنفيذه (مثلاً، وفورات المرتبات، انخفاض عدد الأفراد الذين يحصلون على الخدمات، وغير ذلك).

قطاعات MHSA وفئات التمويل

ينقسم تمويل قانون خدمات الصحة العقلية (MHSA) إلى خمسة قطاعات محددة بموجب القانون: الخدمات والمساعدات المجتمعية، والوقاية والتدخل المبكر، والابتكار، وتعليم وتدريب القوى العاملة، ومرافق رأس المال والاحتياجات التكنولوجية. علاوة على ذلك، يمكن أن تخصص الخدمات والمساعدات المجتمعية تمويلات لدعم الإسكان في MHSA. ويُسرد أدناه وصف موجز ومستوى التمويل لكل جانب من هذه الجوانب.

قطاع الخدمات والمساعدات المجتمعية

تشكل الخدمات والمساعدات المجتمعية (CSS) القطاع الأكبر بين جميع قطاعات MHSA الخمسة، ويتلقى 76% من تمويل خدمات الصحة العقلية. ويدعم علاج الصحة العقلية الشامل للأفراد من جميع الأعمار المتعايشين مع اضطراب انفعالي خطير (SED) أو مرض عقلي خطير (SMI). ويعمد قطاع CSS إلى تطوير وتنفيذ ممارسات واعدة أو مُثبتة مُصممة لزيادة إمكانية وصول المجموعات المحرومة إلى الخدمات، وتحسين جودة الخدمات، وتحسين النتائج وتعزيز التعاون بين الوكالات.

ودخلت العديد من التغييرات المهمة على برامج CSS في التحديث السنوي للخطة عن السنة المالية 2018-2019:

- تم توسيع نطاق توجيه الأقران ليدعم الأفراد في العديد من المسارات الجديدة:
  - يتلقى الأفراد من جميع الأعمار الخدمات في العيادات الخارجية للمقاطعة
  - يستحق المشردون البالغون الحصول على رعاية الفرد الكاملة
  - يحصل البالغون على الخدمات ضمن برنامج منحة تصنيف المرضى (Triage Grant program) بموجب مشروع قانون مجلس الشيوخ (SB) الذي تنتهي صلاحيته في 30 يونيو 2018

قطاع مرافق رأس المال والاحتياجات التكنولوجية

يموّل قطاع مرافق رأس المال والاحتياجات التكنولوجية (CFTN) مجموعة كبيرة من المشروعات الضرورية لدعم نظام تقديم الخدمة، ويحصل على التمويل حاليًا من الخدمات والمساعدات المجتمعية (CSS). وقد تم تحويل إجمالي 9.2 ملايين دولار أمريكي إلى مرافق رأس المال لتمويل مشروعين في السنة المالية 2018-2019: مبلغ 9 ملايين دولار أمريكي لشراء منشأة من أجل الخدمات المشتركة و200.000 دولار أمريكي لأعمال التجديد في مبنى يُستخدم في الخدمات الأساسية للشباب. علاوة على ذلك، حوّلت مقاطعة أورانج 3,756,082 دولارًا أمريكيًا إلى الاحتياجات التكنولوجية بهدف استمرار تنفيذ مشروع السجلات الصحية الإلكترونية (EHR) ضمن خدمات الصحة السلوكية (BHS). ويُقدَّم وصف كامل لجميع البرامج في وصف CFTN ضمن قسم دعم نظام BHS.

الإسكان

بموجب توجيهات مجلس المشرفين، تم تخصيص 20 مليون دولار أمريكي خلال عملية التخطيط المجتمعي للسنة المالية 2017-2018 من أجل تطوير الإسكان الداعم الدائم من خلال برنامج MHSA الإسكاني لتلبية الاحتياجات الخاصة. وبالفعل، تم تخصيص بعض التمويلات للعديد من المشروعات قيد التطوير والتي ستسمح لمقاطعة أورانج بمواصلة تقديم خيارات إسكان دائمة لمن يتعايشون مع مرض عقلي خطير (SMI). ويُقدَّم وصف لكل مشروع في قسم دعم الفرد/الأسرة في تحديث الخطة.

إعادة تنظيم التحديث السنوي للخطة

اعتمد تنظيم البرامج في الخطة سابقًا على قطاع تمويلها (مثلاً، الخدمات والمساعدات المجتمعية (CSS)، والوقاية والتدخل المبكر (PEI)، وغير ذلك). ومع ذلك، فلم يسهم هذا الهيكل بالضرورة في زيادة استيعاب أهداف البرامج أو كيفية ارتباطها بعضها ببعض. ولمعالجة هذا القصور، تم تنظيم تحديث الخطة الحالي على مستويين: (1) مستوى الدعم، الذي يعكس *الهدف* الأساسي للبرنامج المعني بالتدخل/الدعم (مثلاً، المجتمع، الفرد/الأسرة، نظام BHS) و(2) مهمة الخدمة، التي تعكس *الغاية* الأساسية للخدمات المقدمة (مثلاً، الوقاية، الخدمات في أوقات الأزمات، خدمات المرضى الخارجيون، وغير ذلك). ويوجد وصف لمهام الخدمات وبرامج MHSA الموجودة فيها بمزيد من التفاصيل في تحديث الخطة. ومع أن بعض البرامج تمتد على مستويات دعم متعددة (مثلاً، الفرد/الأسرة، المجتمع)، فإن تصنيفها يكون تبعًا لمهمة الخدمة الأساسية.

الهيكل التنظيمي لخطة MHSA

على مدى السنوات التي انقضت منذ إقرار المقترح 63، لم يتوقف القانون عن التطور وساعد على تحسين حياة الأشخاص المصابين بأمراض عقلية، وأسرهم، ومجتمع مقاطعة أورانج بالكامل. وإننا نتطلع إلى مواصلة شراكتنا مع أصحاب المصلحة بينما نعمل على تنفيذ قانون خدمات الصحة العقلية (MHSA) في مقاطعة أورانج.

مرور کلی و خلاصه مدیریتی (FARSI)

عضویت (FSP) در خدمات انتقالی کامل جوانان (TAY) گسترش یافته است تا به سایر جوانانی که در سیستم عدالت کیفری حضور دارند خدمات رسانی شوند.
FSP بزرگسالان گسترش یافته است تا هزینه های درمان در منزل و کمک در منزل که در حال افزایش هستند تحت پوشش قرار بگیرند.
"گسترش و حضور BHS" توسعه یافته است تا هزینه افرادی که برای طرح مراقبت های کامل شخصی واجد شرایط هستند تأمین شود.
بودجه تیم های ارزیابی بحران بزرگسالان/کودکان و TAY (CAT) افزایش یافته است تا تعداد متخصصین بالینی افزایش یابد.
یک برنامه جدید با عنوان "خدمات سلامت تأدیبی برای پیوستن مجدد به جامعه" اضافه شده است تا برنامه جامع و کاملی در زمینه ترخیص افراد از زندان و ارتباط با خدمات سلامت رفتاری ارائه شود و هدف آن کاهش مدت زمان بعدی حبس افراد است.
ه بودجه CSS برای سال مالی 19-2018 برابر با 145,612,490 دلار است. توصیف کاملی از هرکدام از برنامه های CSS به غییرات بالا در بخش های انجمن و پشتیبانی از افراد/خانواده در این طرح ارائه شده است.

پیشگیری و اقدام زودهنگام

I 19% از هزینه خود را به مؤلفه پیشگیری و اقدام زودهنگام (PEI) اختصاص داده است و هدف آن پیشگیری از تشدید های روانی و ناتوان شدن افراد است و تلاش می شود افرادی که در سیستم سلامت روانی به خدمات مناسب دسترسی ندارند به ه خدمات دسترسی داشته باشند. بودجه سالیانه ای که به این مؤلفه تعلق می گیرد 35,452,761 دلار برای سال مالی 19-2018 ا این وجود منابع مالی از بخش خدمات آموزشی، ارزیابی و هماهنگی به بخش آموزش در زمینه پیشگیری از خشونت، خطوط یشگیری از بحران، خدمات پشتیبانی از بازماندگان و Warmline منتقل شده است تا هزینه های اصلی برنامه و/یا افزایش ظرفیت بر اساس نیازهای اعلام شده مشخص شود. علاوه بر آن، کمیته مدیریت MHSA، طرح HCA را تأیید کرده است تا بر اساس انونگذاری (AB) شماره 114 در رابطه با برنامه های PEI موجود در طول سال مالی 19-2018، هزینه های ارجاعی PEI ، شود. توصیفی از هر برنامه در بخش های انجمن و پشتیبانی از افراد/خانواده ارائه شده است.

نوآوری

I 5% از هزینه کانتی را به مؤلفه نوآوری اختصاص داده است. در این مؤلفه منابع مالی به صورت کاملاً مشخص صرف .های جدیدی می شوند که به جای توسعه ارائه خدمات در زمینه یادگیری هستند. این پروژه ها دارای مدت زمان محدود و حداکثر ه هستند، کارآمدی آنها مورد ارزیابی قرار گرفته است و منابع مالی جایگزین برای ادامه تأمین منابع مالی آنها در نظر گرفته شده مه پروژه های فعال در بخش های انجمن و پشتیبانی از افراد/خانواده توصیف شده است.[1]

ر آن HCA درحال گسترش دو پروژه فن آوری با تمرکز بر سلامت روانی است که هدف آنها افزایش دسترسی به خدمات است *ی پروژه های خاص مراجعه کنید)*. یکی از موارد پیشنهادی، ملحق شدن به پروژه "راهکارهای فن آوری در زمینه سلامت است که یک پروژه همکاری در سطح کانتی است، توسط کانتی های لس آنجلس و کرن پیشنهاد شده است و مورد تأیید کمیته و بررسی بر خدمات سلامت روانی (MHSOAC) مورد تأیید قرار گرفته است. HCA نیز درحال حاضر با کارفرمایان انجمن د دارد تا این موارد به صورت جامع اجرا شوند و از فن آوری در جهت بهبود دسترسی به مسکن و دیگر منابع سلامت رفتاری شود. کمیته مدیریت MHSA نیز طرح HCA را برای صرف هزینه های ارجاعی AB 114 برای پروژه های موجود و در ، امکان پروژه هایی که اخیراً تأیید شده اند پذیرفته است تا به این روش تا حد امکان در مصرف هزینه های ارجاعی صرفه جویی

آموزش و پرورش نیروی کار

خش آموزش و پرورش نیروی کار (WET)، افزایش نیروی کار خدمات سلامت روانی و بهبود مهارت های زبانی و فرهنگی است. بودجه سالیانه ای که به WET تعلق می گیرد 5,150,282 دلار برای سال مالی 19-2018 است، با این وجود منابع مالی از تشویق مالی و آموزش و کمک فنی به پشتیبانی پرسنل نیروی کار منتقل شده است تا هزینه های اصلی برنامه مشخص شود. ، کاملی از هر برنامه در بخش پشتیبانی سیستم BHS ارائه شده است.

---

[1] تحقیقات بیشتر در زمینه پروژه های باقیمانده دور 3، چنین نتیجه گیری شد که ایده ها و نظریات ارائه شده در بخش های "آموزش سلامت ، مخصوص کودکان برای رهبران مذهبی"، "غربالگری مهاجرین و ارجاع داده شدگان" و "اقدام جهت بهبود کامل افراد" درحال حاضر در های دیگری اعمال شده اند و احتمال اینکه مورد تأیید MHSOAC قرار بگیرند وجود ندارد.

رأی دهندگان در کالیفرنیا در نوامبر 2004 پیشنهاد 63 را به تصویب رساندند که به آن قانون خدمات سلامت روانی (MHSA) نیز گفته می شود. بر اساس این قانون، مالیات ایالتی 1% بر درآمد بالاتر از 1 میلیون وضع می شود و در آن بر تبدیل سیستم سلامت روانی تأکید می شود تا از این روش کیفیت زندگی افرادی که دچار بیماری های روانی هستند و خانواده آنها بهبود یابد. برنامه های سلامت روانی با 13 سال تأمین منابع مالی توانسته اند پاسخگوی نیازهای قشر متنوعی از افراد در هرکدام از کانتی های کالیفرنیا باشند. در نتیجه انجمن های محلی و ساکنین این انجمن ها همگی از مزایای گسترده ای برخوردار هستند و می توانند به خدمات سلامت روانی پیشرفته دسترسی داشته باشند.

در خدمات سلامت رفتاری اورنج کانتی (BHS) از یک روند جامع کارفرما استفاده می شود تا برنامه های MHSA، از خدمات پیشگیرانه تا خدمات مراقبتی از ساکنین در شرایط بحرانی توسعه یابند. تمرکز اصلی در توسعه و اعمال همه برنامه ها بر همکاری انجمن، شایستگی فرهنگی، خدمات مبتنی بر مشتری و خانواده، یکپارچگی خدمات برای مشتریان و خانواده ها، اولویت خدمات رسانی به افرادی که از خدمات برخوردار نیستند یا خدمات مناسبی دریافت نمی کنند و همچنین تمرکز بر سلامت، بهبود و ارتجاع است. طیف فعلی خدمات شامل بودجه سالیانه 218.9 میلیون برای سال مالی 19-2018 است که به صورت پلکانی افزایش یافته است که در ابتدا بر عملکرد کارفرمایان در سال 2005 تمرکز شده و تا به امروز ادامه یافته است.

به روز رسانی طرح سالیانه سال مالی 19-2018 MHSA در اورنج کانتی ("به روز رسانی طرح" یا "به روز رسانی") و تبدیل آن به برنامه سه ساله و طرح میزان مصرف برای سال های مالی 18-2017 تا 20-2019 توسط هیئت ناظرین در 2018 MONTH تأیید شد. در این به روز رسانی، بودجه "خدمات و پشتیبانی های انجمن" و مؤلفه های "امکانات کلان" و "نیازهای فن آوری" افزایش یافته اند، در همین حال بودجه مربوط به مؤلفه های "پیشگیری و اقدام زودهنگام" و "آموزش و پرورش نیروی کار" همچنان حفظ شده و دوباره توزیع شده است.

روند بررسی بودجه و "تلفیق"

به عنوان بخشی از بررسی مالی جهت آماده سازی برای به روز رسانی طرح سالیانه فعلی، BHS روند دقیقی از همتراز کردن بودجه های برنامه فعلی با هزینه های آخرین سال مالی (یعنی سال مالی 17-2016) در برنامه اصلی را اجرا می کند. "تلفیق" بودجه که در پاییز 2017 انجام شده است به مدیران امکان می دهد روش های کاهش هزینه برای برنامه هایی که امکان انتقال آنها وجود دارد شناسایی شود تا از افزایش بودجه جلوگیری شده و/یا هزینه سایر برنامه ها در مؤلفه مشابه به کار گرفته شود. معمول ترین منبع کاهش هزینه، منابع مالی حقیقی یا پیش بینی شده ای است که در طی توسعه یک برنامه و/یا مرحله اعمال و به کار گیری (مثل صرفه جویی با پرداخت دستمزد کمتر، کم کردن تعداد افراد و دیگر موارد) بلااستفاده باقی مانده اند.

مؤلفه های MHSA و دسته بندی های تأمین مالی

تأمین مالی MHSA به پنج مؤلفه تقسیم می شود که بر اساس قانون تعریف شده اند: خدمات و پشتیبانی های انجمن، پیشگیری و اقدام زودهنگام، نوآوری، آموزش و پرورش نیروی کار، امکانات کلان و نیازهای فن آوری. علاوه بر آن، در بخش خدمات و پشتیبانی های انجمن ممکن است منابع مالی به پشتیبانی از مسکن MHSA تعلق گیرد. توصیفی مختصر و سطح بودجه بندی برای هرکدام از این موارد در زیر ارائه شده است.

مؤلفه خدمات و پشتیبانی انجمن

خدمات و پشتیبانی انجمن (CSS) بزرگترین مؤلفه از بین پنج مؤلفه MHSA است و 76% از بودجه خدمات سلامت روانی است. در این بخش، درمان جامع در حیطه سلامت روانی برای افرادی در همه سنین که دارای اختلال های جدی حسی (SED) یا بیماری های جدی روانی (SMI) هستند ارائه می شود. CSS در جهت افزایش دسترسی گروه هایی که از خدمات مناسب برخوردار نیستند به این خدمات، افزایش کیفیت ارائه خدمات و بهبود نتایج و ارتقای همکاری های درون سازمانی تلاش می کند فعالیت های امیدبخشی را در این زمینه ها داشته باشد.

چندین تغییر مهم در برنامه های CSS در به روز رسانی طرح سالیانه سال مالی 19-2018 اعمال شده است:

- "مربی همتا" با هدف پشتیبانی از افراد در چندین گروه جدید توسعه یافته است:
  - افرادی از همه سنین که خدمات را در کلینیک های بیماران سرپایی کانتی دریافت می کنند
  - بزرگسالان بی خانمان که برای طرح مراقبت های کامل شخصی (Whole Person Care) واجد شرایط هستند
  - بزرگسالانی که در تحت برنامه Senate Bill (SB) 82 Triage Grant هستند که اعتبار آن در تاریخ 30 ژوئن 2018 تمام شده است

مؤلفه امکانات کلان و نیازهای فن آوری

مؤلفه امکانات کلان و نیازهای فن آوری (CFTN) که در حال حاضر از طرف CSS تأمین مالی می شود، هزینه مربوط به طیف گسترده ای از پروژه ها را تأمین می کند تا از سیستم ارائه خدمات پشتیبانی شود. مبلغ کل 9.2 میلیون دلار به بخش امکانات کلان منتقل شده است تا منابع مالی دو پروژه در سال های مالی 19-2018 تأمین شود: 9 میلیون دلار برای خرید ملکی برای خدمات ارائه شده در محل و 200000 دلار برای نوسازی ساختمان به کار رفته برای خدمات مرکزی جوانان. علاوه بر آن اورنج کانتی مبلغ 3,756,082 دلار را به مؤلفه نیازهای فن آوری منتقل کرده است تا همچنان سوابق سلامت الکترونیکی BHS (EHR) ثبت شود. توصیف کاملی از همه پروژه ها در بخش توصیف CFTN در بخش پشتیبانی سیستم BHS ارائه شده است.

مسکن

با هدایت و رهبری هیئت ناظرین، مبلغ 20 میلیون دلار در طول پروسه برنامه ریزی انجمن در سال مالی 18-2017 جمع آوری شد تا مسکن دائمی از طریق برنامه تأمین مسکن و نیازهای خاص MHSA توسعه یابد. بعضی از منابع مالی از قبل به چندین پروژه در زمینه توسعه اختصاص داده شد و در نتیجه اورنج کانتی همچنان می تواند گزینه های مسکن دائمی را برای کسانی که دارای SMI هستند ایجاد کند. توصیف هر پروژه در بخش پشتیبانی افراد/خانواده در به روز رسانی این طرح ارائه شده است.

سازماندهی مجدد به روز رسانی طرح سالیانه

برنامه ها قبلاً با توجه به مؤلفه های مالی خود در طرح سازماندهی شده اند (مثل CSS، PEI و دیگر موارد). با این وجود این ساختار لزوماً سبب ارتقای شناخت عملکرد برنامه ها یا نحوه ارتباط بین آنها نمی شود. برای برطرف کردن این محدودیت، به روز رسانی طرح فعلی دوباره در دو گروه سازماندهی شده است: (1) سطح پشتیبانی که نشان دهنده هدف اولیه برنامه از اقدام/پشتیبانی است (یعنی انجمن، افراد/خانواده، سیستم BHS) و (2) عملکرد سرویس که نشان دهنده هدف اولیه خدمات ارائه شده است (پیشگیری، خدمات بحران، خدمات مربوط به بیماران سرپایی و دیگر موارد). عملکردهای سرویس و برنامه های MHSA که در آنها جای گرفته اند، به صورت دقیق تر در این به روز رسانی طرح توضیح داده شده اند. هرچند که بعضی از برنامه ها چندین سطح پشتیبانی را شامل می شوند (افراد/خانواده، انجمن)، اما با توجه به عملکرد اصلی سرویس دسته بندی می شوند.

ساختار سازمانی طرح MHSA

از زمان تصویب پیشنهاد 63، این قانون مرتباً درحال تغییر و تحول بوده و تلاش شده زندگی کسانی که دارای بیماری های روانی هستند، خانواده آنها و کل انجمن اورنج کانتی بهبود یابد. همچنان در تلاش هستیم همکاری خود را با کارفرمایان خود ادامه دهیم همانطور که MHSA را در اورنج کانتی اجرا کردیم.

종합 보고 개요 (KOREAN)

2004년 11월, 캘리포니아의 투표자들에 의해 Mental Health Services Act(정신 건강 서비스법, MHSA)라고도 알려진 Proposition 63(제안 63)이 통과되었습니다. 본 법률은 1백만 달러 이상의 소득에 1%의 주민세를 부과했으며, 정신 질환을 가지고 있는 개인과 그 가족의 삶의 질을 향상시킬 수 있는 정신 건강 복지 시스템의 변화를 강조합니다. 정신 건강 프로그램은 13년 동안의 재정 지원을 통해 캘리포니아 내 모든 카운티의 다양한 고객 필요를 충족할 수 있도록 조정되었습니다. 그 결과 지역 커뮤니티와 그 거주자들은 더욱 확대되고 향상된 정신 건강 서비스 혜택을 받게 되었습니다.

Orange County Behavioral Health Services(행동 건강 서비스, BHS)는 종합적인 이해관계자 절차를 통해 예방 서비스부터 위기 자택 간호를 아우르는 지역 MHSA 프로그램을 개발하였습니다. 모든 프로그램 개발 및 실행의 핵심은 커뮤니티 협력, 문화적 능력, 고객 및 가족 중심 서비스, 고객과 가족을 위한 서비스 통합, 서비스를 받지 못하거나 지원이 부족한 대상을 위한 우선 서비스 제공, 복지, 회복 및 쾌유에 중점을 두고 있습니다. 회계연도 2018~2019년 한 해 2억 1천8백9십만 달러의 예산이 책정된 서비스의 구성은 2005년 이해관계자들의 기획 노력을 시작으로 오늘날까지 점차 향상되었습니다.

시 의회는 회계연도 2017~2019년도부터 2019~2020년까지의 3년 계획 프로그램과 지출 플랜에 대한 Orange County 회계연도 2018~2019년 MHSA 연간 플랜 업데이트("플랜 업데이트" 또는 "업데이트)를 2018년 X월 승인했습니다. 이 업데이트 내용은 커뮤니티 서비스와 지원, 자본 시설 및 기술적 필요 요소에 대한 재정을 늘리고 예방 및 초기 개입 서비스, 근로자 교육과 트레이닝 요소에 대한 재정을 유지하되 재분배하는 것입니다.

예산 검토 및 "True-Up" 절차

BHS는 현 연간 플랜 업데이트를 준비하는 과정에서 진행된 재정 검토의 일환으로, 최근 회계연도(즉 2016~2017년)부터 기존의 프로그램 예산을 실제 프로그램 지출에 더욱 근접하도록 조정하는 상세 절차를 밟았습니다. 2017년 가을에 진행된 예산 "True up"은 관리자들이 증가한 예산 보충 및/또는 동일한 요소 내 다른 프로그램의 실행 비용으로 전환될 수 있는 프로그램의 비용 절감 상황을 파악할 수 있도록 해주었습니다. 가장 대표적인 절감 부분은 프로그램 개발 및/또는 시행 중 사용되지 않고 남은 실제 혹은 예상 재정이었습니다(예: 급여 절감, 지원 대상 수 감소 등).

MHSA 요소 및 재정 범주

MHSA 재정은 법률에서 정의한 커뮤니티 서비스 및 지원, 예방 및 초기 개입, 혁신, 근로자 교육 및 트레이닝, 자본 시설 및 기술적 필요의 5가지 요소로 나누어집니다. 더불어 커뮤니티 서비스 및 지원은 MHSA 주택 지원을 위한 재정으로 할당될 수 있습니다. 각 영역에 대한 간략한 설명과 재정 수준은 아래와 같습니다.

커뮤니티 서비스 및 지원 요소

Community Services and Supports(커뮤니티 서비스 및 지원, CSS)은 MHSA의 다섯 가지 요소 중 가장 큰 부분을 차지하며 Mental Health Services Fund(정신 건강 서비스 재정)의 76%를 지원받습니다. 이 요소는 심각한 정서 장애(Serious Emotional Disturbance, SED) 또는 심각한 정신 질환(Serious Mental Illness, SMI)을 가지고 있는 모든 연령의 대상을 위한 종합적 정신 건강 치료를 지원합니다. CSS는 지원이 부족한 그룹에 대한 서비스 접근을 증가하고, 서비스의 질을 향상하며, 결과를 개선하고, 기관 간의 협력을 촉진하기 위해 고안한 입증 사례를 개발 및 실행합니다.

CSS 프로그램에 대한 몇 가지 중요한 변화가 회계연도 2018~2019 연간 플랜 업데이트에 다음과 같이 포함되었습니다:

- 몇 가지 새로운 구간에 속한 개인을 지원하기 위해 동료 멘토링이 확장되었습니다.
  - 카운티 외래환자 클리닉에서 서비스를 받는 모든 연령의 개인
  - Whole Person Care에 자격이 있는 성인 노숙자
  - 2018년 6월 30일 만료되는 Senate Bill(SB) 82 Triage Grant(상원 법안 82 분류 보조금)의 지원을 받는 성인
- Transitional Age Youth(과도기 청소년, TAY) Full Service Partnership(전체 서비스 파트너십, FSP)이 형사 사법 체계에 연루된 청소년을 추가로 지원하도록 확대되었습니다.
- 성인 FSP가 증가하는 주택 보조 및 거주형 치료 비용을 부담하도록 확대되었습니다.
- BHS 봉사 및 참여 활동이 전인적 치료에 해당하는 개인을 재정 지원하도록 확대되었습니다.
- 임상의 숫자를 확대하기 위해 Children's and TAY/Adult Crisis Assessment Team(아동 및 TAY/성인 위기 평가팀, CAT)의 재정을 늘렸습니다.
- 추가적인 징역형 발생을 줄이고 행동 건강 서비스로의 종합적인 방면 계획 및 연결 고리를 제공하기 위해 새로운 프로그램인 Correctional Health Services Jail to Community Re-Entry(감옥에서 지역사회로 돌아가기 위한 교정 의료 서비스)가 추가되었습니다.

그 결과 회계연도 2018~2019년의 CSS 예산은 145,612,490달러입니다. 상기 변경 내용을 포함하여 각 CSS 프로그램에 대한 상세 설명은 본 플랜의 커뮤니티 및 개인/가족 지원 섹션에 제공되어 있습니다.

예방 및 초기 개입 요소

MHSA는 정신 질환이 심각해지거나 장애로 발전되는 것을 예방하고, 정신 건강 시스템의 지원이 부족한 대상을 위한 적시의 서비스 접근을 개선하기 위한 Prevention and Early Intervention(예방 및 초기 개입, PEI) 요소에 재정의 19%를 할당합니다. 회계연도 2018~2019년의 전체 연간 예산 수준은 35,452,761달러이지만, 실제 프로그램 지출 반영 및/또는 증명된 필요에 따라 서비스 능력 향상을 위해 트레이닝, 평가 및 조정 서비스 프로그램에서 폭력 예방 교육, 위기 예방 핫라인, 감독 지원 서비스 및 전화 상담 프로그램으로 전환되었습니다. 또한 MHSA 운영 위원회는 Assembly Bill(국회 법안, AB) 114에 따라 회계연도 2018~2019년 동안 기존의 PEI 프로그램에 귀속 PEI 자금을 사용하고자 하는 HCA의 플랜을 승인했습니다. 각 프로그램에 대한 설명은 커뮤니티 및 개인/가족 지원 섹션에 제공되어 있습니다.

혁신 요소

MHSA는 의회 할당량의 5%를 서비스 전달의 확대보다는 학습에 투자하는 새로운 접근 방식을 시도하기 위한 재정용으로 특히 집중하는 혁신 요소에 지정하였습니다. 프로젝트는 최대 5년까지로 기간 제한되어 있으며, 대안적인 자원을 통해 지속적인 재정 지원을 위한 고려 사항 및 효율성을 평가합니다. 모든 활성 프로그램에 대한 설명은 커뮤니티 및 개인/가족 지원 섹션에 제공되어 있습니다.[1]

[1] 나머지 Round 3 프로젝트에 대한 추가적인 조사에 따라, 종교 지도자를 위한 아동 집중 정신 건강 트레이닝, 이민자 건강검진 및 위탁, 전인적 회복 계획 제안의 개념/아이디어는 다른 방식으로 실행되고 있는 것으로 판단되어 MHSOAC의 승인을 받지 못할 것으로 예상됩니다.

또한 HCA는 서비스 접근을 향상하기 위한 정신 건강 중심의 기술 프로젝트 두 가지를 개발 중입니다(특별 프로젝트 섹션 참조). 한 가지 제안은 Los Angeles 및 Kern County에서 최초 제안하고 Mental Health Services Oversight and Accountability Commission(정신 건강 서비스 감독 및 책임 위원회, MHSOAC)에서 승인한 카운티 간 협력 프로젝트인 Mental Health Technology Solutions(정신 건강 기술 솔루션) 프로젝트에 동참하는 것입니다. 또한, HCA는 주택 및 기타 행동 건강 자원에 대한 접근성을 향상하는 기술을 활용할 수 있는 통합 적용 방식을 개발하기 위해 커뮤니티 이해관계자들과 함께 협력하고 있습니다. MHSA 운영 위원회는 자금이 반환되는 것을 최대한 방지하는 방식으로, AB 114 귀속 INN 재정을 기존 프로젝트는 물론, 가능한 경우 새롭게 승인된 프로젝트에 사용하고자 하는 HCA의 플랜을 승인하였습니다.

직원의 문화적 및 언어적 능력을 향상하기 위해 개발되었습니다. WET은 회계연도 2018~2019년 한 해 예산 수준을 5,150,282달러로 유지하나, 실제 프로그램 지출을 반영하여 재정을 자금 혜택 프로그램과 교육 및 기술 지원에서 근로자 직원 지원으로 전환하였습니다. 각 프로그램에 대한 전체 설명은 BHS 시스템 지원 섹션에 제공되어 있습니다.

자본 시설 및 지원 필요 요소

Capital Facilities and Technology Need(자본 시설 및 기술 필요, CFTN) 요소는 서비스 전달 시스템을 돕는 데 필요한 광범위 프로젝트에 재정을 지원하며, 자금은 현재 CSS를 통해 지원됩니다. 회계연도 2018~2019년에는 두 개의 프로젝트를 지원하기 위해 총 920만 달러의 재정이 자본 시설로 전환되었습니다. 이 중 9백만 달러는 장소 공유 서비스를 위한 부동산을 구매를 위해, 20만 달러는 청소년 핵심 서비스에 사용될 건물 보수에 지출됩니다. 또한 Orange County는 BHS Electronic Health Record(전자 건강 기록, EHR)의 지속적인 실행을 위해 3,756,082달러를 기술적 필요 부문에 전환했습니다. 모든 프로젝트에 대한 전체 설명은 BHS 시스템 지원 섹션의 CFTN 설명에 제공되어 있습니다.

주택

시 의회의 지시에 따라, 회계연도 2017~2018년 동안 영구적인 주택 지원 개발을 위해 2000만 달러가 MHSA Special Needs Housing Program(특별 수요 주택 프로그램)을 통해 Community Planning Process(커뮤니티 계획 과정)에 할당되었습니다. 일부 재정은 이미 개발 중인 일부 프로젝트에 할당되었으며, Orange County가 SMI이 있는 대상을 위한 영구적인 주택 옵션을 만들어갈 수 있도록 지원할 것입니다. 각 프로젝트에 대한 설명은 본 플랜 업데이트의 개인/가족 지원 섹션에 제공되어 있습니다.

연간 플랜 업데이트 재구성

프로그램들은 플랜 안에서 재정 요소에 따라 구성되었습니다 (예: CSS, PEI 등). 하지만 이러한 구조는 프로그램의 역할이나 프로그램 간의 관계를 이해하는 데 필요한 도움을 제공하지 못했습니다. 이러한 한계를 해결하기 위해 현 플랜 업데이트는 프로그램이 개입/지원하는 우선 *목표 대상*을 반영한 (1) 지원 수준(예: 커뮤니티, 개인/가족, BHS 시스템), 그리고 제공되는 서비스의 우선 *목적*을 반영한 (2) 서비스 기능(예: 예방, 위기 서비스, 외래환자 서비스 등)의 두 계층으로 재구성되었습니다. 서비스 기능과 이에 포함된 MHSA 프로그램에 대한 자세한 설명은 본 플랜 업데이트에 제공되어 있습니다. 일부 프로그램은 여러 지원 수준(예: 개인/가족, 커뮤니티)에 해당하지만, 우선하는 서비스 기능에 따라 구분되었습니다.

MHSA 플랜 조직 구조

Proposition 63이 통과된 올해 동안 본 법률은 지속적으로 진화하였으며, 정신 질환을 가지고 있는 대상과 그들의 가족, 그리고 전체 Orange County 커뮤니티의 보다 나은 삶을 지원해왔습니다. 앞으로도 Orange County의 MHSA 실행을 위한 여러 이해관계자들과의 파트너십을 기대합니다.

PERSPECTIVA GENERAL Y RESUMEN EJECUTIVO (SPANISH)

En Noviembre del 2004, los votantes de California aprobaron la Proposición 63, también conocida como la Ley de Actualización de Servicios de Salud Mental (MHSA). La Ley implementó un impuesto estatal del 1% sobre los ingresos más de $1 millon de dolares, y subraya la transformación del sistema de salud mental para mejorar la calidad de vida de las personas que viven con enfermedades mentales y a sus familias. Con 13 años de financiación, los programas de salud mental han sido diseñados para satisfacer las necesidades de una clientela diversa en cada condado de California. Como resultado, las comunidades locales y sus residentes están disfrutando los beneficios de la apliación y mejoramiento de los servicios de salud mental.

Orange County Behavioral Health Services (BHS)/Servicios de Salud del Comportamiento del Condado de Orange ha utilizado un proceso amplio de personas concernientes para desarrollar programas de MHSA locales desde los servicios de prevención hasta cuidado residencial para crisis. El desarrollo e implementación de todos los programas es el enfoque de colaboración comunitario, competencia cultural, servicios para bienes del consumidor y la familia, integración de servicios para los consumidores y las familias, prioridad de servicios para server a las personas marginadas y desatendidas, y se centran en el bienestar, la recuperación y la resistencia. La gama de servicios actual, con un presupuesto anual de $218.9 millones de dolares para el Año Fiscal 2018-2019, se desarrolló gradualmente, comenzando con la planificación de esfuerzos de partes interesadas en 2005 y continúa hasta la actualidad.

El Plan de Actualización de MHSA del Año Fiscal 2018-2019 (“Plan de actualización” o “Actualización”) en el programa trienal y el Plan de gastos para los años fiscales 2017-2018 a 2019-2020 fue aprobado por la Junta de Supervisores en MONTH IN SPANISH del 2018. Esta actualización aumenta la financiación para los servicios comunitarios y apoya las instalaciones capitales, necesidades y componentes tecnológicos.; y mantiene y re-distribuye la financiación dentro de los components de prevención y la intervención temprana y la Fuerza Laboral de Capacitación de Educación y Formación.

Revisión del presupuesto y el proceso “verdadero”

como parte del proceso de revisión fiscal realizado en la preparación del plan de actualización anual, BHS participó en un proceso de alineamiento de presupuestos y programas existentes detallado, con los gastos reales del programa del año fiscal más reciente (es decir, del Año Fiscal 2016-17). Este presupuesto “verdadero”, que tuvo lugar en otoño de 2017, permitió a los administradores de identificar ahorros de costos para programas que podrían ser transferidos para cubrir los aumentos de presupuesto y/o costos de implementación de otros programas dentro del mismo componente. La fuente más común de ahorro fue actual o fondos anticipados que no se gastaron durante el desarrollo del programa y/o fase de implementación (por ejemplo, sueldos de ahorro, número de individuos servidos reducido, etc.)

Categorías de Financiación y Componenetes de MHSA

La financiación de MHSA se divide en cinco componentes que están definidas por la ley: Servicios Comunitarios y Apoyo a la Comunidad, la Prevención y la Intervención Temprana, Innovación, Fuerza Laboral de la Educación y la Formación, Instalaciones Capitales y Necesidades Tecnológicas. Además, los Servicios Comunitarios y Apoyo pueden asignar fondos para apoyar la vivienda de MHSA. Una breve descripción y el nivel de financiación para cada una de estas áreas se proporciona abajo.

Componente de Servicios Comunitarios y de Apoyos Comunitarios

Apoyo y Servicios Comunitarios (CSS) es el más grande de los cinco componentes de MHSA y recibe el 76% de los fondo de los servicios de salud mental. Apoya el tratamiento comprensivo de servicios de salud mental para las personas de todas las edades que viven con serious emotional disturbance (SED)/trastornos emocionales graves o serious mental illness (SMI)/enfermedades mentales graves. CSS desarrolla e implementa practices prometedoras diseñadas para aumentar el acceso de los grupos desatendidos a los

Después de investigaciones adicionales sobre el resto de los proyectos de la Ronda 3, se determinó que los con ceptos e ideas presentados en la Capacitación de Salud Mental centrada en los niños para dirigentes religiosos; Evaluaciones y Referencias para Inm igrante; y la iniciativa y propuestas de Curación de toda persona están siendo implementadas en otros lugares y es poco probable que reciba aprobación de MHSOAC.

servicios, mejorar la calidad de los servicios, mejorar los resultados y promover la colaboración interinstitucional.

Varios cambios significativos a programas de CSS fueron incorporadas en el Plan de Actualización y Año Fiscal de 2018-19:

- Tutoría de pares fue ampliado para apoyar a las personas en varios nuevos circuitos:
  - individuos de todas las edades que reciben servicios en clinícas ambulatoirias del condado
  - adultos sin hogar elegible para cuidado de persona íntegra
  - cuidado de adultos bajo el Proyecto de Ley Senatorial (SB) 82 del programa de subvención, que vence el 30 de junio del 2018
- Transitional Age Youth (TAY)/Los Jóvenes en Edad de Transición, Full Service Partnerships (FSP)/ Asociaciones de Servicio Completo fueron ampliados para servir a los jóvenes que participan en el sistema de justicia penal.
- Programs de FSP para adultos se extendieron aumentando la asistencia de vivienda y los costos del tratamiento residencial.
- El programa de Alcance y Participación de BHS se amplió para las personas elegibles para recibir cuidado de la persona íntegra.
- Children's and TAY/Adult Crisis Assessment Teams (CATs)/Los Equipos de evaluación de niños y TAY, recibieron un aumento de financiación para ampliar el número de profesionales clínicos.
- Un programa Nuevo, servicios de salud correccional de la cárcel y reentrada a la Comunidad, fue agregado para proporcionar planificación del alta integrales y vinculación a los servicios de salud del comportamiento con el objetivo de reducir encarcelamientos subsecuentes.

El presupuesto resultante de CSS para el Año Fiscal de 2018-19 es de $145,612,490. Una descripción completa de cada programa de CSS, incluyendo los cambios anteriores, esta disponible en la sección del plan de la Comunidad y el individuo/familia.

Componente de La prevención y la intervención temprana de MHSA

MHSA dedica 19% de su asignación para la Prevención y la intervención temprana (PEI), cual el objetivo es de prevenir que la enfermedad mental sea grave e incapacitante y para mejorar el acceso oportuno a las personas que son desatendidas por el sistema de salud mental. El componente mantuvo un nivel general del presupuesto anual de $35,452,761 para el Año Fiscal 2018-19, aunque los fondos fueron transferidos de la formación, la evaluación y la coordinación de los servicios del programa de Educación para la Prevención de la Violencia, Línea gratuita de Prevención de Crisis, y servicios de apoyo para el sobreviviente y programas Warmline para reflejar los gastos reales del programa y/o aumentar la capacidad de servicio basados en la necesidad demostrada. Además, el Comité Directivo de MHSA aprobó el plan de HCA de gastar fondos revertidos de PEI, por la facture de la asamblea (AB) 114, sobre los actuales programas de PEI, durante el Año Fiscal 2018-19. Una descripción de cada programa esta disponible en la sección del plan de la Comunidad y el individuo/familia.

Componente de Innovación

MHSA designa el 5% de una asignación del condado para el componente de innovación, que específicamente y exclusivamente dedica fondos para probar nuevos enfoques que contribuyen al aprendizaje en lugar de ampliar la prestación de servicios. Los proyectos tienen una duración limitada a un máximo de cinco años y se evalua su eficacia y consideración para la continuación de la financiación a través de una fuente alternativa. Todos los proyectos se describen en la sección del plan de la Comunidad y el individuo/familia.

Además, HCA (Agencia de Cuidado de la Salud) está desarrollando dos proyectos de tecnología centrados en la salud mental destinados a aumentar el acceso a los servicios (ver la sección de proyectos especiales). Una propuesta es de unir las soluciones de tecnología de la Salud Mental, un proyecto transversal, propuesta inicialmente por la colaboración del condado de Los Angeles y los condados de Kern y aprobado por los Servicios de Salud Mental de la Comisión de supervisión y rendición de cuentas (MHSOAC). HCA también actualmente esta trabajando con las personas concernientes de la comunidad para desarrollar una aplicación integrada que permitan aprovechar la tecnología para mejorar el acceso a la vivienda y

Después de investigaciones adicionales sobre el resto de los proyectos de la Ronda 3, se determinó que los conceptos e ideas presentados en la Capacitación de Salud Mental centrada en los niños para dirigentes religiosos; Evaluaciones y Referencias para Inmigrante ; y la iniciativa y propuestas de Curación de toda persona están siendo implementadas en otros lugares y es poco probable que reciba aprobación de MHSOAC.

otros recursos de salud del comportamiento. El Comité Directivo de MHSA asimismo aprobó el plan del HCA para gastar los fondos existentes de AB 114 y si procede, los proyectos recientemente aprobados en la forma en que protege al máximo los fondos de reversión.

Componente de Fuerza Laboral de Educación y Formación

Workforce Education and Training (WET)/Fuerza Laboral de Educación y Formación se destina a aumentar el personal y los servicios de salud mental para mejorar el personal de competencia cultural y lingüística. WET mantuvo un nivel de presupuesto anual de $5,150,282 para el Año Fiscal 2018-19, aunque los fondos fueron transferidos de los incentivos financieros y de programas de capacitación y asistencia técnica para la plantilla de personal de apoyo para reflejar los gastos reales del programa. Una descripción completa de cada programa se proporciona en la sección de soporte del sistema BHS. Una descripción de cada programa esta disponible en la sección del plan del sistema de BHS.

Componente de Instalaciones de Capital y Necesidades de Tecnología

El componente de Capital Facilities and Technology Needs (CFTN)/ Instalaciones de Capital y Necesidades de Tecnología financia una amplia gama de proyectos necesarios para apoyar el sistema de entrega de servicio y actualmente es financiado a través de CSS. Un total de 9,2 millones de dólares fue trasladado a las instalaciones de capital para financiar dos proyectos en el Año Fiscal de 2018-19: $9 millones de dolares para la compra de una propiedad de Servicios Comunes y $200,000 dólares para la renovación de un edificio utilizado para Servicios Centrales para Jóvenes. Además, el Condado de Orange transfirió $3,756,082 a las necesidades tecnológicas para implementación continua de los BHS Electronic Health Record (EHR)/Archivos médicos electrónico. Una descripción de cada programa esta disponible en la sección de CFTN, del plan del sistema de BHS.

Vivienda

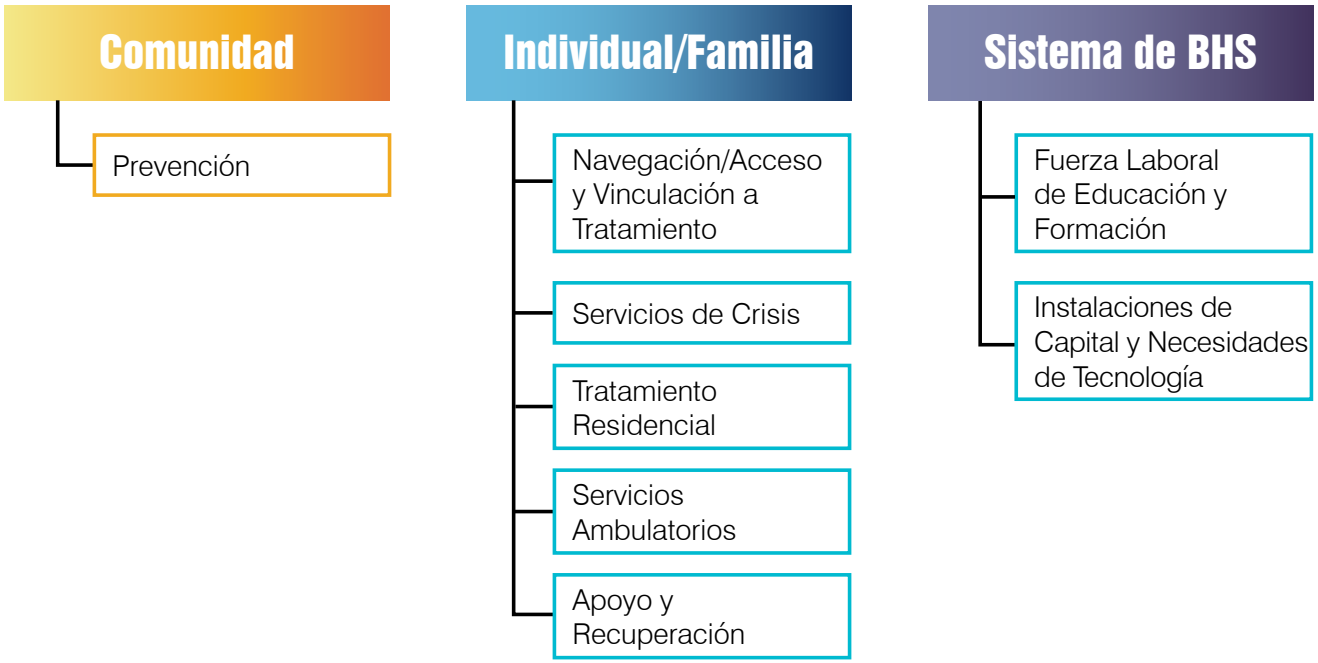
Bajo la dirección de la Junta de Supervisores, se asignaron $20 millones de dólares durante el Proceso de Planificación Comunitario del Año Fiscal 2017-18 para desarrollar vivienda de apoyo permanente a través del programa de las Necesidades Especiales de Vivienda. Algunos fondos ya se han asignado para varios proyectos en desarrollo y permitirán que el Condado de Orange continue creando opciones de vivienda permanente para quienes viven con una enfermedad mental grave. Una descripción de cada proyecto se proporciona en la Sección de Apoyo a la familia/individuales de esta actualización del Plan. Una descripción de cada programa esta disponible en la sección del plan del sistema de BHS.

Después de investigaciones adicionales sobre el resto de los proyectos de la Ronda 3, se determinó que los conceptos e ideas presentados en la Capacitación de Salud Mental centrada en los niños para dirigentes religiosos; Evaluaciones y Referencias para Inmigrante ; y la iniciativa y propuestas de Curación de toda persona están siendo implementadas en otros lugares y es poco probable que reciba aprobación de MHSOAC.

Reorganización del plan de Actualización Anual

Los programas fueron organizados previamente en el plan de acuerdo a su componente de financiación (es decir, CSS, PEI, etc.). Sin embargo, esta estructura no necesariamente promueve la comprensión de qué hicieron los programas o cómo se relacionan entre sí. Para superar esta limitación, el Plan actual de actualización ha sido re-organizado en dos niveles: (1) Nivel de Apoyo, que refleja el objetivo principal del programa de intervención y apoyo (es decir, la Comunidad, la persona o la familia, Sistema de BHS) y (2) la Función de Servicio, lo cual refleja la intención primordial de los servicios (es decir, la prevención de crisis, servicios, servicios ambulatorios, etc.). Las funciones de servicio y programs de MHSA contenidos dentro de ellos se describen en más detalle en este Plan de Actualización. Aunque algunos programas abarcan múltiples niveles de Apoyo (es decir, la persona, familia, comunidad), están clasificadas según su función de servicio principal.

Plan de Estructura Organizativa de MHSA



Durante los años transcurridos desde que se aprobó la Proposición 63, la ley ha seguido evolucionando y ayudar a mejorar las vidas de las personas que viven con una enfermedad mental, sus familias y toda la comunidad del Condado de Orange. Esperamos continuar nuestra asociación con personas concernientes, mientras implementamos la MHSA en el Condado de Orange.

Después de investigaciones adicionales sobre el resto de los proyectos de la Ronda 3, se determinó que los conceptos e ideas presentados en la Capacitación de Salud Mental centrada en los niños para dirigentes religiosos; Evaluaciones y Referencias para Inmigrante ; y la iniciativa y propuestas de Curación de toda persona están siendo implementadas en otros lugares y es poco probable que reciba aprobación de MHSOAC.

TỔNG QUAN VÀ TÓM LƯỢC (VIETNAMESE)

Vào tháng 11 năm 2004, cử tri California đã thông qua Dự luật 63, còn được gọi là Đạo Luật Dịch Vụ Y Tế Tâm Thần (MHSA). Đạo luật đã áp dụng thuế tiểu bang 1% vào thu nhập trên $1 triệu và chú trọng vào việc chuyển đổi hệ thống chăm sóc sức khoẻ tâm thần để nâng cao chất lượng cuộc sống cho những người có bệnh tâm thần và gia đình của họ. Với 13 năm tài trợ, các chương trình chăm sóc sức khoẻ tâm thần đã được điều chỉnh để đáp ứng nhu cầu của nhiều bệnh nhân khác nhau tại mỗi quận ở California. Kết quả là, những cộng đồng địa phương và cư dân ở đó đang được hưởng những lợi ích của những dịch vụ chăm sóc sức khoẻ tâm thần mở rộng và cải thiện.

Chương trình Dịch Vụ Sức Khoẻ Tâm Thần (BHS) Quận Cam đã áp dụng một tiến trình toàn diện với các thành phần có liên quan để phát triển các chương trình MHSA địa phương, bao gồm từ các dịch vụ phòng ngừa đến chăm sóc nội trú trong cơn khủng hoảng. Trung tâm của việc phát triển và thực hiện tất cả các chương trình là tập trung vào sự cộng tác cộng đồng, am tường văn hoá, dịch vụ do bệnh nhân và gia đình chủ động, dịch vụ kết hợp cho bệnh nhân và gia đình, ưu tiên cho những người chưa nhận được dịch vụ và chưa được phục vụ thoả đáng, và tập trung vào đời sống vui khoẻ, sự bình phục và kiên trì chống chọi với bệnh tật.

Mảng dịch vụ hiện tại, với ngân sách hàng năm là $218.9 triệu cho tài khoá 2018-19, đã được khai triển từng bước, bắt đầu từ nỗ lực lập kế hoạch của các thành phần có liên quan trong năm 2005 và tiếp tục đến ngày nay.

Bản Cập Nhật Kế Hoạch MHSA Hàng Năm cho tài khoá 2018-19 của Quận Cam ("Cập Nhật Kế Hoạch" hoặc "Cập Nhật") vào Kế Hoạch Chương Trình Ba Năm và Kế Hoạch Chi Tiêu cho các tài khoá từ 2017-18 đến 2019-20 đã được Ủy Ban Giám Sát thông qua vào tháng ___ 2018. Bản Cập Nhật này gia tăng thêm nguồn kinh phí cho các Dịch Vụ và Hỗ trợ Cộng Đồng và các thành phần Cơ Sở Nguồn Vốn và Đáp Ứng Nhu Cầu Kỹ Thuật, duy trì nhưng phân phối lại kinh phí trong những thành phần Phòng Ngừa và Điều Trị Sớm, và Đào Tạo và Huấn Luyện Lực Lượng Chuyên Môn.

Tái Xét Ngân Sách và Tiến Trình "Sát Với Thực Tế"

Là một phần của đánh giá tài chính được chuẩn bị cho Bản Cập Nhật Kế Hoạch Hàng Năm hiện hành, BHS đã trải qua một tiến trình tinh vi sắp xếp các ngân khoản cho những chương trình hiện tại chặt chẽ hơn với những chi tiêu thực tế của chương trình từ tài khoá gần đây nhất (tức là 2016-17). Ngân sách “sát với thực tế” này, được thực hiện vào mùa thu năm 2017, cho phép các nhà quản lý xác định được mức tiết kiệm chi phí cho các chương trình để có thể chuyển qua những trang trải vào các khoản tăng ngân sách và/hoặc chi phí thực hiện các chương trình khác trong cùng một thành phần. Nguồn tiết kiệm phổ biến nhất là số tiền thực tế hoặc dự kiến vẫn còn chưa xử dụng trong việc phát triển một chương trình và/hoặc giai đoạn thực hiện một chương trình (ví dụ: tiết kiệm tiền lương, giảm số người được phục vụ, v.v.).

Những Thành Phần MHSA và Các Thể Loại Ngân Sách

MHSA tài trợ được chia thành 5 thành phần được định nghĩa bởi Đạo Luật: Dịch Vụ Và Hỗ Trợ Cộng Đồng, Phòng Ngừa và Điều Trị Sớm, Cách Tân, Huấn Luyện và Đào Tạo Lực Lượng Chuyên Môn, Cơ Sở Nguồn Vốn và Đáp Ứng Nhu Cầu Kỹ Thuật. Ngoài ra, chương trình Dịch Vụ và Hỗ Trợ Cộng Đồng có thể phân bổ ngân quỹ để hỗ trợ chương trình nhà ở của MHSA. Mô tả ngắn gọn và mức độ tài trợ cho từng lĩnh vực này sẽ được trình bày dưới đây.

Thành Phần Dịch Vụ và Hỗ Trợ Cộng Đồng

Chương trình Dịch Vụ và Hỗ Trợ Cộng Đồng (CSS) là thành phần lớn nhất trong số năm thành phần của MHSA và nhận được 76% ngân quỹ Dịch Vụ Y Tế Tâm Thần. Thành phần này hỗ trợ việc chăm sóc sức khoẻ tâm thần toàn diện cho mọi người ở mọi lứa tuổi đang sống chung với tình trạng rối loạn cảm xúc nghiêm trọng (SED) hoặc bệnh tâm thần trầm trọng (SMI). CSS phát triển và thực hiện các ứng dụng đầy hứa hẹn hoặc đã được chứng minh nhằm tăng khả năng sự tiếp cận dịch vụ

của những người chưa được phục vụ, nâng cao chất lượng dịch vụ, nâng cao kết quả và thúc đẩy sự hợp tác giữa các cơ quan.

Một số thay đổi quan trọng trong chương trình CSS đã được đưa vào Bản Cập Nhật Kế Hoạch Hàng Năm năm 2018-19:

- Chương trình Tư Vấn Thân Hữu được mở rộng để hỗ trợ các cá nhân trong một vài hạng mục:
  - Các cá nhân thuộc mọi lứa tuổi đang hưởng dịch vụ tại các trung tâm điều trị ngoại trú của Quận
  - Những người trưởng thành vô gia cư được hội đủ điều kiện cho chương trình Chăm Sóc Con Người Toàn Diện
  - Những người trưởng thành đã phục vụ trong chương trình Senate Bill (SB) 82 Grant Triage Grant, hết hạn vào ngày 30 tháng 6 năm 2018
- Những Chương Trình Dịch Vụ Toàn Diện (FSPs) cho Thanh Thiếu Niên Tuổi Chuyển Tiếp (TAY) đã được mở rộng để phục vụ thêm những người trẻ có dính líu đến hệ thống Pháp Lý Hình Sự.
- Những FSP dành cho người trưởng thành được mở rộng để trang trải các chi phí hỗ trợ nhà ở và chăm sóc nội trú đang gia tăng.
- Chương Trình Tiếp Cận và Liên Kết BHS được mở rộng để tài trợ cho các cá nhân hội đủ điều kiện cho chương trình Chăm Sóc Con Người Toàn Diện.
- Đội Thẩm Định Tâm Lý Lúc Khủng Hoảng (CAT) cho Trẻ Em và TAY / Người Trưởng Thành được gia tăng ngân khoản để mở rộng thêm con số các nhà điều trị.
- Một chương trình mới, Dịch Vụ Sức Khoẻ Y Tế Trong Nhà Cải Huấn Để Giúp Tái Hội Nhập Cộng Đồng, được bổ sung để cung cấp kế hoạch toàn diện khi ra tù và liên kết với các dịch vụ chăm sóc sức khoẻ tâm thần nhằm mục đích giảm thiểu các vụ bắt giam sau này.

Kết quả ngân sách của CSS cho tài khoá 2018-19 là $145,612,490. Bản mô tả đầy đủ về mỗi chương trình CSS, bao gồm những thay đổi kể trên, được cung cấp trong phần Hỗ Trợ Cộng Đồng và Cá Nhân / Gia Đình trong Bản Kế Hoạch này.

Thành Phần Phòng Ngừa và Điều Trị Sớm

MHSA dành 19% khoản phân bổ cho chương trình Phòng Ngừa và Điều Trị Sớm (PEI) nhằm ngăn ngừa bệnh tâm thần trở nên trầm trọng và làm mất chức năng con người, và để cải thiện việc tiếp cận kịp thời những người chưa được phục vụ bởi hệ thống chăm sóc sức khoẻ tâm thần. Thành phần này duy trì một mức ngân sách hàng năm tổng thể là $35,452,761 cho tài khoá 2018-19, mặc dù các ngân khoản đã được chuyển từ chương trình Đào tạo, Dịch Vụ Thẩm Định và Điều Hợp đến những chương trình Giáo Dục Ngăn Ngừa Bạo Lực, Đường Dây Nóng Phòng Chống Khủng Hoảng, Dịch Vụ Hỗ Trợ Người Trải Qua Biến Cố và Đường Dây Ấm để phản ánh chi tiêu thực tế và/hoặc gia tăng khối lượng dịch vụ dựa trên nhu cầu đã được chứng minh. Ngoài ra, Ban Chỉ Đạo MHSA đã phê duyệt kế hoạch của HCA trong việc tiêu dụng các ngân khoản đã thu hồi của PEI, theo Dự Thảo Luật (AB) 114, đối với các chương trình PEI hiện hữu trong tài khoá 2018-19. Mô tả chi tiết của mỗi chương trình được cung cấp trong phần Hỗ Trợ Cộng Đồng và Cá Nhân / Gia Đình.

Thành Phần Cách Tân

MHSA chỉ định 5% khoản phân bổ của Quận cho thành phần Cách Tân, dành cụ thể và riêng biệt cho những ngân khoản để thử các phương pháp tiếp cận mới góp phần vào việc nghiên cứu thay vì mở rộng việc cung cấp dịch vụ. Các dự án được giới hạn trong thời gian tối đa là năm năm, và được đánh giá tính hiệu quả và xem xét việc tiếp tục tài trợ thông qua một nguồn khác. Tất cả các dự án đang hoạt động được mô tả trong phần Hỗ Trợ Cộng Đồng và Cá Nhân / Gia Đình. (1)

Ngoài ra, HCA đang xây dựng hai dự án kỹ thuật hướng tới sức khoẻ tâm thần nhằm gia tăng sự tiếp cận với các dịch vụ (xin xem phần Dự Án Đặc Biệt). Có một đề xuất về việc tham gia vào dự án Giải Pháp Kỹ Thuật Cho Sức Khỏe Tâm Thần,

(1) Sau khi nghiên cứu thêm những dự án còn lại ở Vòng 3, những khái niệm / ý tưởng được trình bày trong các kiến nghị về Lớp Giảng Dạy Về Sức Khoẻ Tâm Thần Tập Trung Vào Trẻ Em Cho Những Nhà Lãnh Đạo Tôn Giáo; Truy Tầm Bệnh và Giới Thiệu Điều Trị Cho Di Dân; Sáng Kiến Về Chữa Lành Con Người Toàn Diện được xác định là đang được thực hiện ở những nơi khác và không thể được MHSOAC chấp thuận.

một sự hợp tác giữa các quận ban đầu do các quận Los Angeles và Kern đề nghị và đã được Ủy Ban Giám Sát và Trách Nhiệm Sức Khoẻ Tâm Thần (MHSOAC) thông qua. HCA hiện đang làm việc với các thành phần có liên quan trong cộng đồng để phát triển một ứng dụng kết hợp nhằm khai thác kỹ thuật để cải tiến việc tiếp cận với các nguồn hỗ trợ về nhà ở và sức khoẻ tâm thần khác. Tương tự, Ban Chỉ Đạo MHSA đã phê duyệt kế hoạch của HCA để tiêu dụng những ngân khoản AB 114 đảo ngược của INN trong các dự án hiện có và các dự án mới nếu thích hợp theo cách tối đa để bảo vệ ngân quỹ không bị đảo ngược.

Thành Phần Đào Tạo và Huấn Luyện Lực Lượng Chuyên Môn

Chương Trình Đào Tạo và Huấn Luyện Lực Lượng Chuyên Môn (WET) là nhằm tăng cường lực lượng chuyên môn về chăm sóc sức khoẻ tâm thần và nâng cao sự am tường về văn hoá và ngôn ngữ của nhân viên. WET duy trì ngân sách hàng năm ở mức $5,150,282 cho tài khoá 2018-19, mặc dù các ngân khoản đã được chuyển từ Chương Trình Khích Lệ Về Tài Chính, Huấn Luyện và Hỗ Trợ Kỹ Thuật Cho Lực Lượng Chuyên Môn để phản ánh chi tiêu thực tế của chương trình. Mô tả chi tiết về từng chương trình được trình bày trong phần Hỗ Trợ Hệ Thống BHS.

Thành Phần Cơ Sở Nguồn Vốn và Đáp Ứng Nhu Cầu Kỹ Thuật

Thành phần Cơ Sở Nguồn Vốn và Đáp Ứng Nhu Cầu Kỹ Thuật (CFTN) tài trợ cho một loạt các dự án cần thiết để hỗ trợ hệ thống cung cấp dịch vụ và hiện đang được tài trợ thông qua CSS. Tổng cộng $9.2 triệu đã được chuyển sang Cơ Sở Nguồn Vốn để tài trợ cho hai dự án trong tài khoá 2018-19: $9 triệu để mua một bất động sản cho chương trình Co-Located Services và $200,000 để cải tạo tòa nhà được xử dụng cho chương trình Youth Core Services. Ngoài ra, Quận Cam đã chuyển $3,756,082 đến chương trình Đáp Ứng Nhu Cầu Kỹ Thuật để tiếp tục thực hiện chương trình Hồ Sơ Sức Khoẻ Điện tử BHS (EHR). Mô tả chi tiết về tất cả các dự án của CFTN được trình bày trong phần Hỗ Trợ Hệ Thống BHS.

Chương Trình Nhà Ở

Dưới sự chỉ đạo của Hội Đồng Giám Sát, $20 triệu đã được phân bổ trong Tiến Trình Kế Hoạch Cộng Đồng tài khoá 2017-18 để phát triển chương trình hỗ trợ nhà ở cố định thông qua Chương Trình Nhu Cầu Đặc Biệt Về Nhà Ở của MHSA. Một số ngân khoản đã được phân bổ cho một số dự án đang trong giai đoạn phát triển và sẽ cho phép Quận Cam tiếp tục tạo ra các lựa chọn nhà ở cố định cho những người sống với SMI. Mô tả chi tiết từng dự án được trình bày trong phần Hỗ Trợ Cá Nhân / Gia Đình của bản Cập Nhật Kế Hoạch này.

Tái Sắp Xếp Cập Nhật Kế Hoạch Hằng Năm

Các chương trình đã được sắp xếp trước đây trong Kế Hoạch theo thành phần tài trợ (ví dụ: CSS, PEI, v.v.). Tuy nhiên, cấu trúc này không nhất thiết thúc đẩy sự hiểu biết về những gì các chương trình đã làm hoặc cách chúng liên quan với nhau. Để khắc phục hạn chế này, bản hiện tại đã được tổ chức lại theo hai cấp: (1) Mức Hỗ Trợ, phản ánh mục tiêu chính của chương trình về việc can thiệp / hỗ trợ (ví dụ Cộng Đồng, Cá Nhân / Gia Đình, Hệ Thống BHS) và (2) Chức Năng Dịch Vụ, phản ánh mục đích chính của các dịch vụ được cung cấp (ví dụ Phòng Ngừa, Dịch Vụ Khủng Hoảng, Dịch Vụ Ngoại Trú v.v.). Các Chức Năng Dịch Vụ và các chương trình MHSA trong các mục nêu trên được mô tả chi tiết hơn trong Bản Cập Nhật Kế Hoạch này. Mặc dù một số chương trình trải rộng trên nhiều Mức Độ Hỗ Trợ (Cá Nhân / Gia Đình, Cộng Đồng), chúng được phân loại theo Chức Năng Dịch Vụ chính.

Cấu Trúc Tổ Chức Của Kế Hoạch MHSA

Cộng Đồng

- Ngăn Ngừa

Cá Nhân / Gia Đình

- Hướng Dẫn/Tiếp Cận & Kết Nối với Điều Trị
- Dịch Vụ Lúc Khủng Hoảng
- Điều Trị Tại Nơi CưTrú
- Điều Trị Ngoại Trú
- Phục Hồi & Hỗ Trợ

Hệ Thống BHS

- Đào Tạo & Huấn Luyện Đội Ngũ Chuyên Môn
- CơSở Nguồn Vốn & Đáp Ứng Những Nhu Cầu Kỹ ThuậtTecnología

Trong những năm kể từ khi Dự luật 63 được thông qua, đạo luật đã tiếp tục phát triển và giúp đỡ tốt hơn cho cuộc sống của những người có bệnh tâm thần, gia đình của họ và toàn thể cộng đồng Quận Cam. Chúng tôi mong muốn được tiếp tục hợp tác với các thành phần có liên quan trong việc thực thi MHSA tại Quận Cam.

During the years since Proposition 63 was passed, the Act has continued to evolve and help better the lives of those living with mental illness, their families and the entire Orange County community. We look forward to continuing our partnership with our stakeholders as we implement MHSA in Orange County.

LOCAL MHSA COMMUNITY PLANNING PROCESS

The MHSA was built upon the premise that community members and mental health stakeholders should take an active role in advising the County on mental health needs, services and funding allocations. Since the initial MHSA planning process following the passage of Proposition 63 in November 2004, Orange County has benefited from the contributions of thousands of individuals and providers who have participated in focus groups, conferences, trainings, meetings and surveys. Orange County continues to solicit community input to gather feedback about existing programs and to ensure a high standard of service delivery from its MHSA programs and to ensure program funding remains aligned with the County's current needs. As in previous years, the Orange County Health Care Agency (HCA) developed the FY 2018-19 MHSA Annual Plan Update with direct input from MHSA stakeholders.

MHSA Stakeholders

The MHSA requires that each county partners with local community members and stakeholders for the purpose of community planning. The Act also requires that individuals representing each of the following stakeholder groups participate in this planning:

- Adults and older adults living with a mental illness
- Family members of children, adults and older adults living with a serious mental illness or emotional disturbance
- Mental health service providers
- Law enforcement agencies
- Education
- Social services agencies
- Veterans
- Representatives from Veteran organizations
- Providers of alcohol and drug services
- Health care organizations
- Other important interests

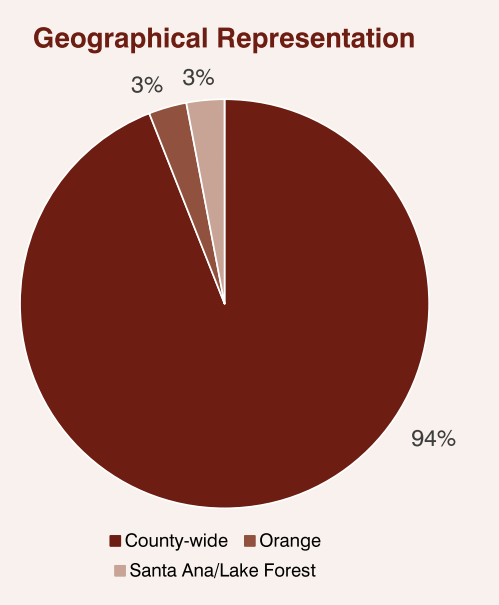
Orange County has two committees specifically designed to solicit input and feedback on local implementation of the MHSA: the MHSA Steering Committee and the Community Action Advisory Committee.

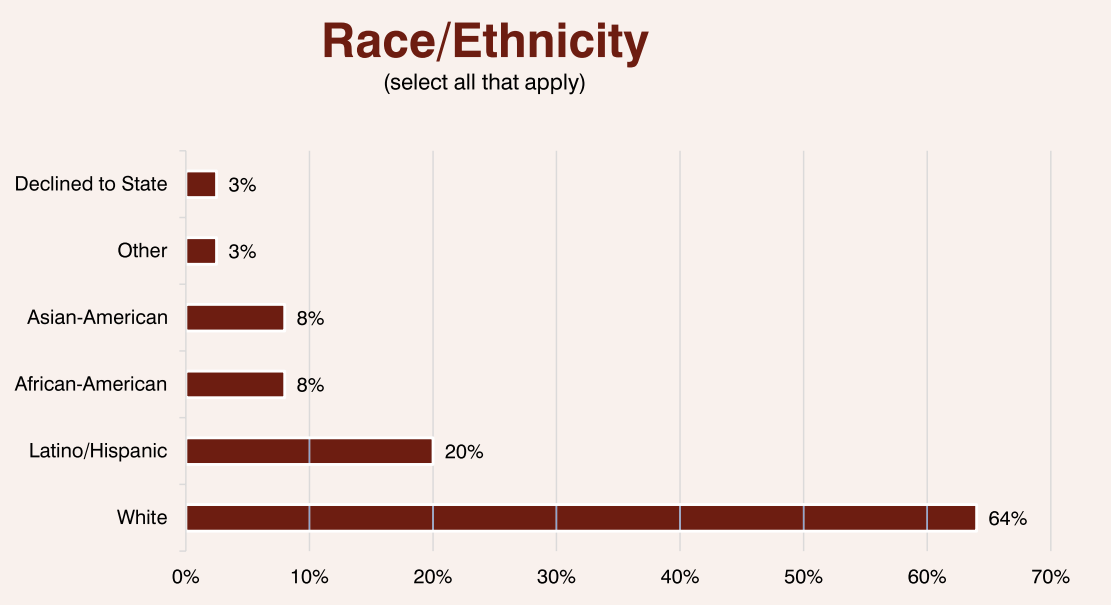
Orange County MHSA Steering Committee

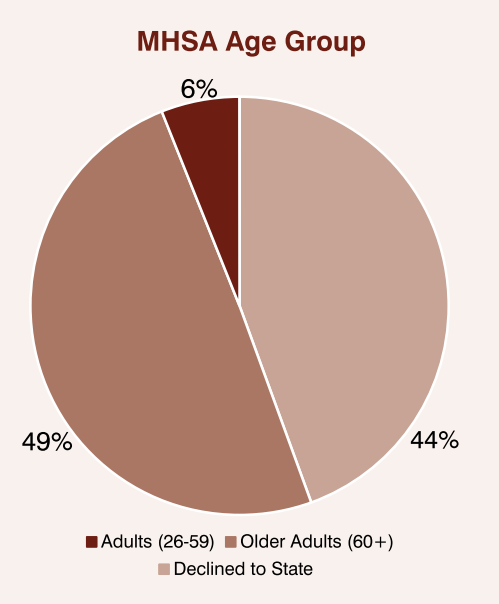
The Orange County MHSA Steering Committee has helped shape MHSA implementation in Orange County since the very first MHSA Three-Year Plan was developed. It is composed of stakeholders from each of the above legislated groups and, in most cases, has more than one member representing each group. At the current time, the MHSA Steering Committee seats 57 members and has eight vacancies. The Steering Committee provides guidance and encourages the Health Care Agency to address new ideas or questions that are brought up throughout the year and is tasked with fulfilling seven responsibilities:

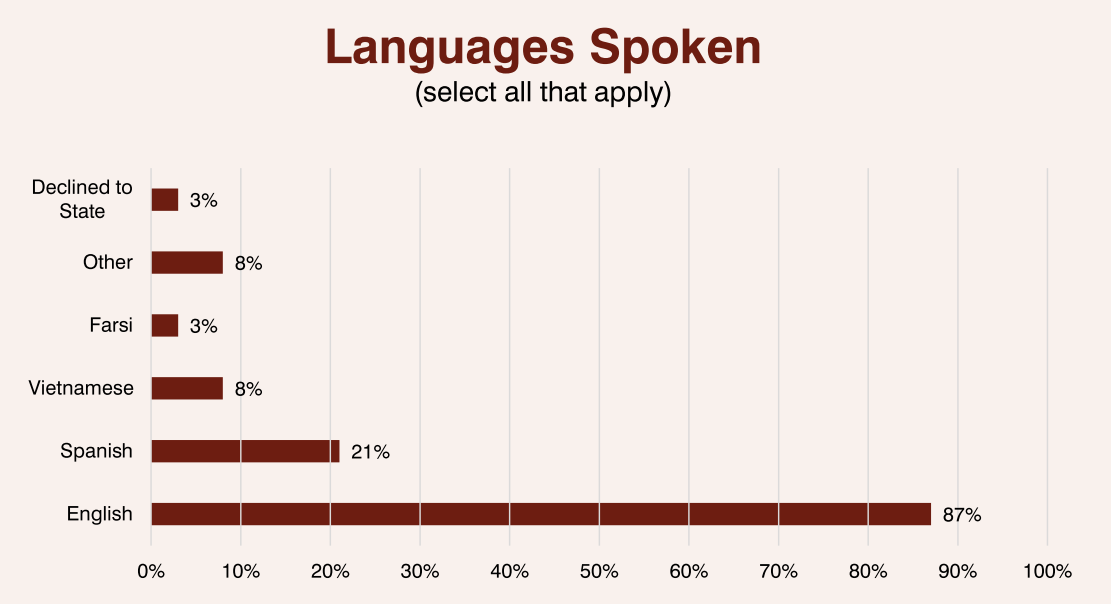
1. Be fully educated about the status of the MHSA funding availability and requirements, as well as the status of Orange County MHSA program implementation.
2. Assist the County with identifying challenges to the development and delivery of MHSA-funded serves and make recommendations for strategies to address these challenges.
3. Remain informed about current stakeholder meetings, and the funding and program recommendations made by members of these groups.
4. Review all MHSA funding proposals and provide critical feedback to ensure that funding is allocated to services for identified needs and priorities.
5. Make timely, effective decisions that maximize the amount of funding secured by Orange County that preclude Orange County from losing funding for which it is potentially eligible.
6. Support the County's ability to meet both State funding requirements and Orange County funding needs.
7. Make recommendations regarding future MHSA allocations so funds will be used to provide services for identified needs and priorities.

In 2017 the MHSA Office surveyed members on key demographics and stakeholder characteristics. Approximately 68% of the surveys were returned (39/57) and yielded the following results:









At present, there are no TAY represented on the Steering Committee as one recently aged into the adult group and the other left the committee to pursue a higher degree. Recruiting TAY representatives and individuals from underserved ethnic and cultural communities will be the focus as the vacancies are filled.

Community Action Advisory Committee

The MHSA Community Action Advisory Committee (CAAC) is a group of 15 individuals who are living with a mental health condition or who have a family member living with a mental health condition. The group meets on a monthly basis to review MHSA programs and their outcomes. They then provide recommendations to the MHSA Steering Committee on service needs and gaps from the consumer/family member perspective.

MHSA Planning Process for the FY 2018-19 Annual Plan Update

In Fall 2017, HCA announced that it would be hosting a Public Forum/Public Comment period where community members and stakeholder could provide feedback on their identified needs and gaps in the BHS/MHSA system of care. The following tables summarize the comments provided, as well as HCA's responses with regard to whether the identified services are already being provided; existing services could be refined or expanded to address the need; or whether the need is an area of potential future expansion.

Identified Area of Need: Persons with Disabilities

People with Intellectual/Developmental Disabilities (DD) are not properly served or deemed eligible for mental health services; relax criteria and create a bridge between DD and mental health services

The following PEI programs currently provide direct services for this population and/or link them to appropriate services:

- Parent Education Services, Family Support Services, Children's Support and Parenting Program, School-Based Early Intervention Services, Outreach and Engagement, School Readiness/Connect the Tots

In addition, Children and Youth Behavioral Health (CYBH) Managers/clinician attend the OC Children's Coordination Committee meeting at the Center for Autism and Neurodevelopment Disorders to assist with referrals and resources. The CYBH Manager attends the OC Regional Center for Autism Work Group, and the Orange County Office of the State Council on Developmental Disabilities Health Care Task Force.

Per regulation, MHSA, EPSDT and MediCal can only be used to serve those diagnosed with DD when their primary condition is a mental health disorder. Orange County is not able to relax criteria to create a bridge between DD and mental health services as the criteria are set by the State.

Expand the number of therapists trained to work with visually impaired children

PEI and Children's CSS/CYBH outpatient programs (MHSA- and non-MHSA funded) can serve children who are blind, deaf-blind or visually impaired. Staff does not necessarily have specialized training for these populations, however, thus this is a potential area for future training/program expansion.

Identified Need: Community Outpatient

Need referrals in the community for low cost psychiatric treatment that includes assessment, diagnosis, medication evaluation, medication management.

PEI has the following programs/services that address the stated needs:

- OC Links, Community Counseling and Supportive Services provide these services for those who are at risk or are diagnosed with a mild to moderate mental health condition.

CSS has the following programs/services that address the stated needs:

- County and Contract Outpatient Clinics provide these services for those diagnosed with SMI

In addition, CalOptima, private insurance and other health plans are available for these services within the broader community.

Identified Need: Veterans

Veterans are suffering from PTSD, TBI and other mental, emotional and behavioral problems. Veterans need to receive counseling from other veterans, including combat veterans, which is rarely offered to them through the VA.

The following PEI programs/services address the stated needs:

- OC4Vets, which is co-located at the VSO.
- OC Links can help with accessing these services

The following Innovation programs/services address the stated needs:

- Strong Families Strong Children – BHS for Military Families project provides services including peer support to veterans, spouses, partners and children
- Continuum of Care for Veterans and Military Families project is under procurement. The project will be staffed with veteran peer navigator who will train FRC staff on how to identify, screen and serve military families. Services will be provided in the FRCs throughout the county.

Identified Need: Arts and Stigma

Focus on arts to help improve and maintain wellness and recovery; Inform and educate the public in order to diminish stigma.

The following PEI programs/services address the stated needs:

- Community Health Mental Health Events, CalMHSA's Each Mind Matters platform

The following CYBH programs/services that address the stated needs:

- Wellness Centers

Identified Need: Housing/Homelessness

MHSA Clients are homeless and need housing, particularly Permanent Supportive Housing

Through the MHSA Bridge Housing program, HCA is contracting with providers to provide housing assistance and housing linkages to individuals, including permanent housing. The program will assist homeless persons with securing housing vouchers and will utilize housing navigators funded by Whole Person Care to find and develop housing options.

During FY 2017-18, under directives from the Orange County Board of Supervisors, HCA allocated a total of $20 million to the Special Needs Housing Program to develop permanent supportive housing for individuals living with serious mental illness. Several housing projects are in different phases of development and some additional dollars remain available for future allocation as new, eligible projects are proposed.

With the up-coming No Place Like Home Initiative, Orange County will continue to look for additional funding options to address the needs of some of our community's most vulnerable residents. Orange County is also engaged in community planning to develop a smartphone/website- based application to assist those looking for housing options.

Provide tax break-incentives for owners of empty commercial buildings to create housing and comprehensive behavioral health multiservice centers that help develop independent living skills, offer job skills training, and foster wellness.

MHSA and HCA/BHS are not authorized to provide tax breaks. Project developers in the MHSA Housing and No Place Like Home programs can apply for tax credits to assist in the financing of construction.

Identifying a site that could address all the needs outlined would be very beneficial.

Identified Need: Laura's Law/AOT, Serious and Persistent Mental Illness

Need presentations by the Laura's Law/AOT, Recovery Court, and WIT Court programs to better understand these programs and role of case managers

The AOT Assessment and Linkage Team provides AOT to the community as requested. Last year, 10 trainings were conducted at hospitals, police departments and community meetings, including NAMI and the Orange County Conservators Assistance Group. BHS program staff do community presentations about AOT and overall system of care.

There are insufficient programs for the SMI with anosognosia (lack of insight). AOT is court-ordered but a participant does not have to follow the judge's orders. Dr. Steven Seager's video Roadmap describes solution (services of increasing intensity, changing civil commitment laws.)

BHS clinicians provide a continuum of services individualized to each person's level of need and insight as a standard practice of care. Although AOT is a 6-month court-ordered program, there are no civil or criminal penalties for someone who does not participate. The program relies on the influence of the collaborative efforts of the court and treatment team. MHSA is not authorized to change AOT or civil commitment laws, and all MHSA programs must be voluntary.

Identified Need: Comprehensive Case Management

Case Management to consistently help patients with Homelessness, Employment, Transportation, Finances, Food Insecurities and Health Care

The Full Service Partnerships (FSPs) and Programs for Assertive Community Treatment (PACT) provide comprehensive case management through an intensive, field-based model that provides "whatever it takes" to support consumers in their recovery. FSPs and PACT serve children, TAY, adults, and older adults and actively strive to reduce homelessness, food insecurity and transportation barriers and increase employment and access to health care.

Identified Need: Supporting Private Conservators

Provide support and assistance for family members who are willing to be private conservators for their high risk and unengaged family members with SMI so that they may remain safely at home with their family and not become homeless.

FSPs provide some support to private conservators through family meetings, encouraging family participation in treatment, providing referrals to OCCAG, assisting with conservatorship documents, and other resources. One track of the STEPS FSP also specifically works with adults who are on Lanterman-Petris-Short (LPS) conservatorship and returning to the community from long-term care placements.

However, an area for potential expansion is to increase the array of in-home family support for private conservators. HCA is having discussions with the Public Guardian about hosting a community planning process in FY 2018-19 to develop an effective program/expansion for this population.

Identified Need: System Navigation

Need more Care Navigators to assist navigating the system

PEI has the following programs/services that address the stated needs:

- OC Links: 855-OCLINKS (855-625-4657) or live chat online at www.ochealthinfo.com/oclinks

CSS has the following programs/services that address the stated needs:

- Peer Mentors are employed throughout the BHS system of care to help consumers and family members to needed community resources, and this program is being expanded in FY 2018-19.

Identified Need: SUD/Co-Occurring

Need a comprehensive continuum of care for substance use (in/out patient) that is county-funded rather than relying on for-profit abuse treatment centers.

Need diversion programs from jails for those with mental health and substance use problems

BHS currently has County and County-contracted co-occurring outpatient and residential treatment programs for adolescents and adults, as well as medical and social model detoxification programs for adults. Adolescents are referred to local hospitals if detoxification is required.

Many MHSA programs specifically address the needs of individuals with mental illness who are involved in the criminal justice system (FSPs, PACTs, O&E). Orange County was also awarded a Proposition 47 grant that will fund system navigators to help link those recently released from jail to appropriate services. In addition, the MHSA Plan Update has a new program, Correctional Health Services Jail to Community Re-Entry that will offer comprehensive discharge planning for individuals with mental health needs as they prepare for release, and will seek to link individuals to needed services/resources.

Identified Need: Linguistic Competency

There is a shortage of bilingual counselors, psychiatrists, and nurse practitioners in mental health

HCA is always looking to recruit additional members who are able to speak more than one threshold language in order to better serve the County's diverse populations. This continues to be a challenging area for our system and remains a future opportunity for growth.

Identified Need: Integrated Care

Need an integration of primary care and mental health services

CSS currently offers the following integrated care programs:

- Integrated Community Services for adults serves primary and mental health needs
- OC Children with Co-Occurring Mental Health and Chronic Acute Severe Physical Illness, Special Needs or Eat Disorders, and this program is expanding to include an FSP.
- All FSPs, PACTs and County and County-contracted clinics work to link individuals to a primary care physician.

Identified Need: Crisis

Need more Crisis Stabilization Units and inpatient beds. Increase CAT to reduce wait times; patients would benefit from timely assessment and intervention for suicide/homicide risk or grave disability.

HCA is in various stages of ongoing negotiations with three potential contractors in order to expand Crisis Stabilization services throughout Orange County. However, per State regulations, MHSA cannot fund inpatient beds. MHSA does, however fund crisis residential programs for individuals ages 13 and older, which recently received increased funding levels. MHSA also funds in-home crisis stabilization services for children and their families to help keep the child in the home. An RFP for similar in-home crisis stabilization services for adults is currently in the process procurement.

CAT was recently approved to increase the children's team by 5 positions and the adult team by 8.

Identified Area of Need: Children Services

Provide in-home services where clinicians and parent educators work with young children who have mental/behavioral health issues

Children's CSS/CYBH programs currently provide in-home services to the 0-5 population.

Provide case management for children/families with mental/behavioral health problems. Provide training in Vietnamese for parents/caregivers of children/young adults with mental health problems.

The following PEI programs currently provide these services:

- Outreach and Engagement Collaborative, Family Support Services (parenting courses also provided in Vietnamese)

The following CYBH programs currently provide these services:

- CYBH PACT, Project FOCUS (specializes in Asian/Pacific Islander children/TAY)
- CYBH will look to hire peer partners for parents in youth in County clinics.

In general, the number of BHS bilingual staff who speak the County threshold languages as of August 2017 is: Spanish (287), Vietnamese (86), Korean (16), Farsi (17), Arabic (3)

A gap in services exists for children/youth with a serious mental health condition (major depression/anxiety), trauma exposure; PEI is critical to breaking ACES exposure

The following PEI programs address ACES:

- School-Based Mental Health Services, Suicide Prevention Trainings and related technical assistance are provided to schools as they implement Suicide Prevention Policies, Crisis Response services address traumatic issues at school sites

The following PEI programs serve children/youth with serious mental health conditions:

- O&E and OCLINKS link this population to appropriate services, Community Counseling and Supportive Services provides Eye Movement Desensitization and Re-processing, a modality to process trauma with all ages.

The following CYBH programs address both these needs:

- CYBH Clinicians in all outpatient and residential programs are trauma-informed and regularly attend trainings on trauma care that have been validated with individuals from a range o f cultural and ethnic backgrounds.
- Staff in programs serving child welfare and probation youth receive additional training on the commercial sexual exploitation of children (CSEC) and screen all youth entering child welfare with a CSE Identification Tool; a staff member provides intensive therapy and case management for any youth with a CSEC history; and staff provides CSEC services for Grace Court which has a peer survivor component.
- CYBH managers participate in the Child Welfare System Improvement Partnership with SSA and community stakeholders.
- CYBH Clinical Evaluation and Guidance Unit is part of tri-agency, trauma-informed training with OCDE and SSA to ensure all Orangewood staff are trained in trauma-informed practices.

In addition, Vicarious Trauma trainings have been conducted for all BHS.

Children's mental health services in all communities continue to receive insufficient HCA support

In addition to the services described above, PEI's School Readiness/Connect the Tots is prepared to work with children from different cultural/ethnic communities.

Provide support for a Trauma-informed curriculum that is currently being piloted for parents of children involved in juvenile justice system

While PEI offers parent education and family strengthening programs that utilize a variety of other evidence-based curricula (i.e., Triple-P, Common Sense Parenting, Strengthen Families, Parent Project), this specific curriculum represents a potential area for future expansion.

At the November 6, 2017 meeting, the above synopsis was presented to the MHSA Steering Committee. An HCA Fiscal Manager also presented initial recommendations for program budgets that were developed based on recent, actual program costs. HCA staff responded to a series of questions about the requested budget increases and the Steering Committee was invited to contact the MHSA Coordination Office with any additional questions via email to the MHSA email inbox (mhsa@ochca.com). Following this meeting, HCA Managers met with the Steering Committee co-chairs to discuss the component budgets in more detail.

At the December 4, 2017 MHSA Steering Committee meeting, Co-Chairs presented budget recommendations for the CSS and PEI components. The Co-Chairs helped explain the justification underlying each of the changes to MHSA, which included data on recent trends in program usage. HCA staff presented the budget recommendations for WET, CFTN and INN (existing projects only), and the proposal to engage in local community planning regarding new technology-based INN projects. All action items were approved by consensus except the INN Tech Solutions project, which passed with majority vote (one abstention, one no vote). In the following months, the Innovations Subcommittee met with community stakeholders to discuss the possibility of joining the Los Angeles/Kern Counties Mental Health Technology Solutions Innovation project (i.e., Tech Solutions), and to develop a proposal for additional Orange County applications.

At a special MHSA Steering Committee meeting held on January 22, 2018, HCA presented the Innovation Tech Solutions project proposal and budget, as well as additional CSS program budget adjustments and expansions for discussion and a vote. All action items were approved by consensus, with the INN project, in particular, receiving overwhelming support.

In all, the following recommendations were discussed and approved by consensus by the MHSA Steering Committee:

- Allocate reverted PEI funds, per AB 114, to fund existing PEI programs in FY 2018-19 to prevent reversion. Unspent PEI dollars resulting from this plan would be brought back to the PEI Subcommittee for planning purposes in order to prevent future reversion.
- Expand BHS Outreach and Engagement and Peer Mentoring using unspent CSS funds ($856,600 per year for five years) to draw down Federal match funds through Whole Person Care.
- Expand FSP services for children/youth involved with Criminal Justice using unspent CSS funds as an ongoing expenditure of $2,250,000 per year.
- Allocate $15 million in unspent CSS funds to CalHFA for Permanent Supportive Housing as a one-time expenditure.
- Approve Orange County's proposal to join all five components of the LA/Kern Counties Mental Health Technology Solutions Innovation Project with a four-year budget totaling $24 million.
- Approve the plan to allow HCA to allocate existing and reverted INN funds, per AB 114, on existing and newly approved INN projects, if any, in a manner that maximally protects INN dollars from reversion.

Public Hearing and Approval by the Board of Supervisors

The MHSA Plan Update for FY 2018-19 was completed, reviewed and approved by the BHS Office of the Director and posted to the Orange County MHSA website on March 5, 2018 for a 30-day review by the public. At the close of the public comment period the MHSA Office and BHS Managers responded to all substantive public comments. The Annual Update, along with public comment summaries and HCA's responses, were submitted to the Mental Health Board.

On April 11, 2018 the Mental Health Board held a Public Forum at the Fullerton Community Center to hear from the community on MHSA. The Public Hearing was advertised through a posting with the Clerk of the Board, emails to the Community Action Advisory Committee, members of the MHSA Steering Committee, and interested community members who have asked to be notified of MHSA meetings and events. In addition, for the first time this year, the Public Hearing was posted on the County-wide Board of Supervisors Event Calendar, as well as distributed through the Health Care Agency's Social Media Channels (i.e., Twitter, Facebook). At the hearing, BHS Executive Management reviewed the highlighted changes to the Plan and answered MHB members' questions, and individuals from MHSA programs gave testimonials to the positive outcomes and transformations in their lives. At the conclusion of the Public Hearing, the Chair of the Mental Health Board called for a vote to approve the plan. The plan was approved with one abstention.

The FY 2018-19 MHSA Plan Update was brought before the Board of Supervisors and approved at the regularly scheduled meeting held on May 22, 2018.

ORANGE COUNTY DEMOGRAPHICS

Orange County is the third most populous county and second most densely populated county in California.

It is home to a little over 3 million (3,172,532) people (Census, v2016), up almost 7% from 2010.

The County's population is comprised of four major racial/ethnic groups:

- Whites (41%), Hispanics (34%), Asian/Pacific Islanders (20%) and Blacks/African Americans (2%).
- 30% of residents are born outside the U.S. (Census, 2012-2016).

Currently, Orange County has five threshold languages (Spanish, Vietnamese, Korean, Farsi and Arabic).

According to Orange County's Healthier Together (2017), English is spoken at home by 54% of the population four years and older, followed by Spanish (26%) and Asian/Pacific Islander languages (14%).

22.5% of the County's population was under age 18 and 14.0% were 65 or older (Census, v2016).

The percentage of the population ages 65 and older is expected to increase over the next 20 years. As the percentage of seniors grows, the need for mental and physical health care is expected to rise.

Approximately 6% (120,558) of the civilian population 18 and older are veterans (Census, 2012-2016).

In one study of OC veterans (OC Veterans Initiative), half of post-9/11 veterans interviewed did not have full-time employment, 18% reported being homeless in the previous year, and nearly half screened positive for posttraumatic stress disorder (PTSD) and/or depression.

Orange County is home to an emerging Lesbian, Gay, Bisexual, Transgender, Intersex, Questioning population.

The California Health Interview Survey estimates that 3.4% of Orange County residents identify as gay, lesbian or bisexual (2016) and over 6,000 same-sex couples live in Orange County (2005).

The County has a well-educated population, with 84.5% ages 25 years and older having graduated from high school and 38.4% having earned a bachelor's degree or higher.

This is slightly higher than the state average of 82.1% having graduated high school and 32.0% having earned a bachelor's degree or higher (Census, 2012-2016).

Since 2007, Orange County has consistently had the highest Cost of Living Index compared to neighboring areas. Although Orange County's cost of living for groceries, utilities, transportation and miscellaneous items tends to rank in the middle among similar jurisdictions, high housing costs make Orange County a very expensive place to live.

- $78,145: Median household income (2012-2016).
- $79,482: Income that a family of two adults with one preschooler and one school-age child needs to meet basic needs. Compare that to $63,979, the income needed statewide (kidsdata.org, 2014).
- $1,608: Median Gross Rent (Census 2012-2016)
- $584,200: Median House Price (Census 2012-2016).
- 7.58%: Unemployment Rate (OC Healthier Together, 2017)
- 12.5%: Individuals below Poverty Level (Census 2012-2016).

MHSOAC REGULATIONS IMPLEMENTATION

In Fall 2016, after receiving input from a number of community stakeholders statewide, the Mental Health Services Oversight and Accountability Commission (MHSOAC) voted to approve a new set of regulations governing PEI and Innovation programs. The regulations define and delineate the following for both components:

- Reporting requirements, including expenditure reports, program and evaluation reports to be submitted to the MHSOAC, demographic data, etc. FY 2016-17 demographic data by program are contained in Appendices II and III of this Plan Update.
- Program evaluation guidelines, including that evaluations are culturally competent and, depending on the type of program, measure one of more the following:
    - For PEI: reduction in prolonged suffering; changes in attitudes, knowledge or behaviors; number of referrals and linkages; duration of untreated mental illness; timeliness of access to care, etc. Relevant outcomes are described within the program descriptions contained in this Plan.
    - For INN: the intended mental health outcomes of the project as they relate to the risk of, manifestation of, and/or recovery from mental illness; improvement of the mental health system; the primary purpose of the project (described below); the impact of any new and/or changed elements as compared to established mental health practices.
- Reporting guidelines for program/project changes, including:
    - For PEI, substantial changes to a Program, Strategy or target population; the resulting impact on the intended outcomes and evaluation; and stakeholder involvement in those changes.
    - For INN: substantial changes to the primary purpose and/or to the practice/approach the project is piloting; increases in the originally approved Innovation budget; and/or a decision to terminate the project prior to the planned end date due to unforeseen legal, ethical or other risk-related reasons.

PEI-Specific Regulations

In addition, there are certain regulations specific to PEI programs:

- General requirements for services, including the age ranges to be served, minimum percent funding allocated to programs serving children and TAY, etc.
- General component requirements, including the minimum number and type of PEI programs that each County shall include in its plan, etc., which are described in more detail below.
- Strategies for program design and implementation, including that programs help create access and linkage to treatment, improve timely access to mental health services, and be non-stigmatizing and non-discriminatory, etc., which are described in more detail below.
- Use of effective methods in bringing about intended program outcomes, including evidence-based practices, promising practices, and/or community- and/or practice-based standards, etc., which are described within each program description.

Required PEI Programs

Per the Regulations, counties not classified as small must include at least one PEI program in each of five category types, and have the option of offering a sixth type. Orange County offers all six types, with some combining two types into one program as permitted by the regulations. The required programs, along with their accompanying Orange County PEI programs, are as follows:

Suicide Prevention Program

- *Activities that aim to prevent suidcide as a consequence of mental illness*

OC Programs:

- Crisis Prevention Hotline (also an Outreach for Increasing Early Signs of Mental Illness program)
- Statewide Projects

Access and Linkage to Treatment

- *Activities to connect individuals with SED/SMI to medically necessary care and treatment as early in the onset of these conditions as practicable*

OC Programs:

- Information and Referral/OC Links
- BHS Outreach & Engagement Services

Prevention

- *Activities that reduce risk factors for developing a potentially serious mental illness and to build protective factors with the goal of promoting mental health*

OC Programs:

- Children's Support & Parenting Program
- Family Support Services
- School-Based Stress Management Services
- Parent Education Services
- School-Based Mental Health Services - Prevention Track
- School-Based Behavioral Health Intervention and Supports
- School Readiness/Connect the Tots - Prevention Track
- Gang Prevention Services
- Violence Prevention Education
- Warmline
- Training in Physical Fitness & Nutrition
- Outreach and Engagement Collaborative

Outreach for Increasing Recognition of Early Signs of Mental Illness

- *Process of engaging, encouraging, educating and/or training and learning frompotential resposenders about ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness*

OC Programs:

- Crisis Prevention Hotline (also a Suicide Prevention program)
- Training, Assessment and Coordination Services

Early Intervention

- *Treatment/services to promote recovery and funtioning for a mentalillness early in its emergence*

OC Programs:

- Community Counseling & Supportive Services
- School Readiness/Connect the Tots Early Intervention Track
- OC ACCEPT
- 1st Onset of Psychiatric Illness - OCCREW
- OC Parent Wellness
- School-Based Behavioral Health Intervention and Supports - Early Intervention Services
- School-Based Mental Health Services - Early Intervention Track
- Stress Free Families
- Survivor Support Services
- College Veterans Program
- OC4 Vets
- Early Intervention Services for Older Adults

Stigma and Discrimination Reduction Program

- *Activities to reduce negative feelings, attitudes, beliefs, stereotypes and/or discrimination related to having a mental illness or seeking services, and to increase accesptance, dignity and inclusion*

OC Programs:

- Mental Health Community Educational Events
- Statewide Projects

Required PEI Service Strategies

In addition to including the above program types, every PEI program must include the following strategies:

Orange County is continuing to bring its program descriptions, data collection and reporting requirements into compliance with the new Regulations. These efforts will be reported in future Annual Plan Updates.

Access and Linkage to Treatment

Strategies for linking individuals who are living with SED or SMI to an appropriate and higher level of care

Improve Timely Access to Mental Health Services for Underserved Populations

Strategies designed to overcome barriers and improve timely access to services for underserved populations

Non-stigmatizing and Non-Discriminatory

Strategies to reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and making services accessible, welcoming and positive

Innovation-Specific Regulations

The MHSOAC also established regulations specific to Innovation projects, including:

- A County may expend Innovation funds on a specific project only after receiving approval from the MHSOAC.
- Innovation projects must do one of the following:
    - Introduce a mental health practice or approach that is new to the overall mental health system
    - Make a change to an existing practice in the field of mental health, including but not limited to, application to a new population
    - Apply to the mental health system a promising community-driven practice or approach that has been successful in non-mental health contexts or settings.
- Innovation projects must select one of the following purposes:
    - Increase access to mental health services to underserved groups
    - Increase the quality of mental health services
    - Promote interagency and community collaboration related to mental health services or supports or outcomes
    - Increase access to mental health services.

These elements are described in each INN project description contained within this Plan Update.

Community Support

Prevention

Community Support programs are specially designed to reach large groups of people at a time. They aim to strengthen the resilience and wellness of a community as a whole by providing information, training and skill-building around mental health.

PREVENTION

Similar to preventative care in the medical system which seeks to prevent disease, prevention programs in the behavioral health system strive to prevent the development of serious emotional or behavioral disorders or mental illness in at-risk individuals. They achieve this through large-scale, population-based efforts designed to reduce risk factors or stressors, build protective factors and skills, and/or increase resilience. Prior to the MHSA, preventative mental health services were not widely available due to financial barriers or the focus of community mental health systems on treating existing mental health problems. Now through the MHSA, efforts can be specifically devoted to promoting mental health and wellness, increasing awareness of available mental health services and resources, and decreasing stigma. There are three service areas in this category, each with a slightly different prevention focus:

- Community Events & Services
- School-Related Services
- Community Training

These program types and the services they provide are described in more detail in the sections that follow.

COMMUNITY EVENTS AND SERVICES

Prevention programs in the Community Events and Services area are large-scale events hosted in Orange County. These events use multi-media platforms to inform the community at large about mental health and to reduce stigma. Orange County currently funds two such program through PEI: Mental Health Community Education Events and Statewide Projects.

Prevention: Community Events & Services	Annual Budgeted Funds in FY 2018-19
Mental Health Community Education Events PEI	$214,333
Statewide Projects PEI	$900,000

Mental Health Community Education Events (PEI)

Program Serves	Symptom Severity	Location of Services	Population Characteristics
2 - 95	At-Risk	Field	All Community Members

The program provides services in English, Spanish, Vietnamese, Farsi, Korean, Arabic, Khmer.

Target Population and Program Characteristics

The Mental Health Community Educational Events program hosts mental health-related educational and artistic events that are open to individuals of all ages living in Orange County. They take place several times throughout the year at different locations across the county. A time-limited Request for Application (RFA) is periodically released to the community inviting individuals and organizations to submit proposals for events. Examples of events that have qualified for funding include art workshops and exhibits, multi-cultural musical and dance performances, and other related activities.

Services

Participants are invited to attend an event and use a visual arts medium to express their thoughts and feelings about mental illness and stigma. Their artwork is then displayed at a community location that is open to the public. While each hosted event is different, they all provide consistent messaging aimed at educating the public on mental illness, the stigma surrounding mental illness and the mental health resources available in their communities. The events also seek to educate the public about the abilities and experiences of those living with a behavioral health issue and to instill self-confidence and hope in people living with mental illness and their family members.

"I do not understand how people in society can be so judgmental toward individuals with special needs. I did not realize how much pain and anger I was carrying in my heart until I joined this Stigma Art class, and was able to recognize and release these emotions in a healthy way."

– Grandfather of a granddaughter with special needs

Several community-based stigma reduction events took place in FY 2016-17. The first was a narrative short film, Perfection, which addressed the subjects of mental illness, stigma, bullying and suicide. There were five film screenings at local libraries and community centers, as well as a widely distributed YouTube link. The film was produced with sub-titles in Spanish, Vietnamese and Farsi and was accompanied by an online toolkit that contained an in depth discussion guide on bullying, stigma and suicide. The film showings provided the community with an opportunity to increase its knowledge about mental illness and learn about issues affecting people in their communities with the hope of changing attitudes and beliefs.

A collaborative of community agencies also held a series of workshop events using the arts to Drawing Out Stigma in multi-ethnic communities. Participants were encouraged to express their thoughts and feelings about stigma and mental illness through visual arts such as painting as well as expressive arts such as poetry, play, music, drama or dance. These events were followed by a month-long Community Art Exhibit to showcase the artistic expressions from the various community-based workshops. At the Art Exhibit, community "Presentation Dialogues" featured an appearance by a professional guest artist who had either experienced mental illness themselves or had a family member with mental illness. The event also served as a platform for meaningful interactions between consumers and attendees.

Finally, three unique stigma art events focusing primarily on Orange County's Latino community included 1) A Storytelling Showcase, a one-time art showcase by Latino/Latina youth who have experienced their own mental health condition or that of a loved one and was aimed

at raising awareness in the Latino community through positive stories of overcoming mental health conditions; 2) El Color de la Edad (the Color of Aging) series of interactive art workshops for monolingual low-income Latino/Latina older adults who may be at risk of developing mental health conditions; and 3) Kids against Stigma Art Fair which presented a play on mental health issues followed by opportunities to assist children in expressing their emotions and feelings about mental illness. Each of these events combined various art forms, music and food as a means to engage Latinos at risk of developing mental health conditions and their families in discussions on a variety of mental health topics and stigma. Program staff collaborated with community agencies and groups to host the events in Central and South Orange County.

Strategies to Promote Recovery/Resilience

The program encourages participants and their family members to attend and participate in stigma reduction activities in their community. Recovery is promoted by tapping into participants' creative energy and encouraging their self-expression to reduce feelings of self-stigma, shame and isolation. The events also work towards reducing stigma and promoting inclusion within the community at large.

Strategies to Increase Timely Access to Services for Underserved Populations

The program is designed to be inclusive of those living with mental illness, as well as those who have loved ones living with mental illness. Community partners who specialize in working with underserved cultural populations are involved to improve community members' access to the events. By hosting local activities, the program also provides an opportunity for these partner agencies to interact with residents living with mental illness, thereby encouraging them to access the agencies' services in the future.

Strategies to Reduce Stigma and Discrimination

The program hosts events that are available to all Orange County residents and are sensitive and responsive to participants' backgrounds. Care is taken to host events in communities of underserved populations where stigma is particularly prevalent. The art displays attempt to educate the surrounding community and dispel misperceptions associated with mental illness. This strategy is employed because art is capable of transcending socioeconomic status, ethnicity, culture, language, mental illness and other such factors that are sometimes a source of discrimination. When art is appreciated, it can open the door to acceptance. Creating and sharing artwork also builds self-esteem and allows people living with mental illness to define themselves by their abilities rather than their disabilities.

Challenges, Barriers and Solutions in Progress

The challenges encountered by the Mental Health Community Educational Events program in FY 2016-17 were primarily related to logistics and coordination. Although there was a great deal of initial interest from many providers, only a few proposals were submitted for consideration and, of these, some did not meet the minimum requirements for implementation. Many providers are not always aware of the complex logistical aspect of providing these services, and while they may have wonderfully creative ideas, are often unable to plan for challenges in marketing, recruiting and/or engaging participants. Providers are also excited to conduct events or activities at schools or universities, but come to find that these venues are difficult to provide outreach to and have specific coordination requirements, timelines, or insurance responsibilities that providers are unable to meet. To assist with these challenges, HCA staff provides technical assistance to the providers during the early stages of the project.

Community Impact

The program has provided services to more than 13,920 individuals since its inception in FY 2012-13. Feedback from participants and attendees indicates that the arts remain one of the greatest assets in empowering and educating the community while raising awareness and understanding of mental health issues.

Statewide Projects (PEI)

Program Serves	Symptom Severity	Location of Services				Population Characteristics							
0-21	Severe	Home	Field	School	Outpatient Clinic	Foster Youth	Parents	Families	LGBTIQ	Homeless/ At Risk	Co-Occurring SUD	Medical	Students

The program provides services in English, Spanish, Vietnamese.

Target Population and Program Characteristics

Statewide Projects serves the Orange County community at large through participation in the following CalMHSA-sponsored initiatives:

- Suicide Prevention: These activities include social marketing and training designed to support helpers and gatekeepers appropriately identify and respond to suicide risk. This program also works with local suicide prevention partners to respond to individuals in crisis through hotlines.
- Stigma and Discrimination Reduction: These activities include implementation of best practices to develop policies, protocols and procedures that support help-seeking behavior and/or build knowledge and change attitudes about mental illness. This initiative also provides informational and online resources, training and educational programs, and culturally responsive media and social marketing campaigns to engage and inform underserved racial and ethnic communities about mental health.
- Student Mental Health: These activities are designed to change school climates and campus environments by promoting mental health and engaging students in kindergarten through higher education. Technical assistance and social media campaigns aimed at increasing awareness and engaging the local community are also provided.

Services

Orange County takes part in a statewide campaign known as Each Mind Matters (www.eachmindmatters.org) to promote the initiatives through a variety of activities and events tailored to the needs of local communities. The campaign is also available in Spanish (i.e., "Sana Mente").

During FY 2016-17, more than 53,400 green ribbons and wristbands, 27,400 California Community College Student Mental Health Program materials, and 87,900 Each Mind Matters materials were disseminated throughout Orange County to increase awareness of mental health and suicide prevention and decrease associated stigma and discrimination. Examples of the Each Mind Matters materials include the "Mental Health Support Guide" in English, Spanish, Korean, and Vietnamese; "Be True and Be You Mental Health Guide" for LGBTQ+ youth; "Aging and LGBT Mental Health Support Guide"; the Social Media Tool Kit; "OC Links Talking Cards: How to Initiate a Conversation About Mental Health" and "Know the Signs/El Suicidio Es Prevenible" educational materials.

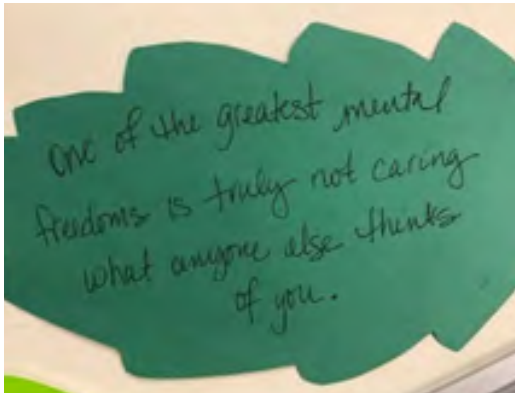
Statewide Projects also reached 45 local agencies including schools and organizations, by providing outreach materials, training and technical assistance on stigma reduction, suicide prevention and/or student mental health. These included:

- 3 National Alliance on Mental Illness (NAMI) Mental Health 101 trainings for diverse communities;

> **“The green streamers were the major eye catcher which started the conversation about Mental Health with our guests and clients. This is our second year we have taken part in this activity and [I’m] looking forward to increase[ing] awareness in 2018.”**
>
> **– DUI Courts Quote staff member**

- 37 NAMI “End the Silence” trainings at various participating high schools reaching a total of 1,590 students;
- Assembly Bill 2246 in-person trainings on programs, policies and procedures for suicide prevention and postvention for 78 school staff from various Orange County school districts;
- In-person QPR (Question, Persuade and Refer) Trainings on suicide prevention for 61 individuals at California State University at Fullerton;
- El Rotafolio Suicide Prevention 2-day in-person training for 27 community workers who work with the Spanish-speaking community;
- Suicide Prevention Media Messaging in-person training on how to create appropriate messaging and report on suicide for 26 media and public information officers;
- Kognito online mental health and suicide prevention trainings for 602 faculty, staff and students at eight community colleges; and
- Student Mental Health Trainings at seven Community Colleges.

In addition, other outreach and other public events were conducted. For example, the Foundation for California Community Colleges conducted mental health outreach to 225 students at three local colleges. The “Active Minds” outreach program was also conducted at three different college campuses and reached approximately 11,141 individuals. Active Minds consists of student-led chapters that engage in capacity building, training, educational programming (i.e., “Send Silence Packing,” etc.) and local community engagement through student-led programs on mental health topics and campus outreach.



Various mental health awareness activities were also hosted by community partners throughout the county. Some of these included arts and crafts displays; workshops and presentations in schools, universities, shelters, Family Resource Centers, parks, older adult community centers, Juvenile Hall, Orange County Courts, police departments, hospitals, Wellness Centers, residential treatment facilities and recovery homes; and a Resource Fair at the Mexican Consulate Office.

High school and college students in Orange County also had the opportunity to participate in “Directing Change,” a statewide video competition that focuses on reducing stigma and promoting suicide prevention. Youth learned about suicide prevention and mental health then created public service announcements that were used to educate the broader community. The Directing Change program received a total of 456 submissions, 46 of which were from Orange County. In the regional competition, three Orange County films were selected as winners in the categories of “Mental Health Matters” (i.e., “Instinct,” “Notice the Signs,” ”Through the Finish Line”) and two films were selected as winners in the “Suicide Prevention” category (i.e., “Just Play,” “The Shadow Lurking in the Dark”). View the 2017 winning films here.

> **“May I have your information? I lost a loved one a few months ago and I feel so sad; after you talked to us I think I need your help and would like to meet with a therapist.”**
>
> **– Participant at a Mental Health event**

Strategies to Promote Recovery/Resilience

Statewide Projects, through its multi-faceted approach, promotes recovery and resilience within Orange County as a whole by providing information and resources to prevent suicide, combat stigma and foster healthy, supportive communities.

Strategies to Improve Timely Access to Services for Underserved Populations

The program uses state and county-wide social marketing campaigns and websites to educate the public about mental illness and increase access to mental health services. For example, in Orange County program staff organized a month-long Each Mind Matters mental health awareness campaign in May 2017. The campaign events took place in a number of different community locations and were designed to initiate conversations about the stigma surrounding mental health conditions, engage youth in stigma reduction and art activities, provide resources and wellness tips, create awareness for community members, and support strategies to link individuals to needed services in a timely manner. An Orange County calendar was also created to highlight these and other community partners' mental health activities.

In addition, Statewide Projects funded mini-grants for various Orange County agencies to create new outreach materials and social marketing campaigns designed to improve timely access of their services by those in need. Participating agencies included various local high schools and colleges, the LGBT Center of Orange County, NAMI Orange County, Active Minds, and Viet-CARE California.

Strategies to Reduce Stigma and Discrimination

Consistent with Statewide Projects' initiatives, strategies to reduce stigma and discrimination related to mental illness are central to the campaign materials, events and training. The message and materials are tailored to be culturally and linguistically appropriate and designed to reach Orange County residents of all ages, including students in Kindergarten through college.

Challenges, Barriers and Solutions in Progress

To mitigate the impact of limited resources and reach a larger geographic area, the program successfully collaborated with community partners to build a network that expanded the program's reach in Orange County. County staff, community partners, local advocates and those with lived experience came together to carry out the Each Mind Matters movement.

Community Impact

The reach of Each Mind Matters continues to grow in Orange County, with an increasing number of individuals, agencies and organizations participating in the campaign each year. Moreover, RAND Corporation evaluated the Directing Change program (www.directingchange.org) and found that 87% of students who were involved with the Directing Change Student video contest increased their understanding of mental illness and suicide after participating in Directing Change. Additionally, the Know the Signs campaign was rated by experts to be aligned with best practices and be one of the best media campaigns on the subject.

SCHOOL-RELATED SERVICES

A key location for prevention efforts is in local schools. Orange County currently funds several school-related prevention programs through the PEI component, and all but one (School Readiness/Connect the Tots) is located on school campuses. These programs and services are described in more detail below.

Prevention: School-Related Services	Estimated Number to be Served in FY 2018-19	Annual Budgeted Funds in FY 2018-19	Estimated Annual Cost Per Person in FY 2018-19
School-Based Behavioral Health Intervention and Supports – Prevention (PEI)	18,700	$1,808,589	$97
Violence Prevention Education (PEI)	12,300	$1,075,651	$87
School-Based Stress Management Services (PEI)	3,500	$155,000	$44
School-Based Mental Health Services (PEI)*	2,800	$2,915,236	$1,041
School Readiness/Connect the Tots (PEI)	1,900	$2,200,000	$1,158
Gang Prevention Services: Gang Reduction Intervention Partnership (PEI)	400	$253,100	$633

* The numbers for School-Based Mental Health Services are the total figures that include the Early Intervention track described in the Early Intervention Outpatient section.

School-Based Behavioral Health Intervention and Support (PEI)

Program Serves	Symptom Severity	Location of Services	Population Characteristics		
5 - 14	At-Risk	School	Parents	Families	Teachers/ School Personnel

The program provides services in English, Spanish.

Target Population and Program Characteristics

The School-Based Behavioral Health Interventions and Support (SBBHIS) program provides a combination of prevention and early intervention services designed to empower families, reduce risk factors, build resilience, and strengthen culturally appropriate coping skills in students and families. Services are provided in elementary, middle and high school classrooms and/or group settings in school districts identified as having the highest rates of behavioral issues based on the California Healthy Kids Survey (CHKS), Academic Performance Index (API) scores, and suspension and expulsion data as reported by school districts.

Services

SBBHIS provides a three-tiered approach to guide program services aimed at preventing and/or intervening early with behavioral health conditions among at risk students and their families:

1. Tier One, Classroom Prevention, is a classroom-based approach that utilizes an evidence-based curriculum with learning modules that focus on key learning objectives such as self-concept, life-skills, positive decision making and respect.
2. Students exhibiting higher-level problem behaviors are provided Tier Two Student-Based Interventions, which utilize smaller, student groups that focus on specific areas of concern such as bullying, anger management, conflict resolution, drug prevention and/or self-esteem.
3. Finally, students who require more intensive services than what is provided in Tier Two or who display symptoms indicative of higher level needs receive Tier Three, Family Inter-

> **"We learned new things like how not to bully and now I'm nicer to my sister."**
>
> – **Elementary student**

vention. This tier provides early intervention services for these at risk families and focuses on family skill-building designed to improve family communication, relationships, bonding and connectedness.

Strategies to Improve Timely Access to Underserved Populations

The school setting generally allows for a large number of students to benefit from prevention and early intervention services, and SBBHIS targets schools with the highest need of prevention services. The program provides direct services in the classroom, which allows students to receive lessons in their current learning environment. This approach reduces classroom disruption and encourages student comfort and compliance. Staff serves all students in the classroom, which assists in reaching those who may be more difficult to reach outside of school hours.

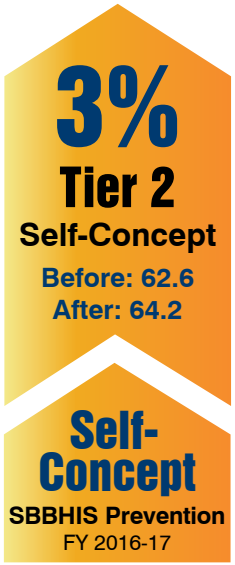
Strategies to Reduce Stigma and Discrimination

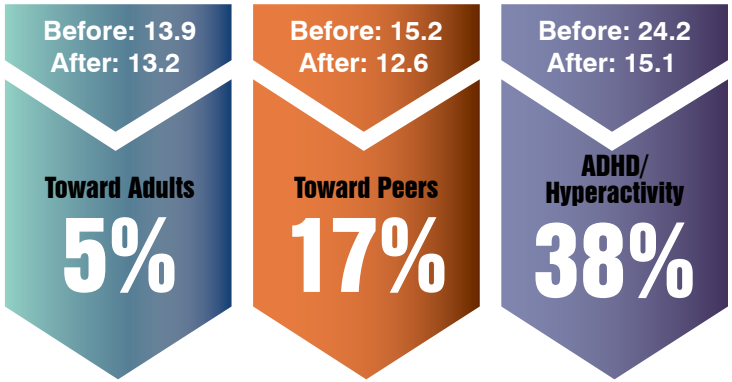
The program strives to make services available to students and parents in participating schools and to provide services that are sensitive and responsive to participants' backgrounds. The program also employs bilingual staff to meet the program's multicultural and language needs.

Outcomes

During 2016-17 a total of 26, 924 participants were served, including 24,242 students, 1,590 parents/guardians, 914 school staff and 178 family members. To assess the program's effectiveness in reducing prolonged suffering, positive self-concept for Tier 2 participants (n=544) and disruptive behaviors for Tier 3 participants (n=32) were assessed between intake (baseline) and program exit. This evaluation strategy reflects cultural competence by utilizing assessment tools that are appropriate both for the ages of the population served and for use in a school environment.

Based on a measure adapted from the Self-Concept Scale (maximum score=80), students in Tier 2 maintained positive self-concepts during FY 2016-17.[1] In addition, parents in Tier 3 reported that their children continue to exhibit low levels of disruptive behavior towards adults, showed small decreases in disruptive behavior towards peers, and demonstrated significant improvements in the frequency of hyperactive/impulsive behaviors (maximum scores=80).[2] Taken together, these findings indicate that SBBHIS program services are associated with helping students maintain the protective factors of having a positive self-concept and with preventing disruptive and impulsive behaviors from becoming severe and disabling among those served.





Challenges, Barriers and Solutions in Progress

Implementing services within a school setting is a complex and multifaceted process that involves coordination and decision-making at all levels of school administration. As a result, obtaining an official Memorandum of Understanding (MOU) from each school district can be a time consuming process and, consequently, access into schools may be delayed. Other notable challenges faced when providing services at schools include changes in class size and limited availability of classroom time. Strategies have been developed to streamline the process of recruiting and partnering with schools. Rapport building and relationship strengthening with administrators has been key to providing service delivery in a streamlined manner.

While the program has had success in implementing the Classroom Prevention and Student

Based Intervention components, it has faced challenges in implementing the Family Intervention component. While parents are often very interested in this level of service, they face challenges in coordinating time and, as a result, often have difficulty attending sessions consistently. The program has adjusted to include one-time workshops with the hope of encouraging parents to engage in the full series given the notable gains made by the families who have participated to date.

Community Impact

The program continues to build capacity in the community through collaboration with community partners and school districts. More than 77,000 students, 4,960 parents/caregivers and 3,242 school staff have participated since program inception.

Reference Notes

1 *Self-Concept: Baseline M=62.6, SD = 9.7; Exit M=64.2, SD=10.2; t(543) = -4.44, p<.001, Cohen's d=-.19*

2 *Behaviors-Adult: Baseline M=13.9, SD = 6.0; Exit M=13.2, SD=4.3; t(28) = 0.9, p<..382, Cohen's d=.18*
Behaviors-Peers: Baseline M=15.2, SD =9.3; Exit M=12.6, SD=6.3; t(32) = 1.9, p<.06, Cohen's d=.37
DHD/Hyperactive/Impulsive: Baseline M=24.2, SD = 16.5; Exit M=15.1, SD=10.6; t(22) = 3.3, p<.01, Cohen's d=.75

Violence Prevention Education (PEI)

Program Serves	Symptom Severity		Location of Services	Population Characteristics			
6-15	At-Risk	Early Onset	School	Parents	Families	Students	School Staff

The program provides services in English, Spanish, Vietnamese, Farsi, Korean.

Target Population and Program Characteristics

The Violence Prevention Education (VPE) program consists of five distinct tracks, each aimed at reducing a different aspect of violence and/or its impact in schools, local neighborhoods and/or families. The target audience for the different programs include students, parents and school staff at participating elementary, middle and high schools throughout Orange County, as well as other community sites such as domestic violence shelters.

Services/Impact

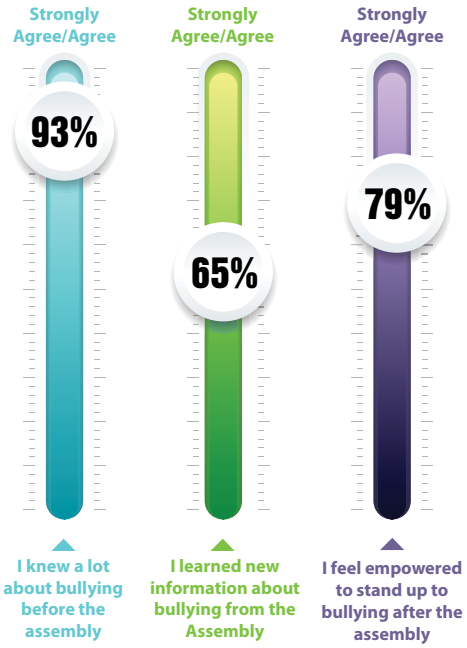
The program has five different tracks designed to promote violence prevention. Four of the tracks are structured as educational/informational presentations and the fifth is a mobile crisis team that responds to schools and other community locations that have experienced a crisis event. Each track uses an evidence-based or practice-based evidence standard geared toward the specific focus being covered, and fidelity to the Evidence-Based Practice (EBP) model is maintained by providing staff with periodic refresher trainings to ensure appropriate implementation. Each track and its associated learning impact are described in more detail to the following page.

– VPE program staff

"As I was leaving the office headed to a presentation, I saw a woman wearing flannel pants, no shoes, and a torn rain coat. I pulled over to give her a pair of flip flops and offer support, and she said, 'I know you, you are one who taught me about violence and the brain by using a cabbage. You also gave me this hope stone (she took the rock out of her pocket).' I said, 'Yes, that's me.' She said, 'I didn't remember your name so I think of you as "hope." She shared that my presentation inspired her to become a better mom and a stronger person. I asked where she was headed with blistered feet. She was on her way to Working Wardrobes so that she could get appropriate work attire for her interview. Her worn shoes had fallen apart as she walked seven miles in order to provide a better life for herself and for her daughter. I offered to take her to the interview, but she respectfully turned me down because she wanted to prove to herself that she could get there. She gave me a hug and said, 'thank you Ms. Hope."

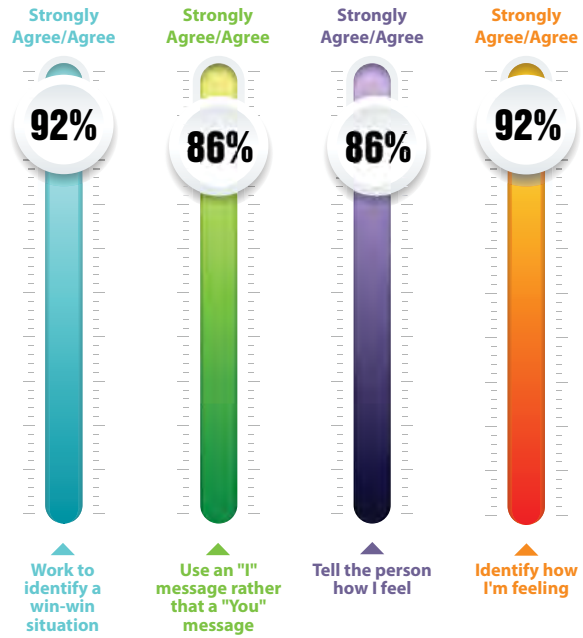
Bullying: This track provides education for students, staff, administrators and parents on bullying and cyber-bullying prevention. It is composed of two components: (1) anti-bullying presentations conducted at school site assemblies in an effort to impact the overall school climate by reducing and/or preventing bullying, and (2) a traditional classroom-based curriculum focused on combating cyber-bullying. In FY 2016-17, the majority of respondents agreed or strongly agreed that they had knew or learned about bullying and felt empowered to stand up to bullying behavior after having attended a student assembly.

Bullying: I've Got Your Back - Student Assemblies
FY 2016-17



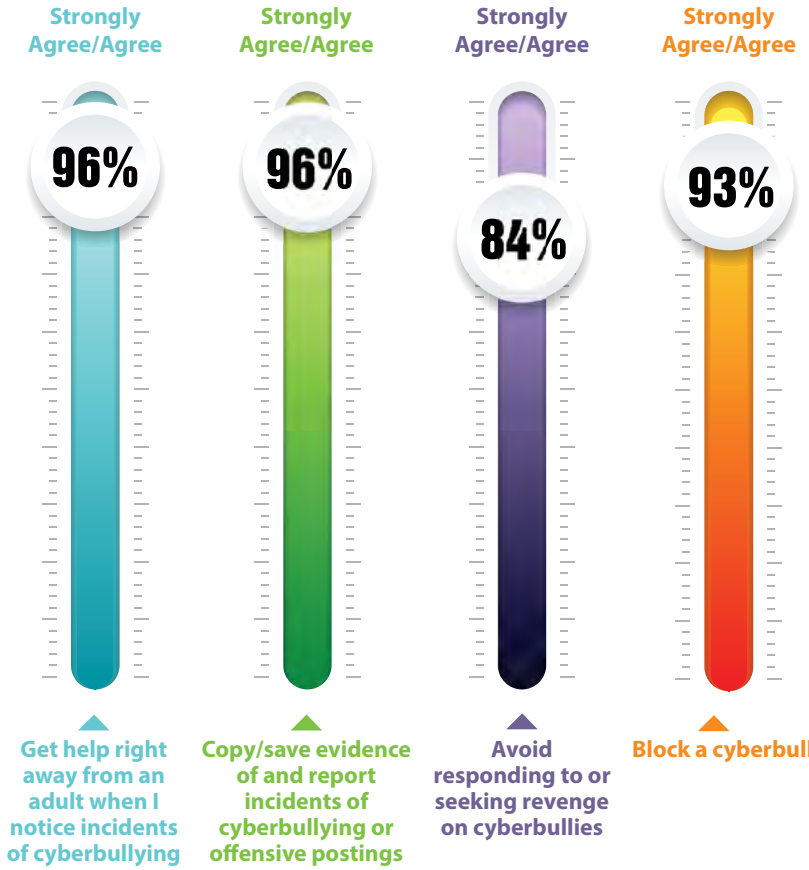
Conflict Resolution: The Conflict Resolution track supports students and parents by providing after school workshops, training and skill-building activities for teachers. The teachers, in turn, work to develop conflict resolution and peer mediation skills in their students. The overwhelming majority of participants agreed or strongly agreed with various statements reflecting their commitment to engage in the healthy/adaptive behaviors promoted during the workshop.

Conflict Resolution: "Because of the training, I will try to do the following in a conflict situation:"
FY 2016-17



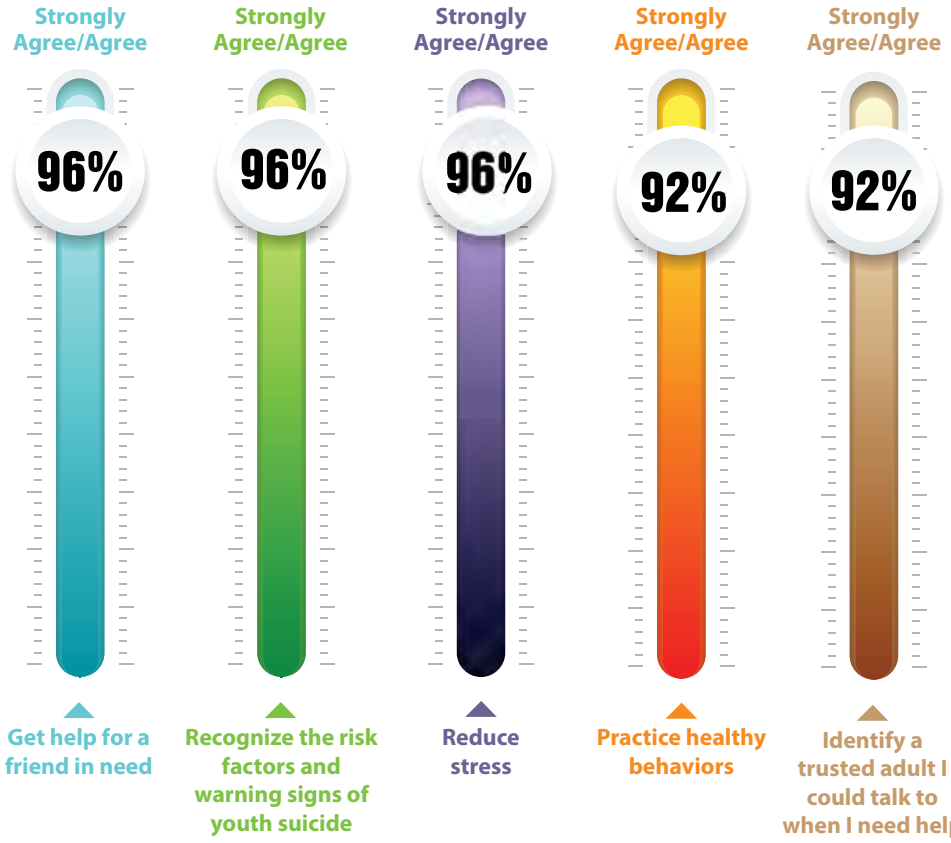
Crisis Response Network: "After today's presentation I will try to do the following:"

FY 2016-17



Crisis Response Network: After today's presentation, I will try to do the following:

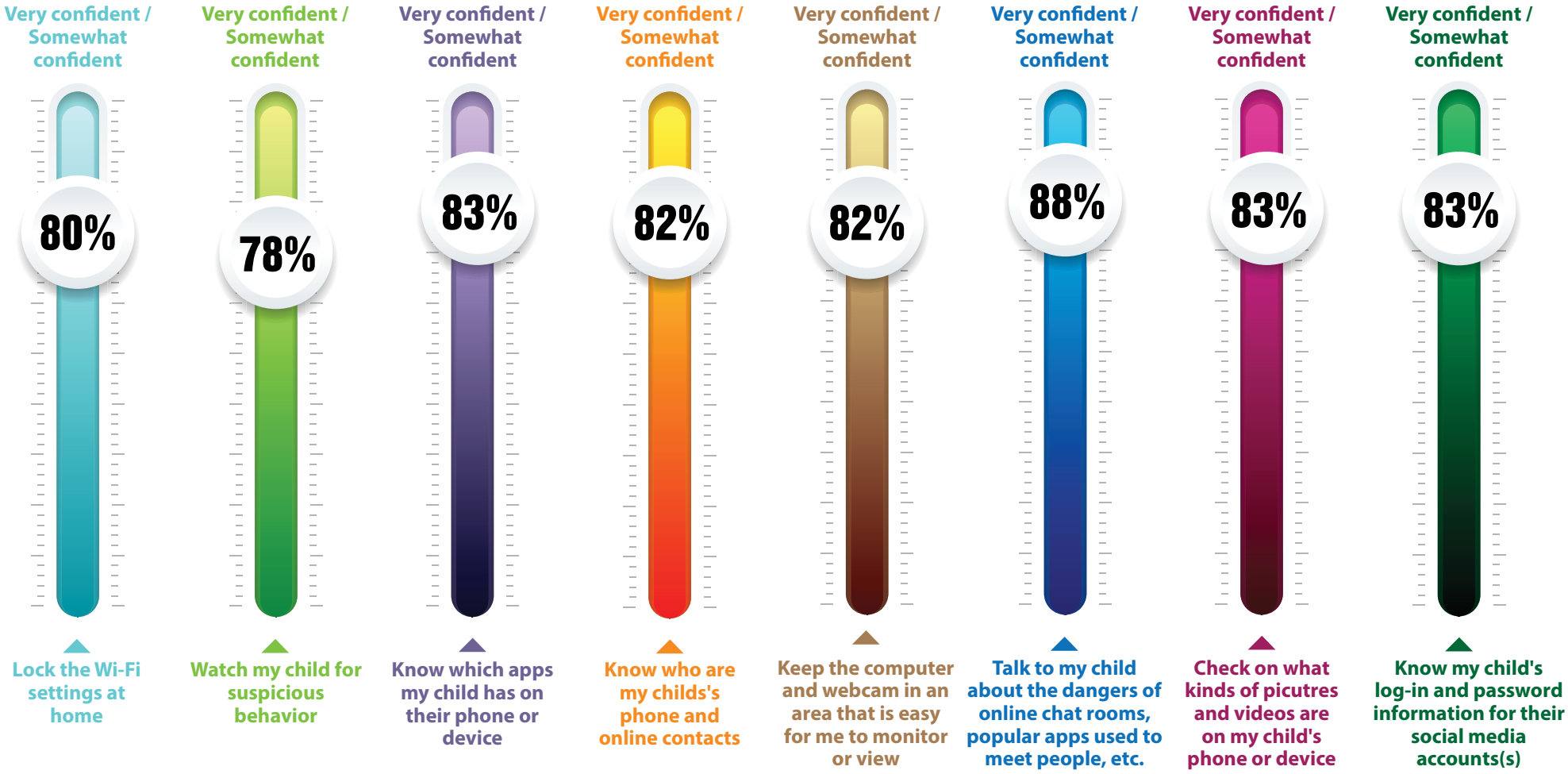
FY 2016-17



Crisis Response Network: The Crisis Response Network coordinates and manages a roster of trained crisis responders who are ready to mobilize and assist a school or community in times of emergency, need or threat. Responders are trained in Crisis Incident Stress Management. The Network also recently introduced the use of crisis dogs to assist students by reducing stress and tension associated with trauma and by providing emotional support. This track also conducts assemblies on cyberbullying in schools.

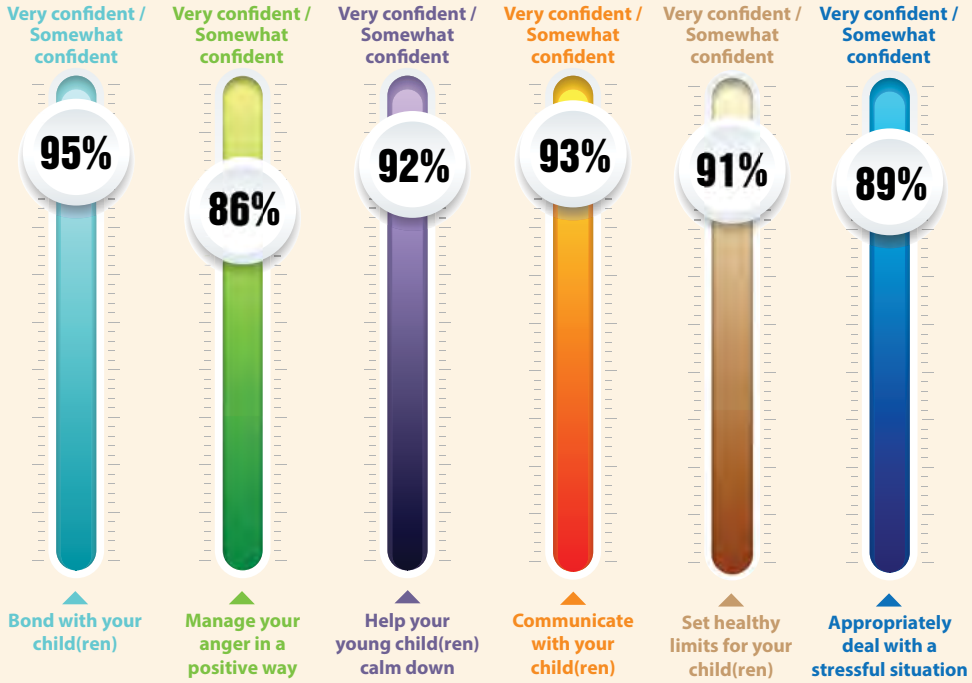
Media Literacy - After the training, how would you rate your confidence to:

FY 2016-17



Media Literacy – The Media Literacy track provides presentations for students, parents and school staff in an effort to reduce students' use of digital media in digital harassment, cyber-bullying, bullying and exploitation. Following the presentations, participants reported feeling confident in their ability to take steps aimed at decreasing their children's risk for digital harassment, bullying and/or exploitation.

Safe From The Start - After the training, how would you rate your confidence to:
FY 2016-17



Safe From The Start: Safe From The Start provides parents with essential knowledge regarding the brain development of young children. More specifically, this track disseminates scientific research on how children's exposure to violence, whether through direct physical contact or as a witness, can impact their neurological development which may then, in turn, compromise their cognitive, social and emotional development. Safe From The Start one-time presentations are provided to parents at school during and after school hours and also at shelters where they are presented as a three-part series. The overwhelming majority of participants reported feeling confident in their ability to better manage emotions and use positive parenting strategies following the training.

Strategies to Promote Recovery/Resilience

School-based activities are designed to promote resilience by encouraging a positive school climate. The various tracks work to reduce risk factors such as bullying and harassment and to develop protective factors such as conflict resolution skills. In addition, the Crisis Response Network facilitates recovery through the support and resources provided immediately in the aftermath of a crisis.

Strategies to Increase Timely Access to Services for Underserved Populations

The Violence Prevention Education program promotes timely access to its services by providing them directly in school sites. Programming is open and available to all schools and districts in Orange County, including nontraditional school sites; charter, access and private schools; and after-school programs. Presentations and informational campaigns generally target the entire student body which includes those who may not be able to be reached outside of the school site. Safe From The Start also provides services at other Orange County locations such as domestic violence shelters and alternative living sites, and the Crisis Response Network will respond anywhere needed in Orange County.

Strategies to Reduce Stigma and Discrimination

VPE presentations and materials are linguistically and culturally appropriate and available for all Orange County residents. VPE also uses trained professionals, school staff and peers to facilitate participant engagement and learning. The tracks utilize various methodologies to maximize the program's impact within different populations and to provide services that are sensitive and responsive to participants' backgrounds.

Challenges, Barriers and Solutions in Progress

The program has found the need to adjust service delivery by focusing on new or modified curricula and/or approaches that serve students and parents in a larger group setting. This has resulted in trainings that are often held in one assembly rather than across multiple classroom sessions in an effort to meet the changing scheduling needs of participating schools and districts.

Community Impact

The program has provided services to more than 113,233 students, 23,875 parents and 6,114 school staff since its inception August 2013, with the goal of reducing violence and its impact in schools, neighborhoods and families. The program has had a strong impact in local communities by increasing awareness about the risks posed by violence and bullying, providing support in times of crisis, and creating educational opportunities for students, staff, parents and Orange County residents.

School Readiness / Connect the Tots (PEI)

Program Serves	Symptom Severity			Location of Services					Population Characteristics							
0-8	At-Risk	Early Onset	Mild-Moderate	Home	Field	School	Workplace	Outpatient Clinic	Foster Youth	Parents	Families	LGBTIQ	Veterans	Homeless/ At Risk	Co-Occuring Medical	Students

The program provides services in English, Spanish, Vietnamese, Korean.

Target Population and Program Characteristics

School Readiness/Connect the Tots serves families with children ages 0 to 8 years who are exhibiting behavioral problems that put them at increased risk of developing mental illness (as determined by behavioral and socio-emotional screening tools) and of school failure. These families often face issues related to crowded living conditions, neighborhoods affected by gangs and drugs, a history of violence in the family, and history of separation from loved ones. Many of the families served are also monolingual (i.e., Spanish and Vietnamese).

Services

The program provides prevention and early intervention services aimed at reducing risk factors for emotional disturbance in young children, promoting school readiness and preparing them for academic success. Services include children's and family needs assessments, parent education/training and coaching, case management, and referral and linkage to community resources. Clinicians use Triple P techniques and materials to provide parenting education, training and coaching.

Strategies to Promote Recovery/Resilience

By identifying risk factors and intervening early, the program promotes resilience through resources and supports that are best matched to the child's and family's needs. These often include strategies to promote self-care, appropriate bonding and positive communication. By providing assessments and services in the home, program staff also observe and identify the needs of young children in the environment in which they are occurring. Completing parenting training curriculum directly in the families' homes also increases the chances of parents successfully implementing the techniques learned.

Strategies to Increase Timely Access to Services for Underserved Populations

Timely access to services is facilitated by clinicians who meet with participants wherever the parent agrees to meet, whether in the home and in the community. Thus, there are no barriers regarding transportation or childcare. Moreover, by seeing participants in their homes, program staff has the opportunity to see and work with the entire family rather than only those who are able or willing to attend appointments scheduled in a traditional clinic setting.

Clinicians also work with the parents to identify appropriate referrals for ongoing services and support as they prepare to discharge from the program. Clinicians often facilitate connections by providing a "warm hand-off" such as completing and forwarding a referral form (after the Authorization to Disclose is signed by the participant's parent) or directly assisting the parent with a phone call to the new agency. In FY 2016-17, School Readiness/Connect the Tots provided 478 referrals and 204 linkages to special needs and disability services, information and referral resources, family support services, private therapists, and health care services.

Strategies to Reduce Stigma and Discrimination

The program strives to make services available to all Orange County residents and to be sensitive and responsive to participants' backgrounds. Staff helps educate participants on behavioral health issues and normalize experiences when appropriate in an effort to decrease stigma associated with help-seeking.

> **“This program really helped me to feel better about my where my child is developmentally and taught me new ways to connect with her.”**
>
> – **Participating parent**

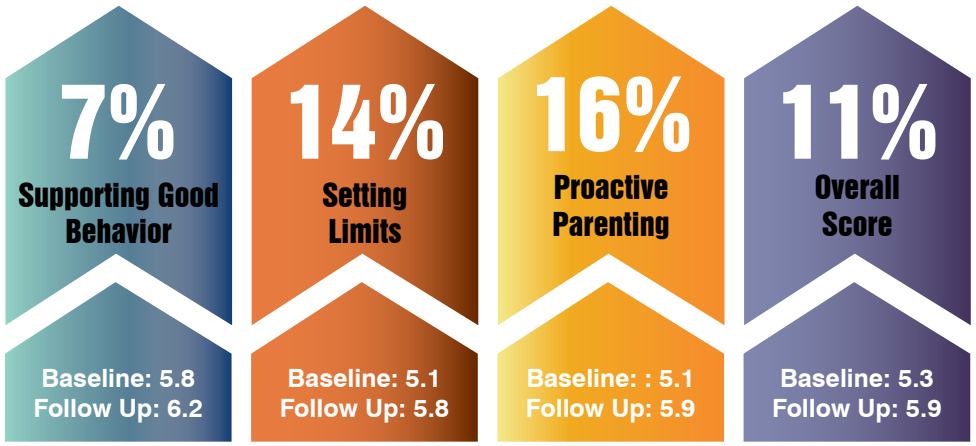
Outcomes

During FY 2016-17, a total of 861 children and 1,035 parents were served by School Readiness/Connect the Tots. The program seeks to increase parenting self-efficacy, as measured by the PARCA-SE, to help prevent the development of serious emotional disturbance in children living in at-risk environments. This measure demonstrates cultural competence in that the original tool was validated for use among diverse racial and ethnic groups (i.e., White, Hispanic, Black, Native American, Asian, Native Hawaiian, Biracial, Other) and the version used by the program is available in multiple threshold languages.

Not only did parents report relatively high levels of parenting skills such as supporting good behavior, setting limits and engaging in proactive parenting as they entered the program (maximum scores=7), they also reported moderate increases in these and other skills while receiving services.[1] Thus, the program was successful at maintaining and increasing high levels of the protective factor parental self-efficacy.

Change in Parental Self-Efficacy

School Readiness/Connect the Tots - FY 2016-17



Challenges, Barriers and Solutions in Progress

The County-operated program will require additional staffing to meet the demand for service across the county. Clinicians in these field-based programs require mobile technology to more efficiently document services. Laptops may also be used for timely referral to community resources and to present educational material to participants.

Community Impact

The program has provided services to thousands of participants since its inception July 2011. Clinicians regularly work with school and Head Start personnel, physicians and nurses to connect families to services. By helping prepare children to participate in a classroom setting, the program works to decrease the potential for school failure, which can be a risk factor for the development of mental illness.

Reference Notes

Supporting Good Behavior: Baseline M=5.8, SD=1.1; Follow Up M=6.2, SD=0.79; t(334)=-7.97, p<.001; Cohen's d=0.45

Setting Limits: Baseline M=5.1, SD=1.3; Follow Up M=5.8, SD=.98; t(334)=-11.28, p<.001; Cohen's d=0.63

Proactive Parenting: Baseline M=5.1, SD=1.4; Follow Up M=5.9, SD=0.98; t(334)=-11.62, p<.001; Cohen's d=0.66

Overall Score: M=5.3, SD=1.1; Follow Up M=5.9, SD=0.85; t(334)=-11.86, p<.001; Cohen's d=0.67

School-Based Stress Management Services (PEI)

Program Serves	Symptom Severity		Location of Services	Population Characteristics	
6 - 17	At-Risk	Early Onset	School	Students	Staff/Providers/ Workforce

The program provides services in English.

Target Population and Program Characteristics

School-Based Stress Management Services (SBSMS) provides training to teachers (Kindergarten through 12th grade) as a way to support students' well-being, academic performance and socioemotional growth. The program is open to Orange County teachers from private, public and non-public schools. Two teachers per school can receive training, and teachers are selected for training based on their ability to meet the program's attendance.

Services

This prevention program strives to reduce the risk of mental illness resulting from unhealthy coping strategies among youth by building protective factors. To achieve this, teachers attend trainings where they learn a variety of resilience, stress management and self-awareness strategies and how to incorporate them in their classrooms. Skills taught include breathing, cognitive reframing and other relaxation practices. Teachers are also taught to recognize the signs and symptoms of stress and its impact on the mind, body, learning and socioemotional development. The curriculum is promoted as a "tool-box" from which teachers may select age-appropriate and culturally sensitive strategies.

The program also includes a component where a staff member observes teachers implementing the various mindfulness techniques in the classroom and follows-up with a debriefing session. This provides teachers the ability to adjust their techniques based on the feedback provided.

Strategies to Promote Recovery/Resilience

School-Based Stress Management Services promotes resilience by educating teachers and, indirectly, their students on how to recognize and manage stress in healthy, adaptive ways. The strategies taught through the program promote wellness, mind-body awareness, and socioemotional development.

Strategies to Increase Timely Access to Services for Underserved Populations

By providing stress management and mindfulness techniques directly in the classroom when they are needed, the program provides immediate access to its services that bypasses barriers such as transportation, child care, scheduling conflicts and/or stigma that may be encountered with more traditional services.

Strategies to Reduce Stigma and Discrimination

The program strives to make its services available to students and teachers in participating schools and to provide services that are sensitive and responsive to participants' backgrounds. The program also specifically trains teachers to use practices that incorporate culturally sensitive considerations so that the program is inclusive for students from diverse backgrounds. Implementing the program directly in classrooms expands its reach to a large number of students who might not otherwise access mental health services provided in more traditional settings.

Outcomes

In FY 2016-17, 64 teachers who reached 3,033 students were trained as part of School-Based Stress Management Services and the Mindful Attention Awareness Scale was administered at baseline, every three months and at discharge (n=64). Teachers reported large gains in mindful attention as a result of the training, thus demonstrating the program's effectiveness of introducing this protective factor into the classroom.

27%

Mindful Attention

Baseline: : 5.1
Follow Up: 5.9

SBSMS Prevention
FY 2016-17

– 6th grade teacher

The kids were all gathered in the classroom awaiting the big 6th grade promotion ceremony and we asked them if they wanted to do one last "Quiet Time" before we went out to the ceremony. They all raised their hand to say yes, so we led them in one last breathing activity. The classroom that had been boisterous with talking and nervous chatter was ABSOLUTELY SILENT, every eye closed and each student peacefully breathing and focused. It was a beautiful moment--2 minutes, actually. When we ended the activity, one boy who had been through a particularly tough year emotionally said that it "hurt his soul" that it was the very last Quiet Time. There were others who commented that they were so thankful for that time to de-stress and be able to take the peace into the ceremony. …We so value the impact of this mindfulness and I just wanted to share with you some of the parting thoughts of our students.

Challenges, Barriers and Solutions in Progress

Due to the inherent nature of a classroom setting, time constraints can impact conditions ideal for implementing the mindfulness techniques, particularly for secondary teachers. In FY 2016-17, the program had fewer high school teachers recruited for training than anticipated, resulting in fewer secondary students being served the first year. The program is working to create a balance between the number of elementary teachers and secondary teachers who are trained in order to better meet the needs of the Orange County learning community.

Community Impact

The program has already provided services to more than 3,097 teachers since its recent inception October 2016. Prior research in other settings indicate that the impact of mindfulness techniques on teachers and students can impact classrooms and schools beyond those directly involved.

Reference Notes

Mindful Attention Awareness: Baseline M=3.27, SD=0.83; Follow Up M=4.21, SD=0.59; t(334)=-6.74, p<.001; Cohen's d=0.85

School-Based Mental Health Services – Prevention Track (PEI)

Program Serves	Symptom Severity		Location of Services	Population Characteristics	
11-15	At-Risk	Mild-Moderate	School	Parents	Students

The program provides services in English, Spanish.

Target Population and Program Characteristics

The prevention track of School-Based Mental Health Services (SBMHS) works with students who are transitioning between elementary and middle school or between middle and high school and their parents. The program conducts outreach to local schools and districts to identify interest in program services. The early intervention track, which provides outpatient services to individuals, is described in the Outpatient Services section.

Services

The SBMHS prevention track utilizes a classroom-based curriculum to provide psycho-education to students on topics such as healthy relationships, appropriate communication of feelings, bullying, mental health symptoms and substance use. The instruction is designed to increase resilience and build protective factors as students transition to a new school setting. Parent sessions are offered at schools in the evening to update parents on the topics their children are learning in class. The curriculum is facilitated by clinicians and seeks to engage students through the use of slide presentations, online videos and interactive classroom activities.

Strategies to Promote Recovery/Resilience

To help promote recovery and resilience among students, their social networks are engaged to create a supportive environment. The program creates buy-in from school partners and families by helping them understand that increased participation in the program promotes resilience, which can help prevent problems later in life.

Strategies to Increase Timely Access to Services for Underserved Populations

SBMHS encourages access by providing services on campus, which reduces potential barriers related to transportation, scheduling and/or reluctance to seek services at a traditional mental health setting.

Strategies to Reduce Stigma and Discrimination

SBMHS reduces stigma through a two-fold process. First, by providing presentations on mental health and wellness to students and parents, SBMHS works directly to counter stigma and misperceptions that may exist within the community. Second, by delivering the classroom-based psychoeducation on campus, students and parents may be more willing to access services because there is less stigma associated with events hosted at schools compared to those provided in traditional mental health settings.

Outcomes

In FY 2016-17, the prevention track served 2,039 students. This track is intended to provide students with coping skills that will allow them to address any existing behavioral health problems more effectively.

Students completed a survey at baseline, every three months and at discharge which assessed their knowledge about different behavioral health coping strategies. Among those who provided follow-up measures (n=1,726), students reported large gains in knowledge,[1] thus indicating that that the program was effective in promoting this protective factor.

16%
Behavioral Health Knowledge
Before: 10.1
After: 11.7

SBMHS Prevention
FY 2016-17

Challenges, Barriers and Solutions in Progress

In FY 2017-18 the two tracks, which had been operating as separate programs, were merged. The merger allows for greater flexibility in meeting the needs of local school districts by increasing the number of staff available to provide both prevention and early intervention services. SBMHS is currently recruiting to hire more clinicians as the program is not yet fully staffed.

> “[I liked…] the fact that I learned new coping skills, I could relax and let out all my anger, confusion, sadness, emptiness.”
>
> – **Participant**

Community Impact

SBMHS collaborates with school districts throughout Orange County to provide its prevention services and is currently providing early Intervention services in two large school districts. Through these efforts, the program has reached more than 10,200 participants since its inception July 2015. Program staff also receive regular in-service training on topics and resources available to the communities they serve in order to best meet the needs of the students and their families.

Reference Notes

[1] *Youth Knowledge Survey: Baseline M=10.1, SD=2.4; Follow Up M=11.7, SD=2.1; t(1724)=-30.2, p<.001; Cohen's d=0.74*

Gang Prevention Services (PEI)

Program Serves	Symptom Severity	Location of Services			Population Characteristics	
						
	At-Risk	Field	School	Hospitals	Parents	Students

The program provides services in English, Spanish.

Target Population and Program Characteristics

Gang Prevention Services (GPS) is a school-based collaboration with the Gang Reduction Intervention Partnership (GRIP) operated by the Orange County District Attorney's office in collaboration with the Probation Department, local Police Departments and school staff. The goal of the program is to create a gang-free environment in schools and the surrounding areas.

The program provides case management to 4th through 8th grade youth who display signs of being at risk for gang activity which, in turn, places them at an increased risk of violence and of developing mental health conditions, particularly those that are trauma-related. Schools are selected to participate in the program by the Orange County District Attorney's Office and the Orange County Probation Department based on high levels of truancy, discipline issues and gang proximity. The program also focuses on being inclusive of all high-risk youth regardless of their familial affiliations to gang activity or behavior.

Services

Youth in GPS are enrolled in case management based on their rates of truancy, disciplinary issues and poor academic performance relative to other students at the same school. At each participating school, staff provides education to students, parents and teachers on gang

“In 2012, a 7th grader was referred to a GRIP Strike Team Intervention for disruptive behavior, poor attendance, bullying tendencies and a violation of the school dress code. At the time of referral, the student advised the team that he wanted to be a ‘gangster’ and that the team was ‘wasting time’ on him. The youth was assigned a GPS mentor and provided intensive case management. He ultimately graduated from high school, is going to community college, and has begun creating a business plan with a partner to start his own company.”

– Shared by a GPS Mentor

prevention and offers workshops, structured group interventions, and weekly case management. Staff also works with students and their families to create an individualized action plan that addresses attendance, academic behavior, disciplinary improvement, parenting contracts and an anti-gang dress code plan. The program also provides curfew and truancy sweeps designed to get youth off the streets and back into the classroom.

Students and parents who successfully complete their behavior contracts are provided incentives such as attending a baseball game or other enrichment activities. Many events include law enforcement, which encourages families to see them in a more positive light and as part of a supportive community.

Strategies to Promote Recovery/Resilience

The program promotes resilience by providing psychoeducation and case management aimed at building adaptive coping and positive decision-making skills in at-risk youth. For youth receiving case management, wraparound activities such as soccer camps, homework clubs and incentive events encourage and motivate youth to reach their goals. GPS staff also works with parents to help them find ways to support their child and increase the transfer of skills learned in the classroom to home and other environments.

Strategies to Increase Timely Access to Services for Underserved Populations

GPS improves access to its services by identifying schools with the highest levels of truancy, discipline issues and gang proximity and then co-locating its program on those campuses. This school-based approach is particularly helpful for students and their parents/caregivers who might otherwise be isolated when not in the school setting. GPS also has staff who are bilingual in English and Spanish to facilitate engagement in the program by the target population.

For youth and families in need of additional services and supports, the program also refers them to community resources. In FY 2016-17, the program provided 866 referrals and 634 linkages to counseling services, adult literacy programs, housing and food assistance, medical referrals, school supplies, enrichment activities.

Strategies to Reduce Stigma and Discrimination

The program strives to provide services that are linguistically and culturally appropriate and enlists the help of trained professionals, school staff, law enforcement and local celebrities to encourage participation in its program activities. These individuals present a positive role model and motivate the parents and students to feel empowered to participate in the behavior contracts.

Outcomes

During FY 2016-17, 426 children were served and asked to complete the PROMIS® Pediatric Global Health at baseline, every three months and at discharge. In FY 2016-17, participants reported maintaining and making moderate gains in global health (35=maximum score; n=401). Thus, GPS was effective at promoting the protective factor of global health and well-being among its program participants.

Challenges, Barriers and Solutions in Progress

In GPS, case managers are constantly encouraging parents to engage with their child by facilitating the establishment of positive social support networks. This is accomplished by creating an open environment with other parents, the school and local law enforcement. The program assists with this coordination by offering parents opportunities to be involved as greeters at their child's school and by encouraging an environment of rapport building with law enforcement. This is an innovative strategy as many communities are often intimidated by law enforcement officials. Youth and their families also meet regularly with case managers to resolve and overcome challenges related to truancy or other school-related behavioral issues in an effort to deter future gang involvement.

Community Impact

GPS has provided services to more than 3,504 students since its inception August 2013. Through its case management services, the program has encouraged youth to avoid high-risk behavior and be more involved in positive decision-making. The program has also strengthened relationships with the community by partnering with organizations and businesses such as the Los Angeles Angels of Anaheim. Through these collaborations, agencies are able to educate and motivate students and to serve as mentors for future career possibilities. The Californian State Association of Counties, which highlights effective and innovative prevention and intervention programs across California, selected GPS for this honor in 2014. The GPS program continues to receive awards for working with Orange County schools on gang suppression, interventions for at-risk students, gang information forums, and parent/ faculty education.

Reference Notes

[1] *PROMIS Global Health 7: Baseline M=24.9, SD=4.3; Follow Up M=27.2, SD=4.1; t(100)=9.46, p<.001; Cohen's d=0.47*

COMMUNITY TRAINING

Prevention: Community Training	Estimated Number to be Served in FY 2018-19	Annual Budgeted Funds in FY 2018-19	Estimated Annual Cost Per Person in FY 2018-19
Religious Leaders Behavioral Health Training Services (INN)	30	$259,450	$8,648
Training, Assessment and Coordination Services (PEI)	N/A	$508,610	N/A

As part of its Prevention services, Community Training programs provide mental health trainings throughout Orange County. The training offered through this service area differs from that offered through the Workforce Education and Training service area in that the former focuses on serving community members, agencies, partners and providers, and the latter generally focuses on serving County-operated and County-contracted providers. Orange County currently has two community-focused training programs – one funded through Innovation and the other through PEI, which are described below.

Religious Leaders Behavioral Health Training Services (INN)

Target Population and Program Characteristics

The Religious Leaders Behavioral Health Training Services project is designed for religious leaders and community members of all faiths in Orange County, as well as their congregants and community members.

Services

The Religious Leaders Behavioral Health Training Services project is designed to increase access to services by utilizing a train-the-trainer model to provide basic behavioral health skills training to religious leaders. Project staff (i.e., training coordinators) conduct outreach at various religious establishments located throughout Orange County to recruit and enroll religious leaders into an 8-hour train-the-trainer course. Trained religious leaders, in turn, provide a 4-hour basic behavioral health skills training to their congregants and community members. Training content for the religious leaders and community members includes culturally competent information and open discussion about the impact of culture and religious beliefs on mental illness and recovery; the cultural impact of stigma; cultural barriers to accessing treatment; cultural variations in defining mental health; and spirituality as a protective factor to address stigma and the effect on their community. All trainings are provided in a group setting and offered at various locations throughout Orange County.

The Religious Leaders Behavioral Health Training Services project was implemented July 1, 2015. Innovation funds for this project will end June 30, 2020.

Strategies to Promote Recovery/Resilience

Culturally specific information is integrated into the training materials to raise awareness about mental illness within different ethnic communities, identify barriers to seeking help, and provide strategies to support individuals experiencing symptoms of mental illness. A section of the 8-hour train-the-trainer curriculum focuses on the recovery model and identifies the various sources of support during an individual's recovery process (i.e., religious leaders, cultural healers, healthcare providers, family members, etc.).

Strategies to Improve Timely Access to Services for Underserved Populations

This training offers a promising new strategy to improve timely access to behavioral health care, as many community members seek guidance from their pastors and religious leaders during crisis, especially among ethnic communities. A portion of the train-the-trainer curriculum for religious leaders focuses on the County and community behavioral health resources available for individuals struggling with symptoms of mental illness. The religious leaders, in turn, impart their knowledge of these resources to the congregants and community members, thus serving as a gateway to behavioral health services. The training not only raises awareness about available resources, but also provides religious leaders with the knowledge and ability to better support their congregants and community members during a mental health crisis.

Strategies to Reduce Stigma and Discrimination

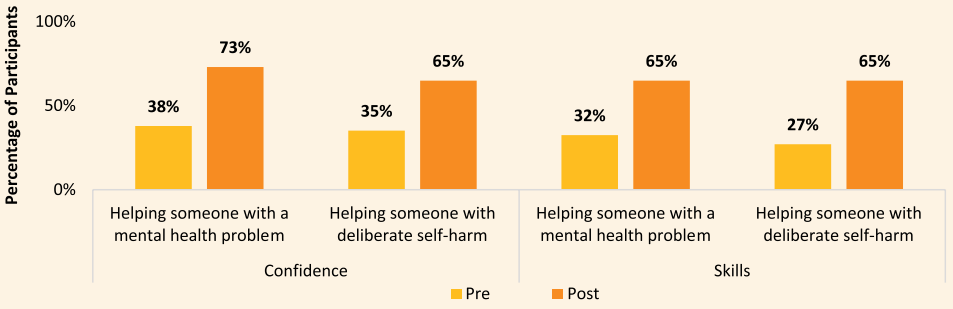
An essential portion of the curriculum is devoted to defining stigma, discussing its impact on individuals and their families, and identifying strategies to reduce stigma. Interactive group discussions and activities are integrated throughout the trainings to engage participants in active discussion about the definition and impact of stigma.

Outcomes

Religious leaders were asked to complete the Mental Health Training and Confidence Questionnaire before and after receiving the 8-hour training. The questionnaire asked participants to rate the degree to which they felt comfortable and had the skills to help someone with a mental health problem or with thoughts/behaviors of self-harm. The training appeared to be effective in increasing comfort and skill with assisting those experiencing mental health symptoms: while only about one-third of the participants rated themselves as high in confidence and/or skills prior to receiving the training, about two-thirds rated themselves as high in these areas after receiving the training (n = 37).

Mental Health Training and Confidence Questionnaire

Religious Leaders - FY 2016-17



> “It was a pleasure being in the training. There is so much information to take home and helping them in my community. Thank you.”
>
> – Religious Leader

> “Presentation was very informative and culturally significant. We need more of this. Should advertised more so more people know about the resource and workshops.”
>
> – Community Members

In addition, religious leaders completed the Knowledge, Attitudes, and Beliefs about Mental Illness Questionnaire before and after receiving the training. After noting unexpected increases in a few items that suggested the training actually promoted misconceptions surrounding mental illness, staff discovered that these unanticipated results almost exclusively occurred among individuals who reported that they had limited English proficiency and/or their preferred language was not English. Thus, staff are reviewing the forms to determine if the quality of the translations are driving these results, and/or whether there are issues related to the training itself. These findings will be addressed in the project's final report.

Challenges, Barriers and Solutions in Progress

The time commitment required of religious leaders to participate in this project has been a challenge. During the first year of services, religious leaders attended a 24-hour training over three consecutive days and were required to provide two separate 8-hour trainings to community members. Religious leaders expressed that their schedules did not permit them to commit to this project and suggested shortening the length of the trainings. Significant changes were made to the curriculum content and length in year two to accommodate feedback received from the religious leaders.

In addition, based on participant feedback, the PowerPoint format of these trainings was too formal and academic for many communities. As a result, the content of trainings was simplified and tailored to match the target audience. Furthermore, training coordinators increased their level of support to the religious leaders at the community trainings, with trainings offered over multiple days in order to accommodate their schedules. Community trainings were also offered at various sites rather than only at the religious sites to reduce any stigma associated with attending the training. This was based on feedback that some participants felt uncomfortable being seen attending a training associated with mental illness.

Community Impact

This project has trained 105 religious leaders and 1,569 community members since its inception July 2015. At the end of each 8-hour train-the-trainer course, religious leaders were asked to rate their satisfaction with program staff and services. In FY 2016-17, results showed that a majority of the religious leaders who completed the survey (n = 37) strongly agreed that they were satisfied with the program (84%), were treated with courtesy and respect (92%), and would recommend the training to others (76%). Similarly, community members were asked to rate their satisfaction with the 4-hour training provided by the religious leaders. Results showed that a majority of responding community members (n = 522) strongly agreed that they were satisfied with the program (66%), were treated with courtesy and respect (76%) and would recommend the training to others (72%).

Training, Assessment & Coordination Services (PEI)

Target Population and Program Characteristics

The Training, Assessment, and Coordination Services program serves the PEI priority populations, their family members, and any community member working with these priority populations such as first responders, probation officers and teachers. The PEI priority populations, as originally defined by the California Department of Mental Health, include trauma-exposed individuals, individuals experiencing onset of serious mental illness, underserved cultural populations, and children and youth in stressed families who are at risk of school failure and/or juvenile justice involvement.

Services

The program is designed to provide a variety of behavioral health-related trainings and supports to better understand, identify and address the potential mental health needs of the PEI priority populations and to help these populations access and utilize local community mental health resources. Included in the program are trainings and incident responses provided by the Behavioral Health Services Disaster Response Team, which included Psychological First Aid (PFA) training and Critical Incident Stress Management (CISM) group and one-on-one debriefings, grief-related education and self-care education.

Strategies to Promote Recovery/Resilience

The training content is specifically tailored to foster recovery and resilience in the target population being served. This can include providing crisis management, self-care skill building, and/or grief education and resources. In addition, they are designed to better inform and/or prepare a wide range of community providers and potential first responders on how to identify behavioral health conditions in all age groups, how to assist individuals exposed to trauma and/or living with behavioral health conditions and their families effectively, and how to increase their knowledge regarding accessing behavioral health services.

Strategies to Improve Timely Access to Services

An assessment was completed to assess the County's training needs. This process involved representation from all of the PEI priority populations, including family members and providers working with these populations. Some of the needs and strategies identified included providing more trainings in south county; providing trainings in Vietnamese, Korean and Farsi; and providing on-going technical assistance after a training to reinforce learning. In addition, the increased need for culturally nuanced mental health awareness training, coupled with information for accessing services, was identified.

Strategies to Reduce Stigma and Discrimination

Consistent with one of the identified areas of concern in the needs assessment, trainings will specifically address the stigma and discrimination faced by those living with mental illness and those seeking services.

Outcomes

The findings from the PEI Training Needs Assessment continue to be implemented with new trainings being offered this year.

Challenges, Barriers and Solutions in Progress

A variety of strategies are being implemented to implement training services out in the community in a timely manner. They include building training components into existing programs and/or contracting out new services.

Community Impact

In FY 2016-17, 185 individuals in the program were provided with one or more behavioral health responses, including Psychological First Aid (PFA), Critical Incident Stress Management (CISM) group debriefings, CISM one-on-one debriefings, grief-related education and self-care education. In addition, approximately 200 individuals from community based organizations, the Orange County Department of Education and Leisure World received trainings on the behavioral health responses taught by the program.

Individual/Family Support

Navigation/Access and Linkage to Treatment/Services
Crisis Services
Residential Treatment
MHSA Outpatient Treatment
Recovery and Supportive Services
Supportive Housing

This level is the largest Support Level in BHS, serving individuals who are living with or at risk of developing a mental health condition and their families. Services are provided at the individual level and customized to meet the needs of the person.

NAVIGATION/ACCESS AND LINKAGE TO SERVICES

Programs that fall within the Navigation/ Access and Linkage to Treatment/Services function are designed to link individuals of all ages who are living with a mental health condition to an appropriate level of care. In addition, for a program in this service function to meet the MHSOAC PEI Regulations criteria, these types of programs and/or program strategies must be designed to link individuals who are living with SED or SMI specifically to the most appropriate higher level of care.

Orange County offers several programs that fulfill this broad service function. The majority of the programs are funded by CSS and tailored to meet the needs of specific unserved populations living with SMI or SPMI (i.e., individuals who are homeless, discharging from jail or a hospital, etc.). The remaining two programs in this section are funded by PEI and serve the broader Orange County community needing assistance with navigating and/or accessing the County behavioral health system of care, regardless of the level of their behavioral health need (i.e., at risk through severe). In addition, the Crisis Assessment Teams (described in the Crisis Services section) provide access and linkage to treatment for individuals with SED/ SMI who are in an acute crisis.

Navigation / Access and Linkage to Treatment/Services	Estimated Number to be Served in FY 18/19	Annual Budgeted Funds in FY 18/19	Estimated Annual Cost Per Person in FY 18/19
Information and Referral/OC Links (PEI)	**10,500**	$1,000,000	$95
Outreach & Engagement Collaborative (PEI)	3,625 (combined engaged participants)	$2,819,044	$1,983 (combined engaged participants)
BHS Outreach and Engagement (CSS/PEI)		$3,069,933 (CSS) $1,300,000 (PEI)	
Multi-Service Center – Courtyard Program (CSS)	250	$500,000	$2,000
Recovery Centers/ Recovery Clinic Services/ Recovery Open Access (CSS) *	3,500	$9,158,531	$2,617
Assisted Outpatient Treatment (CSS) **	1200 calls; 600 referrals; 95 FSP	$5,015,841	$8,360 (across both tracks)
CHS Jail to Community Re-Entry (CSS)	1600	$3,200,000	$1,938

* *The Recovery Centers/Recovery Clinic Services/Recovery Open Access figures include numbers for all three programs. Recovery Centers/Recovery Clinic Services is described in Outpatient Services.*

** *The Assisted Outpatient Treatment figures include both the Assessment and Linkage Team described below and the AOT Full Service Partnership described in the Full Service Partnership section.*

Information and Referral/OC Links (PEI)

Program Serves	Symptom Severity				Location of Services	Population Characteristics										
																
	At-Risk	Early Onset	Mild-Moderate	Severe	Telephone/ Internet	Foster Youth	Parents	Families	LGBTIQ	Veterans	Homeless/ At Risk	Co-Occurring SUD	Co-Occurring Medical	Students	Criminal Justice	Staff/ Providers/ Workforce

The program provides services in English, Spanish, Vietnamese, Farsi, Telecommunications Device for the Deaf (TDD) number for hearing impaired.

Target Population and Program Characteristics

OC Links is a Behavioral Health Services (BHS) Information and Referral Line that serves anyone seeking information or linkage to any of the Health Care Agency's Behavioral Health Services. Because the Navigators who staff the line are clinicians, they are able to work with callers experiencing any level of behavioral health issue.

Services

Serving as the single access point for the HCA/BHS System of Care, OC Links provides telephone and internet chat-based support for any Orange County resident seeking Health Care Agency-funded behavioral health services. Trained Navigators provide screening and assessment, information, and referral and linkage directly to BHS programs that best meet the needs of callers. Navigators make every attempt to connect callers directly to services while they are still on the line. Once the caller is scheduled for their first appointment, the Navigator offers a follow up call within the next 1-2 days to ensure a linkage has occurred.

OC Links operates from 8 a.m. to 6 p.m., Monday through Friday. During these hours, callers may access navigation services through a toll-free phone number (855-OC-Links or 855-625-4657) or a Live Chat option available on the OC Links web page (www.ochealthinfo.com/oclinks). Individuals may also access information about BHS resources on the website at any time (http://www.ochealthinfo.com/bhs/).

Strategies to Promote Recovery/Resilience

OC Links provides trained navigators who are consumer-centered and focused on reducing barriers to client engagement in services. Navigators use recovery principles and techniques such as motivational interviewing to help engage individuals in their recovery journey.

Strategies to Increase Timely Access to Services for Underserved Populations

To increase awareness and usage of OC Links services among unserved and underserved populations in Orange County, various advertising strategies in multiple languages have been used. For example, OC Links displays its information and phone number on rotation every day at the Civic Center Plaza message board; has advertised on Public Access Cable Television Community Resource displays; and has posted advertisements on Facebook and Twitter that direct people to the OC Links website where they can obtain information and connect to Live Chat with the Navigators. Information cards in all of the threshold languages are also handed out at many locations throughout the county, including schools, colleges, community organizations, businesses, court houses, libraries and resource fairs.

Once an individual connects with OC Links, they can work with a Navigator who speaks English, Spanish, Vietnamese, Korean, Arabic or Farsi. The program also has access to a language line translation service to meet the language needs of any caller and offers a Telecommunications Device for the Deaf (TDD) number (714-834-2332) for hearing impaired

> **“You have no idea how much I needed your help, I don’t know what I would have done had I not found you.”**
>
> **– Caller**

callers. In FY 2016-17, OC Links responded to 14,152 callers and referred them to outpatient mental health and substance use programs, residential drug treatment services, detoxification services and crisis services.

Strategies to Reduce Stigma and Discrimination

OC Links has continually prioritized cultural competence in all aspects of the program. Clinicians hired are bilingual/bicultural (see grid) and regularly provide outreach trainings on OC Links and the HCA Behavioral Health System of Care at community agencies, religious organizations, apartment complexes and resource fairs that have a specific cultural focus in their threshold language. Staff also provides trainings to the general community at town hall meetings and resource fairs and to law enforcement hundreds of times per year. With this increased presence in the community, OC Links hopes to reduce the stigma and discrimination attached to those attempting to reach out for behavioral health services.

Due to their bicultural background and training, each Navigator is also able to match callers to the service or program that best meets their cultural needs. Many callers have remarked that having a Navigator who speaks their language has reduced the amount of stigma they felt in reaching out for mental health or substance use services in the first place.

Challenges, Barriers and Solutions in Progress

Increasing community awareness about OC Links and the services available through the county is a constant challenge that must be continually be addressed. In order, to better educate the public about OC Links on an on-going basis, a short video about the program was created and placed on the HCA website. As utilization has increased, the program has noted an increasing need for bilingual speakers. Thus, OC Links continues its recruitment efforts to hire bilingual clinicians who are knowledgeable about the County BHS system.

Community Impact

The program has responded to more than 45,000 participants since its opening Fall 2013. OC Links serves Orange County residents by helping callers navigate a large and complex system of care and linking them to the County and/or county-contracted services best suited to meet their behavioral health needs.

Outreach and Engagement (PEI/CSS)

Outreach and Engagement O&E Collaborative (PEI)

Program Serves	Symptom Severity			Location of Services
				
	At-Risk	Early Onset	Mild-Moderate	Field

The program provides services in English, Spanish, Vietnamese, Farsi, Korean, Arabic, Japanese, Mandarin, Taiwanese, Khmer, Hmong and Samoan.

Outreach and Engagement O&E Collaborative (CSS)

Program Serves	Symptom Severity		Location of Services	Population Characteristics						
										
	Mild-Moderate	Severe	Field	Parents	Families	LGBTIQ	Veterans	Homeless/ At Risk	Co-Occurring SUD	Co-Occurring Medical

The program provides services in Spanish, Vietnamese, Farsi, Korean, Arabic.

Target Population and Program Characteristics

Outreach and Engagement (O&E) provides field-based access and linkage to treatment and/or services for unserved and underserved individuals of all ages living in Orange County. Orange County currently has two O&E programs, each with a specific focus. Both programs work with individuals experiencing a range of symptom severity, with the BHS program specializing in working with those who are homeless or at risk of homelessness and have had difficulty engaging in mental health services on their own. In addition, the PEI-funded O&E Collaborative works with individuals who have had life experiences that make them at risk of developing behavioral health conditions but are hard to reach in traditional ways because of cultural, linguistic or economic barriers. O&E staff from both programs identifies participants through street outreach and referrals from community members and/or providers.

Services

The O&E programs work to identify those in need of mental health services, collaborate with them to determine the services that will best meet their mental health needs, and work to engage them in these on-going services. To promote awareness of, and increase referrals to, their services, the programs perform outreach at community events and locations likely to be frequented by individuals the programs intend to serve and/or the providers that work with them in non-mental health capacities (i.e., health fairs, community festivals, door-to-door outreach, etc. for the O&E Collaborative; street outreach, homeless service provider locations, etc. for BHS O&E). Staff then screen individuals in the community or over the phone to determine what is needed based upon an established level of risk, and provide program-specific linkage strategies described in more detail below.

O&E Collaborative's Linkage Strategies: Participants screened by the collaborative are assigned to one of three levels based on their degree of risk of developing a mental illness:

- Level I is for individuals identified as at-risk or mild risk who are provided referrals for services and able to access them independently.
- Level II is for individuals identified as mild to moderate risk who have a mental health issue and/or barriers to accessing services that require additional engagement efforts.
- Level III is for individuals identified as moderate to high risk who have a mental health issue and/or barriers to accessing services that require intensive engagement efforts.

Staff work to overcome any identified barriers for individuals in Levels II and III by offering educational and skill-building workshops and presentations, support groups, and individual interventions such as crisis intervention, needs assessment, life coaching, individual skill development and wellness/case management. In addition, participants in the highest level of risk are provided appropriate clinical intervention such as mental health counseling and clinical case management until they are able to be linked to on-going care.

BHS O&E's Linkage Strategies: BHS' strategies include developing personalized action plans to decrease barriers to accessing services and evidence-based Seeking Safety psychoeducational groups for those who have experienced trauma and/or substance use. Staff utilizes motivational interviewing, harm reduction, and strength-based techniques when working with participants and assists them in developing and practicing coping skills. All outreach services are focused on making referrals and ensuring linkages to ongoing behavioral health and support services by providing assistance with scheduling appointments, providing transportation to services, addressing barriers and offering ongoing follow-up.

Strategies to Promote Recovery/Resilience

The O&E programs work to build protective factors and developmental assets which, in turn, reduce the vulnerability of the people served. Individuals may have previously experienced trauma or, particularly among the homeless population, are currently experiencing daily trauma and struggling to meet their basic needs, leaving them feeling disenfranchised or stigmatized. In order to engage individuals successfully, staff integrates a strength-based approach that works with individuals in their current stage of recovery and acknowledges and builds upon their existing coping skills. They also use harm reduction techniques, provide unconditional positive regard, and offer supportive services while working to link individuals to treatment.

Strategies to Increase Timely Access to Services for Underserved Populations

O&E has developed collaborative relationships with outside agencies that come into frequent contact with the target populations and, in turn, these agencies provide referrals to the O&E programs. The types of agencies with which the programs have established strong working relationships include community based organizations, homeless service providers, housing programs and shelters, schools, places of worship, law enforcement agencies, hospitals, social service agencies, juvenile justice, the Probation Department, the Orange County Fire Authority, veterans services, community centers, motels, shelter staff, apartment complexes, and other behavioral health service agencies.

Providing services out in the community allows O&E to reach those who would not normally access services due to being isolated because of cultural, linguistic, socioeconomic or transportation reasons. The staff adapts its outreach efforts to match the needs of different sub-populations, cultures, or county regional areas. This allows staff to become experts in particular locations which then allows them to build trust and rapport with individuals more readily. The O&E programs also provide toll-free numbers further increase access.

The O&E programs' primary goal is to increase individuals' willingness to enroll in needed services and facilitate linkage to appointments in as timely a manner as possible. Therefore all services focus on making referrals and linkages. Staff stay up to date on available resources, network and collaborate with other providers, assist with decreasing barriers to accessing services as they are identified, and provide transportation and warm handoffs to ensure linkage to on-going to care. In FY 2016-17, the O&E Collaborative provided 22,424 referrals resulting in 8,407 linkages to services such as health education, disease prevention, wellness and physical fitness; PEI programs; adult education services; family support services; and behavioral health outpatient services, and BHS O&E provided 9,225 referrals resulting in 2,576 linkages to services such as mental health and substance use outpatient and intensive outpatient programs; housing support services; and medical services.

Strategies to Reduce Stigma and Discrimination

Due to the stigma associated with mental illness that can run deep within diverse communities, the O&E programs recruit diverse staff and volunteers who are knowledgeable about the communities they serve. The programs follow the premise that it is not enough for staff to speak the language, but they also need to know the religious and cultural nuances and the traditions of that particular community. Partnering with community agencies that come into regular contact with the target population also helps the programs gain the trust of a community. These strategies allow program staff to establish relationships with participants and their families which, in turn, reduces stigma related to seeking mental health services.

Challenges, Barriers and Solutions in Progress

For many Orange County residents who go unserved, one key barrier to seeking services is transportation. O&E removes this obstacle by bringing information and services such as case management and counseling directly to participants wherever they are in the community.

Lack of affordable housing also continues to be a barrier, especially for the homeless and the programs continue to collaborate with agencies to improve access to affordable housing opportunities. In the past, linking individuals to mental health services was challenging when they were uninsured, underinsured or had other barriers to accessing services (e.g., trans-

> **“You looked into my eyes when you spoke to me and you provided support by going to my appointments with me when I felt stranded. Through your guidance I was able to stabilize and now I will be moving into my place tomorrow!”**
>
> **– BHS O&E participant**

portation, meeting program eligibility criteria, etc.). With the addition of short-term counseling services, O&E collaborative programs can now fill this gap.

To address some participants' reluctance to provide personal information or enroll in engagement services, the programs have reached out to work with trusted community agencies/organizations. Through these partnerships, O&E staff has demonstrated the ability to follow through on commitments to address participants' needs and assisted individuals with accessing referrals, thereby building trust and rapport with participants. Once rapport and some success in linking to resources has been established, participants have been more receptive to engaging in on-going services.

Community Impact

Outreach and Engagement is firmly rooted in Orange County with strong collaborations with various community based organizations, school districts, law enforcement, churches, physician groups, parent groups, housing providers, outreach teams, older adult programs, other behavioral health programs, and other providers of basic needs. The programs have reached individuals of all ages from multiple cultures throughout Orange County and have helped them access needed behavioral health and supportive services.

The BHS O&E team were the recipients of the 2017 Steve Ambriz Team Excellence Award

The Multi-Service Center Courtyard Program (CSS)

Program Serves	Symptom Severity	Location of Services	Population Characteristics				
18+	Severe	Field	Veterans	Homeless/ At Risk	Co-Occurring SUD	Students	Criminal Justice

The program provides services in Spanish, Vietnamese, Farsi and Korean.

Target Population and Program Characteristics

The Multi-Service Center's (MSC) Courtyard program serves residents ages 18 years or older who are living at the Courtyard homeless shelter in Santa Ana and have a serious and persistent mental illness and/or co-occurring substance use disorder. The mobile outreach team from the Multi-Service Center operates at the Courtyard shelter seven days a week on weekends and weekday evening hours to link individuals to mental health and/or substance use services, including detoxification.

Services

Courtyard outreach workers assess residents' strengths and resources to determine their level of psychosocial impairment, substance use, physical health problems, support network, adequacy of living arrangements, financial status, and employment status, potential and training needs. In coordination with BHS Outreach & Engagement staff operating at The Courtyard during traditional business hours, MSC outreach workers facilitate linkage to the most appropriate services for each individual (i.e., case management, outpatient mental health, medical appointments, housing, employment, SSI/SSDI, and other services such as obtaining identification or other personal documents, etc.). The team can transport, or facilitate the transportation of, residents to those services as needed.

Strategies to Increase Timely Access to Services for Underserved Populations

To improve access to its services, the Courtyard outreach team is available 7 days a week and operates during evening hours. The staff is bilingual/bicultural and a language translation service is available when needed. In addition, the team is staffed with peers who share their own lived experience as a way to build the rapport and trust necessary to engage homeless individuals into services. Since The Courtyard Outreach team went live in December 2016, it has made 5,130 outreach contacts, 826 referrals and 278 linkages to services.

Strategies to Reduce Stigma and Discrimination

Outreach workers often have lived experience and are knowledgeable about the field of chronic homelessness, mental health and substance use. They recognize that each person's diverse experiences, values and beliefs impact how they will access services. Using the principles of recovery, they are also trained to identify the underlying conditions associated with homelessness and address them in a judgment-free manner. The staff also upholds cultural values that protect against discrimination and harassment on the basis of race, ethnicity, religion, sexual orientation, national origin, age, physical disability, medical condition, marital status, or any other characteristic that may result in exclusion.

Challenges, Barriers and Solutions in Progress

The MSC Courtyard program strives to build stronger partnerships with the collaborative agencies and community groups focused on integrating the residents at the Courtyard into permanent housing. Communication among community partners is not only necessary but ideal to meet the immediate needs of the residents. The program recently identified the importance of having an on-site Outreach lead to act as the liaison with these other agencies. The Lead will also provide additional support to the team by attending meetings with the collaborative and ensuring that outcomes data are collected properly and presented in a timely manner.

Community Impact

The Courtyard mobile outreach team collaborates with a variety of human services and non-profit providers to help residents meet basic needs and obtain access to behavioral health services, housing, employment, public benefits and personal identification documents. By partnering with the collaborative agencies and the Courtyard residents, the Courtyard mobile outreach team is part of shared goal to help break the cycle of homelessness among those living with serious mental illness.

Recovery Open Access (CSS)

Program Serves	Symptom Severity	Location of Services	Population Characteristics					
								
	Severe	Outpatienet Clinic	LGBTIQ	Veterans	Homeless/ At Risk	Co-Occurring SUD	Co-Occurring Medical	Criminal Justice

The program provides services in Spanish, Vietnamese, Cambodian.

Target Population and Program Characteristics

Recovery Open Access serves individual ages 18 and older living with serious and persistent mental illness and a possible co-occurring disorder who are in need of urgent outpatient behavioral health services. The target population includes adults who are being discharged from psychiatric hospitals, released from jail, or currently enrolled in outpatient BHS services and have an urgent medication need that cannot wait until their next scheduled appointment. These individuals are at risk of further hospitalization or incarceration if not linked to behavioral health services quickly.

Services

Recovery Open Access serves two key functions: (1) it links adults with serious and persistent illness to on-going, appropriate behavioral health services, and (2) it provides access to short-term integrated behavioral health services (i.e., brief assessments, case management, crisis counseling and intervention services, SUD services, temporary medication support) while an individual is waiting to be linked to their (first) appointment. The goal is to see participants within 24 hours of the time of discharge from the hospital or jail and to keep them engaged in services until the link to on-going care in order to decrease their risk of re-hospitalization or recidivism.

Strategies to Promote Recovery/Resilience

By providing timely access to needed care, including mediation support, Recovery Open Access allows individuals to move forward in their recovery instead of hitting roadblocks to their care.

Strategies to Increase Timely Access to Services for Underserved Populations

Individuals in the program face issues related to transportation, difficulty navigating the Behavioral Health system, management of their symptoms, and/or degree of insight into their mental health issues. As described above, Recovery Open Access improves access to care by expediting urgent care needs and by facilitating quicker and smoother linkages to behavioral health treatment for those discharging from inpatient and jail settings. In FY 2016-17 Recovery Open Access made 462 linkages to on-going behavioral health services.

Strategies to Reduce Stigma and Discrimination

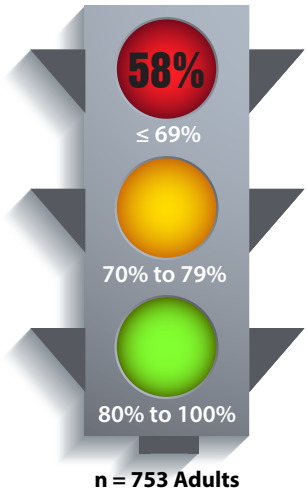
All Clinicians and peer workers are trained yearly in cultural competency, which reviews the concepts of culture, race, ethnicity, diversity, stigma and self-stigma. The training also demonstrates the influence of unconscious thought on a person's judgment as it relates to stereotyping and racism. Through this training and their on-going supervision, Recovery Open Access clinicians are provided strategies to recognize diversity, embrace the uniqueness of cultures beyond mainstream American culture, and incorporate a culturally responsive approach in their service planning, service delivery and interactions with program participants.

Outcomes

During FY 2016-17, Recovery Open Access served a total of 1,357 adults. Performance of the program is measured by whether the program meets or exceeds the following targets:

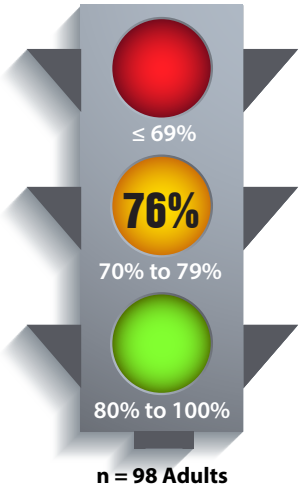
- 80% of adults discharged from a hospital and admitted to Recovery Open Access are linked to medication services within 3 business days
- 80% of adults discharged from jail and admitted to Recovery Open Access are linked to medication services within 3 business days
- 80% of all adults admitted to Recovery Open Access are linked to ongoing care within 30 days

% Discharged From Hospital & Linked to Medication Services in 3 Days Recovery Open Access
FY 2016-17



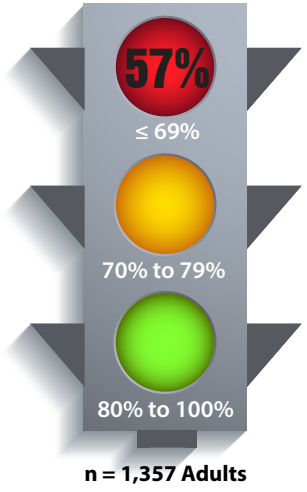
n = 753 Adults

% Discharged From Jail & Linked to Medication Services in 3 Days Recovery Open Access
FY 2016-17



n = 98 Adults

% Seen at Open Access & Linked to On-going Care Within 30 Days Recovery Open Access
FY 2016-17



n = 1,357 Adults

Due to several factors, the program did not reach any of its targets in FY 2016-17. Typically, individuals are discharged from the hospital or jail with approximately a week of medication and, at the time of program implementation, appointments with the Open Access psychiatrist were being scheduled with an emphasis on setting them up prior to when the medication would run out but not necessarily with an emphasis on meeting the three-day target. Program expectations have since been clarified with staff and it is not anticipated that this will be an on-going issue. In contrast, how quickly Open Access staff can link individuals to on-going care is directly affected by how impacted the outpatient clinics are. Thus, while the target of linkage to on-going care within 30 days may not be realistic for the time being due to the high census, Open Access staff works with individuals for as long as it takes to link, thus ensuring that participants continue to receive the behavioral health care that they need.

> **"I don't believe I could have gotten back on my feet without this program."**
>
> **– Participant**

Challenges, Barriers and Solutions in Progress

Recovery Open Access relocated the South County site to Costa Mesa in August 2017 to improve access for people who live in South County and to decrease the workflow at the North County site, which had become unmanageable. The program also plans to request more peer positions to engage consumers and their family members with the goal of improving the ability to help link them to their appointments. To address challenges related missed appointments, the program has implemented Care Managers to do more dedicated follow-up and linkage support for individuals (i.e., accompanying to appointments, home visits, engage in additional follow-up with those who don't link with the provider).

Community Impact

Recovery Open Access has provided services to more than 1,950 individuals since its inception in July 2015. The program collaborates with a variety of community partners including, hospitals, jails homeless shelters, substance abuse programs, community health clinics, mental health clinics, Orange County Probation Department and Orange County Social Services Agency to help individuals receive needed behavioral health care.

Assisted Outpatient Treatment: Assessment and Linkage Team (CSS)

Program Serves	Symptom Severity	Location of Services	Population Characteristics				
							
	Severe	Anywhere	Veterans	Homeless/ At Risk	Co-Occurring SUD	Co-Occurring Medical	Criminal Justice

The program provides services in Spanish, Vietnamese.

Target Population and Program Characteristics

Assisted Outpatient Treatment (AOT) is intended to interrupt the cycle of hospitalization, incarceration and homelessness for adults ages 18 and older who are living with serious mental illness and have been unable and/or unwilling to participate in mental health services on a voluntary basis. In Orange County, AOT accomplishes this through a two-pronged approach: (1) an expanded and specialized referral, assessment and linkage process combined with (2) civil court involvement, whereby a judge may direct participation in outpatient treatment. The former services are provided by the AOT Assessment and Linkage Team (ALT), which engages those who meet AOT criteria and attempts to link them directly to voluntary services prior to going through the court system. Legislative requirements of AOT and ALT services are described in more detail below and the AOT FSP is described in the Full Service Partnerships section of this Plan.

In accordance with California Assembly Bill 1421 (also known as "Laura's Law"), the following criteria must be met for a person to qualify for AOT:

1. Adult is 18 years or older and suffering from a serious mental health illness;
2. A clinical determination is made that the person is unlikely to survive safely in the community without supervision;
3. A history of lack of compliance with treatment for mental illness, in that at least one of the following is true:
   - **a.** The person must have two or more psychiatric hospitalizations in the last 36 months (or been placed on the acute mental health unit in jail) or
   - **b.** The person has had one or more serious acts or threats of violence in the last 48 months;
4. The person has been offered an opportunity to participate in a treatment plan and continues to fail to engage in treatment;
5. The person's condition is substantially deteriorating;
6. It is likely the person will benefit from assisted outpatient treatment;
7. Assisted outpatient treatment is necessary to prevent relapse or deterioration that would be likely to result in grave disability or serious harm to self or others;
8. Participation in assisted the AOT program would be the least restrictive placement necessary to ensure the person's recovery and stability.

Per the Legislation, the following individuals (also known as "qualified requestors") may refer a person for an AOT evaluation: (1) immediate family members such as a parent, sibling, spouse, or adult children of the person, (2) adults residing with the person, (3) the director of any public or private agency, treatment facility, licensed residential care facility or hospital in which the person is a resident or patient, (4) a licensed mental health professional treating the individual, or (5) a peace officer, parole or probation officer supervising the individual.

AOT participants are typically homeless or at risk of homelessness, incarcerated or hospitalized, and have a history of non-compliance with treatment as a result of the severity of their mental illness and lack of awareness of their condition. In addition, AOT participants often have co-occurring substance use issues and physical health problems.

Services

The AOT Assessment and Linkage Team evaluates people referred to the program to determine whether they qualify for AOT, engages those who meet AOT criteria and attempts to link them directly to voluntary services prior to going through the court system. Orange County has established a toll free number (1-855-422-1421) for the general community to call for more information about the AOT program and for qualified requestors to make AOT referrals.

Upon receiving a referral from a qualified requestor, the AOT Assessment and Linkage Team connects with the requestor to gather additional information about the referral, including

> **"I didn't know what to expect going into the AOT program, but I ended up having a great time and learned a lot during my time there. I learned a lot about structure and showing up every day to do it. Mostly, just knowing that I'm not alone with the illness."**
>
> **– Individual who had been hospitalized more than a dozen times and is now a successful student**

identifying information about the requestor and the referred individual; information about their circumstances; and the reason(s) for the AOT referral. When an AOT candidate appears to meet criteria for AOT but refuses voluntary services, a licensed clinical psychologist from the team meets with the candidate, reviews their records, and conducts a psychological assessment to determine if they meet AOT criteria. If the AOT candidate continues to meet criteria and refuses voluntary services, they may be ordered by the court to participate in the AOT FSP (for more information about AOT FSP, please refer to the Full Service Partnership section of this Plan). Despite a court order to participate, however, the judge cannot impose involuntary treatment should a participant fail to comply because AOT in Orange County has been implemented with MHSA funds which can only be used for voluntary services.

Strategies to Promote Recovery/Resilience

The AOT program takes a consumer-focused and recovery-oriented approach to treatment. Program staff work with participants "where they are at," build rapport, identify their goals, hopes and dreams and then tailor treatment based on the participant's unique goals, needs, strengths and stage of recovery.

Strategies to Improve Timely Access to Services for Underserved Populations

There are many issues that may keep individuals from seeking AOT services including limited insight into the mental illness that results in non-compliance with treatment, homelessness or risk of homelessness, history of incarceration, difficulty finding permanent housing, lack of transportation, limited income and limited support. The Assessment and Linkage team works to overcome these barriers by engaging in frequent contact with the participant through visits to their home, hospital, correctional facility or any place the participant is known to be. These contacts focus on building therapeutic relationships that facilitate trust, linkage to services and, ultimately, treatment adherence. Transportation support is also provided for participants as needed. In addition, the program has access to all languages through the use of a contracted interpreter service provider in order to minimize any potential language barriers.

During FY 2016-17, the program received 637 referrals and all eligible AOT individuals who were available for assessment were successfully linked to appropriate mental health services (n=193). Of those linked to services, an overwhelming majority accepted services voluntarily (n=147), thus demonstrating the team's success in working with this marginalized and unserved population.

Strategies for Reducing Stigma and Discrimination

The AOT program recognizes the importance of reducing stigma and discrimination in order to help individuals with mental illness access and accept services. One of the strategies used by the AOT Assessment and Linkage Team is to provide presentations and training at hospitals, police departments and various community meetings to help raise awareness about mental health issues and about the services that are available.

Challenges, Barriers and Solutions in Progress

One of the challenges for the program is misinformation about what AOT can and cannot do for individuals being referred and served in Orange County. Because Orange County implemented AOT with MHSA funds, services must remain voluntary; the judge cannot order medication administration for those who refuse to take prescribed psychotropic medications, for example. The program is working to increase presentations at hospitals, police departments, jails, clinics and community-based organizations to increase community awareness and understanding about AOT and its implementation specifically in Orange County.

Another challenge the program continues to face is being able to locate individuals consistently when they are released from jail and are homeless. The AOT program continues to work with the jails to link individuals to services upon release to try and reduce the number who are lost to follow up due to homelessness.

Community Impact

The AOT Assessment and Linkage team has provided services to 1,119 individuals since its inception in October 2014 and continues to receive a high volume of referrals through the toll-free number (approximately 50 to 60 each month). In addition to providing assessment and linkages services to eligible individuals, the team also provides the community with information about AOT in Orange County. In FY 2016-17 the program responded to 582 informational calls.

CHS Jail to Community Re-Entry (CSS)

Program Serves	Symptom Severity	Location of Services	Population Characteristics
18+	Moderate-Severe	Correctional Facilities	Criminal Justice

The program provides services English, TBD.

Target Population and Program Characteristics

The Correctional Health Services (CHS) Jail to Community Re-entry Program (JCRP) is a collaboration between BHS and Correctional Health Services that will serve adults ages 18 and older who are living with mental illness and detained in a County jail. This new CSS-funded program was developed in response to the high rates of recidivism observed among inmates with mental illness and aims to decrease rates of return to jail by providing access and linkage to needed behavioral health services and supports.

Services

This program will use a comprehensive "in reach" approach to discharge planning and re-entry linkage services for inmates with mental illness at all five County jail facilities. "In reach" services will be conducted while individuals are still in custody and will include thorough risk-needs-responsivity (RNR) assessments, re-entry groups aimed at identifying possible barriers to successful re-entry, and developing tailored discharge plans. Services will also include facilitation of linkages to a range of services upon release, such as counseling, medication support, housing and transportation. Connections with family and other support systems such as forensic peer support mentors will also be facilitated. JCRP staff will work in collaboration with other stakeholders, including the Orange County Sheriff's Department, Orange County Probation Department, Orange County Public Defender, Social Services Agency, Regional Center of Orange County, Orange County Housing Authority and other ancillary agencies, to identify gaps in service delivery and solidify linkages with external stakeholders for a smooth transition from jail to community.

Strategies to Promote Recovery/Resilience

This program will offer intensive mental health case management aimed at bridging the gap between mental health services provided while in custody and the treatment and support services needed upon release from custody.

Strategies to Increase Timely Access to Services for Underserved Populations

Timely access to JCRP services will be provided by beginning the comprehensive discharge planning while the individual is still in custody.

Strategies to Reduce Stigma and Discrimination

These strategies will be further developed as the program is implemented and will be reported in future Plan Updates.

Outcomes

Because this program is not currently implemented, outcomes are not yet available.

CRISIS SERVICES

Orange County has a comprehensive array of Crisis Services that operate 24/7 and are designed to support individuals of all ages who are experiencing a behavioral health emergency. These programs encompass a Crisis Prevention Hotline, mobile Crisis Assessment Teams, and crisis support services provided either in the home or a residential setting. Their goal is (1) to provide access to structured clinical support – either directly or through linkages – so that the person may continue living safely in the community, when appropriate, or (2) to facilitate admission to a psychiatric hospital when a higher level of care is warranted.

Crisis Services	Estimated Number to be Served in FY 18/19	Annual Budgeted Funds in FY 18/19	Estimated Annual Cost Per Person in FY 18/19
Crisis Prevention Hotline (PEI)	7,000	$392,533	$56
Children's CAT (CSS)	4,250	$1,594,904	$375
TAY/Adult CAT/PERT (CSS)	9,136	$5,971,826	$654
Crisis Stabilization Units (CSS)	TBD	$5,000,000	TBD
Children's In-Home Crisis Stabilization (CSS)	400	$1,085,480	$2,714
TAY/Adult In-Home Crisis Stabilization (CSS)	TBD	$1,500,000	TBD
Children's Crisis Residential Program (CSS)	208	$3,338,248	$16,049
TAY Crisis Residential Program (CSS)	96	$1,491,368	$15,535
Adult Crisis Residential Program (CSS)	445	$3,751,229	$8,430

Crisis Prevention Hotline

Program Serves	Symptom Severity		Location of Services
0+	Mild-Moderate	Severe	Via Telephone

The program provides services in English, Spanish, Deaf/Hard of Hearing (text), and other languages using language line.

Target Population and Program Characteristics

The Crisis Prevention Hotline is an accredited 24-hour, toll-free suicide prevention telephone/text/chat service. It is available to anyone in crisis or experiencing suicidal thoughts and for those who are concerned about a loved one attempting suicide. This program is open to anyone wanting to call the hotline for assistance.

Services

Program counselors provide immediate, confidential over-the-phone/text/chat assistance and initiate and assist in active rescues, when necessary. In addition, counselors conduct follow-up calls with individuals who have given their consent to ensure continued safety. This extended care model provides a stronger safety net and reduces the likelihood of attempts and emergency room visits.

The hotline uses the Applied Suicide Intervention Skills Training (ASIST) as its method to prevent suicide. The program has also expanded its services to be inclusive of friends and family members who have been impacted by a loved one's suicide. Callers who are not experiencing a crisis are triaged and offered access to the WarmLine or other appropriate resources.

> **“This service unexpectedly helped me during an emotional night. My chat counselor seemed to be a very compassionate and warm person who truly put herself into my shoes. I would use the chat again….”**
>
> **– Chat line caller**

The Crisis Hotline program also works to educate the wider Orange County community on the signs of serious depression and suicidal ideation, myths associated with talking about suicide, strategies on how to listen to and aid someone in distress, and promotion of the crisis line and its services. Staff provides this information through community outreach, education and information tables at events, and speaking engagements.

Strategies to Promote Recovery/Resilience

Clinicians work with the individual in crisis and/or their family member to identify coping strategies that have been successful in the past or available supports and resources. They also make timely referrals to needed services and supports in order to facilitate crisis stabilization.

Strategies to Improve Timely Access to Services for Underserved Populations

The 24-hour availability of the Crisis Prevention Hotline, as well as the availability of text/chat, allows individuals to access services at any time, wherever they are, in the manner most comfortable for them. Program staff provide services both in English and Spanish and volunteers who speak other languages are utilized whenever available. The language line is used when callers speak other languages not available through staff or volunteers on site. In addition, the Deaf/Hard-of-Hearing population can access services without having to wait for an interpreter by utilizing crisis texting services.

Services are publicized through Orange County's OC Links, County and contracted provider websites, the State's Each Mind Matters website, and outreach to schools, hospitals, provider sites and the community at large.

Strategies to Reduce Stigma and Discrimination

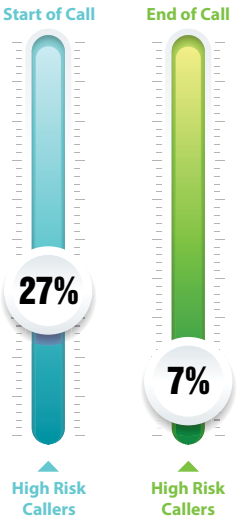
To promote use of the Crisis Prevention Hotline within unserved and underserved populations, the program utilizes California Mental Health Services Act Authority's (CalMHSA) culturally appropriate materials to target under-served communities (i.e., Vietnamese- and Farsi-speaking). The anonymity of the hotline also facilitates the accessing of crisis services by individuals who might otherwise not seek help because of the stigma associated with mental illness. In addition, the hotline collaborates with partner organizations to conduct outreach, reduce stigma and provide education in a manner consistent with the values and perspectives of the community they are trying to engage.

Outcomes

During FY 2016-17, a total of 6807 unduplicated callers made 8,475 total calls to the hotline. To assess the program's effectiveness in reducing prolonged suffering, callers were asked to complete their Self-Rated Intent (SRI) on a 5-point scale at the beginning and end of the call. Risk of suicidal behavior is rated low if a participant caller reported a score of 1 or 2, medium risk if they reported a score of 3, and high risk if he/she selects 4 or 5 as a self-rating of suicidal intent. Movement to a lower risk category by the end of the call suggests that calling the Crisis Line effectively decreased suicidal intent.

The proportion of high risk callers fell from 27% to 7% by the end of the call. In addition, among callers reporting at least some level of suicide risk, there was a notable decrease in callers' suicidal intent from the start to the end of the call. Thus, Crisis Prevention Hotline counselors helped reduce suffering as it relates to suicidal intent and prevented the worsening of crisis symptoms.

Crisis Prevention Hotline - Percentage of High Risk Callers: At Call Start and End
FY 2016-17



Challenges, Barriers and Solutions in Progress

The hotline has seen a steady increase in calls over the last several years which exceeds the current staffing capacity of the hotline. The Steering Committee voted to approve adding funds to the program to address this growing need.

Community Impact

Since program inception in 2010 through June 2017, the Crisis Prevention Hotline has answered a total of 49,314 calls.

Crisis Assessment Teams/Psychiatric Emergency Response Teams

Children's CAT

Program Serves	Symptom Severity		Location of Services						Typical Population Characteristics					
														
	Mild-Moderate	Severe	Home	School	Hospital and ER	Police Station	Group Homes	Field	Families	Parents	LGBTIQ	Homeless/ at Risk	Co-Occurring SUD	Students

The program provides services in English, Spanish, and Vietnamese.

TAY and Adult CAT/ PERT

Program Serves	Symptom Severity		Location of Services						Typical Population Characteristics					
														
	Mild-Moderate	Severe	Home	Workplace	Outpatient Clinics	Hospital and ER	Residential	Field	Families	Parents	LGBTIQ	Homeless/ at Risk	Co-Occurring SUD	Students

The program provides services in English, Spanish, Vietnamese, Farsi, Korean, Arabic, Cambodian, and Mandarin.

Target Population and Program Characteristics

The Crisis Assessment Teams (CAT) provide mobile crisis assessment and response throughout Orange County for individuals of all ages 24 hours a day, 7 days a week, 365 days a year. There are currently 21 children's CAT clinicians and 33 TAY/Adult CAT clinicians who respond to calls from anyone in the community and dispatch to anywhere in Orange County. The programs will also be hiring to add 5 positions to the Children's team and 9 positions to the TAY/Adult team in the coming year.

Psychiatric Emergency Response Teams (PERT) are specialized units comprised of behavioral health clinicians from the TAY/Adult CAT who ride along with police officers. There are currently 15 PERT clinicians who partner with the Orange County Sheriff's Department as well as with police officers in Anaheim, Buena Park, Costa Mesa, Fullerton, Fountain Valley, Garden Grove, Huntington Beach, Irvine, Laguna Beach, Newport Beach, Orange, Santa Ana, Tustin and Westminster during shifts designated by each participating Department.

Services

CAT is a multi-disciplinary program that provides prompt response to anywhere in the county when an individual is experiencing a behavioral health crisis. Clinicians receive specialized training to conduct evaluations and risk assessments that are geared to the individual's age and developmental level and frequently involve interviews with collateral sources such as parents, guardians, family members, law enforcement, Emergency Department staff and school personnel. Clinicians link individuals to an appropriate level of care to ensure their safety, which may involve initiating an involuntary hospitalization. They also conduct follow up contacts with individuals and/or their parents/guardians to provide information and referrals and to encourage linkage to on-going behavioral health services that may help reduce the need for future crisis interventions.

PERT clinicians have established strong partnerships with numerous local law enforcement agencies throughout Orange County. They ride along with police officers on designated shifts and

promptly respond to calls involving individuals with mental health needs. During these calls clinicians conduct assessments, initiate involuntary hospitalizations as necessary and provide appropriate care and linkages to resources in a dignified manner. In addition to assisting individuals in accessing needed behavioral health services, PERT educates police on mental illness and provides officers with tools that allow them to assist individuals living with mental illness more effectively.

Strategies to Promote Recovery/Resilience

During the assessment, clinicians work with the individual in crisis and/or their family members to identify previously successful coping strategies, as well as any available supports and resources. Clinicians also work to make timely referrals and linkages to facilitate recovery and try to prevent need for crisis services in the future.

Strategies to Improve Timely Access to Services for Underserved Populations

Children's and TAY/Adult CAT serve the entire County of Orange and strive to improve timely access to their services in a number of ways. First, CAT advertise their services on the Internet and at community events and accept referrals 24/7 from anyone in the community through a toll-free number. In an effort to encourage utilization by underserved populations, CAT clinicians also conduct trainings and outreach throughout the County to increase recognition of the signs of mental illness and address any associated misperceptions. The teams also provide a mobile response to overcome any transportation barriers on the part of the people they serve and strive to arrive within one hour of receiving the referral and within 30 minutes from the time the clinician dispatches. Finally, the teams have bilingual/bicultural staff with the capacity to provide services in many languages (see grids for language capacity). In addition to working with those in crisis, bilingual/bicultural clinicians work with family members to provide information and culturally appropriate referrals to ensure that individuals and their families receive services in a timely manner.

Both Children's and TAY/Adult CAT/PERT have noted a steady increase in calls over the past several years, particularly as homelessness has persisted and passage of AB 1261 that requires all school districts to have a suicide prevention response in place for students in grades 7 through 12. With requests for services coming from families, hospitals, schools, caregivers, law enforcement, Social Services, treatment providers and the general community at ever increasing rates, CAT and PERT continue to expand their teams to provide better geographic coverage across Orange County and maintain a timely response. Nevertheless, it has proved challenging to keep up with demand, particularly for Children's CAT.

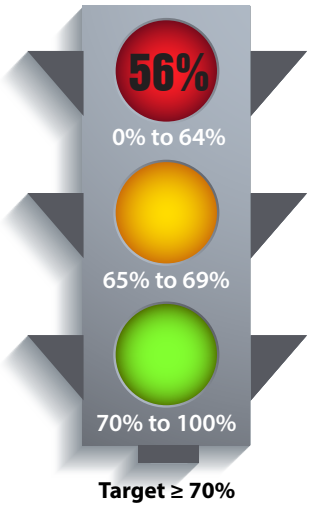
Strategies to Reduce Stigma and Discrimination

CAT/PERT continue to place priority on hiring bilingual and bicultural staff. Staff also attend cultural diversity workshops so that they may conduct evaluations in a sensitive manner and offer culturally appropriate service referrals. In addition, PERT provides police with information and tools to help officers assist individuals who are experiencing a mental health crisis more effectively. The success of these law enforcement/mental health partnerships has resulted in a more compassionate response in the community.

Outcomes

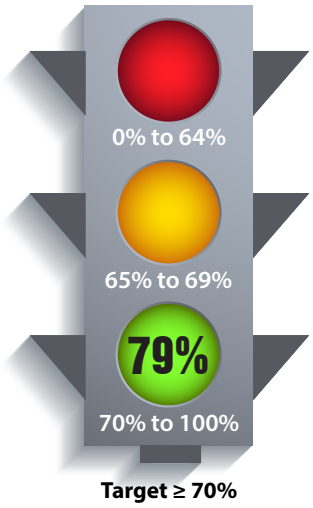
In FY 2016-17, the Children's team conducted 3,039 evaluations, and the TAY/Adult team conducted 4,568 evaluations. The program is evaluated by the timeliness with which CAT is able to respond to calls, with the goal that the dispatch-to-arrival time is 30 minutes or less at least 70% of the time. The Children's team missed its target with a 56% response rate, although the average dispatch to arrival time was 32.3 minutes. TAY/Adult CAT/PERT met its goal with a dispatch-to-arrival rate of 79%.

Dispatch-to-Arrival in 30 minutes or Less
Children's CAT
FY 2016-17



Target ≥ 70%

Dispatch-to-Arrival in 30 minutes or Less
TAY/Adult CAT/PERT
FY 2016-17



Target ≥ 70%

The teams also examine the psychiatric hospitalization rate as a way of monitoring the severity of individuals' presenting problems and the availability of safe alternatives to inpatient services. Consistent with prior years, individuals evaluated by CAT/PERT continued to be hospitalized at a rate of approximately 44% for children and 48% for TAY/adults. The program has noted a growing number of individuals diagnosed with co-occurring disorders who are under the influence of alcohol or other substances at the time of evaluation, which can elevate their risk and increase level of care needs, thereby limiting placement options.

Challenges, Barriers and Solutions in Progress

While the increasing calls from law enforcement, schools and the community are ultimately a reflection of the programs' positive impact in Orange County, this growing demand nevertheless poses challenges. As PERT continues to expand, the TAY/Adult CAT program experiences decreased staffing due to the transition of CAT staff to the new PERT teams. To accommodate increasing call volume, both the Children's and TAY/Adult teams have increased the number of positions, however hiring clinicians remains difficult due to the undesirability of certain shifts in a 24/7 program. Hiring bilingual staff is even more difficult as clinicians who speak languages other than English frequently receive competing job offers for positions that offer a more traditional schedule. HCA is trying to overcome these challenges by offering pay differential for bilingual staff and for those who work the night shift.

Community Impact

Since their inception through June 2017, the crisis teams have responded to calls for more than 15,900 children and 28,200 TAY/Adults. The programs have been successful in safely linking individuals who are experiencing behavioral health crises to appropriate levels of care that are less disruptive and costly than inpatient psychiatric hospitalization, hospital emergency department visits and incarceration. Feedback from law enforcement regarding having PERT clinicians in the field with officers has also been overwhelmingly positive and helped incorporate a more compassionate response when law enforcement encounters individuals experiencing mental health crises.

Crisis Stabilization Units

Program Serves	Symptom Severity			Location of Services	Typical Population Characteristics					
										
13 +	At-Risk	Mild-Moderate	Severe	TBD	Families	Parents	LGBTIQ	Homeless/ at Risk	Co-Occurring SUD	Students

The program provides services in English, Spanish, Vietnamese, Farsi, Korean, Arabic and other language as needed through use of language line services.

Target Population and Program Characteristics

Although HCA operates a County-operated Crisis Stabilization Unit (CSU) for adults using non-MHSA funds, Orange County stakeholders identified a need to dedicate MHSA funding for additional CSUs that would meet increasing demand for services and expand the age range of those served. Similar to the existing program, the MHSA CSUs will provide the community with a 24-hour/7 day a week service for persons who are experiencing a psychiatric crisis and require emergent behavioral health assessment and stabilization. The program will serve Orange County residents ages 13 and older, the majority of whom may likely be on a Welfare and Institutions Code 5150/5585 (i.e., 72-hour civil detention for psychiatric evaluation) due to danger to self, others or grave disability resulting from a mental health disorder. The CSUs will be able to be accessed directly by individuals experiencing a crisis, as well as by family members, law enforcement officers, and others in the community who believe an individual has an emergent behavioral health need. Currently, the County has an approved contract with one provider and is in various stages of ongoing negotiations with three other providers.

Services

The primary goals for the County-contracted CSUs will be to provide timely voluntary and involuntary crisis stabilization services for individuals who cannot wait for a regularly scheduled appointment with their behavioral health care provider; a viable alternative to costly inpatient hospitalization that utilizes the most dignified and least restrictive referral options whenever possible and appropriate; and an appropriate option for individuals whose default presentation would otherwise be to hospital emergency departments.

Services, which are not to exceed 23 hours and 59 minutes, will include psychiatric evaluation, basic medical services, nursing assessment, medication services, crisis intervention, collateral history, and referral and linkage to the appropriate level of continuing care. Clinicians will also provide individual therapy, brief intensive services, motivational interviewing, and short-term group therapy modalities including psycho-education, cognitive behavioral therapy, and self-soothing therapy techniques. Topics may include, but are not be limited to, building a wellness toolbox or resource list, symptom monitoring, identifying triggers and early warning signs of symptoms, identifying a crisis plan, and building a Wellness Recovery Action Plan (WRAP). Services will also include substance use disorder treatment for individuals who have co-occurring substance use disorders.

Strategies to Promote Recovery/Resilience

CSUs will promote recovery and resilience in many ways. All services will be provided in an environment that is compatible with, and supportive of, the recovery model and trauma-informed care principles. Services will be tailored to the unique strengths of each individual and focus on taking personal responsibility for managing one's recovery. The CSUs will also employ peer recovery specialists who will provide support and assist individuals in their recovery by encouraging them to be more independent and engage in meaningful life activities and relationships. Peers will be encouraged to share their stories of recovery to help provide hope to participants and their families that recovery is possible.

Strategies to Improve Timely Access to Services for Underserved Populations

People who are experiencing a crisis may be unable or unwilling to seek out services due to lack of transportation or other resources, homelessness, stigma, fear of the "system" or unknown, and cultural issues. HCA has secured a contract with one provider and is in various stages of ongoing negotiations with three potential contractors in order to expand Crisis Stabilization services throughout Orange County to address some of these access issues. In addition, they

will operate 24/7 so that individuals in crisis can access the services at any time. To meet the needs of Orange County's diverse population, the CSUs will also hire staff who are bilingual/bicultural in all threshold languages, and the language line will be utilized to accommodate individuals who speak languages other than those spoken by staff.

Strategies to Reduce Stigma and Discrimination

Contractors will be required to hire and retain bilingual/bicultural staff whenever possible, as well as recruit, hire and train individuals who are in recovery. Contractors will also provide cultural competency trainings, provide literature in multiple language and formats, and enhance accessibility and sensitivity for individuals who are physically challenged.

Outcomes

Because the MHSA-funded CSUs are not currently implemented, outcomes are not yet available.

In-Home Crisis Stabilization

Children's IHCS

Program Serves	Symptom Severity	Location of Services			Typical Population Characteristics					
0-17	Severe	Home	Hospital	Field	Families	Parents	Medical	Homeless/ at Risk	Co-Occurring SUD	Students

The program provides services in English, Spanish, Vietnamese, Farsi, Korean, Arabic and other language as needed through use of language line services.

TAY/Adult IHCS

Program Serves	Symptom Severity	Location of Services			Typical Population Characteristics						
18+	Severe	Residential	Hospital	Field	Families	Parents	Veteran	Medical	Homeless/ at Risk	Co-Occurring SUD	Students

The program provides services in English, Spanish, Vietnamese, Farsi, Korean, Arabic and other language as needed through use of language line services.

Target Population and Program Characteristics

In-Home Crisis Stabilization (IHCS) programs consist of teams of clinicians and staff with lived experience who provide short-term, intensive in-home services to individuals who have been assessed to be at imminent risk of psychiatric hospitalization/ out-of-home placement but are capable of avoiding such placements if provided appropriate support. The teams operate 24 hours a day, 7 days a week, 365 days a year, and individuals are referred by County behavioral health clinicians, emergency department personnel and triage grant staff. Currently only the Children's IHCS program is operational and is described below. HCA is in the process of selecting a contractor for the TAY/Adult program.

Services

Families are typically referred to IHCS after a clinician has evaluated a child for possible hospitalization and determined that, while they do not meet criteria for hospitalization, they and their family would benefit from supportive services. The evaluator then calls the crisis stabilization team to the site of the evaluation, and the team immediately works with the child and family to develop a stabilization plan. After triggers have been identified and a treatment plan is in place, in-home appointments are made for the next day. The IHCS team then utilizes services such as crisis intervention, short-term treatment and case management to help the child and/or family establish a safety plan, develop coping strategies and ultimately transition to ongoing support. During FY 2017-18, the children's team also began providing respite services for parents and caregivers. Length of stay in the Children's program is usually three weeks but can extend up to six weeks based on clinical need and the amount of time it takes before a youth can be linked to long-term services. All IHCS services are mobile and provided in the home, whenever possible, and/or in any setting that the child or family feels comfortable.

Strategies to Promote Recovery/Resilience

Peer specialists are key members of the IHCS teams and their stories of lived experience, recovery and resilience serve as a source of hope and inspiration for youth and families who are in the midst of a crisis. Services are strength-based and tailored to the needs of the child and family, and families are encouraged to be active participants in the recovery process, which allows them to develop confidence in their ability to handle future challenges successfully.

Strategies to Improve Timely Access to Services for Underserved Populations

The IHCS team responds within two hours to the setting where the behavioral health crisis was initially discovered, which allows the team to establish rapport with the children and family members and increase their likelihood of engaging in services. All services are provided in the home or other locations most comfortable for the family. The program hires bilingual/bicultural staff who speak multiple languages (see grid for specific languages). The language line and/or interpretation services are also available when staff who speak the language of a participant or family member are not available.

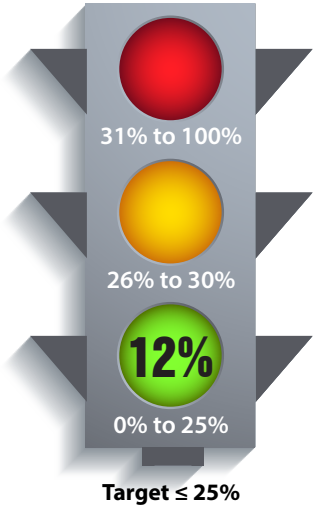
Strategies to Reduce Stigma and Discrimination

Peers and parent partners help decrease stigma by serving as a positive role model and providing hope for the youth and their family that recovery is possible. Staff also participate in various cultural competency trainings so that they can communicate and interact with the youth and family members in ways that respect and value the family's world view.

Outcomes

There were 404 admissions to the Children's program during FY 2016-17. The goal is to maintain a psychiatric hospitalization rate that is 25% or less during the time the youth is enrolled in the program through 60 days post-discharge. This goal was met with a hospitalization rate of 12% during the evaluation period.

Hospitalization Rate - Up to 60 Days Following Discharge
Children's In Home Crisis Stabilization
FY 2016-17



Target ≤ 25%

Challenges, Barriers and Solutions in Progress

An on-going challenge for the program has been receiving referrals in a timely manner so that interventions can be implemented quickly enough to help the child avoid being placed in a more restrictive setting. The County and program have worked diligently to establish effective and timely communication between referral sources and the in-home team, which has resulted in more youth who are experiencing a crisis to be seen in a timely manner and the ability of the program to provide services safely to youth and their families in the community.

Community Impact

There have been more than 2,400 admissions to the Children's In-Home Crisis Stabilization program since its inception in 2006. The program collaborates with referring agencies, behavioral health programs, schools and emergency departments, and will collaborate with the crisis stabilization units (CSUs) once established. The IHCS programs help reduce admissions to local emergency departments and provide a strengths-based, in-home alternative to psychiatric hospitalization for children experiencing behavioral health crises.

Crisis Residential Programs

The Crisis Residential Programs (CRPs) are highly structured, voluntary residential programs that focus on promoting resilience and recovery. Individuals are referred to a CRP if they are in a behavioral health crisis and have been evaluated for psychiatric hospitalization, do not meet inpatient criteria, and they and/or their family is experiencing considerable stress. For children, an additional criterion is that respite would benefit the child/youth and the family. The programs are voluntary and serve anyone in Orange County who meet eligibility requirements. In addition, individuals must be referred by hospitals, CAT/PERT or County or County-contracted behavioral health (i.e., programs do not accept walk-ins, self-referrals).

Target Populations and Program Characteristics

Children's Crisis Residential

Program Serves	Symptom Severity				Location of Services	Typical Population Characteristics			
12 - 17	At Risk	Early Onset	Mild-Moderate	Severe	Residential	LGBTIQ	Homeless/ at Risk	Co-Occurring SUD	Students

The program provides services in English, Spanish, Vietnamese, Korean, and American Sign language (ASL).

The Children's CRP serves children between the ages of 12 and 17 who are experiencing a behavioral health crisis and their families. Many of the children have a history of serious emotional disturbance and are experiencing significant family conflict and/or are at risk of hospitalization or out-of-home placement. The Children's CRP provides services at three sites (Laguna Beach, Huntington Beach and Tustin) with a total of 16 beds. The program generally lasts for three weeks, although children can remain in treatment for up to six weeks if needed.

TAY Crisis Residential

Program Serves	Symptom Severity		Location of Services	Typical Population Characteristics		
18 - 25	Mild-Moderate	Severe	Residential	LGBTIQ	Veteran	Co-Occurring SUD

The program provides services in English, Spanish, Vietnamese, Farsi, Korean, Arabic, Combodian, and Mandarin.

"Thank you all so much for helping me get through this tough time in my life. I've learned so much from all of you, from grounding skills, to ukulele, to how to love myself. I'm going to miss you all very much! To future residents: You guys are lucky to be in this program. Free (good) food, amazing staff, and a nice warm bed to sleep in at night. I know it's hard. You're away from home, your family, your friends, and your life. You're doing great. You've made it this far, another few weeks can't hurt. Good luck on your future endeavors!"

– **Children's CRP participant**

The TAY CRP serves young adults ages 18-25, many of whom have experienced multiple traumas characterized by violence, are homeless or at risk of homelessness, have co-occurring substance use issues and/or little family support. TAY CRP currently has one facility with six beds in Costa Mesa. Like the Children's program, TAY CRP is designed to be three weeks long although youth may remain in treatment for up to six weeks if needed. In addition, TAY who would benefit from a longer-term structured milieu may be referred to the Social Rehabilitation Program (SRP; see Residential Treatment).

Adult Crisis Residential

Program Serves	Symptom Severity		Location of Services	Typical Population Characteristics		
						
	Mild-Moderate	Severe	Residential	LGBTIQ	Veteran	Co-Occurring SUD

The program provides services in English, Spanish, Vietnamese, Farsi, Korean, Arabic, Combodian, and Mandarin.

The Adult CRP serves adults ages 18 to 59 who are County residents, diagnosed with a mental health disorder, may have a co-occurring substance use disorder, and may be at risk of psychiatric hospitalization. The individual must be in crisis and willing to receive crisis residential services voluntarily. The Adult CRP has one facility in Orange with 15 beds, one in Mission Viejo with six beds, and one coming in Anaheim that will have six beds. Stays in the Adult CRP are considerably shorter than the Children's and TAY CRPs and average seven to 14 days.

Services

The CRPs emulate a home-like environment in which intensive and structured psychosocial recovery services are offered. Depending on the program and needs of the individual and/or their family, services can include crisis intervention; individual, group and family counseling/therapy; group education and rehabilitation; assistance with self-administration of medications; training in skills of daily living; case management; development of a Wellness Recovery Action Plan (WRAP), prevention education; recreational activities; activities to build social skills; parent education and skill-building; mindfulness training; and nursing assessments. The evidence-based and best practices most commonly used include cognitive behavior therapy, Dialectical Behavioral Therapy (DBT) and trauma-informed care. Programs also provide substance abuse education and treatment services for people who have co-occurring conditions.

To integrate the individual back into the community effectively, discharge planning starts upon admission. A key aspect of discharge planning involves linkage to community resources and services that build resilience and promote recovery (i.e., FSPs and other on-going behavioral health services; Victim's Assistance; local art, music, cooking and self-protection classes; animal therapy; activity groups). In addition, the Children's CRP offers a weekly drop-in Grad Group.

Strategies to Promote Recovery/Resilience

The CRPs are person-centered and recovery oriented. Services focus on empowering individuals to take responsibility for themselves by giving them choices in their daily activities, helping them develop independent living skills, and assisting them in reintegrating into the community. The children's program also provides opportunities throughout the day to develop protective factors and practice emotional self-regulation. An emphasis is also placed on supportive peer, staff and family relationships. In the TAY CRP, when participants are ready they present their own case for increased independence to the treatment team as a way to prepare for a lower level of care. For adults, the CRP has provided a healthy alternative to psychiatric hospitalization in a therapeutic home like environment for people experiencing an acute behavioral health episode. Each individual admitted to the Crisis Residential Services program has a comprehensive service plan that is unique, meets the individual's needs, and specifies the goals to be achieved for discharge. To effectively integrate the individual back into the community, discharge planning starts upon admission.

Strategies to Improve Timely Access to Services for Underserved Populations

The CRPs hire bilingual/bicultural staff who speak multiple languages (see grid for specific languages). The language line and/or interpretation services are also available when staff who speak the language of a participant or family member is not available. In addition, central to each participant's treatment plan is connection to on-going services and stable supports. Case management and close coordination with partner programs help ensure that participants are linked to appropriate, available resources in the County.

Although family involvement is critical to the success of the Children's CRP, family members may experience transportation difficulties, work/school schedule conflicts, and child care issues that create barriers to participation. To address these challenges and improve families' access to services, programs are located throughout Orange County, scheduling of counseling sessions accommodates family members' work and school schedules, and program staff provide transportation assistance.

Strategies to Reduce Stigma and Discrimination

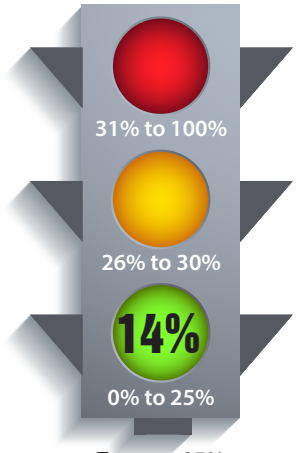
CRPs provide a welcoming, home-like environment that meets individuals and families where they are at in their recovery. This type of environment promotes a sense of emotional safety that, in turn, helps promote mental well-being and recovery. The TAY program also offers its transgender participants a private space in the home, when needed, in order to provide a physically and emotionally safe environment, free of judgement, so they can focus on their recovery.

Outcomes

There were a total of 243 admissions to the children's program, 60 to the TAY program and 426 to the adult program during FY 2016-17. The goal of all three programs is to minimize discharges from the program before the person has achieved an adequate degree of stabilization. For the child and TAY programs, this is quantified as achieving a psychiatric hospitalization rate of 25% or less from the time the youth is enrolled in the program through 60 days post-discharge. Both programs met this goal with hospitalization rates of 14% and 13% for children and TAY, respectively. Because the length of stay is substantially shorter in the Adult CRP compared to the Children's and TAY programs, its target is a hospitalization rate of less than 5% within 48 hours of discharge. The Adult CRP also met its goal in FY 2016-17 as no adults were hospitalized within this time frame.

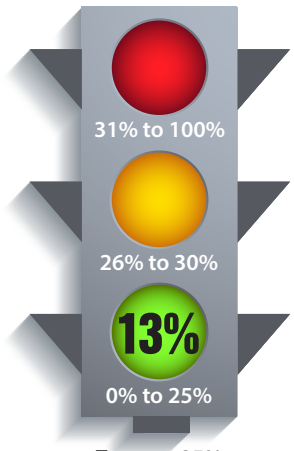
The Adult CRP also tracks the percentage of individuals served who achieved crisis stabilization while in the program and were discharged to a less restrictive level of care such as an outpatient clinic, Full Service Partnership or private psychiatrist/therapist. The target goal established by management is a 90% discharge rate to a lower level of care, which was exceeded during FY 2016-17 (98%).

Hospitalization Rate - Up to 60 Days Following Discharge
Children's Crisis Residential Program
FY 2016-17



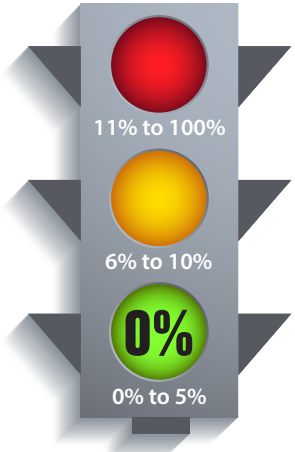
Target ≤ 25%

Hospitalization Rate - Up to 60 Days Following Discharge
TAY Crisis Residential Program
FY 2016-17



Target ≤ 25%

Hospitalization Rate - Up to 48 Hours Following Discharge
Adult Crisis Residential Program
FY 2016-17



Target < 5%

Challenges, Barriers and Solutions in Progress

An ongoing, primary challenge has been the increased demand for Crisis Residential services. In response, the children's, TAY and adult programs have all recently expanded the number of beds and/or locations throughout the county. The newest children's site is centrally located, provides improved access for families (especially those with limited transportation options), and has eliminated the waitlist for services. The adult program has expanded from 15 beds at one location to 21 beds at two locations, with a third location in Anaheim soon increasing capacity by another six beds.

While the addition of a Registered Nurse to the TAY CRP team has provided valuable and needed services, many participants have a co-pay or full pay for their medications which can be cost prohibitive. Another challenge is that there still remains a lack of stable housing available to TAY when they are ready for a lower level of care.

Community Impact

Since inception, the CRPs have assisted 1,290 children (and 3,870 of their family members), 661 TAY and 2,399 adults with intensive services in a therapeutic, home-like environment. The programs reduce admissions to local emergency departments and provide a strengths-based, recovery-oriented alternative to psychiatric hospitals for those experiencing a behavioral health crisis.

To facilitate access into their programs, as well as linkage to on-going services upon discharge, the CRPs work closely with the County Crisis Stabilization Unit, County and County-contracted outpatient clinics, Full Service Partnerships, Programs of Assertive Community Treatment, Older Adult Services, Recovery Services/Centers, and other County-contracted programs.

RESIDENTIAL TREATMENT

Residential Treatment programs provide 24-hour care in a residential setting for individuals whose behavioral health treatment needs exceed the capacity of outpatient programs. Orange County currently funds four residential programs through MHSA/CSS, each with a specific focus. Two are targeted to serve Transitional Age Youth (TAY) with specific residential care needs. The two remaining programs serve those with co-occurring mental health and substance use disorders: one for TAY and the other for adults and older adults. The programs, which are all voluntary, are described in more detail below.

Residential Treatment	Estimated Number to be Served in FY 18/19	Annual Budgeted Funds in FY 18/19	Estimated Annual Cost Per Person in FY 18/19
TAY Social Rehabilitation Program (CSS)	96	$1,491,368	$15,535
Youth Core Services (CSS)*	530	$2,300,000	$4,340
Co-Occurring Mental Health and Substance Use Disorders Residential Treatment – CYBH (CSS)	75	$427,500	$5,700
Co-Occurring Mental Health and Substance Use Disorders Residential Treatment – AOABH (CSS)	TBD	$500,000	TBD

* *The budget for Youth Core Services is the total figure that includes Youth Core Services' Field-Based track described in the Intensive Outpatient section.*

Transitional Age Youth Social Rehabilitation Program

Program Serves	Symptom Severity		Location of Services	Typical Population Characteristics			
							
18 - 25	Mild-Moderate	Severe	Anywhere	LGBTIQ	Homeless/ At Risk	Co-Occurring SUD	Criminal Justice

The program provides services in English, Spanish, Vietnamese, Farsi, Korean, and Arabic.

Target Population and Program Characteristics

The TAY Social Rehabilitation Program (SRP) is a six-bed facility that provides structured and supervised housing for youth between the ages of 18 and 25 who are living with serious mental illness and may have a co-occurring substance use disorder. TAY are referred to the SRP if they would benefit from a high level of supervision provided by a residential program but do not need as intense a placement as Crisis Residential or psychiatric hospitalization. Youth are typically experiencing significant family conflict, are homeless or at risk of being homeless, unserved or underserved, or transitioning out of the juvenile justice or foster care system. Placements typically range from two-to-six-months.

The SRP accepts referrals from the Crisis Assessment Teams (CAT; see program description under Crisis Services) and FSPs. The SRP also serves as a step-down level of care for those who are ready to discharge from the TAY Crisis Residential Program (CRP; see program description under Crisis Services), but would still benefit from a residential placement. Many of the youth referred to this program have difficulty in living situations like Room and Boards and Sober Living homes where they have primary responsibility for structuring their own time. All TAY who enter the SRP are already linked with an FSP. The program does not admit individuals who are registered as a sex offender, conserved or diabetic.

“The staff treated me like a person and not a patient.”

– TAY SRP Participant

Services

The SRP places an emphasis on personal growth and helps prepare youth for returning to the community and living more independently. Services include safe and stable shelter, food, medication assistance, case management, individual and group therapy, and coaching to develop basic living skills. Some of the evidence-based therapeutic interventions used at the SRP include Seeking Safety, Trauma-Focused Cognitive Behavioral Therapy, and Motivational Interviewing. Linkage to ongoing community mental health services and other supports such as assistance with employment and school enrollment are also integral parts of this program.

Strategies to Promote Recovery/Resilience

The SRP staff and clinical team provide 24-hour support and emphasize personal growth to help prepare youth for returning to the community and living more independently. As mentioned above, these youth can have difficulty with conforming to program expectations, so the SRP provides opportunities to learn new behaviors by breaking them down into achievable units and gives the youth reinforcement for accomplishing each part before integrating the behaviors into a whole response.

Strategies to Improve Timely Access to Services for Underserved Populations

Central to each TAY's treatment plan is the connection to services or stable supports, which will allow appropriate transition into the community when their time at SRP is complete. Case management services and close coordination with Full Service Partnership programs ensure the individual benefits from the full range of resources available to them.

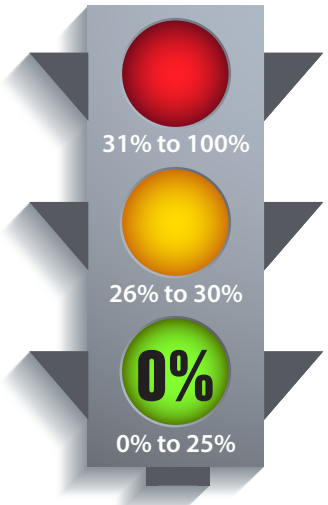
Strategies to Reduce Stigma and Discrimination

By helping SRP youth learn tasks that the great majority of their same-aged peers can accomplish, the program enhances the youth's self-esteem and assists them in integrating with their peers.

Outcomes

Of the 26 TAY served in the SRP during FY 2016-17, a total of 8 were referred directly to the SRP and included in the analysis here. The remaining youth transferred between the Crisis Residential and Social Rehabilitation Programs and are included in the TAY CRP since they had required a higher level of care at some point during their placement. Similar to the CRP, the TAY SRP strives to maintain a psychiatric hospitalization rate of 25% or less during the time the youth is enrolled through 60 days post-discharge. This goal was met in FY 2016-17, with none of the TAY requiring a hospitalization during this timeframe.

Hospitalizations up to 60 Days Following Discharge TAY SRP
FY 2016-17



Target ≤ 25%

Challenges, Barriers and Solutions in Progress

It can be difficult to design a structured program that simultaneously supports and encourages independence. When youth are away from the program, substance use can be problematic even in a flexible harm reduction model. Every attempt is made to empower youth, encouraging their exercise of voice and choice by having participants make as many decisions as possible, e.g., food, outings, house rules, etc. The program also includes as much psychoeducation on substance-related issues as can be useful within a population that is at a developmentally appropriate stage to test limits.

Community Impact

The program has provided services to 191 TAY since its inception in September 2009. The program provides an alternative to hospitalization by providing a safe therapeutic environment that is the first step toward independent living. Youth are also enrolled in FSPs to further assist with their transition to less restrictive levels of care.

Youth Core Services – Residential Track

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics								
0 - 25	Severe	Residential	Foster Youth	Parents	Families	LGBTIQ	Homeless/At Risk	Co-Occurring SUD	Medical	Students

The program provides services in English and TBD as contracts are awarded.

Target Population and Program Characteristics

Starting in FY 2017-18, the Youth Core Services – Residential track was established to serve foster youth from birth through age 25 who need the highest level of behavioral health care in a trauma-informed residential setting. HCA estimates that 150 of the youth served in Youth Core Services will be served specifically in the residential track, which consists of Short-Term Residential Therapeutic Programs (STRTPs). Residential costs will be paid through the foster care system and HCA will contract with the STRTPs to provide MediCal Specialty Mental Health Services to address the Specialty Mental Health mental health needs of wards and dependents placed under the Senate Bill 403 mandate. All referrals to the program will be made by Child Welfare or Probation with approval from the Interagency Placement Committee (IPC), which includes staff from Child Welfare, Probation and HCA. HCA is currently working to establish its initial contracts for the STRTPs and an interagency STRP workgroup is collaborating with different STRTP providers that will meet the needs of this population.

Services

Per State legislation, foster youth can stay in an STRTP up to six months before transitioning to a less restrictive, more family-like setting. While in the placement, the STRTP will provide an integrated program of specialized and intensive behavioral health services and supervision that includes the following: individual, collateral, group and family therapy; medication management; therapeutic behavioral services; in-home behavioral services; intensive case consultation; and case management. Per the regulations, STRTPs are required to provide EBPs that meet the needs of its specific population, thus, the specific treatment interventions will vary among the providers. In addition, the legislation requires that all providers must provide trauma-informed and culturally relevant core services that include:

- Specialty mental health services under the MediCal Early and Periodic Screening, Diagnosis, and Treatment program;
- Transition services to support children, youth and their families during changes in placement;
- Educational and physical, behavioral and mental health supports, including extracurricular activities and social supports;
- Activities designed to support transition-age youth and non-minor dependents in achieving a successful adulthood; and
- Services to achieve permanency, including supporting efforts for adoption, reunification or guardianship and efforts to maintain or establish relationships with family members, tribes, or others important to the child or youth, as appropriate.

Strategies to Promote Recovery/Resilience

Due to the extensive histories of trauma experienced by the youth referred to this program, STRTP providers will foster recovery and resilience by creating a space that provides physical and emotional safety for the children and their caregivers. Program providers will conduct screenings and assessments with sensitivity to identify the trauma-related reactions and risk of the children and adults they serve. Assessments will also factor in how the children's developmental stage and cultural considerations intersect with their trauma experiences, and use this information to connect children with appropriate evidence-based treatments that will (1) address their trauma and other behavioral health symptoms, and (2) help them form positive supportive relationships. Providers will also educate caregivers on how their own trauma histories may be impacting their current behavior and relationships, particularly with their children, and will help adults develop skills and tools to support their children in recovery.

Finally, the STRTP model recognizes that those who work with trauma-exposed individuals can be affected, and programs are encouraged to educate and support staff on how to address these impacts so that they can continue to support the children and families with whom they work. Staff are also expected to partner with youth, families and the other agencies with which they interact (i.e., child welfare, mental health, law enforcement, legal, medical, educational, etc.) so that they are working collaboratively and one system is not 'undoing' the work of another.

Strategies to Improve Timely Access to Services for Underserved Populations

The State has outlined an emergency admission procedure to provide this level of care when it is the only viable alternative. All "pre-placement" activities occur once a youth is placed in the program in order to facilitate timely access to its services. If criteria are subsequently determined not to be met, alternative placements are arranged. The program will also provide services in Spanish, Vietnamese, and other languages through staff who are bicultural/bilingual.

Strategies to Reduce Stigma and Discrimination

Staff hired to work at a STRTP will receive on-going and intensive training in child development, cultural and gender identity issues, and severe trauma. This training will help provide staff with evidence-supported skills and strategies to provide a safe environment that respects the backgrounds and histories of the youth and families and to collaborate with them to identify services and supports that best meets their needs.

Outcomes

The program has not yet been implemented so there are no outcomes to report at this time.

Co-Occurring Mental Health & Substance Use Disorders Residential Treatment

The Co-Occurring Mental Health and Substance Use Disorders Residential Treatment programs ("Co-Occurring") serve individuals living with both types of behavioral health conditions in structured residential settings that provide 24/7 care. Historically Orange County has contracted with traditional residential treatment providers that focus on substance use disorders (SUD). Over the years, it became increasingly apparent that some individuals in these programs had serious mental health conditions that fell outside the scope of practice of the existing providers. Thus, programs were designed to address the specialized needs of this population. Orange County currently has two such programs funded through CSS: one to serve adolescents and the other to serve adults.

Target Populations and Program Characteristics

Children's Co-Occurring

Program Serves	Symptom Severity		Location of Services				Typical Population Characteristics				
13 - 17	Mild-Moderate	Severe	Home	Field	Schools	Outpatient Clinic	Parents	Families	Homeless/ at Risk	Co-Occurring SUD	Criminal Justice

The program provides services in English, Spanish, Vietnamese, and Farsi.

The Children's Co-Occurring Residential Program serves adolescents under age 18 who are living with a substance use disorder and a moderate-to-severe mental health condition. The majority of youth enrolled in the program are involved with the juvenile justice system and/or Probation and come from homes with a history of family drug use and/or trauma. Youth are referred to this program by Probation Officers, Juvenile Recovery Court and family members.

> **“Thank you for giving me a second chance on life. If I was not here I would probably be out on the streets or something. Thank you for believing in kids like us.”**
>
> **- Adolescent Participant**

Adult Co-Occurring

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics				
							
	Severe	Residential	LGBTIQ	Veteran	Homeless/ At Risk	Co-Occurring SUD	Criminal Justice

The program provides services in English, Spanish, Vietnamese, and TBD.

The Adult Co-Occurring Residential Program will serve individuals who are diagnosed with serious and persistent mental illness (SPMI) and a concurrent SUD. Qualifying TAY over the age of 18 will also be able to participate.

Although the contract for the Adult program was awarded by the Board of Supervisors in August 2017, the provider has experienced challenges securing a site. As the adult program is developed more fully, additional information will be articulated in future plan updates. Thus, only the Children's program is described in more detail below.

Services

The Children's Co-Occurring Residential Program provides 24/7 care for adolescents in a structured setting. Recognizing that sustained rates of recovery can be significant when mental health and substance abuse treatment are integrated, the program incorporates individual and group therapy, family therapy, recreational therapy and life skills training while simultaneously addressing underlying issues such as trauma, attachment, abuse, neglect, etc.

With regard to the therapeutic approaches used, the provider has implemented Seeking Safety, Anger Management, Motivational Interviewing, relapse prevention and other evidence-based and best practice strategies. In addition, the program recently acquired musical instruments and exercise equipment to enhance diversity in its treatment approaches and promote alternative coping skills for its residents. Because the family is integral to the adolescent's recovery, their involvement in treatment planning and multi-family groups is encouraged throughout the adolescent's stay.

To facilitate community integration upon discharge from the program, the youth also receive vocational and educational support, 12-step involvement, case management, and referral and linkages to community resources. In addition, the program provides outpatient aftercare treatment to help maintain gains made during the residential stay. As Drug MediCal Organized Delivery System is implemented in Orange County, the distribution of MHSA funding for the residential and outpatient components of this program will be re-evaluated.

Strategies to Promote Recovery and Resilience

The co-occurring program promotes recovery and resilience in its residents by addressing the full range of their needs. The program collaborates with the youth to identify their strengths and existing resources, and then actively works to link them to additional community services that will help support their continued recovery after discharge from the residential setting (i.e., 12-step programs, alumni groups, wraparound services, case management, vocational training, housing, etc.).

Strategies to Improve Timely Access to Services for Underserved Populations

The program maintains an open dialogue with referring partners to ensure continuity of care. If adolescents are in custody when referred to the program, staff will collaborate with the referring agency to conduct the intake while the youth is still in custody to facilitate the admission process. If referred youth do not require this intensive level of service, they may be referred to and enrolled in their co-occurring outpatient program.

The majority of adolescents who come to the residential program are already linked to outside services such as Probation or the CYBH outpatient clinics. If they are not linked and a need exists, program staff will accompany youth to tour the facilities to which they are referred either while still enrolled in the program or at the time of discharge. Staff also accompanies youth to 12-step and other community support groups while they're in treatment to help encourage successful linkage to these services after they discharge from the residential program.

Strategies to Reduce Stigma and Discrimination

The provider educates its staff on a range of topics related to culture, ethnicity, sexual orientation, gender identity, substance use and mental illness. This is done by providing trainings, attending cultural events, and visiting and interacting with other facilities within the larger organization that serve persons with similar backgrounds and diagnoses. Dignity and respect for all is a central tenet of the program and the program's parent agency, and this philosophy is outlined in the program's Core Beliefs, which are reviewed with staff and the youth served on a regular basis.

Outcomes

Outcomes for the Children's Co-Occurring Residential Program are not available at this time due to on-going challenges with data extraction and analysis. HCA is currently working to address this issue and will report outcomes in future Plan Updates.

Challenges, Barriers and Solutions in Progress

The children's residential program has identified a need for additional staffing, as well as additional equipment (i.e., computers, office space, etc.). A weekly Treatment Team meeting is held to address these and other challenges and the Program Director keeps in contact with the Senior Director of Treatment Services to request assistance as needed. The program also encourages open communication between staff to generate solutions in the best interests of its program participants.

The provider for the adult program has been actively trying to identify a facility. Once a facility is identified, the program will need to be approved by the California Department of Health Services and comply with city ordinances prior to admitting participants.

OUTPATIENT SERVICES

The largest Service Function of MHSA-funded programs, both in breadth and depth, is Outpatient Services. These programs provide clinical interventions and other services in a non-hospital/non-residential setting for individuals of all ages who are experiencing mental health symptoms that can range in severity from mild to serious and persistent. To further promote recovery and resilience, many of the programs also provide services and supports for family members. Orange County devotes a considerable proportion of its MHSA allocation to fund a wide array of outpatient programs that include the following types:

- Early Intervention Outpatient
- Clinic-Based Outpatient Mental Health
- Integrated Outpatient Care
- Intensive Outpatient
- Outpatient Recovery
- Specialized Outpatient/Interagency Collaborations

These program types and the services they provide are described in more detail in the sections that follow.

EARLY INTERVENTION OUTPATIENT

The first subcategory of outpatient services is the early intervention programs. These programs serve individuals of all ages who are experiencing mild to moderate mental health symptoms, and most specialize in serving a traditionally underserved group such as Veterans and military-connected families or the lesbian, gay bisexual, transgender community. Consistent with a key MHSA aim of preventing symptoms of mental illness from becoming severe and disabling, Early Intervention Outpatient Services are designed to create a system of first-help and deliver services out in the community to encourage access to their programs. These programs are largely funded by PEI and are described below according to the target populations they are designed to serve.

Early Intervention Outpatient	Estimated Number to be Served in FY 2018-19	Annual Budgeted Funds in FY 2018-19	Estimated Annual Cost Per Person in FY 2018-19
Short-Term Treatment: Community Counseling and Supportive Services (PEI)	700	$2,186,136	$3,123
Suicide Prevention/ Postvention: Survivor Support Services (PEI)	130	$343,693	$2,259
Veterans Services: College Veterans Program (PEI)	100	$400,000	$4,000
OC4Vets (PEI)	180	$1,295,957	$7,200
Strong Families-Strong Children: Behavioral Health Services for Military Families (INN)	50	$445,904	$8,918
LGBTIQ Services: OC ACCEPT (PEI)	150	$490,000	$3,267
Early Onset: 1st Onset of Psychiatric Illness (OC CREW; PEI)	70	$1,500,000	$21,429
Early Intervention Services for Older Adults (PEI)	600	$1,469,500	$2,449
Family Services: OC Parent Wellness (PEI)	700	$2,113,072	$3,019

Early Intervention Outpatient	Estimated Number to be Served in FY 2018-19	Annual Budgeted Funds in FY 2018-19	Estimated Annual Cost Per Person in FY 2018-19
School-Based Outpatient: School-Based Health Intervention and Support – Early Intervention Services (PEI)	16	$440,000	$27,500
School-Based Mental Health Services (PEI)	2,800	$2,915,236	$1,041

Short-Term Treatment

Early Intervention – Short-Term Treatment programs provide outpatient behavioral health treatment for those who are experiencing mild to moderate symptoms of a behavioral health condition or who are at risk of developing a mental health condition. Individuals in this type of service tend to be enrolled for about six months and do not necessarily have a specialized need supported by other Early Intervention Outpatient programs (i.e., Veterans, Early Onset, Family Services, etc.). Orange County currently has one Early Intervention – Short-Term Treatment program that is funded by PEI.

Community Counseling and Supportive Services (PEI)

Program Serves	Symptom Severity			Location of Services		Typical Population Characteristics							
0+	At Risk	Early Onset	Mild-Moderate	Outpatient Clinic	Satellite Locations	Parents	LGBTIQ	Veteran	Homeless/ At Risk	Co-Occurring SUD	Medical	Students	Criminal Justice

The program provides services in English, Spanish, Vietnamese, Korean, Arabic, ASL.

Target Population and Program Characteristics

The target population for Community Counseling and Supportive Services (CCSS) includes Orange County residents of all age groups who have, or are at risk of developing, a mild to moderate behavioral health condition and have limited or no access to behavioral health services. The majority of enrolled participants are un- or underinsured, monolingual Spanish speaking, and have a history of family or domestic violence and/or early childhood trauma. The program is designed to treat the early symptoms of depression, anxiety, alcohol and/or drug use, violence and Post Traumatic Stress Disorder (PTSD). The early onset of mental illness is determined through referrals and screening. Participants are referred to the program by family resource centers, medical offices, and emergency departments within the local community. The program also receives referrals from county-operated and county-contracted programs.

Services

CCSS provides face-to-face individual counseling and groups (i.e., psycho-educational, skill building, and insight oriented), case management, and referral and linkage to community services. Psychiatric medication support and behavioral health nurse wellness evaluations are also provided for established participants. Clinicians utilize evidence-based practices such as Trauma Focused Cognitive Behavioral Therapy (TF-CBT), Eye Movement Desensitization Reprocessing (EMDR), Motivational Interviewing (MI), Cognitive Behavioral Therapy (CBT) and Seeking Safety while working with program participants.

Strategies to Promote Recovery/ Resilience

Clinicians use various strategies such as mindfulness practices, strengths-based approaches and motivational interviewing to reinforce and strengthen resilience in participants. Enrolled participants are engaged

in individualized care planning to promote positive change. The clinic promotes recovery by creating an open, warm and safe place to receive care and individualized services.

Strategies to Improve Timely Access to Underserved Populations

Program participants experience barriers to engaging in services such as lack of childcare or transportation, an inability to take time off work to make counseling appointments during business hours, conflicting family priorities, financial burden, substance use, lack of a support system and mental health stigma. To overcome these barriers, program staff participate in various outreach events in Orange County and through community presentations to de-stigmatize and break down barriers to mental health services. The program also offers evening hours, onsite childcare and bus vouchers for those without a reliable means of transportation. In addition, the program provides bilingual/bicultural staff in the threshold languages to work with non-English speaking participants. The program also partners with community agencies to provide services to highly marginalized populations such as Middle Eastern and North African refugees via "satellite" locations to improve timely access to its services.

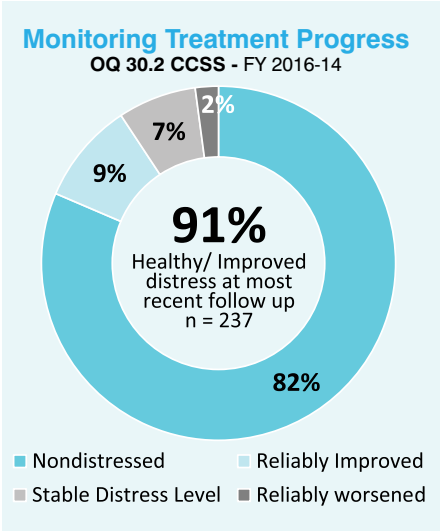
For participants in need of additional resources or who are exiting the program, CCSS provides referrals to appropriate community services and resources in order to promote and sustain recovery. In FY 2016-17, the program provided 328 referrals and 157 linkages primarily to behavioral health services, legal services and advocacy.

Strategies to Reduce Stigma and Discrimination

CCSS serves all eligible Orange County residents regardless of citizenship status. The program employs bilingual and bicultural staff to provide services in a culturally sensitive manner. As mentioned above, it has also partnered with community agencies that work with unserved populations who might be reluctant or unwilling to seek out treatment at a behavioral health clinic but will engage in services in non-behavioral health settings.

Outcomes

CCSS served a total of 467 participants during FY 2016-17 (34 children, 73 TAY, 344 adults, 16 older adults). Individuals ages 18 and older completed the OQ 30.2 at intake, every three months of program participation and at discharge. The difference between intake (baseline) and the most recent follow-up scores was used to determine whether there was a significant reduction in prolonged suffering. This evaluation also reflects cultural competence as the OQ® 30.2 is available in all threshold languages and contains a wide range of symptoms, including somatic symptoms, which may be experienced and/or reported by people from different cultural backgrounds.



Of the 427 participants ages 18 and older, 237 completed the OQ 30.2 at intake and at least one follow up. The overwhelming majority (91%) reported mental health distress levels that were either in the healthy/non-distressed range (82%) or were reliably improved (9%) at the most recent follow up. Thus, CCSS services were associated both with preventing symptoms of mental illness from becoming severe and disabling, as well as with a meaningful reduction in suffering among those who had reported clinically elevated distress levels upon entering the program.

Challenges, Barriers and Solutions in Progress

A full-time psychiatrist was hired this past fiscal year which eliminated the challenge of not being able to provide psychiatric evaluations and medication support. The program has also addressed capacity and waitlist issues by dedicating an Intake Coordinator to screen and schedule intake appointments on a weekly basis to expedite the enrollment process and decrease duration of untreated mental health conditions. The majority of clinicians have been trained in trauma focused treatment approaches as historic and/or recent trauma is a common experience for program participants that can exacerbate or contribute to mental health symptoms.

Community Impact

CCSS has provided services to more than 700 participants since its inception May 2015. It also collaborates with a community based organization (CBO) to provide services to the Arabic speaking community and will begin a partnership with another CBO to provide services to the deaf and hard-of-hearing population beginning March 2018. In addition, the program gives presentations to community partners as requested, to promote awareness and utilization of its services for un- and underserved populations with mental health needs.

Suicide Prevention/Postvention

Another subset of the Early Intervention Outpatient programs specializes in suicide prevention and/or postvention therapeutic interventions for at-risk populations. Orange County currently funds one program through PEI that specializes in these services, although it should be noted that all programs are able to respond to and/or serve any individual expressing suicidal statements and/or behaviors.

Survivor Support Services (PEI)

Program Serves	Symptom Severity				Location of Services	
						
	At Risk	Early Onset	Mild-Moderate	Severe	Field	Community-Based

The program provides services in English, Spanish, Farsi, Korean, Arabic.

Target Population and Program Characteristics

Orange County's contracted PEI program, Survivor Support Services, serves two groups of individuals within this service function: (1) those who have recently experienced the loss of someone to suicide and (2) those who have attempted suicide and may be suffering from depression. The program serves a broad range of people of all ages, and individuals can be self-referred or referred by partner agencies.

Services

Survivors After Suicide. For children, adolescents and adults who are coping with the loss of someone to suicide, the program provides time-limited individual counseling. Short-term bereavement counseling can also be provided to a family to improve their functioning and communication after the loss of a family member. These groups use evidence-supported clinical tools such as active listening.

In addition to counseling, the program offers bereavement groups in two different formats. The first is an eight-week closed format group co-facilitated by a therapist and a survivor. The goal is to establish a safe place without stigma for survivors to share experiences, ask questions and express painful feelings so they can move forward with their lives.

The second type of group for survivors after suicide are drop-in bereavement groups designed to help those who are receiving individual counseling and program alumni to continue the healing process in the months and years following their losses.

Survivors of Suicide Attempts. The program offers closed groups that provide a safe, non-judgmental place for people who have survived a suicide attempt to talk about the feelings that led them to attempt suicide. The goal of this group is to support their recovery and to provide them with skills for coping with deep hurt. The program also provides these individuals with culturally appropriate follow-up care and education. The program uses Applied Suicide Intervention Skills Training (ASIST), which is a practice-based evidence standard, to guide program services for these individuals.

Community Training. In addition to providing early intervention outpatient services, the program also employs, per the PEI Regulations, a strategy to Increase Recognition of Early Signs of Mental Illness. More specifically, the program trains first responders in ASIST and safeTalk so that they are better able to recognize the early warning signs of suicide, depression and/or other types of mental illness and respond appropriately. Audiences include nurses, physicians, teachers and school personnel, law enforcement and other Orange County community members. In FY 2016-17, the program provided 59 trainings that reached 315 potential first responders.

Strategies to Promote Recovery/Resilience

The program promotes recovery and resilience by offering a broad range of services for those affected by suicide so that interventions can be tailored to meet participants where they are in the grieving process and provide them with needed support and resources. The support groups also encourage the continued use of adaptive coping skills and the resources provided after participants discharge from the program.

Strategies to Improve Timely Access to Services for Underserved Populations

Situated near five major freeways, the program is located centrally in Orange County and is accessible from anywhere in the Southern California area to help minimize transportation barriers. The program also offers home/field visits as needed, and community partners provide counseling and support groups in different parts of Orange County to assist with minimizing both transportation and cultural barriers to treatment. Support groups and counseling are also provided in the threshold languages.

Because of the stigma associated with suicide and mental illness, survivors become ready to engage in services at different stages after their loss, which does not always coincide with when they are referred to the program. Staff remain steadfast, patient and ready to provide

treatment at any time the suicide loss survivor is ready for support. If a survivor does not begin services directly after the referral, the program continues to reach out and periodically re-assess readiness for services. For those nearing completion of services, the program also provides referrals to ongoing services in order to help survivors maintain their recovery. In FY 2016-17, the program provided 471 referrals and 226 linkages to mental health services.

Finally, to increase awareness of, and timely access to, its services among underserved populations, the program provides suicide awareness, suicide prevention and program information throughout Orange County. Staff and community partners present at community events, cultural events and fairs, schools, parent and family education events, religious organizations, colleges and other settings in many of the threshold languages, including Spanish, Korean, Arabic and Farsi. In FY 2016-17, the program provided 192 outreach activities to promote suicide awareness and the availability of the program's services.

Strategies to Reduce Stigma and Discrimination

The County strives to make its programs available to all Orange County residents regardless of their backgrounds and to provide services that are sensitive and responsive to participants' cultures and needs. How people deal with loss varies across cultures, religions and age groups, and staff are respectful of these differences. Services are carefully designed to take into account the sensitive nature of loss and differences in the grieving process. For example, non-traditional marketing approaches were used for the Spanish-speaking survivors. Instead of using the more traditional term "support group," which has stigma associated with it in this population, staff referred to their services as "workshops." This approach was so successful that community partners are now utilizing it to overcome cultural barriers and stigma.

Outcomes

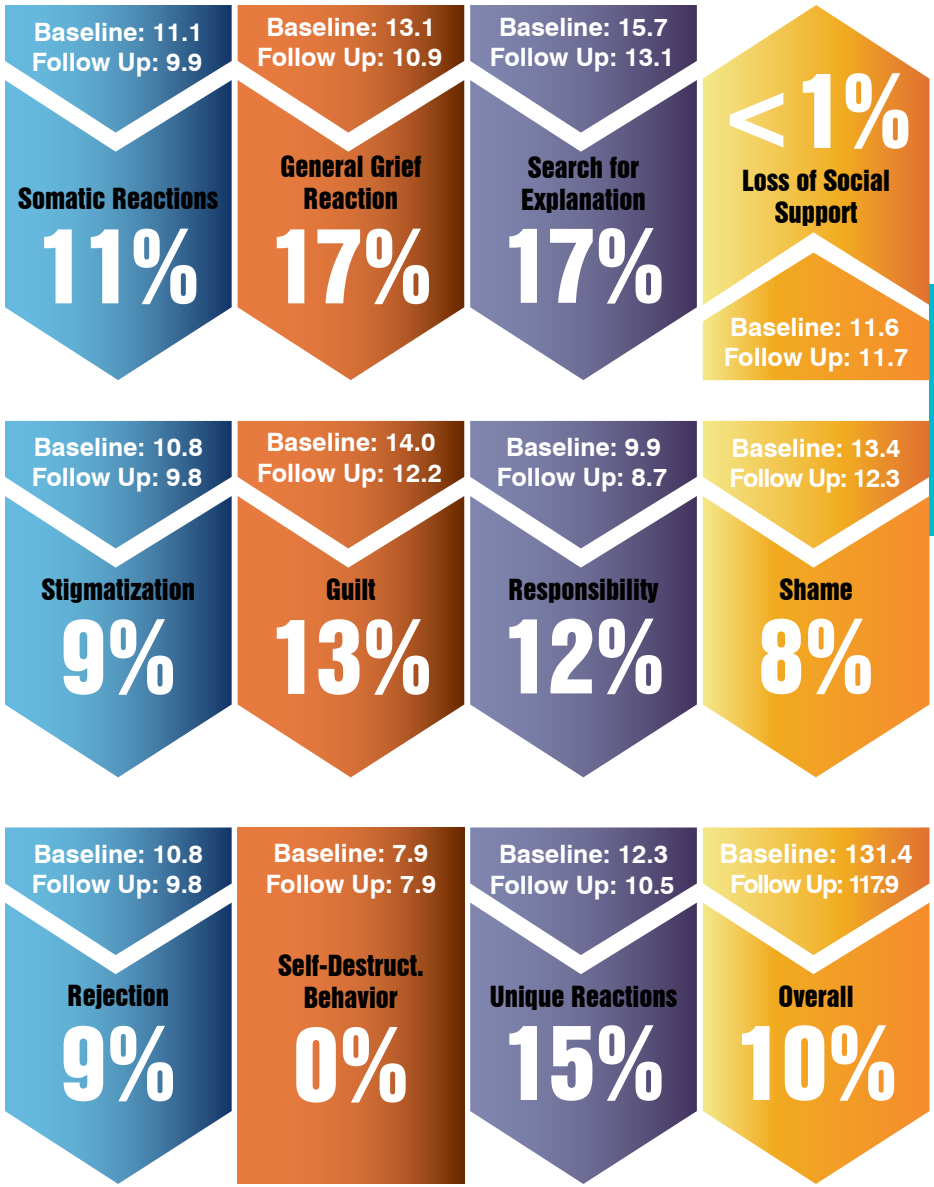
In FY 2016-17, the program served 94 individuals in its closed groups, 59 in its open groups, and 511 in individual counseling services.

To measure reduction in prolonged suffering in a culturally competent manner, participants were asked to complete assessment tools specific to their experience. Individuals completed the measures at intake and program exit, and the difference between scores was used to analyze whether there was a significant reduction of prolonged suffering after receiving program services.

Survivors After Suicide. Individuals reported on their grief over losing someone to suicide on the Grief Experiences Questionnaire (GEQ; n=34-41). Analyses demonstrated that participants reported moderate to substantial decreases on most subscales,[1] including somatic reactions, general grief reaction, search for explanation, guilt, responsibility, rejection, unique reactions and overall grief. Thus, services were associated with a meaningful lessening of grief following the loss of a loved one to suicide.

Change in Symptoms of Grief

SSS - FY 2016-17



In FY 20116-17 Survivor Support Services staff conducted a presentation at an Orange County school. Later a parent, who also is a teacher, wrote a letter to the program thanking the staff and explaining how valuable they found the information. The day after the presentation, the teacher shared some of the resources from the presentation with their students. The teacher also announced that the hotline and website information would be posted.

After class, one of the students approached the teacher and shared that they were feeling suicidal and had a plan. The school worked with the student and parent to access appropriate support and resources, including an emergency evaluation since it was subsequently discovered that the student was experiencing a severe crisis. The teacher reported that, because of the information provided at the Survivor Support Services presentation, they were better prepared to deal with the situation and to make a potentially life-saving difference in this student's life.

– **Student/ Teacher Interface**

Survivors of Suicide Attempts (SOSA). SOSA participants (n=16) were asked to report on the degree of pessimism and negativity they felt about their future; their thoughts, plans and intent to commit suicide; and their perceived burdensomeness and thwarted belongingness (Beck Hopelessness Scale, Beck Scale for Suicidal Ideation and Interpersonal Needs Questionnaire, respectively). During FY 2016-17, data were not statistically analyzed due to the small sample size, but clinicians monitored scores over the course of treatment to track participants' progress and adjust care plans as needed.

Challenges, Barriers and Solutions in Progress

In response to observations that community partners still encounter difficulty referring people from underserved populations to the program, Survivor Support Services has increased its availability in Spanish and has formed workshops for survivors of suicide loss that include an additional psychoeducational focus that addresses misperceptions and stigma related to mental illness and suicide. Due to their positive experience with these groups, some Spanish-speaking survivors have transitioned to individual supportive counseling. To improve linkage to the Survivors of Suicide Attempts groups, the program has begun to work with juvenile hall and continued to work with hospital emergency departments and wellness centers to engage individuals who have attempted suicide.

Community Impact

The program has provided services to more than 719 since its inception in August 2010. One of the key components of the program's success is its collaboration with community partners and agencies that serve ethnic communities. This partnership promotes awareness, breaks down stigma related to mental health and educates communities about available resources.

Reference Notes

[1] *Somatic Reactions: Baseline M=11.1, SD=4.2; Follow Up M=9.9, SD=3.3; t(36)=2.50, p<.01; Cohen's d=0.43*

General Grief Reaction: Baseline M=13.1, SD=4.1; Follow Up M=10.9, SD=3.9; t(34)=4.22, p<.001; Cohen's d=0.71

Search of Explanation: Baseline M=15.7, SD=4.0; Follow Up M=13.1, SD=4.2; t(34)=4.56, p<.001; Cohen's d=0.77

Loss of Social Support: Baseline M=11.6, SD=4.6; Follow Up M=11.7, SD=4.1; t(35)=-0.13, p=.901; Cohen's d=0.02

Stigmatization: Baseline M=10.8, SD=4.1; Follow Up M=9.8, SD=4.3; t(35)=1.74, p=0.09; Cohen's d=0.29

Guilt: Baseline M=14.0, SD=5.0; Follow Up M=12.2, SD=4.6; t(33)=2.89, p<.01; Cohen's d=0.50

Responsibility: Baseline M=9.9, SD=3.4; Follow Up M=8.7, SD=3.7; t(39)=2.79, p<.01; Cohen's d=0.44

Shame: Baseline M=13.4, SD=4.0; Follow Up M=12.3, SD=4.2; t(35)=1.95, p=0.59; Cohen's d=0.33

Rejection: Baseline M=11.6, SD=4.4; Follow Up M=10.3, SD=4.7; t(33)=2.16, p<.05; Cohen's d=0.37

Self-Destructive Behavior: Baseline M=7.9, SD=3.1; Follow Up M=7.9, SD=2.6; t(36)=0.22, p=.831; Cohen's d=0.04

Unique Reactions: Baseline M=12.3, SD=3.2; Follow Up M=10.5, SD=3.4; t(36)=4.27, p<.001; Cohen's d=0.70

Overall Score: Baseline M=131.4, SD=28.9; Follow Up M=117.9, SD=32.7; t(40)=4.09, p<.001; Cohen's d=0.65

Veterans Early Intervention Outpatient Services

Early Intervention Outpatient Services for Veterans provide outpatient services to Orange County Veterans and/or military-connected families who are experiencing, or are at risk of developing, mild to moderate mental health symptoms. HCA currently funds three outpatient programs specifically geared towards Veterans and their families through PEI and INN.

College Veterans Program – Early Intervention Services (PEI)

Program Serves	Symptom Severity	Location of Services			Typical Population Characteristics					
										
	At Risk	Field	School	County Veteran Service Office	LGBTIQ	Veteran	Co-Occurring SUD	Medical	Students	Criminal Justice

The program provides services in English, Spanish, Farsi, Korean, Arabic.

Target Population and Program Characteristics

The College Veterans Program – Early Intervention Services provides services to military veterans who are enrolled at local college campuses. Participants served in this program tend to be between the ages of 22-57 years and, due to unique issues and challenges related to the transition from active military duty to civilian and student life, are at risk of developing mental health conditions and/or of experiencing school failure. Student veterans are self-referred or referred by campus staff or faculty to this PEI program, which was established to meet a need identified by community stakeholders during the MHSA community planning process.

Services

The College Veterans Program places counselors who understand military culture in Orange County community colleges to help veterans navigate available support services and resources. Services include behavioral health screening and assessment to determine whether further evaluation and/or referrals to behavioral health services are needed, individualized case management, brief counseling, and referrals and linkages to appropriate community resources. Services are provided using evidence-based and best practices such as motivational interviewing. Through this program, participants also have access to appointments with a Behavioral Health Services clinician who is a veteran and can understand the unique issues and challenges faced by veterans transitioning to civilian and student life. These services are provided with the goal of helping them succeed at college by reducing their school failure or drop-out rates and by reintegrating them into the community and their families.

Strategies to Promote Recovery/Resilience

College Veterans Program utilizes a Master's level clinician who is also military-connected with lived experience. Utilizing a person-centered and strength-based approach, the interventions work to address barriers to recovery or access to care and promotes resiliency through encouraging healthy choices and positive coping mechanisms. The clinician is located on-site at the assigned campuses and is purposefully incorporated into the student health center or Veteran Resource Center.

Strategies to Increase Timely Access to Services for Underserved Populations

Many participants have limited resources, such as limited or lack of transportation, housing, financial stability or support, adequate employment and/or daycare. Some participants, particularly with their military-connected background, may also hold cultural beliefs that deter them from asking for help. To address these barriers, the program is co-located on campus because there is far less stigma associated with school settings compared to mental health settings.

Clinicians also provide referrals to community-based services and supports as participant needs are identified. Once a referral is made, the clinician follows up with the participant to ensure they attended the first appointment. If a linkage did not occur, the clinician engages the veteran in discussions about the appropriateness of and their desire for change. In FY 2016-17 the program provided 133 referrals and 83 linkages to transportation services; food and nutrition assistance; housing resources and advocacy; employment services and resources; adult education services; legal services and advocacy; behavioral health crisis response; behavioral health outpatient services; financial services; PEI programs;

> **"I am very appreciative of all the help [the clinician] has gotten for me. He was able to connect me with support services that help me with gas and food along with VSO to help me get a disability rating."**
>
> **– Veteran service recipient**

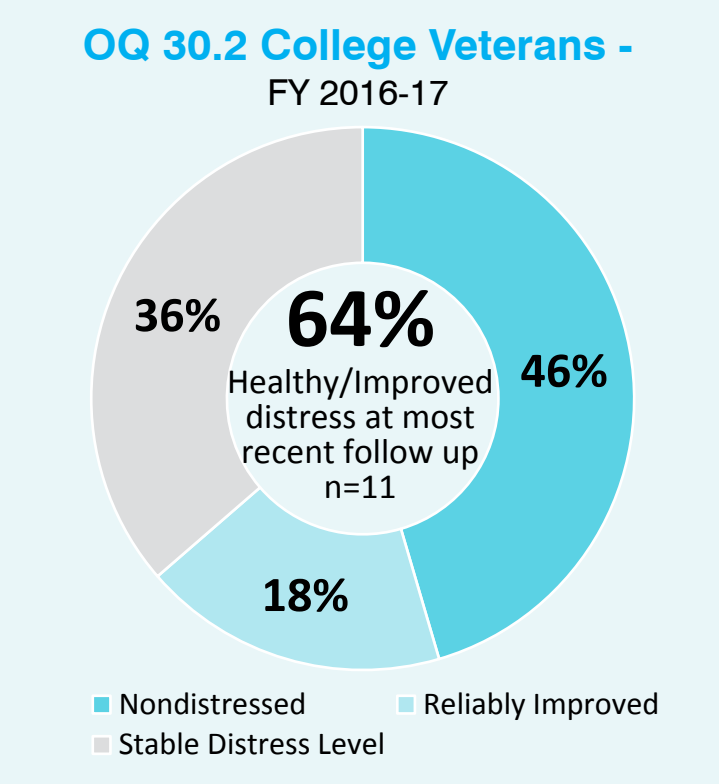
health care services; health education, disease prevention, wellness, and physical fitness; special needs and disability services; and Veteran Entitlement Programs.

Strategies to Reduce Stigma and Discrimination

The program is staffed by military service members or veterans who can address the unique needs of student veterans, including the stigma associated with seeking behavioral health services and how those services might impact Veterans Administration (VA) benefits or be reported to the VA. The on-campus clinician provides frequent education to staff and faculty about ways to engage military-connected students with a culturally competent approach.

Outcomes

The College Veterans program served a total of 27 participants during FY 2016-17. The program intended to administer the OQ 30.2 at intake, every three months and at discharge, although due to implementation issues the measure was only administered at intake and discharge. Paired measures were available for 11 individuals and among these, 64% reported healthy or reliably improved levels of distress at the time of discharge and the remainder reported stable distress levels. While the findings demonstrate that the program prevented symptoms of mental distress from becoming severe and disabling for this subset of participants, it is unclear whether this pattern of results is generalizable to the larger population of veteran students served. Thus, the program is engaging in a twofold process regarding its performance outcomes. First, it is working to improve its completion rate of the outcome measure and, second, it is working with program staff on how to utilize the OQ as a tool that can help inform clinical care.



Challenges, Barriers and Solutions in Progress

As mentioned above, the program experienced issues related to the collection of its performance outcome measure, which is currently being addressed. In addition, the program has had limited visibility due to the current staffing pattern (i.e., only one staff dedicated to the program). With the support of the MHSA Steering committee and HCA Administration, the program will convert from a county-operated to a County-contracted with expanded funding. It is believed these two changes will help improve the program's ability to engage more student veterans and their family members.

Community Impact

The program has provided services to more than 80 participants since its inception in October 2011. The program works with many local veteran organizations, such as the Veterans Service Office (VSO), Veteran's Affairs, and Veterans Resource Centers at local community colleges in order to best meet the needs of Orange County's Veterans.

OC4Vets (PEI)

Program Serves	Symptom Severity		Location of Services				Typical Population Characteristics				
18+	At Risk	Early Onset	Home	Field	Courts	County Operations Center	Foster Youth	Families	LGBTIQ	Veterans	Homeless/ At Risk

The program provides services in English, Spanish, Farsi, Korean, Arabic.

Target Population and Program Characteristics

OC4Vets serves Orange County veterans and their families who currently or previously served in the United States Armed Forces, regardless of the branch, component, era, location(s) or characterization of discharge from their service. OC4Vets is co-located with the Veterans Service Office. A VSO claim's officer completes a referral to OC4Vets for those veterans or family members in need of behavioral health services. Referrals may also be self-referral or from other agencies working with Veterans. This program was originally an Innovation project that was continued with PEI funding due to its demonstrated success.

Services

Program services include case management, behavioral health screening and assessment, employment and housing supportive services, referral and linkage to community resources, outreach and engagement activities, and community trainings. Culturally competent, skilled therapists utilize evidence-based practices such as cognitive behavioral therapy and motivational interviewing when providing clinical interventions. One clinician is also trained in EMDR to serve veterans who are experiencing trauma.

In addition, the program is staffed with Peer Navigators who are Veterans and, through their shared military experience, can provide support and navigation of the healthcare system to participants. Veterans who are involved in legal proceedings with Family Court, Military Diversion or Veterans Treatment Court are also provided clinical case management to support and advocate for Veterans to seek behavioral health treatment in lieu of permanent consequences such as jail or a restraining order.

Strategies to Promote Recovery/Resilience

OC4Vets works from a strength-based approach incorporating recovery principles by using motivational interviewing, developing person-centered and individualized care plans, and focusing on the Veteran's strengths.

Strategies to Improve Timely Access to Services for Underserved Populations

Participants face issues such as lack of transportation, daycare and/or permanent housing, as well as stigma related to mental health. The program works to overcome these barriers to its services by providing them at locations where veterans and their families are already accessing other services or critical supports (i.e., using appointments with the claims officer as a gateway to addressing behavioral health issues). To encourage continued use of services, the program offers case management, behavioral health screening and assessment, and outreach and engagement activities. Staff also conduct community trainings on how to engage or work with Veterans, thus helping agencies or other providers understand military/Veteran culture and increasing their awareness about County services available for Veterans.

Program staff also work with participants to link them to employment, supportive housing services and other community resources. In FY 2016-17, the program provided 363 referrals and 216 linkages to housing resources and advocacy; behavioral health outpatient services; employment services and resources; Veteran Entitlement Programs; transportation services; PEI programs; financial assistance; legal services and advocacy; food and nutrition assistance; entitlement programs; health care services; behavioral health crisis response; financial services; health care benefits; senior services; health education, disease prevention, wellness, and physical fitness; recreation; and family support services.

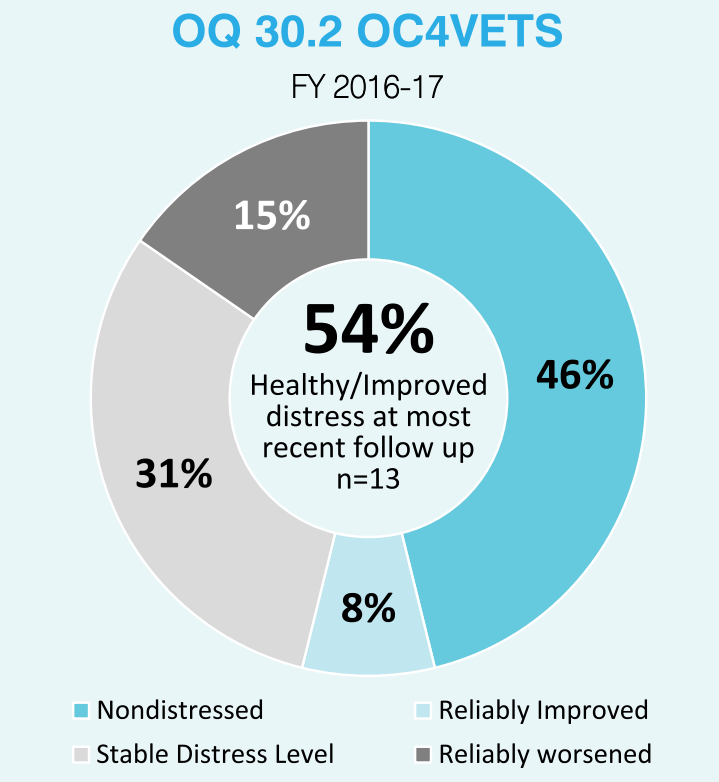
Strategies to Reduce Stigma and Discrimination

The program works to decrease stigma associated with seeking behavioral health services by staffing the program with military service members, veterans and peer navigators who can address the unique needs of veterans.

> **“I don’t know what we would have done if you guys would not have been there for us. We are thankful you guys were there for us for the beginning through the tough times, you guys made a difference in our time of need.”**
>
> **– Veteran service recipient**

Outcomes

OC4Vets served a total of 172 participants during FY 2016-17. As with the College Veterans program, the program experienced administration issues with the outcome measure (OQ 30.2) and paired measures were only available for 13 individuals. A little over half reported healthy or reliably improved levels of distress at the time of discharge and nearly one-third reported stable distress. Because 15% (n=2 Veterans) reported feeling significantly greater distress at the time of discharge, the program is working to implement strategies on how to identify and work with individuals in need of greater support and/or a higher level of care in a timely and effective manner. The program is also working with staff to improve its outcome measure completion rate so that it can determine whether these results are unique to this particular subsample of participants or whether this pattern is reflective of the overall Veteran population served by OC4Vets.



Challenges, Barriers and Solutions in Progress

OC4Vets transitioned from Innovation funding to PEI funding in February 2016 and the program was not fully staffed during this changeover. In order to improve continuity of care for participants through a more robust workforce, full-time peer navigators were hired, replacing part-time navigators. Unfortunately, one clinician position still remains vacant, directly affecting the program’s ability to reach full capacity. The program is also working to improve its OQ administration procedures and its use as a clinical tool.

Community Impact

The program has provided services to more than 664 participants since its inception, first as an Innovation project and then as a PEI program. The program has developed strong collaborations with a number of agencies that serve Orange County’s veteran population, including the Veteran’s Service Office with OCCR, Workforce Investment Office with OCCR, Office on Aging, Veterans’ Affairs Administration, Orange County Superior Courts, and Orange County Family Court.

Strong Families-Strong Children: Behavioral Health Services for Military Families (INN)

Program Serves	Symptom Severity			Location of Services			Typical Population Characteristics		
0+	At Risk	Mild-Moderate	Severe	Home	Field	Outpatient Clinic	Parents	Families	Veteran

The program provides services in Spanish.

Target Population and Program Characteristics

Strong Families-Strong Children (SFSC): Behavioral Health Services for Military Families serves all members in the military family, including veterans, service members, spouses, partners and children. The goals of this project are to improve family functioning, communication and overall well-being. Eligible participants may directly contact the project for services or be referred by behavioral health providers throughout Orange County.

Services

The SFSC project is designed to increase access to military-connected families. It utilizes trained clinicians and peer navigators with experience and knowledge of military culture to address mental health concerns encountered by veterans that may affect the whole family, such as post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), substance use and other conditions. Clinicians provide short-term individual and family therapy to address the impact of traumatic events and experiences on children and family members. Peer navigators provide one-on-one peer support, case management, and referrals and linkages to community resources. Additional project services include outreach and engagement, and screening and assessment to encourage appropriate referrals to and enrollment in program services; workshops and educational support groups for families; and counseling using the Families Overcoming Under Stress (FOCUS) program, which is an evidence-based practice derived from research on military-related risk and protective factors that aims to improve parent-child well-being and family functioning.

The SFSC project was implemented on July 1, 2015; Innovation funds for this project will end on June 30, 2020.

Strategies to Promote Recovery/Resilience

The SFSC project is based on a peer-to-peer model, utilizing individuals with experience and knowledge of military culture to promote recovery and resilience. The peer navigators promote family resilience by helping participants manage their mental health, improve family functioning, strengthen their relationships with others and build support networks, all of which are critical to recovery. The goal of this project is to empower each individual to be proactive in the management of their own recovery, as well as within the family structure. Services are inclusive of the entire family unit, which allows for more effective family communication, functioning and support. Furthermore, enhancing the veteran's support system by strengthening the family unit reinforces the important role family provides in the veteran/active member's recovery process.

Strategies to Improve Timely Access to Services for Underserved Populations

In order to meet the complex needs of military families, a collaboration of non-profit organizations was established to form the Strong Families, Strong Children Collaborative – A Partnership to Support Veteran and Military Families. Peer navigators established strong relationships with community agencies serving veterans in an effort to bridge the gap in services and better link their participants to appropriate resources. Many of the agencies have acknowledged the peer navigators' commitment to the project and their participants, highlighting their passion for helping military-connected families.

In FY 2016-17, the program provided 217 referrals and 106 linkages. As peer navigators became more familiar with local agencies, they were able to provide the most appropriate referrals, thereby improving the ability to link families to services. Peer navigators connected families to a wide range of resources, including basic needs (i.e., food, clothing), housing, mental health, early intervention services, domestic violence prevention, legal services, financial services, employment services and education benefits.

Strategies to Reduce Stigma and Discrimination

The peer-to-peer model has been successful in establishing a safe and trusting relationship between the peer navigator and military family members. Their experience and knowledge of military culture allows peer navigators to broach the sensitive topic of mental health with veterans and service members.

> “As a U.S. Veteran hav[ing] a peer specialist that provides an environment for my children where they can share openly is very important.”

> “At this program I like to play with my counselor, paint, play Jenga and talk about how to make our time better when we are mad.”

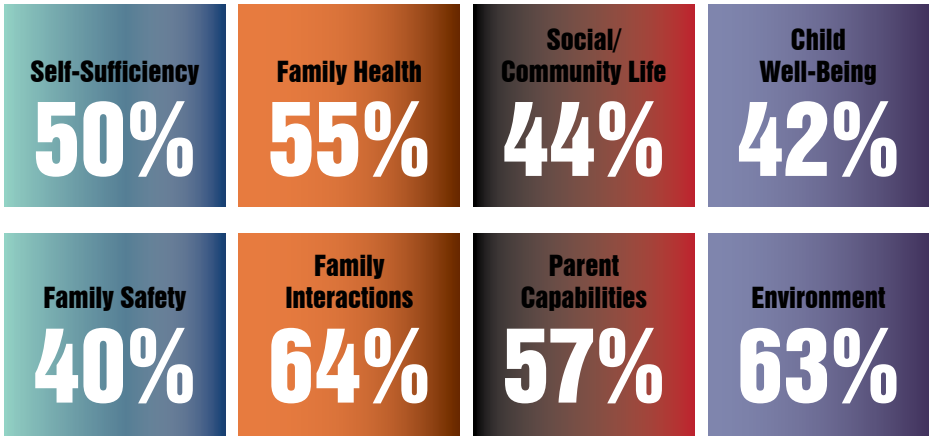
– Military family participants

Outcomes

In FY 2016-17, 277 families were served in the SFSC project. The goals of the project are to improve family communication, functioning and overall well-being, which was evaluated using the North Carolina Family Assessment Scale (NCFAS). Project staff provided ratings at intake and discharge (n=96) which were scored according to whether families demonstrated strengths (i.e., mild, clear), adequate functioning, or needs (i.e., mild, moderate, severe) in each of the domains. The project's success in helping families maintain or improve these protective factors was evaluated by the proportion of families that exhibited strengths or improvement in each domain.

Proportion of Families with Strengths &/or Improvement

SFSC - FY 2016-17



% rated as Clear Strength, Mild Strength or Improved Functioning

Challenges, Barriers and Solutions in Progress

This project faces challenges that include a complex referral system with the veteran courts, difficulty managing multiple agency data systems, and a fragmented system of care for veterans. With regard to court referrals, SFSC peer navigators were initially unable to outreach and engage domestic violence petitioners consistently. In response, a protocol was established to ensure SFSC staff were notified of court hearings in advance so that they could offer outreach and engagement services at the hearing. To address data management issues and the fragmented services for veterans, SFSC is currently working with their partners to master resources needed by military families and develop reliable data systems that move information across agencies.

Community Impact

SFSC and its collaborative partners devoted considerable time to outreach and engagement activities throughout the community, as well as within county and community behavioral health programs. As a result of these efforts, the project has provided services to more than 332 veterans and their family members since its inception in July 2015. SFSC has also strengthened its relationship with other veteran- serving agencies, including the Veterans Affairs Administration (VA) located in Long Beach. This relationship with the VA is especially significant in improving collaborative efforts, linking military-connected families to services and bridging the gap between agencies.

During their enrollment in this project, participants were asked to rate their satisfaction with SFSC staff and services. In FY 2016-17, results showed that of the participants surveyed (n = 25), a majority strongly agreed that they were inspired by their peer navigator to improve their life (75%); would recommend the program to others (89%); and were satisfied with the program (78%).

LGBTIQ Services

While many of Orange County's MHSA and BHS services can meet the needs of its LGBTIQ participants, Orange County also offers early intervention outpatient services designed for individuals who are addressing issues specifically related to sexual orientation and/or gender identity. This program is known as OC ACCEPT (Acceptance through Compassionate Care, Empowerment and Positive Transformation).

OC ACCEPT (PEI)

Program Serves	Symptom Severity		Location of Services			Typical Population Characteristics									
															
	Early Onset	Mild-Moderate	Home	Field	Outpatient Clinic	Foster Youth	Parents	Families	LGBTIQ	Veterans	Homeless/ At Risk	Co-Occurring SUD	Medical	Students	Criminal Justice

The program provides services in English, Spanish.

Target Population and Program Characteristics

OC ACCEPT was originally an Innovation project that was continued with PEI funding due to its demonstrated success. It provides community-based behavioral health and supportive services to individuals struggling with and/or identifying as Lesbian, Gay, Bisexual, Transgender, Intersex or Questioning (LGBTIQ) and to the important people in their lives. OC ACCEPT specializes in addressing issues that are common in the LGBTIQ community, such as confusion, isolation, grief and loss, depression, anxiety, suicidal thoughts, self-medication with drugs, high risk behaviors, self-esteem challenges, victimization by bullying, trauma, homelessness and lack of familial support. Referrals to the program are completed via telephone or walk-in. Self-referrals are preferred but other providers or family members may refer as well.

Services

OC ACCEPT provides a wide range of services to the Orange County community. Highly trained, skilled clinicians provide program participants with individual and/or family counseling using evidence-based therapeutic interventions such as cognitive behavioral treatment, motivational interviewing and other techniques. Peer specialists facilitate discussion groups; promote health and wellness activities; provide social, educational and vocational support; and offer targeted case management to help individuals access needed resources or meet other goal-specific needs. In FY 2016-17, OC ACCEPT provided 96 referrals that resulted in 47 linkages with health care services, food and nutrition, housing resources and advocacy. In addition, OC ACCEPT raises awareness and reduces stigma by providing education about the LGBTIQ population to other mental health providers and the general community.

Strategies to Promote Recovery/Resilience

OC ACCEPT works from a strengths-based approach that incorporates recovery principles by using motivational interviewing, working with participants to develop client-centered and individualized care plans, and focusing on participants' strengths.

Strategies to Improve Timely Access to Services for Underserved Populations

Factors such as stigma or lack of family support may inhibit individuals, particularly youth, from seeking services on their own. Limited transportation can also serve as barrier. To help address these challenges, the clinic is centrally located in Orange County, near major freeways

and streets with access to public transportation. To increase access to care for those who are isolated, services can also be provided in the community.

In addition, for participants with additional needs and/or who are exiting the program, staff works to link them to community support. In FY 2016-17, OC ACCEPT provided 96 referrals that resulted in 47 linkages that were largely to health care services, food and nutrition, and housing resources and advocacy.

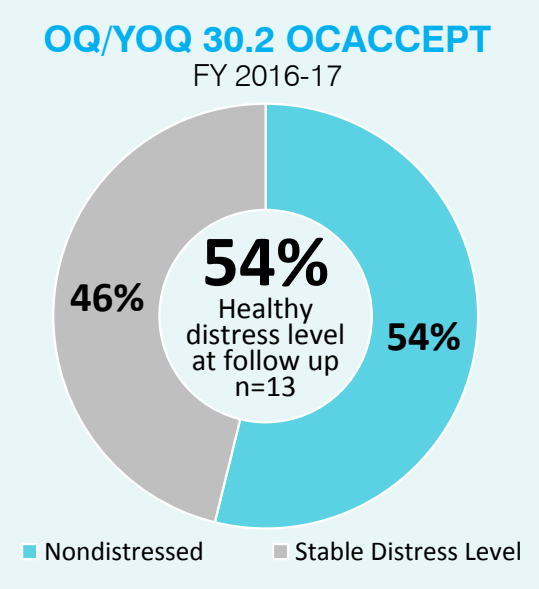
Strategies for Reducing Stigma and Discrimination

OC ACCEPT provides educational and program promotion presentations to the community, including other behavioral health providers, school staff/faculty, public health staff, social services staff and other community members. The focus of these presentations is to educate the community about the needs, challenges and issues faced by the LGBTIQ population, as well as to reduce stigma and discrimination through raising awareness of the various barriers and issues this population faces. In FY 2016-17, OC ACCEPT participated in 41 community events and/or promotions that reached 1,499 attendees, and provided eight community education presentations/trainings to 244 attendees.

Outcomes

During FY 2016-17, 121 participants were served by OC ACCEPT (20 youth under age 18 and 101 adults 18 and older). The program aims to measure reductions in or prevention of prolonged suffering through an age-appropriate form of the OQ® (YOQ® 30.2 for youth and OQ® 30.2 for adults). The goal was for participants to complete the form at intake, every three months of program participation and at program exit, and the difference between intake (baseline) and the most recent follow-up scores would be used to determine whether there was a significant reduction in prolonged suffering.

In FY 2016-17, the program experienced challenges with implementing the OQ®/YOQ®, particularly at follow-up, and only 3 out of 20 youth and 10 out of 121 adults completed more than one valid assessment. Of the 13 with paired assessments, slightly more than half reported feeling non-distressed at follow-up and the remaining reported stable distress levels. Thus, while OC ACCEPT services were associated with preventing symptoms of mental illness from becoming severe and disabling among the few who completed measures, the generalizability of the program's effectiveness should be regarded as tentative until additional data are available for analysis.



Challenges, Barriers and Solutions in Progress

OC ACCEPT transitioned from Innovation funding to PEI funding in March 2016. The program was not fully staffed during this transition, which slightly increased the wait time for assessment appointments. By September 2016, staffing vacancies were filled which eliminated delays in assessments. However, the program experienced continuing difficulties with the implementation of its new outcome measure, resulting in a low number of completed measures that could be used to assess changes in distress between intake and follow-up. To improve the completion rate, the program Service Chief has begun to track administration of the outcome measures through a spreadsheet.

In addition, many of the transgender participants who come to OC ACCEPT are seeking a medical provider to prescribe hormone replacement therapy to facilitate their transition, but have limited understanding of the process. As this is out of the scope of practice for OC ACCEPT staff, it presents a challenge for OC ACCEPT staff who work diligently to find appropriate referrals for this very specific medical issue. Having access to more medical providers who work with transgender participants would be very helpful to OC ACCEPT participants.

Community Impact

OC ACCEPT has provided early intervention outpatient services to more than 350 LGBTIQ individuals since its inception in July 2011, first as an Innovation project and then as a PEI program. The program has also provided valuable education and resources to the Orange County community. In FY 2016-17 alone the program provided education, support and technical assistance to more than 1,880 community members through its collaborations with Orange County agencies and community groups such as the Wellness Center, The Center OC, Public Health, and local high schools and colleges. Moreover, OC ACCEPT provides a safe, non-judgmental and therapeutic space for the LGBTIQ community and their loved ones, for which participants have expressed their gratitude:

Early Onset of Psychiatric Illness

As the name implies, early onset outpatient programs specialize in serving individuals who are experiencing the early onset of psychiatric illness with the goal if intervening early so that symptoms do not progress untreated and become severe and disabling. Orange County currently offers two PEI programs that specialize in early onset diagnosis and treatment, one for youth and the other for older adults.

First Onset of Psychiatric Illness (OC CREW; PEI)

Program Serves	Symptom Severity				Location of Services							Typical Population Characteristics							
12-25	At Risk	Early Onset	Mild-Moderate	Severe	Home	Field	School	Workplace	Outpaitent Clinic	Hospitals	Residential	Parents	Families	LGBTIQ	Homeless/ At Risk	Co-Occurring SUD	Co-Occuring Medical	Students	Staff/ Providers/ Workforce

The program provides services in English, Spanish, Vietnamese, Korean.

Target Population and Program Characteristics

The 1st Onset of Psychiatric Illness Program, also known as Orange County Center for Resiliency Education and Wellness (OC CREW), serves youth ages 12 through 25 years who are experiencing a first episode of psychotic illness with symptom onset within the last 24 months and their families. To be eligible for services, the youth's symptoms cannot be caused by the effects of substance use, a known medical condition, depression, bipolar disorder or trauma. The program receives self-referrals as well as referrals from County-operated and county-contracted specialty mental health plan clinics and community providers.

Services

OC CREW uses Early Detection and Intervention for the Prevention of Psychosis (EDIPP) and a Wellness Recovery Action Plan (WRAP) to guide service planning and delivery. The services offered include individual therapy, case management, psychiatric care, psychoeducation, vocational and educational support, social wellness activities, substance use services, and referral and linkage to community resources. The program also offers collateral services to involve family members. Services provided use the evidence-based and best practices of Cognitive Behavioral Therapy, Assertive Community Treatment, Art Therapy, medication services and Multi-Family Groups (MFG).

In the recent months, the program implemented dedicated intake slots on a weekly basis to increase timely access to services thereby reducing the duration of untreated mental health conditions. With the increase in family attendance at MFGs, the program now conducts MFG on a weekly basis (historically, MFG was offered two times per month).

The program also provides trainings to County and community partners to help providers recognize the early warning signs of adolescent mental illnesses, raise awareness about first episode of psychosis, support youth and their families, and refer individuals to program services.

Strategies to Promote Recovery/Resilience

Resilience-building strategies are a key part of recovery and all delivered services are customized to help each participant and their family reach their recovery goals and to limit the impact of, or prevent, if possible, a recurrence of symptoms. Psychosocial recovery is discussed in a multi-disciplinary group format, as well as in individual and collateral sessions to foster the development of resilience skills. Families are also taught to build and practice resilience skills across the multi-family group curriculum.

Strategies to Increase Timely Access to Services for Underserved Populations

To improve timely access to services, OC CREW staff provides outreach, presentations and trainings to staff and/or attendees at behavioral health clinics, schools, hospitals, community resource/health fairs and community medical providers. During FY 2016-17, the program provided 36 outreach activities to 167 individuals and facilitated seven continuing education trainings for 97 individuals in order to improve understanding of first episode psychosis and to increase timely referrals to the program.

Many referred participants and families who enroll in the program need extensive support and assistance to link with resources that provide necessities such as food, shelter, transportation and childcare. Without them, their ability to participate meaningfully in the program is compromised. To mitigate these challenges, the care team actively provides referrals to community services, and in FY 2016-17 the program provided 104 referrals that resulted in 28 linkages to supports such as behavioral health outpatient services; residential treatment; PEI programs; employment services and resources; information and referral resources; legal services and advocacy; and special needs and disability services. The program also posts community resource information on bulletin boards in public areas for easy access by participants and their families.

With regard to addressing transportation- and childcare-related issues specifically, the program provides field-based services. OC CREW and other PEI staff also provide childcare and transportation assistance. In addition, quarterly psychoeducation workshops are offered on Saturdays and Multi-Family Groups are offered in the evenings to improve access for working family members.

Finally, there have been an increasing number of referrals from non-English speaking families (Vietnamese, Korean). Bilingual/bicultural staff are employed to meet the program's needs for multilingual services and staff have access to a contracted language line for translation services in any needed language.

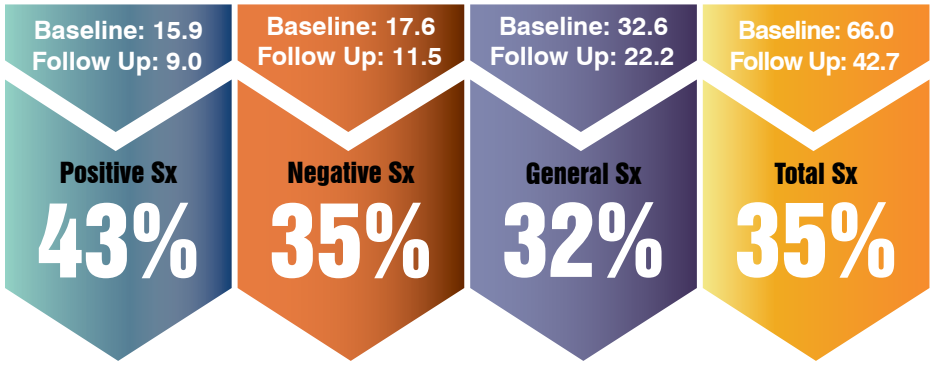
Strategies to Reduce Stigma and Discrimination

The program strives to serve all eligible Orange County residents. The program provides a warm and welcoming environment to all entering the clinic. The program seeks to reduce stigma and discrimination by educating families and participants in the course of services as well as by providing education to the community.

Outcomes

During FY 2016-17, 82 youth and 336 family members (in the Multi-Family Groups) were served by OC CREW. The program's purpose is to reduce prolonged suffering from untreated mental illness as assessed through psychiatrists' ratings of youth's symptoms (Sx) on the Positive and Negative Syndrome Scale (PANSS), which were provided at intake, every three months and at program exit. The difference between intake (baseline) and the most recent follow-up is used to analyze whether there was a significant reduction of prolonged suffering. The evaluation also reflects cultural competence as the assessment tool has demonstrated inter-rater reliability across several geo-cultural groups.

Fifty-one (51) youth served during FY 2016-17 had baseline and follow up ratings on the PANSS. Results revealed moderate (negative symptoms) to large (positive, general and total symptoms) reductions in symptom severity,[1] which is consistent with the program goals that OC CREW reduces prolonged suffering from untreated mental illness and helps prevent first episode psychosis from becoming severe, persistent and disabling.



> **“We wish this program were available 20 years ago because it runs in our family.”**
>
> **– Family member**

> **“We would never have been able to afford this [without MHSA support].”**
>
> **– Family with private insurance**

Challenges, Barriers and Solutions in Progress

The primary barriers faced by the program participants are financial, which impacts their ability to access reliable transportation, childcare and many other daily basic needs that, in turn, impact their ability to access program services. OC CREW addresses this by providing transportation and childcare when needed however, there has not been a dedicated position identified for this purpose for this program. The feasibility of bringing on a dedicated staff member for this purpose is being explored.

Community Impact

The program has provided services to more than 235 participants since its inception in Spring 2011 and has noted positive participant and family member outcomes that include an increase in attendance at the Multi-Family Groups and Multi-Family Workshops. In FY 2016-17, a total of 166 participants and 336 family members were served at the Multi-Family Group and Workshops. Additionally, psychoeducation was provided to 97 community members to increase awareness of the warning signs and symptoms of adolescent mental illness and onset of psychosis. By providing field-based services, the program is able to reach, serve and impact individuals who are reluctant to seek behavioral health treatment for fear of being stigmatized, have limited resources to access clinic-based care, or experience functional limitations due to their mental illness condition.

Reference Notes

[1] *Positive Symptoms: Baseline M=15.9, SD=7.1; Follow Up M=9.0, SD=7.7; t(50)=6.33, p<.001; Cohen's d=0.88*
Negative Symptoms: Baseline M=17.9, SD=8.2; Follow Up M=11.5, SD=8.3; t(50)=4.63, p<.001; Cohen's d=0.65
General Psychopathology: Baseline M=32.6, SD=11.5; Follow Up M=22.2, SD=13.1; t(50)=5.14, p<.001; Cohen's d=0.72
Total Symptoms: Baseline M=66.0, SD=24.4; Follow Up M=42.7, SD=42.7; t(50)=5.74, p<.001; Cohen's d=0.81

Early Intervention Services for Older Adults (PEI)

Program Serves	Symptom Severity		Location of Services	
60+	Early Onset	Mild-Moderate	Home	Field

The program provides services in English, Spanish, Vietnamese, Farsi,Korean, Arabic, Mandarin, Cambodian.

Target Population and Program Characteristics

The Early Intervention Services for Older Adults program provides behavioral health early intervention services to older adults ages 60 years and older who are experiencing the early onset of mental illness and/or those who are at greatest risk of developing behavioral health conditions due to isolation. The program is designed to reduce risk factors that have been linked to mental illness later among older adults. These risk factors include, substance use disorders, physical health decline, cognitive decline, elder abuse or neglect, loss of independence, premature institutionalization and suicide attempts. Participants are referred to program from senior centers, FRC's, the outreach and Engagement Collaborative, community centers and faith-based organizations.

Services

Program staff conducts a comprehensive in-home evaluation which includes psychosocial assessment, screening for depression, and measurement of social functioning, well-being and cognitive impairment. Using the results from the assessment and screening, the program then connects older adults to case managers to develop individualized care plans and to facilitate participants' involvement in support groups, educational training, physical activities, workshops and other activities. A geropsychiatrist is also available to provide a psychiatric assessment of older adults who have undiagnosed mental health conditions. The program recently expanded psychiatry functions from one-time screenings and diagnosis to include follow-up visits and the prescribing of medication as needed. The change was adopted to fill a gap experienced by some older adults who were uninsured or did not have a psychiatrist at the time of screening.

The program utilizes the evidence-based practice Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors) which employs a systematic, team-based approach to identifying and reducing the severity of depressive symptoms in older adults via case management, community linkages and behavioral activation services. To ensure fidelity, the program provides staff with comprehensive training on the Healthy IDEAS model, goals and deliverables of the program, evidence-based interventions, education on mental health and theories of aging, behavioral activation techniques, ethical and legal considerations, cultural competence and humility, field safety, assessment tools and outcome measures, care planning, and effective communication strategies when working with older adults. In addition, the program conducts staff development workshops and in-services. Program staff are also supervised and evaluated on an on-going basis.

Strategies to Promote Recovery/Resilience

Recovery and resilience are promoted by helping participants develop and/or expand their social networks and support systems, thus promoting greater wellbeing and participation in meaningful activities.

Strategies to Increase Timely Access to Services for Underserved Populations

The program builds relationships with community agencies and other individuals who may come into contact with the target population. By doing so, the program is able to identify unmet needs and barriers specific to the underserved communities it aims to serve and provide solutions to overcome those barriers. To increase access for older adults who are homebound or may no longer drive, the program offers in-home services access. Staff also works with participants to identify transportation solutions, which serves a dual goal of improving access to program services as well to the community-based healthcare, support services and social events with which program staff connect older adults. In FY 2016-17, the program provided 9,028 referrals and 3,957 linkages to these types of services and activities. The program also added more psychiatrists with additional linguistic and cultural capabilities that include Korean, Vietnamese, Farsi and Spanish.

Strategies to Reduce Stigma and Discrimination

The program strives to make the services available to all Orange County residents, regardless of their background. The program utilizes culturally congruent, strength-based approaches when developing the participant's individual care plan and delivering individual, peer, family

"I'm very happy with the ReConnect IESOA program and all the services I have received from my case manager and assigned volunteer. This program is very special to me; it has given me the tools to move forward in life. Because of the ReConnect Program, I no longer sleep all day and I now have meaning in my life. Because of this program I no longer think about dying like I once did. I now think about LIVING and I'm happy that I am alive!"

– **Program participant**

and group services. Examples of culturally congruent approaches include recruiting staff who are bicultural and represent a number of different ethnicities and religions. These individuals are then more familiar with how to address the issue of mental health with the program participant and can adjust their approach to serve diverse populations appropriately. Furthermore, the program employs strategies such as peer mentoring, participant and family education, public education and trainings, and community anti-stigma advocacy in order to decrease both public and self-stigma and discrimination.

Outcomes

In FY 2016-17, EISOA served 536 older adults and their improvement in mental health functioning was assessed through the Patient Health Questionnaire (PHQ-9), a commonly used measure of depressive symptom severity. Among the 116 participants who scored in the clinical range at baseline (i.e., score > 10), there was a substantial decrease in their depressive symptoms,[1] with average depression scores decreasing from the moderately severe range to the mild range between baseline and most recent follow up.[1]

Symptom Change

Change in Initial Clinical Depression

EIOSA - FY 2016-17

Challenges, Barriers and Solutions in Progress

Transportation remains a barrier to traditional services. The older adults served have limited income and some are unable to pay for public transportation. To overcome this barrier most program services are provided in the community (i.e., homes, apartment complexes, senior centers, etc.). To encourage self-reliance, the program provides bus vouchers and teach participants to utilize the bus system. For older adults who are hesitant to take the bus, staff travels with them and teaches them how to ride a bus, or seasoned bus riders are paired with new bus riders. Program staff also facilitates carpools between participants.

To overcome the challenge of finding counseling services and other resources in the participants' preferred language, the program hires staff and volunteers who speak the same language as the participants to serve as interpreters/translators in circumstances where there are no available resources in the participants' preferred language.

A more recent challenge has been navigating an increase of targeted incidents against ethnic communities and their members. This has caused older adults to have additional anxiety and many are often afraid to leave their homes and participate in typical community life. More specifically, participants are facing confrontation and hatred based on their beliefs or culture, and their anxiety regarding the future leaves them feeling uneasy. The program has provided a safe, supportive place for older adults' to come together and not feel isolated and services have been more important than ever to our communities during changing times.

Community Impact

The program has experienced positive participant outcomes that include improved mental health status, enhanced quality of life, increased social functioning, more effective management of behavioral health and chronic conditions, enhanced ability to live independently, increased community involvement and development of a supportive network. By providing services in Spanish, Vietnamese, Korean and Farsi, the program is able to reach, serve and impact non-English speaking older adults through its behavioral health self-stigma reduction activities, effective outreach and early intervention services.

Reference Notes

[1] *Baseline: M=14.3, SD=3.7; Follow Up M=8.6, SD=4.4; t(115)=12.68, p < .001; Cohen's d=1.19*

Family Services

Early Intervention Outpatient services specifically designed to improve the overall quality of family life fall within the Family Services category. Orange County currently operates one such program funded through PEI, described below, although many BHS services – especially those that serve children and TAY – work with family members whenever possible.

OC Parent Wellness Program (PEI)

Program Serves	Symptom Severity			Location of Services				Typical Population Characteristics	
									
16-40	At Risk	Early Onset	Mild-Moderate	Home	Field	School	Outpaitent Clinic	Parents	Families

The program provides services in English, Spanish, Vietnamese, Farsi, Korean.

Target Population and Program Characteristics

The Orange County Parent Wellness Program (OCPWP) serves youth and adults of all ages who are pregnant or who have had a child within the last 12 months. Youth, women and men who receive services from OCPWP are experiencing mild to moderate symptoms of anxiety and/or depression which are attributable to either the current pregnancy or recent birth of their child. Referrals come from a variety of sources including self-referrals, hospitals, schools or behavioral health outpatient facilities.

Services

OCPWP provides prevention and early intervention services that include eligibility and needs assessment, case management, individual therapy, family psychoeducation, psychoeducational support groups, wellness activities, psychiatric services, coordination and linkage to community resources, and community outreach and education.

OCPWP also utilizes the following evidenced-based curricula in its service delivery: Mothers and Babies Course: Relaxation Methods for Managing Stress; Mothers and Babies Course: A Reality Management Approach; and Triple P (Positive Parenting Program) tip sheets. Clinicians also utilize Cognitive Behavioral Therapy (CBT) and Eye Movement Desensitization and Reprocessing (EMDR) when indicated.

Strategies to Promote Recovery/Resilience

Services provided are consumer-centered and strength-based with a focus on recovery, resilience, and wellness. A critical component of this focus is the collaborative process between the participant and their assigned therapist when developing treatment goals and a treatment plan.

Strategies to Increase Timely Access to Services for Underserved Populations

Lack of transportation is a common barrier to accessing clinic-based services, including groups and psychiatric services, for participants. To address these obstacles, OCPWP provides services in the field, primarily at home or an agreed upon community location. The program also provides transportation assistance (i.e., bus passes, transportation, etc.) to assist participants in attending groups and wellness activities provided at the clinic.

Lack of childcare or in-home support can also be barriers for some families. For example, a parent of a toddler and an infant who has no in-home support may be unable to engage in home-based services due to the responsibilities of supervising and caring for young children. In these circumstances, OCPWP is able to provide supervision of minors for clinic-based services.

To raise awareness about the program and increase referrals for program services, clinicians conduct community outreach and offer psychoeducational presentations to other community providers. The program also provides outreach at continuation schools in order to increase the likelihood of pregnant youth receiving program services.

In addition to improving access to its program, OCPWP clinicians also work to refer participants to community resources

> **“I’m very happy with the positive changes I have made and all credit for that is due to the services I have received here.”**
>
> **– Program participant**

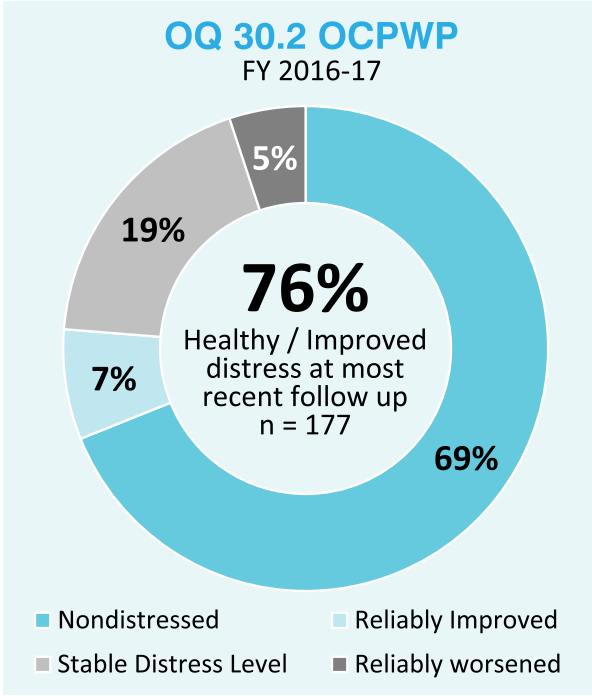
and supports as a way to assist them with their recovery journeys after discharging from the program. To increase the likelihood that the participant will attend the first appointment, the clinician contacts providers with the participant present, if needed or desired. In FY 2016-17, the program provided 447 referrals and 113 linkages to family support services, PEI programs, and basic needs (i.e., donated items, financial assistance and recreation).

Strategies to Reduce Stigma and Discrimination

Many pregnant or new parents may feel isolated by their mood or anxiety symptoms because pregnancy and giving birth are commonly thought of as a happy time of life. The program helps to educate pregnant and new parents and normalize their feelings as a way to encourage help-seeking. Program staff also meets with the participant’s significant other, if requested, to help educate them on mood and anxiety disorders.

Outcomes

During FY 2016-17, 617 participants were served by OCPWP (76 youth under age 18 and 541 adults 18 and older). The program aims to measure reductions in or prevention of prolonged suffering through an age-appropriate form of the OQ® (YOQ® 30.2 for youth and OQ® 30.2 for adults). Participants completed the form at intake, every three months of program participation and at program exit, and the difference between intake (baseline) and the most recent follow-up scores was used to determine whether there was a significant reduction in prolonged suffering. Of the 177 individuals with paired assessments, 76% reported a healthy or reliably improved level of distress at follow-up, thus demonstrating that OCPWP was associated with preventing symptoms of mental illness from becoming severe and disabling for the majority of individuals receiving program services. Due to the fact that 5% reported a significant worsening in their distress, program staff is working to streamline procedures to quickly identify these individuals earlier in the course of treatment and either modify the treatment plan accordingly or refer them to a higher level of care, as needed.



Challenges, Barriers and Solutions in Progress

The program is challenged to serve all of Orange County from a centralized location. Many of the services are provided in the field where clinicians do not have ready access to real-time resource information. To address this issue and to provide a means for more efficient documentation for field-based clinicians, the program will be piloting the use of laptops in the next fiscal year.

Community Impact

The program has provided services to more than 2,023 since its inception in December 2009. The program works closely with providers in the community who work with pregnant and post-partum women. Parents who are depressed or anxious are at increased risk for having difficulty bonding with their babies and caring for the day-to-day needs of their children effectively. The provision of services to this population may reduce the potential for child neglect or maltreatment and result in a healthier, happier home life for children in the family.

School-Based Outpatient Services

PEI currently funds two Early Intervention Outpatient programs that operate on school campuses. One program provides treatment for children who exhibit difficulties with attention, learning, and/or behavior and the other for middle school students who are experiencing symptoms of anxiety and depression.

School-Based Behavioral Health Intervention and Supports – Early Intervention Services (PEI)

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics		
					
	At Risk	School	Families	Co-Occurring Medical	Students

The program provides services in English, Spanish, Vietnamese, Farsi, Korean, Mandarin, French.

Target Population and Program Characteristics

School-Based Behavioral Health Intervention and Supports – Early Intervention Services (SBBHIS-EI) serves families with children in grades 1-8 who are experiencing challenges in attention, behavior and learning, and/or Attention Deficit/Hyperactivity Disorder (ADHD) that impair their regular educational placement and social competencies. Children are referred to the program by local schools, physicians, and other mental health professionals in Orange County. Children are screened by clinicians to identify any behavioral health issues that need to be addressed and determine program eligibility, which includes financial need.

Services

SBBHIS-EI funds 16 of the 90 students served in the program each fiscal year and provides them with a regular education school experience in a classroom that has been specifically modified to meet their psychosocial and academic needs. It uses the Community Parent Education Program (COPE) Parenting Curriculum to guide services, which include academic support, social skills development, parent training and academic transitional support. The duration of the program is 12 to 18 months, after which the child is transitioned to the next academic setting. This specially adapted school-based intervention program is theoretically based on cognitive-behavioral strategies and supported with applied behavior modification techniques such as self-regulation; management of anger, anxiety, frustration, and compliance. In addition, the program utilizes the School-Based Socials Skills intervention model which is specifically designed to meet the needs of children exhibiting behavioral challenges that are preventing them from accessing education and curriculum in a less restrictive setting. This training addresses social pragmatics, relational skills and social reciprocity.

Strategies to Promote Recovery/Resilience

The program is designed to be a whole-family intervention program that uses intense school-based cognitive-behavioral training provided in a regular education setting extensively modified to meet the needs of children with behavior challenges and their families. Parents are required to attend an 8-week parent training course prior to or concurrent with enrollment, and then attend weekly multiple-family group sessions where they learn how to use the same behavioral interventions at home that their children experience in the classroom. This approach supports the generalization of the child's gains from school to the home. Families also set specific goals that give each child a way to chart their individual progress and experience success.

Strategies to Increase Timely Access to Services for Underserved Populations

The program encourages timely access to its services by offering multi-family groups and classes at flexible times multiple days of the week. In addition, the program offers one-on-one consultations to accommodate the family's needs.

Although classes are taught in English, to help mitigate delays in accessing services due to language barriers, the program is able to use the staff who are bilingual in Spanish, Mandarin, Vietnamese, Korean, Farsi and French. The program also has translation services for other languages.

Another challenge is access to basic needs such as food, clothing, shelter, transportation and healthcare among socioeconomically-disadvantaged families, which impacts the well-being of the student as well as the family unit. Staff address these needs by teaching parent's self-advocacy techniques, how to ask for assistance, and how to identify resources to obtain needed services.

> **"The program "is like magic. He has improved so much [and] is doing so much better than he was before."**
>
> **– Mother of a son participating in the program**

Strategies to Reduce Stigma and Discrimination

SBBHIS-EI strives to provide services that are sensitive and responsive to participants' backgrounds. In addition, unlike traditional schools where students are pulled out of regular classroom instruction for their individual service plans, the program fully integrates behavioral interventions with academic instruction into the classroom. This results in reducing the risk for stigma while building self-esteem. Parents are also required to learn to use the same behavioral interventions at home. This helps creates a supportive environment in which the students can learn academics as well as new, more adaptive behaviors. Finally, to address the stigma and uncertainty the parents and/or children feel about the future transition to a different academic setting, the program teaches parents self-advocacy techniques and works with each family on how to collaborate with their child's home school district effectively, how to select an appropriate school placement, and how to work with program officials to ensure a smooth transition to the new academic environment.

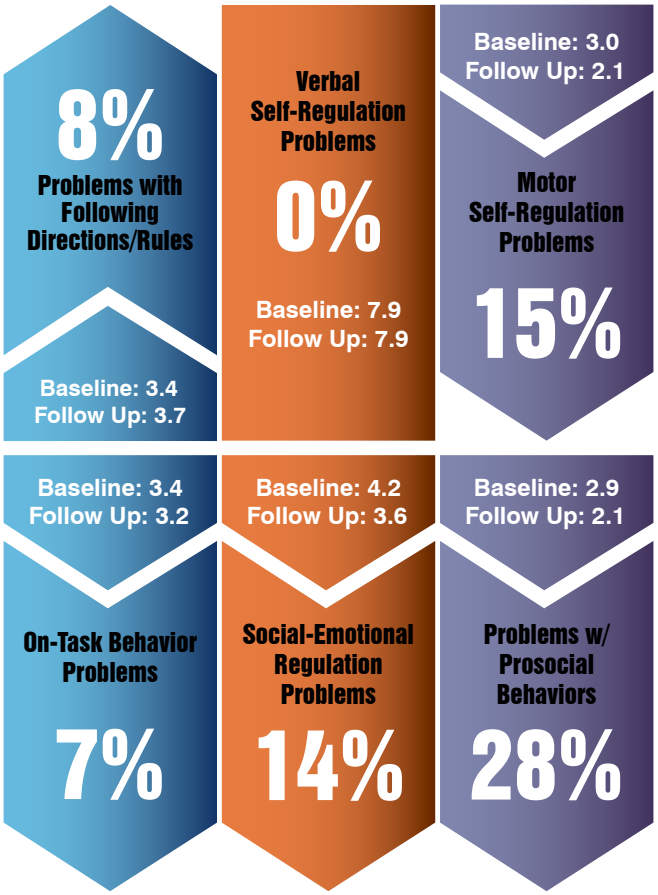
Outcomes

During FY 2016-17, SBBHIS-EI served 24 students. Clinical staff worked with children to set goals aimed at correcting problematic behaviors. Target behaviors were monitored and assessed for severity on a daily basis to measure improvement over time. When a participant achieved the goal for a specific target behavior, another goal was introduced, and participants worked on three to four goals at a time. Behaviors were categorized into the following themes: Following Directions/Rules, Verbal Self-Regulation, Motor Self-Regulation, On-Task, Social-Emotional Regulation, and Prosocial Behaviors.

During FY 2016-17, the number of instances in each of the different target behaviors were identified as a goal ranged from 3 (Verbal Self-regulation) to 17 (Problems with Prosocial Behaviors). Children were rated on the severity of the target behavior problem on a 7-point scale. Based on changes between the baseline and most recent follow-up ratings, children demonstrated some success in improving behavior among participants, particularly with regard to motor self-regulation and prosocial behavior. However, students tended to experience persisting issues with following directions and verbal self-regulation. Thus, these areas, in particular continued to be a target of intervention. Due to the program design which limits the number of children served each year, HCA is in the process of exploring alternate ways of evaluating and presenting data to assess the program's impact among those served.

Change in Problem Behaviors

SBBHIS-EI - FY 2016-17



Challenges, Barriers and Solutions in Progress

The program has recently experienced challenges regarding the overall program funding beyond the MHSA contribution listed. Due to the intensive nature of these services, costs associated with providing the program have increased, which may impact future program operations. The provider is currently exploring options to address these challenges.

Community Impact

The program has provided services to more than 89 students and 146 parents/caregivers since its inception in March 2010. SBBHIS-EI also collaborates with community organizations, local school districts, and providers like the Proposition 10-funded program "Help Me Grow," which is a consortium of community resources that connect families to services that enhance the development, behaviors and learning of children.

School-Based Mental Health Services – Early Intervention Track (PEI)

Program Serves	Symptom Severity		Location of Services	Typical Population Characteristics	
11-15	At Risk	Mild-Moderate	School	Parents	Students

The program provides services in English, Spanish, Korean.

Target Population and Program Characteristics

The School-Based Mental Health Services (SBMHS) - Early Intervention Track provides school-based, early intervention services targeting individual students in grades six through eight who are experiencing mild to moderate depression, anxiety and substance use problems. Referrals to this program track are made by school staff and screened by program clinicians to determine early onset of mental illness.

Services

The early intervention component of the program provides assessment, individual counseling, case management, referral and linkages to community resources utilizing evidenced-based curricula such as Cognitive Behavioral Intervention for Trauma in Schools (C-BITS), Coping Cat, and Seeking Safety, as well as promising practices like Eye Movement Desensitization and Reprocessing (EMDR).

Strategies to Promote Recovery/Resilience

The target population often faces issues such as experiencing multiple traumas or community violence, or coming from first generation/monolingual communities. To promote recovery and resilience within the participant's social network, the program creates buy-in from school partners and participant families by helping them understand that participation in the curricula creates resilience and protects against long-term challenges later in life.

Strategies to Increase Timely Access to Services for Underserved Populations

A number of strategies have been adopted to increase timely access to services. The program is implemented in the school setting, thereby providing access to students and families that might not seek help on their own. In addition, clinicians meet with participants weekly to address immediate needs and make regular attempts to check in with the participant's parent or guardian. The program also has the ability to focus on particular schools, districts and/or specific populations as needed.

Because many participants have limited resources, referrals for supports may be provided to the participant or the participant's family as needs are identified. In addition, clinicians often provide instruction or guidance on how to contact other community providers so that families can be self-sufficient when they are no longer enrolled in services. In FY 2016-17, the program provided 397 referrals and 49 linkages to basic needs items; behavioral health outpatient services; PEI programs; crisis services; and health education, disease prevention, wellness and physical fitness services.

Strategies to Reduce Stigma and Discrimination

Participants often face parent or peer discouragement to engage in program services (stigma), lack of willingness (defiance), or fear of participation. Program staff work closely with the school administrators and counselors through weekly meetings to assist in creating a school climate that promotes the benefits of seeking help and accessing counseling, psychoeducation to promote acceptance, and school bonding to keep students from feeling marginalized. In addition, program staff receive regular in-service training to increase their understanding of the needs, values and challenges faced by the program population so that they are better able to serve them.

> “[I liked] the fact that I learned new coping skills, I could relax and let out all my anger, confusion, sadness, emptiness out.”

> “[I liked] that I can talk about my problems to someone who can give me good advice and to know that I have issues but I’m not the only one.”

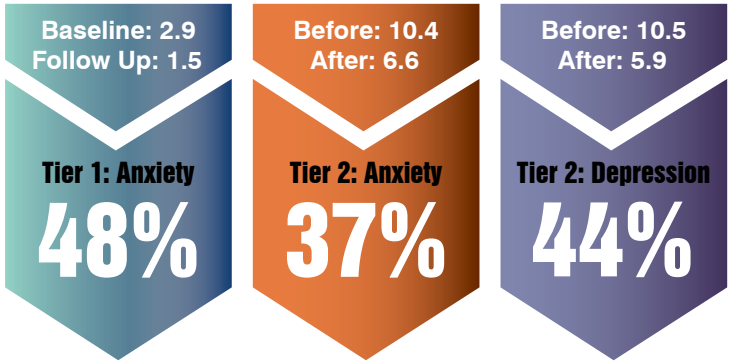
– Student participants

Outcomes

In FY 2016-17, the early intervention track served 623 youth total. Program performance was evaluated through measures administered at intake, every three months of program participation and at discharge. The program assessed changes in anxiety for Tier 1 participants via the SCARED. Tier 2 transitioned from evaluating performance with the PROMIS Pediatric Anxiety and Depression scales to the YOQ 30.2 in FY 2016-17; the results presented here are for the PROMIS measures due to data extraction issues with the YOQ. Among the youth who completed follow up measures (n=442 for Tier 1 and 100 for Tier 2), moderate decreases both in depression and anxiety were observed,[1] thus demonstrating the program’s success at preventing these symptoms from becoming severe and disabling.

Changes in Symptoms of Anxiety and Depression

SBMHSA-EI - FY 2016-17



Challenges, Barriers and Solutions

SBMHS has not been fully staffed since inception. The program is actively recruiting clinicians and identifying strategies to increase retention.

Community Impact

The combined Prevention/Early Intervention program has provided services to more than 10,205 participants since its inception in August 2011. The program collaborates with school districts throughout Orange County and has helped to fill an important and growing need for mental health services in school.

Reference Notes

[1] *Tier 1 Anxiety: SCARED: Baseline M=2.9, SD=2.4; Follow Up M=1.5, SD=1.9; t(441)=12.78, p<.001; Cohen’s d=0.61*

Tier 2 Anxiety: Baseline M=10.4, SD=7.1; Follow Up M=6.6, SD=5.9; t(100)=4.94, p<.001; Cohen’s d=0.50

Tier 2 Depression: Baseline M=10.5, SD=8.5; Follow Up M=5.9, SD=6.2; t(100)=5.44, p<.001; Cohen’s d=0.56

CLINIC-BASED OUTPATIENT MENTAL HEALTH

Clinic-Based Outpatient Mental Health programs provide comprehensive outpatient services to individuals living with serious emotional disturbance or mental illness. Services are typically delivered in a clinic setting but can be provided in the field as needed. HCA offers the overwhelming majority of its clinic-based outpatient services through non-MHSA County-operated and County-contracted clinics located across Orange County. However, Orange County stakeholders identified a need to dedicate MHSA funding for a clinic-based outpatient program dedicated to serving older adults, which is described below.

Clinic-Based Outpatient Mental Health	Estimated Number to be Served in FY 2018-19	Annual Budgeted Funds in FY 2018-19	Estimated Annual Cost Per Person in FY 2018-19
Older Adult Services (CSS)	530	$1,668,135	$3,147

Older Adult Services (CSS)

Program Serves	Symptom Severity	Location of Services							Typical Population Characteristics			
												
	Severe	Home	Field	Workplace	Outpatient Clinic	Courts	Hospitals	Residential	Homeless/At Risk of	Co-Occuring SUD	Medical	Criminal Justice

The program provides services in English, Spanish , Vietnamese, Farsi, Korean, Arabic, Amharic, and Mandarin

Target Population and Program Characteristics

Older Adult Services (OAS) is for individuals age 60 years and older who are living with serious and persistent mental illness (SPMI) and who may also have a co-occurring substance use disorder, medical diagnosis and/or multiple functional impairments. Many of the older adults served in this program are homebound due to physical, mental, financial or other impairments. They are diverse and come from African American, Latino, Vietnamese, Korean and Iranian communities, as well as non-English-speaking monolingual individuals and those who are deaf or hard of hearing. Older Adult Services accepts referrals from all sources.

Services

OAS provides case management, referral and linkages to various community resources, vocational and educational support, substance abuse services, nursing services, crisis intervention, medication monitoring, therapy services (individual, group, and family), and psycho-education for participants, family members and caregivers. Evidence-based practices such as Cognitive Behavioral Therapy, Motivational Interviewing, and EMDR are routinely used, and Seeking Safety will be implemented in FY 2017-18.

Strategies to Promote Recovery/Resilience

All services are highly individualized and provided with the aim of increasing access to community and medical services, maintaining independence and decreasing isolation. The goals are accomplished by providing services that focus on reducing symptoms and increasing skills to cope with life stressors.

– Program participant

" I don't know where I would be if it wouldn't be for my therapist, probably at the bottom of the pit. I have strong anxiety along with a lot of crying. If not for her counseling, I wouldn't be moving on with my daily life. I would be in the streets with no support if it wasn't for the program helping me with medication, therapy, housing and everything I need to be able to live in a beautiful place."

Strategies to Improve Timely Access to Services for Underserved Populations

Transportation is a huge barrier for the older adult population. Many lack the financial resources to own a private vehicle or use taxi services. Some rely on family and caregivers for transportation and are dependent on their availability. Others lack the physical and cognitive capacity to manage public transportation. By making all of its services available to participants out in the community, if needed, OAS Recovery has greatly improved access to services for older adults living with SPMI in Orange County. In addition, program staff provide services in many languages (see grid) through staff who are bicultural/bilingual. Language line translation is also available to provide services in any language not spoken by program staff in order to reduce delays in accessing the program due to language barriers.

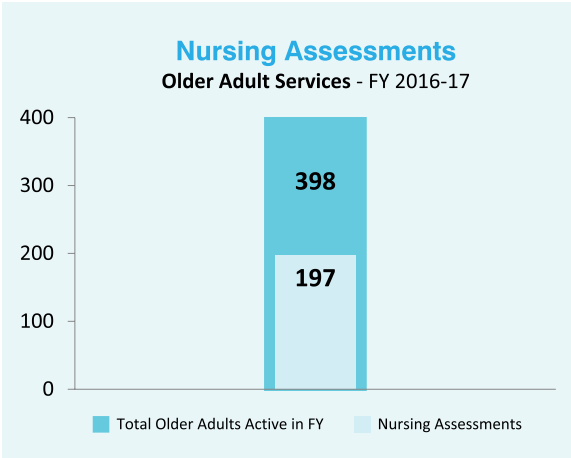
Staff also dedicates a considerable amount of time providing transportation to participants to assist them in accessing community-based providers for other needs not met directly by OAS (i.e., medical appointments, government offices, senior centers).

Strategies to Reduce Stigma and Discrimination

Older adults may hesitate to access OAS due to stigma related to being an older adult. For example, they may fear losing their independence or being removed from their homes, forced to take medications, and/or forced to live in a nursing home due to their age. They may also feel shame due to their belief that, as adults, they should not need anyone's help to live their lives. OAS staff are trained and encouraged to take whatever time is needed to develop trust with participants in order to facilitate engagement into services. Older adults enjoy sharing their life stories and staff taking time to listen is an important engagement tool. OAS also collaborates with Social Services' Senior Santa program to provide necessities to older adults such as household items, clothing and hygiene items, which can serve as a strong contributor to engagement. In addition, the OAS SHOPP program is dedicated to conducting outreach and engagement with individuals referred to OAS, where it can take several friendly home visits before an older adult engages in OAS services.

Outcomes

In FY 2016-17, the program served 398 older adults, 263 of whom were new admissions. One of the program's goals is to help participants maintain their independence and remain safely in the community by increasing access to primary care, which is quantified as the number of nursing assessments completed. Of the total older adults served, half (n=197) had a nursing assessment completed during FY 2016-17.



Challenges, Barriers and Solutions in Progress

OAS has encountered on-going issues collecting outcome measures that evaluate the program's performance (i.e., selection of an appropriate and feasible measure of symptom reduction, adequate completion rates of measures, etc.). Program staff have begun meeting to select metrics appropriate for the target population being served, and future Plan Updates will report on these outcomes once implemented.

In addition, OAS is located in a small space that lacks room to offer evidence-based Seeking Safety groups and socialization groups. The program is working to address this need by exploring the feasibility of moving to a larger space.

Community Impact

Older Adult Services collaborates with the Public Health services Senior Health Outreach & Prevention Program (SHOPP), Council on Aging (Health Insurance Counseling and Advocacy Program, Friendly Visitor), Social Services (Adult Protective Services), Community Senior Centers, Adult Day Health Care, Alzheimer's Association, Ageless Alliance, local police departments, Orange County Probation Department, hospitals, and residential programs, etc. These relationships are important to address the many complicated issues that Orange County older adults face. In particular, program staff works closely with Adult Protective Services to help older adults who are abused by caretakers, are neglecting themselves, isolating or living in poor conditions. They reach out to homebound seniors who are in need of mental health services and are able to provide all mental health services in participants' homes when necessary. Staff also collaborates with the SHOPP program to conduct joint home visits with HCA Public Health nurses to ensure that participants' mental and physical health needs are addressed. Finally, the OAS pharmacist conducts many educational events both for participants and professionals on issues relevant to older adults such as medication management, health- and mental health-related matters, and community services.

INTEGRATED OUTPATIENT CARE

Integrated Outpatient Care programs provide outpatient behavioral health services to individuals who have co-occurring chronic physical health conditions and serious emotional disturbance or mental illness. Multi-disciplinary teams of medical and mental health professionals coordinate the care for individuals receiving services at these specialized outpatient clinics as treatment can be complicated by the interplay of physical and mental health symptoms, medications and medical treatment side effects. Orange County currently funds two such programs through CSS, one program that targets youth who are being seen in specialty medical clinics and the other that targets adults with chronic primary care conditions.

Integrated Outpatient Care	Estimated Number to be Served in FY 2018-19	Annual Budgeted Funds in FY 2018-19	Estimated Annual Cost Per Person in FY 2018-19
Children and Youth Behavioral Health Co-Occurring Medical and Mental Health Clinic (CSS)	325	$2,500,000	$7,692
Integrated Community Services (CSS)	200	$1,848,000	$9,240

Children and Youth Behavioral Health Co-Occurring Medical and Mental Health Clinic (CSS)

Program Serves	Symptom Severity		Location of Services					Typical Population Characteristics					
0 - 25	At-Risk	Severe	School	Outpatient Clinic	Hospitals	Residential	Medical Specialty Clinics	Foster Youth	Parents	Families	LGBTIQ	Homeless/ At risk	Medical

The program provides services in English, Spanish , Vietnamese, Farsi, Japanese.

Target Population and Program Characteristics

The target population for this program is youth through age 20 who are being seen primarily by Oncology, Endocrinology and Neurology services at a local hospital. Youth with severe eating disorders who are at risk of life-threatening physical deterioration are also served in this program. Parents and siblings play an integral part of the treatment process, given the disruption to the family structure when the survival of one family member becomes the family's main focus. Youth are referred to this program by physicians within the local children's hospital. Many of these children and youth are MediCal beneficiaries and MHSA funds serve as a match to the drawdown of federal funds.

> **“My daughter no longer defines herself as a diabetic, but rather as a teenager who also has diabetes. It has made a big difference in her ability to adjust to her illness and has improved her ability to stick to her regimen.”**
>
> **– Mother of a teenager**

Services

The CYBH Co-Occurring Clinic provides individual and family outpatient therapy, medication management if needed, case management, and some limited psychological testing. A variety of evidence-based and best practices are provided to meet the needs of the youth, with some of the more common clinical interventions including Cognitive Behavioral Therapy (CBT), Motivational Interviewing, Trauma-Focused CBT, Exposure and Response Prevention (ERP), Family-Based Therapy, and Parent-Child Interaction Therapy (PCIT). Program staff also has specialty training on the effects of medical and psychological co-existing diagnoses and, thus, are aware of evidence-supported treatments that promote healthy coping and self-management of their diagnoses.

Clinicians also regularly collaborate with other agencies and community groups to provide the support and services needed to treat a child's mental health condition and improve their psychosocial functioning. Some examples include collaboration with wraparound services for youth who have been removed from their family's care due to medical non-adherence (neglect); collaboration and communication with FSPs serving the program's children who are at risk of homelessness or are presenting with early signs of psychosis; and connecting children to additional services such as TBS to provide intensive short term interventions (e.g., in home meal coaching for those with eating disorders). Program clinicians also have the unique opportunity to communicate directly and collaborate closely with the local children's hospital medical teams so that care can be coordinated and consistent across disciplines.

Strategies to Promote Recovery/Resilience

Recovery and resilience are promoted by ensuring that a strong support network is in place to improve the lives of youth with medical and mental health conditions as well as their families. This is achieved by working closely with the child's family using a strengths-based approach to help develop skills to further improve their functioning outside the clinic setting, and by communicating and collaborating with the various providers within their system of care network (e.g. medical teams, school staff, wraparound team, Full Service Partnership, Therapeutic Behavioral Services, community resources, etc.). Because the program is located on the medical campus, program staff have the opportunity to work directly with, and educate the medical team about, the effects of the child's mental health condition and how they can best support the child and their family in their overall recovery rather than focusing exclusively on medical outcomes.

Strategies to Improve Timely Access to Services for Underserved Populations

Lack of transportation is a common issue that families face when seeking services. The clinic and hospital are located on bus lines, but it can be time consuming to use public transportation. The program continues to look for opportunities to provide services within the child's community, such as in schools, the mobile pediatric asthma clinic or the child's residential placement. The program also strives to remove barriers to accessing mental health services by communicating and collaborating with medical teams to ensure continuity of care. Clinicians are mobile and can also provide mental health services during medical appointments and/or hospitalizations to decrease the likelihood that the child and family will drop out of mental health treatment.

In addition to English, the program can provide therapy and psychiatry services in Spanish, Vietnamese, Farsi and Japanese through staff who are bicultural/bilingual. All Co-Occurring Clinic clinicians have access to interpretive phone services to remove language barriers and facilitate communication and service delivery when a clinician who speaks the child's or family's language is not available.

> **"After my daughter's first appointment with her therapist, I saw her smile for the first time in a year. This clinic gave my daughter her life back."**
>
> **– Parent of a school-aged child**

Strategies to Reduce Stigma and Discrimination

Spanish-speaking clinicians are encouraged to participate in a monthly Spanish-speaking clinicians' meeting aimed at discussing and training in topics and issues related to the provision of mental health services in Spanish and cultural and linguistic factors specific to the Hispanic population. Postdoctoral fellows regularly attend seminars that provide education and training on research and evidence-based practices that take into account cultural and diversity factors that impact mental health and psychosocial functioning. The program also regularly educates medical providers on issues related to mental health in an effort to increase understanding and reduce stigma.

Outcomes

During the program's first year of implementation in FY 2016-17, it was determined that the outcome measure initially selected (PROMIS Pediatric) was not adequately detecting mental health symptoms in this population. As a result, the measure was discontinued and replaced with the YOQ. Outcomes for this program will be reported in future Plan Updates.

Challenges, Barriers and Solutions in Progress

Since the program's inception two years ago, the CYBH Co-Occurring Clinic has had a fast and steady rise in the number of children it sees. As a result, the team of clinicians has grown exponentially to meet the demand for services. Also, the number of settings in which the clinicians provide mental health services has expanded significantly. At inception, the majority of mental health services were being provided in the outpatient Co-Occurring Clinic, with a small fraction of children being seen at one medical specialty clinic. Currently, Co-Occurring Clinic clinicians provide mental health services at several medical specialty clinics (i.e., eating disorder, transgendered, oncology, cystic fibrosis, diabetes), as well as inpatient medical units, schools and, on occasion, community settings such as a temporary shelter.

This fast growing client census and clinical team resulted in the need for a uniform and standardized documentation manual to streamline the on-boarding of new clinicians, as well as part-time Quality Improvement staff to perform chart reviews and assure documentation compliance.

In addition, program staff had noted that there is a subset of youth served whose needs exceed the ability of the outpatient clinic to address. A new Full Service Partnership, Children's HEALTH (Harnessing Every Ability for Lifetime Total Health), was developed to meet this need and is anticipated to open during FY 2017-18 (see the Full Service Partnership section).

Community Impact

This new program was developed through the ongoing MHSA community planning process which identified children and youth with co-occurring physical illness and mental health conditions as an un-served and underserved group. The program has already provided services to more than 390 youth and their families since its inception in July 2015, thus confirming the need for these specialized services.

Integrated Community Services (CSS)

Program Serves	Symptom Severity				Location of Services						Typical Population Characteristics								
18+	At-Risk	Early Onset	Mild-Moderate	Severe	Home	Field	School	Outpatient Clinic	Hospitals	Residential	Parents	Families	LGBTIQ	Veterans	Homeless/ At Risk	Co-Occuring SUD	Medical	Students	Criminal Justice

The program provides services in English, Spanish , Vietnamese, Korean.

Target Population and Program Characteristics

Integrated Community Services (ICS) serves individuals ages 18 and older who have chronic primary care and mental health needs. The program, which was originally an Innovation project continued with CSS funding due to its demonstrated success, has two components: ICS County Home and ICS Community Home. On the County side, primary care physicians (PCPs), registered nurses (RNs), and medical care coordinators are placed in behavioral health clinics. On the community side, County therapists and psychiatrists work with mental health caseworkers within contracted and subcontracted primary care sites. This collaboration with community medical clinics and County mental health programs is a healthcare model that bridges the gaps in service for the underserved low-income community. The program serves adults who are MediCal enrolled or eligible, or have third party coverage. Individuals are referred to this program by County behavioral health providers, community organizations and contracted community clinics.

Services

In addition to the medical care provided by the PCPs and RNs, ICS behavioral health staff conducts a number of psychoeducational support groups on topics such as nutrition, diet, chronic diseases, depression, anxiety, exercise and other physical and mental health care subjects. ICS clinicians also provide therapy, counseling, assessment and crisis intervention, and utilize evidence-based and best practices such as Motivational Interviewing, Seeking Safety and Cognitive Behavioral Therapy.

Mental Health Workers also provide case management and help facilitate program participants' linkage to community organizations that provide a range of services (i.e., prescription eyeglasses, free clinic, Serve the People, housing assistance, 211 of Orange County, etc.). They help participants navigate the system of care and share their lived experience to help participants gain insight and make positive choices about their healthcare and behavioral health needs.

Strategies to Promote Recovery/Resilience

ICS' integrated, multi-disciplinary teams promote recovery and resilience by providing coordinated care and enabling adults to better navigate different systems of care within their communities. ICS support groups have also helped raise awareness and provide participants with information they need to make better decisions about their lifestyles that impact their overall health. These groups also serve as a safe place for participants to ask questions and get accurate information about physical and mental health care. By decreasing mental health symptoms and addressing and improving physical health problems, program participants are expected to increase their life expectancy and live a better quality of life. Peer support and role modeling also play a key role in promoting resilience in these participants.

> "I am better now. [The ICS therapist] has helped me fix a lot of my issues in life."
>
> **– Program participant**

Strategies to Improve Timely Access to Services for Underserved Populations

Transportation poses an issue to program access as many participants do not have the means to get to the clinics. Although ICS staff have the ability to go out into the field and outreach, follow through from participants can also pose a challenge. The program attempts to address these barriers by teaching participants how to use public transportation, providing bus passes and placing reminder calls about the date and time of upcoming appointments. In addition, ICS staff are bicultural/bilingual in a number of languages (see grid) and have access to a language line in order to reduce difficulties engaging in services due to language barriers.

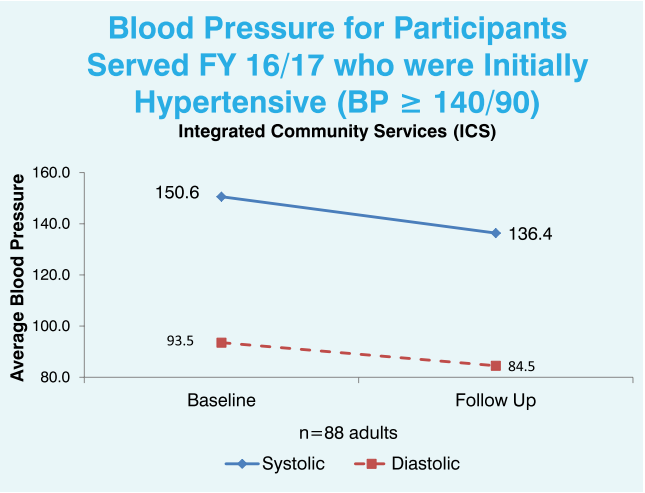
Strategies to Reduce Stigma and Discrimination

ICS provides services to a large number of people in the Asian communities where stigma continues to be associated with mental illness and, as a result, many participants tend to keep issues within the family and not seek needed services. Staff work to reduce stigma through strategies such as educating participants and their family members about mental illness as a brain disease and beginning engagement into services by focusing on somatic symptoms.

Outcomes

A total of 467 adults participated in ICS during FY 2016-17. ICS monitored both mental health symptoms and physical health markers to assess program impact.

Adults who scored in the clinical range on measures of depression (PHQ-9) and anxiety (GAD-7) at baseline (i.e., score > 10), reported a moderate decrease in symptoms at the most recent follow up.[1] More specifically, average depression scores decreased from the moderately severe range to the moderate range and average anxiety scores decreased from the severe range to the moderate range.[1]



In addition to mental health assessments, ICS maintains continual tracking of adults' health outcomes (biometrics) such as blood pressure. Adults with two or more measurements who fit criteria for high blood pressure or hypertension at baseline (i.e., ≥ 140/90) demonstrated moderate decreases of about 10% both in their systolic and diastolic blood pressure while enrolled in ICS.[2]

Changes/Challenges/Barriers

A significant ongoing challenge for the program is not having a County Psychiatrist to provide psychiatric services. This position has remained vacant due to the hard-to-fill nature of psychiatrist positions within the County of Orange. To meet needs, program staff have referred identified participants needing psychiatric services to other community resources, County outpatient clinics and/or private psychiatrists. Because of this, the number of participants served has decreased as those needing on going psychiatric care are referred to other providers.

Staff retention is another challenge for the program. There has been a number of staff turnover in the last year, which has caused delays in workflows and an overflow of work duties to other staff. The contracted provider, however, has been very efficient in hiring new staff in a timely manner and has been creative about distributing workloads during training periods for new staff.

Community Impact

The program has provided services to more than 2,000 adults since its inception as an Innovation project in September 2011. ICS has helped improve their physical and mental well-being and fill an important gap in the BHS system of care. The program, through its partnership with a contracted provider that targets the Asian population, has also brought needed mental health services in a culturally accessible way to this underserved community.

Reference Notes

[1] *PHQ-9: Prior M=18.0, SD=5.0; Since M=13.0, SD=6.9; t (104) = 7.23, p<.001, Cohen's d=.59*

GAD-7: Prior M=16.0, SD=3.5; Since M=11.9, SD=6.3; t (82) = 6.61, p<.001, Cohen's d=.60

[2] *Systolic: Prior M=150.6, SD=18.4; Since M=136.4, SD=23.9; t (87) = 4.87, p<.001, Cohen's d=.47*

Diastolic: Prior M=93.5, SD=8.9; Since M=84.5, SD=14.5; t (87) = 5.29, p<.001, Cohen's d=.54

INTENSIVE OUTPATIENT

Intensive outpatient programs provide comprehensive, wraparound services for individuals of all ages who are living with serious emotional disturbance (SED) or serious mental illness (SMI). Individuals enrolled in these programs have the highest level of need among those served in the outpatient programs based on their history of psychiatric hospitalization, incarceration, criminal justice or foster care involvement, and/or other risk factors. Orange County currently funds three types of CSS-funded programs that serve individuals of all ages in this service area:

- Full Service Partnerships (FSPs)
- Programs for Assertive Community Treatment (PACTs)
- Youth Core Services - Field-Based Track

Intensive Outpatient Programs	Estimated Number to be Served in FY 2018-19	Annual Budgeted Funds in FY 2018-19	Estimated Annual Cost Per Person in FY 2018-19
Children's FSP (CSS)	460	$6,654,575	$14,466
TAY FSP (CSS)	1,175	$10,684,468	$9093
Adults FSP (CSS)	1,290	$21,592,093	$16, 738
Older Adults FSP (CSS)	183	$2,683,249	$14,663
CYBH PACT (CSS)	75	$1,100,000	$14,667
TAY PACT (CSS)	1,200	$9,528,018	$7,940
Adult PACT (CSS)			
Older Adult PACT (CSS)	120	$521,632	$4,347
Youth Core Services (CSS)*	530	$2,300,000	$4,340

* *The budget for Youth Core Services is the total figure that includes Youth Core Services' residential track described in the Residential Treatment section.*

Full Service Partnerships (CSS)

The Full Service Partnership/Wraparound programs (FSPs) provide intensive, community-based services that promote wellness and resilience in those living with serious mental illness. FSPs use a coordinated team approach to provide "whatever it takes," including 24/7 crisis intervention and flexible funding to support people on their recovery journeys. All FSPs are provided by community-based organizations contracted by HCA.

Target Population and Program Characteristics

The target population for the FSPs include individuals of all ages who are living with a SED or SMI, are unserved or underserved and may be homeless or at risk of homelessness, involved in the criminal justice system and/or are frequent users of inpatient psychiatric treatment. There are currently 12 distinct FSPs operating in Orange County, with a 13th under development. Four primarily focus on serving individuals who are homeless or at risk of homelessness and tailor their services based on age/developmental needs (i.e., General FSPs) and the remaining serve those with specialized needs (i.e., Criminal Justice involvement, frequent hospitalization, cultural or linguistic isolation, etc.). More information about each of these programs is provided below.

General FSPs: All General FSPs outreach and engage individuals who are living with a SED or SMI and are unserved, underserved or not successfully engaged in traditional mental health services. Those served in the General FSPs tend to be at particular risk of homelessness and may also experience frequent hospitalizations and/or be involved with the criminal justice system. However, these programs can be accessed by the general community in contrast to the specialized programs that may require a referral from a collaborating agency. Additional eligibility criteria/characteristics for each program are described below.

Project RENEW (Reaching Everyone Needing Effective Wrap)

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics					
									
0-18	Severe	Anywhere	Field	Parents	Families	Homeless/ At Risk	Co-Occuring SUD	Medical	Criminal Justice

The program provides services in English, Spanish, Farsi, Arabic, Hindi, Tagalog.

Project RENEW provides services to children from birth to age 18. In addition to the above criteria, Project RENEW also works with those who are experiencing a first psychotic episode, have parents with serious mental illness (SMI), and/or are under the supervision of social services. Although the majority of children served are between the ages of 12-15 years, Project RENEW also serves very young children between the ages or 0-5 years or school age children who are having notable difficulty functioning due to emotional problems. In addition to the treatment services provided to the children and youth, parents frequently receive job assistance, especially when the needs of their child or youth are so significant that it impacts their ability to maintain employment. Sixteen to eighteen year olds who are referred for FSP services will generally be enrolled in RENEW. If family involvement is limited, however, STAY is usually a better match.

TAO (Telecare and Orange)

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics					
									
18-59	Severe	Anywhere	Field	Parents	Families	Homeless/ At risk	Co-Occuring SUD	Medical	Criminal Justice

The program provides services in English, Spanish, Vietnamese, Farsi,Korean, Arabic, Tagalog, Italian, Hindi, Hebrew, Italian, Urdu, Panjabi, Malayalam.

TAO serves adults ages 18 and older who are living with serious and persistent mental illness. TAO has two locations and a third currently being sited that provides services to adults living anywhere in the county. Referrals can come from different sources including the general community, jails, Probation, etc.

STAY (Support Transitional Age Youth) Process

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics									
16-25	Severe	Anywhere	Field	Foster Youth	Parents	Families	LGBTIQ	Veterans	Homeless/ At risk	Co-Occuring SUD	Medical	Students	Criminal Justice

The program provides services in English, Spanish, Vietnamese, Korean, Arabic.

STAY Process serves TAY ages 16-25 who are living with SED or SMI that is frequently complicated by substance use and/or a history of trauma. TAY are provided support and opportunities to increase skills and abilities that are essential to becoming self-sufficient adults. The majority of TAY referrals have experienced two or more mental health hospitalizations in the last 12 months, are currently homeless or at risk of homelessness, may be/have been involved with Social Services (former foster youth), and require a level of services not afforded in other outpatient settings.
OASIS (Older Adult Support and Intervention System)

OASIS (Older Adult Support and Intervention System)

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics			
60 +	Severe	Anywhere	Field	Homeless/ At Risk	Co-Occuring SUD	Medical	Criminal Justice

The program provides services in English, Spanish, Vietnamese, Tagalog, Hindi.

OASIS provides services to adults ages 60 and older who, in addition to the FSP target population criteria, may be at risk of loss of independence or institutionalization, frequent users of emergency rooms, and/or experiencing a reduction in personal and/or community functioning. Older adults served by OASIS tend to experience a number of health and mobility issues in addition to serious and persistent mental illness. They may also have co-occurring substance use issues.

Specialized FSPs: The specialized FSPs in Orange County serve individuals who meet the FSP target population criteria and would also benefit from the unique focus of a specialized program and/or are only open to those who are referred from a collaborating agency such as Social Services, Probation or the Courts. Consistent with the MHSA, all FSPs – even those affiliated with the Courts and Probation – are voluntary.

Project FOCUS (For Our Children's Ultimate Success)

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics							
											
	Severe	Anywhere	Field	Foster Youth	Parents	Families	LGBTIQ	Homeless/ At Risk	Co-Occuring SUD	Students	Criminal Justice

The program provides services in English, Spanish, Vietnamese, Farsi, Korean, Arabic, Japanese, Mandarin.

Project FOCUS specializes in serving culturally- and/or linguistically-isolated Asian/Pacific Islander (API) children and youth ages 0-25 who are living with SED or Serious Mental Illness (SMI). A bicultural, bilingual team works with children, TAY and their families to provide culturally responsive services while simultaneously working to counter stigma and discrimination associated with mental illness in the API community. This FSP is open to Orange County children and TAY and their families. Beginning in FY 2017-18, Project FOCUS continued providing services to TAY who aged out of the program when they turned 26 if they preferred to remain with Project FOCUS rather than transitioning to an adult FSP that did not specialize in working with an API population.

Children's HEALTH (Harnessing Every Ability for Lifetime Total Health)

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics					
									
	Severe	Anywhere	Field	Foster Youth	Parents	Families	LGBTIQ	Homeless/At Risk	Medical

The program provides services in English, Spanish.

Children's HEALTH is designed to meet the needs of youth ages 0 to 25 years who are diagnosed with SED and a significant and/or chronic physical illness that exceeds the ability of the current integrated care clinic to address (see "OC Children with Co-Occurring Mental Health and Chronic Acute Severe Physical Illness, Special Needs or Eating Disorders" in the Outpatient section). This is a small group of youth and families with needs that are so different from those enrolled in other FSPs that a specialized program would be best to address their range of unique concerns. This FSP is scheduled to open in FY 2017-18 and expected to be close to fully operational in FY 2018-19. It will accept referrals from the MHSA outpatient clinic program, OC Children with Co-Occurring Mental Health and Chronic Acute Severe Physical Illness, Special Needs or Eating Disorders and any program that identifies a youth who fits the profile outlined above.

Collaborative Courts FSP (CCFSP)

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics				
0 - 25	Severe	Anywhere	Field	Parents	Families	Homeless/ At Risk	Co-Occuring SUD	Criminal Justice

The program provides services in English, Spanish, Vietnamese, Farsi, Korean, and Arabic.

CCFSP has two separate contracts, with this one dedicated to working with youth who are living with SED/SMI and referred from the Juvenile Recovery Court or Juvenile Court's Truancy Response Program. Because many of these youth face multiple problems, stressors, a history of trauma and substance use disorders, the program supports them in developing alternative coping skills and providing them with educational opportunities and job training. CCFSP serves youth through age 25 and their families whenever possible.

Youthful Offender Wraparound (YOW)

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics	
0 - 25	Severe	Anywhere	Field	Co-Occuring SUD	Criminal Justice

The program provides services in English, Spanish, Vietnamese, Farsi, Korean, and Arabic.

YOW serves children and youth through age 25 who are experiencing SED/SMI and are involved with the juvenile justice system. The program focuses on maintaining the gains youth make while receiving services in custody and on reintegrating youth into the community after release from Juvenile Hall. Learning how to obtain and maintain employment despite significant mental health issues and a criminal history is a particular focus of this FSP. Eligible youth are primarily referred to YOW by the Orange County Probation Department.

Collaborative Courts FSP (CCFSP) for Foster Youth

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics				
0 - 25	Severe	Anywhere	Field	Parents	Foster Youth	Homeless/ At Risk	Co-Occuring SUD	Criminal Justice

The program provides services in English, and Spanish.

CCFSP for Foster Youth is the second CCFSP contract and works specifically with the Juvenile Girls and Boys Courts to support youth with SED/SMI who are/were in the foster care system and have experienced multiple placement failures. Because these youth face a considerable number of stressors, challenges, and trauma, the program serves youth through age 25 so that they may receive support during their transition into early adulthood.

STEPS (Striving Towards Enhanced Partnerships)

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics					
18-59	Severe	Anywhere	Field	Parents	Families	Homeless/ At Risk	Co-Occuring SUD	Medical	Criminal Justice

The program provides services in English, Spanish, Vietnamese, and Arabic.

STEPS is a program that serves adults ages 18 through 59 who are either on Lanterman-Petris-Shore (LPS) conservatorship and returning to the community from long-term care placements, or who have misdemeanor or felony offenses and are referred by the Public Defender's Office to Assisted Intervention Court – one of the Mental Health Collaborative Courts.

Opportunity Knocks

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics					
									
	Severe	Anywhere	Field	Parents	Families	Homeless/ At risk of	Co-Occuring SUD	Medical	Criminal Justice

The program provides services in English, Spanish, Vietnamese, Japanese, and Hindi.

Opportunity Knocks serves adults ages 18 and older with severe and persistent mental illness (SPMI) who have recent involvement in the criminal justice system or who experience recidivism with the criminal justice system. Individuals are referred by different sources including general community, jails, Probation, etc.

WIT (Whatever It Takes)

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics					
									
	Severe	Anywhere	Field	Parents	Families	Homeless/ At risk of	Co-Occuring SUD	Medical	Criminal Justice

The program provides services in English, Spanish, Vietnamese, Farsi and Korean.

WIT serves adults ages 18 and older who are living with SPMI and are referred through the Orange County Collaborative Courts. The program works in collaboration with the Collaborative Court team which includes the Judge, Probation and the Public Defender's Office to provide treatment and services aimed at re-integrating members into the community.

AOT (Assisted Outpatient Treatment)

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics					
									
	Severe	Anywhere	Field	Parents	Families	Homeless/ At risk of	Co-Occuring SUD	Medical	Criminal Justice

The program provides services in English, Spanish, and Vietnamese.

AOT FSP serves adults 18 and older who have been court-ordered by the Court to participate in the AOT FSP and those who have voluntarily agreed to participate in the AOT FSP. For a more detailed description of AOT eligibility criteria, please see the AOT Assessment and Linkage program description under the Navigation/Access and Linkage to Treatment section.

“I am finally able to go out with my PSC like a normal human being without feeling judged and it’s amazing.”

– Child FSP Participant

FSP Services

The FSPs follow the Assertive Community Treatment (ACT) model of providing comprehensive, community-based interventions, linguistically and culturally competent services, and around-the-clock crisis intervention and support by coordinated, multidisciplinary teams. The teams can include Marriage and Family Therapists, Clinical Social Workers, Personal Services Coordinators, Peer Mentors, Parent Partners, Housing Coordinators, Employment Coordinators, Licensed Clinical Supervisors, Psychiatrists and/or Nurses who are committed to the recovery model and the success of their participants. Working together, the teams provide intensive services that include counseling, case management and peer support, which are described in more detail below.

With regard to clinical interventions, the FSPs provide individual, family and group counseling and therapy to help individuals reduce and manage their symptoms, improve functional impairments and assist with family dynamics. A wide array of Evidence Based Practices are available and, depending on the age and needs of the individual, can include Motivational Interviewing, Cognitive Behavioral Therapy (CBT), Trauma-Focused CBT, Eye Movement Desensitization and Reprocessing (EMDR), Dialectical Behavior Therapy, Integrated Treatment for Co-Occurring Disorders, Seeking Safety, Illness Management and Recovery, Moral Reconation Therapy, Program to Encourage Active Rewarding Lives for Seniors (PEARLS), Parent-Child Interaction Therapy, behavioral modification, and others. Individuals enrolled in an FSP also receive psychiatric care, medication management, psychoeducation, co-occurring substance use disorder services, mindfulness training, crisis intervention and/or 24/7 support as needed.

Due to the notable increase in criminal justice involved adults presenting with co-occurring substance use disorders, Opportunity Knocks now has three licensed substance abuse counselors who provide individual coaching, substance use education and groups such as Relapse Prevention and Co-Occurring Education. The WIT program also recently developed “Co-Occurring Program Extension (COPE)” which provides intensive outpatient services and support to participants with co-occurring substance use disorders. Since its implementation earlier this year, COPE has demonstrated success in helping participants manage their substance use and apply learned skills in a real-world environment.

Personal Services Coordinators (PSCs) provide intensive case management to help individuals access crucial medical care, educational support, social and recreational opportunities, mental health rehabilitation, benefits acquisition, transportation resources, basic needs and other resources available in the community. PSCs and/or other FSP staff also help individuals develop skills to manage problematic behaviors or impairments and work with significant others and caregivers, when available, to support them in learning and practicing the new skills.

Some FSPs also have Employment and/or Housing Coordinators who assist and support their participants in these essential elements of recovery. Employment Coordinators or – when dedicated coordinators are not available – PSCs and other staff lead numerous workshops and classes to teach and hone prevocational and vocational skills such as resume writing, interviewing skills, computer skills, etc. FSP Housing Coordinators (and/or PSCs) also assist individuals with finding and maintaining safe, suitable housing as ameliorating homelessness is one of the target outcomes for the FSPs.

Peer Recovery Specialists, Peer Recovery Coaches and Parent Partners are key members of the FSP teams and play an integral role in promoting wellness and resilience. By sharing their lived experience and learned skills, peer staff support recovery, empowerment and community integration. In addition, Parent/Family Partners work closely with parents, legal guardians, caregivers, significant others and other family members to provide suggestions on how they can best support the participant. Parent Partners also assist with the psychoeducation process to close the generational gap and shift how parents and caregivers view mental health, as well as provide respite care.

Family involvement in treatment and services can be critical to supporting and maintaining an individual’s recovery and has been central to the Children’s and TAY FSPs approach to service and care planning. In addition, the Adult FSP programs have been working on increasing

family inclusion at all levels of treatment and at social events, and TAO (South county location) has begun offering a monthly family support group to provide families with information, education, guidance and support for their own needs, as well as to enable them to assist their family member's recovery.

Strategies to Promote Recovery/Resilience

The FSPs utilize tools from the Recovery Centered Clinical System which focuses on exploring identity, defining hopes and dreams, making choices, reducing harm and making connections. Participants are encouraged to broaden their resources and support systems by increasing their social contacts, improving family relationships when appropriate, and having meaningful roles in the community. Recovery and resilience are also promoted through individualized, client- and family-centered treatment that is strengths-based, aligned with participants' wants and needs and matched to their level of functioning. FSP staff work alongside participants to improve self-direction, and promote health, wellness and stability in all aspects of their lives. Integral to these efforts are Peer Specialists, Peer Coaches and Parent Partners who encourage empowerment, facilitate community integration, and build, enhance and maintain resilience.

Strategies to Improve Timely Access to Services for Underserved Populations

Individuals and families referred to the FSPs often face issues that may keep them from seeking services. These can include language/cultural barriers, recent immigration to the United States, homelessness and/or high risk of homelessness, housing instability, lack of financial or other resources, lack of childcare, transportation issues, stigma, criminal justice involvement and mistrust of "the system."

To counter these barriers, the FSPs seek to facilitate access to their programs in a number of ways. They provide presentations to educate the community about their services and tailor their messages to reach those who are not traditionally referred for mental health treatment. Within Project FOCUS, for example, which serves the API community, staff promote their services through "safe topics" such as how educational or employment attainment can be improved by receiving services that improve mental well-being. Once a referral is received, all FSP staff quickly do outreach and engagement wherever the referred individual is at, including their home, shelters, public areas such as parks/libraries, a hospital, correctional facility or anywhere else the person is known to be. During these contacts, staff focus on building therapeutic relationships in order to facilitate trust and encourage linkage to ongoing services.

In addition, all FSPs strive to provide services in a linguistically and culturally competent manner to diverse, underserved populations in Orange County (see tables for specific bilingual capabilities within each FSP). When bilingual staff are not available, the FSPs have access to all languages through a contracted interpreter service provider that is available when needed. The programs also offers regular staff trainings to increase cultural sensitivity and understanding when providing services to participants and their families who come from cultural backgrounds that are different from their own.

When individuals and/or families seem hesitant to participate in services, staff explore the obstacles preventing them from accessing resources or progressing through their care plan. The individual, family and FSP team attempt to work through the challenges together by adapting strategies, comparing positives and negatives of behaviors and consequences, reframing negative situations to create new momentum, engaging the participant in problem solving, eliciting change statements, reinforcing responsibility, giving praise and encouragement, and cultivating hope in one's ability to succeed. The FSPs also make an effort to educate participants about, and link them to, appropriate resources outside of their programs. This can include financial assistance and benefits, housing, the behavioral health continuum of care, and other community resources that promote self-sufficiency and encourage integration into the community.

Strategies to Reduce Stigma and Discrimination

The FSPs recognize that providing quality services begins with taking into consideration the culture, values, preferences and needs of the individuals and families they serve and, as such, strive to hire bilingual and bicultural staff. All staff participate in on-going trainings related to ethnicity, religious observations, gender identity and sexual orientation. These trainings enable staff to better connect with unserved, underserved, and culturally and linguistically isolated individuals through conversations that fit with the individual's and their family's values and worldview. For example, some of the perspectives that Project FOCUS considers when providing services to API participants include the medical and spiritual aspects of mental health, somatic symptoms, and the chance to improve education or employment outcomes through mental health services. Project FOCUS also hires staff who are sensitive to the fact that the children and youth they serve may have values and perspectives that are different from those of their parents/guardians and staff actively work to bridge any cultural divide.

– TAY FSP Participant

"I was scared, lived with friends from couch to couch, had no job, no home, and no family to turn to. I found Project FOCUS, a program that supported me emotionally, encouraged me to go to college, and helped me find employment. I found myself through this program and now I can say I'm happy. Thank you Project FOCUS for changing my life and giving me hope for a better future."

Outcomes

A total of 339 children, 759 TAY, 1,156 adults and 223 older adults were served in the FSPs during FY 2016-17. The programs' success was evaluated through changes on a number of outcomes related to mental health recovery, living situation, legal involvement, employment and/or school performance before enrolling in the FSP compared to during FY 2016-17. All outcomes except school performance were analyzed statistically using paired samples t-tests and reported according to their resulting effect size.

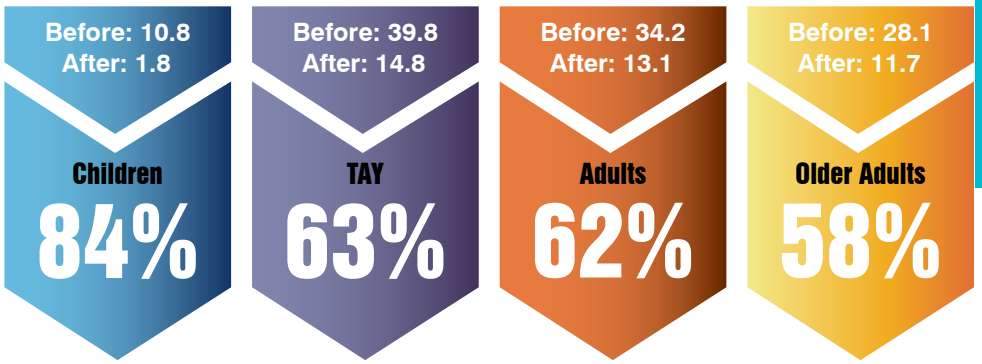
Mental Health Recovery: Mental health recovery was evaluated through changes in two measures: (1) number of days the individual had been psychiatrically hospitalized, and (2) the number of times the individual experienced a mental health emergency intervention (defined as a hospitalization episode, crisis residential placement, emergency room/CSU visit, crisis assessment/WIC 5585 evaluation, or police response due to a mental health crisis).

Children demonstrated a moderate decrease in the average number of days spent psychiatrically hospitalized after FSP enrollment compared to the 12 months prior to FSP enrollment. While the statistical analyses[1] for the other three age groups indicate that their reductions were small in effect, individuals 16 years and older reduced the amount of time spent in the hospital by more than half, suggesting that they nevertheless experienced less disruption in their daily lives.

Compared to the 12 months prior to FSP enrollment, participants also reported moderate to large decreases in the average number of mental health-related emergency interventions[2] experienced during FY 2016-17, further suggesting that they experienced less disruption from mental health-related symptoms and/or behavior. This effect was particularly pronounced for older adults, with the average number of events dropping to nearly zero.

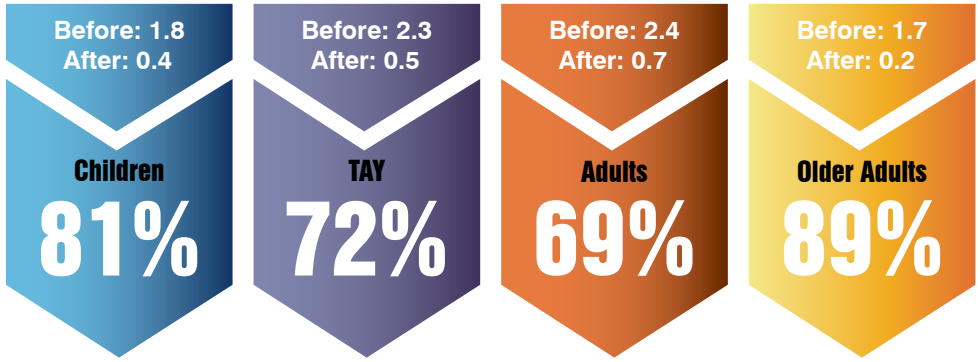
Psychiatric Hospitalization Days

FSPs - FY 2016-17



Mental Health Emergency Intervention

FSPs - FY 2016-17

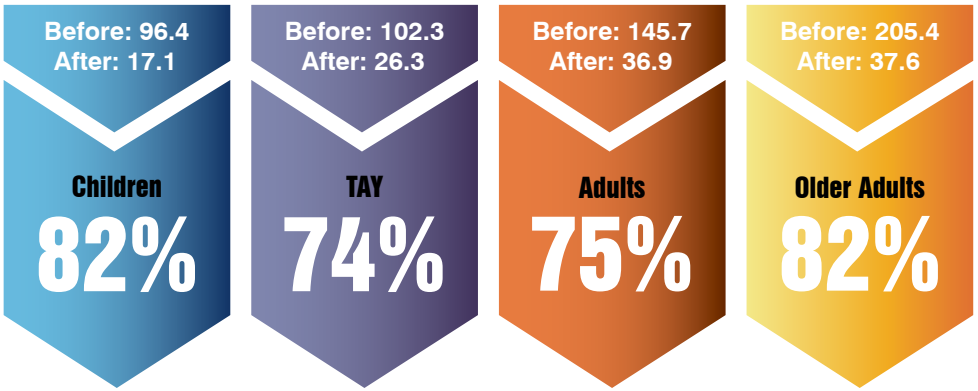


Homelessness and Living Situation: Another goal of the FSPs is to prevent and reduce unsheltered homelessness, emergency shelter stays and, for children, out of home placements. For TAY, Adults and Older Adults, the FSPs also strive to increase the number of days they are able to live in the community independently (i.e., live safely in an unsupervised setting and perform their own activities of daily living).

The FSP programs continued to improve the housing circumstances of their participants as evidenced by the large reduction in the average number of days spent homeless during FY 2016-17 for all except TAY, who demonstrated a moderate decrease in homelessness.[3] Unsheltered homelessness was defined as a residence not intended for human habitation, such as a car, abandoned building, the street, etc. Compared to the 12 months prior to enrollment, participants of all ages also generally experienced moderate decreases in the days spent in emergency shelter, which included "couch surfing." Children tended to spend the fewest days in emergency shelter and older adults tended to spend the most.[4]

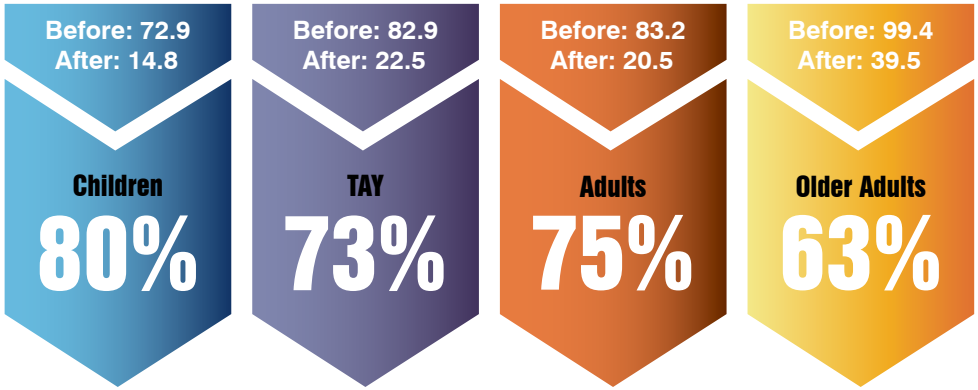
Unsheltered Homeless Days

FSPs - FY 2016-17



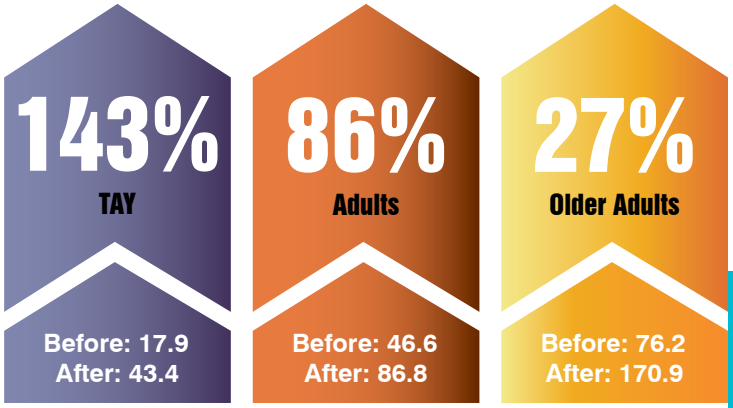
Emergency Shelter Days

FSPs - FY 2016-17



Independent Living Days

FSPs - FY 2016-17



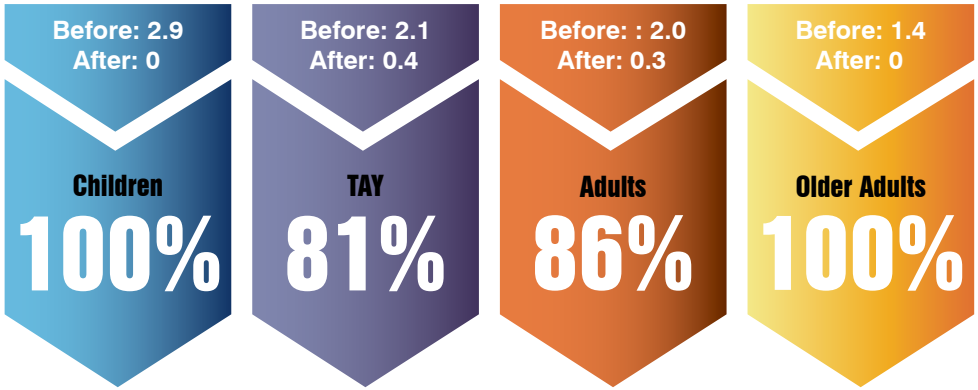
In addition, TAY and adults demonstrated small increases and older adults demonstrated moderate increases in the average number of days spent living independently during FY 2016-17.[5] Independent living is defined as living in an apartment or single room occupancy as opposed to any type of supervised residential placement (see pictograph below).

Finally, for children the goal of the FSPs is to reduce out-of-home placements, which are defined as placement in a group home or residential treatment facility. Consistent with prior years, during FY 2016-17 children experienced large decreases in the average number of days spent in an out-of-home placement compared to the year prior to FSP enrollment.[6]

Out-of-Home Placements

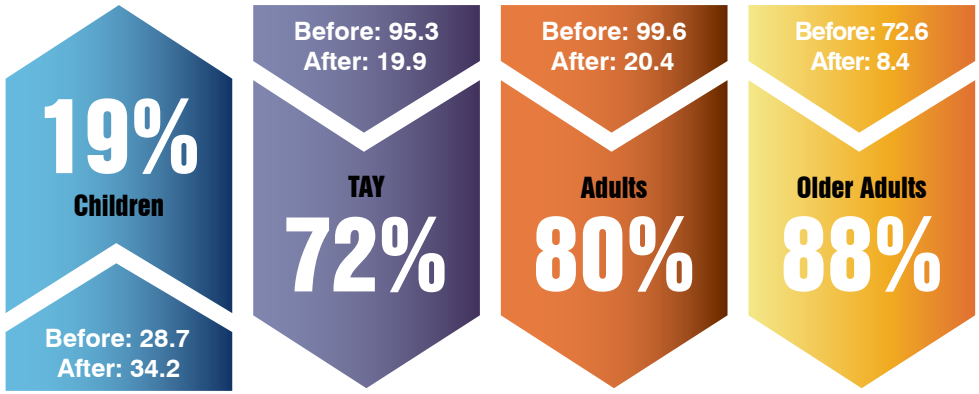
Arrests

FSPs - FY 2016-17



Incarceration Days

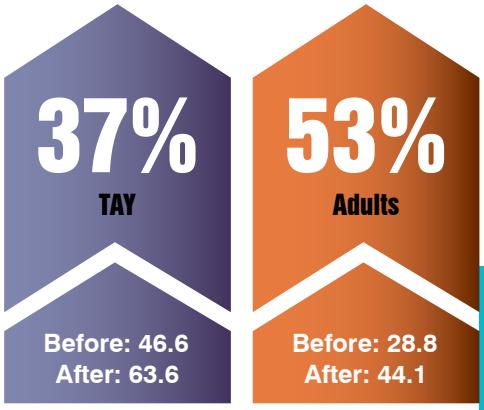
FSPs - FY 2016-17



Legal Involvement: Outcomes related to decreasing individuals' involvement with the legal system were tracked using two measures: days incarcerated in jail or prison and number of arrests. The FSP programs continued to make notable improvements in these areas as evidenced by the large to very large decreases in average number of arrests during FY 2016-17 compared to the year prior to FSP enrollment.[7] Individuals ages 16 and older also reported large decreases in the number of days incarcerated during FY 2016-17. In contrast, children showed a nominal increase in the average number of days spent incarcerated during FY 2016-17, although this was likely due to one individual who was incarcerated for 141 days after enrolling in the FSP.[8]

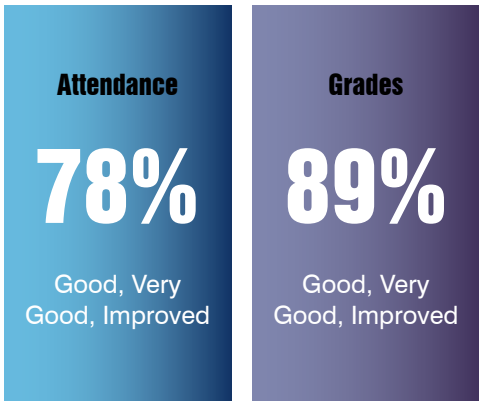
Employment Days

FSPs - FY 2016-17



Employment: The TAY and Adult FSPs also examined days employed, which is vital to recovery but can be difficult to attain for those struggling with the combination of serious mental illness, substance use disorders, homelessness and/or a legal history. Per guidelines established by the County Behavioral Health Directors Association of California (CBHDA), employment was defined as competitive, supported or transitional employment, as well as paid in-house work, work experience, non-paid work experience and other gainful employment activity. While TAY who were 16 years old at the start of FY 2016-17 and therefore eligible to work the duration of the reporting period and adults made statistically significant improvements in days employed during FY 2016-17 compared to the year prior to FSP enrollment, the average gain of approximately 16 days reflected nominal functional change.[9] Thus, increasing employment activity in a meaningful way continues to be a challenging area for the FSPs.

School Performance: The Children's FSPs examined the proportion of children who maintained good/very good school attendance or grades, and/or who improved their attendance or grades while enrolled in the FSP. During FY 2016-17, 78% of school-aged children reported good to improved attendance and 89% reported good to improved grades. Together, these findings demonstrate that the FSPs were successful in maintaining or improving school performance among the children served.



Challenges, Barriers and Solutions in Progress

As housing costs continue to rise, finding safe, affordable and permanent housing in the neigh-

> **"This program has saved my life...I feel hope and worthy of life today."**
>
> **– Adult FSP Participant**

borhoods in which the individuals/families have support networks and/or the children are enrolled in school has continued to be challenging. To address immediate concerns with supply, FSP Housing Specialists work to build relationships in the community and develop housing resources for their participants. Once participants have been placed in housing, FSPs utilize a housing assistance strategy in which the individual/family becomes increasingly responsible with meeting costs so that, when clinical goals are met, the individual/family is able to meet housing costs independently. This strategy creates stability so that clinical advances can be maintained upon discharge from the program. To address the shortage of permanent supportive housing availability, HCA along with the support of the Orange County Board of Supervisors, is continuing to identify and fund new housing development opportunities. In addition, staff has been engaging in the community planning process for No Place Like Home, as well as an Innovation project dedicated to testing a novel approach aimed at increasing housing and improving participants' housing stability.

Employment has also continued to be an on-going and significant challenge despite the recovering job market. The FSPs can encounter difficulties identifying employers who are flexible enough to employ individuals (or their parents/guardians) who may need time away from work to support their (child's) recovery. Yet employment serves as an important aspect of recovery by helping increase people's connection with their community, providing a sense of purpose, and increasing self-sufficiency. Drawing upon these principles, as well as CBHDA's expanded definition of employment, the FSPs are working to increase individuals' participation in meaningful, employment-related activities such as volunteer work and enrollment in educational/training courses as a way to enhance vocational skills, gain experience, and increase their confidence in being able to succeed in the workforce. Nevertheless, more than any other target outcome, the FSPs continue to struggle with supporting individuals in sustaining employment in a consequential way.

The Older Adult FSP has noted that its participants don't always attend groups consistently. The FSP has made an increased effort in recruiting potential participants by engaging them in conversation about the groups and benefits of attending, placing reminder calls, increasing socialization among group participants, and assisting with and/or linking to transportation so that they may attend groups. Feedback from older adults served is also elicited regularly so that improvements to the groups' content and/or structure can be made on an on-going basis.

To address an increase of co-occurring substance use issues among TAY and adult participants, the FSPs are offering more co-occurring groups, working to partner with community substance use treatment programs to expand resources, including residential programs that specialize in co-occurring treatment, and creating their own co-occurring supports and interventions to fill identified service gaps. FSP staff also work collaboratively with Residential Care and Housing staff to address co-occurring issues in order to help individuals maintain their housing.

Finally, the AOT FSP has been actively trying to address misunderstanding within the community about what their program can and cannot do in relation to its implementation of Assisted Outpatient Treatment by virtue of being MHSA-funded and therefore required to be voluntary in nature.

Community Impact

The FSPs provide a strong base in participant-driven services that build on individual strengths using a "Whatever It Takes" approach and field-based services that break down barriers to accessing treatment. With the continued implementation of co-occurring services the FSPs have increased their collaboration with community substance use programs, residential substance use treatment programs and/or detox centers. In addition, the programs that work collaboratively with the Courts, Probation Department, Public Defender's Office, District Attorney's Office, and/or County Counsel continue to prioritize developing treatment approaches that reduce recidivism in the criminal justice system.

“You gave me something money cannot buy, my life and happiness.”

– Adult FSP Participant

The FSPs also work closely with various county-operated and county-contracted providers and other community groups to support participants on their recovery journeys. This includes the Social Security Administration, Social Services Agency, Primary Care Physicians and other medical providers, hospitals, board and care homes, room and boards, sober living homes, Orange County Housing Authority, other housing providers, shelters, Family Resource Centers (FRCs), legal resources, food banks, vocational trade programs, LGBTQ centers, Salvation Army, Goodwill, Wellness Centers, NAMI, immigration services, thrift shops, faith-based leaders, school districts, policy makers, community based organizations and community clinics. By establishing such depth and breadth to their network of collaborators, the FSPs continue to be a leading force for mental health recovery in the community.

Reference Notes

[1] *Psychiatric Hospitalization Days:*
Children: Prior M=10.8, SD=13.6; Since M=1.8, SD=4.6.1; t (70) = 5.05, p<.001, Cohen's d=.65, 84%
TAY: Prior M=39.8, SD=76.6; Since M=14.8, SD=38.3; t (246) = -5.03, p<.001, Cohen's d=.35, 63%
Adults: Prior M=34.2, SD=64.3; Since M=13.1, SD=30.4; t (542) = 6.78, p<0.001, Cohen's d=.32
Older Adults: Prior M=28.1, SD=59.7; Since M=11.7, SD=26.7; t (58) = 1.84, p=0.07, Cohen's d=.28

[2] *Mental Health Emergency Interventions:*
Children: Prior M=1.8, SD=2.6; Since M=0.4, SD=0.7; t (82) = 4.57, p<.001, Cohen's d=.55, 81%
TAY: Prior M=2.3, SD=3.3; Since M=0.6, SD=1.7; t (295) = 7.7, p<.001, Cohen's d=.46, 72%
Adults: Prior M=2.4, SD=2.6; Since M=0.7, SD=1.5; t (629) = 13.10, p<.001, Cohen's d=.59
Older Adults: Prior M=1.7, SD=1.6; Since M=0.2, SD=0.5; t (79) = 8.07, p<.001, Cohen's d=1.02

[3] *Homeless Days:*
Children: Homeless Days: Prior M= 96.4, SD= 129.7; Since M= 17.1, SD= 51.7, t (19) =3.0, p=.007, Cohen's d= 0.80
TAY: Prior M= 102.3, SD= 124.93; Since M= 26.3, SD= 55.79, t (154) =-6.69, p<.001, Cohen's d= 0.57
Adults: Prior M=145.7, SD=122.56; Since M=36.9, SD=73.42; t (611) = 18.68, p<.001, Cohen's d=.79
Older Adults: Prior M=205.4, SD=138.5; Since M=37.6, SD=84.5; t (134) = 12.14, p<.001, Cohen's d=1.06

[4] *Emergency Shelter Days:*
Children: Prior M= 72.9, SD= 108.9; Since M= 14.8; SD=35.4; t (31) =-2.97, p=.006, Cohen's d= 0.61
TAY: Prior M=82.9, SD=117.2; Since M=22.5, SD=51.3; t (162) =-5.90, p<.001, Cohen's d=.50
Adults: Prior M=83.2, SD=112.6; Since M=20.5, SD=53.4; t (341) = 9.18, p<.001, Cohen's d=.53
Older Adults: Prior M=99.4, SD=126.7; Since M=39.5, SD=81.5; t (102) = 3.96, p<.001, Cohen's d=.43

[5] *Independent Living Days:*
TAY: Prior M= 17.9, SD= 65.01; Since M= 43.4, SD= 96.66, t (747) =-6.46, p<.001, Cohen's d= -.24
Adults: Prior M=46.6, SD=105.5; Since M=86.8, SD=139.1; t (1153) = -9.1, p<.001, Cohen's d=-.24%
Older Adults: Prior M=76.2, SD=129.2; Since M=170.9, SD=160.3; t (219) = -7.41, p<.001, Cohen's d=-.46

[6] *Out of Home Placement Days:*
Children: M= 174.4, SD=142.4; Since M= 47.8; SD= 95.4; t (66) =6.35, p=.000, Cohen's d= 0.79

[7] *Arrests:*
Children: Prior M=2.9, SD=4.1; Since M=0.0, SD=0.0; t(6) =1.86, p=.11, Cohen's d=.99
TAY: Prior M= 2.1, SD= 2.97; Since M= 0.4, SD= .83; t (270) =10.211, p=<.000, Cohen's d= 0.79
Adults: Prior M=2.0, SD=2.2; Since M=0.3, SD=0.8; t (598) = 17.58, p<.001, Cohen's d=.82
Older Adults: Prior M=1.4, SD=0.8; Since M=0; t (31) = 10.71, p<.0001, Cohen's d=2.68

[8] *Incarceration Days:*
Children: Prior M= 28.7, SD= 39.1; Since M= 34.2; SD=67.9; t (9) =.194, p=.851, Cohen's d=-0.06
TAY: Prior M=95.3, SD=102.3; Since M=19.9, SD=39.1; t (217) =10.31, p<.001, Cohen's d=.77
Adults: Prior M=99.6, SD=94.5; Since M=20.4, SD=41.7; t (623) = 19.24, p<.001, Cohen's d=.79
Older Adults: Prior M=72.6, SD=90.6; Since M=8.4, SD=24.7; t (29) = 3.72, p<.01, Cohen's d=.79

[9] *Employment Days:*
TAY: Prior M=46.6, SD=95.4; Since M=63.6, SD=110.0; t(624) =3.3, p<.001, Cohen's d=.13
Adults: Prior M=28.8, SD=75.8; Since M=44.1, SD=97.5; t (1150) = 4.58, p<.001, Cohen's d=.12

Programs of Assertive Community Treatment (CSS)

Programs of Assertive Community Treatment (PACT) offer an individualized treatment approach aimed at assisting individuals of all ages with their recovery from mental illness. Orange County PACTs are similar to the FSPs in that they utilize the evidence-based Assertive Community Treatment model to provide comprehensive, intensive outpatient services to persons with serious emotional disturbance or serious mental illness who may have a co-occurring substance use disorder and have experienced difficulty engaging with more traditional outpatient mental health services. The main differences are that the PACTs are County-Operated and do not have flexible funding, and their primary eligibility criteria target individuals who have had two or more hospitalizations and/or incarcerations due to their mental illness in the last year. Orange County currently offers four PACTs organized around the needs specific to different age groups.

Target Population and Program Characteristics

Children and Youth Behavioral Health (CYBH) PACT

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics							
14-21	Severe	Anywhere	Field	Foster Youth	Parents	Families	LGBTIQ	Homeless/ At Risk	Co-Occuring SUD	Medical	Criminal Justice

The program provides services in English and Spanish.

CYBH PACT works with youth ages 14-21 who are at a developmental stage crucial for attaining the independence and skills needed to be successful throughout their lives. In addition to the target criteria described above, these youth may have also experienced one hospitalization lasting 10 or more days. The program is intended to serve those who are socially isolated and/or have minimal support systems. Caregivers may not understand their children's mental health issues and/or may feel disempowered by the hierarchy between traditional treatment teams of "experts" (e.g., psychiatrists, therapists) and the people receiving services. Youth and their families are referred to the program by CYBH County and County-Contracted programs.

TAY PACT

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics					
18 - 25	Severe	Anywhere	Field	Parents	Families	LGBTIQ	Homeless/ At Risk	Co-Occuring SUD	Criminal Justice

The program provides services in English, Spanish, Vietnamese, Farsi,Korean, Arabic, and ASL.

This program serves Transitional Age Youth ages 18-25 who, in addition to the primary PACT criteria, may be homeless or at risk of homelessness or may have had an out of state placement in lieu of the hospitalization criterion. The program also works with culturally and/or linguistically isolated groups such as Latinos, Vietnamese, Korean, Iranian and the Deaf and Hard of Hearing. Referrals are accepted from the community, psychiatric hospitals and jails. TAY are screened for appropriateness by the four regional Adult and Older Adult Behavioral Health (AOABH) outpatient clinics or the two Open Access sites and assigned to the PACT program that will best meet their needs.

Adult PACT

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics				
								
	Severe	Anywhere	Field	LGBTIQ	Veterans	Homeless/ At Risk	Co-Occuring SUD	Criminal Justice

The program provides services in English, Spanish, Vietnamese, Farsi, Korean, and Arabic.

The Adult PACT program serves eligible individuals from diverse backgrounds who are between the ages of 26 and 59. Referrals are accepted from the community, psychiatric hospitals and jails, and follow a similar screening process as described above for TAY.

Older Adult PACT

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics				
								
	Severe	Anywhere	Field	LGBTIQ	Veterans	Homeless/ At Risk	Co-Occuring SUD	Criminal Justice

The program provides services in English, Spanish, Vietnamese, Farsi, Korean, and Arabic.

The Older Adult PACT serves individuals who are ages 60 and older and who, in addition to the primary eligibility criteria described above, may have visited local emergency departments repeatedly or have had to call 911 frequently due to behavioral health issues. The program accepts referrals from the community, psychiatric hospitals and jails, and uses a screening process similar to that used for TAY and adults.

PACT Services

PACTs' overarching goals include engaging individuals into voluntary treatment; helping them remain safely in the community and out of the hospital and criminal justice system; assisting them with reintegrating into the community through stable housing, education, and/or employment; and linking them to community-based support. The PACTs achieve these goals through an individualized treatment approach that offers intensive services provided by multidisciplinary teams out in the community. These teams are staffed with Mental Health Specialists, Clinical Social Workers, Marriage and Family Therapists, Life Coaches, Psychiatrists and Supervisors who work together to provide clinical interventions such as individual and group therapy, crisis intervention, substance abuse services and medication services. The most commonly used evidence-based practices include Assertive Community Treatment, Seeking Safety and Trauma Focused CBT. Children and TAY, in particular, also require intensive family involvement. Thus, collaboration with family participants, which can include family therapy, is provided for youth and their families.

In addition, PACT provides intensive case management for program participants. Team members offer peer and/or caregiver support, vocational and education support, assistance with benefits acquisition, money management, advocacy and psychoeducation on a number of topics. Participants are also referred and linked to a number of community resources such as NAMI, Family Resource Centers and the Wellness Centers to help facilitate their recovery and maintain their gains after being discharged from the program.

Strategies to Promote Recovery/Resilience

Central to all of Orange County's intensive outpatient treatment programs is the emphasis placed on helping individuals move forward in their recovery. The PACTs work with program participants using a strengths-based model to customize their treatment plans. Team members strive to instill hope in the participants with whom they work, identify

> **"This program has saved my life...I feel hope and worthy of life today."**
>
> **– Adult FSP Participant**

their and their families' strengths, maintain a non-judgmental stance, and have empathy for their and their families' struggles. Mental Health Specialists share their lived experience, serve as positive models, and provide valuable support and information both to the participants and the other team members. The ultimate goal of the PACTs is to help participants build positive relationships and social supports in the community so they can move forward in their recovery and manage their behavioral health care needs outside of the public mental health setting.

Strategies to Improve Timely Access to Services for Underserved Populations

Individuals often have difficulty linking to services for a variety of reasons. Some examples include homelessness and/or difficulty finding permanent housing; lack of food, transportation, childcare and/or social support; anxiety about their legal status and the possibility of being deported; difficulty navigating the very large mental health system; lack of open program space; stigma related to having a mental illness; a tendency to attribute mental health symptoms to previous substance use (theirs and/or their parents'); and previous negative experiences with mental health professionals.

To overcome these wide-ranging challenges, PACT Teams operate under the "Whatever it Takes" model to engage individuals in treatment. They provide person-centered, recovery-based interventions primarily in the home or wherever participants are comfortable meeting in order to overcome barriers to access or engagement. The teams also carry smaller caseloads so individuals and their families can be seen more frequently and have their needs met in a timely manner. Moreover, many PACT therapists are bilingual (see grids) and able to communicate with monolingual individuals and family members in their preferred language, thus facilitating their engagement in services.

From an operational standpoint, the TAY, Adult and Older Adult programs recently streamlined the referral and linkage process to (1) allow direct referrals into TAY PACT, and to (2) include more detailed and frequent follow-up with individuals who miss appointments or do not access treatment. As a result of these changes, individuals are linked to services more quickly and feel supported through the process. In addition, with the recent expansion of these programs, new clinicians have been assigned to specific roles related to engaging individuals who are referred from hospitals, homeless shelters like The Courtyard and the MHSA housing projects.

CYBH PACT, the newest program implemented June 2017, has done multiple presentations to educate providers about PACT and which youth and families would be eligible for its services. Once referred, PACT therapists have attended sessions with the referring therapist, psychiatrist, youth and parent in order to explain the program in greater detail and establish rapport with the youth and parent. This method has proven to be effective at increasing access to services: a CYBH psychiatrist expressed gratitude for the PACT therapist who attended an appointment, saying their presence increased the family's level of engagement and trust. Like the other PACTs, CYBH PACT staff also work with hospital staff, Probation Officers and others involved with the youth and family to engage them in their program services.

PACT teams also recognize the importance of successfully linking program participants to community-based providers as they approach discharge from PACT. Clinicians attend appointments with individuals in the new setting to ensure a smooth transition and ease any anxiety they may feel over the change. Although this transition can be difficult and may take several visits, program staff appreciate the value of this process in allowing individuals to continue moving forward on their recovery journeys.

Strategies to Reduce Stigma and Discrimination

In addition to providing valuable direct services and supports to PACT participants, Mental Health Specialists also serve as inspirational role models, which can be powerful in reducing stigma among the people and families served. In addition, all clinicians and peer workers are trained yearly in cultural competency. The training provides an overview of how to incorporate culturally responsive approaches in their interactions with participants. The concepts of culture, race, ethnicity and diversity, as well as stigma and self-stigma, are discussed. The training also demonstrates the influence of unconscious thought on judgment as it relates to stereotyping and racism. Strategies are also provided to recognize diversity and embrace the uniqueness of other cultures beyond mainstream American culture. In addition, many PACT

staff are bilingual and bicultural. Thus, through training and/or experience, PACT staff understand the heightened stigma and misconceptions about mental health that can exist in underserved ethnic communities, and draw upon this information to facilitate engagement with participants, establish rapport and reduce stigma and discrimination.

Outcomes

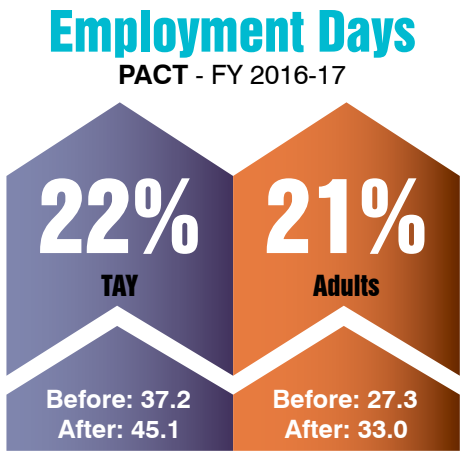
A total of one child/youth, 141 TAY, 928 adults and 103 older adults were served in the PACTs during FY 2016-17. Using the same method and approach as the FSPs, these programs evaluated performance through several recovery-based outcome measures related to life functioning: days spent psychiatrically hospitalized, homeless, incarcerated and, for TAY and adults, employed. Because CYBH PACT was not implemented until June 2017, outcomes are not yet available for this program.

Psychiatric hospitalizations: TAY and adults experienced a moderate decrease in the average number of days spent psychiatrically hospitalized during FY 2016-17 compared to the 12 months prior to enrolling in PACT. While the statistical analysis[1] for older adults indicates that their days spent hospitalized essentially did not change, this is likely due to the fact that a number of older adults remained hospitalized despite being ready for discharge to a lower level of care because a placement option appropriate for their complex medical, physical or Activities of Daily Living needs could not be located.

Homelessness: PACT participants also experienced moderate reductions in the average number of days they spent homeless during FY 2016-17 compared to the 12 months prior to enrolling in the program.[2]

Incarcerations: Compared to the year prior to enrollment, adults and older adults reported moderate decreases and TAY reported small decreases in the average number of days spent incarcerated during FY 2016-17.[3]

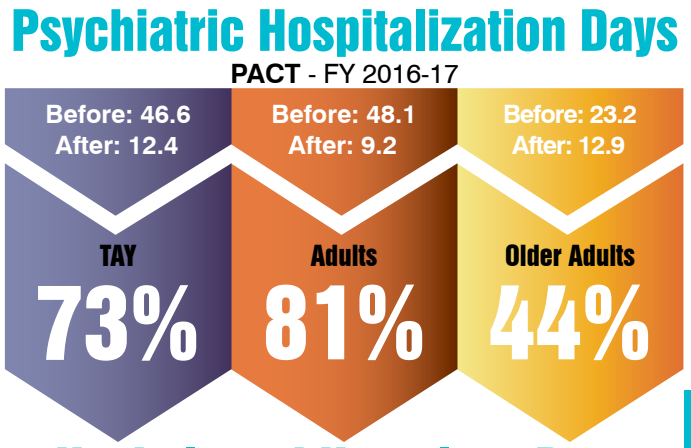
Employment: Similar to the FSPs, TAY and adults served in PACT did not experience meaningful gains in employment, with TAY only increasing their days employed by an average of one week and adults by an average of six days during FY 2016-17. [4]

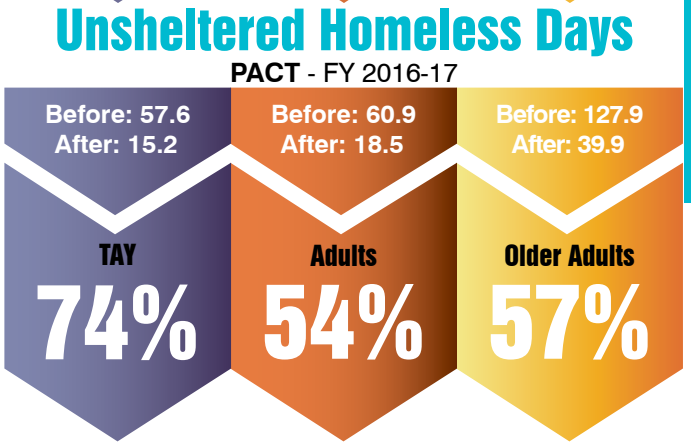


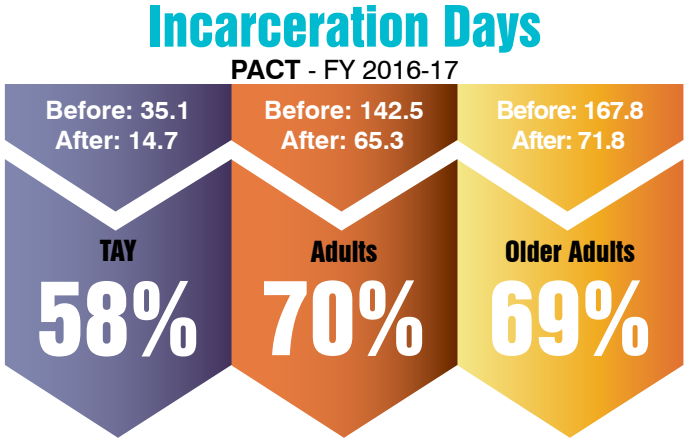
Challenges, Barriers and Solutions in Progress

TAY, Adult and Older Adult PACT have all been expanded recently due to increasing demand for this level of service. There are still 10 vacancies, and the programs hope to begin hiring for these positions in the coming fiscal year.

Like the FSPs, PACTs also struggle with supporting their participants in engaging in and/or sustaining employment. The programs and participants face many of the same challenges as the FSPs, such as difficulty identifying flexible employers and lack of participant work experience and/or confidence.







"PACT has helped me and what I liked best is my Care Coordinator. I have gone without major symptoms in over a year and haven't been hospitalized in a year, I have independent living which I wouldn't have been able to do without the program. What's helpful is the flexibility, the home visits, the willingness to always step up and help me, even if I feel I'm like asking a lot. Having a Life Coach like 'Bob' now as well - he jumped right in."

– PACT Participant

Thus, staff are working to increase individuals' participation in volunteer work and/or educational/training courses as a way to enhance skills that will help them succeed and feel comfortable in the workforce.

While finding safe and affordable housing is a challenge faced by all PACTs, the difficulty identifying housing options for older adults on Social Security and Supplemental Security Income who need assisted living is especially problematic. The Older Adult PACT continually works to expand its list of available resources, however limited options continue to make it very difficult to provide safe and timely placement of older adults.

The OA PACT also encounters challenges in serving older adults who are experiencing age-related cognitive decline. Such decline can have a negative impact on medication compliance, as well as follow-through with medical and other appointments. OA PACT addresses this challenge by utilizing the OA Life Coaches and the Peer Mentoring program to assist with appointments.

Community Impact

The Program of Assertive Community Treatment (PACT) teams in Orange County target high-risk underserved populations which include monolingual Asian/Pacific Islanders, Latino youth and their families, and TAY, adults and older adults living with mental illness. These programs have shown a reduction in psychiatric hospitalization and incarceration days, thereby reducing the need for high-cost crisis services for these individuals.

TAY PACT's success with 18-25 year-olds encouraged the expansion of this program to younger youth. Thus, a new TAY PACT targeting children and youth as young as age 14 was recently implemented in order to reach vulnerable youth who may face problems similar to older TAY, but are at a younger life stage.

The Adult and Older Adult PACTs use a "whatever it takes" approach in assisting adults with serious and persistent mental illness maintain independence in the community and improve their quality of life. The program has assisted individuals navigate their insurance benefits and successfully linked many to needed medical care. As demonstrated by the outcomes presented above, these efforts have had a significant impact on decreasing homelessness, psychiatric hospitalizations and incarcerations among its participants.

Reference Notes

[1] *Psychiatric Hospitalization Days:*
TAY: Prior M=46.6, SD=63.1; Since M=12.4, SD=49.4; t (92) = 4.12, p<0.001, Cohen's d=.43
Adults: Prior M=48.1, SD=76.2; Since M=9.2, SD=27.7; t (687) = 12.59, p<0.001, Cohen's d=.53
Older Adults: Prior M=23.2, SD=43.5; Since M=12.9, SD=28.5; t (52) = 1.64, p=0.11, Cohen's d=.21

[2] *Homeless Days:*
TAY: Prior M=57.6, SD=61.2; Since M=15.2, SD=43.3; t (17) = 3.37, p<0.01, Cohen's d=.57
Adults: Prior M=142.5, SD=126.0; Since M=65.3, SD=104.2; t (242) = 7.97, p<0.001, Cohen's d=.47
Older Adults: Prior M=167.8, SD=145.8; Since M=71.8, SD=108.1; t (30) = 2.81, p=0.009, Cohen's d=.54

[3] *Incarceration Days:*
TAY: Prior M=35.1, SD=31.9; Since M=14.7, SD=43.2; t (29) = 2.48, p<0.05, Cohen's d=.39
Adults: Prior M=60.9, SD=85.5; Since M=18.5, SD=40.2; t (216) = 6.38, p<0.001, Cohen's d=.48
Older Adults: Prior M=127.9, SD=110.7; Since M=39.9, SD=95.7; t (10) = 3.24, p<0.01, Cohen's d=.61

[4] *Employment Days:*
TAY: Prior M=37.2, SD=87.1; Since M=45.1, SD=92.7; t (92) = -0.68, p=0.50, Cohen's d=-.12
Adults: Prior M=27.3, SD=77.5; Since M=33.0, SD=83.5; t (753) =-1.55, p=0.12, Cohen's d=-.05

Youth Core Services – Field-Based Track (CSS)

Program Serves	Symptom Severity	Location of Services				Typical Population Characteristics								
0-21	Severe	Home	Field	School	Outpatient Clinic	Foster Youth	Parents	Families	LGBTIQ	Homeless/ At Risk	Co-Occuring SUD	Medical	Students	Criminal Justice

The program provides services in English, Spanish, and Vietnamese.

Target Population and Program Characteristics

The Youth Core Services Field-Based Track serves youth under age 21 who meet medical necessity criteria for Specialty Mental Health Services and the Pathways to Well-Being subclass (formerly known as "Katie A") which resulted from a settlement agreement that aimed to improve the delivery of MediCal covered mental health and supportive services for children and youth in – or at imminent risk of placement in – foster care in California. The program's field-based track accepts referrals from all sources. Youth Core Services also has a residential program track to serve foster youth placed under the Senate Bill 403 mandate, which is described in the Residential Treatment section of this Annual Plan Update.

Funds for the Youth Core Services Field-Based Track will act as a match to allow for drawdown of Federal Financial Participation funds, which essentially doubles the number of children and youth served for the MHSA dollars spent.

Services

Per Pathways to Well-Being program requirements, participants must be provided an array of services largely provided out in the community, specifically Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) when medically necessary. Examples of activities provided through ICC and IHBS include assessment service planning and implementation, intensive case management, skill-building interventions and activities, psycho-education, and transition planning and services. These services are developed and implemented through the collaborative process of the Child and Family Team (described below).

Strategies to Promote Recovery/Resilience

The program is founded on the Core Practice Model, which states that mental health services and supports are coordinated through a Child and Family Team and provide a forum for the child/youth and family to have a voice and choice in the services they receive throughout their involvement in the system. A service plan that is based on the child's and the family's strengths and needs is developed by the child and family in conjunction with other members of the Child and Family Team. This plan is reviewed regularly to ensure changes are made and services added so that the child and family can achieve their goals for safety, well-being and placement permanency.

Strategies to Improve Timely Access to Services for Underserved Populations

Lack of transportation and stigma are some of the primary barriers to care for these participants, which are mitigated by bringing services directly to youth and their families anywhere in the community rather than relying on them to travel to a behavioral health clinic. In addition, in FY 2017-18 the funding for this track was centralized under one contract provider which facilitated coordination of care and allowed foster youth to receive the level of services required to address trauma and other mental health conditions in a timelier manner.

The program also provides services in multiple languages (see grid) through bicultural/bilingual staff, and can access a language line translation service to assist those who speak other languages, thus reducing language barriers.

> **"I wake up with a smile every day and I'm excited about my day. And the best is that I go to bed every night with an even bigger smile on my face because every day is a good day now."**
>
> **– 5-year old participant**

Strategies for Non-Stigmatization and Non-Discrimination

Services provided to participants in Youth Core Services are delivered based on the principles and values of the Core Practice Model (CPM). The Core Practice Model views the youth from a strengths-based view rather than a diseased-based view. This shift in perspective helps reduce some of the stigma associated with mental illness. Services are also individualized, based on the unique assets and needs of the child/youth and family, and delivered in a manner that is respectful of the child's and family's culture and from a stance of humility that strives to understand the child's and family's world view.

The Core Practice Model also emphasizes the importance of providing services and supports in a manner that takes into account the child or youth's differences and unique life circumstances. The child's culture, ethnicity, gender, sexual orientation and socio-economic status are accepted and addressed throughout the entire time the child or youth is involved with the different child service systems.

Outcomes

Although the program has implemented a performance outcomes measure, during FY 2016-17 data were collected as part of a feasibility study and true baseline data (i.e., at intake) were not collected. Analysis of changes in symptoms from intake through follow up will be reported in future Plan Updates.

Challenges, Barriers and Solutions in Progress

Youth Core Services has experienced on-going issues related to performance outcome measures (i.e., lack of guidance from the State on recommended tools at the time the program launched; implementation difficulties once a measure was selected, etc.). Ongoing efforts are underway to improve the implementation of the selected measure, the Outcome Questionnaire, and future Plan Updates will include more robust outcomes reporting.

Community Impact

The Youth Core Services Field-Based track has provided services to more than 380 youth since its inception in March 2016.

OUTPATIENT RECOVERY

Outpatient Recovery programs serve adults who are living with a serious mental illness and/or co-occurring substance use disorder and have made significant progress on their behavioral health recovery. While these individuals no longer require traditional outpatient treatment, they could still benefit from ongoing support to build meaningful roles in the community, increase their ability to manage their own mental health care, and link to lower levels of care.

Outpatient Recovery	Estimated Number to be Served in FY 2018-19	Annual Budgeted Funds in FY 2018-19	Estimated Annual Cost Per Person in FY 2018-19
Recovery Centers/ Recovery Clinic Services/ Recovery Open Access (CSS) *	3,500	$9,158,531	$2,617

* *The Recovery Centers/Recovery Clinic Services/Recovery Open Access figures include numbers for all three programs. Recovery Open Access is described in the Navigation/Access and Linkage to Treatment/Services section.*

Recovery Clinics and Centers (CSS)

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics				
18+	Severe	Field	Outpatient Clinic	LGBTIQ	Veterans	Homeless/ At Risk	Co-Occuring SUD	Co-Occuring Medical

The program provides services in English, Spanish , Vietnamese, Farsi, Korean, and Igbo.

Target Population and Program Characteristics

Orange County currently offers two CSS-funded Outpatient Recovery programs designed for adults ages 18 and older: the county-contracted Recovery Centers and county-operated Recovery Clinics.

Services

The Recovery Clinics and Centers provide case management, medication services and individual and group counseling, crisis intervention, educational and vocational services, and peer support activities. The primary objectives of the programs are to help adults improve engagement in the community, build a social support network, increase employment and/or volunteer activity, and link to lower levels of care. As participants achieve their care plan goals and maintain psychiatric stability, they are transitioned to a lower level of care where they can continue their recovery journey.

Strategies to Promote Recovery/Resilience

These programs provide adults with self-directed services that focus on community reintegration and linkage to health care. An important feature is a peer-run support program in which adults are able to access groups and peer support activities. These services are delivered in an individualized, person-centered system of care that is tailored to each person's unique stage of recovery and focused on increasing self-reliance and independence in the community.

Strategies to Increase Timely Access to Services

The Outpatient Recovery program sites are either co-located or near the county-operated Adult Outpatient Clinics in order to ease the transfer to a lower level of care. This strategy proves to be essential in promoting a continuum of care model and providing an environment that addresses barriers to change. One of the Recovery Program sites also serves as an access point to services in which walk-ins are encouraged and subsequent referrals within the system are not necessary. All programs are highly encouraged to staff their sites with individuals who speak the county's threshold languages and this requirement is reviewed and discussed regularly when vacancies arise.

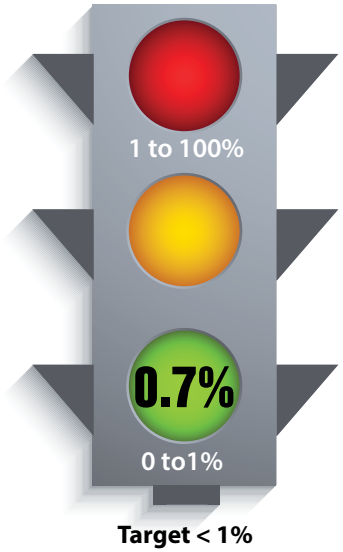
Strategies to Reduce Stigma and Discrimination

These programs also provide services to families and significant others around the behavioral health needs of the individual. Such services include consultation and education to assist with increased utilization of services, improve understanding of mental illness, and encourage family involvement in treatment planning. Collateral services such as family counseling or therapy are provided when needed, and educational activities such as stigma elimination, education on common mental illnesses, recovery principles, and health and wellness classes are also offered at the sites and in the community. A primary focus around reintegration is linking the individual with community-based services that address employment, education, volunteering and other meaningful activities the individual has chosen as part of their recovery.

Outcomes

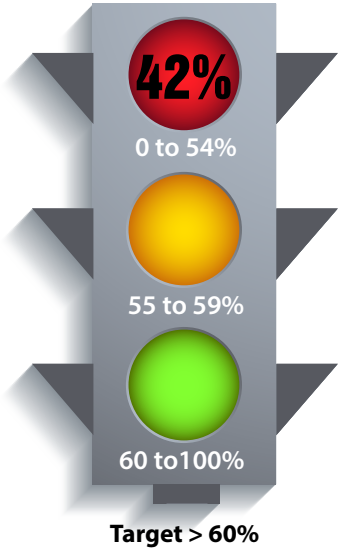
Clinic Recovery Services was implemented during FY 2016-17 and served 209 adults during the partial year it was open. Outcomes for this program will be reported in future Annual Plan Updates. The outcomes reported below are only for the Recovery Centers.

Hospitalization Rate During Enrollment
Recovery Centers
FY 2016-17



Target < 1%

Discharges to Lower Level of Care
Recovery Centers
FY 2016-17



Target > 60%

In FY 2016-17, the Recovery Centers served a total of 1,937 adults. Performance of the program was measured in two ways. The first is whether the program achieved its target of maintaining a psychiatric hospitalization rate of less than 1% while adults were enrolled in the program. As can be seen in the graph below, the Recovery Centers achieved this goal with a hospitalization rate of 0.7%.

In addition, the Recovery Centers strive to assist adults in achieving community reintegration and greater independence by setting a goal of discharging 60% of those served into a lower level of care. During FY 2016-17 the program did not achieve this goal with only 42% of the 366 discharged from the program leaving for a lower level of care.

Challenges, Barriers and Solutions in Progress

The primary challenge to graduating individuals to a lower level of care has been addressing the issues attributed to tenure or length of stay in the programs. Individuals struggle with changes in their treatment team and the peer support/social activities at the programs create a home away from home environment for many of the individuals. The programs have addressed these barriers through broaching the topic of graduation at the onset of services to prepare the individual for this milestone, offering to attend the first appointment with the new provider, and linking the adults to community based programs for continued social support prior to graduation. Programs have also identified graduates who are willing to return to speak with participants at the graduation ceremonies to encourage and allay concerns associated with obtaining treatment in the community and leaving the program where they have become comfortable.

Community Impact

The needs of the individuals accessing the Recovery Centers are uniquely met through services focused on reintegration into the community and overall independence. Individuals and their families are educated about the system of care, are exposed to community resources, and encouraged to set and meet new goals beyond those achieved at the program. Through obtaining employment, pursuing education and/or participating in meaningful activities, individuals who graduate have a better understanding of the tools they can use to support and maintain their recovery after discharge from the program.

SPECIALIZED OUTPATIENT/INTERAGENCY COLLABORATIONS

As part of its continuum of outpatient services, HCA partners with other Orange County agencies to provide specialized outpatient services for individuals with mental health needs who are also involved in other systems. Two of these partnerships are described below: one for adults participating in the Mental Health Collaborative Courts and the other for caregivers referred by the Child Protective Services unit of the Social Services Agency. Interagency collaborations involving the Full Service Partnerships are described in the Intensive Outpatient section.

Outpatient Specialized/Interagency Collaborations	Estimated Number to be Served in FY 2018-19	Annual Budgeted Funds in FY 2018-19	Estimated Annual Cost Per Person in FY 2018-19
Mental Health Court – Probation Services (CSS)	120	$921,000	$7,675
Stress Free Families (PEI)	160	$534,693	$3,342

Mental Health Collaborative Court – Probation Services (CSS)

Target Population and Program Characteristics

The Mental Health Collaborative Courts (MHCC)–Probation Services is a specialized interagency collaboration that uses CSS funds to staff six Probation Officers in the Collaborative Courts. The target population to be served is adults living with mental illness who are on formal probation and meet eligibility and suitability for one of the Collaborative Courts. Probation Services are provided to one of the three following Mental Health Courts, as well as those with mental health needs who are being seen in the Veterans Treatment Court. Each Court has a specific focus and is described below:

Opportunity Court and Recovery Court

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics	
18+	Severe	Anywhere	Field	Co-Occuring SUD	Criminal Justice

The program provides services in English.

Opportunity and Recovery Courts are voluntary programs for non-violent and violent adult offenders who have a chronic and persistent mental illness. Opportunity Court and Recovery Court can refer participants in need of intensive behavioral health services and supports to PACT (see PACT in the Intensive Outpatient section).

WIT "Whatever It Takes" Court

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics		
18+	Severe	Anywhere	Field	Homeless/ At Risk	Co-Occuring SUD	Criminal Justice

The program provides services in English.

WIT Court is a voluntary program for non-violent and violent adult offenders who have a chronic and persistent mental illness and are unserved or underserved and who may be homeless or at risk of homelessness. This Court can refer participants with intensive behavioral health services and supports to the WIT FSP as needed.

> **"It has been life-changing. [My probation officer's] giving me a lot of time and advice. We have built a strong professional relationship that helps keep me out of trouble and guides me in the right direction."**
>
> **– 5-year old participant**

Veterans Treatment Court

Program Serves	Symptom Severity		Location of Services		Typical Population Characteristics							
18+	Mild-Moderate	Severe	Anywhere	Field	Parents	Families	LGBTIQ	Veterans	Homeless/ At Risk	Co-Occuring SUD	Medical	Criminal Justice

The program provides services in English.

The Veterans Treatment Court is designed for veterans who are charged with felony and/or misdemeanor cases and have a history of mental health and/or substance abuse issues. The majority of individuals served in this program are eligible for, and receive their behavioral health treatment from the Veterans Administration (VA) Long Beach Healthcare System.

Services

Probation Officers funded through the Collaborative Courts work in conjunction with the Courts, VA, District Attorney, Public Defender, Full Service Partnerships, PACT, other HCA staff and/or community partners to support recidivism reduction efforts through active judicial monitoring and intensive services. Probation Officers who serve in the Collaborative Court programs require specialized training and carry a reduced caseload due to the intensity of both the needs of participants and the inter-agency collaborative process. Officers conduct evaluations, drug testing, field visits and searches, participate in treatment meetings, and make frequent Court appearances. The officers utilize evidence-based and best practices such as Thinking for Change (T for C), Motivational Interviewing and Intensive Supervision. Probation Officers also use the Effective Practices in Community Supervision model which provides a multi-dimensional approach to address criminogenic behaviors by providing structure and purpose during face-to-face interactions with participants. The model also utilizes interventions that are based on participants' risks and needs and focuses on teaching them about effective problem solving and prosocial skills.

Strategies to Improve Timely Access to Services for Underserved Populations

Program participants face a number of issues that may keep them from seeking services including limited resources such as lack of transportation, limited income, limited support system, difficulty finding permanent housing, and difficulty finding employment due to having a criminal record and/or being on probation. Additionally, many participants have co-occurring substance use disorders and may continue to engage in ongoing substance use and/or criminal behaviors, thus prompting them to avoid seeking services for fear of incarceration and/or extension of their probation terms.

To overcome these barriers, Probation Officers work to build positive working relationship with program participants, and coordinate with HCA and the Court team in order to link individuals to needed services. Probation Officers also provide field and home visits to help facilitate access to services for those with transportation issues. Many program staff are bicultural/bilingual, and the Probation Department has certified interpreters inside the department who are available as needed.

Strategies to Promote Recovery/Resilience

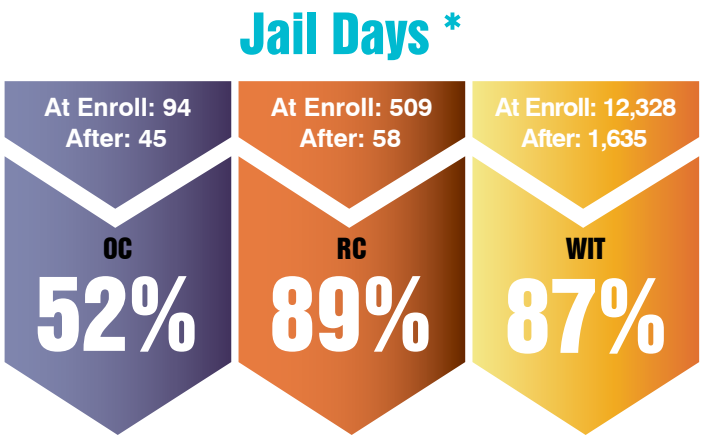
Recovery and resilience are promoted through the use of the evidence-based and best practices described above. These strategies and tools are integrated into the Probation Officers' approach in working with each participant. The officers customize their interventions in order to support participants effectively, increase their resilience and promote ongoing and sustained recovery. The Collaborative Court Program uses a team approach to decision making and includes the participation of a number of different agencies such as the Courts, Probation Department, Public Defenders Offices, and mental health treatment providers.

Strategies to Reduce Stigma and Discrimination

Perhaps one of the most significant ways in which this program works to reduce stigma and discrimination related to mental illness is by incorporating principles of the recovery model into the legal system. Probation Officers work collaboratively with the treatment team to support participants and reduce internal stigma by treating them with care and respect, instilling hope, focusing on their strengths and valuing their choices. The officers provide positive reinforcement and encourage prosocial behaviors and activities such as attending support groups and looking for employment when appropriate.

Outcomes

During FY 2016-17, 24 adults were served in Opportunity Court, 30 in Recovery Court and 180 in WIT Court. In addition, there were 11 program graduates and 31 active participants in Veterans Treatment Court at the end of 2016. Consistent with the Act's intent, the goal of the Collaborative Court programs is to reduce negative functional outcomes such as days spent incarcerated among those living with mental illness by engaging them in appropriate behavioral health services. This is quantified as a reduction in total jail days while participants are involved in the court program compared to jail credit days at the time of program enrollment. The table below illustrates that the program demonstrated reductions in total jail days for Mental Health Collaborative Court participants, thus meeting its goal.



* *Jail Credit Days at Enrollment only includes jail sentences served on case(s) that are in the Mental Health Collaborative Courts. It does not capture jail days served for cases outside of the MHCC.*

Jail Days Saved

2,406

Veterans Court Graduates (n=11)

FSP/PACT outcome data for those MHCC participants who were referred to these services are included as part of the analyses for those respective programs.

Due to issues with data extraction at the time this Update was written, reduced recidivism for Veterans Treatment Court participants was calculated as jail/prison days saved (i.e., total number of jail or prison days that were stayed as a result of the alternative sentence, minus any incarceration days resulting from in-program sanctions). Among its program graduates, the Court saved 2,406 jail and prison days during 2016. In future Plan updates, a consistent method for calculating reduced recidivism across Court programs will be identified.

Changes/Challenges/Barriers

One of the challenges is not having a sufficient number of Probation Officers to maintain the recommended low caseload when working with individuals who have high risk and needs. HCA is working with the Probation Department to explore other staffing resources and trainings to better meet the needs of the MHCC programs.

Community Impact

Having Probation on the collaborative team is a key component of the MHCC model, which has been successful at reducing recidivism among individuals who are living with SPMI and involved in the criminal justice system. Probation collaborates with the Courts, Public Defender, District Attorney, HCA County and County-contracted programs (e.g., FSPs, PACT, and residential treatment), sober living homes, room and boards, and other community based organizations to achieve this goal.

Stress Free Families (PEI)

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics			
							
	Mild-Moderate	Anywhere	Field	Parents	Families	Co-Occuring SUD	Criminal Justice

The program provides services in English, Spanish, Vietnamese, and Korean.

Target Population and Program Characteristics

The Stress Free Families program partners with the Orange County Social Services Agency (SSA) to serve families that have been reported to and/or investigated by Child Protective Services (CPS) for allegations of child abuse and/or neglect. Target participants are the adult parents or caregivers who have come to the attention of the Social Services Agency. This PEI outpatient program is designed to reach and support families experiencing stressors that make family members more vulnerable to behavioral health conditions, including the child(ren) involved in the CPS report.

All referrals to the Stress Free Families program come from SSA, which refers families for whom the child abuse and/or neglect allegation(s) was/were found to be inconclusive, unfounded or unsubstantiated. There can also be no more than 10 investigations for the family. Stress Free Families accepts cases that are pending closure or are currently not open with SSA and that have no current safety threat.

Stress Free Families works with a variety of Orange County's underserved populations: homeless families, families with documented mental health and/or drug abuse issues, and/or history of family violence. The program serves families from a variety of underserved cultural backgrounds and ethnic and monolingual populations such as Spanish, Vietnamese and Korean.

Services

The program provides a range of services intended to reduce risk for behavioral health problems. Services include short-term interventions such as brief counseling, parent education and training, case management, and referral and linkage to community resources. The program uses elements of the Triple-P Positive Parenting Program (Triple P Tip Sheets) to educate parents on a range of topics such as trauma, child abuse, domestic violence, communication and positive parenting, and appropriate bonding techniques. Caregivers are also taught relaxation and anger management skills to help reduce the potential for additional trauma.

Strategies to Promote Recovery/Resilience

The Stress Free Families Program supports recovery by providing psycho-education on the wide range of topics described above to prevent additional trauma and, thus, encourage recovery and build resilience within the family. Participant service plans often include elements of self-care, steps to take toward development of appropriate bonding, and the development of effective, positive communication skills.

Strategies to Improve Timely Access to Services for Underserved Populations

Many participants have limited financial resources and must work during traditional business hours which can make keeping appointments more difficult. Families may also lack transportation or childcare to allow for in-office appointments. Families dealing with domestic violence may also discontinue services if one of the parents puts pressure on the other to drop out of the program.

To overcome transportation and childcare issues, clinicians can meet with participants in their homes or wherever else in the community that the parent agrees to meet, thereby improving access to services. Clinicians have met with participants in parks near their homes, at local Family Resource Centers, at restaurants, as well as the clinician's office, especially if there are any identified safety concerns in the home.

When assessments and services are provided in the home setting, this presents a number of potential advantages. Program staff are able to observe and ascertain the needs of the families in their living environment so that they are better able to tailor their interventions to the family's dynamics. In addition, when parenting training is provided in the same environment in which the parents are expected to use the techniques learned, it increases the likelihood that they will use the new skills going forward.

In addition, parents enrolled in Stress Free Families need extensive support and assistance

> **"Thanks to this program it has helped me so much with my children. Before I started this program, I felt very bad for not knowing what to do but with this help, I've bettered myself and am more understanding."**
>
> **– Program participant**

to link with resources that provide necessities such as food and clothing. Without these necessities, their ability to participate meaningfully in the program's higher-order treatment goals is compromised. To mitigate this challenge, clinicians serve as active case managers, providing referrals to families and diligently following up to ensure linkages to these necessary services are made. In FY 2016-17 the program provided 157 referrals and 32 linkages to basic need items and services, behavioral health outpatient services, information and referral services, legal services and advocacy, PEI programs, financial assistance, health care services and family support services.

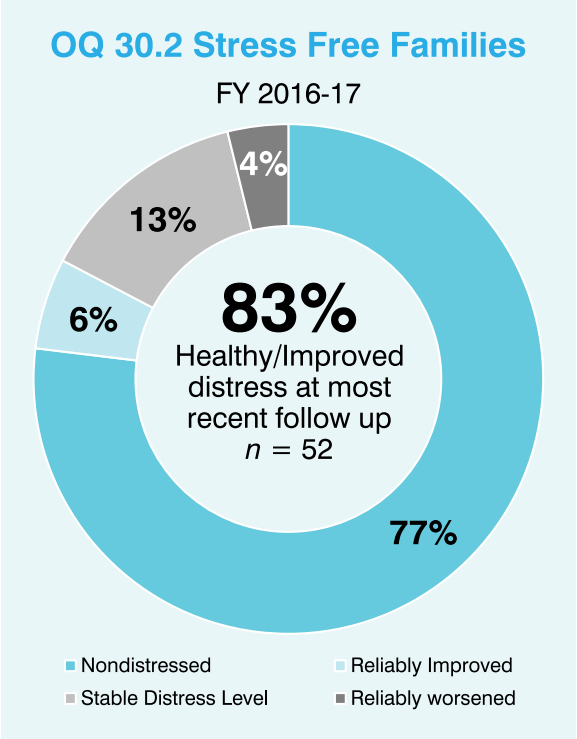
Strategies for Non-Stigmatization and Non-Discrimination

Stress Free Families strives to make services available to all Orange County residents, regardless of their background. The program provides services in English, Spanish, Vietnamese and Korean through staff who are bicultural and bilingual. Clinicians in the program work to meet parents "where they are at" and educates them regarding mental health and substance abuse issues to reduce stigma and encourage engagement in any needed services.

Outcomes

During FY 2016-17, 117 parents/caregivers who had a total of 147 children living in the home were served by Stress Free Families. The program measures reduction in prolonged suffering by examining clinically meaningful changes in psychological distress as measured by the OQ 30.2.

At the time of most recent follow-up, 83% of the 52 participants who had completed more than one OQ reported healthy (77%) or reliably improved (6%) levels of distress since starting services.



Thus, the overwhelming majority of participants either avoided prolonged suffering or experienced clinically meaningful reductions in general psychopathology symptoms while enrolled in Stress Free Families. In addition, program staff is reviewing and implementing strategies to ensure that participants who require more intensive services and/or a higher level of care receive the appropriate supports and/or referrals in a timely manner.

Challenges, Barriers and Solutions in Progress

Referrals to this program are heavily dependent on a strong relationship with its partnering agency, SSA. During this reporting period, SSA moved their Social Workers out of the office that it shared with the program and into a field-based setting. This shift, combined with the high turnover rate in the CPS department introduced communication challenges between program staff and SSA Social Workers, which decreased referrals. This challenge was resolved by the Service Chief who prioritized meeting with SSA Administration on an on-going basis to remind them of the services offered and potential benefits of making referrals. The Service Chief will continue to attend SSA meetings on a regular basis to keep a steady flow of referrals to the program and potentially even increase referrals.

Community Impact

The program has provided services to more than 420 families since its inception and has improved the functioning of the enrolled parents. The program also provides frequent consultation to the Orange County Social Services Agency which has improved SSA's ability to recognize mental health needs in those for whom an allegation of child abuse has been made. This recognition has helped to improve SSA's ability to provide families with timely and appropriate behavioral health resources to prevent further child abuse and/or neglect.

RECOVERY AND SUPPORTIVE SERVICES

Recovery and Supportive Services provides a broad array of supports generally designed to augment and expand an individual's gains made in clinical programs, particularly those within Outpatient Services, Crisis Services and Residential Treatment. These programs, which are funded by CSS, PEI and INN, serve individuals of all ages and are further subdivided into the following categories:

- Peer Support
- Veterans Support
- Family Support
- General Support

PEER SUPPORT

Peer Support programs are staffed with consumers of mental health and/or substance use services and their family members. While Orange County includes peers as part of the service delivery teams in many of its behavioral health programs (i.e., FSPs, PACTs, Veteran's Outpatient, Survivor Support Services, etc.), these programs are different in that the full scope of services they offer are provided exclusively by peers and their family members. By sharing their lived experience, they are able to help support and encourage participants on their own recovery journey.

Recovery and Supportive Services: Peer Support	Estimated Number to be Served in FY 18/19	Annual Budgeted Funds in FY 18/19	Estimated Annual Cost Per Person in FY 18/19
Warmline (PEI)	31,000	$481,566	$16
Step Forward: On-Site Engagement in the Collaborative Courts (INN)	100	$224,015	$2,240
Peer Mentoring (CSS)*	1010	$4,249,888	$4,208
Behavioral Health Services for Independent Living (INN)	100	$402,234	$4,022
Wellness Center (CSS)	1600	$3,254,351	$2,034

* *Peer Mentoring Budget reflects budget that includes Triage Grant and Whole Person Care dollars.*

Warmline (PEI)

Program Serves	Symptom Severity			Location of Services		Typical Population Characteristics
0+	At-Risk	Early Onset	Mild-Moderate	Telephone	Chat Based	Field

The program provides services in Spanish, Vietnamese, Farsi, Arabic, and Language line.

Target Population and Program Characteristics

The WarmLine serves unserved and underserved Orange County residents who are seeking peer support and experiencing mild to moderate symptoms of mental illness or are at risk for mental illness, school failure and/or trauma exposure. This program also serves family members and operates Monday through Friday from 9 a.m. to 3 a.m., and Saturday and Sunday from 10 a.m. to 3 a.m.

Services

The WarmLine provides non-crisis support for callers over the phone or through live chat. Upon connecting with the Warmline, individuals are screened for eligibility and assessed for needed mental health information, support and resources. Staff draw upon their lived experience to connect with callers and provide them with emotional support and referrals to ongoing services as needed. Callers who are experiencing a behavioral crisis are immediately referred to the Crisis Prevention Hotline (see Crisis Services)

Motivational Interviewing and the Family-to-Family curriculum are two evidence based practices used by the program to reduce negative outcomes. Family-to-Family serves as the foundation for understanding mental health issues from the perspectives of holistic and trauma-informed care, stages of recovery, biopsychosocial elements of mental illness, medication, confidentiality and effective communication with individuals living with mental illness. Active listening, a person-centered motivational interviewing skill, is effective in establishing rapport and building empathy, and can be especially useful with callers in the pre-contemplative or contemplative stages of change. In addition, the WarmLine uses Positive Psychology, a resilience-based model that focuses on positive emotions, individual traits and institutions. This model trains mentors to focus on the positive influences in callers' lives such as character, optimism, emotions, relationships and resources, in order to reduce risk factors and enhance protective ones.

Strategies to Promote Recovery/Resilience

WarmLine services promote recovery and resilience by providing mental health information, support and service referrals during extended weekday hours and over the weekend.

Strategies to Increase Timely Access to Services for Underserved Populations

A toll-free number is advertised to ensure access to all Orange County residents. Live chat, text and language line capabilities are available to improve timely access and accommodate the increased need for services. In addition, WarmLine staff has participated in outreach events where they connected with 4880 residents. They have also invited community members to staff meetings and advertised in different media sources serving Orange County's diverse communities. The program has increased bilingual staff capacity, and services are currently available in English, Spanish, Vietnamese and Farsi.

In addition to providing direct support to callers, WarmLine staff refers individuals to on-going community resources as needed. In FY 2016-17 the program made 2,189 referrals to programs such as OC Links, mental health services, Family to Family curriculum, Patients' Rights Advocacy, and suicide prevention programs. At the present time, the Warmline is not currently equipped to track linkages.

Strategies to Reduce Stigma and Discrimination

The WarmLine provides services via phone, live chat and text so that callers who may otherwise not seek mental health services because of the associated stigma may feel comfortable doing so anonymously. The WarmLine staff, who are peers living with mental illness or family members of an individual living with mental illness, are provided comprehensive training in empathy, active listening and suicide assessment. They provide support and information about mental illness to reduce stigma, encourage participation in treatment, and promote effective use of family support systems and community resources. Representatives from Orange County's diverse communities are invited to attend Warmline staff meetings to promote understanding of program services and improve outreach in these communities. Call monitoring is used for training purposes to ensure non-stigmatizing and non-discriminatory services.

> **"The WarmLine is my lifeline, if it weren't for you guys I would be dead."**
>
> **– Program participant**

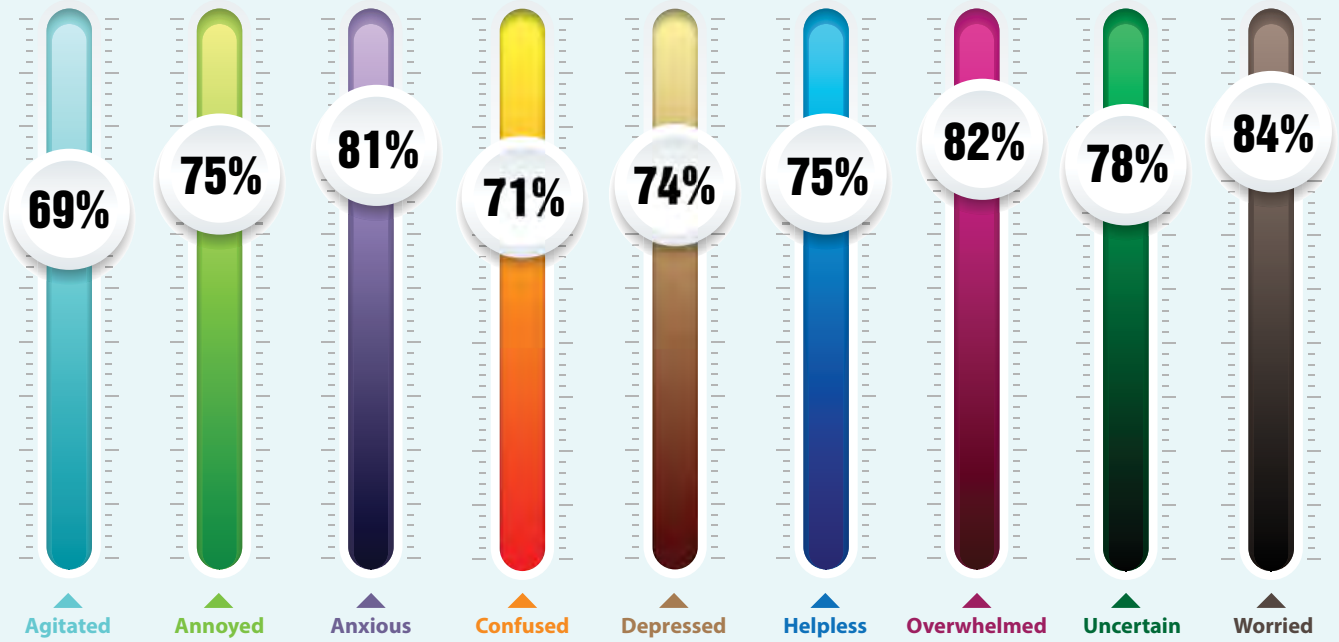
Outcomes

During FY 2016-17, the program received 48,317 calls from 18,381 unduplicated callers, as well as 479 live chats/texts. The majority of calls were from individuals who had used the WarmLine before (87%) and calls typically lasted 20 minutes or less (also 87%).

The WarmLine aims to reduce prolonged suffering from behavioral health problems, which was measured through changes in ratings on the Profile of Mood States (POMS). Callers were asked at the beginning of the call whether they felt different emotions (i.e., worried, uncertain, etc.) and then asked at the end of the call whether they felt better, the same or worse. The evaluation reflects cultural competence in that it assessed for the presence of, and changes in, a range of negative mood states to ensure that different cultural expressions of distress were reflected. In addition, calls were able to be conducted in most threshold languages, and the Language Line could be accessed to assist callers who spoke a different language.

Results show that the majority of callers who reported feeling a specific mood reported feeling better at the end of the call, with the highest rates of improvement observed for callers who said they felt worried, overwhelmed or anxious. Thus, the program was successful in reducing emotional distress through the support and services provided during the telephone contact.

Reported Improvement in Negative Mood States at End of Call
Warmline - FY 2016-17



Challenges, Barriers and Solutions in Progress

A challenge for the program is the significant increase in the overall number of calls. This increase has created longer wait times for callers as staff are not always available to answer incoming calls immediately. The program has adjusted staff shifts to accommodate when the call volume is highest and is always identifying and recruiting new volunteers in order to accommodate the increasing demand for services. In addition, the program received increased funding for FY 2018-19 and is currently exploring other strategies to best adapt to the increased volume, including methods to enhance their technology.

Community Impact

The Warmline has provided services to more than 71,077 individuals since its inception August 2010. The provider also actively collaborates with the community as a whole in order to break down stigma, raise awareness and educate the community about available services.

Step Forward: On-Site Engagement in the Collaborative Courts (INN)

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics		
18+	Severe	Field	Families	Homeless/ At Risk	Criminal Justice

The program provides services in and Spanish.

Target Population and Program Characteristics

The Step Forward: On-site Engagement in Collaborative Courts project serves adults ages 18 and older who are living with mild, moderate or severe and persistent mental illness, and are participants of the Orange County Homeless Outreach Collaborative Courts or their family members/support persons. Participants must be involved in the Homeless Outreach Collaborative Court in order to be eligible for this project. Eligible participants also may be referred to project services by the judge or paralegal. The Homeless Court provides a compassionate response to the fact that the homeless participants, many of whom suffer from chronic mental illness, may receive citations simply because they are homeless, with the result that such charges may hinder their efforts to obtain the government disability assistance that could aid in their rehabilitation. Through this voluntary Court program, participants can address their citations and outstanding warrants by accessing, as appropriate, physical and mental health care and other needed services.

Services

The Step Forward: On-site Engagement in Collaborative Courts project is staffed with Peer Specialists who have experience and knowledge of behavioral health to provide services on-site at the Homeless Collaborative Courts throughout Orange County. Peer staff attend the Homeless Collaborative Courts each week to outreach individuals who are on the court docket, as well as family members who are present to support their loved ones. Services include court outreach, participant and family engagement, behavioral health education courses, referrals and linkages to community resources, and supportive counseling. Peer Specialists facilitate one-on-one or group education modules to court participants and their family members/support persons. Court participants and their family members have the option to attend up to 10 education modules that cover a range of topics, including: substance use, symptom management, medication management, relationship management, goal setting, stigma, life skills, personal finance and community behavioral health resources.

The Step Forward project began services December 1, 2015. Innovation funds for this project will end November 30, 2020.

Strategies to Promote Recovery/Resilience

The goal of this project is to empower participants to be engaged and proactive in the management of their recovery. Court participants are given the opportunity to apply project participation credit toward the completion of their community service obligation, enabling them to complete their obligation, while at the same time allowing them to focus on other aspects of their recovery. The behavioral health modules, created specifically for this project, educate participants about behavioral health and provide strategies to manage well-being, improve activities of daily living, strengthen relationships, as well as build support networks. Modules are offered one-on-one or in a group setting; however, group sessions are encouraged to foster social support and community among participants. Participant feedback is gathered after each module training in order to improve content and tailor information to meet the needs of court participants and their family members/support persons. Along with the education modules, Peer Specialists collaborate with participants to identify goals and offer support to help them reach their stated goals. Family members and support persons are also engaged into services in order to support their loved one's recovery journey.

Strategies to Increase Timely Access to Services for Underserved Populations

Timely access to services are built into the project structure. That is, services are offered to all individuals and their family members as they appear in Court for their scheduled hearing. In addition, Peer Specialists collaborate with the court staff to encourage access to services and the Judge regularly promotes this project by encouraging court participants and their families to enroll in services.

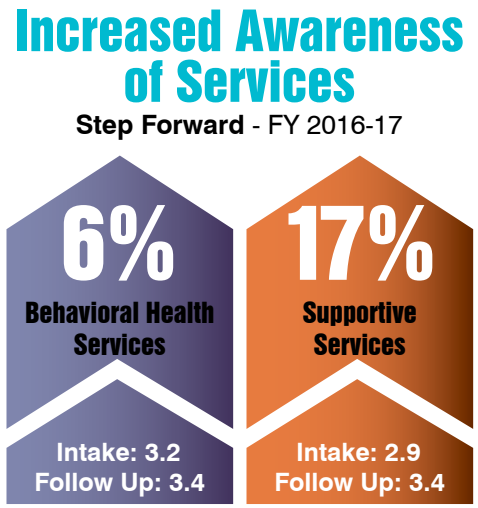
In addition, peer staff actively works to link participants to needed community services and supports through intensive case management. Peers offer to watch over a homeless participant's belongings and/or pets so that they may attend appointments without the fear of having them lost or stolen while away. Peer Specialists also assist with linkages by attending appointments with participants, as needed. They also assist participants in navigating the complex health care system, which can include help with completing applications for food stamps, disability and birth certificates. In FY 2016-17, the program provided 216 referrals and 102 linkages to services such as affordable housing, mental health care, job training, substance use services and job placement.

Strategies to Reduce Stigma and Discrimination

This project utilizes behavioral health education to reduce stigma and discrimination. One of the ten education modules is dedicated to educating participants about the impact of stigma. Peer Specialists identify common stereotypes associated with mental illness, address misconceptions, facilitate a discussion on self-stigma, and discuss strategies to overcome stigma.

Outcomes

In FY 2016-17, the Step Forward project served 68 Court participants and family members with the goal of improving participants' understanding of how to navigate the County's behavioral health system and access needed services. Based on responses to a survey administered at intake and follow up (n=20), participants reported stable levels of knowledge on how to access behavioral health (i.e., mental health, substance use) and supportive services, although it should be noted that the average ending scores were relatively high at 3.4 on a 4-point scale, suggesting that there may be issues with the sensitivity of the outcome measure. In addition, the project's 47% success rate of linking individuals to referred services is on par or exceeds that of other programs.[1]



Challenges, Barriers and Solutions in Progress

Despite efforts to decrease barriers to project services (i.e., providing on-site services, bus passes) enrollment has been a challenge since the inception of this project due to issues such as an inability to remind participants about upcoming hearings because they do not have a phone or stable residence; moving; failing to appear in court. Furthermore, individuals are not mandated to attend court, thus limiting the number of potential court participants that Peer Specialists can reach. To try and mitigate these barriers, peers request multiple emergency contact numbers during enrollment to help locate missing participants if needed.

In addition, gathering survey data has been a challenge due to the high rate of no shows, an inability to locate participants, and the appropriateness of the measure itself. In an effort to increase the number of follow up measures collected, Peer Specialists began administering outcome measures every two months during project enrollment instead of only at intake and discharge.

Community Impact

The program has provided services to more than 90 participants since its inception December 2015. With the incentive to apply project participation toward their community service hours, approximately one-third of the participants applied credits toward completion of their community service hours required by the court. Participants have also expressed positive feedback regarding the education modules. The most popular education course topics include relationship management, goal setting and personal finance. At the participants' request, project staff expanded the education modules in FY 2017-18 to include a new topic covering community behavioral health resources.

Reference Notes

[1] *Behavioral Health Services: Intake M=3.2, SD = .88; Follow Up M=3.4, SD=.74; t(19) = -1.45, p<.16, Cohen's d=.22*
Supportive Services: Intake M=2.9, SD = 1.2; Follow Up M=3.4, SD=.60; t(19) = -1.70, p<.11, Cohen's d=.41

Peer Mentoring (CSS)

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics			
							
	Severe	Field	Outpatient Clinic	Parents	Families	Homeless/ At Risk	Co-Occurring SUD

The program provides services in and Spanish, Vietnamese, Farsi, and Korean.

Target Population and Program Characteristics

The Peer Mentoring program serves individuals who are living with a serious emotional disturbance (SED) or serious mental illness (SMI), may also have a co-occurring disorder, and would benefit from the supportive services from a peer. This CSS program, which was originally created for adults ages 18 and older, and consists of three unique tracks, one of which will be expanded to serve individuals of all ages and their families:

- Track 1 serves participants in County-operated and County-contracted outpatient programs (i.e., Clinics, FSPs) who are referred by their therapist or personal service coordinator for assistance with short-term treatment goals or with re-integration into their community following a recent psychiatric hospitalization or multiple Emergency Room visits. This track will be expanded in FY 2018-19 to serve participants of all ages who are receiving services in the County outpatient clinics as well as their families.
- Track 2, which was originally funded through the Senate Bill 82 Triage Grant and will now be continued with MHSA CSS funds, serves participants being discharged from the County Crisis Stabilization Unit (CSU) or local hospital Emergency Departments and require assistance linking to ongoing behavioral health or community services.
- Track 3, a new track developed as part of the County's Whole Person Care plan, serves participants who are living with serious mental illness, are homeless or at risk of homelessness and are MediCal beneficiaries. Participants are referred to this Peer Mentoring track by the BHS Outreach and Engagement team after they have been placed in housing (see Whole Person Care in the Special Projects section).

Services

Services are customized depending on the individual's needs and the track in which they are participating.

In **Track One**, peers work with participants on achieving short-term treatment goals that are part of a larger, overall treatment plan established by their treatment providers. The goals generally take 60 days or less to achieve and may include, but are not limited to, learning to use and navigate the public transportation system; obtaining identification cards or driver's licenses; assisting with housing applications; increasing socialization activities such as attending groups or activities at the Wellness Centers; helping with the transition from inpatient care back into community living; and/or assisting with stabilizing a person who has experienced multiple Emergency Department visits.

In **Track Two**, peers receive a warm hand-off from licensed Crisis Stabilization Unit staff or Emergency Room triage staff in identified hospitals. After establishing a relationship with the participant, the peer works to link them to necessary follow-up behavioral health or medical appointments. Peers also work with participants on accessing community-based services such as food pantries or emergency overnight shelters as needed. Peer Mentors share their lived experience, which often provides the encouragement a participant needs to engage in ongoing services following a crisis. Peers work to link participants to services within 30 days of engagement, although linkage typically occurs within a week. Longer time periods are often associated with the inability to make or maintain contact with the participant after the engagement period, as many are homeless, don't have telephones and/or may stay at different locations on a nightly basis.

In **Track Three**, a new track that will serve individuals eligible for Whole Person Care services, peers will help participants sustain their housing placements for longer than six months. Peer Mentors will provide supportive and tenancy-sustaining services that may include landlord negotiations, housekeeping, food shopping and preparation, financial management, medication management, transportation, medical care, arranging utilities, phone, insurance and access to community supports and services.

Strategies to Promote Recovery/Resilience

The principles of the Recovery Model are embedded in the program and peers focus on a participant's strengths and foster their sense of empowerment, hope and resilience while on

their recovery journey. Across all tracks, the peer mentoring programs strives to improve participants' wellness and resourcefulness, thus allowing them to re-integrate successfully into their communities.

Strategies to Increase Timely Access to Services for Underserved Populations

The Peer Mentoring program has proactively built relationships with leadership at County Clinics and County-contracted outpatient clients by conducting presentations to inform staff of the referral process, and services provided, and to share success stories. Sharing data on linkage rates and successful goal completion as a result of using peer mentoring services has had a large influence on increasing referrals to the program.

Some individuals receiving Peer Mentoring services have children and/or work. While they understand the benefits of working with a peer, finding the time to meet is perceived as adding another responsibility and, at times, can cause some reluctance to engage in services. Peer Mentors educate the individual's family members or significant support persons about the recovery model and the benefits of participating in follow-up services so that they may encourage their loved one to access those necessary services.

Homelessness is another factor that can affect program access as Peer Mentors often lose touch with individuals who do not have a stable residence or telephone to remind them about their appointments or responsibilities. During initial contact with the participant, peer staff makes significant effort to learn about where a participant may be staying and how to contact them in order to minimize losing contact with them once their initial meeting has ended.

Strategies to Reduce Stigma and Discrimination

The core values of the Peer Mentoring program draw upon cultural strengths and provide services and assistance in a manner that is trusted by, and aligns with, the community's ethnic and culturally diverse populations. Cultural competence is an essential part of the program development, recruitment and hiring of staff. In addition, Peer Mentors encourage participants and other staff working with the participants to use recovery language. They normalize seeking mental health treatment by sharing their own lived experiences and by discussing how any other individual would seek treatment for a physical illness. Peers also demonstrate empathy, caring and concern to bolster participants' self-esteem and confidence. As a result, a unique bond between the peer and the participant can be developed, which gives the participant space to open up about their reluctance or challenges with medication, services, a doctor, etc.

Outcomes

Of the 352 adults and older adults served in Track 1 during FY 2016-17, 248 individuals (70%) successfully completed their goals with assistance from their Peer Mentor. The most common types of goals for which individuals were referred included learning to navigate the public transportation system; obtaining identification cards or driver's licenses; assisting with housing applications; and increasing socialization activities.

Of the 403 adults and older adults served in Track 2 during FY 2016-17, 216 individuals (54%) were successfully linked to their follow-up behavioral health and/or medical appointments.

Challenges, Barriers and Solutions in Progress

The utilization of Peer Mentors within clinical programs is a relatively new strategy in Orange County and, as with any new program concept, it can take time to promote its services. Educating the various referring sources about Peer Mentoring services is a high priority, and staff provides frequent presentations throughout the county about the services they offer. In addition, homelessness continues to be an issue with regard to the peers' ability to maintain contact with the participants and increased efforts have been made during the initial contact to obtain as much identifying information from the participant as possible on to how to reach them. Initial results from these front-end efforts have been promising.

Community Impact

Peer Mentoring has provided services to more than 1,400 adults and older adults since its inception November 2015. The program recognizes that building County and community partnerships is a priority. Besides the strong ongoing partnerships with referrals sources such as the County and County-contracted clinics and the County CSU, the program also partners with the Wellness Centers, the Council of Aging, NAMI and housing agencies.

Behavioral Health Services for Independent Living (INN)

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics		
18+	Severe	Field	Homeless/ At Risk	Co-Occuring SUD	Criminal Justice

The program provides services in Spanish.

Target Population and Program Characteristics

The Behavioral Health Services (BHS) for Independent Living project serves individuals ages 18 and older who are living with severe and persistent mental illness (SPMI) and have typically been dependent on others to manage their day-to-day needs or have not had the opportunity to live in a residence without supervision. This includes individuals who are homeless, at risk of homelessness, and have had a history of homelessness or unstable housing situations. Eligible participants should also be receiving behavioral health treatment throughout the duration of services to participate in this project. The project accepts referrals from County and/or community behavioral health providers.

Services

This project utilizes Peer Specialists with experience and knowledge of behavioral health and/or co-occurring disorders to educate participants about the relationship between behavioral health management and independent living. Peer Specialists help participants develop independent living skills by facilitating modules based on five broad categories: health management, core/basic skills, daily living, social skills and vocational skills. Across the broad categories, participants may learn up to 16 independent living skill sets (i.e., symptom management, personal hygiene, transportation, etc.). The education materials were developed by Peer Specialists specifically for this project and include group activities to engage participants. During enrollment, Peer Specialists collaborate with each participant to identify modules and skills sets specific to the individual's goals. Additional services include outreach and engagement, assessment and screening, case management, peer support, and coordination with County and community behavioral health and supportive housing programs.

This project started July 1, 2017. Innovation funds for this project will end June 30, 2022.

Strategies to Promote Recovery/Resilience

This project empowers participants to be engaged and proactive in the management of their mental health. Peer Specialists utilize the recovery model to collaborate with participants and identify their strengths; express their hopes and desires; and select the appropriate modules and skills sets to fit their stated goals. The introductory course focuses on creating a Wellness Recovery Action Plan (WRAP), a self-management and recovery tool designed to empower participants, assist in managing behavioral health symptoms and improve quality of life.

Strategies to Increase Timely Access to Services for Underserved Populations

BHS for Independent Living enhances timely access to its services by providing skills training and other interventions out in the field where the participant is expected to demonstrate that skillset (i.e., in grocery stores, Wellness Center, public transportation, etc.).

In addition, the project anticipates that teaching independent living skills with a focus on improving individuals' abilities to manage their behavioral health will increase participants' knowledge of and access to County and community behavioral health services. This project began enrolling participants in January 2018. Referrals and linkages to County and community behavioral health services will be reported in future Plan Updates.

Strategies to Reduce Stigma and Discrimination

Education modules are taught in one-on-one or group settings and facilitated in natural settings whenever possible to practice acquired skill sets. This interactive process, offered in a supportive group environment, establishes a safe, less stigmatizing approach to learning and mastering independent living skills alongside their peers and project staff.

Outcomes

This project began enrolling participants in January 2018. Key learning objectives include an evaluation of participants' understanding of their mental health diagnosis, knowledge of county and community behavioral health resources, improvement in independent living skills, and improvement in overall well-being. Outcomes will be reported in future Plan Updates.

Wellness Centers (CSS)

Program Serves	Symptom Severity	Location of Services	
18+	Severe	Field	Outpatient Clinic

The program provides services in Spanish, Vietnamese, Farsi, Korean, and Arabic.

Target Population and Program Characteristics

Orange County funds three Wellness Centers through CSS that serve adults ages 18 and older who are living with a serious and persistent mental illness and may have a co-occurring disorder. Members are relatively stable in, and actively working on, their recovery which allows them to maximize the benefits of participating in Wellness Center groups, classes and activities. The Centers serve a diverse member base and Wellness Center West, in particular, has a unique, dual track program that provides groups, classes and activities in English and monolingual threshold languages that meet the cultural and language needs of the population located in the city of Garden Grove. The predominant threshold language in the monolingual track is Vietnamese.

Services

Wellness Centers are grounded in the Recovery Model and provide a support system of peers to assist members in maintaining their stability while continuing to progress in their personal growth and development. The programs are culturally and linguistically appropriate while focusing on personalized socialization, relationship building, assistance with maintaining benefits, setting educational and employment goals, and giving back to the community via volunteer opportunities.

Recovery interventions are member-directed and embedded within the following array of services: individualized wellness recovery action plans, peer supports, social outings, recreational activities, and linkage to community services and supports. Services are provided by individuals with lived experience and are based upon a model of peer-to-peer support in a non-judgmental environment. A wide variety of weekend, evening and holiday social activities are provided for members to increase socialization and encourage (re)integration into the community. The ultimate goal is to reduce reliance on the mental health system and to increase self-reliance by building a healthy network of support which may involve the members' family, friends or significant others.

The Wellness Centers utilize Member Advisory Boards (MABs) composed of members to develop or modify programming and evaluate the successes or failures of groups, activities and classes. They also use a community town hall model and member Satisfaction and Quality of Life surveys to make decisions about programming and activities.

Strategies to Promote Recovery/Resilience

All three of the Wellness Centers provide a safe and nurturing environment for each individual to achieve their vision of recovery while providing acceptance, dignity and social inclusion. Programs are consumer-run, utilizing staff with a history of participating in mental health services, and are committed to providing peer-to-peer promotion and community integration of emotional, physical, spiritual and social domains.

Strategies to Increase Timely Access to Services for Underserved Populations

Many members have experienced isolation for years and have had limited exposure to the community in which they live. Housing, transportation and difficulties associated with homelessness and symptoms of mental illness also prevent members from joining in Wellness Center activities. To help address these barriers, staff at the Wellness Centers share their lived experience with members and connect with them on a more personal level. They serve as role models to members, provide encouragement and hope that recovery is possible, and share that participating in the groups, classes and/or activities could help them develop confidence and skills to assist them on their own recovery journey.

The Wellness Centers are supportive programs that complement clinical programs, and many members are referred by their treatment teams to assist with their recovery. To encourage on-going referrals, Center flyers and monthly Wellness Center activity calendars are distributed to all County and County-contracted programs. In addition, the Wellness Centers frequently perform outreach activities by staffing booths at behavioral health and other community events, and by presenting to community partners that may work with individuals who could benefit from Wellness Center programming.

“The Wellness Center has changed my life.”

– Wellness Center member

Strategies to Reduce Stigma and Discrimination

All three Wellness Centers provide a warm, welcoming and accepting environment, and serve all members who meet program criteria regardless of their personal history, race, ethnicity, gender identity or sexual orientation. Multi-cultural events such as Hispanic Heritage Day, Black History Month and Multi-Cultural Day are very popular with members, and are frequently held to educate and inform members about other cultures and the customs and traditions they enjoy, including dance, music and food. The Wellness Centers also offer a variety of groups such as Diversity Plus and the LGBTIQ group that are specifically designed for the widely diverse membership.

Utilizing peer staff with lived experience with behavioral health issues is key to operating programs of this nature as these staff can relate on a much deeper level with members because they have often walked in their shoes. Peer staff are from a variety of cultures, ethnicities and backgrounds, and have the ability to serve members from all threshold languages.

Employment preparation offered by the Centers help members focus on their experience, skills and what they have to offer, rather than focusing on their illness. Socialization activities held in the community help to develop confidence in members that they, too, can participate in everything their communities have to offer, which helps to reduce isolation and fear. Members often meet up on their own in the community after these socialization activities.

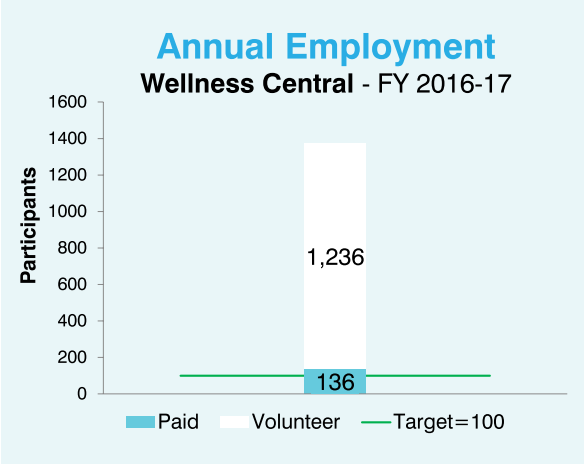
Outcomes

The Wellness Centers served a total of 2,424 adults during FY 2016-17. They assess performance in supporting recovery through two broad categories: social inclusion and self-reliance. Social inclusion is evaluated in two inter-related ways. First, the Wellness Centers encourage their members to engage in two or more groups or social activities each month. As can be seen in the graph, the Centers met this goal as the majority of adults who attended the Wellness Centers were actively engaged in multiple Center-sponsored activities throughout the year (monthly averages ranged from 71% in July to 80-81% in December, February, and June). Second, of the various social activities offered, the Centers particularly encourage their members to engage in community integration activities as a key aspect of promoting their recovery. In FY 2016-17, 2,028 (84%) adults had participated in community integration activities.

Monthly Consumer Participation in Groups

Wellness Centers - FY 2016-17

The Wellness Centers also strive to increase a member's self-reliance, as reflected by school enrollment and employment rates. One hundred and forty one adults enrolled in education classes during FY 2016-17. Thus, this remains a challenging area and HCA staff will continue to work with the providers to strategize new ways to increase interest and enrollment in classes. In contrast, 1,372 adults (56% of total served) were involved in employment during FY 2016-17, largely due to the numbers in volunteer positions (see graph). The programs will continue their efforts to engage members in employment and work toward increasing the number who obtain paid positions.



Challenges, Barriers and Solutions in Progress

A continuing challenge for accessing the Wellness Center programs is transportation, which can take from 45 minutes to two hours each way on public transportation. Each of the Wellness Centers strives to offer activities in different community settings that allow access in members' own neighborhoods without the need for extensive travel on public transportation. With the Centers operating in the West, Central and South regions of the county, access has improved. Development of a Transportation program, not affiliated with any of the Wellness Centers, is also in progress and will assist individuals with the highest transportation needs in accessing these programs.

Community Impact

Since their respective programs' inceptions, more than 6,800 adults have received services at Wellness Center Central, with an average daily attendance of 80 members, six days per week; more than 500 adults at Wellness Center South, with an average daily attendance of 20 members, six days per week; and 800 consumers at Wellness Center West, with an average daily attendance of 55 members per day, six days per week.

FAMILY SUPPORT

A subset of Recovery and Supportive Services focuses on providing support to parents, caregivers and family members as a way to enhance the resilience of children and youth who are at risk of developing, or who are living with, serious emotional disturbance or mental illness. Orange County has four such programs, three of which are funded through PEI and the fourth through CSS.

Recovery and Supportive Services: Family Services	Estimated Number to be Served in FY 18/19	Annual Budgeted Funds in FY 18/19	Estimated Annual Cost Per Person in FY 18/19
Parent Education Services (PEI)	**1,600**	**$1,066,000**	**$666**
Family Support Services (PEI)	**600**	**$282,000**	**$470**
Children's Support and Parenting Program (PEI)	**1,100**	**$1,800,000**	**$1,636**
Mentoring for Children and Youth (CSS)	**200**	**$500,000**	**$2,500**

Parent Education Services (PEI)

Program Serves	Symptom Severity	Location of Services						Typical Population Characteristics					
													
Parents of Children 0-18	At Risk	Home	Field	School	Workplace	Outpatient Clinic	Residential	Families	Homeless/ At Risk	Co-Occurring SUD	Co-Occurring Medical	Students	Criminal Justice

The program provides services in Spanish, Vietnamese, and Farsi.

Target Population and Program Characteristics

Parent Education Services (PES) serves at-risk children and family members, including parents, partners, grandparents, single parents, teenaged parents, guardians or other caregivers in need. Participating families may have behavioral health and mental health issues, substance use or co-occurring disorders, or child welfare or juvenile justice system involvement. They may also be homeless, single-parent households, victims of domestic violence or other trauma, recent immigrants or refugees, or have a child with disabilities (cognitive, emotional, and/or physical). Parents or caregivers are referred to PES from community agencies, schools or other PEI mental health programs that have assessed participants and identified the need for parent education.

Services

The program's purpose is to prevent the occurrence of, or reduce prolonged suffering due to, negative mental health outcomes in children by promoting protective factors in parents and caregivers. It accomplishes this through parenting education classes and individual interventions for parents needing additional support when their issue was not discussed in group or when they needed additional help understanding the parenting curriculum designed to help parents improve their childcare rearing skills, strengthen relationships with their children, increase cooperation and develop problem-solving skills.

The program guides its services through Common Sense Parenting®, an innovative, evidence-based parent training designed to reduce risk factors and increase family protective factors through practical, easy-to-use skills. To ensure fidelity, all parent trainers are required to attend a two-week comprehensive Common Sense Parenting® training prior to conducting classes. Parent trainers are also evaluated in the classroom a minimum of one time per month.

In addition, PES facilitates case management activities, which include engagement, assessment and service coordination and delivery (e.g., navigating and linking to systems, monitoring, and advocating for needs).

Strategies to Promote Recovery/Resilience

"Practicing Self-Care" trainings serve to sustain and/or improve the overall behavioral health of participants and their families. Practicing Self-Care groups provide education and connection with valuable community resources, as well as formal and informal supports. Community providers and participating families offer input that allows staff to facilitate the design and delivery of Practicing Self-Care trainings within a given community.

Strategies to Increase Timely Access to Services for Underserved Populations

PES has developed and implemented county-wide outreach plans that inform residents and agencies on how to identify and refer vulnerable families to the program. The community outreach strategies are conducted by collaborating with existing county and non-profit organizations that serve individuals with trauma, substance use, co-occurring disorders or domestic violence; churches; community and child- and family-serving centers; schools with low achievement rates; early child care centers including Head Start and Early Head Start programs; and

"The single mother of a son who was acting out and having trouble in elementary school shared with the Educator that she felt both of them were experiencing isolation and were both having difficulty with the transition. She additionally shared that she was at a loss of how to help her son and was not sure how to talk with him about the challenges he was having. At the end of the most recent session, she approached the Educator to let her know how much better the relationship between her and her son was. She shared that she utilized the majority of the techniques she learned from the classes to learn how to ask more open-ended questions, engage her son in fun activities, and build a natural support network for herself. She told the Educator that her son's behaviors have decreased and that he is doing much better in school and is very grateful for the classes she has attended."

– Program participant

mental health agencies. The staff also conduct outreach by hosting information tables at health fairs and community and cultural events. Brochures that describe program activities and eligibility are distributed in English, Spanish, Vietnamese and Farsi.

One of PES' challenges is the retention of parents as family and work life often make it difficult for them to attend program activities consistently. To mitigate this challenge, the program works to reduce barriers such as lack of transportation and childcare by conducting the program in locations that are convenient for participants and by providing childcare.

In addition to ensuring timely access to its services, the program works to refer and families to appropriate community supports although these data were not tracked in FY 2016-17.

Strategies to Reduce Stigma and Discrimination

The program determines curriculum for groups based on emerging needs within a community and through collaboration with various community partners. The program employs foreign language speaking professional staff and interpreter services as needed. PES maintains a nondiscrimination admission policy with services making them inclusive to any individual or family that will benefit. To reach the LGBTIQ population, PES staff collaborates with local groups for effective community outreach. Parent Education Services conducts outreach to reach deaf and hard-of-hearing populations via a collaboration developed with the Orange County Deaf Equal Access Foundation (OC DEAF). OC DEAF provides language interpreter services when requested to accommodate participants.

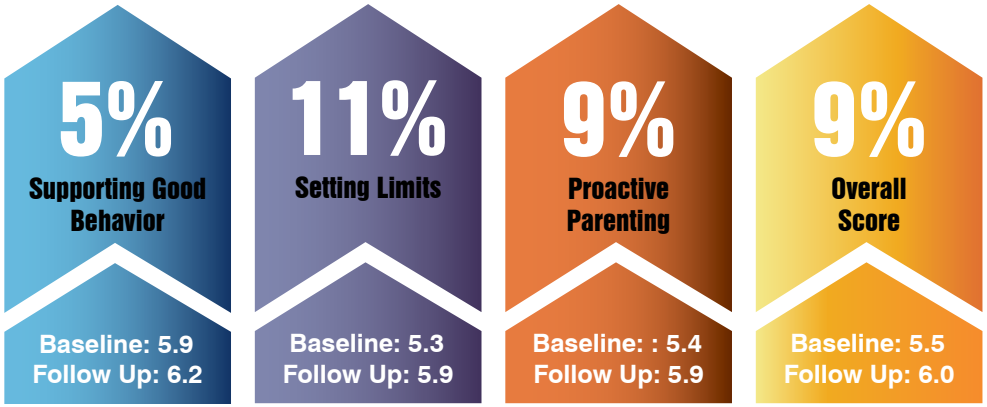
Outcomes

During FY 2016-17, 2,317 participants were served by the program. To assess reduction in negative outcomes, participants' parenting self-efficacy was measured with the PARCA-SE. The evaluation reflects cultural competence as the survey was available in most threshold languages.

During FY 2016-17, parents maintained high levels of parenting efficacy and made small additional gains.[1] The results indicate that the program was effective at maintaining and improving the protective factor of parenting confidence among enrolled participants.

PARCA-SE

PESS - FY 2016-17



Challenges, Barriers and Solutions in Progress

The program recently merged parent education services previously provided through two separate programs based on the age-range of the targeted child/youth: Parent Education and Support Services (PESS) which served families with children ages 0-12, and Family Support Services which served families with youth ages 13-18.

Community Impact

Parent Education Services has provided services to more than 28,000 at risk children and 12,000 families since its inception in October 2012. Program staff have worked collaboratively with area school districts, child welfare, juvenile justice, and children's mental health systems throughout Orange County to support at-risk families.

Reference Notes

[1] *Supporting Good Behavior: Baseline M=5.9, SD = 1.1; Follow up M=6.2, SD=0.9; t(780) = -9.21, p<.001, Cohen's d=.33*

Setting Limits: Baseline M=5.3, SD = 1.3; Follow up M=5.9, SD=1.1; t(780) = -11.25, p<.001, Cohen's d=.41

Proactive Parenting: Baseline M=5.4, SD = 1.3; Follow up M=5.9, SD=1.1; t(780) = -12.09, p<.001, Cohen's d=.44

Overall Score: Baseline M=5.5, SD = 1.1; Follow up M=6.0, SD=1.0; t(780) = -12.04, p<.001, Cohen's d=.43

Family Support Services (PEI)

Program Serves	Symptom Severity		Location of Services	Typical Population Characteristics
0+	At Risk	Early Onset	Field	Families

The program provides services in Spanish, Vietnamese, Farsi, Korean, and Arabic.

Target Population and Program Characteristics

Family Support Services (FSS) serves individuals who are caregivers of persons struggling with behavioral health issues or other stressful conditions that place the caregiver, who is usually a family member, at risk for developing behavioral health issues. The program can also serve other family members as needed. Family Support Services collaborates with community and mental health service providers, especially those that serve ethnically diverse and monolingual communities, to help assess the needs of its community members. By working closely with individuals who know the community, the program is better able to identify those who could benefit from this prevention program.

Services

The program provides ongoing and family education on behavioral health issues to prevent the development of behavioral health problems in other members of the family. Services include a broad range of personalized and peer-to-peer social development services that emphasize behavioral health education, wellness topics and the development of healthy coping tools to support the family. Services are delivered through group support, weekly individual peer mentor support, educational workshops, a volunteer family mentor network and family engagement. The program also recently added a component on practicing self-care when caring for a loved one with a behavioral health condition to the educational workshops.

Strategies to Promote Recovery/Resilience

The model matches trained peer mentors (individuals with lived experience or their family members who have successfully navigated systems of mental and behavioral health services) to families who are currently navigating similar systems. Peer Mentors provide information and individualized instructional and emotional support for families from a first-hand perspective. Family engagement services focuses on creating helpful peer-to-peer relationships between participating families and a trained volunteer family mentor.

Strategies to Increase Timely Access to Services for Underserved Populations

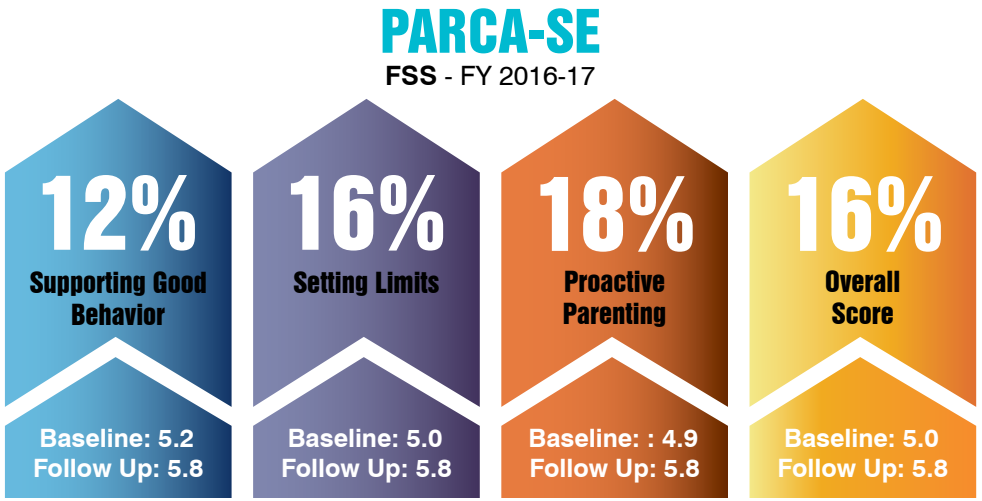
In addition to English, services are available in Spanish, Vietnamese and Farsi, which increases access to services for monolingual, non-English speakers. The program schedules the services at various times (morning, afternoons, evenings) which allows families who work during the day to attend evening classes and families who work during swing or late shifts to attend morning sessions. Family Support Services also conducts classes at locations that are accessible to participants, such as school sites, Family Resource Centers, community centers, churches, county libraries, hospitals, shelters and county jails.

Strategies to Reduce Stigma and Discrimination

The program strives to make its services available to all Orange County residents, regardless of their background, and provides services that are sensitive and responsive to participants' backgrounds. The program employs staff who are bilingual in English and Spanish, Vietnamese and Farsi. Group support and family matching services are available in English, Vietnamese and Spanish. Peer mentoring and childcare services are available in English and Spanish.

Outcomes

During FY 2016-17, a total of 1,741 parents and caregivers were served by the program. The program's purpose is to reduce prolonged suffering from behavioral health issues assessed through increases in participants' parenting self-efficacy. Improvements were noted by measuring the change in parenting PARCA-SE scores between intake (the baseline measurement) and program exit.



There were 651 parents and caregivers served in FY 2016-17 who provided both baseline and follow up assessments. Participants made moderate to large improvements in parenting self-efficacy as evidenced by improvement across all three subscales of the PARCA-SE and the overall parenting score. As with PESS, the FSS results indicate that overall confidence in parenting increased for participants enrolled in the program.

Challenges, Barriers and Solutions in Progress

The program's Family Matching service is challenged with recruitment of participants in the summertime when school is typically out of session and families may be on vacation or busy with summer activities. To mitigate this challenge, the program partners with local community organizations, including Family Resource Centers, which may have direct contact with potential participants during the summer.

Community Impact

The program has served 10,946 total caregivers since program inception October 2012. FSS collaborates with agencies and community groups to ensure that services are provided throughout Orange County. Services are often held at community locations such as libraries and schools.

Reference Notes

[1] *Supporting Good Behavior: Baseline M=5.2, SD = 1.1; Follow up M=5.8, SD=0.9; t(649) = -15.41, p<.001, Cohen's d=.62*
Setting Limits: Baseline M=5.0, SD = 1.2; Follow up M=5.8, SD=0.9; t(648) = -18.18, p<.001, Cohen's d=.73
Proactive Parenting: Baseline M=4.9, SD = 1.2; Follow up M=5.8, SD=1.0; t(647) =-18.34, p<.001, Cohen's d=.73
Overall Parenting: Baseline M=5.0, SD = 1.1; Follow up M=5.8, SD=0.8; t(650) = -19.47, p<.001, Cohen's d=.78

Children's Support and Parenting Program (PEI)

Program Serves	Symptom Severity	Location of Services						Typical Population Characteristics									
6-68	At-Risk	Home	Field	School	Workplace	Outpatient Clinic	Residential	Foster Youth	Parents	Families	LGBTIQ	Veterans	Homeless/ At Risk	Co-Occuring SUD	Co-Occurring Medical	Students	Criminal Justice

The program provides services in Spanish and Vietnamese.

Target Population and Program Characteristics

The program serves a wide range of families from different backgrounds whose stressors make children more vulnerable to developing behavioral health problems. The program serves families that have a common parental history of serious substance use disorder and/or mental illness; families whose family member's actual or potential involvement in the juvenile justice system may make them more vulnerable to behavioral health problems; children living with family members who have developmental or physical illnesses/disabilities; children living in families impacted by divorce, domestic violence, trauma, unemployment and/or homelessness; and children of families of active duty military/returning veterans. Families are referred to the program through Family Resource Centers, schools, behavioral health programs, and other community providers.

Services

The Children's Support and Parenting Program (CSPP) provides a range of services intended to reduce risk factors for children and youth and to increase protective factors through parent training and family-strengthening programs. Services include family assessment; group interventions for children, teens and parents; brief individual interventions to address specific family issues; referral/linkage to community resources; and workshops.

CSPP provides these services utilizing Evidence Based Practice (EBP) curricula, and the program offers two different tracks depending on participant need: Strengthening Families or The Parent Project®. The curricula are delivered in a classroom-type setting in many different types of organizations and agencies such as schools, Family Resource Centers (FRC), treatment facilities, juvenile probation offices and the CSPP program's suite of offices. All staff utilizing one of the EBPs have been trained and certified to deliver the curriculum and adhere to it when presenting the material to participants.

Strategies to Promote Recovery/Resilience

CSPP program curricula are designed to promote recovery from trauma-induced family dysfunction and to increase family resilience. This is done through teaching communication skills, strengthening family roles, defining family goals and rules, teaching families how to take advantage of their own resources and collateral resources, etc.

Strategies to Increase Timely Access to Services for Underserved Populations

Transportation and coordination of schedules can be barriers to services. To address these issues and encourage access to its program, CSPP services are offered in every part of Orange County and are scheduled in the evening to allow most working families to attend. Meals are also served at most CSPP services as a way to encourage participation.

When families share that they have a need for a particular type of resource, clinicians in the program make referrals and follow-up with families to determine whether linkages were successful. In FY 2016-17, the program provided 423 referrals and 162 linkages to the

Community Counseling and Supportive Services program, transportation services, Family Support Services program, food and nutrition assistance, and legal Services and advocacy.

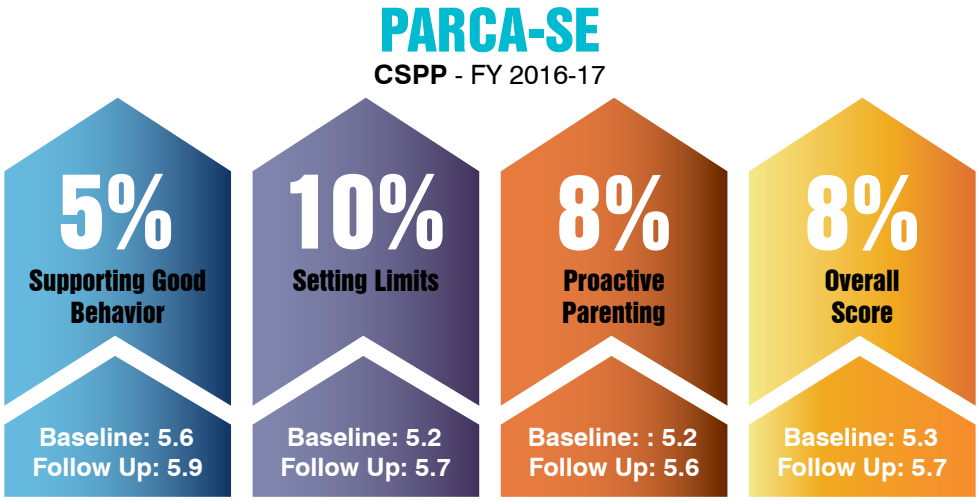
Strategies to Reduce Stigma and Discrimination

Because the stigma of being a "family in need" can be a barrier to seeking services, CSPP is marketed in such a way as to reduce stigma. Most notably, services are offered in community locations where families may already be going for other reasons, such as schools or family resource centers.

Outcomes

During FY 2016-17, 1,065 participants were served by CSPP. The program's purpose is to prevent negative mental health outcomes or reduce prolonged suffering in children by teaching parents effective parenting skills. The presence of skills was measured via the PARCA-SE, which was administered at intake, every three months of program participation and at discharge, and change in scores between intake and the most recent follow-up was evaluated.

The 297 parents who provided baseline and follow up assessments maintained and slightly improved their self-efficacy in the different aspects of parenting skills,[1] thus suggesting that program services helped support positive behaviors in parents.



Challenges, Barriers and Solutions in Progress

Maintenance of program staffing has been challenging in this program as many of the positions are "entry level" in nature and staff quickly promote to other positions. The classification specifications for these programs are being examined to make appropriate changes.

Community Impact

The program has provided services to more than 3,545 participants since its inception July 2011.

Reference Notes

Supporting Good Behavior: Baseline M=5.6, SD=1.1; Follow Up M=5.9, SD=0.94; t(296)=-3.71, p<.001; Cohen's d=0.21
Setting Limits: Baseline M=5.2, SD=1.3; Follow Up M=5.7, SD=0.99; t(296)=-7.50, p<.001; Cohen's d=0.44Proactive Parenting: Baseline M=5.2, SD=1.3; Follow Up M=5.6, SD=1.1; t(296)=-6.42, p<.001; Cohen's d=0.38
Overall Score: M=5.3, SD=1.2; Follow Up M=5.7, SD=0.91; t(296)=-6.59, p<.001; Cohen's d=0.39

Mentoring for Children and Youth (CSS)

Program Serves	Symptom Severity	Location of Services					Typical Population Characteristics	
0 - 25	Severe	Home	Field	School	Workplace	Outpatient Clinic	Parents	Families

The program provides services in Spanish, Vietnamese, Farsi.

Target Population and Program Characteristics

Mentoring for Children and Youth serves youth ages 0-25 who are living with a serious emotional disturbance and are currently receiving behavioral health services at a County or County-contracted outpatient clinic. Youth are referred to the program by their therapist if the therapist has determined that the child could benefit from additional mentoring and socialization experiences out in the community. Parents of participating youth can also receive parent mentoring services.

Services

Mentoring for Children and Youth is a community-based, individual- and family-centered program that recruits, trains and supervises adults to serve as positive role models and mentors for youth. Youth are matched to a mentor who plans 1:1 no-cost or low-cost activities and outings at least three times a month. In addition, the program hosts a group event monthly and a staff/volunteer training quarterly. Working with mentors provides the child an opportunity to socialize, as well as practice skills learned in therapy in a controlled and supportive environment. Mentoring is a logical, cost-effective strategy that provides children and youth with positive reinforcement and caring role models.

Strategies to Promote Recovery/Resilience

Research has demonstrated that formal youth mentoring programs promote positive outcomes such as improved self-esteem, enhanced social skills and resilience when strong relationships are formed and good mentoring practices are implemented.

Strategies to Increase Timely Access to Services for Underserved Populations

Mentoring for Children and Youth encourages timely access to its services by having the mentors provide transportation to and from events, which are scheduled after school hours and on the weekends. In addition, whenever possible, the family is matched with a mentor who speaks the same language to reduce any language barriers to services.

Strategies to Reduce Stigma and Discrimination

Many of the youth referred for these services are isolated, in part, due to experiencing self-stigma. The support of a mentor provides them with the opportunity to participate in important community recreational activities. Something as simple as riding the bus to the mall and having a snack builds confidence in the youth and hope for their families, thus building their resilience and wellness.

Outcomes

A total of 175 children and youth and 21 parents were served in the mentoring program during FY 2016-17. Clinicians and youth identified one or more behavioral goals that would be addressed through mentoring services (i.e., increasing peer socialization, developing hobbies or interests, and/or improving cooperative behavior) and clinicians and mentors rated their progress at the time of discharge. Approximately 2/3 to 3/4 of youth were rated as having made significant progress on these goals, thus demonstrating the mentors' ability to support skill development among participating youth.

Clinician Rating:
Significant Goal Progress
CYBH Mentoring
FY 2016-17

Mentor Rating:
Significant Goal Progress
CYBH Mentoring
FY 2016-17

> **“Helped me with a lot of skills I needed to work with like listening, manners, and being polite. I like it a lot where we just go check stuff out and have some fun.”**
>
> – Youth Participant

Challenges, Barriers and Solutions in Progress

The program succeeds despite two complicated, but necessary processes. First, it is a challenge recruiting volunteer mentors, obtaining background checks and providing training and guidelines on “how to be a mentor.” In addition, CYBH clinicians must identify children and youth who might benefit from the program and then the program must match the child or youth to an appropriate mentor according to characteristics such as gender, interests and/or language spoken. Because of the limited number of mentors available, on occasion it can take some time before a suitable mentor is available and/or identified.

Community Impact

The program has served more than 1,372 children, youth, and their parents since its inception in FY 2009-10. It provides children with the opportunity to practice skills learned in treatment in a safe and controlled environment. Children and youth are provided non-judgmental feedback in a supportive setting, especially when trying out new behaviors.

VETERANS SUPPORTIVE SERVICES

Following upon the success of providing outpatient programs sensitive to the unique needs and culture of Veterans, community stakeholders identified an additional need to extend support to their families. Services such as these promote the health and well-being not just of military-connected family members but of the Veterans themselves by improving the overall resilience, coping strategies and support network of the family unit. HCA currently funds one Veterans Supportive Services project through INN.

Recovery and Supportive Services: Veterans	Estimated Number to be Served in FY 18/19	Annual Budgeted Funds in FY 18/19	Estimated Annual Cost Per Person in FY 18/19
Continuum of Care for Veteran & Military Children and Families (INN)	200	$961,871	$4,000

Continuum of Care for Veteran & Military Children and Families (INN)

The Continuum of Care for Veteran & Military Children and Families Innovation project will provide behavioral health and peer support services to active service members, reservists, veterans (regardless of their discharge status) and their children, spouses, partners and loved ones. The project will integrate military culture and services into Family Resource Centers (FRCs) located throughout Orange County to train non-veteran organizations on how to identify, screen and serve military connected families. It seeks to expand general service providers’ knowledge of how to best meet the needs of military-connected families so that they feel competent and willing to identify and serve this currently hidden population.

Program Serves	Symptom Severity		Location of Services	Typical Population Characteristics	
					
18+	At-Risk	Mild-Moderate	Family Resource Centers	Families	Veterans

The program provides services in Spanish.

Services

The project will be staffed with Peer Navigators who will be co-located within FRCs to provide two key functions: (1) provide case management and peer support to referred participants, and (2) provide military cultural awareness trainings for FRC staff so that they are better able to identify, screen and serve military-connected families. The project will also be staffed with clinicians who, with the on-going support of Peer Navigators, will provide counseling and trauma-informed care, utilizing evidence-based practices.

The project is anticipated to begin services July 1, 2018. Innovation funds for this project will end June 30, 2022.

Strategies to Promote Recovery/Resilience

This project will be staffed with Peer Navigators who have experience and knowledge of military culture. Peer Navigators will train FRC staff on military culture, thereby increasing military cultural awareness among non-veteran organizations. These efforts will promote recovery by building a stronger resource and support network to address the complex needs of veterans and their families.

Strategies to Increase Timely Access to Services for Underserved Populations

By providing services directly within the FRCs, project staff will have the opportunity to connect with participants while they are seeking other services and provide them with timely access to needed behavioral health support and treatment, either directly or by linking them to community programs. The project will also train FRC staff on how best to meet the needs of military connected families so that they feel competent and willing to identify and serve this currently hidden population. More importantly, FRCs will also serve as a new point of entry into behavioral health services, including supportive and treatment services, for military families. The support offered by a military connected peer is expected to increase family members' access to needed services, especially behavioral health care, which they may be reluctant to seek on their own due to the stigma associated with mental illness. The project is anticipated to begin services on July 1, 2018. Referrals and linkages to County and/or community behavioral health services will be reported in future Plan Updates.

Strategies to Reduce Stigma and Discrimination

This project will be embedded in at-risk communities and bring veteran-specific services and support into an easily accessible, inviting and nonclinical setting. Military-connected families seeking FRC resources will have the opportunity to access behavioral health services through a less stigmatizing point of entry. Peer Navigators will also able to connect with families by sharing their military backgrounds, which helps overcome fears of being misunderstood.

Outcomes

The project is anticipated to begin services July 1, 2018. Outcomes will be reported in future Plan Updates.

GENERAL SUPPORTIVE SERVICES

General Supportive Services provide a wide array of supplementary programs designed to improve recovery by helping participants develop skills and/or meet essential needs such as physical fitness or transportation assistance. At present, all programs in this service function are for adults ages 18 and older and are funded through CSS or PEI.

Recovery and Supportive Services: General Support	Estimated Number to be Served in FY 18/19	Annual Budgeted Funds in FY 18/19	Estimated Annual Cost Per Person in FY 18/19
Supported Employment (CSS)	275	$1,371,262	$4,986
Training in Physical Fitness and Nutrition (PEI)	175	$15,000	$86
Transportation (CSS)	TBD	$1,000,000	TBD

Supported Employment (CSS)

Program Serves	Symptom Severity	Location of Services			Typical Population Characteristics				
18+	Severe	Field	Workplace	Outpatient Clinic	LGBTIQ	Veterans	Homeless/ At Risk	Co-Occuring SUD	Criminal Justice

The program provides services in Spanish, Vietnamese, Farsi, and Korean.

Target Population and Program Characteristics

The Supported Employment (SE) program serves Orange County residents ages 18 and older who are living with severe and persistent mental illness, may have a co-occurring substance use disorder, and require job assistance to obtain competitive or volunteer employment. Participants are referred to the program from County and County-contracted Outpatient and Recovery programs, FSPs and select PEI and Innovation programs. Participants must be engaged in behavioral health services during their entire enrollment in the program and have an assigned Plan Coordinator or Personal Services Coordinator who will collaborate with the SE team to assist with behavioral issues that may arise while participating in the program.

Services

The Supported Employment program Individual Employment Plans are developed by the Employment Team with the participant and use the evidence-based Individual Placement & Support employment model to provide services such as volunteer, or competitive job placement, ongoing work-based vocational assessment, benefits planning, individualized program planning, time-unlimited job coaching, counseling and peer support services. These services are provided in English, Spanish, Vietnamese, Korean, Farsi and American Sign Language.

Employment Specialists (ES) and Peer Support Specialists (PSS) work together as an Employment Team. The ES assists participants with employment preparation including, but not limited to, locating job leads, assisting with application submissions and assessments, interviewing, image consultation and transportation issues. The ES also provides one-on-one job support, either by telephone or at the participant's workplace, to ensure successful job retention. The PSS are individuals with lived experience with behavioral health and substance use challenges, and who possess skills learned in formal training, and/or professional roles, to deliver services in a behavioral health setting to promote mind-body recovery and resiliency. PSS work with partici-

> **"I feel the Employment Specialist went above and beyond to help me. All parties at the program were supportive and encouraging. I'm so grateful for it. It is nice to know that there is help and support for people like me."**
>
> **– Program Participant**

pants in developing job skills, and assist the ES in helping the participant identify areas of need for development, and may use techniques such as role modeling, field mentoring, mutual support, and others that foster independence and promote recovery. For those who may not yet be ready for competitive employment, the program offers volunteer opportunities at places of business around the county as a way for them to gain work-related skills and confidence.

Strategies to Increase Recovery/Resilience

Securing meaningful employment represents a significant step toward recovery and re-integration into the community. Staff strives to build working relationships with prospective employers, educate employers to understand mental illness and combat stigma, and serves as the main liaison between the employers and program participants. The ES maintains ongoing, open communication with participant treatment teams to promote positive work outcomes. The PSS provide training and support to participants using the principles of hope, equality, respect, personal responsibility and self-determination. While it is sometimes a concern among the target population that they might lose their benefits such as SSI/SSDI if they become employed, they also recognize that this may be a final step to gaining full independence from the 'system.'

Strategies to Improve Timely Access to Services for Underserved Populations

The SE Program engages in a number of activities to encourage timely access to its services. First, SE staff regularly present at County and County-contracted clinics to encourage referrals to the program. From the day the participant enrolls, the program strives to foster an environment of empathy and hope, which contributes to their ongoing program participation. ES and PSS staff provide person-centered supports in line with the evidence-based model of Individual Placement & Support so that they can support participants in finding and keeping a good job in a supportive work environment. The team is highly mobile and can meet individuals in their communities to provide supported services. The employment team also collaborates with the referring treatment provider to discuss the participant's progress, success stories, and/or any significant behavior that prompts need for clinical interventions.

Strategies to Reduce Stigma and Discrimination

Helping participants find and maintain good jobs in the community is, in and of itself, an act of reducing stigma and discrimination. More and more program participants are requesting assistance in disclosing their barriers to employers. This opens up ample opportunity for staff to have a supportive on-site presence that fosters collaboration and education between the participants and their employers and co-workers. The program promotes participants' successes in maintaining employment and highlights welcoming employers who provide individuals with mental health challenges the opportunity to meaningfully integrate into the communities via competitive employment. This effort is carried out through media exposure via news publication, newsletters, and presentations of success stories at community meetings.

Outcomes

The SE Program served 405 new participants in FY 2016-17, which included 291 new enrollments. Program performance is evaluated by the number of participants who graduate after achieving the State of California job retention benchmark of 90 days in paid employment. In FY 2016-17, 118 of the 203 (58%) job placements resulted in a successful graduation from the program after achieving the employment milestone.

Challenges, Barriers and Solutions in Progress

Demand for SE services has continued to grow and, in response, the north county site expanded in late FY 2015-16 to accommodate up to an additional 50 program participants per year, and south county expanded in FY 2016-17 to accommodate an additional 30 program participants per year.

Community Impact

The SE program has provided services to more than 2,292 adults since its inception August 2006. The program has established a strong presence within Orange County through its collaboration with County and County-contracted clinics and other behavioral health programs, as well as its numerous presentations at job fairs, the Wellness Centers, local MHSA Steering Committee meetings, and the Community Action Advisory Committee meetings.

Training in Physical Fitness and Nutrition (CSS)

Program Serves	Symptom Severity		Typical Population Characteristics		
18+	Mild-Moderate	Severe	Families	Homeless/ At Risk	Criminal Justice

The program provides services in Spanish.

Target Population and Program Characteristics

The Training in Physical Fitness and Nutrition program serves adults ages 18 and older who are experiencing mild to severe symptoms of mental illness and currently receiving County or County-contracted behavioral health services. Participants are referred by the Wellness Centers, Adult Mental Health outpatient clinics, Program for Assertive Community Treatment, and other mental health community programs.

Services

Physical fitness services are provided at a 12,000-square-foot facility specifically designed for people living with physical disabilities or chronic illness. It offers accessible exercise equipment and knowledgeable and trained staff who work with participants to develop a personalized fitness program. The program also offers group support and nutrition education classes.

Strategies to Promote Recovery/Resilience

By encouraging physical activity, proper nutrition and social support in combination with behavioral health services, the program helps promote total health and wellness in its participants.

Strategies to Increase Timely Access to Services for Underserved Populations

By providing gym memberships at no cost, the service allows individuals with limited income to meet their physical fitness and mental health goals that may be set in their care, service or wellness plan.

Strategies to Reduce Stigma and Discrimination

BHS strives to make services available to all Orange County residents and provides services that are sensitive and responsive to participants' backgrounds. The environment is designed to be welcoming and inclusive for people of all levels of physical functioning and mobility.

Outcomes

During FY 2016-17, 68 individuals participated in the program.

Challenges, Barriers and Solutions in Progress

Transportation to the gym was identified as a challenge. To mitigate this barrier, some county behavioral providers provided transportation assistance to the facility.

Community Impact

The program has provided services to 608 participants since its inception September 2013.

Transportation (CSS)

Program Serves	Symptom Severity	Location of Services			Typical Population Characteristics					
										
	Severe	Field	Outpatient Clinics	Hospitals	LGBTIQ	Veterans	Homeless/ At Risk	Co-Occurring SUD	Co-Occurring Medical	Criminal Justice

The program provides services in TBD.

Target Population and Program Characteristics

The Transportation program will serve adults ages 18 and older who need transportation assistance to and from necessary County behavioral health and/or primary care appointments, as well as behavioral health supportive services. Individuals will be referred to the program by their BHS treatment provider.

Services

Individuals will be provided curb-to-curb service, or door-to-door service if they are living with physical disabilities that may require additional assistance entering or exiting the vehicles. All that is required for the person to do is schedule the appointment in advance, and the driver will pick them up at their specified location, take them to their appointment, pick them up after the appointment and take them back to their destination of origin.

Strategies to Promote Recovery/Resilience

A survey on transportation needs conducted at the four large county adult outpatient clinics (Santa Ana, Anaheim, Westminster, and Mission Viejo) indicated that over 40% of missed clinic appointments was a direct result of transportation issues. These issues included, but were not limited to, lack of a car or money for gas or a bus, inability to navigate the public transportation system, the time it takes to use public transportation system, anxiety surrounding using public transportation or riding with others, and reliance on others to get rides to and from appointments. By providing reliable pick-up and drop-off at their requested destinations, it is anticipated that participants will be better able to engage in treatment consistently, thus allowing them to pursue their recovery.

Strategies to Improve Timely Access to Services for Underserved Populations

The program will facilitate timely access to needed behavioral health and medical services for participants with significant transportation-related barriers to care by providing them with the means to attend these appointments.

Strategies to Reduce Stigma and Discrimination

By offering free transportation, the program makes behavioral health and medical treatment equally accessible to individuals in need of care regardless of their socioeconomic means.

Outcomes

The program has not yet been implemented and outcomes will be reported in future Plan Updates.

SUPPORTIVE HOUSING

With the continually increasing cost of housing and its subsequent impact on homelessness, addressing the housing needs of some of our most vulnerable residents, those living with mental illness, has become one of Orange County's most pressing concerns. In partnership with the Orange County Board of Supervisors, the MHSA Steering Committee and community stakeholders, HCA has worked diligently to develop a continuum of MHSA supportive housing programs that range from emergency shelter to permanent supportive housing in order to meet the needs of those living with serious mental illness. In addition to the programs contained in this Service Function, the Full Service Partnerships and BHS Outreach and Engagement provide housing assistance as needed.

Supportive Housing	Annual Budgeted Funds in FY 2018-19
Year-Round Emergency Shelter (CSS)	$1,367,180
Bridge Housing for the Homeless (CSS)	$2,000,000
MHSA/SNHP Housing (CSS)*	$0

* *Although no funding is allocated for the FY 2018-19 budget, at the direction of the Board of Supervisors, $20 million dollars was allocated in the FY 2017-18 budget.*

Year-Round Emergency Shelter

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics				
18+							
18+	Severe	In Shelter	LBGTIQ	Veterans	Homeless/ At Risk	Co-Occuring SUD	Criminal Justice

The program provides services in English, Spanish, and Vietnamese.

Target Population and Program Characteristics

The Year-Round Emergency Shelter program will serve homeless adults with serious mental illness who may also have a co-occurring substance use disorder and are in need of immediate shelter. The beds are expected to be available April 2018. Individuals will be referred to the shelter by BHS Outreach and Engagement (O&E), Orange County Community Resources (OCCR), and a contracted provider that reports to OCCR. Adults will be allowed to bring their pets with them to the shelter.

Services

This program will dedicate 30 beds within an existing 200-bed shelter. In addition to shelter, the program will provide basic needs items (i.e., food, clothing, hygiene goods), as well as case management and linkage to services designed to assist individuals in their transition out of the shelter and into a more stable housing situation. The estimated length of stay for each episode of shelter housing is 120 days. Extensions will be considered on a case-by-case basis.

Strategies to Promote Recovery/Resilience

The program addresses the basic needs of homeless individuals, such as food, shelter and physical safety. Having these needs met is a foundational element of facilitating recovery and preparing individuals for a transition to permanent housing.

Strategies to Improve Timely Access to Services for Underserved Populations

Staff from OCCR's contracted provider and the BHS Outreach and Engagement team will be onsite to conduct needs assessments and make direct linkages to needed services such as to more permanent housing, transportation, behavioral health services, and assistance with benefits acquisition. Bi-cultural/bilingual staff will provide services in English, Spanish and Vietnamese.

Strategies to Reduce Stigma and Discrimination

Individuals who are homeless face a great deal of stigma. While in the shelter, staff works with residents to prepare them to accept permanent housing, so they do not need to live on the streets. Additionally, housing navigators help outreach to potential landlords, to help them see beyond the person's homeless status. This helps to reduce stigma and discrimination from potential landlords, and helps facilitate acquisition of permanent housing.

Outcomes

This program is not yet operational and therefore has no outcomes to report.

Bridge Housing for the Homeless

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics						
										
18+	Severe	Field	Residential Setting	Families	LBGTIQ	Veterans	Homeless/ At Risk	Co-Occuring SUD	Students	Criminal Justice

The program provides services in English and Spanish.

Target Population and Program Characteristics

Bridge Housing will offer transitional housing for adults who have received a certificate from the Orange County Housing Authority for the Continuum of Care (CoC) Program but have been unsuccessful at finding a rental unit, as well as homeless adults who have not yet received a certificate but are beginning the process. Eligible adults (including couples) must be homeless and have a serious mental illness, and may have a co-occurring substance use disorder. People will be referred to the program primarily through HCA Outreach and Engagement (O&E) staff, Orange County Housing Authority (OCHA), County and County-contracted clinics, and Full Service Partnerships (FSPs). This program is scheduled to begin early 2018.

Services

The program will utilize a "Housing First" model, which is an evidence-based approach to getting people off the streets and into housing as soon as possible, even if they are not yet engaged in treatment. Although most will be engaged in services, it is not a requirement for being housed. Services will include housing, meals and assistance in guiding individuals through the CoC process. Staff will assist participants in locating housing units that will accept their CoC certificate, prepare them to be ready to live in permanent housing, and link them to outpatient treatment, if not already linked. Program staff will collaborate with housing navigators and landlords to identify appropriate permanent housing options. Bridge Housing will be available for up to one year for those with certificates and up to 18 months for those who do not yet have a certificate.

Strategies to Promote Recovery/Resilience

The program will address individuals' basic needs, including providing shelter and food. This creates a safe environment in which participants can make progress toward their recovery while securing permanent housing. Staff will use Motivational In-

terviewing to engage participants and help them identify their own needs and struggles. This evidence-based therapeutic approach will facilitate independence through self-discovery, and will help individuals become more ready for independent or supportive housing.

Strategies to Improve Timely Access to Services for Underserved Populations

The Housing First model aims to reduce or eliminate barriers to housing. Staff will work with Housing Navigators and landlords to identify permanent housing options and work with treatment providers to link individuals to services, if they are not already engaged in treatment. Bicultural/bilingual staff will be hired, to ensure availability of services in a variety of languages. They will also collaborate with County and County-contracted clinics and FSPs to link individuals to treatment, as needed.

Strategies to Reduce Stigma and Discrimination

Program staff will conduct community outreach to educate and engage prospective landlords with the goals of improving access to housing options, reducing misconceptions about people living with mental illness and reducing the possibility of discrimination from landlords.

Outcomes

This program is not yet operational and therefore has no outcomes to report.

MHSA Special Needs Housing Program

In contrast to the programs described above that provide time-limited shelter in combination with behavioral health services and supports, the MHSA Special Needs Housing Program is a funding mechanism to develop permanent supportive housing units for individuals living with serious mental illness. It is funded through CSS and governed by requirements that are summarized below.

Program Description and Target Population

Funding for the Local Government Special Needs Housing Program (SNHP), formerly known as MHSA Housing, is used to develop new housing for eligible tenants, with MHSA funding limited to 30% of total development costs for each unit. The California Housing Finance Agency (CalHFA) created the SNHP to replace the MHSA Housing Program which concluded May 2016.

Since the inception of MHSA, Orange County has used MHSA Housing dollars to fund the development of permanent supportive housing (PSH) for some of its most vulnerable residents. Funding allocations include a one-time State allocation of $8 million in FY 2006-07 to develop PSH for Full Service Partnership participants; a one-time State allocation of $33 million in FY 2007-08 carved out of the CSS allocation; the transfer of $5 million in CSS funds in September 2016 following input received during the local community planning process; and the transfer of $20 million total in CSS funds during FY 2017-18 following a directive from the Orange County Board of Supervisors and local community planning process.

SNHP funding, and the MHSA Housing program before it, facilitates the creation of long-term, independent supportive housing for transitional aged youth, adults, and older adults with serious mental illness who may have a co-occurring substance use disorder. To be eligible for MHSA or SNHP housing, a person must be diagnosed with severe and persistent mental illness and be homeless or at risk of homelessness. Additional eligibility requirements can vary at each project due to requirements of other funding partners. Individuals, including couples and families, are referred to permanent supportive housing by County or County-contracted outpatient clinics or FSP providers.

Projects

MHSA Housing/SNHP funds a combination of development costs and Capitalized Operating Subsidy Reserves (COSR). Development costs are used for the acquisition, construction and/or rehabilitation of permanent supportive housing. Operating subsidies primarily help cover the cost difference between what a resident is able to pay and the cost of operating the unit during the time the resident is working on obtaining either entitlement or employment income. Behavioral health and other supportive services are located on-site and off-site to each housing development, to ensure access to mental health, counseling, case management and other supportive services that help residents adjust to and maintain their independent housing.

One-Time Projects:

In FY 2006-07 Orange County was allocated $8 million in one-time CSS funds to develop PSH for individuals with serious mental illness who were receiving services in the Full Service Partnerships. Funds were used to develop 34 units in two housing developments.

MHSA Housing Program:

In FY 2007-08 the State provided Orange County with a one-time allocation of $33 million carved out of the CSS allocation. These funds have been used in 10 housing developments to create an additional 112 new units of PSH in Orange County, with another 48 units under construction. The 48 MHSA units currently under construction are part of three housing developments:

- The Depot at Santiago in Santa Ana has 10 units and will be completed by April 2018.
- Fullerton Heights has 24 units will be completed by summer 2018.
- Oakcrest Heights in Yorba Linda will create an additional 14 MHSA units.

The following table provides details about these one-time and MHSA Housing projects which, together, will result in the development of 194 new permanent supportive housing MHSA units for eligible tenants and their families.

Capestone Family Apartments

One-Time Projects	One Bedroom MHSA Units	Two Bedroom MHSA Units	Manager's Unit	Total Units including MHSA
Diamond Apartments	15	9	1	25
Doria Apts., Phase I	10	0	1	60
Subtotal	**25**	**9**	**2**	**85**
MHSA Housing Projects (Completed)				
Avenida Villas	24	4	1	29
Capestone Apartments	19	0	1	60
Cotton's Point Seniors	15 [1]	0	1	76
Doria Apts., Phase 2	8	2	1	74
Alegre Family Apts.	11	0	1	104
Rockwood Apartments	14	1	1	70
Henderson House[2]	14	0	0	14
Subtotal	**105**	**7**	**6**	**445**
MHSA Housing Projects (Under Construction)				
Depot at Santiago	10	0	1	70
Fullerton Heights	18	6	1	36
Oakcrest Heights	14	0	1	54
Subtotal	**42**	**6**	**3**	**160**
Total	**172**	**22**	**11**	**690**

[3] *An additional 12 units are available for use by MHSA-eligible tenants but were not paid for with MHSA dollars. These units are prioritized for people who qualify for 20 hours/week of IHSS assistance.*

[4] *Henderson House is 14 bedrooms, which are considered units, in shared condos.*

The following table provides additional details showing how the $33 million that was allocated to Orange County as part of the initial MHSA Housing program was spent across the 10 MHSA Housing developments. The numbers reflect interest earned, which remains assigned to CalHFA.

Project	MHSA Units	Total Units	Capital	COSR*	Total
Avenida Villas	28	29	$3,259,600	$3,259,600	$6,519,200
Capestone Apartments	19	60	$2,222,734	$2,222,734	$4,445,468
Cotton's Point Seniors	15	76	$1,622,400	$ 400,000	$2,022,400
Doria Apts., Phase 2	10	74	$1,169,850	$ 850,000	$2,019,850
Alegre Apartments	11	104	$1,286,835	$1,286,835	$2,573,670
Rockwood Apartments	15	70	$1,897,974	$1,325,000	$3,222,974
Henderson House	14	32	$1,771,442	$1,771,442	$3,542,884
Depot at Santiago	10	70	$1,265,320	$ 350,000	$1,615,320
Fullerton Heights	24	36	$3,150,000	$3,150,000	$6,300,000
Oakcrest Heights	14	54	$1,699,143	$ 851,655	$2,550,798
Total	**160**	**605**	**$19,345,298**	**$15,467,266**	**$34,812,564**

* *Capitalized Operating Subsidy Reserves*

MHSA Special Needs Housing Program (SNHP): Local stakeholders have identified an on-going and persistent need for housing for individuals who are living with serious mental illness and are homeless or at risk of homelessness. As such, $5 million in CSS funds was transferred to the SNHP in FY 2016-17 and, upon a directive by the Orange County Board of Supervisors, a total of $20 million was approved and transferred in FY 2017-18. Three projects are in various stages of development (see table below) that will add 64 new SNHP units.

SNHP Projects in the "Pipeline"	Studio SNHP Units	One Bedroom SNHP Units	Two Bedroom SNHP Units	Manager's Unit	Total SNHP Units	Total Units Leveraged Including SNHP	Comments
Veteran's Village	0	20	0	1	20	76	
Aqua	5	4	0	1	9	57	
Econo Lodge	35	0	0	1	35	70	Acquisition/ Rehab project
Total	**40**	**24**	**0**	**3**	**64**	**203**	

Strategies to Promote Recovery/Resilience

Residential Clinical Services Coordinators (RCSCs) visit the various housing developments each week in order to help residents adjust to and maintain permanent housing, including acting as a liaison between property managers and residents to resolve issues.

Strategies to Improve Timely Access to Services for Underserved Populations

Behavioral health programs provide their services on-site or off-site, promoting easy access to services. In addition, most housing sites are located near public transportation routes in order to enhance residents' access to transportation, as many residents do not own a car.

Strategies to Reduce Stigma and Discrimination

Staff educates property managers about mental illness. Property management staff is also provided training in Mental Health First Aid, Safe Talk, and other relevant trainings to help property managers know how to better respond and communicate with residents who have mental illness.

Challenges, Barriers and Solutions in Progress

HCA recognizes that the demand for safe housing for individuals living with mental illness and their families is far outpacing current availability. Thus, staff continually look to identify new opportunities for developing housing for this vulnerable population, which includes staying apprised of No Place Like Home and other funding opportunities, and leveraging resources with other community and County partners.

Community Impact

Increasing access to permanent supportive housing helps to break the cycle of homelessness for many individuals with serious mental illness by improving housing stability, employment, and mental and physical well-being. Permanent supportive housing also results in reduced hospital and emergency room visits, and fewer arrests and incarcerations. In addition, these MHSA units are integrated in larger housing developments that provide an additional 496 non-MHSA units of critically needed affordable housing in Orange County.

Behavioral Health Services
System Support

Workforce Education and Training

Capital Facilities and Technological Needs

BHS System Support refers to the infra-structure that maintains the behavioral health system itself. Funds develop the behavioral health workforce, the facilities in which MHSA services are provided and/or administered, and the technology that supports service delivery.

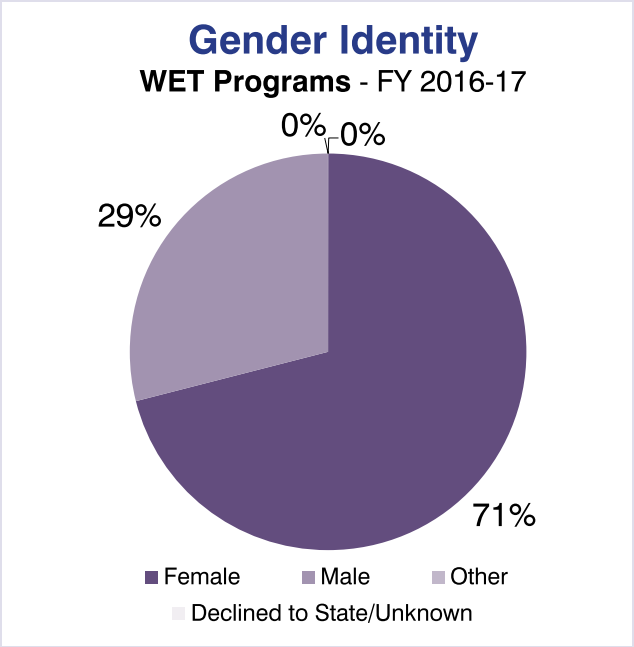
WORKFORCE EDUCATION AND TRAINING

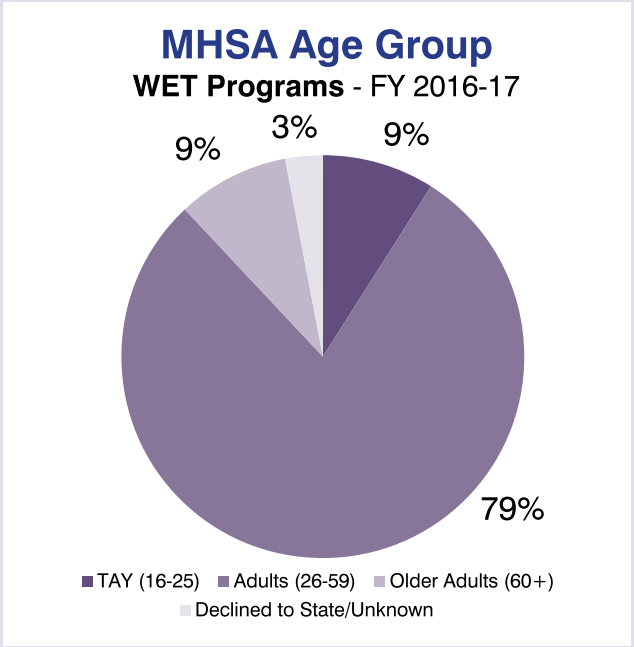
The mission of the MHSA Workforce Education and Training (WET) component is to address community-based occupational shortages in the public mental health system. This is accomplished by training staff and other community members to develop and maintain a culturally and linguistically competent workforce that includes consumers and family members and is capable of providing consumer and family-driven services. Thus, WET offers education and trainings to county staff and contracting community partners that promote wellness, recovery and resilience. The WET Coordinator also serves as a liaison to the Southern California Region (SCRP) of WET Coordinators. WET Coordinators from neighboring counties collaborate on and coordinate mutual projects such as trainings, core competencies and conferences to increase workforce diversity and opportunities in the public mental health system.

Following the passage of Proposition 63, the State provided each county with a one-time funding allocation to develop its WET infrastructure. Orange County's allocation of $8,948,100 was exhausted in FY 2013-14. Since then, available dollars from Community Services and Supports (CSS) have been used to fund WET. Counties are allowed to transfer CSS funds to WET, as well as Capital Facilities and Technological Needs (CFTN), and the Prudent Reserve, so long as the total amount of the transfers within a fiscal year do not exceed 20% of the County's most recent five-year average of its total MHSA allocation. Below are the FY 2018-19 funding allocations for Orange County's WET programs – described in greater detail below – designed to serve the Orange County behavioral health workforce, mental health consumers and their family members.

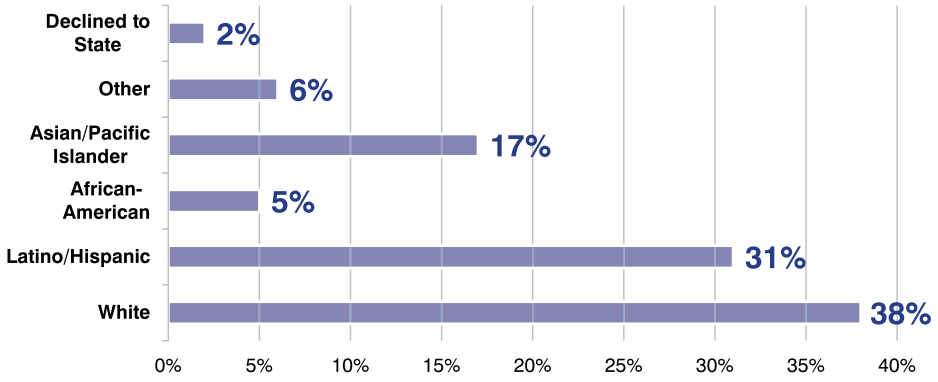
Workforce Education and Training Programs	FY 2018-19 Budgeted Funds
Workforce Staffing Support (CSS)	$1,120,000
Training and Technical Assistance (CSS)	$1,438,000
Mental Health Career Pathways (CSS)	$927,000
Residencies and Internships (CSS)	$238,381
Financial Incentives Programs TOTAL (CSS)	$641,265

In FY 2016-17, a total of 8,949 individuals attended WET trainings and activities. As can be seen in the graphs below, an overwhelming proportion of participants who completed a survey (87%) identified as adult, female, English-speaking, and White/Caucasian or Latino/Hispanic.

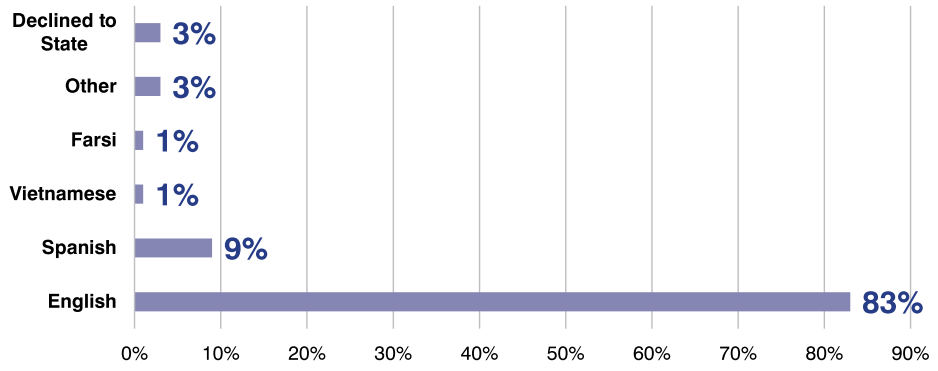




Race/Ethnicity
WET Programs - FY 2016-17



Primary Language
WET Programs - FY 2016-17



Workforce Staffing Support

Program Serves	Typical Population Characteristics			
18+	Parents	Families	Staff/Providers/ Workforce	Regional Counties WET Coordinator, Teachers, Caregivers, Consumers, General Community Members

The program provides services in English, Spanish, Vietnamese, Farsi, Arabic, and Declined to State.

Program Description / Impact

The Workforce Staffing Support (WSS) program performs four functions: (1) Workforce Education and Training Coordination, (2) Consumer Employment Specialist Trainings, (3) Consumer Employment Specialist One-on-One Consultations, and (4) the Liaison to the Regional Workforce Education and Training Partnership. WSS services are provided for the Orange County behavioral health workforce, consumers, family members, and the wider Orange County community.

Workforce Education and Training Coordination:
Orange County WET regards coordination of workforce education and training as a key strategy to promoting recovery, resilience, and culturally competent services. As part of WSS, multidisciplinary staff members design and monitor WET programs, research pertinent training topics and contents, and provide and coordinate trainings. In FY 2015-16, staff members sought to increase training access by launching an online training program that offered Continuing Education (CE) and Continuing Medical Education (CME) credits. This online service provided an alternative to county and county-contracted providers who otherwise would not be able to attend a live training. In FY 2016-17, WET provided nine online trainings.

In addition, WET provided a large number of in-person professional development trainings in FY 2016-17. Training subjects included, but were not limited to, Law and Ethics; Legal Requirements and Ethical Guidelines with Confidentiality, Client Records, Documentations and Mandated Reporting; 5150/5585 Involuntary Hospitalization and Designation; Patients'

Rights Advocacy Services; Respect and Dignity; Rights for Individuals in Inpatient and Outpatient Mental Health Facilities; Developing and Enhancing Competence in Clinical Supervision; Housing Placement; Raising Awareness About First Episode of Psychosis; Psychopharmacology; Current Drug Trends in Orange County; Orange County Crisis Response Training; Putting the Puzzle Together: The Road to Child Protection; and Understanding ASAM Criteria in the Context of the California Treatment System.

136
Trainings

3,997
Attendees

The Multicultural Development Program (MDP), which falls under WET, consists of staff with language proficiency and culturally-responsive skills who support the workforce by providing trainings on various multicultural issues and by providing translation/interpretation services. In FY 2016-17, a total of 104 interpretations in Spanish, Vietnamese, Arabic, Farsi and ASL were conducted at MHSA Steering Committee and other community meetings. MDP staff also translated, reviewed and field-tested a total of 419 documents into the threshold languages of Spanish, Vietnamese, Farsi, Korean and Arabic. In addition, a Licensed Marriage Family Therapist (LMFT) serves in the MDP as a Deaf and Hard-of-Hearing Coordinator to ensure that American-Signed-Language (ASL) interpretation support is provided at trainings and MHSA Steering Committee and community meetings.

In FY 2016-17, the Ethnic Services Manager and staff continued organizing the Cultural Competence Committee meetings. The Committee consists of multi-ethnic partners and multi-cultural experts in Orange County. Over the fiscal year, 223 (duplicated) committee members attended and provided input on how to incorporate cultural sensitivity and awareness into BHS-sponsored trainings on various behavioral health topics. The goal of these activities was to provide linguistically and culturally appropriate behavioral health information, resources and trainings to underserved consumers and family members.

67
Trainings

691
Attendees

Consumer Employment Specialist Trainings/Consumer Employment Specialist One-on-One Consultations:
As part of WSS, a Consumer Employment Support Specialist works with Behavioral Health Services, contract providers and community partners to educate consumers on disability benefits. In FY 2016-17 the specialist provided trainings on topics such as Ticket-to-Work, Reporting Overpayment, Housing, and Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI). One-on-one SSI/SSDI Work Incentive consultation was also provided to consumers who requested more in-depth guidance.

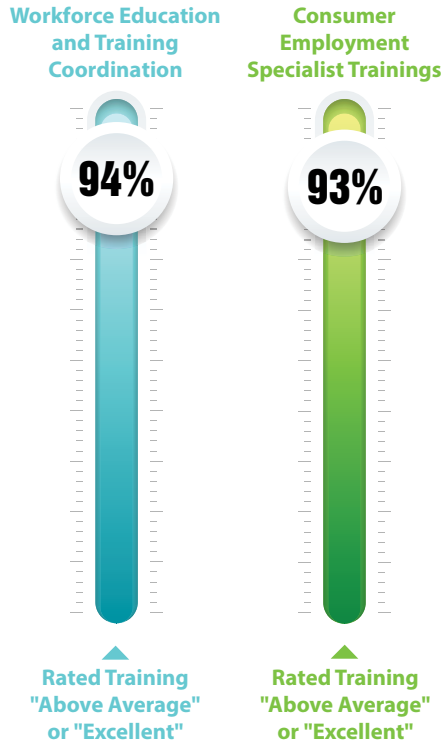
Liaison to Regional Workforce Education and Training Partnership:
The Liaison represents Orange County in the following activities: coordinating regional educational programs; disseminating information and strategies regarding consumer and family member employment throughout the region; sharing strategies that increase diversity in the public mental health system workforce; disseminating Orange County program information to other counties within our region; and coordinating regional actions that can take place within Orange County.

Participant Satisfaction

In FY 2016-17, WSS programs provided trainings to a total of 4,689 individuals including County staff, County-contracted staff and general community members. Satisfaction ratings were collected and reported by participants who filled out a survey after completing training. Of the 3,997 individuals who attended a training, 85% completed a survey. Trainings received an average score of 8.9 on a 10-point scale on overall satisfaction. In addition, 94% of the respondents rated their training as "Above Average" or "Excellent."

Eighty-three (83) percent of 611 individuals who received trainings from the Consumer Employment Specialist in FY 2016-17 filled out a training survey. Participants reported an average satisfaction rating of 8.9 on a 10-point scale and 93% rated the training as "Above Average" or "Excellent."

Workforce Staffing Support
FY 2016-17



Training and Technical Assistance

Program Serves	Typical Population Characteristics					
18+	Parents	Families	Students	Law Enforcement	Staff/Providers/ Workforce	Teachers, Caregivers, Consumers, General Community Members

The program provides services in English, Spanish, Vietnamese, Farsi, Korean, Arabic, and ASL.

Program Description/Impact

The Training and Technical Assistance (TTA) program offers trainings on evidence-based practices, the consumer and family member perspective, and multicultural competency for mental health providers, and on mental health training for law enforcement. In FY 2016-17, TTA provided a total of 112 trainings for 3,465 attendees, which are described in more detail below.

Evidence-Based Practices:

57 Trainings **1,318** Attendees

Trainings on Evidence-Based Practices were conducted to help behavioral health providers stay current on best practice standards in their field. County and contracted staff, community partners, consumers and their family members attended evidence-based training on topics such as Mental Health First Aid, Eye Movement Desensitization and Reprocessing (EMDR), Nonviolent Crisis Intervention Training, Applied Suicide Intervention Skills Training (ASIST), Anger Management and Integrative Treatment of Complex Trauma for Adolescents.

Consumer and Family Member Perspective:

Consumers and their family members sat on a panel where they shared their lived experience with county and county-contracted behavioral health personnel. The panel members presented on their lived experiences to help reduce stigma and to raise awareness of behavioral health conditions.

9 Trainings **378** Attendees

30 Trainings **1,324** Attendees

Cultural Competence:

Culturally responsive trainings were conducted to raise cultural awareness and humility among behavioral health providers and community partners. Topics included Mental Health Interpreter Training and Principles, How to Communicate Effectively with Deaf and Hard-of-Hearing Individuals, Working Effectively with Sign Language Interpreters in a Behavioral Health Setting, Understanding Client Culture and Journeys, and Spiritual Resilience, Healing and the Brain.

Foster Parents & Others Working with Foster Children & Youth:

1 Trainings **73** Attendees

WET conducted a training on Trauma-Informed Care for Children, Youth, Transitional Age Youth (TAY) and Families in Foster Care. The training recognized the impact of grief, loss and trauma as it relates to the social, emotional and behavioral functioning for individuals within the foster care system.

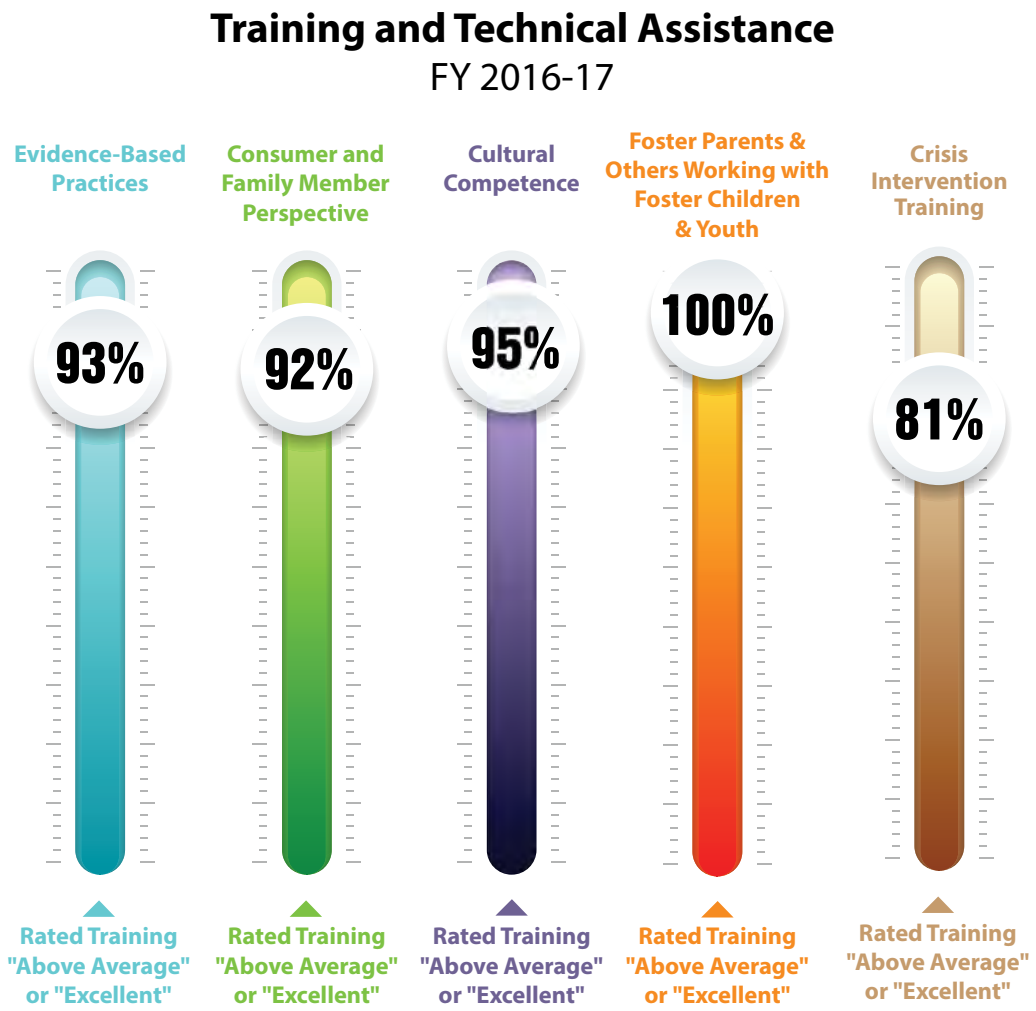
Crisis Intervention Training for Law Enforcement:

15 Trainings **372** Attendees

The best-practice Crisis Intervention Training (CIT) was provided to Orange County law enforcement officers to help raise their awareness about the mental health needs of the community. As first responders, law enforcement officers can help provide linkages to available mental health resources when responding to mental health crises. The 16-hour CIT I curriculum was conducted by a psychologist, subject matter experts, law enforcement, contracted providers, and individuals living with mental illness and their family members. In FY 2015-16, an eight-hour CIT II class was added to the Professional Officer Standards Training (POST) and Standards and Training for Corrections (STC) certified curriculum to include training on Dementia, Developmental Disorders-including Autism Spectrum Disorder, and how to work with Deaf-and-Hard of Hearing individuals. An Interactive Video Simulator with behavioral health scenarios provided hands-on training

“Wonderful training! One of the best I have experienced in 15 years with the county.”

– Foster Parents & Others Working with Foster Children and Youth participant



and prepared law enforcement officers and public safety personnel to identify the various needs of individuals grappling with mental health, substance use, dual diagnosis and homelessness.

Participant Satisfaction

WET trainings and technical assistance continue to be well-received by participants. The average participant satisfaction ratings ranged from 8.0-9.5 on a 10-point scale across the categories:

- Evidence-Based Practices: 9.1
- Consumer and Family Member Perspective: 8.9
- Cultural Competence: 9.4
- Foster Parents & Others Working with Foster Children and Youth: 9.5
- CIT for Law Enforcement: 8.0

In addition, as can be seen in the graphic, the percentage of participants who rated their training as “Above Average” or “Excellent” was extremely high.

Mental Health Career Pathways

Program Serves	Typical Population Characteristics									
18+	Foster Youth	Parents	Families	LGBTIQ	Veterans	Homeless/ At Risk	Co-Occuring SUD	Students	Criminal Justice	Staff/Providers/ Workforce

The program provides services in English, Spanish, Vietnamese, Farsi, and ASL.

Program Description/Impact

Mental Health Career Pathways offers courses through the Recovery Education Institute (REI), which prepares individuals living with mental illness and their family members to pursue a career in behavioral health. REI provides training on basic life skills, career management and academic preparedness, and offers certified programs to solidify the personal and academic skills necessary to work in behavioral health. Most REI staff possesses personal lived experience. In FY 2016-17, REI provided 187 total trainings to 750 active students. Of the 223 newly enrolled students, 54% identified themselves as living with a behavioral health condition, 30% identified themselves as family members of those living with a behavioral health condition and 16% identified as both.

REI also employs academic advisors and peer success coaches to mentor and tutor students. In FY 2016-17, REI enrolled 223 new students. The number of one-on-one support sessions provided to students is reported below.

Support Sessions

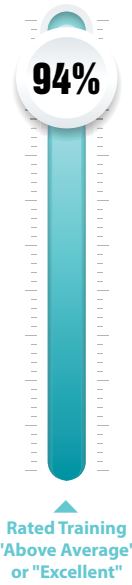
Academic Advisement	Success Coach Contacts	Total	
2,130 Duplicated	1,119 Duplicated	2,130 Duplicated	479 Unduplicated

Workshops	Pre-Vocational Courses	Extended Education	College Credit Courses
95 offered	65 offered	10 offered	17 offered
66% completion rate	94% completion rate	71% completion rate	93% completion rate

At REI, a wide variety of trainings are offered including Introduction to Microsoft Excel Spreadsheets, Elementary Spanish for Public Speaking, Introduction to Psychology, Case Management, Vocational Skills Building, and Self-Esteem and Confidence. REI collaborates with adult education programs, links students to local community colleges for prerequisite classes, and provides accredited college classes and certificate courses on-site. As can be seen below, a high percentage of students completed the REI workshops and classes that were offered in FY 2016-17.

In addition, REI contracts with Saddleback College to offer a Mental Health Worker Certificate program that prepares students to enter the public mental health workforce. Students gain knowledge and skills in the areas of cultural competency, the Recovery Model, co-occurring disorders, early identification of mental illness and evidence-based practices to name a few. To receive certification, students must complete nine three-unit courses and a two-unit, 120-hour internship. In addition, REI/Saddleback College added courses in alcohol and drug studies that integrates theory and practical experience to develop the skills necessary to work with individuals living with substance use disorders. Students who complete all required courses also receive a certificate in Alcohol & Drug Studies.

Mental Health Career Pathways
FY 2016-17



Participant Satisfaction

The average overall satisfaction rating reported by the 553 participants who filled out a survey after completing a Recovery Education Institute Program in FY 2016-17 was 9.2 on a 10-point scale. In addition, 94% of the respondents rated their training as "Above Average" or "Excellent."

Residency and Internship Programs

Program Serves	Typical Population Characteristics	
18+	Students	Staff/Providers/Workforce

The program provides services in English and has a TDD number for hearing impaired callers.

Program Description/Impact

The Residencies and Internships program trains and supports individuals who aspire to work in the public mental health system. In FY 2016-17, eight pre-doctoral student interns participated in the California Psychology Internship Council (CAPIC) program and volunteered a total of 15,000 clinical hours. Three of the eight student interns were placed in WET's Neurobehavioral Testing Unit (NBTU) and were supervised by a licensed psychologist.

In collaboration with the Psychiatry Department at the University of California Irvine (UCI) School of Medicine, WET funded six residencies and three fellowships in FY 2016-17. The psychiatry residents and fellows provided a total of 3,744 clinical hours. Supervised trainings provided in the program teach the recovery philosophy; enhance cultural humility and understanding from the consumer and family perspectives; and recruit talented psychiatry residents and fellows into the public mental health system. The funded positions and training are one strategy used to address the shortage of child and community psychiatrists working in community mental health.

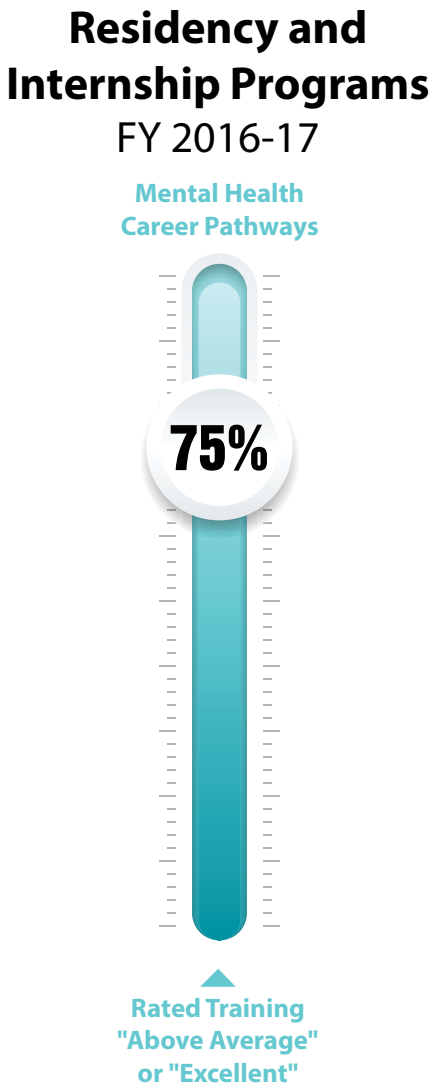
8 Psychology Intern
15,000 Clinical Hours

3 Psychiatry Fellows
1,248 Clinical Hours

6 Psychiatry Residents
2,496 Clinical Hours

Participant Satisfaction

The average overall satisfaction rating reported participants who filled out a survey after completing the Residency and Internship Program in FY 2016-17 was 7.5 on a 10-point scale. In addition, 75% of the respondents rated their training as "Above Average" or "Excellent."



"I'm deeply grateful for the opportunity to complete my undergraduate education. Without this program, I wouldn't be able to accomplish the educational goal while working in a full time job and being a single mother. I'm also grateful for the flexibility my supervisor has given to me and the FIP Coordinator has made it very easy for me because I didn't have to worry about the financial part of my education."

– Program participant

Financial Incentive Programs

Program Serves	Typical Population Characteristics
	 Staff/Providers/Workforce

The program provides services in Spanish, Vietnamese, and Korean.

Program Description/Impact

As part of the current Three-Year Plan, the Financial Incentives Programs category now contains two tracks: the Financial Incentive Program for college students and the Psychiatrist Loan Repayment Program. The former program provides financial incentive stipends to BHS County employees at the Bachelor (BA/BS), and Masters (MA/MS) levels to expand a diverse bilingual and bicultural workforce. The Orange County WET Office collaborates with numerous colleges and universities to provide stipends to students who, in return, are encouraged to work for county or county-contracted agencies upon their graduation. In FY 2016-17, tuition incentives were provided to 20 staff, three of whom were undergraduates and 17 of whom were Masters' degree candidates. Eleven identified as Mexican or other Latino, 10 of whom reported Spanish as their primary language, and six identified as Asian and Pacific Islander.

Beginning in FY 2015-16, Financial Incentives Programs introduced the Orange County Mental Health Loan Assumption Program (OC-MHLAP) for psychiatrists. The program attempts to address the shortage of community psychiatrists working in the Public Mental Health System (PMHS) that is further impacted by strong recruiting competition from private sector organizations and other governmental agencies. To be eligible for the program, an award recipient must work in the County PMHS in exchange for the loan assumption. This additional OC-MHLAP program will help achieve staffing goals and enhance the quality of care to Orange County's population by improving the recruitment and retention of qualified psychiatrists. In FY 2016-17, a total of eight psychiatrists participated in the Loan Repayment Program.

BA Stipends	Graduate Degree Stipends	Psychiatry MHLAP
3	17	8

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS

The Capital Facilities and Technological Needs (CFTN) component of the Mental Health Services Act (MHSA) was designed to enhance the existing public mental health services infrastructure. It provides resources for two types of infrastructure:

1. Capital Facilities funding may be used for the delivery of MHSA services for mental health clients and their families or used for MHSA administrative offices.

2. Technology funding may be used to modernize and transform clinical and administrative information systems and increase consumer and family empowerment by providing the tools for secure consumer and family access to health information.

CFTN funding is one-time funding. Counties were given one allocation to cover both purposes, and were given the discretion to divide the funding between Capital Facilities and Technological needs. Orange County received slightly more than $37 million for this component. Of that amount, 35% was allocated to Capital Facilities and 65% was allocated to Technology.

Capital Facilities

Requirements for CF Funds

A county may use MHSA Capital Facility funds for the following types of projects:

- Acquire and build upon land that will be county-owned
- Acquire buildings that will be county-owned
- Construct buildings that will be county-owned
- Renovate buildings that are county-owned
- Renovate buildings that are privately-owned and dedicated and used to provide MHSA services if certain provisions are met (i.e., renovations benefit MHSA clients or MHSA administration's ability to provide services/programs in the county's Three-Year Plan, costs are reasonable and consistent with what a prudent buyer would incur, a method for protecting the capital interest in the renovation is in place)
- Establish a capitalized repair and replacement reserve for buildings acquired or constructed with Capital Facilities funds, and/or personnel cost directly associated with a CF project, i.e., a project manager. The reserve will be controlled, managed and disbursed by the county.

In addition, the California Department of Mental Health outlined the following requirements for CF funds:

- Capital Facilities funds can only be used for those portions of land and buildings where MHSA programs, services and administrative supports are provided and must be consistent with the goals identified in the Community Services and Supports and Prevention and Early Intervention components of the county's Three-Year Plan.
- Land acquired and built upon or construction/renovation of buildings using CF funds shall be used to provide MHSA programs/services and/or supports for a minimum of twenty years.
- All buildings through CF must comply with federal, state and local laws and regulations including zoning and building codes and requirements; licensing requirements, where applicable; fire safety requirements; environmental reporting and requirements; hazardous materials requirements; the Americans with Disabilities Act (ADA), California Government Code Section 11135 and other applicable requirements.
- The county shall ensure that the property is updated to comply with applicable requirements, and maintained as necessary, and that appropriate fire, disaster and liability insurance coverage is maintained.

- Under limited circumstances counties may "lease (rent) to own" a building. The county must provide justification why "lease (rent) to own" is preferable to the outright purchase of the building and why the purchase of such property with MHSA Capital Facilities funds is not feasible.

For purchase of land with no MHSA funds budgeted for construction of a building or purchase of a building (i.e. modular, etc.), the County must explain its choice and provide a timeline with expected sources of income for the planned construction or purchase of building upon this land and how this serves to increase the County's infrastructure.

Use of One-Time CF Allocation

In May 2012, the Health Care Agency completed the construction of a Capital Facilities-funded project on County-owned property located at 401 S. Tustin Street in Orange. The completed project occupies approximately three acres and includes three facilities designated for use by three different MHSA programs, surface parking, underground utilities, sidewalks, landscaping, landscape irrigation, fire lanes, recreation areas, an amphitheater, area lighting, building security, signage, and perimeter fencing. The official ribbon-cutting ceremony was held on April 19, 2012. The first program took occupancy and became operational on May 19, 2012 and the remaining two programs became operational by August 2012.

Programs that occupy the Tustin Street Facility include the:

1. Wellness/Peer Support Center - Central, which facilitates over 85 groups weekly, including social outings, and has a growing number of members volunteering in the community as their way of giving back.
2. AOABH Crisis Residential Program, which serves as an alternative to hospitalization for individuals experiencing a behavioral health crisis who may be at risk of psychiatric hospitalization.
3. Education and Training Center, which provides support to individuals living with mental illness and their families who want to enhance living skills or basic education, or aspire to a career in mental health.

CSS Transfers to CF

Youth Core Services Renovations: A one-time $200,000 transfer to CFTN from unspent FY 2017-18 Youth Core Services funds will be used to cover upgrade costs to a County-owned CYBH facility that houses MHSA staff and/or serves MHSA clients. Renovations will bring the facility up to code to meet safety and American's with Disabilities Act, etc. regulations.

Co-Located Services Facility: As part of Orange County's current MHSA Three-Year Program and Expenditure, $9 million has been transferred from CSS to Capital Facilities for purchase of a building to be used for the Co-Located Services strategic priority (Anita Drive Facility). This facility will offer co-located mental health and substance use services programs loosely modeled after the Restoration Center in San Antonio, Texas. The current $9 million in CF will be used specifically for the purchase of a facility identified in Orange and future funds will likely be requested to cover renovation costs. It is anticipated that the facility will house services such as a Crisis Stabilization Unit, Crisis Residential Program, and other intensive behavioral health outpatient services that are still pending development. On-going funding for services will be covered under CSS.

Technological Needs

Requirements for Use of Technology Funds

Any MHSA-funded technology project must meet certain requirements to be considered appropriate for this funding category.

1. It must fit in with the State's long-term goal to develop an Integrated Information Systems Infrastructure where all counties have integrated information systems that can securely access and exchange information.
2. It must be part of and support the County's overall plan to achieve an Integrated Information Systems infrastructure through the implementation of an Electronic Health Record (EHR).

Use of Technology Funds (One-Time and CSS Transfers)

County of Orange Behavioral Health Services (BHS) is implementing a fully integrated EHR system that supports the goals of MHSA to promote wellness, recovery and resilience. It also aims to comply with the federal requirements for Meaningful Use which is a standard designed to benefit the individuals served. This is a large project that has been divided into three phases that will span several years, and includes acquisition and implementation of software, technology infrastructure upgrades and services to develop and implement the overall system.

The first phase of the project plan culminated in the completion of enhanced functionality to the BHS EHR (Integrated Records Information System or IRIS), and successful implementation at a pilot clinic. The enhancements included documentation software designed to help clinicians avoid common errors, as well as electronic prescription software to help psychiatrists manage clients' prescriptions. Additional technical improvements to the EHR include document imaging (which includes functionality such as electronic signature pads and the ability to scan documents), compliance monitoring, auditing and reporting for privacy and security, and enhanced disaster recovery. BHS also successfully implemented kiosks that provide individuals with mental illness and their family members with increased access to computers and the internet at several BHS County-operated outpatient clinics.

The second phase of the project is nearing completion. The EHR continues to be implemented at the remaining County-operated outpatient Mental Health clinics. Technology infrastructure and software enhancements to support additional staff use of the EHR are ongoing. The client portal has been implemented and voice-activated documentation for staff with physical challenges is being piloted at select location. Overall, implementation of the EHR at the County-operated outpatient Mental Health clinics has gone very well and user acceptance is extremely high.

The final phase will address the County's ability to interface securely with its contract providers and to participate in consent-based Health Information Exchanges outside County Behavioral Health Services, as appropriate, including continued compliance with the federal EHR Meaningful Use program. An additional $3,756,082 is being transferred from CSS to bring the FY 2018-19 TN budget to $8,152,825. These funds will cover hardware and software server costs; comprehensive data analytics software; and other EHR and data warehouse upgrades.

Special Projects

Orange County Special Projects are projects that are unique in scale or scope and may cross over several Support Levels and/or Service Functions, often because they involve multiple services, systems and/or agencies.

Mental Health Technology Solutions

Special Projects	Estimated Number to be Served	Annual Budgeted Funds	Estimated Annual Cost Per Person
Mental Health Technology Solutions (INN)*	320,000	$6,000,000	TBD

* *Project features, elements and budget are subject to change based on on-going stakeholder input*

Target Population and Project Characteristics/Background

In October 2017, Los Angeles and Kern Counties sought approval from the Mental Health Services Oversight and Accountability Commission (MHSOAC) for the Mental Health Technology Solutions Innovation project. The suite of mental health-focused apps is designed to increase access to services and the project consists of five core components:

- Tech Apps (3):
  - 24/7 AI (Artificial Intelligence) assisted Peer Chat
  - Therapy Avatar
  - Customized Wellness Coach
- Marketing
- Evaluation

Upon approval, the MHSOAC provided the opportunity for other counties to join as part of a cross-county collaboration, with the conditions that each county facilitates a Community Planning Process, develops its own budget, and seeks individual approval from the MHSOAC to join the project.

In December 2017, Orange County began an extensive Community Planning Process to gather local stakeholder input on joining the project. Weekly meetings were held from December 11, 2017 through January 19, 2018, during which time interest in joining the project, areas of identified need for the suite of technology apps, and a proposed budget were identified and/or developed.

On January 22, 2018, the MHSA Steering Committee approved, with an overwhelming positive response, Orange County's plans to move forward with participating in this project at a four-year total budget of $24 million. The Mental Health Technology Solutions Innovation project will be available to all Orange County residents who own a smartphone or tablet, and/or have access to a computer.

Services

Orange County proposes to join all five components of the Mental Health Technology Solutions project, three of which will provide services to Orange County residents:

- 24/7 Peer Chat app that will offer support delivered by a trained peer mentor, who will be assisted by AI during the chat session. The chat option will also include group chat rooms facilitated by the peer mentors, specifically for family members and/or parents of children living with mental illness.
- Therapy Avatar app that will offer scripted mindfulness exercises and Cognitive Behavioral Therapy interventions delivered through an Avatar. Exercises will be customized through AI and based on a person's responses, allowing for an interactive process between the person and the Avatar.
- A Customized Wellness Coach app that will use the information already gathered by a person's mobile device and use the information to automatically tailor wellness strategies to the person's needs.

Strategies to Promote Recovery/Resilience

The mental health-focused apps each play a significant role in promoting resilience or recovery. The 24/7 Peer Chat component provides support to individuals with behavioral health concerns, helping individuals build resilience and/or supporting them through their recovery. The Therapy Avatar offers behavioral health strategies to aid in symptom management. Lastly, the Customized Wellness Coach offers wellness strategies tailored to each individual and has the potential to detect early warning signs of mental illness. Collectively, the use of the entire suite of apps will support an individual at any stage of their mental health journey and be available when traditional services are unavailable.

Strategies to Increase Timely Access to Services for Underserved Populations

Many individuals cannot access services in a timely manner as a result of challenges related to transportation, finances, employment and/or childcare. Some may also hold cultural beliefs that deter them from seeking help in traditional outpatient settings. Technology has the potential to address these barriers and increase timely access to services through its large-scale impact and around-the-clock access to services and support. The Peer Chat and Therapy Avatar components will offer access to support at any time during the day or night, increasing the options available to individuals seeking help. To address potential barriers for individuals who may not own a smartphone, the peer chat component will also be available via public computers and kiosks. Chat services will also be available in all identified County threshold languages to further reduce barriers related to accessing services.

Strategies to Reduce Stigma and Discrimination

The 24/7 Peer Chat and Therapy Avatar components also have the potential to reduce stigma and discrimination. The chat component will be staffed with peer mentors who have lived experience in behavioral health and recovery. Furthermore, the interaction with an Avatar can offer a sense of safety and security for individuals who experience stigma or shame associated with mental illness. These two components can encourage engagement in mental health support and provide an access point for individuals who prefer support from peers who understand their journey, as well as safety and comfort through the anonymity offered by technology.

Outcomes

This project will evaluate several key learning questions:

- Will individuals either at risk of or who are experiencing symptoms of mental illness use virtual peer chatting accessed through a website or through a phone application?
- Will individuals who have accessed virtual peer chatting services be compelled to engage in manualized virtual therapeutic interventions?
- Will the use of virtual peer chatting and peer-based interventions result in users reporting greater social connectedness, reduced symptoms and increases in well-being?
- What virtual strategies contribute most significantly to increasing an individual's capability and willingness to seek support?
- Can passive data from mobile devices accurately detect changes in mental status and effectively prompt behavioral change in users?
- How can digital data inform the need for mental health intervention and coordination of care?
- What are effective strategies to reduce time from detection of a mental health problem to linkage to treatment?
- Can we learn the most effective engagement and treatment strategies for patients from passive mobile device data in order to improve outcomes and reduce readmissions?
- Can mental health clinics effectively use early indicators of mental illness risk or of relapse to enhance clinical assessment and treatment?
- Is early intervention effective in reducing relapse, reducing resource utilization and improving outcomes and does it vary by demographic, ethnographic, condition, intervention strategy and delays in receiving intervention?
- Can online social engagement effectively mitigate the severity of mental health symptoms?
- What are the most effective strategies or approaches in promoting the use of virtual care and support applications and for which populations?

Community Impact

Based on recent statistics from the National Institute of Mental Health (2016), one in six adults experiences mental illness and one in 25 adults lives with a serious mental illness. Prevention and early intervention are critical, with half of all lifetime cases of mental illness identified by age 14 and 75% by age 24. With a population of approximately 3.2 million residents, this project has the potential for large-scale impact and the ability to support individuals with a range of mental health concerns.

Orange County's Additional Component to the Technology Solutions Project

Special Projects	Estimated Number to be Served in FY 18/19	Annual Budgeted Funds in FY 18/19	Estimated Annual Cost Per Person in FY 18/19
Orange County Additional Component to Technology Solutions*	TBD	$2,000,000	TBD

* *Project features, elements and budget are subject to change based on on-going stakeholder input*

Proposed Target Population and Project Characteristics

With the recent approval of Los Angeles and Kern Counties Mental Health Technology Solutions project, counties were also afforded an opportunity to propose additional components to the core suite of applications. Orange County plans to propose an additional component that will be available to all County residents and designed to increase access to behavioral health services and supports.

In conjunction with the planning process for the Mental Health Technology Solutions project, Orange County facilitated ongoing, weekly meetings beginning in December 2017, to develop the general concept for this additional component. The community planning meetings are expected to continue through April 2018.

Services

The additional Orange County component will include several features to assist individuals in key areas related to mental health, including:

- Housing Assistance (i.e., matching individuals to real-time available housing and providing therapeutic support to promote housing stability)
- Transportation Assistance (e.g., step-by-step directions on how to travel to appointments)
- Coordinated Care (e.g., automated reminders/alerts, etc.)
- Education/Resources (customized to Orange County resources); and
- Crisis Management (pre-crisis/crisis/post-crisis management)

General features of this app will include:

- Synchronization with the Mental Health Technology Solutions suite of apps
- Face-to-face peer support and case management for individuals currently receiving County behavioral health services to assist with system navigation and technical assistance with the app
- Information tailored to users, family members, healthcare providers, first responders

This additional component is still in development. The app name, features, elements and budget may be modified based on stakeholder input during planning meetings, which are open to all Orange County stakeholders.

Whole Person Care

Special Projects	Estimated Number to be Served in FY 18/19	Annual Budgeted Funds in FY 18/19	Estimated Annual Cost Per Person in FY 18/19
Whole Person Care	Whole Person Care funds are included in the Peer Mentoring and BHS Outreach & Engagement program budgets		

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
	 Severe	 Field	 Homeless/At risk

Target Population and Project Characteristics

Whole Person Care (WPC) is the coordination of physical, behavioral, health and social services in a person-centered approach with the goal of improving health and well-being through comprehensive, streamlined service delivery. WPC services are for MediCal beneficiaries living with serious and persistent mental illness (SPMI) and struggling with homelessness.

BHS is leveraging a total of $856,600 in MHSA funds per year for five years to draw down Whole Person Care Federal match dollars. Resulting in a total of $31 million over five years, these dollars fund an array of health services for adults participating in WPC.

- BHS Services:
  - The BHS Outreach and Engagement expansion team uses MHSA funds to identify individuals eligible for WPC and engage them into needed services ($475,927 in MHSA per year)
  - Housing Navigators address barriers that prevent BHS participants from making successful housing placements and work to increase the inventory of available units for homeless adults living with SPMI (funded by WPC)
  - Peer Mentoring expansion provides housing and tenancy-sustaining services to help WPC participants be successful in their housing placements ($380,673 in MHSA per year)
  - Recuperative/Respite Care provides recuperative care beds for homeless adults who are recovering from an acute illness or injury, are no longer in need of acute care but are unable to sustain recovery if living on the street or other unsuitable place (funded by WPC).

Exhibits and Appendices

EXHIBIT A: BUDGET EXHIBIT

FY 2018-2019 Mental Health Services Act Annual Update
Funding Summary

County: **Orange**

Date: **2/23/18**

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2018-19 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years[a/]	104,620,727	36,448,520	30,013,791	0	0	
2. Estimated New FY 2018-19 Funding	119,342,084	29,990,800	7,965,987	0	0	
3. Transfer in FY 2018-19[b/]	(25,626,616)			5,150,282	20,476,334	0
4. Access Local Prudent Reserve in FY 2018-19	0	0				0
5. Estimated Available Funding for FY2018-19	198,336,195	66,439,320	37,979,778	5,150,282	20,476,334	
B. Estimated FY2018-19 Expenditures	145,612,490	35,452,761	12,205,299	5,150,282	20,476,334	

C. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2017	70,921,582
2. Contributions to the Local Prudent Reserve in FY 2017/18	0
3. Distributions from the Local Prudent Reserve in FY 2017/18	0
4. Estimated Local Prudent Reserve Balance on June 30, 2018	70,921,582
5. Contributions to the Local Prudent Reserve in FY 2018/19	0
6. Distributions from the Local Prudent Reserve in FY 2018/19c/	(11,343,034)
7. Estimated Local Prudent Reserve Balance on June 30, 2019 c/	59,578,548

a/ *Estimated Unspent CSS funds from Prior Fiscal Years presented here do not account for the March 2018 Board directive to transfer CSS funds to permanent supportive housing in FY 2017-18.*

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

c/ *PEI funds allocated for FY 2008-09 and thereafter that had been placed in the Prudent Reserve are being reclassified as "Estimated Unspent [PEI] Funds from Prior Fiscal Years." This adjustment was made so that the estimated local prudent reserve balance corresponds to DHCS' balance for Orange County's Prudent Reserve.*

FY 2018-2019 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Component Worksheet

County: **Orange** Date: **2/23/18**

	MHSA Funding					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realign-ment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Intensive Outpatient (FSP Programs)						
1. Children's Full Service Partnership/Wraparound	7,975,272	6,654,575	1,320,697	0	0	0
2. Children and Youth Behavioral Health Program of Assertive Community Treatment	1,185,000	1,100,000	85,000	0	0	0
3. Transitional Age Youth Full Service Partnership/ Wraparound	12,287,138	10,684,468	1,602,670	0	0	0
4. Adult Full Service Partnership	26,405,060	21,592,093	4,616,217	0	0	196,750
5. Adult Program of Assertive Community Treatment	10,041,700	8,631,926	1,329,076	0	0	80,698
6. Transitional Age Youth(Adult) Program of Assertive Community Treatment	1,089,684	896,092	186,084	0	0	7,508
7. Assisted Outpatient Treatment	5,367,205	5,015,841	344,200	0	0	7,164
8. Mental Health Court - Probation Services	921,000	921,000	0	0	0	0
9. Older Adult Full Service Partnership	2,891,800	2,683,249	201,965	0	0	6,586
10. Older Adult Program of Assertive Community Treatment	663,836	521,632	134,392	0	0	7,812
11. FSP Percent of Non Admin Programs Below	18,299,174	16,042,428	2,041,549	0	0	215,197

FY 2018-2019 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Component Worksheet

County: **Orange** Date: **2/23/18**

	Fiscal Year 2018-19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realign-ment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Non-FSP Programs Navigation/Access and Linkage to Treatment						
1. BHS Outreach and Engagement	1,227,973	1,227,973	0	0	0	0
2. Correctional Health Services: Jail to Community Re-Entry	3,200,000	3,200,000	0	0	0	0
3. The Courtyard (outreach)	475,000	475,000	0	0	0	0
Crisis						
4. Children's CAT	1,742,413	1,265,613	348,800	0	0	128,000
5. Adult and TAY CAT/PERT	4,794,267	4,451,183	313,011	0	0	30,074
6. Crisis Stabilization Units	4,250,000	4,250,000	0	0	0	0
7. Children's In-Home Crisis Stabilization	497,076	325,644	171,432	0	0	0
8. Adult/TAY In-Home Crisis Stabilization	1,593,750	1,275,000	318,750	0	0	0
9. Children's Crisis Residential	1,098,224	1,001,474	96,750	0	0	0
10. TAY Crisis Residential	82,068	74,568	7,500	0	0	0
11. Adult Crisis Residential	3,821,671	3,000,983	785,856	0	0	34,832

FY 2018-2019 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Component Worksheet

County: **Orange** Date: **2/23/18**

	Fiscal Year 2018-19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realign-ment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Outpatient Treatment						
12. Youth Core Services	3,050,000	2,300,000	750,000	0	0	0
13. OC Children with Co-Occurring Mental Health Disorder	1,550,000	1,250,000	300,000	0	0	0
14. Integrated Community Services	1,848,000	1,848,000	0	0	0	0
15. Recovery Centers/Clinic Recovery/Open Access	11,950,081	8,975,360	2,876,370	0	0	98,351
16. Older Adult Services	2,047,663	1,568,047	449,615	0	0	30,001
Supportive Housing						
17. Housing and Year Round Emergency Shelter	957,026	957,026	0	0	0	0
18. Bridge Housing for Homeless	1,000,000	1,000,000	0	0	0	0
19. Housing	120,644	120,644	0	0	0	0
Residential Treatment						
20. Adolescent Dual Diagnosis Residential Treatment	492,500	427,500	65,000	0	0	0
21. Adult Dual Diagnosis Residential Treatment	50,000	50,000	0	0	0	0

FY 2018-2019 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Component Worksheet

County: **Orange** Date: **2/23/18**

	Fiscal Year 2018-19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realign-ment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Recovery and Supportive Services						
12. Mentoring for Children and Youth	500,000	500,000	0	0	0	0
13. Peer Mentoring	4,249,888	4,249,888	0	0	0	0
14. Wellness Centers	2,766,198	2,766,198	0	0	0	0
15. Supported Employment	1,097,010	1,097,010	0	0	0	0
16. Transportation Program	1,000,000	1,000,000	0	0	0	0
CSS Administration	22,212,075	22,212,075	0	0	0	0
Total CSS Program Estimated Expenditures	164,800,396	145,612,490	18,344,934	0	0	842,973
FSP Programs as Percent of Total	51.3%					

FY 2018-2019 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Component Worksheet

County: **Orange** Date: **2/23/18**

	Fiscal Year 2018-19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realign-ment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Prevention						
School-Focused						
1. Connect the Tots and School Readiness	2,200,000	2,200,000				
2. School-Based Behavioral Health Intervention and Support	1,808,589	1,808,589				
3. School-Based Stress Management Services	155,000	155,000				
4. Violence Prevention Education	1,105,651	1,105,651				
5. Gang Prevention Services	253,100	253,100				
Community Events and Education						
6. Training, Assessment and Coordination Services	508,610	508,610				
7. Mental Health Community Education Events	214,333	214,333				
8. Statewide Projects (CalMHSA)	900,000	900,000				
Navigation/Access and Linkage to Treatment						
9. OCLinks	1,000,000	1,000,000				
10. BHS Outreach and Engagement Team	1,300,000	1,300,000				
11. Outreach and Engagement Collaborative	2,819,044	2,819,044				

FY 2018-2019 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Component Worksheet

County: **Orange** Date: **2/23/18**

	Fiscal Year 2018-19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realign-ment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Crisis						
12. Crisis Prevention Hotline	392,533	392,533				
Outpatient Treatment						
13. OC Parent Wellness	2,113,072	2,113,072				
14. Stress Free Families	534,693	534,693				
15. 1st Onset of Psychiatric Illness, OC CREW	1,500,000	1,500,000				
16. Early Intervention Services for Older Adults	1,469,500	1,469,500				
17. School-Based Mental Health Services (combined prevention and early intervention)	2,915,236	2,915,236				
18. School-Based Behavioral Health Intervention & Support - Early Intervention Services	440,000	440,000				
19. Survivor Support Services	343,693	343,693				
20. Community Counseling and Supportive Services	2,186,136	2,186,136				
21. OC ACCEPT	490,000	490,000				
22. OC4VETS	1,295,957	1,295,957				
23. College Veterans	400,000	400,000				

FY 2018-2019 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Component Worksheet

County: **Orange**

Date: **2/23/18**

	Fiscal Year 2018-19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realign-ment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Recovery and Supportive Services						
24. Parent Education Services	1,066,000	1,066,000				
25. Family Support Services	282,000	282,000				
26. Children's Support and Parenting Program	1,800,000	1,800,000				
27. Warmline	536,566	536,566				
28. Training in Physical Fitness and Nutrition	15,000	15,000				
PEI Administration	5,408,048	5,408,048				
PEI Assigned Funds	0	0				
Total PEI Program Estimated Expenditures	35,452,761	35,452,761				

FY 2018-2019 Mental Health Services Act Annual Update
Innovations (INN) Component Worksheet

County: **Orange** Date: **2/23/18**

	Fiscal Year 2018-19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realign-ment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Prevention						
Community Events and Education						
1. Religious Leaders Behavioral Health Training Services	259,450	259,450				
Outpatient Treatment						
Early Intervention						
2. Strong Families - Strong Children: Behavioral Health Services for Military Families	495,904	495,904				
Recovery and Supportive Services						
3. Continuum of Care for Veteran & Military Children and Families	961,871	961,871				
4. Step Forward: On-Site Engagement in the Collaborative Courts	224,015	224,015				
5. Behavioral Health Services for Independent Living	402,234	402,234				
Special Projects						
6. Mental Health Technology Solutions	6,000,000	6,000,000				
7. OC Additional Component to Tech Solutions	2,000,000	2,000,000				
INN Administration	1,861,825	1,861,825				
Total INN Project Estimated Expenditures	**12,205,299**	**12,205,299**	**0**	**0**	**0**	**0**

FY 2018-2019 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Component Worksheet

County: **Orange** Date: **2/23/18**

	Fiscal Year 2018-19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realign-ment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Workforce Staffing Support	1,120,000	1,120,000				
2. Training and Technical Assistance	1,438,000	1,438,000				
3. Mental Health Career Pathways Programs	927,000	927,000				
4. Residencies and Internships	238,381	238,381				
5. Financial Incentives Programs	641,265	641,265				
WET Administration	785,636	785,636				
Total WET Program Estimated Expenditures	**5,150,282**	**5,150,282**	**0**	**0**	**0**	**0**

FY 2018-2019 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: **Orange**

Date: **2/23/18**

	Fiscal Year 2018-19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realign-ment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Co-Located Services Facility	9,000,000	9,000,000				
2. Youth Core Services Building Upgrades	200,000	200,000				
CFTN Programs - Technological Needs Projects						
6. Electronic Health Record (E.H.R)	8,152,825	8,152,825				
CFTN Administration	3,123,509	3,123,509				
Total CFTN Program Estimated Expenditures	**20,476,334**	**20,476,334**	**0**	**0**	**0**	**0**

EXHIBIT B: COUNTY COMPLIANCE CERTIFICATION

MHSA COUNTY COMPLIANCE CERTIFICATION

County: Orange

Local Mental Health Director	Program Lead
Name: Jeff Nagel	Name: Sharon Ishikawa
Telephone Number: 714-834-7024	Telephone Number: 714-834-6587
E-mail: jnagel@ochca.com	E-mail: SIshikawa@ochca.com
County Mental Health Mailing Address: Health Care Agency Behavioral Health Services 405 W. 5th Street Santa Ana, CA 92701	

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

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

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

All documents in the attached annual update are true and correct.

Jeff Nagel
Local Mental Health Director/Designee (PRINT)

Jeff Nagel 4/19/18
Signature Date

County: Orange

Date: 4/19/18

EXHIBIT C: COUNTY FISCAL CERTIFICATION

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: Orange

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

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Jeff Nagel	Name: Eric Woolery
Telephone Number: 714-834-7024	Telephone Number: 714-834-2450
E-mail: jnagel@ochca.com	E-mail: eric.woolery@ac.ocgov.com
Local Mental Health Mailing Address: Health Care Agency Behavioral Health Services 405 W. 5th Street Santa Ana, CA 92701	

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

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

Jeffrey A. Nagel, Director of Operations
Local Mental Health Director (PRINT)

Jeffrey A Nagel 4/19/18
Signature Date

I hereby certify that for the fiscal year ended June 30, 2017, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated _____ for the fiscal year ended June 30,_____. I further certify that for the fiscal year ended June 30,_____, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

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

Cindy Wong for Eric Woolery
County Auditor Controller / City Financial Officer (PRINT)

4/19/18
Signature Date

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

APPENDIX I: GLOSSARY OF OUTCOME MEASURES

Generalized Anxiety Disorder (GAD-7)

- Description: The GAD-7 is a widely used, 7-item measure of anxiety. It assesses the severity of symptoms related to social phobia, post-traumatic stress disorder and panic disorder. Scores can be classified according to their severity level (i.e., minimal, mild, moderate, severe, etc.).
- Rater: Clinician, staff, self-report; for individuals ages 18 and older

Grief Experiences Questionnaire (GEQ)

- Description: The GEQ is a 55-item measure of grief that captures the unique experience associated with losing someone to suicide. It examines various components of grief, including somatic reactions; general grief reactions; search for explanation; loss of social support; stigmatization; self-destructive behavior or orientation; feelings of guilt, responsibility, shame or embarrassment, abandonment or rejection; and reactions specific to this unique form of death.
- Rater: Self-report

North Carolina Family Assessment Scale (NCFAS)

- Description: The NCFAS is an assessment tool designed to examine family functioning at the individual and aggregate level. Family functioning is measured on five domains: Environment, Parental Capabilities, Family Interactions, Family Safety and Child Well-Being. The NCFAS-General Services also includes the five domains of the NCFAS and three additional domains of Social/Community Life, Self-Sufficiency, and Family Health. Scores reflect the extent to which a family demonstrates strengths or problems in the respective domains.
- Rater: Clinician, Staff

Outcome Questionnaire (OQ) 30.2

- Description: The OQ measures the treatment progress for adults receiving any form of behavioral health treatment. This 30-item scale is sensitive to short-term change and assesses the frequency with which adults are experiencing general psychopathology symptoms and functioning related to intrapersonal distress, somatic concerns, interpersonal relations, social problems, behavioral dysfunction, and more. The measure contains a clinical cutoff that identifies scores that fall in the clinical range of severity, as well as a reliable change index that quantifies whether the difference between baseline and follow up scores is clinically meaningful rather than the result of random fluctuation.
- Rater: Self-report for adults ages 18 and older

PARCA-SE

- Description: The PARCA-SE is a 19-item survey with 3 subscales that measure parents' confidence (self-efficacy) regarding their ability to support good behaviors, set limits, and use proactive parenting strategies.
- Rater: Self-report

Patient Health Questionnaire (PHQ-9)

- Description: The PHQ-9 is a widely used, 9-item screening instrument for diagnosing, monitoring and measuring the severity of depression. Scores can be classified according to their severity level (i.e., minimal, mild, moderate, moderately severe, severe).
- Rater: Clinician, staff, self-report; for individuals ages 18 and older

Profile of Mood States (POMS)

- Description: The POMS is a scale that assesses the extent to which an individual is experiencing affective mood states: calm, agitated, annoyed, anxious, confused, depressed, helpless, overwhelmed, uncertain and worried.
- Rater: Self-rated

PROMIS Global Health

- Description: The PROMIS Global Health is a 10-item self-assessment of a participant's perceived overall health and functioning. This measure is from the National Institutes

of Health (NIH) Patient Reported Outcome Measurement Information System (PROMIS) and includes subscales for Global Mental Health and Global Physical Health with a measure-defined cutoff score for each of the subscales.

- Rater: Self-report for adults ages 18 and older

PROMIS Pediatric Global Health

- Description: The PROMIS Pediatric and PROMIS Parent Proxy Global Health are 7-item measures that assess a child's overall evaluations of their physical, mental and social health. These scales are conceptually equivalent to its PROMIS adult counterpart, except these measures yield a single global health score that do not have a cutoff.
- Rater: Self-report for youth ages 8-17 and parent-proxy for children ages 5-17

PROMIS Pediatric Anxiety

- Description: The PROMIS Anxiety is an 8-item measure that assesses common experiences and sensations of fear, anxiety, hyperarousal and somatic symptoms in youth. The measure assesses anxiety over the past seven days and yields a clinical cutoff identifying scores that fall in the clinical range of severity.
- Rater: Self-report for youth ages 8-17 and parent-proxy for children ages 5-17

PROMIS Pediatric Depression

- Description: The PROMIS Pediatric Depression is a brief measure that assesses mood, cognitive, interpersonal and somatic symptoms experienced by youth over the past seven days. The measure contains a clinical cutoff that identifies scores that fall in the clinical range of severity.
- Rater: Self-report for youth ages 8-17 and parent-proxy for children ages 5-17

Youth Outcome Questionnaire (YOQ) 30.2

- Description: The YOQ is the youth analog of the OQ 30.2. It is sensitive to short-term change and assesses the frequency with which youth are experiencing general psychopathology symptoms and functioning related to intrapersonal distress, somatic concerns, interpersonal relations, social problems, behavioral dysfunction, and more. The measure contains a clinical cutoff that identifies scores that fall in the clinical range of severity, as well as a reliable change index that quantifies whether the difference between baseline and follow up scores is clinically meaningful.
- Rater: Self-report for youth ages 12-18 and parent-report for youth ages 4-17

APPENDIX II: DEMOGRAPHIC DATA TABLES FOR PEI PROGRAMS

There are known issues with the data extraction tool for these reports that may affect the accuracy of some numbers. HCA is currently working to address them.

PROGRAM NAME	Children's Support & Parenting Program - Track 1									
Prevention:	P	Early Intervention:		Access to Tx:		Timely Access to services for:				
Outreach:		Stigma/Discrimination:		Suicide:						

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	177
Age 16-25 (TAY)	35
Age 26-59 (Adult)	269
Age 60+ (Older Adult)	6
Decline/Unknown	2

PRIMARY LANGUAGE	
Arabic	1
English	291
Farsi	1
Korean	1
Spanish	189
Vietnamese	2
Decline/Unknown	1
Other	3

ETHNICITY	
Hispanic/Latino	401
Non-Hispanic/Non-Latino	
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	3
Asian	18
Black/African American	4
Native Hawaiian/PI	0
White	39
Multi-Race	1
Decline/Unknown	2
Other	21

SEXUAL ORIENTATION	
Gay or Lesbian	4
Heterosexual	424
Bisexual	6
Questionning	1
Queer	0
Decline/Unknown	53
Other	1

GENDER - Assigned sex at birth	
Male	181
Female	308
Decline/Unknown	0
Other	

DISABILITY	
Disability "Yes"	27
Disability "No"	462
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	26
Veteran "No"	351
Decline/Unknown	112

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 489

PROGRAM NAME	Children's Support & Parenting Program - Track 2 (Stop The Cycle)									
Prevention:	P	Early Intervention:		Access to Tx:		Timely Access to services for:				
Outreach:		Stigma/Discrimination:		Suicide:						

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	256
Age 16-25 (TAY)	38
Age 26-59 (Adult)	278
Age 60+ (Older Adult)	4
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	228
Farsi	0
Korean	0
Spanish	332
Vietnamese	2
Decline/Unknown	12
Other	2

ETHNICITY	
Hispanic/Latino	528
Non-Hispanic/Non-Latino	10
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	3
Asian	8
Black/African American	0
Native Hawaiian/PI	2
White	3
Multi-Race	0
Decline/Unknown	26
Other	6

SEXUAL ORIENTATION	
Gay or Lesbian	1
Heterosexual	396
Bisexual	3
Questionning	1
Queer	0
Decline/Unknown	171
Other	4

GENDER - Assigned sex at birth	
Male	242
Female	332
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	11
Disability "No"	563
Decline/Unknown	2

VETERAN STATUS	
Veteran "Yes"	18
Veteran "No"	490
Decline/Unknown	68

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 576

PROGRAM NAME: Family Support Services

Prevention: P | Early Intervention: | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	151
Age 16-25 (TAY)	187
Age 26-59 (Adult)	1,340
Age 60+ (Older Adult)	63
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	2
English	450
Farsi	61
Korean	2
Spanish	597
Vietnamese	123
Decline/Unknown	479
Other	27

ETHNICITY	
Hispanic/Latino	821
Non-Hispanic/Non-Latino	317
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	22
Asian	195
Black/African American	22
Native Hawaiian/PI	4
White	308
Multi-Race	0
Decline/Unknown	258
Other	117

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	381
Female	1,360
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	26
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	1
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 1,747

PROGRAM NAME: School-Based Stress Management Services

Prevention: P | Early Intervention: | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	1,108
Age 16-25 (TAY)	481
Age 26-59 (Adult)	59
Age 60+ (Older Adult)	4
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	0
Farsi	0
Korean	0
Spanish	0
Vietnamese	0
Decline/Unknown	0
Other	0

ETHNICITY	
Hispanic/Latino	646
Non-Hispanic/Non-Latino	243
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	24
Asian	52
Black/African American	50
Native Hawaiian/PI	3
White	464
Multi-Race	0
Decline/Unknown	0
Other	195

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	793
Female	844
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 3,097

PROGRAM NAME: Parent Education Services

Prevention: P | Early Intervention: | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	8
Age 16-25 (TAY)	470
Age 26-59 (Adult)	1,727
Age 60+ (Older Adult)	35
Decline/Unknown	77

PRIMARY LANGUAGE	
Arabic	4
English	1,739
Farsi	7
Korean	2
Spanish	430
Vietnamese	1
Decline/Unknown	88
Other	46

ETHNICITY	
Hispanic/Latino	1,071
Non-Hispanic/Non-Latino	190
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	27
Asian	106
Black/African American	60
Native Hawaiian/PI	9
White	883
Multi-Race	0
Decline/Unknown	86
Other	74

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	21

GENDER - Assigned sex at birth	
Male	1,052
Female	1,246
Decline/Unknown	11
Other	8

DISABILITY	
Disability "Yes"	62
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	22
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 2,317

PROGRAM NAME: School-Based Mental Health Services - Prevention - Track 2 (Transition)

Prevention: P | Early Intervention: | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	1,646
Age 16-25 (TAY)	385
Age 26-59 (Adult)	0
Age 60+ (Older Adult)	0
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	4
English	1,906
Farsi	11
Korean	5
Spanish	44
Vietnamese	1
Decline/Unknown	0
Other	68

ETHNICITY	
Hispanic/Latino	589
Non-Hispanic/Non-Latino	405
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	50
Asian	152
Black/African American	60
Native Hawaiian/PI	9
White	871
Multi-Race	0
Decline/Unknown	46
Other	347

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	1,195
Female	829
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	2,039

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 2,039

PROGRAM NAME: School-Based Behavioral Health Intervention & Supports - Prevention

Prevention: P | Early Intervention: | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	9,871
Age 16-25 (TAY)	365
Age 26-59 (Adult)	0
Age 60+ (Older Adult)	0
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	26
English	8,920
Farsi	6
Korean	6
Spanish	903
Vietnamese	43
Decline/Unknown	0
Other	179

ETHNICITY	
Hispanic/Latino	4,084
Non-Hispanic/Non-Latino	1,537
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	182
Asian	619
Black/African American	76
Native Hawaiian/PI	45
White	1,499
Multi-Race	0
Decline/Unknown	0
Other	908

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	5,563
Female	5,237
Decline/Unknown	67
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 23,877

PROGRAM NAME: School Readiness - Track 1

Prevention: P | Early Intervention: | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	546
Age 16-25 (TAY)	0
Age 26-59 (Adult)	0
Age 60+ (Older Adult)	0
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	3
English	261
Farsi	4
Korean	0
Spanish	271
Vietnamese	0
Decline/Unknown	3
Other	4

ETHNICITY	
Hispanic/Latino	346
Non-Hispanic/Non-Latino	78
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	2
Asian	56
Black/African American	1
Native Hawaiian/PI	0
White	92
Multi-Race	0
Decline/Unknown	27
Other	22

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	339
Female	206
Decline/Unknown	1
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 546

PROGRAM NAME: School Readiness - Track 2 (Connect The Tots)

Prevention: | Early Intervention: P | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	315
Age 16-25 (TAY)	0
Age 26-59 (Adult)	0
Age 60+ (Older Adult)	0
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	2
English	139
Farsi	0
Korean	1
Spanish	148
Vietnamese	22
Decline/Unknown	1
Other	2

ETHNICITY	
Hispanic/Latino	237
Non-Hispanic/Non-Latino	44
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	0
Asian	35
Black/African American	8
Native Hawaiian/PI	2
White	19
Multi-Race	0
Decline/Unknown	2
Other	12

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	214
Female	101
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 315

PROGRAM NAME: Gang Prevention Services

Prevention: P | Early Intervention: | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	426
Age 16-25 (TAY)	4
Age 26-59 (Adult)	419
Age 60+ (Older Adult)	3
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	2
English	353
Farsi	0
Korean	2
Spanish	493
Vietnamese	2
Decline/Unknown	0
Other	0

ETHNICITY	
Hispanic/Latino	802
Non-Hispanic/Non-Latino	12
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	0
Asian	4
Black/African American	6
Native Hawaiian/PI	6
White	26
Multi-Race	0
Decline/Unknown	0
Other	8

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	852
Other	0

GENDER - Assigned sex at birth	
Male	334
Female	518
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	
Decline/Unknown	852

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	852
Decline/Unknown	

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 852

PROGRAM NAME: Violence Prevention Education

Prevention: P | Early Intervention: | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	10,926
Age 16-25 (TAY)	950
Age 26-59 (Adult)	1,406
Age 60+ (Older Adult)	50
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	49
English	7,431
Farsi	32
Korean	178
Spanish	3,690
Vietnamese	308
Decline/Unknown	0
Other	518

ETHNICITY	
Hispanic/Latino	6,220
Non-Hispanic/Non-Latino	3,623
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	250
Asian	1,446
Black/African American	249
Native Hawaiian/PI	73
White	2,180
Multi-Race	0
Decline/Unknown	0
Other	2,235

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	5,764
Female	6,995
Decline/Unknown	0
Other	2

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 48,805

PROGRAM NAME: Warmline

Prevention: P | Early Intervention: | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	67
Age 16-25 (TAY)	1,891
Age 26-59 (Adult)	21,025
Age 60+ (Older Adult)	7,219
Decline/Unknown	5,879

PRIMARY LANGUAGE	
Arabic	20
English	35,389
Farsi	14
Korean	4
Spanish	153
Vietnamese	1
Decline/Unknown	0
Other	39

ETHNICITY	
Hispanic/Latino	0
Non-Hispanic/Non-Latino	0
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	0
Asian	0
Black/African American	0
Native Hawaiian/PI	0
White	0
Multi-Race	0
Decline/Unknown	0
Other	0

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	16,234
Female	19,056
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	401
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 48,796

PROGRAM NAME: Training in Physical Fitness & Nutrition

Prevention: P | Early Intervention: | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	0
Age 16-25 (TAY)	7
Age 26-59 (Adult)	48
Age 60+ (Older Adult)	13
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	56
Farsi	2
Korean	0
Spanish	8
Vietnamese	1
Decline/Unknown	0
Other	1

ETHNICITY	
Hispanic/Latino	0
Non-Hispanic/Non-Latino	0
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	0
Asian	5
Black/African American	4
Native Hawaiian/PI	0
White	18
Multi-Race	0
Decline/Unknown	23
Other	18

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	41
Female	27
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 68

PROGRAM NAME: Outreach and Engagement Collaborative

Prevention: P | Early Intervention: | Access to Tx: | Timely Access to services for: P

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	20,941
Age 16-25 (TAY)	17,405
Age 26-59 (Adult)	54,478
Age 60+ (Older Adult)	7,883
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	647
English	49,719
Farsi	191
Korean	276
Spanish	43,643
Vietnamese	2,285
Decline/Unknown	0
Other	2,276

ETHNICITY	
Hispanic/Latino	59,649
Non-Hispanic/Non-Latino	12,312
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	94
Asian	8,028
Black/African American	1,796
Native Hawaiian/PI	219
White	21,199
Multi-Race	0
Decline/Unknown	0
Other	5,490

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	30,144
Female	50,691
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	1,429
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	689
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 103,554

PROGRAM NAME: Community Counseling & Supportive Services

Prevention: | Early Intervention: P | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	34
Age 16-25 (TAY)	73
Age 26-59 (Adult)	344
Age 60+ (Older Adult)	16
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	9
English	161
Farsi	0
Korean	3
Spanish	290
Vietnamese	3
Decline/Unknown	0
Other	1

ETHNICITY	
Hispanic/Latino	361
Non-Hispanic/Non-Latino	62
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	1
Asian	33
Black/African American	4
Native Hawaiian/PI	7
White	27
Multi-Race	0
Decline/Unknown	12
Other	22

SEXUAL ORIENTATION	
Gay or Lesbian	15
Heterosexual	271
Bisexual	9
Questionning	1
Queer	0
Decline/Unknown	94
Other	1

GENDER - Assigned sex at birth	
Male	140
Female	326
Decline/Unknown	1
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	37
Veteran "No"	392
Decline/Unknown	38

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 467

PROGRAM NAME: OC ACCEPT

Prevention: | Early Intervention: P | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	12
Age 16-25 (TAY)	42
Age 26-59 (Adult)	56
Age 60+ (Older Adult)	11
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	98
Farsi	2
Korean	0
Spanish	18
Vietnamese	3
Decline/Unknown	0
Other	0

ETHNICITY	
Hispanic/Latino	47
Non-Hispanic/Non-Latino	15
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	1
Asian	9
Black/African American	5
Native Hawaiian/PI	0
White	37
Multi-Race	0
Decline/Unknown	16
Other	3

SEXUAL ORIENTATION	
Gay or Lesbian	39
Heterosexual	15
Bisexual	11
Questionning	3
Queer	0
Decline/Unknown	6
Other	5

GENDER - Assigned sex at birth	
Male	70
Female	46
Decline/Unknown	3
Other	2

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	21
Veteran "No"	82
Decline/Unknown	18

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 121

PROGRAM NAME: 1st Onset of Psychiatric Illness - OCCREW

Prevention: | Early Intervention: P | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	16
Age 16-25 (TAY)	66
Age 26-59 (Adult)	0
Age 60+ (Older Adult)	0
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	67
Farsi	0
Korean	2
Spanish	12
Vietnamese	1
Decline/Unknown	0
Other	0

ETHNICITY	
Hispanic/Latino	40
Non-Hispanic/Non-Latino	18
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	0
Asian	10
Black/African American	2
Native Hawaiian/PI	1
White	22
Multi-Race	0
Decline/Unknown	0
Other	7

SEXUAL ORIENTATION	
Gay or Lesbian	2
Heterosexual	52
Bisexual	4
Questionning	0
Queer	0
Decline/Unknown	21
Other	3

GENDER - Assigned sex at birth	
Male	59
Female	23
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 82

PROGRAM NAME: OC Maternal & Family Wellness - Track 1 (OCPPW)

Prevention: | Early Intervention: P | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	4
Age 16-25 (TAY)	150
Age 26-59 (Adult)	376
Age 60+ (Older Adult)	0
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	4
English	256
Farsi	4
Korean	0
Spanish	256
Vietnamese	6
Decline/Unknown	0
Other	4

ETHNICITY	
Hispanic/Latino	389
Non-Hispanic/Non-Latino	73
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	2
Asian	38
Black/African American	7
Native Hawaiian/PI	9
White	58
Multi-Race	0
Decline/Unknown	6
Other	21

SEXUAL ORIENTATION	
Gay or Lesbian	2
Heterosexual	406
Bisexual	5
Questionning	1
Queer	0
Decline/Unknown	1
Other	1

GENDER - Assigned sex at birth	
Male	1
Female	529
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	41
Veteran "No"	468
Decline/Unknown	21

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 530

PROGRAM NAME: OC Maternal & Family Wellness - Track 2 (Youth As Parent)

Prevention: | Early Intervention: P | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	11
Age 16-25 (TAY)	76
Age 26-59 (Adult)	0
Age 60+ (Older Adult)	0
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	60
Farsi	0
Korean	0
Spanish	26
Vietnamese	0
Decline/Unknown	1
Other	0

ETHNICITY	
Hispanic/Latino	81
Non-Hispanic/Non-Latino	1
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	0
Asian	0
Black/African American	2
Native Hawaiian/PI	0
White	2
Multi-Race	0
Decline/Unknown	1
Other	1

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	64
Bisexual	1
Questionning	1
Queer	0
Decline/Unknown	18
Other	3

GENDER - Assigned sex at birth	
Male	9
Female	77
Decline/Unknown	1
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	4
Veteran "No"	72
Decline/Unknown	11

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 87

PROGRAM NAME: School-Based Behavioral Health Intervention & Supports - Early Intervention

Prevention: | Early Intervention: P | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	17
Age 16-25 (TAY)	0
Age 26-59 (Adult)	0
Age 60+ (Older Adult)	0
Decline/Unknown	6

PRIMARY LANGUAGE	
Arabic	0
English	16
Farsi	0
Korean	0
Spanish	0
Vietnamese	0
Decline/Unknown	7
Other	0

ETHNICITY	
Hispanic/Latino	8
Non-Hispanic/Non-Latino	1
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	0
Asian	1
Black/African American	0
Native Hawaiian/PI	0
White	6
Multi-Race	0
Decline/Unknown	0
Other	0

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	13
Female	3
Decline/Unknown	7
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 59

PROGRAM NAME: School-Based Mental Health Services - Early Intervention - Track 1

Prevention: | Early Intervention: P | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	623
Age 16-25 (TAY)	0
Age 26-59 (Adult)	0
Age 60+ (Older Adult)	0
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	388
Farsi	1
Korean	0
Spanish	234
Vietnamese	0
Decline/Unknown	0
Other	0

ETHNICITY	
Hispanic/Latino	594
Non-Hispanic/Non-Latino	12
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	1
Asian	6
Black/African American	3
Native Hawaiian/PI	0
White	4
Multi-Race	0
Decline/Unknown	9
Other	6

SEXUAL ORIENTATION	
Gay or Lesbian	2
Heterosexual	492
Bisexual	8
Questionning	9
Queer	0
Decline/Unknown	28
Other	10

GENDER - Assigned sex at birth	
Male	282
Female	341
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 623

PROGRAM NAME: Stress Free Families

Prevention: | Early Intervention: P | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	0
Age 16-25 (TAY)	6
Age 26-59 (Adult)	109
Age 60+ (Older Adult)	2
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	46
Farsi	0
Korean	0
Spanish	65
Vietnamese	4
Decline/Unknown	0
Other	2

ETHNICITY	
Hispanic/Latino	89
Non-Hispanic/Non-Latino	9
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	0
Asian	28
Black/African American	1
Native Hawaiian/PI	1
White	12
Multi-Race	0
Decline/Unknown	4
Other	2

SEXUAL ORIENTATION	
Gay or Lesbian	1
Heterosexual	76
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	40
Other	0

GENDER - Assigned sex at birth	
Male	14
Female	103
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	14
Veteran "No"	96
Decline/Unknown	7

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 117

PROGRAM NAME: Survivor Support Services

Prevention: | Early Intervention: P | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	12
Age 16-25 (TAY)	18
Age 26-59 (Adult)	85
Age 60+ (Older Adult)	17
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	5
English	99
Farsi	3
Korean	3
Spanish	19
Vietnamese	0
Decline/Unknown	2
Other	1

ETHNICITY	
Hispanic/Latino	45
Non-Hispanic/Non-Latino	38
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	1
Asian	13
Black/African American	0
Native Hawaiian/PI	2
White	48
Multi-Race	0
Decline/Unknown	8
Other	15

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	4

GENDER - Assigned sex at birth	
Male	38
Female	94
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	39
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 132

PROGRAM NAME: College Veterans Program

Prevention: | Early Intervention: P | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	0
Age 16-25 (TAY)	2
Age 26-59 (Adult)	23
Age 60+ (Older Adult)	0
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	25
Farsi	0
Korean	0
Spanish	0
Vietnamese	0
Decline/Unknown	0
Other	0

ETHNICITY	
Hispanic/Latino	9
Non-Hispanic/Non-Latino	0
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	1
Asian	0
Black/African American	4
Native Hawaiian/PI	0
White	9
Multi-Race	0
Decline/Unknown	2
Other	0

SEXUAL ORIENTATION	
Gay or Lesbian	1
Heterosexual	23
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	1
Other	0

GENDER - Assigned sex at birth	
Male	19
Female	6
Decline/Unknown	0
Other	

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	25

VETERAN STATUS	
Veteran "Yes"	24
Veteran "No"	1
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 25

PROGRAM NAME: OC4Vets - Track 1

Prevention: | Early Intervention: P | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	0
Age 16-25 (TAY)	7
Age 26-59 (Adult)	93
Age 60+ (Older Adult)	39
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	133
Farsi	0
Korean	1
Spanish	3
Vietnamese	0
Decline/Unknown	0
Other	2

ETHNICITY	
Hispanic/Latino	44
Non-Hispanic/Non-Latino	13
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	2
Asian	9
Black/African American	11
Native Hawaiian/PI	1
White	68
Multi-Race	0
Decline/Unknown	16
Other	4

SEXUAL ORIENTATION	
Gay or Lesbian	1
Heterosexual	114
Bisexual	2
Questionning	1
Queer	0
Decline/Unknown	7
Other	0

GENDER - Assigned sex at birth	
Male	106
Female	32
Decline/Unknown	1
Other	

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	139

VETERAN STATUS	
Veteran "Yes"	131
Veteran "No"	4
Decline/Unknown	4

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 139

PROGRAM NAME: OC4Vets - Track 2 (Veterans Court)

Prevention: | Early Intervention: P | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	0
Age 16-25 (TAY)	4
Age 26-59 (Adult)	29
Age 60+ (Older Adult)	1
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	32
Farsi	0
Korean	0
Spanish	2
Vietnamese	0
Decline/Unknown	0
Other	0

ETHNICITY	
Hispanic/Latino	10
Non-Hispanic/Non-Latino	4
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	0
Asian	2
Black/African American	2
Native Hawaiian/PI	0
White	13
Multi-Race	0
Decline/Unknown	5
Other	2

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	30
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	4
Other	0

GENDER - Assigned sex at birth	
Male	33
Female	1
Decline/Unknown	0
Other	

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	28
Veteran "No"	4
Decline/Unknown	2

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 34

PROGRAM NAME: Early Intervention Services for Older Adults

Prevention: | Early Intervention: P | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	0
Age 16-25 (TAY)	0
Age 26-59 (Adult)	2
Age 60+ (Older Adult)	523
Decline/Unknown	11

PRIMARY LANGUAGE	
Arabic	46
English	117
Farsi	27
Korean	38
Spanish	140
Vietnamese	95
Decline/Unknown	3
Other	70

ETHNICITY	
Hispanic/Latino	148
Non-Hispanic/Non-Latino	276
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	0
Asian	199
Black/African American	8
Native Hawaiian/PI	1
White	102
Multi-Race	0
Decline/Unknown	2
Other	75

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	1

GENDER - Assigned sex at birth	
Male	151
Female	383
Decline/Unknown	2
Other	0

DISABILITY	
Disability "Yes"	536
Disability "No"	177
Decline/Unknown	9

VETERAN STATUS	
Veteran "Yes"	31
Veteran "No"	257
Decline/Unknown	7

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 536

PROGRAM NAME: Crisis Prevention Hotline

Prevention: | Early Intervention: | Access to Tx: | Timely Access to services for:

Outreach: P | Stigma/Discrimination: | Suicide: P

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	414
Age 16-25 (TAY)	1,923
Age 26-59 (Adult)	1,872
Age 60+ (Older Adult)	219
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	0
Farsi	0
Korean	8
Spanish	9
Vietnamese	4
Decline/Unknown	477
Other	0

ETHNICITY	
Hispanic/Latino	985
Non-Hispanic/Non-Latino	795
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	24
Asian	0
Black/African American	193
Native Hawaiian/PI	23
White	1,985
Multi-Race	0
Decline/Unknown	0
Other	795

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	2,487
Female	3,244
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	1,919
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	117
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 8,475

PROGRAM NAME: Training, Assessment and Coordination Services

Prevention: | Early Intervention: | Access to Tx: | Timely Access to services for:

Outreach: P | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	0
Age 16-25 (TAY)	0
Age 26-59 (Adult)	0
Age 60+ (Older Adult)	0
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	0
Farsi	0
Korean	0
Spanish	0
Vietnamese	0
Decline/Unknown	0
Other	0

ETHNICITY	
Hispanic/Latino	0
Non-Hispanic/Non-Latino	0
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	0
Asian	0
Black/African American	0
Native Hawaiian/PI	0
White	0
Multi-Race	0
Decline/Unknown	0
Other	0

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	0
Female	0
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 1,354

PROGRAM NAME: Information and Referral / OC Links

Prevention: | Early Intervention: | Access to Tx: P | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	9
Age 16-25 (TAY)	1,538
Age 26-59 (Adult)	8,433
Age 60+ (Older Adult)	1,451
Decline/Unknown	2,674

PRIMARY LANGUAGE	
Arabic	8
English	12,725
Farsi	53
Korean	18
Spanish	1,097
Vietnamese	168
Decline/Unknown	3
Other	33

ETHNICITY	
Hispanic/Latino	4,224
Non-Hispanic/Non-Latino	853
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	57
Asian	226
Black/African American	381
Native Hawaiian/PI	36
White	5,625
Multi-Race	0
Decline/Unknown	2,703
Other	0

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	30

GENDER - Assigned sex at birth	
Male	4,983
Female	9,097
Decline/Unknown	16
Other	9

DISABILITY	
Disability "Yes"	8
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	16
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 14,105

PROGRAM NAME	BHS Outreach & Engagement Services						
Prevention:		Early Intervention:		Access to Tx:	P	Timely Access to services for:	
Outreach:		Stigma/Discrimination:		Suicide:			

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	669
Age 16-25 (TAY)	2,069
Age 26-59 (Adult)	26,068
Age 60+ (Older Adult)	6,750
Decline/Unknown	354

PRIMARY LANGUAGE	
Arabic	0
English	28,617
Farsi	69
Korean	12
Spanish	5,669
Vietnamese	1,430
Decline/Unknown	48
Other	65

ETHNICITY	
Hispanic/Latino	12,184
Non-Hispanic/Non-Latino	0
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	0
Asian	2,385
Black/African American	5,156
Native Hawaiian/PI	0
White	15,553
Multi-Race	0
Decline/Unknown	0
Other	231

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	22,113
Female	13,697
Decline/Unknown	66
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program	35,910

APPENDIX III: DEMOGRAPHIC DATA TABLES FOR INN PROGRAMS

There are known issues with the data extraction tool for these reports that may affect the accuracy of some numbers. HCA is currently working to address them.

PROGRAM NAME	Religious Leaders Behavioral Health Training Services							
Prevention:		Early Intervention:		Access to Tx:		Timely Access to services for:		
Outreach:		Stigma/Discrimination:		Suicide:				

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	0
Age 16-25 (TAY)	1
Age 26-59 (Adult)	22
Age 60+ (Older Adult)	13
Decline/Unknown	1

PRIMARY LANGUAGE	
Arabic	0
English	15
Farsi	0
Korean	8
Spanish	5
Vietnamese	0
Decline/Unknown	0
Other	9

ETHNICITY	
Hispanic/Latino	12
Non-Hispanic/Non-Latino	22
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	0
Asian	13
Black/African American	1
Native Hawaiian/PI	0
White	13
Multi-Race	1
Decline/Unknown	1
Other	2

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	17
Bisexual	1
Questionning	0
Queer	0
Decline/Unknown	19
Other	0

GENDER - Assigned sex at birth	
Male	16
Female	15
Decline/Unknown	6
Other	0

DISABILITY	
Disability "Yes"	1
Disability "No"	16
Decline/Unknown	20

VETERAN STATUS	
Veteran "Yes"	2
Veteran "No"	28
Decline/Unknown	7

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 37

PROGRAM NAME	Step Forward Program: Collaborative Courts On-site Engagement							
Prevention:		Early Intervention:		Access to Tx:		Timely Access to services for:		
Outreach:		Stigma/Discrimination:		Suicide:				

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	0
Age 16-25 (TAY)	6
Age 26-59 (Adult)	76
Age 60+ (Older Adult)	11
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	86
Farsi	0
Korean	0
Spanish	7
Vietnamese	0
Decline/Unknown	0
Other	0

ETHNICITY	
Hispanic/Latino	34
Non-Hispanic/Non-Latino	43
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	3
Asian	1
Black/African American	8
Native Hawaiian/PI	4
White	65
Multi-Race	1
Decline/Unknown	0
Other	9

SEXUAL ORIENTATION	
Gay or Lesbian	1
Heterosexual	86
Bisexual	1
Questionning	0
Queer	0
Decline/Unknown	5
Other	0

GENDER - Assigned sex at birth	
Male	46
Female	47
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	40
Disability "No"	47
Decline/Unknown	6

VETERAN STATUS	
Veteran "Yes"	2
Veteran "No"	80
Decline/Unknown	11

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 93

PROGRAM NAME	BHS Outreach & Engagement Services						
Prevention:		Early Intervention:		Access to Tx:	P	Timely Access to services for:	
Outreach:		Stigma/Discrimination:		Suicide:			

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	669
Age 16-25 (TAY)	2,069
Age 26-59 (Adult)	26,068
Age 60+ (Older Adult)	6,750
Decline/Unknown	354

PRIMARY LANGUAGE	
Arabic	0
English	28,617
Farsi	69
Korean	12
Spanish	5,669
Vietnamese	1,430
Decline/Unknown	48
Other	65

ETHNICITY	
Hispanic/Latino	12,184
Non-Hispanic/Non-Latino	0
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	0
Asian	2,385
Black/African American	5,156
Native Hawaiian/PI	0
White	15,553
Multi-Race	0
Decline/Unknown	0
Other	231

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	22,113
Female	13,697
Decline/Unknown	66
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program	35,910

APPENDIX IV: SUMMARY OF PUBLIC COMMENTS AND RESPONSES (March 5, 2018 – April 4, 2018)

Comments re: Expanding PEI Program Services

1. Increase services for Early Intervention Services for Older Adults. See a need with a waiting list of approx. 3 months.
2. Gap in Outreach and Engagement Services to provide cultural and linguistic services to the Cambodian population in Orange County. BHS O&E do not have the appropriate capacity to serve this population.
3. Expand existing school-based PEI programs.
4. Develop full-enrollment, school-based programs K-12.
5. Update mental health skill sets for the County's 1600 pediatricians and Family Practice Physicians.
6. Expand OC Links coverage and hours to include 6-9pm and weekends.
7. Provide PEI, children's and early childhood services (through Community Opportunity Fund [COF], see below).
8. Provide mental health services for the most vulnerable residents in Orange County (through COF, see below).

Response

Thank you for these suggested areas of need. Beginning this summer the MHSA Office will be coordinating planning meetings with the MHSA/PEI subcommittee to review and update local PEI programs, and these needs can be presented in the meetings. We invite you to be part of the planning process.

Comment re: CHS Jail to Community Re-Entry Program

Would like to see a medication provision to the Correctional In-Reach Program. Concerned about not being able to receive any appointments upon discharge, thus having a gap in services and an increased chance for recidivism.

Response

We will make sure to provide your feedback as we develop the program services and structure with Correctional Health Services.

Comment re: Trauma-Informed Care

1. Train the workforce in trauma-informed care.
2. The Plan does not provide a trauma-informed prevention program to educate and engage the community.

Response

WET provides trauma-informed trainings for the BHS workforce on practices such as Trauma-Focused CBT, Integrative Treatment for Complex Trauma for Adolescents, Eye Movement Desensitization and Reprocessing (EMDR), Motivational Interviewing, Seeking Safety, etc. throughout the year. HCA has also conducted Vicarious Trauma trainings for all BHS clinicians.

In addition, BHS Managers collaborate with other agencies and collaboratives (i.e., SSA, Child Welfare System Improvement Partnership, OC Department of Education) to provide a coordinated approach to trauma-informed care for participants. Two BHS Division Managers are also working with the National Council for Behavioral Health on a nationwide learning collaborative over the next year, with the goal of aligning Orange County's BHS system with the Council's seven recommended domains for a trauma-informed system of care (i.e., Early Screening and Comprehensive Assessment; Consumer Driven Care and Services; Trauma-Informed, Educated and Responsive Workforce; Trauma-Informed, Evidenced-based and Emerging Best Practices; Safe and Secure Environments; Community Outreach and Partnership Building; Ongoing Performance Improvement and Evaluation).

Orange County also funds a wide array of trauma-related programs including, but not limited to, trauma-informed prevention programs for the community. These services include:

Programs that provide Trauma-Informed Prevention Education:

- PEI offers various parent education workshops, student curricula, and student interactive services that aim to increase protective factors and resilience, as well as decrease risk factors and improve school climate (i.e., gang and violence prevention, stress reduction, mindfulness).
- PEI family-strengthening programs and small student groups are provided in community locations such as schools, Family Resource Centers and Youth Reporting Centers.
- O&E provides prevention and early intervention services to these families in community locations such as homes, schools.
- PEI School-Based Mental Health Services works with middle school students in the SAUSD and AUHSD experiencing depression or anxiety that may be the result of trauma. Sites were selected based on risk factors including poverty indicators.

BHS Programs that provide Trauma-Informed Intervention Services:

- As described above, CYBH, PEI and AOABH staff are regularly offered training in age-appropriate trauma-informed practices and other evidence-based practices, which are implemented throughout the BHS system of care.
- CYBH Staff in programs serving child welfare and probation youth received additional training on the commercial sexual exploitation of children (CSEC).
- All youth entering child welfare and probation systems are screened with the Commercially Sexually Exploited Children-Identification Tool (CSE-IT), and a staff member is designated to provide intensive therapy and case management for any youth with a confirmed CSEC history to provide CSEC Services for Grace Court, which will provide a peer survivor component.
- PEI School-Based Mental Health Services provides behavioral health services to middle school students in the SAUSD and AUHSD experiencing depression or anxiety that may be the result of trauma. Sites were selected based on risk factors including poverty indicators.
- PEI Suicide Prevention Trainings and related technical assistance are provided to schools as they implement mandated Suicide Prevention, Intervention and Postvention Policies.
- Crisis Response Network services address the needs of those who may experience traumatic issues at school and community sites.
- O&E and OCLINKS staff work with this population to link them to appropriate services.

Comment re: Revised Proposal for Community Opportunity Fund

There is a need for a Mental Health Services Act Community Opportunity Fund (COF) to provide services to Orange County's vulnerable residents through an array of organizations, provider networks and institutions. Funding requests would be made through an RFA process. Eight Local Grant Application Administrators (LGAAs) would be in charge of reviewing and awarding proposals, as well as monitor outcomes and regulations. Contractors would be required to demonstrate compliance with all contracts over a 5 year period, as well as the capacity and structural stability to apply for funding. The RFAs would be made towards the MHSA Priority Areas that were identified and submitted to the MHSA Steering Committee during the recent community planning process. LGAAs would be contracted directly with the County to ensure continuity of governance by the Board of Supervisors. An RFP would be issued by HCA or CEO to select the LGAAs to begin receiving applications on July 1, 2018. 100% of the $51,744,226 designated to the MHSA COF would be distributed to LGAAs for grant making as of July 1, 2018. Likewise, 100% of the funds designated to the MHSA COF based on the amount of MHSA underspending in FY 2017/2018 would be distributed on December 31, 2018.

Response

The revised Community Opportunity Fund has been presented to the Mental Health Board and MHSA Steering Committee for their consideration.

HCA was directed to identify $70.5 million for housing and homelessness services for eligible participants, which will be presented to the Board of Supervisors on April 17. This plan will utilize all available CSS funds. The MHSA Office and PEI Department will be hosting planning meetings with the MHSA/PEI subcommittee beginning this summer to review and update local PEI programming and identify plans for available funds. Thus, it is anticipated year-to-year balances of available funds will be insufficient to support a COF.

Comment re: services for those with anosgnosia

What is being done to help those with anosgnosia? When will Orange County provide these services?

Dr. Stephen Seager – Roadmap: Making a Mental Health System that Actually Works – is suggested to be viewed.

Response

When conducting a clinical assessment, BHS clinicians use the best practice of assessing a person's insight and judgment as they relate to their current functioning. In conjunction with other information gathered, as well as their discussions with the client, the clinician then develops a care plan that best meets the person's needs. This care plan evolves over time to continue to reflect the individual's level of insight. Individuals can also participate in groups offered at the outpatient clinics and/or work with Peer Specialists to help increase insight regarding their mental health condition, symptoms, and functioning.

Thank you for suggesting Dr. Seager's video. Please note, however, that MHSA funds cannot be used for inpatient hospitalization/locked facilities.

Comment re: improving outreach to and access to behavioral health services by communities of color and other vulnerable groups

We request that Orange County work to better address the behavioral health disparities in low income communities of color and other vulnerable populations, particularly with regard to:

Specific Areas:

1. Targeting Outreach and Engagement to underserved ethnic and other vulnerable groups (i.e., LGBTQ, uninsured, etc.), and perhaps fund MH Navigators to provide these services
2. Develop Innovation projects that target communities of color, train local decision-makers in Innovation requirements, and explain if and how the technology projects will reduce behavioral health disparities in communities of color.

3. Hire more bilingual/bicultural individuals

4. Be more inclusive of the family unit when providing services (rather than just the identified client), as the family is often central to the individual's identity and the suffering is shared by family members.

Responses

1-2. Thank you for your feedback, and we invite you to be a part of the continuing development of Orange County's proposal to join the Technology Solutions Innovation project. Developing targeted outreach and engagement strategies, as well as user features within the apps themselves, that are appropriate for and accepted by different vulnerable populations and communities of color is a main focus of Orange County's proposal. To this end, we have specifically included line-items in our proposed budget for targeted outreach and promotional activities on ethnic radio stations, in ethnic community newspapers, etc., and we have funds devoted specifically to support professional translation of all project materials, and to support an evaluation on the effectiveness of the Tech Solutions apps in communities of color and other vulnerable populations. In addition, one of the apps is capable of providing support in over 150 languages. If approved to join the project, Orange County will actively participate on the Cross-County Steering Committee and help inform the evaluation.

3. HCA recognizes this need and continues to recruit for bilingual/culturally competent staff. Job bulletins reflect the County's commitment to staff MFT, CSW, Psychologist and Psychiatrist positions with bilingual/culturally competent practitioners. For example, wraparound contracts with providers state "CONTRACTOR shall include bilingual/bicultural services to meet the needs of threshold languages as determined by COUNTY. Whenever possible, bilingual/ bicultural staff should be retained."

4. Many MHSA-funded specifically work to provide services that include the family; please feel free to review the posted MHSA Annual Plan Update for FY 2018-19 and refer to the program grids, where you can identify all programs that provide services to family members.

Comment re: caseloads

Reduce PACT, Peer, FSP and Clinic caseloads as necessary.

Response

The FSP and PACT caseloads are already at 15-20:1 and are monitored closely. BHS is working to address issues related to outpatient clinic caseloads by expanding the number of MHSA-funded Peers available to partner with individuals and their families. BHS also recently expanded both the PACT and FSP programs and added the Clinic Recovery Services/ Recovery Centers step-down outpatient programs to help reduce caseloads in the outpatient programs. In addition, BHS is actively working to fill existing vacancies in the outpatient clinics to help alleviate caseloads. These measures have already decreased caseloads at the outpatient clinics by about 25%, and there are ongoing efforts to continue this process. In addition to the above measures, there are additional expansion positions coming that will help decrease caseloads even more.

Comment re: PERT

Place PERT in all 34 Orange County cities.

Response

The decision to provide PERT services comes from the cities and Police Departments themselves, and all that have requested PERT has received them. No requests have been declined. We are currently in the process of hiring to expand the number PERT clinicians to requesting police departments by an additional 8 FTEs.

Comment re: Orange County MHSA Evaluation/ Audit by External Organizations

Make the UCSD and CHPS reports publicly available.

Response

These projects are on-going (UCSD) or have not yet started (CHPS); we plan to post the final reports when they become available.

Comment re: MHSA housing and homelessness

1. Homelessness and viable housing solutions look different for different groups, with certain communities of color remaining hidden and unlikely to access County resources such as Kraemer Place. Thus, any project on homelessness that would provide targeted outreach to ethnic populations would be helpful.
2. MHSA funds used for housing should include sufficient wrap around services, otherwise housing becomes warehousing.

Response

As noted above, HCA was directed to identify a $70.5 million plan for housing and homelessness services for eligible participants, which will be presented to the Board of Supervisors on April 17. We will include your comments in this plan for the Board's consideration.

Comment re: needs of conservators

Provide public and private conservators with the same access to services.

Response

HCA plans to conduct community planning for the FY 2019-20 MHSA Annual Plan Update on support services specifically geared for private conservators, and we invite you and others to be a part of this process.

Comment re: needs of those identified as gravely disabled

Follow LA's lead on Gravely Disabled programs

Response

Thank you for your comment. We will look at MHSA program implementation in Los Angeles County as it relates to Gravely Disabled programs and look for opportunities to incorporate different approaches for these individuals and their families.

Comment re: need for funds to fully cover mental health and substance use program costs

We have been providing mental health services in OC for over 40 years. Though we've held contracts with HCA, none of the contracts cover the full cost of running those programs. Unfortunately, due to the Drug Medi-Cal requirements and low reimbursement rates and no funding for regular Substance Abuse Services, we were unable to continue the SUD contract we've had with HCA for over 25 years. We currently serve about 2,000 residents through our program every year. If we had the ability to hire staff and administrative support, we could increase that number and provide additional services for OC's residents.

Response

Thank you for your comments, and we encourage you to bid on any County solicitations that match your match your areas of interest. Please note that MHSA funds cannot be used to provide substance use services unless there is a primary, co-occurring mental health diagnosis.

Comment re: the Role of the MHB and MHSA Steering Committee in MHSA

Increase opportunity for the MHB and MHSA Steering Committee to provide community input, offer new ideas and analyze results.

Response

The existing Community Planning processes and workflow are being revised to enhance the feedback and collaboration with the MHB and MHSA Steering Committee. Some of these efforts include:

a) Increased opportunities for community engagement and feedback. The annual Community Forum will be moved earlier in the year to allow the MHSA Steering Committee (SC) more time to evaluate the stated needs and provide recommendations to HCA.

b) The MHSA Office and MHSA Steering Committee Co-Chairs has been meeting frequently to discuss the Community Planning Process (CPP) and funding needs, thus affording additional opportunities to discuss local programming needs and priorities.

c) The MHSA Office has been working to establish relationships with a network of community organizations so that staff may present at their meetings and hear about the needs they have identified, which will be brought back to the MHSA co-chairs, SC and HCA.

d) The MHSA Office has worked with the MHSA SC co-chairs to develop a Community Input form, which has been converted to an electronic survey and will be made available online to enhance opportunity for community feedback.

e) The MHSA Office will be hosting Community Forums throughout the County to review and receive feedback on the full BHS Continuum of Care.

Comments re: MHSA processes and MHSA Unspent Funds

1. MHSA is a funding mechanism and not a program generator to support people with a primary diagnosis of a mental health disorder. MHSA can fill the gaps for public and private insurance, and leverage funds by coordinating and leveraging funding.
2. Unspent funds means non-working funds, and non-working funds are not helping to address the 125k people with SMI.
3. Videotape all MHB and MHSA Steering Committee meetings.
4. Create a paid publicity PR media campaign to create countywide awareness for resources and services.

Response

Thank you for your comments on the various processes related to MHSA implementation in Orange County.

In addition to the enhanced community planning activities the MHSA Office is currently developing, we will explore the suggestions provided here. The CEO's Budget Office will be managing and providing oversight of the MHSA Fund and related budgets. In addition, HCA was recently directed to identify $70.5 million for housing and homelessness services for eligible participants, which will utilize all available CSS funds. HCA has also been actively developing INN projects and will begin hosting planning meetings this summer to review and update local PEI programming and identify plans for available PEI funds.

APPENDIX V: MINUTES FROM MENTAL HEALTH PUBLIC HEARING

BOARD OF SUPERVISORS

Andrew Do, Chairman
First District

Shawn Nelson, Vice Chairman
Fourth District

Michelle Steel
Second District

Todd Spitzer
Third District

Lisa Bartlett
Fifth District

MHB MEMBERS

Michaell Rose, DrPH, LCSW, Chair

Matthew Holzmann, Vice Chair

Supervisor Andrew Do,
First District

Alisa Chatprapachai, OTD, OTR/L

Karyl Dupee, LMFT

Sandra Finestone, Psy.D.

Fasi Siddiqui

Gregory Swift, MFT

Joy Torres

HEALTH CARE AGENCY

Jeff Nagel, Ph.D.,
Director of Operations
Behavioral Health Services

Karla Perez
Staff Specialist
Behavioral Health Services

County of Orange
Mental Health Board

405 W. 5th Street
Santa Ana, CA 92701
TEL: (714) 834-5481
MHB Website:
http://ochealthinfo.com/bhs/about/mhb

Wednesday, April 11, 2018
6:00 p.m. – 7:30 p.m.

Fullerton Community Center
340 W. Commonwealth Center
Fullerton, CA 92832

MINUTES
Page 1 of 2

Members Present: Alisa Chatprapachai, Karyl Dupee, Matthew Holzmann, Michaell Rose, Fasi Siddiqui, Joy Torres

Members Absent: Supervisor Andrew Do, Gregory Swift,

Call to Order at 6:12 p.m. by Michaell Rose

Welcome and Introductions

- Pledge of Allegiance
- Each member of the Board introduced themselves and their respective affiliation.

Public Comment

- Joshua Collins-
  Mr. Collins is an advocate for the homeless who was inspired to attend today's meeting and learn more about how to help out the in the community and address the homeless population issues.

Open MHSA Public Hearing

- Opening Remarks: Dr. Jeff Nagel, BHS Director of Operations & Dr. Sharon Ishikawa, MHSA Coordinator
  - Dr. Nagel thanked the guests in attendance and the members of the Mental Health Board. He explained the purpose of the Public Hearing and made mention of the value of hearing program directors and members of various programs sharing their success stories. He also presented some highlights, facts and history on MHSA and reviewed the MHSA Annual Plan Update timeline. Dr. Ishikawa presented the Community Services and Supports; (CSS) new program and program expansions; spending plan for PEI, spending plan for Innovation (INN), including the new Mental Health Technology Solutions Collaborative project; and new allocations for housing. She answered several questions from the Mental Health Board, and then provided a written summary of and reviewed all public comments received during the 30-day public comment period for the plan. There were a total of 9 written public comments received.

BOARD OF SUPERVISORS

Andrew Do, Chairman
First District

Shawn Nelson, Vice Chairman
Fourth District

Michelle Steel
Second District

Todd Spitzer
Third District

Lisa Bartlett
Fifth District

MHB MEMBERS

Michaell Rose, DrPH, LCSW, Chair

Matthew Holzmann, Vice Chair

Supervisor Andrew Do,
First District

Alisa Chatprapachai, OTD, OTR/L

Karyl Dupee, LMFT

Sandra Finestone, Psy.D.

Fasi Siddiqui

Gregory Swift, MFT

Joy Torres

HEALTH CARE AGENCY

Jeff Nagel, Ph.D.,
Director of Operations
Behavioral Health Services

Karla Perez
Staff Assistant
Behavioral Health Services

County of Orange
Mental Health Board

405 W. 5th Street
Santa Ana, CA 92701
TEL: (714) 834-5481
MHB Website:

Wednesday, April 11, 2018
6:00 p.m. – 7:30 p.m.

MINUTES
Page 2 of 2

- Guest Speakers:
  - A total of seven (7) individuals spoke in support of the MHSA Annual Plan Update for Fiscal Year 2018 – 2019. These individuals represented a consumer, family member, professional, and public interest point of view.
- Public Comment:
  - There were a total of thirteen (13) public comments; one (1) individual shared his concern on the need for child preventative services in schools. Four (4) individuals expressed concern about MHSA unspent funds and would like plan revisions for additional services. Two (2) individuals shared their vision for additional veteran support services. One (1) individual would like to see more faith-based services. Three (3) individuals shared their concerns with regard to lack of housing and addressing the homeless population's needs. Two (2) individuals shared their concerns with regard to low oversight on the MHSA plan.

Close Public Hearing and MHB Vote: Action Item

- Chair Michaell Rose called for a motion to approve the MHSA Annual Plan Update Fiscal Year 2018-2019. The MHSA Plan Update was approved with a 5 yes/ 1 abstention vote.

Adjournment

- 8:05 pm

Officially submitted by: Karla Perez
Note: Copies of all writings pertaining to items in these MHB minutes are available for public review in the Behavioral Health Services Advisory Board Office, 405 W. 5th Street, Santa Ana, CA 92701, 714.834.5481 or Email:* kperez@ochca.com *

APPENDIX VI: ORANGE COUNTY BOARD OF SUPERVISORS MINUTE ORDER

ORANGE COUNTY BOARD OF SUPERVISORS

MINUTE ORDER

May 22, 2018

Submitting Agency/Department: HEALTH CARE AGENCY

Approve annual updates to Three-Year Program and Expenditure Plan for Mental Health Services Act, Proposition 63 programs and services, 7/1/18 - 6/30/19 ($218,897,166); direct Human Resource Services to amend master position control to add 58 positions to Health Care Agency; and authorize Director or designee to execute annual updates to Three-Year Plan - All Districts

The following is action taken by the Board of Supervisors:

APPROVED AS RECOMMENDED ☐ OTHER ☒

APPROVED AS RECOMMENDED; DIRECTED TO HOLD SIX OPEN PUBLIC MEETINGS THROUGHOUT THE YEAR WITH 2 MEETINGS TO BE HELD IN EACH SERVICE PLANNING AREA TO PROVIDE OPPORTUNITIES FOR COMMUNITY INPUT; AND DIRECTED HEALTH CARE AGENCY TO INCLUDE BOARD STAFF IN MENTAL HEALTH SERVICES ACT STEERING COMMITTEE'S WORK EARLY IN THE PROCESS FOR BOARD INPUT AND TO INCLUDE COMMUNITY STAKEHOLDERS IN THE PROCESS

Unanimous ☒ (1) DO: Y (2) STEEL: Y (3) SPITZER: Y (4) NELSON: Y (5) BARTLETT: Y
Vote Key: Y–Yes; N=No; A–Abstain; X=Excused; B.O.–Board Order

Documents accompanying this matter:

☐ Resolution(s)
☐ Ordinances(s)
☐ Contract(s)

Item No. 35

Special Notes:

Copies sent to:

I certify that the foregoing is a true and correct copy of the Minute Order adopted by the Board of Supervisors, Orange County, State of California
Robin Stieler, Clerk of the Board

By: _____ Deputy

1

Agenda Item 35

AGENDA STAFF REPORT

ASR Control 18-000293

MEETING DATE:	05/22/18
LEGAL ENTITY TAKING ACTION:	Board of Supervisors
BOARD OF SUPERVISORS DISTRICT(S):	All Districts
SUBMITTING AGENCY/DEPARTMENT:	Health Care Agency (Approved)
DEPARTMENT CONTACT PERSON(S):	Jeff Nagel (714) 834-7024 Richard Sanchez (714) 834-2830

SUBJECT: Mental Health Services Act Annual Plan Update FY 2018-19

CEO CONCUR	COUNTY COUNSEL REVIEW	CLERK OF THE BOARD
Concur	No Legal Objection	Discussion 3 Votes Board Majority

Budgeted: N/A **Current Year Cost:** N/A **Annual Cost:** FY 2018-19 $218,897,166

Staffing Impact: Yes **# of Positions:** 58 **Sole Source:** N/A
Current Fiscal Year Revenue: N/A
Funding Source: State: 100% (Mental Health Services Act/Prop 63) **County Audit in last 3 years:** No

Prior Board Action: 3/27/2018 S14E, 3/13/2018 #14, 1/9/2018 #15, 6/27/2017 #52

RECOMMENDED ACTION(S):

1. Approve the annual updates to the Orange County Mental Health Services Act Three-Year Program and Expenditure Plan for the provision of the Mental Health Services Act, Proposition 63, programs and services for the period of July 1, 2018, through June 30, 2019, in the amount of $218,897,166.

2. Direct Human Resource Services to amend the Master Position Control to add 58 positions to Health Care Agency, Budget Control 042, to implement the Mental Health Services Act Plan Update, as follows:
   - 30 Mental Health Worker II, class code 7104CS
   - 10 Clinical Social Worker II, class code 7076HP
   - Eight Mental Health Specialist, class code 7105CS
   - Six Marriage Family Therapist, class code 7114HP
   - Two HCA Service Chief II, class code 7131SM
   - One Staff Specialist, class code 8543GE
   - One Office Technician, class code 0522CL

3. Authorize the Health Care Agency Director, or designee, to execute the annual updates to the

Page 1

County's Mental Health Services Act Three-Year Program and Expenditure Plan as referenced in the Recommended Actions above.

SUMMARY:

Approve the FY 2018-19 annual updates to the County's Mental Health Services Act Three-Year Program and Expenditure Plan and approve the amendment of the Master Position Control to add 58 positions to Health Care Agency, Budget Control 042.

BACKGROUND INFORMATION:

In November 2004, California voters approved Proposition 63, the Mental Health Services Act (MHSA). MHSA provides counties a source of funding for expanded county mental health programs The overall goal of the expanded county mental health programs is to not only reduce the long-term adverse impact of untreated mental illness but also provide a comprehensive system of care for the target population through the various MHSA programs, e.g. Prevention and Early Intervention, Innovation, Community Services and Support evidence-based programs and practices.

Welfare and Institutions Code § 5847 and §5848 require that a three-year program and expenditure plan, and annual updates, be prepared through a meaningful stakeholder process at the local level and subsequently adopted by the county board of supervisors prior to its submission to the Mental Health Services Oversight and Accountability Commission and State Department of Health Care Services. On June 27, 2017, your Honorable Board approved the County's three-year program and expenditure plan (Three-Year Plan) for FY 2017-18 through FY 2019-20. The Board has also approved subsequent amendments to the Three-Year Plan on January 9, 2018, and March 13, 2018, to allocate to Special Needs Housing Program a total of $20 million in MHSA funds for the purposes of developing permanent supportive housing in the County for adults and older adults with severe and persistent mental illness and families of children with serious emotional disturbance who are homeless or at risk of homelessness. The Health Care Agency (HCA) also plans to bring forward an amendment to the Three-Year Plan at a later date this year to address the available and allowable means to use the $70.5 million in MHSA funds for supportive housing programs for mental health clients pursuant to your Board's directive on March 27, 2018.

The FY 2018-19 annual update to the Three-Year Program is a comprehensive look at all County's MHSA programs, budgets and outcomes from the previous fiscal year. For the upcoming fiscal year, the proposed annual update to the Three-Year Plan provides expected community impacts, challenges and estimated numbers of clients to be served. The proposed annual update was developed through a comprehensive process of seeking community input and feedback on all sections of the MHSA. The community input thus enabled HCA to make recommendations for increasing current MHSA program budgets or creating new mental health programs where a need or gap in services was identified. The MHSA Steering Committee approved by consensus the proposed programs and budgets included in the proposed annual update at their regularly scheduled meeting on December 4, 2017, and a special meeting on January 22, 2018. In accordance with Welfare and Institution Code Section 5848, the proposed annual plan update was posted and distributed throughout the community for a 30-day Public Comment period on March 5, 2018, through April 4, 2018, and at the close of the Public Comment period, the Mental

Health Board held a Public Hearing on the Plan Update on April 11, 2018, with five members voting in favor and one member abstaining from vote.

Notable Changes/Additions to the Three-Year Plan as the Result of the Proposed Annual Updates:

Community Services and Supports (CSS)

- Peer Mentoring was expanded, adding funding and 30 positions to support individuals in several new tracks:
  - Individuals of all ages receiving services in County outpatient clinics.
  - Homeless adults eligible for Whole Person Care.
  - Adults served in the Senate Bill 82 Triage Grant program that expires on June 30, 2018.
- Expansion of Transitional Age Youth (TAY) Full Service Partnerships (FSP) for youth involved in the Criminal Justice system.
- Adult FSPs were expanded to cover housing assistance and residential treatment costs.
- Expansion of Behavioral Health Services (BHS) Outreach and Engagement to serve individuals through the Whole Person Care collaborative.
- Both the Children and TAY/Adult Crisis Assessment Teams expanded the number of clinicians.
- A new Correctional Health Services, Jail to Community Re-Entry program was added along with 28 positions to provide comprehensive discharge planning and linkage to BHS with a goal of reducing recidivism.

Prevention and Early Intervention (PEI)

- PEI funds that were targeted for reversion, per Assembly Bill (AB) 114, were approved to be spent out across existing PEI programs during FY 2018-19.
- PEI Programs maintained a level budget, but transferred funding from the Training, Assessment and Coordination Services Program to Violence Prevention Education, the Crisis Prevention Hotline, Survivor Support Services, and the Warmline to reflect actual expenditures by those programs in the previous fiscal year.

Innovation

- Innovation funds that were targeted for reversion were approved to be spent out on existing and, if applicable, newly approved projects in a manner that maximally protects funds from reversion per Assembly Bill (AB) 114.
- HCA is developing two mental health-focused technology projects aimed at increasing access to services: (1) a proposal to join a cross-county collaborative Mental Health Technology Solutions MHSA Innovation project in order to decrease stigma and increase access to mental health services throughout the County, and (2) an integrated application that may include, but not be limited to matching individuals to existing housing in real-time and providing transportation assistance, automated alerts and reminders, education, resources and technical assistance. HCA received approval from the Orange County Board of Supervisors on April 10, 2018 and then approval from the State Mental Health Oversight and Accountability Commission on April 26, 2018 for the Mental Health Technology Solutions project. HCA will return to the Board to begin the approval process for the second project after the community planning process and proposal have been completed.

Capital Facilities and Technology Needs (CFTN)

- $9 million of CSS funding was transferred for the purchase of the Anita Property for Co-Located Services project.

- $200,000 of CSS funding was transferred for renovations to a building for Youth Core Services Program.
- In addition, $3,756,082 of CSS funding was transferred to Technological Needs to continue implementation of the BHS Electronic Health Record.

With the above changes, the total increase for FY 2018-19 County's MHSA Three-Year Plan as the result of the annual plan updates is $24,915,386 for an overall budget of $218,897,166:

Component	Requested Increase	Proposed FY 2018-19 Budget
CSS	$4,069,015	$145,612,490
PEI	$0	$35,452,761
INN	$5,558,195	$12,205,299
WET	$0	$5,150,282
CFTN	$15,288,177	$20,476,334
TOTAL	$24,915,386	$218,897,166

FINANCIAL IMPACT:

Appropriations for the annual plan updates are included in the FY 2018-19 Recommended Budget and will be included in the budgeting process for future years.

STAFFING IMPACT:

Add 58 positions, effective July 1, 2018, as referenced in the Recommended Action. These positions are 100% funded by Mental Health Services Act.

ATTACHMENT(S):

Attachment A - Mental Health Services FY 2018-19 Plan Update
Attachment B - Welfare and Institutions Code § 5847 and § 5848
Attachment C - Assembly Bill 114

405 W. 5th Street
Santa Ana, CA 92701
ochealthinfo.com/mhsa
ochealthinfo.com