2020-2023

ORANGE COUNTY

Mental Health Services Act

Three-Year Program and Expenditure Plan
Fiscal Years 2020-2021 thru 2022-2023

WELLNESS • RECOVERY • RESILIENCE

OC health CARE AGENCY

TABLE OF CONTENTS

MESSAGE FROM THE AGENCY DIRECTOR

This year marks the start of a new Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan and, with it, the opportunity to review our progress to date and look toward the future. Following an extensive community planning process and evaluation of our system of care, we look to address three strategic priorities over the next several years: 1) extend the scope and reach of mental health awareness campaigns, community training and education; 2) strengthen the County's suicide prevention efforts by expanding the programs making up our crisis services continuum; and 3) improve access to needed behavioral health services. Through these inter-related efforts, the MHSA will continue to transform the Orange County (OC) 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.

Our progress to date 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, advocates for the unserved and underserved, members of our provider organizations, OC Health Care Agency (HCA) and County staff, and the multitude of consumers and family members who have so graciously given their time and expertise to create the successes achieved over the past 15 years.

Nevertheless, there is still more work to be done. Following a $70.5 million investment in FY 2018-19, the Board of Supervisors and HCA remain committed to providing safe housing for individuals living with mental illness and continue to work diligently on new permanent supportive housing developments. We are also embarking on several Innovation projects designed to transform our system of care through new performance- and value-based contracting practices, evaluation strategies based upon learning health care networks, and the use of technology. The continuing emergence of the public-private partnership with Be Well OC, a coalition of Orange County behavioral health stakeholders including the HCA, CalOptima, local hospital systems, and nonprofit, academic and faith-based organizations, and family members, also provides an unparalleled opportunity for us to work together to support optimal mental health and well-being for all Orange County residents through a culturally responsive and inclusive system.

I am pleased with the continued success of many of our programs and encouraged by the plans to expand our system in new and exciting ways. 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 health conditions here in Orange County.

Sincerely,

Jeffrey A. Nagel, Ph.D.

Deputy Agency Director for
Behavioral Health Services

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 over 15 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 was developed incrementally, starting with the planning efforts of stakeholders in 2005 and continuing to present day. A description of the most recent planning process for the Three-Year Plan is provided below.

DEVELOPMENT OF THE ORANGE COUNTY MHSA THREE-YEAR PLAN

STATE REQUIREMENTS FOR THE DEVELOPMENT OF THE THREE-YEAR PLAN

Per the California Code of Regulations (CCR) 3650, while developing the Community Services and Supports (CSS) component of its Three-Year Plan, the County shall include the following:

- **Assessment of the Mental Health Needs** of unserved, underserved/inappropriately served and fully served county residents who qualify for MHSA services, including:
  - An analysis by age group, race/ethnicity and primary language, and
  - Assessment data that includes racial/ethnic, age and gender disparities.
- **Identification of Issues** resulting from a lack of mental health services and supports as identified through the Community Program Planning Process, categorized by age group.
- **Identification of the Issues that will be Priorities** in the CSS component.
- **Identification of Full Service Partnership (FSP) Population**, including:
  - An estimate of the number of clients, in each age group, to be served in the FSP for each fiscal year of the Three-Year Program

and Expenditure Plan, and

- A description how the selection of FSP participants will reduce the identified disparities.

- **Proposed Programs/Services**, including:
  - Program descriptions and work plans for each proposed program/service, including the budget and estimated number of individuals to be served by fiscal year and
  - The breakdown of the FSP population by fiscal year, including the number of individuals to be served by gender, race/ethnicity, linguistic group and age.

- **County's Capacity to Implement** the proposed programs/services, including a description of:
  - Strengths and limitations of the County and its service providers to meet the needs of racially/ethnically diverse populations, including language proficiency in the county's threshold languages, and
  - Identification of barriers to implementing the proposed programs/services, and potential solutions for addressing these barriers.

BUDGET REVIEW AND "TRUE UP" PROCESS

As part of the fiscal review done in preparation for the current Three-Year Plan, 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 2018-19). This budget "true up," which took place during Fall 2019, 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 MHSA component. The most common source of savings was actual or anticipated funds that remained unspent during a program's development and/or implementation phase (i.e., salary savings, reduced number of individuals served, etc.).

ORANGE COUNTY MHSA STEERING COMMITTEE

The MHSA requires that each County partner with local community members and stakeholders for the purpose of community planning. Orange County has been utilizing an MHSA Steering Committee since the very first Three-Year Plan was developed to support its community planning process. The Committee is currently composed of 51 members representing the following stakeholder groups:

- Adults/Older Adults living with a mental illness
- Family members of individuals living with SMI/SED
- Mental Health Providers
- Law Enforcement Agencies
- Education Services
- Social Services
- Health Organizations
- Veteran Organizations
- Providers of Drug and Alcohol abuse services
- Housing Organizations
- Representatives from ethnic/cultural minority organizations
- Local Government Official representatives
- Mental Health Board

The Steering Committee is tasked with the following responsibilities:

1. Remain educated about the status of MHSA funding 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 services 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 MHSA funding proposals and provide feedback to ensure funding is allocated to services for identified needs and priorities.
5. Provide timely recommendations 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 2018, the monthly MHSA Steering Committee meeting was switched from the first Monday to the third Monday of each month to accommodate a state MHSA meeting, at which point Committee member attendance dropped off. Of particular note was the low participation rates of consumers and family members relative to provider and County agency members. Thus, the HCA made a concerted effort to increase outreach during the most recent community planning process.

ORANGE COUNTY COMMUNITY PLANNING PROCESS FOR THE THREE-YEAR PLAN

The HCA modified its approach to the MHSA Community Planning Process this year to accomplish two goals: 1) to better align the community feedback received with community planning requirements outlined in the California Code of Regulations (CCR; see above) and 2) to increase the feedback received from consumers, their family members and the general community. As such, the community planning process for the Three-Year Plan consisted of the following strategies and steps:

- Distribution of a **Community Feedback Survey**, where respondents were asked to identify the target populations most in need of different types of behavioral health services.
- Participation in **Community Engagement Meetings**, where participants worked in small groups to identify solutions for improving service delivery among different target populations.
- Review of **Identified Priorities, Programs and Program Budgets**, where HCA staff presented and discussed the proposed priority areas, as well as the recommended programs and budgets, with MHSA Steering Committee, Mental Health Board, and Alcohol and Drug Advisory Board members.

Community Feedback Survey

Between October and November 2019, the MHSA Office distributed a Community Feedback Survey to hear directly from Orange County community members on the five priority populations they identified as having the greatest need or disparities within different types of behavioral health services. The service types included were based on the different types of behavioral programs provided by the County using MHSA funds, and the priority populations were identified through the MHSA itself (see table for list of service types and priority populations).

Paper versions were distributed at community events and BHS programs. Electronic surveys were distributed to 1,320 stakeholders on the MHSA, Be Well and BHS Contract Provider distribution lists. Although the electronic survey was originally set to close on October 25, 2019, it remained open for another two weeks so that participants at the Community Engagement Meetings who had not had a chance to complete it had the opportunity to do so.

A total of 1,136 paper and electronic surveys were returned. Of note, 61% of respondents on the paper survey[1] identified as consumers and/or family members, all stakeholder groups required by the MHSA were represented among the respondents, and 16% of respondents were adolescents or Transitional Age Youth (TAY), whose previous participation in community planning had been low to non-existent. In addition, the racial and ethnic diversity of survey respondents reflected the diversity of the county as a whole (see Appendix I for descriptive characteristics of respondents).

12 Service Types
Behavioral Health System Navigation
Outreach & Engagement
Early Intervention
Outpatient Treatment
Crisis Services
Residential Treatment (non-emergency)
Supportive Services
Peer Support
Stigma & Discrimination Reduction
Mental Health & Well-Being Promotion
Violence & Bullying Prevention
Suicide Prevention

MHSA Priority Populations
Children (0-15 years)
Youth (16-25 years)
Adults (26-59 years)
Older Adults (60+)
Foster Youth
Parent/Families
LGBTQ
Homeless
Students at Risk of School Failure
Veterans
Criminal Justice Involved
Mental Health w/Substance Use
Mental Health w/Medical Conditions
Racial/Ethnic Groups
Monolingual/Limited English
Other

[1] The electronic version of the survey did not ask about whether the respondent identified as a consumer or family member because the electronic survey stored IP addresses, which is considered a personal identifier.

Respondents identified three age groups and two specialized populations as being among the top five groups with unmet need (see Appendix I for details):

- **Youth** (16-25 years) in **12** of the 12 service types (and making the number one spot for 8 of the 12 service types)
- **Adults** (26-59 years) in **10** of the 12 service types (i.e., all except Early Intervention and Violence and Bullying Prevention)
- **Children** (0-15 years) in **8** of the 12 service types
- **Individuals Living with Co-Occurring Mental Health and Substance Use Disorders** in **7** of the 12 service types
- **Homeless Individuals** in **7** of the 12 service types

These results were used to help identify the strategic priorities for the Three-Year Plan by aligning community input from the surveys with findings from published reports. This approach supports both the CCR requirement of a mental health needs assessment and the general MHSA principle of community collaboration. Tables containing summaries of the survey data can be found in Appendix I.

Consumer Stakeholder Training

Prior to the first Community Engagement Meeting (CEM), the MHSA Office hosted an MHSA Stakeholder training for consumers, family members and general community members (n=81 participants). Transportation and food were provided to help encourage attendance, and stipends were provided to those who completed a Community Engagement Survey. Training was provided by an external consultant who is a subject matter expert in consumer stakeholder engagement. The training, held on September 30, 2020, covered the following topics:

- MHSA Values, CPP Overview, Relevant Laws and Regulations
- Effective Participation Skills
  - CPP Meeting Process: How it Could Work and How to Participate at a Meeting
  - Being Heard: Public Speaking Tips
  - CPP and the Art of Moving Forward Despite Disagreements
- Putting it All Together
  - Ongoing Engagement in Stakeholder Processes and Organizing

Community Engagement Meetings *(CEMs)*

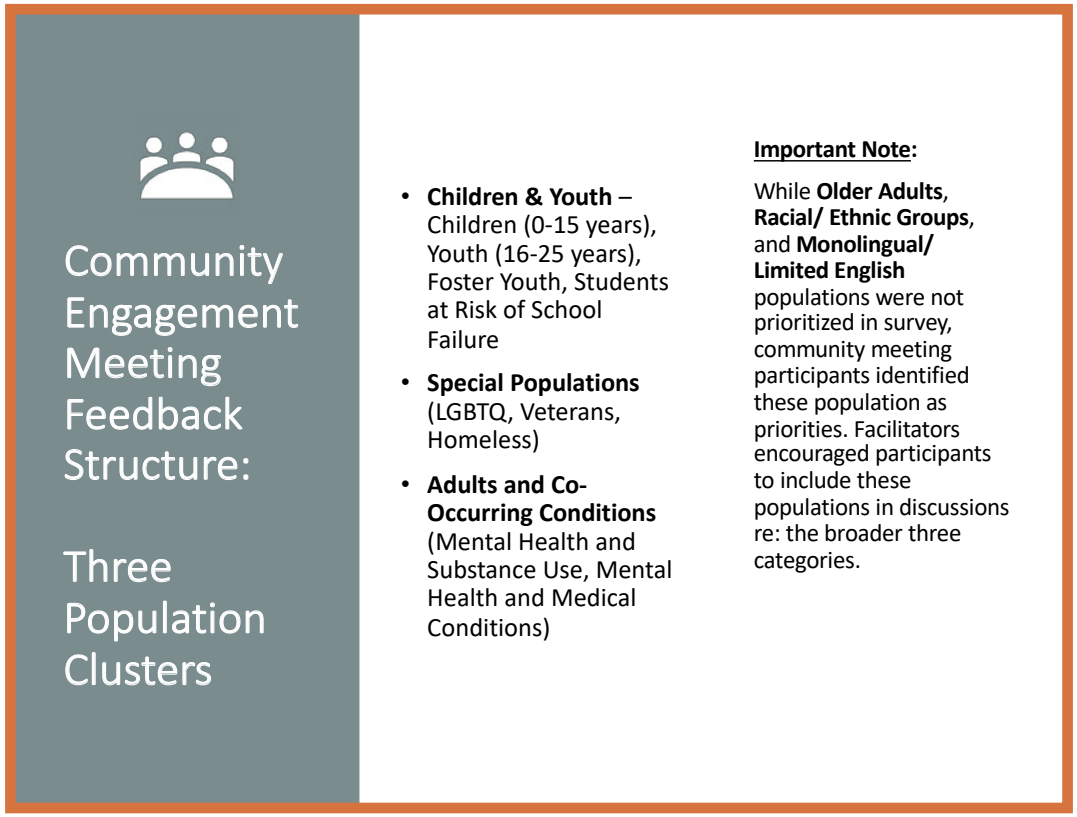
Following the training, the MHSA Office hosted a total of eight CEMs between October and November for four different stakeholder groups (described below). The goal of the CEMs was to stimulate discussions and elicit strategies intended to remove barriers and improve service delivery for specific, identified target populations. Each CEM was facilitated following the same general structure:

- Facilitators reviewed relevant background information to frame the subsequent discussion.
- Participants broke out into smaller workgroups to discuss prompt questions and reported themes of their discussion to the overall group.
- Facilitators wrapped up the discussion.
- HCA staff briefly described next steps in the planning process.

County Service Planning Areas (SPAs) CEMs

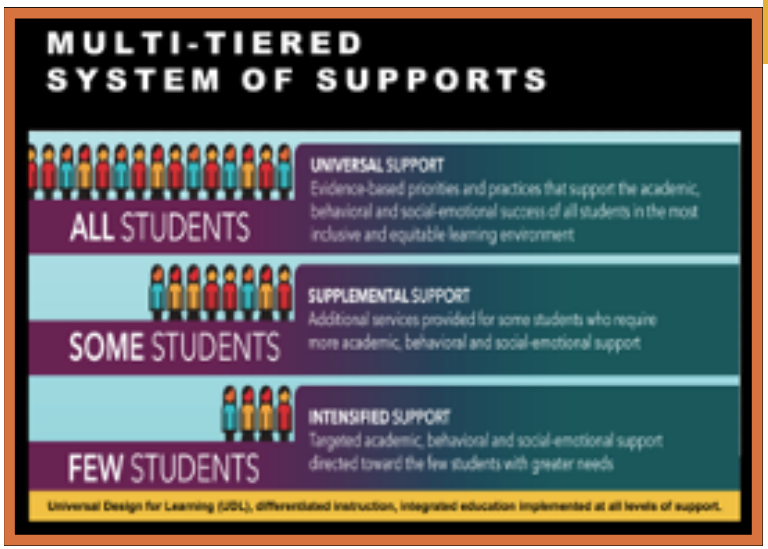
- Meetings for two different community stakeholder groups:
  - Three general provider/advisory board member CEMs (n=78 total), facilitated by Desert Vista Consulting.
  - Three consumer/family member/general community CEMs (n=75 total), facilitated by an external Consumer Stakeholder consultant and Desert Vista Consulting.
  - Because the SPA CEMs were intended to elicit feedback from these two groups of community stakeholders, they were held in three cities across the county to make the meetings accessible to as many interested parties as possible (i.e., Fullerton, Santa Ana, Laguna Niguel).
  - Participants could attend one CEM. The provider/advisory board and consumer/family member/community CEMs were held simultaneously in each SPA.
- CEM Structure:
  - Participants worked in two sequential workgroups where they discussed five question prompts regarding the challenges, barriers and successful strategies for addressing the needs of the identified target population, and reported out key points to the larger group.
- Target Populations (identified through preliminary survey results from 865 respondents):
  - Children & Youth (i.e., 0-25, Foster, Students at risk of school failure).
  - Special Populations (i.e., LBGTQ, Veterans, Homeless).
  - Adults & Individual w/ Co-Occurring Conditions (i.e., SUD, medical).

Note: Meeting participants also identified Older Adults, Racial Ethnic Groups, and Monolingual/ Limited English populations identified as priorities, and facilitators encouraged participants to include these populations in discussions within the broader three categories outlined above.



K-12 Public School Districts CEM

- Meeting:
  - Meeting with Superintendents, Assistant Superintendents, School Psychologists, Counselors, District Office staff, etc. (n=110), co-facilitated by the HCA and Orange County Department of Education (OCDE).
- CEM Structure:
  - Each School District worked to identify the needs of its students, staff, etc., according to the Multi-Tier System of Support (MTSS):
    - "Universal Support" for all students
    - "Supplemental Support" for some students
    - "Intensified Support" for few students
- Target Populations:
  - K-12 students and staff in the Orange County public school system.



Criminal Justice CEM

- Meeting:
  - Meeting with Criminal Justice and Juvenile Justice Agencies representatives (n=13) participating in the Integrated Services workgroup, facilitated by the HCA.
- CEM Structure:
  - The group refined needs according to Pillars from the Integrated Services 2025 Vision Plan that were applicable to MHSA:
    - "Prevention" Pillar
    - "Courts" Pillar
    - "Re-Entry" Pillar
  - The "Juvenile/Transition Age Youth" Pillar was integrated into the above pillar discussions to ensure that adolescent and TAY needs were addressed.
- Target Populations:
  - Individuals involved in the Orange County Criminal Justice/Juvenile Justice system.

SPA Community CEMs

Children/Youth:

- Residential programs
- Mental Health Spirit Week in schools
- Family retreats
- School counselors
- Mindfulness-required curriculum

Adults and Individuals with Co-Occurring:

- Transportation assistance
- Supportive Housing
- Peer supports
- Increased integration and communication
- Consistent training
- Employment supports
- Residential programs
- Therapists and therapy

Special Populations:

- Residential programs for those with mental health issues and developmental disabilities
- Better access/coordination with medical providers
- Public hygiene centers for homeless
- Safe parking lots (night services, homeless living in cars)
- Partnership with private funded services
- Unified case management
- Linkage programs (e.g. Vets, Big Brothers/Big Sisters)

Public K-12 CEMs

Universal Support (All students):

- Mental Health Awareness and Stigma and Discrimination Reduction Campaigns
- Bullying Prevention Campaigns
- Crisis Response and Support
- Mental Health and Well-Being Curricula
- Digital Citizenship
- Teacher and Staff Trainings to build knowledge, awareness and skills related to MH
- Needs assessments and screeners
- Wellness Centers

Supplemental Support (Some Students):

- Small student groups designed to promote Mental Health/Well-Being among at-risk students
- Violence and Gang Prevention
- Screening, referral, linkage to needed services
- Parenting classes and workshops
- Counseling
- Services for target populations (i.e., homeless, foster youth, LGBTIQ, undocumented, etc.)

Intensified Support (Few Students):

- Early Intervention Outpatients services
- Support for students experiencing a behavioral health crisis

Criminal Justice CEMs

Prevention Pillar:

- Public Awareness campaigns
- Training for Agency/Partner staff, First Responders, Law Enforcement
- More STRTP beds for Juveniles/TAY
- Clinician added to North SMART for youth
- Clinicians co-located at Probation, SSA for adults
- More clinicians on Collaborative Court teams
- Streamlined referral process

Courts Pillar:

- Tool for tracking data/individuals moving through the Collaborative Court process
- Expansion of Specialty Courts
- Improvement in Court-County Relationship

Re-Entry Pillar:

- Coordinated MH/BH case management from admission through post-custody
- Continuous communication trail as person moves through the CJ system
- More nurses for post-release/re-entry support
- Psychiatric medication one week post-release
- More professional staff for in-reach
- A Re-Entry Center less than one mile from jail
- Transportation to Behavioral Health resources

It should be noted that the HCA recognizes the CEMs are an important first step in the dialogue with community stakeholders that will help identify strategies responsive to the needs of unserved and underserved populations. The HCA intends to continue discussions with these and other stakeholder groups (i.e., ethnic groups, LGBTIQ community, etc.) periodically through the Three-Year Plan period to monitor progress in addressing community needs and reducing disparities.

Identifying MHSA Strategic Priorities: Integrating Community Feedback and County Health Trends and Disparities

At the December 16, 2019 MHSA Steering Committee meeting, Desert Vista Consulting, Richard Krzyzanowski, the OCDE, and the Orange County Sheriff's Department presented a summary of findings from their respective CEMs. Desert Vista Consulting also presented summaries of the Community Feedback Survey. Following the presentation, the Steering Committee was invited to share their thoughts and reactions to the information provided and, as part of that discussion, requested that HCA return the following month with its recommendations on programming and funding priorities for the Three-Year Plan.

As part of identifying recommended priorities and as required by the CCR, HCA conducted an Assessment of Mental Health Needs. Using a multi-step process, the MHSA Office reviewed mental health trends and disparities identified in several published reports:

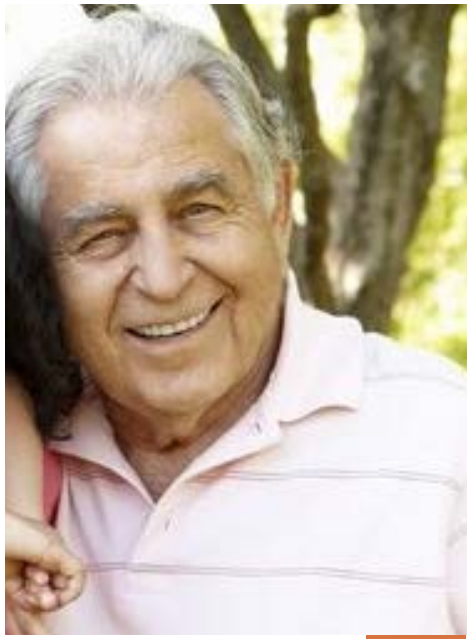
- Orange County Needs and Gaps Analysis (October 2019, UCSD)
- CalOptima Member Health Needs Assessment (March 2018)
- The 25th Annual Report of the Conditions of Children in Orange County
- Suicide Deaths in Orange County, CA (2014-2018)
- Orange County Healthier Together Website, accessed January 2020

The MHSA Office reviewed the findings from these reports, looking for:

- Commonalities across the reports.
- Alignment with State and Local initiatives.
- Correspondence with feedback from the 2018 and 2019 Community Program Planning Process (i.e., 2019 Community Feedback Survey, 2018 and 2019 Community Engagement Meetings, 2018 PEI Planning Meetings).

As part of a review of its capacity to implement per the CCR, BHS Managers reported that consumers seeking MHSA services primarily experienced these challenges:
While many individual programs have implemented strategies to address these issues (which are described within each program description), transportation, the number of bilingual service providers and stigma remain persistent challenges across the overall system of care.

Barriers to Implementing by MHSA Program/ Program Category	Transportation Assistance		Child Care Issues		Monolingual/ Limited English Proficiency		Stigma	
	PEI	CSS	PEI	CSS	PEI	CSS	PEI	CSS
Mental Health Community Education Events for Reducing Stigma & Discrimination	X	-	X	-		-	X	-
Outreach for Increasing Recognition of Early Signs of Mental Illness	X	-	X	-	X	-	X	-
Mental Health and Well-being Promotion Programs	X	-	X	-		-	X	-
Violence and Bullying Prevention Programs		-		-		-	X	-
Navigation/ Access		X			X		X	X
Crisis		X				X	X	X
Outpatient Treatment	X	X	X	X	X	X	X	X
Supportive Services	X	X	X	X	X	X	X	X



Proposed Strategic Priorities for the Three-Year Plan

Based on this assessment and review, the HCA proposed the following MHSA Strategic Priorities for the MHSA Three-Year Plan:

- Mental Health Awareness and Stigma Reduction (PEI)
- Suicide Prevention (PEI, CSS)
- Access to Services (PEI, CSS)

The rationale and strategies for addressing each proposed priority are outlined below. The complete slide decks and crosswalk of report findings presented to the Steering Committee on January 13 and 29, 2020 are provided in Appendix III.

Recommended Priority: Mental Health Awareness and Stigma Reduction (PEI)

Consistent with 1) data from several reports where stigma was frequently identified as a barrier to accessing needed behavioral health services and 2) local and state initiatives, Orange County proposes to further expand campaigns, training and community education that is focused on increasing awareness of mental health signs and available resources, as well as stigma reduction. These areas were also identified during the 2018 PEI Community Planning Process (see Appendix IV for summary) and initially expanded in the FY 2019-20 Plan Update. During this Three-Year Plan, the HCA plans to further enhance these efforts using additional carryover PEI funds, which includes approval via the community planning process to increase funding for campaigns mid-year, if available, to expand the reach and/or scope of the campaigns and trainings.

The priority populations for targeted outreach through these campaigns, based on the UCSD Needs and Gaps Analysis and/or 2019 Community Feedback Survey, include:

Slides from January 13, 2020 MHSA Steering Committee Meeting

- LGBTIQ
- Boys ages 4-11 years
- TAY
- Adults ages 25-34 and 45-54
- Adults with a high school education or some college education (but no degree)
- Unemployed
- Homeless
- Individuals living with a co-occurring mental health and substance use disorders
- Older Adults, per the recommendation of the Mental Health Board

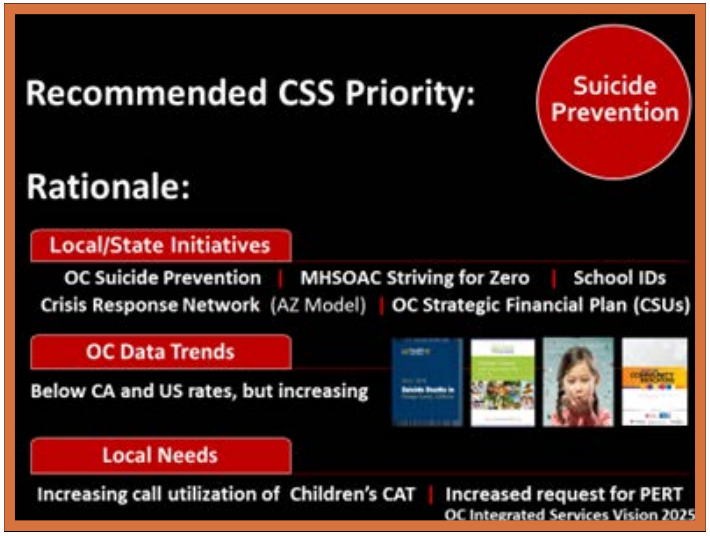
To achieve this MHSA Priority, the HCA will continue partnering with local groups that successfully engage these and other unserved and underserved populations, as well as CalMHSA's Statewide Projects and other media/marketing organizations that have specialized expertise in this area. In addition, the HCA will incorporate the findings and recommendations from recent RAND reports on social marketing related to mental health and mental-health related stigma, as appropriate.

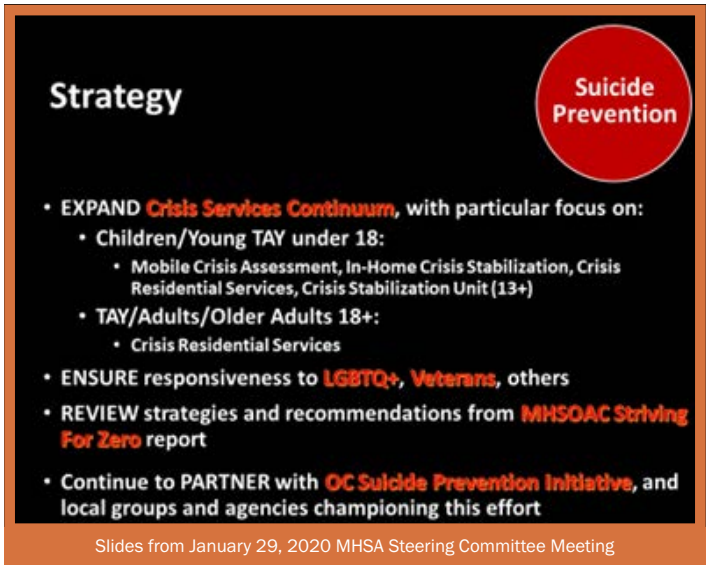
Recommended Priority: Suicide Prevention

Consistent with 1) data reported primarily in the Suicide Report and Conditions of Children Report and 2) several local and state initiatives, Orange County proposes to expand support for its suicide prevention efforts. All PEI- and CSS-funded suicide and crisis prevention/support programs have been expanded in the Three-Year Plan using carryover funds. In addition, these programs have been approved via the community planning process to receive additional PEI and/or CSS carryover funding mid-year, if available, should demand for services outpace the augmented budgets.

Based on the report on suicide deaths in Orange County, 2019 Community Feedback Survey, 2019 CEMs and the BHS capacity assessment, the HCA priority populations and programs to be supported through this effort, include:

- Increased funding for the Warmline and Suicide Prevention Services (PEI, all ages).
- Increased crisis services for children and TAY under age 18, including:
  - Mobile Crisis Assessment
  - In-Home Crisis Stabilization
  - Crisis Residential Services





Slides from January 29, 2020 MHSA Steering Committee Meeting

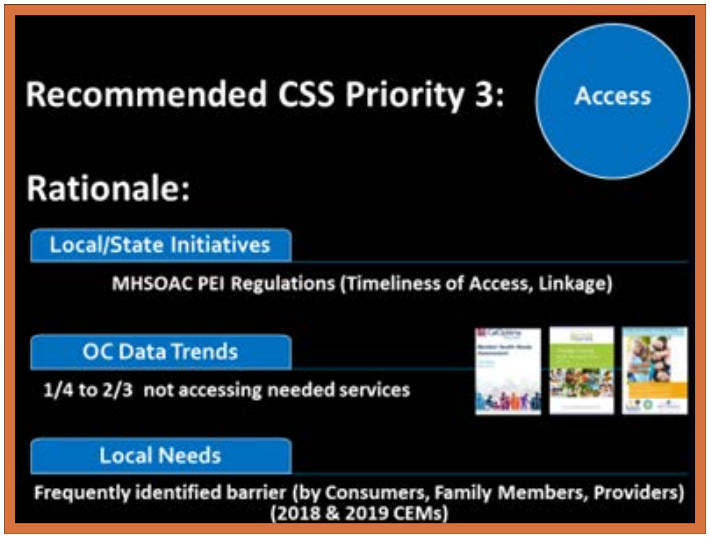
- Increased Crisis Residential Services for adults ages 18 and older, including:
  - Dedicated beds/facility for older adults

To achieve this MHSA Priority, the HCA will incorporate strategies and recommendations from the MHSOAC Striving for Zero report and continue partnering with the local OC Suicide Prevention Initiative. Per the 2019 Community Feedback Survey, the HCA will also work to ensure that crisis services and suicide prevention efforts are responsive to the needs of the different MHSA age groups (i.e. children, TAY, adults, and older adults), individuals who are homeless, individuals living with a co-occurring mental health and substance use disorder, the LGBTIQ community, and Veterans.

Recommended Priority: Access

Consistent with 1) several reports finding that a significant proportion of Orange County residents face barriers to accessing needed behavioral health services and 2) HCA's capacity assessment noting that transportation challenges persist for consumers, Orange County proposed three strategies designed to improve access to behavioral health services as part of the Three-Year Plan:

- Expand transportation services (PEI, CSS).
- Expand school-focused mental health services (PEI, CSS).
- Offer telehealth and virtual behavioral health care options for individuals of all ages who are living with serious emotional disturbance or serious mental illness, with an initial focus on those who are 18 and older (CSS).
- Work with the community to identify and integrate strategies and approaches that improve the cultural and linguistic responsiveness of the BHS system of care (PEI, CSS).



Slides from January 29, 2020 MHSA Steering Committee Meeting

With regard to the Transportation program, the expansion will provide assistance to participants enrolled in PEI programs. The HCA will also explore 1) options for expanding services to youth and to families with children, including those who must be transported in child safety seats, 2) the feasibility of expanding the program to include transportation assistance to support services that help address social determinants of health, and 3) opportunities to leverage transportation assistance provided by other partners and agencies (i.e., CalOptima, etc.) so that efforts are not being duplicated unnecessarily.

The UCSD report found that the target populations least likely to receive minimally adequate treatment were Asian/Pacific Islander, Latino/Hispanic and African-American adults. Thus, the HCA will continue to monitor its penetration rates into these and other priority populations and partner with community-based organizations to improve its cultural and linguistic responsiveness, including for Chinese consumers as Mandarin Chinese recently became a threshold language in Orange County.

As with the other MHSA Strategic Priorities for the Three-Year Plan, and per the community planning process, budgets for the above programs and strategies may be augmented mid-year should demand for their services outpace the augmented budgets and carryover PEI and/or CSS funding is available. Per the recommendation of the Mental Health Board, this includes periodically evaluating whether Older Adults have access to needed services and directing carryover CSS and/or PEI funding, if available, to increase service capacity of older adults mid-year, if needed.

ORANGE COUNTY AT-A-GLANCE

POPULATION: 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 (3,185,968) people *(Census, v2018)*, up almost 7% from 2010.
ETHNIC/RACIAL DIVERSITY: 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, 2018 5-yr estimates 2014-2018)*.
LANGUAGES SPOKEN: Currently, Orange County has six threshold languages (Spanish, Vietnamese, Korean, Farsi, Arabic, Mandarin Chinese).	According to Orange County's Healthier Together (2020), English is spoken at home by 53.2% of the population four years and older, followed by Spanish (26%) and Asian/Pacific Islander languages (14%).
AGE GROUPS: 22.5% of the County's population was under age 18 and 15% were 65 or older. (Census, v2018)	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.
VETERANS: Approximately 5% (112,264) of the civilian population 18 and older are veterans. (Census, 2018 5-yr estimates 2014-2018	In one study of OC veterans, 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 *(OC Veterans Initiative)*.
LGBTIQ: Orange County is home to a growing and diverse Lesbian, Gay, Bisexual, Transgender, Intersex, Queer/Questioning population.	Approximately 4% of Orange County residents identify as gay, lesbian, homosexual or bisexual, and 24% of teenagers report they are not gender conforming *(CA Health Interview Survey, 2018)*.
EDUCATION LEVEL: The County has a well-educated population, with 85% of residents ages 25 years and older having a high school diploma and 40% having earned a bachelor's degree or higher.	This is slightly higher than the state average of 84% having graduated high school and 34% having earned a bachelor's degree or higher *(Census, 2018 5-yr estimates 2014-2018)*.
COST OF LIVING: 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.	■ 85,851: Median household income ■ $1,777: Median Gross Rent ■ $652,900: Median House Price ■ 5.1%: Unemployment Rate ■ 11.5%: Individuals below Poverty Level *(Census, 5-yr estimates 2014-2018)*

ORANGE COUNTY CSS/PEI BUDGETS AND PROJECTED NUMBERS TO BE SERVED, BY FISCAL YEAR AND DEMOGRAPHIC CHARACTERISTICS

FY 2020-21 – 2022-23 Component Budget		
Fiscal Year	**CSS**	**PEI**
Actual FY 2019-20 Budget	$174,195,419	$43,490,187
Proposed FY 2020-21 Budget	$155,088,175	$47,061,483
Proposed FY 2021-22 Budget	$164,627,171	$49,286,926
Proposed FY 2022-23 Budget	$165,320,336	$40,988,101

Projected Unduplicated # to Be Served by Component		
Fiscal Year	**CSS**	**PEI**
FY 2019-20	55,503	195,333
FY 2020-21	61,623	216,898
FY 2021-22	68,242	204,483
FY 2022-23	73,066	173,549

Estimated Proportion of Clients to be Served by Component and Demographic Characteristic								
Age Group	**CSS**	**PEI**	**Gender**	**CSS**	**PEI**	**Race/Ethnicity**	**CSS**	**PEI**
0-15 years	9%	47%	**Female**	42%	54%	**African American/Black**	7%	3%
16-25 years	16%	18%	**Male**	56%	42%	**American Indian/Alaskan Native**	1%	3%
26-59 years	63%	25%	**Transgender**	2%	1%	**Asian/Pacific Islander**	10%	14%
60+ years	12%	10%	**Genderqueer**			**Caucasian/White**	42%	23%
			Questioning/Unsure			**Latino/Hispanic**	34%	47%
			Other		2%	**Middle Eastern/North African**	1%	1%
						Other	5%	9%

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.

Based off of the budget true-up, priorities identified through the community planning process and needs/disparities assessment, several existing CSS programs have been identified for increased funding during this Three-Year Plan:

Crisis Prevention and Support Services

- Mobile Crisis Assessment (Children's team)
- Crisis Stabilization Units (ages 13 and older)
- In-Home Crisis Stabilization (Children's team)
- Crisis Residential Services (all ages)

Clinic Expansion Programs

- Children & Youth Clinic Services
- OC Children with Co-Occurring Mental Health Disorders
- Services for the Short-Term Residential Short-Term Therapeutic Residential Program
- Full Service Partnership (older adults)
- Program for Assertive Community Treatment (older adults)
- Older Adult Services

Supportive Services

- Transportation (expand capacity for the following populations):
  - Adults
  - Older adults
  - TAY
  - Children

The following changes to the CSS component are also proposed:

- Discontinue MHSA funding for the Adult Dual Diagnosis Residential Treatment program (services will continue to be provided in full through Drug Medi-Cal and Medi-Cal funding).
- Implement a new program offering telehealth and virtual behavioral health care solutions.
- Procure and implement the Supportive Services for Residents in Permanent Supportive Housing program, initially proposed in the FY

2019-20 Annual Plan Update, as a target population to be served by a Full Service Partnership provider rather than as a standalone program.

Using carry-over funding, the CSS component budget will temporarily expand over its annual ongoing budget amount of approximately $138 million, resulting in these proposed annual budgets:

FY 2020-21
$155,088,175
FY 2021-22
$164,627,171
FY 2022-23
$165,320,336

Slightly over half of the CSS budget, excluding transfers to WET and CFTN, is dedicated to serving individuals enrolled in and/or eligible to be enrolled in a Full Service Partnership program. A description of each CSS program is provided in 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 HCA engaged in an extensive community planning process in 2018 (see sidebar) to identify PEI programs that would receive time-limited funding in order to expend unspent funds carried over from recent prior fiscal years.

Based off of the budget true-up, the priorities identified through the current community planning process and needs/disparities assessment, several PEI programs have been identified for increased funding during this Three-Year Plan:

- Statewide Projects
- Transportation Assistance
- WarmLine
- Suicide Prevention Services
- Stress Free Families

For the upcoming Three-Year Plan, several program consolidations will be occurring to streamline operations and create efficiencies without negatively impacting service delivery:

- The Suicide Prevention Hotline and Survivor Support Services are being combined into one County-contracted program: Suicide Prevention Services.
- Three County-operated, family-focused early intervention programs are being combined into one program with specialized service tracks for specific target populations: OC Parent Wellness Program.
- Two County-operated early intervention programs serving all age-groups and culturally diverse populations are being combined into the Community Counseling and Supportive Services Program.
- Six programs providing similar outreach and training activities are being consolidated into a single program, Outreach to Increase Recognition of the Early Signs of Mental Illness. Services will be delivered by different providers that each specialize in working with specific target populations.

Because the first year in the Three-Year Plan is a “bridge” year between the old and new program structure, where appropriate, the new program may provide information from the former, individual programs.

Finally, School-Based Behavioral Health Intervention & Support- Early Intervention Services will be discontinued due to the unsustainability of program operation costs at its new location.

The PEI component budget will temporarily expand over its annual ongoing budget amount of approximately $36 million using carry-over funding for proposed annual budgets as follows:

FY 2020-21
$47,061,483
FY 2021-22
$49,286,926
FY 2022-23
$40,988,101

Consistent with PEI requirements, 64% of total PEI budget is dedicated to serving youth who are under age 26 years. PEI is governed by additional regulations and legislation, which are described in Appendix V. A description of each PEI program is provided in this Plan.

2018 PEI Community Planning Workshops

As described in the MHSA Annual Plan Update for FY 2019-20, an extensive community planning process took place in 2018 to plan for the spending of PEI carryover funds that had been unallocated to programs and services at the time the community planning took place. As a result of this community planning, new PEI priorities (described in the PEI and INN Regulations Section) as well as local data regarding community need, nine recommendations for funding allocations were identified. These recommendations will continue to be implemented in this Three-Year Plan:

1. An early childhood mental health program targeting early childcare providers serving families and children
2. Expand school-based services to better address mental health needs, K-12
3. Expand existing Gang Prevention Services
4. Implement services for TAY and young adults at community colleges and universities
5. Expand existing services for isolated older adults
6. Provide a variety of behavioral health community trainings
7. Expand outreach to cultural and linguistic populations that continue to be underserved
8. Expand Community Mental Health Education Events to Reduce Stigma
9. Expand services for Veterans

Innovation Component

The MHSA designates 5% of a County's allocation to the Innovation component, which specifically and exclusively dedicates funds to trying new 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 CSS, PEI or other funds. All active projects are described in this Plan, and regulations governing the INN component are described in Appendix VI.

In addition, the HCA is in various stages of exploring several new potential Innovation projects, which are listed in alphabetical order and briefly described in the Special Projects section of this Plan:

- allcove
- Mental Health Adult and Older Adult Residential Facilities
- Mental Health Participant Pet Boarding Services
- Mental Health Participant Pet Veterinary Care
- Middle School Student Wellness Centers
- Mobile Phones
- Older Veterans Support Program
- Peer Intervention Journal
- Psychiatric Advance Directives – Supportive Decision Making
- Psychiatry Clinical Extender Program
- Shelter Grade Housing
- Shelter Living Skills Curriculum
- Social Media & Prediction Technology
- Approaches to Stigma Reduction
- Young Children at-risk of ADHD

Finally, the following Innovation projects are concluding during FY 2019-20 and will not be continued in the Three-Year Plan. A summary of project outcomes from inception to end date for each of these projects will be provided in their respective Final Innovative Project Report.

- The Religious Leaders Behavioral Health Training Services Innovation Project ended services in June 2019. The training component of this project was identified as a priority during the 2018 PEI Community Planning meetings and incorporated into the Outreach to Increase Recognition of Early Signs of Mental Illness program (Behavioral Health Community Training & Technical Assistance track).
- The Onsite Engagement in Collaborative Courts Innovation Project ended services in November 2019.
- The Behavioral Health Services for Independent Living Innovation Project will end services in June 2020.

The INN component budget per FY for currently approved projects is as follows:

FY 2020-21	$18,346,360
FY 2021-22	$9,009,773
FY 2022-23	$2,042,071

Workforce Education and Training Component

Workforce Education and Training (WET) component is intended to increase the mental health services workforce and to improve staff cultural and language competency. It is currently funded through transfers from CSS and the proposed budgets per FY is as follows:

FY 2020-21	$6,216,634
FY 2021-22	$5,219,984
FY 2022-23	$5,296,662

The increased budget in FY 2020-21 is to cover a one-time transfer of funds in the amount of $1,071,050 to CalMHSA as part of Orange County's contribution to the statewide 2020-2025 WET Five-Year Plan.

A full description of each WET program is provided in the System Supports section.

Capital Facilities and Technological Needs Component

The Capital Facilities and Technological Needs (CFTN) component funds a wide range of projects necessary to support the service delivery system and is currently funded through transfers from CSS. Funds are being transferred to CFTN to support several projects over the next three years:

- Renovations for a behavioral health training facility.
- Continued development and enhanced functionality of the HCA Behavioral Health Services electronic health record (EHR).
- Development and on-going support of a County Data Integration Project, which will facilitate appropriate, allowable data-sharing across County departments and with external stakeholders with the goal of delivering essential and critical services, including behavioral health care, to county residents in a more efficient and timely manner.

The proposed annual CFTN component budgets are as follows:

FY 2020-21	$12,519,749
FY 2021-22	$8,840,752
FY 2022-23	$8,966,158

In addition, if a viable site for another Wellness Campus is identified, additional CSS funds may be transferred into CFTN during this three-year period, pending the availability of funds and compliance with the requirement that the annual combined transfer amount to CFTN, WET and the Prudent Reserve does not exceed 20% of the average amount of total MHSA funds allocated to Orange County for the previous five years.

CSS Housing

Under direction from the Board of Supervisors, a total of $70,500,000 of CSS funds was allocated during FY 2018-19 to the development of permanent supportive housing. It is anticipated that all funds will be allocated to projects in various phases of development by the end of FY 2020-21.

Community Planning Expenditures

Per California Welfare and Institutions Code (WIC) 5892, a county is authorized to use **up to** 5% of its total annual allocation to cover community planning costs, where planning costs shall "include funds for County's MHSA programs to pay for the costs of consumers, family members, and other stakeholders to participate in the planning process and for the planning and implementation required for private contracts to be significantly expanded to provide additional services pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850)."

Consistent with the WIC, the HCA shall use MHSA funds for allowable purchases of food, refreshments, transportation assistance, parking fees and/or promotional items. These items will be offered to consumers, family members, the public, committee and advisory board members, non-HCA providers and other stakeholders to encourage them to participate in planning and feedback activities, learn about MHSA and/or Orange County's services, and/or publicly recognize the achievements of MHSA's consumers and programs (e.g., graduation ceremonies, etc.). The items may be provided at conferences, meetings, training events, award ceremonies, representation activities, community outreach activities, and other similar events where consumer, family members and/or other potential stakeholders may be likely to attend. In addition, MHSA funds may be used to purchase gift cards and/or provide stipends for consumers, family members and/or community stakeholders who actively engage with the HCA to provide valuable feedback regarding programming, services, strategies for overcoming barriers to accessing services, etc. This feedback may be provided through surveys, workshops, focus groups or other similar types of activities.

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 the MHSA in Orange County.

PUBLIC HEARING AND APPROVAL BY THE BOARD OF SUPERVISORS

The MHSA Three-Year Program and Expenditure Plan for FYs 2020-21 through 2022-23 was completed, reviewed and approved by the BHS Director and posted to the Orange County MHSA website on March 16, 2020 for a 30-day review by the public. At the close of the of the public comment period the MHSA Office and BHS Managers responded to all substantive public comments which were submitted to the Mental Health Board. On April 22, 2020 the Mental Health Board (MHB) held a Public Hearing via a Zoom virtual meeting due to physical distancing requirements and a prohibition against large gatherings as a result of COVID-19. The Public Hearing was advertised through a posting with the Clerk of the Board and emails sent to members of the MHSA Steering Committee and interested community members who have asked to be notified of meetings and events from the MHSA Office. In addition, the Public Hearing was posted on the Board of Supervisors Event Calendar, promoted through the Health Care Agency's social media applications (Twitter, Facebook), and through advertisements in newspapers/magazines in all County threshold languages.

At the April 22nd Public Hearing, BHS Management reviewed the strategic priorities for the proposed Three-Year Plan, as well as significant changes from the current Plan ending FY 2019-2020. In addition, individuals from MHSA programs provided testimonials to the positive impact that services have had on their lives and public comments were received. The Chair of the Mental Health Board led a discussion among the members, of which there was a quorum, and the Mental Health Board unanimously approved the following recommendations, to which the HCA has provided an analysis:

- MHB Recommendation 1: BHS and the Board of Supervisors (BOS) emphasize and implement public health models in outreaching to all members of the Orange County population and to coordinate multi-agency collaboration to meet these needs.
  - Analysis: Operating off of the four areas of the public health model (i.e., defining the problem; identifying risk and protective factors; developing and testing prevention strategies; assuring widespread adoption), the identification of the three Strategic Priorities in the Plan is recognized as the first step in *defining the problem* (i.e., trend of increasing deaths by suicide; persistent challenges around mental health-related stigma and discrimination, awareness of available mental health resources, etc.; persistent challenges faced by consumers and family members in accessing needed

behavioral health services). In addition, refinement of the priorities will continue through integration of strategies proposed in Statewide reports (i.e., MHSOAC's Striving for Zero: California's Strategic Plan for Suicide Prevention 2020-2025, RAND's 2019 Social Marketing of Mental Health Treatment: California's Mental Illness and Stigma Reduction Campaign, RAND's 2018 Differential Association of Stigma with Perceived Need and Mental Health Services Use) and on-going community planning and feedback.

The HCA also welcomes the opportunity to work with community stakeholders, partner agencies and provider organizations to:

- Ensure coordination (rather than duplication) of services across MHSA-funded programs/services and those provided by other organizations and agencies.
- Identify strategies, approaches, messaging, etc. that are responsive and tailored to the needs of unserved and underserved consumers and their family members.
- Monitor progress in addressing community needs and reducing disparities.
- *Identify risk and protective factors* experienced by, and *develop intervention strategies* responsive to, Orange County's diverse communities.

Throughout the Three-Year Plan period, the HCA intends to continue discussions begun in the Community Engagement Meetings with diverse stakeholder groups (i.e., ethnic groups, LGBTIQ community, Veterans, families, Older Adults, etc.) focused on the above areas, with a greater push towards increasing the consumer and family member voice. Having provider organizations and partner agencies in these conversations can also help facilitate *widespread adoption* of the interventions and strategies, as appropriate/applicable.

In addition, the HCA will be over-sampling Orange County residents on the California Health Interview Survey (CHIS) and improving HCA-developed surveys and distribution methods. It will also continue to improve its program outcomes data collection and reporting as the technical infrastructure is put in place and to implement metrics identified by the state. This shift to a more data-informed and population-based approach will, in part, help facilitate the identification of which strategies are successful and under what conditions (i.e., *developing and testing prevention strategies*), which will help further inform future MHSA community planning.

- MHB Recommendation 2: Older Adults should be a priority population.
  - Analysis: Older Adults have been added as a target population in each of the Strategic Priorities for the Three-Year Plan
- MHB Recommendation 3: The MHB supports the Plan but recognizes that there may be substantial financial impact from the current economic crisis. We recommend that the BOS, BHS and the MHB collaborate in revisiting the MHSA Plan once there is clarity on future revenue adjustment.
  - Analysis: As described in more detail below ("*Preparing for the Impact of COVID-19*"), the HCA and CEO Budget staff have been, and will continue to, monitor the impact of COVID-19 on revenue and expenditures. In support of this recommendation by the MHB, the HCA and/or CEO Budget will provide regular updates to the MHSA Steering Committee and Mental Health Board on the fiscal landscape affecting the MHSA Three-Year Plan. Should it become necessary to make significant budgetary adjustments to the Plan, the HCA will take any required steps, including stakeholder involvement and/or notification, to amend the Plan in accordance with the California Welfare and Institutions Code.

After receiving formal recommendation by the Mental Health Board, the MHSA Three-Year Plan for FY 2020-21 through FY 2022-23 was brought before the Orange County Board of Supervisors and approved at the regularly scheduled meeting held on June 2, 2020.

Preparing for the Impact of COVID-19

The MHSA Three-Year Program and Expenditure Plan serves as a stakeholder-informed framework, developed through a community planning and needs identification process, that outlines all programs eligible to be funded through local MHSA dollars. Each program in the Plan contains a description of its services, the target population it intends to serve, estimated costs and, if already implemented, outcomes and a narrative of any significant challenges or changes the program encountered in the previous year of operation. Once the Plan is approved and submitted to the State, the County is authorized to implement the Plan. All expenditures related to the MHSA Three-Year Program and Expenditure Plan are approved by the Orange County Board of Supervisors through separate actions, in accordance with County budgeting and procurement processes. The HCA recognizes that while the *services* themselves will remain consistent with what is described in the Plan and any existing contracts, the service *delivery structure* may be adapted to remain flexible in the face of changing public health requirements related to COVID-19 (e.g., school-based mental health services delivered via telehealth if schools remain closed or students attend school on a staggered schedule; networking events hosted via teleconference and campaign messaging posted on social media and promoted through email blasts while large gatherings remain prohibited; etc.).

The economic disruption caused by COVID-19 is likely to have an impact on future MHSA revenue and HCA is planning accordingly. Along with CEO Budget Office, HCA is actively monitoring MHSA revenue and any deviations from current projections that were used to develop this Three-Year Plan. The Department of Health Care Services' fiscal consultant has provided projections on the MHSA revenue impacts due to COVID-19, and HCA is making adjustments based on those projections. Any reduction in future MHSA revenue will also need to be factored against potential savings due to reduced MHSA expenditures in FY 2019-20, and possibly part of FY 2020-21, because of reduced and/or postponed programming. Even prior to COVID-19, BHS had begun working to identify and implement efforts to better leverage other funding sources (such as Federal Financial Participation or Medi-Cal) using MHSA-funded services as the source of match for these federal dollars. This strategy is especially important now with reductions in other state-derived revenue sources such as 1991 and 2011 Realignment.

The HCA and/or CEO Budget will provide regular updates to the MHSA Steering Committee and Mental Health Board on the fiscal landscape affecting the MHSA Three-Year Plan. Should it become necessary to make significant budgetary adjustments to the Plan, the HCA will take any required steps, including stakeholder involvement and/or notification, to amend the Plan in accordance with the California Welfare and Institutions Code.

MENTAL HEALTH
Awareness Campaigns
AND EDUCATION

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

MENTAL HEALTH AWARENESS CAMPAIGNS AND EDUCATION

Program Serves	Symptom Severity	Location of Services	Population Characteristics			
2-95	At-Risk	Field / Community	All Community Members	Students	LGBTIQ	Mono-Lingual/Ethnic Community

Several programs offer a range of activities that help promote mental health awareness and stigma reduction efforts in Orange County:

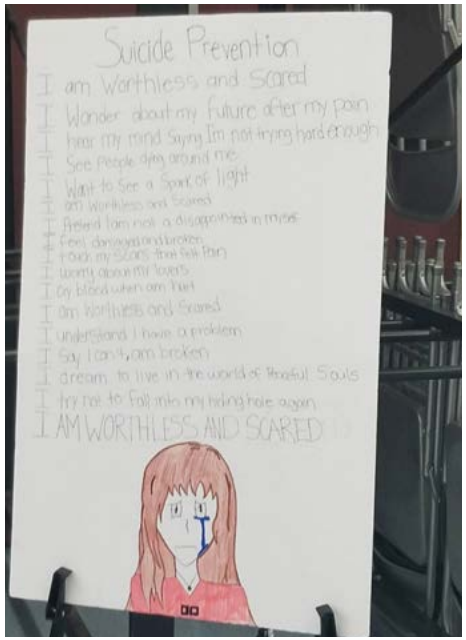
- ***Mental Health Community Education Events for Reducing Stigma and Discrimination***
- ***Outreach for Increasing Recognition of Early Signs of Mental Illness***
- Several ***Prevention*** programs focused on mental health and well-being promotion and violence and bullying prevention

These programs are designed to reach large groups of people through resource booths, art fairs, assemblies, media/social media marketing, door-to-door outreach and other strategies. They aim to strengthen the resilience and well-being of a community as a whole by providing information, training and skill-building around mental health. The programs often use creative and culturally appropriate strategies for engaging different populations, especially unserved and underserved communities.

Based on community feedback from 2018 and 2019, these programs have been identified as a funding priority in the current Three Year Plan. All programs are receiving time-limited (i.e., 3- to 5-year) expansions to their budgets, with the exception of School-Based Stress Management Services which is receiving level funding. Funding will return to the base, on-going budget amount in different fiscal years, depending on whether the temporary augmentation for a given program was for 3- or 5-years and in what year the augmentation first occurred (see program budget grids). The purpose of these budget augmentations is to increase the scale and reach of these different campaigns and community training efforts.

Community planning also identified that, in the event that the demand or opportunities for awareness campaigns and educational/training efforts outpaces these proposed budget increases, impacted programs may have their funding augmented midyear, pending availability of funds.

MENTAL HEALTH COMMUNITY EDUCATION EVENTS FOR REDUCING STIGMA & DISCRIMINATION (PEI)



FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$881,000	FY 2019-20	16,556
Proposed FY 2020-21 Budget	$881,000	FY 2020-21	16,500
Proposed FY 2021-22 Budget	$881,000	FY 2021-22	16,500
Proposed FY 2022-23 Budget	$214,333	FY 2022-23	8,300

Language Capacity of Outreach Providers					
✓	Spanish	✓	Arabic	✓	Khmer
✓	Vietnamese	✓	Farsi		Other:
✓	Korean	✓	Mandarin		Language Line as Needed

Target Population and Program Characteristics

The **Mental Health Community Education Events for Reducing Stigma and Discrimination** program hosts mental health-related educational and artistic events that aim to reduce stigma and discrimination related to mental health. Collectively, the events are open to individuals of all ages living in Orange County, with specific events intended to reach identified unserved and underserved ethnic communities. 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, plays, conferences, multi-cultural musical and dance performances, and other related activities.

Services/Events

Participants are invited to attend an event and participate in different activities designed to help them learn about and/or express their thoughts and feelings about mental illness and stigma. Activities can include viewing or creating artwork, watching performances or presentations, creating videos, storytelling and other forms of self-expression and group-learning. 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.

During FY 2018-19, community-based organizations hosted the following events:

Provider	Event Name and Description	Target Audience	# Reached
Casa de la Familia	**De Sabios y Locos (De Locos):** A play performed in Spanish with the goal of reducing stigma surrounding mental illness within Latino communities and to increase knowledge and access to mental health resources and services (6 performances in May-June 2019 in Santa Ana and Anaheim).	Latino families who exhibit limited English proficiency	575
Access California	**Peace of Mind:** A conference and family wellness event where mental health professionals and religious leaders who are trusted members of the community engaged residents in dialogue about a variety of mental health topics, provided resources and encouraged members to seek mental health services (April 14, 2019 in Santa Ana).	Middle Eastern, South Asian, and Muslim American communities	361
Latino Health Access	**La Vida a Todo Color (Life in Full Color):** Art workshop series that used artistic expression to educate participants on a variety of mental health topics, provide resources and encourage participants and family members to seek help (9 in Santa Ana, 1 in San Clemente from December 2018 through May 2019). **Our Forest of Hope:** A one-time art showcase event by young children that focuses on children who have experienced various types of trauma and are on their journey of healing (June 2019, Santa Ana). **In Our Words:** A one-time event to engage youth and young adults between ages 12-18 by showcasing their voices and mental health experiences through a variety of media and provide a safe space to encourage open conversations about mental health (June 2019, Santa Ana). **Breaking the Silence:** Events that highlight child abuse in the Latino community and "break the silence" around the topics of mental illness and the subsequent emotional and psychological impact of child abuse (2 events in April-May 2019 in Santa Ana, Anaheim).	Latino families, family friendly and open to the public	1,744
LGBT Center Orange County	**LGBTQ Youth Convening:** Presentations, spoken narratives and educational workshops to create safe and supportive schools and community spaces for LGBTQ youth (April 2019, Spurgeon Intermediate School in Santa Ana).	LGBTQ youth and young adults	180
Multi-Ethnic Collaborative of Community Agencies (MECCA)	**Drawing out Stigma Workshops:** A 7-part series of videotaped workshops that engaged participants in discussions about mental health and stigma. The resulting 3-5 minute ethnic community-specific videos were screened at various community locations throughout OC (March – April 2019 at the seven MECCA provider sites). **Multi-Ethnic Mental Health Arts Festival:** A Multi-Ethnic Mental Health film and art festival to commemorate Mental Health Awareness Month (May 2019 at the Bowers Museum in Santa Ana). **Community Receptions:** Each MECCA agency hosted an opening reception to showcase a video screening presentation followed by a meaningful dialogue about mental health perspectives of their ethnic community to further break stigma of mental illness (May – June 2019 at the seven MECCA provider sites).	Middle Eastern, South Asian, and Muslim American communities	5,473

Note: All providers were contracted to host the event(s) under a provider-specific Agreement titled "Mental Health Community Educational Event Services"

In FYs 2020-21 through 2022-23, the program intends to host events similar to what was offered in FY 2018-19, as well as adding a social media campaign in South County, a 2.5 K "Fun Run" and Resource Fair, community reading and writing events, and additional events targeting older adults.

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, encouraging their self-expression to reduce feelings of self-stigma, shame and isolation, and building connections with the larger community through interactive events open to the general community

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 encourages people living with mental illness to define themselves by their abilities rather than their disabilities.

Strategies to Increase Access to Services: Timely Access for Underserved Populations and Linkage to Treatment

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

Outcomes

HCA has been working on identifying tools and strategies for measuring stigma reduction, which can be challenging, particularly at large-scale events and performances. One provider (MECCA) asked event participants to complete a survey on their beliefs and attitudes about mental health, and a snapshot of the results are included below:

- **Drawing Out Stigma - Youth Participatory Video Workshops:** % "agreed" or "completely agreed" with the following statements (n=12)
  - **92%** "learned something new about mental health"
  - **92%** "stated that "viewing the event positively changed [their] perspective about individuals who have a mental illness"
  - **100%** "learned ways to prevent discrimination against people with mental health conditions"
  - **58%** "learned where to find more services or programs on mental health"
  - **75%** "disagreed or completely disagreed that a "person with a mental health condition is dangerous"
- **Drawing Out Stigma: Adult Participatory Video Workshops** (n=111)
  - **91%** "learned something new about mental health"
  - **83%** "stated that "viewing the event positively changed [their] perspective about individuals who have a mental illness"
  - **91%** "learned ways to prevent discrimination against people with mental health conditions"
  - **84%** "learned where to find more services or programs on mental health"
  - **71%** "disagreed or completely disagreed that a "person with a mental health condition is dangerous"
- **Community Educational Screenings** (n=517)
  - **88%** "learned something new about mental health"
  - **80%** "stated that "viewing the event positively changed [their] perspective about individuals who have a mental illness"
  - **84%** "learned ways to prevent discrimination against people with mental health conditions"
  - **81%** "learned where to find more services or programs on mental health"
  - **64%** "disagreed or completely disagreed that a "person with a mental health condition is dangerous"
- **Multi-Ethnic Mental Health Arts and Festival** (n=383)
  - **86%** "learned something new about mental health"
  - **83%** "stated that "viewing the event positively changed [their] perspective about individuals who have a mental illness"
  - **84%** "learned ways to prevent discrimination against people with mental health conditions"
  - **83%** "learned where to find more services or programs on mental health"
  - **50%** "disagreed or completely disagreed that a "person with a mental health condition is dangerous"

Taken together, the results suggest that these events were particularly effective in promoting positive messages about mental health and people living with mental health conditions among youth and adult

participants. Given the nature of the events, it is not surprising that the educational screenings and art event/festival were more effective in informing participants about available services compared to the participatory videos.

Challenges, Barriers and Solutions in Progress

The challenges encountered by the program in FY 2018-19 were primarily related to planning and coordination. While providers have wonderfully creative ideas, they may not always be aware of the complex logistical aspects of coordinating large-scale community events, including marketing, recruiting and/or engaging participants. 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 nearly 30,000 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.

OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS (PEI)

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$6,810,711	FY 2019-20	19,297
Proposed FY 2020-21 Budget	$9,336,945	FY 2020-21	38,483
Proposed FY 2021-22 Budget	$11,336,945	FY 2021-22	39,081
Proposed FY 2022-23 Budget	$6,278,245	FY 2022-23	16,100

Language Capacity of Outreach Providers					
✓	Spanish	✓	Arabic	✓	Khmer
✓	Vietnamese	✓	Farsi		Other:
✓	Korean	✓	Mandarin		Language Line as Needed

Target Population and Program Characteristics

The **Outreach for Increasing Recognition of Early Signs of Mental Illness** program is intended to reach "potential responders," i.e., community members who are working with or likely to encounter individuals who are experiencing, or at elevated risk of experiencing, a mental health challenge. At risk individuals can include, but is not limited to, PEI Priority Populations such as unserved and underserved racial/ethnic communities; immigrants and refugees; children and youth who are at risk of school failure and/or juvenile justice involvement; foster youth and non-minor dependents; individuals who have been exposed to trauma or are experiencing the onset of serious mental illness; the LGBTQ community; and those experiencing homelessness. This program is new to the Three-Year Plan and is a consolidation of six existing PEI programs designed to provide the same outreach and training activities by different providers each specialized in working with different communities/groups:

1. Behavioral Health Community Training & Technical Assistance
2. Early Childhood Mental Health Consultation Services
3. K-12 School-Based Mental Health Services Expansion
4. Services for TAY and Young Adults
5. Mental Health & Well-Being Promotion for Diverse Communities
6. Statewide Projects

Potential responders reached through this program include officers of the Courts, Probation or law enforcement; first responders; religious leaders; school personnel and students at public, charter and non-traditional schools; family members; and other community members who are working with or likely to encounter individuals in the PEI priority populations described above. This program aims to provide potential responders with information on how to 1) identify early warning signs

of mental illness and suicide risk, 2) communicate with and effectively engage individuals who are struggling with mental health conditions, 3) reduce stigma and 4) better assist individuals in accessing needed behavioral health resources.

In addition to reaching potential responders, the program conducts mental health awareness outreach to individuals of all ages who have had life experiences that place them at risk of developing behavioral health conditions but remain hard to reach in traditional ways because of cultural, linguistic or economic barriers.

Services

The program aims to better inform and/or prepare a wide range of potential responders on how to identify behavioral health conditions in all age groups as early in their onset as practicable, how to assist individuals exposed to trauma and/or living with behavioral health conditions and their families effectively, and how to increase knowledge regarding accessing behavioral health services. The five strategies used to accomplish these goals include 1) training, 2) educational/ material development, 3) community events/networking/activation efforts, 4) media campaigns, and 5) door-to-door/street outreach, and are described below.

- **Training, Technical Assistance, Consultations and Programming** for potential responders can include one or more of the following methods/ strategies/approaches:
  - *Identifying and Responding to Early Signs of Mental Illness/ Suicide Prevention/Outreach to Unserved and Underserved Cultural Communities*
    - i.e., Each Mind Matters, Sana Mente, and Ending the Silence mental health awareness materials on topics such as mental health wellness, stigma reduction, how to have conversations about mental health, identifying early signs of mental health risk, recognizing stressors and coping strategies, advocating for self, navigating the behavioral health system; social-emotional skills development, screening and assessing for challenging behaviors in young children; evidence-based or -supported curricula such as Psychological First Aid, Mental Health First Aid, Crisis Intervention Training (CIT), CIT for Law Enforcement, Kognito online mental health and suicide prevention trainings, Means Restrictions, Know the Signs; Strategies to Collaborate with Native Communities, etc.
  - *Trauma-Informed Care*
    - i.e., Critical Incident Stress Management training (please see *Crisis Services* section for critical incident support responses), Disaster Preparedness for Disaster Service Workers, Vicarious Trauma: Impact and Skills to Help You Cope, Adverse Childhood Experiences, etc.
  - *Other related topics*

RAND Social Marketing of Mental Health Treatment: *CA's Mental Illness Stigma Reduction Campaign (2019)*

- 87% of those who completed the Kognito training report that they are better prepared to identify, approach and refer students exhibiting signs of psychological distress.
- 66% of California Community College faculty who completed Kognito training report an increase in the number of conversations they had with other faculty and staff about students they were concerned about.

Training Program Strategy	FY 2016-17	FY 2017-18	FY 2018-19
Identifying and Responding to Early Signs of Mental Illness/ Suicide Prevention/Outreach to Unserved and Underserved Cultural Communities *(see endnotes for specific trainings provided by FY)*	14 Trainings,[1] 1,264 attendees	16 Trainings,[2] 929 attendees	23 Trainings,[3] 3,820 attendees

- **Educational/Informational Materials** that are culturally responsive and available in print, podcasts or online for potential responders and members of the PEI Priority Populations can address one or more of the following topics:
  - *Identifying and Responding to Early Signs of Mental Illness, Suicide Prevention, Outreach to Unserved and Underserved Cultural Communities*
    - i.e., "OC Links Talking Cards: How to Initiate a Conversation About Mental Health," CalMHSA/Statewide Projects Toolkits and Tipsheets on Stigma Reduction, Mental Health Awareness and Suicide Prevention, "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," Latinx LGBTQ + Immigrant Youth Provider Fact Sheet, etc.
  - *Trauma-Informed Care*
  - *Other related topics*

In addition, resource navigation for materials will be facilitated through an online resource/website so that information can be accessed by potential responders even after training or consultation has been completed.

- **Community Events, Networking and Activation Efforts** for potential responders and members of a PEI Priority Population can include one or more of the following methods/strategies/approaches:

  Events:
  - *Art Exhibits* showcasing artwork created by program participants that promote mental health awareness, suicide prevention, stigma reduction, etc.
    - i.e., Send the Silence Packing suicide prevention exhibit, local arts and photographic displays, etc.
  - *Performances*
    - i.e., professional theatre performances that highlight different mental health topics and followed by panel discussions that are facilitated by mental health professionals
  - *Creative Self-Expression*
    - i.e., "Directing Change," a statewide video competition where students create public service announcements focused on educating the broader community on stigma and suicide prevention (see table for information about Orange County student participation); "Life Stories," a 10-12 week evidence-based program designed for self-expression through the creation of original dramatic works where participants use their own life experiences as inspiration to others; etc.
  - *Conferences and Forums*
    - i.e., Youth Convening, to empower LGBTIQ youth, conferences targeting TEDx, TEDx Salon, Story-Telling events, Pop-up talk, etc.
  - *Resource Fairs*
  - *Other related event*s, such as wellness fairs, Teen Toolbox (events for teens and parents)

  Community Networking:
  - *Informational and Networking Forums* for schools, school districts, colleges and universities, providers and other community organizations to learn from each other about evidence-based, practice-based and community-defined best practices, etc.
  - *Other related events*

  Community Activation:
  - *On-Campus Clubs* and promotion of Student-led Activities around mental health
    - i.e., Active Minds, NAMI on Campus, Lesbian Gay Bisexual Transgender Intersex Questioning (LGBTIQ) clubs, Friday Night Live, Peer Assistance Leadership groups, Associated Student Body, etc.
  - *Community Collaborations* and/or coalitions or partnerships aimed at expanding behavioral health knowledge and awareness
  - *Other related events*

- **Media Campaigns** (i.e., culturally responsive/tailored print, radio, television, internet, social, etc.):
  - *Each Mind Matters* public service announcements (PSAs)
  - *Sana Mente PSA "Cuidate"* (i.e., "Take Care"), targeting the Spanish-speaking community between the ages 25-29
  - *Know the Signs* suicide prevention
  - *Stigma Free OC* launched October 2019
  - *"My True Colors"* Media Campaign for stigma reduction using participant created art display on public transit and bus shelters to combat negative stereotypes.
- **Door-to-Door/Street/Event-Based Outreach**
  - Door-to-door and/or street outreach conducted by provider staff, who are often trusted members of the community. Staff canvas neighborhoods to raise awareness, educate the community about mental health topics and provide them information about available services and resources. This is achieved by building rapport and trust with the community, especially with those who may be unaware of available resources and how to access them.
  - Other outreach strategies include making presentations and providing information via resource tabling at small- or large-scale community events such as health fairs, conferences, church events, 5k races, etc.

Each Mind Matters Mental Health Awareness Promotion Activity	FY 2016-17	FY 2017-18	FY 2018-19
Green Ribbons & Wristbands	53,400	77,490	57,254

Directing Change Highlights

View winning films from Orange County: https://www.directingchangeca.org/films-by-county/#Orange

FY 2018-19	■ 1,063 submissions statewide ■ 84 Orange County submissions, with 210 Orange County youth participants ■ Regional Competition Winners: ○ 3 Orange County films in the "Mental Health Matters" category ○ 3 Orange County films in the "Suicide Prevention" category Honorable mentions ○ 3 Orange County films in the "Through the Lens of Culture" category ○ 10 "Mental Health Matters" category ○ 9 "Suicide Prevention" category ○ 1 "Sana Mente" Category ○ 2 "Animated Shorts" category
FY 2017-18	■ 742 submissions statewide ■ 134 Orange County submissions, with 342 Orange County youth participants ■ Regional Competition Winners: ○ 3 Orange County films in the "Mental Health Matters" category ○ 3 Orange County films in the "Suicide Prevention" category ○ 1 Orange County film in the "Through the Lens of Culture" category
FY 2016-17	■ 456 submissions statewide ■ 46 Orange County submissions ■ Regional Competition Winners: ○ 3 Orange County films in the "Mental Health Matters" category ○ 2 Orange County films in the "Suicide Prevention" category

97% of students who participated in **Directing Change** pledged to support a friend with a mental health challenge

from: RAND Social Marketing of Mental Health Treatment: CA's Mental Illness Stigma Reduction Campaign (2019)

Location of Outreach Trainings, Activities and Events: These outreach strategies and methods are provided at locations convenient for the different potential responders and can include early childcare facilities (licensed and licensed exempt, family and faith-based childcare programs, non-state/non-federally funded programs); K-12, college and university campuses and District Offices; faith institutions; Juvenile Hall, Orange County Courts, law enforcement/police departments, hospitals, first responder stations/locations; community-based organizations; Social Services Agency; shelters, Family Resource Centers, parks, older adult community centers, wellness centers, residential treatment facilities and recovery homes; Mexican Consulate Office; the HCA Behavioral Health training facility; and other community locations convenient for target population to be trained.

Informational resources, educational materials, and promotional and behavioral health-related advertising campaigns can also be provided at community events (e.g., NAMI walk, events at County parks, health fairs, community festivals, sporting events, etc.) and/or in public locations (e.g., sporting venues, bus stops, billboards, etc.) where potential responders and members of PEI priority populations may frequent, as well as through door-to-door outreach.

When working to provide outreach directly to unserved and underserved target populations, program staff work with partner agencies such as LGBTIQ alliances, social services agencies and cultural ambassadors from trusted community-based organizations.

Strategies to Promote Recovery/Resilience

The program uses different strategies to promote recovery and resilience. For providers, the program offers trainings in critical incident stress management. For parents and family members, the program offers peer support and skill-building. For consumers, resilience is fostered by building on protective factors, addressing risk factors and providing peer support.

Strategies to Increase Access to Services: Timely Access for Underserved Populations and Linkage to Treatment

When appropriate, staff provides referrals to treatment and/or support services for individuals of any age who need additional services and/or supports. Referrals are determined based on the individual's needs, with greater levels of support provided to those who face greater challenges and barriers to accessing care. In addition, the program leverages opportunities through CalMHSA Statewide Projects, such as competitive mini-grants awarded to local agencies, so that they may create tailored outreach materials and social marketing campaigns designed to improve timely access of their services.

Strategies to Reduce Stigma and Discrimination

Reducing stigma and discrimination related to mental illness is central to the outreach materials, events and training. Providers employ bilingual staff to meet the program's multicultural and language needs and materials are designed to be culturally and linguistically responsive and tailored to reach Orange County residents of all ages from diverse backgrounds and cultures. Providers also adopt a collaborative approach across agencies and systems of care and utilize evidence-based best practices that are culturally and linguistically responsive.

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.

Community Impact

The consolidated program continues its mission of increasing awareness of mental health, early signs of mental health challenges, and available resources; providing support in times of crisis; and creating educational opportunities for students, staff, parents and other Orange County residents. Through a network of providers, the program is able to provide effective outreach and training to diverse communities throughout the county. In addition, several new activities (i.e., resource fairs, networking events, etc.) have been added to or expanded in the Three-Year Plan in response to community requests.

SETTINGS Where Potential Responders Were Engaged	POTENTIAL RESPONDERS								
	Teachers, School Staff , Administrators	Staff Working w/At-Risk, Unserved	Law Enforce. (i.e., police, probation, etc.)	First Responders (i.e., fire paramedics, etc.)	Hospital, Medical, Nursing Staff	Religious Leaders	Students/ Youth	Family Members	Other Community Members
Childcare Facilities [1, 2, 6]	X	X						X	
School and College Campuses, District Offices [1, 3, 4, 5, 6]	X	X					X	X	
Faith Institutions [1, 5, 6]		X				X	X	X	X
Criminal Justice Settings [1, 4, 6] (i.e., Juvenile Hall, Courts, Sheriff/ Probation/Police, etc.)		X	X						
First Responder Locations [1, 6] (i.e., Fire Departments, etc.)		X		x					
Hospitals/Medical Offices [1, 6]		X			x				
Residential Treatment Facilities, Recovery Homes [1, 6]		X							
Community-Based Organizations [1, 4, 5, 6]		X					X	x	x
Social Services Agency Sites [1, 6]		X							
Shelters [1, 4, 6]		X						x	X
Family Resource Centers [1, 4, 5, 6]		X					X	X	X
Older Adult Community Centers [1, 5, 6]		X						X	
Wellness Centers [1, 4, 5, 6]		X						x	x
Mexican Consulate [1, 4, 5, 6]		X							
Parks, Fairgrounds, Public Events [1, 4, 5, 6]									
HCA Behavioral Health Training Facility [1, 4, 6]	x	X	x	x	x	x	x	x	x
Other Locations [1, 6]									

[1] Behavioral Health Community Training & Technical Assistance
[2] Early Childhood Mental Health Consultation Services
[3] K-12 School-Based Mental Health Services Expansion
[4] Services for TAY and Young Adults
[5] Mental Health & Well-Being Promotion for Diverse Communities
[6] Statewide Projects

[1] **FY 2016-17 Trainings**: Working with Sign Language Interpreters, Working Effectively with BH Sign Language Interpreters, Communicating Effectively with Deaf & Hard of Hearing, Cultural Competency Training (Online), Cultural Sensitive Supervision, Ancestral Wisdom Teachings and Applications in Working with Latinos, Spirituality and Religion, Understanding Client Culture and Journeys, Spiritual Resilience - Healing & the Brain, Clinical Considerations when Working with Members of the Baha'i Faith, Faithful Felons, Mental Health Interpreter Training, Spirituality Beliefs and Hope, and Military Culture.

[2] **FY 2017-18 Trainings**: Working with Sign Language Interpreters, Working Effectively with BH Sign Language Interpreters, Cultural Competency Training (Online), Bio-Spiritual Focusing – Listening to the Wisdom of the Body, Caring for Gender Nonconforming and Transgender Youth, Clinical Considerations when Working with Patients and Families of the Sikh Faith, Mindful Listening, Role of Forgiveness in Psychotherapy, Spirituality in Therapy – A Developmental Model, Veteran Conference, Treating Trauma and Substance Use – A Mindfulness-Based Multi-Modal Approach, Recovery – The Promise of Hope, and Meeting of the Minds.

[3] **FY 2018-19 Trainings**: Working with Sign Language Interpreters, Working Effectively with BH Sign Language Interpreters, Communicating Effectively with Deaf & Hard of Hearing People, Cultural Competency Training (Online), Bio-Spiritual Focusing Training – Companioning Others on the Journey toward Healing and Wholeness, Addiction Treatment Services with Los Angeles Jail System – From Concept to Implementation, Meeting of the Minds, OC Asian and Pacific Islander Mental Health Summit, Marijuana and Psychopharmacology, Recovery Based Treatment Planning, Recovery – The Promise of Hope, Crisis In Faith, Liberating Latina/o, Project Kinship (Medication & Spirituality, Substance Use & Spirituality), Spirituality Conference, Spirituality Training (Moral/Spiritual Injury), and Veteran's Conference.

PREVENTION PROGRAMS

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. These programs 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 well-being, increasing awareness of available mental health services and resources, and decreasing stigma. There are two service areas in this category, each with a slightly different focus, but all programs are school-based/student-focused.

- Mental Health and Well-being Promotion
- Violence and Bullying Prevention

MENTAL HEALTH AND WELL-BEING PROMOTION PROGRAMS

Programs in this area are designed to promote healthy coping behaviors and skill-building in children and/or their parents in order to reduce the risk of a child developing a serious mental health condition. HCA currently funds three programs, two of which are school-based, and one of which focuses on helping support young children who may be at increased risk of struggling in school.

School Readiness (PEI)

Program Serves	Symptom Severity		Location of Services		Population Characteristics			
								
	At-Risk	Mild-Moderate	Field	Community Based	Other/ 1st Responders	Parents	Families	Students

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

FY 2020-21 to FY 2022-23 Program Budget *		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$1,600,000	FY 2019-20	3,600
Proposed FY 2020-21 Budget	$1,600,000	FY 2020-21	3,600
Proposed FY 2021-22 Budget	$1,600,000	FY 2021-22	3,600
Proposed FY 2022-23 Budget	$1,600,000	FY 2022-23	3,600

**5-year, temporary budget augmentation began in FY 2018-19 and concludes in FY 2022-23*

Proportion to be Served by Demographic Characteristic					
Age Group %	**%**	**Gender**	**%**	**Race/Ethnicity**	**%**
0 -15	100	Female	54	African American/Black	2
16 - 25		Male	45	American Indian/Alaskan Native	1
26 - 6		Transgender		Asian/Pacific Islander	9
65 +		Genderqueer		Caucasian/White	17
		Questioning/Unsure		Latino/Hispanic	71
		Other	1	Middle Eastern/North African	
				Other	

Language Capacity of Direct Service Providers					
✓	Spanish	✓	Arabic		Khmer
✓	Vietnamese	✓	Farsi		Other:
✓	Korean	✓	Mandarin		Language Line as Needed

Target Population and Program Characteristics

School Readiness serves families with children from birth to age 8 who are exhibiting behavioral problems and emotional distress which places them at increased risk of developing mental illness and failing in school. 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, Vietnamese).

Services

The program, which was expanded during FY 2018-19 provides prevention services aimed at reducing risk factors for emotional disturbance in young children, promoting school readiness and preparing them for academic success. Services for children and their families include developmental screening, child and family needs assessments, parent education/training and coaching using Triple P Positive Parenting Program techniques, case management, and referral and linkage to community resources. The program also goes out into the community to train parents/caregivers, family members, day care staff, early education staff and other professionals working with the target population on how to recognize the early signs of emotional disturbance and behavioral conditions and to be aware of available resources.

Outcomes

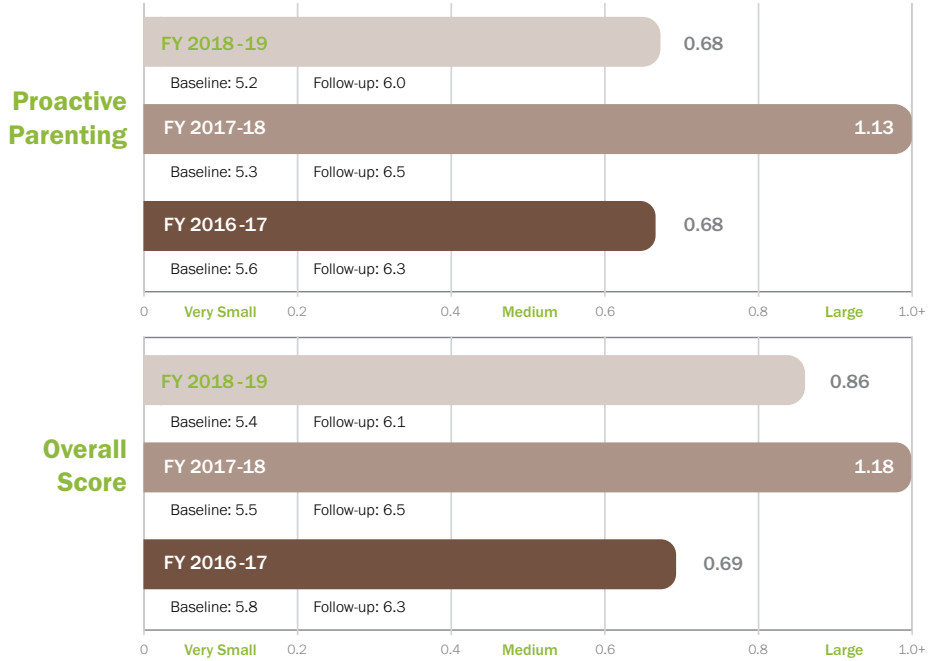
To measure the extent to which the program promotes the protective factor of parenting self-efficacy, parents completed the Parenting Children and Adolescents Scale-Self-Efficacy (PARCA-SE) at baseline and follow-up to assess for changes in overall parenting self-efficacy, support of good behavior, limit setting, and proactive parenting. The PARCA-SE is culturally sensitive, as it has been validated for use among diverse racial and ethnic groups (i.e., White, Hispanic, Black, Native American, Asian, Native Hawaiian, Biracial or Other), and is available in multiple threshold languages.

Across all three fiscal years, parents reported medium to large improvements in overall self-efficacy, support of good behavior, limit setting and proactive parenting, with positive impact tending to be somewhat stronger in FY 2017-18 compared to the other two fiscal years.

School Readiness Numbers Served	FY 2016-17	FY 2017-18	FY 2018-19
Children	863	873	746
Parents/Guardians	1,035	1,139	1,152

Impact on Parent Self-Efficacy

School Readiness (Parents of At-Risk Young Children)



Challenges, Barriers and Solutions in Progress

The Early Development Index (EDI) data indicated that there were several areas of high need that were not covered by existing services. Thus, in FY 2018-19, services were expanded with an additional provider to create a School Readiness collaborative to cover all of Orange County. This new model requires that School Readiness providers work strategically to leverage their efforts and relationships in the community.

Attendance at the community trainings has been a challenge so providers have been actively outreaching to promote this component. The program is beginning to see an increase in attendance from these efforts and the providers are establishing new community partnerships.

The program has provided services to thousands of participants since its inception in April 2013. Staff 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

FY 2018-19: Baseline M=5.8, SD=0.95; Follow-up M=6.3, SD=0.74; t(417)=11.83, p<.001; Cohen's d=0.59

Fy 2017-18: Baseline M=6.0, SD=0.95; Follow-up M=6.6, SD=0.53; t(298)=12.65, p<.001; Cohen's d=0.80

FY 2016-17: Baseline M=6.3, SD=0.68; Follow-up M=6.5, SD=0.56; t(118)=5.66, p<.001; Cohen's d=0.53

Setting Limits

FY 2018-19: Baseline M=5.2, SD=1.15; Follow-up M=6.0, SD=0.87; t(417)=15.71, p<.001; Cohen's d=0.79

FY 2017-18: Baseline M=5.2, SD=1.30; Follow-up M=6.4, SD=0.74; t(298)=17.57, p<.001; Cohen's d=1.11

FY 2016-17: Baseline M=5.5, SD=1.13; Follow-up M=6.1, SD=0.86; t(118)=6.12, p<.001; Cohen's d=0.57

Proactive Parenting

FY 2018-19: Baseline M=5.2, SD=1.22; Follow-up M=6.0, SD=1.00; t(418)=13.68, p<.001; Cohen's d=0.68

FY 2017-18: Baseline M=5.3, SD=1.30; Follow-up M=6.5, SD=0.71; t(298)=17.65, p<.001; Cohen's d=1.13

FY 2016-17: Baseline M=5.6, SD=1.15; Follow-up M=6.3, SD=0.88; t(118)=17.65, p<.001; Cohen's d=0.68

Overall Score

FY 2018-19: Baseline M=5.4, SD=0.96; Follow-up M=6.1, SD=0.75; t(385)=16.46 p<.001; Cohen's d=0.86

FY 2017-18: Baseline M=5.5, SD=1.07; Follow-up M=6.5, SD=0.61; t(298)=18.49, p<.001; Cohen's d=1.18

FY 2016-17: Baseline M=5.8, SD=0.89; Follow-up M=6.3, SD=0.71; t(118)=7.34, p<.001; Cohen's d=0.69

School-Based Stress Management (PEI)

Program Serves	Symptom Severity	Location of Services	Population Characteristics				
6-17	At-Risk	School	Other/1st Responders	Students	Families	Parents	Teachers

The program provides services in English.

FY 2020-21 to FY 2022-23 Program Budget *		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$155,000	FY 2019-20	3,570
Proposed FY 2020-21 Budget	$155,000	FY 2020-21	3,570
Proposed FY 2021-22 Budget	$155,000	FY 2021-22	3,570
Proposed FY 2022-23 Budget	$155,000	FY 2022-23	3,570

**5-year, temporary budget augmentation began in FY 2018-19 and concludes in FY 2022-23*

Proportion to be Served by Demographic Characteristic					
Age Group %	**%**	**Gender**	**%**	**Race/Ethnicity**	**%**
0 -15	76	Female	53	African American/Black	3
16 - 25	24	Male	46	American Indian/Alaskan Native	4
26 - 6		Transgender		Asian/Pacific Islander	21
65 +		Genderqueer		Caucasian/White	21
		Questioning/Unsure		Latino/Hispanic	46
		Other	1	Middle Eastern/North African	
				Other	5

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. At a minimum, two teachers per school site can receive training, and teachers are selected for training based on their ability to meet the program's attendance and other implementation requirements. All trainings are provided in English.

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 socio-emotional 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.

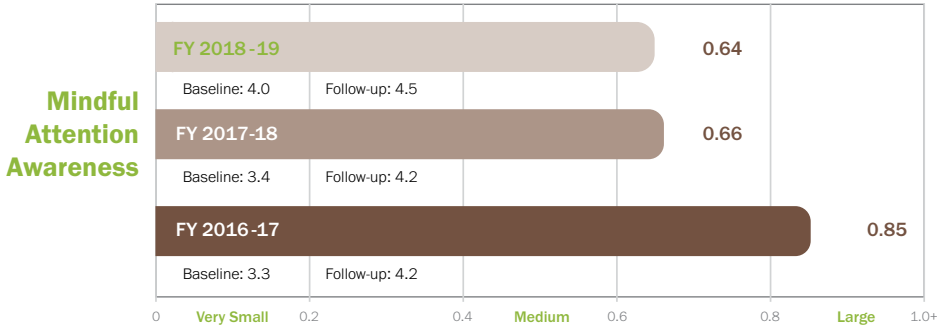
Outcomes

To assess the program's effectiveness at enhancing the protective factors of mindfulness, teachers completed the Mindful Attention Awareness Scale at baseline and two follow-up points. Across all three fiscal years, teachers reported medium to large gains in mindful attention awareness. Although student increases in self-awareness are anecdotal, they nevertheless strongly suggest that students employ the breathing and mindfulness skills taught by participating teachers.

Stress Management Services Numbers Served	FY 2016-17	FY 2017-18	FY 2018-19
Teachers	64	77	75
Number of Students Reached	3,033	4,094	4,231
Districts/Schools	14/27	18/29	13/30

Impact on Mindful Attention Awareness

School-Based Stress Management



Challenges, Barriers and Solutions in Progress

Due to the structure of the program, when teachers must withdraw from the program at the last minute it is difficult to assign a new teacher to the vacated position, since the teacher's pre-test surveys are administered two weeks prior to the first day of training. To address this issue, the program overbooks teachers into each training cohort whenever possible. Due to the tremendous success of the program, the demand

for the program has exceeded the capacity of the program to accept all the eligible teachers. This challenge is addressed by creating a waitlist.

Community Impact

The program has already provided services to more than 11,000 students and 200 teachers since its recent inception in October 2016 and initial outcomes indicate that the program is having a positive effect in Orange County classrooms.

Reference Notes

Mindful Attention Awareness

FY 2018-19: Baseline M=4.0, SD=0.84; Follow-up M=4.5, SD=0.65; t(37)=3.86, p<.001; Cohen's d=0.64

FY 2017-18: Baseline M=3.4, SD= 0.8; Follow-up M= 4.2, SD=0.7, t(76) =-5.77, p<.001; Cohen's d=-0.66

FY 2016-17: Baseline M=3.3, SD=0.8; Follow-up M=4.2, SD=0.6; t(64)=-6.74, p<.001; Cohen's d=-0.85

School-Based Behavioral Health Intervention and Support (PEI)

Program Serves	Symptom Severity	Location of Services	Population Characteristics			
5-14	At-Risk	School	Other/ 1st Responders	Parents	Families	Students

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$3,408,589	FY 2019-20	40,500
Proposed FY 2020-21 Budget	$3,408,589	FY 2020-21	40,500
Proposed FY 2021-22 Budget	$3,408,589	FY 2021-22	26,680
Proposed FY 2022-23 Budget	$1,808,589	FY 2022-23	26,680

Proportion to be Served by Demographic Characteristic

Age Group %	%	Gender	%	Race/Ethnicity	%
0 -15	90	Female	48	African American/Black	3
16 - 25	10	Male	50	American Indian/Alaskan Native	6
26 - 6		Transgender	1	Asian/Pacific Islander	12
65 +		Genderqueer		Caucasian/White	22
		Questioning/Unsure		Latino/Hispanic	53
		Other	1	Middle Eastern/North African	
				Other	4

Language Capacity of Direct Service Providers

✓	Spanish		Arabic		Khmer
	Vietnamese		Farsi		Other:
	Korean		Mandarin		Language Line as Needed

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 at risk 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/or 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. Classroom prevention is a classroom-based approach that utilizes an evidence-based curriculum with learning modules focused on key learning objectives such as self-concept, life-skills, positive decision-making and respect.
2. Students exhibiting higher-level problem behaviors are provided student-based interventions, which utilize smaller student groups focused on specific areas of concern such as bullying, anger management, conflict resolution, drug prevention and/or self-esteem.
3. Finally, students who display symptoms indicative of higher level needs and require more intensive services than what is provided in classrooms or small groups receive Tier Three, Family Intervention. This tier provides early intervention family services focused on building skills to improve family communication, relationships, bonding and connectedness.

Outcomes

Different measures of effectiveness were used in each tier due to differences in services and level of student need. At each tier, the respective measure was assessed at baseline and program exit, and the change in scores was analyzed and reported according to effect size, which reflects, in part, the extent to which a change is meaningful for the students. It should be noted that while surveys are completed at the start and end of Tier 1 and 2 activities, due to the large volume of students completing the measures at one time, combined with errors in filling in their identifying information, many surveys are unable to be matched.

SBBHIS Numbers Served	FY 2016-17	FY 2017-18	FY 2018-19 [1]
Total	**26,924**	**26,358**	**36,319**
Students	24,242	21,869	32,835
Parents/Guardians (Family Members)	1,590 (178)	3,500 (228)	2,218 (266)
School Staff	914	995	1,000
Districts/Schools	7/30	8/34	9/50

SBBHIS Numbers Served[2]	FY 2016-17	FY 2017-18	FY 2018-19
Total Students Served in Tier 1	21,373	18,643	28,779
Baseline + 1 Follow-up PGH7 Completed	-	-	7,209[3]
Total Students Served in Tier 2	2,628	2,909	3,769
Baseline + 1 Follow-up PGH7 Completed	-	-	876
Total Students Served in Tier 3	241	317	328
Baseline + 1 Follow-up CADBI Completed	24-39	66-67	37-46
Baseline + 1 Follow-up PGH7 Completed	-	-	38

Tier 1: To measure the extent to which the program increased the protective factor of well-being among Tier 1 participants, the Pediatric Global Health-7 (PGH-7) was administered in FY 2018-19. Self-reported student ratings showed that students maintained positive health during the weeks they participated in Tier 1 programming.

Tier 2: In FY 2018-19, the PGH-7 was used to measure student global health in Tier 2. In previous fiscal years, positive self-concept was measured with a modified Self-Concept Scale. The PGH-7 was adopted so that Tier 2 services were evaluated using a psychometrically validated tool. Self-reported student ratings showed that students maintained positive health or self-concept during the weeks they participated in Tier 2 programming.

Tier 3: To assess the effectiveness in reducing prolonged suffering among Tier 3 participants, different types of disruptive behaviors were rated by the students' parents on the Child and Adolescent Disruptive Behavior Inventory (CADBI) at baseline and program exit, and the change in scores over time is reported according to effect size (FY 2018-19: 49, FY 2017-18: 66; FY 2016-17: 32).

1 The increase in numbers served in FY 2018-19 occurred due to the addition of another service provider.

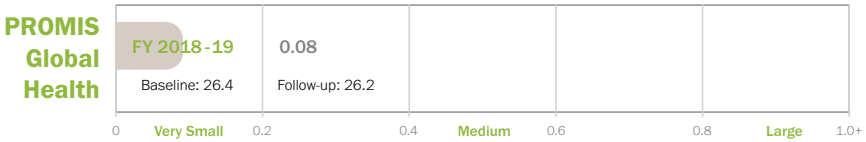
2 Due to technical challenges and issues related to measure sensitivity and validity, Tier 1 & Tier 2 data are not presented for FY 2016-17 or FY 2017-18.

3 The new service provider is working to update its data collection system so that measures completed in Tiers 1 and 2 can be separated by Tier. Thus, the numbers in Tiers 1 and 2 only represent the activity of one service provider.

In FYs 2018-19 and 2017-18, parents reported that their children showed moderate decreases in disruptive behavior toward both adults and peers, as well as small to moderate decreases in impulsive and hyperactive behaviors. As noted in the FY 2019-20 Annual Plan Update, HCA made changes in the program structure FY 2017-18 to increase Tier 3 participation. Not only has this reorganization resulted in many more families being served in Tier 3, it has also ensured that students and families are placed in appropriate tier of services based on their level of need, which is underscored by the continued trend of decreased disruptive behaviors observed in FYs 2017-18 and 2018-19 relative to FY 2016-17.

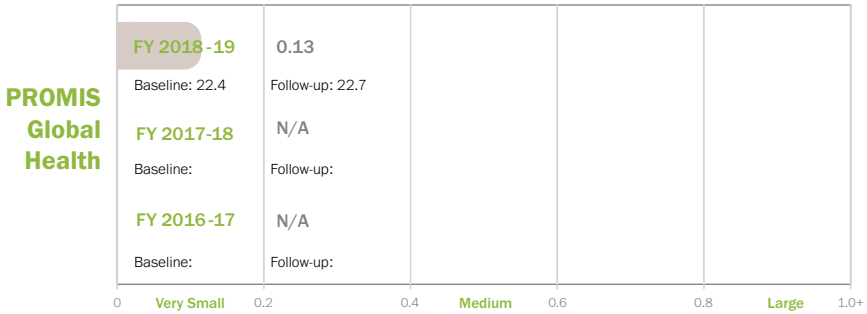
SBBHIS Tier 1

PROMIS Global Health



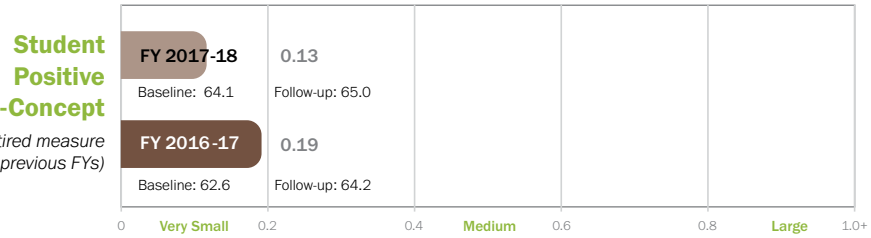
SBBHIS Tier 2

PROMIS Global Health



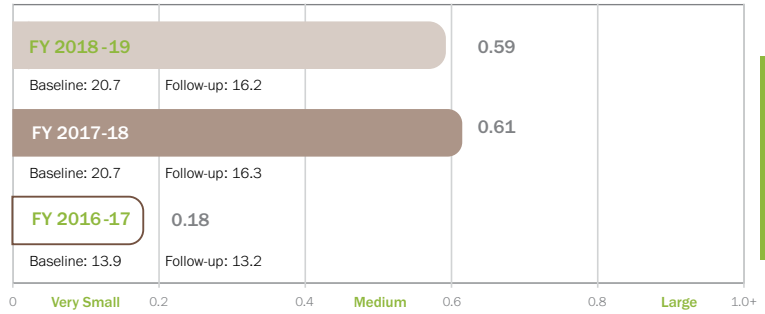
Student Positive Self-Concept

(retired measure from previous FYs)

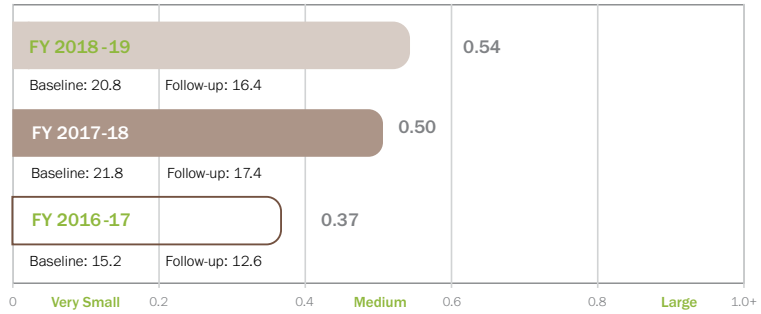


SBBHIS Tier 3

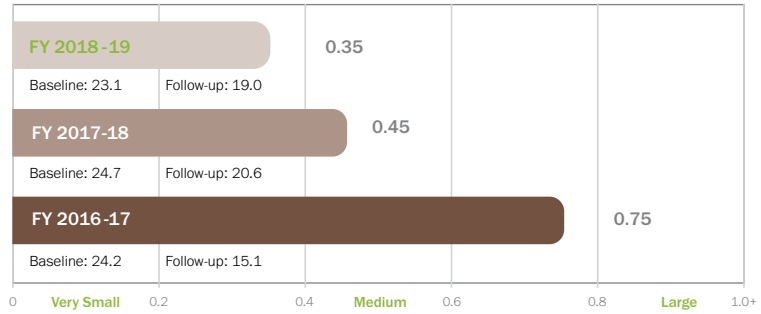
Impact on Disruptive Behavior Toward Adults



Impact on Disruptive Behavior Toward Peers



Impact on ADHD/ Hyperactive/ Impulsive



Challenges, Barriers and Solutions in Progress

Implementing services within a school setting is a complex and multi-faceted 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 have been key to providing service delivery in a streamlined manner.

Community Impact

The program continues to build capacity in the community through collaboration with community partners and school districts. PEI conducted a community planning process in FY 2018-19 for time-limited unspent carryover funds and, as a result, one additional service provider was added. The service expansion was made to include services to 20 additional schools in Orange County with an emphasis on South Orange County schools. As a result, the program will serve 60 schools. More than 130,000 students, 8,500 parents/caregivers and 5,000 schools staff have participated since program inception.

Reference Notes

Tier 1: PROMIS Global Health

FY 2018-19: Baseline M=26.4, SD=4.68; Follow-up M=26.2, SD=4.75; t(3,621)=4.91, p<.001; Cohen's d=0.08

Tier 2: PROMIS Global Health

FY 2018-19: Baseline M=22.4, SD=3.26; Follow-up M=22.7, SD=3.67; t(6,253)=10.02, p<.001; Cohen's d=0.13

FY 2017-18: N/A

FY 2016-17: N/A

Tier 2: Student Positive Self-Concept (retired measure from previous FYs)

FY 2017-18: Baseline M=64.1, SD=9.1; Follow-up M= 65.0, SD=8.9, t(506)=2.91, p<.01; Cohen's d=0.13

FY 2016-17: Baseline M=62.6, SD=9.7; Follow-up M=64.2, SD=10.2; t(543)=-4.44, p<.001; Cohen's d=-0.19

Tier 3: Disruptive Behavior Toward Adults

FY 2018-19: Baseline M=20.7, SD=9.38; Follow-up M=16.2, SD=7.77; t(38)=4.35, p<.001; Cohen's d=0.59

FY 2017-18: Baseline M=20.7, SD=13.6; Follow-up M=16.3 SD=19.9; t(66)=4.46, p<.001; Cohen's d=0.61

FY 2016-17: Baseline M=13.9, SD=6.0; Follow-up M=13.2, SD=4.3; t(28)=0.90, p=<.382; Cohen's d=0.18

Tier 3: Disruptive Behavior Toward Peers

FY 2018-19: Baseline M=20.8, SD=11.09; Follow-up M=16.4, SD=8.67; t(48)=3.65, p<.001; Cohen's d=0.54

FY 2017-18: Baseline M=21.8, SD=14.8; Follow-up M=17.4, SD=12.3; t(66)=3.96, p<.001; Cohen's d=0.50

FY 2016-17: Baseline M=15.2, SD=9.3; Follow-up M=12.6, SD=6.3; t(32)=1.90, p=.06; Cohen's d=0.37

Tier 3: ADHD/Hyperactive/Impulsive

FY 2018-19: Baseline M=23.1, SD=13.47; Follow-up M=19.0, SD=11.91; t(46)=2.39, p<.021; Cohen's d=0.35

FY 2017-18: Baseline M=24.7, SD=15.0; Follow-up M= 20.6, SD=12.7; t(65)=3.53, p<.001; Cohen's d=0.45

FY 2016-17: Baseline M=24.2, SD=16.5; Follow-up M=15.1, SD=10.6; t(22) =3.30, p<.01; Cohen's d=0.75

VIOLENCE AND BULLYING PREVENTION PROGRAMS

Programs in this area are designed to reduce risk factors of violence exposure, including bullying, that may place children at an increased risk of developing a serious mental health condition. HCA currently funds two programs with this focus, both of which are school-based.

Violence Prevention Education (PEI)

Program Serves	Symptom Severity	Location of Services	Population Characteristics				
	At-Risk	 School	 Other/ 1st Responders	 Parents	 Families	 Students	 Trauma-Exposed Clients

FY 2020-21 to FY 2022-23 Program Budget *		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$1,352,651	FY 2019-20	29,879
Proposed FY 2020-21 Budget	$1,352,651	FY 2020-21	29,879
Proposed FY 2021-22 Budget	$1,352,651	FY 2021-22	29,879
Proposed FY 2022-23 Budget	$1,352,651	FY 2022-23	29,879

** 5-year, temporary budget augmentation began in FY 2018-19 and concludes in FY 2022-23*

Proportion to be Served by Demographic Characteristic					
Age Group %	**%**	**Gender**	**%**	**Race/Ethnicity**	**%**
0 -15	75	Female	52	African American/Black	3
16 - 25	25	Male	43	American Indian/Alaskan Native	4
26 - 6		Transgender		Asian/Pacific Islander	21
65 +		Genderqueer		Caucasian/White	15
		Questioning/Unsure		Latino/Hispanic	46
		Other	5	Middle Eastern/North African	
				Other	11

Language Capacity of Direct Service Providers					
✓	Spanish		Arabic		Khmer
✓	Vietnamese	✓	Farsi		Other:
✓	Korean		Mandarin		Language Line as Needed

Target Population and Program Characteristics

The Violence Prevention Education (VPE) program aims to reduce violence and/or its impact in schools, local neighborhoods and/or families. The target audience for the program includes 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

VPE Numbers Served	FY 2016-17	FY 2017-18	FY 2018-19
Students	36,583	44,633	33,399
Parents	10,728 [3]	3,585	3,800
Teachers/School Staff	1,371	1,124	2,253

Services/Impact

The program has five different tracks designed to promote violence prevention. In FY 2017-18 VPE underwent significant change by adding new components (i.e., Boys and Girls Restorative Practices, Threat Assessment Simulation), and tailoring the Anti-Bullying assembly content to different grade levels. Each track uses an evidence-based or practice-based evidence standard geared toward its specific focus, and fidelity to the Evidence-Based Practice (EBP) model is maintained by providing staff with periodic refresher trainings to ensure appropriate implementation.

- **Bullying**: Educates students, staff, administrators and parents on bullying and cyber-bullying prevention using two methods: (1) anti-bullying presentations conducted at school assemblies in an effort to impact the overall school climate by reducing and/or preventing bullying; and (2) a classroom-based curriculum focused on combating cyber-bullying. In FY 2018-19, the majority of respondents agreed or strongly agreed that they knew or learned about bullying and felt empowered to stand up to bullying behavior after having attended a student assembly.
- **Restorative Practices**: Offers a trauma-informed, research-based training for teachers to promote resilience in youth, particularly those who have been exposed to violence and varying degrees of trauma. Teachers utilize "circle practices" in the classroom to promote healthy relationships and help create calmer, more focused classrooms. The "circle practice" encourages students to strengthen relationships with their peers and teachers, thus, creating a safe and supportive environment for effective communication, expression of emotion, and exploration and acceptance of differences. Teachers who use these methods often find that the overall portion of time dedicated to managing behavior is reduced, thus freeing up more time for instruction. In FY 2018-19, the majority of students agreed or strongly agreed that they had engaged in healthy habits or accepted others, although fewer girls endorsed having a positive body image or engaging in a meaningful activity.

[3] FY 2016-17 was an unusual year, in that there were multiple crisis events in the community that increased the demand for Crisis Response Network services.

- **Safe From The Start**: Educates parents on scientific research demonstrating how exposure to violence, whether through direct physical contact or as a witness, can impact children's neurological development which may, in turn, compromise their cognitive, social and emotional development. Presentations are provided to parents at campus during and after school hours, as well as at shelters. The overwhelming majority of participants reported feeling confident in their ability to better manage emotions and use positive parenting strategies following the training.

- **Threat Assessment**: Provides training to school administrators, teachers, mental health counselors, school resource officers and other school staff to assess threats and respond appropriately, and survey results indicate that those who received the simulation drills (see below) felt more confident in their ability to assess and respond to potential threats. The program consists of three components:

  - Proactive Threat Assessment Training, a full-day training covering the definition of threat, threat types and levels, how to screen and assess threats, behavioral indicators to look for, a response protocol, addressing stigma and mental health resources;

  - Threat Assessment Simulation Drills, covering situational awareness to increase confidence and a sense of empowerment during an emergency, which includes classroom and front office lockdown steps and procedures, and a post-drill debrief to reflect on shared experience, distress reactions, and the importance of self-care;

  - Community Forums, facilitates discussion around the importance of violence prevention and early intervention, shares best practices for school safety, and supports families and community members in identifying ways they can participate in violence prevention efforts, as well as how to support children in times of crisis, and access mental health services and resources.

- **Crisis Response Network**: A network of crisis responders trained in Crisis Incident Stress Management who mobilize and assist a school or community in times of emergency, need or threat. The Network also uses crisis dogs to provide emotional support to students and help reduce stress and tension associated with trauma. Pre-incident and crisis management trainings are also provided to the schools and the community.

Challenges, Barriers and Solutions in Progress

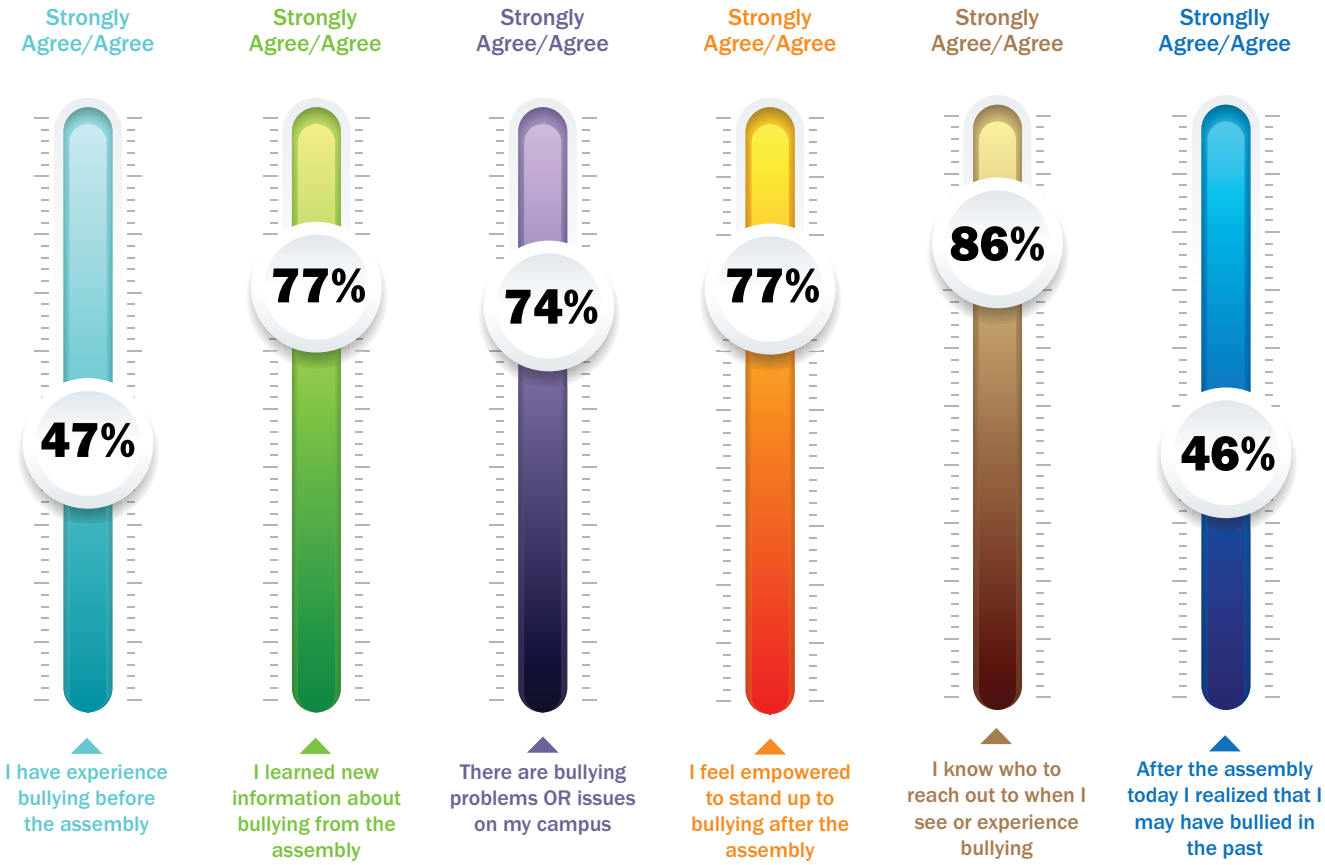
In an effort to meet the changing scheduling needs of participating schools and districts, the program has adjusted service delivery or curricula so that trainings and presentations can be held in a single, large-format assembly rather than multiple, smaller classroom sessions.

Community Impact

The program has provided services to more than 190,000 students, 31,200 parents and 9,450 school staff since its inception in August 2013. 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.

VPE - Anti-Bullying Student Assembly

Percent Agreement FY 2018-19



FY 2017-18

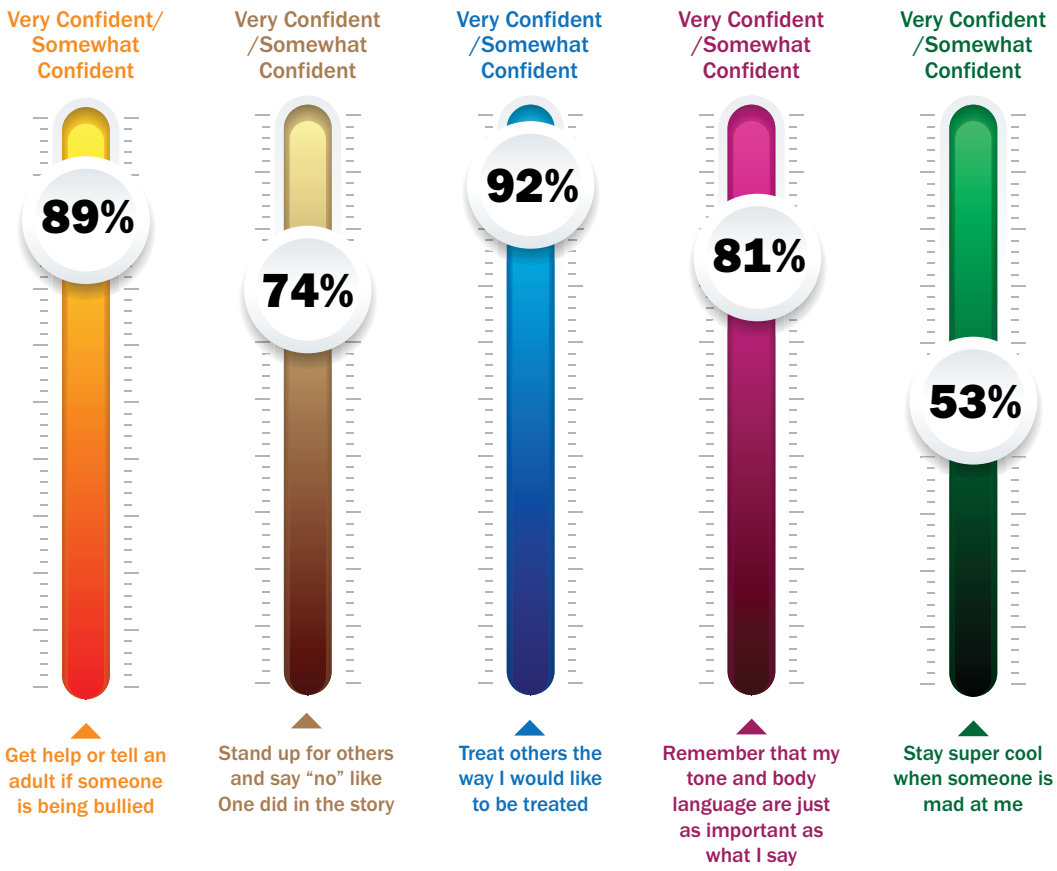
94%	61%	61%	73%	-	-

FY 2016-17

93%	65%	57%	79%	-	-

VPE - Anti-Bullying (ONE) Assembly

Percent Confident FY 2018-19



FY 2017-18

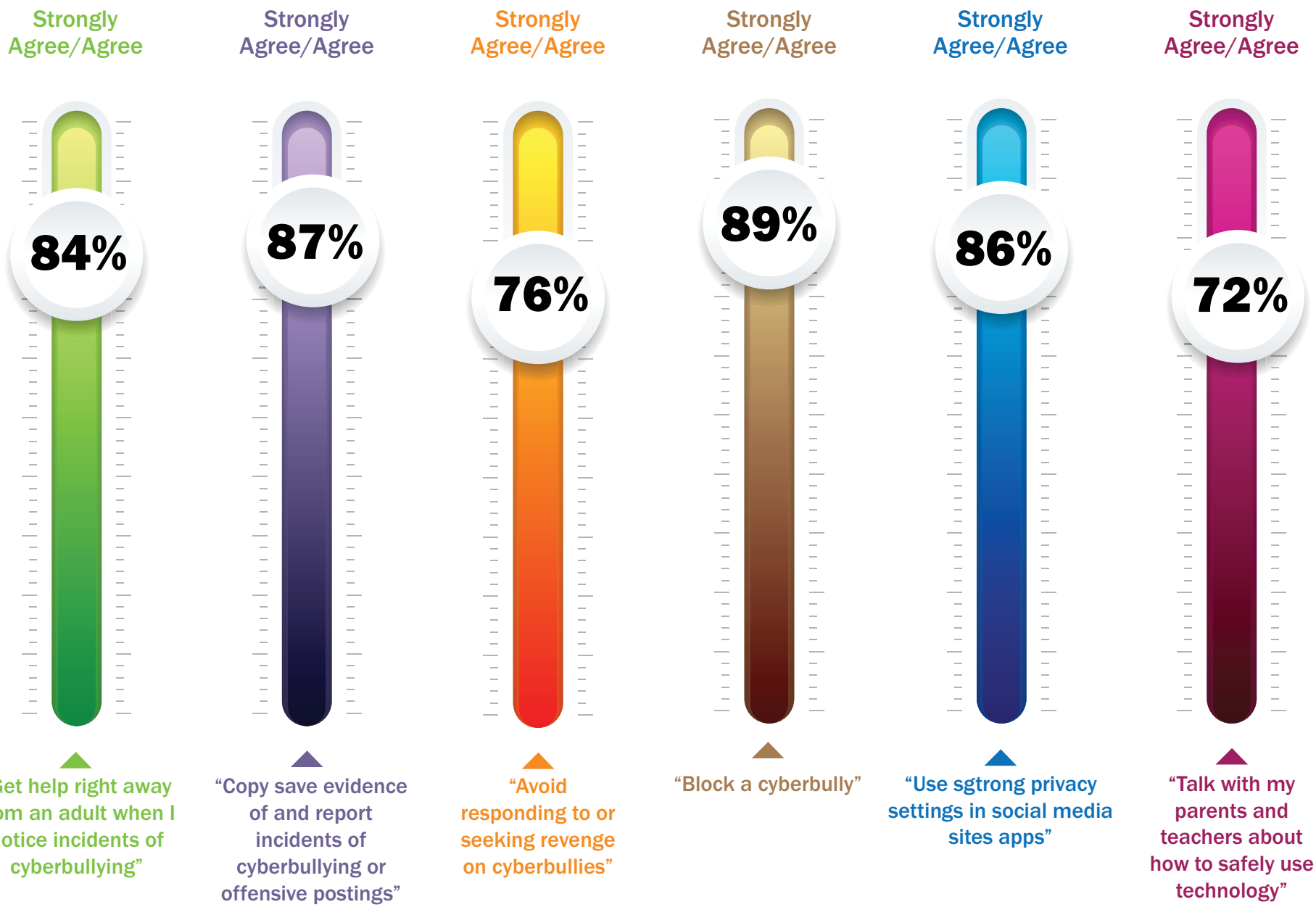
87%	73%	89%	80%	52%

FY 2016-17

87%	74%	89%	79%	55%

VPE - Cyberbullying*

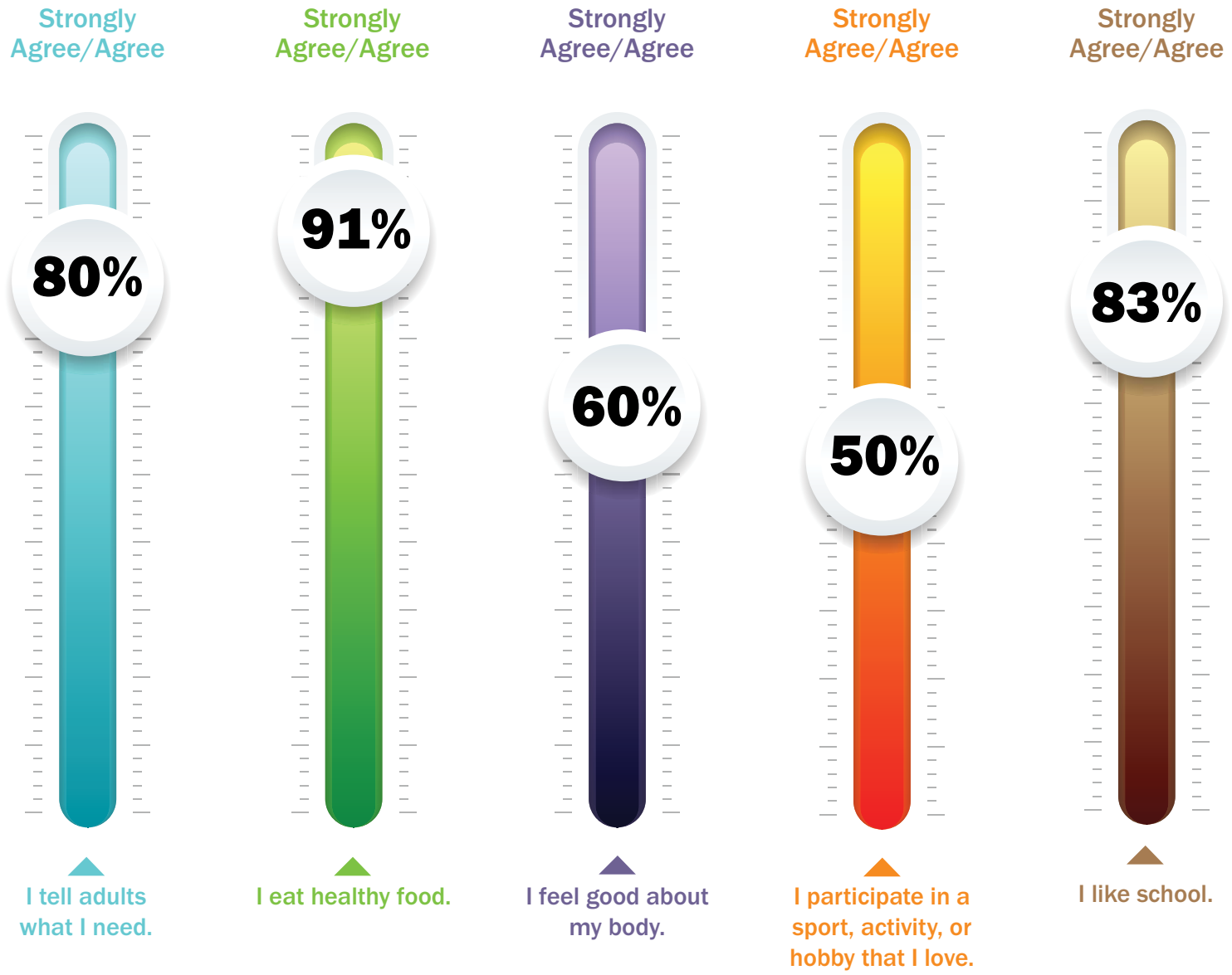
Percent Agreement FY 2018-19



* Not adopted in FY 2017-18 and FY 2016-17

VPE - Girls Resorative Practice*

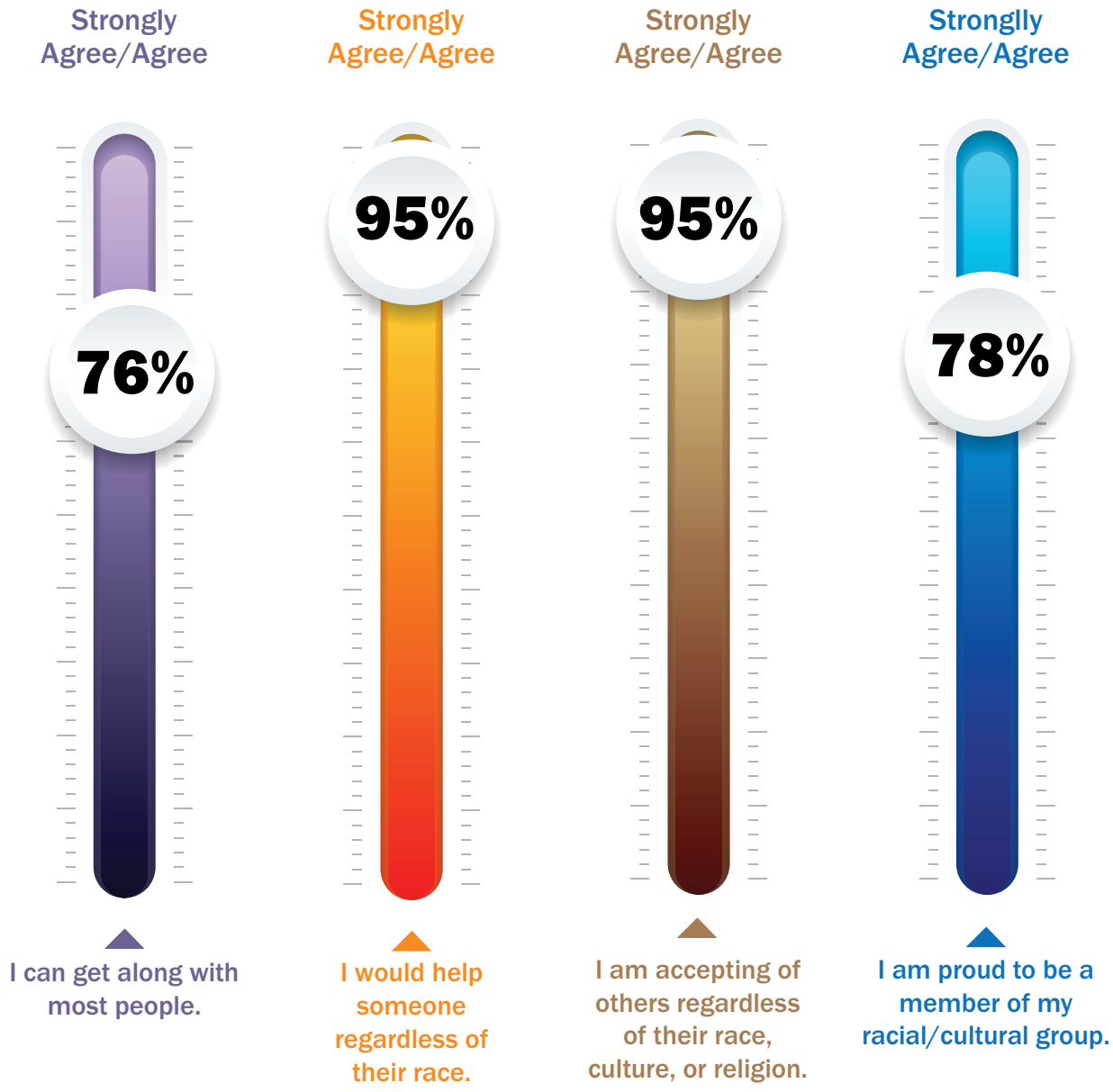
Percent Agreement FY 2018-19



* Not adopted in FY 2017-18 and FY 2016-17

VPE - Boys Restorative Practice*

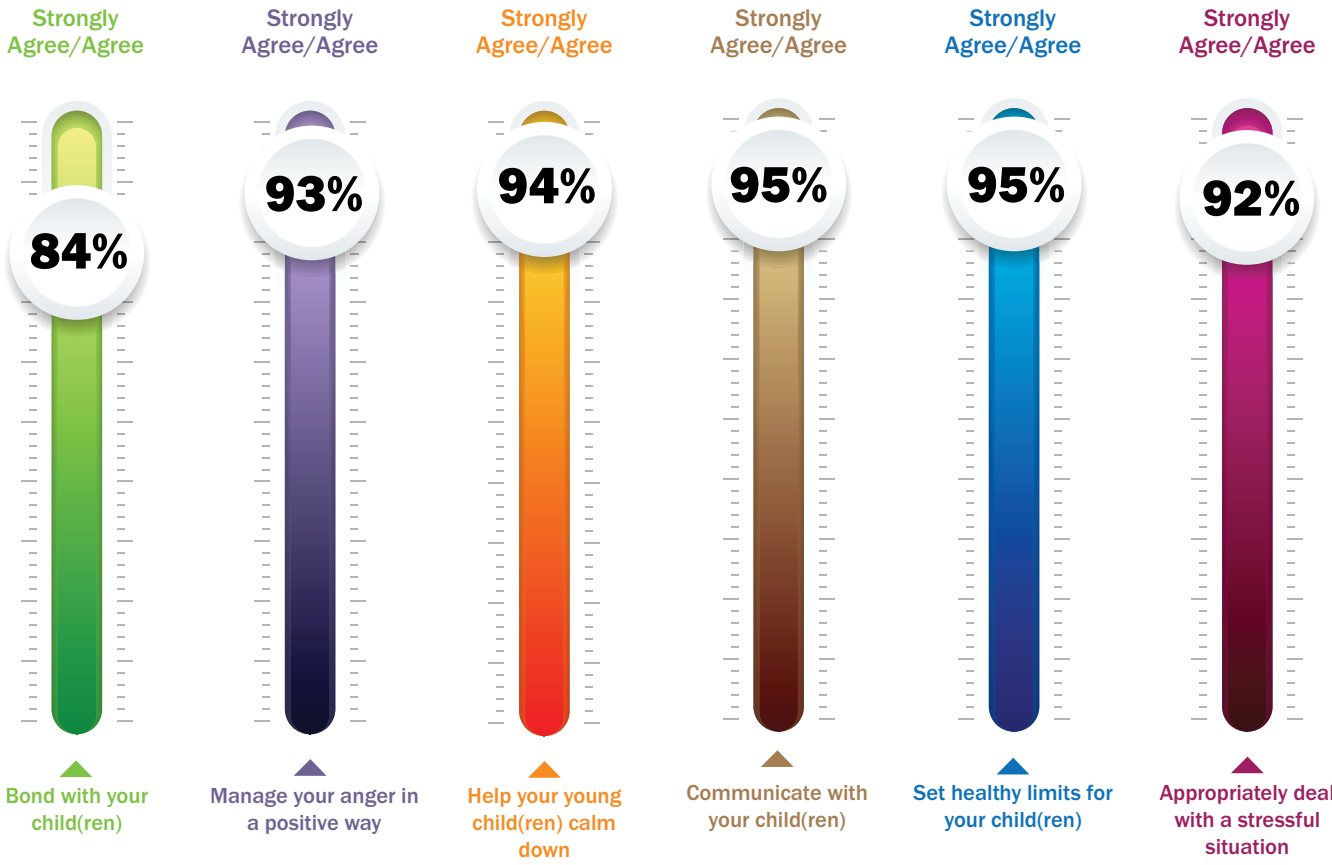
Percent Agreement FY 2018-19



* Not adopted in FY 2017-18 and FY 2016-17

VPE - Safe From the Start

Percent Agreement FY 2018-19



FY 2017-18

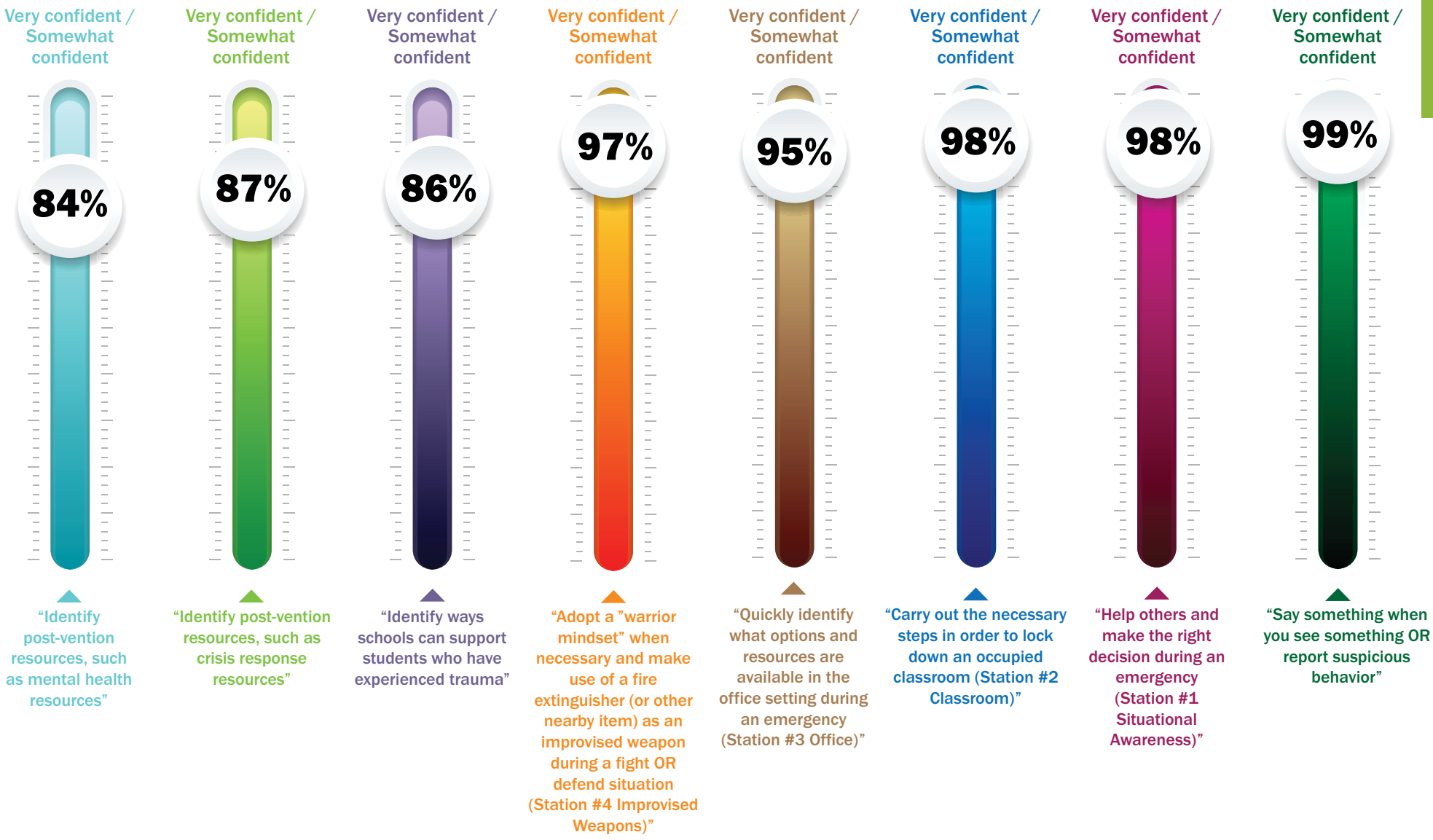
Bond with your child(ren)	Manage your anger in a positive way	Help your young child(ren) calm down	Communicate with your child(ren)	Set healthy limits for your child(ren)	Appropriately deal with a stressful situation
97%	90%	89%	90%	89%	89%

FY 2016-17

Bond with your child(ren)	Manage your anger in a positive way	Help your young child(ren) calm down	Communicate with your child(ren)	Set healthy limits for your child(ren)	Appropriately deal with a stressful situation
92%	65%	68%	69%	67%	66%

VPE - Threat Assessment Simulation*

Percent Confident FY 2018-19



* Not adopted in FY 2017-18 and FY 2016-17

Gang Prevention Services (PEI)

Program Serves	Symptom Severity	Location of Services	Population Characteristics		
9-15	At-Risk	School	Families	Parents	Students

Language Capacity of Direct Service Providers					
✓	Spanish		Arabic		Khmer
	Vietnamese		Farsi		Other:
	Korean		Mandarin		Language Line as Needed

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$403,100	FY 2019-20	600
Proposed FY 2020-21 Budget	$403,100	FY 2020-21	600
Proposed FY 2021-22 Budget	$403,100	FY 2021-22	600
Proposed FY 2022-23 Budget	$253,100	FY 2022-23	440

Proportion to be Served by Demographic Characteristic					
Age Group %	**%**	**Gender**	**%**	**Race/Ethnicity**	**%**
0 -15	100	Female	59	African American/Black	2
16 - 25		Male	41	American Indian/Alaskan Native	
26 - 6		Transgender		Asian/Pacific Islander	2
65 +		Genderqueer		Caucasian/White	3
		Questioning/Unsure		Latino/Hispanic	93
		Other		Middle Eastern/North African	
				Other	

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 conjunction with the Probation Department, local police departments and school staff.

GPS 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. The Orange County District Attorney's Office and the Orange County Probation Department select schools to participate in the program based on high rates of truancy, discipline issues and gang proximity. The program focuses on being inclusive of all high-risk youth in the identified schools, regardless of their familial affiliations to gang activity or behavior.

Services

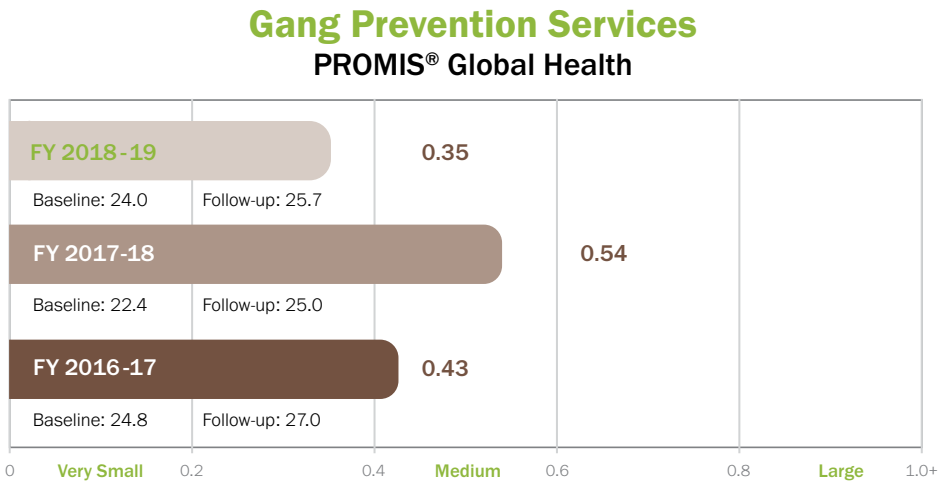
At each participating school, staff provides education to students, parents and teachers on gang prevention and offers workshops, structured group interventions, and weekly case management. Staff also works with students and their families to create an individualized action plan that addresses attendance,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

VPE Numbers Served	FY 2016-17	FY 2017-18	FY 2018-19
Students	426	427	441
Districts/Schools	8/34	11/39	11/42

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.

Outcomes

To measure the extent to which GPS increased the protective factor of health and well-being, students completed the PROMIS® Pediatric Global Health at baseline, every three months and at discharge. The change in scores between baseline and the most recent follow-up was analyzed and reported according to effect size, which reflects, in part, the extent to which a change is meaningful for the students served. In all three years, the program was associated with small to moderate gains in global health, which was high upon entry to the program. Thus, the program was associated with maintaining and somewhat improving this protective factor. In addition, in FY 2018-19, 77% students increased attendance; 81% decreased truancy and 72% decreased curfew violations.



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 4,300 students and parents since its inception in August 2013. Through its case management services, the program has encouraged youth to avoid high-risk behavior and engage in more positive decision-making. The program has also strengthened relationships with the community by partnering with organizations and businesses such as the Los Angeles Angels. Through these collaborations, agencies are able to educate and motivate students and to serve as mentors for future career possibilities. 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

PROMIS® Global Health

FY 2018-19: Baseline M=24.0, SD=4.02; Follow-up M=25.7, SD=4.35; t(438)=7.40, p<.001; Cohen's d=0.35

FY 2017-18: Baseline M=22.4, SD=3.02; Follow-up M=25.0, SD=3.92; t(338)=9.85, p<.001; Cohen's d=0.54

FY 2016-17: Baseline M=24.8, SD=4.27; Follow-up M=27.0, SD=4.52; t(400)=8.68, p<.001; Cohen's d=0.43

SUMMARY OF MHSA STRATEGIES USED BY PREVENTION PROGRAMS

Strategies to Promote Recovery/Resilience

By identifying risk factors and intervening early, these school-based prevention programs promote resilience through resources and supports that are best matched to the level of support provided. For example, School-Based Stress Management Services, Violence and Prevention Education, and Tier 1 of SBBHIS adopt a public mental health approach by educating teachers from across the county and/or their students on how to foster a positive, supportive school climate. Depending on the specific program, this is achieved by educating teachers, school staff, students and/or parents on stress management, mind-body awareness, healthy self-concept, positive decision-making skills, life skills, or awareness on violence, bullying and/or digital literacy.

For at-risk children and families with higher level of needs, these prevention programs provide more targeted support which include strategies to promote appropriate family bonding, positive peer/family relationships, adaptive communication and conflict resolution strategies, and community/civic engagement. Because School Readiness provides assessments and parenting training curriculum directly in the families' services, staff tailor approaches and strategies to the young child's unique environment, thus increasing the chances of parents being able to successfully implement and sustain the techniques learned. Similarly, the school-based programs include strategies to help encourage the application of skills learned in the classroom to the home or other environments.

Strategies to Reduce Stigma and Discrimination

A number of strategies are used across these programs to reduce stigma and discrimination. For example, curricula provided in the schools employ various methodologies to maximize the program's impact across different populations and be inclusive of students from diverse backgrounds. Programs that provide services directly to children and families also employ bilingual/bicultural staff to meet their multicultural and language needs in a responsive manner.

These programs leverage the positive influence of trained professionals, school staff and/or student peers when providing education on behavioral health issues and resources. The violence and bullying prevention programs also enlist the help of law enforcement and local celebrities to encourage participation in their program activities.

Strategies to Increase Access to Services: Timely Access for Underserved Populations and Linkage to Treatment

Underserved children, youth and families living in high-risk/need regions of the county often face challenges in accessing care due to transportation, childcare, scheduling or availability of appointments, and stigma. School-based programs (i.e., School-Based Stress Management Services, SBBHIS, VPE, GPS) provide timely access to their prevention services by providing support directly in the classroom and/or other school settings, which can encourage student comfort and engagement, particularly among those who may be more difficult to reach outside of school hours. Some programs also provide some of their services in the field. For example, School Readiness meets with families where ever the parent would like to meet, whether in the home or the community. Seeing families in their homes also increases the opportunity for staff to work with the entire family rather than only those who are able or willing to attend appointments in a clinic setting. Similarly, VPE's Safe From the Start provides its curriculum at domestic violence shelters and alternative living sites in addition to the different school sites they serve, and the Crisis Response Network responds anywhere in Orange County where its services are needed.

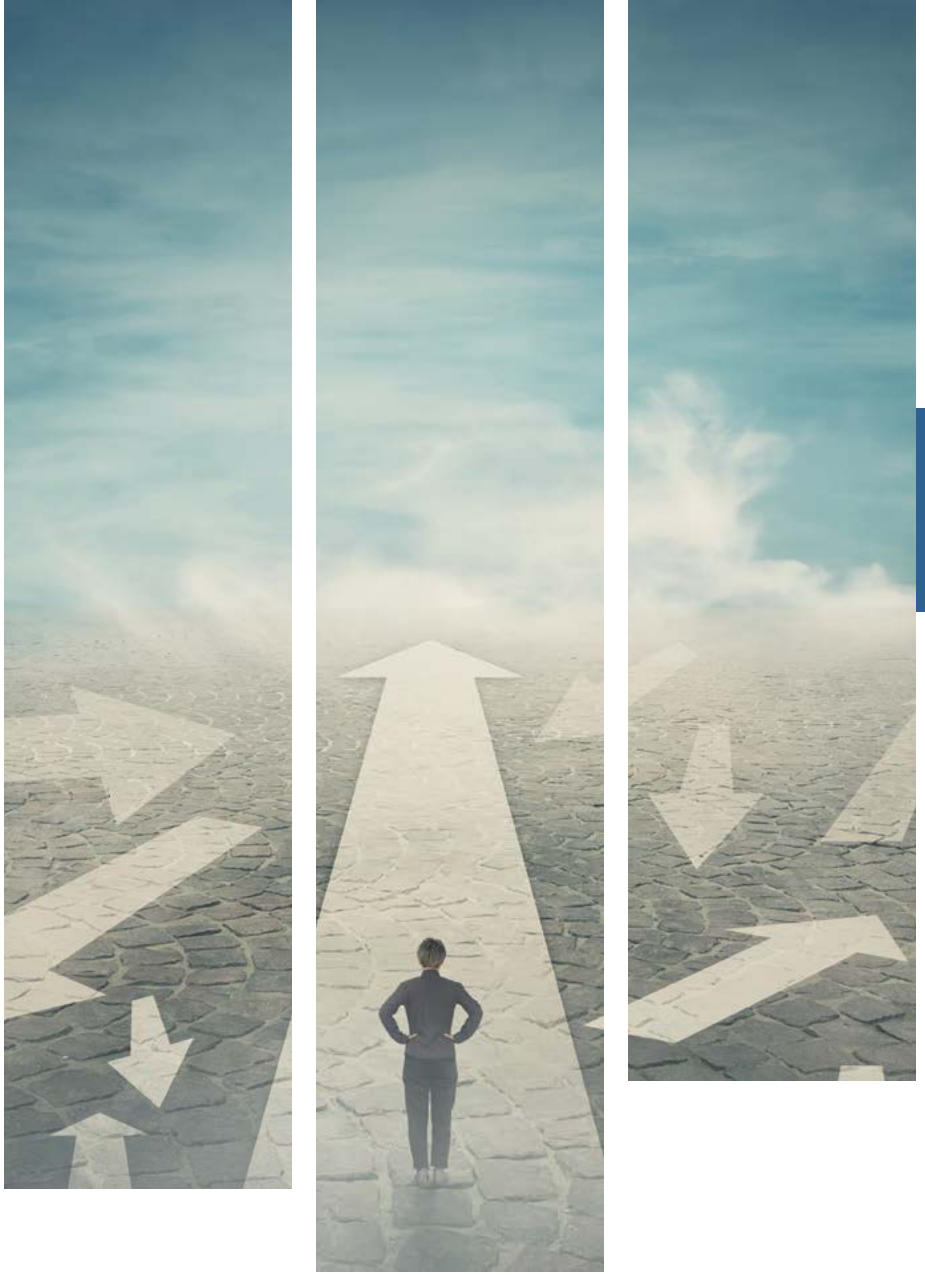
In addition, children and families enrolled in School Readiness or GPS who need a higher level or longer duration of support are referred to outpatient treatment and other supportive services. Staff often facilitates connections by working with the family to identify the appropriate and desired services and by assisting the parent with calling the new agency.

	Prevention Program					
Linkage Metrics *per PEI Regulations*	**School Rediness**			**Gang Prevention Services**		
	FY16-17	FY17-18	FY18-19	FY16-17	FY17-18	FY18-19
# Referrals	273	670	744	866	1,360	554
# Linkages	88	229	176	634	1,050	496
Types of Linkages	Special needs/disability services; behavioral health prevention, early intervention programs; information and referral resources; family support; recreation activities; basic needs			Counseling services, adult literacy programs, housing and food assistance, medical care, school supplies, enrichment activities		

Note: The Family Services component of SBBHIS is working to implement tracking of referrals and linkages as outlined in the MHSOAC PEI Regulations. The School-Based Stress Management and Violence Prevention Education programs are not structured to provide and track referrals/linkages for individual students since the curricula are presented in large assembly and classroom formats. If students do approach the presenter with concerns following a training, per the MOU with the school, they direct students to school staff (i.e., their teacher, counselor, nurse, etc.).

NAVIGATION AND LINKAGE TO Treatment/Services

Programs that fall within the Navigation and Linkage to Services/Treatment function are designed to link individuals of all ages who are living with a mental health condition to an appropriate level of care and needed supportive services. Orange County offers several programs in this category, although only BHS Outreach and Engagement is subject to PEI regulations.[1] The remaining 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.).



[1] To meet the MHSOAC PEI Regulations criteria, the program and/or program strategies must provide written referrals and be designed to link individuals who are living with SED or SMI to the most appropriate higher level of care.

OC Links (PEI)

Program Serves	Symptom Severity				Location of Services	Population Characteristics												
																	
	At-Risk	Early Onset	Mild-Moderate	Severe	Telephone	BH WorkForces	Other/1st Responders	Parents	Families	LGBTQ	Veterans	Homeless/ At Risk	Co-Occurring (SUD)	Students	Criminal Justice	Community Providers	Trauma-Exposed Clients	Mono-Lingual/ Ethnic Community

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$1,000,000	FY 2019-20	19,034
Proposed FY 2020-21 Budget	$1,000,000	FY 2020-21	19,986
Proposed FY 2021-22 Budget	$1,000,000	FY 2021-22	20,985
Proposed FY 2022-23 Budget	$1,000,000	FY 2022-23	22,034

Proportion to be Served by Demographic Characteristic					
Age Group %	**%**	**Gender**	**%**	**Race/Ethnicity**	**%**
0-15		Female	65	African American/Black	4
16-25	13	Male	35	American Indian/Alaskan Native	1
26-64	75	Transgender		Asian/Pacific Islander	7
65+	12	Genderqueer		Caucasian/White	49
		Questioning/Unsure		Latino/Hispanic	36
		Other		Middle Eastern/North African	0
				Other	3

Language Capacity of Direct Service Providers					
✓	Spanish		Arabic		Khmer
✓	Vietnamese	✓	Farsi		Other:
	Korean		Mandarin	✓	Language Line as Needed

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 BHS programs. 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 HCA Behavioral Health services. 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 webpage (www.ochealthinfo.com/oclinks). Individuals may also access information about BHS resources on the website at any time (http://www.ochealthinfo.com/bhs/).

During a call or live chat, trained Navigators provide screening, 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 (see table).

In addition, staff attends numerous community events each year where they provide outreach and education on mental health awareness and the availability of OC Links.

Program	Linkage Metrics					Outreach Metrics		
	FY	# Calls	# Referrals	# Linkages	Types of Linkages	FY	# Events	# Attendees
OC Links	FY 2016-17	14,152	16,769	4,456	Outpatient mental health and substance use programs; prevention and early intervention services	FY 2016-17	84	2,162
	FY 2017-18	17,509	15,017	4,782		FY 2017-18	80	2,364
	FY 2018-19	18,128	15,356	5,508		FY 2018-19	112	5,323

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 continually be addressed. In order to better educate the public about OC Links on an ongoing 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.

Community Impact

The program has responded to more than 80,000 participants since opening in the Fall of 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.

BHS Outreach and Engagement (O&E) (PEI/CSS)

Program Serves	Symptom Severity				Location of Services			Population Characteristics								
0+	At-Risk	Early Onset	Mild-Moderate	Severe	Field	Community Based	Other/1st Responders	Parents	Families	LGBTQ	Criminal Justice	Homeless/ At Risk	Co-Occurring (SUD)	Co-Occurring (Medical)	Trauma-Exposed Clients

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$2,232,523	FY 2019/20	25,103
Proposed FY 2020-21 Budget	$2,232,523	FY 2020-21	26,358
Proposed FY 2021-22 Budget	$2,232,523	FY 2021-22	27,676
Proposed FY 2022-23 Budget	$2,232,523	FY 2022-23	29,030

Language Capacity of Direct Service Providers					
✓	Spanish		Arabic		Khmer
✓	Vietnamese	✓	Farsi		Other:
	Korean		Mandarin	✓	Language Line as Needed

Proportion to be Served by Demographic Characteristic					
Age Group %	**%**	**Gender**	**%**	**Race/Ethnicity**	**%**
0-15	1	Female	37	African American/Black	10
16-25	5	Male	63	American Indian/Alaskan Native	2
26-64	76	Transgender		Asian/Pacific Islander	10
65+	18	Genderqueer		Caucasian/White	45
		Questioning/ Unsure		Latino/Hispanic	32
		Other		Middle Eastern/North African	0
				Other	1

Target Population and Program Characteristics

BHS Outreach and Engagement (O&E) provides field-based access and linkage to treatment and/or support services for those who are homeless or at risk of homelessness and who have had difficulty engaging in mental health services on their own. O&E staff identifies participants through street outreach and referrals from community members and/or providers.

Services

To promote awareness of, and increase referrals to, its services, BHS O&E performs outreach at community events and locations likely to be frequented by individuals the program intends to serve and/or the providers that work with

them in non-mental health capacities (i.e., street outreach, homeless service provider locations, etc.). When a person is referred to the program, staff screens them in the community or over the phone to determine what is needed based upon an established level of risk. Once their needs are identified, staff employ various strategies to link individuals, such as personalized action plans aimed 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.

Challenges, Barriers and Solutions in Progress

Lack of affordable housing continues to be a barrier, especially for the homeless, and the program continues to collaborate with agencies to improve access to affordable housing opportunities. 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

Program	Linkage Metrics				
	FY	# Calls	# Referrals	# Linkages	Types of Linkages
BHS Outreach & Engagement	FY 2016-17	29,461	9,225	2,576	Outpatient mental health and substance use programs; prevention and early intervention services
	FY 2017-18	30,269	8,718	2,493	
	FY 2018-19	23,908	14,094	2,137	

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 have been established, participants have been more receptive to engaging in ongoing services. BHS O&E has been called upon to engage individuals at homeless encampments across the county in partnership with cities and local law enforcement agencies many times over the past few years. After the large-scale riverbed engagement two years ago, the community saw the impact of the Outreach Team engaging and linking homeless individuals to treatment, shelter and services. Due to their cultural competence working with this population, many cities and police/sheriff departments have requested BHS O&E support for one-time and ongoing engagement projects in communities across the county. This has necessitated increases in staffing and working hours/days resulting in the program now being active seven days per week and expanding their daily hours until 8 p.m. on weekdays.

Community Impact

O&E 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 program has reached homeless individuals of all ages from multiple cultures throughout Orange County and has helped them access needed behavioral health and supportive services, including housing. The homeless and provider community widely accepts O&E as a supportive program to help individuals, families and agencies seeking linkage to mental health and substance use programs. This impact has resulted in significant increases in daily calls to the Outreach (800) phone line, requests for community response and partnerships for city-based homeless encampment engagements and street outreach. Outreach has added ten additional staff positions to manage these requests.

The Courtyard Outreach Program (CSS)

Program Serves	Symptom Severity	Location of Services		Population Characteristics								
18+	Severe	Field	Community Based	Families	Parents	LGBTQ	Veterans	Homeless/At Risk of	Co-Occurring (SUD)	Co-Occurring (Medical)	Trauma-Exposed Clients	Mono-Lingual/ Ethnic Community

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$900,000	FY 2019-20	675
Proposed FY 2020-21 Budget	$900,000	FY 2020-21	675
Proposed FY 2021-22 Budget	$900,000	FY 2021-22	675
Proposed FY 2022-23 Budget	$900,000	FY 2022-23	675

Language Capacity of Direct Service Providers					
✓	Spanish		Arabic		Khmer
✓	Vietnamese		Farsi		Other:
	Korean		Mandarin	✓	Language Line as Needed

Proportion to be Served by Demographic Characteristic					
Age Group %	**%**	**Gender**	**%**	**Race/Ethnicity**	**%**
0-15	0	Female	60	African American/Black	14
16-25	6	Male	40	American Indian/Alaskan Native	1
26-64	76	Transgender		Asian/Pacific Islander	5
65+	18	Genderqueer		Caucasian/White	52
		Questioning/ Unsure		Latino/Hispanic	32
		Other		Middle Eastern/North African	1
				Other	1

Target Population and Program Characteristics

The **Courtyard Outreach** program serves residents ages 18 years or older who are living at The Courtyard homeless shelter in Santa Ana and have a serious 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 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, employment status and basic needs. In coordination with BHS O&E staff operating at The Courtyard during traditional business hours, Courtyard 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 additional 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. As can be seen in the table below, the number of contacts has increased by 38% and the number of referrals has increased by 31% from FY 2016-17 to FY 2018-19. This upward trend is most likely a result of stable staffing. Although the number of contacts and referrals have increased in recent years, the number of linkages has decreased. Program staff is currently evaluating the reasons behind this trend.

Program	Linkage Metrics				
	FY	# Calls	# Referrals	# Linkages	Types of Linkages
Courtyard Outreach	FY 2016-17	7,431	896	642	Basic needs; Education; MHA Multi-Service Center; Information and Referral Sources; Employment Services and Resources; Legal Services and Advocacy
	FY 2017-18	8,194	786	577	
	FY 2018-19	10,262	1,172	555	

Challenges, Barriers and Solutions in Progress

The Courtyard Outreach 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 has an on-site Outreach Lead to act as the liaison with these other agencies. The Lead also provides 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 outreach team collaborates with a variety of human services and nonprofit 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 shares in the goal of helping break the cycle of homelessness among those living with serious mental illness.

CHS Jail to Community Re-Entry (CSS)

Program Serves	Symptom Severity				Location of Services	Population Characteristics
18+	At-Risk	Early Onset	Moderate-Severe	Severe	Other	Criminal Justice

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$2,600,000	FY 2019-20	-
Proposed FY 2020-21 Budget	$2,200,000	FY 2020-21	3,500
Proposed FY 2021-22 Budget	$2,700,000	FY 2021-22	7,000
Proposed FY 2022-23 Budget	$2,800,000	FY 2022-23	8,750

Proportion to be Served by Demographic Characteristic

Age Group %	%	Gender	%	Race/Ethnicity	%
0-15		Female	31	African American/Black	7
16-25	19	Male	67	American Indian/Alaskan Native	
26-64	77	Transgender	2	Asian/Pacific Islander	8
65+	4	Genderqueer		Caucasian/White	45
		Questioning/ Unsure		Latino/Hispanic	39
		Other		Middle Eastern/North African	
				Other	1

Target Population and Program Characteristics

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

Services

This program uses a comprehensive approach to discharge planning and re-entry linkage services for inmates with mental illness at all five County jail facilities. Discharge planning services are conducted while individuals are still in custody and include thorough risk assessments, comprehensive individualized case management, and evidence-based re-entry groups such as Moral Reconation Therapy (MRT) aimed at identifying possible barriers to successful re-entry and developing tailored discharge plans. Services also include facilitation of linkage to a range of services upon release, such as counseling, medication support, housing, Medi-Cal enrollment, and essential needs such as clothing and transportation. Connections with family and other support systems such as forensic peer support mentors are also facilitated. JCRP staff works in collaboration with other stakeholders, including the Orange County Sheriff's Department (OCSD), 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. JCRP has established a 7-day release process which provides face-to-face contact and re-entry resources for all inmates leaving the Central Jail Complex. JCRP also works in collaboration with medical case managers to meet with any inmate the day of their release who may have unmet needs.

Outcomes

The program was still ramping up in FY 2018-19 and outcomes will be reported in future Plan Updates.

Challenges, Barriers and Solutions in Progress

The JCRP program is faced with the challenge of finding appropriate placement options for the number of inmates living with serious mental illness who discharge from County jail facilities. In addition, although transportation is a determining factor in solidifying linkages with external stakeholders for a smooth transition from jail to community, at this time only a few programs provide transportation services for inmates leaving the facility and JCRP does not currently have the capability to provide transportation internally. There is also a challenge linking inmates who are at OCJ for only a short period of time (0-7 days) to services since many community programs require a substantial amount of time for their referral process. JCRP has been working with Open Access North/South and Opportunity Knocks to close this gap in services, and clinicians are now able to make appointments for Opportunity Knocks up until the day before an inmate's release and for Open Access on the same day of their release. Going forward, the program hopes to expand this option for "last minute" referral and linkage to other programs in the county. Finally, JCRP staff have established a weekly re-entry planning meeting with OCSD, Probation and other ancillary agencies to review case plans and discuss the urgent needs of inmates prior to their release. This process serves to address any unmet needs of the inmates prior to release.

Recovery Open Access (CSS)

Program Serves	Symptom Severity	Population Characteristics			
18+	Severe	Homeless/ At Risk	Co-Occurring (SUD)	Hosp DCs	Jail DCs

Language Capacity of Direct Service Providers					
✓	Spanish		Arabic		Khmer
✓	Vietnamese		Farsi	✓	Other: Laotian
	Korean		Mandarin	✓	Language Line as Needed

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	See note*	FY 2019-20	1,850
Proposed FY 2020-21 Budget	$2,300,000	FY 2020-21	1,850
Proposed FY 2021-22 Budget	$2,300,000	FY 2021-22	1,900
Proposed FY 2022-23 Budget	$2,300,000	FY 2022-23	1,900

** Open Access budget was included in the Outpatient Recovery Centers/Clinics budget*

Proportion to be Served by Demographic Characteristic

Age Group %	%	Gender	%	Race/Ethnicity	%
0-15	0	Female	43	African American/Black	4
16-25	25	Male	56	American Indian/Alaskan Native	1
26-64	74	Transgender		Asian/Pacific Islander	8
65+	1	Genderqueer		Caucasian/White	41
		Questioning/ Unsure		Latino/Hispanic	26
		Other	1	Middle Eastern/North African	1
				Other	19

Target Population and Program Characteristics

Recovery Open Access serves individuals ages 18 and older living with serious and persistent mental illness and a possible co-occurring disorder who are in need of accessing urgent outpatient behavioral health services. The target population includes adults who are being discharged from psychiatric hospitals, released from jail or are 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 mental illness to ongoing, 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. In order to decrease the risk of re-hospitalization or recidivism, staff try to see participants within 24 hours of the time of discharge from the hospital or jail and to keep them engaged in services until they link to ongoing care.

Outcomes

Performance of the program was measured by whether the program met or exceeded the following targets:

- **80%** of adults discharged from a hospital and referred for medication are linked to Open Access medication services within 3 business days
- **80%** of adults discharged from a jail and referred for medication are linked to Open Access medication services within 3 business days
- **80%** of adults referred by Open Access to ongoing care are linked within 30 days

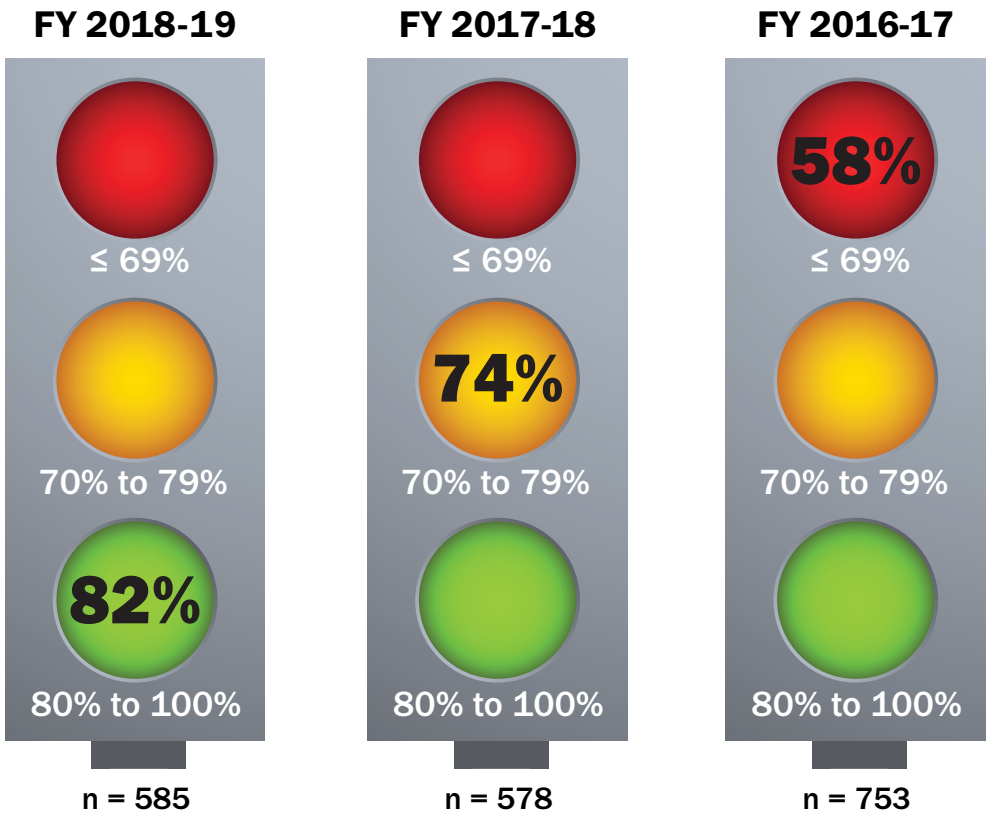
Total Individuals Served		
FY 2016-17	**FY 2017-18**	**FY 2018-19**
1,357	1,762	1,852

The program continued to meet its targets in FY 2018-19 after staff expectations around scheduling appointments with the Open Access psychiatrist, receiving medication and receiving ongoing care were clarified at the end of FY 2016-17. Additional staff has resulted in smaller caseloads, and this has allowed staff to more closely monitor linkages and follow-up on missed appointments. These improvements, in addition to the implementation of a Performance Improvement Project (PIP) in October 2018 that focused on linking hospitalized clients to Open Access and outpatient services, may have contributed in the upward trend in linkages since 2016-17.

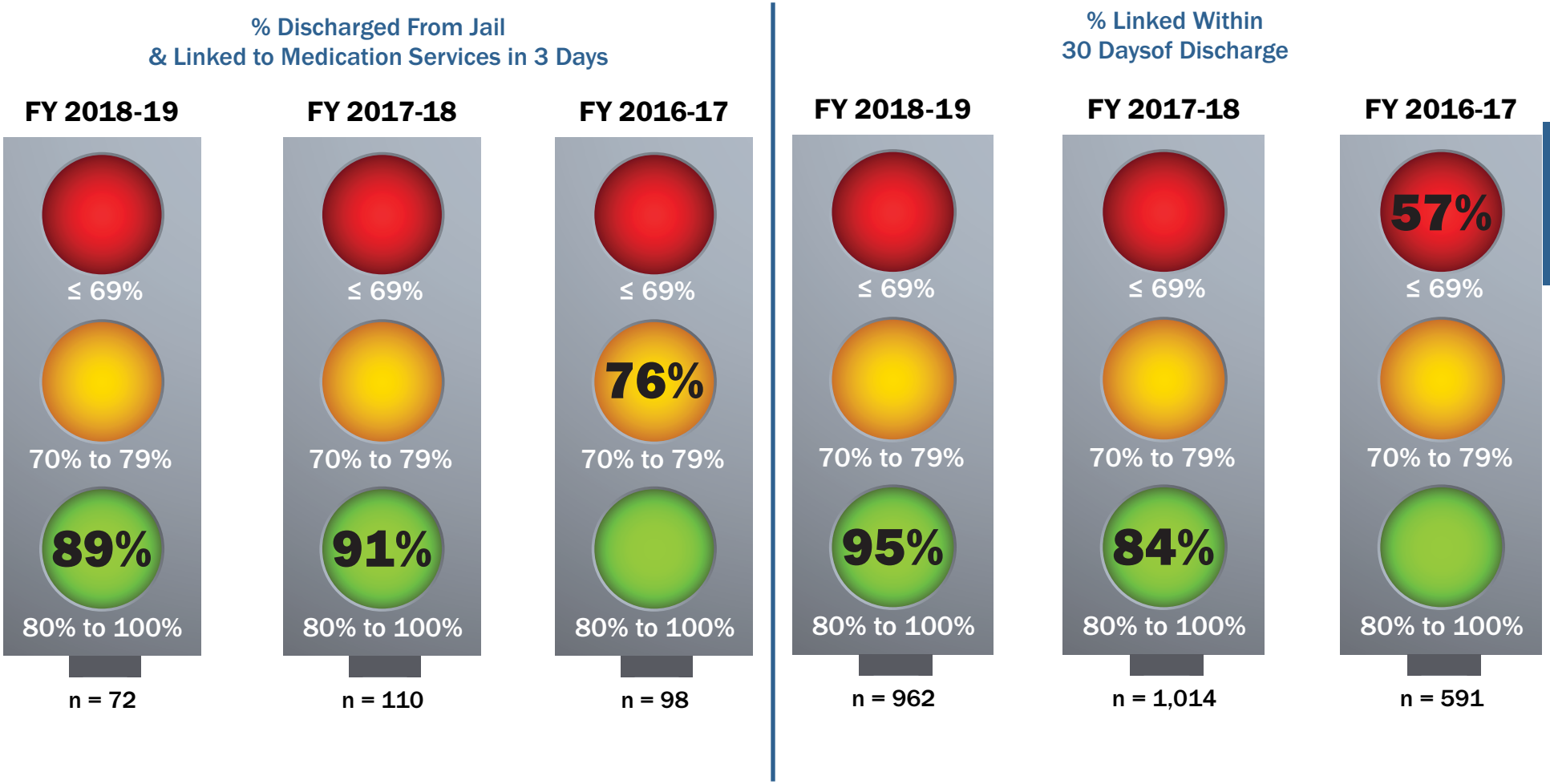
Target	FY 2016-17		FY 2017-18		FY 2018-19	
Referred to Open Access Medication Services	**By Hospital**	**By Jail**	**By Hospital**	**By Jail**	**By Hospital**	**By Jail**
# Referred for Medication by Discharge Location	**753**	**98**	**578**	**110**	**585**	**72**
% Linked Within 3 Business Days	**58%**	**76%**	**74%**	**91%**	**82%**	**89%**
Referred by Open Access to Ongoing Care						
# Referred to Ongoing Care	**591**		**1,014**		**962**	
% Linked Within 30 Days	**57%**		**84%**		**95%**	

Recovery Open Access

% Discharge From Hospital & Linked to Medication Services in 3 Days



Recovery Open Access



Challenges, Barriers and Solutions in Progress

Since relocating the Open Access South site from Mission Viejo to Costa Mesa, the work load across the north and south locations has become more balanced. In addition, a peer is now employed at Open Access south to assist participants with linking to their appointments at the outpatient clinics and aligning the south site with the peer support already provided at the north site. As part of a PIP for the Mental Health Plan, Open Access will have an intake counselor provide on-site intake assessments at local hospitals for those participants who have been previously hospitalized multiple times but did not attend their intake appointments at Open Access following discharge from the hospital.

Community Impact

Recovery Open Access has provided services to more than 4,861 individuals since its inception through the end of FY 2018-19. The program collaborates with a variety of community partners including: hospitals, jails, homeless shelters, substance use programs, community health clinics, mental health clinics, OC Probation and Orange County Social Services Agency (SSA) to help individuals receive needed behavioral health care.

Summary of MHSA Strategies Used by Prevention Programs

Strategies to Promote Recovery/Resilience

Navigation/Access and Linkage to Treatment (N/ALT) programs work with some of the most marginalized and unserved populations in the county, including those who are homeless and/or involved in the criminal justice system. These individuals may have previously experienced trauma or, particularly among the homeless population, are currently experiencing daily trauma and are struggling to meet their basic needs, leaving them feeling disenfranchised or stigmatized. In order to engage individuals successfully, staff integrates a consumer-centered, 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, help to reduce barriers and offer supportive services while working to link individuals to treatment. Staff use recovery principles and techniques such as motivational interviewing to help engage individuals in their recovery journey.

Strategies to Reduce Stigma and Discrimination

N/ALT programs engage in a number of 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 ongoing supervision, staff is 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.

In addition, outreach workers who work with homeless individuals 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 trained to identify the underlying conditions associated with homelessness and to 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.

N/ALT program staff, particularly OC Links and BHS O&E, also provides hundreds of outreach trainings throughout the county at community events, resource fairs, law enforcement departments, etc. With this increased presence in the community, programs hope to reduce the stigma and discrimination attached to those attempting to reach out for behavioral health services.

Strategies to Increase Access to Services: Timely Access for Underserved Populations and Linkage to Treatment

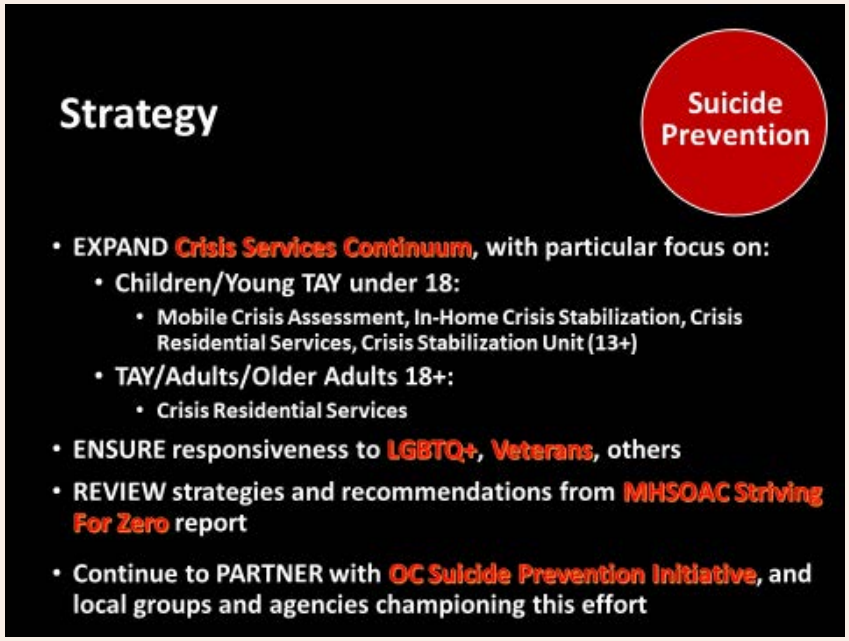
The Navigation program, OC Links, encourages timely access by promoting its services among unserved and underserved populations in Orange County. For example, the program displays its information and phone number on rotation every day at the Civic Center Plaza message board; has advertised on Public 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 hard of hearing callers.

In addition, the ALT programs provide face-to-face services to increase unserved individuals' willingness to enroll in needed services and facilitate linkage to appointments in as timely a manner as possible. 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 ongoing care. Staff are bilingual/bicultural and a language translation service is available when needed. In addition, BHS O&E is staffed with peers who share their own lived experience as a way to build the rapport and trust necessary to engage homeless individuals. 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 addition, all N/ALT programs have developed collaborative relationships with outside agencies that come into frequent contact with the programs' respective target populations and, in turn, these agencies provide referrals to N/ALT services. 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 Orange County Probation Department (OC Probation), the Orange County Fire Authority (OCFA), veterans services, community centers, motels, shelter staff, apartment complexes, and other behavioral health service agencies.

CRISIS PREVENTION AND SUPPORT SERVICES

Orange County has a comprehensive array of crisis services that operate 24/7, every day of the year, and are designed to support individuals of all ages who are experiencing, or at risk of experiencing, a behavioral health emergency. These programs range from telephone-based prevention programs through intensive crisis support services provided either in the home, residential setting or anywhere in the community. The goal is to 1) provide peer and clinical support – either directly or through linkages to other services – so that the person may continue living safely in the community, when appropriate, or 2) facilitate admission to a psychiatric hospital when a higher level of care is needed to ensure the health and safety of an individual.



Through community planning and a county needs assessment, this service area has been identified as a funding priority in the Three-Year Plan. As such, all of the programs making up the County's Crisis Prevention and Support Services continuum are being expanded. Initial efforts of this expansion, (see presentation slide from January 29, 2020 MHSA Steering Committee meeting), include:

- Increase overall service capacity for youth under age 18.
- Increase Crisis Residential Services capacity for individuals ages 18 and older, including establishing a Silver Treehouse for older adults.
- Ensure responsiveness to LGBTIQ, Veterans and other vulnerable, marginalized and high-risk populations.

As presented at the January 13, 2020 Steering Committee meeting, PEI funding will also be expanded for the WarmLine and Suicide Prevention Services.

In addition, these and other programs in the Crisis Services continuum have been approved via the community planning process to receive additional PEI and/or CSS carryover funding mid-year, if available, should demand for services outpace the augmented budgets.

The HCA is committed to aligning its efforts with the strategies and recommendations from the MHSOAC's Striving for Zero report and will continue to partner with the OC Suicide Prevention Initiative, which is comprised of local groups and agencies committed to improving the mental health and well-being of Orange County residents.

WarmLine (PEI)

Program Serves	Symptom Severity				Location of Services	Typical Population Characteristics
0+	At-Risk	Early Onset	Mild-Moderate	Severe	Telephone	Non-crisis support for anyone struggling with mental health and substance abuse issues.

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$536,566	FY 2019-20	32,000
Proposed FY 2020-21 Budget	$1,116,667	FY 2020-21	32,000
Proposed FY 2021-22 Budget	$1,116,667	FY 2021-22	32,000
Proposed FY 2022-23 Budget	$1,116,667	FY 2022-23	32,000

Proportion to be Served by Demographic Characteristic

Age Group %	%	Gender	%	Race/Ethnicity	%
0-15		Female	56	African American/Black	Not collected on call
16-25	6	Male	44	American Indian/Alaskan Native	
26-64	67	Transgender		Asian/Pacific Islander	
65+	27	Genderqueer		Caucasian/White	
		Questioning/ Unsure		Latino/Hispanic	
		Other		Middle Eastern/North African	
				Other	

Language Capacity of Direct Service Providers					
✓	Spanish		Arabic		Khmer
✓	Vietnamese	✓	Farsi		Other:
	Korean		Mandarin	✓	Language Line as Needed

Target Population and Program Characteristics

The **WarmLine** provides peer support to unserved and underserved Orange County residents who are experiencing mild to moderate symptoms of a mental health disorder or who are at risk of developing a mental health disorder, challenges at school and/or trauma exposure. The program also serves family members. This telephone service 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 plays an important role in Orange County's Crisis and Suicide Prevention continuum by providing non-crisis or crisis prevention support over the phone or through live chat, for anyone struggling with mental health and substance use issues. 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.

Active listening, a person-centered motivational interviewing skill, is effective in establishing rapport and demonstrating empathy, and can be especially useful with callers in the pre-contemplative or contemplative stages of change. The WarmLine also uses Positive Psychology, a resilience-based model that focuses on positive emotions, 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.

Outcomes

The WarmLine continues to demonstrate an increasing number of callers and amount of activity. The majority of calls were from individuals who had used the WarmLine before and calls typically lasted 20 minutes or less.

WARMLINE	FY 2016-17	FY 2017-18	FY 2018-19
Total Unduplicated Served	18,381	22,678	26,463
Total Calls	48,796	50,392	53,890
Total Live Chats/Texts	479	602	740

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.

Results across fiscal years 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 anxious, overwhelmed or helpless. Thus, the program appears to be successful in reducing emotional distress through the support and services provided during the telephone contact.

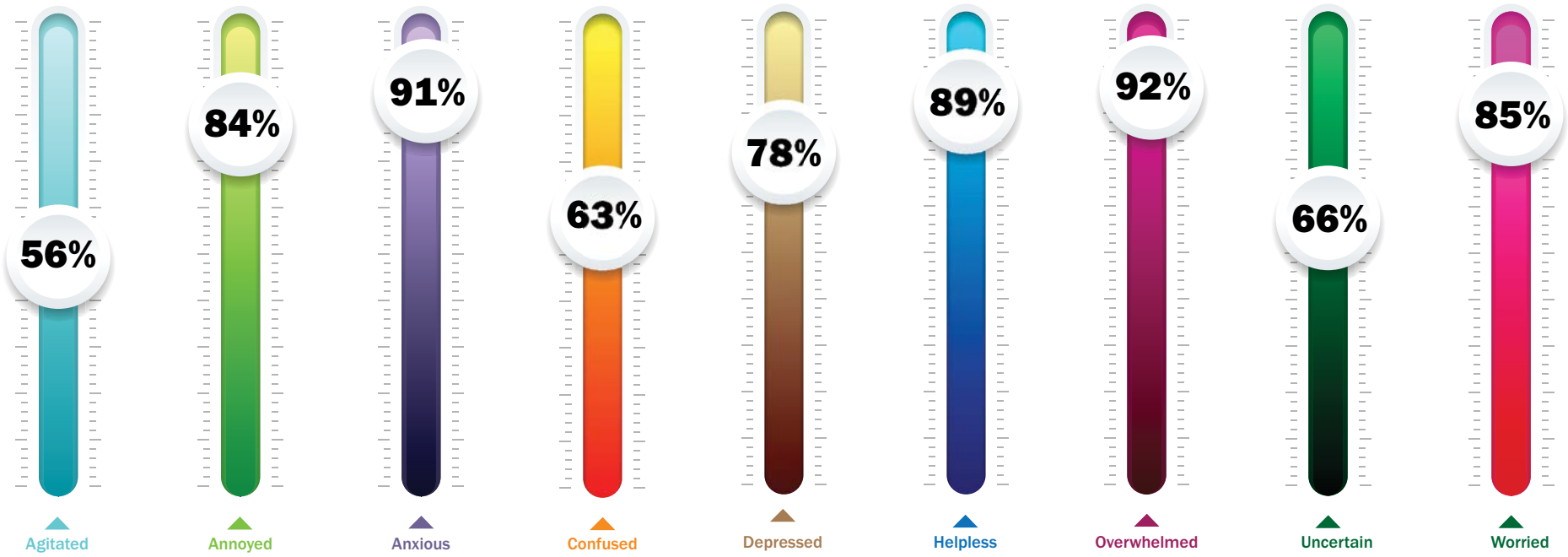
Challenges, Barriers and Solutions in Progress

An ongoing challenge for the program has been the continuing increase in calls year after year. This increase has created longer wait times as staff are not always available to answer incoming calls immediately. The program has adjusted staff shifts to accommodate when call volume is highest and is always identifying and recruiting new volunteers to try and accommodate the increasing demand for services. The program also received increased funding for FY 2018-19 and, through the community planning process, was identified as a program that can receive additional carryover funds over the course of this Three-Year Plan if demand for services exceeds its recently augmented budget. The provider is also exploring other strategies to adapt to the increased volume, including methods to enhance their technology. In addition, as a result of the recent hiring of bilingual staff, the program's voicemail system was expanded from English and Spanish to include Farsi and Vietnamese language voicemail options. Callers who speak these languages can now leave a voicemail requesting support from a staff who speaks their preferred language as soon as they become available rather than having to make repeated calls to the line in hopes of connecting with a bilingual staff by chance.

Community Impact

The WarmLine has provided services to more than 93,755 individuals since its inception in August 2010. The provider also actively collaborates within the community as a whole in order to break down stigma, raise awareness and educate the community about available services.

Reported Improvement in Negative Mood States at End of Call WarmLine by FY 2018-19



FY 2017-18

Agitated	Annoyed	Anxious	Confused	Depressed	Helpless	Overwhelmed	Uncertain	Worried
81%	85%	92%	77%	84%	90%	93%	83%	87%

FY 2016-17

Agitated	Annoyed	Anxious	Confused	Depressed	Helpless	Overwhelmed	Uncertain	Worried
69%	75%	81%	71%	74%	75%	82%	78%	84%

Suicide Prevention Services (PEI)

Program Serves	Symptom Severity				Location of Services	Typical Population Characteristics
0+	At-Risk	Early Onset	Mild-Moderate	Severe	Telephone	Non-crisis support for anyone struggling with mental health and substance abuse issues.

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$736,226	FY 2019-20	10,283
Proposed FY 2020-21 Budget	$1,200,000	FY 2020-21	12,147
Proposed FY 2021-22 Budget	$1,200,000	FY 2021-22	12,147
Proposed FY 2022-23 Budget	$1,200,000	FY 2022-23	12,147

Proportion to be Served by Demographic Characteristic

Age Group %	%	Gender	%	Race/Ethnicity	%
0-15	9	Female	41	African American/Black	4
16-25	41	Male	53	American Indian/Alaskan Native	1
26-59	43	Transgender	1	Asian/Pacific Islander	15
60+	7	Genderqueer		Caucasian/White	30
		Questioning/ Unsure		Latino/Hispanic	20
		Other	5	Middle Eastern/North African	
				Other	30

Language Capacity of Direct Service Providers					
✓	Spanish	✓	Arabic		Khmer
	Vietnamese	✓	Farsi		Other:
✓	Korean		Mandarin	✓	Language Line as Needed

Target Population and Program Characteristics

The **Suicide Prevention Services** program represents a strategic integration of the existing Crisis Prevention Hotline and Survivor Support Services programs. While the actual services will remain the same, this operational shift will allow for more seamless delivery of support services for individuals whose lives are affected by suicide in some manner. The services are available to individuals of all ages who 1) are experiencing a behavioral health crisis and/or suicidal thoughts, 2) have attempted suicide and may be living with depression, 3) are concerned about a loved one possibly attempting suicide, and/or 4) are coping with the loss of a loved one who died by suicide. The program serves a broad range of people of all ages, and individuals can be self-referred or referred by family members, providers or other partner agencies. The toll-free, accredited hotline operates 24 hours a day, 7 days a week.

Services

The program uses Applied Suicide Intervention Skills Training (ASIST), which provides practical suicide intervention training for clinicians, first responders, medical providers and caregivers seeking to prevent the immediate risk of suicide.

Telephone Hotline Support: Trained counselors provide immediate, confidential, over-the-phone/text/chat assistance and can initiate active rescues when necessary. For callers who have given their consent, counselors conduct follow-up calls to ensure continued safety and reduce the likelihood of attempts and emergency room visits. Callers who are not experiencing a crisis are triaged and offered access to the WarmLine or other appropriate resources. The toll-free suicide prevention service is available to anyone in crisis or experiencing suicidal thoughts or to someone who is concerned about a loved one attempting suicide.

Individual Counseling for Survivors after Suicide: Children, adolescents, adults and older adults who are coping with the loss of someone to suicide can receive time-limited individual counseling. Short-term bereavement counseling is also available to families who want to improve their functioning and communication after the loss of a family member.

Survivors after Suicide Bereavement Groups: Two different bereavement groups are offered for anyone who is coping with the loss of someone to suicide. 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 group is a drop-in bereavement group designed to help individuals receiving individual counseling (described above), and program alumni so that they continue the healing process in the months and years following their losses.

Survivors of Suicide Attempts (SOSA) Support Group: 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 provide them with skills for coping with deep hurt. The program also provides individuals with culturally appropriate follow-up care and education.

Community Training/Outreach: Consistent with PEI regulations, the program trains potential first responders in ASIST and SafeTalk so that they are 1) better able to recognize signs of depression, suicidal ideation and other mental health conditions, and 2) informed about myths associated with talking about suicide, strategies on how to listen to and aid someone in distress, and awareness of the Suicide and Crisis Prevention Services program. Audiences include nurses, physicians, teachers and school personnel, law enforcement and other Orange County community members.

Program staff also provides informational/program promotional material through information tables at events and speaking engagements throughout the county.

COMMUNITY OUTREACH/TRAINING	FY 2016-17	FY 2017-18	FY 2018-19
Trainings	59	70	64
Potential Responders Reached	1,390	2,015	1,779

Outcomes

Corresponding to its increased outreach efforts, the hotline has seen a steady increase in the number of individuals served. Outcomes for the different types of services are summarized below.

Crisis Prevention Hotline: To assess the hotline's effectiveness in reducing prolonged suffering, callers were asked to complete a Self-Rated Intent (SRI) on a 5-point scale at the beginning and end of the call. Risk of suicidal behavior was rated low if a caller reported their suicidal intent as a score of 1 or 2, medium if they reported a score of 3, and high if they reported a 4 or 5. A score that moved to a lower risk category by the end of the call or remained in the low risk category for the duration of the call suggests that services effectively stabilized or decreased suicidal intent. The proportion of high-risk callers has consistently dropped by the end of the call. Thus, Crisis Prevention Hotline counselors helped reduce suicidal intent and prevented the worsening of crisis symptoms.

Suicide Prevention Services	FY 2016-17	FY 2017-18	FY 2018-19
Unduplicated Hotline Callers	6,807	9,200	10,137
Hotline Calls	8,475	11,607	13,536
% High-Risk at Call Start	27%	23%	19%
% High-Risk at Call End	7%	8%	5%

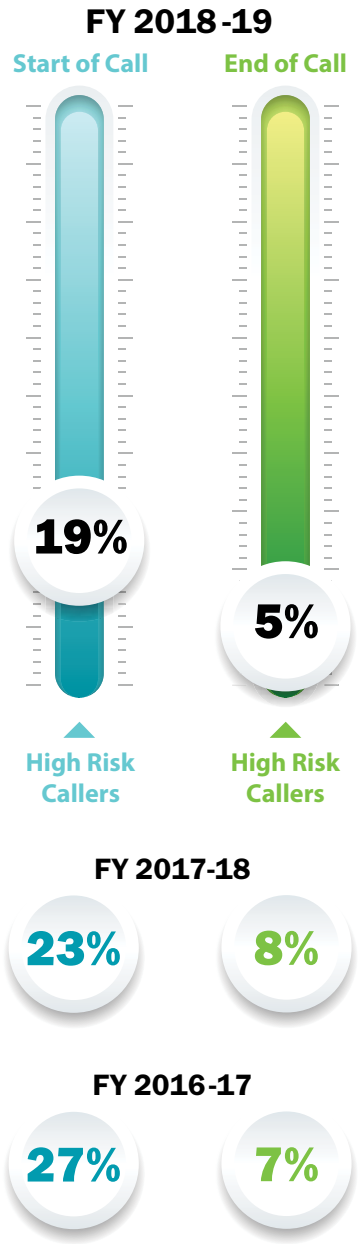
Face-to-Face Services: The program also provides in-person services, which have remained relatively consistent in the numbers of people served over the past few years, and a trend towards more individual counseling sessions and fewer support groups.

In-Person Services	FY 2016-17	FY 2017-18	FY 2018-19
Total Served	132 people	148 people	140 people
Total # Support Groups	59 groups	64 groups	29 groups
Total # Individual Counseling Sessions	511 sessions	559 sessions	678 sessions
# SAS Baseline & 1+ GEQ Follow-Up	20	22	31

To measure the reduction in prolonged suffering in a culturally competent manner, individuals participating in individual or group counseling were asked to complete measures specific to their experience. Measures were administered 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. Results are reported according to their calculated effect size, which reflects, in part, the extent to which a change in scores over time is clinically meaningful for the individuals served in the program.

- Survivors after Suicide (SAS): Based on individuals' responses on the Grief Experiences Questionnaire (GEQ), services were generally associated with a meaningful lessening of

Percent High Risk Callers at Call Start and End



grief following the loss of a loved one to suicide, Although degree of improvement varied across subscales and fiscal years, given the small sample sizes, it cannot yet be determined whether these differences reflect a change in the impact of services, the nature of the individuals served or other factors. The HCA will continue to monitor these outcomes to see if a trend can be identified.

- Survivors of Suicide Attempts: SOSA participants (FY 2018-19 n=10; FY 2017-18 n=14; FY 2016-17: n=13) completed the Beck Hopelessness Scale, Beck Scale for Suicidal Ideation and Interpersonal Needs Questionnaire to assess for pessimism and negativity they felt about their future; their thoughts, plans and intent to commit suicide; and their perceived burdensomeness and thwarted belongingness, respectively. Due to the small sample size of participants who completed both a baseline and follow-up of these measures, data were not statistically analyzed. However clinicians monitored scores over the course of treatment to track participants' progress and adjust care plans as needed. The HCA is currently identifying ways to improve collection and/or measurement of performance outcome for this group.

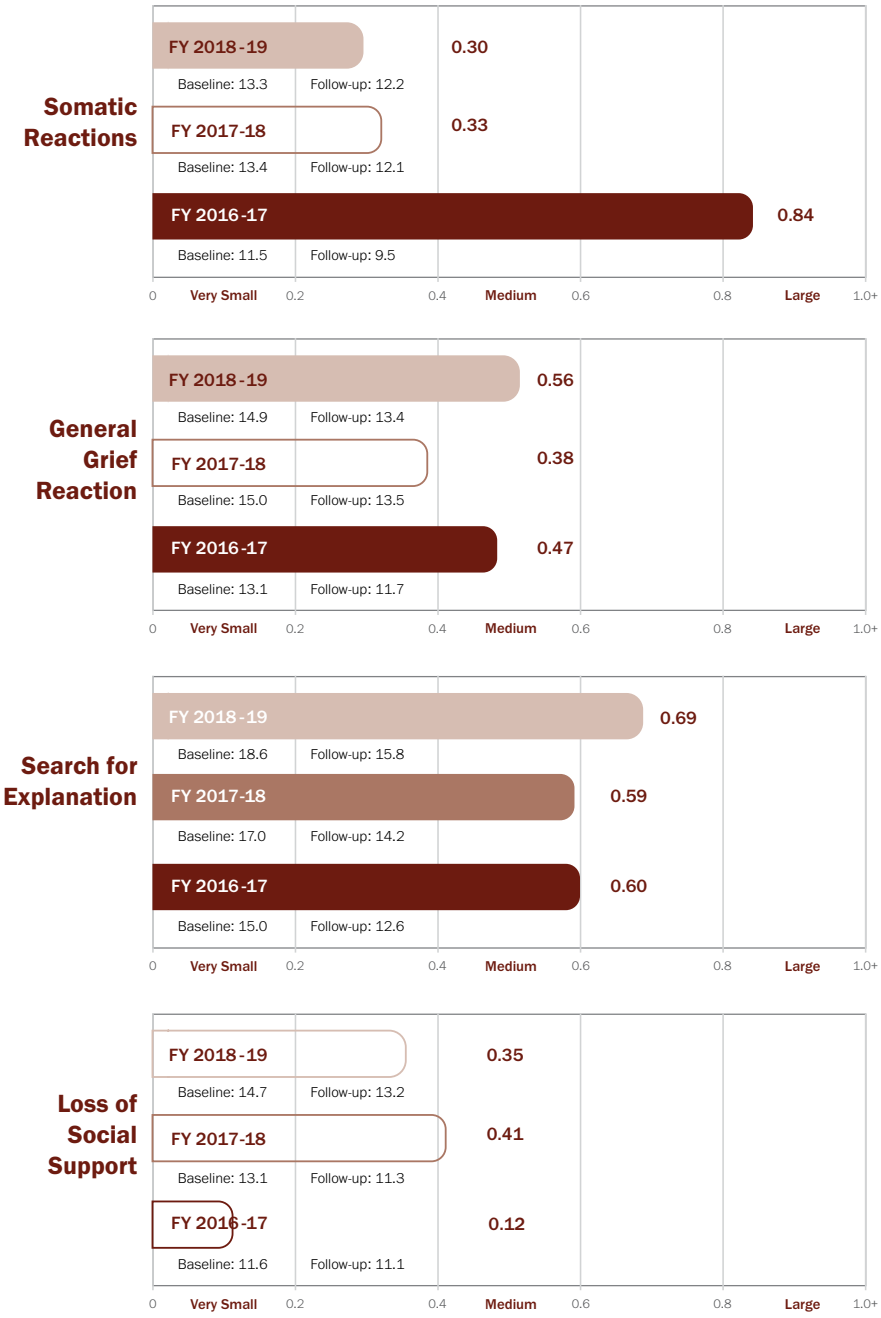
Challenges, Barriers and Solutions in Progress

Similar to the WarmLine, the crisis hotline has seen a steady increase in calls over the past several years which exceeded its staffing capacity. In response, the program received increased funding beginning FY 2018-19. Through the recent community planning process, the integrated Suicide and Crisis Prevention Services program was also identified as a program that can receive additional carryover funds over the course of this Three-Year Plan if, demand for services exceeds its recently augmented budget. The program recently relocated to a new building with more space to accommodate additional staff and volunteers, and the facility is equipped with updated, state-of-the-art technology.

Stigma regarding suicide continues to be a barrier to seeking services, which the program is addressing by conducting more community outreach and presentations, especially in different ethnic communities, and the program has hired bilingual staff who speak Korean and

Suicide Prevention Services:

SAS - Impact on Improving Grief Experiences



Spanish. In addition, program has incorporated a workshop model to conduct outreach. This strategy has been especially successful in the Spanish-speaking community, as noted by an increase in Spanish-speaking participants.

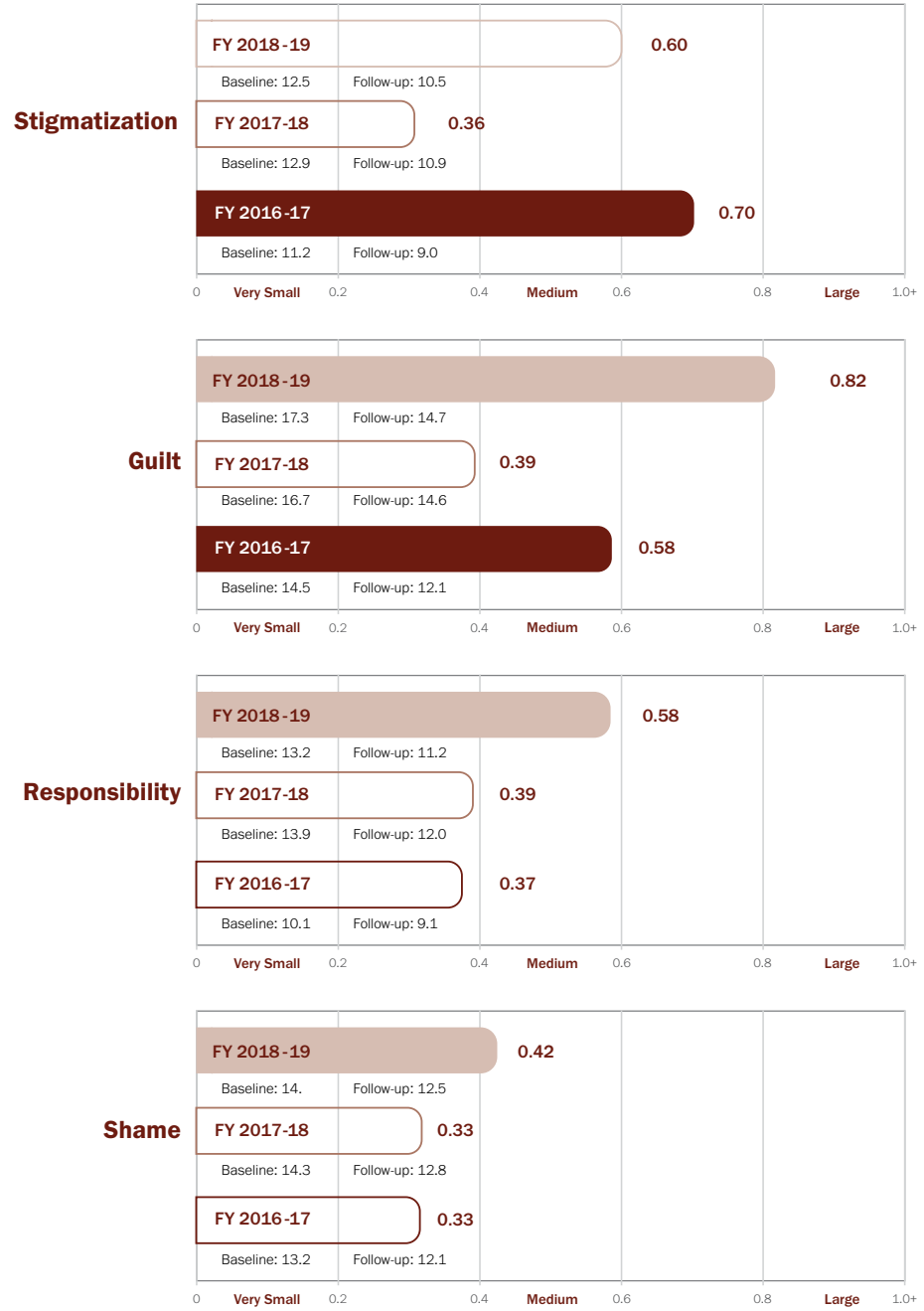
In addition, the program conducts outreach in Arabic, Farsi, Urdu and Hindi languages through its partnership with a community agency serving the Middle Eastern and North African communities. The increased outreach efforts have been successful and the program is seeing an increase in demand for individual sessions, especially from Survivors of Suicide Attempters (SOSA) and Survivors after Suicide (SAS). However, stigma continues to be a barrier for group sessions, especially for SOSA groups. Recognizing that a survivor of a suicide attempt may need additional time to engage in services, the program periodically reaches out to the individual to assess their readiness for services. The program is working to collaborate with hospitals, such as Hoag and Mission Hospital, in hopes of increasing referrals for SOSA groups.

Community Impact

The integrated program has answered a total of 74,457 calls and provided face-to-face services to more than 867 since services launched 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.

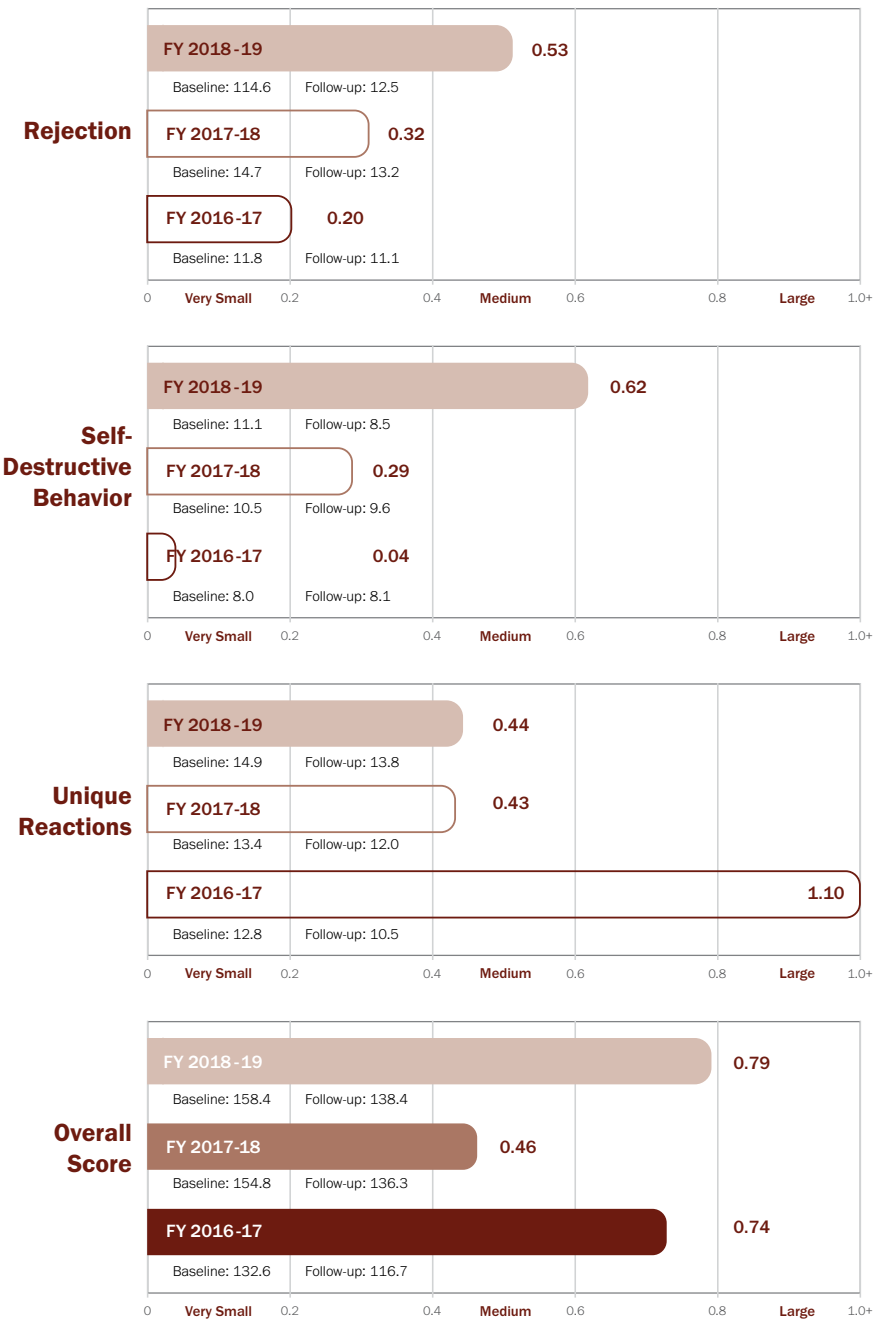
Suicide Prevention Services:

SAS - Impact on Improving Grief Experiences



Suicide Prevention Services:

SAS - Impact on Improving Grief Experiences



Reference Notes:

Somatic Reactions:

FY 2018-19: Baseline M=13.3, SD=3.21; Follow-up M=12.2, SD=3.83; t(30)=1.64, p<.012; Cohen's d=0.30

FY 2017-18: Baseline M=13.4, SD=5.0; Follow-up M=12.1, SD=3.6; t(21)=1.47, p=.16; Cohen's d=0.33

FY 2016-17: Baseline M=11.5, SD=4.2; Follow-up M=9.5, SD=2.7; t(19)=3.23, p<.01; Cohen's d=0.84

General Grief Reaction:

FY 2018-19: Baseline M=14.9, SD=3.77; Follow-up M=13.4, SD=3.85; t(30)=3.14, p<.012; Cohen's d=0.56

FY 2017-18: Baseline M=15.0, SD=4.1; Follow-up M=13.5, SD=3.6; t(21)=1.75, p=.10; Cohen's d=0.38

FY 2016-17: Baseline M=13.1, SD=4.4; Follow-up M=11.7, SD=4.3; t(19)=2.01, p<.05; Cohen's d=0.47

Search for Explanation:

FY 2018-19: Baseline M=18.6, SD=3.51; Follow-up M=15.8, SD=3.85; t(30)=5.10, p<.001; Cohen's d=0.69

FY 2017-18: Baseline M=17.0, SD=4.8; Follow-up M=14.2, SD=5.1; t(21)=2.77, p<.05; Cohen's d=0.59

FY 2016-17: Baseline M=15.0, SD=3.5; Follow-up M=12.6, SD=3.7; t(19)=2.70, p<.05; Cohen's d=0.60

Loss of Social Support:

FY 2018-19: Baseline M=14.7, SD=6.03; Follow-up M=13.2, SD=6.33; t(30)=1.96, p<.059; Cohen's d=0.35

FY 2017-18: Baseline M=13.1, SD=5.6; Follow-up M=11.3, SD=3.8; t(21)=1.46, p=.16; Cohen's d=0.41

FY 2016-17: Baseline M=11.6, SD=4.3; Follow-up M=11.1, SD=4.0; t(19)=0.55, p=.59; Cohen's d=0.12

Stigmatization:

FY 2018-19: Baseline M=12.5, SD=5.32; Follow-up M=10.5, SD=4.88; t(30)=3.29, p<.059; Cohen's d=0.60

FY 2017-18: Baseline M=12.9, SD=5.4; Follow-up M=10.9, SD=4.8; t(21)=1.67, p=.11; Cohen's d=0.36

FY 2016-17: Baseline M=11.2, SD=4.8; Follow-up M=9.0, SD=4.0; t(19)=3.05, p<.01; Cohen's d=0.70

Guilt:
FY 2018-19: Baseline M=17.3, SD=5.76; Follow-up M=14.7, SD=5.80; t(30)=4.57, p<.001; Cohen's d=0.82
FY 2017-18: Baseline M=16.7, SD=4.9; Follow-up M=14.6, SD=4.7; t(21)=1.81, p=.08; Cohen's d=0.39
FY 2016-17: Baseline M=14.5, SD=4.5; Follow-up M=12.1, SD=3.4; t(19)=2.55, p<.05; Cohen's d=0.58

Responsibility:
FY 2018-19: Baseline M=13.2, SD=5.17; Follow-up M=11.2, SD=4.79; t(30)=3.22, p<.003; Cohen's d=0.58
FY 2017-18: Baseline M=13.9, SD=4.8; Follow-up M=12.0, SD=4.7; t(21)=1.84, p=.08; Cohen's d=0.39
FY 2016-17: Baseline M=10.1, SD=3.4; Follow-up M=9.1, SD=2.9; t(19)=1.65, p=.12; Cohen's d=0.37

Shame:
FY 2018-19: Baseline M=14.4, SD=4.40; Follow-up M=12.5, SD=4.99; t(30)=2.31, p<.027; Cohen's d=0.42
FY 2017-18: Baseline M=14.3, SD=4.8; Follow-up M=12.8, SD=5.2; t(21)=1.53, p=.11; Cohen's d=0.33
FY 2016-17: Baseline M=13.2, SD=4.0; Follow-up M=12.1, SD=3.5; t(19)=1.47, p=.16; Cohen's d=0.33

Rejection:
FY 2018-19: Baseline M=114.6, SD=5.24; Follow-up M=12.5, SD=5.57; t(30)=2.96, p<.006; Cohen's d=0.53
FY 2017-18: Baseline M=14.7, SD=5.8; Follow-up M=13.2, SD=5.6; t(21)=1.51, p=.15; Cohen's d=0.32
FY 2016-17: Baseline M=11.8, SD=4.8; Follow-up M=11.1, SD=4.6; t(19)=0.89, p=.39; Cohen's d=0.20

Self-Destructive Behavior:
FY 2018-19: Baseline M=11.1, SD=4.07; Follow-up M=8.5, SD=3.02; t(30)=3.21, p<.003; Cohen's d=0.62
FY 2017-18: Baseline M=10.5, SD=4.2; Follow-up M=9.6, SD=3.7; t(21)=1.34, p=.19; Cohen's d=0.29
FY 2016-17: Baseline M=8.0, SD=3.5; Follow-up M=8.1, SD=3.1; t(19)=-0.17, p=.87; Cohen's d=0.04

Unique Reactions:
FY 2018-19: Baseline M=14.9, SD=2.87; Follow-up M=13.8, SD=3.74; t(30)=2.33, p<.027; Cohen's d=0.44
FY 2017-18: Baseline M=13.4, SD=3.5; Follow-up M=12.0, SD=3.9; t(21)=2.00, p=.06; Cohen's d=0.43
FY 2016-17: Baseline M=12.8, SD=2.6; Follow-up M=10.5, SD=2.7; t(19)=4.92, p<.001; Cohen's d=1.10

Overall Score:
FY 2018-19: Baseline M=158.4, SD=33.09; Follow-up M=138.4, SD=38.56; t(30)=4.33, p<.001; Cohen's d=0.79
FY 2017-18: Baseline M=154.8, SD=38.4; Follow-up M=136.3, SD=33.6; t(21)=2.16, p<.05; Cohen's d=0.46
FY 2016-17: Baseline M=132.6, SD=32.6; Follow-up M=116.7, SD=30.7; t(19)=3.28, p<.01; Cohen's d=0.74

Mobile Crisis Assessment Team (CSS)

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics		
						
0-17	Crisis	Field	Community Based	Homeless/At Risk	Students	Trauma-Exposed Clients

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics		
						
18+	Crisis	Field	Community Based	Homeless/At Risk	Students	Trauma-Exposed Clients

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$8,835,858	FY 2019-20	9,837
Proposed FY 2020-21 Budget	$9,135,858	FY 2020-21	10,820
Proposed FY 2021-22 Budget	$9,135,858	FY 2021-22	11,901
Proposed FY 2022-23 Budget	$9,135,858	FY 2022-23	13,090

Language Capacity of Direct Service Providers					
✓	Spanish		Arabic		Khmer
✓	Vietnamese	✓	Farsi		Other:
✓	Korean	✓	Mandarin	✓	Language Line as Needed

Proportion to be Served by Demographic Characteristic					
Age Group %	**%**	**Gender**	**%**	**Race/Ethnicity**	**%**
0-15	29	Female	51	African American/Black	5
16-25	28	Male	48	American Indian/Alaskan Native	
26-59	35	Transgender	1	Asian/Pacific Islander	10
60+	8	Genderqueer		Caucasian/White	41
		Questioning/Unsure		Latino/Hispanic	31
		Other		Middle Eastern/North African	1
				Other	12

Target Population and Program Characteristics

The mobile **Crisis Assessment Team (**CAT) program serves individuals of all ages who are experiencing a behavioral health crisis. Clinicians respond to calls from anyone in the community 24 hours a day, 7 days a week year-round and dispatch to locations throughout Orange County other than inpatient psychiatric or skilled nursing facilities which are staffed to conduct such evaluations. There are currently 27 clinicians on the children's crisis assessment team (CAT) serving youth under age 18, and 41 clinicians on the TAY/Adult/Older Adult team serving individuals ages 18 and older.[1] The teams are also staffed with Service Chiefs who are responsible for overseeing the day-to-day operations of the program.

The CAT also includes the Psychiatric Emergency Response Teams (PERTs), which consist of CAT clinicians who ride along with assigned law enforcement officers to address behavioral health-related calls in their assigned city. PERT provides all the same services as CAT and also initiates involuntary hospitalizations as necessary. The HCA currently has 16 PERT collaborations across Orange County, including the Orange County Sheriff's Department and police departments in the cities of Anaheim, Buena Park, Costa Mesa, Fullerton, Fountain Valley, Garden Grove, Huntington Beach, Irvine, Laguna Beach, Newport Beach, Orange, Santa Ana, Seal Beach, Tustin and Westminster.

Services

This multi-disciplinary program provides prompt response in the county when an individual is experiencing a behavioral health crisis. Clinicians receive specialized training and are designated to conduct evaluations and risk assessments that are geared to the individual's age and developmental level. The evaluations include interviews with the individual, as well as parents, guardians, family members, law enforcement, emergency department staff and/or school personnel, if available. Clinicians link individuals to an appropriate level of care to ensure their safety, which may involve initiating a hospitalization. CAT clinicians also follow-up with individuals and/or their parents/guardians to provide information, referrals and linkage to on-going behavioral health services that may help reduce the need for future crisis interventions.

In addition, PERT clinicians educate police on behavioral health issues and provide officers with tools that allow them to assist individuals living with behavioral health issues more effectively.

The Children's team provides ongoing trainings and education to schools, school districts, hospitals, police departments and other community stakeholders upon request to increase collaboration and support for children and youth experiencing a behavioral health crisis event.

Outcomes

Age Group	FY 2016-17	FY 2017-18	FY 2018-19
	Evaluations Completed	Evaluations Completed	Evaluations Completed
0-17 years	3,039	3,786	4,037
18 years & older	4,568	4,553	4,869

The program is evaluated by the timeliness with which the teams are able to respond to calls, with the goal of a dispatch-to-arrival time that is 30 minutes or less at least 70% of the time. While the TAY/Adult/Older Adult team continues to meet this goal, the Children's team has missed the target over the past three years, with a decreasing rate each year (the average response time still tends to be approximately 35 minutes).

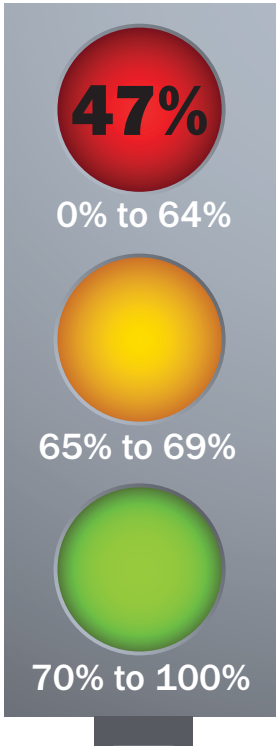
One notable factor contributing to the delayed response time of the Children's team is that a majority of their calls come in the late afternoon and early evening hours during peak traffic times. The team is continuing to examine the number of calls from areas that are farthest from the office location to identify ways to improve response times, as this is aligned with one of the

[1] At the time the Plan went to print, 2 positions on the Children's team and 4 positions on the Adult team were vacant.

Dispatch-to-Arrival Rate in 30 Minutes or Less by FY

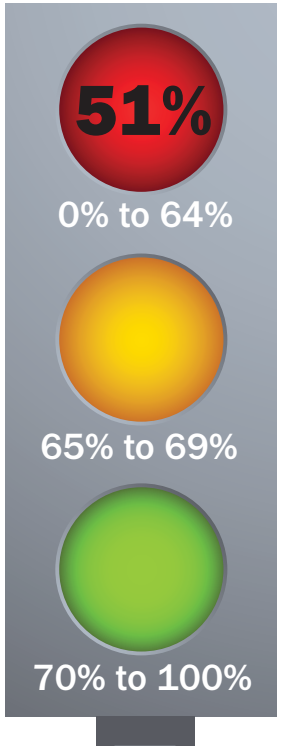
Children's CAT

FY 2018-19



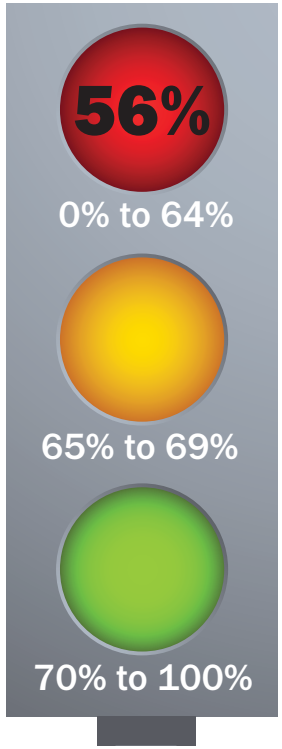
Target ≥ 70%
n = 4,037

FY 2017-18



Target ≥ 70%
n = 3,786

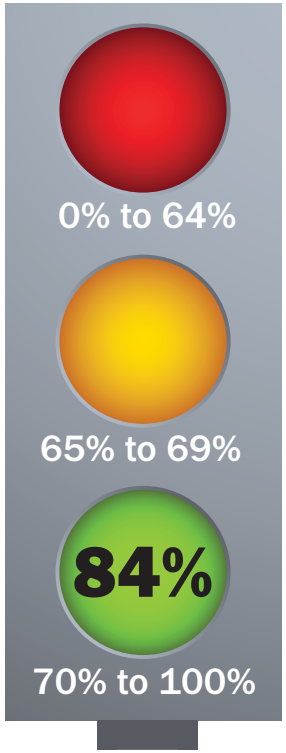
FY 2016-17



Target ≥ 70%
n = 3,039

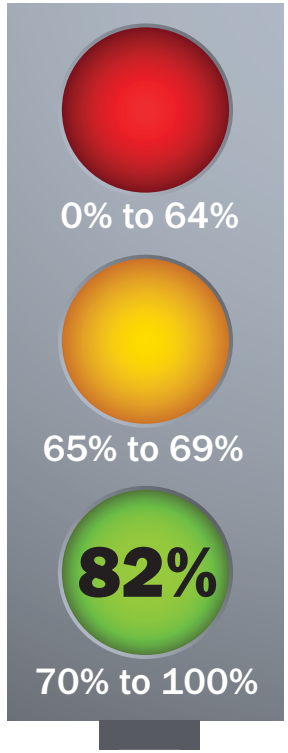
TAY/Adult CAT/PERT

FY 2018-19



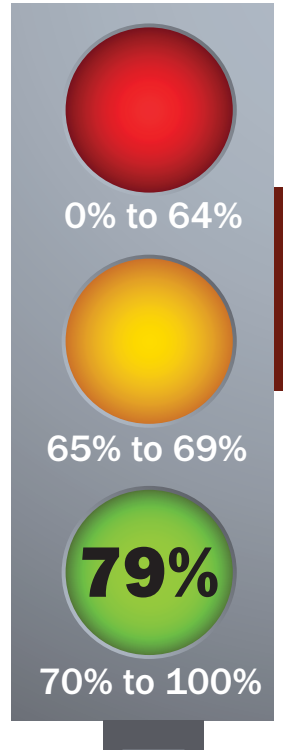
Target ≥ 70%
n = 4,869

FY 2017-18



Target ≥ 70%
n = 4,553

FY 2016-17



Target ≥ 70%
n = 4,568

Three-Year Plan strategic priorities (Suicide Prevention).

In addition to dispatch-to-arrival times, the teams examine the rate at which individuals are psychiatrically hospitalized as a way of monitoring the severity of the presenting problems experienced by the individuals served and the availability of safe alternatives to inpatient services. Consistent with prior years, individuals continued to be hospitalized less than half the time (44%, 40% and 42% in FYs 2016-17 through 2018-19 for children; 48%, 45% and 46% in FYs 2016-17 through 2018-19 for TAY, adults and older adults).

Challenges, Barriers and Solutions in Progress

While the increasing calls from law enforcement, schools and the community are ultimately a reflection of the program's positive impact in Orange County, this growing demand nevertheless poses challenges. As PERT continues to expand, the TAY/Adult/Older Adult team experiences decreased staffing due to the transition of CAT staff to the new PERTs. To accommodate increasing call volume, both the Children's and TAY/Adult/Older Adult teams have increased the number of positions, however hiring remains difficult due to the inherent challenges in staffing a 24/7 program. Hiring bilingual staff is also difficult as clinicians who speak languages other than English frequently receive competing job offers for positions that offer a more traditional schedule. The HCA is working to overcome these challenges by offering pay differential for bilingual staff and for those who work the night shift. To address the increase in volume during daytime hours, CAT has also been supported by Lanterman Petris Short (LPS)-designated clinicians from County-operated outpatient clinics and, for the Adult team, clinicians from the Program for Assertive Community Treatment.

While the Children's team has continued to evaluate the impact of call location on response time, current staffing shortages have prevented the team from stationing a clinician in a high-volume or remote location. During high volume call times, all staff are generally in the field on evaluations and being dispatched from one field location to the next. Increased staffing to support the continually increasing call volume will allow the consideration of other dispatch locations throughout Orange County. The Children's team has been supported by LPS-designated clinicians in the County-operated Children and Youth Behavioral Health regional outpatient clinics to address the increasing volume of crisis assessments during daytime hours and at school locations.

Community Impact

Since their inception in January 2003 through June 2019, the mobile crisis teams have responded to calls for more than 28,500 children under age 18 and 48,000 adults ages 18 and older. The teams have been successful in safely linking individuals who are experiencing behavioral health crises to appropriate levels of care that are less restrictive or costly and more recovery-oriented than inpatient psychiatric hospitalization, hospital emergency department visits and incarceration. Feedback from law enforcement about having clinicians out in the field with officers has also been overwhelmingly positive, helping to incorporate a more compassionate response when law enforcement interacts with individuals experiencing behavioral health crises.

Crisis Stabilization Units (PEI)

Program Serves	Location of Services	Typical Population Characteristics			
					
	Clinic	Families	Parents	Homeless/At Risk	Trauma-Exposed Clients

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$4,150,000	FY 2019-20	6,570
Proposed FY 2020-21 Budget	$6,700,000	FY 2020-21	7,227
Proposed FY 2021-22 Budget	$10,000,000	FY 2021-22	7,949
Proposed FY 2022-23 Budget	$10,000,000	FY 2022-23	8,743

Language Capacity of Direct Service Providers					
✓	Spanish		Arabic		Khmer
✓	Vietnamese		Farsi	✓	Other: Tagalog
	Korean		Mandarin		Language Line as Needed

Target Population and Program Characteristics

In the prior MHSA Three-Year Plan, stakeholders identified a need to expand **Crisis Stabilization Unit** (CSU) capacity. The MHSA CSUs will provide the community with a 24-hour, 7-day a week, year-round service for individuals who are experiencing a behavioral health crisis requiring emergent stabilization that cannot wait until a regularly scheduled appointment. One of the contracted programs will serve Orange County residents ages 13 and older, the majority of whom may be on a 72-hour civil detention for psychiatric evaluation due to danger to self, others or grave disability resulting from a behavioral health disorder (i.e., Welfare and Institutions Code 5150/5585). The CSUs will be able to be accessed directly by individuals experiencing a crisis, as well as by family members, law enforcement and others in the community who believe an individual has an emergent behavioral health need. College Hospital CSU in Costa Mesa opened its doors for services at the end of February 2020 for individuals 18 and older, and another site in Orange will launch for individuals 13 and older once the Anita Wellness Campus opens (construction anticipated to be complete in early 2021). Additional opportunities for expanding the number of new sites and/or service capacity in existing CSUs will be pursued if the need is identified and funds are available.

Services

Services, which are not to exceed 23 hours and 59 minutes, will include psychiatric evaluation, basic medical services, individual and group therapy as appropriate, nursing assessment, collateral services with significant others, individual and family education, medication services, crisis intervention, peer mentor services, referral, linkage and follow up services and transfer to inpatient level of care as appropriate. Services will also include substance use disorder treatment for individuals who have co-occurring substance use disorders.

In-Home Crisis Stabilization (CSS)

Children's IHCS

Program Serves	Location of Services		Typical Population Characteristics
0-17	Field	Community Based	Hosp DCs

TAY/Adult IHCS

Program Serves	Symptom Severity			Location of Services		Typical Population Characteristics				
18+	Early Onset	Mild-Moderate	Severe	Field	Community Based	Families	Parents	Homeless / At Risk	Students	Trauma- Exposed Clients

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$2,585,480	FY 2019-20	1,068
Proposed FY 2020-21 Budget	$2,935,480	FY 2020-21	1,187
Proposed FY 2021-22 Budget	$2,935,480	FY 2021-22	1,320
Proposed FY 2022-23 Budget	$2,935,480	FY 2022-23	1,468

Language Capacity of Direct Service Providers					
✓	Spanish		Arabic		Khmer
✓	Vietnamese		Farsi		Other:
	Korean		Mandarin	✓	Language Line as Needed

Proportion to be Served by Demographic Characteristic					
Age Group %	%	Gender	%	Race/Ethnicity	%
0-15	54	Female	59	African American/Black	5
16-25	32	Male	39	American Indian/Alaskan Native	1
26-59	13	Transgender	2	Asian/Pacific Islander	11
60+	1	Genderqueer		Caucasian/White	32
		Questioning/ Unsure		Latino/Hispanic	47
		Other		Middle Eastern/North African	1
				Other	3

Target Population and Program Characteristics

The **In-Home Crisis Stabilization** (IHCS) program operates a 24-hour, 7-day a week, year-round service which consists of family stabilization teams that provide short-term, intensive in-home services to individuals who have been assessed to be at imminent risk of psychiatric hospitalization or out-of-home placement but are capable of remaining safely in the community and out of the hospital with appropriate support. The teams include clinicians and peers with lived experience, with one set of teams serving youth under age 18 and another serving TAY, adults and older adults ages 18 and older. Individuals are referred by County behavioral health clinicians and emergency department personnel.

Services

Individuals and their families or identified support networks (i.e., "family") are typically referred to IHCS after a clinician has evaluated an individual for possible hospitalization and determined that, while they may not meet criteria for hospitalization, they and their family would safely 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 individual and their family to develop a stabilization plan. After triggers have been identified and a safety plan is in place, in-home appointments are made for the next day.

The IHCS teams utilize strategies such as crisis intervention, assessment, short-term individual therapy, peer support services, collateral services and case management to help the individual and their family establish a treatment plan, develop coping strategies and ultimately transition to ongoing support. Length of stay in the program is usually three weeks but can be extended based on clinical need and the amount of time it takes before an individual is linked to long-term services. All IHCS services are mobile and, whenever possible, provided in the home, at the identified residence of individuals who are experiencing homelessness, and/or in any community setting that the individual or family feels comfortable.

Outcomes

The goal of IHCS is to help the person manage their behavioral health crisis and make positive gains in recovery, which is quantified as achieving a psychiatric hospitalization rate of 25% or less from the time the individual is enrolled in the program through 60 days post-discharge. Both teams continue to be successful in meeting this goal.

The Adult team also tracks additional measures, which can be found in Appendix VII.

Age Group	FY 2016-17	FY 2017-18	FY 2018-19
	Admissions	Admissions	Admissions
0-17 years	423	672	748
18 years & older	-	-	211

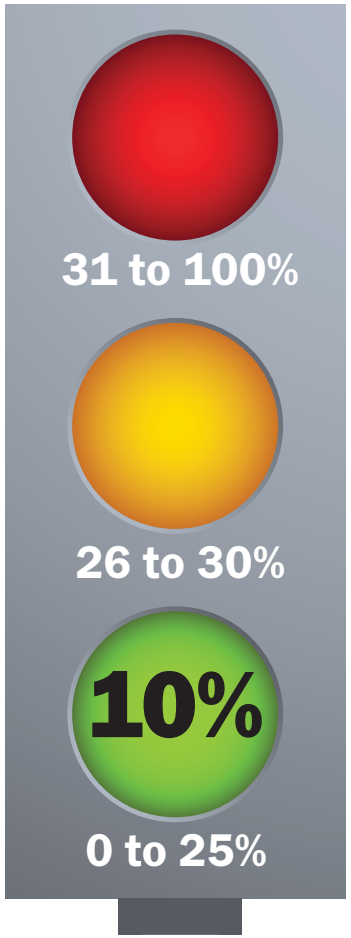
Challenges, Barriers and Solutions in Progress

The Children's team has seen continuous growth in referrals since program inception, and works to stay within a three-week timeframe to address crisis events for children and youth. Due to the increased numbers of clients, the program has seen delays in the ability to link clients to ongoing services by the end of the three week period. To address this, the program has been increasing focus on the discharge process and working to link the children and their families as early as possible during the treatment period. Linking children with private insurance has been increasingly challenging for the Children's team. The program has worked to address this by increasing outreach to private insurance providers to educate and increase collaboration for linkages to covered outpatient or other appropriate services.

Community Impact

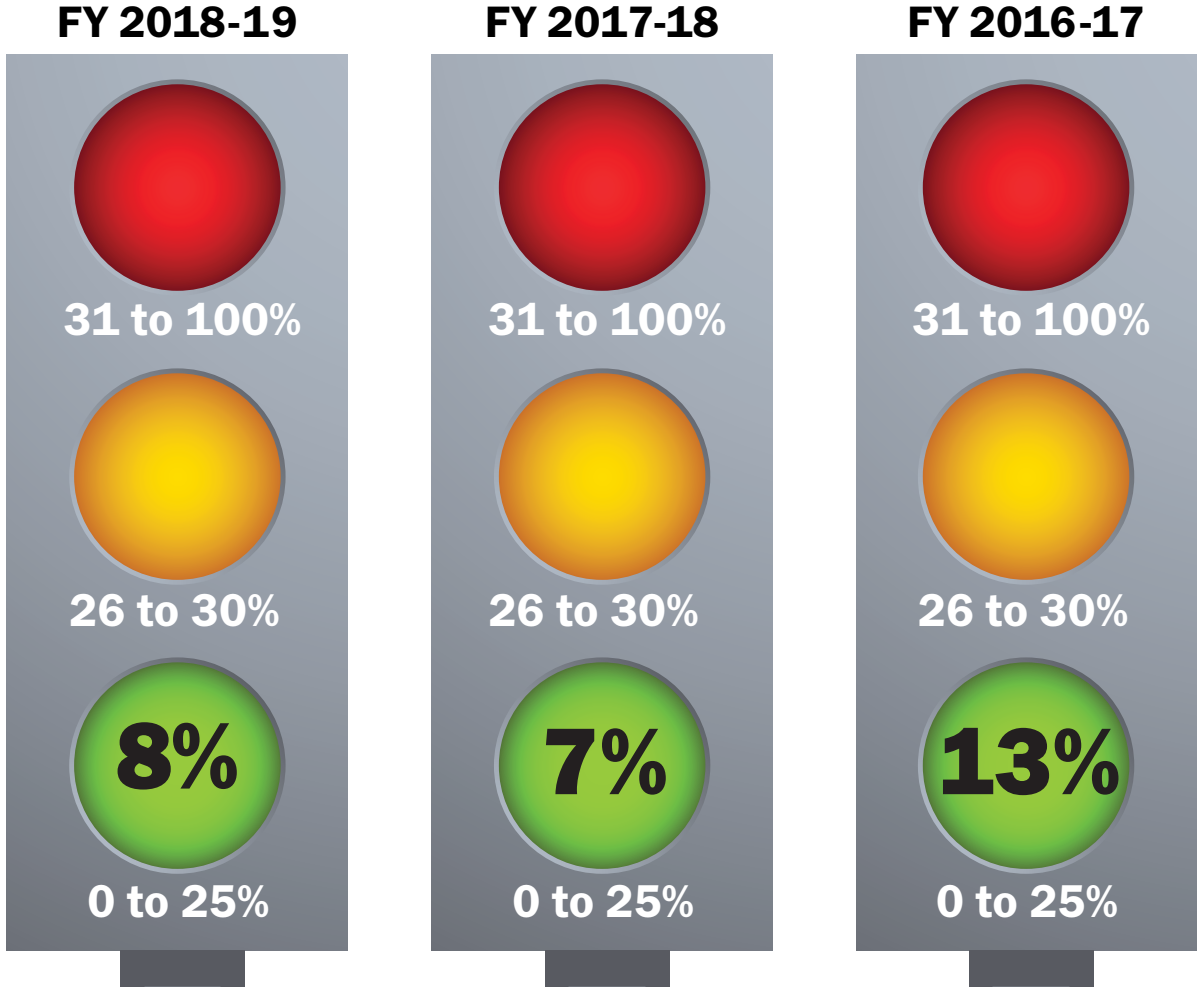
More than 3,700 children have received in-home support since services began in 2006 and more than 200 adults have received support since services began in 2018. The program collaborates with referring agencies, behavioral health programs, schools and emergency departments, and will collaborate with the crisis stabilization units (CSUs) once established. The IHCS program strives to reduce admissions to local emergency departments and provide a strengths-based, in-home alternative to psychiatric hospitalization for individuals experiencing behavioral health crisis and their families.

Hospitalization Rate - Up to 60 Days Following Discharge for TAY/Adult IHCS



Target ≤ 25%
(n=211)

Hospitalization Rate - Up to 60 Days Following Discharge for Children's Crisis IHCS by FY



Target ≤ 25%
(n=748)

Target ≤ 25%
(n=672)

Target ≤ 25%
(n=423)

* In prior years, hospitalization rates were tracked by a different target (i.e., less than 5% within 48 hours of discharge) and was shifted to be consistent with the target used by the Children's team in this Three-Year Plan. This previous target was also reached across the three FYs reported above (i.e., 0-1%).

Crisis Residential Services (CSS)

TAY Crisis Residential Services

Program Serves	Location of Services	Typical Population Characteristics				
18 - 25	Residential	Criminal Justice	LGBTQ	Homeless/ At Risk	Co-Occurring SUD	Trauma-Exposed Clients

Adult Crisis Residential Servioces

Program Serves	Symptom Severity			Location of Services	Typical Population Characteristics	
18 +	Early Onset	Mild-Moderate	Severe	Residential	Homeles/At Risk	Trauma-Exposed Clients

Children's Crisis Residential

Program Serves	Location of Services	Typical Population Characteristics						
12 - 17	Residential	Families	Parents	LGBTQ	Homeless/ At Risk	Co-Occurring SUD	Criminal Justice	Trauma-Exposed Clients

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$7,730,845	FY 2019-20	1,125
Proposed FY 2020-21 Budget	$9,030,845	FY 2020-21	1,161
Proposed FY 2021-22 Budget	$11,280,845	FY 2021-22	1,199
Proposed FY 2022-23 Budget	$11,280,845	FY 2022-23	1,280

Proportion to be Served by Demographic Characteristic					
Age Group %	**%**	**Gender**	**%**	**Race/Ethnicity**	**%**
0-15	16	Female	53	African American/Black	7
16-25	34	Male	45	American Indian/Alaskan Native	1
26-59	49	Transgender	1	Asian/Pacific Islander	6
60+	1	Genderqueer		Caucasian/White	45
		Questioning/Unsure		Latino/Hispanic	33
		Other	1	Middle Eastern/North African	1
				Other	7

Language Capacity of Direct Service Providers					
✓	Spanish	✓	Arabic		Khmer
✓	Vietnamese	✓	Farsi		Other:
✓	Korean	✓	Mandarin	✓	Language Line as Needed

Target Population and Program Characteristics

The **Crisis Residential Services** provides highly structured, voluntary services in a residential setting for individuals experiencing a behavioral health crisis. Individuals ages 12 and older can be referred to the program if they have been evaluated for psychiatric hospitalization, can safely be referred to a less restrictive, lower level of care and they and/or their family are experiencing considerable distress. The program is voluntary and serves anyone in Orange County who meets eligibility requirements. Individuals must be referred by hospitals (for the Children's sites), County CAT/PERTs or County or County-contracted Specialty Mental Health Plan programs (i.e., the program does not accept walk-ins, self-referrals). CRS has a number of sites throughout the county and different sites are tailored to meet the needs of different age groups:

- **Children** between the ages of 12 and 17 receive services at three sites (i.e., Laguna Beach, Huntington Beach, Tustin) with a total of 16 beds. Services generally last for three weeks, although children can remain in treatment for up to six weeks if needed. Additional Children's sites will be added to comply with State-mandated Continuum of Care (COC) Children's Crisis Residential Program (CCRP) services.
- **TAY** between the ages of 18-25 receive services at a site with six beds in Costa Mesa. Services generally last for three weeks, although youth can remain in treatment for up to six weeks if needed. Because many TAY admitted to the program have experienced multiple trauma characterized by violence, are homeless or at risk of homelessness, have co-occurring substance use issues and/or receive little family support, some may receive less intensive residential services for several months to allow for greater stabilization and prevent the recurrence of behavioral health crises.
- **Adults/Older Adults** ages 18 and older receive services at three sites (Orange (15 beds), Mission Viejo (6 beds), Anaheim (6 beds)) with a total of 27 beds. Stays last an average of 7 to 14 days. The Orange site at the 401 S. Tustin campus has 4 ADA beds available. The Anaheim site is in the process of being converted into a Silver Treehouse that will exclusively serve adults ages 60 and over. Construction has started at the site and a temporary wall has been established to renovate the location with

a larger non-ambulatory bedroom and ADA-accessible bathroom, while still being accessible to the community. A new exterior door providing a direct exit from the new ADA bedroom will be provided. The office and medication room will be relocated to a smaller existing bedroom. ADA accessible ramps will be provided on both exits from the house. All 6 beds will be available to the age group 60 years and over and 2 beds will be ADA compliant to serve individuals who are not ambulatory. The HCA hopes to provide this service by the end of FY 2019-20.

Services

The residences emulate home-like environments in which intensive and structured psychosocial, trauma-informed, recovery services are offered. Depending on the individual's age and their or their family's needs, 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 use disorders education and treatment services for people who have co-occurring disorders.

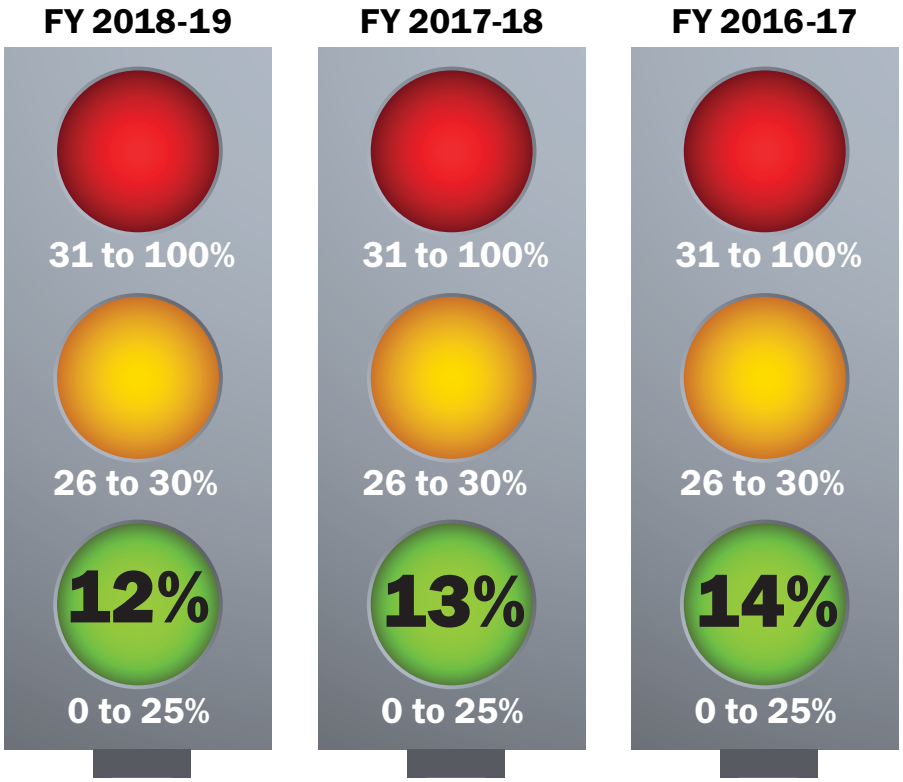
To integrate the individual back into the community effectively, discharge planning starts upon admission. A key aspect of discharge planning involves linkage to community resources and services that build resilience and promote recovery (i.e., FSPs and other on-going behavioral health services; victim's assistance; local art, music, cooking, self-protection classes; animal therapy; activity groups designed to support the individual; etc.). Children also have the option to participate in a weekly graduate drop-in group.

Outcomes

The goal of the program is to help the person manage their behavioral health crisis and make positive gains in recovery, which is quantified as achieving a psychiatric hospitalization rate of 25% or less from the time the individual is enrolled in the program through 60 days post-discharge. The program met this goal with hospitalization rates ranging from 12% to 19% across all fiscal years and age groups.

Age Group	FY 2016-17	FY 2017-18	FY 2018-19
	Admissions	Admissions	Admissions
Children, 0-17 years	243	277	288
TAY, 18-25 years	68	75	69
Adult/Older Adults, 18-99+ years	426	626	821

Hospitalization Rate – Up to 60 Days Following Discharge Children's Crisis Residential Program by FY

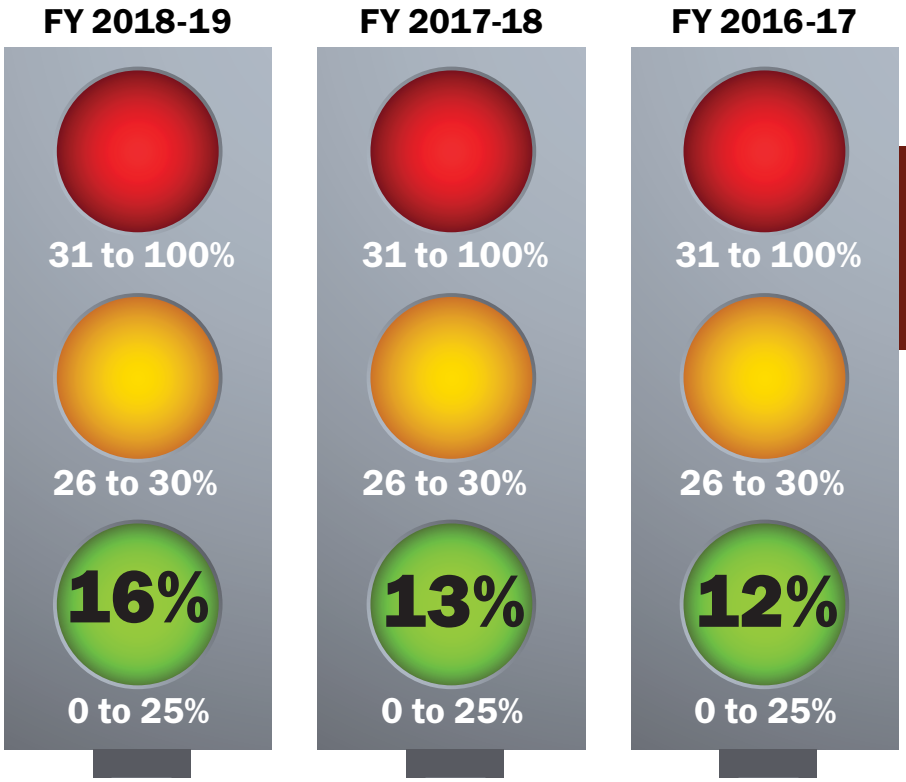


Target ≤ 25%
(n=288)

Target ≤ 25%
(n=277)

Target ≤ 25%
(n=243)

Hospitalization Rate – Up to 60 Days Following Discharge TAY Crisis Residential Program by FY



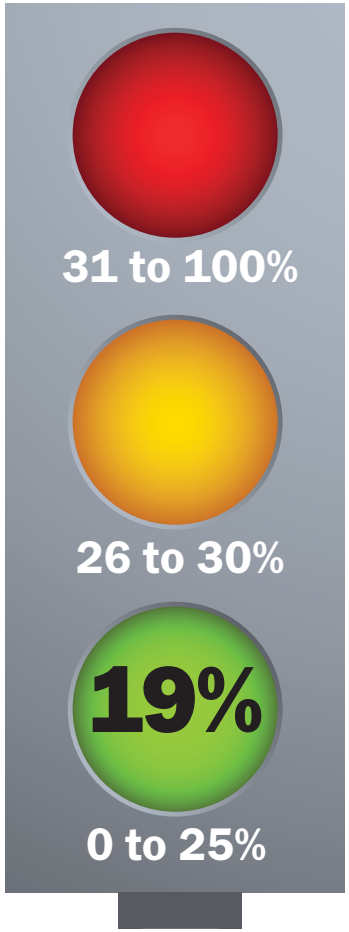
Target ≤ 25%
(n=69)

Target ≤ 25%
(n=75)

Target ≤ 25%
(n=68)

Hospitalization Rate – Up to 60 Days Following Discharge Adult Crisis Residential Program by FY

FY 2018-19*



Target ≤ 25%
(n=821)

Challenges, Barriers and Solutions in Progress

An ongoing, primary challenge has been the increased demand for Crisis Residential Services, with the community identifying a particular need for a facility specifically geared towards older adults. The HCA is actively working on addressing this service gap and, as mentioned above, anticipates the introduction of a Silver Treehouse that will exclusively address the needs of older adults in crisis starting by the end of FY 2019-20. TAY continue to face challenges with the lack of stable housing available when youth are ready for a lower level of care, and children periodically showed an increased demand for services throughout the past calendar year and, at times, either had to be placed on a waitlist or diverted to other crisis services such as in-home crisis. The HCA is examining these trends to determine projected need for Children's Crisis Residential Services over the course of the next three year period. As part of this, the HCA is considering how the new State requirement for a CCRP level of care and facility type will affect the children's crisis residential needs moving forward to ensure a sufficient number of beds are available for youth determined to need this level of care.

Community Impact

Since inception, the program has assisted more than 1,700 children, 1,600 TAY, and 4,000 adults/older adults with intensive services provided in a therapeutic, home-like environment. The program reduces admissions to local emergency departments and provides a strengths-based, recovery-oriented alternative to psychiatric hospitals for those experiencing a behavioral health crisis.

* In prior years, hospitalization rates were tracked by a different target (i.e., less than 5% within 48 hours of discharge) and was shifted to be consistent with the target used by the Children's sites in this Three-Year Plan. This previous target was also reached across the three FYs reported above (i.e., 0-1%).

BHS Disaster Response (CSS)

Program Characteristics and Services

The Behavioral Health Services Disaster Response (BHSDR) program[2] is a mobile team of BHS clinicians who receive specialized training in Critical Incident Stress Management (CISM). The team is on-call to provide support to residents with the goal of minimizing lasting, negative impacts from critical, traumatic and/or disruptive events. The team responds anywhere in Orange County or surrounding areas and its services include CISM group debriefings, CISM one-on-one debriefings, CISM briefings and education on grief, stress reactions and self-care.

The number of requests for services and/or the individuals supported varies based on the number and/or magnitude of critical incidents that may occur in any given year. A summary of recent BHSDR team activity is provided below.

Critical Incident Stress Management	FY 2016-17	FY 2017-18	FY 2018-19
Community Requests for Services	18	26	24
Individuals Supported	185	256	103

In addition, the team provides Psychological First Aid training to community members.

Community Impact

During February 2018 – May 2018, BHSDR played a large role in supporting homeless individuals living at the Flood Control Channel (FCC) as they transitioned to emergency shelters and other living placements. BHSDR staff were called upon to join BHS Outreach and Engagement in providing various services to the population including, but not limited to, assessing former residents of the FCC, referring and linking FCC residents to various needed services, and providing motel vouchers. BHSDR staff worked extensive hours on the project and contributed to the success of the effort.

2 Funding for the BHSDR team is contained within the Behavioral Health Community Training & Technical Assistance budget line contained within the Outreach for Increasing Recognition of Early Signs of Mental Illness program.

Summary of MHSA Strategies Used by Suicide and Crisis Prevention Programs

Strategies to Promote Recovery/Resilience

Programs in the HCA's Crisis Prevention continuum promote recovery and resilience in several ways. Services are tailored to the unique strengths of the individual. They focus on empowering people to manage their recovery by working with them to identify previously successful coping strategies, develop independent living skills, and, in residential settings, make choices in their daily activities. In addition, the WarmLine, CSUs and In-Home Crisis Stabilization program employ peer specialists, and the Suicide Prevention Services program has a survivor co-facilitate the bereavement support group. These staff support individuals in their recovery by promoting self-sufficiency, encouraging engagement in meaningful life activities and sharing their stories of recovery to inspire a sense of hope and inspiration in participants and their families.

Strategies to Reduce Stigma and Discrimination

Programs engage in a number of strategies to reduce stigma and discrimination related to mental health in an effort to limit the impact of this potential barrier to seeking support. First, staff across all programs provides numerous community presentations to correct misperceptions and misinformation about mental health that may contribute to stigma. Programs also adjust their terminology and messaging to be responsive to diverse cultures. For example, when the Suicide Prevention Services program learned "support group" was a stigmatizing term within the Latino/Hispanic community, staff began to refer to their services as "workshops." This approach was so successful in increasing access to its services, that community partners have also adopted this approach.

Additional strategies include the ability to engage in Crisis Prevention Hotline and WarmLine services anonymously. WarmLine calls are also monitored to ensure the use of non-stigmatizing, and non-discriminatory practices and representatives from Orange County's diverse communities are invited to attend WarmLine staff meetings to increase understanding of its services and improve outreach in these communities. Crisis Residential Services strives to provide physically and emotionally safe environments that are free of judgment to all residents so they can focus on their recovery. This includes providing transgender TAY, adults and older adults with their choice of room assignment based on what they most identify with or prefer (i.e., male, female, private).

Strategies to Increase Access to Services: Timely Access for Underserved Populations and Linkage to Treatment

People who are experiencing a behavioral health crisis face barriers to receiving services such as lack of transportation or other resources, homelessness, stigma, fear of the "system" or unknown, cultural factors or linguistic issues. In an effort to encourage utilization by underserved populations, program clinicians and staff conduct culturally appropriate trainings and outreach throughout the county to increase recognition of the signs of behavioral health crisis across diverse communities and to raise awareness of program services. All programs (including crisis residential) either provide transportation assistance or field-based services. Moreover, crisis residential sites are located throughout Orange County to improve the opportunity for family members to participate in services.

These programs all place priority on hiring bilingual/bicultural staff who speak multiple languages, and may access the language line for interpretation services when bilingual staff is not available. Staff participates in cultural competency trainings in order to communicate and interact with individuals in ways that respect and value their and their family's backgrounds and world views. They also offer culturally responsive service referrals and provide literature in multiple languages, including California Mental Health Services Act Authority's (CalMHSA) culturally appropriate materials that target underserved monolingual communities. In addition, PERT's partnership with law enforcement has resulted in a more compassionate response in the community.

Because people who have survived the loss of someone to suicide become ready to engage in services at different stages after their loss, staff remains steadfast, patient and ready to provide treatment at any time the survivor is ready to engage since their readiness does not always coincide with when they are referred to the program. If a survivor does not begin services directly after the referral, staff continues to reach out and periodically re-assess readiness for service.

Finally, central to each participant's treatment plan is connection to on-going services and stable supports once they discharge from one of the programs in the Crisis Prevention Services continuum. Staff provides case management and close coordination with partner programs such as County and County-contracted outpatient clinics, Full Service Partnerships, Programs of Assertive Community Treatment, Older Adult Services, Recovery Services/Centers and others to ensure participants are linked to appropriate, available resources.

Crisis Prevention and Support Services Programs		Linkage Metrics		
		# Referrals	# Linkages	Types of Linkages
WarmLine	FY 2016-17	4,663	See Note *	OC Links, mental health services, Family Support Service, Patients' Rights Advocacy, suicide prevention programs
	FY 2017-18	2,139		
	FY 2018-19	2,189		
Suicide Prevention Services (Survivor Support Services only)	FY 2016-17	471	226	Early Intervention, Private/Community Outpatient, Outpatient Clinic-Based, Outpatient Crisis Services, Supportive Services
	FY 2017-18	692	220	
	FY 2018-19	983	119	
In Home Crisis Stabilization (Adult team)	FY 2016-17	-	See Note **	Lower level of outpatient behavioral health care services
	FY 2017-18	-		
	FY 2018-19	206	141	

* *At the present time, the WarmLine is not currently equipped to track linkages.*

** *At the present time, the Children's team is not currently able to report on referrals and linkages. The Adult team launched in August 2018 so data are available beginning 2018-19.*

OUTPATIENT TREATMENT

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 Programs
- Clinic Expansion Programs
- Full Service Partnership Programs
- Program for Assertive Community Treatment

EARLY INTERVENTION PROGRAMS

The first subcategory of outpatient treatment is early intervention. 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 help-first, community-based system that encourages access to care as early as possible following the onset of symptoms. These programs are funded by PEI and organized below according to the target populations they are designed to serve.

- Community Services - All Ages
- Child- and Youth-Focused
- Family Strengthening Focused
- Older Adult-Focused
- Veteran-Focused

Community Services - All Ages

Community Counseling and Supportive Services (PEI)

Program Serves	Symptom Severity		Location of Services	Typical Population Characteristics							
											
	At Risk	Mild-Moderate	Clinic	Other/1st Responders	Parents	Families	Co-Occurring SUD	Students	Criminal Justice	Trauma-Exposed Clients	Mono-Lingual/ Ethnic Communication

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$2,536,136	FY 2019-20	690
Proposed FY 2020-21 Budget	$2,536,136	FY 2020-21	690
Proposed FY 2021-22 Budget	$2,536,136	FY 2021-22	690
Proposed FY 2022-23 Budget	$2,536,136	FY 2022-23	690

Proportion to be Served by Demographic Characteristic					
Age Group %	**%**	**Gender**	**%**	**Race/Ethnicity**	**%**
0-15	5	Female	67	African American/Black	1
16-25	19	Male	31	American Indian/ Alaskan Native	1
26-59	71	Transgender	2	Asian/Pacific Islander	7
60+	5	Genderqueer		Caucasian/White	15
		Questioning/Unsure		Latino/Hispanic	66
		Other		Middle Eastern/ North African	5
				Other	5

Language Capacity of Direct Service Providers					
✓	Spanish	✓	Arabic		Khmer
✓	Vietnamese		Farsi	✓	Other: ASL
	Korean		Mandarin		Language Line as Needed

Target Population and Program Characteristics

Beginning in FY 2020-21, the **Community Counseling and Supportive Services (CCSS)** will merge with OC ACCEPT to serve Orange County residents of all age groups who have, or are at risk of developing, a mild to moderate behavioral health condition and limited or no access to behavioral health services. The majority of enrolled participants are uninsured or underinsured, monolingual Spanish speaking, and have a history of family or domestic violence and/or early childhood trauma.

With the merging of OC ACCEPT, CCSS has also expanded capacity to provide specialized expertise working with individuals struggling with and/or identifying as Lesbian, Gay, Bisexual, Transgender, Intersex or Questioning (LGBTIQ), and the important people in their lives.

CCSS is designed to address the early symptoms of depression, anxiety, alcohol and/or drug use, suicidal thoughts, violence and Post Traumatic Stress Disorder (PTSD) that may be experienced by all participants, as well as the confusion, isolation, grief and loss, high-risk behaviors, self-esteem challenges, victimization by bullying, trauma, homelessness and lack of familial support frequently experienced by individuals specifically identifying as LGBTIQ. The early onset of mental illness is determined through the referral screening process, and participants are referred to the program by family resource centers, medical offices, community based organizations, County-operated and County-contracted programs, and self-referral.

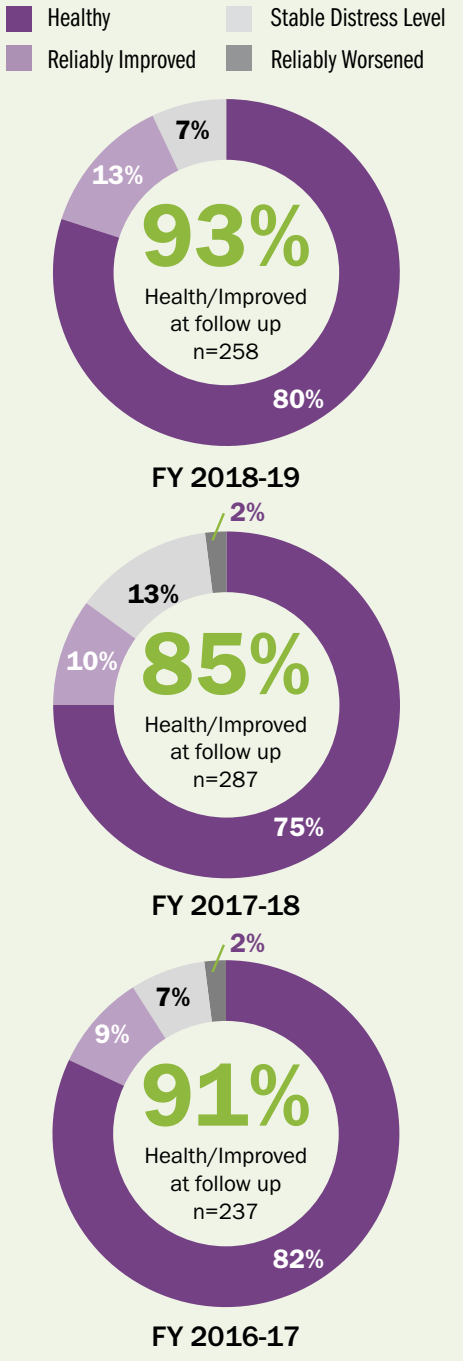
Services

CCSS provides face-to-face individual and collateral counseling, groups (i.e., psychoeducational, skill-building, insight oriented, etc.), clinical case management, and referral and linkage to community services. Clinicians utilize evidence-based practices such as Eye Movement Desensitization and Reprocessing (EMDR), Motivational Interviewing (MI), Cognitive Behavioral Therapy (CBT) and Seeking Safety while working with program participants. In addition, 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. Services are tailored to meet the age, developmental and cultural needs of each participant.

Outcomes

Participants completed the age-appropriate OQ® 30.2 at intake, every three months of program participation, and at discharge. Scores were compared to the measure's clinical benchmarks to determine program effectiveness at reducing prolonged suffering. This measure

QQ 30.2 CCSS General



reflects cultural competence as it 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. 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, 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 then to compare scores to the measure's clinical benchmarks to determine program effectiveness at improving symptoms.

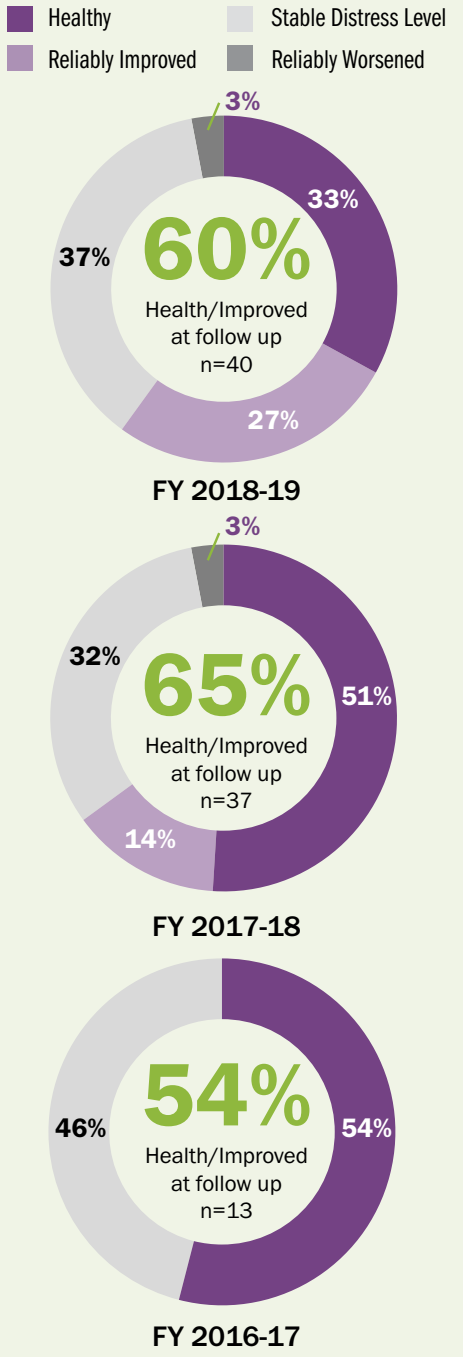
		FY 2016-17	FY 2017-18	FY 2018-19
General Unit (original CCSS)	Total Served	467	492	422
	Baseline + 1 Follow-up OQ® Completed	237	287	258
LGBTIQ Unit (OC ACCEPT)	Total Served	121	121	79[2]
	Baseline + 1 Follow-up OQ® Completed	13	37	40

Across all three fiscal years, the overwhelming majority of individuals served in the CCSS general unit and a little over half served in the LGBTIQ unit reported mental health distress levels that were either in the healthy/non-distressed range or were reliably improved at the most recent follow-up. Within the LGBTIQ unit, over one-third to nearly one-half if individuals reported stable (i.e., non-worsening) levels of distress. 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 enrolling, particularly within the general unit.

With regard to what appears to be differential symptom improvement between the general and LGBTIQ units, it should be noted that across the three years reported here, the LGBTIQ unit enrolled participants experiencing severe and persistent mental illness whereas the general unit referred these individuals to other programs. This difference in enrollment and referral practice may account for the larger proportion of LGBTIQ participants reporting stable functioning (as opposed to healthy and/or reliably improved functioning) relative to the other CCSS participants and other early intervention outpatient programs. As the intent of the program is to serve those who are experiencing mild to moderate mental health symptoms, the LGBTIQ unit implemented procedures during FY 2018-19 to identify those with greater needs and refer them to the appropriate level of care. Thus, while the program has demonstrated some success at preventing symptoms of mental illness from becoming severe and disabling among the few LGBTIQ participants who completed measures, the conclusiveness of the program's effectiveness should be regarded as tentative until additional data are available following these changes in enrollment practices.

1 The decline in the number of clients served in FY 2018-29 was due to changes in program eligibility requirements implemented that year.

QQ 30.2 CCSS LGBTQ+



Challenges, Barriers and Solutions in Progress

Beginning FY 2017-18, both units of the expanded CCSS program have implemented a new Intake Coordinator role to assist with better identifying individuals eligible for services and referring others to a more appropriate resource. Subsequently, the program has been more effective in screening and triaging referred participants to the most appropriate level of care, as well as tracking the number of screenings conducted for individuals who are ultimately referred and linked to other services. Improved screening processes have resulted in fewer individuals enrolling into the general unit compared to prior years, and the program is continuing to outreach and create new partnerships so that they may reach and serve greater numbers of eligible participants. In contrast, client enrollment in the LGBTIQ unit increased during FY 2018-19. This unit had been challenged with not having a full-time program supervisor located on-site after services transitioned to PEI from Innovation in March 2016. In addition to implementing the dedicated Intake Coordinator position, a full-time program supervisor was hired in November 2018. Since then, several changes have taken place to improve program operations, including staff training, outreach to new referral sources, clarification of eligibility criteria, and outcomes data collection.

Although a psychiatrist was hired in FY 2016-17 to provide medication support services, in FY 2019-20 it was determined that these services could be discontinued as there was not high demand for them. In the event that an individual requests, or a clinician identifies an individual might benefit from, medication support services, the clinician will work closely with the participant to link them to their primary care provider or a community psychiatrist.

Community Impact

CCSS collaborates with community-based organizations to provide culturally responsive services to the Arabic-speaking, deaf-and-hard-of-hearing and LGBTIQ communities. Since inception, the expanded program has provided services to more than 2,100 individuals, 431 of whom were part of its LGBTIQ service. Additionally in FY 2018-19, 1,029 individuals (of 1,124 referred to the program), were screened by the Intake Coordinator. The Intake Coordinator position has reinforced the program's ability to accurately identify and enroll participants into services that fall within the mild to moderate spectrum. Conversely, participants presenting with higher severity symptoms are referred and linked to the appropriate level of care that addresses their specific need in a timely manner.

The expanded program has also provided valuable education and resources to various unserved and underserved populations with mental health needs in order to promote awareness of and encourage use of its services. In this FY, the program provided 24 community educations presentations and trainings to over 719 attendees, raising awareness and reducing stigma about the LGBTIQ population. To better serve those residing in south Orange County, CCSS has identified a satellite office in Mission Viejo and is currently enrolling participants at its new site.

Child and Youth Focused

School-Based Mental Health Services (PEI)

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

Language Capacity of Direct Service Providers					
✓	Spanish		Arabic		Khmer
	Vietnamese		Farsi		Other:
	Korean		Mandarin	✓	Language Line as Needed

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$2,315,236	FY 2019-20	720
Proposed FY 2020-21 Budget	$2,525,236	FY 2020-21	1,000
Proposed FY 2021-22 Budget	$2,525,236	FY 2021-22	1,000
Proposed FY 2022-23 Budget	$2,525,236	FY 2022-23	1,000

Proportion to be Served by Demographic Characteristic

Age Group %	%	Gender	%	Race/Ethnicity	%
0-15	100	Female	42	African American/Black	1
16-25		Male	58	American Indian/Alaskan Native	
26-59		Transgender		Asian/Pacific Islander	1
60+		Genderqueer		Caucasian/White	2
		Questioning/Unsure		Latino/Hispanic	95
		Other		Middle Eastern/North African	
				Other	1

Target Population and Program Characteristics

The **School-Based Mental Health Services** (SBMHS) program provides school-based, early intervention services for individual students in grades 6 through 8 who are experiencing mild to moderate depression, anxiety and/or substance use problems. Students are referred by school staff and screened by program clinicians to determine early-onset of mental illness and program eligibility.

Services

The program provides assessment, individual counseling, case management, and referral and linkage to community resources. It uses evidenced-based curricula such as Cognitive Behavioral Intervention for Trauma in Schools (C-BITS), Coping Cat and Seeking Safety, as well as Eye Movement Desensitization and Reprocessing (EMDR).

Outcomes

Program performance was evaluated through measures administered at intake, every three months and at discharge. The program assessed reductions in or prevention of prolonged suffering via the YOQ® 30.2 beginning in FY 2017-18.

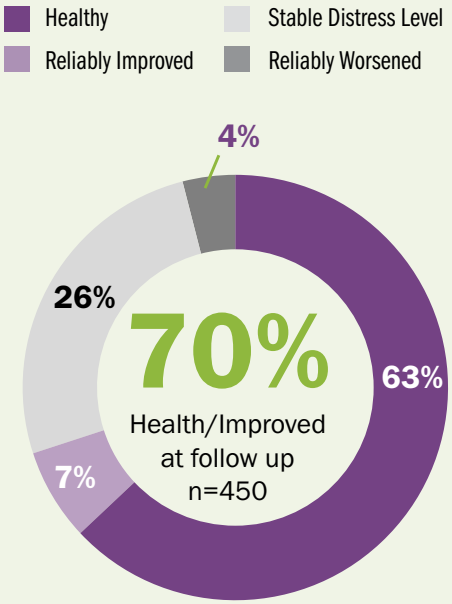
		FY 2016-17	FY 2017-18	FY 2018-19
SB Mental Health Services	Total Served	623	612	672
	Baseline + 1 Follow-up OQ® Completed	N/A	404	450

Results indicate that program services are associated with preventing symptoms of mental illness from becoming severe and disabling for the majority of students served across the past two years. The HCA has noted the shift in the proportion of youth reporting healthy versus stable distress levels in FY 2018-19 (63% vs 26%) compared to FY 2017-18 (75% vs 13%), and will explore possible factors underlying this change and monitor trends over time.

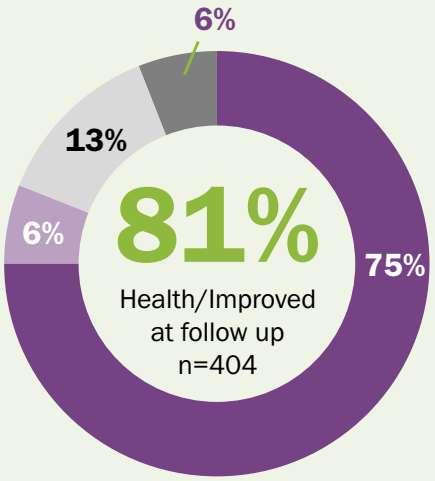
Challenges, Barriers and Solutions

In FY 2017-18, the program expanded services to a new district (n=2 schools) and the program has been working through a number of factors that have impacted its ability to fully scale up its direct services to students. First, the program experienced several staff vacancies that it was ultimately able to address through leveraging the clinicians in the SBMHS prevention track. In

YOQ 30.2 SBMHS



FY 2018-19



FY 2017-18

addition, services were delayed until appropriate office space was identified and the referral processes with the school were worked out. Finally, students' access to services and the number of students that could be seen in a day was limited due to a request that appointments not be scheduled during math and language arts classes whenever possible.

As mentioned above, clinicians from the SBMHS prevention track help addressed staffing shortages in the early intervention outpatient track when services were expanded to a new district. Since then, two additional school districts have requested early intervention services and are in the process of establishing a Memorandum of Understanding with the HCA. To meet these requests, as well as future anticipated requests, the SBMHS prevention track will merge with the early intervention track beginning in FY 2020-21. This integration will allow the SBMHS program to accommodate schools' requests for increased clinical support by allowing all program clinicians to provide early intervention outpatient services when clinically indicated, while still continuing to provide prevention curriculum as an adjunct group service for students not enrolled in outpatient treatment. The program is also seeking Medi-Cal certification as a way to further expand staffing and increase capacity to serve additional students.

Community Impact

The combined Prevention/Early Intervention program has provided services to more than 14,750 students since its inception in August 2011. The program collaborates with nine school districts and has helped to fill an important and growing need for mental health services in schools.

First Onset of Psychiatric Illness (OC CREW; PEI)

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics					
12-25	Early Onset	Field	Community Based	Other/1st Responders	Parents	Families	Co-Occurring SUD	Students	Trauma-Exposed Clients

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$1,500,000	FY 2019-20	75
Proposed FY 2020-21 Budget	$1,500,000	FY 2020-21	80
Proposed FY 2021-22 Budget	$1,500,000	FY 2021-22	80
Proposed FY 2022-23 Budget	$1,500,000	FY 2022-23	80

Language Capacity of Direct Service Providers					
✓	Spanish		Arabic		Khmer
✓	Vietnamese		Farsi		Other:
	Korean	✓	Mandarin	✓	Language Line as Needed

Proportion to be Served by Demographic Characteristic					
Age Group %	**%**	**Gender**	**%**	**Race/Ethnicity**	**%**
0-15	25	Female	37	African American/Black	2
16-25	75	Male	63	American Indian/Alaskan Native	
26-59	0	Transgender		Asian/Pacific Islander	22
60+	0	Genderqueer		Caucasian/White	17
		Questioning/Unsure		Latino/Hispanic	47
		Other		Middle Eastern/North African	2
				Other	10

Target Population and Program Characteristics

The **First Onset of Psychiatric Illness** program, also known as Orange County Center for Resiliency, Education and Wellness (OC CREW), serves youth ages 12 through 25 who are experiencing a first episode of psychotic illness with symptom onset within the past 24 months. The program also serves the families of eligible youth. To be eligible for services, the youths' symptoms cannot be caused by the effects of substance use, a known medical condition, depression, bipolar disorder or trauma. The program receives self-referrals and referrals from County-operated and County-contracted specialty mental health 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. In addition to collateral services and evidence-based practices, including Cognitive Behavioral Therapy, Assertive Community Treatment, Art Therapy, medication services and Multi-Family Groups (MFG), the program offers community and professional training on the First Onset of Psychosis.

Outcomes

		FY 2016-17	FY 2017-18	FY 2018-19
OC CREW	Total Served	82	91	73
	Baseline + 1 Follow-up PANSS Completed	51	51	54

OC CREW's purpose is to reduce prolonged suffering from untreated mental illness as assessed through ratings on the Positive and Negative Syndrome Scale (PANSS), which is a culturally sensitive assessment that has been tested and validated with diverse ethnic/racial and cultural groups. Psychiatrists provided ratings at intake, every six months and at program exit, and the difference between intake (baseline) and the most recent follow-up is used to determine whether there was a reduction of prolonged suffering. Results are reported according to the calculated effect size, which reflects, in part, the extent to which a change in scores over time is clinically meaningful for the youth served in the program.

Medium to large reductions in symptoms were consistently observed across the three years, with slightly greater impact noted in FY 2016-17 than in FYs 2018-19 and 2017-18. Taken together, these findings suggest that OC CREW reduces prolonged suffering from untreated mental illness and helps prevent first episode psychosis from becoming severe, persistent and disabling.

Impact on Psychosis Symptoms by FY

First Onset of Psychiatric Illness (OC Crew)

Challenges, Barriers and Solutions in Progress

The primary barrier faced by program participants is financial, which affects their ability to access reliable transportation, childcare and many other daily basic needs that, in turn, affect their ability to access program services. OC CREW addresses this by providing transportation and childcare when needed.

Additional operational challenges occurring during this reporting period include several vacancies in key staff roles (i.e., program supervisor, psychiatrist, clinicians, mental health specialist). These existing vacancies affected the program's ability to enroll new participants. To address this challenge, staff from different programs who have the necessary skill set have been identified to provide much needed cross coverage. This will allow existing enrolled participants to continue to receive the appropriate level of care needed since external program staff will provide clinical case management and group facilitation, thus freeing up existing clinicians to screen and enroll new participants.

As part of its participation in a statewide Innovation project, OC CREW consulted with the Early Psychosis Learning Health Care Network (EPLHCN), a network of experts that utilizes data to improve early psychosis care, and moved from the PANSS, a psychometric completed by the psychiatrist, to the Brief Psychiatric Rating Scale (BPRS), a brief psychometric completed by the clinician. This will allow the psychiatrist to provide more direct client care and, as a result, increase the ability to enroll new participants to the program. Also, the program is seeking Medi-Cal certification to expand staffing and increase capacity to serve additional participants.

Community Impact

The program has provided services to more than 580 participants since its inception in the Spring of 2011. 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 health symptoms.

During this FY, OC CREW joined the Early Psychosis Learning Health Care Network (EPLHCN, see next page) which is an Innovation project that seeks to support collaboration between Early Psychosis programs at the state and national level to identify ways in which we can improve care and make a greater impact on the community served.

Reference Notes

Positive Symptoms:

FY 2018-19: Baseline M=16.7, SD=6.68; Follow-up M=11.7, SD=5.94; t(54)=5.53, p<.001; Cohen's d=0.75

FY 2017-18: Baseline M=16.1, SD=7.0; Follow-up M=10.8, SD=7.9; t(50)=4.47, p<.001; Cohen's d=0.63

FY 2016-17: Baseline M=15.9, SD=7.0; Follow up M=9.0, SD=7.7; t(50)=6.33, p<.001; Cohen's d=0.88

Negative Symptoms:

FY 2018-19: Baseline M=19.0, SD=7.66; Follow-up M=14.0, SD=7.20; t(54)=4.62, p<.001; Cohen's d=0.62

FY 2017-18: Baseline M=17.9, SD=7.1; Follow-up M=12.0, SD=7.4; t(48)=5.42, p<.001; Cohen's d=0.77

FY 2016-17: Baseline M=17.2, SD=8.3; Follow up M=11.5, SD=8.3; t(50)=4.63, p<.001; Cohen's d=0.65

General Psychopathology:

FY 2018-19: Baseline M=34.9, SD=11.40; Follow-up M=27.8, SD=10.65; t(54)=3.75, p<.001; Cohen's d=0.51

FY 2017-18: Baseline M=33.5, SD=11.6; Follow-up M=24.7, SD=14.2; t(50)=3.95, p<.001; Cohen's d=0.56

FY 2016-17: Baseline M=32.2, SD=11.9; Follow up M=22.2, SD=13.1; t(50)=5.14, p<.001; Cohen's d=0.72

Total Symptoms:

FY 2018-19: Baseline M=70.6, SD=23.29; Follow-up M=53.0, SD=21.15; t(54)=5.06, p<.001; Cohen's d=0.68

FY 2017-18: Baseline M=68.2, SD=24.0; Follow-up M=48.6, SD=29.6; t(50)=4.72, p<.001; Cohen's d=0.67

FY 2016-17: Baseline M=65.3, SD=25.0; Follow up M=42.7, SD=27.4; t(50)=5.74, p<.001; Cohen's d=0.81

Early Psychosis Learning Health Care Network (INN)

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$500,000	FY 2019-20	75
Proposed FY 2020-21 Budget	$500,000	FY 2020-21	80
Proposed FY 2021-22 Budget	$510,584	FY 2021-22	80
Proposed FY 2022-23 Budget	$561,234	FY 2022-23	80

Target Population and Program Characteristics

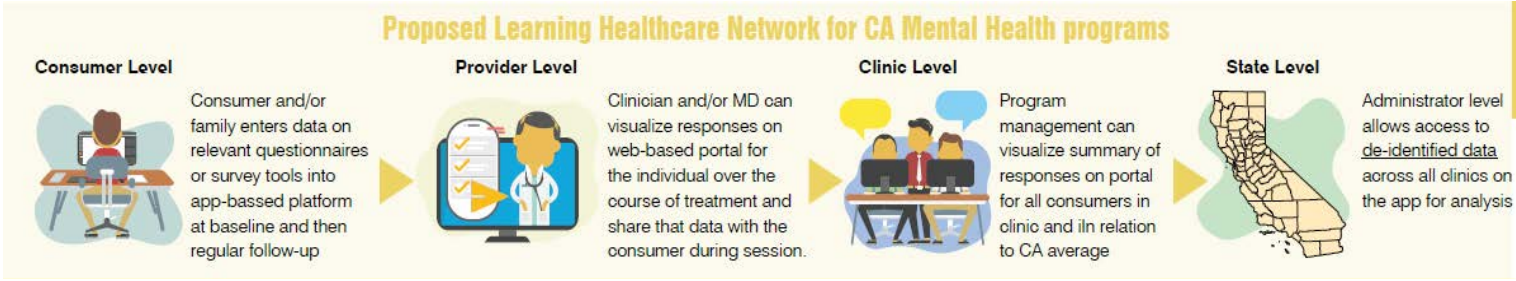
The **Early Psychosis Learning Health Care Network** (LHCN) is a multi-county Innovation (INN) project led by University of California, Davis. The project aims to evaluate early psychosis (EP) programs across the state with the primary purpose of increasing the quality of mental health services, including measureable outcomes, and the goal of introducing a mental health practice or approach that is new to the overall mental health system, including, but not limited to, prevention and early intervention. The aim of the EP LHCN is to standardize the evaluation of EP programs across participating counties; establish shared learning; and provide an opportunity to improve OC CREW outcomes, program impact and cost-effectiveness. This project will not require that OC CREW change the clinical services that it provides.

Orange County's participation was approved by the MHSOAC in 2018 and local project start up began in January 2020. At present, a total of 5 counties are participating, including Orange County with its First Onset of Psychiatric Illness program (i.e., OC CREW). OC CREW participants and their families will have the option of participating in the INN project while they are enrolled in OC CREW and/or for the length of this INN project, whichever is shorter.

Services

During the initial implementation, OC CREW program staff, participants and family members will engage in voluntary focus groups to provide feedback on the selection of EP outcome measures. OC CREW staff will then administer selected measures to program participants and/or their family members throughout the duration of this INN project. Ongoing focus groups with program staff, participants and their families will be facilitated to gather feedback on the use of measures.

Outcome measures and focus group data will be analyzed to assess the impact of the LHCN on consumer- and program-level metrics, as well as utilization and cost rates of EP programs (see diagram of the implementation and evaluation process below). This will provide counties the opportunity to adjust program operations and/or services, if appropriate, based on lessons learned through multiple research approaches.



Outcomes

This program was not operational in FY 2018-19 so there are no outcomes to report at this time. Outcomes will be reported in future Plan Updates.

Family Strengthening-Focused

OC Parent Wellness Program (PEI)

Program Serves	Symptom Severity		Location of Services		Typical Population Characteristics					
										
14-50	At Risk	Mild-Moderate	Field	Community Based	Other/1st Responders	Parents	Families	Trauma-Exposed Clients	Mono-Lingual/ Ethnic Communication	Pregnant

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$3,488,072	FY 2019-20	600
Proposed FY 2020-21 Budget	$3,738,072	FY 2020-21	900
Proposed FY 2021-22 Budget	$3,738,072	FY 2021-22	900
Proposed FY 2022-23 Budget	$3,738,072	FY 2022-23	900

Language Capacity of Direct Service Providers				
✓	Spanish		Arabic	Khmer
✓	Vietnamese		Farsi	Other:
	Korean		Mandarin	Language Line as Needed

Proportion to be Served by Demographic Characteristic					
Age Group %	**%**	**Gender**	**%**	**Race/Ethnicity**	**%**
0-15	28	Female	98	African American/Black	2
16-25	18	Male	2	American Indian/Alaskan Native	
26-59	54	Transgender		Asian/Pacific Islander	7
60+		Genderqueer		Caucasian/White	13
		Questioning/Unsure		Latino/Hispanic	72
		Other		Middle Eastern/North African	4
				Other	2

Target Population and Program Characteristics

Beginning in FY 2020-21, the **Orange County Parent Wellness Program** will be re-organized and include Stress Free Families and Connect the Tots. The expanded OC Parent Wellness Program will specialize in serving at-risk and stressed families with children under age 18. This includes pregnant females and partners affected by the pregnancy or birth of a child within the past 12 months, families that have been reported to Child Protective Services (CPS) for allegations of child abuse or neglect, or families with a young child between the ages of 0 and 8 years who are exhibiting mild to moderate behavioral health symptoms that may negatively impact their readiness for school.

Referrals come from a variety of sources including self-referrals, hospitals, schools, behavioral health outpatient facilities, and the Social Services Agency (SSA). Eligibility criteria for families referred by SSA is that the most recent child abuse and/or neglect allegation(s) was found to be inconclusive, unfounded or unsubstantiated.

Services

The expanded OC Parent Wellness Program provides early intervention outpatient treatment that includes screening and needs assessment, clinical case management, individual counseling, parent education, psychoeducational support groups, wellness activities, referral and linkage to community resources, and community outreach and education.

The counseling approaches used by clinicians include Cognitive Behavioral Therapy (CBT), Eye Movement Desensitization and Reprocessing (EMDR) and art therapy, when indicated. The program also utilizes the evidenced-based curriculum, Triple P (Positive Parenting Program), with staff having been recently trained in providing more intensive Triple P parent education to better meet the needs of the families served. Clinicians also receive specialized training on additional evidence-based curricula (i.e., Mothers and Babies, Understanding Childhood Trauma), to ensure they follow the fidelity of these models and remain current on best practices when working with trauma-exposed individuals.

Outcomes

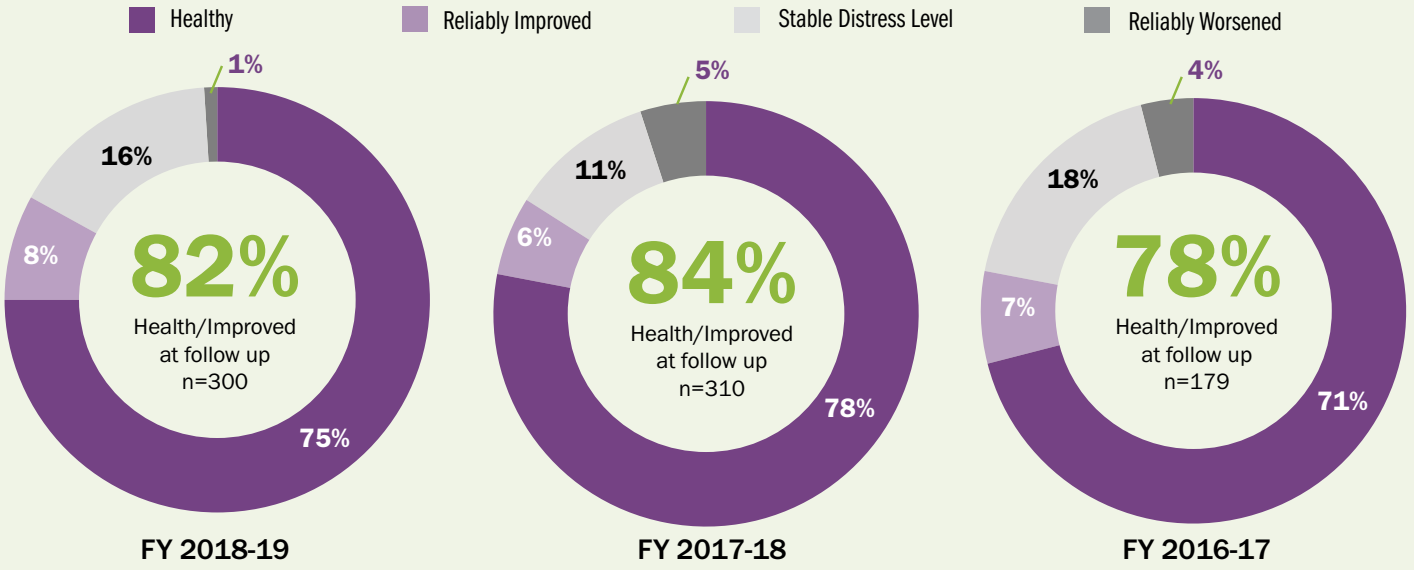
The program measures reductions in or prevention of prolonged suffering through an age-appropriate form of the OQ® or the PROMIS PGH-7 and PARCA-SE. Participants completed the identified measure at intake, every three months and program exit. OQ® scores were compared to the measure's clinical benchmarks, and change in PROMIS/PARCA-SE scores were analyzed and reported by effect size, to determine program effectiveness.

		FY 2016-17	FY 2017-18	FY 2018-19
Pregnant or New Parents (former OC PWP)	Total Served *Age Breakdown*	617 *< 18=76* *> 18+ = 541*	506 *< 18=45* *> 18+ = 461*	539 *< 18=34* *> 18+ = 541*
	Baseline + 1 Follow-up Y/ OQ® Completed	179	310	300
Parents Referred by CPS/SSA (former SFF)	Total Parents/Caregivers Served	117	148	147
	Total Children in the Home	147	342	189
	Baseline + 1 Follow-up Y/ OQ® Completed	52	104	108
At-Risk Children (former CTT)	Total Served			
	Baseline + 1 Follow-up PGH-7 Completed	-	38	31
	Baseline + 1 Follow-up PARCA Completed	215	204	156

Across the three fiscal years, anywhere from 75% through 90% of enrolled parents who were expecting, had a child within the past year, or had been referred by CPS/SSA reported healthy or reliably improved levels of distress, as measured by the OQ®, since starting services. Thus, services were associated with preventing symptoms of mental illness from becoming severe and disabling for the overwhelming majority of parents served. For the parents who report a significant worsening in their distress, program staff have been streamlining procedures to quickly identify these individuals earlier in the course of treatment, modify the treatment plan to include increased face-to-face time, or, when appropriate, refer them to a higher level of care with warm handoffs to behavioral health clinics, contract providers, or psychiatrists.

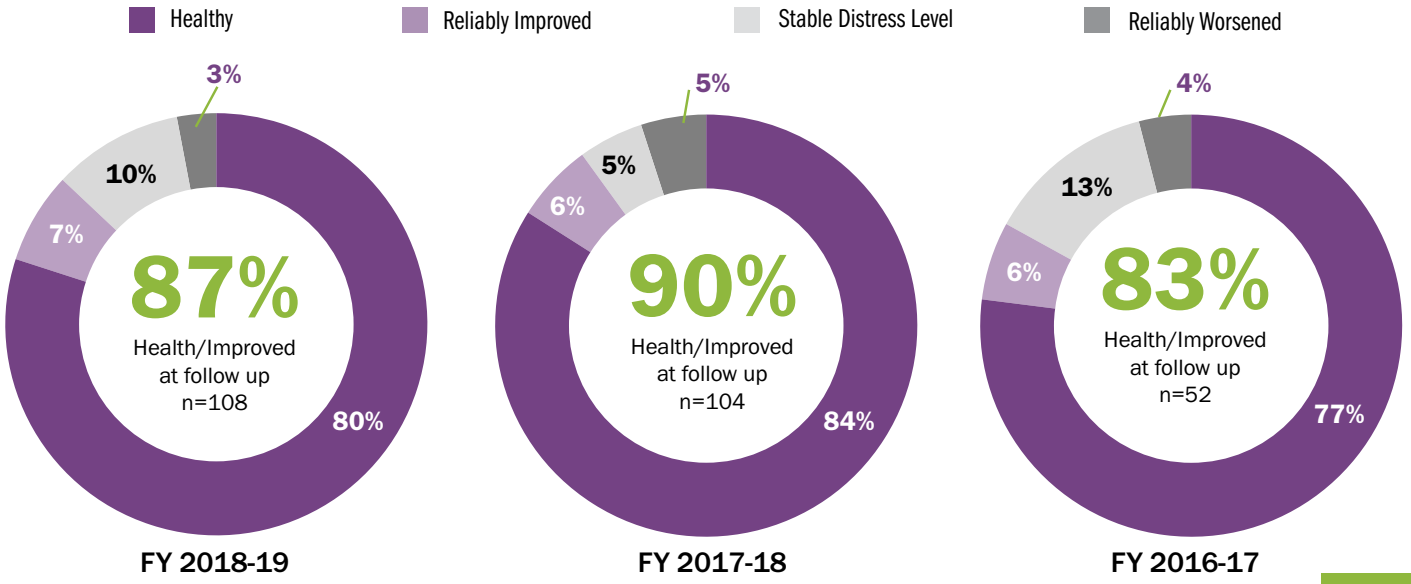
OQ® 30.2 OCPWP

New/Expecting Parents



OQ® 30.2 OCPWP

Referred by CPS/SSA

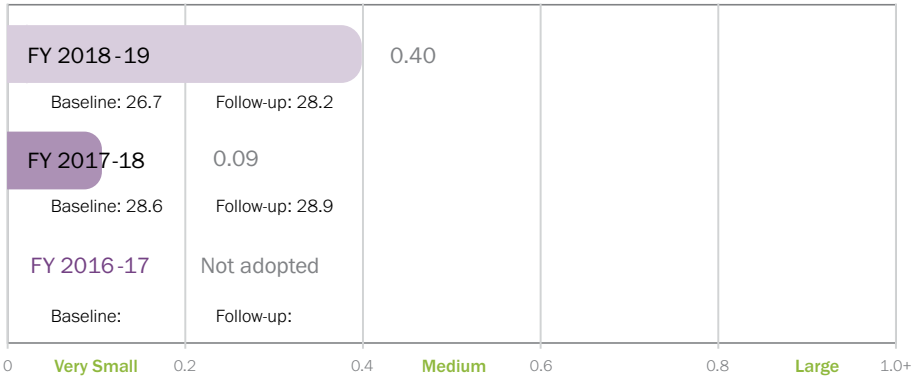


For families with young children exhibiting mild to moderate behavioral health symptoms that may impact their readiness for school, the program measures reductions in or prevention of prolonged suffering by having parents rate their children's global health, which was assessed via the PROMIS Pediatric Global Health-7 Proxy. It also aims to prevent the development or worsening of mental health conditions by maintaining and/or strengthening the protective factor of effective parenting skills, which was assessed via the PARCA-SE. Ratings for both measures were provided at intake, every three months of program participation and program exit, and the change in scores between intake and follow-up is evaluated.

Across the two years the PROMIS was completed, parents consistently reported high levels of global health in their children and high levels of parenting self-efficacy as they entered the program. Moreover, children were reported by their parents to have made additional, moderate gains in global health in FY 2018-19, and parents reported having made additional, moderate gains in different facets of parenting self-efficacy over all three years. Thus, services appeared to be effective in maintaining and/or enhancing the protective factor of global health among the young children, as well as parenting self-efficacy, in the at-risk families served in the program.

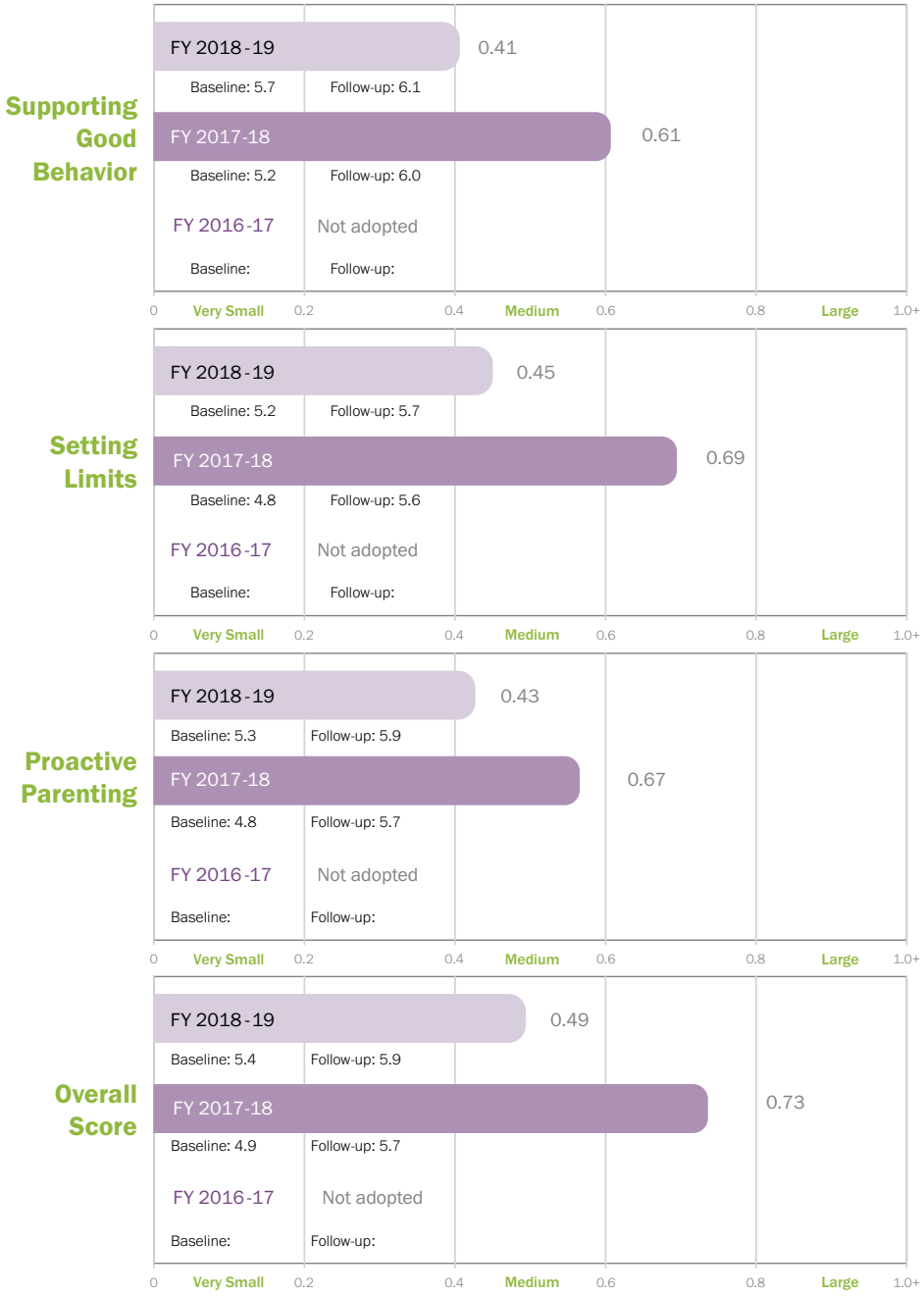
Impact on Pediatric Global Health

OC Parent Wellness (Parents of At-Risk Young Children)



Impact on Parent Self-Efficacy

OC Parent Wellness (Parents of At-Risk Young Children)



Challenges, Barriers and Solutions in Progress

Due to the challenges of serving all of Orange County from a centralized location, staff began to provide many services in the field. This resulted in additional challenges for clinicians who could not access real-time resource information while out in the field. Mobile phones were provided enabling clinicians to have immediate access to resources, work schedules, GPS/Maps and real-time consultation with the program Service Chief. For clinicians providing field-based services in South Orange County, which is particularly difficult to reach from the main clinic in the city of Orange, a satellite office and laptops were provided allowing clinicians to access the Electronic Health Record thereby assisting them in updating records in a more timely manner.

During this reporting period, program services were impacted by several factors. For example, in FY 2017-18 enrollment of pregnant and new parents declined due to several staff vacancies. Enrollment has been ramping back up as all positions have since been filled. Despite these staffing challenges in FY 2017-18, the program continued to refine and improve its data collection processes and, compared to FY 2016-17, staff more than doubled the number of follow-up assessments completed by new and expecting parents.

In addition, the program's ability to enroll and serve families that have been reported to, or investigated by Child Protective Services (CPS), is heavily dependent on a strong relationship with its partnering agency, SSA. During this reporting period, SSA shifted their social workers into the field and out of the office it shared with HCA program staff. This shift, combined with frequent staffing changes in the CPS department, ultimately decreased program referrals. To adjust to the new operations, meetings with SSA Administration were prioritized to regularly inform them of the services offered and encourage them to refer eligible families. A dedicated Outlook inbox was created to enable SSA social workers to directly email referrals while out in the field rather than having to fax or call them in.

Finally, during this reporting period, the program's partnership with the School Readiness Collaborative resulted in a new referral process. This new process created an unintended delay in referring parents/caregivers in need of services. This challenge was addressed by opening lines of communication with additional community partners specializing in serving families with children 0-8 and allowing them to directly refer eligible families rather than having all referrals go through the School Readiness prevention program. During this next fiscal year, the program will also shift from enrolling the child to enrolling the parent/caregiver and providing family counseling sessions. Staff will continue to assess the individual needs of the child and, when appropriate, refer them to the appropriate level of behavioral health care.

Beginning in FY 2020-21, three parent- and family-focused early intervention programs (i.e., OC PWP, Stress Free Families, Connect the Tots) will be combined into an expanded OC Parent Wellness Program. This consolidation is designed to improve overall efficiency by combining administrative elements shared across the three programs, while having clinical staff retain their specialized training/focus to ensure quality of care. Not only does this allow the HCA to increase its capacity to serve more Orange County families/parents/caregivers, it will simultaneously reduce the wait time for referred families to be screened and linked to care. This will be accomplished by utilizing dedicated Intake Coordinators who will screen all referral calls within 24-48 hours and ensure callers are either offered an appointment or linked to a more appropriate resource as quickly as possible. The OC Parent Wellness Program will also have one contact number and a dedicated email account providing the community a simplified avenue to refer or speak to a program specialist, further streamlining the referral process.

Community Impact

Since inception of its respective services, OC Parent Wellness has worked with more than 3,400 new and expecting parents, 900 families referred by Child Protective Services/SSA, and 1,900 families with young children at risk of not being ready for school. Clinicians work directly with parents and caregivers to address their mild to moderate behavioral health conditions (most commonly anxiety and depression), develop positive skills (i.e., communication, parenting), and improve family relationships and bonding, thus resulting in healthier, happier home lives for at-risk children. Program staff also provide consultation to various community partners and County agencies and educate them on the early signs of mental health symptoms and program eligibility requirements and referral processes, thus increasing families' access to timely and appropriate behavioral health services.

References

PROMIS Pediatric Global Health-7 Proxy (i.e., parent completes re: child behavior)

FY 2018-19: Baseline M=26.7, SD=4.86; Follow-up M=28.2, SD=3.65; t(30)=1.94, p<.062; Cohen's d=0.40

FY 2017-18: Baseline M=28.6, SD=5.21; Follow-up M=28.9, SD=3.54; t(37)=0.52, p<.609; Cohen's d=0.09

FY 2016-17: Not adopted

PARCA-SE Supporting Good Behavior

FY 2018-19: Baseline M=5.7, SD=1.02; Follow-up M=6.1, SD=0.84; t(278)=6.78, p<.001; Cohen's d=0.41

FY 2017-18: Baseline M=5.2, SD=1.29; Follow-up M=6.0, SD=0.90; t(126)=6.69, p<.001; Cohen's d=0.61

FY 2016-17: Not adopted

PARCA-SE Setting Limits

FY 2018-19: Baseline M=5.2, SD=1.23; Follow-up M=5.7, SD=1.00; t(278)=7.41, p<.001; Cohen's d=0.45

FY 2017-18: Baseline M=4.8, SD=1.40; Follow-up M=5.6, SD=0.99; t(126)=7.50, p<.001; Cohen's d=0.69

FY 2016-17: Not adopted

PARCA-SE Proactive Parenting

FY 2018-19: Baseline M=5.3, SD=1.24; Follow-up M=5.9, SD=0.99; t(278)=7.12, p<.001; Cohen's d=0.43

FY 2017-18: Baseline M=4.8, SD=1.50; Follow-up M=5.7, SD=1.03; t(126)=7.26, p<.001; Cohen's d=0.67

FY 2016-17: Not adopted

PARCA-SE Overall Score

FY 2018-19: Baseline M=5.4, SD=1.07; Follow-up M=5.9, SD=0.88; t(278)=8.01, p<.001; Cohen's d=0.49

FY 2017-18: Baseline M=4.9, SD=1.33; Follow-up M=5.7, SD=0.90; t(126)=7.78, p<.001; Cohen's d=0.73

FY 2016-17: Not adopted

Older Adult-Focused

Early Intervention Services for Older Adults (PEI)

Program Serves	Symptom Severity			Location of Services		Typical Population Characteristics				
60+	At Risk	Early Onset	Mild-Moderate	Field	Community Based	LGBTQ	Co-Occurring SUD	Trauma-Exposed Clients	Mono-Lingual/ Ethnic Communication	Older Adults

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$2,469,500	FY 2019-20	1,202
Proposed FY 2020-21 Budget	$2,469,500	FY 2020-21	1,300
Proposed FY 2021-22 Budget	$2,469,500	FY 2021-22	1,300
Proposed FY 2022-23 Budget	$1,469,500	FY 2022-23	1,300

Language Capacity of Direct Service Providers					
✓	Spanish	✓	Arabic	✓	Khmer
✓	Vietnamese	✓	Farsi		Other:
✓	Korean	✓	Mandarin	✓	Language Line as Needed

Proportion to be Served by Demographic Characteristic					
Age Group %	**%**	**Gender**	**%**	**Race/Ethnicity**	**%**
0-15		Female	78	African American/Black	
16-25		Male	22	American Indian/Alaskan Native	
26-59	1	Transgender		Asian/Pacific Islander	40
60+	99	Genderqueer		Caucasian/White	36
		Questioning/Unsure		Latino/Hispanic	23
		Other		Middle Eastern/North African	1
				Other	

Target Population and Program Characteristics

The **Early Intervention Services for Older Adults** (EISOA) program provides behavioral health early intervention services to older adults ages 50 years and older who are experiencing the early onset of mental illness and/or who are at greatest risk of developing behavioral health conditions due to isolation or other risk factors, such as substance use disorders, physical health decline, cognitive decline, elder abuse or neglect, loss of independence, premature institutionalization and suicide attempts. Participants are referred from senior centers, FRCs, community centers, faith-based organizations and the PEI Outreach to Increase Recognition of Early Signs of Mental Illness program.

Services

Program staff conducts a comprehensive in-home evaluation that includes psychosocial assessment, screening for depression, and measurement of social functioning, well-being and cognitive impairment. Using these results, staff then connects older adults to case managers who develop individualized care plans and facilitate participants' involvement in support groups, educational training, physical activity, workshops and other activities. A geropsychiatrist is also available to provide a psychiatric assessment of older adults who may have undiagnosed mental health conditions, as well as medication monitoring and management.

EISOA 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, program goals and deliverables, 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-service trainings.

Outcomes

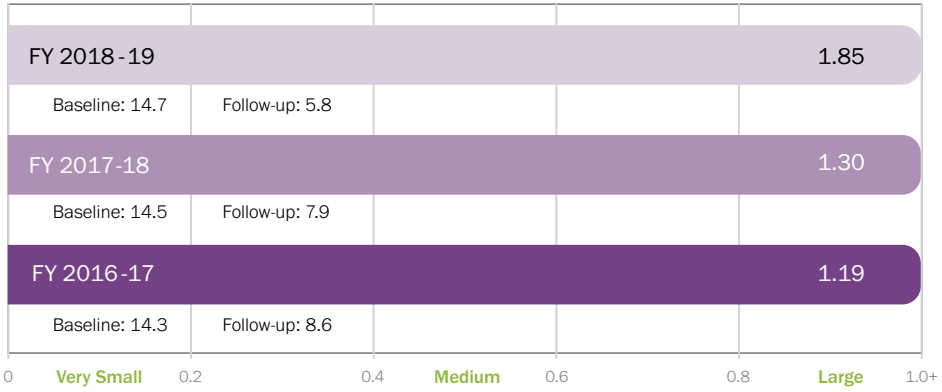
Fewer older adults were served in FY 2018-19 relative to previous years due to a change in the program's admission and discharge criteria. This change occurred in the second half of FY 2017-18 and affected participant recruitment and engagement in FY 2018-19.

		FY 2016-17	FY 2017-18	FY 2018-19
Older Adults	Total Served	536	601	409
	Baseline + 1 Follow-up PHQ-9 Completed	252	231	150
	Above Clinical Cutoff at Baseline	116	74	60
	Below Cutoff at Baseline and Follow-up	126	153	89
	Above Cutoff at Follow-up	10	4	1

Mental health functioning was assessed through the Patient Health Questionnaire (PHQ-9), a commonly used measure of depressive symptom severity. Measures were completed at intake, every three months and at discharge. Change in scores among participants who scored in the clinical range at intake (i.e., score > 10) was evaluated to assess the program's effectiveness at reducing depression symptoms. Across all three FYs, older adults who entered the program feeling depressed experienced substantial decreases (effect sizes > 1) in their depression symptoms, with average scores decreasing from the moderate range to the mild range at follow-up. In addition, the majority of older adults reported depression symptoms in the none-to-mild range both at intake and follow-up. Taken together, these findings suggest that the program is effective at reducing prolonged suffering and/or preventing mental health symptoms from becoming severe and persistent.

Impact on Depression Among Clinically-Distressed Older Adults by FY

Early Intervention Services for Older Adults



Challenges, Barriers and Solutions in Progress

Transportation remains a barrier to traditional services as the older adults served tend to 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 teaches 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 help alleviate transportation barriers, EISOA expanded transportation services for its participants with time-limited, PEI carryover funds.

Feedback from a recent PEI community planning process indicated that the eligible age for services should be lowered from the current age of 60 to include those who are 50 years or older, as individuals within this broadened age range from underserved communities, especially new immigrants and refugees, continue to feel isolated. These individuals not only face linguistic challenges, but are also unable to find employment successfully, which further adds to their isolation. To meet these identified needs, the time-limited carryover funds were utilized to expand the program criteria to serve participants who are 50 years and older and otherwise eligible for program services.

An unanticipated challenge faced by program staff was the collection of required PEI demographic data, particularly regarding gender identity. Many participants indicated the word "queer" was stigmatizing and that they felt offended by the term. Additionally, due to stigma, many participants hesitated to disclose their sexual orientation/gender identity for fear of being "outed." To address these challenges, staff organized LGBTIQ sensitivity training for staff and participants.

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, Khmer, Arabic and Farsi, the program is able to reach, serve and impact non-English speaking older adults through its self-stigma reduction activities, effective outreach and early intervention services.

Reference Notes

FY 2018-19: Baseline: M=14.7, SD=3.9; Follow-up M=5.8, SD=3.9; t(59)=14.36, p<.001; Cohen's d=1.85

FY 2017-18: Baseline: M=14.5, SD=3.6; Follow-up M=7.9, SD=5.1; t(74)=10.96, p<.001; Cohen's d=1.30

FY 2016-17: 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

Veteran-Focused

Early Intervention Veteran Services (PEI)

OC4Vets

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

College Veterans Programs

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics				
								
	Mild-Moderate	Field	Community Based	Co-Occurring SUD	LGBTQ	Veterans	Homeless/At Risk	Trauma-Exposed Clients

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$1,695,957	FY 2019-20	209
Proposed FY 2020-21 Budget	$1,695,957	FY 2020-21	219
Proposed FY 2021-22 Budget	$1,400,000	FY 2021-22	230
Proposed FY 2022-23 Budget	$1,400,000	FY 2022-23	242

Proportion to be Served by Demographic Characteristic					
Age Group %	**%**	**Gender**	**%**	**Race/Ethnicity**	**%**
0-15		Female	20	African American/Black	15
16-25	5	Male	80	American Indian/Alaskan Native	2
26-59	67	Transgender		Asian/Pacific Islander	4
60+	28	Genderqueer		Caucasian/White	46
		Questioning/Unsure		Latino/Hispanic	31
		Other		Middle Eastern/North African	
				Other	2

Target Population and Program Characteristics

Early Intervention Veteran Services represents a merging of two similar veteran-focused early intervention programs that outreach to and enroll veterans from different sites: college campuses (the former College Veterans program) and veteran-focused community organizations such as the Veterans Resource Centers and the Veteran Service Organization (VSO; the former OC4Vets program). This combined program 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. The original OC4Vets program began as an Innovation project and continued with PEI funding beginning February 2016. As part of the current Three-Year Plan consolidation, these programs were combined since they provide overlapping services for veterans and the primary difference was whether or not the veteran was referred for services on a college campus.[1]

Veterans and their families are referred to the program by local veteran organizations such as the Veterans Service Office (VSO), Veterans Affairs Administration, Veterans Resource Centers at local community colleges, other campus staff or faculty, Orange County Superior Courts, Orange County Family Court, Peer Navigators, outreach workers and self-referral.

Services

The program is co-located at the Veterans Service Office (VSO) of OCCR and Veterans Resource Centers at seven local community colleges. Services include individualized behavioral health screening and assessment to determine whether further evaluation and/or referrals to behavioral health services are needed, brief individual counseling, case management, employment and housing support services, referral and linkage to appropriate 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 brief counseling. Two clinicians are also trained in EMDR to serve veterans who are experiencing trauma, and all clinicians are trained in understanding the unique issues faced by veterans transitioning to civilian and student life.

Peer Navigators who are veterans, provide support through their shared military experience and assist with navigating the health care system, employment assistance, and housing navigation. Participants involved in legal proceedings with Family Court, Military Diversion or Veterans Treatment Court are also provided clinical case management to support and advocate for them to seek behavioral health treatment in lieu of consequences such as jail or a restraining order.

Outcomes

Veterans completed an OQ® measure at intake, every one to three months of program participation, and at discharge. Scores were compared to the measure's clinical benchmarks to determine program effectiveness at reducing prolonged suffering. Because the OQ® is a measure of symptom distress and a tool to help inform care planning, beginning in FY 2018-19 the program began to administer the OQ® only to participants who were enrolled in individual counseling. In prior years all participants had been asked to complete the measure even if they were not receiving counseling.

The clear majority of those participating in therapy during FY 2018-19 reported healthy or reliably improved levels of distress at their most recent follow up. These findings are notably different from prior years when only approximately one- to two-thirds of all participants who completed the measure (even if not receiving counseling) reported healthy or reliably improved levels of distress.

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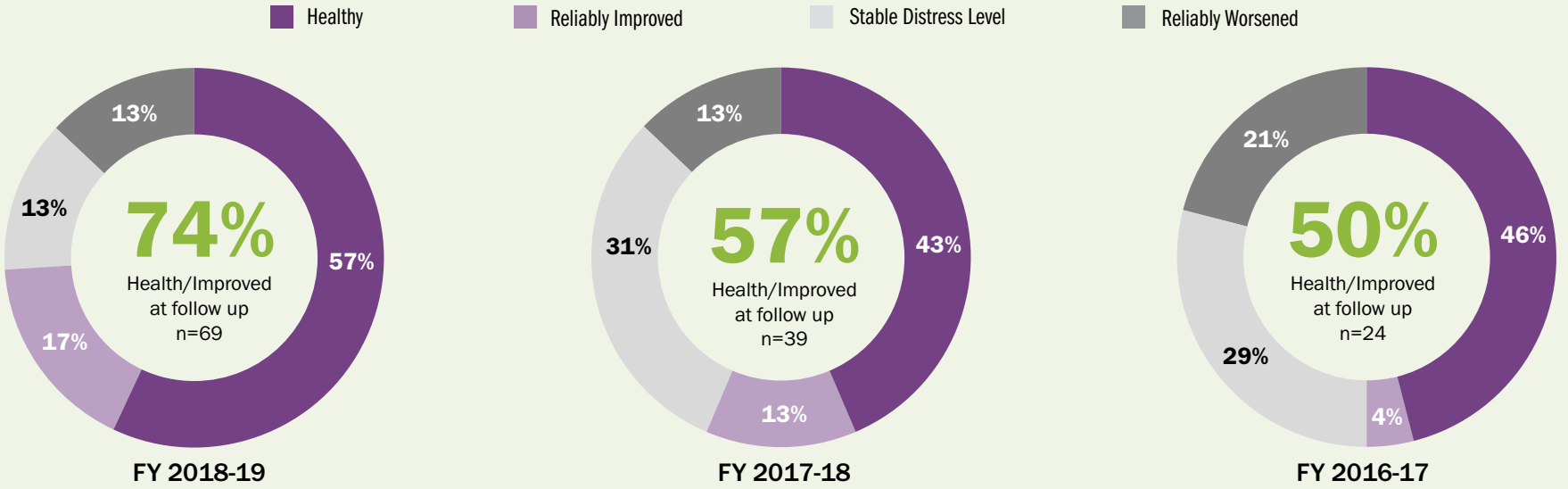
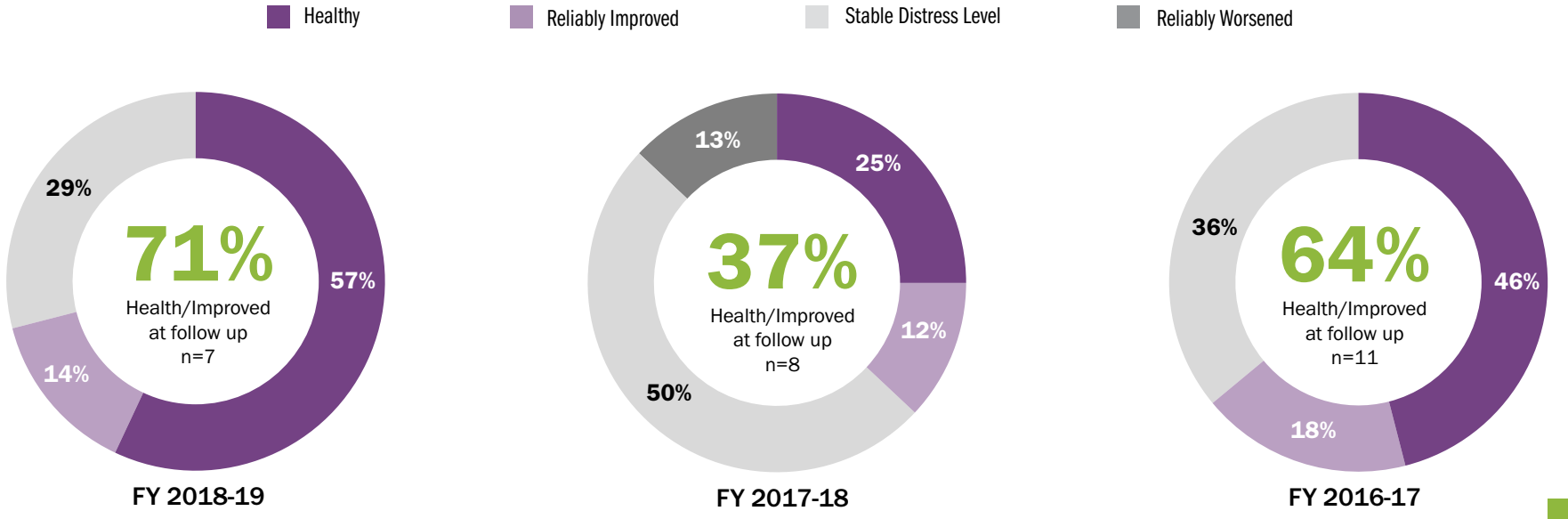
1 OC4Vets was previously expanded to include two other veteran-focused programs, Court Support 4 Vets and Peer Navigators, in an earlier Three-Year Plan.

OQ® Early Intervention Veteran Services

Veteran Community Locations



College Locations



		FY 2016-17	FY 2017-18	FY 2018-19
College Locations (original College Veterans)	Total Served	25	14	82
	Baseline + 1+ Follow-up OQ® Completed	11	8	7
Community (original OC4Vets)	Total Served	139	104	118
	Baseline + 1+ Follow-up OQ® Completed	13	39	69

While the results, particularly recent ones, suggest that services help prevent symptoms from becoming severe and disabling, the HCA has taken steps to work with staff to improve its measure completion rate so that it can determine whether these results are unique to just participants who complete the forms, or whether this pattern is reflective of the overall veteran population receiving counseling services. Both providers engage with participants who are generally reluctant to ask for help and to discuss the personal traumas they have experienced and to counter this, staff worked closely with the veterans to build trust and establish rapport. In turn, this delayed the intake process and completion of measures. Steps have been taken to encourage more timely completion of forms, including providing training on administration timing and procedures, how to incorporate the results into care planning, and continuous support and follow-up.

For veterans not receiving individual counseling but instead primarily receiving case management, information on referrals and linkage to needed county/community resources is provided in the "Summary of MHSA Strategies used by Early Intervention Programs" at the end of this section.

Challenges, Barriers and Solutions in Progress

As noted above, the program is working to improve its OQ® administration procedures and use as a clinical tool. It is also implementing changes with the hopes of expanding its reach and serving larger numbers of student veterans in Orange County. For example, in the first half of the FY, the County worked on streamlining intake procedures, engaging participants through phone check-ins, coordinating peer follow-ups, increasing community partnerships, coordinating with Veterans Affairs (VA) services, and increasing outreach efforts to engage those who are more difficult to reach. Starting January 1st, 2019 the provider switched to a County-contracted provider.

In addition, some participants, particularly with their military-connected background, may hold cultural beliefs that deter them from asking for help. To address these barriers, the program is designed to support timely access to services by co-locating services in non-mental health settings already frequented by veterans (i.e., college campuses, VSO, Court).

Community Impact

The program has provided services to more than 720 veterans in the community since July 2012 and more than 250 Veterans in college since its inception in October 2011. Program staff 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, Orange County Family Court and Veterans Resource Centers at local community colleges in order to best meet the needs of Orange County's veterans.

Behavioral Health Services for Military Families (PEI)

Program Serves	Location of Services		Typical Population Characteristics					
0+	Field	Community Based	Parents	Families	Homeless/ At Risk	Veterans	Trauma-Exposed Clients	Mono-Lingual/ Ethnic Community

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$1,000,000	FY 2019-20	150
Proposed FY 2020-21 Budget	$1,000,000	FY 2020-21	300
Proposed FY 2021-22 Budget	$1,000,000	FY 2021-22	300
Proposed FY 2022-23 Budget	$1,000,000	FY 2022-23	300

Language Capacity of Direct Service Providers					
✓	Spanish		Arabic		Khmer
	Vietnamese		Farsi		Other:
	Korean		Mandarin	✓	Language Line as Needed

Proportion to be Served by Demographic Characteristic					
Age Group %	**%**	**Gender**	**%**	**Race/Ethnicity**	**%**
0-15	50	Female	50	African American/Black	5
16-25	5	Male	50	American Indian/Alaskan Native	
26-59	40	Transgender		Asian/Pacific Islander	5
60+	5	Genderqueer		Caucasian/White	30
		Questioning/Unsure		Latino/Hispanic	35
		Other		Middle Eastern/North African	
				Other	25

Target Population and Program Characteristics

Behavioral Health Services for Military Families (BHSFMF) serves all members in the military family, including veterans, service members, spouses, partners and children. Eligible participants may self-refer or be referred by behavioral health providers throughout Orange County.

Services

BHSFSC 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. 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 services include outreach and engagement, 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.

This program was approved as an Innovation project in 2014, launched services in July 2015 and transitioned to PEI funding in July 2020 after the Innovation project period ended.

Outcomes

To prevent the onset and/or worsening of mental health conditions, BHSFSC aims to increase the protective factors of family communication, functioning and overall well-being, which was assessed using the North Carolina Family Assessment Scale (NCFAS). The NCFAS assesses several domains of family functioning that are rated on a 6-point continuum, 0 (serious problem) to 6 (clear strength). Ratings were made at intake and program exit, and the difference in scores was used to analyze whether there was improvement in, or maintenance of, healthy family functioning. Results are reported according to the calculated effect size, which reflects, in part, the extent to which a change in scores over time is clinically meaningful for the individuals served in the program.

		FY 2016-17	FY 2017-18	FY 2018-19
BHSFMF	Total Families Served	45	49	105
	Total Family Members Served	288	323	413
	Baseline + 1+ Follow-up NCFAS Completed	49	40	32

Project services were associated with medium-to-large improvements in environment (e.g., housing stability, personal hygiene), family safety, self-sufficiency (e.g., family income, food), and family health (e.g., physical and mental health) across all three fiscal years, with greater effects observed in FY 2016-17 and FY 2017-18. Project services were also associated with small improvements in family interactions (e.g., relationship between caregivers), child well-being (e.g., school performance), and social/community life across all fiscal years. There were notably greater effects observed in social/community life in FY 2018-19 compared to FY 2017-18 and greater effects in child well-being and family interactions in FY 2016-17 and FY 2017-18 compared to FY 2018-19. The difference in effects observed in FY 2018-19 compared to previous fiscal years may be due to capacity issues, including understaffing within agencies and staff turnover, as well as reduced leverage funding from partners, resulting in increased referrals outside of the project to link families to needed support. However, taken together, these findings suggest that project services help families maintain and/or strengthen different aspects of family functioning, which can serve as an important protective factor for military families.

Impact on Family Functioning

Behavioral Health Services for Military Families

Challenges, Barriers and Solutions in Progress

BHSFSC has encountered several challenges throughout FY 2018-19, including the complex referral system with the veteran and family courts, inconsistencies around assessing and linking participants to domestic violence services, unplanned staff turnover, participants' shifting needs, and a continuing need for participant legal assistance.

To address court referrals, BHSFSC peer navigators refined their approach within each court to ensure that the referral process aligns with the participant's treatment progress. They established protocols to ensure that referrals into the BHSFSC program were given only after potential participants completed their court program.

To ensure families with domestic violence concerns were adequately identified and served, BHSFSC implemented new strategies to engage veteran and military families during the initial phone screening, revised the language used with families about domestic violence to be more military competent, and provided additional training for staff. These efforts led to an increase in the identification of families needing support around domestic violence issues. In FY 2018-19, twenty-four families were identified compared to four families in FY 2017-18, six families in FY 2016-17 and three families in FY 2015-16.

The project also experienced challenges related to staff turnover and participants' shifting needs. Due to the time it takes to train new staff, capacity issues were a concern and affected the speed at which new participants could enter the project. In order to address this, project staff was cross trained on multiple duties and were also utilized to train incoming staff in order to sustain the program's capabilities and address staffing shortages as they arose. More frequent staff trainings were conducted in order to keep new staff informed on project resources and processes. However, the challenge of clients' shifting needs remained and all staff were regularly updated on available services in the community.

Finally, there was a continuing need for legal services for families, particularly around child custody issues. Most legal agencies have limited knowledge on how to help the non-veteran parent navigate potential benefits for their child. BHSFSC partner, Veterans Legal Institute, continues to work on finding viable solutions to support custodial non-veteran parents.

Community Impact

BHSFSC 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 822 individual participants since its inception in July 2015. BHSFSC continues to strengthen its relationship with other veteran-serving agencies, including the Veterans Administration (VA), Long Beach, The Tierney Center at Goodwill, and the Los Alamitos Joint Forces Training Base. The relationship with the VA is especially significant in improving collaborative efforts, linking military-connected families to services and bridging the gap between agencies. They also continue to expand their reach into non-veteran serving institutions by building relationships within the Orange County School District. This collaboration at both the superintendent and individual school leadership level has not only increased their visibility within the community, it has given them the opportunity to provide on-site services within Orange County schools.

Reference Notes

Environment:

FY 2018-19: Baseline M=2.9, SD=.79; Follow-up M=2.6, SD=.68; t(31)=2.33, p=.03; Cohen's d=0.41

FY 2017-18: Baseline M=2.9, SD=1.13; Follow-up M=2.3, SD=.85; t(39)=4.21, p<.001; Cohen's d=0.69

FY 2016-17: Baseline M=2.9, SD=1.1; Follow-up M=2.1, SD=.90; t(48)=5.16, p<.001; Cohen's d=0.74

Parental Capabilities:

FY 2018-19: Baseline M=2.6, SD=.45; Follow-up M=2.6, SD=.57; t(31)=.33, p=.75; Cohen's d=0.07

FY 2017-18: Baseline M=2.7, SD=.73; Follow-up M=2.4, SD=.84; t(39)=2.67, p=.01; Cohen's d=0.43

FY 2016-17: Baseline M=2.6, SD=.73; Follow-up M=2.3, SD=.84; t(48)=3.25, p=.002; Cohen's d=0.48

Family Interactions:

FY 2018-19: Baseline M=3.2, SD=.52; Follow-up M=3.0, SD=.67; t(31)=1.56, p=.13; Cohen's d=0.28

FY 2017-18: Baseline M=3.3, SD=.87; Follow-up M=3.1, SD=.95; t(39)=2.13, p=.04; Cohen's d=0.34

FY 2016-17: Baseline M=2.9, SD=.87; Follow-up M=2.5, SD=.95; t(48)=3.0, p=.01; Cohen's d=0.44

Family Safety:

FY 2018-19: Baseline M=2.7, SD=.65; Follow-up M=2.4, SD=.70; t(31)=2.98, p=.006; Cohen's d=0.53

FY 2017-18: Baseline M=2.8, SD=.79; Follow-up M=2.4, SD=.93; t(39)=4.01, p<.001; Cohen's d=0.64

FY 2016-17: Baseline M=2.6, SD=.79; Follow-up M=2.2, SD=.93; t(48)=4.16, p<.001; Cohen's d=0.60

Child Well-Being:

FY 2018-19: Baseline M=3.0, SD=.50; Follow-up M=2.8, SD=.44; t(30)=1.57, p=.13; Cohen's d=0.28

FY 2017-18: Baseline M=3.0, SD=.50; Follow-up M=2.9, SD=.61; t(39)=1.98, p=.06; Cohen's d=0.32

FY 2016-17: Baseline M=2.6, SD=.50; Follow-up M=2.3, SD=.61; t(48)=3.56, p=.001; Cohen's d=0.51

Social/Community Life:

FY 2018-19: Baseline M=3.0, SD=.57; Follow-up M=2.9, SD=.63; t(31)=1.09, p=.29; Cohen's d=0.20

FY 2017-18: Baseline M=2.9, SD=.56; Follow-up M=2.7, SD=.69; t(39)=1.75, p=.09; Cohen's d=0.28

FY 2016-17: Baseline M=2.7, SD=.56; Follow-up M=2.4, SD=.69; t(48)=3.08, p=.003; Cohen's d=0.44

Self-Sufficiency:

FY 2018-19: Baseline M=3.1, SD=.93; Follow-up M=2.8, SD=.85; t(31)=2.24, p=.03; Cohen's d=0.40

FY 2017-18: Baseline M=3.6, SD=1.0; Follow-up M=3.1, SD=1.1; t(39)=4.02, p<.001; Cohen's d=0.64

FY 2016-17: Baseline M=3.3, SD=1.0; Follow-up M=2.8, SD=1.1; t(48)=4.15, p<.001; Cohen's d=0.59

Family Health:

FY 2018-19: Baseline M=3.1, SD=.39; Follow-up M=2.9, SD=.54; t(31)=2.18, p=.04; Cohen's d=0.39

FY 2017-18: Baseline M=3.0, SD=.53; Follow-up M=2.8, SD=.60; t(39)=3.65, p=.001; Cohen's d=0.59

FY 2016-17: Baseline M=2.9, SD=.54; Follow-up M=2.6, SD=.60; t(48)=4.03, p<.001; Cohen's d=0.58

Summary of MHSA Strategies Used by Early Intervention Programs

Strategies to Promote Recovery/Resilience

Early intervention outpatient services are person-centered and strengths-based with a focus on recovery, resilience and well-being. Treatment plans are developed via a collaborative process between the consumer, family, if applicable, and therapist, and incorporate goals such as learning self-care, communicating effectively, preventing additional trauma, improving family relationships and/or parent-child bonding, expanding social networks and support systems, and increasing participation in meaningful activities. Developing and reinforcing these skills early helps promote resilience and protect against long-term challenges later in life.

Strategies to Reduce Stigma and Discrimination

These programs utilize culturally congruent, strengths-based approaches when developing the participant's individual care plan and delivering individual, peer, family and group services. Examples of these approaches include recruiting staff who are bicultural and represent different ethnicities and religions, may be more familiar with how to address the issue of mental health with the program participant, thus allowing them to adjust their approaches to diverse populations readily. Furthermore, the programs employ strategies such as participant and family education, public education and trainings, and community anti-stigma advocacy to decrease both public and self-stigma and discrimination.

In addition, programs work to decrease stigma associated with seeking behavioral health services by staffing the program with people who have similar lived experiences (i.e., military service members, veterans, LGBTQ, etc.. For example, peer navigators with knowledge of military culture can broach the sensitive topic of mental health with veterans and service members.

Similarly, students often face parent or peer discouragement to engage in program services (stigma), lack of willingness or fear of participation. Program staff works 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, providing psychoeducation to promote acceptance, and promoting 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. CCSS staff with expertise also provides educational and program promotion presentations 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. Presentations are provided to behavioral health providers, school staff/faculty, public health staff, social services staff and other community members.

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.

Strategies to Increase Access to Services: Timely Access for Underserved Populations and Linkage to Treatment

The providers for the four Early Intervention Outpatient Program categories have expertise in engaging and working with distinct underserved populations, including at-risk children families or older adults, LGBTQ individuals, ethnic/monolingual communities, Veterans and youth experiencing early onset of psychiatric illness. Despite their varied backgrounds and unique experiences, participants across these programs face similar barriers to engaging in behavioral health services. These include mental health stigma, lack of support from family or others to seek mental health services, lack of transportation or childcare, and/or an inability to take time off work during traditional business hours for appointments.

Increasing timely access begins with program staff participating in community outreach events and giving presentations throughout Orange County in locations and venues likely to be frequented by individuals from the underserved populations identified above. Using culturally responsive education and materials, program staff strive to de-stigmatize mental health, help others learn to recognize and appropriately respond to the early signs of mental health challenges, and promote awareness of available services. In addition, the programs builds relationships with community agencies and other individuals who may come into contact with eligible individuals/families to raise awareness and increase referrals for program services.

For enrolled participants, programs offer transportation assistance to their services, onsite childcare, and extended program hours. Clinicians are also able to meet participants in their homes or other preferred community locations, including parks, Family Resource Centers, restaurants, school/college campuses, etc. To encourage timely access by individuals with limited English proficiency, programs prioritize hiring bilingual/bicultural staff and, in the case of CCSS, partner with community agencies to set up "satellite" locations and provide services to highly marginalized populations such as the Middle Eastern and North African refugees and the Deaf and Hard of Hearing communities.

In addition, when an individual's/family's needs exceed the capacity of the program, clinicians refer and link participants to appropriate level and type of community resources, as summarized below.

Early Intervention Program: First Onset		Linkage Metrics		
		# Referrals	# Linkages	Types of Linkages
OC CREW	FY 2016-17	104	28	Behavioral health outpatient services; residential treatment; other PEI programs; employment services, resources; information and referral resources; legal services and advocacy; employment services and resources; recreational activities; special needs and disability services
	FY 2017-18	64	22	
	FY 2018-19	37	24	

Early Intervention Program: Parent Wellness		Linkage Metrics		
		# Referrals	# Linkages	Types of Linkages
OC Parent Wellness	**FY 2016-17**	447	113	Family support services, other PEI programs, legal services, advocacy; basic needs (i.e., donated items, financial assistance); recreation
	FY 2017-18	222	40	
	FY 2018-19	344	112	
Connect the Tots *(merged with OC Parent Wellness FY 2020-21)*	**FY 2016-17**	205	116	Behavioral Health Outpatient; Behavioral Health Recovery Support; Prevention & Early Intervention Programs
	FY 2017-18	149	89	
	FY 2018-19	115	83	
Stress Free Families *(merged with OC Parent Wellness FY 2020-21)*	**FY 2016-17**	157	32	Basic need items, services; behavioral health outpatient services; information and referral services; legal services, advocacy; PEI programs; financial assistance; health care services; family support services
	FY 2017-18	229	26	
	FY 2018-19	81	31	

Early Intervention Programs: General Services		Linkage Metrics		
		# Referrals	# Linkages	Types of Linkages
CCSS (OC ACCEPT)	**FY 2016-17**	328 (96)	157 (47)	Behavioral health services; legal services, advocacy; health care benefits/services; (+ food/nutrition, housing for LGBTIQ)
	FY 2017-18	298 (73)	156 (29)	
	FY 2018-19	139	97	
SB MHS	**FY 2016-17**	397	49	Basic needs items; behavioral health outpatient services; PEI programs; crisis services; health education, disease prevention, wellness, physical fitness services
	FY 2017-18	391	44	
	FY 2018-19	293	59	
EISOA	**FY 2016-17**	9,028	3,957	Social Support; Basic Needs; Community Events; Ancillary Services; Education; Behavioral Health Outpatient services; Legal/Financial; Education; Medical; Employment; Family Support; Peer Support, Housing Support
	FY 2017-18	10,880	6,191	
	FY 2018-19	5,156	3,054	

Early Intervention Program: Veteran-Focused		Linkage Metrics		
		# Referrals	# Linkages	Types of Linkages
Early Intervention Veteran Services - Community	**FY 2016-17**	363	216	Housing resources, advocacy; behavioral health outpatient services; employment services, resources; veteran entitlement programs; transportation services; other PEI programs; financial assistance; legal services, 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; family support services
	FY 2017-18	155	96	
	FY 2018-19	337	76	
Early Intervention Veteran Services - Colleges *	**FY 2016-17**	133	83	Transportation services; food and nutrition assistance; housing resources, advocacy; employment services, resources; adult education services; legal services, advocacy; behavioral health crisis response; behavioral health outpatient services; financial services; PEI programs; health care services; health education, disease prevention, wellness, and physical fitness; special needs, disability services; veteran entitlement programs
	FY 2017-18	249	10	
	FY 2018-19	377	76	
BHSFMF	**FY 2016-17**	217	106	Basic needs (i.e., food, clothing); housing; mental health; early intervention services; domestic violence prevention; legal services; financial services; employment services; education benefits
	FY 2017-18	278	157	

* Because many of the referrals provided to college veterans are provided in group settings, it is difficult to follow-up with participants and determine linkages.

Early Intervention Treatment Program*	Target Population Specialization/Focus						
	Children/ Youth	Parent/ Families	Adults	Older Adults	Trauma-Exposed Individuals	LGBTIQ	Monolingual/ Ethnic Communities
CCSS	X	X	X	X	X		X
OC ACCEPT	X	X	X	X	X	X	X
School-Based Mental Health Services	X	X			X		X
Early Intervention Services for Older Adults		X		X	X		X
OC Parent Wellness Program	X	X	X		X		X
Stress Free Families	X	X	X		X		X
Connect the Tots	X	X			X		X
First Onset of Psychiatric Illness (OC CREW)	X	X			X		X
Early Intervention Veteran Services							
OC4Vets		X	X		X		
College Veterans		X	X		X		
Behavioral Health Services for Military Families	X	X			X		

* Please note that all Early Intervention Treatment providers assess for substance use disorders (SUD). When a referred individual has a need for primary SUD intervention, they are referred and linked to a specialty SUD program.

CLINIC EXPANSION

The HCA offers the overwhelming majority of its outpatient clinic services through non-MHSA County-operated and County-contracted facilities located across Orange County. Because demand for services exceeds the clinics' capacity, various programs have been established through the MHSA to address these gaps in care. These expansion programs tailor their services to the age group and target population being served.

Child and Youth Programs

Children and Youth Expansion Services (CSS)

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics					
0-21	Severe	Field	Community Based	Foster Youth	Parents	Families	Students	Trauma- Exposed Clients	Mono-Lingual/Ethnic Community

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$500,000	FY 2019-20	380
Proposed FY 2020-21 Budget	$2,500,000	FY 2020-21	400
Proposed FY 2021-22 Budget	$3,000,000	FY 2021-22	400
Proposed FY 2022-23 Budget	$3,000,000	FY 2022-23	400

Proportion to be Served by Demographic Characteristic					
Age Group %	**%**	**Gender**	**%**	**Race/Ethnicity**	**%**
0-15	76	Female	35	African American/Black	8
16-25	24	Male	65	American Indian/ Alaskan Native	1
26-64		Transgender		Asian/Pacific Islander	5
65+		Genderqueer		Caucasian/White	21
		Questioning/Unsure		Latino/Hispanic	64
		Other		Middle Eastern/ North African	
				Other	1

Language Capacity of Direct Service Providers					
✓	Spanish		Arabic		Khmer
	Vietnamese		Farsi		Other: ASL
	Korean		Mandarin	✓	Language Line as Needed

Target Population and Program Characteristics

The **Children and Youth Expansion Services** program is a major modification of the Youth Core Services program (Field-Based Track) from the FY 2017-18 Three-Year Plan. Based on recent community planning feedback and the needs/disparities assessment, Children and Youth Expansion services will broadly serve youth under age 21 who meet the following additional eligibility criteria and their families/caregivers:

- Living with serious emotional disturbance (SED) or serious mental illness (SMI) and
  - Qualifies for Specialty Mental Health Services as part of the Pathways to Well-Being subclass (formerly known as "Katie A" and the original target population for the Youth Core Services program);
  - Is in foster care, at risk of foster care involvement, and/or eligible for mental health services under the State-mandated program Therapeutic Foster Care (TFC) and referred by the Social Services Agency (SSA);
  - Has Medi-Cal and qualifies for Specialty Mental Health Services;
  - Has been screened for trauma in primary care settings through the ACES Aware Initiative and referred for mental health services; or
  - Is struggling in school due to their SED/SMI and not already receiving or eligible for mental health services through the school or other provider.

Whenever possible, MHSA funds will act as a match to draw down Federal Financial Participation (FFP) funds and increase the number of children and youth who can be served through this program. Similarly, HCA will work with the Orange County Department of Education (OCDE) and local school districts to identify Local Control and Accountability Plan (LCAP) funds that can be used to leverage FFP and increase the number of students who can be served from school districts that are contributing dollars. Because this partnership with schools is new, planning for expansion of student-focused services will also include development of MOUs, data metrics and data-sharing agreements, referral procedures, etc., with the goal of launching services as soon as practicable in FY 2020-21. Children and youth can be referred to this program by community agencies, other behavioral health providers, pediatricians, SSA, school personnel, general community, families, etc.

Services

Outpatient services provided through this program are tailored to meet the needs of the youth and their family, and can include screening/assessment, individual and family outpatient therapy, group therapy, crisis intervention and support, case management, referral and linkage to supportive services, and/or medication management, if needed. Services are linguistically and culturally competent and provided in the clinic, out in the community or at a school (with permission) depending on what the youth/family prefers. For youth enrolled under Pathways to Well-Being, services will comply with program requirements, including those for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS) and Child and Family Teams.

Outcomes

Although a performance outcomes measure has been implemented, outcomes are not available for reporting at this time due to data collection and reporting issues encountered by the provider. HCA will continue to work with the provider so that outcomes can be reported in future Plan updates.

Challenges, Barriers and Solutions in Progress

The provider for Pathways to Well-Being services (formerly Youth Core Services) continues to address issues related to confounding factors that may be influencing performance outcome data, such as low initial scores on the Outcome Questionnaire despite having significant behavioral health problems. Solutions to address these factors include having other parties related to the youth complete the questionnaire, assisting parents with literacy problems complete the questionnaire, and ensuring the questionnaire is completed at intake.

Community Impact

The program, while operating as the Youth Core Services Field-Based track, provided services to more than 1,700 youth since its inception in March 2016.

Services for the Short-Term Residential Therapeutic Program

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics		
0-21	Severe	Residential Setting	Foster Youth	Juvenile/Criminal Justice	Trauma- Exposed Clients

Language Capacity of Direct Service Providers					
✓	Spanish		Arabic		Khmer
	Vietnamese	✓	Farsi		Other:
✓	Korean	✓	Mandarin	✓	Language Line as Needed

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$4,870,000	FY 2019-20	200
Proposed FY 2020-21 Budget	$6,500,000	FY 2020-21	200
Proposed FY 2021-22 Budget	$8,000,000	FY 2021-22	200
Proposed FY 2022-23 Budget	$8,000,000	FY 2022-23	200

Proportion to be Served by Demographic Characteristic					
Age Group %	**%**	**Gender**	**%**	**Race/Ethnicity**	**%**
0-15	25	Female	62	African American/Black	15
16-25	75	Male	36	American Indian/Alaskan Native	
26-64		Transgender	2	Asian/Pacific Islander	5
65+		Genderqueer		Caucasian/White	29
		Questioning/Unsure		Latino/Hispanic	50
		Other		Middle Eastern/North African	1
				Other	

Target Population and Program Characteristics

Starting in FY 2017-18, **Services for the Short-Term Residential Therapeutic Program** (S-STRTP; previously a track in the former Youth Core Services program called STRTP) was established to serve Wards and Dependents of the Court ages six to 17 and Non-Minor Dependents (NMD) ages 18 to 21 who need the highest level of behavioral health care in a trauma-informed residential setting. Residential costs are paid through the foster care system, and HCA contracts with the STRTP facilities to provide Medi-Cal Specialty Mental Health Services (SMHS) to eligible youth and NMDs placed under the Assembly Bill 403 mandate. All referrals to the program are 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 in the process of contracting with up to eight facilities in which to provide services:

- Three providers are in varying stages of transitioning to Permanent STRTP Licensure.
- Three providers are provisionally licensed and in negotiations with HCA to contract for SMHS.
- Two providers are waiting for Provisional STRTP Licensure, and HCA anticipates entering into contract negotiations if they are approved.

Services

Per State legislation, youth who meet eligibility criteria can stay in an STRTP facility up to six months, with an option for a six month extension, as needed, 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 that may include the following: individual, collateral, group, and family therapy; medication management; therapeutic behavioral services; intensive home-based services; intensive care coordination; and case management. Per the regulations, STRTP facilities are required to provide evidence based practices(EBP's) that meet the needs of its specific population. Thus, the specific treatment interventions may vary among the providers. In addition, the legislation requires that all providers must deliver trauma-informed and culturally relevant core services that include:

- Specialty Mental Health Services under the Medi-Cal 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 extra-curricular activities and social supports;
- Activities designed to support transitional-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 and NMDs referred to this program, STRTP providers foster recovery and resilience by creating a space that provides physical and emotional safety for the youth. Providers sensitively conduct screenings and assessments to identify the trauma-related reactions and risk of the children and youth they serve. Assessments also factor in how the youth's developmental stages and cultural considerations intersect with their trauma experiences and use this information to connect the youth with appropriate evidence-based treatments that: (1) address their trauma and other behavioral health symptoms, and (2) help them form positive supportive relationships. Providers also educate caregivers on how their own trauma histories may be impacting their current behaviors and relationships, particularly with their children, and help the 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 the staff on how to address these impacts so that they can continue to support the youth, NMDs, and

families with whom they work. Staff are also expected to partner with youth, NMDs, 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 STRTP in order to facilitate timely access to its services. If criteria are subsequently determined not to be met, alternative placements are arranged. The programs 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 an STRTP facility receive on-going and intensive training in child development, cultural and gender identity issues, and severe trauma. This training helps provide staff with evidence-supported skills and strategies to offer a safe environment that respects the backgrounds and histories of the youth, NMD, and families and to collaborate with them to identify services and supports that best meet their needs.

Outcomes

The STRTP facilities were ramping up in FY 2018-19 so there are no outcomes to report at this time.

Children and Youth 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 of	Medical

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$600,000	FY 2019-20	500
Proposed FY 2020-21 Budget	$1,000,000	FY 2020-21	525
Proposed FY 2021-22 Budget	$1,000,000	FY 2021-22	550
Proposed FY 2022-23 Budget	$1,000,000	FY 2022-23	600

Language Capacity of Direct Service Providers					
✓	Spanish		Arabic		Khmer
	Vietnamese		Farsi		Other:
	Korean		Mandarin	✓	Language Line as Needed

Proportion to be Served by Demographic Characteristic					
Age Group %	**%**	**Gender**	**%**	**Race/Ethnicity**	**%**
0-15	47	Female	62	African American/Black	1
16-25	53	Male	37	American Indian/Alaskan Native	1
26-64		Transgender	1	Asian/Pacific Islander	8
65+		Genderqueer		Caucasian/White	19
		Questioning/Unsure		Latino/Hispanic	66
		Other		Middle Eastern/North African	1
				Other	4

Target Population and Program Characteristics

The target population for the **Children and Youth Co-Occurring Medical and Mental Health Clinic** 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 Medi-Cal beneficiaries with MHSA funds serving as a match to draw down federal funds.

Services

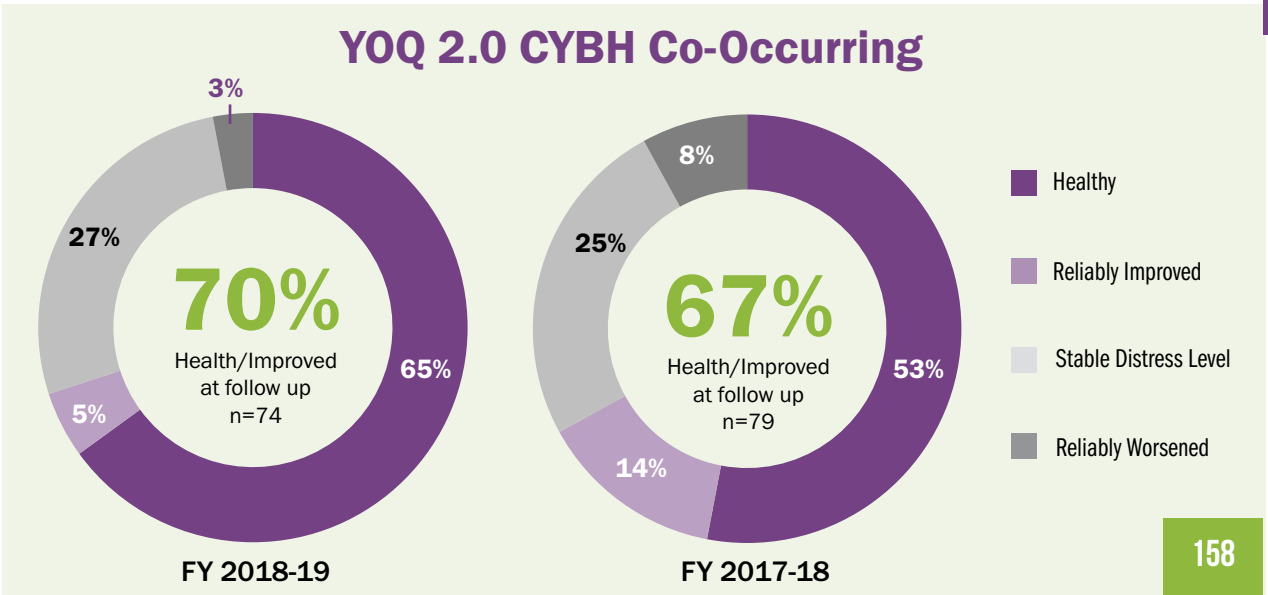
This program provides individual and family outpatient therapy, case management, limited psychological testing and medication management, if needed. A variety of evidence-based and best practices are provided to meet the needs of the youth, with some of the more common clinical interventions including Cognitive Behavioral Therapy (CBT), Motivational Interviewing, Trauma-Focused CBT, and Exposure and Response Prevention (ERP). Program staff also have specialty training on the effects of medical and psychological co-existing diagnoses and employ evidence-supported treatments that promote healthy coping and self-management of their diagnoses.

Clinicians 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 Therapeutic Behavioral Services (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.

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 2.0. Individuals completed the measure at intake, every month of program participation and at discharge, and participants' scores were compared to the measure's clinical benchmarks to determine program effectiveness at improving symptoms.

		FY 2016-17	FY 2017-18	FY 2018-19
Children & Youth Co-Occurring Medical & Mental Health Clinic	Total Served	348	445	430
	Baseline + 1 Follow-up YOQ Completed	-	74	74



The majority of youth (70%) served in FY 2018-19 reported healthy or reliably improved distress levels at follow-up, which was an increase over the 55% of youth in FY 2017-18. Importantly, there was a notable decrease in the proportion of youth reporting reliable worsening of their symptoms while receiving services. Longer lengths of stay may, in part, account for this jump in performance outcomes. As with the previous year, however, it should be noted that the baseline assessment may not reflect a true baseline for youth who had already been engaged in treatment prior to YOQ implementation. Nevertheless, results continue to suggest that the program's services are associated both with preventing symptoms of mental illness from becoming severe and disabling, as well as with meaningfully reducing suffering among those who report clinically elevated distress during program enrollment.

Challenges, Barriers and Solutions in Progress

The CYBH Co-Occurring Clinic census has continued to increase since inception. Due to the unique nature of the population served, with co-occurring behavioral and physical health conditions, the program has provided on-going trainings for staff around documentation of services to ensure interventions are clearly tied to behavioral health impairments. The program utilizes primarily psychologists and psychologist fellows to provide direct treatment, but as the program has continued to grow, so have the needs of the population. The need for higher than expected case management support has necessitated the addition of clinical staff (i.e., (LCSW, LMFT, LPCC, ASW, AMFT, APCC) dedicated to support this role. During FY 2018-19, there was a significant increase in referrals to the program, which delayed access to the service. This led to an expansion of the program for FY 2019-20 to meet the projected needs of Orange County children and youth.

Community Impact

The program has already provided services to more than 785 youth and their families since its inception in July 2015, thus underscoring the need for these specialized services. Because the program is located on the medical campus, program staff has 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.

Summary of MHSA Strategies Used by Clinic Expansion: Child and Youth Programs

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 children, youth and their families. This is achieved by working closely with the child and family using a strengths-based approach to help develop skills that further improve their functioning, as well as by communicating and collaborating with the various providers that work with the child and family (i.e., medical teams, school staff, wraparound team, Social Services Agency, community resources, schools, etc.).

Strategies to Reduce Stigma and Discrimination

Operating from a strengths-based view rather than an illness-based view helps reduce some of the stigma associated with mental illness. Staff from these programs also recognize the importance of providing services and supports in a manner that takes into account and accepts the child or youth's differences and unique life circumstances, including culture, ethnicity, gender, sexual orientation and socioeconomic status. In the co-occurring physical health/mental health program, several unique opportunities are available since the program is located at a teaching hospital. For example, 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, as well as 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.

Strategies to Increase Access to Services: Timely Access for Underserved Populations and Linkage to Treatment

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 out in the community, including schools, medical offices, hospitals, etc., rather than relying on them to travel to a behavioral health clinic. These programs also provide services in multiple languages through bicultural/bilingual staff, and can access a language line translation service to assist those who speak other languages, thus reducing language barriers that may impeded engaging in services.

Adult and Older Adult Programs

Outpatient Recovery (CSS)

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics		
18+	Severe	Outpatient Clinic	Co-Occuring SUD	Trauma- Exposed Clients	Mono-Lingual/ Ethnic Communication

Language Capacity of Direct Service Providers					
✓	Spanish	✓	Arabic		Khmer
✓	Vietnamese		Farsi		Other:
✓	Korean		Mandarin	✓	Language Line as Needed

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$8,458,531	FY 2019-20	2,500
Proposed FY 2020-21 Budget	$6,158,531	FY 2020-21	2,500
Proposed FY 2021-22 Budget	$6,158,531	FY 2021-22	2,500
Proposed FY 2022-23 Budget	$6,158,531	FY 2022-23	2,500

Proportion to be Served by Demographic Characteristic

Age Group %	%	Gender	%	Race/Ethnicity	%
0-15		Female	53	African American/Black	4
16-25	6	Male	47	American Indian/Alaskan Native	1
26-64	83	Transgender		Asian/Pacific Islander	13
65+	11	Genderqueer		Caucasian/White	32
		Questioning/Unsure		Latino/Hispanic	42
		Other		Middle Eastern/North African	1
				Other	7

Target Population and Program Characteristics

The **Outpatient Recovery** program is designed for adults ages 18 and older who are living with a serious mental illness and possible co-occurring substance use disorder. The program is operated at multiple locations throughout the county, with County-contracted locations referred to as Recovery Centers and County-operated locations referred to as Recovery Clinics. Individuals are referred to the program by Plan Coordinators in the Adult and Older Adult Behavioral Health (AOABH) Outpatient Clinics after all emergent mental health issues have resolved. This typically occurs within the first 3 to 6 months of being opened in an AOABH clinic. Individuals are referred to the contracted Recovery Centers after they have been in the AOABH outpatient system of care for one year and have remained out of the hospital or jail, are stable on their medication regimen and have consistently attended their appointments.

Services

The Recovery Clinics/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.

Outcomes

The Outpatient Recovery program monitors performance by whether the program met or exceeded the following targets:

- Psychiatric hospitalization rate of less than 1% while participants are enrolled in Outpatient Recovery services
- Discharging at least 60% of those with known discharge dispositions (i.e., not discharged as missing in action, MIA) into a lower level of care

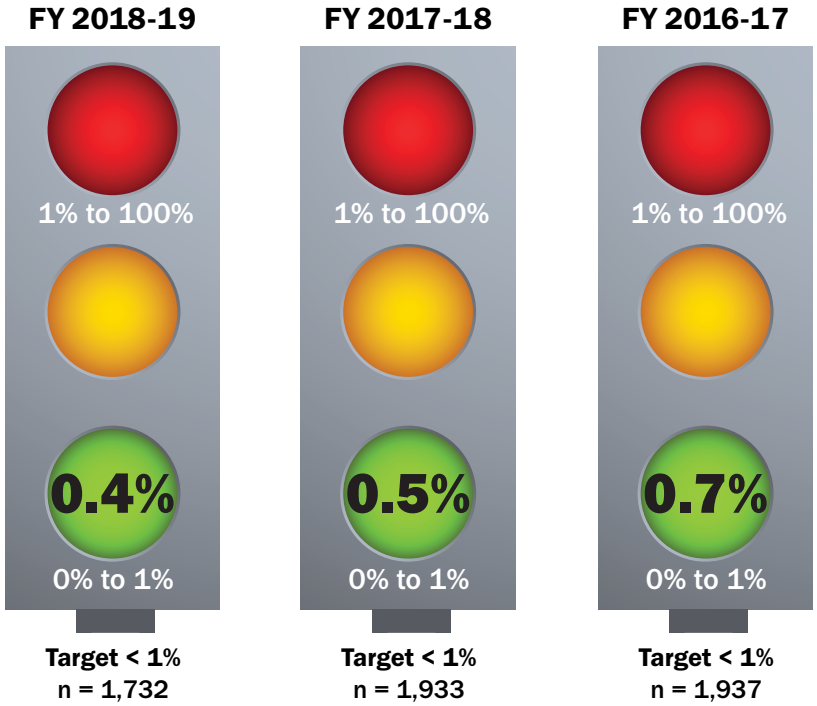
The program has met these goals across sites and fiscal years, with the exception of the number of discharges to lower level of care in FY 2016-17.

Outpatient Recovery	FY 2016-17	FY 2017-18	FY 2018-19
	People Served	People Served	People Served
Recovery Centers	1,937	1,933	1,732
Recovery Clinics	209 *	589	498

** First year of operation (partial year)*

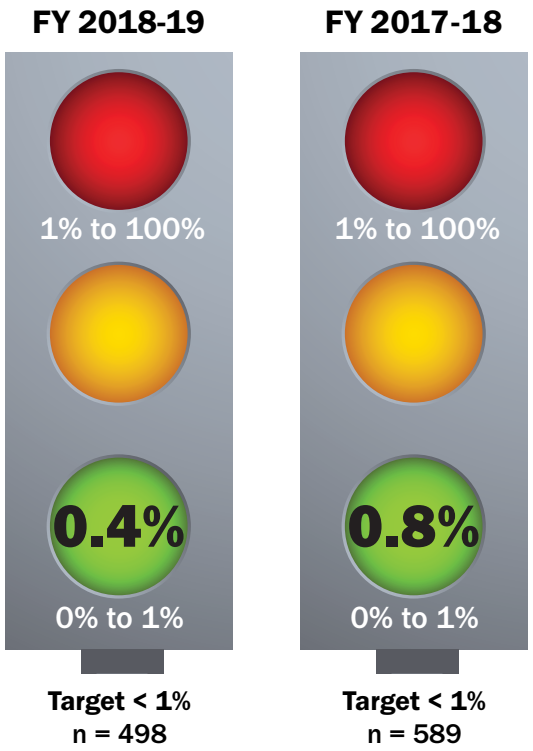
Hospitalization Rate - During Enrollment

County-Contracted Recovery Center



Hospitalization Rate - During Enrollment

County-Operated Recovery Clinic



Challenges, Barriers and Solutions in Progress

After reviewing program data, the HCA modified how it calculated the rate of discharge to a lower level of care by removing from the calculation participants who dropped out of treatment for unidentified reasons (i.e., n=55 at Recovery Centers and 15 at Recovery Clinics in FY 2018-19). Because these participants have left unexpectedly, a level of care determination cannot be made. In FY 2019-20, the HCA began tracking the progress a participant was making towards their goals (i.e., satisfactory, unsatisfactory), and goal progress at the time a participant leaves treatment for unknown reasons will be reported in future Plan Updates.

Nevertheless, the program recognizes that individuals can struggle with staying engaged in services when they experience changes in their treatment team or uncertainty over graduating from the program. Therefore, the program has taken steps to minimize premature discontinuation of services, such as providing peer support, planning social activities to help create a home-away-from-home environment for participants, offering to attend the first appointment with the new provider prior to discharge, and linking participants 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. This helps to encourage participants and allay concerns associated with obtaining treatment in the community and leaving the program where they have become comfortable.

Due to challenges with receiving appropriate referrals, the HCA has diligently worked on collaborating with referral sources and providing them with education on when in the individual's recovery journey it is most appropriate to refer clients to the program. In addition, the HCA has increased peer support provided in this program and hired 17 peers whose main focus is to assist individuals with transitions to different levels of care.

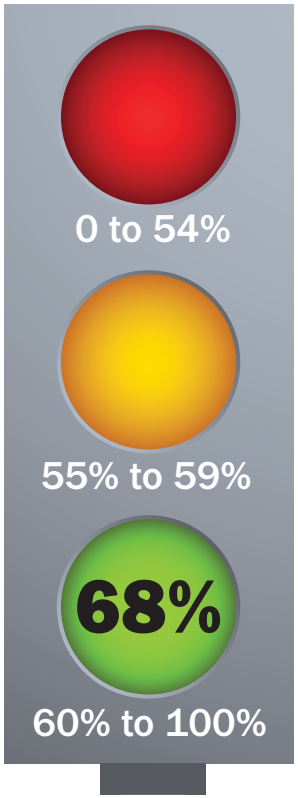
Community Impact

The needs of the individuals accessing the Recovery Centers and Clinics 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, 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.

Discharge Rates to Lower Level of Care

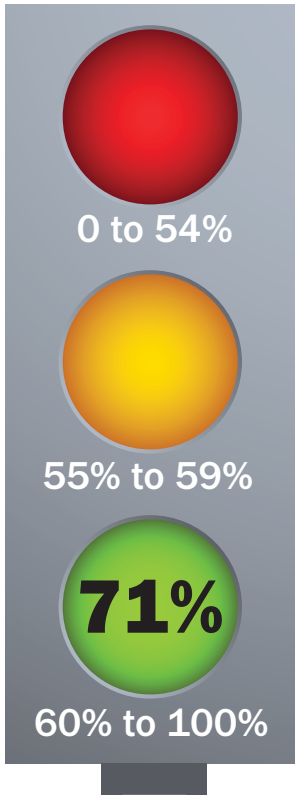
County-Contracted Recovery Center

FY 2018-19



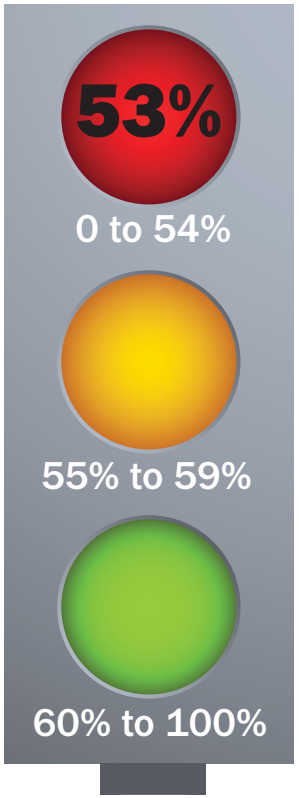
Target > 60%
n = 1,732

FY 2017-18



Target > 60%
n = 1,933

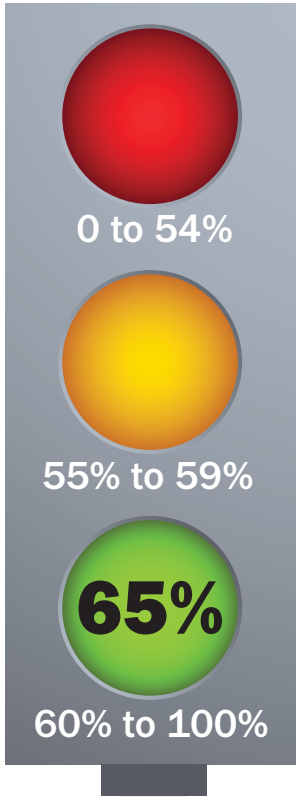
FY 2016-17



Target > 60%
n = 1,937

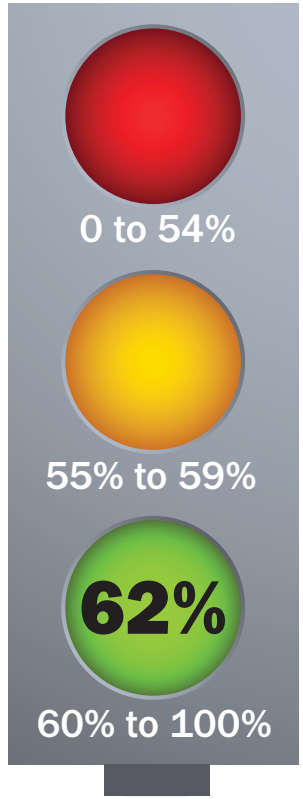
County-Operated Recovery Clinic

FY 2018-19



Target > 60%
n = 498

FY 2017-18



Target > 60%
n = 589

Integrated Community Services (CSS)

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics		
18+	Severe	Outpatient Clinic	Co-Occuring (SUD)	Co-Occuring (Medical)	Mono-Lingual/ Ethnic Communication

Language Capacity of Direct Service Providers					
✓	Spanish		Arabic		Khmer
✓	Vietnamese		Farsi		Other:
✓	Korean		Mandarin	✓	Language Line as Needed

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$1,648,000	FY 2019-20	600
Proposed FY 2020-21 Budget	$1,197,000	FY 2020-21	600
Proposed FY 2021-22 Budget	$1,197,000	FY 2021-22	600
Proposed FY 2022-23 Budget	$1,197,000	FY 2022-23	600

Proportion to be Served by Demographic Characteristic

Age Group %	%	Gender	%	Race/Ethnicity	%
0-15		Female	46	African American/Black	5
16-25	7	Male	53	American Indian/Alaskan Native	2
26-64	82	Transgender	1	Asian/Pacific Islander	19
65+	11	Genderqueer		Caucasian/White	43
		Questioning/Unsure		Latino/Hispanic	26
		Other		Middle Eastern/North African	1
				Other	4

Target Population and Program Characteristics

Integrated Community Services (ICS) serves individuals ages 18 and older who live with chronic primary medical care and mild to severe 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 ICS County Home side, primary care physicians (PCPs), Nurse Practitioners (NPs), registered nurses (RNs), and medical care coordinators are co-located in County behavioral health clinics. On the ICS Community Home 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 health care model that bridges the gaps in service for the underserved low-income community. The program serves adults who are Medi-Cal 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, NPs 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, crisis assessment and intervention and utilize evidence-based and best practices such as Motivational Interviewing, Seeking Safety and Cognitive Behavioral Therapy.

Peer Specialists 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. ICS community Home also participates in community outreach events to educate this hard to reach population about the services at ICS.

Outcomes

ICS monitored both mental health symptoms (i.e., depression as measured by the PHQ-9, anxiety as measured by the GAD7) and physical health markers (i.e., blood pressure) to assess program impact.

Over the past two years, adults with elevated depression and/or anxiety at baseline (i.e., scores > 10), experienced large reductions in their symptoms at follow-up.

		FY 2016-17	FY 2017-18	FY 2018-19
Integrated Community Services	Total Served	467*	500	468
	Baseline + 1 Follow-up PHQ-9 Completed	140	66	94
	Baseline PHQ-9 Above Clinical Cutoff (>10)	105	45	63
	Baseline + 1 Follow-up GAD7 Completed	137	62	93
	Baseline GAD7 Above Clinical Cutoff (>10)	83	40	47
	Baseline Blood Pressure > 140/90	88	67	52

** The time frame for FY 2016-17 was extended to capture all participants served in ICS when the program transitioned from INN to CSS in February 2016.*

In addition, adults who met criteria for hypertension at baseline (i.e., ≥ 140/90) demonstrated large decreases in their systolic and diastolic blood pressure during FY 2018-19, which is an improvement from the small to moderate decreases observed in previous years.

ICS has diligently worked this past year to standardize procedures, processes and guidelines that resulted in increased staff retention and collaboration with the HCA, which may have contributed to these improved outcomes.

Impact on Severe Mood Symptoms by FY

Integrated Community Services

Impact on Impact on Blood Pressure for Participants Who Were Initially Hypertensive (BP≥140/90)

Integrated Community Services

Challenges, Barriers and Solutions in Progress

In the first quarter of FY 2019-20, the contracted provider serving the Korean community decided to terminate services. From December 2019, the HCA and program provider began working on a timeline that would allow a smooth transition for clients, and the contract will terminate on June 30, 2020. In March 2020, a new solicitation for ICS services was released and the HCA anticipates having a new provider of services in early in FY 2020-21.

Community Impact

The program has provided services to more than 2,100 adults since its inception as an Innovation project in September 2011. ICS has helped improve participants' 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

PHQ-9:

FY 2018-19: Prior M=17.5, SD=5.0; Since M=12.2, SD=7.2; t (62) = 6.08, p<.001, Cohen's d=0.79

FY 2017-18: Prior M=19.6, SD=5.04; Since M=13.3, SD=7.67; t (44) = 6.22, p<.001, Cohen's d=0.98

FY 2016-17: Prior M=18.0, SD=5.0; Since M=13.0, SD=6.9; t (104) = 7.23, p<.001, Cohen's d=0.59

GAD-7:

FY 2018-19: Prior M=16.0, SD=3.5; Since M=11.7, SD=5.8; t (46) = 5.10, p<.001, Cohen's d=0.79

FY 2017-18: Prior M=16.7, SD=3.6; Since M=12.1, SD=6.1; t (39) = 5.27, p<.001, Cohen's d=0.90

FY 2016-17: Prior M=16.0, SD=3.5; Since M=11.9, SD=6.3; t (82) = 6.61, p<.001, Cohen's d=0.60

Systolic Blood Pressure:

FY 2018-19: Prior M=151.3, SD=14.3; Since M=135.4, SD=17.2; t (51) = 6.11, p<.001, Cohen's d=0.86

FY 2017-18: Prior M=151.4, SD=15.7; Since M=136.0, SD=24.9; t (66) = 4.30, p<.001, Cohen's d=0.54

FY 2016-17: Prior M=150.6, SD=18.4; Since M=136.4, SD=23.9; t (87) = 4.87, p<.001, Cohen's d=0.47

Diastolic Blood Pressure:

FY 2018-19: Prior M=91.4, SD=9.3; Since M=83.5, SD=10.5; t (51) = 5.39, p=<.001, Cohen's d=0.75

FY 2017-18: Prior M=91.3, SD=9.2; Since M=85.0, SD=15.6; t (66) = 3.00, p<.01, Cohen's d=0.38

FY 2016-17: Prior M=93.5, SD=8.9; Since M=84.5, SD=14.5; t (87) = 5.29, p<.001, Cohen's d=0.54

Older Adult Services (CSS)

Program Serves	Symptom Severity	Location of Services		Population Characterisitics
60+	Severe	Field	Community Based	AOT/ Laura's Law

Language Capacity of Direct Service Providers					
✓	Spanish	✓	Arabic		Khmer
✓	Vietnamese	✓	Farsi		Other:
✓	Korean	✓	Mandarin	✓	Language Line as Needed

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$1,668,135	FY 2019-20	530
Proposed FY 2020-21 Budget	$2,168,135	FY 2020-21	530
Proposed FY 2021-22 Budget	$2,168,135	FY 2021-22	530
Proposed FY 2022-23 Budget	$2,168,135	FY 2022-23	530

Proportion to be Served by Demographic Characteristic					
Age Group	**%**	**Gender**	**%**	**Race/Ethnicity**	**%**
0-15		Female	40	African American/Black	4
16-25		Male	59	American Indian/Alaskan Native	1
26-64	1	Transgender		Asian/Pacific Islander	17
65+	99	Genderqueer		Caucasian/White	38
		Questioning/Unsure		Latino/Hispanic	12
		Other	1	Middle Eastern/North African	1
				Other	27

Target Population and Program Characteristics

Older Adult Services (OAS) serves individuals ages 60 years and older who are living with serious and persistent mental illness (SPMI), experience multiple functional impairments and may also have a co-occurring substance use disorder. 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. OAS accepts referrals from all sources.

Services

OAS provides case management, referral and linkages to various community resources, vocational and educational support, substance use services, nursing services, crisis intervention, medication monitoring, therapy services (individual, group, and family), and psychoeducation for participants, family members and caregivers. Evidence-based practices such as Cognitive Behavioral Therapy, Motivational Interviewing, Eye Movement Desensitization and Reprocessing (EMDR), Dialectical Behavioral Therapy (DBT), problem solving therapy, solution focused therapy, harm reduction, Seeking Safety and trauma-informed care.

Outcomes

		FY 2016-17	FY 2017-18	FY 2018-19
Older Adult Services	Total Served	398	443	430
	New Admissions	*263*	*298*	*296*

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 adults recently served, 21%, had a nursing assessment completed in FY 2017-18 and 26% had an assessments completed in FY 2018-19. In contrast, approximately half (49%) had a nursing assessment completed in FY 2016-17. This reduction is partly due to an increase in client no-shows after the office had to be evacuated in early April 2018 due to a leak in the roof. As a result, staff had been spread out over multiple offices, which affected program operations and service delivery. The program moved to a new location in March 2019 and it is anticipated that an increase in nursing assessments will occur.

Challenges, Barriers and Solutions in Progress

OAS continues to encounter 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 has continued meeting to identify metrics appropriate for the target population being served. Future Plan Updates will report these outcomes once implemented.

With the move to a new location, OAS staff can now offer EBP (Emergency Base Practice) groups and education for client and family members in a clubhouse atmosphere.

Community Impact

Older Adult Services collaborates with the Public Health Services Senior Health Outreach and Prevention Program (SHOPP), Council on Aging (Health Insurance Counseling and Advocacy Program, Friendly Visitor), Social Services Agency (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 collaboratively 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 the HCA Public Health nurses to ensure that participants' mental and physical health needs are addressed. Finally, the OAS pharmacist conducts many educational events for both participants and professionals on issues relevant to older adults such as medication management, health- and mental health-related matters and community services.

Summary of MHSA Strategies Used by Clinic Expansion: Adult and Older Adult Programs

Strategies to Promote Recovery/Resilience

These programs provide adults and older adults with self-directed services that focus on reintegrating them into their communities, linking them to health care, maintaining independence and decreasing isolation. Services are delivered in an individualized, person-centered approach that is tailored to each persons' unique stage of recovery as well as their physical and/or mobility needs.

Strategies to Reduce Stigma and Discrimination

Clinic expansion programs for adults and older adults engage in culturally responsive strategies to reduce mental-health related stigma and discrimination. For example, 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 works to reduce stigma by educating participants and their family members about mental illness as a brain disease and beginning engagement into services by focusing on somatic symptoms. In addition, older adults may hesitate to access OAS due to stigma related to being an older adult. 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.

Strategies to Increase Access to Services: Timely Access for Underserved Populations and Linkage to Treatment

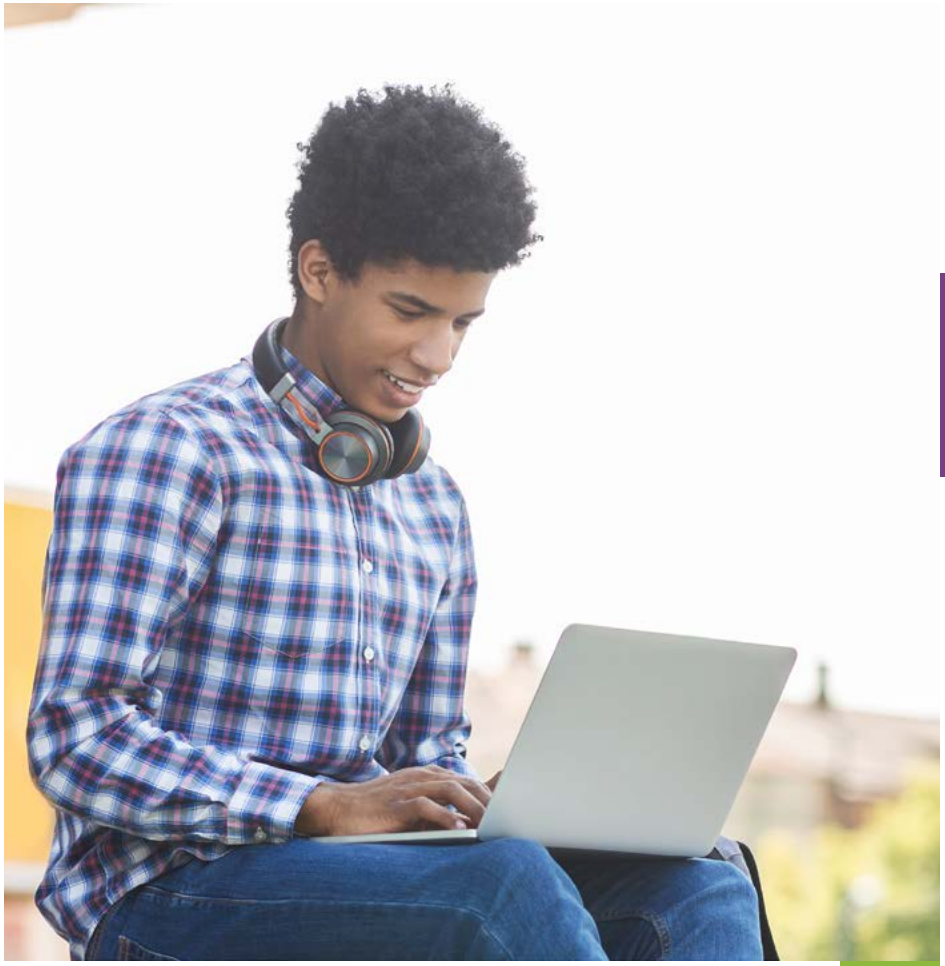
Transportation is a challenge for many participants, and these programs work to overcome this barrier by co-locating their services, teaching participants how to use public transportation, providing bus passes and offering field-based services. The programs also provides services in many languages through staff who are bicultural/bilingual, and a language line translation service is 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. Finally, for older adults hesitant to enroll in OAS, staff from another program (OAS SHOPP) is dedicated to conducting outreach and engagement with referred individuals to OAS and recognize that it may require several friendly home visits before an older adult engages in OAS services.

Telehealth/Virtual Behavioral Health Care (CSS)

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	-	FY 2019-20	-
Proposed FY 2020-21 Budget	$2,500,000	FY 2020-21	3,000
Proposed FY 2021-22 Budget	$3,000.000	FY 2021-22	3,000
Proposed FY 2022-23 Budget	$3,000,000	FY 2022-23	3,000

Target Population and Program Characteristics

The **Telehealth/Virtual Behavioral Health Care** program is new to the Three-Year Plan and will support telehealth and/or virtual behavioral health care options for individuals ages 13 years and older who are living with serious emotional disturbance or serious mental illness. It may also offer support for parents and caregivers of children of all ages.



Services

Through one or more applications and/or telehealth providers, this program will offer a range of tele-mental health care including, but not limited to, individual therapy, crisis intervention, telepsychiatry and/or peer support. Digital solutions that offer psychoeducation, navigation to needed resources, and training and coaching in relaxation skills, meditation, mindfulness, etc. may also be identified. This program may offer standalone services to individuals, or provide adjunctive supports to individuals engaged in face-to-face behavioral health services.

The services provided through this program will be evidence-supported or established practices. In contrast, the Help@Hand Innovation project will support 1) the identification, development and/or evaluation of new and/or emerging technologies, and 2) the identification and development of administrative processes necessary to create a 'digital mental health system of care' capable of responding to rapid changes in technology and/or its regulatory environment.

FULL SERVICE PARTNERSHIP (FSP)

FY 2020-21 to FY 2022-23 Program Budgets: Combined and by FSP Age Group					
Budget by FY	**COMBINED ***	**Children**	**TAY**	**Adult**	**Older Adult**
Actual FY 2019-20 Budget	$53,530,226	$11,054,575	$8,184,468	$21,592,093	$2,683,249
Proposed FY 2020-21 Budget	$53,766,876	$11,054,575	$8,184,468	$21,592,093	$3,219,899
Proposed FY 2021-22 Budget	$53,766,876	$11,054,575	$8,184,468	$21,592,093	$3,219,899
Proposed FY 2022-23 Budget	$53,766,876	$11,054,575	$8,184,468	$21,592,093	$3,219,899

** Combined budget amount includes administrative fees, which are not included in budgets for each age groups*

FY 2020-21 to FY 2022-23 Projected Unduplicated to be Served: Combined and by FSP Age Group					
	COMBINED	**Children**	**TAY**	**Adult ****	**Older Adult**
FY 2019-20	3,676	410	1,020	2,052	194
FY 2020-21	3,521	430	1,070	1,825	196
FY 2021-22	3,591	440	1,120	1,835	196
FY 2022-23	3,661	450	1,170	1,845	196

*** Includes numbers to be served by AOT Assessment and Linkage Team, which also serves TAY and older adults*

Proportion to be Served by Demographic Characteristic: Combined and by FSP Age Group							
Age Group	**% COMBINED**	**Gender**	**% COMBINED**	**% Children**	**% TAY**	**% Adult**	**% Older Adult**
0-15	13	Female	41	42	43	38	47
16-25	35	Male	58	56	53	62	53
26-59	43	Transgender	1	2	4		
60+	9	Genderqueer					
		Questioning/Unsure					
		Other					

*** Includes numbers to be served by AOT Assessment and Linkage Team, which also serves TAY and older adults*

Proportion to be Served by Demographic Characteristic: Combined and by FSP Age Group					
Race/Ethnicity	**% COMBINED**	**% Children**	**% TAY**	**% Adult**	**% Older Adult**
African American/Black	7	5	5	9	9
American Indian/Alaskan Native	1	1	1	1	1
Asian/Pacific Islander	11	19	11	9	6
Caucasian/White	38	13	22	52	64
Latino/Hispanic	38	59	56	23	13
Middle Eastern/North African	1	1	1	1	1
Other	4	2	4	5	6

Target Population and Program Characteristics

A **Full Service Partnership** (FSP) is designed to provide intensive, community-based outpatient services to a county's most vulnerable individuals, and the HCA has established eligibility criteria to ensure that the FSPs reach Orange County residents who are experiencing disparities in access to behavioral health care. Thus, the target population includes individuals of all ages who are living with a SED or SMI; unserved or underserved; and are homeless, at risk of homelessness, involved in the criminal justice system, frequent users of inpatient psychiatric treatment, culturally or linguistically isolated, and/or have complex medical needs.

Orange County currently has four distinct FSP programs organized by the MHSA-defined age groups (i.e., Children's FSP, TAY FSP, Adult FSP, Older Adult FSP). In addition to tailoring services and supports to the members' age and developmental stage, three of the FSP programs (i.e., Children's, TAY, Adult) offer additional tracks for individuals with more specialized needs. Due to their expertise, providers within these specialized tracks often serve individuals across multiple age groups. The most common age groups spanned are Children/TAY and Adult/Older Adult, although there are some exceptions (see tables below). The HCA contracts out all FSP services, with the exception of the County-operated Assisted Outpatient Treatment (AOT) Assessment and Linkage Team. Consistent with the MHSA, all FSP services – even those affiliated with the Courts and Probation – are voluntary.

Children and TAY (CSS)

Program Serves		Symptom Severity	Location of Services		Typical Population Characteristics								
0-18	16-25												
Children	TAY	Severe	Field	Community Based	Foster Youth	Criminal Justice	Parents	Families	Homeless/ At risk	Co-Occuring (SUD)	Co-Occuring (Medical)	Trauma- Exposed Clients	Mono-Lingual/ Ethnic Community

Language Capacity of Children & TAY Direct Service Providers					
✓	Spanish		Arabic	✓	Khmer
✓	Vietnamese	✓	Farsi		Other:
✓	Korean	✓	Mandarin	✓	Language Line as Needed

Children's FSP Program *and* TAY FSP Program

Track	Identified Unserved/Underserved Target Population	Children 0-15	% TAY 16 -17	% TAY 18 -25	Adults 26-59	Older Adults 60+
Project RENEW *Referrals from:*	Children/youth (mostly 12-15 years) and their parents/caregivers. County and County-contracted outpatient clinics, primary care physicians, emergency departments, SSA, inpatient units, schools, Children's CAT	■	▒			
STAY Process *Referrals from:*	TAY who have minimal family involvement. County and County-contracted outpatient clinics, primary care physicians, emergency departments, SSA, inpatient units, schools, CYBH CAT, AOT		■	■		
CCFSP *Referrals from:*	Court-referred youth and their parents/caregivers. Juvenile Court (Recovery, Girls, Boys, Grace); Truancy Response Program	■	■	■		
YOW *Referrals from:*	Criminal-Justice Involved youth and their parents/caregivers. Probation Department, Clinical Evaluation Guidance Unit (CEGU), hospitals, jails, courts, AOT	■	■	■		
Project HEALTH *Referrals from:*	Youth with significant/chronic physical illness and their families. Hospitals, physicians, specialty medical clinics, County and County-contracted clinics	■	■	■		
Project FOCUS *Referrals from:*	Culturally/linguistically-isolated Asian/Pacific Islander youth/families. County and County-contracted outpatient clinics, primary care physicians, emergency departments, SSA, inpatient units, schools, CYBH CAT	■	■	■	*See note	

* *Beginning in FY 2017-18, the provider continued offering services to TAY who aged out of the program when they turned 26 because there is currently no similar specialized FSP for adults.*

■ Primary/Predominant age group(s) served ▒ Secondary/Potential age group(s) served

Adult (CSS)

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics				
18 +	Severe	Field	Community Based	Homeless/At risk	Co-Occuring (SUD)	Adult/Criminal Justice	Difficult to Engage	Returning from Long Term Care

Language Capacity of Adult Direct Service Providers					
✓	Spanish		Arabic	✓	Khmer
✓	Vietnamese	✓	Farsi		Other:
✓	Korean	✓	Mandarin	✓	Language Line as Needed

Adult FSP Program						
Track	Identified Unserved/Underserved Target Population	Children 0-15	% TAY 16 -17	% TAY 18 -25	Adults 26-59	Older Adults 60+
TAO *Referrals from:*	FSP-eligible adults who are homeless or at risk of homelessness. Jails, probation, general community					
STEPS *Referrals from:*	LPS conservatorship, returning from long-term care, court-involved. Long-term care facilities, Collaborative Courts, general community					
AOT *Referrals from:*	Voluntarily agreed/court-ordered to participate in AOT FSP. AOT Assessment and Linkage Team (see Appendix VIII for details)					
Opportunity Knocks *Referrals from:*	Criminal-Justice Involved or high risk of criminal justice recidivism. Jails, probation, general community					
WIT *Referrals from:*	Court-Involved. Collaborative Courts					
Housing: (RFP) *Referrals from:*	FSP-eligible adults at risk of losing permanent housing. County outpatient clinics and programs, private providers, property managers, general community					

Primary/Predominant age group(s) served

Secondary/Potential age group(s) served

Older Adult (CSS)

Program Serves	Symptom Severity	Location of Services	
			
	Severe	Field	Community Based

Adult FSP Program						
Track	Identified Unserved/Underserved Target Population	Children 0-15	% TAY		Adults 26-59	Older Adults 60+
			16 -17	18 -25		
OASIS *Referrals from:*	FSP-eligible older adults (also tend to have health/mobility issues). Hospitals, Adult Protective Services, outpatient clinics, senior centers, jail, OC Links, family members, CAT, general community					

Primary/Predominant age group(s) served

Secondary/Potential age group(s) served

FSP Services

The FSP programs 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. They 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, Youth Mentors, Parent Partners, Housing Coordinators, Employment Coordinators, Clinical Dietitians, 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 FSP provides 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, Parent Child Interaction Therapy (PCIT), Seeking Safety, Illness Management and Recovery, Moral Reconation Therapy (MRT), Program to Encourage Active Rewarding Lives for Seniors (PEARLS), behavioral modification and others. Individuals enrolled in an FSP program 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, the Adult FSP program has certified substance use counselors who provide individual coaching, substance use education and groups such as Relapse Prevention and Co-Occurring Education. One provider (Telecare WIT) also developed "Co-Occurring Program Extension (COPE)" which provides intensive outpatient services and support to participants with co-occurring substance use disorders. Since its implementation, COPE has demonstrated success in helping participants manage their substance use and apply learned skills in a real-world environment. In addition, the adult providers that serve justice-involved individuals are working to have more staff trained in MRT and offer more MRT groups.

Pending Board of Supervisors approval, the Project RENEW provider identified to serve children will be expanded in FY 2020-21 to serve 20 additional children/youth placed in Intensive Services Foster Care (ISFC) homes. ISFC is a placement model of home-based family care for eligible children/youth whose needs for safety, permanency and well-being require specially trained resource parents and access to intensive supportive services. The provider will utilize the "whatever it takes" model of treatment to provide the necessary behavioral health services to support the child/youth and the foster family.

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 providers 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/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 and TAY FSP program providers' approach to service and care planning. In addition, the Adult FSP program has been working on increasing family inclusion at all levels of treatment and at social events, and several providers offer 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

Most of the adult providers 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 Reduce Stigma and Discrimination

FSP program staff recognizes 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 individuals' and their families' values and worldview. For example, some of the perspectives that the provider serving the Asian and Pacific Islander (API) population considers when providing services to 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. They also hire 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.

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 FSP providers 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. For example, the provider serving the API community promotes its 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, FSP providers across all programs 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 focuses on building therapeutic relationships in order to facilitate trust and encourage linkage to ongoing services.

In addition, providers strive to provide services in a linguistically and culturally competent manner to diverse, underserved populations in Orange County. When bilingual staff are not available, the staff has access to all languages through a contracted interpreter service provider that is available when needed. The programs also offer 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 providers 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 resources that promote self-sufficiency and encourage community.

Outcomes

The programs evaluated changes on outcomes related to mental health recovery, living situation, legal involvement, employment and/or school performance by comparing functioning in the 12 months prior to enrolling in the FSP to functioning during the fiscal year being evaluated. With the exception of school performance, all results were statistically analyzed and reported according to the calculated effect size, which reflects, in part, the extent to which a change in functioning over time is clinically meaningful for the individuals served in the FSP.

Numbers Served	FY 2016-17	FY 2017-18	FY 2018-19
Children's FSP	339	401	496
TAY FSP	759	768	838
Adult FSP	1,156	1,224	1,184
Older Adult FSP	223	205	189

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).

Across fiscal years, the FSPs generally made a small impact on decreasing the amount of time participants spent in a psychiatric hospital, with TAY, adult and older adult participants having spent, on average, about 4-5 weeks in the hospital during the year prior to enrolling in an FSP compared to about 1-2 weeks in the hospital after enrolling. Relative to the other FSP participants, children spent considerably less time in the hospital both prior to and after enrolling in an FSP (i.e., 1-1.5 weeks an average prior; 2-4 days an average after). Overall, this suggests that participants experienced somewhat less disruption in their daily lives by spending less time in the hospital while receiving FSP services. The HCA is exploring factors associated with hospitalization usage.

In addition, FSPs demonstrated medium to large decreases in the average number of mental health-related emergency interventions that participants experienced across each of the three fiscal years, further suggesting that they experienced recovery while receiving FSP services. This effect was particularly pronounced for older adults, with the average number of events essentially dropping to zero.

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 generally large reduction (moderate for TAY) in the average number of days spent homeless during each of the past three FYs. Improvements were most pronounced for adult and older adults, who typically experienced greater homelessness prior to FSP enrollment. Unsheltered homelessness was defined as a residence not intended for human habitation, such as a car, abandoned building, the street, etc.

The impact of FSPs on reducing days spent in emergency shelter varied across age group and fiscal year. Children, TAY and adults generally experienced small to moderate decreases while enrolled in the FSP over the past three FYs. Efforts to relocate a large number of homeless adults living in the Flood Control Channel and Santa Ana Civic Center area during FYs 2017-18 and 2018-19 likely contributed to the reduced impact on this outcome as the TAO Central FSP provider worked to place adults living in these areas in emergency

shelters temporarily. In support of this speculation, when homeless adults served by this provider are removed from the analysis, the remaining adults experienced moderate reductions (0.48) in emergency shelter use during FY 2018-19, which is consistent with findings from FY 2016-17. In contrast, older adults FSP demonstrated the opposite pattern (i.e., shifting from a moderate impact in FY 2016-17 to a large impact in the past two FYs), which may be attributable to a few participants who had very long emergency shelter motel stays while receiving services in FY 2016-17 before transitioning to permanent living placements in FY 2017-18. Thus, unique factors/activities across the past three FYs may account for the fluctuating impact on emergency shelter use rather than true changes in the FSPs' ability to improve this outcome.

While TAY and adults experienced a small increase in the average number of days spent living independently across FYs, older adults demonstrated moderate to large increases. Thus, the Older Adult FSP appears to be relatively effective at helping support independent living, which is defined as living in an apartment or single room occupancy as opposed to any type of supervised residential placement. These improvements appear to be the result of changes implemented in FY 2017-18 when the increased impact was first observed. During this time the provider implemented a more collaborative, structured approach where the treatment team collectively discussed and problem-solved ways to engage members who were at high risk of hospitalization and/or incarceration. In addition to weekly contact with personal service coordinators, teams increased contact with the older adult by including visits with life coaches, therapists or housing coordinators or members of the medical team. In addition, staff has worked diligently to increase the number of groups offered, and created new and more interesting group topics and events based on client interests and needs. As result, the program has seen a significant increase in group participation over the past fiscal years. These improvements are thought to have positively impacted overall functioning and not just independent living, as evidenced by improvements across all outcomes during the past two FYs relative to FY 2016-17.

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. It should be noted that a very small number of children are affected by an out-of-home placement either prior to enrolling

Impact on Psychiatric Hospitalization Days by FY

in the FSP or during the fiscal year being evaluated (i.e., n= 20 in FY 2016-17, n= 14 in FY 2017-18, n= 17 in FY 2018-19). Thus, it is difficult to draw firm conclusions on the overall efficacy of FSPs in reducing out-of-home placements for children, although the average number of days children were placed out-of-the-home did decrease during all three fiscal years when compared to the year prior to their enrollment in the FSP.

Legal Involvement: Outcomes related to decreasing individuals' involvement with the legal system were tracked using two measures: number of arrests and days incarcerated in jail or prison. Participants of all ages generally experienced large to very large decreases in arrests during all fiscal years compared to the year prior to FSP enrollment, with the exception of moderate to large reductions experienced by children and TAY in FY 2018-19.

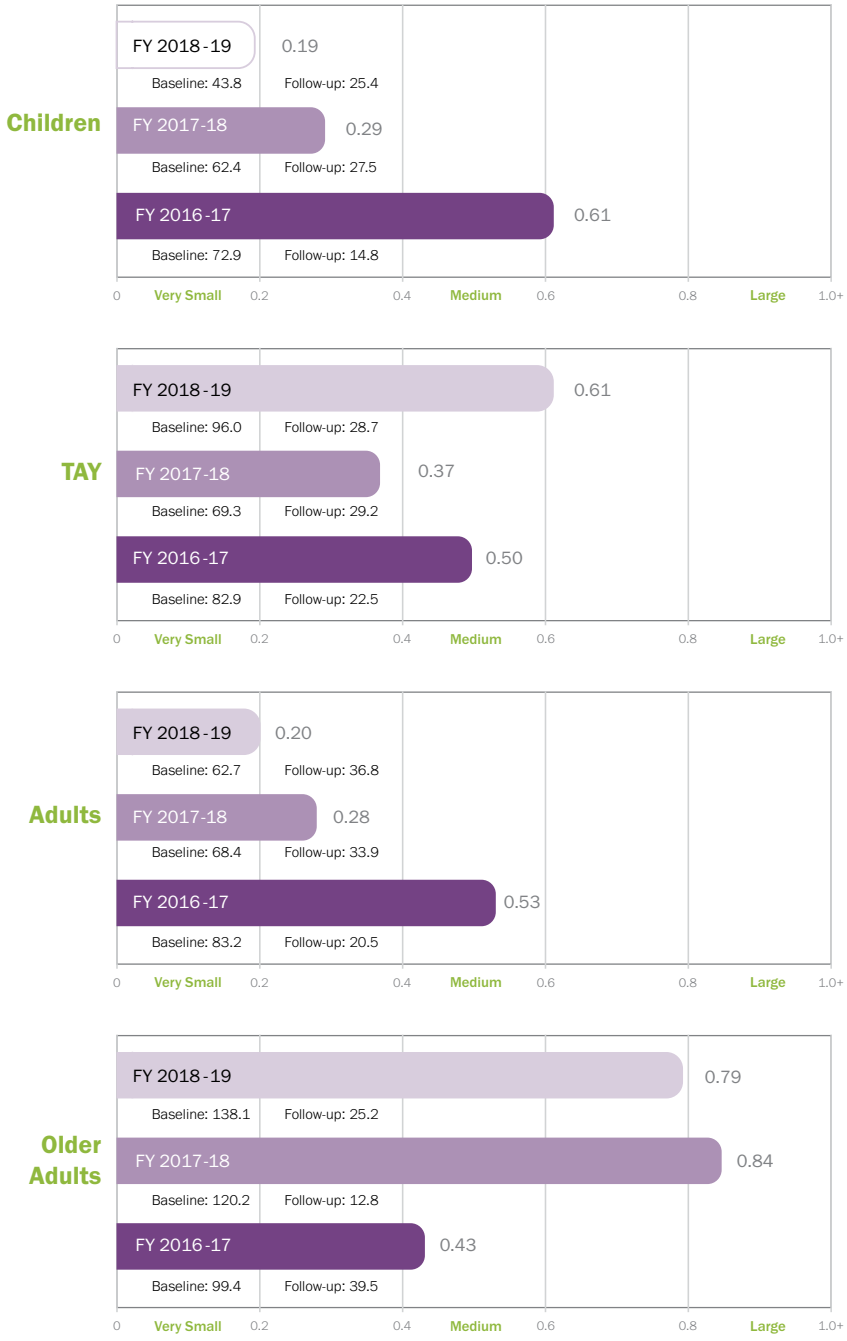
There was variability across age groups and fiscal years with regard to the impact on the number of days individuals have been incarcerated. Adults showed consistently large decreases in days incarcerated across all three fiscal years, and older adults tended to show moderate decreases. In FY 2018-19, TAY dropped to a moderate decrease in days incarcerated from a historical trend of large decreases. Over the past three FYs, children have shown a steady increase in "improved" incarceration outcomes, although these higher rates of reductions are also accompanied by a steadily increasing number of children who have been incarcerated either prior to or while enrolled in an FSP. The HCA is currently exploring possible underlying reasons for these shifts in incarceration patterns among TAY and children.

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. Compared to the year prior to FSP enrollment, the FSPs had no impact in FY 2016-17 and a small impact in FYs 2017-18 and 2018-19 on employment for adults and TAY who were at least 16 years old at the

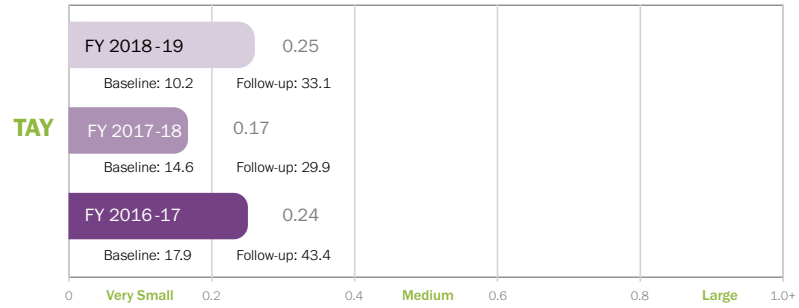
Impact on Mental Health Emergency Intervention by FY

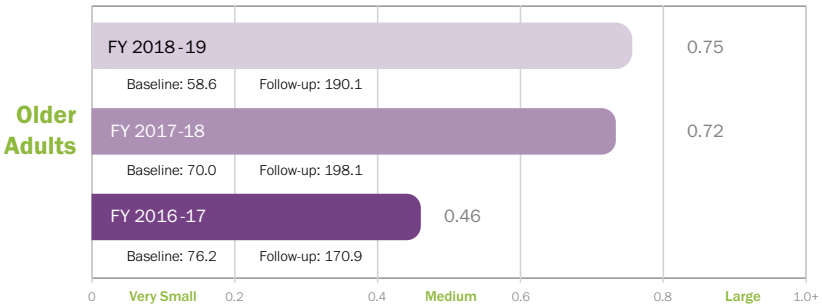
Impact on Unsheltered Homeless Days by FY

Impact on Emergency Shelter Days by FY

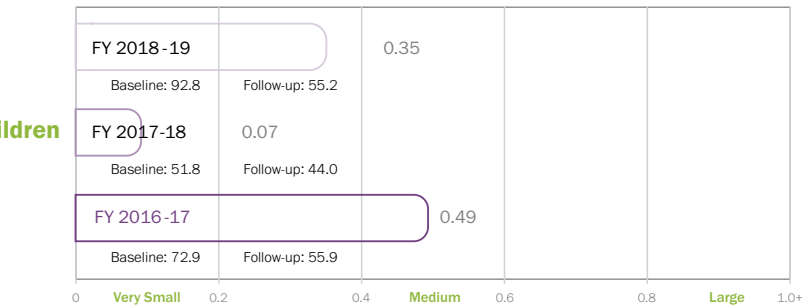


Impact on Independent Living Days by FY

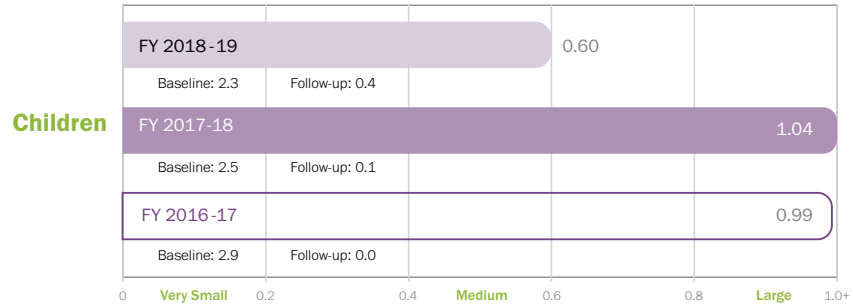


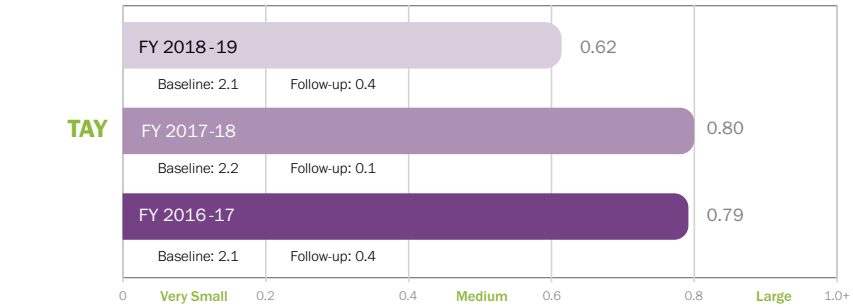


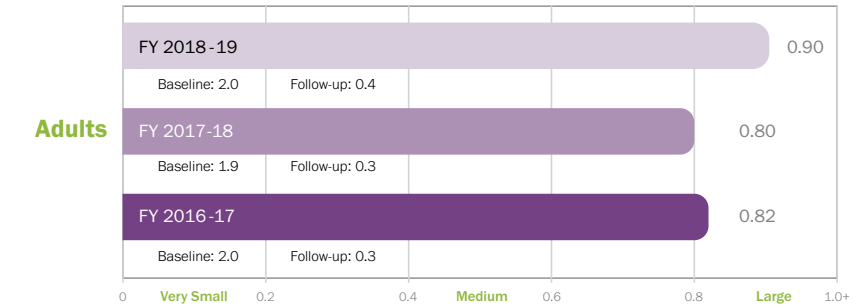
Impact on Out-of-Home Placements by FY

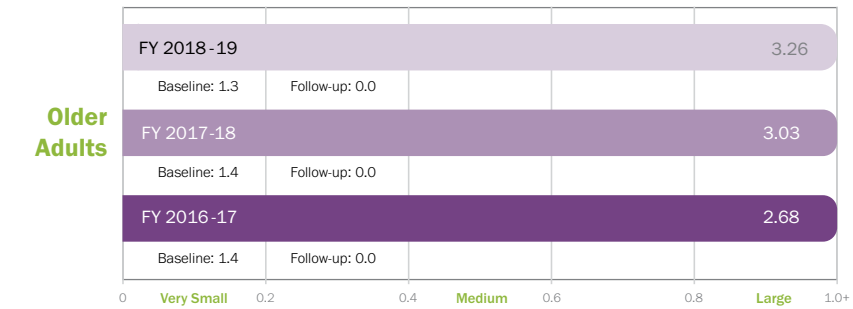


Impact on Arrests by FY



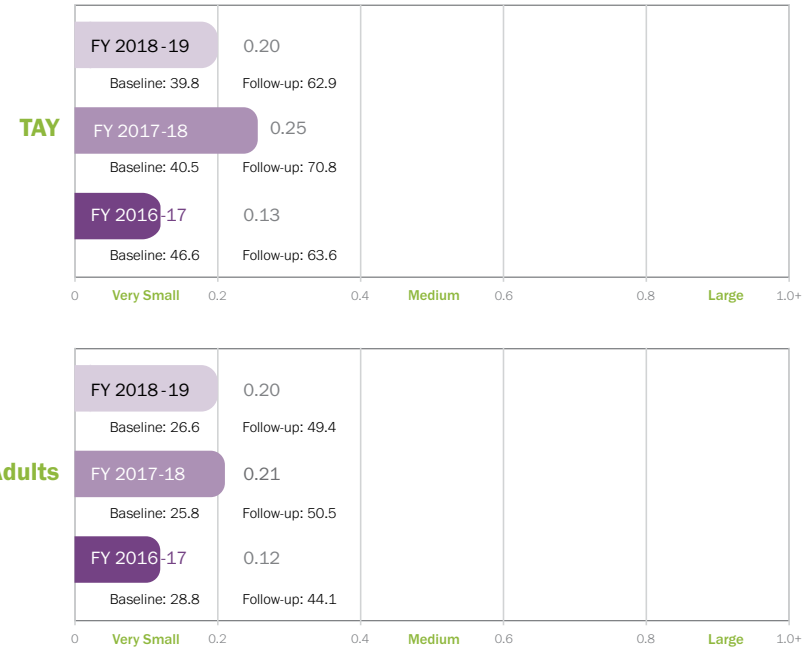






Impact on Incarceration Days by FY

Impact on Employment Days by FY



start of the fiscal year (and therefore eligible to work the duration of the reporting period). Thus, increasing employment activity in a meaningful way continues to be a particularly challenging area for the FSPs.

School Performance: The Children's FSPs examined the proportion of children who (1) maintained good/very good school attendance or grades and/or who (2) improved their attendance or grades while enrolled in the FSP. Although the majority of children reported good/improved attendance across both fiscal years, the proportion reporting good/improved grades fell from 89% in FY 2016-17 to 52% in FY 2017-18. Thus, while the findings generally suggest that the FSPs are successful in maintaining or improving school performance among the children served, the HCA will continue monitor the FSPs' impact on grades to determine whether or not the FY 2017-18 results are an anomaly.

Challenges, Barriers and Solutions in Progress

Finding safe, affordable and permanent housing in the neighborhoods 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 maintain housing independently. This strategy creates stability so that clinical advances can be maintained upon discharge from the program. The HCA is also in the process of creating an FSP track that will assist individuals and families who are living in permanent housing but struggling to maintain their housing and are at risk of becoming homeless. To address the shortage of permanent supportive housing, the HCA along with the support of the Orange County Board of Supervisors, is continuing to identify and fund new housing development opportunities. In addition, the HCA has partnered with Orange County Community Resources, housing developers and other community partners to apply for federal and state housing funding, including No Place Like Home.

Employment has also continued to be an on-going and significant challenge despite the recovering job market. FSP programs 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 a critical component of recovery by helping increase peoples' 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 programs 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. Over the past year, the Adult FSP program has worked to secure additional community opportunities and created internal opportunities for volunteer work. Nevertheless, more than any other target outcome, the program continues to struggle with supporting individuals in sustaining employment in a consequential way. Over the next year, FSP program staff will review

School Performance by FY

Children/Youth FSP - FY 2018-19

Attendance	Grades
86%	60%
Good, Very Good, Improved	Good, Very Good, Improved

Children/Youth FSP - FY 2017-18

Attendance	Grades
82%	52%
Good, Very Good, Improved	Good, Very Good, Improved

Children/Youth FSP - FY 2016-17

Attendance	Grades
78%	89%
Good, Very Good, Improved	Good, Very Good, Improved

referrals and linkages to employment services to see if opportunities exist to increase referrals and better support linkage to these services.

In addition, the Older Adult FSP program has noted that its participants do not always attend groups consistently. The provider has made an increased effort to recruit 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 FSP programs 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 works collaboratively with Housing and Supportive Services staff to help individuals with co-occurring issues maintain their housing.

Finally, the Adult FSP program provider for AOT-focused services actively continues 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

Since program inception dates, the FSPs have served more than 2,100 children (approximately 18%), nearly 4,000 TAY (approximately 35%), more than 4,600 adults (approximately 40%) and nearly 700 older adults (approximately 6%). The FSP programs 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 programs have increased their collaboration with community substance use programs, residential substance use treatment programs and/or detoxification centers. In addition, providers 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.

The FSP programs 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, recovery residences, Orange County Housing Authority, other housing providers, shelters, Family Resource Centers (FRCs), legal resources, food banks, vocational trade programs, LGBTIQ centers, Salvation Army, Goodwill, Wellness Centers, NAMI, immigration services, thrift shops, faith-based leaders, school districts, policymakers, 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

Psychiatric Hospitalization Days:

Children:

FY 2018-19: Prior M=9.9, SD= 11.6; Since M=3.8, SD 7.0; t(90)=4.0, p<.001, Cohen's d=0.43, -62%

FY 2017-18: Prior M= 7.7, SD= 6.7; Since M=3.8, SD= 8.9; t(75)=2.67, p<.01, Cohen's d=0.31, -51%

FY 2016-17: Prior M=10.8, SD=13.6; Since M=1.8, SD=4.6.1; t(70)=5.05, p<.001, Cohen's d=0.65,-83%

TAY:

FY 2018-19: Prior M=23.0, SD=42.1; Since M=6.7, SD=19.8; t(265)=-6.14, p<.001, Cohen's d=0.41, -71%
FY 2017-18: Prior M=28.6, SD= 52.1; Since M=8.6, SD=26.8; t(274)=5.59, p<.001, Cohen's d=0.35, -70%
FY 2016-17: Prior M=39.8, SD=76.6; Since M=14.8, SD=38.3; t (246)=-5.03, p<.001, Cohen's d=0.35, -63%

Adults:
FY 2018-19: Prior M=36.7, SD=65.1; Since M=13.2, SD=29.7; t (556)=8.08, p<.001, Cohen's d=0.37, -64%
FY 2017-18: Prior M=34.0, SD=59.7; Since M=14.4, SD=31.9; t(559)=6.92, p<.001, Cohen's d=0.31, -58%
FY 2016-17: Prior M=34.2, SD=64.3; Since M=13.1, SD=30.4; t(542)=6.78, p<0.001, Cohen's d=0.32, -62%

Older Adults:
FY 2018-19: Prior M=37.2, SD=70.4; Since M=7.6, SD=24.0; t(52)=3.53, p <.001, Cohen's d=0.65, -80%
FY 2017-18: Prior M=39.4, SD=76.1; Since M=5.0, SD=12.8; t(57)=3.41, p<.001, Cohen's d=0.55, 87%
FY 2016-17: Prior M=28.1, SD=59.7; Since M=11.7, SD=26.7; t(58)=1.84, p=0.07, Cohen's d=0.28, -58%

Mental Health Emergency Interventions:

Children:
FY 2018-19: Prior M=1.8, SD=1.7; Since M=0.3, SD=.78; t(241), p<.001, Cohen's d=0.89, -83%
FY 2017-18: Prior M=1.8, SD=1.9; Since M=0.5, SD=1.1; t(158)=7.61, p<.001, Cohen's d=0.62, -72%
FY 2016-17: Prior M=1.8, SD=2.6; Since M=0.4, SD=0.7; t(82)=4.57, p<.001, Cohen's d=0.55, -78%

TAY:
FY 2018-19: Prior M=2.6, SD=3.3; Since M=0.3, SD=.7; t(500)=15.12, p<.001, Cohen's d=0.83, -88%
FY 2017-18: Prior M=2.7, SD=3.6; Since M=0.4, SD=3.6; t(365)=12.14, p<.001, Cohen's d=0.74, -85%
FY 2016-17: Prior M=2.3, SD=3.3; Since M=0.6, SD=1.7; t(295)=7.7, p<.001, Cohen's d=0.46, -74%

Adults:
FY 2018-19: Prior M=2.5, SD=2.4; Since M=0.8, SD=1.7; t(658)=14.43, p<.001, Cohen's d=0.57, -67%
FY 2017-18: Prior M=3.2, SD=3.7; Since M=1.0, SD=2.0; t(809)=14.88, p<.001, Cohen's d=0.54, -68%
FY 2016-17: Prior M=2.4, SD=2.6; Since M=0.7, SD=1.5; t(629)=13.10, p<.001, Cohen's d=0.59, -69%

Older Adults:
FY 2018-19: Prior M=2.1, SD=1.7; Since M=0, SD=0.0; t(66)=10.25, p<.001, Cohen's d=1.77, -100%
FY 2017-18: Prior M=3.2, SD=4.6; Since M=0, SD=0.0; t(121)=7.58, p<.001, Cohen's d=0.97, -100%
FY 2016-17: 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, -89%

Homeless Days:

Children:
FY 2018-19: Prior M=56.0, SD=94.7; Since M=1.9; SD=7.1; t(25)=2.87, p<.001, Cohen's d=0.70, -97%
FY 2017-18: Prior M=88.8, SD=101.8; Since M=7.3, SD=19.7; t(23)=3.86, p<.01, Cohen's d=0.96, -92%
FY 2016-17: Prior M=96.4, SD=129.7; Since M=17.1, SD=51.7; t(19)=-3.0, p<.01, Cohen's d=0.80, -82%

TAY:
FY 2018-19: Prior M=92.8, SD=113.9; Since M=15.1, SD=33.2; t(146)=8.51, p<.001, Cohen's d=0.70, -84%
FY 2017-18: Prior M=101.6, SD=118.8; Since M=21.9, SD=46.1; t(168)=8.13, p<.001, Cohen's d=0.68, -78%
FY 2016-17: 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, -74%

Adults:
FY 2018-19: Prior M=179.9, SD=134.1; Since M=30.6, SD=70.0; t(640)=25.4, p<.001, Cohen's d=1.05, -83%
FY 2017-18: Prior M=178.7, SD=132.0; Since M=25.2, SD=60.7; t(666)=26.17, p<.001, Cohen's d=1.07, -86%
FY 2016-17: Prior M=145.7, SD=122.56; Since M=36.9, SD=73.42; t(611)=18.68, p<.001, Cohen's d=0.79, -75%

Older Adults:
FY 2018-19: Prior M=216.4, SD=140.0; Since M=27.8, SD=76.1; t(124)=13.89, p<.001, Cohen's d=1.31, -87%

FY 2017-18: Prior M=217.5, SD=136.2; Since M=27.7, SD=67.2; t(128)=14.99, p<.001, Cohen's d=1.42, -87%
FY 2016-17: 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, -82%

Emergency Shelter Days:

Children:
FY 2018-19: Prior M= 43.8, SD=79.6; Since M=25.4; SD=45.1; t(83)=1.7, p=.094, Cohen's d=0.19,-37%
FY 2017-18: Prior M=62.4, SD=100.4; Since M=27.5; SD=55.7; t(48)=1.99, p=.05, Cohen's d=0.29, -56%
FY 2016-17: Prior M=72.9, SD=108.9; Since M=14.8; SD=35.4; t(31)=-2.97, p<.01, Cohen's d=0.61, -80%

TAY:
FY 2018-19: Prior M= 96.0, SD=109.5; Since M=28.7, SD=57.2; t(215)=-.041, p<.05, Cohen's d=0.61, -51%
FY 2017-18: Prior M=69.3, SD=101.3; Since M=29.2, SD=54.5; t(155)=4.38, p<.001, Cohen's d=0.37, -58%
FY 2016-17: Prior M=82.9, SD=117.2; Since M=22.5, SD=51.3; t(162)=-5.90, p<.001, Cohen's d=0.50, -73%

Adults:
FY 2018-19: Prior M=62.7, SD=103.3; Since M=36.8, SD=63.9; t(406)=4.01, p<.001, Cohen's d=0.20, -41%
FY 2017-18: Prior M=68.4, SD=102.6; Since M=33.9, SD=53.6; t(430)=5.66, p<.001, Cohen's d=0.28, -50%
FY 2016-17: Prior M=83.2, SD=112.6; Since M=20.5, SD=53.4; t(341)=9.18, p<.001, Cohen's d=0.53, -75%

Older Adults:
FY 2018-19: Prior M=138.1, SD=139.4; Since M=25.2, SD=60.6; t(87)=6.89, p<.001, Cohen's d=0.79, -82%
FY 2017-18: Prior M=120.2, SD=136.9; Since M=12.8, SD=34.4; t(95)=7.27, p<.001, Cohen's d=0.84, -89%
FY 2016-17: Prior M=99.4, SD=126.7; Since M=39.5, SD=81.5; t(102)=3.96, p<.001, Cohen's d=0.43, -63%

Independent Living Days:

TAY:
FY 2018-19: Prior M=10.2, SD=49.0; Since M=33.1, SD=89.6; t(787)=-6.69, p<.001, Cohen's d=-0.25, 225%
FY 2017-18: Prior M=14.6, SD= 60.8; Since M=29.9, SD=81.2; t(743)=-4.57, p<.001, Cohen's d=-0.17, 105%
FY 2016-17: Prior M=17.9, SD= 65.01; Since M=43.4, SD=96.66; t(747)=-6.46, p<.001, Cohen's d=-0.24, 142%

Adults:
FY 2018-19: Prior M=38.3, SD=95.2; Since M=89.8, SD=133.4; t(1111)=-11.81, p<.001, Cohen's d=-0.36, 134%
FY 2017-18: Prior M=38.7, SD=95.8; Since M=75.7, SD=127.1; t(1144)=-9.01, p<.001, Cohen's d=-0.27, 96%
FY 2016-17: Prior M=46.6, SD=105.5; Since M=86.8, SD=139.1; t(1153)=-9.10, p<.001, Cohen's d=-0.24, 86%

Older Adults:
FY 2018-19: Prior M=58.6, SD=116.1; Since M=190.1, SD=156.2; t(181)=-9.95, p<.001, Cohen's d=-0.75, 224%
FY 2017-18: Prior M=70.0, SD=125.3; Since M=198.1, SD=152.3; t(190)=-9.82, p<.001, Cohen's d=-0.72, 183%
FY 2016-17: Prior M=76.2, SD=129.2; Since M=170.9, SD=160.3; t(219)=-7.41, p<.001, Cohen's d=-0.46, 124%

Out-of-Home Placement Days:

Children:
FY 2018-19: Prior M=92.8, SD=135.44; Since M=55.2, SD=93.1; t(16)=1.38, p=.19, Cohen's d=0.35, -41%
FY 2017-18: Prior M=51.8, SD=74.3; Since M=44.0, SD=66.2; t(13)=0.27, p=.79, Cohen's d=0.07, -15%
FY 2016-17: Prior M=72.9, SD=102.2; Since M=55.9, SD=104.1; t(19)=.643m, p=0.53, Cohen's d=0.49, -23%

Arrests:

Children:
FY 2018-19: Prior M=2.3, SD=.4; Since M=0.4, SD=.8; t(61)=3.69, p<.001, Cohen's d=0.60, -83%
FY 2017-18: Prior M=2.5, SD=2.6; Since M=0.1, SD=0.4; t(24)=4.48, p<.001, Cohen's d=1.04, -72%
FY 2016-17: Prior M=2.9, SD=4.1; Since M=0.0, SD=0.0; t(6)=1.86, p=.11, Cohen's d=0.99, -78%

TAY:

FY 2018-19: Prior M=2.1, SD=3.0; Since M=0.4, SD=.84; t(220)=7.9, p<.001, Cohen's d= 0.62, -81%
FY 2017-18: Prior M=2.2, SD=3.1; Since M=0.1, SD=0.5; t(216)=9.81, p<.001, Cohen's d=0.80, -95%
FY 2016-17: Prior M=2.1, SD=3.0; Since M=0.4, SD=.83; t(270)=10.21, p<.001, Cohen's d= 0.79, -81%

Adults:
FY 2018-19: Prior M=2.0, SD=1.7; Since M=0.4, SD=0.8; t(554)=19.84, p<.001, Cohen's d=0.90, -82%
FY 2017-18: Prior M=1.9, SD=1.9; Since M=0.3, SD=0.8; t(586)=18.26, p<.001, Cohen's d=0.80, -84%
FY 2016-17: Prior M=2.0, SD=2.2; Since M=0.3, SD=0.8; t(598)=17.58, p<.001, Cohen's d=0.82, -86%

Older Adults:
FY 2018-19: Prior M=1.3, SD=0.6; Since M=0, SD=0.0; t(39)=14.58, p<.001, Cohen's d=3.26, -100%
FY 2017-18: Prior M=1.4, SD=0.7; Since M=0, SD=0.0; t(32)=12.34, p<.001, Cohen's d=3.03, -100%
FY 2016-17: Prior M=1.4, SD=0.8; Since M=0, SD=0.0; t(31)=10.71, p<.001, Cohen's d=2.68, -100%

Incarceration Days:

Children:
FY 2018-19: Prior M=43.0, SD=69.4; Since M=22.1; SD=42.6; t(52)=1.93, p=.059, Cohen's d=0.27, -48%
FY 2017-18: Prior M=75.4, SD=97.4; Since M=29.8; SD=42.6; t(21)=2.07, p=.05, Cohen's d=0.48, -60%
FY 2016-17: Prior M=28.7, SD=39.1; Since M=34.2; SD=67.9; t(9)=.194, p=.851, Cohen's d=-0.06, 19%

TAY:
FY 2018-19: Prior M=99.7, SD=102.4; Since M=44.9, SD=82.5, (215)=5.9, p<.001, Cohen's d=0.4, -55%
FY 2017-18: Prior M=114.1, SD=107.4; Since M=22.5, SD=42.9, t(210)=12.19, p<.001, Cohen's d= 0.94, -80%
FY 2016-17: Prior M=95.3, SD=102.3; Since M=19.9, SD=39.1, t(217)=10.31, p<.001, Cohen's d=0.77, -79%

Adults:
FY 2018-19: Prior M=105.6, SD=102.2; Since M=24.5, SD=48.3; t(555)=18.03, p<.001, Cohen's d=0.83, -77%
FY 2017-18: Prior M=103.8, SD=97.6; Since M=17.3, SD=38.3; t(585)=20.38, p<.001, Cohen's d=0.93, -83%
FY 2016-17: Prior M=99.6, SD=94.5; Since M=20.4, SD=41.7; t(623)=19.24, p<.001, Cohen's d=0.79, -80%

Older Adults:
FY 2018-19: Prior M=71.4, SD=91.2; Since M=19.3, SD=48.9; t(37)=2.98, p<.05, Cohen's d=0.5, -73%
FY 2017-18: Prior M=46.6, SD=75.0; Since M=11.5, SD=39.5; t(29)=2.28, p<.05, Cohen's d=0.44, -75%
FY 2016-17: Prior M=72.6, SD=90.6; Since M=8.4, SD=24.7; t(29)=3.72, p<.01, Cohen's d=0.79, -88%

Employment Days:

TAY:
FY 2018-19: Prior M=39.8, SD=87.3; Since M=62.9, SD=109.5; t(848)=-5.74, p<.001, Cohen's d=-0.20, 58%
FY 2017-18: Prior M=40.5, SD=89.5; Since M=70.8, SD=115.3; t(764)=-6.88, p<.001, Cohen's d=-0.25, 75%
FY 2016-17: Prior M=46.6, SD=95.4; Since M=63.6, SD=110.0; t(624)=3.30, p<.001, Cohen's d=-0.13, 36%

Adults:
FY 2018-19: Prior M=26.6, SD=74.4; Since M=49.4, SD=106.0; t(1111)=-6.50, p<.001, Cohen's d=-0.20, 85%
FY 2017-18: Prior M=25.8, SD=70.9; Since M=50.5, SD=108.2; t(1144)=-6.91, p<.001, Cohen's d=-0.21, 96%
FY 2016-17: Prior M=28.8, SD=75.8; Since M=44.1, SD=97.5; t(1150)=-4.58, p<.001, Cohen's d=-0.12, 53%

PROGRAM OF ASSERTIVE COMMUNITY TREATMENT (PACT)

CYBH TAY (CSS)

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics								
14-21	Severe	Field	Community Based	Foster Youth	Parents	Families	Homeless/ At risk	Co-Occuring (SUD)	Medical	Criminal Justice	Trauma- Exposed Clients	Mono-Lingual/ Ethnic Community

Adult/TAY (CSS)

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics		
18-59	Severe	Field	Community Based	Co-Occuring (SUD)	Trauma- Exposed Clients	Mono-Lingual/ Ethnic Community

Older Adult (CSS)

Program Serves	Symptom Severity	Location of Services	
60+	Severe	Field	Community Based

Language Capacity of Direct Service Providers					
✓	Spanish		Arabic		Khmer
✓	Vietnamese		Farsi		Other:
✓	Korean		Mandarin	✓	Language Line as Needed

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$10,799,650	FY 2019-20	1,410
Proposed FY 2020-21 Budget	$10,599,650	FY 2020-21	1,430
Proposed FY 2021-22 Budget	$10,599,650	FY 2021-22	1,430
Proposed FY 2022-23 Budget	$10,599,650	FY 2022-23	1,430

Proportion to be Served by Demographic Characteristic					
Age Group %	**%**	**Gender**	**%**	**Race/Ethnicity**	**%**
0-15	3	Female	47	African American/Black	4
16-25	21	Male	53	American Indian/Alaskan Native	1
26-59	66	Transgender		Asian/Pacific Islander	16
60+	10	Genderqueer		Caucasian/White	46
		Questioning/Unsure		Latino/Hispanic	28
		Other		Middle Eastern/North African	
				Other	5

Target Population and Program Characteristics

The **Program of Assertive Community Treatment** (PACT) is the County-operated version of a Full Service Partnership program. Like the FSPs, it utilizes the evidence-based Assertive Community Treatment model to provide comprehensive, "whatever it takes", field-based outpatient services to persons ages 14 and older who are living with serious emotional disturbance or serious mental illness. Individuals enrolled in PACT may also have a co-occurring substance use disorder, experience social, cultural and/or linguistic isolation, and have had difficulty engaging with more traditional outpatient mental health services.

The main difference from an FSP is that the PACT specifically targets individuals who have had two or more hospitalizations and/or incarcerations due to their mental illness in the past year. The PACT accepts referrals from County-operated and, in the case of children, County-contracted outpatient clinics. The PACT staffing is separated into teams that provide age and developmentally targeted services (Children/youth ages 14-21, TAY ages 18-25, adults ages 26-59, older adults ages 60 and older). Youth ages 18-21 are served by the Child/Youth team or the TAY team based on their level of caregiver involvement and developmental age.

Services

The PACT is staffed by multidisciplinary teams that provide an individualized treatment approach offering intensive, age-appropriate services out in the community. The teams include Mental Health Specialists, Clinical Social Workers, Marriage and Family Therapists, Peer Specialists, Psychiatrists and Supervisors who work together to provide clinical interventions such as individual and group therapy, crisis intervention, substance use services and medication services. The most commonly used evidence-based and best practices include Assertive Community Treatment, Seeking Safety and Trauma-Focused Cognitive Behavioral Therapy. Children and TAY, in particular, also require intensive family involvement. Thus, collaboration with family members, which can include family therapy, is provided.

The PACT also provides intensive case management. 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.

As needed, the PACT uses flexible funding to support the needs of participants and/or their families and is intended to cover the costs of services and supports not otherwise reimbursable, as well as items such as incentives, stipends, tickets/admission fees, food, refreshments, and ancillary supports such as child care or family involvement, etc. so that the participant may fully engage in the recovery-focused activity.

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 PACT works with 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 their and their families' strengths, maintain a non-judgmental stance, and have empathy for their and their families' struggles. Peer 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 PACT 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 Reduce Stigma and Discrimination

In addition to providing valuable direct services and supports to PACT participants, Peer 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 understands the heightened stigma and misconceptions about mental health that can exist in underserved ethnic communities, and draws upon this information to facilitate engagement with participants, establish rapport and reduce stigma and discrimination.

Strategies to Increase Access to Services: Timely Access for Underserved Populations and Linkage to Treatment

Individuals often have difficulty linking to services for a variety of reasons such as 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 and able to communicate with monolingual individuals and family members in their preferred language, thus facilitating their engagement in services.

The teams serving adults and older adults also offer a streamlined referral and linkage process to (1) allow direct referrals into PACT, and/or to (2) include more detailed and frequent follow-up with individuals who miss appointments or do not access treatment. As a result of these operational changes, individuals are linked to services more quickly and feel supported through the process. In addition, some clinicians are specifically assigned to engage individuals who are referred from hospitals, and homeless shelters such as The Courtyard and the MHSA housing programs.

The Child/Youth team, recently implemented in June 2017, has worked to increase timely access to its services by presenting to providers about PACT services and eligibility criteria. Once referred, Child/Youth therapists have attended sessions with the referring therapist, psychiatrist, youth and parent in order to explain the program in detail and establish rapport with the youth and parent. Like the other teams, the Child/Youth team also works with hospital staff, Probation Officers and others involved with the youth and family to engage them in their program services.

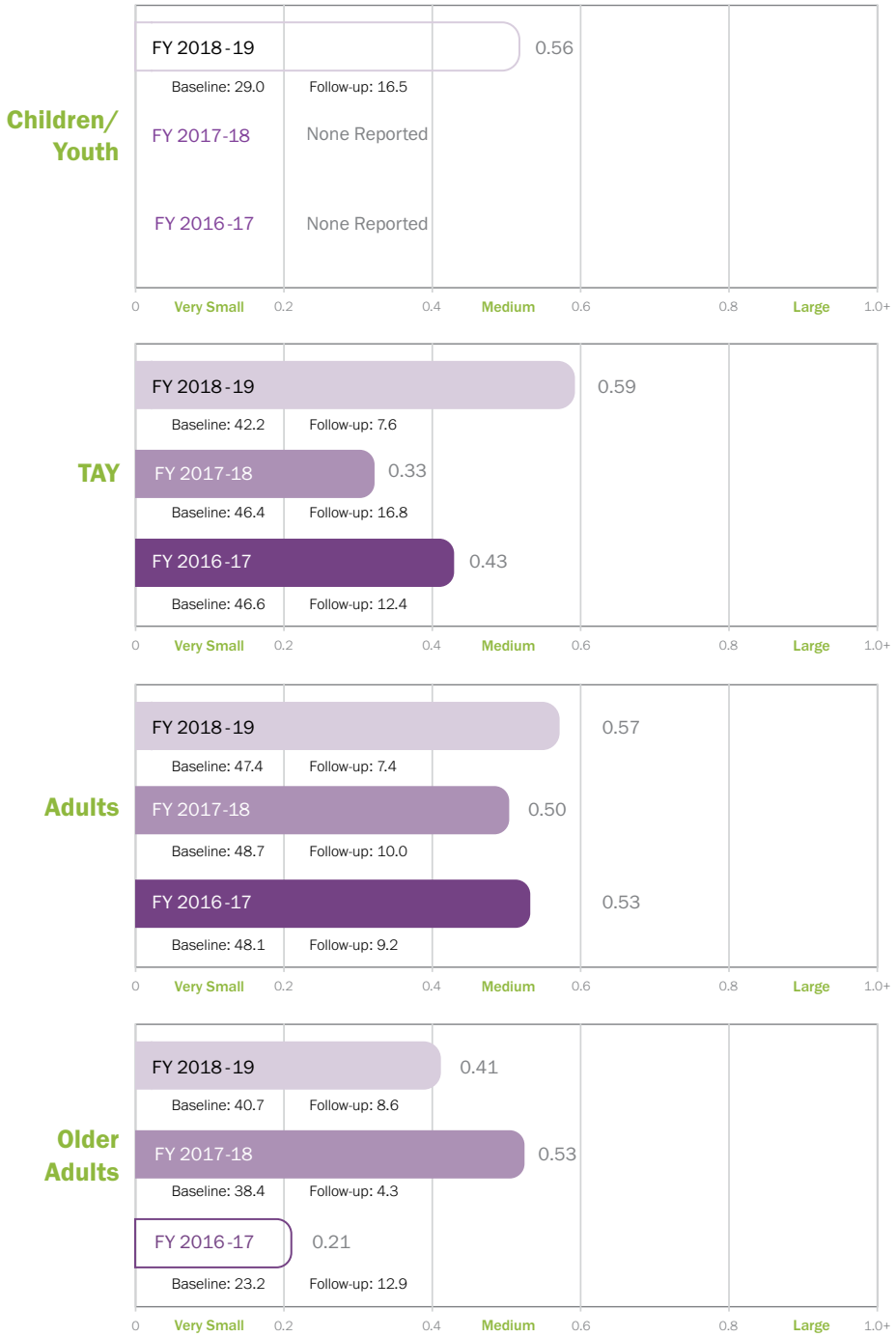
PACT teams also recognize the importance of successfully linking program participants to community-based providers as they approach discharge from PACT. Clinicians attend appointments with individuals in the new setting to ensure a smooth transition and ease any anxiety they may feel over the change. 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.

Outcomes

Using the same approach as the FSPs, the PACT evaluated performance through several recovery-based outcome measures related to life functioning: days spent psychiatrically hospitalized, homeless, incarcerated and, for TAY and adults, employed. For children/youth under age 18, PACT also evaluated grades and school attendance. Program effectiveness was measured by comparing differences in functioning during the 12 months prior to enrolling in the PACT to the fiscal year being evaluated. Results were statistically analyzed and reported according to the calculated effect size, which reflects, in part, the extent to which a change in functioning over time is clinically meaningful for the individuals served in the FSP. For all functional measures other than employment or education, only individuals who reported that they experienced the functional outcome (i.e., hospitalization, homelessness, incarceration) either before or after enrollment were included in the outcomes analysis. All TAY and adults were included in the employment analysis and all children/youth were included in the school attendance/grades evaluation.

Numbers Served	FY 2016-17	FY 2017-18	FY 2018-19
Children/Youth	1	45	79
TAY	141	178	182
Adults	928	887	794
Older Adult	103	89	103

Impact on Psychiatric Hospitalization Days by FY



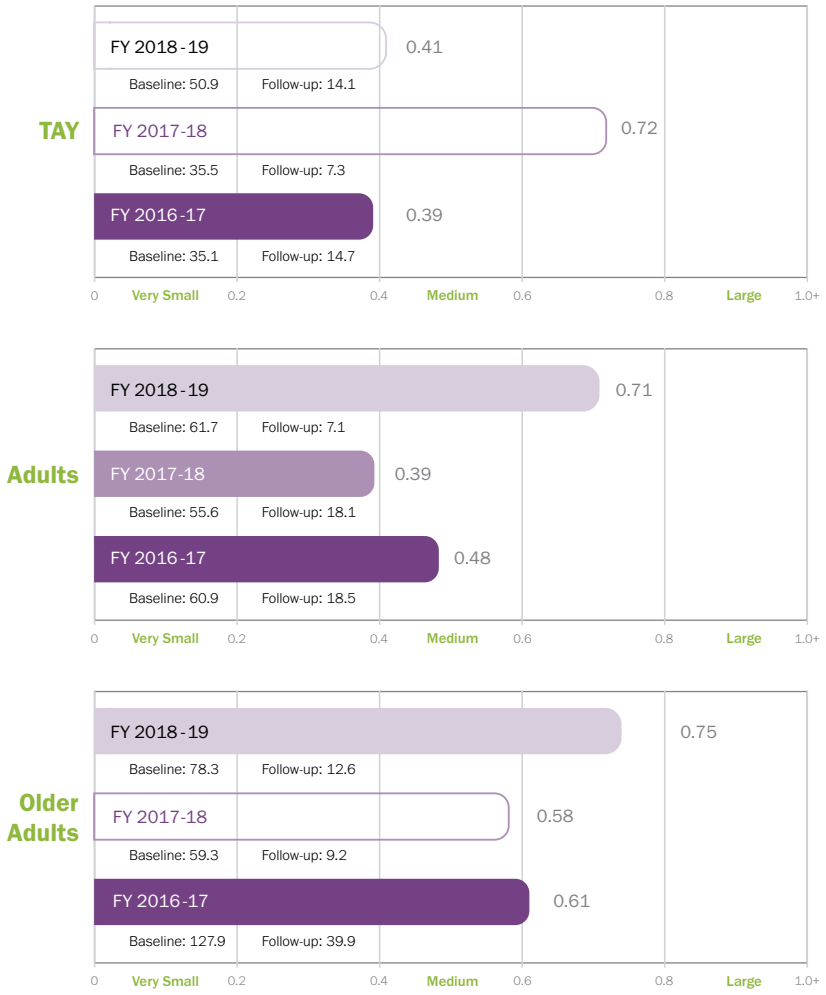
Psychiatric hospitalizations: Adults experienced a moderate reduction in psychiatric hospitalization days during each of the three fiscal years reported here, as did children/youth in FY 2018-19, the first full year in which the team serving this younger age group was fully operational. In contrast, TAY and older adults demonstrated some variability, ranging from small to moderate, in reduced days spent in the hospital while served in PACT. Older adults continue to face challenges with discharge placement options that can accommodate complex medical or physical needs of consumers, which has led to longer hospitalization stays during some years. TAY, on the other hand, experienced a moderate decrease in days hospitalized in FY 2018-19, an improvement from the two prior years. The HCA will continue to monitor the rates in future years to see if this improved reduction continues for TAY.

Homelessness: Because individuals who are homeless and living with SED/SMI are largely referred to FSP services, the number of individuals enrolled in PACT who experience unsheltered homelessness tends to be lower than those who are in an FSP. Consistent with this, no children/youth reported experiencing unsheltered homelessness in the year prior to enrollment in PACT and/or while receiving services in FY 2018-19.

TAY, adults and older adults experienced moderate to large decreases in days spent homeless over each of the past three fiscal years (i.e., average days spent homeless while enrolled in PACT ranged from 1.5-2.5 weeks for TAY, 7-9 weeks for adults, 7-10 weeks for older adults). The number of TAY and older adults affected by homelessness tends to be much lower than the number of adults affected, thus the differences across the age groups may reflect unique characteristics of the TAY or older adults served in any given year rather than a change in overall program efficacy. The HCA will continue to monitor trends in homelessness for PACT participants over time.

Impact on Unsheltered Homeless Days by FY

Impact on Incarceration Days by FY



Incarcerations: TAY, adults and older adults enrolled in PACT also experienced moderate to large decreases in days spent incarcerated over each of the past three fiscal years (i.e., average days incarcerated while enrolled in PACT was typically 1-2.5 weeks across all three age groups). Similar to homelessness findings, the number of TAY and older adults who had been incarcerated tended to be much lower than the number of adults. Thus, the differences across age groups and fiscal years may reflect unique characteristics of the TAY or older adults served in any given year rather than a change in program efficacy. The HCA will continue to monitor trends in incarceration for PACT participants over time.

In FY 2018-19, the first year in which the child/youth team was fully implemented, 2 of the 79 children/youth had experienced incarceration: one reported having been incarcerated 121 days prior to enrollment and no days in FY 2018-19, and the other reported having been incarcerated 30 days prior to enrollment and 19 days after.

Impact on Employment Days by FY

Employment: Across all three fiscal years, PACT showed minimal to no impact on improving employment, with an exception in 2018-19 where a small increase was noted for TAY. As with the FSP programs, PACT continues to struggle with making inroads on this functional domain.

Education: During FY 2018-19, for children/youth, 74% of youth showed good, very good or improved school attendance while enrolled in PACT, compared to the year prior to enrollment. In addition, 53% of youth showed good, very good or improved grades while enrolled in PACT. These findings are consistent with educational outcomes among FSP participants.

Challenges, Barriers and Solutions in Progress

The Child/Youth team launched in June 2017. The first year involved extensive outreach to bring awareness about this program as a possible referral source. Now that the team is fully operational, one challenge has been the reluctance of the children/youth to use existing work/ vocational programs. Instead, they prefer to seek employment on their

School Performance by FY

Children/Youth PACT - FY 2018-19

Attendance
74%
Good, Very Good, Improved

Grades
53%
Good, Very Good, Improved

Children/Youth PACT - FY 2017-18

Attendance
82%
Good, Very Good, Improved

Grades
52%
Good, Very Good, Improved

Children/Youth PACT - FY 2016-17

Attendance
78%
Good, Very Good, Improved

Grades
89%
Good, Very Good, Improved

own with coaching from program staff. The program supports participants by providing guidance on obtaining employment and offers the assistance of Peer Specialists and Mental Health Workers. In addition, the HCA would like to offer services to children/youth and their families in additional threshold languages but will need additional staff to meet this need.

The TAY, Adult and Older Adult teams have all recently been expanded due to increasing demand for PACT services. There are currently 5 vacancies due to staffing turnover, and the HCA hopes to begin hiring for these positions in the coming fiscal year.

Like the FSPs, PACT struggles with supporting its participants in engaging in and/or sustaining employment. The program and its 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. Thus, staff is 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 PACT teams, the difficulty identifying housing options for older adults on Social Security and Supplemental Security Income who need assisted living and/or ADL-compliant housing is especially problematic. The Older Adult team continually works to expand a list of available resources, however limited options continue to make it very difficult to provide safe and timely placement of older adults.

The Older Adult team is also encountering increasing challenges in serving those who are experiencing age-related cognitive decline. Such decline can have a negative impact on medication compliance and follow-through with medical and other appointments. The program addresses this challenge by utilizing the Peer Mentoring program and Older Adult Life Coaches. Peers and coaches assist older adults with making and/or attending appointments and by working closely with IHSS and SHOPP nurses and medical providers.

Community Impact

The 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 serious mental illness. The program has shown a modest reduction in psychiatric hospitalization and incarceration days, thereby reducing the need for high-cost crisis services for these individuals.

Reference Notes

Psychiatric Hospitalization Days:

Children/Youth:

FY 2018-19: Prior M=29.0, SD=27.4; Since M=16.5, SD=10.8; t(7)=1.4, p<0.21; Cohen's d=0.56, -44%
FY 2017-18: None reported
FY 2016-17: None reported

TAY:

FY 2018-19: Prior M=42.2, SD=68.2; Since M=7.6, SD=30.6; t(113)=5.6, p<0.001; Cohen's d=0.59, -84%
FY 2017-18: Prior M=46.4, SD=62.8; Since M=16.8, SD=61.1; t(82)=2.97, p<.01; Cohen's d=0.33, -64%
FY 2016-17: Prior M=46.6, SD=63.1; Since M=12.4, SD=49.4; t(92)=4.12, p<0.001; Cohen's d=0.43, -73%

Adults:

FY 2018-19: Prior M=47.4, SD=78.3; Since M=7.4, SD=24.7; t(590) = 12.12, p<0.001; Cohen's d=0.57, -84%
FY 2017-18: Prior M=48.7, SD=77.8; Since M=10.0, SD=35.7; t(659)=11.86, p<.001; Cohen's d=0.50, -79%
FY 2016-17: Prior M=48.1, SD=76.2; Since M=9.2, SD=27.7; t(687)=12.59, p<0.001; Cohen's d=0.53, -81%

Older Adults:

FY 2018-19: Prior M=40.7, SD=75.5; Since M=8.6, SD=32.9; t(63) = 3.07, p=0.003; Cohen's d=0.41, -79%
FY 2017-18: Prior M=38.4, SD=74.8; Since M=4.3, SD=17.3; t(69)=3.73, p<.001; Cohen's d=0.53, -89%
FY 2016-17: Prior M=23.2, SD=43.5; Since M=12.9, SD=28.5; t(52)=1.64, p=0.11; Cohen's d=0.21, -44%

Homeless Days:

Children/Youth:
FY 2018-19: None reported

TAY:
FY 2018-19: Prior M=71.8, SD=89.8; Since M=11.2, SD=29.8; t(16) = 2.53, p=0.022; Cohen's d=0.67, -84%
FY 2017-18: Prior M=73.2, SD=59.2; Since M=19.9, SD=42.7; t(16)=3.36, p<.01; Cohen's d=0.83, -73%
FY 2016-17: Prior M=57.6, SD=61.2; Since M=15.2, SD=43.3; t(17)=3.37, p<0.01; Cohen's d=0.57, -74%

Adults:
FY 2018-19: Prior M=165.4, SD=131.0; Since M=52.4, SD=93.1; t(207)=10.47, p<0.001; Cohen's d=0.74, -68%
FY 2017-18: Prior M=152.6, SD=136.1; Since M=65.8, SD=104.7; t(227)=7.62, p<.001; Cohen's d=0.51, -57%
FY 2016-17: Prior M=142.5, SD=126.0; Since M=65.3, SD=104.2; t(242)=7.97, p<0.001; Cohen's d=0.47, -54%

Older Adults:
FY 2018-19: Prior M=174.6, SD=152.5; Since M=69.0, SD=115.1; t(30)=3.50, p<=0.002; Cohen's d=0.72, -60%
FY 2017-18: Prior M=187.0, SD=141.5; Since M=49.6, SD=102.3; t(33)=4.96, p<.001; Cohen's d=0.86, -74%
FY 2016-17: Prior M=167.8, SD=145.8; Since M=71.8, SD=108.1; t(30)=2.81, p=<0.01; Cohen's d=0.54, -57%

Incarceration Days:

Children/Youth:
FY 2018-19: See narrative for number of days for two youth who reported having been incarcerated

TAY:
FY 2018-19: Prior M=50.9, SD=94.6; Since M=14.1, SD=32.6; t(13)=1.38, p=0.19; Cohen's d=0.41, -72%
FY 2017-18: Prior M=35.5, SD=36.0; Since M=7.3, SD=15.2; t(19)=3.02, p=.07; Cohen's d=0.72, -79%
FY 2016-17: Prior M=35.1, SD=31.9; Since M=14.7, SD=43.2; t(29)=2.48, p<0.05; Cohen's d=0.39, -58%

Adults:
FY 2018-19: Prior M=61.7, SD=83.4; Since M=7.1, SD=21.9; t(176)=8.29, p<0.001; Cohen's d=0.71, -89%
FY 2017-18: Prior M=55.6, SD=83.9; Since M=18.1, SD=50.3; t(200)=5.38, p<.001; Cohen's d=0.39, -67%
FY 2016-17: Prior M=60.9, SD=85.5; Since M=18.5, SD=40.2; t(216)=6.38, p<0.001; Cohen's d=0.48, -70%

Older Adults:
FY 2018-19: Prior M=78.3, SD=99.3; Since M=12.6, SD=25.5; t(13)-=2.40, p=0.032; Cohen's d=0.75, -84%
FY 2017-18: Prior M=59.3, SD=85.1; Since M=9.2, SD=22.7; t(12)=1.93, p=.08; Cohen's d=0.58, -84%
FY 2016-17: Prior M=127.9, SD=110.7; Since M=39.9, SD=95.7; t(10)=3.24, p<0.01; Cohen's d=0.61, -69%

Employment Days:

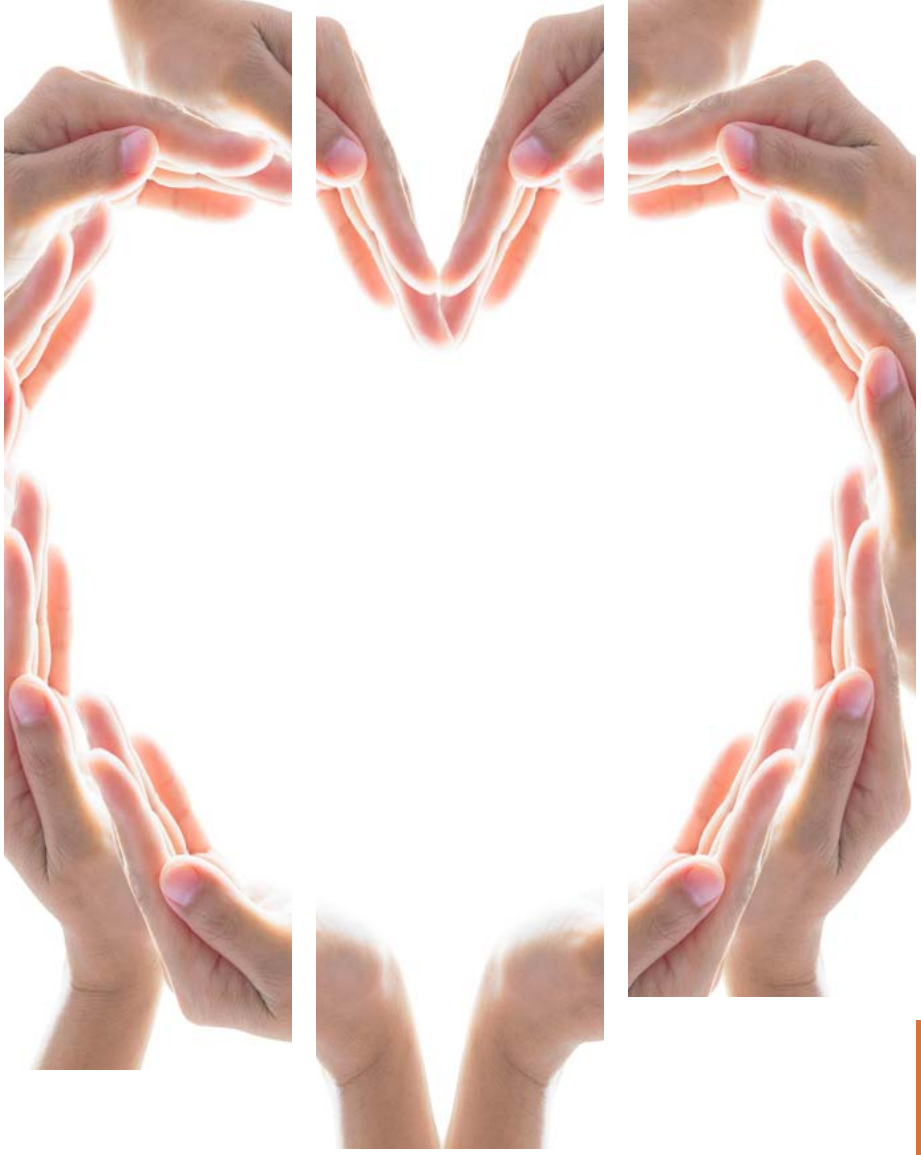
Children:
Not assessed for children

TAY:
FY 2018-19: Prior M=26.8, SD=69.3; Since M=46.8, SD=98.4; t(96)=-2.04, p=0.044; Cohen's d=-0.21, 75%
FY 2017-18: Prior M=26.2, SD=72.9; Since M=33.7, SD=82.7; t(90)=-0.73, p=.47; Cohen's d=-0.08, 29%
FY 2016-17: Prior M=37.2, SD=87.1; Since M=45.1, SD=92.7; t(92)=-0.68, p=0.50; Cohen's d=-0.12, 22%

Adults:
FY 2018-19: Prior M=29.7, SD=77.9; Since M=34.3, SD=83.1; t(640)=-1.20, p=0.231; Cohen's d=-0.05, 15%
FY 2017-18: Prior M=30.2, SD=81.0; Since M=40.0, SD=93.6; t(718)=-2.41, p<.05; Cohen's d=-0.09, 33%
FY 2016-17: Prior M=27.3, SD=77.5; Since M=33.0, SD=83.5; t(753)=-1.55, p=0.12; Cohen's d=-0.05, 21%

SUPPORTIVE SERVICES

Supportive Services provides a broad array of supports generally designed to augment and expand an individual's gains made in treatment programs, particularly those within Outpatient Treatment, Crisis Prevention and Support Services, and Residential Treatment. These programs, which are funded by CSS and PEI serve individuals of all ages and are further subdivided into the following categories:



- Peer Support
- Family Support
- General Support
- Housing Support

PEER SUPPORT

Peer Support programs are staffed with individuals who have lived experience with mental health and/or substance use recovery, and their family members (i.e., parent partners of child/youth clients). While Orange County includes peers and parent partners as part of the service delivery teams of many of its behavioral health programs (i.e., FSPs, PACT, Veteran-Focused Early Intervention Outpatient, Suicide Prevention Services, etc.) the programs described here 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, peers and parent partners are able to help support and encourage participants in their own recovery journeys.

Peer Mentor and Parent Partner Support (CSS)

Peer Mentoring for Children and TAY

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics									
18+	Severe	Field	Community Based	Foster Youth	Criminal Justice	Homeless/ At risk	Parents	Families	LGBTIQ	Co-Occurring (Medical)	Co-Occuring SUD	Trauma-Exposed Clients	Mono-Lingual/ Ethnic Community

Peer Mentoring for All Ages

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics						
18+	Severe	Field	Community Based	Homeless/ At risk	Veterans	LGBTIQ	Co-Occurring (Medical)	Co-Occuring SUD	Trauma-Exposed Clients	Mono-Lingual/ Ethnic Community

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$4,249,888	FY 2019-20	2,434
Proposed FY 2020-21 Budget	$4,249,888	FY 2020-21	2,638
Proposed FY 2021-22 Budget	$4,249,888	FY 2021-22	2,771
Proposed FY 2022-23 Budget	$4,249,888	FY 2022-23	2,884

Proportion to be Served by Demographic Characteristic

Age Group %	%	Gender	%	Race/Ethnicity	%
0-15	21	Female	42	African American/Black	5
16-25	32	Male	57	American Indian/Alaskan Native	1
26-64	39	Transgender	1	Asian/Pacific Islander	8
65+	8	Genderqueer		Caucasian/White	28
		Questioning/Unsure		Latino/Hispanic	51
		Other		Middle Eastern/North African	2
				Other	5

Language Capacity of Direct Service Providers

✓	Spanish		Arabic		Khmer
✓	Vietnamese	✓	Farsi		Other:
	Korean	✓	Mandarin	✓	Language Line as Needed

Target Population and Program Characteristics

Funding was authorized during FY 2017-18 to expand the Peer Mentoring program to serve youth and their families enrolled in Children and Youth Behavioral Health (CYBH) programs. This expanded program, **Peer Mentor and Parent Partner Support**, serves individuals who are living with a serious emotional disturbance (SED) or serious mental illness (SMI), may also have a co-occurring substance use disorder, and would benefit from the supportive services from a Peer Specialist. Peer Specialists may include peer or youth mentors, as well as parent partners, who work with client's family members who would benefit from the supportive services of a parent mentor. Depending on the nature of support to be provided, participants are referred to the program by County or County-contracted providers in one of the following ways:

- Referrals for support with linking to services are provided by:
  - Therapists who are working with individuals who need additional support transitioning between behavioral health services and/or levels of care
    - i.e., from Open Access to an Outpatient Clinic, from an Outpatient Clinic to a lower level of care such as a Recovery Center or to a higher level of care such as inpatient hospitalization or a Full Service Partnership program, etc.
  - Staff in a Crisis Stabilization Unit (CSU), Royale Therapeutic Residential Center or crisis services program who are working to connect individuals into ongoing outpatient care
  - Therapists or Personal Service Coordinators who are working with an individual as they re-integrate into their community following a recent hospitalization, incarceration/juvenile detention, or shelter stay (i.e., Orangewood, etc.)
- Referral for support with achieving one or more recovery goals are provided by:
  - Behavioral Health Services (BHS) therapists who are working with an individual, and perhaps their families, on their treatment goals within an outpatient clinic and/or community setting
  - BHS Outreach and Engagement team and Housing Navigators working with individuals in need of housing sustainability assistance after they have been placed as part of Orange County's Whole Person Care plan

Services

Through this program, Peer Specialists work with participants to help them achieve identified goals. By sharing their lived experience, Peer Specialists are often able to provide the encouragement and support a person needs to engage in ongoing services and achieve their personal goals. The support provided is customized depending on the individuals' needs and personal recovery goals, and can include the following:

- Support in linking to services that may involve activities such as:
  - Accessing behavioral health or medical appointments
  - Accessing community-based services such as food pantries or emergency overnight shelters as needed
  - Re-integrating into the community following discharge from inpatient care, hospitalization, emergency department visits and/or incarceration/in-custody stays
- Support in building skills that may involve activities such as:
  - Learning independent living skills, such as how to use and navigate the public transportation system
  - Increasing socialization activities such as attending groups or activities at the Wellness Centers and/or facilitating or assisting with groups
  - Managing and preventing behavioral health crises
  - Obtaining identification cards or driver's licenses
  - Learning skills to find, obtain and/or sustain housing placements, which 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.[1]

[1] This area is the focus of the provider supporting Orange County's Whole Person Care plan.

Outcomes

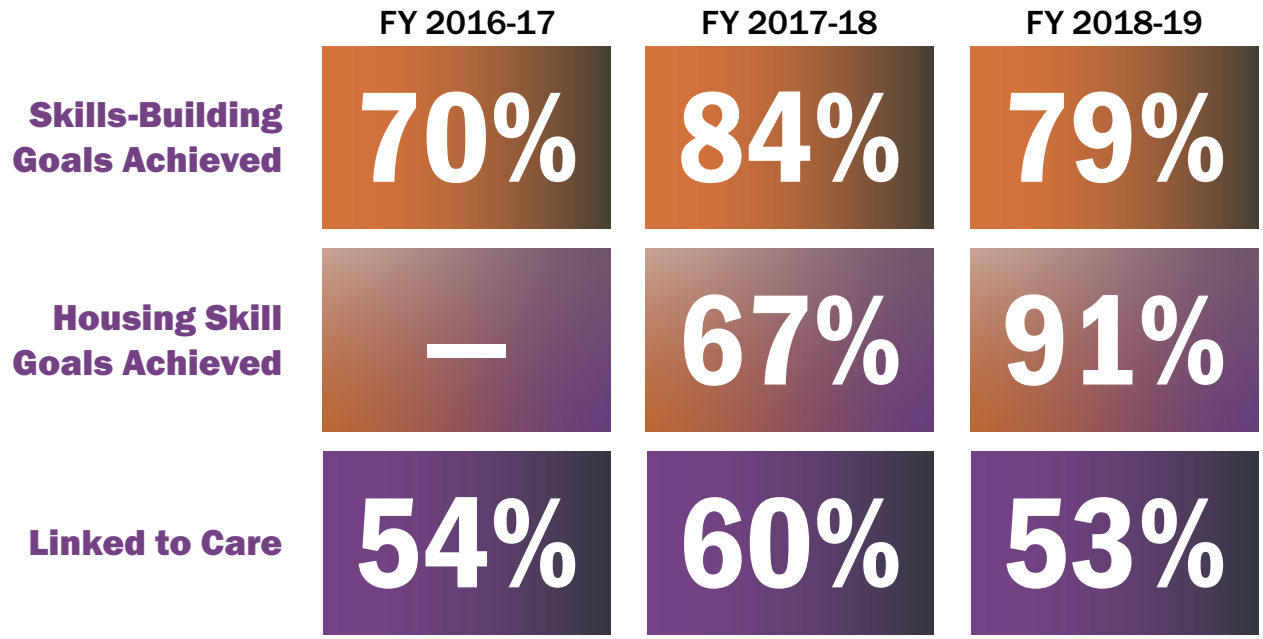
Across the three fiscal years reported here, adults and older adults engaged in outpatient care were largely successful in achieving their skill-building goals with the support of their peer. The most common types of goals included learning to navigate the public transportation system, obtaining identification cards or driver's licenses, completing with housing applications, and increasing socialization activities. The program was expanded to serve children/youth in FY 2017-18, and implementation began ramping up in FY 2018-19. Outcomes for this age group are still in development and will be reported in future Plan Updates.

Numbers Served	FY 2016-17	FY 2017-18	FY 2018-19
Children/Youth	-	-	644
Adults/Older Adults	755	829	767

In its first full year of implementation, nearly all (i.e., 91%) individuals supported by the Whole Person Care provider achieved their housing-related goals. Provider improvements in staffing, the referral and screening process, as well as closer collaboration with Housing Services, contributed to this higher goal attainment rate in FY 2018-19 relative to FY 2017-18, which was the first year these services were provided.

Supportive Services – Peer Supported Goal Setting

Adult/Older Adult



A little over half of adults and older adults were successfully linked to behavioral health and/or medical appointments with the support of their peer.

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 how to best reach them. Initial results from these front-end efforts have been promising.

Community Impact

Peer Mentoring has provided services to approximately 3,000 adults and older adults since services began in November 2015, and 644 children and youth since services were first added for this age group in FY 2018-19. The program recognizes that building County and community partnerships is a priority. In addition to the strong ongoing partnerships with referral sources such as the County and County-contracted clinics and the County Crisis Stabilization Unit, the program also partners with the Wellness Centers, the Council on Aging, NAMI and housing agencies.

Wellness Centers (CSS)

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics			
18+	Severe	Other	LGBTIQ	Veterans	Co-Occuring (SUD)	Trauma-Exposed Clients

Language Capacity of Direct Service Providers					
✓	Spanish		Arabic		Khmer
✓	Vietnamese	✓	Farsi		Other:
✓	Korean		Mandarin	✓	Language Line as Needed

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$3,254,351	FY 2019-20	2,500
Proposed FY 2020-21 Budget	$3,354,351	FY 2020-21	2,550
Proposed FY 2021-22 Budget	$3,354,351	FY 2021-22	2,600
Proposed FY 2022-23 Budget	$3,354,351	FY 2022-23	2,600

Proportion to be Served by Demographic Characteristic					
Age Group %	**%**	**Gender**	**%**	**Race/Ethnicity**	**%**
0-15		Female	46	African American/Black	5
16-25	10	Male	52	American Indian/Alaskan Native	1
26-64	81	Transgender		Asian/Pacific Islander	14
65+	9	Genderqueer		Caucasian/White	43
		Questioning/Unsure		Latino/Hispanic	22
		Other	2	Middle Eastern/North African	1
				Other	14

Target Population and Program Characteristics

Orange County funds three **Wellness Center** locations that serve adults 18 and older who are living with a serious 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 who 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.

Outcomes

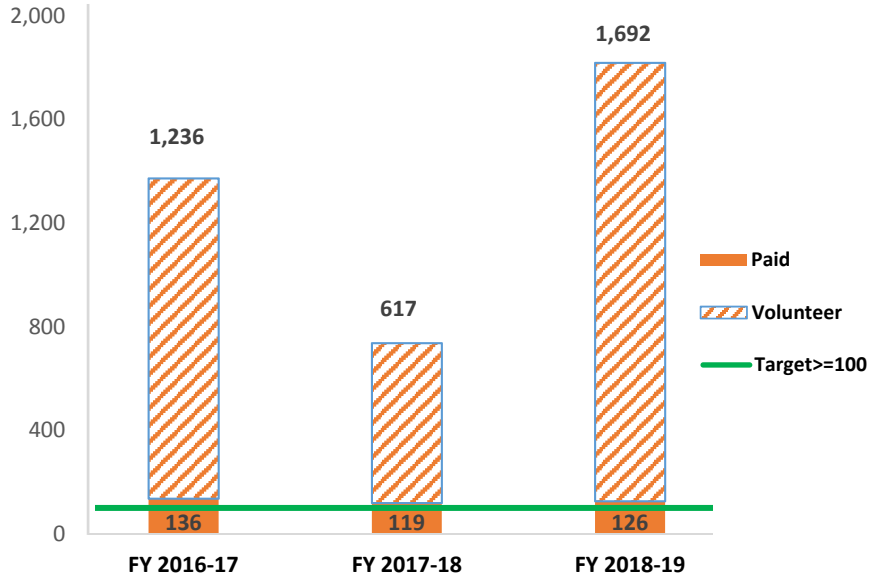
The Wellness Centers monitor their success in supporting recovery through two broad categories: social inclusion and self-reliance. Social inclusion is evaluated in two interrelated ways. First, the Wellness Centers encourage their members to engage in two or more groups or social activities each month. As can be seen in the graph, the Centers met this goal with 74-81% of members participating in two or more groups/activities each month during FY 2018-19. This is comparable to FY 2017-18 and FY 2016-17 in which 76% and 77% of members participated in two or more groups/activities each month respectively (see Appendix VII for graphs).

Individuals Served		
FY 2016-17	FY 2017-18	FY 2018-19
2,424	2,412	2,448

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 2018-19, 2,385 (97%) adults participated in community integration activities. This is an increase over the prior two FYs, during which 2,038 (84%) and 2,026 (84%) adults participated in community integration activities during FYs 2016-17 and 2017-18, respectively.

The Wellness Centers also strive to increase a member's self-reliance, as reflected by school enrollment and employment rates. A total of 219, 146 and 141 adults enrolled in education classes in FY 2018-19, FY 2017-18, and FY 2016-17, respectively. Thus, school enrollment 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.

Wellness Centers - Annual Employment



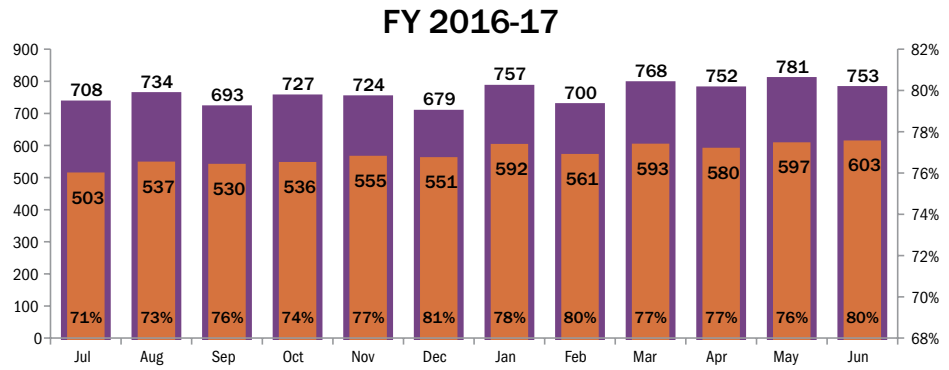
In contrast, 1,818 adults in FY 2018-19, 736 adults in FY 2017-18, and 1,372 adults in FY 2016-17 were involved in employment, largely due to the large proportion in volunteer positions. The programs will continue their efforts to engage members in employment-related activities and work toward increasing the number who obtain paid positions.

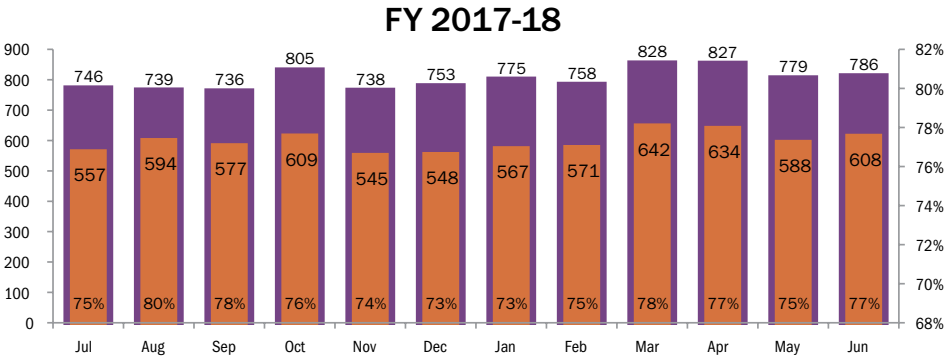
Challenges, Barriers and Solutions in Progress

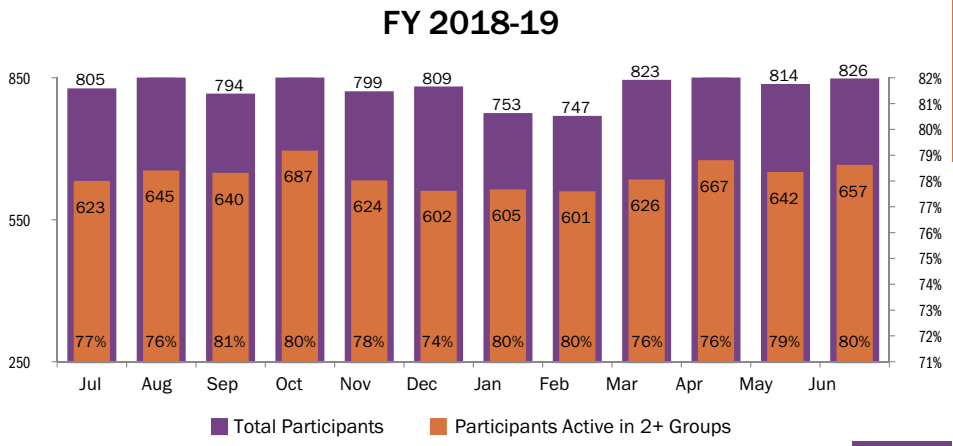
A continuing challenge for accessing the Wellness Centers is transportation, which can take from 45 minutes to two hours each way on public transportation. Each of the Wellness Centers strives to offer activities in different community settings that allow access in members' own neighborhoods without the need for extensive travel. With the centers operating in the west, central and south regions of the county, access has improved. The south county center is particularly challenging when it comes to public transportation, as the majority of bus routes are no longer in operation in that region. To assist individuals with accessing and utilizing the south center, HCA has authorized the utilization of its Transportation program to assist those individuals with the most challenging transportation needs to get to the center.

Monthly Consumer Participation in Groups

Wellness Centers







Community Impact

Since their respective programs' inceptions, 6,110 adults have received services at Wellness Center Central, with an average daily attendance of 92 members, six days per week; more than 731 adults at Wellness Center South, with an average daily attendance of 24 members, six days per week; and 1,616 members at Wellness Center West, with an average daily attendance of 64 members per day, six days per week.

Summary of MHSA Strategies Used by Supportive Services Programs: Peer Services

Strategies to Promote Recovery/Resilience

In one-on-one services, peers and parent partners focus on a participant's strengths and foster their sense of empowerment, hope and resilience while on their recovery journey. The activities in which participants engage are designed to enhance their resourcefulness and well-being in emotional, physical, spiritual and social domains, thus allowing them to re-integrate successfully into their communities. In addition, the Wellness Centers provide a safe and nurturing environment where each individual can achieve their vision of recovery while in a setting that promotes acceptance, dignity and social inclusion.

Strategies to Reduce Stigma and Discrimination

Cultural competence is an essential part of the development, recruitment and hiring of staff in both of these programs. Within the clinic settings where the peer mentors and parent partners work, peers/partners strive to reduce stigma and discrimination by drawing upon their 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. In addition, peers/partners encourage participants and other staff working in the Clinics/Programs 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/partners 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, doctors, etc.

In addition, the Wellness Centers reduce stigma and discrimination by providing a warm, welcoming and accepting environment, and serving 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 their widely diverse membership.

Employment preparation, offered both by the Centers and Peer Mentors/Parent Partners, also helps participants focus on their experiences, skills and what they have to offer, rather than on their illness. Socialization activities held in the community help to develop confidence in participants that they, too, can participate in everything their communities have to offer, which helps to reduce isolation and fear.

Strategies to Increase Access to Services: Timely Access for Underserved Populations and Linkage to Treatment

The programs conduct outreach to potential referral sources in order to increase awareness of and access to their services. For example, the Wellness Center distributes flyers and monthly activity calendars to all County and County-contracted programs, and frequently staffs booths at behavioral health and other community events. The Peer Mentoring/Parent Partner program has proactively built relationships with leadership at County and County-contracted outpatient clinics 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.

Referred individuals may face barriers to engaging in services due to housing, transportation, child care, challenges with scheduling and/or symptoms of mental illness may prevent members from engaging in Peer Mentoring services and/or Center activities. 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 individuals 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

Homelessness is another factor that can affect access to Peer Mentoring program services, in particular, as mentors can lose touch with individuals who do not have a stable residence or telephone to remind them about their appointments or responsibilities. Peers proactively address this potential challenge at their first meeting by making 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.

FAMILY SUPPORT

A subset of 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 one through CSS.

Mentoring for Children and Youth (CSS)

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics							
0-25	Severe	Field	Community Based	Foster Youth	Parents	Families	Criminal Justice	LGBTIQ	Co-Occuring SUD	Trauma-Exposed Clients	Mono-Lingual/ Ethnic Community

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$500,000	FY 2019-20	225
Proposed FY 2020-21 Budget	$500,000	FY 2020-21	230
Proposed FY 2021-22 Budget	$500,000	FY 2021-22	230
Proposed FY 2022-23 Budget	$500,000	FY 2022-23	230

Language Capacity of Direct Service Providers					
✓	Spanish		Arabic	✓	Khmer
✓	Vietnamese		Farsi		Other:
	Korean		Mandarin		Language Line as Needed

Proportion to be Served by Demographic Characteristic					
Age Group %	**%**	**Gender**	**%**	**Race/Ethnicity**	**%**
0-15	58	Female	38	African American/Black	4
16-25	35	Male	62	American Indian/Alaskan Native	
26-64	7	Transgender		Asian/Pacific Islander	6
65+		Genderqueer		Caucasian/White	20
		Questioning/Unsure		Latino/Hispanic	69
		Other		Middle Eastern/North African	
				Other	1

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 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 structured and supportive environment.

Outcomes

Numbers Served	FY 2016-17	FY 2017-18	FY 2018-19
Children/Youth	175	217	220
Adults/Older Adults	21	17	17

Children/Youth Making Some or Significant Progress on Goals Upon Discharge

	FY 2016-17		FY 2017-18		FY 2018-19	
Goal Area	**Clinician-Rating**	**Mentor-Rating**	**Clinician-Rating**	**Mentor-Rating**	**Clinician-Rating**	**Mentor-Rating**
Cooperation (n=116 clinicians, 114 mentors)	71%	74%	75%	79%	78%	81%
Hobbies/Interests (n=108 each)	66%	62%	71%	79%	66%	74%
Personal Growth (n=118 clinicians, 120 mentors)	65%	70%	70%	77%	74%	80%
Peer Socialization (n=118 each)	66%	71%	75%	77%	73%	84%

At the start of services, clinicians and youth identify one or more behavioral goals to be addressed through mentoring (i.e., increasing peer socialization, developing hobbies or interests, improving cooperative behavior). When clients discharge from the program, clinicians and mentors then rate the extent to which participants made progress on each of their goals.

Across all three fiscal years, clinicians and mentors indicated that participants had made some or significant progress approximately two-thirds to three-quarters of the time, depending on the identified goal. These results help demonstrate the mentors' ability to support skill development among participating youth.

Challenges, Barriers and Solutions in Progress

The program succeeds despite two complicated, but necessary processes. It is a challenge recruiting volunteer mentors, obtaining background checks and providing training and guidelines on "how to be a mentor." In addition, Children Youth Behavioral Health clinicians must identify children and youth who might benefit from the program and then the program has to 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, particularly when male, bilingual mentors are requested. In addition, the program moved locations in FY 2018-19.

Youth Who Made Progress on Goals at Discharge by FY

Clinician Rating

	FY 2016-17	FY 2017-18	FY 2018-19
Cooperative Behavior	71%	75%	78%
Hobbies/ Interests	66%	71%	66%
Personal Growth	65%	70%	74%
Peer Socialization	66%	75%	73%

Mentor Rating

	FY 2016-17	FY 2017-18	FY 2018-19
Cooperative Behavior	74%	79%	81%
Hobbies/ Interests	62%	79%	74%
Personal Growth	70%	77%	80%
Peer Socialization	71%	77%	84%

Community Impact

The program has served more than 1,600 children and youth, and 180 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.

Children's Support and Parenting Program (PEI)

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics					
6-18	At-Risk	Field	Community Based	Foster Youth	Parents	Families	Students	Criminal Justice	Mono-Lingual/ Ethnic Community

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$1,700,000	FY 2019-20	1,000
Proposed FY 2020-21 Budget	$1,700,000	FY 2020-21	1,000
Proposed FY 2021-22 Budget	$1,700,000	FY 2021-22	1,000
Proposed FY 2022-23 Budget	$1,700,000	FY 2022-23	1,000

Language Capacity of Direct Service Providers					
✓	Spanish		Arabic	✓	Khmer
✓	Vietnamese		Farsi		Other:
	Korean		Mandarin		Language Line as Needed

Proportion to be Served by Demographic Characteristic					
Age Group %	**%**	**Gender**	**%**	**Race/Ethnicity**	**%**
0-15	84	Female	70	African American/Black	1
16-25	16	Male	30	American Indian/Alaskan Native	
26-64		Transgender		Asian/Pacific Islander	2
65+		Genderqueer		Caucasian/White	8
		Questioning/Unsure		Latino/Hispanic	89
		Other		Middle Eastern/North African	
				Other	

Target Population and Program Characteristics

Children's Support and Parenting Program (CSPP) serves a wide range of families from different backgrounds whose stressors make children more vulnerable to developing behavioral health problems. These stressors can include parental history of serious substance use disorder and/or mental illness; a family member's actual or potential involvement in the juvenile justice system; family members who have developmental or physical illnesses/disabilities; families impacted by divorce, domestic violence, trauma, unemployment and/or homelessness; and families with 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 program provides parent training and family-strengthening programs designed to reduce risk factors and increase protective factors for children and youth. 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.

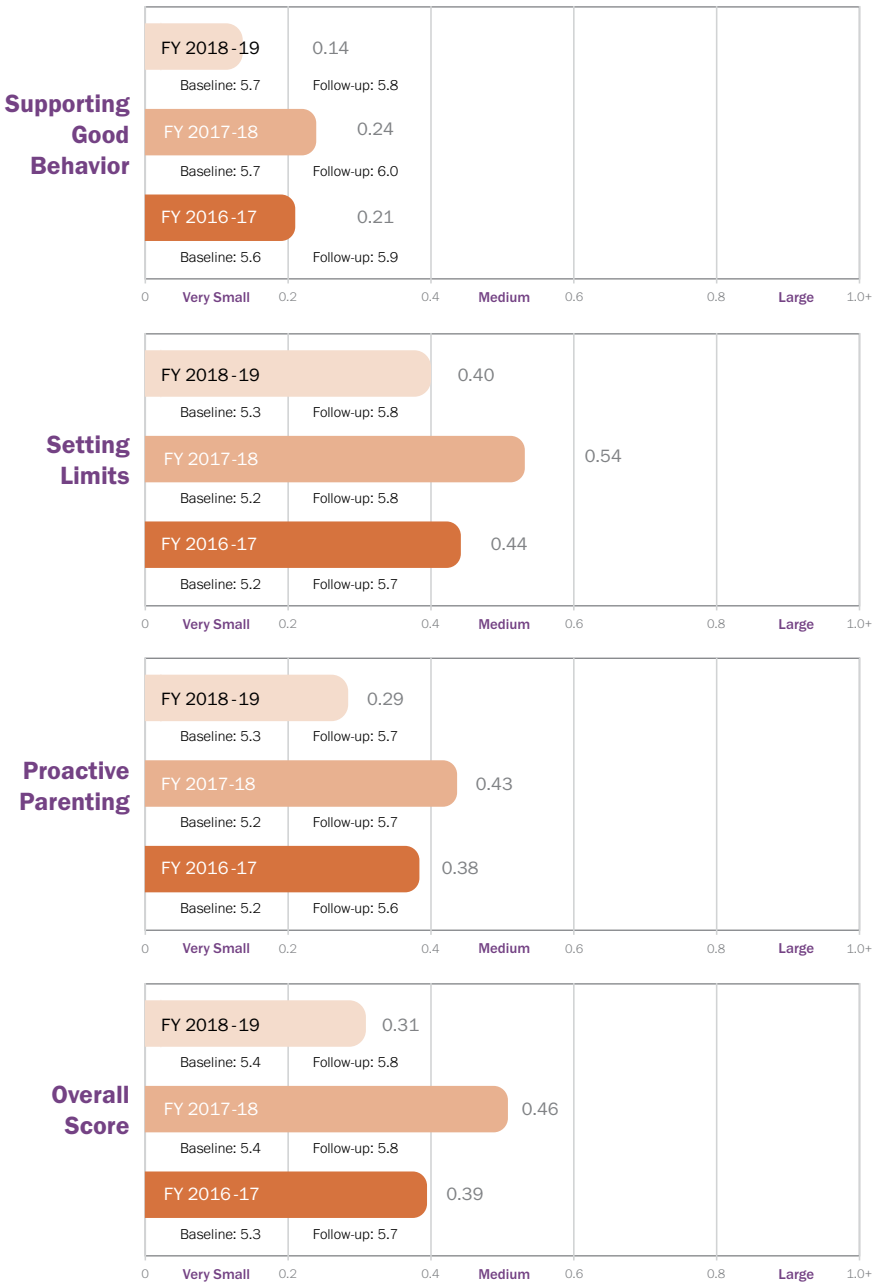
CSPP provides these services utilizing evidence-based curricula, and the program offers two different tracks depending on participant need: Strengthening Families or The Parent Project®. The curricula are delivered in a classroom-type setting in many different types of organizations and agencies such 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 Evidence Based Practices have been trained and certified to deliver the curriculum and adhere to it when presenting the material to participants.

Outcomes

Numbers Served		
FY 2016-17	FY 2017-18	FY 2018-19
1,065	897	875

Impact on PARCA-SE by FY

Children Support Service and Parenting Program



CSPP aims to prevent the development or worsening of mental health conditions by maintaining and/or strengthening the protective factor of effective parenting skills, which was assessed via the PARCA-SE. The PARCA-SE was administered at intake, every three months of program participation and at discharge, and the change in scores between intake and the most recent follow-up was analyzed and reported according to effect size, which reflects, in part, the extent to which a change is clinically meaningful for the individuals served.

Results across all three years show that parents not only consistently reported maintaining healthy levels of parenting efficacy but also made additional small to medium gains, particularly with regard to setting appropriate limits, while receiving services.

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 4,442 participants since its inception in July 2011. The program continues to provide educational series throughout the community at schools, Youth Reporting Centers, Family Resource Centers and other Community Based Organizations.

Reference Notes

Supporting Good Behavior:

FY 2018-19: Baseline M=5.7, SD=1.08; Follow-up M=5.8, SD=1.19; t(310)=2.45, p<.015; Cohen's d=0.14

FY 2017-18: Baseline M=5.7, SD=1.1; Follow-up M=6.0, SD=0.9; t(340)=-4.43, p<.001; Cohen's d=-0.24

FY 2016-17: Baseline M=5.6, SD=1.1; Follow-up M=5.9, SD=0.9; t(296)=-3.71, p<.001; Cohen's d=-0.21

Setting Limits:

FY 2018-19: Baseline M=5.3, SD=1.25; Follow-up M=5.8, SD=1.04; t(310)=6.95, p<.001; Cohen's d=0.40

FY 2017-18: Baseline M=5.2, SD=1.3; Follow-up M=5.8, SD=1.0; t(338)=-9.68, p<.001; Cohen's d=-0.54

FY 2016-17: Baseline M=5.2, SD=1.3; Follow-up M=5.7, SD=1.0; t(296)=-7.50, p<.001; Cohen's d=-0.44

Proactive Parenting:

FY 2018-19: Baseline M=5.3, SD=1.31; Follow-up M=5.7, SD=1.09; t(310)=5.03, p<.001; Cohen's d=0.29

FY 2017-18: Baseline M=5.2, SD=1.3; Follow-up M=5.7, SD=1.0; t(338)=-7.76, p<.001; Cohen's d=-0.43

FY 2016-17: 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:

FY 2018-19: Baseline M=5.4, SD=1.13; Follow-up M=5.8, SD=1.00; t(310)=5.48, p<.001; Cohen's d=0.31

FY 2017-18: Baseline M=5.4, SD=1.1; Follow-up M=5.8, SD=0.9; t(340)=-8.39, p<.001; Cohen's d=-0.46

FY 2016-17: Baseline M=5.3, SD=1.2; Follow-up M=5.7, SD=0.9; t(296)=-6.59, p<.001; Cohen's d=-0.39

Parent Education Services (PEI)

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics		
						
	At Risk	Field	Community Based	Parents	Families	Mono-Lingual/ Ethnic Community

Language Capacity of Direct Service Providers					
✓	Spanish	✓	Arabic		Khmer
✓	Vietnamese	✓	Farsi		Other:
✓	Korean		Mandarin		Language Line as Needed

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$1,064,770	FY 2019-20	1,969
Proposed FY 2020-21 Budget	$1,064,770	FY 2020-21	1,900
Proposed FY 2021-22 Budget	$1,064,770	FY 2021-22	1,900
Proposed FY 2022-23 Budget	$1,064,770	FY 2022-23	1,900

Proportion to be Served by Demographic Characteristic					
Age Group %	**%**	**Gender**	**%**	**Race/Ethnicity**	**%**
0-15	90	Female	72	African American/Black	1
16-25	10	Male	20	American Indian/Alaskan Native	1
26-64		Transgender	1	Asian/Pacific Islander	18
65+		Genderqueer		Caucasian/White	14
		Questioning/Unsure		Latino/Hispanic	63
		Other	7	Middle Eastern/North African	1
				Other	2

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 and 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, exposed to 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.

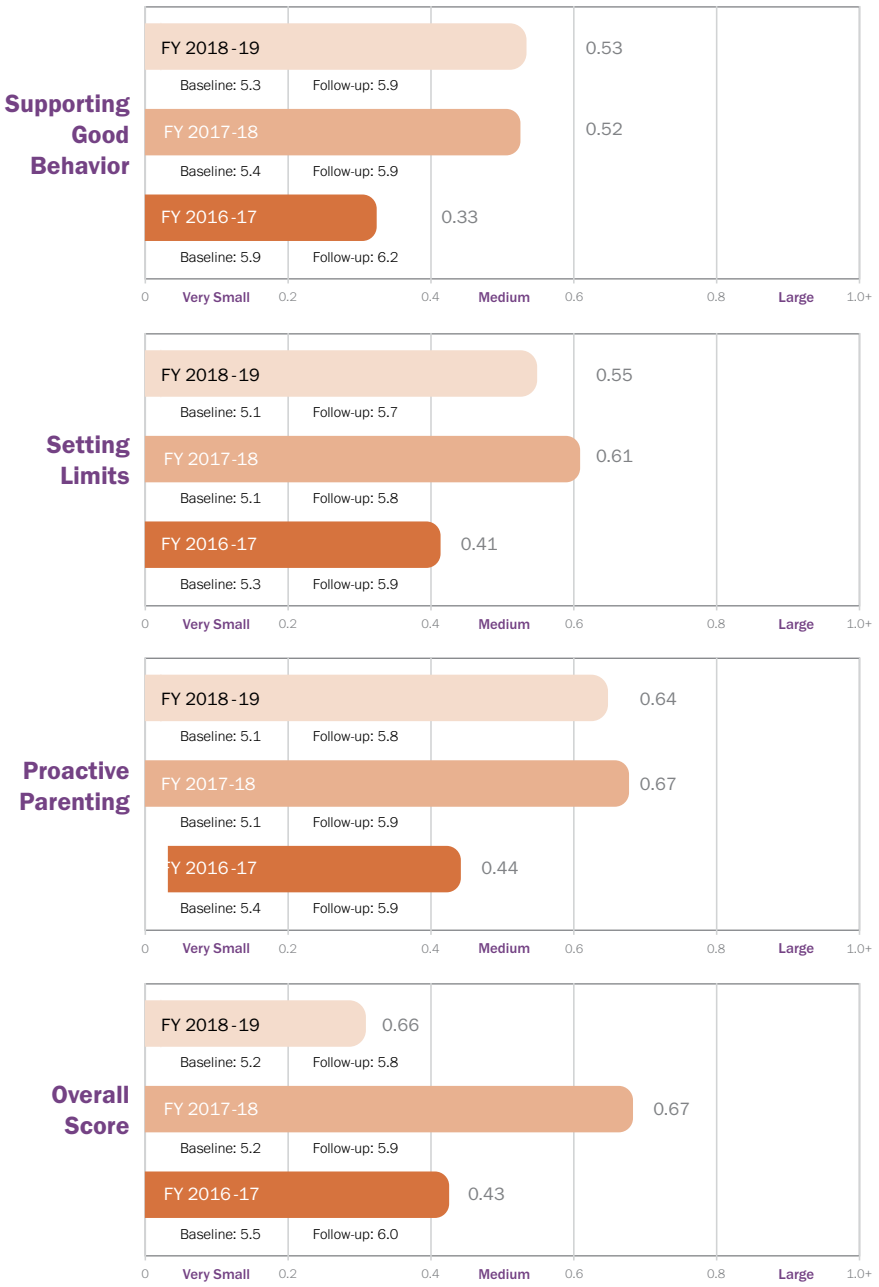
Services

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 by providing parenting education classes and individual interventions to parents and by providing additional support when parents need clarification about individual issues or need help in understanding the parenting curriculum.

The program guides its services through Active Parenting, an evidence-based parent training designed to reduce risk factors and increase family protective factors through practical, easy-to-use skills such as assisting parents in strengthening relationships with their children, reducing problem behaviors exhibited by children and increasing success of children in schools, by increasing cooperation and developing problem-solving skills. To ensure fidelity, all parent trainers are required to attend a comprehensive training prior to conducting classes. Parent trainers are also evaluated in the classroom a minimum of one time per month. In addition, PES provides case management activities, which include engagement, assessment and service coordination and delivery (e.g., navigating and linking to systems, monitoring, advocating for needs).

Impact on PARCA-SE by FY

Parent Education Services



Outcomes

Numbers Served		
FY 2016-17	**FY 2017-18[2]**	**FY 2018-19**
2,317	818	1,832

Similar to CSPP, program effectiveness for PES was evaluated through an assessment of the protective factor, parenting self-efficacy. Results generally demonstrated that parents not only maintained high levels of parenting efficacy while receiving services, but also made additional small to medium gains, with gains tending to be somewhat larger in the latter two years.

Challenges, Barriers and Solutions in Progress

The program continues to expand its reach in the community to address the needs of the diverse population of the County. Attendance from the LGBTIQ community and the deaf and hard of hearing community continues to grow. In addition, more classes for survivors of domestic violence are being offered and attended throughout the county, and these classes are formatted as closed sessions not open to the general public to protect the identity of the women. Most recently, the program was successful in getting access to the Orange County jails to provide classes to incarcerated women and men. Parenting classes are provided in multiple languages including Vietnamese, Korean, Farsi, Arabic, in addition to English and Spanish.

Community Impact

Parent Education Services has provided services to 13,067 at-risk children and families since its inception in October 2012. Program staff has 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

Supporting Good Behavior:

FY 2018-19: Baseline M=5.3, SD=1.12; Follow-up M=5.9, SD=0.88; t(1386)=19.17, p<.001; Cohen's d=0.53

FY 2017-18: Baseline M=5.4, SD=1.1; Follow-up M=5.9, SD=0.9; t(631)=-12.92, p<.001; Cohen's d=0.52

FY 2016-17: Baseline M=5.9, SD=1.1; Follow-up M=6.2, SD=0.9; t(780)=-9.21, p<.001; Cohen's d=0.33

Setting Limits:

FY 2018-19: Baseline M=5.1, SD=1.26; Follow-up M=5.7, SD=0.97; t(155)=20.10, p<.001; Cohen's d=0.55

FY 2017-18: Baseline M=5.1, SD=1.2; Follow-up M=5.8, SD=1.0; t(629)=-15.07, p<.001; Cohen's d=0.61

FY 2016-17: Baseline M=5.3, SD=1.3; Follow-up M=5.9, SD=1.1; t(780)=-11.25, p<.001; Cohen's d=0.41

Proactive Parenting:

FY 2018-19: Baseline M=5.1, SD=1.23; Follow-up M=5.8, SD=1.00; t(1381)=23.41, p<.001; Cohen's d=0.64

FY 2017-18: Baseline M=5.1, SD=1.3; Follow-up M=5.9, SD=1.0; t(629)=-16.32, p<.001; Cohen's d=0.67

FY 2016-17: Baseline M=5.4, SD=1.3; Follow-up M=5.9, SD=1.1; t(780)=-12.09, p<.001; Cohen's d=0.44

Overall Score:

FY 2018-19: Baseline M=5.2, SD=1.10; Follow-up M=5.8, SD=0.88; t(1386)=24.10, p<.001; Cohen's d=0.66

FY 2017-18: Baseline M=5.2, SD=1.1; Follow-up M=5.9, SD=0.9; t(632)=-16.66, p<.001; Cohen's d=0.67

FY 2016-17: Baseline M=5.5, SD=1.1; Follow-up M=6.0, SD=1.0; t(780)=-12.04, p<.001; Cohen's d=0.43

2 The program was not fully operational in FY 2017-18 and only served participants between October and June. Services were not offered in the first quarter (July-October) due to the closure of one provider site a month prior to the start of the fiscal year.

Family Support Services (PEI)

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics							
0-25	Severe	Field	Community Based	Foster Youth	Parents	Families	Criminal Justice	LGBTIQ	Co-Occuring SUD	Trauma-Exposed Clients	Mono-Lingual/ Ethnic Community

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$282,000	FY 2019-20	1,800
Proposed FY 2020-21 Budget	$282,000	FY 2020-21	1,800
Proposed FY 2021-22 Budget	$282,000	FY 2021-22	1,800
Proposed FY 2022-23 Budget	$282,000	FY 2022-23	1,800

Language Capacity of Direct Service Providers					
✓	Spanish		Arabic	✓	Khmer
	Vietnamese	✓	Farsi		Other:
✓	Korean		Mandarin		Language Line as Needed

Proportion to be Served by Demographic Characteristic					
Age Group %	**%**	**Gender**	**%**	**Race/Ethnicity**	**%**
0-15	2	Female	33	African American/Black	4
16-25	21	Male	23	American Indian/Alaskan Native	3
26-64	53	Transgender		Asian/Pacific Islander	10
65+	24	Genderqueer		Caucasian/White	60
		Questioning/Unsure		Latino/Hispanic	23
		Other	44	Middle Eastern/North African	
				Other	

Target Population and Program Characteristics

Family Support Services (FSS) serves families in which children, youth or adults are experiencing behavioral health or other stressful circumstances that may place the family at-risk. FSS 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

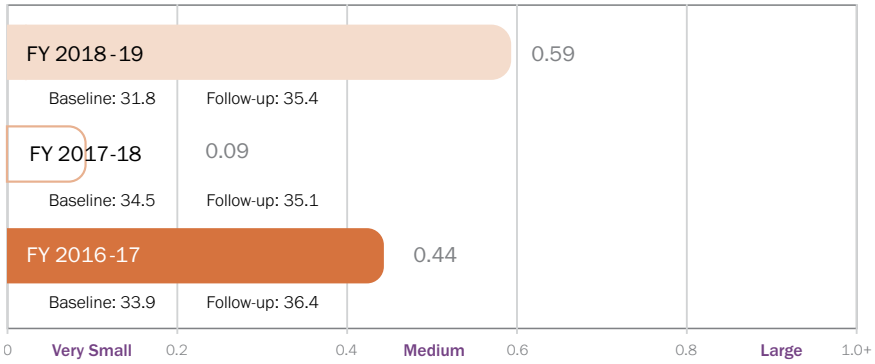
Services are designed to sustain and/or improve families' overall behavioral health by increasing protective factors through education and social support. The program provides ongoing family education on behavioral health issues to prevent the development of behavioral health problems in other members of the family. Family Support Services includes family-to-family support, behavioral health education, and support groups, and delivers 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. The program targets children, adults, and their families throughout Orange County experiencing behavioral health or other stressful circumstances that may place families at-risk with the goal to prevent the development of more intense mental health conditions. 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 perspective 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. Services are delivered through group support, weekly individual peer mentor support, educational workshops, a volunteer family mentor network and family engagement. The program also includes a component on practicing self-care when caring for a loved one with a behavioral health condition within the educational workshops.

Outcomes

Family Support Services	FY 2016-17	FY 2017-18[3]	FY 2018-19
Number of Parents/ Caregivers Served	1,741	1,502	1,997
Baseline + 1 Follow-up PROMIS GH Completed	557	107[4]	81

Impact on Global Health - PROMIS by FY

Family Support Services



FSS aims to prevent the development or worsening of mental health conditions by maintaining and/or strengthening the protective factor of Global Health as measured by the PROMIS. The PROMIS was administered at intake (baseline) and program exit (follow-up), and the

3 The program was not fully operational in FY 2017-18 and only served participants between October and June. Services were not offered in the first quarter (July-October) due to the closure of one provider site, a month prior to the start of the fiscal year.

4 In FY 2017-18, FSS services split off from PES. During this transition year, there was a drop in completed outcome measures.

difference in scores was analyzed and reported according to calculated effect size, which reflects, in part, the extent to which a change in functioning over time is clinically meaningful for the individuals served.

Across all three years, parents consistently reported high levels of global health as they entered the program and even made additional, moderate gains in FYs 2016-17 and 2018-19. Thus, FSS appeared to be effective in maintaining and/or enhancing the protective factor of global health among the participants it serves.

Challenges, Barriers and Solutions in Progress

The program faces challenges recruiting participants in the summertime when schools are 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.

Another significant challenge the program experiences is attendance at the Basics class, a six-week course designed to educate parents of children living with a mental illness about mental illness, parenting skills, caring for siblings, self-care and collaborating with providers and educators. The low attendance is due to difficulties the families have finding appropriate childcare. In response, the provider offers several classes at a time allowing so participants have multiple opportunities to attend, classes are offered throughout Orange County so participants can choose the most convenient location, and childcare is provided on site.

Community Impact

The program has served 12,448 total families/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

PROMIS Global Health:

FY 2018-19: Baseline M=31.8, SD=7.74; Follow-up M=35.4, SD=6.39; t(80)=5.18, p<.001; Cohen's d=0.59

FY 2017-18: Baseline M=34.5, SD=6.2; Follow-up M=35.1, SD=7.1; t(106)=-0.93, p=.35; Cohen's d=0.09

FY 2016-17: Baseline M=33.9, SD=6.7; Follow-up M=36.4, SD=5.6; t(556)=-10.31, p<.001, ;Cohen's d=0.44

Continuum of Care for Veterans and Military Families (INN)

Program Serves	Location of Services		Typical Population Characteristics		
					
	Field	Community Based	Parents	Families	Veterans

Language Capacity of Direct Service Providers					
✓	Spanish		Arabic		Khmer
	Vietnamese		Farsi		Other:
	Korean		Mandarin	✓	Language Line as Needed

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$962,445	FY 2019-20	200
Proposed FY 2020-21 Budget	$962,445	FY 2020-21	200
Proposed FY 2021-22 Budget	-	FY 2021-22	-
Proposed FY 2022-23 Budget	-	FY 2022-23	-

Proportion to be Served by Demographic Characteristic					
Age Group %	**%**	**Gender**	**%**	**Race/Ethnicity**	**%**
0-15	50	Female	50	African American/Black	15
16-25	10	Male	50	American Indian/Alaskan Native	
26-64	35	Transgender		Asian/Pacific Islander	10
65+	5	Genderqueer		Caucasian/White	45
		Questioning/Unsure		Latino/Hispanic	30
		Other		Middle Eastern/North African	
				Other	

Target Population and Program Characteristics

The **Continuum of Care for Veteran & Military Children and Families** Innovation project integrates military culture and services into Families and Communities Together (FaCT) Family Resource Centers (FRCs) located throughout Orange County. 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. The target population served includes active service members, reservists, veterans (regardless of their discharge status) and their children, spouses, partners and loved ones.

Services

Peer Navigators with lived military experience are 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 is also staffed with clinicians who, with the on-going support of Peer Navigators, provide counseling and trauma-informed care utilizing evidence-based practices. Additional services include referral and linkage to County and community programs.

Continuum of Care for Veteran & Military Children and Families was implemented July 1, 2018. The primary purpose of this project is to increase access to mental health services, with a goal of making a change to an existing practice in the field of mental health, including but not limited to, application to a different population. Innovation funds for this project will end June 30, 2021.

Outcomes

During FY 2018-19, program staff collaborated with 10 FaCT FRC sites to integrate services throughout Orange County and to increase their visibility within the community. Staff conducted 37 community outreach events and will continue to expand services into the remaining five FRC sites in coming fiscal years. Peer Navigators, clinicians and the Veterans Legal Institute conducted 151 staff trainings for FRC staff, which included 38 specialty trainings on military legal issues, domestic violence and housing. During the program's initial year, staff refined the FRC intake procedures to better screen for both military affiliation and domestic violence, created a comprehensive training on working with military-connected families, and began developing an online, military-specific training platform for all FRC staff.

In FY 2018-19, 37 military-connected families (n=140 individual family members) were served. A total of 475 case management and 83 clinical sessions were provided to families, which included 281 specialty sessions focused on housing and domestic violence. Due to their lived experience and extensive training, the Peer Navigators were able to identify needs and appropriately refer the families to resources, thereby increasing the likelihood that families would receive needed services in a timely manner.

Challenges, Barriers and Solutions in Progress

The largest challenge within the first year of services was the immense collaboration involved to move the project into existing Family Resource Centers throughout Orange County. Each FRC has its own culture and process tailored to meet the needs of its unique community. Learning how to best serve within each FRC included embedding the project staff fully into the FRC. This included attending FRC-related events and meetings and working closely with the staff to learn their specific system and design. Project leadership staff also invested time to meet with key stakeholders within the FRC network's FACT Leadership Council as well as the FRC's Coordinators Council. Due to all of the partner agencies involved, implementing new processes takes time. Project staff continues to work on refining processes in order to reduce this barrier. Another challenge was the trend towards families indicating a present or past experience with domestic violence. The collaborative partner agency Human Options was able to provide specialty clinical and case management to these families and to also meet and train FRC Coordinators on how to screen, assess and respond to these families.

Community Impact

The lead agency for this project, Child Guidance Center, and their collaborative partners, is committed to informing nonmilitary community organizations about the importance of identifying, engaging and serving military families to best meet their needs. These partners presented at the FaCT Annual Conference on "The Sacrifices of Service: The Unique Experiences of Military Members, Veterans, and Their Families" and facilitated two breakout sessions that focused on the current systems in place for military families, its gaps, and solutions to address those gaps. This was the first time in the history of the FaCT conference that a breakout session was conducted regarding military-connected families. To further train community agencies on the topic, the collaborative partners also provided an in-service training available to all FRC staff and community providers throughout Orange County titled, "Building Military Cultural Competency in the FRCs to Collaboratively Serve Military Families." These trainings were well received by both the FRC staff, the FaCT Program Administrators, and has increased interest on being trained in this area amongst community providers.

Summary of MHSA Strategies Used by Supportive Services Programs: Family Support

Strategies to Promote Recovery/Resilience

These programs help promote recovery and resilience by helping participants enhance their communication skills and social skills, and by assisting parents/caregivers, in particular, to strengthen family roles, define family goals and rules and leverage their own resources and collateral resources, etc. In addition, the FSS 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. In addition, the Continuum of Care project is staffed with Peer Navigators who have specific experience and knowledge of military culture and they train FRC staff on military culture and identifying military-connected families, which has increased military cultural awareness among non-veteran serving organizations.

Strategies to Reduce Stigma and Discrimination

The programs strive to make their services available to all eligible Orange County residents in a manner that is sensitive and responsive to participants' diverse backgrounds. This is reflected, in part, by partnering with local trusted groups who work with unserved communities (i.e., LGBTIQ, deaf and hard-of-hearing, monolingual, veterans and military-connected families, etc.) and providing services/materials in multiple languages. In addition, because the stigma of being a "family in need" can be a barrier to seeking services, programs operate in community locations where families may already be going for other reasons, such as schools or family resource centers. Military-connected families seeking FRC resources have the opportunity to access behavioral health services through a less stigmatizing point of entry. Peer Navigators also connect with families by sharing their military backgrounds, which helps overcome fears of being misunderstood. Finally, many of the youth referred for mentoring 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 helps to build confidence in the youth and hope for their families, thus building their resilience and wellness.

Strategies to Increase Access to Services: Timely Access for Underserved Populations and Linkage to Treatment

To increase access to their respective programs, staff conducts outreach to potential referral sources (i.e., County outpatient clinics for all programs; organizations serving at-risk families, churches, community centers, child- and family-serving centers, schools with low achievement rates, early child care centers including Head Start and Early Head Start programs, and mental health agencies for the parent/family support programs). CSPP, PES and FSS staff also host information tables at health fairs and community and cultural events.

For youth and families referred to their programs, transportation, childcare, coordination of schedules can be barriers to accessing services. As such, mentors for children and youth provide transportation to and from events, which are scheduled after school hours and on the weekends. Similarly, CSPP and PES offer their services throughout the county at locations that are accessible to participants, such as school sites, family resource centers, community centers, churches, county libraries, hospitals, shelters and county jails. They also schedule services at various times (morning, afternoons and evenings), offer childcare, and frequently provide meals as a way to encourage participation. Finally, programs provide services and materials in multiple languages.

To meet the specific, complex needs of military families, the collaboration of non-profit community organizations, Strong Families, Strong Children (SFSC) Collaborative, provided specialty services to families with domestic violence, housing and legal needs. Providing access to these services directly within the FRCs enables Peer Navigators to connect with participants while they are seeking other support services and provide them with timely access to behavioral health support and treatment, as well as other needed services.

The INN project also trains 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 target population. FRCs also serve as a new point of entry into behavioral health and supportive services for military families. The support offered by a military-connected peer increases 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.

In addition to ensuring timely access to its own services, the parent/family programs work to refer families to appropriate community resources:

Supportive Services Programs: Family Support		Linkage Metrics		
		# Referrals	# Linkages	Types of Linkages
CSPP (PEI)	FY 2016-17	224	67	Behavioral Health Prevention, Intervention and Outpatient programs; transportation assistance; basic needs (e.g., donate services); food and nutrition assistance; housing resources and advocacy; and legal services and advocacy
	FY 2017-18	114	105[5]	
	FY 2018-19			
Continuum of Care for Veterans and Military Families (INN)	FY 2016-17	-	-	Legal services, mental health care, transportation, homeless services, affordable housing, primary/dental care, clothing, job placement, food and nutrition, job placement, food/ nutrition, other services (i.e., child support, financial, utility assistance, etc.)
	FY 2017-18	-	-	
	FY 2018-19	158	113	

[5] Beginning in FY 2017-18, CSPP focused referrals on services with a high likelihood that clients would link. Therefore, the nmber of referrals decreased, but the linkage rate increased.

GENERAL SUPPORT

General Support programs provide supplementary services designed to improve recovery by helping participants meet essential needs such as transportation assistance and/or develop skills. At present, all programs in this subset are for adults 18 and older and are funded through CSS. However, the transportation program, described below, will be expanded to include assistance for children (while accompanied by their parent/caregiver).

Transportation (CSS, PEI)

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics						
18+	Severe	Field	Community Based	LGBTIQ	Veterans	Homeless/At risk	Co-Occurring (SUD)	Co-Occurring (Medical)	Trauma-Exposed Clients	Mono-Lingual/ Ethnic Community

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$900,000	FY 2019-20	1,200
Proposed FY 2020-21 Budget	$1,150,000	FY 2020-21	1,575
Proposed FY 2021-22 Budget	$1,300,000	FY 2021-22	1,650
Proposed FY 2022-23 Budget	$1,300,000	FY 2022-23	1,650

** The budget and projected rides currently only reflect CSS funds; PEI costs will be added once transportation need and costs have been projected.*

Target Population and Program Characteristics

The Transportation program currently serves adults ages 18 and older, who have a serious mental illness or substance use disorder, and who need transportation assistance to and from necessary County behavioral health and/or primary care appointments, as well as behavioral health supportive services. Individuals are referred to the program by their BHS treatment provider, following an assessment of their transportation needs and their history of missing their scheduled appointments due to transportation issues.

Based on results of the community planning process, this program is being expanded to provide transportation assistance to participants enrolled in PEI programs. In addition, HCA will explore: 1) options for

expanding services to youth and to families with children, including those who must be transported in child safety seats; 2) the feasibility of expanding the program to include transportation assistance to support services that help address social determinants of health; and 3) how to leverage transportation assistance provided by other partners and agencies (i.e., CalOptima, etc.) so that efforts are not being duplicated unnecessarily.

Services

Individuals are 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. Individuals also have the ability to stop and get their prescriptions filled as necessary.

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 were 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 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.

Strategies to Improve Timely Access to Services for Underserved Populations

The program facilitates 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.

Program Utilization (Outcomes)

The contract began 7/1/2018, with the first ride on 7/12/2018. The total number of rides provided in its first year of operations was 22,202.

Challenges, Barriers and Solutions in Progress

One of the biggest challenges for this program is for clients to remember to schedule their transportation service 24-hours in advance of their appointment times. The purpose of this is to allow the Transportation provider to schedule its fleet of drivers the night before for their appointments the next day. With the high demand for transportation services on a daily basis (Monday-Friday), in all regions of the county, it has been very challenging for drivers to get to their scheduled pick-up/drop-off locations on time without the 24-hour notice. In an effort to ensure drivers can be at the right place at the right time, the Transportation provider has identified the highest utilized areas, and increased its driver fleet in those areas during known times when there is a high need, which has resulted in minimizing any delays for pick-ups/drop-offs. Additional contingency plans are under development that will enable the Transportation provider to meet the high demands despite not always getting a 24-hour notice for service.

Supported Employment

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics				
								
	Severe	Field	Community Based	LGBTIQ	Veterans	Homeless/ At risk	Co-Occuring (SUD)	Trauma-Exposed Clients

Language Capacity of Direct Service Providers					
✓	Spanish		Arabic		Khmer
✓	Vietnamese	✓	Farsi		Other:
	Korean		Mandarin	✓	Language Line as Needed

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$1,371,262	FY 2019-20	360
Proposed FY 2020-21 Budget	$1,371,262	FY 2020-21	360
Proposed FY 2021-22 Budget	$1,371,262	FY 2021-22	360
Proposed FY 2022-23 Budget	$1,371,262	FY 2022-23	360

Proportion to be Served by Demographic Characteristic					
Age Group %	**%**	**Gender**	**%**	**Race/Ethnicity**	**%**
0-15		Female	40	African American/Black	6
16-25	20	Male	60	American Indian/Alaskan Native	1
26-64	71	Transgender		Asian/Pacific Islander	10
65+	9	Genderqueer		Caucasian/White	43
		Questioning/Unsure		Latino/Hispanic	35
		Other		Middle Eastern/North African	1
				Other	4

Target Population and Program Characteristics

The **Supported Employment** (SE) program serves Orange County residents 18 and older who are living with serious 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.

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 participants to develop 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.

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 many opportunities 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 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.

Strategies to Increase Access to Services: Timely Access for Underserved Populations and Linkage to Treatment

The Supported Employment 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 and 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. In addition, services are provided in English, Spanish, Vietnamese, Korean, Farsi and American Sign Language.

Outcomes

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. A total of 68% met this benchmark during FY 2018-19, continuing the trend of an increasing graduation rate since FY 2016-17. This is notable as improving employment outcomes for adults in the BHS system of care continues to be challenging for many other programs.

Numbers Served	FY 2016-17	FY 2017-18	FY 2018-19
TOTAL	405	474	432
New Enrollments	291	334	311
% Served Who Graduated	58%	49%	68%

Challenges, Barriers and Solutions in Progress

During FY 2017-18, SE experienced changes in staffing by only having one program manager managing the two regions instead of two managers. There was also rapid staffing turnover at both North and South. In addition, referrals to the program in South County have been low, and the provider has increased its outreach efforts to programs in that region to improve referrals.

Community Impact

The Supported Employment program has provided services to more than 3,000 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 and local MHSA steering committee meetings.

HOUSING SUPPORT

Short-Term Housing Services (CSS)

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics		
0-21	Severe	Residential	Foster Youth	Criminal Justice	Trauma- Exposed Clients

Language Capacity of Direct Service Providers					
✓	Spanish		Arabic		Khmer
✓	Vietnamese	✓	Farsi		Other:
	Korean		Mandarin	✓	Language Line as Needed

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$1,367,180	FY 2019-20	90
Proposed FY 2020-21 Budget	$1,367,180	FY 2020-21	90
Proposed FY 2021-22 Budget	$1,367,180	FY 2021-22	90
Proposed FY 2022-23 Budget	$1,367,180	FY 2022-23	90

Target Population and Program Characteristics

Short-Term Housing Services (formerly called Year-Round Emergency Shelter) serves adults experiencing homelessness with serious mental illness who may also have a co-occurring substance use disorder and are in need of immediate shelter. Individuals referred to the program are actively participating in services at an Adult and Older Adult Behavioral Health County or County-contracted outpatient clinic, PACT or Assembly Bill (AB) 109 program.

Services

This program has MHSA-dedicated beds within an existing 200-bed shelter. In addition to daily shelter, the program provides 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 are considered on a case-by-case basis.

Outcomes

As reported below, the program has been successful in reaching its goals:

Short-Term Housing Services Metrics	FY 2017-18	FY 2018-19
Total Served	95	89
Average Length of Stay (ALOS) is 120 Days or Less	ALOS = 82 days	ALOS = 58 days
% Who Found Permanent or Transitional Housing within 120 Days is > 25%	40%	33%

Strategies to Promote Recovery/Resilience

The program addresses the basic needs of adults experiencing homelessness, 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 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 can smoothly transition to housing from the streets and end their episodes of homelessness. In additional, 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.

Strategies to Increase Access to Services: Timely Access for Underserved Populations and Linkage to Treatment

Staff from the Office of Care Coordination's contracted provider is onsite daily and the BHS Outreach and Engagement team is onsite two times per week to conduct needs assessments and make direct linkages to needed services such as more permanent housing, transportation, behavioral health services and assistance with benefits acquisition. Bicultural/ bilingual staff provides services in English, Spanish and Vietnamese.

Challenges, Barriers and Solutions in Progress

The facility does not allow in-and-out day access which can be a difficult adjustment for participants who are not used to a shelter environment. The program works to increase receptiveness to staying in the shelter by addressing other important needs, including allowing pets and partners to stay in the shelter with participants, as well as providing medication storage, storage of personal items and case management. In addition, having BHS Outreach and Engagement staff go to the shelter allows participants to receive support from the outreach worker with whom they have already built rapport, which can help facilitate their engagement in behavioral health services now that they are in a more stable environment.

Bridge Housing for the Homeless (CSS)

Program Serves	Location of Services	Typical Population Characteristics	
18+	Residential Setting	Homeless/At risk	Co-Occuring SUD

Language Capacity of Direct Service Providers					
✓	Spanish		Arabic		Khmer
	Vietnamese		Farsi		Other:
	Korean		Mandarin	✓	Language Line as Needed

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$2,000,000	FY 2019/20	80
Proposed FY 2020-21 Budget	$2,000,000	FY 2020/21	80
Proposed FY 2021-22 Budget	$2,000,000	FY 2021/22	80
Proposed FY 2022-23 Budget	$2,000,000	FY 2022/23	80

Target Population and Program Characteristics

Bridge Housing for the Homeless offers 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. The program also serves adults experiencing homelessness who have not yet received a certificate but are beginning the process. Adults (including couples) are eligible if they are homeless, are living with a serious mental illness, and may have a co-occurring substance use disorder. Participants are referred to the program primarily by staff from HCA Outreach and Engagement (O&E), Orange County Housing Authority (OCHA), County and County-contracted clinics, and Full Service Partnership programs.

Services

The program uses 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 are already engaged in services, it is not a requirement for being housed. Services include housing, meals and assistance in guiding individuals through the CoC process. Staff assists participants in locating housing units that will accept their CoC certificate, prepares them to be ready to live in permanent housing, and, if needed, links them to outpatient treatment. Program staff collaborates with housing navigators and landlords to identify appropriate permanent housing options. Bridge Housing is available for up to one year for those with certificates and up to 18 months for those who in the process of applying for a certificate.

Outcomes

Bridge Housing for the Homeless tracks a number of measures to monitor its performance in supporting adults living with serious mental illness find permanent housing. During FY 2018-19, its first year of operation, the program successfully reached all of its targets measurable during that year.

Bridge Housing for the Homeless Metrics	FY 2018-19
Total Served	**78**
Average # of potential landlords contacted per month (Target: > 15)	27
% of clients with CoC certificates who moved into permanent housing within 1 year (Target: > 50%)	100%
% of clients w/out CoC certificates who moved into permanent housing within 18 months (Target: > 50%)	In progress* (16% housed in 12 months)
% of clients who secured work or entitlements w/in 6 mo. of intake (Target: > 50%)	60%

** Services launched in July 2018 so the18-month mark had not yet passed by the end of FY 2018-19.*

Strategies to Promote Recovery/Resilience

The program addresses individuals' basic needs, including shelter and food. This creates a safe environment in which participants can make progress toward their recovery while securing permanent housing. Staff uses Motivational Interviewing to engage participants and help them identify their own needs and challenges. This evidence-based therapeutic approach facilitates independence through self-discovery, and helps individuals become more ready for independent or supportive housing.

Strategies to Reduce Stigma and Discrimination

Program staff conducts 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.

Strategies to Increase Access to Services: Timely Access for Underserved Populations and Linkage to Treatment

The Housing First model aims to reduce or eliminate barriers to housing. Staff works 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 ensure availability of services in a variety of languages. They also collaborate with County and County-contracted clinics and FSPs to link individuals to treatment, as needed.

MHSA/CSS Housing Program (CSS)

Target Population and Program Characteristics

In contrast to the programs described above that provide time-limited shelter in combination with behavioral health services and supports, the **MHSA/CSS Housing Program** 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 and are experiencing homelessness or risk of homelessness. Additional eligibility requirements can vary at each location due to requirements of other funding partners.

The program funds development costs and Capitalized Operating Subsidy Reserves (COSR). Development costs are used for the acquisition, construction and/or rehabilitation of permanent supportive housing. COSR primarily helps cover the 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 entitlement and/or employment income. Behavioral health and other supportive services are located on- and off-site to ensure access to a continuum of services that help residents adjust to and maintain their independent housing.

Original funding allocations for this program included:

- A one-time State allocation of $8 million in FY 2006-07 to develop permanent supportive housing for individuals with serious mental illness who were receiving services in the Full Service Partnership programs. Funds were used to develop 34 housing units in two developments
- A one-time State allocation of $33 million in FY 2007-08 carved out of the CSS allocation (i.e., MHSA Housing Program) and used for 10 housing developments that created an additional 194 new units of PSH in Orange County

The table below provides details about these projects which resulted in the development of 194 new PSH MHSA units for eligible tenants and their families.

Housing Projects Funded by One-Time Allocations

Project	Year	1-Bedroom Units	2-Bedroom Units	Manager's Unit	Total MHSA Unit	Total Units Including MHSA	Total
Alegre Apartments	2015	11	0	1	11	104	$2,912,200
Avenida Villas	2014	24	4	1	28	29	$6,519,200
Capestone Apartments	2014	19	0	1	19	60	$4,445,468
Cotton's Point Seniors	2014	15	0	1	15	76	$2,022,400
Depot at Santiago	2018	10	0	1	10	70	$1,615,320
Diamond Apartments	2009	15	9	1	24	25	$1,583,222
Doria Apartments , Phase I	2011	10	0	1	10	60	$1,500,000
Doria Apartments, Phase II	2013	8	2	1	10	74	$2,019,850
Fullerton Heights	2018	18	6	1	24	36	$6,300,000
Henderson House	2016	14	0	0	14	14	$3,542,884
Oakcrest Heights	2018	7	7	1	14	54	$2,550,798
Rockwood Apartments	2016	14	1	1	15	70	$3,222,974
TOTAL					**194**	**672**	**$37,895,786**

MHSA Special Needs Housing Program (SNHP)

When the MHSA Housing Program concluded in May 2016, the state created the Local Government Special Needs Housing Program (SNHP). Local stakeholders identified an on-going and persistent need for housing for individuals living with serious mental illness and who are homeless or at risk of homelessness. As such, multiple CSS transfers to the SNHP operated by the California Housing Finance Agency's (CalHFA) occurred over several years:

- $5 million in FY 2016-17 following local community planning input
- $20 million total in FY 2017-18 upon directive by the Board of Supervisors
- $70.5 million total in FY 2018-19 was approved upon directive by the Board of Supervisors
  - To date, $40 million was transferred to the SNHP to fund the development of new MHSA-eligible housing units throughout Orange County, leaving a balance of $30,500,000 available for future projects
  - On December 12, 2019, the Board approved allocating $10 million to the 2020 Supportive Housing Notice of Funding Availability and the remaining $20.5 million to the Orange County Housing Finance Trust (Trust)[6]

Strategies to Promote Recovery/Resilience

The HCA Behavioral Health Services is involved with development, leasing, onsite supportive services, crosswalk and management meetings, maintaining the MHSA waitlist, and providing oversight of all of the MHSA Housing projects. Each MHSA housing project offers onsite supportive services provided by Full Service Partnerships, the Program for Assertive Community Treatment (PACT) and Residential Clinical Services Coordinators (RCSC). All services are customized and comprehensive, which supports housing stability and community integration among residents receiving MHSA housing.

Strategies to Reduce Stigma and Discrimination

Staff trains property management staff and managers in Mental Health First Aid, SafeTalk and other relevant trainings to help build their understanding on how to better respond to and communicate with residents who are living with serious mental illness.

Strategies to Increase Access to Services: Timely Access for Underserved Populations and Linkage to Treatment

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.

Challenges, Barriers and Solutions in Progress

The 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 other funding opportunities and leveraging resources with other community and County partners.

Community Impact

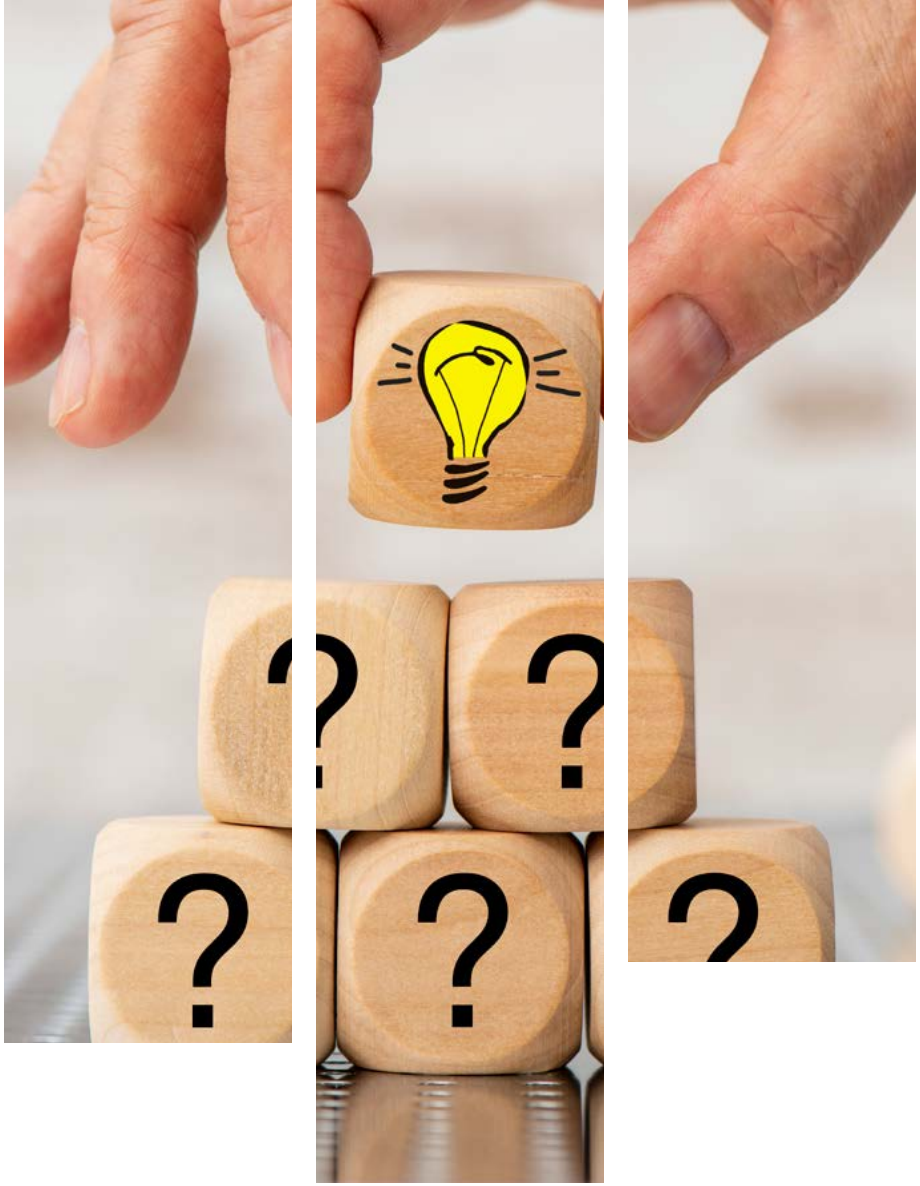
Increasing access to permanent supportive housing helps to break the cycle of homelessness for many individuals with serious mental illness by improving housing stability, employment and mental and physical well-being. In addition, these MHSA units are integrated in larger housing developments that provide non-MHSA units of critically needed affordable housing in Orange County.

6 In September 2018, CalHFA issued an initial notice to jurisdictions that they would discontinue the Program considering the passage of Proposition 2 and the creation of the No Place Like Home (NPLH) program. On November 29, 2018, CalHFA provided a final notice to counties that the SNHP would be discontinued and no longer accept additional applications for eligible projects after January 3, 2020, which is why remaining funds were not transferred to the SNHP.

Housing Project Pipeline						
Project	**City**	**Estimated Completion**	**SNHP Units**	**NPLH Units**	**Total MHSA Units**	**Total Units**
Santa Ana Arts Collective	Santa Ana	2019	15	0	15	58
Aqua	Santa Ana	2020	28	0	28	57
Santa Ana Veteran Village	Santa Ana	2020	20	0	20	76
Jamboree PSH	Anaheim	2021	35	0	35	70
Altrudy Seniors	Yorba Linda	2021	10	10	10	48
Francis Xavier	Santa Ana	2021	13*	9	13	17
Legacy Square	Santa Ana	2022	10	16	16	93
Westminster Crossing	Westminster	2021	20	0	20	65
Villa St. Joseph	Orange	2022	18	18	18	50
The Groves Senior Apartments	San Juan Capistrano	2021	10	0	10	75
Mountain View	Lake Forest	2022	12	12	12	71
Casa Paloma	Midway City	2022	24	24	24	49
Airport Inn Apartments	Buena Park	2021	28	19	28	58
Orchard View Gardens	Buena Park	2022	8	8	8	66
Santa Angelina Senior Community	Placentia	2022	16	16	16	65
Center for Hope	Anaheim	2022	0	48	48	100
Cartwright Family Apartments	Irvine	2022	10	0	10	60
Lincoln Avenue Apartments	Buena Park	2022	10	0	10	55
Westview	Santa Ana	2021	0	26	26	85
Huntington Beach Senior Housing	Huntington Beach	2022	0	20	20	43
TOTAL			**287**	**226**	**388**	**1,261**

** 9 of the 13 SNHP units were also awarded NPLH funds, as shown in the NPLH column*

SYSTEM SUPPORT



- Workforce Education and Training
- Capital Facilities and Technological Needs
- Special Projects

WORKFORCE EDUCATION AND TRAINING

FY 2020-21 to FY 2022-23 Program Budget	
Actual FY 2019-20 Budget	$5,085,282
Proposed FY 2020-21 Budget	$6,216,634
Proposed FY 2021-22 Budget	$5,219,984
Proposed FY 2022-23 Budget	$5,296,662

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 well-being, recovery and resilience. The WET Coordinator also serves as a liaison to the Southern California Regional Partnership (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. Orange County continues to fund WET programs, described in greater detail below, to serve the Orange County behavioral health workforce, mental health consumers and their family members.

Collectively, WET programs continue to reach a large audience, with FY 2018-19 demonstrating a 21% increase in attendance from FY 2016-17. In FY 2018-19, roughly 10,831 individuals and/or community members attended WET trainings and activities. Attendance in previous fiscal years found that 6,258 and 8,949 individuals attended WET trainings and activities in FYs 2017-18 and 2016-17, respectively.[1]

[1] Data was reported incorrectly in the FY 19-20 MHSA Plan Update.

Statewide WET Program

The FY 2019-20 state budget included approximately $40 million to fund county MHSA WET programs statewide. To secure these funds, county behavioral health agencies must collectively provide a 33% match or $13.2 million by 2025. County contributions must also be transferred to a third party entity and used for WET purposes to fund pipeline/career awareness, scholarships, stipends and loan repayment programs. The County Behavioral Health Directors Association (CBHDA) has proposed that CalMHSA act as this entity and ensures contributions are returned to the county for WET purposes. In addition, CBHDA was authorized by its Board to calculate a suggested contribution for each county based on the current MHSA allocation formula. Based on the current MHSA allocation formula, the suggested contribution for Orange County's share of the match is **$1,071,050**. Orange County proposes to transfer the full amount of its suggested contribution in FY 2020-21.

Workforce Staffing Support

Program Description/Impact

The **Workforce Staffing Support** (WSS) program performs three functions: (1) Workforce Education and Training Coordination, (2) Consumer Employment Specialist Trainings and One-on-One Consultations, and (3) 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. In FY 2018-19, WSS programs provided trainings to a total of 3,927 individuals including County staff, County-contracted staff and general community members. This is an increase from FY 2017-18, where a total of 3,108 individuals attended WSS trainings. In FY 2016-17, WSS programs provided trainings for 4,689 individuals.

- **Workforce Education and Training Coordination**: Orange County regards coordination of workforce education and training as a key strategy to promoting recovery, resilience and culturally competent services. Multidisciplinary staff members design and monitor WET programs, research pertinent training topics and contents, and provide and coordinate trainings. As noted in the table, WET provided a large number of in-person professional development trainings between FYs 2016-17 and 2018-19. Training topics included Law and Ethics, 5150/5585 Involuntary Hospitalization and Designation, Patients' Rights Respect and Dignity, Rights for Individuals in Inpatient and Outpatient Mental Health Facilities, Developing and Enhancing Competence in Clinical Supervision, Group and Individual Crisis Response, Housing Placement, Raising Awareness About First Episode of Psychosis, Response to Active Shooters, Meeting of the Minds, Continuum of Care, and Understanding ASAM Criteria in the Context of the California Treatment System.

  In FY 2015-16, WET sought to increase access to training by launching online training that offered Continuing Education (CE) and Continuing Medical Education (CME) credits for County and County-contracted providers who could not attend a live training. In the first two fiscal years after launch, nine online trainings were offered annually. In FY 2018-19 only one online training was offered as HCA transitioned to a new Learning Management System (LMS) where employees now have access to over 70 online trainings annually.

- **Consumer Employment Specialist Trainings/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. The specialist provided training on topics such as Ticket to Work, Reporting Overpayment, 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.

WSS Trainings and Consultations	FY 2016-17		FY 2017-18		FY 2018-19	
	Trainings	Attendees	Trainings	Attendees	Trainings	Attendees
Professional Development	136[2]	3,997[2]	102[2]	2,556[2]	82	3,351
Consumer Employment Support	67	691	65	551	63	575

[2] Data was reported incorrectly in the FY 19-20 MHSA Plan Update.

- **Multicultural Development Program**: The Multicultural Development Program (MDP) consists of staff with language proficiency and culturally-responsive skills who support the workforce by providing trainings on various multicultural issues. The MDP also provides translation/interpretation services utilizing in-house staff and a contracted provider. During FY 2018-19, there was a dramatic increase in the number of interpretation services provided in Spanish, Vietnamese, Arabic, Farsi and ASL,[3] which was attributable to the fact that HCA programs are more aware of and, thus, utilizing the different interpretation resources now available. This includes interpretation services provided on-site and over the phone.

  MDP staff and Language Line services also translated, reviewed and field-tested a total of 223 documents into the threshold languages of Spanish, Vietnamese, Farsi, Korean and Arabic in FY 2018-19, which was level from the previous fiscal year.[4] In addition, a Licensed Marriage Family Therapist (LMFT) serves in the MDP as a Deaf and Hard-of-Hearing Coordinator to ensure that American Sign Language (ASL) interpretation support is provided at trainings, MHSA Steering Committee and community meetings.

  In FY 2017-18, 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 who meet and provide input on how to incorporate cultural sensitivity and awareness into the BHS system of care. Although the overall count of unduplicated participants declined in FY 2018-19 compared to the previous two fiscal years, this was likely due to meeting cancelations. The goal of these meetings was to provide linguistically and culturally-appropriate behavioral health information, resources and trainings to underserved consumers and family members.

Multicultural Development Activities	FY 2016-17	FY 2017-18	FY 2018-19
Interpretations	95 on-site	241 on-site	2,392 on-site & telephone
Translated Documents	442	216	223
Cultural Competence Committee Meeting Attendance	223	219	188

- **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 in the region; and coordinating regional actions that can take place in Orange County such as Trauma-Informed trainings, the annual conference focused on hard-to-reach clients, and cultural humility trainings.

[3] For FY 2018-19, 106 on site interpretations were provided by MDP and Language Line, 272 ASL interpretation services were provided by WIN, and 2,014 telephonic interpretations were provided by Language Line.

[4] Data was reported incorrectly in the FY 19-20 MHSA Plan Update.

Training and Technical Assistance

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 mental health training for law enforcement. The number of trainings offered in this area fluctuates from year to year depending on the number of professional development requests from HCA staff and community members. In FY 2018-19, TAA provided a total of 89 trainings for 5,711 attendees, which are described in more detail below. In FY 2017-18, TTA provided a total of 88 trainings for 2,573 attendees and 112 trainings were provided for 3,465 attendees in FY 2016-17.

- **Evidence-Based Practices**: 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, Motivational Interviewing, Children Adolescent Needs and Strengths (CANS), a Trauma-Informed Care series, Trauma Focused Cognitive Behavioral Therapy, Treating Trauma and Substance Use, and Dialectical Behavioral Therapy. During FY 2018-19, more requests were submitted by HCA staff and/or community members for trainings focused in different Evidence-Based Practices, compared to previous years.
- **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. Over the past three years, fewer requests have been made for Consumer and Family Perspective trainings.
- **Cultural Competence**: Culturally responsive trainings were conducted to raise cultural awareness and humility among behavioral health providers and community partners. Topics included Caring for Gender Nonconforming and Transgender Youth, Clinical Considerations when Working with Patients and Families from the Sikh Faith, Mindful Listening, Role of Forgiveness in Psychotherapy, Spirituality and Therapy, and Bio-Spiritual Focusing. Beginning in FY 2018-19, WET established an online Cultural Competency training for all BHS staff. Each year, new and ongoing staff are required to take this training as part of their professional development and per state regulations. Due to the establishment of this new annual training, the total number of attendees increased significantly. This is an increase from FY 2017-18, when WET consolidated several content-specific trainings into a single, comprehensive training.
- **Crisis Intervention Training for Law Enforcement**: 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. The 8-hour CIT II class, which is part of the Professional Officer Standards Training, and Standards and Training for Corrections certified curriculum, provides 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 and prepared law enforcement officers and public safety personnel to identify the various needs of individuals dealing with mental health, substance use, dual diagnosis and homelessness. CIT III provided an overview of signs and symptoms of mental

illness, availability of community services, and mental illness procedures within the justice system. CIT for Dispatchers (CIT IV) was added in November 2018. This 16-hour training for public safety dispatchers provides training on mental illness, tools to assess suicidal callers and crisis intervention techniques. The number of CIT trainings have increased over the past three years due to a higher volume of requests. Law enforcement agencies across Orange County recognize the importance of educating their staff on how to best address situations where a participant's mental health could be a factor.

Training and Technical Assistance Topic	FY 2016-17		FY 2017-18		FY 2018-19	
	Trainings	Attendees	Trainings	Attendees	Trainings	Attendees
Evidence-Based Practices	57	1,318	49	1,380	78	2,387
Consumer and Family Member Perspective	9	378	6	230	4	156
Cultural Competence	30	1,324	7	563	7	3,168
Crisis Intervention Training for Law Enforcement	15	372	26	400	33	587

Mental Health Career Pathways

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 have personal lived experience.

Similar to previous fiscal years, in FY 2018-19, REI provided a total of 161 trainings to 567 active students. Of the 274 newly enrolled students, 72% identified themselves as living with a behavioral health condition, 10% identified themselves as family members of those living with a behavioral health condition and 18% identified as both. In FY 2017-18, REI provided 156 trainings to 535 active students. Of the 292 newly enrolled students, 71% identified themselves as living with a behavioral health condition, 13% identified themselves as family members of those living with a behavioral health condition and 17% identified as both. In FY 2016-17, REI provided 187 trainings to 750 active students. 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. REI enrolled 274 new students in FY 2018-19, 292 new students in FY 2017-18, and 223 in FY 2016-17. During FY 2018-19, fewer students engaged in Academic Advisement and Success Coaching sessions. This was due to staff turnover during the fiscal year, but since then, REI has made efforts to recruit and fill vacant positions.

REI Student Mentoring	FY 2016-17	FY 2017-18	FY 2018-19
Academic Advisement (duplicated)	**2,130**	**2,525**	**2,096**
Success Coach Contacts (duplicated)	**1,119**	**1,999**	**1,264**
Total	**3,249**[5] Duplicated	**4,524** Duplicated	**3,360** Duplicated
	1,384[6] Unduplicated	**1,627** Unduplicated	**1,567** Unduplicated

In addition, REI offers a wide variety of trainings, including Introduction to Microsoft Excel Spreadsheets, Elementary Spanish for Public Speaking, Introduction to Psychology, Case Management, Vocational Skills Building, and Self-Esteem and Confidence (see "Workshops & Classes" in table below). 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.

REI also offers a series of pre-vocational workshops to prepare students to enter the workforce. These workshops include job search techniques, resume building, interview skills, and dressing for job interviews. In addition, REI offers ESL and GED classes for students to benefit employment opportunities. A high percentage of students completed the REI

[5] Data was reported incorrectly in the FY 19-20 MHSA Plan Update.
[6] Data was reported incorrectly in the FY 19-20 MHSA Plan Update.

workshops and classes in FY 2018-19 and FY 2017-18 (see "Pre-Vocational Courses" below). This increase in completion rates from FY 2016-17 is due to an administrative efficiency created when WET consolidated classes and workshops and staff were better able to track course completion rates. However, there was a decrease in the number of students who completed Extended Education courses in FY 2018-19 due to several reasons (see "Extended Education" below), including:

- Extended Education courses meet more frequently, compared to other workshops and college courses in the REI curriculum.
- The Extended Education course model is an open entry and exit format. This creates a revolving door for students who may need courses on a short-term basis.
- The REI College Courses have a strict dropout policy due to popularity of the courses being offered. This creates a higher level of commitment for those students to complete their courses, compared to Extended Education courses.

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 3-unit courses and a 2-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 (see "College Credit Course" below).

REI Student Mentoring	FY 2016-17	FY 2017-18[7]	FY 2018-19
Workshops & Classes	95 offered 66% completion rate	76 offered 95% completion rate	79 offered 83% completion rate
Pre-Vocational Courses	65 offered 94% completion rate	51 offered 91% completion rate	52 offered 93% completion rates
Extended Education	10 offered 71% completion rate	12 offered 71% completion rate	14 offered 54% completion rate
College Credit Course	17 offered 93% completion rate	16 offered 85% completion rate	16 offered 86% completion rate

[7] Data was reported incorrectly in the FY 19-20 MHSA Plan Update.

Residency and Internship Programs

Program Description/Impact

The **Residencies and Internships** program trains and supports individuals who aspire to work in the public mental health system. The California Psychology Internship Council (CAPIC) matches interns with a placement site based on a set of criteria. WET requests the same number of interns each year; however, CAPIC will match based on the number of students who have enrolled and availability of sites all CAPIC students were placed in a behavioral health program during FY 2018-19, with two student interns being placed at WET's Neurobehavioral Testing Unit (NBTU) and four placed at Children Youth Behavioral Health (CYBH) sites. FY 2017-18, four student interns placed at WET's NBTU and two were placed at CYBH sites. All interns were supervised by a licensed psychologist.

In collaboration with the Psychiatry Department at the University of California-Irvine (UCI) School of Medicine, WET funds residencies and fellowships. 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 the County uses to address the shortage of child and community psychiatrists working in community mental health.

Residency and Internship Support	FY 2016-17	FY 2017-18	FY 2018-19
Psychology Interns	8 interns 15,000 clinical hours	6 interns 12,000 clinical hours	6 interns 11,000 clinical hours
Psychiatry Fellows	3 fellows 1,248 clinical hours	3 fellows 1,200 clinical hours	4 fellows 1,536 clinical hours
Psychiatry Residents	6 residents 2,496 clinical hours	5 residents 2,080 clinical hours	5 residents 2,080 clinical hours

Financial Incentive Programs

Program Description/Impact

The **Financial Incentives Program** (FIP) seeks to expand a diverse bilingual and bicultural workforce by providing financial incentive stipends to BHS County employees seeking bachelor's (BA/BS) and master's (MA/MS) degrees, and to address the community psychiatrist shortage by offering loan repayment for psychiatrists working in the Orange County public mental health system. The WET Office collaborates with numerous colleges and universities to offer stipends and encourage students to work for County or County-contracted agencies upon graduation. WET also offers the Orange County Mental Health Loan Assumption Program (OC-MHLAP), which offers loan assumption in exchange for working in the County Public Mental Health System. The number of students/psychiatrists that enroll in FIP each year is determined by the pre-approved budget and number of applicants who meet eligibility. FY 2018-19 showed a decline in the number of graduate student stipends awarded. Although the County still faces a shortage of community psychiatrists, the number participating in FY 2018-19 was nearly double that of FY 2017-18.

In FY 2018-19, over half of all those receiving BA/MA stipends self-identified as Mexican/Hispanic (65%), followed by Caucasian (24%) and Asian (12%) descent. The primary languages spoken were English (59%) and Spanish (53%), and roughly one-third said they spoke multiple languages (29%). In FY 2017-18, stipends were provided to 22 staff. More than half of staff self-identified as Mexican/Hispanic (54.6%), followed by Asian (27.2%) or European (18.2%) descent. While over one-third indicated their primary language was English (36.3%), a large proportion indicated they spoke more than one language (45.5%). Of the 20 staff receiving stipends in FY 2016-17, six identified as Asian/Pacific Islander and 11 identified as Mexican/Other Latino, 10 of whom reported Spanish as their primary language.

Financial Incentives	FY 2016-17	FY 2017-18	FY 2018-19
BA Stipends	3	3	3
Graduate Degree Stipends	17	19	10
Psychiatry MHLAP	8[8]	6	11

During FY 2017-18, WET conducted a survey with all staff who had participated in FIP since its inception. This survey was sent out to roughly 114 staff who previously participated in FIP, and a total of 27 staff responded (24% response rate). Of those who responded, the majority of participants self-identified as female (70%) and were between the ages of 26-59 (93%). A large proportion indicated their racial or ethnic background as being either Mexican/Other Latino (42%), Caucasian/White (15%), Vietnamese (12%), or Multi-Ethnic (12%). Participants surveyed reported that they were more likely to be promoted and/or earn advanced degrees (e.g., bachelor's or master's) after completing FIP. In FY 2019-20, WET plans to administer this survey to the most recent employees who participated in FIP.

[8] Data was reported incorrectly in the FY 19-20 MHSA Plan Update.

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)

FY 2020-21 to FY 2022-23 Program Budget	
Actual FY 2019-20 Budget	$28,787,797
Proposed FY 2020-21 Budget	$12,519,749
Proposed FY 2021-22 Budget	$8,840,752
Proposed FY 2022-23 Budget	$8,966,158

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 to purchase, build or renovate land and/or facilities for the delivery of MHSA services to consumers 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.

Counties were initially given one-time allocation to cover both purposes, and had 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. This initial allocation has been spent and CFTN projects are now funded through transfers from CSS as allowed by the Act and accompanying regulations.

Capital Facilities (CF)

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 to benefit MHSA clients or MHSA administration's ability to provide services/programs in 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 CF funds and/or the personnel cost directly associated with a CF project (i.e., project manager, with the reserve controlled, managed and disbursed by the County).

The former California Department of Mental Health (now Department of Health Care Services, DHCS) outlined the following requirements for Capital Facilities funds:

- CF 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 CSS and PEI 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 CF funds is not feasible.

Completed Orange County Capital Facilities Projects

One-Time State CF Allocation: Using a one-time allocation from the state, the HCA constructed a project on County-owned property located at 401 S. Tustin Street in Orange. The project occupies approximately three acres and includes three facilities designated for use by 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 Wellness Center Central, Recovery Education Institute and Crisis Residential Services for adults have been located at this location since construction was completed and the location opened for services in 2012.

CSS Transfers to CF: Orange County has continued to fund renovations using CSS funds transferred to CFTN. Completed projects include:

- FY 2017-18: Renovation of a County-owned building serving clients and MHSA staff to bring the facility up to code to meet safety, Americans with Disabilities Act and other regulations. Renovations began in FY 2018-19 and were completed in FY 2019-20.
- FY 2018-19: Renovations to space(s) that would be used for one or MHSA-funded Crisis Stabilization Units. Due to contract negotiations, renovations were carried over to and completed in FY 2019-20.

Current Capital Facilities Projects

Anita Wellness Campus: In the 2016 Strategic Financial Plan, a need for a wellness campus designed to provide urgent behavioral health care in Orange County was identified as a strategic priority. The HCA worked with the County's CEO Office/Real Estate to purchase a building located at 265 S. Anita Drive in the city of Orange. The HCA program planning process for the Anita site evolved in parallel with the co-creation of Be Well OC, a coalition of county stakeholders representing both private and public sectors, including the HCA, CalOptima, hospital systems, nonprofit organizations, academic and faith-based organizations. An opportunity emerged for a public-private partnership between the HCA and Mind OC to design and construct a 60,000 square foot building for the purpose of providing co-located mental health and substance use disorder services for all residents in Orange County. Of the $47.8 million investment in the Anita Wellness Campus, to-date Orange County has invested approximately $24.4 million in CSS/CFTN funds to support the purchase and renovation of the building. The Campus held a ground-breaking ceremony in October 2019 and has an anticipated completion date of Fall 2020. Once constructed, the Campus proposes to include mental health and substance use disorder services that include but are not limited to:

- Crisis Stabilization Unit (CSU) for adults and adolescents ages 13 and older.
- Crisis Residential.
- Substance Use Disorder Intake & Referral.
- Withdrawal Management.
- Substance Use Disorder and Co-Occurring Residential Treatment.
- Integrated Support Center offering services to help prepare and support individuals when they re-integrate into their community.

Behavioral Health Training Services Renovations: Beginning in FY 2018-19, the HCA began to divert CSS funds from WET to CFTN to cover capital expense renovations to a long-term leased space used for the Behavioral Health Training Center. WET offers and facilitates hundreds of trainings to the Orange County behavioral health workforce each year and has faced challenges in finding appropriate locations and workshops in which to provide them. This center will be able to accommodate up to 200 people with dedicated parking, and have the flexibility to provide multiple rooms for breakout sessions or smaller workshops as needed. This site will also be made available to the community for planning and meeting space. The total amount approved for the renovations will not exceed $650,000 and will be transferred incrementally over the course of the 10-year lease.

Technological Needs (TN)

Requirements for Use of Technology Funds

Any MHSA-funded technology project must meet certain requirements to be considered appropriate for this funding category:

- 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.
- 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)

HCA EHR: Behavioral Health Services (BHS) is implementing a fully integrated EHR system that supports the goals of MHSA to promote well-being, 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, ongoing project that has been divided into three phases spanning several years, and includes acquisition and implementation of software, technology infrastructure upgrades and services to develop and implement the overall system.

1. The first phase of the project plan enhanced the functionality of the BHS EHR (Integrated Records Information System or IRIS), and successful implementation at a pilot clinic. Enhancements included documentation software designed to help clinicians avoid common errors, as well as electronic prescription software to help psychiatrists manage clients' medications. Additional technical improvements to the EHR included document imaging (which included 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.
2. The second phase of the project allowed for expanded staff use of the EHR through technology infrastructure and software enhancements. A client portal was implemented and voice-activated documentation for staff with physical challenges was piloted at select locations. Overall, implementation of the EHR at the County-operated outpatient clinics has gone well and user acceptance has been extremely high.
3. The third phase will allow the County to interface securely with its contract providers and to participate, as appropriate, in consent-based Health Information Exchanges outside County Behavioral Health Services, including with the Federal EHR Meaningful Use program. Phase 3 project costs will include, but not be limited to, software licenses, network infrastructure such as servers, storage and network monitoring appliances, other EHR and data warehouse upgrades, consolidation of data from multiple sources, internal human resources, external consultants and training.

County Data Integration Project: $1 million of the Three-Year Plan TN budget will fund a portion of the development and ongoing support for a System of Care Data Integration System. This system will facilitate appropriate, allowable data-sharing across County departments and with external stakeholders with the goal of delivering essential and critical services, including behavioral health care, to county residents in a more efficient and timely manner.

SPECIAL PROJECTS

Help@Hand (INN)

Program Serves	Symptom Severity		Location of Services		Typical Population Characteristics					
										
16+	At Risk	Mild-Moderate	Field	Community Based	Other/1st Responders	Parents	Families	Trauma-Exposed Clients	Mono-Lingual/ Ethnic Community	Pregnant

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$8,000,000	FY 2019-20	100
Proposed FY 2020-21 Budget	$6,000,000	FY 2020-21	3,000
Proposed FY 2021-22 Budget	$3,000,000	FY 2021-22	3,000
Proposed FY 2022-23 Budget	above carryover	FY 2022-23	3,000

Project Characteristics

Help@Hand (formerly Tech Suite) is a statewide project comprised of 14 counties and cities that leverages interactive technology-based mental health solutions (i.e., internet-based and/or mobile applications) to help improve access to care and outcomes for people across the state. The project seeks to understand how technology is introduced and works within the public behavioral health system of care. Help@Hand aims to provide diverse populations with access to mobile applications ("apps") designed to educate users on the signs and symptoms of mental illness, improve early identification of emotional/behavioral destabilization, connect individuals seeking help in real time, and/or increase user access to mental health services when needed.

Peers are integral to Help@Hand, and the vision of the Peer Role is to incorporate Peer input, expertise, knowledge and lived experience at all levels of the project, and to support the use of identified apps through Peer outreach and training. The Peer component of the project holds significant importance as it:

- Creates transparency around basic cautions, clarity about user choice, and highlights that technology does not replace in-person mental health services offered
- Provides clarity on the project definition of peers, roles, and serves as an example of a Peer staffing ladder

- Supports collaboration of Peer Leads across the state important to project learning, connection, and problem-solving
- Responds to county/city community stakeholder specific needs by developing digital mental health literacy curriculum that will support project learning and stakeholder's ability to make informed choices
- Trains the Peer workforce to facilitate digital mental health literacy sessions that will keep learning at the local level and sustainable
- Trains project partners on Peer culture, experience, and history supporting better project integration
- Integrates consumer expertise and voice in evaluation thus enhancing the work
- Incorporates lived experience and perspective on how possible future technology can help the project be responsive to consumer needs

Services

Orange County was approved to join this Innovation project in April 2018 and began project implementation planning immediately. The HCA originally applied as a four-year project and was recently approved by the MHSOAC for a one-year, no-cost extension. Thus, the project will end for Orange County in April 2023. The primary purpose of this project is to increase access to mental health services to underserved groups, with the goal of introducing a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention.

Help@Hand consists of several main components of which participating counties have chosen to opt in or out, based on their local needs. Orange County was approved to implement all project components, which includes:

- Technology Apps (3):
  - 24/7 Peer Chat, which will offer around-the-clock, anonymous Peer chat support to an individual
  - Therapy Avatar, which will offer virtual manualized evidence-based interventions delivered via an avatar in a simple, intuitive fashion (e.g., mindfulness exercises, cognitive behavioral or dialectical behavior interventions)
  - Customized Wellness Coach, which will utilize passive sensory data to engage, educate and suggest behavioral activation strategies to users
- Marketing and Outreach
- Evaluation

During FY 2018-19, Orange County focused its planning efforts on a technology app that fits within the Customized Wellness Coach component. Program staff engaged in system readiness, planning and preparation to launch the pilot of Mindstrong Health in 2020. This app is a service that provides access to round-the-clock telehealth support augmented by a new form of digital mood and cognitive measurement. Mindstrong telehealth services are delivered by a team of licensed psychiatrists and licensed or supervised therapists who can help maintain well-being between appointments or after office hours. While telehealth services are an established behavioral health practice, the Mindstrong automatic notifications (i.e., biomarkers) are a new and emerging approach to care and derived from the touches, scrolls and taps a person makes throughout the day as they use their phone. These notifications may provide an early indication of changes in the moods and symptoms associated with an individual's condition that may help facilitate earlier access to care and support. The Health app and services will only be available to eligible participants within specific partnered programs within Orange County.

Outcomes

Help@Hand will examine the following learning objectives:

- Detect and acknowledge mental health symptoms sooner.
- Reduce stigma associated with mental illness by promoting wellness.
- Increase access to the appropriate level of support and care.
- Increase purpose, belonging and social connectedness of individuals served.

- Analyze and collect data to improve mental health needs assessment and service delivery.

Because outcome metrics take time to yield results after deployment and utilization of the technology, a formative evaluation will provide a look beyond performance outcomes to examine the progress of the project and offer suggestions along the way. Outcomes related to the Mindstrong pilot and the overall project formative evaluation will be reported in future Plan Updates.

Challenges, Barriers and Solutions in Progress

The 14 participating cities/counties are at the forefront of innovation to understand how technology is introduced and works within the public behavioral health system of care. When faced with challenges or barriers, the collaborative offers the benefit of a shared learning experience that accelerates learning. The initial year of this Innovation project has provided key learnings that have allowed the collaborative to develop and strengthen the Help@Hand infrastructure necessary to support the work ahead.

Throughout this process, the most significant lesson learned is that the primary focus of Help@Hand is not the implementation of apps, but rather the development of a sustainable digital mental health system of care for California (i.e., infrastructure building). As such, initial efforts should prioritize system preparation; user, program and agency readiness for change; and implementation planning. An effective work plan and checklist of pre-launch activities are essential to prioritize the necessary and required preconditions prior to the launch of an app (i.e., roadmap of involved parties and logical order/priorities for Information Technology (IT), data sharing, Compliance, clinical integration, etc.).

The initial planning phase should also include strategies for an effective communication and decision-making process. System readiness requires collaboration and ongoing communication with program managers and staff in programs where an app will be launched. It is critical to obtain feedback from clinicians and Peers early on to assess interest and/or readiness to use the app services. Equally as critical is communication with vendors, checking in to ensure information, messaging and shared vision is accurate. The public behavioral health system and the private industry have their own language and communication style. As a result, it is important to frequently define terms to ensure shared understanding. Furthermore, existing technology is not necessarily geared with the County mental health plan consumer in mind, so when exploring and procuring technology, it is important to be clear in including the type of technology the target population will likely have access to, as well as language capabilities.

With regard to the planning, development and implementation of apps, it is essential for this process to be streamlined and sustainable in the future. This includes the involvement of County Counsel, Compliance and IT teams throughout the process. Additional considerations include outlining a process for procuring and learning about new apps/vendors, creating a systematic process for testing apps, and addressing potential safety, risk and liability concerns.

Community Impact

Beginning in June 2019, Help@Hand partnered with participating counties to engage their community members and seek their input on concerns and needs around technology. In turn, this input was used to support the development of a Digital Mental Health Literacy Curriculum. This education will help support decision-making about technology usage, provide insight on security and privacy, and a better understanding of how to engage in the digital world. From June to August 2019, Help@Hand facilitated community stakeholder sessions in 11 of the 14 participating counties/cities reaching over 300 community stakeholders. Orange County hosted the first stakeholder session and represented 108 of the approximately 300 community stakeholders who participated. Findings and outcomes from these meetings resulted in the development of seven micro-learning Digital Mental Health Literacy videos. This important curriculum will be provided not only to the Help@Hand counties, but will be made available to the public at large.

Behavioral Health System Transformation (INN)

FY 2020-21 to FY 2022-23 Program Budget	
Actual FY 2019-20 Budget	$9,000,000
Proposed FY 2020-21 Budget	$9,477,500
Proposed FY 2021-22 Budget	$4,010,833
Proposed FY 2022-23 Budget	-

Project Characteristics

The **Behavioral Health System Transformation** (BHST) project is an INN project designed to create a system that can serve all Orange County residents, regardless of insurance status, type, or level of clinical need. Its primary purpose is to promote interagency and community collaboration related to mental health services, supports or outcomes, with the goal of introducing a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention.

Unlike the majority of INN projects that tend to focus on new or modified approaches to service delivery, the BHST project will strive to transform the behavioral health system of care by identifying strategies to braid public and private funding; creating a value-based system; and improving navigation of and access to needed resources.

Orange County's BHST project proposal was approved by the MHSOAC in May 2019 and local project start up began in October 2019.

Services

This project involves planning meetings and stakeholder input from consumers, family members, behavioral health providers, the HCA, CalOptima, private insurance, Department of Health Care Services and related organizations. Project activities are divided into two parts:

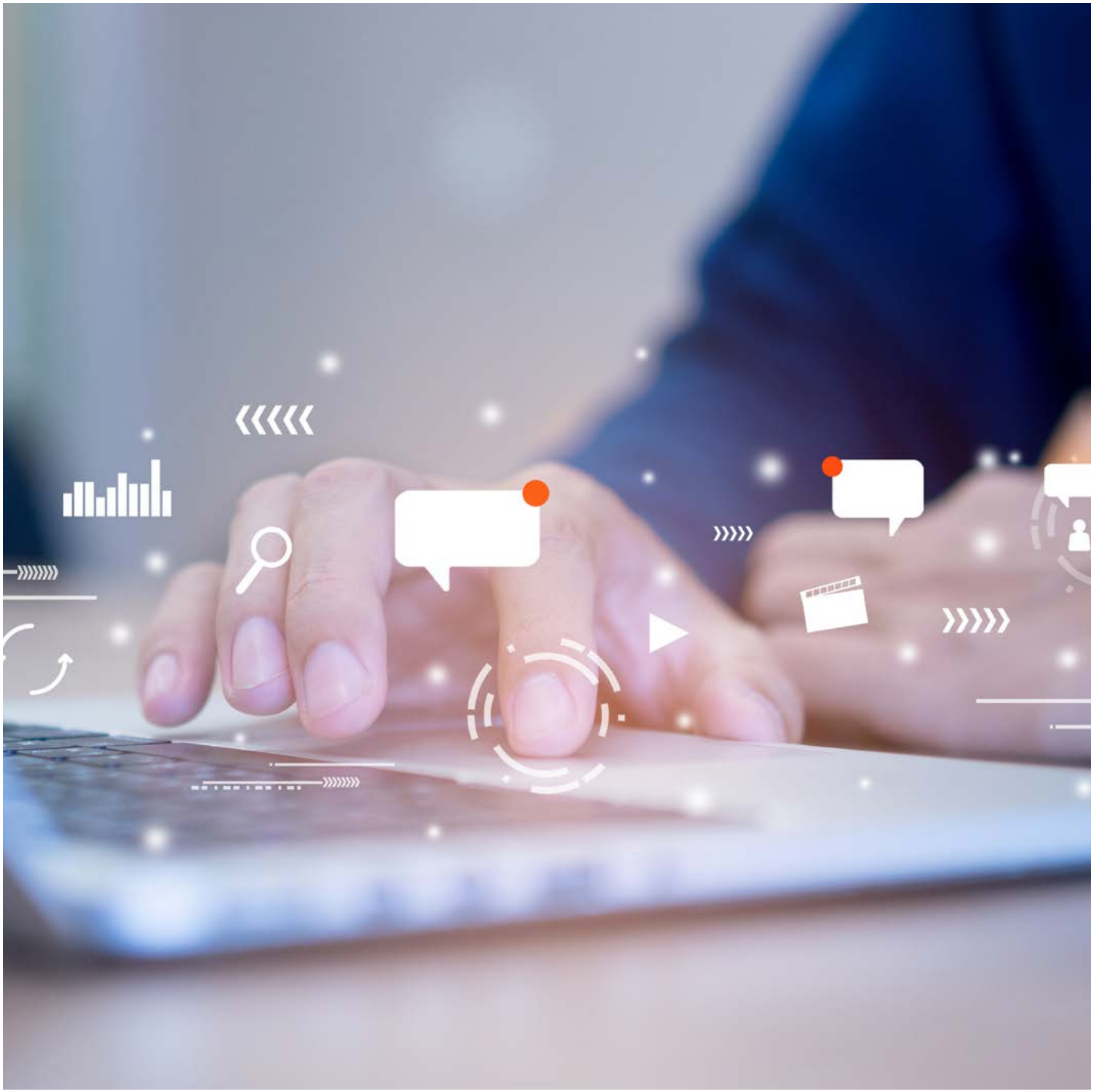
BHST Part 1, Performance and Value-Based Contracting, addresses the plan to create a value-based system that braids public and private funding. Key steps and activities include:

- Establishing community-defined values and metrics
- Identifying braiding strategies for public and private funding
- Aligning community-defined outcomes with legal, fiscal and regulatory requirements
- Developing new provider contract templates
- Providing technical assistance to assist providers

BHST Part 2, Digital Resource Navigator and Overall Project Evaluation, involves the development of a digital navigation tool, as well as the evaluation of the overall BHST project (i.e., Part 1 & digital resource navigator). The features, functionality and list of resources in the digital resource navigator will be developed through a participatory process that involves community members, including consumers, family members and behavioral health providers. Core features of the directory will include an optional social determinants survey, curated list of resources prioritized based on an individual's needs, and ability for providers to update resource information in real-time. Key steps and activities include:

- Identifying directory resources, features and functionality
- Directory development and testing
- Continuous review and refinement
- Project evaluation and lessons learned

Due to its focus on identifying methods to change processes and integrate policies across the public and private sectors, this project will utilize a formative evaluation. One of the key goals of a formative evaluation is to identify influences – both potential and real – on the progress and/or effectiveness of a project's implementation. Information is collected at all phases of execution and is used as part of a continuous feedback loop to improve the ultimate likelihood of successful project implementation.



Through focus groups, interviews, observational studies, and surveys of stakeholders, subject matter experts and meeting participants, the evaluation will allow Orange County to identify successful and unsuccessful strategies employed throughout the various project activities, including inter-agency and inter-departmental meetings and workgroups. Similarly, the formative evaluation will determine whether Orange County is able to identify ways to engage a diverse group of community stakeholders successfully and elicit meaningful participation, guidance and feedback.

Outcomes

This project was not operational in FY 2018-19 so there are no outcomes to report at this time. Outcomes will be reported in future Plan Updates.

Potential INN Projects (INN)

The HCA will explore potential Innovation project ideas submitted through the HCA Idea Generation Website, as well as statewide project opportunities. Each idea considered viable after initial vetting, will include a community planning process and must be approved by the MHSOAC before implementation. Project ideas that are most aligned with MHSA Community Planning Process results and/or most feasible, will be prioritized for exploration. Potential INN project ideas include:

Project Name	Brief Description
allcove	Integrated youth drop-in centers for ages 12 - 25.
Mental Health Adult and Older Adult Residential Facilities	Create training curriculum for staff in Assisted Living Facility serving adults living with mental illness. Training would address recognizing early signs of mental illness, basic support techniques and knowledge of how to refer to basic, appropriate mental health resources.
Mental Health Participant Pet Boarding Services	Focus on creating a network of veterinarians, boarding programs, animal day care, and animal foster volunteers who would be available to outreach programs to immediately foster pets for day, overnight and up to 30 days for individuals ready to seek treatment and/or shelter. The program would also engage previously homeless individuals who have been housed in the past year or two, and train them to be animal foster sites.
Mental Health Participant Pet Veterinary Care	Veterinary care will be available for pets of homeless participants who are seeking shelter and treatment.
Middle School Student Wellness Centers	Each Wellness Center will comprehensively address mental and physical health by placing a nurse, nutrition, outreach, mental health and drug intervention support within these sites.
Mobile Phones	Provide mobile phones to provide access to mental health services and support. Previously approved project that was unable to be procured but will now leverage the technology partners involved in Help@Hand INN Project.
Older Veterans Support Program	Identify where isolated veterans are and enroll them into an engaging socialization program that would refer to other collaborative partners for additional services.
Peer Intervention Journal	Proposes that Peer projects throughout the state be complied into a journal in order to share information.
Psychiatric Advance Directives – Supportive Decision-Making	Statewide collaborative that aims to enhance individual independence for people with needs with the goal of reducing recidivism in the criminal justice system and empowering clients.
Psychiatry Clinical Extender Program	High school and medical students would be offered the opportunity to volunteer with clients within the Wellness Centers or other unlocked centers to gain experience and knowledge of working with this population. This could include advertising about careers in the behavioral health field.
Shelter Grade Housing	Proposes a design competition among local universities to design a shelter that promotes mental health and wellness.
Shelter Living Skills Curriculum	Focus on developing a new shelter-specific-living-skills curriculum that incorporates group, individual, case management and daily assignments. Each participant will be given a needs assessment upon intake and will work with a peer group and individual support person to complete their daily goals.
Social Media & Prediction Technology	Participants at a high risk for mental health disorders will agree to have their smartphone social media data monitored and will take periodic surveys to assess their MH related behaviors and outcomes.
Approaches to Stigma Reduction	Test competing models of stigma reduction campaigns to determine which approaches, strategies and/or techniques are more effective within different target populations. Identify, develop and test a method for measuring short-term and long-term effects on mental-health-related stigma.
Young Children at risk of ADHD	Development and testing of a new technology that will use a wearable and connected system that combines a fitness and health tracker, mobile phone app, and web portal with an online community. The system can be used to deliver interventions and monitor progress over time for parents of children at risk for ADHD or related behavioral disorders.

** Project ideas are listed in alphabetical order and do not reflect prioritization or order of exploration.*

Whole Person Care Pilot

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 Medi-Cal 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 over $30 million over five years, these dollars fund an array of health services for adults participating in WPC.

BHS is providing the following services through the WPC pilot, which is set to expire on December 31, 2020:

- 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 GRIDS

FY 2020-21 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan Funding Summary

County: **Orange**

Date: 3/13/2020

	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 2020-21 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	34,212,383	32,272,329	24,850,606		4,176,508	33,258,769
2. Estimated New FY2020-21 Funding	138,000,000	34,500,000	9,100,000			
3. Transfer in FY2020-21	(14,559,875)	-		6,216,634	8,343,241	
4. Access Local Prudent Reserve in FY2020-21	-	-				
5. Estimated Available Funding for FY2020-21	157,652,508	66,772,329	33,950,606	6,216,634	12,519,749	33,258,769
B. Estimated FY 2020-21 Expenditures	127,172,304)	(42,355,334)	(18,346,360)	(6,216,634)	(12,519,749)	
C. Estimated FY 2021-22 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	30,480,204	24,416,995	15,604,246			33,258,769
2. Estimated New FY2021-22 Funding	139,200,000	34,800,000	9,200,000			
3. Transfer in FY2021-22	(14,060,736)	-		5,219,984	8,840,752	
4. Access Local Prudent Reserve in FY2021-22	-	-				
5. Estimated Available Funding for FY2021-22	155,619,468	59,216,995	24,804,246	5,219,984	8,840,752	33,258,769
D. Estimated FY 2021-22 Expenditures	(134,994,280)	(44,358,233)	(9,009,773)	(5,219,984)	(8,840,752)	

E. Estimated FY 2022-23 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	20,625,188	14,858,762	15,794,473			33,258,769
2. Estimated New FY 2022-23 Funding	139,200,000	34,800,000	9,200,000			
3. Transfer in FY 2022-23	(14,262,820)	-		5,296,662	8,966,158	
4. Access Local Prudent Reserve in FY 2022-23	-	-				
5. Estimated Available Funding for FY 2022-23	145,562,368	49,658,762	24,994,473	5,296,662	8,966,158	33,258,769
F. Estimated FY 2022-23 Expenditures	(135,562,676)	(36,889,291)	(2,042,071)	(5,296,662)	(8,966,158)	
G. Estimated FY 2022-23 Unspent Fund Balance	$9,999,692	$12,769,471	22,952,401	$-	$-	$33,258,769

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2020	$33,258,769
2. Contributions to the Local Prudent Reserve in FY 2020-21	-
3. Distributions from the Local Prudent Reserve in FY 2020-21	-
4. Estimated Local Prudent Reserve Balance on June 30, 2021	-
5. Contributions to the Local Prudent Reserve in FY 2021-22	-
6. Distributions from the Local Prudent Reserve in FY 2021-22	-
7. Estimated Local Prudent Reserve Balance on June 30, 2022	-
8. Contributions to the Local Prudent Reserve in FY 2022-23	-
9. Distributions from the Local Prudent Reserve in FY 2022-23	-
10. Estimated Local Prudent Reserve Balance on June 30, 2023	$33,258,769

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

b/ Estimated expenditures for CSS for FY 20/21 are anticipated to be within funding limits avaialble but are budgeted at full-program's costs. Historical trends show actual expenditures to be under the annual budget due to various factors, such as unanticipated revenue offsets, or cost savings. The Financial Team monitors and projects the revenues and expenditures throughout the fiscal year to ensure the funds are not overspent. CSS expenditures are estimated at 82% and PEI expenditures are estimated at 90% of the budgeted amounts for each fiscal year.

c/ Per MHSUDS Info Notice No. 19-017 dated March 20, 2019, each county is now required to establish a Prudent Reserve that does not exceed 33 percent of the average Community Services and Supports (CSS) revenue received for the Local Mental Health Serices Fund in the preceding five years. Maximum Prudent Reserve amount for FY 2020-21 is capped at the average of 33% of the previous 5 FY's CSS allocation. Orange County's current Prudent Reserve amount is $33,258,769 and this same amount is budgeted for FY 2020-21 through FY 2022-23. Orange County's Prudent Reserve will be re-assessed in FY 2023-24 by using the actuals from FY 2018-19 through FY 2022-23.

d/ Estimated Unspent Fund Balances in CSS and PEI are allocated to support the Strategic Priorities and a potential Wellness Campus identified in the three-year plan.

FY 2020-2023 Three-Year Plan Update - Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: **Orange** Date: 3/13/2020

Program Description	Fiscal Year 2020-21					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
1. Children's Full Service Partnership	**13,220,698**	**11,054,575**	**2,166,123**			
2. Transitional Age Youth (TAY) Full Service Partnership	**10,251,318**	**8,184,468**	**2,066,850**			
3. Adult Full Service Partnership	**35,522,590**	**31,307,934**	**3,976,372**			**238,284**
Adults	25,321,027	21,592,093	3,558,806			170,128
Assisted Outpatient Treatment Assessment & Linkage	5,201,563	4,715,841	417,566			68,156
Clients at-risk of losing permanent housing	5,000,000	5,000,000				
4. *Older Adult Full Service Partnership*	***3,709,327***	***3,219,899***	***465,863***			***23,565***
5. Program for Assertive Community Treatment	**13,673,655**	**10,599,650**	**2,736,160**			**337,845**
Children/ Youth	1,550,000	1,100,000	450,000			
Transitional Age Youth (TAY) and Adults	10,978,837	8,528,018	2,135,051			315,768
Older Adults	1,144,818	971,632	151,109			22,077

County: **Orange** Date: 3/13/2020

Program Description	Fiscal Year 2020-21					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
NON-FSP PROGRAMS FUNDED PARTIALLY BY FSP FUNDING:						
Access and Linkage to Treatment Section:						
1. BHS Outreach and Engagement	**1,541,960**	**1,541,960**				
2. The Courtyard Outreach	**45,000**	**45,000**				
3. CHS Jail to Community Re-Entry	**1,100,000**	**1,100,000**				
4. Recovery Open Access	**58,490**	**46,000**	**10,892**			**1,598**
Suicide & Crisis Prevention Section:						
5. Mobile Crisis Assessment Team	**4,667,155**	**3,451,094**	**827,113**			**388,948**
Children 0-17	2,918,419	1,898,419	660,000			360,000
Adult/Older Adults 18+	1,748,736	1,552,675	167,113			28,948
6. Crisis Stabilization Units (CSUs)	**1,507,500**	**1,005,000**	**502,500**			
7. In-Home Crisis Stabilization	**1,686,094**	**1,229,836**	**456,258**			
Children 0-17	1,404,844	1,004,836	400,008			
Adult/Older Adults 18+	281,250	225,000	56,250			
8. Crisis Residential Services	**5,821,261**	**4,706,319**	**1,084,384**			**30,559**
Children (0-17)	2,893,274	2,441,774	451,500			
Transitional Age Youth (TAY)	1,772,929	1,464,300	308,629			
Adults/Older Adults	1,155,059	800,246	324,254			30,559

County: **Orange** Date: 3/13/2020

Program Description	Fiscal Year 2020-21					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Clinic Expansion:						
9. Children & Youth Expansion	-	-				
10. Services for the Short-Term Residential Therapeutic Program	-	-				
11. Children & Youth Co-Occurring Medical & MH Clinic	**1,000,000**	**500,000**	**500,000**			
12. Outpatient Recovery	**170,141**	**123,171**	**45,008**			**1,962**
13. Integrated Community Services	-	-				
14. Older Adult Services	**171,752**	**130,088**	**35,346**			**6,318**
15. Telehealth/Virtual Behavioral Health Care	-	-				
Supportive Services Section:						
16. Mentoring for Children and Youth	-	-				
17. Peer Mentor and Parent Partner Support	-	-				
18. Wellness Centers	**503,153**	**503,153**				
19. Supported Employment	**274,252**	**274,252**				
20. Transportation	-	-				
Supportive Housing/Homelessness Section:						
21. Short-Term Housing Services	**410,154**	**410,154**				
22. Bridge Housing for the Homeless	**1,300,000**	**1,300,000**				
23. MHSA/CSS Housing	**220,259**	**220,259**				
OCCR Housing MOU	220,259	220,259				
Permanent Supportive Housing	-	-				
Sub-Total	***$96,854,758***	***$80,952,811***	***$14,872,868***	***$-***	***$-***	***$1,029,080***

County: **Orange** Date: 3/13/2020

Program Description	Fiscal Year 2020-21					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
NON-FSP PROGRAMS NOT FUNDED BY FSP FUNDING:						
Access and Linkage to Treatment Section:						
1. BHS Outreach and Engagement	**1,027,973**	**1,027,973**				
2. The Courtyard Outreach	**855,000**	**855,000**				
3. CHS Jail to Community Re-Entry	**2,866,010**	**2,254,000**	**533,701**			**78,309**
4. Recovery Open Access	**1,100,000**	**1,100,000**				-
Suicide & Crisis Prevention Section:						
5. Mobile Crisis Assessment Team,	**6,922,784**	**5,684,764**	**915,628**			**322,392**
Children 0-17	1,945,613	1,265,613	440,000			240,000
Adult/Older Adults 18+	4,977,171	4,419,151	475,628			82,392
6. Crisis Stabilization Units (CSUs)	**8,542,500**	**5,695,000**	**2,847,500**			
7. In-Home Crisis Stabilization	**2,195,826**	**1,705,644**	**490,182**			
Children 0-17	602,076	430,644	171,432			
Adult/Older Adults 18+	1,593,750	1,275,000	318,750			
8. Crisis Residential Services	**5,953,522**	**4,324,526**	**1,506,761**			**122,234**
Children (0-17)	1,239,974	1,046,474	193,500			
Transitional Age Youth (TAY)	93,312	77,068	16,244			
Adults/Older Adults	4,620,235	3,200,983	1,297,018			122,234

County: **Orange** Date: 3/13/2020

Program Description	Fiscal Year 2020-21					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Clinic Expansion:						
9. Children & Youth Expansion	3,000,000	2,500,000	500,000			
10. Services for the Short-Term Residential Therapeutic Program	13,000,000	6,500,000	6,500,000			
11. Children & Youth Co-Occuring Medical & MH Clinic	1,000,000	500,000	500,000			
12. Outpatient Recovery	8,336,885	6,035,360	2,205,374			96,150
13. Integrated Community Services	1,197,000	1,197,000				
14. Older Adult Services	2,690,789	2,038,047	553,756			98,986
15. Telehealth/Virtual Behavioral Health Care	2,500,000	2,500,000				
Supportive Services Section:						
16. Mentoring for Children and Youth	500,000	500,000				
17. Peer Mentor and Parent Partner Support	4,249,888	4,249,888				
18. Wellness Centers	2,851,198	2,851,198				
19. Supported Employment	1,097,010	1,097,010				
20. Transportation	1,150,000	1,150,000				
Supportive Housing/Homelessness Section:						
21. Short-Term Housing Services Shelter	957,026	957,026				

County: **Orange** Date: 3/13/2020

Program Description	Fiscal Year 2020-21					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
22. Bridge Housing for the Homeless	**700,000**	**700,000**				
23. MHSA/CSS Housing	**73,420**	**73,420**				
OCCR Housing MOU	73,420	73,420				
Permanent Supportive Housing	-	-				
Sub-Total	***$72,766,829***	***$55,495,856***	***$16,552,903***	***$-***	***$-***	***$718,070***
CSS Administration	18,639,508	18,639,508				
Total CSS Program Estimated Expenditures	**$188,261,096**	**$155,088,175**	**$31,425,771**	**$-**	**$-**	**$1,747,150**
FSP Programs as Percent of Total		**52%**				

FY 2021-22 Annual Update - Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: **Orange** Date: 3/13/2020

Program Description	Fiscal Year 2021-22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
1. Children's Full Service Partnership	**13,220,698**	**11,054,575**	**2,166,123**			
2. Transitional Age Youth (TAY) Full Service Partnership	**10,251,318**	**8,184,468**	**2,066,850**			
3. Adult Full Service Partnership	**35,522,590**	**31,307,934**	**3,976,372**			**238,284**
Adults	25,321,027	21,592,093	3,558,806			170,128
Assisted Outpatient Treatment Assessment & Linkage	5,201,563	4,715,841	417,566			68,156
Clients at-risk of losing permanent housing	5,000,000	5,000,000				
4. Older Adult Full Service Partnership	**3,709,327**	**3,219,899**	**465,863**			**23,565**
5. Program for Assertive Community Treatment	**13,673,655**	**10,599,650**	**2,736,160**			**337,845**
Children/ Youth	1,550,000	1,100,000	450,000			
Transitional Age Youth (TAY) and Adults	10,978,837	8,528,018	2,135,051			315,768
Older Adults	1,144,818	971,632	151,109			22,077

County: **Orange** Date: 3/13/2020

Program Description	Fiscal Year 2021-22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
NON-FSP PROGRAMS FUNDED PARTIALLY BY FSP FUNDING:						
Access and Linkage to Treatment Section:						
1. BHS Outreach and Engagement	**1,541,960**	**1,541,960**				
2. The Courtyard Outreach	**45,000**	**45,000**				
3. CHS Jail to Community Re-Entry	**1,350,000**	**1,350,000**				
4. Recovery Open Access	**58,490**	**46,000**	**10,892**			**1,598**
Suicide & Crisis Prevention Section:						
5. Mobile Crisis Assessment Team	**4,667,155**	**3,451,094**	**827,113**			**388,948**
Children 0-17	2,918,419	1,898,419	660,000			360,000
Adult/Older Adults 18+	1,748,736	1,552,675	167,113			28,948
6. Crisis Stabilization Units (CSUs)	**2,250,000**	**1,500,000**	**750,000**			
7. In-Home Crisis Stabilization	**1,686,094**	**1,229,836**	**456,258**			
Children 0-17	1,404,844	1,004,836	400,008			
Adult/Older Adults 18+	281,250	225,000	56,250			
8. Crisis Residential Services	**7,021,261**	**5,906,319**	**1,084,384**			**30,559**
Children (0-17)	3,943,274	3,491,774	451,500			
Transitional Age Youth (TAY)	1,772,929	1,464,300	308,629			
Adults	1,305,059	950,246	324,254			30,559

County: **Orange** Date: 3/13/2020

Program Description	Fiscal Year 2021-22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Clinic Expansion:						
9. Children & Youth Expansion	-	-				
10. Services for the Short-Term Residential Therapeutic Program	-	-				
11. Children & Youth Co-Occurring Medical & MH Clinic	**1,000,000**	**500,000**	**500,000**			
12. Outpatient Recovery	**170,141**	**123,171**	**45,008**			**1,962**
13. Integrated Community Services	-	-	-			
14. Older Adult Services	**171,752**	**130,088**	**35,346**			**6,318**
15. Telehealth/Virtual Behavioral Health Care	-	-				
Supportive Services Section:						
16. Mentoring for Children and Youth	-	-				
17. Peer Mentor and Parent Partner Support	-	-				
18. Wellness Centers	**503,153**	**503,153**				
19. Supported Employment	**274,252**	**274,252**				
20. Transportation	-	-				
Supportive Housing/Homelessness Section:						
21. Short-Term Housing Services Shelter	**410,154**	**410,154**				
22. Bridge Housing for the Homeless	**1,300,000**	**1,300,000**				
23. MHSA/CSS Housing	**226,866**	**226,866**				
OCCR Housing MOU	226,866	226,866				
Permanent Supportive Housing	-	-				
Sub-Total	***$99,053,866***	***$82,904,419***	***$15,120,368***	***$-***	***$-***	***$1,029,080***

County: **Orange** Date: 3/13/2020

Program Description	Fiscal Year 2021-22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
NON-FSP PROGRAMS NOT FUNDED BY FSP FUNDING:						
Access and Linkage to Treatment Section:						
1. BHS Outreach and Engagement	**1,027,973**	**1,027,973**				
2. The Courtyard Outreach	**855,000**	**855,000**				
3. CHS Jail to Community Re-Entry	**1,350,000**	**1,350,000**				
4. Recovery Open Access	**2,866,010**	**2,254,000**	**533,701**			**78,309**
Suicide & Crisis Prevention Section:						
5. Mobile Crisis Assessment Team	**6,922,784**	**5,684,764**	**915,628**			**322,392**
Children 0-17	1,945,613	1,265,613	440,000			240,000
Adult/Older Adults 18+	4,977,171	4,419,151	475,628			82,392
6. Crisis Stabilization Units (CSUs)	**12,750,000**	**8,500,000**	**4,250,000**			
7. In-Home Crisis Stabilization	**2,195,826**	**1,705,644**	**490,182**			
Children 0-17	602,076	430,644	171,432			
Adult/Older Adults 18+	1,593,750	1,275,000	318,750			
8. Crisis Residential Services	**7,003,522**	**5,374,526**	**1,506,761**			**122,234**
Children (0-17)	1,689,974	1,496,474	193,500			
Transitional Age Youth (TAY)	93,312	77,068	16,244			
Adults	5,220,235	3,800,983	1,297,018			122,234

County: **Orange** Date: 3/13/2020

Program Description	Fiscal Year 2021-22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Clinic Expansion:						
9. Children & Youth Expansion	3,000,000	3,000,000				
10. Services for the Short-Term Residential Therapeutic Program	16,000,000	8,000,000	8,000,000			
11. Children & Youth Co-Occurring Medical & MH Clinic	1,000,000	500,000	500,000			
12. Outpatient Recovery	8,336,885	6,035,360	2,205,374			96,150
13. Integrated Community Services	1,197,000	1,197,000	-			
14. Older Adult Services	2,690,789	2,038,047	553,756			98,986
15. Telehealth/Virtual Behavioral Health Care	3,000,000	3,000,000				
Supportive Services Section:						
16. Mentoring for Children and Youth	500,000	500,000				
17. Peer Mentor and Parent Partner Support	4,249,888	4,249,888				
18. Wellness Centers	2,851,198	2,851,198				
19. Supported Employment	1,097,010	1,097,010				
20. Transportation	1,300,000	1,300,000				
Supportive Housing/Homelessness Section:						
21. Short-Term Housing Services Shelter	957,026	957,026				
22. Bridge Housing for the Homeless	700,000	700,000				
23. MHSA/CSS Housing OCCR Housing MOU Permanent Supportive Housing	75,622 75,622 -	75,622 75,622 -				
Sub-Total	***$81,926,532***	***$62,253,059***	***$18,955,403***	**$-**	**$-**	***$718,070***
CSS Administration	19,469,693	19,469,693				
Total CSS Program Estimated Expenditures	**$200,450,092**	**$164,627,171**	**$34,075,771**	**$-**	**$-**	**$1,747,150**
FSP Programs as Percent of Total		**50%**				

FY 2022-23 Annual Update - Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: **Orange** Date: 3/13/2020

Program Description	Fiscal Year 2022-23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
1. Children's Full Service Partnership	**13,220,698**	**11,054,575**	**2,166,123**			
2. Transitional Age Youth (TAY) Full Service Partnership	**10,251,318**	**8,184,468**	**2,066,850**			
3. Adult Full Service Partnership	**35,522,590**	**31,307,934**	**3,976,372**			**238,284**
Adults	25,321,027	21,592,093	3,558,806			170,128
Assisted Outpatient Treatment Assessment & Linkage	5,201,563	4,715,841	417,566			68,156
Clients at-risk of losing permanent housing	5,000,000	5,000,000				
4. Older Adult Full Service Partnership	**3,709,327**	**3,219,899**	**465,863**			**23,565**
5. Program for Assertive Community Treatment	**13,673,655**	**10,599,650**	**2,736,160**			**337,845**
Children/ Youth	1,550,000	1,100,000	450,000			
Transitional Age Youth (TAY) and Adults	10,978,837	8,528,018	2,135,051			315,768
Older Adults	1,144,818	971,632	151,109			22,077

County: **Orange** Date: 3/13/2020

Program Description	Fiscal Year 2022-23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
NON-FSP PROGRAMS FUNDED PARTIALLY BY FSP FUNDING:						
Access and Linkage to Treatment Section:						
1. BHS Outreach and Engagement	**1,541,960**	**1,541,960**				
2. The Courtyard Outreach	**45,000**	**45,000**				
3. CHS Jail to Community Re-Entry	**1,400,000**	**1,400,000**				
4. Recovery Open Access	**58,490**	**46,000**	**10,892**			**1,598**
Suicide & Crisis Prevention Section:						
5. Mobile Crisis Assessment Team	**4,667,155**	**3,451,094**	**827,113**			**388,948**
Children 0-17	2,918,419	1,898,419	660,000			360,000
Adult/Older Adults 18+	1,748,736	1,552,675	167,113			28,948
6. Crisis Stabilization Units (CSUs)	**2,250,000**	**1,500,000**	**750,000**			
7. In-Home Crisis Stabilization	**1,686,094**	**1,229,836**	**456,258**			
Children 0-17	1,404,844	1,004,836	400,008			
Adult/Older Adults 18+	281,250	225,000	56,250			
8. Crisis Residential Services	**7,021,261**	**5,906,319**	**1,084,384**			**30,559**
Chilldren (0-17)	3,943,274	3,491,774	451,500			
Transitional Age Youth (TAY)	1,772,929	1,464,300	308,629			
Adults/Older Adults	1,305,059	950,246	324,254			30,559

County: **Orange** Date: 3/13/2020

Program Description	Fiscal Year 2022-23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Clinic Expansion:						
9. Children & Youth Expansion	-	-				
10. Services for the Short-Term Residential Therapeutic Program	-	-				
11. Children & Youth Co-Occurring Medical & MH Clinic	**1,000,000**	**500,000**	**500,000**			
12. Outpatient Recovery	**170,141**	**123,171**	**45,008**			**1,962**
13. Integrated Community Services	-	-				
14. Older Adult Services	**171,752**	**130,088**	**35,346**	-	-	**6,318**
15. Telehealth/Virtual Behavioral Health Care	-	-				
Supportive Services Section:						
16. Mentoring for Children and Youth	-	-				
17. Peer Mentor and Parent Partner Support	-	-				
18. Wellness Centers	**503,153**	**503,153**				
19. Supported Employment	**274,252**	**274,252**				
20. Transportation	-	-				
Supportive Housing/Homelessness Section:						
21. Short-Term Housing Services Shelter	**410,154**	**410,154**				
22. Bridge Housing for the Homeless	**1,300,000**	**1,300,000**				
23. MHSA/CSS Housing	**233,672**	**233,672**				
OCCR Housing MOU	233,672	233,672				
Permanent Supportive Housing	-	-				
Sub-Total	***$99,110,672***	***$99,110,672***	***$15,120,368***	***$-***	***$-***	***$1,029,080***

County: **Orange** Date: 3/13/2020

Program Description	Fiscal Year 2022-23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
NON-FSP PROGRAMS NOT FUNDED BY FSP FUNDING:						
Access and Linkage to Treatment Section:						
1. BHS Outreach and Engagement	**1,027,973**	**1,027,973**				
2. The Courtyard Outreach	**855,000**	**855,000**				
3. CHS Jail to Community Re-Entry	**1,400,000**	**1,400,000**				
4. Recovery Open Access	**2,866,010**	**2,254,000**	**533,701**			**78,309**
Suicide & Crisis Prevention Section:						
5. Mobile Crisis Assessment Team	**6,922,784**	**5,684,764**	**915,628**			**322,392**
Children 0-17	1,945,613	1,265,613	440,000			240,000
Adult/Older Adults 18+	4,977,171	4,419,151	475,628			82,392
6. Crisis Stabilization Units (CSUs)	**12,750,000**	**8,500,000**	**4,250,000**			
7. In-Home Crisis Stabilization	**2,195,826**	**1,705,644**	**490,182**			
Children 0-17	602,076	430,644	171,432			
Adult/Older Adults 18+	1,593,750	1,275,000	318,750			
8. Crisis Residential Services	**7,003,522**	**5,374,526**	**1,506,761**			**122,234**
Chilldren (0-17)	1,689,974	1,496,474	193,500			
Transitional Age Youth (TAY)	93,312	77,068	16,244			
Adults/Older Adults	5,220,235	3,800,983	1,297,018			122,234

County: **Orange** Date: 3/13/2020

Program Description	Fiscal Year 2022-23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Clinic Expansion:						
9. Children & Youth Expansion	3,000,000	3,000,000				
10. Services for the Short-Term Residential Therapeutic Program	16,000,000	8,000,000	8,000,000			
11. Children & Youth Co-Occurring Medical & MH Clinic	1,000,000	500,000	500,000			
12. Outpatient Recovery	8,336,885	6,035,360	2,205,374			96,150
13. Integrated Community Services	1,197,000	1,197,000	-			
14. Older Adult Services	2,690,789	2,038,047	553,756			98,986
15. Telehealth/Virtual Behavioral Health Care	3,000,000	3,000,000				
Supportive Services Section:						
16. Mentoring for Children and Youth	500,000	500,000				
17. Peer Mentor and Parent Partner Support	4,249,888	4,249,888				
18. Wellness Centers	2,851,198	2,851,198				
19. Supported Employment	1,097,010	1,097,010				
20. Transportation	1,300,000	1,300,000				
Supportive Housing/Homelessness Section:						
21. Short-Term Housing Services Shelter	957,026	957,026				
22. Bridge Housing for the Homeless	700,000	700,000				
23. MHSA/CSS Housing	75,622	75,622				
OCCR Housing MOU	75,622	75,622				
Permanent Supportive Housing	-	-				
Sub-Total	***$81,978,801***	***$62,305,327***	***$18,955,403***	**$-**	**$-**	***$718,070***
CSS Administration	20,053,784	20,053,784				
Total CSS Program Estimated Expenditures	**$201,143,257**	**$165,320,336**	**$34,075,771**	**$-**	**$-**	**$1,747,150**
FSP Programs as Percent of Total		**50%**				

FY 2020-2023 Three-Year Plan Update - Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: **Orange** Date: 3/13/2020

Program Description	Fiscal Year 2020-21					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Stigma Reduction						
1. MH Community Educ. Events for Reducing Stigma & Discrimination	**881,000**	**881,000**				
Outreach for Increasing Recognition of Early Signs of Mental Illness						
2. Outreach for Increasing Recognition of Early Signs of Mental Illness	**9,336,945**	**9,336,945**				
Behavioral Health Community Training & Technical Assistance	700,000	700,000				
Early Childhood Mental Health Providers Training	829,533	829,533				
Mental Health & Well-Being Promotion for Diverse Communities	3,385,711	3,385,711				
Services for TAY and Young Adults	1,250,000	1,250,000				
K-12 School-Based Mental Health Services Expansion	2,312,500	2,312,500				
Statewide Projects	859,201	859,201				

County: **Orange** Date: 3/13/2020

Program Description	Fiscal Year 2020-21					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Prevention: Mental Health & Well-Being Promotion						
3. School Readiness	1,600,000	1,600,000				
4. School-Based Behavioral Health Intervention & Support - Prevention	3,408,589	3,408,589				
5. School-Based Stress Management Services	155,000	155,000				
Prevention: Violence & Bullying Prevention						
6. Violence Prevention Education	1,352,651	1,352,651				
7. Gang Prevention Services	403,100	403,100				
Supportive Services						
8. Parent Education Services	1,064,770	1,064,770				
9. Family Support Services	282,000	282,000				
10. Children's Support & Parenting	1,700,000	1,700,000				
11. Transportation Assistance	150,000	150,000				
Access & Linkage to Treatment						
12. OCLinks	1,000,000	1,000,000				
13. BHS Outreach & Engagement	2,232,523	2,232,523				
Suicide & Crisis Prevention						
14. Warmline	1,116,667	1,116,667				
15. Suicide Prevention Services	1,200,000	1,200,000				
Crisis Prevention Hotline	600,000	600,000				
Survivor Support Services	600,000	600,000				

County: **Orange** Date: 3/13/2020

Program Description	Fiscal Year 2020-21					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Outpatient Treatment (Early Intervention)						
16. Community Counseling & Supportive Services	**2,536,136**	**2,536,136**				
Community Counseling & Supportive Services	1,986,136	1,986,136				
OC ACCEPT	550,000	550,000				
17. School-Based Mental Health Services	**2,525,236**	**2,525,236**				
18. Early Intervention Services for Older Adults	**2,469,500**	**2,469,500**				
19. OC Parent Wellness Program	**3,738,072**	**3,738,072**				
Parent Wellness Program	1,943,072	1,943,072				
Connect the Tots	1,200,000	1,200,000				
Stress Free Families	595,000	595,000				
20. First Onset of Psychiatric Illness	**1,500,000**	**1,500,000**				
21. Early Intevention Services for Veterans	**1,695,957**	**1,695,957**				
OC4VETS	1,295,957	1,295,957				
Veterans School-Based Intervention	400,000	400,000				
22. Behavioral Health Services for Military Families	**1,000,000**	**1,000,000**				
PEI Administration	**5,713,337**	**5,713,337**				
Total PEI Program Estimated Expenditures	**$47,061,483**	**$47,061,483**	**$-**	**$-**	**$-**	**$-**

FY 2021-22 Annual Update - Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: **Orange** Date: 3/13/2020

Program Description	Fiscal Year 2021-22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Stigma Reduction						
1. Mental Health Community Educ. Events for Reducing Stigma & Discrimination	**881,000**	**881,000**				
Outreach for Increasing Recognition of Early Signs of Mental Illness						
2. Outreach for Increasing Recognition of Early Signs of Mental Illness	**11,336,945**	**11,336,945**				
Behavioral Health Community Training & Technical Assistance	700,000	700,000				
Early Childhood Mental Health Providers Training	829,533	829,533				
Mental Health & Well-Being Promotion for Diverse Communities	3,385,711	3,385,711				
Services for TAY and Young Adults	1,250,000	1,250,000				
K-12 School-Based Mental Health Services Expansion	2,312,500	2,312,500				
Statewide Projects	2,859,201	2,859,201				

County: **Orange** Date: 3/13/2020

Program Description	Fiscal Year 2021-22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Prevention: Mental Health & Well-Being Promotion						
3. School Readiness	1,600,000	1,600,000				
4. School-Based Behavioral Health Intervention & Support - Prevention	3,408,589	3,408,589				
5. School-Based Stress Management Services	155,000	155,000				
Prevention: Violence & Bullying Prevention						
6. Violence Prevention Education	1,352,651	1,352,651				
7. Gang Prevention Services	403,100	403,100				
Supportive Services						
8. Parent Education Services	1,064,770	1,064,770				
9. Family Support Services	282,000	282,000				
10. Children's Support & Parenting	1,700,000	1,700,000				
11. Transportation Assistance	500,000	500,000				
Access & Linkage to Treatment						
12. OCLinks	1,000,000	1,000,000				
13. BHS Outreach & Engagement	2,232,523	2,232,523				
Suicide & Crisis Prevention						
14. Warmline	1,116,667	1,116,667				
15. Suicide Prevention Services	1,200,000	1,200,000				
Crisis Prevention Hotline	600,000	600,000				
Survivor Support Services	600,000	600,000				

County: **Orange** Date: 3/13/2020

Program Description	Fiscal Year 2021-22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Outpatient Treatment (Early Intervention)						
16. Community Counseling & Supportive Services	**2,536,136**	**2,536,136**				
Community Counseling & Supportive Services	1,986,136	1,986,136				
OC ACCEPT	550,000	550,000				
17. School-Based Mental Health Services	**2,525,236**	**2,525,236**				
18. Early Intervention Services for Older Adults	**2,469,500**	**2,469,500**				
19. OC Parent Wellness Program	**3,738,072**	**3,738,072**				
Parent Wellness Program	1,943,072	1,943,072				
Connect the Tots	1,200,000	1,200,000				
Stress Free Families	595,000	595,000				
20. First Onset of Psychiatric Illness	**1,500,000**	**1,500,000**				
21. Early Intevention Services for Veterans	**1,400,000**	**1,400,000**				
OC4VETS	1,000,000	1,000,000				
Veterans School-Based Intervention	400,000	400,000				
22. Behavioral Health Services for Military Families	**1,000,000**	**1,000,000**				
PEI Administration	**5,884,737**	**5,884,737**				
Total PEI Program Estimated Expenditures	**$49,286,926**	**$49,286,926**	**$-**	**$-**	**$-**	**$-**

FY 2022-23 Annual Update - Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: **Orange** Date: 3/13/2020

Program Description	Fiscal Year 2022-23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Stigma Reduction						
1. MH Community Educ. Events for Reducing Stigma & Discrimination	**214,333**	**214,333**				
Outreach for Increasing Recognition of Early Signs of Mental Illness						
2 Outreach for Increasing Recognition of Early Signs of Mental Illness	**6,278,245**	**6,278,245**				
Behavioral Health Community Training & Technical Assistance	700,000	700,000				
Early Childhood Mental Health Providers Training	-	-				
Mental Health & Well-Being Promotion for Diverse Communities	2,719,044	2,719,044				
Services for TAY and Young Adults	-	-				
K-12 School-Based Mental Health Services Expansion	-	-				
Statewide Projects	2,859,201	2,859,201				

County: **Orange** Date: 3/13/2020

Program Description	Fiscal Year 2022-23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Prevention: Mental Health & Well-Being Promotion						
3. School Readiness	1,600,000	1,600,000				
4. School-Based Behavioral Health Intervention & Support - Prevention	1,808,589	1,808,589				
5. School-Based Stress Management Services	155,000	155,000				
Prevention: Violence & Bullying Prevention						
6. Violence Prevention Education	1,352,651	1,352,651				
7. Gang Prevention Services	253,100	253,100				
Supportive Services						
8. Parent Education Services	1,064,770	1,064,770				
9. Family Support Services	282,000	282,000				
10. Children's Support & Parenting	1,700,000	1,700,000				
11. Transportation Assistance	500,000	500,000				
Access & Linkage to Treatment						
12. OCLinks	1,000,000	1,000,000				
13. BHS Outreach & Engagement	2,232,523	2,232,523				
Suicide & Crisis Prevention						
14. Warmline	1,116,667	1,116,667				
15. Suicide Prevention Services	1,200,000	1,200,000				
Crisis Prevention Hotline	600,000	600,000				
Survivor Support Services	600,000	600,000				

County: **Orange** Date: 3/13/2020

Program Description	Fiscal Year 2022-23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Outpatient Treatment (Early Intervention)						
16. Community Counseling & Supportive Services	**2,536,136**	**2,536,136**				
Community Counseling & Supportive Services	1,986,136	1,986,136				
OC ACCEPT	550,000	550,000				
17. School-Based Mental Health Services	**2,525,236**	**2,525,236**				
18. Early Intervention Services for Older Adults	**1,469,500**	**1,469,500**				
19. OC Parent Wellness Program	**3,738,072**	**3,738,072**				
Parent Wellness Program	1,943,072	1,943,072				
Connect the Tots	1,200,000	1,200,000				
Stress Free Families	595,000	595,000				
20. First Onset of Psychiatric Illness	**1,500,000**	**1,500,000**				
21. Early Intevention Services for Veterans	**1,400,000**	**1,400,000**				
OC4VETS	1,000,000	1,000,000				
Veterans School-Based Intervention	400,000	400,000				
22. Behavioral Health Services for Military Families	**1,000,000**	**1,000,000**				
PEI Administration	**6,061,279**	**6,061,279**				
Total PEI Program Estimated Expenditures	**$40,988,101**	**$40,988,101**	**$-**	**$-**	**$-**	**$-**

FY 2020-2023 Three-Year Plan Update - Mental Health Services Act Expenditure Plan Innovation (INN) Component Worksheet

County: **Orange**

Date: 3/13/2020

Program Description	Fiscal Year 2020-21					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
1. Contiuum of Care for Veterans and Military Families	962,445	962,445				
2. Statewide Early Psychosis Learning Health Care Collaborative Network	510,584	510,584				
3. Behavioral Health System Transformation	9,477,500	9,477,500				
4. Mental Health Technology Suite	6,000,000	6,000,000				
Subtotal Of All INN Programs	***16,950,529***	***16,950,529***				
INN Administration	1,395,831	1,395,831				
Total INN Program Estimated Expenditures	**$18,346,360**	**$18,346,360**	**$-**	**$-**	**$-**	**$-**

Program Description	Fiscal Year 2021-22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
1. Contiuum of Care for Veterans and Military Families	-	-				
2. Statewide Early Psychosis Learning Health Care Collaborative Network	561,234	561,234				
3. Behavioral Health System Transformation	4,010,833	4,010,833				
4. Mental Health Technology Suite	3,000,000	3,000,000				
Subtotal Of All INN Programs	***7,572,067***	***7,572,067***				
INN Administration	1,437,706	1,437,706				
Total INN Program Estimated Expenditures	**$9,009,773**	**$9,009,773**	**$-**	**$-**	**$-**	**$-**

Program Description	Fiscal Year 2022-23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
1. Contiuum of Care for Veterans and Military Families	-	-				
2. Statewide Early Psychosis Learning Health Care Collaborative Network	561,234	561,234				
3. Behavioral Health System Transformation	-	-				
4. Mental Health Technology Suite	-	-				
Subtotal Of All INN Programs	***561,234***	***561,234***				
INN Administration	1,480,837	1,480,837				
Total INN Program Estimated Expenditures	**$2,042,071**	**$2,042,071**	**$-**	**$-**	**$-**	**$-**

FY 2020-2023 Three-Year Plan Update - Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: **Orange** Date: 3/13/2020

Program Description	Fiscal Year 2020-21					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
1. Workforce Staffing Support	1,710,584	1,710,584				
2. Training and Technical Assistance	1,223,390	1,223,390				
3. Mental Health Career Pathways	1,046,663	1,046,663				
4. Residencies and Internships	170,000	170,000				
5. Financial Incentives Programs	526,968	526,968				
6. WET Five-Year Plan with CalMHSA	1,071,050	1,071,050				
Subtotal Of All WET Programs	***5,748,655***	***5,748,655***				
WET Administration	467,979	467,979				
Total WET Program Estimated Expenditures	**$6,216,634**	**$6,216,634**	**$-**	**$-**	**$-**	**$-**

Program Description	Fiscal Year 2021-22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
1. Workforce Staffing Support	1,761,901	1,761,901				
2. Training and Technical Assistance	1,232,434	1,232,434				
3. Mental Health Career Pathways	1,046,663	1,046,663				
4. Residencies and Internships	170,000	170,000				
5. Financial Incentives Programs	526,968	526,968				
6. WET Five-Year Plan with CalMHSA	-	-				
Subtotal Of All WET Programs	***4,737,966***	***4,737,966***				
WET Administration	482,018	482,018				
Total WET Program Estimated Expenditures	**$5,219,984**	**$5,219,984**	**$-**	**$-**	**$-**	**$-**

Program Description	Fiscal Year 2022-23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
1. Workforce Staffing Support	1,814,758	1,814,758				
2. Training and Technical Assistance	1,241,794	1,241,794				
3. Mental Health Career Pathways	1,046,663	1,046,663				
4. Residencies and Internships	170,000	170,000				
5. Financial Incentives Programs	526,968	526,968				
6. WET Five-Year Plan with CalMHSA	-	-				
Subtotal Of All WET Programs	***4,800,183***	***4,800,183***				
WET Administration	496,479	496,479				
Total WET Program Estimated Expenditures	**$5,296,662**	**$5,296,662**	**$-**	**$-**	**$-**	**$-**

FY 2020-2023 Three-Year Plan Update - Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: **Orange** Date: 3/13/2020

Program Description	Fiscal Year 2020-21					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Capital Facilities Projects						
1. Behavioral Health Training Facility	65,000	65,000				
Technological Needs Projects						
2. Electronic Health Record (E.H.R)	12,154,749	12,154,749				
CFTN Administration	***300,000***	***300,000***				
Total CFTN Program Estimated Expenditures	**$12,519,749**	**$12,519,749**	**$-**	**$-**	**$-**	**$-**

Program Description	Fiscal Year 2021-22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Capital Facilities Projects						
1. Behavioral Health Training Facility	65,000	65,000				
Technological Needs Projects						
2. Electronic Health Record (E.H.R)	8,466,752	8,466,752				
CFTN Administration	***309,000***	***309,000***				
Total CFTN Program Estimated Expenditures	**$8,840,752**	**$8,840,752**	**$-**	**$-**	**$-**	**$-**

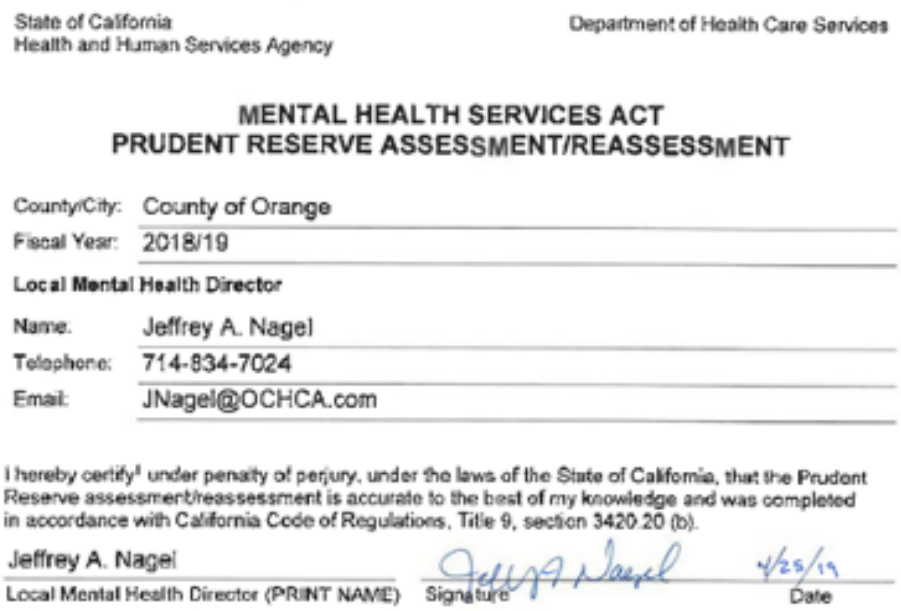
Program Description	Fiscal Year 2022-23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Capital Facilities Projects						
1. Behavioral Health Training Facility	65,000	65,000				
Technological Needs Projects						
2. Electronic Health Record (E.H.R)	8,582,888	8,582,888				
CFTN Administration	***318,270***	***318,270***				
Total CFTN Program Estimated Expenditures	**$8,966,158**	**$8,966,158**	**$-**	**$-**	**$-**	**$-**

EXHIBIT B: MAXIMUM PRUDENT RESERVE CALCULATION AND PRUDENT RESERVE ASSESSMENT

The Prudent Reserve Calculation and Assessment are to be completed every five years. The next calculation and assessment will occur in FY 2023-24.

FY 2019-20 33% Maximum Prudent Reserve Calculations

Funding Year	Total MHSA Allocations July 1, 2013 - June 30, 2018
FY 13-14	$99,072,771.39
FY 14-15	$138,031,688.98
FY 15-16	$115,045,914.79
FY 16-17	$149,134,711.87
FY 17-18	$161,768,522.68
5-yr Total	$663,053,609.71
CSS portion of total allocation (76%)	$503,920,743.38
5-yr Average of CSS funds	$100,784,148.68
Prudent Reserve Limit for FY 18-19 (33%)	**$33,258,769.06**



State of California
Health and Human Services Agency

Department of Health Care Services

MENTAL HEALTH SERVICES ACT
PRUDENT RESERVE ASSESSMENT/REASSESSMENT

County/City: County of Orange
Fiscal Year: 2018/19

Local Mental Health Director

Name: Jeffrey A. Nagel
Telephone: 714-834-7024
Email: JNagel@OCHCA.com

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

Jeffrey A. Nagel — Local Mental Health Director (PRINT NAME)
Signature
4/25/19 — Date

EXHIBIT C: COUNTY COMPLIANCE CERTIFICATION

MHSA COUNTY COMPLIANCE CERTIFICATION

County: Orange

Local Mental Health Director	Program Lead
Name: Jeffrey Nagel, PhD.	Name: Sharon Ishikawa, PhD.
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: 405 E. 5th St. 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 06/02/2020.

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

All documents in the attached annual update are true and correct.

Dr. Jeffrey Nagel, PhD.
Local Mental Health Director/Designee (PRINT)

Signature

Date

County: Orange

Date: 06/11/2020

EXHIBIT D: COUNTY FISCAL CERTIFICATION

Enclosure 1

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: Jeffrey Nagel, Ph.D.	Name: Frank Davies
Telephone Number: (714) 834-7024	Telephone Number: (714) 834-2450
E-mail: jnagel@ochca.com	E-mail: frank.davies@ac.ocgov.com
Local Mental Health Mailing Address: 405 W 5th St. 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 counties in future years.

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

Jeffrey K. Nagel — Local Mental Health Director (PRINT)
Signature — Date: 3/16/20

I hereby certify that for the fiscal year ended June 30, 2019, 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 12/16/19 for the fiscal year ended June 30, 2019. I further certify that for the fiscal year ended June 30, 2019, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

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

CINDY WONG FOR FRANK DAVIES — County Auditor Controller / City Financial Officer (PRINT)
Signature — Date: 3/16/2020

[1] Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)
Three-Year Program and Expenditure Plan, Annual Update, and RER Certification (07/22/2013)

APPENDIX I: 2019 COMMUNITY FEEDBACK SURVEY DATA
(Compiled by Desert Vista Consulting)

Characteristics of Survey Respondents

Paper Survey Responses by Location	Frequency	Percentage
CCSS PEI Program	288	35%
Picnic in the Park	195	24%
NAMI Walk	176	22%
Wellness Center	59	7%
Community Stakeholder Training	51	6%
Halloween Event	29	4%
BHS Outpatient Clinics	15	2%
Peer Support Program	4	1%
Supported Employment Program	3	0.4%
TOTAL	**820**	**100%**

Identification as Consumer/Client and/or Family Member	Frequency	Percentage
Consumer/Client	325	29%
Family Member	174	15%
Neither	189	17%
Not Captured	448	39%
TOTAL	**1,136**	**100%**

NOTE: Data for this question was not captured for a total of 448 survey respondents, including 132 paper survey respondents who did not answer this question, as well as the online survey respondents. The question was omitted from the online survey to protect personal information.

Stakeholder Group *(could select more than 1)*	Frequency	Percentage
Community-Based Organization	320	28%
Provider of Mental Health Services	205	18%
Advocate/Advocacy Organization	193	17%
Medical/Health Care Organization	160	14%
Religious/Spiritual	154	14%
Educational Agency/Institution	147	13%
Other	99	9%
Social Service Agency	74	7%
Provider of Alcohol or Other Drug Services	43	4%
Law Enforcement/Court	30	3%
Other Orange County Government Agency	28	3%
Veterans/Veterans Organizations	16	1%

Age	Frequency	Percentage
15 or younger	17	2%
16-24	147	14%
25-59	758	71%
60 and older	140	13%
TOTAL	**1,062**	**100%**

Gender Identity	Frequency	Percentage
Female	728	70%
Male	299	29%
Transmale/Transman	1	<1%
Transfemale/Transwoman	3	<1%
Other	5	<1%
Prefer Not to Answer	11	1%
TOTAL	**1,047**	**100%**

Language	Frequency	Percentage
English	885	78%
Spanish	165	15%
Vietnamese	53	5%
Khmer (Cambodian)	25	2%
Korean	7	1%
Farsi	1	0.1%
TOTAL	**1,136**	**100%**

Race/Ethnicity	Frequency	Percentage	County Census
African American/Black	27	2%	2%
Amer. Indian/Native Alaskan	13	1%	<0.5%
Asian/Pacific Islander	242	21%	20%
Hispanic/Latino	406	36%	34%
Middle Eastern/North African	13	1%	-
White/Caucasian	325	29%	41%
*Other	16	1%	<0.5%
Prefer Not to Answer	37	3%	-
TOTAL	**1,136**	**100%**	

Summary of Survey Responses:
Top Five Prioritized Populations by Behavioral Health Service Area

Service Area: Behavioral Health System Navigation; Outreach & Engagement; Early Intervention; Outpatient Treatment

Behavioral Health System Navigation	Outreach & Engagement	Early Intervention	Outpatient Treatment
Youth (16-25 years)	Youth (16-25 years)	Children (0-15 years)	Youth (16-25 years)
Children (0-15 years)	Homeless	Youth (16-25 years)	Adults (26-59 years)
Mental Health w/ Substance Use	Adults (26-59 years)	Students at Risk of School Failure	Mental Health w/ Substance Use
Homeless	Mental Health w/ Substance Use	Foster Youth	Homeless
Adults (26-59 years)	Children (0-15 years)	Parent/Families	Mental Health w/ Medical Conditions

Service Area: Crisis Services; Residential Treatment (non-emergency); Supportive Services; Peer Support

Crisis Services	Residential Treatment (non-emergency)	Supportive Services	Peer Support
Youth (16-25 years)	Mental Health w/ Substance Use	Homeless	Youth (16-25 years)
Mental Health w/ Substance Use	Homeless	Youth (16-25 years)	Adults (26-59 years)
Homeless	Adults (26-59 years)	Adults (26-59 years)	Foster Youth
Adults (26-59 years)	Youth (16-25 years)	Mental Health w/ Substance Use	Children (0-15 years)
Children (0-15 years)	Older Adults	Veterans	Students at Risk of School Failure

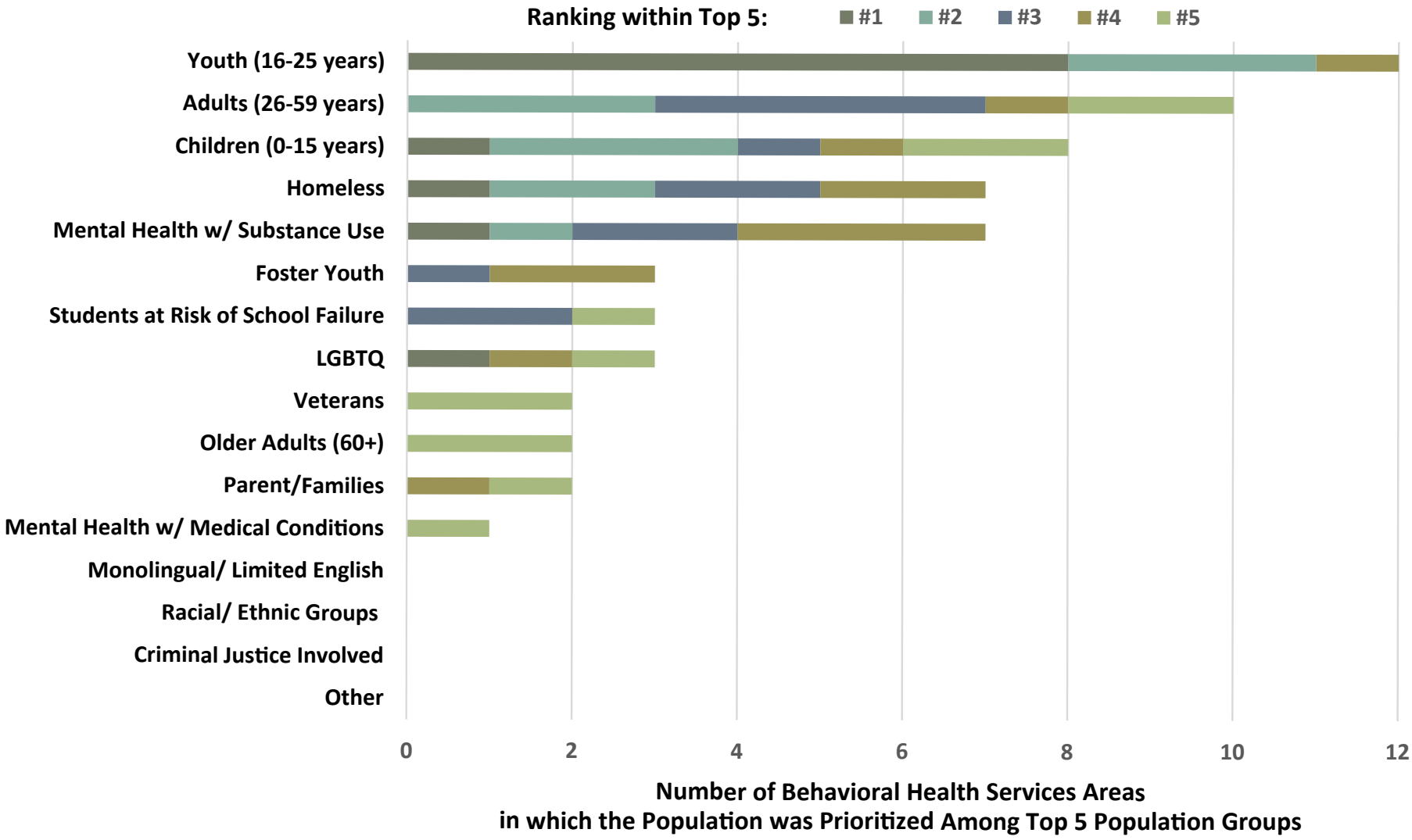
Service Area: Stigma & Discrimination Reduction; Mental Health & Well-Being Promotion; Violence & Bullying Prevention; Suicide Prevention

Stigma & Discrimination Reduction	Mental Health & Well-Being Promotion	Violence & Bullying Prevention	Suicide Prevention
LGBTQ	Youth (16-25 years)	Youth (16-25 years)	Youth (16-25 years)
Youth (16-25 years)	Adults (26-59 years)	Children (0-15 years)	Children (0-15 years)
Homeless	Children (0-15 years)	Students at Risk of School Failure	Adults (26-59 years)
Mental Health w/ Substance Use	Parent/Families	Foster Youth	LGBTQ
Adults (26-59 years)	Older Adults	LGBTQ	Veterans

Summary of Survey Responses:
Frequency that Specific Groups Were Among the Top Five Prioritized Populations

The following chart summarizes the frequency that specific populations were among the top five prioritized by respondents, along with the ranking within the "top 5."

Chart 1: Population Frequency in "Top 5" Across 12 Service Types



MHSA Steering Committee

December 16, 2019

DesertVista™ CONSULTING

Richard Krzyzanowski
Consultant

OC health CARE AGENCY

MENTAL HEALTH SERVICES ACT PROPOSITION 63 CALIFORNIA
WELLNESS • RECOVERY • RESILIENCE

Meeting Purpose

Highlight participation and engagement of the community

Combined meeting – dedicated opportunity for boards and committees to come together and hear feedback and key findings from community engagement activities

Identify key information to inform approach to identifying funding priorities

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Summary of Community Engagement Meeting Feedback and Preliminary Survey Results

Agenda

- Welcome and Agenda Review
- Review summary of community engagement meeting feedback and preliminary survey results
- Review Criminal Justice and K-12 Public School Feedback
- Review identified gaps and disparities from meetings and reports
- Questions and Answers
- Break
- Discussion Among Committee and Board Members: Reactions and considerations for prioritizing this information
  - Approach to identifying funding priorities and factors for considering distribution of potential extra funds
  - Approach to identifying programs to target in the event of excess or deficiency of funds
- Review next steps for planning process
- Public Comment
- Closing

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Survey Design

- 12 types of behavioral health services (next slide)
- 16 groups/population categories (subsequent slide)
- Respondents asked to provide demographic information and indicate top six groups they identified as having the greatest needs or disparities across the different types of behavioral health services the County of Orange provides
- Survey distributed electronically and in hardcopy at array of community events and made available in a variety of languages
- Online survey link emailed to 1,320 stakeholders

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Survey Design

12 types of behavioral health services

- Behavioral Health System Navigation
- Outreach & Engagement
- Early Intervention
- Outpatient Treatment
- Crisis Services
- Residential Treatment (non-emergency)
- Supportive Services
- Peer Support
- Stigma & Discrimination Reduction
- Mental Health & Well-Being Promotion
- Violence & Bullying Prevention
- Suicide Prevention

Preliminary Survey Results

- 1,136 surveys completed (313 online, 823 hard copy)

Language	#	%
English	885	78%
Spanish	165	15%
Vietnamese	53	5%
Khmer (Cambodian)	25	2%
Korean	7	1%
Farsi	1	0.1%
TOTAL	1,136	100%

Age	#	%
15 or younger	17	2%
16-25	147	14%
26-59	758	71%
60 and older	140	13%
TOTAL	1,062	100%

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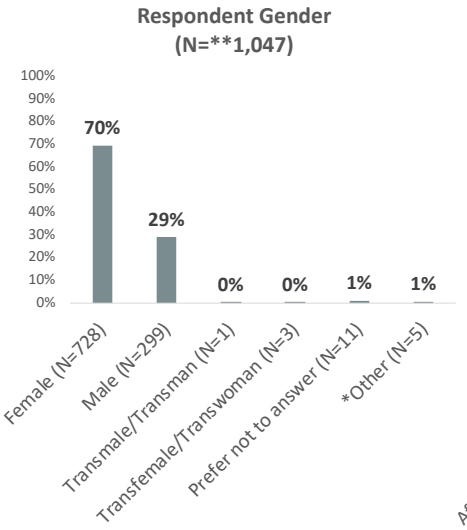
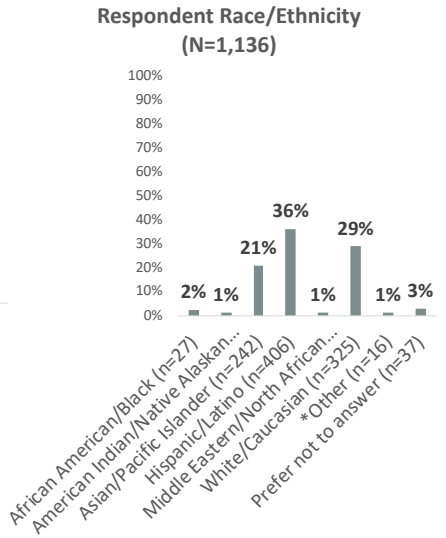
Survey Design

16 groups/ population categories

- Children (0-15 years)
- Youth (16-25 years)
- Adults (26-59 years)
- Older Adults (60+)
- Foster Youth
- Parent/ Families
- LGBTQ
- Homeless
- Students at Risk of School Failure
- Veterans
- Criminal Justice Involved
- Mental Health w/ Substance Use
- Mental Health w/ Medical Conditions
- Racial/ Ethnic Groups (please specify)
- Monolingual/ Limited English (please specify)
- Other (Please specify)

Preliminary Survey Results (continued)





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Preliminary Survey Results (continued)

Do you identify as a consumer/ client? [Paper surveys only]	#	%
No	189	27%
Consumer/Client	325	47%
Family Member	174	25%
TOTAL	688	100%

Have you/your organization ever received a County MHSA service provider contract?	#	%
No	748	73%
Yes	283	27%
TOTAL	1,031	100%

Which stakeholder groups do you identify with or are you a part of? (check all that apply)	#	%
Community-based Organization	320	28%
Provider of Mental Health Services	205	18%
Advocate/Advocacy Organization	193	17%
Religious/Spiritual	154	14%
Medical/Health Care Organization	160	14%
Educational Agency/Institution	147	13%
Other	99	9%
Social Service Agency	74	7%
Provider of Alcohol/Other Drug Services	43	4%
Law Enforcement/Court	30	3%
Other OC Government Agency	28	3%

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Preliminary Survey Results (continued) Population Prioritization (Top 5)

Behavioral Health System Navigation	Outreach & Engagement	Early Intervention	Outpatient Treatment
Youth (16-25 years)	Youth (16-25 years)	Children (0-15 years)	Youth (16-25 years)
Children (0-15 years)	Homeless	Youth (16-25 years)	Adults (26-59 years)
Mental Health w/ Substance Use	Adults (26-59 years)	**Students at Risk of School Failure**	Mental Health w/ Substance Use
Homeless	Mental Health w/ Substance Use	**Foster Youth**	Homeless
Adults (26-59 years)	Children (0-15 years)	**Parent/Families**	**Mental Health w/ Medical Conditions**

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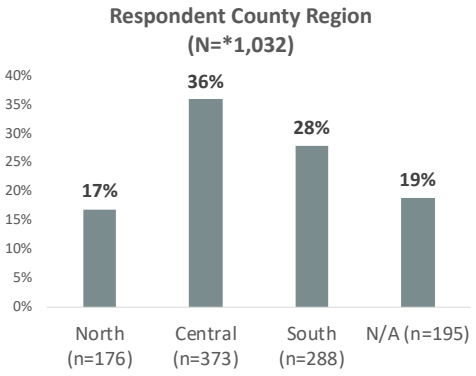
Preliminary Survey Results (continued)



Location Paper Surveys Collected	#	%
Community Counseling and Supportive Services (CCSS)	288	35%
Picnic in the Park	195	24%
NAMI Walk	176	22%
Wellness Center	59	7%
Community Stakeholder	51	6%
Halloween Event	29	4%
Clinics	15	2%
Peer Support Program	4	1%
Community Counseling and Supportive Services (CCSS)	288	35%
TOTAL	820	100%

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Preliminary Survey Results (continued) Population Prioritization (Top 5)

Crisis Services	Residential Treatment (non-emergency)	Supportive Services	Peer Support
Youth (16-25 years)	Mental Health w/ Substance Use	Homeless	Youth (16-25 years)
Mental Health w/ Substance Use	Homeless	Youth (16-25 years)	Adults (26-59 years)
Homeless	Adults (26-59 years)	Adults (26-59 years)	**Foster Youth**
Adults (26-59 years)	Youth (16-25 years)	Mental Health w/ Substance Use	Children (0-15 years)
Children (0-15 years)	**Older Adults**	**Veterans**	**Students at Risk of School Failure**

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Preliminary Survey Results (continued) Population Prioritization (Top 5)

Stigma & Discrimination Reduction	Mental Health & Well-Being Promotion	Violence & Bullying Prevention	Suicide Prevention
LGBTQ	Youth (16-25 years)	Youth (16-25 years)	Youth (16-25 years)
Youth (16-25 years)	Adults (26-59 years)	Children (0-15 years)	Children (0-15 years)
Homeless	Children (0-15 years)	**Students at Risk of School Failure**	Adults (26-59 years)
Mental Health w/ Substance Use	**Parent/Families**	**Foster Youth**	**LGBTQ**
Adults (26-59 years)	**Older Adults**	**LGBTQ**	**Veterans**

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Community Engagement Meeting Feedback Three Meetings / Two Groups for Each

	Anaheim (North)	Santa Ana (Central)	Aliso Viejo (South)	Total
Organization/ Sector Representatives (Providers, Advocates, Etc.)	29	28	21	**78**
Individual Consumer, Family, and Community Participants	22	37	16	**75**
Total	**51**	**65**	**37**	**153**

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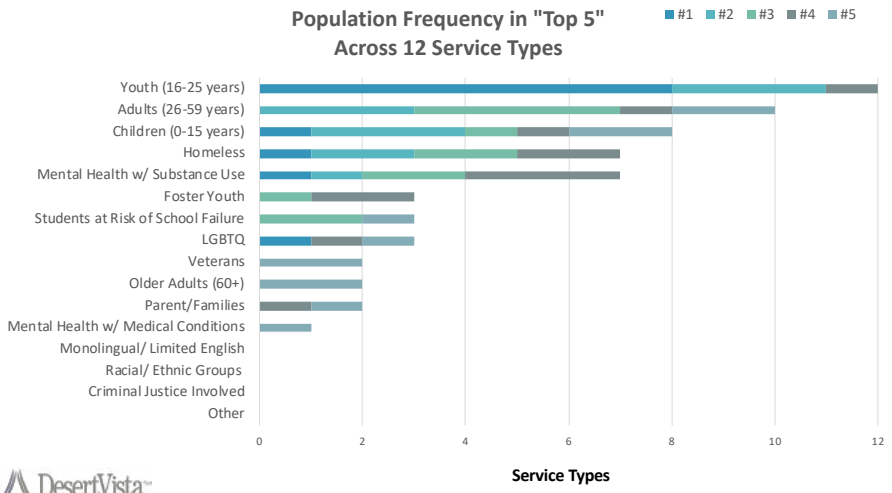
Preliminary Survey Results (continued) Population Prioritization



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Community Engagement Meeting Feedback Structure:

Three Population Clusters

- **Children & Youth** – Children (0-15 years), Youth (16-25 years), Foster Youth, Students at Risk of School Failure
- **Special Populations** (LGBTQ, Veterans, Homeless)
- **Adults and Co-Occurring Conditions** (Mental Health and Substance Use, Mental Health and Medical Conditions)

Important Note:

While **Older Adults**, **Racial/ Ethnic Groups**, and **Monolingual/ Limited English** populations were not prioritized in survey, community meeting participants identified these population as priorities. Facilitators encouraged participants to include these populations in discussions re: the broader three categories.

Community Engagement Meeting Feedback Structure: 5 Discussion Questions per Population

1. What unique barriers limit service opportunities for these populations? (5 Minutes)
   If discussing Funding, Transportation, Staffing, or Translation, please be very specific about how the barrier presents for this population.
2. What outreach and engagement strategies or activities are needed (or work best) for these populations? (10 Minutes)
3. What existing programs, activities, and/or interventions are most successful in meeting the needs of these populations? (10 Minutes)
4. What new programs, activities, and/or interventions should be considered to meet the needs of these populations? (5 Minutes)
5. What one new or existing program, activity, or intervention is the most important or most innovative for meeting the needs of these populations? (5 minutes)

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Cross-Cutting Successful Outreach & Engagement Strategies

- Culturally and linguistically appropriate attention to population-specific needs
- Meeting people where they are (not just MH and health/wellness fairs)
- Faith community
- Peer services
- Wellness Centers
- Consistent communication across providers
- Customer service and empathy
- Harm reduction approach
- Supported transitions of care
- Stable housing

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Barriers Summary (Meetings, reports, etc.)

Policy Level	• Lack of funding, Limited program capacity, geographic variation
Organization or System Level	• Fragmentation, limitations in care coordination, care transitions • Cultural, linguistic, physical • Lack of trust • Variation in consumer experience across service settings
Individual/Family/ Community Level	• Lack of information about mental health and resources • Stigma, self-stigma and stigma from family and community members, fear of discrimination • Housing across the continuum (affordable, PSH, transitional, shelter) • Employment • Transportation • Social isolation

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Specific Successful Outreach Strategies

Children/Youth	Special Populations	Adults & Co-Occurring
Social media	**Shelter-targeted activities**	**Telepsychiatry**
Schools/teachers on early identification of MH issues	**Community-based efforts (not from a desk)**	**Harm reduction approach**
Educate youth on importance/value of therapy for stress and emotion management	**Include consumers in design and development of strategies. Incorporate sufficient time and space to include consumer voice -- not just over a few weeks.**	**Agency collaboration (provider)**
Incorporate fun, engaging, age-appropriate activities such as sports, games, art in outreach and engagement efforts	**LGBTQ is an umbrella term — it's not a homogeneous group. There is great diversity of experience and different services/approaches work for different groups w/in LGBTQ**	**Integrated PC and MH**
Leverage schools for proximity to youth	**Re-entry/transition support**	**Social clubs, senior centers**
Youth-oriented organizations like Little League, AYSO, Special Olympics	**Designated safe spaces/clubs**	**Wellness Centers**
Parent education		

Community Identified Successful Programs

Children/Youth

- 211
- After school programs & clubs
- Anti-bullying hotlines
- Art classes
- ASPIRE
- Boys and Girls Club
- CHOC mental health programs
- Didi Hirsch hotline
- Drug abuse prevention programs
- Help Me Grow
- Huntington Beach youth shelter model
- internetmatters.net
- "Know the Signs" Training for parents and teachers
- Live Stream, Instagram, Social media — can enhance connection, but can also have negative impacts if not monitored
- savethekids.us
- School based services – screening and counseling
- Seneca Adoption support services
- socialemotionalpaws.com
- South Coast Children's
- Sports/recreational activities
- VROC support services for LGBT youth. Also includes intergenerational work, language support, social connection
- Western Youth Services programs for 0-5

Programs for New or Additional Funding

Organization/ System Level	• Crisis stabilization units • Transitional and long-term supportive housing • Community education campaigns • Contracting shifts to support integration and alignment of services and communication, including cross training of service providers • Culturally and linguistically appropriate attention to population-specific needs • Social media to promote awareness of services
Individual/Family/ Community Level	• Community-based services – where people are • Parent and Family engagement • Integrated whole-person approaches to care • Care coordination • Peer-based services • Targeted outreach

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Examples of Successful Programs

Special Populations	Adults and Co-Occurring
LGBTQ tailored services (community centers, shelter beds/supports)	Wellness Centers
Mental Health First Aid	Social worker/Case Manager assistance at hospital discharge
Life skill development	Court Diversion programs
Employment supports	"One stop shop" agencies
	Integrated primary care and mental health

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Programs for New or Additional Funding

Children/Youth	Special Populations	Adults and Co-Occurring
Residential programs	Residential programs for those with developmental disabilities and mental health issues	Transportation assistance
MH Spirit Week in Schools	Better access and coordination with medical treatment providers	Supportive Housing
Family retreats	Public hygiene centers for homeless	Peer supports
School counselors	Safe parking lots (for services at night, for homeless living in cars)	Increased integration and communication
Mindfulness required curriculum	Partnership with private funded services; MHSA cannot do it all (Community)	Consistent training
	Unified case management	Employment supports
	Linkage programs (e.g. Vets & Big Brothers / Big Sisters)	Residential programs
		Therapists and therapy

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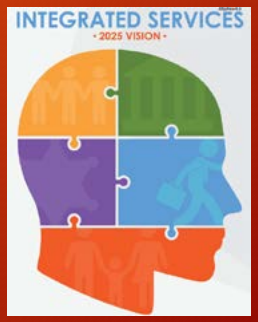
Criminal Justice and K-12 Public School Feedback

Criminal Justice CPP Meeting

- **Held December 10, 2019**
- **Integrated Services Workgroup (n=13):**
  - Orange County Courts
  - District Attorney's Office
  - Public Defender Office
  - Sheriff's Department
  - Probation Department
  - Correctional Health Services
  - Social Services Agency
- **Discussion focused on refining needs/ gaps/activities using Integrated Services Pillars**
  - Emphasis on what is applicable to MHSA



Criminal Justice Community Planning

for the Orange County MHSA Three-Year Plan FYs 2020-21 through 2022-23

Captain Lisa Von Nordheim
Orange County Sheriff's Department
December 16, 2019

Pillar 1 - Prevention

"Increase Public Awareness of various mental health & substance abuse topics and resources"

Public Awareness Campaign Needs:

- Use data-driven approach to identify populations (*who*) and/or zip codes (*where*) for increased campaign efforts
- Ensure messages are both culturally responsive and appropriate

Pillar 1 - Prevention

"Increase Public Awareness of various mental health & substance abuse topics and resources" *Cont'd*

Training Needs:

- Train Agency/Partner staff to promote behavioral health awareness when encountering at-risk and vulnerable populations, w/ messages that are culturally responsive/appropriate
- Train First Responders/Law Enforcement on:
  - Recognizing signs and Sx
  - Alternatives to bringing individuals to Emergency Department/Jail

Pillar 1 - Prevention

"Increase Public Awareness of various mental health & substance abuse topics and resources" *Cont'd*

Public Awareness Campaign Needs (specific for):

- Juvenile/Transitional Age Youth (TAY)
  - Include families at-risk of Criminal Justice involvement
  - Schools
  - LGBTQ Youth
  - Foster Youth
- Adults
  - Increase awareness of resources such as CalWORKS and other benefits

Pillar 1 - Prevention

"Increase staffing resources to address increased demands for mental health services"

Needs/Approach for:

- **Juveniles/TAY**
  - Increase STRTP beds
  - Add clinician to North SMART
- **Adults**
  - Increase/Co-Locate clinicians at Probation and SSA sites
- **General**
  - Increase clinicians on Collaborative Court teams
  - Create a streamlined (continuous) referral process

Pillar 2 - Courts

"Develop a tool for tracking data/individuals moving through the Collaborative Court process to be used by County departments and OC Courts to evaluate program effectiveness"

Needs/Approach:

- Identify appropriate information-sharing approaches/strategies to facilitate clinical care
  - Streamline referral process
  - Discuss/address conditions for (universal) consent
  - Do not put this task on the 'backburner'

Pillar 2 - Courts

"Court-County Relationship"

Are there additional mental health resources not discussed above that would help support safe, effective diversion options?

Needs:

- Adults – Facilitate linkage to outpatient behavioral health programs while person is still in custody/jail
  - Overcome barriers as to why clinicians won't come in jail before discharge

Pillar 2 - Courts

"Explore expansion of Specialty Courts"

What specific mental health supports are needed?

Needs:

- Increase Co-Occurring Collaborative Services
- Place a clinician in every Court (not just Collaborative Courts)

Pillar 4 – Re-Entry

"Establish a re-entry system to provide for successful re-integration"

Are there additional needs beyond the existing/planned re-entry programs for individuals with MH needs? What are solutions for barriers to implementation that exist?

Needs:

- Coordinate MH/BH case management, starting at admission and lasting through the person's journey, including post-custody
- Provide continuous communication trail as person moves through the CJ system

Pillar 4 – Re-Entry

"Establish a re-entry system to provide for successful re-integration" *Cont'd*

Are there additional needs beyond the existing/planned re-entry programs for individuals with MH needs? What are solutions for barriers to implementation that exist?

Needs:

- Increase nurses for post-release/re-entry support
- Continue psychiatric medication support for one week post-release
- Increase professional staff for in-reach

Thank You!

Pillar 4 – Re-Entry

"Establish a re-entry system to provide for successful re-integration" *Cont'd*

Are there additional needs beyond the existing/planned re-entry programs for individuals with MH needs? What are solutions for barriers to implementation that exist?

Needs:

- Establish a Re-Entry Center less than one mile from jail
- Provide transportation post-custody to facilitate linkage to Open Access and other BH resources

OC health CARE AGENCY

ORANGE COUNTY MHSA COMMUNITY PLANNING

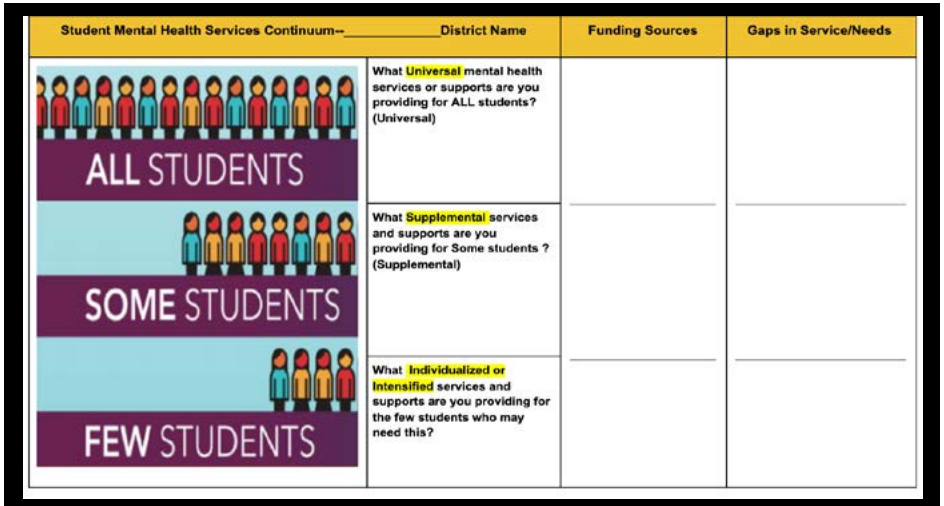
STUDENT MENTAL HEALTH NEEDS

STACY DEEBLE-REYNOLDS

ORANGE COUNTY DEPARTMENT OF EDUCATION

MEETING INFORMATION

- Held Monday, October 21, 2019
- Invited Superintendents, Assistant Superintendents, Principals, School Counselors, School Psychologists, District Office Staff
- 110 participants attended, representing 27 Districts
- Co-Facilitated with OCDE, CEO Budget



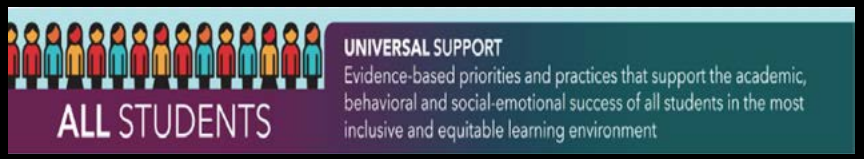
- *District needs generally consistent with results from 2019 Community Survey identifying TAY and/or Children as priority populations across all 12 service areas*
- *General Themes: Immediate resources/no wait period, transportation, timeliness of services, increase clinical support/reduce caseloads*

SCHOOL NEEDS & GAPS BY MTSS LEVEL

Group Activity — Each district learned about existing services and came to consensus on its areas of greatest student mental health needs, by MTSS Tier and Grade Level

Wall Activity — Each District placed consensus ratings on wall posters, by MTSS Tier and Grade Level

Brief Review — Brief discussion on wall activity results



Campus / School Campaigns

- ✓ Mental Health Awareness / Stigma & Discrimination Reduction
- Suicide Prevention *(Community Survey identified this as a need for TAY, LGBTQ)*
- ✓ Bullying Prevention

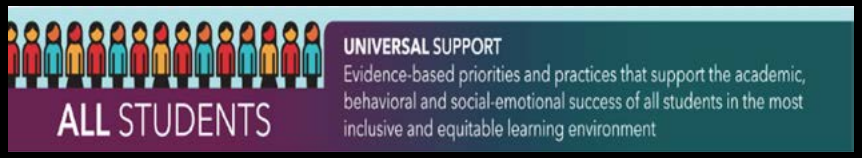
✓ Crisis Response & Support

following a critical incident affecting the school

Classroom / Student Curriculum

- ✓ Mental health and well-being curricula
- ✓ Digital Citizenship

(see handout for details)



Teacher & Staff Trainings

Some stated preference for within-District, local trainings rather than centralized location

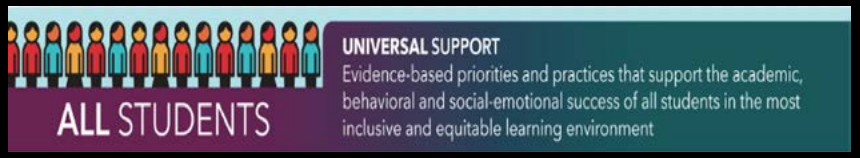
Building Knowledge & Awareness

- ✓ Stigma & Discrimination Reduction ***(also identified as a need for parents)***
- ✓ Educational / Networking Forums for schools and school districts
- ✓ Digital Citizenship

Building Skills

- ✓ How to effectively communicate with and engage students who are struggling
- ✓ How to appropriately identify and respond to:
  - ✓ early warning signs of mental illness ***(also identified as a need for parents)***
  - ✓ grief
  - ✓ trauma exposure
  - suicide risk

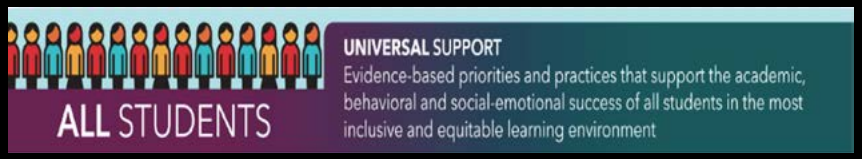
(see handout for details)



Other Identified Universal Level Needs

- ✓ Screeners: Universal, all levels, staff for follow up support, sharing data w/ County to note trends
- ✓ Wellness Centers: on campus, all levels, after-hours services
- ✓ Comprehensive Needs Assessment Tool

(see handout for details)



Teacher & Staff Trainings

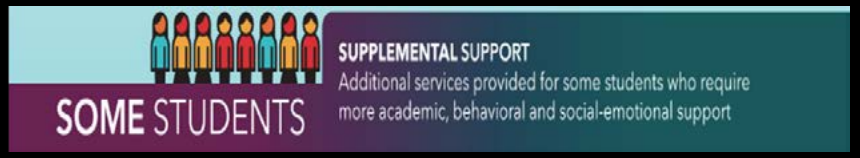
note if your District also has interest in related parent / caregiver modules

Building Skills *con't*

- ✓ How to help others access needed behavioral health resources ***(also id'd for parents)***
- ✓ Threat Assessment
- ✓ Violence / Gang Prevention
- Neurocognitive effects of exposure to violence on children
- ✓ Stress Management / Mindfulness techniques to use in classrooms ***(id'd for parents)***
- ✓ Restorative Practices

- ✓ Other identified training: Support for undocumented youth/DACA recipients, secondary grades; for teachers who need additional support

(see handout for details)



MH & Well-Being Support

- ✓ Small student groups for at-risk students *(see handout for specific topics)*

Violence Exposure & Gang Prevention

- ✓ Small student groups for at-risk students

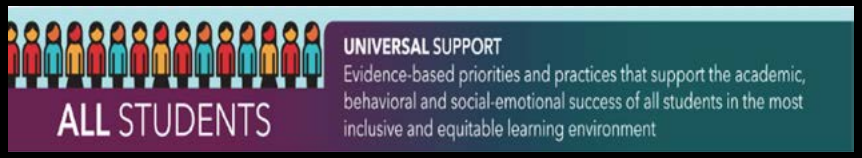
Access & Linkage to Treatment

- ✓ Screening, referral & linkage to needed services

Supportive Services

- ✓ Parenting Classes / Workshops
- Family-to-Family peer support
- Self-Care techniques / tips for the caregiver

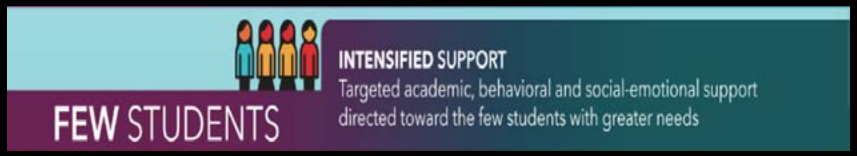
(see handout for details)



Other Identified Supplemental Level Needs

- ✓ Counseling: Individual, family, small-group, trauma-focused, school-based, all grade levels, including for those without Medi-Cal
- ✓ Substance use services: including low cost
- ✓ Wrap around services
- ✓ Mentoring: Elementary, secondary
- ✓ Services for target populations: homeless, foster, newcomer, Student Equity Center for LGBTQ, undocumented, etc.
- ✓ Check-In Check-Out

(see handout for details)



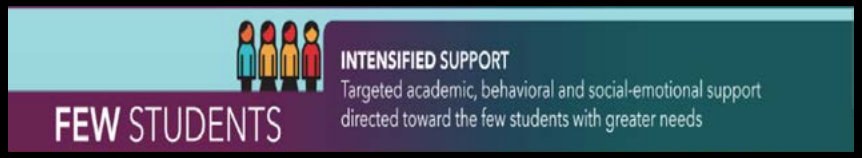
Suicide Prevention

- Crisis / Suicide Prevention Hotline
- ✓ Students experiencing a behavioral health emergency

Feedback:

Crisis Assessment Team: expanded services/availability, more timely response, regardless of insurance type

(see handout for details)



Early Intervention Outpatient Services

Students Experiencing Mental Health Conditions / Symptoms

- ✓ Children and their parents / caregivers / families
- Children affected by suicide
- Youth experiencing early-onset of psychosis

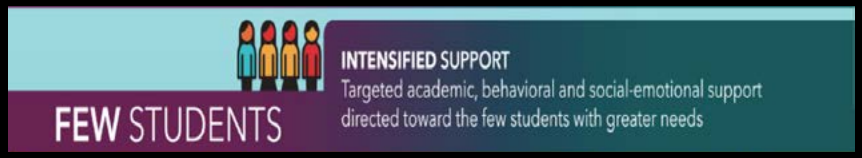
Students at Increased Risk of Developing a Mental Health Condition

- New / expecting youth parents
- Children in military families
- LGBTQ youth

Feedback:

Identified needs focused on increasing general school-based outpatient services, regardless of insurance, rather than on specialized treatment

(see handout for details)



Other Identified Intensified Level Needs

- ✓ Staff one school Social Worker per site
- ✓ Continue services through summer
- ✓ Wraparound services
- ✓ Behavioral management
- ✓ Partnerships (providers, OCDE, HCA)

(see handout for details)

For more information, go to:

https://ocde.us/mhcos/Pages/default.aspx

So very many reports…

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Identified Gaps & Disparities From Meetings & Reports

For your reading enjoyment:

- Orange County Needs and Gaps Analysis (UCSD) *to be released soon*
- 2018 CalOptima Member Health Needs Assessment: https://www.caloptima.org/~/media/Files/CalOptimaOrg/508/Community/CommunityGrants/2018_MHNAFinalReport.ashx
- Annual Report on the Conditions of Children in Orange County: http://www.ochealthinfo.com/phs/about/family/occp/report
- 2018 Hate Crimes Report: http://www.ochumanrelations.org/hatecrime/hate-crime-reports/
- Orange County Health Improvement Plan 2017-19: http://www.ochealthinfo.com/about/admin/pubs/ochealthimprovementplan
- 2019-20 Community Indicators Report: https://www.ocbc.org/wp-content/uploads/2019/09/CommIndicators_Report_091219-WEB.pdf
- Addressing the Opioid Crisis: http://www.ochealthinfo.com/civicax/filebank/blobdload.aspx?BlobID=106463
- 2014-2018 Suicide Deaths in Orange County: http://www.ochealthinfo.com/about/admin/pubs/selfharm
- California Association of Public Hospitals and Health Systems Reducing Health Disparities at California's Public Health Care Systems: https://caph.org/wp-content/uploads/2018/04/disparity-reduction-brief-1.pdf
- And many more County reports are aggregated here: http://www.ochealthinfo.com/about/admin/pubs

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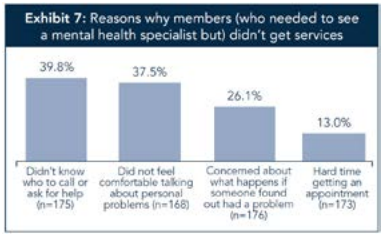
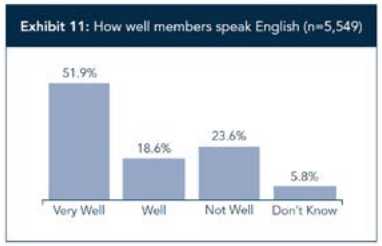
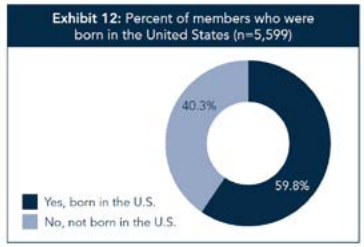
2018 CalOptima Member Health Needs Assessment







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UCSD Orange County Needs and Gaps Analysis

Figure 3. Serious Psychological Distress in the Past Year among Adults, by Sexual Orientation, 2011-2016

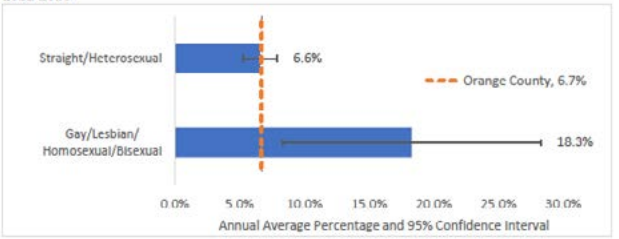

Figure 4. Serious Psychological Distress in the Past Year among Transitional-aged Youth, by Sexual Orientation, 2011-2016

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UCSD Orange County Needs and Gaps Analysis

***Figure 1.** Serious Psychological Distress in the Past Year among Adults, by Race, 2011-2016*

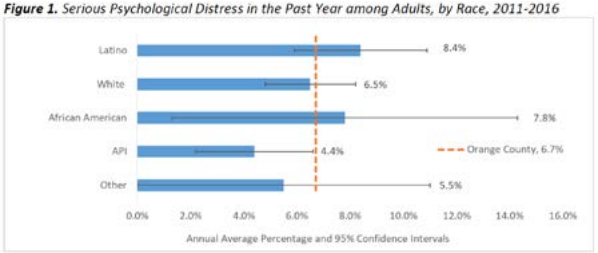
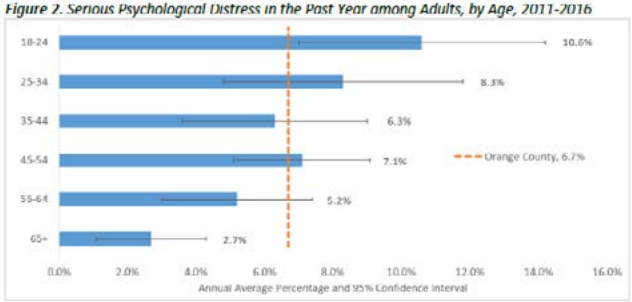


Figure 2. Serious Psychological Distress in the Past Year among Adults, by Age, 2011-2016



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Good (?) News! – Reports, surveys, and community feedback tend to align!

2018 CalOptima Member Health Needs Assessment

- **SDOH:** Financial stressors, social isolation and safety concerns impact the overall health and well-being of CalOptima members.
- **STIGMA:** Lack of knowledge and fear of stigma are key barriers to using mental health services.
- **Culture:** Members are culturally diverse and want providers who both speak their language and understand their culture.

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Good (?) News! – Reports, surveys, and community feedback tend to align!

UCSD Orange County Needs and Gaps Analysis

- Continue to Engage MHSA **Priority Populations** in Mental Health **Outreach and Care**.
- Develop a dedicated workgroup to explore creating or supporting programs addressing **African-American** community's mental health needs in Orange County.
- Add BHS resources in areas with higher levels of publicly insured/uninsured residents with no BHS treatment facilities (Capistrano Beach, San Juan Capistrano, and Trabuco Canyon)
- Relocate or Support **Increased Availability of Bilingual Staff** in Facilities where Speakers of Korean, Chinese, Farsi, Tagalog and Khmer Reside.
- Strive to develop a **mental health work force that reflects the population it serves.**
- Increase availability of **peer supports** across more programs, with a focus on **cultural concordance**.
- Expand opportunities for **professional development** related to **empathy and building trust** with diverse sub-populations.
- Scale up educational strategies to **address stigma** in Orange County.

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Discussion

What stood out to you about the information presented? (5 minutes)

How did this information influence your thinking from when you arrived today? (5 minutes)

What additional questions do you have about the data and information provided? (10 minutes)

How does this information inform your approach to identifying funding priorities? (10 minutes)

Break!

Next Steps for Planning Process

January 2020 Component Budget Updates and Program Review

Monday, **January 13th**, 2020 from 1-4pm: WET, CFTN, PEI

Wednesday, **January 29th**, 2020 from 1-4pm: CSS, (INN)

at the Delhi Center

Handout on Needs Identified at K-12 Public Schools CEM

DISTRICT IDENTIFIED GAPS IN MENTAL HEALTH SERVICES

October 21, 2019 Community Planning Meeting with Orange County K-12 School Districts

UNIVERSAL SUPPORT
Evidence-based priorities and practices that support the academic, behavioral and social-emotional success of all students in the most inclusive and equitable learning environment

ALL STUDENTS

Campus/School Campaigns (Student Activities)

Campaign activities include, but are not limited to, presentations, educational materials, school-wide events/assemblies, online resources, media and social marketing campaigns, etc.

Currently Offered / Available	Stated District Need
• Mental Health Awareness / Stigma & Discrimination Reduction	• Activities for Mental Health Month • NAMI on Campus • Prevention Education (Elementary) • Anti-discrimination Education *(moved from student ed)*
• Bullying Prevention	• Bullying Prevention Resources (incld. for teachers) • Bullying Prevention (Elementary, Secondary) • District-wide Bullying Prevention Campaign
• Suicide Prevention	

Other Identified Universal Level Needs

Screeners
- Universal mental health, social emotional, and behavior screening at all levels
- Providing screener data to county to offer insight on trends
- Staff to provide follow up support

Wellness Centers
- Wellness centers on campus for all levels
- After-hours services at wellness centers

Resources
- Needs Assessment tool for comprehensive school mental health

Crisis Response & Support

following a critical incident affecting the school

Currently Offered / Available	Stated District Need
• Crisis responders trained in Crisis Incident Stress Management who mobilize and assist a school or community in times of emergency, need or threat	• Develop protocols/procedures for Crisis/Threat

DISTRICT IDENTIFIED GAPS IN MENTAL HEALTH SERVICES

October 21, 2019 Community Planning Meeting with Orange County K-12 School Districts

Student Education/Curriculum (Classroom/Student Curriculum)

Currently Offered / Available	Stated District Need
• Curricula designed to increase mindfulness, positive coping skills, healthy habits and social support, and to enhance resilience, recovery and well-being for students and families	• Alcohol/drug Prevention • Prevention Education (Elementary) • MH Awareness education (grade-appropriate) • SEL curriculum
• Digital Citizenship, Violence Prevention Education	• Digital Citizenship/Social Media Literacy

Parent Education

Currently Offered / Available	Stated District Need
Building Knowledge & Awareness • Stigma/discrimination reduction related to mental health and/or seeking mental health services • Educational/networking forums for schools and school districts to learn from each other about resources, opportunities, lessons learned, and efforts that are making a difference • Digital Citizenship (i.e., cyberbullying, media literacy, etc.)	• Stigma awareness and reduction • How to address mental health and Social Emotional Wellness at home • Parent outreach, mentoring and improving awareness/access to services • Early Warning Signs • Stress Management • Digital Citizenship/Social Media Literacy • Youth Mental Health First Aid
Building Skills • How to effectively communicate with and engage students who are struggling • How to appropriately identify and respond to: o early warning signs of mental illness o grief o trauma exposure o suicide risk • How to help others access needed behavioral health resources • Threat Assessment (i.e., proactive threat assessment training, simulation drills, community forums) • Violence / Gang Prevention • Neurocognitive effects of exposure to violence on children, and future impact on learning, achievement & socio-emotional development	• *Not specifically requested but overlaps with above identified needs*

DISTRICT IDENTIFIED GAPS IN MENTAL HEALTH SERVICES

October 21, 2019 Community Planning Meeting with Orange County K-12 School Districts

Teacher & Staff (Educator) Training

Currently Offered / Available	Stated District Need
Building Knowledge & Awareness	
• Mental Health Awareness, Stigma/discrimination reduction related to mental health and/or seeking mental health services	• Teacher education resources on Mental Health, Wellness, Behavior, and Self-care • Adverse Childhood Experiences Training • Restorative Practices Policy and Practice • Youth Mental Health First Aid • OC Human Relations partnership
• Educational/networking forums for schools and school districts to learn from each other about resources, opportunities, lessons learned, and efforts that are making a difference * *new* *	• Referrals to community agencies/services • Informational website with mental health resources (directory/centralized hub) • Networking Opportunity
• Bullying Prevention, Digital Citizenship	• Need identified under *"School Campaign"*
Building Skills	
• Stress Management/Mindfulness techniques for teachers to use in classrooms • Restorative Practices that strengthen peer and student/teacher relationships & communication • Neurocognitive effects of exposure to violence on children, and future impact on learning, achievement & socio-emotional development • How to effectively communicate with/engage students who are struggling	• Stress Management/Mindfulness • Classroom management • How to engage the hard to reach students • How to Teach Empathy and SEL • Training regarding Tier 2 practices (*Supplemental*) • Developmental self-regulation skills for students • Strategies and Behavioral Supports
• How to appropriately identify and respond to: o early warning signs of mental illness o grief o trauma exposure o suicide risk	• Early Warning Signs • Mental health identification and Response • Grief/Trauma • Trauma Informed Education
• How to help others access needed BH resources	• Training on how to access resources • Resources/Intervention materials, practices (*Supplemental*)
• Threat Assessment (i.e., proactive threat assessment training, simulation drills, community forums)	• Threat Assessment training
• Violence / Gang Prevention	

Other Identified Universal Training Needs

- Preference for training within-district instead of at OCDE; Staff training at the local level
- Training/coaching for teachers who need additional support
- Training on how to support undocumented youth/DACA recipients (secondary)

DISTRICT IDENTIFIED GAPS IN MENTAL HEALTH SERVICES

October 21, 2019 Community Planning Meeting with Orange County K-12 School Districts

Mental Health & Well-Being Support

Currently Offered / Available	Stated District Need
• Small student groups that provide support, education and skills to address coping with bullying, anger management, conflict resolution, drug prevention, self-esteem, etc. for at-risk students	• Coping Skills x 2 • Social Skills x 2 • Skill-building workshops • Anger Management • Support for undocumented youth/DACA recipients (secondary) • Resources/Intervention materials for small groups identified as in-need (early childhood, elementary) • Other groups using evidence-based practices
	• Small group support for parents
	• Individual counseling • Clinical counseling therapy for students & families in need within district • Elem. counseling & psychological support services • Mental Health counseling for students and families which does not supplant school counselors • Trauma-focused counseling for TK through 6th grade • Counseling for non-MediCal students (secondary) • School-based Behavioral Health (elem. & secondary) • Small group counseling using data-driven curriculum • Advocates on school campuses • School Social Workers (PPS credentialed staff) • Staffing needed to meet need at Intermediate / HS • One mental health professional per school site
Not MHSA-Funded • SUD School-Based Prevention Curriculum • ADEPT Programs • Friday Night Light (K-12 specific chapters)	• Substance Abuse Program • Low cost/no cost counseling for students experiencing drug/substance abuse

Violence Exposure & Gang Prevention

Currently Offered / Available	Stated District Need
• Small student groups for youth at increased risk for gang activity/involvement and/or violence exposure	• Gang Prevention

DISTRICT IDENTIFIED GAPS IN MENTAL HEALTH SERVICES

October 21, 2019 Community Planning Meeting with Orange County K-12 School Districts

Access & Linkage to Treatment

Programs that help individuals find and enroll in the behavioral health service(s) best suited to their needs.

Currently Offered / Available	Stated District Need

• Screening, referral and linkage to BHS programs that best meet the needs of callers
  o over the phone
  o face-to-face
• Child/family needs assessments
• Referral/linkage to community resources
• Case management
	• School-based social workers for case managing linkages
	• Linkages/resources to series for families
	• Access/linkages/connecting parents to services
	• Immediate referral network
	• Connecting/linking students to community-based services
	• Assigned DISTRICT case manager/healthcare liaison (Single Point of Contact)
	• Access/linkages/connecting parents to services (*Universal*)
	• Staff to perform on-site identification, assessment and linkage services (*Universal*)
	• Additional outside agencies to connect families

Supportive Services

Services that help parents/caregivers of youth who are living with a mental health condition

Currently Offered / Available	Stated District Need

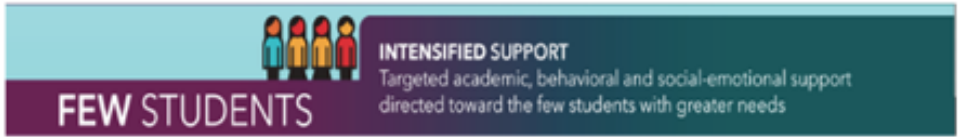
• Parenting education classes/workshops designed to improve family relationships and increase family protective factors
• Family-to-Family peer support
  o individual
  o groups
  o over the phone
• Self-care techniques/tips for the caregiver
	• Parent support/resources
	• Community Support
	• *Also see 'Parent Education' needs identified in the Universal section*

Other Identified Supplemental Needs

- Check-in Check-Out (elementary & secondary)
- Transient Population (homeless, foster, newcomer)
- Student Equity Center (LGBTQ, undocumented, etc.)
- Interventions flexible to needs of site/students
- Wrap around Services for students and families
- Mentoring (Elementary & Secondary)

DISTRICT IDENTIFIED GAPS IN MENTAL HEALTH SERVICES

October 21, 2019 Community Planning Meeting with Orange County K-12 School Districts



Early Intervention Outpatient Services

(Mental Health Counseling for Students/Families, Student Individual Mental Health Counseling)

Currently Offered / Available	Stated District Need
Students Experiencing MH Conditions / Symptoms • Children and their parents / caregivers / families • Children affected by suicide • Youth experiencing early-onset of psychosis **Students at Increased Risk of Developing a Mental Health Condition** • New / expecting youth parents • Children in military families • LGBTQ youth • Non-MHSA SUD services	• Counseling for students who are not Medi-Cal eligible • Counseling for all parents/families (even those without Medi-Cal) x 3 (1 specified secondary grades in *Supplemental*) • In-home counseling/services • Early Intervention/Outpatient program • Tier 3 School-based MH therapy/ services • Need more intensive and immediate mental health services for students • Alcohol & Drug Intervention

Suicide Prevention

Currently Offered / Available	Stated District Need
• Crisis / Suicide Prevention Hotline • Students experiencing a behavioral health emergency	• Additional crisis services to resource when Centralized Assessment Team (CAT) is impacted or declines call based on lack of insurance • Refusal of emergency services (CAT) due to lack of proper insurance (i.e., MediCal) or messaging from service provider indicating they will come if family pays (early childhood, elementary) • County CAT response is slow - need more timely assistance x2 • Expand CAT services/availability • Crisis Response Network (CRN)

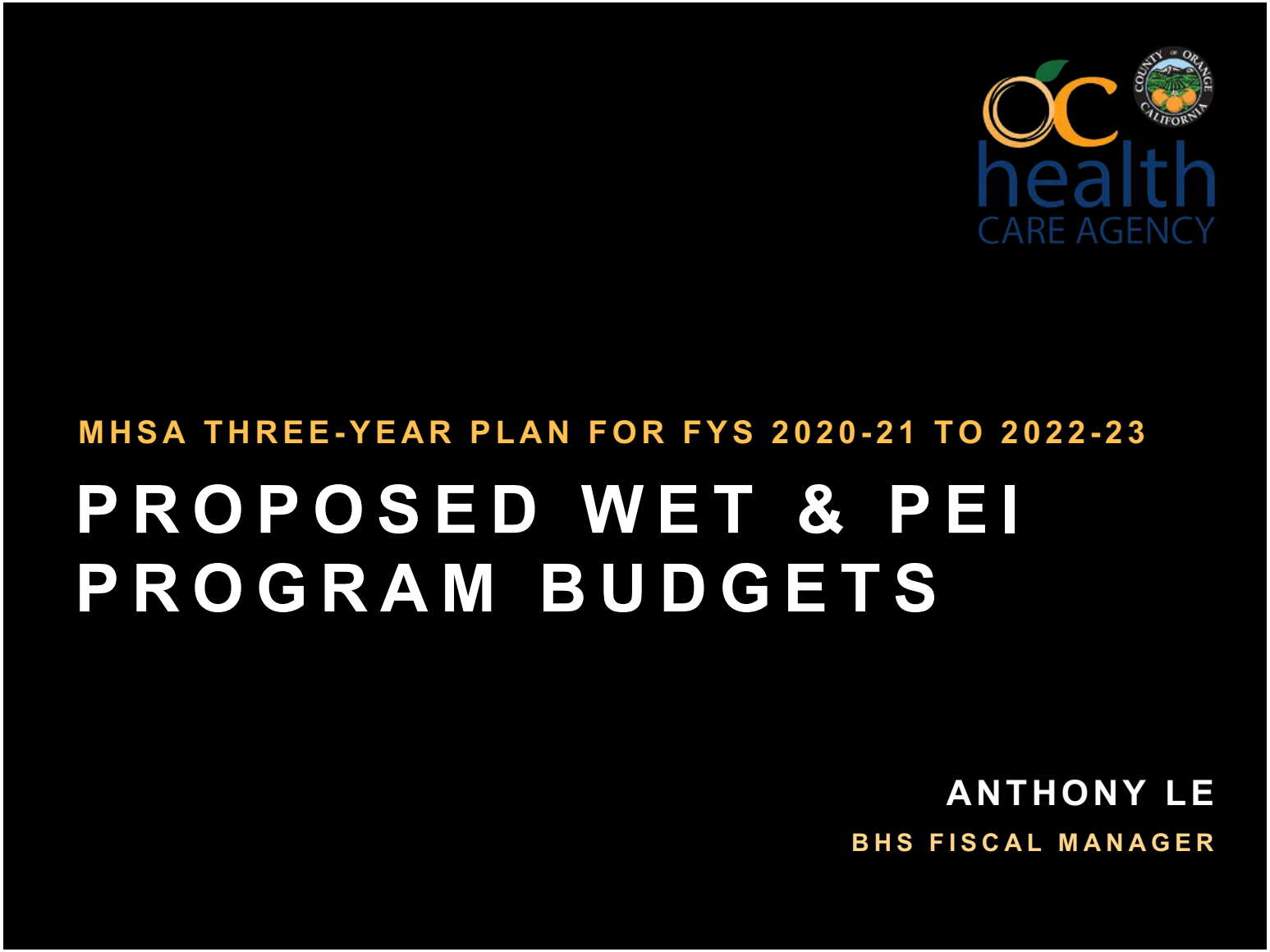
DISTRICT IDENTIFIED GAPS IN MENTAL HEALTH SERVICES

October 21, 2019 Community Planning Meeting with Orange County K-12 School Districts

Other Identified Intensified Level Needs
Staffing / Continuity of Care • School Social Workers - one per site • Continued services through summer break Resources • Wrap around Services for students and families • Internal Educationally Related Mental Health Services (ERMHS) Behavioral Management • In-home behavior management • Intensified behavior management Partnerships • Western Youth Services (WYS) • Orange County Asian and Pacific Islander Community Alliance (OCAPICA) • Health Care Agency (HCA • Orange County Department of Education (OCDE)

OTHER GENERAL THEMES
Resources • Need immediate resource available without a wait period • Transportation Timely Services • Delay in services Staffing • Caseload capacity • Need services during summer months • Need for more counselors • Need to reduce workload

APPENDIX III: JANUARY 2020 OVERVIEW OF PROPOSED MHSA PRIORITIES FOR THREE-YEAR PLAN



Budget Update Process for MHSA Three-Year Plan (3YP)

- CONFIRM expenditures for FY 2018-19
- PROJECT FY 2019-20 expenditures
- COMPARE projections to budgets
- TRUE-UP budget
- ADJUST true-up to account for known or anticipated changes over next three years

PEI CATEGORY 1: MH Awareness Campaigns & Education				
SUBCATEGORIES	Approved FY 19/20	Requested FY 20/21	Requested FY 21/22	Requested FY 22/23
1a. Stigma Reduction	$881,000	$881,000	$881,000	$214,333
1b. Outreach for Increasing Recognition of Early Signs of Mental Illness	$6,810,711	$9,336,945	$9,336,945	$4,278,245
1c. Prevention: Mental Health & Well Being	$5,163,589	$5,163,589	$5,163,589	$3,563,589
1d. Prevention: Violence & Bullying Prevention	$1,755,751	$1,755,751	$1,755,751	$1,605,751
MH Awareness Campaigns & Education SUBTOTAL	$14,611,051	$17,137,285	$17,137,285	$9,661,918

Understanding the Budget Grid

FY 2018-19	FY 2019-20	
Actual Expenditures	Approved Budget	Anticipated Expenditures (Projected as of Nov 2019)

FY 2020-21			
Requested On-Going Budget	Use of Carryover Funds from Previous FYs	Total Requested Budget	Variance FY20-21 vs. FY19-20 Budget

PEI CATEGORIES 2- 4: Supportive Services, Access & Linkage to Treatment, Suicide & Crisis Prevention				
CATEGORY SUBTOTALS	Approved FY 19/20	Requested FY 20/21	Requested FY 21/22	Requested FY 22/23
2. Supportive Services	$3,046,770	$3,046,770	$3,046,770	$3,046,770
3. Access & Linkage to Treatment	$3,232,523	$3,232,523	$3,232,523	$3,232523
4. Suicide & Crisis Prevention	$1,272,792	$2,316,667	$2,316,667	$2,316,667

PEI CATEGORY 5: Early Intervention Outpatient

SUBCATEGORIES	Approved FY 19/20	Requested FY 20/21	Requested FY 21/22	Requested FY 22/23
5a. General Services – all ages	$7,320,872	$7,530,872	$7,530,872	$6,530,872
5b. Family Focused	$3,928,072	$3,738,072	$3,738,072	$3,7338,072
5c. Early-Onset Psychosis	$1,500,000	$1,500,000	$1,500,000	$1,500,000
5d. Veteran-Focused	$2,695,957	$2,695,957	$2,400,000	$2,400,000
PEI Early Intervention Outpatient CATEGORY SUBTOTAL	$15,444,901	$15,464,901	$15,168,944	$14,168,944

PEI CATEGORIES 1 - 5 Subtotals

CATEGORIES	Approved FY 19/20	Requested FY 20/21	Requested FY 21/22	Requested FY 22/23
1. Mental Health Awareness Campaigns & Education	$14,611,051	$17,137,285	$17,137,285	$9,661,918
2. Supportive Services	$3,046,770	$3,046,770	$3,046,770	$3,046,770
3. Access & Linkage to Treatment	$3,232,523	$3,232,523	$3,232,523	$3,232,523
4. Suicide & Crisis Prevention	$1,272,792	$2,316,667	$2,316,667	$2,316,667
5. Early Intervention Outpatient	$15,444,901	$15,464,901	$15,168,944	$14,168,944
Subtotals of All PEI Programs	$37,608,037	$41,198,146	$41,902,189	$32,426,822
Administrative Costs	$5,882,150	$5,713,337	$5,884,737	$6,061,279
GRAND TOTAL	$43,490,187	$46,911,483	$46,786,926	$38,488,101

MHSA PEI Budget Analysis for Three-Year Plan

FY's 2020-21 through 2022-23

Purpose: To provide projected PEI balances for 3-year planning.

**Figures reflect current Three-Year Plan amounts from existing PEI funded programs*

PEI FY 2019-20	
Beginning Balance	$41,086,097
Projected Revenue	$33,265,248
Projected Expenditures (Exp.)	$(43,139,016)
Ending Balance	$31,212,329

PEI FY 2020-21		at 90% Spending
Projected Beginning Balance	$31,212,329	
Projected Revenue	$34,500,000	
Prelim On-Going Budget Exp.	$(35,048,058)	$(31,543,252)
Prelim Carryover Budget Exp.	$(11,863,425)	$(10,677,083)
Projected Ending Balance	$18,800,846	$23,491,994

MHSA PEI Budget Analysis for Three-Year Plan

FY's 2020-21 through 2022-23

Purpose: To provide projected PEI balances for 3-year planning.

**Figures reflect current Three-Year Plan amounts from existing PEI funded programs*

PEI FY 2021-22		at 90% Spending
Projected Beginning Balance	$23,491,994	
Projected Revenue	$34,800,000	
Preliminary On-Going Budget	$(35,219,458)	$(31,697,512)
Preliminary Carryover Funds Budget	$(11,567,468)	$(10,410,721)
Projected Ending Balance	$11,505,068	$16,183,761

PEI FY 2022-23		at 90% Spending
Projected Beginning Balance	$16,183,761	
Projected Revenue	$34,800,000	
Preliminary On-Going Budget	$(36,896,000)	$(33,206,400)
Preliminary Carryover Funds Budget	$(1,592,101)	$(1,432,891)
Projected Ending Balance	$12,495,660	$16,344,470

MHSA THREE-YEAR PLAN FOR FYS 2020-21 TO 2022-23

SYNOPSIS OF IDENTIFIED NEEDS & DISPARITIES

SHARON ISHIKAWA
MHSA COORDINATOR

Community Planning - Recap

Community Feedback Surveys

GOAL

- Obtain community feedback on MHSA priority populations most in need of services, by service type

PURPOSE

- Align community input with findings identified through data reports to identify strategic priorities for MHSA Three-Year Plan

METHOD

- Paper surveys at community events, BHS programs
- Electronic surveys distributed to MHSA, Be Well, BHS Contract Provider lists
- n=1,136 returned

Community Planning - Overview

- Community Feedback Surveys
- Community Engagement Meetings
- Preliminary Results Summary 12-16-2019
- HCA Synopsis of Health Trends/Disparities
- HCA Proposed Priorities for PEI Carryover Funds

Community Planning - Recap

Community Engagement Meetings

GOAL

- Facilitate community discussions around barriers and strategies for specific populations
  - SPA Meetings: Populations identified from preliminary survey results (n=153 participants)
  - K-12 School Districts (n=110)
  - Criminal Justice Agencies (n=13)

PURPOSE

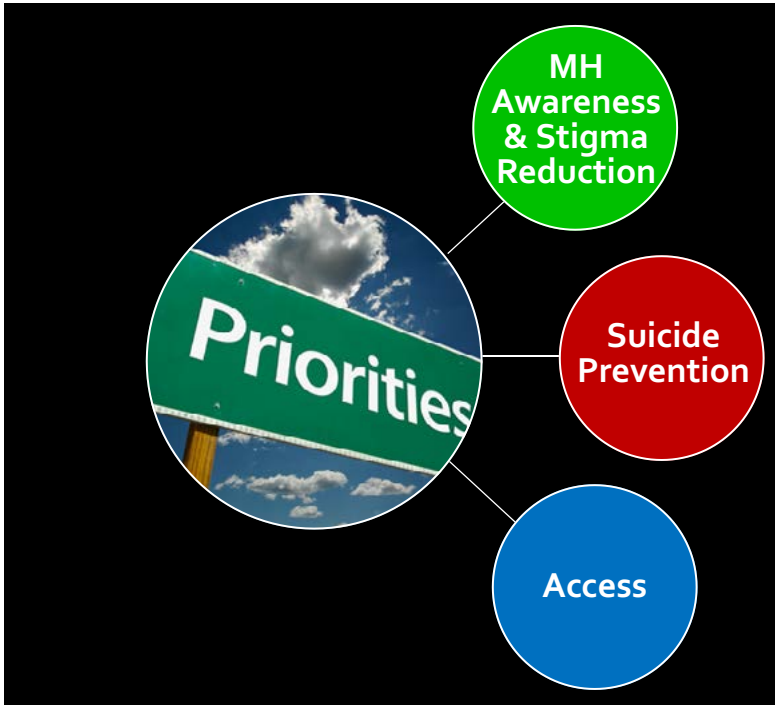
- Begin to identify strategies that are responsive to the needs of specific populations

METHOD

- Small group discussions/activities, report out

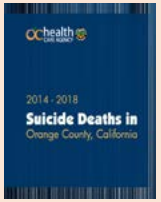
Community Planning - Overview

- Community Feedback Surveys
- Community Engagement Meetings
- Preliminary Results Summary 12-16-2019
- HCA Synopsis of Health Trends/Disparities
- HCA Proposed Priorities for PEI Carryover Funds



Community Planning - Update

Synopsis of Health Trends/Disparities

HCA Reviewed for:

- ***Commonalities across reports***
- ***Alignment w/ Local & State initiatives***
- ***Correspondence w/ 2018 & 2019 Community Feedback***

(see handout for details)

Recommended PEI Priority 1:

MH Awareness & Stigma Reduction

Rationale:

Local/State Initiatives

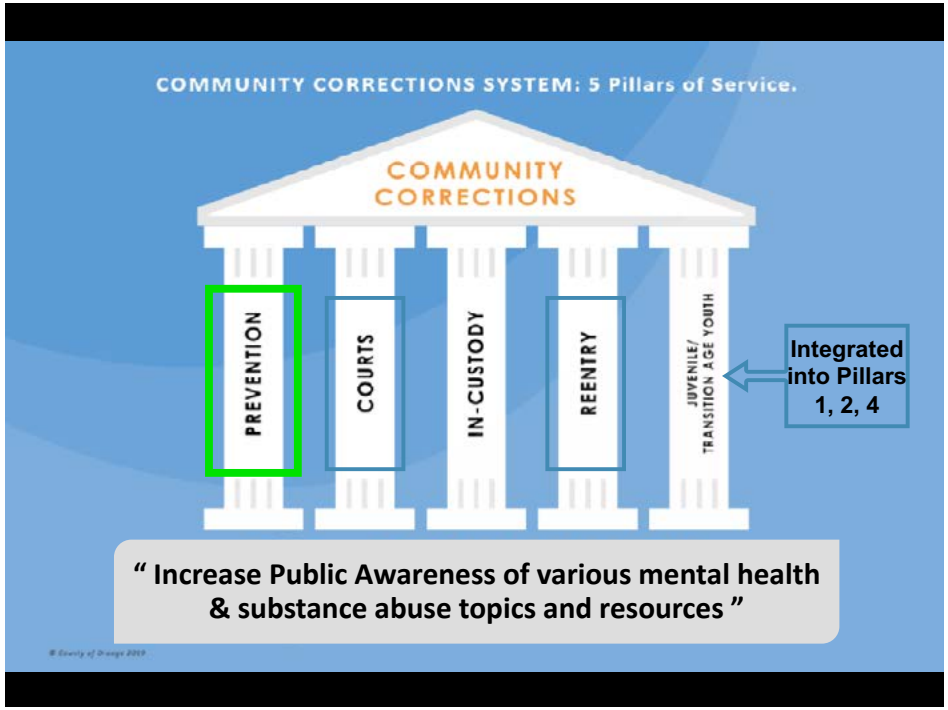
MHSOAC PEI Regulations | OC Integrated Services Vision 2025

OC Data Trends

Stigma frequently identified as barrier

Local Needs

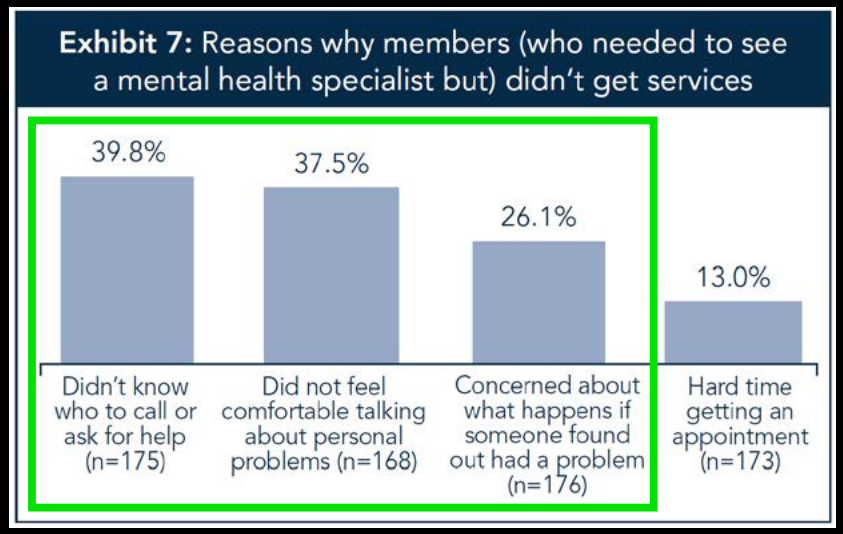
Stigma Reduction | Increased Awareness (Signs & Resources)
(2018 & 2019 CEMs and 2019 Surveys)



Preliminary Survey Results (continued) Population Prioritization (Top 5)

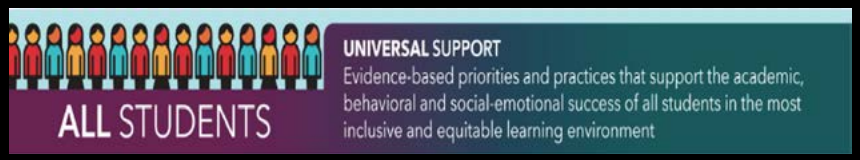
MH Awareness Campaigns & Education			
Stigma & Discrimination Reduction	**Mental Health & Well-Being Promotion**	**Violence & Bullying Prevention**	**Suicide Prevention**
LGBTQ	**Youth** (16-25 years)	**Youth** (16-25 years)	Youth (16-25 years)
Youth (16-25 years)	**Adults** (26-59 years)	**Children** (0-15 years)	Children (0-15 years)
Homeless	**Children** (0-15 years)	**Students at Risk of School Failure**	Adults (26-59 years)
Mental Health w/ Substance Use	**Parent/Families**	**Foster Youth**	LGBTQ
Adults (26-59 years)	**Older Adults**	**LGBTQ**	Veterans

2018 CalOptima Member Health Needs Assessment



Preliminary Survey Results (continued) Population Prioritization (Top 5)

BH System Navigation	**Outreach & Engagement**	Early Intervention	Outpatient Treatment
Youth (16-25 years)	**Youth** (16-25 years)	Children (0-15 years)	Youth (16-25 years)
Children (0-15 years)	**Homeless**	Youth (16-25 years)	Adults (26-59 years)
Mental Health w/ Substance Use	**Adults** (26-59 years)	Students at Risk of School Failure	Mental Health w/ Substance Use
Homeless	**Mental Health w/ Substance Use**	Foster Youth	Homeless
Adults (26-59 years)	**Children** (0-15 years)	Parent/Families	Mental Health w/ Medical Conditions



Campus / School Campaigns

- ✓ **Mental Health Awareness / Stigma & Discrimination Reduction**
- Suicide Prevention *(Community Survey identified this as a need for TAY, LGBTQ)*
- ✓ **Bullying Prevention**

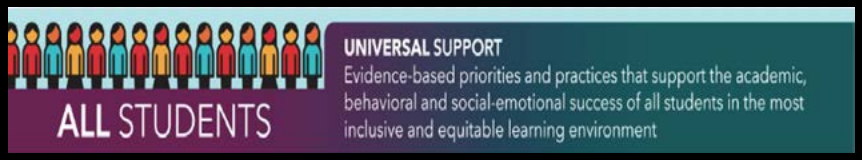
✓ Crisis Response & Support

following a critical incident affecting the school

Classroom / Student Curriculum

- ✓ **Mental health and well-being curricula**
- ✓ **Digital Citizenship**

(see handout for details)



Teacher & Staff Trainings

Some stated preference for within-District, local trainings rather than centralized location

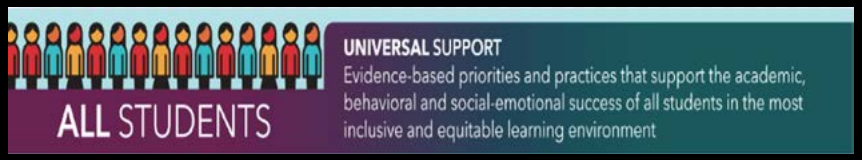
Building Knowledge & Awareness

- ✓ Stigma & Discrimination Reduction ***(also identified as a need for parents)***
- ✓ Educational / Networking Forums for schools and school districts
- ✓ Digital Citizenship

Building Skills

- ✓ How to effectively communicate with and engage students who are struggling
- ✓ How to appropriately identify and respond to:
  - ✓ early warning signs of mental illness ***(also identified as a need for parents)***
  - ✓ grief
  - ✓ trauma exposure
  - suicide risk

(see handout for details)



Teacher & Staff Trainings

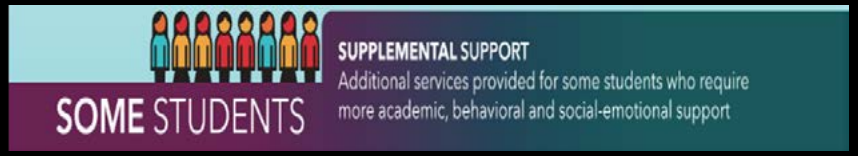
note if your District also has interest in related parent / caregiver modules

Building Skills *con't*

- ✓ How to help others access needed behavioral health resources ***(also id'd for parents)***
- ✓ Threat Assessment
- ✓ Violence / Gang Prevention
  - Neurocognitive effects of exposure to violence on children
- ✓ Stress Management / Mindfulness techniques to use in classrooms ***(id'd for parents)***
- ✓ Restorative Practices

- ✓ Other identified training: Support for undocumented youth/DACA recipients, secondary grades; for teachers who need additional support

(see handout for details)



MH & Well-Being Support

- ✓ **Small student groups for at-risk students *(see handout for specific topics)***

Violence Exposure & Gang Prevention

- ✓ **Small student groups for at-risk students**

Access & Linkage to Treatment

- ✓ **Screening, referral & linkage to needed services**

Supportive Services

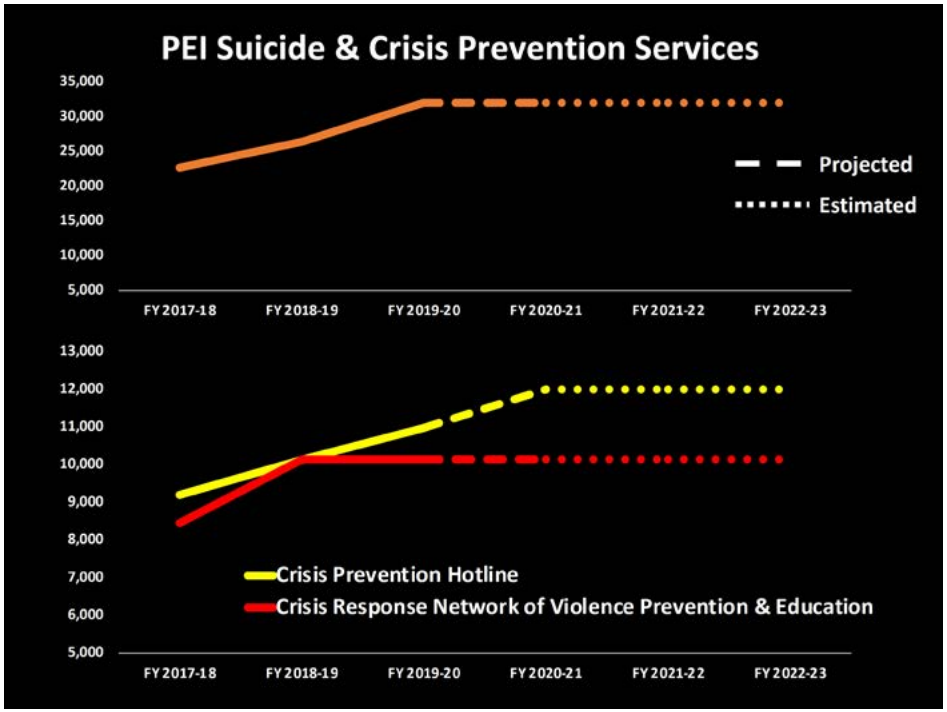
- ✓ Parenting Classes / Workshops
- Family-to-Family peer support
- Self-Care techniques / tips for the caregiver

(see handout for details)

Strategy

MH Awareness & Stigma Reduction

- Will incorporate findings and recommendations from recent RAND reports:
  - *Social Marketing of Mental Health Treatment: CA's Mental Illness Stigma Reduction Campaign — 2019*
  - *Differential Association of Stigma with Perceived Need and Mental Health Service Use - 2018*
- And continue to partner with local groups who successfully engage these and other priority populations



Recommended PEI Priority 2:

Suicide Prevention

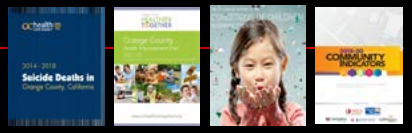
Rationale:

Local/State Initiatives

OC Suicide Prevention | MHSOAC Striving for Zero | School IDs
Crisis Response Network (AZ Model)

OC Data Trends

Below CA and US rates, but increasing



Local Needs

Increasing call utilization of Warmline and Crisis Prevention Hotline

Strategy

Suicide Prevention

- Will review strategies and recommendations from MHSOAC Striving For Zero report
- And continue to partner with local groups and agencies who are championing this effort

Recommended PEI Priority 3:

Access: (Transportation)

Rationale:

Local/State Initiatives

MHSOAC PEI Regulations (Timeliness of Access, Linkage)

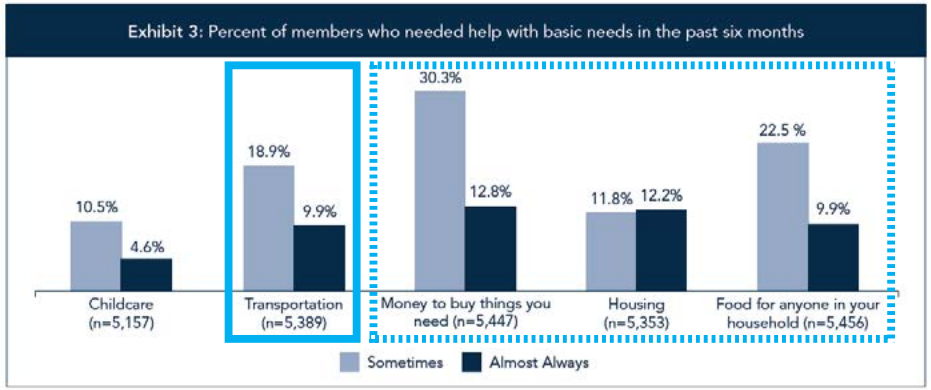
OC Data Trends

1/4 to 2/3 not accessing needed services

Local Needs

Frequently identified barrier (by Consumers, Family Members, Providers) (2018 & 2019 CEMs)

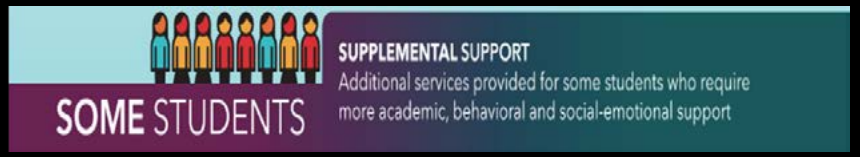
2018 CalOptima Member Health Needs Assessment



Still requires planning and development of strategies / guidelines

Preliminary Survey Results (continued)
Population Prioritization (Top 5)

BH System Navigation	Outreach & Engagement	Early Intervention	Outpatient Treatment
Youth (16-25 years)	Youth (16-25 years)	Children (0-15 years)	Youth (16-25 years)
Children (0-15 years)	Homeless	Youth (16-25 years)	Adults (26-59 years)
Mental Health w/ Substance Use	Adults (26-59 years)	Students at Risk of School Failure	Mental Health w/ Substance Use
Homeless	Mental Health w/ Substance Use	Foster Youth	Homeless
Adults (26-59 years)	Children (0-15 years)	Parent/Families	Mental Health w/ Medical Conditions



MH & Well-Being Support

✓ Small student groups for at-risk students *(see handout for specific topics)*

Violence Exposure & Gang Prevention

✓ Small student groups for at-risk students

Access & Linkage to Treatment

✓ **Screening, referral & linkage to needed services**

Supportive Services

✓ Parenting Classes / Workshops
- Family-to-Family peer support
- Self-Care techniques / tips for the caregiver

(see handout for details)

Steering Committee Handout on WET Proposed Three-Year Budget

WET Program and Budget Review on January 13, 2020

WET Updated January 27, 2020	FY 2018-19			FY 2019-20		
	Approved Budget	Actual Expenditures	% Change	Approved Budget	Anticipated Expenditures	% Change
Workforce Staffing Support	1,140,000	1,433,187	126%	1,140,000	1,660,761	146%
Training and Technical Assistance	1,373,000	1,038,592	76%	1,573,000	1,062,724	68%
Mental Health Career Pathways	927,000	862,093	93%	927,000	927,000	100%
Residencies and Internships	238,381	156,355	66%	238,381	174,667	73%
Financial Incentives Programs	870,322	345,968	40%	654,225	526,968	81%
2020-2025 WET Five-Year Plan with CalMHSA	-	-	0%	-	-	0%
Subtotal Of WET Programs	4,548,703	3,836,194	84%	4,532,606	4,352,120	96%
Administrative Costs	536,579	454,349	85%	552,676	448,400	81%
Total MHSA Requested Budget	$ 5,085,282	$ 4,290,542	84%	$ 5,085,282	$ 4,800,520	94%

1) All WET programs are now funded by CSS funds

WET Updated January 27, 2020	FY 2020-21			FY 2021-22		
	PRIOR Year (FY 2019-20) Approved Budget	Proposed Changes	Requested FY 2020-21 Budget	PRIOR Year (FY 2020-21) Approved Budget	Proposed Changes	Requested FY 2021-22 Budget
Workforce Staffing Support	1,140,000	570,584	1,710,584	1,710,584	51,317	1,761,901
Training and Technical Assistance	1,573,000	(349,610)	1,223,390	1,223,390	9,044	1,232,434
Mental Health Career Pathways	927,000	119,663	1,046,663	1,046,663	-	1,046,663
Residencies and Internships	238,381	(68,381)	170,000	170,000	-	170,000
Financial Incentives Programs	654,225	(127,257)	526,968	526,968	-	526,968
2020-2025 WET Five-Year Plan with CalMHSA	-	1,071,050	1,071,050	1,071,050	(1,071,050)	-
Subtotal Of WET Programs	4,532,606	1,216,049	5,748,655	5,748,655	(1,010,689)	4,737,966
Administrative Costs	552,676	(84,697)	467,979	467,979	14,039	482,018
Total MHSA Requested Budget	$ 5,085,282	$ 1,131,352	$ 6,216,634	$ 6,216,634	$ (996,650)	$ 5,219,984

1) All WET programs are now funded by CSS funds

WET Updated January 27, 2020	FY 2022-23 PRIOR Year (FY 2021-22) Approved Budget	Proposed Changes	Requested FY 2022-23 Budget	Notes
Workforce Staffing Support	1,761,901	52,857	1,814,758	Right Sized budget based off of historic data
Training and Technical Assistance	1,232,434	9,360	1,241,794	Increased budget due to increase in training as well as additonal costs for BH Training Facility.
Mental Health Career Pathways	1,046,663	-	1,046,663	Expansion of REI contract. Adding new curriculum courses for Peer Specialists
Residencies and Internships	170,000	-	170,000	Right Sized budget based off of historic data
Financial Incentives Programs	526,968	-	526,968	Right Sized budget based off of historic data
2020-2025 WET Five-Year Plan with CalMHSA	-	-	-	
Subtotal Of WET Programs	4,737,966	62,217	4,800,183	
Administrative Costs	482,018	14,461	496,479	Methodology for budgeting Admin Costs changed from using a flat 18% rate to using actuals from Previous year and adding a 3% inflation rate.
Total MHSA Requested Budget	$ 5,219,984	$ 76,678	$ 5,296,662	

1) All WET programs are now funded by CSS funds

Goals of Today's Meeting

- Recap of OC Community Planning & MH Trends
- Review of OC MHSA Strategic Priorities
- Review of Proposed CSS Programs & Budgets
- Review of Proposed CFTN Projects & Budgets
- Review of Amended PEI Budget & WET Follow Up

MHSA THREE-YEAR PLAN FOR FYS 2020-21 TO 2022-23

SYNOPSIS OF IDENTIFIED NEEDS & DISPARITIES

SHARON ISHIKAWA
MHSA COORDINATOR

CSS Planning –
CA Code of Regulations (CCR) 3650

1. Assessment of mental health (MH) needs
2. Community identification of MH issues
3. Proposed programs & services (specific requirements for FSPs)
4. County capacity to implement, including diverse racial/ethnic populations
5. County MHSA Plan

Community Planning - Overview

CA CCR Step	
1, 2	Community Feedback Surveys
1, 2	Community Engagement Meetings
1, 2	Preliminary Results Summary 12-16-2019
1, 2	HCA Synopsis of Health Trends/Disparities
3, 4	HCA Proposed Priorities for Carryover Funds

Community Planning - Recap

Community Feedback Surveys

GOAL

- Obtain community feedback on MHSA priority populations most in need of services, by service type

PURPOSE

- Align community input with findings identified through data reports to identify strategic priorities for MHSA Three-Year Plan

METHOD

- Paper surveys at community events, BHS programs
- Electronic surveys distributed to MHSA, Be Well, BHS Contract Provider lists
- n=1,136 returned

Community Planning - Overview

CA CCR Step

- 1, 2 Community Feedback Surveys
- 1, 2 Community Engagement Meetings
- 1, 2 Preliminary Results Summary 12-16-2019
- 1, 2 HCA Synopsis of Health Trends/Disparities
- 3, 4 HCA Proposed Priorities for Carryover Funds

Community Planning - Recap

Community Engagement Meetings

GOAL

- Facilitate community discussions around barriers and strategies for specific populations
  - SPA Meetings: Populations identified from preliminary survey results (n=153 participants)
  - K-12 School Districts (n=110)
  - Criminal Justice Agencies (n=13)

PURPOSE

- Begin to identify strategies that are responsive to the needs of specific populations
- *Discussions will be on-going throughout 3YP Period*

METHOD

- Small group discussions/activities, report out

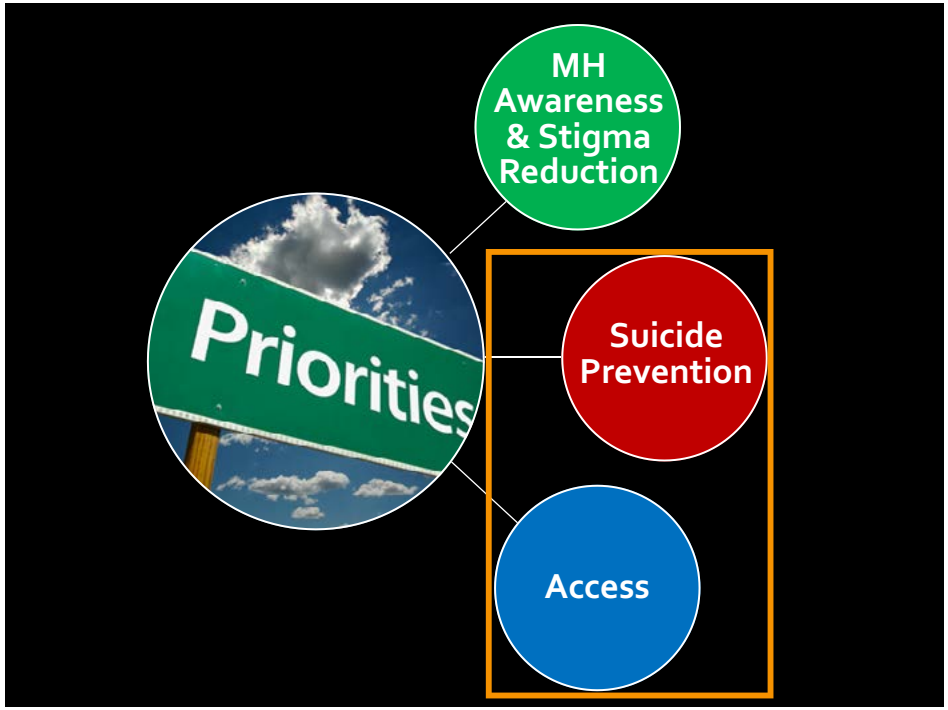
Community Planning - Recap

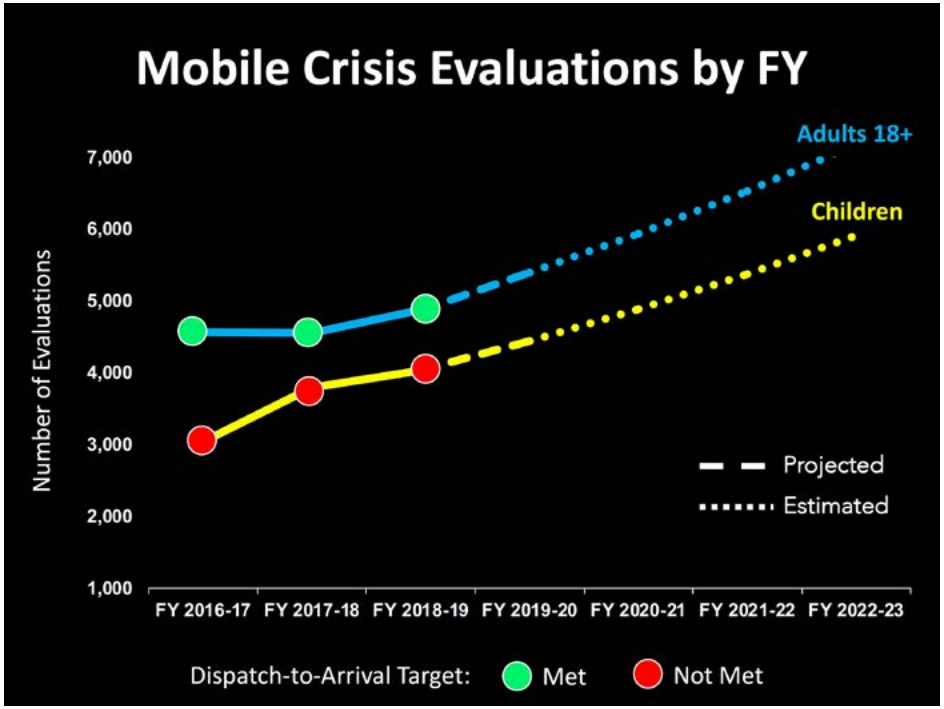
Synopsis of Health Trends/Disparities

HCA Reviewed for:

- *Commonalities across reports*
- *Alignment w/ Local & State initiatives*
- *Correspondence w/ 2018 & 2019 Community Feedback*

(see handout for details)





Recommended CSS Priority:

Suicide Prevention

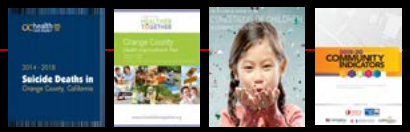
Rationale:

Local/State Initiatives

OC Suicide Prevention | MHSOAC Striving for Zero | School IDs
Crisis Response Network (AZ Model) | OC Strategic Financial Plan (CSUs)

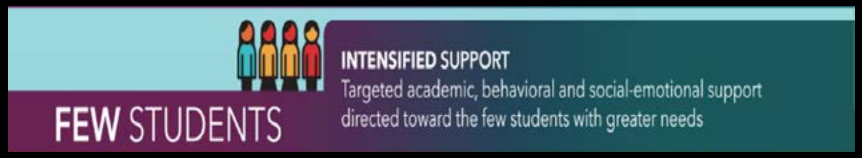
OC Data Trends

Below CA and US rates, but increasing



Local Needs

Increasing call utilization of Children's CAT | Increased request for PERT
OC Integrated Services Vision 2025



Suicide Prevention

- Crisis / Suicide Prevention Hotline

✓ **Students experiencing a behavioral health emergency**

Feedback:

Crisis Assessment Team: expanded services/availability, more timely response, regardless of insurance type

(see handout for details)

Priority Populations for Suicide Prevention
(based on Preliminary Survey Results)

Stigma & Discrimination Reduction	Mental Health & Well-Being Promotion	Violence & Bullying Prevention	Suicide Prevention
LGBTQ	Youth (16-25 years)	Youth (16-25 years)	**Youth (16-25 years)**
Youth (16-25 years)	Adults (26-59 years)	Children (0-15 years)	**Children (0-15 years)**
Homeless	Children (0-15 years)	Students at Risk of School Failure	**Adults (26-59 years)**
Mental Health w/ Substance Use	Parent/Families	Foster Youth	**LGBTQ**
Adults (26-59 years)	Older Adults	LGBTQ	**Veterans**

Recommended CSS Priority 3: Access

Rationale:

Local/State Initiatives

MHSOAC PEI Regulations (Timeliness of Access, Linkage)

OC Data Trends

1/4 to 2/3 not accessing needed services

Local Needs

Frequently identified barrier (by Consumers, Family Members, Providers) (2018 & 2019 CEMs)

Strategy

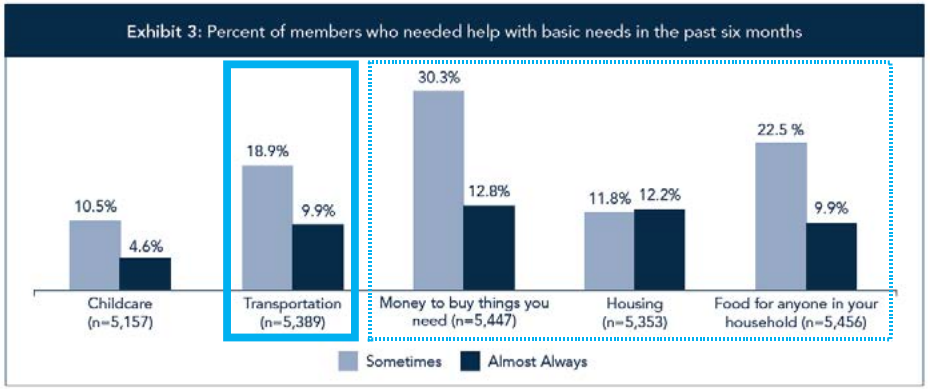
Suicide Prevention

- EXPAND Crisis Services Continuum, with particular focus on:
  - Children/Young TAY under 18:
    - Mobile Crisis Assessment, In-Home Crisis Stabilization, Crisis Residential Services, Crisis Stabilization Unit (13+)
  - TAY/Adults/Older Adults 18+:
    - Crisis Residential Services
- ENSURE responsiveness to LGBTQ+, Veterans, others
- REVIEW strategies and recommendations from MHSOAC Striving For Zero report
- Continue to PARTNER with OC Suicide Prevention Initiative, and local groups and agencies championing this effort

Priority Populations for Access
(based on UCSD Needs and Gaps Analysis)

- 6-11 yr olds
- 12-17 yr olds
- Asian Pacific Islander (API) Adults
- Highest Rates of No Treatment
- Latino/a/x Adults
- Least likely to receive MAT:
- API, Latino/a/x, African-Amer. Adults

2018 CalOptima Member Health Needs Assessment



Still requires planning and development of strategies / guidelines

MHSA THREE-YEAR PLAN FOR FYS 2020-21 TO 2022-23

PROPOSED CSS & CFTN PROGRAM BUDGETS

ANTHONY LE

BHS FISCAL MANAGER

Strategy

Access

- **Strategies to improve access to services for those living with SED/SMI:**
  - **EXPAND transportation to families with young children** (all ages)
  - **EXPAND school-based mental health services** (children/young TAY)
  - **OFFER / EXPLORE tele-/virtual behavioral health care options** (all ages, initial focus 18+)
  - ***Partnering with the community to identify and integrate strategies and approaches that improve the cultural and linguistic responsiveness of the system of care*** *(CSS & PEI)*

Budget Update Process for MHSA Three-Year Plan (3YP)

1. **CONFIRM expenditures for FY 2018-19**
2. **PROJECT FY 2019-20 expenditures**
3. **COMPARE projections to budgets**
4. **TRUE-UP budget**
5. **ADJUST true-up to account for known or anticipated future changes, identified needs**

MHSA THREE-YEAR PLAN FOR FYS 2020-21 TO 2022-23

CSS ACCESS & LINKAGE TO TREATMENT SECTION

CSS SECTION 1: Access & Linkage to Treatment

SECTION SUBTOTAL	Approved FY 19/20	Requested FY 20/21	Requested FY 21/22	Requested FY 22/23
1. Access & Linkage to Treatment	$6,069,933	$7,969,933	$8,469,933	$8,569,933

Increase due to shifting Open Access budget here (removing from Recovery Center/Clinic budget)

Modest increases over these two years due to continuing ramp up of CHS Jail to Community Re-Entry hiring

ACCESS & LINKAGE TO TREATMENT

Who Are They For?
Individuals of all ages living with SMI or SPMI.

What Do These Programs Do?
Link individuals to the appropriate level of care. Tailored to meet the needs of specialized, unserved populations (i.e., homeless, community re-entry)

CSS-Funded Programs

- BHS Outreach & Engagement
- Courtyard (After-Hours)
- Open Access
- CHS Jail to Community Outreach

PEI-Funded Programs

- OC Links

MHSA THREE-YEAR PLAN FOR FYS 2020-21 TO 2022-23

CSS SUICIDE & CRISIS PREVENTION SECTION

SUICIDE & CRISIS PREVENTION PROGRAMS

Who Are They For?
Individuals of all ages experiencing a behavioral health emergency

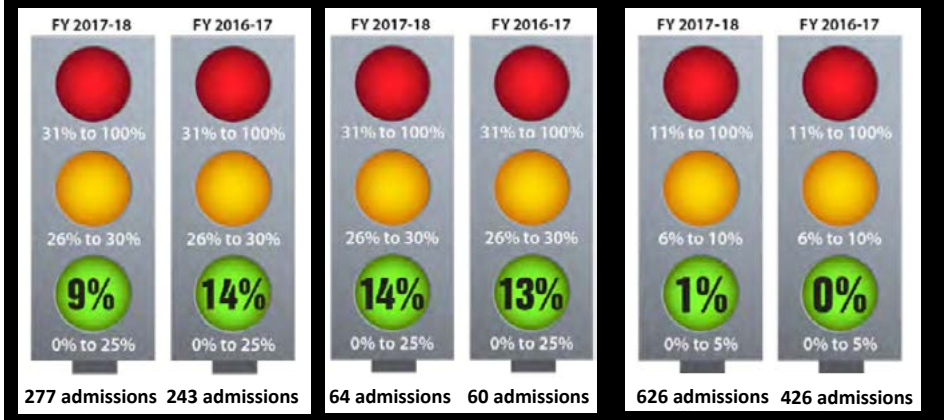
What Do These Programs Do?
Support individuals by providing access to services or facilitating admission to a psychiatric hospital

CSS-Funded Programs
- Mobile Crisis Assessment
- Crisis Stabilization Units
- In-Home Crisis Stabilization
- Crisis Residential Services

PEI-Funded Programs
- Warmline
- Suicide Prevention

Crisis Residential Services

Hospitalization Rate



≤ 25 % Up to 60 Days Following Discharge

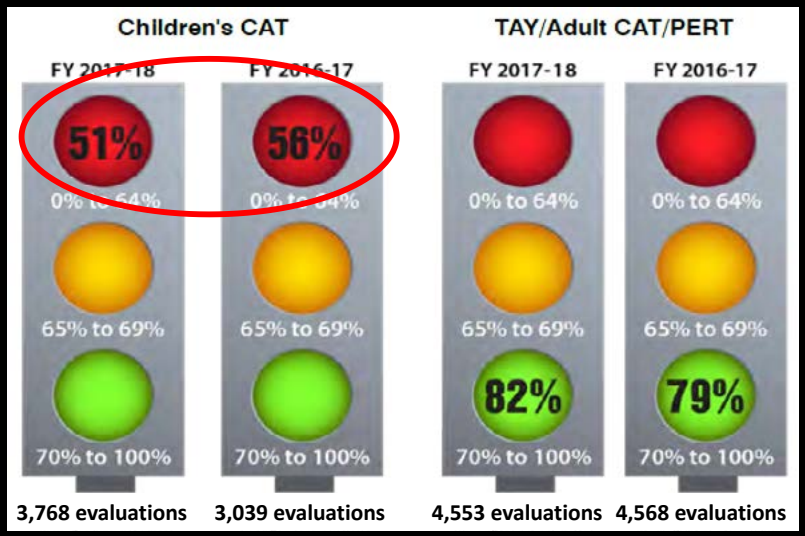
≤ 5% Up to 48 Hours Following Discharge

In-Home Crisis Stabilization

Children's

Hospitalization Rate: Up to 60 Days Following Discharge

Mobile Crisis Assessment



Dispatch-to-Arrival ≤ 30 minutes

CSS SECTION 2: Suicide & Crisis Prevention

SUBSECTIONS	Approved FY 19/20	Requested FY 20/21	Requested FY 21/22	Requested FY 22/23
2a. Mobile Crisis Assessment	$8,835,858	$9,135,858	$9,135,858	$9,135,858
2b. Crisis Stabilization Units	$4,150,000	$6,700,000	$10,000,000	$10,000,000
2c. In-Home Crisis Stabilization	$2,585,480	$2,935,480	$2,935,480	$2,935,480
2d. Crisis Residential Services	$7,730,845	$9,030,845	$11,280,845	$11,280,845
Suicide & Crisis Prevention SUBTOTAL	$23,302,183	$27,802,183	$33,352,183	$33,352,183

OUTPATIENT TREATMENT

Who Are They For?
Individuals of all ages who are experiencing mental health symptoms or living with SED/SMI.

What Do These Programs Do?
Provide outpatient clinical interventions and other services designed to promote recovery and resilience.

CSS-Funded Programs

- FSP, PACT
- Clinic Expansion
- Residential Treatment

PEI-Funded Programs

- Early Intervention
  - General - all ages
  - Family-Focused
  - Veteran-Focused
  - Early-Onset Psychosis

OC health CARE AGENCY

MHSA THREE-YEAR PLAN FOR FYS 2020-21 TO 2022-23

CSS OUTPATIENT TREATMENT SECTION

REDUCTION IN NEGATIVE OUTCOMES FOR FSP PARTNERS

	Psychiatric Hospitalization Days		Homeless Days		Incarceration Days	
	FY16/17	FY17/18	FY16/17	FY17/18	FY16/17	FY17/18
CHILDREN	83%	51%	83%	92%	19%	60%
TAY Transitional Aged Youth	63%	70%	74%	78%	79%	80%
ADULTS	62%	58%	75%	86%	80%	83%
OLDER ADULTS	58%	87%	82%	87%	88%	75%

REDUCTION IN NEGATIVE OUTCOMES FOR PACT PARTNERS

	Psychiatric Hospitalization Days		Homeless Days		Incarceration Days	
	FY16/17	FY17/18	FY16/17	FY17/18	FY16/17	FY17/18
CHILDREN	-	-	-	-	-	-
TAY Transitional Aged Youth	74%	64%	74%	**73%**	58%	**79%**
ADULTS	81%	79%	54%	57%	70%	67%
OLDER ADULTS	44%	89%	57%	**73%**	69%	84%

OC health CARE AGENCY

MHSA THREE-YEAR PLAN FOR FYS 2020-21 TO 2022-23

SUPPORTIVE SERVICES SECTION

CSS SECTION 3: Outpatient Treatment

SUBSECTIONS	Approved FY 19/20	Requested FY 20/21	Requested FY 21/22	Requested FY 22/23
3a. FSP	$53,530,226	$53,766,876	$53,766,876	$53,766,876
3b. PACT	$10,799,650	$10,599,650	$10,599,650	$10,599,650
3c. Clinic-Expansion	$12,874,666	$15,523,666	$16,523,666	$16,523,666
3d. Residential Treatment	$5,370,000	$6,500,000	$8,000,000	$8,000,000
Outpatient Tx SUBTOTAL	$82,574,542	$86,390,192	$88,890,192	$88,890,192

SUPPORTIVE SERVICES

Who Are They For?
Individuals of all ages who are experiencing mental health symptoms or living with SED/SMI.

What Do These Programs Do?
Provide a broad array of supports generally designed to augment / expand upon an individual's gains made in other treatment programs.

CSS-Funded Programs

- Mentoring, Peer Mentoring
- Supported Employment
- Wellness Centers
- Transportation
- Supportive Housing, Shelter

PEI-Funded Programs

- Family Support
  - Parent Education
  - Family Support Services
  - Children's Support & Parenting

CSS SECTIONS 4-5: Supportive Services, Supportive Housing/Homelessness

SECTION SUBTOTALS	Approved FY 19/20	Requested FY 20/21	Requested FY 21/22	Requested FY 22/23
4. Supportive Services	$10,275,501	$10,625,501	$10,775,501	$10,775,501
5. Supportive Housing/ Homeless-ness	$34,139,757	$3,660,858	$3,669,668	$3,678,743

MHSA CSS Budget Analysis for Three-Year Plan

FY's 2020-21 through 2022-23

Purpose: To provide projected CSS balances for 3-year planning.

Figures reflect current Three-Year Plan amounts from existing CSS funded programs

CSS FY 2019-20	
Beginning Balance	$56,390,458
Projected Revenue	$133,061,697
Projected Expenditures	-$152,924,317
Projected WET Transfer	-$4,196,082
Projected CFTN Transfer	-$24,439,152
Shift from Prudent Reserve	$26,319,779
Ending Balance	$34,212,383

CSS FY 2020-21		Est. 82% Spending
Projected Beginning Balance	$34,212,383	$34,212,383
Projected Revenue	$138,000,000	$138,000,000
Carryover CFTN Remaining Balance	$4,176,508	$4,176,508
Preliminary Budget	-$155,088,175	-$127,172,304
Preliminary WET Transfer	-$5,145,584	-$5,145,584
Preliminary CFTN Transfer	-$12,519,749	-$12,519,749
Projected Ending Balance	-$34,753,508	$31,551,255

CSS Section Subtotals & Grand Total

SECTIONS	Approved FY 19/20	Requested FY 20/21	Requested FY 21/22	Requested FY 22/23
1. Access & Linkage to Treatment	$6,069,933	$7,969,933	$8,469,933	$8,569,933
2. Suicide & Crisis Prevention	$23,302,183	$27,802,183	$33,352,183	$33,352,183
3. Outpatient Treatment	$82,574,542	$86,390,192	$88,890,192	$88,890,192
4. Supportive Services	$10,275,501	$10,625,501	$10,775,501	$10,775,501
5. Supp. Housing/ Homelessness	$34,139,757	$3,660,858	$3,669,668	$3,678,743
CSS Subtotal	$156,361,916	$136,448,667	$145,157,477	$145,266,552
Admin. Costs	$17,833,503	$18,639,508	$19,469,693	$20,053,784
CSS GRAND TOTAL	$174,195,419	$155,088,175	$164,627,171	$165,320,336

MHSA CSS Budget Analysis for Three-Year Plan (continued)

CSS FY 2021-22		Est. 82% spending
Projected Beginning Balance	$31,551,255	$31,551,255
Projected Revenue	$139,200,000	$139,200,000
Preliminary Budget	-$164,627,171	-$134,994,280
Preliminary WET Transfer	-$5,219,584	-$5,219,584
Preliminary CFTN Transfer	-$8,840,752	-$8,840,752
Projected Ending Balance	-$39,487,507	$21,696,638

CSS FY 2022-23		Est. 82% spending
Projected Beginning Balance	$21,696,638	$21,696,638
Projected Revenue	$139,200,000	$139,200,000
Preliminary Budget	-$165,320,336	-$135,562,676
Preliminary WET Transfer	-$5,296,662	-$5,296,662
Preliminary CFTN Transfer	-$8,966,158	-$8,966,158
Projected Ending Balance	-$40,383,156	$11,071,143

Projected Unspent CSS funds at the end of three-year plan ending FY 22/23	$11,071,143
Future projects the unspent funds will be allocated to:	-$11,071,143
- Expansion of Crisis Services (Suicide Prevention)	
- Transportation Assistance Program (Access)	
- Increase cultural & linguistic responsiveness (Access)	
- Additional Wellness Campus	
Projected Ending Balance	$0

Steering Committee Handout on
Health Trends and Disparities in Orange County

(handed out at January 13 and 29 meetings)

HCA Synopsis of Health Trend and Disparity Data

REPORTS	CATEGORY	SUBCATEGORY	CHILDREN			TAY		ADULTS	OLDER ADULTS
			0-5 years	6-11 years	12-15 years	16-17 years	18-25 years	26-59 years	60+ years
OC Needs & Gaps Analysis Data Source: CHIS 2011-2016  Serious psychological distress = SPD no significant difference = NSD Minimally Adequate Treatment = MAT, 4+ visits with a MH profess. in past 12 months and taking Rx med. for MH) **Rates in bold font** = Statistically significant	**Social Determinants of Health**	**Marital Status**					**Unmarried (9.7%) > Married (3.8%): SPD Rates (p9)**; NSD for Access to MAT (p18)		
		Homelessness (2017 PIT Count)					Estimated 12% of homeless adults have SMI (~474); Of the chronically homeless, 44% (n=393) may have a mental health condition (may not be SMI) and 63% (n=529) never received tx (p26)		
		Education Level / Employment Status					**Unemployed (9.2%)** and **HS (9.4%)/Some College (8.1%) >** employed (9.2%) or other education levels (4.9% BA higher, less than HS 6.3%) (SPD rates; p9); NSD for Access to MAT (p18)		
	Navigation / Awareness	**Age Groups**		4-11 higher rates than CA (pg 23)	Adol. 12-17 slightly higher rates of SPD than CA, with 12-14 > 15-17 (pg 22)		**Rates of SPD among 18+ are above OC average for these ages (25-34 & 45-54; p7)** **SPD Rate: 10.6% (p7)**	**SPD Rate: 8.3% for 25-34 yr olds; 7.1% for 45-54 yr olds (p7)**	SPD Rate: 5.2% for 55-64 yr olds; 2.7% for 65+ (p7)
		Gender		**Boys 4-11 > girls** (p22-23)	Adol. Age 12-17 females higher rates than males (p22)		Female (7.9%) > Male (5.5%) SPD rates (pg. 9)		
			19% of OC residents not fluent in English (p33) Highest density of Spanish-speaking in Huntington Beach, Costa Mesa, Anaheim, Orange, Santa Ana & San Juan Cap. (p34) Majority of Vietnamese-speaking in Northwest OC (p36); Chinese- & Farsi speaking in Northeast OC (p40 & 46) Korean- & Khmer speaking in North OC (p38 & 48); Tagalog county-wide (p42); Arabic in northern & southern OC (p44)						
		Race/Ethnicity (Language)		Latino 4-11 > non-Latino in abnormal MH development (p22-23)	12-17 yr old Latinos > non-Latino (p22-23)		Adult Latinos & African Americans have SPD rates above the OC average (p6) Within API, Korean and Filipino had highest rates of SPD (p8)		
		Sexual Orientation					**LGBTQ+ SPD rate (39.7%) > hetero-sexual/ straight (8.7%) & OC aver. (6.7%; p10)**	**LGBTQ+ SPD rate (18.3%) > hetero-sexual/straight (6.6%), overall OC (6.7%; p8)**	

Legend for Proposed Recommended Priorities: Green Font: MH Awareness & Stigma Reduction; Red Font: Suicide Prevention; Blue Font: Access

Compiled January 11, 2020

REPORTS	CATEGORY	SUBCATEGORY	CHILDREN			TAY		ADULTS	OLDER ADULTS
			0-5 years	6-11 years	12-15 years	16-17 years	18-25 years	26-59 years	60+ years
OC Needs & Gaps Analysis con't Data Source: CHIS 2011-2016 	Access/ Availability/ Prevalence Rates	Geography	Geographic inequity between BHS Sites & SPD; High BHS & low SPD: La Palma, Newport Beach, Laguna Beach, Laguna Hills, Santa Ana, Westminster, Midway City; Low BHS to high SPD: Orange, San Juan Cap, Anaheim, Brea, Irvine, Rancho Santa Margarita, Foothill Ranch, Capistrano Beach (p52)						
		Age Groups		56.6% rec'd no psychological or emotional counseling in past year (p23)	63% received no psychological or emotional counseling in past year (pg 22)		No significant differences in MAT, although No Treatment rates were 45.9% for 18+ and 57.7% for those 18-24 (p18)		
		Gender					No significant differences in MAT (p18)		
		Race/Ethnicity (Language)					API, Latino & African Amer. groups least likely to receive MAT (p16) w/ highest rates of No Treatment in API, Latino groups; NSD for language, although LEP (64%) higher rates of No Treatment		
		Sexual Orientation					LGBTQ+ (48.2%) > heterosexual/straight (17%) for MAT (p17) but comparable in rates of No Treatment		
CalOptima Member Health Needs Assessment	Social Determinants of Health	Housing	Housing insecurity rates highest among Vietnamese- & Farsi- CalOptima members (pg 32)						
		Social / Linguistic Isolation	23.6% of members did not speak English well (p16). English, Farsi & Korean had highest rates of feeling lonely or isolated (p13)						
	Navigation / Awareness	Race/Ethnicity (Language)	Least likely to see MH specialist (all members, 24.8%), w/ somewhat higher rates among Korean- (35.6%), Arabic- (34.5%), Farsi- (34.4%), Spanish-speaking (33.3%); North Orange County (31.3%) 39.8% didn't know how to call or ask for help 37.5% didn't feel comfortable talking about problems (p42) 26.1% concerned about what happens if someone finds out had problem (p 42)						
	Access/ Availability		Transportation difficulties highest among Vietnamese-, Korean-, Farsi-, Arabic- & Chinese-speaking members (pg 32)						
			Rate least likely to see mental health specialist: all members weighted: 24.8% For children under age 18: 35.5%, particularly ages 0-5 (47.6%)						

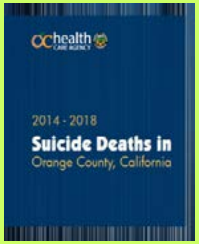
Legend for Proposed Recommended Priorities: Green Font: MH Awareness & Stigma Reduction; Red Font: Suicide Prevention; Blue Font: Access

Compiled January 11, 2020

REPORTS	CATEGORY	SUBCATEGORY	CHILDREN			TAY		ADULTS	OLDER ADULTS
			0-5 years	6-11 years	12-15 years	16-17 years	18-25 years	26-59 years	60+ years
OC HIP Data Source: OC Healthier Together Website, accessed January 2020  (serious psychological distress = SPD; Minimally Adequate Treatment = MAT and defined as 4+ visits with a MH professional in past 12 months and taking prescription medication for mental health) **Rates in bold font** = significant difference	**Social Determinants of Health**	**Poverty**	16.1% of OC residents w/no insurance; Latinos 28.2% (p33) Increasing trend of Children Living Below Poverty Line: Currently 16.4 OC rate lower than CA (20.8%) and US (20.3%) rates. Rates signficantly higher than overall OC Value: **Amer. Indian/Alaska Native (~ 22%), Latino/Hispanic (~ 25%), Other (~30%)**						
		Education Level / Employment Status	Decreasing rates of youth not in school or working (improving trend from 2008-12 through 2013-17): Currently 1.5%						
	Navigation / Awareness / Prevalence Rates	**Age Groups**	Not reported on website				Overall Rate of SPD for OC Adults Ages 18+ is 10.1%		
							SPD Rate: ~ 14%	SPD Rate: ~15.5% (25-34 yr olds); ~ 7.1% (45-64 yr olds)	**SPD Rate: ~ 2% for 65+** signif. < 18-64
		Gender					Female (~ 9.5%) > Male (~10.5%) SPD rates		
		Race/Ethnicity (Language)					Adult Latinos (~ 12.5%) & Two or More Races (~20%) have SPD rates above OC average		
	Access / Availability	**Age Groups**	Not reported on website				Overall Rate of Receiving Needed BH Care Services for OC Adults Ages 18+ is 59.0%		
							Receiving Needed Services: ~ 38%	Receiving Needed Service: ~ 52% (25-34 yrs); ~ 75% (45-64 yrs)	Receiving Needed Service: ~ 70% for 65+
		Gender					Males (~52%) < Females (~62%)		
		Race/Ethnicity (Language)					**More Than 2 Races (~ 12%)**, API (50%), Latino (52%) reported lower rates of recdeiving needed BH services than OC Average/Other Racial/Ethnic Groups		
		Sexual Orientation	Subcategory not reported						

Legend for Proposed Recommended Priorities: Green Font: MH Awareness & Stigma Reduction; Red Font: Suicide Prevention; Blue Font: Access

Compiled January 11, 2020

REPORTS	CATEGORY	SUBCATEGORY	CHILDREN			TAY		ADULTS	OLDER ADULTS
			0-5 years	6-11 years	12-15 years	16-17 years	18-25 years	26-59 years	60+ years
2019-20 OC Community Indicators 	**Social Determinants of Health**	**Homelessness**					Assuming 12% of homeless adults have SMI, ~823 per 2019 PIT (p64)		
		Education Level / Employment Status	29% not ready for Kinder. in Prosocial & Helping Behavior; 10% not ready in Overall Social Competence (p72; see Conditions of Children Report for details)		HS Drop Out ≥ 5%: Garden Grove Unified, Anaheim Union High, Santa Ana Unified, Orange Unified, Newport-Mesa Unified (p79; see Conditions of Children Report for additional details)				
	Navigation / Awareness		Rates of uninsured holding steady at 7% (p89)						
	Access / Availability		Mental Health Hospitalizations (85% increase 2008-17), driven largely by Major Depression & Mood Disorders Hospitalizations (140% increase)						
2014-18 Suicide Deaths in OC 	**Age Groups**		From 2014-18, there were 1,648 deaths by suicide among OC residents: ~330 deaths each year Rate per 100,000 OC Residents: 10.3 (5-yr average from 2014-2018)						
				10-17 years: 2.3		18-24 years: 9.0		25-34 years: 10.5 35-44 years: 9.7 **45-54 years: 13.8**	**55-64 years: 16.4** **65-74 years: 15.6** **75-84 years: 18.7** **85+ years: 19.5**
	Ethnicity			Rate per 100,000 (% deaths by suicide 2014-18) **White: 16.8 (68.1%)** Hispanic: 4.6 (15.8%) API: 6.6 (12.8%) Black: 11.1 (1.3%) Other/Unknown: 6.7 (2.0%) (p10)					
	Geography			w/ higher rates in coastal and south Orange County (p14)					
2018 Hate Crimes Report 	**Social Determinants of Health**		42% of hate crimes based on race/ethnicity/national origin (p4); 34% of hate crimes based on religious intolerance; 16% of hate crimes anti-LGBTQ+						

REPORTS	CATEGORY	SUBCATEGORY	CHILDREN			TAY		ADULTS	OLDER ADULTS
			0-5 years	6-11 years	12-15 years	16-17 years	18-25 years	26-59 years	60+ years
25th Annual Report on the Conditions of Children in OC 	**Social Determinants of Health**	**Safety**	Substantiated child abuse rates (6.2) decreased from 2009, lower than CA rate (7.2); Rates highest in Anaheim (10.7) & Santa Ana (9.5; p67) **36.5% children entering foster care placed in permanent home within 12 months, lower than national goal of ≥ 40.5%**						
				Juvenile arrests (age 10-17) highest in Anaheim, Garden Grove & Santa Ana (p71); Sustained juvenile petitions highest in Santa Ana (and Anaheim & Stanton; p73); Over 90% of youth in gangs are Latino (p74)					
		Homelessness / Financial Insecurity	Indicators that Increased from 2008-09/2009-10): 6% of children **insecurely housed** (up from 3.4%), 48.6% eligible for **free/reduced lunch** (up from 45.0%), 16.5% receiving **CalFresh** (up from 9.3%) (p36)						
		Education Level / Employment Status	Lowest rates of children ready for kindergarten in La Habra, Stanton, Villa Park, Midway City, Santa Ana & Orange (2019; p51)	**Chronic absenteeism** increased slightly from 2016-17, is disproportionately high among foster & homeless youth, students w/ disabilities, American Indian/Alaska Native, Pacific Islander, Black students (p48, 61); HS drop out rates highest in Brea-Olinda, Fullerton Joint, Garden Grove, Tustin, Laguna Beach, Saddleback Valley (pg 57); Foster Youth have high rates (26.9; pg 57); Hispanic & Black student drop out rates the highest (p57)					
	Navigation / Awareness				14% Latinos lack health Insurance				
	Access /Availability		Hospitalization rate for serious mental illness (esp Depression/Mood Disorders) & substance abuse per 10,000 children at 25.4 in 2017 (p12), with highest rates in North Tustin/Tustin, Orange, Westminster, Fountain Valley, Huntington Beach, Costa Mesa & Dana Point (p35)						
					18 deaths by suicide in 2018 (unconfirmed, increasing trend); 861 ED visits for self-harm among 10-19 year olds in 2017 (level; p4), with highest rates in Anaheim, Midway City/Villa Park, Santa Ana, Costa Mesa & Lake Forest (p6)				

Legend for Proposed Recommended Priorities: Green Font: MH Awareness & Stigma Reduction; Red Font: Suicide Prevention; Blue Font: Access

Compiled January 11, 2020

Steering Committee Handout on CFTN Proposed Three-Year Budget

CFTN Program and Budget Review on January 29, 2020

CF-TN Updated January 27, 2020	FY 2018-19			FY 2019-20		
	FY 2018-19 Approved Budget	Actual Expenditures	% Change	FY 2019-20 Approved Budget	Anticipated Expenditures Projected as of Nov 2019	% Change
CAPITAL FACILITIES PROJECTS						
Wellness Campus	9,000,000	9,359,008	104%	16,600,000	16,600,000	100%
Youth Core Services Building Upgrades	70,000	200,000	286%	130,000	-	0%
Crisis Stabilization Unit Renovations	-			850,000	850,000	100%
Behavioral Health Training Facility	65,000		0%	65,000	65,000	100%
Subtotal	9,135,000	9,559,008	105%	17,645,000	17,515,000	99%
TECHNOLOGY NEEDS PROJECTS						
Electronic Health Record (E.H.R.)	11,695,972	6,839,838	58%	10,815,504	10,768,399	100%
Administrative Costs	317,761	276,016	87%	327,293	300,000	92%
Subtotal	12,013,733	7,115,853	59%	11,142,797	10,961,385	98%
Total MHSA/CFTN Requested Budget	$ 21,148,733	$ 16,674,861	79%	$ 28,787,797	$ 28,476,385	99%

1) In the event costs of approved CF or TN projects are lower than originally anticipated, remaining funds may be used to fund future CF or TN projects. HCA and CEO Budget will monitor any carryover balances to ensure that all funds transferred to CFTN are spent within the 10-year reversion timeframe.
2) Project funds approved for a specific project within one FY of a Three-Year Plan may be used to cover that project's costs during a different FY within the
3) Beginning FY 18/19, methodology for budgeting Admin Costs changed from using a flat 18% rate to using actuals from Previous year and adding a 3% inf

CF-TN

Updated January 27, 2020

	FY 2020-21			FY 2021-22		
	PRIOR Year (FY 2019-20) Approved Budget	Proposed Changes	Requested FY 2020-21 Budget	PRIOR Year (FY 2020-21) Approved Budget	Proposed Changes	Requested FY 2021-22 Budget
CAPITAL FACILITIES PROJECTS						
Wellness Campus	16,600,000	(16,600,000)	-	-	-	-
Youth Core Services Building Upgrades	130,000	(130,000)	-	-	-	-
Crisis Stabilization Unit Renovations	850,000	(850,000)	-	-	-	-
Behavioral Health Training Facility	65,000	-	65,000	65,000	-	65,000
Subtotal	17,645,000	(17,580,000)	65,000	65,000	-	65,000
TECHNOLOGY NEEDS PROJECTS						
Electronic Health Record (E.H.R.)	10,815,504	1,339,245	12,154,749	12,154,749	(3,687,997)	8,466,752
Administrative Costs	327,293	(27,293)	300,000	300,000	9,000	309,000
Subtotal	11,142,797	1,311,952	12,454,749	12,454,749	(3,678,997)	8,775,752
Total MHSA/CFTN Requested Budget	$ 28,787,797	$ (16,268,048)	$ 12,519,749	$ 12,519,749	$ (3,678,997)	$ 8,840,752

CF-TN

Updated January 27, 2020

	FY 2020-21			FY 2021-22		
	PRIOR Year (FY 2019-20) Approved Budget	Proposed Changes	Requested FY 2020-21 Budget	PRIOR Year (FY 2020-21) Approved Budget	Proposed Changes	Requested FY 2021-22 Budget
CAPITAL FACILITIES PROJECTS						
Wellness Campus	16,600,000	(16,600,000)	-	-	-	-
Youth Core Services Building Upgrades	130,000	(130,000)	-	-	-	-
Crisis Stabilization Unit Renovations	850,000	(850,000)	-	-	-	-
Behavioral Health Training Facility	65,000	-	65,000	65,000	-	65,000
Subtotal	17,645,000	(17,580,000)	65,000	65,000	-	65,000
TECHNOLOGY NEEDS PROJECTS						
Electronic Health Record (E.H.R.)	10,815,504	1,339,245	12,154,749	12,154,749	(3,687,997)	8,466,752
Administrative Costs	327,293	(27,293)	300,000	300,000	9,000	309,000
Subtotal	11,142,797	1,311,952	12,454,749	12,454,749	(3,678,997)	8,775,752
Total MHSA/CFTN Requested Budget	$ 28,787,797	$ (16,268,048)	$ 12,519,749	$ 12,519,749	$ (3,678,997)	$ 8,840,752

CF-TN

Updated January 27, 2020

	FY 2022-23			FY 21-23 Notes
	PRIOR Year (FY 2021-22) Approved Budget	Proposed Changes	Requested FY 2022-23 Budget	
CAPITAL FACILITIES PROJECTS				
Wellness Campus	-	-	-	
Youth Core Services Building Upgrades	-	-	-	
Crisis Stabilization Unit Renovations	-	-	-	
Behavioral Health Training Facility	65,000	-	65,000	Capital Facility Costs for BH Training facility will be for 10 years. Started FY 18/19 ends FY 27/28
Subtotal	65,000	-	65,000	
TECHNOLOGY NEEDS PROJECTS				
Electronic Health Record (E.H.R.)	8,466,752	116,136	8,582,888	Funds are to continue the work of consolidating data from multiple sources into the EHR, as well as integrating with Contract Providers' health information exchange. EHR project costs will include, but not be limited to: software licenses, network infrastructure such as servers, storage and network monitoring appliances, and internal human resources and external consultants. Adding $1M budget for Data Integration System. These funds will support the development and ongoing support for a System of Care Data Integration System designed to coordinate appropriate data sharing across county departments and external stakeholders. Data integration will aid in providing essential and critical services that include mental health care to county residents in a more efficient and timely manner.
Administrative Costs	309,000	9,270	318,270	Beginning FY 18/19, methodology for budgeting Admin Costs changed from using a flat 18% rate to using actuals from Previous year and adding a 3% inflation rate.
Subtotal	8,775,752	125,406	8,901,158	
Total MHSA/CFTN Requested Budget	$ 8,840,752	$ 125,406	$ 8,966,158	

APPENDIX IV: 2018 PEI COMMUNITY PLANNING AND MHSA CEMS RESULTS

Summary of the MHSA Prevention & Early Intervention (PEI) Community Planning Orange County Health Care Agency Behavioral Health Services

Mark Lawrenz
Prevention & Intervention Division Manager

September 25, 2018

Overview of the Community Planning Process

- The first meeting on August 7th, provided an overview to create a common understanding and framework of the PEI Planning Process.
- Four targeted discussions on community needs identified, within specific populations:

August 14:	Focusing on family support programs, program serving families with children from birth to age 8
August 21:	Focusing on school-based programs, children/youth 9-16, and TAY
August 29:	Focusing on adult and older adult programs
September 11:	Revisited TAY

- A fifth meeting on September 25 will bring all the feedback together for a discussion on the over-arching themes and service needs identified

Identified Need #2:
Systematic screenings for mental illness

- Expand screenings for older adults to determine if symptoms are caused by depression or dementia

Identified Need #1:
Increased Awareness of/Improved Navigation of the Behavioral Health System

- Need for an comprehensive resources inventory to assess unmet need including geo-mapping of resources
  - A comprehensive resource inventory of school-based mental health resources, including all districts
  - Resource guide for older adults, their families and providers
- Care coordination to better link children with mental health challenges to appropriate specialty services.
- Use of technology, smart phones and apps, especially for the younger generations as it is being piloted in Innovations Technology Suite to link youth to services

Identified Need# 3:
Training for individuals, families and providers

- Expand workforce capacity/skills to work with young children to promote, educate, prevent, identify and link to services
- Increase training opportunities through BHS Training and PEI in higher education
- Training for parents whose children are on probation
- Prevention education to foster parents on LGBTIQ and TAY issues
- Trauma-focused trainings to providers serving all target populations & age groups

Identified Need #4:
Implementation and/or Expansion of Peer Support Models

- Peer support for families, such as parent partners, to build trust and assist in navigating the services, especially for underserved and homeless families
- Peer support in the schools to further address bullying, trauma and suicide prevention
- More peer support in colleges and universities, especially for the LGBTIQ community and Veterans
- Peer support for LGBTIQ, specifically in the foster care system
- Peer support for Veterans especially not in college system
- Peer navigators and support for seniors

Identified Need #6:
Time-Limited Funding of New Services

- Services for homeless youth and home schooled youth not accessing schools
- Services targeting TAY not attending Colleges or Universities
- Older adult services for adults, age 50 years and older, especially from the immigrant communities

Identified Need #5:
Time-Limited Expansion of Existing Direct Services

- System-wide expansion of resources to promote perinatal mental health services, including for fathers (more screenings, case management and early intervention)
- Expansion of County counseling program to support need for bilingual therapists
- Expansion of early intervention services for older adults, age 60 and older including more gero-psychiatric hours

HCA Prevention and Intervention Planning Recommendations

October 15, 2018

A. Allocate funding for an early childhood mental health program targeting early childcare providers serving families and children

Recommendation includes components from identified need 1, 2, 3 and 6 from the PEI Planning Meetings.

Need identified in the initial Public Forum, in the PEI Planning Meetings and in the BHS Community Engagement Meetings.

HCA Recommendation	What the MHSA/PEI Regulations Indicate	What we know about the need
Allocate funding for an early childhood mental health program targeting early childcare providers serving young children exhibiting problematic behaviors, who are at risk of expulsion and mental illness. Services would include: • On-site Mental Health Consultation • Education and training of Early Childcare Providers • Screening/ Assessment • Parent Education • Navigation and Linkage to Services.	Per SB 1004, approved 9/27/18, "Childhood trauma prevention and early intervention to deal with the early origins of mental health needs" is an identified priority. Included in these services is the implementation of appropriate trauma and developmental screenings and linkages to early intervention services/ primary care.	• Children in preschool are expelled at 3 times the rate of children in K-12 • 1996 CSU Fullerton Survey, "Experiences Caring for Children with Behavioral Challenges or Possible Mental Health Conditions," demonstrated the need for these services • Early Developmental Index (EDI) measures the status of a child's early development. It provides information about kindergarteners in five developmental areas, including social-emotional that are known to affect well-being and school performance. This data demonstrates need for supports in specific areas of the County. • UCSD Needs & Gaps Analysis identified that the mental health need among children, ages 4-11, in OC was 5.9% and highest for Latino children (8.3%) with over half not receiving any treatment in the past year.

B. Allocate funding to expand school-based services to better address the mental health needs, K-12

Recommendation includes components from identified need 1, 3, 4, 6 and 7 from the PEI Planning Meetings.

Need identified in the initial Public Forum, in the PEI Planning Meetings and in the BHS Community Engagement Meetings.

HCA Recommendation	What the MHSA/PEI Regulations Indicate	What we know about the need
Expand school-based services for addressing mental health issues in K-12 schools County-wide. Allocated PEI funding could be used for: • Educational and Networking Forums • Trauma-informed Teacher and Staff Trainings/ Parent Education • Pilot Evidenced- Based Peer-Support Models • School-based Suicide Prevention and Stigma Reduction Campaigns and Activities **Innovation is exploring an opportunity to help support this Recommendation through a potential expansion of the Tech Suite to address the mental health needs of children and adolescents ***Recommend schools to implement universal screening.	Per SB 1004, Childhood trauma prevention and early intervention to deal with the early origins of mental health needs" is an identified priority. Included in these services is the implementation of appropriate trauma and developmental screenings and linkages to early intervention services/ primary care. In addition, "Youth outreach and engagement strategies that target secondary schools". Services may include stigma reduction and suicide prevention education, training staff and parents on the early identification, intervention and referral of students with mental health needs and youth mental health programming.	• UCSD Needs & Gaps Analysis identified that the mental health need among children, ages 4-11 years, in OC was 5.9% and highest for Latino children (8.3%) with over half not receiving any treatment in the past year. In addition, UCSD identified that the mental health need for adolescents, ages 12-17 years, in OC was 4.2% with nearly two-thirds not receiving any treatment in the past year. Among adolescents, the mental health need was higher for younger adolescents, ages 12-14 years. • With 28 school districts with varying levels of need and resources, further assessment is needed to determine how to best impact system with available funding.

C. Allocate funding to expand existing Gang Prevention Services

Recommendation includes components from identified need 1, 3, and 5 from the PEI Planning Meetings.

Need identified in the initial Public Forum, in the PEI Planning Meetings and in the BHS Community Engagement Meetings.

HCA Recommendation	What the MHSA/PEI Regulations Indicate	What we know about the need
Expand the existing MHSA/PEI Gang Prevention Services to increase services provided in the schools, targeting 5th to 8th graders at risk of gang involvement. Services would include: • Teacher, Parent and Student Education • Case Management • Navigation and Linkage to Services	Per SB 1004, Childhood trauma prevention and early intervention to deal with the early origins of mental health needs" is an identified priority. Included in these services is the implementation of appropriate trauma and developmental screenings and linkages to early intervention services/ primary care. In addition, "Youth outreach and engagement strategies that target secondary schools. Included are, "interventions for youth with signs of behavioral or emotional problems who are at risk of, or have had any, contact with the juvenile justice system."	• UCSD Needs & Gaps Analysis identified that the mental health need among children, ages 4-11 years, in OC was 5.9% and highest for Latino children (8.3%) with over half not receiving any treatment in the past year. In addition, UCSD identified that the mental health need for adolescents, ages 12-17 years, in OC was 4.2% with nearly two-thirds not receiving any treatment in the past year. Among adolescents, the mental health need was higher for younger adolescents, ages 12-14 years. • Current program demonstrates greater need than capacity through the growing number of schools in need of services. The program served 427 individuals in FY 17/18, and outcomes demonstrated improvements in protective factors and global health.

D. Allocate funding to implement services for TAY and young adults at community colleges and universities

Recommendation includes components from identified need 1, 3, 4, 6 and 7 from the PEI Planning Meetings.

Need identified in the initial Public Forum, in the PEI Planning Meetings and in the BHS Community Engagement Meetings.

HCA Recommendation	What the MHSA/PEI Regulations Indicate	What we know about the need
Implement new services specifically targeting partnerships with college mental health programs that educates and engages students and provide either on-campus support and/or linkage to off-campus mental health services. Services could be used for: • Educational and Networking Forums • Teacher and Staff Trainings • Pilot Evidenced- Based Peer-Support Models • Suicide Prevention and Stigma Reduction Campaigns and Activities • Prevention education to at-risk TAY (including LGBTIQ/Veterans) • Outreach to TAY (young men of color/LGBTIQ) ***The Innovation Tech Suite project could support this Recommendation through targeted outreach and marketing events on college campuses throughout the County to promote the use of the apps within the Suite, including the 24/7 peer chat support.	Per SB 1004, "Youth outreach and engagement strategies that target secondary schools and transitional age youth, with a priority partnership with college mental health programs". Furthermore, services may include stigma reduction and suicide prevention education, training staff and students on the early identification, intervention and referral of students with mental health needs and youth mental health programming. Serving underserved communities including LGBTIQ, victims of violence/abuse and veterans. Program would also be tasked with reducing racial disparities in access to mental health services.	• The only existing MHSA/PEI funded program formally partnering with Colleges is serving Veterans with a small amount of funding through CalMHSA to Active Minds • UCSD Needs and Gaps Analysis identified TAY as the age group with the highest unmet mental health need, especially for the LGBTIQ, Latinos and African Americans

E. Allocate funding to expand existing services for isolated older adults

Recommendation includes components from identified need 1, 2, 4, 5, 6 and 8 from the PEI Planning Meetings.

Need identified in the initial Public Forum, in the PEI Planning Meetings and in the BHS Community Engagement Meetings.

HCA Recommendation	What the MHSA/PEI Regulations Indicate	What we know about the need
Expand the only MHSA/PEI-funded program, specifically targeting older adults, age 60 and above: the Early Intervention Services for Older Adults Program. This would address the current wait list for services especially for the Cambodian community, services would include: • Geo-psychiatric services • Screening/Assessment • Case Management • Educational /Support groups • Navigation and Linkage to resources • Transportation Assistance (new component) • Peer Support In addition, the eligibility criteria would be expanded to include those adults age 50-59 who are isolated due social and/or economic circumstances	Per SB 1004, "Strategies targeting the mental health needs of older adults" is an identified priority for use of PEI funds.	• California Mental Health Older Adult System of Care Project by UCLA conducted key informant interviews and provided findings that identified a similar need • Current program demonstrates greater need than capacity. The program served approximately 600 individuals in FY 17/18, and outcomes demonstrated decreases in depression and increases in social functioning and global health. • Many seniors don't drive or have access to transportation. They need transportation to access basic needs, doctor's appointments, or EISOA classes at senior centers. There are not sufficient bus routes. Takes 2-3 hours to reach their destination. In addition, Senior Access program but has restricted access. Also, the cost is $7.20/ride. People on SSI cannot afford. • CalOptima Member Health Needs Assessment identified lack of transportation as a barrier to access and 29% surveyed indicated needing help getting transportation.

F. Allocate funding to provide a variety of behavioral health community trainings.

Recommendation includes components from identified need 1, 3 and 5 from the PEI Planning Meetings.

Need identified in the initial Public Forum, in the PEI Planning Meetings and in the BHS Community Engagement Meetings.

HCA Recommendation	What the MHSA/PEI Regulations Indicate	What we know about the need
Provide a variety of behavioral health community trainings for individual, families and providers. Emphasis on trauma-informed, culturally and linguistically appropriate trainings, including suicide prevention and trainings for specific communities including TAY, Veterans, LGBTIQ, families with children on probation and parents of foster youth. Trainings would include: • Recognizing the early signs and symptoms of mental illness across life span • Education related to supporting and engaging someone who needs help • Increasing awareness of resources and how to access the behavioral health system of care • Training peer support navigators	PEI Regulations require a program and strategies for Outreach for increasing recognition of early signs of mental Illness, which is defined as the process of engaging, encouraging, educating and/or training and learning from potential responders about ways to recognize and respond effectively to early signs of potential severe and disabling mental illness.	• CalOptima Member Health Needs Assessment identified Lack of Knowledge as a barrier to access with 40% of those surveyed didn't know who to call or ask for help • UCSD Needs and Gaps Analysis identified TAY as the age group with the highest unmet mental health need, especially for the LGBTIQ, Latinos and African Americans

G. Allocate funding to expand outreach to cultural and linguistic populations that continue to be underserved

Recommendation includes components from identified need 1, 2, 3 and 5 from the PEI Planning Meetings.

Need identified in the initial Public Forum, in the PEI Planning Meetings and in the BHS Community Engagement Meetings.

HCA Recommendation	What the MHSA/PEI Regulations Indicate	What we know about the need
Expand Outreach & Engagement (O&E) for targeted populations who are underserved in the existing O&E programs. Services would include: • Outreach & Engagement • Screening/ Assessment • Case Management • Navigation and Linkage to Resources • Support Groups & Education ***The Innovation Tech Suite project could support this Recommendation by working with the Tech Suite Marketing vendor to identify and implement targeted outreach/marketing strategies that are designed to engage diverse communities.	Per SB1004, culturally competent and linguistically appropriate prevention and intervention services are an identified priority	• CalOptima Member Health Needs Assessment identified Lack of Knowledge as a barrier to access with 40% of those surveyed didn't know who to call or ask for help when seeking a mental health specialist

H. Allocate funding to existing Community Mental Health Educational Events to Reduce Stigma

Recommendation includes components from identified need 1, 3 and 7 from the PEI Planning Meetings.

Need identified in the initial Public Forum, in the PEI Planning Meetings and in the BHS Community Engagement Meetings.

HCA Recommendation	What the MHSA/PEI Regulations Indicate	What we know about the need
Expand funding for Community Mental Health Educational Events. Services would include: • Increasing awareness of behavioral health resources • Education regarding mental health and stigma associated with mental illness and seeking services, promoting positive messages of hope ***Innovation is exploring opportunities to help support this Recommendation through a technology-based project designed to identify specific regions with the greatest need for prevention and early intervention efforts and stigma reduction trainings.	PEI Regulations require a Stigma and Discrimination Reduction Program, which is defined as activities to reduce negative feelings, attitudes, beliefs, stereotypes and/or discrimination related to having a mental illness or seeking services, and to increase acceptance, dignity and inclusion	• CalOptima Member Health Needs Assessment identified Stigma as a barrier to access with 26% of those surveyed being concerned about what happens if someone found out about their mental health needs

I. Allocate funding to expand services for Veterans

Recommendation includes components from identified need 1, 2, 3, 4, and 5 from the PEI Planning Meetings.

Need identified in the initial Public Forum, in the PEI Planning Meetings and in the BHS Community Engagement Meetings.

HCA Recommendation	What the MHSA/PEI Regulations Indicate	What we know about the need
Expand funding to support services for veterans and military connected families. Services would include: • Outreach & Engagement • Screening/ Assessment • Counseling • Case Management • Navigation and Linkage to Resources • Support Groups & Education ***Innovation is currently providing services to veterans and military connected families through the Behavioral Health Services for Military Families: Strong Families Strong Children project. The project is in its final year of services as an Innovation project. HCA recommends to continue funding this project through PEI funding beginning July 1, 2019 to maintain continuity of services. From project launch on July 1, 2015 through July 30, 2018, the project served 156 families and a total of 540 individual family members. Outcomes demonstrate improvement in family functioning and communication, particularly in areas of family safety, environment and social/community life.	PEI Regulations require a Prevention Program to reduce risk factors for mental illness that are associated with a greater than average risk of developing a potentially serious mental illness. Examples of risk factors include, but are not limited to, experience of severe trauma, ongoing stress, family conflict or domestic violence, traumatic loss, etc.	• Over 70% of military families live in civilian communities (National Military Family Association, 2011), but are often not known to be military-connected. • In a recent USC Veterans study and survey of over 1,200 Orange County veterans, over 70% of veterans reported their child's school was not aware that their child is military connected (Castro, Kintzle, & Hassan, 2015). • Military-connected families often go unnoticed due to the community's limited knowledge of military culture; limitations in assessment strategies; lack of coordinated community based services; and stigma associated with mental illness. • 44% of post 9/11 veterans reported not knowing where to go for help and about 24% of veterans believed they could handle the problem on their own (Castro, Kintzle, & Hassan, 2015).

Eight Needs Identified Across Planning Meeting:

1. Increased Awareness of/Improved Navigation of the Behavioral Health System
2. Systematic screenings for mental illness
3. Training for individuals, families and providers
4. Implementation and/or Expansion of Peer Support Models
5. Time-Limited Expansion of Existing Direct Services
6. Time-Limited Funding of New Services
7. Targeted Stigma Reduction Programs
8. Additional Supports to Remove Barriers to Increase Access/Training

1

BHS Community Engagement / PEI Community Planning Meeting Summary

Sharon Ishikawa, MHSA Coordinator
Mark Lawrenz, PEI Division Manager
Anthony Le, HCA BHS Fiscal Manager

October 15, 2018

2

Overview

- Community Engagement Meetings
- PEI Community Planning
- Synthesized Feedback

3

BHS Community Engagement Meetings

4

CEMs: When?

July 31: Central
- Delhi Community Center

August 8: North
- Fullerton Community Center

August 13: South
- Norman P. Murray Community & Sr Center

August 27: Central
- Community Action Advisory Committee

5

CEMs: What?

- Meetings in each of three county Service Planning Areas (SPA):
  - North, Central, South
- Two Workgroups per SPA (n = 131 total):
  - *Provider (n=93)*
  - *Community (n=38)*
- Focus on overall Behavioral Health system

6

CEMs: How?

- Participants randomly assigned to small workgroups (n=5)
- Each workgroup given a list of Service Areas
  - *all of BHS, not just MHSA*
- Each small workgroup identified the top 5 Service Areas
  - *not rank ordered*

7

Behavioral Health Service Areas

- Prevention
- Provider Training in BH Topics/ Issues
- Crisis Prevention
- Crisis Assessment
- Crisis Treatment
- Substance Use Education
- SUD Outpatient Clinic Services
- SUD Residential Treatment
- SUD Maint. Recovery Support
- Navigation/Access & Linkage
- BH Clinic Outpatient Services
- Mobile BH Outpatient Services
- School-Based Mental Health
- Parent/Family Education
- Transportation
- Services for those living in Supportive Housing
- Employment, Educational, Vocational Support
- LPS Conservatorship Support
- Peer/Family Support
- Other (specified)

8

CEMs: How? con't

For each meeting:

- Staff tallied the Top 5 areas across the tables
- Participants used Post-Its to provide feedback within each Service Area:
  - *types of services*
  - *target populations*
- MHSA Staff facilitated group discussion

9

CEMs: Results

	Provider			Community		
Service Priority Area	**N**	**C**	**S**	**N**	**C**	**S**
Prevention	●	●	●		●	●
School-Based Mental Health	●	●	●			●
Clinic-Based Outpatient	●		●	●	●	
Housing *		●	●	●		●
Crisis Assessment & Treatment *	●		●		●	●
SUD Services *	●		●	●		
Navigation / Access & Linkage		●				
Employ. / Educ. / Voc. Support		●				
Peer / Family Support		●			●	

** Only identified in CEMs (not PEI CPP meetings)*

10

CEM Priority Service Area: Housing

Focal Target Populations:
- Older Adults
- TAY (Foster, LGBTIQ)
- Vulnerable populations

11

CEM Housing Themes

Increased Availability
- Provider CEMs: Central, South
- Community CEMs: South

Examples:
- Permanent Supportive Housing
- Affordable housing
- In all regions of county
- SUD Housing for recovery / support

12

CEM Housing Themes

Housing Assistance
- Community CEMs: North, South

Examples:
- Rental Assistance/subsidized rent
- Eviction prevention and advocacy
- Better quality, basic standards

13

CEM Housing Themes

Supportive Services

- Provider CEMs: Central, South

Examples:

- Linkage to services
  - i.e., employment, therapy, support, case management
- Onsite services
- Skills building
  - i.e., financial, life skills, empowerment and knowledge, case management

14

CEM Priority Service Area: Crisis Assessment/Treatment

Focal Target Populations:

- Children / Youth / Minors
- TAY

15

CEM Crisis Assessment/Tx Themes

Crisis Stabilization

- Provider CEMs: North, South
- Community CEMs: Central

Examples:

- Site CSUs
- Expand In-Home Crisis Stabilization
- Implement 'buddy care' system to facilitate stabilization

16

CEM Crisis Assessment/Tx Themes

Crisis Assessment

- Provider CEMs: North
- Community CEMs: Central

Examples:

- Quicker response times for assessment, stabilization
- Culturally appropriate services 24/7

17

CEM Crisis Assessment/Tx Themes

Crisis Aftercare/ Support

- **Provider CEMs: South**
- **Community CEMs: South**

Examples:

Link youth and minors to services
Provide aftercare

- **Coordinate care**
- **Enhance navigation assistance and resources for family members**

18

CEM Crisis Assessment/Tx Themes

Additional

- ***Central Community:*** **Increase LPS trained nurse/staff**
- ***South Provider:*** **Provide family services**

19

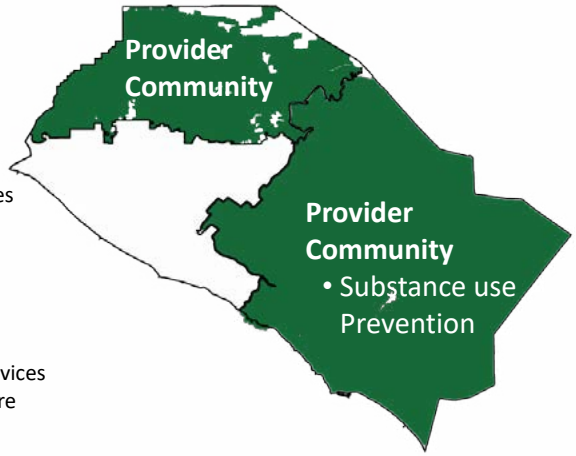
Region-Specific CEM Priority: Substance Use Services

North Provider Themes

- Detox Centers
- Coordination of after care – lower levels of care
- TAY Services: detox, dual diagnosis treatment
- Expanded outpatient services

North Community Themes

- Wrap services
- Expanded medical detox services
- Housing options for after care
- SUD treatment for all ages

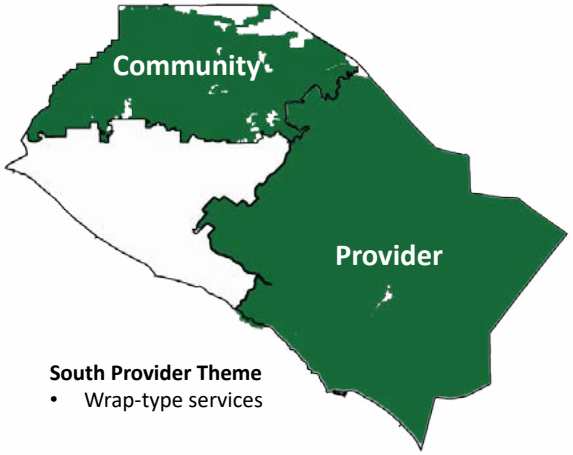


20

Region-Specific CEM Priority: Clinic-Based Outpatient

North Community Themes

- Wrap-type services for:
  - All ages
  - Culturally underserved
  - Individuals with co-occurring and substance use needs



South Provider Theme

- Wrap-type services

21

CEM Feedback Available at:

http://www.ochealthinfo.com/bhs/about/pi/mhsa

22

PEI Community Planning Meetings

23

PEI CPP: When?

August 7: Overview, MHSOAC PEI Regulations

August 14: Family support programs, programs serving families w/ children 0-8

August 21: School-based programs, children/youth 9-16, TAY

August 29: Adult and Older Adult programs

September 11: TAY revisited

September 25: Summary

24

PEI CPP: What?

- To provide the MHSA Steering Committee with a list of community service needs and target populations for prioritization in the use of available MHSA funds
- To take a deeper dive into the PEI needs of the community to better inform all MHSA/PEI programing

25

PEI CPP: How?

- Held a series of meetings, with each meeting focused on a specific target population
- Participants identified needs and priorities in small workgroups and reported out to group
- PEI Staff summarized feedback and themes from each meeting

26

PEI CPP: Results

	PEI CPP Identified Needs
1	Increased awareness / Improved navigation of the Behavioral Health System
2	Systematic screenings for mental illness
3	Training for individuals, families and providers
4	Implementation and/or expansion of peer support models
5	Time-limited expansion of existing direct services
6	Time-limited funding of new services
7	Targeted stigma reduction programs
8	Additional supports to remove barriers to access/training

27

PEI CPP-Specific Themes

Identified Need #2 - Systematic screenings for mental illness:

- Translate information and tools in a culturally aware manner
- Expand screenings for Older Adults to determine if symptoms are caused by depression or dementia

Identified Need #5: Time-Limited Expansion of Existing Direct Services:

- Expand screenings for Older Adults to determine if symptoms are caused by depression or dementia
- System-wide expansion to promote perinatal MH services, including for fathers (more screenings, case management, early intervention)
- Expansion of early intervention services for older adults, with a focus on immigrant communities; include increased geropsychiatry hours
- Services targeting TAY not attending Colleges or Universities

28

PEI CPP-Specific Themes con't

Identified Need #8 - Additional Supports to Remove Barriers to Increase Access / Training

- Provide childcare

29

Integrated CEM / PEI Results

30

Prevention

Focal Target Populations:

- Children
- 0-15 year olds
- TAY
- LGBTIQ
- College Students
- Older Adults
- Culturally / linguistically isolated and unserved

31

Prevention Themes

Stigma Reduction

- **Provider CEMs: North, Central**
- **Community CEMs: Central**
- **PEI CPP**

Examples:

Awareness campaigns for:

- **first responders working w/ young children**
- **older adults**
- **Veterans, LGBTIQ community, immigrants**

Increased information and education in culturally sensitive and appropriate messaging with inclusive language

32

Prevention Themes

Improved Navigation / Access & Linkage

PEI CPP

Also in Provider and Community CEMs

Examples

- **Comprehensive resource inventory…:**
  - **to assess unmet need, including geomapped resources**
  - **of school-based mental health resources, including all districts**
  - **for older adults, their families and providers**
- **Care coordination to better link children to appropriate specialty/mental health services**
- **Use of technology, smart phones and apps as being piloted in INN Tech Suite, with emphasis on linking youth to services**

33

Prevention Themes

Suicide Prevention

- Community CEMs: Central, South
- PEI CPP

Examples:

Expansion of violence prevention and suicide prevention
focus on children, TAY, school-aged youth

34

Prevention Themes

Parent/Family Support Peers

- Provider CEMs: South
- PEI CPP

Examples:

Peer support:
in schools to further address bullying, trauma and suicide prevention
in colleges and universities, especially for the LGBTIQ community and Veterans
for LGBTIQ, specifically in foster care
for Veterans not in the college system

- Peer navigators and support for seniors
- Parent partners who build trust and assist in navigating services, especially for underserved and homeless families

35

Prevention Themes

Training

- Provider CEMs: North, Central, South
- Community CEMs: South
- PEI CPP

Examples:

Expanded workforce capacity/skills to work with young children to promote, educate, prevent, identify, link to services

- Increased training opportunities through BHS Training and PEI in higher education
- Training for parents whose children are on probation
- Prevention educ. on LGBTIQ and TAY issues for foster parents
- Trauma-focused trainings to providers serving all populations
- Trainings for:
  - support service providers for isolated and older adults, e.g., Meals on Wheels volunteers
  - faith-based community
  - providers who serve TAY, LGBTIQ and Veterans

36

Prevention Themes

Integrated Care

- Community CEMs: South
- PEI CPP

Examples

- Demonstration project of Behavioral Health integration in pediatric primary care

37

School-Based Mental Health

Focal Target Populations:
- Students of all ages
- LGBTIQ students
- Parents
- School staff

38

School-Based MH Themes

Mental Health Services
- Provider CEMs: North, Central, South
- Community CEMs: Central
- PEI CPP

Examples:

Increase school counselors, social workers, therapists to provide more early intervention

Increase bilingual therapists
- Develop Wellness Centers in schools
- Provide specialized services for LGBTIQ students
- Provide mobile services

39

School-Based MH Themes

Parent Support
- Provider CEMs: North, Central
- Community CEMs: South
- PEI CPP

Examples:

Provide family strengthening programs

Provide parent education and training

40

School-Based MH Themes

Education/ Training
- Provider CEMs: North, Central
- Community CEMs: South
- PEI CPP

Examples:

Training on mental health for:
school staff, counselors & administrators, including colleges and universities

Compensation for substitutes so teachers can attend trainings

41

School-Based MH Themes

Screening

- Provider CEMs: North, South
- Community CEMs: South
- PEI CPP

Examples:

- Implement universal screening tools in pediatric primary care, early childcare and school settings
- Provide developmental screening for all ages
- Assess adverse childhood experiences (ACES)

42

Clinic-Based Outpatient

Focal Target Populations:

- Older Adults
- Children
- Vulnerable populations

43

Clinic-Based Outpatient Themes

Mobile Services/ Telehealth

- Provider CEMs: North, South
- PEI CPP

Examples:

- Telehealth, especially for families with children from birth to age 8
- Transportation services
  - Including for seniors who are home-bound

44

Clinic-Based Outpatient Themes

Expanded Services

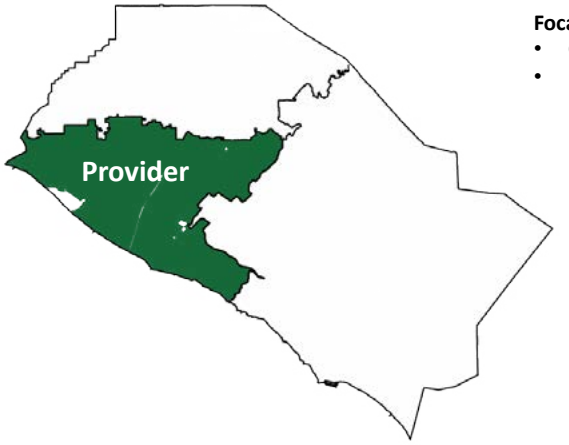
- Provider CEMs: North, South
- Community CEMs: North, Central
- PEI CPP

Examples:

- Expanded services:
  - Children's services
  - Co-occurring services, including for TAY
  - Bilingual CCSS therapists
- Daily groups on life skills, mindfulness, stress
- Stress reduction services
- Care Coordination
- Culturally/linguistically appropriate services addressing stigma, trauma, outreach, esp. for Cambodian community

45

Navigation/Access to Treatment



Focal Target Populations:
- Older Adults
- Monolingual Communities

46

Navigation/ Tx Access Themes

Navigation / Access

- Provider CEMs: Central
- PEI CPP

Examples:

Expand Outreach and Engagement Services
- Target specific populations:
  - Older adults
- Cultural and linguistic services:
  - Bilingual staffing: Spanish, Vietnamese, Cambodian speaking
- Media Campaigns, linkage fairs, drop in centers

47

Employment / Education / Vocational Support

Focal Target Populations:
- TAY

48

Employ. / Educ. / Vocational Support Themes

Employ. / Educ. Support

- Provider CEMs: Central
- PEI CPP

Examples:

Expand employment services:
training, resources, job developers
- Employ paraprofessionals/staff with lived experiences
- Provide employment, training activities for individuals with mental illness to promote employment and meaningful activities

49

Peer / Family Support

Focal Target Populations:
- Older Adults
- LGBTIQ
- Veterans
- Foster Youth
- College Students
- Monolingual Communities

50

Peer / Family Support Themes

Peer / Family Support
- **Provider CEMs: Central**
- **Community CEMs: Central**
- **PEI CPP**

Examples:
- **Expansion of peer services in all age groups:**
  - **Parent Partners/Peer support for families to assist in navigating services, especially for:**
    - **underserved and homeless families**
    - **culturally appropriate – Cambodian pop.**
  - **Peer support in the schools:**
    - **on bullying, trauma and suicide prevention**
    - **for LGBTIQ, Veteran communities**
  - **Board and care, designated facilities, private conservators**
- **Language access**

51

PEI CPP System-wide Themes

52

Partnering, Integration and Collaboration

- Build relationships at the leadership levels between HCA, school superintendents, FRC's, colleges/universities to help eliminate systemic barriers such as time taken for MOU's, permission and access into schools
- Organized and systematic networking opportunities to share available resources, such as sharing success stories via a newsletter
- More partnering with community based organizations to provide behavioral health services at trusted community sites
- Private/Public partnerships/Integration

53

PEI CPP Summaries Available at:

http://www.ochealthinfo.com/bhs/about/pi/mhsa

54

Funds Available for PEI Planning

	Proj. FY 19/20 PEI Allocation (inc. int)	* PEI Carry Over Funds	Total
CEO Projected Available PEI Funds for FY 2019-20:	$30.6M	$34.1M	$64.7M
Current on-going PEI FY 19/20 budget:	($30.6M)	($4M)	($34.6M)
** Carry over funds for PEI programs in FY 18/19:		($0.2M)	($0.2M)
** Additional carry over funds for PEI programs in FY 19/20:		($2.9M)	($2.9M)
** Carry over funds for PEI programs in future years (FY's 20/21-22/23):		($4.5M)	($4.5M)
*** Projected funds available for PEI Programs:	$0	$22.5M	$22.5M

** Carry Over funds are finite. Once spent, these funds will not be replenished.*

*** PEI programs using Carry Over PEI funds:*

1. *OC4VETs–Carry over funding expires FY 19/20*
2. *OC Links–Carry over funding expires FY 22/23*
3. *School Based BH–Carry over funding expires FY 20/21*
4. *Violence Prevention–Carry over funding expires FY 22/23*
5. *School Readiness–Carry over funding expires FY 22/23*

**** As of 9/17/18. Amount available is subject to change pending further directed priorities.*

55

APPENDIX V: PEI REGULATIONS AND LEGISLATION

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, which were amended in July 2018, define and/or delineate the following for both components:

- Reporting requirements, including expenditure reports, program and evaluation reports to be submitted to the MHSOAC, etc.
- 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 Regulations

In addition, the MHSOAC and, most recently, Senate Bill (SB) 1004, implemented several 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 is 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.

MHSOAC-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 listed in the table at the end of this section.

- **Stigma and Discrimination Reduction**: Activities to reduce negative feelings, attitudes, beliefs, stereotypes and/or discrimination related to having a mental illness or seeking services, and to increase acceptance, dignity and inclusion.
- **Outreach for Increasing Recognition of Early Signs of Mental Illness**: Process of engaging, encouraging, educating and/or training and learning from potential responders about ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness.
- **Prevention**: Activities that reduce risk factors for developing a potentially serious mental illness and to build protective factors with the goal or promoting mental health.
- **Early Intervention**: Treatment/services that promote recovery and functioning for a mental illness early in its emergence.
- **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.
- **Suicide Prevention** (optional): Activities that aim to prevent suicide as a consequence of mental illness.

MHSOAC-Required PEI Service Strategies

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

- **Improve Timely Access to Mental Health Services for Underserved Populations**: Strategies designed to overcome barriers and improve timely access to services for underserved populations.
- **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.
- **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.

Orange County is continuing to bring its PEI program descriptions, data collection and reporting into compliance with the new Regulations, particularly with regard to:

- Assessment of the duration an individual's mental illness remained untreated.
- Collection of the full demographic categories in County-operated programs as the electronic health record still needs to be modified.
- Process to un-duplicate demographic data counts when complete personally identifying information is not available in/across programs within a fiscal year.
- Length of time from when (1) a written referral to a higher level of mental health service is provided to individuals living with serious mental illness/serious emotional disturbance and (2) when that person attends the first appointment.
- Collection of all data elements required for Outreach for Increasing Recognition of Early Signs of Mental Illness programs.

To address the above issues, the County continues to work on modifying its own Electronic Health Record and on developing and coordinating standardized data collection procedures across County-operated and County-contracted programs, and will report on its progress in these and other areas in future Annual Plan Updates. Other required PEI Report elements are contained within this Plan Update (i.e., demographic information is on the following pages, service strategies are described in each service area section).

Senate Bill 1004 and PEI Priorities

Senate Bill (SB) 1004, passed in 2018, establishes priorities for the use of PEI funds that are in addition to the MHSOAC PEI regulations. These priorities are as follows:

- Childhood trauma prevention and early intervention as defined in Section 5840.6(d) to deal with the early origins of mental health needs.
- Early psychosis and mood disorder detection and intervention, and

mood disorder and suicide prevention programing as defined in Section 5840.6(d).

- Youth outreach and engagement strategies as defined in Section 5840.6(d) that target secondary school and TAY, with a priority on developing partnerships with colleges/universities.
- Culturally competent and linguistically appropriate prevention and intervention as defined in Section 5840.6(d).
- Strategies targeting mental health needs of older adults.
- Other programs the commission identifies, with stakeholder participation, that are proven effective in achieving, and are reflective of, the goals stated in Section 5840 (as of March 2020, the Commission has not identified additional priorities).

A series of tables below summarizes the information a County is required to report in its PEI Component of the Three-Year Plan, per SB 1004:

- The specific PEI Priorities addressed in the Plan,
- An estimate of the share of PEI funding allocated to each priority, and
- If the County has determined to pursue alternative or an additional priority to those listed above, a description of how it made this determination through its stakeholder process and identify the metric(s) used to assess the program's effectiveness.

An explanation of how stakeholder input contributed to the priorities and allocations is provided in the section describing the 2019 Community Planning Process for the Three-Year Plan, as well as in Appendix IV describing the 2018 Community Planning Process.

A required by SB 1004, the table below provides an estimated share of the annual projected PEI **component** budget allocated to each of the PEI Priorities by FY. In addition, subsequent tables show the estimated share of **individual program** budgets allocated to each of the PEI Priorities, which were used to calculate the estimated shares for the annual projected component budget. Please note, these estimates may change if there are changes in the projected annual allocations, program expenditures and/or budgets, or PEI priorities.

Projected (Proj.) Annual PEI Component Budget by FY	Estimated Share by SB 1004 Priority					
	Childhood Trauma	Early Psychosis/ Mood	Secondary School/TAY	Culturally/ Linguistically Competent	Older Adults	Other
FY 2020-21 Proj. PEI Budget = $47,061,483 (Est. % of annual PEI Budget)	$17,631,930 (37%)	$8,026,047 (17%)	$7,411,580 (16%)	$6,988,942 (15%)	$6,698,569 (14%)	$304,415 (<1%)
FY 2021-22 Proj. PEI Allocation = $49,286,926 (Est. % of annual PEI Budget)	$18,091,164 (37%)	$8,453,942 (17%)	$7,838,421 (16%)	$7,243,166 (15%)	$7,001,185 (14%)	$659,047 (<1%)
FY 2022-23 Proj. PEI Allocation = $40,988,101 (Est. % of annual PEI Budget)	$14,083,058 (34%)	$8,420,174 (21%)	$6,079,610 (15%)	$6,051,959 (15%)	$5,689,481 (14%)	$663,818 (<2%)

Estimated Share of Annual PEI Program Budget Assigned to SB 1004 Priority, by MHSOAC PEI Program Categories

MHSOAC-Required PEI Program	Estimated Share by SB 1004 Priority					
	Childhood Trauma	Early Psychosis/ Mood	Secondary School/TAY	Culturally/ Linguistically Competent	Older Adults	Other
ACCESS AND LINKAGE TO TREATMENT						
OCLinks	20%	20%	20%	20%	20%	
BHS Outreach & Engagement			70%		30%	

MHSOAC-Required PEI Programs Names in *italics* reflect separate programs that are being consolidated into the **BOLD** program name in the Three-Year Plan. Future Plan Updates will report on the **BOLD** program name only.	Estimated Share by SB 1004 Priority					
	Childhood Trauma	Early Psychosis/ Mood	Secondary School/TAY	Culturally/ Linguistically Competent	Older Adults	Other
STIGMA AND DISCRIMINATION REDUCTION PROGRAM						
MH Community Educ. Events for Reducing Stigma & Discrimination	25%		25%	25%	25%	
OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS PROGRAM						
Beh. Health Community Training & Technical Assistance	20%	20%	20%	20%	20%	
Early Childhood Mental Health Providers Training	100%					
MH & Well-Being Promotion for Diverse Communities	25%		25%	25%	25%	
Services for TAY and Young Adults		5%	70%	25%		
K-12 School-Based MH Services Expansion	50%		25%	25%		
Statewide Projects	20%	20%	20%	20%	20%	

MHSOAC-Required PEI Programs Names in *italics* reflect separate programs that are being consolidated into the **BOLD** program name in the Three-Year Plan. Future Plan Updates will report on the **BOLD** program name only.	**Estimated Share by SB 1004 Priority**					
	Childhood Trauma	**Early Psychosis/ Mood**	**Secondary School/TAY**	**Culturally/ Linguistically Competent**	**Older Adults**	**Other**
PREVENTION PROGRAM						
School Readiness	100%					
School-Based Beh. Health Intervention & Support	100%					
School-Based Stress Management Services	100%					
Violence Prevention Education	100%					
Gang Prevention Services	100%					
Parent Education Services	100%					
Family Support Services	25%		25%	25%	25%	
Children's Support & Parenting	100%					
Transportation Assistance*						100%*
EARLY INTERVENTION PROGRAMS						
Community Counseling & Supportive Services						
Community Counseling & Supportive Services		50%	10%	30%	10%	
OC ACCEPT		30%	20%	50%		
School-Based Mental Health Services		100%				
Early Intervention Services for Older Adults					100%	
OC Parent Wellness Program						
Parent Wellness Program	40%	40%		20%		
Connect the Tots	40%	40%		20%		
Stress-Free Families	40%	40%		20%		
First Onset of Psychiatric Illness (OC CREW)		50%	50%			
Early Intervention Services for Veterans						
OC4Vets				60%	40%	
Veterans School-Based Intervention			50%	50%		
Behavioral Health Services for Military Families	50%	10%	10%	30%		

** This is a new program to the PEI Component and metrics will be developed once the scope of work and services is determined.*

MHSOAC-Optional PEI Programs Names in *italics* reflect separate programs that are being consolidated into the **BOLD** program name in the Three-Year Plan. Future Plan Updates will report on the **BOLD** program name only.	Estimated Share by SB 1004 Priority					
	Childhood Trauma	Early Psychosis/ Mood	Secondary School/TAY	Culturally/ Linguistically Competent	Older Adults	Other
SUICIDE PREVENTION						
Warmline	20%	20%	20%	20%	20%	
Suicide Prevention Services						
Crisis Prevention Hotline		25%	25%	25%	25%	
Survivor Support Services	20%	20%	20%	20%	20%	

Other Recent California Legislation Affecting PEI Programming

In addition to the MHSOAC Regulations and SB 1004, California has recently passed a number of bills that either directly affect PEI or align with PEI's general goals and purpose. These include:

- **Assembly Bill (AB) 2246 (Pupil Suicide Prevention Policies)**, effective the beginning of the 2017-18 school year, requires schools serving students in grades 7-12 to adopt policy on pupil suicide including prevention, intervention and postvention.
- **SB 972 (Pupil and Student Health: Identification cards: Suicide Prevention Hotline)**, effective July 1,2019, requires schools serving students in grades 7-12 to issue student identification cards that have the National Suicide Prevention Lifeline on the card.
- **AB 293 (Maternal Mental Health Screening and Supports)**, effective July 1, 2019, requires obstetricians to confirm that screenings for maternal depression has occurred or to screen women directly, at least once during the pregnancy or the postpartum period. It also requires private and public health plans and health insurers to create maternal health programs.
- **AB 3032 (Hospital Maternal Mental Health)**, effective Jan 1, 2020, requires hospitals to provide maternal mental health training to clinical staff who work with pregnant and postpartum women, and to educate woman and families about the signs and symptoms of maternal mental health disorders as well as local treatment options.

MHSOAC-Required Demographic Fields for PEI-Funded Programs

Mental Health & Well-Being Promotion for Diverse Communities (Outreach and Engagement Collaborative)

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
AGE GROUP	Age 0-15 (Child)	20,941	28,492	2,281
	Age 16-25 (TAY)	17,405	21,202	1,589
	Age 26-59 (Adult)	54,478	65,491	1,492
	Age 60+ (Older Adult)	7,883	14,188	766
	Decline/Unknown	0	0	775
PRIMARY LANGUGE	Arabic	647	0	40
	English	49,719	72,359	3,904
	Farsi	191	7,055	489
	Korean	276	2,897	60
	Spanish	43,643	39,362	1,034
	Vietnamese	2,285	2,801	50
	Decline/Unknown	0	0	1,071
	Other	2,276	4,032	310
SEXUAL ORIENTATION	Gay or Lesbian	0	0	32
	Heterosexual	0	0	2,192
	Bisexual	0	0	54
	Questionning	0	0	16
	Queer	0	0	6
	Decline/Unknown	0	0	2,698
	Other	0	0	9

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
RACE	American Indian/Alaska Native	94	80	135
	Asian	8,028	18,923	1,288
	Black/African American	1,796	2,302	246
	Native Hawaiian/PI	219	85	0
	White	21,199	26,849	1,960
	Multi-Race	0	0	0
	Decline/Unknown	0	0	733
	Other	5,490	8,832	3,015
ETHNICITY	Hispanic/Latino	59,649		3,015
	Non-Hispanic/Non-Latino	12,312	14,433	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	30,144	49,473	2,583
	Female	50,691	81,546	3,761
	Decline/Unknown	0	0	564
	Other	0	1,395	3
DISABILITY	Disability "Yes"	1,429	0	570
	Disability "No"	0	0	2,053
	Decline/Unknown	0	0	2,512
VETERAN STATUS	Veteran "Yes"	689	0	36
	Veteran "No"	0	0	2,258
	Decline/Unknown	0	0	2,404

2/21/2020 1:57:21 PM

Prevention Mental Health & Well-Being Promotion: School Readiness

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
AGE GROUP	Age 0-15 (Child)	546	1	961
	Age 16-25 (TAY)	0	44	73
	Age 26-59 (Adult)	0	733	841
	Age 60+ (Older Adult)	0	16	5
	Decline/Unknown	0	0	0
PRIMARY LANGUGE	Arabic	3	15	20
	English	261	229	834
	Farsi	4	1	22
	Korean	0	2	0
	Spanish	271	459	885
	Vietnamese	0	96	43
	Decline/Unknown	3	0	27
	Other	4	5	62
SEXUAL ORIENTATION	Gay or Lesbian	0	0	6
	Heterosexual	0	0	1,487
	Bisexual	0	0	3
	Questionning	0	0	0
	Queer	0	0	0
	Decline/Unknown	0	0	173
	Other	0	0	0

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
RACE	American Indian/Alaska Native	2	9	8
	Asian	56	118	176
	Black/African American	1	11	40
	Native Hawaiian/PI	0	4	4
	White	92	100	333
	Multi-Race	0	0	0
	Decline/Unknown	27	0	24
	Other	22	8	1,426
ETHNICITY	Hispanic/Latino	346	558	1,408
	Non-Hispanic/Non-Latino	78	0	18
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	339	0	754
	Female	206	0	916
	Decline/Unknown	1	0	15
	Other	0	0	0
DISABILITY	Disability "Yes"	0	0	78
	Disability "No"	0	0	1,576
	Decline/Unknown	0	0	38
VETERAN STATUS	Veteran "Yes"	0	0	5
	Veteran "No"	0	0	1,295
	Decline/Unknown	0	0	69

2/21/2020 2:01:37 PM

Prevention Mental Health & Well-Being Promotion: School-Based Behavioral Health Intervention & Supports

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
AGE GROUP	Age 0-15 (Child)	9,871	5,819	11,651
	Age 16-25 (TAY)	365	206	179
	Age 26-59 (Adult)	0	0	91
	Age 60+ (Older Adult)	0	0	2
	Decline/Unknown	0	0	1
PRIMARY LANGUGE	Arabic	26	14	51
	English	8,920	5,341	8,500
	Farsi	6	5	4
	Korean	6	29	14
	Spanish	903	492	2,932
	Vietnamese	43	159	84
	Decline/Unknown	0	0	63
	Other	179	80	263
SEXUAL ORIENTATION	Gay or Lesbian	0	0	42
	Heterosexual	0	0	1,951
	Bisexual	0	0	118
	Questionning	0	0	39
	Queer	0	0	6
	Decline/Unknown	0	0	445
	Other	0	0	27

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
RACE	American Indian/Alaska Native	182	90	695
	Asian	619	409	1,573
	Black/African American	76	9	304
	Native Hawaiian/PI	45	14	260
	White	1,499	792	5,267
	Multi-Race	0	0	
	Decline/Unknown	0	569	1,326
	Other	908	0	7,174
ETHNICITY	Hispanic/Latino	4,084	2,492	7,115
	Non-Hispanic/Non-Latino	1,537	0	59
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	5,563	0	5,797
	Female	5,237	0	5,976
	Decline/Unknown	67	0	182
	Other	0	0	4
DISABILITY	Disability "Yes"	0	0	496
	Disability "No"	0	0	1,952
	Decline/Unknown	0	0	223
VETERAN STATUS	Veteran "Yes"	0	0	1
	Veteran "No"	0	0	85
	Decline/Unknown	0	0	5

2/21/2020 2:02:27 PM

Prevention Mental Health & Well-Being Promotion: School-Based Stress Management Services

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
AGE GROUP	Age 0-15 (Child)	1,108	171	1,849
	Age 16-25 (TAY)	481	841	576
	Age 26-59 (Adult)	59	69	0
	Age 60+ (Older Adult)	4	7	0
	Decline/Unknown	0	0	0
PRIMARY LANGUGE	Arabic	0	31	4
	English	0	1,745	2,060
	Farsi	0	22	3
	Korean	0	83	12
	Spanish	0	355	239
	Vietnamese	0	156	45
	Decline/Unknown	0	0	7
	Other	0	275	68
SEXUAL ORIENTATION	Gay or Lesbian	0	0	1
	Heterosexual	0	0	71
	Bisexual	0	0	2
	Questionning	0	0	0
	Queer	0	0	1
	Decline/Unknown	0	0	3
	Other	0	0	0

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
RACE	American Indian/Alaska Native	24	14	123
	Asian	52	953	589
	Black/African American	50	66	89
	Native Hawaiian/PI	3	30	39
	White	464	543	628
	Multi-Race	0	0	0
	Decline/Unknown	0	0	0
	Other	195	0	0
ETHNICITY	Hispanic/Latino	646	609	1,364
	Non-Hispanic/Non-Latino	243	0	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	793	1,224	1,154
	Female	844	1,442	1,319
	Decline/Unknown	0	0	30
	Other	0	0	0
DISABILITY	Disability "Yes"	0	0	2
	Disability "No"	0	0	35
	Decline/Unknown	0	0	4
VETERAN STATUS	Veteran "Yes"	0	0	0
	Veteran "No"	0	0	78
	Decline/Unknown	0	0	0

2/21/2020 2:03:08 PM

Prevention Violence & Bullying Prevention: Violence Prevention Education

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
AGE GROUP	Age 0-15 (Child)	10,926	7,486	9,375
	Age 16-25 (TAY)	950	1,579	1,060
	Age 26-59 (Adult)	1,406	1,341	1,896
	Age 60+ (Older Adult)	50	66	137
	Decline/Unknown	0	0	393
PRIMARY LANGUGE	Arabic	49	45	52
	English	7,431	5,642	7,707
	Farsi	32	41	52
	Korean	178	180	212
	Spanish	3,690	3,102	3,121
	Vietnamese	308	159	640
	Decline/Unknown	0		0
	Other	518	498	0
SEXUAL ORIENTATION	Gay or Lesbian	0	0	0
	Heterosexual	0	0	0
	Bisexual	0	0	0
	Questionning	0	0	0
	Queer	0	0	0
	Decline/Unknown	0	0	0
	Other	0	0	0

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
RACE	American Indian/Alaska Native	250	180	526
	Asian	1,446	1,143	2,879
	Black/African American	249	173	454
	Native Hawaiian/PI	73	51	242
	White	2,180	1,656	2,295
	Multi-Race	0	0	0
	Decline/Unknown	0	0	1,202
	Other	2,235	834	7,335
ETHNICITY	Hispanic/Latino	6,220	5,281	6,918
	Non-Hispanic/Non-Latino	3,623	0	417
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	5,764	4,358	0
	Female	6,995	5,525	0
	Decline/Unknown	0	0	0
	Other	2	2	0
DISABILITY	Disability "Yes"	0	0	0
	Disability "No"	0	0	0
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	0	0	0
	Veteran "No"	0	0	0
	Decline/Unknown	0	0	0

2/21/2020 2:04:08 PM

Prevention Violence & Bullying Prevention: Gang Prevention Services

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
AGE GROUP	Age 0-15 (Child)	426	427	441
	Age 16-25 (TAY)	4	18	3
	Age 26-59 (Adult)	419	407	431
	Age 60+ (Older Adult)	3	2	7
	Decline/Unknown	0	0	0
PRIMARY LANGUGE	Arabic	2	0	0
	English	353	345	535
	Farsi	0	0	0
	Korean	2	0	0
	Spanish	493	509	344
	Vietnamese	2	0	1
	Decline/Unknown	0	0	0
	Other	0	0	2
SEXUAL ORIENTATION	Gay or Lesbian	0	0	0
	Heterosexual	0	0	0
	Bisexual	0	0	0
	Questionning	0	0	0
	Queer	0	0	0
	Decline/Unknown	852	0	0
	Other	0	0	0

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
RACE	American Indian/Alaska Native	0	0	3
	Asian	4	10	12
	Black/African American	6	16	16
	Native Hawaiian/PI	6	22	7
	White	26	42	31
	Multi-Race	0	0	0
	Decline/Unknown	0	0	0
	Other	8	2	1,203
ETHNICITY	Hispanic/Latino	802	762	1,203
	Non-Hispanic/Non-Latino	12	0	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	334	346	358
	Female	518	508	524
	Decline/Unknown	0	0	0
	Other	0	0	0
DISABILITY	Disability "Yes"	0	0	2
	Disability "No"	0	0	0
	Decline/Unknown	852	0	0
VETERAN STATUS	Veteran "Yes"	0	0	0
	Veteran "No"	852	0	0
	Decline/Unknown		0	0

2/21/2020 2:03:36 PM

Parent Education Services

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
AGE GROUP	Age 0-15 (Child)	8	1	98
	Age 16-25 (TAY)	470	44	1,524
	Age 26-59 (Adult)	1,727	733	46
	Age 60+ (Older Adult)	35	16	154
	Decline/Unknown	77	0	0
PRIMARY LANGUGE	Arabic	4	15	59
	English	1,739	229	483
	Farsi	7	1	11
	Korean	2	2	68
	Spanish	430	459	921
	Vietnamese	1	96	131
	Decline/Unknown	88	0	0
	Other	46	5	44
SEXUAL ORIENTATION	Gay or Lesbian	0	0	2
	Heterosexual	0	0	1,170
	Bisexual	0	0	12
	Questionning	0	0	0
	Queer	0	0	2
	Decline/Unknown	0	0	586
	Other	21	0	5

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
RACE	American Indian/Alaska Native	27	9	21
	Asian	106	118	323
	Black/African American	60	11	43
	Native Hawaiian/PI	9	4	12
	White	883	100	259
	Multi-Race	0	0	0
	Decline/Unknown	86	0	106
	Other	74	8	1,759
ETHNICITY	Hispanic/Latino	1,071	558	1,748
	Non-Hispanic/Non-Latino	190	0	11
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	1,052	0	364
	Female	1,246	0	1,375
	Decline/Unknown	11	0	88
	Other	8	0	1
DISABILITY	Disability "Yes"	62	0	263
	Disability "No"	0	0	1,412
	Decline/Unknown	0	0	203
VETERAN STATUS	Veteran "Yes"	22	0	21
	Veteran "No"	0	0	1,499
	Decline/Unknown	0	0	304

2/21/2020 2:01:01 PM

Family Support Services

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
AGE GROUP	Age 0-15 (Child)	151	192	1
	Age 16-25 (TAY)	187	191	36
	Age 26-59 (Adult)	1,340	361	320
	Age 60+ (Older Adult)	63	154	143
	Decline/Unknown	0	0	106
PRIMARY LANGUGE	Arabic	2	4	0
	English	450	509	483
	Farsi	61	3	5
	Korean	2	3	0
	Spanish	597	56	51
	Vietnamese	123	4	1
	Decline/Unknown	479	0	56
	Other	27	20	13
SEXUAL ORIENTATION	Gay or Lesbian	0	0	5
	Heterosexual	0	0	231
	Bisexual	0	0	4
	Questionning	0	0	1
	Queer	0	0	3
	Decline/Unknown	0	0	367
	Other	0	0	1

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
RACE	American Indian/Alaska Native	22	9	15
	Asian	195	69	51
	Black/African American	22	13	24
	Native Hawaiian/PI	4	4	4
	White	308	332	331
	Multi-Race	0	0	0
	Decline/Unknown	258		85
	Other	117	19	135
ETHNICITY	Hispanic/Latino	821	56	124
	Non-Hispanic/Non-Latino	317	54	11
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	381	318	182
	Female	1,360	569	341
	Decline/Unknown	0	0	89
	Other	0	4	0
DISABILITY	Disability "Yes"	26	0	260
	Disability "No"	0	0	156
	Decline/Unknown	0	0	276
VETERAN STATUS	Veteran "Yes"	1	0	13
	Veteran "No"	0	0	265
	Decline/Unknown	0	0	332

2/21/2020 1:56:23 PM

Children's Support & Parenting Program

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
AGE GROUP	Age 0-15 (Child)	177	133	295
	Age 16-25 (TAY)	35	54	60
	Age 26-59 (Adult)	269	265	499
	Age 60+ (Older Adult)	6	4	21
	Decline/Unknown	2	0	0
PRIMARY LANGUGE	Arabic	1	3	2
	English	291	288	364
	Farsi	1	2	1
	Korean	1	0	0
	Spanish	189	136	475
	Vietnamese	2	1	10
	Decline/Unknown	1	8	12
	Other	3	18	13
SEXUAL ORIENTATION	Gay or Lesbian	4	6	6
	Heterosexual	424	376	726
	Bisexual	6	5	7
	Questionning	1	1	1
	Queer	0	0	4
	Decline/Unknown	53	58	128
	Other	1	4	3

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
RACE	American Indian/Alaska Native	3	6	15
	Asian	18	20	32
	Black/African American	4	10	12
	Native Hawaiian/PI	0	1	2
	White	39	59	0
	Multi-Race	1	0	0
	Decline/Unknown	2	7	6
	Other	21	29	747
ETHNICITY	Hispanic/Latino	401	324	743
	Non-Hispanic/Non-Latino	39	51	4
	More than one ethnicity	0	0	0
	Decline/Unknown	0	6	0
GENDER	Male	181	159	0
	Female	308	289	0
	Decline/Unknown	0	6	0
	Other	0	2	0
DISABILITY	Disability "Yes"	27	0	0
	Disability "No"	462	0	0
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	26	40	5
	Veteran "No"	351	345	639
	Decline/Unknown	112	69	62

2/21/2020 1:54:51 PM

Information and Referral / OC Links

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
AGE GROUP	Age 0-15 (Child)	10	15	25
	Age 16-25 (TAY)	1,545	1,666	1,658
	Age 26-59 (Adult)	8,468	10,357	10,570
	Age 60+ (Older Adult)	1,454	1,900	1,856
	Decline/Unknown	2,675	3,571	4,019
PRIMARY LANGUGE	Arabic	8	6	9
	English	12,768	15,507	15,820
	Farsi	53	92	152
	Korean	18	93	82
	Spanish	1,100	1,522	1,774
	Vietnamese	168	234	225
	Decline/Unknown	3	6	1
	Other	34	49	65
SEXUAL ORIENTATION	Gay or Lesbian	0	0	0
	Heterosexual	0	0	0
	Bisexual	0	0	0
	Questionning	0	0	0
	Queer	0	0	0
	Decline/Unknown	0	0	0
	Other	32	13	19

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
RACE	American Indian/Alaska Native	57	89	91
	Asian	839	1,168	1,165
	Black/African American	382	540	511
	Native Hawaiian/PI	38	35	42
	White	5,889	6,833	6,497
	Multi-Race	0	0	0
	Decline/Unknown	2,705	3,587	4,222
	Other	4,242	5,257	5,600
ETHNICITY	Hispanic/Latino	4,242	5,257	5,600
	Non-Hispanic/Non-Latino	948	1,426	1,273
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	5,007	5,998	6,354
	Female	9,120	11,450	11,700
	Decline/Unknown	16	47	40
	Other	9	14	34
DISABILITY	Disability "Yes"	9	10	12
	Disability "No"	0	0	0
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	17	44	25
	Veteran "No"	0	0	0
	Decline/Unknown	0	0	0

3/25/2020 7:20:34 AM

BHS Outreach & Engagement Services

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
AGE GROUP	Age 0-15 (Child)	669	138	116
	Age 16-25 (TAY)	2,069	1,628	1,234
	Age 26-59 (Adult)	26,068	25,303	24,388
	Age 60+ (Older Adult)	6,750	5,839	6,164
	Decline/Unknown	354	3,936	216
PRIMARY LANGUGE	Arabic	0	8	0
	English	28,617	30,027	24,719
	Farsi	69	56	63
	Korean	12	14	9
	Spanish	5,669	3,624	4,196
	Vietnamese	1,430	2,719	1,906
	Decline/Unknown	48	327	27
	Other	65	69	100
SEXUAL ORIENTATION	Gay or Lesbian	0	0	0
	Heterosexual	0	0	0
	Bisexual	0	0	0
	Questionning	0	0	0
	Queer	0	0	0
	Decline/Unknown	0	0	0
	Other	0	0	0

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
RACE	American Indian/Alaska Native	0	0	0
	Asian	2,385	3,615	2,602
	Black/African American	5,156	3,460	2,772
	Native Hawaiian/PI	0	0	0
	White	15,553	15,001	15,473
	Multi-Race	0	0	8
	Decline/Unknown	0	4,394	1,882
	Other	231	198	10,937
ETHNICITY	Hispanic/Latino	12,184	10,176	10,814
	Non-Hispanic/Non-Latino	0	0	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	22,113	19,691	19,442
	Female	13,697	13,846	12,503
	Decline/Unknown	66	3,292	0
	Other	0	2	93
DISABILITY	Disability "Yes"	0	0	0
	Disability "No"	0	0	0
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	0	0	0
	Veteran "No"	0	0	0
	Decline/Unknown	0	0	0

2/21/2020 1:54:27 PM

Warmline

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
AGE GROUP	Age 0-15 (Child)	67	44	28,270
	Age 16-25 (TAY)	1,891	2,184	57
	Age 26-59 (Adult)	21,025	22,360	1,808
	Age 60+ (Older Adult)	7,219	8,908	9,721
	Decline/Unknown	5,879	0	2,491
PRIMARY LANGUGE	Arabic	20	6	6
	English	35,389	37,028	23,049
	Farsi	14	2	6
	Korean	4	0	1
	Spanish	153	137	133
	Vietnamese	1	4	0
	Decline/Unknown	0	0	0
	Other	39	18	23
SEXUAL ORIENTATION	Gay or Lesbian	0	0	0
	Heterosexual	0	0	0
	Bisexual	0	0	0
	Questionning	0	0	0
	Queer	0	0	0
	Decline/Unknown	0	0	0
	Other	0	0	560

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
RACE	American Indian/Alaska Native	0	0	0
	Asian	0	0	0
	Black/African American	0	0	0
	Native Hawaiian/PI	0	0	0
	White	0	0	0
	Multi-Race	0	0	0
	Decline/Unknown	0	0	0
	Other	0	0	0
ETHNICITY	Hispanic/Latino	0	0	0
	Non-Hispanic/Non-Latino	0	0	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	16,234	16,120	0
	Female	19,056	20,751	0
	Decline/Unknown	0	0	0
	Other	0	0	0
DISABILITY	Disability "Yes"	0	0	1,302
	Disability "No"	0	0	6,363
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	401	0	0
	Veteran "No"	0	0	0
	Decline/Unknown	0	0	0

2/21/2020 2:14:34 PM

Suicide Prevention (Crisis Prevention Hotline)

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
AGE GROUP	Age 0-15 (Child)	414	0	663
	Age 16-25 (TAY)	1,923	2,737	2,923
	Age 26-59 (Adult)	1,872	2,415	3,108
	Age 60+ (Older Adult)	219	298	483
	Decline/Unknown	0	0	0
PRIMARY LANGUGE	Arabic	0	0	0
	English	0	10,970	0
	Farsi	0	0	0
	Korean	8	4	11
	Spanish	9	630	370
	Vietnamese	4	3	2
	Decline/Unknown	477	0	0
	Other	0	0	2
SEXUAL ORIENTATION	Gay or Lesbian	0	0	0
	Heterosexual	0	0	0
	Bisexual	0	0	0
	Questionning	0	0	0
	Queer	0	0	0
	Decline/Unknown	0	0	0
	Other	0	0	0

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
RACE	American Indian/Alaska Native	24	34	21
	Asian	0	350	1,219
	Black/African American	193	252	241
	Native Hawaiian/PI	23	32	60
	White	1,985	2,261	2,654
	Multi-Race	0	0	0
	Decline/Unknown	0	0	0
	Other	795	323	2,082
ETHNICITY	Hispanic/Latino	985	1,600	1,796
	Non-Hispanic/Non-Latino	795	0	286
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	2,487	4,606	0
	Female	3,244	6,454	0
	Decline/Unknown	0	0	0
	Other	0	8	0
DISABILITY	Disability "Yes"	1,919	0	0
	Disability "No"	0	0	0
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	117	0	0
	Veteran "No"	0	0	0
	Decline/Unknown	0	0	0

2/21/2020 2:11:47 PM

Suicide Prevention (Survivor Support Services)

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
AGE GROUP	Age 0-15 (Child)	12	10	7
	Age 16-25 (TAY)	18	16	8
	Age 26-59 (Adult)	85	96	76
	Age 60+ (Older Adult)	17	25	25
	Decline/Unknown	0	0	0
PRIMARY LANGUGE	Arabic	5	1	0
	English	99	122	116
	Farsi	3	2	1
	Korean	3	4	2
	Spanish	19	17	13
	Vietnamese	0	0	0
	Decline/Unknown	2	0	0
	Other	1	2	0
SEXUAL ORIENTATION	Gay or Lesbian	0	0	2
	Heterosexual	0	0	87
	Bisexual	0	0	2
	Questionning	0	0	1
	Queer	0	0	0
	Decline/Unknown	0	0	30
	Other	4	0	0

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
RACE	American Indian/Alaska Native	1	1	5
	Asian	13	19	14
	Black/African American	0	0	2
	Native Hawaiian/PI	2	1	4
	White	48	74	77
	Multi-Race	0	0	0
	Decline/Unknown	8	0	11
	Other	15	8	39
ETHNICITY	Hispanic/Latino	45	17	37
	Non-Hispanic/Non-Latino	38	0	2
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	38	0	31
	Female	94	0	98
	Decline/Unknown	0	0	6
	Other	0	0	0
DISABILITY	Disability "Yes"	39	0	0
	Disability "No"	0	0	0
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	0	0	1
	Veteran "No"	0	0	95
	Decline/Unknown	0	0	33

2/21/2020 2:12:20 PM

Community Counseling and Supportive Services – General Unit (originally CCSS)

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
AGE GROUP	Age 0-15 (Child)	34	29	14
	Age 16-25 (TAY)	73	87	73
	Age 26-59 (Adult)	344	357	312
	Age 60+ (Older Adult)	16	19	18
	Decline/Unknown	0	0	0
PRIMARY LANGUGE	Arabic	9	29	24
	English	161	181	163
	Farsi	0	2	1
	Korean	3	0	0
	Spanish	290	260	202
	Vietnamese	3	7	5
	Decline/Unknown	0	0	0
	Other	1	13	7
SEXUAL ORIENTATION	Gay or Lesbian	15	0	0
	Heterosexual	271	25	0
	Bisexual	9	1	0
	Questionning	1	0	0
	Queer	0	0	0
	Decline/Unknown	94	9	0
	Other	1	1	0

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
RACE	American Indian/Alaska Native	1	7	4
	Asian	33	33	23
	Black/African American	4	5	5
	Native Hawaiian/PI	7	3	3
	White	27	61	48
	Multi-Race	0	0	0
	Decline/Unknown	12	9	7
	Other	22	35	283
ETHNICITY	Hispanic/Latino	361	339	283
	Non-Hispanic/Non-Latino	62	28	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	140	149	120
	Female	326	343	297
	Decline/Unknown	1	0	0
	Other	0	0	0
DISABILITY	Disability "Yes"	0	0	0
	Disability "No"	0	0	0
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	37	43	8
	Veteran "No"	392	415	343
	Decline/Unknown	38	2	35

5/7/2020 7:15:16 PM

Community Counseling and Supportive Services – LGBTIQ Unit (originally OC ACCEPT)

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
AGE GROUP	Age 0-15 (Child)	12	21	15
	Age 16-25 (TAY)	42	49	27
	Age 26-59 (Adult)	56	46	35
	Age 60+ (Older Adult)	11	5	2
	Decline/Unknown	0	0	0
PRIMARY LANGUGE	Arabic	0	0	0
	English	98	100	66
	Farsi	2	1	0
	Korean	0	1	0
	Spanish	18	18	12
	Vietnamese	3	0	0
	Decline/Unknown	0	0	0
	Other	0	1	1
SEXUAL ORIENTATION	Gay or Lesbian	39	0	0
	Heterosexual	15	1	0
	Bisexual	11	0	0
	Questionning	3	0	0
	Queer	0	0	0
	Decline/Unknown	6	0	0
	Other	5	3	0

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
RACE	American Indian/Alaska Native	1	2	0
	Asian	9	9	7
	Black/African American	5	7	3
	Native Hawaiian/PI	0	0	0
	White	37	30	27
	Multi-Race	0	0	0
	Decline/Unknown	16	0	7
	Other	3	6	0
ETHNICITY	Hispanic/Latino	47	53	33
	Non-Hispanic/Non-Latino	15	11	1
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	70	56	0
	Female	46	44	0
	Decline/Unknown	3	3	0
	Other	2	18	0
DISABILITY	Disability "Yes"	0	0	0
	Disability "No"	0	0	0
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	21	15	2
	Veteran "No"	82	92	56
	Decline/Unknown	18		9

5/7/2020 7:16:25 PM

School-Based Mental Health Services - Early Intervention

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
AGE GROUP	Age 0-15 (Child)	623	612	672
	Age 16-25 (TAY)	0	0	0
	Age 26-59 (Adult)	0	0	0
	Age 60+ (Older Adult)	0	0	0
	Decline/Unknown	0	0	0
PRIMARY LANGUGE	Arabic	0	0	0
	English	388	415	467
	Farsi	1	0	0
	Korean	0	0	0
	Spanish	234	195	203
	Vietnamese	0	0	0
	Decline/Unknown	0	0	0
	Other	0	2	2
SEXUAL ORIENTATION	Gay or Lesbian	2	0	0
	Heterosexual	492	69	0
	Bisexual	8	2	0
	Questionning	9	1	0
	Queer	0	0	0
	Decline/Unknown	28	6	0
	Other	10	2	0

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
RACE	American Indian/Alaska Native	1	2	1
	Asian	6	6	11
	Black/African American	3	3	7
	Native Hawaiian/PI	0	0	2
	White	4	12	18
	Multi-Race	0	0	0
	Decline/Unknown	9	0	22
	Other	6	6	0
ETHNICITY	Hispanic/Latino	594	561	594
	Non-Hispanic/Non-Latino	12	0	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	282	259	0
	Female	341	352	0
	Decline/Unknown	0	0	0
	Other	0	0	0
DISABILITY	Disability "Yes"	0	0	0
	Disability "No"	0	0	0
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	0	0	1
	Veteran "No"	0	0	565
	Decline/Unknown	0	0	82

2/21/2020 1:40:20 PM

School-Based Mental Health Services – Prevention (formerly Track 2, now part of Early Intervention)

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
AGE GROUP	Age 0-15 (Child)	1,646	968	2,003
	Age 16-25 (TAY)	385	247	287
	Age 26-59 (Adult)	0	144	0
	Age 60+ (Older Adult)	0	3	0
	Decline/Unknown	0	0	1
PRIMARY LANGUGE	Arabic	4	3	8
	English	1,906	1,120	2,076
	Farsi	11	3	1
	Korean	5	6	3
	Spanish	44	151	143
	Vietnamese	1	24	5
	Decline/Unknown	0	0	10
	Other	68	54	45
SEXUAL ORIENTATION	Gay or Lesbian	0	0	0
	Heterosexual	0	0	0
	Bisexual	0	0	0
	Questionning	0	0	0
	Queer	0	0	0
	Decline/Unknown	0	0	0
	Other	0	0	0

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
RACE	American Indian/Alaska Native	50	27	37
	Asian	152	123	180
	Black/African American	60	13	29
	Native Hawaiian/PI	9	8	10
	White	871	279	445
	Multi-Race	0	0	0
	Decline/Unknown	46	0	44
	Other	347	169	1,452
ETHNICITY	Hispanic/Latino	589	737	1,452
	Non-Hispanic/Non-Latino	405	0	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	1,195	0	0
	Female	829	0	0
	Decline/Unknown	0	0	0
	Other	0	0	0
DISABILITY	Disability "Yes"	0	0	0
	Disability "No"	0	0	0
	Decline/Unknown	2,039	0	0
VETERAN STATUS	Veteran "Yes"	0	0	2
	Veteran "No"	0	0	1,870
	Decline/Unknown	0	0	192

5/7/2020 7:19:15 PM

Early Intervention Services for Older Adults

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
AGE GROUP	Age 0-15 (Child)	0	0	0
	Age 16-25 (TAY)	0	0	0
	Age 26-59 (Adult)	2	3	3
	Age 60+ (Older Adult)	523	598	506
	Decline/Unknown	11	0	0
PRIMARY LANGUGE	Arabic	46	35	27
	English	117	127	152
	Farsi	27	52	30
	Korean	38	31	25
	Spanish	140	138	100
	Vietnamese	95	119	98
	Decline/Unknown	3	0	0
	Other	70	99	73
SEXUAL ORIENTATION	Gay or Lesbian	0	0	3
	Heterosexual	0	0	298
	Bisexual	0	0	0
	Questionning	0	0	1
	Queer	0	0	0
	Decline/Unknown	0	0	58
	Other	1	0	1

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
RACE	American Indian/Alaska Native	0	0	0
	Asian	199	234	126
	Black/African American	8	7	12
	Native Hawaiian/PI	1	1	0
	White	102	193	179
	Multi-Race	0	0	0
	Decline/Unknown	2	0	0
	Other	75	8	114
ETHNICITY	Hispanic/Latino	148	154	114
	Non-Hispanic/Non-Latino	276	242	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	151	172	284
	Female	383	429	93
	Decline/Unknown	2	0	0
	Other	0	0	0
DISABILITY	Disability "Yes"	536	0	1,193
	Disability "No"	177	0	34
	Decline/Unknown	9	0	5
VETERAN STATUS	Veteran "Yes"	31	0	14
	Veteran "No"	257	0	470
	Decline/Unknown	7	0	7

2/21/2020 1:55:57 PM

OC Parent Wellness Program (Track 1: new/expecting parents, Track 2: parents of young, at-risk children)

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
AGE GROUP	Age 0-15 (Child)	4	9	7
	Age 16-25 (TAY)	150	167	155
	Age 26-59 (Adult)	376	330	377
	Age 60+ (Older Adult)	0	0	0
	Decline/Unknown	0	0	0
PRIMARY LANGUGE	Arabic	4	4	6
	English	256	271	285
	Farsi	4	2	3
	Korean	0	1	2
	Spanish	256	216	223
	Vietnamese	6	4	6
	Decline/Unknown	0	0	0
	Other	4	8	14
SEXUAL ORIENTATION	Gay or Lesbian	2	0	0
	Heterosexual	406	48	0
	Bisexual	5	1	0
	Questionning	1	0	0
	Queer	0	0	0
	Decline/Unknown	1	0	0
	Other	1	1	0

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
RACE	American Indian/Alaska Native	2	1	0
	Asian	38	20	27
	Black/African American	7	8	11
	Native Hawaiian/PI	9	10	5
	White	58	69	71
	Multi-Race	0	0	0
	Decline/Unknown	6	2	0
	Other	21	11	419
ETHNICITY	Hispanic/Latino	389	394	402
	Non-Hispanic/Non-Latino	73	20	17
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	1	5	0
	Female	529	500	0
	Decline/Unknown	0	1	0
	Other	0	0	0
DISABILITY	Disability "Yes"	0	0	0
	Disability "No"	0	0	0
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	41	41	2
	Veteran "No"	468	449	477
	Decline/Unknown	21	0	25

5/7/2020 7:21:17 PM

OC Parent Wellness Program (Track 3: parents referred by SSA)

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
AGE GROUP	Age 0-15 (Child)	0	0	10
	Age 16-25 (TAY)	6	12	132
	Age 26-59 (Adult)	109	130	0
	Age 60+ (Older Adult)	2	6	5
	Decline/Unknown	0	0	0
PRIMARY LANGUGE	Arabic	0	0	0
	English	46	59	59
	Farsi	0	0	0
	Korean	0	0	0
	Spanish	65	79	81
	Vietnamese	4	8	5
	Decline/Unknown	0	0	0
	Other	2	2	2
SEXUAL ORIENTATION	Gay or Lesbian	1	0	0
	Heterosexual	76	0	0
	Bisexual	0	0	0
	Questionning	0	0	0
	Queer	0	0	0
	Decline/Unknown	40	0	0
	Other	0	0	0

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
RACE	American Indian/Alaska Native	0	0	0
	Asian	28	16	11
	Black/African American	1	0	4
	Native Hawaiian/PI	1	1	0
	White	12	15	0
	Multi-Race	0	0	1
	Decline/Unknown	4	0	3
	Other	2	0	0
ETHNICITY	Hispanic/Latino	89	109	105
	Non-Hispanic/Non-Latino	9	0	1
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	14	0	0
	Female	103	0	0
	Decline/Unknown	0	0	0
	Other	0	0	0
DISABILITY	Disability "Yes"	0	0	0
	Disability "No"	0	0	0
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	14	0	1
	Veteran "No"	96	0	133
	Decline/Unknown	7	0	1

5/7/2020 7:23:07 PM

First Onset of Psychiatric Illness (OC CREW)

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
AGE GROUP	Age 0-15 (Child)	16	32	16
	Age 16-25 (TAY)	66	59	56
	Age 26-59 (Adult)	0	0	1
	Age 60+ (Older Adult)	0	0	0
	Decline/Unknown	0	91	0
PRIMARY LANGUGE	Arabic	0	0	0
	English	67	69	54
	Farsi	0	0	0
	Korean	2	3	3
	Spanish	12	16	13
	Vietnamese	1	1	1
	Decline/Unknown	0	0	0
	Other	0	2	2
SEXUAL ORIENTATION	Gay or Lesbian	2	0	0
	Heterosexual	52	1	0
	Bisexual	4	0	0
	Questionning	0	0	0
	Queer	0	0	0
	Decline/Unknown	21	1	0
	Other	3	0	0

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
RACE	American Indian/Alaska Native	0	0	0
	Asian	10	14	13
	Black/African American	2	2	2
	Native Hawaiian/PI	1	1	1
	White	22	21	16
	Multi-Race	0	0	0
	Decline/Unknown	0	91	1
	Other	7	9	49
ETHNICITY	Hispanic/Latino	40	44	33
	Non-Hispanic/Non-Latino	18	26	16
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	
GENDER	Male	59	58	41
	Female	23	33	32
	Decline/Unknown	0	0	0
	Other	0	0	0
DISABILITY	Disability "Yes"	0	0	0
	Disability "No"	0	0	0
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	0	0	8
	Veteran "No"	0	2	54
	Decline/Unknown	0	0	11

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Early Intervention Veteran Services - Community Locations (formerly OC4Vets)

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
AGE GROUP	Age 0-15 (Child)	0	0	0
	Age 16-25 (TAY)	7	6	4
	Age 26-59 (Adult)	93	46	56
	Age 60+ (Older Adult)	39	8	12
	Decline/Unknown	0	0	0
PRIMARY LANGUGE	Arabic	0	0	0
	English	133	58	64
	Farsi	0	0	0
	Korean	1	0	0
	Spanish	3	0	2
	Vietnamese	0	0	0
	Decline/Unknown	0	0	6
	Other	2	0	0
SEXUAL ORIENTATION	Gay or Lesbian	1	0	0
	Heterosexual	114	6	0
	Bisexual	2	0	0
	Questionning	1	0	0
	Queer	0	0	0
	Decline/Unknown	7	54	0
	Other	0	0	0

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
RACE	American Indian/Alaska Native	2	1	0
	Asian	9	2	3
	Black/African American	11	7	5
	Native Hawaiian/PI	1	0	0
	White	68	21	12
	Multi-Race	0	0	0
	Decline/Unknown	16	0	41
	Other	4	1	11
ETHNICITY	Hispanic/Latino	44	14	10
	Non-Hispanic/Non-Latino	13	0	3
	More than one ethnicity	0	0	7
	Decline/Unknown	0	0	0
GENDER	Male	106	47	52
	Female	32	12	16
	Decline/Unknown	1	0	4
	Other		0	0
DISABILITY	Disability "Yes"	0	0	0
	Disability "No"	0	0	0
	Decline/Unknown	139	0	0
VETERAN STATUS	Veteran "Yes"	131	52	54
	Veteran "No"	4	5	1
	Decline/Unknown	4	3	17

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Early Intervention Veteran Services - Community Locations (formerly OC4 Vets-Veterans Court)

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
AGE GROUP	Age 0-15 (Child)	0	0	0
	Age 16-25 (TAY)	4	4	6
	Age 26-59 (Adult)	29	38	38
	Age 60+ (Older Adult)	1	2	2
	Decline/Unknown	0	0	0
PRIMARY LANGUGE	Arabic	0	0	0
	English	32	42	44
	Farsi	0	0	0
	Korean	0	0	0
	Spanish	2	1	1
	Vietnamese	0	0	0
	Decline/Unknown	0	0	1
	Other	0	0	0
SEXUAL ORIENTATION	Gay or Lesbian	0	0	0
	Heterosexual	30	1	0
	Bisexual	0	0	0
	Questionning	0	0	0
	Queer	0	0	0
	Decline/Unknown	4	0	0
	Other	0	0	0

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
RACE	American Indian/Alaska Native	0	0	0
	Asian	2	1	1
	Black/African American	2	1	0
	Native Hawaiian/PI	0	0	1
	White	13	14	23
	Multi-Race	0		0
	Decline/Unknown	5		10
	Other	2	1	11
ETHNICITY	Hispanic/Latino	10		7
	Non-Hispanic/Non-Latino	4	2	2
	More than one ethnicity	0	0	7
	Decline/Unknown	0	0	0
GENDER	Male	33	42	41
	Female	1	0	4
	Decline/Unknown	0	0	1
	Other		0	0
DISABILITY	Disability "Yes"	0	0	0
	Disability "No"	0	0	0
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	28	38	35
	Veteran "No"	4	3	5
	Decline/Unknown	2	3	6

5/15/2020 6:16:37 AM

Early Intervention Veteran Services - College Locations (formerly College Veterans Program)

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19
AGE GROUP	Age 0-15 (Child)	0	0
	Age 16-25 (TAY)	3	25
	Age 26-59 (Adult)	11	52
	Age 60+ (Older Adult)	0	4
	Decline/Unknown	0	1
PRIMARY LANGUGE	Arabic	0	0
	English	14	77
	Farsi	0	0
	Korean	0	0
	Spanish	0	1
	Vietnamese	0	2
	Decline/Unknown	0	1
	Other	0	1
SEXUAL ORIENTATION	Gay or Lesbian	0	1
	Heterosexual	0	75
	Bisexual	0	4
	Questionning	0	0
	Queer	0	0
	Decline/Unknown	0	2
	Other	0	0

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19
RACE	American Indian/Alaska Native	0	1
	Asian	2	22
	Black/African American	1	6
	Native Hawaiian/PI	0	0
	White	5	29
	Multi-Race	0	0
	Decline/Unknown	0	0
	Other	0	31
ETHNICITY	Hispanic/Latino	4	31
	Non-Hispanic/Non-Latino	0	25
	More than one ethnicity	0	8
	Decline/Unknown	0	0
GENDER	Male	9	61
	Female	4	20
	Decline/Unknown	0	1
	Other	0	0
DISABILITY	Disability "Yes"	0	87
	Disability "No"	0	29
	Decline/Unknown	0	10
VETERAN STATUS	Veteran "Yes"	11	74
	Veteran "No"	2	3
	Decline/Unknown	0	5

5/15/2020 6:15:08 AM

Behavioral Health Services for Military Families

MHSOAC Innovation Demographic Categories		FY 16-17	FY 17-18	FY 18-19
AGE GROUP	Age 0-15 (Child)	123	154	199
	Age 16-25 (TAY)	23	35	38
	Age 26-59 (Adult)	108	119	154
	Age 60+ (Older Adult)	10	11	13
	Decline/Unknown	13	4	9
PRIMARY LANGUGE	Arabic	0	0	0
	English	267	313	396
	Farsi	0	0	0
	Korean	0	0	0
	Spanish	4	10	12
	Vietnamese	0	0	0
	Decline/Unknown	3	0	0
	Other	3	0	5
SEXUAL ORIENTATION	Gay or Lesbian	2	0	1
	Heterosexual	245	300	388
	Bisexual	0	0	0
	Questionning	0	1	1
	Queer	0	0	0
	Decline/Unknown	30	22	23
	Other	0	0	0

MHSOAC Innovation Demographic Categories		FY 16-17	FY 17-18	FY 18-19
RACE	American Indian/Alaska Native	8	6	4
	Asian	14	8	11
	Black/African American	26	30	30
	Native Hawaiian/PI	0	0	9
	White	109	141	197
	Multi-Race	37	53	51
	Decline/Unknown	26	8	13
	Other	57	77	98
ETHNICITY	Hispanic/Latino	276	135	198
	Non-Hispanic/Non-Latino	58	69	91
	More than one ethnicity	9	25	19
	Decline/Unknown	211	95	94
GENDER	Male	128	173	215
	Female	149	150	198
	Decline/Unknown	0	0	0
	Other	0	0	0
DISABILITY	Disability "Yes"	54	76	97
	Disability "No"	136	218	273
	Decline/Unknown	95	31	42
VETERAN STATUS	Veteran "Yes"	61	70	96
	Veteran "No"	214	253	317
	Decline/Unknown	2	0	0

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School-Based Mental Health Services - Early Intervention*

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
AGE GROUP	Age 0-15 (Child)	623	612	672
	Age 16-25 (TAY)	0	0	0
	Age 26-59 (Adult)	0	0	0
	Age 60+ (Older Adult)	0	0	0
	Decline/Unknown	0	0	0
PRIMARY LANGUGE	Arabic	0	0	0
	English	388	415	467
	Farsi	1	0	0
	Korean	0	0	0
	Spanish	234	195	203
	Vietnamese	0	0	0
	Decline/Unknown	0	0	0
	Other	0	2	2
SEXUAL ORIENTATION	Gay or Lesbian	2	0	0
	Heterosexual	492	69	0
	Bisexual	8	2	0
	Questionning	9	1	0
	Queer	0	0	0
	Decline/Unknown	28	6	0
	Other	10	2	0

MHSOAC PEI Demographic Categories		FY 16-17	FY 17-18	FY 18-19
RACE	American Indian/Alaska Native	1	2	1
	Asian	6	6	11
	Black/African American	3	3	7
	Native Hawaiian/PI	0	0	2
	White	4	12	18
	Multi-Race	0	0	0
	Decline/Unknown	9	0	22
	Other	6	6	0
ETHNICITY	Hispanic/Latino	594	561	594
	Non-Hispanic/Non-Latino	12	0	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	282	259	0
	Female	341	352	0
	Decline/Unknown	0	0	0
	Other	0	0	0
DISABILITY	Disability "Yes"	0	0	0
	Disability "No"	0	0	0
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	0	0	1
	Veteran "No"	0	0	565
	Decline/Unknown	0	0	82

* Program discontinued in FY 2020-21

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APPENDIX VI: INN 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, including, but not limited to, prevention and early intervention.
  - 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, including measureable outcomes.
  - 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.

MHSOAC Demographic information for active INN projects that enroll participants are on the following pages.

Continuum of Care for Veterans and Military Families

MHSOAC Innovation Demographic Categories		FY 16-17	FY 17-18	FY 18-19
AGE GROUP	Age 0-15 (Child)	0	0	68
	Age 16-25 (TAY)	0	0	20
	Age 26-59 (Adult)	0	0	47
	Age 60+ (Older Adult)	0	0	4
	Decline/Unknown	0	0	2
PRIMARY LANGUGE	Arabic	0	0	0
	English	0	0	132
	Farsi	0	0	0
	Korean	0	0	0
	Spanish	0	0	8
	Vietnamese	0	0	1
	Decline/Unknown	0	0	0
	Other	0	0	0
SEXUAL ORIENTATION	Gay or Lesbian	0	0	0
	Heterosexual	0	0	138
	Bisexual	0	0	0
	Questionning	0	0	0
	Queer	0	0	0
	Decline/Unknown	0	0	3
	Other	0	0	0

MHSOAC Innovation Demographic Categories		FY 16-17	FY 17-18	FY 18-19
RACE	American Indian/Alaska Native	0	0	1
	Asian	0	0	7
	Black/African American	0	0	17
	Native Hawaiian/PI	0	0	0
	White	0	0	60
	Multi-Race	0	0	13
	Decline/Unknown	0	0	6
	Other	0	0	1
ETHNICITY	Hispanic/Latino	0	0	50
	Non-Hispanic/Non-Latino	0	0	42
	More than one ethnicity	0	0	4
	Decline/Unknown	0	0	45
GENDER	Male	0	0	65
	Female	0	0	76
	Decline/Unknown	0	0	0
	Other	0	0	0
DISABILITY	Disability "Yes"	0	0	22
	Disability "No"	0	0	104
	Decline/Unknown	0	0	15
VETERAN STATUS	Veteran "Yes"	0	0	21
	Veteran "No"	0	0	120
	Decline/Unknown	0	0	0

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APPENDIX VII: SUPPLEMENTAL OUTCOMES AND METRICS

In Home Crisis Stabilization (IHCS)

The IHCS program tracks additional measures for the adult team:

- The hospitalization rate within 48 hours of discharge from the program (target rate of less than 5%) to ensure that individuals achieve an adequate degree of stabilization before being discharged.
- The frequency with which the adult team arrives to meet with a referred individual within two hours of receiving the referral to monitor the timeliness of response.

The adult team met the hospitalization rate target in FY 2018-19, the first year of operation, and was able to respond within two hours of receiving a referral the overwhelming majority of the time:

IHCS Metrics	FY 2018-19
Hospitalizations within 48 hours of discharge (Target: < 5%)	1%
% of Time In Home Team Arrives Within Two Hours of Receiving Referral	95%

Crisis Residential Services (CRS)

For adult providers, the program tracks additional measures to ensure that individuals achieve an adequate degree of stabilization before being discharged:

- The hospitalization rate within 28 hours of discharge from the program (target rate of less than 5%).
- Rate of readmission within 14 days of discharge (target rate of less than 5%).

Adult providers met both of these targets across the past three FYs:

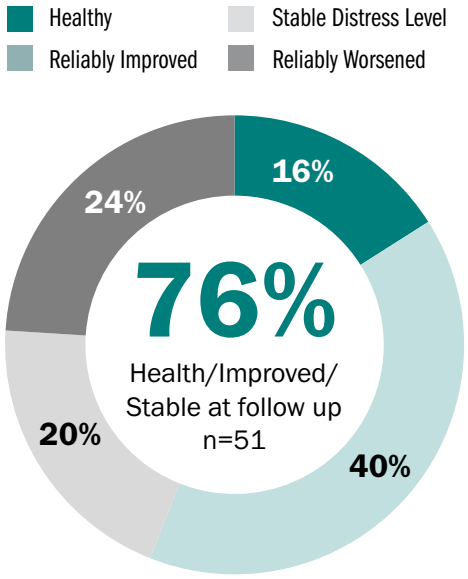
Crisis Residential Services Metrics	FY 2016-17	FY 2017-18	FY 2018-19
Hospitalizations within 48 hours of discharge (Target: < 5%)	0%	1%	1%
Readmission to CRS within 14 days of discharge (Target: < 5%)	2%	2%	2%

PACT

Children/youth served in PACT completed the YOQ® 2.0/2.01 to report on their levels of overall clinical distress, somatic complaints, depression/anxiety symptoms and social isolation, as well as conduct problems, aggressive behavior, hyperactivity/distractibility. This longer version is particularly well-suited for PACT, which is intended to serve youth who are experiencing severe symptoms, which often includes co-occurring SUD symptoms, and who are facing significant challenges such as involvement with the criminal justice system or school failure. In contrast to Early Intervention programs where program effectiveness is evaluated by the proportion of individuals reporting Healthy and/or Reliably Improved Distress levels at follow-up, effectiveness of CSS programs serving a SED/SMI population is measured by the proportion of individuals reporting Reliably Improved, Stable and, to a lesser extent, Healthy Distress levels at follow-up. This is because the teams are designed to work with youth experiencing the most severe symptoms and stressors (i.e., those reporting Stable or Worsening Distress). As a youth experiences significant improvement and/or healthy distress levels, the team typically works with them to transition out of PACT and to a lower level of care.

Of the 79 youth served in FY 2018-19, 51 completed the measure at baseline and follow-up. Results showed that 76% reported feeling Healthy, Reliably Improved or Stable Distress levels at follow-up, thus demonstrating the program's effectiveness at stabilizing psychiatric symptoms and promoting recovery among youth participants. In addition, PACT clinicians closely monitored symptom levels and increased intensity of services for participants who demonstrated a worsening of symptoms.

Children/Youth PACT



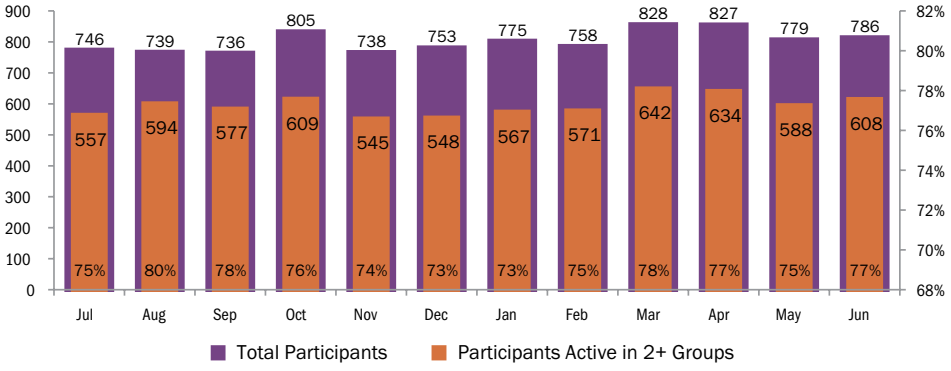
FY 2018-19

Wellness Centers

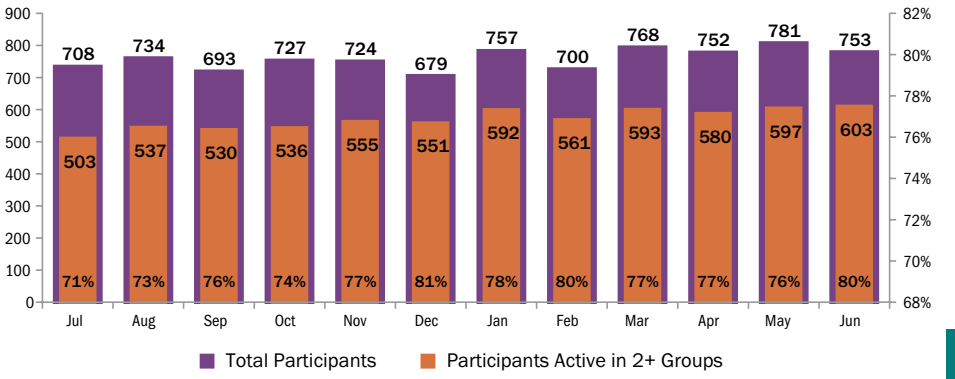
Monthly Consumer Participation in Groups

Wellness Centers

FY 2017-18



FY 2016-17



APPENDIX VIII: DESCRIPTION OF ASSISTED OUTPATIENT TREATMENT (AOT) SCREENING CRITERIA AND PROCEDURES

AOT Criteria

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 accordance with California Assembly Bill 1421 (AB 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 past 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 past 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; and
8. Participation in the AOT program would be the least restrictive placement necessary to ensure the person's recovery and stability.

AOT Screening & Eligibility Determination

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. 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.

Due to the complexity of qualifying for AOT, Orange County has dedicated a trained, County-operated team to screen and assess all individuals referred for an AOT evaluation. The team determines whether referred individuals 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 as follows:

- Upon receiving a referral from a qualified requestor, the team connects with the requestor to gather additional information about the referral, including 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. 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 Improve Timely Access to Services for Underserved Populations

There are many issues that may keep individuals from engaging in 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 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 team has access to all languages through the use of a contracted interpreter service provider in order to minimize any potential language barriers.

Of those linked to services, an overwhelming majority continue to accept services voluntarily (76-81% over the past three years), thus demonstrating the team's success in working with this marginalized and unserved population.

AOT Assessment & Linkage Team Activity

	FY 2016-17	FY 2017-18	FY 2018-19
# Referrals	637	488	611
# Eligible for AOT	193	194	222
# Linked to Service	193	194	222
% Voluntarily Linked to Services	76% (n=147)	80% (n=156)	81% (n=179)

Community Impact

Through FY 2018-19, the AOT ALT has provided services to over 1,800 individuals since its inception in October 2014 and continues to receive a high volume of referrals through the toll-free number (approximately 30 to 45 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. The program responded to 303 calls in FY 2017-18 and 582 informational calls in FY 2016-17.

APPENDIX IX: 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 assesses various components of grief and generates on overall score, as well as the following subscale scores:
  - 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
  - Unique Reactions (i.e., reactions specific to this unique form of death).
- Rater: Self-report for adults ages 18 and older

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. It is used to inform the development of a service plan, as well as assess changes in family functioning between pre-and post-service delivery.

  The family functioning domains assessed include:
  - Environment (i.e., housing stability/habitability, neighborhood safety, etc.).
  - Parental Capabilities (i.e., supervision/ disciplinary practices, enrichment opportunities, etc.).
  - Family Interactions (i.e., emotional support, family bonding, etc.).
  - Family Safety (i.e., abuse and/or neglect of children).
  - Child Well-Being (i.e., mental health, behavior, school performance, etc.).

  The NCFAS-General Services also assesses the following general functioning domains:
  - Social/Community Life (i.e., social relationships, connection to neighborhood/cultural/ ethnic community, relationships with child care, schools, extracurricular services, etc.).
  - Self-Sufficiency (i.e., stability of caregiver employment, family income).
  - Family Health. (i.e., physical and mental health of the caregiver).
- 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 cutoffs 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 fluctuations.
- Rater: Self-Report for adults ages 18 and older

Parenting Children and Adolescents (PARCA-SE)

- Description: The PARCA-SE is a brief self-report measure designed to assess the frequency in which parents engaged in three important types of parenting behaviors. This measure consists of 19 questions that generate an Overall Score, as well as the following three subscale scores:
  - Supporting Positive Behavior (e.g., "Notice and praise your child's good behavior?").
  - Setting Limits (e.g., "Make sure your child followed the rules you set all or most of the time?")
  - Proactive Parenting (e.g., "Prepare your child for a challenging situation.").

  Each question rates how often they were able to engage in each parenting strategy on a scale from 1 (not at all) to 7 (most of the time) during the last month.
- Rater: Self-report for parents/caregivers

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 (verbal rating) by individuals of any age calling the WarmLine

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 mea- sure-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; parent-report for youth ages 5-17

Youth Outcome Questionnaire (YOQ)

- 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.
- YOQ 2.0 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 (Both instruments): Self-report for youth ages 12-18; parent-report for youth ages 4-17.

APPENDIX X: ORANGE COUNTY MHSA PROGRAM PROVIDERS AND CONTRACTS BY SERVICE AREA (in progress)

Outreach for Increasing Recognition of Early Signs of Mental Illness Program	
Behavioral Health Community Training & Technical Assistance (formerly: Training, Assessment and Coordination Services)	Provider(s): County Provider(s): Western Youth Services Contract Name(s): Behavioral Health Training Services *Note: Successful components of the Innovation Project, Religious Leaders Behavioral Health Training Services, will continue to be provided, as needed, through existing BHS training programs beginning July 2020*
Early Childhood Mental Health Consultation Services (formerly: Early Childhood Mental Health Providers Training)	Provider(s): Charitable Ventures Orange County Contract: Early Childhood Mental Health Consultation Services
K-12 School-Based Mental Health Services Expansion	Provider: Latino Center for Prevention and Action in Health & Welfare dba Latino Health Access Contract Name: K-12 School-Based Mental Health Training Services Provider: Orange County Department of Education for provision Contract Name: K-12 School-Based Mental Health Education Services Provider: Center for Applied Research Solutions Contract Names: K-12 School-Based Mental Health Resource Development Services, K-12 School-Based Mental Health Community Networking Services
Services for TAY and Young Adults	Provider: Laguna Play House Contract Name: Transitional Age Youth and Young Adult Mental Health Outreach Services Provider: NAMI OC Contract Name: Transitional Age Youth and Young Adult Mental Health Educational Activities Provider: National Council on Alcoholism and Drug Dependency Contract Names: Transitional Age Youth and Young Adult Mental Health Community Networking Services
Mental Health & Well-Being Promotion for Diverse Communities (formerly: Outreach and Engagement Collaborative)	Provider: County Provider: Other(s) TBD; solicitation to be released to add contracted provider(s) Contract Name(s): TBD
Statewide Projects	Provider: County Contract Name: Participation Agreement with CalMHSA Contract Name: Mental Health Awareness Campaign with Angels Baseball LP Contract Name: Others TBD

Prevention Programs: Mental Health and Well-Being Promotion	
School Readiness	Provider: Orange County Child Abuse Prevention Center, Inc. dba Child Abuse Prevention Center Contract Name: School Readiness Services Provider: Children's Bureau of Southern California Contract Name: School Readiness Services
School-Based Behavioral Health Interventions and Support	Provider: Phoenix House Orange County, Inc. Contract Name: School Based Behavioral Health Intervention and Support Services Provider: Western Youth Services Contract Name: School Based Behavioral Health Intervention and Support Services
School-Based Stress Management	Provider: Orange County Superintendent of Schools dba OC DEPARTMENT OF EDUCATION Contract Name: School Based Stress Management Education Services
Prevention Programs: Violence and Bullying Prevention	
Violence Prevention Education	Provider: Orange County Superintendent of Schools dba Orange County Department of Education Contract Name: School Based Violence Prevention Education Services
Gang Prevention Services	Provider: Waymakers Contract Name: School-Based Gang Prevention Services

Navigation and Access/Linkage to Treatment	
OC Links (PEI)	Provider: County
HBS Outreach and Engagement (PEI, CSS)	Provider: County
On-Site Engagement in Collaborative Courts (INN)	Provider: Mariposa Women and Family Center Contract: On-Site Engagement in Collaborative Courts

Crisis Prevention and Support Services	
Warmline	Provider: NAMI Orange County Contract Name: Warmline Network Services
Crisis Prevention Hotline	Provider: Didi Hirsch Psychiatric Service dba Didi Hirsch Mental Health Services Contract Name: Crisis Prevention Hotline
Survivor Support Services	Provider: Didi Hirsch Psychiatric Service dba Didi Hirsch Mental Health Services Contract Name: Survivor Support Services
Mobile Crisis Assessment Team/PERT	Provider: County
Crisis Stabilization Units	Provider: Exodus Recovery, Inc. Contract: Crisis Stabilization Services Provider: College Hospital Costa Mesa Contract: CSU, LLC, dba College Hospital Crisis Stabilization Unit
In Home Crisis Stabilization	Provider: Orange County Child Abuse Prevention Center, INC. Contract: Adult In-Home Crisis Stabilization Services Provider: CAPC Contract: Children's In-Home Crisis Stabilization Services
Crisis Residential Services	Provider: Waymakers (children) Contract: Children's Crisis Residential Services Provider: SCCS (TAY) Contract: Transitional Age Youth Crisis Residential Services Provider: Telecare Corporation (Adult/OA) Contract: Adult Crisis Residential Services North Region Provider: Telecare Corporation (Adult/OA) Contract: Adult Crisis Residential Services Central Region Provider: Telecare Corporation (Adult/OA) Contract: Adult Crisis Residential Services South Region

Outpatient Treatment: Early Intervention Programs	
CCSS (OC ACCEPT)	Provider: County
School-Based Mental Health Services	Provider: County
Early Intervention Services for Older Adults	Provider: Multi-Ethnic Collaborative of Community Agencies Contract: Early Intervention Services for Older Adults Provider: Council on Aging Contract: Early Intervention Services for Older Adults
OC Parent Wellness Program (Stress-Free Families, Connect the Tots)	Provider: County
First Onset of Psychiatric Illness (OC CREW)	Provider: County
Early Psychosis Learning Healthcare Network	Administrative Oversight: California Mental Health Services Authority (CALMHSA) Participant Agreement Name: Early Psychosis Learning Healthcare Network (EPLHCN)
Early Intervention Services for Veterans	Provider: County Provider: Working Wardrobes Contract: Veteran Peer Support Services Provider: United States Veterans Initiative Contract Name: Early Intervention Services for Veteran College Students
Behavioral Health Services for Military Families	Provider: Child Guidance Center, Inc. Contract Name: Behavioral Health Services for Military Families

Outpatient Treatment: Clinic Expansion Programs	
Child and Youth Clinic Expansion *(Formerly, in part, Youth Core Services)*	Provider: Western Youth Services for Katie A Outpatient Contract: Children and Youth Expansion Services
Services for the Short-Term Residential Therapeutic Program	Provider: New Alternatives, Inc. Contract: Short-Term Residential Therapeutic Programs Provider: Olive Crest Contract: Short-Term Residential Therapeutic Programs Provider: Rite of Passage Adolescent Treatment Centers and Schools, Inc. Contract: Short-Term Residential Therapeutic Programs
Children and Youth with Co-Occurring Medical and Mental Health Disorders	Provider: CHOC Contract: Behavioral Health Services for Children and Youth
Recovery Center/ Clinic	Provider: County Provider: College Community Services Contract: Recovery Center Provider: Mental Health Association Contract: Recovery Center
Integrated Community Services	Provider: Southland Integrated Services, INC. Contract: Integrated Community Services

Outpatient Treatment: Full Service Partnership Programs	
Children's/TAY FSPs	Provider: Pathways Community Services, LLC. Contract: Full Service Partnership/Wraparound Services Provider: Pathways Community Services, LLC. Contract: Children's Full Service Partnership/Wraparound Services Provider: Orange County Asian and Pacific Islander Community Alliance, Inc. Contract: Children and Transitional Age Youth Full Service Partnership/Wraparound Services Provider: Children's Hospital of Orange County, DBA Choc Children's Contract: Children and Transitional Age youth Full Service Partnership/Wraparound Services for Co-Occurring Disorders Provider: Waymakers Contract: Collaborative Courts Full Service Partnership/Wraparound Services Provider: Orangewood Foundation Contract: Collaborative Courts Full Service Partnership/Wraparound Services Provider: Waymakers Contract: Full Service Partnership/Wraparound Services for Youthful Offenders
Adult FSPs	Provider: College Community Services Contract: Older Adult Full Service Partnership Services Provider: Telecare Corporation Contract: General Population Region A Full Service Partnership Services Provider: Telecare Corporation Contract: General Population Region B Full Service Partnership Services Provider: Telecare Corporation Contract: Assisted Outpatient Treatment Full Service Partnership Services
Older Adult FSP	Provider: College Community Services Contract: Older Adult Full Service Partnership Services

Outpatient Treatment: Clinic Expansion Programs	
PACT	Provider: County

Supportive Services	
Parent Education Services	Provider: Olive Crest Contract Name: Parent Education Services
Family Support Services	Provider: Family Support Services Contract Name: National Alliance on Mental Illness Orange County
Children's Support and Parenting	Provider: County
Mentoring for Children and Youth	Provider: MHA --Orange County Association for Mental Health DBA Mental Health Association of Orange County Contract: Children and Transitional Age Youth Mentoring Services
Peer Mentor/Parent Partner Support	Provider: College Community Services Contract: Peer Mentoring Services for Adults and Older Adults
Wellness Centers	Provider: College Community Services Contract: Mental Health Peer Support and Wellness Center Services Central Region Provider: Orange County Association for Mental Health dba Mental Health Association of Orange County Contract: Mental Health Peer Support and Wellness Center Services South Region Provider: Orange County Association for Mental Health dba Mental Health Association of Orange County Contract: Mental Health Peer Support and Wellness Center Services West Region
Transportation	Provider: CABCO Yellow, INC. DBA California Yellow Cab Contract: Non-Emergency Transportation Services
Supported Employment	Provider: Goodwill Industries of Orange County Contract: Adult Supported Employment Services
Behavioral Health Services for Independent Living (INN)	Provider: College Community Services Contract: Behavioral Health Services for Independent Living
Continuum of Care for Veterans and Military Families (INN)	Provider: Child Guidance Center Contract: Continuum of Care for Veterans and Military Families

Special Projects	
Mental Health Technology Suite (INN)	Administrative Oversight: California Mental Health Services Authority (CALMHSA) Participant Agreement Name: Mental Health Services Act Innovation Program
Behavioral Health System Transformation Innovation Project (INN)	Provider: Mind OC Contract: Behavioral Health System Transformation Innovation Project

APPENDIX XI - PUBLIC COMMENTS AND RESPONSE

Public Comments on the Orange County MHSA Three-Year Plan for FYs 2020-21 through 2022-23
30-Day Posting Period: March 16, 2020 – April 15, 2020

Public Comments Received* During 30-Day Posting

(March 16, 2020 – April 15, 2020)

** 20 substantive comments received*

Public Comments on the Orange County MHSA Three-Year Plan for FYs 2020-21 through 2022-23
30-Day Posting Period: March 16, 2020 – April 15, 2020

Comment 1a Theme: **MHSA Planning/Response to COVID-19**

PERSONAL INFORMATION			
Name	Karyl L. Dupée, LMFT		
Agency/Organization	St. Jude Medical Center / Senior Services Department		
Phone number	***-***-****	E-mail	**********
Mailing address (street)			
City, State, Zip			

MY ROLE IN THE MENTAL HEALTH SYSTEM			
☐	Person in recovery	☐	Probation
X ☐	Family member	☐	Education
X ☐	Service provider	☐	Social Services
☐	Law enforcement/criminal justice	☐	Other (please state) MHB Member

The OC Older Adult Mental Health Council recommends that MHSA demonstrate an awareness that COVID-19 will undoubtedly impact our budgets, and encourages them to recognize that reprioritizing projects, programs and budgets with some flexibility may be required going forward.

Specifically and particularly in light of the fact that older adults are one of the principal vulnerable target populations impacted by COVID-19 and that mental health issues (specifically anxiety and depression) are natural outcomes and effects of an pandemic that targets that population. It is important for MHSA to get in front of the very real likelihood that increased efforts in both Outreach and Engagement and Prevention and Early Intervention policies and strategies for the older adult population will need to be ramped up quickly and considerably to ward off a spike in mental health issues, and even suicides The OC Older Adult Mental Health Council believes that the impact on older adults, homeless seniors and the issues of isolation during COVID-19 distancing will provide an opportunity for new conversations regarding mental health.

Comment 1b Themes: OA Funding & Service Levels; OA Veterans INN; Outreach to Increase Recognition

1. Older adults 65 and older in Orange County make up 14.8% of the population, however, only 4% of Community Services and Supports (CSS) proposed expenditures and only 4.7% of Prevention and Early Intervention (PEI) proposed expenditures are specifically targeted for older adults. While many other programs serve adults 18 and over, the need for specifically tailored programs for older adults is critical and under allocated. The services that are currently in place are typically well done, but their scope, intent and funding is simply too small with far too few older adults actually reached and helped.

2. Many of the services targeted for both adults and older adults are anticipated to serve a very small percentage of older adults age 60 and over as compared to other age groups, i.e., crisis residential – 11%; In home crisis stabilization 1%; mobile CAT 8%; Suicide Prevention 7%; and Navigation 12%. Given the high rate of suicide among seniors (older adults have the 2nd highest rate of suicide in OC), the programs need to serve a higher percentage of seniors. And specific programs need to be designed to focus on the underlying causes for suicides in older adults – intervention campaigns are useless unless the underlying causes are identified. This is an incredibly difficult population to reach, so designing successful strategies to go along with the underlying causes is key.

3. The programs specifically targeting older adults serve very small numbers. Orange County California is home to over 450,000 adults over the age of 65. Prevention and Early Intervention services for Older Adults serve only 1,300 per year and Community Support Services serve only 530 clients per year. These small numbers indicate the value that OC places on the lives and mental health of older adults – what do we need to do to increase these numbers?

4. There are no Innovation funds directly focused on older adult programs. The current Innovation Projects need to carve out specific ways to include and serve older adults.

5. Outreach and Engagement services need a much greater ability to specifically target and reach out to older adults living in mobile home parks, low-income housing, senior housing, etc., who are already isolated and unconnected with services and supports in Orange County. The incrementally small amount of funding currently allocated for Outreach and Engagement barely scratches the surface of the number of older adults who need to be aware of services and programs.

Comment 2 Themes: MHSA Planning/Response to COVID-19; Student & Youth/Available Resources; Student & Youth/School-Based Services

PERSONAL INFORMATION			
Name	Tina Rocha/Heidi Cisneros/Sonia Llamas		
Agency /Organization	Santa Ana Unified School District/Pupil Support Services		
Phone number		E-mail	
Mailing address (street)			
City, State, Zip		CA	92704

MY ROLE IN THE MENTAL HEALTH SYSTEM			
☐	Person in recovery	☐	Probation
☐	Family member	☒	Education
☒	Service provider	☐	Social Services
☐	Law enforcement/criminal justice	☐	Other (please state)

COMMENTS

As part of the MHSA plan, it may be important to consider the following:

- Given COVID-19, we have seen an increase in anxiety and depression with an already vulnerable population. Districts will be carrying the brunt of this work. It is crucial for the state to disseminate additional funds to Districts to provide the level of mental health support to meet the need and demand of the populations served
- Additionally, as a result of Covid-19, funding to provide no-cost training for professionals that include best practices, new/adjusted protocols and policies (ie. HIPAA/FERPA etc.) in telephone and telehealth Crisis and MH service provision models
- Continuum of Care Collaborative focused on Child/Pediatric (pre/during/post) MH hospitalization and multidisciplinary cross trainings that include teams from Schools, Crisis Assessment Teams (CAT), Law Enforcement, Hospitals and Post-hospitalization
  - Possible pilot within SAUSD
- Funding and coordination towards school-based MH support for parents that includes training and support groups to address warning signs of mental illness and suicide, MH hospitalization, and discharge/re-entry/post-hospitalization support
  - Possible pilot within SAUSD
- Funding and coordination towards school based MH student peer based training and support to identify address warning signs of mental illness and suicide
  - Possible pilot within SAUSD

Comment enlarged below for easier reading:

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  - Possible pilot within SAUSD

Comment 3 Themes: **Student & Youth/Early Childhood Mental Health**

Q2. Name (First & Last)

Sandy Avzaradel

Q3. Agency/Organization

Early Childhood OC

MY ROLE IN THE MENTAL HEALTH SYSTEM (Select all that apply)

- ☑ Family member
- ☐ Service provider
- ☐ Law enforcement/criminal justice
- ☐ Probation
- ☑ Education
- ☑ Social Services
- ☑ Other (please state) Policy & Advocacy

COMMENTS

I have been a part of all of the community MHSA events and have spoken on the importance of the 'upstream' concept. In this plan, I do not see a focus on true prevention and intervention. Prioritizing the prevention of mental health issues before they are a concern is true PEI. We can move the needle if we begin with pre-natal education on the effects of maternal mental health and the growing fetus, followed by how to develop strong social and emotional skills, which build resilience, followed by supporting challenging behaviors before they become habits, a way of life and a stigma of being a "bad child". We know that early traumatic experiences have a direct impact on the trajectory of child's life. Let's give parents the skills they need to support the social and emotional wellbeing of their children through true early intervention. In addition, I would like to see early childhood called out as its own age group (Pre-natal to five/eight) as this is the time when we can really build brain architecture and a positive trajectory like no other time in life. Categorizing and collecting data on a broad age range of "children" is not helpful if we want to look at the affects of an 'upstream' concept.

Comment enlarged below for easier reading:

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Comment 4:

PERSONAL INFORMATION			
Name	**Donald Stukes**		
Agency/Organization			
Phone number		**E-mail**	
Mailing address (street)			
City, State, Zip	**Brea**	**CA**	**92823**

MY ROLE IN THE MENTAL HEALTH SYSTEM			
☐	**Person in recovery**	☐	**Probation**
☐	**Family member**	☐	**Education**
☐	**Service provider**	☐	**Social Services**
☐	**Law enforcement/criminal justice**	☐	**Other (please state)**

COMMENTS

I am a military veteran and 20 plus year orange county resident. I am also a MFT trainee performing my practicum at an Orange County University. I am also involoved in multiple OC healthcare community commitees. Thank you for a great job putting this information together and disseminating it. Lots of hard work and it is very informative. I will be sure to use a few of the funded programs.

HCA RESPONSE: *Thank you for your comment.*

Comment 5 Themes: MHSA Planning/Strategic Program & Fiscal; MHSA Planning/Braided Funding; Supportive Services/Housing; MH Awareness/Leveraging Campaigns; Student & Youth/School-Based Services

PERSONAL INFORMATION					
Name	Barry Ross				
Agency/Organization	Providence St. Joseph Health				
Phone number		E-mail			
Mailing address (street)					
City, State, Zip		CA	92835		
MY ROLE IN THE MENTAL HEALTH SYSTEM					
☐	Person in recovery	☐	Probation		
☐	Family member	☐	Education		
☐	Service provider	☐	Social Services		
☐	Law enforcement/criminal justice	x☐	Other (please state)	Health Care	
COMMENTS					
1. There are a number of programs being funded that have been showing decreasing enrollment. Is it time to evaluate if these programs are needed? 2. As the Mental Health Wellness Hubs thru Be Well come on line, it would be helpful to see if there could be braided funding with MHSA and these hubs built in as part of the plan. 3. Many of the programs are budgeted to serve a very small number of people. For example, the Older Adult Services is budgeted to serve 530 older adults. Given the growth of the Older Adult population in Orange County there is a need to serve more older adults, perhaps using a different model. 4. The number of persons served in the short term housing and Bridge housing programs are less than 100 each. With the growing homeless population of between 6,800-10,000 people the investment in homeless services does not seem to be in line with the need. 5. The report mentions partnering with existing Stigma Reduction Campaigns. Providence St. Joseph Health has made a significant investment in Each Mind Matters/Promise to Talk campaign. I recommend that the County work together with this campaign rather than do its own campaigns. 6. The need to provide services in the schools was mentioned. It would be helpful to see an initiative that provided this service at a higher level of funding. 7. While there is a recognition of the need for navigation, the support of existing services is not sufficient to meet this need or we will see the same results. 8. The number of shelters and recuperative care faciltities in the County is increasing. We need mental health and psychiatry services at all of these sites. This will reduce homelessness. 9. Overall, I would like to recommend a more focused approach that will reach larger popualtions with greater impact.					

Comment enlarged below for easier reading:

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9. Overall, I would like to recommend a more focused approach that will reach larger popualtions with greater impact.

Comment 6 Themes: MH Awareness/Targeting Populations; Supportive Services/Navigation; Supportive Services/Legal Services; Supportive Services/Housing; MHSA Planning/COVID-19; OA Funding & Service Levels; Veterans/Older Adult INN; Veterans/Early Intervention; Veterans/Military Families INN

Q2. Name (First & Last)

Leigh Ferrin

Q3. Agency/Organization

Public Law Center

Q10

MY ROLE IN THE MENTAL HEALTH SYSTEM (Select all that apply)

☐ Family member	☐ Education
☑ Service provider	☐ Social Services
☐ Law enforcement/criminal justice	☐ Other (please state)
☐ Probation	

April 14, 2020 County of Orange Health Care Agency, Behavioral Health Services MHSA Office 405 W. 5th St. Suite 354 Santa Ana, CA 92701 [Submitted via online portal] Re: Comments on Proposed Mental Health Services Act Three-Year Program and Expenditure Plan FY 2020/21 to FY 2022/23

To Whom It May Concern: Public Law Center (PLC) writes to provide its input on Orange County's Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan FY 2020/21 – FY 2022/23 ("Three-Year Plan"). PLC is a 501(c)(3) legal services organization that provides free civil legal services to low-income individuals and families across Orange County. Our services are provided across a range of substantive areas of law,including consumer, family, immigration, housing, veterans, community organizations, and health law. In all areas of law, PLC works with low-income individuals who have been diagnosed with a mental health disability, who are in need of treatment, and who would benefit from appropriate holistic services. PLC appreciates the time and effort that went into creating the Three-Year Plan, and particularly that the Steering Committee prioritized the input of consumers. From its work with low-income individuals and those with mental health disabilities, one of the barriers we find our clients run into most frequently is agencies and organizations not listening to them. PLC also appreciates that the Three-Year Plan will incorporate actions initiated and pursued by BeWell OC. PLC believes in the mission of BeWell and is excited to participate in their continued efforts. PLC also appreciates the priorities identified by the Three-Year Plan, and provides the following comments:

Mental Health Awareness and Stigma Reduction: PLC believes that, with all the progress that has been made, there is still a long way to go before the public understands and accepts mental health disabilities. PLC represents clients who need to request reasonable accommodations from their landlord or employer as a result of mental health disabilities. PLC encourages the Health Care Agency (HCA) to ensure outreach is conducted not just to the general public, but also to specific, target audiences, like Orange County employers and landlords. If PLC could be of assistance in that area, it could be possible for PLC to identify landlords that have significant units that would benefit from outreach, or for PLC to be able to recommend/encourage specific landlords to seek out support from the HCA. PLC also appreciates the focus on targeting specific communities where mental health issues are generally not discussed and often misunderstood. Identifying and coordinating outreach efforts with related campaigns, such as groups fighting mothers' postpartum

mental health disabilities, would be another method for outreach. Those mental health issues cross numerous barriers, including language, class and culture.

Navigation and Linkage to Services: PLC appreciates the work that the HCA has done over the past few years particularly with respect to the Courtyard and the Riverbed advocacy in which it engaged PLC believes that the HCA has done over the past few years, particularly with respect to the Courtyard and the Riverbed advocacy in which it engaged. PLC believes that the OC Links, BHC Outreach and Engagement and the Courtyard Outreach Program could connect with even more community partners, and/or create specialized points of contact for community partners who work with the same client population. As mentioned several times in the report, there is a concern with access, particularly related to transportation, to be able to access services. Many of PLC's clients in need of mental health services do not have adequate access to transportation, which does present a challenge. Some clients are homeless and do not have reliable (or any) transportation. Public transportation in Orange County is not adequate for the needs of the community, especially considering the geographic size of the county. We appreciate that the HCA is keeping the transportation issue at the forefront of its planning. It is possible that community organizations, such as Abrazar, that currently provide some amount of transportation, may be able to assist with transportation for clients, particularly in the Peer Support and Wellness Center programs.

Suicide and Crisis Prevention Programs: Following up on the prior comment relating to transportation, PLC appreciates the depth and variety of programs that the HCA offers to individuals in need of services. Allowing individuals to access services via telephone and other remote means is incredibly important for the low-income population in Orange County. The discussion of Help@Hand is promising.

Because this comment is being submitted during an unprecedented time in the County's, and really the Country's history, PLC anticipates that the HCA will have additional remote service options going forward. While remote services, such as telehealth and virtual behavioral health care, may not be ideal, they are certainly better than no care at all, so long as they are carried out in an effective manner. As PLC has adjusted to remote legal services, PLC imagines that the HCA and its various partners are experiencing the same challenges, and hopefully also successes that can be carried forward as life slowly moves closer to "normal."

Outpatient Treatment: PLC specifically supports the HCA's efforts in the Early Intervention Services for Older Adults (EISOA), as PLC has developed a legal assistance program for older adults in the last three years. PLC believes that these services are critical, but are also even more challenging. Our older adult clients are less likely to have transportation, and are less likely to know how to utilize technology to identify and connect with resources. Similar to prior comments, PLC would like to see a plan to provide holistic services, as mental health issues impact other social services issues, like income maintenance, legal issues and community support. PLC is collaborating with Council on Aging – Southern California to provide outreach, education and screening for the older adult community in Orange County. This program specifically focuses on preventing older adults from being victimized by scams and abusers, which often arise when the older adult has a mental or physical disability. PLC would like to work more closely with programs such as the EISOA to ensure that clients with these needs are receiving the support needed to move forward in a number of aspects of their lives.

PLC specifically supports the HCA's efforts in the Early Intervention for Veterans program. PLC appreciates that the program is in the community as much as it is, at the VSO and at Community Colleges. PLC greatly appreciates the participation in the Community Courts, as those programs have been so beneficial for its client population. However, as mentioned in the report, PLC would like to see the program expanded to other locations, such as supportive housing locations or other resource centers where Veterans frequently seek assistance, such as US Vets or Volunteers of America.

PLC supports the HCA expanding the INN program for Older Adult Veterans, as PLC believes that is a population that will only get more difficult to reach in the coming years. We believe this is especially true because many of those veterans

Public Comments on the Orange County MHSA Three-Year Plan for FYs 2020-21 through 2022-23
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served during the Vietnam War, are more likely to have mental health diagnoses (or challenges, if they have not yet been diagnosed), and may be less likely to seek help due, in part, to the stigma associated with the request.

PLC would welcome the opportunity to work with non-custodial veteran parents to help them navigate the benefits to which the children may be entitled. PLC has a veterans unit, Operation Veterans ReEntry, and also has a substantial family law practice, both of which have expertise in the areas mentioned. PLC believes it could be a resource for both the Veterans and Military Families continuum of care program and the EISOA programs, and would be happy to discuss the needs of the community further with the HCA.

MHSA Strategies for Early Intervention: PLC applauds the HCA's efforts to address so many of the challenges that low-income individuals face, including transportation and childcare. These are two barriers that we see regularly in our work with low-income individuals, and they are barriers that are often overlooked. Because one barrier is sometimes enough to discourage someone from seeking appropriate and necessary services, PLC cannot emphasize enough the importance of the work that the HCA is doing to remove as many barriers as possible.

System Support – Workforce Education and Training: PLC appreciates that the HCA is educating providers, potential providers, consumers and the community, among others, particularly on the interaction between employment and benefits. PLC believes there may be an opportunity where consumers facing legal issues related to their benefits could be referred to local legal services organizations. PLC provides assistance and representation to clients who appeal adverse benefit determinations. PLC is looking forward to the opening of the Anita Wellness Center, as many of PLC's clients will benefit greatly from the services provided. When PLC clients with mental health diagnoses utilize traditional health care providers, even including those such as the Veterans Administration, which is used to working with individuals with mental health issues, their physical needs may be cared for, but their mental and emotional health is not always adequately addressed. PLC believes that the Anita Wellness Center will at least partially fill that gap, and looks forward to seeing the progression of the Center, as well as hopefully an expansion as it develops and grows.

Access to Legal Services: PLC can attest that the less support an individual with mental health disabilities has, the more likely they are to need legal services. While PLC does not have a social worker on staff, PLC regularly works together with social workers and case managers at other community organizations to support their mutual clients. PLC has seen the impact on the client when a person or persons in the client's life is able to provide needed support. For instance, PLC had a client with a disability who had been denied benefits and needed to appeal. PLC was able to assist with the appeal, but needed the client to collect a variety of documents to support his claim. The client luckily had a case worker who was able to transport the client to the government agencies and to our office for appointments. Without that support, it is unclear whether or not the client would have been able to continue with the case. Additionally, when working with clients who have mental health issues, particularly when requesting reasonable accommodations, or advocating on the clients' behalf with a government agency, PLC has found it more difficult for the adverse party to understand and agree to that will work for a client with mental health disabilities. PLC believes that access to legal services should be a key concern in the MHSA Three-Year Program and Expenditure Plan. The access to legal services may be incorporated through a number of different aspects of the plan, whether it is supportive housing, the services identified for specific populations like Older Adults or Veterans, or other programs. Legal services can improve housing and income stability and restore a measure of dignity to an individual with mental health disabilities.

Access to Housing: Finally, PLC implores the HCA to continue advocating for the need for affordable housing, and particularly supportive housing, for those who have mental health disabilities. PLC is impressed with the positive report for housing outcomes in the Peer Support section. An improved screening process, as well as collaboration with Housing Services, seems to be particularly important. PLC supports the focus on a "housing first" model, as we have seen repeatedly with our clients that, while there may be urgent legal issues, the client cannot focus on those issues until his or her housing is stabilized. PLC understands there are a number of sites set to open in the next two to three years, which is promising. But PLC is also concerned about the significant cut in the housing/homelessness budget – from $34 million down to $4 million per year for the next three years. Considering the housing crisis throughout the state, but for purposes of this comment particularly in Orange County, it is difficult to understand why it makes sense to cut the

housing budget by almost 90%. While PLC understands that these budget adjustments are the result of various transfers and allocations by the Board of Supervisors, it still is concerning to see just a significant decrease in funding for housing at a time when it is needed more than ever. PLC regularly advocates on behalf of individual clients and with community partners for large-scale affordable housing in various jurisdictions throughout Orange County. PLC would be happy to work with the HCA in advocating for additional funding and to get approval for local sites, whether it be through allocations by the Board of Supervisors or through public-private partnerships.

While the Health Care Agency could not possibly have predicted what was coming when the Three-Year Program and Expenditure Plan was released, the current worldwide pandemic has exposed so many of these issues. For individuals with mental health disabilities, particularly those who are low-income, they have lost access to their support system, whether that involves physical contact with people, medications, or other supportive services. PLC anticipates that one result of the pandemic is that more people will experience mental health disabilities, and there will be fewer systems, agencies and organizations available to provide the necessary assistance. While the hope is that a pandemic the size of the current COVID-19 pandemic does not occur annually, it is worthwhile to note the deficits exhibited by the current crisis and work to address them for the future. The HCA is already doing some of this, particularly with respect to its Help@Hand project, and PLC looks forward to seeing that program, and others that may be identified currently or in the near future, come to fruition. We commend the Orange County Health Care Agency for most all of the proposed Three-Year Plan, and urge the HCA to consider those additional issues identified and addressed by this comment. PLC sincerely hopes that it has the opportunity to collaborate and support the HCA in its efforts over the next three years to provide culturally competent, accessible, and effective services to those Orange County residents in need of treatment for a mental health disability.

Sincerely,
PUBLIC LAW CENTER Leigh E. Ferrin Director of Litigation and Pro Bono (714) 541-1010 * lferrin@publiclawcenter.org

Comment 7 Theme: Student & Youth/Available Resources

PERSONAL INFORMATION			
Name	Barb Davis		
Agency/Organization	Ocean View School District		
Phone number		E-mail	
Mailing address (street)			
City, State, Zip		CA	92647

MY ROLE IN THE MENTAL HEALTH SYSTEM			
☐	Person in recovery	☐	Probation
☐	Family member	X	Education
☐	Service provider	☐	Social Services
☐	Law enforcement/criminal justice	☐	Other (please state)

COMMENTS

Thank you for all the services provided to schools by the OCHCA. Since so many of the services listed in the Plan are underutilized by or unknown to our school and district staff, I would encourage outreach by OCHCA. Our staff, parents, preschools and mental health speciailists would all benefit from knowing about the services provided by OCHCA. Any outreach in the form of advertisement, training flyers etc. would be appreciated and supported by our district.

Comment 8 Theme: **Student & Youth/School-Based Services**

Q2. Name (First & Last)

Adela Cruz

Q3. Agency/Organization

AUHSD

Q10.

MY ROLE IN THE MENTAL HEALTH SYSTEM (Select all that apply)

- ☐ Family member
- ☐ Service provider
- ☐ Law enforcement/criminal justice
- ☐ Probation
- ☑ Education
- ☐ Social Services
- ☐ Other (please state)

Q12.

COMMENTS

The plan is comprehensive in covering all areas of mental health. We want to stress the need for direct mental health services on school campus, outreach and engage with parents, and peer to peer support for parents who have students with a mental illness.

Comment enlarged below for easier reading:

The plan is comprehensive in covering all areas of mental health. We want to stress the need for direct mental health services on school campus, outreach and engage with parents, and peer to peer support for parents who have students with a mental illness.

Comment 9 Themes: **Student & Youth/School-Based Services**; **MHSA Planning/COVID-19**

PERSONAL INFORMATION					
Name	**Crystal Turner, Ed.D.**				
Agency/Organization	**Saddleback Valley Unified School District**				
Phone number		**E-mail**			
Mailing address (street)					
City, State, Zip		**CA**	**92691**		

MY ROLE IN THE MENTAL HEALTH SYSTEM			
☐	**Person in recovery**	☐	**Probation**
☐	**Family member**	X	**Education**
☐	**Service provider**	☐	**Social Services**
☐	**Law enforcement/criminal justice**	☐	**Other (please state)**

COMMENTS

We conditionally support the new MHSA 3 year Program and Expenditure Plan proposal for Orange County, with a request to continue working with school districts to provide input for support in our schools. For example, the cyber bullying education plan listed in the plan is a duplicate to programs that we already offer and is not needed- this funding could be used elsewhere. The increase in communication between your agency and our school districts is the only way to ensure that students receive the care that they need. We work with them for a majority of their day and need any possible resources to be made available for both early prevention and education, as well as services when students desperately need them. I respectfully request that you have myself or a fellow superintendent colleague as part of your planning and lead task force groups to allow for true and honest input for our agencies to work more collaboratively.

Prior to COVID-19 school dismissals, Orange County was already in dire need for additional funding and supports for Mental Health services for our school aged children. You may be familiar with the 24th Annual Report for Conditions of Children in Orange County (2016). There was a 73% increase from the last report in 2007 on Mental Health Hospitalizations for children in Orange County. This phenomena is also reflected in our school district in South Orange County. The Saddleback Valley Unified School District has seen a steady increase in the amount of students falling in the moderate-high range for level of risk for suicide assessments over the past 3 years. Now with this unprecedented time of school dismissals and social isolation spanning between 3-4 months across school districts, the mental wellness of our students is and will be of utmost importance. Those that were already struggling with their mental wellness prior to School Dismissal are now even at higher risk, and those that were not struggling prior to School Dismissal may be on the threshold or well over the threshold in requiring support. Our children will need this support, as well as our agencies to work collaboratively for them to move forward successfully.

Comment 10 Themes: Older Adults/OA Funding & Service Levels; Veterans/OA INN

PERSONAL INFORMATION			
Name	Chase Wickersham		
Agency/Organization	American Legion Post 291		
Phone number		E-mail	
Mailing address (street)			
City, State, Zip		CA	92663

MY ROLE IN THE MENTAL HEALTH SYSTEM			
☐	Person in recovery	☐	Probation
☐	Family member	☐	Education
X	Service provider	X	Social Services
☐	Law enforcement/criminal justice	☐	Other (please state)

COMMENTS

Older adults are under-represented in MHSA funding. As the fastest growing population in the County, there needs to be more focus on the needs of older adults. Low income older adults on fixed incomes are at a higher risk of mental depression and find themselves under extreme stress. Most are "rent burdened" paying more than 50% of their income for housing. A special population would be senior veterans living by themselves who are socially isolated and at risk of suicide.
There are no Innovation funds directly focused on older adult programs and a program was considered but rejected to outreach to **senior veterans** who are socially isolated but it was rejected. This program was endorsed by the VA hospital in Long Beach (by the Hospital Director, Walt Dannenberg) and could have been a visible public/private partnership.
If there are 450,000 adults over 65 in the County, MHSA funding appears to be serving only 1830 adults per year based upon this approved budget. That is a serious missed opportunity apparently ignoring a population with mental health needs who are at risk of suicide. The outreach program for **senior veterans who are socially isolated** would be a welcome and visibly improvement to the existing plan.

Public Comments on the Orange County MHSA Three-Year Plan for FYs 2020-21 through 2022-23
30-Day Posting Period: March 16, 2020 – April 15, 2020

Comment 11 Theme: Underserved Populations/Needs of Deaf and Hard-of-Hearing

PERSONAL INFORMATION			
Name	Jacinto Contreras		
Agency/Organization	Orange County Deaf Equal Access Foundation		
Phone number		E-mail	
Mailing address (street)			
City, State, Zip		CA	90630

MY ROLE IN THE MENTAL HEALTH SYSTEM			
☐	Person in recovery	☐	Probation
☐	Family member	☐	Education
X	Service provider	☐	Social Services
☐	Law enforcement/criminal justice	☐	Other (please state)

COMMENTS

TDD/TTY still exists but mostly the older generation uses them. Still important until its completely obsolute. Most people use Video Phones under Sorenson. This is the best way for the deaf and hard of hearing to communicate though phone calls. I would encourage you to find a person who knows American Sign Language (ASL) who could communicate thorugh their language. This gives them more understand through a video phone.

Also need to set aside funding for getting an ASL interpreter. Many times mental health providers say they don't have the money for an interpreter or do not know where to get one. ADA requires all state/govt and public business to provide effective accomdations for the deaf and hard of hearing. This has been an issue often. Often people send complains to DOJ and ADA.org because service providers refuse to. All centers who provide health services should be able to get an interpreter when requested. Also take more steps to train therapist and counselors who are deaf or know ASL. There is a lack of providers that could communicate with AL. A special program with support for more deaf/hard of hearing people to work in this field that would greatly help.

More senstivity trainings needs to be given to organizations and mental health providers.

Thank you.

Comment 12 Theme: Student & Youth/School-Based Services

PERSONAL INFORMATION					
Name	Wendy Pospichal, Ed.D.				
Agency/Organization	Capistrano Unified School District				
Phone number		E-mail			
Mailing address (street)					
City, State, Zip		CA	92675		
MY ROLE IN THE MENTAL HEALTH SYSTEM					
☐	Person in recovery	☐	Probation		
☐	Family member	☒	Education		
☐	Service provider	☐	Social Services		
☐	Law enforcement/criminal justice	☐	Other (please state)		
COMMENTS					

I appreciate that per legislative mandate the majority of prevention and early intervention services are targeted for youth as early intervention is critical in addressing mental health issues.

As an educator, I request that mental health dollars are used to fund services which directly impact students. School districts are in the position of being able to identify students in need but the funds we have access to, to address the needs of youth, are increasingly limited. We have staff and resources in place to provide universal lessons and activities to support mental health stigma reduction and education. Students are increasingly willing to discuss mental health concerns and are increasingly open to self-referral or refer friends for additional support. Having avenues close at hand to respond to the ever increasing needs of our students is the challenge of 2020. Please continue to support schools, youth, and suicide prevention with direct funding.

Thank you!

Comment 13 Theme: Student & Youth/School-Based Services

Q2. Name (First & Last)

Mary ONeill Grace

Q3. Agency/Organization

Anaheim Elementary School District

MY ROLE IN THE MENTAL HEALTH SYSTEM (Select all that apply)

- ☐ Family member
- ☐ Service provider
- ☐ Law enforcement/criminal justice
- ☐ Probation
- ☑ Education
- ☐ Social Services
- ☐ Other (please state)

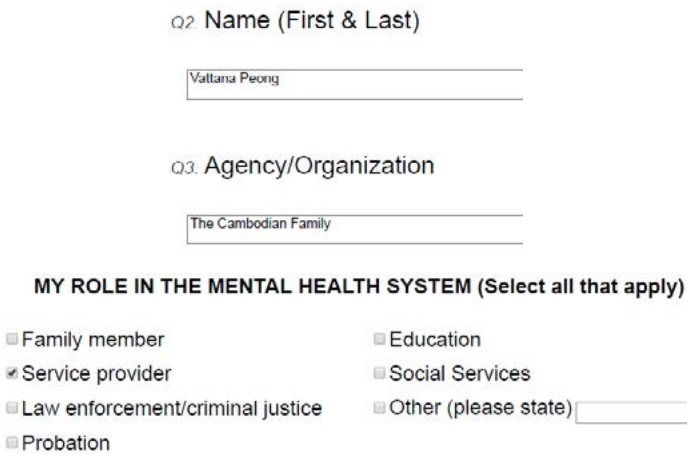
COMMENTS

AESD participated in the planning process for this grant, we have a good plan in place to address Mental Health issues and are excited that this collaboration with the county and surrounding districts will further our efforts in the area of Outreach and Prevention of Mental Health and the Well-being of our students and families. In addition we along with all the other districts are in need of more Crisis Prevention and Supports.

Comment enlarged below for easier reading:

AESD participated in the planning process for this grant, we have a good plan in place to address Mental Health issues and are excited that this collaboration with the county and surrounding districts will further our efforts in the area of Outreach and Prevention of Mental Health and the Well-being of our students and families. In addition we along with all the other districts are in need of more Crisis Prevention and Supports.

Comment 14 Themes: OA Funding & Services Levels; Underserved Populations/MH & Well-Being; Student & Youth/BH System Navigation by Youth


Q2 Name (First & Last)

Vattana Peong

Q3. Agency/Organization

The Cambodian Family

MY ROLE IN THE MENTAL HEALTH SYSTEM (Select all that apply)

- ☐ Family member
- ☑ Service provider
- ☐ Law enforcement/criminal justice
- ☐ Probation
- ☐ Education
- ☐ Social Services
- ☐ Other (please state)

Comment #1 The Cambodian Family (TCF) Community Center would like to express our sincere thanks for the opportunity to provide our comments. Reading through the current 3-year plan, it has been especially heartwarming and motivating to see that the county has explicitly developed this plan with the direct input of our community members in mind. The accommodations the MHSA/HCA made towards access/transportation & translation and interpretation are wonderful and welcomed. The MHSA Coordinator of the OC HCA, understood that the input of smaller (although no less crucial) monolingual communities like ours still deserve the chance to be heard, and we're happy to see that her/the MHSA's extension of the 2019 Community Feedback Survey was reflected in the plan. We would also finally like to note that our advocacy for older, LEP/monolingual communities does not stop at the Cambodian Community. Orange County is incredibly diverse, and its communities are multi-layered and complex. When we advocate for more culturally and linguistically sensitive resources (PEI, translation & interpretation, etc.) we hope to foundationally alter the way the Orange County health care system understands and interacts with older, LEP/monolingual communities.

Comment #2 We strongly encourage MH Board/MHSA Steering Committee/HCA to continue to support our older adult services through the Early Intervention Services for Older Adults (EISOA). In partnership and with the support from Multi-Ethnic Collaborative of Community Agencies (MECCA), TCF has served over 100 older adults in accessing mental health care, connecting them to resources in the community and providing social activities to help decrease their level of isolation and depression. The mental health needs of our older adults, particularly among socially and linguistically isolated ones, continue to increase, especially during and after the COVID-19 pandemic time. Therefore, we strongly urge MH Board/MHSA Steering Committee/HCA to increase funding for this program.

Comment #3 We would like to ask the MH Board/MHSA Steering Committee/HCA to consider increasing fundings for Outreach and Engagement (O&E) for underserved/Limited English Speaking community members in Central and North regions of the county. We have partnered with the Orange County Asian Pacific Islander Community Alliance (OCAPICA) to implement O&E and have already exceeded our annual goals before the end of the contract period. There are more needs to be met. Therefore, an increase in funding for O&E for ethnic community-serving community-based

organizations will allow us to be responsive to the increasing needs of our ethnic communities like Cambodian in a timely manner, especially during and after the COVID-19 pandemic time.

Comment #4 Increasing mental health programs and services for youth age 18 and under in Central Orange County. The needs of these programs and services for youth are learned through TCF's Plan Ahead Youth Program which has been in operation for more than 30 years. As we are facing a challenging time, we are finding that it is quite challenging for youth to navigate the mental health systems. TCF has a program where we are focused on academics and life skills but when our youth need mental health services, it has been challenging for them to navigate and access services because of the complex school and mental health system. There should be programs that promote mental wellness among students. – youth friendly mental health services in and out of school settings, particularly in Central Orange County. It will be helpful if there was a way to expand mental health services for youth with the collaboration between county, community based organizations, and school districts.

Comment #5 Increasing Community Engagement Opportunities for MHSA Plan and Plan Update. TCF would like to thank MH Board/MHSA Steering Committee/HCA for the great work and accommodations that have taken place in the past few years to increase meaningful community participation in the MHSA planning process. In addition to this current great work, TCF would like to ask MH Board/MHSA Steering Committee/HCA to increase its efforts in engaging more ethnic communities and to increase the number of meetings in different parts of the county. The last community engagement meetings in 2019 were hosted 1 in South County, 1 in North County, and 1 in Central County, which were limited and we would like to suggest having at least 3 meetings at different times per region so that more communities could have the opportunities to participate and support the process.

Thank you so much again for the opportunity to provide comments.

Comment 15 Themes: MHSA Planning/COVID-19

Q2. Name (First & Last)

Matt Holzmann

Q3. Agency/Organization

Manral Health Board

MY ROLE IN THE MENTAL HEALTH SYSTEM (Select all that apply)

- [x] Family member
- [ ] Service provider
- [ ] Law enforcement/criminal justice
- [ ] Probation
- [ ] Education
- [ ] Social Services
- [ ] Other (please state)

COMMENTS

At present there is no gauge of the financial impact of the current shutdown. MHSAOAC reported a significant drop in March 2020 MHSA dispersed revenue (funds received a/o 2-15-20). MHSA funding is seasonal and April/May funding numbers will be critical in beginning to understand how the crisis will impact revenue moving forward and thus the MHSA 3 year plan. At present my concern is that we fund public health/PEI on a wide scale as well as crisis and critical services. I would comment that Behavioral Health come up with best case/worst case models on revenue in order to establish priorities moving forward. It is my opinion that the current 3 year plan will have to be drastically revised as more information become available.

Comment enlarged below for easier reading:

At present there is no gauge of the financial impact of the current shutdown. MHSAOAC reported a significant drop in March 2020 MHSA dispersed revenue (funds received a/o 2-15-20). MHSA funding is seasonal and April/May funding numbers will be critical in beginning to understand how the crisis will impact revenue moving forward and thus the MHSA 3 year plan. At present my concern is that we fund public health/PEI on a wide scale as well as crisis and critical services. I would comment that Behavioral Health come up with best case/worst case models on revenue in order to establish priorities moving forward. It is my opinion that the current 3 year plan will have to be drastically revised as more information become available.

Comment 16 Themes: MHSA Planning/Strategic Program & Fiscal; MHSA Planning/COVID-19; Underserved/Populations/Ensuring Responsiveness

PERSONAL INFORMATION				
Name	Steve McNally			
Agency/Organization				
Phone number		E-mail		
Mailing address (street)				
City, State, Zip				

MY ROLE IN THE MENTAL HEALTH SYSTEM			
☐	Person in recovery	☐	Probation
☐	Family member	☐	Education
☐	Service provider	☐	Social Services
☐	Law enforcement/criminal justice	☐	Other (please state)

COMMENTS

The plan is expansive; @500 pages is a lot to read and understand on a computer.

The plan lacks context in defining the community needs, service under/over capacity, and complementary relationships (Cal Optima,Public Health, Housing/Homeless, School Districts), By context, I mean showing plan delivery addressing @150,000 SPD, @480,000 k-12 students, @20,000 Teachers, etc.

Summary exhibits for the outcomes and budgets would help understanding. There is a lot of good stuff here and there; as a reader, I found it difficult to summarize. Cutting and Paste selected areas into a simpler executive summary would help the reader.

Given Covid 19 and MHSA Refresh discussions before Covid 19, I think a strategy/tactics to set priorities is necessary. Future budget availability and cashflow from tax revenues is unknown. The new FY starts July1 @2 months from now.

These are some areas of concern; given the budgeting considerations, I am not going into depth about the plan.

- Community Planning Process (CPP) is inadequate for size of the three year budget. There is no context to the survey information ie the number of respondents by area is not included, multiple surveys were used, survey questions were not program specific relative to user experience. service capacity/waitlists or operational considerations. County can spend up to 5% (or $5 Million for each increment of $100.0M) to inform and research community needs.
- Federal Funds Participation (FFP) is significantly low versus other counties

UCSD study as well as the Cultural Competency Plan identify threshold language deficiency.

Comment 16 Themes: MHSA Planning/Strategic Program & Fiscal; MHSA Planning/COVID-19; Underserved/Populations/Ensuring Responsiveness

PERSONAL INFORMATION					
Name	Steve McNally				
Agency/Organization					
Phone number		E-mail			
Mailing address (street)					
City, State, Zip					
MY ROLE IN THE MENTAL HEALTH SYSTEM					
☐	Person in recovery	☐	Probation		
☐	Family member	☐	Education		
☐	Service provider	☐	Social Services		
☐	Law enforcement/criminal justice	☐	Other (please state)		

COMMENTS

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These are some areas of concern; given the budgeting considerations, I am not going into depth about the plan.

- Community Planning Process (CPP) is inadequate for size of the three year budget. There is no context to the survey information ie the number of respondents by area is not included, multiple surveys were used, survey questions were not program specific relative to user experience. service capacity/waitlists or operational considerations. County can spend up to 5% (or $5 Million for each increment of $100.0M) to inform and research community needs.
- Federal Funds Participation (FFP) is significantly low versus other counties

UCSD study as well as the Cultural Competency Plan identify threshold language deficiency.

Comment 17 Themes: Student & Youth/Early Childhood; MHSA Planning/Strategic Program & Fiscal

PERSONAL INFORMATION					
Name	Michael Arnot				
Agency/Organization	Children's Cause Orange County				
Phone number	949-690-5274	E-mail	marnot@childrenscauseoc.org		
Mailing address (street)	13217 Jamboree Road, #235				
City, State, Zip	Tustin	CA	92782		
MY ROLE IN THE MENTAL HEALTH SYSTEM					
☐	Person in recovery	☐	Probation		
☐	Family member	☐	Education		
☐	Service provider	☐	Social Services		
☐	Law enforcement/criminal	☒	Other (please)	Mental Health Advocacy	

COMMENTS

This year's MHSA Plan Update (2020-21) continues to develop with a better description of community engagement activities and inputs that supported its development. A survey on participants' assessment of the meaningfulness of these activities to them would also be helpful.

The Update includes an increased investment in Early Childhood Mental Health (ECMH) but would benefit from having a dedicated section for ECMH and how these programs are coordinated as part of a comprehensive strategy for this population. This is something that has been called for by multiple stakeholders in previous years.

Expenditure Plan

The Update still lacks a cause-of-change report with the specific reasons why budget goals will not be met in the prior year(s) in spite of an acknowledgment by staff last year of the need for such a report. This may be due to the intentional practice of overinflating the budget knowing that a significant portion of the expenditures will never take place. This is an unimaginative and problematic response to a public policy dilemma created by restrictive state mandates on reserves combined with continued challenges to increase HCA's operational capacity and ability to implement new programs on a timely basis. As an alternative, a well-articulated contingency plan can be included in each update. Something also recommended last year. Additionally, HCA could increase its effectiveness in implementing programs (or reducing them if needed) by shifting to a responsive funding approach. At the last NAMI California Conference, Dr. Nagel told attendees that the agency's first efforts at releasing a community-responsive funding mechanism would be here soon. Something that we have yet to see. Because this was also not included in the Plan Update there is no clear indication that HCA intends to make progress in this area.

Comment 18 Themes: **Student & Youth/School-Based BHIS**; **Underserved Populations/MH & Well-Being**; **MHSA Planning/Contracted Program Budgets**

PERSONAL INFORMATION			
Name	Lorry Leigh Belhumeur		
Agency/Organization			
Phone number		E-mail	
Mailing address (street)			
City, State, Zip			

MY ROLE IN THE MENTAL HEALTH SYSTEM			
☐	Person in recovery	☐	Probation
☐	Family member	☐	Education
☐	Service provider	☐	Social Services
☐	Law enforcement/criminal justice	☐	Other (please state)

COMMENTS

Social-emotional learning through School Based Behavioral Health Intervention and Support Services has been essential to the health and wellbeing of students, schools, and communities. We, along with the community of teachers and parents, are pleased that OCHCA continues to make this powerful level of prevention a priority. However, it is noted that the funding for these services significantly reduces in the 3rd year, when demand for services continues to increase. These services were expanded to include all regions of the county. It is recommended that the plan include at least level funding in the 3rd year.

Outreach & Engagement is a vital program, and its engagement aspect is a hugely important service. It is one of the few programs that offers a component that truly helps anyone from falling through the cracks. Through being able to walk alongside individuals as they develop coping resources and find ways to link to long term support systems, O&E promotes healing for kids, families, and communities. It is highly valued by all who experience its benefit.

In general, it appears as though the practice is to seek approval for level funding year over year, with a corresponding consistent level of services. However, the cost of business increases, especially costs associated with salaries to keep up with minimum wage laws. Please consider increasing funding for programs each year to keep up with the rising cost of doing business.

Thank you.

Comment 19 Theme: **MHSA Planning/COVID-19**

From: Annette [redacted]
Sent: Friday, March 27, 2020 5:59 PM
To: MHSA <mhsa@ochca.com>
Subject: Re: MHSA Three-Year Program and Expenditure Plan - 30 Day Public Comment

Don't you think this will change drastically given the current circumstances of our financial positions? I didn't read it as I assumed it would need dramatic revisions now.

On Mar 27, 2020, at 3:45 PM, MHSA <mhsa@ochca.com> wrote:

The MHSA Office hopes you are all doing well and staying healthy in these challenging times.

This is a friendly reminder that the Orange County Mental Health Services Act Three-Year Program and Expenditure Plan for FY 2020-21 through FY 2022-23 has been posted for a 30-Day Public Comment Period.

Comment 20:

From: Jessica Cruz <[redacted]
Sent: Tuesday, April 14, 2020 4:49 PM
To: MHSA <mhsa@ochca.com>
Subject: Re: MHSA Three Year-Program and Expenditure Plan - 30 Day Public Comment - Last Day

I'm so impressed by the activity level of gathering stakeholder input. Your county is doing a great job during these unprecedented times to still hear from stakeholders.

Great work!
Jessica

Sent from my iPhone

On Apr 14, 2020, at 4:44 PM, MHSA <mhsa@ochca.com> wrote:

This is the final reminder for Public Comments on the Orange County Mental Health Services Act Three Year Program and Expenditure Plan for FY 2020-21 through FY 2022-23. All Public Commer

HCA RESPONSE: *Thank you for your comment.*

OC HCA Responses to Substantive Public Comments

on the MHSA Three-Year Program and Expenditure Plan for FY 2020-21 to FY 2022-23

Comments and Responses Organized by Topic

30-Day Public Comment Period: March 16, 2020 – April 15, 2020

MHSA PLANNING

Response to COVID-19

Comments
1. At present there is no gauge of the financial impact of the current shutdown. MHSAOAC reported a significant drop in March 2020 MHSA dispersed revenue (funds received a/o 2-15-20). MHSA funding is seasonal and April/May funding numbers will be critical in beginning to understand how the crisis will impact revenue moving forward and thus the MHSA 3 year plan. At present my concern is that we fund public health/PEI on a wide scale as well as crisis and critical services. I would comment that Behavioral Health come up with best case/worst case models on revenue in order to establish priorities moving forward. It is my opinion that the current 3 year plan will have to be drastically revised as more information become available.
2. The OC Older Adult Mental Health Council recommends that MHSA demonstrate an awareness that COVID-19 will undoubtedly impact our budgets, and encourages them to recognize that reprioritizing projects, programs and budgets with some flexibility may be required going forward. Specifically and particularly in light of the fact that older adults are one of the principal vulnerable target populations impacted by COVID-19 and that mental health issues (specifically anxiety and depression) are natural outcomes and effects of an pandemic that targets that population. It is important for MHSA to get in front of the very real likelihood that increased efforts in both Outreach and Engagement and Prevention and Early Intervention policies and strategies for the older adult population will need to be ramped up quickly and considerably to ward off a spike in mental health issues, and even suicides The OC Older Adult Mental Health Council believes that the impact on older adults, homeless seniors and the issues of isolation during COVID-19 distancing will provide an opportunity for new conversations regarding mental health.
3. Suicide and Crisis Prevention Programs: Following up on the prior comment relating to transportation, PLC appreciates the depth and variety of programs that the HCA offers to individuals in need of services. Allowing individuals to access services via telephone and other remote means is incredibly important for the low-income population in Orange County. The discussion of Help@Hand is promising. Because this comment is being submitted during an unprecedented time in the County's, and really the Country's history, PLC anticipates that the HCA will have additional remote service options going forward. While remote services, such as telehealth and virtual behavioral health care, may not be ideal, they are certainly better than no care at all, so long as they are carried out in an effective manner. As PLC has adjusted to remote legal services, PLC imagines that the HCA and its various partners are experiencing the same challenges, and hopefully also successes that can be carried forward as life slowly moves closer to "normal."
4. Given COVID-19, we have seen an increase in anxiety and depression with an already vulnerable population. Districts will be carrying the brunt of this work. It is crucial for the state to disseminate additional funds to Districts to provide the level of mental health support to meet the need and demand of the populations served
5. Prior to COVID-19 school dismissals, Orange County was already in dire need for additional funding and supports for Mental Health services for our school aged children. You may be familiar with the 24th Annual Report for Conditions of Children in Orange County (2016). There was a 73% increase from the last report in 2007 on Mental Health Hospitalizations for children in Orange County. This phenomena is also reflected in our school district in South Orange County. The Saddleback Valley Unified School District has seen a steady increase in the amount of students falling in the moderate-high range for level of risk for suicide assessments over the past 3 years. Now with this unprecedented time of school dismissals and social isolation spanning between 3-4 months across school districts, the mental wellness of our students is and will be of utmost importance. Those that were already struggling with their mental wellness prior to School Dismissal are now even at higher risk, and those that were not struggling prior to School Dismissal may be on the threshold or well over the threshold in requiring support. Our children will need this support, as well as our agencies to work collaboratively for them to move forward successfully.

6. While the Health Care Agency could not possibly have predicted what was coming when the Three-Year Program and Expenditure Plan was released, the current worldwide pandemic has exposed so many of these issues. For individuals with mental health disabilities, particularly those who are low-income, they have lost access to their support system, whether that involves physical contact with people, medications, or other supportive services. PLC anticipates that one result of the pandemic is that more people will experience mental health disabilities, and there will be fewer systems, agencies and organizations available to provide the necessary assistance. While the hope is that a pandemic the size of the current COVID-19 pandemic does not occur annually, it is worthwhile to note the deficits exhibited by the current crisis and work to address them for the future. The HCA is already doing some of this, particularly with respect to its Help@Hand project, and PLC looks forward to seeing that program, and others that may be identified currently or in the near future, come to fruition. We commend the Orange County Health Care Agency for most all of the proposed Three-Year Plan, and urge the HCA to consider those additional issues identified and addressed by this comment. PLC sincerely hopes that it has the opportunity to collaborate and support the HCA in its efforts over the next three years to provide culturally competent, accessible, and effective services to those Orange County residents in need of treatment for a mental health disability.

7. Don't you think this will change drastically given the current circumstances of our financial positions? I didn't read it as I assumed it would need dramatic revisions now.

Response re: COVID-19

Seemingly overnight, the COVID-19 pandemic has significantly impacted many aspects of daily life, including emotional well-being. Behavioral Health Services (BHS) has responded by rapidly increasing "essential services," including community outreach, early intervention outpatient services, Public Service Announcements (PSAs), a Mental Health Support and Services resource webpage on COVID-19, referral and linkage to needed services (including emergency shelter), and other supports designed to help people cope with COVID-19. As needed, BHS staff have been temporarily re-deployed to serve as Disaster Response Workers and/or to augment BHS' capacity to meet community behavioral health needs during this public health crisis.

The HCA is also sensitive to the fact that community planning for, and development of, the Three-Year Plan for FYs 2020-21 through 2022-23 occurred prior to the broader outbreak of COVID-19 and State and local stay at home orders. The HCA also recognizes that the emotional impacts may outlast the pandemic itself. Similar to how the BHS workforce is currently providing and scaling up needed services under the FY 2019-20 MHSA Plan, the programs proposed in the Three-Year Plan beginning July 1, 2020 will have the same flexibility to adapt to changing conditions and impacts here in Orange County, including those resulting from COVID-19. This can include maintaining expanded program hours or staffing to respond to the behavioral health needs of the community, continuing telehealth and telephonic services, providing COVID-related resources to staff to help assist the community, providing updated and targeted PSAs and Mental Health Resources websites to the community directly, and continuing to collaborate with other County Agencies and stakeholders as we adapt to COVID-19 and its after-effects. Moreover, these efforts and adaptations can occur without requiring substantive changes to the draft Plan as the Plan already contains clauses allowing diversion of available dollars to Strategic Priority areas around increased mental health awareness and stigma reduction, improved access to behavioral health services, and enhanced suicide prevention.

With regard to the Strategic Priority funding clauses, concerns as to whether there will be enough funding to address community needs are to be expected. HCA and CEO fiscal staff have responded accordingly and are actively monitoring MHSA revenue to see if there are deviations from the projections used to develop the Three-Year Plan earlier this calendar year. The HCA is also awaiting updated fiscal projections from its financial consultant, and will use the revised forecasts to assess whether and/or to what extent modifications to proposed program budgets may be needed in the future. Any reduction in future MHSA revenue will be factored against savings resulting from reduced MHSA expenditures in FY 2019-20 and FY 2020-21 as a result of non-clinical/"non-essential" programming being reduced and/or postponed. The County and HCA has also been tracking State and Federal Government funding sources that support elevated need during COVID-19, and can share relevant information with community partners, including school districts. In addition, even prior to COVID-19, BHS had begun working to identify and implement efforts to better leverage other funding sources (e.g., Medi-Cal, etc.), and this focus will continue following the pandemic. Thus, while future MHSA

program budgets will in all likelihood be impacted, fiscal staff are waiting on key pieces of information needed before being able to propose budget modifications (e.g., updated projections from the fiscal consultant; how long shelter in home orders will remain in effect; the extent and nature of the emotional, health insurance, fiscal and other impacts experienced by different underserved groups and communities; Federal dollars related to COVID-19, etc.). As more becomes known about these factors, the MHSA Plan can be amended through the community planning process, as needed.

Strategic Program and Fiscal Planning

Comments
1. Suicide prevention is to receive carryover funds from PEI and CSS mid-year if available. How will Suicide prevention be funded if the demand increases and there aren't sufficient carryover funds?
2. Many of the programs are budgeted to serve a very small number of people. For example, the Older Adult Services is budgeted to serve 530 older adults. Given the growth of the Older Adult population in Orange County there is a need to serve more older adults, perhaps using a different model. While there is a recognition of the need for navigation, the support of existing services is not sufficient to meet this need or we will see the same results. There are a number of programs being funded that have been showing decreasing enrollment. Is it time to evaluate if these programs are needed? Overall, I would like to recommend a more focused approach that will reach larger popualtions with greater impact.
3. Are there timely checkpoints (6 months, 12 months) to assess the effectiveness of the current plan?
4. If a program isn't effective is there flexibility in 3-year the plan to discontinue funding for that program?
5. This year's MHSA Plan Update (2020-21) continues to develop with a better description of community engagement activities and inputs that supported its development. A survey on participants' assessment of the meaningfulness of these activities to them would also be helpful. The Update includes an increased investment in Early Childhood Mental Health (ECMH) but would benefit from having a dedicated section for ECMH and how these programs are coordinated as part of a comprehensive strategy for this population. This is something that has been called for by multiple stakeholders in previous years. Expenditure Plan The Update still lacks a cause-of-change report with the specific reasons why budget goals will not be met in the prior year(s) in spite of an acknowledgment by staff last year of the need for such a report. This may be due to the intentional practice of overinflating the budget knowing that a significant portion of the expenditures will never take place. This is an unimaginative and problematic response to a public policy dilemma created by restrictive state mandates on reserves combined with continued challenges to increase HCA's operational capacity and ability to implement new programs on a timely basis. As an alternative, a well-articulated contingency plan can be included in each update. Something also recommended last year. Additionally, HCA could increase its effectiveness in implementing programs (or reducing them if needed) by shifting to a responsive funding approach. At the last NAMI California Conference, Dr. Nagel told attendees that the agency's first efforts at releasing a community-responsive funding mechanism would be here soon. Something that we have yet to see. Because this was also not included in the Plan Update there is no clear indication that HCA intends to make progress in this area.

6. The plan is expansive; @500 pages is a lot to read and understand on a computer.

   The plan lacks context in defining the community needs, service under/over capacity, and complementary relationships (Cal Optima,Public Health, Housing/Homeless, School Districts), By context, I mean showing plan delivery addressing @150,000 SPD, @480,000 k-12 students, @20,000 Teachers, etc.

   Summary exhibits for the outcomes and budgets would help understanding. There is a lot of good stuff here and there; as a reader, I found it difficult to summarize. Cutting and Paste selected areas into a simpler executive summary would help the reader.

   Given Covid 19 and MHSA Refresh discussions before Covid 19, I think a strategy/tactics to set priorities is necessary. Future budget availability and cashflow from tax revenues is unknown. The new FY starts July1 @2 months from now.

   These are some areas of concern; given the budgeting considerations, I am not going into depth about the plan.
   • Community Planning Process (CPP) is inadequate for size of the three year budget. There is no context to the survey information ie the number of respondents by area is not included, multiple surveys were used, survey questions were not program specific relative to user experience. service capacity/waitlists or operational considerations. County can spend up to 5% (or $5 Million for each increment of $100.0M) to inform and research community needs.
   • Federal Funds Participation (FFP) is significantly low versus other counties
   • UCSD study as well as the Cultural Competency Plan identify threshold language deficiency.

7. Increasing Community Engagement Opportunities for MHSA Plan and Plan Update. TCF would like to thank MH Board/MHSA Steering Committee/HCA for the great work and accommodations that have taken place in the past few years to increase meaningful community participation in the MHSA planning process. In addition to this current great work, TCF would like to ask MH Board/MHSA Steering Committee/HCA to increase its efforts in engaging more ethnic communities and to increase the number of meetings in different parts of the county. The last community engagement meetings in 2019 were hosted 1 in South County, 1 in North County, and 1 in Central County, which were limited and we would like to suggest having at least 3 meetings at different times per region so that more communities could have the opportunities to participate and support the process. Thank you so much again for the opportunity to provide comments.

Response re: Strategic Program and Fiscal Planning

With each year the HCA continues to learn from and improve upon its community planning process. Over this upcoming Three-Year Plan period, the MHSA Office will engage in on-going dialogue and planning with community stakeholders from the priority populations that remain unserved and underserved in Orange County, as well as with the community organizations and groups that serve them. The goal will be to identify effective outreach, engagement and service strategies that are responsive to the unique needs of different cultural, ethnic and monolingual/Limited English Speaking communities. Per the 2019 community planning process, available carryover PEI and/or CSS funds may be redirected to support this stakeholder engagement and learning, as well as the implementation of identified strategies, pending availability of funds. In addition, pending availability of funds, community planning dollars will be used to oversample Orange County residents on the CA Health Interview Survey in order to collect more stable estimates over time and improve the HCA's ability to track disparities in access to needed services.

During its recent MHSA Program Review of Orange County, Department of Health Care Services commented on the large number of MHSA programs offering the same services. In response, the HCA is in the process of merging programs providing the same services to different age groups, for example, into a single, larger program. These consolidations will increase administrative efficiencies while still maintaining clinicians and staff with specialized expertise and training to serving different target populations, and will help simplify navigation of the BHS system of care. The Plan represents an initial step in this direction, with the goal of further refinement of improvement in program organization occurring across the next several Annual Plan Updates.

Many factors can contribute to decreasing enrollment that are not necessarily a reflection of declining need or interest, the most common being staffing vacancies, inability to site a program and/or operational processes. For example, several PEI programs have been consolidated, as described above, some of which had been experiencing lower than projected enrollments. Within these programs, the consolidation will allow for greater efficiencies in screening of referrals, the intended goal of which is to increase program enrollment and/or reduce wait times.

Regarding concern about whether there is insufficient capacity to serve individuals navigating into the system, the Access to Behavioral Health strategic priority has included dedicated expansions to outpatient services, primarily among youth under age 18 and older adults. All programs within the Crisis Prevention and Support Services area are also being expanded, again with a focus on youth and older adults. Both of these strategic priorities can also increase service capacity and augment program budgets, as described in the Plan, pending availability of funds. It should be noted that when a program experiences lower than anticipated enrollment, its budget may be adjusted during the true-up process to reflect these cost-savings. Those dollars then become available to other programs needing budget augmentations, which can include outpatient treatment and crisis programs. BHS revenue and expenditures will be closely monitored for impacts related to COVID-19. In addition, most of the outpatient services and Suicide Prevention and Support programs funded through MHSA/CSS funds are eligible to bill Medi-Cal or private insurance, thus helping ensure their ability to meet any increasing demand for services.

As noted in several comments received during the 30-Day Posting and in prior discussions with stakeholders, in addition to tracking service utilization/program enrollment it is also important to monitor program performance. At present, the HCA has the resources to conduct annual performance outcome evaluations (which are reported in the MHSA Three-Year Plan and/or Annual Plan Update) and is incrementally building its capacity to engage in more frequent evaluations. A critical aspect of this is building its technology infrastructure to streamline data collection, extraction, analysis and visualization. In addition, BHS Program Managers monitor their programs on a monthly basis to ensure services and other deliverables are being met and/or addressing barriers and challenges the program is encountering.

If a program is experiencing challenges and barriers, steps are taken to address any issues and then later evaluated after sufficient time has passed to determine whether these steps brought about the expected improvements. If, a program continues to underperform despite the quality improvement process, funding could potentially be discontinued as part of the community planning process. In other circumstances, underperformance may be the result of under-funding or other factors suggesting a change in provider or operations rather than in a complete discontinuation of the program.

Contracted Program Budgets

Comment
1. In general, it appears as though the practice is to seek approval for level funding year over year, with a corresponding consistent level of services. However, the cost of business increases, especially costs associated with salaries to keep up with minimum wage laws. Please consider increasing funding for programs each year to keep up with the rising cost of doing business.
Response re: Contracted Program Budgets
The Health Care Agency pays a provider based on the terms of an agreed upon negotiated contract. When entering a contract with a provider, the provider determines the wages of their employees as well as all costs associated with their services as identified through BidSync and the RFP process. HCA Procurement staff and the assigned Contract Administrator review all submitted budgeted items to determine and negotiate the appropriate level of funding for the proposed services. Through this process, a providers funding can be kept level, increased, or decreased based on the negotiated cost to provide the requested services. On a monthly basis the Contract Administrator and Program staff monitor budget expenditures and service delivery and work closely with the provider to improve service delivery and positive outcomes. Contract Services staff, program managers and fiscal program support staff work together in evaluating the level of services needed and the total amount of funding that can be provided in order to best benefit Orange County's mental health service system for our community members.

Braided Funding

Comment
1. As the Mental Health Wellness Hubs thru Be Well come on line, it would be helpful to see if there could be braided funding with MHSA and these hubs built in as part of the plan.
Response re: Braided Funding
The braiding of funding would occur at the contract level and not within the MHSA Plan. As we are able to claim revenue from other health plans, this will decrease the need to spend MHSA funds. With each payor (health or insurance plan) contributing when appropriate, a payor agnostic campus could be a full community resource with financial contributions from across the healthcare system.

FSP Negative Outcomes

Comment
1. Please explain "Reduction in Negative Outcomes"
Response re: School Outreach
"Reduction in negative outcomes" refers to negative outcomes, such as psychiatric hospitalizations, homelessness, incarcerations, etc. that are identified in the MHSA itself and intended to be reduced by FSP services. Please see the Plan for more information on how each outcome was operationalized and analyzed.

STUDENT and YOUTH MENTAL HEALTH

Early Childhood Mental Health

Comment
1. I have been a part of all of the community MHSA events and have spoken on the importance of the 'upstream' concept. In this plan, I do not see a focus on true prevention and intervention. Prioritizing the prevention of mental health issues before they are a concern is true PEI. We can move the needle if we begin with pre-natal education on the effects of maternal mental health and the growing fetus, followed by how to develop strong social and emotional skills, which build resilience, followed by supporting challenging behaviors before they become habits, a way of life and a stigma of being a "bad child". We know that early traumatic experiences have a direct impact on the trajectory of child's life. Let's give parents the skills they need to support the social and emotional wellbeing of their children through true early intervention. In addition, I would like to see early childhood called out as its own age group (Pre-natal to five/eight) as this is the time when we can really build brain architecture and a positive trajectory like no other time in life. Categorizing and collecting data on a broad age range of "children" is not helpful if we want to look at the affects of an 'upstream' concept.
2. The Update includes an increased investment in Early Childhood Mental Health (ECMH) but would benefit from having a dedicated section for ECMH and how these programs are coordinated as part of a comprehensive strategy for this population. This is something that has been called for by multiple stakeholders in previous years.
Response re: Early Childhood Mental Health
Thank you for your comments. The HCA recognizes the importance of prevention of mental health issues before they are a concern and underscores this as the foundational assumption of all its prevention and intervention behavioral health programs that serve individuals from birth onwards, including pregnant mothers. These programs, especially the Orange County Department of Education's Safe from the Start, Orange County Parent Wellness Program, School Readiness, Early Childhood Education and Mental Health Services and the Parent Education program, address mental health from prenatal to birth to early childhood. By utilizing evidence-based, trauma-informed programs, these programs focus on: 1) the impact of trauma on the brain of the developing fetus as well as the mother, 2) building resiliency and reducing risk factors by focusing on prosocial and emotional skills building, 3) provide developmental screening for children and family needs assessment, 4) training and coaching of parents and early childhood education providers and 5) parent education. These upstream efforts are funded by the PEI component, which represents 19% of MHSA funding. The age range for children is defined by the MHSA (0-15 years), but the HCA recognizes that a broad range of developmental stages and milestones are reflected in this singular range. The HCA will work to further refine this broader category into smaller, meaningful children's subgroups over the next several Annual Plan Updates.

BH System Navigation by Youth

Comments
1. Increasing mental health programs and services for youth age 18 and under in Central Orange County. The needs of these programs and services for youth are learned through TCF's Plan Ahead Youth Program which has been in operation for more than 30 years. As we are facing a challenging time, we are finding that it is quite challenging for youth to navigate the mental health systems. TCF has a program where we are focused on academics and life skills but when our youth need mental health services, it has been challenging for them to navigate and access services because of the complex school and mental health system. There should be programs that promote mental wellness among students. – youth friendly mental health services in and out of school settings, particularly in Central Orange County. It will be helpful if there was a way to expand mental health services for youth with the collaboration between county, community based organizations, and school districts.
Response re: BH System Navigation by Youth
Thank you for your comment. The HCA appreciates and recognizes that navigating the mental health system can be challenging. The HCA continually evaluates its system of care to address the needs of the community, particularly those residents of Orange County who may be underserved. During FY 2018-19, the HCA partnered with the Orange County Department of Education (OCDE) in developing and implementing a school mental health services needs assessment survey which was completed by representatives from all school districts. Based on local data like this and on an extensive community planning process that included many key stakeholders such as the school districts, school teachers, OCDE, community service providers and community members, the HCA has developed a new program focusing on K-12 school-based mental health services. These services include four projects that will serve school students, families and school staff by providing: 1) Training, 2) Educational activities, 3) Resource Development and d) Community Networking. All four projects seek to promote mental wellness among students, reduce mental health stigma and support and engage students, their families and school staff in schools throughout the County including Central Orange County. These projects aim to increase access to behavioral health services by improving help-seeking behaviors, assisting with service navigation and increasing knowledge of available resources. There will be robust community networking opportunities across school districts for key stakeholders to allow for a coordinated effort to address student mental health needs. As a reminder, HCA has OCLinks, the BHS information and referral line that is available to help with navigation and has recently expanded its services in response to the COVID-19 crisis.

School-Based Services

Comments
1. The need to provide services in the schools was mentioned. It would be helpful to see an initiative that provided this service at a higher level of funding.
2. The plan is comprehensive in covering all areas of mental health. We want to stress the need for direct mental health services on school campus, outreach and engage with parents, and peer to peer support for parents who have students with a mental illness.

3. Increasing mental health programs and services for youth age 18 and under in Central Orange County. The needs of these programs and services for youth are learned through TCF's Plan Ahead Youth Program which has been in operation for more than 30 years. As we are facing a challenging time, we are finding that it is quite challenging for youth to navigate the mental health systems. TCF has a program where we are focused on academics and life skills but when our youth need mental health services, it has been challenging for them to navigate and access services because of the complex school and mental health system. There should be programs that promote mental wellness among students. – youth friendly mental health services in and out of school settings, particularly in Central Orange County. It will be helpful if there was a way to expand mental health services for youth with the collaboration between county, community based organizations, and school districts.

Secondary Theme: Leveraging/Collaborating/Avoiding Duplication of Services

4. I appreciate that per legislative mandate the majority of prevention and early intervention services are targeted for youth as early intervention is critical in addressing mental health issues.

   As an educator, I request that mental health dollars are used to fund services which directly impact students. School districts are in the position of being able to identify students in need but the funds we have access to, to address the needs of youth, are increasingly limited. We have staff and resources in place to provide universal lessons and activities to support mental health stigma reduction and education. Students are increasingly willing to discuss mental health concerns and are increasingly open to self-referral or refer friends for additional support. Having avenues close at hand to respond to the ever increasing needs of our students is the challenge of 2020. Please continue to support schools, youth, and suicide prevention with direct funding.

Secondary Theme: Leveraging/Collaborating/Avoiding Duplication of Services

5. We conditionally support the new MHSA 3 year Program and Expenditure Plan proposal for Orange County, with a request to continue working with school districts to provide input for support in our schools. For example, the cyber bullying education plan listed in the plan is a duplicate to programs that we already offer and is not needed- this funding could be used elsewhere. The increase in communication between your agency and our school districts is the only way to ensure that students receive the care that they need. We work with them for a majority of their day and need any possible resources to be made available for both early prevention and education, as well as services when students desperately need them. I respectfully request that you have myself or a fellow superintendent colleague as part of your planning and lead task force groups to allow for true and honest input for our agencies to work more collaboratively.

Secondary Theme: Crisis Services

6. AESD participated in the planning process for this grant, we have a good plan in place to address Mental Health issues and are excited that this collaboration with the county and surrounding districts will further our efforts in the area of Outreach and Prevention of Mental Health and the Well-being of our students and families. In addition we along with all the other districts are in need of more Crisis Prevention and Supports.

Secondary Theme: Crisis Services

7. As part of the MHSA Plan, it is important to consider the following [possible pilots within SAUSD]
   - Continuum of Care Collaborative focused on Child/Pediatric (pre/during/post) MH hospitalization and multidisciplinary cross trainings that include teams from Schools, Crisis Assessment Teams (CAT), Law Enforcement, Hospitals and Post-hospitalization
   - Funding and coordination towards school-based MH support for parents that includes training and support groups to address warning signs of mental illness and suicide, MH hospitalization, and discharge/re-entry/post-hospitalization support
   - Funding and coordination towards school-based MH student peer-based training and support to identify address warning signs of mental illness and suicide

Response re: School-Based Services
The HCA recognizes the importance of prevention and early intervention services in helping to prevent the onset or worsening of behavioral health conditions in at-risk groups, and appreciates the increased interest of School District Superintendents and other school personnel in collaborating with the HCA on ways to improve behavioral service delivery for students and their families. The needs identified through the community planning process by the K-12 School Districts, Department of Education and other stakeholders for increased school-based services that focus on increased early intervention, crisis services and services for youth with significant mental health needs have been recognized in the Plan. For example, the consolidation of the PEI-funded School-Based Mental Health Services Prevention and Early Intervention programs into a single School-Based Mental Health Services program allows clinicians from the prevention track to shift to providing early intervention outpatient services to students as needed without requiring an increase in the overall (combined) program budget. The CSS-funded Children and Youth Expansion Services program is also increasing both its budget and capacity to serve Orange County youth experiencing serious emotional disturbance (SED) and/or serious emotional illness (SMI). Part of this expansion includes the opportunity for the HCA to partner with interested Orange County school districts and use Local Control and Accountability Plan and MHSA funds to leverage Medi-Cal, thereby at least doubling the program's capacity to serve students living with SED/SMI and their families on school campus. Funding for programs serving particularly high-risk and vulnerable populations (i.e., foster youth, youth involved with the Social Services Agency, youth living with SED/SMI and significant chronic medical conditions) have also been increased. In addition, all CSS- and PEI-funded programs within the Crisis Prevention and Support Services are being expanded, with a significant focus on increasing service capacity for youth under age 18. Because these programs fall under the Plan's Suicide Prevention Strategic Priority, any program within the Crisis Prevention and Support Services area can increase service capacity, adapt service strategies to best meet the needs of the students and other individuals being served, and augment their budgets mid-year, pending availability of funds. While the initially proposed budgeted amounts for CSS school-based mental health services in the Plan may appear modest, this was by design. Orange and other counties throughout California have been under intense scrutiny over the past several years due to large unspent/unallocated funds being carried over from year to year. Because this partnership with schools is new, prior to launching services the HCA and schools must work together on the development of MOUs, data metrics and data-sharing agreements, policies and procedures that adhere to HIPAA and FERPA, referral procedures, etc. The HCA must also procure a service provider(s) certified to bill Medi-Cal. Thus, first year funding for these services reflect partial year implementation due to the planning and implementation ramp up time required before services can be launched. However, because school-based mental health services are one of the strategies for the MHSA Strategic Priority of improving Access to Behavioral Health, unallocated CSS and PEI dollars can be diverted to augment these program budgets, depending on demonstrated need and pending availability of funds. Thus, if services launch earlier than anticipated, it is possible for mid-year expansion of these programs based on prioritized needs and available funding. Finally, part of the on-going collaboration between the HCA and Orange County's school districts could include discussions on how to leverage mental health-related programming by public mental health and public education. This could help maximize available funding by reducing unnecessary duplication in some Universal prevention-level programming where the District already offers such programming, while still ensuring those Districts without their own Universal programs still have access to these prevention services.

Available Resources

Comment
Secondary Theme: School Outreach 1. Thank you for all the services provided to schools by the OCHCA. Since so many of the services listed in the Plan are underutilized by or unknown to our school and district staff, I would encourage outreach by OCHCA. Our staff, parents, preschools and mental health speciailists would all benefit from knowing about the services provided by OCHCA. Any outreach in the form of advertisement, training flyers etc. would be appreciated and supported by our district.
Response re: School Outreach
Thank you for your comment. As described above in the "BH System Navigation by Youth" response, the HCA has developed a new PEI program: K-12 School-Based Mental Health Services Expansion. This program includes four projects that will serve students, families and school staff by providing: 1) Training, 2) Educational activities, 3) Resource Development and d) Community Networking. There will be robust community networking opportunities across school districts for key stakeholders to learn about available behavioral health programs and services, and to allow for a coordinated effort to address student mental health needs. In addition, HCA currently has OC Links, the BHS information and referral line that is available to help callers navigate the County behavioral health system. OC Links has recently expanded its service hours in response to the COVID-19 crisis.

Comment
Secondary Theme: Training **1.** Additionally, as a result of Covid-19, funding to provide no-cost training for professionals that include best practices, new/adjusted protocols and policies (ie. HIPAA/FERPA etc.) in telephone and telehealth Crisis and MH service provision models
Response re: Training
Through a recent PEI-funded contract (Behavioral Health Training Collaboration), trainings for professionals are being developed and the provider is open to developing trainings applicable to specific audiences. In response to COVID 19 restrictions, virtual platforms such as Zoom and GoToMeeting are being utilized to facilitate various trainings. For more information on their current trainings, contact training@westernyouthservices.org or visit www.ocbhtc.org

School-Based BHIS Program

Comment
1. Social-emotional learning through School Based Behavioral Health Intervention and Support Services has been essential to the health and wellbeing of students, schools, and communities. We, along with the community of teachers and parents, are pleased that OCHCA continues to make this powerful level of prevention a priority. However, it is noted that the funding for these services significantly reduces in the 3rd year, when demand for services continues to increase. These services were expanded to include all regions of the county. It is recommended that the plan include at least level funding in the 3rd year.
Response re: SB BHIS
The proposed budget for this program in the Three-Year Plan reflects the outcome of community feedback and planning during the 2018 PEI Community Planning Process. Discussions on funding for this and other programs currently receiving time-limited augmentations to their budgets using carry over funds will occur during the community planning process for the Annual Plan Update for FY 2022-23.

OLDER ADULTS

OA Funding and Service Levels

Comments
1. Older adults 65 and older in Orange County make up 14.8% of the population, however, only 4% of Community Services and Supports (CSS) proposed expenditures and only 4.7% of Prevention and Early Intervention (PEI) proposed expenditures are specifically targeted for older adults. While many other programs serve adults 18 and over, the need for specifically tailored programs for older adults is critical and under allocated. The services that are currently in place are typically well done, but their scope, intent and funding is simply too small with far too few older adults actually reached and helped. Many of the services targeted for both adults and older adults are anticipated to serve a very small percentage of older adults age 60 and over as compared to other age groups, i.e., crisis residential – 11%; In home crisis stabilization 1%; mobile CAT 8%; Suicide Prevention 7%; and Navigation 12%. Given the high rate of suicide among seniors (older adults have the 2nd highest rate of suicide in OC), the programs need to serve a higher percentage of seniors. And specific programs need to be designed to focus on the underlying causes for suicides in older adults – intervention campaigns are useless unless the underlying causes are identified. This is an incredibly difficult population to reach, so designing successful strategies to go along with the underlying causes is key. The programs specifically targeting older adults serve very small numbers. Orange County California is home to over 450,000 adults over the age of 65. Prevention and Early Intervention services for Older Adults serve only 1,300 per year and Community Support Services serve only 530 clients per year. These small numbers indicate the value that OC places on the lives and mental health of older adults – what do we need to do to increase these numbers?
2. Older adults are under-represented in MHSA funding. As the fastest growing population in the County, there needs to be more focus on the needs of older adults. Low income older adults on fixed incomes are at a higher risk of mental depression and find themselves under extreme stress. Most are "rent burdened" paying more than 50% of their income for housing. A special population would be senior veterans living by themselves who are socially isolated and at risk of suicide. If there are 450,000 adults over 65 in the County, MHSA funding appears to be serving only 1830 adults per year based upon this approved budget. That is a serious missed opportunity apparently ignoring a population with mental health needs who are at risk of suicide. The outreach program for senior veterans who are socially isolated would be a welcome and visibly improvement to the existing plan.
3. We strongly encourage MH Board/MHSA Steering Committee/HCA to continue to support our older adult services through the Early Intervention Services for Older Adults (EISOA). In partnership and with the support from Multi-Ethnic Collaborative of Community Agencies (MECCA), TCF has served over 100 older adults in accessing mental health care, connecting them to resources in the community and providing social activities to help decrease their level of isolation and depression. The mental health needs of our older adults, particularly among socially and linguistically isolated ones, continue to increase, especially during and after the COVID-19 pandemic time. Therefore, we strongly urge MH Board/MHSA Steering Committee/HCA to increase funding for this program.

4. PLC specifically supports the HCA's efforts in the Early Intervention Services for Older Adults (EISOA), as PLC has developed a legal assistance program for older adults in the last three years. PLC believes that these services are critical, but are also even more challenging. Our older adult clients are less likely to have transportation, and are less likely to know how to utilize technology to identify and connect with resources. Similar to prior comments, PLC would like to see a plan to provide holistic services, as mental health issues impact other social services issues, like income maintenance, legal issues and community support. PLC is collaborating with Council on Aging – Southern California to provide outreach, education and screening for the older adult community in Orange County. This program specifically focuses on preventing older adults from being victimized by scams and abusers, which often arise when the older adult has a mental or physical disability. PLC would like to work more closely with programs such as the EISOA to ensure that clients with these needs are receiving the support needed to move forward in a number of aspects of their lives.

Response re: OA Funding and Service Levels

As previously mentioned with regard to school-based services, the HCA appreciates the importance of services designed to help prevent the onset or worsening of behavioral health conditions in at-risk groups, and further recognizes the impact on mental health and suicide risk that COVID-19 poses for older adults, in particular.

The Plan reflects some of the identified needs of older adults in the following ways. First, all CSS- and PEI-funded programs within the Crisis Prevention and Support Services area are being expanded. While the initial focus of the expansion primarily focuses on youth under age 18 (with the exception of Crisis Residential Services designed specifically for older adults ages 60 and older), the Suicide Prevention strategic priority would nevertheless allow the opportunity for any of these programs to increase service capacity, adapt service strategies, and augment their budgets mid-year to better serve older adults, pending demonstrated need and availability of funds. In addition, with County-funded MHSA dollars, Be Well OC is leading a Community Suicide Prevention Initiative in Orange County that has prioritized older adults as one of the target populations of focus in its Action Plan for 2020, with special attention paid to homebound seniors, nursing home residents, cultural minorities, unemployed men and veterans.

With regard to outpatient services for older adults, the time-limited augmentation of the PEI-funded EISOA program budget reflects the outcome of community feedback and planning during the 2018 PEI Community Planning Process. If PEI carryover funds continue to be available in the future, discussions on whether to extend a time-limited augmentation of this program would occur during the community planning process for the Annual Plan Update for FY 2022-23. In addition, in the proposed Three-Year Plan all three CSS-funded programs (i.e., Older Adult FSP, the Older Adult team of the Program for Assertive Community Treatment, Older Adult Services) are receiving additional funds to increase service capacity for older adults living with serious mental illness. Finally, implementation of the new telehealth/virtual behavioral health program contained in this Plan could contain elements specifically designed to increase access to needed services for older adults (i.e., telehealth geropsychiatry). Nevertheless, a potential opportunity to better serve older adults in a more flexible manner would be to include this target population and their associated CSS and PEI program services under the Access to Behavioral Health strategic priority, similar to the way school-based mental health services are included.

OA and Outreach to Increase Recognition

Comment
1. Outreach and Engagement services [now called MH and Well-Being Promotion] need a much greater ability to specifically target and reach out to older adults living in mobile home parks, low-income housing, senior housing, etc., who are already isolated and unconnected with services and supports in Orange County. The incrementally small amount of funding currently allocated for Outreach and Engagement barely scratches the surface of the number of older adults who need to be aware of services and programs.
Response re: OA and Outreach to Increase Recognition…
HCA is continuing to strive for these services to address the needs of individuals within the entire life span, ranging from families with young children to older adults. Some of the Outreach for Increasing Recognition of Early Signs of Mental Illness time-limited program expansions were added as the result of community feedback and new legislative guidance regarding priorities through Senate Bill 1004, leading to specific programs added targeting young children, school age children and TAY. As the HCA continues to enhance and ramp up other services in this program category, consideration will be given to the specific needs of older adults. For example, behavioral health community training and technical assistance provided as part of this program are now offered through a new contract provider, which is working to facilitate trainings that reach a broad community audience, including older adults, their families and those serving older adults. The training provider is seeking input regarding community training needs and would like to know about the training needs specific tor older adults. Please contact training@westernyouthservices.org or visit www.ocbhtc.org Another example of HCA's efforts to increase outreach to older adults is through the Mental Health & Well-Being Promotion for Diverse Communities program (previously the O&E Collaborative). As this program is redesigned, the needs of older adults will be strongly considered in its service delivery. Just to note, efforts focusing on older adults have similarly increased in other PEI program categories: additional time-limited dollars were allocated to the Early Intervention Services for Older Adult Program beginning this fiscal year; older adults are currently a primary focus of the Community Suicide Prevention Initiative; and one of the Community Mental Health Education Events this year is a media campaign focusing on older adults.

Silver Treehouse

Comment
1. Silver Tree House questions regarding time frame to implementation, qualifications, program design, LoS
Response re: Silver Treehouse
Adults/Older Adults ages 18 and older receive services at three sites (Orange (15 beds), Mission Viejo (6 beds), Anaheim (6 beds)) with a total of 27 beds. Stays last an average of 7 to 14 days. The Orange site at the 401 S. Tustin campus has 4 ADA beds available. The Anaheim site is in the process of being converted into a Silver Treehouse that will exclusively serve adults ages 60 and over. Construction has started at the site and a temporary wall has been established to renovate the location with a larger non-ambulatory bedroom and ADA-accessible bathroom, while still being accessible to the community. A new exterior door providing a direct exit from the new ADA bedroom will be provided. The office and medication room will be relocated to a smaller existing bedroom. ADA accessible ramps will be provided on both exits from the house. All 6 beds will be available to the age group 60 years and over and 2 beds will be ADA compliant to serve individuals who are not ambulatory. The HCA hopes to provide begin this service by the end of FY 2019-20.

VETERANS

Older Adult Veterans INN

Comments
1. There are no Innovation funds directly focused on older adult programs. The current Innovation Projects need to carve out specific ways to include and serve older adults.
2. There are no Innovation funds directly focused on older adult programs and a program was considered but rejected to outreach to senior veterans who are socially isolated but it was rejected. This program was endorsed by the VA hospital in Long Beach (by the Hospital Director, Walt Dannenberg) and could have been a visible public/private partnership.
3. PLC supports the HCA expanding the INN program for Older Adult Veterans, as PLC believes that is a population that will only get more difficult to reach in the coming years. We believe this is especially true because many of those veterans served during the Vietnam War, are more likely to have mental health diagnoses (or challenges, if they have not yet been diagnosed), and may be less likely to seek help due, in part, to the stigma associated with the request
Response re: OA Veterans INN
Thank you for your interest in supporting older Orange County veterans. While there are no Innovation Projects currently focused on this target population, the older adult veteran project idea submitted via the Innovation Idea Generation Website has been selected for further exploration. If, following the vetting process, the idea is deemed viable to be developed into an Innovation project proposal and ultimately approved for implementation, this project would include outreach to older and socially isolated veterans. This idea was listed as a potential Innovation project on page 217 in the MHSA 3-Year Program and Expenditure Draft Plan. The HCA encourages your agency's on-going participation in the community planning and feedback process as this and other Innovation ideas are explored.

Early Intervention Services for Veterans

Comment
1. PLC specifically supports the HCA's efforts in the Early Intervention for Veterans program. PLC appreciates that the program is in the community as much as it is, at the VSO and at Community Colleges. PLC greatly appreciates the participation in the Community Courts, as those programs have been so beneficial for its client population. However, as mentioned in the report, PLC would like to see the program expanded to other locations, such as supportive housing locations or other resource centers where Veterans frequently seek assistance, such as US Vets or Volunteers of America.
Response re: Early Intervention for Veterans
Thank you for your feedback on the current locations where the HCA provides behavioral health services for veterans. Currently the OC4Vets and Peers from the contracted program, Working Wardrobes, go to the CRRC—the VA's community resource and referral center – to assist their walk-ins and enrolled participants weekly. Additionally, HCA staff frequently coordinate services with VOA, US Vets, and the multi-service Tierney Center. Since the VOA and US Vets do not have an Orange County office to see veterans, much of these services are

field-based outreach or telephonic service coordination. Staff talk with them several times each week. The program also participates in the Marching Home homeless veteran initiative to end Veteran Homelessness by 2020, and in many of the OC Veteran Military Family Collaborative workgroups, including housing, behavioral health, and children and families. To further assist veterans in accessing housing, the program participates in the Coordinated Entry system for housing opportunities and attends the match meetings weekly. The program accepts referrals and partners with outreach groups such as BHS Outreach and Engagement; however since all of the behavioral health services for veterans conduct outreach in the community, the HCA is open to other suggested sites for field-based engagement.

Military Families INN

Comment
1. PLC would welcome the opportunity to work with non-custodial veteran parents to help them navigate the benefits to which the children may be entitled. PLC has a veterans unit, Operation Veterans ReEntry, and also has a substantial family law practice, both of which have expertise in the areas mentioned. PLC believes it could be a resource for both the Veterans and Military Families continuum of care program and the EISOA programs, and would be happy to discuss the needs of the community further with the HCA.
Response re: Military Families INN
Thank you for your interest in collaborating with the HCA in supporting Orange County veterans and families. The HCA is continuously looking to expand their knowledge of available resources and welcomes the opportunity to learn more about the services provided by your agency.

UNDERSERVED POPULATIONS

Ensuring Responsiveness

Comment
1. UCSD Study as well as the Cultural Competency Plan identify threshold language deficiency.
2. How does the HCA ensure that Suicide Prevention efforts are responsive to different groups (ie TAY, homeless)?
3. How will the HCA monitor its penetration rates into priority populations that are least likely to receive minimum adequate treatment such as the Latino/Hispanic population?
Response re: Ensuring Responsiveness
From a planning and implementation perspective, over the course of the Three-Year Plan period the HCA will continue discussions with members of the identified target populations, as well as different stakeholder groups that work with these target populations. The goal of these discussions is to identify strategies and methods that are responsive to the unique needs of different communities for Suicide Prevention and other efforts, including the bilingual capacity of direct service providers. From a data/monitoring perspective, penetration rates will be computed from demographic information collected from on the clients served in County-operated and County-contracted outpatient treatment programs. In addition, penetration rates for minimum adequate treatment per the CA Health Interview Survey (CHIS) will continue to be monitored. Pending availability of funds, community planning dollars will be used to oversample Orange County residents on the CHIS in order to collect more stable estimates over time and improve the HCA's ability to track disparities in access to needed services.

MH and Well-Being Promotion Prevention Program

Comment
1. We would like to ask the MH Board/MHSA Steering Committee/HCA to consider increasing fundings for Outreach and Engagement (O&E) for underserved/Limited English Speaking community members in Central and North regions of the county. We have partnered with the Orange County Asian Pacific Islander Community Alliance (OCAPICA) to implement O&E and have already exceeded our annual goals before the end of the contract period. There are more needs to be met. Therefore, an increase in funding for O&E for ethnic community-serving community-based organizations will allow us to be responsive to the increasing needs of our ethnic communities like Cambodian in a timely manner, especially during and after the COVID-19 pandemic time.
Response re: MH and Well-Being Promotion
Community feedback from 2018 and 2019, as well as findings from various published reports that document existing health disparities, underscores this critical need to improve both awareness of, and access to, needed behavioral health services among various underserved and Limited English Speaking communities. As such, one of the strategic priorities of the Three-Year Plan focuses on Mental Health Awareness and Stigma Reduction. The 2018 Community Planning process identified these services as a priority need and additional time-limited funding was added beginning the 2019-20 FY. Per the continuing community planning process, budgets for programs and strategies detailed under this priority area, including the Prevention program described above, may be augmented mid-year should demand for their services outpace the augmented budgets and carryover PEI funding is available. Moreover, one of the key approaches the HCA will employ is to work with trusted cultural ambassadors from the community to identify approaches tailored to the needs of different cultural groups. The HCA further recognizes that the approaches and strategies used may need to be adapted as a result of the lingering impacts of COVID-19.

Needs of the Deaf and Hard-of-Hearing

Comment
1. TDD/TTY still exists but mostly the older generation uses them. Still important until its completely obsolute. Most people use Video Phones under Sorenson. This is the best way for the deaf and hard of hearing to communicate though phone calls. I would encourage you to find a person who knows American Sign Language (ASL) who could communicate thorugh their language. This gives them more understand through a video phone. Also need to set aside funding for getting an ASL interpreter. Many times mental health providers say they don't have the money for an interpreter or do not know where to get one. ADA requires all state/govt and public business to provide effective accomdations for the deaf and hard of hearing. This has been an issue often. Often people send complains to DOJ and ADA.org because service providers refuse to. All centers who provide health services should be able to get an interpreter when requested. Also take more steps to train therapist and counselors who are deaf or know ASL. There is a lack of providers that could communicate with AL. A special program with support for More senstivity trainings needs to be given to organizations and mental health providers.more deaf/hard of hearing people to work in this field that would greatly help.

Response re: Needs of the Deaf and Hard-of-Hearing
The HCA utilizes a variety of methods to meet the needs of the Deaf and Hard of Hearing (DHH) population. Attached is the policy in place outlining key points of contact for accessing services of our DHH population. Additionally, the HCA contracts with a vendor to provide American Sign Language (ASL) services. All of the available request forms for the clinics and point-of-access sites are available on the website and at each site so clinicians and program staff can easily request ASL interpretation at any point. The HCA has a Deaf Services Coordinator who is a licensed clinician. She provides consultation services to the DHH community as well as trainings to the County and County-contracted provider clinicians and support staff on DHH subjects, including how to utilize the services of an ASL interpreters. For general public besides Sorenson, there are also other video relay services (VRS) like Purple Communications and Convo Communications that provide VRS services to meet the DHH's varied communication needs.

MH AWARENESS and STIGMA REDUCTION

Leveraging Campaigns

Comment
1. The report mentions partnering with existing Stigma Reduction Campaigns. Providence St. Joseph Health has made a significant investment in Each Mind Matters/Promise to Talk campaign. I recommend that the County work together with this campaign rather than do its own campaigns.
Response re: Leveraging Campaigns
Thank you for your comment. The HCA appreciates the importance of collaborating with other organizations doing related campaigns so as to maximize their reach and impact, not just geographically, but also with regard to messages and approaches that are tailored for different unserved and underserved populations living within Orange County. All HCA-funded Prevention and Intervention programs, and Community Mental Health Awareness programs in particular, utilize Each Mind Matters (EMM) messaging in their program. EMM materials and campaigns, which are part of the CalMHSA Statewide Projects, are funded by county MHSA dollars, and Orange County makes significant annual contributions to the Statewide Project funding.

Targeting Populations

Comment
1. Mental Health Awareness and Stigma Reduction: PLC believes that, with all the progress that has been made, there is still a long way to go before the public understands and accepts mental health disabilities. PLC represents clients who need to request reasonable accommodations from their landlord or employer as a result of mental health disabilities. PLC encourages the Health Care Agency (HCA) to ensure outreach is conducted not just to the general public, but also to specific, target audiences, like Orange County employers and landlords. If PLC could be of assistance in that area, it could be possible for PLC to identify landlords that have significant units that would benefit from outreach, or for PLC to be able to recommend/encourage specific landlords to seek out support from the HCA. PLC also appreciates the focus on targeting specific communities where mental health issues are generally not discussed and often misunderstood. Identifying and coordinating outreach efforts with related campaigns, such as groups fighting mothers' postpartum mental health disabilities, would be another method for outreach. Those mental health issues cross numerous barriers, including language, class and culture.
Response re: Targeting Populations
Thank you for your comment. The HCA recognizes that reducing stigma and discrimination related to mental illness is an ongoing effort. Many of HCA's behavioral health Prevention and Early Intervention programs conduct outreach in the community to raise awareness regarding mental health and the surrounding stigma. For example, the Mental Health and Well-Being Promotion program focuses its services on conducting outreach in the community, educating the community and raising awareness. We appreciate your suggestion of landlords and employers as important target audiences, and will ensure that the O&E Collaborative includes and expands their outreach to this target population. In addition, the Stigma Free OC campaign strives to increase support for recovery and wellness among employers and organizations, and will continue to expand on this recently launched effort.

Thank you for also recommending collaboration with organizations that work with mothers experiencing post-partum mental health conditions. HCA recognizes that this is an important target population and currently has the Orange County Parent Wellness Program which serves underserved at-risk families with children, including pregnant women and new mothers with postpartum depression. Services include early intervention services that include behavioral health outpatient treatment, case management, wellness activities, community outreach and education, referrals and linkages to community resources. The program actively collaborates with other similar agencies and will continue to outreach to this target population and highlight the message of reducing stigma.

SUPPORTIVE SERVICES

Navigation & Linkage to Services

Comment
Secondary Theme: Courtyard Outreach 1. Navigation and Linkage to Services: PLC appreciates the work that the HCA has done over the past few years particularly with respect to the Courtyard and the Riverbed advocacy in which it engaged PLC believes that the HCA has done over the past few years, particularly with respect to the Courtyard and the Riverbed advocacy in which it engaged. PLC believes that the OC Links, BHC Outreach and Engagement and the Courtyard Outreach Program could connect with even more community partners, and/or create specialized points of contact for community partners who work with the same client population.
Response re: Courtyard Outreach
Thank you for your comment. Collectively, these BHS programs continue to support the Courtyard seven days per week providing engagement, referrals and linkage to BHS services and community resources The HCA is interested in continuing to develop and support partnerships between its programs and community organizations that serve individuals who are experiencing homelessness.

Comment
Secondary Theme: Transportation 1. As mentioned several times in the report, there is a concern with access, particularly related to transportation, to be able to access services. Many of PLC's clients in need of mental health services do not have adequate access to transportation, which does present a challenge. Some clients are homeless and do not have reliable (or any) transportation. Public transportation in Orange County is not adequate for the needs of the community, especially considering the geographic size of the county. We appreciate that the HCA is keeping the transportation issue at the forefront of its planning. It is possible that community organizations, such as Abrazar, that currently provide some amount of transportation, may be able to assist with transportation for clients, particularly in the Peer Support and Wellness Center programs.
Response re: Transportation
The HCA is pleased with the popularity and success of the Transportation program and looks forward to expanding this critical service for consumers. As planning for the expansion begins in the next fiscal year, the HCA hopes to collaborate with partners and agencies that are also providing transportation assistance to leverage existing efforts and not unnecessarily duplicate or overlap this service.

Housing

Comment
Secondary Theme: Short-Term Housing 1. The number of persons served in the short term housing and Bridge housing programs are less than 100 each. With the growing homeless population of between 6,800-10,000 people the investment in homeless services does not seem to be in line with the need.
Response re: Short-Term Housing
HCA short term housing and bridge housing program has been very successful in providing a continuum of housing opportunities that contributes to the overall System of Care. These programs are transitional with the goal of placing individuals in permanent supportive housing. These programs have served over 160 individuals in the last fiscal year (18-19). In fiscal year 19-20 the Bridge housing program increased the bed availability by approximately 30 beds, this, in turn, is projected to increase the number of individuals served.

Comment
Secondary Theme: Shelters and Recuperative Care 2. The number of shelters and recuperative care faciltities in the County is increasing. We need mental health and psychiatry services at all of these sites. This will reduce homelessness.
Response re: Shelters and Recuperative Care
The Short-Term Housing and Bridge Housing programs serve clients who are receiving services from a County outpatient clinic, PACT or FSP program. The treatment team works in collaboration to meet the individual's needs. Specifically, the housing program staff focus on housing readiness, navigation and placement, and the mental health providers focus on mental health treatment.

Comment
Secondary Theme: Affordable Housing/PSH 3. Access to Housing: Finally, PLC implores the HCA to continue advocating for the need for affordable housing, and particularly supportive housing, for those who have mental health disabilities. PLC is impressed with the positive report for housing outcomes in the Peer Support section. An improved screening process, as well as collaboration with Housing Services, seems to be particularly important. PLC supports the focus on a "housing first" model, as we have seen repeatedly with our clients that, while there may be urgent legal issues, the client cannot focus on those issues until his or her housing is stabilized. PLC understands there are a number of sites set to open in the next two to three years, which is promising. But PLC is also concerned about the significant cut in the housing/homelessness budget – from $34 million down to $4 million per year for the next three years. Considering the housing crisis throughout the state, but for purposes of this comment particularly in Orange County, it is difficult to understand why it makes sense to cut the housing budget by almost 90%. While PLC understands that these budget adjustments are the result of various transfers and allocations by the Board of Supervisors, it still is concerning to see just a significant decrease in funding for housing at a time when it is needed more than ever. PLC regularly advocates on behalf of individual clients and with community partners for large-scale affordable housing in various jurisdictions throughout Orange County. PLC would be happy to work with the HCA in advocating for additional funding and to get approval for local sites, whether it be through allocations by the Board of Supervisors or through public-private partnerships.

Response re: Affordable Housing/PSH
HCA continues to work closely with Orange County Community Resources housing developers and other County agencies to maximize funding available for permanent supportive housing for behavioral health clients. In 2018 No Place Like Home (NPLH) funding was approved by the voters as Proposition 2 and this, in turn, changed the way the State made MHSA funding available. The NPLH consists of a competitive and non-competitive application process. Orange County is a Large County and, as such, project applications submitted by Orange County compete against other Large County projects. Orange County has applied for both Round 1 and Round 2 of the NPLH Competitive application process and will be allocated the Non-Competitive NPLH funds by February 2021. Orange County will continue to apply for NPLH funding in any future rounds.

Legal Services

Comment
1. System Support – Workforce Education and Training: PLC appreciates that the HCA is educating providers, potential providers, consumers and the community, among others, particularly on the interaction between employment and benefits. PLC believes there may be an opportunity where consumers facing legal issues related to their benefits could be referred to local legal services organizations. PLC provides assistance and representation to clients who appeal adverse benefit determinations. […] Access to Legal Services: PLC can attest that the less support an individual with mental health disabilities has, the more likely they are to need legal services. While PLC does not have a social worker on staff, PLC regularly works together with social workers and case managers at other community organizations to support their mutual clients. PLC has seen the impact on the client when a person or persons in the client's life is able to provide needed support. For instance, PLC had a client with a disability who had been denied benefits and needed to appeal. PLC was able to assist with the appeal, but needed the client to collect a variety of documents to support his claim. The client luckily had a case worker who was able to transport the client to the government agencies and to our office for appointments. Without that support, it is unclear whether or not the client would have been able to continue with the case. Additionally, when working with clients who have mental health issues, particularly when requesting reasonable accommodations, or advocating on the clients' behalf with a government agency, PLC has found it more difficult for the adverse party to understand and agree to that will work for a client with mental health disabilities. PLC believes that access to legal services should be a key concern in the MHSA Three-Year Program and Expenditure Plan. The access to legal services may be incorporated through a number of different aspects of the plan, whether it is supportive housing, the services identified for specific populations like Older Adults or Veterans, or other programs. Legal services can improve housing and income stability and restore a measure of dignity to an individual with mental health disabilities.
Response re: Legal Services
A multitude of programs described in the Plan provide referrals and linkages to community and supportive services, which can include legal services. Your comment highlights that, while programs specifically list legal services in their program description when it is a referral made frequently, a broader understanding of how often legal and other services are needed by consumers is nevertheless lacking. The HCA is continuing to build its capacity to be able to do more in-depth analysis of the types of referrals needed and linkages by BHS/MHSA programs. While the data capture and reporting systems necessary to do this level of analysis may not be in place in time for next year's Annual Plan Update, the HCA can provide an update on its progress in this area. In addition, the HCA welcomes the opportunity to utilize community agencies as a referral location for legal services and other resources as appropriate.

Health Care Agency **Behavioral Health Services** **Policies and Procedures**	Section Name: Sub Section: Section Number: Policy Status:	Client's Rights Cultural Competency 02.01.07 ☒New ☐Revised

	SIGNATURE	DATE APPROVED
Director of Operations Behavioral Health Services	Signature on File	11/6/19

SUBJECT: Meeting Deaf and Hard of Hearing Language Needs at Key Points of Contact

PURPOSE:

To ensure that all Deaf and Hard of Hearing Medi-Cal beneficiaries receiving services in Orange County Behavioral Health Services (BHS) within the Mental Health Plan (hereby referred to as Orange MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS) have access to linguistically appropriate services through staff or interpreters proficient in beneficiary's primary language, e.g., American Sign Language (ASL). This policy also applies to non-Medi-Cal clients receiving services within BHS.

POLICY:

All BHS beneficiaries/clients shall have access to linguistically appropriate services.

SCOPE:

This policy apply to all functions of BHS County and County contracted programs involved in the linkage and treatment of beneficiaries/clients receiving services.

REFERENCES:

Code of Federal Regulations (CFR), Title 28, Part 35, ADA of 1990

California Code of Regulations (CCR), Title 9, Chapter 11, Section 1810.410 (a) (2) (b) (e) (3)

DMH Information Notice No. 02-03 Addendum for Implementation Plan for Phase II Consolidation of Medi-Cal Specialty Mental Health Services-Cultural Competence Plan Requirements

Dymally-Alatorre Bilingual Services Act 1973

PROCEDURE:

I. As defined in the Orange MHP and in the DMC-ODS, each service site is considered a key point of contact for Orange County.

II. Auxiliary aides must be made available to Deaf and Hard of Hearing beneficiaries/clients. Aides to be used will be determined in consultation with the

beneficiary/client to determine what aide(s) is (are) the best fit. These aides may include but are not limited to the following:

A. Qualified sign language interpreter

B. Note takers

C. Screen readers

D. Written materials

E. Telephone handset amplifiers

F. Assistive listening systems or devices

G. Hearing aid-compatible telephones

H. Communication boards

I. Open or closed captioning, including real-time captioning

J. Video remote interpreting services (VRI)

K. voice, text and video-based telecommunication products and systems

L. Videotext displays

M. Description of visually presented materials

N. Exchange of written notes

O. Video relay services

P. Other effective methods of making orally delivered materials available to the Deaf and people who are hard of hearing.

III. For Non-Emergency Sign Language Interpreting Service, the BHS County staff shall contact the BHS contracted interpreting agency (current agency information available at HCA Forms under BHS Forms-Language Service ASL Interpretation - Instructions) with requests for ASL interpreters during routine clinic hours. The Deaf Services Coordinator may be contacted for assistance with the request procedure if needed. A short notice fee will be applied by the contracting agency, if a request is made in less than 72 hours for non-emergency counseling services. County Contracted providers will need to contract with an interpreting agency to arrange for Non-Emergency Sign Language Interpreting Services.

IV. For Emergency Sign Language Interpreting Service when the primary BHS contracted agency is unable to provide services or is unavailable, if the immediate need arises during the day, on a weekend, or after hours, the staff shall contact a secondary

interpreting agency. (Secondary interpreting agency information available at HCA Forms under BHS Forms-Language Service ASL Interpretation-Instructions). The Deaf Services Coordinator may be contacted for assistance with the request procedure during business hours, if needed. The higher fees are applied to all emergency cases. County Contracted providers will need to contract with an interpreting agency to arrange for Emergency Sign Language Interpreting Services.

V. Each key point of contact in BHS shall be provided with a roster of linguistically proficient staff/interpreters throughout the Health Care Agency (HCA). This language roster shall be updated annually.

VI. Clinics with deaf or hard of hearing staff are familiar with and able to utilize Video Relay Services (VRS) in order to take calls or make calls to deaf or hard of hearing beneficiaries/clients in Orange County. Any caller using the deaf or hard of hearing's videophone numbers will be automatically connected to VRS.

VII. Initial access logs maintained at the service sites shall indicate whether an interpreter was needed and the response to offers of interpreting services.

VIII. Signage shall be posted at each BHS County and County Contracted clinic indicating interpreting Services for the Deaf and Hard of Hearing are available free of charge to each beneficiary.

IX. Staff shall not expect that family members will provide interpreter services.

A. A beneficiary may choose to use a family member or friend as an interpreter after being informed of the availability of free interpreter services.

B. Minor children should not be used as an interpreter.

APPENDIX XII - PUBLIC HEARING PRESENTATION

STRATEGIC PRIORITIES

Access

- Expand Transportation
  - All ages
  - CSS, PEI
- Expand school-based MH
  - CSS
- Develop tele-/virtual health
  - All ages, start 18+
  - CSS
- Improve cultural & linguistic responsiveness

MH Awareness

- Expand MH Awareness & Stigma Reduction Efforts
- Tailor to different age & cultural groups

Suicide Prevention

- Expand Crisis Services
  - Children, Older Adults
  - Culturally responsive
  - CSS, PEI

Estimated Budget

FY 2020-21

$155,088,175

FY 2021-22

$164,627,171

FY 2022-23

$165,320,366

COMMUNITY SERVICES & SUPPORTS

PREVENTION and EARLY INTERVENTION

Estimated Budget

FY 2020-21	FY 2021-22	FY 2022-23
$47,061,483	$49,286,926	$40,988,101

Estimated Budget

FY 2020-21	FY 2021-22	FY 2022-23
$18,346,360	$9,009,773	$2,042,071

INNOVATION

Estimated Budget

FY 2020-21

$6,216,634

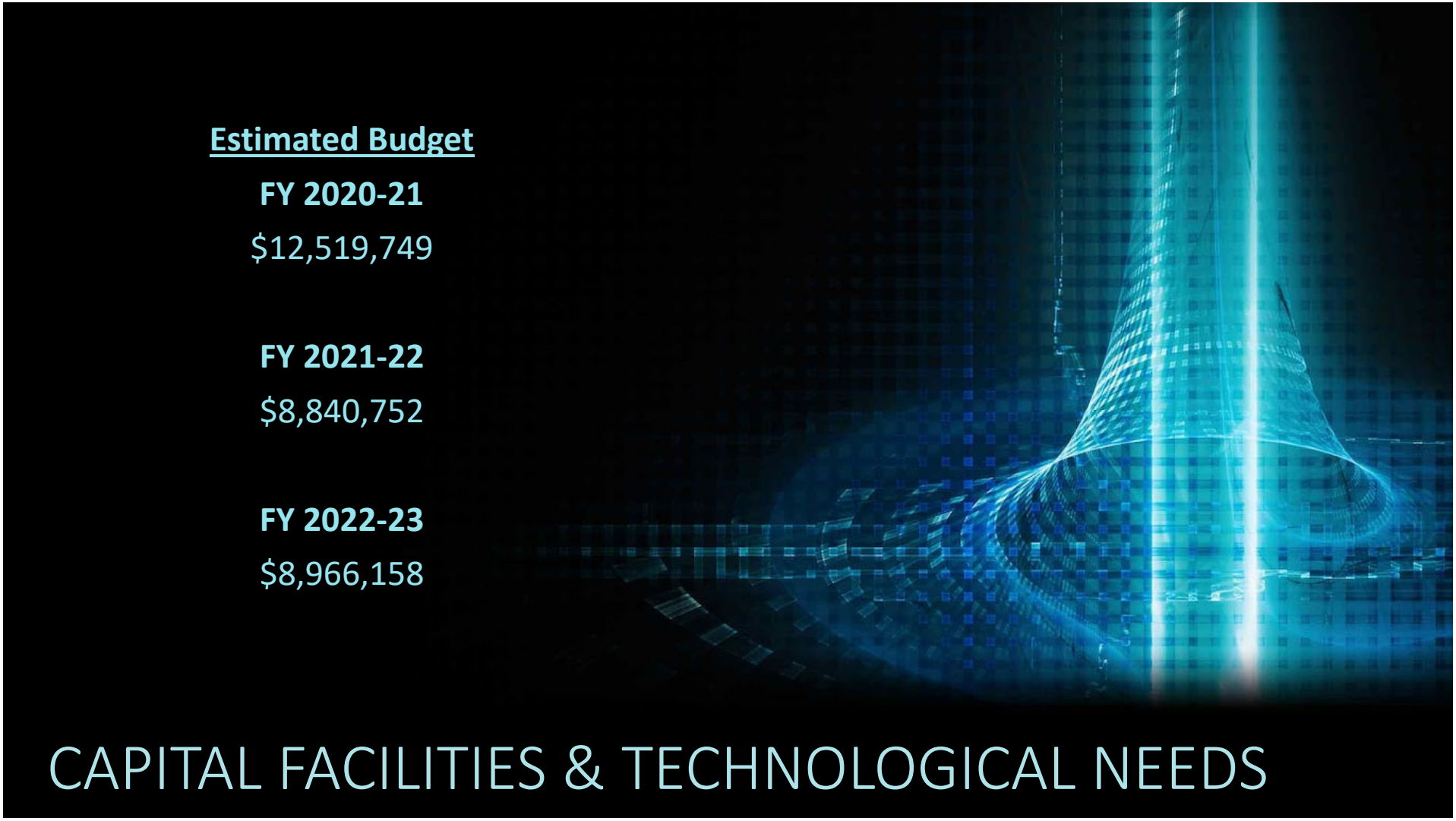
FY 2021-22

$5,219,984

FY 2022-23

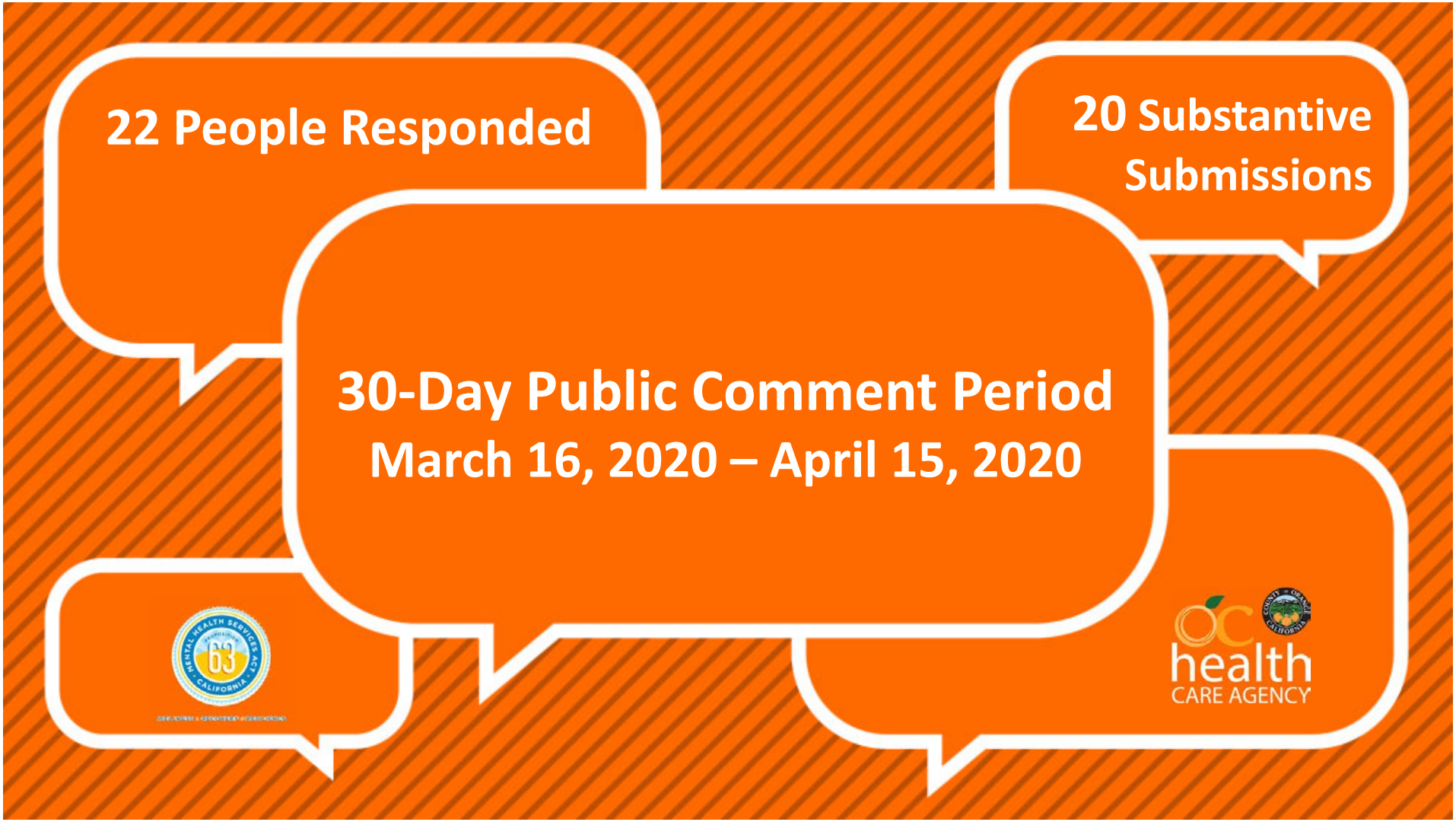
$5,296,662

WORKFORCE EDUCATION & TRAINING


Estimated Budget
FY 2020-21
$12,519,749
FY 2021-22
$8,840,752
FY 2022-23
$8,966,158
CAPITAL FACILITIES & TECHNOLOGICAL NEEDS

Estimated Total Three-Year Budget

FY 2020-21	FY 2021-22	FY 2022-23
$239,232,401	$236,984,606	$222,613,328


22 People Responded
20 Substantive Submissions
30-Day Public Comment Period
March 16, 2020 – April 15, 2020
health
CARE AGENCY


thank
Teachers
number
program
context
Cambodian
current
Update
programs
Board
more
activities
survey
make
crisis
opportunities
increasing
before
considerations
Outreach
planning
ethnic
during
practice
systems
among
need
LEP/monolingual
efforts
especially
see
like
organizations
Intervention
MH
Early
area
older
school
process
other
adults
plan
last
community
service
Behavioral
revenue
understand
all
cost
help
consider
experience
keep
O&E
districts
Something
collaboration
time
place
addition
challenging
level
areas
COVID
youth
each
TCF
resources
moving
specific
budget
meetings
Central
Prevention
students
still
Accommodations
implement
needs
support
health
Based
included
Steering
information
Summary
years
continues
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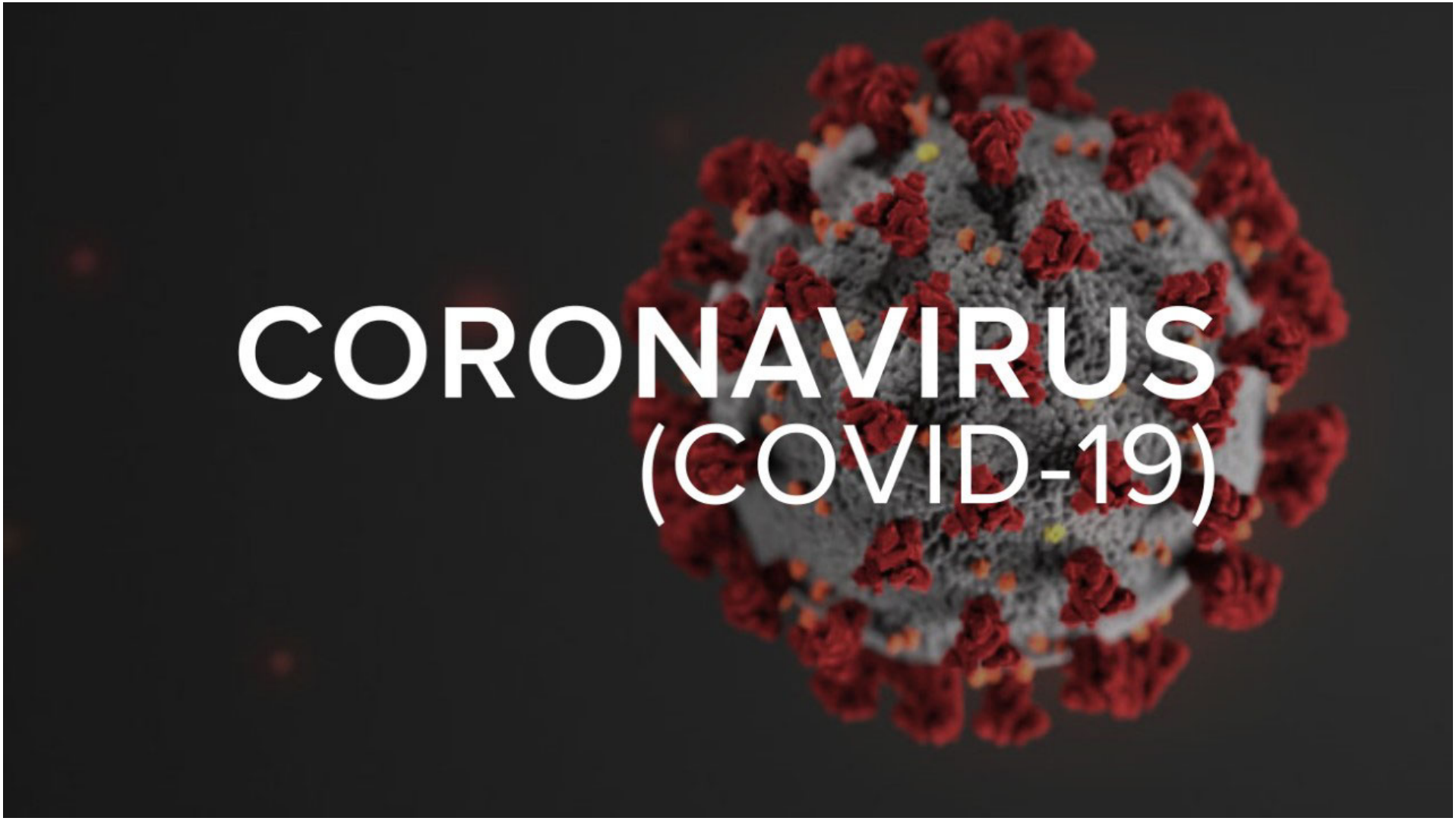
CORONAVIRUS
(COVID-19)

Comment Summary

- Financial impact
- Emotional, financial and other impacts will increase community need for services
- Plan needs dramatic revisions

Response

- BHS' rapid response to COVID-19 occurring under FY 2019-20 Plan
- Three-Year Plan (3YP) offers greater flexibility by allowing automatic diversion of dollars to Strategic Priority Areas
- 3YP not a commitment to spend
- HCA and CEO Fiscal monitoring revenue & expenditures closely
- Federal & State funds available for COVID-related costs
- Can amend 3YP if needed

STRATEGIC PLANNING

Comment Summary

- Increase community engagement, refine community planning
- Sufficient services to accommodate improved navigation?
- Decreasing enrollment = discontinued program?
- Timely checkpoints to assess effectiveness of Plan?
- If program is not effective, can it be discontinued?

Response

- BHS to engage in planning w/ diverse community stakeholders over 3YP
- Crisis, several treatment programs expanded in 3YP
- PEI consolidations designed to decrease wait times, increase enrollment
- Oversample CHIS to obtain more reliable estimates of MH trends
- If QI efforts not effective, program could be discontinued


Budget

Comment Summary	Response
• Can there be braided funding with Be Well Hubs; include Hubs in Plan?	• Braided funding will happen at contract level, not in MHSA Plan • CFTN can receive CSS transfers, pending availability of funds, should additional location(s) be identified
• Level funding practice in contracted program budgets?	• *Please see written response*

EARLY CHILDHOOD MENTAL HEALTH

Comment Summary

- Need greater focus on 'upstream' concept:
  - Maternal mental health
  - Early intervention that provides parents w/ skills to support children's socio-emotional development, addresses traumatic experiences
- Age range of children (0-15) is too broad; dedicate section to Early Childhood Mental Health

Response

- Several PEI programs provide these services:
  - "Safe from the Start" (in Violence Prevention Education program)
  - OC Parent Wellness Program
  - School Readiness
  - Early Childhood Education and MH Services
  - Parent Education Services
- External audits have noted too many programs/sections; Age range defined by the MHSA but will work to break down age bands, where possible


OUTREACH
&
SERVICE NAVIGATION

Comment Summary

- Difficult to navigate system or know what services are available, especially for youth

- BHS O&E, Courtyard Outreach & OC Links could connect w/ more community partners

Response

- K-12 School-Based MH Services program will increase awareness of available resources, support students, families, school staff:
  - Resource Development
  - Community Networking
  - Training
  - Educational Activities
- OC Links is available (w/ *expanded hours in response to COVID-19*)

- HCA continues to be interested in supporting partnerships w/ community organizations

SCHOOL-BASED MENTAL HEALTH

Comment Summary

- Need more MH services on campus
  - Crisis services
- Collaborate w/ schools, avoid duplication in what schools and HCA offers

Response

- The 3YP offers the following:
  - Increase CSS outpatient treatment for youth, including new school-based services that leverage Local Control & Accountability Plan (LCAP) and Medi-Cal funds
    - 1st year = partial funds for planning, can be increased if needed, pending availability of funds
  - Increase all Crisis Prevention & Support programs, primary focus on children under age 18
  - Increase School-Based MHS program capacity by consolidation
- Will continue to strengthen collaboration w/ schools

OLDER ADULTS

Comment Summary

- Older adults (OAs) are under-represented in MHSA funding
- Continue expanded funding for Early Intervention Services for Older Adults (EISOA)

Response

- The 3YP offers the following:
  - Increase in CSS outpatient treatment programs for OAs
  - Targeted content for OAs in PEI "Outreach" and "MH/Well-Being"
  - Ability to augment Crisis Prevention & Support programs to meet OA needs
  - Opportunity to target some telehealth options for OAs
- Community planning for FY 2022-23 will help determine whether to continue increase budget for EISOA
- **Potential Opportunity**: Add OAs as priority population under "Access" strategic priority, allowing for greater flexibility in adjusting budgets/programs for OAs


VETERANS

Comment Summary	Response
• No INN projects focusing on OA veterans	• An OA veteran project idea submitted via the INN Idea Generation website has been selected as one of the potential ideas to undergo further vetting
• Expand Early Intervention for Veterans program to additional locations	• HCA is open to other suggested sites for field-based engagement of Veterans

UNDERSERVED POPULATIONS

Comment Summary

- How will the HCA ensure Suicide Prevention efforts are responsive to different groups?
- BHS programs have threshold language deficiency
- How will penetration rates into priority populations least likely to receive Minimally Adequate Treatment be monitored?
- Continue TDD/TYY until obsolete; get ASL interpreter, who can communicate over Video Phone; offer more sensitivity trainings

Response

- BHS will engage members of priority populations, stakeholder groups to identify strategies that are responsive to unique needs of different communities, including ways to increase language capacity
- Penetration rates computed using client/census demographic data
  - Oversample CHIS, track disparities
- HCA contracts with vendor to provide ASL services when requested; has a Deaf Services Coordinator who provides trainings and consultations

HOUSING / SHELTER

Comment Summary

- Shelters and recuperative care facilities are increasing and need mental health and psychiatry services on site
- Concern about 90% cut in the housing budget – from $34 million down to $4 million per year for the next three years; advocate for additional funding, secure approval for local sites

Response

- Short-Term Housing and Bridge Housing serve clients receiving BHS outpatient treatment and provide field-based mental health treatment
- $30.5 million is dedicated to build Permanent Supportive Housing (PSH) over the next several years; the remaining ~$4 million are annual costs for the Year-Round Shelter & Bridge Housing programs
- HCA continues to work closely with OCCR to maximize funding for PSH and has been, and will continue to, apply for No Place Like Home funds to develop housing for individuals living w/ SMI

LEGAL SERVICES

Comment Summary

- Consumers facing legal issues related to their benefits could be referred to local legal services organizations

- Access to legal services should be a key concern in the 3YP

Response

- HCA welcomes the opportunity to utilize community agencies as a referral location for legal services as appropriate

- Legal services listed when frequent; broader understanding of how often legal services are needed is lacking
- HCA is continuing to build data analytics capacity; will report status updates in future Plans

AWARENESS / MEDIA CAMPAIGNS

Comment Summary

- Partner w/ existing Each Mind Matters (EMM)/Promise to Talk campaigns and don't create own
- More work needs to be done to address stigma, including w/ landlords, employers
- Recommend collaboration with organizations that work w/ mothers experiencing post-partum MH conditions

Response

- HCA appreciates importance of coordinating efforts; has been a long-time contributor to EMM
- The HCA will ensure the MH & Well-Being program will expand to include employers, landlords
  - Stigma Free OC campaign strives to increase support for recovery and well-being among employers & organizations
- OC PWP will continue to outreach to this target population and work to reduce MH-related stigma

Recommendation from the MHSA Steering Committee

Implement telehealth components, and the technology needed to support telehealth, into the Scope of Work and budgets of programs in the coming FY, as appropriate, to be monitored yearly for right-sizing / sustainment / growth, as dictated by new environmental challenges and learnings from changes necessitated by the current pandemic.

Add a disclaimer to the Executive Summary or the beginning of the Plan stating that service delivery systems may be adapted using individual promising practices and/or technology (i.e., telehealth, telephonic, video conferencing, etc.) to ensure appropriate access to, and quality of, services.


THANK
YOU

APPENDIX XIII - PUBLIC HEARING MINUTES

health CARE AGENCY

BOARD OF SUPERVISORS

Michelle Steel, Chairwoman
Second District

Andrew Do, Vice Chair
First District

Lisa Bartlett
Fifth District

Donald P. Wagner
Third District

Doug Chaffee
Fourth District

MHB MEMBERS

Michaell Rose, DrPH, LCSW, Chair

Matthew Holzmann, Vice Chair

Supervisor Andrew Do,
First District

Clayton Chau, MD, PhD

Christine Costa, DNP, PMHNP-BC

Karyl Dupee, LMFT

Sandra Finestone, Psy.D.

Mark Levy

Stephen McNally

Kristen Pankratz, MSW

Bethsabe Romero, PhD

Courtney Smith

Nita Tewari, PhD

Joy Torres

Duan Tran, MSW

ADAB MEMBERS

Frederick Williams, LMFT, Chair

Margaret Fleitman, 1st Vice Chair

Lauren Slivinski, 2nd Vice Chair

Stacey Deeble- Reynalds

Johnnie Harris

Geoffrey Henderson

Debra Kelsey

County of Orange
Mental Health Board &
Alcohol and Drug Advisory Board

405 W. 5th Street
Santa Ana, CA 92701
TEL: (714) 834-5481
MHB Website:
http://ochealthinfo.com/bhs/about/mhb

Wednesday, April 22, 2020
5:30 p.m. – 8:00 p.m.

Teleconference meeting via Zoom
By Computer: https://zoom.us/j/572370431
By Phone: +1 301 715 8592
Meeting ID: 572 370 431

MINUTES
Page 1 of 5

Members Present: Clayton Chau, Stacy Deeble-Reynolds, Karyl Dupee, Sandra Finestone, Johnnie Harris, Geoffrey Henderson, Matthew Holzmann, Stephan Lambert, Lorraine Martinez, Stephen McNally, Kristen Pankratz, Bethsabe Romero, Michaell Rose, Nita Tewari, Duan Tran, Frederick Williams

Members Absent: Supervisor Andrew Do, Margaret Fleitman, Debra Kelsey, Mark Levy, John Merwald, Lauren Slivinski, Joy Torres,

Call to Order at 5:34 p.m. by Dr. Michaell Rose

Welcome and Introductions
- Pledge of Allegiance
- Members introduced themselves via roll call.

Public Comment
- Christine Tolbert:
  Ms. Tolbert provided information on a virtual event that would provide information on eligibility requirements and program benefits for CalABLE.
- Michael Arnot:
  Mr. Arnot thanked the Board for continuing to hold their meeting in the midst of the pandemic. He recommended that the Board change their resource and finance ad hoc to a standing committee to track funding, budget cuts, and financial impacts.

Open MHSA Public Hearing
- Opening Remarks and Brief Overview: Sharon Ishikawa, MHSA Coordinator
  - Dr. Ishikawa thanked the guests in attendance and the members of the Mental Health Board and the Alcohol and Drug Advisory Board. She explained the purpose of today's Public Hearing, which included a brief overview and all public comments received during the 30-day public comment period. Dr. Ishikawa provided a detailed presentation which included a brief overview of the Three-Year MHSA Plan strategic priorities and proposed budgets.

health CARE AGENCY

ADAB MEMBERS
(Continued)

Stephan Lambert

Lorraine Martinez

John Merwald

Jane Palmer

HEALTH CARE AGENCY

Jeff Nagel, Ph.D.,
Deputy Agency Director
Behavioral Health Services

Annette Mugrditchian, LCSW
Director of Operations
Behavioral Health Services

Karla Perez
Staff Specialist
Behavioral Health Services

County of Orange
Mental Health Board &
Alcohol and Drug Advisory Board

Wednesday, April 22, 2020
5:30 p.m. – 8:00 p.m.

MINUTES
Page 2 of 5

Opening Remarks and Brief Overview: *Continued*
- The strategic priorities included **Access**, to include expansion of transportation, expanding school-based mental health, developing tele/virtual health, improve cultural and linguistic responsiveness. The second priority is **Mental Health Awareness**, to include expansion of mental health awareness and stigma reduction efforts, tailored to different age and cultural groups. Third priority is **Suicide Prevention**, to include expansion of crisis services. In addition, she provided estimated budgets for all MHSA Components. The estimated total three-year budgets include: FY 2020-21 at $239,232,401, FY 2021-22 at $236,984,606, and FY 2022-23 at $222,613,328. Furthermore, Dr. Ishikawa provided a copy and overview of all public comments received during the 30-day public comment period for the MHSA Plan. There were a total of 20 substantive submissions received by the MHSA Office. Responses were organized based on the following categories: Coronavirus (COVID-19), Strategic Planning, Budget, Early Childhood Mental Health, Outreach & Service Navigation, School-Based Mental Health, Older Adults, Veterans, Underserved Populations, Housing/ Shelter, Legal Services, and Awareness and Media Campaigns. In addition, she reviewed a recommendation from the MHSA Steering Committee regarding telehealth services.

Identified Programs and MHSA Participants:
- A total of ten (10) identified individuals provided a comment with regard to MHSA-funded services they have received. These individuals represented a consumer, family member, professional, and public interest point of view. Programs represented were as follows: Opportunity Knocks Full Services Partnership (FSP; provided by Telecare), Early Intervention Services for Older Adults (provided by Council on Aging), Mental Health Community Education Events for Reducing Stigma and Discrimination (provided by Latino Health Access' Life in Full Color Program), Older Adult Services Program (provided by the HCA), Wellness and Prevention Center's Event of Back Together4Teens (an event funded by PEI) , In Home Crisis Stabilization Program (provided by the adult team from The Prevention Center), Early Intervention Services for Older Adults (provided by The Cambodian Family, as part of MECCA), School Readiness Program (provided by The Priority Center), WarmLine (provided by NAMI OC), and Project RENEW FSP (provided by Pathways).

Public Comment: (3)
- Michael Arnot:
  Mr. Arnot urged the Board to do everything possible in advising BHS to not make any cuts or reduction of programs. He asked for MHSA to have a plan in utilizing savings, spreading out restrictions to release funds and save programs. In addition, looking into MHSA reserves before considering any cutting of programs.

Public Comment: *continued*

- Vattana Peong:
  Mr. Peong thanked HCA for creating an MHSA Plan with community input. He urged the Board to support older adult services, COVID-19 will bring an increase in mental health services in the coming months. In addition, there is a need for youth programs in central Orange County that are school-based and community based.
- Phatana Ith:
  Ms. Ith thanked HCA for all of their efforts for providing support to increase meaningful community participation in the MHSA Community Planning Process. Grateful to have been a part of this year's community planning process and seeing the Cambodian Community be included. She recommends that there be additional meetings, held on different days of the week and time frames as well by region, to accommodate all members of the community.

Close Public Hearing and MHB Vote: Action Item

- Dr. Rose called for a discussion amongst all members, both ADAB and MHB members in providing any substantive recommendations for the MHSA 3-Year Plan.

- The following substantive recommendations were made by the Boards, and a motion to approve each recommendation was made. Quorum for the MHB was met, and vote was made via roll call.

- **Recommendation #1**: The MHB recommends that BHS and the Board of Supervisors (BOS) emphasize and implement public health models in outreaching to all members of the Orange County population. In addition, to coordinate multi-agency collaboration to meet these needs.

  1st Motion: Duan Tran, 2nd Motion: Nita Tewari. 12 yes/ 0 No

Name	Yes	No	Abstain
Supervisor Andrew Do			
Clayton Chau, MD, PhD	X		
Christine Costa, DNP, PMHNP-BC	X		
Karyl Dupee, LMFT	X		
Sandra Finestone, Psy.D.	X		
Matthew Holzmann	X		
Mark Levy			
Stephen McNally	X		
Kristen Pankratz, MSW	X		
Michaell Rose, DrPh, LCSW	X		
Bethsabe Romero, PhD	X		
Courtney Smith	X		
Joy Torres			
Nita Tewari, PhD	X		
Duan Tran, MSW	X		

County of Orange
Mental Health Board &
Alcohol and Drug Advisory Board
Wednesday, April 22, 2020
5:30 p.m. – 8:00 p.m.

- **Recommendation #2**: Older Adults should be a priority population.

  1st Motion: Sandra Finestone, 2nd Motion: Matthew Holzmann. 12 yes/ 0 No

Name	Yes	No	Abstain
Supervisor Andrew Do			
Clayton Chau, MD, PhD	X		
Christine Costa, DNP, PMHNP-BC	X		
Karyl Dupee, LMFT	X		
Sandra Fineston, Psy.D.	X		
Matthew Holzmann	X		
Mark Levy			
Stephen McNally	X		
Kristen Pankratz, MSW	X		
Michaell Rose, DrPh, LCSW	X		
Bethsabe Romero, PhD	X		
Courtney Smith	X		
Joy Torres			
Nita Tewari, PhD	X		
Duan Tran, MSW	X		

- **Recommendation #3**: The MHB supports the Plan but recognizes that there may be substantial financial impact from the current economic crisis. We recommend that the BOS, BHS, and the MHB collaborate in revisiting the MHSA Plan once there is clarity on future revenue adjustment.

  1st Motion: Sandra Finestone, 2nd Motion: Karyl Dupee. 12 yes/ 0 No

Name	Yes	No	Abstain
Supervisor Andrew Do			
Clayton Chau, MD, PhD	X		
Christine Costa, DNP, PMHNP-BC	X		
Karyl Dupee, LMFT	X		
Sandra Fineston, Psy.D.	X		
Matthew Holzmann	X		
Mark Levy			
Stephen McNally	X		
Kristen Pankratz, MSW	X		
Michaell Rose, DrPh, LCSW	X		
Bethsabe Romero, PhD	X		
Courtney Smith	X		
Joy Torres			
Nita Tewari, PhD	X		
Duan Tran, MSW	X		

County of Orange
Mental Health Board &
Alcohol and Drug Advisory Board

Wednesday, April 22, 2020
5:30 p.m. – 8:00 p.m.

- Dr. Rose called for a motion for their vote in support to move forward with the MHSA 3-Year Plan FY 20/21 – 22/23. The Board supported moving forward with the Plan for the approval of the BOS, with a 12 yes/ 0 No vote.

  1st Motion: Matthew Holzmann, 2nd Motion: Nita Tewari.

Name	Yes	No	Abstain
Supervisor Andrew Do			
Clayton Chau, MD, PhD	X		
Christine Costa, DNP, PMHNP-BC	X		
Karyl Dupee, LMFT	X		
Sandra Fineston, Psy.D.	X		
Matthew Holzmann	X		
Mark Levy			
Stephen McNally	X		
Kristen Pankratz, MSW	X		
Michaell Rose, DrPh, LCSW	X		
Bethsabe Romero, PhD	X		
Courtney Smith	X		
Joy Torres			
Nita Tewari, PhD	X		
Duan Tran, MSW	X		

Adjournment
- 8:34 p.m.

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: OCMentalHealthBoard@ochca.com ***

APPENDIX XIV - ORANGE COUNTY BOARD OF SUPERVISORS MINUTE ORDER

ORANGE COUNTY BOARD OF SUPERVISORS
MINUTE ORDER
June 02, 2020

Submitting Agency/Department: HEALTH CARE AGENCY

Approve Orange County Mental Health Services Act Three-Year Program and Expenditure Plan for Mental Health Services Act, Proposition 63 programs and services, 7/1/20 - 6/30/23; and authorize Director or designee to execute plan - All Districts

The following is action taken by the Board of Supervisors:
APPROVED AS RECOMMENDED ☒ OTHER ☐

Unanimous ☒ (1) DO: **Y** (2) STEEL: **Y** (3) WAGNER: **Y** (4) CHAFFEE: **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. 52

Special Notes:

Copies sent to:

HCA – Annette Mugrditchian

6/5/20

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

6/11/2020 AGENDA STAFF REPORT

Agenda Item

AGENDA STAFF REPORT

ASR Control 20-000355

MEETING DATE:	06/02/20
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):	Annette Mugrditchian (714) 834-5026 Jeff Nagel (714) 834-7024

SUBJECT: Mental Health Services Act Three-Year Program and Expenditure Plan

CEO CONCUR	**County Counsel Review**	**Clerk of the Board**
Concur	N/A	Discussion 3 Votes Board Majority

Budgeted: N/A **Current Year Cost:** N/A **Annual Cost:** FY 2020-21: $239,232,401
FY 2021-22: $236,984,606
FY 2022-23: $222,613,328

Staffing Impact: No **# of Positions:** **Sole Source:** N/A
Current Fiscal Year Revenue: N/A
Funding Source: 100% (Mental Health Services Act/Prop 63) **County Audit in last 3 years:** No

Prior Board Action: 05/21/2019 #33

RECOMMENDED ACTION(S):

1. Approve 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, 2020, through June 30, 2023.
2. Authorize the Health Care Agency Director, or designee, to execute the County's Mental Health Services Act Three-Year Program and Expenditure Plan as referenced in the Recommended Actions above.

SUMMARY:

Approval of the Orange County Mental Health Services Act Three-Year Program and Expenditure Plan will fund all Mental Health Services Act Programs for FY 2020-21 through FY 2022-23.

BACKGROUND INFORMATION:

In November 2004, California voters approved Proposition 63, the Mental Health Services Act (MHSA). The MHSA provides counties a source of funding that is separated into five components: Community Services and Support (CSS), Prevention and Early Intervention (PEI), Innovation (INN), Workforce Education and Training (WET) and Capital Facilities and Technological Needs (CFTN). The overall goal of the MHSA is to provide services designed to reduce the long-term adverse impact of untreated mental illness and create a comprehensive system of behavioral health care.

Welfare and Institutions Code (WIC) §5847 and §5848 require that the MHSA Three-Year Program and Expenditure Plan (Plan) is developed through a stakeholder process, adopted by your Honorable Board of Supervisors (Board), and then submitted to the state Department of Health Care Services (DHCS) and Mental Health Services Oversight and Accountability Commission (MHSOAC). On May 21, 2019, the Board approved the final Annual Plan Update to the Three-Year Plan for FYs 2017-18 through 2019-20.

The MHSA Three-Year Program and Expenditure Plan (Plan) serves as a stakeholder-informed framework, developed through a community planning and needs identification process that outlines all programs eligible to be funded through local MHSA dollars. Each program in the Plan contains a description of its services, the target population it intends to serve, estimated costs and, if already implemented, outcomes and a narrative of any significant challenges or changes the program encountered in the previous year of operation. Once the Plan is approved and submitted to the state, the County is authorized to implement the Plan. All expenditures related to the MHSA Plan are approved by your Board through separate actions, in accordance with County budgeting and procurement processes.

The economic disruption caused by COVID-19 is expected to have an impact on future MHSA revenue and the Health Care Agency (HCA) is planning accordingly. Along with the County Executive Office (CEO) Budget Office, HCA is actively monitoring MHSA revenue and any deviations from current projections that were used to develop this Plan under consideration. The DHCS' fiscal consultant has provided projections on the MHSA revenue impacts due to COVID-19, and HCA is making adjustments based on those projections. Any reduction in future MHSA revenue will also need to be factored against potential savings due to reduced MHSA expenditures because of reduced and/or postponed programming. Even prior to COVID, Behavioral Health Services (BHS) had begun working to identify and implement efforts to better leverage other funding sources (such as Federal Financial Participation or Medi-Cal) using MHSA-funded services as the source of match for these federal dollars. This strategy is more important now with expected reductions in other state derived revenue sources, such as 1991 and 2011 Realignment.

The proposed Plan for FYs 2020-21 through 2022-23 was developed through a required community program planning process. The MHSA Coordination Office greatly expanded community stakeholder involvement by distributing a Community Feedback Survey; hosting a MHSA Consumer Stakeholder Training; facilitating eight Community Engagement Meetings for four stakeholder groups (i.e., service providers, consumers and family members, K-12 Public School Districts, Criminal Justice representatives); and identifying behavioral health needs and disparities from published reports (i.e., Orange County Needs and Gaps Analysis (October 2019 UCSD), CalOptima Member Health Needs Assessment (March 2018), 25th Annual Report on the Conditions of Children in Orange County, Suicide Deaths in Orange County, CA (2014-2018), Orange County Healthier Together Website (accessed in January 2020)).

Findings were consolidated across these sources and strategic priorities for the Plan were identified per the request of the MHSA Steering Committee:

- Improve Mental Health Awareness and Stigma Reduction among Orange County residents by increasing funding to various PEI-funded programs that provide community outreach, education, training, public services announcements and awareness campaigns and events, making sure to tailor messages to different age groups and cultural communities.
- Enhance the County's suicide prevention efforts by increasing PEI and CSS funding to all programs in the MHSA Crisis Prevention and Support Services area, with a particular focus on expanding capacity for children/Transitional Age Youth under age 18 and older adults, and ensuring responsiveness to LGBTQ, Veterans and other underserved cultural groups. Over the next

three years, HCA will review and incorporate strategies from the MHSOAC's Striving for Zero report and continue partnering with the OC Suicide Prevention Initiative and local organizations championing this effort.

- Improve Access to Behavioral Health by increasing funding in order to expand transportation assistance to families with young children and additional adult consumers (PEI, CSS); expand school-based mental health services (CSS); offer new telehealth and/or virtual behavioral health care options to consumers of all ages as appropriate (CSS); and identify and integrate strategies that improve the cultural and linguistic responsiveness of the system of care (PEI, CSS).

Strategies for tracking incremental progress in implementing the priorities and monitoring the effectiveness of the strategies and their impact will be developed and reported in future Annual Plan Updates and the next Three-Year Plan.

The MHSA Steering Committee, Mental Health Board and Alcohol and Drug Advisory Board reviewed community feedback on December 16, 2019, and the proposed strategic priorities, programs and budgets on January 13 and 29, 2020. Per the WIC §5848, the draft Plan was posted and electronically distributed on March 16, 2020, for a 30-day Public Comment period. The Mental Health Board held a virtual Public Hearing on April 22, 2020. There were 20 comments submitted by the public and responded to by the HCA.

As noted at the end of the Executive Summary, community planning for the Plan occurred prior to the broader outbreak of COVID-19 and the stay-at-home orders. The pandemic has impacted many aspects of daily life, including emotional well-being, and BHS provides essential services capable of addressing such impacts. Similar to how the BHS workforce continues to provide services to the community under the FY 2019-20 MHSA Plan and other public mental health funding streams, the behavioral health programs and services proposed in the Three-Year Plan beginning FY 2020-21 will have the same flexibility to adapt to changing conditions, including the emotional impacts of the pandemic here in Orange County. This can include maintaining expanded program hours or staffing to respond to the behavioral health needs of the community, continuing telehealth and telephonic services, providing COVID-related resources to staff to help assist the community, providing Public Service Announcements and Mental Health Resources websites to the community directly and continuing to collaborate with other County departments and stakeholders. In addition, HCA and CEO fiscal staff will continue to monitor MHSA revenue and expenditures closely and assess whether modifications to proposed program budgets may be needed in the future.

MHSA Component Information:

WET will continue with level funding. Notable changes to other components in the Plan are outlined below:

CSS:

- Expand funding for and service capacity of Crisis Prevention and Support Services Programs (Suicide Prevention priority): Mobile Crisis Assessment; Crisis Stabilization Units; In-Home Crisis Stabilization; and Crisis Residential Services.
- Expand funding for and service capacity of Clinic Expansion Programs (Access to Behavioral Health priority): Children and Youth Expansion Services (including school-based services for students living with serious emotional disturbance/serious mental illness); OC Children with Co-Occurring Mental Health Disorders; Services for Short-Term Residential Short-Term Therapeutic Residential Program; Older Adult Full Service Partnership (FSP); Program for Assertive Community Treatment (older adult team); Older Adult Services and Adult FSP (by converting the Supportive Services for Residents in Permanent Supportive Housing program to a specific FSP target population).
- Expand funding for and ride capacity of the Transportation program (all ages; Access to Behavioral Health priority).
- Develop a new Telehealth/Virtual Behavioral Health Care Program (Access to Behavioral Health priority).
- Discontinue MHSA funds for the Adult Dual Diagnosis Residential Treatment Program;

services will continue using Drug Medi-Cal and Medi-Cal funding.

PEI:

- Expand funding and/or service capacity of statewide Projects (Mental Health Awareness and Stigma Reduction priority); the WarmLine and Suicide Prevention Services (Suicide Prevention priority); and the OC Parent Wellness Program (for families referred by the Social Services Agency).
- Provide new PEI funding for Transportation Assistance (Access to Behavioral Health priority).

Innovation:

- In addition to continuing existing projects, several ideas are being explored as potential new projects, some of which may be brought before the Board in the future. Ideas that will be the initial focus of exploration include allcove (integrated youth drop-in centers), middle school student wellness centers, adaptation of previously approved mobile phones Innovation project that was not launched due to lack of response to the original Request for Proposal, multi-county psychiatric advance directives project and innovative approaches to stigma reduction.
- The Religious Leaders Behavioral Health Training project will continue through the PEI-funded Outreach for Increasing Recognition of Early Signs of Mental Illness program.
- CFTN will continue to support renovation costs for the Behavioral Health Training Facility, which were built into the ongoing lease rather than paid in full upfront; development of the HCA Electronic Health Record; and partial costs for the County Data Integration Project.

Below is the summary of MHSA's Plan Budget for each component:

Component	CSS	PEI	INN	WET	CFTN	Total
FY 2020-21	$155,088,175	$47,061,483	$18,346,360	$6,216,634	$12,519,749	**$239,232,401**
FY 2021-22	$164,627,171	$49,286,926	$9,009,773	$5,219,984	$8,840,752	**$236,984,606**
FY 2022-23	$165,320,336	$40,988,101	$2,042,071	$5,296,662	$8,966,158	**$222,613,328**

HCA requests that the Board approve the Orange County MHSA Three-Year Program and Expenditure Plan for FY 2020-21 through FY 2022-23 as referenced in the Recommended Actions.

FINANCIAL IMPACT:

All expenditures related to the MHSA Three-Year Program and Expenditure Plan are approved by the Board through separate actions, in accordance with County budgeting and procurement processes.

Appropriations and Revenue for the MHSA Plan will be included in Budget Control 042 FY 2020-21 Budget and in the budgeting process for the future years.

STAFFING IMPACT:

N/A

ATTACHMENT(S):

Attachment A - MHSA Three Year Program and Expenditure Plan
Attachment B - Welfare and Institutions Code §5847 and §5848