WELLNESS • RECOVERY • RESILIENCE

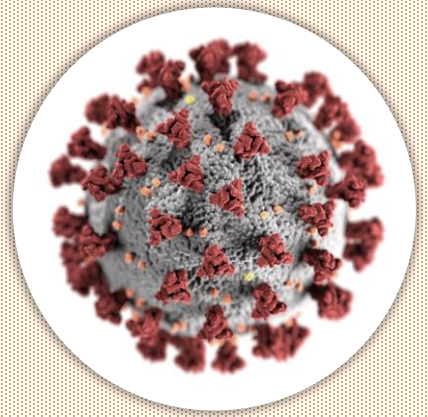
Orange County MHSA Annual Plan Update

for
FY 2021-22

A Snapshot of Emotional Well-Being in Orange County during COVID-19

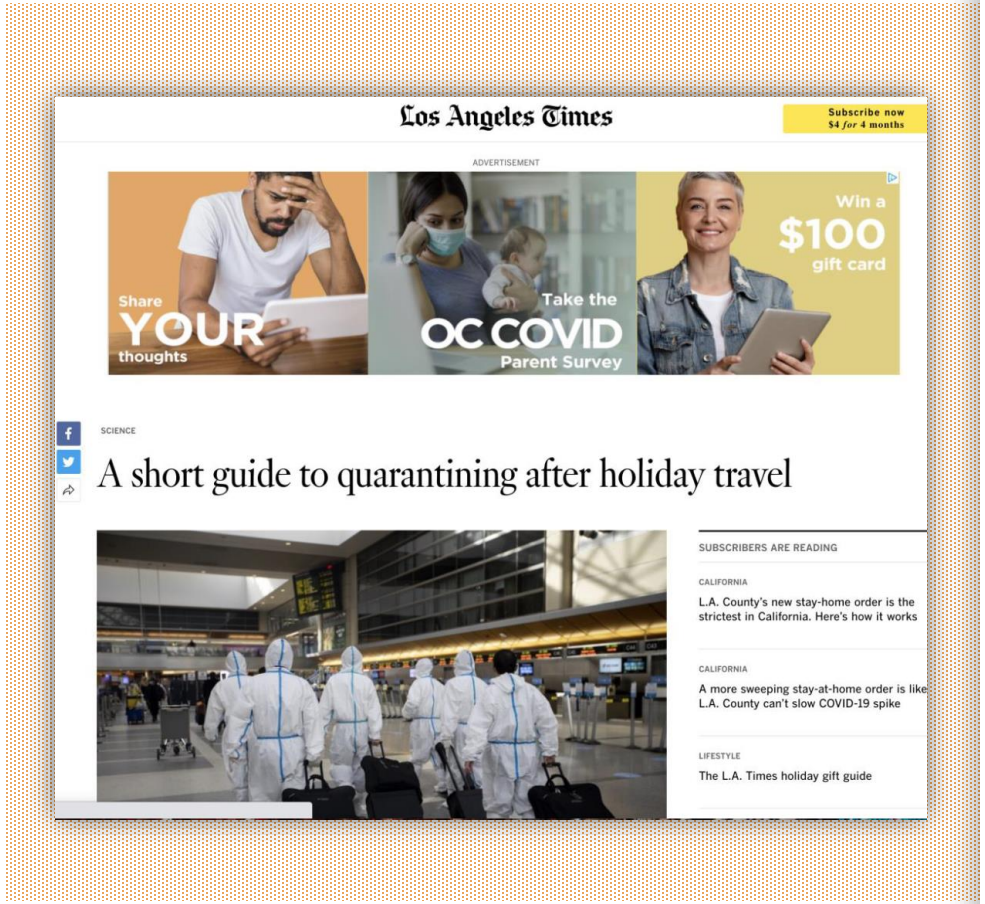
Results from the OC COVID-19 Surveys

OC COVID-19 SURVEYS: WHY?



- Assess emotional well-being of OC residents during COVID-19 pandemic (Nov–Dec 2020)
- Assist the HCA in anticipating the potential impact of the pandemic on mental health
- Help improve responsiveness of county behavioral health services

OC COVID-19 SURVEYS: WHAT?

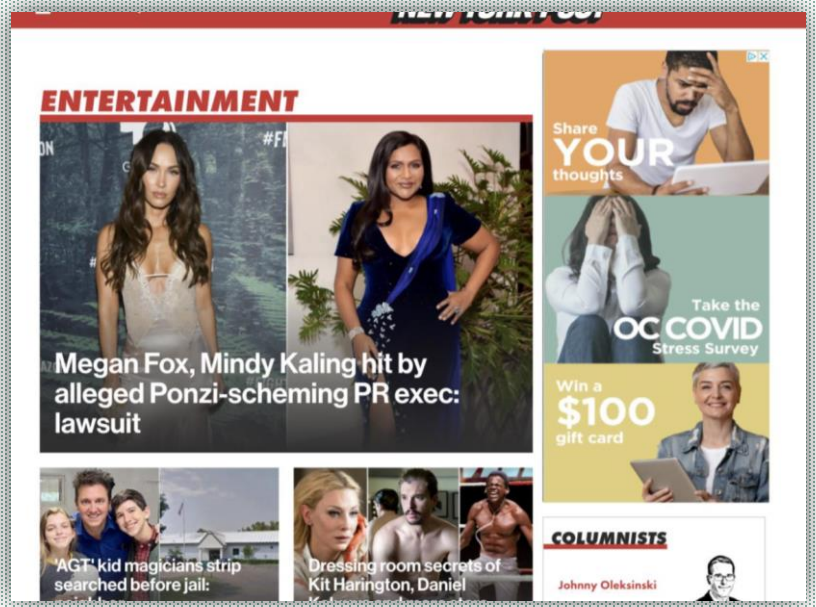


COVID-19 Related Items:
Adapted from CDC survey

Distress Items:
Kessler-6 (*adults*); Pediatric Symptom Checklist-17

Checklists on:
Coping Strategies, Healthcare Access, Barriers

OC COVID-19 SURVEYS: WHO?



Any Orange County adult ages 18+ years old *or* adult parent of a child ages 4-17 years

If 1+ child in household, parent asked to report on child "most affected" by COVID

Fluent in Arabic, English, Farsi, Khmer, Korean, Mandarin Chinese, Spanish, Vietnamese

OC COVID-19 Surveys: SUMMARY

- **COVID-19 has taken its toll on Orange County adults' well-being:**
  - over 1/2 reporting high levels of stress or anger,
  - 1/3 reporting increased or new use of substances or gambling,
  - over 1/4 reporting an elevated level of serious psychological distress, and
  - nearly 1/3 indicating they were having a "very" or "extremely" difficult time coping during the pandemic
- Orange County parents similarly noted that their **children's well-being was affected during COVID-19:**
  - approximately 1/5 of children exhibiting elevated levels of disruptive behavior and
  - nearly 1/2 experiencing elevated sadness or worry

- Fortunately, **Orange County residents have been resilient**, with an overwhelming number having stayed connected with their friends, family or social network and relying on them as a resource for maintaining their well-being during the pandemic (78% adults, 62% youth/parents).
- About 1/4 each of adults and children/parents also **sought help from a healthcare professional** for their stress or emotions during the pandemic, with the majority who tried having successfully connected with a therapist or a physician.

- Nevertheless, Orange County residents still face multiple **barriers when trying to connect to mental health care** (28% adults, 18% children/parents), with some of the most common challenges being lack of insurance or an ability to pay, inconvenient or delayed appointment times and uncertainty over who to call.

- **Less than 5% of adults or parents/youth had used a warmline, hotline or crisis line**, suggesting a potential area for improved outreach and marketing.

2021 Community Engagement Meetings: Summary of Process and Findings

Community Stakeholder Input on Needs and Strategies

- The HCA partnered with a diverse group of community-based organizations (CBO's) to co-host Community Engagement Meetings (CEMs) with clients, consumers and family members
- The purpose was to hear their recommendations on how to continue to advance Orange County's Strategic Priorities for the current MHSA Three-Year Plan (FY 2020-21 through FY 2022-23)

MHSA STRATEGIC PRIORITIES

- **Mental Health Awareness & Stigma Reduction**
- **Suicide Prevention**
- **Access to Behavioral Health Services**

CBO PARTNERS IN 2021 CEMS

2021 CEM Outreach to Priority Populations

CEM (n=21 meetings)	# Registered (n=480)	Children	TAY	Adults	Older Adults	Additional Population Characteristics
Arabic/Muslim Community	8			X	X	
Parents/Families (in Spanish)	8	X	X			Latino/Hispanic
BHS Consumers	31			X	X	Persons In Recovery w/ SUD
HCA Peers	12			X	X	
Cambodian Community	16			X	X	Asian/Pacific Islander
Chinese Community	6			X	X	Asian/Pacific Islander
Filipino Community	5			X	X	Asian/Pacific Islander
Family Resource Centers of OC	61	X	X			Latino/Hispanic
Korean Community	8			X	X	Asian/Pacific Islander
LatinX Transwomen	28					LGBTIQ, Latino/Hispanic
LGBTQ Community	6		X	X		LGBTIQ
LGBTQ Community (in Spanish)	4		X	X		LGBTIQ, Latino/Hispanic
LGBTQ Community (in Vietnamese/English)	6		X	X		LGBTIQ, Asian/Pacific Islander
Older Adults (two meetings*)	26 / 31				X	
Parent Partners	11	X	X			
Permanent Supportive Housing Residents	9		X	X		Persons in Recovery, *(Homeless Individuals)*
Persons In Recovery	41			X		Persons in Recovery w/ SUD
Veterans / Military-Connected Families	30	X	X	X	X	Veterans
Vietnamese Community	107		X	X	X	Asian/Pacific Islander
Wellness Center Members	30			X		

*** Two meetings facilitated in English, both of which supported Farsi-speaking individuals and one of which supported Khmer-speaking individuals through interpreters**

Input received in the 2021 CEMs

Breakout sessions gathered input from Consumers, Clients and Family Members on two areas that covered all three MHSA Strategic Priorities:

1

BREAKOUT SESSION 1:

Strategies programs can use to improve outreach, advertising and messaging on mental health and suicide prevention in diverse communities

2

BREAKOUT SESSION 2:

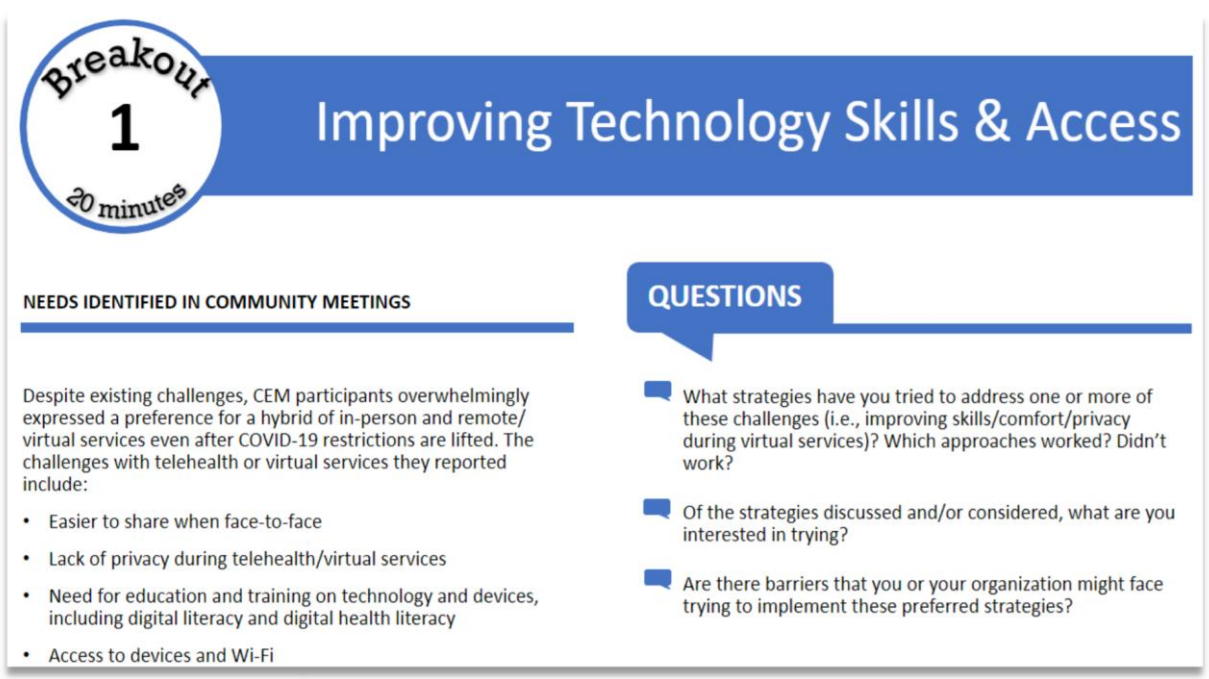
Strategies programs can use to make mental health services more welcoming and easier to connect with, especially for individuals from unserved communities

Collecting input from Clients, Consumers and Family Members

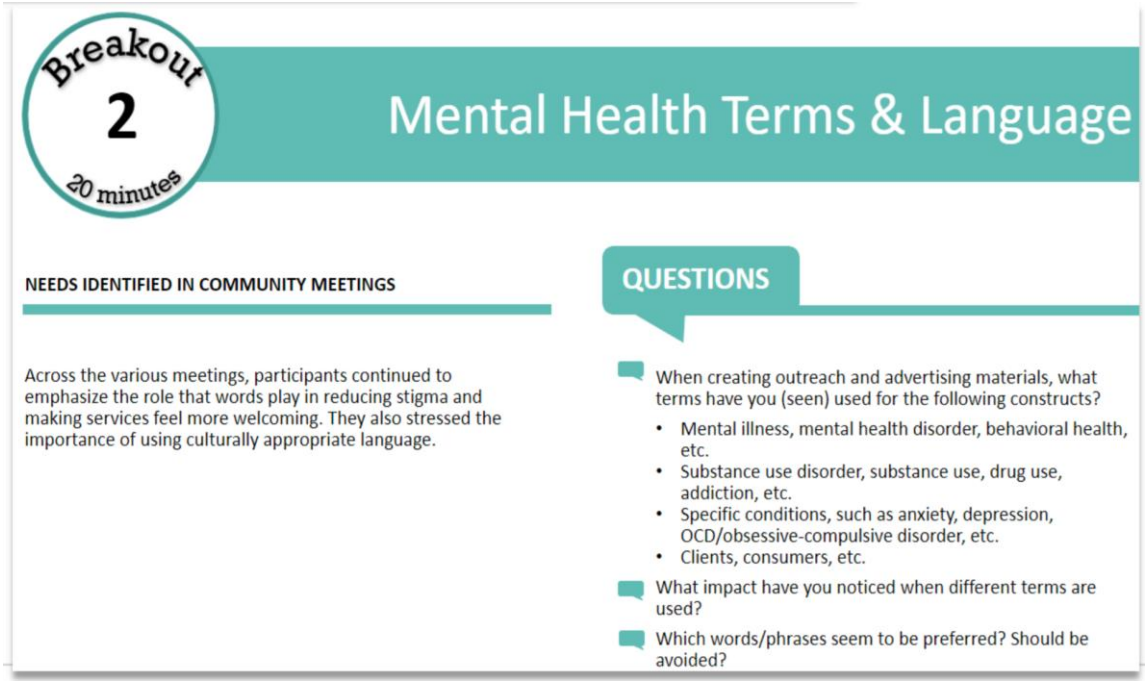
- A pair of CBO staff joined meeting participants in each Zoom breakout room
- One staff facilitated the group's discussion of the structured questions, and another took notes documenting the themes and main points discussed
- The breakout rooms were not audio recorded to encourage open discussion
- Following the CEM, CBO staff submitted their notes summarizing their group's discussion through an online MHSA Post-CEM Summary survey
- 61 surveys were returned and feedback was analyzed and synthesized according to themes

2021 Provider Engagement Meeting (PEM)

Breakout Room Questions



Corresponds to CEM Breakout Room 2: Strategies to Improve Access



Corresponds to CEM Breakout Room 1: Strategies to Improve Awareness

2021 CEM:
Analysis of Feedback
(Advertising and Outreach Strategies)

Prompts

Most Effective Advertising and Outreach Strategies

- **Social Media**, **Television**, and **Events/Fairs** were rated as the top three most effective advertising and outreach strategies overall
- Maps on to what participants reported in pre-CEM polling as the most common places where they remember seeing an ad

Least Effective Advertising and Outreach Strategies

- **Emails**, **Bus Shelter Ads**, **Newspapers**, and **Billboards** were rated as among the least effective advertising and outreach strategies overall, with some age group differences for Newspapers
- Maps on to low endorsement in pre-CEM polling as a place where they remember seeing an ad

Prompt

Are certain ways of advertising/promoting
better at reaching people of different ages, backgrounds, etc.?

SOCIAL MEDIA (YOUNGER ADULTS)

TV, RADIO & NEWSPAPERS (BILINGUAL & OLDER ADULTS)

COMMUNITY CENTERS (OLDER ADULTS)

Prompt

What would make an ad something you would remember or want to learn more about?*

REPRESENTATION & CULTURALLY APPROPRIATE MESSAGING

Prompt

Are some ways of advertising/promoting better suited for certain types of messages/ information than others?

SIMPLE WORDING FROM COMMUNITY OF INTEREST

APPROPRIATE & REPRESENTATIVE LANGUAGE

SHORT & PRECISE CONTENT

SPECIFIC RESOURCES

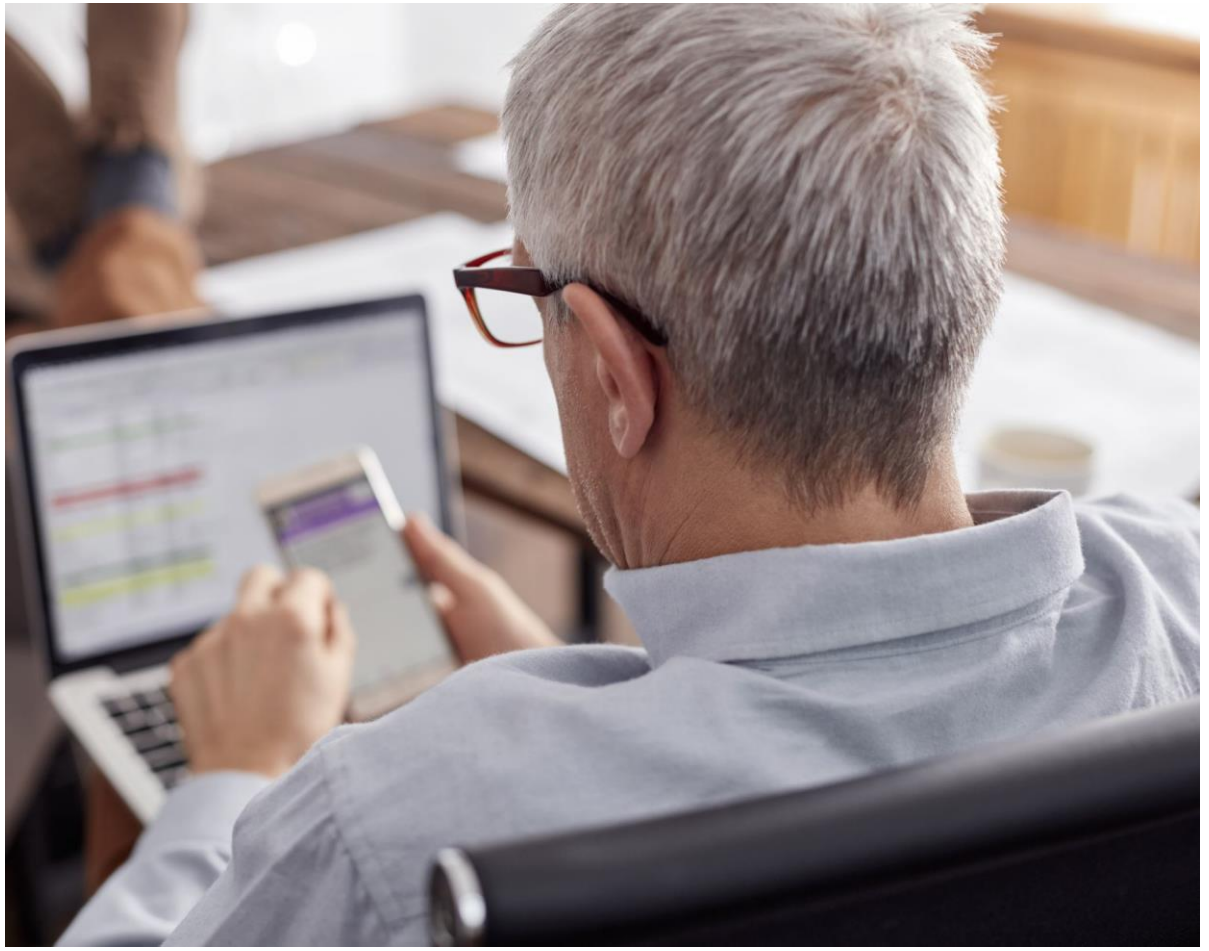
POSITIVE MESSAGING REFLECTED IN WORDS & IMAGES

GOOD VISUALS & COLOR

** Strategies & suggestions here were also discussed as part of "Improving Access" discussion "What would be most helpful to someone from my community in overcoming barriers like these?"*

Language:
Positive, Simple, Clear

- **Simplify** reading level (n = 15)
- **Reduce stigmatization** of material
- Use **slogans / phrases**
- Focus on **encouraging phrases**:
  - *"It's never too late to reach out for help."*
  - *"You've worked so hard until now."*
  - *"Let's do this together."*
  - *"Don't give up."*



Lengthy emails, including spam, can be ignored or missed

New PEI Expenditures Proposed as a Result of the CPPP

STRATEGIC PRIORITY: Mental Health Awareness & Stigma Reduction

Expand campaigns, trainings & community education focused on increasing awareness of mental health signs & available resources, as well as reducing stigma

Priority Populations

- LGBTIQ individuals
- Boys ages 4-11
- Transitional Age Youth (TAY) ages 18-25
- Adults ages 25-34 and 45-54
- Unemployed adults
- Homeless individuals
- Individuals living with co-occurring mental health and substance use conditions
- Older Adults ages 60+

Recommended/Preferred Strategies

From CEMs:

- **Engage through Social Media, Internet, Events/Fairs**
  - TV radio, newspapers, senior centers for older adults
- Focus on **positive** messages, **simple** language, good **visuals** & **color**, slogans & phrases, *not jargon*
- **Culturally representation** (authentically)
- Use **trusted sources, celebrities, influencers**

From PEMs:

- Increase inter-agency Increase inter-agency collaboration and group activities

Proposed Activities for FY 2021-22

- Increase FY 21-22 budget for Mental Health Community Education Events to $1.2m total, with set aside for Veteran-specific event
- Continue improvement of StigmaFree OC website and countywide campaign, drawing upon consumer feedback from CEMs
- Contract out web designer, copy writer to work with BHS program and HCA IT to improve organization, navigation and content of HCA website (ochealthinfo.com), drawing upon consumer feedback from CEMs
- Begin planning to host Directing Change Awards Ceremony in OC*
- Continue to pay for tv slots to air an OC Directing Change video as public service announcement, post/share on social media*
- Increase/expand use of social marketing
- **Add $3 million to Mental Health Awareness Campaigns & Education** (Stigma, Outreach program budgets)

** Also responsive to feedback about increasing collaborative/group activities to "help make services more welcoming for members of my community"*

from pg 12 of DRAFT MHSA Annual Plan Update for FY 2021-22

2021 CEM: Analysis of Feedback (Clinic Environment)

Prompt

What types of changes or improvements would make it easier for my community to connect with services, including telehealth?

- Have **more services** and **outreach locations**
- Provide services in the consumers' preferred language and be culturally responsive/reflective of the communities served
- Increase **collaborative** or **group activities**
  - i.e., Subgroup collaboration, community activities

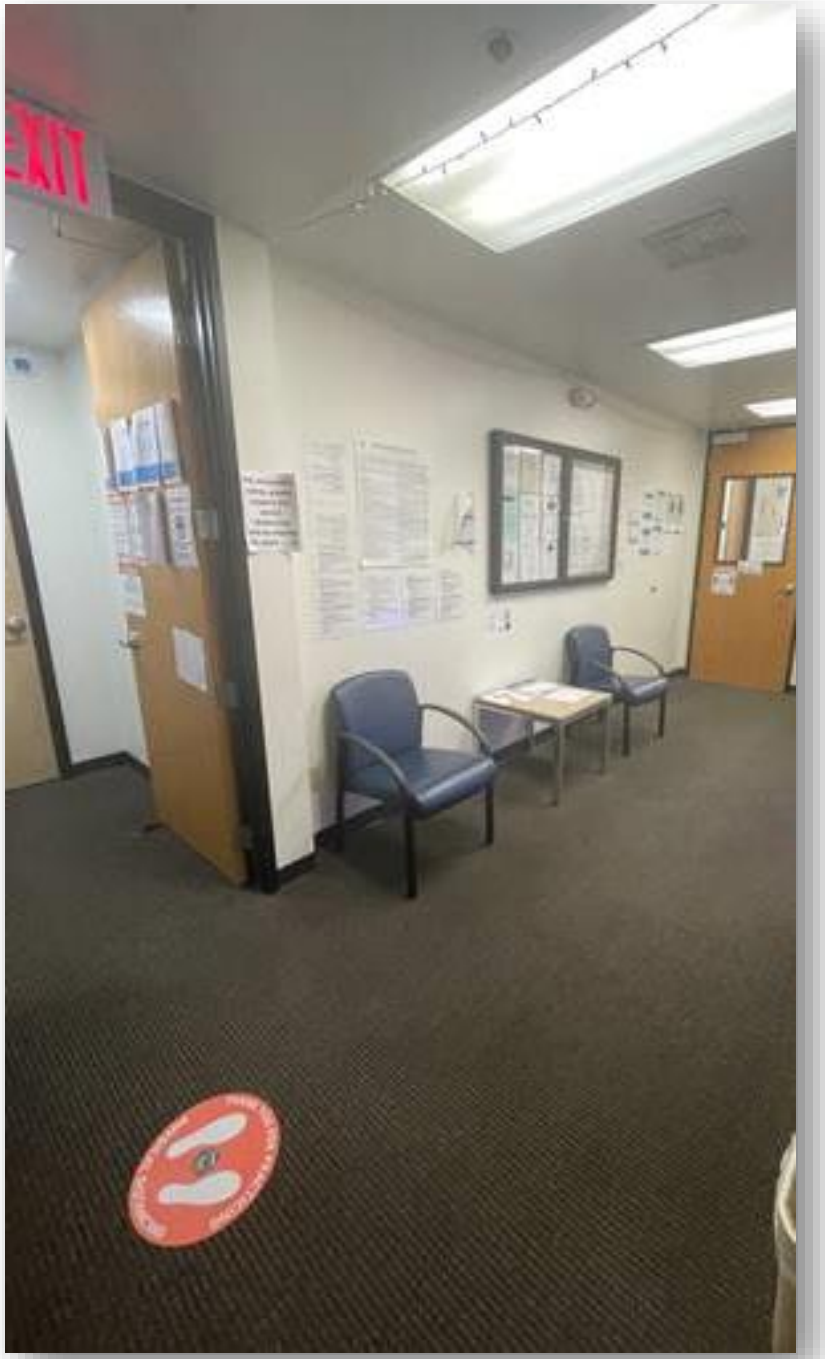
and

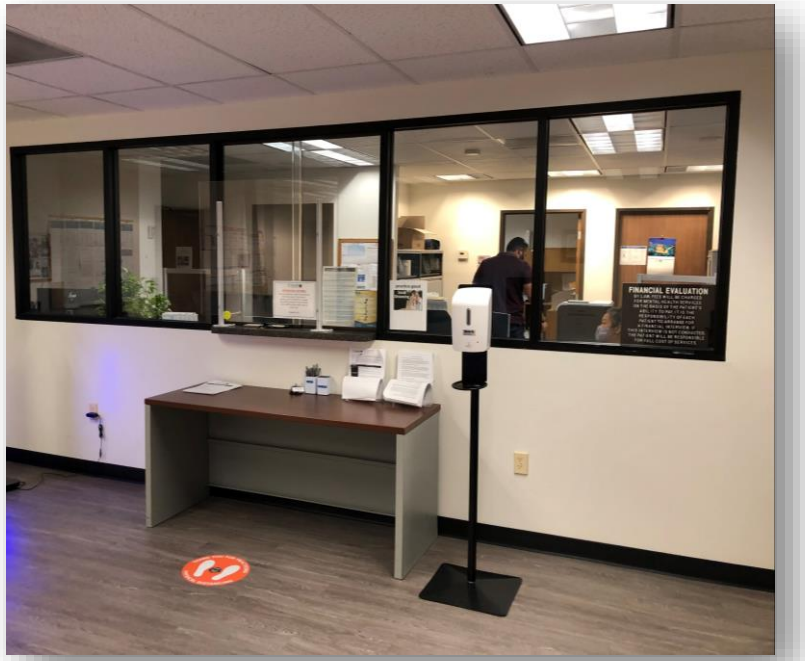
"Avoid sterile, hospital-like relationships and counseling spaces that may be intimidating to disclose personal information. Create a more welcoming and home-like atmosphere."

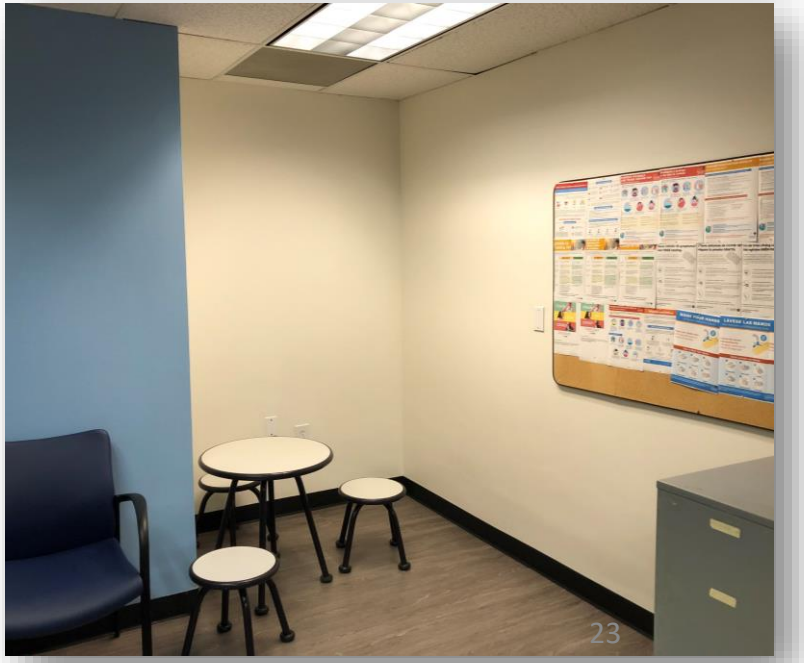
– CEM participant


Be Well
ORANGE COUNTY
Be Well
Be Well
Be Well
Be Well
Be Well
Be Well


Connection
Belonging
Healing
Care
HAPPENS HERE.


EXIT


FINANCIAL EVALUATION



New CSS Expenditures Proposed as a Result of the CPPP: #2

STRATEGIC PRIORITY: Access to Behavioral Health Services

Improve access to behavioral health services and address transportation challenges

Priority Populations

- Youth
- Families with children living with a mental health condition
- Asian/Pacific Islander
- Latino/Hispanic
- Black/African-American

Strategies Discussed During CEMs

WHAT WORKS

- Culturally appropriate and representative images, materials in preferred language
- Collaborative, group, community activities
- Focus on the positive, use encouraging phrases

WHAT DOESN'T WORK

- Depicting sadness, despair or vulnerability through colors, imagery, stigmatizing and/or illness-focused language

Proposal: Create more welcoming spaces in clinic common areas

- Identify Lobby and common areas in BHS outpatient clinics eligible for and in need of upgrades:
- Use CSS funds for paint, "homey" touches (e.g., end tables, artwork, framed posters/art, pamphlet/brochure displays, etc.
- Begin w/ needs assessment (of physical space, input from consumers)
- Coordinate through peer project manager (e.g., PEACe, the BHS peer workgroup)
- Host art fair with consumers to create artwork that could potentially be used in clinics***
- Encumber funds: up to $80k/clinic for materials, supplies, labor, decorative furnishings, artwork, art fair event etc., up to 5 clinics = Max/NTE $400k

from pg 8 of DRAFT MHSA Annual Plan Update for FY 2021-22

2021 CEM:
Analysis of Feedback
(Telehealth Access & Digital Literacy)

Prompts:

What would be most helpful to someone from my community in overcoming barriers like these?*

What types of changes or improvements would make it easier for my community to connect with services, including telehealth?

- Include a **hybrid** of telehealth and in-person services
  - n = 241 hybrid services and n = 35 telehealth only out of 454 CEM registrants (n=92 w/ no preference)
- Provide technology upskilling and improved access
  - **Learning** and navigating technology
  - Enhancing **digital literacy** and **digital health literacy**
  - Improving **access** to computers internet, Wi-Fi and tech support
  - **Providing telehealth access** at Wellness Centers

* Identified Barriers:
  1) Stigma
  2) Preference for face-to-face services *(compared to telehealth during COVID)*

Prompt

What strategies have you tried to address one or more of these challenges?

i.e., improving skills/comfort/privacy during virtual services

Which approaches worked? Didn't work?

WORKED	DIDN'T WORK
Training staff on mobile technology, telehealth, and other remote service options	**Merely providing devices** (i.e., headsets, phones) **due to issues with privacy and Wi-fi access**
Scheduling one-on-one meetings with up-to-date information and in a combination of synchronous (i.e., live) **& asynchronous formats**	**Using a one-size-fits-all approach with both the language and the content itself;** **All material should be population-specific**

Prompt

Of the strategies discussed and/or considered,
what are you interested in trying?

Demonstrate the use of technology in both live and asynchronous sessions to teach the necessary steps in accessing the various platforms

Improve tele-visits platforms (i.e., platforms that have chat, video, and audio functionality)

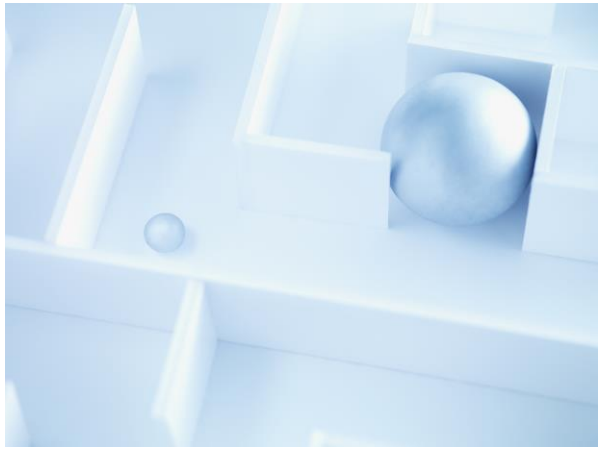
Increase collaboration between organizations and diverse individuals

i.e., Connect older adults with students or interns

Emphasize cultural and linguistic competency of staff members through workforce education and training

Prompt

Are there barriers that you or your organization might face trying to implement these preferred strategies?



For consumers who cannot meet through video, offering text or chat options is one alternative

Language, representation and cultural barriers as mentioned in the CEM findings

New CSS Expenditures Proposed as a Result of the CPPP: #1

STRATEGIC PRIORITY: Access to Behavioral Health Services

Improve access to behavioral health services and address transportation challenges

Priority Populations

- Youth
- Families with children living with a mental health condition
- Asian/Pacific Islander
- Latino/Hispanic
- Black/African-American

Strategies Discussed During PEMs

WHAT WORKED

- **Training** staff on mobile technology, telehealth, other remote service options
- Scheduling **one-on-one meetings** with up-to-date information and in a combination of synchronous (i.e., live) and asynchronous format

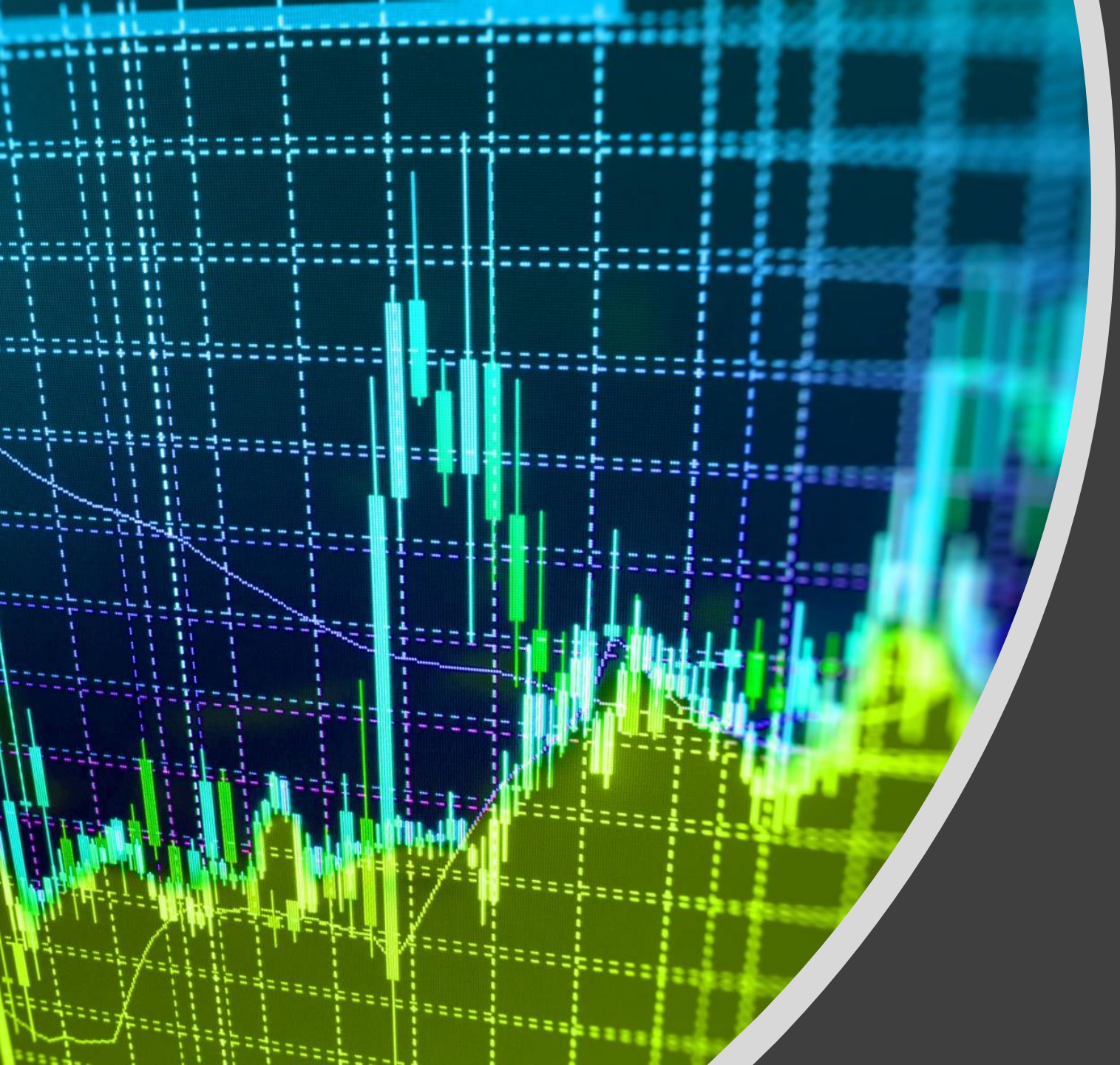
WHAT DIDN'T WORK

- Merely providing devices (ex. Headsets and phones) due to issues with privacy and Wi-fi access
- **Using a one-sized fits all** approach with both the language of content and the content itself, all material should be population specific

Proposal: Reinstate and expand scope of Telehealth Virtual Healthcare

- Reinstate CSS Telehealth/Virtual Behavioral Health Care program
- Conduct an assessment of consumer and provider needs around devices, Wi-Fi and/or cellular data to better understand their barriers and challenges when trying to utilize telehealth during the pandemic
- Incorporate a variety of training and technical assistance tools for consumers and providers to improve digital literacy
- Partner with local agencies and organizations to ensure the materials/trainings are culturally responsive and linguistically appropriate
- Accelerate the implementation of digital literacy basics for individuals and groups most in need of in-person training by the end of Summer 2021 to provide those with the greatest gaps in digital knowledge the opportunity to receive hands-on assistance while in-person gatherings and meetings are permitted, since it remains unknown whether there will be new safer-at-home orders in the fall/winter

from pg 7 of DRAFT MHSA Annual Plan Update for FY 2021-22



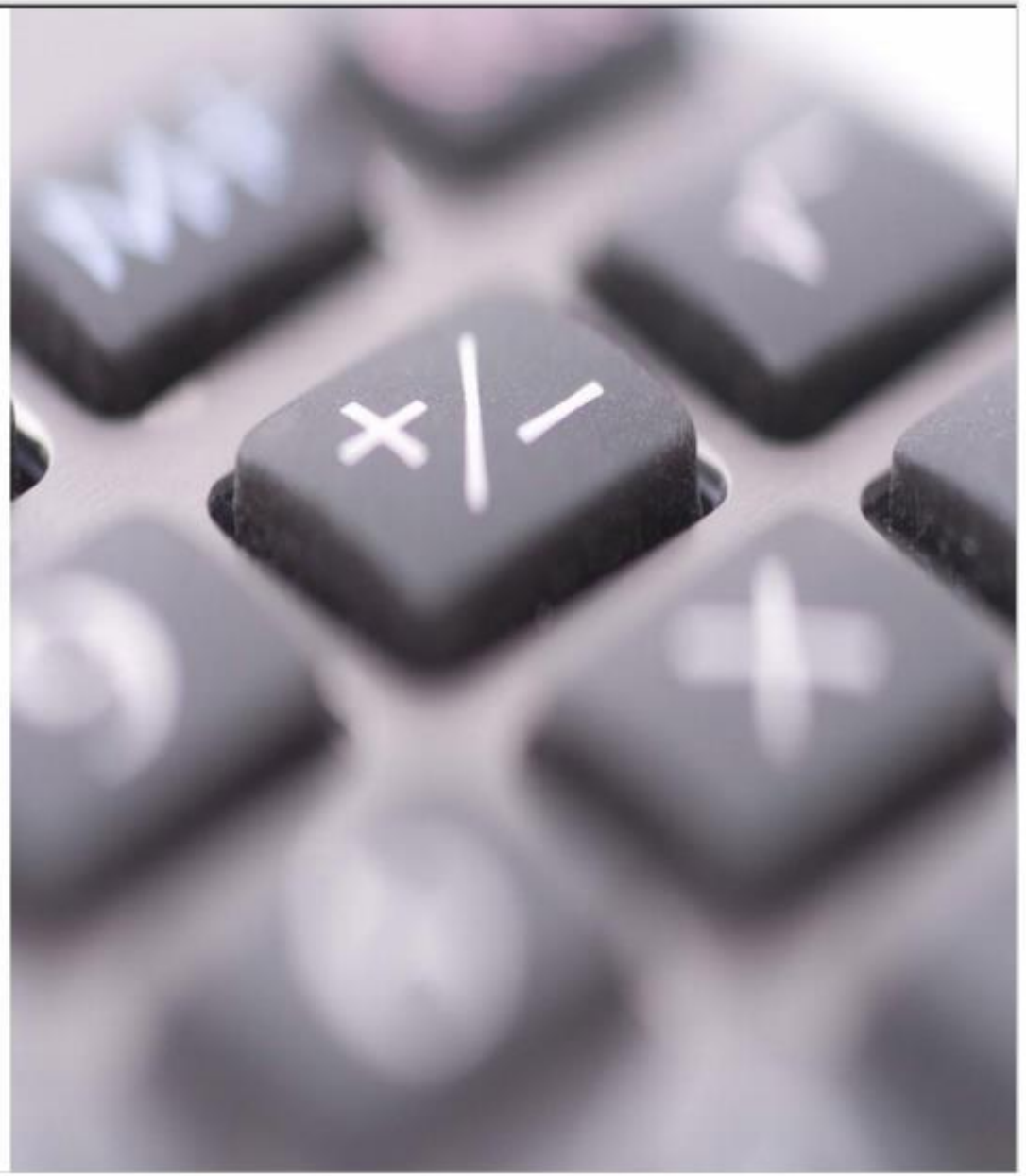
Proposed Updates to FY 2021-22 MHSA Component Budgets

Fiscal Planning Recap

Local MHSA budget planning conducted by HCA and reviewed with the MHSA Steering Committee during the end of 2020 were from State projections provided two months prior in December 2020.

State Fiscal Consultant Mike Geiss provided updated State MHSA projections in early February 2021.

There was a significant shift in the anticipated fiscal landscape with the February 2021 projections.



Initially presented at March 15, 2021 MHSA Steering Committee meeting

Anticipated Increase in OC'S CSS Allocation
REVISED 2-4-2021

OC CSS Projections	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
Projected Revenue as of 12-9-20	$112,568,067	$128,987,800	$125,115,114	$95,422,728
Projected Revenue as of 2-4-21	$112,568,067	$149,997,573	$157,742,884	$132,391,790
Change from 12-9-20 to 2-4-21	N/A	+ $21,009,773	+ $32,627,740	+ $36,969,062

- FY 2019-20 Revenue are actuals.
- Total projected CSS revenue increase of $90,606,575 through FY 22/23 (cumulative)

Approved in 3YP

FY 2020-21

$155,088,175

FY 2021-22

$164,627,171

FY 2022-23*

$165,320,336

** FY 2022-23 Budget as reported in the approved 3YP.*
Does not reflect potential changes resulting from proposed FY 2021-22 updates.

COMMUNITY SERVICES & SUPPORTS

Synopsis of proposed and modified CSS budget adjustments. The following tables summarize which CSS programs had proposed shifts to funding at the March 15, 2021 MHSA Committee meeting (middle column), and whether there were further modifications proposed following the more favorable MHSA fiscal forecast released in February 2021. Thus, if there are adjustments in the right column, they generally reflect recommendations to *restore* a program's budget rather than reduce it.

CSS	PROGRAM	ORIGINAL PROPOSED UPDATE per presentation on March 15, 2021; see Appendix II	MODIFIED PROPOSED UPDATE as reflected in Exhibit A FY 2021-22 Budget Grids
ACCESS & LINKAGE TO TREATMENT	**BHS Outreach & Engagement**	**Transfer all costs** to PEI (~$2.6m CSS savings annually)	*No change from March 15, 2021 budget worksheet*
	Recovery Open Access	Right-size and **increase annual budget** to $2.6m	*No change from March 15, 2021 budget worksheet*
CRISIS PREVENTION & SUPPORT	**Crisis Residential Services (CRS)**	Net decrease of $265k due to: Delaying expansion of Children's Crisis Residential Program for 6 months to start of FY 2021-22; Maintaining CYBH-managed TAY CRS beds at 6 rather than expanding to 12 (this provider's services were significantly under-utilized by TAY relative to those offered by the AOABH-operated CRS provider, thus planned expansion not proceeding); and Increasing budget due to lease costs at Anita Be Well Campus	**No decrease** to CRS budget. Remain level at $11,280,845 and instead encumber the $265k net savings for psychiatrist to support CRS; depending on how long candidate search and hiring process goes, funds may be spent in later FY. In addition, should DHCS release requirements for children's Psychiatric Residential Treatment Facilities (PRTF), additional unencumbered CSS funds (above $265k in originally proposed savings) may be used to expand CRS for children's PRTF beds

from pgs 5-6 of DRAFT MHSA Annual Plan Update for FY 2021-22

CSS	PROGRAM	ORIGINAL PROPOSED UPDATE per presentation on March 15, 2021; see Appendix II	MODIFIED PROPOSED UPDATE as reflected in Exhibit A FY 2021-22 Budget Grids
CLINIC EXPANSION	**Children & Youth Clinic Services**	**Time-limited decrease** to account for decreased expenditures resulting from COVID-19 impacts and related delays impacting start-up	*No change from March 15, 2021 budget worksheet.* However, should start-up go faster than anticipated, available CSS funds may be added during FY 21/22 if demand for services exceeds proposed budget
	Services for the Short-Term Residential Therapeutic Program (STRTP)	**Time-limited decrease** so budget better reflects savings accrued during lengthy DHCS licensure/approval process that results in significant delays before services can be offered	*No change from March 15, 2021 budget worksheet*
	Outpatient Recovery	**Decrease** to right-size, including savings from vacancies	*No change from March 15, 2021 budget worksheet*
	Integrated Community Services	**Retire** as a result of services having been transitioned to CalOptima during FY 2019-2020	*No change from March 15, 2021 budget worksheet*
	Telehealth/Virtual Behavioral Health Care	**Cancel** implementation of new program offering telehealth and virtual behavioral health care solutions	In response to community feedback, reinstate new program, with program implementation and ramp up including needs assessment and initial focus on increasing digital literacy and digital health literacy both of consumers and service providers *(see description under NEW CSS EXPENDITURES)*
FSP / PACT	**Full Service Partnership (FSP)**	**Overall decrease** of $2m due to 1) right-sizing TAY provider budget and 2) a time-limited decrease in the Adult Housing FSP provider budget resulting from reduced expenditures during program ramp up combined with use of alternative funding	**No decrease** to combined FSP budget; remain level funding at ~$53.8m, adding $500k to each age group (Children increased to ~$11.6m, TAY level at ~$8.2m, Adult increased to ~$30.3m, Older Adult increased to ~$3.7m) so several providers that recently began operating at full capacity can continue to serve participants at an appropriate, reduced FSP-caseload. Actual adjustments may vary depending on need.
	Program for Assertive Community Treatment (PACT)	**On-going increase** to cover increased staffing for Older Adult team, enhanced flexible funding for non-billable services that support the "Whatever It Takes" intervention model, and after-hours coverage	*No change from March 15, 2021 budget worksheet*

CSS	PROGRAM	ORIGINAL PROPOSED UPDATE per presentation on March 15, 2021; see Appendix II	MODIFIED PROPOSED UPDATE as reflected in Exhibit A FY 2021-22 Budget Grids
SUPPORTIVE SERVICES	**CSS Housing**	**On-going increase** to cover increase in staff salaries covered by MOU with OCCR that were the result of recent labor negotiations	*No change from March 15, 2021 budget worksheet*
	Mentoring Program for Children and Youth	**Retire** program due to multiple factors, including challenges with ability to demonstrate program efficacy; youth and parents will continue to receive peer/parent partner support through the Peer Mentoring and Parent Partner Support program	*No change from March 15, 2021 budget worksheet*
ADMIN	**CSS Administrative Costs**	**Net increase** of $71k to transition CSS programs into OC Navigator, the digital tool being developed as part of the BH System Transformation INN Project. Funds will also support development of automated/electronic features designed to increase productivity and operational efficiency (i.e., electronic bed board for CSUs, CRS, etc.; dashboards, reports; integration with HCA EHR, etc.)	In response to community feedback, **add additional, time-limited funds**, in an amount not to exceed $400k, for BHS facility improvements *(see description under NEW CSS EXPENDITURES)*

from pgs 5-6 of DRAFT MHSA Annual Plan Update for FY 2021-22

Approved in 3YP

FY 2020-21

$155,088,175

FY 2021-22

$164,627,171

Proposed Update*

$158,785,110

FY 2022-23*

$165,320,336

Projected Balance*

$26,089,149

** FY 2022-23 Budget as reported in the approved 3YP.*
Does not reflect potential changes resulting from proposed FY 2021-22 updates.

COMMUNITY SERVICES & SUPPORTS

PREVENTION

and EARLY INTERVENTION

Approved in 3YP

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

** FY 2022-23 Budget as reported in the approved 3YP.*
Does not reflect potential changes resulting from proposed FY 2021-22 updates.

Anticipated Increase in OC'S PEI Allocation
REVISED 2-4-2021

OC PEI Projections	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
Projected Revenue as of 12-9-20	$28,142,017	$32,246,950	$31,278,786	$23,855,682
Projected Revenue as of 2-4-21	$28,142,017	$37,499,393	$39,435,721	$33,097,947
Change from 12-9-20 to 2-4-21	N/A	+ $5,252,443	+ $8,156,935	+ $9,242,265

- FY 2019-20 Revenue are actuals.
- Total projected PEI revenue increase of $22,651,643 through FY 22/23 (cumulative)

Initially presented at March 15, 2021 MHSA Steering Committee meeting

PEI

	PROGRAM	ORIGINAL PROPOSED UPDATE per presentation on March 15, 2021; see Appendix II	MODIFIED PROPOSED UPDATE as reflected in Exhibit A FY 2021-22 Budget Grids
MH AWARENESS & STIGMA REDUCTION	**MH Community Education Events for Reducing Stigma and Discrimination**	No proposed change	Time-limited increase of $319k to FY 21-22 budget, resulting in a total budget of $1.2m with set-aside for Veteran-specific event (see description under NEW PEI EXPENDITURES)
	Outreach for Increasing Recognition of Early Signs of Mental Illness	**Time-limited net decrease** due to impact of COVID-19 and restrictions/limitations on large events/mass gatherings	In response to community feedback, **increase** by ~$2.7million (see description under NEW PEI EXPENDITURES)
PREVENTION	**School Readiness**	**Decrease** due to one provider contract not being renewed	*No change from March 15, 2021 budget worksheet*
	Parent Education Services	**Increase** Parent Education Services using funds from School Readiness budget reduction to provide support to families with children ages 0-8 years	*No change from March 15, 2021 budget worksheet*
	Children's Support & Parenting Program	**Decrease** due to savings from vacancies and temporary staff re-deployments to other programs in response to COVID-19	*No change from March 15, 2021 budget worksheet*
	School-Based Health Intervention & Support	**Reduce** back to on-going budget level due to ending of time-limited expansion using carryover funds	*No change from March 15, 2021 budget worksheet*
	School-Based Stress Management Services	Following the retirement of the provider's Subject Matter Expert, **discontinue** standalone program and continue to provide mindfulness training for students/school staff through BH Training Services	*No change from March 15, 2021 budget worksheet*

from pgs 10-11 of DRAFT MHSA Annual Plan Update for FY 2021-22

PEI	PROGRAM	ORIGINAL PROPOSED UPDATE per presentation on March 15, 2021; see Appendix II	MODIFIED PROPOSED UPDATE as reflected in Exhibit A FY 2021-22 Budget Grids
ACCESS & LINKAGE TO TREATMENT	**OC Links**	In response to Board Directive for HCA to create a 24/7 Behavioral Health Line, OC Links budget **increased** by $1.2m annually to cover 24/7 expansion including crisis calls and dispatch	**Add** a total of $3m ($1.8 additional) to cover additional staffing needs beyond what was first projected when program shifted to 24/7 operations, as well as county-wide marketing campaign advertising the BHS single access line; per CEM/community feedback, ensure that materials are tailored/customized to the specific target audiences (language, images, culture, etc)
	BHS Outreach and Engagement	**On-going increase** to cover shift of program MHSA-related costs to be covered entirely by PEI (rather than being shared with CSS; other funding sources also being used)	*No change from March 15, 2021 budget worksheet*
CRISIS PREVENTION & SUPPORT	**Warmline**	**On-going increase** to cover increased staffing costs due to services being increased to 24/7 and time-limited increase to cover increased lease costs at Anita Be Well Campus	**On-going increase** by $500k to improve staffing/shift coverage now that program has shifted to 24/7 operations, bringing total budget to $2 million
	Suicide Prevention Services	No proposed change	**Increase ongoing budget of contracted provider by $500k** in response to community need, a**nd increase on-going budget by additional $1million** to implement programming through the BHS Office of Suicide Prevention, established in response to Board Directive (see description under NEW PEI EXPENDITURES)

from pgs 10-11 of DRAFT MHSA Annual Plan Update for FY 2021-22

PEI	PROGRAM	ORIGINAL PROPOSED UPDATE per presentation on March 15, 2021; see Appendix II	MODIFIED PROPOSED UPDATE as reflected in Exhibit A FY 2021-22 Budget Grids
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	BHS Outreach and Engagement	**On-going increase** to cover shift of program MHSA-related costs to be covered entirely by PEI (rather than being shared with CSS; other funding sources also being used)	*No change from March 15, 2021 budget worksheet*
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from pgs 10-11 of DRAFT MHSA Annual Plan Update for FY 2021-22

New PEI Expenditures per a Board Directive

STRATEGIC PRIORITY: Office of Suicide Prevention

Expand support for suicide prevention efforts

Priority Populations

- People from all MHSA age groups
- Homeless individuals
- Individuals living with co-occurring mental health and substance use conditions
- LGBTIQ individuals
- Veterans

Board of Supervisors Directive

- On October 6, 2020, the Board directed the County Executive Officer and HCA Director to create an Office of Suicide Prevention to:
  - Reach out to high risk populations to find and engage those in need
  - Maintain contact with those in need and support continuity of care
  - Improve the lives of those in need through comprehensive services and supports, and
  - Build community awareness, reduce stigma and promote help-seeking

Proposed Activities

- The newly formed Office will be responsible for identifying and implementing promising pilot programs utilizing the above-referenced systems-approach for each of the initial populations of focus: youth and young adults, men in their middle years and older adults. The Office will also be responsible for integrating new and existing services and supports across the suicide prevention continuum and throughout the entire County to ensure all suicide prevention activities are linked to other behavioral health activities/services and directly targeted populations in need. The Office will create a systems approach to suicide prevention that leverages existing community and agency resources to build hope, purpose and connection for individuals in need.
- The Office and its activities will be a component of the Suicide Prevention Services program in the Orange County MHSA Plan. The Office will be funded through PEI and have a **budget of $1.5 million in FY 2021-22**.

from pg 12 of DRAFT MHSA Annual Plan Update for FY 2021-22

PEI

	PROGRAM	ORIGINAL PROPOSED UPDATE (per presentation on March 15, 2021; see Appendix II)	MODIFIED PROPOSED UPDATE (as reflected in Exhibit A FY 2021-22 Budget Grids)
EARLY INTERVENTION OUTPATIENT	**School-Based Mental Health Services (SB MHS)**	**On-going decrease** of PEI funds due to anticipated Medi-Cal revenue generation	**No decrease**; keep level PEI funding due to unanticipated effect of Medi-Cal billing process resulting in reduced referrals to program
	OC CREW	**On-going decrease** of PEI funds due to anticipated Medi-Cal revenue generation	Adjust projected PEI savings from $204k to $50k due to lower than anticipated Medi-Cal revenue as program readjusts to new billing requirements. In contrast to SB MHS, OC CREW not experiencing same impact on referrals after beginning to bill Medi-Cal
SUPPORTIVE SERVICES	**Transportation**	**Time-limited decrease**, resulting from impact of COVID-19 on delaying start-up of program in PEI	*No change from March 15, 2021 budget worksheet.* However, available PEI funds may be added during FY 21/22 if demand for transportation exceeds current proposed budget
ADMIN	**PEI Administrative Costs**	**Net increase** of $600k to transition PEI programs into OC Navigator, the digital tool being developed as part of the BH System Transformation INN Project. Funds will also support development of automated/electronic features designed to increase productivity and operational efficiency (i.e., electronic bed board for CSUs, CRS, etc.; dashboards, reports; integration with HCA EHR, etc.)	*No change from March 15, 2021 budget worksheet*

from pgs 10-11 of DRAFT MHSA Annual Plan Update for FY 2021-22

PREVENTION

and EARLY INTERVENTION

Approved in 3YP

FY 2020-21	FY 2021-22	FY 2022-23*
$47,061,483	$49,286,926	$40,988,101
	Proposed Update	**Projected Balance***
	$56,144,101	**$15,024,304**

** FY 2022-23 Budget as reported in the approved 3YP.*
Does not reflect potential changes resulting from proposed FY 2021-22 updates.

INNOVATION

Approved in 3YP

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

Updated amount includes adding into the FY 2021-22 Innovation budget the final year of MHSOAC-approved funding for the Continuum of Care for Veterans and Military Families project.

In addition, Community planning for potential projects is currently underway or in the queue to begin in the next few months; projected ending available balance subject to change if any ideas are approved

Approved in 3YP

FY 2020-21

$6,216,634

FY 2021-22

$5,219,984

Proposed Update

No change

FY 2022-23

$5,296,662

WORKFORCE EDUCATION & TRAINING

Approved in 3YP

FY 2020-21

$12,519,749

FY 2021-22

$8,840,752

FY 2022-23

$8,966,158

Adding funds to cover costs of transitioning County BHS EHR functions to the Cerner cloud, which will become necessary over the next year due to a shift in the Cerner business model

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

Proposed Update

$247,455,769

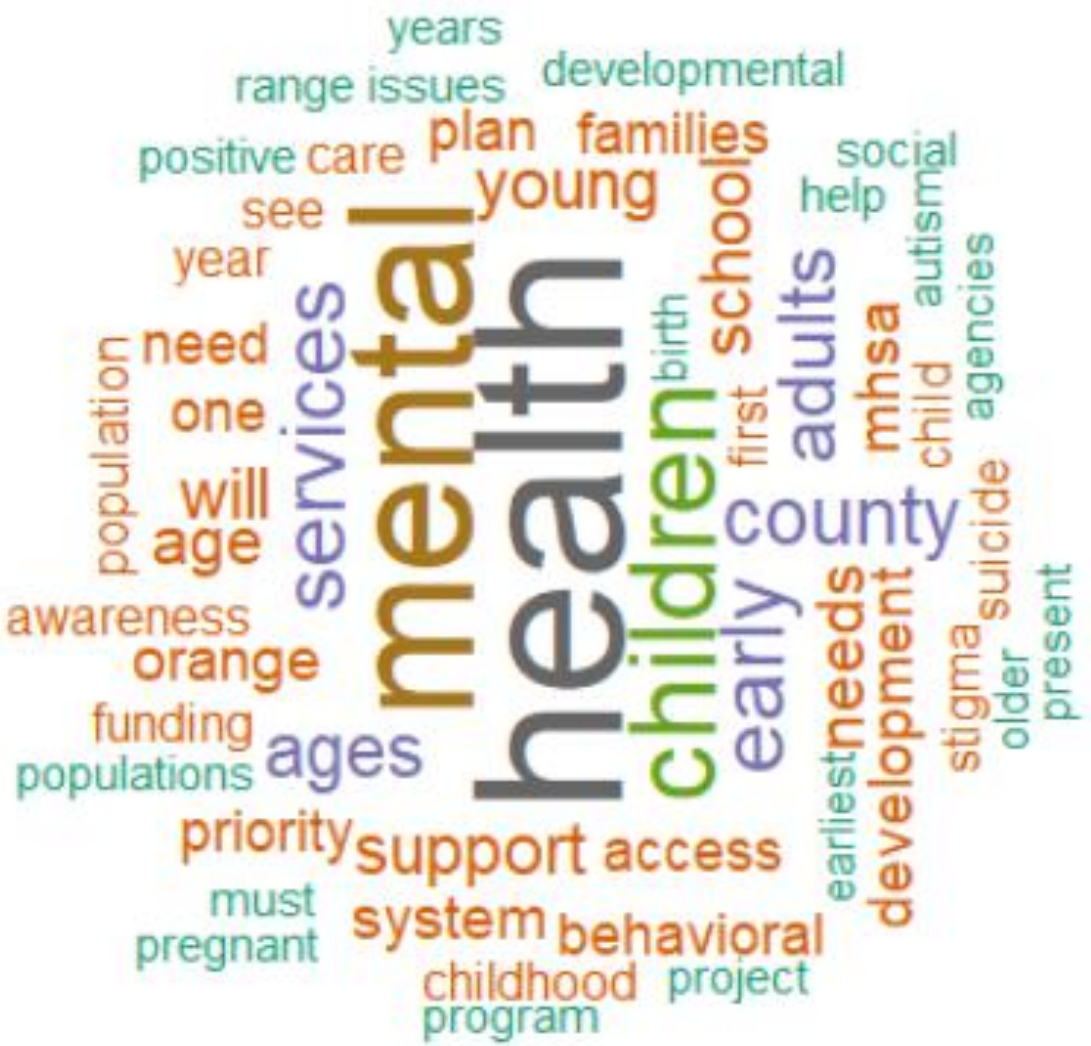
8 People Responded

9 Substantive Submissions

30-Day Public Comment Period

May 2, 2021 – June 1, 2021

*** Please refer to accompanying PDFs of public comments received and responses from HCA staff ***

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YOU

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2021-2022

DRAFT

ORANGE COUNTY

Mental Health Services Act

2022 Annual Plan Update

2021-2022

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ORANGE COUNTY

Mental Health Services Act

2022 Annual Plan Update

WELLNESS • RECOVERY • RESILIENCE

OC health CARE AGENCY

Sections of the Plan

Main Body (pgs 1-234)

- Message from the Agency Director
- Executive Summary
- Community Planning Process
- Mental Health Awareness & Prevention
- Access & Linkage to Treatment/Services
- Crisis Prevention & Support
- Outpatient Treatment
- Supportive Services
- Workforce Education & Training
- CFTN
- Special Projects

Program Descriptions

Community Counseling & Supportive Services (PEI)

Community Counseling and Supportive Services (CCSS) serves residents of all ages 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 are uninsured or underinsured, monolingual Spanish speaking, and have a history of family or domestic violence and/or early childhood trauma. Beginning FY 2020-21, OC ACCEPT merged with CCSS and expanded its capacity to provide specialized expertise working with individuals identifying as Lesbian, Gay, Bisexual, Transgender, Intersex or Questioning (LGBTIQ), and the important people in their lives.

CCSS is designed to help participants address the early symptoms of depression, anxiety, alcohol and/or drug use, suicidal thoughts, violence and Post Traumatic Stress Disorder (PTSD), 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 identifying as LGBTIQ. Participants are referred to the program by family resource centers, medical offices, community-based organizations, County-operated and County-contracted programs and self-referral.

AGE RANGE

All Ages

PRIMARY LOCATION

Clinic

TARGET POPULATION

At-Risk ✓ Mild-Moderate ✓ Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

✓ Arabic	Korean	TDD/CHAT
Farsi	Mandarin	✓ Vietnamese
Khmer	✓ Spanish	✓ Other: ASL

PROGRAM SPECIALIZATIONS

BH Providers; 1st Responders; Students / School; Foster Youth; Parents; Families; Medical Co-Morbidities; Criminal-Justice Involved; Ethnic Communities; Homeless / At-Risk of; Recovery from SUD; LGBTIQ+; Trauma-Exposed Individuals; Veterans / Military-Connected

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	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
		Another	-	Middle Eastern/North African	5
				Another	5

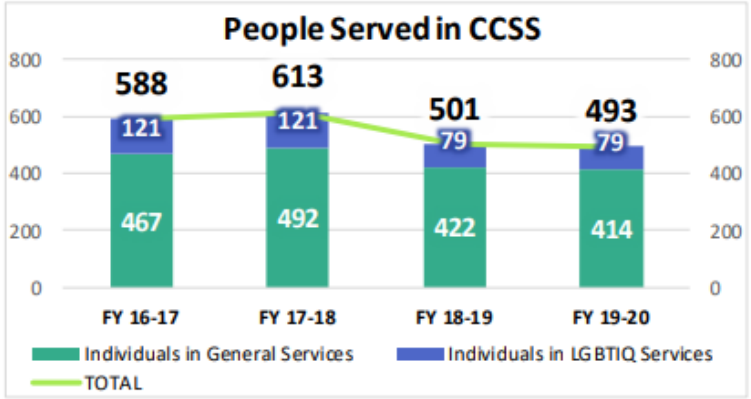
BUDGETS & PROJECTED #'s TO BE SERVED FROM 3YP

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$2,536,136	690
FY 2021-22*	$2,536,136	690
FY 2022-23	$2,536,136	690

No proposed changes to FY 2021-22

SERVICES

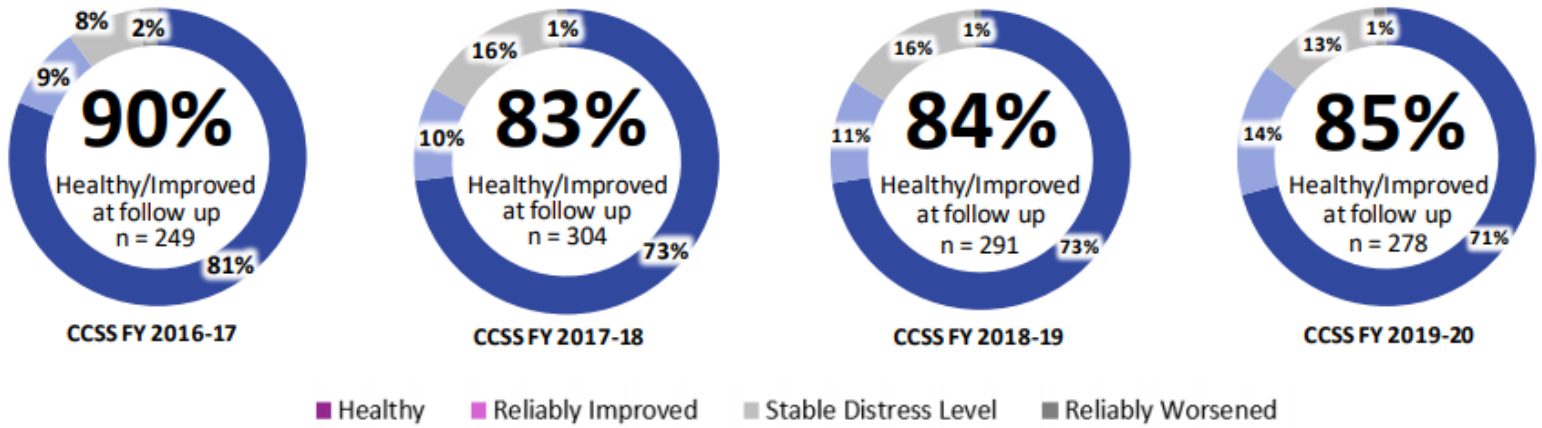
CCSS provides face-to-face individual and collateral counseling, groups (i.e., psychoeducational, skill-building, insight oriented, etc.), clinical case management, and referral and linkage to community services. Clinicians utilize evidence-based practices such as Eye Movement Desensitization and Reprocessing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

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). Participants completed the measure 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 improving symptoms and reducing prolonged suffering. This measure 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.

Across all four fiscal years, a majority of participants (83-90%) reported healthy or clinically improved levels of distress at the most recent follow up.



Overall, this improvement in scores between intake and follow up suggests that the services of CCSS were associated both with preventing symptoms of a mental health condition 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. In addition, because it was also noted that LGBTQ+ participants tended to report higher levels of distress based on the OQ scores at baseline and follow up in comparison to cisgender/straight participants, the program implemented procedures to identify those with greater needs and refer them to programs that serve individuals with more severe mental health conditions.

CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

In fiscal 2019-20, as a result of the COVID-19 pandemic, in person services were halted and the program transitioned to a virtual and telephonic platform. The pandemic had a significant impact on the number of referrals received. In response to this challenge, several measures were taken. The program created a dedicated Outlook inbox and modified their referral forms so that they could be completed electronically and securely emailed from community agencies to CCSS. In response to the behavioral health needs of "first responders," business hours were extended to late evenings to accommodate their schedules. In addition, the number of bilingual clinicians in the program was increased- now over 90% of clinicians are bilingual in two of the County's threshold languages thereby increasing the program's ability to serve monolingual communities. Furthermore, all clinicians have received specialized training in a variety of modalities to better serve participants in the treatment of complex trauma, Post Traumatic Stress Disorder (PTSD), anxiety & depression. An area for further development is to increase outreach efforts in south Orange County, where a satellite CCSS office is open.

In anticipation of the consolidation of CCSS and OC ACCEPT to one CCSS, OC ACCEPT made several adaptations to their screening and intake processes to align practices with CCSS. This included staff training, outreach to new referral sources, clarification of eligibility criteria, and outcome data collection. In FY 2019-20 the program was progressing positively with numerous outreach and training in the community. Additionally, the number of enrollments increased and the program was enrolling more participants by November 2019 compared to the previous fiscal year. However, by January 2020 when the COVID-19 pandemic started, the program was significantly impacted by a significant reduction in outreach and enrollment. In March 2020, OC ACCEPT stopped outreach and trainings to collaborative partners and community members as the program transitioned to a virtual platform. Since that time, referrals have significantly decreased leading to low enrollment numbers for the remainder of the fiscal year.

COMMUNITY IMPACT

CCSS collaborates with community-based organizations to provide culturally responsive services to ethnic minorities, deaf-and-hard-of-hearing, and LGBTIQ communities. Since inception, the expanded program has provided services to more than 2,593 individuals, 510 of whom were part of its LGBTIQ service. Additionally, in FY 2019-20, 743 individuals (of 913 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 to promote awareness of, and encourage use of, its services. In this FY, the program provided 26 community education presentations and trainings to over 386 attendees, raising awareness and reducing stigma about the LGBTIQ population.

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, who 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, LGBTIQ, 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 work closely with the school administrators and counselors through weekly meetings to assist in creating a school climate that promotes the benefits of seeking help and accessing counseling, 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 provide educational and program promotion presentations about the needs, challenges and issues faced by the LGBTIQ population to reduce stigma and discrimination by 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, the program 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, LGBTIQ 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 build 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 refugee and the deaf and hard of hearing communities.

In addition, clinicians refer and link participants to an appropriate level and type of community resource, as summarized below.

Early Intervention Programs: Specialized Services		Linkage Metrics		
		# Referrals	# Linkages	Types of Linkages
CCSS	FY 16-17	424	204	Behavioral health services; legal services, advocacy; health care benefits/services LGBTIQ individuals also referred/linked to food/nutrition, housing
	FY 17-18	371	185	
	FY 18-19	139	97	
	FY 19-20	197	131	
EISOA	FY 16-17	9,028	3,957	Social support; basic needs; community events; ancillary services; education; Behavioral Health Outpatient Services; legal/financial; medical; employment; family support; peer support, housing support
	FY 17-18	10,880	6,191	
	FY 18-19	5,156	3,054	
	FY 19-20	9,779	5,567	

Early Intervention Programs: Child, Youth, Parent Focused		Linkage Metrics		
		# Referrals	# Linkages	Types of Linkages
SB MHS	FY 16-17	397	49	Basic needs items; behavioral health outpatient services; PEI programs; crisis services; health education, disease prevention, wellness, physical fitness services
	FY 17-18	391	44	
	FY 18-19	293	59	
	FY 19-20	455	110	
OC Parent Wellness	FY 16-17	809	261	Family support services, legal services, advocacy; basic needs (i.e., donated items, financial assistance); recreation; Behavioral Health Outpatient; Behavioral Health Recovery Support; other Prevention & Early Intervention Programs; information and referral services; health care services
	FY 17-18	600	155	
	FY 18-19	540	226	
	FY 19-20	461	243	
OC CREW	FY 16-17	104	28	
	FY 17-18	64	22	

Sections of the Plan

Main Body (pgs 1-234)

- Message from the Agency Director
- Executive Summary
- Community Planning Process
- Mental Health Awareness & Prevention
- Access & Linkage to Treatment/Services
- Crisis Prevention & Support
- Outpatient Treatment
- Supportive Services
- Workforce Education & Training
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- Special Projects

Program Descriptions

Exhibits & Appendices (pgs 235-576)

- Exhibits A - D: Budget Grids and other certifications
  - ***Appendix A has the budget grid, listing each program receiving MHSA funds by MHSA component***
- Appendices I – XII: Supporting documents

FY 2021-22 Annual Update - Mental Health Services Act Expenditure Plan
Funding Summary

County: **Orange** Date: 4/28/2020

	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
Estimated FY2021-22 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	34,654,881	28,017,720	20,549,159	-	-	33,258,769
2. Estimated New FY2021-22 Funding	158,352,053	39,751,693	10,587,336	-	-	-
3. Transfer in FY2021-22	(21,527,368)	-		5,219,984	16,307,384	-
4. Access Local Prudent Reserve in FY2021-22	-	-				-
5. Estimated Available Funding for FY2021-22	171,479,566	67,769,413	31,136,495	5,219,984	16,307,384	33,258,769
Estimated FY2021-22 Expenditures	(130,203,791)	(50,529,691)	(10,999,190)	(5,219,984)	(16,307,384)	
Estimated FY2021-22 Unspent Fund Balance	**$ 41,275,775**	**$ 17,239,722**	**$ 20,137,305**	**$ -**	**$ -**	**$ 33,258,769**

Estimated Local Prudent Reserve Balance	
Estimated Local Prudent Reserve Balance on June 30, 2021	$ 33,258,769
5. Contributions to the Local Prudent Reserve in FY 2021-22	-
6. Distributions from the Local Prudent Reserve in FY 2021-22	-
Estimated Local Prudent Reserve Balance on June 30, 2022	**$ 33,258,769**

FY 2021-22 Annual Update - Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Orange Date: 4/28/2021

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
Full Service Partnership (FSP Programs)						
1. Children's Full Service Partnership	**13,197,468**	**11,554,575**	**1,642,893**	**-**	**-**	**-**
2. Transitional Age Youth (TAY) Full Service Partnership	**9,889,331**	**8,184,468**	**1,519,924**	**-**	**-**	**184,939**
3. Adult Full Service Partnership	**36,080,254**	**30,307,934**	**5,589,458**	**-**	**-**	**182,862**
Adults	27,149,297	22,092,093	4,887,076	-	-	170,128
Assisted Outpatient Treatment Assessment & Linkage	5,430,957	4,715,841	702,382	-	-	12,734
Supportive services for clients in permanent housing	3,500,000	3,500,000	-	-	-	-
4. Older Adult Full Service Partnership	**4,204,615**	**3,719,899**	**484,716**	**-**	**-**	**-**
5. Program for Assertive Community Treatment	**13,749,990**	**10,699,650**	**3,006,786**	**-**	**-**	**43,554**
Non-FSP Programs Partially Categorized as FSP:						
Access and Linkage to Treatment Section:						
1. Multi-Service Center for Homeless Mentally Illness Adults	**45,000**	**45,000**	**-**	**-**	**-**	**-**
2. Open Access	**1,505,114**	**1,300,000**	**199,317**	**-**	**-**	**5,797**
3. CHS Jail to Community Re-Entry	**-**	**-**	**-**	**-**	**-**	**-**
Crisis & Crisis Prevention Section:						
4. Mobile Crisis Assessment Team	**4,492,060**	**3,451,094**	**840,164**	**-**	**-**	**200,802**
5. Crisis Stabilization Units (CSUs)	**2,086,366**	**1,500,000**	**586,366**	**-**	**-**	**-**
6. In-Home Crisis Stabilization	**1,583,370**	**1,229,836**	**337,790**	**-**	**-**	**15,744**
7. Crisis Residential Services	**5,281,435**	**4,597,008**	**752,021**	**-**	**-**	**40,395**