Orange County Mental Health Services Act Three-Year Plan

FY 14/15 - 16/17

MHSA Three-Year Program and Expenditure Plan

FY 2014-15 through FY 2016-17

May 19, 2014

600 W. Santa Ana Blvd., Suite 510, Santa Ana, CA 92701 | (714) 667-5600 | MHSA@ochca.com | www.OCHealthinfo.com/MHSA

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Overview and Executive Summary

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Overview and Executive Summary

This year is the first time since 2005/06 that counties have been asked to prepare a Three-Year-Program and Expenditure Plan. It is the first time that counties have developed a Three-Year Plan that includes all of the Mental Health Services Act (MHSA) components.

This Plan retains stable funding for the vast majority of programs that were operational during FY 13/14. However, it also includes some new or expanded programs. Based on projections of MHSA revenues for the next three years, it was determined that there will be about $25 million per year available for expansion of existing programs and/or implementation of new programs to address identified unmet needs for services. These funds are a combination of projected revenue increases and unspent funds from prior years.

The Health Care Agency worked with the Mental Health Board to develop preliminary recommendations, which were then reviewed and discussed by MHSA subcommittees and the MHSA Steering Committee. In addition, a public input process was held in December to get additional ideas for new/expanded programs. Approximately 90 comments were received. The information from the public input process was then considered by MHSA Subcommittees and the entire MHSA Steering Committee. As a result of this community planning process, the following program expansions and additions are included in the Three-Year Plan, which starts July 2014.

The following Community Services and Supports (CSS) programs will be added or expanded.

1. Program for Assertive Community Treatment (PACT) Expansion – Current caseloads at the Adult Outpatient Clinics have been growing and creating large client to staff ratios. The plan would add 33 clinical staff to the program in five locations. PACT provides assessment, linkages, individual and group therapy, extensive case management, advocacy, medication support and a variety of other recovery based services for adults. **(Expanded)**
2. Children's Crisis Residential – The program offers temporary, short-term placement into a structured environment. Admissions are voluntary and available 24/7 depending on availability. This was one of the initial programs funded by MHSA, but has been limited in size to just six beds, causing the waiting lists to build up. This expansion will provide six new beds in a facility that is already licensed. **(Expanded)**
3. Children's In-Home Stabilization – The program provides in-home crisis response therapy, case management, and rehabilitation services focusing on maintaining family stabilization and preventing moving the child to a hospital or home placement. The number of client families to use the services has nearly doubled in the five years it has been operating. Expansion of the program will add six new direct staff members to the eight in place. **(Expanded)**

4. Wellness Center (South County) - With the success of the Wellness Center located at 401 S. Tustin, in Orange, the recommendation was made to open a new Wellness Center located in South Orange County. Many potential clients who would like to access Wellness Center services are unable to find adequate transportation to the existing site because of the distance. Opening a new location with similar programs will help advance the goals of the clients to achieve a higher level of recovery. **(New)**
5. Transportation – Since the inception of MHSA, transportation has always been an issue for many clients. This service will help those who have a difficult time securing transportation needed to get to appointments to assist them in recovery. The program will be handled through a subcontractor and pay for the vans and drivers needed to transport clients on a greater scale than previously possible. **(New)**
6. Laura's Law Program/Assisted Outpatient Treatment – This program has been called for by numerous members of the community. It is designed to assist those clients who are resistant to obtaining and/or maintaining treatment. This is an intensive program that will help not only the individual with a mental illness, but their families as well. The services will provide a "whatever it takes" approach to attaining recovery, including having access to a team member 24/7. The hope for this program is that the clients will be able to get help before they become a danger to themselves or others and prevent a revolving door of homelessness, hospitalizations, and incarcerations. For this program to be implemented in Orange County, the Board of supervisors must pass a resolution to implement AB 1421 (Laura's Law). **(New)**
7. Adult/Transitional Age Youth In-Home Crisis Stabilization Program – This approach has been very successful with children and adolescents in crisis. This new program will provide similar services for TAY and adults living at home. The program will provide 24/7 in-home crisis response and short term in-home therapy, case management and rehabilitation services that focus on family stabilization and prevention of a hospitalization or home placement. **(New)**
8. FSP Expansion – FSPs have been operating since the start of MHSA. During this time, operation costs and salaries of staff have also increased, resulting in some position eliminations. With the additional funding, FSPs in all age groups will be able to improve their services and enroll new clients. **(Expanded**)
9. Mental Health Court (Probation Officers) – With this funding, five probation officers, ½ a supervisor and ½ a clerical support position can be hired to work for the adult mental health courts. Research has shown that collaborative/supervision/case management services by probation officers are identified as the best/promising practices. **(New)**
10. Drop in Center – This will establish a drop in center in Central Orange County that will be accessible to the persons currently residing in the Santa Ana/Civic Center

Plaza area. There are many mentally ill homeless in this area who are unable to access the current MHSA drop in center. **(New)**

11. Housing for Homeless – This program will likely purchase one or more small houses for homeless adults with severe mental illness. Supportive services will be provided along with housing. **(New)**
12. Housing and Year Round Emergency Shelter Services – This program will dedicate funding for mental health beds in a planned year-round emergency shelter or any other shelter opportunity program. The shelter will be used as a point of entry for potential MHSA clients. (**New)**
13. Orange County Children with co-occurring mental health and chronic/severe acute illnesses. – This program will offer specialized mental health services provided with an integrated health care system that is coordinated with medical treatment. There is an extensive wait list for those eligible for these programs. Incorporated within this program will be outpatient mental health clinics for children, as well programs to improve the treatment of eating disorders in adolescents. **(New)**
14. Outpatient Mental Health Services Expansion: Children and Youth – Youth referrals have been growing rapidly as more families become eligible for services. Currently for every one Medi-Cal eligible family, the clinics receive two that are not eligible. This program will increase the ability of these clinics to take on bigger caseloads of families that wouldn't otherwise be able to receive treatment and services. **(Expanded)**

The following Prevention and Early Intervention (PEI), programs will be added or expanded.

1. BHS Mental Health Counseling Program - This program was recommended by community stakeholders, and will assist clients by providing resources on a short term basis for counseling and psychiatric services for those who do not meet the current criteria for services at a community clinic. **(New)**
2. Orange County Post-Partum Wellness (OCPPW) Program – The OCPPW program has seen increases in enrollment by 40% in just two years. The waiting list has grown to more than 40 mothers in the last six months. The program will be able to add more positions, remove the waiting list and increase the clients from 120 to 160. The program will also now be able to address the needs of pregnant women, as well as new mothers who are at risk for depression. **(Expanded)**
3. Socialization Program – The Socialization program has been operating for three years and has been found to be successful in services to both adults and older adults. This program expansion will be solely for the older adult specific program. With the additional funding, 922 additional home visits can be made, 49 educational groups and 106 socialization groups can be formed. **(Expanded)**

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4. A K-12 Coping skill to manage stress –A program consisting of evidence-based mindfulness has shown success in piloted OC schools. With 12-20% of children having a diagnosed anxiety disorder, coping skills are necessary to promote resiliency amongst students. **(New)**
5. Continue funding Statewide Projects – CalMHSA initiatives for suicide prevention, student mental health, and stigma reduction have been able to provide services to Orange County residents, stretching dollars 35-50% further by purchasing materials across counties. **(New)**
6. Continuation of the WarmLine for after-hours services – With local MHSA funding, the WarmLine has been providing needed phone services to those in non-crisis situations from 8 a.m. – 11 p.m. Statewide PEI funding has been paying for after-hours services from 11 p.m. to 3 a.m. To continue these after-hours services once the statewide projects have ended, additional funding is needed. **(Expanded)**

As for the other MHSA components, the original Workforce Education and Training funds have been spent, but the programs continue using Community Services and Supports funding. Progress has continued in developing an Electronic Health Record, which will be pilot tested this spring in a select group of outpatient Behavioral Health Clinics. To provide increased consumer access to computers and the internet, Kiosks have been established in five BHS outpatient clinics. Implementation of the first round of Innovations program (Group 1) has continued, and the second round of programs (Group 2) was approved by the Mental Health Services Oversight and Accountability (MHSOAC) on April 24, 2014. Now that approval has been given, implementation of those projects will begin shortly.

During the years since Proposition 63 was passed, the Mental Health Services Act has continued to go through changes to help better the lives of the clients and the entire Orange County community. The new growth funding programs will continue to advance the goals that the voters envisioned when MHSA was first passed.

EXHIBIT A:

COUNTY COMPLIANCE CERTIFICATION

600 W. Santa Ana Blvd., Suite 510, Santa Ana, CA 92701 | (714) 667-5600 | MHSA@ochca.com | www.OCHealthinfo.com/MHSA

MHSA COUNTY COMPLIANCE CERTIFICATION

County: Orange

Local Mental Health Director	Program Lead
Name: Mary R. Hale	Name: Bonnie Birnbaum
Telephone Number: 714-834-6032	Telephone Number: 714-667-5624
E-mail: mhale@ochca.com	E-mail: bbirnbaum@ochca.com
County Mental Health Mailing Address:	Health Care Agency Behavioral Health Services 405 W. 5th Street Santa Ana, CA 92701

I hereby certify that I am the official responsible for the administration of county mental health services in and for said county and that the County has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this annual update, including stakeholder participation and nonsupplantation requirements.

This annual update has been developed with the participation of stakeholders in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft annual update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on May 13, 2014.

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.

Mary R. Hale
Local Mental Health Director/Designee (PRINT)

Mary R. Hale 5-13-14
Signature Date

County: Orange

Date: May 13, 2014

EXHIBIT B:

COUNTY FISCAL CERTIFICATION

600 W. Santa Ana Blvd., Suite 510, Santa Ana, CA 92701 | (714) 667-5600 | MHSA@ochca.com | www.OCHealthinfo.com/MHSA

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: Mary R. Hale	Name: Jan Grimes
Telephone Number: 714-834-6032	Telephone Number: 714-834-2450
E-mail: mhale@ochca.com	E-mail: jan.grimes@ac.ocgov.com
Local Mental Health Mailing Address: Health Care Agency Behavioral Health Services 405 W. 5th Street Santa Ana, CA 92701	

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

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

Mary R. Hale
Local Mental Health Director (PRINT)

Mary R Hale 5.16.14
Signature Date

I hereby certify that for the fiscal year ended June 30, 2013, 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 5/16/14 for the fiscal year ended June 30, 2013. I further certify that for the fiscal year ended June 30, 2013, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

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

Kim Engelby for Jan E. Grimes
County Auditor Controller / City Financial Officer (PRINT)

KEngelby 5/19/14
Signature Date

[1] Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)
Three-Year Program and Expenditure Plan, Annual Update, and RER Certification (02/14/2013)

Exhibit C:

Workforce Needs Assessment

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Exhibit C: Workforce Needs Assessment

Methodology:

An electronic survey was conducted within each of the five divisions of Behavioral Health Services (BHS). These are Adult Mental Health Services (AMHS), Alcohol and Drug Abuse Services (ADAS), Children and Youth Services (CYS), Prevention and Intervention P &I), and Center of Excellence (COE).

It included County employees, employees in the county contract agencies, and individual county contractors. Results from each division were compiled together to obtain results for all BHS. The survey asked for budgeted and currently filled positions by job titles, number of estimated personnel needed to meet current client caseload, number of positions designated for consumers and family members and occupied by consumers or family members (self-reported), and the capability of staff (based on bilingual pay status) in providing services in a threshold language (Spanish, Vietnamese, Farsi and Korean).

A. Needs by occupational category

Across BHS, direct service staff and non-direct service staff categories have the most need for additional staff to meet the needs of current clientele (Tables 2 & 3). Among the direct service staff the greatest need is in the areas of licensed clinical social workers, licensed substance abuse specialists, mental health workers, life coaches and employment specialists/job coaches (data available but not shown here.) The current workforce in the program for the directors or service chief category appears to be in line with the number needed to meet the current needs (Table 1). Across BHS, 86% of the needed positions are currently filled. ADAS, AMHS and COE all have over 90% of their total needed positions currently filled while only 65% in P&I and 85% in CYS. Among the divisions, P&I and CYS have the greatest need for additional staff especially in the direct service and non-direct service categories (Table 2). For both, P&I and CYS, the number of full time equivalents (FTEs) budgeted, however, is less than the number of FTEs actually needed to meet current client needs (Table 4).

B. Positions designated for individuals for consumers or family members

Across all BHS, 29% of the budgeted positions are designated for consumers/family members, and 17% of the currently filled positions are occupied by self-disclosed consumers/family members (Table 4). Since individuals may self-disclose or not, depending on their preference, the number is highly likely to be under-reported. The majority (79%) of consumers/family members occupy positions in the direct service staff

category, and this trend is true across all divisions of BHS (Tables 3 &4). These figures highlight the number of positions (i.e. peer mentors) that have recently been created and occupied by the graduates of our consumer training program. Among the divisions, COE and ADAS have nearly 50% of their current workforce self-identified as consumers/family members. Between 39 to 50% of budgeted positions in ADAS, AMHS and COE are designated for consumers and family members (Table 4).

C. Language proficiency

There are four threshold languages in Orange County. These include, Spanish, Vietnamese, Farsi and Korean. Across all BHS, 30% of the current workforce is able to provide services in Spanish, 8 % in Vietnamese, 2% in Farsi and 2% in Korean (Table 4). Among the program directors/service chiefs, a similar ranking (13% in Spanish, 2% in Vietnamese, 1% in Farsi and 2% in Korean) of language proficiency was observed (Table 1). Among the non-direct and direct service staff categories, the threshold languages are similarly represented with about 30% in Spanish, 6% in Vietnamese, and less than 3% in Farsi and Korean languages (Tables 2 and 3).

At least 25% of ADAS, AMHS, P&I and CYS workforce is able to provide services in Spanish. Proficiency in Vietnamese is highest in COE (18%) followed by AMHS (13%), P&I (6%), CYS (4%) and ADAS (1%). Up to 3% of the current workforce in each of the divisions (except COE with 7% in Korean) is able to provide services in Farsi or Korean. By division, ADAS has only 1% of the current workforce that is able to provide services in Vietnamese and none is able to provide services in Korean. AMHS has the highest percentage of the workforce being able to provide services in Spanish (26%) and second highest in Vietnamese (13%) (Table 4).

In addition, data was analyzed on the number of clients in our Integrated Records Information System (IRIS) during FY 2011-12 who had requested services in one of the threshold languages. These data show that across BHS, 16% requested services in Spanish, 3% in Vietnamese, 0.5% in Farsi and 0.5% in Korean. Among the divisions, P&I had the highest percentage of its clients requesting services in Spanish (63%), followed by CYS (24%), COE (11%), AMHS (10%) and ADAS (9%). The number of clients requesting Vietnamese language was highest in AMHS (6%). The number of clients requesting Farsi or Korean languages remained consistent (less than 1% except for Korean, 3%, in COE) across all divisions (table 5). Comparison of these numbers to the current language proficiency of our workforce might suggest that our current workforce is over-represented in Spanish and is well-represented in other threshold languages. It is expected that later this year, Chinese will become a threshold language in Orange County, but that remains to be seen.

Table 1. Workforce needs assessment among Program Directors/Svc Chiefs by division in BHS									
Division	Number of FTEs budgeted (FTE = Full Time Equivalents)	Number of current FTEs	Number of FTEs actually needed to meet the needs of current number of clients	Of column (2), how many individuals are specifically designated for consumers or family members	Of column (3), how many are disclosed as consumers or family members	Of Column (3), how many are capable of providing services in	Of Column (3), how many are capable of providing services in	Of Column (3), how many are capable of providing services in	Of Column (3), how many are capable of providing services in
	Col-2	Col-3	Col-4	Col-5	Col-6	Spanish	Vietnamese	Farsi	Korean
ADAS	41	34	29	13	12	7 21.4%	1 3.0%	0 0.0%	0 0.0%
AMHS	90	86	81	17	7	13 15.6%	1 1.2%	1 1.2%	5 5.8%
COE	16	15	17	0	1	1 6.7%	0 0.0%	0 0.0%	0 0.0%
P&I	38	37	38	0	0	2 4.1%	1 2.7%	1 2.2%	0 0.0%
CYS	101	95	103	4	4	13 13.2%	3 3.3%	1 1.1%	1 1.1%
BHS	285	266	268	34	24	36 13.4%	6 2.3%	3 1.1%	6 2.3%

Percentages shown were calculated prior to rounding of the raw numbers to whole numbers. Therefore, these percentages may vary slightly from the percentages calculated using the whole numbers shown in the table.

Table 2. Workforce needs assessment among non-direct service staff by division in BHS									
Division	Number of FTEs budgeted (FTE = Full Time Equivalents)	Number of current FTEs	Number of FTEs actually needed to meet the needs of current number of clients	Of column (2), how many individuals are specifically designated for consumers or family members	Of column (3), how many are disclosed as consumers or family members	Of Column (3), how many are capable of providing services in	Of Column (3), how many are capable of providing services in	Of Column (3), how many are capable of providing services in	Of Column (3), how many are capable of providing services in
	Col-2	Col-3	Col-4	Col-5	Col-6	Spanish	Vietnamese	Farsi	Korean
ADAS	58	48	24	15	20	20 40.4%	0 0.0%	2 4.1%	0 0.0%
AMHS	142	127	119	23	12	47 37.4%	14 11.1%	2 1.6%	0 0.0%
COE	22	22	25	5	5	1 4.5%	1 2.2%	0 0.0%	1 2.2%
P&I	29	26	129	0	0	8 29.5%	1 3.9%	0 0.0%	0 0.0%
CYS	148	141	162	4	6	51 35.9%	5 3.5%	0 0.0%	1 0.7%
BHS	400	365	459	47	43	126 34.7%	21 5.6%	4 1.1%	2 0.4%

Percentages shown were calculated prior to rounding of the raw numbers to whole numbers. Therefore, these percentages may vary slightly from the percentages calculated using the whole numbers shown in the table.

Table 3. Workforce needs assessment among direct service staff by division in BHS									
Division	Number of FTEs budgeted (FTE = Full Time Equivalents)	Number of current FTEs	Number of FTEs actually needed to meet the needs of current number of clients	Of column (2), how many individuals are specifically designated for consumers or family members	Of column (3), how many are disclosed as consumers or family members	Of Column (3), how many are capable of providing services in	Of Column (3), how many are capable of providing services in	Of Column (3), how many are capable of providing services in	Of Column (3), how many are capable of providing services in
	Col-2	Col-3	Col-4	Col-5	Col-6	Spanish	Vietnamese	Farsi	Korean
ADAS	194	178	210	85	92	40 22.6%	2 1.1%	1 0.6%	0 0.0%
AMHS	462	411	478	284	67	100 24.4%	65 15.7%	17 4.1%	10 2.4%
COE	77	69	75	50	48	16 23.4%	18 26.3%	2 2.9%	7 9.5%
P&I	142	136	142	0	0	55 40.4%	11 7.7%	5 3.8%	4 3.2%
CYS	530	456	554	115	41	200 44.0%	22 4.8%	5 1.2%	8 1.8%
BHS	1404	1249	1458	534	248	412 33.0%	117 9.4%	31 2.5%	29 2.3%

Percentages shown were calculated prior to rounding of the raw numbers to whole numbers. Therefore, these percentages may vary slightly from the percentages calculated using the whole numbers shown in the table.

Table 4. Workforce needs assessment among all classifications by division and BHS									
Division	Number of FTEs budgeted (FTE = Full Time Equivalents)	Number of current FTEs	Number of FTEs actually needed to meet the needs of current number of clients	Of column (2), how many individuals are specifically designated for consumers or family members	Of column (3), how many are disclosed as consumers or family members	Of Column (3), how many are capable of providing services in	Of Column (3), how many are capable of providing services in	Of Column (3), how many are capable of providing services in	Of Column (3), how many are capable of providing services in
	Col-2	Col-3	Col-4	Col-5	Col-6	Spanish	Vietnamese	Farsi	Korean
ADAS	293	260 98.1%	263	113 38.6%	124 47.6%	67 25.7%	3 1.2%	3 1.2%	0 0.0%
AMHS	694	623 91.8%	678	323 46.6%	86 13.8%	161 25.8%	80 12.8%	20 3.2%	15 2.4%
COE	115	106 91.4%	116	55 48.1%	54 52.2%	18 17.0%	19 17.5%	2 1.9%	7 6.6%
P&I	208	199 64.4%	309	0 0%	0 0%	64 32.3%	13 6.3%	6 3.0%	4 2.2%
CYS	778	692 84.6%	818	123 15.8%	51 7.4%	264 38.1%	30 4.3%	6 0.9%	10 1.5%
ALL BHS	2089	1880 86.1%	2185	615 29.4%	315 16.8%	574 30.5%	144 7.6%	37 2.0%	36 1.9%

Percentages shown were calculated prior to rounding of the raw numbers to whole numbers. Therefore, these percentages may vary slightly from the percentages calculated using the whole numbers shown in the table. Col (3) percentages: (Col-3 / Col-4)

Table 5. Fiscal Year 2011-2012 Clients with Requested Primary Languages in IRIS by Division							
Division	Farsi	Korean	Spanish	Vietnamese	Total Requested Languages By Division	Total All Other Languages In Divisions	Total Division Clients
ADAS	8	8	593	33	642	5686	6328
% ADAS to All Clients in ADAS	0.13%	0.13%	9.37%	0.52%	10.15%	89.85%	100.00%
AMHS IP/Res	3	23	88	84	198	1306	1504
% AMHS IP/Res to All Clients in AMHS IP/Res	0.20%	1.53%	5.85%	5.59%	13.16%	86.84%	100.00%
AMHS OP Oper	101	90	1214	701	2106	9622	11728
% AMHS OP Oper to All Clients in AMHS OP Oper	0.86%	0.77%	10.35%	5.98%	17.96%	82.04%	100.00%
CYS	29	20	3516	90	3772	10897	14669
% CYS to All Clients in CYS	0.20%	0.14%	23.97%	0.61%	25.71%	74.29%	100.00%
PEI	1	0	116	0	117	69	186
% PEI to All Client in PEI	0.54%	0.00%	62.37%	0.00%	62.90%	37.10%	100.00%
BOCE	0	6	23	57	86	128	214
% BOCE to All Clients in BOCE	0.00%	2.80%	10.75%	26.64%	40.19%	59.81%	100.00%
Total Languages	142	141	5527	908	6835	27580	34629
% Grand Total Languages to All Divisions	0.41%	0.41%	15.96%	2.62%	19.74%	79.64%	100.00%

County Demographics

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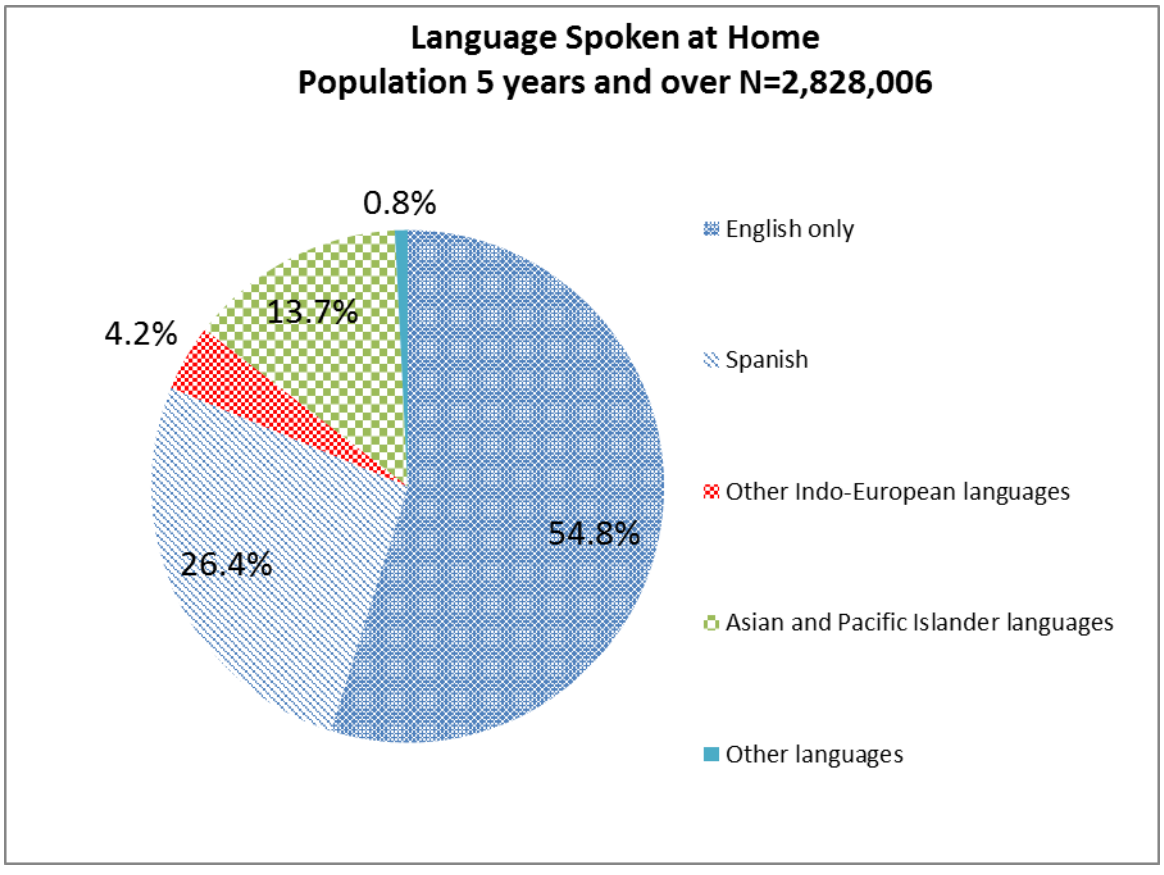
County Demographics

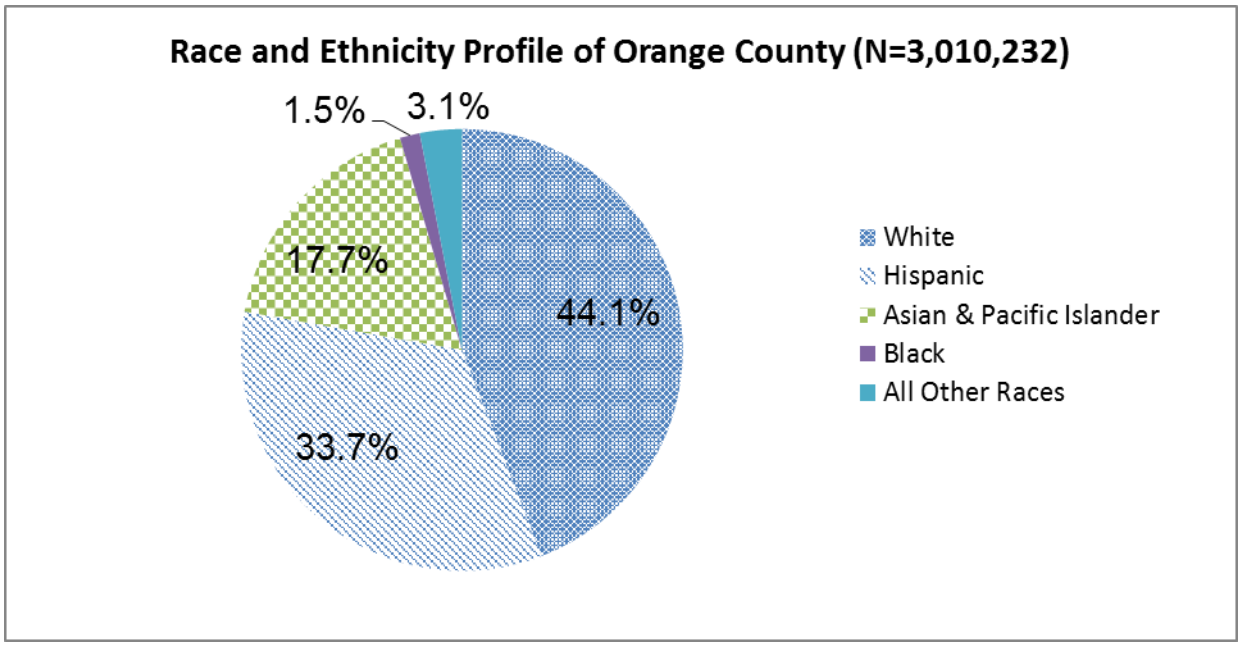
Geography and Racial/Ethnic Profile of Orange County

County of Orange is approximately 798.3 square miles in size and is comprised of 34 incorporated cities. It is home to a little over 3 million (3,010,232) people and is proud of its rich ethnic makeup.

Although many perceive Orange County as predominantly White and English-speaking, that is not accurate. Currently, Orange County has three threshold languages (Spanish, Vietnamese and Farsi). English is spoken at home by 54.8% of the population five years and over, followed by Spanish (26.4%) and Asian/Pacific Islander languages (13.7%). The County is comprised of four major racial/ethnic groups Whites (44.1%), Hispanics (33.7%), Asian & Pacific Islanders (17.7%) and Blacks (1.5%). According to California Department of Finance projections, by year 2020 Orange County's population will become increasingly diverse with a rapid increase in the percentage of Hispanics (37.1%). By 2030, it is projected that Hispanics will become the majority (38.6%) ethnic group in the County, surpassing Whites (36.7%).



Source: U.S. Bureau of the Census, 2010 Decennial Census



Source: U.S. Bureau of the Census, 2010 Decennial Census

Social and Economic Indicators

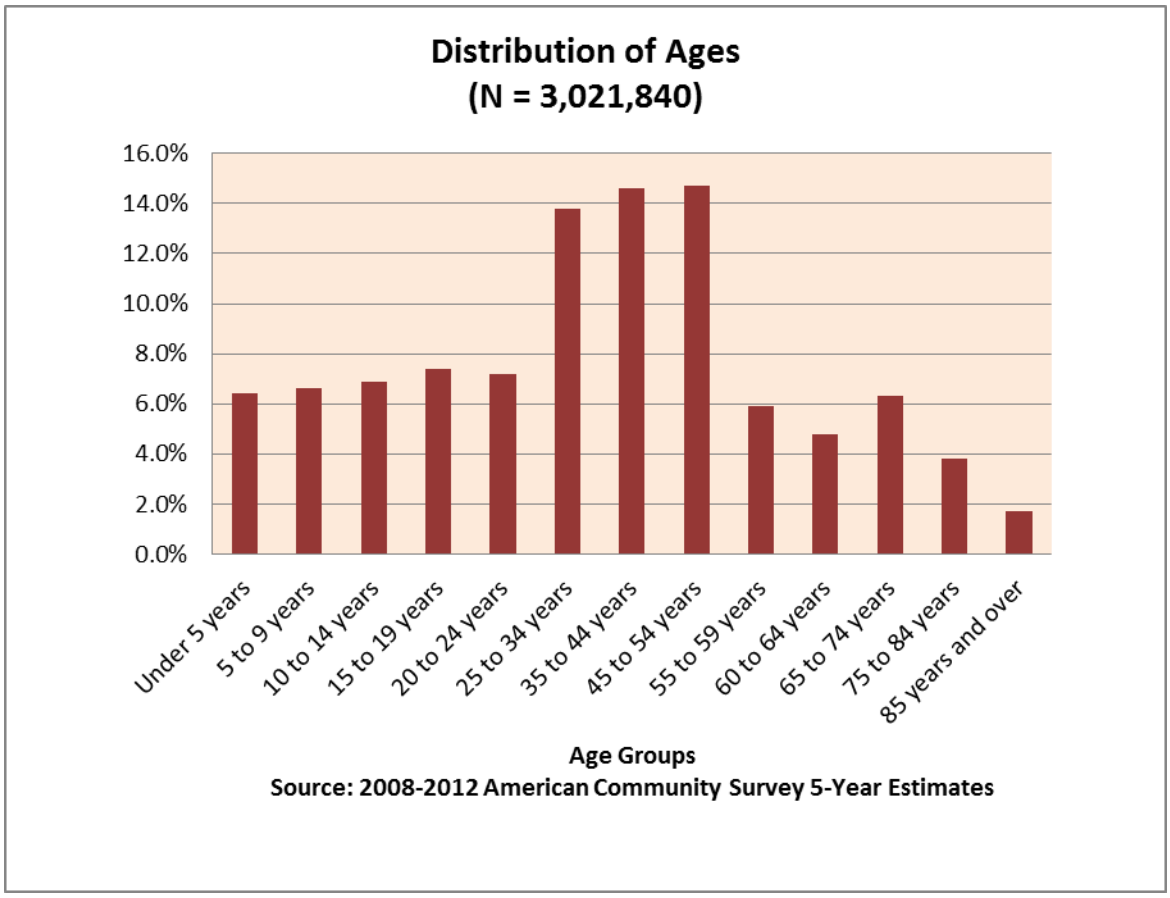
In 2011, 12.9% of Orange County's population lived under 100% of the federal poverty level (FPL), which is $10,890 annual income for single-person household size. In 2013, 5.7% of Orange County residents 16 years and older did not have jobs. In 2011, the Family Economic Self-Sufficiency Standard index was calculated for 156 family types ranging from a single adult with no children to three or more adults with four or more children. The Family Economic Self-Sufficiency Standard measures how much income is needed for a family of a certain size in a particular county to adequately meet its minimal basic needs including housing, child care, food, transportation, out-of-pocket medical expenses, taxes, and other necessary spending. By this standard, a family of two adults with two school-age children living in Orange County would need $65,761 family annual income to meet its minimal basic needs.

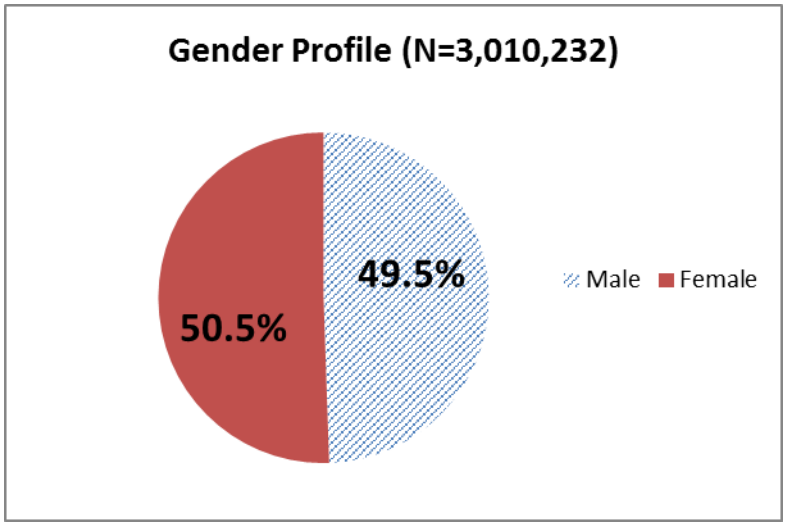
These figures reflect Orange County's high Cost of Living Index which compares prices of housing, groceries, utilities, transportation, health care, and other consumer items for Orange County and peer metropolitan regions as found by the Council for Community and Economic Research. Since 2007, Orange County has consistently had the highest Cost of Living Index compared to neighboring areas. Orange County's cost of living measures for groceries, utilities, transportation, and miscellaneous items tended to rank in the middle among similar jurisdictions, but high housing costs significantly affected the index, making Orange County a very expensive place to live.

In 2012, 23.6% of the County's population was under the age of 17, 38.1% were 18-44 years of age, 26.0% were 45-64 years of age, and 12.3% were 65 or older. The percentage of County population age 65 or older is expected to increase over the next 20 years. As percentage of seniors grows, the need for mental and physical health care is expected to rise.

Age, Gender and Household Characteristics

The median age is 36.2 years distributed almost equally between males and females. The average household size is 2.9 with 1,048,907 housing units and a homeless population of just over twelve thousand individuals (Point in Time Survey, 2013).





Source: U.S. Bureau of the Census, 2010 Decennial Census

Other Unique Characteristics

During the past ten years, Orange County also became a minority majority county, meaning the non-Hispanic white population no longer comprises more than 50% of the county population (Orange County Change: Census 2000-2010 by CSU Fullerton CDR). Orange County is also home for an emerging Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ) population. Specific services are available in the County to address the unique needs of this population. Accurate statistics on the LGBTQ population in the County are not available. However, based on 2000 census data and other available resources, an estimated 4% of males and 2% of females in Orange County are gay or lesbian. The census 2000 reported 2,901 same sex *male* couple households and 2,623 same sex *female* couple households in Orange County. Approximately 6.0% (2,282,766) of the civilian population over 18 years are veterans. The County has a well-educated population, with 83.6% of the population age 25 years and over being a high school graduate or higher and 36.6% having a bachelor's degree or higher.

Community Program Planning

600 W. Santa Ana Blvd., Suite 510, Santa Ana, CA 92701 | (714) 667-5600 | MHSA@ochca.com | www.OCHealthinfo.com/MHSA

Community Program Planning

The Planning Process for the Three-Year Mental Health Services Act (MHSA) Plan for FY 14/15 through FY 16/17 builds on the previous MHSA planning processes conducted in Orange County. The current array of services was created based on the extensive planning efforts of thousands of stakeholders from 2005 to the current day. These processes included hundreds of focus groups, community planning meetings, approval by the Orange County MHSA Steering Committee and public hearings held by the Orange County Mental Health Board. As in prior years, the MHSA planning process included a diverse group of stakeholders including clients, family members and representatives of unserved and underserved populations.

The MHSA planning process is guided by a Steering Committee composed of approximately 65 individuals. This Steering Committee includes representatives from many stakeholder groups. These include consumers of mental health services, family members, law enforcement, schools, the criminal justice system, veterans, providers of alcohol and substance abuse services, social services, healthcare organizations, homeless prevention/housing organizations, consumer advocacy groups, probation, the Mental Health Board, and underserved ethnic communities. Translators are available at the meetings, including one for American Sign Language.

There is meaningful stakeholder involvement in all aspects of the planning process for MHSA-funded services. This includes: program selection, budget allocations for types of services, quality improvement, and program evaluation. In addition to the MHSA Steering Committee, there is a Community Action Advisory group made up of an ethnically diverse group of consumers and family members. This group meets monthly and provides input into the MHSA planning process.

In 2012, the Steering Committee adopted a new structure to enhance the planning process and provide additional opportunities for MHSA Steering Committee members and the public to provide input. The Steering Committee developed Subcommittees that are organized by MHSA component and by each of the age groups within Community Services and Supports (CSS). The role of each Subcommittee is to make recommendations on services and level of funding for MHSA programs.

The four Subcommittees are:

- CSS Children and Transitional Aged Youth (TAY)
- CSS Adults and Older Adults
- Prevention and Early Intervention (PEI)
- Workforce Education and Training (WET) and Innovation (INN)

Members of the MHSA Steering Committee and Alternates may join up to two Subcommittees of their choice. Members of the public who would like to become Subcommittee members may apply to become members of one or two Subcommittees.

Subcommittee members are expected to make a commitment to participate for at least one year. Meetings are held on even numbered months, and additional meetings are held as needed. Meetings are open to the public. The Steering Committee as a whole meets on odd number months.

As part of the MHSA Planning Process for this Three-Year Plan, data on budgets, program expenditures, people served and other relevant topics was presented to each Subcommittee for the components/age groups within their area of interest.

Based on the revenue projections provided by Mike Geiss (a fiscal consultant working for Orange County and the California Mental Health Directors Association), it is estimated that Orange County will have an increase in revenue for the fiscal years covered by the Three-Year Plan. Behavioral Health Services (BHS) staff and the local Mental Health Board collaborated in developing recommendations to meet the needs and fill current gaps in services utilizing approximately $22 million in CSS funds and $3 million in PEI funds from a combination of growth funds and unspent balances from prior years.

These recommendations included expansion of the following three CSS Programs: Program of Assertive Community Treatment (PACT), Children's Crisis Residential, and Children's In-Home Stabilization. In addition, expansion of two PEI programs was recommended: O.C. Post-Partum Wellness Program and Socialization for adults and Older Adults. At the September Steering Committee, the above-mentioned program expansions were approved for the Three-Year Plan.

In November 2013, the subcommittees met and considered recommending that some new programs proposed by the Mental Health Board and BHS be added to the continuum of care. CSS new programs included a new Wellness Center Program in South County, a Transportation Program, a Program of Assisted Outpatient Treatment, and an Adult/Transitional Age Youth In-Home Crisis Stabilization Program. A new PEI program (Behavioral Health Counseling) was also recommended for approval by the MHSA Steering Committee. In addition the Subcommittees recommended that except for those programs that had been expanded, current programs be continued at the FY 13/14 level.

In December, 2013, the MHSA Steering Committee conducted a community input process that included a public forum and an opportunity for the community to provide written comments on suggestions for new or expanded programs to address unmet needs for mental health and supportive services. Between the Public Forum and the written comments, the Steering Committee received approximately 90 recommendations. Recommendations were submitted by a wide variety of stakeholders, including clients, families, service providers, advocacy groups, and knowledgeable professionals. Staff reviewed the comments and grouped them by unmet need to be addressed or service recommendation. They then developed a chart showing which suggestions might possibly be funded and which represented needs that were already being addressed or not eligible for MHSA funds.

In January 2014, the MHSA subcommittees met to discuss those recommendations that pertained to each subcommittee's area of interest. There was a combined subcommittee for WET and CSS, since any continued funding of WET programs would need to be paid for through CSS component funding given that all WET funds have been expended. To sustain the existing WET programs, CSS unspent funds from previous years were allocated to WET. This is a permissible use of CSS funding as long as the amount does not exceed 20% of the current year's CSS allocation.
The amount allocated was within the stated limits.

The CSS/WET subcommittee recommended that the MHSA Steering committee fund the following new or expanded programs:

- Expansion of FSP programs for all age groups
- Mental Health Court Probation Case Management Services
- A new Drop-in Center
- Housing for the Homeless
- Housing and Dedicated Emergency Shelter Beds for those with serious Mental Illness
- Services for Children with Co-Occurring Mental Health diagnoses and Chronic/Acute Physical Illness, Eating Disorders, or other Special Needs
- Expansion of Core Youth Outpatient Treatment

The PEI subcommittee recommended that the MHSA Steering Committee approve:

- A new K through twelve Program on coping skills to manage stress
- Continuation of Statewide PEI Projects
- After-Hours staffing of the BHS Behavioral Health WarmLine.

On February 3, 2014, the MHSA Steering Committee approved all of the subcommittee recommendations. The Plan was then written by staff and reviewed internally by BHS Executive Management. After executive approval, the Plan was posted by the Clerk of the Board of Supervisors for Public Comment for 30 days, March 20, 2014 through April 21, 2014. The draft Plan Update was also posted on the Orange County MHSA website and the Network of Care website. In addition, copies were made available at Orange County libraries. Twelve written public comments were received. A summary of the comments and the responses to those comments may be found in Appendix III.

The Orange County Mental Health Board (MHB) held a Public Hearing on April 23, 2014. The Mental Health board then held a separate meeting on April 30, 2014 to consider approval of the MHSA Three-Year Plan. The Plan was unanimously approved by the Orange County Mental Health Board on April 30, 2014. On May 13, 2014, the Plan was unanimously approved by the Board of Supervisors.

Community Services and Supports

600 W. Santa Ana Blvd., Suite 510, Santa Ana, CA 92701 | (714) 667-5600 | MHSA@ochca.com | www.OCHealthinfo.com/MHSA

Community Services and Supports

A. Component Information

Community Services and Supports (CSS) was the first component to be implemented and is the largest of all five components. Currently, 75% of each year's MHSA allocation is budgeted for CSS. Services provided by CSS have the goal of improving access to underserved populations, bringing recovery approaches to the current systems, and providing "whatever it takes" services to those most in need. New programs offered under CSS programs are integrated recovery-oriented mental health treatment, offering case-management and linking to essential services such as housing, vocational support, and self-help.

CSS programs are available for all age groups, and some programs serve more than one age group of clients. .A balanced approach was taken to meeting the mental health services and supports needs of:

- Children (ages birth to 15)
- Transitional Age Youth (ages 16-25)
- Adults (ages 26-59) and
- Older Adults (ages 60 and above)

CSS Funds are also divided into three functional categories:

- Full Service Partnerships (FSPs) Intensive team approach, 24/7, with flex funding, for those homeless or at high risk of homelessness. (More than 50% of CSS funds must be spent on FSPs)
- Outreach and Engagement (O&E)
- General Systems Development (GSD) Improve programs, services and supports for all clients and families.
  Examples of General Systems Development programs include:
    - Children's Outreach and Engagement
    - Children's In-Home Stabilization
    - Children's Crisis Residential
    - Children's Centralized Assessment Team (CAT)
    - Transitional Age Youth (TAY) Crisis Residential
    - TAY Mentoring
    - TAY CAT
    - TAY Program of Assertive Community Treatment (PACT)
    - Recovery Center Program
    - Supportive Employment
    - Adult Crisis Residential
    - Adult Centralized Assessment Team and Psychiatric Evaluation Team (CAT/PERT)

- Wellness Center
- Adults and Older Adults PACT

B. CSS Program Information & Outcomes

C1. Children's Full Service Partnership	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**371**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$5,954,575**
Estimated Annual Cost Per Client	**$16,050**

1. Program Description

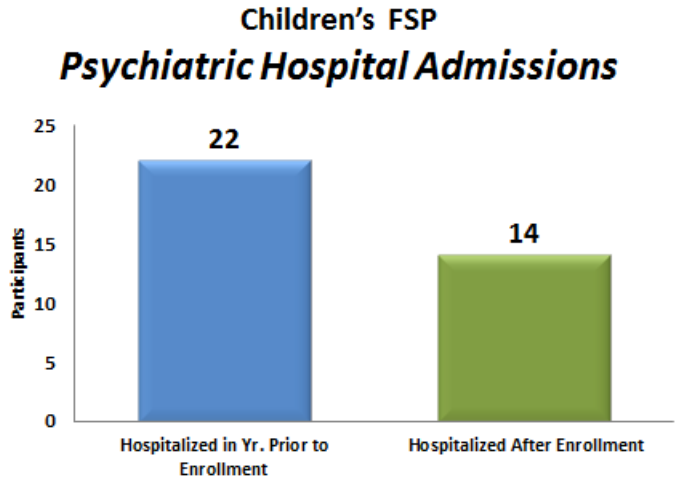
The four Children's Full Service Partnership (FSP) programs focus on several areas prescribed in the original legislation and several defined by local need within the broader targets. One FSP focuses on the more general community. This program takes referrals from the Outreach and Engagement teams, Centralized Assessment Team, and County and contract clinics. Prominent among their referrals are the homeless or those at risk of homelessness. Parents frequently need job assistance, especially when the needs of their Seriously Emotionally Disturbed child impact their ability to maintain employment. The second FSP program focuses on the culturally and linguistically isolated, particularly those in the Vietnamese and Korean Communities. The third program serves a small number of children who entered the juvenile justice system at a younger age, and after in-custody rehabilitation, need support reintegrating into the community. The fourth children's FSP is a program for those young people who come to the attention of the Juvenile Court, especially those who require the services of specialized collaborative courts.

Additional funds have been set aside for Children's FSPs. These dollars will be distributed among the existing programs based upon the history of program spending and the impact of shifting costs in the community. Programs will be able to serve more clients and more funds will be available to cover raising costs, especially in housing.

2. Outcomes

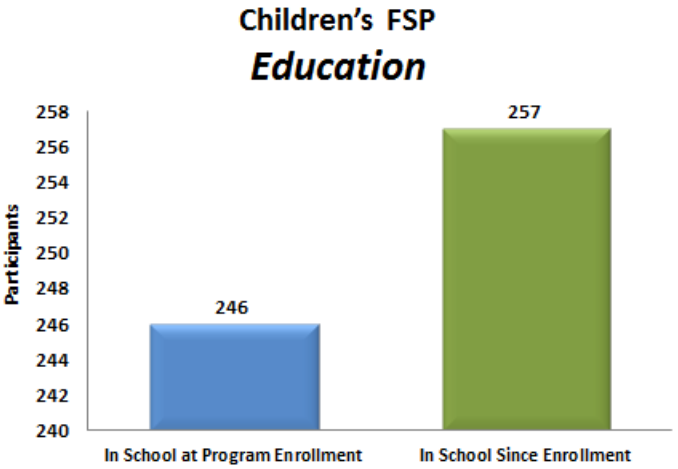
One of the goals of the FSPs is to reduce the number of hospitalizations that the participants experience. In the year prior to enrollment in the FSPs, 22 out of 260 (8%) children reported that they had been hospitalized. Since enrollment in

an FSP, 14 (5%) of these children were hospitalized, resulting in a 36% decrease in the hospitalization rate during FY12-13 (see graph below).



In addition to a decrease in the overall hospitalization rate, there was a corresponding 57% decrease in the total number of days the children were hospitalized after enrolling with an FSP (i.e., 298 days during the year prior to enrolling and 128 days after enrolling in an FSP).

At the time of enrollment in an FSP during FY12-13, 246 (94%) children were enrolled in school. Since joining an FSP, 257 out of 260 (99%) children were enrolled. This represents a 5% increase and, even more importantly, reflects that nearly all school-aged children were enrolled in school.



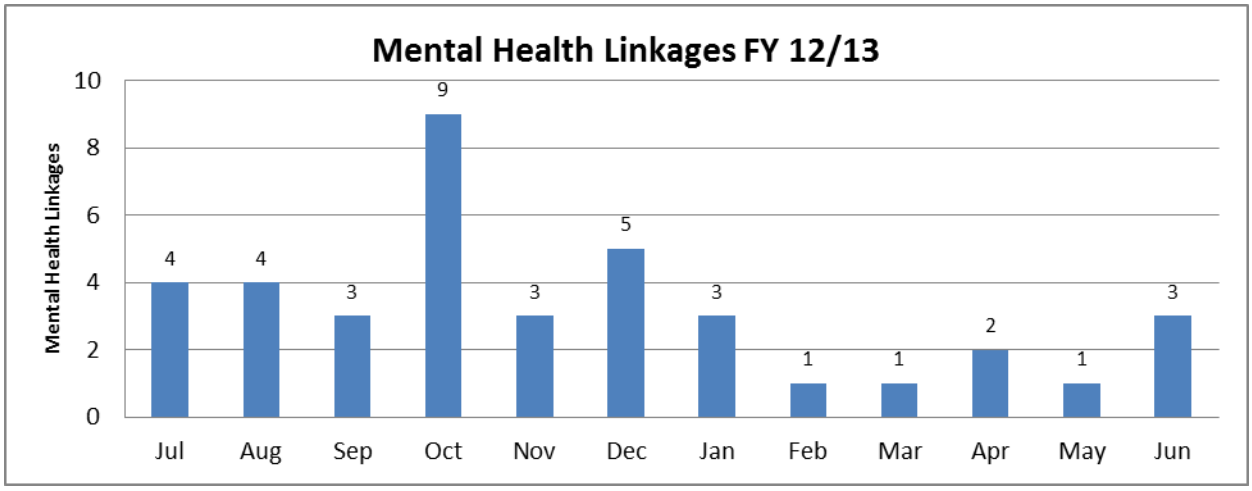
C2. Children's Outreach and Engagement	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**50**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**123,594**
Estimated Annual Cost Per Client	**$2,472**

1. Program Description

The Mental Health Services Act (MHSA) Children's Outreach and Engagement program serves Seriously Emotionally Disturbed (SED) and Mentally Ill (SED/SMI) children ages birth to 18 whose families are homeless or on the verge of homelessness. The program assists the unserved or underserved children and their families with accessing culturally and linguistically appropriate full service partnerships, mental health services, and/or linkages with other needed community resources. The program also focuses on reducing the stigma associated with mental illness and increasing the acceptance of treatment and services that improve the quality of life and stability of children/families in the community of choice. Outreach is conducted in schools and other locations by establishing engaging activities in neighborhoods throughout the County.

2. Outcomes

The program is relied upon to handle community referrals where a serious mental illness and homelessness (at risk) is involved. The program assists families with accessing mental health services and/or linkages with other needed community resources. The graph below displays data on the number of successful linkages to mental health services during FY 12/13. The number of linkages varies from one to nine per month.



C3. Children's In-Home Crisis Stabilization	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**400**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$1,085,480**
Estimated Annual Cost Per Client	**$2,714**

1. Program Description

The target population is youth up to their 18th birthday who are being considered for psychiatric hospitalization, but who don't meet criteria for admission. This program consists of teams of professionals and staff with lived experience who are available 24/7 to meet with families in crisis and assist in stabilization. Typically a Children and Youth Services (CYS) staff person is asked to evaluate a youth for possible hospitalization. Once it is determined that the youth does not meet criteria for hospitalization but it is clear that the family needs assistance, the evaluator calls the crisis stabilization team who come to the site of the evaluation and begin to (1) work out a plan to identify causes of the current crisis and (2) begin to work on healthful ways of avoiding future crises. There are times when families are drained by the crisis and the evaluation process, and in those incidents, in-home appointments are made for the next day to begin the stabilization process. The team targets a brief intervention period of usually three weeks, occasionally extending to six. The In-Home Crisis Stabilization Team helps the family and child develop coping strategies and linkages to on-going support.

The program was expanded in January 2014 effectively increasing direct service clinical staff from eight to 14. For FY 14-15 and the years beyond the goal for a fully staffed program is to serve 400 children and their families.

2. Outcomes

Outcomes for the program are measured in two ways. First is the number of clients served. During FY 12-13 the expectation was that a minimum of 160 clients be served. The program served 240. During FY 12-13 the program showed an 86% diversion rate from hospitalization during the time that the case was open and for 60 days post discharge.

C4. Children's Crisis Residential Program	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**200**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$3,289,966**
Estimated Annual Cost Per Client	**$16,450**

1. Program Description

This program was developed to address a system gap. An alternative to hospitalization or In-home Crisis Services was needed. The target population is youth up to their 18th birthday who are at risk of psychiatric hospitalization. This need arises when the following occur:

- A youth in crisis is evaluated for psychiatric hospitalization;
- The youth does not meet in-patient criteria;
- The home situation is volatile; and
- A "cooling off" period would benefit both youth and family.

Referrals are accepted on a 24/7 basis. The target is a three week stay, which may be expanded to six if the clinical situation warrants. The youth are provided a structured setting where they maintain their school work and are introduced to problem solving techniques which they can employ in family therapy. Parent education and skill building are important components of the program. The youth interact in structured groups and participate in activities like meal preparation and clean-up.

Throughout FY 12-13 and the early parts of FY 13-14 the program had many more referrals than it could serve. As counter-intuitive as it may seem, a waiting list was established for this crisis program. Many potential referrers were discouraged by this and did not even attempt to place their client on the waiting list. When additional funding became available, negotiations began to expand the program. The plan for FY 14-15 is to double the size of the program from 6 to 12 beds.

2. Outcomes

The expectation of this program is to serve a minimum of 200 clients per year. During FY 12-13 the program served 90 clients with an average length of stay of 18.5 days. The target was to serve children and their families in the community and avoid inpatient hospitalization when safe and viable. Eighty-four percent of clients met the criteria of avoiding hospitalization between admission to the program and sixty days post-discharge.

C5. Mentoring for Children	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**146**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$352,620**
Estimated Annual Cost Per Client	**$2,415**

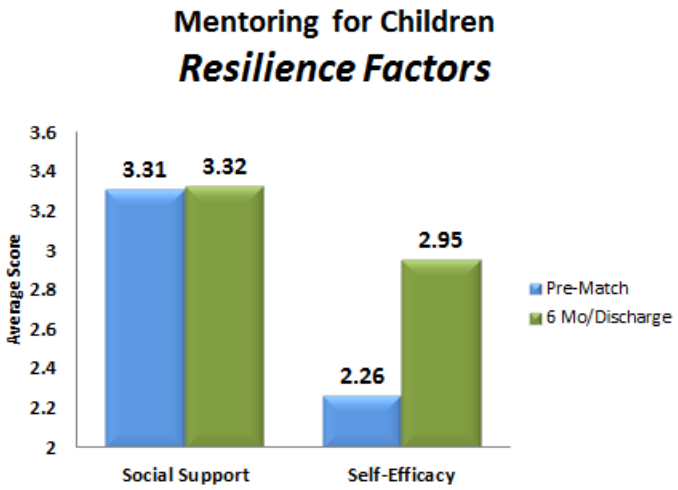
1. Program Description

The Mentoring Program is a community-based, individual and family centered program that recruits, trains and supervises responsible adults to serve as positive role models and mentors for seriously emotionally disturbed (SED) children and youth who are receiving outpatient services through Children and Youth Services (CYS) and its contractors. Parents/caregivers of SED children and youth may also receive parent mentoring services.

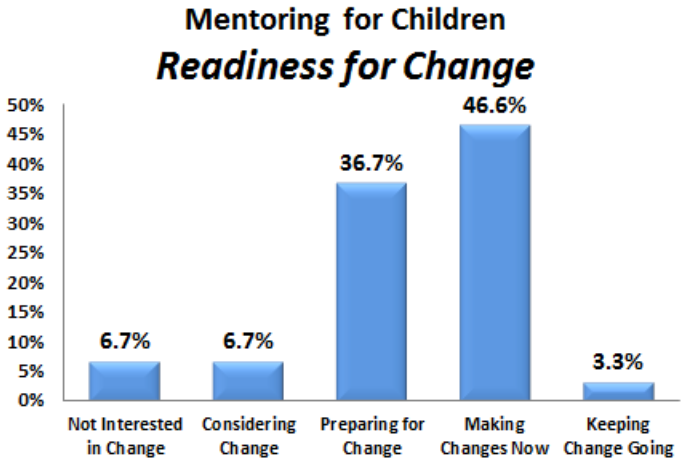
One-to-one mentoring has the potential to impact youth in a positive way as strong relationships are formed and good mentoring practices are implemented. Research conducted by the National Mentoring Partnership indicates that youth mentoring holds great promise in helping young people succeed in life. Studies of programs that provide youth with formal one-to-one mentoring relationships have provided strong evidence of reducing the incidence of delinquency, substance use and academic failure. Formal youth mentoring programs promote positive outcomes, such as improved self-esteem, enhanced social skills and resiliency. Children and Youth Services has an extensive history of using mentors as an adjunct to formal treatment for children receiving mental health services. It provides the youth an opportunity to practice the skills learned in therapy in a controlled and supportive environment. Mentoring is a logical, cost-effective strategy that provides youth with positive reinforcement and caring role models.

2. Outcomes

Youth in the Mentoring program are asked to complete a Resilience Scale prior to being matched with a mentor and once again after being in the program for 6 months (which typically coincides with discharge). There are two primary factors of resilience measured on the scale: social support and self-efficacy. As can be seen in the graph below, during FY12-13 youth maintained their high level of social support and showed gains in self-efficacy after being matched with a mentor.



In addition, the clinicians and/or mentors complete a Readiness for Change measure at discharge, which reflects the extent to which they believe the youth is ready to make positive changes in his/her behavior. Fifty percent of children were described as making or keeping positive changes going and 37% were rated as preparing for change, suggesting that the majority of children were mobilized to make and/or maintain positive changes in their lives following their involvement with the mentor program. In addition, another 7% were considering making positive changes, whereas only 7% were not interested in making any changes.



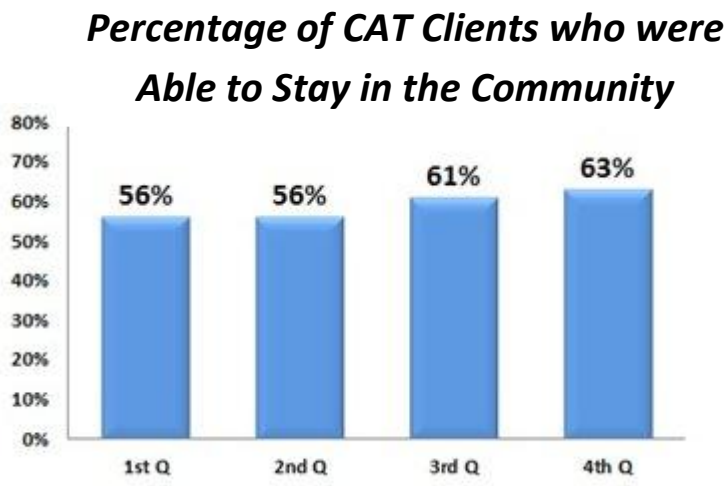
C6. Children's Centralized Assessment Team	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**2,140**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$1,594,904**
Estimated Annual Cost Per Client	**$745**

1. Program Description and Target Population

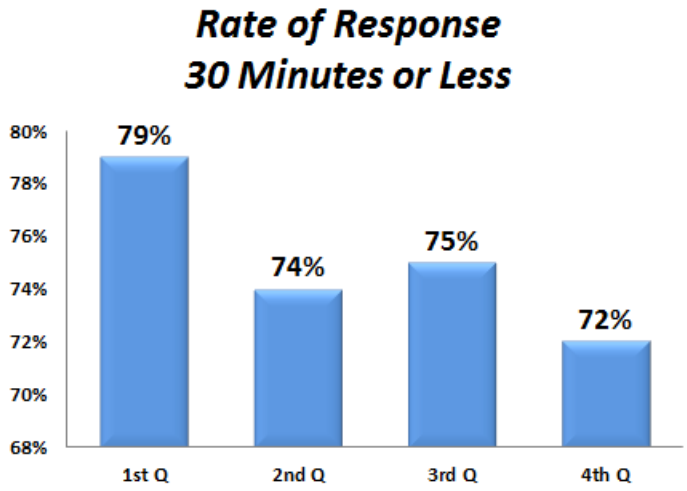
The Children's Centralized Assessment Team (CAT) responds to psychiatric emergencies for any youth under 18 years of age, anywhere in the county. The team operates 24 hours a day, 365 days per year. The scope of the CAT teams charge shifted in April 2012 when it expanded its responses to home-based assessments (with police accompaniment) and to any youth regardless of insurance coverage (if requested to assist). Prior to that time, evaluations were restricted to emergency rooms, police stations, schools and group homes and only unfunded or Medi-Cal clients were seen. The purpose of the team is to intervene in crisis situations. If safety cannot be assured, the CAT member will write a 72-hour hold and facilitate the child's placement in a psychiatric hospital. If the child can be successfully treated at a less restrictive level of care, the team member will assure that the linkage is made. The team has been expanded as the workload has increased.

2. Outcomes

The primary outcome for the CAT team is the number of clients placed in the most appropriate level of care. Many clients can be served in the In-Home Crisis Stabilization Program, the Crisis Residential Program, and the various full service partnerships (FSPs), as well as more traditional outpatient programs. The goal is to keep at least 60% of the clients in the community, although a variety of factors impact the result, especially the availability of community treatment options. As can be seen in the following chart, that goal was met in the last half of FY 12-13.



In addition, the efficiency of the CAT team is measured by the amount of time between dispatch and arrival at the evaluation location. The chart below shows the percent of dispatch-to-arrival times that were 30 minutes or less during FY12-13. The target rate is 70%, which was exceeded for all four quarters during FY12-13 despite the high call volume (i.e., over 1700 calls for FY12-13). Of note, the average response time for each quarter was 23 minutes.



C.7 OC Children with Co-occurring Mental Health and Chronic Acute Severe Physical Illness, Special Needs, or Eating Disorders	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17*	**200**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$500,000**
Estimated Annual Cost Per Client	**$2,500**

*In the chart above, the annual estimated number to be served in FY 14/15, 15/16 and 16/17 is considered to be the same; however, the actual number to be served in the first year will be less than in subsequent years due to the program start-up process, such as hiring staff and contract procurement. The exact numbers to be served in the first year will depend on the program implementation date.

1. Program Description and Target Population

During the MHSA public planning process a group of un-served and underserved youth was identified. This group consists of young people with physical disease complicated by their mental health issues. Many had some mental health issues but subsequently experienced significant health challenges. The result is a young person whose physical recovery is complicated by their mental health issues and whose reactions to physical health issues exacerbate their mental health issues to the SED level. Also included in this group are clients with severe eating disorders where physical deterioration is intertwined with mental health to the extent of life threatening risk. It is anticipated that many of these youth will have Medi-Cal and the MHSA funds will serve as match for the federal funds.

2. Outcomes

Outcomes will be measured using the Youth Outcomes Questionnaire (YOQ), which is a 64-item measure that assesses functioning in the following domains: Intrapersonal Distress, Somatic Symptoms, Interpersonal Relations, Social Problems, and Behavioral Dysfunction. The YOQ takes approximately 10 minutes to complete and is available in English, Spanish, Vietnamese, and Korean. In addition to this overall measure of functioning, symptom-specific measures (e.g., eating disorders, pain, etc.) will be administered as appropriate.

As the State develops Performance Outcomes for Medi-Cal specialty mental health services for children and youth, those measures will be incorporated into the outcome plan for this project.

C8. Children and Youth Outpatient Services Expansion	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17*	**250**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$500,000**
Estimated Annual Cost Per Client	**$2,000**

*In the chart above, the annual estimated number to be served in FY 14/15, 15/16 and 16/17 is considered to be the same; however, the actual number to be served in the first year will be less than in subsequent years due to the program start-up process, such as hiring staff and contract procurement. The exact numbers to be served in the first year will depend on the program implementation date.

1. Program Description and Target Population

This program expands services to children and youth ages birth through 20 in the 15 contracted outpatient clinics serving Medi-Cal beneficiaries throughout Orange County. Children and youth who suffer from a wide variety of behavioral health disorders will be provided services that include individual, collateral, group, and family therapy; medication management; and case management.

These funds will act as a “match” to allow for drawdown of Federal Financial Participation funds, which will essentially double the number of youth served for the MHSA funds spent.

Services are needed for the following reasons:

(a) Increased need for psychiatric medication management for children due expanded benefits under the Affordable Care Act.

(b) Increased caseloads due to Healthy Families transition to Medi-Cal and need for services by therapists beyond normal business hours.

(c) Expanded services to foster youth under “Katie A” services.

(d) Increased expenses related to national shortage of child psychiatrists and need to provide competitive rates.

2. Outcomes

As the State develops Performance Outcomes for Medi-Cal specialty mental health services for children and youth, those measures will be incorporated into the outcome plan for these services.

T1. Transitional Age Youth Full Service Partnership	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**900**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$6,334,468**
Estimated Annual Cost Per Client	**$7,038**

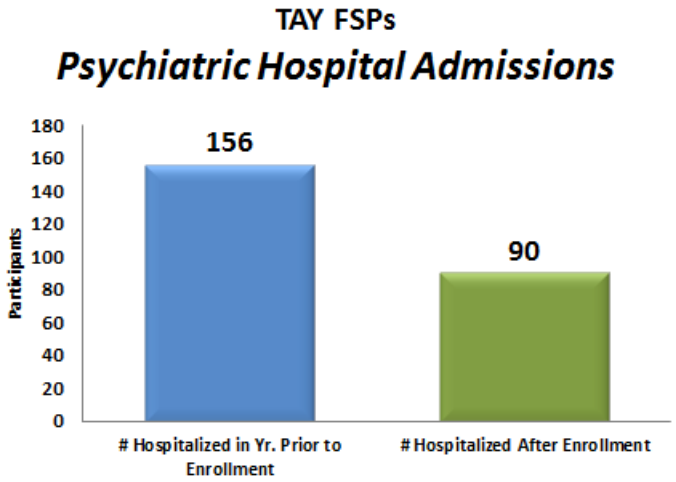
1. Program Description

The target groups for these programs are youth who are 16-25 who are homeless or at risk of homelessness, culturally or linguistically isolated, and/or at risk of incarceration or psychiatric hospitalization because of mental illness, frequently complicated by substance use. There are four programs in this category. One serves a broad spectrum of youth in the community including youth experiencing a first psychotic break and former foster youth, almost all of whom are at some risk of homelessness. A second focuses on the unique needs of the Pacific Islander community with particular focus on the Korean and Vietnamese populations. The third is a program designed to meet the needs of youth who had been exposed to significant rehabilitation attempts while in the custody of the Orange County Probation Department. This program focuses on maintaining the gains the youth has made and integrating back into the community. Learning how to obtain and maintain employment despite significant mental health issues is a particular focus. The fourth program was designed to meet the needs of a variety of youth involved with the Juvenile Court. This program works with the Juvenile Drug Court, particularly, to provide services once they graduate from the Court and are released from Probation. This program also serves youth who are Dual status (i.e. both wards and dependents of the court). These are multi-problem youth who may require services well into early adulthood. This FSP also works with children and families who come to the attention of the Truancy Court. For many multi-problem youth, this is the first time they come to the attention of the "helping system."

Additional funds have been set aside for TAY FSPs. These dollars will be distributed among the existing programs based upon the history of program spending and the impact of shifting costs in the community. Programs will be able to serve more clients and more funds will be available to cover rising costs especially housing.

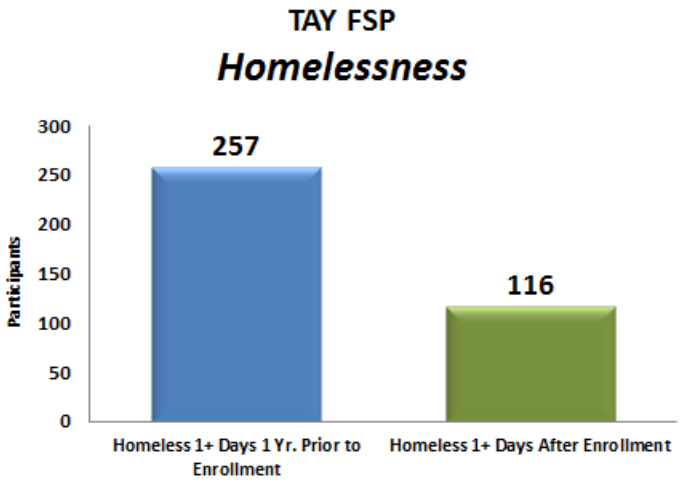
2. Outcomes

One of the primary goals of the FSPs is to reduce psychiatric admissions among a group of young people who traditionally have high recidivism rates. As can be seen in the chart below, 156 out of 864 (18%) TAY were hospitalized during the year prior to enrolling in an FSP, whereas only 90 (10%) were hospitalized after enrolling in an FSP. This reflects a 42% decrease in the rate of psychiatric admissions during FY12-13.



In conjunction with the decreased hospitalization rate, there was also a 60% decrease in the total number of days TAY spent in a psychiatric hospital during FY12-13 (i.e., 4237 during the year prior to enrolling and 1702 after enrolling in an FSP).

In addition, 257 out of 864 (30%) TAY spent at least one night homeless in the year prior to enrolling in an FSP. After enrolling in an FSP, 116 (13%) TAY spent at least one day homeless, representing a 55% drop in homelessness (please see graph on next page).



Finally, there was a 30% increase in the number of TAY enrolled in school (i.e., 263 at FSP enrollment and 519 after FSP enrollment), and a 43% decrease in the number of TAY incarcerated (i.e., 332 in the year prior to enrollment and 189 after enrollment) during FY12-13.

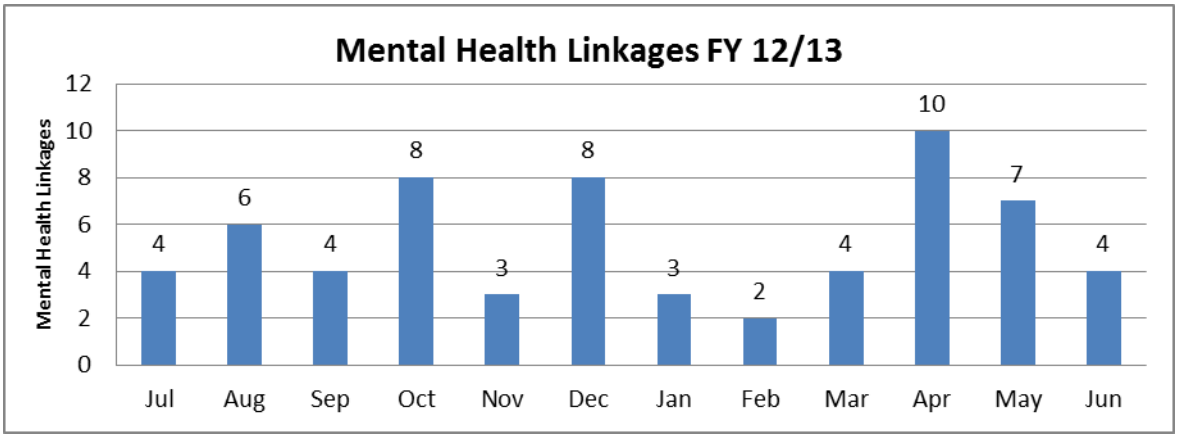
T2. Transitional Age Youth Outreach and Engagement	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**70**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$128,638**
Estimated Annual Cost Per Client	**$1,838**

1. Program Description

The Mental Health Services Act (MHSA) Transitional Age Youth (TAY) Outreach and Engagement program serves Seriously Mentally Ill (SMI) adults with co-occurring disorders from ages 18 to 25 that are homeless or on the verge of homelessness. The program assists the unserved or underserved TAY with accessing culturally and linguistically appropriate full service partnerships, mental health services, and/or with other linkages to community resources. The program adheres to a "best practice" model by offering services using a strength-based and recovery-based approach that focuses on resiliency and the establishment and growth of local support systems. On-going Street Outreach is conducted to increase the acceptance of treatment and services and improve the stability of the individual in the community of choice.

2. Outcomes

The program is relied upon to handle community referrals where a serious mental illness and homelessness (at risk) is involved. The team participates in activities throughout the county which provide greater access to the target population and increase community awareness of available services. The graph below displays data on the number of successful linkages to service during FY 12/13. The number of linkages varies from two to ten per month.



T3. Transitional Age Youth Crisis Residential Services	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**96**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$1,198,950**
Estimated Annual Cost Per Client	**$12,489**

1. Program Description

The target population for this program is youth 18-25 who are at risk of psychiatric hospitalization but do not meet criteria for involuntary holds. The program provides crisis residential services for this group. The program may also serve as an intermediate level of care between inpatient or out-of-state group home and living in the community. The program is licensed as a Social Rehabilitation Program by the State. The program is located in a suburban community and has six client beds. The typical stay in the program is three weeks with extensions up to six weeks when clinically indicated. Due to the difficulty with finding longer term structured and supervised housing for TAY, a second six bed facility was opened under the same license and serves as a two to six month placement when structure is clinically indicated, but the program does not require the emphasis on crisis and is designed to be a learning step before returning to programs in the community and more independent living.

2. Outcomes

The primary measure of program effectiveness is in keeping clients in the community and out of the hospital. The standard is no hospitalizations from admission until 60 days post discharge. In FY 12-13 this goal was achieved 80% of the time. Given the challenges of this population, this result is positive. The program also tracked on the number of clients served. The Crisis program served 50 clients, considerably below the target of 78. There was significant difficulty providing safe housing for clients as they completed the Crisis phase of the program. Thus, many needed to stay longer until appropriate structured and supportive alternatives were located, thereby decreasing the total number of clients who could be served over the course of the year. In the longer term program, the target was exceeded; serving 27 clients when their goal had been 18.

T4. Transitional Age Youth Mentoring Program	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**80**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$147,380**
Estimated Annual Cost Per Client	**$1,842**

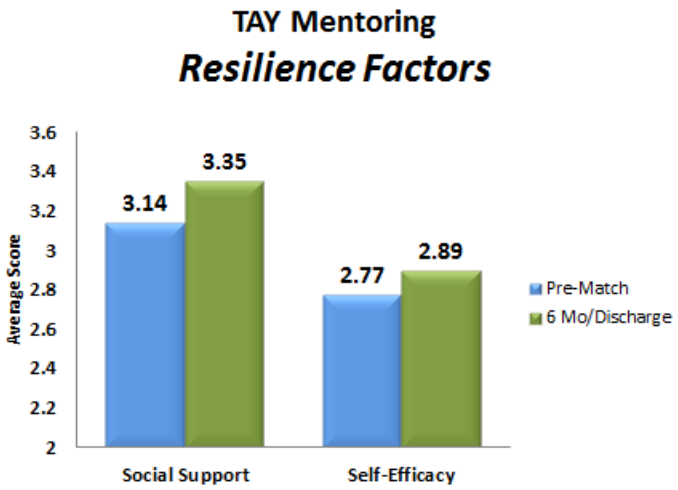
1. Program Description

This program provides Mentoring services for Transitional Age Youth (TAY) between 16 and 25 who are receiving outpatient services through CYS and its contractors. The Mentoring Program is a community-based, individual and family-centered program that recruits, trains and supervises responsible adults to serve as positive role models and mentors for seriously emotionally disturbed (SED) children and youth and severely mentally ill (SMI) transitional age youth.

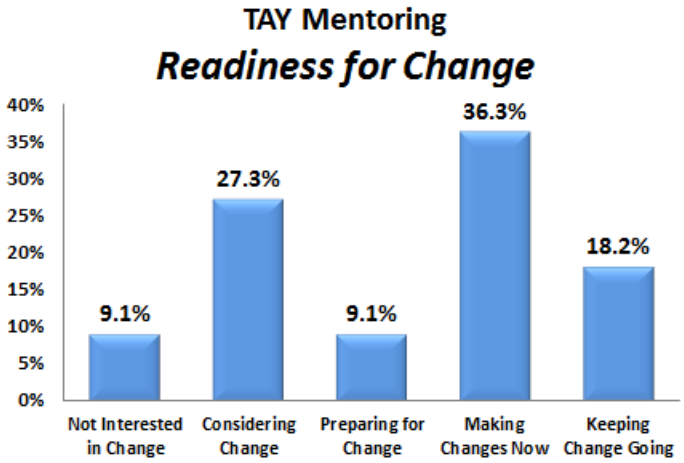
One-to-one mentoring has the potential to impact youth in a positive way. Strong relationships are formed and good mentoring practices are implemented. Research conducted by the National Mentoring Partnership indicates that youth mentoring holds great promise in helping young people succeed in life. Studies of programs that provide youth with formal one-to-one mentoring relationships have provided strong evidence of reducing the incidence of delinquency, substance use and academic failure. Formal youth mentoring programs promote positive outcomes, such as improved self-esteem, enhanced social skills, resiliency, and for TAYS, enhanced life skills. Children and Youth Services has an extensive history of using mentors as an adjunct to formal treatment for TAY receiving mental health services. It provides the youth an opportunity to practice the skills learned in therapy in a controlled and supportive environment. Mentoring is a logical, cost-effective strategy that provides youth with positive reinforcement and caring role models.

2. Outcomes

TAY in the Mentoring program complete a Resilience Scale prior to being matched with a mentor and once again after being in the program for six months (which typically coincides with discharge). As can be seen in the graph below, during FY12-13, TAY showed modest improvements both in social support and self-efficacy after being matched with a mentor.



At discharge, therapists and/or mentors also rate TAY on their readiness for making positive changes in their behavior. At the conclusion of their matches, 54% of TAY were reported as currently making changes and/or keeping changes going. Another 9% were rated as preparing for positive changes and 27% were rated as considering change. In contrast, only 9% were uninterested in making changes. These findings suggest that involvement with a mentor corresponds to improvements in positive behavior.



T5. Transitional Age Youth Centralized Assessment Team	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**435**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$320,314**
Estimated Annual Cost Per Client	**$736**

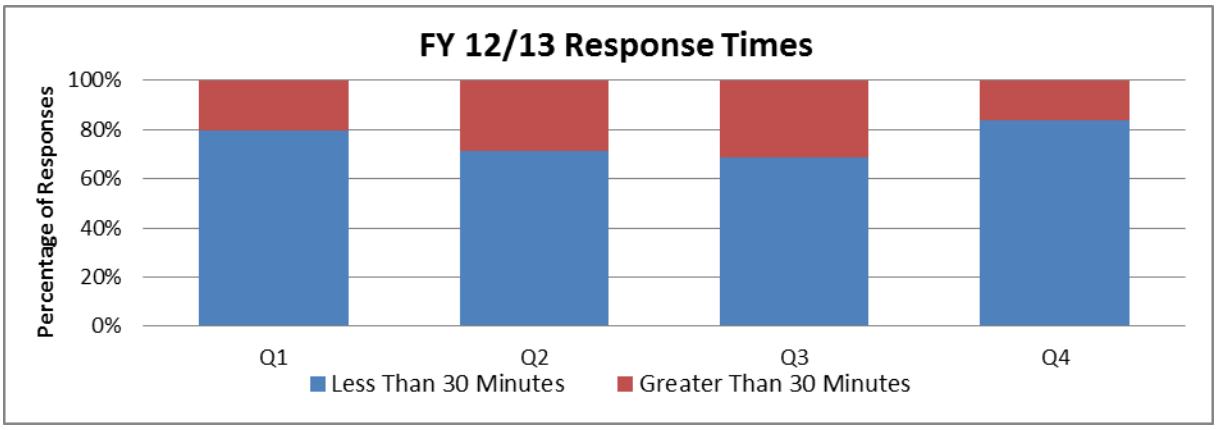
1. Program Description

The Centralized Assessment Team (CAT) provides mobile response, including mental health evaluations/assessment, 24 hours per day/7 days per week, for those who are experiencing a mental health crisis. In response to psychiatric emergencies, staff provides crisis intervention, assessments for lower levels of care, evaluations for involuntary hospitalizations, and assistance for police, fire, and social service agencies. Bilingual/bi-cultural staff members work with family members to provide information, referrals, and community support services.

The Centralized Assessment Team has a Transitional Age Youth (TAY) component that provides specialized services to adults from 18-25 years of age. This program currently has three staff members that have expertise and additional training in working with the TAY population.

2. Outcomes

TAY CAT served 337 members during FY12/13. Data on the source of TAY CAT referrals shows that the largest referral source was “Private and Other” at 58%, which includes family/significant others, clients, treatment centers, and others. The second largest referral category was from law enforcement at 32%. For FY 12/13, 48% of the evaluations resulted in referral to a lower level of care. The average response time was just under 20 minutes. On average 77% of the calls were below 30 minutes. The graph on the next page shows quarterly response time data for FY12/13.


FY 12/13 Response Times
Percentage of Responses
100%
80%
60%
40%
20%
0%
Q1
Q2
Q3
Q4
Less Than 30 Minutes
Greater Than 30 Minutes

T6. TAY Program of Assertive Community Treatment	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**200**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$896,092**
Estimated Annual Cost Per Client	**$4,480**

1. Program Description

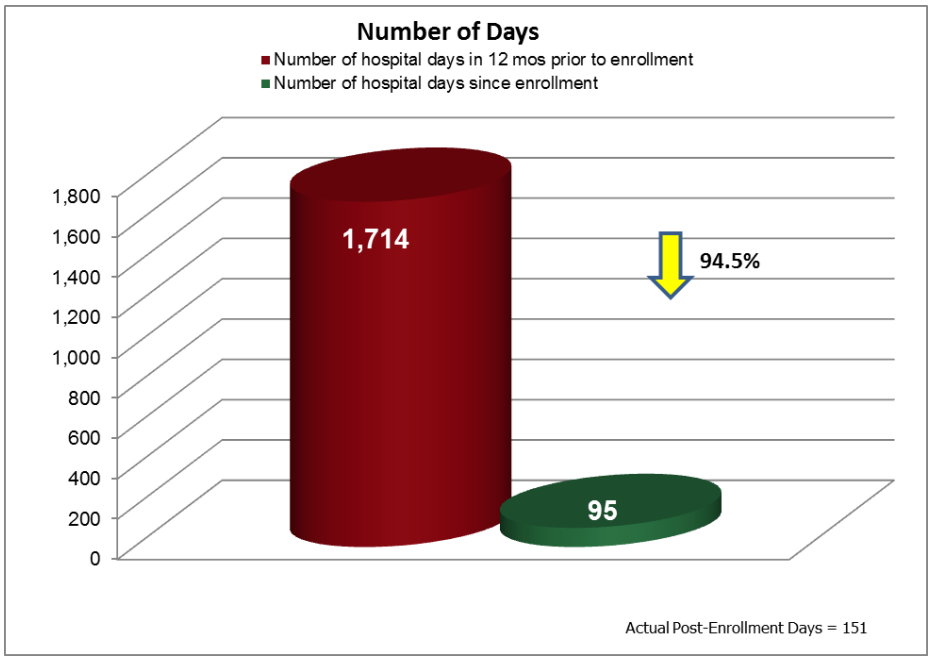
The Program for Assertive Community Treatment (PACT) teams in Orange County target high risk underserved populations such as the monolingual Pacific Asian community, mentally ill Transitional Age Youth (TAY) community, and mentally ill adults and older adults. To qualify for PACT services, individuals have to have been psychiatrically hospitalized in the last year for being considered dangerous to people in the community and/or themselves, or because they were unable to avail themselves to basic food, clothing or shelter due to their mental illness. In addition, treatment at a lower level of care must have failed to maintain the person's stability. The target population for the Transitional Age Youth PACT program is diverse, chronically mentally ill TAY, ages 18 to 25. In particular, the program targets the underserved ethnic populations of Latinos, Vietnamese, Korean and Iranian, as well as the linguistically isolated, which includes the Deaf and Hard of Hearing. Assertive Community Treatment is a best practices model and Orange County PACT teams work to further their fidelity to this model.

The program provides consumer focused, recovery-based services, and provides intervention primarily in the home and community in order to reduce access or engagement barriers. Collaboration with family members and other community supports are stressed in this multidisciplinary model of treatment. The treatment team is comprised of a multidisciplinary group of professional staff, including Clinical Social Workers, Marriage Family Therapists, Mental Health Specialists, Psychiatrists, and a Supervisor. This team provides medication services, individual and group therapy, substance abuse and family therapy. In addition, supportive services such as money management and linkage are offered. The focus of recovery for this population is to address age appropriate developmental issues such as re-integration into school and employment, developing and sustaining social support systems, and attaining independence. This program is sensitive to the individual needs of the Transitional Age Youth consumer, and staff is knowledgeable of the resources and issues for this population.

This population struggles with the onset of acute and chronic symptoms of mental illness and often presents with co-occurring diagnoses and multiple functional impairments. This is a crucial developmental stage for these individuals in attaining independence and skills needed to be successful throughout their adult lives. Individuals eligible for this treatment model have been hospitalized and/or incarcerated prior to admission to the program. This population requires frequent and consistent contact to engage and remain in treatment. This multicultural population typically requires intensive family involvement.

2. Outcomes

TAY PACT programs have served 157 clients during FY 2012/2013. The PACT program has outcome data for fiscal years 08/09, 09/10, 10/11, 11/12. There is a gap in data from July 2012 – January 2013 is due to the development and implementation of a new and improved database. The new database is currently in use, consistently throughout the PACT teams. The outcome measures used for PACT remain consistent and include reduction of hospitalizations, reduction of incarcerations, reductions in homelessness, and increases in linkage to primary care. Preliminary data shows a decrease of 92% in homeless days and a decrease of 94.5% in psychiatric hospital days.



A1. Adult Full Service Partnership	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**875**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$14,571,114**
Estimated Annual Cost Per Client	**$16,653**

1. Program Description

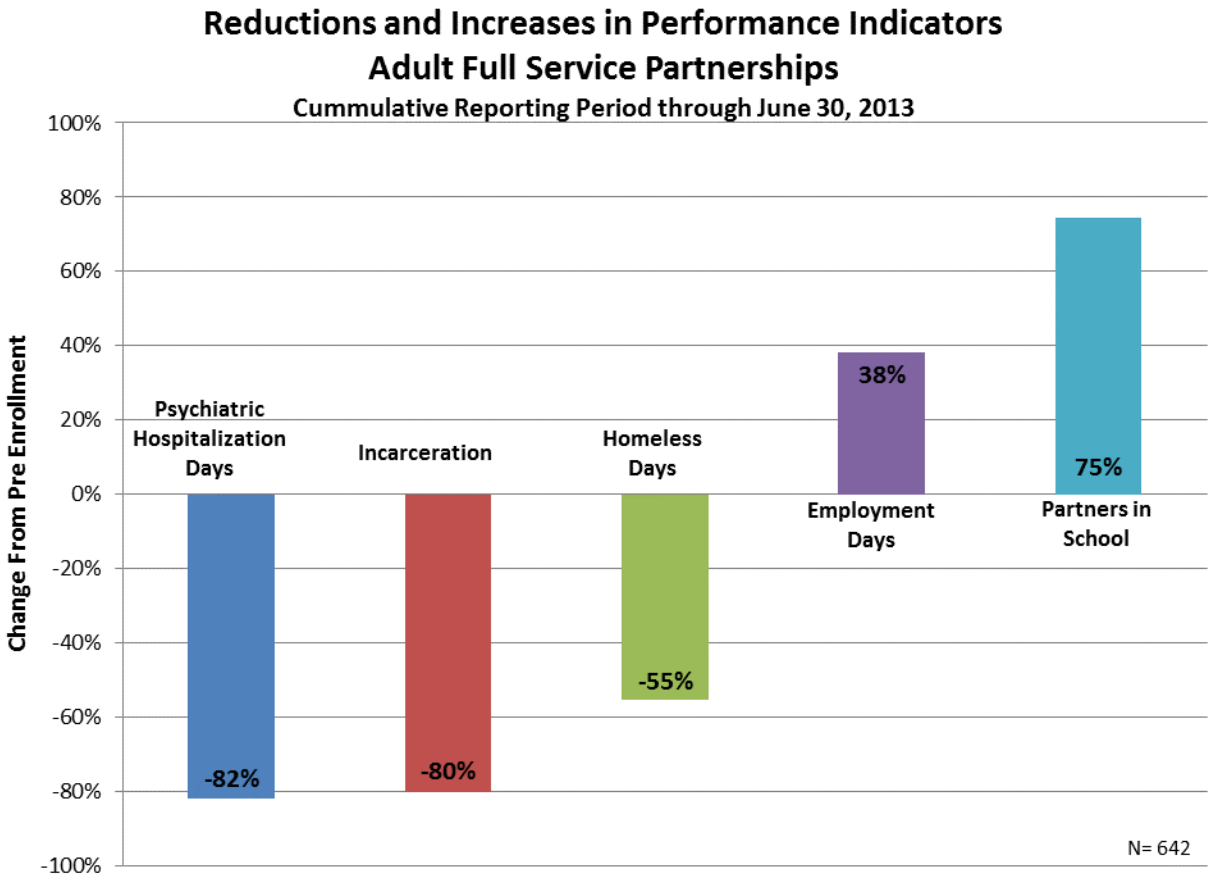
The MHSA Full Service Partnership (FSP) program serves adults ages 18-59. The target populations for the FSP programs are the homeless or at risk of homeless adults who have a mental illness and may also have co-occurring disorders, those being released from long-term care, those being released from jail, and those who are at risk of long jail sentences for minor crimes related to their illness. There are several separate programs within the FSP category, which serve particular target populations.

- The Opportunity Knocks (OK) program develops a collaborative relationship with partners who have current issues or a history with the criminal justice system, who are diagnosed with a severe mental illness, and who are homeless or at risk of homelessness.
- Telecare and Orange (TAO) exists to help people living with chronic mental illness reach their full potential. Our mission is to deliver and manage excellent services and systems of care for people with serious mental illness.
- Striving Towards Enhanced Partnerships (STEPS) STEPS is a program that serves adults with persistent mental illness coming out of residential or locked facilities and adults referred by the Mental Health Court. The program is committed to connect each individual with the desire to embark in their journey of recovery.
- "Whatever It Takes" Court (WIT) is a voluntary program for non-violent offenders who have been diagnosed as chronically, persistently mentally ill and are homeless or at risk of homelessness. The participants must have a diagnosis of a mental illness and are provided with mental health counseling, psychiatric services, drug and alcohol abuse counseling, residential treatment, safe housing, family counseling and peer mentoring. Clients are also assisted in accessing medical services, employment counseling, job training and placement, benefits, and housing. The program involves frequent court appearances, regular drug and alcohol testing, meetings with the WIT Court support team, and direct access to specialized services

The adult program provides intensive case management/wrap-around-services, community based outpatient services, peer mentoring, supported education/employment services, transportation services, housing, benefit acquisition, and co-occurring disorder treatment. Personal Services Coordinators (PSC) provide services to clients where they live and may be available 24 hours a day, 7 days a week. These programs are linguistically and culturally competent, and provide services to the underserved cultural populations in Orange County, such as Latinos, Vietnamese, Koreans, Iranians, monolingual non-English speakers, and the Deaf and Hard of Hearing. Additional funding will be added starting in FY 14/15 to allow an increase in the number of clients served.

2. Outcomes

The Adult FSP programs are evaluated by measuring outcomes to decrease incarcerations, hospitalizations, and homelessness and increase safe and adequate housing, employment, education and promote recovery wellness concepts. The Adult FSP programs had an 82% decrease in psychiatric hospitalization days and an 80% decrease in incarceration days. The graph below illustrates the reductions and increases of FSP performance indicators as of June 30, 2013.


Reductions and Increases in Performance Indicators
Adult Full Service Partnerships
Cummulative Reporting Period through June 30, 2013
Change From Pre Enrollment
100%
80%
60%
40%
20%
0%
-20%
-40%
-60%
-80%
-100%
Psychiatric Hospitalization Days
-82%
Incarceration
-80%
Homeless Days
-55%
38%
Employment Days
75%
Partners in School
N= 642

A2. Adult Centralized Assessment Team	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**1970**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$4,007,323**
Estimated Annual Cost Per Client	**$2,034**

1. Program Description

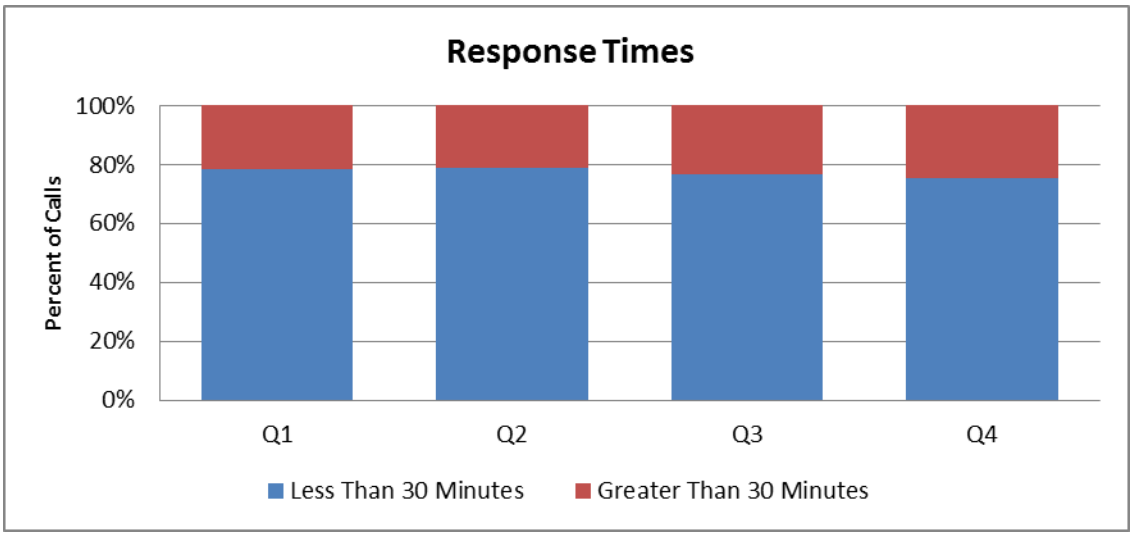
The Centralized Assessment Team (CAT) provides 24 hour mobile response services to any adult who has a psychiatric emergency. This program assists law enforcement, social service agencies, and families in providing mental health crisis intervention services. CAT is a multi-disciplinary program that conducts risk assessments, initiates involuntary hospitalizations, provides resources and linkages and conducts follow up contacts for individuals evaluated. Bilingual/bi-cultural staff members work with family members to provide information, referrals, and community support services.

The Psychiatric Evaluation and Response Team (PERT) is designed to create a mental health and law enforcement response team. The primary purpose of the partnership is to assist mental health clients in accessing Behavioral Health Services. PERT provides a mental health clinician to ride along with a police officer to provide prompt response to mental health clients, assess the need of individuals, and provide them with the appropriate care and linkages to other resources as needed in a dignified manner. During 2013, the PERT team has significantly expanded adding Newport Beach, Irvine, Fullerton and Anaheim. This is in addition to the existing teams of Westminster, Garden Grove, Orange, Costa Mesa, and Orange County Sheriff and now brings a total of nine PERT teams to service the County of Orange. One of the goals of the PERT team is also to educate police on mental illness and provide them with the tools necessary to more effectively assist clients who are mentally ill. During the year PERT teams provided 37 trainings to various police and fire departments throughout Orange County.

2. Outcomes

CAT & PERT served 1,528 clients during FY 12/13. The percent of total crisis response interventions from hospitalization continues to be monitored regularly. For FY 12/13, 52% of the evaluations resulted in referral to a lower level of care.

The average response time was just under 20 minutes. An average of 77% of calls was below 30 minutes. The graph on the following page shows quarterly response time data for FY 12/13.



A3. Adult Crisis Residential	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**300**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$1,651,229**
Estimated Annual Cost Per Client	**$5,504**

1. Program Description

The Crisis Residential Program provides short term crisis intervention services to meet the needs of adults in a mental health crisis and who may be at risk of psychiatric hospitalization. The program emulates a home-like environment in which intensive and structured psychosocial recovery services are offered 24-hours a day, 7 days a week. Stays are voluntary and average 7-14 days. The program is client-centered and recovery-oriented and focuses on personal responsibility for the client's illness and reintegration into the community. Services include crisis intervention, development of a Wellness Recovery Action Plan (WRAP), group education and rehabilitation, assistance with self-administration of medications, case management and discharge planning.

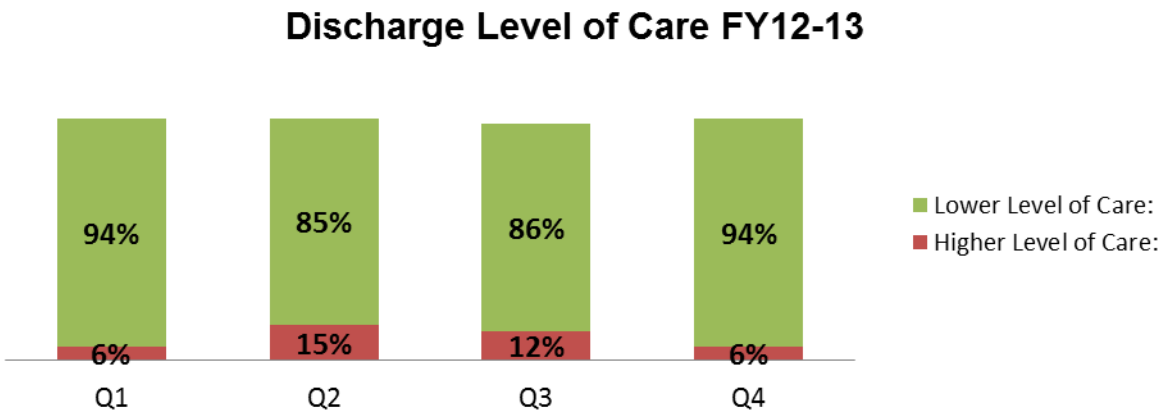
The Crisis Residential Program also provides assessment and treatment services that include, but are not limited to individual and group counseling; monitoring psychiatric medications; substance abuse education and treatment; and family and significant-other involvement whenever possible. Each client admitted to the Crisis Residential Services Program has a comprehensive service plan that is unique, meets the individual's needs, and specifies the goals to be achieved for discharge. To effectively integrate the client back into the community, discharge planning starts upon admission.

The target population for this program is diverse adults (18-59) who are experiencing a mental health crisis. The program also provides dual diagnosis services for people who are experiencing a mental health crisis and also have substance use or abuse issues and may have a co-occurring disorder. These are clients who otherwise may have been admitted to an emergency room or hospitalized.

The current capacity expanded from six adults to fifteen adults in FY 12/13.

2. Outcomes

The program served 276 (unduplicated) members during FY 12/13. Ninety-four percent were discharges to a lower level of care and 97% did not require hospitalization within 48 hours of discharge. From total discharges, 77% of clients were linked to a provider. The occupancy rate for the program was an average of 72% for the fiscal year.



A4. Supported Employment	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**350**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$1,021,417**
Estimated Annual Cost Per Client	**$2,918**

Program Description

The Supported Employment program provides evidence-based services which includes; job placement, ongoing work-based vocational assessment, benefits planning, individualized program planning, job coaching, counseling, and peer support to individuals with serious and persistent mental illness and/or co-occurring substance abuse disorders. Services are provided in English, Spanish, Vietnamese, Farsi and American Sign Language.

Each individual placed into competitive employment has the ongoing support of an Employment Specialist (ES). Program participants work with the ES to locate job leads using a variety of sources including in-the-field employer canvassing, newspaper publications, online job search engines, job fairs, business mixers, regional job developer conferences and recruitments. The ES strives to build working relationships with prospective employers through cold calling and in-person presentations, and is the main liaison between the employer and the program participant. It is the responsibility of the ES to help the employer understand mental illness and combat stigmatization. In addition to locating promising job leads and potential employers, the ES assists consumers with application submissions and assessments, interviewing, image consultation, and transportation services.

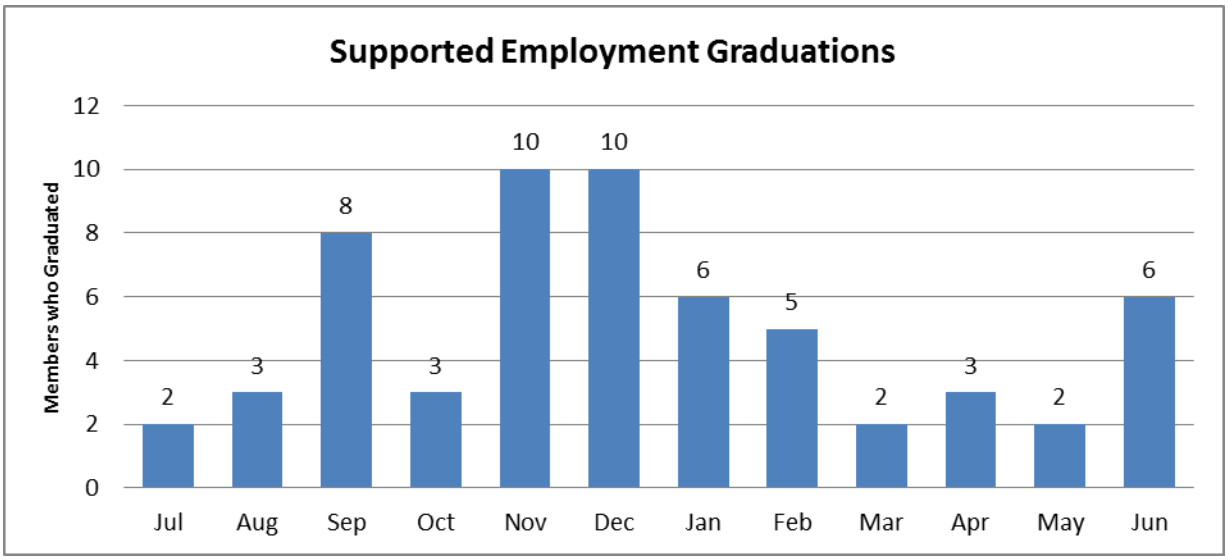
The ES is responsible for providing the consumer with one-on-one job support to ensure successful job retention. Specifically, the ES models appropriate behavior, participates in the training of the consumer to ensure a foundational grasp of job responsibilities, communicates regularly with job site staff to recognize and address consumer successes and challenges, provides consistent encouragement, and practices conflict resolution. The ES maintains ongoing, open communication with clinical care coordinators to promote positive work outcomes.

A significant change to the staffing model in FY 2012-13, included combining the duties of the Job Developer and Job Coach to create the Employment Specialist position. This change has brought significant positive results in the first few

months of FY 2012-13. Maintaining the relationship with one staff member throughout the entire job development/placement process has resulted in greater client participation and fewer program dis-enrollments by maintaining consistency and familiarity throughout the entire program. Data is still being collected to determine the full outcome of this modification.

Outcomes

The Supported Employment Program served 296 participants in FY 12/13, which included 148 new enrollments. During FY 12/13, the program placed 126 program participants in employment. Additionally, 60 program participants graduated from the program after successfully reaching the State of California job retention benchmark which is greater than 90 days in paid employment.



A5. Adult Outreach and Engagement	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**150**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$517,701**
Estimated Annual Cost Per Client	**$3,451**

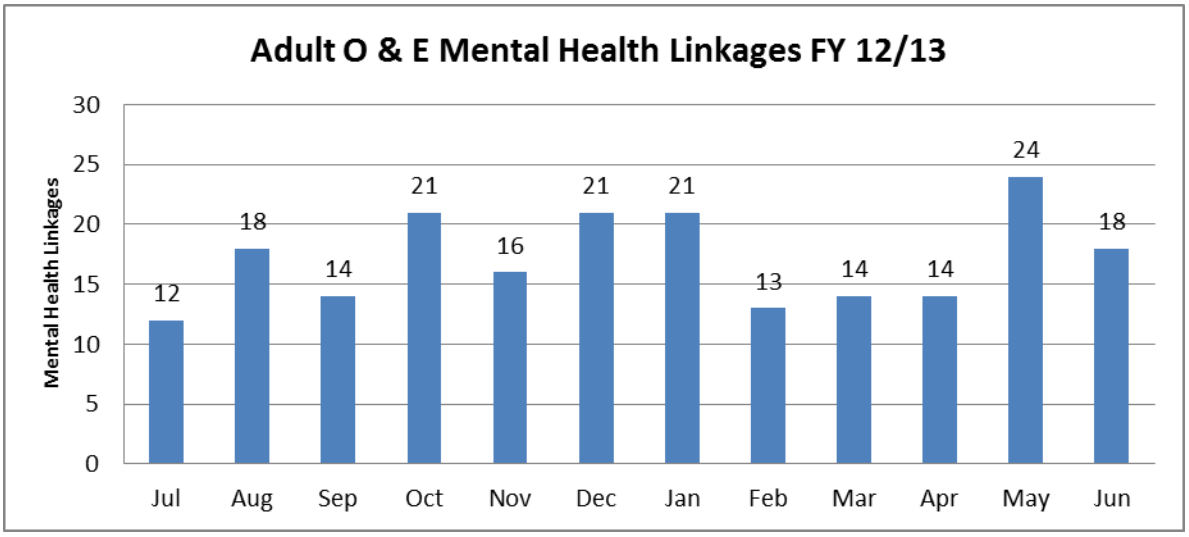
1. Program Description

The Mental Health Services Act (MHSA) Adult Outreach and Engagement (O & E) program serves Seriously Mentally Ill (SMI) adults with co-occurring disorders from ages 26 and up that are homeless or on the verge of homelessness. The program assists the unserved or underserved adult with accessing culturally and linguistically appropriate behavioral health services which may include; full service partnerships, outpatient mental health services, and/or with other linkages to community resources. The program adheres to a "best practice" model by offering services using a strength-based and recovery-based approach that focuses on resiliency and the establishment and growth of local support systems. On-going Street Outreach is conducted to increase the acceptance of treatment and services and improve the stability of the individual in the community of choice.

2. Outcomes

The program is relied upon to handle community referrals where a serious mental illness and homelessness (at risk) is involved. The team participates in activities throughout the county which provide greater access to the target population and increase community awareness of available services. The graph on the following page displays data on the number of successful linkages to service during each month in FY 12/13. The number of linkages to any mental health or supportive service varies from 12 per month to 24 per month.

For the first six months of FY13/14, 10% of client contacts resulted in referrals for service. The top three categories of referrals were for mental health services (15%), social services (14%) and shelters (13%).



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A6. Adult Program of Assertive Community Treatment	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**750**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$9,731,926**
Estimated Annual Cost Per Client	**$12,976**

Program Description

The Adult Program of Assertive Community Treatment (PACT) in Orange County targets high risk or at risk underserved populations, such as the monolingual Pacific Asian community, Transitional Age Youth, and adults who have a chronic mental illness. Individuals qualifying for PACT services have been psychiatrically hospitalized multiple times in the last year. In addition, treatment at a lower level of care has failed to keep the person engaged in services. PACT teams serve consumers who are most in need of treatment due to multiple hospitalizations or incarcerations and have not been able to access appropriate treatment. Assertive Community Treatment is a best practices model and Orange county PACT teams work to further their fidelity to this model.

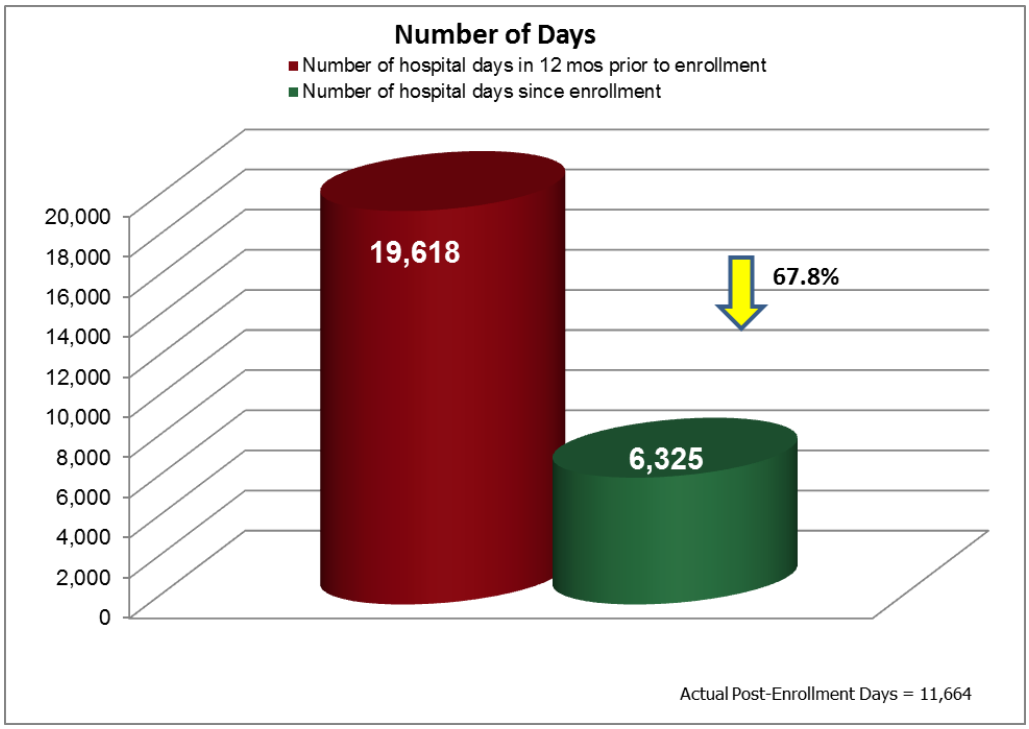
The program focuses on delivering culturally competent services to adults in the community, to achieve their maximum recovery and independence in functioning. The program provides consumer-focused, culturally/linguistically competent, strength-based services. Interventions are usually provided in the home and community in order to reduce access or engagement barriers. A holistic team approach is stressed in this program, which is in and of itself culturally competent, in that it requires intense collaboration with primary care providers, family members, and other community supports. It is a multidisciplinary team model, comprised of Clinical Social Workers, Marriage Family Therapists, Mental Health Specialists, Psychiatrists, and a Supervisor. This team provides medication services, individual and group therapy, substance abuse and family therapy, as well as supportive services such as money management and linkage to community supportive services. The focus for this population is to address individual strengths and empower consumers to reach their highest potential. Re-integration into community institutions and organizations such as school, employment, and independent housing is stressed. Staff is sensitive to the

individual needs of each adult consumer and is knowledgeable of the resources and issues for this population.

This program will be expanded this year to serve additional clients. The caseload ratios remain at 1:15 in order to effectively provide assertive and intensive services.

Outcomes

The PACT program has outcome data for fiscal years 08/09, 09/10, 10/11, 11/12. There is a gap in data from July 2012 – January 2013 due to the development and implementation of a new and improved database. The new database is currently in use, throughout the PACT teams. The adult PACT program continues to focus on measuring outcomes, which include reduction of hospitalizations, reduction of incarcerations, reductions in homelessness, and increases in linkage to primary care. Preliminary data shows a decrease of 68% in psychiatric hospital days. Adult PACT program has served 653 clients during FY 2012/2013.



A7. Wellness Center-North County	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**1,150**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$1,469,448**
Estimated Annual Cost Per Client	**$1,278**

1. Program Description

The Wellness Center's mission is to provide a safe and nurturing environment for each individual to achieve his or her vision of recovery while providing acceptance, dignity and social inclusion. The Wellness Center is committed to providing peer-to-peer promotion and community integration of emotional, physical, spiritual and social domains. The Wellness Center facilitates over 100 groups weekly, including social outings, and has a growing number of members volunteering in the community as their way of giving back.

The Wellness Center supports clients who have achieved recovery by offering a program that is culturally and linguistically appropriate, while focusing on personalized socialization, relationship building, assistance maintaining benefits, setting employment goals, and providing educational opportunities. The Wellness Center is grounded in the recovery model and will provide services to a diverse client base. These services facilitate and promote recovery and empowerment in mental health consumers.

Recovery interventions are client-directed and embedded within the following array of services, including individualized wellness recovery action plans, peer supports, social outings, and recreational activities. Services are provided by clients or those with lived experience with mental illness. The Wellness Center program is 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 clients to increase socialization and encourage 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 client's family, friends, and significant others.

The philosophy of the Wellness Center draws upon cultural strengths and utilizes service delivery and assistance in a manner that is trusted by, and familiar to,

many of Orange County's ethnically and culturally diverse populations. Wellness Center Program staff are consumers of mental health services or those with lived experience with mental illness. The Wellness Center uses a Member Advisory Board, a community town hall model, and member satisfaction survey results to make many of their decisions on programming.

The target group for the Wellness Center consists of those adults residing in Orange County, who are:

1. Over 18 years of age and have been diagnosed with a serious mental illness and may (or may not) have a co-occurring disorder;
2. Relatively stable and have accomplished treatment goals;
3. Require a support system to succeed in remaining stable while continuing to progress in their recovery.

The program targets culturally/linguistically diverse groups such as Latinos, Vietnamese, Korean and Iranian, as well as non-English speaking monolingual individuals.

2. Outcomes

The Wellness Center had 1,506 members actively participate during fiscal year 12/13.

The Wellness Center outcome measures are:

1. Achieve monthly participation by 30 or more active members in community integration activities. Forty-six members participated in community integration activities including attending DBSA and Self-Empowerment groups in South County, NAMI walk, Getty museum outing, Celebration Recovery picnic, bowling, movies and beach picnics.

2. Achieve monthly participation by active members in two or more groups or activities offered either at the Center or in the community. This is a new outcome and data is still being collected at this time.

3. Achieve annual member employment, paid or volunteer, of a minimum of 100 members as a result of skills learned in employability classes provided by the program as well as participation of the annual Job Fair sponsored by the program. Over 1,860 hours of volunteerism was completed during FY 12-13 by 123 members. Paid employment outcomes are still being collected at this time.

4. Achieve annual enrollment of a minimum of 50 members in education classes offered at local community colleges, the Education Center at Tustin Campus, or other educational setting as a result of educational training groups/classes provided by the program. This is a new outcome and data is still being collected at this time.

5. Achieve annual participation by a minimum of 50 members in facilitating all or portions of community meetings. For the last six month of FY 12-13, 37 members participated in presenting information at the weekly community meeting.

The Wellness Center has recently begun the collection of data for these measures. We anticipate having data available to report for fiscal year 2014 – 2015.

A7. Wellness Center-South County	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17*	**1,150**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$1,500,000**
Estimated Annual Cost Per Client	**$1,304**

*In the chart above, the annual estimated number to be served in FY 14/15, 15/16 and 16/17 is considered to be the same; however, the actual number to be served in the first year will be less than in subsequent years due to the program start-up process, such as hiring staff and contract procurement. The exact numbers to be served in the first year will depend on the program implementation date.

1. Program Description

This is a new program. The county has had a Wellness Center operating in North Orange County for several years. Clients living in South County had difficulty accessing the services due to distance from residence and lack of transportation. During the planning process for FY 14/15, the need for a similar program in South County was identified. This program will become operational as a provider and site are established. The description below is based on the current model being used in North Orange County.

The Wellness Center's mission is to provide a safe and nurturing environment for each individual to achieve his or her vision of recovery while providing acceptance, dignity and social inclusion. The Wellness Center is committed to providing peer-to-peer promotion and community integration of emotional, physical, spiritual and social domains. The Wellness Center facilitates over 100 groups weekly, including social outings, and has a growing number of members volunteering in the community as their way of giving back.

The Wellness Center supports clients who have achieved recovery by offering a program that is culturally and linguistically appropriate, while focusing on personalized socialization, relationship building, assistance maintaining benefits, setting employment goals, and providing educational opportunities. The Wellness Center is grounded in the recovery model and will provide services to a diverse client base. These services facilitate and promote recovery and empowerment in mental health consumers.

Recovery interventions are client-directed and embedded within the following array of services, including individualized wellness recovery action plans, peer supports, social outings, and recreational activities. Services are provided by clients or those with lived experience with mental illness. The Wellness Center program is 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 clients to increase socialization and encourage 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 client's family, friends, and significant others.

The philosophy of the Wellness Center draws upon cultural strengths and utilizes service delivery and assistance in a manner that is trusted by, and familiar to, many of Orange County's ethnically and culturally diverse populations. Wellness Center Program staff are consumers of mental health services or those with lived experience with mental illness. The Wellness Center uses a Member Advisory Board, a community town hall model, and member satisfaction survey results to make many of their decisions on programming.

The target group for the Wellness Center consists of those adults residing in Orange County, who are:

1. Over 18 years of age and have been diagnosed with a serious mental illness and may (or may not) have a co-occurring disorder;
2. Relatively stable and have accomplished treatment goals;
3. Require a support system to succeed in remaining stable while continuing to progress in their recovery.

The program targets culturally/linguistically diverse groups such as Latinos, Vietnamese, Korean and Iranian, as well as non-English speaking monolingual individuals.

2. Outcomes

Proposed outcomes include the following:

1. Achieve monthly participation by 30 or more active members in community integration activities.
2. Achieve monthly participation by active members in 2 or more groups or activities offered either at the center or in the community.
3. Achieve annual member employment, paid or volunteer, of a minimum of 100 members as a result of skills learned in employability classes provided by the

program as well as participation of the annual Job Fair sponsored by the program.

4. Achieve annual enrollment of a minimum of 50 members in education classes offered at local community colleges, the Education Center at Tustin Campus, or other educational setting as a result of educational training groups/classes provided by the program.
5. Achieve annual participation by a minimum of 50 members in facilitating all or portions of community meetings.

A8. Recovery Centers	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**2,600**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$8,658,531**
Estimated Annual Cost Per Client	**$3,330**

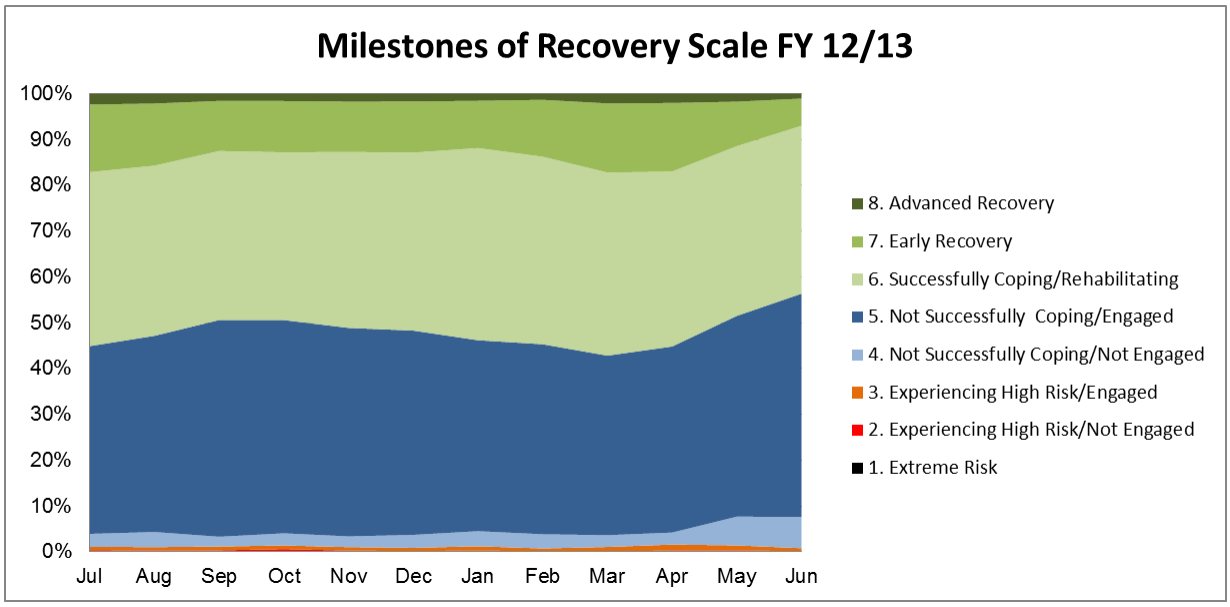
Program Description

The Recovery Center program provides a lower level of care for consumers who no longer need traditional outpatient treatment, yet need to continue receiving medication and case management support. This program allows diverse consumers to receive distinct, mostly self-directed services that focus on community reintegration and linkage to health care. To a great extent, the program relies on client self-management. In addition, an important feature is a peer-run support program where consumers are able to access groups and peer support activities. These services are delivered along a continuum of care model that addresses individual needs of the client based upon their stage of recovery and are targeted to reduce reliance on the mental health system and increase self-responsibility. Services include, but are not limited to, medication management, individual and group mental health services, case management, crisis intervention, educational and vocational services, and peer support activities.

Outcomes

The Recovery Centers have maintained hospitalization rate of less than 1%. The program had a .7% hospitalization rate during FY 12/13. The Recovery Centers have shown consistent movement in graduations from their programs with 217 graduations during FY 12/13.

The Milestones of Recovery Scale (MORS) is a recovery based evaluation tool in which there are eight levels. The score reflects where an individual is in his or her process of recovery at that moment in time. The score is determined once a month and indicates how engaged that individual is in recovery, level of risk, and level of skills and supports. The MORS score for Older Adults is essentially the same as the Adult scale, but includes some unique elements in the area of skills and supports. The graph on the following page displays the percentage of clients with a particular MORs by month in FY 12/13.


Milestones of Recovery Scale FY 12/13
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
8. Advanced Recovery
7. Early Recovery
6. Successfully Coping/Rehabilitating
5. Not Successfully Coping/Engaged
4. Not Successfully Coping/Not Engaged
3. Experiencing High Risk/Engaged
2. Experiencing High Risk/Not Engaged
1. Extreme Risk

A9. Adult Peer Mentoring	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**250**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$332,179**
Estimated Annual Cost Per Client	**$1,329**

1. Program Description

The Adult Peer Mentoring program was created to build community support services that bridge existing gaps in the recovery continuum. The Adult Peer Mentoring Program pairs qualified, culturally/linguistically competent peers, with individuals in psychiatric hospitals, who are preparing to be discharged, and assists them in successfully transitioning back to the community, and successfully linking with outpatient treatment providers. In addition, the peers work with individuals who are at risk of being hospitalized, and provide them with additional intensified support to assist them in gaining their independence at home. The services target some of the most common reasons for re-hospitalization after discharge, including interruption of medication, lack of social support and unstable housing. Services are very timely, and typically take place in the field. Services are often provided in the individual's home, a hospital, Dr.'s office, treatment facility, or community resource. The field work helps to engage individuals and reduce access barriers. Peer Mentors provide social support, assistance with basic household items, food, clothing, and transportation needs. This program serves clients from diverse cultural groups such as Latino, Vietnamese, Korean, and Iranian, as well as non-English-speaking monolingual individuals, and individuals who are deaf and hard of hearing.

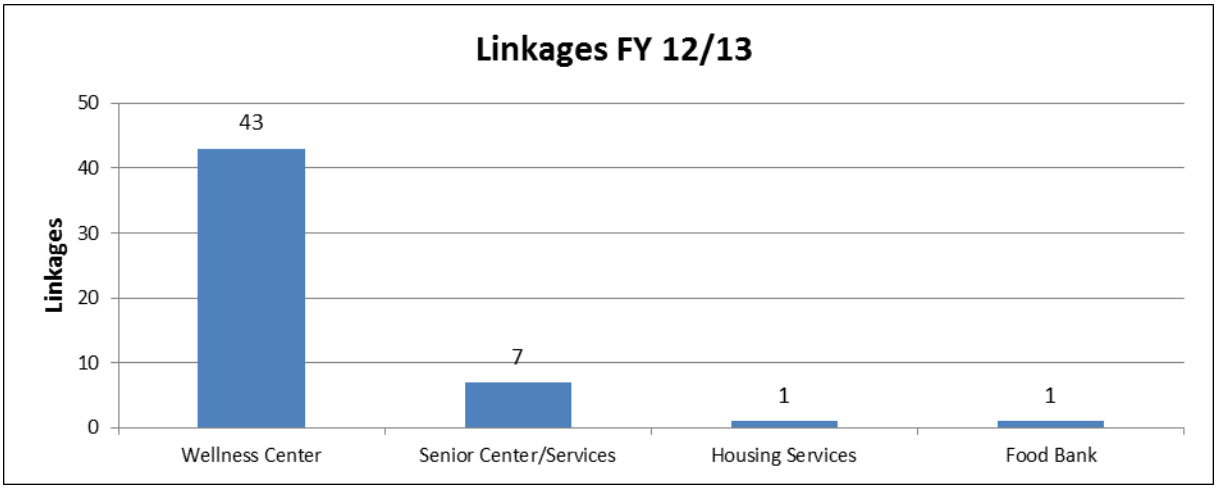
Peer Mentors support the individual's recovery goals and therapeutic needs. Examples of activities include: helping clients get to the first appointment; meeting with the individual's assigned Care Coordinator or Psychiatrist; assisting clients in picking up prescribed medications at a local pharmacy; and encouraging (and at times participating) in their recovery activities. Peer Mentors also assist in other needs of community living (e.g., acquiring benefits, food, and clothing; doing laundry; learning the bus routes, etc.). Peer Mentors have caseloads of six to eight individuals, and work a schedule that allows for

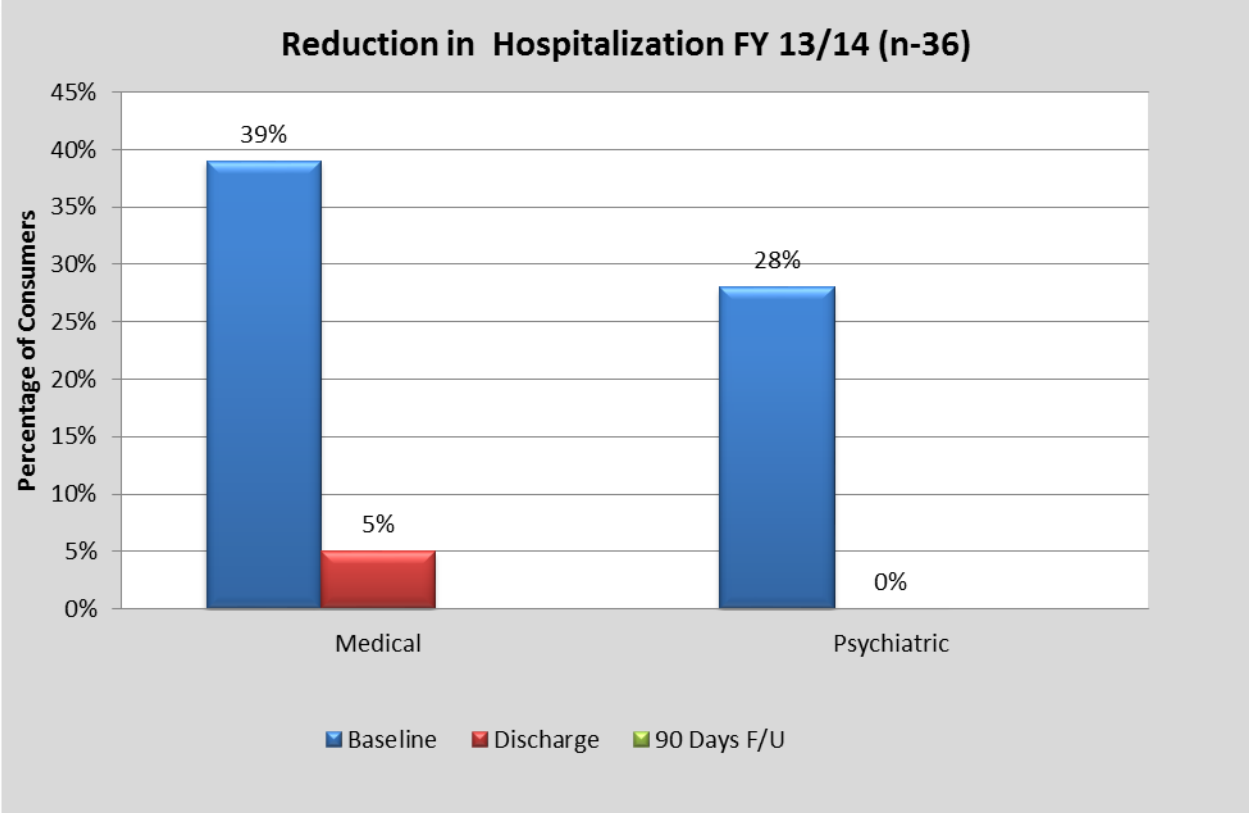
some flexibility and rotational on-call in the evening and one weekend approximately every two months.

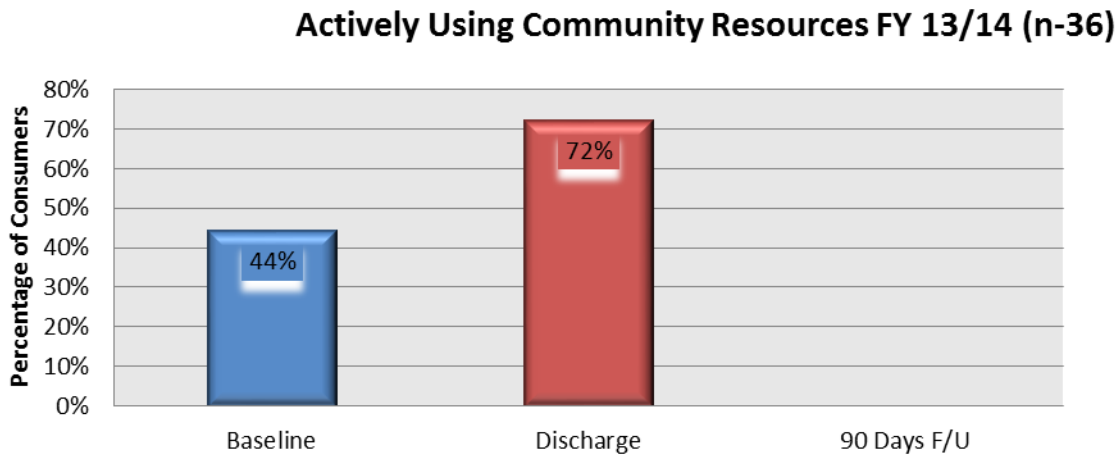
2. Outcomes

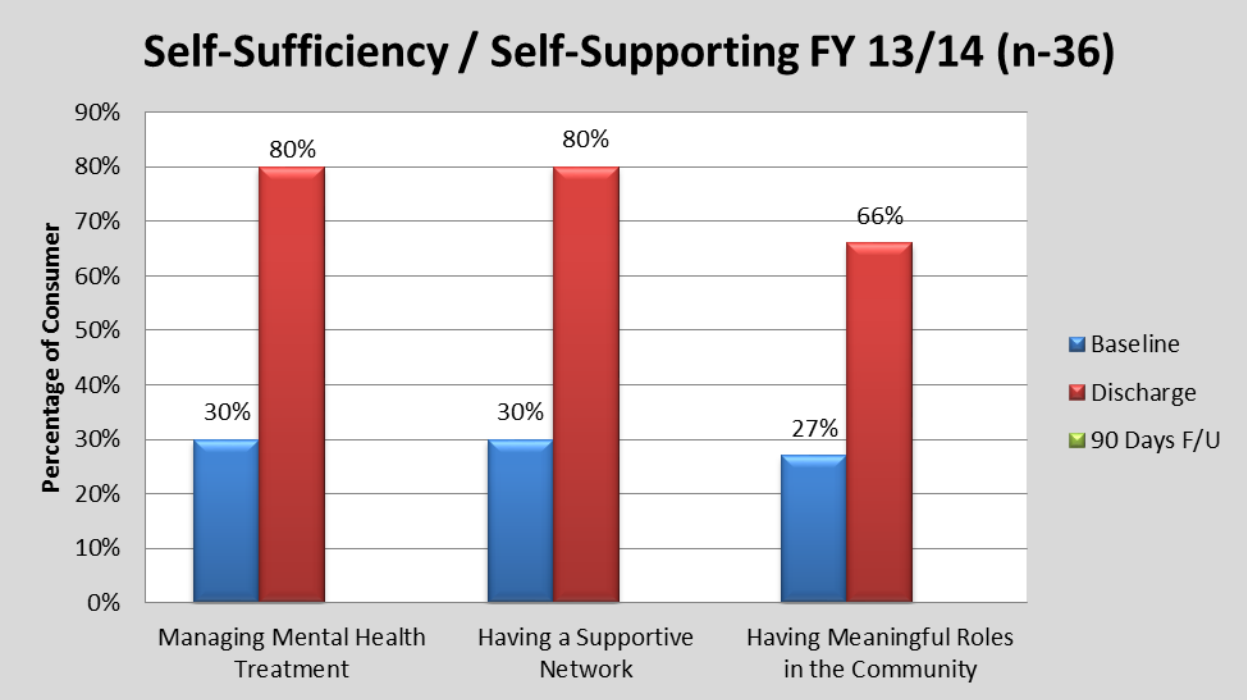
The Peer Mentoring program has identified three primary outcomes which include reduction of hospitalization, actively using community resources, and participation in self-sufficient activities.

During FY 12/13, Adult Peer Mentoring program served 236 clients. The graphs below display community referrals provided and linkages made during fiscal year 12/13. These referrals and linkages are crucial in facilitating the consumer's re-integration into the community and participation in self-sufficient activities. Results displayed are for Adults and Older Adults combined.




Reduction in Hospitalization FY 13/14 (n-36)
Percentage of Consumers
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
39%
5%
28%
0%
Medical
Psychiatric
Baseline
Discharge
90 Days F/U


Actively Using Community Resources FY 13/14 (n-36)
Percentage of Consumers
80%
70%
60%
50%
40%
30%
20%
10%
0%
44%
72%
Baseline
Discharge
90 Days F/U


Self-Sufficiency / Self-Supporting FY 13/14 (n-36)
Percentage of Consumer
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
80%
80%
66%
30%
30%
27%
Managing Mental Health Treatment
Having a Supportive Network
Having Meaningful Roles in the Community
Baseline
Discharge
90 Days F/U

A10. Assisted Outpatient Treatment (AOT)	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17*	**125**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$4,436,820**
Estimated Annual Cost Per Client	**$35,495**

*In the chart above, the annual estimated number to be served in FY 14/15, 15/16 and 16/17 is considered to be the same; however, the actual number to be served in the first year will be less than in subsequent years due to the program start-up process, such as hiring staff and contract procurement. The exact numbers to be served in the first year will depend on the program implementation date.

1. Program Description

This is a new program. Implementation is contingent on the Orange County Board of Supervisors approving a Resolution to authorize the program in Orange County. Recent legislation (SB 585) clarified that MHSA funding could be used to provide this program.

A person subject to AOT must live in the County and have a history of not participating in needed mental health treatment. The person must be unlikely to survive safely in the community without supervision, based on an investigation and resultant clinical determination. All persons placed on AOT must meet threshold criteria: the person's mental illness (1) has twice been a factor leading to psychiatric hospitalizations or incarcerations within the prior 36 months, or (2) has resulted in one or more actual or attempted serious acts of violence toward self or others within the prior 48 months.

If the criteria are satisfied, the County Mental Health Director or designee may file a certified petition with the court indicating that AOT is needed to help prevent relapse or deterioration that would likely result in grave disability or serious harm to self or others. Such a petition must establish that the person has been offered an opportunity to voluntarily participate in a treatment plan but continues not to engage in treatment and is deteriorating.

Legislation specifies that certain individuals can request an AOT evaluation. These include (1) immediate family members, (2) adults residing with the individual, (3) a hospital director or licensed mental health professional treating the individual, or (4) a peace officer, parole or probation officer supervising the

individual. Once an AOT order has been issued, a treatment plan for the client is developed.

Outcomes

The proposed outcome measures will be consistent with the Full Service Partnership and PACT programs and include reduction of hospitalizations, reduction of incarcerations, and reduction of homelessness.

A11. Mental Health Court-Probation Services	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17*	**100**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$696,000**
Estimated Annual Cost Per Client	**$6,960**

*In the chart above, the annual estimated number to be served in FY 14/15, 15/16 and 16/17 is considered to be the same; however, the actual number to be served in the first year will be less than in subsequent years due to the program start-up process, such as hiring staff and contract procurement. The exact numbers to be served in the first year will depend on the program implementation date.

1. Program Description

Collaborative Courts are specialized court tracks that address underlying issues that may be present in the lives of persons who come before the court on matters. These life-changing programs involve active judicial monitoring and a team approach to decision making, and include the participation of a variety of different agencies, such as Probation and mental health treatment providers. Probation Officers act as case managers for clients appearing in these specialized courts. Below is a brief description of each of the Collaborative Court programs offered by the County of Orange.

Opportunity Court and Recovery Court

Opportunity Court and Recovery Court are voluntary programs for individuals who as a result of their chronic, persistent mental illness are unable to comply with the requirements of another program. Opportunity and Recovery Court program involves frequent court appearances, weekly meetings with the Probation Officer and Health Care Coordinator, mental health treatment, medication monitoring, drug and alcohol testing. Participants are also assisted in accessing medical services, employment counseling, job training and placement, benefits, and housing.

WIT Court

WIT “Whatever It Takes” Court is a voluntary program for non-violent offenders who have been diagnosed as chronically, persistently mentally ill and are homeless or at risk of homelessness. The participants must have a diagnosis of a mental illness and are provided with mental health counseling, psychiatric

services, drug and alcohol abuse counseling, residential treatment, safe housing, family counseling and peer mentoring. Clients are also assisted in accessing medical services, employment counseling, job training and placement, benefits, and housing. The program involves frequent court appearances, regular drug and alcohol testing, meetings with the WIT Court support team, and direct access to specialized services.

2. Outcomes

These outcomes will be similar to the Full Service Partnership and PACT program outcomes as these probation officers are part of the treatment team. Examples include reduction in incarcerations and hospitalizations. All collaborative court clients are enrolled in either a PACT or Full Service Partnership.

A12. Drop in Center – Civic Center	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**300**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$500,000**
Estimated Annual Cost Per Client	**$1,667**

*In the chart above, the annual estimated number to be served in FY 14/15, 15/16 and 16/17 is considered to be the same; however, the actual number to be served in the first year will be less than in subsequent years due to the program start-up process, such as hiring staff and contract procurement. The exact numbers to be served in the first year will depend on the program implementation date

1. Program Description

This is a new program. There is an overflow of homeless mentally ill individuals who congregate in the Civic Center area. Although there is another Drop-In Center in Santa Ana, it is difficult for homeless people to get there with all their possessions. An alternative Drop-In Center is needed to provide day time services and linkages to community supportive services for these individuals.

The alternative site in close proximity to the Civic Center area would provide the following services during the day:

a. Assessment of basic needs
b. Breakfast, lunch and snacks
c. Safe resting area
d. Secure location to keep belongings while there during the day
e. Showers
f. Clothing supply and laundry facilities
g. Personal hygiene items
h. Mailing address
i. Housing assistance
j. Employment assistance
k. Substance abuse assistance
l. Socialization opportunities and activities
m. Bus passes
n. Additional services as identified

2. Outcomes

Program is not yet implemented. The following outcome measures are proposed once the program is operational:

- Refer 100% of program participants to individually assessed needed community services.
- Successfully link 50% of participants to community behavioral health services.

A13. Housing for Homeless	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**40**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$1,000,000**
Estimated Annual Cost Per Client	**$25,000**

*In the chart above, the annual estimated number to be served in FY 14/15, 15/16 and 16/17 is considered to be the same; however, the actual number to be served in the first year will be less than in subsequent years due to the program start-up process, such as hiring staff and contract procurement. The exact numbers to be served in the first year will depend on the program implementation date.

1. Program Description and Target Population

This housing will serve up to six individuals at a time as interim housing (three to 18 months) for individuals who are identified as severely and persistently mentally ill, homeless, and may have co-occurring medical issues that make them more fragile and at greater risk if left on the streets. County outreach teams working will be the identifying referral source.

Criteria will be developed similar to that used by Skid Row Housing Trust in Los Angeles which was very successful at identifying the most fragile homeless individuals who were using the most public services while unhoused. This program surveyed the homeless people on the streets for the frequency of utilization of public services such as hospitals, jails, and shelters, and also assessed risk factors such as health indicators, length of time on the streets, and age. They then focused their efforts on permanently housing these homeless people first, working with them in targeted ways to accept the housing and begin their recoveries. It has been found that targeted outreach of this type coupled with housing results in significant savings of public resources such as emergency rooms, jails, and hospitals.

Residents will have case management and psychiatric services provided by county or county-contracted programs attached to each participant. A nurse would visit the facility to ensure compliance with medication and other health regimens. The financing would be used to secure a residence and furnishings, hygiene and living necessities, and basic stocks of food. The treatment emphasis would be on medical and psychiatric stabilization and life skills/independent living.

There will be initial costs associated with leasing and furnishing the home. A replacement reserve will be maintained to replace furniture and other objects in the house as needed. In addition some funding will be reserved for resident activities, transportation, food, supplies, etc. The assumption is that as people improve their independent living skills they will improve in the area of money management and require less assistance providing for basic needs.

A subcommittee of community partners will be created to further develop this housing component.

2. Outcomes

The program is not yet implemented. The following outcome measures are proposed.

- Utilization of public services, such as jails, hospitals, etc. will decline significantly.
- Clients will be linked to permanent housing once they exit the program.

A14. Housing and Year-Round Emergency Shelter	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17*	**780 (may be duplicated)**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$1,367,180**
Estimated Annual Cost Per Client	**$1,752**

*In the chart above, the annual estimated number to be served in FY 14/15, 15/16 and 16/17 is considered to be the same; however, the actual number to be served in the first year will be less than in subsequent years due to the program start-up process, such as hiring staff and contract procurement. The exact numbers to be served in the first year will depend on the program implementation date.

1. Program Description and Target Population

The County of Orange is limited to seasonal sheltering capacity for the homeless population. The 2013 Point in Time study estimated a total annual homeless census in OC of 12,707 who spend at least one night either sheltered or unsheltered without having a permanent residence. This is an extrapolation from the 4,251 that were located during the one night physical count. Of these, 480 were determined to be severely mentally ill.

The community would like to have a year round program coupled with onsite services to provide shelter and the possibility of longer term solutions for those living on the streets, river beds, and other locations unfit for human habitation of OC. The task force for the Ten Year Plan to End Homelessness has been working to establish a year-round shelter. Recently, the MHSA Steering Committee voted to dedicate some new CSS funding to guarantee some of the planned shelter's capacity is reserved for the mentally ill homeless.

The County of Orange's Ten Year Plan to End Homelessness has been working to establish a year-round shelter for all homeless individuals. This funding will be folded into that effort in order to secure beds for the mentally ill homeless. This effort is consistent with HUD's plan to shorten shelter stays and move people more quickly into permanent housing.

The estimated length of stay per client for each episode of shelter housing is seven days. The cost estimates are based on 15 dedicated beds at any one time, with the option of more if needed.

2. Outcomes

The program is not yet implemented. The following outcome measures are proposed.

- Temporary housing and an evening meal for approximately 15 individuals with serious and persistent mentally illness per night.
- A minimum of 50% of SPMI participants will be connected with permanent housing upon exiting the shelter program.

A15. Transportation	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17*	**750**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$1,000,000**
Estimated Annual Cost Per Client	**$1,333**

*In the chart above, the annual estimated number to be served in FY 14/15, 15/16 and 16/17 is considered to be the same; however, the actual number to be served in the first year will be less than in subsequent years due to the program start-up process, such as hiring staff and contract procurement. The exact numbers to be served in the first year will depend on the program implementation date.

1. Program Description

This program will provide countywide transportation services for consumers who require assistance in transportation to get to medical appointments and other services available through Behavioral Health that may be otherwise difficult to access. Clients will be able to have transportation to and from the various programs that are needed to help them to manage their behavioral health treatment and enhance their progress in recovery. The programs where members could be transported to may include, but not necessarily be limited to, Outpatient Behavioral Health Clinics, Recovery Centers, Wellness Centers, Tustin Mental Health Campus, Older Adult Services, PACT Programs and other Behavioral Health Services. These services will be provided with vans.

2. Outcomes

The program is not yet implemented. Outcomes may include:

- Improved timeliness to appointments.
- Reduction in “no shows.”
- Increase consumer’s self-sufficiency in transportation.

A16. Adult In-Home Crisis Stabilization	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**300**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$1,500,000**
Estimated Annual Cost Per Client	**$5,000**

*In the chart above, the annual estimated number to be served in FY 14/15, 15/16 and 16/17 is considered to be the same; however, the actual number to be served in the first year will be less than in subsequent years due to the program start-up process, such as hiring staff and contract procurement. The exact numbers to be served in the first year will depend on the program implementation date.

1. Program Description

This program will provide 24/7 in-home crisis response, short term in-home therapy, case management, and rehabilitation services, with a focus on maintaining family stabilization and preventing hospitalization and/or out-of-home placement. This innovative approach to addressing crisis situations has been very successful when children and adolescents are in crisis and will have considerable applicability for adults who are living at home. It is an option that is not presently available and a viable alternative to hospitalization.

The target population is adults aged 18 and older who are being considered for psychiatric hospitalization, but who don't meet criteria for admission. An evaluation will be provided by Adult services to determine if the individual meets the target population. The crisis stabilization team will come to the site of the evaluation and begin to (1) work out a plan to identify causes of the current crisis and (2) begin to work on healthful ways of avoiding future crises. The team will target a brief intervention period usually three weeks, occasionally extending to six. The In-Home Crisis Stabilization Team will help the family and individual develop coping strategies and linkages to on-going support.

2. Outcomes

The anticipated program outcome is for clients and their families to adaptively function at a higher and more productive level in the community. This will be measured by the number of clients who are not psychiatrically hospitalized during their time in the program and for 60 days after discharge from the program.

O1. Older Adult Mental Health Recovery Program	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**450**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$1,668,135**
Estimated Annual Cost Per Client	**$3,707**

1. Program Description

The Older Adult Recovery Program serves individuals 60 years of age or older who are living with persistent mental illness. The Recovery Program provides initial psychiatric services in the consumer's home. As clients progress in their recovery they are scheduled for follow-up appointments at the Recovery Clinic. Participants have access to case management, crisis intervention, medication monitoring, and therapy (individual, group, and family) services.

This program serves clients from diverse cultural groups such as Latino, Vietnamese, Korean, and Iranian as well as non-English-speaking monolingual individuals, and Deaf and Hard of Hearing. The target population struggles with the acute and chronic symptoms of mental illness and often presents with co-occurring diagnoses and multiple functional impairments. Individuals eligible for this program typically have a chronic mental illness that is complicated by at least one medical condition. Older adults receiving this service are often very isolated, homebound, and have limited resources. This population is disproportionately represented in the suicide statistics as well as victimization statistics.

2. Outcomes

In FY 12/13, the program refined the targeted goals, data gathering procedures, and developed a new database to track the outcomes. The three primary goals identified were: to decrease depression in older adults, increase access with primary care, and improve level of recovery. The program is utilizing the PHQ9 to measure depression, using nursing assessments to assess linkage to primary care, and the Milestones of Recovery Scale (MORS) to assess level of recovery. The Milestones of Recovery Scale (MORS) is a recovery based evaluation tool in which there are eight levels. The score reflects where an individual is in his or her process of recovery at that moment in time. The score is determined once a month and indicates how engaged that individual is in recovery, level of risk, and

level of skills and supports. The MORS score for Older Adults is essentially the same as the Adult scale, but includes some unique elements in the area of skills and supports.

The program served 558 clients during FY 12/13. A Behavioral Health Nurse joined the team in January 2013 and has since completed 199 nursing assessments and successfully linked 39 individuals to primary care.

O2. Older Adult FSP Older Adult Support Intervention Systems (OASIS)	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**220/year**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$2,536,395/year**
Estimated Annual Cost Per Client	**$11,529**

1. Program Description

The Mental Health Services Act Full Service Partnership (MHSA FSP) Older Adults Program serves the target population of 60 and over. These seniors are at risk of institutionalization, criminal justice involvement and are homeless or at risk of homelessness. Services include; intensive case management/wraparound services, community based outpatient services, peer mentoring, housing supports, meal services, transportation services, benefit acquisition, supported employment/education services, linkage to primary health care and integrated services for co-occurring disorder treatment. Personal Services Coordinators (PSC's) are also available to clients where they live, 24 hours a day, 7 days a week.

Full Service Partnerships provide an integrated team to work with the consumer to develop plans for and provide the full spectrum of community services, so that consumers can reach their identified goals. Programs are strength-based, with the focus on the person rather than the disease. Services are delivered at the consumer's home. The program works with families and significant others to ensure that the client is able to remain in the lowest level of placement. The Program is linguistically and culturally capable of providing services to the underserved ethnic populations in Orange County, including Vietnamese and Spanish-speaking consumers. Additional funding will be added starting in FY 14/15 to allow an increase in the number of clients served. It is anticipated that the average annual cost for each client enrolled will remain the same as before the expansion.

Full Service Partnership programs are considered 'best practice' strategies because they are effective at enhancing and promoting an individual's chance of recovery. The concepts of recovery are embedded within this service delivery model. Some of those concepts include client empowerment, hope, and self-direction, and the ability to live, work, learn and participate fully in their communities. To ensure that the goals and concepts of recovery inherent in the

program are practiced and reinforced, staff will receive ongoing training and work development from a variety of sources.

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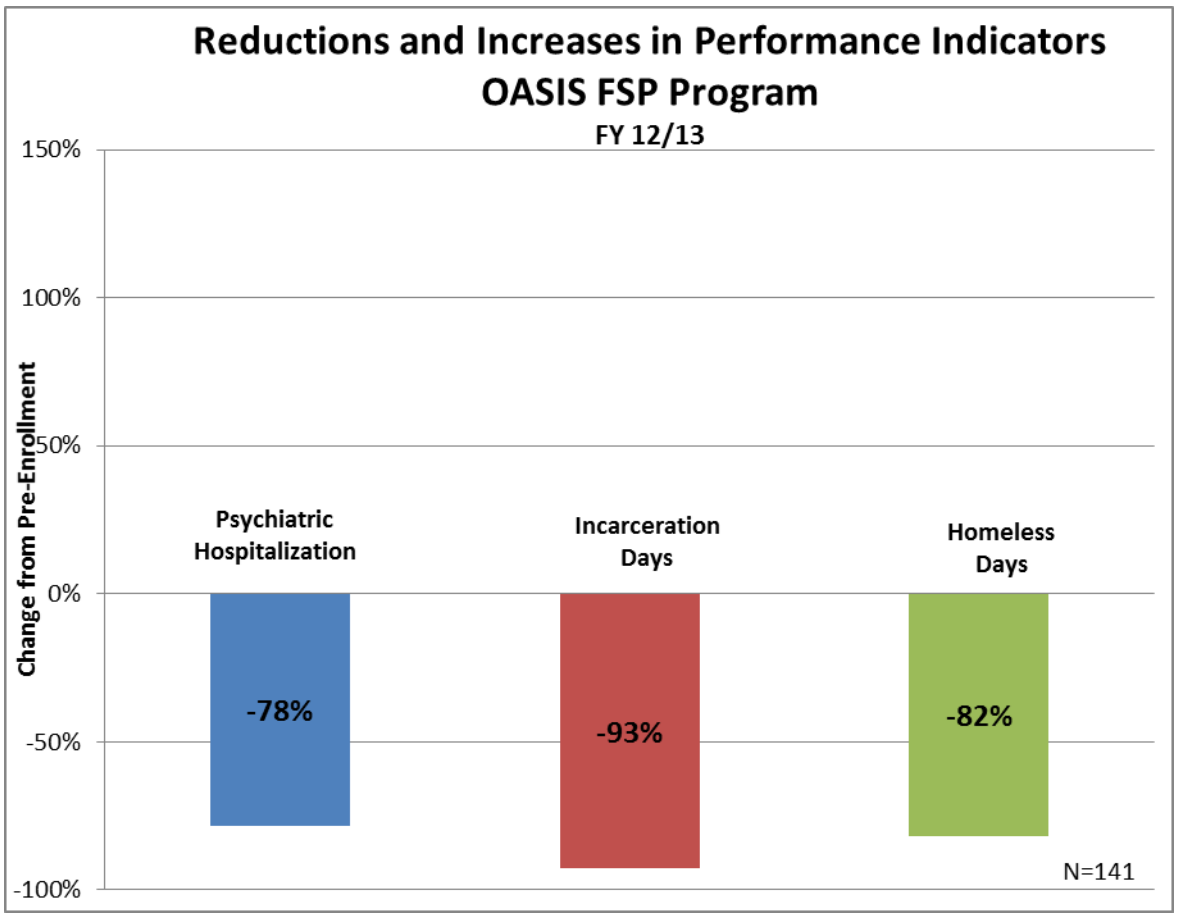
2. Outcomes

The Older Adult FSP program outcomes are to decrease incarcerations, hospitalizations, and homelessness; and increase safe and adequate housing, employment, education; and promote recovery wellness concepts. This program had a 78% decrease in psychiatric hospitalization days and an 93% decrease in incarceration days. The graph below illustrates the reductions and increases of FSP performance indicators as of June 30, 2013.



O3. Older Adult Program of Assertive Community Treatment	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**90**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$521,632**
Estimated Annual Cost Per Client	**$5796**

1. Program Description

The Older Adult Program of Assertive Community Treatment (PACT) team in Orange County provides intensive community based services to adults over the age of 60. The target population includes individuals who have been psychiatrically hospitalized and/or incarcerated due to their symptoms of mental illness within the past year. In addition, Older Adults who have repeated emergency room visits or excessive 911 calls due to behavioral health issues are also appropriate for PACT. Individuals in PACT typically have not benefited from traditional programs. Assertive Community Treatment is a best practices model and Orange County PACT teams work to further their fidelity to this model.

The program focuses on delivering culturally competent services to seniors in the community, so that individuals may achieve their maximum level of functioning and independence. The program provides consumer-focused, recovery-based services, and provides intervention, primarily in the home and community, to reduce access or engagement barriers. Collaboration with primary physical health care and providers of community and family supportive services is a priority in this multidisciplinary model of treatment.

The population struggles with the acute and chronic symptoms of mental illness and consumers often present with multiple diagnoses and multiple functional impairments. This population requires frequent and consistent contact to engage and remain in treatment. The target population is multicultural and includes Latino, Vietnamese, Korean and Iranian, and is disproportionately represented in the suicide statistics, as well as victimization statistics.

2. Outcomes

The Older Adult PACT program served 70 clients during FY 2012/2013. There is a gap in outcome data from July 2012 – January 2013 due to the development and implementation of a new and improved database. The new database is

currently in use, consistently throughout the PACT teams. The older adult PACT program continues to focus on measuring outcomes which include reduction of hospitalizations, reduction of incarcerations, reductions in homelessness, and increases in linkage to primary care. Preliminary data for FY 13/14 shows a 100% decrease in homeless days and a decrease of 81.5% in psychiatric hospital days.

04 Older Adult Peer Mentoring	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**150**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$792,709**
Estimated Annual Cost Per Client	**$5,285**

1. Program Description

The Older Adult Peer Mentoring program was created to build community support services that bridge existing gaps in the recovery continuum. The Older Adult Peer Mentoring Program pairs qualified, culturally/linguistically competent peers with individuals in psychiatric hospitals, who are preparing to be discharged, and assists them in successfully transitioning back to the community, and successfully linking with outpatient treatment providers. In addition, the peers work with individuals who are at risk of being hospitalized, and provide them with additional intensified support to assist them in maintaining their independence at home. With the Older Adult population, individuals who frequent the emergency rooms or excessively call 911 due to behavioral health issues are also appropriate for peer mentoring.

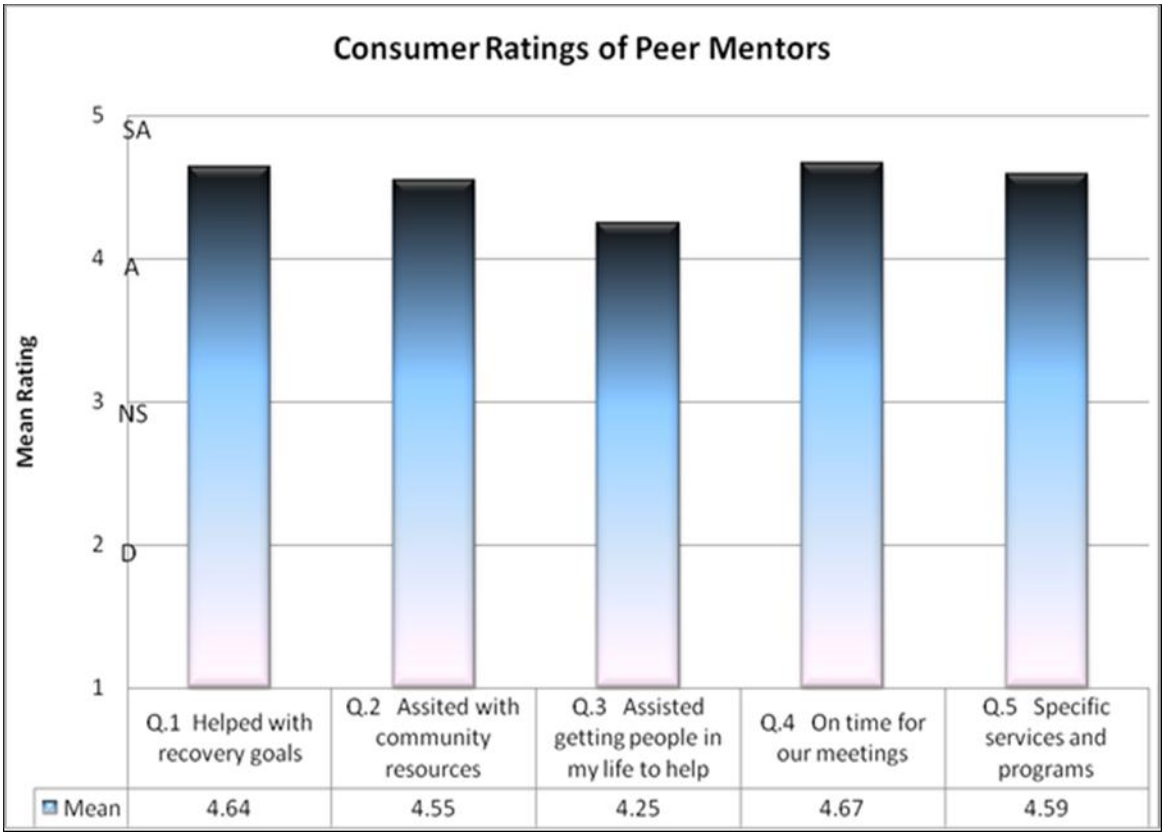
The services target some of the most common reasons for re-hospitalization after discharge, including interruption of medication, lack of social support and unstable housing. The services are timely, and typically take place in the field. Services are often provided in the home, a hospital, Dr.'s office, treatment facility, or community resource. The field work helps to engage individuals and reduce access barriers. Peer Mentors provide social support, assistance with basic household items, food, clothing, and transportation needs to facilitate successful reintegration into the community.

Peer Mentors support the individual's recovery goals and therapeutic needs. Examples of activities include helping clients get to the first appointment; meeting the individual's assigned Care Coordinator or Psychiatrist; assisting clients in picking up prescribed medications at a local pharmacy; assisting clients to re-connect with family and friends or to develop a support network; and encouraging (and at times participating in) their recovery activities. Peer Mentors also assist in accessing other needs of community living (e.g. assisting in acquiring benefits, food, and clothing; doing laundry; learning the bus routes).

2. Outcomes

During FY 12/13, the Older Adult Peer Mentoring Program served 73 consumers. Over all, consumer ratings averaged 4.5 out of 5, reflecting a high satisfaction with services. The graph below displays consumer ratings for Peer Mentor services in FY 12/13.

During FY 12/13, Older Adult Peer Mentoring program identified three primary outcomes: reduction of hospitalization, actively using community resources, and participation in self-sufficient activities. New surveys were developed and implemented to gather data for FY 13/14. The first quarter results reflect a 34% decrease in medical hospitalizations, 100% decrease in psychiatric hospitalizations, 28% increase in utilizing community resources, and an overall increase in self-sufficient and self-supporting activities. These results include Adults and Older Adults Peer Mentoring.



WORKFORCE EDUCATION AND TRAINING

Workforce Education and Training

A. Component Information

MHSA-Workforce Education and Training (WET) component was designed to address occupational community-based shortages in the public mental health system. WET is focused on training staff members with necessary skill sets to provide services in accordance with MHSA principals, offering education and training that promote wellness, recovery, and resilience to county staff and that of contracting community partners.

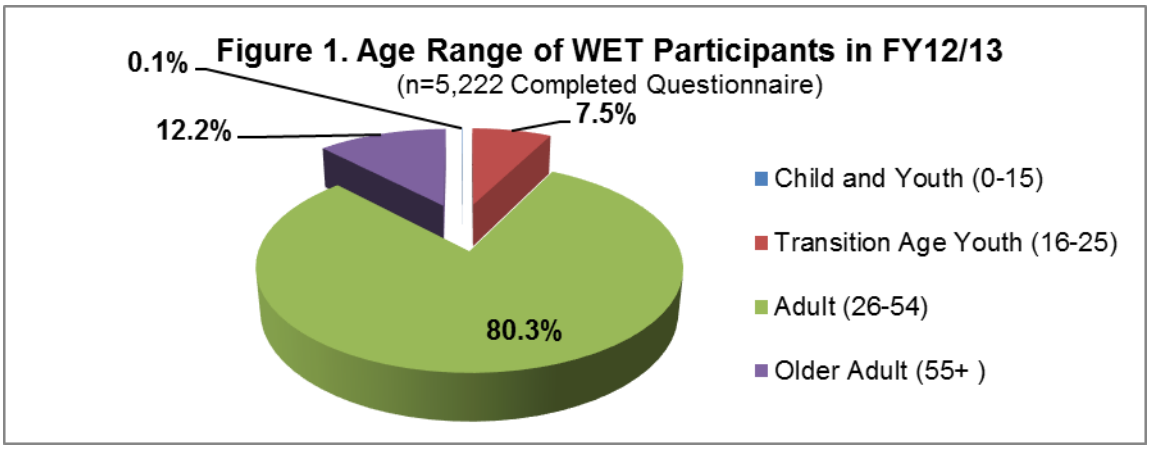
Skills building and education are also being provided to prepare and encourage the employment of mental health consumers and family members within the behavioral health system. Effort is also focused on developing and maintaining a culturally responsive, bicultural/bilingual workforce that also includes consumers and family members, who are capable of providing consumer and family-driven services.

Programs were created to increase the capacity of postsecondary education through Master degree level to meet the needs of identified behavioral health occupational shortages, and to provide stipend programs for staff, as well as graduates from consumer training programs enrolled in academic institutions who want to be employed in the mental health system. Financial incentive programs for Associate of Arts, Bachelor's and Master's level offer stipends in return for a commitment to employment in the local public mental health system. A portion of WET was also used for training and to develop a child psychiatry residency program.

The WET allocation was one-time funding. Use of the WET funding was spread over several years. However, the one-time fund for the WET component was exhausted in June 2012 and unspent dollars from Community Services and Supports (CSS) are being used to support the programs. In the future, WET Programs will need to be maintained with CSS funding.

As discussed above, WET funds a variety of disparate programs/services. To provide a better a picture of who is being served with WET funding, a decision was made to focus on Trainings/Conferences since that activity has by far the largest number of participants. In FY 12/13, 7,399 attendees participated. However, not all completed the training evaluation form and all the questions.

Presented in aggregate, the demographic data in Figure 1 represents 5,222 (70.6 percent) of total FY 12/13 WET participants who responded to the age survey question on the training evaluation. Figure 2 indicates the race and ethnicity of 6,295 attendees (85.1 percent) who answered the question. Figure 3 reports the primary language spoken at home for 5,182 participants (70.6 percent) who responded to the language survey question. Special population status was also queried. However, the number of responses to this question was extremely low (772 or 10.4 % of the people who turned in a survey). Of those people answering this question, 41% indicated that they were lesbian, gay, bisexual, transgender intersex or questioning (LGBTIQ). Nineteen percent indicated that they were veterans and 40% stated that they were a member of some other special population.



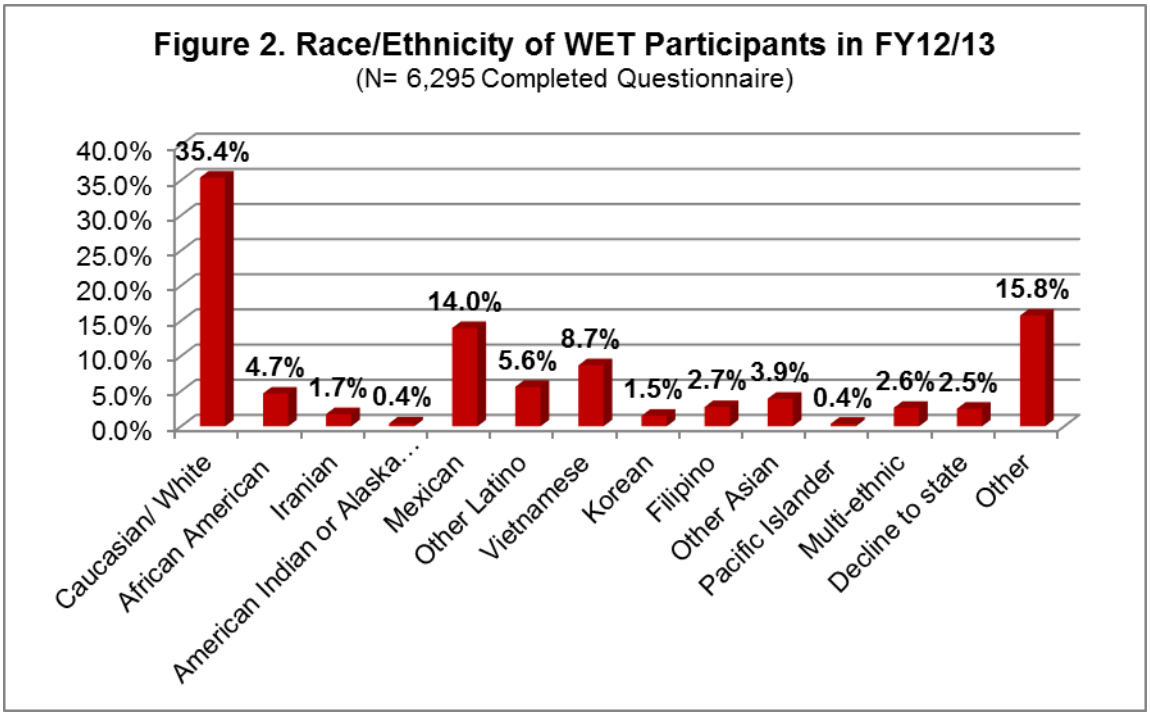


Figure 2. Race/Ethnicity of WET Participants in FY12/13
(N= 6,295 Completed Questionnaire)
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
35.4%
4.7%
1.7%
0.4%
14.0%
5.6%
8.7%
1.5%
2.7%
3.9%
0.4%
2.6%
2.5%
15.8%
Caucasian/ White
African American
Iranian
American Indian or Alaska…
Mexican
Other Latino
Vietnamese
Korean
Filipino
Other Asian
Pacific Islander
Multi-ethnic
Decline to state
Other

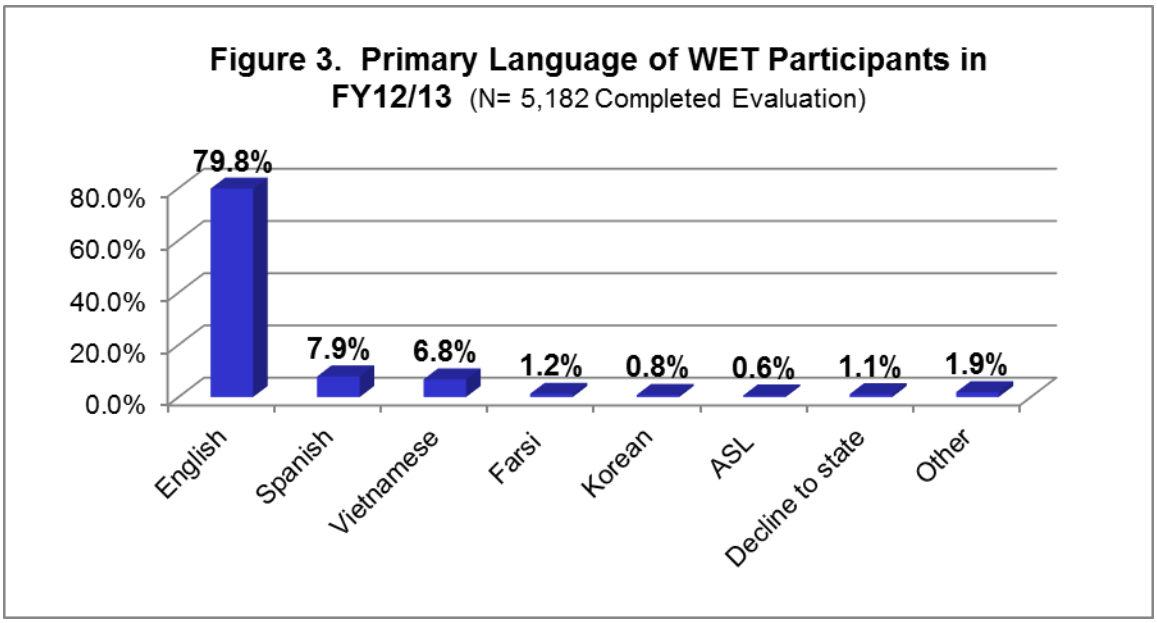


Figure 3. Primary Language of WET Participants in FY12/13 (N= 5,182 Completed Evaluation)
80.0%
60.0%
40.0%
20.0%
0.0%
79.8%
7.9%
6.8%
1.2%
0.8%
0.6%
1.1%
1.9%
English
Spanish
Vietnamese
Farsi
Korean
ASL
Decline to state
Other

B. Program Information

Program categories based on the original WET plan have been condensed in FY 12/13 to group programs for the new plan. Estimated funds to be expended for the next three fiscal years are as follows:

Table 1. Annual Funds Budgeted for FY 14/15, FY 15/16, FY 16/17

WET Programs	Each Fiscal Year
1.Workforce Staffing Support	$276,137
2.Training and Technical Assistance	$777,657
3. Mental Health Career Pathways	$817,000
4. Residencies and Internships	$699,879
5. Financial Incentives Programs	$174,789
Total of All Programs (1-5)	**$2,745,462**

1. Workforce Staffing Support

The Workforce Education and Training plan requires a training coordinator who also serves as a liaison to work collaboratively with the Southern Region and participates in regional conference calls to plan training activities and increase work force diversity/opportunities in the public mental health system. In FY 12/13 Orange County hosted the public mental health forum for the Office of Statewide Health Planning and Development (OSHPD) to obtain community feedback on an integrated mental health service delivery system for the WET Five-Year 2014-2019 State Plan.

The Orange County WET plan also requires continued coordination with county behavioral health, numerous contractors, consumers, family members, and the

wider community to promote recovery, resiliency, and culturally competent services. Numerous multidisciplinary staff members with language proficiency and cultural responsive skills work to effectively coordinate, provide trainings, research, formulate, evaluate, and monitor WET programs. Staff time is also dedicated to interpretation, translation of materials into threshold languages Spanish, Vietnamese, and Farsi and providing linguistically appropriate behavioral health information and resources to the underserved monolingual consumers and family members. A Consumer Employment Support staff person is assigned to interface with Behavioral Health, its contract agencies and community partners to promote and support employment of consumers in the public mental health system.

2. Training and Technical Assistance

Trainings under this category includes evidence-based practices, consumer employment support training and consultation, trainings provided by consumers and family members for staff and the community, development of multi-cultural competency for staff and the community, training for foster parents and others working with foster children and youth, and mental health training for law enforcement. Trainings, continuing education credits, developing program evaluations and tracking outcomes to training partners are part of providing technical assistance.

Forty-four trainings on Ticket to Work and SSI/SSDI Work Incentives & Employment Training were offered to 520 consumers and providers in FY 12/13 to raise awareness on work incentives. SSI/SSDI Work Incentive consultation was also provided to 80 consumers who requested more in-depth guidance sessions.

In FY 12/13, 43 trainings were provided on evidence-based best practices such as Trauma-Focused Cognitive Behavior Therapy (TF-CBT), Non-Violent Crisis Intervention (NVCI), Critical Incident Stress Management, and Motivational Interview. A total of 1,189 County and county-contracted staff, community partners, and consumers/family members attended. Of these 43 evidence-based trainings, 11 Mental Health First Aid classes were offered to 104 community partners and members.

A total of 13 trainings on recovery were implemented in FY 12/13 by and from the lived-experience perspectives of consumers/family members and non-English speaking communities to reduce stigma among staff in the mental health system and to raise awareness of behavioral health conditions across communities.

NAMI Provider Education courses were also offered. The third Annual Institute for Peer Support Services conference and a regional conference on “Supporting Lived Experience in the Workforce” were conducted to provide skills building and networking resources to peer professionals. A total of 363 peers, peer mentors, providers, community partners and members participated in this program.

Thirty-two culturally responsive trainings were conducted to raise awareness and acceptance of cultural diversity among behavioral health providers and community partners in FY 12/13, and 1,286 people attended. A collaborative interfaith community and behavioral health advisory board continues to guide topics and contents of a workshop series that integrates spirituality with behavioral health. A culturally responsive approach in working with the Deaf and Hard-of-Hearing consumers and underserved populations, Client Culture, Understanding Vietnamese American Culture were conducted along with the first conferences on “Spirituality Integration” and “Vietnamese American Recovery from History of Trauma.”

Fifteen best-practice classes of the Crisis Intervention Training (CIT) curriculum were taught to a total of 356 Orange County law enforcement officers in FY 12/13. This 16-hour curriculum was conducted by psychiatrists, a psychologist, subject matter experts, and contracted providers from a community college, along with the participation of mental health consumers and family members. Staff effort was also put forth in FY 12/13 to coordinate, support and host the California Region Crisis Intervention Therapy (CIT) conference.

The WET program also provides a wide variety of trainings including recovery, disparity and stigma reduction to the community, consumers, family members, primary care and behavioral health providers. A total of 3,201 attendees participated in 69 of these trainings that included Immersion, Clinical Supervision, Laws and Ethics, 5150 & 5585 Voluntary Hospitalization, Integrating Physical and Mental Health Care, Prescription Drugs Abuse, Mental Health Patients’ Rights, Current Drugs Trends Among At-Risk Adolescents, Treatment for Anxiety, Workplace Violence Preparedness, Transformational Care Planning, and How Health Care Reform Impacts Mental Health. Three large conferences “Eliminating Racial Disparity & Disproportionality,” “Veterans’ Behavioral Health,” “Health Literacy,” and a joined conference on “DSM-V” with the University of California, Irvine (UCI) and University of Missouri/Thompson Center for Autism and Neurodevelopmental Disorders were also implemented.

3. Mental Health Career Pathways

Included in this category are the Recovery Education Institute Program that prepares consumers and family members for careers in behavioral health, and graduate student supervision provided by licensed staff to interns in neurobehavioral testing and clinical licensure tracks in behavioral health. To help overcome Behavioral Health work shortages, Psychiatry Residencies and Fellowships are also provided.

To prepare consumers and family members who aspire to a career in behavioral health, the Recovery Education Institute (REI) provides training on basic life and career management skills, academic preparedness and certified programs needed to solidify the personal and academic skills necessary to work in the system. REI employs Academic Advisors to mentor and Peer Success Coaches to tutor students. The program also collaborates with adult education programs and links students to local community colleges for pre-requisite classes, as well as providing accredited college classes and certificate courses. In FY 12/13, a total of 321 trainings were offered. Wellness Recovery Action Plans, Peer Empowering Peer, and Self-Managing Wellness were among the variety of courses offered. The total (duplicated) number of attendees was 3,538.

4. Residencies and Internships

To increase a culturally diverse, bilingual work force committed to working in the public behavioral health system, clinical supervision is provided by county-licensed staff to graduate student interns who served in non-MHSA clinical programs and are on a clinical licensure track in social work, psychology, marriage and family therapy, or psychiatric nursing. In FY 12/13, a total of 8,210 supervision hours were provided to 81 interns. In addition, 18 were pre-doctorate California Psychology Internship Council (CAPIC) student interns who were supervised by a licensed psychologist to administer neurobehavioral testing.

In order to overcome the shortage of child and community psychiatrists working in the public mental health system, supervision, multicultural and client-centered training are provided to psychiatry residents and fellows to recruit talented physicians, reduce stigma and enhance understanding from the consumer and family perspectives. In FY 12/13, WET funded seven residencies and three fellowships through the Psychiatry Department at the University of California Irvine (UCI) School of Medicine.

5. Financial Incentives Programs

In this category of the WET plan, financial incentive stipends are offered to county and contracting staff as well as graduates from consumer training programs at the Associate of Arts (AA), Bachelor of Arts (BA), and Masters of Arts (MA) levels to increase a diverse bilingual/bicultural workforce. The County of Orange collaborates with numerous colleges and universities to provide stipends to students who, upon graduation, are then required to work for county or county-contracted agencies in return.

C. Outcomes

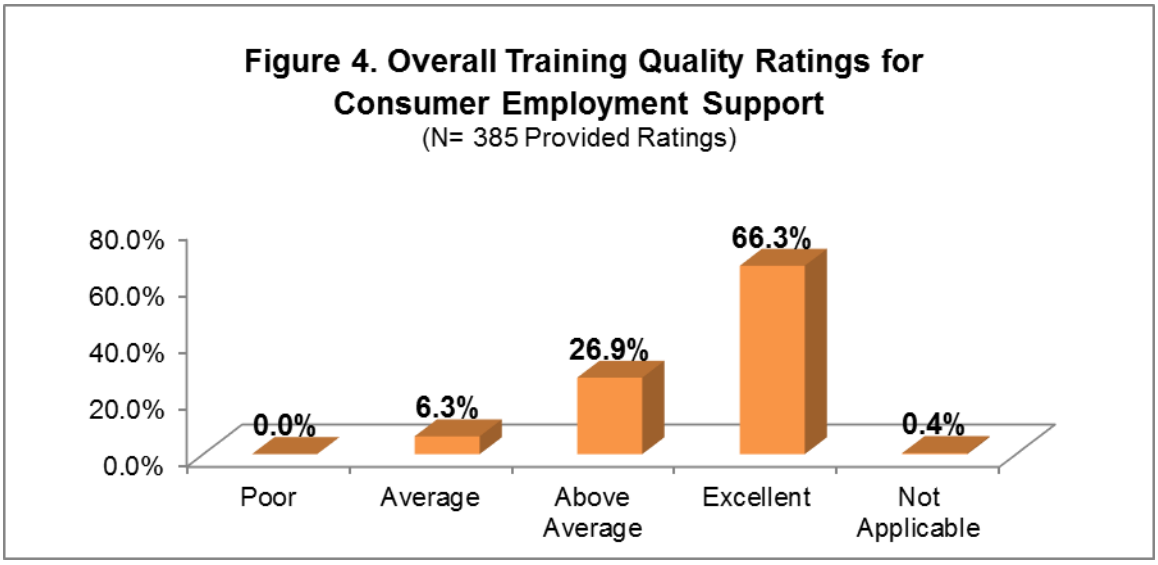
1. Workforce Staffing Support

In FY 12/13, WET staff devoted time, coordination and support to 201 behavioral health trainings (in addition to those provided by REI and Golden West College), and provided training activities to 7,339 county and contracted providers, community partners, consumers and family members.

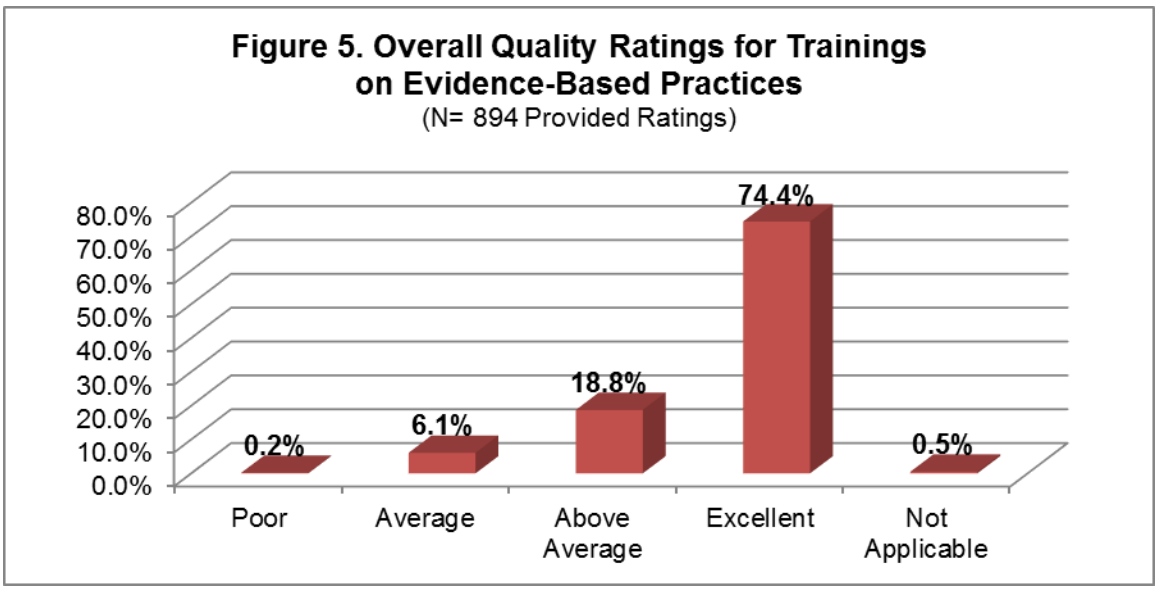
2. Training and Technical Assistance

- Overall Training Program Quality Rating:

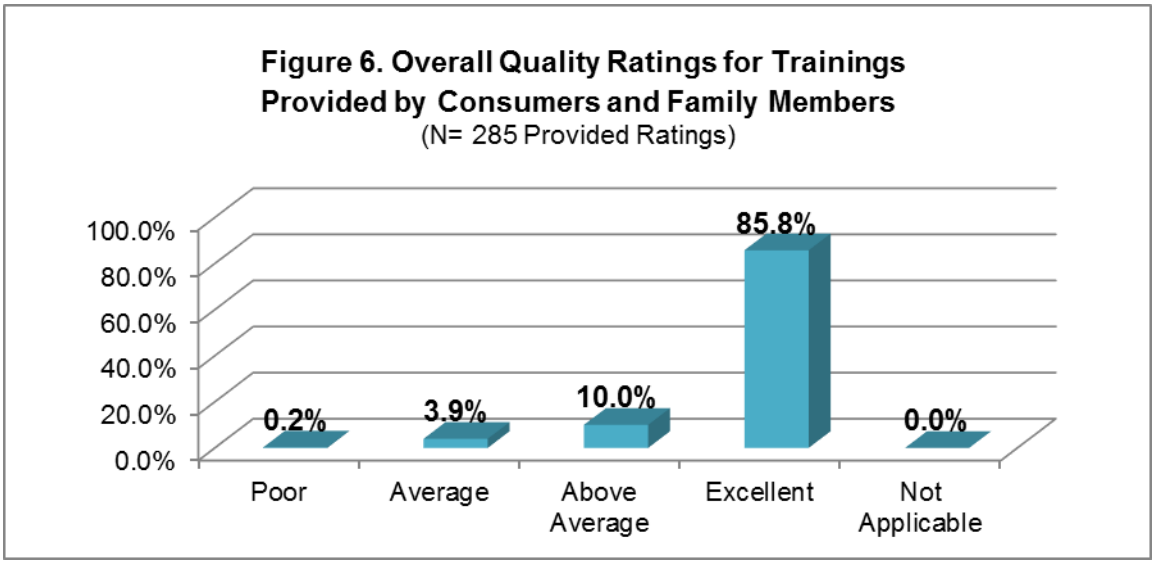
Of the 520 total individuals who attended Ticket to Work (SSI/SSDI Work Incentives and Employment Trainings in FY 12/13, 385 (74 percent) provided ratings on the overall training quality. Presented in Figure 4 and in aggregate, 66.3 percent of 385 participants gave an “Excellent” rating, and 26.9 percent marked “Above Average.” The combined percentage for “Excellent” and “Above Average” ratings of these consumer employment support training activities equals 93.2 percent.



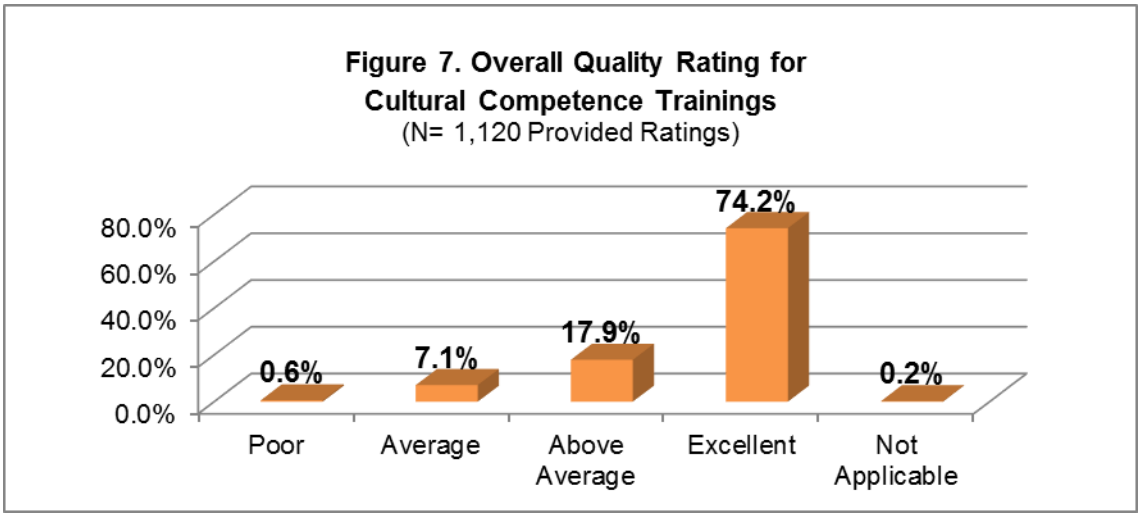
Out of the 1,189 individuals attended the evidence-based practices trainings, 894 participants (75.2 percent) completed the rating on the overall quality for these activities. While 18.8 percent gave an "Above Average" rating, 74.4 percent provided an "Excellent" rating as depicted in Figure 5. The combined percentage of "Excellent" and "Above Average" ratings equals 93.2 percent.



Of the 363 individuals attended trainings provided by consumers and family members, 285 participants (78.5 percent) gave ratings on the overall training quality. Figure 6 shows 85.8 percent gave an "Excellent" rating while 10.0 percent provided an "Above Average" rating in aggregate. The combined percentage of "Excellent" and "Above Average" ratings equals 95.8 percent.

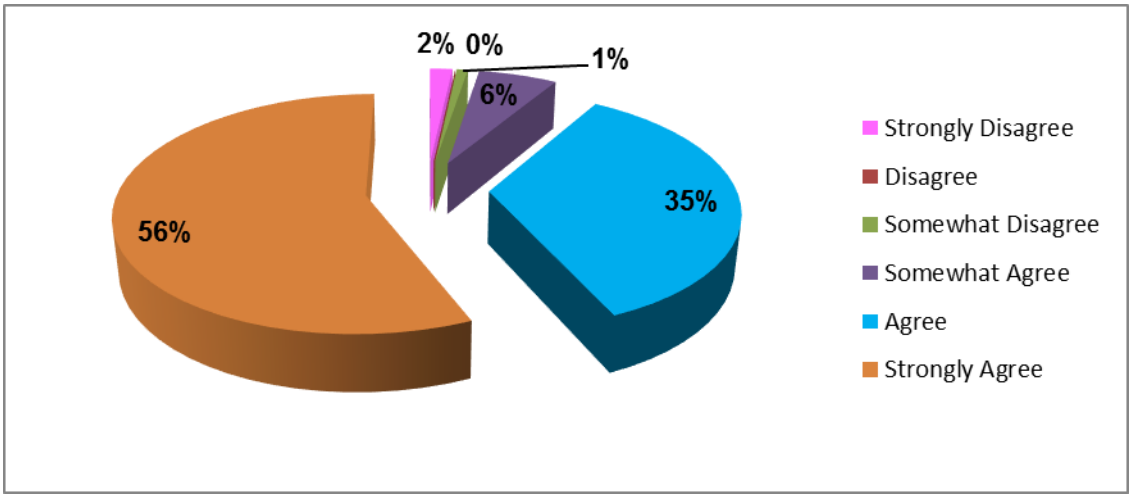


Of the 1,286 total individuals who attended cultural competence trainings in FY 12/13, 1,120 (87.1 percent) provided ratings on the overall training quality. Presented in Figure 7 in aggregate, 74.2 percent of 1,120 participants gave an "Excellent" rating, and 17.9 percent marked "Above Average." The combined percentage for "Excellent" and "Above Average" ratings of these training activities equals 92.1 percent.



The overall quality rating measure for law enforcement training was not yet aligned in FY 12/13 with that of WET until the following fiscal year as a different training evaluation form was utilized by a contracted local college. However, ratings for the questionnaire "if trainings provided skills and/or knowledge that can be used in the job" are reported in Figures 8. The combined percentage 56 for "Strongly Agree" and 35 "Agree" ratings equals 91 percent.

Figure 8. Law Enforcement Officers' Ratings: If Training Provided Skills and/or Knowledge that Can Be Used in Their Jobs



- Overall Satisfaction Rating with Training Activities

Mean rating by participants on the scale of 1 to 10 (1= with the least satisfaction, 10= with the most satisfaction) for the overall satisfaction with the training and technical assistance category is depicted in Table 2.

For the consumer employment support training activities in FY 12/13, 344 participants (66.1 percent) out of 520 total attended provided a mean rating of 8.7 in aggregate on the 1 to 10 scale for the overall satisfaction. The combined percentage in aggregate for high scale 8, 9, and 10 ratings equals 89 percent.

In FY 12/13, out of the 1,189 total attended, 894 participants (75.2 percent) provided a mean rating in aggregate of 9.0 on the 1 to 10 scale for the overall satisfaction of the trainings in evidence-based practices. The combined percentage in aggregate for high scale 8, 9, and 10 ratings equals 90 percent.

Of the total 363 individuals attended the trainings provided by consumers and family members in FY 12/13, 285 (78.5 percent) provided ratings on the overall training quality. Presented in aggregate, a mean rating of 8.9 on the 1 to 10 scale was given for these training activities. The combined percentage in aggregate for high scale 8, 9, and 10 ratings equals 86 percent.

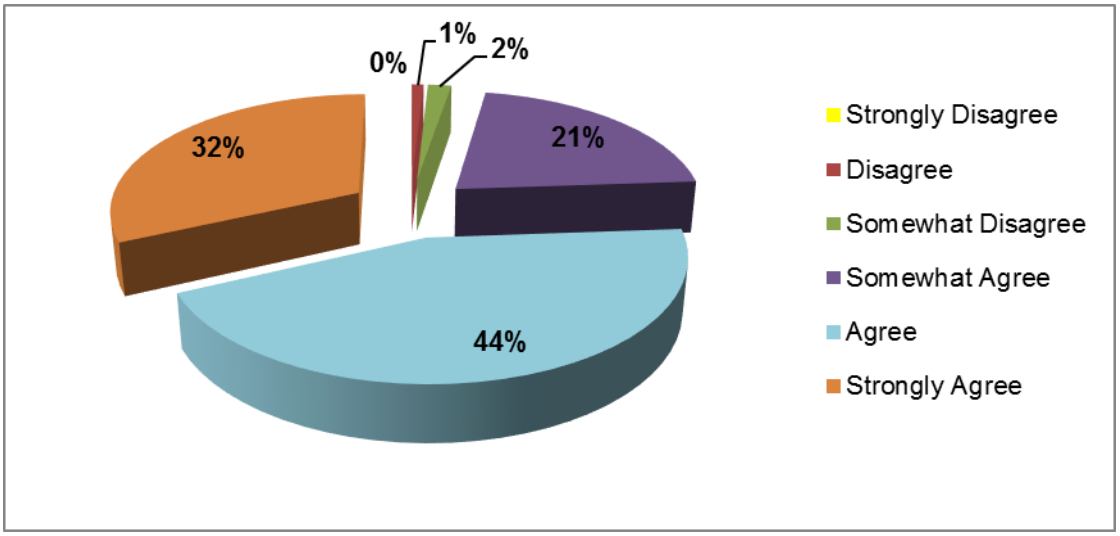
For the cultural competence training activities in FY 12/13, 976 participants (75.9 percent) out of 1,286 total attended provided a mean rating of 8.9 in aggregate on the 1 to 10 scale for the overall satisfaction. The combined percentage in aggregate for high scale 8, 9, and 10 ratings equals 87 percent.

Table 2. Overall Satisfaction Ratings by Participants for Training and Technical Assistance
(1= With the Least Satisfaction, 10= With the Most Satisfaction)

Satisfaction Level	1	2	3	4	5	6	7	8	9	10	Mean Rating
Consumer Employment Support Trainings	0%	0%	0%	1%	2%	2%	5%	28%	28%	33%	8.7
Evidence-Based Practices Trainings Trainings	0%	0%	0%	0%	2%	2%	5%	15%	25%	50%	9.0
Provided by Consumers/ Family Members	0%	1%	1%	1%	1%	1%	8%	15%	24%	47%	8.9
Cultural Competence Trainings	0%	0%	0%	1%	2%	3%	6%	17%	25%	45%	8.9

Similarly, for law enforcement trainings, the overall satisfaction outcome measure was not yet been aligned in FY 12/13 until the following fiscal year. Figure 9 shows results collected for the questionnaire "if training would be referred to members of the same department or another agency." The combined percentage 32 for "Strongly Agree" and 44 for "Agree" ratings equals 76 percent.

Figure 9. Law Enforcement Officers' Ratings: If Training Would Be Referred To Members of the Same Department or Another Agency



3. Mental Health Career Pathways

The Recovery Education Institute reported a high level of productivity in FY 12/13 both in the number of courses provided and in the number of participants as depicted in Table 3.

Table 3. Number of Courses REI Offered in FY 12/13 and The Total Number of Students Attended

REI Courses/Advisement Sessions	Total Number of Courses Offered	Total Number of Students Attended
Workshop	**198**	**267**
Pre-Vocational	**102**	**218**
Extended Education	**16**	**721**
College Credit	**5**	**535**
Academic Advisement Sessions	**--**	**428**
Total	**321**	**3,538**

4. Residencies and Internships

In FY 12/13, 81 supervised interns provided 73,548 clinical hours to Behavioral Health Services (BHS). Table 4 indicates 23,520 clinical hours provided by unlicensed staffs who are working toward various clinical licensures. Table 5 reports the total 50,028 clinical hours contributed by clinical supervised volunteers including the 18 supervised pre-doctorate CAPIC students who provided 25,476 neurobehavioral testing service hours to BHS.

Table 4. Total Hours Unlicensed Staff Under Clinical Supervision Provided in FY 12/13 to Behavioral Health Services

Unlicensed Staff	Total No.	Total Monthly Hours	Total FY 12/13 (Monthly Hours X 12)
Supervisees working toward LCSW	11	890	10,680
Supervisees working toward LMFT	11	910	10,920
Supervisees working toward Psychologist Licensure	4	160	1,920
TOTAL	**30**	**2,216**	**23,520**

Table 5. Total Hours Volunteers Under Clinical Supervision Provided in FY 12/13 to Behavioral Health Services

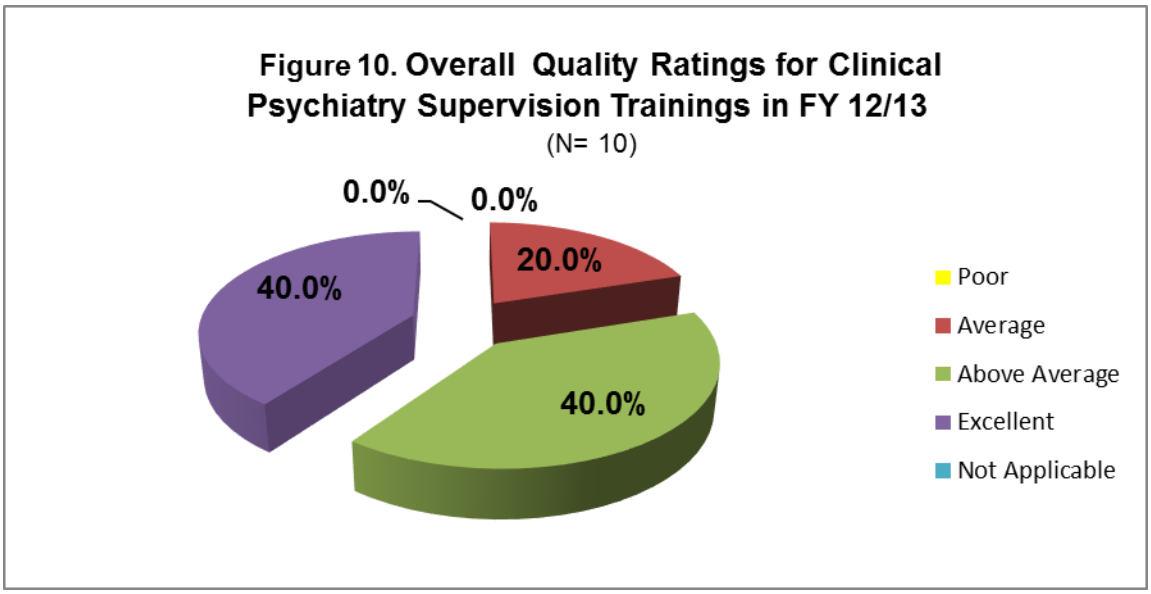
Supervisees as Volunteers	Total No.	Total Monthly Hours	Total FY12-13 (Monthly Hours X 12)
MSW Students (Pre-Master)	4	284	3,408
MSW Associates (Post-Master)	1	60	720
MFT Practicum Students (Pre-Master)	4	180	2160
MFT Interns (Post-Master)	6	227	2,724
Psychology Practicum Students	14	775	9,300
CAPIC Pre-Doctorate Students	18	2,123	25,476
Post-Doctorates	2	240	2,880
Non-licensure track	2	280	3,360
TOTAL	**51**	**4,169**	**50,028**

In FY 12/13, the clinically supervised psychiatry residents and fellows provided a total of 3,840 clinical hours to Behavioral Health Services as shown in Table 6.

Table 6. Total Hours Psychiatry Residents/Fellows Under Clinical Supervision Provided in FY 12/13 Behavioral Health Services

Psychiatry Supervisees	Total No.	Total Monthly Hours	Total FY12-13 (Monthly Hours X 12)
Fellows	3	96	1,152
Residents	7	224	2,688
TOTAL	**10**	**320**	**3,840**

Seven psychiatry residents and three fellows provided ratings on the overall quality of the clinical psychiatry supervision trainings received in FY 12/13. As depicted in Figure 10, 40 percent gave an "Excellent" rating while another 40 percent marked "Above Average." The combined percentage for "Excellent" and "Above Average" ratings equals 80 percent.



5. Financial Incentives Programs

In FY 12/13, tuition incentives were provided to 19 potential staff to obtain the necessary educational skills for their AA and BA degrees and to 13 potential staff to acquire the needed educational skills toward their Master of Arts.

Prevention and Early Intervention

600 W. Santa Ana Blvd., Suite 510, Santa Ana, CA 92701 | (714) 667-5600 | MHSA@ochca.com | www.OCHealthinfo.com/MHSA

Prevention and Early Intervention (PEI)

A. Component Information

The Mental Health Services Act (MHSA) represents a comprehensive approach to the development of community based mental health services and supports. The Act addresses a broad continuum of prevention, early intervention, and service needs and the necessary infrastructure to support the system. Prevention and Early Intervention approaches in and of themselves are transformational in the way they structure the mental health system to embody a "help first" philosophy. Prevention and Early Intervention services involve reducing risk factors or stressors, building protective factors and skills, and increasing resiliency.

The Orange County Health Care Agency, Behavioral Health Services, Prevention and Intervention Division developed a PEI plan that makes resources available for addressing the earliest signs of mental health problems, and a service system that is accessible to a diverse population. As a continuum of care component, the plan builds capacity for mental health early intervention services at sites where people go for other routine activities such as health providers, education facilities and community organizations.

According to a 2009 study by the National Research Council and the Institute of Medicine, "Making use of some of the effective, evidence-based interventions already at hand could potentially save billions of dollars by addressing behavioral problems before they reach the threshold for a diagnosis and require expensive treatment." The PEI plan is a framework upon which protective factors can be built to decrease the need for costly, future mental health treatment.

Orange County's PEI Plan

The original PEI Plan was approved by the California Department of Mental Health (DMH) and the Oversight and Accountability Committee (OAC) in April 2009 after a multi-stage process that took nearly two years and involved extensive community involvement. The PEI Plan was for a three year period and was updated each year through the annual update report to the State. The original Plan consisted of 8 project areas with a combined total of 33 programs.

A restructuring of the Plan was initiated in 2012 to address issues identified during the first three years of implementation. The restructuring addressed areas of overlap in services, inconsistencies, and unsuccessful solicitations due to a lack of community response. The goal was to simplify the Plan by streamlining the existing programs so that it would better meet the prevention and early intervention needs of the community and, whenever possible, take advantage of economies of scale. The re-packaged Plan maintained all services, but re-organized them into three Service Areas consisting of 23 programs. These Areas are: Community Focused Services, School Focused Services, and System Enhancement Services.

FY 13/14 Changes to the Plan

In 2013, PEI growth funds were approved for two program expansions and for a new program. The Orange County Postpartum Wellness (OCPPW) Program was expanded to increase program capacity for meeting the increasing demand for existing services and to add a maternal wellness component for providing services to pregnant women experiencing mild to moderate anxiety and depression. In addition, the Socialization for Isolated Adults and Older Adults Program was expanded to increase program capacity for serving older adults, age 60 and above. Both programs were receiving increased referrals and had a continual wait time to enroll participants into services. Besides these expansions, growth funds were also approved for a new behavioral health counseling program. The goal of this program is to provide behavioral health early intervention services for all age groups including short-term counseling and psychiatric services for those not meeting the criteria at the community mental health clinics. This type of service has frequently been identified by stakeholders as an unmet need in the community.

In addition to the changes above, other recommendations were made and approved in FY 13/14 including the recommendation not to implement the Behavioral Health Response Services since several MHSA programs had been implemented that were already providing similar services. Instead, the recommendation was made to retain some funding for Crisis Response Network Services under Training, Assessment and Coordination and retain some additional funding for Information and Referral Services for the anticipated expansion of OCLinks. Besides these recommendations, the majority of the funding was freed up to be considered for other programs based on community input regarding the unmet needs in the community and how funding could be best utilized.

A public forum was held to gather community feedback regarding how to use freed-up funding, and suggestions were also encouraged to be submitted electronically. All suggestions were considered and evaluated. Recommendations were approved for the following three programs: continuation of funding for the Statewide Projects/ CalMHSA Initiatives for Suicide Prevention, Student Mental Health, and Stigma Reduction, for the share of cost of services for Orange County; continuation of funding for the WarmLine's extended hours from 10 pm to 3 am; and funding a school based school curriculum targeting students with anxiety.

Although the original PEI Plan has evolved, the Plan continues to address community mental health needs identified in the original PEI plan as well as targeting the same priority populations. Plan changes have been discussed and approved by the MHSA Sub-committee and the MHSA Steering Committee and presented to the Mental Health Advisory Board for review and feedback.

This PEI plan continues to address the Community Mental Health Needs identified in the original plan (2009):

1. Disparities in Access to Mental Health Services
2. Psycho-Social Impact of Trauma
3. At-Risk Children, Youth and Young Adult Populations
4. Stigma and Discrimination
5. Suicide Risk

The revised PEI plan also continues to target the same Priority Populations:

1. Trauma Exposed Individuals
2. Individuals Experiencing Onset of Serious Psychiatric Illness
3. Children and Youth in Stressed Families
4. Children and Youth at Risk for School Failure
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement
6. Underserved Cultural Populations

B. PEI Program Information & Outcomes : Community-Focused (CF) Programs

COMMUNITY-FOCUSED EARLY INTERVENTION PROGRAMS CF1 Early Intervention Services for Stress Free Families	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**160**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$534,693**
Estimated Annual Cost Per Client (for direct service programs only)	**$3,342**

1. Program Description

The Stress Free Families Program serves families that have been reported and/or investigated by Child Protective Services for allegations of child abuse and/or neglect. The program is designed to reach and support these families whose stressors make the children and parents more vulnerable to behavioral health conditions. Services consist of short term interventions including brief counseling, parent education and training, case management and referral and linkage to community resources. Staff is co-located at a Social Services Agency (SSA) site to provide consultation and receive referrals from SSA staff.

2. Outcomes

During FY 12/13, 103 families were served by Stress Free Families. The Social and Occupational Functioning Assessment Scale (SOFAS) was used to assess participants' current level of social and occupational functioning, at the time of enrollment, every three months, and at program exit. Of the 75 participants with matched pretest and post-test, 92% reported improved social and occupational functioning scores over time. Participants whose SOFAS score improved did so by an average of 14%.

The Protective Factors Survey was used to measure changes in a family's protective factors in five areas: family functioning/resiliency, social support, concrete support, nurturing and attachment, and knowledge of parenting/child development. Families reported the greatest average improvements in their perceived social support, knowing what to do as a parent and how to help their

child learn, and Family Functioning/Resiliency. Between pretest and post-test, 72% of the participants improved in the area of Social Support, and 68% of participants improved in the area of Family Functioning/Resiliency. Of the 60 participants with matched pretest and posttest, 100% demonstrated improved scores in one or more areas of family protective factors.

COMMUNITY-FOCUSED EARLY INTERVENTION PROGRAMS CF2 1st Onset of Psychiatric Illness (OC CREW)	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17*	**70**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$1,500,000**
Estimated Annual Cost Per Client (for direct service programs only) *	**$21,429**

*Estimated number served does not take into account family members served in multi-family groups or participants receiving community trainings.

1. Program Description

The Orange County Center for Resiliency Education and Wellness (OC CREW) serves individuals ages 14-25 that are experiencing the first onset of psychotic illness and provides services to their families. Services include: psychiatric care; psycho-education; cognitive-behavioral intervention; multi-family groups; peer mentoring; development of long-term economic and social support; opportunities for physical fitness activity; and services to address substance misuse and Wellness Recovery Action Plans.

This program also provides trainings to persons and organizations most likely to encounter individuals presenting with early warning signs of mental illness. Training is provided on how to recognize these early warning signs, how to support these individuals/families and how to refer persons from diverse ethnic/ cultural groups.

2. Outcomes

During FY 12/13, 59 participants were served by the OC CREW program. The Positive and Negative Syndrome Scale (PANSS) was administered to assess the symptom severity of participants with schizophrenia. The PANSS was administered to OC CREW participants upon enrollment, every six months following, and again at program exit. For participants who have taken the assessment more than once, their initial score and most recent post-test scores were matched to identify changes over time. Of the 31 participants, 94% improved their total PANSS score indicating a decrease in the severity of psychotic symptoms.

On average, OC CREW participants also showed improvements in general well-being as measured by the World Health Organization Well-Being Index (WHO-5). Among the 81% of participants whose well-being improved between pretest and post-test, WHO-5 scores increased by an average of 33%.

Additionally, 18 presentations were provided to the greater community reaching 355 individuals.

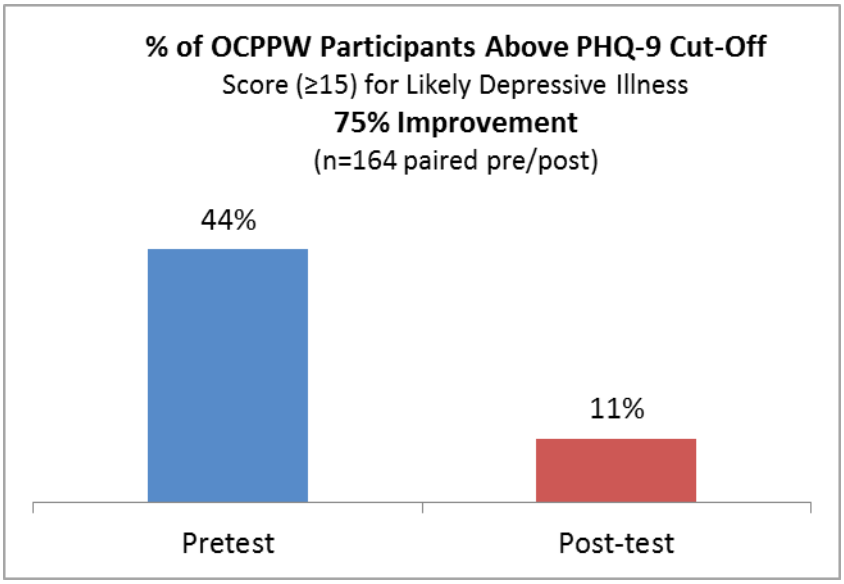
COMMUNITY-FOCUSED EARLY INTERVENTION PROGRAMS CF3 Orange County Postpartum Wellness (OCPPW)	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**600**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$1,913,072**
Estimated Annual Cost Per Client (for direct service programs only)	**$3,188**

1. Program Description

This program provides early intervention services to new mothers, up to one year postnatal, experiencing mild to moderate postpartum depression. Services include assessment, case management, individual, family and group counseling, educational groups, wellness activities and coordination and linkage to community resources and community education. In FY 13/14, this program expanded to maternal wellness to serve the many women who develop perinatal depression.

2. Outcomes

During FY 12/13, 231 participants were served by the OCPPW Program. The majority of program participants served experienced significant decreases in depression symptoms as measured by the Patient Health Questionnaire 9 (PHQ-9). A PHQ-9 was administered upon enrollment, every three months, and at program exit. Among the 80% of participants whose depression severity was reduced between pretest and post-test, PHQ-9 scores improved by an average of 66%. As shown in the graph on the following page, 44% of pretest scores were above the clinical cut-off for likely depressive illness (score ≥ 15); yet only 11% were above the cut off at post-test. This indicates a 75% improvement (i.e. reduction in percentage of participants above the clinical cut-off for depression).



OCPPW Participants: Pre/Post Severity of Depressive Symptoms	# Pre	% Pre	# Post	% Post
None	16	7%	82	49%
Mild	45	21%	37	22%
Moderate	60	28%	29	18%
Moderately Severe	62	29%	14	8%
Severe	32	15%	4	2%
Total	215	100%	166	100%

In addition, the vast majority of participants (75%) also showed improvements in general well-being as measured by the World Health Organization Well-Being Index (WHO-5). Over-all, based on 127 matched pretests and post-tests, participant well-being increased by an average of 46%. Among the 75% of participants whose well-being improved between pretest and post-test, WHO-5 scores increased by an average of 155%.

COMMUNITY-FOCUSED EARLY INTERVENTION PROGRAMS CF4 Early Intervention Services for Older Adults (previously known as the Socialization Program for Adults and Older Adults)	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**800**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$1,419,500**
Estimated Annual Cost Per Client (for direct service programs only)	**$1,774**

1. Program Description

The Early Intervention Services for Older Adults provides behavioral health early intervention services to older adults who are experiencing the early onset of mental illness and/or those who are at greatest risk of developing behavioral health conditions due to isolation. The program conducts comprehensive in-home assessments and connects participants to trained Life Coaches and volunteers to develop individualized socialization plans and to facilitate involvement in support groups, educational training, physical activities, workshops, and other activities. Based on the needs of the participants, the program also links participants to outside resources and services. Tele-geropsychiatric services are also available to consult with primary care physicians, participants and families.

2. Outcomes

During FY 12/13, 560 participants were served by the Socialization Program for Adults and Older Adults. The majority (73%) of program participants served experienced significant decreases in depression symptoms as measured by the Patient Health Questionnaire 9 (PHQ-9). Overall, self-rated depression severity decreased for participants by 40% based on 262 matched pretests and post-tests.

The majority (77%) of participants also showed improvements in general well-being as measured by the World Health Organization Well-Being Index (WHO-5). Overall, participant well-being increased by an average of 54%.

COMMUNITY-FOCUSED EARLY INTERVENTION PROGRAMS CF5 Youth as Parents	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**100**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$500,000**
Estimated Annual Cost Per Client (for direct service programs only)	**$5,000**

1. Program Description

The Youth as Parents Program serves pregnant and parenting youth who are at risk of behavioral health problems and their children. The goal of the program is to prevent or mitigate the onset of behavioral health issues in the teen parents and to identify such issues in their children early in their development. Services include case management, brief counseling, parenting training and education groups, and referral and linkage to community resources.

2. Outcomes

During FY 12/13, 87 teen parents were served by the Youth as Parents Program. In addition, 1,505 teen parents were served in parenting workshops throughout Orange County, including 182 teen fathers at the Youth Leadership Academy. The Parenting Tasks Checklist was used to measure changes in a parent's self-efficacy (confidence) in their ability to successfully handle their children's difficult behaviors in a variety of situations/settings. A higher score indicates a higher level of self-efficacy. Based on 28 matched pretests and post-tests, parenting self-efficacy increased for 86% of the participants. Their scores improved by an average of 23%.

The majority (72%) of participants also showed improvements in general well-being as measured by the World Health Organization Well-Being Index (WHO-5), and among these participants whose well-being improved between pretest and post-test, scores increased by an average of 35%.

COMMUNITY-FOCUSED EARLY INTERVENTION PROGRAMS CF6 Behavioral Health Counseling Program	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17*	**600**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$1,800,000**
Estimated Annual Cost Per Client (for direct service programs only)	**$3,000**

*In the chart above, the annual estimated number to be served in FY 14/15, 15/16 and 16/17 is considered to be the same; however, the actual number to be served in the first year will be less than in subsequent years due to the program start-up process, such as hiring staff and contract procurement. The exact numbers to be served in the first year will depend on the program implementation date.

1. Program Description

The Behavioral Health Counseling Program will provide behavioral health treatment services for all age groups including short term counseling and psychiatric services for those not meeting the criteria at the community mental health clinics. Staffing will include psychiatrist, behavioral health nurse and clinicians with the capacity of supervising a team of interns to further increase the program's capacity.

2. Outcomes

Services are scheduled to begin FY 14/15. Outcome measures will be determined as part of the program evaluation plan which will include the completion of a program logic model. Proposed outcome measures may include the PHQ-9 (adult and adolescent versions) and GAD-7, for measuring decreases in symptom severity for depression and anxiety, as well as the WHO-5, for measuring improvements in general well-being.

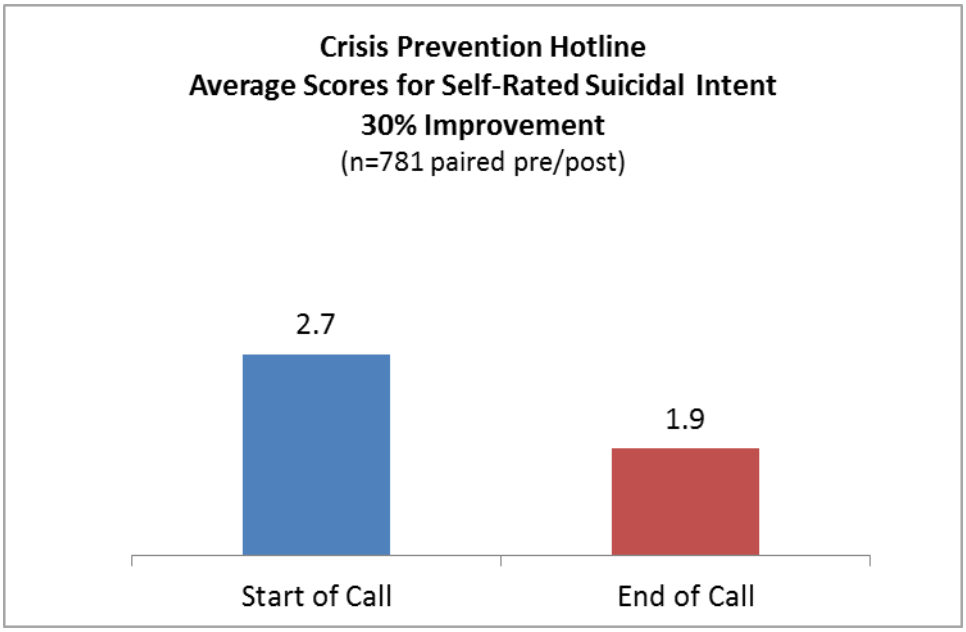
COMMUNITY-FOCUSED EARLY INTERVENTION PROGRAMS CF7 Crisis Prevention Hotline	
Estimated annual number of calls in FY 14/15, 15/16 & 16/17	**6,500**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$272,533**
Estimated Annual Cost Per Client (for direct service programs only)	**$42**

1. Program Description

The Crisis Prevention Hotline is an accredited 24-hour, toll-free suicide prevention service available to anyone in crisis or experiencing suicidal thoughts. Services include immediate, confidential over-the-phone assistance for anyone seeking crisis and/or suicide prevention services for themselves or someone they know. Hotline counselors will also conduct follow-up calls for individuals who give their consent to ensure their continued safety. Callers who are not experiencing a crisis are triaged and offered access to a WarmLine or other appropriate resources.

2. Outcomes

During FY 12/13, 5,843 callers were served by the Crisis Prevention Hotline and a total of 6,565 calls were received. Crisis calls made up 69% of the calls received, 26% were information/referral, and 5% were classified as “other”. Almost 50% of participants with both pre- and post-survey scores showed a decline in their risk for suicide during the call, as measured by a Suicidal Intent Assessment. Risk for suicide is scored on a scale of 1-5, with 5 indicating a higher level of risk. As shown in the graph on the following page, the average score for participants decreased from 2.7 at the beginning of the call to 1.9 at the end of the call indicating an average 30% reduction in self-rated suicidal intent. Additionally, 3,602 participants were referred for other services.


Crisis Prevention Hotline
Average Scores for Self-Rated Suicidal Intent
30% Improvement
(n=781 paired pre/post)
2.7
1.9
Start of Call
End of Call

COMMUNITY-FOCUSED EARLY INTERVENTION PROGRAMS CF8 Survivor Support Services	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**200**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$270,693**
Estimated Annual Cost Per Client (for direct service programs only)	**$1,353**

1. Program Description

Survivor Support Services provides support for those who have lost a loved one to suicide, and educates the community on suicide prevention and intervention. These services include outreach, crisis support, bereavement groups, individual support, and training. Trainings on suicide prevention and survivor support groups are available to Orange County residents and serve a broad range of people whose lives have been impacted by mental illness and, in particular, suicide. Culturally appropriate follow-up care, education, referrals and support target those who have attempted suicide and those who have lost someone to suicide. Through a peer-led group support model, this program aims to provide education and information regarding the personal and social impact of suicide, and to address survivors' emotions and needs. The service is also designed to improve family functioning/communication, identify and understand the factors that promote a survivor's resilience and strength, provide bereavement services and support, and address issues of stigma and shame.

2. Outcomes

During FY 12/13, 200 participants were served by Survivor Support Services. The majority (67%) of program participants served experienced significant decreases in their level of grief as measured by the Traumatic Grief Inventory (TGI modified). Scores range from 0 to 76, with a higher score indicating a greater degree of traumatic grief. The average scores for traumatic grief decreased from 29.1 to 24.7, a 15% decrease since enrollment.

COMMUNITY-FOCUSED PREVENTION PROGRAMS CF9 Parent Education and Support Services	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**3,400**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$507,590**
Estimated Annual Cost Per Client (for direct service programs only)	**$149**

1. Program Description

Parent Education and Support Services provides parent education to strengthen parenting skills and family communication. The program's over-arching goal is to reduce child abuse and substance abuse, juvenile delinquency, gang violence, learning disorders, behavior problems, and emotional disturbances. The program utilizes an evidence-based training model called COPE and provides parent education classes to parents and caregivers of children ages 0-12.

2. Outcomes

During FY 12/13, 3,372 participants were served by Parent Education and Support Services. The majority (62%) of the program participants served experienced improvement in general well-being as measured by the World Health Organization Well-being Index 5 (WHO 5). Overall, based on 729 matched pretests and post-tests, participant well-being increased by an average of 13%.

The Protective Factors Survey was used to measure changes in family protective factors. Based on 712 matched pretests and post-tests, the majority (56%) of the participants showed improvement in the area of Nurturing and Attachment, and 70% of participants improved or maintained their score in at one or more areas of family protective factors.

COMMUNITY-FOCUSED PREVENTION PROGRAMS CF10 Family Support Services	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**1,600**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$718,424**
Estimated Annual Cost Per Client (for direct service programs only)	**$449**

1. Program Description

Family Support Services provides ongoing support for families struggling with behavioral health issues. The focus is on supporting and educating families about behavioral health and parenting issues to prevent the development of behavioral health problems in other members of the family. Services include group and individual support, weekly peer mentor support, educational workshops, a volunteer family mentor network, family matching and parenting classes. Family Support Services are available to family members/caregivers of individuals with behavioral health issues, and parenting classes are available to parents and caregivers of children ages 13 to 18.

2. Outcomes

During FY 12/13, 1,496 participants were served in Family Support Services. The majority (72%) of participants showed improvements in general well-being as measured by the World Health Organization Well-being Index 5 (WHO-5). Based on 501 matched pretests and post-tests, participant "well-being" increased by an average of 21%.

The Protective Factors Survey was used to measure changes in family protective factors. Between pretest and post-test, the majority (61%) of the participants showed improvements in the area of Nurturing and Attachment, and 77% of participants improved or maintained their score in one or more areas of family protective factors.

COMMUNITY-FOCUSED PREVENTION PROGRAMS CF11 Children's Support and Parenting Program	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**650**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$1,400,000**
Estimated Annual Cost Per Client (for direct service programs only)	**$2,154**

1. Program Description

The 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. Program serves families that have a common parental history of serious substance abuse and/or mental illness; children living with family members who have developmental or physical illnesses/disabilities; children living in families that are impacted by divorce, domestic violence, trauma, unemployment, homelessness, etc.; and children of families of active duty military/ returning veterans. This program focuses on reducing risk factors for children and youth and increasing protective factors through parent training and family-strengthening programs. Services include family assessment, group interventions for children, teens and parents, brief individual interventions to address specific family issues, referral/linkage to community resources, and workshops.

2. Outcomes

During FY 12/13, 476 participants were served by the Children's Support and Parenting Program. The majority (60%) of parents showed improvements in general well-being as measured by the World Health Organization Well-Being Index (WHO-5), and among these participants whose well-being improved between pretest and post-test, scores increased by an average of 46%.

The Protective Factors Survey was used to measure changes in family protective factors. Between pretest and post-test, 53% of participants improved in the area of Social Support, and 56% improved in the area of Family Functioning and Resiliency.

The majority of participants showed improvements in parenting skill and child behavior scores as measured by the How's It Going parent survey. Families reported the greatest average improvements in the child decreasing drug and alcohol use (60% decrease), decreasing verbal threats to harm others (58% decrease), and skipping school less (65% decrease).

COMMUNITY-FOCUSED PREVENTION PROGRAMS CF12 PEI Services for Parents and Siblings of Youth in the Juvenile Justice System (Stop the Cycle)	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**450**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$1,000,000**
Estimated Annual Cost Per Client (for direct service programs only)	**$2,222**

1. Program Description

The Stop the Cycle Program serves a broad range of families from different backgrounds whose family member's actual or potential involvement in the juvenile justice system may make them vulnerable to behavioral health problems. This program focuses on reducing risk factors for children and youth and increasing protective factors through parent training and family-strengthening programs. Services include family assessment, group interventions for children, teens and parents, brief individual interventions to address specific family issues, and referral/linkage to community resources.

2. Outcomes

During FY 12/13, 196 participants were served by the Stop the Cycle program. The Protective Factors Survey was used to measure changes in family protective factors. Between pretest and post-test, 65% of participants improved in the area of Nurturing & Attachment and 60% improved in the area of Concrete Support.

The majority (70%) of parents also showed improvements in general well-being as measured by the World Health Organization Well-Being Index (WHO-5), and among these participants whose well-being improved between pretest and post-test, scores increased by an average of 50%.

The majority of participants showed improvements in parenting skill and child behavior scores as measured by the How's It Going parent survey. Families reported the greatest average improvements in their child skipping school less (29% decrease), and their child decreasing drug and alcohol use (29% decrease).

COMMUNITY-FOCUSED PREVENTION PROGRAMS	
CF13 Outreach and Engagement Collaborative	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**18,000**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$3,819,044**
Estimated Annual Cost Per Client (for direct service programs only)	**$212**

1. Program Description

The Outreach and Engagement Collaborative provides mental health preventative services to unserved and underserved populations at risk of mental illness and behavioral health problems. It is designed for those people who have had life experiences that may make them vulnerable to mental health problems, but who are hard to reach in traditional ways because of cultural or linguistic barriers. Identification with potential target groups or individuals is accomplished through already established relationships with community organizations, (e.g., non-profits, schools, community agencies, health care providers, first responders, judicial system, correctional system, etc.) that have developed trust with the community and have contact with the individuals, families or groups who require assistance in accessing prevention and/or early intervention services. Staff asks respected members of the community organization to introduce them to those needing information and assistance and maintain the contact with that individual or family until no further assistance is needed. Mental health interventions and wellness activities at community sites focus on coping with the impact of trauma and provide easy and immediate access, information, and referral assistance to culturally competent, early intervention services as needed.

2. Outcomes

During the FY 12/13 more than 18,000 participants were served by the Outreach and Engagement Collaborative. The majority (71%) of participants showed improvements in general well-being as measured by the World Health Organization Well-Being Index (WHO-5). Based on 433 matched pretests and post-tests, well-being increased for participants by an average of 33%.

For the Outreach and Engagement Collaborative Partners that provided services to children and their families, the Protective Factors Survey was administered to caregivers to assess changes in family protective factors. Families reported the greatest average improvements in knowing how to help their child learn and their

perceived social support. Of the participants with matched pretests and post-test, 75% improved in the area of Family Functioning and Resiliency, 66% improved in perceived social support, 50% improved in the area of Concrete Support and 63% improved in area of Nurturing and Attachment.

A total of 16,662 referrals were made to other community services and 33% (5,481) of those referrals resulted in successful linkages. The top linkage categories were mental health care, family welfare, food and nutrition/food stamp/WIC, and adult education/literacy services.

COMMUNITY-FOCUSED PREVENTION PROGRAMS CF14 WarmLine	
Estimated annual number of calls in FY 14/15, 15/16 & 16/17	**25,000**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$441,566**
Estimated Annual Cost Per Client (for direct service programs only)	**$18**

1. Program Description

WarmLine is telephone-based, non-crisis support for anyone struggling with mental health and substance abuse issues. The staff providing the services has been through a similar journey, either as a mental health or substance abuse services consumer, or as a family member of an individual receiving these services. The WarmLine operates Monday through Friday 9am-11pm and Saturday and Sunday 10am-11pm. Additional funding ($76,552) has been budgeted to continue the extended WarmLine hours from 11pm to 3 am as it is anticipated that the previous funding source will discontinue.

2. Outcomes

During FY 12/13, 6,478 callers were served by the WarmLine and a total of 16,352 calls were received. Participant mood was measured by the Profile of Mood States (POMS) with participants stating their mood at the beginning of each call. Participants are then asked how they are feeling at the end of the call. The majority (87%) of participants initially indicating negative mood states showed marked improvement by the end of the call. The WarmLine also serves as an information and referral line. Additionally, WarmLine mentors referred 1,819 participants to other community resources.

COMMUNITY-FOCUSED PREVENTION PROGRAMS CF15 Professional Assessors	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**3,130**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$536,136**
Estimated Annual Cost Per Client (for direct service programs only)	**$171**

1. Program Description

Professional Assessors provide services to individuals that have been exposed to trauma to determine whether further evaluation and referrals to behavioral health services is needed. Services include screening, assessment, case-management and referral/ linkages to community resources. Professional Assessors are placed at community sites likely to encounter individuals exposed to trauma including Veterans Treatment and Family Court, hospital emergency rooms and Evaluation and Treatment Services.

2. Outcomes

During F/Y 12/13, 47 veterans were served by the Veterans' Courts Program. Among the veterans participating in the program 75% experienced a decrease in the severity of their PTSD symptoms, as recorded from their PTSD Check List-Military (PCL-M) scores.

The outcomes measure above is for only one of the services in this program category. The other three Professional Assessor program services have been in various stages of development/ start-up, and data for all Professional Assessor services will be available for FY13/14 for future reporting.

C. PEI Program Information & Outcomes: School-Focused (SF) Programs

SCHOOL-FOCUSED EARLY INTERVENTION PROGRAMS SF1 School Based Mental Health Services	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**800**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$2,000,000**
Estimated Annual Cost Per Client (for direct service programs only)	**$2,500**

1. Program Description

The School-Based Mental Health Services will provide a combination of prevention and intervention services to empower families, reduce risk factors, build resiliency, and strengthen culturally appropriate coping skills in students. These school based-services will also utilize peer-to-peer helping programs to play a role in reducing the alienation and disconnectedness many youth feel from their schools, families, and society.

Services will include parent education, individual/group counseling, crisis intervention, case management, community linkages, referrals, educational groups, screening and early intervention.

2. Outcomes

Services are scheduled to begin late FY 13/14. Outcome measures will be determined as part of the program evaluation plan which will include the completion of a program logic model. Proposed outcome measures may include the Child & Youth Questionnaire, for measuring improvements in youth resilience and coping skills, the PHQ-A, for measuring decreases in symptom severity for depression in adolescents, the Protective Factors Survey, for measuring increases in family protective factors, a parenting and/or family relationship scale, for measuring improvements in parenting skills and/or family relationships, and participant feedback surveys to measure such things as increased knowledge of how to access community resources, satisfaction with the peer-to-peer interactions and overall services.

SCHOOL-FOCUSED EARLY INTERVENTION PROGRAMS SF2 School Based Behavioral Health Intervention and Support-Early Intervention Services	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**16**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$400,000**
Estimated Annual Cost Per Client (for direct service programs only)	**$25,000**

1. Program Description

The School Based Behavioral Health Intervention and Support-Early Intervention Services serves families with children, K-7, experiencing challenges in attention, behavior and learning, and/or Attention Deficit/Hyperactivity Disorder (ADHD). The program provides a regular education school experience with modifications and skill development to meet the psychosocial and academic needs of children and families. Program services include academic support, social skills development, parent training and academic transitional support. The program is for 12-24 months, after which the child is transitioned to the next academic setting.

2. Outcomes

During FY 12/13, 17 children and 33 parents/caregivers were served by the program. The majority (82%) of the student participants showed an improvement in their ability to behave at school, based on the SNAP-IV assessment measures for Attention Deficit/Hyperactivity Disorder (ADHD) symptoms. The majority (83%) of the parent/caregiver participants showed an improvement on the Disruptive Behavior Stress Inventory (DBSI) 40-item tool to assess frequency and severity of specific behavior-related stressors that result from having a child with ADHD. Overall, the parent/caregiver DBSI scores improved by an average of 34%, indicating a significant reduction in stress in the caregivers.

SCHOOL-FOCUSED EARLY INTERVENTION PROGRAMS SF3 School Readiness Program/Connect the Tots	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**1,500**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$1,800,000**
Estimated Annual Cost Per Client (for direct service programs only)	**$1,200**

1. Program Description

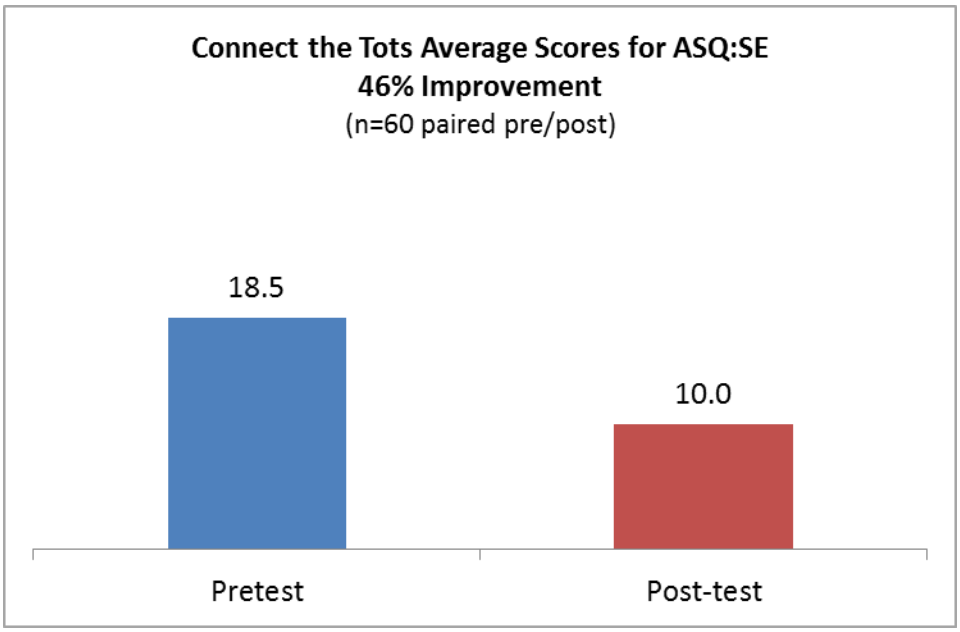
School Readiness Program/Connect the Tots provides services to underserved families with children age 0-6 years who are exhibiting behavioral problems, putting them at increased risk of developing mental illness and experiencing school failure. The focus of these program services is to reduce risk factors for emotional disturbance in young children and to promote school readiness and prepare them for academic success. The School Readiness Program/Connect the Tots services include children's and family needs assessment, parent education and training, case management and referral and linkage to community resources.

2. Outcomes

During FY 12/13, 194 children and 285 parents/caregivers were served by Connect the Tots. Additionally, 41 parenting workshops were provided serving 510 parents/ caregivers out in the community. The Protective Factors Survey was used to measure changes in family protective factors. Connect the Tots families reported the greatest average improvements in their perceived social support, knowing what to do as a parent, and understanding that their child doesn't misbehave just to upset them. Between pretest and post-test, 50% of participants improved in the area of Social Support, and increased their score by an average of 80%.

The Ages & Stages Questionnaires: Social Emotional® (ASQ: SE) was used to measure parent ratings of the frequency of specific child behaviors using age-specific surveys. Between pretest and post-test, 87% of parents reported less frequent child behavior problems. As shown in the graph on the following page,

the average improvement among all paired pre/post-tests was 46%, indicating a significant reduction in these problematic behaviors.



IN addition, the majority (64%) of parents also showed improvements in general well-being as measured by the World Health Organization Well-Being Index (WHO-5), and among these participants whose well-being improved between pretest and post-test, scores increased by an average of 56%.

The contracted School Readiness Program began May 2013 with data to be available for FY 13/14.

SCHOOL- FOCUSED PREVENTION PROGRAMS SF4 College Veteran's Program (The Drop Zone)	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**50**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$150,000**
Estimated Annual Cost Per Client (for direct service programs only)	**$3,000**

1. Program Description

The College Veterans' Program is a collaborative with local community colleges. The program provides services to veteran students on campus at the Veterans' Resource Center. Veteran students have access to appointments with a BHS clinician who is a veteran. Some of the direct interventions available include behavioral health screening and assessment, individualized case management, referrals and linkage to appropriate community resources. The clinician also provides outreach and engagement on Orange County campuses using veteran specific events and support groups to encourage discussion of barriers to successful transition to college and civilian life.

2. Outcomes

During the FY 12-13, 20 veterans were served in case management services by the College Veterans' Program and an additional 452 participants served in campus outreach events and group support sessions. The programs administered the PTSD Check List-Military (PCL-M) to assess changes in participants' PTSD symptoms. It is recommended to use a 5-point minimum threshold for determining whether an individual has responded to intervention and a 10-point minimum threshold for determining whether the improvement is clinically meaningful. Among those veterans who completed the PCL-M, 73% experienced a decrease in the severity of their PTSD symptoms, between the pretest and post-test, and their PCL-M scores improved by an average of 18% (10 points).

The program collected information on general well-being as measured by the World Health Organization Well-Being Index (WHO-5). Overall, well-being increased for participants by an average of 22%. Among the 78% of participants whose overall well-being improved, WHO-5 scores improved by an average of 16 points on the scale of 0-100.

SCHOOL-FOCUSED PREVENTION PROGRAMS SF5 School Based Behavioral Health Intervention and Support	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**20,500**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$1,749,589**
Estimated Annual Cost Per Client (for direct service programs only)	**$85**

1. Program Description

School Based Behavioral Health Interventions and Supports (BHIS) provide services and curriculum for students and their families for the purpose of preventing and/or intervening early with behavioral health conditions. Services are provided in elementary, middle and high schools in school districts that have the highest indicators of behavioral issues, including dropout rates, expulsion, and suspensions. Curriculum is implemented at the classroom level for all students in these schools and more intensive curriculum is available for students and families with a higher level of need.

2. Outcomes

During FY 12/13, 35,150 participants were served by Positive Behavioral Interventions and Supports (PBIS). The majority of schools served experienced improvements in school safety as measured by the School Safety Survey. This survey is intended to measure perceived school safety, and percentages are used to indicate the magnitude of perceived risk and protective factors. Average protective factors increased by 9% from baseline and average risk decreased by 2% from baseline. The majority of high fidelity school sites also showed improvements in suspension rates as measured by school level suspension data. Improvements in the suspension rates are measured by percent reduction in suspension referrals. Average school site suspension decreased by 26%.

BHIS began in July 2013, replacing the PBIS Program. Outcomes data for BHIS will be available for FY 13/14.

SCHOOL-FOCUSED PREVENTION PROGRAMS SF6 Violence Prevention	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**12,775**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$1,287,751**
Estimated Annual Cost Per Client (for direct service programs only)	**$101**

1. Program Description

The Violence Prevention Education (VPE) program's goal is to reduce violence and its impact in the schools, local neighborhoods and families. There are six programs under the Violence Prevention Education component.

Safe from the Start

The Safe from the Start program provides essential knowledge specific to the brain development of young children. This program disseminates scientific research based on how exposure to violence, whether through direct physical impact or witnessing violence, can impact the neurological development of young children. Such exposure can negatively compromise learning and normal cognitive development, as well as social and emotional development.

Gang Reduction Intervention Partnership (GRIP)

The Gang Reduction Intervention Partnership (GRIP) provides case management services in schools across Orange County. GRIP provides services to 4th through 8th grade youth who display signs of being at risk for gang activity. Schools selected for service include sites with high levels of truancy, discipline issues and gang proximity. Case-managed youth are enrolled based on individual rates of truancy, disciplinary issues, and poor academic performance in comparison to other students at the school site.

Crisis Response Network

The Crisis Response Network coordinates, manages and mobilizes a roster of trained crisis responders who are ready and can assemble to assist the school and community in times of emergency or need. The Crisis Response Network is a resource for schools and the community for situations that may be a threat and/or crisis to student(s).

Bullying
The Bullying program provides education for staff, administrators and parents on prevention of bullying and cyber-bullying.

Media Literacy
The Media Literacy program provides training and support for students, parents and school staff on areas related to the use of digital media, bullying, and cyber-bullying. Programs are designed to decrease opportunities for digital harassment, bullying and exploitation at the student level.

Conflict Resolution
The Conflict Resolution program Provides support to students and parents in the development of conflict resolution and peer mediation skills. Training and skill-building activities are available for students to learn and develop needed skills related to solving conflicts at the school level.

2. Outcomes

During FY 12/13, 8,910 participants were served by the Violence Prevention programs. Universal program surveys reflected that the majority of program participants served learned new information, skills or knowledge and planned to use the knowledge/skills presented. Both categories revealed an average rating across programs of 3.7 out of 4. The majority of 6^{th} to 12^{th} grade participants in the cyber-bullying program also showed improvements in cyber bullying knowledge as measured by the program specific pretests and post-tests. Average participant knowledge increased for participants by 30%.

FY 13/14 data will be available in future reporting for OC GRIP which began July 2013. Outcome measures include the Child & Youth Questionnaire, for measuring improvements in youth resilience and coping skills, the Protective Factors Survey, for measuring increases in family protective factors, as well as school data to report increases in school attendance and decreases in truancy and law enforcement data to report decreases in curfew violations.

SCHOOL-FOCUSED PREVENTION PROGRAMS SF7 Transitions	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**2,000**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$915,236**
Estimated Annual Cost Per Client (for direct service programs only)	**$458**

1. Program Description

Transitions is a prevention program serving youth making a transition in their lives, such as transitioning from elementary to middle school and middle to high school. The goal of the program is to develop protective factors and create resilience in youth to better meet the new academic and social challenges and educate parents about these challenges and how they can assist their transitioning youth. Services include curriculum provided in the classroom and workshops for parents and caregivers.

2. Outcomes

During the FY 12-13, 1,540 participants were served by the Transitions program at nine schools. Students were given a pretest and post-test to assess knowledge based on the curriculum. Overall, students demonstrated increased understanding of substance abuse issues and effective communication practices. Between pretest and post-test, 29% more students demonstrated knowledge that assertive communication is the most successful and 16% more students knew the signs of withdrawal from substance use. The parents who participated in the Transitions program expressed high satisfaction ratings overall. Average overall satisfaction with the program was 8.8 on a scale of 0-10 (n=87). In addition, parents were asked to rate how useful specific sessions were, and the majority of parents found them very useful.

In addition to outcome data collected via surveys of Transitions participants, student records data was provided by the school district to track attendance problems of individual students over time. The data compared students who did not receive Transitions to students who did receive Transitions. Over time, 30% of Transitions students had fewer attendance problems compared to 13% of non-Transitions students.

SCHOOL-FOCUSED PREVENTION PROGRAMS SF8 K-12 Coping Skills to Manage Stress	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17*	**4,720**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$120,000**
Estimated Annual Cost Per Client (for direct service programs only)	**$26**

*In the chart above, the annual estimated number to be served in FY 14/15, 15/16 and 16/17 is considered to be the same; however, the actual number to be served in the first year will be less than in subsequent years due to the program start-up process, such as hiring staff and contract procurement. The exact numbers to be served in the first year will depend on the program implementation date.

1. **Program Description**

This program will serve students in grades K-12. Services include utilizing evidence based mindfulness practices to reduce stress and increase coping skills. This program has been piloted in OC schools and shown to promote resiliency and increase students' ability to manage their stress through learned stress reduction techniques.

2. Outcomes

Program not implemented yet. Outcome measures will be determined as part of the program evaluation plan which will include the completion of a program logic model. Proposed outcome measures may include the Child & Youth Questionnaire, for measuring improvements in youth resilience and coping skills, as well as program-specific survey items to assess satisfaction with the program and increased knowledge, self-efficacy (confidence) and/or skills in the area of mindfulness-based stress management.

D. PEI Program Information & Outcomes: System Enhancement (SE) Programs

SYSTEM ENHANCEMENT PREVENTION PROGRAMS SE1 Information and Referral/OC Links	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**8,400**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$800,000**
Estimated Annual Cost Per Client (for direct service programs only)	**$95**

1. Program Description

OCLinks is a telephone and internet chat based information and referral line that serves as a single access point for any community member seeking behavioral health services through the County of Orange's Health Care Agency/Behavioral Health Services department. Clinical Navigators have been extensively trained on all of the Child/Adult Mental Health, Alcohol and Drug inpatient and outpatient, and Prevention/Early Intervention programs provided through County and County contracted operation. Program services include callers' needs assessment and direct linkage to appropriate program.

2. Outcomes

OC Links began providing services in October 2013. Program operations were focused on startup logistics and coordination. Outcome data will be available for FY 13/14. Outcome measures include the number of referrals and linkages and referral sources will be surveyed for satisfaction.

SYSTEM ENHANCEMENT PREVENTION PROGRAMS SE2 Training, Assessment and Coordination Services	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	*****
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$1,184,777**
Estimated Annual Cost Per Client (for direct service programs only)	**Not a direct service program**

*Cannot estimate annual number to be served. There are currently no agreements and we cannot anticipate what agreements may be approved.

1. Program Description

The goal of the Training Assessment Program is to provide a variety of relevant behavioral health-related trainings for the many communities in Orange County. Included in this program, is funding specifically for Crisis Response Network Services for increasing the County's capacity for responding to the mental health needs of the community during disasters and crises.

Since many things have changed in the economy and environment since the original Plan was created, a more up to date needs assessment is needed before the training plans can be developed and implemented. To obtain this information, a Countywide Needs assessment(s) will be completed to determine the current training needs of caregivers and service providers.

Once the needs assessment is completed and the program is implemented, ongoing services will include the development and coordination of county-wide training plans.

2. Outcomes

To be developed upon program implementation. Outcome measures will use pretests and post-tests to measure satisfaction with training and increases in knowledge.

SYSTEM ENHANCEMENT PREVENTION PROGRAMS	
SE3 Training in Physical Fitness and Nutrition Services/Goodwill	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**100**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$50,000**
Estimated Annual Cost Per Client (for direct service programs only)	**$500**

1. Program Description

The Goodwill Fitness Center is a 12,000-square-foot facility specifically designed for people living with physical disabilities or chronic illness. The Fitness Center offers accessible exercise equipment, knowledgeable, trained staff, a personalized fitness program as well as group support and nutrition education classes. This program makes this service available for individuals receiving Behavioral Health Services.

2. Outcomes

During FY 12/13, 103 participants were served. Physical fitness tests are conducted during orientation as part of the gym membership.

SYSTEM ENHANCEMENT PREVENTION PROGRAMS	
SE4 Community-Based Stigma Reduction	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	*
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$214,333**
Estimated Annual Cost Per Client (for direct service programs only)	

*Cannot estimate annual number to be served. There are currently no agreements and we cannot anticipate what agreements may be approved.

1. Program Description

Community-Based Stigma Reduction services provide artistic events and activities that support self-confidence and hope in consumers and their family members and educate the general public about the abilities and experiences of those living with a behavioral health issue. Activities include art workshops and exhibits, musical and dance performances representing many cultures, and other activities as approved. These events provide a creative outlet and entertainment with consistent messages aimed at ending the silence of mental illness.

2. Outcomes

During FY 12/13, Community-Based Stigma Reduction program provided artistic events and activities to 685 participants. The art classes resulted in a significant increase in the quality of life of participants served as measured by the World Health Organization Well-being Index (WHO-5). Between pretest and post-test, participants' WHO-5 scores increased by an average of 17%.

Additionally, the Recovery Scale was utilized to assess attitudes towards people with mental illness having the capability to overcome their psychological problems. Possible scores range from 13 to 117 with lower scores representing less negative attitudes. The average scores decreased by 5%.

SYSTEM ENHANCEMENT PREVENTION PROGRAMS SE5 Statewide Projects	
Estimated annual number to be reached in FY 14/15, 15/16 & 16/17	**35,946**
Annual Budgeted funds for FY 14/15, 15/16 & 16/17	**$900,000**
Estimated Annual Cost Per Client (for direct service programs only)	**$25**

1. Program Description

Statewide Prevention and Early Intervention (PEI) Projects include the Suicide Prevention, Stigma and Discrimination Reduction and Student Mental Health Initiatives. Suicide Prevention activities include social marketing and training to support helpers and gatekeepers identify and respond to suicide risk and work with local suicide prevention partners to respond to individuals in crisis through hotlines. Stigma and Discrimination Reduction activities include implementation of best practices to support help-seeking behavior, build knowledge and change attitudes through development of policies, protocols, and procedures; informational/online resources; training and educational programs; and media and social marketing campaigns, including cultural adaptations to engage and inform underserved racial and ethnic communities. Student Mental Health activities include partnerships from Kindergarten-Higher Education to change school climate and campus environments by promoting mental health, engaging peers, providing student screening and providing technical assistance and social media campaigns to support efforts, increase awareness and engage community locally.

2. Outcomes

An interim evaluation report of the three Statewide Projects has been drafted by CalMHSA, with research conducted by the RAND Corporation. A general population survey was conducted to establish baseline levels of knowledge, attitudes, and beliefs about Suicide Prevention, Stigma and Discrimination Reduction and Student Mental Health. Surveys will continue to be used to measure changes in these areas as well as additional measures for specific activities in Orange County. Future outcomes reporting will be coordinated with CalMHSA.

Innovation

600 W. Santa Ana Blvd., Suite 510, Santa Ana, CA 92701 | (714) 667-5600 | MHSA@ochca.com | www.OCHealthinfo.com/MHSA

Innovation

A. Component Information

An innovative project is defined, for purposes of the CA Department of Mental Health (DMH) guidelines, as one that contributes to learning rather than a primary focus on providing that service. By providing the opportunity to "try out" new approaches that can inform current and future practices/approaches in communities, an innovation contributes to learning in one or more of the following three ways.

1. Introduces new mental health practices/approaches including prevention and early intervention that have never been done;
2. Makes a change to an existing mental health practice/approach, including adaptation for a new setting or community;
3. Introduces a new application to the mental health system of a promising community driven practice/approach or a practice/approach that has been successful in non-mental health contexts or settings.

The Innovation (INN) programs are research projects to evaluate the effectiveness of new approaches and practices. By their very nature, not all INN projects will be successful. Innovation projects are expected to be about one to three years long - although in some instances the length of the project may be extended. A thorough evaluation of each project will be conducted and the findings disseminated. Those projects deemed "unsuccessful" will be discontinued. To continue those projects showing positive outcomes, another funding source must be identified.

In addition to contributing to learning, all of the current Orange County Innovation Projects serve one or more of the following purposes:

1. Increase access to underserved group
2. Increase the quality of services, including better outcomes
3. Promote interagency collaboration
4. Increase access to services

The initial nine Innovation projects share a common theme, which is the involvement of consumers and family members (Peer Specialists) to provide services and/or direct the activities involved in the projects. In some cases, it is precisely this consumer and family member involvement in implementing the project that is the greatest innovation. In other cases, nearly all aspects of the

project, including the involvement of consumers and family members, are innovative. A major purpose of our innovation projects, in addition to their other learning goals, is to increase paid employment opportunities for our trained consumers and family members and to assess how well this works.
The overarching question we seek to answer from the 9 projects is: “Can a well-trained consumer/family member be an effective paraprofessional in all clinical settings?”

The nine initial Innovation projects are:

1. Integrated Community Services
2. Collective Solutions formerly Family Focused Crisis Management and Community Outreach
3. Volunteer to Work
4. OC ACCEPT (formerly OK to Be Me)
5. OC4Vets (formerly VetConnect)
6. Community Cares Project
7. Project Life Coach
8. Training to Meet the Mental Health needs of the Deaf Community
9. Brighter Futures (formerly Consumer Early Childhood Mental Health)

Now all of the nine projects have been implemented. In the FY 2013/14 Annual Update, an additional eight programs were approved locally. Of these three were deemed not to be innovative by the MHSOAC. The five remaining programs were approved by the MHSOAC on April 24, 2014.

B. Project Information & Outcomes: Group 1 (9 Projects)

Group 1 INN 1. Integrated Community Services	
Estimated number to be served in FY 14/15, 15/16 & 16/17	**600**
Budgeted funds for FY 14/15, 15/16 & 16/17	**No new funds**
Estimated Annual Cost Per Client (for direct service programs only)	**N/A**

1. Program Description and Implementation Status

The Integrated Community Services (ICS) pilot project provides outreach to the medical community to facilitate bi-directional services and fully integrate both physical and mental health care. This collaboration with community medical clinics and county mental health programs is a healthcare model that will prove to bridge the gaps in service for the underserved low-income community and increase overall health outcomes for the participants involved.

There are two components to the Project: ICS Community Home and ICS County Home. In the ICS Community Home project, a Mental Health Team (Psychiatrist, and/or a BHS Clinician and Mental Health Caseworker/ Peer Specialist) collaborates with existing community health clinics such as Southland Health Center, Central City Community Health Center and KCS Health Center. The mental health team complements existing patient services and allows full integration of patient care in each location. This program provides services to adult Orange County residents who are Medi-Cal or MSI enrolled or eligible and have both a chronic primary care and a mental health care need. The team provides medical case management, care coordination, supportive counseling, educational groups, medication consultation, and linkage to community resources. The program provides services in English, Spanish, Vietnamese and Korean.

The ICS County Home project provides primary medical care services to transitional age youth, adults and older adults, who are residents of Orange County, are Medi-Cal or Medical Services for the Indigent (MSI) eligible or enrolled, have a chronic health problem and are currently receiving behavioral health services at an Orange County Behavioral Health Clinic in Santa Ana, Westminster or Anaheim. A Medical Doctor, Registered Nurse and a Medical Care Coordinator/Peer Specialist provide medical care, case management, care

coordination, supportive counseling, educational groups, medication consultation, and linkage to community resources. The program provides services in English, Spanish, Vietnamese and Korean.

2. Outcomes

Individuals with a serious mental illness can have a life span that is dramatically shorter than the general population. Many factors can play a role, but potential factors include inadequate medical care, and the failure to integrate the patients' behavioral health care with their physical health care. The ICS program aims to integrate primary health care with behavioral health care; therefore, measures in both areas are taken throughout the program.

One mental health measure used is the Patient Health Questionnaire (PHQ-9). The PHQ-9 is a nine-item depression screening tool based on the nine DSM-IV criteria for depression. The PHQ-9 scores range from 0 to 27 as indicated in the table below.

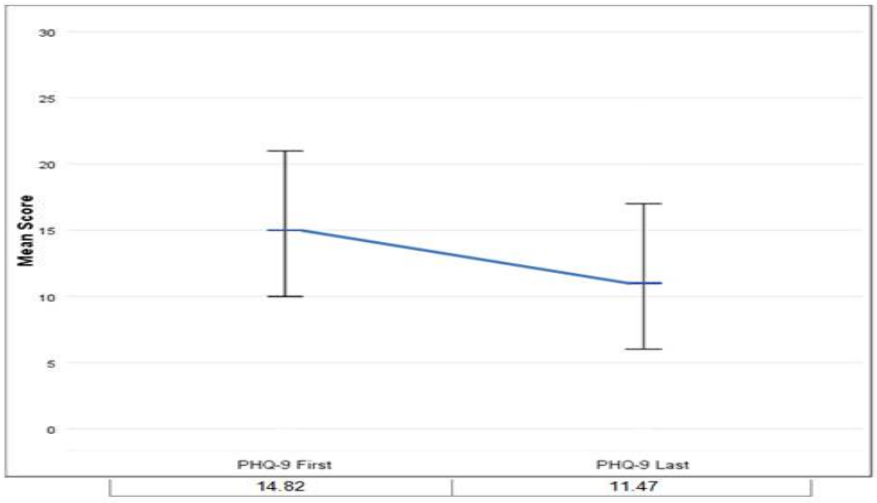
PHQ-9 Depression Scale

Total Score	Depression Severity
0-4	None-Minimal
5-9	Mild Depression
10-14	Moderate Depression
15-19	Moderately Severe Depression
20-27	Severe Depression

Upon intake, each participant is given the PHQ-9 as a pre-test (baseline) measure and post-tests are given upon follow-up visits. The PHQ-9 was given at least twice to 397 participants during FY 2011/2012 and FY 2012/2013. There was a mean of 222 days between the first and last administration. The scores of paired samples were evaluated to determine whether participants' depression decreased while receiving both physical health and mental health services during the stated timeframe. The mean for the first score was 14.82 while the last administration mean was 11.47. On average, scores decreased by 3.34 points, a statistically significant improvement. This difference is shown in the figure below.

Change in Depression Scores

(from first to last administration of the test)



Within the ICS Program participants are required to meet with their Primary Care Physician (PCP) at least once every three months to follow-up on their chronic health condition. Several physical health measures are taken at each patient's intake and at each medical visit. Two of the more common chronic health conditions seen are hypertension (high blood pressure) and diabetes.

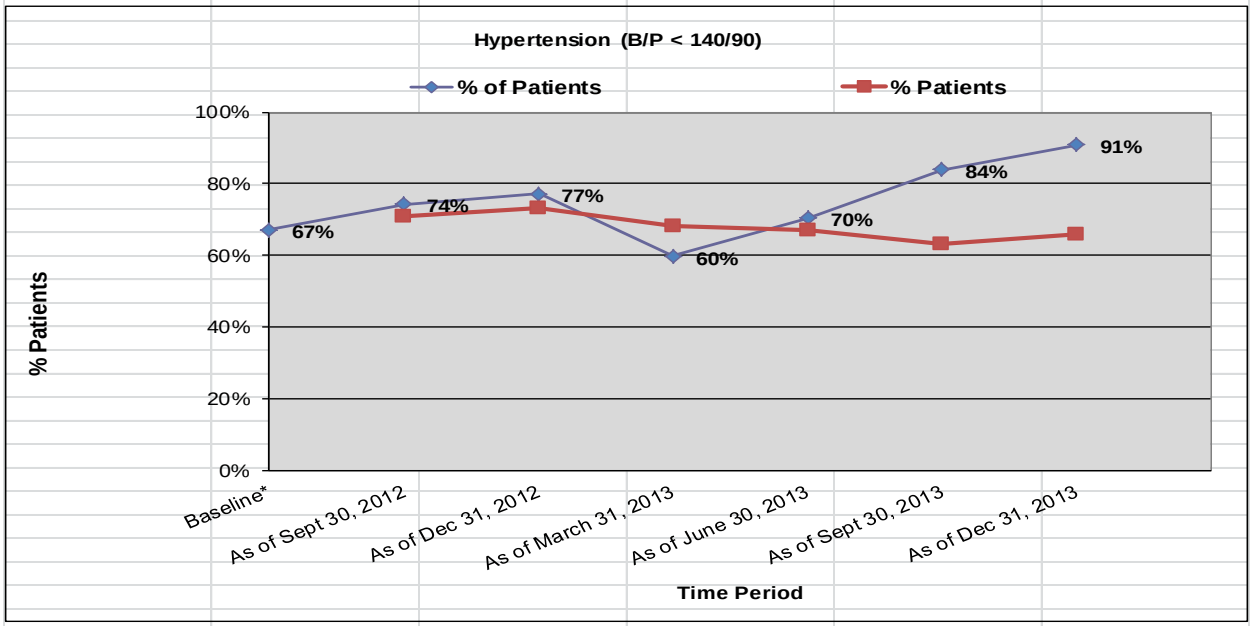
The Program studied the improvement of ICS hypertensive participants in the period from September 2012-December 2013 and compared it to the

improvement for the non-ICS Southland Health Center Clinic hypertension patient population. It was found that the quality measures improved dramatically with ICS participants versus the general clinic population in controlling their blood pressure over the course of 15 months. Please see chart and graph on the following page.

Control of Hypertension

Hypertension (B/P < 140/90)

Time Period	Denominator: Eligible patients ages 40 to 85 with diagnosis of HTN during measurement period (no diabetes)	Numerator: Number of patients with last BP less than 140/90 during measurement period	Quality Measure: % Patients	Goal	Total Patient % Patients
Baseline*	73	49	67%	74%	
As of Sept 30, 2012	66	49	74%	74%	71%
As of Dec 31, 2012	61	47	77%	74%	73%
As of March 31, 2013	62	37	60%	74%	68%
As of June 30, 2013	71	50	70%	74%	67%
As of Sept 30, 2013	81	68	84%	74%	63%
As of Dec 31, 2013	88	80	91%	74%	66%



Note: Beginning April 1, 2013 all persons with hypertension included in denominator (including persons with diabetes)

Blood pressure control rate for your ICS patient subset = 91.7%

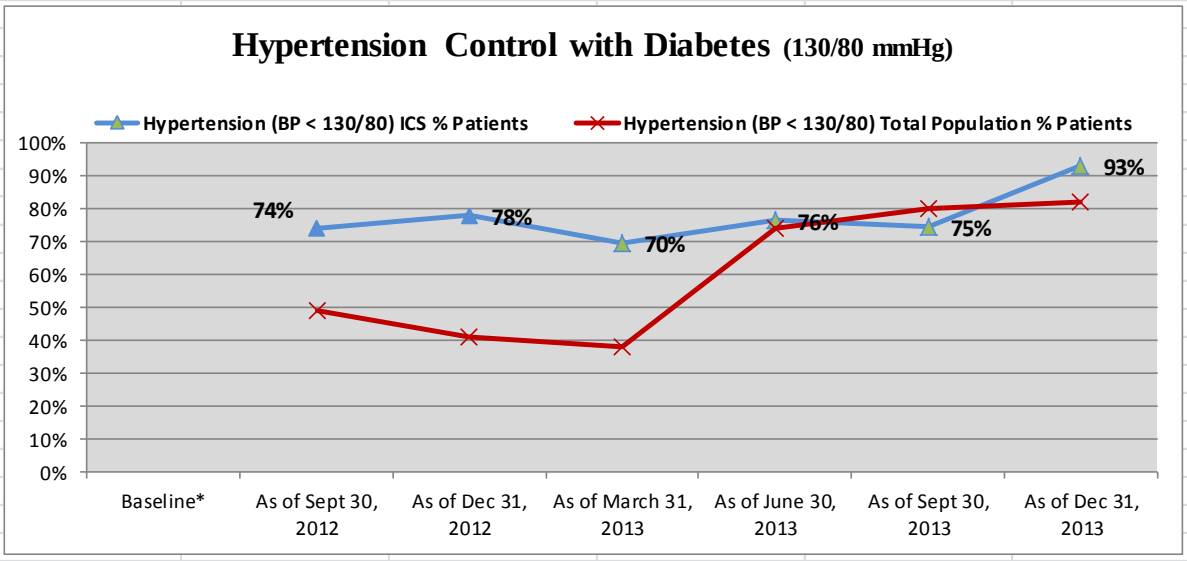
For diabetic patients, it is important for them to control their blood pressure to prevent a stroke or hemorrhages. When looking at ICS participants who were diagnosed with both diabetes and hypertension, ICS participants showed

significant improvement in controlling their blood pressure when compared to the general diabetic and hypertensive clinic patient population.

Please see table and graph below:

Hypertension Control with Diabetes (BP <130/80mmHg)

Time Period	Denominator: Eligible patients ages 40 to 85 with diagnosis of HTN during measurement period (no diabetes)	Numerator: Number of patients with last BP less than 130/80 during measurement period	ICS % Patients	Goal: Goal:	Total Population % Patients
Baseline*					
As of Sept 30, 2012	35	25	74%	55%	49%
As of Dec 31, 2012	45	35	78%	55%	41%
As of March 31, 2013	66	46	70%	55%	38%
As of June 30, 2013	59	45	76%	55%	74%
As of Sept 30, 2013	55	41	75%	55%	80%
As of Dec 31, 2013	48	44	93%	55%	82%



Blood Pressure Control for ICS patient subset = 93.3%

Group 1 INN 2. Collective Solutions	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**150**
Annual budgeted funds for FY 14/15, 15/16 & 16/17	**No new funds**
Estimated Annual Cost Per Client (for direct service programs only)	**N/A**

1. Program Description and Implementation Status

Collective Solutions is a 16-week project that provides counseling and supportive services to families struggling to cope with a loved one's mental illness. Collective solutions seeks to assist families by raising awareness about mental illness, increasing positive communication, connecting families to community resources, and developing an individualized plan of action to help support their loved ones.

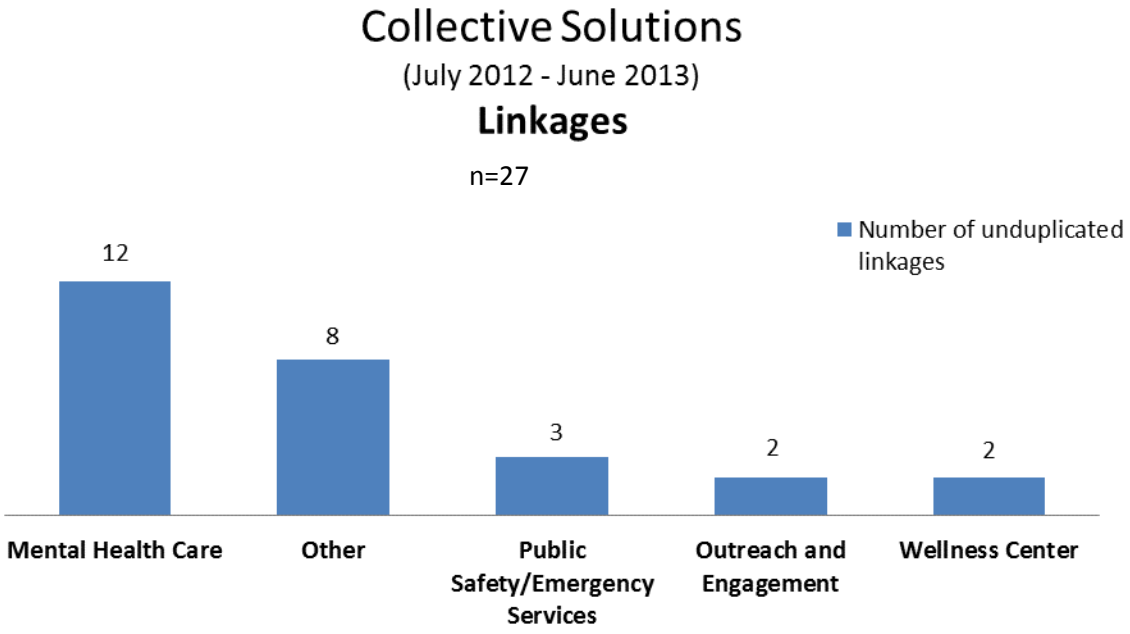
Collective Solutions is staffed with two master's level clinicians and three peer specialists. Clinicians and peer specialists provided weekly services to participants as well as additional family members impacted by their loved ones struggle with mental illness. Program services initially limited to 16-weeks were extended for participants who requested additional support and counseling, resulting in an extension of services up two years in most cases due to the severity of impact on family members. Peer specialists provided case management services, guiding program participants to appropriate resources, services, and agencies within Orange County. Families were successfully linked to community resources, including mental health care, public safety and emergency services, and programs aimed at educating the public about mental illness (i.e., NAMI Peer and Family to Family, Mental Health First Aid).

Program participant's completed the GAD-7, PHQ-9, Protective Factors Survey, and WHOQOL administered at the initial meeting and every four months throughout the duration of services. The GAD-7 and PHQ-9 were utilized to measure the level of anxiety and depression related to coping and managing a loved one's mental illness. Program services provided by clinicians focusing on coping skills, relaxation, stress-reduction, and self-care aimed at decreasing scores on the GAD-7 and PHQ-9 at the end of services. The Protective Factors survey was utilized to measure family functioning/resiliency, and social support.

Program goals aimed at increasing positive communication and crisis management focused on increasing levels of resiliency and social support as measured by the Protective Factors Survey. The WHOQOL was utilized to determine the extent of improvement in participants' quality of life.

2. Outcomes

Referrals and linkages are both considered outputs of program activities. A linkage is considered an outcome when a referral or hand-off results in participants or their family members receiving needed health care or supportive services. Collective Solutions has linked program participants, as well as their family members, to mental health care and supportive services within Orange County, including programs aimed at mental health care (e.g., Adult Mental Health Services, NAMI Warmline, NAMI Family-to-Family, NAMI support groups, Outreach and Engagement, Casa de la Familia, Community Cares), Public Safety/Emergency Services (e.g., Centralized Assessment Team, Evaluation and Treatment Services, Adult Protective Services), Recreation (e.g., Wellness Center), among others (e.g., Legal services/Advocacy, Social Services Agency, housing assistance, adult literacy and education, patient's rights advocacy, and job placement).



In addition to serving program participants, Collective Solutions extended services to family members also impacted by their loved one's struggle with mental illness. While 37 participants were enrolled for program services, a total of an additional 35 individuals and family members were provided with services to cope with and manage their of stress.

Group 1 INN 3. Volunteer to Work	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**100**
Annual budgeted funds for FY 14/15, 15/16 & 16/17	**No new funds**
Estimated Annual Cost Per Client (for direct service programs only)	**N/A**

1. Program Description and Implementation Status

Volunteer to Work (VTW) is a contracted project currently delivered through Goodwill Industries of Orange County (GIOC). Volunteer to Work is a consumer-run program that utilizes trained peer specialists to facilitate the preparation and involvement of program participants in volunteer and paid jobs in the community. The focus will be on the development of stepwise volunteer positions as opportunities to "try out" employment roles, while being supported by other consumers. The purpose is to obtain a gradual and flexible work role program with a continuing supported employment model. The mission is to support Participants living with a mental health diagnosis to overcome barriers and reach the highest level of personal independence.

Services include providing training and educational tracks which incorporate a combination of career training classes to Participants, computer training classes, social groups and event outings. Then a 90-day personally tailored and goal-oriented volunteer training position at a host site in Orange County of the Participant's choosing is offered to each individual. The program provides support to Participants throughout the entire process with Peer Support Specialists, all of whom are trained consumers or family members of consumers.

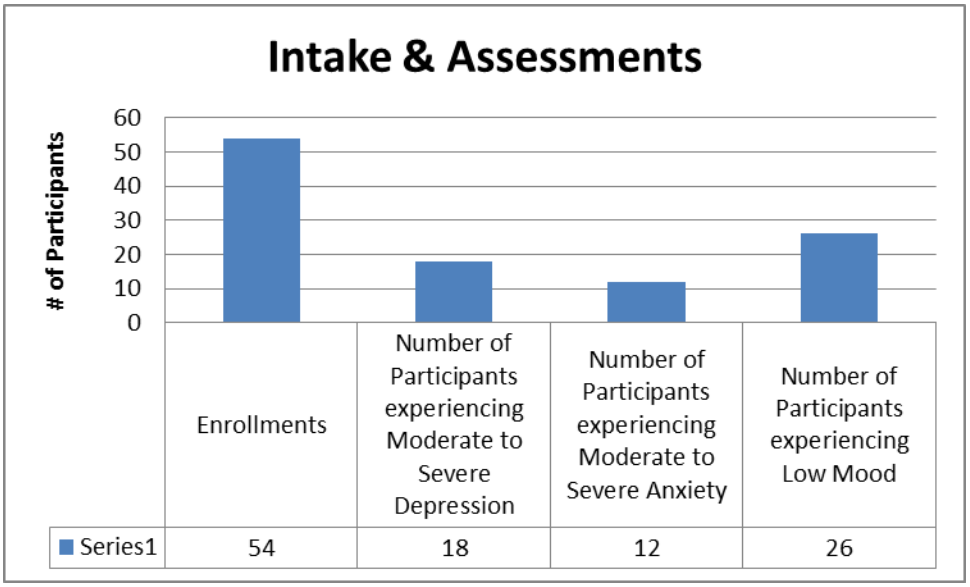
Volunteer to Work began services in fiscal year 13/14 and will run through fiscal year 14/15. If deemed successful VTW will continue services with alternate funding sources.

2. Outcomes

Since the program began, Volunteer to Work has had 54 persons actively enrolled in the project, with 14 volunteer placements in the community. Two persons have graduated from the program, meaning they successfully completed 90 days at a given site. Graduation from the program may mean a competitive

wage position, but that isn't always the case. The experience gained from the program is used as a starting point to gain relevant experience, skills, and network at the volunteer position site. If employment isn't reached at graduation, VTW staff link the consumer with e-works, a public supported employment program (one stops), Project Life Coach (another Innovations program), or help them with the next step which might be to continue in their volunteer position.

VTW uses surveys at intake, time of placement, 90-days of successful volunteer work, and at 90-day post-graduation to measure depression, anxiety and well-being. An increase in depression and anxiety survey scores indicate a higher level severity of symptoms, while a lower score on the well-being survey indicates lower mood. Of the 54 Participants entering the program, 22% had scores indicating moderate to severe anxiety, 32% had scores indicating moderate to severe depression, and 47% had scores indicating low mood or worse sense of well-being.



Once a Participant is placed, the second set of surveys is administered. Starting a new job seems to trigger increased anxiety and depression and decreased sense of well-being. For the 18 placements, when compared to baseline scores, 44% of scores indicated an increase in anxiety, 44% scores indicated an increase in depression, and 33% scores indicated a decrease in well-being. After 30 days at volunteer placements, the participant's anxiety and depression reduced far below their original intake assessment baselines with increases in their overall well-being.

One of the VTW successful graduates enrolled in the program and was assigned to a Peer Support Specialist (PSS) and Employment Specialist (ES). She began taking the training track courses and meeting with her ES to develop a host site. After reviewing the options, she applied to volunteer at the Heritage Museum. The team prepared her for the interview and the screening went well. She began her volunteer assignment the same week. Her training included help with creating outreach material. This included painting an oil based portrait (one of her passions) for the host site.

After this assignment ended, she transferred over to the Delhi Center to complete her 90 days. There she was assigned to the Children's after school art program as the lead teacher. She continues to teach the after school class. Once she graduated, she was referred to Goodwill Industries OC Beyond Jobs supported employment program to continue her transition into the workforce.

Group 1 INN 4. OC ACCEPT	
Estimated number to be served in FY 14/15, 15/16 & 16/17	**150**
Budgeted funds for FY 14/15, 15/16 & 16/17	**No new funds**
Estimated Annual Cost Per Client (for direct service programs only)	**N/A**

1. Program Description and Implementation Status

OC ACCEPT (formerly OK to Be Me) provides community-based mental health and supportive services to individuals struggling with and/or identifying as Lesbian, Gay, Bisexual, Transgender, Intersex or Questioning (LGBTIQ) and the important people in their lives. The program specializes in addressing issues that are common in the LGBTIQ community, such as confusion, isolation, grief and loss, depression, anxiety, suicidal thoughts, self-medication with drugs, high risk behaviors, self-esteem challenges, victimization by bullying, trauma, homelessness, and lack of familial support. *OC ACCEPT* seeks to provide a safe environment with acceptance and compassion for individuals to express their feelings, build resilience, become empowered and connect with others for support. The program also raises awareness and reduces stigma by providing education about the LGBTIQ population to the community at large. The program provides services to Orange County residents in English, Spanish and Vietnamese. *OC ACCEPT* began serving participants in June of 2011.

2. Outcomes

In fiscal year 12/13, OC ACCEPT provided service to a total of 127 unduplicated participants. Individuals engage in a variety of services, including: case management, individual/family counseling, and social support services. Table 1 provides a brief demographic data summary of participants served. Individuals ages 0-15 made up the smallest group (4%). Whereas, individuals ages 26-59 made up almost half of all participants (47%). Participants who identify as females made up 21% and those identifying as males made up 65% of those served. Moreover, individuals who identify as transgender made up more than 12%.

Table 1: FY 12/13 Age-Gender						
Age	**Female**	**Male**	**Transgender**	**Other**	**Declined to State**	**Total**
0-15	2	3	0	0	0	5
16-25	11	30	11	0	0	52
26-59	12	41	5	1	1	60
60+	2	8	0	0	0	10
Total	**27**	**82**	**16**	**1**	**1**	**127**

In addition to providing direct services to participants, OC ACCEPT provides LGBTQ Cultural Competency Trainings and conduct promotional outreach events. These two activities were implemented to increase visibility in the community and increase access to care. Agencies that have utilized the trainings included: Orange County Department of Education, foster care agencies, Transitional Age Youth group homes, social services agencies, Kaiser Permanente, Cal Optima, and Garden Grove Police Department. Table 2 shows a total of 22 cultural competency trainings provided, training a total of 488 individuals. Moreover, table 3 shows a total of 36 promotional outreach events, reaching a total of 1767 individuals.

Table 2: FY 12/13 LGBTQ Cultural Competency Trainings	
# of Trainings	22
# of People Trained	488

Table 3: FY 12/13 Promotional Outreach Events	
# of Outreach Events	36
# of People Outreached	1767

Under the case management component of OC ACCEPT, referrals and linkages are made in order to increase utilization of services in the community. Table 4 on the following page shows the top three types of referrals made: STD/HIV Education and Testing, additional support services, and transgender/primary health care. The first two were also the top two linkages made in fiscal year 2012-2013.

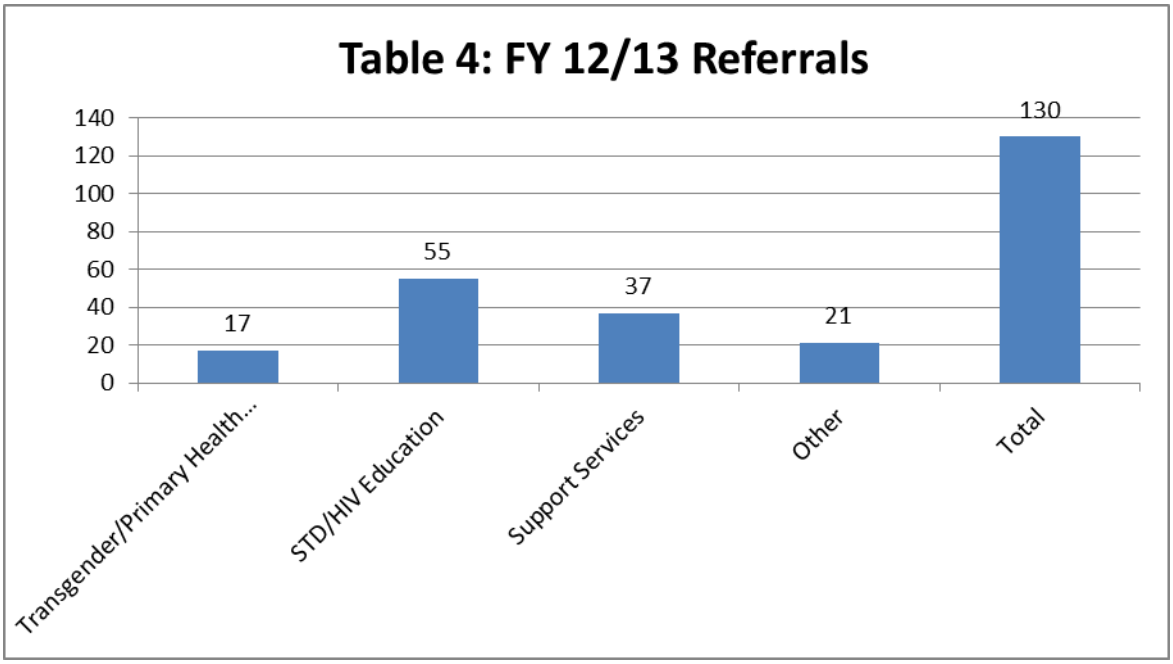


Table 4: FY 12/13 Referrals
140
120
100
80
60
40
20
0
17
55
37
21
130
Transgender/Primary Health...
STD/HIV Education
Support Services
Other
Total

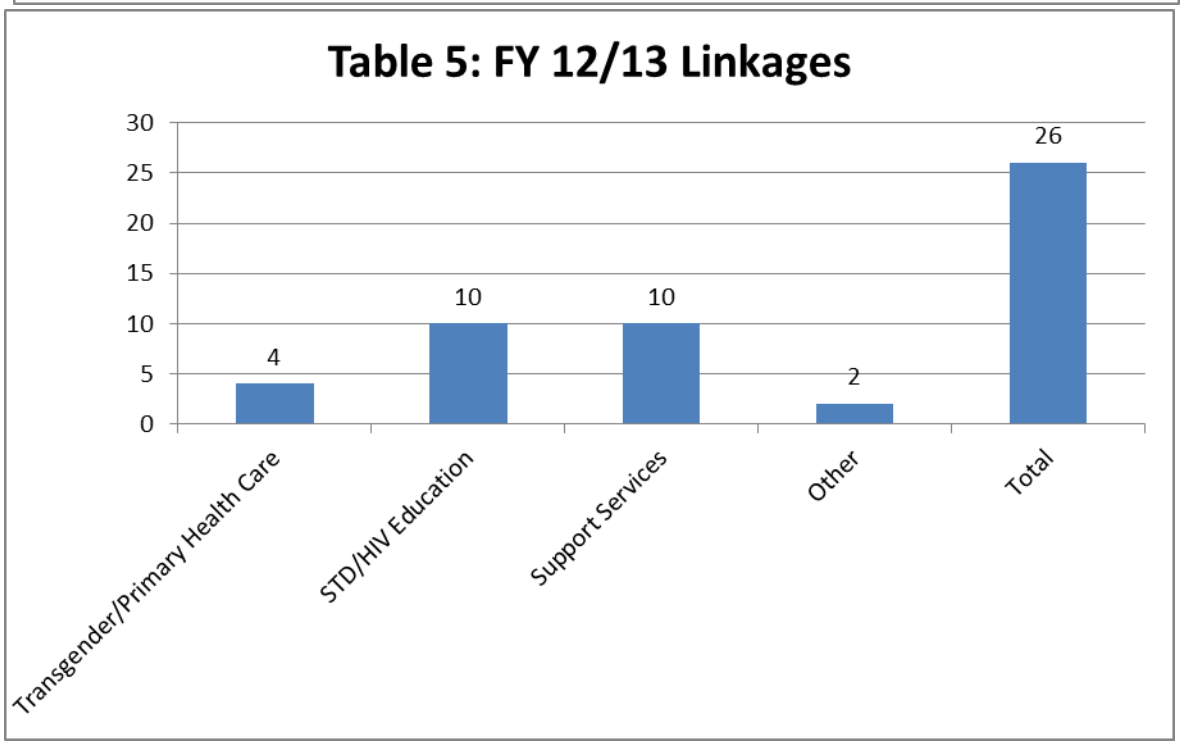


Table 5: FY 12/13 Linkages
30
25
20
15
10
5
0
4
10
10
2
26
Transgender/Primary Health Care
STD/HIV Education
Support Services
Other
Total

Group 1 INN 5. OC4VETS	
Estimated number to be served in FY 14/15, 15/16 & 16/17	**150**
Budgeted funds for FY 14/15, 15/16 & 16/17	**No new funds**
Estimated Annual Cost Per Client (for direct service programs only)	**N/A**

1. Program Description and Implementation Status

OC4VETS is a collaborative project using existing Orange County agencies with expertise in the critical elements necessary for veterans to overcome barriers to obtaining necessary behavioral health preventive services, early intervention, or treatment. HCA/BHS Veterans' Services is the project lead and provides administrative oversight, behavioral health clinical expertise; rehabilitative treatment (via contract); behavioral health case management; referral, linkage, community trainings and outreach activities. OC Community Resources (OCCR) provides services that are complementary to those provided by this project. OCCR's Veteran Service Office (VSO) frequently provides the point of access for veterans, as veterans in need often seek assistance with acquiring veteran benefits, or come to the VSO looking for assistance with other services.

The VSO claim officers are all veterans who have the knowledge and experience to process all aspects of the veteran's benefits and compensation claims. The OCCR's Workforce Investment Board's staff provides job skill enhancement, job search, and housing.

OC4VETS is innovative in its approach to serve veterans and/or their family members by using peers who are veterans or family members, most of whom have experienced behavioral health issues and are in recovery. These peers provide navigation and solid connections with existing community resources. They use the 'buddy system' that is familiar to all military veterans to provide assistance without creating a sense of dependence in the veteran.

2. Outcomes

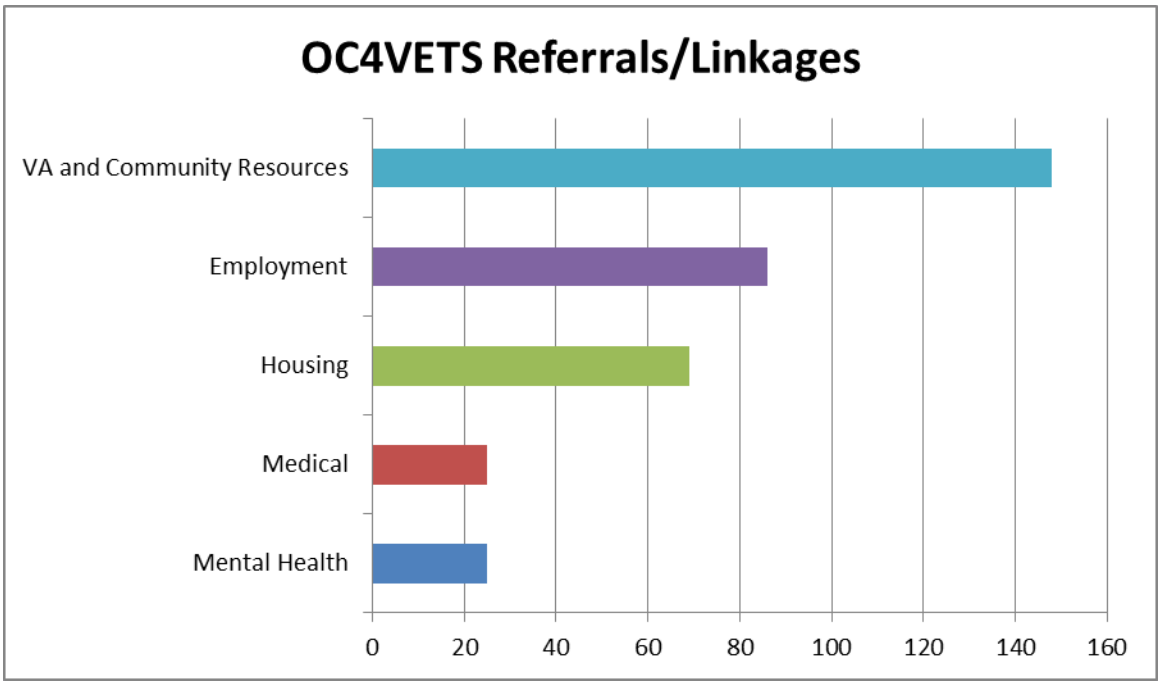
Veterans have been identified as a sub-group (culture) that has existing barriers to accessing behavioral health care. It is assumed that veterans who find it easy (no-lower barriers) to find needed resources are not the focus of this program. The programs' focus is veterans who are not likely to admit that they are experiencing behavioral health problems, or have other barriers to their

accessing needed care. During this first year the program enrolled 108 participants (105 unduplicated). The ethnic breakdown closely follows the demographics of OC veterans identified from the 2010 census data, with slightly more minority participants(45%) than the general OC veteran population. 18% of those enrolled were female.

During this first year of operation, the program assessed the behavioral health needs of participants assessed by administering the SBIRT Screening tool at time of initial enrollment. This tool screens for depression (PHQ-2); anxiety (GAD-2); and substance use disorders (SUD) (Audit-3). Of the 105 unduplicated participants screened, 70 scored high for anxiety; and 56 scored high for depression. Interestingly, only 16 scored high on the substance disorder AUDIT tool though when clinicians were interviewed, their subjective belief is that probably about 80% or more of all participants have a Substance use disorder related issue.

The PCL-M (Post Traumatic Stress Disorder) assessment tool was also administered to all participants at enrollment. Seventy-one percent of the participants assessed were positive for PTSD symptoms.

One of the other outcomes tracked is the ability to link or refer to appropriate community resources. There were 238 linkages and 115 referrals for the 105 enrolled participants during this first year. Sixty nine linkage/referrals were for housing; 86 were for employment, 25 were for medical and 25 for mental health; the remainder were to various VA and community resources.



19% of all participants were partnered with a Veteran Peer Navigator. Most of these partnerships were during the last six months of the year as the peers were newly hired at the beginning and through the first six months received training before being partnered with participants.

Group 1 INN 6. Orange County Community Cares Project	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**N/A***
Annual budgeted funds for FY 14/15, 15/16 & 16/17	**No new funds**
Estimated Annual Cost Per Client (for direct service programs only)	**N/A**

*This Innovations Project will be discontinued at the end of FY 13/14. A similar program using an alternative funding source is expected to become operational in FY 14/15, and clients from Community Cares will be linked to the new program.

1. Program Description and Implementation Status

The Orange County Community Cares Project (OCCCP) strives to improve access to mental health services and decrease the negative effects of mild to moderate symptoms of depression and or anxiety. The project provides a referral-based system for individuals to receive short-term *pro-bono* mental health treatment by a multidisciplinary team: project lead, clinicians, and peer mentors. Project staff deliver culturally and linguistically appropriate assessments, case management, individual psychotherapeutic services, and follow-up services to evaluate the effectiveness and satisfaction with services.

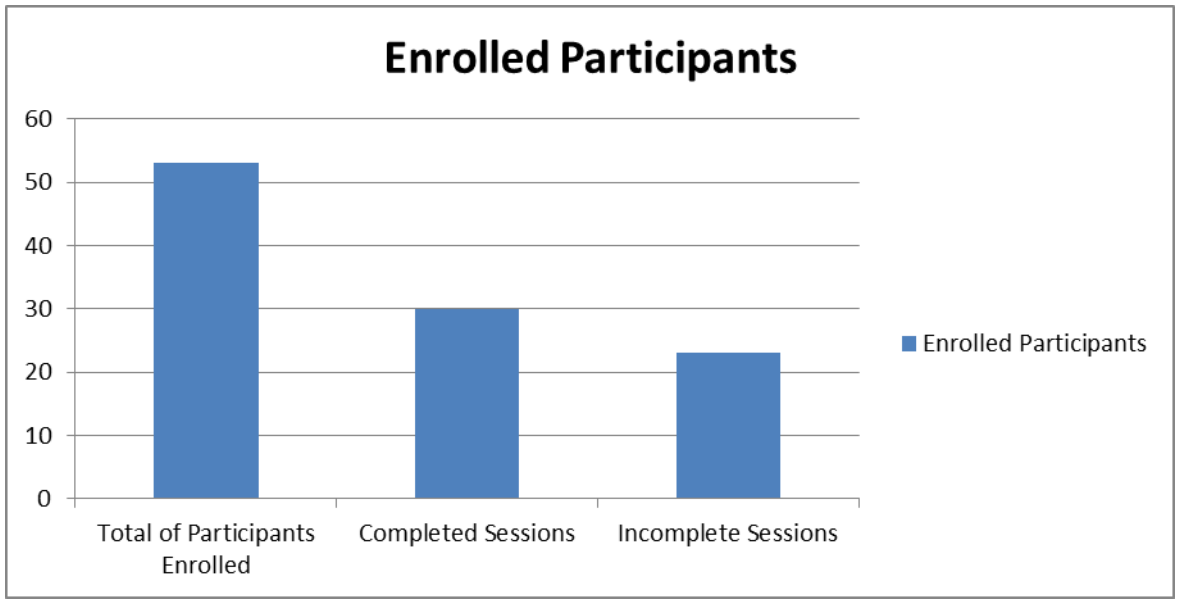
All individuals who are referred to the OCCCP project are initially evaluated by project staff during the intake interview. If eligible, the participant will be linked to a mental health provider in the community who best meets their need for a total of 12 therapy sessions. Project services are provided to Orange County residents with no insurance or benefits who need access to individual therapeutic services and possess mild to moderate symptoms of anxiety and/or depression. The program provides services in English, Spanish, and Vietnamese.

2. Outcomes

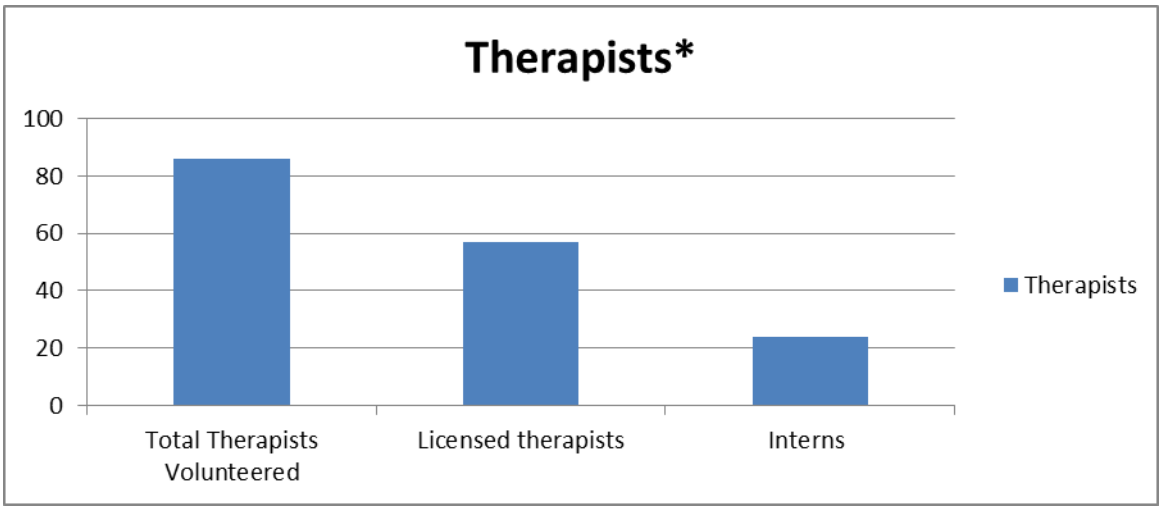
Community Cares Project will report two outcomes in the FY 2012/2013, dates July 1st, 2012- June 30th, 2013. One outcome is the enrollment of participants and the other is the number of therapists that volunteered to deliver pro- bono therapy.

Outcome 1: A total of 53 participants were enrolled in the program during this time. Out of 53, 30 participants completed their therapy sessions and 23 participants did not complete their sessions.

*The total number of participants enrolled includes (drop outs) those who never received therapy or minimal sessions, received 1-21 sessions, matched pairs, and post- tests.



Outcome 2: A total of 86 therapists were recruited and volunteered their time to provide pro-bono individual therapy sessions to participants of OCCCP. Of the 86 providers, 57 licensed therapists volunteered and 24 interns have served the participants of OCCCP.



*The total number of therapists includes all those who volunteered, but could not serve clients due to lack of office space, interns who volunteered but did not serve, those who initially agreed to serve and later declined, licensed therapists who utilized interns to serve, and interns or therapists who have served one or more participants.

Group 1 INN 7. Project Life Coach	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**150**
Annual budgeted funds for FY 14/15, 15/16 & 16/17	**No new funds**
Estimated Annual Cost Per Client (for direct service programs only)	**N/A**

1. Program Description and Implementation Status

Project Life Coach (PLC) provides assessment and linkage services to individuals that have been diagnosed with mental illness. Project Life Coach partners with the participants by assisting them to identify their current situation and their future goals. The focus is on monolingual or those with limited English proficiency Latino, Iranian, Vietnamese and Korean community members while remaining accessible to the community at large. Culturally and linguistically appropriate assessments, case management, groups, brief individual therapy and support services are provided by peer specialists and clinicians.

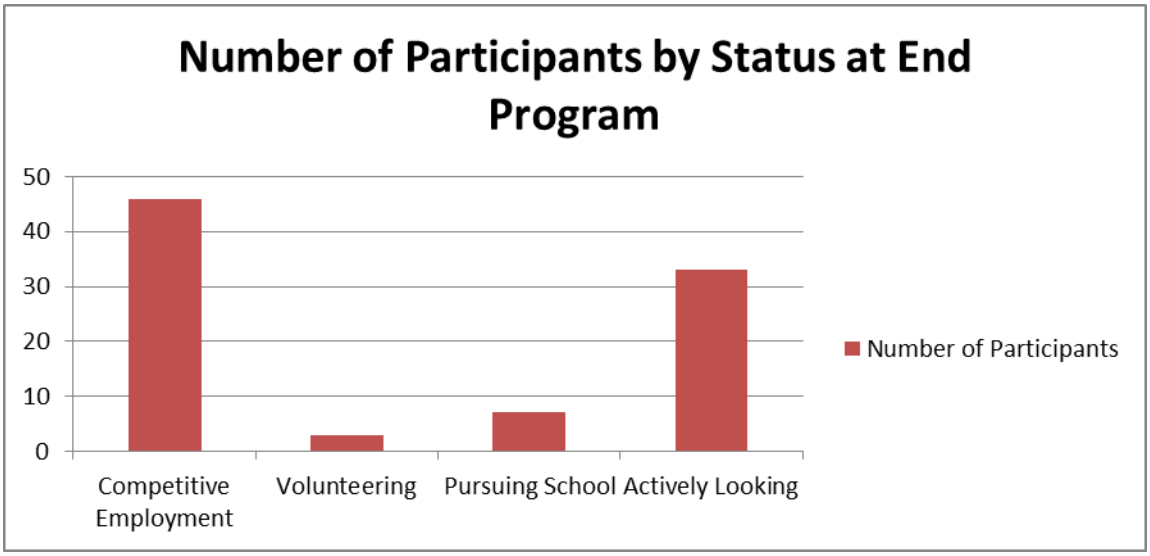
Project Life Coach began implementing services in July 2012. Initially, Project Life Coach was focused on assisting participants with supportive employment services. PLC has expanded services to include coaching in all areas of a participant's life to empower and promote living well. Project Life Coach is staffed with three full-time Master's level clinicians and one part-time Master's level clinician. Services are provided in Spanish, Vietnamese, Farsi and Korean. Participants meet with clinicians initially to complete all intake paperwork and assessments. Clinicians remain on board with the case if both the participant and clinician feel that the participant needs ongoing brief individual therapy. Peer Specialists meet with individuals at least once a week to check-in, provide resources, provide linkages, set goals, and offer on-going strength-based supportive services.

Program participants complete three measures at initial enrollment, six months into the program and at the one year discharge. These measures are the Gad-7, the PHQ-9 and the WHOQOL-BREF 26. The GAD-7 and the PHQ-9 are utilized to assess an individual's level of anxiety and depression. THE WHOQOL-BREF 26 is utilized to assess an individual's satisfaction with different areas in their life. The clinicians provide participants with a Vocational Assessment in which information was gathered regarding the participant's work history, short and long term goals for employment, strengths and barriers in regards to employment,

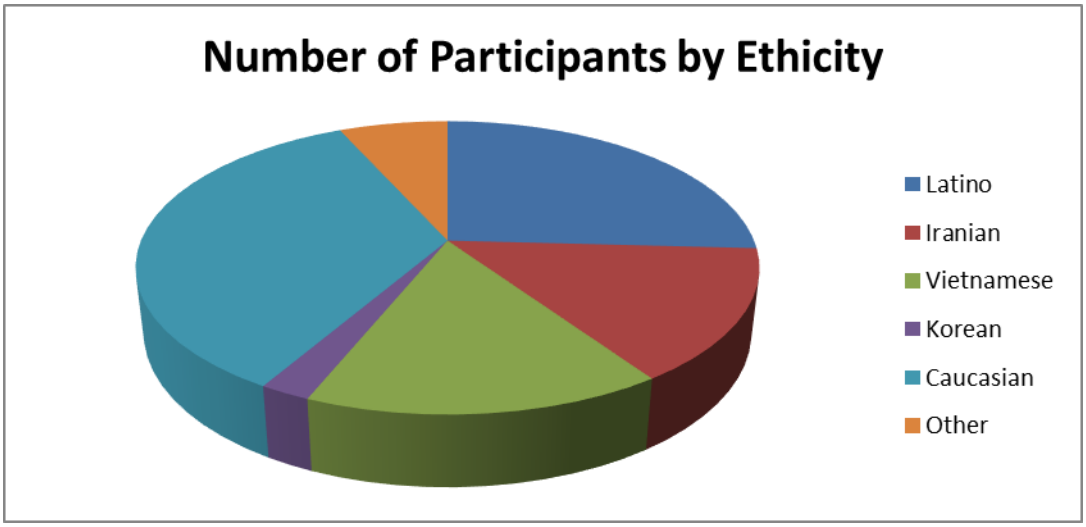
identifying their mental illness and the utilization of coping skills, and services required to assist them in their journey to employment.

2. Outcomes

Project Life Coach has placed 46 out of the 89 of its participants in competitive employment. The 45 participants not placed in competitive employment either opted for volunteer placement or decided to pursue their education as they actively searched for employment on their own.



Project Life Coach has also focused on providing services to the specific ethnicities of the Orange County community, including Latino, Iranian, Vietnamese and Korean community members. Out of the 89 participants that were served, the breakdown is as follows: 23 Latino, 13 Iranian, 14 Vietnamese, and 2 Korean. We have also served the other ethnicities of Caucasian, Indian, Japanese, African-American, and Filipino.



Group 1 INN 8. Training to Meet the Needs of the Deaf Community	
Estimated number to be served in FY 14/15, 15/16 & 16/17	**0***
Budgeted funds for FY 14/15, 15/16 & 16/17	**N/A**
Estimated Annual Cost Per Client (for direct service programs only)	**N/A**

*The funding for this Innovations Project from the MHSA funding dollars will end FY13-14; however, Saddleback College will continue this project as part of the Mental Health Worker Certificate Program. The MHSA funds were to design and implement the program, which has been done. The classes will continue using a different funding source.

1. Program Description and Implementation Status

This Innovations Project is intended to help address mental health needs of the Deaf and Hard-of-Hearing (HOH) community, and is progressing steadily towards its primary goal of training individuals to become mental health workers with the skills and knowledge to help meet the mental health needs of this highly underserved community. Innovations include: a focus on training of Deaf and HOH individuals to serve the community of which they are a part; focused recruitment of Deaf and HOH individuals to become mental health workers serving the Deaf community; developing and implementing innovative teaching strategies to enhance interaction between Deaf, HOH, and Hearing students in the classroom; innovative training for faculty to sensitize them to the classroom needs of Deaf and HOH students; inclusion of students with mental health 'lived experience'; increasing accessibility to instruction for Deaf and HOH students through development and implementation of online course components and addition of Deaf and HOH course curriculum within the mental health certificate training program at Saddleback College. This type of focused outreach, training and integrated learning experiences to benefit the mental health needs of the Deaf and HOH community has never been done before and is laying groundwork for continued advancements in service to this highly underserved community.

2. Outcomes

Components that address the cultural needs of the Deaf and Hard of Hearing (HOH) are embedded throughout the Mental Health courses. To augment these

components, guest speakers, including Deaf and HOH Professionals, are invited to some of the classes to discuss the culturally-specific and mental health needs of the Deaf and HOH, along with the incorporation of specific readings, PowerPoint presentations, topic-specific assignments, and relevant articles, all of which are made available to students in Blackboard.

The first ASL/MH Advisory Committee Meeting was established through this project, and was well attended by a multidisciplinary group of Deaf/HOH professionals and faculty as well as hearing professionals and faculty members. Fifty (50) percent of the 16 attendees were Deaf/HOH from the mental health field. This advisory board will continue to meet on an annual basis.

Ongoing and focused outreach efforts continue to increase the provision of training to Deaf and HOH and Hearing individuals to become mental health workers to meet the needs of the Deaf and HOH community.

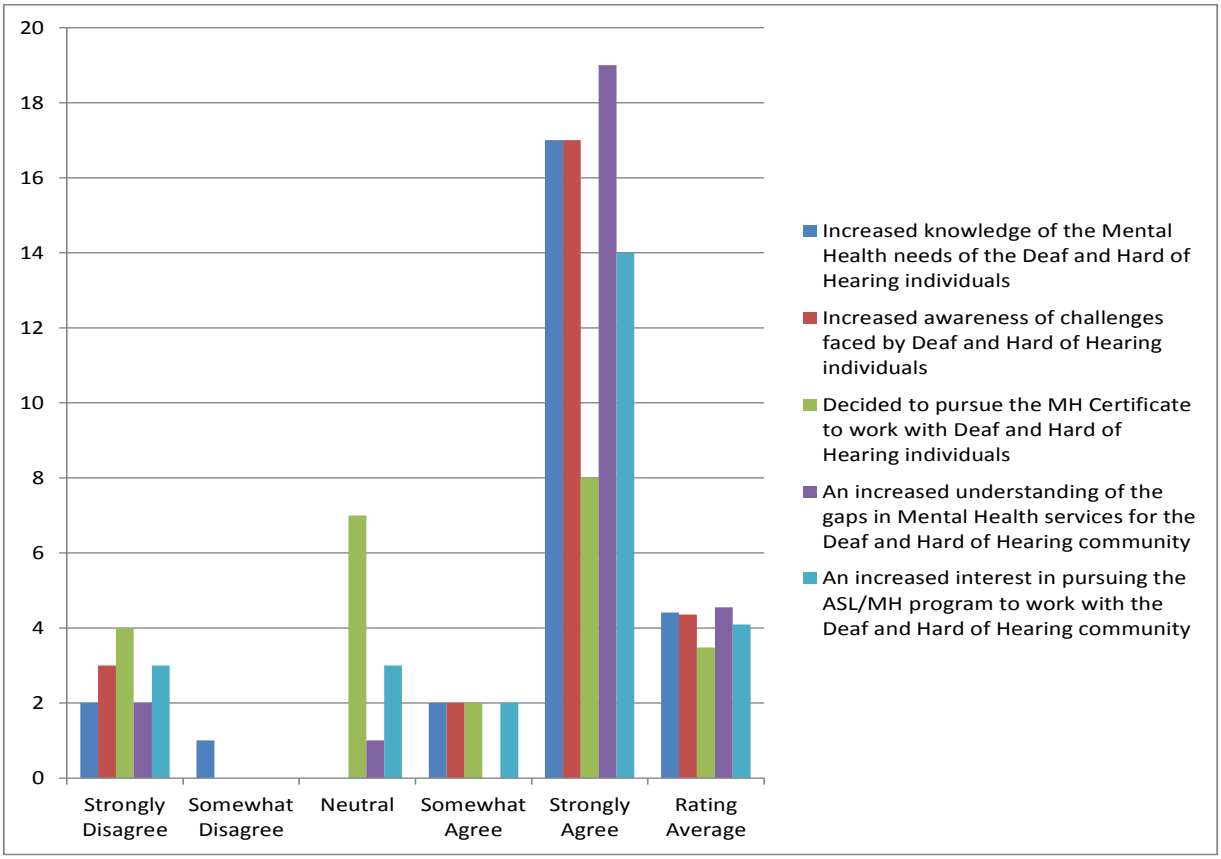
FY 12-13, Fall 2013 Semester: Appraisals were implemented in two of the courses to evaluate students' experiences with learning about the mental health needs of the Deaf and HOH along with other pertinent information relevant to the program.

As noted in the graphs and tables on the following two pages, as a result of taking these courses, in aggregate, 80% of students expressed Increased knowledge of the Mental Health needs of the Deaf and HOH individuals; 84% of the students expressed an Increased understanding of the gaps in Mental Health services for the Deaf and HOH community; and, 36% of the students indicated An increased interest in pursuing the ASL/MH program to work with the Deaf and HOH community.

Student Evaluations HS 100

Saddleback College
Division of Health Sciences and Human Services
Appraisal Results
(MH/ASL Innovation Project)
HS 100
Fall 2013

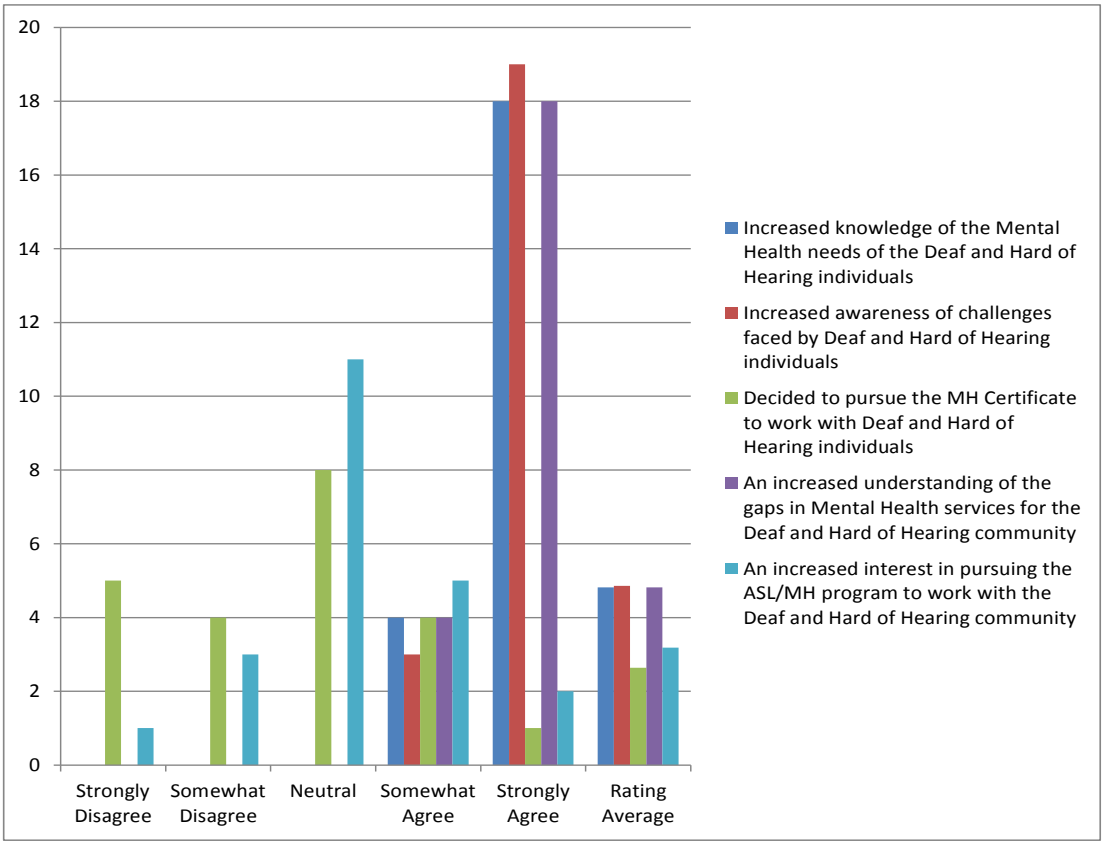
Question	Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly Agree	Rating Average
Increased knowledge of the Mental Health needs of the Deaf and Hard of Hearing individuals	2	1	0	2	17	4.41
Increased awareness of challenges faced by Deaf and Hard of Hearing individuals	3	0	0	2	17	4.36
Decided to pursue the MH Certificate to work with Deaf and Hard of Hearing individuals	4	0	7	2	8	3.48
An increased understanding of the gaps in Mental Health services for the Deaf and Hard of Hearing community	2	0	1	0	19	4.55
An increased interest in pursuing the ASL/MH program to work with the Deaf and Hard of Hearing community	3	0	3	2	14	4.09



Student Evaluations, HS 176

Saddleback College
Division of Health Sciences and Human Services
Appraisal Results
(MH/ASL Innovation Project)
HS 176
Fall 2013

Question	Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly Agree	Rating Average
Increased knowledge of the Mental Health needs of the Deaf and Hard of Hearing individuals	0	0	0	4	18	4.82
Increased awareness of challenges faced by Deaf and Hard of Hearing individuals	0	0	0	3	19	4.86
Decided to pursue the MH Certificate to work with Deaf and Hard of Hearing individuals	5	4	8	4	1	2.64
An increased understanding of the gaps in Mental Health services for the Deaf and Hard of Hearing community	0	0	0	4	18	4.82
An increased interest in pursuing the ASL/MH program to work with the Deaf and Hard of Hearing community	1	3	11	5	2	3.18



Group 1 INN 9. Brighter Futures	
Estimated number to be served in FY 14/15, 15/16 & 16/17	**150**
Budgeted funds for FY 14/15, 15/16 & 16/17	**No new funds**
Estimated Annual Cost Per Client (for direct service programs only)	**N/A**

1. Program Description and Implementation Status

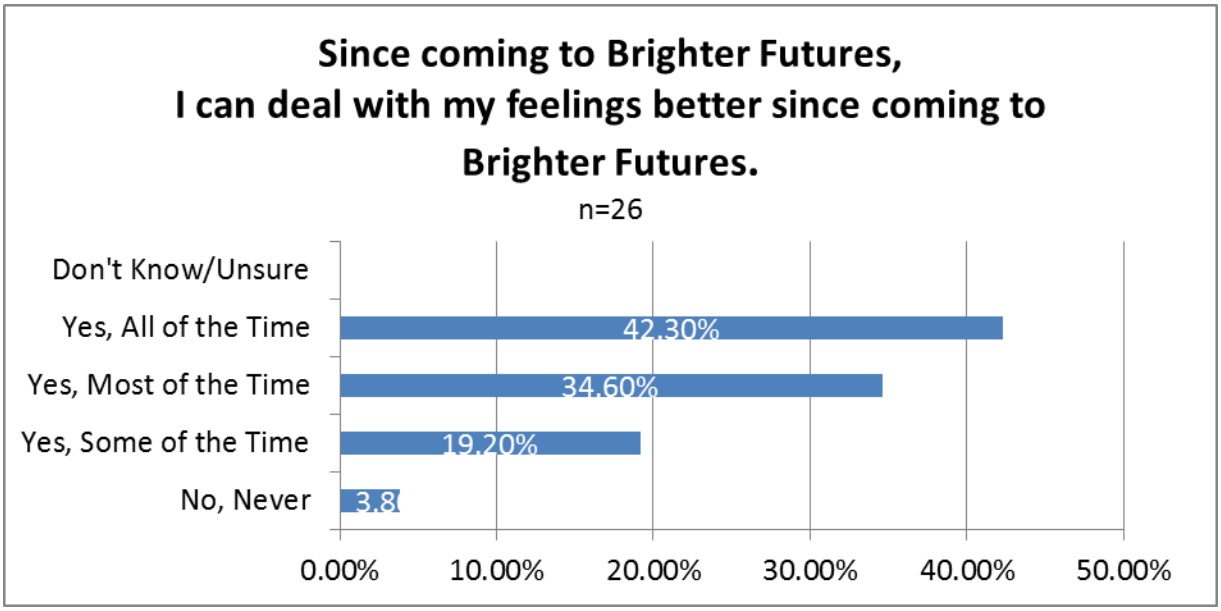
Brighter Futures: (formerly Consumer Early Childhood Mental Health) provides community-based services to families with children who experience social, emotional, and behavioral health problems. The goal is to reduce isolation and form a supportive network. The program offers brief interventions; helps build personal resiliency and healthy relationships between parents and children. A multidisciplinary clinical team provides culturally and linguistically appropriate peer-mentorships, case management, parent education, psychotherapeutic services and linkages to supportive community services. Services are provided to Orange County residents, parents/families with children ages 6-13 years old. At this time, the program provides services in English and Spanish.

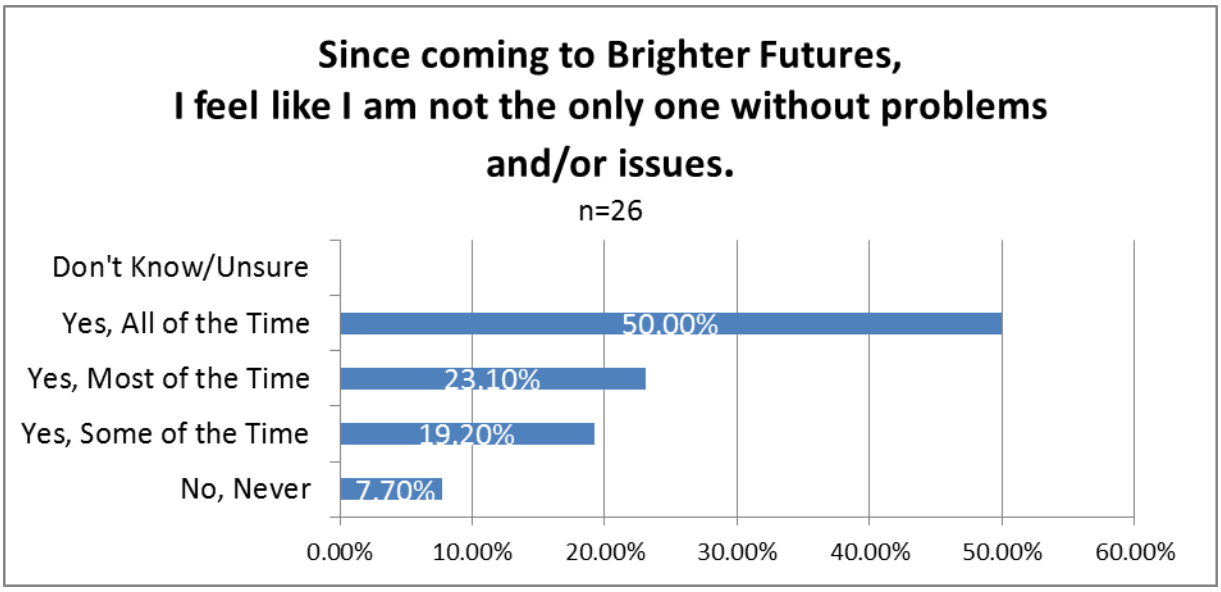
2. Outcomes

The Youth Satisfaction Survey was designed to be answered by the participant. The tool measures satisfaction, knowledge, and socialization. The survey consists of thirteen questions. Response answers are as follow: No, Never; Yes, Some of the time; Yes, Most of the time; Yes, All of the time; don't Know/ Unsure. The survey was completed by 26 participants.

Most youth agreed that they improved their coping skills to manage with problems/issues they face. Many of the participants and their families come from underserved communities with high needs (including trauma). Elements of Trauma Focused-Cognitive Behavior Therapy (TF-CBT) have been utilized in the program to teach participants to identify when they are in distress and how to appropriately cope. In addition, TF-CBT also provides psychoeducation so parents are able to understand the struggles their children face and how best support them.

On the next page are two graphs that depict the results of the Youth Satisfaction Survey.





Half of those surveyed reported feeling that they are not the only individuals with problems and/or issues. Many of participants and their families are in high distress/high needs and are reluctant or unable to seek services due to various barriers such as stigma, culture, or not knowing where to ask for help. Brighter Futures program staff focuses treatment and psychoeducation to normalize/generalize the experience of having problems and/or issues for participants as a means to help reduce stigma and educate participants about mental health.

C. Project Information & Outcomes: Group 2 (5 Projects)

In the FY 2013-14 Annual Update, an additional eight projects were approved locally. Of these eight, three were deemed not to be innovative by MHSA Oversight and Accountability Commission standards. Therefore, the County will move forward with the five remaining projects and work with the County MHSA Steering Committee to identify and select revised or alternate projects to which funds will be reallocated from the three excluded projects.

Information on each of the five new Innovation Projects proposed to be implemented in FY 2014-15 is presented below. A three-year total of $15 million is allocated to the second round projects, with $5 million being allocated each year. These dollars will fund the five newly approved projects, as well as the additional projects yet to be selected and approved locally. The projects are presented in the order that they were ranked by the County MHSA Steering Committee and each is expected to operate a minimum of three years. At the Steering Committee meeting where approval was received, it was noted that the following five projects were identified by the Innovations subcommittee to be of highest priority and that any other projects would be implemented if sufficient funds were available. As such, these five projects will have an annual cost of approximately $2.31 million, which will leave approximately $2.69 million for the additional projects yet to be identified.

The five Group 2 Innovation projects are:

1. Proactive On-site Engagement in the Collaborative Courts
2. Religious Leaders Trained in Mental Health First Aid
3. Access to Mobile/Cellular/Internet Devices in Improving
4. Veterans Services for Military/Veteran Families and Caregivers
5. Skills Sets for Independent Living Project

Group 2 INN 1. Proactive On-site Engagement in the Collaborative Courts	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**300**
Annual budgeted funds for FY 14/15, 15/16 & 16/17	**$416,622**
Estimated Annual Cost Per Client (for direct service programs only)	**$1,389**

1. Program Description

There is a growing need for more integration of education and services between the criminal justice system and the mental health community. With the development of the mental health criminal courts, participants are now being given an opportunity to reduce the severity of their sentence by completing court ordered requirements, one of which is to attend a community based program to obtain a better understanding of their mental health condition. This project is designed to increase access to mental health services by offering mental health education and peer support, with the belief that these services will significantly reduce recidivism.

Bringing a community mental health representative on-site increases and eases access to provide a unique opportunity to engage and offer educational programs that the participant and/ or their family members would not otherwise have had exposure to. Through active engagement, the participant can learn about various programs and services that will help them not only increase their understanding of their mental illness but also learn how to "live well" and productively with their illness.

The physical presence of a community mental health representative is expected to not only increase and ease access to resources and services, but also to help display the support of the court and community to help de-stigmatize mental illness. This integration of mental health services demonstrates to the participants that the court recognizes and values these services. The participant will have many opportunities to connect with the community mental health representative through the various stages of the probation program. During the initial contact with the mental health representative, each participant will complete an intake form. If the participant is not ready to participate in and join the educational program, the participant will continue to check-in with the mental health representative each time they return to court and update their status in the court program, current contact information and desired date and location to take the mental health educational classes.

This project expects to create positive change in the participant's and his/her family's understanding of mental health and how it may affect their daily living. This project uses an innovative approach to reach and provide mental health education and peer support. Employing trained peers (consumers and family members) as community mental health representatives is expected to increase the rapport between the participant and worker which will help reduce the stigma of mental illness through example and empathy. This personal connection will increase the likelihood that the participant will stay engaged through intake, enrollment and ultimately, the completion of the educational program. The re-occurring connection also is expected to help staff to keep in contact with the participant, and update contact information, should the client be in the midst of moving between residences as they get settled.

2. Outcomes

Performance outcomes will be measured by intake, enrollment and mental health education completion statistics, referral and linkages, and pre/posttests measuring mental health awareness. Program outcomes will measure the effectiveness of the mental health and service system navigation education by analyzing court records and self-reported hospitalization history. Other information from intake and quarterly status reports from the Peer Specialist, (such as employment status, housing, medication compliance, hospitalization, probation status, etc.) will also be tracked in a narrative monthly report for additional information related to each participant's level of functioning. The expected program outcomes include, but are not limited to the following:

- Providing mental health education courses to participants' and their families will increase understanding of serious persistent mental illness (to be measured by pre and posttest mental health awareness surveys related to the specific course topics).
- Teaching participants and their families how to navigate the mental health system will increase participants' engagement and access to mental health services (to be measured by tracking referrals and linkages to County and community mental health resources and services).
- As a result of mental health education and learning how to navigate the mental health system, the participants will learn to manage and live well with serious persistent mental illness. As a result of the project services, participants will experience reduced recidivism and hospitalization rates (to be measured by court records and participant self-reports).
- To examine the overall benefits of mental health education, this project will collect and compare data from the 4 years of the Collaborative Court project to 5 years of court records and participant self-reports of jail time and hospitalization prior to the implementation of the project.

Group 2 INN 2. Religious Leaders Trained in Mental Health First Aid	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**30**
Annual budgeted funds for FY 14/15, 15/16 & 16/17	**$315,106**
Estimated Annual Cost Per Client (for direct service programs only)	**$10,504**

1. Program Description

Surveys reveal that some individuals would prefer to first turn to family and friends for help with mental health problems, religious leaders are ranked second, and mental health professionals are ranked last. Most religious leaders have little to no training on mental health issues. A promising direction to increase access to mental health care, reduce stigma and improve community collaboration is to bring Mental Health First Aid training to consumers through the religious community.

This project will use a train the trainer technique where, those in the mental health field along with peer specialists will help to train religious leaders in Orange County on Mental Health First Aid (an evidence-based program) with basic skill sets including, but not limited to, basic listening, suicide prevention and supportive skills. Religious leaders will be trained and certified in Mental Health First Aid practices and, in turn, train other congregants with mental health first aid skill sets.

This project is designed to increase access to mental health services by introducing mental health training into the religious community, which will thereby:

1) Increase the number of lay persons trained in Mental Health First Aid.
2) Increase access to mental health services through religious communities.

At minimum, this project will target a variety of 30 faith-based organizations and religious establishments and their leaders. It is proposed that a leader from each of the organizations will be trained and certified in Mental Health First Aid. In turn, each religious leader must hold three trainings per year to maintain his/her certification. Thus, the number of congregants and community members that each religious leader is estimated to train annually is about 20 per class at three classes per year.

Having this type of training available in the religious community breeds a supportive environment and provides a unique opportunity to engage the participant and/ or their family members to address mental health issues that they might not otherwise have had exposure to. It is important to note that congregants/community members trained are not intended to replace professional support, but merely to assess the person for risk of harm or suicide, listen non-judgmentally, give reassurance, and encourage the person to follow up and seek professional help, they will keep someone safe and stabilized until the professional help is available. The physical presence of a trained mental health first aider not only increases and eases access to resources and services but also helps display the support of the religious community to help de-stigmatize mental illness. This integration of mental health services demonstrates to the participants, that the religious community recognizes and values theses services.

2. Outcomes

Performance outcomes will be measured by intake and enrollment data, self-assessment surveys and interviews. This project will collect data that will help evaluate the utilization and effectiveness of the training program. Enrollment and completion of train-the-trainer and general training numbers will be tracked. Each religious leader and subsequent trainees will be given a survey and a pre and post mental health awareness survey to gauge their increase in knowledge about mental health compared to those religious leaders who did not participate in the project. Each religious leader and those trained will be asked to keep track of mental health referrals and linkages provided and the number of congregants trained by each religious leader After the project's end, if the County chooses to continue these services, the project work plan will explore and consider transition to CSS funding and/or other funding sources.

It is expected that participants of the project who enrolled and completed behavioral health training would show improvement in the following areas, as measured by self-assessment tools:

- Religious Leader Participants will show an increase in understanding/awareness of mental health, as evidenced by an increase in mental health awareness survey scores.
- Trainees (those trained by the Religious Leaders) will show an increase in understanding/ awareness of mental health, as evidenced by an increase in mental health awareness survey scores.
- Participants and trainees will report increased referral/linkage to County/community mental health services and resources, as evidenced by self-report data logs.

Group 2 INN 3. Access to Mobile/Cellular/Internet Devices in Improving Quality of Life	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**50**
Annual budgeted funds for FY 14/15, 15/16 & 16/17	**$271,946**
Estimated Annual Cost Per Client (for direct service programs only)	**$5,439**

1. Program Description

This project is designed to improve health outcomes and the quality of life of adults living with severe and persistent mental illness through the use of mobile devices, cellular technology and the internet.

A recent survey found that the majority of residents living in low-income housing lacked technological connectivity, including but not limited to cellular phones and internet access. Residents of low-income housing in Orange County statistically have less access to technology than those in similar housing situations in other areas. Fewer than 50% of Orange County's supportive housing residents own a cellular telephone and approximately only 25% own a computer with internet connectivity.

In comparison, the Pew Internet and American Life Project (2011-2012) found that 88% of all U.S. adults own a cellular phone (of which 53% own a smart phone with internet connectivity). The Pew Research Center also found that 27% of adults living with a disability in the U.S. are significantly less likely to actively use the internet.

This project strives to connect those on the other side of the digital divide with the capability and resources needed for success, one of which is access to technology. This project will imbed the proposed innovation into its existing programming and community partnerships, using the following methodology:

a. Connecting consumers with affordable digital devices and cellular/ internet services utilizing bulk purchasing and government/ private sector subsidies for accessing affordable technology.

b. Training consumers and persons in their social networks, on the use of technology for personal and professional gain.
c. Engaging peer specialists (employed and volunteer) in the training and support of consumers.
d. Creating networks of emotionally supportive friends and peers on-line.

2. Outcomes

Performance outcomes will be measured by intake data, quality of life self-assessment surveys and weekly one-on-one sessions with the Peer Specialists. Other information from intake and quarterly status reports from the Peer Specialist, (such as mental health management, employment status, housing, medication compliance, hospitalization, social networks, etc.) will also be considered in the measurement of performance outcomes.

It is expected that participants of the project who receive access to technology/mobile smart phones would show improvement in the following areas, as measured by self-assessment tools:

a. Increased access to mental health services (to be measured by self-reports, intake and enrollment information about habits and access before receiving the mobile smartphone to after receipt of by weekly data about mobile smartphone usage, frequency and purpose).
b. Reduced social isolation and increased support networks (to be measured by self-reports, intake and enrollment information about habits and existing social activities to activities and networks after receipt of the mobile smartphones).
c. Increased self-reliance and management of mental health treatment (data on usage, frequency and purpose of mobile smartphone use that might reveal ability to make and keep appointments, medication reminders, etc.).
d. Improved overall quality of life and well-being (to be measured by baseline WHO-5 quality of life survey taken at intake compared to WHO-5 taken at the project's end or when/if a participant leaves the project before its end.

The data from participants who enroll and receive access to technology/mobile devices will be compared to those not enrolled in the project that are in the same housing or FSP programs as our project participants. Data from participants who received the phones in project year one may also be compared to those who received phones in project year two. Comparing these two data sets may contribute additional information to the evaluation, showing those that had use of the phones for two years versus one year had better outcomes, or the results may show that access of any duration has the same benefit for participants.

Group 2 INN 4.	Veterans Services for Military/Veteran Families and Caregivers
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**50**
Annual budgeted funds for FY 14/15, 15/16 & 16/17	**$616,245**
Estimated Annual Cost Per Client (for direct service programs only)	**$12,325**

1. Program Description

OC4Military Families will expand on the current HCA/Behavioral Health Services (BHS) Veterans programs, especially the OC4 Vets program. Experts agree that the entire family unit should be considered when dealing with people in 'recovery'. Using the principles of Recovery-Based Care, it is not practical to only serve the veteran/military member without assisting the other members of the family unit. The tension and stress associated with multiple deployments, discharge from the military, and return to civilian life impacts the entire family and must be addressed for the veteran/military member to be successful. The OC4Military Families will be an adjunct to the current OC BHS programs that have focused primarily on the veteran.

The proposed program will provide trained behavioral health clinicians, and peers to provide services to family members of veterans who are currently either being seen in a behavioral health program (county, VA, or private) and who have direct family members or caregivers that are in need of increased understanding of behavioral health and principles of recovery. Referrals may come from veterans participating in either BHS Veterans programs such as OC4Vets, the Non-Criminal Domestic Violence Veterans' Court, or the Veterans' Courts program, and the 'Drop Zone program. Additionally, referrals will be accepted from the entire community and on a self-referral basis. These family members may also need linkage to resources or require either personal behavioral health intervention, and prevention (i.e., resiliency) or family intervention.

Those eligible to participate in the program will be family units/members who have a close family member (i.e. spouse, child, father, or mother) who has served in the U.S. Armed Forces. Each family member enrolled in this program will be screened and a Family (Individual/Caregiver) Service Plan detailing goals, objectives, and Interventions will be developed for him/her. Peers will provide

participants with a “warm linkage” to appropriate services. Peers will also provide individual or direct support groups, as well as psycho-social education either individually or in groups to facilitate understanding of behavioral health issues and family dynamics (especially with family members suffering from PTSD). Using peers provide individual or group support classes will encourage family members to participate. An effort will be made to match peers with similar race/ethnicity and language backgrounds.

The current innovation project OC4Vets is co-located with OCCR’s Veterans’ Service Office. It is anticipated that the OC4Military Families will also be located in proximity to this site in order to take advantage of support elements from the OC4 Vets program.

2. Outcomes

This program will use standardized screening tools already used for other MHSA Prevention and Early Intervention children and family programs. It will also use the Post-Traumatic Stress Disorder Checklist (PCL-C) to measure for civilian trauma and a comprehensive SBIRT tool; the World Health Organization Quality of Life Questionnaire (WHOQL) and Participant Questionnaire, Child Behavior Check List (CBCL), Dimensions of Anger II (DARII) and Secondary Trauma Scale (STS). These results will be collected at program entry, each 90 days, and at program completion. The expected outcome is that the Military Family Member Peers (MFMPs) will provide an essential service to the family unit by helping them establish a warm linkage with necessary services. The primary measurement tool for this outcome will be a program generated questionnaire and continue engagement with the program. An additional expected outcome will be improved family functioning of the family unit. This will be measured by using published tools to track common secondary trauma symptoms, such as anxiety depression, communication problems, anger and family inter-relational challenges.

Group 2 INN 5. Skills Sets for Independent Living Project	
Estimated annual number to be served in FY 14/15, 15/16 & 16/17	**100**
Annual budgeted funds for FY 14/15, 15/16 & 16/17	**$389,526**
Estimated Annual Cost Per Client (for direct service programs only)	**$3,895**

1. Program Description

This project will provide a foundation for independent living skill sets to empower participants with the confidence for a successful transition to independent living. The target population will include, but not be limited to, individuals who typically have been dependent on others to manage their day-to-day needs; individuals who have not had the opportunity or circumstances to live in a residence without supervision; and/or individuals who have had a history of homelessness or transiency.

This project will target underserved, chronically ill, adult participants who have been homeless or are at risk of homelessness to provide them with an opportunity to learn independent living skills prior to being placed in publically subsidized housing or other living situations. The independent living skills learned will improve the likelihood of the participants retaining their housing and remaining in stable residences and living situations for longer periods of time. Overall, it is expected that this would reduce the participant's tendency to return to homelessness or transient lifestyles.

The SAMHSA Homeless Resource Center report (2009) indicates that a primary barrier to moving from homelessness to more permanent housing was the lack of functional independent living skills. This project will teach participants independent living skills, including but not limited to: medication management, mental health management, transportation, cooking, shopping, cleaning, personal hygiene, organization and scheduling, pet care, safety and problem solving. The project will link the participant with community resources as needed.

- This project seeks to do the following:
- Increase independent living skill sets to identified participants;
- Help identified participants understand daily living skills involved in maintaining stable housing;

- Provide mental health education to give participants a better understanding of their mental health issues as well as the tools and skills necessary to self-manage their mental health independently; and
- Link participants to resources and services to promote indepdent living that the participant would not otherwise have been achieved. Through active engagement, the participant can learn about various programs and services that will help them live well, independently.

This project is expected to create a positive change in each participant's ability to live independently by increasing their understanding of daily living skills, including their mental health and how it may affect their daily living. Employing trained peers (consumers and family members) will engage the participants and serve as a model of competency that participants may achieve. It increases and eases access to independent living with the expectation that increased independent living skills and an understanding of their mental illness will empower clients to retain stable housing for longer periods of time. This project highlights the participant's strengths and the development of resilience in the promotion of recovery and total wellness.

2. Outcomes

Performance outcomes will be measured by intake and enrollment data, self-assessment surveys, pre/posttests and participant interviews. Additionally, all participants will be tracked for completion of independent living skill set courses and follow through on any referrals and linkages given.

It is expected that project participants would show improvement in the following areas:

- Increased participant’s understanding of their own mental health diagnosis (to be measured by pre and posttest mental health awareness survey related to participant’s specific diagnosis and symptoms that are being reviewed and addressed, as related to successful independent living, as identified in each participant’s individual service plan).
- Increased participant’s independent living skill sets while managing mental health symptoms (to be measured by comparing diagnosis and module specific pre/posttests, as outlined in each participant’s individual service plan).
- Increased participant’s quality of life through learning independent living skills (to be measured and compared to periodic self-assessment quality of life (WHO-5) surveys, as evidenced by an increase in the WHO-5 scores).

Capital Facilities and Technological Needs

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Capital Facilities and Technological Needs

The Capital Facilities and Technological Needs (CFTN) component of the Mental Health Services Act (MHSA) was designed to enhance the existing public mental services infrastructure. It provides resources for two types of infrastructure:

1. Capital Facilities funding may be used for the delivery of MHSA services for mental health clients and their families or used for MHSA administrative offices.

2. Technology funding may be used to modernize and transform clinical and administrative information systems and increase consumer and family empowerment by providing the tools for secure consumer and family access to health information.

CFTN funding is one-time funding. Counties were given one allocation to cover both purposes, and were given the discretion to divide the funding between Capital 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.

Use of Capital Facilities Funds

In May 2012, the Health Care Agency completed the construction of a Capital Facilities-funded project on County-owned property located at 401 S. Tustin Street in Orange. The completed project occupies approximately three acres and includes three facilities designated for use by three different MHSA programs, surface parking, underground utilities, sidewalks, landscaping, landscape irrigation, fire lanes, recreation areas, amphitheater, area lighting, building security, signage, and perimeter fencing. The official ribbon-cutting ceremony was held on April 19, 2012. The first program took occupancy and became operational on May 19, 2012 and the remaining two programs were in place and operational by August 2012.

Programs that occupy the Tustin Street Facility include the:

1. Adult Crisis Residential Program, which serves as an alternative to hospitalization for acute and chronic mentally ill persons.

2. Wellness/Peer Support Center, which offers assistance with benefits, employment, socialization, and self-reliance.

3. Education and Training Center, which provides support to consumers and their families who aspire to a career in mental health.

Requirements for Use of Technology Funds

Any MHSA funded technology project must meet certain requirements to be considered appropriate for this funding.

1. It must fit in with the State's long term goal to develop an Integrated Information Systems Infrastructure where all counties have integrated information systems that can securely access and exchange information.

2. It must be part of and support the County's overall plan to achieve an Integrated Information Systems infrastructure through the implementation of an Electronic Health Record (EHR).

Use of Technology Funds

County of Orange Behavioral Health Services (BHS) plans to implement a fully integrated EHR system that supports the goals of MHSA (promote wellness, recovery and resiliency). It will also comply with the federal requirements for Meaningful Use, which will benefit the county's clients. Implementation involves two stages. Orange County has completed the 1st stage of upgrading its infrastructure to provide the necessary platform upon which to develop the functionality needed to further enhance its EHR.

The County has now begun the 2nd stage: building the enhancements to its EHR, Integrated Records Information System (IRIS), which will provide clinical documentation and decision support. This is a large project and will be accomplished in three phases. The 1st phase will be implemented at a select number of Mental Health Outpatient clinics beginning in spring 2014. The 1st phase enhancements include the core clinical documentation management system with clinical decision support; medication and prescription management; mobile access to the EHR; additional technical improvements to Orange County's EHR include document imaging (which includes such functionality as electronic signature pads and the ability to scan documents); compliance auditing, monitoring, and reporting. In later phases, the County will include consumer access via a portal and the ability to securely interface with contract providers and to participate in Health Information Exchanges outside County BHS, as appropriate. Further enhancements will be made to the disaster

recovery system and ensure continued control over clinical data security and privacy.

An additional Technology project is the implementation of kiosks in selected locations to afford increased consumer/family access to computers and the internet. Kiosks have been installed in five outpatient BHS clinics across Orange County in the 1st phase. More are planned at additional clinics next fiscal year.

Housing

MHSA Housing Program Update

1. Program Description and Target Population

The MHSA Housing Program's funding is used to develop new housing for enrolled or eligible tenants. Participants are eligible if they are diagnosed with an included, serious and persistent mental illness and are homeless or at risk of homelessness.

To date this program has built and leased 72 new units of housing. An additional 45 units (within 3 projects) are currently under construction and will be completed before the end of 2014, and another 54 units (within 4 projects, including one shared housing project) are engaged in pre-development activities and if successful will lease by or before 2016, and approximately 12 additional units are under discussion. When the construction is completed this program will have created 183 units of permanent housing for eligible tenants and their families where applicable.

Two projects, representing 34 units total were built using our CSS One-Time funds, and thus are not included in the chart below. Since it is unclear when or if some of these projects are going to be completed it is difficult to determine annual spending or per/resident costs. The following is a current accounting of the original $33,000,000 allocation which was assigned to CalHFA.

	MHSA Units	Total Units	Capital	COSR	Total
			$22,105,500	$11,052,800	$33,158,300
Avenida Villas	28	29	$3,259,600	$3,259,600	$6,519,200
Cerritos Family Apartments	19	60	$2,222,734	$2,222,734	$4,445,468
San Clemente Senior Apartments	15	76	$1,622,400	$400,000	$2,022,400
Doria II	10	74	$1,169,850	$850,000	$2,019,850
Anesi Apartments	11	104	$1,286,835	$1,286,835	$2,573,670
Santa Ines Senior Villas	10	42	$1,216,650	$1,216,650	$2,433,300

	MHSA Units	Total Units	Capital	COSR	Total
CalHFA 1% Administrative Fee			$331,583		$331,583

Total Committed at CalHFA	93	385	$11,109,652	$9,235,819	$20,345,471
Balance Remaining			**$10,995,848**	**$1,816,981**	**$12,812,829**
Planned Units					
Friendship Shelter (Shared)	14	32	$1,703,310	$1,703,310	$3,406,620
A Community Of Friends	18	36	$1,800,000	$1,800,000	$3,600,000
Payne Development	12	39	$1,518,380	$1,518,380	$3,036,760
TBD	12	TBD	$1,459,980	$1,459,980	$2,919,960
Total Pipeline	56	107	$6,481,670	$6,481,670	$12,963,340
Total Committed/Planned	149	492			
Balance Remaining			**$75,256**	**$75,256**	**$150,511**
(+ One Time $ Units)	34				
Total Units	183				

Another recent addition to the program is the addition of two Residential Clinical Services Coordinators (RCSCs) to the Residential Care and Housing Office staff. These masters' level staff members are located at MHSA Housing Program sites to provide additional services to support other clinical services staff and tenants with the ability to respond rapidly to immediate needs for linkage and to provide supplemental clinical services such as groups.

2. Outcomes

- 90% of referred, eligible tenants to remain housed in permanent housing for a minimum of one year.
- The program will complete and lease 56 additional new units during years 2015-17, and complete the construction phase of the MHSA Housing Program.

Exhibit D

Budgets

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

Funding Summary

County: Orange Date: 3/10/14

		MHSA Funding					
		A	B	C	D	E	F
		Community Services and Supports	**Prevention and Early Intervention**	**Innovation**	**Workforce Education and Training**	**Capital Facilities and Technological Needs**	**Prudent Reserve**
A. Estimated FY 2014/15 Funding							
1.	Estimated Unspent Funds from Prior Fiscal Years	46,634,027	39,192,496	17,015,536		9,356,196	
2.	Estimated New FY2014/15 Funding	87,069,090	23,218,424	5,804,606			
3.	Transfer in FY2014/15[a/]	(3,239,645)			3,239,645		
4.	Access Local Prudent Reserve in FY2014/15						0
5.	Estimated Available Funding for FY2014/15	130,463,472	62,410,920	22,820,142	3,239,645	9,356,196	
B. Estimated FY2014/15 MHSA Expenditures		97,391,132	33,281,826	7,615,067	3,239,645	3,908,496	
C. Estimated FY2015/16 Funding							
1.	Estimated Unspent Funds from Prior Fiscal Years	33,072,340	29,129,094	15,205,075	(0)	5,447,700	
2.	Estimated New FY2015/16 Funding	85,490,006	22,797,335	5,699,334			
3.	Transfer in FY2015/16[a/]	(3,239,645)			3,239,645		

4.	Access Local Prudent Reserve in FY2015/16						0
5.	Estimated Available Funding for FY2015/16	115,322,701	51,926,429	20,904,409	3,239,645	5,447,700	
D. Estimated FY2015/16 Expenditures		97,391,132	33,281,826	7,184,131	3,239,645	5,447,700	
E. Estimated FY2016/17 Funding							
1.	Estimated Unspent Funds from Prior Fiscal Years	17,931,568	18,644,604	13,720,278	(0)	0	
2.	Estimated New FY2016/17 Funding	96,080,232	25,621,395	6,405,349			
3.	Transfer in FY2016/17[a/]	(3,239,645)			3,239,645		
4.	Access Local Prudent Reserve in FY2016/17						0
5.	Estimated Available Funding for FY2016/17	110,772,155	44,265,999	20,125,627	3,239,645	0	
F. Estimated FY2016/17 Expenditures		97,391,132	33,281,826	2,371,147	3,239,645	0	
G. Estimated FY2016/17 Unspent Fund Balance		13,381,023	10,984,173	17,754,481	(0)	0	
H. Estimated Local Prudent Reserve Balance							
	1. Estimated Local Prudent Reserve Balance on June 30, 2014		70,921,582				
	2. Contributions to the Local Prudent Reserve in FY 2014/15		0				
	3. Distributions from the Local Prudent Reserve in FY 2014/15		0				
	4. Estimated Local Prudent Reserve Balance on June 30, 2015		70,921,582				
	5. Contributions to the Local Prudent Reserve in FY 2015/16		0				

	6. Distributions from the Local Prudent Reserve in FY 2015/16		0				
	7. Estimated Local Prudent Reserve Balance on June 30, 2016		70,921,582				
	8. Contributions to the Local Prudent Reserve in FY 2016/17		0				
	9. Distributions from the Local Prudent Reserve in FY 2016/17		0				
	10. Estimated Local Prudent Reserve Balance on June 30, 2017		70,921,582				

a/ Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

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

Community Services and Supports (CSS) Component Worksheet

County: Orange Date: 3/10/14

		Fiscal Year 2014/15					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs							
1.	C1 - Children's Full Service Partnership	6,364,297	5,954,575	409,722	0	0	0
2.	T1 - TAY Full Service Partnership	6,924,067	6,334,468	589,599	0	0	0
3.	A1 - Adult Full Service Partnership	17,641,223	14,571,114	2,782,906	0	0	287,203
4.	O2 - Older Adult FSP & Support & Intervention Systems	3,389,981	2,536,395	838,422	0	0	15,164
5.	FSP Percent of Non Admin Programs Below	14,362,439	12,606,231	1,712,837	0	0	43,371
Non-FSP Programs							
1.	C2 - Children's Outreach & Engagement	12,359	12,359	0	0	0	0
2.	C3 - Children's In-Home Crisis Stabilization	1,100,344	759,836	340,508	0	0	0
3.	C4 - Children's Crisis Residential Services	2,528,726	2,302,976	225,750	0	0	0
4.	C5 - Mentoring for Children	352,620	352,620	0	0	0	0
5.	C6 - Children's CAT	1,275,028	956,942	318,085	0	0	0
6.	C7 - OC Children with Co-Occurring MH Services for Children	400,000	400,000	0	0	0	0
7.	C8 - Outpatient Mental Health Services Expansion: Children and Youth	650,000	325,000	325,000	0	0	0

8.	C9 - Dual Diagnosis Residential Treatment	300,000	300,000	0	0	0	0
9.	C10 - Medi-cal Match: Mental Health Services	127,500	127,500	0	0	0	0
10.	T2 - TAY Outreach & Engagement	12,864	12,864	0	0	0	0
11.	T3 - TAY Crisis Residential Services	127,395	119,895	7,500	0	0	0
12.	T4 - TAY Mentoring Program	147,380	147,380	0	0	0	0
13.	T5 - TAY- CAT	272,267	272,267	0	0	0	0
14.	T6 - TAY PACT	853,020	672,069	171,614	0	0	9,337
15.	A2 - Adult CAT	3,609,743	3,005,492	588,251	0	0	16,001
16.	A3 - Adult Crisis Residential	2,145,594	1,320,983	732,010	0	0	92,600
17.	A4 - Supportive Employment	919,275	919,275	0	0	0	0
18.	A5 - Adult Outreach & Engagement	51,770	51,770	0	0	0	0
19.	A6 - Adult PACT	8,323,557	7,298,945	1,003,278	0	0	21,335
20.	A7 - Wellness Center	2,672,503	2,672,503	0	0	0	0
21.	A8 - Recovery Center Program	11,544,885	8,571,946	2,959,293	0	0	13,646
22.	A9 - Adult Peer Monitoring	253,817	249,134	0	0	0	4,683
24.	A10 - Assisted Outpatient Treatment	1,841,125	1,730,360	110,765	0	0	0
25.	A11 - Mental Health Court - Probation Services	696,000	696,000	0	0	0	0
26.	A12 - Drop in Center	425,000	425,000	0	0	0	0
27.	A13 - Housing for Homeless	950,000	950,000	0	0	0	0
28.	A14 - Housing and Year-Round Emergency Shelter	683,590	683,590	0	0	0	0

23.	A15 - Transportation Program	800,000	800,000	0	0	0	0
29.	A16 - In-Home Stabilization Services	1,496,250	1,425,000	71,250	0	0	0
30.	O1 - Older Adult Recovery Services	2,266,857	1,584,728	679,590	0	0	2,538
31.	O3 - Older Adult PACT	649,400	511,199	108,978	0	0	29,223
32.	O4 - Older Adult Peer Mentoring	686,469	673,803	0	0	0	12,666
33.	H1 - CSS MHSA Housing Program Assigned Funds	200,638	200,638	0	0	0	0
CSS Administration		14,954,872	14,856,274	0	0	0	98,598
Total CSS Program Estimated Expenditures		112,012,855	97,391,132	13,975,359	0	0	646,364
FSP Programs as Percent of Total		50.0%					

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

Community Services and Supports (CSS) Component Worksheet

County: Orange Date: 3/10/14

		Fiscal Year 2015/16					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs							
1.	C1 - Children's Full Service Wraparound	6,364,297	5,954,575	409,722	0	0	0
2.	T1 - TAY Full Service Wraparound	6,924,067	6,334,468	589,599	0	0	0
3.	A1 - Adult Full Service Partnership	17,641,223	14,571,114	2,782,906	0	0	287,203
4.	O2 - Older Adult FSP & Support & Intervention Systems	3,389,981	2,536,395	838,422	0	0	15,164
5.	FSP Percent of Non Admin Programs Below	14,362,439	12,606,231	1,712,837	0	0	43,371
Non-FSP Programs							
1.	C2 - Children's Outreach & Engagement	12,359	12,359	0	0	0	0
2.	C3 - Children's In-Home Crisis Stabilization	1,100,344	759,836	340,508	0	0	0
3.	C4 - Children's Crisis Residential Services	2,528,726	2,302,976	225,750	0	0	0
4.	C5 - Mentoring for Children	352,620	352,620	0	0	0	0
5.	C6 - Children's CAT	1,275,028	956,942	318,085	0	0	0
6.	C7 - OC Children with Co-Occurring MH Services for Children	400,000	400,000	0	0	0	0

7.	C8 - Outpatient Mental Health Services Expansion: Children and Youth	650,000	325,000	325,000	0	0	0
8.	C9 - Dual Diagnosis Residential Treatment	300,000	300,000	0	0	0	0
9.	C10 - Medi-cal Match: Mental Health Services	127,500	127,500	0	0	0	0
10.	T2 - TAY Outreach & Engagement	12,864	12,864	0	0	0	0
11.	T3 - TAY Crisis Residential Services	127,395	119,895	7,500	0	0	0
12.	T4 - TAY Mentoring Program	147,380	147,380	0	0	0	0
13.	T5 - TAY- CAT	272,267	272,267	0	0	0	0
14.	T6 - TAY PACT	853,020	672,069	171,614	0	0	9,337
15.	A2 - Adult CAT	3,609,743	3,005,492	588,251	0	0	16,001
16.	A3 - Adult Crisis Residential	2,145,594	1,320,983	732,010	0	0	92,600
17.	A4 - Supportive Employment	919,275	919,275	0	0	0	0
18.	A5 - Adult Outreach & Engagement	51,770	51,770	0	0	0	0
19.	A6 - Adult PACT	8,323,557	7,298,945	1,003,278	0	0	21,335
20.	A7 - Wellness Center	2,672,503	2,672,503	0	0	0	0
21.	A8 - Recovery Center Program	11,544,885	8,571,946	2,959,293	0	0	13,646
22.	A9 - Adult Peer Monitoring	253,817	249,134	0	0	0	4,683
24.	A10 - Assisted Outpatient Treatment	1,841,125	1,730,360	110,765	0	0	0
25.	A11 - Mental Health Court - Probation Services	696,000	696,000	0	0	0	0
26.	A12 - Drop in Center	425,000	425,000	0	0	0	0
27.	A13 - Housing for Homeless	950,000	950,000	0	0	0	0
28.	A14 - Housing and Year-Round Emergency Shelter	683,590	683,590	0	0	0	0

23.	A15 - Transportation Program	800,000	800,000	0	0	0	0
29.	A16 - In-Home Stabilization Services	1,496,250	1,425,000	71,250	0	0	0
30.	O1 - Older Adult Recovery Services	2,266,857	1,584,728	679,590	0	0	2,538
31.	O3 - Older Adult PACT	649,400	511,199	108,978	0	0	29,223
32.	O4 - Older Adult Peer Mentoring	686,469	673,803	0	0	0	12,666
33.	H1 - CSS MHSA Housing Program Assigned Funds	200,638	200,638	0	0	0	0
CSS Administration		14,954,872	14,856,274	0	0	0	98,598
Total CSS Program Estimated Expenditures		112,012,855	97,391,132	13,975,359	0	0	646,364
FSP Programs as Percent of Total		50.0%					

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

Community Services and Supports (CSS) Component Worksheet

County: Orange Date: 3/10/14

		Fiscal Year 2016/17					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs							
1.	C1 - Children's Full Service Wraparound	6,364,297	5,954,575	409,722	0	0	0
2.	T1 - TAY Full Service Wraparound	6,924,067	6,334,468	589,599	0	0	0
3.	A1 - Adult Full Service Partnership	17,641,223	14,571,114	2,782,906	0	0	287,203
4.	O2 - Older Adult FSP & Support & Intervention Systems	3,389,981	2,536,395	838,422	0	0	15,164
5.	FSP Percent of Non Admin Programs Below	14,362,439	12,606,231	1,712,837	0	0	43,371
Non-FSP Programs							
1.	C2 - Children's Outreach & Engagement	12,359	12,359	0	0	0	0
2.	C3 - Children's In-Home Crisis Stabilization	1,100,344	759,836	340,508	0	0	0
3.	C4 - Children's Crisis Residential Services	2,528,726	2,302,976	225,750	0	0	0
4.	C5 - Mentoring for Children	352,620	352,620	0	0	0	0
5.	C6 - Children's CAT	1,275,028	956,942	318,085	0	0	0
6.	C7 - OC Children with Co-Occurring MH Services for Children	400,000	400,000	0	0	0	0

7.	C8 - Outpatient Mental Health Services Expansion: Children and Youth	650,000	325,000	325,000	0	0	0
8.	C9 - Dual Diagnosis Residential Treatment	300,000	300,000	0	0	0	0
9.	C10 - Medi-cal Match: Mental Health Services	127,500	127,500	0	0	0	0
10.	T2 - TAY Outreach & Engagement	12,864	12,864	0	0	0	0
11.	T3 - TAY Crisis Residential Services	127,395	119,895	7,500	0	0	0
12.	T4 - TAY Mentoring Program	147,380	147,380	0	0	0	0
13.	T5 - TAY- CAT	272,267	272,267	0	0	0	0
14.	T6 - TAY PACT	853,020	672,069	171,614	0	0	9,337
15.	A2 - Adult CAT	3,609,743	3,005,492	588,251	0	0	16,001
16.	A3 - Adult Crisis Residential	2,145,594	1,320,983	732,010	0	0	92,600
17.	A4 - Supportive Employment	919,275	919,275	0	0	0	0
18.	A5 - Adult Outreach & Engagement	51,770	51,770	0	0	0	0
19.	A6 - Adult PACT	8,323,557	7,298,945	1,003,278	0	0	21,335
20.	A7 - Wellness Center	2,672,503	2,672,503	0	0	0	0
21.	A8 - Recovery Center Program	11,544,885	8,571,946	2,959,293	0	0	13,646
22.	A9 - Adult Peer Monitoring	253,817	249,134	0	0	0	4,683
24.	A10 - Assisted Outpatient Treatment	1,841,125	1,730,360	110,765	0	0	0
25.	A11 - Mental Health Court - Probation Services	696,000	696,000	0	0	0	0
26.	A12 - Drop in Center	425,000	425,000	0	0	0	0
27.	A13 - Housing for Homeless	950,000	950,000	0	0	0	0
28.	A14 - Housing and Year-Round Emergency Shelter	683,590	683,590	0	0	0	0

23.	A15 - Transportation Program	800,000	800,000	0	0	0	0
29.	A16 - In-Home Stablization Services	1,496,250	1,425,000	71,250	0	0	0
30.	O1 - Older Adult Recovery Services	2,266,857	1,584,728	679,590	0	0	2,538
31.	O3 - Older Adult PACT	649,400	511,199	108,978	0	0	29,223
32.	O4 - Older Adult Peer Mentoring	686,469	673,803	0	0	0	12,666
33.	H1 - CSS MHSA Housing Program Assigned Funds	200,638	200,638	0	0	0	0
CSS Administration		14,954,872	14,856,274	0	0	0	98,598
Total CSS Program Estimated Expenditures		112,012,855	97,391,132	13,975,359	0	0	646,364
FSP Programs as Percent of Total		50.0%					

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

Workforce, Education and Training (WET) Component Worksheet

County: Orange Date: 3/10/14

		Fiscal Year 2014/15					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs							
1.	Workforce Staffing Support	276,137	276,137				
2.	Training and Technical Assistance	777,657	777,657				
3.	Mental Health Career pathways Programs	817,000	817,000				
4.	Residencies and Internships	699,879	699,879				
5.	Financial Incentives Programs	174,789	174,789				
6.		0					
7.		0					
8.		0					
9.		0					
10.		0					
11.		0					
12.		0					
13.		0					
14.		0					
15.		0					
16.		0					
17.		0					
WET Administration		494,183	494,183				
Total WET Program Estimated Expenditures		3,239,645	3,239,645	0	0	0	0

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

Workforce, Education and Training (WET) Component Worksheet

County: Orange Date: 3/10/14

		Fiscal Year 2015/16					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs							
1.	Workforce Staffing Support	276,137	276,137				
2.	Training and Technical Assistance	777,657	777,657				
3.	Mental Health Career pathways Programs	817,000	817,000				
4.	Residencies and Internships	699,879	699,879				
5.	Financial Incentives Programs	174,789	174,789				
6.		0					
7.		0					
8.		0					
9.		0					
10.		0					
11.		0					
12.		0					
13.		0					
14.		0					
15.		0					
16.		0					
17.		0					
WET Administration		494,183	494,183				
Total WET Program Estimated Expenditures		3,239,645	3,239,645	0	0	0	0

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

Workforce, Education and Training (WET) Component Worksheet

County: Orange Date: 3/10/14

		Fiscal Year 2016/17					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs							
1.	Workforce Staffing Support	276,137	276,137				
2.	Training and Technical Assistance	777,657	777,657				
3.	Mental Health Career pathways Programs	817,000	817,000				
4.	Residencies and Internships	699,879	699,879				
5.	Financial Incentives Programs	174,789	174,789				
6.		0					
7.		0					
8.		0					
9.		0					
10.		0					
11.		0					
12.		0					
13.		0					
14.		0					
WET Administration		494,183	494,183				
Total WET Program Estimated Expenditures		3,239,645	3,239,645	0	0	0	0

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

Prevention and Early Intervention (PEI) Component Worksheet

County: Orange Date: 3/10/14

		Fiscal Year 2014/15					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention							
1.	CF9 - Parent Education For Youth	507,590	507,590				
2.	CF10 - Family Support Services	718,424	718,424				
3.	CF11 - Children's Support and Parenting Program (CSPP)	1,400,000	1,400,000				
4.	CF12 - PEI Services for Parents and Siblings of Youth in the Juvenile Justice System-Stop the Cycle	1,000,000	1,000,000				
5.	CF13 - Outreach and Engagement Collaborative	3,819,044	3,819,044				
6.	CF14 - Warm Line	441,566	441,566				
7.	CF15 - Professional Assessors	536,136	536,136				
8.	SF4 - College Veterans' Program	150,000	150,000				

9.	SF5 - School Based Behavioral Health Intervention and Support	1,749,589	1,749,589				
10.	SF6 - Violence Prevention	1,287,751	1,287,751				
11.	SF7 – Transitions	915,236	915,236				
12.	SF8 - K-12 Coping Skills to Manage Stress	120,000	120,000				
13.	SE1 - Information and Referral / OC Links	800,000	800,000				
14.	SE2 - Training, Assessment and Coordination Services	1,184,777	1,184,777				
15.	SE3 - Training in Physical Fitness and Nutrition Services	50,000	50,000				
16.	SE4 - Community Based Stigma Reduction	214,333	214,333				
17.	SE5 - Cal MHSA Statewide Projects	900,000	900,000				
PEI Programs - Early Intervention							
18.	CF1 - Early Intervention Services for Stress Free Families	534,693	534,693				
19.	CF2 - 1st Onset of Psychiatric Illness (OC CREW)	1,500,000	1,500,000				

20.	CF3 - Orange Co. Postpartum Wellness (OCPPW)	1,913,072	1,913,072				
21.	CF4 - Socialization Program for Adults and Older Adults	1,419,500	1,419,500				
22.	CF5 - Youth As Parents	500,000	500,000				
23.	CF6 - Behavioral Health Counseling Program	1,800,000	1,800,000				
24.	CF7 - Crisis Prevention Hotline	272,533	272,533				
25.	CF8 - Survivor Support Services	270,693	270,693				
26.	SF1 - School Based Mental Health Services	2,000,000	2,000,000				
27.	SF2 - School Based Behavioral Health Intervention and Support-Early Intervention Services	400,000	400,000				
28.	SF3 - School Readiness Programs / Connect the Tots	1,800,000	1,800,000				
PEI Administration		5,076,889	5,076,889				
PEI Assigned Funds		0	0				
Total PEI Program Estimated Expenditures		33,281,826	33,281,826	0	0	0	0

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

Prevention and Early Intervention (PEI) Component Worksheet

County: Orange Date: 3/10/14

		Fiscal Year 2015/16					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention							
1.	CF9 - Parent Education For Youth	507,590	507,590				
2.	CF10 - Family Support Services	718,424	718,424				
3.	CF11 - Children's Support and Parenting Program (CSPP)	1,400,000	1,400,000				
4.	CF12 - PEI Services for Parents and Siblings of Youth in the Juvenile Justice System-Stop the Cycle	1,000,000	1,000,000				
5.	CF13 - Outreach and Engagement Collaborative	3,819,044	3,819,044				
6.	CF14 - Warm Line	441,566	441,566				
7.	CF15 - Professional Assessors	536,136	536,136				
8.	SF4 - College Veterans' Program	150,000	150,000				

9.	SF5 - School Based Behavioral Health Intervention and Support	1,749,589	1,749,589				
10.	SF6 - Violence Prevention	1,287,751	1,287,751				
11.	SF7 - Transitions	915,236	915,236				
12.	SF8 - K-12 Coping Skills to Manage Stress	120,000	120,000				
13.	SE1 - Information and Referral / OC Links	800,000	800,000				
14.	SE2 - Training, Assessment and Coordination Services	1,184,777	1,184,777				
15.	SE3 - Training in Physical Fitness and Nutrition Services	50,000	50,000				
16.	SE4 - Community Based Stigma Reduction	214,333	214,333				
17.	SE5 - Cal MHSA Statewide Projects	900,000	900,000				
PEI Programs - Early Intervention							
18.	CF1 - Early Intervention Services for Stress Free Families	534,693	534,693				
19.	CF2 - 1st Onset of Psychiatric Illness (OC CREW)	1,500,000	1,500,000				

20.	CF3 - Orange Co. Postpartum Wellness (OCPPW)	1,913,072	1,913,072				
21.	CF4 - Socialization Program for Adults and Older Adults	534,693	1,419,500				
22.	CF5 - Youth As Parents	1,500,000	500,000				
23.	CF6 - Behavioral Health Counseling Program	1,913,072	1,800,000				
24.	CF7 - Crisis Prevention Hotline	1,419,500	272,533				
25.	CF8 - Survivor Support Services	500,000	270,693				
26.	SF1 - School Based Mental Health Services	2,000,000	2,000,000				
27.	SF2 - School Based Behavioral Health Intervention and Support-Early Intervention Services	400,000	400,000				
28.	SF3 - School Readiness Programs / Connect the Tots	1,800,000	1,800,000				
PEI Administration		5,076,889	5,076,889				
PEI Assigned Funds							
Total PEI Program Estimated Expenditures		34,886,365	33,281,826	0	0	0	0

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

Prevention and Early Intervention (PEI) Component Worksheet

County: Orange Date: 3/10/14

		Fiscal Year 2016/17					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention							
1.	CF1 - Parent Education For Youth	507,590	507,590				
1.	CF9 - Parent Education For Youth	507,590	507,590				
2.	CF10 - Family Support Services	718,424	718,424				
3.	CF11 - Children's Support and Parenting Program (CSPP)	1,400,000	1,400,000				
4.	CF12 - PEI Services for Parents and Siblings of Youth in the Juvenile Justice System-Stop the Cycle	1,000,000	1,000,000				
5.	CF13 - Outreach and Engagement Collaborative	3,819,044	3,819,044				
6.	CF14 - Warm Line	441,566	441,566				
7.	CF15 - Professional Assessors	536,136	536,136				
8.	SF4 - College Veterans' Program	150,000	150,000				

9.	SF5 - School Based Behavioral Health Intervention and Support	1,749,589	1,749,589				
10.	SF6 - Violence Prevention	1,287,751	1,287,751				
11.	SF7 - Transitions	915,236	915,236				
12.	SF8 - K-12 Coping Skills to Manage Stress	120,000	120,000				
13.	SE1 - Information and Referral / OC Links	800,000	800,000				
14.	SE2 - Training, Assessment and Coordination Services	1,184,777	1,184,777				
15.	SE3 - Training in Physical Fitness and Nutrition Services	50,000	50,000				
16.	SE4 - Community Based Stigma Reduction	214,333	214,333				
17.	SE5 - Cal MHSA Statewide Projects	900,000	900,000				
PEI Programs - Early Intervention							
18.	CF1 - Early Intervention Services for Stress Free Families	534,693	534,693				
19.	CF2 - 1st Onset of Psychiatric Illness (OC CREW)	1,500,000	1,500,000				
20.	CF3 - Orange Co. Postpartum Wellness (OCPPW)	1,913,072	1,913,072				

21.	CF4 - Socialization Program for Adults and Older Adults	1,419,500	1,419,500				
22.	CF5 - Youth As Parents	500,000	500,000				
23.	CF6 - Behavioral Health Counseling Program	1,800,000	1,800,000				
24.	CF7 - Crisis Prevention Hotline	272,533	272,533				
25.	CF8 - Survivor Support Services	270,693	270,693				
26.	SF1 - School Based Mental Health Services	2,000,000	2,000,000				
27.	SF2 - School Based Behavioral Health Intervention and Support-Early Intervention Services	400,000	400,000				
28.	SF3 - School Readiness Programs / Connect the Tots	1,800,000	1,800,000				
PEI Administration		5,076,889	5,076,889				
PEI Assigned Funds		0					
Total PEI Program Estimated Expenditures		33,281,826	33,281,826	0	0	0	0

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

Innovations (INN) Component Worksheet

County: Orange Date: 3/10/14

		Fiscal Year 2014/15					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
GROUP 2 INN Programs							
1.	INN1-Proactive On-Site Engagement in the Collaborative Courts to Offer Access to Mental Health Education Programs to Reduce Recidivism	416,622	416,622				
2.	INN2-Religious Leaders Mental Health First Aid	315,106	315,106				
3.	INN3-Access to Mobile/Cellular/Internet Devices in Improving Quality of Life	271,946	271,946				
4.	INN4-Veterans Services for Military Families and Caregivers	616,245	616,245				
5.	INN5-Skill Sets for Independent Living Project	389,526	389,526				
GROUP 1 INN Programs							
1.	INN1- Integrated Community Services	1,666,423	1,666,423				

2.	INN2-Collective Solutions	216,370	216,370				
3.	INN3-Volunteer to Work	463,432	463,432				
4.	INN4-OC Accept	518,256	518,256				
5.	INN5-OC4VETS	662,135	662,135				
6.	INN7-Project Life Coach	428,666	428,666				
7.	INN9-Brighter Futures	359,676	359,676				
8.	Program Monitoring	129,042	129,042				
INN Administration		1,161,620	1,161,620				
Total INN Program Estimated Expenditures		7,615,067	7,615,067	0	0	0	0

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

Innovations (INN) Component Worksheet

County: Orange Date: 3/10/14

		Fiscal Year 2015/16					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
GROUP 2 INN Programs							
1.	INN1-Proactive On-Site Engagement in the Collaborative Courts to Offer Access to Mental Health Education Programs to Reduce Recidivism	416,622	416,622				
2.	INN2-Religious Leaders Mental Health First Aid	315,106	315,106				
3.	INN3-Access to Mobile/Cellular/Internet Devices in Improving Quality of Life	271,946	271,946				
4.	INN4-Veterans Services for Military Families and Caregivers	616,245	616,245				
5.	INN5-Skill Sets for Independent Living Project	389,526	389,526				
GROUP 1 INN Programs							
1.	INN1- Integrated Community Services	1,666,432	1,666,432				
2.	INN2-Collective Solutions	216,370	216,370				
3.	INN3-Volunteer to	0	0				

	Work						
4.	INN4-OC Accept	518,256	518,256				
5.	INN5-OC4VETS	662,135	662,135				
6.	INN7-Project Life Coach	428,666	428,666				
7.	INN9-Brighter Futures	359,676	359,676				
8.	Program Monitoring	227,265	227,265				
INN Administration		1,095,884	1,095,884				
Total INN Program Estimated Expenditures		7,184,131	7,184,131	0	0	0	0

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

Innovations (INN) Component Worksheet

County: Orange Date: 3/10/14

		Fiscal Year 2016/17					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
GROUP 2 INN Programs							
1.	INN1-Proactive On-Site Engagement in the Collaborative Courts to Offer Access to Mental Health Education Programs to Reduce Recidivism	416,622	416,622				
2.	INN2-Religious Leaders Mental Health First Aid	315,106	315,106				
3.	INN3-Access to Mobile/Cellular/Internet Devices in Improving Quality of Life	271,946	271,946				
4.	INN4-Veterans Services for Military Families and Caregivers	616,245	616,245				
5.	INN5-Skill Sets for Independent Living Project	389,526	389,526				
6.							
7.							
INN Administration		361,700	361,700				
Total INN Program Estimated Expenditures		2,371,147	2,371,147	0	0	0	0

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

Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Orange Date: 3/10/14

	Fiscal Year 2014/15					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11. Electronic Health Record (E.H.R)	3,804,458	3,804,458				
12.	0					
13.	0					
14.	0					
15.	0					
20.	0					
CFTN Administration	104,038	104,038				
Total CFTN Program Estimated Expenditures	3,908,496	3,908,496	0	0	0	0

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

Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Orange Date: 3/10/14

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
CFTN Programs - Technological Needs Projects						
11. Electronic Health Record (E.H.R)	5,343,662	5,343,662				
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	104,038	104,038				
Total CFTN Program Estimated Expenditures	5,447,700	5,447,700	0	0	0	0

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

Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Orange Date: 3/10/14

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
CFTN Programs - Technological Needs Projects						
11. Electronic Health Record (E.H.R)	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0	0				
Total CFTN Program Estimated Expenditures	0	0	0	0	0	0

APPENDICES

APPENDIX 1: Minutes from the Mental Health Public Hearing on April 23, 2014 and the Mental Health Board Meeting on April 30, 2014.

600 W. Santa Ana Blvd., Suite 510, Santa Ana, CA 92701 | (714) 667-5600 | MHSA@ochca.com | www.OCHealthinfo.com/MHSA

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County of Orange
Mental Health Board

405 W. 5th Street, Suite 405
Santa Ana, CA 92701
TEL: (714) 834-5481 / FAX: (714) 796-0194
Email: ddaniels@ochca.com

Wednesday, April 23, 2014
9:00 a.m. – 10:30 a.m.

Hall of Administration
Planning Commission Hearing Room
333 W. Santa Ana Blvd.
Santa Ana, CA 92701

Members Present: Brian Jacobs, April Guajardo, Judith Lewis (via Teleconference), Nomi Lonky, Richard McConaughy, Carolyn Nguyen, Michaell Rose, Gregory Swift, Ehsan Gharadjedaghi, Karyn Mendoza

Members Absent: Jeffrey Davis, Supervisor Patricia C. Bates

Call to Order at 9:03 a.m. by Richard McConaughy.

Welcome and Introductions

- Each member and attendee introduced themselves and respective affiliation.

Approval of Minutes – Action Item

- March 26, 2014
  - Brian Jacobs made a motion to approve the minutes and Carolyn Nguyen seconded the motion. The minutes from March 26, 2014 were approved and placed on file. Vote: 10yes/0 no

Committee Reports

California Association of Local Mental Health Boards and Commissions (CALMHB/C): Richard McConaughy

- Richard updated the board on the recent CALMHB/C and Mental Health Planning Council (MHPC) conferences in Irvine, which he attended various meeting over a few days. Particularly, in regards to the training hosted by the California Institute of Mental Health (CiMH), there was a nice turn out and the training was productive. Attendees had the opportunity to get updates on how to evaluate local behavioral health programs. Additionally, in regards to OCLinks, Richard shared information about this program at the CALMHB/C and CiMH training and it was also well received.
- Further, the MHPC has composed a Data Notebook for each county. This notebook includes data collection questions which will require a response from both BHS staff and the MHB. Richard shared that this is a good project as it motivates the board to look into the local mental health system. Also, the MHB will discuss the process of responding to the questions in the data notebook during an upcoming Study Committee meeting.

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Wednesday, April 23, 2014
9:00 a.m. – 10:30 a.m.

Committee Reports continued

Centralized Assessment Team (CAT) Ad Hoc Committee: Judith Lewis
Judith inquired on the process of the CAT Manual. The hard copy of this manual is now available for review in the BHS Administration Office – Adult and Older Adult Services. The electronic copy of this manual will be distributed to the MHB prior to the MHB May - Study Committee meeting.

Public Comment
Madeline Hall, Children's Hospital of Orange County (CHOC) – Inpatient services for children in Orange County.

Open Public Hearing at 9:30 a.m.
Mental Health Services Act (MHSA) Three-Year Plan – Fiscal Year 2014/15 – 2016/17

Welcome and Opening Remarks: Mary Hale
Mary thanked and welcomed all in attendance to the meeting. She highlighted OCLinks as one of the many successful programs available to the residents of Orange County which was implemented and funded by MHSA in 2013. Also, Mary shared information about the MHSA planning process and acknowledged how collaborative the process has been between BHS Administration and the MHB. Mary briefly shared information about the new and expanded programs. Further, Mary recognized the feedback BHS received from prior years on the MHSA Plan from the MHB and how helpful it was when planning this current plan. Finally, Mary thanked the MHB for their leadership, time and input they've contributed to the MHSA Three-Year Plan.

Overview of the MHSA Three-Year Plan: Bonnie Birnbaum
Bonnie shared background information on the progress of the MHSA Planning process over the past 10 years. Also, she discussed how BHS and the community involvement process have improved each year since Proposition 63 was passed. Bonnie shared that the planning process to compose the plan was a joint team effort amongst BHS, the MHSA Steering Committee, the MHSA Steering Community Sub-Committees, the MHB, and the community. One thing that was unique with this plan is the additional funding of $26M in growth funds compared to prior years. With the additional funding and inclusive collaboration between BHS and the stakeholders, new programs and expanded programs where identified which are outlined in the plan. Finally, Bonnie recognized the transformation of the system since the implementation of MHSA and his excited about the continued progress of behavioral health services in Orange County.

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Wednesday, April 23, 2014
9:00 a.m. – 10:30 a.m.

Guest Speakers
The following speakers shared their experience, personal testimonies, and thoughts on the MHSA programs and services in Orange County:

- Helen Cameron
- Martin Salcedo
- Cheryl Prutsman
- David Gibson
- Hashem Aljarrah
- Daria Waetjen

Public Comment
The following three public comments were received during the public hearing:

Ann Menasche –	Ms. Menasche challenged the underlying law of Laura's Law and believes that the law is not truthful. Further, she believes that the majority of clients are not violent or dangerous and Laura's Law is another form of stigma.
Healther Huszti -	Ms. Huszti acknowledged the board for their work on the MHSA Plan. Happy to hear the speakers and positive outcomes from MHSA funding.
Steve McNally -	Mr. McNally thanked the board for serving as advocates for Orange County and shared information about his sons experience including homelessness. Also, he believes there should have been increased advertisement for the meeting.

Close Public Hearing at 10:20 a.m.

Adjournment: Action Item
Richard called for a motion to adjourn the meeting. Michaell Rose motioned and Nomi Lonky seconded the motion. The meeting was adjourned at 10:21 a.m. Vote: 10 yes/0 no

Officially submitted by:
Danielle A. Daniels Danielle A. Daniels

***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: ddaniels@ochca.com* **

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Special Meeting
Wednesday, April 30, 2014
9:00 a.m. – 10:30 a.m.

Hall of Administration
Planning Commission Hearing Room
333 W. Santa Ana Blvd.
Santa Ana, CA 92701

MINUTES Page 1 of 2

Members Present: Brian Jacobs, April Guajardo, Judith Lewis (via Teleconference), Nomi Lonky, Richard McConaughy, Carolyn Nguyen, Michaell Rose, Gregory Swift, Ehsan Gharadjedaghi, Karyn Mendoza

Members Absent: Jeffrey Davis, Supervisor Patricia C. Bates

Call to Order at 9:02 a.m. by Richard McConaughy.

Announcements

- Richard reminded board members to review the Orange County Data Notebook which they have received an electronic copy and a hard copy as well. The board will discuss how to respond to the questions at the May Study Committee meeting. Richard also thanked BHS for the efforts put into the Mental Health Services Act Three-Year Plan.

Public Comment

- None

MHSA Three-Year Plan for Fiscal Year 2014/15-2016/17: Action Item

- *Discussion:*
  - Richard opened the discussion on the MHSA Three-Year Plan. Gregory Swift acknowledged Joy Torres for her creative input on the plan. Also, board members recognized BHS and the community stakeholder process in composing the plan. Members commented that this plan is the best plan in the past 10 years and they appreciate the collaborative efforts between BHS and the MHB in drafting this plan. Furthermore, board members inquired on the public comments that were received and we informed that summarized responses will be included in the appendix section of the final plan. Finally, board members also shared their concerns in ensuring that the most underserved populations will benefit from MHSA funding.
- *Vote:*
  - Richard called for a motion for the approval of the MHSA Three-Year Plan for Fiscal Year 2014/15-2016/17. Brian Jacobs motioned and Carolyn Nguyen seconded the motion. The MHSA Three-Year Plan for Fiscal Year 2014/15-2016-17 was unanimously approved with a 10 yes/0 no vote.

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Wednesday, April 30, 2014
9:00 a.m. – 10:30 a.m.

Adjournment: Action Item

Richard called for a motion to adjourn the meeting. Gregory Swift motioned and Karyn Mendoza seconded the motion. The meeting was adjourned at 9:46 a.m. with a 10 yes/0 no vote.

Officially submitted by:

Danielle A Daniels

Danielle A. Daniels

***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: ddaniels@ochca.com ***

APPENDIX II: Minute Orders from the Board of Supervisors

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ORANGE COUNTY BOARD OF SUPERVISORS
MINUTE ORDER
May 13, 2014

Submitting Agency/Department: HEALTH CARE AGENCY

Approve Mental Health Services Act Three-Year Program and Expenditure Plan for FY 2014 - 15 through FY 2016-17 ($428,264,350); 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) NGUYEN: **Y** (2) MOORLACH: **Y** (3) SPITZER: **Y** (4) NELSON: **Y** (5) BATES: **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. 29

Special Notes:

Copies sent to:

HCA – Jenny Qian

5/16/14

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.
Susan Novak, Clerk of the Board

By: _____
Deputy

1

600 W. Santa Ana Blvd., Suite 510, Santa Ana, CA 92701 | (714) 667-5600 | MHSA@ochca.com | www.OCHealthinfo.com/MHSA

ORANGE COUNTY BOARD OF SUPERVISORS
MINUTE ORDER
May 13, 2014

Submitting Agency/Department: HEALTH CARE AGENCY

Adopt resolution authorizing implementation of Assisted Outpatient Treatment in accordance with Welfare and Institutions Code Sections 5345 - 5349.5 of Laura's Law; and making related findings - All Districts

The following is action taken by the Board of Supervisors:
APPROVED AS RECOMMENDED ☒ OTHER ☐

Unanimous ☒ (1) NGUYEN: **Y** (2) MOORLACH: **Y** (3) SPITZER: **Y** (4) NELSON: **Y** (5) BATES: **Y**
Vote Key: Y=Yes; N=No; A=Abstain; X=Excused; B.O.=Board Order

Documents accompanying this matter:

☒ Resolution(s) 14-031
☐ Ordinances(s)
☐ Contract(s)

Item No. 22

Special Notes:

Copies sent to:

HCA – Jenny Qian

5/16/14

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.
Susan Novak, Clerk of the Board

By: _____
Deputy

1

600 W. Santa Ana Blvd., Suite 510, Santa Ana, CA 92701 | (714) 667-5600 | MHSA@ochca.com | www.OCHealthinfo.com/MHSA

APPENDIX III: Public Comments

600 W. Santa Ana Blvd., Suite 510, Santa Ana, CA 92701 | (714) 667-5600 | MHSA@ochca.com | www.OCHealthinfo.com/MHSA

Public Comments

The Orange County MHSA Three-Year Program and Expenditure Plan for FY 2014/2015 through FY 2016/17 was available for Public Comment from March 20, 2014 through April 21, 2014. During that time a total of 12 comments were received. Some of the comments were just requests for further information and others dealt with substantive issues related to the Plan. Below is a summary of the substantive comments and the County's responses.

Comment 1

This comment addressed a variety of issues related to Assisted Outpatient Treatment (AOT). One of the new programs included in the MHSA Three-Year Plans is AOT.

AOT is a controversial program that has been discussed in Orange County for the past several years. It is based on AB 1421, enacted in 2003 which provides for discretionary authority for counties to implement a program that provides involuntary treatment for, court-imposed outpatient treatment for people who are mentally ill and meet certain criteria. In summary, Comment 1 provided several arguments in opposition to implementing AB 1421 in Orange County. The comment included arguments that "AOT is a costly program that would undermine the fundamental civil and constitutional rights of individuals who are diagnosed with serious mental illness without any clear gain to them or society."

Response to Comment 1:

The decision to implement AOT in Orange County rests with the County Board of Supervisors (BOS). The BOS has heard extensive testimony regarding this proposed action. The Mental Health Board in Orange County has recommended implementation of AOT, and stakeholders involved in the process of developing the MHSA Three-Year Plan have advocated for the inclusion of AOT in the Plan. Although such a program has been implemented in only one California County, similar programs have been successfully implemented elsewhere in the United States.

While we understand that implementing AOT can be controversial, that the cost of AOT is high, and there are very specific legal requirements that must be met, as stated above, extensive stakeholder testimony and input has been solicited and provided and there has been overwhelming support for the inclusion of the program in the MHSA Plan. Furthermore, implementation of AOT in Orange County will be conducted in a

compliant manner and will provide a spectrum of services for those individuals who have been difficult to engage in the community and that have demonstrated that they are unlikely to survive safely in the community without supervision, based on an investigation and resultant clinical determination. We concur that there are unwarranted stereotypes of those with mental disabilities and strive to dispel those characterizations through our various stigma reduction campaigns.

The addition of AOT to the continuum of care in Orange County will provide another method to help those who are most severely affected by mental illness and their family members who struggle to care for them. The expectation is that this program will decrease homelessness, incarceration and hospitalization, which are primary objectives of the MHSA. As AOT is implemented, we will monitor all individuals that are placed in AOT and will track all data and outcomes associated with implementing this and will report this data as required by law.

Comment 2

This comment addressed three new programs that are intended to assist with the goal of reducing homelessness among the population living with mental illness. These programs are:

- A 12 Drop-In Center
- A 13 Housing for the Homeless
- A 14 Housing and Year-Round Emergency Shelter Beds

The comment supports the addition of these programs and points out the importance of moving people quickly from emergency shelter to permanent housing. It also recommends working with community stakeholders, including the committees charged with implementing Orange County's Ten Year Plan to End Homelessness.

Response to Comment 2:

Concur.

Comment 3

This comment advocates for:

- Increased funding for Crisis Intervention and Law Enforcement Training
- An increase in the proportion of crisis response team members who are licensed medical personnel

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- Incorporation of crisis intervention services into the 911 system
- Increased funding for collaborative mental health courts
- An increase in supervised housing along with day treatment programs.

Response to Comment 3:

The level of funding for the Crisis Intervention Program (CIT) program was approved as part of the extensive stakeholder process that is part of MHSA planning. Should the level of funding be something that the Steering Committee process chooses to increase, that could be accommodated with proportionate reductions in other CSS programs. The CIT program provided intensive two day training for 224 law enforcement personnel in 2013-2014 as of 4/10/14. Behavioral Health Services (BHS) also supports an annual CIT conference which makes available an additional two days of training for law enforcement personnel. Law enforcement participation is only with the approval of local police departments and sheriffs. Training has been made available to all the agencies that have requested it. In addition, BHS has approved funding for a new training system to be used as part of the CIT training beginning in FY 2014-15. This system was used at the last annual CIT conference and received positive comments from the attendees. The system is a judgment evaluation and force options training system. It creates a safe, effective and realistic learning environment for law enforcement, military and security professionals.

CIT is only one part of BHS' ongoing interaction with and training for Law Enforcement. Other training continues to occur and includes education provided at law enforcement roll call meetings and inclusion of Psychiatric Emergency Response Team members to ride along with law enforcement officers. We continue to work with law enforcement to educate them on Behavioral Health Services and how to access the Crisis Response Team.

The Centralized Assessment Team includes three behavioral health nurses who work as a comprehensive team. The team also includes: clinical social workers, marriage and family therapists and mental health specialists. We will continue to assess the need for medical staff and may add staff as appropriate.

Incorporation of crisis intervention into the 911 system is outside the scope of Health Care Agency authority. 911 emergency systems are operated by various law enforcement agencies; Behavioral Health crisis intervention services, including CAT, are coordinated with local law enforcement, and we are always open to finding ways to improve our coordination.

Increased funding for the collaborative courts has been provided in this Plan, in part by the addition of expanded dollars for the Full Service Partnerships- FSPs (specifically any of the new funds that support the Whatever It Take Court FSP and the Assisted Intervention/Steps FSP) and for a new program that has been added A 11 Mental Health Court Probation Services.

Supervised Housing is available through our MHSA Housing program which provides housing along with supportive services for people who have a serious mental illness and are homeless or at high risk of homelessness. As of this writing, 72 units of new housing have been built and leased, 45 units are currently under construction, another 54 units are in the predevelopment stage.

Additional services for homeless mentally ill will be provided by:

- A 12 Drop-In Center
- A 13 Housing for the Homeless
- A 14 Housing and Year-Round Emergency Shelter Beds

In particular, in the new A 13 program, funding will be used to buy a house that can be used for interim housing tied to supportive services.

Comment 4

Six comments were received that support the use of MHSA funds to provide services for children and adolescents who have co-occurring mental health and physical health disorders, including eating disorders. The new program, C7 Children with Co-Occurring Mental Health and Chronic/Acute/Severe Physical Health, Special Needs, and Eating Disorders was added to this year's Plan. One of these comments also asked for additional training for medical personnel on the mental health aspects of the treatment for these patients.

Response to Comment 4:

Concur that services are needed for this population and will be provided in this Plan. The need for Education and Training programs is continuously evaluated, and once C7 is implemented, the possibility of providing additional training for medical personnel serving to this population will be considered.

Comment 5

This comment indicated support for several programs included in the Plan: Collaborative Mental Health Courts, Assisted Outpatient Treatment, and Training for Law Enforcement. The comment also posed questions about the usefulness of

combining funding for different types of Behavioral Health Counseling programs; the amount of funding used for Behavioral Health Counseling compared to the amount budgeted for AOT; the use of MHSA funding on inpatient facilities and use of MHSA to provide more school counselors.

Response to Comment 5:

Concur about the need for the specific programs mentioned in the comment and included in the Plan. MHSA funds may not be used for involuntary treatment. Both School Counselors and inpatient treatment facilities are funded through sources other than MHSA.

In regards to the comment on combining the different types of counseling programs, there are many programs that provide counseling as a service or as one of the services within CSS, PEI and Innovations programs. However, there are differences between programs for reaching specific target populations, and there are unique needs in the diverse communities in OC which may account for variations between programs. The programs in the MHSA Plan are the result of community stakeholder input, and the continuation of services depends on program effectiveness as measured by outcomes data.

With regard to the amount of funding spent on Behavioral Health Counseling compared to the amount that will be spent on AOT, the concern seems to be that Behavioral Health Counseling does not address the needs of those most seriously mentally ill, but somehow implies a lower level of care. The term Behavioral Health Counseling is often used to loosely describe a variety of services. It is often provided to those with serious mental illness, as well as to others in need of a more moderate level of care.

The Act requires that more than 50% of Community Services and Supports funding be spent on clients enrolled in Full Service Partnerships (FSPs). FSPS provide the highest intensity of service to those who are seriously mental ill and homeless or at high risk of homelessness. Some type of behavioral health counseling is usually provided to clients enrolled in FSPs, and they also receive a high level of other services such as case management; help with food, clothing, education, and employment; medication; and psychiatric services. Other programs targeting the most seriously mentally ill, such as Program of Assertive Community Treatment (PACT) also provide a variety of services aimed at helping people living with severe mental illness achieve and maintain recovery.

We believe that $4.4 million is sufficient for AOT services. It is a new program, and there will be opportunities in annual updates to adjust the amount of funding allocated to AOT once we have experience with operating the program.

It is established by law that PEI funded programs must account for 20% of the MHSA funding, and that services target all age groups. The rationale behind this mandate is that to avoid the high personal and financial cost of mental illness, it is important to intervene early and provide support before a situation deteriorates.

As mentioned above, program planning and implementation is the result of a community stakeholder process. The School Readiness Expansion was one of the 33 programs in the original Plan. These programs are not meant to be a substitute for pre-school programs and provide behavioral health services in the home, removing barriers to access. Furthermore, these programs benefit schools and their mental health resources by addressing behavioral health issues at the earliest age possible, often prior to enrollment in school. There are other PEI programs addressing the needs of older students including the School Based Behavioral Health Intervention and Support, Violence Prevention Education Services, OC GRIP, Transitions, the new School Based Mental Health Services being implemented and the K-12 Coping Skills to Manage Stress upon Plan approval.

Comment 6

This comment requested that some additional information be include in future plans and asked for some minor wording changes in the current Plan. It also makes suggestions for revising the way outcomes are described for the Children's Centralized Assessment Team and asks that we supply data on referrals to specific types of lower levels of care. It also asks that PEI programs be evaluated in terms of the extent to which they prevent mental illness from becoming severe and disabling and points out that there are also services available for children with some disabilities funded by the Individuals with Disabilities Education Act (IDEA). It suggests that we continue to evaluate Innovation programs with respect to whether they accomplish the purpose and intent of Proposition 63. Finally, it requests that a study utilizing cost-benefit analysis be done evaluating the distribution of resources and a report prepared on the percentage of costs for each MHSA program that is allocated to administration as compared to the percentage spent on direct services.

Response to Comment 6:

Minor wording changes will made as needed. With regard to the outcomes measures for the Children's Centralized Assessment Team, we concur that directing children to the

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appropriate level of care is optimal. As far as listing the specific number of referrals to various types of care, we began collecting that data in January, and will be able to provide additional information in the future.

With regard to the evaluation of PEI programs, it should be noted that program planning and implementation has been in compliance with the guidelines provided by the California Department of Mental Health. The PEI plans are the result of an extensive community stakeholder process and are approved by the MHSA Steering Committee and then the Board of Supervisors. The original plan was approved by the MHSA Oversight and Accountability Commission (OAC).

The OAC is currently going through the regulatory review process for PEI Regulations, and it is anticipated that these regulations will be finalized by the end of the calendar year. In the meantime, Behavioral Health Services continues its commitment to evaluate all MHSA programs. BHS worked with a consultant, Resource Development Associates, to establish evaluation plans, logic models, data collection methods and outcome measurement tools to evaluate the effectiveness of the PEI Programs. In regards to the comment on children with learning disabilities and with Attention Deficit/Hyperactivity Disorder (ADHD) qualifying for Individuals with Disabilities Education Act (I.D.E.A.) funding, HCA has no control over funding that goes directly to the school districts. MHSA/PEI services are designed to meet the needs of the unserved and underserved families, and the children who receive these PEI funded services have been identified as having an unmet need that has not been served through existing programs and services.

As for Innovation Projects, each of the Phase One Innovations projects was approved by the State Oversight and Accountability Commission (OAC), and Orange County has recently received approval to continue operating and evaluating these projects. As the OAC has approved these projects and their continuation, they are consistent with the original purpose and intent of Proposition 63.

Finally, with regard to the requested cost/benefit study, such a study would require substantial resources. It would be a time consuming and complex task. The community would have to prioritize the study and recommend taking funding from one or more other priority programs to fund this.

Comment 7

This comment contained a list of questions related to MHSA, the format of the Plan and how MHSA fits into the whole continuum of publicly funded behavioral health services in Orange County.

Response to Comment 7:

This comment did not include any substantive recommendations as to the type of programs included in the Plan or the individual funding levels. Answers to the questions are a matter of public record and staff members in the Health Care Agency are available to meet with the individual who submitted the comment to help find the information requested.