County of Orange
Health Care Agency
Behavioral Health Services
Mental Health Services Act

2007
Community Services & Supports
Implementation Progress Report

MHSA
Mental Health Services Act

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Community Services and Supports Implementation Progress Report

Introduction and Overview

This report covers the period from January 1, 2007 through December 31, 2007. By the end of that time period, almost all of the programs in the original Three-Year Community Services and Supports (CSS) Plan had been implemented, as well as most of the new programs and program expansions that were approved in July 2007 by the Department of Mental Health (DMH) part of the 07/08 CSS Growth Funding Plan.

Those programs and program expansions that had not yet been implemented made progress in selecting providers; negotiating contracts; obtaining Board of Supervisors' approval, where necessary; recruiting, hiring, and training staff; and conducting outreach to prospective clients. Two exceptions are the Adult Crisis Residential Program and the Wellness Center. A site for these two programs has been identified and will be incorporated into the County's Capital Facilities and Technology Plan. The Guidance for that Plan was received in March 2008, and progress has been made in developing that Plan.

A review of the programs included in Orange County's CSS Plan shows that, to a large extent, the implementation activities are proceeding as described in the County's approved plan and subsequently adopted MHSA Performance Contract.

The major differences include: a delay in start-up due to the time needed to complete the Request for Proposals (RFP) and contracting process; higher than anticipated costs to provide some services to the clients (particularly housing and medical care), and less Medi-Cal revenues than had been originally budgeted. In addition, there were challenges in developing a site for the Adult Residential Care Program.

Despite these issues, Orange County has been very successful in implementing the CSS Programs as planned. The County has continued to use the MHSA guiding principles in designing and implementing services. Orange County is making progress in transforming its public mental health system into one that is based on community collaboration and provides coordinated and integrated services that are culturally and linguistically competent, client/family-driven, and wellness/recovery/resiliency-focused.

A. Program/Services Implementation

1) The County is to briefly report by Work Plan on **how implementation of the approved program/services is proceeding**. The suggested length for the response for this section is **no more than half a page per Work Plan.** Small counties may combine Work Plans and provide a comprehensive update in two to three pages.

a. Report on whether the implementation activities are generally proceeding as described in the County's approved Plan and subsequently adopted in the MHSA Performance Contract/MHSA Agreement. If not, please identify the key differences.
b. Describe for each FSP Work Plan what percent of anticipated clients have been enrolled. **Counties that have submitted their current Exhibit 6, Three-Year Plan—Quarterly Progress Goals and Report, have the option of not including the FSP information in this report.**
c. Describe for each System Development Work Plan what percent of anticipated clients have received the indicated program/service. **Counties that have submitted their current Exhibit 6, Three-Year Plan—Quarterly Progress Goals and Report, have the option of not including the System Development information in this report.**
d. Describe the major implementation challenges that the County has encountered.

Orange County has submitted all required Quarterly Progress Goals and Reports. Thus, for all programs, the answer to questions 1 b and 1 c are omitted.

Implementation of Work Plans:
Work Plan C1: Children's Full/Service Wraparound
a. This is a community-based, family-centered program where individualized, family-driven plans are developed. Services include, but are not limited to: 24/7 intensive in-home case management and wraparound services, community-based mental health services, youth and parent mentoring, transportation, housing, benefits acquisition, and respite care.

By the end of 2007, the Children's Full Service Partnership/Wraparound program had provided service to 240 families. The focus this year for the oldest program, Project Renew, has been on integrating treatment and wraparound services, locating feasible family housing, and refining the charting and data inputting systems. Guidelines were developed, implemented and refined in these areas. A work still in progress is the Caminar database. Although the system has been installed and staff

trained for many months, it is just now becoming operational due to statewide issues. The Caminar database is expected to provide outcome data to support the positive anecdotal evidence currently available.

The newest FSP, Project Focus, which is designed to serve the Asian Pacific Islander population, opened in the fall of 2007. A site was secured, staff hired and trained, and procedures implemented. Through December 2007, the program served 23 families of seriously emotionally disturbed (SED) children.

The year 2007 also saw the awarding of a contract for additional FSP services focused on probation youth. The youthful offenders project developed the program model, identified key staff, created a budget, set criteria for admission, and completed other tasks in preparation for opening early in 2008

d. Housing continues to be the major program challenge. A criterion for many of the available housing funds is the presence of a seriously mentally ill (SMI) Transitional Age Youth (TAY) or adult. A seriously emotionally disturbed child does not qualify a family for special housing benefits. Also, family housing – usually two bedrooms or more as the average family size is three children - is much more expensive than that needed for single TAY or adults. Thus, the program must use flex funds to support housing needs. Master leasing agreements are a solution that is being explored. Another challenge faced by the Children's FSP program (as in all of the Full Service Partnerships) is additional requests for services when the program is full. The largest challenge this year was that Medi-Cal revenues had been overestimated in the budget. The difference between budgeted and actual Medi-Cal revenue was resolved through the use of local reserve funds.

Work Plan C2: Children's Outreach and Engagement

a. This program provides outreach and engagement activities in order to increase utilization of mental health services by unserved seriously emotionally disturbed (SED) children and their families in the neighborhood where they reside or by those who are homeless.

Implementation of the Children's Outreach and Engagement program is predicated on hiring consumers and/or family members that are linguistically and culturally similar to those in the communities where they conduct outreach. The goal is to increase utilization of mental health services to those unserved and/or homeless SED children and their families.

The program is built around the staff members that actually do the outreach and engagement. The program has been highly successful in developing a staff that is diverse and linguistically competent. For example, the county-

run component of the program currently has hired six outreach workers, five of whom are bilingual (four Spanish-speaking and one Vietnamese-speaking). This culturally competent staff facilitates the outreach into the underserved communities outlined in the plan, which include the high concentration of Spanish speaking individuals in the cities of Santa Ana and Anaheim, and the large population of Vietnamese-speaking individuals in Westminster.

Services are provided in a culturally competent, family-focused, strength and community-based manner that builds trust and encourages the establishment and growth of local support systems. Outreach workers have met or exceeded their expectation of linking an annual minimum of 33 children/families to FSPs or community mental health services.

Additionally, the Orange County Asian Pacific Islander Community Alliance (OCAPICA), a contract provider of the County, provides outreach and engagement services to the Korean community through a subcontract with Korean Community Services. Generally speaking, the Korean community has been somewhat isolated from receiving mental health services for a number of reasons; however, implementation of this program has allowed a significant increase in education and awareness of the help available for those suffering with mental illness in the Korean community. This provider initiated service in January 2007. OCAPICA outreaches to the Vietnamese, Korean, Chinese, Filipino, Cambodian, and other Asian communities in Orange County. Its success is indicated by the linkages made to the Full Service Partnership (FSP) that targets the Asian Pacific Islander community.

d. Challenges for continued implementation are threefold: (1) heavy use of FSP slots leading to challenges in placing clients in the best destination for referrals, (2) more referrals than same-language providers available (e.g., Korean-speaking therapists/psychiatrists), and (3) smooth integration and communication of “new“ MHSA programs with already established programs (i.e., getting everyone “on-board” and educated in established programs about how the new programs operate).

Work Plan C3: In-Home Stabilization

a. The Children’s In-Home Crisis Stabilization Program promotes resiliency in youth and children by teaching them and their families coping strategies that reduce at-risk behaviors leading to peer and family problems, out-of-home placement, and involvement in the child welfare or juvenile justice system.

Three Family Support Teams (FST), each consisting of a mental health professional and a mental health worker, are available to provide services to

families in crisis on a 24-hour per day, 7 days per week basis. Upon referral, the FST engages the family and mutually assesses each child's and family's immediate needs. The FST also provides direct service in the form of crisis intervention, individual and family therapy, and case management to assist the child and family in establishing a full service partnership if needed to develop a long-term safety plan and provide ongoing support and assistance.

d. Implementation challenges have been in two areas. Recruiting bi-lingual and bi-cultural staff is always difficult. The program has been able to fill its positions, but the process takes longer. The implementation of 24/7 availability was challenging initially, but as the program has matured, the creation of a rotational schedule and on-call compensation has resolved the issue.

Work Plan C4: Children's Crisis Residential

a. The Children's Crisis Residential Program promotes resiliency in youth in crisis by providing them and their families with a short-term, temporary residential resource that can facilitate the teaching of coping strategies to reduce at-risk behaviors, peer and family problems, out-of-home placement, hospitalization, and involvement in the child welfare and juvenile justice systems.

The program began accepting referrals in January 2007. A total of 57 clients were served. Thirty were referrals from crisis situations and 27 were step-downs from inpatient hospitalization. Twelve clients were hospitalized sometime after participation in the program, but eleven of these clients had prior hospitalizations. Only one client who had no previous inpatient exposure required hospitalization after the program. It appears that the program is an effective alternative to inpatient psychiatric hospitalization.

d. There have been implementation challenges in several areas. Recruiting staff to match the referred population is always difficult. In this instance, there was a staff in place as the program converted from an emergency shelter to the Crisis Residential Program. All new hiring has been focused on bilingual, bicultural or former clients and family. This will continue to be a focus as vacancies occur. The program overcame a culture change as staff members learned to deal with more impaired adolescents with fewer community supports. Staff trainings were designed to address this challenge.

Work Plan C5: Children's Mentoring

a. The Mentoring Program for Children is a community-based, individual and family-centered program that recruits, trains, and supervises responsible adults and transitional age youth to serve as positive role

models and mentors for seriously emotionally disturbed (SED) children and youth who are receiving services through any Children & Youth Services (CYS) county-operated or contract program, including the Full Service/Wraparound programs. This program was added to the continuum of care in Orange County using CSS FY07/08 Growth Funding.

Implementation of the Children's Mentoring program differed from the Plan, in that the time required for the Request for Proposals and the review, evaluation, and provider selection process delayed the start of the program. Nevertheless, once this new program got started, a staff made up of bilingual and bicultural employees was quickly assembled. The program currently employs two Vietnamese-speaking mentor coordinators and one Spanish-speaking mentor coordinator. Eighteen "matches" have been made to children already receiving services in the County's system of care since the startup of the program.

This program is also designed to provide mentors to parents whose children are being seen in county-operated mental health programs. Implementation of that portion of the program is projected to occur shortly, as soon as policies and procedures for this unique aspect of this MHSA mentoring program are finalized.

d. Implementation challenges include recruiting, not only bilingual mentors, but also male mentors. Additionally, the program relies highly on smooth integration with County and contract providers already established as well as integration with the "new" MHSA programs so the referral process is consistent across all providers. Because the program matches mentors with clients in both established and "new" programs, great effort and time is required to educate all the programs about the referral process and ongoing case management requirements with each mentor match.

Work Plan T1: TAY Full Service/Wraparound

a. This is a community-based family-centered program where individualized, family-driven plans are developed. Services include, but are not limited to: 24/7 intensive in-home case management and wraparound services, community-based mental health services, youth and parent mentoring, transportation, housing, benefits acquisition, supported employment and education, co-occurring services, and respite care.

The largest Transitional Age Youth (TAY) Full Service/Wraparound Program, the Project Stay program, reached its original capacity before the end of the first fiscal year of operation and was expanded by 50 slots using CSS Growth Funding. Staff turnover halted enrollments for one month in the

fall of 2007, but the program is now at full capacity. In addition to expansion, 2007 has seen the extension of the program into several "satellite sites" through collaborations with community providers of education, job training or other services. Refinement of the application of the recovery model in the program has also been a focus during this year.

The newest FSP, Project Focus, which is designed to serve the Asian Pacific Islander population, opened in the fall of 2007. A site was secured, staff hired and trained, and procedures implemented. Through December 2007, the program served three seriously mentally ill TAY.

The year 2007 also saw the awarding of a contract for additional FSP services focused on probation youth. The youthful offenders project developed the program model, identified key staff, created a budget, set criteria for admission and completed other tasks in preparation for opening early in 2008

d. The typical program participant is male, 19 years old, homeless, unemployed and has both a mood disorder and a substance use problem. Developing effective ways of encouraging participation in treatment for both diagnoses requires creativity and persistence and has been an ongoing challenge this year. Finding, securing, and retaining housing for participants remains a challenge for the program, but the availability of special housing funds for this age group has helped. When the program is full, additional requests for services are a challenge in this and all of the FSPs. The largest challenge this year was that Medi-Cal revenues had been overestimated in the budget. The difference between budgeted and actual Medi-Cal revenue was resolved through the use of local reserves.

Work Plan T2: TAY Outreach and Engagement

a. The Transitional Age Youth (TAY) Outreach and Engagement (O&E) Program seeks to increase utilization of mental health services to unserved seriously emotionally disturbed /seriously mentally ill (SED/SMI) TAY in the neighborhoods where they reside, or to those who are homeless or at risk of homelessness.

The program is built around the staff that actually do the outreach and engagement. The program has been highly successful in developing a staff that is diverse and linguistically competent. For example, the county-run component of the program currently has hired six outreach workers, five of whom are bilingual (four Spanish-speaking and one Vietnamese-speaking). This culturally competent staff facilitates the outreach into the underserved communities outlined in the plan, which include the high concentration of Spanish speaking individuals in the cities of Santa Ana and Anaheim, and the large population of Vietnamese-speaking individuals in Westminster.

Services are provided in a culturally competent, family-focused, strength and community-based manner that builds trust and encourages the establishment and growth of local support systems. Outreach workers have met or exceeded their expectation of linking an annual minimum of 33 children/families to FSPs or community mental health services.

Additionally, the Orange County Asian Pacific Islander Community Alliance (OCAPICA), a contract provider of the County, provides outreach and engagement services to the Korean community through a subcontract with Korean Community Services. Generally speaking, the Korean Community has been somewhat isolated from receiving mental health services for a number of reasons; however, implementation of this program has allowed a significant increase in education and awareness of the help available for those suffering in the Korean community. This provider initiated service in January 2007. OCAPICA outreaches to the Vietnamese, Korean, Chinese, Filipino, Cambodian, and other Asian communities in Orange County. Its success is indicated by the linkages made to the Full Service Partnership (FSP) that targets the Asian Pacific Islander community.

The county-run component of the program currently has hired six outreach workers, five of whom are bilingual (four Spanish-speaking and one Vietnamese-speaking). This culturally competent staff facilitates the outreach into the underserved communities outlined in the plan, which include the high concentration of Spanish speaking individuals in the cities of Santa Ana and Anaheim, and the large population of Vietnamese-speaking individuals in Westminster. Each full-time outreach and engagement worker is expected to link at least 33 consumers to FSP or other community mental health services per year. Staff have met or exceeded this expectation.

d. Challenges for continued implementation along the lines indicated in the plan are threefold: (1) heavy use of FSP slots leading to challenges in finding the best destination for referrals, (2) More referrals than same-language providers available (e.g., Vietnamese-speaking therapists/psychiatrists), and (3) smooth integration and communication of "new" MHSA programs with already established programs (i.e., getting everyone "on-board" and educated in established programs about how the new programs operate).

Work Plan T3: TAY Crisis Residential

a. The TAY Crisis Residential Program promotes resiliency in seriously emotionally disturbed/seriously mentally ill (SED/SMI) TAY in crisis by providing them and their families (if applicable) with a short-term, temporary residential resource that can facilitate the teaching of coping strategies to

reduce at-risk behaviors, peer and family problems, homelessness, and involvement in the justice system.

The program was not yet operational in 2007. Currently, a contract provider has been chosen; contract negotiations were protracted due to unanticipated facility and staffing costs. These issues were resolved, but delayed approval by the Board of Supervisors until June 2007. Extensive building modifications were required to meet licensing and code requirements. Program start up was scheduled for the first quarter of Calendar Year 2008.

d. Implementation has been slowed by unanticipated construction delays. In addition, the contractor selected is a new provider. Meeting the licensing expectations of Community Care Licensing and the Department of Mental Health was challenging. This provider has become the first local program licensed as a Social Rehabilitation program. Now, the program is on a firm path to its scheduled opening in the first quarter of Calendar Year 2008.

Work Plan T4: TAY Mentoring

a. The Mentoring Program for Transitional Age Youth is a community-based, individual and family-centered program that recruits, trains, and supervises responsible adults and transitional age youth to serve as positive role models and mentors for seriously emotionally disturbed/severely mentally ill (SED/SMI) transitional age youth (TAY) who are receiving services through any Children & Youth Services (CYS) county-operated or contract program, including the Full Service/Wraparound programs. This program was added to the county's CSS Plan with FY 2007/08 CSS Growth funds.

Implementation of the Transitional Age Mentoring (TAY) program differed from the plan in that the time required for the Request for Proposals and the review, evaluation, and provider selection process delayed the start of the program. Nevertheless, once this new program got started, a staff made up of bilingual and bicultural employees was quickly assembled. The program currently employs two Vietnamese-speaking mentor coordinators and one Spanish-speaking mentor coordinator. Six "matches" have been made to TAY already receiving services in the County's system of care since the startup of the program. The ethnicity of the young adults served includes 50% Latino and 50% Caucasian.

d. Implementation challenges include recruiting, not only bilingual mentors, but also male mentors. Additionally, the program relies highly on smooth integration with County and contract providers already established as well as integration with the "new" MHSA programs so the referral process is consistent across all providers. Because the program matches mentors

with both established and "new" programs, great effort and time is required to educate all the programs about the referral process and ongoing case management requirements with each mentor match.

Work Plan A1: Adult Full Service Partnership (FSP)

a. The Adult Integrated Services Program is a Full Service Partnership Program with three different community-based providers, each with its own target population. Each uses a multidisciplinary team, which includes a psychiatrist, a nurse, a Master's prepared Clinical Director, Team Leaders and Personal Service Coordinators with backgrounds in drug/alcohol, vocational rehabilitation and/or housing/community resources. Services are focused on recovery to encourage the highest level of client empowerment and independence.

Services include, but are not limited to, the following: crisis management; housing, 24/7 intensive case management, community-based wraparound recovery services, vocational and educational services, flexible fund account for immediate needs, medication support, dual diagnosis services, linkage to financial benefits/entitlements, family and peer support and supportive socialization and participation in meaningful community roles. Each FSP has focused on the same general target population (seriously mentally ill and homeless or at risk of homelessness) but providers have collaborated so that there are several portals where clients may enter the system. The total number of individuals enrolled for the Adult FSP's for 2007 was 401.

This year the FSP's have focused on staff development in regards to documentation and data collection. Also, programs have been developing substance abuse services for enrolled clients. In addition, staff members have been developing their skills and education on the integration of substance abuse and mental health services for enrolled clients.

d. One of the challenges for all of the Full Service Partnership programs has been identifying and retaining appropriate housing for its members. This includes the full range of housing types - from emergency housing to permanent housing. Programs have collaborated with housing vendors and have assisted clients in applying for housing vouchers when available. A solution that is being explored is the development of Master Leasing Agreements.

Work Plan A2: Centralized Assessment Team (CAT) and Psychiatric Emergency Response Team (PERT)

a. CAT/PERT provides a centralized assessment team to provide emergency mental health evaluations throughout Orange County, including

emergency rooms. The mission of these collaborative teams is to provide rapid response to mental health clients, assess their needs and make community based referrals, resulting in diversion to reduce hospitalization, incarceration, and reliance on the hospital emergency rooms. Follow-up is an essential part of the program in order to reduce the frequency of calls to police departments and ensure linkage to appropriate services. Services are available 24/7.

The Program also provides Psychiatric Emergency Response Teams that collaborate with law enforcement to provide mental health evaluations. Thus far, four PERT teams have been established. Each involves a partnership with a local law enforcement agency. Both the CAT and PERT teams address the MHSA goals of integrated services and timely access to care.

This year's focus has been to educate the community and police departments on the services of the Centralized Assessment Team. There has been a 44% increase in police calls to this unit in 2007. In addition, we have added two PERT units in 2007. For 2007, this team has had 2,309 contacts and 5,408 follow-up contacts with clients. There has been a 65% diversion from hospitalization on crisis assessments.

d. This program has been successfully implemented. Currently the CAT Team is based in Central Orange County. One of the challenges encountered by this team has been the amount of time to respond to calls from individuals in South Orange County. The program has been identifying locations to site staff in that region and has also begun a PERT partnership with law enforcement in South County.

Work Plan A3: Adult Crisis Residential

a. This program would provide a residential treatment alternative to hospitalization for mentally ill persons in acute psychiatric crisis who cannot be safely and effectively managed on an outpatient basis. The Program has not been implemented due to challenges in finding an appropriate provider with access to a suitable facility.

d. A request for proposals had previously been released with no response. One of the challenges has been difficulty in identifying a potential location for the program. The County has identified a potential site for this program and the RFP will be re-released.

Work Plan A4: Supported Employment

a. This program was designed to provide job preparation, education and support to clients for the purpose of obtaining competitive employment. The program includes job coaches who assess clients on the job and assist with skill development and problem resolution. Job Developers are also a critical

component of this program in that they work with potential employers in the community in creating jobs and reducing the stigma associated with mental illness.

The focus this year has been on developing relationships with the community. Job Developers have worked on identifying potential long-term employers for the consumers. The program has also focused on developing relationships with the community mental health programs and assisting them in identifying potential consumers to refer to the program. During 2007, there were 133 clients enrolled in the program, with 68 successful placements.

d. This program has been successfully implemented, consistent with the CSS plan. One of the challenges has been in identifying culturally appropriate employment opportunities and trainings for the Asian Pacific Community. The provider has arranged for appropriate training for program staff and has done extensive outreach to the Asian Pacific Community by arranging for a program Open House, and conducting education on their program to specific providers that serve this community.

Work Plan A5: Adult Outreach and Engagement

a. This program provides outreach and engagement services to the unserved and underserved minority populations in Orange County. The primary focus is to penetrate the community by networking with local organizations, attending faith-based gatherings, and collaborating with temples, churches, health fairs, community centers, and in essence, anywhere the local population may congregate.

There are two providers that perform outreach and engagement to individuals who historically have been unserved and underserved for their mental illness. One provider serves the Asian Pacific community and collaborates with other community organizations and faith-based organizations. The other provider focuses its efforts on the Latino community and uses “promotores” as outreach and engagement staff.

Both providers offer screening, information, referral and linkage services for those individuals that they engage. Both providers began operation in August 2007. This year, their focus has been on developing community relationships and identifying locations to provide education on mental illness and mental health resources to organizations and individuals. For 2007, they had 951 outreach contacts and had engaged 582 individuals.

d. The Plan identifies that staff will be co-located in community health settings and primary care physician offices. Staff was to provide assessment, mental health interventions and provide education. As these

programs were developed and appropriate staff selected, it became apparent that the level of staff needed to provide outreach and engagement could not provide clinical services. Their strength was in developing relationships in the community where traditional mental health providers have not had access. Both outreach providers have struggled to identify appropriate services in the community that can provide services that are both culturally and linguistically competent.

Work Plan A6: Program of Assertive Community Treatment

a. This program provides intensive services, including medication, individual, group, substance abuse and family therapy, in several geographic locations throughout the county. There was a delay in implementing this program due to issues related to the County budget. However, at this time, the program is on track for hiring staff and identifying clients for the program.

d. The major challenge has been the need to wait for County budget issues to be resolved before authorization to hire staff was granted.

Work Plan A7: Consumer-Run Wellness/Peer Support Center

a. This program has not been implemented. The County has gone through an extensive community process to gather information on the development of this Center. A request for proposals for this program is expected to be released in May 2008. The County expects that the provider will identify a pre-location prior to moving to a permanent location that will be built with Capital Facilities funding.

d. This project has required extensive time for program planning and for developing a plan for building a facility to serve as a permanent home for the program. Another challenge will be the length of time required for the County Request for Proposals and contracting process.

Work Plan O1: Older Adult Recovery Services

a. The Older Adult Recovery program provides behavioral health services to individuals who are 60 years of age or older and who have serious and persistent mental illness. This program was developed to perform ongoing behavioral health services. The program operates on a team model of recovery and serves seniors who are frail, unable or unwilling to access traditional services and who may be at risk of losing independent living in the community. The Recovery Program has served over 340 mentally ill, frail older adults. As a result of visiting the older adults in their homes, several health related issues were identified, and clients were successfully linked to much needed medical care.

There were clients who initially refused to enter into traditional mental health services, but after participating in the program for awhile, were willing to go to a clinic setting for services. Therefore, in November of 2007, a new clinic was opened to serve this population. The clinic was designed to create a comfortable milieu for this population and is intended to expand options to clients by offering Recovery groups, crafts, reading groups, educational groups, discussion groups and medication education groups in the near future. Many of these clients are becoming more independent, able to leave their home environment, reintegrate with their families, and enjoy activities in the community.

d. A major challenge faced in operating this program has been the difficulty in hiring staff that has been trained to serve a geriatric population. Positions are hard to fill and may remain vacant for an extended length of time.

Work Plan O2: Older Adult Support and Intervention System (OASIS)

a. OASIS is a Full Service Partnership program for older adults. The goal of the OASIS program is to assist homeless mentally ill seniors, age 60 and over in Orange County. The program provides mental health assessments, mental health services, transitional housing, linkage to physical health care and other services mentally ill seniors may require to provide stability and to eventually reintegrate into the community.

During this last year, OASIS reached client capacity. However, housing costs continued to escalate, severely impacting the budget. The program creatively developed a plan to have consumers select a roommate and share a portion of their housing costs at motels. This also helped them prepare for the time when they move to more independent community housing as opportunities become available.

Clients were prepared by meeting with them; discussing real options for them in independent living; and offering group sessions on making good choices for independent living, selecting a roommate, contributing to housing costs, planning budgets for independent living, anger management, etc.

To increase their motivation to participate, clients were offered incentives by the program. Once clients transitioned into shared living, groups continued to meet regarding budgeting, food preparation, interpersonal relationships and boundary setting. The clients appear eager and willing to be a part of the program. Nonetheless, it was deemed necessary to reduce the number of clients served in order to cover escalating housing costs.

In the interim, Program Directors continue to meet with county staff to work on the development of alternative housing within the community that is appropriate for the older adult population. Master leases are being

developed, as well as some long term independent living situations which will take time to complete. Six clients have moved into shared housing designated specifically for older adults.

d. The major challenge this past year has been the higher than expected level of cost needed to serve this population. In response to the higher than expected costs of providing housing and medical care, additional funding for the program was included in the FY 2007/08 CSS Growth Funding Plan.

Work Plan E1: Education and Training

a. Orange County's MHSA Education and Training Program was funded by one-time CSS money. It consists of a wide variety of classes, each targeted at specific audiences. The Program is designed to support system development and addresses the training of clients and family members, community partners, mental health administrators, and behavioral health staff who work with clients of all ages.

All of the training activities planned in the 2005 CSS plan have either been implemented or are scheduled to be implemented, with the exception of the Recovery Training Institute, which was envisioned to provide additional sources of funding for sustaining training programs. With the release of funding provided through the Workforce Education and Training component, development of an additional method of securing funding was not seen as a priority. The number of persons trained has been less than that originally projected, due to both delays in the contracting process and difficulties scheduling all staff to attend trainings. However, through December 31, 2007 a total of 5,429 people attended 75 trainings on a wide variety of topics.

d. The major obstacles to implementing education and training activities have been the long timelines for developing Requests for Proposals and contracts and the difficulty scheduling all staff to attend live trainings. These factors have resulted in delays in completing trainings, but have not seriously altered training plans.

Work Plan H1: Housing

a. The Orange County Housing Program created a Housing Trust Fund to support the construction/renovation of housing units for members of the Full Service Partnership programs. In addition, the Housing Trust Fund has been used to develop a full range of supportive housing, including transitional and permanent housing, for people with serious mental illness who are homeless or at risk of homelessness.

The Health Care Agency continued the successful collaboration with Housing and Community Services to encourage housing development for

the MHSA population. There has been ongoing dialogue with developers to attract new housing opportunities. One-time funds continued to be available through a Notice of Funds Availability with Housing and Community Services. Financing for Diamond Aisle Apartments was finalized, and the groundbreaking is planned for April 2008. A senior housing project was submitted for review, and several developers were in the process of submitting housing project applications.

d. Challenges that the program has faced include the high cost of land and a lack of special needs developers with strong experience leveraging special needs funding from various sources (CalHFA, State Housing and Community Services, HUD, etc.) Another challenge has been educating developers to increase their comfort level in serving the MHSA population in mixed population housing. The mortgage crisis may be offering us an opportunity to obtain housing at a reduced cost and may attract more developers to this population.

2) For each of the five general standards in California Code of Regulations, Title 9, Section 3320, very briefly describe **one example of a successful activity**, strategy or program implemented through CSS funding and why you think it is an example of success e.g. **what was the result of your activity**. Please be specific. The suggested length for the response to this section is **three pages total** (or one page for small counties).

a. Community collaboration between the mental health system and other community agencies, services, ethnic communities etc.

Successful Strategies for Community Collaboration: Wellness/Peer Support Center Planning

In Orange County, a successful community collaboration was developed to plan for a Consumer-Run Wellness/Peer Support Center that was approved as part of the FY07/08 CSS Growth Funding Plan. In the CSS FY 07/08 Growth Funding planning process, input was gathered from the County's MHSA Consumer Action Advisory Committee and a wide variety of community stakeholders, including law enforcement, education, social services agencies, health care providers, and agencies providing mental health services.

After the Plan was approved by the California Department of Mental Health, a Wellness/Peer Support Center Planning Committee made up of consumers and family members was established to provide input to the County on the design and type of services committee members would like incorporated into the new Wellness/Peer Support Center. The Committee met a total of eight times. At the meetings, experts from other California

counties and other states presented information about what was working and what was not working in the Wellness/Peer Support Center programs with which they were affiliated.

The Committee used the information provided by the experts to establish priorities for features/services to be included in the new Wellness/Peer Support Center. The consumer priority recommendations will be included in the Request for Proposals (RFP) for the Wellness/Peer Support Center. In Orange County, this is the first time consumer input has been gathered to shape the requirements to be included in an RFP.

The Committee included representation from underserved ethnic communities. To facilitate their participation, translation services were provided. This collaboration between the Health Care Agency, consumers/family members, and representatives from sites where model programs have been established involved a tremendous effort by all parties to ensure that the planned Wellness/Peer Support Center will not only include best and emerging practices, but truly reflect the community's preferences and values.

b. Cultural competence

Cultural Competence: Vietnamese Collaborative

In an effort to successfully outreach to and engage our unserved and underserved population, staff in OC HCA Behavioral Health Services partnered with the Asian Pacific Islander (API) communities to develop a new collaborative. HCA staff sent out requests for community town hall meetings to API consumers/family members and API non-profit organizations that traditionally had not provided mental health services, but clearly had provided a wide variety of social services to the API communities.

These API organizations have had a strong history of grass roots work in Orange County. An Orange County Asian Pacific Islander Behavioral Health Collaborative was formed and since then, has received several MHSA contracts with the County to provide culturally appropriate and quality services to the County's API communities. Moreover, the Vietnamese consumers and family members group has participated in every level of MHSA planning in the County, providing a culturally competent voice in the public mental health system transformation process. Translation has been provided to ensure that the voice of this community was heard.

c. Client/family driven mental health system

Client/Family-Driven Mental Health System:
Consumer/Family Member Vocational Training Program

As part of the 2005/06 CSS plan approved for Orange County, one-time funding was provided for a program to develop and support the training of 100 consumers and family members over a two-year period to work in the mental health system. The goal was to enable them to become service providers or operators of consumer-run services so that the public mental health system in Orange County reflects a meaningful inclusion of consumers and family members as service providers. The model of training that was developed included three components:

- Classroom training of consumers and family members in basic human services and mental health concepts/knowledge, using a curriculum that emphasizes wellness and recovery principles. This component of the program has been provided at no charge through a local community college.
- Fieldwork training of consumers and family members in jobs using skills related to working within the mental health system.
- Training of current mental health system staff and administrators in philosophy, concepts, and skills necessary to work alongside of and incorporate consumers and family members as full partners in providing mental health services. The goal is to promote an integrated service experience for consumers and family members.

This contracted program has been successfully implemented through a partnership between a local mental health service provider and a local community college. The program includes a director, two job coaches, two employment specialists, and two peer mentors. Twenty-five consumers and family members have completed the classroom portion of the program, and of these, 21 have been successfully placed in six-month paid field work placements within the public mental health field.

A second class with 28 students began at the community college in February 2008, and a third class with 30 students began in March 2008. A fourth class is scheduled to begin in September. Staff and administrators of the current placement sites have gone through a full-day training and a half-day follow-up training. Prospective sites for the next wave of field placements will receive a full-day training in May. It is the County's plan to continue this successful program after the one-time CSS funding has been spent. At that time, MHSA Workforce Education and Training component funding will be used to fund this program.

d. Wellness/recovery/resiliency focus

Wellness/Recovery/Resiliency Focus: Older Adult Recovery Program

In 2006, the Older Adult Recovery Program began serving the seniors of OC. This was the first program in OC to offer in-home mental health services on an ongoing basis to seniors unable or unwilling to access traditional mental health services. Services include case management, rehabilitative mental health services, medication management services and crisis intervention. The target population of homebound older adults had not been served in OC until this program was developed. Because seniors are reluctant to discuss mental illness and anticipate great stigma among their peers, mental illness often goes undetected and/or untreated. Therefore, these older adults do not seek treatment, and their functioning declines to the point where they are no longer able to remain living independently in the community. Providers, including primary care physicians, tend to consider depression a normal part of aging and frequently do not address the problem with the older adult.

This new program has been very successful and is well-accepted by the community providers and older adults. The Older Adult Recovery program employs staff who are specially trained and experienced in working with mentally ill older adults and who are able to identify issues specific to this population, so appropriate services can be rendered in an expedient manner. In November 2007, the program opened the doors of a clinic for the participants of the Recovery Program who have been rehabilitated and wish to normalize their lives by coming into the clinic for services. This is a positive step for these individuals who previously were very isolated and were not willing or able to leave their residences. There are approximately 30 clients who now visit the clinic. Eventually, the clinic will provide groups for socialization, recovery issues, crafts, medication education, wellness, and more to encourage further participation in the community.

e. Integrated services experience for clients and families: changes in services that result in services being seamless or coordinated so that all necessary services are easily accessible to clients and families.

Integrated Services: Transitional Age Youth Full Service/Wraparound

The wraparound model (on which the TAY FSP is based) provides an integrated, individualized service experience for clients and families. It is possible to provide all services, housing, supported employment, therapy, and medical, at one site, as the old state hospitals did, but of course that model meant that all participants received the same services, whether they fit or not. The wraparound model allows integration through the

development of the participant's team, but also individualization and true partnership because the team composition depends on the participant's interests, strengths and needs.

The TAY FSP program has evolved to include a wide range of housing, employment, education, therapy, and medical options for participants ranging from very sheltered in-house activities to traditional community services.

Housing includes shared apartments, single rooms, board and care, and sober living homes with only TAY residents. Choice is determined by availability, financial status, appropriateness and interests. More options are being developed through master leasing plans.

Supported employment is available through community services such as those offered by the Workforce Investment Board, by individual job placement and coaching by FSP staff, by a community sheltered workshop program allied with the FSP (the Monkey Business Café and Thrift Shop), and by job readiness activities and classes conducted by FSP staff. Similarly, continuation of education is supported by a program at a local community college, individual support, and tutoring by FSP staff and volunteers and program activities.

Therapy is available both within the FSP and through community clinics and private providers. This allows participants to continue with former therapists, if they wish, or start fresh. In–house groups are available and are especially helpful for those who are ambivalent about continued treatment. The peer mentors and other FSP staff conduct wellness group activities for participants. Psychiatry services are available on site for those who are unable or unwilling to use community clinics. Medical assessments and services are provided by a local provider with offices throughout the County.

The variety of services available to the FSP insures an individualized program that is designed by the participant and other members of his or her team. A "wellness" plan is developed by the team in the first month of service, and can change as needs, interests, and strengths change. Flex funds are used to support services temporarily when needed. The inclusion of community as well as in-house services means that participants ready to leave can continue their services "post FSP", but those needing a very sheltered program are also accommodated. Additional refinements and services are needed and will be added, but the TAY FSP seems to be off to a good start in providing integrated services in an urban environment.

3) For the Full Service Partnership category only:

a. If the County has not implemented the SB 163 Wraparound (Welfare and Institutions Code, Section 18250) and has agreed to work with their county department of social services and the California Department of Social Services toward the implementation of the SB 163 Wraparound, please describe the progress that has been made, identify any barriers encountered, and outline the next steps anticipated.

Orange County has implemented the SB 163 Wraparound Program.

b. Please provide the total amount of MHSA funding approved as Full Service Partnership funds that was used for short-term acute inpatient services.

Orange County has spent **no** MHSA funding for short-term acute inpatient services.

4) For the General System Development category only, briefly describe how the implementation of the General System Development programs have strengthened or changed the County's overall public mental health system. The suggested length for response to this section is **one page**. If applicable, provide an update on any progress made towards addressing any conditions that may have been specified in your DMH approval letter.

Orange County did not have any conditions in its DMH approval letter.

Strengthening the Public Mental Health System: Children's In-Home Crisis Stabilization Program

The Orange County planning process for the Mental Health Services Act (MHSA) identified a systems development need to provide alternatives to psychiatric hospitalization for minors. The Children's In-Home Crisis Stabilization program is based on "best practice" models from Massachusetts and New Jersey. The In-Home Program was designed for three teams of two, each comprised of a clinician paired with a paraprofessional to form a Family Stabilization Team (FST). Each team has at least one bilingual staff person. The service is available on a 24-hour, 7-day per week basis.

Typically, county staff will evaluate a youth for possible psychiatric hospitalization. If hospitalization is not indicated but there are significant family issues, the staff contacts the In-Home Program and a team member speaks with the parent. The FST may come to an emergency room, meet the family when they return home or set up a meeting for the next day. The FST will devise an intervention plan with the family and the youth to stabilize the family situation and

link them to necessary on-going services in an MHSA Full Service partnership, a regional clinic or whatever assistance is needed to avoid future crises and hospitalizations.

The program provides three weeks of service, although additional time is approved if clinically appropriate. Also included in the model was the concept that this level of service might be helpful to youth who are returning home from psychiatric hospitalizations or other extended out-of-home placements. As the program developed, clinicians pointed out that there were situations that they encountered that were just days away from reaching crisis stage and that In-Home services would be useful. The program criteria were modified to accept a limited number of these referrals.

During 2007, there were 115 admissions to the Program. The goal for the program was to avoid inpatient psychiatric hospitalization. In the 115 referrals reviewed, psychiatric hospitalization was avoided 113 times.

The program has been tracked in a variety of ways to ensure its faithfulness to the MHSA model. These successful interventions are spread over an age range of seven to seventeen, with a mean age of 14.4. The pattern seen in a number of HCA programs is replicated here. The great majority of children and adolescents function comfortably in English, while many of the parents prefer to receive mental health services in Spanish or Vietnamese. Considering the outreach emphasis of MHSA, the number of clients in their first episode of care is informative. Three out of five referrals to the In-Home Program were for clients in their first episode of care with HCA.

Eight children were hospitalized sometime after receiving services from the program. This represents 7% of those served. This subpopulation has some interesting characteristics. All eight have had multiple hospitalizations and there has been Social Services Agency involvement in four of the eight cases. These young people are among the most impaired that HCA deals with. In-Home Crisis is one of the many strategies attempted to intervene in these difficult situations.

The data indicate that the delivery of services for children and adolescents has been enhanced; hospitalizations averted, and that clients and families have been linked to services in a more efficient manner than before this program became available.

B. Efforts to Address Disparities—
The suggested response length for this section is **three pages** (or one page for small counties)

1) Briefly describe one or two successful current efforts/strategies to address disparities in access and quality of services to unserved or underserved

populations targeted in the CSS component of your Plan. If possible, include results of the effort/strategy.

Successful Effort to Address Disparities: the Asian Pacific Islander Collaborative

A contract for a combined Children's and TAY Full Service/Wraparound Program was awarded to the Asian Pacific Islander (API) Collaborative in the summer of 2007. Located near "Little Saigon," the program opened in the first quarter of FY 07/08. The API Collaborative consists of three grassroots organizations with long histories of service in the community. It provides linguistically appropriate services to Vietnamese, Korean, Chinese, Philippino, Cambodian, and other Asian families.

The same collaborative also provides Outreach and Engagement services in this community. Initially, referrals to the FSP were slow as a new program, even one run by well-known providers, was viewed with caution. Now, however, that barrier has been overcome, and all available slots of the FSP are filled.

The challenges to this program are quite different from those in the other children's and TAY FSPs. Systems navigation is a major problem for most, if not all, of the families served. Many of the traditional human service organizations do not have even Vietnamese (a threshold language in Orange County) speakers easily available, and non-threshold languages such as Korean or Cambodian pose serious challenges for clients in securing therapy, general assistance, child welfare, and other services. Homelessness is relatively rare as a presenting problem, as multi-generational living arrangements are common within the community. Intergenerational conflict, however, is common and frequently the focus of treatment. Another challenge for the program is the "family team" model, which relies on the discussion of "family business" with neighbors, friends, teachers, etc. and which may not be a culturally accepted activity.

The services provided by this program are the same as the other Children's and TAY FSPs in Orange County. Experience with this program and the necessary modifications that are made should prove useful in defining the differences in effective interventions with diverse cultural groups.

2) Briefly describe one challenge you faced in implementing efforts/strategies to overcome disparities, including where appropriate what you have done to overcome the challenge.

Challenges in Implementing Strategies to Overcoming Disparities: Training on Cultural Competency

The sheer number of trainings the County has offered on all aspects of the CSS component, including Cultural Competency has in itself been a challenge. It has been logistically challenging to train all Behavioral Health Services staff, as well as County contractors and all of the new CSS program staff due to a number of reasons.

- Lack of training space to accommodate large groups of staff;
- The lengthy county process of Request For Proposals (RFP) required for all county vendors, such as presenters for the Cultural Competency trainings;
- Difficulty in getting all staff time off to attend all of the trainings developed as outlined in the CSS Plan.

Therefore, while the identified trainings have yielded very positive results (as evidenced by pre/post tests and program evaluations) the number of staff trained has been lower than anticipated.

To overcome this challenge, the Cultural Competency Department has co-located trainings for smaller numbers of staff at actual clinic sites and/or adjacent buildings to make attendance easier. The Department has also video-taped at least one session of each presentation to archive and make available to all county/contract staff via DVD. The DVDs will be provided for all trainings. They will also be kept in a Training Manual for each service site and made available to outreach/engagement staff and those staff who have non-traditional roles under the new CSS programs. This helps ensure that all staff have access to the trainings in the event they were not able to attend, and/or for new staff who may have missed the original training date.

The Department has continued to work closely with the internal Health Care Agency contract system to get Request For Proposals (RFPs) out to the public as quickly as possible, and is developing a training session for community-based organizations and other community members on the RFP process, so that non-traditional providers understand the process as well as how and where to apply.

3) Indicate the number of Native American organizations or tribal communities that have been funded to provide services under the MHSA and what results you are seeing to date if any.

Native American Tribes

None have applied for funding. However, during 2007, the County's Cultural Competency Department held discussions with tribal representatives to plan for several activities that were to be held in 2008. For example, a Cultural Competency Training on Native Culture has been scheduled for the month of June by the County's only State-recognized tribe, the Juaneno Mission Band of Indians. In addition, an outreach and engagement Health Fair was just held (4/12/08) in South Orange County to reach out to the Native population regarding mental health services, including those funded through the CSS. Also, the tribe worked with the Cultural Competency Department on the development of an assessment tool that was completed by direct providers of service, support staff and managers/administration on their knowledge base on Native American mental health issues, which is being shared with all programs, and will help guide the training scheduled for June, 2008.

4) List any policy or system improvements specific to reducing disparities, such as the inclusion of linguistic/cultural competence criteria to procurement documents and/or contracts.

System Improvements to Reduce Disparities: Casa de la Familia Program

Casa de la Familia program has been contracted to provide outreach and engagement to the Latino Population and the Nhan Hoa clinic to the Vietnamese speaking population in Orange County. These are community-based programs and are well-recognized and accepted as part of the ethnic/cultural communities they represent, advocate for, and serve. Orange County has long recognized that the traditional system was well suited for those who were further along the acculturation process and could navigate the system, but left out those who were less acculturated, with minimal English language capabilities, and still responded to the cultural norms of their country/culture of origin.

These programs attempt to reduce these disparities in services by educating at the community level, in a cultural/linguistic relevant manner. those who would otherwise go without the needed services to remain stable, productive, and continue along their own process of recovery and wellness.

Both programs use the well-recognized "Promotor o Promotora" Model, which is mainly the use of members of the same community which they are attempting to engage in services. Promotor/Promotoras have credibility in their respective communities and are seen as safe and trustworthy members of their own community who have often experienced the same issues and anxiety the member or client is experiencing.

One of the first requirements is an excellent ability to communicate in the language of the target population. The outreach workers or promotoras must also have a cultural connection to the population they are trying to engage. The program provides education about the services offered, using the community's own language, and supports the community by participating in cultural events and public forums, and offering assistance navigating the referral process.

C. Stakeholder Involvement

As counties have moved from planning to implementation many have found a need to alter in some ways their Community Program Planning and local review processes. Provide a summary description of any changes you have made during the time period covered by this report in your Community Program Planning Process. This would include things like addition/deletion/alteration of steering committees or workgroups, changes in roles and responsibilities of stakeholder groups, new or altered mechanisms for keeping stakeholders informed about implementation, new or altered stakeholder training efforts. Please indicate the reason you made these changes. The suggested response length for this section is **two pages** (or one page for small counties).

Community Planning Process

Planning for Orange County's original Three-Year Community Services and Supports Plan was open, participatory, and inclusive of a wide variety of stakeholders, including consumers and family members. Approximately 4,000 attendees participated in various planning meetings.

The planning process was well-constructed and comprehensive. Thirty-five Public Information meetings were held to inform interested parties about the legislation. In addition, 12 community outreach meetings were held (including monolingual Spanish and Vietnamese meetings). Then seven Mental Health Services Act (MHSA) Training Workshops were held to prepare stakeholders for the planning process.

The planning process was guided by a 59-member Steering Committee composed of consumers, family members and representatives from a wide range of community organizations, including law enforcement, social services, education, the National Alliance for Mental Illness (NAMI), mental health services providers, hospitals, children's and older adult advocates, and a member of the Orange County Board of Supervisors.

Work groups were formed for each of the Department of Mental Health-specified age groups. Input was gathered from 15 client focus groups and 25 stakeholder groups. In addition, staff went into the community and interviewed homeless mentally ill individuals about the things the County could provide to improve their

quality of life. These interviews were made into a twenty-minute documentary film, which was shown to the Steering Committee and many community groups. Workgroups were held where participants identified and prioritized the issues resulting from untreated mental illness and made recommendations regarding strategies to address these issues to the Steering Committee.

As Orange County began to plan for the CSS Growth funds and the new MHSA components, a less intensive, but thorough, planning process was established. A Consumer Action Advisory Committee (CAAC) of approximately 30 consumers was formed. CAAC's role is to advise the Health Care Agency (HCA) Behavioral Health Services on issues related to the delivery of MHSA-funded services in Orange County. CAAC assists HCA in ensuring that these services are high quality, accessible, culturally competent, client-driven, client and family-centered, recovery and resiliency-based, and cost-effective. CAAC meetings are currently held twice a month at HCA, in addition to an agenda planning meeting held once per month for HCA staff and CAAC executive members.

The CAAC meetings are open to the public and have been used to collect community input so that Orange County is more equipped to better serve its consumers. CAAC meetings have been held since mid 2006. CAAC has gone on tours of the MHSA-funded Full Service Partnership programs and the County Mental Health clinics. Based on CAAC member's experiences and perceptions of the facilities they toured, the committee developed recommendations for improving services. Committee members intend to submit their findings and recommendations to the Behavioral Health Executive Team.

Orange County included a consumer-run Wellness/Peer Support Center in its FY2007/08 CSS Growth Plan. A planning committee was formed to provide input to HCA Contracts Development and Management Department on the features consumers wanted to see in the Request for Proposals that was written to solicit a provider for the Wellness/Peer Support Center. The Committee consisted of consumers as well as family members affected by mental illness.

Before the Wellness/Peer Support Center Planning Committee meetings were held, extensive research was collected on various Wellness Centers throughout the state and the country. Executive Directors of Wellness Centers or similar programs were invited to come to the Committee meetings and share their experiences and information about their respective programs. Speakers also answered questions from Committee members and addressed issues concerning the creation and implementation of a new Wellness/Peer Support Center in Orange County. The Wellness/Peer Support Center meetings produced a comprehensive inventory of ideas of how to better achieve a culturally competent Wellness Center that is client-directed, supports recovery and resiliency, produces desired outcomes, and is accountable to the community.

In conclusion, Orange County used a broad, time-intensive, and complex system for developing the initial CSS Plan. Since then, the planning process has been more focused and less complicated, while maintaining mechanisms to obtain consumer/family member input, as well as the opinions of important stakeholders, and technical expertise from subject matter experts. These changes in the planning process have proved to be less time-intensive for both HCA staff and the community, while providing the information needed to develop strong plans that the community supports.

D. Public Review and Hearing

Provide a brief description of how the County circulated this Implementation Progress Report for a 30-day public comment and review period including the public hearing. The statute requires that the update be circulated to stakeholders and anyone who has requested a copy. The suggested response length for this section is **two pages** (or one page for small counties). This section should include the following information:

1) The dates of the 30-day stakeholder review and comment period, including the date of the public hearing conducted by the local mental health board or commission. (The public hearing may be held at a regularly scheduled meeting of the local mental health board or commission.)

- This Report was available for public review and comment for a thirty-day period from April 25, 2008 through May 25, 2008.

- The Public hearing was held by the Mental Health Board on 5/28/08. The Report was approved unanimously by the seven Board members present.

2) The methods that the County used to circulate this progress report and the notification of the public comment period and the public hearing to stakeholder representatives and any other interested parties.

This CSS Progress Implementation Report and a public comment form were posted on the Mental Health Services Act website and the Network of Care website. A notice was sent to community stakeholders, announcing that the report is available for review and comment. In addition, the County distributed a press release to all local media, including the Latino and Vietnamese media, to publicize the Report and its availability for public comment.

Copies of the Report and the public comment form were available at Orange County libraries, mental health clinics and the MHSA Office. A hard copy was provided to all individuals requesting one.

3) A summary and analysis of any substantive recommendations or revisions.

No substantive comments were received.