

EXECUTIVE SUMMARY

Background

Proposition 63, which proposed a 1% tax on adjusted annual income over \$1,000,000, was passed by California voters in November 2004 and enacted into law as the Mental Health Services Act (MHSA) effective January 1, 2005. The Mental Health Services Act was designed to reduce the long-term adverse impact of untreated serious mental illness (SMI) and serious emotional disturbance (SED) by expanding the use of successful, innovative and evidence-based practices at the county level. Planning money was made available to counties in the spring of 2005 (\$636,415 for Orange County) to implement a community planning process to develop a three-year comprehensive plan for improving mental health Community Services and Supports (CSS). The expectation is that these improvements will result in better outcomes for the populations to be served.

The Department of Mental Health (DMH) proposed a model, in which counties would: (1) identify issues resulting from untreated mental illness; (2) analyze the mental health needs in the community; (3) identify populations for Full Service Partnerships; (4) identify program strategies to meet the needs; (5) assess capacity to expand current programs and implement new strategies; and (6) develop work plans with timeframes and budgets/staffing. The plan developed by Orange County (OC) is consistent with this model.

In Orange County, a community planning process was designed and implemented to accomplish the tasks required by DMH. However, there were certain restrictions that DMH imposed on the content of the plans developed by all counties. For example, DMH requires that more than 50% of the funding be used for Full Service Partnerships (FSPs). FSPs are programs where a small caseload of clients is assigned to a Personal Services Coordinator who is responsible for ensuring that the clients have access to “whatever it takes” to foster resiliency and recovery. Clients in an FSP have access to someone to provide assistance 24 hours a day, seven days a week. DMH also established two other categories of programs that could be funded by the MHSA: Systems Development and Outreach and Engagement. Systems Development Funds may be used improve programs, services, and supports; Outreach and Engagement funds may be used to conduct activities to reach unserved populations.

The three fiscal years covered by this plan are 2005-06, 2006-07, and 2007-08. It is expected that Orange County will receive approximately \$25.5 million in each of these years. Because a substantial part of the first year was needed for planning, DMH has allowed counties to prorate the program funding for Year 1, based on the actual number of months that services will be offered. Counties may request the remainder of the first year funding as one-time money, to be used for one-time activities such as systems development, rather than ongoing program costs.

The Plan was approved by the MHSA Steering Committee on September 28, 2005. As part of the Plan, the MHSA Steering Committee approved a percentage allocation of program dollars to each of four age groups. The distribution is: 20.3% for Children and Youth, 18.7% for Transitional Age Youth, 47% for Adults and 14% for Older Adults.

The Plan was distributed for public comment on November 7, 2005. After a thirty-day public comment period, the Mental Health Board held a public hearing on the Plan. Upon approval by the Mental Health Board, the Plan was approved by the Orange County Board of Supervisors on December 13, 2005.

Public Planning Process

Orange County's community planning process was open, participatory and inclusive of a wide variety of stakeholders, including groups not often heard from such as homeless individuals and their families. Meaningful consumer/family member participation in the planning process was encouraged and supported through a number of mechanisms, including grocery vouchers, transportation, childcare, and meals at meetings. Orange County conducted community outreach to inform the public about the MHSA and the planning process. Special attention was given to reaching unserved/underserved ethnic minorities and marginalized populations.

Planning process participants were provided broad-based training on topics including, but not limited to, the Mental Health Services Act, the current public mental health system, cultural competence, the local planning process, DMH implementation guidelines, identification of service gaps, and evidence-based practices. Trainings were conducted in English, Spanish and Vietnamese. In addition, a special one-day workshop on the Recovery Model was presented to planning group members and provider staff.

Workgroups were established for each of the DMH-required age groups, and a 59-person Steering Committee composed of consumers, family members, community leaders, service providers and other interested parties (e.g. law enforcement, social services, education, the Office on Aging and the faith-based community) provided leadership in the decision-making process. Input was provided by fifteen focus groups and twenty-five stakeholder group meetings. In addition, MHSA outreach staff went to homeless shelters, clubhouses, and street locations to interview individuals and families. From these interviews, staff created a short documentary on the needs of the homeless mentally ill in Orange County. A total of approximately 4,000 attendees participated in Orange County MHSA planning activities, demonstrating strong public involvement and support for the planning process.

The Orange County Mental Health Board held a public hearing on the plan on December 8, 2005. Approximately 400 individuals attended, of which about half were consumers and family members. The Mental Health Board unanimously approved the plan.

Community Issues

Priority community issues were identified by the Workgroups for each specified age range. Although a comprehensive list of issues was identified, the priority issues to be addressed in the first three years are those deemed currently most critical to Orange County. They are shown in the table below.

Priority Issues by Age Group

CHILDREN/YOUTH	TRANSITIONAL AGE YOUTH	ADULTS	OLDER ADULTS
1. Inability to succeed in mainstream school environment *	1. Peer and family problems*	1. Homelessness*	1. Homelessness*
2. Involvement in the child welfare and/or juvenile justice systems*	2. Substance use*	2. Inability to work*	2. Increased risk of suicide, homicide, violence, isolation; need for 24/7 crisis services*
3. Peer and family problems*	3. Involvement in the child welfare and/or juvenile justice systems*	3. Frequent hospitalization and emergency room care*	3. System of care issues*
4. Substance use*	4. Homelessness or at risk of homelessness affordable housing*	4. Inability to manage independence*	4. Lack of education and resources for older adult issues and meaningful activities*
5. Homelessness*	5. Inability to work or manage independence*	5. Incarceration*	5. Educational programs for community partners*
	6. Suicide*	6. Involuntary care / institutionalization*	6. Peer support services*
	7. Frequent hospitalization and/or emergency room care*		

* Priority Issues to be addressed in first three years.

Mental Health Needs/Disparities

A significant need for Orange County is to increase the access to and outcomes of mental health services for racial and ethnic minorities. As will be shown in the discussion below, for each age category, there are significant differences in access to mental health services. People who neither live in the County nor have much contact with county residents often perceive OC as mainly Caucasian and English-speaking. However, US census data does not support that conclusion. According to California Department of Finance estimates for 2003, Orange County has only a slight majority of Caucasians (51%). Latinos make up about 31% of the population and Asian/Pacific Islanders (A/PI) account for about 14%. African Americans are about 1.5% of the total population. Moreover, the racial/ethnic composition of the Orange County population is changing rapidly. It is projected that by 2010, Caucasians will be only 43% of the OC population. Equal access to culturally competent, language appropriate mental health services must be addressed now, or the situation will only become worse.

In the discussion below, data was analyzed by age group. It should be noted that the data is categorized by *non-overlapping age groups*. Children and Youth data includes ages birth-15; Transitional Age Youth includes ages 16-25; Adults data includes ages 26-59; and Older Adults data includes those individuals 60 or older. The data was organized this way to allow for discrete categories. However, the actual age groups that are served by MHSAs programs include some overlap. Programs serving Children and Youth target individuals from birth-18 and those up through age 21 if they are Special Education pupils. Programs serving TAY target individuals 16-25. Adult programs serve those 18-59, and Older Adult programs target individuals who are sixty or more years of age.

Children and Youth, age 0-15

Latino children and youth represent 55% of the children in the County and 69% of the low-income children. Among ethnic groups within the County, Latinos age 0-15 represent the greatest number of children and youth who are seriously emotionally disturbed. Latino children and youth comprise 49% of all the children age 0-15 who were provided mental health services by the County, but they are seriously under-represented relative to their numbers in the low-income population, as are A/PI children, who represent just over 5 % of all the children served.

Only 3% of the low-income Latino children and youth receive County mental health services. For A/PI low-income children and youth, less than 2% receive mental health services; while for Native American/Indigenous, who comprise less than 1% of the County's child and youth population, the rate is 9%. Similarly, the rate for Caucasian children and youth is over 9%, and for African-American, children and youth it is 12% (although the absolute number of African-American children and youth is low). Thus, among the low-income Latino and A/PI population, there are large numbers of children and youth that are unserved (10,340 and 2,099, respectively.) In contrast, most of the low-income Caucasian and African-American children with SED are being served.

Transitional Age Youth (TAY), age 16-25

Looking at the distribution of TAY by ethnicity, Latino transitional-age youth represent the greatest number of transitional-age youth with SMI in the County. Latino TAY comprised 41% of the TAY in the County and 55% of the low-income TAY. Latino TAY comprised 42% of all the transitional-age youth who were provided mental health services by the County. A/PI TAY, who comprised 16% of TAY in the general County population and 15% of the low-income TAY population, represented less than 6% of all the TAY who were seen.

Only about 4% of the low-income Latino TAY receive mental health services. The corresponding rate for A/PI TAY is 2%; while for Native American/Indigenous TAY (who comprise less than 1% of the County’s TAY) the rate is 6%. The rate for Caucasian TAY is 8% and for African-American TAY, it is 19%; however, this represents only 407 African-American TAY.

In FY 2003-2004, the number of unserved, low-income TAY was 7,349. Although both Caucasian and African-American TAY were seen in adequate numbers relative to the prevalence of SMI in the population, the numbers of unserved Latino and A/PI TAY were quite high (4,252 and 1,530, respectively).

Adults, age 26-59

According to tables provided by DMH, the prevalence of severe mental illness in Orange County, among low-income people in this age group, was 9% in 2004. In contrast, only less than 5% of low-income people in this age range were served by the County for mental health services in FY 2003-2004. Over half (51%) of the clients seen were Caucasian. Latinos made up 21% of the clients seen; A/PIs, 12% of the clients; and African-American and Native American/Indigenous much smaller percentages, reflecting their smaller numbers in the population.

The percentage of the low-income population receiving mental health service differed among the ethnic groups. African Americans and Caucasians had the highest rates (12% and 8%, respectively), although this only represented 485 African-American clients. The rate for A/PIs was about 3%; while for Latinos, it was less than 2%.

In Orange County in 2004, an estimated total of 26,312 low-income persons within the 26-59 age range had SMI. During that year, 13,731 persons were provided mental health services by the County, leaving an estimated 12,581 persons unserved. The largest group of unserved clients (10,805) was in the Latino population. Among A/PIs unmet need was estimated to be 2,405 persons. In contrast, for Caucasians, African Americans and Native Americans the level of unmet need is estimated to be quite small.

Older Adults, ages 60 and older

Within the low-income population, Latinos represent the largest numbers. Latino older adults constitute 52% of the Orange County residents with incomes less than 200% of the federal poverty level. The next largest ethnic group within the low-income population

is Caucasians, who represent 28% of the low-income population. A/PIs comprise 16% and African-Americans and Native American/Indigenous people much smaller percentages.

According to DMH tables, the prevalence of SMI in the low-income population of older adults in Orange County in 2004 was just under 7%. Of these 5,106 seriously mentally ill persons, Orange County provided services to 2,839 clients in FY 2003-2004.

The population served differed by ethnicity. Nearly 7% of low-income Caucasian older adults were served. African-American residents were seen at a rate of almost 6% of their numbers in the low-income population, and Native American/Indigenous people at a rate of about 4%. The corresponding percentage for A/PI clients was 3% and for Latinos, only 1%.

Populations for Full Service Partnerships

Full Service Partnerships are proposed for all age groups. Below is a brief description by age group of the situational characteristics of the priority populations to be served by FSPs.

Populations for Full Service Partnerships

Children and Youth (0-18 or 21 if in Special Education)
<ul style="list-style-type: none"> ▪ Preschool and school-age children unable to function in a mainstream school setting because of emotional problems ▪ SED children at risk for out-of-home placement ▪ SED children whose families are homeless, including those living in motels because of a lack of permanent residence ▪ SED children who are in the foster-care system ▪ SED children of parents who themselves have serious mental illness ▪ SED children who are exiting incarceration in the juvenile justice system ▪ Uninsured SED children ▪ SED children who are unserved or underserved because of linguistic or cultural barriers ▪ Children with multiple psychiatric hospitalizations ▪ Children with co-occurring disorders

Transitional Age Youth (16-25)

- School-age youth unable to function in a mainstream school setting because of emotional problems
- SED youth at risk for out-of-home placement
- SED youth whose families are homeless, or themselves are homeless, including those living in motels because of a lack of permanent residence
- SED youth who are in the foster-care system
- SED youth who are exiting incarceration in the juvenile justice system or the adult correctional system
- SED youth who are aging out of the foster care or juvenile justice system
- SED children of parents who themselves have serious mental illness
- Uninsured SED youth and young adults
- SED youth or young adults who are unserved or underserved because of linguistic or cultural barriers
- Youth or young adults with multiple psychiatric hospitalizations
- Youth or young adults who are losing Wraparound funding because of aging out of the child welfare system
- Youth and young adults experiencing their first episode of psychosis
- SED youth with co-occurring disorders

Adults (18-59)

- Adults with SMI who are homeless or at risk of homelessness, including those living in temporary residences, such as motels
- Adults with SMI who have co-occurring substance abuse problems
- Adults with SMI who are about to be or have recently been discharged from the criminal justice system
- Adults with SMI who are about to be or were recently discharged from psychiatric hospitals, whether hospitalized voluntarily or involuntarily
- Adults with SMI who have come to the attention of the justice system
- Adults with SMI who have been frequently hospitalized or are frequent users of emergency room services for psychiatric problems
- Adults with SMI who are in Skilled Nursing Facilities or Institutes for Mental Disease, but could live with support in the community

Older Adults (60 and older)

- Older adults with SMI who are unserved by the mental health system
- Older adults with SMI who are frequent users of emergency room services for psychiatric problems or are frequently hospitalized
- Older adults with SMI who are in Skilled Nursing Facilities or Institutes for Mental Disease, but could live (with support) in the community
- Older adults with SMI who are about to be or were recently discharged from psychiatric hospitals, whether hospitalized voluntarily or involuntarily
- Older adults with SMI who have co-occurring substance abuse problems
- Older adults with SMI who are about to be or have recently been discharged from the criminal justice system
- Older adults with SMI who have come to the attention of the justice system but have not been incarcerated
- Older adults with SMI who are at risk for suicide

Programs

The plan contains 18 separate programs. There are four for Children and Youth, five for Transitional Age Youth, five for Adults, two for Older Adults and two that cross age groups (training and housing). Below is a brief summary by age group of the programs for which funding is being requested. Although all of these programs will be provided in the first three years, because of the use of one-time money in the first year, programs may vary slightly in Years 2 and 3.

Children & Youth (CY) – 4 Programs

1. CYS Integrated/Wraparound Services Program

The Children’s Full Service/Wraparound (FS/W) Program will be a community-based, family-centered program where individualized, family-driven plans are developed. It will focus on family strengths, and meet the needs of children and families across life domains to promote success, safety, and permanence in home, school and community through a “whatever-it-takes” approach. Through direct delivery, use of community resources and access to flexible funding, services secured will 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, supported employment or education, transportation, housing, benefit acquisition, respite care, co-occurring disorders services, etc.

2. Outreach & Engagement Services

This program seeks to establish outreach and engagement activities in order to increase utilization of mental health services to unserved SED children and their families in the neighborhoods where they reside, or those who are homeless. By promoting access to services in a locally integrated environment, the stigma of

receiving mental health services will be reduced. Services offered in a culturally competent, family-focused, strength and community-based manner will provide opportunities to build trust and encourage the establishment and growth of local support systems. The concept of community collaboratives, local resource development, and strength-based services is well established as a best practice model. This program will employ culturally competent outreach workers trained in recovery and resiliency concepts, who are locally-based, highly visible, and resource knowledgeable, to not only facilitate access to community mental health services, but to build on-going community supports that will sustain future efforts in healthful living.

3. In-Home Crisis Stabilization Services

This program will provide family stabilization teams that deliver intensive, in-home crisis intervention services those SED children (and their families) who have been assessed as being at imminent risk of psychiatric hospitalization or out-of-home placement. The provision of in-home crisis stabilization services will promote resiliency in children and youth 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 and juvenile justice system.

4. Crisis Residential Services

The provision of crisis residential services will promote resiliency in youth in crisis by providing them and their families with a short-term, temporary residential resource that can provide respite and also facilitate the learning of coping strategies that reduce at-risk behaviors, peer and family problems, out-of-home placement, and involvement in the child welfare and juvenile justice system.

Transitional Age Youth (TAY) – 5 Programs

1. TAY Integrated Services Program

The Transitional Age Youth (TAY) Full Service/Wraparound (FS/W) Program will be a community-based, client-centered program where individualized, client-driven plans are developed. It will focus on client strengths, and meet the needs of transitional age youth and, in many cases, their families across life domains. This program will promote success in school or work, safety, wellness and recovery through a “whatever-it-takes” approach. It will be modeled on the Orange County Health Care Agency’s experience in the current, successful Orange County Wraparound program and follow Children’s System of Care principles.

2. Outreach & Engagement Services

This program seeks to establish outreach and engagement activities in order 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 those who are homeless. By promoting access to services in a locally integrated environment, the stigma of receiving mental health services will be reduced. Services offered in a culturally competent, strength and community-based

manner will provide opportunities to build trust and encourage the establishment and growth of local support systems. The concepts of community collaboratives, local resource development, and strength-based services are well established as best practices. This program will employ culturally competent outreach workers trained in recovery and resiliency concepts, who are locally-based, highly visible, age consistent with those they are serving, and resource knowledgeable, to not only facilitate access to community mental health services, but to build on-going community supports that will sustain future efforts in healthful living.

3. Education & Employment Services

The Transitional Age Youth (TAY) Supported Education and Employment Program will be a community-based, client-centered, program where individualized, client-driven education and employment options are developed. It will assist the transitional age youth in meeting a key element of resilience and recovery, engagement in education or employment through a “whatever-it-takes” approach. It will support the TAY Full Services /Wraparound (FS/W) Program and will follow Children’s System of Care principles.

4. Crisis Residential Services

The provision of crisis residential services will promote 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 provide respite and also facilitate the learning of coping strategies that reduce at-risk behaviors, peer and family problems, homelessness, and involvement in the justice system.

5. Transitional Age Youth Housing

The Transitional Age Youth (TAY) Supportive Housing Program will be a community-based, client-centered program where individualized, client-driven housing options are developed. It will assist the transitional age youth in meeting a key element of resilience and recovery, a safe and stable living environment through a “whatever-it-takes” approach. It will support the TAY Full Services /Wraparound (FS/W) Program and will follow Children’s System of Care principles.

Adult (ADL) – 5 Programs

1. Adult Integrated Service Program

The Adult Integrated Service Program will provide county-wide individualized, integrated culturally-competent services for adults with a serious mental illness. High priority populations are those who are homeless and those who may have co-occurring disorders. Individuals will enroll in a voluntary program with a single point of responsibility. Each enrolled individual participates in the development of a plan that is focused on recovery and wellness. Each Personal Services Coordinator (PSC) will have a low client-to-staff ratio. Services include: 24/7 availability and linkage to or provision of all needed services. Services are founded on a “whatever it takes” commitment.

2. Crisis Assessment Teams & Psychiatric Emergency Response Teams

This program will provide one centralized assessment team to provide emergency mental health evaluation throughout Orange County, including emergency rooms. It will also provide one Psychiatric Emergency Response Team to collaborate with law enforcement to conduct mental health evaluations. This program advances the MHSA goal of integrated services and timely access.

3. Crisis Residential Services

This program provides a residential treatment alternative to hospitalization for seriously mentally ill persons in acute psychiatric crisis who cannot be safely and effectively managed on an outpatient bases. Services are offered 24/7 by a culturally competent multi-disciplinary staff dedicated to the values of the Recovery Model.

4. Supported Employment Services for SMI Clients

This program will provide education and support to people with mental illness and co-occurring disorders, who require long-term job supports, to obtain competitive employment. The program will provide: (1) job preparation training, which will include pre-employment classes aimed at identifying individual clients' skills and interests; (2) workplace responsibilities and expectations; (3) communication skills; (4) managing symptoms and stress in the workplace; (5) grooming and dressing for success; (6) resume writing; and (7) successful job application techniques. Job developers will act as liaisons in the community, assisting potential employers to better understand mental illness. The job developer will locate a variety of employment opportunities in the community. Job coaches will assist clients on-the-job with workplace skill development, business interactions and problem resolution. Job coaches will maintain contact with care coordinators and Personal Services Coordinators to assure seamless service delivery.

5. Outreach and Engagement Services

This program will foster co-location of mental health services in existing primary care practitioners' offices and community clinics enabling access to services for the unserved population. Primary care and mental health integration is a best practice model to more effectively engage individuals who do not traditionally seek mental health services due to stigma associated with traditional mental health settings.

Older Adults (OA) – 2 Programs

1. Older Adult Services (OAS)

OAS will provide behavioral health services to seniors who are age 60 and over and who have serious mental illness. This program will operate on a team model of Recovery and consist of a program supervisor, program support staff, mental health clinicians, a geropsychiatrist, a pharmacist, peer support counselors, and Public Health nurses. Services will include: (1) assessment, (2) mental health rehabilitative and recovery services, (3) services for co-occurring disorders, (4) physical health

care screenings, (5) education regarding proper use of medications, (6) client and family-member education about mental illness, and (7) case management and linkage services, as necessary. All services will be provided to the seniors in their place of residence, or in a senior center, faith-based organization, community center, adult day care center or other site of their choice.

2. Older Adult Support and Intervention System (OASIS)

The OASIS is a new full service partnership program targeted at mentally ill seniors who are unserved or underserved and homeless or at risk of homelessness. The program will focus on attaining and maintaining maximum independence in the community for each of the participants and will utilize a “whatever it takes” approach to achieve individualized goals. There is an emphasis on client/family/caregiver-driven services as well as a focus on the inclusion of underserved/unserved ethnic groups and cultures in order to reduce disparities in access to services.

Wellness for seniors will be stressed and clients will be linked to coordinated primary physical health care and mental health treatment. Mental health and co-occurring substance abuse services will be delivered according to individualized treatment plans by personal services coordinators. Public Health nurses will perform physical health screening. A geropsychiatrist will assess the need for medication management to reduce symptoms. Medication education will be completed by a pharmacist.

Peer counselors, known as Life Coaches, will be trained to assist the seniors, their families and/or caregivers in many ways, including access to entitlements and community resources and stigma elimination. A recovery philosophy will guide all treatment planning. Seniors will be assisted by trained peer counselors to be linked to benefits acquisition and health coverage advocacy, housing, transportation, meal services, services supporting employment and training opportunities, other social services, and legal services, as needed and desired. Family members and caregivers will be linked to respite care services.

The outreach and education program in Older Adult Services (OAS) will provide a Geriatric Educator who will reach into the community to seniors, their family members and caregivers to assist in combating stigma. It is well known that mental illness can begin at any age. When symptoms appear in seniors, they are often misunderstood as being a normal part of aging. The educator will teach the seniors and families/caregivers the signs to watch for, so appropriate treatment can be accessed in a timely manner.

Collaboration is critical as older adults tend to utilize multiple services provided by multiple agencies in the community. Therefore, the educator will establish relationships with these organizations and departments to provide information to them as well. Examples include: the police and fire/paramedics, emergency room staff, community clinic staff, primary care physicians, in-home service providers, landlords, board and care operators, assisted living center staff, senior center staff,

adult day care staff, faith based organizations, professionals and paraprofessionals working with the seniors. Additionally, this program will distribute materials about mental illness and co-occurring disorders with resources available to them.

Intergenerational Programs – 2 Programs

1. Education & Training

It is proposed that one-time funding be used to support system development through an Education and Training Program. This program will provide training of clients and family members, community partners, mental health administrators and behavioral health staff who work with clients of all ages. Examples of the types of training to be provided include the following:

- 1) Early identification of mental illness
- 2) Cultural competency, including training of staff and outreach to underserved cultural groups, with materials in threshold and emerging languages
- 3) Training of clients and family members to work within the mental health services system
- 4) Training of community partners (education, criminal justice, social services, housing community, medical community, etc.)
- 5) Training of behavioral health staff, including consumer and family member staff, to improve working with families. This will include outreach and support to families of clients and potential clients who may be involved with child welfare, juvenile justice, corrections, primary health care, the educational system, or elder services.
- 6) Training of staff on co-occurring disorders and integrated treatment
- 7) Training of staff and consumers in methods of benefits acquisition
- 8) Development of a nonprofit Training Institute, with consumer and family member direction, to pursue continued funding of recovery-based training and evaluation activities after the end of the one-time funding period

2. Housing

Safe affordable housing is one of the basic requirements needed in order to promote recovery/wellness for individuals (and their families) with severe mental illness or serious emotional disturbance. Appropriate housing is crucial to maintaining stability in the community. For those with very low income and who are homeless, finding safe affordable housing in Orange County is a real challenge. This housing program will include a flexible pool of money in a housing trust fund to support the members of full service partnerships. A continuum of housing will be developed that will include short-term transitional, supportive, and permanent housing. One time funds will be used for short term lodging in shelter beds, motel vouchers, transitional housing, shared group housing, augmented residential care facilities, rental subsidies for permanent supportive housing, security deposits and other potential housing assistance. Funds will be available for housing specialists that can assist in locating housing resources and successfully obtaining housing for individuals and families. Housing will be developed and provided in a culturally sensitive manner, with special attention paid to language, ethnicity, gender, and client culture.

Conclusion

In conclusion, the Orange County planning process was a concentrated effort by a large group of consumers, family members, service providers, and representatives of interested organizations. The goal was to develop a plan to better serve those individuals and families residing in Orange County who are in need of community mental health services and supports. The plan described above cannot meet the large backlog of unmet needs. It can, however, make exciting progress in transforming the Orange County Mental Health System by enhancing the continuum of services currently available and increasing access to care for racial and ethnic minority populations that have traditionally been underserved. The local MHSA planning process and Orange County's plan for using this funding have also brought an intangible benefit to the community, i.e., hope that for individuals and families affected by mental illness, the future will be better than the past.