2021-2022

DRAFT

ORANGE COUNTY

Mental Health Services Act

2022 Annual Plan Update

WELLNESS • RECOVERY • RESILIENCE

OC health CARE AGENCY

MESSAGE FROM THE AGENCY DIRECTOR

This year marks one year into our current Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan. It also marks one year into an unprecedented public health crisis, during which time counties have been working diligently to protect and support the physical health and mental well-being of their residents. Importantly, we must also prepare for the fact that the emotional impact of coronavirus illnesses can persist for years following the worst of the pandemic. As such, we remain committed to advancing the three strategic priorities of the current MHSA Three-Year Plan: 1) extend the scope and reach of mental health awareness campaigns, community training and education; 2) strengthen the County's suicide prevention efforts by expanding the programs making up our crisis services continuum; and 3) improve access to needed behavioral health services. Through these inter-related efforts, the MHSA will continue to transform the Orange County mental health system via the principles of community collaboration; cultural competence; wellness, recovery and resilience; consumer- and family-driven decision-making; integrated service experiences; and increased access for unserved and underserved populations.

While it remains a top priority to ensure that we provide our consumers, family members and participants with exemplary services, we are also called to pay attention to our own cultural awareness and sensitivity. As we do our work, it is incumbent that we do so from a health equity perspective – addressing longstanding inequalities in service delivery and outcomes based on race, ethnicity and culture. An important step in this transformation is a continued commitment to engage meaningfully with the people, families and communities we have the privilege of working with every day, and whose voices have helped shape this MHSA Annual Plan Update.

Our progress to date would not have been possible without the support and guidance of groups and entities including the Orange County Board of Supervisors, Behavioral Health Advisory Board, MHSA Steering Committee, advocates for the unserved and underserved, members of our provider organizations, OC Health Care Agency (HCA) and County staff and, most importantly, the multitude of consumers and family members who have so graciously given their time and expertise to create the successes achieved over the past 16 years.

I am pleased with the continued success of many of our programs and encouraged by the plans to expand our system and outreach methods in new and exciting ways. This was truly a collaborative effort between our outstanding county residents, community partners and Behavioral Health Services staff, and demonstrates our dedication to improving the lives of the individuals and family members affected by mental health conditions here in Orange County.

Sincerely,

Jeffrey A. Nagel, Ph.D.
Deputy Agency Director for Behavioral Health Services

Table of Contents

EXECUTIVE SUMMARY

In November 2004, California voters passed Proposition 63, also known as the Mental Health Services Act (MHSA). The Act implemented a 1% state tax on income over $1 million and emphasizes transforming the mental health system to improve the quality of life for individuals living with a mental health condition and their families. With 16 years of funding, mental health programs have been tailored to meet the needs of diverse consumers in each county in California. As a result, local communities and their residents are experiencing the benefits of expanded and improved mental health services.

Orange County Behavioral Health Services (BHS) has used a comprehensive stakeholder process to develop local MHSA programs that range from prevention services to crisis residential care. Central to the development and implementation of all programs is the focus on community collaboration; cultural competence; consumer- and family-driven services; service integration for consumers and families; prioritization of serving the unserved and underserved; and a focus on wellness, recovery and resilience. The current array of services was developed incrementally, starting with the planning efforts of stakeholders in 2005 and continuing to present day.

This Executive Summary contains a synopsis of the significant changes being proposed for Orange County's MHSA programs and/or program budgets in Fiscal Year (FY) 2021-22. To understand the context of these changes, a review of the Strategic Priorities for the County's MHSA Three-Year Program and Expenditure Plan for FYs 2020-21 through 2022-23 is provided below. The full Annual Plan Update also includes a detailed description of the HCA's community program planning process (CPPP), descriptions of the target population to be served, the services to be provided and outcomes achieved by each MHSA-funded program, and supporting documentation in the Appendices.

MHSA Three-Year Plan Progress Update

Strategic Priorities for the Three-Year Plan

Following the community planning process in 2019 and 2020 that was used to develop the Three-Year Plan (3YP) beginning in FY 2020-21, the HCA identified the following MHSA Strategic Priorities:

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

In preparation for the community planning process for the FY 2021-22 Annual Plan Update, the HCA reviewed the current status of each of OC's MHSA priorities (see below). Based on this review, as well as HCA's commitment to on-going discussions with community stakeholders from unserved and underserved populations, this year's community planning focused on engaging with community members to pinpoint potential approaches that would be responsive and tailored to the identified priority populations ('starred' sections below):

STRATEGIC PRIORITY: Mental Health Awareness & Stigma Reduction

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

Priority Populations

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

Strategies

- ★ **Continue partnering with local groups engaged with the priority populations**
- Continue partnering with CalMHSA's Statewide Projects and other organizations
- Partner with media/marketing organizations

- Incorporate findings & recommendations from RAND reports on social marketing

Progress Update

- ✔ **Establishing and/or strengthening outreach partnerships with trusted local organizations that serve priority populations**
- ✔ Offering range of mental health trainings for various community organizations
- ✔ Expanding reach of CalMHSA *Directing Change* project in OC schools
  Launched local digital stigma reduction and awareness campaigns *(click links to learn more)*:
  - Stigma Free OC Campaign
  - Stigma Free OC website
  - Connect OC Coalition website
- ⋯ Beginning to increase/expand use of social marketing to promote mental health-related messages

STRATEGIC PRIORITY: Access to Behavioral Health Services

Improve access to behavioral health services and address transportation challenges

★ Priority Populations

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

Strategies

- **Work with community to identify and integrate culturally and linguistically responsive strategies and approaches**
- Offer telehealth/virtual behavioral health care options for people of all ages living w/ significant mental health conditions
- Expand school-focused mental health services

- Expand transportation services

Progress Update

- ✔ **Establishing and/or strengthening partnerships with trusted local organizations that serve priority populations**
- ✔ Made rapid, systemwide transition to various virtual behavioral health services and supports in response to COVID-19
  - *Continuing to work through challenges in accessing, transitioning to, and using technology by providers and/or clients*
  - *Expanded hours/availability of counseling services*
- ✔ Launched outreach, peer support, networking and resource activities for K-12 students, college students and TAY
- ✔ Along with OC Department of Education and OC School Districts, implementing a grant to coordinate referrals and linkages, and to train school staff on mental health topics
- ⏸ Waiting for State direction on new Medi-Cal program in schools
- ⏸ Transportation support remains available at reduced levels due to COVID-19 and expansion on pause

✔ Completed & ongoing ⋯ In progress, some delays due to COVID ⏸ Paused due to COVID

STRATEGIC PRIORITY: Suicide Prevention

Expand support for suicide prevention efforts

★ Priority Populations	Strategies	Progress Update
• **People from all MHSA age groups** • **Homeless individuals** • **Individuals living with co-occurring mental health and substance use conditions** • **LGBTIQ individuals** • **Veterans**	• Increase capacity of Warmline and Suicide Prevention Services	✔ Warmline expanded to 24/7 ✔ Suicide Prevention Services increased staffing to manage rising call volume and community training requests ○ *While there has been some success outreaching to monolingual & limited English-speaking communities, cultural & generational barriers persist and callers continue to be predominantly English-speaking. A gradual shift in perceptions has been observed in younger generations, and there is also growing interest in suicide prevention in the Korean media*
	• Increase crisis services for youth under 18 • Increase Crisis Residential Services for adults/older adults	✔ Crisis residential services expanded for adolescents, adults/older adults
	• Continue partnering with OC Community Suicide Prevention Initiative	✔ Examples of resulting activities/campaigns *(also leverage CalMHSA's Know the Signs information; click links to view):* ○ Suicide Prevention Campaign for Adult/Older Adult Men ○ Adult "Help is Here" website ○ Youth "Be a Friend for Life" website
	• Use strategies from MHSOAC Striving for Zero report	⊙ HCA ramped up various suicide prevention and mental health resources in response to COVID pandemic (*click* here *for example)*. These and other activities will be cross-walked to the MHSOAC strategies as time permits.

MHSA Components and Funding Categories

MHSA funding is broken down into five components that are defined by the Act: Community Services and Supports (CSS), which includes funding allocations for MHSA Housing, Prevention and Early Intervention (PEI), Innovation (INN), Workforce Education and Training (WET), and Capital Facilities and Technological Needs (CFTN). A brief description and the funding level for each of these areas is provided below. This section first begins with a brief description of the budget "true up" process, which helps to identify availability of funds.

Budget Review and "True up" Process

As part of the fiscal review done in preparation for the current MHSA Annual Plan Update, HCA staff engaged in a detailed process of aligning existing program budgets more closely with actual program expenditures from the most recent fiscal year (i.e., FY 2019-20). This budget "true up," which is done annually, allows managers to identify cost savings for programs that could be transferred to cover budget increases and/or implementation costs of other programs within the same MHSA component.

Based on the significant MHSA budget shortfall initially projected by the state during the COVID-19 pandemic, the HCA prepared to close a projected $72 million deficit in CSS and PEI the end of FY 2022-23. BHS program and HCA fiscal managers spent several intensive months identifying cost savings that would have the least impact on consumers. Staff reviewed and discussed the proposed changes with the MHSA Steering Committee over several months, which concluded in November 2020 (see Appendix I), and was used to inform the proposed component budgets presented at the March 2021 MHSA meeting (see Appendix II).

In February 2021, as HCA staff were finalizing the proposed updates, the state issued dramatically revised projections, swinging Orange County from a projected deficit of $72 million to a projected surplus of nearly $50 million in CSS and PEI at the end of FY 2022-23. At the same time, the MHSA Office was in the midst of conducting its 2021 CPPP. With an anticipated increase in available funding, at the conclusion of the last CPPP meeting held on April 19, 2021, the MHSA Office rapidly analyzed stakeholder feedback, program and financial services managers re-evaluated program budgets and BHS staff identified additional opportunities to update the MHSA Annual Plan based on consumer and family member feedback.

Most of the current proposed changes are to 1) reverse budget reductions identified in 2020 during a very different financial landscape and/or 2) respond to Board of Supervisor directives. In addition, there are three proposals for new uses of CSS and PEI funding, described in more detail below. These proposals were developed based on community feedback, anticipated community needs and the projected availability of funds. Importantly, all new funding proposals are naturally time-limited and can be discontinued with minimal impact to Orange County consumers and family members should the fiscal landscape shift once again. This flexibility was regarded as important given the marked volatility in MHSA projections and lingering uncertainties related to the future of COVID-19.

Community Services and Supports Component

Community Services and Supports (CSS) is the largest of all five MHSA components and receives 76% of the Mental Health Services Fund. It supports comprehensive mental health treatment for people of all ages who are living with a serious mental health condition that is significantly impacting their daily activities and functioning. CSS develops and implements promising or proven practices designed to increase underserved groups' access to services, enhance quality of services, improve outcomes and promote interagency collaboration.

Several changes to the CSS component are proposed for Orange County's FY 2021-22 MHSA Plan Update. These include shifts in program budgets, discontinuation of programs and implementation of new projects. While the proposed modifications generate a net increase in the overall CSS component budget, it remains lower than what was originally approved in the Three-Year Plan and closely approximates the annual CSS revenue of approximately $158 million that is currently projected by the state at the writing of this report.

Slightly over half of the CSS budget (51%), excluding transfers to WET and CFTN, is dedicated to serving individuals enrolled in and/or eligible to be enrolled in a Full Service Partnership program. A description of each CSS program is provided in this Plan.

FISCAL YEAR	CSS
FY 2020-21 *(from 3YP)*	$155,088,175
FY 2021-22 *(from 3YP)*	$164,627,171
FY 2021-22 *(proposed)*	**$158,785,110**
FY 2022-23 *(from 3YP)*	$165,320,336

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

CSS	PROGRAM	ORIGINAL PROPOSED UPDATE (per presentation on March 15, 2021; see Appendix II)	MODIFIED PROPOSED UPDATE (as reflected in Exhibit A FY 2021-22 Budget Grids)
ACCESS & LINKAGE TO TREATMENT	**BHS Outreach & Engagement**	**Transfer all costs** to PEI (~$2.6m CSS savings annually)	*No change from March 15, 2021 budget worksheet*
	Recovery Open Access	Right-size and **increase annual budget** to $2.6m	*No change from March 15, 2021 budget worksheet*
CRISIS PREVENTION & SUPPORT	**Crisis Residential Services (CRS)**	Net decrease of $265k due to: Delaying expansion of Children's Crisis Residential Program for 6 months to start of FY 2021-22; Maintaining CYBH-managed TAY CRS beds at 6 rather than expanding to 12 (this provider's services were significantly under-utilized by TAY relative to those offered by the AOABH-operated CRS provider, thus planned expansion not proceeding); and Increasing budget due to lease costs at Anita Be Well Campus	**No decrease** to CRS budget. Remain level at $11,280,845 and instead encumber the $265k net savings for psychiatrist to support CRS; depending on how long candidate search and hiring process goes, funds may be spent in later FY. In addition, should DHCS release requirements for children's Psychiatric Residential Treatment Facilities (PRTF), additional unencumbered CSS funds (above $265k in originally proposed savings) may be used to expand CRS for children's PRTF beds
CLINIC EXPANSION	**Children & Youth Clinic Services**	**Time-limited decrease** to account for decreased expenditures resulting from COVID-19 impacts and related delays impacting start-up	*No change from March 15, 2021 budget worksheet.* However, should start-up go faster than anticipated, available CSS funds may be added during FY 21/22 if demand for services exceeds proposed budget
	Services for the Short-Term Residential Therapeutic Program (STRTP)	**Time-limited decrease** so budget better reflects savings accrued during lengthy DHCS licensure/approval process that results in significant delays before services can be offered	*No change from March 15, 2021 budget worksheet*
	Outpatient Recovery	**Decrease** to right-size, including savings from vacancies	*No change from March 15, 2021 budget worksheet*
	Integrated Community Services	**Retire** as a result of services having been transitioned to CalOptima during FY 2019-2020	*No change from March 15, 2021 budget worksheet*
	Telehealth/Virtual Behavioral Health Care	**Cancel** implementation of new program offering telehealth and virtual behavioral health care solutions	In response to community feedback, reinstate new program, with program implementation and ramp up including needs assessment and initial focus on increasing digital literacy and digital health literacy both of consumers and service providers (see description under NEW CSS EXPENDITURES)

CSS	PROGRAM	ORIGINAL PROPOSED UPDATE (per presentation on March 15, 2021; see Appendix II)	MODIFIED PROPOSED UPDATE (as reflected in Exhibit A FY 2021-22 Budget Grids)
FSP/PACT	**Full Service Partnership (FSP)**	**Overall decrease** of $2m due to 1) right-sizing TAY provider budget and 2) a time-limited decrease in the Adult Housing FSP provider budget resulting from reduced expenditures during program ramp up combined with use of alternative funding	**No decrease** to combined FSP budget; remain level funding at ~$53.8m, adding $500k to each age group (Children increased to ~$11.6m, TAY level at ~$8.2m, Adult increased to ~$30.3m, Older Adult increased to ~$3.7m) so several providers that recently began operating at full capacity can continue to serve participants at an appropriate, reduced FSP-caseload. Actual adjustments may vary depending on need.
	Program for Assertive Community Treatment (PACT)	**On-going increase** to cover increased staffing for Older Adult team, enhanced flexible funding for non-billable services that support the "Whatever It Takes" intervention model, and after-hours coverage	*No change from March 15, 2021 budget worksheet*
SUPPORTIVE SERVICES	**CSS Housing**	**On-going increase** to cover increase in staff salaries covered by MOU with OCCR that were the result of recent labor negotiations	*No change from March 15, 2021 budget worksheet*
	Mentoring Program for Children and Youth	**Retire** program due to multiple factors, including challenges with ability to demonstrate program efficacy; youth and parents will continue to receive peer/parent partner support through the Peer Mentoring and Parent Partner Support program	*No change from March 15, 2021 budget worksheet*
ADMIN	**CSS Administrative Costs**	**Net increase** of $71k to transition CSS programs into OC Navigator, the digital tool being developed as part of the BH System Transformation INN Project. Funds will also support development of automated/electronic features designed to increase productivity and operational efficiency (i.e., electronic bed board for CSUs, CRS, etc.; dashboards, reports; integration with HCA EHR, etc.)	In response to community feedback, **add additional, time-limited funds**, in an amount not to exceed $400k, for BHS facility improvements (see description under NEW CSS EXPENDITURES)

New CSS Expenditures Proposed as a Result of the CPPP

In addition to the above recommended shifts, the HCA is proposing two recommendations for new or enhanced funding based on feedback received from consumers, clients and family members during the 2021 community engagement meetings (CEM). A brief summary of the focus group discussions that generated these recommendations is below.

The first recommendation is to reinstate the Telehealth/Virtual Behavioral Health Care program because of CEM participants' overwhelming preference to engage in both in-person and telehealth services even after the pandemic ends and even though they had experienced challenges with telehealth during the pandemic. Rather than rejecting telehealth as a service delivery option out-right, they expressed a need to learn about how to use and navigate technology and, to a lesser extent, improving access to (quality) devices and Wi-Fi.

STRATEGIC PRIORITY: Access to Behavioral Health Services

Improve access to behavioral health services and address transportation challenges

Priority Populations

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

Strategies Discussed During PEMs

WHAT WORKED

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

WHAT DIDN'T WORK

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

Proposal: Reinstate and expand scope of Telehealth Virtual Healthcare

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

CEM participants were also asked about the types of changes or improvements that would make services feel more welcoming and easier for their community to connect with services. Much of the discussion focused on the importance of meeting a person where they were at, understanding their culture and having a shared language. Interestingly, participants also indicated that the physical space helped set a tone.

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

STRATEGIC PRIORITY: Access to Behavioral Health Services

Improve access to behavioral health services and address transportation challenges

Priority Populations

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

Strategies Discussed During CEMs

WHAT WORKS

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

WHAT DOESN'T WORK

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

Proposal: Create more welcoming spaces in clinic common areas

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

Prevention and Early Intervention Component

MHSA dedicates 19% of its allocation to Prevention and Early Intervention (PEI), which is intended to prevent mental health conditions from becoming severe and disabling and to improve timely access for people who are underserved by the mental health system.

As part of the current Three-Year Plan, several PEI program consolidations were implemented to streamline operations and create efficiencies without negatively impacting service delivery. They are as follows:

- The *Suicide Prevention Services* program is the consolidation of the former Suicide Prevention Hotline and Survivor Support Services into a single County-contracted program. Beginning FY 2021-22, this program will also include the newly formed Office of Suicide Prevention within the HCA's Behavioral Health Services area.
- The *OC Parent Wellness Program* is the consolidation of the former County-operated, family-focused early intervention programs that provides comparable services tailored to meet the needs of three specific target populations
- The *Community Counseling and Supportive Services Program* is the consolidation of two County-operated early intervention programs serving all age-groups and culturally diverse populations.
- The *Outreach to Increase Recognition of the Early Signs of Mental Illness* program is the consolidation of six programs that provide similar outreach and training activities through a network of providers that each specialize in working with specific target populations.

Several changes to the PEI component are proposed for Orange County's FY 2021-22 MHSA Plan Update. These include shifts in program budgets, discontinuation of a program and implementation of new projects, which are summarized in a series of tables below.

Consistent with PEI requirements, 59.71% of the total PEI budget is dedicated to serving youth who are under age 26 years. PEI is governed by additional regulations and legislation, which are described in Appendix III. A description of each PEI program is provided in this Plan.

FISCAL YEAR	PEI
FY 2020-21 *(from 3YP)*	$47,061,483
FY 2021-22 *(from 3YP)*	$49,286,926
FY 2021-22 *(proposed)*	**$56,144,101**
FY 2022-23 *(from 3YP)*	$40,988,101

Synopsis of proposed and modified PEI budget adjustments. Similar to CSS, the following tables summarize the shifts in PEI program funding between March 15, 2021 MHSA Committee meeting (middle column), and the draft Plan currently posted (right column).

PEI	PROGRAM	ORIGINAL PROPOSED UPDATE (per presentation on March 15, 2021; see Appendix II)	MODIFIED PROPOSED UPDATE (as reflected in Exhibit A FY 2021-22 Budget Grids)
MH AWARENESS & STIGMA REDUCTION	**MH Community Education Events for Reducing Stigma and Discrimination**	No proposed change	Time-limited increase of $319k to FY 21-22 budget, resulting in a total budget of $1.2m with set-aside for Veteran-specific event (see description under NEW PEI EXPENDITURES)
	Outreach for Increasing Recognition of Early Signs of Mental Illness	**Time-limited net decrease** due to impact of COVID-19 and restrictions/limitations on large events/mass gatherings	In response to community feedback, **increase** by ~$2.7million (see description under NEW PEI EXPENDITURES)
PREVENTION	**School Readiness**	**Decrease** due to one provider contract not being renewed	*No change from March 15, 2021 budget worksheet*
	Parent Education Services	**Increase** Parent Education Services using funds from School Readiness budget reduction to provide support to families with children ages 0-8 years	*No change from March 15, 2021 budget worksheet*
	Children's Support & Parenting Program	**Decrease** due to savings from vacancies and temporary staff re-deployments to other programs in response to COVID-19	*No change from March 15, 2021 budget worksheet*
	School-Based Health Intervention & Support	**Reduce** back to on-going budget level due to ending of time-limited expansion using carryover funds	*No change from March 15, 2021 budget worksheet*
	School-Based Stress Management Services	Following the retirement of the provider's Subject Matter Expert, **discontinue** standalone program and continue to provide mindfulness training for students/school staff through BH Training Services	*No change from March 15, 2021 budget worksheet*
ACCESS & LINKAGE TO TREATMENT	**OC Links**	In response to Board Directive for HCA to create a 24/7 Behavioral Health Line, OC Links budget **increased** by $1.2m annually to cover 24/7 expansion including crisis calls and dispatch	**Add** a total of $3m ($1.8 additional) to cover additional staffing needs beyond what was first projected when program shifted to 24/7 operations, as well as county-wide marketing campaign advertising the BHS single access line; per CEM/community feedback, ensure that materials are tailored/customized to the specific target audiences (language, images, culture, etc)
	BHS Outreach and Engagement	**On-going increase** to cover shift of program MHSA-related costs to be covered entirely by PEI (rather than being shared with CSS; other funding sources also being used)	*No change from March 15, 2021 budget worksheet*

PEI	PROGRAM	ORIGINAL PROPOSED UPDATE (per presentation on March 15, 2021; see Appendix II)	MODIFIED PROPOSED UPDATE (as reflected in Exhibit A FY 2021-22 Budget Grids)
CRISIS PREVENTION & SUPPORT	**Warmline**	**On-going increase** to cover increased staffing costs due to services being increased to 24/7 and time-limited increase to cover increased lease costs at Anita Be Well Campus	**On-going increase** by $500k to improve staffing/shift coverage now that program has shifted to 24/7 operations, bringing total budget to $2 million
	Suicide Prevention Services	No proposed change	**Increase ongoing budget of contracted provider by $500k** in response to community need, a**nd increase on-going budget by additional $1million** to implement programming through the BHS Office of Suicide Prevention, established in response to Board Directive (see description under NEW PEI EXPENDITURES)
EARLY INTERVENTION OUTPATIENT	**School-Based Mental Health Services (SB MHS)**	**On-going decrease** of PEI funds due to anticipated Medi-Cal revenue generation	**No decrease**; keep level PEI funding due to unanticipated effect of Medi-Cal billing process resulting in reduced referrals to program
	OC CREW	**On-going decrease** of PEI funds due to anticipated Medi-Cal revenue generation	Adjust projected PEI savings from $204k to $50k due to lower than anticipated Medi-Cal revenue as program readjusts to new billing requirements. In contrast to SB MHS, OC CREW not experiencing same impact on referrals after beginning to bill Medi-Cal
SUPPORTIVE SERVICES	**Transportation**	**Time-limited decrease**, resulting from impact of COVID-19 on delaying start-up of program in PEI	*No change from March 15, 2021 budget worksheet.* However, available PEI funds may be added during FY 21/22 if demand for transportation exceeds current proposed budget
ADMIN	**PEI Administrative Costs**	**Net increase** of $600k to transition PEI programs into OC Navigator, the digital tool being developed as part of the BH System Transformation INN Project. Funds will also support development of automated/electronic features designed to increase productivity and operational efficiency (i.e., electronic bed board for CSUs, CRS, etc.; dashboards, reports; integration with HCA EHR, etc.)	*No change from March 15, 2021 budget worksheet*

New PEI Expenditures Proposed as a Result of the CPPP

In addition, the HCA is proposing to respond to CPPP input and enhance funding for mental health awareness campaigns and education. Upon a Board Directive,

the HCA will also use PEI funds to support a new Office of Suicide Prevention. A brief summary of these recommendations is below.

STRATEGIC PRIORITY: Mental Health Awareness & Stigma Reduction

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

Priority Populations

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

Recommended/Preferred Strategies

From CEMs:

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

From PEMs:

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

Proposed Activities for FY 2021-22

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

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

STRATEGIC PRIORITY: Office of Suicide Prevention

Expand support for suicide prevention efforts

Priority Populations

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

Board of Supervisors Directive

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

Proposed Activities

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

Innovation Component

The MHSA designates 5% of a County's allocation to the Innovation (INN) component, which specifically and exclusively dedicates funds to trying new approaches that contribute to learning rather than expanding service delivery. Projects are time-limited to a maximum of five years and evaluated for effectiveness and consideration for continued funding through CSS, PEI or other funds. All active projects are described in this Plan, and regulations governing the INN component are described in Appendix IV.

In addition, the HCA is in various stages of exploring several new potential INN projects, listed below (please see Special Projects for the complete list).

- allcove
- Middle School Student Wellness Centers
- Mobile Phones
- Psychiatric Advanced Directives
- Social Media & Approaches to Stigma Reduction

The Continuum of Care for Veterans and Military Families project was extended for one additional year to continue data gathering and evaluation, utilizing the remaining INN project-approved budget and timeline. The remaining project budget was not reflected in the FY 2020-2023 MHSA Three-Year Program Expenditure Plan due to an oversight. It is included in the Annual Plan Update, which resulted in an adjusted INN component budget.

FISCAL YEAR	INN
FY 2020-21 *(from 3YP)*	$18,346,360
FY 2021-22 *(from 3YP)*	$9,009,773
FY 2021-22 *(proposed)*	**$10,999,190**
FY 2022-23 *(from 3YP)*	$2,042,071

Workforce Education and Training Component

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

The budget in FY 2021-22 is to remain the same from that which was approved in the MHSA Three-Year Plan. Increases to the Training and Technical Assistance program and the Financial Incentives Program are offset by a decrease to the Residencies and Internships Program. A full description of each WET program is provided in the Plan Update.

FISCAL YEAR	WET
FY 2020-21 *(from 3YP)*	$6,216,634
FY 2021-22 *(from 3YP)*	$5,219,984
FY 2021-22 *(proposed)*	**No Change**
FY 2022-23 *(from 3YP)*	$5,296,662

Capital Facilities and Technological Needs Component

The Capital Facilities and Technological Needs (CFTN) component funds projects necessary to support the service delivery system. CFTN is now funded through transfers from CSS, which will support several projects:

- Renovations for a behavioral health training facility
- Continued development and enhanced functionality of the HCA electronic health record (EHR), which will include the transfer of additional funds in FY 2020-21 to migrate the EHR into the cloud
- Development and on-going support of a County Data Integration Project that will facilitate appropriate, allowable and timely data-sharing across County departments and with external stakeholders, to effectively delivering essential and critical services, including behavioral health care, to county residents.

FISCAL YEAR	CFTN
FY 2020-21 *(from 3YP)*	$12,519,749
FY 2021-22 *(from 3YP)*	$8,840,752
FY 2021-22 *(proposed)*	**$16,307,384**
FY 2022-23 *(from 3YP)*	$8,966,158

CSS Housing

Under direction from the Board of Supervisors, a total of $70,500,000 of CSS funds was allocated during FY 2018-19 to the development of permanent supportive housing. Following a $70.5 million investment in FY 2018-19, the Board of Supervisors and HCA remain committed to providing safe housing for individuals living with mental illness, with all dollars now having been allocated or in process of being allocated to various permanent supportive housing projects. At the end of FY 20-21 all funds have been allocated to projects in various phases of development.

Community Planning Expenditures

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

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

Orange County MHSA Three-Year Plan Budgets by Fiscal Year

FISCAL YEAR	CSS	PEI	INN	WET	CFTN	TOTAL
FY 2020-21	$155,088,175	$47,061,483	$18,346,360	**$6,216,634**	12,519,749	$239,232,401
FY 2021-22*	**$158,785,110**	**$56,144,101**	**$10,999,190**	**$5,219,984**	**$16,307,384**	**$247,455,769**
FY 2022-23	$165,320,336	$40,988,101	$2,042,071	$5,296,662	$8,966,158	$222,613,328

** Reflects proposed revised budgets for FY 2021-22 Annual Plan Update*

***

During the years since Proposition 63 was passed, the Act has continued to evolve and help better the lives of those living with mental illness, their families and the entire Orange County community. We look forward to continuing our partnership with our stakeholders as we implement the MHSA in Orange County.

COMMUNITY PLANNING PROCESS

WELLNESS • RECOVERY • RESILIENCE

Orange County At-A-Glance

CA County Ranking

3rd
Most Populous

2nd
Most Densely Populated

OC Residents

About 3.2 million

- Veterans: 5%
- LGBTQ+: 7%
- Adults w/ HS Diploma: 86%

OC Age Groups

22%
Under 18

15%
65 & Older

Language Spoken at Home

53%
English

26%
Spanish

14%
Asian / Pacific-Islander

Highest Cost of Living

Compared to neighboring counties, driven by high housing costs

Median household income: $90,234

Median gross rent: $1,854

Median house price: $679,300

Financial Insecurity

5.1% **Residents unemployed**

11.5% **Living below poverty level**

Census, v2019
CA Health Interview Survey, 2019

Individuals Served in CSS & PEI by Demographic Feature

OC CENSUS

Orange County Residents by Demographic Characteristic

Age	2019 Census
0-14 yrs	18%
15-24 yrs	13%
26-59 yrs	48%
60+ yrs	20%
2019 Population:	3,175,692

Gender	2019 Census
Female	51%
Male	47%
Transgender	2%
Genderqueer	<1%
Questioning/Unsure	<1%
Another	<1%

Race/Ethnicity	2019 Census
African American/Black	2%
American Indian/Alaskan Native	1%
Asian/Pacific Islander	20%
Caucasian/White	39%
Latino/Hispanic	33%
Middle Eastern/North African	NOT COLLECTED
Two or More Races	4%

CSS/MHSA

Individuals Served in CSS Clinical Services by Demographic Characteristic

Age	Estimated	Actual
0-15 yrs	9%	17%
16-25 yrs	16%	25%
26-59 yrs	63%	47%
60+ yrs	12%	11%
Projected Duplicated:	61,623	
Actual Unduplicated:	14,758	

Gender Identity	Estimated	Actual
Female	42%	48%
Male	56%	52%
Transgender	2%	*0.1%*
Genderqueer	-	*0.1%*
Questioning/Unsure	-	*0.1%*
Another	-	*0.1%*

Race/Ethnicity	Estimated	Actual
African American/Black	7%	5%
American Indian/Alaskan Native	1%	1%
Asian/Pacific Islander	10%	10%
Caucasian/White	42%	35%
Latino/Hispanic	34%	37%
Middle Eastern/North African	1%	1%
Another	5%	11%

Demographic breakdown based on individuals entered into Electronic Health Record. Those served only in Supportive Services not included.

PEI/MHSA

Individuals Served in PEI Programs by Demographic Characteristic

Age	Estimated	Actual*
0-15 yrs	47%	22%
16-25 yrs	18%	8%
26-59 yrs	25%	53%
60+ yrs	10%	17%
Projected Duplicated:	216,898	
Actual Unduplicated:	178,009	

Gender Identity	Estimated	Actual
Female	54%	51%
Male	42%	49%
Transgender	1%	0%
Genderqueer	-	-
Questioning/Unsure	-	-
Another	2%	-

Race/Ethnicity	Estimated	Actual
African American/Black	7%	13%
American Indian/Alaskan Native	1%	1%
Asian/Pacific Islander	10%	19%
Caucasian/White	42%	38%
Latino/Hispanic	34%	29%
Middle Eastern/North African	1%	0%
Another	5%	-

** Age reflects the age of the person served. These percentages do not reflect the expenditure breakdown, where programs that enroll adult caregivers and guardians in support of their children and youth count as youth-focused programming.*

Estimated percentages are for FY 2020-21. Actuals are based on individuals served in FY 2019-20

MHSA Community Planning Process

State Requirements for the Development of the Three-Year Plan

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

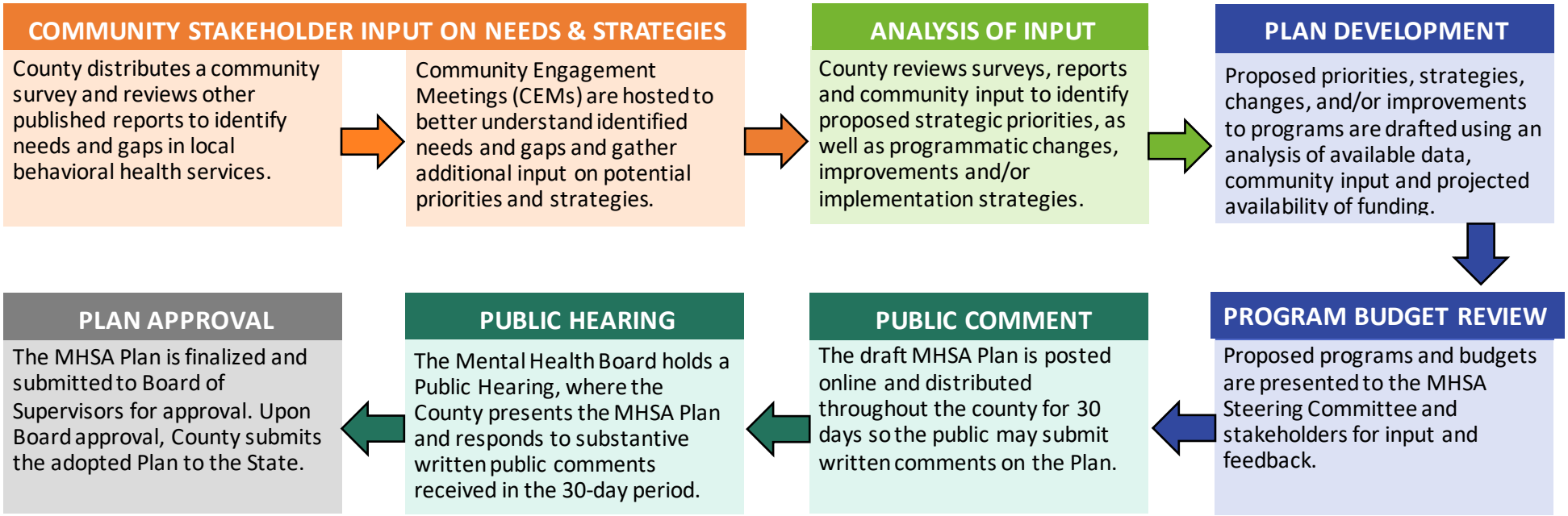
- **Assessment of the Mental Health Needs** of unserved, underserved, inappropriately and fully served county residents who qualify for MHSA services, including a) an analysis by age group, race/ethnicity and primary language, and b) assessment data that includes racial/ethnic, age and gender disparities
- **Identification of Issues** resulting from a lack of mental health services and supports as identified through the CPPP, categorized by age group
- **Identification of the Issues that will be Priorities** in the CSS component
- **Identification of Full Service Partnership (FSP) Population**, including a) an estimate of the number of clients, in each age group, to be served in the FSP for each fiscal year of the Three-Year Plan, and b) a description how the selection of FSP participants will reduce the identified disparities
- **Proposed Programs/Services**, including a) descriptions and work plans for each proposed program/service, including the budget and estimated number of individuals to be served by fiscal year, and b) the breakdown of the FSP population by gender, race/ethnicity, linguistic group and age, by fiscal year
- **County's Capacity to Implement** the proposed programs/services, including a) the strengths and limitations of the County and its service providers to meet the needs of racially/ethnically diverse populations, including language proficiency in the county's threshold languages, and b) Identification of barriers to Implementing the proposed programs/services, and potential solutions for addressing these barriers

OC Community Program Planning Process

Orange County has operationalized the community planning requirements outlined in the California Code of Regulations (CCR) into the general strategies and steps described in the graphic below. Over the past several years the HCA has been refining its approach to integrate data into its planning process more systematically, particularly as part of assessing mental health needs and identifying issues and priorities. It has also expanded and refined its approach to engaging community stakeholders in the planning process, evolving from a single community meeting that followed an extended public comment format to a series of semi-structured discussions and focus groups with community stakeholders.

As described in Orange County's MHSA Three-Year Plan (page 14the HCA was and is committed to increasing meaningful engagement with clients, consumers and family members, particularly those who identify with one or more of the MHSA Priority Populations. However, due to the COVID-19 pandemic, the HCA had to adapt its Community Program Planning Process (CPPP) activities in 2021 and shift away from in-person interactions and meetings. As such, the HCA recognizes that the feedback and input received to-date for the FY 2021-22 Annual Plan Update may more accurately reflect the perspectives and interests of those with the financial means, access to technology and digital literacy to engage in a virtual and/or electronic format. As opportunities for in-person gatherings become available, the MHSA Office will seek to engage those who were unable to participate in this year's virtual meetings and/or online surveys.

Orange County Community Planning Process



OC MHSA Steering Committee

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

- Adults/Older Adults living with a mental illness
- Family members of individuals living with SMI/SED
- Mental Health Providers
- Law Enforcement Agencies
- Education Services
- Social Services
- Health Organizations
- Veteran Organizations
- Providers of Substance Use Services
- Housing Organizations
- Representatives from ethnic/cultural minority organizations
- Local government official representatives
- Mental Health Board

The Steering Committee was tasked with the following responsibilities:

1. Remain educated about the status of MHSA funding and requirements, as well as the status of Orange County MHSA program implementation.
2. Assist the County with identifying challenges to the development and delivery of MHSA-funded services and make recommendations for strategies to address these challenges.

3. Remain informed about current stakeholder meetings and the funding and program recommendations made by members of these groups.
4. Review MHSA funding proposals and provide feedback to ensure funding is allocated to services for identified needs and priorities.
5. Provide timely recommendations that maximize the amount of funding secured by Orange County that preclude Orange County from losing funding for which it is potentially eligible.
6. Support the County's ability to meet both State funding requirements and Orange County funding needs.
7. Make recommendations regarding future MHSA allocations so funds will be used to provide services for identified needs and priorities.

In March 2021 the Orange County Board of Supervisors approved the merging of the Mental Health Board and Alcohol and Drug Advisory Board into a single Behavioral Health Advisory Board (BHAB). As part of this reorganization, MHSA Steering Committee functions were transferred to a new MHSA Committee to be formed as part of the BHAB. The HCA continued to work with and present to the MHSA Steering Committee during this time of transition while the new BHAB MHSA Committee is being established. The first official BHAB meeting took place in April 2021.

Considerations for FY 2021-22 CPPP

WHAT barrier to implementing program services will be the focus of FY 2021-22? As part of last year's CPPP and capacity assessment undertaken for the current Three-Year Plan, BHS Managers reported that consumers seeking MHSA services frequently experienced challenges to accessing needed services (see table below). While many programs have individually implemented strategies to address these issues (described within each program description), transportation, the number of bilingual service providers, stigma and, to a lesser but still significant extent, childcare remain persistent challenges across the overall system of care. In response, transportation was expanded as part of the current Three-Year Plan and efforts to mitigate transportation issues are underway.

Barriers to Implementing Program Services

MHSA Program/Program Category	Transportation Assistance		Child Care Issues		LEP / Monolingual		Stigma	
	PEI	CSS	PEI	CSS	PEI	CSS	PEI	CSS
Mental Health Community Education Events for Reducing Stigma & Discrimination	X	-	X	-	-	-	X	-
Outreach for Increasing Recognition of Early Signs of Mental Illness	X	-	X	-	X	-	X	-
Prevention Programs	X	-	X	-	-	-	X	-
Access and Linkage to Treatment/Services	-	X	-	-	X	-	X	X
Crisis Services and Support	-	X	-	-	-	X	X	X
Outpatient Treatment	X	X	X	X	X	X	X	X
Supportive Services	X	X	X	X	X	X	X	X

LEP = Limited English Proficiency

As part of this year's CPPP, the HCA opted to primarily focus on identifying potential solutions to reducing mental health-related stigma that could be implemented in FY 2021-22 with minimal impact from COVID-19 safety precautions. The HCA also initiated conversations on ways to increase the language/linguistic capacity of direct service providers specifically and enhance the cultural responsiveness of staff and the system more generally.

WHO do we hope to engage? As part of last year's CPPP and mental health needs and disparities assessment, the HCA identified that the individuals from certain groups and communities in Orange County were disproportionately affected by mental health conditions or barriers to accessing needed mental healthcare:

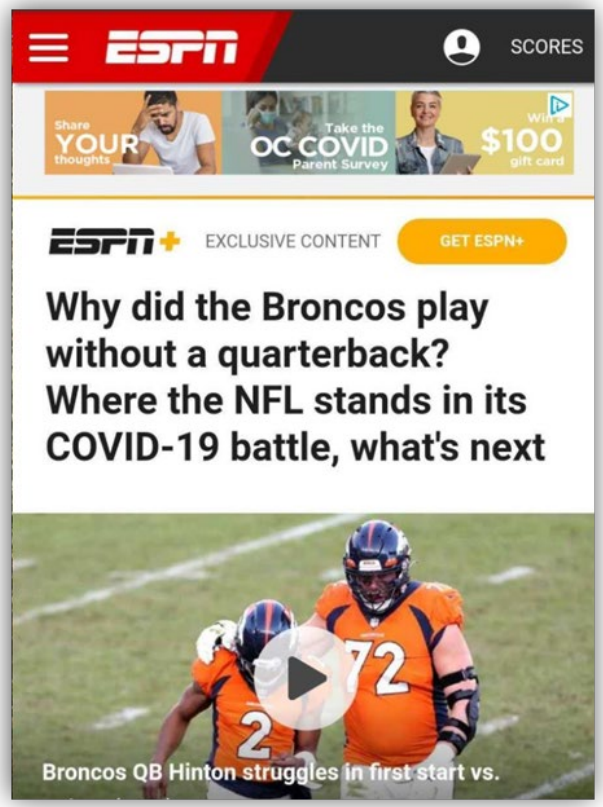
- Children, including boys age 4-11 years
- Transitional Age Youth
- Families of children/youth living with a mental health condition
- Adults, especially ages 25-34 and 45-54 years, those with a high school education or some college education but no degree, and those who are unemployed
- Older Adults
- Individuals experiencing homelessness
- Individuals living with a co-occurring substance use and mental health condition
- Veterans
- LGBTIQ+ community
- Asian/Pacific-Islander (API), Hispanic/Latinx and Black/African-American Communities

HOW will we engage? Due to COVID-19, HCA staff modified its approaches and used electronic surveys and web-based meetings since in-person events were not permitted. MHSA Office staff also coordinated with BHS program staff to try and engage individuals living with serious mental health conditions who might not have access to their own devices and/or private Wi-Fi or cellular data, thereby precluding them from being able to participate in the CPPP. Despite these efforts, participation of the county's most vulnerable residents nevertheless appears to have been limited due to the inability to engage in person.

The HCA conducted community planning in three phases, beginning with a county-wide electronic survey to assess how Orange County residents were coping eight months into the COVID-19 pandemic, followed by focus groups with consumers and family members to learn what strategies and solutions they believed to be most effective and responsive to their community's unique needs; and (3) feedback and input from service providers on how to respond to and/or support the feedback provided by consumers and family members. Each of these three steps, and their accompanying results, are described in more detail below.

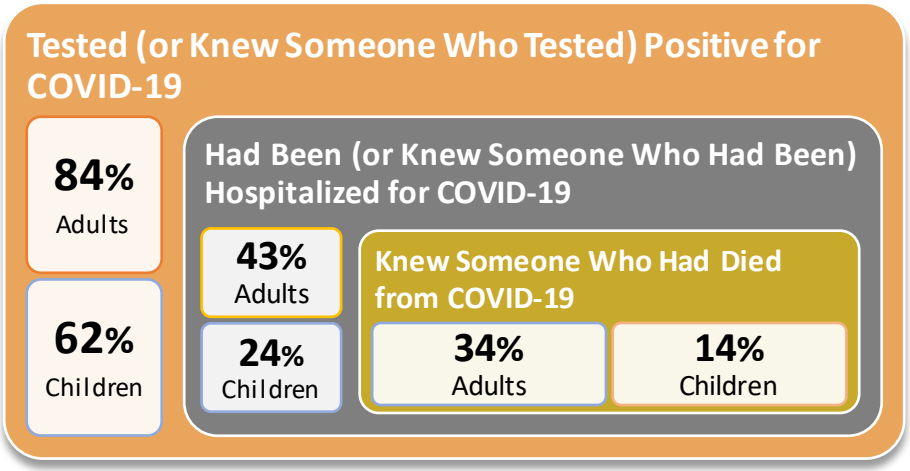
Community Survey Method and Results

Methods. Between November 23 and December 30, 2020, the HCA assessed the impact COVID-19 was having on the emotional well-being of Orange County residents through two electronic surveys: the *Adult Stress Survey* for adults 18+ years and a *Parent Survey* for parents of a child 4-17 years old. The surveys assessed individual's experiences with COVID-19, their emotional well-being (i.e., Kessler-6 for adults; Pediatric Symptom Checklist-17, PSC-17, for youth), informal/peer/paraprofessional support, access and barriers to professional healthcare and demographic characteristics. The surveys were anonymous, multiple choice and only available electronically due to COVID-19. They were primarily distributed through a countywide digital media marketing campaign and accessed through advertisements placed on the internet and social media. The survey was also offered via iPad to BHS clinic clients checking in for in-person appointments, and through a link emailed to stakeholders on the MHSA, Be Well and BHS Contract Provider distribution lists. Ads and the surveys were available in all county threshold languages and Khmer. To encourage participation, eligible respondents could enter a drawing for a chance to win a $100 Amazon gift card.



A total of 10,785 surveys were started, with approximately 7,380 adults and 1,420 parents having completed the survey in entirety. Of note, 7% of adult respondents identified as 60+ years of age, an under-representation of older adults based on 2019 Census data, and 23% of adult respondents were between the ages of 18-25 years), which is up from 16% in last year's survey and reflecting the HCA's continued progress on engaging Transitional Age Youth (TAY) in community planning efforts. In addition, the racial and ethnic diversity of respondents reflected the diversity of the county as a whole, although the overwhelming majority of surveys (>96%) were completed in English. It was also noted, that adults were disproportionately female (73%) which may limit the generalizability of findings on the adult survey to Orange County residents identifying as other genders. Parents reported on a roughly equal number of boys and girls. See Appendix V for descriptive characteristics of respondents.

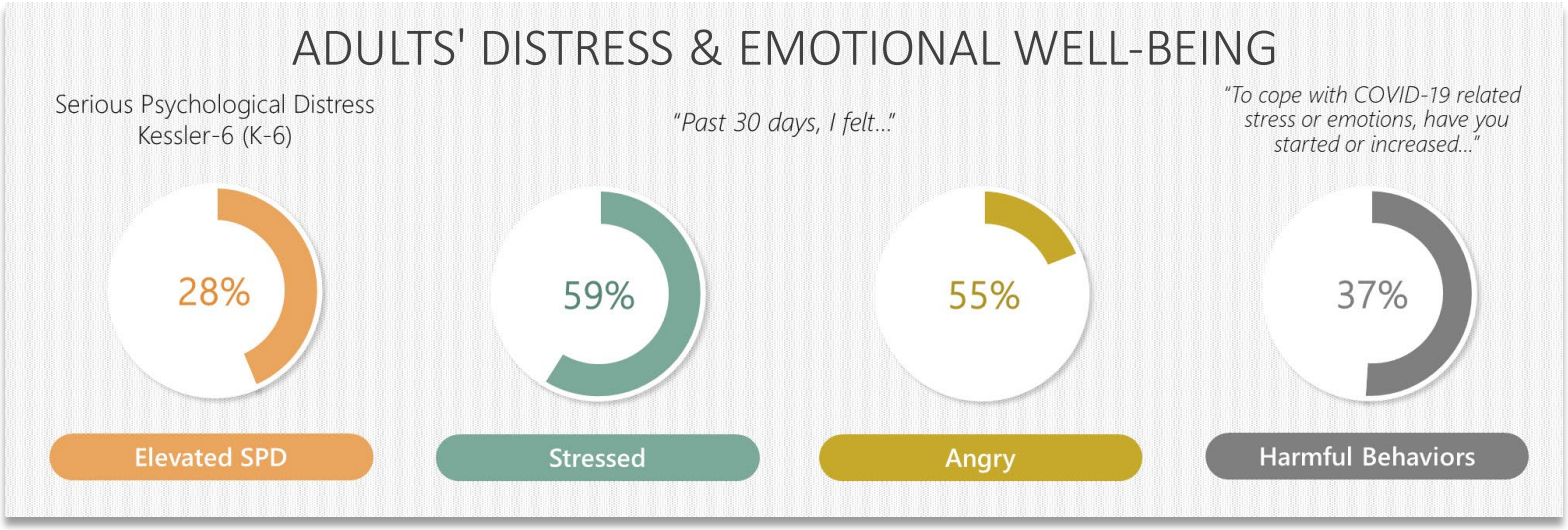
Experiences with COVID-19. A substantial proportion of Orange County adults and youth had some personal experience or impact related to COVID-19 (*see graphic to the right*). Moreover, Hispanic adults and children were significantly more likely to report that they (their child) or someone they (their child) knew had tested positive, had been hospitalized or had died from COVID-19. In addition, about half of adults and over one-third of parents indicated that they or someone in their immediate family had delayed getting healthcare due to COVID-19.



Adult Well-Being. Not surprisingly, a high proportion of Orange County adults reported experiencing struggles with their emotional well-being during the pandemic. More specifically, 28% indicated they were experiencing 'serious psychological distress' on the Kessler-6, which was twice the rate reported by Orange County adults on the California Health Interview Survey in 2019 (14%). Adults also reported feeling stressed or angry, and/or that they had started or increased use of one or more harmful behaviors (alcohol, drug and/or tobacco use, gambling) to cope

with COVID-19-related stress or emotions (*see graphic below*). Moreover, adults who were more likely to report experiencing serious psychological distress on the K-6 were:

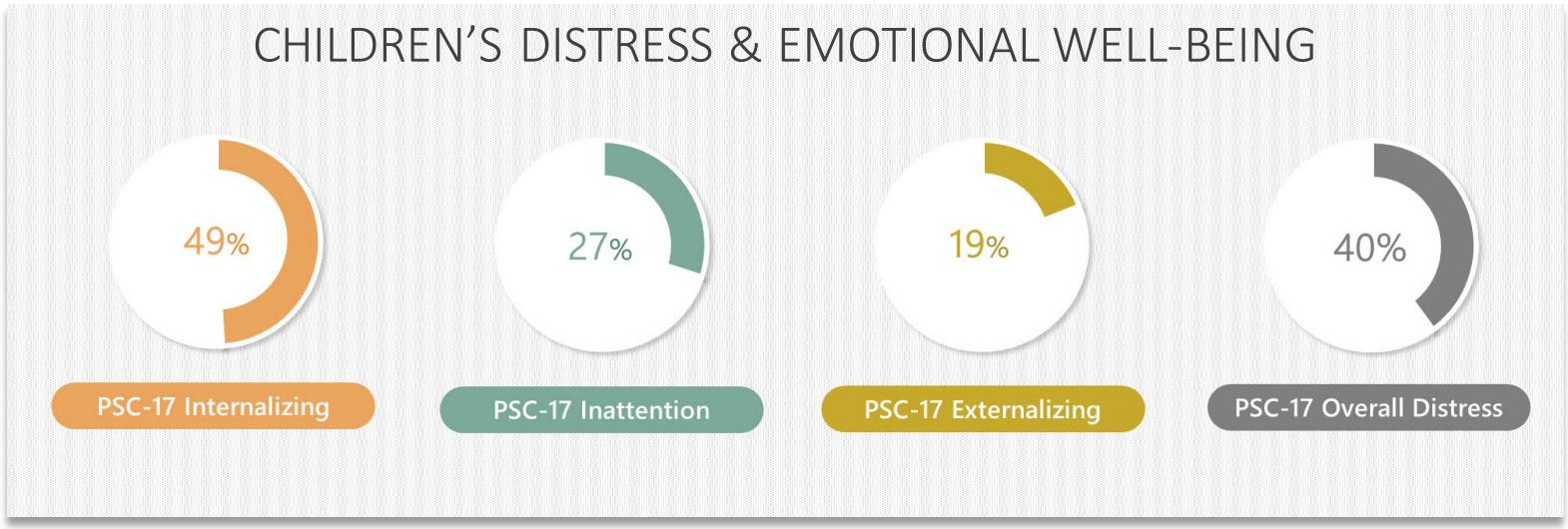
- TAY (ages 18-25 years)
- More than one race/ ethnicity
- Unemployed
- Uninsured or had public insurance
- An unpaid caregiver for another adult and/or
- Lived in North county



Finally, nearly one-third of adults indicated they were having a "very" or "extremely difficult" time coping with the stress and emotional impact of COVID-19.

Children's Well-Being.

Orange County parents reported that their children were feeling distressed during the pandemic, with the proportion ranging from about one-fifth to one-half depending on the nature of the distress (i.e., externalizing, disruptive behaviors; internalizing symptoms such as sadness and worry; etc.).

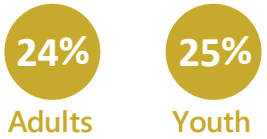


In contrast to the findings observed for adults, distress among youth did not differ based on the their racial/ethnic back-ground, gender identity, insurance status, the region of the county in which they lived, and/or their personal experiences with COVID-19.

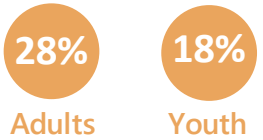
Other Survey Findings.

Adults and parents also reported on their use of informal, peer and/or paraprofessional support, as well as access and barriers to professional healthcare. Key findings are briefly listed here, with additional details available on the slides in Appendix V.

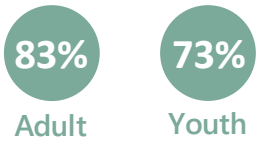
- % reporting they tried to seek help from a healthcare professional regarding their/their child's stress or emotions



- % reporting they experienced two or more barriers to seeking professional healthcare for their/their child's stress or emotions



- % reporting they used one or more informal supports to seeking professional healthcare for their/their child's stress, with the overwhelming majority reaching out to family, friends and their social network



List of Potential Barriers

- Prefer face-to-face*
- No childcare
- No insurance/can't afford*
- Inconvenient/delayed appt times*
- Don't know who to call*
- People think something wrong w/ us
- No transportation
- Problems w/ accessing telehealth
- Provider doesn't speak child's language
- Other

**Most common barriers encountered*

List of Informal Supports

- Family, friends, social network
- Faith/spiritual leader
- Teacher, professor, coach, mentor, etc.
- Hotlines, Crisis lines, Warmline, etc.
- Support groups
- Other support
- AA, NA, other 12-step programs/sponsors (*adult survey only*)

Community Engagement Meetings (CEMs)

CBO Engagement

To engage more meaningfully with clients, consumers and family members, HCA staff emailed various community based organizations (CBOs) that are trusted members of their communities and inquired about the CBO staff's interest in co-hosting a MHSA community engagement meeting for their community members. HCA staff explained the County's desire to increase representation from members of the MHSA Priority Populations and hear directly from unserved and underserved individuals as part of its CPPP. They described what CBO participation would entail and began planning with interested CBO partners. CBO staff also promoted the CEM they were hosting.

CEM Orientation for Community Based Organization Partners

Prior to facilitating a CEM, CBO partners attended an orientation hosted by the MHSA Office, allowing MHSA staff the opportunity to connect directly with provider organizations who had not collaborated or worked with the HCA or MHSA Office in the past. Topics covered in the orientation included historical information about the MHSA, community planning requirements, the HCA's operationalization of the planning process, and Orange County's strategic priorities in the MHSA Three-Year Plan (see Appendix V for materials). In addition, MHSA staff held an optional in-service training that CBO facilitating staff could attend if they wished to practice and/or enhance their facilitation skills prior to the CEM. At the in-service, CBO staff could ask questions and go through role-playing scenarios.

Community Engagement Meeting Format

In partnership with the CBOs, the MHSA Office co-hosted 21 CEMs for consumers, client and community stakeholders between February and March 2020 (see table below). Due to the COVID-19 pandemic, all meetings were held virtually over Zoom with participants joining via computer, tablet and/or phone. Because CBO staff facilitated the breakout rooms, meeting capacity was limited by the number of CBO facilitators (i.e., approximately 10 participants per CBO facilitator). Participants registered online and meeting materials were hand-delivered or emailed to all participants prior to the CEM so that they could follow along in the event they were unable to see the presentation. Meetings were conducted in English, Spanish, Vietnamese, Korean, Mandarin, Tagalog and Khmer, in addition to interpretation services for Farsi-speaking individuals. A total of 484 people registered for a CEM and approximately 327 attended.

2021 CEM Outreach to Priority Populations

Community Engagement Meeting	Date	# Registered	Children	TAY	Adults	Older Adults	Additional Population Characteristics
Arabic/Muslim Community	3/11/2021	8			X	X	
Parents/Families (in Spanish)	2/18/2021	8	X	X			Latino/Hispanic
BHS Consumers	3/18/2021	31			X	X	In Recovery w/ SUD
HCA Peers	3/25/2021	12			X	X	
Cambodian Community	2/24/2021	16			X	X	Asian/Pacific Islander
Chinese Community	3/2/2021	6			X	X	Asian/Pacific Islander
Filipino Community	3/3/2021	5			X	X	Asian/Pacific Islander
Family Resource Centers of OC	2/3/2021	61	X	X			Latino/Hispanic
Korean Community	3/10/2021	8			X	X	Asian/Pacific Islander
LatinX Transwomen	3/2/2021	28					LGBTIQ, Latino/Hispanic
LGBTQ Community (in English)	¾/2021	6		X	X		LGBTIQ
LGBTQ Community (in Spanish)	2/26/2021	4		X	X		LGBTIQ, Latino/Hispanic
LGBTQ Community (in Vietnamese/ English)	2/26/2021	6		X	X		LGBTIQ, Asian/Pacific Islander
Older Adults (two meetings)	2/23 & 3/9/2021	26 / 31				X	
Parent Partners	3/9/2021	11	X	X			
Permanent Supportive Housing Residents	3/4/2021	9		X	X		Persons in Recovery, *(Homeless Individuals)*
Persons In Recovery	3/11/2021	41			X		Persons in Recovery w/ SUD
Veterans / Military-Connected Families	3/9/2021	30	X	X	X	X	Veterans
Vietnamese Community	2/25/2021	107		X	X	X	Asian/Pacific Islander
Wellness Center Members	2/26/2021	30			X		

Each CEM was facilitated following the same general structure:

- Welcome, Introductions
- Overview of MHSA
- Breakout Session 1: Improve Awareness
- Report Out 1
- Breakout Session 2: Improve Access
- Report Out 2
- Wrap Up

In the breakout sessions, participants moved into smaller, virtual rooms where CBO staff facilitated a 20-minute discussion. Everyone returned to the main room and a volunteer shared themes from their group's discussion. To help prompt and/or guide the group's discussion, polling responses from the registration form for that meeting were aggregated and presented in the breakout rooms.

Breakout 1 20minutes

IMPROVING AWARENESS

MAIN QUESTION

"What are the advertising and outreach strategies that would be most effective in getting mental health-related messages out to my community? The least effective?"

EXAMPLES OF ADVERTISING/OUTREACH

- Billboards
- Bus Ads
- Bus Shelter Ads

Which locations?

- Television
- Radio
- Newspapers
- Internet
- Social Media

Names of most trusted or commonly used stations, papers, apps and/or websites?

- Emails
- Events/Fairs

Who should these come from/be hosted by?

- Other

PROMPTS TO HELP US BETTER UNDERSTAND:

- What would make an ad something you would remember or want to learn more about?
- Are some ways of advertising/promoting better suited for certain types of messages/information than others?
- Are certain ways of advertising/promoting better at reaching people of different ages, backgrounds, etc.?

Breakout 2 20minutes

IMPROVING ACCESS

MAIN QUESTION

In recent surveys of Orange County residents (2020) and CalOptima members (2018), two common barriers to accessing mental health services included:

Stigma

"Don't want people to think something is wrong with me"
"Did not feel comfortable talking about personal problems"

Preference for face-to-face services *compared to telehealth during COVID*

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

PLEASE PROVIDE SPECIFIC EXAMPLES OF:

- Cultural practices
- Language: terms/phrasing to use? To avoid?
- Types of interventions that support well-being
- Finding a private space if you live with others to help make a telehealth session more comfortable

PROMPTS TO HELP US BETTER UNDERSTAND:

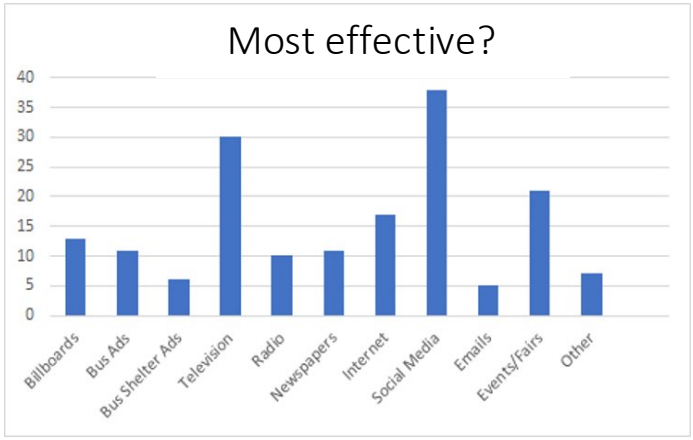
- What types of changes or improvements would make services more welcoming for members of my community?
- What types of changes or improvements would make it easier for my community to connect with services, including telehealth?
- What are short-term strategies the OC Health Care Agency can use now to encourage people from diverse backgrounds (to apply) to work in the public mental health system?

Analysis of CEM Feedback

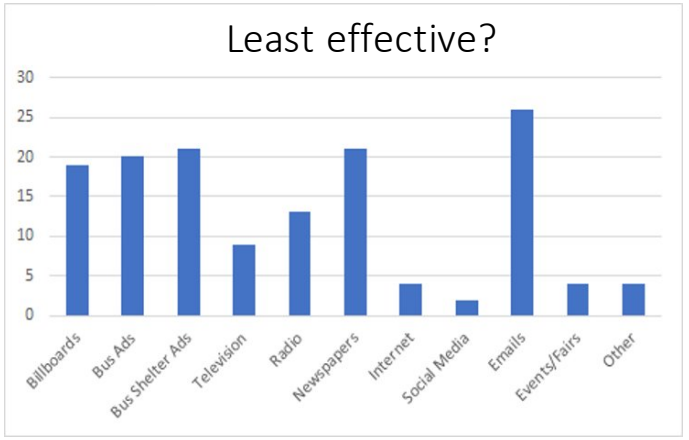
After the CEM, MHSA staff emailed an electronic, Post-CEM Summary form to participating CBO staff, who provided a written summary of their notes. Feedback from these surveys (n=61) were analyzed using a mixed method approach, allowing for the combining of information from quantitative survey data and qualitative open-ended responses (see Appendix VII for full analytic strategy). The following tables illustrate several item frequencies, and details of all CEM findings and analytic strategy used can be found in Appendix VIII). Below is a synopsis of the strategies and approaches that consumers, family and community members recommended for improving mental health-related messaging and for making services feel more welcoming and engaging.

Of note, preferences for an overall approach (i.e., social media vs newspapers) tended to ***vary by a person's age*** or were ***universally shared*** (i.e., focus on hope, positive messaging, reflect the culture of the person you are trying to reach). Differences related to cultural background emerged when discussing specifics around preferred terms, images, etc., thus underscoring the critical importance of involving members of the audience of interest during the creation of content.

What are the advertising and outreach strategies that would be most effective in getting mental health-related messages out to my community? Least effective?



Social media, television, and events / fairs



Emails, bus shelter ads, newspapers, and billboards

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

Representation & Culturally Appropriate Messaging

Positive Messaging

Good Visuals & Color

Simple Wording, Accessible Language, Culturally Appropriate & Representative Language

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

Provide Specific Resources

Use Simple Language from Community of Interest

Short and Precise Content

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

Social Media (Younger Adults)

TV and Radio (Bilingual & Older Adults)

Community Centers (Older Adults)

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

Cultural Representation

Technology Upskilling

Simplified Reading Level

What types of changes or improvements would make services more welcoming for members of my community?

Socialize content of services (don't make lists)

Use appropriate and representative language

Increase collaboration and group activities

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

Have more services and outreach locations

Include blend of hybrid, remote, and in-person services

Enhanced digital and digital health literacy

What are short-term strategies the OC Health Care Agency can use now to encourage people from diverse backgrounds (to apply) to work in the public mental health system?

Provide internships

Create Volunteer Opportunities

Outreach in respective communities

Provider Engagement Meetings

Recommendations and suggestions provided by clients, family members and community members during the CEMs were synthesized, and two areas of focus were identified for initial discussion with providers and advocates: 1) how to better improve technology skills and access, and 2) how to more accurately articulate mental health terms and language to better reach and connect with individuals from unserved and underserved communities. Meetings with providers and advocates were intended to better understand to what extent their organization may have tried different approaches identified by CEM participants, sharing of lessons learned and assessing their interest in and capacity to potentially implement different recommendations generated in the CEMs. The process and key findings from meetings with providers are described below.

Provider Engagement Meeting Format

In partnership with the provider organizations, the MHSA Office held two provider engagement meetings (PEMs) on April 14th and 19th, 2021. Due to the COVID-19 pandemic, meetings were held virtually over Zoom with participants joining via computer, tablet and/or phone. Because the April 19th provider engagement meeting was held during the MHSA Steering Committee Meeting and was also attended by HCA staff, HCA direct service staff were invited to participate in the breakout room discussions and administrative staff and management were invited to listen to the discussion and feedback during the report out periods.

Participants registered online and meeting materials were emailed to all registrants prior to the PEMs so that they could follow along in the event they were unable to see the presentation. The meetings were conducted in English and facilitated following the same general structure as the CEMs, although the breakout rooms were not facilitated and instead self-directed by the group using the materials provided by the HCA:

- Welcome,
- Introductions
- Overview of CEM Findings
- Breakout Session 1: Improve Technology Skills & Access
- Report Out 1
- Breakout Session 2: Improve Mental Health Terms & Language
- Report Out 2
- Wrap Up

Provider Engagement Meeting Breakout Room Questions

Similar to the CEMs, participants in the PEM were provided with discussion prompts and questions, which are provided below.

Improving Technology Skills & Access

NEEDS IDENTIFIED IN COMMUNITY MEETINGS

Despite existing challenges, CEM participants overwhelmingly expressed a preference for a hybrid of in-person and remote/ virtual services even after COVID-19 restrictions are lifted. The challenges with telehealth or virtual services they reported include:

- Easier to share when face-to-face
- Lack of privacy during telehealth/virtual services
- Need for education and training on technology and devices, including digital literacy and digital health literacy
- Access to devices and Wi-Fi

QUESTIONS

- What strategies have you tried to address one or more of these challenges (i.e., improving skills/comfort/privacy during virtual services)? Which approaches worked? Didn't work?
- Of the strategies discussed and/or considered, what are you interested in trying?
- Are there barriers that you or your organization might face trying to implement these preferred strategies?

Mental Health Terms & Language

NEEDS IDENTIFIED IN COMMUNITY MEETINGS

Across the various meetings, participants continued to emphasize the role that words play in reducing stigma and making services feel more welcoming. They also stressed the importance of using culturally appropriate language.

QUESTIONS

- When creating outreach and advertising materials, what terms have you (seen) used for the following constructs?
  - Mental illness, mental health disorder, behavioral health, etc.
  - Substance use disorder, substance use, drug use, addiction, etc.
  - Specific conditions, such as anxiety, depression, OCD/obsessive-compulsive disorder, etc.
  - Clients, consumers, etc.
- What impact have you noticed when different terms are used?
- Which words/phrases seem to be preferred? Should be avoided?

Analysis of PEM Feedback

A total of 91 individuals responded to a multiple-choice pre-meeting survey when registering for the PEM, and approximately 65 people across the two meetings participated in the breakout room discussions. The analytical strategy that was used for the PEM feedback mirrored the same mixed method approach utilized in the CEM feedback analysis, combining both qualitative and quantitative inferences. Key findings, which tended to focus on the value of building capacity and increasing skills for both consumers and provider staff are summarized below, and more details can be found in Appendix IX. Because the second breakout discussion was abbreviated in both PEMs, the focus of the summaries is on telehealth.

What strategies have you tried to address one or more of these challenges (i.e., improving skills/comfort/ privacy during virtual services)? Which approaches worked? Didn't work?

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

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

- Increase collaboration between organizations and diverse individuals (ex. Connect older adults with students or interns)
- Emphasize cultural and linguistic competency of staff members through workforce learning opportunities
- Improve tele-visits platforms (I.e., platforms that have chat, video, and audio functionality)
- Demonstrate the use of technology in both live and asynchronous sessions to teach the necessary steps in accessing the various platforms

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

- For consumers who cannot meet through video, offering text or chat options is one alternative
- Language, representation, and cultural barriers as mentioned in the CEM findings

Putting it All Together

Drawing upon findings from the community survey, CEMs and PEMs, several overarching themes emerged that helped inform the recommended updates within this FY 2021-22 Plan Update:

- COVID-19 has taken its toll on Orange County adults, with over one-half reporting high levels of stress or anger, one-third reporting increased or new use of substances or gambling, over one-quarter reporting an elevated level of serious psychological distress, and nearly one-third indicating they were having a "very" or "extremely" difficult time coping during the pandemic.
- Orange County parents similarly noted that their children's well-being was affected during COVID-19, with approximately one-fifth of children exhibiting elevated levels of disruptive behavior and nearly one-half experiencing elevated sadness or worry.
- Nevertheless, Orange County residents have been resilient, with an overwhelming number having stayed connected with their friends, family or social network and relying on them as a resource for maintaining their well-being during the pandemic (78% adults, 62% youth/parents).
- About one-quarter each of adults and children/parents also sought help from a healthcare professional for their stress or emotions during the pandemic, with the majority who tried having successfully connected with a therapist or a physician.
- Nevertheless, Orange County residents still face multiple barriers when trying to connect to mental health care (28% adults, 18% children/parents), with some of the most common challenges being lack of insurance or an ability to pay, inconvenient or delayed appointment times and uncertainty over who to call.
- Less than 5% of adults or parents/youth had used a warmline, hotline or crisis line, suggesting a potential area for improved outreach and marketing.
- Consumers' outreach and communication preferences tended to ***vary by age*** (i.e., social media vs newspapers) or were ***universally shared*** (i.e., focus on hope, positive messaging, culture of the person you are trying to reach). Differences related to cultural background emerged when discussing specifics around preferred terms, images, etc., thus underscoring the critical importance of involving members of the intended audience during the creation and/or approval of content.
- While individuals expressed a preference for face-to-face services and generally found it easier to share in person, an overwhelming majority nevertheless stated they would like to engage in telehealth services at least some of the time, even after COVID-19 was "done" and there were no restrictions on in-person meetings.
- Both individuals and providers reported they would be interested in and could benefit from learning how to use and navigate technology.
- Some individuals and/or groups also had need for reliable devices and/or Wi-Fi.
- Finally, meeting people "where they were at" is core to fostering hope, healing and health. An essential element of this is understanding and authentically engaging the diverse cultural backgrounds of those we are seeking to engage and support on their recovery journeys.

Looking ahead to FY 2021-22 and beyond, the HCA and MHSA Office will continue to gauge trends in well-being, stress and coping among Orange County residents; monitor the MHSA fiscal outlook; and continue to adjust and adapt as needed to ensure needed services and supports are not disrupted. Moreover, we remain committed to partnering with consumers, family members, service providers and community organizations as, together, we strive to anticipate future needs, close existing gaps, address persisting disparities and support the health and well-being of Orange County's residents.

"Desire to do justice to the person"

- PEM Participant

Public Hearing and Approval by the Board of Supervisors

The MHSA Plan Update for FY 2021-22 was completed, reviewed and approved by the BHS Director and posted to the Orange County MHSA website on April 30, 2021 for a 30-day review by the public. At the close the of the public comment period the MHSA Office and BHS Managers responded to all substantive public comments. The Plan, with the additional comments and responses, was submitted to the Behavioral Health Advisory Board (BHAB), and on DATE the BHAB held a Public Hearing via Zoom Teleconference. The Public Hearing was advertised through a posting with the Clerk of the Board and emails to members of the MHSA Steering Committee and interested community members who have asked to be notified of meetings and events from the MHSA Office. In addition, the Public Hearing was posted on the Board of Supervisors Event Calendar and promoted through the Health Care Agency's social media applications (Twitter, Facebook). At the hearing, BHS Management reviewed the key priorities and changes to the Plan and individuals from MHSA programs provided testimonials to the positive impact that MHSA services has had on their lives. At [INSERT], the Chair of the Behavioral Health Advisory Board led a discussion among the members and called for a vote to approve the BHAB's recommendation of the Plan. The plan was [INSERT OUTCOME].

After receiving formal recommendation by the Behavioral Health Advisory Board, the MHSA Three-Year Plan for FY 2020-21 through FY 2022-23 was brought before the Orange County Board of Supervisors and [INSERT OUTCOME] at the regularly scheduled meeting held on DATE.

IMPACT OF COVID-19 ON MHSA PROGAMS & SERVICES

With the onset of COVID-19 and the subsequent closure of many community sites, programs had to quickly transition to providing services virtually or over the phone, while many participants lacked access to reliable technology. Referrals decreased due to the reduction of outreach opportunities but, due to the economic effects of the pandemic, participants had an increased need for essentials such as food, housing and supplies. With ingenuity, dedication and the utilization of CARES Act funds, programs were able to address these challenges.

MENTAL HEALTH AWARENESS & PREVENTION

Mental health awareness and prevention programs strive to prevent the development of serious emotional or behavioral disorders or mental health conditions in at-risk individuals. These programs achieve this through large-scale, population-based efforts designed to educate and inform the public about mental health and well-being, reduce risk factors or stressors, build protective factors and skills, and/or increase resilience. They aim to strengthen the resilience and wellbeing of a community as a whole by providing information, training and skill-building around mental health. The programs often use creative and culturally appropriate strategies for engaging different populations, especially unserved and underserved communities.

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

- Mental Health Community Education Events for Reducing Stigma and Discrimination
- Outreach for Increasing Recognition of Early Signs of Mental Illness
- Prevention (several programs focused on mental health and well-being)

Mental Health Community Education Events for Reducing Stigma and Discrimination (PEI)

The **Mental Health Community Education Events for Reducing Stigma and Discrimination** program hosts mental health-related educational and artistic events that aim to reduce stigma and discrimination related to mental health. Collectively, the events are open to individuals of all ages living in Orange County, with specific events intended to reach identified unserved and underserved communities. A time-limited Request for Application (RFA) is periodically released inviting individuals and organizations to submit proposals for events. Examples of events that have received funding include art workshops and exhibits, plays, conferences, multi-cultural musical and dance performances, and other related activities.

AGE RANGE

All Ages

PRIMARY LOCATION

Community

TARGET POPULATION

At-Risk | Mild-Moderate | Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

- ✔ Arabic
- ✔ Farsi
- ✔ Khmer
- ✔ Korean
- Mandarin
- ✔ Spanish
- TDD/CHAT
- ✔ Vietnamese
- Other:

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	Gender	%	Race/Ethnicity	%
0-15	100	Female	54	African American/Black	2
16-25	-	Male	45	American Indian/Alaskan Native	1
26-59	-	Transgender	-	Asian/Pacific Islander	9
60+	-	Genderqueer	-	Caucasian/White	17
		Questioning/Unsure	-	Latino/Hispanic	71
		Another	1	Middle Eastern/North African	
				Another	

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

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$881,000	16,500
FY 2021-22*	$1,200,000	17,500
FY 2022-23	$214,333	8,300

*5-year, temporary budget augmentation concludes after FY 2021-22. *Based on CPPP, propose adding additional funds to FY 21-22 budget with set aside for Veteran-focused event(s).*

SERVICES/EVENTS

Participants are invited to take part in activities designed to help them learn about and/or express their thoughts and feelings about mental health and stigma. Activities can include viewing or creating artwork, watching performances or presentations, creating videos, storytelling and other forms of self-expression and group-learning. While each event is different, they all provide messaging aimed at educating the public on mental health conditions, the stigma surrounding mental health conditions and the mental health resources available in their communities. The events also seek to educate the public about the abilities and experiences of those living with a behavioral health issue and to instill self-confidence and hope in people living with a mental health condition and their family members.

During FY 2019-20, community-based organizations hosted a series of events. Due to the Public Health emergency beginning March 2020, all in-person events and activities were put on hold and allowed providers an additional six months to adapt their services to public health guidelines. In addition, the HCA funded four social marketing campaigns focused on mental health awareness, suicide prevention and stigma reduction to address the anticipated increase in need for mental health services and support due to the pandemic.

Latino Health Access

LA VIDA A TODO COLOR DESCRIPTION:

Art workshop series that used artistic expression to educate participants on mental health topics, provide resources and encourage participants and family members to seek help. Eight of nine planned workshops were provided (8 in Santa Ana from Nov. 2019 through March 2020 in Santa Ana). The contract was terminated early by the provider due to needing to shift focus to responding to the pandemic.

CELEBRANDO NUESTRA CULTURA DESCRIPTION:

Series of events that openly discussed mental health and stigma while celebrating emotional resilience and culture. Each event included a discussion of mental health topics and engaging activities. Three of five planned events had to be cancelled due to the pandemic. (Nov. 2019-Dec. 2020 in Santa Ana).

TARGET AUDIENCE:

Latino families, family friendly, open to the public

 # REACHED:

733

Casa de la Familia

DESCRIPTION:

Series of plays that openly discussed mental health and stigma while celebrating emotional resilience and culture. Each play included a discussion of mental health topics and engaging activities. Three of five planned plays had to be cancelled due to the pandemic. (Nov. 2019-Dec. 2020 in Santa Ana).

TARGET AUDIENCE:

Latino families w/ limited English proficiency

 # REACHED:

176 in person
4,782 Facebook views
1,001 Facebook comments
652 surveys completed

LGBTQ Center Orange County

LGBTQ YOUTH CONVENING:

Presentations, spoken narratives and educational workshops to create safe and supportive schools and community spaces for LGBTQ youth

(Three separate virtual workshops May 2020

TARGET AUDIENCE:

LGBTQ youth & young adults

 # REACHED:

395 registrants
332 workshop attendees
300+ YouTube views, comments

Access California

PEACE OF MIND:

Virtual conference & family wellness event over two days where mental health professionals and religious leaders who are trusted members of the community engaged residents in dialogue about mental health, provided resources and encouraged members to seek mental health services (Sep. 27, Oct. 4, 2020)

TARGET AUDIENCE:

Middle Eastern, South Asian & Muslim American communities

 # REACHED:

410

STIGMA REDUCTION WORKSHOP:

Workshop for youth congregants at a local Mosque on "How to Cope with Ongoing Stress" offered by trusted religious leader who is also a licensed marriage & family therapist. Workshop raised awareness on mental health topics including toxic stress. Youth discussed stigma & barriers to seeking help. (Jan. 10, 2020).

TARGET AUDIENCE:

Middle Eastern, South Asian & Muslim American communities

 # REACHED:

248

Multi-Ethnic Collaborative of Community Agencies (MECCA)

WRITING OUR STORY:

Series of community-based writing workshops for adults and youth focused on stigma reduction (38 in-person workshops at seven provider sites from Oct. 2019-March 2020 prior to the pandemic; 18 online workshops from Sep.–Dec. 2020). Each workshop focused on different writing media (poetry, short stories, memoirs, other literary concepts) and were led by award-winning writer/mental health advocate Kelechi Ubozoh, poet Marcus Omari, and writers Amanda Fletcher, Natashia Deon and Brandon Easton. During the workshops, participants were invited to share their stories and engage in a dialogue about their experiences with mental health. Click to learn more:

Stories: www.ocmecca.org

Videos: "These Are Our Stories"

Also hosted several webinars on mental health conditons, suicide and stigma featuring panelists on Facebook Live

TARGET AUDIENCE:

Community at large

 # REACHED:

346
workshop participants

970
online participants

2,988
email recipients

10,786
through social media

2,674
digital/printed chapbooks of participants' personal stories distributed

Wellness Prevention Center
(WPC)

BACK TOGETHER 4TEENS

Activities such as panels on mental health and diverse communities, communicating with loved ones about mental health, focus groups on stigma campaigns, art, meditation and other wellness activities (Jan. 2020. Aliso Vieio. South OC)

73
participants

MENTAL HEALTH AWARENESS WEEK EVENTS

- "Quaranteen" Kits w/ self-care items: 53 kits distributed
- Mental health-related Chalk Art Contest: 20 submissions
- Virtual Comedy Night: 109k promotion impressions, 71 participants
- Social media posts: 340 likes 1,612 IG story views

MENTAL HEALTH AWARENESS PUBLC SERVICE CAMPAIGN

- Print ads in local South County newspapers: 45,350 distributed
- Facebook (FB) impressions: 67,075
- FB reach: 38,384
- FB clicks: 1,014
- Landing page engagement: 201

YOUR TEEN TOOLBOX

Eight events on the health and well-being of teens and their families (4 in-person events in San Clemente, Aliso Viejo Nov. 2019-Feb. 2020; 4 online events April 2020-May 2020)

98
in person

91
virtually

TARGET AUDIENCE:
Youth 12 +, parents, students, school staff, community

Council on Aging Southern California
(COASC)

ART THERAPY FOR SENIORS:

An 8-week virtual series of art workshops intended to reduce stigma and change ideas and feelings about mental health conditons and ultimately reduce self-stigma (Dec. 2020)

3,957
art participants

TRUE COLORS MEDIA CAMPAIGN:

Campaign focused on reducing public and institutional stigma through participant art on public transit & bus shelters to counter negative stereotypes and beliefs; 1st campaign: May- June 2020; 2nd campaign: Dec. 2020

7.7m
bus shelter impressions

10m
bus impressions

MENTAL HEALTH AND AGING EDUCATIONAL FORUM:

Forum focused on reducing stigma and promoting mental health awareness through lectures, community mental health resources, and keynote

206
forum attendees

140
YouTube views

TARGET AUDIENCE:
Older Adults, mental health & aging providers, participating artists from the community

National Alliance on Mental Illness - OC
(NAMI-OC)

LOUD AND PROUD MUSIC AND ART FESTIVAL

A virtual Loud and Proud Music and Art series featured local LGBTQIA+ musicians and artists who performed and displayed art with the intention of opening up conversation about mental health for Pride celebrations during Pride month. (September 2020).

Social/Digital Media: Channel Q made a targeted post containing a fun 22 second video including music by Loud and Proud performer, Chioke Dmachi

TARGET AUDIENCE:

LGBTQIA+ /Hearing Loss

52.5
Webpage impressions

420
Clicks

26
Likes

37
Instagram (IG) posts

12.3k
Reached on IG

2.5 K FUN RUN TO STOMP OUT STIGMA AND SELF CARE FAIR

A 2.5 K "Fun Run" and Resource Fair aimed towards grades 1-6 to promote a culture that prioritizes youth mental health

TARGET AUDIENCE:

Youth & School-Aged Children/All ability levels

 # REACHED:

248

All providers were contracted to host the event(s) under a provider-specific Agreement titled "Mental Health Community Educational Event Services." In FY 2021-22 and 2022-23, the program intends to host events similar to what was offered in FY 2019-20.

STRATEGIES TO PROMOTE RECOVERY/RESILIENCE

The program encourages participants and their family members to attend and participate in stigma reduction activities in their community. Recovery is promoted by tapping into participants' creative energy, encouraging their self-expression to reduce feelings of self-stigma, shame and isolation, and building connections with the larger community through interactive events open to all.

STRATEGIES TO REDUCE STIGMA AND DISCRIMINATION

The program hosts events that are open to all Orange County residents and are sensitive and responsive to participants' backgrounds. Care is taken to host events in communities of underserved populations where stigma is particularly prevalent. The projects attempt to educate the surrounding community and dispel misperceptions regarding mental health. This strategy is employed because art transcends socioeconomic status, ethnicity, culture, language, mental health condition and other factors that are sometimes a source of discrimination. When art is appreciated, it can open the door to acceptance. Creating and sharing artwork also builds self-esteem and encourages people living with a mental health condition to define themselves by their abilities rather than their disabilities.

STRATEGIES TO INCREASE ACCESS TO SERVICES: TIMELY ACCESS FOR UNDERSERVED POPULATIONS AND LINKAGE TO TREATMENT

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

OUTCOMES

HCA has been working on identifying tools and strategies for measuring stigma reduction, which can be challenging, particularly at large-scale events and performances. In FY 2019-20, due to the emphasis on virtual evens and digital campaigns, programs tracked number of participants and digital media impressions as outcomes (reported in tables above).

In FY 2018-19, one provider (MECCA) asked event participants to complete a survey on their beliefs and attitudes about mental health:

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

Taken together, the results suggest that these events were particularly effective in promoting positive messages about mental health and people living with mental health conditions among youth and adult participants. Given the nature of the events, it is not surprising that the educational screenings and art event/festival were more effective in informing participants about available services compared to the participatory videos.

Outcomes data are not available for FY 2018-19.

CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

The challenges encountered by the program in FY 2019-20 were primarily related to planning and coordination around the public health emergency and all the restrictions imposed. Although the providers were able to pivot most of their programming in creative ways on the virtual digital platform, they found that participant attendance and collection of surveys was the biggest challenge. Large numbers of participants registered for the events but fewer actually attended and many were reluctant to complete the surveys.

COMMUNITY IMPACT

The program has provided services to nearly 40,000 individuals since its inception in FY 2012-13. Feedback from participants indicates that the arts remain one of the greatest assets in empowering the community while raising awareness and understanding of mental health.

Outreach for Increasing Recognition of Early Signs of Mental Illness (PEI)

The **Outreach for Increasing Recognition of Early Signs of Mental Illness** program is intended to reach "potential responders," i.e., community members who are working with or likely to encounter individuals who are experiencing, or at elevated risk of experiencing, a mental health challenge. At risk individuals can include, but are not limited to, PEI Priority Populations such as unserved and underserved racial/ethnic communities; immigrants and refugees; children and youth who are at risk of school failure and/or juvenile justice involvement; foster youth and non-minor dependents; individuals who have been exposed to trauma or are experiencing the onset of serious mental illness; the LGBTQ community; and those experiencing homelessness.

AGE RANGE

All Ages

PRIMARY LOCATION

Community

TARGET POPULATION

At-Risk | Mild-Moderate | Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

- ✔ Arabic
- ✔ Farsi
- ✔ Khmer
- ✔ Korean
- ✔ Mandarin
- ✔ Spanish
- TDD/CHAT
- ✔ Vietnamese
- Other:

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	Gender	%	Race/Ethnicity	%
0-15	100	Female	54	African American/Black	2
16-25	-	Male	45	American Indian/Alaskan Native	1
26-59	-	Transgender	-	Asian/Pacific Islander	9
60+	-	Genderqueer	-	Caucasian/White	17
		Questioning/Unsure	-	Latino/Hispanic	71
		Another	1	Middle Eastern/North African	-
				Another	-

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

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$9,336,945	38,483
FY 2021-22*	$13,118,412	39,081
FY 2022-23	$6,278,245	16,100

5-year, temporary budget augmentation concludes in FY 2021-22. Proposed decrease in FY 2020-21 due to pause in expanding outreach at mass gatherings (i.e., sporting events).

SERVICES

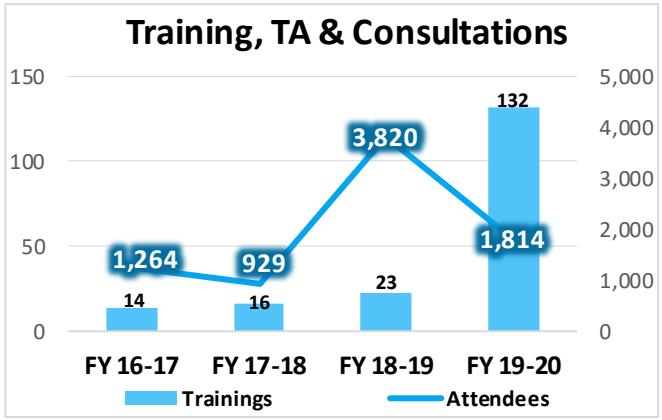
The program aims to better inform and/or prepare a wide range of potential responders on how to: identify behavioral health conditions in all age groups as early in their onset as practicable, assist individuals exposed to trauma and/or living with behavioral health conditions and their families, and increase knowledge on how to access behavioral health services. The program also conducts mental health awareness outreach to individuals of all ages who have had life experiences that place them at risk of developing behavioral health conditions but remain hard to reach in traditional ways because of cultural, linguistic or economic barriers. The program strategies used include 1) training, technical assistance and consultation, 2) educational/informational material development, 3) community events, networking and activation, 4) media campaigns and 5) door-to-door/street outreach. In addition, the content and/or format used within each strategy is tailored for two audience types:

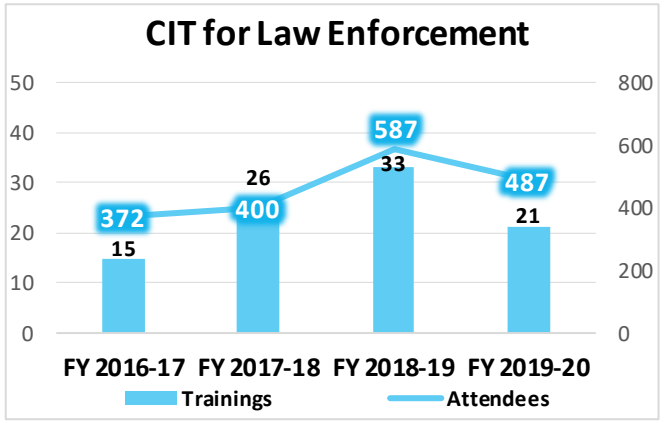
- Tier 1 is for members of the general public seeking information about behavioral health, including individuals such as parents, youth, students, neighbors, etc.
- Tier 2 is for members of professional communities, other than behavioral health, who interact or work with individuals who are experiencing, or at risk of experiencing, a behavioral health issue, including staff from public or private schools, childcare sites, colleges/universities, veteran organizations, law enforcement, probation/parole, housing providers, shelters, religious leaders/faith-based centers, businesses, etc.

Trainings for behavioral health providers are described in the *Workforce Education and Training* (WET) section.

Strategy 1: Training, Technical Assistance and Consultations

Trainings, technical assistance (TA) and consultations cover topics such as *Identifying and Responding to the Early Signs of Mental Illness*, *Trauma-Informed Care*, *Suicide Prevention*, *Resilience and Well-Being*, and other related subjects. In response to community feedback during the Summer of 2018, the Behavioral Health Training Collaborative was formed to provide behavioral health trainings on the signs and symptoms of behavioral health conditions and ways to help. The collaborative began serving the community in December 2019 and, as can be seen in the graph on the left, the number of trainings available for the community substantially increased. In addition, beginning FY 2020-21, Crisis Intervention Training (CIT) for Law Enforcement was moved from WET to PEI.





CIT FOR LAW ENFORCEMENT

Crisis Intervention Training (CIT) for law enforcement officers helps to equip and train officers to de-escalate mental health crises to improve the safety of the officers and those individuals with mental health conditions. CIT is a 40-hour curriculum covering topics such as signs/symptoms of behavioral health conditions, dementia and other conditions that older adults may face, autism and developmental disorders, and suicide. In previous years, the curriculum was offered in modules to accommodate officer schedules. Beginning FY 2020-21, additional curriculum was developed to train all first responders starting that year. This includes law enforcement (sworn and non-sworn staff), correctional staff, probation staff, dispatchers, and fire/EMS personnel. Specific curriculum addresses the unique issues each first responder may encounter. Starting FY 2021-22, the law enforcement curriculum will be provided in one week over 40 hours at the request of local law enforcement agencies. See graph for CIT activity since FY 2016-17.

TIER 1: Trainings for Community Members*

Early Signs of Mental Illness

- Multi-Cultural Mental Health Training
- What is Mental Health

Trauma-Informed Care

- Adverse Childhood Experiences

Suicide Prevention

- Means Restrictions
- CalMHSA Know the Signs

Resilience & Well-Being

- Resilience
- 40 Developmental Assets
- Healthy Coping Skills
- Virtual Engagement Best Practices
- NAMI Family-to-Family
- NAMI Peer-to-Peer
- Pathways to Permanence

** Open to the general public, including parents, youth, students, neighbors, etc. and who are seeking information about behavioral health*

TIER 2: Trainings for Non-Behavioral Health Professionals*

Early Signs of Mental Illness

- CalMHSA Each Mind Matters and related areas (i.e., *How to Have Conversations About Mental Health*, Strategies to Collaborate with Native Communities, *etc.)*
- Crisis Intervention Training (CIT) for Law Enforcement
- Screening and assessing for challenging behaviors in young children
- Mental Health First Aid
- Paraprofessional Training Modules I and II

Trauma-Informed Care

- Critical Incident Stress Management training (see Crisis Services section for description)
- Disaster Preparedness for Disaster Service Workers
- Vicarious Trauma: Impact and Skills to Help You Cope
- Training Qualified Educators in Understanding ACEs
- Building Trauma-Informed School Communities

Suicide Prevention

- Means Restrictions
- CalMHSA Know the Signs
- Kognito online trainings
- Collaborative Safety Planning
- Suicide Prevention & Assessment
- Responding to Crisis Calls and Messages

Resilience & Well-Being

- Positive Behavioral Interventions
- Unconditional Pride: Creating Affirming Spaces for Trans and Queer Youth
- Talking About Bullying
- Self-Care, Self-Control & Preferred Self
- Mindfulness
- Virtual Engagement Best Practices
- Assessing Student's Wellbeing During Virtual Instruction

** Open to non-mental health professionals who interact with/provide services to Orange County residents who may be experiencing a mental health issue; this can include teachers, childcare providers, veteran organizations, law enforcement, housing providers. religious/faith leaders, businesses, etc.*

For a list of all trainings offered in FY 2019-20, go to: https://www.eventbrite.com/o/behavioral-health-training-collaborative-27819159453

Online resources are available for select trainings so that students and families can access information after a training has been completed: ocstudentmentalhealth.org

Strategy 2: Educational/Informational Materials

Culturally responsive educational and informational materials for potential responders and members of the PEI Priority Populations are available in print, podcast or online. Materials address one or more of the following topics and are tailored for both Tier 1 and Tier 2:

- *Identifying and Responding to Early Signs of Mental Illness, Suicide Prevention, Outreach to Unserved and Underserved Cultural Communities*
  - i.e., "OC Links Talking Cards: How to Initiate a Conversation About Mental Health," CalMHSA/Statewide Projects Toolkits and Tipsheets on Stigma Reduction, Mental Health Awareness and Suicide Prevention, "Mental Health Support Guide" in English, Spanish, Korean and Vietnamese, "Be True and Be You Mental Health Guide" for LGBTQ+ youth, "Aging and LGBT Mental Health Support Guide," Latinx LGBTQ+ Immigrant Youth Provider Fact Sheet, etc.
- *Trauma-Informed Care*
- *RESET Toolbox:* A collection of trainings designed to increase developmental assets, protective factors and mental health resilience among children, developed by Western Youth Services in collaboration with CHOC Children's Hospital and Orange County Department of Education. The toolbox also equips parents, educators, school/district administrators and leaders of youth-serving collaborative agencies with multi-modal tools to mitigate the effects of toxic stress due to isolation in the wake of the COVID-19 pandemic

Each Mind Matters Ribbons & Wristbands

FY 19-20	N/A
FY 18-19	**57,254**
FY 17-18	**77,490**
FY 16-17	**53,400**

Strategy 3: Community Events, Networking and Activation Efforts

Community events, networking and activation efforts for potential responders and members of a PEI Priority Population include one or more of the following methods, strategies and approaches**:**

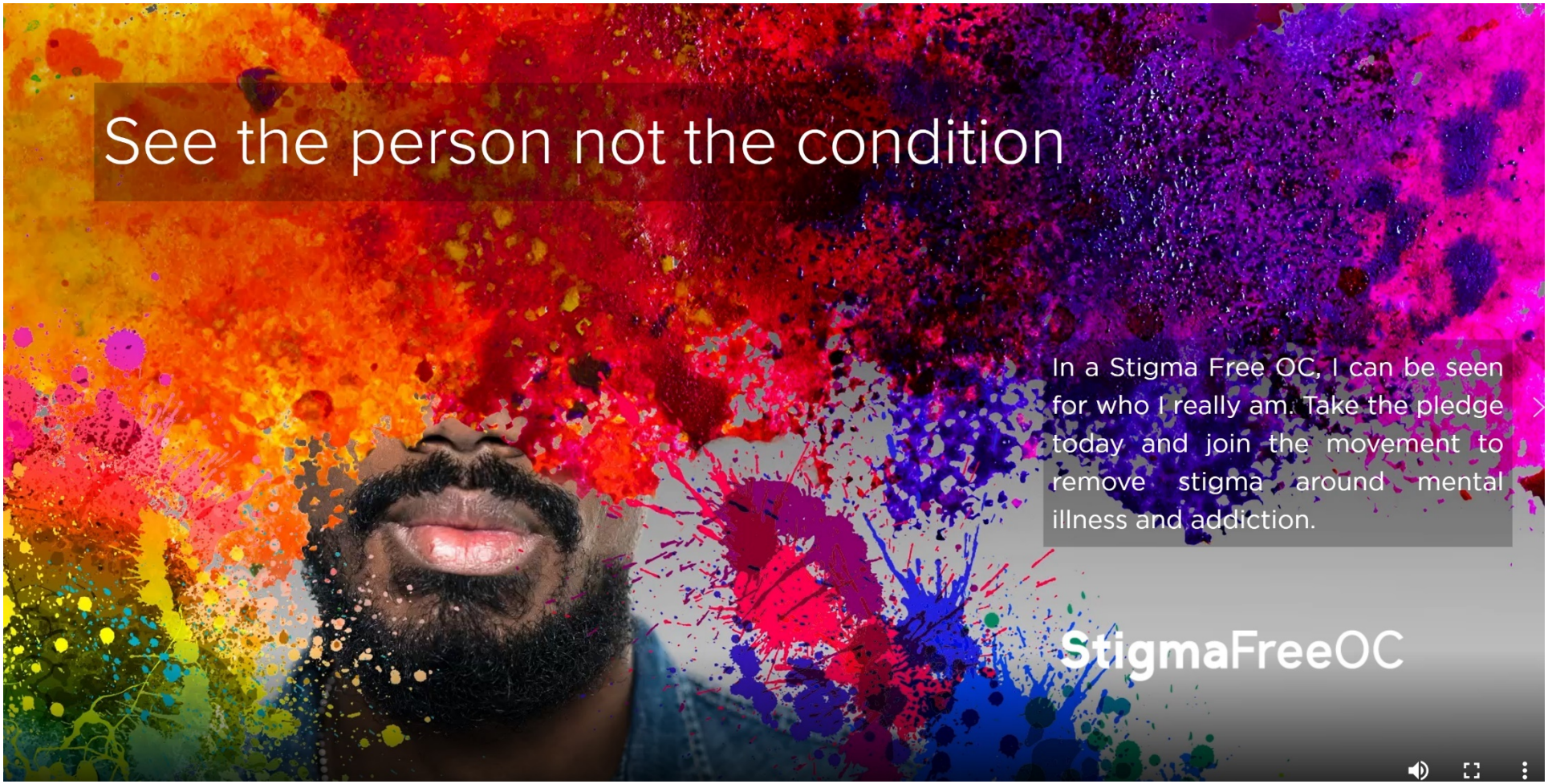
- Events: *Tier 1*
  - In-person and virtual Art Exhibits showcasing artwork created by program participants that promote mental health awareness, suicide prevention, stigma reduction, etc.; examples: *Send the Silence Packing* suicide prevention exhibit, local arts and photographic displays, etc.
- Performances: *Tier 1*
  - In-person and virtual professional theatre performances that highlight mental health topics and are followed by panel discussions facilitated by mental health professionals
- Conferences and Forums: *Tiers 1, 2*
  - In-person and virtual events such as Book clubs, Salon, Story-Telling events, Pop-up talks, resource and/or wellness fairs, Teen Toolbox (events for teens and parents), Youth Convening to empower LGBTIQ youth, etc.
- Community Networking: *Tiers 1, 2*
  - In-person and virtual Informational and networking forums for schools, school districts, colleges and universities, providers and other community organizations to learn from each other about evidence-based, practice-based and community-defined best practices, etc.
- Community Activation
  - *Tier 1:* Virtual and on-campus clubs and promotion of student-led activities on mental health, i.e., Active Minds, NAMI on Campus, Lesbian Gay Bisexual Transgender Intersex Questioning (LGBTIQ) clubs, Friday Night Live, Peer Assistance Leadership groups, Associated Student Body, etc.
  - *Tier 1, 2:* Community collaborations, coalitions or partnerships aimed at expanding behavioral health knowledge and awareness, etc.
- Creative Self-Expression: *Tiers 1, 2*
  - "Life Stories," a 10-12 week evidence-based program designed for self-expression through the creation of original dramatic works where participants use their own life experiences as inspiration for others; "Directing Change," a statewide video competition where students create public service announcements focused on educating the broader community on stigma and suicide prevention (see table below); etc.

FISCAL YEAR	# SUBMISSIONS Statewide	# SUBMISSIONS from OC	DIRECTING CHANGE HIGHLIGHTS View winning films from Orange County: **https://www.directingchangeca.org/films-by-county/#Orange**
FY 19/20	**1,080**	**78** **237 OC youth**	**Regional Competition Winners**: • 3 Orange County films in the "*Mental Health Matters*" category • 2 Orange County films in the "*Suicide Prevention*" category • 1 Orange County film in the "Animated Shorts" category **Honorable mentions**: • 1 "*Through the Lens of Culture*" category • 7 "*Mental Health Matters*" category • 6 "*Suicide Prevention*" category • 2 "*Sana Mente*" category • 1 "*Animated Shorts*" category • 2 "Walk in Our Shoes" category
FY 18/19	**1,063**	**84** **210 OC youth**	**Regional Competition Winners**: • 3 Orange County films in the "*Mental Health Matters*" category • 3 Orange County films in the "*Suicide Prevention*" category **Honorable mentions**: • 3 Orange County films in the "*Through the Lens of Culture*" category • 10 "*Mental Health Matters*" category • 9 "*Suicide Prevention*" category • 1 "*Sana Mente*" category • 2 "*Animated Shorts*" category
FY 17/18	**742**	**134** **342 OC youth**	**Regional Competition Winners**: • 3 Orange County films in the "*Mental Health Matters*" category • 3 Orange County films in the "*Suicide Prevention*" category • 1 Orange County film in the "*Through the Lens of Culture*" category
FY 16/17	**456**	**46**	**Regional Competition Winners**: • 3 Orange County films in the "*Mental Health Matters*" category • 2 Orange County films in the "*Suicide Prevention*" category

Strategy 4: Media Campaigns

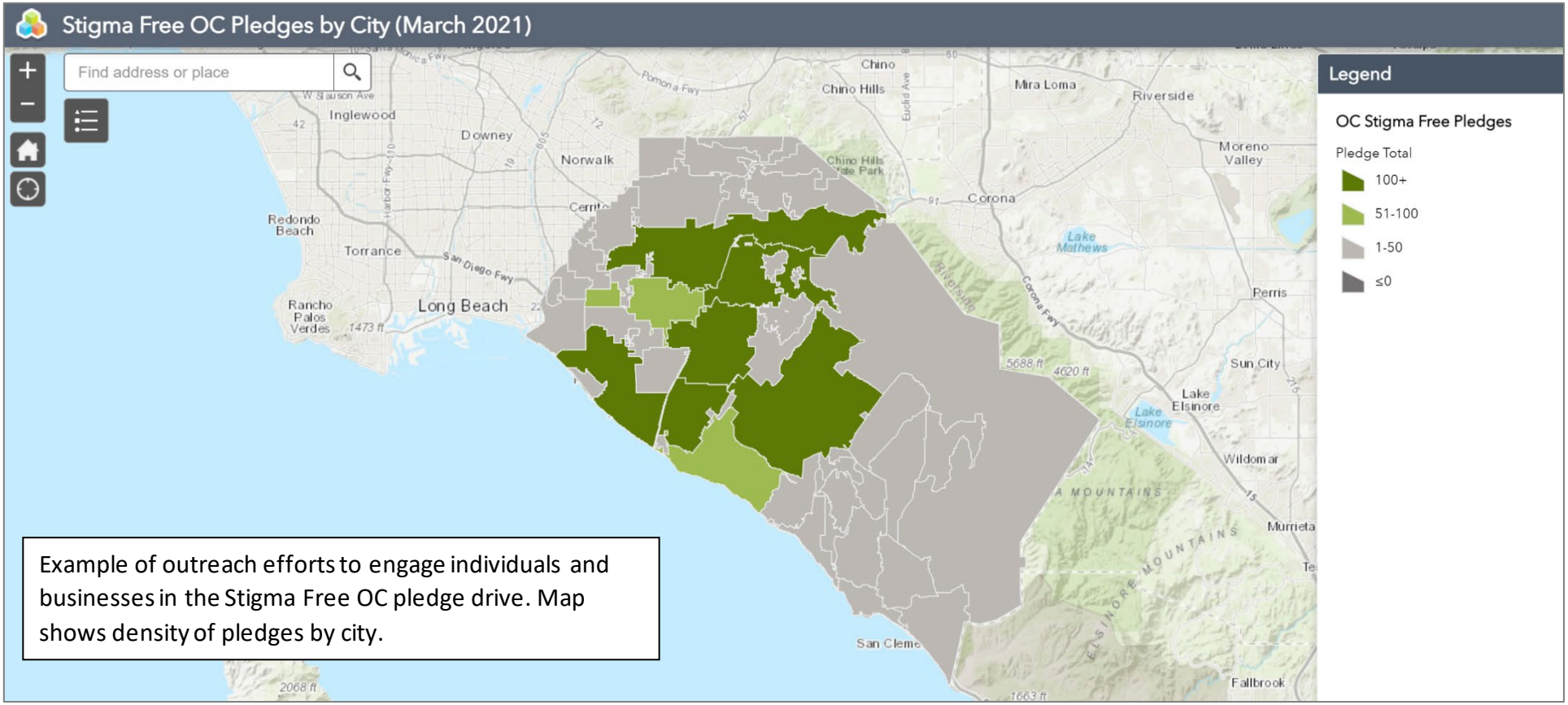
(i.e., culturally responsive/tailored print, radio, television, internet, social, etc.):

- *Each Mind Matters* public service announcements (PSAs)
- *Sana Mente PSA "Cuidate"* (i.e., "Take Care"), targeting the Spanish-speaking community between the ages 25-29
- *Know the Signs* suicide prevention
- *Stigma Free OC* launched October 2019 and the website was revamped and a new promotional campaign, "See the Person, not the Condition," was relaunched in November 2020



Strategy 5: Door-to-Door/Street/Event-Based Outreach *(Tiers 1, 2)*

- Door-to-door, street, virtual and telephone outreach conducted by provider staff, who are often trusted members of the community. Staff canvas neighborhoods and make phone calls to raise awareness, educate the community about mental health topics and provide them information about available services and resources. This is achieved by building rapport and trust with the community, especially with those who may be unaware of available resources and how to access them.
- Other outreach strategies include making in-person and online presentations and providing information via resource tabling at small- or large-scale community events such as health fairs, conferences, church events, 5k races, etc.



Example of outreach efforts to engage individuals and businesses in the Stigma Free OC pledge drive. Map shows density of pledges by city.

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

Location of Outreach Trainings and Events

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

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

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

STRATEGIES TO PROMOTE RECOVERY/RESILIENCE

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

STRATEGIES TO INCREASE ACCESS TO SERVICES: TIMELY ACCESS FOR UNDERSERVED POPULATIONS AND LINKAGE TO TREATMENT

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

STRATEGIES TO REDUCE STIGMA AND DISCRIMINATION

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

CHANGES, CHALLENGES AND SOLUTIONS IN PROGRESS

To mitigate the impact of limited resources and reach a larger geographic area, the program successfully collaborated with community partners to build a network that expanded the program's reach in Orange County. In addition, the stand-alone, PEI-funded School-Based Stress Management Services (SMS) program was discontinued beginning FY 2020-21 following the retirement of the contracted subject matter expert who oversaw this program. School-based/student-focused mindfulness trainings will continue to be offered through this Outreach program.

COMMUNITY IMPACT

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

School Readiness (PEI)

School Readiness serves families with children from birth to age 8 who are exhibiting behavioral problems and emotional distress which places them at increased risk of developing a mental health condition and failing in school. These families often face issues related to crowded living conditions, neighborhoods affected by gangs and drugs, a history of violence in the family, and history of separation from loved ones. Many of the families served are also monolingual (i.e., Spanish, Vietnamese).

AGE RANGE

Ages 0-8

PRIMARY LOCATION

Field | Community

TARGET POPULATION

At-Risk | Mild-Moderate | Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

- ✔ Arabic
- ✔ Farsi
- Khmer
- ✔ Korean
- ✔ Mandarin
- ✔ Spanish
- TDD/CHAT
- ✔ Vietnamese
- Other:

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	Gender	%	Race/Ethnicity	%
0-15	100	Female	54	African American/Black	2
16-25	-	Male	45	American Indian/Alaskan Native	1
26-59	-	Transgender	-	Asian/Pacific Islander	9
60+	-	Genderqueer	-	Caucasian/White	17
		Questioning/Unsure	-	Latino/Hispanic	71
		Another	1	Middle Eastern/North African	-
				Another	-

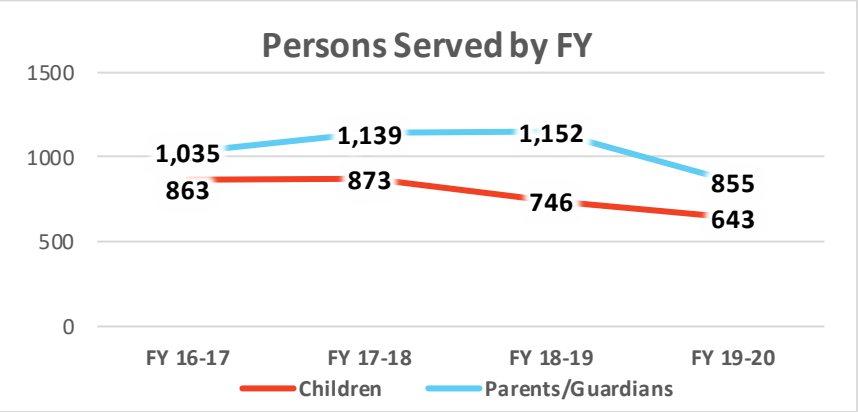
BUDGETS & PROJECTED #'s TO BE SERVED FROM 3YP

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$1,600,000	3,600
FY 2021-22*	$1,000,000	1705
FY 2022-23	$1,000,000	TBD

5-year, temporary budget augmentation concludes in FY 2022-23
**Proposed decrease in FY 2021-22 due to not renewing one provider contract.*

SERVICES

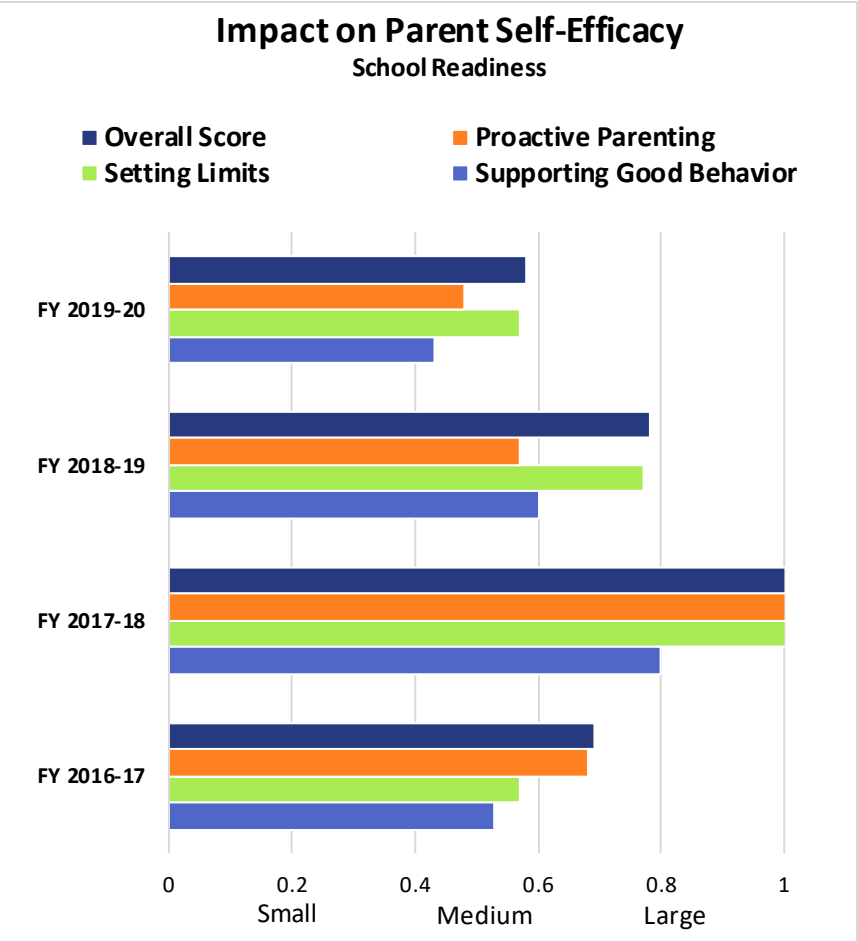
Services for children and their families include developmental screening, child and family needs assessments, parent education/training and coaching using Triple P Positive Parenting Program techniques, case management, and referral and linkage to community resources. The program also goes out into the community to train parents/caregivers, family members, day care staff, early education staff and other professionals working with the target population on how to recognize the early signs of emotional disturbance and behavioral conditions and to be aware of available resources.



OUTCOMES

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

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



CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

The challenges encountered by the program in FY 2019-20 were primarily related to planning and coordination around the public health emergency and all the restrictions imposed. Although the School Readiness providers were able to pivot their programming on the virtual digital platform, they found conducting screening and assessments and collecting the survey data were a challenge. On the other hand, attendance at trainings was steady; parents and caregivers found it easier to attend the virtual training. Going into FY 2021-22, only one of two provider contracts are being renewed with an increase in the contracted maximum obligation and resulting in a net decrease in the overall program budget and number of participants to be served. The remaining unencumbered program funds (i.e., $600,000) were redistributed to other programs/providers also serving families with young children ages 0-8 (i.e., Parent Education Services; the early childhood provider in the Outreach to Increase recognition of the Early Signs of Mental Illness program).

REFERENCE NOTES

Supporting Good Behavior

FY 2019-20: Baseline M=6.0, SD=0.86; Follow-up M=6.4, SD=0.77; t (227)=-6.53, p<.001; Cohen's d=0.43
FY 2018-19: Baseline M=5.8, SD=0.95; Follow-up M=6.3, SD=0.71; t(288)=-9.93, p<.001; Cohen's d=0.60
FY 2017-18: Baseline M=6.0, SD=0.95; Follow-up M=6.6, SD=0.53; t(298)=12.65, p<.001; Cohen's d=0.80
FY 2016-17: Baseline M=6.3, SD=0.68; Follow-up M=6.5, SD=0.56; t(118)=5.66, p<.001; Cohen's d=0.53

Setting Limits

FY 2019-20: Baseline M=5.4, SD=1.08; Follow-up M=6.0, SD=1.01; t(227)=-8.66, p<.001; Cohen's d=0.57
FY 2018-19: Baseline M=5.4, SD=1.10; Follow-up M=6.1, SD=0.80; t(288)=-12.71, p<.001; Cohen's d=0.77
FY 2017-18: Baseline M=5.2, SD=1.30; Follow-up M=6.4, SD=0.74; t(298)=17.57, p<.001; Cohen's d=1.11
FY 2016-17: Baseline M=5.5, SD=1.13; Follow-up M=6.1, SD=0.86; t(118)=6.12, p<.001; Cohen's d=0.57

Proactive Parenting

FY 2019-20: Baseline M=5.6, SD=1.10; Follow-up M=6.2, SD=0.89; t(227)=-7.10, p<.001; Cohen's d=0.48
FY 2018-19: Baseline M=5.5, SD=1.21; Follow-up M=6.1, SD=1.04; t(288)=-9.62, p<.001; Cohen's d=0.57
FY 2017-18: Baseline M=5.3, SD=1.30; Follow-up M=6.5, SD=0.71; t(298)=17.65, p<.001; Cohen's d=1.13
FY 2016-17: Baseline M=5.6, SD=1.15; Follow-up M=6.3, SD=0.88; t(118)=17.65, p<.001; Cohen's d=0.68

Overall Score

FY 2019-20: Baseline M=5.7, SD=0.89; Follow-up M=6.2, SD=0.81; t(227)=-8.66, p<.001; Cohen's d=0.58
FY 2018-19: Baseline M=5.6, SD=0.94; Follow-up M=6.2, SD=0.76; t(288)=-13.06, p<.001; Cohen's d=0.78
FY 2017-18: Baseline M=5.5, SD=1.07; Follow-up M=6.5, SD=0.61; t(298)=18.49, p<.001; Cohen's d=1.18
FY 2016-17: Baseline M=5.8, SD=0.89; Follow-up M=6.3, SD=0.71; t(118)=7.34, p<.001; Cohen's d=0.69

COMMUNITY IMPACT

The program has provided services to thousands of participants since its inception in April 2013. Staff regularly work with school and Head Start personnel, physicians and nurses to connect families to services. By helping prepare children to participate in a classroom setting, the program works to decrease the potential for school failure, which can be a risk factor for the development of a mental health condition.

Parent Education Services (PEI)

Parent Education Services (PES) serves at-risk children birth -18 years of age and family members, including parents, partners, grandparents, single parents, teenaged parents, guardians and other caregivers in need. Participating families may experience behavioral health or mental health issues, substance use or co-occurring disorders, or child welfare or juvenile justice system involvement. They may also be homeless, single-parent households, exposed to domestic violence or other trauma, recent immigrants or refugees, or have a child with disabilities (cognitive, emotional, and/or physical). Parents or caregivers are referred to PES from community agencies, schools or other PEI programs that have assessed participants and identified the need for parent education.

AGE RANGE

Ages 0-18

PRIMARY LOCATION

Field | Community

TARGET POPULATION

At-Risk | Mild-Moderate | Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

- ✔ Arabic
- ✔ Farsi
- Khmer
- ✔ Korean
- Mandarin
- ✔ Spanish
- TDD/CHAT
- ✔ Vietnamese
- Other:

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	Gender	%	Race/Ethnicity	%
0-15	90	Female	72	African American/Black	1
16-25	10	Male	20	American Indian/Alaskan Native	1
26-59	-	Transgender	1	Asian/Pacific Islander	18
60+	-	Genderqueer	-	Caucasian/White	14
		Questioning/Unsure	-	Latino/Hispanic	63
		Another	7	Middle Eastern/North African	1
				Another	2

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

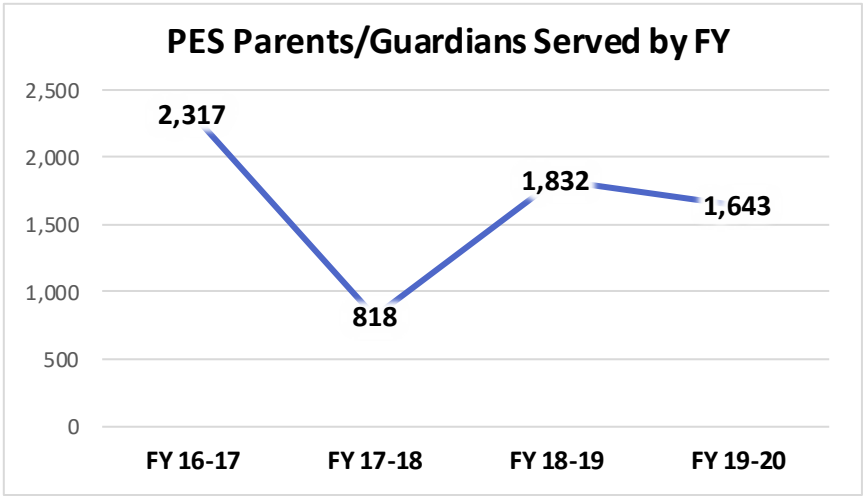
Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$1,064,770	1,600
FY 2021-22*	$1,450,000	2,000
FY 2022-23	$1,064,770	2,000

**Proposed increases for FY 2021-22 using savings from School Readiness program.*
Error in FY 2020-21 # Served corrected.

SERVICES

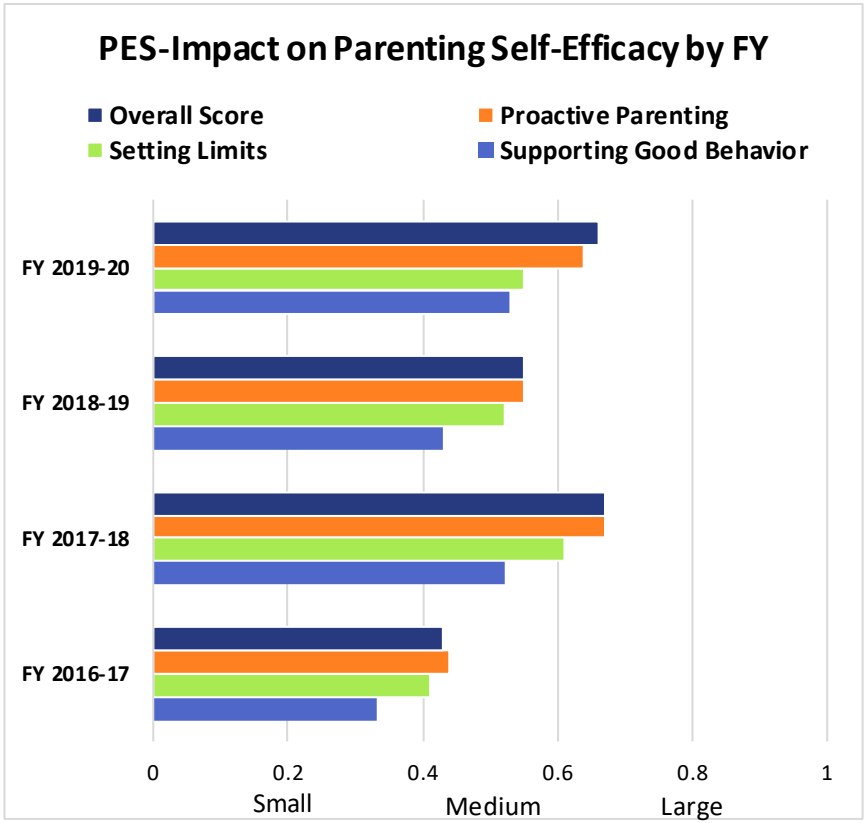
The program's purpose is to prevent the occurrence of, or reduce prolonged suffering due to, negative mental health outcomes in children by promoting protective factors in parents and caregivers. It accomplishes this by providing parenting education classes and individual interventions or additional support when parents need clarification about individual issues or help in understanding the parenting curriculum.

The program guides its services through Active Parenting, an evidence-based parent training designed to reduce risk factors and increase family protective factors through practical, easy-to-use skills such as assisting parents in strengthening relationships with their children, reducing problem behaviors exhibited by children and increasing success of children in schools, by increasing cooperation and developing problem-solving skills. To ensure fidelity, all parent trainers are required to attend a comprehensive training prior to conducting classes. Parent trainers are also evaluated in the classroom a minimum of one time per month. In addition, PES provides case management activities, which include engagement, assessment and service coordination and delivery (e.g., navigating and linking to systems, monitoring, advocating for needs).



OUTCOMES

Program effectiveness for PES was evaluated through an assessment of the protective factor, parenting self-efficacy. Results generally demonstrated that parents not only maintained high levels of parenting efficacy while receiving services, but also made additional small to medium gains, with gains tending to be somewhat larger over the past three years compared to FY 2016-17.



CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

The program continues to expand its reach in the community to address the needs of the diverse population of the County. Attendance from the LGBTIQ community and the deaf and hard of hearing community continues to grow. In addition, more classes for survivors of domestic violence are being offered and attended throughout the county, and these classes are formatted as closed sessions, not open to the general public, to protect the identity of the women. Prior to the pandemic, the program was successful in getting access to the Orange County jails to provide classes to incarcerated women and men. Due to the public health emergency, access to the jails was restricted. The program will add more parenting classes specifically for parents with children birth – 8 years of age. Parenting classes for all age groups are provided in multiple languages including Vietnamese, Korean, Farsi, Arabic, in addition to English and Spanish. In response to the pandemic, the program successfully recreated and provided the Active Parenting training remotely to allow access to training during the pandemic shut-down.

REFERENCE NOTES

Supporting Good Behavior:

FY 2019-20: Baseline M=5.3, SD=1.12; Follow-up M=5.9, SD=0.88; t(1386)=19.17, p<.001; Cohen's d=0.53
FY 2018-19: Baseline M=5.3, SD=1.22; Follow-up M=5.8, SD=1.02; t(1091)=14.04, p<.001; Cohen's d=0.43
FY 2017-18: Baseline M=5.4, SD=1.1; Follow-up M=5.9, SD=0.9; t(631)=-12.92, p<.001; Cohen's d=0.52
FY 2016-17: Baseline M=5.9, SD=1.1; Follow-up M=6.2, SD=0.9; t(780)=-9.21, p<.001; Cohen's d=0.33

Setting Limits:

FY 2019-20: Baseline M=5.1, SD=1.26; Follow-up M=5.7, SD=0.97; t(155)=20.10, p<.001; Cohen's d=0.55
FY 2018-19: Baseline M=5.0, SD=1.22; Follow-up M=5.6, SD=1.02; t(1091)=16.93, p<.001; Cohen's d=0.52
FY 2017-18: Baseline M=5.1, SD=1.2; Follow-up M=5.8, SD=1.0; t(629)=-15.07, p<.001; Cohen's d=0.61
FY 2016-17: Baseline M=5.3, SD=1.3; Follow-up M=5.9, SD=1.1; t(780)=-11.25, p<.001; Cohen's d=0.41

Proactive Parenting:

FY 2019-20: Baseline M=5.1, SD=1.23; Follow-up M=5.8, SD=1.00; t(1381)=23.41, p<.001; Cohen's d=0.64
FY 2018-19: Baseline M=5.1, SD=1.32; Follow-up M=5.7, SD=1.06; t(1097)=17.88, p<.001; Cohen's d=0.55
FY 2017-18: Baseline M=5.1, SD=1.3; Follow-up M=5.9, SD=1.0; t(629)=-16.32, p<.001; Cohen's d=0.67
FY 2016-17: Baseline M=5.4, SD=1.3; Follow-up M=5.9, SD=1.1; t(780)=-12.09, p<.001; Cohen's d=0.44

Overall Score:

FY 2019-20: Baseline M=5.2, SD=1.10; Follow-up M=5.8, SD=0.88; t(1386)=24.10, p<.001; Cohen's d=0.66
FY 2018-19: Baseline M=5.1, SD=1.18; Follow-up M=5.7, SD=0.97; t(1019)=18.06, p<.001; Cohen's d=0.55
FY 2017-18: Baseline M=5.2, SD=1.1; Follow-up M=5.9, SD=0.9; t(632)=-16.66, p<.001; Cohen's d=0.67
FY 2016-17: Baseline M=5.5, SD=1.1; Follow-up M=6.0, SD=1.0; t(780)=-12.04, p<.001; Cohen's d=0.43

COMMUNITY IMPACT

Parent Education Services has provided services to 13,067 at-risk children and families since its inception in October 2012. Program staff has worked collaboratively with area school districts, child welfare, juvenile justice, and children's mental health systems throughout Orange County to support at-risk families.

Children's Support & Parenting Program (PEI)

Children's Support and Parenting Program (CSPP) serves a wide range of families from different backgrounds whose stressors make children more vulnerable to developing behavioral health problems. These stressors can include parental history of serious substance use disorder and/or mental health condition; a family member's actual or potential involvement in the juvenile justice system; family members who have developmental or physical illnesses/disabilities; families impacted by divorce, domestic violence, trauma, unemployment and/or homelessness; and families with active duty military/returning veterans. Families are referred to the program through Family Resource Centers, schools, behavioral health programs and other community providers.

AGE RANGE

6-18

Ages 6-18

PRIMARY LOCATION

Field | Community

TARGET POPULATION

✔ At-Risk | Mild-Moderate | Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

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

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	Gender	%	Race/Ethnicity	%
0-15	34	Female	67	African American/Black	-
16-25	7	Male	33	American Indian/Alaskan Native	-
26-59	57	Transgender	-	Asian/Pacific Islander	3
60+	2	Genderqueer	-	Caucasian/White	3
		Questioning/Unsure	-	Latino/Hispanic	92
		Another	-	Middle Eastern/North African	-
				Another	2

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

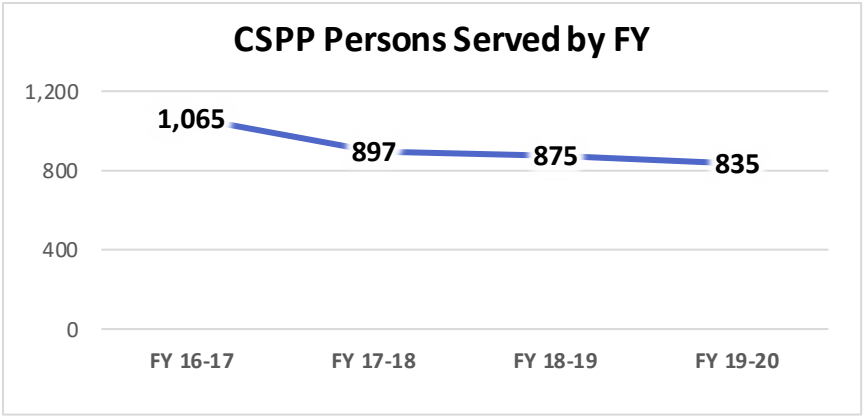
Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$1,700,000	1,000
FY 2021-22*	$1,000,000	1,000
FY 2022-23	$1,700,000	1,000

**Proposed decrease for FY 2021-22 budget due to vacancies and right-sizing*

SERVICES

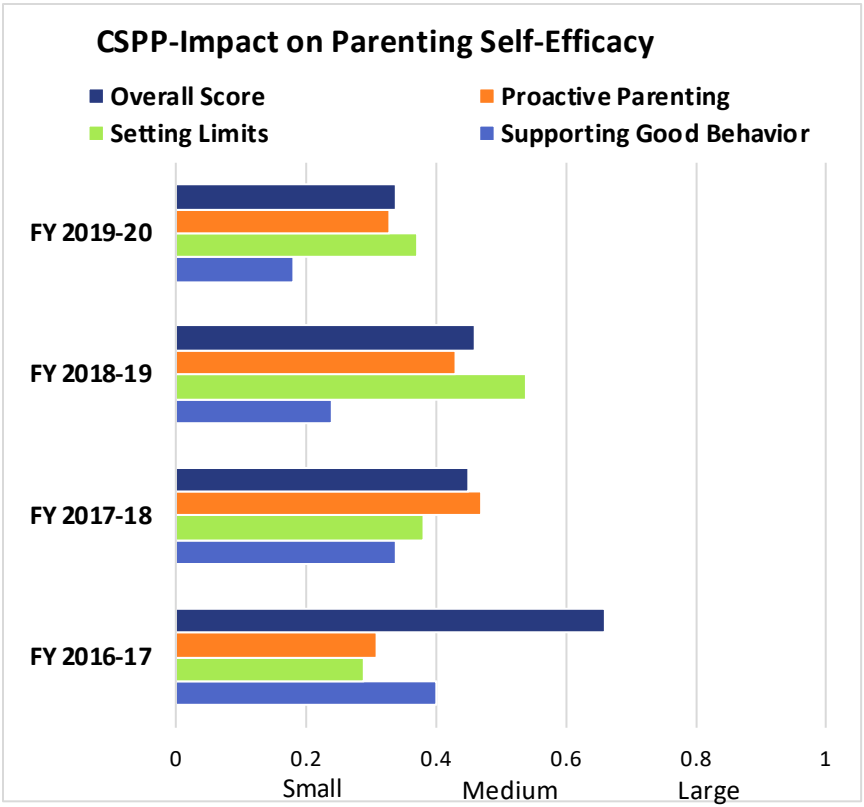
The program provides parent training and family-strengthening programs designed to reduce risk factors and increase protective factors for children and youth. Services include family assessment; group interventions for children, teens and parents; brief individual interventions to address specific family issues; referral and linkage to community resources; and workshops.

CSPP provides these services utilizing evidence-based curricula depending on participant need: Strengthening Families or The Parent Project®. The curricula are delivered in a classroom-type setting in many different types of organizations such as schools, Family Resource Centers (FRC), treatment facilities, juvenile probation offices and the CSPP offices. All staff utilizing an Evidence Based Practices are certified to deliver the curriculum and adhere to it when presenting the material to participants.



OUTCOMES

CSPP strives to prevent the development or worsening of mental health conditions by maintaining and/or strengthening the protective factor of effective parenting skills. CSPP measured parenting development using the PARCA-SE, which assesses different domains of parenting self-efficacy. Administered at intake, every three months of program participation and at discharge, the PARCA-SE was analyzed for change in scores between intake and the most recent follow-up and reported according to effect size. Results from FY 2016-17 through FY 2019-20 show that parents not only reported maintaining healthy levels of parenting efficacy but also made small additional gains while receiving services.



CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

Maintenance of program staffing has been challenging in this program as many of the positions are “entry level” in nature and staff quickly promote to other positions. The classification specifications for these programs are being examined to make appropriate changes. In addition, due to the nature of services provided on school campuses or community sites, with the COVID-19 Pandemic, CSPP services were abruptly halted which impacted total number served. Through CARES Act funding, licenses for the Positive Parenting Program (Triple P) online were purchased for caregivers to have remote access to parent education and supports. CSPP staff were made available as parent liaisons for those desiring additional assistance with the curriculum.

REFERENCE NOTES

Supporting Good Behavior:

FY 2019-20: Baseline M=5.7, SD=1.04; Follow-up M=5.9, SD=0.91; t(215)=2.67, p=.008; Cohen's d=0.18
FY 2018-19: Baseline M=5.7, SD=1.05; Follow-up M=6.0, SD=0.92; t(340)=4.43, p<.001; Cohen's d=0.24
FY 2017-18: Baseline M=5.8, SD=1.19; Follow-up M=6.1, SD=0.92; t(141)=3.96, p<.001; Cohen's d=0.34
FY 2016-17: Baseline M=5.3, SD=1.25; Follow-up M=5.8, SD=1.04; t(310)=6.95, p<.001; Cohen's d=0.40

Setting Limits:

FY 2019-20: Baseline M=5.3, SD=1.21; Follow-up M=5.8, SD=1.00; t(215)=5.40, p<.001; Cohen's d=0.37
FY 2018-19: Baseline M=5.2, SD=1.29; Follow-up M=5.8, SD=1.00; t(338)=9.68, p<.001; Cohen's d=0.54
FY 2017-18: Baseline M=5.3, SD=1.28; Follow-up M=5.8, SD=1.09; t(141)=3.96, p<.001; Cohen's d=038
FY 2016-17: Baseline M=5.3, SD=1.31; Follow-up M=5.7, SD=1.09; t(310)=5.03, p<.001; Cohen's d=0.29

Proactive Parenting:

FY 2019-20: Baseline M=5.3, SD=1.27; Follow-up M=5.7, SD=1.00; t(215)=4.70, p<.001; Cohen's d=0.33
FY 2018-19: Baseline M=5.2, SD=1.31; Follow-up M=5.7, SD=1.02; t(338)=7.76, p<.001; Cohen's d=0.43
FY 2017-18: Baseline M=5.2, SD=1.39; Follow-up M=5.8, SD=1.04; t(141)=5.47, p<.001; Cohen's d=0.47
FY 2016-17: Baseline M=5.4, SD=1.13; Follow-up M=5.8, SD=1.00; t(310)=5.48, p<.001; Cohen's d=0.31

Overall Score:

FY 2019-20: Baseline M=5.5, SD=1.87; Follow-up M=5.8, SD=0.88; t(215)=4.96, p<.001; Cohen's d=0.34
FY 2018-19: Baseline M=5.4, SD=1.10; Follow-up M=5.8, SD=0.90; t(340)=8.39, p<.001; Cohen's d=0.46
FY 2017-18: Baseline M=5.4, SD=1.19; Follow-up M=5.9, SD=0.94; t(141)=5.27, p<.001; Cohen's d=0.45
FY 2016-17: Baseline M=24.9, SD=3.39; Follow-up M=27.4, SD=3.57; t(13)=-2.48, p<.05; Cohen's d=0.66

School-Based Behavioral Health Intervention & Support (PEI)

The **School-Based Behavioral Health Interventions and Support** (SBBHIS) program provides a combination of prevention and early intervention services designed to empower families, reduce risk factors, build resilience and strengthen culturally appropriate coping skills in at risk students and families. Services are provided in elementary, middle and high school classrooms and/or group settings in school districts identified as having the highest rates of behavioral issues based on the California Healthy Kids Survey (CHKS), Academic Performance Index (API) scores and/or suspension and expulsion data as reported by school districts.

AGE RANGE

Ages 5-14

PRIMARY LOCATION

Schools

TARGET POPULATION

✓ At-Risk Mild-Moderate Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

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

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	Gender	%	Race/Ethnicity	%
0-15	90	Female	48	African American/Black	3
16-25	10	Male	50	American Indian/Alaskan Native	6
26-59	-	Transgender	1	Asian/Pacific Islander	12
60+	-	Genderqueer	-	Caucasian/White	22
		Questioning/Unsure	-	Latino/Hispanic	53
		Another	1	Middle Eastern/North African	-
				Another	4

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

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$3,408,589	40,500
FY 2021-22*	$1,808,589	26,680
FY 2022-23	$1,808,589	26,680

SERVICES

SBBHIS provides a three-tiered approach to program services aimed at preventing and/or intervening early among at risk students and their families:

Tier 1: Classroom prevention is a classroom-based approach that utilizes an evidence-based curriculum, Positive Action, with learning modules focused on key learning objectives such as self-concept, life-skills, positive decision-making, respect and bullying prevention. Tier 1 students also have access to an application (app), *You and*, for on-demand digital support for their social and emotional well-being.

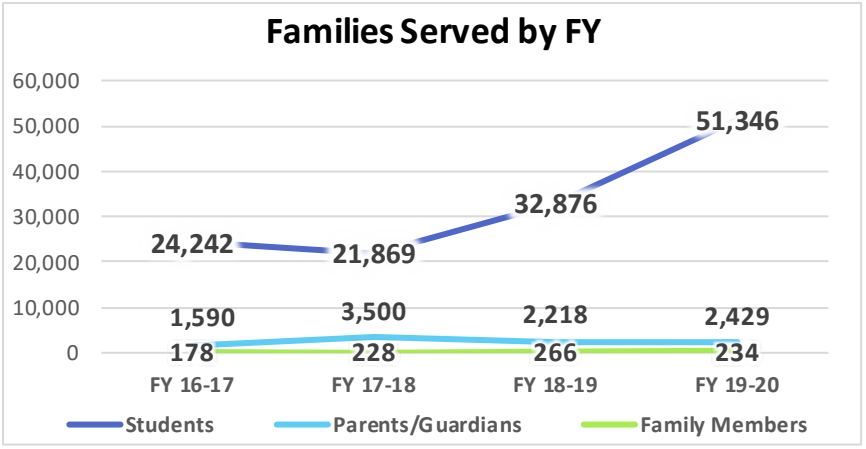
Tier 2: Students exhibiting higher-level problem behaviors are provided student-based interventions, which utilize smaller student groups focused on specific areas of concern such as bullying, anger management, conflict resolution, drug prevention and/or self-esteem. Tier 2 students also have access to the *You and* app.

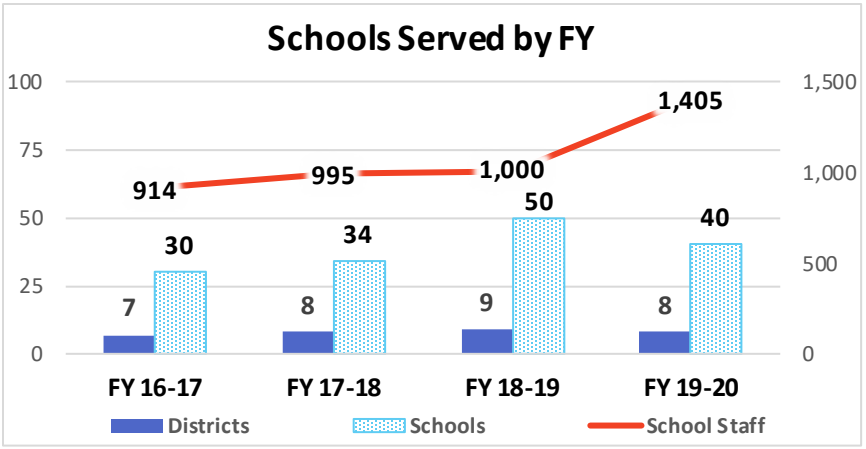
Tier 3: Students who display symptoms indicative of higher-level needs and require more intensive services than provided in Tiers 1 or 2 receive Tier 3, Family Intervention. This tier provides early intervention family services focused on building skills to improve family communication, relationships, bonding and connectedness.

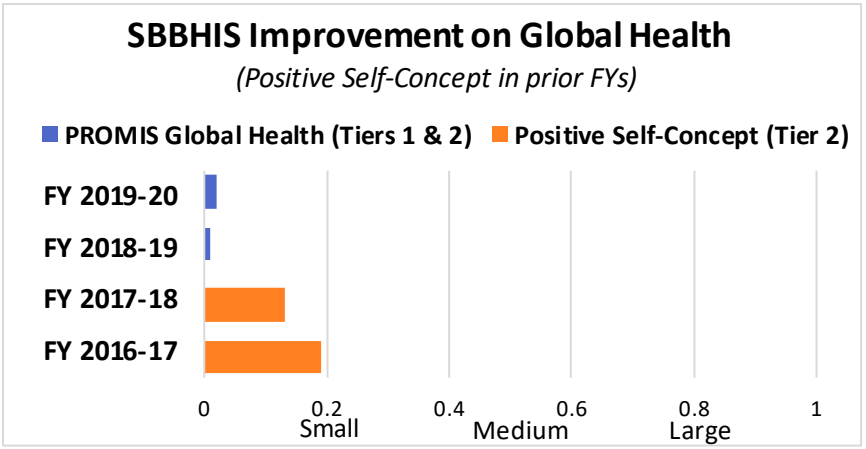
OUTCOMES

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

Tiers 1 and 2: To measure the extent to which the program increased the protective factor of well-being among Tier 1 and Tier 2 participants, the program began administering the PROMIS Pediatric Global Health-7 (PGH-7) in FY 2018-19. Because one of the providers was unable to separate the outcome data by tiers, analyses combined Tier 1 and Tier 2 PGH-7 data. Self-reported student ratings since FY 2018-19 showed that students maintained adequate levels of positive health while participating in Tier 1/Tier 2 (i.e., average score falling around the 50th percentile, negligible effect size). In earlier fiscal years, program performance was measured with a modified Self-Concept Scale. Self-reported student ratings similarly showed that students maintained positive self-concept during the weeks they participated in Tier 2 programming.

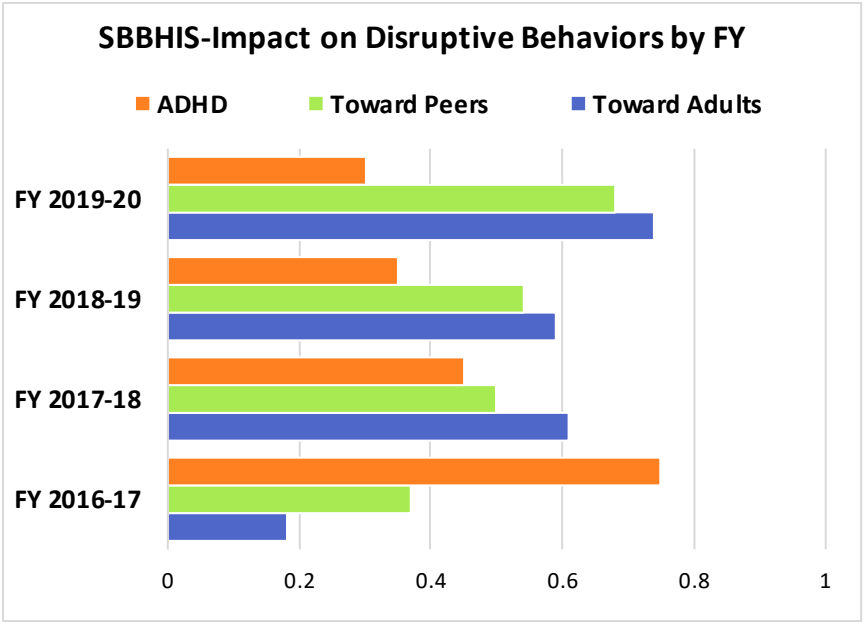






Tier 3: To assess the effectiveness in reducing prolonged suffering among Tier 3 participants, different types of disruptive behaviors were rated by the students' parents on the Child and Adolescent Disruptive Behavior Inventory (CADBI) at baseline and program exit. Change in scores over time is reported according to effect size.

Since 2016-17, parents generally reported that their children showed moderate decreases in disruptive behavior toward both adults and peers, as well as small to moderate decreases in impulsive and hyperactive behaviors.



CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

In response to the pandemic and school closures, the program was successful in continuing to serve students by recreating their program curriculum and providing it on a virtual platform. In addition, a provider created the "Safer from Home" series for middle school students in response to the pandemic and received outstanding reviews form participants and their teachers. Finally, with the use of CARES Act funding, this same provider developed a computer and mobile interactive app, called "You And," for school age youth designed to maintain social and emotional well-being of students, their mental health, improve resiliency, develop positive coping skills, and stay connected to their peers. The content is tailored to engage four educational groupings: K-2, 3-5, Middle School and High School. Based on requests from individual schools, the provider will integrate the 6-week curriculum within the Tier 1 and Tier 2 services.

REFERENCE NOTES

Tier 1/Tier 2: PROMIS Global Health

FY 2019-20: Baseline M=24.5, SD=4.35; Follow-up M=24.6, SD=4.35; t(9853)=2.36, p=.018; Cohen's d=.02
FY 2018-19: Baseline M=24.3, SD=4.52; Follow-up M=24.2, SD=4.48; t(8084)=1.12, p=.263; Cohen's d=-.01

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

FY 2017-18: Baseline M=64.1, SD=9.1; Follow-up M= 65.0, SD=8.9, t(506)=2.91, p<.01; Cohen's d=0.13
FY 2016-17: Baseline M=62.6, SD=9.7; Follow-up M=64.2, SD=10.2; t(543)=-4.44, p<.001; Cohen's d=-0.19

Tier 3: Disruptive Behavior Toward Adults

FY 2019-20: Baseline M=19.2, SD=8.85; Follow-up M=15.0, SD=5.79; t(39)=4.19, p<.001; Cohen's d=0.74
FY 2018-19: Baseline M=20.7, SD=9.38; Follow-up M=16.2, SD=7.77; t(38)=4.35, p<.001; Cohen's d=0.59
FY 2017-18: Baseline M=20.7, SD=13.6; Follow-up M=16.3, SD=19.9; t(66)=4.46, p<.001; Cohen's d=0.61
FY 2016-17: Baseline M=13.9, SD=6.0; Follow-up M=13.2, SD=4.3; t(28)=0.90, p=<.382; Cohen's d=0.18

Tier 3: Disruptive Behavior Toward Peers

FY 2019-20: Baseline M=20.9, SD=12.47; Follow-up M=15.0, SD=7.58; t(37)=3.69, p<.001; Cohen's d=0.68
FY 2018-19: Baseline M=20.8, SD=11.09; Follow-up M=16.4, SD=8.67; t(48)=3.65, p<.001; Cohen's d=0.54
FY 2017-18: Baseline M=21.8, SD=14.8; Follow-up M=17.4, SD=12.3; t(66)=3.96, p<.001; Cohen's d=0.50
FY 2016-17: Baseline M=15.2, SD=9.3; Follow-up M=12.6, SD=6.3; t(32)=1.90, p=.06; Cohen's d=0.37

COMMUNITY IMPACT

The program continues to build capacity in the community through collaboration with community partners and school districts. Since program inception, more than 160,000 students, 10,500 parents/ caregivers and 6,000 school staff have participated.

Tier 3: ADHD/Hyperactive/Impulsive

FY 2019-20: Baseline M=25.0, SD=14.19; Follow-up M=21.2, SD=13.5; t(36)=1.80, p<.081; Cohen's d=0.30
FY 2018-19: Baseline M=23.1, SD=13.47; Follow-up M=19.0, SD=11.91; t(46)=2.39, p<.021; Cohen's d=0.35
FY 2017-18: Baseline M=24.7, SD=15.0; Follow-up M= 20.6, SD=12.7; t(65)=3.53, p<.001; Cohen's d=0.45
FY 2016-17: Baseline M=24.2, SD=16.5; Follow-up M=15.1, SD=10.6; t(22) =3.30, p<.01; Cohen's d=0.75

Violence Prevention Education (PEI)

The **Violence Prevention Education** (VPE) program aims to reduce violence and/or its impact in schools, local neighborhoods and/or families. The target audience for the program includes students, parents and school staff at participating elementary, middle and high schools throughout Orange County, as well as other community sites such as domestic violence shelters.

AGE RANGE

Ages 6-18

PRIMARY LOCATION

Schools

TARGET POPULATION

✔ At-Risk | Mild-Moderate | Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

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

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	Gender	%	Race/Ethnicity	%
0-15	75	Female	52	African American/Black	3
16-25	25	Male	43	American Indian/Alaskan Native	4
26-59	-	Transgender	-	Asian/Pacific Islander	21
60+	-	Genderqueer	-	Caucasian/White	15
		Questioning/Unsure	-	Latino/Hispanic	46
		Another	5	Middle Eastern/North African	-
				Another	11

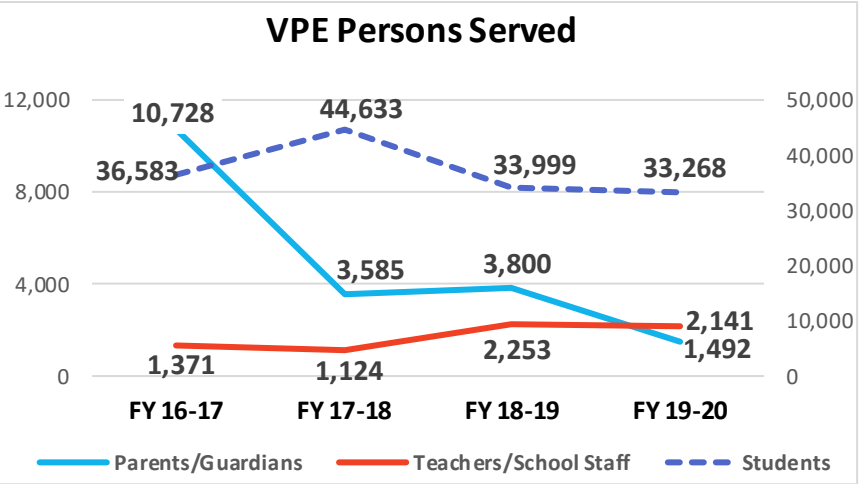
BUDGETS & PROJECTED #'s TO BE SERVED FROM 3YP

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$1,352,651	29,879
FY 2021-22*	$1,352,651	29,879
FY 2022-23	$1,352,651	29,879

**5-year, temporary budget augmentation concludes after FY 2022-23. No proposed changes to FY 2021-22.*

SERVICES/IMPACT

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



In FY 2016-17 there were an unusually high number of crisis events in the community that increased the demand for Crisis Response Network services provided to parents/guardians

- **Bullying/Cyber-Bullying**: Educates students, staff, administrators and parents on bullying and cyber-bullying prevention through: (1) presentations conducted at school assemblies in an effort to impact the overall school climate by reducing and/or preventing bullying; and (2) a classroom-based curriculum focused on combating cyber-bullying. From FY 2016-17 through FY 2019-20, the majority of respondents agreed or strongly agreed that they knew or learned about bullying (61-87%) and felt empowered to stand up to bullying behavior (73-83%) after attending a student assembly. In FYs 2018-19 and 2019-20, when the post-training measure was implemented, the majority of students who took part in the cyber-bullying curriculum (72%-96%) stated that they had learned a digital literacy skill.
- **Restorative Practices:** Offers a trauma-informed, research-based training for teachers to promote resilience in youth, particularly those who have been exposed to violence and varying degrees of trauma. Teachers utilize "circle practices" in the classroom to promote healthy relationships and help create calmer, more focused classrooms. The "circle practice" encourages students to strengthen relationships with their peers and teachers, thus, creating a safe and supportive environment for effective communication, expression of emotion, and exploration and acceptance of differences. Teachers who use these methods often find that the overall portion of time dedicated to managing behavior is reduced, thus freeing up more time for instruction. In FY 2019-20, the majority of students agreed or strongly agreed that they had engaged in healthy habits or accepted others, although fewer girls endorsed having a positive body image or engaging in a meaningful activity.
- **Safe From The Start**: Educates parents on research demonstrating how exposure to violence, whether through direct physical contact or as a witness, can impact children's neurological development which may, in turn, compromise their cognitive, social and emotional development. Presentations are provided to parents at campus during and after school hours, as well as at shelters. Across the last four fiscal years (FY 2016-17 through FY 2019-20), the majority of respondents reported feeling confident in their ability to better manage emotions and use positive parenting strategies following the training (65-99%).
- **Threat Assessment:** Provides training to school administrators, teachers, mental health counselors, school resource officers and other school staff to assess threats and respond appropriately, and survey results indicate that those who received the simulation drills (see below) felt more confident in their ability to assess and respond to potential threats. The program consists of three components:
    - Proactive Threat Assessment Training, a full-day training covering the definition of threat, threat types and levels, how to screen and assess threats, behavioral indicators to look for, a response protocol, addressing stigma and mental health resources;
    - Threat Assessment Simulation Drills, covering situational awareness to increase confidence and a sense of empowerment during an emergency, which includes classroom and front office lockdown steps and procedures, and a post-drill debrief to reflect on shared experience, distress reactions, and the importance of self-care;

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

In FYs 2018-19 and 2019-20, when the training was implemented, the majority of school staff who took part in the training (86%-99%) stated that they had learned information on how to identify and/or respond to a potential threat.

- **Crisis Response Network**: A network of crisis responders trained in Crisis Incident Stress Management who mobilize and assist a school or community in times of emergency, need or threat. Pre-incident and crisis management trainings are also provided to the schools and the community. Across the last four fiscal years (FY 2016-17 through FY 2019-20), the majority of respondents agreed or strongly agreed that they learned how to recognize risk factors and practice healthy coping or support behaviors (85-100%).

CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

In an effort to meet the changing scheduling needs of participating schools and districts, the program had adjusted service delivery or curricula so that trainings and presentations can be held in a single, large-format assembly rather than multiple, smaller classroom sessions. The program faced challenges in providing most of their services due to the public health emergency since March 2019, when schools were on lockdown.

COMMUNITY IMPACT

The program has provided services to more than 220,000 students, 32,600 parents and 11,550 school staff since its inception in August 2013. The program has had a strong impact in local communities by increasing awareness about the risks posed by violence and bullying, providing support in times of crisis, and creating educational opportunities for students, staff, parents and Orange County residents.

Gang Prevention Services (PEI)

Gang Prevention Services (GPS) is a school-based collaboration with the Gang Reduction Intervention Partnership (GRIP) operated by the Orange County District Attorney's (OCDA) Office in conjunction with the Probation Department, local police departments and school staff. It provides case management to 4th through 8th grade youth who display signs of being at risk for gang activity which, in turn, places them at an increased risk of violence and of developing mental health conditions, particularly those that are trauma-related. The OCDA Office and the Orange County Probation Department select schools to participate in the program based on high rates of truancy, discipline issues and gang proximity. The program focuses on being inclusive of all high-risk youth in the identified schools, regardless of their familial affiliations to gang activity or behavior.

AGE RANGE

Ages 6-15

PRIMARY LOCATION

Schools

TARGET POPULATION

- ✔ At-Risk
- Mild-Moderate
- Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

- Arabic
- ✔ Farsi
- Khmer
- ✔ Korean
- Mandarin
- ✔ Spanish
- TDD/CHAT
- ✔ Vietnamese
- Other:

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	Gender	%	Race/Ethnicity	%
0-15	100	Female	59	African American/Black	2
16-25	-	Male	41	American Indian/Alaskan Native	-
26-59	-	Transgender	-	Asian/Pacific Islander	2
60+	-	Genderqueer	-	Caucasian/White	3
		Questioning/Unsure	-	Latino/Hispanic	93
		Another	-	Middle Eastern/North African	-
				Another	-

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

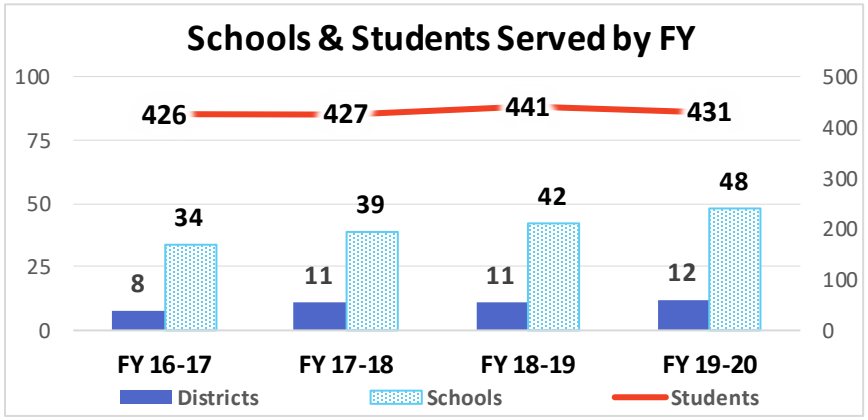
Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$403,100	600
FY 2021-22	$403,100	600
FY 2022-23	$253,100	440

**5-year, temporary budget augmentation concludes after FY 2022-23. No proposed changes in FY 21-22.*

SERVICES

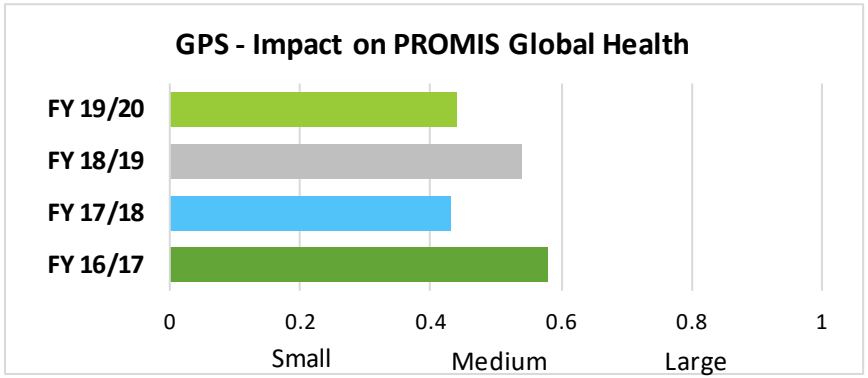
At each participating school, staff provides education to students, parents and teachers on gang prevention and offers workshops, structured group interventions, and weekly case management. Staff also works with students and their families to create an individualized action plan that addresses attendance,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

Students and parents who successfully complete their behavior contracts are provided incentives such as attending a baseball game or other enrichment activities. Many events include law enforcement, which encourages families to see them in a more positive light and as part of a supportive community.



OUTCOMES

To measure the extent to which GPS increased the protective factor of health and well-being, students completed the PROMIS® Pediatric Global Health at baseline, every three months and at discharge. The change in scores between baseline and the most recent follow-up was analyzed and reported according to effect size, which reflects, in part, the extent to which a change is meaningful for the students served. In all four years, youth not only maintained their global health but also made small additional gains while receiving services. Thus, the program was associated with maintaining and somewhat improving this protective factor. In addition, in FY 2019-20, 64% students increased attendance; 95% decreased truancy and 100% decreased curfew violations.



CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

In GPS, case managers are constantly encouraging parents to engage with their child by facilitating the establishment of positive social support networks. This is accomplished by creating an open environment with other parents, the school and local law enforcement. The program assists with this coordination by offering parents opportunities to be involved as greeters at their child's school and by encouraging an environment of rapport building with law enforcement. This is an innovative strategy as many communities are often intimidated by law enforcement officials. Youth and their families also meet regularly with case managers to resolve and overcome challenges related to truancy or other school-related behavioral issues to deter future gang involvement. Due to the pandemic and school closures, the program was not able to add new students to the case management services during the latter part of the fiscal year. However, there was an overall need for more case management services for students and families already receiving services.

REFERENCE NOTES

PROMIS Global Health

FY 2019-20: Baseline M=23.6, SD=3.60; Follow-up M=25.5, SD=3.87; t(414)=9.02, p<.001; Cohen's d=0.44
FY 2018-19: Baseline M=22.4, SD=3.02; Follow-up M=25.0, SD=3.92; t(338)=9.85, p<.001; Cohen's d=0.54
FY 2017-18: Baseline M=24.8, SD=4.27; Follow-up M=27.0, SD=4.52; t(400)=8.68, p<.001; Cohen's d=0.43
FY 2016-17: Baseline M=24.5, SD=3.92; Follow-up M=27.2, SD=4.03; t(354)=10.92, p<.001; Cohen's d=0.58

COMMUNITY IMPACT

GPS has provided services to more than 4,700 students and parents since its inception in August 2013. Through its case management services, the program has encouraged youth to avoid high-risk behavior and engage in more positive decision-making. The program has also strengthened relationships with the community by partnering with organizations and businesses such as the Los Angeles Angels. Through these collaborations, agencies are able to educate and motivate students and to serve as mentors for future career possibilities. The GPS program continues to receive awards for working with Orange County schools on gang suppression, interventions for at risk students, gang information forums and parent/ faculty education.

Family Support Services (PEI)

Family Support Services (FSS) serves families in which children, youth or adults are experiencing behavioral health conditions or other stressful circumstances that may place the family at-risk. FSS collaborates with community and mental health service providers, especially those that serve ethnically diverse and monolingual communities, to help assess the needs of its community members. By working closely with individuals who know the community, the program is better able to identify those who could benefit from this prevention program.

AGE RANGE

All Ages

PRIMARY LOCATION

Field | Community

TARGET POPULATION

At-Risk | Mild-Moderate | Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

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

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	Gender	%	Race/Ethnicity	%
0-15	2	Female	33	African American/Black	4
16-25	21	Male	23	American Indian/Alaskan Native	3
26-59	53	Transgender	-	Asian/Pacific Islander	10
60+	24	Genderqueer	-	Caucasian/White	60
		Questioning/Unsure	-	Latino/Hispanic	23
		Another	44	Middle Eastern/North African	
				Another	

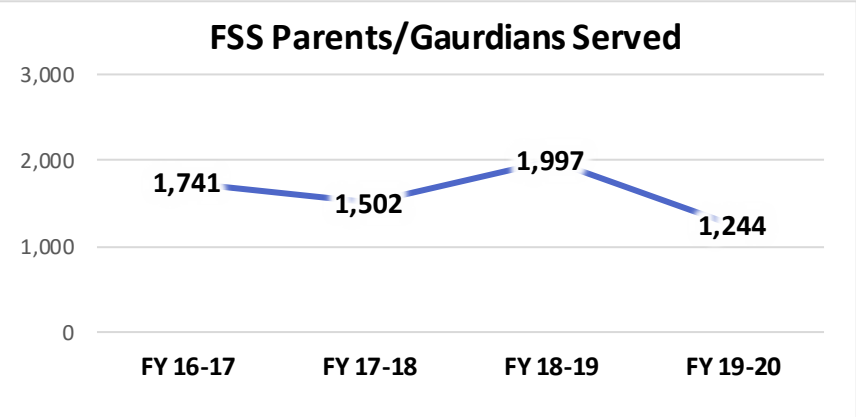
BUDGETS & PROJECTED #'s TO BE SERVED FROM 3YP

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$282,000	1,800
FY 2021-22*	$282,000	1,800
FY 2022-23	$282,000	1,800

**No proposed changes for FY 2021-22*

SERVICES

Services are designed to sustain and/or improve families' overall behavioral health by increasing protective factors through education and social support. The program provides ongoing family education on behavioral health issues to prevent the development of behavioral health problems in other members of the family. FSS includes family-to-family support, behavioral health education and support groups, and delivers a broad range of personalized and peer-to-peer social development services that emphasize behavioral health education, wellness topics and the development of healthy coping tools to support the family. Motivational Interviewing and the Family-to-Family curriculum are two evidence-based practices used by the program to reduce negative outcomes. Family-to-Family serves as the foundation for understanding mental health issues from the perspective of holistic and trauma-informed care, stages of recovery, biopsychosocial elements of mental health conditions, medication, confidentiality and effective communication with individuals living with a mental health condition. Services are delivered through group support, weekly individual peer mentor support, educational workshops, a volunteer family mentor network and family engagement. The program also includes a component on practicing self-care when caring for a loved one with a behavioral health condition within the educational workshops.

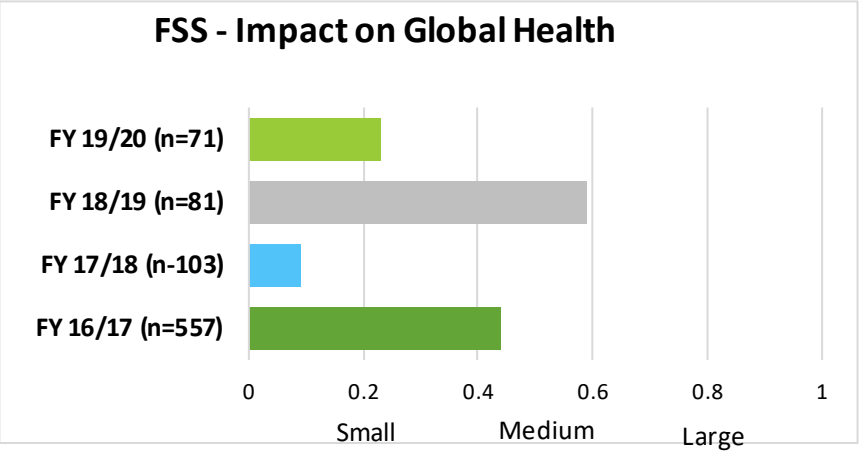


The program was not fully operational in FY 2017-18 and only served participants between October and June. Services were not offered in the first quarter (July-October) due to the closure of one provider site, a month prior to the start of the fiscal year.

OUTCOMES

FSS aims to prevent the development or worsening of mental health conditions by maintaining and/or strengthening the protective factor of Global Health as measured by the PROMIS. The PROMIS was administered at intake (baseline) and program exit (follow-up), and the difference in scores was analyzed and reported according to calculated effect size, which reflects, in part, the extent to which a change in functioning over time is clinically meaningful for the individuals served. In FY 2017-18, FSS services split off from PES. During this transition year, there was a drop in completed outcome measures.

Across 3 of 4 fiscal years, parents consistently reported high levels of global health as they entered the program and made additional, small-to-moderate gains, with the exception of FY 2017-18 when FSS became a standalone program. Thus, FSS appeared to be effective in maintaining and/or enhancing the protective factor of global health among the participants it serves.



CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

The program faces challenges recruiting participants in the summertime when schools are typically out of session and families may be on vacation or busy with summer activities. To mitigate this challenge, the program partners with local community organizations, including Family Resource Centers, which may have direct contact with potential participants during the summer.

Another significant challenge the program experiences is attendance at the Basics class, a six-week course designed to educate parents of children living with a mental health condition about mental health conditions, parenting skills, caring for siblings, self-care and collaborating with providers and educators. The low attendance is due to difficulties the families have finding appropriate childcare. In response, the provider offers several classes at a time allowing so participants have multiple opportunities to attend, classes are offered throughout Orange County so participants can choose the most convenient location, and childcare is provided on site.

In response to the pandemic, the program added support groups for first responders through CARES Act funding. Since CARES Act funding expired and these services were identified as a valuable support, they will continue to be provided through MHSA funding.

REFERENCE NOTES

PROMIS Global Health:

FY 2019-20: Baseline M=31.9, SD=6.78; Follow-up M=33.4, SD=4.92; t(70)=1.90, p<.061; Cohen's d=0.23
FY 2018-19: Baseline M=31.8, SD=7.74; Follow-up M=35.4, SD=6.39; t(80)=5.18, p<.001; Cohen's d=0.59
FY 2017-18: Baseline M=34.5, SD=6.2; Follow-up M=35.1, SD=7.1; t(106)=-0.93, p=.35; Cohen's d=0.09
FY 2016-17: Baseline M=33.9, SD=6.7; Follow-up M=36.4, SD=5.6; t(556)=10.31, p<.001; Cohen's d=0.44

COMMUNITY IMPACT

The program has served 13,692 total families/caregivers since program inception October 2012. FSS collaborates with agencies and community groups to ensure that services are provided throughout Orange County. Services are often held at community locations such as libraries and schools.

Summary of MHSA Strategies Used by Prevention Programs

STRATEGIES TO PROMOTE RECOVERY/RESILIENCE

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

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

STRATEGIES TO REDUCE STIGMA AND DISCRIMINATION

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

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

STRATEGIES TO INCREASE ACCESS TO SERVICES: TIMELY ACCESS FOR UNDERSERVED POPULATIONS AND LINKAGE TO TREATMENT

To increase awareness of their services and facilitate appropriate referrals to their programs, staff conduct outreach to various organizations (i.e., County outpatient clinics for all programs; organizations serving at-risk families, churches, community centers, child- and family-serving centers, schools with low achievement rates, early child care centers including Head Start and Early Head Start programs, and mental health agencies for the parent/family support programs). CSPP and PES also host information tables at health fairs and community and cultural events. Programs engage in these outreach methods.

Underserved children, youth and families living in high-risk/need regions of the county often face challenges in accessing care due to transportation, childcare, scheduling or availability of appointments, and stigma. These programs strive to counter these challenges and increase timely access to services by providing their services throughout the county at locations that are accessible to participants, such as the person's home, school sites, family resource centers, community centers, churches, county libraries, hospitals, shelters and county jails. They also schedule services at various times (morning, afternoons and evenings), offer childcare, and frequently provide meals as a way to encourage participation. Finally, programs provide services and materials in multiple languages.

As children and families are identified as needing a higher level or longer duration of support, program staff make the appropriate referrals to outpatient treatment and other supportive services. Staff often facilitates connections by working with the family to identify the appropriate and desired services and by assisting the parent with calling the new agency.

Prevention Programs		Linkage Metrics		
		# Referrals	# Linkages	Types of Linkages
School Readiness	FY 2016-17	273	88	Special needs/disability services; behavioral health prevention, early intervention programs; information and referral resources; family support; recreation activities; basic needs
	FY 2017-18	670	229	
	FY 2018-19	744	176	
	FY 2019-20	930	197	
CSPP	FY 2016-17	224	67	Access & Linkage; BHS Outpatient Early Intervention: Family Services;
	FY 2017-18	114	105	
	FY 2018-19	253	168	
	FY 2019-20	32	18	
GPS	FY 2016-17	866	634	Counseling services, adult literacy programs, housing and food assistance, medical care, school supplies, enrichment activities
	FY 2017-18	1360	1050	
	FY 2018-19	554	496	
	FY 2019-20	694	667	

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

ACCESS & LINKAGE to TREATMENT/ SERVICES

Programs that fall within the Access and Linkage to Services/Treatment function are designed to link individuals of all ages who are living with a mental health condition to an appropriate level of care and needed supportive services. Orange County offers several programs in this category, although only BHS Outreach and Engagement is subject to PEI regulations.[1] The remaining programs are funded by CSS and tailored to meet the needs of specific unserved populations living with SMI or SPMI (i.e. individuals who are homeless, discharging from jail or a hospital, etc.).

- OC Links
- BHS Outreach & Engagement
- Multi-Service Center for Homeless Adults CHS
- Jail to Community Re-Entry
- Recovery Open Access

OC Links (PEI)

OC Links is the Behavioral Health Services (BHS) line that provides information and linkage to any of the OC Health Care Agency's (HCA) Behavioral Health Services, including crisis services, via telephone and online chat. Because the navigators who staff the line are clinicians, they can work with callers and chatters experiencing any level of behavioral health issue, ranging from prevention through crisis identification and response. Beginning February 2021, OC Links began operating 24 hours a day, 7 days a week.

AGE RANGE

All Ages

PRIMARY LOCATION

Telephone

TARGET POPULATION

- ☑ At-Risk
- ☑ Mild-Moderate
- ☑ Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

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

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	Gender	%	Race/Ethnicity	%
0-15	-	Female	65	African American/Black	4
16-25	13	Male	35	American Indian/Alaskan Native	1
26-59	75	Transgender	-	Asian/Pacific Islander	7
60+	12	Genderqueer	-	Caucasian/White	49
		Questioning/Unsure	-	Latino/Hispanic	36
		Another	-	Middle Eastern/North African	-
				Another	3

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

Fiscal Year	Program Budget	Duplicated # of Calls/Chats
FY 2020-21	$1,000,000	19,986
FY 2021-22*	$4,000,000	35,000
FY 2022-23	$1,000,000	*37,500*

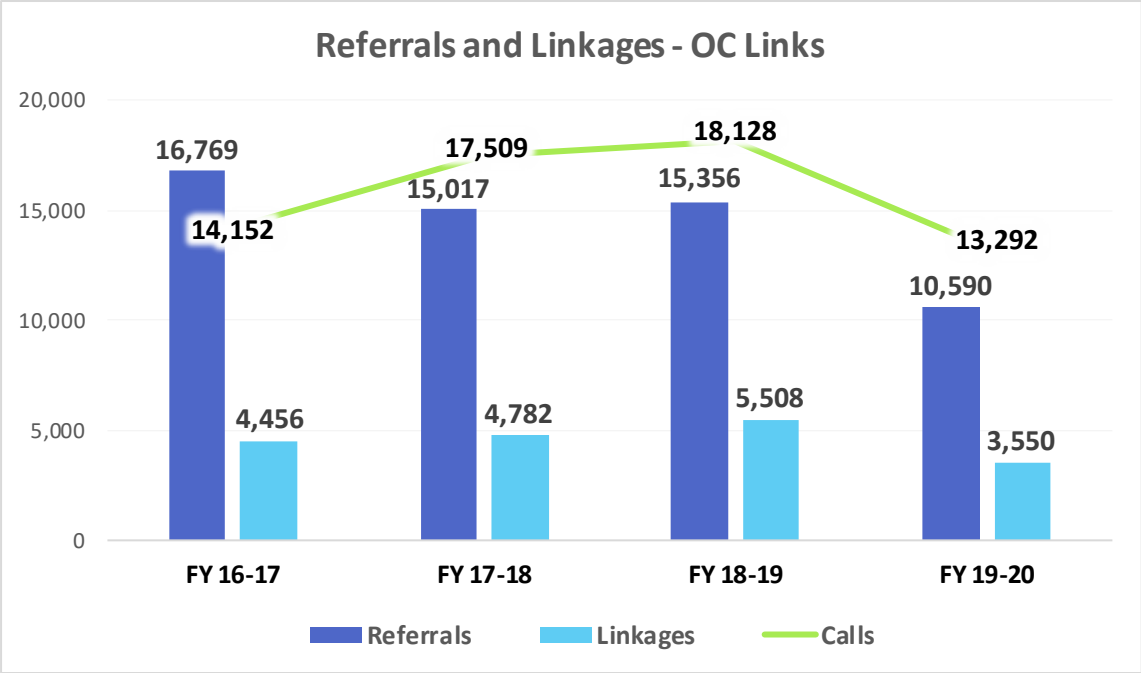
**Proposed increases for FY 2021-22 (anticipated to be on-going)*

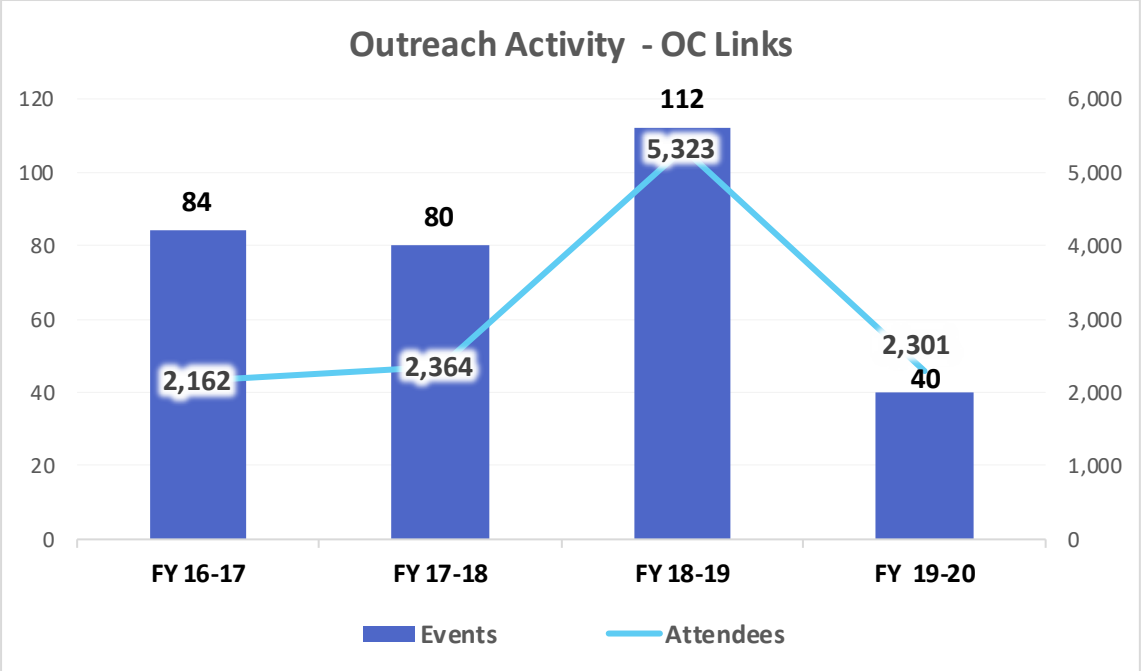
SERVICES/OUTCOMES

Serving as the single access point for the HCA BHS System of Care, OC Links provides telephone and internet, chat-based support for any Orange County resident seeking HCA Behavioral Health services. OC Links now operates 24 hours a day, 7 days a week, year-round. Callers may access navigation services through a toll-free phone number (855-OC-Links or 855-625-4657) or a live chat option available on the OC Links webpage (www.ochealthinfo.com/oclinks). Individuals may also access information about BHS resources on the website at any time (http://www.ochealthinfo.com/bhs/).

During a call or live chat, trained navigators provide screening, information, and referral and linkage directly to BHS programs that best meet the needs of callers. Navigators make every attempt to connect callers directly to services while they are still on the line. Once the caller is scheduled for their first appointment, the navigator offers a follow-up call within the next 1-2 days to ensure a linkage has occurred (see Referral and Linkages graph).

In addition, staff attends numerous community events each year where they provide outreach and education on mental health awareness and the availability of OC Links. The number of referrals, linkages and outreach activity was somewhat lower in FY 2019-20 compared to recent years, likely due to the impact of COVID-19 (see Outreach Activity graph).



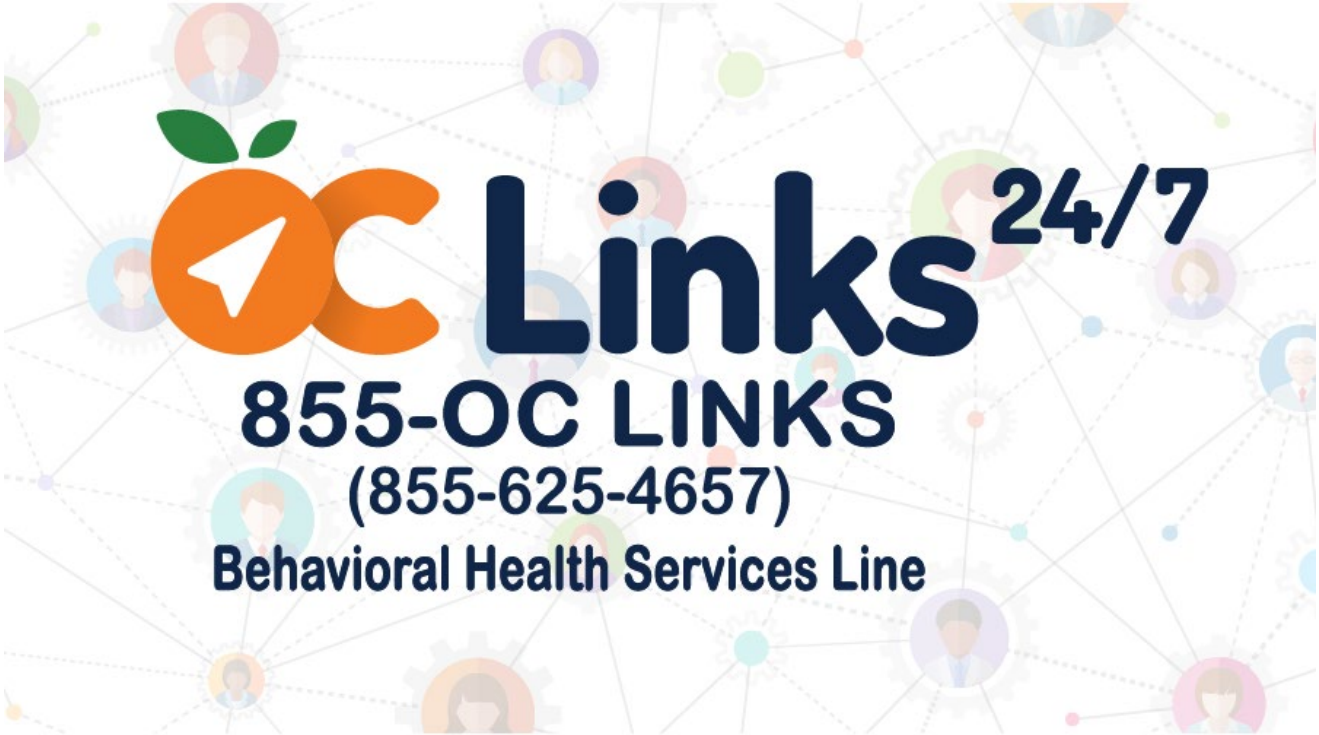


Most Common Linkages Made

OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE PROGRAMS; PREVENTION AND EARLY INTERVENTION SERVICES

CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

Increasing community awareness about OC Links and the services available through the County of Orange is a constant challenge that must continually be addressed. To better educate the public about OC Links on an ongoing basis, the team participates in community events and offers presentations to service providers and community groups. The program also provides OC Links informational cards to locations throughout the community in the threshold languages to promote services. As utilization has increased, the program has noted an increasing need for bilingual speakers. Thus, OC Links continues its recruitment efforts to hire bilingual clinicians who are knowledgeable about the County BHS. Challenges that arose due to COVID-19 impacted the daily work shifts and the type of outreach OC Links was able to perform. In response to the pandemic, hours of operation were expanded to cover from 8 a.m. to 8 p.m., and then in February 2021 the program permanently shifted to operate 24/7. Community outreach in the form of tabling events were also suspended. There was a small impact felt by callers who identified specifics issues relating to COVID-19 and these issues were addressed by shifting work schedules to cover the additional hours. Local organizations that requested presentations were able to be accommodated by using meeting software platforms.



COMMUNITY IMPACT

The program has responded to more than 90,000 participants since opening in the Fall of 2013. OC Links serves Orange County residents by helping callers navigate a large and complex system of care and linking them to the County and/or County-contracted services best suited to meet their behavioral health needs.

BHS Outreach and Engagement (PEI)

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

AGE RANGE

All Ages

PRIMARY LOCATION

Field | Community

TARGET POPULATION

At-Risk | Mild-Moderate | Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

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

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	Gender	%	Race/Ethnicity	%
0-15	1	Female	37	African American/Black	10
16-25	5	Male	63	American Indian/Alaskan Native	2
26-59	76	Transgender	-	Asian/Pacific Islander	10
60+	18	Genderqueer	-	Caucasian/White	45
		Questioning/Unsure	-	Latino/Hispanic	32
		Another	-	Middle Eastern/North African	-
				Another	1

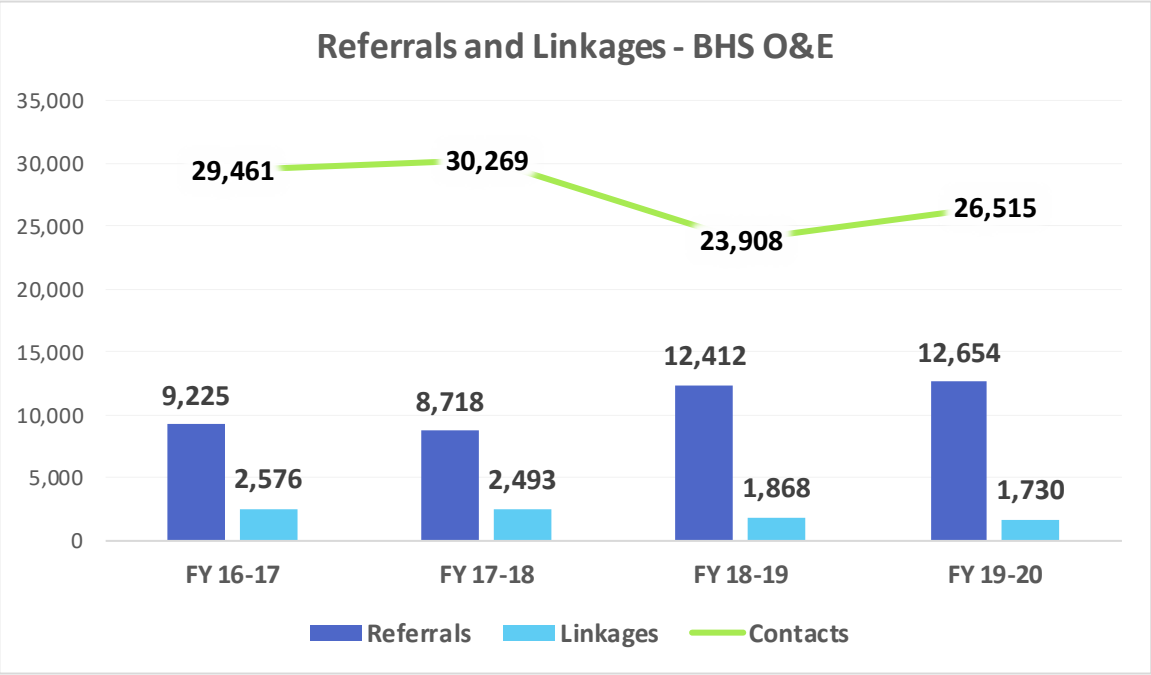
BUDGETS & PROJECTED #'s TO BE SERVED FROM 3YP

Fiscal Year	Program Budget	Duplicated # of Contacts
FY 2020-21	$2,232,523	26,358
FY 2021-22*	$3,129,668	27,676
FY 2022-23	$2,232,523	29,030

** Net increase for FY 2021-22 w/CSS costs shifted to PEI*

SERVICES/OUTCOMES

To promote awareness of, and increase referrals to its services, BHS O&E performs outreach at community events and locations likely to be frequented by individuals the program intends to serve and/or the providers that work with them in non-mental health capacities (i.e., street outreach, homeless service provider locations, etc.). When a person is referred to the program, staff screens them in the community or over the phone to determine the individual's needs. Once their needs are identified, staff employ various strategies to link individuals, such as personalized action plans aimed to decrease barriers to accessing services and evidence-based psychoeducational groups for those who have experienced trauma and/or substance use. Staff utilizes motivational interviewing, harm reduction, and strength-based techniques when working with participants and assists them in developing and practicing coping skills. All outreach services are focused on making referrals and ensuring linkages to ongoing behavioral health and support services by assisting with scheduling appointments, providing transportation to services, addressing barriers, and offering ongoing follow-up (see Referrals and Linkages graph).



Most Common Linkages Made

OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE PROGRAMS, INTENSIVE OUTPATIENT PROGRAMS, HOUSING SUPPORT, MEDICAL SERVICES

CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

Lack of affordable housing continues to be a barrier, especially for individuals who are homeless, and the program continues to collaborate with agencies to improve access to affordable housing opportunities. To address some participants' reluctance to provide personal information or enroll in engagement services,

the programs have reached out to work with trusted community agencies/organizations. Through these partnerships, O&E staff have demonstrated the ability to follow through on commitments to address participants' needs and assisted individuals with accessing referrals, thereby building trust and rapport with participants. Once rapport and some success in linking to resources have been established, participants have been more receptive to engaging in ongoing services. BHS O&E has been called upon to engage individuals at homeless encampments across the county in partnership with cities and local law enforcement agencies many times over the past few years. After the large-scale riverbed engagement three years ago, the community saw the impact of the Outreach Team engaging and linking homeless individuals to treatment, shelter and services. Due to their cultural competence working with this population, many cities and police/sheriff departments have requested BHS O&E support for one-time and ongoing engagement projects in communities across the county. This has necessitated increases in staffing and working hours/days resulting in the program now being active six days per week including Saturdays.

The onset of the COVID-19 pandemic had a significant impact on the elderly homeless population and those with high risk conditions. BHS O&E was tasked with helping to identify those at high risk for serious COVID-19 infection and referring them to Project Room Key (PRK) for further assistance and care. More specifically, PRK was a program that placed high-risk homeless individuals into motel settings. BHS O&E staff took referrals, conducted outreach and offered services to those with the highest of needs.

Another challenge the BHS O&E encountered was the lack of available shelter beds due to the COVID-19 pandemic. During this time, shelters were required to have social distancing protocols in place resulting in fewer available beds. O&E team members researched and advocated for their participants to find shelter options.

COMMUNITY IMPACT

O&E is firmly rooted in Orange County with strong collaborations with various community-based organizations, school districts, law enforcement, faith-based, physician groups, parent groups, housing providers, outreach teams, older adult programs, other behavioral health programs and other providers of basic needs. The program has reached homeless individuals of all ages from multiple cultures throughout Orange County and has helped them access needed behavioral health and supportive services, including housing. The homeless and provider community widely accepts O&E as a supportive program to help individuals, families and agencies seeking linkage to mental health and substance use programs. This impact has resulted in significant increases in daily calls to the Outreach (800) phone line, requests for community response and partnerships for city-based homeless encampment engagements and street outreach. Outreach has added six additional staff positions to manage these requests.

Multi-Service Center for Homeless Adults (CSS)

The Multi-Service Center for Homeless Mentally Ill Adults (MSC) program, formerly call Courtyard Outreach, serves residents ages 18 years or older who are experiencing homelessness and living with a serious mental illness and/or co-occurring substance use disorder. The outreach team links individuals receiving supportive services at the Multi-Service Center to mental health and/or substance use services.

AGE RANGE

Ages 18+

PRIMARY LOCATION

Field | Community

TARGET POPULATION

At-Risk | Mild-Moderate | ✓ Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

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

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	Gender	%	Race/Ethnicity	%
0-15	-	Female	60	African American/Black	14
16-25	6	Male	40	American Indian/Alaskan Native	1
26-59	76	Transgender	-	Asian/Pacific Islander	5
60+	18	Genderqueer	-	Caucasian/White	52
		Questioning/Unsure	-	Latino/Hispanic	32
		Another	-	Middle Eastern/North African	1
				Another	1

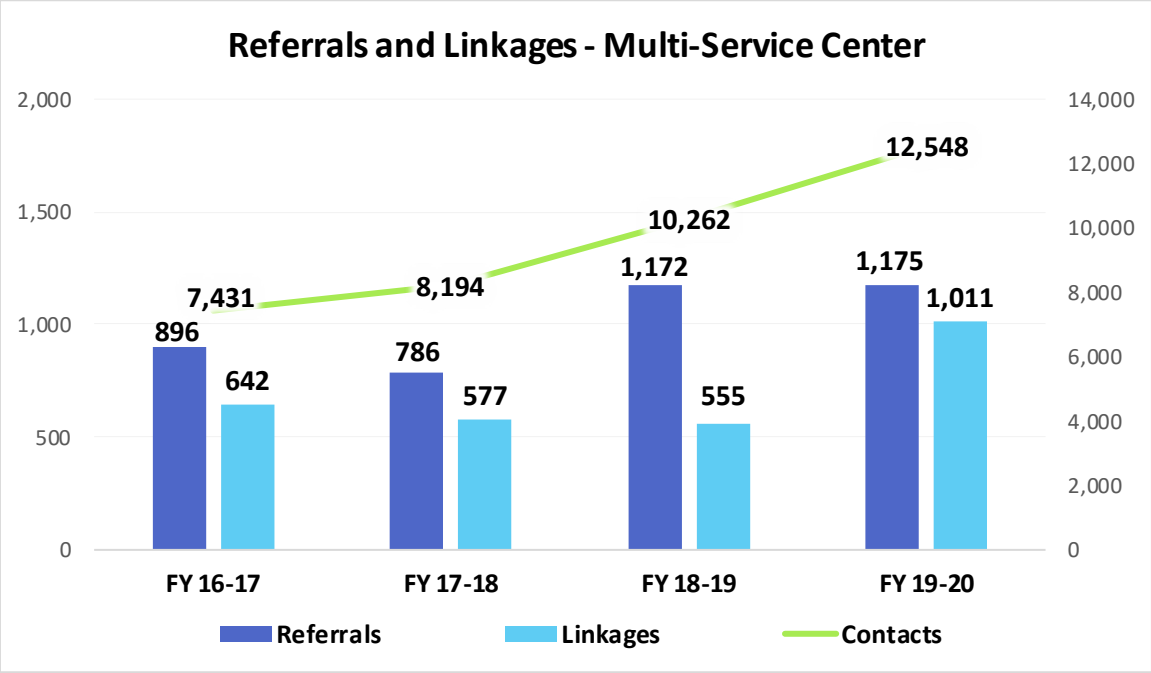
BUDGETS & PROJECTED #'s TO BE SERVED FROM 3YP

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$900,000	675
FY 2021-22*	$900,000	675
FY 2022-23	$900,000	675

**No proposed changes to FY 2021-22*

SERVICES/OUTCOMES

The MSC outreach workers assess residents' strengths and resources to determine their level of psychosocial impairment, substance use, physical health problems, support network, adequacy of living arrangements, financial status, employment status and basic needs. They facilitate linking participants to the most appropriate services for each individual (i.e., case management, outpatient mental health, medical appointments, housing, employment, SSI/SSDI and additional services such as obtaining identification or other personal documents, etc.). The team can transport, or facilitate the transportation of, residents to those services as needed. As can be seen in the graph below, the number of contacts has increased by approximately 41% and the number of referrals has increased by approximately 31% from FY 2016-17 to FY 2019-20. This upward trend is most likely a result of stable staffing. In addition, program staff rebounded with an improved linkage rate in FY 2019-20 compared to FY 2018-19, when it had dropped compared to the prior two fiscal years.



Most Common Linkages Made

BASIC NEEDS; EDUCATION; MHA MULTI-SERVICE CENTER; INFORMATION AND REFERRAL SOURCES; EMPLOYMENT SERVICES

CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

The Courtyard shelter in Santa Ana, the original location of Courtyard Outreach services, moved locations in February 2021, and the new shelter is offering these same services under a different (non-MHSA) funding stream. To avoid duplication of effort, and to enable the provider at the new shelter to fulfill its contractual obligations, the MSC program team will continue to serve the same population at a different location in Santa Ana where there is a need for these services. The program strives to build stronger partnerships with the collaborative agencies and community groups focused on integrating the program participants into permanent housing. Communication among community partners is not only necessary but ideal to meet the immediate needs of the residents. The MSC program team acts as the liaison with these other agencies and attends meetings with the collaborative ensuring that outcomes data are collected properly and presented in a timely manner.

COMMUNITY IMPACT

The MSC team collaborates with a variety of human services and nonprofit providers to help its participants meet basic needs and obtain access to behavioral health services, housing, employment, public benefits and personal identification documents. By partnering with the collaborative agencies and program participants, the MSC team shares in the goal of helping break the cycle of homelessness among those living with serious mental illness.

CHS Jail to Community Re-Entry (CSS)

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

AGE RANGE

Ages 18+

PRIMARY LOCATION

Other (Jail)

TARGET POPULATION

- ✓ At-Risk
- ✓ Mild-Moderate
- ✓ Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

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

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	Gender	%	Race/Ethnicity	%
0-15	-	Female	9	African American/Black	8
16-25	19	Male	90	American Indian/Alaskan Native	-
26-59	80	Transgender	1	Asian/Pacific Islander	4
60+	1	Genderqueer	-	Caucasian/White	28
		Questioning/Unsure	-	Latino/Hispanic	58
		Another	-	Middle Eastern/North African	-
				Another	2

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

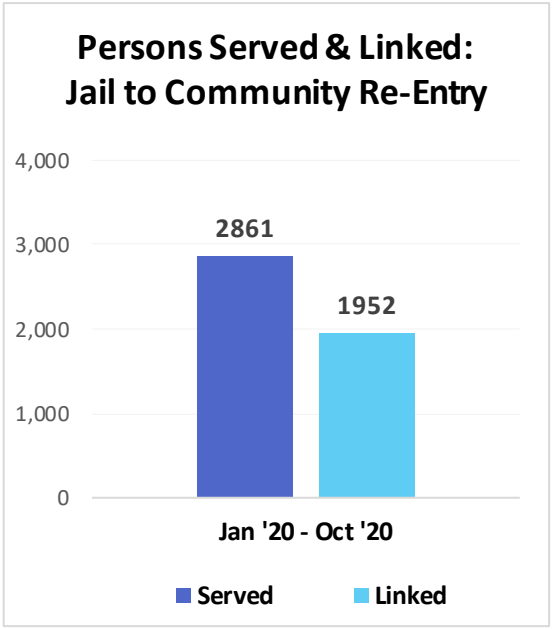
Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$2,200,000	3,500*
FY 2021-22	$2,700,000	7,000*
FY 2022-23	$2,800,000	8,750*

**Numbers served may change depending on status of the pandemic. No change to FY 2021-22 budget.*

SERVICES/OUTCOMES

The JCRP uses a comprehensive approach to discharge planning and re-entry linkage services for inmates with mental illness at all County jail facilities. Discharge planning services are conducted while individuals are still in custody and include thorough risk assessments, comprehensive individualized case management and evidence-based re-entry groups including Moral Reconation Therapy (MRT) aimed at identifying possible barriers to successful re-entry and developing tailored discharge plans.

Services also include facilitation of linkage to a range of services upon release, such as counseling, medication support, housing, Medi-Cal enrollment and essential needs such as clothing and transportation. Connections with family and support systems such as peer support mentors is also facilitated. JCRP staff work in collaboration with other stakeholders, including the Orange County Probation Department, Orange County Public Defender, Social Services Agency, Regional Center of Orange County, Orange County Housing Authority and other ancillary agencies to identify gaps in service delivery and solidify linkage with external stakeholders for a smooth transition from jail to the community. JCRP has established a 7-day release process which provides face-to-face contact and re-entry resources for all inmates leaving the Central Jail Complex and the Theo Lacy Facility. Additionally, the JCRP is now able to make direct referrals to the HCA Residential Treatment programs and assist with facilitating transitions for clients requiring residential in-treatment services.



Beginning January 2020, JCRP established a process of measuring referral and linkage outcomes. Due to the challenges brought about by the pandemic, the program had to readjust services depending on the available services and programs in the community.

From January 2020 to October 2020, 2,861 inmates who received mental health services while incarcerated were released from Orange County jails. Of these inmates served, 1,952 were referred to external programs by the JCRP team. The individuals who were not referred either had directly declined or had a previous established transition arrangement.

Linkage outcome data is limited to the programs that confirm that our clients have linked to their programs once they have been released. The programs include Opportunity Knocks, North/South HCA Open Access clinics, Assisted Outpatient Treatment (AOT) program and a community based mental health service provider, APAIT.

CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

The COVID-19 pandemic impacted in-reach in the jail facilities and supportive programs available for patients transitioning from incarceration. Although the JCRP operation tempo increased due to a higher than normal number of inmates released during the beginning of the pandemic (i.e. January, February and March) community provider service availability decreased and linkage outcomes were impacted. The quick decision to control the spread of COVID-19 by decreasing the jail population similarly impacted the ability of the JCRP staff to link and refer clients. The JCRP program has been faced with various challenges. Some challenges have involved the pandemic and others are associated with changing the traditional approach for assisting individuals who have been incarcerated and released. Challenges have included finding appropriate placement and transporting clients during this challenging time. Although some of these services have resumed, JCRP continues to work with programs to reintegrate the linkage process.

The JCRP is also tasked with linking clients who have been released after serving only a short period of time in jail (0-7 days). This group involves 40% of inmates released from custody. Discharge planning can be a complex process depending on the client's needs. Time becomes extremely valuable when it's limited and JCRP staff must remain flexible and ready to coordinate transitions.

JCRP has been working with Open Access North/South and Opportunity Knocks to close the gap in service accessibility. As relationships between programs are increased, coordination improves and outcomes are expected to increase. JCRP has been working with community programs to increase in-reach services and improve the warm hand-off process during the pandemic. Data suggests that programs which provide transportation and warm hand-offs from jail and conduct in-reach services, have a significantly higher likelihood of inmates linking once they are released.

On April 26, 2019 CHS hired its first Behavioral Health Clinician for JCRP and on October 18, 2019 a dedicated supervisor (Service Chief) was assigned to the program. Since then the team has grown to 10 Behavioral Health Clinicians, three Mental Health Specialists, one Office Technician and two Service Chiefs. The program continues to focus on outcomes and is driven by the success of its client population.

COMMUNITY IMPACT

On July 1, 2020 JCRP expanded services to the Theo Lacy Facility. The Release Team replicates the services provided at the Intake and Release Center. This includes a Release Clinician who reviews all documents for patients scheduled for release and confirms discharge plans have been established. Currently the team is pending the addition of a dedicated nurse and, while awaiting this addition, coordination is made with the nursing team when patients require medical attention and education regarding their discharge plans.

Recovery Open Access (CSS)

Recovery Open Access serves individuals ages 18 and older living with serious and persistent mental illness and a possible co-occurring disorder who are in need of accessing urgent outpatient behavioral health services. The target population includes adults who are being discharged from psychiatric hospitals, released from jail or are currently enrolled in outpatient BHS services and have an urgent medication need that cannot wait until their next scheduled appointment. These individuals are at risk of further hospitalization or incarceration if not linked to behavioral health services quickly.

AGE RANGE

Ages 18+

PRIMARY LOCATION

Clinic

TARGET POPULATION

At-Risk | Mild-Moderate | Severe ✓

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

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

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	Gender	%	Race/Ethnicity	%
0-15	-	Female	43	African American/Black	4
16-25	25	Male	56	American Indian/Alaskan Native	1
26-59	74	Transgender	-	Asian/Pacific Islander	8
60+	1	Genderqueer	-	Caucasian/White	41
		Questioning/Unsure	-	Latino/Hispanic	26
		Another	1	Middle Eastern/North African	1
				Another	19

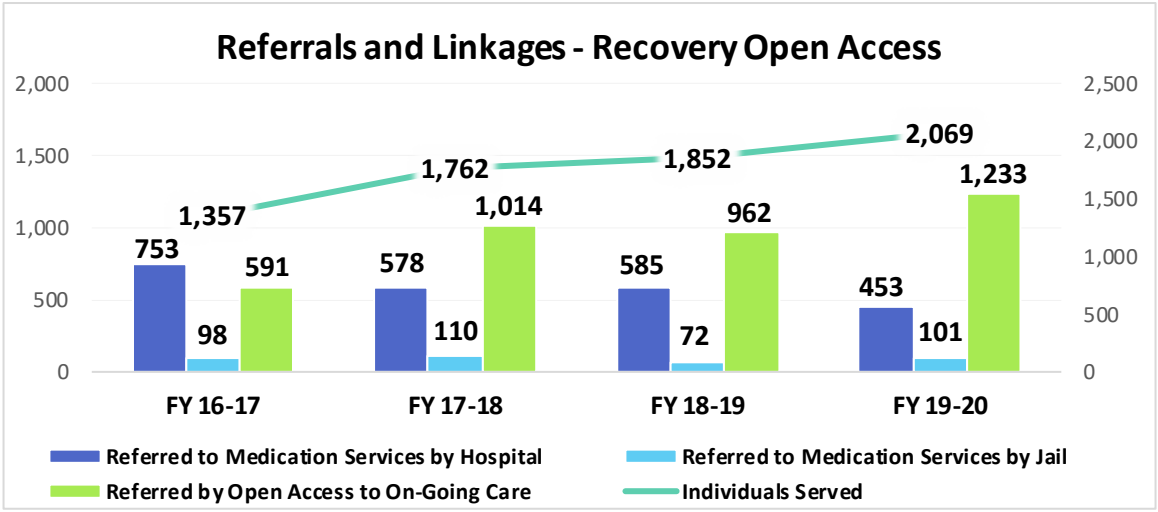
BUDGETS & PROJECTED #'s TO BE SERVED FROM 3YP

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$2,300,000	1,850
FY 2021-22*	$2,600,000	2,000
FY 2022-23	$2,300,000	2,000

** Proposed increases for FY 2021-22*

SERVICES

Recovery Open Access serves two key functions: (1) linking adults with serious and persistent mental illness to ongoing, appropriate behavioral health services and (2) providing access to short-term integrated behavioral health services (i.e., brief assessments, case management, crisis counseling and interventions, SUD services, temporary medication support) while an individual is waiting to be linked to their (first) appointment. In order to decrease the risk of re-hospitalization or recidivism, staff try to see participants within 24 hours of the time of discharge from the hospital or jail and to keep them engaged in services until they link to ongoing care.

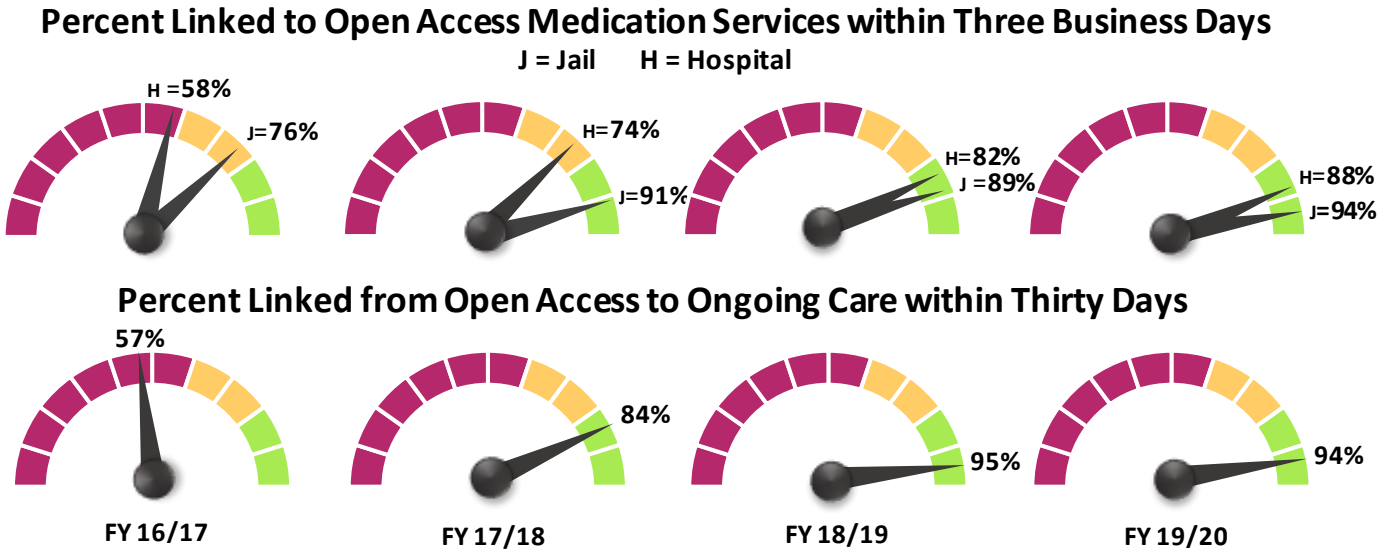


OUTCOMES

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

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

The program continued to meet its targets in FY 2019-20 after clarifying service benchmarks with program staff at the end of FY 2016-17. Additional staff has resulted in smaller caseloads, and this has allowed staff to monitor linkages more closely and follow up on missed appointments. These improvements, in addition to the implementation of a Performance Improvement Project (PIP) in October 2018 that focused on linking hospitalized clients to Open Access and outpatient services, may have contributed in the upward trend in linkages since 2016-17.



CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

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

COMMUNITY IMPACT

Recovery Open Access has provided services to more than 6,400 individuals since its inception through the end of FY 2018-19. The program collaborates with a variety of community partners, including hospitals, jails, homeless shelters, substance use programs, community health clinics, mental health clinics, OC Probation and Social Services Agency to help individuals receive needed behavioral health care.

Summary of MHSA Strategies Used by Access and Linkage to Treatment Programs

STRATEGIES TO PROMOTE RECOVERY/RESILIENCE

Access and Linkage to Treatment (ALT) programs work with some of the most marginalized and unserved populations in the county, including those who are homeless and/or involved in the criminal justice system. These individuals may have previously experienced trauma or, particularly among the homeless population, are currently experiencing daily trauma and are struggling to meet their basic needs, leaving them feeling disenfranchised or stigmatized. In order to engage individuals successfully, staff integrates a consumer-centered, strength-based approach that works with individuals in their current stage of recovery and acknowledges and builds upon their existing coping skills. They also use harm reduction techniques, provide unconditional positive regard, help to reduce barriers and offer supportive services while working to link individuals to treatment. Staff use recovery principles and techniques such as motivational interviewing to help engage individuals in their recovery journey.

STRATEGIES TO REDUCE STIGMA AND DISCRIMINATION

ALT programs engage in a number of strategies to reduce stigma and discrimination. All clinicians and peer workers are trained yearly in cultural competency, which reviews the concepts of culture, race, ethnicity, diversity, stigma and self-stigma. The training also demonstrates the influence of unconscious thought on a person's judgment as it relates to stereotyping and racism. Through this training and their ongoing supervision, staff is provided strategies to recognize diversity, embrace the uniqueness of cultures beyond mainstream American culture and incorporate a culturally responsive approach in their service planning, service delivery and interactions with program participants.

In addition, outreach workers who work with homeless individuals often have lived experience and are knowledgeable about the field of chronic homelessness, mental health and substance use. They recognize that each person's diverse experiences, values and beliefs impact how they will access services. Using the principles of recovery, they are trained to identify the underlying conditions associated with homelessness and to address them in a judgment-free manner. The staff also upholds cultural values that protect against discrimination and harassment on the basis of race, ethnicity, religion, sexual orientation, national origin, age, physical disability, medical condition, marital status or any other characteristic that may result in exclusion.

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

STRATEGIES TO INCREASE ACCESS TO SERVICES: TIMELY ACCESS FOR UNDERSERVED POPULATIONS AND LINKAGE TO TREATMENT

The Navigation program, OC Links, encourages timely access by promoting its services among unserved and underserved populations in Orange County. For example, the program displays its information and phone number on rotation every day at the Civic Center Plaza message board; has advertised on Public Access Cable Television Community Resource displays; and has posted advertisements on Facebook and Twitter that direct people to the OC Links website where they can obtain information and connect to Live Chat with the navigators. Information cards in all threshold languages are also handed out at many locations throughout the county, including schools, colleges, community organizations, businesses, court houses, libraries and resource fairs. Once an individual connects with OC Links, they can work with a navigator who speaks English, Spanish, Vietnamese, Korean, Arabic or Farsi. The program also has access to a language line translation service to meet the language needs of any caller and offers a Telecommunications Device for the Deaf (TDD) number (714-834-2332) for deaf and hard of hearing callers.

In addition, the ALT programs provide face-to-face services to increase unserved individuals' willingness to enroll in needed services and facilitate linkage to appointments in as timely a manner as possible. Staff stay up-to-date on available resources, network and collaborate with other providers, assist with decreasing barriers to accessing services as they are identified, and provide transportation and warm handoffs to ensure linkage to ongoing care. Staff are bilingual/bicultural and a language translation service is available when needed. In addition, BHS O&E is staffed with peers who share their own lived experience as a way to build the rapport and trust necessary to engage homeless individuals. Open Access improves access to care by expediting urgent care needs and by facilitating quicker and smoother linkages to behavioral health treatment for those discharging from inpatient and jail settings.

In addition, all ALT programs have developed collaborative relationships with outside agencies that come into frequent contact with the programs' respective target populations and, in turn, these agencies provide referrals to ALT services. The types of agencies with which the programs have established strong working relationships include community-based organizations, homeless service providers, housing programs and shelters, schools, places of worship, law enforcement agencies, hospitals, social service agencies, juvenile justice, the OC Probation Department , the Orange County Fire Authority, veterans services, community centers, motels, shelter staff, apartment complexes, and other behavioral health service agencies.

CRISIS PREVENTION AND SUPPORT

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

- WarmLine
- Suicide Prevention Services
- Mobile Crisis Assessment
- Crisis Stabilization Units
- In-Home Crisis Stabilization
- Crisis Residential Services
- BHS Disaster Response

WarmLine (PEI)

The **WarmLine** provides peer support to unserved and underserved Orange County residents who are experiencing mild to moderate symptoms of a mental health disorder or who are at risk of developing a mental health disorder, challenges at school and/or trauma exposure. The program also serves family members. Beginning July 2020, the WarmLine began providing services 24 hours a day, seven days a week, year-round.

AGE RANGE

All Ages

PRIMARY LOCATION

Telephone

TARGET POPULATION

- ✔ At-Risk
- ✔ Mild-Moderate
- ✔ Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

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

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	Gender	%	Race/Ethnicity	%
0-15	-	Female	56	African American/Black	Not Collected on Call
16-25	6	Male	44	American Indian/Alaskan Native	
26-59	67	Transgender	-	Asian/Pacific Islander	
60+	27	Genderqueer	-	Caucasian/White	
		Questioning/Unsure	-	Latino/Hispanic	
		Another	-	Middle Eastern/North African	
				Another	

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

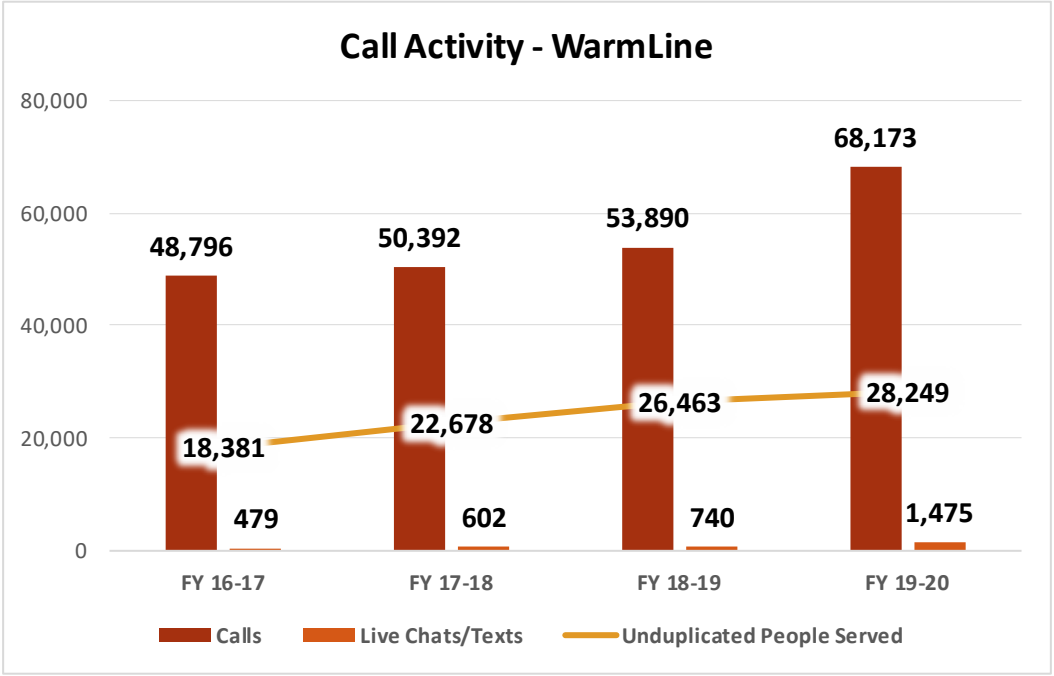
Fiscal Year	Program Budget	Call/Chat Volume
FY 2020-21	$1,116,667	36,000
FY 2021-22*	$2,000,000	65,000
FY 2022-23	$1,116,667	65,000

**Proposed increases for FY 2021-22*

SERVICES

The WarmLine plays an important role in Orange County's Crisis and Suicide Prevention continuum by providing non-crisis or crisis prevention support over the phone or through live chat, for anyone struggling with mental health and substance use issues. Upon connecting with the WarmLine, individuals are screened for eligibility and assessed for needed mental health information, support and resources. Staff draw upon their lived experience to connect with callers and provide them with emotional support and referrals to ongoing services as needed. Callers who are experiencing a behavioral crisis are immediately referred to the Crisis Prevention Hotline.

Active listening, a person-centered motivational interviewing skill, is effective in establishing rapport and demonstrating empathy, and can be especially useful with callers in the pre-contemplative or contemplative stages of change. The WarmLine also uses Positive Psychology, a resilience-based model that focuses on positive emotions, traits and institutions. This model trains mentors to focus on the positive influences in callers' lives such as character, optimism, emotions, relationships and resources in order to reduce risk factors and enhance protective ones.

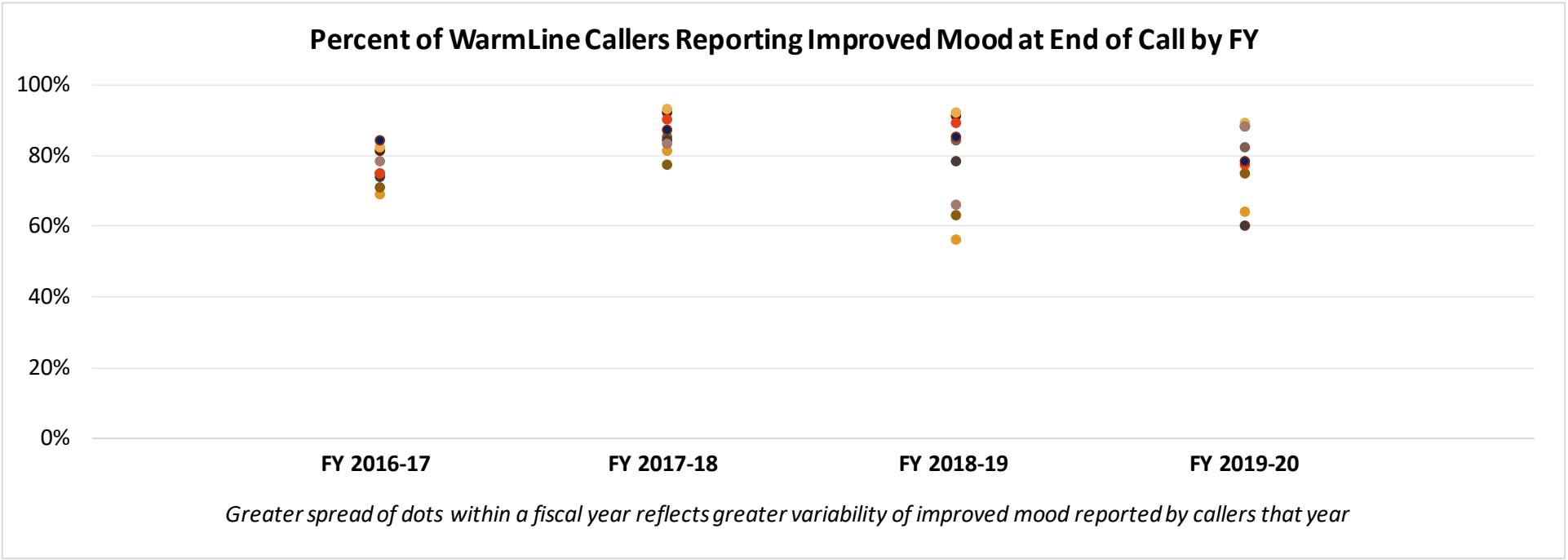


OUTCOMES

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

The WarmLine aims to reduce prolonged suffering from behavioral health problems, which was measured through changes in ratings on the Profile of Mood States (POMS). Callers were asked at the beginning of the call whether they felt different emotions (i.e., worried, uncertain, etc.) and then asked at the end of the call whether they felt better, the same or worse. The evaluation reflects cultural competence in that it assessed for the presence of, and changes in, a range of negative mood states to ensure that different cultural expressions of distress were reflected.

While the extent of improvement varied across specific mood states, overall results across fiscal years show that the majority of callers reported feeling better at the end of the call, with the highest rates of improvement observed for callers feeling anxious, overwhelmed or helpless, and the lowest rate for those feeling agitated. Thus, the program appears to be successful in reducing emotional distress through the support and services provided during the telephone contact.



CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

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

COMMUNITY IMPACT

The WarmLine has provided services to more than 122,000 individuals since its inception in August 2010. The provider also actively collaborates within the community as a whole to break down stigma, raise awareness and educate the community about available services.

Suicide Prevention Services (PEI)

The **Suicide Prevention Services** program services are available to individuals of all ages who 1) are experiencing a behavioral health crisis and/or suicidal thoughts, 2) have attempted suicide and may be living with depression, 3) are concerned about a loved one possibly attempting suicide, and/or 4) are coping with the loss of a loved one who died by suicide. The program serves a broad range of people of all ages, and individuals can be self-referred or referred by family members, providers or other partner agencies. The toll-free, accredited hotline operates 24 hours a day, 7 days a week. This program will now also be supported by a new Office of Suicide Prevention, which was established in the HCA's Behavioral Health Services area upon the direction of the Orange County Board of Supervisors in 2021.

AGE RANGE

All Ages

PRIMARY LOCATION

Telephone

TARGET POPULATION

- ✓ At-Risk
- ✓ Mild-Moderate
- ✓ Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

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

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

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

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

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$1,200,000	12,147
FY 2021-22*	$3,200,000	12,147
FY 2022-23	$1,200,000	12,147

**Proposed budget increase for FY 2021-22. Increase in numbers to be served to be determined.*

SERVICES

The program currently offers a range of services that use Applied Suicide Intervention Skills Training (ASIST), which provides practical suicide intervention training for clinicians, first responders, medical providers and caregivers seeking to prevent the immediate risk of suicide. During the COVID-19 pandemic, ASIST trainings were temporarily paused since they are required to be done in person; the provider offered other virtual trainings in its place.

Telephone Hotline Support:

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

TELEPHONE HOTLINE CALL VOLUME	FY 16/17	FY 17/18	FY 18/19	FY 19/20
Callers	6,807	9,200	10,137	9,886
Calls	8,475	11,607	13,536	13,613

Face-to-Face Services:

- **Individual Counseling for Survivors after Suicide**: Children, adolescents, adults and older adults who are coping with the loss of someone to suicide can receive time-limited individual counseling. Short-term bereavement counseling is also available to families who want to improve their functioning and communication after the loss of a family member.
- **Survivors after Suicide Bereavement Groups**: Two different bereavement groups are offered for anyone who is coping with the loss of someone to suicide. The first is an eight-week, closed format group, co-facilitated by a therapist and a survivor. The goal is to establish a safe place without stigma for survivors to share experiences, ask questions, and express painful feelings so they can move forward with their lives. The second group is a drop-in bereavement group designed to help individuals receiving individual counseling (described above), and program alumni so that they continue the healing process in the months and years following their losses.
- **Survivors of Suicide Attempts (SOSA) Support Group***:* The program offers closed groups that provide a safe, non-judgmental place for people who have survived a suicide attempt to talk about the feelings that led them to attempt suicide. The goal of this group is to support their recovery and provide them with skills for coping with deep hurt. The program also provides individuals with culturally appropriate follow-up care and education.

INDIVIDUALS SERVED IN FACE-TO-FACE SERVICES			
FY 16/17	FY 17/18	FY 18/19	FY 19/20
132	148	140	156

TOTAL NUMBER OF INDIVIDUAL SESSIONS			
FY 16/17	FY 17/18	FY 18/19	FY 19/20
511	559	678	745

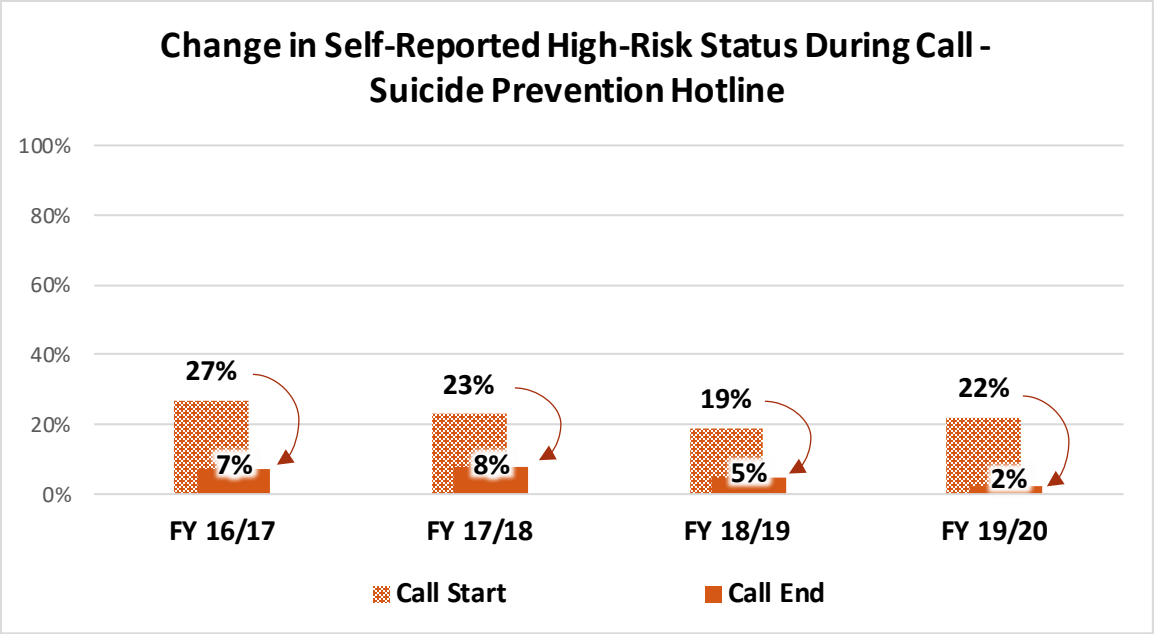
TOTAL NUMBER OF SAS & SOSA GROUPS			
FY 16/17	FY 17/18	FY 18/19	FY 19/20
59	64	91	104

Community Training/Outreach*:*

- Consistent with PEI regulations, the program trains potential first responders in ASIST and SafeTalk so that they are 1) better able to recognize signs of depression, suicidal ideation and other mental health conditions, and 2) informed about myths associated with talking about suicide, strategies on how to listen to and aid someone in distress, and awareness of the Suicide and Crisis Prevention Services program. Audiences include nurses, physicians, teachers and school personnel, law enforcement and other Orange County community members. Program staff also provides informational/program promotional material through information tables at events and speaking engagements throughout the county.

OUTCOMES

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



Telephone Hotline Support

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

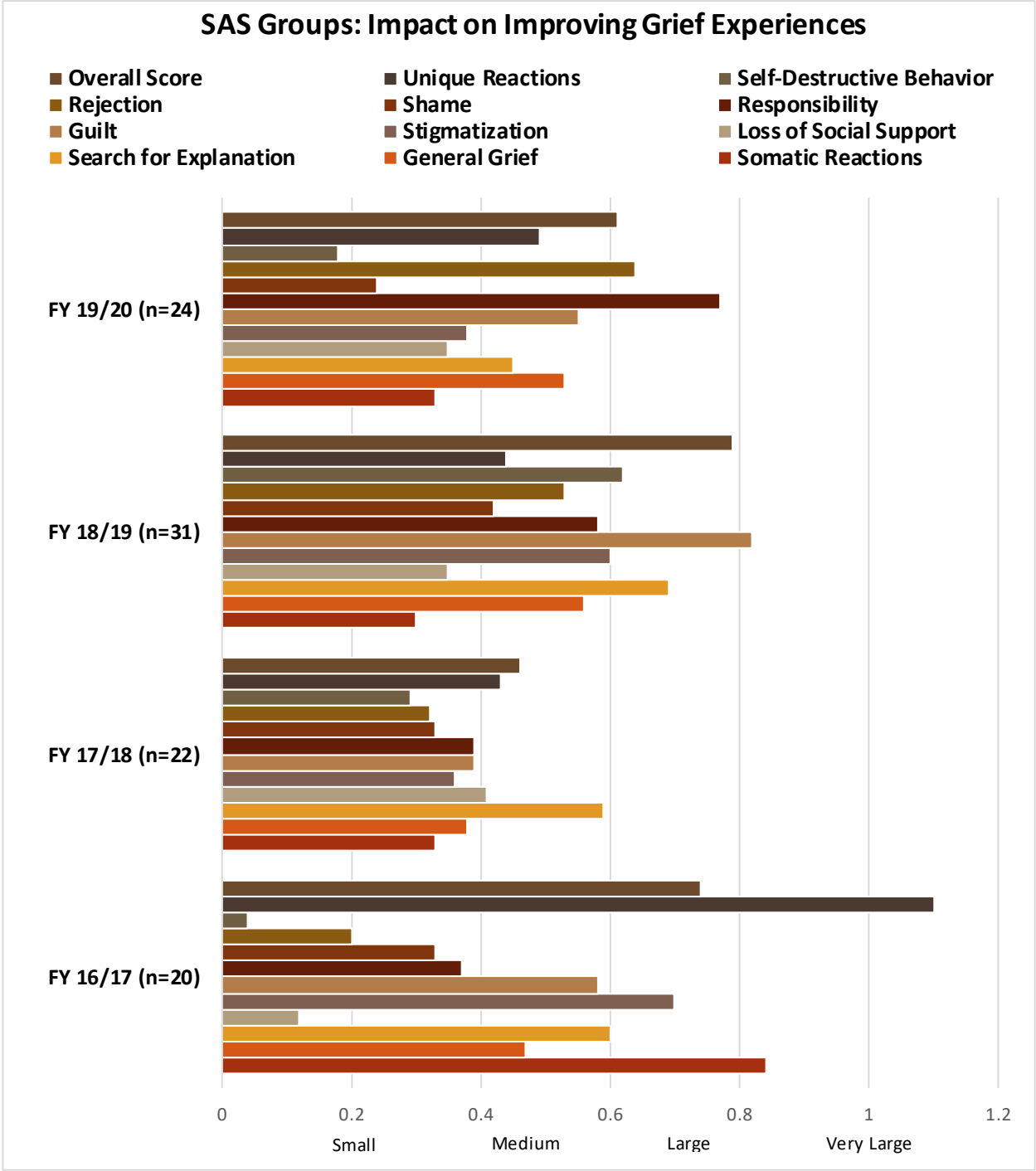
Face-to-Face Services

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

To measure the reduction in prolonged suffering in a culturally competent manner, individuals participating in individual or group counseling were asked to complete measures specific to their experience. Measures were administered at intake and program exit, and the difference between scores was used to analyze whether there was a significant reduction of prolonged suffering after receiving program services. Results are reported according to the calculated effect size, which reflects, in part, the extent to which a change in scores over time is clinically meaningful for the individuals served in the program.

- **Survivors of Suicide Attempts (SOSA)**: SOSA participants (FY 2019-20 n=2; FY 2018-19 n=10; FY 2017-18 n=14; FY 2016-17: n=13) completed the Beck Hopelessness Scale, Beck Scale for Suicidal Ideation and Interpersonal Needs Questionnaire to assess for pessimism and negativity they felt about their future; their thoughts, plans and intent to commit suicide; and their perceived burdensomeness and thwarted belongingness, respectively. Due to the small sample size of participants who completed both a baseline and follow-up of these measures, data were not statistically analyzed. However, clinicians monitored scores over the course of treatment to track participants' progress and adjust care plans as needed. The HCA is currently identifying ways to improve collection and/or measurement of performance outcome for this group.

- **Survivors after Suicide (SAS)**: Based on individuals' responses on the Grief Experiences Questionnaire (GEQ), services were generally associated with a meaningful lessening of grief following the loss of a loved one to suicide, Although degree of improvement varied across subscales and fiscal years, given the small sample sizes, it cannot yet be determined whether these differences reflect a change in the impact of services, the nature of the individuals served or other factors. The HCA will continue to monitor these outcomes to see if a trend can be identified.



CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

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

Stigma regarding suicide continues to be a barrier to seeking services, which the program is addressing by conducting more community outreach and presentations, especially in different ethnic communities, and the program has hired bilingual staff who speak Korean and Spanish. In addition, the program has incorporated a workshop model to conduct outreach. This strategy has been especially successful in the Spanish-speaking community, as noted by an increase in Spanish-speaking participants.

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

COMMUNITY IMPACT

The integrated program has answered more than 88,000 calls and provided face-to-face services to more than 1,000 since services launched in August 2010. One of the key components of the program's success is its collaboration with community partners and agencies that serve ethnic communities. This partnership promotes awareness, breaks down stigma related to mental health, and educates communities about available resources.

OFFICE OF SUICIDE PREVENTION

On October 6, 2020, the Board directed the County Executive Officer and HCA Director to create an Office of Suicide Prevention to:

1. *Reach out to high risk populations to find and engage those in need*
2. *Maintain contact with those in need and support continuity of care*
3. *Improve the lives of those in need through comprehensive services and supports, and*
4. *Build community awareness, reduce stigma and promote help-seeking*

The newly formed Office will be responsible for identifying and implementing promising pilot programs utilizing the above-referenced systems-approach for each of the initial populations of focus: youth and young adults, men in their middle years and older adults. The Office will also be responsible for integrating new and existing services and supports across the suicide prevention continuum and throughout the entire County to ensure all suicide prevention activities are linked to other behavioral health activities/services and directly targeted populations in need. The Office will create a systems approach to suicide prevention that leverages existing community and agency resources to build hope, purpose and connection for individuals in need.

REFERENCE NOTES

Somatic Reactions:

FY 2019-20: Baseline M=13.3, SD=3.67; Follow-up M=12.4, SD=3.80; t(23)=1.60, p<.124; Cohen's d=0.33
FY 2018-19: Baseline M=13.3, SD=3.21; Follow-up M=12.2, SD=3.83; t(30)=1.64, p<.012; Cohen's d=0.30
FY 2017-18: Baseline M=13.4, SD=5.0; Follow-up M=12.1, SD=3.6; t(21)=1.47, p=.16; Cohen's d=0.33
FY 2016-17: Baseline M=11.5, SD=4.2; Follow-up M=9.5, SD=2.7; t(19)=3.23, p<.01; Cohen's d=0.84

General Grief Reaction:

FY 2019-20: Baseline M=15.8, SD=3.65; Follow-up M=13.5, SD=3.65; t(23)=2.60, p<.016; Cohen's d=0.53
FY 2018-19: Baseline M=14.9, SD=3.77; Follow-up M=13.4, SD=3.85; t(30)=3.14, p<.012; Cohen's d=0.56
FY 2017-18: Baseline M=15.0, SD=4.1; Follow-up M=13.5, SD=3.6; t(21)=1.75, p=.10; Cohen's d=0.38
FY 2016-17: Baseline M=13.1, SD=4.4; Follow-up M=11.7, SD=4.3; t(19)=2.01, p<.05; Cohen's d=0.47

Search for Explanation:

FY 2019-20: Baseline M=18.5, SD=3.65; Follow-up M=16.6, SD=3.87; t(23)=5.10, p<.001; Cohen's d=0.45
FY 2018-19: Baseline M=18.6, SD=3.51; Follow-up M=15.8, SD=3.85; t(30)=5.10, p<.001; Cohen's d=0.69
FY 2017-18: Baseline M=17.0, SD=4.8; Follow-up M=14.2, SD=5.1; t(21)=2.77, p<.05; Cohen's d=0.59
FY 2016-17: Baseline M=15.0, SD=3.5; Follow-up M=12.6, SD=3.7; t(19)=2.70, p<.05; Cohen's d=0.60

Loss of Social Support:

FY 2019-20: Baseline M=15.5, SD=6.35; Follow-up M=13.9, SD=4.27; t(23)=1.60, p<.123; Cohen's d=0.35
FY 2018-19: Baseline M=14.7, SD=6.03; Follow-up M=13.2, SD=6.33; t(30)=1.96, p<.059; Cohen's d=0.35
FY 2017-18: Baseline M=13.1, SD=5.6; Follow-up M=11.3, SD=3.8; t(21)=1.46, p=.16; Cohen's d=0.41
FY 2016-17: Baseline M=11.6, SD=4.3; Follow-up M=11.1, SD=4.0; t(19)=0.55, p=.59; Cohen's d=0.12

Stigmatization:

FY 2019-20: Baseline M=14.9, SD=4.44; Follow-up M=13.2, SD=4.78; t(23)=1.86, p<.076; Cohen's d=0.38
FY 2018-19: Baseline M=12.5, SD=5.32; Follow-up M=10.5, SD=4.88; t(30)=3.29, p<.059; Cohen's d=0.60
FY 2017-18: Baseline M=12.9, SD=5.4; Follow-up M=10.9, SD=4.8; t(21)=1.67, p=.11; Cohen's d=0.36
FY 2016-17: Baseline M=11.2, SD=4.8; Follow-up M=9.0, SD=4.0; t(19)=3.05, p<.01; Cohen's d=0.70

Guilt:

FY 2019-20: Baseline M=18.0, SD=5.26; Follow-up M=15.7, SD=4.12; t(23)=2.63, p<.015; Cohen's d=0.55
FY 2018-19: Baseline M=17.3, SD=5.76; Follow-up M=14.7, SD=5.80; t(30)=4.57, p<.001; Cohen's d=0.82
FY 2017-18: Baseline M=16.7, SD=4.9; Follow-up M=14.6, SD=4.7; t(21)=1.81, p=.08; Cohen's d=0.39
FY 2016-17: Baseline M=14.5, SD=4.5; Follow-up M=12.1, SD=3.4; t(19)=2.55, p<.05; Cohen's d=0.58

Responsibility:

FY 2019-20: Baseline M=15.6, SD=5.64;. Follow-up M=12.9, SD=5.30; t(23)=3.75, p<.001; Cohen's d=0.77
FY 2018-19: Baseline M=13.2, SD=5.17; Follow-up M=11.2, SD=4.79; t(30)=3.22, p<.003; Cohen's d=0.58
FY 2017-18: Baseline M=13.9, SD=4.8; Follow-up M=12.0, SD=4.7; t(21)=1.84, p=.08; Cohen's d=0.39
FY 2016-17: Baseline M=10.1, SD=3.4; Follow-up M=9.1, SD=2.9; t(19)=1.65, p=.12; Cohen's d=0.37

Shame:

FY 2019-20: Baseline M=13.9, SD=6.23; Follow-up M=13.1,D=5.66; t(23)=1.16, p<.259; Cohen's d=0.24
FY 2018-19: Baseline M=14.4, SD=4.40; Follow-up M=12.5, SD=4.99; t(30)=2.31, p<.027; Cohen's d=0.42

FY 2017-18: Baseline M=14.3, SD=4.8; Follow-up M=12.8, SD=5.2; t(21)=1.53, p=.11; Cohen's d=0.33
FY 2016-17: Baseline M=13.2, SD=4.0; Follow-up M=12.1, SD=3.5; t(19)=1.47, p=.16; Cohen's d=0.33

Rejection:

FY 2019-20: Baseline M=17.5, SD=6.58; Follow-up M=15.0, SD=5.13; t(23)=2.95, p<.007; Cohen's d=0.64
FY 2018-19: Baseline M=114.6, SD=5.24; Follow-up M=12.5, SD=5.57; t(30)=2.96, p<.006; Cohen's d=0.53
FY 2017-18: Baseline M=14.7, SD=5.8; Follow-up M=13.2, SD=5.6; t(21)=1.51, p=.15; Cohen's d=0.32
FY 2016-17: Baseline M=11.8, SD=4.8; Follow-up M=11.1, SD=4.6; t(19)=0.89, p=.39; Cohen's d=0.20

Self-Destructive Behavior:

FY 2019-20: Baseline M=10.9, SD=3.62;. Follow-up M=10.3, SD=2.77 ; t(23)=0.84, p<.407; Cohen's d=0.18
FY 2018-19: Baseline M=11.1, SD=4.07; Follow-up M=8.5, SD=3.02; t(30)=3.21, p<.003; Cohen's d=0.62
FY 2017-18: Baseline M=10.5, SD=4.2; Follow-up M=9.6, SD=3.7; t(21)=1.34, p=.19; Cohen's d=0.29
FY 2016-17: Baseline M=8.0, SD=3.5; Follow-up M=8.1, SD=3.1; t(19)=-0.17, p=.87; Cohen's d=0.04

Unique Reactions:

FY 2019-20: Baseline M=14.9, SD=3.49; Follow-up M=13.5, SD=4.08; t(23)=2.37, p<.026; Cohen's d=0.49
FY 2018-19: Baseline M=14.9, SD=2.87; Follow-up M=13.8, SD=3.74; t(30)=2.33, p<.027; Cohen's d=0.44
FY 2017-18: Baseline M=13.4, SD=3.5; Follow-up M=12.0, SD=3.9; t(21)=2.00, p=.06; Cohen's d=0.43
FY 2016-17: Baseline M=12.8, SD=2.6; Follow-up M=10.5, SD=2.7; t(19)=4.92, p<.001; Cohen's d=1.10

Overall Score:

FY 2019-20: Baseline M=168.9, SD=34.98; Follow-up M=150.2, SD=35.36; t(23)=2.96, p<.006; Cohen's d=0.61
FY 2018-19: Baseline M=158.4, SD=33.09; Follow-up M=138.4, SD=38.56; t(30)=4.33, p<.001; Cohen's d=0.79
FY 2017-18: Baseline M=154.8, SD=38.4; Follow-up M=136.3, SD=33.6; t(21)=2.16, p<.05; Cohen's d=0.46
FY 2016-17: Baseline M=132.6, SD=32.6; Follow-up M=116.7, SD=30.7; t(19)=3.28, p<.01; Cohen's d=0.74

Mobile Crisis Assessment (CSS)

The mobile **Crisis Assessment Team** (CAT) program serves individuals of all ages who are experiencing a behavioral health crisis. Clinicians respond to calls from anyone in the community 24 hours a day, 7 days a week year-round and dispatch to locations throughout Orange County other than inpatient psychiatric or skilled nursing facilities which are staffed to conduct such evaluations. The CAT also includes the Psychiatric Emergency Response Teams (PERTs), which consist of CAT clinicians who are stationed or ride along with assigned law enforcement officers to address behavioral health-related calls in their assigned city. PERT provides all the same services as CAT and also initiates involuntary hospitalizations as necessary.

AGE RANGE

All Ages

PRIMARY LOCATION

Telephone

TARGET POPULATION

- ✓ At-Risk
- ✓ Mild-Moderate
- ✓ Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

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

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

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

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

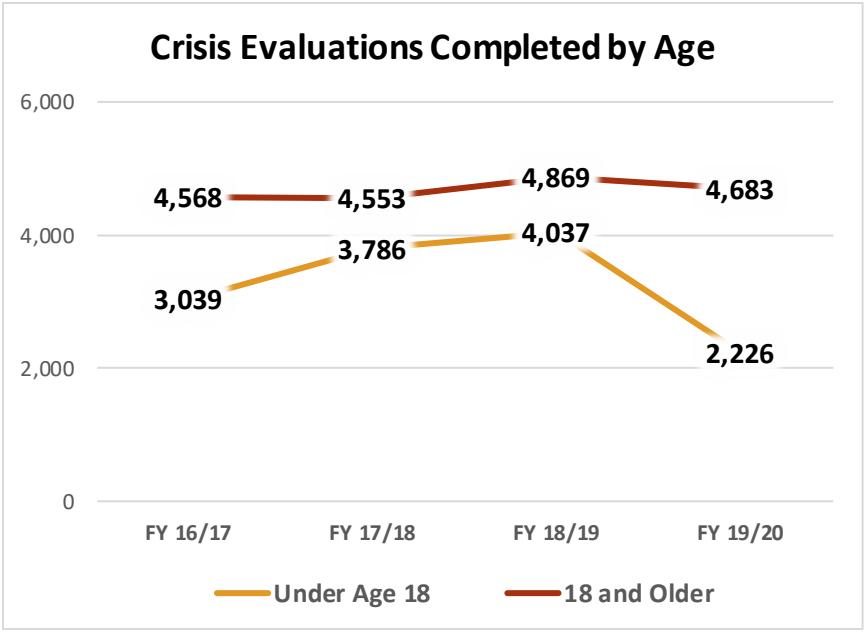
Fiscal Year	Program Budget	Total Evaluations
FY 2020-21	$9,135,858	7,689
FY 2021-22*	$9,135,858	8,837
FY 2022-23	$9,135,858	10,241

**No proposed budget change for FY 2021-22. #s served now reflect evaluations conducted rather than persons served*

SERVICES

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

The Children's team provides ongoing trainings and education to schools, school districts, hospitals, police departments and other community stakeholders upon request to increase collaboration and support for children and youth experiencing a behavioral health crisis event. PERT clinicians similarly educate police on behavioral health issues and provide officers with tools that allow them to assist individuals living with behavioral health issues more effectively.



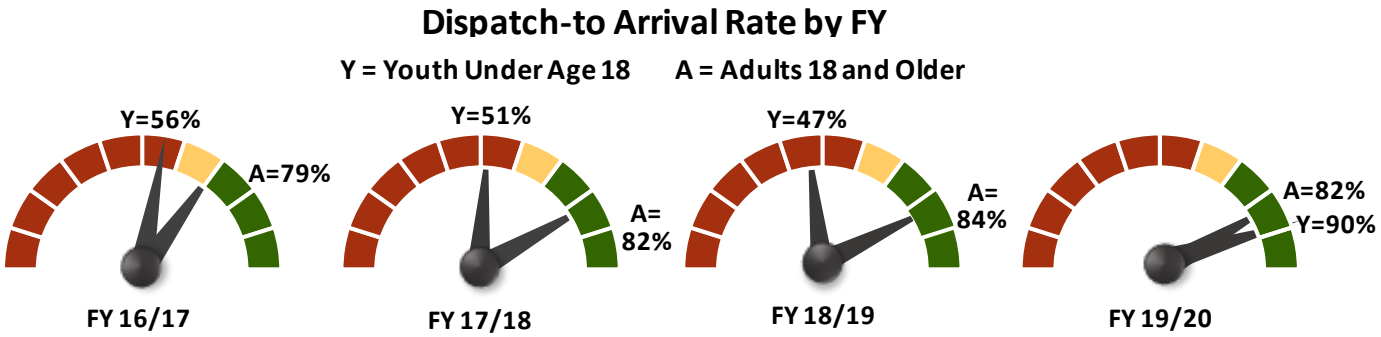
There are currently 27 clinicians on the children's crisis assessment team (CAT) serving youth under age 18, and 41 clinicians on the TAY/Adult/Older Adult team serving individuals ages 18 and older. The teams are also staffed with Service Chiefs who are responsible for overseeing the day-to-day operations of the program. The HCA currently has 17 PERT collaborations across Orange County, including the Orange County Sheriff's Department and police departments in the cities of Anaheim, Buena Park, Costa Mesa, Fullerton, Fountain Valley, Garden Grove, Huntington Beach, Irvine, Laguna Beach, Newport Beach, Orange, Santa Ana, Seal Beach, Tustin, University of California at Irvine, and Westminster.

The Children's team experienced a decrease in total calls received in FY 2019-20. A contributing factor to the decrease in calls was the impact of the COVID-19 public health emergency. The program demonstrated a drop in totals call starting in March through the end of the fiscal year. Schools are one of the main referral sources for the Children's team and the program saw a decrease in calls that correlates with the closing of in-person school services for children and youth.

OUTCOMES

The program is evaluated by the timeliness with which the teams are able to respond to calls, with the goal of a dispatch-to-arrival time that is 30 minutes or less at least 70% of the time. The Children's and TAY/Adult/Older Adult team meet this goal for FY 2019-20. While the TAY/Adult/Older Adult team has continued to meet this goal, this was the first time in the last four fiscal years that the Children's team reached this goal. The re-location of the children's team to a new facility, combined with reduced traffic during the COVID-19 Public Health emergency, contributed to the Children's program reaching the goal for FY 2019-20.

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



CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

As an essential service, both Adult and Children's CAT continued to respond to calls throughout the COVID-19 pandemic and were required to implement new processes to keep our clients and clinicians safe. All clinicians started responding to calls with Personal Protective Equipment (PPE), including but not limited to masks, gloves, and face shields. Both teams started the process of having clinicians dispatching from home to reduce the number of clinicians in the office. While maintaining social distancing guidelines, evaluating clients in the field/home added a layer of complexity. Targeted training was provided for CAT to ensure PPE was being put on, worn and taken off in the appropriate manner.

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

While the Children's team has continued to evaluate the impact of call location on response time, current COVID-19 impact has led to a decrease in calls for evaluation, freeing up staff to respond more quickly and improve response time. The HCA will continue to monitor call volume and the impact on response time.

COMMUNITY IMPACT

Since their inception in January 2003 through June 2019, the mobile crisis teams have responded to calls for more than 30,000 children under age 18 and 52,000 adults ages 18 and older. The teams have been successful in safely linking individuals who are experiencing behavioral health crises to appropriate levels of care that are less restrictive or costly and more recovery-oriented than inpatient psychiatric hospitalization, hospital emergency department visits and incarceration. Feedback from law enforcement about having clinicians out in the field with officers has also been overwhelmingly positive, helping to incorporate a more compassionate response when law enforcement interacts with individuals experiencing behavioral health crises.

Crisis Stabilization Units (CSS)

Crisis Stabilization Units (CSUs) provide the community with 24-hour, 7-day a week, year-round service for individuals who are experiencing a behavioral health crisis requiring emergent stabilization that cannot wait until a regularly scheduled appointment. One of the units serves Orange County residents ages 13 and older, the majority of whom may be on a 72-hour civil detention for psychiatric evaluation due to danger to self, others or grave disability resulting from a behavioral health disorder (i.e., Welfare and Institutions Code 5150/5585). The CSUs can be accessed directly by individuals experiencing a crisis, as well as by family members, law enforcement and others in the community who believe an individual has an emergent behavioral health need.

AGE RANGE

13+

Ages 13+

PRIMARY LOCATION

Clinic

TARGET POPULATION

- ✓ At-Risk
- ✓ Mild-Moderate
- ✓ Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

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

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	Gender	%	Race/Ethnicity	%
0-15	12	Female	40	African American/Black	8
16-25	25	Male	60	American Indian/Alaskan Native	1
26-59	59	Transgender	<1	Asian/Pacific Islander	8
60+	4	Genderqueer	-	Caucasian/White	46
		Questioning/Unsure	-	Latino/Hispanic	36
		Another	-	Middle Eastern/North African	1

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

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$6,700,000	7,227
FY 2021-22*	$10,000,000	7,949
FY 2022-23	$10,000,000	8,743

**No proposed changes for FY 2021-22*

SERVICES

Services, which are not to exceed 23 hours and 59 minutes, will include psychiatric evaluation, basic medical services, individual and group therapy as appropriate, nursing assessment, collateral services with significant others, individual and family education, medication services, crisis intervention, peer mentor services, referral, linkage and follow up services and transfer to inpatient level of care as appropriate. Services will also include substance use disorder treatment for individuals who have co-occurring substance use disorders. As an essential service, the CSUs continued to remain fully operational throughout the COVID-19 pandemic and were required to implement new processes to keep our clients and clinicians safe, such as a decreased census in order to uphold physical distancing standards, the use of PPE and COVID-19 testing.

The MHSA-funded CSUs were not operational in FY 2019-20, the year for which outcomes are being reported in this Plan Update. Outcomes will be reported in future Plans.

COMMUNITY IMPACT

College Hospital CSU in Costa Mesa opened its doors for services at the end of February 2020 for individuals 18 and older, and the Exodus CSU in Orange launched on February 1st, 2021 for voluntary clients and was able to begin accepting involuntary clients as of March 17, 2021 following its designation by the County of Orange. The CSU in Orange serves individuals ages 13 and older.

In-Home Crisis Stabilization (CSS)

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

AGE RANGE

All Ages

PRIMARY LOCATION

Field

TARGET POPULATION

- ✓ At-Risk
- ✓ Mild-Moderate
- ✓ Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

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

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

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

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

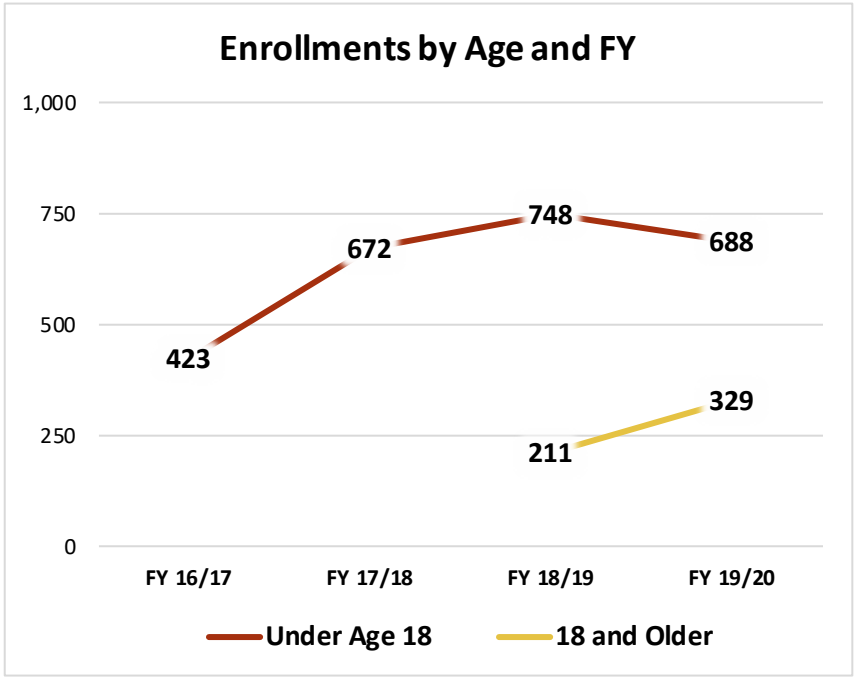
Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$2,935,480	1,187
FY 2021-22*	$2,935,480	1,320
FY 2022-23	$2,935,480	1,468

**No proposed changes for FY 2021-22*

SERVICES

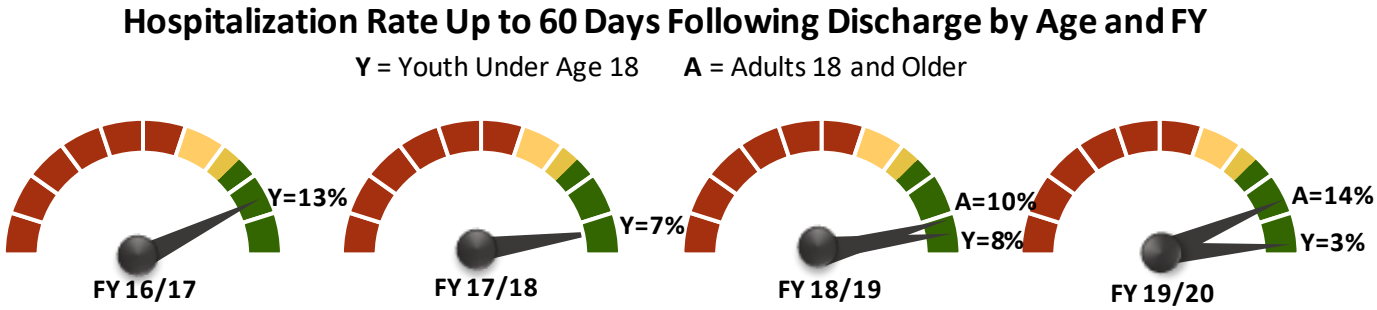
Individuals and their families or identified support networks (i.e., "family") are typically referred to IHCS after a clinician has evaluated an individual for possible hospitalization and determined that, while they may not meet criteria for hospitalization, they and their family would safely benefit from supportive services. The evaluator calls the crisis stabilization team to the site of the evaluation and the team is required to respond in person within two hours, immediately working with the individual and their family or identified support network to develop a stabilization plan. After triggers have been identified and a safety plan is in place, additional in-home appointments are made for the next day.

The IHCS teams utilize strategies such as crisis intervention, assessment, short-term individual therapy, peer support services, collateral services and case management to help the individual and their family establish a treatment plan, develop coping strategies and ultimately transition to ongoing support. Length of stay in the program is usually three weeks but can be extended based on clinical need and the amount of time it takes before an individual is linked to long-term services. All IHCS services are mobile and, whenever possible, provided in the home, at the identified residence of individuals who are experiencing homelessness, and/or in any community setting that the individual or family feels comfortable. As an essential service, the IHCS Teams continued to remain fully operational throughout the COVID-19 pandemic and were required to implement new processes to keep both clients and clinicians safe, such as the use of telehealth and PPE.



OUTCOMES

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



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

CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

The Children's team strives to stay within the three-week timeframe to address crisis events for children and youth. The program has made progress in maintaining the three-week structure of the program. The program is continuing to focus on the discharge process and working to link children and their families as early as possible during the treatment period. Linking children with private insurance has continued to be a challenge for the Children's team. The program continues to address this by increasing outreach to private insurance providers to educate about its program services and increase collaboration for linkages to covered outpatient or other appropriate services.

COMMUNITY IMPACT

More than 4,300 children have received in-home support since services began in 2006 and more than 500 adults have received support since services began in 2018. The program collaborates with referring agencies, behavioral health programs, schools, emergency departments, crisis stabilization units and the mobile crisis assessment teams with a focus on assisting the County's most vulnerable clients and ensuring their linkage to ongoing services. In addition, the adult IHCS team has begun to partner with the Crisis Residential Services program to serve as a step down for Older Adult clients in order to solidify their gains during their Crisis Residential Services stay. Overall, the IHCS program strives to reduce admissions to local emergency departments and provide a strengths-based, in-home alternative to psychiatric hospitalization for individuals experiencing a behavioral health crisis and their families.

Crisis Residential Services (CSS)

The **Crisis Residential Services** (CRS) program provides highly structured, voluntary services in a residential setting for individuals who are experiencing a behavioral health crisis and meet eligibility requirements. Individuals ages 12 and older can be referred if they have been evaluated for psychiatric hospitalization, can be safely referred to a less restrictive, lower level of care and they and/or their family are experiencing considerable distress. Individuals must be referred by hospitals (for the Children's and TAY sites), County CAT/PERTs or County or County-contracted Specialty Mental Health Plan programs (i.e., the program does not accept walk-ins, self-referrals). The Adult CRS program currently has 42 beds available at 4 sites located throughout Orange County.

AGE RANGE

Ages 12+

PRIMARY LOCATION

Residential

TARGET POPULATION

- ✓ At-Risk
- ✓ Mild-Moderate
- ✓ Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

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

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

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

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

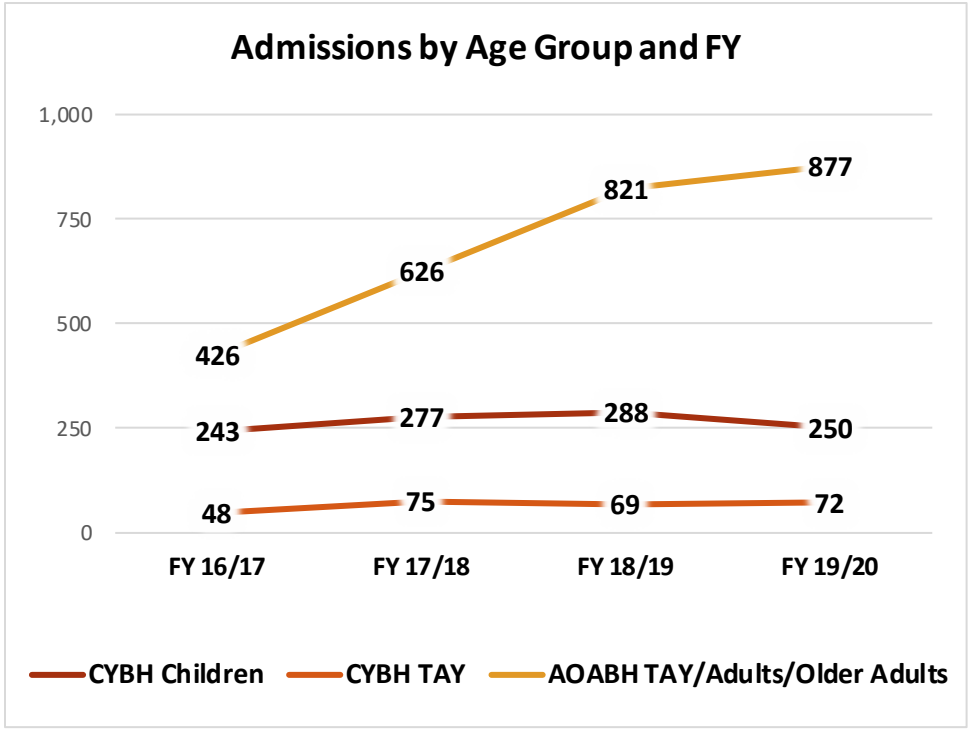
Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$9,030,845	1,161
FY 2021-22*	$11,280,845	1,199
FY 2022-23	$11,280,845	1,280

**No changes to FY 2021-22*

SERVICES

CRS has several sites across the county tailored to meet the needs of different age groups:

- **Children** ages of 12 to 17 receive services at three sites operated by Children Youth and Behavioral Health (CYBH; i.e., Laguna Beach, Huntington Beach, Tustin) with a total of 16 beds. Services generally last for three weeks, although children can remain in treatment for up to six weeks, if needed. Additional sites are being added to address the needs of dependents as part of Continuum of Care (COC) Children's Crisis Residential Program (CCRP) services and/or DHCS' Psychiatric Residential Treatment Facilities (PRTF).
- **TAY** between the ages of 18-25 receive services at a site operated by CYBH with six beds. Services generally last for three weeks, although youth can remain in treatment for up to six weeks if needed. TAY may also receive services at the TAY/Adults sites operated by Adult and Older Adult Behavioral Health (AOABH).
- **TAY/Adults** ages 18 and older receive services at three sites operated by AOABH (2 sites in Orange, 1 in Mission Viejo) with a total of 36 beds, four of which are ADA-compliant. Stays last an average of 7 to 14 days.
- **Older Adults** ages 50 and older receive services at a newly renovated Older Adult CRS operated by AOABH in Anaheim (6 beds, 2 of which are ADA-compliant). Stays last an average of 7 to 14 days.



The residences emulate home-like environments in which intensive and structured psychosocial, trauma-informed, recovery services are offered. Depending on the individual's age and their or their family's/significant other's needs, services can include crisis intervention; individual, group and family counseling/therapy; group education and rehabilitation; assistance with self-administration of medications; training in skills of daily living; case management; development of a Wellness Recovery Action Plan (WRAP); prevention education; recreational activities; activities to build social skills; parent education and skill-building; mindfulness training; narrative therapy, reminiscence groups, educational and didactic groups specific to older adults, issues associated with aging, stigma associated with aging, safety issues, adaptive equipment, fragility issues and "silver" fitness groups, outings and activities. and nursing assessments. The evidence-based and best practices most commonly used include cognitive behavior therapy, Dialectical Behavioral Therapy (DBT) and trauma-informed care. Programs also provide substance use disorder education and treatment services for people who have co-occurring disorders.

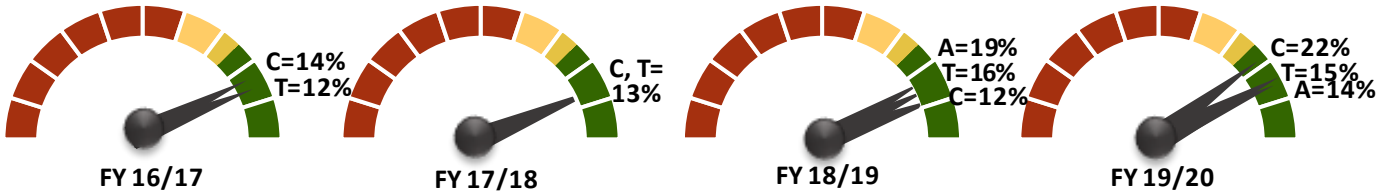
To integrate the individual back into the community effectively, discharge planning starts upon admission. A key aspect of discharge planning involves linkage to community resources and services that build resilience and promote recovery (i.e., FSPs and other on-going behavioral health services; victim's assistance; local art, music, cooking, self-protection classes; animal therapy; activity groups designed to support the individual; etc.). Children also have the option to participate in a weekly graduate drop-in group. As an essential service the CRPs remained fully operational throughout the COVID-19 pandemic and implemented new practices to keep clients and staff safe, including the use of PPE, COVID-19 testing and reducing the census as necessary to allow for isolation and quarantine.

OUTCOMES

The goal of the program is to help the person manage their behavioral health crisis and make positive gains in recovery, which is quantified as achieving a psychiatric hospitalization rate of 25% or less from the time the individual is enrolled in the program through 60 days post-discharge. The program met this goal with hospitalization rates ranging from 14%-22% across all fiscal years and age groups.

Hospitalization Rate Up to 60 Days Following Discharge by Age and FY

CT = Children/TAY Under 18 (CYBH) T = TAY 18-25 (CYBH) A = TAY/Adults/Older Adults 18 (AOABH)



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

CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

An ongoing, primary challenge has been the increased demand for Crisis Residential Services, with the community identifying a particular need for a facility specifically geared towards older adults. The HCA is actively working on addressing this service gap and opened the Silver Treehouse on September 1, 2021, that exclusively addresses the needs of older adults in behavioral health crisis. TAY continue to face challenges with the lack of stable housing available when youth are ready for a lower level of care, and children periodically showed an increased demand for services throughout the past two calendar years and, at times, either had to be placed on a waitlist or diverted to other crisis services such as in-home crisis. The HCA is examining these trends to determine projected need for Children's Crisis Residential Services over the course of the next three-year period. As part of this, the HCA is considering how the new State requirement for a CCRP level of care and facility type will affect the children's crisis residential needs moving forward to ensure a sufficient number of beds are available for youth determined to need this level of care.

COMMUNITY IMPACT

Since inception, the program has assisted more than 1,900 children, 1,600 TAY, and 4,800 adults/older adults with intensive services provided in a therapeutic, home-like environment. The program reduces admissions to local emergency departments and provides a strengths-based, recovery-oriented alternative to psychiatric hospitals for those experiencing a behavioral health crisis.

BHS Disaster Response (PEI)

The **Behavioral Health Services Disaster Response** (BHSDR) program is a mobile team of BHS clinicians who receive specialized training in Critical Incident Stress Management (CISM). The team is on-call to provide support to residents with the goal of minimizing lasting, negative impacts from critical, traumatic and/or disruptive events. The team responds anywhere in Orange County or surrounding areas. It is part of the PEI-funded program, Outreach for Increasing Recognition of Early Signs of Mental Illness and is described here due to its specific focus on crisis response.

AGE RANGE

All Ages

PRIMARY LOCATION

Telephone

TARGET POPULATION

- ✔ At-Risk
- ✔ Mild-Moderate
- ✔ Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

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

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	Gender	%	Race/Ethnicity	%
0-15	-	Female	56	African American/Black	Not Collected
16-25	6	Male	44	American Indian/Alaskan Native	
26-59	67	Transgender	-	Asian/Pacific Islander	
60+	27	Genderqueer	-	Caucasian/White	
		Questioning/Unsure	-	Latino/Hispanic	
		Another	-	Middle Eastern/North African	
				Another	

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

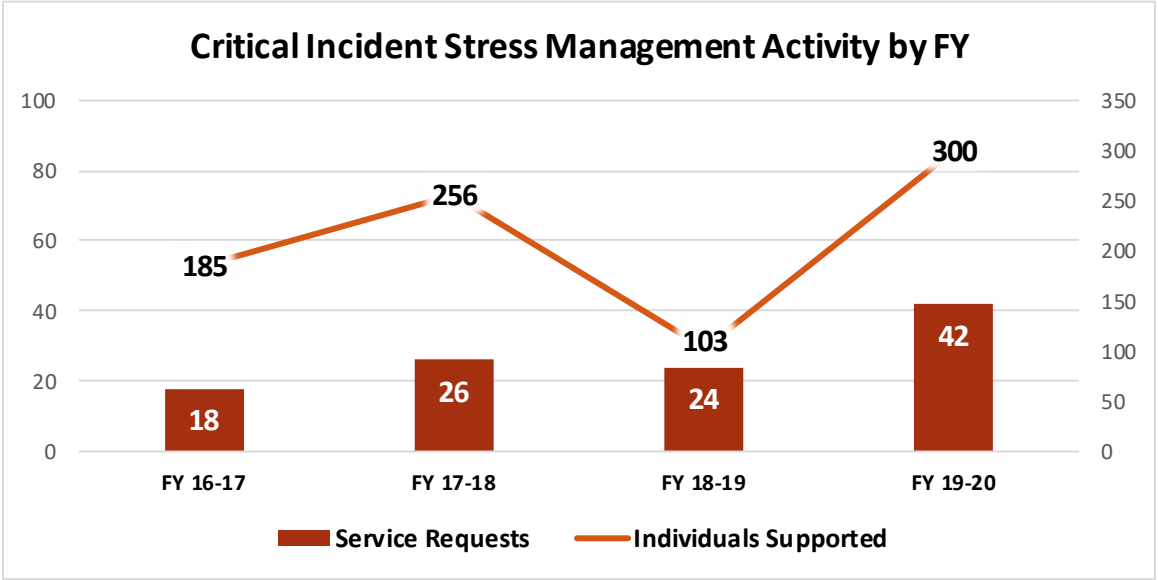
Funding is contained within the Outreach for Increasing Recognition of Early Signs of Mental Illness program.

The number of requests for services and/or individuals supported varies based on the number and/or magnitude of critical incidents that may occur in any given year.

SERVICES

BHSDR provides Critical Incident Stress Management (CISM) group debriefings, CISM one-on-one debriefings, CISM briefings and education on grief, stress reactions and self-care. In addition, the team provides Psychological First Aid training to community members. The number of requests for services and/or individuals supported varies based on the number and/or magnitude of critical incidents that may occur in any given year.

Notably, during FY 2019-20 several scheduled meetings, exercises, activities and trainings were canceled during the last quarter due to the COVID-19 crisis. BHSDR shifted its focus to assist with many activities to support the County's response to the pandemic.



More specifically, the team helped with:

- Coordination of Personal Protective Equipment (PPE) distribution
- Redeployment of team members to homeless shelters (i.e., Salvation Army in Santa Ana for three weeks in April 2020; Joplin Youth Center in May 2020), where they provided outreach and engagement, case management, crisis intervention and referral and linkage to supportive services
- Coordination and oversight of supportive services provided to the vulnerable homeless population residing in motels during the COVID-19 crisis
- Development of a debriefing process for hotline workers at the Loma Ridge Emergency Operations Center (EOC)
- Facilitation of 12 trainings to 346 individuals throughout FY 2019 – 2020, including Psychological First Aid (PFA); Disaster Preparedness for Disaster Service Workers (DSW); Vicarious Trauma: Impact and Skills to Help You Cope; and a new training focused on Grief and Loss that reached approximately 272 community partners from Waymakers, Social Service Agency, HOPE Animal Assisted Crisis Response, HCA Public Health Nursing and several Community Emergency Response Teams (CERT).

In addition, 27 BHSDR Team members received training in Grief Following Trauma through the International Critical Incident Stress Foundation (ICISF).

COMMUNITY IMPACT

BHSDR staff served a critical role in responding to the COVID-19 pandemic, supporting both essential workers and vulnerable individuals. The team continues to work tirelessly to support County clients and staff during this unprecedented time, and recently received recognition from the HCA BHS Director's office for their efforts.

Summary of MHSA Strategies Used by Suicide and Crisis Prevention Programs

STRATEGIES TO PROMOTE RECOVERY/RESILIENCE

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

STRATEGIES TO REDUCE STIGMA AND DISCRIMINATION

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

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

STRATEGIES TO INCREASE ACCESS TO SERVICES: TIMELY ACCESS FOR UNDERSERVED POPULATIONS AND LINKAGE TO TREATMENT

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

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

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

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

Crisis Prevention and Support Services Programs		Linkage Metrics		
		# Referrals	# Linkages	Types of Linkages
WarmLine	**FY 2016-17**	4,663	See note*	OC Links, mental health services, Family Support Service, Patients' Rights Advocacy, suicide prevention programs
	FY 2017-18	2,139		
	FY 2018-19	2,189		
	FY 2019-20	2,629		
Suicide Prevention Services (Survivor Support Services only)	**FY 2016-17**	471	226	Early Intervention, Private/Community Outpatient, Outpatient Clinic-Based, Outpatient Crisis Services, Supportive Services
	FY 2017-18	692	220	
	FY 2018-19	983	119	
	FY 2019-20	526	32	
In Home Crisis Stabilization (Adult team)	**FY 2016-17**	-	See note**	Lower level of outpatient behavioral health care services
	FY 2017-18	-		
	FY 2018-19	206	141	
	FY 2019-20	434	208	

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

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

OUTPATIENT TREATMENT

The largest service function of Mental Health Services Act (MHSA)-funded programs, both in breadth and depth, is Outpatient Services. These programs provide clinical interventions and other services in a non-hospital/non-residential setting for individuals of all ages who are experiencing mental health symptoms that can range in severity from mild, to serious and persistent. To further promote recovery and resilience, many of the programs also provide services and support for family members. Orange County devotes a considerable proportion of its MHSA allocation to fund a wide array of outpatient programs.

- Early Intervention Outpatient Treatment Programs
- Clinic Expansion Programs
- Full Service Partnership Programs and Program for Assertive Community Treatment

EARLY INTERVENTION is the first subcategory of outpatient treatment. Consistent with a key MHSA aim of preventing symptoms of a mental health condition from becoming severe and disabling, Early Intervention Outpatient Services are designed to create a help-first, community-based system that encourages access to care as early as possible, following the onset of symptoms. These programs are funded by PEI and organized below according to the target populations they are designed to serve: 1) Child, Youth and Family Focused and 2) Specialized Services

School-Based Mental Health Services (PEI)

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

AGE RANGE

Ages 11-15

PRIMARY LOCATION

Field

TARGET POPULATION

At-Risk	Mild-Moderate	Severe
✓	✓	

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

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

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

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

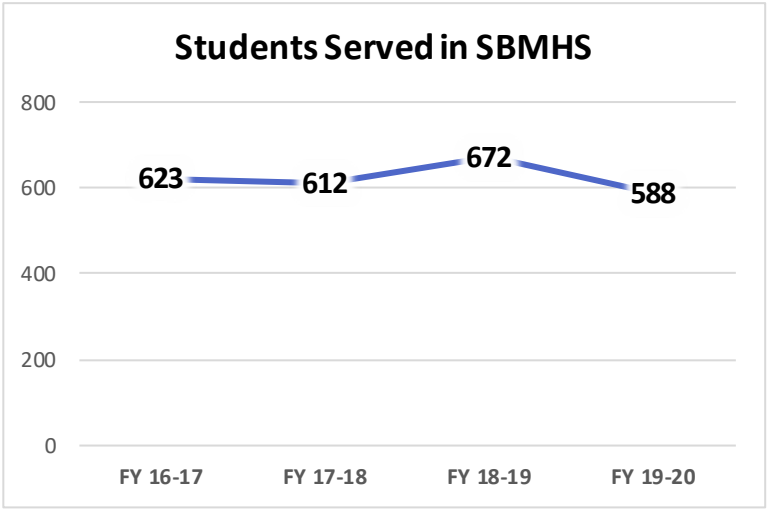
BUDGETS & PROJECTED #'s TO BE SERVED FROM 3YP

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$2,525,236	1,000
FY 2021-22*	$2,525,236	750
FY 2022-23	$2,525,236	*750*

**Budget kept level and not reduced for anticipated Medi-Cal revenue generation. Numbers served adjusted down to reflect historical trend for engagement in individual rather than group therapy.*

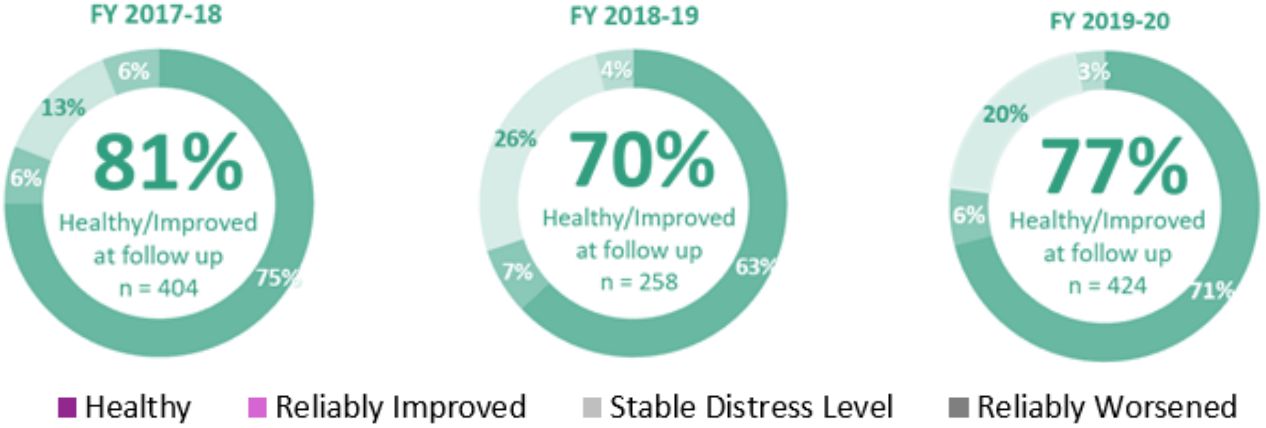
SERVICES

SBMHS provides a range of services to develop protective factors and create resilience in youth to better meet new academic and social challenges. This includes educating parents about these challenges and how they can assist their transitioning youth. Services include assessment, individual counseling, group interventions, case management, and referral and linkage to community resources. It uses evidenced-based curricula such as Cognitive Behavioral Intervention for Trauma in Schools (C-BITS), Coping Cat and Seeking Safety, as well as Eye Movement Desensitization and Reprocessing (EMDR).



OUTCOMES

Beginning in FY 2017-18, SBMHS assessed reductions in, or prevention of, prolonged suffering via the YOQ® 30.2, which was administered at intake, every three months and at discharge. Results indicate that program services are associated with preventing symptoms of a mental health condition from becoming severe and disabling for the majority of students served across the past three years.



COMMUNITY IMPACT

The SBMHS program has provided services to more than 15,338 students since its inception in August 2011. In FY 2020-21, the program will collaborate with the Orange County Department of Education's (OCDE) Mental Health Student Services Act (MHSSA) Regional Mental Health Coordinators to meet the need for mental health services in schools throughout Orange County.

CHALLENGES, BARRIERS AND SOLUTIONS

In FY 2019-20, the program expanded services to new districts (n=6 schools) and was on track to meet their target enrollment goal. However, due to the COVID-19 pandemic, Orange County schools began distance learning in March of 2020 and SBMHS clinicians had to creatively engage students via phone or telehealth since they could not go on campus. Many participants declined telehealth services because they did not want to be seen from home, or they didn't have access to technology and/or privacy. As a result, the program was unable to continue group interventions. During this period the program also experienced a significant drop in referrals as school partners shared their own difficulties in engaging students to attend regular classes. Additional program challenges included staff vacancies and limited access to students during instruction time since clinicians could no longer pull students out of class for counseling sessions as they had done prior to the pandemic. To increase access to students and address barriers to telehealth, the program has extended their business hours and offers to engage students outside of the school setting. SBMHS became Medi-Cal certified to further expand staffing and increase capacity to serve additional students.

First Onset of Psychiatric Illness (OC CREW) (PEI)

The **First Onset of Psychiatric Illness** program, also known as Orange County Center for Resiliency, Education and Wellness (OC CREW), serves youth ages 12 through 25 who are experiencing a first episode of psychotic illness with symptom onset within the past 24 months. The program also serves the families of eligible youth. To be eligible for services, the youths' symptoms cannot be caused by the effects of substance use, a known medical condition, depression, bipolar disorder or trauma. The program receives self-referrals and referrals from County-operated and County-contracted specialty mental health clinics and community providers.

AGE RANGE

Ages 12-25

PRIMARY LOCATION

Clinic | Field

TARGET POPULATION

At-Risk | Mild-Moderate | Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

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

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

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

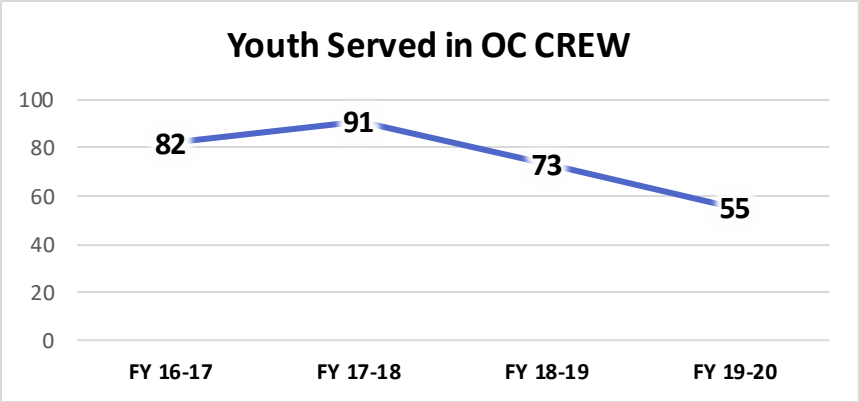
BUDGETS & PROJECTED #'s TO BE SERVED FROM 3YP

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$1,500,000	80
FY 2021-22*	$1,450,000	80
FY 2022-23	$1,500,000	80

**Proposed decrease for FY 2021-22 PEI budget due to anticipated Medi-Cal revenue generation*

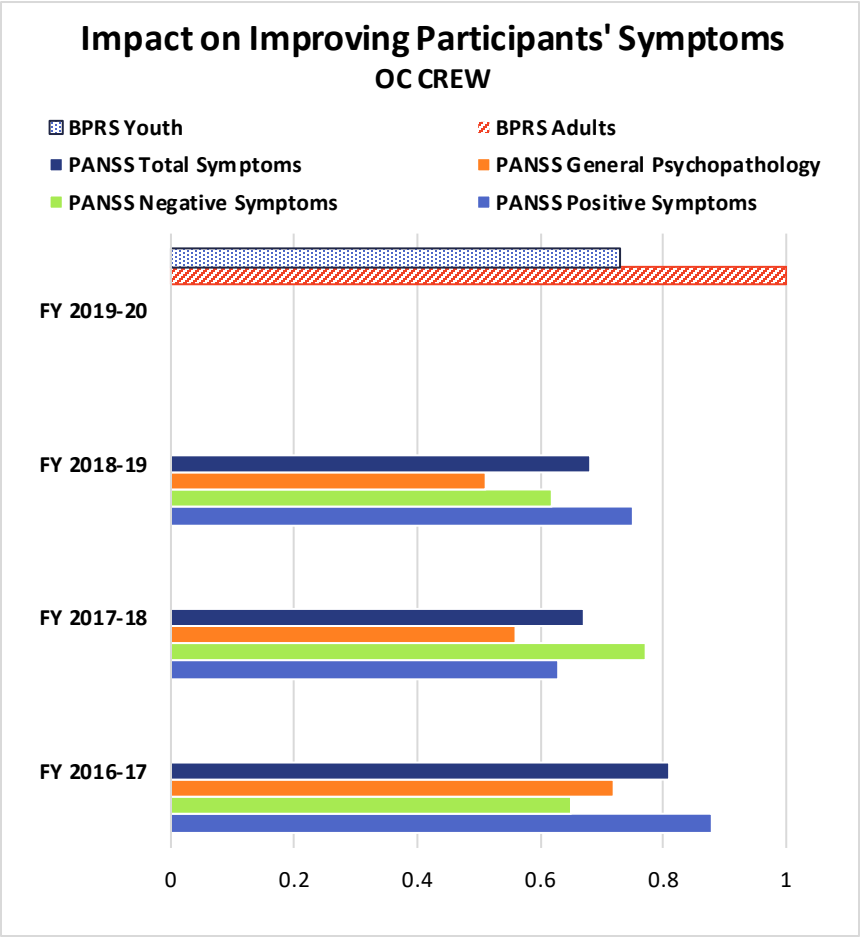
SERVICES

OC CREW uses Early Detection and Intervention for the Prevention of Psychosis (EDIPP) and a Wellness Recovery Action Plan (WRAP) to guide service planning and delivery. The services offered include individual therapy, case management, psychiatric care, psychoeducation, vocational and educational support, social wellness activities, substance use services, and referral and linkage to community resources. In addition to collateral services and evidence-based practices, including Cognitive Behavioral Therapy for Psychosis, Assertive Community Treatment, medication services and Multi-Family Groups (MFG), the program offers community and professional training on the First Onset of Psychosis.



OUTCOMES

The goal of OC CREW is to reduce prolonged suffering from an untreated mental health condition. From FYs 2016-17 to 2018-19, this was measured using psychiatrists' ratings on the Positive and Negative Syndrome Scale (PANSS). In FY 2019-20, OC CREW began using the Brief Psychiatric Rating Scale (BPRS). Both are widely used measures that assess the frequency and/or severity of psychiatric symptoms, particularly schizophrenia. The 24-item BPRS was used for adults and the 21-item was used for youth ages 12-17 with each item rated on a 7-point scale ranging from 'not present' to 'extremely severe.'



Clinicians provided PANSS and BPRS ratings at intake, every six months and at program exit, and the difference between intake (baseline) and the most recent follow-up was used to determine whether there was a reduction of prolonged suffering. Results are reported according to the calculated effect size, which reflects, in part, the extent to which a change in scores over time is clinically meaningful for the youth served in the program. Effect sizes are standardized and are interpreted the same way across different measures. Medium to large reductions in symptoms were consistently observed across all years, suggesting that OC CREW reduces prolonged suffering from an untreated mental health condition and is effective in helping to prevent first episode psychosis from becoming severe, persistent and disabling.

CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

In March 2020, the program filled several vacant positions: Service Chief, Mental Health Specialist, and two Behavioral Health Clinicians, with the psychiatrist position still vacant. Filling the positions was anticipated to increase the number of youth enrolled in the program, however that same month coincided with the start of the COVID-19 pandemic. In response, OC CREW revamped its internal enrollment process and the way it provided its services. The program temporarily transitioned from clinic- and field-

based services to a largely telephone- and telehealth-based platform, with in-person appointments still available as clinically indicated. With the new team members and treatment platform, efforts were focused on training staff to increase engagement of telehealth services and to provide quality care to the community. Public health restrictions due to the COVID-19 pandemic led to a reduction in group services, community outreach to increase awareness of psychosis and the numbers of First Break of Psychosis presentations. As COVID-19-related restrictions are lifted over the course of the next fiscal year, the goal is to increase the coordinated specialty care services provided to better serve the community.

In addition, the program continues to participate in the Early Psychosis Learning Health Care Network (EPLHCN) Statewide Collaboration. The Medi-Cal certification process is complete and the program is now billing Medi-Cal. As a Medi-Cal Certified program, OC CREW can look to expand staffing and increase their capacity to serve additional participants as the need arises.

COMMUNITY IMPACT

OC CREW has provided services to more than 635 participants since its inception in the Spring of 2011. By providing field based services the program is able to reach, serve and impact individuals who are reluctant to seek behavioral health treatment for fear of being stigmatized, have limited resources to access clinical based care or experience functional limitation due to their mental health symptoms.

REFERENCE NOTES

Brief Psychiatric Rating Scale (BPRS):

Children:

FY 2019-20: Baseline M=57.0, SD=18.02; Follow-up M=48.9, SD=21.17; t(8)=-2.11, p>.05; Cohen's d=0.73

Adult:

FY 2019-20: Baseline M=54.3, SD=18.17; Follow-up M=42.3, SD=12.57; t(17)=-3.90, p<.01; Cohen's d=1.00

PANSS:

Positive Symptoms:

FY 2018-19: Baseline M=16.7, SD=6.68; Follow-up M=11.7, SD=5.94; t(54)=5.53, p<.001; Cohen's d=0.75
FY 2017-18: Baseline M=16.1, SD=7.0; Follow-up M=10.8, SD=7.9; t(50)=4.47, p<.001; Cohen's d=0.63
FY 2016-17: Baseline M=15.9, SD=7.0; Follow-up M=9.0, SD=7.7; t(50)=6.33, p<.001; Cohen's d=0.88

Negative Symptoms:

FY 2018-19: Baseline M=19.0, SD=7.66; Follow-up M=14.0, SD=7.2; t(54)=4.62, p<.001; Cohen's d=0.62
FY 2017-18: Baseline M=17.9, SD=7.1; Follow-up M=12.0, SD=7.4; t(48)=5.42, p<.001; Cohen's d=0.77
FY 2016-17: Baseline M=17.2, SD=8.3; Follow-up M=11.5, SD=8.3; t(50)=4.63, p<.001; Cohen's d=0.65

General Psychopathology:

FY 2018-19: Baseline M=34.9, SD=11.40; Follow-up M=27.8, SD=10.65; t(54)=3.75, p<.001; Cohen's d=0.51
FY 2017-18: Baseline M=33.5, SD=11.6; Follow-up M=24.7, SD=14.2; t(50)=3.95, p<.001; Cohen's d=0.56
FY 2016-17: Baseline M=32.2, SD=11.9; Follow-up M=22.2, SD=13.1; t(50)=5.14, p<.001; Cohen's d=0.72

Total Symptoms:

FY 2018-19: Baseline M=70.6, SD=23.29; Follow-up M=53.0, SD=21.15; t(54)=5.06, p<.001; Cohen's d=0.68
FY 2017-18: Baseline M=68.2, SD=24.0; Follow-up M=48.6, SD=29.6; t(50)=4.72, p<.001; Cohen's d=0.67
FY 2016-17: Baseline M=65.3, SD=25.0; Follow-up M=42.7, SD=27.4; t(50)=5.74, p<.001; Cohen's d=0.81

Early Psychosis Learning Health Care Network (INN)

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

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

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$500,000	-
FY 2021-22	$510,584	-
FY 2022-23	$561,234	-

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

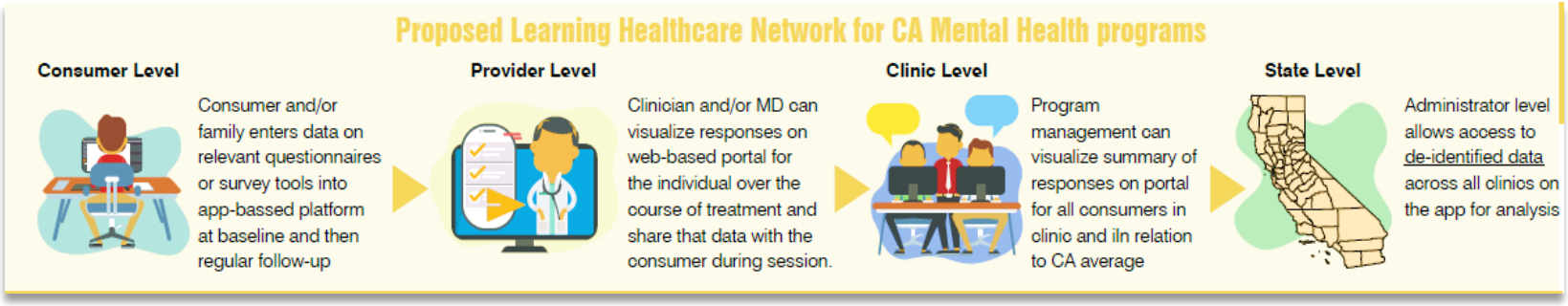
SERVICES

During the initial year of implementation, OC CREW program staff, participants and family members participated in voluntary focus groups to provide feedback on the selection of EP outcome measures. Focus group results from all participating counties, as well as a detailed description of project activities within the first year of implementation are available in the MHSA INN Annual Project Report.

As selected outcome measures are administered, ongoing focus groups with OC CREW staff, participants and their families will be facilitated to gather feedback on the use of measures. Outcome measures and focus group data will be analyzed to assess the impact of the LHCN on consumer- and program-level metrics, as well as utilization and cost rates of EP programs (see diagram of the implementation and evaluation process below). This will provide counties the opportunity to adjust program operations and/or services, if appropriate, based on lessons learned through multiple research approaches.

OUTCOMES

This first year of this project focused on the process of selecting appropriate measures, so there are no outcomes to report at this time. Outcomes will be reported in future Plan Updates.



OC Parent Wellness Program (PEI)

The **Orange County Parent Wellness Program** (OCPWP) has been expanded to include the former Stress Free Families and Connect the Tots programs and provide services to at-risk and stressed families with children under age 18, including pregnant females and partners affected by the pregnancy or birth of a child within the past 12 months, families that have been reported to Child Protective Services (CPS) for allegations of child abuse or neglect, or families with a young child between the ages of 0 and 8 years who are exhibiting mild to moderate behavioral health symptoms that may negatively impact their readiness for school.

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

AGE RANGE

All Ages

PRIMARY LOCATION

Field | Clinic

TARGET POPULATION

At-Risk | Mild-Moderate | Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

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

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

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

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

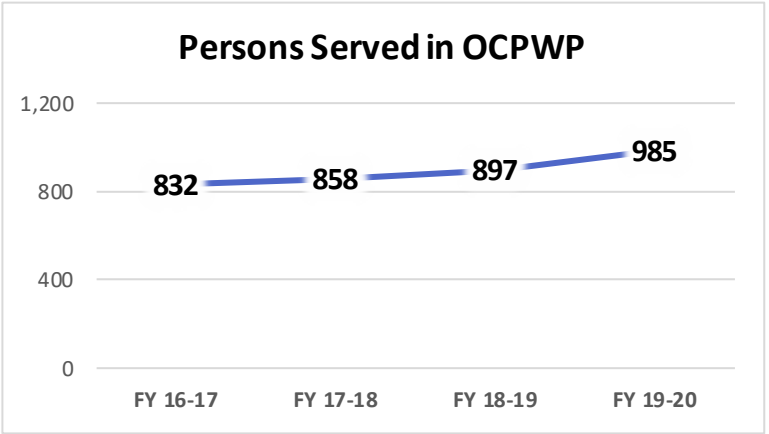
Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$3,738,072	900
FY 2021-22*	$3,738,072	900
FY 2022-23	$3,738,072	900

**No proposed changes to FY 2021-22*

SERVICES

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

The counseling approaches used by clinicians include Cognitive Behavioral Therapy (CBT) and Eye Movement Desensitization and Reprocessing (EMDR) when clinically indicated. The program also utilizes the evidenced-based curriculum, Triple P (Positive Parenting Program) and Mothers and Babies (MB), with staff having been recently trained more intensively to ensure they follow the fidelity of these models and remain current on best practices when working with trauma-exposed individuals.

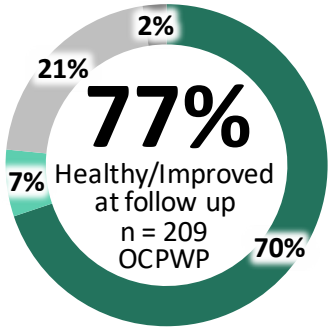


OUTCOMES

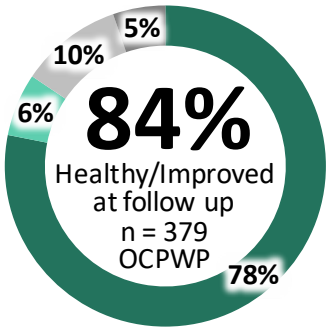
The program measures reductions in or prevention of prolonged suffering through an age-appropriate form of the OQ® and PARCA-SE. Participants completed the identified measure at intake, every three months and at program exit. OQ® scores were compared to the measure's clinical benchmarks and change in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

Across the four fiscal years, anywhere from 78% to 90% of enrolled parents reported healthy or reliably improved levels of distress, as measured by the OQ®, since starting services. Thus, services were associated with preventing symptoms of a mental health condition from becoming severe and disabling for the overwhelming majority of parents served. For the parents who report a significant worsening in their distress, program staff have been streamlining procedures to quickly identify these individuals earlier in the course of treatment, modify the treatment plan to include increased face-to-face time, or, when appropriate, refer them to a higher level of care with warm handoffs to behavioral health clinics, contract providers, or psychiatrists.

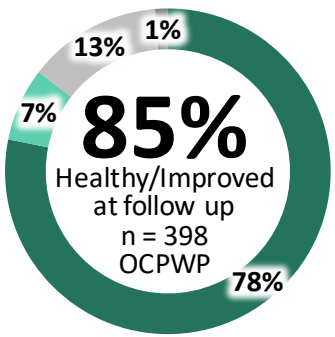
For parent participants with young children, the program also aims to prevent the development or worsening of mental health conditions by maintaining and/or strengthening the protective factor of effective parenting skills, which was assessed using the PARCA-SE. Across the four years, parents consistently reported increased levels of confidence in their parenting skills between intake and follow up. Thus, services appeared to be effective in maintaining and/or enhancing the protective factor related to parental self-efficacy among those parents in the at-risk families served in the program.



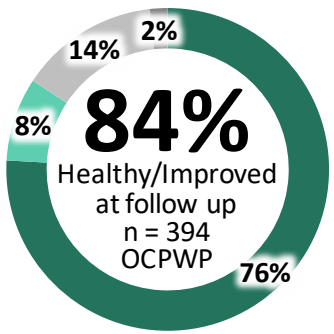
OC PWP: FY 2016-17



OC PWP: FY 2017-18



OC PWP: FY 2018-19



OC PWP: FY 2019-20

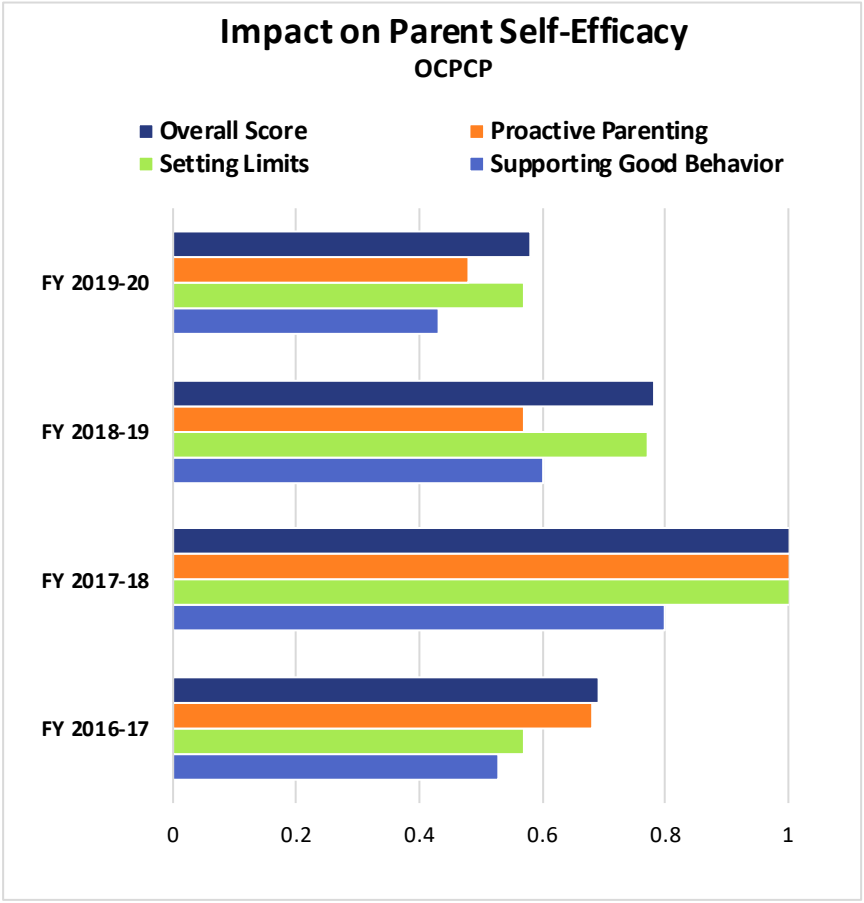
Healthy | Reliably Improved | Stable Distress Level | Reliably Worsened

CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

In FY 2019-20, OCPWP received an increase in referrals following implementation of the state law requiring practitioners who see women before and after pregnancy to screen for maternal mental health conditions. This necessitated the restructuring of the intake process. The program implemented 25 intake slots on a weekly basis which led to individuals being enrolled for program services more quickly thus decreasing the duration of untreated mental health conditions. Additionally, staff received formal training and post training consultation groups on the Mothers and Babies Course, an evidence-based curriculum focused on both the prevention and treatment of major depression during the prenatal and postpartum periods. This intervention is offered in both group and individual settings to enrolled participants. Furthermore, the program continues to make strides toward becoming more father-inclusive by employing a male provider to outreach and engage expectant and new fathers.

OCPWP continues to maintain its strong collaborative relationships with community partners and with the increase in referrals, the program required two mental health specialists to shift from their role as case carrying providers to Intake Coordinators (IC). As the IC's, they conduct screenings to determine if program referrals meet the basic criteria for suitability and, when appropriate, to immediately schedule an initial Intake session with a therapist to ensure timely access to care. This IC system improves overall efficiency as staff are simultaneously screening for all three specialty areas thus reducing the wait time and increasing linkage to the appropriate level of care.

Lastly, the COVID-19 pandemic transformed the program service provision from in-person care to virtual visits that include telehealth and telephonic services. Despite this, staff provided 4,498 face-to-face contacts and 3,456 telephonic correspondences.



REFERENCES

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

FY 2019-20: Baseline M=17.0, SD=2.35; Follow-up M=20.4, SD=4.45; t(4)=-1.20, p>.10; Cohen's d=0.54
FY 2018-19: Baseline M=26.7, SD=4.86; Follow-up M=28.2, SD=3.65; t(30)=1.94, p<.062; Cohen's d=0.40
FY 2017-18: Baseline M=28.6, SD=5.21; Follow-up M=28.9, SD=3.54; t(37)=0.52, p<.609; Cohen's d=0.09
FY 2016-17: Not adopted

PARCA-SE Supporting Good Behavior

FY 2019-20: Baseline M=5.7, SD=1.18; Follow-up M=6.1, SD=0.83; t(313)=-5.68, p<.001; Cohen's d=0.33
FY 2018-19: Baseline M=5.7, SD=1.02; Follow-up M=6.1, SD=0.84; t(278)=6.78, p<.001; Cohen's d=0.41
FY 2017-18: Baseline M=5.2, SD=1.29; Follow-up M=6.0, SD=0.90; t(126)=6.69, p<.001; Cohen's d=0.61
FY 2016-17: Not adopted

PARCA-SE Setting Limits

FY 2019-20: Baseline M=5.2, SD=1.31; Follow-up M=5.6, SD=1.07; t(313)=-6.54, p<.001; Cohen's d=0.37
FY 2018-19: Baseline M=5.2, SD=1.23; Follow-up M=5.7, SD=1.00; t(278)=7.41, p<.001; Cohen's d=0.45
FY 2017-18: Baseline M=4.8, SD=1.40; Follow-up M=5.6, SD=0.99; t(126)=7.50, p<.001; Cohen's d=0.69
FY 2016-17: Not adopted

PARCA-SE Proactive Parenting

FY 2019-20: Baseline M=5.3, SD=1.29; Follow-up M=5.8, SD=0.98; t(313)=-6.67, p<.001; Cohen's d=0.39
FY 2018-19: Baseline M=5.3, SD=1.24; Follow-up M=5.9, SD=0.99; t(278)=7.12, p<.001; Cohen's d=0.43
FY 2017-18: Baseline M=4.8, SD=1.50; Follow-up M=5.7, SD=1.03; t(126)=7.26, p<.001; Cohen's d=0.67
FY 2016-17: Not adopted

PARCA-SE Overall Score

FY 2019-20: Baseline M=5.4, SD=1.17; Follow-up M=5.8, SD=0.89; t(313)=-7.14, p<.001; Cohen's d=0.41
FY 2018-19: Baseline M=5.4, SD=1.07; Follow-up M=5.9, SD=0.88; t(278)=8.01, p<.001; Cohen's d=0.49
FY 2017-18: Baseline M=4.9, SD=1.33; Follow-up M=5.7, SD=0.90; t(126)=7.78, p<.001; Cohen's d=0.73
FY 2016-17: Not adopted

COMMUNITY IMPACT

Since inception of its respective services, OC Parent Wellness has worked with more than 3,992 new and expecting parents, 1,054 families referred by Child Protective Services/SSA, and 2,139 families with young children at risk of not being ready for school. Clinicians work directly with parents and caregivers and program staff provide consultation to various community partners and County agencies on the early signs of mental health symptoms, program eligibility and referral processes, thus increasing families' access to timely and appropriate behavioral health services.

Community Counseling & Supportive Services (PEI)

Community Counseling and Supportive Services (CCSS) serves residents of all ages who have, or are at risk of developing, a mild to moderate behavioral health condition and limited or no access to behavioral health services. The majority are uninsured or underinsured, monolingual Spanish speaking, and have a history of family or domestic violence and/or early childhood trauma. Beginning FY 2020-21, OC ACCEPT merged with CCSS and expanded its capacity to provide specialized expertise working with individuals identifying as Lesbian, Gay, Bisexual, Transgender, Intersex or Questioning (LGBTIQ), and the important people in their lives.

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

AGE RANGE

All Ages

PRIMARY LOCATION

Clinic

TARGET POPULATION

- ✓ At-Risk
- ✓ Mild-Moderate
- Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

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

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

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

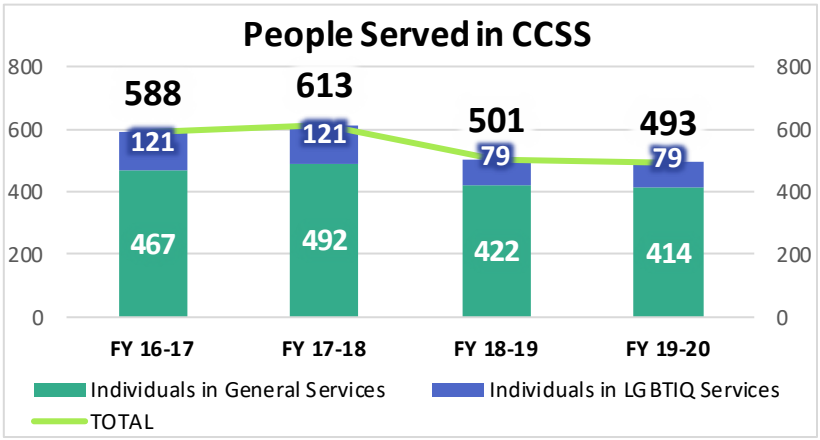
BUDGETS & PROJECTED #'s TO BE SERVED FROM 3YP

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

**No proposed changes to FY 2021-22*

SERVICES

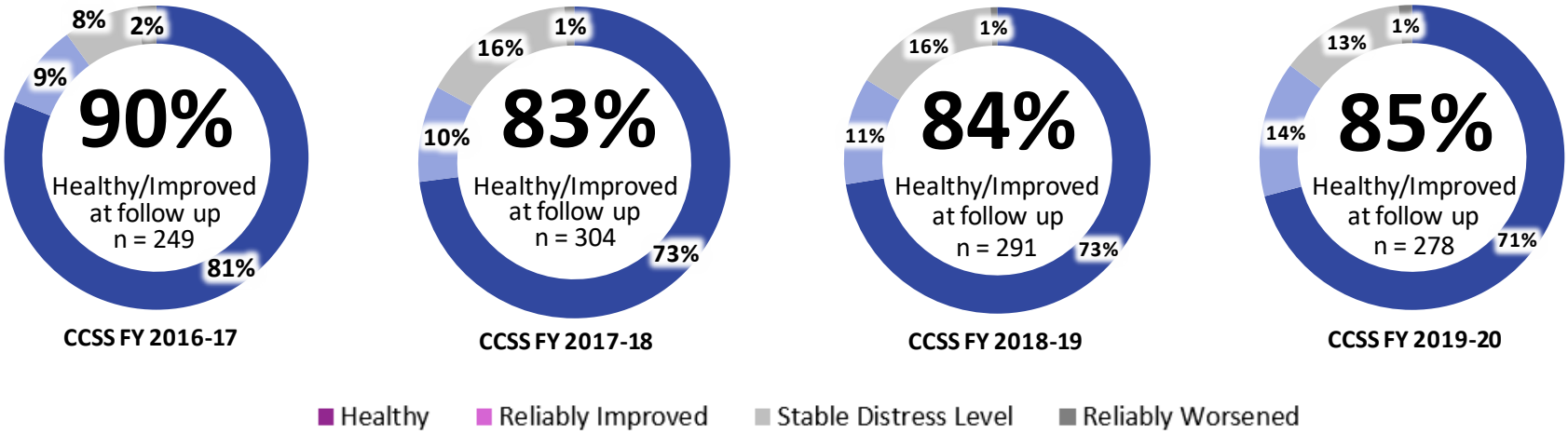
CCSS provides face-to-face individual and collateral counseling, groups (i.e., psychoeducational, skill-building, insight oriented, etc.), clinical case management, and referral and linkage to community services. Clinicians utilize evidence-based practices such as Eye Movement Desensitization and Reprocessing (EMDR), Motivational Interviewing (MI), Cognitive Behavioral Therapy (CBT) and Seeking Safety while working with program participants. In addition, peer specialists provide social, educational and vocational support and offer targeted case management to help individuals access needed resources or meet other goal-specific needs. Services are tailored to meet the age, developmental and cultural needs of each participant.



OUTCOMES

The program aims to measure reductions in, or prevention of, prolonged suffering through an age-appropriate form of the OQ® (YOQ® 30.2 for youth, OQ® 30.2 for adults). Participants completed the measure at intake, every three months of program participation, and at discharge. Scores were compared to the measure's clinical benchmarks to determine program effectiveness at improving symptoms and reducing prolonged suffering. This measure reflects cultural competence as it is available in all threshold languages and contains a wide range of symptoms, including somatic symptoms, which may be experienced and/or reported by people from different cultural backgrounds.

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



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

CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

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

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

COMMUNITY IMPACT

CCSS collaborates with community-based organizations to provide culturally responsive services to ethnic minorities, deaf-and-hard-of-hearing, and LGBTIQ communities. Since inception, the expanded program has provided services to more than 2,593 individuals, 510 of whom were part of its LGBTIQ service. Additionally, in FY 2019-20, 743 individuals (of 913 referred to the program), were screened by the Intake Coordinator. The Intake Coordinator position has reinforced the program's ability to accurately identify and enroll participants into services that fall within the mild to moderate spectrum. Conversely, participants presenting with higher severity symptoms are referred and linked to the appropriate level of care that addresses their specific need in a timely manner.

The expanded program has also provided valuable education and resources to various unserved and underserved populations with mental health needs to promote awareness of, and encourage use of, its services. In this FY, the program provided 26 community education presentations and trainings to over 386 attendees, raising awareness and reducing stigma about the LGBTIQ population.

Early Intervention Services for Older Adults (PEI)

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

AGE RANGE

Ages 50+

PRIMARY LOCATION

Field, Community

TARGET POPULATION

At-Risk, Mild-Moderate, Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

- ✔ Arabic
- ✔ Farsi
- ✔ Khmer
- ✔ Korean
- ✔ Mandarin
- ✔ Spanish
- TDD/CHAT
- ✔ Vietnamese
- Other:

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

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

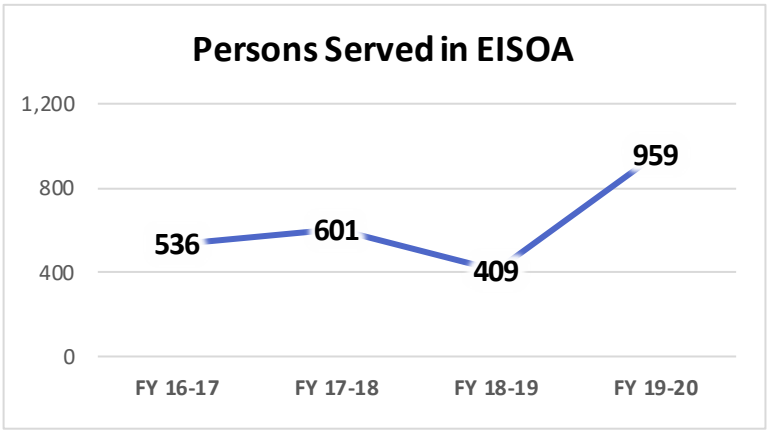
BUDGETS & PROJECTED #'s TO BE SERVED FROM 3YP

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$2,469,500	1,300
FY 2021-22*	$2,469,500	1,300
FY 2022-23	$1,469,500	1,300

**No proposed changes to FY 2021-22*

SERVICES

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

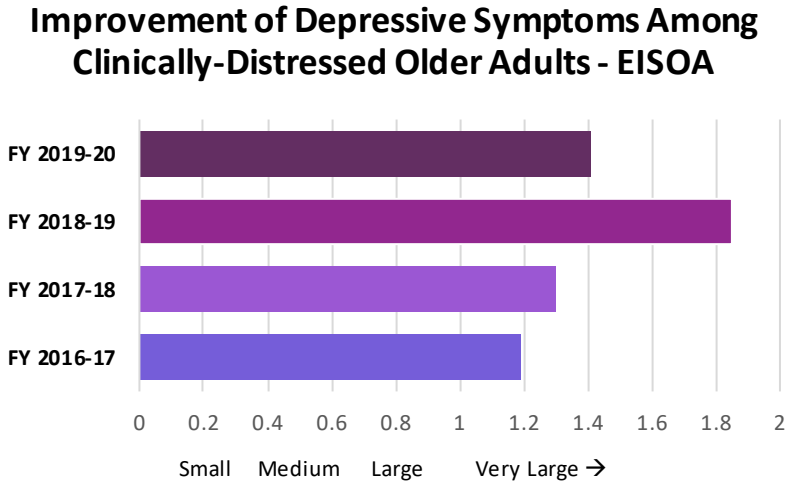


EISOA utilizes the evidence-based practice Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors) which employs a systematic, team-based approach to identifying and reducing the severity of depressive symptoms in older adults via case management, community linkages and behavioral activation services. To ensure fidelity, the program provides staff with comprehensive training on the Healthy IDEAS model, program goals and deliverables, evidence-based interventions, education on mental health and theories of aging, behavioral activation techniques, ethical and legal considerations, cultural competence and humility, field safety, assessment tools and outcome measures, care planning, and effective communication strategies when working with older adults. In addition, the program conducts staff development workshops and in-service trainings.

OUTCOMES

Larger numbers of older adults were served in FY 2019-20 relative to previous years due to an increase in funding allocation for these services. The dip in older adults served in FY 2018-19 was due to a change in the program's admission and discharge criteria that occurred in the second half of FY 2017-18 and affected participant recruitment and engagement the following fiscal year.

Mental health functioning was assessed through the Patient Health Questionnaire (PHQ-9), a commonly used measure of depressive symptom severity. Measures were completed at intake, every three months and at discharge. Change in scores among participants who scored in the clinical range at intake (i.e., score > 10) was evaluated to assess the program's effectiveness at reducing depression symptoms. Clinically distressed older adults have consistently reported substantial declines in depressive services while enrolled in program services. These findings suggest that the program is effective at reducing prolonged suffering and/or preventing mental health symptoms from becoming severe and persistent.



CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

Due to the increased risk that COVID-19 pandemic posed for the older adult population, additional supports were provided through CARES Act funding during the 2020 calendar year. Rental assistance and essential items such as masks, toiletries, cleaning supplies, nutritional drinks, clothing, prepared meals, fresh food and pet supplies were delivered, allowing participants to remain safely in their homes while still ensuring their basic needs were met. Program staff remained in contact

with the participants telephonically to provide emotional support during this time, and computer devices, hot spots/Wi-Fi and training were provided to those who did not have access to technology.

Prior to the COVID-19 pandemic, transportation had been identified as a barrier to accessing services as the older adults served tend to have limited income and some are unable to pay for public transportation. To overcome this barrier, most program services are provided in the community (i.e., homes, apartment complexes, senior centers, etc.). To encourage self-reliance, the program provided bus vouchers and taught participants to utilize the bus system. For older adults who were hesitant to take the bus, staff traveled with them and taught them how to ride a bus, or seasoned bus riders were paired with new bus riders. Program staff also facilitated carpools between participants. Finally, to help alleviate remaining transportation barriers, EISOA expanded transportation services for its participants with time-limited, PEI carryover funds.

REFERENCE NOTES

FY 2019-20: Baseline: M=13.7, SD=3.45; Follow-up M=6.7, SD=4.75; t(226)=20.84, p<.001; Cohen's d=1.41
FY 2018-19: Baseline: M=14.7, SD=3.9; Follow-up M=5.8, SD=3.9; t(59)=14.36, p<.001; Cohen's d=1.85
FY 2017-18: Baseline: M=14.5, SD=3.6; Follow-up M=7.9, SD=5.1; t(74)=10.96, p<.001; Cohen's d=1.30
FY 2016-17: Baseline: M=14.3, SD=3.7; Follow-up M=8.6, SD=4.4; t(115)=12.68, p < .001; Cohen's d=1.19

COMMUNITY IMPACT

The program has experienced positive participant outcomes that include improved mental health status, enhanced quality of life, increased social functioning, more effective management of behavioral health and chronic conditions, enhanced ability to live independently, increased community involvement and development of a supportive network. By providing services in Spanish, Vietnamese, Korean, Khmer, Mandarin, Arabic and Farsi, the program is able to reach, serve and impact non-English speaking older adults through its self-stigma reduction activities, effective outreach and early intervention services.

OC4Vets (PEI)

OC4Vets are veteran-focused early intervention programs that support targeted subpopulations within the Orange County veteran community: adult veterans and military connected individuals, veterans engaged with County Courts, veteran college students, and military connected families with children under the age of 18 (the latter of which used to be the standalone Innovation project, Behavioral Health Services for Military Families). The OC4Vets, County- and contract-operated, programs serve Orange County veterans and families who currently or previously served in the United States Armed Forces, regardless of the branch, component, era, location(s) or characterization of discharge from their service. Referrals into the programs come from established collaborative relationships with outside community programs supporting Orange County veterans, veteran groups within the county, the Veterans Affairs Administration, Veterans Resource Centers at local community colleges, the Veterans Service Office (VSO), and directly from the veterans and family members looking for support.

AGE RANGE

All Ages

PRIMARY LOCATION

Field | Community

TARGET POPULATION

At-Risk | Mild-Moderate | Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

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

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

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

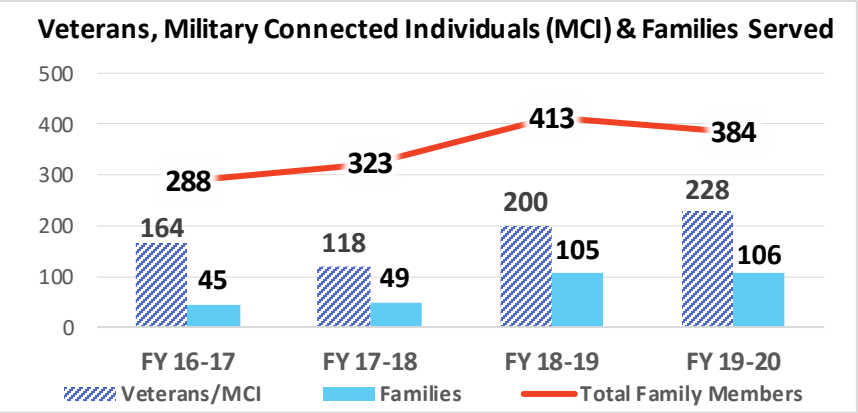
BUDGETS & PROJECTED #'s TO BE SERVED FROM 3YP

Fiscal Year	Program Budget	Unduplicated # to be Served*
FY 2020-21	$1,695,957	519
FY 2021-22	$2,400,000	530
FY 2022-23	$2,400,000	542

**No proposed changes to FY 2021-22 budget or numbers served other than adding BHS for Military Families budget and services into OC4Vets program*

SERVICES

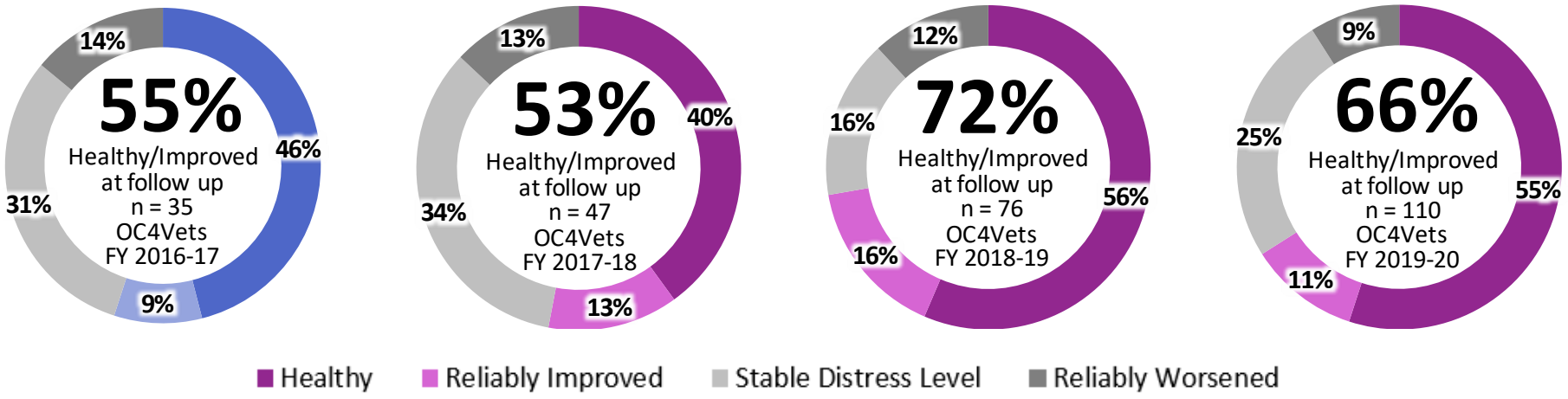
OC4Vets has five distinct service delivery options for the veteran community, each with a distinct referral path that offers a wide range of services and supports for veterans, military-connected individuals and their families. The array of services are tailored to meet the needs of the individuals and/or the families and can include peer support, community outreach, housing navigation and assistance, employment support, behavioral health screening and assessment, referral and linkages to community and behavioral health resources, clinical case management, individual counseling, family counseling, group counseling, domestic violence support, workshops and educational support groups for families, and legal support and advocacy services. Each referral path is described in more detail below:



- **Referral Path 1:** Adult veterans who have not yet integrated into the Department of Veterans Affairs (VA) system, do not have access to the VA system, are unaware of their need for behavioral health services, or are seeking alternative services to the VA system.
- **Referral Path 2:** Veterans and military connected adults who would benefit from partnering with peer navigators. Peer navigators have an understanding of military culture and are veterans themselves who work with program participants to identify their behavioral health needs, overcome barriers that may limit access to care and connect to on-going treatment.
- **Referral Path 3:** Veterans and military connected adults engaged with the Orange County Courts (i.e., Veterans Treatment, Military Diversion, Family), many of whom exhibit mental health symptoms related to trauma exposure.
- **Referral Path 4:** Military connected students in local community colleges who would benefit from a military connected behavioral health clinician located on campus. The clinician also provides outreach and engagement on Orange County campuses using veteran-specific events and support groups to encourage discussion of barriers to a successful transition to college and civilian life. Services are provided on campus, in areas that are comfortable and accessible to the veterans, such as the campus Veterans Resource Center and virtually for groups and individual services.
- **Referral Path 5:** Military connected families who would benefit from working with trained clinicians and peer navigators with experience and knowledge of military culture to address mental health concerns encountered by veterans that may affect the whole family, such as Post Traumatic Stress Disorder (PTSD), traumatic brain injury (TBI), substance use and other conditions. Services are inclusive of the entire family unit, which allows for more effective family communication, functioning and support. Services can be provided via telehealth.

OUTCOMES

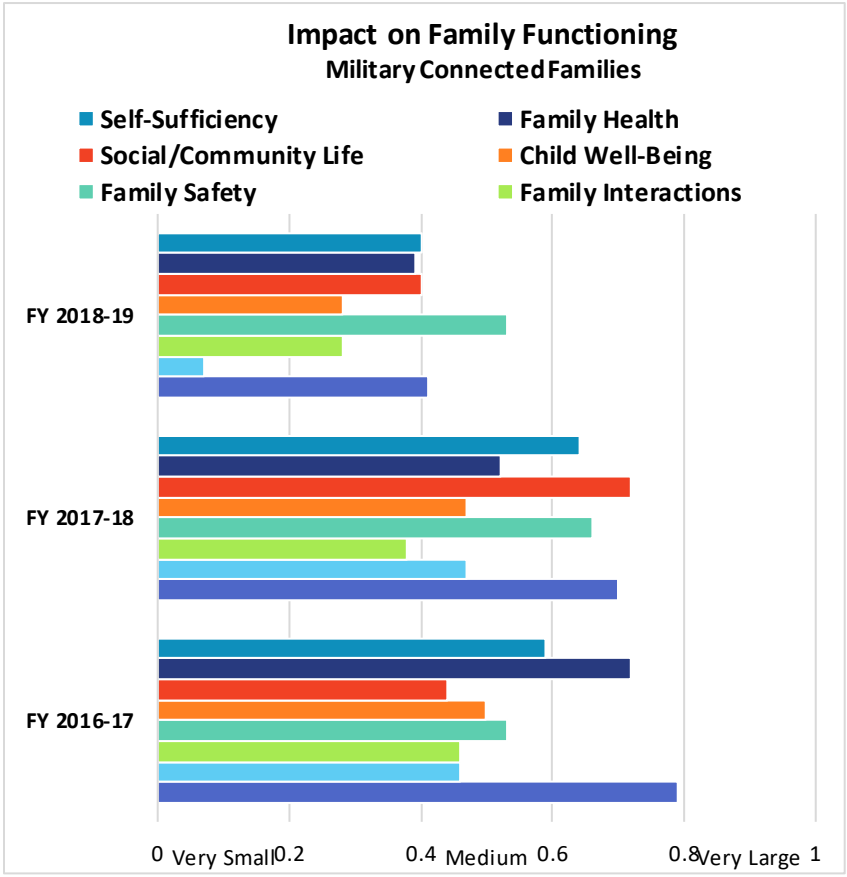
Depending on a participant's age, they completed the age-appropriate OQ at intake, every one to three months of program participation, and at discharge (YOQ® 30.2 for youth, OQ® 30.2 or OQ® 45.2 for adults). Scores were compared to the measure's clinical benchmarks to determine program effectiveness at reducing prolonged suffering. Because the OQ® is a measure of symptom distress and a tool to help inform care planning, beginning in FY 2018-19 the programs began to administer the OQ® to participants who were enrolled in individual counseling. Additionally, since some programs provide clinical interventions to single individuals within a family unit or the family as a whole, the OQ® was administered to participants depending on which family members were identified as the primary participant(s).



After noting the low completion rate of measures in FY 2016-17, OC Health Care Agency (HCA) staff provided guidance and course corrective actions to providers to ensure data were collected reliably and consistently. Steps have been taken to encourage more timely completion of forms, including providing training on administration timing and procedures, how to incorporate the results into care planning, and continuous support and follow up. As a result, an increasing number of completed forms have been returned over the past few years (i.e., 35, 47, 76 and 110 from FY 2016-17 through FY 2019-20, respectively).

Overall results from the OQ® suggest that OC4Vets services help prevent participants' symptoms from becoming severe and disabling, with the proportion of OC4Vets participants reporting a healthy or reliably improved level of distress at follow up increased from 40-46% in FYs 2016-17 and 2017-18 to 55-56% in the past two fiscal years. Moreover, this is largely accounted for by more veterans enrolled in community-based programs reporting healthy distress levels at follow up (64% community-based veterans compared to 26% of college student veterans).

Before FY 2019-20, the onset and/or worsening of mental health conditions specifically among military connected families was assessed using the North Carolina Family Assessment Scale (NCFAS). Ratings were made at intake and program exit, and the difference in scores was used to analyze whether there was improvement in, or maintenance of, healthy family functioning. Results were reported according to the calculated effect size, which reflects, in part, the extent to which a change in scores over time was clinically meaningful for the families served in the program. Depending on the construct measured, program services were associated with small to medium/large improvements, with larger improvements generally noted in environment (e.g., housing



stability, personal hygiene), family safety, self-sufficiency (e.g., family income, food), and family health (e.g., physical and mental health), and greater effects observed in FY 2016-17 and FY 2017-18 compared to FY 2018-19. The difference in effects observed in FY 2018-19 compared to previous fiscal years may be due to capacity issues, including understaffing within agencies and staff turnover, as well as reduced leverage funding from partners, resulting in increased referrals outside of the project to link families to needed support. Beginning in FY 2019-20, military connected families began to complete the OQ® to 1) standardize data collection and reporting across program referral paths and 2) allow for more direct assessment of clinical improvement given that this is an early intervention program.

For program participants who primarily receive case management rather than therapy services, information on referrals and linkage to needed resources is provided in the "Summary of MHSA Strategies used by Early Intervention Programs" at the end of this section.

CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

As noted above, the programs are working to improve their OQ administration procedures and use as a clinical tool. They are also implementing changes with the hopes of expanding their reach and serving larger numbers of veterans in Orange County. For example, in the first half of the FY, the County worked on streamlining intake procedures, engaging participants through phone check-ins, coordinating peer follow-ups, increasing community partnerships, coordinating with Veterans Affairs services, and increasing outreach efforts to engage those who are more difficult to reach.

The military culture tends to enhance the stigma associated with seeking support and their cultural beliefs often deter veterans from asking for help. In many cases, veterans do not seek out help until their behavioral health conditions have severely affected their ability to function at work, school or within their relationships. To address these barriers, the program is designed to support timely access to services by co-locating services in non-mental health settings already frequented by veterans (i.e., college campuses, VSO, Court).

Although providers experienced some barriers to success as a result of COVID-19, they were able to adjust their service delivery models rapidly to help overcome these barriers. The primary barrier was the closure of the community settings in which they typically engaged with the veterans and family members. This eliminated the opportunity for the programs to outreach to and provide services for veterans as had been done in the past. Most providers were also unable to offer face-to-face therapy sessions for student participants. To overcome these obstacles, Outside the Wire worked with the colleges to help develop new strategies to reach out to veterans for nearly half of the FY. To overcome the barriers the veterans faced in accessing care, the programs transitioned to a telehealth model of service delivery. While they saw a reduction in referrals and enrollments and a significant reduction in group therapy attendance, providers were able to continue providing individual and family therapy to veterans and started to offer virtual outreach events. The programs also saw an increase in the clinical needs of many enrolled participants related to COVID-19 stressors and impacts; as there was a reduction in new enrollments, providers were able to increase the frequency and duration of treatment for participants to ensure that the intensity of treatment met the increased need for intervention.

COMMUNITY IMPACT

OC4Vets has provided services to more than 840 veterans and military connected adults in the community since July 2012, more than 340 veterans in college since its inception in October 2011, and more than 1,206 individual family participants since July 2015. Program staff has developed strong collaborations with a number of agencies that serve Orange County's veteran population, including the Veteran's Service Office with OC Community Resources (OCCR), Workforce Investment Office with OCCR, Office on Aging, Veterans Affairs Administration, the Tierney Center at Goodwill, and the Los Alamitos Joint Forces Training Base OC Superior Courts, OC Family Court, Veterans Resource Centers at local community colleges, and Orange County schools to best meet the needs of Orange County's veterans and their families.

REFERENCE NOTES

NCFAS

Environment:
FY 2019-20: Baseline M=27.3, SD=3.7; Follow-up M=29.1, SD=3.5; t(52)=3.9, p<.001; Cohen's d=0.54
FY 2018-19: Baseline M=2.9, SD=.79; Follow-up M=2.6, SD=.68; t(31)=2.33, p=.03; Cohen's d=0.41
FY 2017-18: Baseline M=2.9, SD=1.13; Follow-up M=2.3, SD=.85; t(39)=4.21, p<.001; Cohen's d=0.69
FY 2016-17: Baseline M=2.9, SD=1.1; Follow-up M=2.1, SD=.90; t(48)=5.16, p<.001; Cohen's d=0.74

Parental Capabilities:
FY 2019-20: Baseline M=27.2, SD=2.4; Follow-up M=33.2, SD=3.3; t(54)=16.5, p<.001; Cohen's d=2.31
FY 2018-19: Baseline M=2.6, SD=.45; Follow-up M=2.6, SD=.57; t(31)=.33, p=.75; Cohen's d=0.07
FY 2017-18: Baseline M=2.7, SD=.73; Follow-up M=2.4, SD=.84; t(39)=2.67, p=.01; Cohen's d=0.43
FY 2016-17: Baseline M=2.6, SD=.73; Follow-up M=2.3, SD=.84; t(48)=3.25, p=.002; Cohen's d=0.48

Family Interactions:
FY 2019-20: Baseline M=31.1, SD=3.8; Follow-up M=32.2, SD=3.36; t(54)=2.8, p<.008; Cohen's d=0.37
FY 2018-19: Baseline M=3.2, SD=.52; Follow-up M=3.0, SD=.67; t(31)=1.56, p=.13; Cohen's d=0.28
FY 2017-18: Baseline M=3.3, SD=.87; Follow-up M=3.1, SD=.95; t(39)=2.13, p=.04; Cohen's d=0.34
FY 2016-17: Baseline M=2.9, SD=.87; Follow-up M=2.5, SD=.95; t(48)=3.0, p=.01; Cohen's d=0.44

Family Safety:
FY 2019-20: Baseline M=32.2, SD=3.8; Follow-up M=32.8, SD=3.7; t(54)=1.2, p<.228; Cohen's d=0.16
FY 2018-19: Baseline M=2.7, SD=.65; Follow-up M=2.4, SD=.70; t(31)=2.98, p=.006; Cohen's d=0.53
FY 2017-18: Baseline M=2.8, SD=.79; Follow-up M=2.4, SD=.93; t(39)=4.01, p<.001; Cohen's d=0.64
FY 2016-17: Baseline M=2.6, SD=.79; Follow-up M=2.2, SD=.93; t(48)=4.16, p<.001; Cohen's d=0.60

Child Well-Being:
FY 2019-20: Baseline M=18.2, SD=2.0; Follow-up M=14.0, SD=1.8; t(54)=-15.7, p<.001; Cohen's d=2.12
FY 2018-19: Baseline M=3.0, SD=.50; Follow-up M=2.8, SD=.44; t(30)=1.57, p=.13; Cohen's d=0.28
FY 2017-18: Baseline M=3.0, SD=.50; Follow-up M=2.9, SD=.61; t(39)=1.98, p=.06; Cohen's d=0.32
FY 2016-17: Baseline M=2.6, SD=.50; Follow-up M=2.3, SD=.61; t(48)=3.56, p=.001; Cohen's d=0.51

Social/Community Life:
FY 2019-20: Baseline M=22.8, SD=2.5; Follow-up M=23.2, SD=2.6; t(54)=1.6, p<.127; Cohen's d=0.21
FY 2018-19: Baseline M=3.0, SD=.57; Follow-up M=2.9, SD=.63; t(31)=1.09, p=.29; Cohen's d=0.20
FY 2017-18: Baseline M=2.9, SD=.56; Follow-up M=2.7, SD=.69; t(39)=1.75, p=.09; Cohen's d=0.28
FY 2016-17: Baseline M=2.7, SD=.56; Follow-up M=2.4, SD=.69; t(48)=3.08, p=.003; Cohen's d=0.44

Self-Sufficiency:
FY 2019-20: Baseline M=21.9, SD=2.9; Follow-up M=22.9, SD=2.9; t(54)=2.0, p<.004; Cohen's d=0.41
FY 2018-19: Baseline M=3.1, SD=.93; Follow-up M=2.8, SD=.85; t(31)=2.24, p=.03; Cohen's d=0.40
FY 2017-18: Baseline M=3.6, SD=1.0; Follow-up M=3.1, SD=1.1; t(39)=4.02, p<.001; Cohen's d=0.64
FY 2016-17: Baseline M=3.3, SD=1.0; Follow-up M=2.8, SD=1.1; t(48)=4.15, p<.001; Cohen's d=0.59

Family Health:
FY 2019-20: Baseline M=30.4, SD=2.9; Follow-up M=32.2, SD=2.9; t(54)=5.1, p<.001; Cohen's d=0.69

FY 2018-19: Baseline M=3.1, SD=.39; Follow-up M=2.9, SD=.54; t(31)=2.18, p=.04; Cohen's d=0.39
FY 2017-18: Baseline M=3.0, SD=.53; Follow-up M=2.8, SD=.60; t(39)=3.65, p=.001; Cohen's d=0.59
FY 2016-17: Baseline M=2.9, SD=.54; Follow-up M=2.6, SD=.60; t(48)=4.03, p<.001; Cohen's d=0.58

Summary of MHSA Strategies Used by Early Intervention Programs

STRATEGIES TO PROMOTE RECOVERY/RESILIENCE

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

STRATEGIES TO REDUCE STIGMA AND DISCRIMINATION

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

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

Similarly, students often face parent or peer discouragement to engage in program services (stigma), lack of willingness or fear of participation. Program staff work closely with the school administrators and counselors through weekly meetings to assist in creating a school climate that promotes the benefits of seeking help and accessing counseling, providing psychoeducation to promote acceptance, and promoting school bonding to keep students from feeling marginalized. In addition, program staff receive regular in-service training to increase their understanding of the needs, values and challenges faced by the program population so that they are better able to serve them. CCSS staff with expertise also provide educational and program promotion presentations about the needs, challenges and issues faced by the LGBTIQ population to reduce stigma and discrimination by raising awareness of the various barriers and issues this population faces. Presentations are provided to behavioral health providers, school staff/faculty, public health staff, social services staff and other community members.

The program employs bilingual and bicultural staff to provide services in a culturally sensitive manner. As mentioned above, the program has also partnered with community agencies that work with unserved populations who might be reluctant or unwilling to seek out treatment at a behavioral health clinic but will engage in services in non-behavioral health settings.

STRATEGIES TO INCREASE ACCESS TO SERVICES: TIMELY ACCESS FOR UNDERSERVED POPULATIONS AND LINKAGE TO TREATMENT

The providers for the four Early Intervention Outpatient Program categories have expertise in engaging and working with distinct underserved populations, including at risk children, families or older adults, LGBTIQ individuals, ethnic/monolingual communities, veterans and youth experiencing early onset of psychiatric illness. Despite their varied backgrounds and unique experiences, participants across these programs face similar barriers to engaging in behavioral health services.

These include mental health stigma, lack of support from family or others to seek mental health services, lack of transportation or childcare, and/or an inability to take time off work during traditional business hours for appointments.

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

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

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

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

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

	FY 18-19	37	24	Behavioral Health Outpatient Services; residential treatment; other PEI programs; resources; information and referral resources; legal services and advocacy; employment services and resources; recreational activities; special needs and disability services
	FY 19-20	25	13	
Early Intervention Program: OC4Vets		**Linkage Metrics**		
		# Referrals	**# Linkages**	**Types of Linkages**
Veterans/Military Connected Adult referral path	**FY 16/17**	363	216	Housing resources, advocacy; behavioral health outpatient services; employment services, resources; veteran entitlement programs; transportation services; other PEI programs; financial assistance; legal services, advocacy; food and nutrition assistance; health care services; behavioral health crisis response; senior services; health education, disease prevention, wellness, and physical fitness; recreation; family support services
	FY 17-18	155	96	
	FY 18-19	305	136	
	FY 19-20	341	122	
College Veterans referral path*	**FY 16-17**	133	83	Transportation services; food & nutrition assistance; housing resources, advocacy; employment services, resources; adult education; legal services, advocacy; behavioral health crisis response; behavioral health outpatient services; financial services; PEI programs; health care services; health education, disease prevention, wellness & physical fitness; special needs, disability services; veteran entitlement programs
	FY 17-18	249	10	
	FY 18-19	85	58	
	FY 19-20	196	185	
Military Families referral path	**FY 16-17**	217	106	Basic needs (i.e., food, clothing); housing; mental health; early intervention services; domestic violence prevention; legal services; financial services; employment services; education benefits
	FY 17-18	278	157	
	FY 18-19	300	168	
	FY 19-20	405	238	
BH Peer Support referral path	**FY 19-20**	1,726	458	Recovery support services; housing assistance; outpatient behavioral health

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

Early Intervention Treatment Programs*	**Target Population Specialization/Focus**						
	Children/ Youth	**Parent/ Families**	**Adults**	**Older Adults**	**Trauma-Exposed Individuals**	**LGBTIQ**	**Monolingual/ Ethnic Communities**
CCSS	**X**	**X**	**X**	**X**	**X**	**X**	**X**
School-Based Mental Health Services	**X**	**X**			**X**		**X**
Early Intervention Services for Older Adults		**X**		**X**	**X**		**X**
OC Parent Wellness Program	**X**	**X**	**X**		**X**		**X**
First Onset of Psychiatric Illness (OCCREW)	**X**	**X**			**X**		**X**
OC4Vets	**X**	**X**	**X**		**X**		

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

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

Children and Youth Clinic Services (CSS)

The **Children and Youth Clinic Services** program serves youth under age 21 who meet the following eligibility criteria and their families/caregivers:

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

Youth can be referred by community agencies, other behavioral health providers, pediatricians, SSA, school personnel, general community, families, etc.

AGE RANGE

Ages 0-21

PRIMARY LOCATION

Clinic

TARGET POPULATION

At-Risk | Mild-Moderate | Severe

Language CAPACITY OF DIRECT SERVICE PROVIDERS

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

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	Gender	%	Race/Ethnicity	%
0-15	76	Female	35	African American/Black	8
16-25	24	Male	65	American Indian/Alaskan Native	1
26-59	-	Transgender	-	Asian/Pacific Islander	5
60+	-	Genderqueer	-	Caucasian/White	21
		Questioning/Unsure	-	Latino/Hispanic	64
		Another	-	Middle Eastern/North African	-
				Another	1

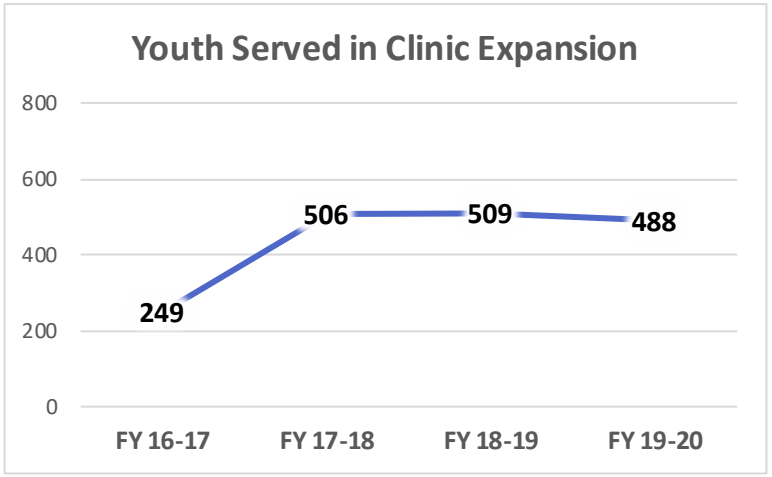
BUDGETS & PROJECTED #'s TO BE SERVED FROM 3YP

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$2,500,000	400
FY 2021-22*	$2,500,000	500
FY 2022-23	$3,000,000	500

**Proposed decrease for FY 2021-22 budget to adjust for delayed program start up due to COVID-19 and increased youth served based on historical trends.*

SERVICES

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



OUTCOMES

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

CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

The Children and Youth Expansion Services program will face a variety of challenges in FY 21-22. Increased incidents of depression and anxiety are being identified by providers at all the clinics throughout Orange County. As children and youth deal with the adverse impact of the COVID –19 pandemic, providers are seeing more mental health problems with high acuity requiring more intensive levels of intervention. Overcoming barriers to access that children and their parents face such as childcare, public transportation, unemployment, and hybrid school schedules will be of paramount importance to the program. Some of the solutions providers have developed include implementation of audio/video technology to provide telehealth services for children and their families who cannot, or who do not yet feel safe to receive services in the clinics. Another solution providers are using is to make changes to both clinic procedures and the physical environment that allows for adequate social distancing, screening for health symptoms, and increased outreach to clients by providing resource information on children's mental health and daily living needs such as where and how to obtain vaccinations, transportation, housing, and food.

COMMUNITY IMPACT

Where possible, MHSA funds will act as a match to draw down Federal Financial Participation (FFP) funds and increase the number of youth who can be served through this program. Similarly, HCA will work with the Orange County Department of Education (OCDE) and local school districts to identify Local Control and Accountability Plan (LCAP) funds that can be used to leverage FFP and increase the number of students who can be served from school districts that contribute dollars. Because this partnership is new, planning for expansion of student-focused services will include development of MOUs, data metrics and data-sharing agreements, referral procedures, etc., with the goal of launching services as soon as practicable in FY 2021-22, depending on the impact of COVID-19. The program, while operating as the Youth Core Services Field-Based track, provided services to more than 1,700 youth since its inception in March 2016.

Children and Youth Co-Occurring Medical and Mental Health Clinic (CSS)

The target population for the **Children and Youth Co-Occurring Medical and Mental Health Clinic** is youth through age 20 who are being seen primarily by Oncology, Endocrinology and Neurology services at a local hospital. Youth with severe eating disorders who are at risk of life-threatening physical deterioration are also served in this program. Parents and siblings play an integral role in the treatment process, given the disruption to the family structure when the survival of one family member becomes the family's main focus. Youth are referred to this program by physicians within the local children's hospital. Many of these children and youth are Medi-Cal beneficiaries with MHSA funds serving as a match to draw down federal funds.

AGE RANGE

Ages 0-20

PRIMARY LOCATION

Field | Community | Clinic

TARGET POPULATION

At-Risk | Mild-Moderate | Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

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

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	Gender	%	Race/Ethnicity	%
0-15	47	Female	62	African American/Black	1
16-25	53	Male	37	American Indian/Alaskan Native	1
26-59	-	Transgender	1	Asian/Pacific Islander	8
60+	-	Genderqueer	-	Caucasian/White	19
		Questioning/Unsure	-	Latino/Hispanic	66
		Another	-	Middle Eastern/North African	1
				Another	4

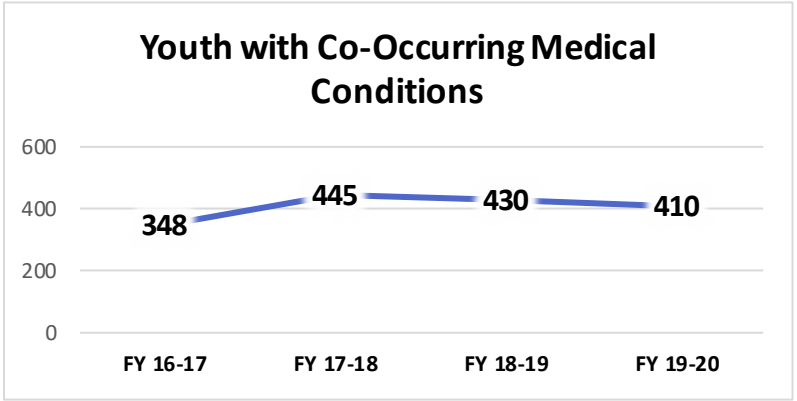
BUDGETS & PROJECTED #'s TO BE SERVED FROM 3YP

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$1,000,000	525
FY 2021-22*	$1,000,000	550
FY 2022-23	$1,000,000	600

**No proposed changes for FY 2021-22*

SERVICES

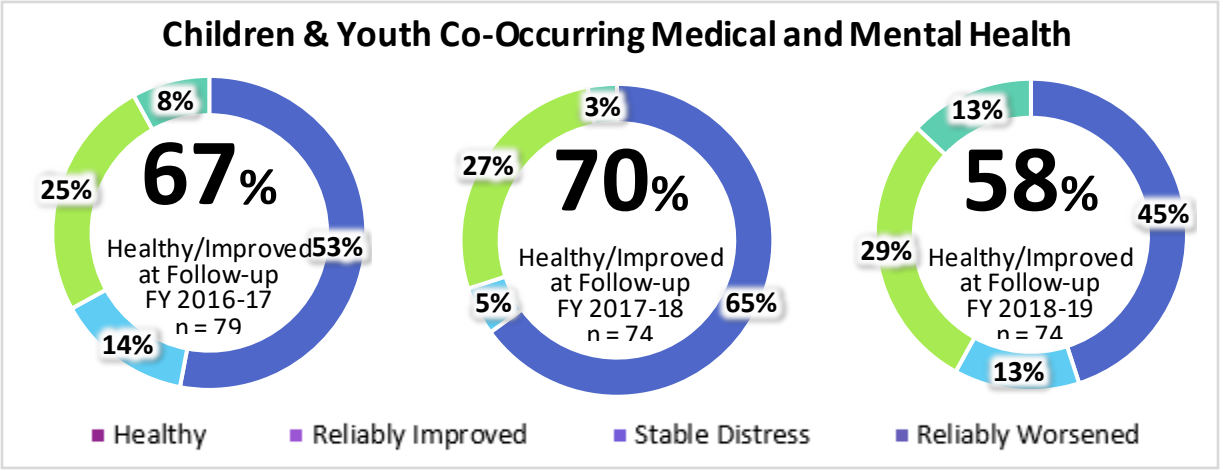
This program provides individual and family outpatient therapy, case management, limited psychological testing and medication management, if needed. A variety of evidence-based and best practices are provided to meet the needs of the youth, with some of the more common clinical interventions including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



Clinicians regularly collaborate with other agencies and community groups to provide the support and services needed to treat a child's mental health condition and improve their psychosocial functioning. Some examples include collaboration with wraparound services for youth who have been removed from their family's care due to medical non-adherence (neglect); collaboration and communication with FSPs serving the program's children who are at risk of homelessness or are presenting with early signs of psychosis; and connecting children to additional services such as Therapeutic Behavioral Services (TBS) to provide intensive short term interventions (e.g., in home meal coaching for those with eating disorders). Program clinicians also have the unique opportunity to communicate directly and collaborate closely with the local children's hospital medical teams so that care can be coordinated and consistent across disciplines.

OUTCOMES

During the program's first year of implementation in FY 2016-17, it was determined that the outcome measure initially selected (PROMIS Pediatric) was not adequately detecting mental health symptoms in this population. As a result, the measure was discontinued and replaced with the YOQ 2.0. Individuals completed the measure at intake, every 3 months of program participation and at discharge, and participants' scores were compared to the measure's clinical benchmarks to determine program effectiveness at improving symptoms.



Overall, the program's services appear to be associated with preventing symptoms of mental illness from becoming severe and disabling and with meaningfully reducing suffering among those who report clinically elevated distress during program enrollment. However, in FY 2019-20, the proportion of youth who reported a healthy or reliably improved level of distress at follow up decreased, and the proportion of those reporting a reliable worsening of symptoms increased, relative to prior fiscal years. The HCA will continue to monitor program performance over time to note trends and patterns.

CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

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

Beginning in March 2020, the program was faced with the COVID-19 Public Health emergency and needed to adapt the in-person treatment model to ensure safety requirements were met. The shift was made to providing services in a telehealth format which allowed the program to continue to provide services for their clients. The program noted increased engagement for some families, saving them travel time to the program which could often take three hours via public transportation. Some challenges were experienced with younger participants around engagement and a noted decrease in the length of sessions provided via telehealth. The program has been exploring new ways to engage participants through the telehealth format.

COMMUNITY IMPACT

The program has already provided services to more than 785 youth and their families since its inception in July 2015, thus underscoring the need for these specialized services. Because the program is located on the medical campus, program staff has the opportunity to work directly with, and educate the medical team about, the effects of the child's mental health condition and how they can best support the child and their family in their overall recovery rather than focusing exclusively on medical outcomes.

Services for the Short-Term Residential Therapeutic Program (CSS)

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

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

AGE RANGE

Ages 0-21

PRIMARY LOCATION

Residential

TARGET POPULATION

At-Risk | Mild-Moderate | Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

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

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	Gender	%	Race/Ethnicity	%
0-15	25	Female	62	African American/Black	15
16-25	75	Male	36	American Indian/Alaskan Native	-
26-59	-	Transgender	2	Asian/Pacific Islander	5
60+	-	Genderqueer	-	Caucasian/White	29
		Questioning/Unsure	-	Latino/Hispanic	50
		Another	-	Middle Eastern/North African	1
				Another	

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

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$6,500,000	200
FY 2021-22*	$7,000,000	200
FY 2022-23	$8,000,000	200

**Proposed, time-limited decrease for FY 2021-22*

SERVICES

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

- Specialty Mental Health Services under the Medi-Cal Early and Periodic Screening, Diagnosis and Treatment program,
- Transition services to support children, youth and their families during changes in placement,
- Educational and physical, behavioral and mental health supports, including extra-curricular activities and social supports,
- Activities designed to support transitional-age youth and non-minor dependents in achieving a successful adulthood; and
- Services to achieve permanency, including supporting efforts for adoption, reunification, or guardianship and efforts to maintain or establish relationships with family members, tribes, or others important to the child or youth, as appropriate.

OUTCOMES

The STRTP facilities have been in program implementation so there are no outcomes to report at this time. Performance outcomes will be reported in future Plan Updates.

Outpatient Recovery (CSS)

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

AGE RANGE

Ages 18+

PRIMARY LOCATION

Clinic | Field

TARGET POPULATION

At-Risk | Mild-Moderate | Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

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

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	Gender	%	Race/Ethnicity	%
0-15	-	Female	53	African American/Black	4
16-25	6	Male	47	American Indian/Alaskan Native	1
26-59	83	Transgender	-	Asian/Pacific Islander	13
60+	11	Genderqueer	-	Caucasian/White	32
		Questioning/Unsure	-	Latino/Hispanic	42
		Another	-	Middle Eastern/North African	1
				Another	7

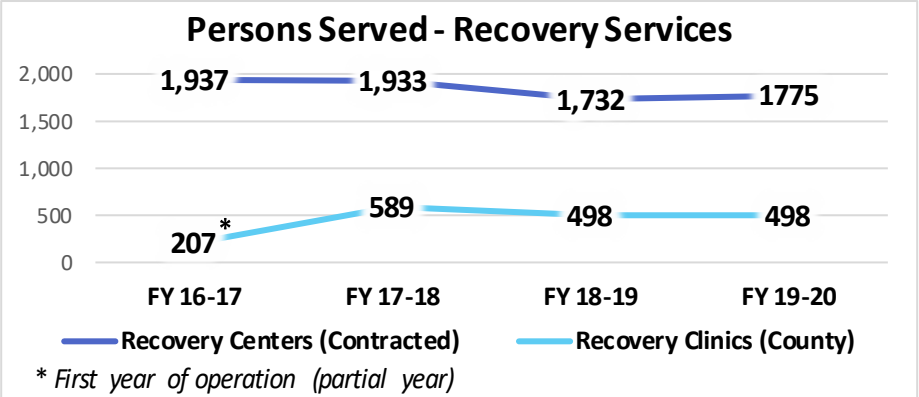
BUDGETS & PROJECTED #'s TO BE SERVED FROM 3YP

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$6,158,531	2,500
FY 2021-22*	$5,858,531	2,500
FY 2022-23	$6,158,531	2,500

**Proposed decrease for FY 2021-22 from right-sizing*

SERVICES

The Recovery Clinics/Centers provide case management, medication services and individual and group counseling, crisis intervention, educational and vocational services, and peer support activities. The primary objectives of the programs are to help adults improve engagement in the community, build a social support network, increase employment and/or volunteer activity, and link to lower levels of care. As participants achieve their care plan goals and maintain psychiatric stability, they are transitioned to a lower level of care where they can continue their recovery journey.

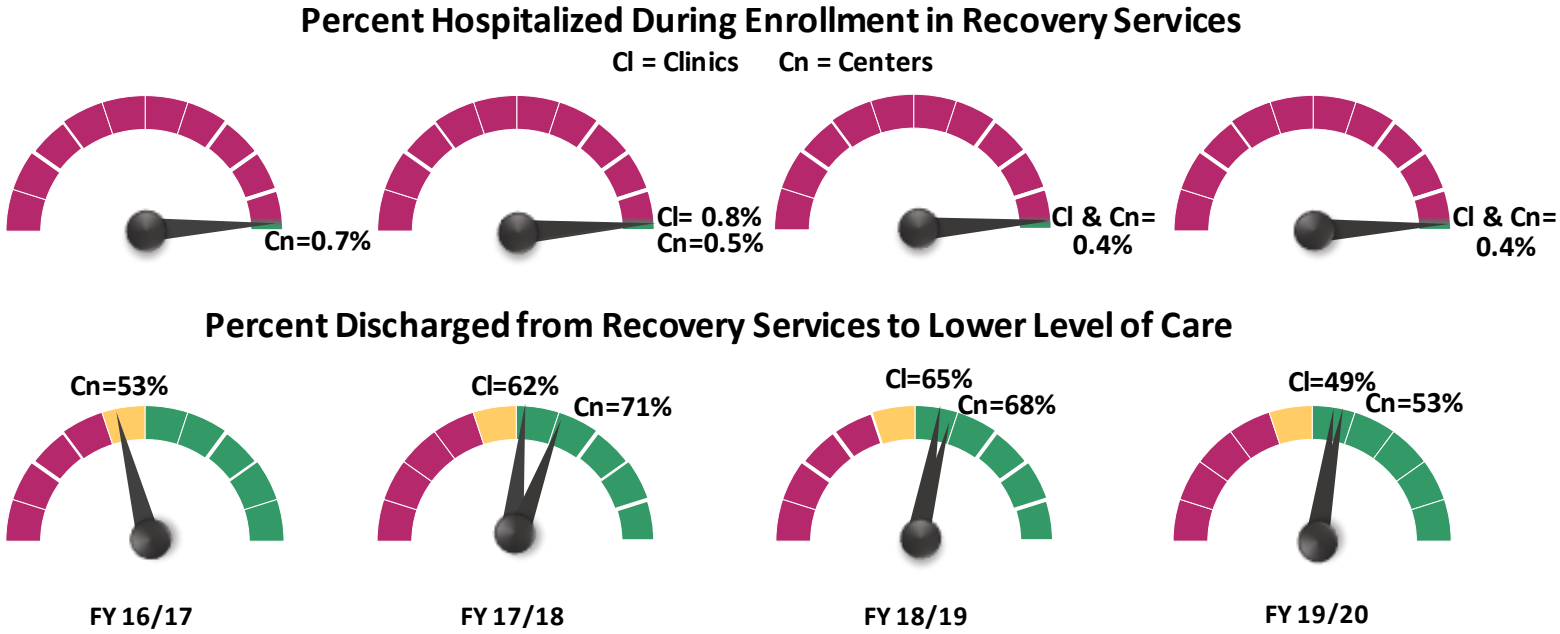


OUTCOMES

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

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

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



CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

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

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

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

COMMUNITY IMPACT

The needs of the individuals accessing the Recovery Centers and Clinics are uniquely met through services focused on reintegration into the community and overall independence. Individuals and their families are educated about the system of care, exposed to community resources and encouraged to set and meet new goals beyond those achieved at the program. Through obtaining employment, pursuing education and/or participating in meaningful activities, individuals who graduate have a better understanding of the tools they can use to support and maintain their recovery after discharge.

Older Adult Services (CSS)

Older Adult Services (OAS) serves individuals ages 60 years and older who are living with serious and persistent mental illness (SPMI), experience multiple functional impairments and may also have a co-occurring substance use disorder. Many of the older adults served in this program are homebound due to physical, mental, financial or other impairments. They are diverse and come from African American, Latino, Vietnamese, Korean and Iranian communities. OAS accepts referrals from all sources.

AGE RANGE

Ages 60+

PRIMARY LOCATION

Field | Community

TARGET POPULATION

At-Risk | Mild-Moderate | Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

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

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

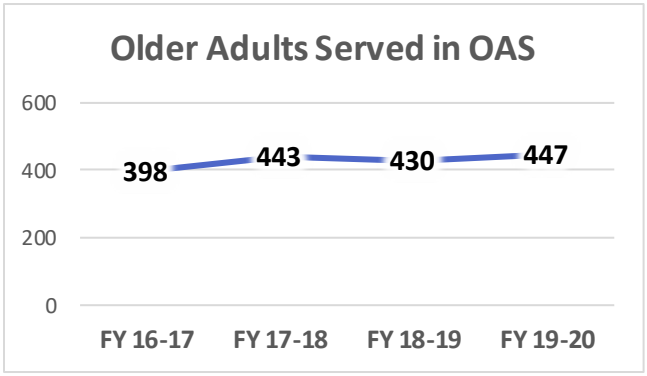
Age	%	Gender	%	Race/Ethnicity	%
0-15	-	Female	40	African American/Black	4
16-25	-	Male	59	American Indian/Alaskan Native	1
26-59	1	Transgender	-	Asian/Pacific Islander	17
60+	99	Genderqueer	-	Caucasian/White	38
		Questioning/Unsure	-	Latino/Hispanic	12
		Another	1	Middle Eastern/North African	1
				Another	27

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

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$2,168,135	530
FY 2021-22*	$2,168,135	530
FY 2022-23	$2,168,135	530

**No proposed changes for FY 2021-22*

SERVICES



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

OUTCOMES

One of the program's goals is to help participants maintain their independence and remain safely in the community by increasing access to primary care, which is quantified as the number of nursing assessments completed. Of the older adults served each fiscal year, 49%, 19%, 21% and 26% had an assessment completed in FYs 2016-17 through 2019-20, respectively. This reduction since 2016-17 is partly due to an increase in client no-shows after the office had to be evacuated in early April 2018 due to a leak in the roof. As a result, staff were spread out over multiple offices, which affected program operations and service delivery. The program moved to a new location in March 2019 and nursing assessments increased. However during COVID-19, nursing assessments were abbreviated due to the lack of face-to-face interviews with participants. The nurse was not able to obtain vital signs and interviewed new participants on the phone prior to the appointment with the psychiatrist for past medical conditions, current and past medications, education on diet and nutrition, sleep hygiene, PCP information, labs and allergies.

CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

OAS continues to encounter on-going issues collecting outcome measures that evaluate the program's performance (i.e., selection of a feasible measure of symptom reduction, adequate completion rates, etc.). Program staff has continued meeting to identify metrics appropriate for the target population being served. Future Plan Updates will report these outcomes once implemented. With the move to a new location, OAS staff can now offer evidence-based practice groups and education for participants and their family members in a clubhouse atmosphere. During COVID 19, older adults became even more vulnerable since they were sheltering at home. OAS was able to obtain a small amount of CARES ACT funding to provide participants with sanitation packages, hygiene items, nutrition drinks, home delivered healthy meals, needed food items for companion animals and other essential items. Because of their co-morbid medical issues and mental health symptoms, they were not able to stand in line at food banks or go to multiple grocery stores for essential items. OAS staff were able to deliver items and simultaneously provide mental health services while practicing social distancing.

COMMUNITY IMPACT

OAS collaborates with the Public Health Services Senior Health Outreach and Prevention Program (SHOPP), Council on Aging, Social Services Agency (Adult Protective Services), community senior centers, adult day health care, Alzheimer's Association, Ageless Alliance, local police departments, Orange County Probation Department, hospitals and residential programs, etc. These relationships are important to address the many complicated issues that Orange County older adults face, which can include ensuring the safety of seniors, reaching out to homebound seniors in need of mental health services, coordinating joint home visits with the HCA Public Health nurses to ensure that participants' mental and physical health needs are addressed, and providing educational events for older adults and professionals on issues relevant to seniors, such as medication management, health- and mental health-related matters and community services.

Telehealth/Virtual Behavioral Health Care (CSS)

The **Telehealth/Virtual Behavioral Health Care** program was new to the Three-Year Plan and intended to provide telehealth and/or virtual behavioral health care options for individuals 13 years and older living with serious mental health conditions, and for parents and caregivers of children of all ages. Due to the use of CARES Act funding that supported the transition of many MHSA-funded programs into providing telehealth and virtual mental health services, program implementation was paused in FY 2020-21.

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

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	-	-
FY 2021-22*	$2,500,000	TBD
FY 2022-23	$3,000,000	TBD

**Proposed decrease for FY 2021-22*

SERVICES

Through one or more applications and/or telehealth providers, this program is intended to offer a range of tele-mental health care including, but not limited to, individual therapy, crisis intervention, telepsychiatry and/or peer support. Digital solutions that offer psychoeducation, navigation to needed resources, and training and coaching in relaxation skills, meditation, mindfulness, etc. may also be identified. This program may offer standalone services to individuals and/or provide adjunctive supports to individuals engaged in face-to-face behavioral health services. The services provided through this program will be evidence-supported or established practices. In contrast, the Help@Hand Innovation project will support 1) the identification, development and/or evaluation of new and/or emerging technologies, and 2) the identification and development of administrative processes necessary to create a 'digital mental health system of care' capable of responding to rapid changes in technology and/or its regulatory environment.

In response to considerable feedback from consumers, clients, family members and service providers during the 2021 CPPP, this program will also address a key barrier to engaging in virtual care, namely gaps in understanding how to use technology safely, efficiently and effectively. As such, this program will also include a robust training and technical assistance (TA) piece that will include, but not be limited to:

- Needs assessment to determine whether/how to replace/upgrade outdated provider devices
- Development of tipsheets, brief video tutorials available on-demand online, drop-in scheduled "Appy Hours," and multi-session courses on digital literacy and digital mental health literacy topics
- Partnership with local agencies and community organizations as needed to develop and adapt materials and training that are culturally responsive and linguistically appropriate
- Accelerated development and implementation of in-person training and TA for consumers, family members, prioritizing in-person training/TA for those most in need
- Ongoing market surveillance scan of digital MH solutions

In response to community feedback, the HCA will also strive to provide training on digital literacy basics to individuals and groups most in need of in-person training by the end of Summer 2021. This would allow those with the greatest gaps in digital knowledge an opportunity to receive hands-on assistance while in-person gatherings and meetings are permitted since it is still unknown whether there will be new safer-at-home orders in the fall/winter.

Summary of MHSA Strategies Used by Clinic Expansion

STRATEGIES TO PROMOTE RECOVERY/RESILIENCE

Recovery and resilience are promoted by ensuring that a strong support network is in place to improve the lives of individuals served in these programs and their families. This is achieved by working closely with the individuals and family members, when appropriate, using a strengths-based approach to help develop skills that further improve their functioning, maintain independence and decrease isolation, as well as by communicating and collaborating with the various providers involved in their care (i.e., medical teams and other healthcare providers, community resources, school staff, wraparound team, Social Services Agency, schools, etc.). STRTP providers also help foster recovery and resilience by creating a space that provides physical and emotional safety for the youth, sensitively conducting screenings and assessments to identify the trauma-related reactions and risk of the children and youth they serve, and educating caregivers on how their own trauma histories may be impacting their current behaviors and relationships, particularly with their children, and helping the adults develop skills and tools to support their children in recovery.

STRATEGIES TO REDUCE STIGMA AND DISCRIMINATION

Operating from a strengths-based view rather than an illness-based view helps reduce some of the stigma associated with mental health conditions. Staff also recognize the importance of providing services and supports in a manner that takes into account and accepts the individual's differences and unique life circumstances, including culture, ethnicity, gender identity, sexual orientation and socioeconomic status. In the co-occurring physical health/mental health program, several unique opportunities are available since the program is located at a teaching hospital. For example, Spanish-speaking clinicians are encouraged to participate in a monthly Spanish-speaking clinicians' meeting aimed at discussing and training in topics and issues related to the provision of mental health services in Spanish, as well as cultural and linguistic factors specific to the Hispanic population. Postdoctoral fellows regularly attend seminars that provide education and training on research and evidence-based practices that consider cultural and diversity factors that impact mental health and psychosocial functioning. The program also regularly educates medical providers on issues related to mental health to increase understanding and reduce stigma. In addition, older adults may hesitate to access services due to stigma related to being an older adult. They may fear losing their independence or being removed from their homes, forced to take medications and/or forced to live in a nursing home due to their age. They may also feel shame due to their belief that, as adults, they should not need anyone's help to live their lives. OAS staff are trained and encouraged to take whatever time is needed to develop trust with participants and facilitate engagement into services.

STRATEGIES TO INCREASE ACCESS TO SERVICES: TIMELY ACCESS FOR UNDERSERVED POPULATIONS AND LINKAGE TO TREATMENT

Lack of transportation and stigma are some of the primary barriers to care for these participants, which are mitigated by bringing services directly to individuals and their families out in the community, including co-locating services at schools, medical offices, hospitals, etc., rather than relying on them to travel to a behavioral health clinic. Program staff also teach participants how to use public transportation and provide bus passes. These programs also provide services in multiple languages through bicultural/bilingual staff, or a language line translation service as needed, to assist those who speak other languages, thus reducing language barriers that may impeded engaging in services. In addition, for older adults hesitant to enroll in OAS, staff from another program (OAS SHOPP) is dedicated to conducting outreach and engagement with referred individuals to OAS and recognize that it may require several friendly home visits before an older adult engages in OAS services.

Discontinued Program

Integrated Community Services (CSS)

Integrated Community Services (ICS), which serves individuals ages 18 and older living with chronic primary medical care and mild to severe mental health needs, will no longer be funded through MHSA/CSS. Instead the program has been transitioning over to CalOptima, with funding provided through Medi-Cal and other non-MHSA sources.

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

Full Service Partnership Programs (CSS)

A Full Service Partnership (FSP) is designed to provide intensive, community-based outpatient services to a county's most vulnerable individuals, and the OC Health Care Agency (HCA) has established eligibility criteria to ensure that the FSPs reach Orange County (OC) residents who are experiencing disparities in access to behavioral health care. Thus, the target population includes individuals of all ages who are living with a SED or SMI; unserved or underserved; and are homeless, at risk of homelessness, involved in the criminal justice system, frequent users of inpatient psychiatric treatment, culturally or linguistically isolated, and/or have complex medical needs.

Orange County has four distinct FSP programs organized by the MHSA-defined age groups (i.e., Children, TAY, Adult, Older Adult). In addition to tailoring services and supports to the members' age and developmental stage, three (i.e., Children, TAY, Adult) offer additional tracks for individuals with more specialized needs and providers within these specialized tracks often serve individuals across multiple age groups. The most common age groups spanned are Children/TAY and Adult/Older Adult, although there are some exceptions (see tables below). All FSP services – even those affiliated with the Courts and OC Probation – are voluntary.

AGE RANGE

All Ages

PRIMARY LOCATION

Field

Community

TARGET POPULATION

At-Risk | Mild-Moderate | Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

- ✔ Arabic
- ✔ Farsi
- ✔ Khmer
- ✔ Korean
- ✔ Mandarin
- ✔ Spanish
- TDD/CHAT
- ✔ Vietnamese
- Other:

PROGRAM SPECIALIZATIONS

BH Providers

1st Responders

Students / School

Foster Youth

Parents

Families

Medical Co-Morbidities

Criminal-Justice Involved

Ethnic Communities

Homeless / At-Risk of

Recovery from SUD

LGBTIQ+

Trauma-Exposed Individuals

Veterans / Military-Connected

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	Gender	%	Race/Ethnicity	%
0-15	13	Female	41	African American/Black	7
16-25	35	Male	58	American Indian/Alaskan Native	1
26-59	43	Transgender	1	Asian/Pacific Islander	11
60+	9	Genderqueer	-	Caucasian/White	38
		Questioning/Unsure	-	Latino/Hispanic	38
		Another	-	Middle Eastern/North African	1
				Another	4

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

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$53,766,876	3,521
FY 2021-22*	$53,766,876	3,591
FY 2022-23	$53,766,876	3,661

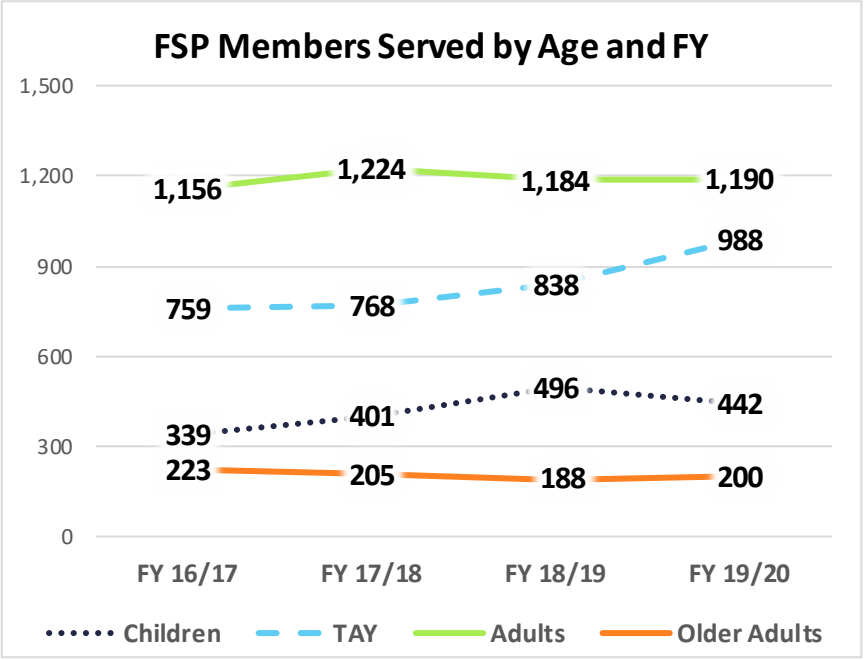
** Several providers at capacity; propose keeping overall FSP budget level rather than rightsizing as initially planned.*

Identified Unserved/Underserved Target Populations for Children/TAY FSP Programs	Children 0-15	TAY 16-17	TAY 18-25	Adults 26-59	Older Adults 60+
Children/youth (mostly 12-15 years) and their parents/caregivers (Project RENEW) *Referrals from:* County and County-contracted outpatient clinics, primary care physicians, emergency departments, SSA, inpatient units, schools, Children's CAT	■	■			
TAY who have minimal family involvement (STAY Process) *Referrals from:* County and County-contracted outpatient clinics, primary care physicians, emergency departments, SSA, inpatient units, schools, CYBH CAT, AOT		■	■		
Court-referred youth and their parents/caregivers (CCFSP) *Referrals from:* Juvenile Court (Recovery, Girls, Boys, Grace); Truancy Response Program	■	■	■		
Criminal-Justice Involved youth and their parents/caregivers (YOW) *Referrals from:* Probation Department, Clinical Evaluation Guidance Unit (CEGU), hospitals, jails, courts, AOT	■	■	■		
Youth with significant/chronic physical illness and their families (Project HEALTH) *Referrals from:* Hospitals, physicians, specialty medical clinics, County and County-contracted clinics	■	■	■		
Culturally/linguistically-isolated Asian/Pacific Islander youth/families (Project FOCUS) *Referrals from:* County and County-contracted outpatient clinics, primary care physicians, emergency departments, SSA, inpatient units, schools, CYBH CAT	■	■	■	** see note*	

** Beginning in FY 2017-18, the provider continued offering services to TAY who aged out of the program when they turned 26 because there is currently no similar specialized FSP for adults.*

Identified Unserved/Underserved Target Populations for Adult/Older Adult FSP Programs	Children 0-15	TAY 16-17	TAY 18-25	Adults 26-59	Older Adults 60+
FSP-eligible adults who are homeless or at risk of homelessness (TAO) *Referrals from:* Jails, probation, general community				■	
LPS conservatorship, returning from long-term care, court-involved (STEPS) *Referrals from:* Long-term care facilities, Collaborative Courts, general community				■	
Voluntarily agreed/court-ordered to participate in AOT FSP *Referrals from:* Assisted Outpatient Treatment (AOT) Assessment and Linkage Team (see Appendix X for details)				■	
Criminal-Justice Involved or high risk of criminal justice recidivism (Opportunity Knocks) *Referrals from:* Jails, OC Probation, general community				■	
Court-Involved (WIT/Whatever It Takes) *Referrals from:* Collaborative Courts				■	
FSP-eligible adults at risk of losing permanent housing (Home First) *Referrals from:* County outpatient clinics and programs, private providers, property managers, general community				■	
FSP-eligible older adults (also tend to have health/mobility issues) (OASIS) *Referrals from:* Hospitals, Adult Protective Services, outpatient clinics, senior centers, jail, OC Links, family members, CAT, general community					■

SERVICES



The FSP programs use a coordinated team approach to provide "whatever it takes," including 24/7 crisis intervention and flexible funding to support people on their recovery journeys. They follow the Assertive Community Treatment (ACT) model of providing comprehensive, community-based interventions, linguistically and culturally competent services, and around-the-clock crisis intervention and support by coordinated, multidisciplinary teams. The teams can include Marriage and Family Therapists, Clinical Social Workers, Personal Services Coordinators, Peer Mentors, Youth Mentors, Parent Partners, Housing Coordinators, Employment Coordinators, Clinical Dietitians, Licensed Clinical Supervisors, Psychiatrists and/or Nurses who are committed to the recovery model and the success of their participants. Working together, the teams provide intensive services that include counseling, case management and peer support, which are described in more detail below.

With regard to clinical interventions, the FSP provides individual, family and group counseling and therapy to help individuals reduce and manage their symptoms, improve functional impairments and assist with family dynamics. A wide array of evidence-based practices are available and, depending on the age and needs of the individual, can include Motivational Interviewing, Cognitive Behavioral Therapy (CBT), Trauma-Focused CBT, Eye Movement Desensitization and Reprocessing (EMDR), Dialectical Behavior Therapy, Integrated Treatment for Co-Occurring Disorders, Parent Child Interaction Therapy (PCIT), Seeking Safety, Illness Management and Recovery, Moral Reconation Therapy (MRT), Program to Encourage Active Rewarding Lives for Seniors (PEARLS), behavioral modification and others. Individuals enrolled in an FSP program also receive psychiatric care, medication management, psychoeducation, co-occurring substance use disorder services, mindfulness training, crisis intervention and/or 24/7 support as needed.

Personal Services Coordinators (PSCs) provide intensive case management to help individuals access crucial medical care, educational support, social and recreational opportunities, mental health rehabilitation, benefits acquisition, transportation resources, basic needs and other resources available in the community. PSCs and/or other FSP staff also help individuals develop skills to manage problematic behaviors or impairments and work with significant others and caregivers, when available, to support them in learning and practicing the new skills.

Some providers also have employment and/or housing coordinators who assist and support their participants in these essential elements of recovery. Employment coordinators, or when dedicated coordinators are not available, PSCs and other staff, lead numerous workshops and classes to teach and hone prevocational and vocational skills such as resume writing, interviewing skills, computer skills, etc. FSP housing coordinators (and/or PSCs) also assist individuals with finding and maintaining safe, suitable housing, as reducing homelessness is one of the target outcomes for the FSPs.

Peer Recovery Specialists/Coaches and Parent Partners are key members of the FSP teams and play an integral role in promoting wellness and resilience. By sharing their lived experience and learned skills, peer staff support recovery, empowerment and community integration. In addition, Parent/Family Partners work closely with parents, legal guardians, caregivers, significant others and other family members to provide suggestions on how they can best support the participant. Parent Partners also assist with the psychoeducational process to close the generational gap and shift how parents and caregivers view mental health, as well as provide respite care.

Family involvement in treatment and services can be critical to supporting and maintaining an individual's recovery and has been central to the Children and TAY FSP program providers' approach to service and care planning. In addition, the Adult FSP program providers have been working on increasing family inclusion at all levels of treatment and at social events, and several providers offer a monthly family support group to provide families with information, education, guidance and support for their own needs, as well as to enable them to assist their family member's recovery.

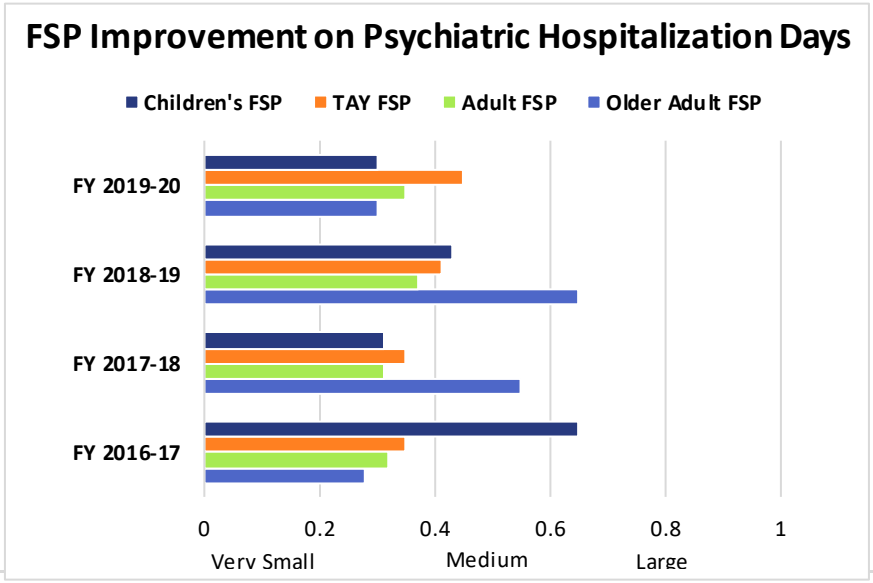
OUTCOMES

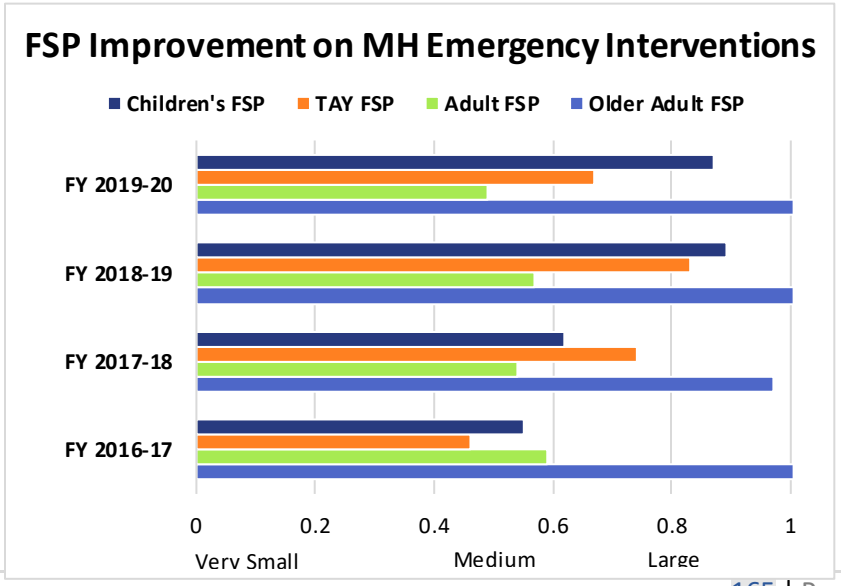
The programs evaluated changes on outcomes related to mental health recovery, living situation, legal involvement, employment and/or school performance by comparing functioning in the 12 months prior to enrolling in the FSP to functioning during the fiscal year being evaluated. With the exception of school performance, all results were statistically analyzed and reported according to the calculated effect size, which reflects, in part, the extent to which a change in functioning over time is clinically meaningful for the individuals served in the FSP program.

Mental Health Recovery: Mental health recovery was evaluated through changes in two measures: (1) number of days the individual had been psychiatrically hospitalized, and (2) the number of times the individual experienced a mental health emergency intervention (defined as a hospitalization episode, crisis residential placement, emergency room/CSU visit, crisis assessment/WIC 5585 evaluation or police response due to a mental health crisis).

Across fiscal years, the FSPs generally made a small impact on decreasing the amount of time participants spent in a psychiatric hospital, with TAY, adult and older adult participants having spent, on average, about 4-5 weeks in the hospital during the year prior to enrolling in an FSP compared to about 1-2 weeks in the hospital after enrolling. Relative to the other FSP participants, children spent considerably less time in the hospital both prior to and after enrolling in an FSP (i.e., 1-1.5 weeks an average prior; 2-4 days an average after). Overall, this suggests that participants experienced somewhat less disruption in their daily lives by spending less time in the hospital while receiving FSP services.

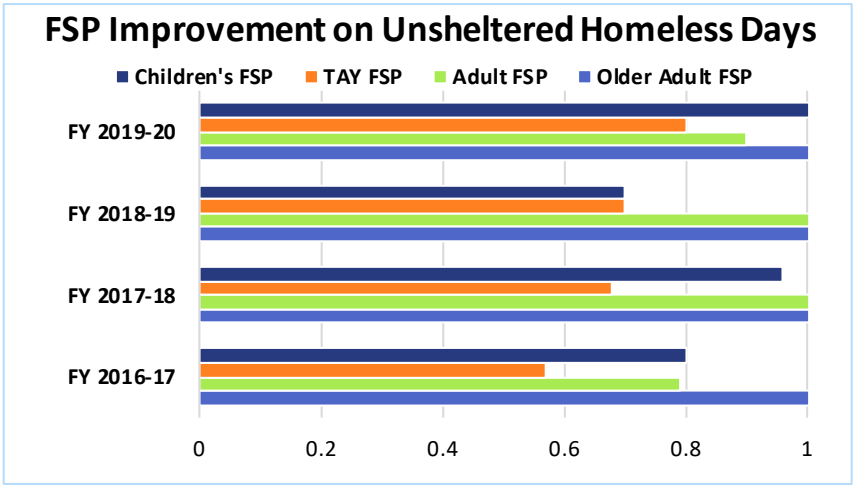
In addition, FSPs demonstrated medium to large decreases in the average number of mental health-related emergency interventions that participants experienced across each of the fiscal years, further suggesting that they experienced recovery while receiving FSP services. This effect was particularly pronounced for older adults, with the average number of events essentially dropping to zero.



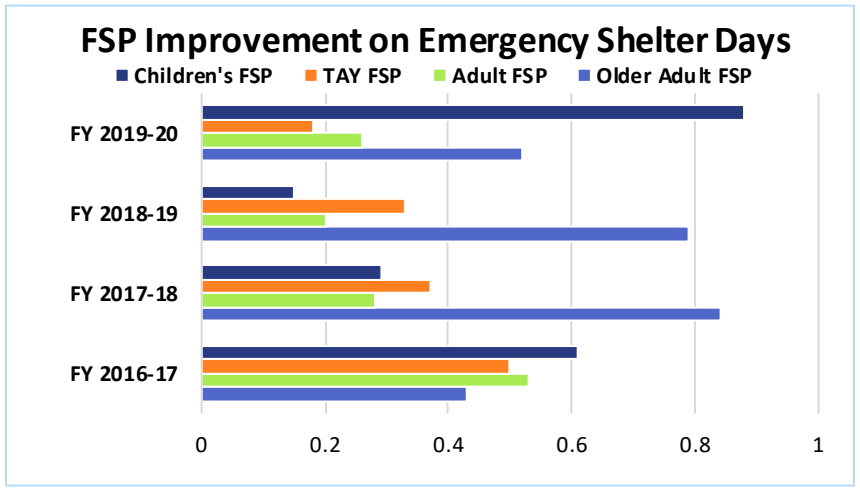


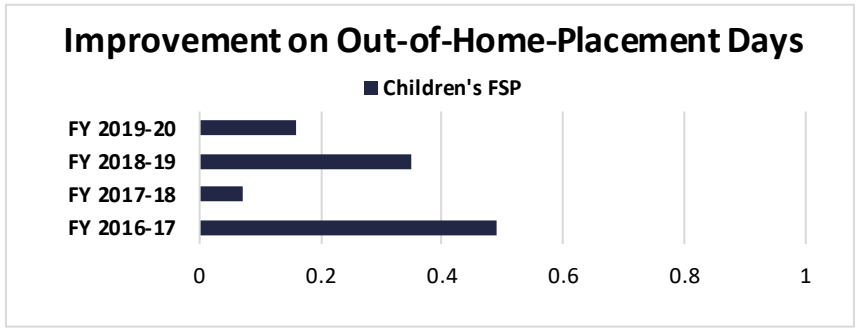
Homelessness and Living Situation: Another goal of the FSPs is to prevent and reduce unsheltered homelessness, emergency shelter stays and, for children, out-of-home placements. For TAY, Adults and Older Adults, the FSPs also strive to increase the number of days they are able to live in the community independently (i.e., live safely in an unsupervised setting and perform their own activities of daily living).

The FSP programs continued to improve the housing circumstances of their participants as evidenced by the generally large reduction (moderate for TAY) in the average number of days spent homeless during each of the past FYs. Improvements were most pronounced for adult and older adults, who typically experienced greater homelessness prior to FSP enrollment. Unsheltered homelessness was defined as a residence not intended for human habitation, such as a car, abandoned building, the street, etc.



The impact of FSPs on reducing days spent in emergency shelter varied across age group and fiscal year. Children, TAY and adults generally experienced small to moderate decreases while enrolled in the FSP over the past several FYs. Efforts to relocate a large number of homeless adults living in the Flood Control Channel and Santa Ana Civic Center area during FYs 2017-18 and 2018-19 likely contributed to the reduced impact on this outcome as the TAO Central FSP provider worked to place adults living in these areas in emergency shelters temporarily. In support of this speculation, when homeless adults served by this provider are removed from the analysis, the remaining adults experienced moderate reductions (0.48) in emergency shelter use during FY 2018-19, which is consistent with findings from FY 2016-17. In contrast, older adults FSP demonstrated the opposite pattern (i.e., shifting from a moderate impact in FY 2016-17 to a large impact in the past two FYs), which may be attributable to a few participants who had very long emergency shelter motel stays while receiving services in FY 2016-17 before transitioning to permanent living placements in FY 2017-18. Finally, while fewer children served in FY 2019-20 had stayed in emergency shelters prior to enrolling in the FSP compared to prior fiscal years, those that had reported unusually long shelter days, resulting in a large decrease once the FSP was able to provide housing for these children and their families. Thus, unique factors across the past four FYs may account for the fluctuating impact on emergency shelter use rather than true changes in the FSPs' ability to improve this outcome.





While TAY and adults experienced a small increase in the average number of days spent living independently across FYs, older adults demonstrated moderate to large increases. Thus, the Older Adult FSP appears to be relatively effective at helping support independent living, which is defined as living in an apartment or single room occupancy as opposed to any type of supervised residential placement. These improvements appear to be the result of changes implemented in FY 2017-18 when the increased impact was first observed. During this time the provider implemented a more

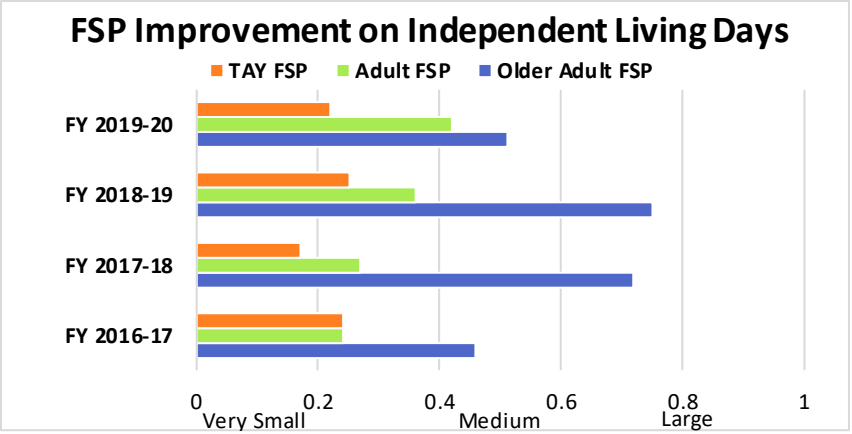
Very Small Medium Large

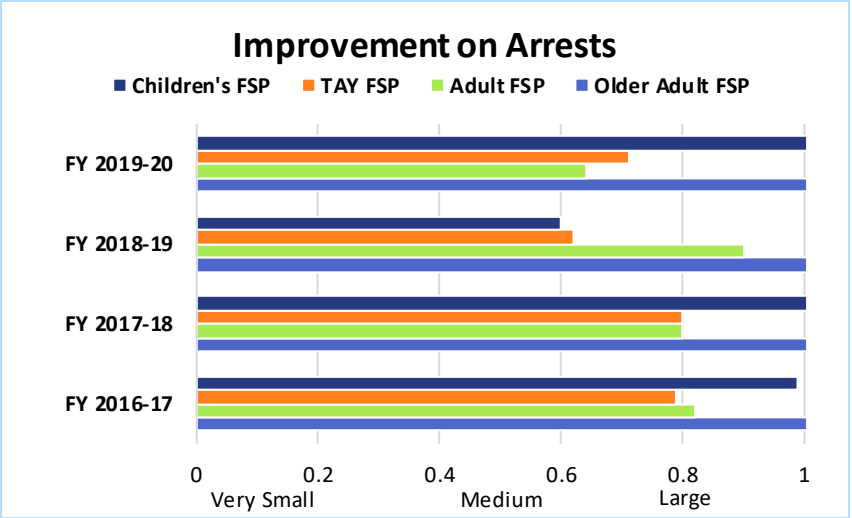
collaborative, structured approach where the treatment team collectively discussed and problem-solved ways to engage members who were at high risk of hospitalization and/or incarceration. In addition to weekly contact with personal service coordinators, teams increased contact with the older adults by including visits with life coaches, therapists or housing coordinators or members of the medical team. In addition, staff has worked diligently to increase the number of groups offered and created new and more interesting group topics and events based on client interests and needs. As a result, the program has seen a significant increase in group participation over the past fiscal years. These improvements are thought to have positively impacted overall functioning and not just independent living, as evidenced by improvements across all outcomes during the past two FYs relative to FY 2016-17.

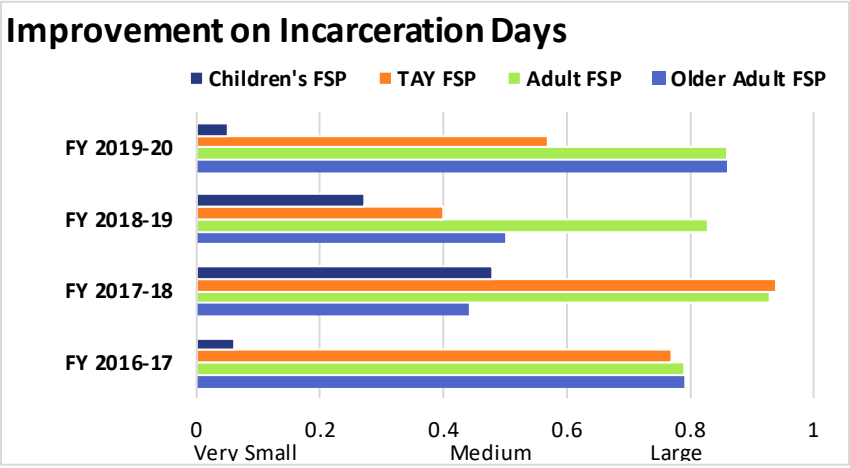
Finally, for children the goal is to reduce out-of-home placements, which are defined as placement in a group home or residential treatment facility. It should be noted that a very small number of children are affected by an out-of-home placement either prior to enrolling in the FSP or during the fiscal year being evaluated (i.e., n= 20 in FY 2016-17, n= 14 in FY 2017-18, & n= 17 in FY 2018-19). Thus, it is difficult to draw firm conclusions on the overall efficacy of FSPs in reducing out-of-home placements for children, although the average number of days children were placed out-of-the-home did decrease during all three fiscal years when compared to the year prior to their enrollment in the FSP.

Legal Involvement: Outcomes related to decreasing individuals' involvement with the legal system were tracked using two measures: number of arrests and days incarcerated in jail or prison. Participants of all ages generally experienced large to very large decreases in arrests during all fiscal years compared to the year prior to FSP enrollment, with the exception of moderate to large reductions experienced by children and TAY in FYs 2018-19 and 2019-20.

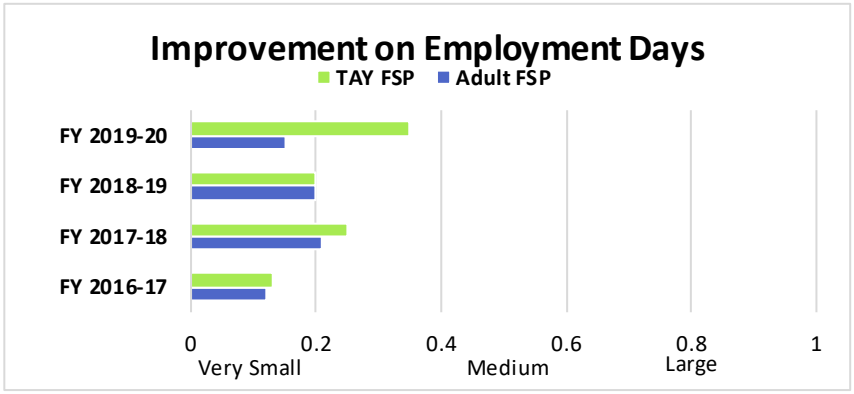
There was variability across age groups and fiscal years with regard to the impact on days spent incarcerated. Adults showed consistently large decreases in days incarcerated across all four fiscal years, and TAY and older adults tended to show moderate-to-large decreases. Over the past four FYs, children have shown large fluctuations in incarceration outcomes. The HCA is currently exploring possible underlying reasons for these shifts in incarceration patterns among TAY and children.







Employment: The TAY and Adult FSPs also examined days employed, which is vital to recovery but can be difficult to attain for those struggling with the combination of serious mental illness, substance use disorders, homelessness and/or a legal history. Per guidelines established by the County Behavioral Health Directors Association of California (CBHDA), employment was defined as competitive, supported or transitional employment, as well as paid in-housework, work experience, non-paid work experience and other gainful employment activity. Compared to the year prior to FSP enrollment, the FSPs had no impact in FY 2016-17 and a small impact in FYs 2017-18 and 2018-19 on employment for adults and TAY who were at least 16 years old at the start of the fiscal year (and therefore eligible to work the duration of the reporting period). Thus, increasing employment activity in a meaningful way continues to be a particularly challenging area for the FSPs.



School Performance: The Children's FSPs examined the proportion of children who (1) maintained good/very good school attendance or grades and/or who (2) improved their attendance or grades while enrolled in the FSP. Although the majority of children reported good/improved attendance across both fiscal years, the proportion reporting good/improved grades fell from 89% in FY 2016-17 to 52% in FY 2017-18. Thus, while the findings generally suggest that the FSPs are successful in maintaining or improving school performance among the children served, the HCA will continue to monitor the FSPs' impact on grades to determine whether or not the FY 2017-18 results are an anomaly.

School Performance
Children/Youth FSP

	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20
Good, Very Good, Improved Attendance	78%	82%	86%	72%
Good, Very Good, Improved Grades	89%	52%	60%	55%

CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

Finding safe, affordable and permanent housing in the neighborhoods in which the individuals/families have support networks and/or the children are enrolled in school has continued to be challenging. To address immediate concerns with supply, FSP housing specialists work to build relationships in the community and develop housing resources for their participants. Once participants have been placed in housing, FSPs utilize a housing assistance strategy in which the individual/family becomes increasingly responsible with meeting costs so that, when clinical goals are met, the individual/family is able to maintain housing independently. This strategy creates stability so that clinical advances can be maintained upon discharge from the program. The HCA is also in the process of creating an FSP track that will assist individuals and families who are living in permanent housing but struggling to maintain their housing and are at risk of becoming homeless. To address the shortage of permanent supportive housing, the HCA along with the support of the Orange County Board of Supervisors, is continuing to identify and fund new housing development opportunities. In addition, the HCA has partnered with Orange County Community Resources, housing developers and other community partners to apply for federal and state housing funding, including No Place Like Home.

Employment has also continued to be an on-going and significant challenge despite the recovering job market. FSP programs can encounter difficulties identifying employers who are flexible enough to employ individuals (or their parents/guardians) who may need time away from work to support their (child's) recovery. Yet employment serves as a critical component of recovery by helping increase peoples' connection with their community, providing a sense of purpose and increasing self-sufficiency. Drawing upon these principles, as well as CBHDA's expanded definition of employment, the programs are working to increase individuals' participation in meaningful, employment-related activities such as volunteer work and enrollment in educational/ training courses as a way to enhance vocational skills, gain experience, and increase their confidence in being able to succeed in the workforce. Over the past year, the Adult FSP program has worked to secure

additional community opportunities and created internal opportunities for volunteer work. Nevertheless, more than any other target outcome, the program continues to struggle with supporting individuals in sustaining employment in a consequential way. Over the next year, FSP program staff will review referrals and linkages to employment services to see if opportunities exist to increase referrals and better support linkage to these services.

In addition, the Older Adult FSP program has noted that its participants do not always attend groups consistently. The provider has made an increased effort to recruit potential participants by engaging them in conversation about the groups and benefits of attending, placing reminder calls, increasing socialization among group participants and assisting with and/or linking to transportation so that they may attend groups. Feedback from older adults served is also elicited regularly so that improvements to the groups' content and/or structure can be made on an on-going basis.

To address an increase of co-occurring substance use issues among TAY and adult participants, the FSP programs are offering more co-occurring groups; working to partner with community substance use treatment programs to expand resources, including residential programs that specialize in co-occurring treatment; and creating their own co-occurring supports and interventions to fill identified service gaps. FSP staff also works collaboratively with Housing and Supportive Services staff to help individuals with co-occurring issues maintain their housing. The Adult FSP providers that serve justice-involved individuals are working to have more staff trained in MRT in order to provide more MRT groups and have increased collaboration with Correctional Health Services to support linkage by providing in reach services and coordinating for transportation upon release.

The Adult FSP program provider for Assisted Outpatient Treatment (AOT) focused services actively continues to address misunderstanding within the community about what their program can and cannot do in relation to its implementation of AOT by virtue of being MHSA-funded and therefore required to be voluntary in nature.

The Adult Housing FSP provider began providing services in Fall 2020. The provider effectively engages individuals who have come from homelessness and provides intensive and comprehensive treatment and support that focuses on preventing loss of housing while increasing housing sustainability.

Finally, the Children's Project RENEW provider was expanded in FY 2020-21 to serve 20 additional children/youth placed in Intensive Services Foster Care (ISFC) homes. ISFC is a placement model of home-based family care for eligible children/youth whose needs for safety, permanency and well-being require specially trained resource parents and access to intensive supportive services.

COMMUNITY IMPACT

Since program inception dates, the FSPs have served more than 2,100 children (approximately 18%), nearly 4,000 TAY (approximately 35%), more than 4,600 adults (approximately 40%) and nearly 700 older adults (approximately 6%). The FSP programs provide a strong base in participant-driven services that build on individual strengths using a "whatever it takes" approach and field-based services that break down barriers to accessing treatment. With the continued implementation of co-occurring services, the programs have increased their collaboration with community substance use programs, residential substance use treatment programs and/or detoxification centers. In addition, providers that work collaboratively with the Courts, Probation Department, Public Defender's Office, District Attorney's Office, and/or County Counsel continue to prioritize developing treatment approaches that reduce recidivism in the criminal justice system.

The FSP programs also work closely with various providers and other community groups to support participants on their recovery journeys. This includes the Social Security Administration, Social Services Agency, primary care physicians and other medical providers, hospitals, board and care homes, room and boards, recovery residences, housing providers, shelters, Family Resource Centers, legal resources, food banks, vocational trade programs, LGBTIQ centers, Salvation Army, Goodwill, Wellness Centers, NAMI, immigration services, thrift shops, faith-based leaders, school districts, policymakers, community based organizations and community clinics. By establishing such depth and breadth to their network of collaborators, the FSPs continue to be a leading force for mental health recovery in the community.

REFERENCE NOTES

Psychiatric Hospitalization Days:

Children:

FY 2019-20: Prior M=14.8, SD= 37.7; Since M= 4.5, SD 12.5; t(82)=2.4, p<.02, Cohen's d= 0.30, -70%
FY 2018-19: Prior M=9.9, SD= 11.6; Since M=3.8, SD 7.0; t(90)=4.0, p<.001, Cohen's d=0.43, -62%
FY 2017-18: Prior M= 7.7, SD= 6.7; Since M=3.8, SD= 8.9; t(75)=2.67, p<.01, Cohen's d=0.31, -51%
FY 2016-17: Prior M=10.8, SD=13.6; Since M=1.8, SD=4.6.1; t(70)=5.05, p<.001, Cohen's d=0.65,-83%

TAY:

FY2019-20: Prior M=17.2, SD=23.8; Since M=5.2, SD=17.6; t(245)=-7.0, p<.001, Cohen's d=.45, -70%
FY 2018-19: Prior M=23.0, SD=42.1; Since M=6.7, SD=19.8; t(265)=-6.14, p<.001, Cohen's d=0.41, -71%
FY 2017-18: Prior M=28.6, SD= 52.1; Since M=8.6, SD=26.8; t(274)=5.59, p<.001, Cohen's d=0.35, -70%
FY 2016-17: Prior M=39.8, SD=76.6; Since M=14.8, SD=38.3; t (246)=-5.03, p<.001, Cohen's d=0.35, -63%

Adults:

FY2019-20: Prior M=37.7, SD=65.9; Since M=13.8, SD=31.6; t (599) = 8.06, p<.001, Cohen's d=.35, -63%
FY 2018-19: Prior M=36.7, SD=65.1; Since M=13.2, SD=29.7; t (556)=8.08, p<.001, Cohen's d=0.37, -64%
FY 2017-18: Prior M=34.0, SD=59.7; Since M=14.4, SD=31.9; t(559)=6.92, p<.001, Cohen's d=0.31, -58%
FY 2016-17: Prior M=34.2, SD=64.3; Since M=13.1, SD=30.4; t(542)=6.78, p<0.001, Cohen's d=0.32, -62%

Older Adults:

FY 2019-20: Prior M=36.3, SD=67.9; Since M=8.7, SD=24.4; t (55) = 2.89, p <.05, Cohen's d=.43, -76%
FY 2018-19: Prior M=37.2, SD=70.4; Since M=7.6, SD=24.0; t(52)=3.53, p <.001, Cohen's d=0.65, -80%
FY 2017-18: Prior M=39.4, SD=76.1; Since M=5.0, SD=12.8; t(57)=3.41, p<.001, Cohen's d=0.55, 87%
FY 2016-17: Prior M=28.1, SD=59.7; Since M=11.7, SD=26.7; t(58)=1.84, p=0.07, Cohen's d=0.28, -58%

Mental Health Emergency Interventions:

Children:

FY 2019-20: Prior M=2.1, SD=2.0; Since M=0.3, SD=1.0; t(169)=11.8, p<.001, Cohen's d=0.87, -86%
FY 2018-19: Prior M=1.8, SD=1.7; Since M=0.3, SD=.78; t(241), p<.001, Cohen's d=0.89, -83%
FY 2017-18: Prior M=1.8, SD=1.9; Since M=0.5, SD=1.1; t(158)=7.61, p<.001, Cohen's d=0.62, -72%
FY 2016-17: Prior M=1.8, SD=2.6; Since M=0.4, SD=0.7; t(82)=4.57, p<.001, Cohen's d=0.55, -78%

TAY:

FY2019-20: Prior M=2.4, SD=3.4; Since M=0.3, SD=1.0; t(460)=13.3, p<.001, Cohen's d=0.67, -88%
FY 2018-19: Prior M=2.6, SD=3.3; Since M=0.3, SD=.7; t(500)=15.12, p<.001, Cohen's d=0.83, -88%
FY 2017-18: Prior M=2.7, SD=3.6; Since M=0.4, SD=3.6; t(365)=12.14, p<.001, Cohen's d=0.74, -85%
FY 2016-17: Prior M=2.3, SD=3.3; Since M=0.6, SD=1.7; t(295)=7.7, p<.001, Cohen's d=0.46, -74%

Adults:

FY 2019-20: Prior M=2.3, SD=2.3; Since M=0.81, SD=2.0; t (700) = 13.00, p<.001, Cohen's d=.49, -65%
FY 2018-19: Prior M=2.5, SD=2.4; Since M=0.8, SD=1.7; t(658)=14.43, p<.001, Cohen's d=0.57, -67%
FY 2017-18: Prior M=3.2, SD=3.7; Since M=1.0, SD=2.0; t(809)=14.88, p<.001, Cohen's d=0.54, -68%
FY 2016-17: Prior M=2.4, SD=2.6; Since M=0.7, SD=1.5; t(629)=13.10, p<.001, Cohen's d=0.59, -69%

Older Adults:
FY 2019-20: Prior M=2.5, SD=2.4; Since M=0.01, SD=0.12; t (73) = 8.68, p<.001, Cohen's d=1.35, -100%
FY 2018-19: Prior M=2.1, SD=1.7; Since M=0, SD=0.0; t(66)=10.25, p<.001, Cohen's d=1.77, -100%
FY 2017-18: Prior M=3.2, SD=4.6; Since M=0, SD=0.0; t(121)=7.58, p<.001, Cohen's d=0.97, -100%
FY 2016-17: Prior M=1.7, SD=1.6; Since M=0.2, SD=0.5; t(79)=8.07, p<.001, Cohen's d=1.02, -89%

Homeless Days:
Children:
FY2019-20: Prior M=81.5, SD=109.3; Since M=0.0; SD=0.0; t(17)= 3.2, p<.006, Cohen's d=1.10, -100%
FY 2018-19: Prior M=56.0, SD=94.7; Since M=1.9; SD=7.1; t(25)=2.87, p<.001, Cohen's d=0.70, -97%
FY 2017-18: Prior M=88.8, SD=101.8; Since M=7.3, SD=19.7; t(23)=3.86, p<.01, Cohen's d=0.96, -92%
FY 2016-17: Prior M=96.4, SD=129.7; Since M=17.1, SD=51.7; t(19)=-3.0, p<.01, Cohen's d=0.80, -82%
TAY:
FY2019-20: Prior M=77.8, SD=91.4; Since M=11.7, SD=41.3; t(132)=8.4, p<.001, Cohen's d= .80, -85%
FY 2018-19: Prior M=92.8, SD=113.9; Since M=15.1, SD=33.2; t(146)=8.51, p<.001, Cohen's d=0.70, -84%
FY 2017-18: Prior M=101.6, SD=118.8; Since M=21.9, SD=46.1; t(168)=8.13, p<.001, Cohen's d=0.68, -78%
FY 2016-17: Prior M=102.3, SD=124.93; Since M=26.3, SD=55.79; t(154)=-6.69, p<.001, Cohen's d=0.57, -74%
Adults:
FY 2019-20: Prior M=159.8, SD=127.8; Since M=30.9, SD=71.3; t (669) = 22.4, p<.001, Cohen's d=.90, -81%
FY 2018-19: Prior M=179.9, SD=134.1; Since M=30.6, SD=70.0; t(640)=25.4, p<.001, Cohen's d=1.05, -83%
FY 2017-18: Prior M=178.7, SD=132.0; Since M=25.2, SD=60.7; t(666)=26.17, p<.001, Cohen's d=1.07, -86%
FY 2016-17: Prior M=145.7, SD=122.56; Since M=36.9, SD=73.42; t(611)=18.68, p<.001, Cohen's d=0.79, -75%
Older Adults:
FY 2019-20: Prior M=204.9, SD=133.8; Since M=25.7, SD=70.4; t (119) = 13.3, p<.001, Cohen's d=1.28, -87%
FY 2018-19: Prior M=216.4, SD=140.0; Since M=27.8, SD=76.1; t(124)=13.89, p<.001, Cohen's d=1.31, -87%
FY 2017-18: Prior M=217.5, SD=136.2; Since M=27.7, SD=67.2; t(128)=14.99, p<.001, Cohen's d=1.42, -87%
FY 2016-17: Prior M=205.4, SD=138.5; Since M=37.6, SD=84.5; t(134)=12.14, p<.001, Cohen's d=1.06, -82%

Emergency Shelter Days:
Children:
FY 2019-20: Prior M= 88.2, SD=112.9; Since M=7.7, SD=20.6; t(22)=3.4, p=.003, Cohen's d=0.88, -91%
FY 2018-19: Prior M= 43.8, SD=79.6; Since M=25.4; SD=45.1; t(83)=1.7, p=.094, Cohen's d=0.19,-37%
FY 2017-18: Prior M=62.4, SD=100.4; Since M=27.5; SD=55.7; t(48)=1.99, p=.05, Cohen's d=0.29, -56%
FY 2016-17: Prior M=72.9, SD=108.9; Since M=14.8; SD=35.4; t(31)=-2.97, p<.01, Cohen's d=0.61, -80%
TAY:
FY 2019-20: Prior M= 54.2, SD=85.7; Since M=32.6, SD=75.3; t(205)=2.6, p<.011, Cohen's d= 0.18, -40%
FY 2018-19: Prior M= 96.0, SD=109.5; Since M=28.7, SD=57.2; t(215)=-.041, p<.05, Cohen's d=0.61, -51%
FY 2017-18: Prior M=69.3, SD=101.3; Since M=29.2, SD=54.5; t(155)=4.38, p<.001, Cohen's d=0.37, -58%
FY 2016-17: Prior M=82.9, SD=117.2; Since M=22.5, SD=51.3; t(162)=-5.90, p<.001, Cohen's d=0.50, -73%

Adults:
FY 2019-20: Prior M=66.5, SD=102.6; Since M=32.6, SD=67.0; t (385) = 5.03, p<.001, Cohen's d=.26, -51%
FY 2018-19: Prior M=62.7, SD=103.3; Since M=36.8, SD=63.9; t(406)=4.01, p<.001, Cohen's d=0.20, -41%
FY 2017-18: Prior M=68.4, SD=102.6; Since M=33.9, SD=53.6; t(430)=5.66, p<.001, Cohen's d=0.28, -50%
FY 2016-17: Prior M=83.2, SD=112.6; Since M=20.5, SD=53.4; t(341)=9.18, p<.001, Cohen's d=0.53, -75%
Older Adults:
FY 2019-20: Prior M=118.2, SD=130.8; Since M=40.0, SD=73.6; t (109) = 5.27, p<.001, Cohen's d=.52, -66%
FY 2018-19: Prior M=138.1, SD=139.4; Since M=25.2, SD=60.6; t(87)=6.89, p<.001, Cohen's d=0.79, -82%
FY 2017-18: Prior M=120.2, SD=136.9; Since M=12.8, SD=34.4; t(95)=7.27, p<.001, Cohen's d=0.84, -89%
FY 2016-17: Prior M=99.4, SD=126.7; Since M=39.5, SD=81.5; t(102)=3.96, p<.001, Cohen's d=0.43, -63%

Independent Living Days:
TAY:
FY2019-20: Prior M=8.5, SD=43.3; Since M=25.23, SD=77.2; t(910)= -6.4, p<.001, Cohen's d=-0.22, 196%
FY 2018-19: Prior M=10.2, SD=49.0; Since M=33.1, SD=89.6; t(787)=-6.69, p<.001, Cohen's d=-0.25, 225%
FY 2017-18: Prior M=14.6, SD= 60.8; Since M=29.9, SD=81.2; t(743)=-4.57, p<.001, Cohen's d=-0.17, 105%
FY 2016-17: Prior M=17.9, SD= 65.01; Since M=43.4, SD=96.66; t(747)=-6.46, p<.001, Cohen's d=-0.24, 142%
Adults:
FY 2019-20: Prior M=34.5, SD=89.4; Since M=94.9, SD=136.7; t (1187) = -13.9, p<.001, Cohen's d=-.42, 175%
FY 2018-19: Prior M=38.3, SD=95.2; Since M=89.8, SD=133.4; t(1111)=-11.81, p<.001, Cohen's d=-0.36, 134%
FY 2017-18: Prior M=38.7, SD=95.8; Since M=75.7, SD=127.1; t(1144)=-9.01, p<.001, Cohen's d=-0.27, 96%
FY 2016-17: Prior M=46.6, SD=105.5; Since M=86.8, SD=139.1; t(1153)=-9.10, p<.001, Cohen's d=-0.24, 86%
Older Adults:
FY 2019-20: Prior M=55.4, SD=113.9; Since M=145.3, SD=161.9; t (199) = -7.12, p<.001, Cohen's d=-.51, 162%
FY 2018-19: Prior M=58.6, SD=116.1; Since M=190.1, SD=156.2; t(181)=-9.95, p<.001, Cohen's d=-0.75, 224%
FY 2017-18: Prior M=70.0, SD=125.3; Since M=198.1, SD=152.3; t(190)=-9.82, p<.001, Cohen's d=-0.72, 183%
FY 2016-17: Prior M=76.2, SD=129.2; Since M=170.9, SD=160.3; t(219)=-7.41, p<.001, Cohen's d=-0.46, 124%

Out-of-Home Placement Days:
Children:
FY 2019-20: Prior M=45.5, SD=95.1; Since M=27.4; SD=50.9; t(9)=0.50, p=.63, Cohen's d=0.16, -40%
FY 2018-19: Prior M=92.8, SD=135.44; Since M=55.2, SD=93.1; t(16)=1.38, p=.19, Cohen's d=0.35, -41%
FY 2017-18: Prior M=51.8, SD=74.3; Since M=44.0, SD=66.2; t(13)=0.27, p=.79, Cohen's d=0.07, -15%
FY 2016-17: Prior M=72.9, SD=102.2; Since M=55.9, SD=104.1; t(19)=.643m, p=0.53, Cohen's d=0.49, -23%

Arrests:
Children:
FY 2019-20: Prior M= 2.0, SD=1.7; Since M=0.2, SD=.5; t(28)=6.5, p<.001, Cohen's d=1.60, -90%
FY 2018-19: Prior M=2.3, SD=.4; Since M=0.4, SD=.8; t(61)=3.69, p<.001, Cohen's d=0.60, -83%

FY 2017-18: Prior M=2.5, SD=2.6; Since M=0.1, SD=0.4; t(24)=4.48, p<.001, Cohen's d=1.04, -72%
FY 2016-17: Prior M=2.9, SD=4.1; Since M=0.0, SD=0.0; t(6)=1.86, p=.11, Cohen's d=0.99, -78%

TAY:

FY 2019-20: Prior M= 2.5, SD=3.6; Since M=.3, SD=.8; t(308)=10.3, p<.001, Cohen's d= 0.71, -88%
FY 2018-19: Prior M=2.1, SD=3.0; Since M=0.4, SD=.84; t(220)=7.9, p<.001, Cohen's d= 0.62, -81%
FY 2017-18: Prior M=2.2, SD=3.1; Since M=0.1, SD=0.5; t(216)=9.81, p<.001, Cohen's d=0.80, -95%
FY 2016-17: Prior M=2.1, SD=3.0; Since M=0.4, SD=.83; t(270)=10.21, p<.001, Cohen's d= 0.79, -81%

Adults:

FY 2019-20: Prior M=2.1, SD=3.0; Since M=.4, SD=0.9; t (613) = 13.72, p<.001, Cohen's d=.64, -81%
FY 2018-19: Prior M=2.0, SD=1.7; Since M=0.4, SD=0.8; t(554)=19.84, p<.001, Cohen's d=0.90, -82%
FY 2017-18: Prior M=1.9, SD=1.9; Since M=0.3, SD=0.8; t(586)=18.26, p<.001, Cohen's d=0.80, -84%
FY 2016-17: Prior M=2.0, SD=2.2; Since M=0.3, SD=0.8; t(598)=17.58, p<.001, Cohen's d=0.82, -86%

Older Adults:

FY 2019-20: Prior M=1.6, SD=1.5; Since M=0; SD=0.0 t (43) = 7.0, p<.001, Cohen's d=1.49, -100%
FY 2018-19: Prior M=1.3, SD=0.6; Since M=0, SD=0.0; t(39)=14.58, p<.001, Cohen's d=3.26, -100%
FY 2017-18: Prior M=1.4, SD=0.7; Since M=0, SD=0.0; t(32)=12.34, p<.001, Cohen's d=3.03, -100%
FY 2016-17: Prior M=1.4, SD=0.8; Since M=0, SD=0.0; t(31)=10.71, p<.001, Cohen's d=2.68, -100%

Incarceration Days:

Children:

FY2019-20: Prior M=33.3, SD=47.8; Since M=37.7; SD=76.1; t(22)= -.25, p=.81, Cohen's d=-.05, 13%
FY 2018-19: Prior M=43.0, SD=69.4; Since M=22.1; SD=42.6; t(52)=1.93, p=.059, Cohen's d=0.27, -48%
FY 2017-18: Prior M=75.4, SD=97.4; Since M=29.8; SD=42.6; t(21)=2.07, p=.05, Cohen's d=0.48, -60%
FY 2016-17: Prior M=28.7, SD=39.1; Since M=34.2; SD=67.9; t(9)=.194, p=.851, Cohen's d=-0.06, 19%

TAY:

FY2019-20: Prior M=83.5, SD=96.6; Since M=24.4, SD=48.2, t(290)=9.3, p<.001, Cohen's d=0.57, -71%
FY 2018-19: Prior M=99.7, SD=102.4; Since M=44.9, SD=82.5, t(215)=5.9, p<.001, Cohen's d=0.4, -55%
FY 2017-18: Prior M=114.1, SD=107.4; Since M=22.5, SD=42.9, t(210)=12.19, p<.001, Cohen's d= 0.94, -80%
FY 2016-17: Prior M=95.3, SD=102.3; Since M=19.9, SD=39.1, t(217)=10.31, p<.001, Cohen's d=0.77, -79%

Adults:

FY 2019-20: Prior M=117.9, SD=107.0; Since M=26.0, SD=49.9; t (620) = 20.04, p<.001, Cohen's d=.86, -78%
FY 2018-19: Prior M=105.6, SD=102.2; Since M=24.5, SD=48.3; t(555)=18.03, p<.001, Cohen's d=0.83, -77%
FY 2017-18: Prior M=103.8, SD=97.6; Since M=17.3, SD=38.3; t(585)=20.38, p<.001, Cohen's d=0.93, -83%
FY 2016-17: Prior M=99.6, SD=94.5; Since M=20.4, SD=41.7; t(623)=19.24, p<.001, Cohen's d=0.79, -80%

Older Adults:

FY 2019-20: Prior M=106.9, SD=111.1; Since M=12.6, SD=44.1; t (32) = 4.54, p<.001, Cohen's d=0.86, -88%
FY 2018-19: Prior M=71.4, SD=91.2; Since M=19.3, SD=48.9; t(37)=2.98, p<.05, Cohen's d=0.5, -73%
FY 2017-18: Prior M=46.6, SD=75.0; Since M=11.5, SD=39.5; t(29)=2.28, p<.05, Cohen's d=0.44, -75%
FY 2016-17: Prior M=72.6, SD=90.6; Since M=8.4, SD=24.7; t(29)=3.72, p<.01, Cohen's d=0.79, -88%

Employment Days:

TAY:

FY2019-20: Prior M=28.2, SD=75.3, Since M=68.2, SD=114.7; t(897)=-10.2, p<.001, Cohen's d=-0.35, 142%

FY 2018-19: Prior M=39.8, SD=87.3; Since M=62.9, SD=109.5; t(848)=-5.74, p<.001, Cohen's d=-0.20, 58%

FY 2017-18: Prior M=40.5, SD=89.5; Since M=70.8, SD=115.3; t(764)=-6.88, p<.001, Cohen's d=-0.25, 75%

FY 2016-17: Prior M=46.6, SD=95.4; Since M=63.6, SD=110.0; t(624)=3.30, p<.001, Cohen's d=-0.13, 36%

Adults:

FY 2019-20: Prior M=28.6, SD=76.4; Since M=45.5, SD=103.6; t (1181) = -4.92, p<.001, Cohen's d=-.15, 59%

FY 2018-19: Prior M=26.6, SD=74.4; Since M=49.4, SD=106.0; t(1111)=-6.50, p<.001, Cohen's d=-0.20, 85%

FY 2017-18: Prior M=25.8, SD=70.9; Since M=50.5, SD=108.2; t(1144)=-6.91, p<.001, Cohen's d=-0.21, 96%

FY 2016-17: Prior M=28.8, SD=75.8; Since M=44.1, SD=97.5; t(1150)=-4.58, p<.001, Cohen's d=-0.12, 53%

Program of Assertive Community Treatment (PACT) (CSS)

The **Program of Assertive Community Treatment** (PACT) is the County-operated version of a Full Service Partnership program. Like the FSPs, it utilizes the evidence-based Assertive Community Treatment model to provide comprehensive, "whatever it takes", field-based outpatient services to persons ages 14 and older who are living with serious emotional disturbance (SED) or serious mental illness (SMI). Individuals enrolled in the PACT may also have a co-occurring substance use disorder, experience social, cultural and/or linguistic isolation, and have had difficulty engaging with more traditional outpatient mental health services. The main difference from an FSP is that the PACT specifically targets individuals who have had two or more hospitalizations and/or incarcerations due to their mental illness in the past year. The PACT accepts referrals from County-operated and, in the case of children, County-contracted outpatient clinics. The PACT staffing is separated into teams that provide age and developmentally targeted services (Children/youth ages 14-21, TAY ages 18-25, adults ages 26-59, older adults ages 60 and older). Youth ages 18-21 are served by the Child/Youth team or the TAY team based on their level of caregiver involvement and developmental age.

AGE RANGE

Ages 14+

PRIMARY LOCATION

Field | Community

TARGET POPULATION

At-Risk | Mild-Moderate | Severe ✔

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

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

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	Gender	%	Race/Ethnicity	%
0-15	3	Female	47	African American/Black	4
16-25	21	Male	53	American Indian/Alaskan Native	1
26-59	66	Transgender	-	Asian/Pacific Islander	16
60+	10	Genderqueer	-	Caucasian/White	46
		Questioning/Unsure	-	Latino/Hispanic	28
		Another	-	Middle Eastern/North African	-
				Another	5

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

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$10,599,650	1,430
FY 2021-22*	$10,699,650	1,430
FY 2022-23	$10,599,650	1,430

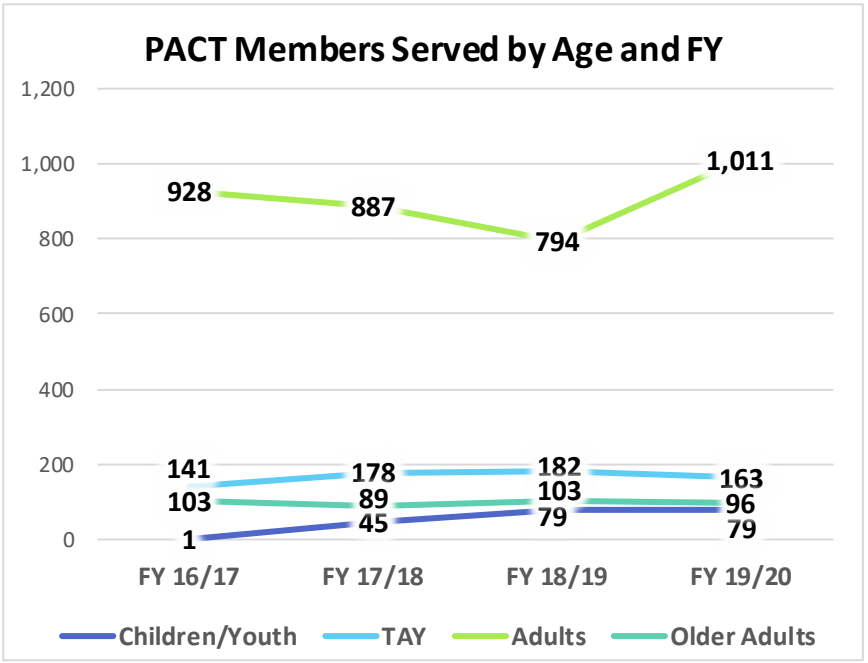
** Proposed increase for FY 2021-22 budget for flexible funding and increased after-hours coverage*

SERVICES

The PACT is staffed by multidisciplinary teams that provide an individualized treatment approach offering intensive, age-appropriate services out in the community. The teams include Mental Health Specialists, Clinical Social Workers, Marriage and Family Therapists, Peer Specialists, Psychiatrists and Supervisors who work together to provide clinical interventions such as individual and group therapy, crisis intervention, substance use services and medication services. The most commonly used evidence-based and best practices include Assertive Community Treatment, Seeking Safety and Trauma-Focused Cognitive Behavioral Therapy. Children and TAY, in particular, also require intensive family involvement. Thus, collaboration with family members, which can include family therapy, is provided.

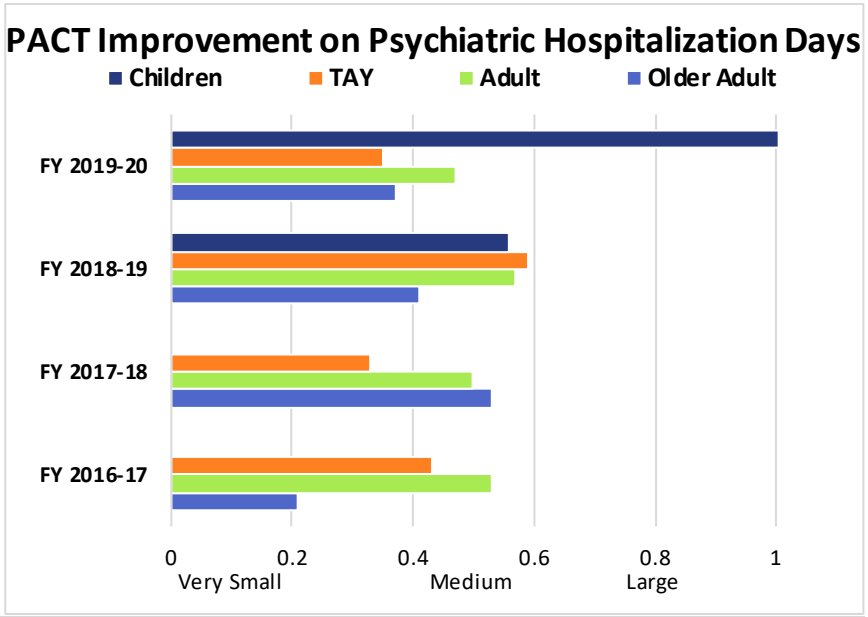
The PACT also provides intensive case management. Team members offer peer and/or caregiver support, vocational and education support, assistance with benefits acquisition, money management, advocacy and psychoeducation on a number of topics. Participants are also referred and linked to a number of community resources such as NAMI, Family Resource Centers and the Wellness Centers to help facilitate their recovery and maintain their gains after being discharged from the program.

As needed, the PACT uses flexible funding to support the needs of participants and/or their families and is intended to cover the costs of services and supports not otherwise reimbursable, as well as items such as incentives, stipends, tickets/admission fees, food, refreshments, and ancillary supports such as child care or family involvement, etc. so that the participant may fully engage in the recovery-focused activity.



OUTCOMES

Using the same approach as the FSPs, the PACT evaluated performance through several recovery-based outcome measures related to life functioning: days spent psychiatrically hospitalized, homeless, incarcerated and, for TAY and adults, employed. For children/youth under age 18, the PACT also evaluated grades and school attendance. Program effectiveness was measured by comparing differences in functioning during the 12 months prior to enrolling in the PACT to the fiscal year being evaluated. Results were statistically analyzed and reported according to the calculated effect size, which reflects, in part, the extent to which a change in functioning over time is clinically meaningful for the individuals served in the PACT. For all functional measures other than employment or education, only individuals who reported that they experienced the functional outcome (i.e., hospitalization, homelessness, incarceration) either before or after enrollment were included in the outcomes analysis. All TAY and adults were included in



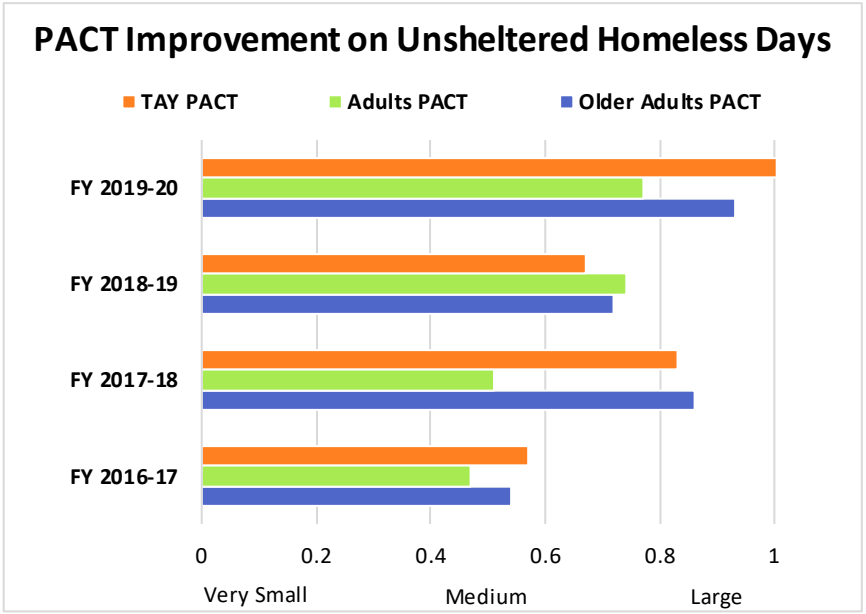
the employment analysis and all children/youth were included in the school attendance/grades evaluation.

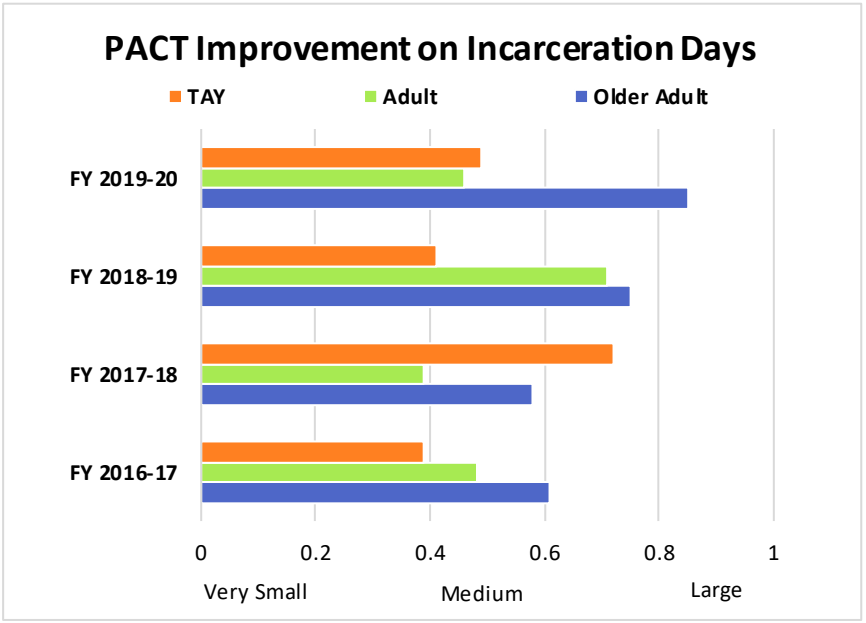
Psychiatric hospitalizations: Adults experienced a moderate reduction in psychiatric hospitalization days during each of the fiscal years reported here, as did children/youth in FY 2018-19, the first full year in which the team serving this younger age group was fully operational. In contrast, TAY and older adults demonstrated variable effectiveness, ranging from small to moderate, in reducing days spent in the hospital while served in the PACT. Older adults continue to face challenges with discharge placement options that can accommodate complex medical or physical needs of consumers, which has led to longer hospitalization stays during some years. TAY, on the other hand, experienced a moderate decrease in days hospitalized in FY 2018-19, an improvement from the two prior years. The HCA will continue to monitor the rates in future years to see if this improved reduction continues for TAY.

Homelessness: Because individuals who are homeless and living with SED/SMI are largely referred to FSP services, the number of individuals in the PACT who experience unsheltered homelessness tends to be lower than those who are in an FSP. Consistent with this, no children/youth reported experiencing unsheltered homelessness in the year prior to enrollment in the PACT and/or while receiving services in FY 2018-19.

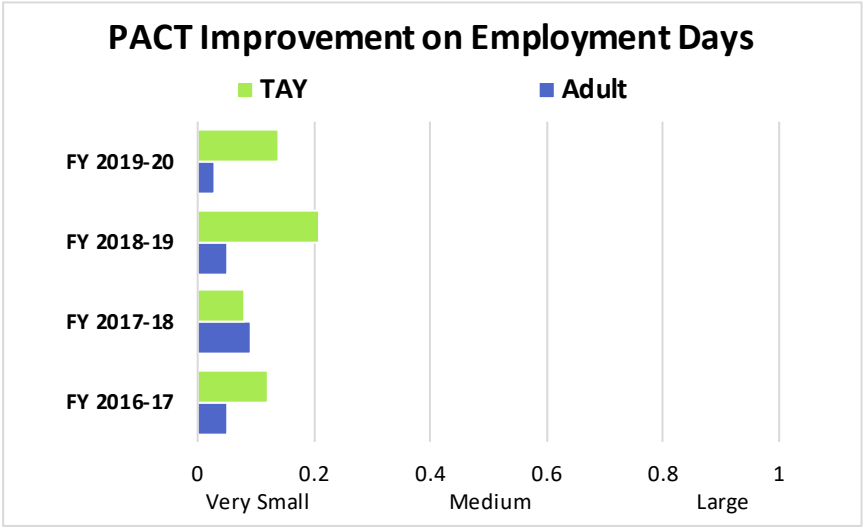
TAY, adults and older adults experienced moderate to large decreases in days spent homeless over each of the past four fiscal years (i.e., average days spent homeless while enrolled in the PACT generally ranged from 1.5-2.5 weeks for TAY except FY 2019-20 which averaged 30 days; 7-9 weeks for adults, 7-10 weeks for older adults). The number of TAY and older adults affected by homelessness tends to be much lower than the number of adults affected, thus the differences across the age groups may reflect unique characteristics of the TAY or older adults served in any given year rather than a change in overall program efficacy. The HCA will continue to monitor trends in homelessness for the PACT participants over time.

Incarcerations: TAY, adults and older adults generally experienced moderate to large decreases in days spent incarcerated over each of the past four fiscal years (i.e., average days incarcerated while enrolled in the PACT was typically 1-2.5 weeks across all age groups). Similar to findings on days spent homeless, the number of TAY and older adults who had been incarcerated tended to be much lower than the number of adults. Thus, the differences across age groups and fiscal years may reflect unique characteristics of the TAY or older adults served in any given year rather than a change in program efficacy. The HCA will continue to monitor trends in incarceration for the PACT participants.





Very few children/youth reported incarcerations prior to or during enrollment in the PACT. During FY 2019-20, two clients were incarcerated prior to enrollment for a total of 168 days (one for 28 days, one for 140 days). There were no incarceration days during enrollment in the PACT. In FY 2018-19, the first year in which the child/youth team was fully implemented, 2 of the 79 children/youth experienced incarceration (one for 121 days prior to enrollment and no days in FY 2018-19; the other reported for 30 days prior to enrollment and 19 days after).

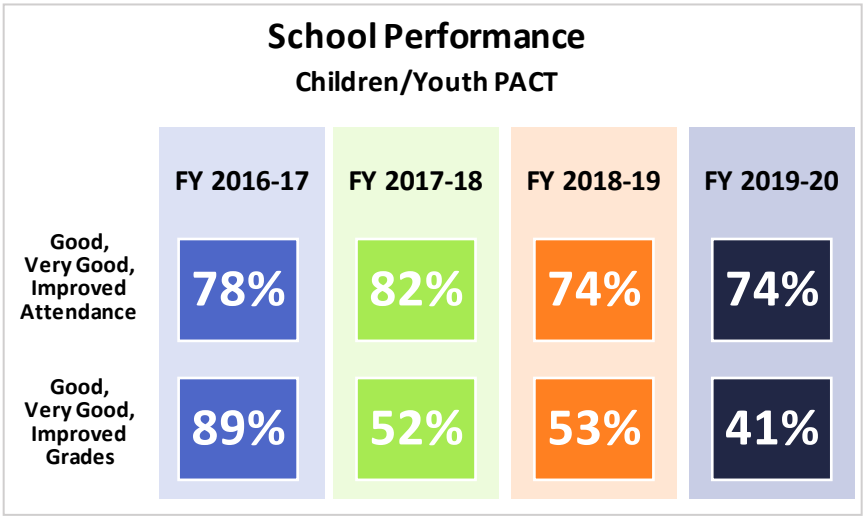


Employment: Across all fiscal years, the PACT showed minimal to no impact on improving employment, with an exception in 2018-19 where a small increase was noted for TAY. As with the FSP programs, the PACT continues to struggle with making progress on this functional domain.

Education: Across the past four fiscal years, the majority (74-82%) of children/youth demonstrated good, very good or improved school attendance while enrolled in the program compared to prior to enrollment. During the three most recent fiscal years, about half (41-53%) of youth showed good, very good or improved grades while enrolled in the PACT, which is a decline from a high of 89% observed in FY 2016-17. These findings are consistent with educational outcomes among FSP participants.

CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

The Children/Youth team is frequently at capacity, resulting in waitlists. With a small number of staff in the program, enrolling new clients can take longer. Another ongoing challenge has been the reluctance of the children/youth to use existing work/vocational programs. Instead, they prefer to seek employment on their own with coaching from program staff. In the two years since the program began, many clients have obtained employment, suggesting that this challenge may decrease as clients stabilize and take advantage of the vocational support provided by the program. In the future, the HCA would like to offer services to children/youth and their families in additional threshold languages but will need staff that speak the languages to meet this need.



The TAY, Adult and Older Adult teams have experienced some new challenges during the COVID-19 pandemic. While the teams never stopped providing services to the clients, the methods of delivery were constantly changing to maintain safety for the clients and the staff providing the services. The programs have been able to increase their use of telehealth services through WebEx to continue face-to-face services for clients who have adequate technology. For clients who do not have access to technology, the programs have received telepresence machines where the participant is able to come into the program and be in one room while their clinician is in another room. Some older adults are not comfortable using telehealth services as they feel it is not a trustworthy way of talking to their clinician. They are able to access services over the phone or in person.

Finding safe and affordable housing continues to be a challenge for the Older Adult PACT due to clients having limited supplemental Social Security Income and housing resources. This issue has increased especially during the COVID Pandemic as most shelters, Assisted Living Facilities, and Board and Care facilities are closed or are not accepting new clients. Most Older Adult PACT clients are scared and fearful of going to shelters as they are more vulnerable and are at higher risk in regard to COVID-19. There has been an increase in Older Adult PACT referrals for individuals who are homeless, at risk of evictions, and struggling to find placement which often exacerbates their mental health condition resulting in frequent hospitalizations. The PACT clinicians are addressing these challenges by increasing their visits with clients to provide additional support and continue to utilize life coaches and peer mentors to expand the list of available housing resources.

The challenges of medication adherence and follow through with medical and other appointments have improved by utilizing peer mentors and life coaches to assist with appointments. The Older Adult PACT clinicians are also using County resources such as iPhones to assist clients in connecting with their primary care doctors and psychiatrists during the COVID-19 Pandemic to address their physical and mental health needs.

New challenges that Older Adult PACT participants face during the COVID-19 pandemic are social isolation, food insecurity, and a lack of sanitizing supplies that can have a tremendous impact on their mental and physical health. The Older Adult team has addressed these issues by increasing the frequency of case management visits and bringing clients food and supplies from the food bank.

COMMUNITY IMPACT

The PACT teams in Orange County target high-risk underserved populations, which include monolingual Asian/Pacific Islanders, Latino youth and their families, and TAY, adults and older adults living with serious mental illness. The program has shown a modest reduction in psychiatric hospitalization and incarceration days, thereby reducing the need for high-cost crisis services for these individuals.

REFERENCE NOTES

Psychiatric Hospitalization Days:

Children/Youth:

FY 2019-20: Prior M=20.1, SD= 16.0; Since M= 5.8, SD 9.9; t(51)=8.0, p<.001, Cohen's d= 1.23, -71%
FY 2018-19: Prior M=29.0, SD=27.4; Since M=16.5, SD=10.8; t(7)=1.4, p<0.21; Cohen's d=0.56, -44%
FY 2017-18: None reported
FY 2016-17: None reported

TAY:

FY 2019-20: Prior M=38.1, SD=61.1; Since M=11.2, SD=49.6; t (126) = 3.92, p<0.001, Cohen's d=.35, -71%
FY 2018-19: Prior M=42.2, SD=68.2; Since M=7.6, SD=30.6; t(113)=5.6, p<0.001; Cohen's d=0.59, -84%
FY 2017-18: Prior M=46.4, SD=62.8; Since M=16.8, SD=61.1; t(82)=2.97, p<.01; Cohen's d=0.33, -64%
FY 2016-17: Prior M=46.6, SD=63.1; Since M=12.4, SD=49.4; t(92)=4.12, p<0.001; Cohen's d=0.43, -73%

Adults:

FY 2019-20: Prior M=
FY 2018-19: Prior M=47.4, SD=78.3; Since M=7.4, SD=24.7; t(590) = 12.12, p<0.001; Cohen's d=0.57, -84%
FY 2017-18: Prior M=48.7, SD=77.8; Since M=10.0, SD=35.7; t(659)=11.86, p<.001; Cohen's d=0.50, -79%
FY 2016-17: Prior M=48.1, SD=76.2; Since M=9.2, SD=27.7; t(687)=12.59, p<0.001; Cohen's d=0.53, -81%

Older Adults:

FY 2019-20: Prior M=45.0, SD=69.1; Since M=14.6, SD=61.7; t (55) = 2.78, p<0.05, Cohen's d=.37, -67%
FY 2018-19: Prior M=40.7, SD=75.5; Since M=8.6, SD=32.9; t(63) = 3.07, p=0.003; Cohen's d=0.41, -79%
FY 2017-18: Prior M=38.4, SD=74.8; Since M=4.3, SD=17.3; t(69)=3.73, p<.001; Cohen's d=0.53, -89%
FY 2016-17: Prior M=23.2, SD=43.5; Since M=12.9, SD=28.5; t(52)=1.64, p=0.11; Cohen's d=0.21, -44%

Homeless Days:

Children/Youth:

FY 2019-20: one reported
FY 2018-19: None reported

TAY:

FY 2019-20: Prior M=155.4, SD=119.2; Since M=31.0, SD=68.5; t (21) = 4.73, p<0.001, Cohen's d=1.06, -80%
FY 2018-19: Prior M=71.8, SD=89.8; Since M=11.2, SD=29.8; t(16) = 2.53, p=0.022; Cohen's d=0.67, -84%
FY 2017-18: Prior M=73.2, SD=59.2; Since M=19.9, SD=42.7; t(16)=3.36, p<.01; Cohen's d=0.83, -73%
FY 2016-17: Prior M=57.6, SD=61.2; Since M=15.2, SD=43.3; t(17)=3.37, p<0.01; Cohen's d=0.57, -74%

Adults:

FY 2019-20: Prior M=163.6, SD=137.5; Since M=48.6, SD=90.3; t (261) = 12.07, p<0.001, Cohen's d=.77, -70%
FY 2018-19: Prior M=165.4, SD=131.0; Since M=52.4, SD=93.1; t(207)=10.47, p<0.001; Cohen's d=0.74, -68%
FY 2017-18: Prior M=152.6, SD=136.1; Since M=65.8, SD=104.7; t(227)=7.62, p<.001; Cohen's d=0.51, -57%
FY 2016-17: Prior M=142.5, SD=126.0; Since M=65.3, SD=104.2; t(242)=7.97, p<0.001; Cohen's d=0.47, -54%

Older Adults:

FY 2019-20: Prior M=174.05, SD=144.53; Since M=55.1, SD=113.87 t (20)=4.16, p<0.001, Cohen's d=.93, -68%
FY 2018-19: Prior M=174.6, SD=152.5; Since M=69.0, SD=115.1; t(30)=3.50, p<=0.002; Cohen's d=0.72, -60%
FY 2017-18: Prior M=187.0, SD=141.5; Since M=49.6, SD=102.3; t(33)=4.96, p<.001; Cohen's d=0.86, -74%
FY 2016-17: Prior M=167.8, SD=145.8; Since M=71.8, SD=108.1; t(30)=2.81, p=<0.01; Cohen's d=0.54, -57%

Incarceration Days:

Children/Youth:

FY 2019-20: See narrative for number of days for two youth who reported having been incarcerated
FY 2018-19: See narrative for number of days for two youth who reported having been incarcerated

TAY:

FY 2019-20: Prior M=64.4, SD=105.9; Since M=13.4, SD=35.3; t (25) = 2.28 p <.05, Cohen's d=.49, -79%
FY 2018-19: Prior M=50.9, SD=94.6; Since M=14.1, SD=32.6; t(13)=1.38, p=0.19; Cohen's d=.41, -72%
FY 2017-18: Prior M=35.5, SD=36.0; Since M=7.3, SD=15.2; t(19)=3.02, p=.07; Cohen's d=0.72, -79%
FY 2016-17: Prior M=35.1, SD=31.9; Since M=14.7, SD=43.2; t(29)=2.48, p<0.05; Cohen's d=0.39, -58%

Adults:

FY 2019-20: Prior M=57.33, SD=82.6; Since M=15.4, SD=42.6; t (201) = 6.27, p<0.001, Cohen's d=.46, -73%
FY 2018-19: Prior M=61.7, SD=83.4; Since M=7.1, SD=21.9; t(176)=8.29, p<0.001; Cohen's d=0.71, -89%
FY 2017-18: Prior M=55.6, SD=83.9; Since M=18.1, SD=50.3; t(200)=5.38, p<.001; Cohen's d=0.39, -67%
FY 2016-17: Prior M=60.9, SD=85.5; Since M=18.5, SD=40.2; t(216)=6.38, p<0.001; Cohen's d=0.48, -70%

Older Adults:

FY 2019-20: Prior M=86.96, SD=91.88; Since M=7.27, SD=24.03; t (14) = 3.04, p<0.05, Cohen's d=.85, -92%
FY 2018-19: Prior M=78.3, SD=99.3; Since M=12.6, SD=25.5; t(13)- =2.40, p=0.032; Cohen's d=0.75, -84%
FY 2017-18: Prior M=59.3, SD=85.1; Since M=9.2, SD=22.7; t(12)=1.93, p=.08; Cohen's d=0.58, -84%
FY 2016-17: Prior M=127.9, SD=110.7; Since M=39.9, SD=95.7; t(10)=3.24, p<0.01; Cohen's d=0.61, -69%

Employment Days:

Children:

Not assessed for children

TAY:

FY 2019-20: Prior M=27.2, SD=71.0; Since M=40.4, SD=86.0; t (136) = -1.63, p=.105, Cohen's d=-.14, 49%
FY 2018-19: Prior M=26.8, SD=69.3; Since M=46.8, SD=98.4; t(96)=-2.04, p=0.044; Cohen's d=-0.21, 75%
FY 2017-18: Prior M=26.2, SD=72.9; Since M=33.7, SD=82.7; t(90)=-0.73, p=.47; Cohen's d=-0.08, 29%
FY 2016-17: Prior M=37.2, SD=87.1; Since M=45.1, SD=92.7; t(92)=-0.68, p=0.50; Cohen's d=-0.12, 22%

Adults:

FY 2019-20: Prior M=24.1, SD=71.0; Since M=27.0, SD=75.1; t (722) =-.94, p=0.349, Cohen's d=-.03, 12%
FY 2018-19: Prior M=29.7, SD=77.9; Since M=34.33, SD=83.1; t(640)=-1.20, p=0.231; Cohen's d=-.05, 15%
FY 2017-18: Prior M=30.2, SD=81.0; Since M=40.0, SD=93.6; t(718)=-2.41, p<.05; Cohen's d=-0.09, 33%
FY 2016-17: Prior M=27.3, SD=77.5; Since M=33.0, SD=83.5; t(753)=-1.55, p=0.12; Cohen's d=-0.05, 21%

Summary of MHSA Strategies Used by FSP/PACT

STRATEGIES TO PROMOTE RECOVERY/RESILIENCE

Central to all of Orange County's intensive outpatient treatment programs is the emphasis placed on helping individuals move forward in their recovery. The PACT and FSP provider staff work with participants using a strengths-based model to customize their individualized, client- and family-centered treatment plans, aligned with participants' wants and needs, and matched to their level of functioning. Many of the adult providers utilize tools from the Recovery Centered Clinical System, which focuses on exploring identity, defining hopes and dreams, making choices, reducing harm and making connections. All participants are encouraged to broaden their resources and support systems by increasing their social contacts, improving family relationships when appropriate, and having meaningful roles in the community. Team members strive to instill hope in the participants with whom they work, identify their and their families' strengths, maintain a non-judgmental stance, and have empathy for their and their families' struggles. Integral to these efforts are Peer Specialists, Peer Coaches and Parent Partners who share their lived experience, serve as positive models, encourage empowerment, facilitate community integration, and build, enhance and maintain resilience.

STRATEGIES TO REDUCE STIGMA AND DISCRIMINATION

FSP and the PACT program staff also recognize that providing quality services begins with taking into consideration the culture, values, preferences and needs of the individuals and families they serve and, as such, strive to hire bilingual and bicultural staff. All staff participate in on-going trainings related to ethnicity, religious observations, gender identity and sexual orientation. These trainings provide staff with an overview of how to incorporate culturally responsive approaches in their interactions with participants, and enable staff to better connect with unserved, underserved and culturally and linguistically isolated individuals through conversations that fit with the individuals' and their families' values and worldview. For example, some of the perspectives that the provider serving the Asian and Pacific Islander (API) population considers when providing services to participants include the medical and spiritual aspects of mental health, somatic symptoms and the chance to improve education or employment outcomes through mental health services. They also hire staff who are sensitive to the fact that the children and youth they serve may have values and perspectives that are different from those of their parents/guardians and staff actively work to bridge any cultural divide. Thus, through training and/or experience, staff understands the heightened stigma and misconceptions about mental health that can exist in underserved ethnic communities and draws upon this information to facilitate engagement with participants, establish rapport and reduce stigma and discrimination. In addition to providing valuable direct services and supports to participants, Peer Specialists also serve as inspirational role models, which can be powerful in reducing mental health-related stigma among the people and families served.

STRATEGIES TO IMPROVE TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS

Individuals and families referred to the PACT and FSP programs often face issues that may keep them from seeking services. These can include language/cultural barriers; recent immigration to the United States; anxiety about their legal status and the possibility of being deported; homelessness, high risk of homelessness, or housing instability; lack of financial or other resources; lack of food or childcare, transportation challenges; criminal justice involvement and mistrust of "the system;" difficulty navigating the very large mental health system; lack of open program space; stigma related to having a mental health condition; a tendency to attribute mental health symptoms to previous substance use (theirs and/or their parents'); and previous negative experiences with mental health professionals.

To counter these barriers, the FSP providers seek to facilitate access to their programs in a number of ways. They provide presentations to educate the community about their services and tailor their messages to reach those who are not traditionally referred for mental health treatment. For example, the provider serving the API community promotes its services through "safe topics" such as how educational or employment attainment can be improved by receiving services that improve mental well-being. Once a referral is received, FSP providers across all programs quickly do outreach and engagement wherever the referred individual is at,

including their home, shelters, public areas such as parks/libraries, a hospital, correctional facility or anywhere else the person is known to be. During these contacts, staff focuses on building therapeutic relationships in order to facilitate trust and encourage linkage to ongoing services.

In addition, providers strive to provide services in a linguistically and culturally competent manner to diverse, underserved populations in Orange County. When bilingual staff are not available, the staff has access to all languages through a contracted interpreter service provider that is available when needed. The programs also offer regular staff trainings to increase cultural sensitivity and understanding when providing services to participants and their families who come from cultural backgrounds that are different from their own.

When individuals and/or families seem hesitant to participate in services, staff explore the obstacles preventing them from accessing resources or progressing through their care plan. The individual, family and FSP team attempt to work through the challenges together by adapting strategies, comparing positives and negatives of behaviors and consequences, reframing negative situations to create new momentum, engaging the participant in problem-solving, eliciting change statements, reinforcing responsibility, giving praise and encouragement and cultivating hope in one's ability to succeed. The providers also make an effort to educate participants about, and link them to, appropriate resources outside of their programs. This can include financial assistance and benefits, housing, the behavioral health continuum of care and other resources that promote self-sufficiency and encourage community.

STRATEGIES TO INCREASE ACCESS TO SERVICES: TIMELY ACCESS FOR UNDERSERVED POPULATIONS AND LINKAGE TO TREATMENT

To overcome these wide-ranging challenges, the PACT teams operate under the "whatever it takes" model to engage individuals in treatment. They provide person-centered, recovery-based interventions primarily in the home or wherever participants are comfortable meeting to overcome barriers to access or engagement. The teams also carry smaller caseloads so individuals and their families can be seen more frequently and have their needs met in a timely manner. Moreover, many of the PACT therapists are bilingual and able to communicate with monolingual individuals and family members in their preferred language, thus facilitating their engagement in services.

The teams serving adults and older adults also offer a streamlined referral and linkage process to (1) allow direct referrals into the PACT, and/or to (2) include more detailed and frequent follow-up with individuals who miss appointments or do not access treatment. As a result of these operational changes, individuals are linked to services more quickly and feel supported through the process. In addition, some clinicians are specifically assigned to engage individuals who are referred from hospitals, and homeless shelters such as The Courtyard and the MHSA housing programs.

The Child/Youth team, implemented in June 2017, has worked to increase timely access to its services by presenting to providers about the PACT services and eligibility criteria. Once referred, Child/Youth therapists have attended sessions with the referring therapist, psychiatrist, youth and parent in order to explain the program in detail and establish rapport with the youth and parent. Like the other teams, the Child/Youth team also works with hospital staff, child welfare, Probation Officers and others involved with the youth and family to engage them in their program services.

The PACT teams also recognize the importance of successfully linking program participants to community-based providers as they approach discharge from the PACT. Clinicians attend appointments with individuals in the new setting to ensure a smooth transition and ease any anxiety they may feel over the change. Although this transition can be difficult and may take several visits, program staff appreciate the value of this process in allowing individuals to continue moving forward on their recovery journeys.

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

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

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

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

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

Proportion to be Served by Demographic Characteristic: Combined and by FSP Age Group					
Race/Ethnicity	% COMBINED	% Children	% TAY	% Adult	% Older Adult
African American/Black	7	5	5	9	9
American Indian/Alaskan Native	1	1	1	1	1
Asian/Pacific Islander	11	19	11	9	6
Caucasian/White	38	13	22	52	64
Latino/Hispanic	38	59	56	23	13
Middle Eastern/North African	1	1	1	1	1
Other	4	2	4	5	6

SUPPORTIVE SERVICES

Supportive Services provides a broad array of supports generally designed to augment and expand an individual's gains made in treatment programs, particularly those within Outpatient Treatment, Crisis Prevention and Support Services, and Residential Treatment. These programs, which are funded by CSS and PEI serve individuals of all ages and are further subdivided into the following categories:

- Peer Support
- Family Support
- General Support
- Housing Support

Peer Support programs are staffed with individuals who have lived experience with mental health and/or substance use recovery, and their family members (i.e., parent partners of child/youth participants). While Orange County includes peers and parent partners as part of the service delivery teams of many of its behavioral health programs (i.e., FSPs, PACT, Veteran-Focused Early Intervention Outpatient, Suicide Prevention Services, etc.) the programs described here are different in that the full scope of services they offer are provided exclusively by peers and their family members. By sharing their lived experience, peers and parent partners are able to help support and encourage participants in their own recovery journeys.

Peer Mentor and Parent Partner Support (CSS)

The **Peer Mentor and Parent Partner Support** program serves individuals who are living with a serious emotional disturbance (SED) or serious mental illness (SMI), may also have a co-occurring substance use disorder, and would benefit from the supportive services of a Peer Specialist. Peer Specialists may include peer or youth mentors and/or parent partners who work with participants' family members who would benefit from the supportive services of a parent mentor. Individuals referred to this program can receive support with linkage to services and/or with achieving one or more recovery goals.

AGE RANGE

All Ages

PRIMARY LOCATION

Field | Clinic

TARGET POPULATION

At-Risk | Mild-Moderate | ✔ Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

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

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	Gender	%	Race/Ethnicity	%
0-15	21	Female	42	African American/Black	5
16-25	32	Male	57	American Indian/Alaskan Native	1
26-59	39	Transgender	1	Asian/Pacific Islander	8
60+	8	Genderqueer	-	Caucasian/White	28
		Questioning/Unsure	-	Latino/Hispanic	51
		Another	-	Middle Eastern/North African	2
				Another	5

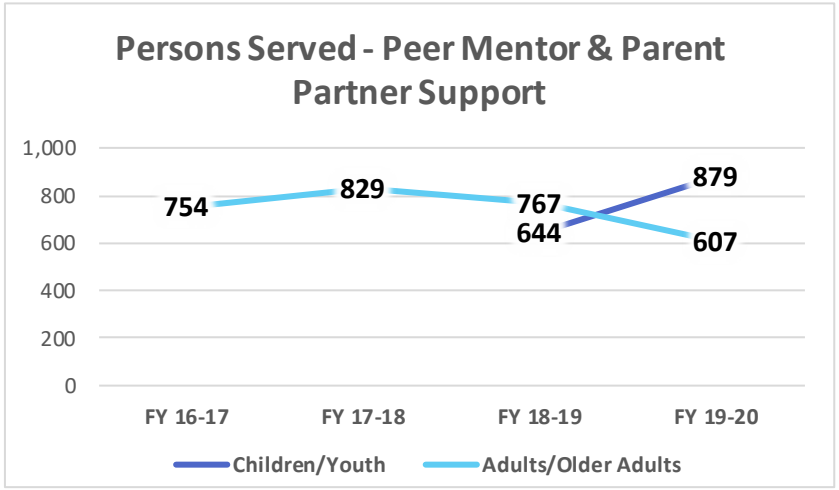
BUDGETS & PROJECTED #'s TO BE SERVED FROM 3YP

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$4,249,888	2,638
FY 2021-22*	$4,249,888	2,771
FY 2022-23	$4,249,888	2,884

**No proposed changes for FY 2021-22*

SERVICES

Through this program, Peer Specialists work with participants to help them achieve identified goals. By sharing their lived experience, Peer Specialists are often able to provide the encouragement and support a person needs to engage in ongoing services and achieve their personal goals. The support provided is customized depending on the individuals' needs and personal recovery goals, and can include the following:



- Support in linking to services that may involve activities such as:
  - Accessing behavioral health or medical appointments
  - Accessing community-based services such as food pantries or emergency overnight shelters as needed
  - Re-integrating into the community following discharge from inpatient care, hospitalization, emergency department visits and/or incarceration/in-custody stays
- Support in building skills that may involve activities such as:
  - Learning independent living skills, such as how to use and navigate the public transportation system
  - Increasing socialization activities such as attending groups or activities at the Wellness Centers and/or facilitating or assisting with groups
  - Managing and preventing behavioral health crises
  - Obtaining identification cards or driver's licenses
  - Learning skills to find, obtain and/or sustain housing placements, which may include landlord negotiations, housekeeping, food shopping and preparation, financial management, medication management, transportation, medical care, arranging utilities, phone, insurance and access to community supports and services[1]

Referrals for support with linkage to services are provided by: 1) Therapists working with individuals who need additional support when transitioning between behavioral health services and/or levels of care; 2) Staff in a Crisis Stabilization Unit (CSU), Royale Therapeutic Residential Center or crisis services program connecting individuals into ongoing outpatient care; and/or 3) Therapists or Personal Service Coordinators working with an individual as they re-integrate into their community following a recent hospitalization, incarceration/juvenile detention, or shelter stay (i.e., Orangewood, etc.). Referrals for support with achieving one or more recovery goals are provided by: 1) BHS therapists working with an individual, and perhaps their families, on their treatment goals within an outpatient clinic and/or community setting; and/or 2) BHS Outreach & Engagement (O&E) team and Housing Navigators working with individuals in need of housing sustainability assistance after being placed as part of Orange County's Whole Person Care plan.

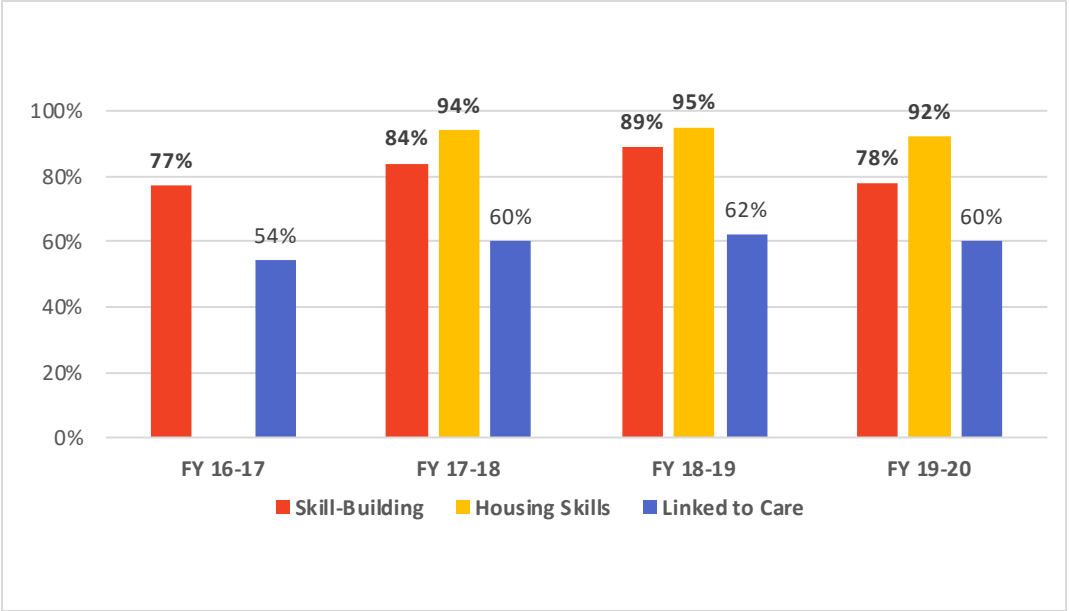
OUTCOMES

Across the three fiscal years reported here, adults and older adults engaged in outpatient care were largely successful in achieving their skill-building goals with the support of their peer. The most common types of goals included learning to navigate the public transportation system, obtaining identification cards or driver's licenses, completing housing applications, and increasing socialization activities. The program was expanded to serve children/youth in FY 2017-18, and implementation began ramping up in FY 2018-19. Outcomes for this age group are still in development and will be reported in future Plan Updates.

[1] This area is the focus of the provider supporting Orange County's Whole Person Care plan.

In its first full year of implementation, nearly all (i.e., 91%) individuals supported by the Whole Person Care provider achieved their housing-related goals. Provider improvements in staffing, the referral and screening process, as well as closer collaboration with Housing Services, contributed to this higher goal attainment rate in FY 2018-19 relative to FY 2017-18, which was the first year these services were provided.

A little over half of adults and older adults were successfully linked to behavioral health and/or medical appointments with the support of their peer.



CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

The utilization of peer mentors within clinical programs is a relatively new strategy in Orange County and, as with any new program concept, it can take time to promote its services. Educating the various referral sources about Peer Mentoring services is a high priority, and staff provides frequent presentations throughout the county about the services they offer. In addition, homelessness continues to be an issue with regard to the peers' ability to maintain contact with the participants and increased efforts have been made during the initial contact to obtain as much identifying information from the participant as possible on how to best reach them. Initial results from these front-end efforts have been promising.

COMMUNITY IMPACT

Peer Mentoring has provided services to approximately 3,000 adults and older adults since services began in November 2015, and 644 children and youth since services were first added for this age group in FY 2018-19. The program recognizes that building County and community partnerships is a priority. In addition to the strong ongoing partnerships with referral sources such as the County and County-contracted clinics and the County Crisis Stabilization Unit, the program also partners with the Wellness Centers, the Council on Aging, NAMI and housing agencies.

Wellness Centers (CSS)

Orange County funds three **Wellness Center** locations that serve adults 18 and older who are living with a serious mental illness and may have a co-occurring disorder. Members are relatively stable in, and actively working on their recovery, which allows them to maximize the benefits of participating in Wellness Center groups, classes and activities. The Centers serve a diverse member base and Wellness Center West, in particular, has a unique dual track program that provides groups, classes and activities in English and monolingual threshold languages that meet the cultural and language needs of the population located in the city of Garden Grove. The predominant threshold language in the monolingual track is Vietnamese.

AGE RANGE

All Ages

PRIMARY LOCATION

Field | Community

TARGET POPULATION

At-Risk | Mild-Moderate | Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

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

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	Gender	%	Race/Ethnicity	%
0-15	-	Female	46	African American/Black	5
16-25	10	Male	52	American Indian/Alaskan Native	1
26-59	81	Transgender	-	Asian/Pacific Islander	14
60+	9	Genderqueer	-	Caucasian/White	43
		Questioning/Unsure	-	Latino/Hispanic	22
		Another	2	Middle Eastern/North African	1
				Another	14

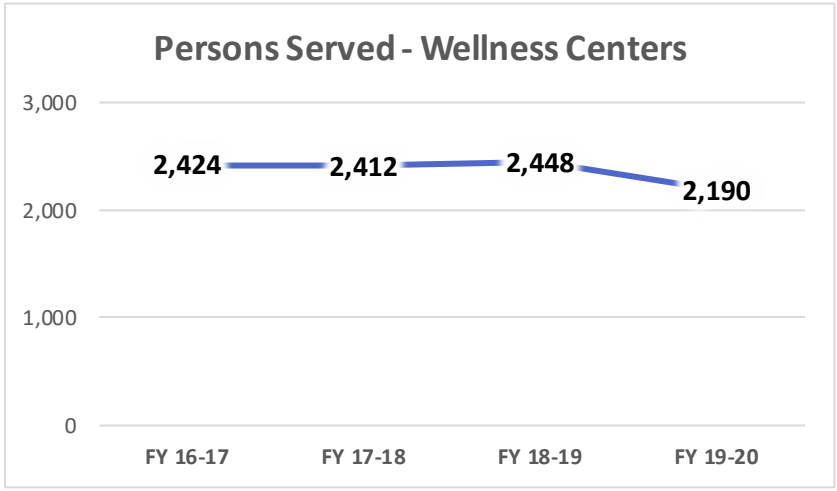
BUDGETS & PROJECTED #'s TO BE SERVED FROM 3YP

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$3,354,351	2,550
FY 2021-22*	$3,354,351	2,600
FY 2022-23	$3,354,351	2,600

**No proposed changes for FY 2021-22*

SERVICES

Wellness Centers are grounded in the Recovery Model and provide a support system of peers to assist members in maintaining their stability while continuing to progress in their personal growth and development. The programs are culturally and linguistically appropriate while focusing on personalized socialization, relationship building, assistance with maintaining benefits, setting educational and employment goals, and giving back to the community via volunteer opportunities.

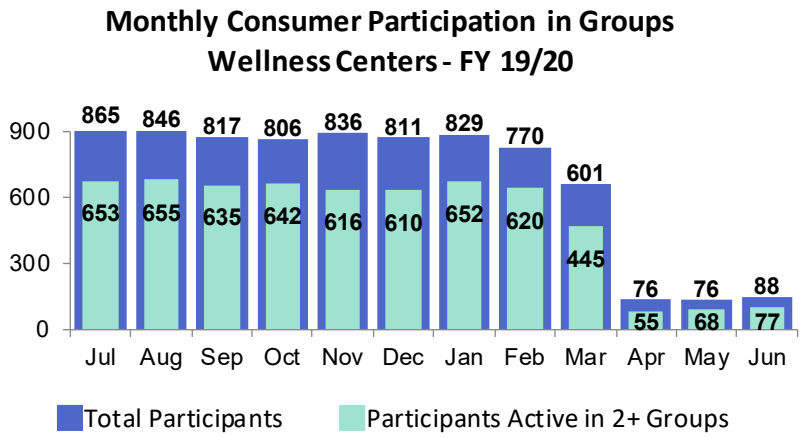


Recovery interventions are member-directed and embedded within the following array of services: individualized wellness recovery action plans, peer supports, social outings, recreational activities, and linkage to community services and supports. Services are provided by individuals with lived experience and are based upon a model of peer-to-peer support in a non-judgmental environment. A wide variety of weekend, evening and holiday social activities are provided for members to increase socialization and encourage (re)integration into the community. The ultimate goal is to reduce reliance on the mental health system and to increase self-reliance by building a healthy network of support which may involve the members' family, friends or significant others.

The Wellness Centers utilize Member Advisory Boards (MABs) composed of members who develop or modify programming and evaluate the successes or failures of groups, activities and classes. They also use a community town hall model and member Satisfaction and Quality of Life surveys to make decisions about programming and activities.

OUTCOMES

The Wellness Centers monitor their success in supporting recovery through two broad categories: social inclusion and self-reliance. Social inclusion is evaluated in two interrelated ways. First, the Wellness Centers encourage their members to engage in two or more groups or social activities each month. As can be seen in the graph, the Centers met this goal with 72-89% of members participating in two or more groups/activities each month during FY 2019-20. This is comparable to FY 2016-17 through FY 2018-19 (see Appendix VII for graphs).

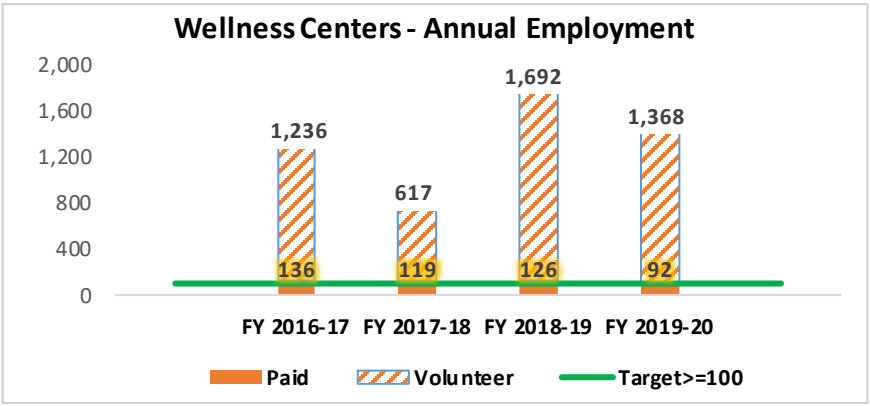


Second, of the various social activities offered, the Centers particularly encourage their members to engage in community integration activities as a key aspect of promoting their recovery. In FY 2019-20, 1,638 adults (75%) participated in community integration activities, which is lower than the rates in FY 2016-17 through FY 2018-19, (84%, 84% and 97%, respectively) and was likely attributable to the COVID-19 pandemic that began in the last quarter of the fiscal year.

The Wellness Centers also strive to increase a member's self-reliance, as reflected by school enrollment and employment rates. A total of 153, 219, 146 and 141 adults enrolled in education classes in FY 2019-20, FY 2018-19, FY 2017-18, and FY 2016-17, respectively. Thus, school enrollment remains a challenging area and HCA staff will continue to work with the providers to strategize new ways to increase interest and enrollment in classes. To assist members in furthering their

education in ways that may not require a long term school commitment, members are encouraged and have been completing on-line courses that are shorter in duration and which issue a certificate of completion at the end of the course. This has been well received by members and serves to build confidence by achieving shorter term goals and often leads to more interest by members in furthering their education.

In contrast, 1,460 adults in FY 2019-20, 1,818 adults in FY 2018-19, 736 adults in FY 2017-18, and 1,372 adults in FY 2016-17 were involved in employment, primarily due to the large proportion in volunteer positions. The programs will continue their efforts to engage members in employment-related activities and work toward increasing the number who obtain paid positions.



CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

A continuing challenge for accessing the Wellness Centers is transportation, which can take from 45 minutes to two hours each way on public transportation. Each of the Wellness Centers strives to offer activities in different community settings that allow access in members' own neighborhoods without the need for extensive travel. With the centers operating in the west, central and south regions of the county, access has improved. The south county center is particularly challenging when it comes to public transportation, as the majority of bus routes are no longer in operation in that region. To assist individuals with accessing and utilizing the south center, HCA has authorized the utilization of its Transportation program to assist those individuals with the most challenging transportation needs to get to the south center.

COMMUNITY IMPACT

Since their respective programs' inceptions, over 6,300 adults have received services at Wellness Center Central, with an average daily attendance of 66 members, six days per week; more than 850 adults at Wellness Center South, with an average daily attendance of 29 members, six days per week; and nearly 1,800 members at Wellness Center West, with an average daily attendance of 47 members per day, six days per week.

Continuum of Care for Veterans and Military Families (INN)

The **Continuum of Care for Veterans and Military Families** Innovation project integrates military family culture and services into Families and Communities Together (FaCT) Family Resource Centers (FRCs) located throughout Orange County. It seeks to expand general service providers' knowledge of how to best meet the needs of military-connected families so that they feel competent and willing to identify and serve this currently hidden population. The target population served includes active service members, reservists, veterans (regardless of their discharge status) and their children, spouses, partners and loved ones.

AGE RANGE

All Ages

PRIMARY LOCATION

Field | Community

TARGET POPULATION

At-Risk | Mild-Moderate | Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

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

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	Gender	%	Race/Ethnicity	%
0-15	55	Female	50	African American/Black	15
16-25	10	Male	50	American Indian/Alaskan Native	-
26-59	35	Transgender	-	Asian/Pacific Islander	10
60+	-	Genderqueer	-	Caucasian/White	45
		Questioning/Unsure	-	Latino/Hispanic	30
		Another	-	Middle Eastern/North African	-
				Another	-

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

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$962,445	250
FY 2021-22*	$728,500	100
FY 2022-23	-	

**Proposed increase to correct for oversight on including final year of project budget in the 3YP*

SERVICES

Peer Navigators with lived military experience are co-located within FRCs to provide two key functions: (1) provide case management and peer support to referred participants, and (2) provide military family culture awareness trainings for FRC staff so that they are better able to identify, screen and serve military-connected families. The project is also staffed with clinicians who, with the on-going support of Peer Navigators, provide counseling and trauma-informed care utilizing evidence-based practices. Additional services include referral and linkage to County and community programs.

Continuum of Care for Veterans and Military Families was implemented July 1, 2018. The primary purpose of this project is to increase access to mental health services, with a goal of making a change to an existing practice in the field of mental health, including but not limited to, application to a different population. Innovation funds for this project will end in March 2023.

OUTCOMES

In FY 2019-20, program staff integrated into all 15 FaCT FRC sites throughout Orange County. However, community outreach events were significantly impacted due to stay-at-home orders and social distancing requirements in response to the COVID-19 pandemic. Staff conducted 17 community outreach events, compared to the 37 events held in FY 2018-19. In FY 2019-20, Peer Navigators, clinicians and collaborative partners provided 256 trainings related to military family culture to FRC staff, which included specialty trainings on military legal issues, domestic violence and housing. This is an increase from the 151 trainings provided in FY 2018-19. In the upcoming year, the program will further expand on trainings to include e-Learns, brief microlearning sessions that will be available online to FRC staff.

In FY 2019-20, 47 military-connected families (n=175 individual family members) were served, which is an increase from FY 2018-19 (37 military-connected families; n=140 individual family members). A total of 1,728 case management session were provided to families, in contrast to the 475 sessions provided in FY 2018-19. Due to their lived experience and extensive training, the Peer Navigators were able to identify needs and appropriately refer military-connected families to resources, thereby increasing the likelihood that families would receive needed services in a timely manner.

CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

A significant challenge in this program involves the collaboration with FRCs due to their unique population needs and variation in operations across the different sites. FaCT FRCs include over 100 funded and unfunded community partners, adding complexity to the collaboration, training and partnership elements of this program. To address this challenge, program staff continue to attend FRC meetings and work closely with FRC staff to learn about the unique culture and needs of each site. The program is also currently developing brief online trainings on various topics to increase FRC staff's access to information about military family culture, based on their specific needs.

COMMUNITY IMPACT

The lead agency for this project, Child Guidance Center, and their collaborative partners, is committed to informing nonmilitary community organizations about the importance of identifying, engaging and serving military families to best meet their needs. These partners presented at the FaCT Annual Conference on "The Sacrifices of Service: The Unique Experiences of Military Members, Veterans, and Their Families" and facilitated two breakout sessions that focused on the current systems in place for military families, its gaps, and solutions to address those gaps. This was the first time in the history of the FaCT conference that a breakout session was conducted regarding military-connected families. To further train community agencies on the topic, the collaborative partners also provided an in-service training for all FRC staff and Orange County community providers titled, "Building Military Cultural Competency in the FRCs to Collaboratively Serve Military Families." These trainings were well received by both the FRC staff and FaCT Program Administrators, and has increased interest on being trained in this area among community providers.

Summary of MHSA Strategies Used by Supportive Services Programs: Peer Services

STRATEGIES TO PROMOTE RECOVERY/RESILIENCE

In one-on-one services, peers, parent partners and peer navigators focus on a participant's strengths and foster their sense of empowerment, hope and resilience while on their recovery journey. The activities in which participants engage are designed to enhance their resourcefulness and well-being in emotional, physical, spiritual and social domains, thus allowing them to re-integrate successfully into their communities. In addition, the Wellness Centers provide a safe and nurturing environment where each individual can achieve their vision of recovery while in a setting that promotes acceptance, dignity and social inclusion. Peer Navigators in the Continuum of Care project also have specific experience and knowledge of military culture and train FRC staff on military culture and identifying military-connected families, which has increased military cultural awareness among non-veteran serving organizations.

STRATEGIES TO REDUCE STIGMA AND DISCRIMINATION

The programs strive to make their services available to all eligible Orange County residents in a manner that is sensitive and responsive to participants' diverse backgrounds. Cultural competence is an essential part of the development, recruitment and hiring of staff. Within the clinic settings where the peer mentors and parent partners work, peers/partners strive to reduce stigma and discrimination by drawing upon their cultural strengths and providing services and assistance in a manner that is trusted by, and aligns with, the community's ethnic and culturally diverse populations. In addition, peers/partners encourage participants and other staff working in the Clinics/Programs to use recovery language. They normalize seeking mental health treatment by sharing their own lived experiences and by discussing how any other individual would seek treatment for a physical illness. Peers/partners also demonstrate empathy, caring and concern to bolster participants' self-esteem and confidence. As a result, a unique bond between the peer and the participant can be developed, which gives the participant space to open up about their reluctance or challenges with medication, services, doctors, etc.

In addition, the Wellness Centers reduce stigma and discrimination by providing a warm, welcoming and accepting environment, and serving all members who meet program criteria regardless of their personal history, race, ethnicity, gender identity or sexual orientation. Multi-cultural events such as Hispanic Heritage Day, Black History Month and Multi-Cultural Day are very popular with members, and are frequently held to educate and inform members about other cultures and the customs and traditions they enjoy, including dance, music and food. The Wellness Centers also offer a variety of groups such as Diversity Plus and the LGBTIQ group that are specifically designed for their widely diverse membership.

Employment preparation, offered both by the Centers and Peer Mentors/Parent Partners, also helps participants focus on their experiences, skills and what they have to offer, rather than on their mental health condition. Socialization activities held in the community help to develop confidence in participants that they, too, can participate in everything their communities have to offer, which helps to reduce isolation and fear.

Finally, military-connected families seeking FRC resources have the opportunity to access behavioral health services through a less stigmatizing point of entry. Peer Navigators also connect with families by sharing their military backgrounds, which helps overcome fears of being misunderstood.

STRATEGIES TO INCREASE ACCESS TO SERVICES: TIMELY ACCESS FOR UNDERSERVED POPULATIONS AND LINKAGE TO TREATMENT

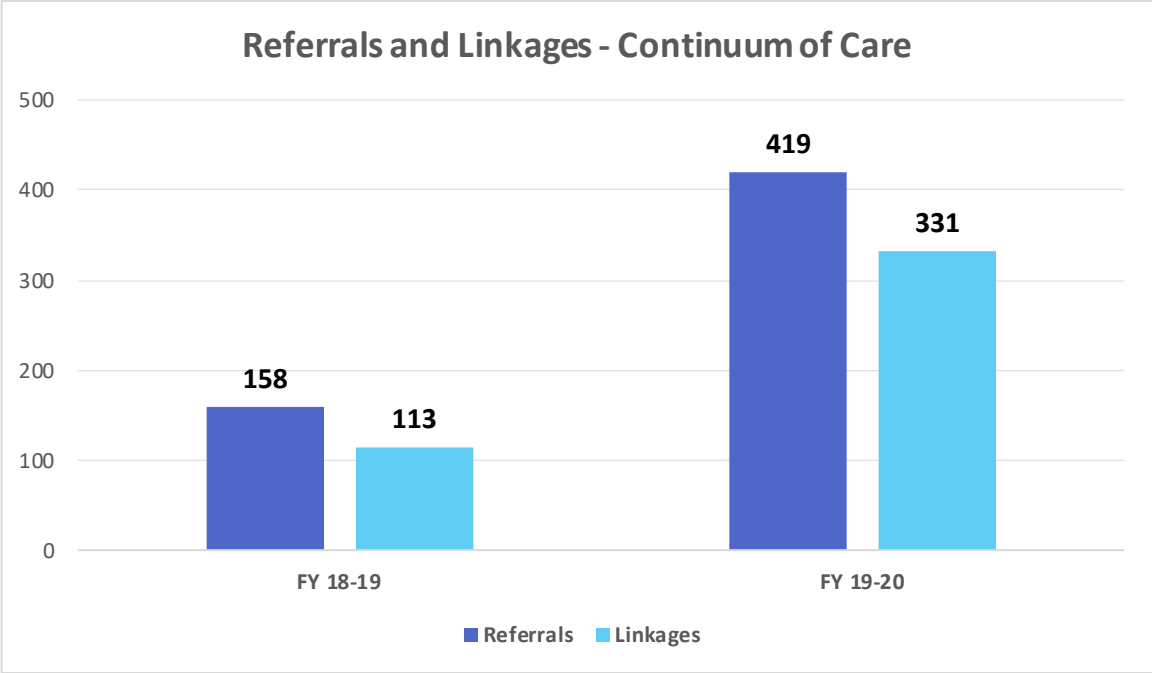
The programs conduct outreach to potential referral sources in order to increase awareness of and access to their services. For example, the Wellness Center distributes flyers and monthly activity calendars to all County and County-contracted programs, and frequently staff booths at behavioral health and other community events. The Peer Mentoring/Parent Partner program has proactively built relationships with leadership at County and County-contracted outpatient

clinics by conducting presentations to inform staff of the referral process, services provided, and to share success stories. Sharing data on linkage rates and successful goal completion as a result of using Peer Mentoring services has had a large influence on increasing referrals to the program.

Referred individuals may face barriers to engaging in services due to housing, transportation, childcare, challenges with scheduling and/or symptoms of a mental health condition may prevent members from engaging in Peer Mentoring services and/or Center activities. Utilizing peer staff with lived experience with behavioral health issues is key to operating programs of this nature as these staff can relate on a much deeper level with individuals because they have often walked in their shoes. Peer staff are from a variety of cultures, ethnicities and backgrounds, and have the ability to serve members in all threshold languages

Homelessness is another factor that can affect access to Peer Mentoring program services, in particular, as mentors can lose touch with individuals who do not have a stable residence or telephone to remind them about their appointments or responsibilities. Peers proactively address this potential challenge at their first meeting by making a significant effort to learn about where a participant may be staying and how to contact them to minimize losing contact with them once their initial meeting has ended.

Finally, to meet the specific, complex needs of military families, the collaboration of non-profit community organizations supporting the Continuum of Care project provided specialty services to families with domestic violence, housing and legal needs. Providing access to these services directly within the FRCs enables Peer Navigators to connect with participants while they are seeking other support services and provide them with timely access to behavioral health support and treatment, as well as other needed services. The project also trains FRC staff on how best to meet the needs of military-connected families so that they feel competent and willing to identify and serve this target population. FRCs also serve as a new point of entry into behavioral health and supportive services for military families. The support offered by a military-connected peer increases family members' access to needed services, especially behavioral health care, which they may be reluctant to seek on their own due to the stigma associated with mental health conditions.



Most Common Linkages Made

LEGAL SERVICES, MENTAL HEALTH CARE, TRANSPORTATION, HOMELESS SERVICES, AFFORDABLE HOUSING, PRIMARY/DENTAL CARE, CLOTHING, JOB PLACEMENT, FOOD AND NUTRITION, JOB PLACEMENT, FOOD/ NUTRITION, OTHER SERVICES (I.E., CHILD SUPPORT, FINANCIAL, UTILITY ASSISTANCE, ETC.)

General Support programs provide supplementary services designed to improve recovery by helping participants meet essential needs such as transportation assistance and/or develop skills. At present, all programs in this subset are for adults 18 and older and are funded through CSS. However, the transportation program, described below, will be expanded to include assistance for children (while accompanied by their parent/caregiver).

Transportation (CSS, PEI)

The **Transportation** program serves adults ages 18 and older, who have a serious mental illness or substance use disorder, and who need transportation assistance to and from necessary County behavioral health or primary care appointments or select supportive services (particularly housing-related). Individuals are referred by their BHS treatment provider, following an assessment of their transportation needs and history of scheduled appointments missed due to transportation issues. Based on the community planning process for the Three-Year Plan, this program was to be expanded to support participants with additional transportation needs. However, due to the lingering impact of COVID-19, exploration of expanding services to youth and families with children, including those who must be transported in child safety seats, and to support services that help address social determinants of health, may be postponed.

AGE RANGE

Ages 18+

PRIMARY LOCATION

Community

TARGET POPULATION

At-Risk | Mild-Moderate | Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

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

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	Gender	%	Race/Ethnicity	%
0-15	-	Female	65	African American/Black	4
16-25	13	Male	35	American Indian/Alaskan Native	1
26-59	75	Transgender	-	Asian/Pacific Islander	7
60+	12	Genderqueer	-	Caucasian/White	49
		Questioning/Unsure	-	Latino/Hispanic	36
		Another	-	Middle Eastern/North African	-
				Another	3

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

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$1,150,000	1,575
FY 2021-22*	$1,300,000	1,650
FY 2022-23	$1,300,000	1,650

**Proposed decrease to account for temporary reduced use of transportation services due to COVID-19. $200k of FY 2021-22 budget is from PEI*

SERVICES

Individuals are provided curb-to-curb service or door-to-door service if they are living with physical disabilities that may require additional assistance entering or exiting the vehicles. All that is required for the person to do is schedule the appointment in advance and the driver will pick them up at their specified location, take them to their appointment, pick them up after the appointment and take them back to their destination of origin. Individuals can also stop and get their prescriptions filled as necessary. Transportation services have also been authorized for use by both CSS and PEI field outreach teams for a one-time use to link participants served in the field to their initial behavioral health appointments. In addition, Transportation services may be used to link participants being discharged from the County's Crisis Stabilization Unit to their follow-up appointments at either of the County's Open Access clinics.

STRATEGIES TO PROMOTE RECOVERY/RESILIENCE

A survey on transportation needs conducted at the four large county adult outpatient clinics (Santa Ana, Anaheim, Westminster and Mission Viejo) indicated that over 40% of missed clinic appointments were a direct result of transportation issues. These issues included, but were not limited to, lack of a car or money for gas or a bus, inability to navigate the public transportation system, the time it takes to use public transportation system, anxiety surrounding using public transportation or riding with others, and reliance on others to get rides to and from appointments. By providing reliable pick-up and drop-off at their requested destinations, participants have been better able to engage in treatment consistently, thus allowing them to pursue their recovery.

STRATEGIES TO REDUCE STIGMA AND DISCRIMINATION

By offering free transportation, the program makes behavioral health and medical treatment equally accessible to individuals in need of care regardless of their socioeconomic means.

STRATEGIES TO IMPROVE TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS

The program facilitates timely access to needed behavioral health and medical services for participants with significant transportation-related barriers to care by providing them with the means to attend these appointments.

PROGRAM UTILIZATION (OUTCOMES)

The contract began 7/1/2018, with the first ride on 7/12/2018. The total number of rides provided in its first year of operations was 22,202.

CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

One of the biggest challenges for this program is for participants to remember to schedule their transportation service 24-hours in advance of their appointment times. The purpose of this is to allow the Transportation provider to schedule its fleet of drivers the night before for their appointments the next day. With the high demand for transportation services on a daily basis (Monday-Friday), in all regions of the county, it has been very challenging for drivers to get to their scheduled pick-up/drop-off locations on time without the 24-hour notice. In an effort to ensure drivers can be at the right place at the right time, the Transportation provider has identified the highest utilized areas, and increased its driver fleet in those areas during known times when there is a high need, which has resulted in minimizing any delays for pick-ups/drop-offs. To assist with the high demand for these services, additional drivers have been added to the taxi fleet that has enabled the Transportation provider to meet the high demands despite not always getting a 24-hour notice for service. Finally, BHS programs will continue to identify ways to leverage transportation assistance provided by other partners and agencies (i.e., CalOptima, etc.) so that efforts are not being duplicated unnecessarily.

Supported Employment (CSS)

The **Supported Employment** (SE) program serves Orange County residents 18 and older who are living with serious mental illness, may have a co-occurring substance use disorder and require job assistance to obtain competitive or volunteer employment. Participants are referred to the program from County and County-contracted Outpatient and Recovery programs, FSPs and select PEI and Innovation programs. Participants must be engaged in behavioral health services during their entire enrollment in the program and have an assigned Plan Coordinator or Personal Services Coordinator who will collaborate with the SE team to assist with behavioral issues that may arise while participating in the program.

AGE RANGE

Ages 18+

PRIMARY LOCATION

Field | Community

TARGET POPULATION

At-Risk | Mild-Moderate | Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

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

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	Gender	%	Race/Ethnicity	%
0-15	-	Female	40	African American/Black	6
16-25	20	Male	60	American Indian/Alaskan Native	1
26-59	71	Transgender	-	Asian/Pacific Islander	10
60+	9	Genderqueer	-	Caucasian/White	43
		Questioning/Unsure	-	Latino/Hispanic	35
		Another	-	Middle Eastern/North African	1
				Another	4

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

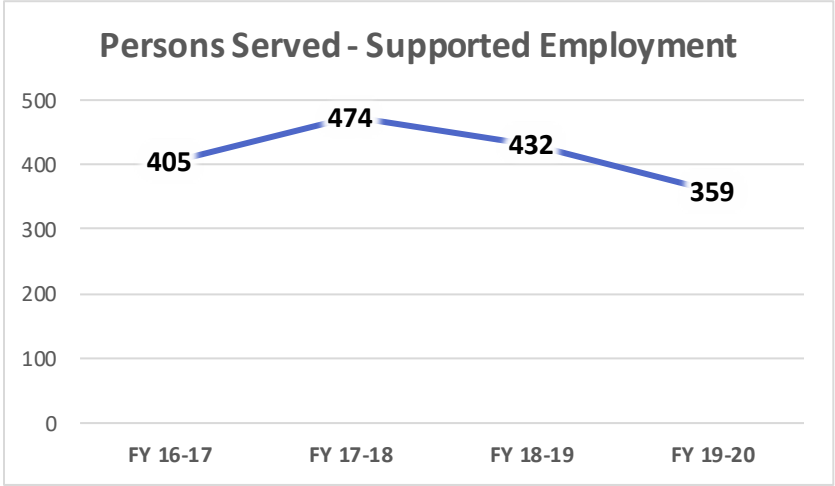
Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$1,371,262	360
FY 2021-22*	$1,371,262	360
FY 2022-23	$1,371,262	360

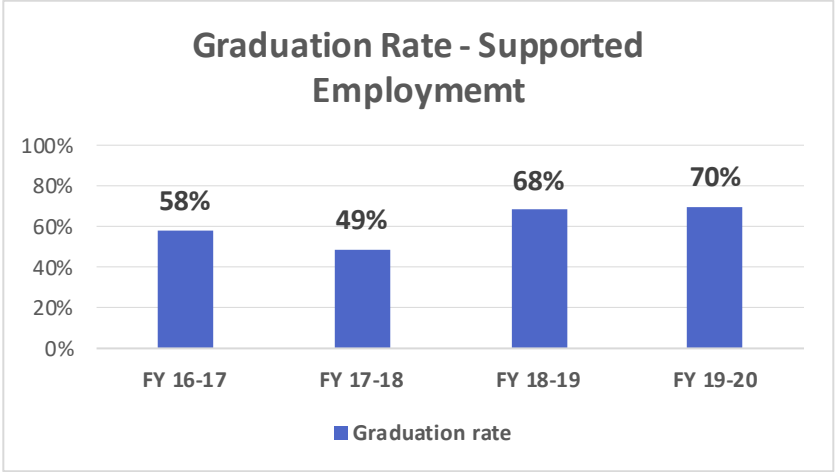
**No proposed changes for FY 2021-22*

SERVICES

The Supported Employment program Individual Employment Plans are developed by the employment team with the participant and closely follow the evidence-based Individual Placement & Support employment model to provide services such as volunteer or competitive job placement, ongoing work-based vocational assessment, benefits planning, individualized program planning, time-unlimited job coaching, counseling and peer support services.

Employment Specialists (ES) and Peer Support Specialists (PSS) work together as an Employment Team. The ES assists participants with employment preparation including, but not limited to, locating job leads, assisting with application submissions and assessments, interviewing, image consultation and transportation issues. The ES also provides one-on-one job support, either by telephone or at the participant's workplace, to ensure successful job retention. The PSS are individuals with lived experience with behavioral health and substance use challenges, and who possess skills learned in formal training, and/or professional roles, to deliver services in a behavioral health setting to promote mind-body recovery and resiliency. The PSS work with participants to develop job skills, and assist the ES in helping the participant identify areas of need for development, and may use techniques such as role modeling, field mentoring, mutual support, and others that foster independence and promote recovery. For those who may not yet be ready for competitive employment, the program offers volunteer opportunities at places of business around the county as a way for them to gain work-related skills and confidence.





OUTCOMES

Program performance is evaluated by the number of participants who graduate after achieving the State of California job retention benchmark of 90 days in paid employment. A total of 70% met this benchmark during FY 2019-20, continuing the trend of an increasing graduation rate since FY 2016-17. This is notable, as improving employment outcomes for adults in the BHS system of care continues to be challenging for many other programs.

STRATEGIES TO INCREASE RECOVERY/RESILIENCE

Securing meaningful employment represents a significant step toward recovery and re-integration into the community. Staff strives to build working relationships with prospective employers, educate employers to understand mental health conditions and combat stigma, and serves as the main liaison between the employers and program participants. The ES maintains ongoing, open communication with participant treatment teams to promote positive work outcomes. The PSS provide training and support to participants using the principles of hope, equality, respect, personal responsibility and self-determination. While it is sometimes a concern among the target population that they might lose their benefits such as SSI/SSDI if they become employed, they also recognize that this may be a final step to gaining full independence.

STRATEGIES TO REDUCE STIGMA AND DISCRIMINATION

Helping participants find and maintain good jobs in the community is, in and of itself, an act of reducing stigma and discrimination. More and more program participants are requesting assistance in disclosing their barriers to employers. This opens up many opportunities for staff to have a supportive on-site presence that fosters collaboration and education between the participants and their employers and co-workers. The program promotes participants' successes in maintaining employment and highlights welcoming employers who provide individuals with mental health challenges, the opportunity to integrate into the community via competitive employment. This effort is carried out through media exposure via news publication, newsletters and presentations of success stories at community meetings.

STRATEGIES TO INCREASE ACCESS TO SERVICES: TIMELY ACCESS FOR UNDERSERVED POPULATIONS AND LINKAGE TO TREATMENT

The Supported Employment program engages in a number of activities to encourage timely access to its services. First, SE staff regularly present at County and County-contracted clinics to encourage referrals to the program. From the day the participant enrolls, the program strives to foster an environment of empathy and hope, which contributes to their ongoing program participation. ES and PSS staff provide person-centered supports in line with the evidence-based model of Individual Placement and Support so that they can support participants in finding and keeping a good job in a supportive work environment. The team is highly mobile and can meet individuals in their communities to provide supported services. The employment team also collaborates with the referring treatment provider to discuss the participant's progress, success stories and/or any significant behavior that prompts need for clinical interventions. In addition, services are provided in English, Spanish, Vietnamese, Korean, Farsi and American Sign Language.

CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

During FY 2017-18, SE experienced changes in staffing by only having one program manager managing the two regions instead of two managers. There was also rapid staffing turnover at both the north and south sites. In addition, referrals to the program in South County have been low, and the provider has increased its outreach efforts to programs in that region to improve referrals.

COMMUNITY IMPACT

The Supported Employment program has provided services to more than 3,500 adults since its inception in August 2006. The program has established a strong presence within Orange County through its collaboration with County and County-contracted clinics and other behavioral health programs, as well as its numerous presentations at job fairs, the Wellness Centers, and local MHSA steering committee meetings.

Housing Support programs serve Orange County adults who are experiencing homelessness and living with a serious mental health condition. They range from providing short-term emergency shelter to permanent supportive housing and are designed to meet individuals where there are at and support them in their recovery.

Year-Round Emergency Shelter (CSS)

Year-Round Emergency Shelter (formerly called Short-Term Housing Services) serves adults experiencing homelessness with serious mental illness who may also have a co-occurring substance use disorder and are in need of immediate shelter. Individuals referred to the program are actively participating in services at an Adult and Older Adult Behavioral Health County or County-contracted outpatient clinic, PACT or Assembly Bill (AB) 109 program.

AGE RANGE

Ages 18+

PRIMARY LOCATION

Residential

TARGET POPULATION

At-Risk | Mild-Moderate | ✓ Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

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

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	Gender	%	Race/Ethnicity	%
0-15	-	Female	65	African American/Black	4
16-25	13	Male	35	American Indian/Alaskan Native	1
26-59	75	Transgender	-	Asian/Pacific Islander	7
60+	12	Genderqueer	-	Caucasian/White	49
		Questioning/Unsure	-	Latino/Hispanic	36
		Another	-	Middle Eastern/North African	-
				Another	3

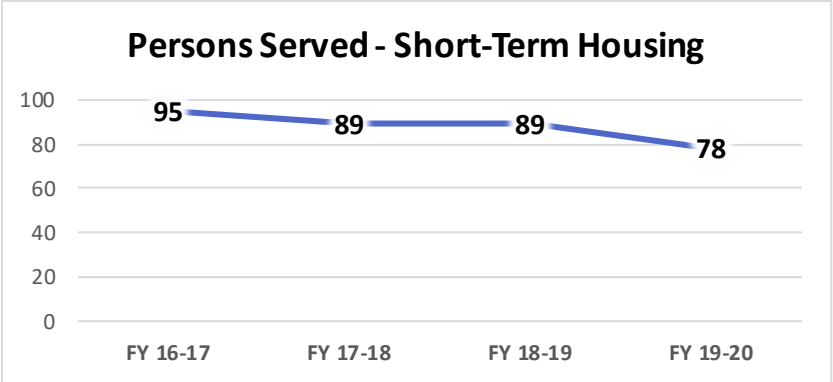
BUDGETS & PROJECTED #'s TO BE SERVED FROM 3YP

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$1,367,180	90
FY 2021-22*	$1,367,180	90
FY 2022-23	$1,367,180	90

**No proposed changes for FY 2021-22*

SERVICES

This program has MHSA-dedicated beds within five existing shelters. In addition to daily shelter, the program provides basic needs items (i.e., food, clothing, hygiene goods), as well as case management and linkage to services designed to assist individuals in their transition out of the shelter and into a more stable housing situation. The estimated length of stay for each episode of shelter housing is 120 days. Extensions are considered on a case-by-case basis.



OUTCOMES

As reported below, the program has been successful in reaching its goals:

Short-Term Housing Services Metrics	FY 2017-18	FY 2018-19	FY 2019-20
Average Length of Stay (ALOS) is 120 Days or Less	ALOS = 82 days	ALOS = 58 days	ALOS= 80 days
% Who Found Permanent or Transitional Housing within 120 Days is > 25%	40%	33%	53%

CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

Due to COVID-19 and the stay at home order the facilities did not allow in-and-out day access which was a difficult adjustment for participants who are not used to a shelter environment. The program provided the participants with support and virtual activities to increase receptiveness to staying in the shelter. The program addressed other important needs, including supportive services such as transitional or permanent housing assistance and linkage to needed community support services in coordination with the Plan Coordinator from the outpatient clinic. Some facilities allowed pets and partners to stay in the shelter with participants and permitted BHS Outreach and Engagement staff into the shelter. This allowed participants to receive support from the outreach worker with whom they had already built rapport, which could help facilitate their engagement into behavioral health services now that they were in a more stable environment.

Bridge Housing for the Homeless (CSS)

Bridge Housing for the Homeless offers interim housing for adults who have received a certificate from the Orange County Housing Authority for the Continuum of Care (CoC) Program but have been unsuccessful at finding a rental unit. The program also serves adults experiencing homelessness who have not yet received a certificate but are beginning the process. Adults (including couples) are eligible if they are homeless, are living with a serious mental illness, and may have a co-occurring substance use disorder. Referrals for the Homeless Bridge Housing Services are accepted on an ongoing basis by Adult and Older Adult Behavioral Health (AOABH) Housing and Supportive Services. Participants can only be referred to the Homeless Bridge Housing Services if they are actively participating in treatment at an AOABH outpatient clinic.

AGE RANGE

All Ages

PRIMARY LOCATION

Residential

TARGET POPULATION

- ✓ At-Risk
- ✓ Mild-Moderate
- ✓ Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

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

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	Gender	%	Race/Ethnicity	%
0-15	-	Female	51	African American/Black	8
16-25	2	Male	46	American Indian/Alaskan Native	3
26-59	96	Transgender	3	Asian/Pacific Islander	7
60+	2	Genderqueer	-	Caucasian/White	78
		Questioning/Unsure	-	Latino/Hispanic	30
		Another	-	Middle Eastern/North African	-
				Another	11

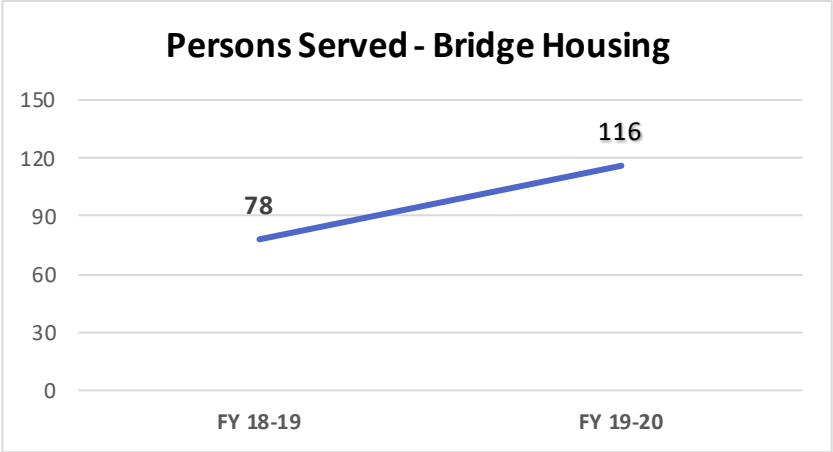
BUDGETS & PROJECTED #'s TO BE SERVED FROM 3YP

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$2,000,000	80
FY 2021-22*	$2,000,000	80
FY 2022-23	$2,000,000	80

**No proposed changes for FY 2021-22*

SERVICES

The program provides housing coordination and navigation to assist participants in acquiring permanent housing. The provider also provides life skills and independent living skills training to support the participants' transition to independent living. The provider assists participants in obtaining housing opportunities that include Continuum of Care (CoC) certificates, housing vouchers, locating rental units, negotiating leases and securing other housing options. The estimated length of stay is 18 months. Participants who are not able to find housing within the 18- month period are able to stay in Bridge Housing Services and continue to look for permanent housing as long as they are actively working towards their housing goals.



OUTCOMES

Bridge Housing for the Homeless tracks a number of measures to monitor its performance in supporting adults living with serious mental illness find permanent housing. During FY 2018-19, its first year of operation, the program successfully reached all measurable targets during that year.

Bridge Housing for the Homeless Metrics	FY 2018-19	FY 2019-20
Average # of potential landlords contacted per month (Target: > 15)	**27**	**39**
% of participants with CoC certificates who moved into permanent housing within 1 year (Target: > 50%)	**100%**	**74%**
% of participants w/out CoC certificates who moved into permanent housing within 18 months (Target: > 50%)	**In progress* (16% housed in 12 months)**	**41%**
% of participants who secured work or entitlements w/in 6 mo. of intake (Target: > 50%)	**60%**	**78%**
Persons Served – Bridge Housing	**78**	**116**

** Services launched in July 2018 so the18-month mark had not yet passed by the end of FY 2018-19.*

MHSA/CSS Housing Program (CSS)

In contrast to the programs described above that provide time-limited shelter in combination with behavioral health services and supports, the **MHSA/CSS Housing Program** facilitates the creation of long-term, independent supportive housing for transitional aged youth, adults and older adults with serious mental illness who may have a co-occurring substance use disorder and are experiencing homelessness or risk of homelessness. Additional eligibility requirements can vary at each location due to requirements of other funding partners.

The program funds development costs and Capitalized Operating Subsidy Reserves (COSR). Development costs are used for the acquisition, construction and/or rehabilitation of permanent supportive housing. COSR primarily helps cover the difference between what a resident is able to pay and the cost of operating the unit during the time the resident is working on obtaining entitlement and/or employment income. Behavioral health and other supportive services are located on- and off-site to ensure access to a continuum of services that help residents adjust to and maintain their independent housing.

AGE RANGE

Ages 18+

PRIMARY LOCATION

Residential

TARGET POPULATION

- ✓ At-Risk
- ○ Mild-Moderate
- ✓ Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

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

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	Gender	%	Race/Ethnicity	%
0-15	-	Female	58	African American/Black	8
16-25	5	Male	41	American Indian/Alaskan Native	<1
26-59	64	Transgender	<1	Asian/Pacific Islander	5
60+	31	Genderqueer	-	Caucasian/White	38
		Questioning/Unsure	1	Latino/Hispanic	11
		Another	-	Middle Eastern/North African	2
				Another	37

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

Fiscal Year	Program Budget
FY 2020-21	$293,678
FY 2021-22*	$356,046
FY 2022-23	$302,488

**Proposed increase for FY 2021-22 adjusts for increase in salaries, per bargaining unit negotiations*

Original funding allocations for this program included:

- A one-time State allocation of $8 million in FY 2006-07 to develop permanent supportive housing for individuals with serious mental illness who were receiving services in the Full Service Partnership programs. Funds were used to develop 34 housing units in two developments
- A one-time State allocation of $33 million in FY 2007-08 carved out of the CSS allocation (i.e., MHSA Housing Program) and used for 10 housing developments that created an additional 194 new units of PSH in Orange County

The table below provides details about these projects, which resulted in the development of 194 new PSH MHSA units for eligible tenants and their families.

Housing Projects Funded by One-Time Allocations							
Project	**Year**	**1-Bedroom Units**	**2-Bedroom Units**	**Manager's Unit**	**MHSA Units**	**Total Units (w/ MHSA)**	**TOTAL**
Alegre Apartments	**2015**	**11**	**0**	**1**	**11**	**104**	**$2,912,200**
Avenida Villas	**2014**	**24**	**4**	**1**	**28**	**29**	**$6,519,200**
Capestone Apartments	**2014**	**19**	**0**	**1**	**19**	**60**	**$4,445,468**
Cotton's Point Seniors	**2014**	**15**	**0**	**1**	**15**	**76**	**$2,022,400**
Depot at Santiago	**2018**	**10**	**0**	**1**	**10**	**70**	**$1,615,320**
Diamond Apartments	**2009**	**15**	**9**	**1**	**24**	**25**	**$1,583,222**
Doria Apartments, Phase I	**2011**	**10**	**0**	**1**	**10**	**60**	**$1,500,000**
Doria Apartments, Phase II	**2013**	**8**	**2**	**1**	**10**	**74**	**$2,019,850**
Fullerton Heights	**2018**	**18**	**6**	**1**	**24**	**36**	**$6,300,000**
Henderson House	**2016**	**14**	**0**	**0**	**14**	**14**	**$3,542,884**
Oakcrest Heights	**2018**	**7**	**7**	**1**	**14**	**54**	**$2,550,798**
Rockwood Apartments	**2016**	**14**	**1**	**1**	**15**	**70**	**$3,222,974**
TOTAL					**194**	**672**	**$37,895,786**

MHSA SPECIAL NEEDS HOUSING PROGRAM (SNHP)

When the MHSA Housing Program concluded in May 2016, the state created the Local Government Special Needs Housing Program (SNHP). Local stakeholders identified an on-going and persistent need for housing for individuals living with serious mental illness and who are homeless or at risk of homelessness. As such, multiple CSS transfers to the SNHP operated by the California Housing Finance Agency's (CalHFA) occurred over several years totaling $95.5 million:

- $5 million in FY 2016-17 following local community planning input
- $35 million total in FY 2017-18 upon directive by the Board of Supervisors
- $25 million total in FY 2018-19
- $30.5 million total in FY 2019-20

On December 12, 2019, the Board approved allocating $10 million to the 2020 Supportive Housing Notice of Funding Availability (OCCR 2020 NOFA) and the remaining $20.5 million to the Orange County Housing Finance Trust (Trust).

Project	Year	MHSA Units	Total Units	Total
Santa Ana Arts Collective	2020	15	58	$4,724,430
Hero's Landing	2020	20	76	$2,912,000
Casa Querencia	2021	28	57	$7,035,800
Total		63	191	$14,672,230

CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

The HCA recognizes that the demand for safe housing for individuals living with a mental health condition and their families is far outpacing current availability. Thus, staff continually look to identify new opportunities for developing housing for this vulnerable population, which includes staying apprised of other funding opportunities and leveraging resources with other community and County partners.

COMMUNITY IMPACT

Increasing access to permanent supportive housing helps to break the cycle of homelessness for many individuals living with serious mental illness by improving housing stability, employment and mental and physical well-being. In addition, these MHSA units are integrated in larger housing developments that provide non-MHSA units of critically needed affordable housing in Orange County.

Housing Project Pipeline Using MHSA Funding								
Project	City	Estimated Completion	SNHP Units	NPLH Units	Trust	OCCR 2020 NOFA	Total MHSA Units	Total Units
Jamboree PSH (Buena Esperanza)	Anaheim	2021	35	0	0	0	35	70
Altrudy Seniors	Yorba Linda	2021	10	10	0	0	10	48
Francis Xavier	Santa Ana	2022	13	9	0	0	13	17
Legacy Square	Santa Ana	2022	10	16	0	0	16	93
Westminster Crossing	Westminster	2021	20	0	0	0	20	65
Villa St. Joseph	Orange	2022	18	18	0	0	18	50
The Groves Senior Apartments	San Juan Capistrano	2022	10	0	0	0	10	75
Mountain View	Lake Forest	2023	12	12	0	0	12	71
Casa Paloma	Midway City	2022	24	0	0	0	24	49
Airport Inn Apartments	Buena Park	2021	28	0	0	0	28	58
Orchard View Gardens	Buena Park	2023	8	13	5	0	13	66
Santa Angelina Senior Community	Placentia	2023	16	21	5	0	21	65
Center for Hope	Anaheim	2022	0	34	16	4	34	72
Cartwright Family Apartments	Irvine	2023	10	10	0	0	10	60
Lincoln Avenue Apartments	Buena Park	2022	10	0	0	0	10	55
Westview	Santa Ana	2023	0	26	0	26	26	85
North Harbor Village	Santa Ana	2022	0	0	14	0	14	90
Huntington Beach Senior Housing	Huntington Beach	2023	0	21	0	21	21	43
Paseo Adelanto	San Juan Capistrano	2023	0	0	0	24	24	41
TOTAL			224	143	40	75	359	1,173

Summary of MHSA Strategies Used by Supportive Services Programs: Supportive Housing Services

STRATEGIES TO PROMOTE RECOVERY/RESILIENCE

These programs address the basic needs of adults experiencing homelessness, such as food, shelter and physical safety. This creates a safe environment in which participants can make progress toward their recovery while securing and/or maintaining permanent housing. Staff uses Motivational Interviewing to engage participants and help them identify their own needs and challenges. This evidence-based therapeutic approach facilitates independence through self-discovery, and helps individuals become more ready for independent or supportive housing.

STRATEGIES TO REDUCE STIGMA AND DISCRIMINATION

While in the shelter or bridge housing, staff works with residents to prepare them to accept permanent housing so they can smoothly transition to housing from the streets and end their episodes of homelessness. Program staff also conducts community outreach to educate and engage prospective landlords with the goals of improving access to housing options, reducing misconceptions about people living with a mental health disorder, reducing the possibility of discrimination from landlords, and helping to facilitate acquisition of permanent housing.

STRATEGIES TO INCREASE ACCESS TO SERVICES: TIMELY ACCESS FOR UNDERSERVED POPULATIONS AND LINKAGE TO TREATMENT

Staff works with treatment providers to link individuals to services, if they are not already engaged in treatment. Bicultural/bilingual staff ensure availability of services in a variety of languages. Behavioral health programs provide their services on-site or off-site, promoting easy access to services. In addition, most housing sites are located near public transportation routes to enhance residents' access to transportation, as many residents do not own a car.

Discontinued Program

Mentoring for Children and Youth (CSS)

Mentoring for Children and Youth served youth ages 0-25 living with a serious emotional disturbance and receiving behavioral health services at a County or County-contracted outpatient clinic. Youth were referred by their therapist if the therapist determined that the child could benefit from additional mentoring and socialization experiences out in the community. Parents of participating youth also received parent mentoring services. After consideration of multiple factors including challenges with the ability to demonstrate program efficacy, the program is being discontinued beginning in FY 2021-22. Youth and parents will continue to receive peer/parent partner support through the Peer Mentoring and Parent Partner Support program.

FY 2020-21 to FY 2022-23 Program Budget		Projected Unduplicated # to be Served	
Actual FY 2019-20 Budget	$500,000	FY 2019-20	225
Proposed FY 2020-21 Budget	-$500,000	FY 2020-21	230
Proposed FY 2021-22 Budget	-$500,000	FY 2021-22	230
Proposed FY 2022-23 Budget	-$500,000	FY 2022-23	230

WORKFORCE EDUCATION & TRAINING

Workforce Education and Training (WET) is intended to address community-based occupational shortages in the public mental health system. This is accomplished by training staff and other community members to develop and maintain a culturally and linguistically competent workforce that includes consumers and family members and that is capable of providing consumer and family-driven services.

WET COMPONENT OVERVIEW

The mission of the Mental Health Services Act (MHSA) Workforce Education and Training component is to address community-based occupational shortages in the public mental health system. This is accomplished by training staff and other community members to develop and maintain a culturally and linguistically competent workforce that includes consumers and family members and is capable of providing consumer and family-driven services. Thus, WET offers education and trainings to County staff and contracting community partners that promote well-being, recovery and resilience. The WET Coordinator also serves as a liaison to the Southern California Regional Partnership (SCRP) of WET Coordinators. WET Coordinators from neighboring counties collaborate on and coordinate mutual projects such as trainings, core competencies and conferences to increase workforce diversity and opportunities in the public mental health system.

Following the passage of Proposition 63, the state provided each county with a one-time funding allocation to develop its WET infrastructure. Orange County's (OC) allocation of $8,948,100 was exhausted in FY 2013-14. Since then, available dollars from Community Services and Supports (CSS) have been used to fund WET. Counties are allowed to transfer CSS funds to WET, as well as Capital Facilities and Technological Needs (CFTN) and the Prudent Reserve, so long as the total amount of the transfers within a fiscal year do not exceed 20% of the county's most recent five-year average of its total MHSA allocation. Orange County continues to fund WET programs, described in greater detail below, to serve the Orange County behavioral health workforce, mental health consumers and their family members.

WET programs continue to reach a large audience; however, compared to last fiscal year, WET saw a decrease in the number of trainings and attendees. This was largely due to the impact of the COVID-19 global pandemic. In FY 2019-20, approximately 6,740 individuals and/or community members attended WET trainings and activities. Attendance in previous fiscal years found that 10,831 and 6,258 individuals attended WET trainings and activities between FYs 2018-19 and 2017-18, respectively.

The WET component currently funds the following major training and program areas:

- Workforce Staffing Support
- Training and Technical Assistance
- Mental Health Career Pathways
- Residency and Internship Programs
- Financial Incentive Programs

STATEWIDE WET PROGRAM

The FY 2019-20 state budget included approximately $40 million to fund county MHSA WET programs statewide. To secure these funds, county behavioral health agencies must collectively provide a 33% match or $13.2 million by 2025. County contributions must also be transferred to a third-party entity and used for WET purposes to fund pipeline/career awareness, scholarships, stipends and loan repayment programs. The County Behavioral Health Directors Association (CBHDA) has proposed that CalMHSA act as this entity and ensures contributions are returned to the county for WET purposes. In addition, CBHDA was authorized by its Board to calculate a suggested contribution for each county based on the current MHSA allocation formula. Based on the current MHSA allocation formula, the suggested contribution for Orange County's share of the match is **$904,713**. Orange County proposes to transfer the full amount of its suggested contribution in FY 2020-21.

Workforce Staffing Support

The Workforce Staffing Support (WSS) program performs three functions: (1) Workforce Education and Training Coordination; (2) Consumer Employment Specialist Trainings and One-on-One Consultations; and (3) the Liaison to the Regional Workforce Education and Training Partnership. WSS services are provided for the Orange County behavioral health workforce, consumers, family members and the wider Orange County community. In FY 2019-20, WSS provided trainings to a total of 2,073 individuals including County staff, County-contracted staff and general community members. This was a decrease from previous fiscal years where over 3,000 individuals were provided trainings. This is mostly attributed to the impact of the COVID-19 global pandemic. Very few trainings were facilitated between March and June 2020 while all in-person learning was shifted to virtual platforms.

PROPOSED BUDGETS FROM 3YP

Fiscal Year	Program Budget
FY 2020-21	$1,710,584
FY 2021-22	$1,761,902
FY 2022-23	$1,814,758

STAFFING DESCRIPTIONS/OUTCOMES

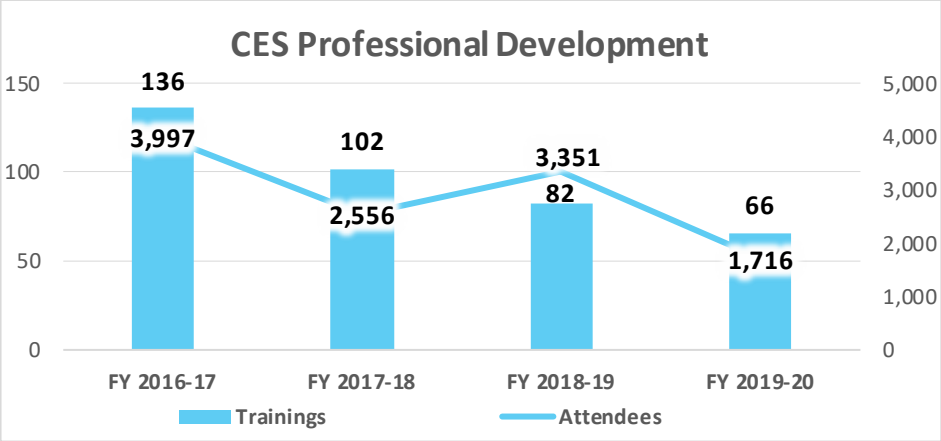
Workforce Education and Training Coordination:

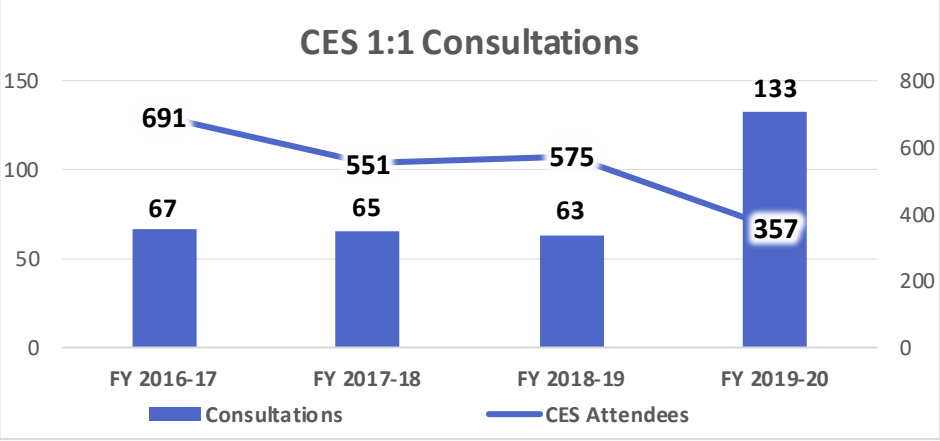
Orange County regards coordination of workforce education and training as a key strategy to promoting recovery, resilience and culturally competent services. Multidisciplinary staff members design and monitor WET programs, research pertinent training topics and content, and provide and coordinate trainings. As noted in the table, WET provided a large number of in-person professional development trainings between FYs 2017-18 and 2018-19. Toward the latter half of FY 2019-20, all trainings had to shift to virtual platforms to accommodate the restrictions associated with in-person trainings due to the COVID-19 pandemic. Training topics included Law and Ethics, 5150/5585 Involuntary Hospitalization and Designation, Patients' Rights Respect and Dignity, Rights for Individuals in Inpatient and Outpatient Mental Health Facilities, Developing and Enhancing Competence in Clinical Supervision, Group and Individual Crisis Response, Housing Placement, Raising Awareness About First Episode of Psychosis, Response to Active Shooters, Meeting of the Minds, Continuum of Care, and Understanding American Society of Addiction Medicine (ASAM) Criteria in the Context of the California Treatment System.

In FY 2015-16, WET launched online training that offered Continuing Education (CE) and Continuing Medical Education (CME) credits for County and County-contracted providers who could not attend a live training. In the first two years after launch, nine trainings were offered annually. In FY 2018-19 only one pre-recorded on-demand online training was offered as the OC Health Care Agency (HCA) transitioned to a new Learning Management System (LMS) where employees have access to over 70 online trainings annually. Moreover, in FY 2019-20, live virtual instruction trainings were offered due to the global COVID-19 pandemic. Some of these trainings were recorded and offered to staff at a later date.

Consumer Employment Specialist Trainings/One-on-One Consultations:

As part of WSS, Consumer Employment Support (CES) Specialists work with Behavioral Health Services, contract providers and community partners to educate consumers on disability benefits. One of the Consumer Specialists provides educational and outreach services exclusively in American Sign Language (ASL). The specialists provided training on topics such as Ticket to Work, Reporting Overpayment, and Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI). One-on-one SSI/SSDI Work Incentive consultation was also provided to consumers who requested more in-depth guidance. Additional services for those who are deaf and hard of hearing include advocacy/education, group or individual consultations, and information/referral to resources.

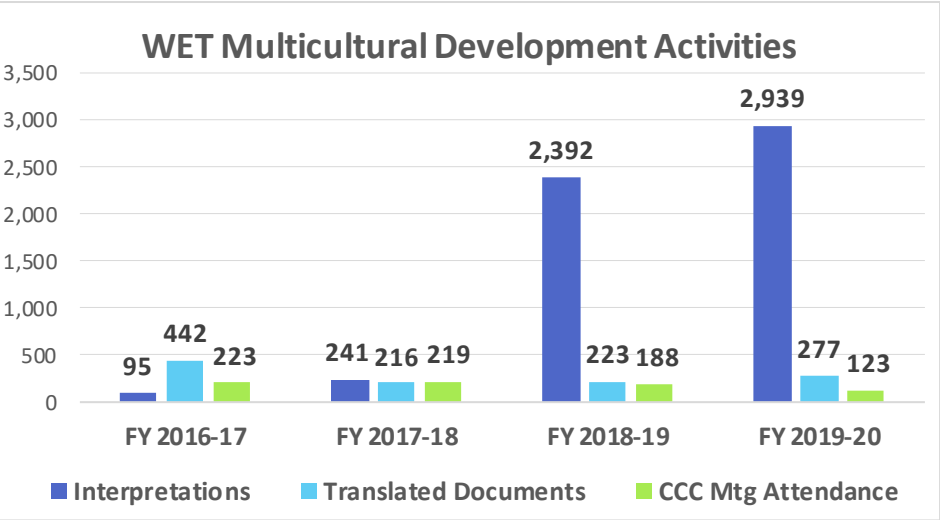




Multicultural Development Program:

The Multicultural Development Program (MDP) consists of staff with language proficiency and culturally responsive skills who support the workforce by providing trainings on various multicultural issues. The MDP also coordinates requests and provides translation/interpretation services through in-house staff and a contracted provider. During FY 2019-20, there was a continued increase in the number of interpretation services provided in Spanish, Vietnamese, Arabic, Farsi and ASL both onsite and over the phone. This increase appeared, in part, to be related to an increase in COVID-19-related document translation requests.

MDP staff and Language Line services also translated, reviewed and field-tested a total of 277 documents into the threshold languages of Spanish, Vietnamese, Farsi, Korean and Arabic in FY 2019-20, which was level from the previous fiscal years. In addition, a Licensed Marriage Family Therapist serves in the MDP as a Deaf and Hard-of-Hearing Coordinator to ensure that American Sign Language interpretation support is provided at trainings and community meetings.



In FY 2019-20, the Ethnic Services Manager and staff continued organizing the Cultural Competence Committee (CCC) meetings. The CCC consists of multi-ethnic partners and multi-cultural experts in Orange County who meet to provide input on how to incorporate cultural sensitivity and awareness into the Behavioral Health Services (BHS) system of care and how to provide linguistically and culturally appropriate behavioral health information, resources and trainings to underserved consumers and family members. Although the count of unduplicated participants declined in FY 2019-20 compared to prior years, this was likely due to meeting cancelations.

Liaison to Regional Workforce Education and Training Partnership:

The Liaison represents Orange County by coordinating regional educational programs; disseminating information and strategies about consumer and family member employment throughout the region; sharing strategies that increase diversity in the public mental health system workforce; disseminating Orange County program information to other counties in the region; and coordinating regional actions that take place in Orange County such as Trauma-Informed trainings, the annual conference focused on hard-to-reach clients, and cultural humility trainings.

Training and Technical Assistance

The Training and Technical Assistance (TTA) program offers trainings on evidence-based practices, the consumer and family member perspective, and multicultural competency for mental health providers, and mental health training for law enforcement. The number of trainings offered in this area fluctuates from year to year depending on the number of professional development requests from HCA staff and community members. Additionally, the TTA program not only hosts several behavioral health trainings each year, but also provides continuing education units to other departments in the HCA requesting trainings for their clinical or medical staff. Examples of requested trainings include Psychological First Aid, Raising Awareness about First Episode of Psychosis, Rights for Individuals in Inpatient Settings, and Rights for Individuals in Outpatient Settings. In FY 2019-20, TAA provided a total of 78 trainings for 3,642 attendees, which are described in detail below. In FY 2018-19, TAA provided 89 trainings for 5,711 attendees, and in FY 2017-18, 88 trainings were facilitated to 2,573 attendees.

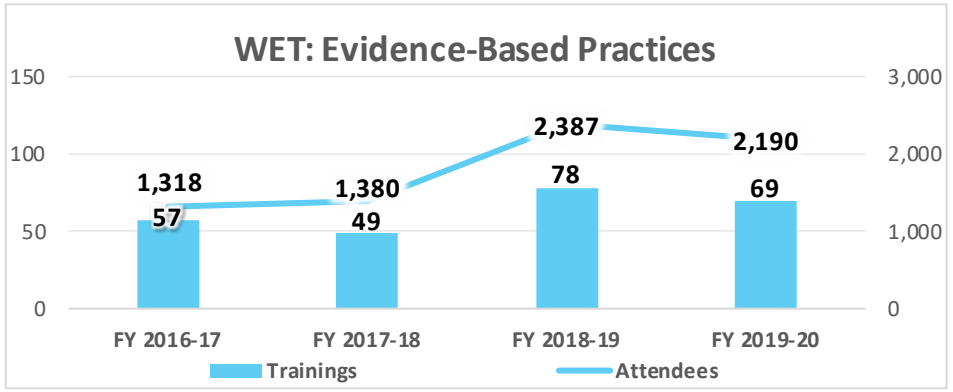
PROPOSED BUDGETS FROM 3YP

Fiscal Year	Program Budget
FY 2020-21	$1,223,390
FY 2021-22	$1,282,434
FY 2022-23	$1,241,794

TRAINING DESCRIPTIONS / OUTCOMES

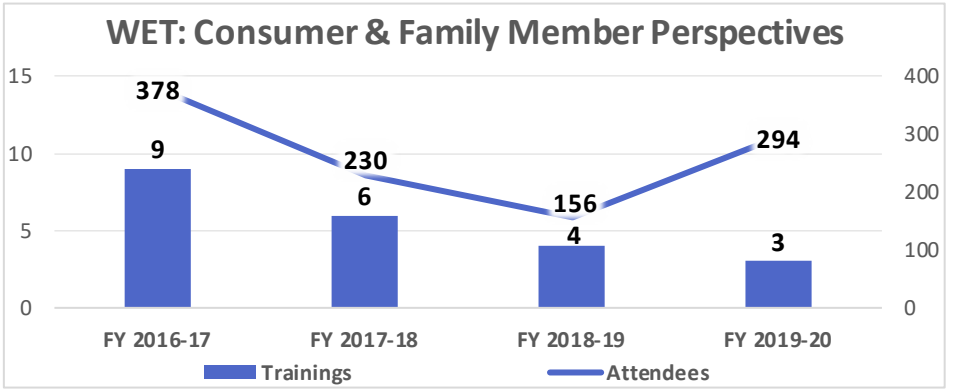
Evidence-Based Practices:

Trainings on Evidence-Based Practices were conducted to help behavioral health providers stay current on best practice standards in their field. County and contracted staff, community partners, consumers and their family members attended evidence-based training on topics such as Mental Health First Aid, Eye Movement Desensitization and Reprocessing (EMDR), Nonviolent Crisis Intervention Training, Motivational Interviewing, Children Adolescent Needs and Strengths (CANS), a Trauma-Informed Care series, Trauma Focused Cognitive Behavioral Therapy, Treating Trauma and Substance Use, and Dialectical Behavioral Therapy. During FY 2018-19, more requests were submitted by HCA staff and/or community members for trainings focused in different Evidence-Based Practices, compared to previous years.



Consumer and Family Member Perspective:

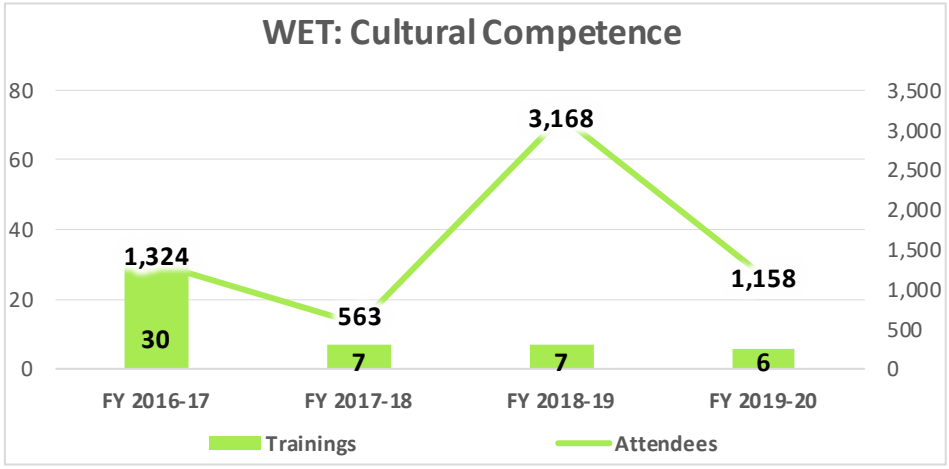
Consumers and their family members sat on a panel where they shared their lived experience with County and County-contracted behavioral health personnel. Panel members presented on their lived experiences to help reduce stigma and raise awareness of behavioral health conditions. Over the past three years, fewer requests have been made for these trainings. During FY 2019-20, WET included consumer and family member perspectives through the use of peer specialists and highlighted key principles of recovery which includes the consumer perspective. These concepts were interwoven into most trainings.



Cultural Competence:

Culturally responsive trainings were conducted to raise cultural awareness and humility among behavioral health providers and community partners. Topics included Caring for Gender Nonconforming and Transgender Youth, Clinical Considerations when Working with Patients and Families from the Sikh Faith, Mindful Listening, Role of Forgiveness in Psychotherapy, Spirituality and Therapy, and Bio-Spiritual Focusing. Beginning in FY 2018-19, WET established an online Cultural Competency training for all BHS staff. Each year, new and ongoing staff are required to take this training as part of their professional development and per state regulations. Due to the establishment of this new annual training, the total number of attendees increased.

Crisis Intervention Training (CIT), which is now being funded through PEI, is reported in *Outreach to Increase Recognition of the Early Signs of Mental Illness.*



Mental Health Career Pathways

Mental Health Career Pathways offers courses through the Recovery Education Institute (REI), which prepares individuals living with mental health conditions and their family members to pursue a career in behavioral health. REI provides training on basic life skills, career management and academic preparedness, and offers certified programs to solidify the personal and academic skills necessary to work in behavioral health. Most REI staff have personal lived experience.

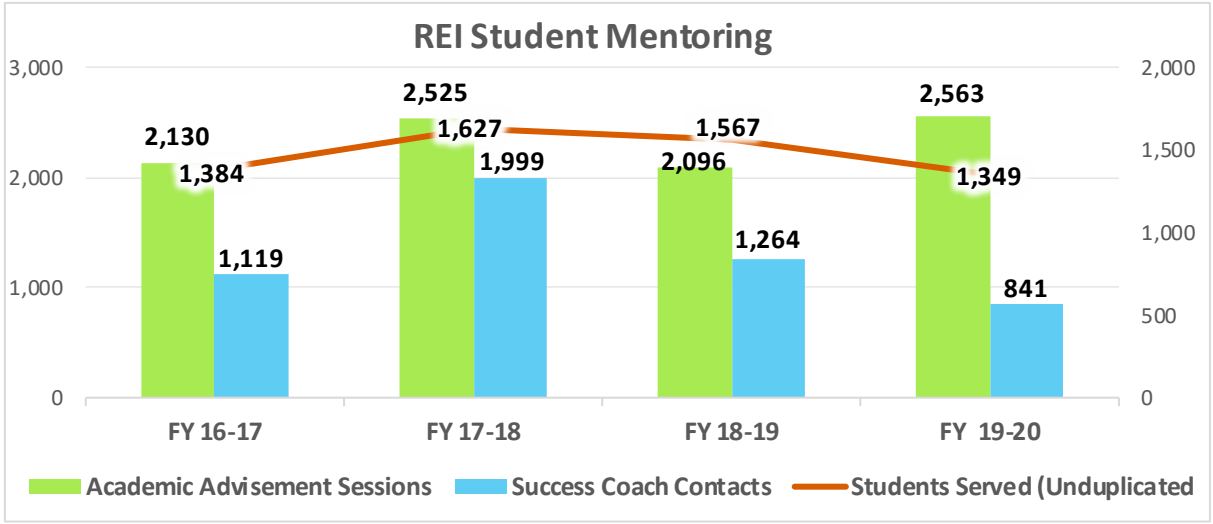
PROPOSED BUDGETS FROM 3YP

Fiscal Year	Program Budget
FY 2020-21	$1,046,663
FY 2021-22	$1,046,663
FY 2022-23	$1,046,663

PROGRAM DESCRIPTION/OUTCOMES

Similar to previous fiscal years, in FY 2019-20 REI provided a total of 153 trainings to 499 active students. Of the 210 newly enrolled students, 76% identified themselves as living with a behavioral health condition, 10% identified themselves as a family member of someone living with a behavioral health condition, and 13% identified as both. These percentages are similar to what was reported in previous fiscal years. In FY 2018-19, REI provided a total of 161 trainings to 567 active students. Of the 274 newly enrolled students, 72% identified themselves as living with a behavioral health condition, 10% identified themselves as family members of those living with a behavioral health condition and 18% identified as both. In FY 2017-18, REI provided 156 trainings to 535 active students. Of the 292 newly enrolled students, 71% identified themselves as living with a behavioral health condition, 13% identified themselves as family members of those living with a behavioral health condition and 17% identified as both.

REI also employs academic advisors and peer success coaches to mentor and tutor students. REI enrolled 210 new students in FY 2019-20, 274 new students in FY 2018-19, and 292 new students in FY 2017-18. During FY 2019-20, more students engaged in Academic Advisement and Success Coaching sessions. This was due to changes in service modalities. Due to the COVID-19 global pandemic the program provided more accessibility to resources. REI distributed Chromebooks to students to enable them to utilize online courses and academic advisement sessions. Students had immediate access to advising sessions, rather than having to travel to campus to seek guidance. Also, another shift was offering monthly course schedules, rather than semester-based schedules. Therefore, students had up-to-date information regarding advisement hours and workshop courses that were available.



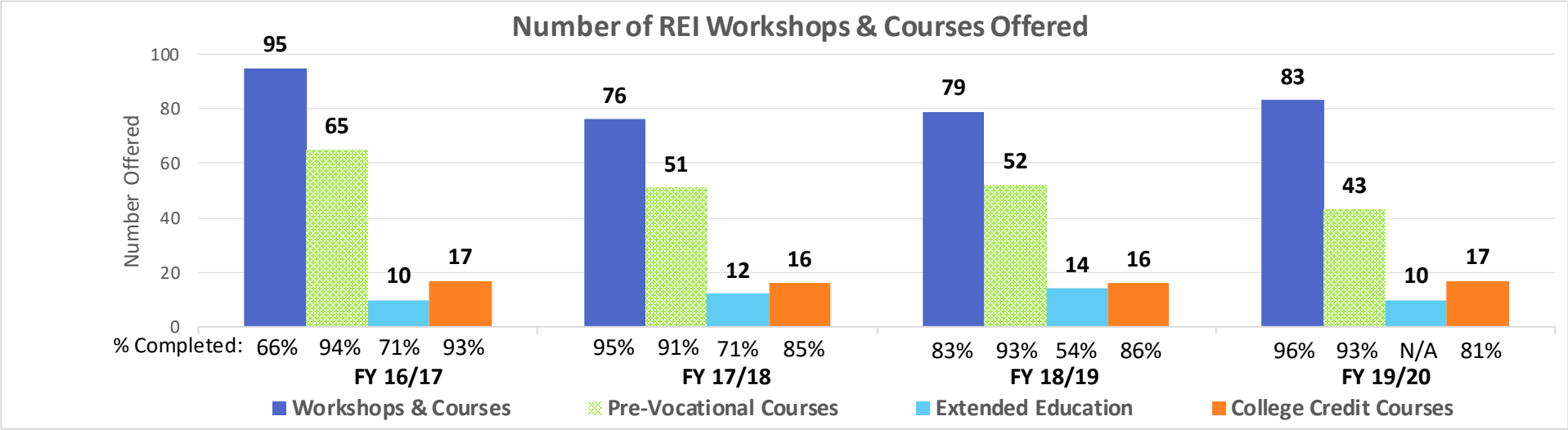
In addition, REI offers a wide variety of trainings, including Introduction to Microsoft Excel Spreadsheets, Elementary Spanish for Public Speaking, Introduction to Psychology, Case Management, Vocational Skills Building, and Self-Esteem and Confidence (see "Workshops & Classes" in table below). REI collaborates with adult education programs, links students to local community colleges for prerequisite classes, and provides accredited college classes and certificate courses onsite.

REI also offers a series of pre-vocational workshops to prepare students to enter the workforce. These workshops include job search techniques, resume building, interview skills, and dressing for job interviews. In addition, REI offers ESL and General Education Development classes for students to benefit their employment

opportunities. A high percentage of students completed the REI workshops and classes between FY 2019-20 and FY 2017-18 (see "Pre-Vocational Courses" below). This increase in completion rates from FY 2017-18 is due to an administrative efficiency created when WET consolidated classes and workshops and staff were better able to track course completion rates. Additionally, compared to last fiscal year, in FY 2019-20, there was a decrease in the number of Extended Education courses offered due to several reasons (see "Extended Education" below), including:

- Extended Education courses meet more frequently over a long period of time, compared to other workshops and college courses in the REI curriculum.
- The Extended Education course model is an open entry and exit format. This creates a revolving door for students who may need courses on a short-term basis.
- The REI College Courses have a strict dropout policy due to the popularity of the courses being offered. This creates a higher level of commitment for those students to complete their courses, compared to Extended Education courses.

In addition, REI contracts with Saddleback College to offer a Mental Health Worker Certificate program that prepares students to enter the public mental health workforce. Students gain knowledge and skills in the areas of cultural competency, the Recovery Model, co-occurring disorders, early identification of mental health conditions and evidence-based practices to name a few. To receive certification, students must complete nine 3-unit courses and a 2-unit, 120-hour internship. In addition, REI/Saddleback College added courses in alcohol and drug studies that integrates theory and practical experience to develop the skills necessary to work with individuals living with substance use disorders. Students who complete all required courses also receive a certificate in Alcohol & Drug Studies (see "College Credit Course" below). During FY 2019-20, fewer students completed the certificate programs than the previous fiscal year due to the COVID-19 global pandemic. Students were not able to complete the internship portion of the program, and many decided to postpone their certificate completion to later academic years.



[3] In FY 2019-20, WET discontinued calculated Completion Rates for Extended Education courses. Since the Extended Education courses are structured in an open entry and exit format, there is no specific "Completion" date for these courses. Students can join or exit a course at any point during the semester, for any reason. Therefore, completion rates were not calculated for Extended Education courses.

Residency and Internship Programs

The Residencies and Internships program trains and supports individuals who aspire to work in the public mental health system. The California Psychology Internship Council (CAPIC) matches pre-doctoral candidates with a placement site based on a set of criteria. WET requests the same number of interns each year. However, CAPIC will match based on the number of students who have enrolled and site availability. All CAPIC students were placed in a behavioral health program during FY 2019-20, with three students being placed at WET's Neurobehavioral Testing Unit (NBTU) and two placed at Children Youth Behavioral Health (CYBH) sites. In FY 2018-19, two student interns were placed at WET's NBTU and four were placed at CYBH sites. Additionally, in FY 2017-18, four student interns were placed at WET's NBTU and two were placed at CYBH sites. All interns were supervised by a licensed psychologist.

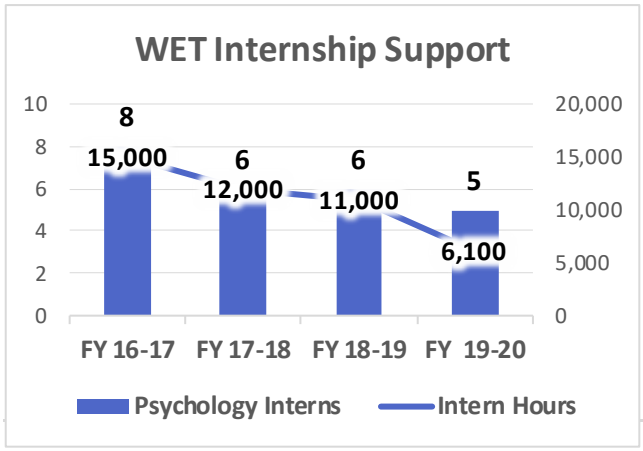
PROPOSED BUDGETS FROM 3YP

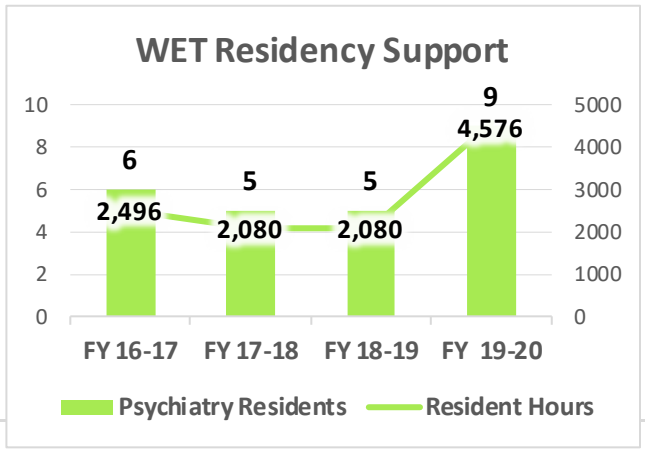
Fiscal Year	Program Budget
FY 2020-21	$170,000
FY 2021-22	$5,000
FY 2022-23	$170,000

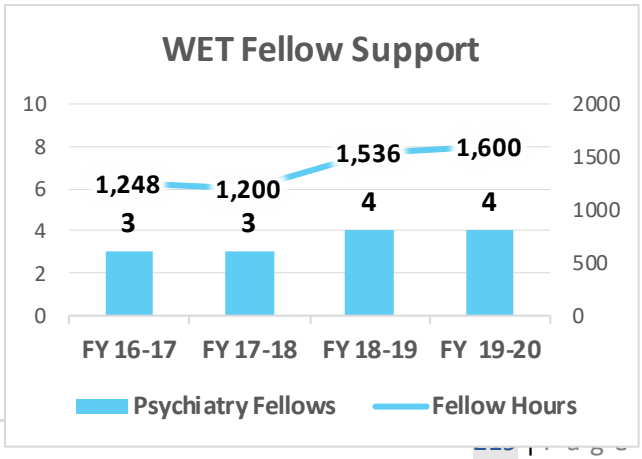
PROGRAM DESCRIPTION/OUTCOMES

In collaboration with the Psychiatry Department at the University of California-Irvine (UCI) School of Medicine, supervised trainings were provided in the program to teach the recovery philosophy; enhance cultural humility and understanding from the consumer and family perspectives; and recruit talented psychiatry residents and fellows into the public mental health system. The funded positions and training are one strategy the County uses to address the shortage of child and community psychiatrists working in community mental health. FY 2019-20 CAPIC students completed fewer clinical internship hours compared to previous years. This decrease was due to one student exiting the program early as well as the inability to conduct in-person testing due to the restrictions imposed because of the global pandemic of COVID-19.

In spring 2020, WET distributed an online survey to all FY 2019-20 CAPIC interns, as well as psychiatry residents and fellows to examine their experiences during the program. The two CAPIC interns who responded to the survey were very satisfied with their experience, were provided ample support and mentorship from their supervisor, and received professional development opportunities to refine their skills (e.g., hands on experience, working with clients, utilizing clinical skills, etc.). Similarly, all psychiatry resident and fellow interns who responded (n=9) were satisfied with their experiences during the program. The clinical supervisors were perceived as knowledgeable, supportive, and positive. All of the interns also felt they gained the skills necessary to perform their tasks in the field (e.g., hands on experience, working with clients, utilizing clinical skills, etc.).







Financial Incentive Programs

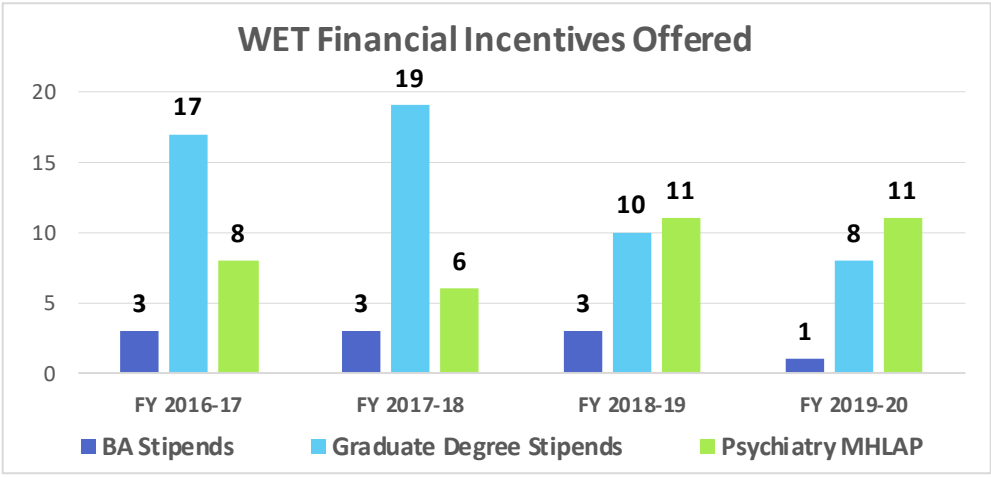
The Financial Incentives Program (FIP) seeks to expand a diverse bilingual and bicultural workforce by providing financial incentive stipends to BHS County employees seeking bachelor's (BA/BS) and master's (MA/MS) degrees, and to address the community psychiatrist shortage by offering loan repayment for psychiatrists working in the Orange County public mental health system. The WET office collaborates with numerous colleges and universities to offer stipends and encourage students to work for County or County-contracted agencies upon graduation. WET also offers the Orange County Mental Health Loan Assumption Program (OC-MHLAP), which offers loan assumption in exchange for working in the Orange County public mental health system. The pre-approved budget and number of eligible applicants determine the exact number of students/psychiatrists who are enrolled in FIP each year. FY 2018-19 showed a decline in the number of graduate student stipends awarded. Although the county still faces a shortage of community psychiatrists, the number participating in FY 2018-19 was nearly double that of FY 2017-18.

PROPOSED BUDGETS FROM 3YP

Fiscal Year	Program Budget
FY 2020-21	$526,968
FY 2021-22	$646,968
FY 2022-23	$526,968

PROGRAM DESCRIPTION/OUTCOMES

Similar to previous years, in FY 2019-20, over half of all those receiving BA/MA stipends self-identified as Mexican/Hispanic (70%), followed by Caucasian (20%), and Asian (10%) descent. The primary languages spoken were English (50%) and Spanish (50%). In FY 2018-19, over half of all those receiving BA/MA stipends self-identified as Mexican/Hispanic (64%), followed by Caucasian (24%) and Asian (12%) descent. The primary languages spoken were English (35%) and Spanish (35%). Roughly one-quarter said they spoke multiple languages (29%). In FY 2017-18, stipends were provided to 22 staff. More than half of staff self-identified as Mexican/Hispanic (54.6%), followed by Asian (27.2%) or Caucasian (18.2%) descent. While over one-third indicated their primary language was English (36.3%), a large proportion indicated they spoke more than one language (45.5%).



During FY 2019-20, WET conducted an online survey with all staff who participated in FIP during FY 2019-20. Out of the 20 staff enrolled in the program, nine responded to the online survey (45% response rate). Of those who responded, the majority of participants self-identified as female (63%) and were between the ages of 26-59 (89%). A large proportion indicated their racial or ethnic background as being either Mexican/Other Latino (67%), Caucasian/White (22%), or Asian (11%). All staff indicated they were employed with the County and worked at several behavioral health locations including OC ACCEPT, Community Counseling and Supportive Services, Outreach & Engagement, Clinical Evaluation Guidance Unit (CEGU), Children's Support and Parenting Program, Assisted Outpatient Treatment (AOT), or Inpatient/Residential Services.

Staff were asked to identify their organizational roles prior to and after participating in FIP. Prior to enrolling in the FIP program, 89% of staff indicated they were direct services providers, while 11% identified as support staff. One (n = 1, 11%) staff indicated that after participating in the program they advanced to a new role of Administrative or Manager and the remaining participants were still in their same roles. In addition, staff were asked if they earned an advanced degree as a result of their participation in FIP. All staff said that FIP helped them to earn a higher educational degree or level of schooling, as well as assisted them with

achieving their educational goals (100%). More specifically, prior to participating in FIP, participants either had some college experience (11%) or earned a bachelor's degree (89%). After engaging in FIP, 44% of staff had advanced their education by earning a master's level degree.

The vast majority of staff said that FIP helped them to advance in their careers (89%). When asked to list all the ways FIP helped them, a large percentage stated the program helped them to advance their education (89%), invested in their abilities (78%), helped them develop new skills (78%), increased their earning potential (78%), and increased their awareness of cultural and linguistically diverse services (78%). Other ways in which FIP helped staff included networking with other professionals (67%), helped them increase motivation related to their job (67%), provided opportunities to develop leadership skills (56%), and helped them to step out of their comfort zone (44%).

In the future, staff would like to see specific changes made to FIP to improve its effectiveness. Specifically, staff would like to see more support provided during the program (44%), the establishment of a mentorship/transition program for after graduation (44%), more resources to help apply knowledge and skills in the workforce (22%), and a streamlining of the application process (11%). While staff had recommendations for program improvements, overall, all staff who responded to the survey were satisfied with their FIP experiences, felt they were treated with courtesy and respect by staff, and would recommend the program to their colleagues. The majority also felt the program was very or extremely effective in developing a bilingual/bicultural workforce (22% and 44%, respectively). The remaining responses indicated the program was somewhat effective (33%) in developing a bilingual/bicultural workforce.

CAPITAL FACILITIES & TECHNOLOGICAL NEEDS

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

1. Capital facilities funding may be used to purchase, build or renovate land and/or facilities for the delivery of MHSA services to consumers and their families or used for MHSA administrative offices.
2. Technology funding may be used to modernize and transform clinical and administrative information systems and increase consumer and family empowerment by providing the tools for secure consumer and family access to health information.

CFTN projects are now funded through transfers from CSS as allowed by the Act and accompanying regulations.

Capital Facilities

PROPOSED BUDGETS FROM 3YP

Fiscal Year	Program Budget
FY 2020-21	$12,519,749
FY 2021-22	$16,307,384
FY 2022-23	$8,966,158

REQUIREMENTS FOR CAPITAL FACILITIES (CF) FUNDS

A county may use MHSA Capital Facility funds for the following types of projects:

- Acquire and build upon land that will be County-owned.
- Acquire buildings that will be County-owned.
- Construct buildings that will be County-owned.
- Renovate buildings that are County-owned.
- Renovate buildings that are privately-owned and dedicated, and used to provide MHSA services if certain provisions are met (i.e., renovations to benefit MHSA participants or MHSA administration's ability to provide services/programs in County's Three-Year Plan, costs are reasonable and consistent with what a prudent buyer would incur, a method for protecting the capital interest in the renovation is in place).
- Establish a capitalized repair and replacement reserve for buildings acquired or constructed with CF funds and/or the personnel cost directly associated with a CF project (i.e., project manager, with the reserve controlled, managed and disbursed by the County).

The former California Department of Mental Health (now Department of Health Care Services) outlined the following requirements for Capital Facilities funds:

- CF funds can only be used for those portions of land and buildings where MHSA programs, services and administrative supports are provided and must be consistent with the goals identified in the CSS and PEI components of the County's Three-Year Plan.
- Land acquired and built upon or construction/renovation of buildings using CF funds shall be used to provide MHSA programs, services and/or supports for a minimum of 20 years.
- All buildings through CF must comply with federal, state, and local laws and regulations, including zoning and building codes and requirements; licensing requirements, where applicable; fire safety requirements; environmental reporting and requirements; hazardous materials requirements; the Americans with Disabilities Act (ADA), California Government Code Section 11135 and other applicable requirements.
- The County shall ensure that the property is updated to comply with applicable requirements, and maintained as necessary, and that appropriate fire, disaster and liability insurance coverage is maintained.
- Under limited circumstances counties may "lease (rent) to own" a building. The County must provide justification why "lease (rent) to own" is preferable to the outright purchase of the building and why the purchase of such property with MHSA CF funds is not feasible.

CURRENT CAPITAL FACILITIES PROJECTS

Behavioral Health Training Services Renovations:
Beginning in FY 2018-19, the OC Health Care Agency (HCA) began to divert CSS funds from WET to CFTN to cover capital expense renovations to a long-term leased space used for the Behavioral Health Training Center. WET offers and facilitates hundreds of trainings to the Orange County behavioral health workforce each year and has faced challenges in finding appropriate locations and workshops in which to provide them. This center can accommodate up to 200 people with dedicated parking and has the flexibility to provide multiple rooms for breakout sessions or smaller workshops as needed. This site will also be made available to the community for planning and meeting space. The total amount approved for the renovations will not exceed $650,000 and will be transferred incrementally over the course of the 10-year lease.

Technological Needs

REQUIREMENTS FOR USE OF TECHNOLOGY FUNDS

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

- It must fit in with the state's long-term goal to develop an Integrated Information Systems Infrastructure where all counties have integrated information systems that can securely access and exchange information.
- It must be part of and support the County's overall plan to achieve an Integrated Information Systems Infrastructure through the implementation of an Electronic Health Record (EHR).

CURRENT TECHNOLOGY PROJECTS

HCA Electronic Health Record (EHR):

Behavioral Health Services (BHS) is implementing a fully integrated EHR system that supports the goals of MHSA to promote well-being, recovery and resilience. It also aims to comply with the federal requirements for Meaningful Use which is a standard designed to benefit the individuals served. This is a large, ongoing project that has been divided into three phases spanning several years, and includes acquisition and implementation of software, technology infrastructure upgrades and services to develop and implement the overall system.

1. The first phase of the project plan enhanced the functionality of the BHS EHR (Integrated Records Information System or IRIS), and successful implementation at a pilot clinic. Enhancements included documentation software designed to help clinicians avoid common errors, as well as electronic prescription software to help psychiatrists manage participants' medications. Additional technical improvements to the EHR included document imaging (which included functionality such as electronic signature pads and the ability to scan documents), compliance monitoring, auditing and reporting for privacy and security, and enhanced disaster recovery. BHS also successfully implemented kiosks that provide individuals with a mental health condition and their family members with increased access to computers and the internet at several BHS County-operated outpatient clinics.
2. The second phase of the project allowed for expanded staff use of the EHR through technology infrastructure and software enhancements. A client portal was implemented and voice-activated documentation for staff with physical challenges was piloted at select locations. Overall, implementation of the EHR at the County-operated outpatient clinics has gone well and user acceptance has been extremely high.
3. The third phase will allow the County to interface securely with its contract providers and to participate, as appropriate, in consent-based Health Information Exchanges outside County Behavioral Health Services, including with the federal EHR Meaningful Use program. Phase 3 project costs will include, but not be limited to, software licenses, network infrastructure such as servers, storage and network monitoring appliances, other EHR and data warehouse upgrades, consolidation of data from multiple sources, internal human resources, external consultants and training. Additional funds are being requested for transfer in FY 2021-22 to support the migration of the HCA EHR to the cloud.

County Data Integration Project:

$1 million of the Three-Year Plan TN budget will fund a portion of the development and ongoing support for a System of Care Data Integration System. This system will facilitate appropriate, allowable data-sharing across County departments and with external stakeholders with the goal of delivering essential and critical services, including behavioral health care, to county residents in a more efficient and timely manner.

SPECIAL PROJECTS

SPECIAL PROJECTS

Orange County Special Projects are projects that are unique in scale or scope and may involve multiple services, systems and/or agencies. These programs include:

- Help@Hand
- Behavioral Health System Transformation
- Potential INN Projects
- Whole Person Care

Help@Hand (INN)

Help@Hand (formerly Tech Suite) is a statewide project comprised of 14 counties and cities that leverages interactive technology-based mental health solutions (i.e., internet-based and/or mobile applications) to help improve access to care and outcomes for people across the state. The project seeks to understand how technology is introduced and works within the public behavioral health system of care. Help@Hand aims to provide diverse populations with access to mobile applications ("apps") designed to educate users on the signs and symptoms of mental illness, improve early identification of emotional/behavioral destabilization, connect individuals seeking help in real time, and/or increase user access to mental health services when needed.

PROPOSED BUDGETS FROM 3YP

Fiscal Year	Program Budget
FY 2020-21	**$6,000,000**
FY 2021-22	**$3,100,000**
FY 2022-23	***above carryover***

SERVICES

Orange County was approved to join this Innovation project in April 2018 and began project implementation planning immediately. The HCA originally applied as a four-year project and was recently approved by the MHSOAC for a one-year, no-cost extension. Thus, the project will end for Orange County in April 2023. The primary purpose of this project is to increase access to mental health services to underserved groups, with the goal of introducing a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention.

Help@Hand consists of several main components of which participating counties have chosen to opt in or out, based on their local needs. Orange County was approved to implement all project components, which includes:

- Technology Apps (3):
  - 24/7 Peer Chat, which will offer around-the-clock, anonymous Peer chat support to an individual
  - Therapy Avatar, which will offer virtual manualized evidence-based interventions delivered via an avatar in a simple, intuitive fashion (e.g., mindfulness exercises, cognitive behavioral or dialectical behavior interventions)
  - Customized Wellness Coach, which will utilize passive sensory data to engage, educate and suggest behavioral activation strategies to users
- Marketing and Outreach
- Evaluation

Peers are integral to Help@Hand, and the vision of the Peer Role is to incorporate Peer input, expertise, knowledge and lived experience at all levels of the project, and to support the use of identified apps through Peer outreach and training. The Peer component of the project holds significant importance as it:

- Creates transparency around basic cautions, clarity about user choice, and highlights that technology does not replace in-person mental health services
- Provides clarity on the project definition of peers, roles, and serves as an example of a Peer staffing ladder
- Supports collaboration of Peer Leads across the state important to project learning, connection, and problem-solving
- Responds to county/city community stakeholder specific needs by developing digital mental health literacy curriculum that will support project learning and stakeholder's ability to make informed choices
- Trains the Peer Workforce to facilitate digital mental health literacy sessions that will keep learning at the local level and sustainable
- Trains project partners on Peer culture, experience, and history supporting better project integration
- Integrates consumer expertise and voice in evaluation thus enhancing the work
- Incorporates lived experience and perspective on how possible future technology can help the project be responsive to consumer needs

During FY 2019-20, Orange County continued its planning efforts to launch Mindstrong, a technology app that fits within the Customized Wellness Coach component. This app is a service that provides access to round-the-clock telehealth support augmented by a new form of digital mood and cognitive measurement. Mindstrong telehealth services are delivered by a team of licensed psychiatrists and licensed or supervised therapists who can help maintain well-being between appointments or after office hours. While telehealth services are an established behavioral health practice, the Mindstrong automatic notifications (i.e., biomarkers) are a new and emerging approach to care and derived from the touches, scrolls and taps a person makes throughout the day as they use their phone. These notifications may provide an early indication of changes in the moods and symptoms associated with an individual's condition that may help facilitate earlier access to care and support. The Health app and services will only be available to eligible participants within specific partnered programs within Orange County.

In preparation for the app launch, the project team visited the pilot site to learn about staffing, services and workflows. This allowed the staff to understand and better streamline how Mindstrong would integrate into daily operations. Project activities also focused on identifying eligibility criteria, developing implementation materials (i.e., referral tracking log, communication templates, brochures, OC Help@Hand website content) and drafting an informed consent form. The development of an informed consent form involved extensive conversations with Peers, Mindstrong and HCA Compliance. The Mindstrong pilot launched in May 2020. In response to the COVID-19 pandemic and stay-at-home orders, project staff focused their efforts in digitizing all content, including the development of an outreach video and plans for a digital informed consent. Project staff also partnered with a video production company for the digitization of the consent form and project materials.

In addition to preparing for local implementation, project staff also participated in collaborative activities and priorities. Details about the Help@Hand Collaborative activities during FY 2019-20 are available in the MHSA INN Annual Project Report.

OUTCOMES

Help@Hand will examine the following learning objectives:

- Detect and acknowledge mental health symptoms sooner.
- Reduce stigma associated with mental illness by promoting wellness.
- Increase access to the appropriate level of support and care.
- Increase purpose, belonging and social connectedness of individuals served.
- Analyze and collect data to improve mental health needs assessment and service delivery.

Since the pilot launch in May, 5 participants were enrolled in Mindstrong services. Because outcome metrics take time to yield results after deployment and utilization of the technology, a formative evaluation will provide a look beyond performance outcomes to examine the progress of the project and offer suggestions along the way. Outcomes related to the Mindstrong pilot and the overall project formative evaluation will be reported in future Plan Updates and/or project reports.

CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

The 14 participating cities/counties are at the forefront of innovation to understand how technology is introduced and works within the public behavioral health system of care. When faced with challenges or barriers, the collaborative offers the benefit of a shared learning experience that accelerates learning.

Throughout this process, the most significant lesson learned is that the primary focus of Help@Hand is not the implementation of apps, but rather the development of a sustainable digital mental health system of care for California (i.e., infrastructure building). As such, initial efforts should prioritize system preparation; user, program and agency readiness for change; and implementation planning. An effective work plan and checklist of pre-launch activities are essential to prioritize the necessary and required preconditions prior to the launch of an app (i.e., roadmap of involved parties and logical order/priorities for Information Technology (IT), data sharing, Compliance, clinical integration, etc.).

The initial planning phase should also include strategies for an effective communication and decision-making process. System readiness requires collaboration and ongoing communication with program managers and staff in programs where an app will be launched. It is critical to obtain feedback from clinicians and Peers early on to assess interest and/or readiness to use the app services. Equally as critical is communication with vendors, checking in to ensure information, messaging and shared vision is accurate. The public behavioral health system and the private industry have their own language and communication style. As a result, it is important to frequently define terms to ensure shared understanding. Furthermore, existing technology is not necessarily geared with the County mental health plan consumer in mind, so when exploring and procuring technology, it is important to be clear in including the type of technology the target population will likely have access to, as well as language capabilities.

With regard to the planning, development and implementation of apps, it is essential for this process to be streamlined and sustainable in the future. This includes the involvement of County Counsel, Compliance and IT teams throughout the process. Additional considerations include outlining a process for procuring and learning about new apps/vendors, creating a systematic process for testing apps, and addressing potential safety, risk and liability concerns. Project staff identified additional lessons learned that are highlighted in the Orange County Spotlight.

Behavioral Health System Transformation (INN)

The **Behavioral Health System Transformation** (BHST) project is an INN project designed to create a system that can serve all Orange County residents, regardless of insurance status, type, or level of clinical need. Its primary purpose is to promote interagency and community collaboration related to mental health services, supports or outcomes, with the goal of introducing a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention. Orange County's BHST project proposal was approved by the MHSOAC in May 2019 and local project start up began in October 2019.

PROPOSED BUDGETS FROM 3YP

Fiscal Year	Program Budget
FY 2020-21	$9,477,500
FY 2021-22	$5,355,250
FY 2022-23	*above carryover*

SERVICES

Unlike the majority of INN projects that tend to focus on new or modified approaches to service delivery, the BHST project will strive to transform the behavioral health system of care by identifying strategies to braid public and private funding; creating a value-based system; and improving navigation of and access to needed resources. Project activities are divided into two parts:

BHST Part 1, Performance and Value-Based Contracting, addresses the plan to create a value-based system that braids public and private funding. Key steps and activities include:

- Establishing community-defined values and metrics
- Identifying braiding strategies for public and private funding
- Aligning community-defined outcomes with legal, fiscal and regulatory requirements
- Developing new provider contract templates
- Providing technical assistance to assist providers

BHST Part 2, Digital Resource Navigator and Overall Project Evaluation, involves the development of a digital navigation tool, as well as the evaluation of the overall BHST project (i.e., Part 1 & digital resource navigator). The features, functionality and list of resources in the digital resource navigator will be developed through a participatory process that involves community members, including consumers, family members and behavioral health providers. Core features of the directory will include an optional social determinants survey, curated list of resources prioritized based on an individual's needs, and ability for providers to update resource information in real-time. Key steps and activities include:

- Identifying directory resources, features and functionality
- Directory development and testing
- Continuous review and refinement
- Project evaluation and lessons learned

Due to its focus on identifying methods to change processes and integrate policies across the public and private sectors, this project will utilize a formative evaluation. One of the key goals of a formative evaluation is to identify influences – both potential and real – on the progress and/or effectiveness of a project's implementation. Information is collected at all phases of execution and is used as part of a continuous feedback loop to improve the ultimate likelihood of successful project implementation.

Through focus groups, interviews, observational studies, and surveys of stakeholders, subject matter experts and meeting participants, the evaluation will allow Orange County to identify successful and unsuccessful strategies employed throughout the various project activities, including inter-agency and inter-departmental meetings and workgroups. Similarly, the formative evaluation will determine whether Orange County is able to identify ways to engage a diverse group of community stakeholders successfully and elicit meaningful participation, guidance and feedback.

OUTCOMES

The BHST project does not provide direct services, as a result, there are no outcomes to report. However, during FY 2029-20, BHST Part 1 and Part 2 made significant progress in their respective key steps and activities. A full report of all project activities can be found in the MHSA INN Annual Project Report.

Potential INN Projects (INN)

The HCA will explore potential Innovation project ideas submitted through the HCA Idea Generation Website, as well as statewide project opportunities. Each idea considered viable after initial vetting will include a community planning process and must be approved by the MHSOAC before implementation. Project ideas that are most aligned with MHSA Community Program Planning Process results and/or most feasible, will be prioritized for exploration. The tables below provide a description and current status for each potential INN project idea.

Prioritized Ideas, listed in alphabetical order:

Potential Idea	Brief Description	Status
allcove	Integrated youth drop-in centers for ages 12 - 25.	Pending implementation and further review of Youth Drop-in Center grant **Prioritized based on existing grant**
Mobile Phones	Understand the technical capacity of LifeLine phones and/or service plans to support a variety of existing digital mental health apps and products. Develop a process for testing future mental health apps to determine whether they are usable and acceptable to consumers using LifeLine phones.	Pending further review of INN requirements, fit with MHSA priorities and FY 20-21 CEM results **Prioritized based on FY 20-21 CEM results**
Psychiatric Advance Directives	Statewide collaborative that aims to enhance individual independence for people with needs with the goal of reducing recidivism in the criminal justice system and empowering clients.	Community Planning Process in progress to determine whether to move forward with MHSOAC approval. **Prioritized based on multi-county INN project opportunity**
Social Media	Participants at a high risk for mental health disorders will agree to have their smartphone social media data monitored and will take periodic surveys to assess their MH related behaviors and outcomes.	Pending further review of INN requirements, fit with MHSA priorities and FY 20-21 CEM results **Prioritized based on FY 20-21 CEM results**
Stigma Reduction	Test competing models of stigma reduction campaigns to determine which approaches, strategies and/or techniques are more effective within different target populations. Identify, develop and test a method for measuring short-term and long-term effects on mental-health-related stigma.	Pending further review of INN requirements, fit with MHSA priorities and FY 20-21 CEM results **Prioritized based on FY 20-21 CEM results**

Potential ideas pending further exploration:

Potential Idea	Brief Description	Status
Mental Health Adult and Older Adult Residential Facilities	Create training curriculum for staff in Assisted Living Facility serving adults living with mental illness. Training would address recognizing early signs of mental illness, basic support techniques and knowledge of how to refer to basic, appropriate mental health resources.	Pending further review of INN requirements, fit with MHSA priorities and FY 20-21 CEM results
Mental Health Participant Pet Boarding Services	Focus on creating a network of veterinarians, boarding programs, animal day care, and animal foster volunteers who would be available to outreach programs to immediately foster pets for day, overnight and up to 30 days for individuals ready to seek treatment and/or shelter. The program would also engage previously homeless individuals who have been housed in the past year or two, and train them to be animal foster sites.	Pending further review of INN requirements, fit with MHSA priorities and FY 20-21 CEM results
Mental Health Participant Pet Veterinary Care	Veterinary care will be available for pets of homeless participants who are seeking shelter and treatment.	Pending further review of INN requirements, fit with MHSA priorities and FY 20-21 CEM results
Middle School Student Wellness Centers	Each Wellness Center will comprehensively address mental and physical health by placing a nurse, nutrition, outreach, mental health and drug intervention support within these sites.	Pending further review of INN requirements, fit with MHSA priorities and FY 20-21 CEM results
Peer Intervention Journal	Proposes that Peer projects throughout the state be complied into a journal in order to share information.	Pending further review of INN requirements, fit with MHSA priorities and FY 20-21 CEM results
Psychiatry Clinical Extender Program	High school and medical students would be offered the opportunity to volunteer with clients within the Wellness Centers or other unlocked centers to gain experience and knowledge of working with this population. This could include advertising about careers in the behavioral health field.	Pending further review of INN requirements, fit with MHSA priorities and FY 20-21 CEM results
Shelter Grade Housing	Proposes a design competition among local universities to design a shelter that promotes mental health and wellness.	Pending further review of INN requirements, fit with MHSA priorities and FY 20-21 CEM results
Shelter Living Skills Curriculum	Focus on developing a new shelter-specific-living-skills curriculum that incorporates group, individual, case management and daily assignments. Each participant will be given a needs assessment upon intake and will work with a peer group and individual support person to complete their daily goals.	Pending further review of INN requirements, fit with MHSA priorities and FY 20-21 CEM results

Young Children at risk of ADHD	Development and testing of a new technology that will use a wearable and connected system that combines a fitness and health tracker, mobile phone app, and web portal with an online community. The system can be used to deliver interventions and monitor progress over time for parents of children at risk for ADHD or related behavioral disorders.	Pending further review of INN requirements, fit with MHSA priorities and FY 20-21 CEM results

Proposed ideas that that will no longer be explored as a potential INN project:

Potential Idea	Brief Description	Status
Older Veterans Support Program	Identify where isolated veterans are and enroll them into an engaging socialization program that would refer to other collaborative partners for additional services.	After further exploration and discussion with community members who proposed the concept, it was determined that this idea does not meet INN criteria and would better fit as a potential PEI program.

Whole Person Care Pilot (PEI)

Whole Person Care (WPC) is the coordination of physical, behavioral, health and social services in a person-centered approach with the goal of improving health and well-being through comprehensive, streamlined service delivery. WPC services are for Medi-Cal beneficiaries living with serious and persistent mental illness (SPMI) and struggling with homelessness.

BHS is leveraging a total of $856,600 in MHSA funds per year for five years to draw down Whole Person Care Federal match dollars. Resulting in over $30 million over five years, these dollars fund an array of health services for adults participating in WPC.

BHS is providing the following services through the WPC pilot, which is set to expire on December 31, 2020:

- The BHS Outreach and Engagement expansion team uses MHSA funds to identify individuals eligible for WPC and engage them into needed services ($475,927 in MHSA per year).
- Housing Navigators address barriers that prevent BHS participants from making successful housing placements and work to increase the inventory of available units for homeless adults living with SPMI (funded by WPC).
- Peer Mentoring expansion provides housing and tenancy-sustaining services to help WPC participants be successful in their housing placements ($380,673 in MHSA per year).
- Recuperative/Respite Care provides recuperative care beds for homeless adults who are recovering from an acute illness or injury, are no longer in need of acute care but are unable to sustain recovery if living on the street or other unsuitable place (funded by WPC).

EXHIBITS

&

APPENDICES

EXHIBIT A: Budget Grids

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

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

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
Estimated FY2021-22 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	34,654,881	28,017,720	20,549,159	-	-	33,258,769
2. Estimated New FY2021-22 Funding	158,352,053	39,751,693	10,587,336	-	-	-
3. Transfer in FY2021-22	(21,527,368)	-		5,219,984	16,307,384	-
4. Access Local Prudent Reserve in FY2021-22	-	-				-
5. Estimated Available Funding for FY2021-22	171,479,566	67,769,413	31,136,495	5,219,984	16,307,384	33,258,769
Estimated FY2021-22 Expenditures	(130,203,791)	(50,529,691)	(10,999,190)	(5,219,984)	(16,307,384)	
Estimated FY2021-22 Unspent Fund Balance	**$ 41,275,775**	**$ 17,239,722**	**$ 20,137,305**	**$ -**	**$ -**	**$ 33,258,769**

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

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

b/ Estimated expenditures for CSS/PEI for FY 21/22 are anticipated to be within funding limits avaialble but are budgeted at full-program's costs. Historical trends show actual expenditures to be under the annual budget due to various factors, such as unanticipated revenue offsets, or cost savings. The Financial Team monitors and projects the revenues and expenditures throughout the fiscal year to ensure the funds are not overspent. CSS expenditures are estimated at 82% and PEI expenditures are estimated at 90% of the budgeted amounts for each fiscal year.

c/ Per MHSUDS Info Notice No. 19-017 dated March 20, 2019, each county is now required to establish a Prudent Reserve that does not exceed 33 percent of the average Community Services and Supports (CSS) revenue received for the Local Mental Health Serices Fund in the preceding five years. Maximum Prudent Reserve amount for FY 2020-21 is capped at the average of 33% of the previous 5 FY's CSS allocation. Orange County's current Prudent Reserve amount is $33,258,769 and this same amount is budgeted for FY 2020-21 through FY 2022-23. Orange County's Prudent Reserve will be re-assessed in FY 2023-24 by using the actuals from FY 2018-19 through FY 2022-23.

d/ Estimated Unspent Fund Balances in CSS and PEI are allocated to support the Strategic Priorities identified in the three-year plan.

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

County: Orange Date: 4/28/2021

Program Description	Fiscal Year 2021-22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Full Service Partnership (FSP Programs)						
1. Children's Full Service Partnership	**13,197,468**	**11,554,575**	**1,642,893**	**-**	**-**	**-**
2. Transitional Age Youth (TAY) Full Service Partnership	**9,889,331**	**8,184,468**	**1,519,924**	**-**	**-**	**184,939**
3. Adult Full Service Partnership	**36,080,254**	**30,307,934**	**5,589,458**	**-**	**-**	**182,862**
Adults	27,149,297	22,092,093	4,887,076	-	-	170,128
Assisted Outpatient Treatment Assessment & Linkage	5,430,957	4,715,841	702,382	-	-	12,734
Supportive services for clients in permanent housing	3,500,000	3,500,000	-	-	-	-
4. Older Adult Full Service Partnership	**4,204,615**	**3,719,899**	**484,716**	**-**	**-**	**-**
5. Program for Assertive Community Treatment	**13,749,990**	**10,699,650**	**3,006,786**	**-**	**-**	**43,554**
Non-FSP Programs Partially Categorized as FSP:						
Access and Linkage to Treatment Section:						
1. Multi-Service Center for Homeless Mentally Illness Adults	**45,000**	**45,000**	**-**	**-**	**-**	**-**
2. Open Access	**1,505,114**	**1,300,000**	**199,317**	**-**	**-**	**5,797**
3. CHS Jail to Community Re-Entry	**-**	**-**	**-**	**-**	**-**	**-**
Crisis & Crisis Prevention Section:						
4. Mobile Crisis Assessment Team	**4,492,060**	**3,451,094**	**840,164**	**-**	**-**	**200,802**
5. Crisis Stabilization Units (CSUs)	**2,086,366**	**1,500,000**	**586,366**	**-**	**-**	**-**
6. In-Home Crisis Stabilization	**1,583,370**	**1,229,836**	**337,790**	**-**	**-**	**15,744**
7. Crisis Residential Services	**5,281,435**	**4,597,008**	**752,021**	**-**	**-**	**40,395**

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

County: Orange Date: 4/28/2021

Program Description	Fiscal Year 2021-22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
OUTPATIENT TREATMENT: Clinic Expansion						
8. Children & Youth Expansion	-	-	-	-	-	-
9. OC Children with Co-Occurring Mental Health Disorders	1,014,887	500,000	500,000	-	-	14,887
10. Outpatient Recovery	169,052	117,171	51,165	-	-	716
11. Older Adult Services	177,129	130,088	46,686	-	-	355
12. Services for the Short-Term Residential Therapeutic Program	-	-	-	-	-	-
13. Telehealth/Virtual Behavioral Health Care	1,250,000	1,250,000				
Supportive Services Section:						
14. Peer Mentor and Parent Partner Support	-	-	-	-	-	-
15. Wellness Centers	368,979	368,979	-	-	-	-
16. Supported Employment	274,252	274,252	-	-	-	-
17. Transportation	-	-	-	-	-	-
Supportive Housing/Homelessness Section:						
18. Housing & Year Round Emergency Shelter	410,154	410,154	-	-	-	-
19. Bridge Housing for the Homeless	1,300,000	1,300,000	-	-	-	-
20. CSS Housing	267,035	267,035	-	-	-	-
FSP Sub-Total	***$ 97,346,490***	***$ 81,207,143***	***$ 15,557,284***	***$ -***	***$ -***	***$ 690,051***

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

County: Orange Date: 4/28/2021

Program Description	Fiscal Year 2021-22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Non-FSP Programs Not Categorized as FSP:						
Access and Linkage to Treatment Section:						
1. Multi-Service Center for Homeless Mentally Illness Adults	855,000	855,000	-	-	-	-
2. Open Access	1,505,114	1,300,000	199,317	-	-	5,797
3. CHS Jail to Community Re-Entry	2,700,000	2,700,000	-	-	-	-
Crisis & Crisis Prevention Section:						
4. Mobile Crisis Assessment Team	6,786,742	5,684,764	952,773	-	-	149,205
5. Crisis Stabilization Units (CSUs)	11,822,739	8,500,000	3,322,739	-	-	-
6. In-Home Crisis Stabilization	2,151,802	1,705,644	439,410	-	-	6,748
7. Crisis Residential Services	9,226,945	6,683,837	2,632,080	-	-	68,039
OUTPATIENT TREATMENT: Clinic Expansion						
8. Children & Youth Expansion	3,033,490	2,500,000	500,000	-	-	33,490
9. OC Children with Co-Occurring Mental Health Disorders	1,014,887	500,000	500,000	-	-	14,887
10. Outpatient Recovery	8,283,534	5,741,360	2,507,080	-	-	35,094
11. Older Adult Services	2,775,018	2,038,047	731,412	-	-	5,559
12. Services for the Short-Term Residential Therapeutic Program	10,500,000	7,000,000	3,500,000	-	-	-
13. Telehealth/Virtual Behavioral Health Care	1,250,000	1,250,000				
Supportive Services Section:						
14. Peer Mentor and Parent Partner Support	4,249,888	4,249,888	-	-	-	-
15. Wellness Centers	2,985,372	2,985,372	-	-	-	-
16. Supported Employment	1,097,010	1,097,010	-	-	-	-
17. Transportation	1,100,000	1,100,000	-	-	-	-

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

County: Orange Date: 4/28/2021

Program Description	Fiscal Year 2021-22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Supportive Housing/Homelessness Section:						
18. Housing & Year Round Emergency Shelter	**957,026**	**957,026**	**-**	**-**	**-**	**-**
19. Bridge Housing for the Homeless	**700,000**	**700,000**	**-**	**-**	**-**	**-**
20. CSS Housing	**89,011**	**89,011**	**-**	**-**	**-**	**-**
Sub-Total	***$ 73,083,577***	***$ 57,636,959***	***$ 15,284,812***	***$ -***	***$ -***	***$ 318,818***
CSS Administration	19,941,008	19,941,008	-	-	-	
Total CSS Program Estimated Expenditures	**$ 190,371,075**	**$ 158,785,110**	**$ 30,842,096**	**$ -**	**$ -**	**$ 1,008,869**
FSP Programs as Percent of Total	**51%**					

FY 2021-22 Annual Update - Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: **Orange** Date: 4/28/2021

Program Description	Fiscal Year 2021-22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Prevention: Child, Youth and Parent Programs						
1. School Readiness	**1,002,786**	**1,000,000**				**2,786**
2. Parent Education Services	**1,456,018**	**1,450,000**				**6,018**
3. Children's Support & Parenting	**1,018,474**	**1,000,000**				**18,474**
4. School-Based Behavioral Health Intervention & Support	**2,131,970**	**2,128,589**				**3,381**
5. Violence Prevention Education	**1,352,651**	**1,352,651**				**-**
6. Gang Prevention Services	**412,299**	**403,100**				**9,199**
7. Family Support Services	**282,649**	**282,000**				**649**
MENTAL HEALTH AWARENESS & STIGMA REDUCTION CAMPAIGNS & EDUCATION						
8. Mental Health Community Educ. Events for Reducing Stigma & Discrimination	**1,200,000**	**1,200,000**				**-**
9. Outreach for Increasing Recognition of Early Signs of Mental Illness	**13,130,213**	**13,118,412**				**11,801**
Behavioral Health Training Services	1,183,695	1,180,000				3,695
School-Based Stress Management Services	-	-				-
Early Childhood Mental Health Providers Training	1,000,000	1,000,000				-
Mental Health & Well-Being Promotion for Diverse Communities	3,393,817	3,385,711				8,106
K-12 School-Based Mental Health Services Expansion	2,312,500	2,312,500				-
Services for TAY and Young Adults	580,000	580,000				-
Statewide Projects	4,660,201	4,660,201				-

FY 2021-22 Annual Update - Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: **Orange** Date: 4/28/2021

Program Description	Fiscal Year 2021-22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CRISIS PREVENTION & SUPPORT						
10. Warmline	2,000,000	2,000,000				-
11. Suicide Prevention Services	3,200,000	3,200,000				-
SUPPORTIVE SERVICES						
12. Transportation Assistance	200,000	200,000				-
ACCESS & LINKAGE TO TREATMENT (TX)						
13. OCLinks	4,000,000	4,000,000				-
14. BHS Outreach & Engagement (O&E)	3,129,668	3,129,668				-
OUTPATIENT TREATMENT - Early Intervention						
15. School-Based Mental Health Services	2,562,185	2,525,236				36,949
16. 1st Onset of Psychiatric Illness	1,527,178	1,450,000	50,000			27,178
17. OC Parent Wellness Program	3,826,748	3,738,072				88,676
18. Community Counseling & Supportive Services	2,591,559	2,536,136				55,423
19. Early Intervention Services for Older Adults	2,469,500	2,469,500				-
20. OC4VETS	2,402,316	2,400,000				2,316
PEI Administration	6,560,737	6,560,737				
Total PEI Program Estimated Expenditures	$ 56,456,951	$ 56,144,101	$ 50,000	$ -	$ -	$ 262,850

FY 2021-22 Annual Update - Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: **Orange** Date: 4/28/2021

Program Description	Fiscal Year 2021-22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
1. Contiuum of Care for Veterans and Military Families	745,000	745,000	-	-	-	-
2. Help @ Hand *(formally known as Mental Health Technology Suite)*	3,100,000	3,100,000	-	-	-	-
Statewide Early Psychosis Learning Health Care	561,234	561,234				
3. Collaborative Network			-	-	-	-
4. Behavioral Health System Transformation	5,355,250	5,355,250	-	-	-	-
Subtotal Of All INN Programs	***9,761,484***	***9,761,484***	**-**	**-**	**-**	**-**
INN Administration	1,237,706	1,237,706	-	-	-	-
Total INN Program Estimated Expenditures	**$ 10,999,190**	**$ 10,999,190**	**$ -**	**$ -**	**$ -**	**$ -**

FY 2021-22 Annual Update - Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: **Orange** Date: 4/28/2021

Program Description	Fiscal Year 2021-22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
1. Workforce Staffing Support	1,761,901	1,761,901	-	-	-	-
2. Training and Technical Assistance	1,282,434	1,282,434	-	-	-	-
3. Mental Health Career Pathways	1,046,663	1,046,663	-	-	-	-
4. Residencies and Internships	5,000	5,000	-	-	-	-
5. Financial Incentives Programs	646,968	646,968	-	-	-	-
	-	-	-	-	-	-
Subtotal Of All WET Programs	***4,742,966***	***4,742,966***	**-**	**-**	**-**	**-**
WET Administration	477,018	477,018	-	-	-	-
Total WET Program Estimated Expenditures	**$ 5,219,984**	**$ 5,219,984**	**$ -**	**$ -**	**$ -**	**$ -**

FY 2021-22 Annual Update - Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: **Orange** Date: 4/28/2021

Program Description	Fiscal Year 2021-22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Capital Facilities Projects						
1. Behavioral Health Training Facility	65,000	65,000	-	-	-	-
Technological Needs Projects						
2. Electronic Health Record (E.H.R)	16,042,384	16,042,384	-	-	-	-
CFTN Administration	200,000	200,000	-	-	-	-
Total CFTN Program Estimated Expenditures	**$ 16,307,384**	**$ 16,307,384**	**$ -**	**$ -**	**$ -**	**$ -**

EXHIBIT B: Maximum Prudent Reserve Calculation and Prudent Reserve Assessment

The Prudent Reserve Calculation and Assessment are to be completed every five years. The next calculation and assessment will occur in FY 2023-24.

FY 2019-20 33% Maximum Prudent Reserve Calculations

Funding Year	Total MHSA Allocations July 1, 2013 - June 30, 2018
FY 13/14	$99,072,771.39
FY 14/15	$138,031,688.98
FY 15/16	$115,045,914.79
FY 16/17	$149,134,711.87
FY 17/18	$161,768,522.68
5-yr Total	663,053,609.71
CSS portion of total allocation (76%)	503,920,743.38
5-yr Avg of CSS funds	100,784,148.68
Prudent Reserve Limit for FY 18/19 (33%)	**33,258,769 .06**

State of California
Health and Human Services Agency

Department of Health Care Services

MENTAL HEALTH SERVICES ACT
PRUDENT RESERVE ASSESSMENT/REASSESSMENT

County/City: County of Orange
Fiscal Year: 2018/19

Local Mental Health Director

Name: Jeffrey A. Nagel
Telephone: 714-834-7024
Email: JNagel@OCHCA.com

I hereby certify[1] under penalty of perjury, under the laws of the State of California, that the Prudent Reserve assessment/reassessment is accurate to the best of my knowledge and was completed in accordance with California Code of Regulations, Title 9, section 3420.20 (b).

Jeffrey A. Nagel — Local Mental Health Director (PRINT NAME)
Signature
4/25/19 — Date

EXHIBIT C: County Compliance Certification

PLACEHOLDER –

TO BE SIGNED AND INCLUDED UPON BOARD OF SUPERVISORS APPROVAL OF THE PLAN

EXHIBIT D: County Fiscal Certification

Enclosure 1

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: Orange

☐ Three-Year Program and Expenditure Plan
☒ Annual Update
☐ Annual Revenue and Expenditure Report

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Jeffrey Nagel, PhD	Name: Frank Davies
Telephone Number: (714) 834-7024	Telephone Number: (714) 834-2450
E-mail: jnagel@ochca.com	E-mail: frank.davies@ac.ocgov.com
Local Mental Health Mailing Address: 405 W. 5th Street, Suite 477 Santa Ana, CA 92701	

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

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

Jeffrey Nagel, PhD
Local Mental Health Director (PRINT)

Signature

4/12/21
Date

I hereby certify that for the fiscal year ended June 30, 2020, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated 2020 for the fiscal year ended June 30, 2020. I further certify that for the fiscal year ended June 30, 2020, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

I declare under penalty of perjury under the laws of this state that the foregoing, and if there is a revenue and expenditure report attached, is true and correct to the best of my knowledge.

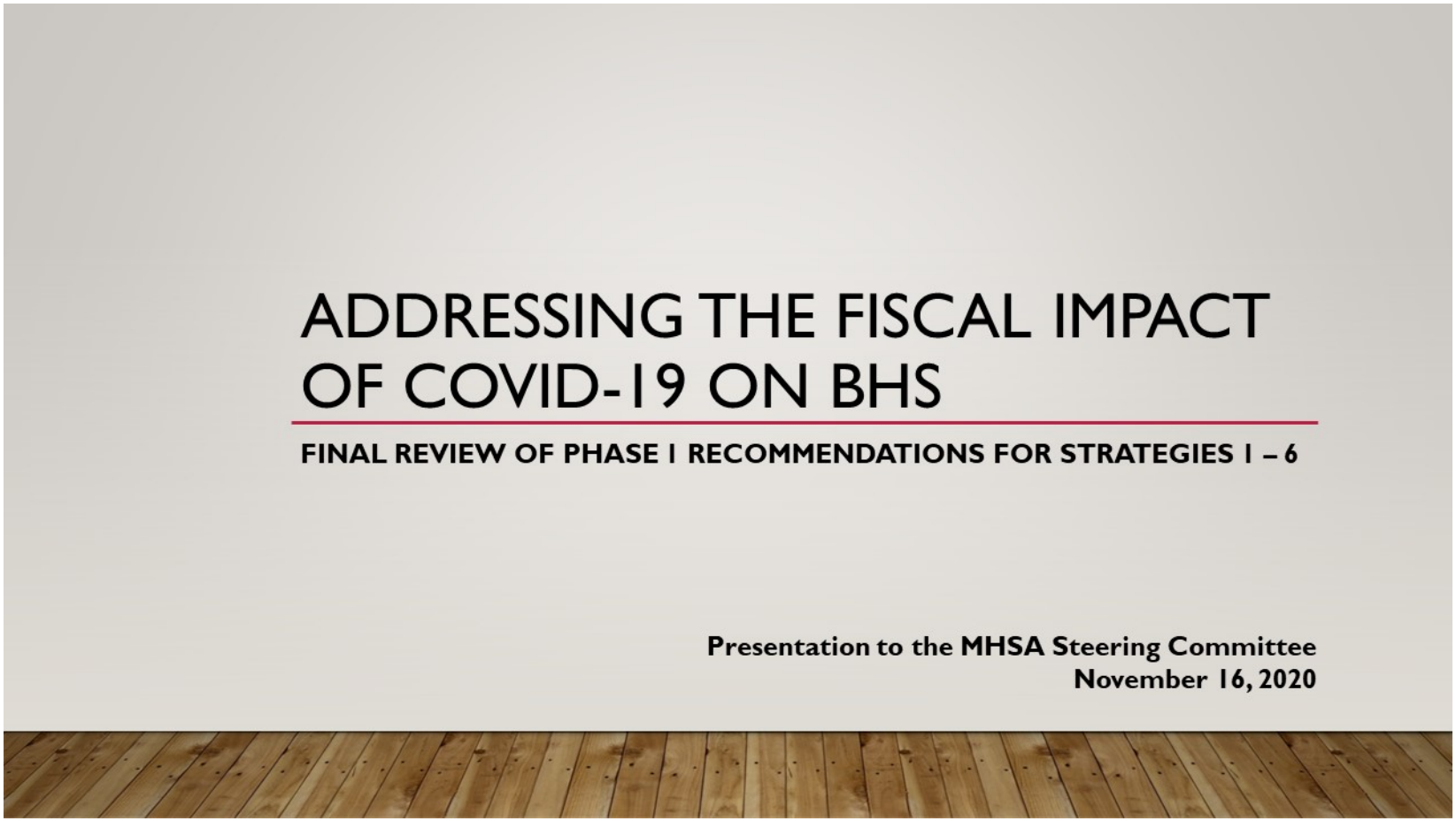
CINDY WONG
County Auditor Controller / City Financial Officer (PRINT)

Signature

4/22/2021
Date

[1] Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)
Three-Year Program and Expenditure Plan, Annual Update, and RER Certification (07/22/2013)

APPENDIX I: Addressing the Fiscal Impact of COVID-19 on BHS November 2020



ROADMAP FOR FEEDBACK AND PLANNING: FY 2020-21 MHSA ANNUAL PLAN UPDATE

- **TODAY:** Final review of Recommended Strategies 1-6
  - *Slide numbers from the October 26th meeting provided here for your reference*
- **December 14:** Innovation Updates
- **January 25, 2021**: Community Survey Results

Dates/Times may change

GOAL AND RATIONALE FOR PHASE I STRATEGIES AND RECOMMENDATIONS

- **GOAL**:
  - Close MHSA (CSS & PEI) budget gap due to projected fiscal impacts of COVID-19
- **RATIONALE FOR PHASE I STRATEGY RECOMMENDATIONS**:
  - Look at strategies already in process and intentionally maximize cost saving impact
  - Were unavoidable due to COVID
  - Buy us time to see if we can avoid making higher impact reductions
  - Do least harm

PROJECTED FY 2022-23 ENDING BALANCES:* PHASE I STRATEGIES

Cells with updated amounts have been highlighted in yellow.

Projected FY 2022-23 Amounts	CSS	PEI
Ending Balances, without Adjustments	-$71,007,389	-$1,008,409
***Adjustment:* Prudent Reserve**	+$27,688,130	-
***Adjustment:* Savings from Right-Sizing Budgets**	+$2,666,337	-
***Adjustment:* Savings from Delayed Programs**	+$14,400,000	+$1,036,000
***Adjustment:* Savings from Alternate Revenue**	+$11,571,099	-$4,586,099
***Adjustment:* Projected Increased Medi-Cal**	TBD	+$2,092,000
Adjustment: Eliminate Program Funding, if needed	~~+$1,651,600~~	+$1,404,000
Ending Balances, with all Phase I Adjustments	-$14,681,823	-$1,062,508

* *Slide updated to reflect impact of keeping 5% in the Prudent Reserve (primarily PEI reserves) per recommendation from state fiscal consultant Mike Geiss, and the removal of savings originally based on eliminating program funding in Strategy 6 (on hold)*

STRATEGY 6 OVERVIEW: ELIMINATION OF PROGRAM FUNDING

- Reduces PEI budget by an estimated $1,404,000 over three FYs (Oct 26: Slide 10)

PROGRAM	SERVICE LEVEL IMPACT (PEI)	TOTAL SAVINGS
Vacant Positions (PEI) *(In progress)* (Oct 26: Slide 11)	None; positions have remained vacant over several years with no impact on service levels	$1,404,000
Potential End of PEI Expansions *(On hold)* (Oct 26: Slide 12)	On hold	-
Potential CSS Eliminations *(On hold)* (Oct 26: Slide 13)	On hold	-

STRATEGY 2 OVERVIEW: RIGHT-SIZING PROGRAM BUDGETS

- Reduces CSS budget by **$2,666,337** over three years (Oct 26: Slides 18-

PROGRAM	SERVICE LEVEL IMPACT	TOTAL SAVINGS
CSS/WET Transfer to OSHPD (Oct 26: Slide 19) *(In progress, based on update from OSHPD)*	No impact on local programs	$166,337
TAY FSP (Oct 26: Slide 20)	No impact on #s served	$1,000,000
TAY Crisis Residential (Oct 26: Slides 21-22)	No impact on #s served	$1,500,000

STRATEGY 3 OVERVIEW: DELAY START OF PROGRAMS - CSS

- Reduces CSS budget by $14,400,000 over three years (Oct 26: Slides 24-25)

PROGRAM	SERVICE LEVEL IMPACT	TOTAL SAVINGS
Telehealth/Virtual BH *(In progress)* (Oct 26: Slide 26)	No impacts; using alternate funding	$8,500,000
Children's Continuum of Care Reform Children's Crisis Residential Program (CCR CCRP) *(In progress, in part, due to DHCS delays)* (Oct 26: Slides 27-28)	Minimal; local delays initially resulted from DHCS delays in releasing guidelines; HCA now determining local provider interest in meeting DHCS' stipulations for COC CRP; *non-COC crisis residential services continue to be available*	$500,000
Housing FSP *(In progress)* (Oct 26: Slides 29-30)	No impacts; using alternate funding	$4,800,000
Transportation *(In progress due to COVID)* (Oct 26: Slide 31)	Minimal; reductions already occurring due to COVID and programs providing telehealth & telephonic services	$600,000

STRATEGY 3 OVERVIEW: DELAY START OF PROGRAMS - PEI

- Reduces PEI budget by $1,036,000 over one FY (Oct 26: Slide 32)

PROGRAM	SERVICE LEVEL IMPACT	Total Savings
MH Community Events *(In progress due to COVID)* (Oct 26: Slide 33)	None due to this recommendation; these savings are a result of the impact of COVID	$881,000
School-Based Stress Management *(In progress due to retirement of subject matter expert [SME])* (Oct 26: Slide 34)	None due to this recommendation; these savings are a result of the SME's retirement	$155,000

STRATEGY 4 OVERVIEW: IDENTIFY ALTERNATE REVENUE

- Reduces CSS budget by an estimated $11,571,099 and increases PEI budget by an estimated $4,586,099 over three years (Oct 26: Slide 36)

PROGRAM SAVINGS	SERVICE LEVEL IMPACT	TOTAL SAVINGS CSS	TOTAL SAVINGS PEI *
ICS *(In progress)* (Oct 26: Slide 37)	None; to be provided by CalOptima	$3,600,000	-
BHS O&E (CSS/PEI) *(In progress)* (Oct 26: Slide 38)	None	$7,709,799	-$4,684,799
Shift CSS position to PEI *(Still being explored)* (Oct 26: Slide 40)	None	$261,300	-$261,300
OC Links *(In progress)* (Oct 26: Slide 39)	None	-	$360,000

* *PEI amounts reflect net added expenditures (not savings) after shifting some program costs being shifted from CSS to PEI and applying HMIOT and SABG savings.*

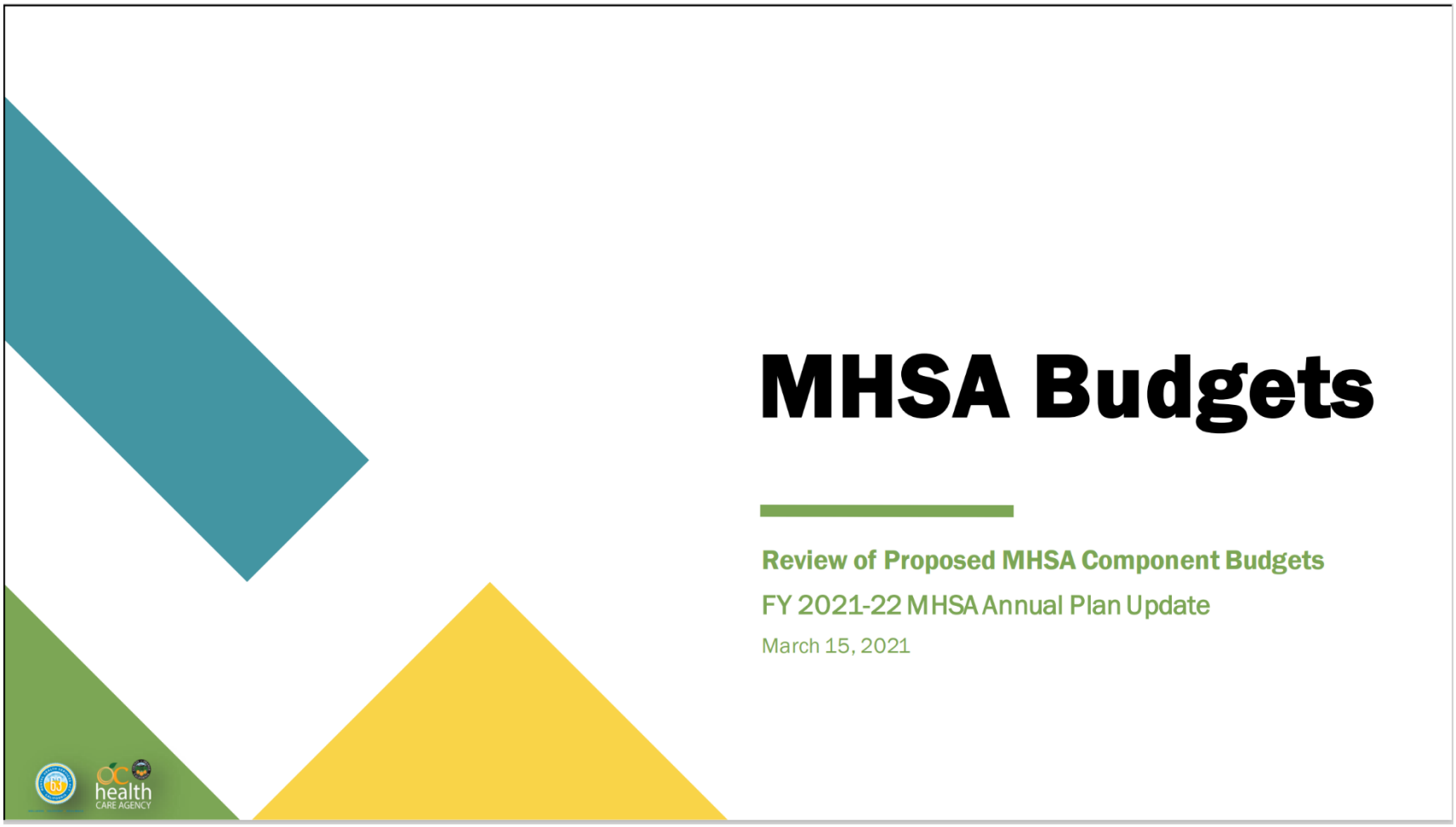
STRATEGY 5 OVERVIEW: INCREASE MEDI-CAL REVENUE

- Reduces PEI budget by an estimated $2,092,000 over three FYs; CSS amount still to be determined (Oct 26: Slide 4)

PROGRAM SAVINGS	SERVICE LEVEL IMPACT	TOTAL SAVINGS
OC CREW *(In progress)* (Oct 26: Slide 5)	None	$612,000
School-Based MH Services *(In progress)* (Oct 26: Slide 6)	None	$1,300,000
OC4Vets *(Still being explored)* (Oct 26: Slide 7)	None	$180,000
CSS Programs *(In progress)* (Oct 26: Slide 8)	None	TBD


THANK YOU

APPENDIX II: Review of Proposed MHSA Component Budgets March 2021



Agenda

01. MHSA Revenue

Review of MHSA revenue projections as of Feb 2021 and impact of change from Dec 2020 projections

02. CSS

50 min

- Proposed CSS Budget Review
- Steering Committee Questions
- Questions from the Public

03. WET & CFTN

50 min

- Proposed WET & CFTN Budgets Review
- Steering Committee Questions
- Questions from the Public

04. PEI

50 min

- Proposed PEI Budget Review
- Steering Committee Questions
- Questions from the Public

05. Public Comments

15 min

- Members of the public may address the Steering Committee, although no action will be taken at this time. Comments will be limited to 2-3 minutes, based on the number of requests received

06. SC Comments

15 min

- Members of the Steering Committee may make comments or ask questions

Times are approximate

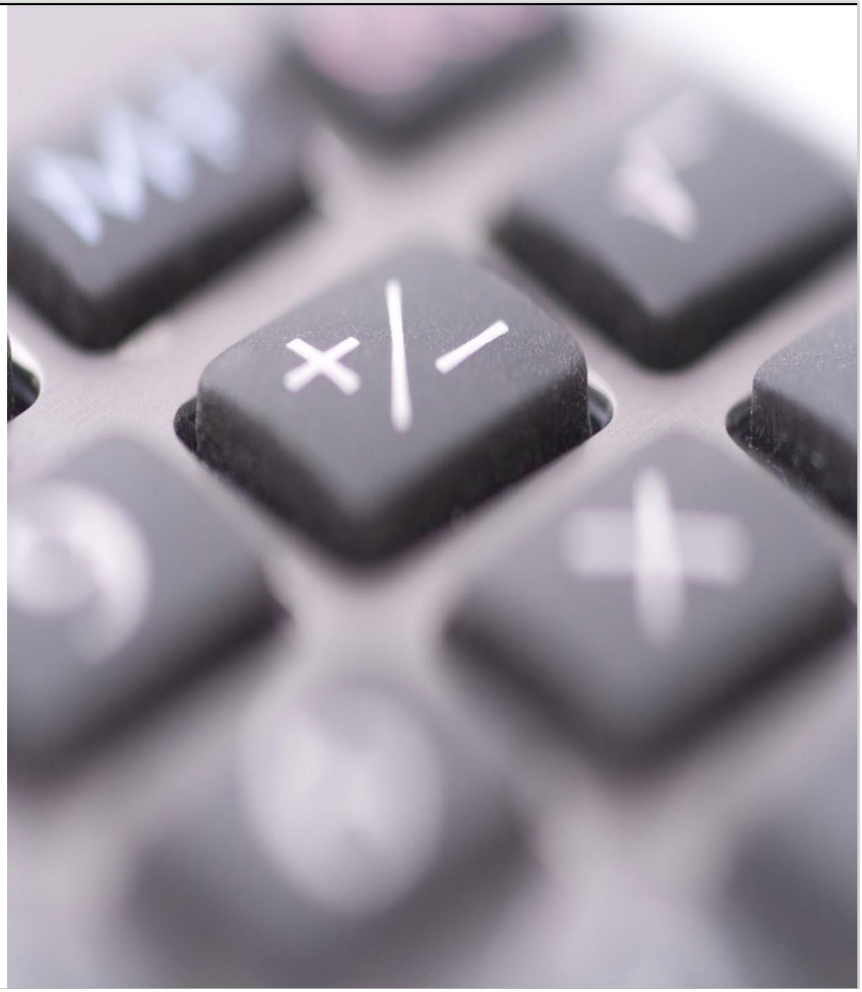
01 MHSA Revenue

Fiscal Planning Recap

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

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

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



OC'S Total Allocation as of 12-9-2020: A Recap

OC MHSA Projections	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
Projected Revenue as of 12-9-20	$148,115,877	$169,720,789	$164,625,189	$125,556,222

- Based on projections received from the State through December 2020, OC was facing a projected $72 million deficit in CSS and PEI revenue if reductions in planned spending were not identified
- HCA presented and discussed cost-saving, administrative strategies and recommendations with the Steering Committee, which were finalized in November 2020 (i.e., using Prudent Reserve, increasing Medi-Cal revenue, using alternative revenue streams, right-sizing budgets based on historical spending or identified other strategies such as vacancies, etc.)
- These strategies closed the majority of the revenue gap, however approximately $15 million in savings still needing to be identified based on state projections received through December 2020
- In order to close this remaining $15 million gap, HCA was in the process of identifying which CSS- and PEI-funded programs and services could be reduced or eliminated
- Then in February 2021, the State released revised revenue projections that dramatically changed the anticipated MHSA fiscal landscape over the next two-and-a-half fiscal years

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

OC MHSA Projections	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
Projected Revenue as of 12-9-20	$148,115,877	$169,720,789	$164,625,189	$125,556,222
Projected Revenue as of 2-4-21	$148,115,877	$197,365,228	$207,556,427	$174,199,724
Change from 12-9-20 to 2-4-21	N/A	+ $27,644,439	+ $42,934,238	+ $48,643,502

- FY 2019-20 Revenue are actuals.
- Total projected MHSA revenue increase of $119,222,179 through FY 22/23 (cumulative)

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

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

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

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

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

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

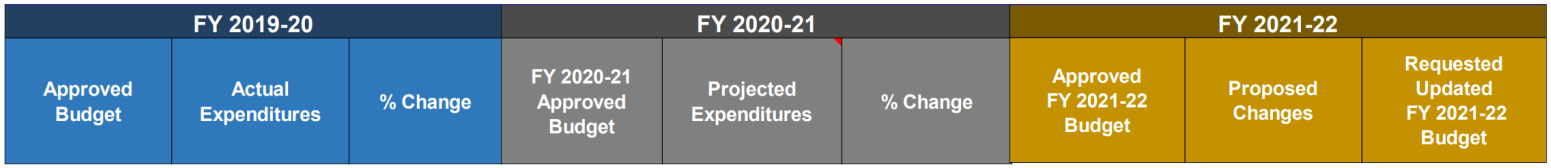
Understanding the Budget Grid

Presented in Proposed Budget PDF Handouts

FY 2019-20

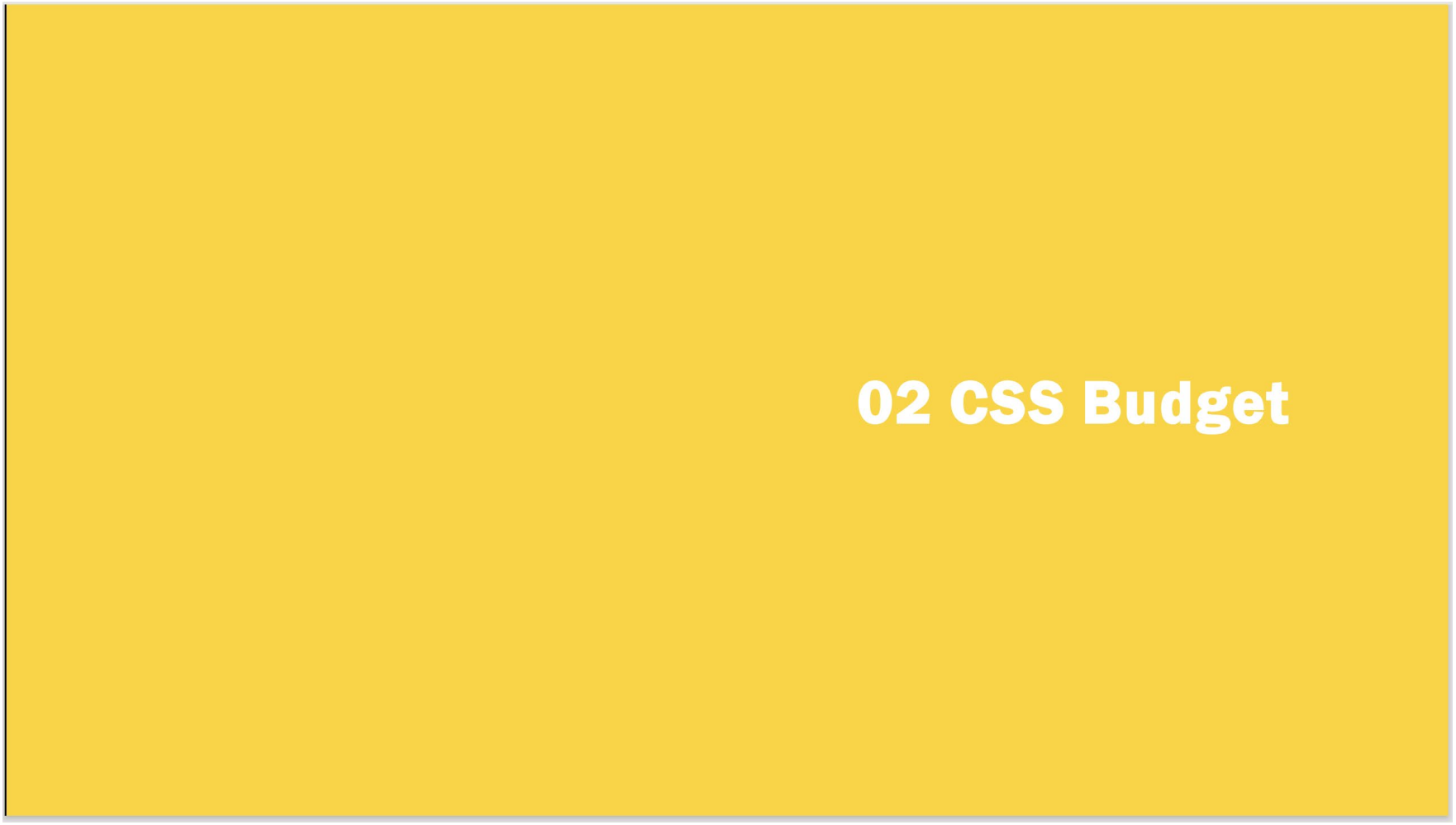
Presented in Proposed Budget PDF Handouts
and the slides of the component section budget grids

FY 2021-22



FY 2020-21

Presented in Proposed Budget PDF Handouts


02 CSS Budget

CSS Current Balances

Orange County MHSA CSS Budget Analysis for Three-Year Plan

Fiscal Years: 2020-21 through 2022-23

Purpose: To provide projected CSS balances for 3-year planning

Updated as of 3/12/2021

Current Balances for Planning

CSS FY 2019-20	
Beginning Balance	$55,747,255
Actual Revenue (inc. Interest)	$114,583,988
Actual Expenditures	-$152,779,182
Actual WET Transfer	-$3,823,525
Actual CFTN Transfer	-$14,799,492
Shift from Prudent Reserve	$22,906,915
Ending Balance	$21,835,959

CSS FY 2020-21	Dec 2020 Projections Used for Planning	Projections as of 2/18/21
Projected Beginning Balance	$21,835,959	$21,835,959
Projected Revenue (inc. Interest)	$128,900,000	$150,989,449
Carryover CFTN Remaining Balance	$0	$0
	Approved Budget from Three-Year Plan	
	-$155,088,175	-$122,038,378
Approved WET Transfer	-$6,216,634	-$5,038,928
Approved CFTN Transfer	-$12,519,749	-$11,093,221
Projected Ending Balance	-$23,088,599	$34,654,881

CSS FY 2021-22	Dec 2020 Projections Used for Planning	Est. 82% spending for CSS
Projected Beginning Balance	$34,654,881	$34,654,881
Projected Revenue (inc. Interest)	$125,724,313	$158,352,053
	Proposed Budget Presented 3/15/21	
	-$153,620,111	-$125,968,491
Proposed WET Transfer	-$5,219,584	-$5,219,984
Proposed CFTN Transfer	-$16,307,384	-$16,307,384
Projected Ending Balance	-$14,767,885	$45,511,075

CSS FY 2022-23	Dec 2020 Projections Used for Planning	Est. 82% spending for CSS
Projected Beginning Balance	$45,511,075	$45,511,075
Projected Revenue (inc. Interest)	$95,922,728	$133,000,959
	Approved Budget from Three-Year Plan	
	-$165,320,336	-$135,562,676
Approved WET Transfer	-$5,296,662	-$5,296,662
Approved CFTN Transfer	-$8,966,158	-$8,966,158
Projected Ending Balance	-$38,149,353	$28,686,539

Projected Unspent CSS funds at the end of three-year plan ending FY 22/23	$28,686,539
Projects / programs to receive available unspent funds:	
- Operating Reserve	
- Expansion of Crisis Services (Suicide Prevention)	
- Transportation Assistance Program (Access)	
- Increase cultural & linguistic responsiveness (Access)	

CSS Current Balances *con't*

Projected Unspent CSS funds at the end of three-year plan ending FY 22/23	**$28,686,539**
Projects / programs to receive available unspent funds:	
- Operating Reserve	
- Expansion of Crisis Services (Suicide Prevention)	
- Transportation Assistance Program (Access)	
- Increase cultural & linguistic responsiveness (Access)	

MHSA Strategic Priorities

Three Strategic Priorities were identified as part of the MHSA Three-Year Plan for FY 20/21 through FY 22/23.

To continue advancing these priorities, the planning effort identified that programs supporting these areas could receive additional funding if needed, pending availability of funds.

*See pages 17-19 of the **Orange County MHSA Three-Year Program and Expenditure Plan FYs 20/21 through 22/23** for more information on the three Strategic Priorities.*

CSS Current Balances *con't*

CSS FY 2019-20	
Beginning Balance	$55,747,255
Actual Revenue (inc. interest)	$114,583,988
Actual Expenditures	-$152,779,182
Actual WET Transfer	-$3,823,525
Actual CFTN Transfer	-$14,799,492
Shift from Prudent Reserve	$22,906,915
Ending Balance	$21,835,959

CSS FY 2020-21	Dec 2020 Projections Used for Planning	Projections as of 2/18/21
Projected Beginning Balance	$21,835,959	$21,835,959
Projected Revenue (inc. Interest)	$128,900,000	$150,989,449
Carryover CFTN Remaining Balance	$0	$0
	Approved Budget from Three-Year Plan	
	-$155,088,175	-$122,038,378
Approved WET Transfer	-$6,216,634	-$5,038,928
Approved CFTN Transfer	-$12,519,749	-$11,093,221
Projected Ending Balance	-$23,088,599	$34,654,881

CSS Current Balances *con't*

CSS FY 2021-22	Dec 2020 Projections Used for Planning	Est. 82% spending for CSS
Projected Beginning Balance	$34,654,881	$34,654,881
Projected Revenue (inc. Interest)	$125,724,313	$158,352,053
	Proposed Budget Presented 3/15/21	
	-$153,620,111	-$125,968,491
Proposed WET Transfer	-$5,219,584	-$5,219,984
Proposed CFTN Transfer	-$16,307,384	-$16,307,384
Projected Ending Balance	-$14,767,885	$45,511,075

CSS FY 2022-23	Dec 2020 Projections Used for Planning	Est. 82% spending for CSS
Projected Beginning Balance	$45,511,075	$45,511,075
Projected Revenue (inc. Interest)	$95,922,728	$133,000,959
	Approved Budget from Three-Year Plan	
	-$165,320,336	-$135,562,676
Approved WET Transfer	-$5,296,662	-$5,296,662
Approved CFTN Transfer	-$8,966,158	-$8,966,158
Projected Ending Balance	-$38,149,353	$28,686,539

CSS Current Balances *con't*

Projected Unspent CSS funds at the end of three-year plan ending FY 22/23	**$28,686,539**
Projects / programs to receive available unspent funds:	
- Operating Reserve	
- Expansion of Crisis Services (Suicide Prevention)	
- Transportation Assistance Program (Access)	
- Increase cultural & linguistic responsiveness (Access)	

CSS SECTION 1:
Access & Linkage to Treatment

What Do These Programs Do?

Link individuals to the appropriate level of care.

Who Are They For?

Individuals of all ages who are living with SMI or SPMI. Tailored to meet the needs of specialized, unserved populations *(i.e., homeless, community re-entry)*

CSS-Funded Programs

- Multi-Service Center for Homeless Adults Living with Mental Illness
- Open Access
- CHS Jail to Community Outreach

PEI-Funded Programs

- OC Links
- BHS Outreach & Engagement

CSS SECTION 1:
Access & Linkage to Treatment

SECTION Programs	Approved FY 21/22	Proposed Changes	Requested FY 21/22
BHS Outreach & Engagement (O&E)	$2,569,933	($2,569,933)	$0
Multi-Service Center for Homeless Adults Living with Mental Illness	$900,000	-	$900,000
Open Access	$2,300,000	$300,000	$2,600,000
Correctional Health Services: Jail to Community Re-Entry Program	$2,700,000	-	$2,700,000
Access & Linkage to Treatment	**$8,469,933**	**($2,269,933)**	**$6,200,000**

Net reduction of $2.3m, resulting from CSS portion of BHS O&E being shifted to PEI and the Substance Abuse Block Grant. There will be no reduction in BHS O&E services. Open Access right-sized by increasing budget by $300k due to over-expenditures in FY 20/21.

CSS SECTION 2:
Crisis Prevention & Support

What Do These Programs Do?

Support individuals experiencing a BH emergency by providing access to clinical support or by facilitating admission to a psychiatric hospital

Who Are They For?

Individuals of all ages who are experiencing a behavioral health emergency

CSS-Funded Programs

- Mobile Crisis Assessment
- Crisis Stabilization Units
- In-Home Crisis Stabilization
- Crisis Residential Services

PEI-Funded Programs

- Warmline
- Suicide Prevention Services

CSS SECTION 2:
Crisis Prevention & Support

SECTION Programs	Approved FY 21/22	Proposed Changes	Requested FY 21/22
Mobile Crisis Assessment	$9,135,858	-	$9,135,858
Crisis Stabilization Units	$10,000,000	-	$10,000,000
In-Home Crisis Stabilization	$2,935,480	-	$2, 935,480
Crisis Residential Services	$11,280,845	($265,000)	$11,015,845
Crisis Prevention & Support	**$33,352,183**	**($265,000)**	**$33,087,183**

Net reduction in CSS Section 2 of $265k, resulting from keeping CYBH-operated TAY CRS at 6 beds (-$500k) and increasing AOABH-operated CRS budget by $235k due to increased lease costs

CSS SECTION 3:
Outpatient Treatment

What Do These Programs Do?
Provide outpatient clinical interventions and other services designed to promote recovery and resilience

Who Are They For?
Individuals of all ages who are experiencing mental health symptoms or living with SED/SMI

CSS-Funded Programs

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

PEI-Funded Programs

- Early Intervention
  - Child, Youth & Parent Focused Programs:
    - School-Based MH Services
    - First Onset of Psychiatric Illness (OC CREW)
    - OC Parent Wellness Program
  - Other Specialized Programs:
    - Community Counseling & Supportive Services
    - EI Services for Older Adults
    - OC4Vets

CSS SECTION 3:
Outpatient Treatment

SECTION 3 SUBTOTALS	Approved FY 21/22	Proposed Changes	Requested FY 21/22
3a. Full Service Partnership Programs & PACT	$64,366,526	($1,900,000)	$62,466,526
3b. Clinic Expansion Programs	$24,523,666	($5,997,000)	$18,526,666
Outpatient Treatment	**$88,890,192**	**($7,897,000)**	**$80,993,192**

Net reduction in CSS Section 3 of $7.9m, resulting from right-sizing, savings during program start up and using alternate funding:

- $2m reduction in FSP ($500k right-sizing of CYBH-operated TAY FSP budget; $1.5m reduction in AOABH-operated FSP due to savings resulting from planned pilot ramp up of FSP serving residents of Permanent Supportive Housing and alternate revenue in FY 21-22
- $500k decrease due to Budgeting LCAP-match under Children & Youth Clinic Services at FY 20/21's start-up level rather than at full implementation level due to delays resulting from COVID-19
- Right-sizing Outpatient Recovery services by $300k due to on-going savings from vacant positions
- One-year, $1m reduction in the Services for Short-Term Residential Therapeutic Program to account for extended start up needed due to DHCS' lengthy Mental Health Program Approval process
- $4.2m reductions from transitioning Integrated Community Services to CalOptima and canceling Telehealth/Virtual BH Care program
- $100k increase in PACT to fund after-hours coverage and increased flexible funding

CSS SECTION 4:
Supportive Services

What Do These Programs Do?
Provide a broad array of supports generally designed to augment/ expand upon an individual's gains made in other treatment programs

Who Are They For?
Individuals of all ages who are experiencing mental health symptoms or living with SED/SMI

CSS-Funded Programs

- Peer Mentor & Parent Partner Program
- Wellness Centers
- Supported Employment
- Transportation Program

PEI-Funded Programs

- Transportation Assistance

CSS SECTION 4:
Supportive Services

	Approved FY 21/22	Proposed Changes	Requested FY 21/22
Supportive Services	$10,775,501	($700,000)	$10,075,501

Net reduction in CSS Section 4 of $700k, resulting from retiring the Children & Youth Mentoring Program ($500k annual savings beginning FY 21-22), and one-year reduction of $200k in Transportation Services due to decreased need for services resulting from COVID-19

CSS SECTION 5:
Supportive Housing & Homeless Services

What Do These Programs Do?
Provide a range of housing support for individuals receiving behavioral health services

Who Are They For?
Individuals living with a SMI who are homeless or at risk of homelessness

CSS-Funded Programs

- Housing & Year-Round Emergency Shelter
- Bridge Housing for the Homeless
- CSS Housing

	Approved FY 21/22	Proposed Changes	Requested FY 21/22
Supportive Housing & Homeless Services	$3,669,668	$53,558	$3,723,226

Net increase to cover increase in staff salaries per recently negotiated terms with labor unions

CSS Subtotals

SECTION SUBTOTALS	Approved FY 21/22	Proposed Changes	Requested FY 21/22
Access & Linkage to Treatment	$8,469,933	($2,269,933)	$6,200,000
Crisis Prevention & Support	$33,352,183	($265,000)	$33,087,183
Outpatient Treatment	$88,890,192	(7,897,000)	$80,993,192
Supportive Services	$10,775,501	($700,000)	$10,075,501
Supportive Housing & Homeless Services	$3,669,668	$53,558	$3,723,226
CSS Admin	**$19,469,693**	**$71,315**	**$19,541,008**
TOTAL CSS	**$164,627,171**	**($11,007,060)**	**$153,620,111**

Net increase of $71k to admin resulting from 1) keeping admin costs level with FY 20/21 admin budget ($830k reduction and 2) adding $901k to cover costs related to transitioning multiple CSS programs into the OC Navigator (part of the BH System Transformation INN Project) and developing functionality to increase productivity and operational efficiency of multiple CSS programs.

02 CFTN & WET Budgets

CSS Transfer:
Workforce Education & Training

	Approved FY 21/22	Proposed Changes	Requested FY 21/22
Workforce Education & Training (WET)	$5,219,985	-	$5,219,985

Maintain level funding

CSS Transfer:
Capital Facilities & Technological Needs

	Approved FY 21/22	Proposed Changes	Requested FY 21/22
Capital Facilities & Technological Needs (CFTN)	$8,840,502	$7,466,632	$16,307,384

Net increase of $7.5M, resulting from carrying over unspent funds FY 20/21, adding funds to transition HCA EHR to the cloud, and integrating approved digital solutions with the HCA EHR

03 PEI Budget

PEI Current Balances

Orange County MHSA PEI Budget Analysis for Three-Year Plan

Fiscal Years: 2020-21 through 2022-23

Purpose: To provide projected PEI balances for 3-year planning

Updated as of 3/12/2021

Current Balances for Planning

PEI FY 2019-20	
Beginning Balance	$41,309,501
Actual Revenue (inc. Interest)	$29,262,641
Actual Expenditures	-$39,790,578
Shift from Prudent Reserve to meet 33% Max. Req.	$3,412,864
Ending Balance	$34,194,428

FY 2020-21	Dec 2020 Projections Used for Planning	Projections as of 2/18/21
Projected Beginning Balance	$34,194,428	$34,194,428
Projected Revenue (inc. Interest)	$32,220,000	$37,977,619
	Approved Budget from Three-Year Plan	
	-$47,061,483	-$44,154,327
Projected Ending Balance	$19,352,945	$28,017,720

FY 2021-22	Dec 2020 Projections Used for Planning	Est. 90% spending
Projected Beginning Balance	$28,017,720	$28,017,720
Projected Revenue (inc. Interest)	$34,800,000	$39,751,693
	Proposed Budget Presented 3/15/21	
	-$47,878,768	-$43,090,891
Projected Ending Balance	$14,938,952	$24,678,522

FY 2022-23	Dec 2020 Projections Used for Planning	Est. 90% spending
Projected Beginning Balance	$24,678,522	$24,678,522
Projected Revenue (inc. Interest)	$34,800,000	$33,255,933
	Approved Budget from Three-Year Plan	
	-$40,988,101	-$36,889,291
Projected Ending Balance	$18,490,421	$21,045,164

Projected Unspent PEI funds at the end of three-year plan ending FY 22/23	$21,045,164
Projects / programs to receive available unspent funds:	
- Operating Reserve	
- OC Links (Strategic Priorities: Access, Suicide Prevention)	
- Office of Suicide Prevention (Strategic Priority: Suicide Prevention)	
- Mental Health Campaigns (Strategic Priority: Mental Health Awareness & Stigma Reduction)	
- Crisis Services (Strategic Priority: Suicide Prevention)	
- Transportation Assistance (Strategic Priority: Access)	
- Increase cultural & linguistic responsiveness of services/providers (Strategic Priority: Access)	
- School-Focused Services (Strategic Priority: Access)	

PEI Current Balances *con't*

Projected Unspent PEI funds at the end of three-year plan ending FY 22/23	**$21,045,164**
Projects / programs to receive available unspent funds:	
- Operating Reserve	
- OC Links (Strategic Priorities: Access, Suicide Prevention)	
- Office of Suicide Prevention (Strategic Priority: Suicide Prevention)	
- Mental Health Campaigns (Strategic Priority: Mental Health Awareness & Stigma Reduction)	
- Crisis Services (Strategic Priority: Suicide Prevention)	
- Transportation Assistance (Strategic Priority: Access)	
- Increase cultural & linguistic responsiveness of services/providers (Strategic Priority: Access)	
- School-Focused Services (Strategic Priority: Access)	

PEI Current Balances *con't*

PEI FY 2019-20	
Beginning Balance	$41,309,501
Actual Revenue (inc. Interest)	$29,262,641
Actual Expenditures	-$39,790,578
Shift from Prudent Reserve to meet 33% Max. Req.	$3,412,864
Ending Balance	$34,194,428

FY 2020-21	Dec 2020 Projections Used for Planning	Projections as of 2/18/21
Projected Beginning Balance	$34,194,428	$34,194,428
Projected Revenue (inc. Interest)	$32,220,000	$37,977,619
	Approved Budget from Three-Year Plan	
	-$47,061,483	-$44,154,327
Projected Ending Balance	$19,352,945	$28,017,720

PEI Current Balances *con't*

FY 2021-22	Dec 2020 Projections Used for Planning	Est. 90% spending
Projected Beginning Balance	$28,017,720	$28,017,720
Projected Revenue (inc. Interest)	$34,800,000	$39,751,693
	Proposed Budget Presented 3/15/21	
	-$47,878,768	-$43,090,891
Projected Ending Balance	$14,938,952	$24,678,522

FY 2022-23	Dec 2020 Projections Used for Planning	Est. 90% spending
Projected Beginning Balance	$24,678,522	$24,678,522
Projected Revenue (inc. Interest)	$34,800,000	$33,255,933
	Approved Budget from Three-Year Plan	
	-$40,988,101	-$36,889,291
Projected Ending Balance	$18,490,421	$21,045,164

PEI Current Balances *con't*

Projected Unspent PEI funds at the end of three-year plan ending FY 22/23	**$21,045,164**
Projects / programs to receive available unspent funds:	
- Operating Reserve	
- OC Links (Strategic Priorities: Access, Suicide Prevention)	
- Office of Suicide Prevention (Strategic Priority: Suicide Prevention)	
- Mental Health Campaigns (Strategic Priority: Mental Health Awareness & Stigma Reduction)	
- Crisis Services (Strategic Priority: Suicide Prevention)	
- Transportation Assistance (Strategic Priority: Access)	
- Increase cultural & linguistic responsiveness of services/providers (Strategic Priority: Access)	
- School-Focused Services (Strategic Priority: Access)	

PEI SECTION 1:
Prevention

What Do These Programs Do?
Strive to prevent the development of serious emotional or behavioral disorders or mental illness

Who Are They For?
Individuals of all ages who are at-risk of developing a serios mental health condition

PEI-Funded Programs

- Child, Youth & Parent Programs:
  - School Readiness
  - Parent Education Services
  - Children's Support & Parenting Program
  - School-Based BH Interventions & Support
  - Violence Prevention Education
  - Gang Prevention Services
- Family Support Services

PEI SECTION 1:
Prevention

SECTION Programs	Approved FY 21/22	Proposed Changes	Requested FY 21/22
1a. Child, Youth & Parent Programs	$9,529,110	($2,514,770)	$7,014,340
1b. Family Support Services	$282,000	$0	$282,000
Prevention	**$9,811,110**	**($2,514,770)**	**$7,296,340**

Net reduction in PEI Section 1 of $2.5m, resulting from:

- Scheduled end of three-year, time-limited expansion to School-Based BH Interventions & Support ($1.6m)
- Savings from Children's Support and Parenting Program staff vacancies and re-deployments to other programs with need for increased support (-$700k)
- Reducing School Readiness program budget by $600k due to non-renewal of one provider's contract. Transfer of ~ $385k of this $600k to Parent Education Services to increase this provider's capacity to serve families with children ages 0-8 (same age range served by School Readiness provider)

PEI SECTION 2:
Mental Health Campaigns & Education

What Do These Programs Do?
Strengthen the resilience and wellbeing of a community as a whole by providing information, training and skill-building around mental health

Who Are They For?
Individuals of all ages

PEI-Funded Programs

- Mental Health Community Education Events for Reducing Stigma & Discrimination
- Outreach for Increasing Recognition of Early Signs of Mental Health

PEI SECTION 2:
Mental Health Campaigns & Education

SECTION Programs	Approved FY 21/22	Proposed Changes	Requested FY 21/22
MH Community Education Events for Reducing Stigma & Discrimination	$881,000	$0	$881,000
Outreach for Increasing Recognition of Early Signs of Mental Illness	$11,491,945	($1,054,533)	$10,437,412
MH Campaigns & Education	**$12,372,945**	**($1,054,533)**	**$11,318,412**

Net reduction in PEI Section 2 of ~$1m, resulting from:

- Reduction of ~$880k in local mental health campaigns leveraging Statewide PEI Projects social marketing campaigns (i.e., Know The Signs, Mental Health Matters (formerly known as Each Mind Matters). Funding can/will be reinstated when COVID-19-related restrictions on large gatherings are lifted
- Elimination of funding for Subject Matter Expert providing School-Based Stress Management Services training because expert retired and mindfulness trainings for students, parents and teachers/school staff are currently being provided by the Behavioral Health Training Collaborative.

PEI SECTION 3:
Crisis Prevention & Support

What Do These Programs Do?

Support individuals experiencing a BH emergency by providing access to clinical support or by facilitating admission to a psychiatric hospital

Who Are They For?

Individuals of all ages who are experiencing a behavioral health emergency

CSS-Funded Programs

- Mobile Crisis Assessment
- Crisis Stabilization Units
- In-Home Crisis Stabilization
- Crisis Residential Services

PEI-Funded Programs

- Warmline
- Suicide Prevention Services

PEI SECTION 3:
Crisis Prevention & Support

	Approved FY 21/22	Proposed Changes	Requested FY 21/22
Crisis Prevention & Support	$2,316,667	$392,000	$2,708,667

Net increase in PEI Section 3 of $392k, resulting from continuing the expansion of WarmLine to 24/7 hours (had been expanded to 24/7 using CARES Act funding in 2020) and program's increasing lease costs of ~ $60k annually

PEI SECTION 4:
Supportive Services

What Do These Programs Do?
Provide a broad array of supports generally designed to augment/ expand upon an individual's gains made in other treatment programs

Who Are They For?
Individuals of all ages who are experiencing mental health symptoms or living with SED/SMI

CSS-Funded Programs

- Peer Mentor & Parent Partner Program
- Wellness Centers
- Supported Employment
- Transportation Program

PEI-Funded Programs

- Transportation Assistance

PEI SECTION 4:
Supportive Services

	Approved FY 21/22	Proposed Changes	Requested FY 21/22
Supportive Services (Transportation)	**$500,000**	**($300,000)**	**$200,000**

Net decrease in PEI Section 4 of $300k, resulting from delay in transportation services start up that was originally planned for FY 20/21. Due to COVID-19, budget for FY 21/22 has been reduced to reflect anticipated expenditures as program starts up and potential impact of COVID-19 on service demand during Q1 of FY 21/22.

PEI SECTION 5:
Access & Linkage to Treatment

What Do These Programs Do?

Link individuals to the appropriate level of care.

Who Are They For?

Individuals of all ages who are living with SMI or SPMI. Tailored to meet the needs of specialized, unserved populations *(i.e., homeless, community re-entry)*

CSS-Funded Programs

- Multi-Service Center for Homeless Adults Living with Mental Illness
- Open Access
- CHS Jail to Community Outreach

PEI-Funded Programs

- OC Links
- BHS Outreach & Engagement

PEI SECTION 5:
Access & Linkage to Treatment

SECTION Programs	Approved FY 21/22	Proposed Changes	Requested FY 21/22
OC Links	$1,000,000	$1,200,000	$2,200,000
BHS Outreach & Engagement (O&E)	$2,232,523	$897,145	$3,129,668
Access & Linkage to Treatment	**$3,232,523**	**$2,097,145**	**$5,329,668**

Net increase in PEI Section 5 of $2.1m, resulting from:

- Expanding OC Links hours/staffing to become a 24/7 program
- Net transfer amount to absorb CSS BHS O&E costs, after accounting for the right-sizing of PEI's O&E expenditures and the use of alternative funding (i.e., Substance Abuse Block Grant)

PEI SECTION 6:
Outpatient Treatment – Early Intervention

What Do These Programs Do?
Provide outpatient clinical interventions and other services designed to promote recovery and resilience

Who Are They For?
Individuals of all ages who are experiencing mental health symptoms or living with SED/SMI

CSS-Funded Programs

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

PEI-Funded Programs

- Early Intervention
  - Child, Youth & Family Focused Programs:
    - School-Based MH Services
    - First Onset of Psychiatric Illness (OC CREW)
    - OC Parent Wellness Program
  - Other Specialized Programs:
    - Community Counseling & Supportive Services
    - EI Services for Older Adults
    - OC4Vets

PEI SECTION 6:
Outpatient Treatment

	Approved FY 21/22	Proposed Changes	Requested FY 21/22
Outpatient Treatment	**$15,168,944**	**($704,000)**	**$14,464,944**

Net decrease in PEI Section 6 of ~$700k, resulting from anticipated generation of Medi-Cal revenue by School-Based Mental Health Services ($500k) and First Onset of Psychiatric Illness (OC CREW; $204k). Level funding for other programs

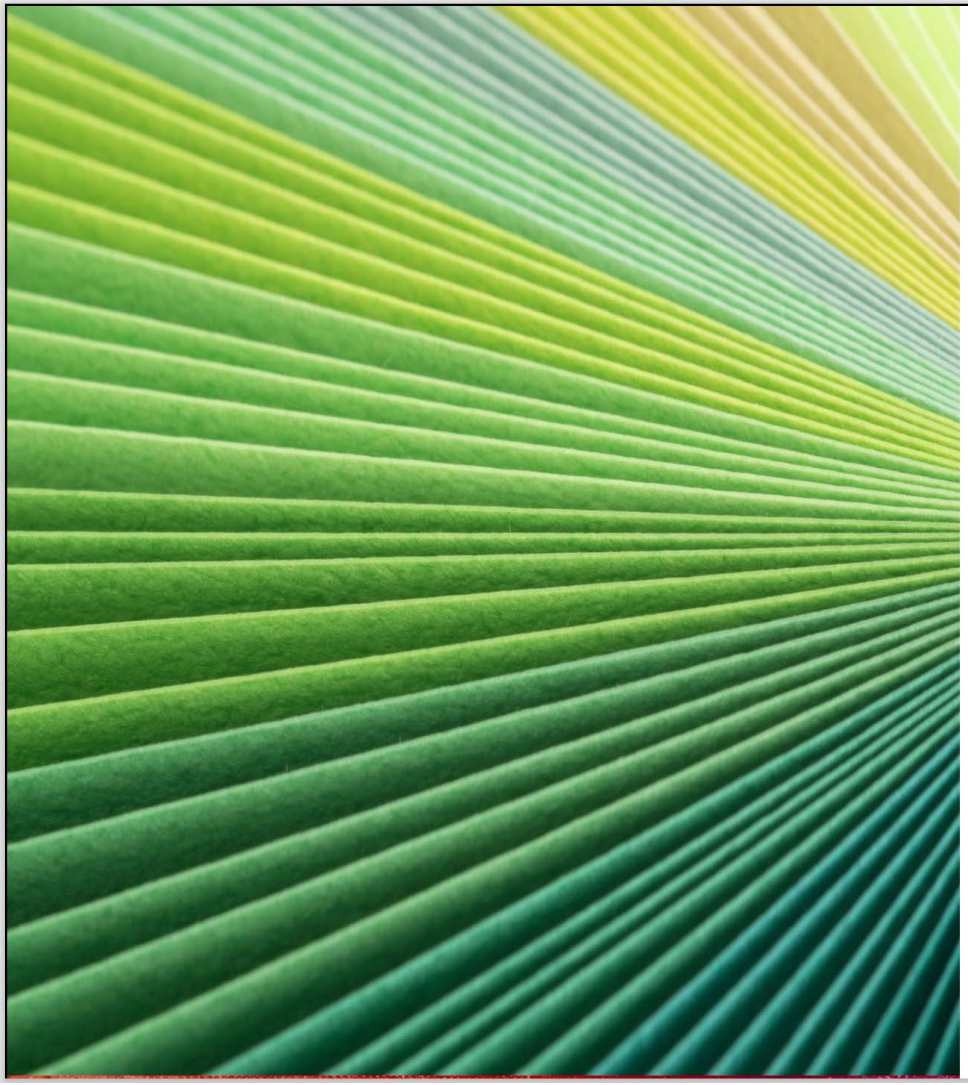
PEI Subtotals

SECTION SUBTOTALS	Approved FY 21/22	Proposed Changes	Requested FY 21/22
Prevention	$9,811,110	($2,514,770)	$7,296,340
MH Campaigns & Education	$12,372,945	($1,054,533)	$11,318,412
Crisis Prevention & Support	$2,316,667	$392,000	$2,708,667
Supportive Services	$500,000	($300,000)	$200,000
Access & Linkage to Treatment	$3,232,523	$2,097,145	$5,329,668
Outpatient Treatment	$15,168,944	($704,000)	$14,464,944
PEI Admin	**$5,884,737**	**$676,000**	**$6,560,737**
TOTAL PEI	**$49,286,926**	**($1,408,158)**	**$47,878,768**

Net increase of ~$600k resulting from funds to cover costs related to transitioning multiple CSS programs into the OC Navigator (part of the BH System Transformation INN Project) and developing functionality to increase productivity and operational efficiency of multiple PEI programs.

04 Public Comment

05 Steering Committee Comments



Thank you

MHSA Coordination Office

mhsa@ochca.com

CSS

Updated March 12, 2021

		FY 2019-20			FY 2020-21			FY 2021-22				
		FY 2019-20 Approved Budget	Actual Expenditures	% Change	FY 2020-21 Approved Budget	Projected Expenditures	% Change	Approved FY 2021-22 Budget	Proposed Changes	Requested Updated FY 2021-22 Budget	FY 20/21 Budget Reduction and FY21/22 Plan Update Notes	Original 3 Yr Plan Notes
ACCESS & LINKAGE TO TREATMENT (TX)	**BHS Outreach & Engagement (O&E)** (all ages) (pg 76, FY 2019-20 MHSA Annual Plan Update)	2,569,933	2,059,798	80%	2,569,933	1,183,361	46%	2,569,933	(2,569,933)	-	FY 20/21: Partially shifted CSS O&E budget to PEI, resulting in a $1.4M decrease. FY 21/22: Fully shifted CSS budget to PEI (see SC PPT 11-16-20)	Keep the budget same level for the lease cost as program will need to relocate in FY20/21.
	Multi-Service Center for Homeless Mentally Illness Adults	900,000	713,465	79%	900,000	798,446	89%	900,000		900,000		
	Open Access (pg 82, FY 2019-20 Plan)				2,300,000	2,585,397	112%	2,300,000	300,000	2,600,000	FY 21/22: Right-sizing budget due to over-expenditures in FY 20/21.	Open Access previously part of Recovery Center program. Programs separated beginning FY 20/21, with level funding.
	Correctional Health Services: Jail to Community Re-Entry Program (JCRP) (pg 80, FY 2019-20 Plan)	2,600,000	1,290,624	50%	2,200,000	1,364,941	62%	2,700,000		2,700,000	FY 20/21: Savings due to use of CARES revenue.	Program approved for 28 FTEs and has been diligently trying to hire despite on-going hiring challenges. As of mid-January 2020, program has filled 17 FTEs, and antipcates being being fully staffed by FY 22-23. Budget request for the Three-Year Plan are based on estimated increases in costs due to continual filling of remaining 11 vacancies over each Fiscal Year.
	SUBTOTAL Access & Linkage to Tx	6,069,933	4,063,887	67%	7,969,933	5,932,145	74%	8,469,933	(2,269,933)	6,200,000		
CRISIS PREVENTION & SUPPORT	**Mobile Crisis Assessment** (pg 99, FY 2019-20 MHSA Plan)	8,835,858	8,691,031	98%	9,135,858	9,375,708	103%	9,135,858	-	9,135,858		
	portion of "Mobile Crisis Assessment" budget operated by CYBH for individuals ages 0-17 years	*2,864,032*	*2,859,992*	*100%*	*3,164,032*	*3,541,991*	*112%*	*3,164,032*	-	*3,164,032*	FY 20/21: Higher expenditures due to impact of lower Medi-Cal revenue being generated due to COVID.	Beginning FY 2020-21, increase budget back up to approved FY 2018-19 budget to support efforts to improve response time.
	portion of "Mobile Crisis Assessment" budget operated by AOABH for individuals ages 18 and older	*5,971,826*	*5,831,039*	*98%*	*5,971,826*	*5,833,717*	*98%*	*5,971,826*		*5,971,826*		Budget for new lease cost at 4000 Metropolitan.
	Crisis Stabilization Units (CSUs) (pg 103)	4,150,000	2,667,339	64%	6,700,000	5,055,061	75%	10,000,000		10,000,000	FY 21/22: Difference in approved budget from FY 20/21 to FY 21/22 reflect the fact that CSU's were in start up during FY 20/21 and will be fully operational in FY 21/22.	Requesting to add one new CSU in FY20/21 at Anita Wellness Campus. The total amount will support 2 CSUs (1 at College Hospital in Costa Mesa serving 18+ and 1 at Anita Wellness Campus serving 13+). Budget reflects partial funding for Anita CSU in FY 2020-21.
	In-Home Crisis Stabilization (pg 104)	2,585,480	2,203,200	85%	2,935,480	2,458,206	84%	2,935,480	-	2,935,480		
	portion of "In-Home Crisis Stabilization" budget operated by CYBH for individuals ages 0-17 years	*1,085,480*	*1,196,727*	*110%*	*1,435,480*	*1,220,451*	*85%*	*1,435,480*	-	*1,435,480*		Requesting an annual increase of $350,000 beginning FY 2020-21. Children's provider is currently serving 700 clients, which is 300 over the contracted number of 400 clients.
	portion of "In-Home Crisis Stabilization" budget operated by AOABH for individuals ages 18 and older	*1,500,000*	*1,006,472*	*67%*	*1,500,000*	*1,237,755*	*83%*	*1,500,000*		*1,500,000*		Program launched in FY 2018-19. Propose to keep funding at approved budget level as program is still fully ramping up.
	Crisis Residential Services (CRS) (pg 107)	7,730,845	6,417,083	83%	9,030,845	7,855,863	87%	11,280,845	(265,000)	11,015,845		
	portion of "Crisis Residential Services" budget operated by CYBH for individuals ages 0-17 years	*2,988,248*	*3,173,955*	*106%*	*3,488,248*	*2,811,455*	*81%*	*4,988,248*	-	*4,988,248*	FY 20/21: Reduction of $500K resulting from CCRP not being implemented until FY 21/22 (see SC PPT 11-16-20). Timing of most recent projections indicating an increase in future MHSA revenue occurred too late for RFP to be released and CCRP contract(s) to be awarded prior to July 1, 2021	**Track 1**: Existing Crisis Residential Services - current budget for this program is $2,988,248 and will remain level for the next 3 fiscal years. **Track 2**: Crisis Children's Residential (New State Mandated Service as part of Continuum of Care reform) - Program is requesting to add $500,000 for FY 2020-21 which will be carried forward to FY 2021-23; in FY 2021-22, Program is requesting an additional increase of $1.5 million to fully implement the program, which will be carried forward to FY 2022-23. Timelines are estimated as HCA still waiting for final guidelines to be released by DHCS. Waymakers:
	portion of "Crisis Residential Services" budget operated by CYBH for individuals ages 18-25 years	*1,491,368*	*1,367,932*	*92%*	*1,541,368*	*1,449,598*	*94%*	*1,541,368*	*(500,000)*	*1,041,368*	FY 21/22: Savings of $500K resulting from keeping CYBH TAY CRP at 6 beds and not continuing with 6 SRP beds that were consistently underutilized (see SC PPT 11 16-20). No loss of services due to continued availability of CRP beds that serve 16-25 year olds operated by CYBH and AOABH.	$50k increase beginning FY 2020-21 to cover increased lease costs.
	portion of "Crisis Residential Services" budget operated by AOABH for individuals ages 18 and older	*3,251,229*	*1,875,196*	*58%*	*4,001,229*	*3,594,810*	*90%*	*4,751,229*	*235,000*	*4,986,229*	FY 21/22: Additional annual cost of $235,000 to be added for Anita lease.	$1.5M increase due to adding new 15-bed facility at Anita Wellness Campus beginning FY 20/21. Budget reflects partial funding for Anita CSU in FY 2020-21. Program is creating beds for Older Adults; due to high MediCal reimbursement by provider, no additional CSS funding was needed to increase capacity to serve for Older Adults.
	SUBTOTAL Crisis Prevention & Support	23,302,183	19,978,653	86%	27,802,183	24,744,838	89%	33,352,183	(265,000)	33,087,183	***As part of the MHSA Strategic Priority of "Suicide Prevention," available funding may be added to one or more of the programs in this section to meet program and/or Strategic Priority Needs.***	

	CSS Updated March 12, 2021	FY 2019-20			FY 2020-21			FY 2021-22			FY 20/21 Budget Reduction and FY21/22 Plan Update Notes	Original 3 Yr Plan Notes
		FY 2019-20 Approved Budget	Actual Expenditures	% Change	FY 2020-21 Approved Budget	Projected Expenditures	% Change	Approved FY 2021-22 Budget	Proposed Changes	Requested Updated FY 2021-22 Budget		
OUTPATIENT TREATMENT: Full Service Partnership Programs	**Children's FSP Program** (pg 173)	11,054,575	10,147,015	92%	11,054,575	8,811,278	80%	11,054,575	-	11,054,575		
	Transitional Age Youth (TAY) FSP Program (pg 173)	8,184,468	6,879,791	84%	8,184,468	6,242,645	76%	8,184,468	(500,000)	7,684,468	FY 21/22: Reduction of ($500,000) based on average historical data of $7.7M expenditures versus the $8.2M originally budgeted (see SC PPT on 11-16-20).	Approved/requested budgets are to cover the contracted maximum obligations for services. Annual CSS expenditures vary based on MediCal billing. HCA is working with providers to increase MediCal billing, and as less CSS funds are needed, CSS budgets will be adjusted accordingly. Adult budget is also less lease costs due to one program being housed temporarily at another FSP clinic.
	Adult FSP Program (pg 173)	31,607,934	20,501,165	65%	31,307,934	25,212,009	81%	31,307,934	(1,500,000)	29,807,934		
	portion of "Adult FSP" budget operated by AOABH for individuals ages 18 and older being assesed for Assisted Outpatient Treatment FSP eligibility (pg 117)	*5,015,841*	*4,316,911*	*86%*	*4,715,841*	*4,248,907*	*90%*	*4,715,841*		*4,715,841*		FY 20-21 reduction of $300K based on the current year FY 19-20 projection and prior year's actuals.
	portion of "Adult FSP" budget operated by AOABH for individuals ages 18 and older residing in Permanent Supportive Housing (pg 165)	*5,000,000*		*0%*	*5,000,000*	*1,300,000*	*26%*	*5,000,000*	*(1,500,000)*	*3,500,000*	FY 20/21 savings of $3.7M and FY 21/22 savings of $1.5M due to 1) planned pilot ramp up of FSP serving residents of Permanent Supportive Housing and 2) use of alternate revenue identified during these FYs (see SC PPT 11-16-20).	Program will specifically support clients who are living with SPMI and in permanent supportive housing.
	Older Adult FSP Program (pg 173)	2,683,249	2,232,677	83%	3,219,899	2,582,548	80%	3,219,899		3,219,899		Increase to serve 30 additional clients for a total of 180 clients.
	Program for Assertive Community Treatment (PACT; *county-operated FSP, pg 191*)	10,799,650	8,592,847	80%	10,599,650	8,945,653	84%	10,599,650	100,000	10,699,650		
	portion of "PACT" budget operated by CYBH for individuals ages 0-21	*1,100,000*	*758,096*	*69%*	*1,100,000*	*836,269*	*76%*	*1,100,000*	*100,000*	*1,200,000*	FY 21-22: Increase of $100,000 to fund after-hours on-call coverage and expanded flexible spending used to support people on their recovery journeys (i.e., housing assistance, tuition payment, tutoring, childcare, etc.) in line with FSP program requirements. Program has been operating with a part-time psychiatrist and other staffing vacancies which resulted in savings. However when program is fully staffed, additional funds will be needed to cover 24/7 on-call and flexible funding for clients.	Program launched in FY 2018-19. Propose to keep funding at approved budget level as program is still fully ramping up and looking for additional ways to increase crisis responsiveness, which will result in additional costs.
	portion of "PACT" budget operated by AOABH for individuals ages 18 and older	*9,028,018*	*7,319,157*	*81%*	*8,528,018*	*7,526,664*	*88%*	*8,528,018*		*8,528,018*		Right-sized budget while retaining funds for 6 FTEs that will be transferred (4 from ICS program) beginning in FY 20-21, and looking for additional ways to increase crisis responsiveness, which will result in additional costs.
OUTPATIENT TREATMENT: Clinic Expansion	**Children & Youth Clinic Services** (pg 151, FY 2019-20 MHSA Plan)	500,000	372,324	74%	2,500,000	76,311	3%	3,000,000	(500,000)	2,500,000	FY 20/21: Of the $2 million added in FY20/21, $1.2 million was for clinic expansion, $300,000 was for Therapeutic Foster Care (TFC) and $500,000 was for the LCAP match to support student outpatient services. Due to the impact of COVID-19, none of these expansions occurred in FY 20/21 and funds were not expended. FY 21/22: An additional $500,000 was planned to be added for LCAP match to support student outpatient services, bringing the total for this service to $1 million in FY 21/22. Because program start-up did not begin in FY 20/21 as originally anticipated, it is recommended that we regard FY 21/22+R3 as the start-up year and keep funding for LCAP match at $500,000 (i.e., resulting in $500k budget reduction in FY 21/22). // In addition, $1.2 million is in the process of being added to FY 21/22 contracts in anticipation that Therapeutic Foster Care will be implemented this year. *As part of the MHSA Strategic Priority to "Improve Access to Behavioral Health Services," available funding may be added if demand for services exceeds currently projected budget.*	**Existing Outpatient Services** (formerly Youth Core Services): Current budget is $500,000 which will remain level for the next 3 FYs. Proposing to expand services to all eligible youth living with SED/SMI (and not just youth elgibile for State Pathways to Well-Being program, as described in the last Three-Year Plan). // **Beginning FY 2020-21:** $1.5 million annually is requested to implement mental health services to support the State-mandated program Therapeutic Foster Care (TFC). Funds would also provide mental health services for youth referred by Social Services Agency who are in foster care and/or at-risk of foster care involvement, as well as for youth screened in primary care settings through the ACES Aware Initiative. At full implementation, the numbers of youth referred by these sources is estimated to be up to an additional 2,500 youth. // In support of the Access and Suicide Prevention Priorities, also proposing adding $500k for planning with school-districts/OCDE on expanding outpatient treatment for school-aged youth experiencing SED and their families. Planning will include identifying schools that will match MHSA dollars with LCAP or other funds. Proposed services will also draw down Medi-Cal FFP, thus promoting sustainability and increased service capacity. Planning will also include establishing data-sharing metrics and methods, MOUs, etc with participating schools. // **Beginning FY 2021-22:** Add another $500k (for a total of $1million annually) for LCAP match to support student outpatient treatment, with continued drawing down of MediCal. TFC/ACES/SSA-referred services will continue at $1.5 million and Existing Outpatient Services will continue at $500k annually. Services provided may be clinic- or field-based depending on the needs of the child/youth/family. // STRTP costs have been moved to the Residential Treatment category.
	OC Children with Co-Occurring Mental Health Disorders (pg 157, FY 2019-20 MHSA Plan)	600,000	1,169,080	195%	1,000,000	799,269	80%	1,000,000		1,000,000		$400,000 increase was moved from the corresponding Children's FSP contract to adjust for the budget increase of this contract.

CSS Updated March 12, 2021	FY 2019-20			FY 2020-21			FY 2021-22			FY 20/21 Budget Reduction and FY21/22 Plan Update Notes	Original 3 Yr Plan Notes
	FY 2019-20 Approved Budget	Actual Expenditures	% Change	FY 2020-21 Approved Budget	Projected Expenditures	% Change	Approved FY 2021-22 Budget	Proposed Changes	Requested Updated FY 2021-22 Budget		
Outpatient Recovery *(formerly known as Recovery Clinics / Centers)* (pg 161, FY 2019-20 Plan)	8,458,531	7,994,409	95%	6,158,531	5,689,666	92%	6,158,531	(300,000)	5,858,531	FY 21/22: Right-sizing budget with additional savings from vacant positions	Separated Open Access' $2.3M budget from Recovery Center's budget and moved to Access & Linkage to Treatment Section; level funding for program.
Older Adult Services (pg 169, FY 2019-20 Plan)	1,668,135	1,607,796	96%	2,168,135	1,568,686	72%	2,168,135		2,168,135	FY 20/21: Savings resutling from eligible expenditures being funded with CARES Act.	Increasing to right-size budget, incorporating increased lease costs at 4000 Metropolitan.
Services for the Short-Term Therapeutic Residential Program (STRTP) (pg 154, FY 2019-20 MHSA Plan)	4,870,000	2,527,478	52%	6,500,000	2,732,948	42%	8,000,000	(1,000,000)	7,000,000	FY 21-22: Proposing a 1-year reduction of $1 million to account for extended needed for program start up due to DHCS' lengthy Mental Health Program Approval process. *As part of the MHSA Strategic Priority to "Improve Access to Behavioral Health Services," available funding may be added if demand for services exceeds currently projected budget.*	**Beginning FY 2020-21**: Transfer annual budget of $4,870,000 from Continuum of Care (formerly Youth Core Services) to separate STRTP program (which was previously embedded within the former Youth Core Services program), and increase the annual budget by $130,000 to right-size the annual budget since those funds had been previously transferred to CFTN for capital renovations to bring an office serving MHSA clients up to code, thus bringing current annual STRTP budget to $5 million. Also requesting an increase of $1.5 million in FY 2020-21 to cover the increasing number of providers signing onto this State-mandated program, as well as the increasing costs of these intensive services, bringing total requested FY 2020-21 budget to $6.5 million. **Beginning FY 2021-22:** Add another increase of $1.5 million to cover additional providers and high cost of these intensive services, bringing total on-going annual budget to $8 million.
RETIRED: Integrated Community Services (pg 165, FY 2019-20 Plan)	1,648,000	1,654,589	100%	1,197,000	4,265	0%	1,197,000	(1,197,000)	-	FY 20/21 and FY 21/22 annual savings of $1.2M resulting from program being transitioned to CalOptima at end of FY 19/20 (see SC PPT 11-16-20).	4 County FTEs will move to PACT in FY 20-21 because program will no longer provide county-operated services within the Community Health Clinic.
CANCELED: Telehealth/Virtual Behavioral Health Care (pg 172)	-			2,500,000	-	0%	3,000,000	(3,000,000)	-	FY 20/21 savings of $2.5M and FY 21/22 savings of $3M due to rapid expansion of telehealth services across multiple programs in response to COVID-19 using other revenue sources (see SC PPT 11-16-20).	Proposed expansion using tele- & virtual behavioral health options to promote access to services, alleviate high caseloads in outpatient clinics, and provide the option for increased telepsychiatry services. HCA will monitor service demand/capacity and program expenditures, and transfer CSS carryover funds should service demand/expenditures exceed the current proposed budget. HCA will update the Steering Committee should the need for additional CSS carryover funds be identified.
RETIRED: Adolescent Co-Occurring MH & SUD Residential Treatment	-	6,328	0%			0%					Program continuing through non-MHSA funds.
RETIRED: Adult Co-Occurring MH & SUD Residential Treatment	500,000	-	0%	-		N/A					Program will be at Anita Campus and funded through non-MHSA funds.
SUBTOTAL ALL Outpatient Treatment	82,574,542	63,685,499	77%	86,390,192	62,665,278	73%	88,890,192	(7,897,000)	80,993,192		
SUPPORTIVE SERVICES											
RETIRING: Mentoring for Children and Youth (pg 210, FY 2019-20 MHSA Plan)	500,000	492,268	98%	500,000	488,489	98%	500,000	(500,000)	-	FY 21/22: Savings of $500K resulting from contract ending 6/30/2021 and not being renewed. It is anticipated that these supportive services will continue to be provided, at least in part, through the "Peer Mentor and Parent Partner Support" program.	
Peer Mentor and Parent Partner Support (all ages; pg 201, FY 2019-20 MHSA Plan)	4,249,888	3,739,043	88%	4,249,888	3,990,109	94%	4,249,888		4,249,888	As noted above, this program will allow for continued support of children, youth and their parents following the discontinuation of "Mentoring for Children and Youth" program.	FY 2019-20 are partial expenditures due to vacancies for positions added when program expanded in FY 2018-19 mid-year. Hiring for FTEs is nearing completion, thus requesting to keep budget level.
Wellness Centers (pg 205, FY 2019-20 MHSA Plan)	3,254,351	3,247,607	100%	3,354,351	3,333,217	99%	3,354,351		3,354,351		Adjusted per contract agreements and facility maintenance/ improvements at Wellness Center Central.
Supported Employment (pg 228, FY 2019-20 MHSA Plan)	1,371,262	1,147,774	84%	1,371,262	1,298,548	95%	1,371,262		1,371,262		
Transportation Program (pg 226, FY 2019-20 MHSA Plan)	900,000	965,862	107%	1,150,000	560,000	49%	1,300,000	(200,000)	1,100,000	FY 20/21 savings of $600K and FY 21/22 savings of $200K resulting from decreased tranportation usage during COVID-19 pandemic (see SC PPT 11-16-20). *As part of the MHSA Strategic Priority to "Improve Access to Behavioral Health Services," available CSS funds may be added during FY 21/22 if demand for transportation services exceeds current proposed budget.*	Requesting to add $250K starting FY 20/21 to increase transportation assistance, which includes right-sizing rides for adults 18+ and beginning transportation assistance to families with young minors. Increase budget by another $150k beginning FY 21/22 as expansion for families is fully implemented. HCA will monitor service demand/capacity and program expenditures, and transfer CSS carryover funds should service demand/expenditures exceed the current proposed budget. HCA will update the Steering Committee should the need for additional CSS carryover funds be identified.
SUBTOTAL Supportive Services	10,275,501	9,592,554	93%	10,625,501	9,670,363	91%	10,775,501	(700,000)	10,075,501		

CSS Updated March 12, 2021		FY 2019-20			FY 2020-21			FY 2021-22			FY 20/21 Budget Reduction and FY21/22 Plan Update Notes	Original 3 Yr Plan Notes
		FY 2019-20 Approved Budget	Actual Expenditures	% Change	FY 2020-21 Approved Budget	Projected Expenditures	% Change	Approved FY 2021-22 Budget	Proposed Changes	Requested Updated FY 2021-22 Budget		
SUPPORTIVE HOUSING / HOMELESSNESS	**Housing & Year Round Emergency Shelter** (pg 231, FY 2019-20 MHSA Plan; *formerly known as Short-Term Housing Services*)	1,367,180	224,279	16%	1,367,180	609,000	45%	1,367,180		1,367,180	AOABH Housing and Supportive Services has worked closely with the Office of Coordination to allocate beds and streamline the admission process for AOABH clients at Kramer and Yale. This will increase access, utilization and spending at both shelters, thus it is anticipated that the full budget will be spent in FY 21/22 and right-sizing of budget not recomended at this time.	
	Bridge Housing for Homeless (pg 233)	2,000,000	1,573,174	79%	2,000,000	1,983,567	99%	2,000,000		2,000,000		
	CSS Housing includes MOU with OCCR and funds for development of permanent supportive housing; (pg 235)	30,772,577	30,729,723	100%	293,678	293,678	100%	302,488	53,558	356,046		Combines OCCR Housing MOU & PSH Funds into single budget line
	SUBTOTAL Supportive Housing/Homelessness	34,139,757	32,527,176	95%	3,660,858	2,886,245	79%	3,669,668	53,558	3,723,226		
	Subtotal Of All CSS Programs	156,361,916	129,847,769	83%	136,448,667	105,898,869	78%	145,157,477	(11,078,375)	134,079,102		
	Administrative Costs	17,833,503	18,108,124	102%	18,639,508	16,139,508	87%	19,469,693	71,315	19,541,008	FY 20/21 Expenditures were lower than originally budgeted due to shift in staff to support the COVID-19 response (i.e., Disaster Response), and hours worked were paid for through CARES Act. FY 21/22: Initially adjusted admin budget to remain level with FY 20/21 budget (i.e., reduction of $830,185 from approved FY 21/22 admin budget). This reduction was due to 1) increased Medi-Cal generation and 2) shift in BHS' decision to deploy surveys in-house through marketing firm, rather than oversampling on the CHIS, so data could be returned more quickly for planning use (CHIS data become available ~18 months after collection). Shift away from CHIS resulted in ~$250k in savings annually. After leveling FY 21/22 budget to FY 20/21 amount, added $901.5k to cover costs related to transitioning CSS programs into the OC Navigator, the digital resource navigator tool being developed as part of the BH System Transformation INN Project. These funds will also be used to begin development of automated and electronic features designed to increase productivity and operational efficiency of multiple programs (i.e, electronic bed board for CSUs, CRS, etc.; dashboards and generated reports; integration with HCA EHR, etc.)	Added 3% increases per FY due to the recently approved COLAs for OCEA's and OCMA's members. Propose to add $542,000 annually to 100% oversample CHIS in Orange County. Data would be used to support community planning through a systematic, existing effort to identify mental health disparities in Orange County.
	Total MHSA/CSS Funds Requested	174,195,419	147,955,892	85%	155,088,175	122,038,377	79%	164,627,171	(11,007,060)	153,620,111		
	CSS TRANSFERS TO OTHER COMPONENTS SECTION											
	to WET	5,085,282	3,823,525	75%	6,216,634	5,038,928	81%	5,219,984	-	5,219,984		
	to CFTN	28,787,797	14,799,492	51%	12,519,749	11,093,221	89%	8,840,752	7,466,632	16,307,384	See CFTN worksheet for explanation of proposed increase to FY 21/22 transfer from CSS.	
	to Prudent Reserve	-	-		-			-				
	Subtotal CSS Transfers Section	33,873,080	18,623,017	55%	18,736,383	16,132,149	86%	14,060,736	7,466,632	21,527,368		

PEI

Updated March 12, 2021

		FY 2019-20			FY 2020-21			FY 2021-22				
		FY 2019-20 Approved Budget	Actual Expenditures	% Change	FY 2020-21 Approved Budget	Projected Expenditures	% Change	FY 2021-22 Approved Budget	Proposed Changes	Requested Updated FY 2021-22 Budget	FY 20/21 Budget Reduction and FY21/22 Plan Update Notes	Original 3 Yr Plan Notes
	Child, Youth and Parent Programs											
Prevention	School Readiness (pg 46)	1,600,000	1,512,277	95%	1,600,000	1,559,275	97%	1,600,000	(600,000)	1,000,000	FY 21/22: budget reduced due to one of the provider contracts not being renewed. Dollars were shifted over to the remaining contract provider to allow the remaining provider to increase their capacity/ units of services. In addition, a remaining $600K will be redistributed to the Early Childhood Mental Health Provider Training and to the Parent Education Services program budgets. Both programs will utilize these additional dollars to expand their capacity/ units of services specifically targeting families with young children.	FY 18/19 and FY 19/20 budgets included carryover funds for 5-year School Readiness expansion. Expansion started FY18/19 and ends FY 22/23. Annual Carryover Amount=$600,000 and full 5-Yr Carryover Obligation=$2,700,000 (FY 18/19 is partial year funding)
	Parent Education Services (pg 216)	1,064,770	1,014,342	95%	1,064,770	1,040,189	98%	1,064,770	385,230	1,450,000	FY 21/22: budget to increase to support community needs. Using Savings from School Readiness Program for services supporting families with children including 0-8 age group.	
	Children's Support & Parenting Program (pg 213)	1,700,000	1,535,716	90%	1,700,000	662,799	39%	1,700,000	(700,000)	1,000,000	FY 20/21 and FY 21/22: Savings due to not filling vacant positions because the pandemic resulted in reduced services, and most program staff had/have been temporily redeployed to other programs in need. Additional savings in FY 21/22 anticipated as program structure and services are further evaluated.	
	School-Based Behavioral Health Intervention & Support (pg 52)	3,408,589	3,319,122	97%	3,408,589	2,968,841	87%	3,408,589	(1,600,000)	1,808,589	FY 21/22: budget reduced due to ending of carryover expansion in FY 20/21.	FY 18/19 and FY 19/20 budgets included carryover funds for 3-year expansion. Expansion started FY18/19 and ends FY 20/21. Annual Carryover Amount=$1,600,000 and full 3-yr Obligation=$4,000,000 (FY 18/19 is partial year funding)
	Violence Prevention Education (pg 57)	1,352,651	1,189,779	88%	1,352,651	1,300,325	96%	1,352,651	-	1,352,651		FY 18/19 and FY 19/20 budgets included carryover funds for adding a 5- yr Active Shooter Contract. Contracts started FY18/19 and ends FY 22/23. Annual Carryover Amount=$247,000 and full 5-yr Carryover Obligation=$1,235,000
	Gang Prevention Services (pg 67)	403,100	326,534	81%	403,100	368,486	91%	403,100	-	403,100		**FY 19/20: PEI CPP: Priority #7** Budget includes carryover funds for 3-yr expansion. Expansion starts FY19/20, and ends FY 21/22. Annual Carryover Amount=$150,000 and full 3-yr Carryover Obligation=$450,000
	Subtotal: Child, Youth and Parent	$ 9,529,110	$ 8,897,769	93%	$ 9,529,110	$ 7,899,915	83%	$ 9,529,110	$ (2,514,770)	$ 7,014,340		
	Family Support Services (pg 219)	282,000	277,169	98%	282,000	279,996	99%	282,000	-	282,000		
	SUBTOTAL Prevention	$ 9,811,110	$ 9,174,938	94%	$ 9,811,110	$ 8,179,911	83%	$ 9,811,110	$ (2,514,770)	$ 7,296,340		

PEI

Updated March 12, 2021

		FY 2019-20			FY 2020-21			FY 2021-22				
		FY 2019-20 Approved Budget	Actual Expenditures	% Change	FY 2020-21 Approved Budget	Projected Expenditures	% Change	FY 2021-22 Approved Budget	Proposed Changes	Requested Updated FY 2021-22 Budget	FY 20/21 Budget Reduction and FY21/22 Plan Update Notes	Original 3 Yr Plan Notes
MENTAL HEALTH AWARENESS & STIGMA REDUCTION CAMPAIGNS & EDUCATION	**Mental Health Community Education Events for Reducing Stigma and Discrimination** (pg 33, FY 2019-20 MHSA Plan)	881,000	394,728	45%	881,000	486,272	55%	881,000	-	881,000	FY 19/20 and FY 20/21: Expenditures across these two FYs total $881K and represent the full FY 19/20. Some of FY 19/20 funds spent in FY 20/21 due to events begin postponed to Dec 2020 because of COVID-19. $0 spent from FY 20/21's budget (see SC PPT 11-16-20).	**FY 19/20: PEI CPP: Priority #8** Budget includes carryover funds for 3-yr expansion. Expansion starts FY19/20 and ends FY 21/22. Annual Carryover Amount=$666,667 and full 3-yr Carryover Obligation=$2,000,000.
	Outreach for Increasing Recognition of Early Signs of Mental Illness (pg 38)	$ 6,965,711	$ 6,323,170	91%	$ 9,491,945	$ 9,707,167	102%	$ 11,491,945	(1,054,533)	$ 10,437,412		
	portion of "Outreach for Increasing Recognition" budget operated by Behavioral Health Training Services (BHTS) Office through former Behavioral Health Community Training & Technical Assistance	*700,000*	*781,709*	*112%*	*700,000*	*1,092,658*	*156%*	*700,000*	*480,000*	*1,180,000*	FY 21/22: Budget increased as a result of transferring Crisis Intervention Training (CIT) from CSS/WET and transitioning "School-Based Stress Management" to the BHTS-operated training services componet of the Outreach for Increasing Recognition of Early Signs of Mental Illness. CIT, with its focus on training law enforcement, is more appropriate as a PEI-funded program (rather than a behavioral health workforce-funded program), and School-Based Stress Management is being retired as a stand-alone program. ** Since January 2020, the Behavioral Health Training Collaborative/ RESET completed 14 mindfulness trainings with 352 participants, including 255 teachers. In addition, a library of self-paced trainings on some of the most commonly requested topics of mental health, mindfulness, coping skills, and more was created. Ready Set Resilience is a new series of brief video lessons on mindfulness geared for middle-school aged students. BHTS, through its training collaborative, will continue to provide these types of trainings, including for teachers, parents, and students.*	**FY 19/20: PEI CPP: Priority #9** Budget includes carryover funds for 3-yr expansion. Expansion starts FY19/20 and ends FY 21/22. Annual Carryover Amount=$500,000 and full 3-yr Carryover Obligation=$1,500,000
	portion of "Outreach for Increasing Recognition" budget operated by PEI through former School-Based Stress Management Services	*155,000*	*118,071*	*76%*	*155,000*	*36,929*	*24%*	*155,000*	*(155,000)*	-	FY 20/21 Following the retirement of the subject matter expert providing these trainings, funding for this stand-alone provider is being discontinued. Mindfulness training services are also being provided by BHTS, as referenced in the row immediately above (see SC PPT 11-16-20). Thus, discontinuing the funding on this row will not impact the availability of these types of trainings.	
	portion of "Outreach for Increasing Recognition" budget operated by PEI through former Early Childhood Mental Health Providers Training	*400,000*	-	*0%*	*829,533*	*800,639*	*97%*	*829,533*	*170,467*	*1,000,000*	FY 21/22: budget increased due to shift of savings from the School Readiness program to increase capacity/ units of services to the same target population within this program.	**FY 19/20: PEI CPP: Priority #3** Budget includes carryover funds for 3 yrs of these services. Program starts FY19/20 and ends FY 21/22. Full 3-yr Carryover Obligation=$2,000,000
	portion of "Outreach for Increasing Recognition" budget operated by PEI through former Outreach & Engagement Collaborative / Mental Health and Wellbeing for Diverse Communities	*3,385,711*	*3,264,899*	*96%*	*3,385,711*	*3,365,121*	*99%*	*3,385,711*	-	*3,385,711*		**FY 19/20: PEI CPP: Priority #6** Budget includes carryover Funds for 3- yr O&E Collaborative expansion. Expansion starts FY19/20 and ends FY 21/22. Full Annual Amount=$666,667 3-yr Obligation=$2,000,000
	portion of "Outreach for Increasing Recognition" budget from former K-12 School-Based Mental Health Services Expansion	*925,000*	*246,602*	*27%*	*2,312,500*	*2,005,127*	*87%*	*2,312,500*	-	*2,312,500*		**FY 19/20: PEI CPP: Priority #2** Budget includes carryover funds for 3-yr expansion. Expansion starts FY19/20 and ends FY 21/22. Annual Carryover Amount= $2,312,500 and full 3-yr Carryover Obligation=$5,550,000
	portion of "Outreach for Increasing Recognition" budget operated by PEI through former Services for TAY and Young Adults	*500,000*	*1,052,688*	*211%*	*1,250,000*	*457,492*	*37%*	*1,250,000*	*(670,000)*	*580,000*	FY 20/21 expenditures and FY 21/22 budget shifted from "Services for TAY and Young Adults" to "Statewide Projects" row below due to leveraging of CalMHSA Statewide Project campaigns.	**FY 19/20: PEI CPP: Priority #1** Budget includes carryover funds for 3 yrs of these services. Program starts FY19/20 and ends FY 21/22. Annual Carryover Amount=$1,250,000 and full 3-yr Carryover Obligation= $3,000,000.
	portion of "Outreach for Increasing Recognition" budget operated by PEI through former Statewide Projects (includes local mental health campaigns)	*900,000*	*859,201*	*95%*	*859,201*	*1,949,201*	*227%*	*2,859,201*	*(880,000)*	*1,979,201*	FY 20/21 expenses and FY 21/22 budget moved from "Services for TAY and Young Adults" program above to Statewide Projects due to leveraging of CalMHSA Statewide PEI Projects campaigns.. FY 21/22: Budget reduced due to COVID and public health orders restricting large public gatherings/events where large-scale mental health capaigns were going to be promoted with these funds.	**Statewide Projects** (CalMHSA) include Each Mind Matters (green ribbon), Know the Signs, Cognito, Directing Change, Walk in Our Shoes, technical assistance, etc managed/operated by CalMHSA. **Local mental health campaigns:** Proposed expansion is for local funds to be used for large-scale, local mental health awareness campaigns and community educational activities. These efforts will partner with and leverage the community reach and existing efforts of local professional sports teams, universities/colleges, County Agency partners, etc. If additional potential projects/ campaigns are identified that exceed the proposed amount ($2 million annually), HCA will update the Steering Committee.
SUBTOTAL MH Awareness & Stigma Reduction		$ 7,846,711	$ 6,717,898	86%	$ 10,372,945	$ 10,193,439	98%	$ 12,372,945	(1,054,533)	$ 11,318,412	**As part of the MHSA Strategic Priority of "Increase MH Awareness," available funding may be added to one or more of the programs in this section to meet program and/or Strategic Priority Needs, drawing upon feedback received during community engagement meetings.**	

PEI

Updated March 12, 2021

		FY 2019-20			FY 2020-21			FY 2021-22				
		FY 2019-20 Approved Budget	Actual Expenditures	% Change	FY 2020-21 Approved Budget	Projected Expenditures	% Change	FY 2021-22 Approved Budget	Proposed Changes	Requested Updated FY 2021-22 Budget	FY 20/21 Budget Reduction and FY21/22 Plan Update Notes	Original 3 Yr Plan Notes
CRISIS PREVENTION & SUPPORT	**Warmline** (pg 89)	536,566	536,566	100%	1,116,667	1,142,825	102%	1,116,667	392,000	1,508,667	FY 21/22: Increase due to expanding program to 24/7 operations and to increased lease costs. The cost to staff program 24/7 is an additional $332K a year, and there is an increased lease cost of $60K annually.	Budget right-sized to meet increasing call volume. The Crisis Prevention Hotline and Survivior Support Services will be combined into a single, expanded Suicide Prevention Program in the Three-Year Plan. Per identified need, HCA will monitor service demand/capacity and program expenditures, and transfer PEI carryover funds should service demand/expenditures exceed the current right-sized budget. HCA will update the Steering Committe should the need for additional PEI carryover funds be identified.
	Suicide Prevention Services (includes Crisis Prevention Hotline and Survivor Support Services (pg 92)	736,226	738,572	100%	1,200,000	1,118,887	93%	1,200,000	-	1,200,000		
	SUBTOTAL Crisis Prevention & Support	$ 1,272,792	$ 1,275,138	100%	$ 2,316,667	$ 2,261,712	98%	$ 2,316,667	$ 392,000	$ 2,708,667	As part of the MHSA Strategic Priority of "Suicide Prevention," available funding may be added to one or more of the programs in this section to meet program and/or Strategic Priority Needs.	
SUPPORTIVE SERVICES	**Transportation Assistance**				150,000	-	0%	500,000	(300,000)	200,000	FY 20/21: Expansion of transportation services to PEI delated due to impact of COVID-19. FY 21/22: O&E has identified need for transportatiion services, and budget is temporarily reduced to account for anticipated, on-going impact of COVID-19. Budget to be restored to full amount in FY 22/23 when in-person service levels are expected to increase/return to pre-COVID levels.	To address one of the identified needs (i.e., challenges with accessing behavioral health services), carryover PEI funds will be used to provide transportation assistance for enrolled PEI clients. Planning, particularly with regard to meeting the specialized transportation needs of families with young children and older adults, procurement and program ramp-up will occur in FY 2020-21, with full implementation anticipated beginning in FY 2021/22. HCA will monitor service demand/ capacity and program expenditures, and transfer PEI carryover funds should service demand/expenditures exceed the proposed budgets. HCA will update the Steering Committe should the need for additional PEI carryover funds be identified.
	SUBTOTAL Supportive Services	$ -	$ -	-	$ 150,000	$ -	0%	$ 500,000	$ (300,000)	$ 200,000		
ACCESS & LINKAGE TO TREATMENT (TX)	**OCLinks** (pg 73)	1,000,000	764,437	76%	1,000,000	1,225,911	123%	1,000,000	1,200,000	2,200,000	FY 20/21 and FY 21/22: HCA had initially proposed budget reduction (see Per SC PPT 11-16-20) but due to Board Directive for HCA to create a 24/7 Behavioral Health Line, budget was increased by $1.2M in FY 21/22 for 24/7 expansion including crisis calls and dispatch. *As part of the MHSA Strategic Priorities to "Improve Access to Behavioral Health Services" and "Suicide Prevention," available funding may be added to develop infrastructure for program to serve as the BHS Access Line and dispatch service for mobile crisis assessment.*	
	BHS Outreach & Engagement (O&E) (pg 76)	2,232,523	1,413,983	63%	2,232,523	2,984,254	134%	2,232,523	897,145	3,129,668	FY 20/21: Shifted $1,544,933 in program costs to PEI from CSS and in FY 21/22 shifting $1,569,933 in CSS costs to PEI (see SC PPT 11-16-20). However, due to savings from vacant positions, net increase to PEI budget was only $897K in FY 21/22	**FY 19/20:** Additional funds are per 11/23/18 Board directive to add new positions (n=12 FTEs); 5 FTEs filled as of Dec 2019
	SUBTOTAL Access & Linkage to Tx	$ 3,232,523	$ 2,178,420	67%	$ 3,232,523	$ 4,210,165	130%	$ 3,232,523	$ 2,097,145	$ 5,329,668		

PEI

Updated March 12, 2021

		FY 2019-20			FY 2020-21			FY 2021-22				
		FY 2019-20 Approved Budget	Actual Expenditures	% Change	FY 2020-21 Approved Budget	Projected Expenditures	% Change	FY 2021-22 Approved Budget	Proposed Changes	Requested Updated FY 2021-22 Budget	FY 20/21 Budget Reduction and FY21/22 Plan Update Notes	Original 3 Yr Plan Notes
OUTPATIENT TREATMENT - Early Intervention	*Child, Youth and Parent Programs*											
	School-Based Mental Health Services (pg 120)	2,315,236	2,670,658	115%	2,525,236	2,283,915	90%	2,525,236	(500,000)	2,025,236	FY 21/22: Decrease in PEI budget due to savings resulting from generation of Medi-Cal revenue (see SC PPT 11-16-20) will begin in FY 21/22 *As part of the MHSA Strategic Priority to "Improve Access to Behavioral Health Services," available funding may be added if demand for services exceeds currently projected budget.*	
	1st Onset of Psychiatric Illness (OC CREW) (pg 123)	1,500,000	1,188,697	79%	1,500,000	1,070,176	71%	1,500,000	(204,000)	1,296,000	FY 20/21 and FY 21/22:Decrease in PEI budget due to savings resulting from generation of Medi-Cal revenue (see SC PPT 11-16-20)	
	OC Parent Wellness Program (pg 128)	3,488,072	3,867,428	111%	3,738,072	3,505,149	94%	3,738,072	-	3,738,072		New legislation effective Jan 2018 requires perinatal screening for all new mothers. BHS will continue to monitor program referrals and may return with amendment for increased funds if needed. Connect the Tots and Stress Free Families will be combined with OC Parent Wellness Program. The merge will allow for greater administrative efficiences and no decrease in services.
	RETIRED PROGRAM:School Based Behav. Health Intervention & Support - Early Intervention (pg 99)	440,000	123,714	28%	-							Contract Expires at the end of FY 19/20. Not Renewing
	Subtotal Child, Youth and Parent	$ 7,743,308	$ 7,850,497	101%	$ 7,763,308	$ 6,859,240	88%	$ 7,763,308	(704,000)	$ 7,059,308		
	Community Counseling & Supportive Services includes LGBTIQ+ services (pg 116)	2,536,136	2,168,378	85%	2,536,136	2,042,950	81%	2,536,136	-	2,536,136		Community Counseling & Supportive Services and OC ACCEPT will be merged into a single, expanded counseling program in the Three-Year Plan. The merge will allow for greater administrative efficiencies and no loss of services or specialization in providing culturally responsive and appropriate services for the LGBTQ community.
	Early Intervention Services for Older Adults includes older adults from diverse cultural/ racial/ethnic backgrounds (pg 134)	2,469,500	2,442,007	99%	2,469,500	2,469,499	100%	2,469,500	-	2,469,500		**FY 19/20: PEI CPP: Priority #5** Budget includes carryover funds for 3-yr expansion. Expansion starts FY19/20 and ends FY 21/22. Annual Carryover Amount=$1,000,000 and full 3-yr Carryover Obligation=$3,000,000
	OC4VETS includes, college students, court-involved, and military-connected families *(formerly called Early Intervention Servies for Veterans;* pg 137)	2,695,957	2,255,425	84%	2,695,957	2,204,269	82%	2,400,000	-	2,400,000		**FY 19/20:** Budget includes carryover funds to keep OC4Vets at level funding for 2 yrs. Carryover funds applied in FY 19/20 and FY 20/21. Annual Carryover Amount=$295,957 and full 2-yr Carryover Obligation=$591,914.
	portion of OC4Vets budget from former Behavioral Health Srvcs for Military Families (pg 141)	*1,000,000*	*808,205*	*81%*	*1,000,000*	*920,057*	*92%*	*1,000,000*	-	*1,000,000*		**FY 19/20: PEI CPP: Priority #4** Budget includes carryover funds for 3- yr funding of BHS Military Families innovation program that is ending. PEI funding starts FY19/20 and ends FY 21/22. Annual Amount= $1,000,000 and full 3-yr Obligation=$3,000,000.
	SUBTOTAL ALL Outpatient Treatment	$ 15,444,901	$ 14,716,308	95%	$ 15,464,901	$ 13,575,958	88%	$ 15,168,944	(704,000)	$ 14,464,944		
	Subtotal All PEI Programs	$ 37,608,037	$ 34,062,701	91%	$ 41,348,146	$ 38,421,185	93%	$ 43,402,189	(2,084,158)	$ 41,318,031		
	Administrative Costs	5,882,150	5,727,876	97%	5,713,337	5,733,142	100%	5,884,737	676,000	6,560,737	FY 21/22: $600k added to admin to cover costs related to transitioning programs' various resources and referrals databases into the OC Navigator, the digital resource navigator tool being developed as part of the BH System Transformation INN Project.These funds will also be used to begin development of automated and electronic features designed to increase productivity and operational efficiency of multiple programs (i.e, enhanced chat functions with public; dashboards and generated reports; integration with HCA EHR, etc.).	*Component budgets are approximations based on program estimates. Within the PEI component, funds can be shifted to meet actual expenditures. These shifts will be reflected each year during the Annual Plan Update.*
	GRAND TOTAL PEI	$ 43,490,187	$ 39,790,577	91%	$ 47,061,483	$ 44,154,327	94%	$ 49,286,926	(1,408,158)	$ 47,878,768		

WET Updated March 12, 2021	FY 2019-20			FY 2020-21			FY 2021-22			FY 20/21 Budget Reduction and FY21/22 Plan Update Notes	Original 3 Yr Plan Notes
	Approved Budget	Actual Expenditures	% Change	FY 2020-21 Approved Budget	Projected Expenditures	% Change	Approved FY 2021-22 Budget	Proposed Changes	Requested Updated FY 2021-22 Budget		
Workforce Staffing Support	1,140,000	1,596,733	140%	1,710,584	1,373,599	80%	1,761,902	-	1,761,902	FY 20/21: Expenditures were lower than originally budgeted due to shift in activity to support the COVID-19 response, i.e., staff were redeployed to Disaster Response and hours worked were paid for through CARES Act. FY 21/22: Keeping Workforce Staffing budget at current approved level.	Right Sized budget based off of historic data
Training and Technical Assistance	1,573,000	1,296,551	82%	1,223,390	956,398	78%	1,232,434	50,000	1,282,434	FY 21/22: Increase to cover additional funding for Mental Health First Aid, presenter fees for hosted trainings, trainings, and staff time based on historic spending level from FY 19/20.	Increased budget due to increase in training as well as additonal costs for BH Training Facility.
Mental Health Career Pathways	927,000	869,871	94%	1,046,663	947,252	91%	1,046,663	-	1,046,663		Expansion of REI contract. Adding new curriculum courses for Peer Specialists
Residencies and Internships	238,381	169,362	71%	170,000	28,479	17%	170,000	(165,000)	5,000	FY 21/22: Decrease because Psychological Testing Program closed down starting Nov20	Right Sized budget based off of historic data
Financial Incentives Programs	654,225	266,098	41%	526,968	426,968	81%	526,968	120,000	646,968		Right Sized budget based off of historic data
WET Statewide Five-Year Plan with CalMHSA	-	-	0%	1,071,050	904,713	84%	-	-	-	FY 20/21: Savings of $166,337 due to updated OC Contribution amounts as identified in SC PPT 11-16-20	
Subtotal Of WET Programs	$ 4,532,606	$ 4,198,615	93%	5,748,655	4,637,409	81%	4737967	5000	$4,742,967		
Administrative Costs	552,676	471,835	85%	467,979	401,519	86%	482,018	(5,000)	477,018	FY 21/22: Right sizing due to historic spending levels.	Methodology for budgeting Admin Costs changed from using a flat 18% rate to using actuals from Previous year and adding a 3% inflation rate.
Total MHSA/WET Funds Requested	$ 5,085,282	$ 4,670,450	92%	$ 6,216,634	$ 5,038,928	81%	$ 5,219,985	$ -	$ 5,219,985		

1) All WET programs are now funded by CSS funds

CF-TN

Updated March 12, 2021

	FY 2019-20			FY 2020-21			FY 2021-22			FY 20/21 Budget Reduction and FY21/22 Plan Update Notes	Original 3 Yr Plan Notes
	FY 2019-20 Approved Budget	Actual Expenditures	% Change	FY 2020-21 Approved Budget	Projected Expenditures	% Change	Approved FY 2021-22 Budget	Proposed Changes	Requested Updated FY 2021-22 Budget		
Capital Facilities Projects											
Wellness Campus	16,600,000	16,600,000	100%	-	-	-	-	-	-		
Youth Core Services Building Upgrades	130,000	-	0%	-	-	-	-	-	-		
Crisis Stabilization Unit Renovations	850,000	850,000	100%	-	-	-	-	-	-		
Behavioral Health Training Facility	65,000	12,544	19%	65,000	21,504	33%	65,000	-	65,000		Capital Facility Costs for BH Training facility will be for 10 years. Started FY 18/19 ends FY 27/28
SUBTOTAL Capital Facilities	**17,645,000**	**17,462,544**	**99%**	**65,000**	**21,504**	**33%**	**65,000**	**-**	**65,000**		
Technological Needs Projects											
Electronic Health Record (E.H.R.)	10,815,504	5,493,602	51%	12,154,749	10,905,564	90%	8,466,752	7,575,632	16,042,384	FY 21/22: Proposed increase includes carrying over unspent funds from FY 20/21 and adding $6.3 million to be used for: transitioning EHR from on-premises/ local management to cloud-based management to improve accessiblity and functioning of the EHR for both county and county-contracted providers and integrating approved digital solutions with the EHR to exchange information, which will help to increase workforce efficiency. Funds will also be used to hire consultants to project manage the IT projects to ensure timely completion and execution of deliverables.	Funds are to continue the work of consolidating data from multiple sources into the EHR, as well as integrating with Contract Providers' health information exchange. EHR project costs will include, but not be limited to: software licenses, network infrastructure such as servers, storage and network monitoring appliances, and internal human resources and external consultants. Adding $1M budget for Data Integration System. These funds will support the development and ongoing support for a System of Care Data Integration System designed to coordinate appropriate data sharing across county departments and external stakeholders. Data integration will aid in providing essential and critical services that include mental health care to county residents in a more efficient and timely manner.
Administrative Costs	327,293	214,795	66%	300,000	166,153	55%	309,000	(109,000)	200,000		Beginning FY 18/19, methodology for budgeting Admin Costs changed from using a flat 18% rate to using actuals from Previous year and adding a 3% inflation rate.
SUBTOTAL Technological Needs	**11,142,797**	**5,708,397**	**51%**	**12,454,749**	**11,071,717**	**89%**	**8,775,752**	**7,466,632**	**16,242,384**		
Total MHSA/CFTN Funds Requested	**$ 28,787,797**	**$23,170,941**	**80%**	**$12,519,749**	**$11,093,221**	**89%**	**$ 8,840,752**	**$ 7,466,632**	**$ 16,307,384**		

1) In the event costs of approved CF or TN projects are lower than originally anticipated, remaining funds may be used to fund future CF or TN projects.
HCA and CEO Budget will monitor any carryover balances to ensure that all funds transferred to CFTN are spent within the 10-year reversion timeframe.
2) Project funds approved for a specific project within one FY of a Three-Year Plan may be used to cover that project's costs during a different FY within the Three-Year plan depending on the project's implementation timeline.

APPENDIX III: PEI Regulations and Legislation

In Fall 2016, after receiving input from a number of community stakeholders statewide, the Mental Health Services Oversight and Accountability Commission (MHSOAC) voted to approve a new set of regulations governing PEI and Innovation programs. The regulations, which were amended in July 2018, define and/or delineate the following for both components:

- Reporting requirements, including expenditure reports, program and evaluation reports to be submitted to the MHSOAC, etc.
- Program evaluation guidelines, including that evaluations are culturally competent and, depending on the type of program, measure one of more the following:
    - For PEI: reduction in prolonged suffering; changes in attitudes, knowledge or behaviors; number of referrals and linkages; duration of untreated mental illness; timeliness of access to care; etc. Relevant outcomes are described within the program descriptions contained in this Plan.
    - For INN: the intended mental health outcomes of the project as they relate to the risk of, manifestation of, and/or recovery from mental illness; improvement of the mental health system; the primary purpose of the project (described below); the impact of any new and/or changed elements as compared to established mental health practices.
- Reporting guidelines for program/project changes, including:
    - For PEI, substantial changes to a Program, Strategy or target population; the resulting impact on the intended outcomes and evaluation; and stakeholder involvement in those changes.
    - For INN: substantial changes to the primary purpose and/or to the practice/ approach the project is piloting; increases in the originally approved Innovation budget; and/or a decision to terminate the project prior to the planned end date due to unforeseen legal, ethical or other risk-related reasons.

PEI Regulations

In addition, the MHSOAC and, most recently, Senate Bill (SB) 1004, implemented several regulations specific to PEI programs:

- General requirements for services, including the age ranges to be served, minimum percent funding allocated to programs serving children and TAY, etc.
- General component requirements, including the minimum number and type of PEI programs that each County shall include in its plan, etc., which are described in more detail below.
- Strategies for program design and implementation, including that programs help create access and linkage to treatment, improve timely access to mental health services, and be non-stigmatizing and non-discriminatory, etc., which is described in more detail below.
- Use of effective methods in bringing about intended program outcomes, including evidence-based practices, promising practices, and/or community- and/or practice-based standards, etc., which are described within each program description.

MHSOAC-Required PEI Programs

Per the Regulations, counties not classified as small must include at least one PEI program in each of five category types, and have the option of offering a sixth type. Orange County offers all six types, with some combining two types into one program as permitted by the regulations. The required programs, along with their accompanying Orange County PEI programs, are listed in the table at the end of this section.

- **Stigma and Discrimination Reduction**: Activities to reduce negative feelings, attitudes, beliefs, stereotypes and/or discrimination related to having a mental illness or seeking services, and to increase acceptance, dignity and inclusion.
- **Outreach for Increasing Recognition of Early Signs of Mental Illness**: Process of engaging, encouraging, educating and/or training and learning from potential responders about ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness.
- **Prevention**: Activities that reduce risk factors for developing a potentially serious mental illness and to build protective factors with the goal or promoting mental health.
- **Early Intervention**: Treatment/services that promote recovery and functioning for a mental illness early in its emergence.
- **Access and Linkage to Treatment**: Activities to connect individuals with SED/SMI to medically necessary care and treatment as early in the onset of these conditions as practicable.
- **Suicide Prevention** (optional): Activities that aim to prevent suicide as a consequence of mental illness.

MHSOAC-Required PEI Service Strategies

In addition to including the above program types, every PEI program must include the following strategies:

- **Improve Timely Access to Mental Health Services for Underserved Populations**: Strategies designed to overcome barriers and improve timely access to services for underserved populations.
- **Access and Linkage to Treatment**: Activities to connect individuals with SED/SMI to medically necessary care and treatment as early in the onset of these conditions as practicable.
- **Non-stigmatizing and non-discriminatory**: Strategies to reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and making services accessible, welcoming and positive.

Orange County is continuing to bring its PEI program descriptions, data collection and reporting into compliance with the new Regulations, particularly with regard to:

- Assessment of the duration an individual's mental illness remained untreated.
- Collection of the full demographic categories in County-operated programs as the electronic health record still needs to be modified.
- Process to un-duplicate demographic data counts when complete personally identifying information is not available in/across programs within a fiscal year.
- Length of time from when (1) a written referral to a higher level of mental health service is provided to individuals living with serious mental illness/serious emotional disturbance and (2) when that person attends the first appointment.
- Collection of all data elements required for Outreach for Increasing Recognition of Early Signs of Mental Illness programs.

To address the above issues, the County continues to work on modifying its own Electronic Health Record and on developing and coordinating standardized data collection procedures across County-operated and County-contracted programs, and will report on its progress in these and other areas in future Annual Plan Updates. Other required PEI Report elements are contained within this Plan Update (i.e., demographic information is on the following pages, service strategies are described in each service area section).

Senate Bill 1004 and PEI Priorities

Senate Bill (SB) 1004, passed in 2018, establishes priorities for the use of PEI funds that are in addition to the MHSOAC PEI regulations. These priorities are as follows:

- Childhood trauma prevention and early intervention as defined in Section 5840.6(d) to deal with the early origins of mental health needs.
- Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programing as defined in Section 5840.6(d).
- Youth outreach and engagement strategies as defined in Section 5840.6(d) that target secondary school and TAY, with a priority on developing partnerships with colleges/universities.
- Culturally competent and linguistically appropriate prevention and intervention as defined in Section 5840.6(d).
- Strategies targeting mental health needs of older adults.
- Other programs the commission identifies, with stakeholder participation, that are proven effective in achieving, and are reflective of, the goals stated in Section 5840 (as of March 2020, the Commission has not identified additional priorities).

A series of tables below summarizes the information a County is required to report in its PEI Component of the Three-Year Plan, per SB 1004:

- The specific PEI Priorities addressed in the Plan,
- An estimate of the share of PEI funding allocated to each priority, and
- If the County has determined to pursue alternative or an additional priority to those listed above, a description of how it made this determination through its stakeholder process and identify the metric(s) used to assess the program's effectiveness.

An explanation of how stakeholder input contributed to the priorities and allocations is provided in the section describing the 2019 Community Planning Process for the Three-Year Plan, as well as in Appendix IV describing the 2018 Community Planning Process.

A required by SB 1004, the table below provides an estimated share of the annual projected PEI **component** budget allocated to each of the PEI Priorities by FY. In addition, subsequent tables show the estimated share of **individual program** budgets allocated to each of the PEI Priorities, which were used to calculate the estimated shares for the annual projected component budget. Please note, these estimates may change if there are changes in the projected annual allocations, program expenditures and/or budgets, or PEI priorities.

Projected (Proj.) Annual PEI Component Budget by FY	Estimated Share by SB 1004 Priority					
	Childhood Trauma	Early Psychosis/ Mood	Secondary School/TAY	Culturally/ Linguistically Competent	Older Adults	Other
FY 2020-21 Proj. PEI Budget = $47,061,483 (Est. % of annual PEI Budget)	$17,631,930 (37%)	$8,026,047 (17%)	$7,411,580 (16%)	$6,988,942 (15%)	$6,698,569 (14%)	$304,415 (<1%)
FY 2021-22 Proj. PEI Allocation = $49,286,926 (Est. % of annual PEI Budget)	**$18,091,164 (37%)**	**$8,453,942 (17%)**	**$7,838,421 (16%)**	**$7,243,166 (15%)**	**$7,001,185 (14%)**	**$659,047 (<1%)**
FY 2022-23 Proj. PEI Allocation = $40,988,101 (Est. % of annual PEI Budget)	$14,083,058 (34%)	$8,420,174 (21%)	$6,079,610 (15%)	$6,051,959 (15%)	$5,689,481 (14%)	$663,818 (<2%)

Estimated Share of Annual PEI Program Budget Assigned to SB 1004 Priority, by MHSOAC PEI Program Categories

** This is a new program to the PEI Component and metrics will be developed once the scope of work and services is determined.*

MHSOAC-Required PEI Program	Estimated Share by SB 1004 Priority					
	Childhood Trauma	Early Psychosis/ Mood	Secondary School/TAY	Culturally/ Linguistically Competent	Older Adults	Other
ACCESS AND LINKAGE TO TREATMENT						
OCLinks	20%	20%	20%	20%	20%	
BHS Outreach & Engagement			70%		30%	

MHSOAC-Optional PEI Program Names in *italics* reflect separate programs that are being consolidated into the **BOLD** program name in the Three-Year Plan. Future Plan Updates will report on the **BOLD** program name only.	Estimated Share by SB 1004 Priority					
	Childhood Trauma	Early Psychosis/ Mood	Secondary School/TAY	Culturally/ Linguistically Competent	Older Adults	Other
SUICIDE PREVENTION						
Warmline	20%	20%	20%	20%	20%	
Suicide Prevention Services	20%	20%	20%	20%	20%	

MHSOAC-Required PEI Programs Names in *italics* reflect separate programs that are being consolidated into the **BOLD** program name in the Three-Year Plan. Future Plan Updates will report on the **BOLD** program name only.	Estimated Share by SB 1004 Priority					
	Childhood Trauma	Early Psychosis/ Mood	Secondary School/TAY	Culturally/ Linguistically Competent	Older Adults	Other
EARLY INTERVENTION PROGRAMS						
Community Counseling & Supportive Services		85%		15%		
School-Based Mental Health Services		100%				
Early Intervention Services for Older Adults					100%	
OC Parent Wellness Program	35%	65%				
First Onset of Psychiatric Illness (OC CREW)		50%	50%			
OC4Vets	20%	5%	5%	50%	20%	

MHSOAC-Required PEI Programs Names in *italics* reflect separate programs that are being consolidated into the **BOLD** program name in the Three-Year Plan. Future Plan Updates will report on the **BOLD** program name only.	Estimated Share by SB 1004 Priority					
	Childhood Trauma	Early Psychosis/ Mood	Secondary School/TAY	Culturally/ Linguistically Competent	Older Adults	Other
STIGMA AND DISCRIMINATION REDUCTION PROGRAM						
MH Community Educ. Events for Reducing Stigma & Discrimination	25%		25%	25%	25%	
OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS PROGRAM						
Beh. Health Community Training & Technical Assistance	20%	20%	20%	20%	20%	
Early Childhood Mental Health Providers Training	100%					
MH & Well-Being Promotion for Diverse Communities	25%		25%	25%	25%	
Services for TAY and Young Adults		5%	70%	25%		
K-12 School-Based MH Services Expansion	50%		25%	25%		
Statewide Projects	20%	20%	20%	20%	20%	
PREVENTION PROGRAM						
School Readiness	100%					
School-Based Behavioral Health Intervention & Support	100%					
Violence Prevention Education	100%					
Gang Prevention Services	100%					
Parent Education Services	100%					
Family Support Services	25%		25%	25%	25%	
Children's Support & Parenting	100%					
Transportation Assistance*						100%*

Other Recent California Legislation Affecting PEI Programming

In addition to the MHSOAC Regulations and SB 1004, California has recently passed a number of bills that either directly affect PEI or align with PEI's general goals and purpose. These include:

- **Assembly Bill (AB) 2246 (Pupil Suicide Prevention Policies)**, effective the beginning of the 2017-18 school year, requires schools serving students in grades 7-12 to adopt policy on pupil suicide including prevention, intervention and postvention.
- **SB 972 (Pupil and Student Health: Identification cards: Suicide Prevention Hotline),** effective July 1, 2019, requires schools serving students in grades 7-12 to issue student identification cards that have the National Suicide Prevention Lifeline on the card.
- **AB 293 (Maternal Mental Health Screening and Supports),** effective July 1, 2019**, r**equires obstetricians to confirm that screenings for maternal depression has occurred or to screen women directly, at least once during the pregnancy or the postpartum period. It also requires private and public health plans and health insurers to create maternal health programs.
- **AB 3032 (Hospital Maternal Mental Health)**, effective Jan 1, 2020, requires hospitals to provide maternal mental health training to clinical staff who work with pregnant and postpartum women, and to educate woman and families about the signs and symptoms of maternal mental health disorders as well as local treatment options.

MHSOAC-Required Demographic Fields for PEI-Funded Programs

School Readiness

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
AGE GROUP	Age 0-15 (Child)	1	961	644
	Age 16-25 (TAY)	44	73	63
	Age 26-59 (Adult)	733	841	767
	Age 60+ (Older Adult)	16	5	23
	Decline/Unknown	0	0	0
PRIMARY LANGUGE	Arabic	15	20	9
	English	229	834	699
	Farsi	1	22	8
	Korean	2	0	0
	Spanish	459	885	691
	Vietnamese	96	43	27
	Decline/Unknown	0	27	18
	Other	5	62	42
SEXUAL ORIENTATION	Gay or Lesbian	0	6	5
	Heterosexual	0	1,487	1,369
	Bisexual	0	3	0
	Questioning	0	0	0
	Queer	0	0	0
	Decline/Unknown	0	173	113
	Other	0	0	0

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
RACE	American Indian/Alaska Native	9	8	14
	Asian	118	176	142
	Black/African American	11	40	29
	Native Hawaiian/PI	4	4	2
	White	100	333	261
	Multi-Race	0	0	0
	Decline/Unknown	0	24	30
	Other	8	1,426	0
ETHNICITY	Hispanic/Latino	558	1,408	1,107
	Non-Hispanic/Non-Latino	0	18	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	124	888	687
	Female	694	987	790
	Decline/Unknown	0	20	21
	Other	0	0	0
DISABILITY	Disability "Yes"	0	78	41
	Disability "No"	0	1,576	1,443
	Decline/Unknown	0	38	20
VETERAN STATUS	Veteran "Yes"	0	5	7
	Veteran "No"	0	1,295	1,468
	Decline/Unknown	0	69	22

3/26/2021 8:48:53 AM

Parent Education Services

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
AGE GROUP	Age 0-15 (Child)	1	98	99
	Age 16-25 (TAY)	44	1,524	1,424
	Age 26-59 (Adult)	733	46	44
	Age 60+ (Older Adult)	16	154	0
	Decline/Unknown	0	0	0
PRIMARY LANGUGE	Arabic	15	59	48
	English	229	483	536
	Farsi	1	11	15
	Korean	2	68	0
	Spanish	459	921	731
	Vietnamese	96	131	98
	Decline/Unknown	0	0	0
	Other	5	44	152
SEXUAL ORIENTATION	Gay or Lesbian	0	2	0
	Heterosexual	0	1,170	0
	Bisexual	0	12	0
	Questioning	0	0	0
	Queer	0	2	0
	Decline/Unknown	0	586	0
	Other	0	5	0

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
RACE	American Indian/Alaska Native	9	21	36
	Asian	118	323	329
	Black/African American	11	43	44
	Native Hawaiian/PI	4	12	5
	White	100	259	264
	Multi-Race	0	0	0
	Decline/Unknown	0	106	0
	Other	8	1,759	0
ETHNICITY	Hispanic/Latino	558	1,748	1,024
	Non-Hispanic/Non-Latino	0	11	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	124	350	0
	Female	694	1,276	0
	Decline/Unknown	0	192	0
	Other	0	0	0
DISABILITY	Disability "Yes"	0	263	0
	Disability "No"	0	1,412	0
	Decline/Unknown	0	203	0
VETERAN STATUS	Veteran "Yes"	0	21	0
	Veteran "No"	0	1,499	0
	Decline/Unknown	0	304	0

3/26/2021 8:48:53 AM

Children's Support & Parenting Program

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
AGE GROUP	Age 0-15 (Child)	133	295	281
	Age 16-25 (TAY)	54	60	56
	Age 26-59 (Adult)	265	499	463
	Age 60+ (Older Adult)	4	21	13
	Decline/Unknown	0	0	0
PRIMARY LANGUGE	Arabic	3	2	0
	English	288	364	299
	Farsi	2	1	0
	Korean	0	0	0
	Spanish	136	475	487
	Vietnamese	1	10	15
	Decline/Unknown	8	12	0
	Other	18	13	8
SEXUAL ORIENTATION	Gay or Lesbian	6	6	0
	Heterosexual	376	726	0
	Bisexual	5	7	0
	Questioning	1	1	0
	Queer	0	4	0
	Decline/Unknown	58	128	0
	Other	4	3	0

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
RACE	American Indian/Alaska Native	6	15	0
	Asian	20	32	25
	Black/African American	10	12	3
	Native Hawaiian/PI	1	2	0
	White	59	0	19
	Multi-Race	0	0	0
	Decline/Unknown	7	6	0
	Other	29	747	16
ETHNICITY	Hispanic/Latino	324	743	736
	Non-Hispanic/Non-Latino	51	4	0
	More than one ethnicity	0	0	0
	Decline/Unknown	6	0	0
GENDER	Male	0	328	0
	Female	0	542	0
	Decline/Unknown	0	4	0
	Other	0	1	0
DISABILITY	Disability "Yes"	0	0	0
	Disability "No"	0	0	0
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	40	5	5
	Veteran "No"	345	639	606
	Decline/Unknown	69	62	6

3/26/2021 8:48:53 AM

School-Based Behavioral Health Intervention & Support

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
AGE GROUP	Age 0-15 (Child)	5,819	11,651	18,851
	Age 16-25 (TAY)	206	179	176
	Age 26-59 (Adult)	0	91	130
	Age 60+ (Older Adult)	0	2	4
	Decline/Unknown	0	1	0
PRIMARY LANGUGE	Arabic	14	51	0
	English	5,341	8,500	12,630
	Farsi	5	4	2
	Korean	29	14	205
	Spanish	492	2,932	4,143
	Vietnamese	159	84	0
	Decline/Unknown	0	63	0
	Other	80	263	1,198
SEXUAL ORIENTATION	Gay or Lesbian	0	42	0
	Heterosexual	0	1,951	0
	Bisexual	0	118	0
	Questioning	0	39	0
	Queer	0	6	0
	Decline/Unknown	0	445	0
	Other	0	27	0

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
RACE	American Indian/Alaska Native	90	695	0
	Asian	409	1,573	4,170
	Black/African American	9	304	559
	Native Hawaiian/PI	14	260	0
	White	792	5,267	8,857
	Multi-Race	0	0	0
	Decline/Unknown	569	1,326	0
	Other	0	7,174	284
ETHNICITY	Hispanic/Latino	2,492	7,115	3,558
	Non-Hispanic/Non-Latino	0	59	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	3,133	1,287	0
	Female	3,004	1,249	0
	Decline/Unknown	0	92	0
	Other	0	9	0
DISABILITY	Disability "Yes"	0	496	0
	Disability "No"	0	1,952	0
	Decline/Unknown	0	223	0
VETERAN STATUS	Veteran "Yes"	0	1	0
	Veteran "No"	0	85	0
	Decline/Unknown	0	5	0

3/26/2021 8:48:53 AM

Violence Prevention Education

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
AGE GROUP	Age 0-15 (Child)	7,486	9,375	6,413
	Age 16-25 (TAY)	1,579	1,060	468
	Age 26-59 (Adult)	1,341	1,896	1,325
	Age 60+ (Older Adult)	66	137	62
	Decline/Unknown	0	393	0
PRIMARY LANGUGE	Arabic	45	52	46
	English	5,642	7,707	5,103
	Farsi	41	52	45
	Korean	180	212	78
	Spanish	3,102	3,121	2,122
	Vietnamese	159	640	382
	Decline/Unknown	0	0	0
	Other	498	0	312
SEXUAL ORIENTATION	Gay or Lesbian	0	0	0
	Heterosexual	0	0	0
	Bisexual	0	0	0
	Questioning	0	0	0
	Queer	0	0	0
	Decline/Unknown	0	0	0
	Other	0	0	0

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
RACE	American Indian/Alaska Native	180	526	321
	Asian	1,143	2,879	1,831
	Black/African American	173	454	20
	Native Hawaiian/PI	51	242	162
	White	1,656	2,295	1,597
	Multi-Race	0	0	0
	Decline/Unknown	0	1,202	0
	Other	834	7,335	0
ETHNICITY	Hispanic/Latino	5,281	6,918	4,563
	Non-Hispanic/Non-Latino	0	417	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	0	5,464	3,549
	Female	0	6,704	4,500
	Decline/Unknown	0	688	0
	Other	0	5	0
DISABILITY	Disability "Yes"	0	0	0
	Disability "No"	0	0	0
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	0	0	0
	Veteran "No"	0	0	0
	Decline/Unknown	0	0	0

3/26/2021 8:48:53 AM

Gang Prevention Services

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
AGE GROUP	Age 0-15 (Child)	427	441	431
	Age 16-25 (TAY)	18	3	426
	Age 26-59 (Adult)	407	431	1
	Age 60+ (Older Adult)	2	7	4
	Decline/Unknown	0	0	0
PRIMARY LANGUGE	Arabic	0	0	0
	English	345	535	560
	Farsi	0	0	2
	Korean	0	0	0
	Spanish	509	344	293
	Vietnamese	0	1	1
	Decline/Unknown	0	0	0
	Other	0	2	0
SEXUAL ORIENTATION	Gay or Lesbian	0	0	0
	Heterosexual	0	0	0
	Bisexual	0	0	0
	Questioning	0	0	0
	Queer	0	0	0
	Decline/Unknown	0	0	0
	Other	0	0	0

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
RACE	American Indian/Alaska Native	0	3	8
	Asian	10	12	6
	Black/African American	16	16	19
	Native Hawaiian/PI	22	7	8
	White	42	31	43
	Multi-Race	0	0	0
	Decline/Unknown	0	0	0
	Other	2	1,203	0
ETHNICITY	Hispanic/Latino	762	1,203	793
	Non-Hispanic/Non-Latino	0	0	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	0	0	0
	Female	0	0	0
	Decline/Unknown	0	0	0
	Other	0	0	0
DISABILITY	Disability "Yes"	0	2	0
	Disability "No"	0	0	0
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	0	0	0
	Veteran "No"	0	0	0
	Decline/Unknown	0	0	0

3/26/2021 8:48:53 AM

Family Support Services

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
AGE GROUP	Age 0-15 (Child)	192	1	0
	Age 16-25 (TAY)	191	36	24
	Age 26-59 (Adult)	361	320	257
	Age 60+ (Older Adult)	154	143	105
	Decline/Unknown	0	106	0
PRIMARY LANGUGE	Arabic	4	0	1
	English	509	483	345
	Farsi	3	5	2
	Korean	3	0	2
	Spanish	56	51	24
	Vietnamese	4	1	1
	Decline/Unknown	0	56	0
	Other	20	13	14
SEXUAL ORIENTATION	Gay or Lesbian	0	5	0
	Heterosexual	0	231	0
	Bisexual	0	4	0
	Questioning	0	1	0
	Queer	0	3	0
	Decline/Unknown	0	367	0
	Other	0	1	0

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
RACE	American Indian/Alaska Native	9	15	6
	Asian	69	51	46
	Black/African American	13	24	3
	Native Hawaiian/PI	4	4	9
	White	332	331	214
	Multi-Race	0	0	0
	Decline/Unknown	0	85	0
	Other	19	135	0
ETHNICITY	Hispanic/Latino	56	124	112
	Non-Hispanic/Non-Latino	54	11	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	0	139	0
	Female	0	207	0
	Decline/Unknown	0	0	0
	Other	0	1	0
DISABILITY	Disability "Yes"	0	260	0
	Disability "No"	0	156	0
	Decline/Unknown	0	276	0
VETERAN STATUS	Veteran "Yes"	0	13	0
	Veteran "No"	0	265	0
	Decline/Unknown	0	332	0

3/26/2021 8:48:53 AM

Outreach for Increasing Recognition of Early Signs of Mental Illness

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
AGE GROUP	Age 0-15 (Child)	28,663	4,130	3,719
	Age 16-25 (TAY)	22,043	2,165	1,639
	Age 26-59 (Adult)	65,560	1,492	2,336
	Age 60+ (Older Adult)	14,195	766	485
	Decline/Unknown	0	775	33
PRIMARY LANGUGE	Arabic	31	44	280
	English	74,104	5,964	5,101
	Farsi	7,077	492	372
	Korean	2,980	72	93
	Spanish	39,717	1,273	1,322
	Vietnamese	2,957	95	86
	Decline/Unknown	0	1,078	338
	Other	4,307	378	389
SEXUAL ORIENTATION	Gay or Lesbian	0	33	0
	Heterosexual	0	2,263	0
	Bisexual	0	56	0
	Questioning	0	16	0
	Queer	0	7	0
	Decline/Unknown	0	2,701	0
	Other	0	9	0

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
RACE	American Indian/Alaska Native	94	258	371
	Asian	19,876	1,877	1,438
	Black/African American	2,368	335	334
	Native Hawaiian/PI	115	39	120
	White	27,392	2,588	2,696
	Multi-Race	0	0	0
	Decline/Unknown	0	733	917
	Other	8,832	3,015	236
ETHNICITY	Hispanic/Latino	609	4,379	4,106
	Non-Hispanic/Non-Latino	14,433	0	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	0	1,081	1,561
	Female	0	2,412	2,535
	Decline/Unknown	0	304	263
	Other	0	20	12
DISABILITY	Disability "Yes"	0	572	852
	Disability "No"	0	2,088	2,637
	Decline/Unknown	0	2,516	917
VETERAN STATUS	Veteran "Yes"	0	36	46
	Veteran "No"	0	2,336	3,241
	Decline/Unknown	0	2,404	880

3/26/2021 8:48:53 AM

Warmline

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
AGE GROUP	Age 0-15 (Child)	44	28,270	73
	Age 16-25 (TAY)	2,184	57	2,427
	Age 26-59 (Adult)	22,360	1,808	38,832
	Age 60+ (Older Adult)	8,908	9,721	16,213
	Decline/Unknown	0	2,491	0
PRIMARY LANGUGE	Arabic	6	6	127
	English	37,028	23,049	49,960
	Farsi	2	6	244
	Korean	0	1	117
	Spanish	137	133	1,664
	Vietnamese	4	0	775
	Decline/Unknown	0	0	0
	Other	18	23	3,234
SEXUAL ORIENTATION	Gay or Lesbian	0	0	1,519
	Heterosexual	0	0	46,257
	Bisexual	0	0	3,732
	Questioning	0	0	820
	Queer	0	0	22
	Decline/Unknown	0	0	3,599
	Other	0	560	322

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
RACE	American Indian/Alaska Native	0	0	305
	Asian	0	0	6,009
	Black/African American	0	0	13,209
	Native Hawaiian/PI	0	0	0
	White	0	0	0
	Multi-Race	0	0	0
	Decline/Unknown	0	0	8,684
	Other	0	0	0
ETHNICITY	Hispanic/Latino	0	0	4,664
	Non-Hispanic/Non-Latino	0	0	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	0	8,569	20,450
	Female	0	14,480	35,799
	Decline/Unknown	0	339	701
	Other	0	0	17
DISABILITY	Disability "Yes"	0	1,302	6,045
	Disability "No"	0	6,363	13,501
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	0	0	2,578
	Veteran "No"	0	0	47,688
	Decline/Unknown	0	0	7,039

3/26/2021 8:48:53 AM

Suicide Prevention Services (Crisis Prevention Hotline)

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
AGE GROUP	Age 0-15 (Child)	0	663	712
	Age 16-25 (TAY)	2,737	2,923	2,932
	Age 26-59 (Adult)	2,415	3,108	3,181
	Age 60+ (Older Adult)	298	483	517
	Decline/Unknown	0	0	0
PRIMARY LANGUGE	Arabic	0	0	0
	English	10,970	0	13,613
	Farsi	0	0	0
	Korean	4	11	5
	Spanish	630	370	197
	Vietnamese	3	2	2
	Decline/Unknown	0	0	0
	Other	0	2	1
SEXUAL ORIENTATION	Gay or Lesbian	0	0	0
	Heterosexual	0	0	0
	Bisexual	0	0	0
	Questioning	0	0	0
	Queer	0	0	0
	Decline/Unknown	0	0	0
	Other	0	0	0

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
RACE	American Indian/Alaska Native	34	21	21
	Asian	350	1,219	987
	Black/African American	252	241	233
	Native Hawaiian/PI	32	60	38
	White	2,261	2,654	2,649
	Multi-Race	0	0	0
	Decline/Unknown	0	0	0
	Other	323	2,082	0
ETHNICITY	Hispanic/Latino	1,600	1,796	1,507
	Non-Hispanic/Non-Latino	0	286	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	0	4,172	4,660
	Female	0	5,313	4,749
	Decline/Unknown	0	184	633
	Other	0	0	0
DISABILITY	Disability "Yes"	0	0	0
	Disability "No"	0	0	0
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	0	0	0
	Veteran "No"	0	0	0
	Decline/Unknown	0	0	0

3/26/2021 8:48:53 AM

Suicide Prevention Services (Survivor Support Services)

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
AGE GROUP	Age 0-15 (Child)	10	7	12
	Age 16-25 (TAY)	16	8	11
	Age 26-59 (Adult)	96	76	83
	Age 60+ (Older Adult)	25	25	21
	Decline/Unknown	0	0	0
PRIMARY LANGUGE	Arabic	1	0	0
	English	122	116	119
	Farsi	2	1	2
	Korean	4	2	0
	Spanish	17	13	25
	Vietnamese	0	0	1
	Decline/Unknown	0	0	0
	Other	2	0	5
SEXUAL ORIENTATION	Gay or Lesbian	0	2	0
	Heterosexual	0	87	0
	Bisexual	0	2	0
	Questioning	0	1	0
	Queer	0	0	0
	Decline/Unknown	0	30	0
	Other	0	0	0

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
RACE	American Indian/Alaska Native	1	5	4
	Asian	19	14	25
	Black/African American	0	2	6
	Native Hawaiian/PI	1	4	0
	White	74	77	70
	Multi-Race	0	0	0
	Decline/Unknown	0	11	0
	Other	8	39	0
ETHNICITY	Hispanic/Latino	17	37	58
	Non-Hispanic/Non-Latino	0	2	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	43	30	0
	Female	105	100	0
	Decline/Unknown	0	9	0
	Other	0	0	0
DISABILITY	Disability "Yes"	0	0	0
	Disability "No"	0	0	0
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	0	1	0
	Veteran "No"	0	95	0
	Decline/Unknown	0	33	0

3/26/2021 8:48:53 AM

OC Links

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
AGE GROUP	Age 0-15 (Child)	15	25	19
	Age 16-25 (TAY)	1,666	1,658	1,282
	Age 26-59 (Adult)	10,357	10,570	7,046
	Age 60+ (Older Adult)	1,900	1,856	1,345
	Decline/Unknown	3,571	4,019	3,600
PRIMARY LANGUGE	Arabic	6	9	3
	English	15,507	15,820	11,684
	Farsi	92	152	114
	Korean	93	82	38
	Spanish	1,522	1,774	1,297
	Vietnamese	234	225	116
	Decline/Unknown	6	1	1
	Other	49	65	39
SEXUAL ORIENTATION	Gay or Lesbian	0	0	0
	Heterosexual	0	0	0
	Bisexual	0	0	0
	Questioning	0	0	0
	Queer	0	0	0
	Decline/Unknown	0	0	0
	Other	13	19	12

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
RACE	American Indian/Alaska Native	89	91	62
	Asian	1,168	1,165	728
	Black/African American	540	511	297
	Native Hawaiian/PI	35	42	25
	White	6,833	6,497	4,584
	Multi-Race	0	0	0
	Decline/Unknown	3,587	4,222	3,429
	Other	5,257	5,600	4,167
ETHNICITY	Hispanic/Latino	5,257	5,600	4,167
	Non-Hispanic/Non-Latino	1,426	1,273	715
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	0	0	0
	Female	0	0	0
	Decline/Unknown	0	0	0
	Other	0	0	0
DISABILITY	Disability "Yes"	10	12	9
	Disability "No"	0	0	0
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	44	25	57
	Veteran "No"	0	0	0
	Decline/Unknown	0	0	0

3/26/2021 8:48:53 AM

BHS Outreach & Engagement (O&E)

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
AGE GROUP	Age 0-15 (Child)	138	116	127
	Age 16-25 (TAY)	1,628	1,234	952
	Age 26-59 (Adult)	25,303	24,388	29,108
	Age 60+ (Older Adult)	5,839	6,164	8,873
	Decline/Unknown	3,936	216	501
		36,844	32,118	39,561
PRIMARY LANGUGE	Arabic	8	0	5
	English	30,027	24,719	32,187
	Farsi	56	63	37
	Korean	14	9	7
	Spanish	3,624	4,196	2,433
	Vietnamese	2,719	1,906	4,466
	Decline/Unknown	327	27	15
	Other	69	100	31
		36,844	31,020	39,181
SEXUAL ORIENTATION	Gay or Lesbian	0	0	6
	Heterosexual	0	0	219
	Bisexual	0	0	8
	Questioning	0	0	1
	Queer	0	0	0
	Decline/Unknown	0	0	10
	Other	0	0	109

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
RACE	American Indian/Alaska Native	0	0	50
	Asian	3,615	2,602	5,000
	Black/African American	3,460	2,772	2,741
	Native Hawaiian/PI	0	0	0
	White	15,001	15,473	19,968
	Multi-Race	0	8	17
	Decline/Unknown	4,394	1,882	493
	Other	198	10,937	5,377
ETHNICITY	Hispanic/Latino	10,176	10,814	2,895
	Non-Hispanic/Non-Latino	0	0	1,171
	More than one ethnicity	0	0	17
	Decline/Unknown	0	0	0
GENDER	Male	0	0	99
	Female	0	0	113
	Decline/Unknown	0	0	31
	Other	0	0	0
DISABILITY	Disability "Yes"	0	0	1,555
	Disability "No"	0	0	54
	Decline/Unknown	0	0	7
VETERAN STATUS	Veteran "Yes"	0	0	369
	Veteran "No"	0	0	206
	Decline/Unknown	0	0	26

3/26/2021 8:48:53 AM

School-Based Mental Health Services

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
AGE GROUP	Age 0-15 (Child)	1,580	2,675	2,381
	Age 16-25 (TAY)	247	287	197
	Age 26-59 (Adult)	144	0	0
	Age 60+ (Older Adult)	3	0	0
	Decline/Unknown	0	1	4
PRIMARY LANGUGE	Arabic	3	8	3
	English	1,535	2,543	2,234
	Farsi	3	1	2
	Korean	6	3	1
	Spanish	346	346	290
	Vietnamese	24	5	2
	Decline/Unknown	0	10	24
	Other	56	47	23
SEXUAL ORIENTATION	Gay or Lesbian	0	0	0
	Heterosexual	69	0	0
	Bisexual	2	0	0
	Questioning	1	0	0
	Queer	0	0	0
	Decline/Unknown	6	0	0
	Other	2	0	0

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
RACE	American Indian/Alaska Native	29	38	36
	Asian	129	191	167
	Black/African American	16	36	34
	Native Hawaiian/PI	8	12	11
	White	291	463	326
	Multi-Race	0	0	94
	Decline/Unknown	0	66	79
	Other	175	1,452	18
ETHNICITY	Hispanic/Latino	1,298	2,046	1,814
	Non-Hispanic/Non-Latino	0	0	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	693	1,573	0
	Female	668	1,379	0
	Decline/Unknown	0	6	0
	Other	0	4	0
DISABILITY	Disability "Yes"	0	0	0
	Disability "No"	0	0	0
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	0	3	213
	Veteran "No"	0	2,435	2,145
	Decline/Unknown	0	274	221

3/26/2021 8:48:53 AM

1st Onset of Psychiatric Illness (OC CREW)

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
AGE GROUP	Age 0-15 (Child)	32	16	20
	Age 16-25 (TAY)	59	56	35
	Age 26-59 (Adult)	0	1	0
	Age 60+ (Older Adult)	0	0	0
	Decline/Unknown	91	0	0
PRIMARY LANGUGE	Arabic	0	0	0
	English	69	54	43
	Farsi	0	0	0
	Korean	3	3	2
	Spanish	16	13	7
	Vietnamese	1	1	1
	Decline/Unknown	0	0	0
	Other	2	2	2
SEXUAL ORIENTATION	Gay or Lesbian	0	0	0
	Heterosexual	1	0	0
	Bisexual	0	0	0
	Questioning	0	0	0
	Queer	0	0	0
	Decline/Unknown	1	0	0
	Other	0	0	0

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
RACE	American Indian/Alaska Native	0	0	0
	Asian	14	13	14
	Black/African American	2	2	1
	Native Hawaiian/PI	1	1	1
	White	21	16	6
	Multi-Race	0	0	0
	Decline/Unknown	91	1	0
	Other	9	49	6
ETHNICITY	Hispanic/Latino	44	33	27
	Non-Hispanic/Non-Latino	26	16	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	0	0	0
	Female	0	0	0
	Decline/Unknown	0	0	0
	Other	0	0	0
DISABILITY	Disability "Yes"	0	0	0
	Disability "No"	0	0	0
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	0	8	7
	Veteran "No"	2	54	43
	Decline/Unknown	0	11	5

3/26/2021 8:48:53 AM

OC Parent Wellness Program

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
AGE GROUP	Age 0-15 (Child)	9	17	4
	Age 16-25 (TAY)	179	287	164
	Age 26-59 (Adult)	460	377	572
	Age 60+ (Older Adult)	6	5	6
	Decline/Unknown	0	0	0
PRIMARY LANGUGE	Arabic	4	6	3
	English	330	344	448
	Farsi	2	3	1
	Korean	1	2	1
	Spanish	295	304	274
	Vietnamese	12	11	9
	Decline/Unknown	0	0	0
	Other	10	16	10
SEXUAL ORIENTATION	Gay or Lesbian	0	0	0
	Heterosexual	48	0	0
	Bisexual	1	0	0
	Questioning	0	0	0
	Queer	0	0	0
	Decline/Unknown	0	0	0
	Other	1	0	0

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
RACE	American Indian/Alaska Native	1	0	1
	Asian	36	38	52
	Black/African American	8	15	18
	Native Hawaiian/PI	11	5	8
	White	84	71	131
	Multi-Race	0	1	0
	Decline/Unknown	2	3	5
	Other	11	419	12
ETHNICITY	Hispanic/Latino	503	507	519
	Non-Hispanic/Non-Latino	20	18	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	16	27	0
	Female	132	659	0
	Decline/Unknown	0	0	0
	Other	0	0	0
DISABILITY	Disability "Yes"	0	0	0
	Disability "No"	0	0	0
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	41	3	54
	Veteran "No"	449	610	670
	Decline/Unknown	0	26	22

3/26/2021 8:48:53 AM

Community Counseling & Supportive Services

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
AGE GROUP	Age 0-15 (Child)	50	29	40
	Age 16-25 (TAY)	136	100	118
	Age 26-59 (Adult)	403	347	313
	Age 60+ (Older Adult)	24	20	22
	Decline/Unknown	0	0	0
PRIMARY LANGUGE	Arabic	29	24	24
	English	281	229	247
	Farsi	3	1	1
	Korean	1	0	0
	Spanish	278	214	201
	Vietnamese	7	5	2
	Decline/Unknown	0	0	0
	Other	14	8	18
SEXUAL ORIENTATION	Gay or Lesbian	0	0	0
	Heterosexual	26	0	0
	Bisexual	1	0	0
	Questioning	0	0	0
	Queer	0	0	0
	Decline/Unknown	9	0	0
	Other	4	0	0

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
RACE	American Indian/Alaska Native	9	4	0
	Asian	42	30	44
	Black/African American	12	8	7
	Native Hawaiian/PI	3	3	3
	White	91	75	100
	Multi-Race	0	0	0
	Decline/Unknown	9	14	10
	Other	41	283	15
ETHNICITY	Hispanic/Latino	392	316	314
	Non-Hispanic/Non-Latino	39	1	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	56	151	32
	Female	44	329	22
	Decline/Unknown	3	3	2
	Other	3	2	5
DISABILITY	Disability "Yes"	0	0	0
	Disability "No"	0	0	0
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	58	10	52
	Veteran "No"	507	399	400
	Decline/Unknown	2	44	41

3/26/2021 8:48:53 AM

Early Intervention Services for Older Adults

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
AGE GROUP	Age 0-15 (Child)	0	0	0
	Age 16-25 (TAY)	0	0	0
	Age 26-59 (Adult)	3	3	6
	Age 60+ (Older Adult)	598	506	938
	Decline/Unknown	0	0	0
PRIMARY LANGUGE	Arabic	35	27	51
	English	127	152	268
	Farsi	52	30	56
	Korean	31	25	104
	Spanish	138	100	204
	Vietnamese	119	98	136
	Decline/Unknown	0	0	2
	Other	99	73	134
SEXUAL ORIENTATION	Gay or Lesbian	0	3	0
	Heterosexual	0	298	0
	Bisexual	0	0	0
	Questioning	0	1	0
	Queer	0	0	0
	Decline/Unknown	0	58	0
	Other	0	1	0

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
RACE	American Indian/Alaska Native	0	0	5
	Asian	234	126	391
	Black/African American	7	12	14
	Native Hawaiian/PI	1	0	1
	White	193	179	303
	Multi-Race	0	0	0
	Decline/Unknown	0	0	4
	Other	8	114	2
ETHNICITY	Hispanic/Latino	154	114	0
	Non-Hispanic/Non-Latino	242	0	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	0	126	283
	Female	0	378	662
	Decline/Unknown	0	0	0
	Other	0	0	0
DISABILITY	Disability "Yes"	0	1,193	1,927
	Disability "No"	0	34	135
	Decline/Unknown	0	5	22
VETERAN STATUS	Veteran "Yes"	0	14	49
	Veteran "No"	0	470	875
	Decline/Unknown	0	7	21

3/26/2021 8:48:53 AM

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
AGE GROUP	Age 0-15 (Child)	0	0	193
	Age 16-25 (TAY)	13	35	73
	Age 26-59 (Adult)	95	146	395
	Age 60+ (Older Adult)	10	18	53
	Decline/Unknown	0	1	8
PRIMARY LANGUGE	Arabic	0	0	0
	English	114	185	693
	Farsi	0	0	0
	Korean	0	0	0
	Spanish	1	4	9
	Vietnamese	0	2	5
	Decline/Unknown	0	8	14
	Other	0	1	1
SEXUAL ORIENTATION	Gay or Lesbian	0	1	3
	Heterosexual	7	75	538
	Bisexual	0	4	5
	Questioning	0	0	0
	Queer	0	0	3
	Decline/Unknown	54	2	172
	Other	0	0	1

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
RACE	American Indian/Alaska Native	1	1	6
	Asian	5	26	29
	Black/African American	9	11	50
	Native Hawaiian/PI	0	1	1
	White	40	64	290
	Multi-Race	0	0	74
	Decline/Unknown	0	51	116
	Other	2	53	150
ETHNICITY	Hispanic/Latino	18	48	138
	Non-Hispanic/Non-Latino	2	30	60
	More than one ethnicity	0	22	27
	Decline/Unknown	0	0	5
GENDER	Male	0	61	347
	Female	0	20	232
	Decline/Unknown	0	1	15
	Other	0	0	0
DISABILITY	Disability "Yes"	0	87	230
	Disability "No"	0	29	344
	Decline/Unknown	0	10	97
VETERAN STATUS	Veteran "Yes"	101	163	369
	Veteran "No"	10	9	338
	Decline/Unknown	6	28	15

3/26/2021 8:48:53 AM

Alcohol & Drug Prevention

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
AGE GROUP	Age 0-15 (Child)	1,874	1,989	1,463
	Age 16-25 (TAY)	310	437	215
	Age 26-59 (Adult)	1	0	0
	Age 60+ (Older Adult)	0	0	0
	Decline/Unknown	0	0	0
PRIMARY LANGUGE	Arabic	7	5	8
	English	2,021	2,195	1,492
	Farsi	11	7	14
	Korean	4	12	2
	Spanish	86	145	124
	Vietnamese	1	13	12
	Decline/Unknown	0	24	0
	Other	38	25	19
SEXUAL ORIENTATION	Gay or Lesbian	0	0	0
	Heterosexual	0	0	0
	Bisexual	0	0	0
	Questioning	0	0	0
	Queer	0	0	0
	Decline/Unknown	0	0	0
	Other	0	0	0

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
RACE	American Indian/Alaska Native	52	0	10
	Asian	185	317	187
	Black/African American	57	60	29
	Native Hawaiian/PI	15	19	7
	White	818	812	525
	Multi-Race	0	0	0
	Decline/Unknown	0	0	0
	Other	163	1,125	94
ETHNICITY	Hispanic/Latino	847	1,125	772
	Non-Hispanic/Non-Latino	202	0	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	0	1,388	0
	Female	0	1,015	0
	Decline/Unknown	0	19	0
	Other	0	2	0
DISABILITY	Disability "Yes"	0	0	0
	Disability "No"	0	0	0
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	245	1	191
	Veteran "No"	1,723	1,873	1,300
	Decline/Unknown	190	265	181

3/26/2021 8:48:53 AM

APPENDIX IV: INN Regulations

The MHSOAC also established regulations specific to Innovation projects, including:

- A County may expend Innovation funds on a specific project only after receiving approval from the MHSOAC.
- Innovation projects must do one of the following:
    - Introduce a mental health practice or approach that is new to the overall mental health system, including, but not limited to, prevention and early intervention.
    - Make a change to an existing practice in the field of mental health, including but not limited to, application to a new population.
    - Apply to the mental health system a promising community-driven practice or approach that has been successful in non-mental health contexts or settings.
- Innovation projects must select one of the following purposes:
    - Increase access to mental health services to underserved groups.
    - Increase the quality of mental health services, including measureable outcomes.
    - Promote interagency and community collaboration related to mental health services or supports or outcomes.
    - Increase access to mental health services.

These elements are described in each INN project description contained within this Plan.

MHSOAC Demographic information for active INN projects that enroll participants are on the following pages.

Continuum of Care for Veterans and Military Families

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
AGE GROUP	Age 0-15 (Child)	0	68	0
	Age 16-25 (TAY)	0	20	0
	Age 26-59 (Adult)	0	47	0
	Age 60+ (Older Adult)	0	4	0
	Decline/Unknown	0	2	0
PRIMARY LANGUGE	Arabic	0	0	0
	English	0	132	0
	Farsi	0	0	0
	Korean	0	0	0
	Spanish	0	8	0
	Vietnamese	0	1	0
	Decline/Unknown	0	0	0
	Other	0	0	0
SEXUAL ORIENTATION	Gay or Lesbian	0	0	0
	Heterosexual	0	138	0
	Bisexual	0	0	0
	Questioning	0	0	0
	Queer	0	0	0
	Decline/Unknown	0	3	0
	Other	0	0	0

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
RACE	American Indian/Alaska Native	0	1	0
	Asian	0	7	0
	Black/African American	0	17	0
	Native Hawaiian/PI	0	0	0
	White	0	60	0
	Multi-Race	0	13	0
	Decline/Unknown	0	6	0
	Other	0	1	0
ETHNICITY	Hispanic/Latino	0	50	0
	Non-Hispanic/Non-Latino	0	42	0
	More than one ethnicity	0	4	0
	Decline/Unknown	0	45	0
GENDER	Male	0	65	0
	Female	0	42	0
	Decline/Unknown	0	4	0
	Other	0	45	0
DISABILITY	Disability "Yes"	0	22	0
	Disability "No"	0	105	0
	Decline/Unknown	0	15	0
VETERAN STATUS	Veteran "Yes"	0	21	0
	Veteran "No"	0	120	0
	Decline/Unknown	0	0	0

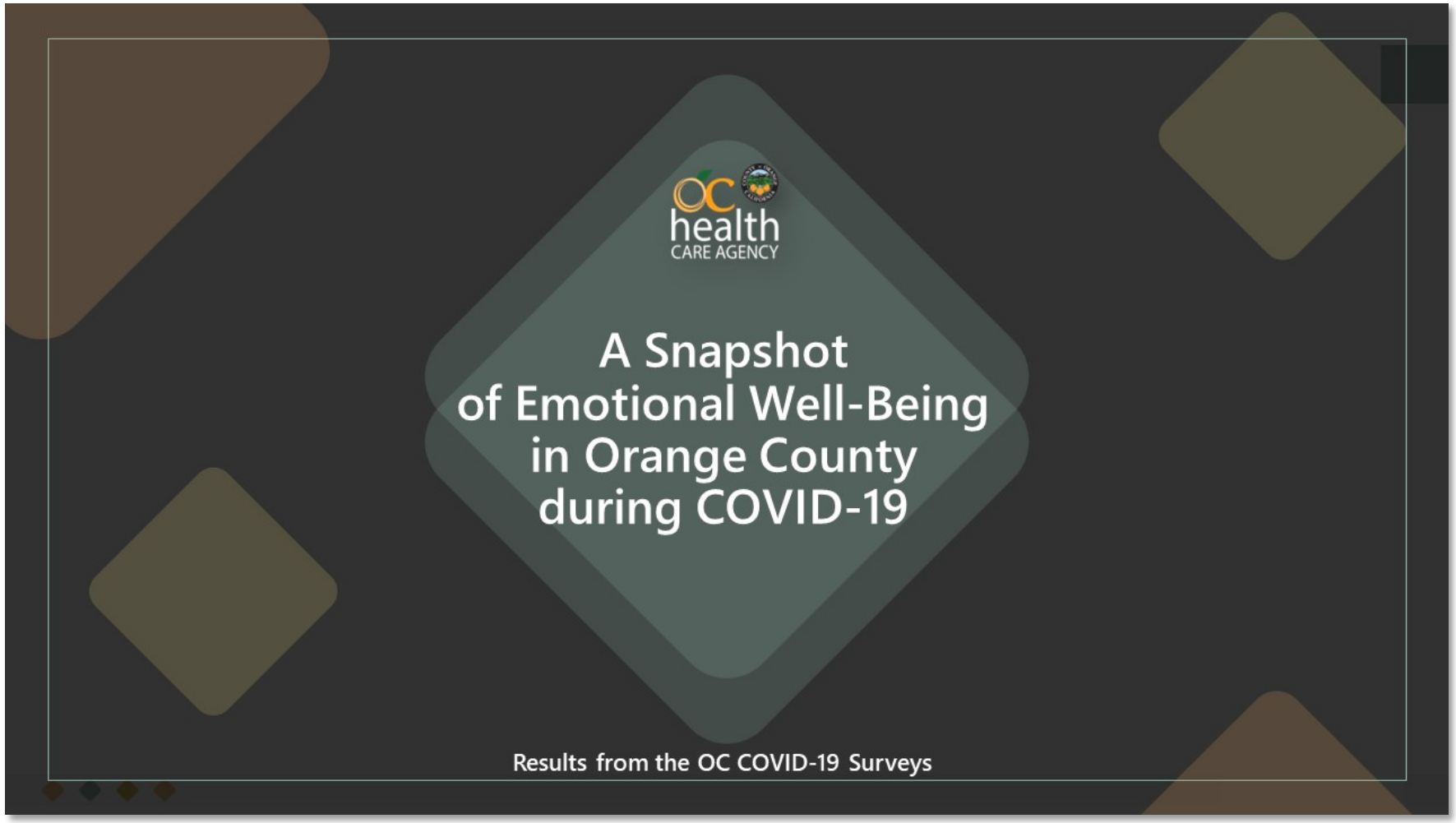
3/26/2021 8:48:53 AM

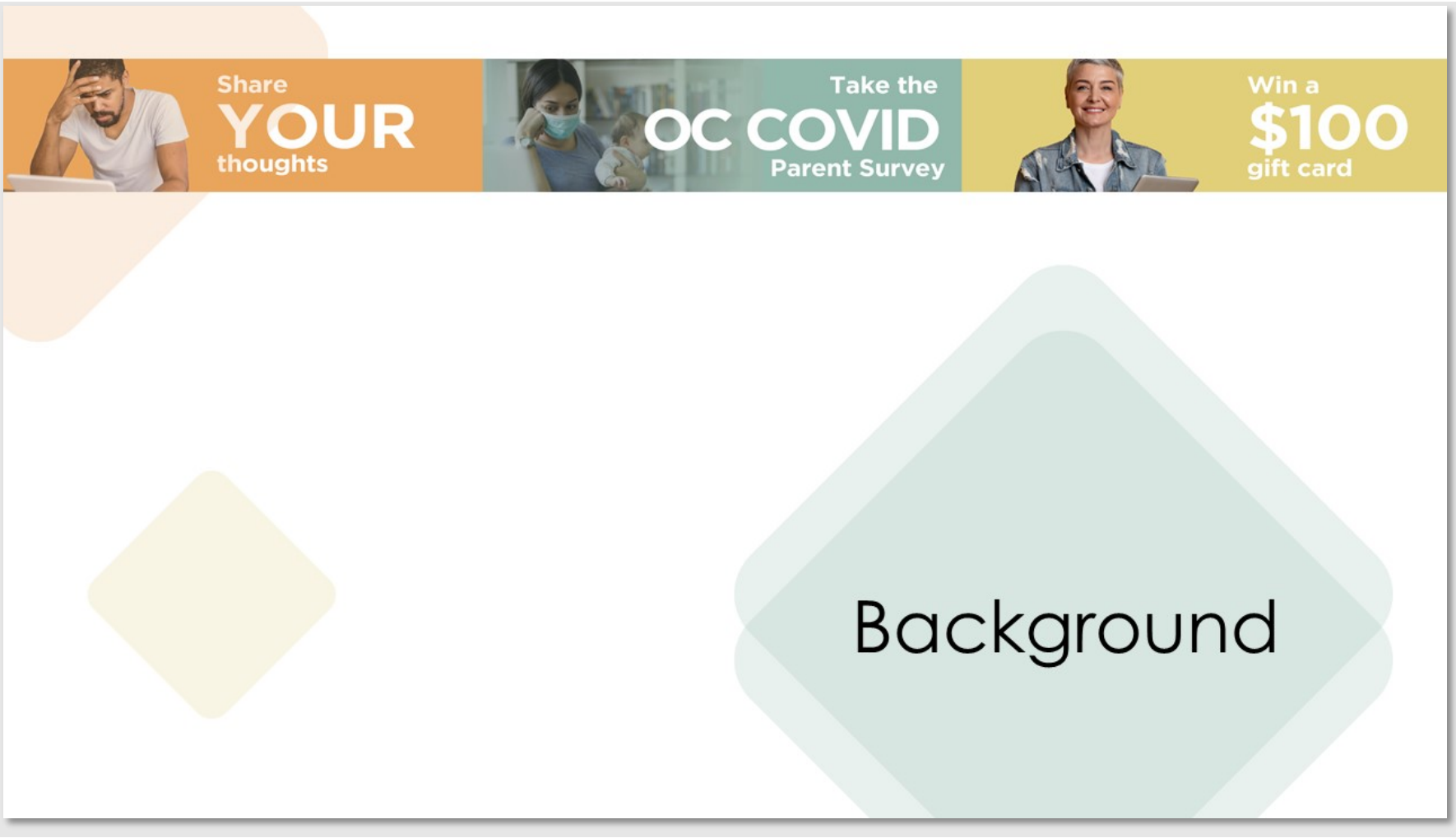
Help@Hand: Mindstrong

Enrolled in Mindstrong

MHSOAC PEI Demographic Categories		FY 17-18	FY 18-19	FY 19-20
AGE GROUP	Age 0-15 (Child)	0	0	0
	Age 16-25 (TAY)	0	0	1
	Age 26-59 (Adult)	0	0	5
	Age 60+ (Older Adult)	0	0	1
	Mean Age:	0	0	29
GENDER	Male	0	0	2
	Female	0	0	5
	Decline/Unknown	0	0	0
	Other	0	0	0

APPENDIX V: A Snapshot of Emotional Well-Bring in Orange County during COVID-19




Share
YOUR
thoughts
Take the
OC COVID
Parent Survey
Win a
$100
gift card
Background

CDC COVID-19 SURVEY

3

Among 5,412 US adults responding to a CDC survey in late June 2020…

31%

Reported **anxiety or depressive symptoms**

11%

Seriously considered **suicide**

13%

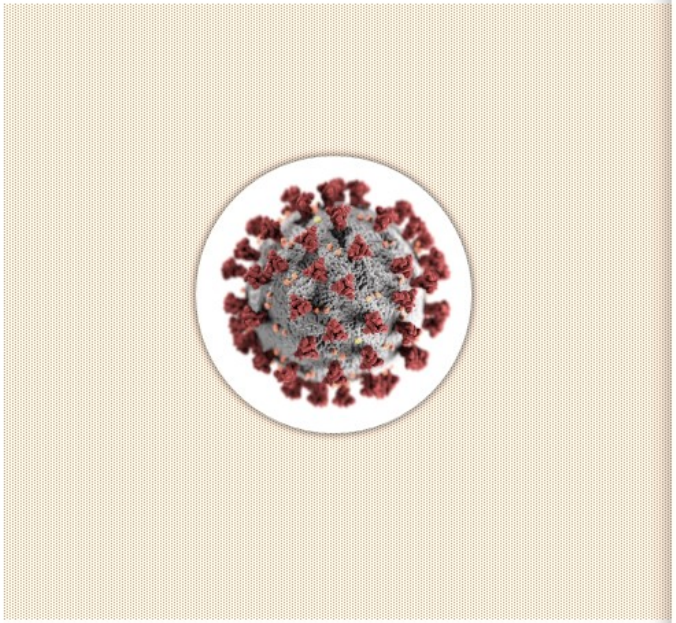
Started or increased **substance use** in a way not recommended by their physician

… in the 30 days preceding the survey

from: "MENTAL HEALTH, SUBSTANCE USE, AND SUICIDAL IDEATION DURING THE COVID-19 PANDEMIC — UNITED STATES, JUNE 24–30, 2020"

https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6932a1-H.pdf

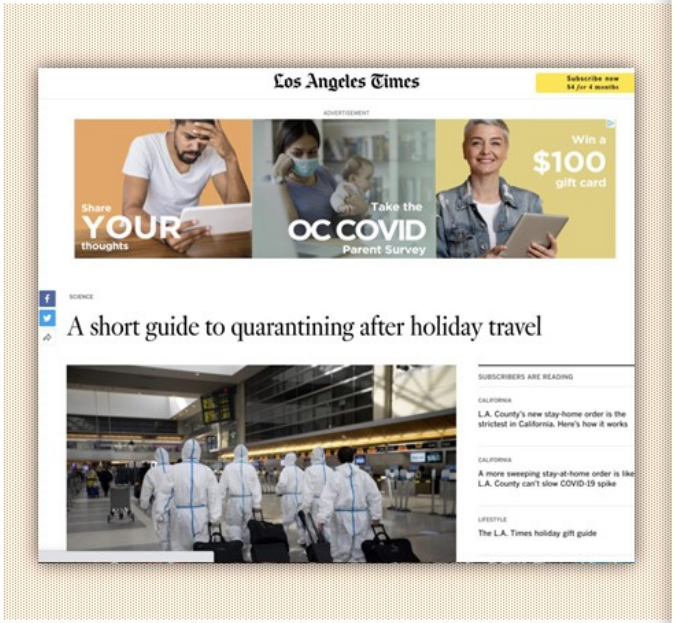
OC COVID-19 SURVEYS: WHY?



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


Share
YOUR
thoughts
Take the
OC COVID
Parent Survey
Win a
$100
gift card
The Surveys

OC COVID-19 SURVEYS: WHAT?

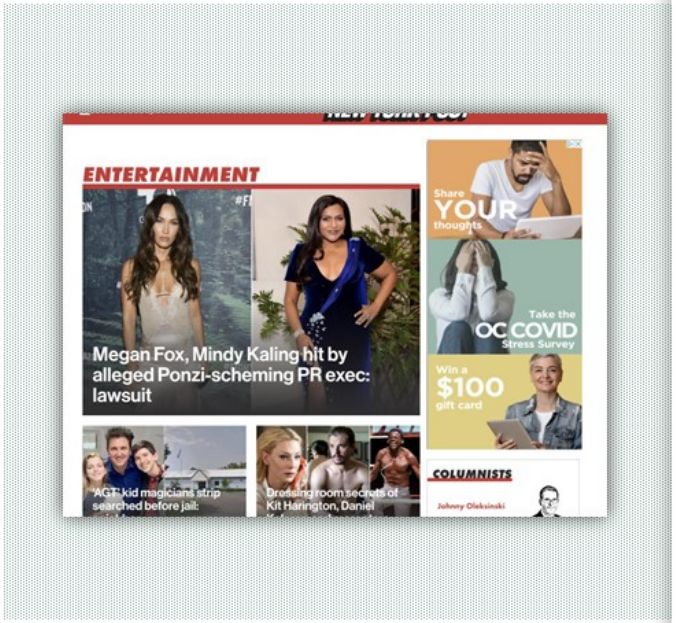


COVID-19 Related Items:
Adapted from CDC survey

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

Checklists on:
Coping Strategies, Healthcare Access, Barriers

OC COVID-19 SURVEYS: WHO?

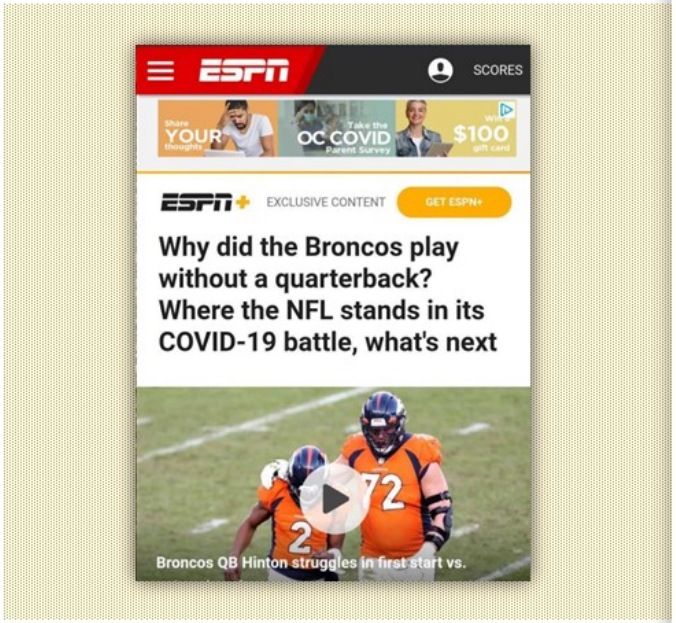


Any Orange County adult ages 18+ years old *or* adult parent of a child ages 4-17 years

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

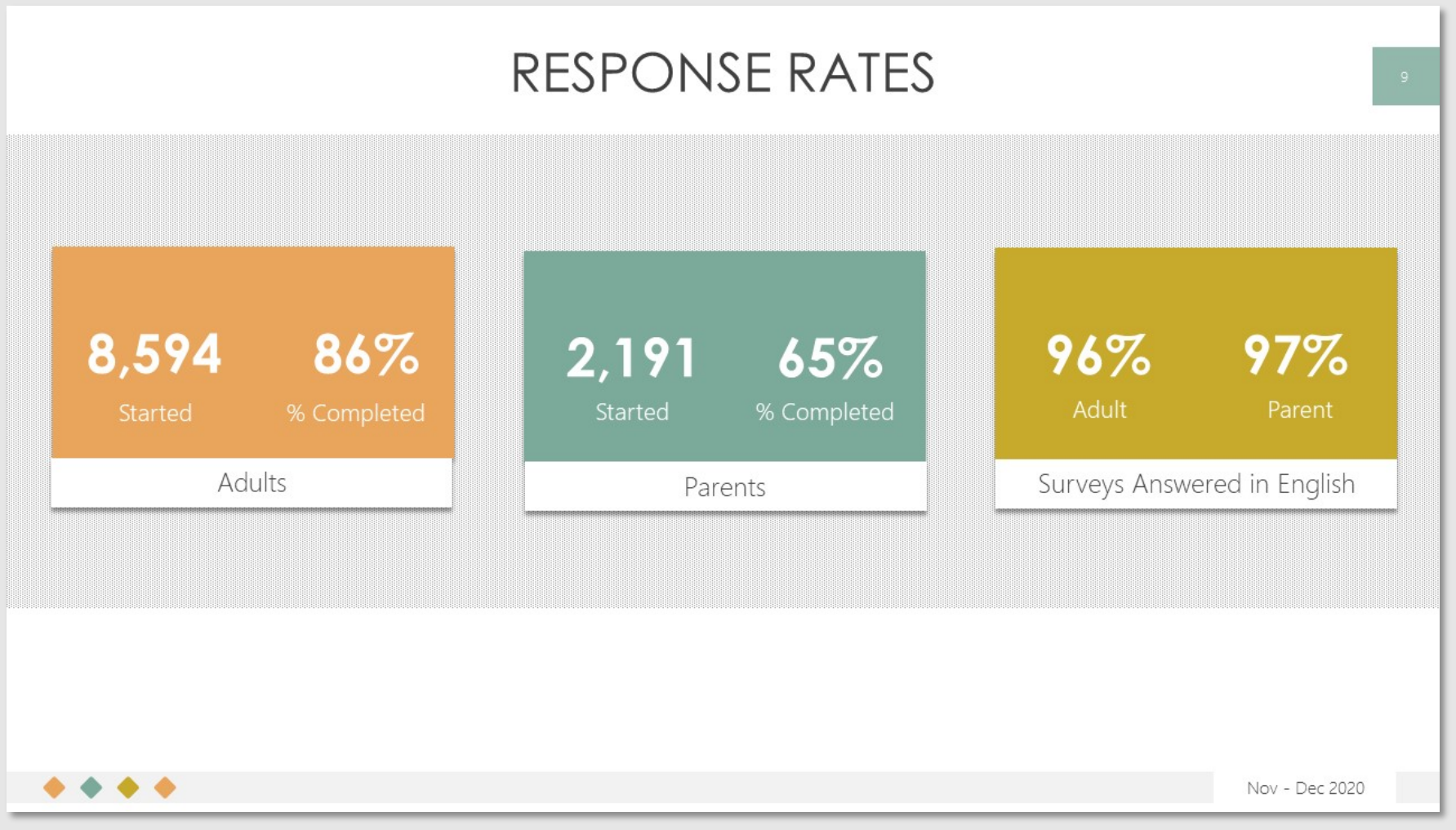
Fluent in Arabic, English, Farsi, Khmer, Korean, Mandarin Chinese, Spanish, Vietnamese

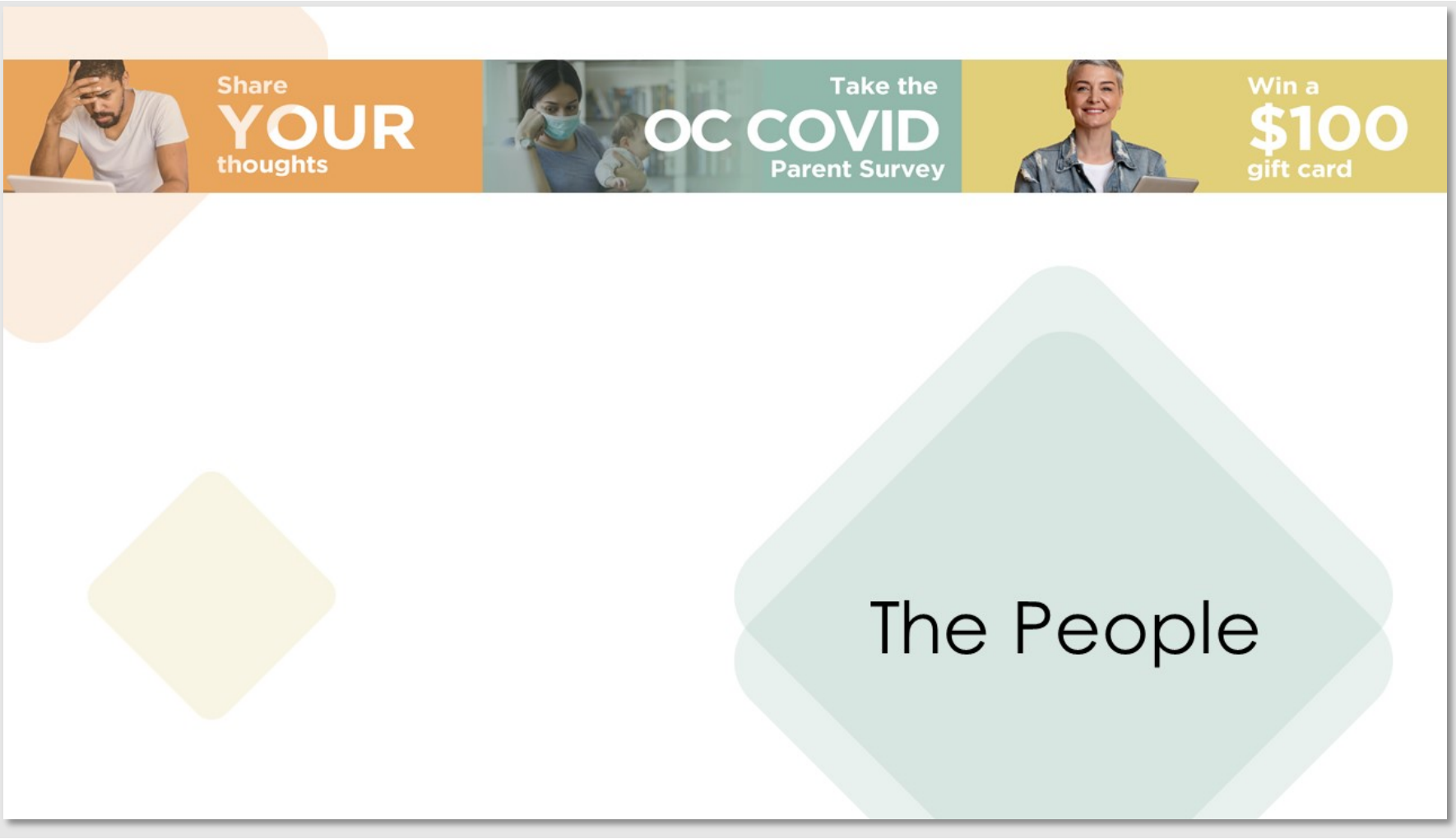
OC COVID-19 SURVEYS: HOW?



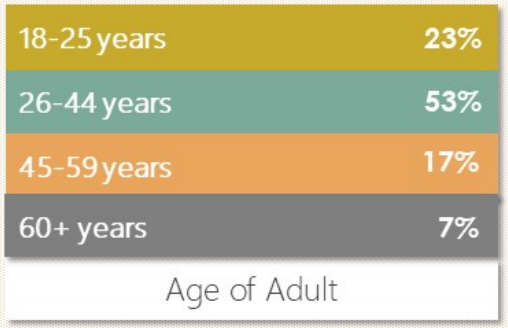
- Countywide digital media marketing campaign, ads on internet and social media
- Anonymous, multiple choice, *no text/fill-in responses*
- Opportunity to win $100 Amazon gift card

Nov - Dec 2020

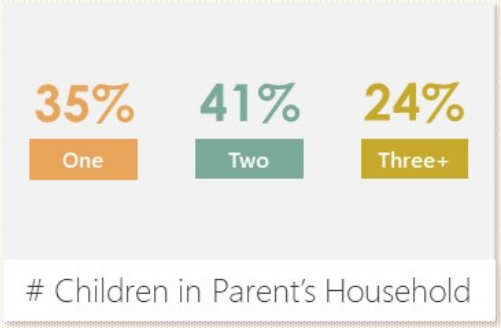

RESPONSE RATES
9
8,594
Started
86%
% Completed
Adults
2,191
Started
65%
% Completed
Parents
96%
Adult
97%
Parent
Surveys Answered in English
Nov - Dec 2020


Share
YOUR
thoughts
Take the
OC COVID
Parent Survey
Win a
$100
gift card
The People

RESPONDENT CHARACTERISTICS



n=1,110 unknown n=7,491



n=268 unknown n=2,056

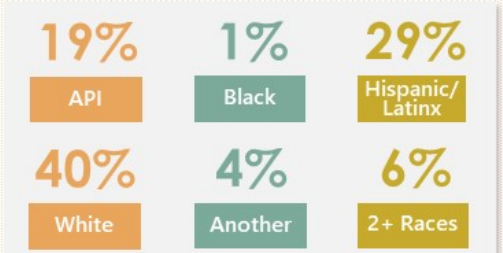
n=570 unknown n=1,763

Numbers may not total 100% due to rounding.

Nov - Dec 2020

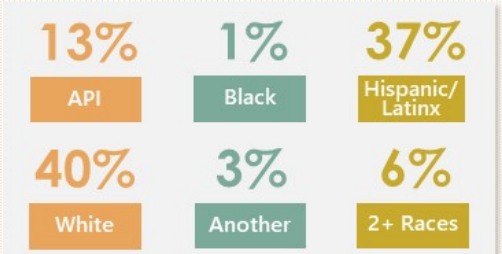
RESPONDENT CHARACTERISTICS

12



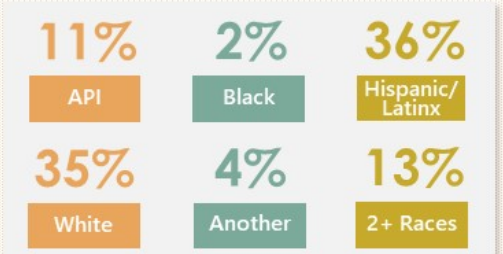
n=1,137 unknown

n=7,464



n=903 unknown

n=1,430



n=551 unknown

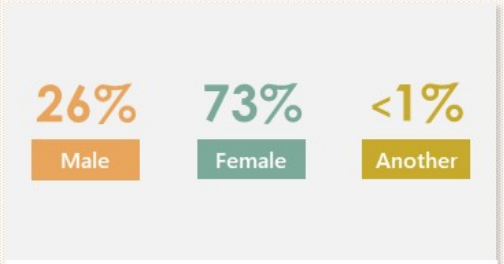
n=1,782

Numbers may not total 100% due to rounding.

Nov - Dec 2020

RESPONDENT CHARACTERISTICS

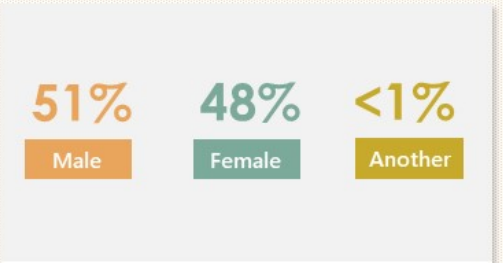
13



Adult Gender Identity

n=1,135 unknown

n=7,466



Child Gender Identity

n=550 unknown

n=1,783

Numbers may not total 100% due to rounding.

Nov - Dec 2020

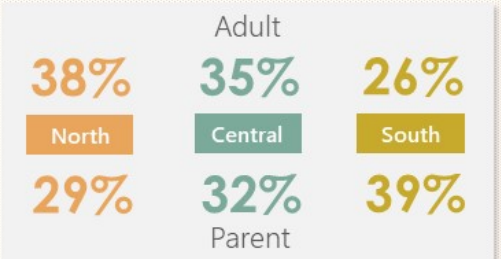
RESPONDENT CHARACTERISTICS

	Adult	Parent
Employed	70%	70%
Unemployed	26%	29%
Retired	4%	<1%

Employment Status

n=7,457 adults
n=1,144 unknown

n=1,425 parents
n=908 unknown



County Region

n=7,408 adults
n=1,193 unknown

n=1,415 parents
n=918 unknown

	Adult	Parent
Commercial	65%	62%
Public	25%	34%
None	10%	4%

Insurance Status

n=7,442 adults
n=1,159 unknown

n=1,785 parents
n=548 unknown

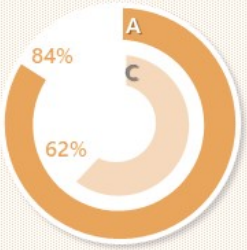
Numbers may not total 100% due to rounding.

Nov - Dec 2020

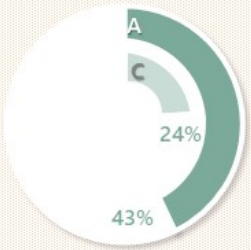
Their Experiences

EXPERIENCES WITH COVID-19

"I (My child), or someone I (my child) know(s)..."

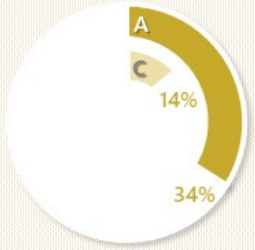


Tested Positive [1]



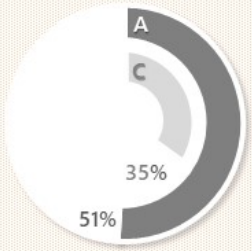
Was Hospitalized [1,4,6,7]

"I (My child) knew someone who..."



Died [1,3,6]

"I or, someone in my (my child's) immediate family..."



Delayed Healthcare [2,5,7]

A = Adults C = Children

[1] Hispanic Adults, Children > Those from other racial/ethnic backgrounds
[2] White Adults, Children > Those from other racial/ethnic backgrounds
[3] Adults w/ No Insurance > Public or Commercial Insurance
[4] Children w/ Public Insurance > No or Commercial Insurance
[5] Adults in South County > Adults in North, Central County
[6] Children in North County > Children in Central, South County
[7] Parents of 13-17 year olds > Parents of younger children

n = 8,322 Adults 18+Year of Age /n = 1,728 Children

ADULTS' DISTRESS & EMOTIONAL WELL-BEING

17

Serious Psychological Distress
Kessler-6 (K-6)

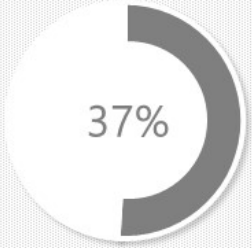
"Past 30 days, I felt..."

"To cope with COVID-19 related stress or emotions, have you started or increased..."

Elevated SPD

Stressed

Angry



Harmful Behaviors

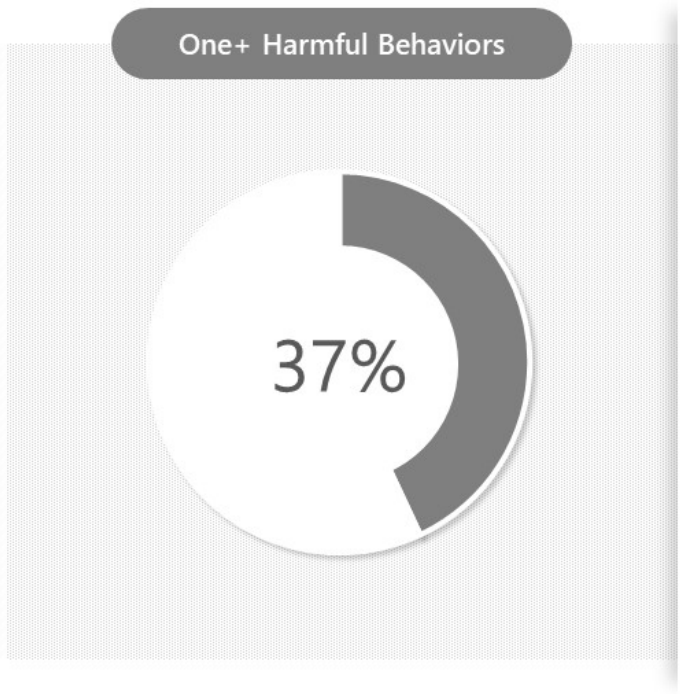
Each measure converted into a dichotomous variable:

- Kessler-6 total score converted into Serious Psychological Distress (SPD) – elevated or not elevated, n = 7,324
- Stressed item rated using same scale as K-6 – high (most, all) low (none, a little, some), n = 7,461
- Angry item rated using same scale as K-6 – high (some, most, all) low (none, a little), n = 7,438
- Harmful Behaviors – started or increased use of one or more included behaviors, n = 7,533 (see next slide for details)

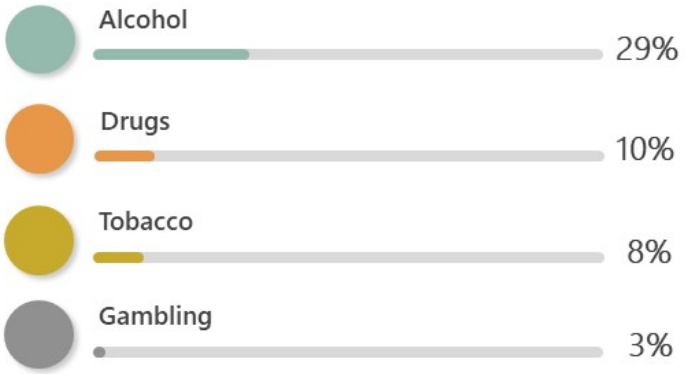
Adults 18+Years of Age

ADULTS' ONSET / INCREASE IN HARMFUL BEHAVIOR

18

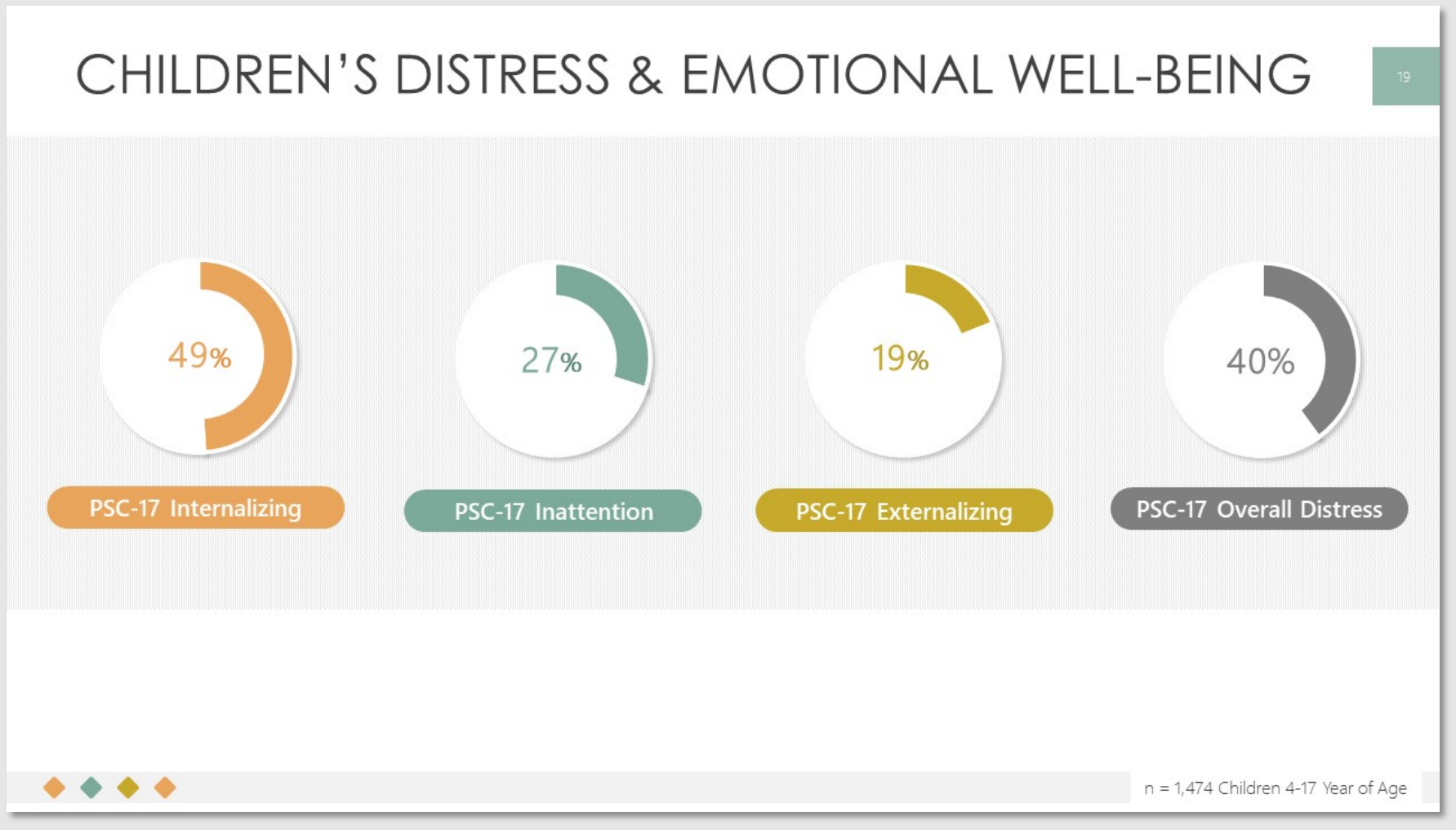


"To cope with COVID-19 related stress or emotions, have you started or increased..."



% Reporting 2 or more: 4%

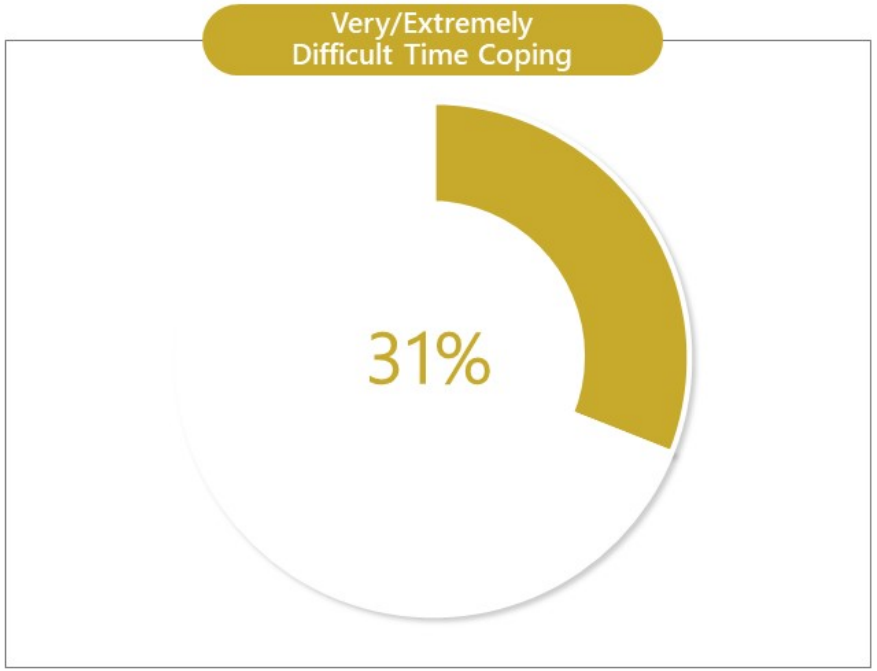
n = 7,480 Adults 18+Year of Age


CHILDREN'S DISTRESS & EMOTIONAL WELL-BEING
19
49%
PSC-17 Internalizing
27%
PSC-17 Inattention
19%
PSC-17 Externalizing
40%
PSC-17 Overall Distress
n = 1,474 Children 4-17 Year of Age

Challenges & Coping

ADULTS' COPING WITH STRESS & EMOTIONS

21



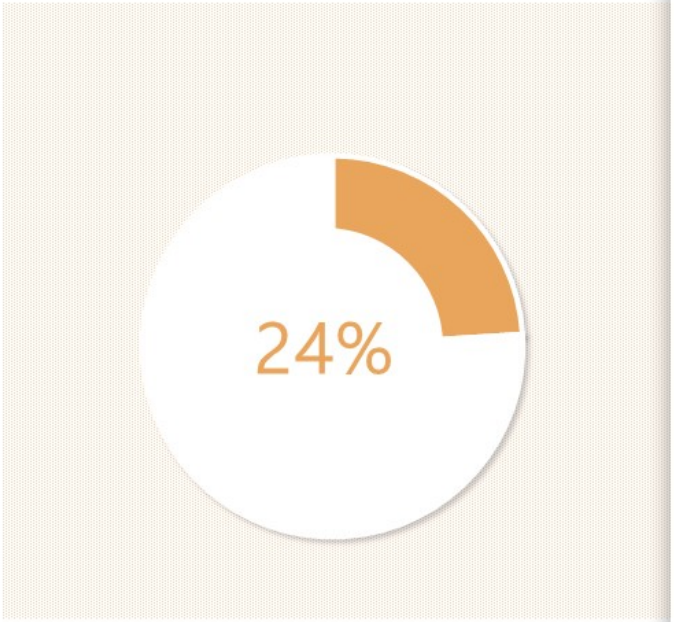
"How difficult have these feelings made it for you to do your work, take care of things at home, or get along with other people?"

Not At All	16%
Somewhat	53%
Very	20%
Extremely	11%

n = 7,688 Adults 18+Year of Age

ADULTS SEEKING PROFESSIONAL HEALTHCARE

22



Adults experiencing elevated distress were more likely to seek professional help

% ELEVATED, BY DISTRESS INDICATOR

K6 SPD:	Stress:	Anger:	Harmful Behaviors:
44%	26%	24%	47%

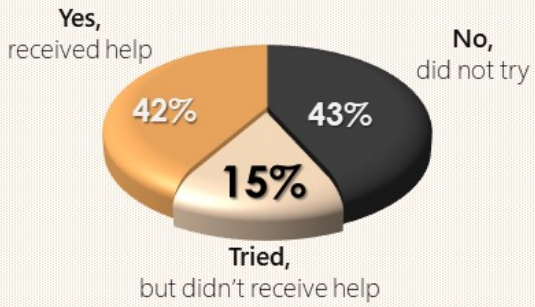
Help-seeking differed by age and insurance status, and was less influenced by gender or race/ethnicity

n = 7,603 Adults 18+Year of Age

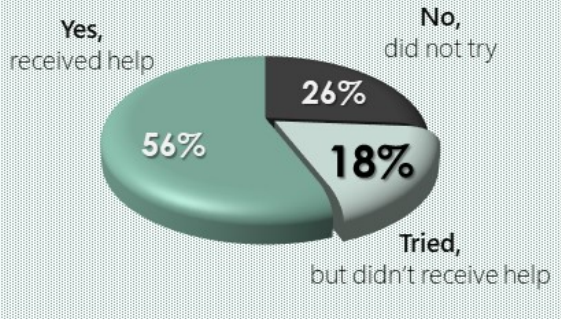
ADULTS SEEKING PROFESSIONAL HEALTHCARE

23

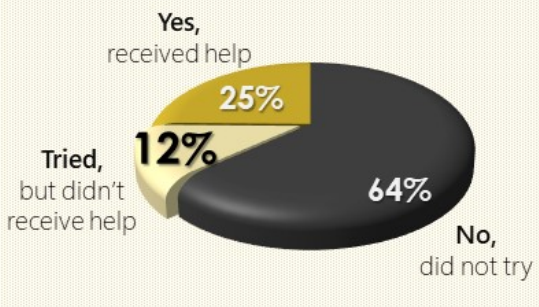
Primary Care Physician



Therapist



Psychiatrist

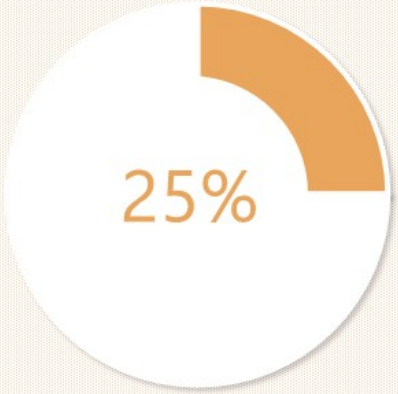


n = 1,786 Adults 18+Year of Age

FAMILIES SEEKING PROFESSIONAL HEALTHCARE

24

"Since COVID-19 began, have you tried to get help from a healthcare professional regarding your child's stress or emotions?"



Children experiencing some type of distress (or their parent) were more likely to seek professional help

% ELEVATED, BY PSC-17 INDICATOR

Internalizing:	Inattention:	Externalizing:	Total:
70%	39%	38%	84%

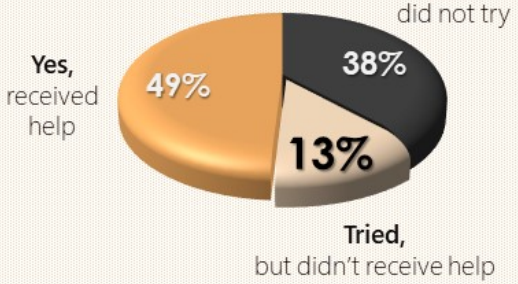
Help-seeking differed by age and insurance status, and was less influenced by gender or race/ethnicity

n = 7,603 Adults 18+Year of Age

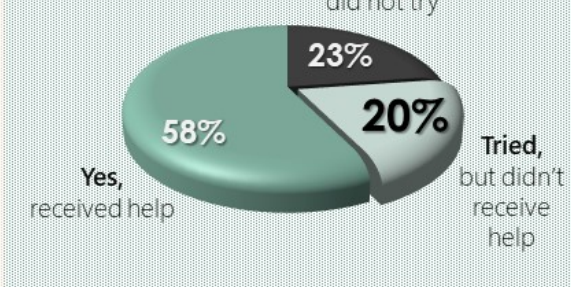
FAMILIES SEEKING PROFESSIONAL HEALTHCARE

25

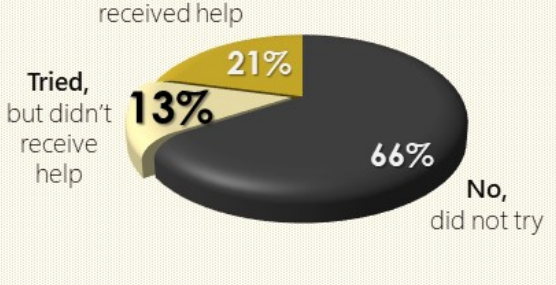
Pediatrician



Therapist



Psychiatrist

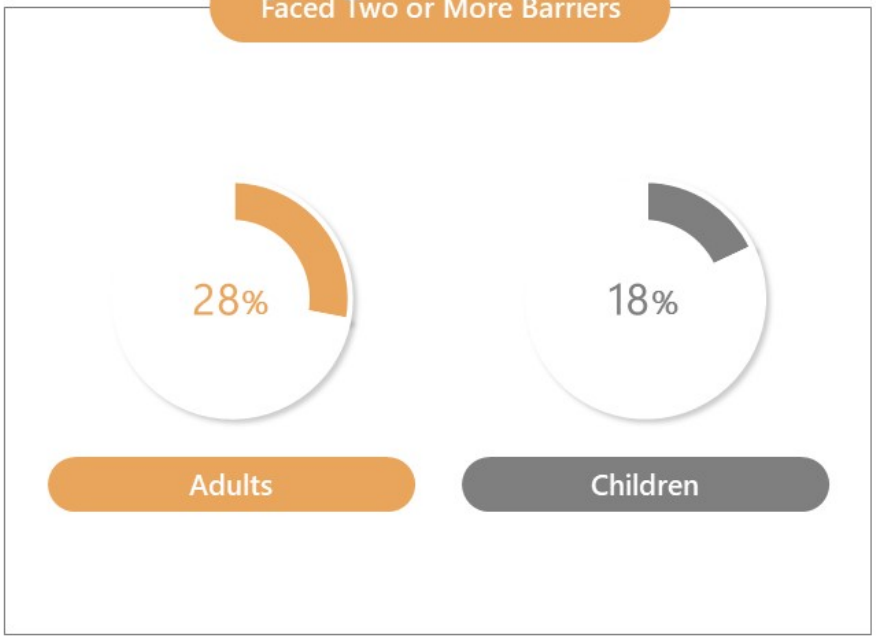


n = 362 4-17 Year Olds

BARRIERS TO PROFESSIONAL HEALTHCARE

26

Faced Two or More Barriers



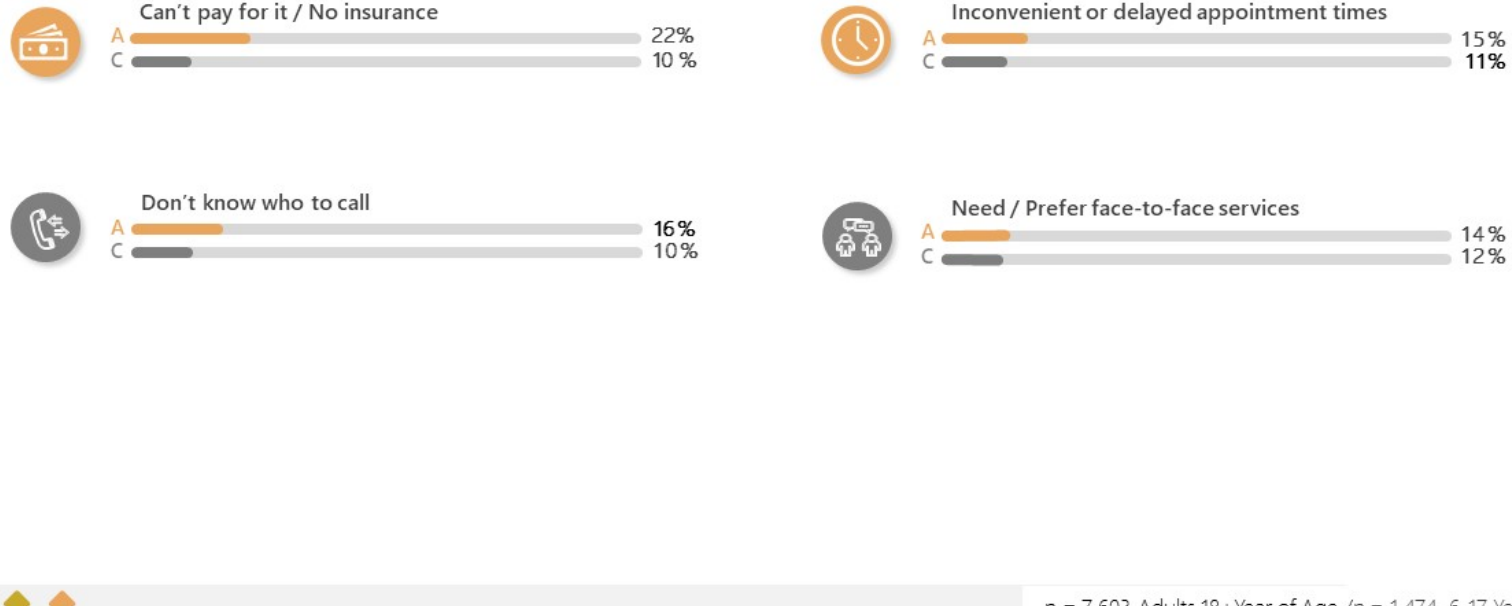
List of Potential Barriers

- Prefer face-to-face
- No childcare
- No insurance/can't afford
- Inconvenient/delayed appt times
- Don't know who to call
- People think something wrong w/ us
- No transportation
- Problems w/ accessing telehealth
- Provider doesn't speak child's language
- Other

n = 7,514 Adults 18+Year of Age

MOST COMMON BARRIERS ENCOUNTERED

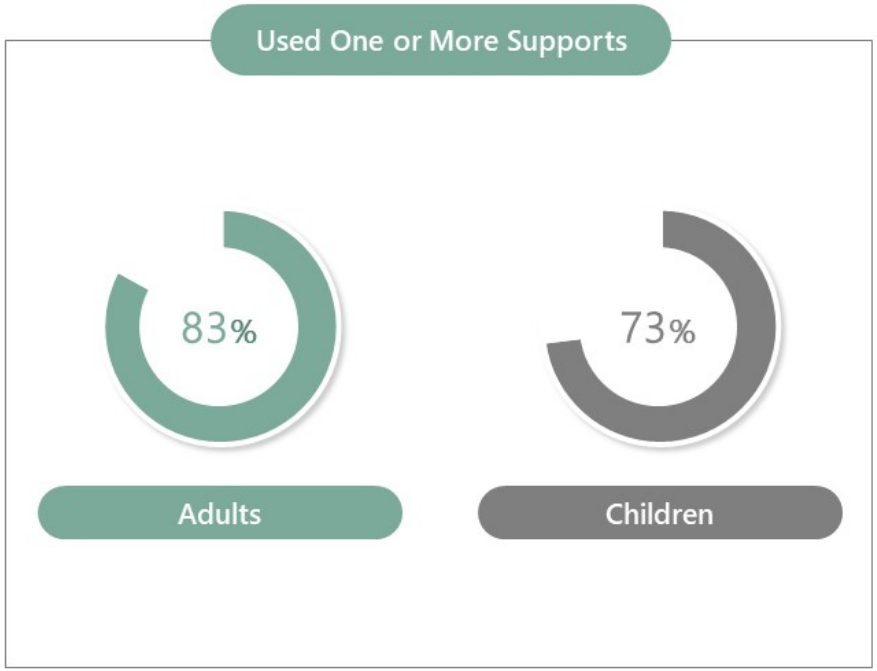
27

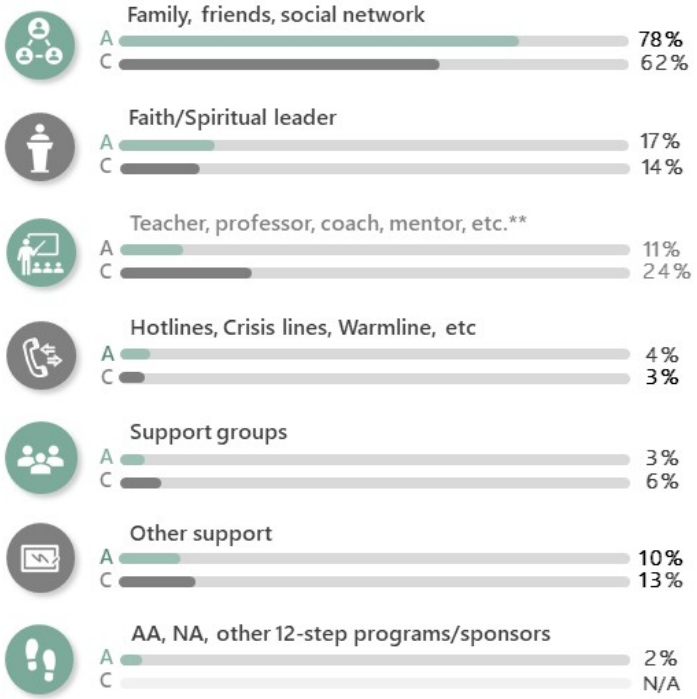


n = 7,603 Adults 18+Year of Age /n = 1,474 6-17 Year Olds

USE OF INFORMAL SUPPORTS DURING COVID-19

28



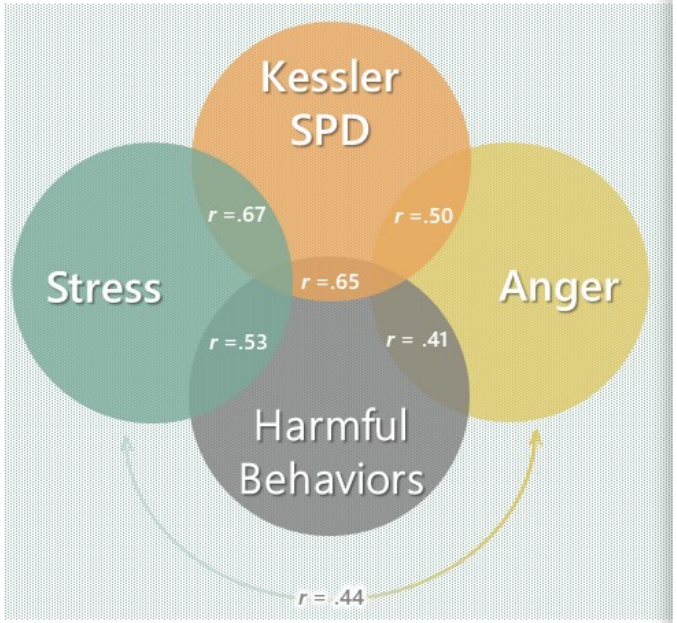


n = 7,603 Adults 18+Year of Age /n = 1,474 6-17 Year Olds

Their "Journey"

OVERLAP BETWEEN ADULT DISTRESS INDICATORS

30



If a person scored "high" on one distress item, they were likely to score "high" on another item

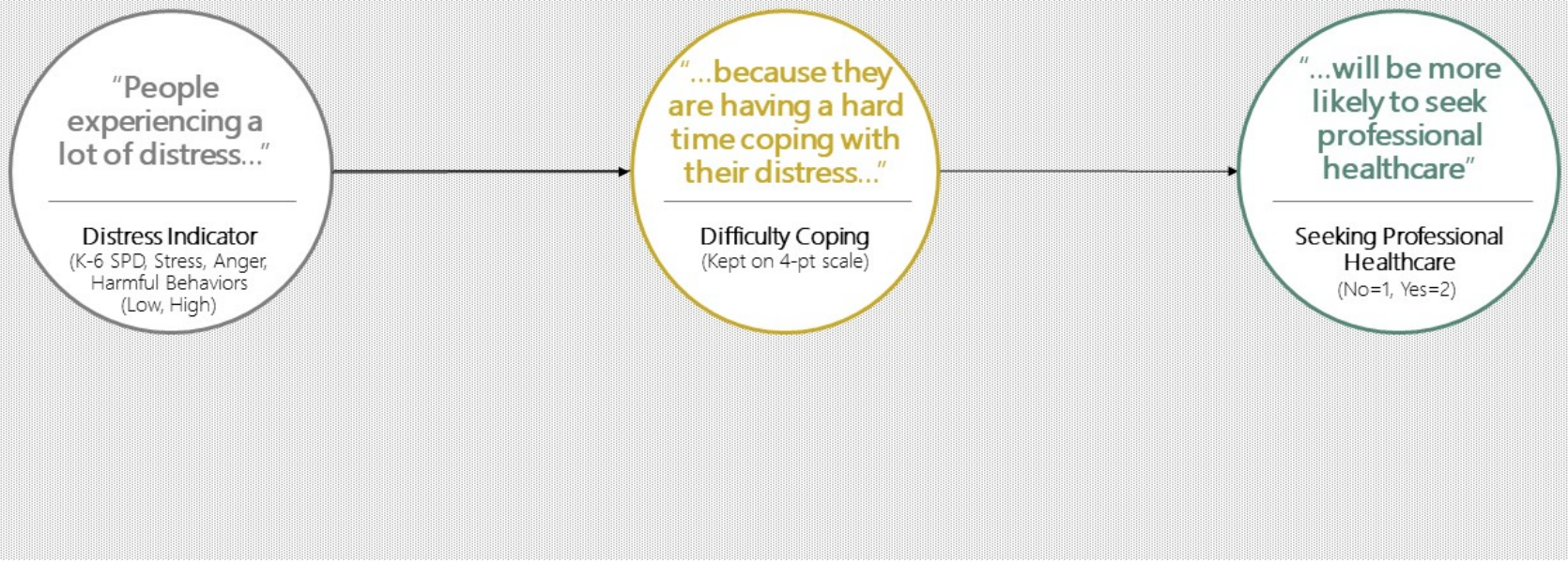
The strongest relationships were between Kessler SPD and Stress, and SPD and Harmful Behaviors

While the measures appear to be inter-related, they do not appear to be inter*changeable*

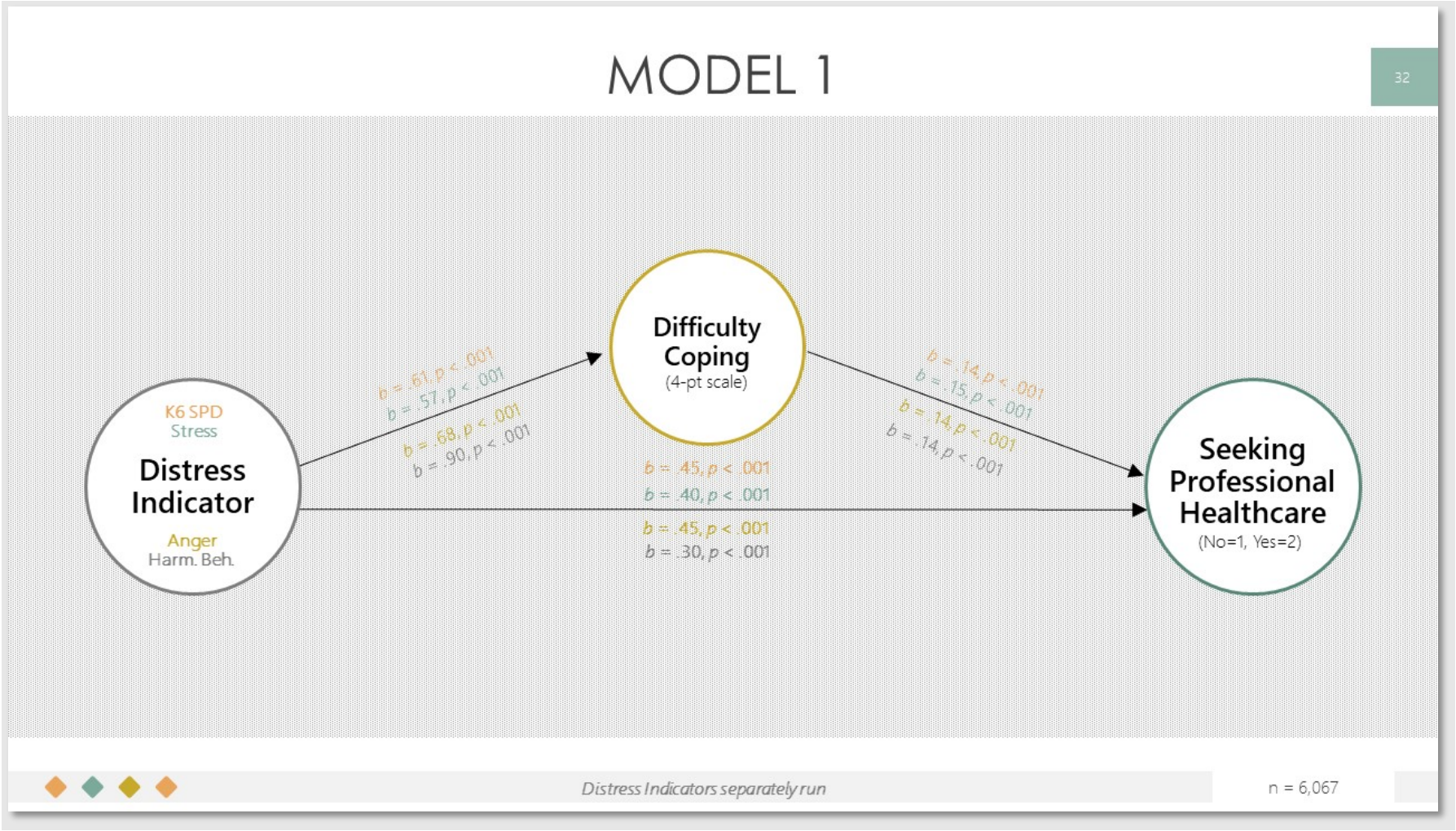
Venn diagram illustrative, not to scale

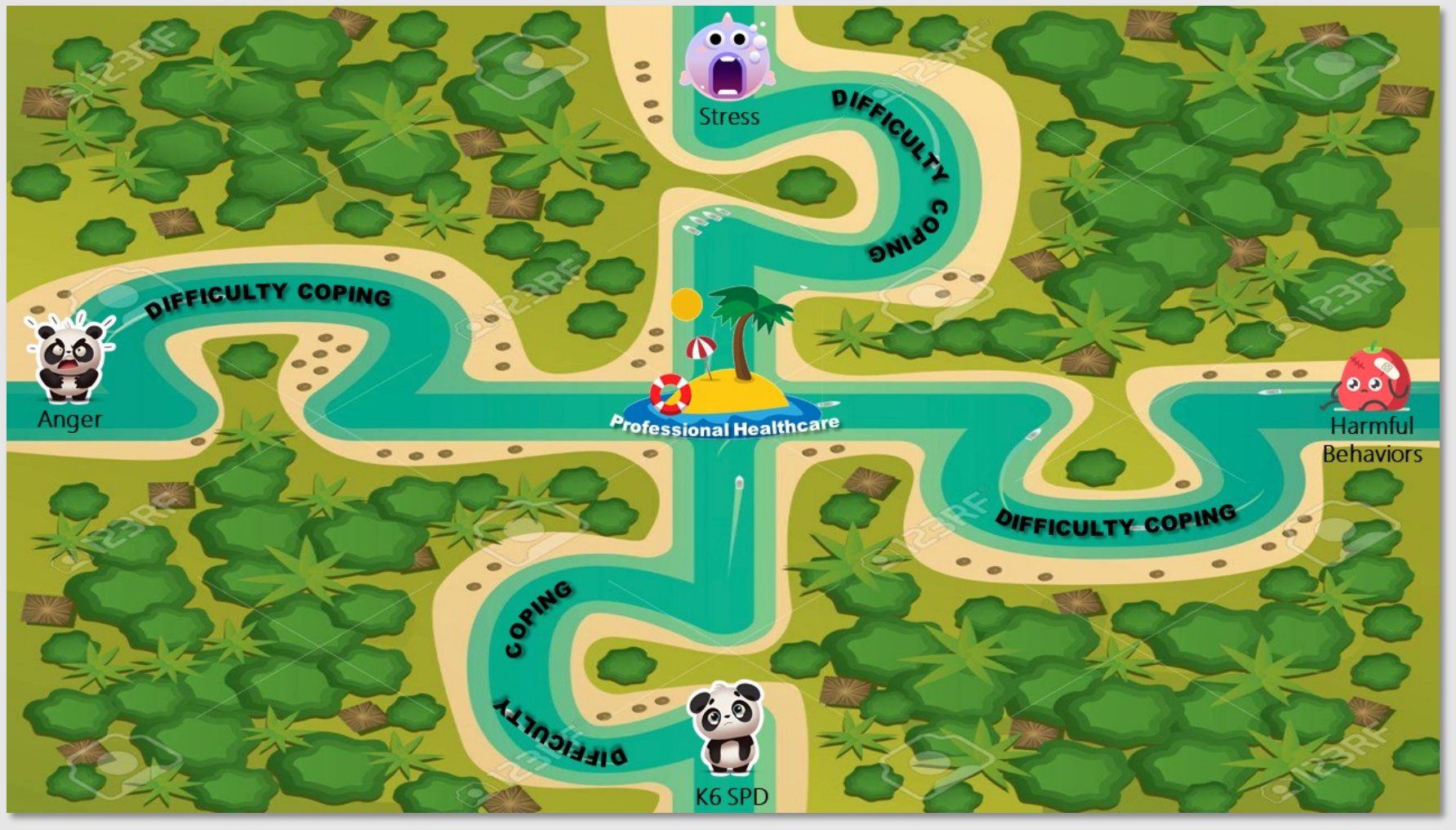
n = 7,465 to 7,691, *** $p < 0.001$ (2-tailed)

THEORETICAL MODEL



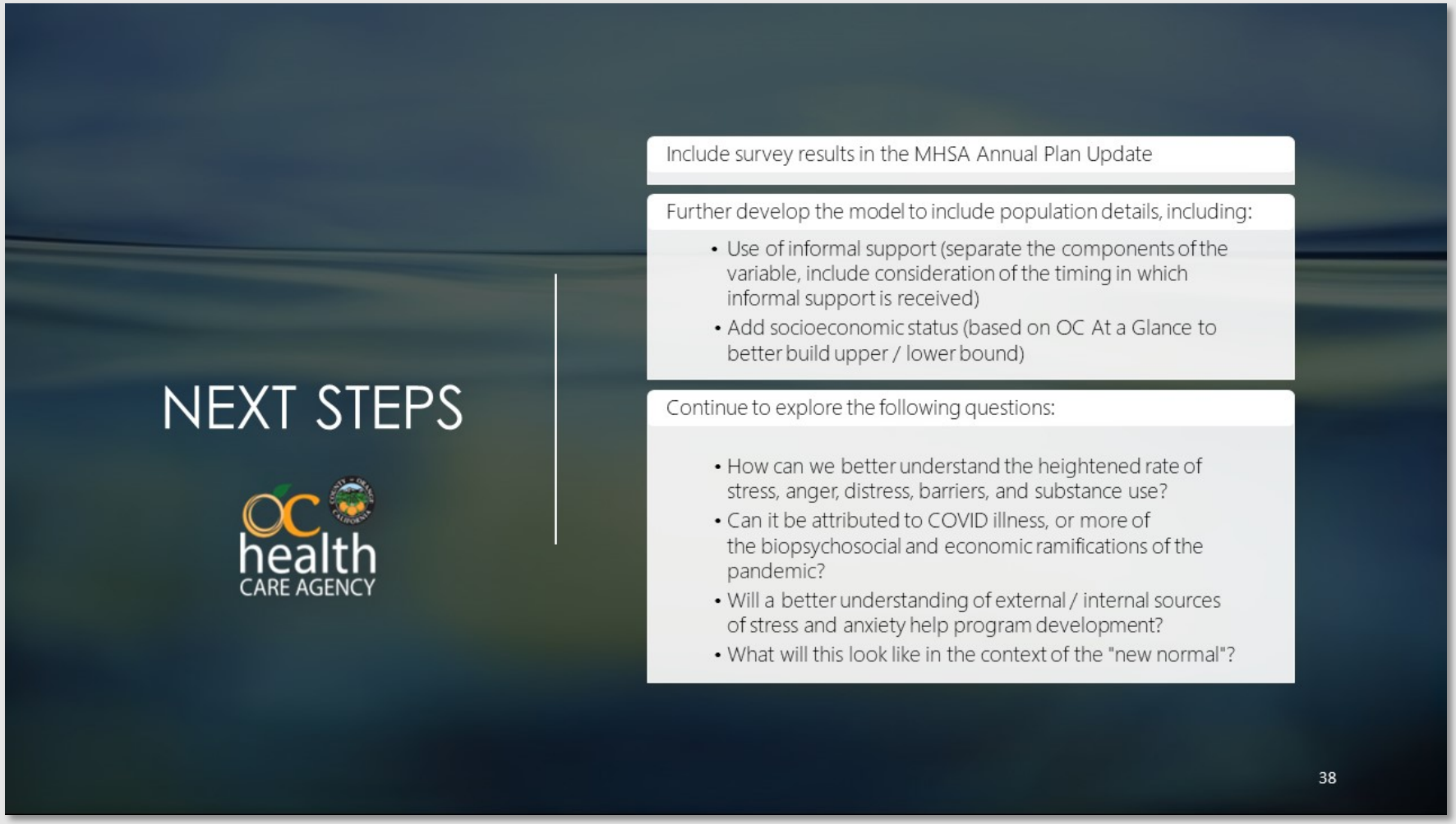
n = 6,067

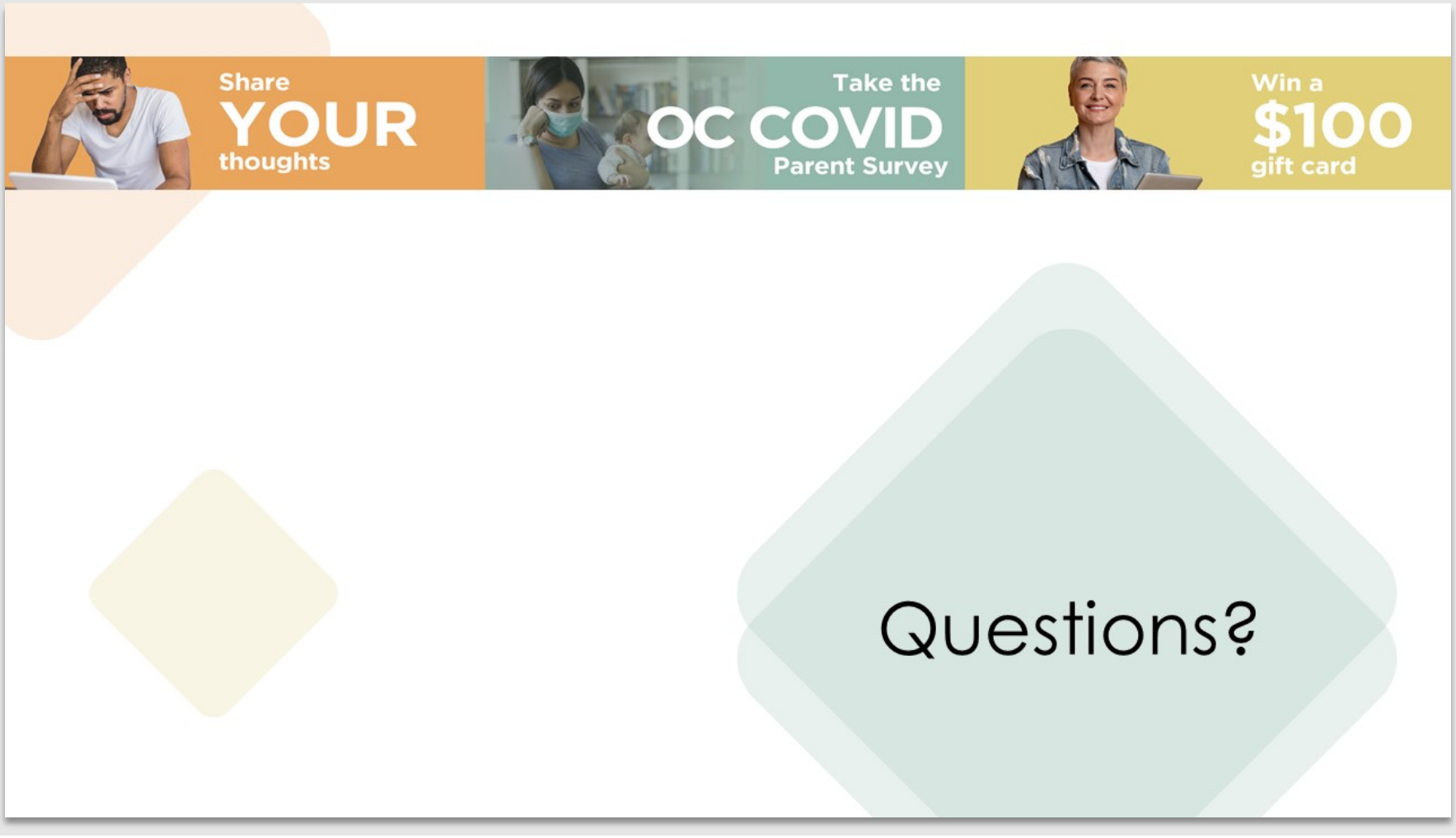

MODEL 1
32
K6 SPD
Stress
Distress
Indicator
Anger
Harm. Beh.
Difficulty
Coping
(4-pt scale)
Seeking
Professional
Healthcare
(No=1, Yes=2)
b = .61, p < .001
b = .57, p < .001
b = .68, p < .001
b = .90, p < .001
b = .45, p < .001
b = .40, p < .001
b = .45, p < .001
b = .30, p < .001
b = .14, p < .001
b = .15, p < .001
b = .14, p < .001
b = .14, p < .001
Distress Indicators separately run
n = 6,067

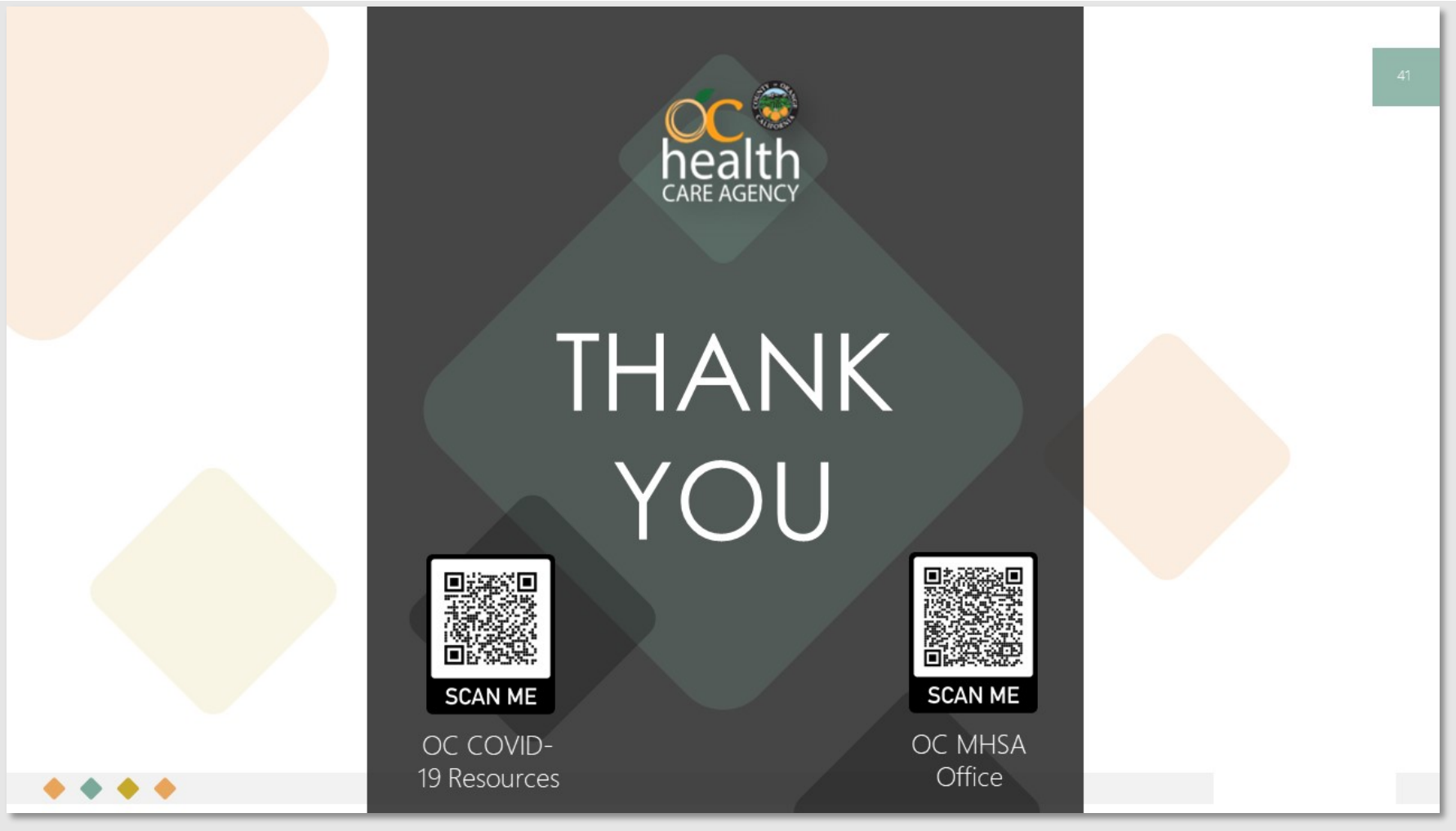

Stress
DIFFICULTY COPING
DIFFICULTY COPING
Anger
Professional Healthcare
Harmful Behaviors
DIFFICULTY COPING
COPING DIFFICULTY
K6 SPD


Share
YOUR
thoughts
Take the
OC COVID
Parent Survey
Win a
$100
gift card

Next Steps


NEXT STEPS
OC health CARE AGENCY
Include survey results in the MHSA Annual Plan Update
Further develop the model to include population details, including:
• Use of informal support (separate the components of the variable, include consideration of the timing in which informal support is received)
• Add socioeconomic status (based on OC At a Glance to better build upper / lower bound)
Continue to explore the following questions:
• How can we better understand the heightened rate of stress, anger, distress, barriers, and substance use?
• Can it be attributed to COVID illness, or more of the biopsychosocial and economic ramifications of the pandemic?
• Will a better understanding of external / internal sources of stress and anxiety help program development?
• What will this look like in the context of the "new normal"?
38


Share
YOUR
thoughts
Take the
OC COVID
Parent Survey
Win a
$100
gift card
Questions?


41
health
CARE AGENCY
THANK
YOU
SCAN ME
OC COVID-
19 Resources
SCAN ME
OC MHSA
Office


42
Appendix
health
CARE AGENCY

RELATIONSHIP BETWEEN DISTRESS & SUPPORT ITEMS

Correlations (Spearman's rho)

		Kessler (K-6)	Stressed	Angry	Coping	Informal Support	Professional Help
Kessler (K-6)	Correlation Coefficient	1.000	.672**	.503**	.646**	-.099**	.239**
	Sig. (2-tailed)		0.000	0.000	0.000	0.000	0.000
	N	7611	7609	7595	7548	7465	7465
Stressed	Correlation Coefficient		1.000	.435**	.529**	-.097**	.194**
	Sig. (2-tailed)			0.000	0.000	0.000	0.000
	N		7745	7722	7681	7597	7597
Angry	Correlation Coefficient			1.000	.406**	-.046**	.110**
	Sig. (2-tailed)				0.000	0.000	0.000
	N			7724	7660	7576	7576
Coping	Correlation Coefficient				1.000	-.068**	.214**
	Sig. (2-tailed)					0.000	0.000
	N				7688	7603	7603
Informal Support	Correlation Coefficient					1.000	-.176**
	Sig. (2-tailed)						0.000
	N					7603	7603
Professional Help	Correlation Coefficient						1.000
	Sig. (2-tailed)						
	N						7603

**. Correlation is significant at the 0.01 level (2-tailed).

DIFFICULTY COPING BY DISTRESS GROUPS

46

Kruskal Wallis ANOVA	df	H	n^2	*p*
K-6	1	364.35	.10	< .001
Stress	1	334.03	.10	< .001
Anger	1	364.35	.10	< .001
Harmful Behaviors	1	493.38	.10	< .001

***epsilon*-squared**

Small effect	0.01 to < 0.08
Medium effect	0.08 to < 0.26
Large effect	≥ 0.26

*** $p < 0.001$ (2-tailed), Kruskal Wallis Non-parametric ANOVA

n = 6,067 Adults 18+Year of Age

LIKELIHOOD OF SEEKING HEALTHCARE BY DISTRESS

47

Kruskal Wallis ANOVA	df	H	η^2	*p*
K-6	1	224.08	.04	< .001
Stress	1	177.60	.03	< .001
Anger	1	224.08	.04	< .001
Harmful Behaviors	1	91.00	.01	< .001

***epsilon*-squared**

Small effect	0.01 to < 0.08
Medium effect	0.08 to < 0.26
Large effect	≥ 0.26

*** $p < 0.001$ (2-tailed), Kruskal Wallis Non-parametric ANOVA

n = 6,067 Adults 18+Year of Age

APPENDIX VI: Community Engagement Meeting (CEM) Orientation Materials

Purpose: To provide your input and help inform planning for the FY 2021-22 Mental Health Services Act (MHSA) Annual Plan Update

Wellness Centers Virtual Community Engagement Meeting

Space is Limited

- **DATE: February 25, 2021**
- **TIME: 1:00 PM – 3:00 PM**
- **LOCATION: Zoom link will be provided after registration**
- **REGISTRATION/ RSVP REQUIRED: https://cutt.ly/9kQleKP**
- **Deadline to register is 8pm Feb. 24, 2021**
- **CONTACT: mhsa@ochca.com**

$20 gift card to those who participate in the entire meeting

Co-Hosted By

College Community Services | Pathways | mha Mental Health Association of Orange County | OC health CARE AGENCY

CEM Orientation

for Community Partners

FY 2021-22 MHSA Annual Plan Update

Today's Agenda

- Welcome & Introductions
- Before CEM Day: How to Prepare
- On CEM Day: Getting Ready
- During the CEM: Review of CEM Materials
- Zoom Breakout Room Practice
- Nuts & Bolts
- Questions

Before CEM Day

MHSA Community Planning
for FY 2021-22

CEM CHECKLIST FOR FACILITATORS

BEFORE THE DAY OF THE CEM

- ☑ Confirm the identified Notetaker is available to take notes during the breakout discussions
- ☑ Attend MHSA CEM Orientation
- ☑ Review CEM meeting materials:
  - MHSA Strategic Priorities from Three-Year Plan
  - 2021 Participant Breakout Room Questions
- ☑ Make sure you have a computer or laptop with a functioning microphone and webcam, and stable Wi-Fi/Internet connection
  - ***Do not*** use a tablet, iPad or smartphone
- ☐ Review Zoom facilitator tips on YouTube here

On CEM Day

MHSA Community Planning
for FY 2021-22

CEM CHECKLIST FOR FACILITATORS

DAY OF THE CEM – BEFORE THE START OF THE MEETING

Prepare your physical space

☐ Prepare yourself and your environment
- Make sure you are in a quiet space with limited interruptions or distractions
- Be aware of your background on camera
- Have a bottled water on hand

☐ Have your CEM Facilitator Packet PDF easily accessible. The Packet includes:
- MHSA Strategic Priorities from Three-Year Plan
- 2021 Participant Breakout Room Questions
- CEM Slide deck
- Participating Effectively as a MHSA Stakeholder

☐ Make sure your computer is plugged in

Prepare your virtual space

☐ Have Breakout Session PowerPoint Slides open on your computer and ready to screenshare

☐ Close programs, emails, documents or any other materials that are not related to the CEM. Turn off all notifications.

☐ Go to your Outlook Calendar to access the Zoom link. Facilitators and Notetakers will **log in 15-minutes before** the start of the CEM to complete *all* the following
- Make sure your name on Zoom matches the name provided to HCA prior to the CEM to be admitted from the wait-room
- Be assigned as a Co-Host by HCA
- Rename your Zoom name so it identifies your CBO after your name. Example: John Doe, OCHCA
- Test microphone and speakers to make sure they are working properly

During the CEM

MHSA Community Planning
for FY 2021-22

Community Engagement Meeting

Co-HOSTS:

Downtown Family Resource Center

Magnolia Park Family Resource Center

MinnieStreet

Manzanita Park Family Resource Center

HUMAN OPTIONS
PREVENT. PROTECT. EMPOWER. TRANSFORM.

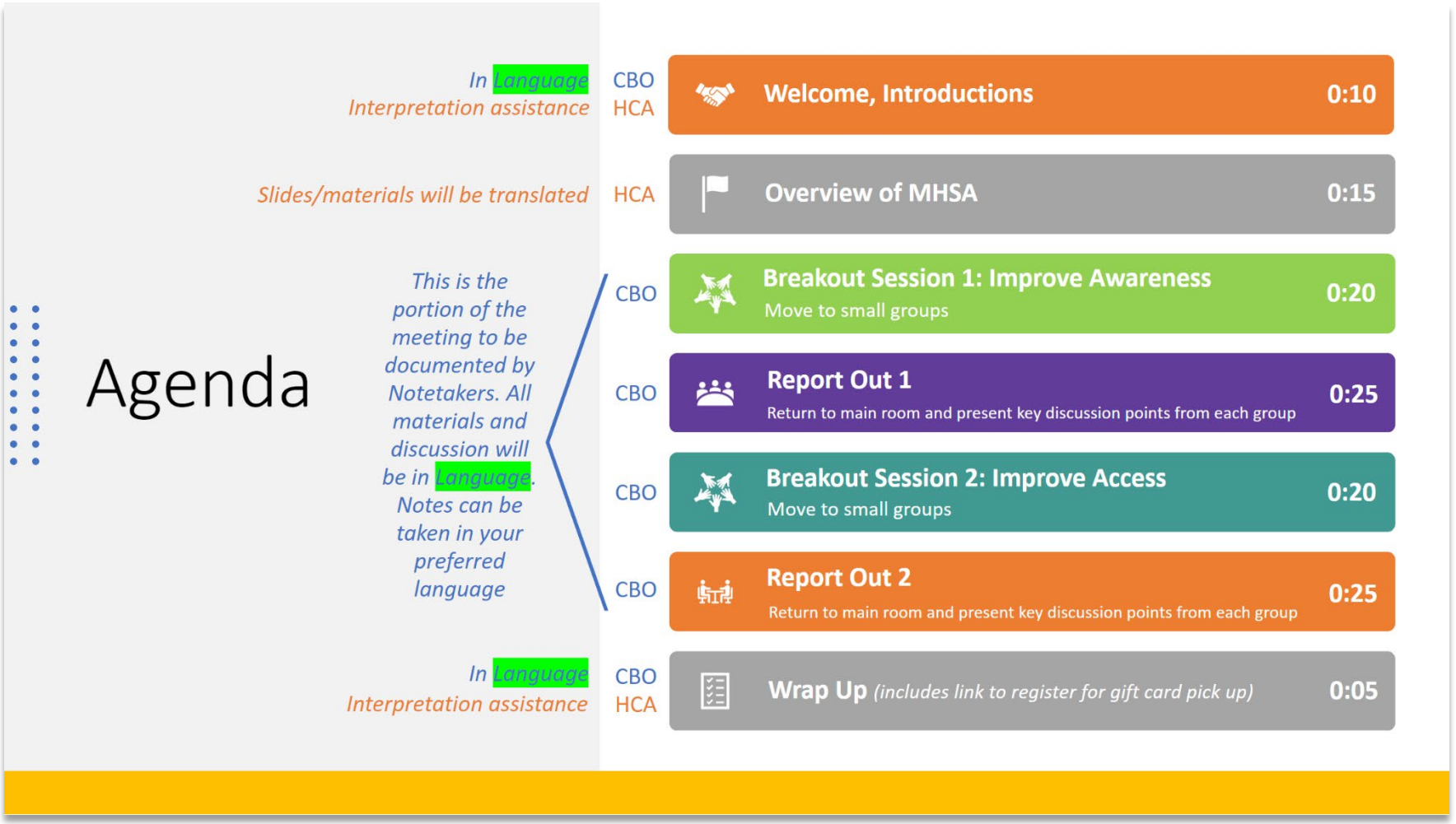
South Orange County Family Resource Center

Westminster WFRC family resource center

CHEC Family Resource Center

FY 2021-22 MHSA Annual Plan Update

OC health CARE AGENCY


Agenda
In Language Interpretation assistance
CBO HCA
Welcome, Introductions 0:10
Slides/materials will be translated
HCA
Overview of MHSA 0:15
This is the portion of the meeting to be documented by Notetakers. All materials and discussion will be in Language. Notes can be taken in your preferred language
CBO
Breakout Session 1: Improve Awareness
Move to small groups
0:20
CBO
Report Out 1
Return to main room and present key discussion points from each group
0:25
CBO
Breakout Session 2: Improve Access
Move to small groups
0:20
CBO
Report Out 2
Return to main room and present key discussion points from each group
0:25
In Language Interpretation assistance
CBO HCA
Wrap Up (includes link to register for gift card pick up) 0:05

How to Zoom

The meeting in the Main Room is recorded.
Breakout Room discussions are not recorded.

In Zoom

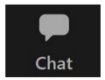
You can hear and see who is speaking

UNMUTED
Mic is **ON**

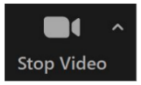
MUTED
Mic is **OFF**

find by your name

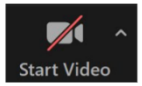
or tap MORE to find the hand



*with **EVERYONE** vs*
*Direct Message that is only seen by **Co-Host***



Video is **ON**



Video is **OFF**

If you are in a place with background noise, please keep your device/phone MUTED when you're not speaking *

To ask questions / make comments, use:

"RAISE HAND"

and the Co-Host will call on you when it's your turn to speak

or **CHAT**

Chat to EVERYONE is seen by everyone. Attendees can also direct message the OCHCA Co-Host who will read your message anonymously

If the Zoom connection is breaking up, turning your video OFF may help

On Phone

You can only hear who is speaking

press *6
to **MUTE** and **UNMUTE**

press *9
to **RAISE HAND** and let the Co-Host know you would like to speak

** Participants who are On Zoom with a computer or tablet and calling in over a telephone may need to mute/unmute both, and watch out for feedback*

We appreciate and value your time! To help create a comfortable and safe virtual environment, please be respectful of others when sharing your comments and opinions.

How to Claim the Gift Card

Please be respectful of others when sharing your comments and opinions. Participants who use inappropriate or offensive language will be removed from the meeting and no longer eligible for a gift card.

We appreciate your ideas and suggestions! Participants who attend the entire meeting are eligible for a $20 gift card to a grocery store.
All gift cards are physical gift cards and must be received in person.

TO RECEIVE YOUR GIFT CARD:

1. **Attend the entire meeting**
   a. *We will take attendance throughout the meeting so if you get disconnected we can readmit you to the meeting and you can still participate.*

2. **Decide how you would like to pick up the card:**
   a. Come to HCA in Santa Ana:
      - M - W - F between 8am-11am (except holidays)
      - T - Th between 2-5pm (except holidays)
      - *Please call before coming to confirm someone will be available to help you*

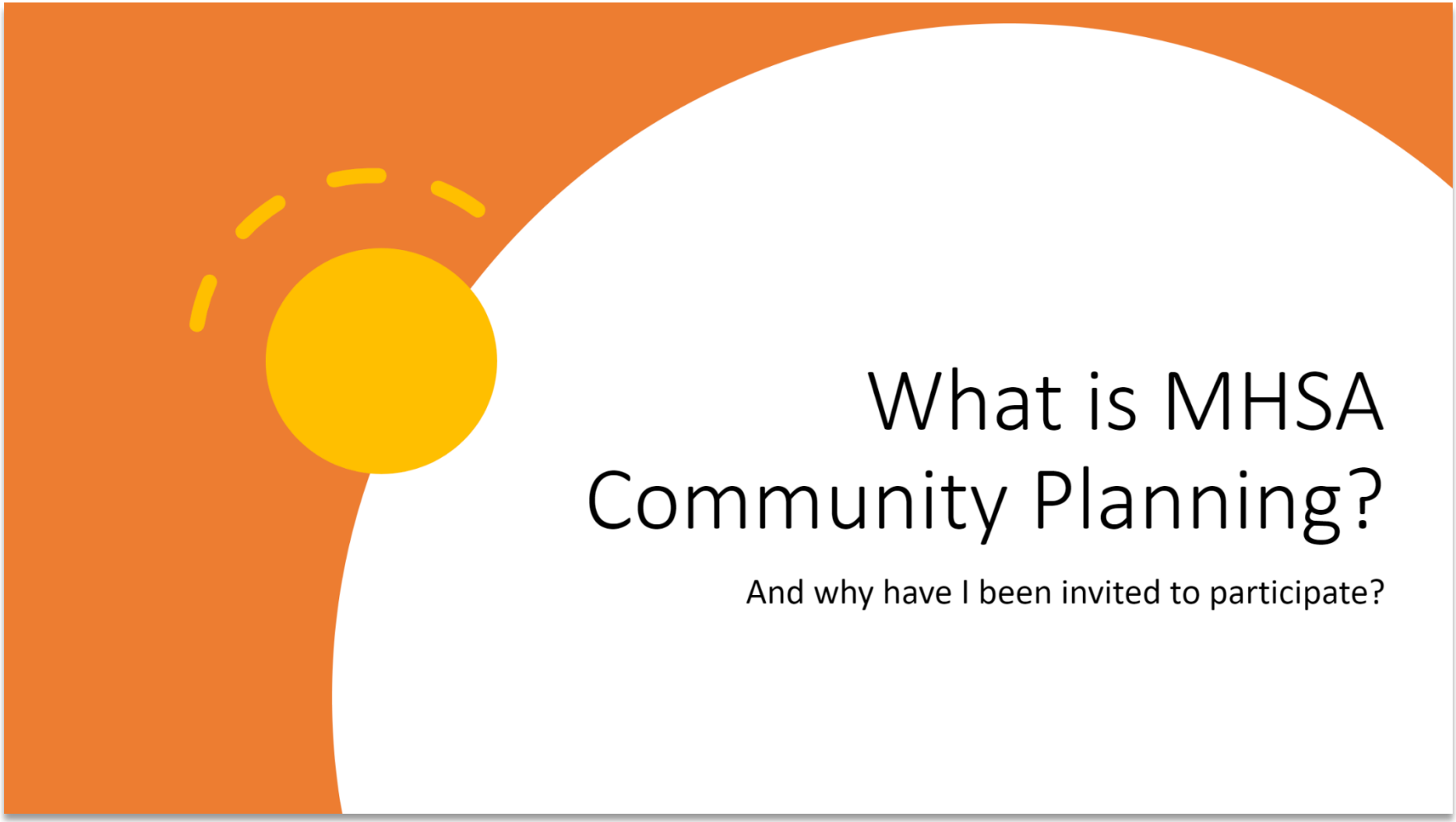
      OR

   b. Come to a community location:
      b. Dates, time and locations to be arranged
      c. *We will email/call when scheduled*

3. **Tell us what your preference for pick up is:**
   a. At the end of today's meeting:
      - Click on the URL link that will be sent through Zoom chat
      - Complete a brief, anonymous feedback survey
      - Click to go register in a separate gift card registration link

      OR

   b. After today's meeting, contact us at:
      - mhsa@ochca.com or
      - 714-834-3104


What is MHSA Community Planning?
And why have I been invited to participate?

What is the **MHSA**?

Mental Health Services Act

- Passed by California voters in November 2004
- Implemented a 1% tax on income over $1 million
- Emphasizes transformation of the mental health system
- Strives to improve the quality of life for Californians living with a mental illness, particularly those living with serious mental illness (SMI) or serious emotional disturbance (SED), and their families

What are MHSA's **Core Values**?

- Community **Collaboration**
- **Cultural** Competence
- **Client** and **Family** Driven
- **Wellness**, **Recovery** and **Resilience** Focused
- **Integrated Services Experience** for Clients and their Families

- *Focus of the Feb-March 2021 CEMs*

CA Code of Regulations § 3320
CA Welfare & Institutions Code 5848

What is the **MHSA CPPP**?

Community Program Planning Process

- Refers to the **process used by the County** to **develop** the MHSA Three-Year Plan or Plan Updates, in partnership with stakeholders
- Involves clients with SED/SMI and their family members **in all aspects**
- Includes participation of **stakeholders**
- **Provides training**, as needed, to stakeholders, clients and family members participating in the CPPP

CA Code of Regulations 3200.070
CA Code of Regulations 3300

Who are **MHSA's Stakeholders**?

- **Adults and seniors living with severe mental illness**
- **Families of children, adults and seniors living with severe mental illness**
- Providers of services
- Law enforcement agencies
- Education
- Social services agencies
- Veterans, Representatives from Veterans organizations
- Providers of alcohol and drug services
- Health care organizations
- Other important interests

CA Welfare & Institutions Code 5848

- Stakeholders must include representatives of **un-/ under-served populations** & their **family** members
- Stakeholders should reflect the **diversity** of the county (i.e., geographic location, age, gender, race/ethnicity)

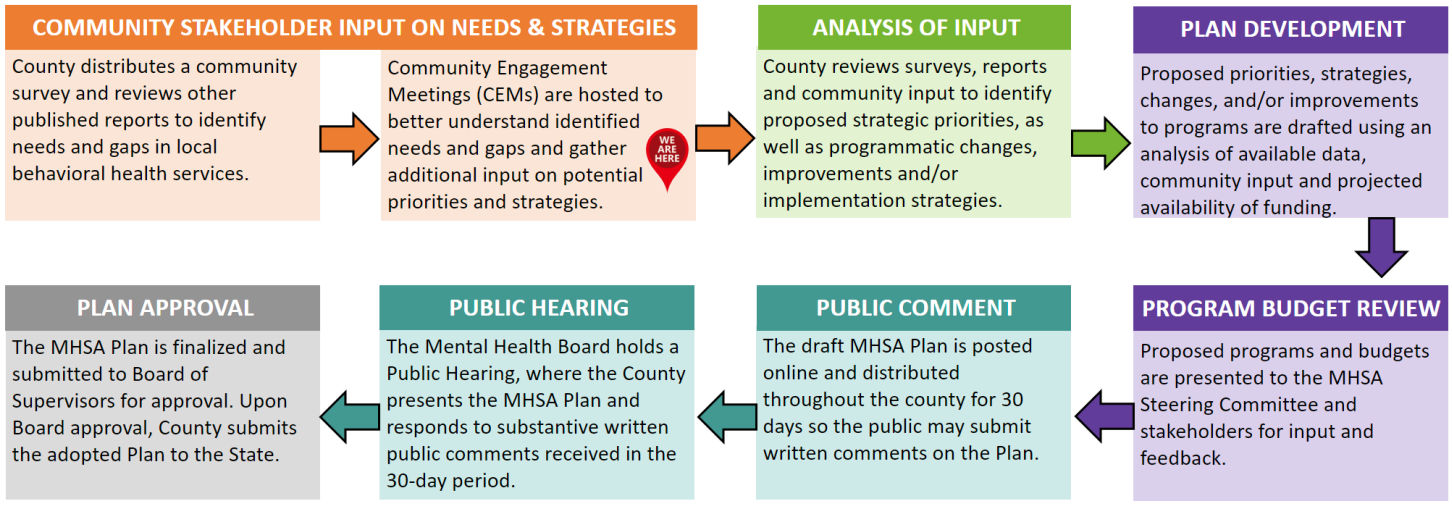
CA Code of Regulations 3300

- *Target audience for the Feb-March 2021 CEMs*

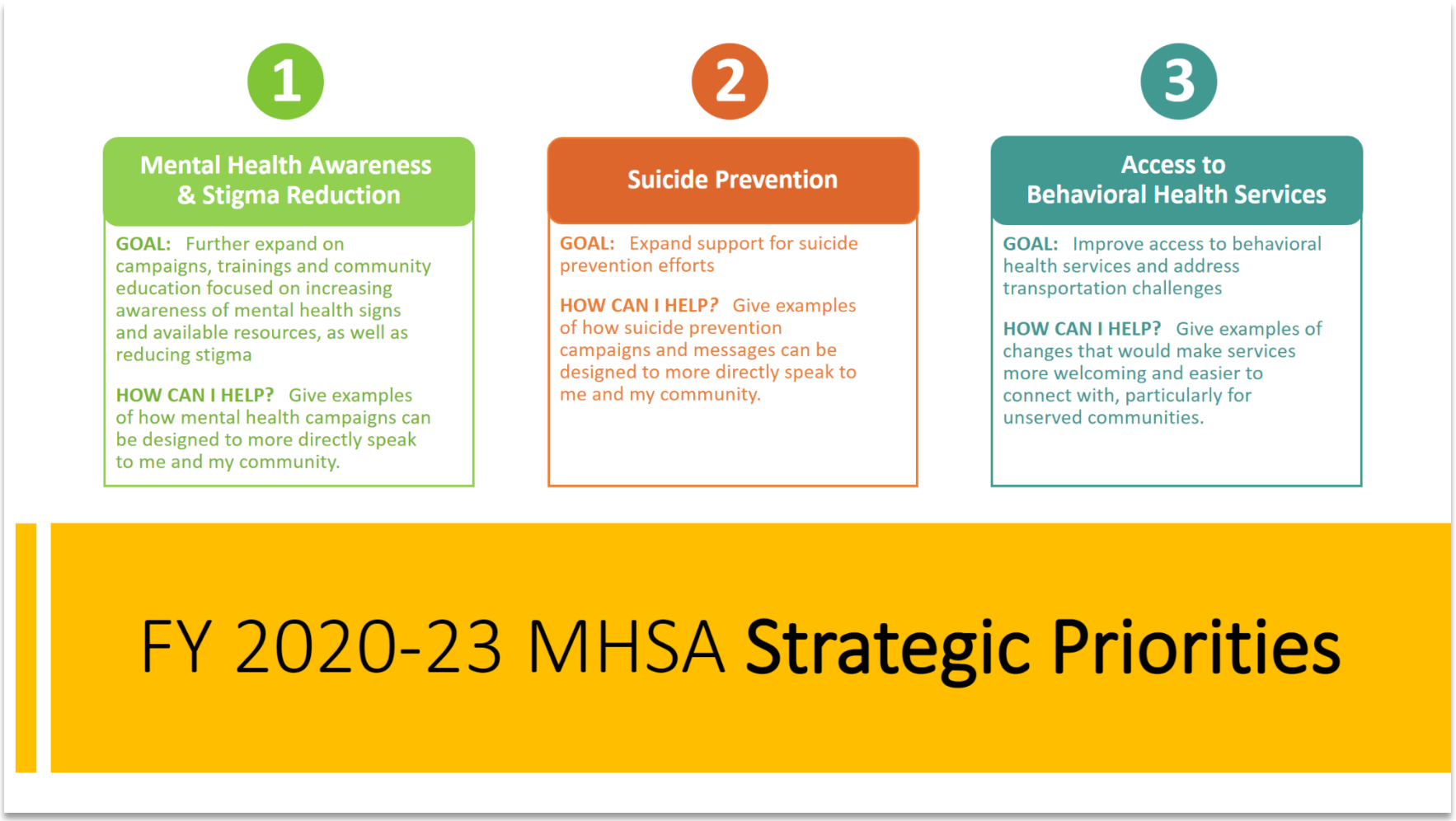
What is the **Goal** of the CPPP?

- Through the CPPP, local MHSA stakeholders help:
  - Identify **community issues** related to mental illness resulting from lack of community services and supports, including any issues identified during the implementation of the MHSA
  - Analyze the **mental health needs** in the community
  - Identify and re-evaluate **priorities** and **strategies** to meet those mental health needs

CA Code of Regulations 3200.070



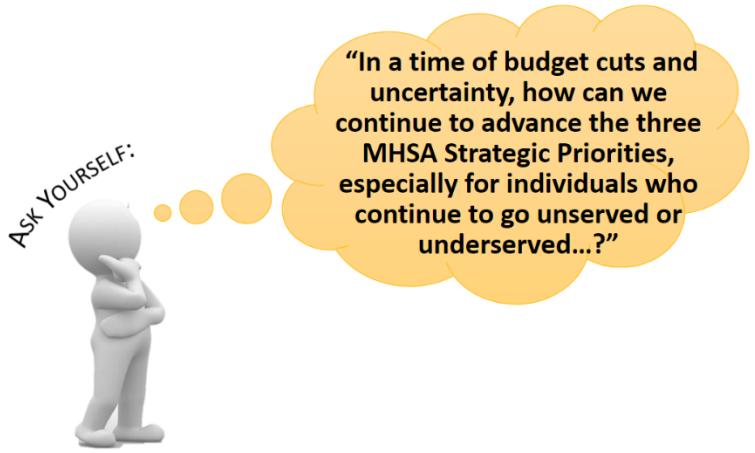
What are the **Steps** in OC's CPPP?


1
Mental Health Awareness & Stigma Reduction
GOAL: Further expand on campaigns, trainings and community education focused on increasing awareness of mental health signs and available resources, as well as reducing stigma
HOW CAN I HELP? Give examples of how mental health campaigns can be designed to more directly speak to me and my community.
2
Suicide Prevention
GOAL: Expand support for suicide prevention efforts
HOW CAN I HELP? Give examples of how suicide prevention campaigns and messages can be designed to more directly speak to me and my community.
3
Access to Behavioral Health Services
GOAL: Improve access to behavioral health services and address transportation challenges
HOW CAN I HELP? Give examples of changes that would make services more welcoming and easier to connect with, particularly for unserved communities.
FY 2020-23 MHSA Strategic Priorities

What to **Consider** for the 2021 CEMs?

- Due to the fiscal impact of COVID-19, HCA had to evaluate its MHSA program budgets
- Initial budget reductions have been identified by HCA and reviewed with the MHSA Steering Committee
- Additional savings are currently being identified to help ensure continuity of services over the next several years

What does this mean for the 2021 CEMs?



Focus of the 2021 CEMs

Breakout sessions will gather input on two areas that cover all three MHSA Strategic Priorities:

1

BREAKOUT SESSION 1:
Strategies programs can use to improve outreach, advertising and messaging on mental health and suicide prevention in diverse communities

2

BREAKOUT SESSION 2:
Strategies programs can use to make mental health services more welcoming and easier to connect with, especially for individuals from unserved communities

Breakout Room discussions are not recorded.


Breakout Discussion 1:
Improving Awareness
20 Minutes then return to Main Room
Breakout Room discussions are not recorded

CEM CHECKLIST FOR FACILITATORS

DURING THE BREAKOUT ROOM DISCUSSIONS

☐ To help create a comfortable and safe virtual environment, please review the following group agreement:
- Be respectful
- Take turns speaking
- Stay present and engaged
- Support each other, even when you disagree

Note: You have the ability to remove participants who use inappropriate or offensive language. Please notify the MHSA Host by direct message if a participant is removed from the meeting.

☐ Remind participants how to mute/unmute and raise/lower hand, especially if a participant joined by phone only (i.e., use ***9 to raise/lower hand** and ***6 to mute/unmute**)

☐ Identify a participant who will report out main discussion ideas to the larger group

☐ Share the Breakout Room Discussion purpose and goal

☐ Use the following facilitation Tips:
- Use questions and prompts provided by HCA
- Create a "parking lot" for ideas that are unrelated to questions/prompts
- Keep an eye on the time
- Encourage solution-focused discussions
- Balance participation so everyone has a chance to contribute
- Paraphrase comments to confirm they were captured accurately
- Draw upon your experience and use terms that connect with your community
- When the 120s countdown begins, transition to reviewing the main points the group participant will share in the Main Room

Breakout 1 — 20 minutes

IMPROVING AWARENESS

MHSA Strategic Priorities: Expand on campaigns and trainings focused on increasing awareness of mental health, suicide prevention and available resources, as well as reducing stigma

MAIN QUESTION

"What are the advertising and outreach strategies that would be most effective in getting mental health-related messages out to my community? The least effective?"

EXAMPLES OF ADVERTISING/OUTREACH METHODS:

- Billboards
- Bus Ads
- Bus Shelter Ads

Which locations?

- Television
- Radio
- Newspapers
- Internet
- Social Media

Names of most trusted or commonly used stations, papers, apps and/or websites?

- Emails
- Events/Fairs

Who should these come from/ be hosted by?

- Other

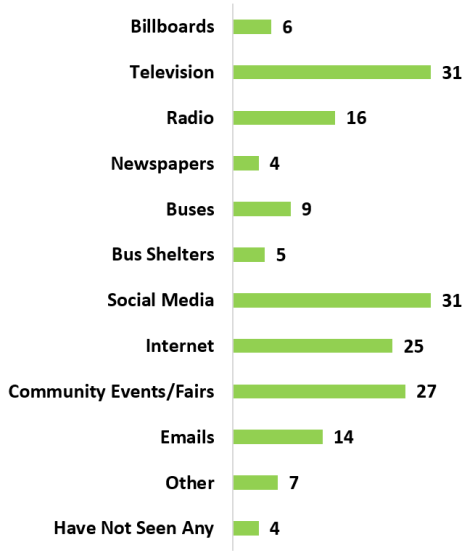
PROMPTS TO HELP US BETTER UNDERSTAND

- What would make an ad something you would remember or want to learn more about?
- Are some ways of advertising/promoting better suited for certain types of messages/information than others?
- Are certain ways of advertising/promoting better at reaching people of different ages, backgrounds, etc.?

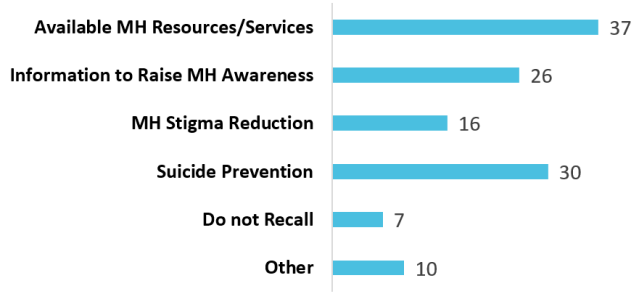
Participant Polling

Updated today!

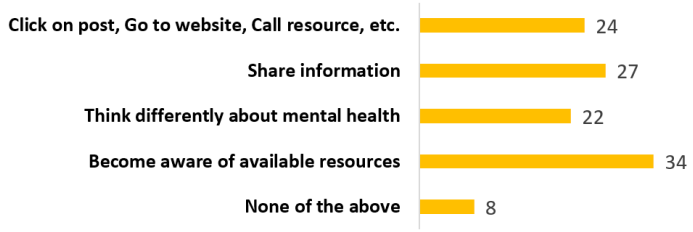
You Have Seen Mental Health-Related Ads On:



The Ads You Saw Were About:



The Ads Prompted You To:

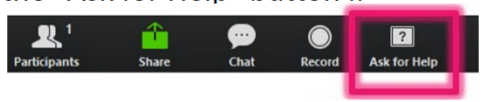


All questions were"select all that apply"

17

About the Breakout Rooms

- MHSA Host will assign attendees and Facilitator Co-Hosts to the breakout rooms during the overview
- In the breakout rooms, the Facilitator Co-Host will share their screen and show the *Breakout Room Slides* to help guide the discussion
- The Notetaker can use the "Ask for Help" button if assistance from the MHSA Host is needed

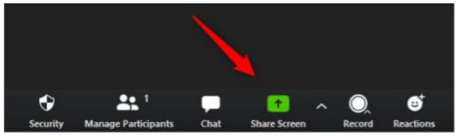


- MHSA Host may broadcast messages to the Breakout Rooms to help keep track of time
- You will see a 2-minute timer, which is a cue to begin wrapping up the discussion and identify talking points for the group's report out

Breakout Room discussions are not recorded

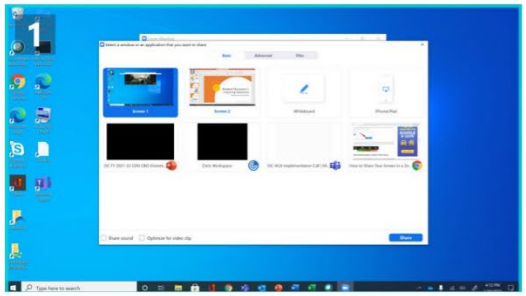
How to Share Your Screen

1



Go to Zoom controls and click “Share Screen”

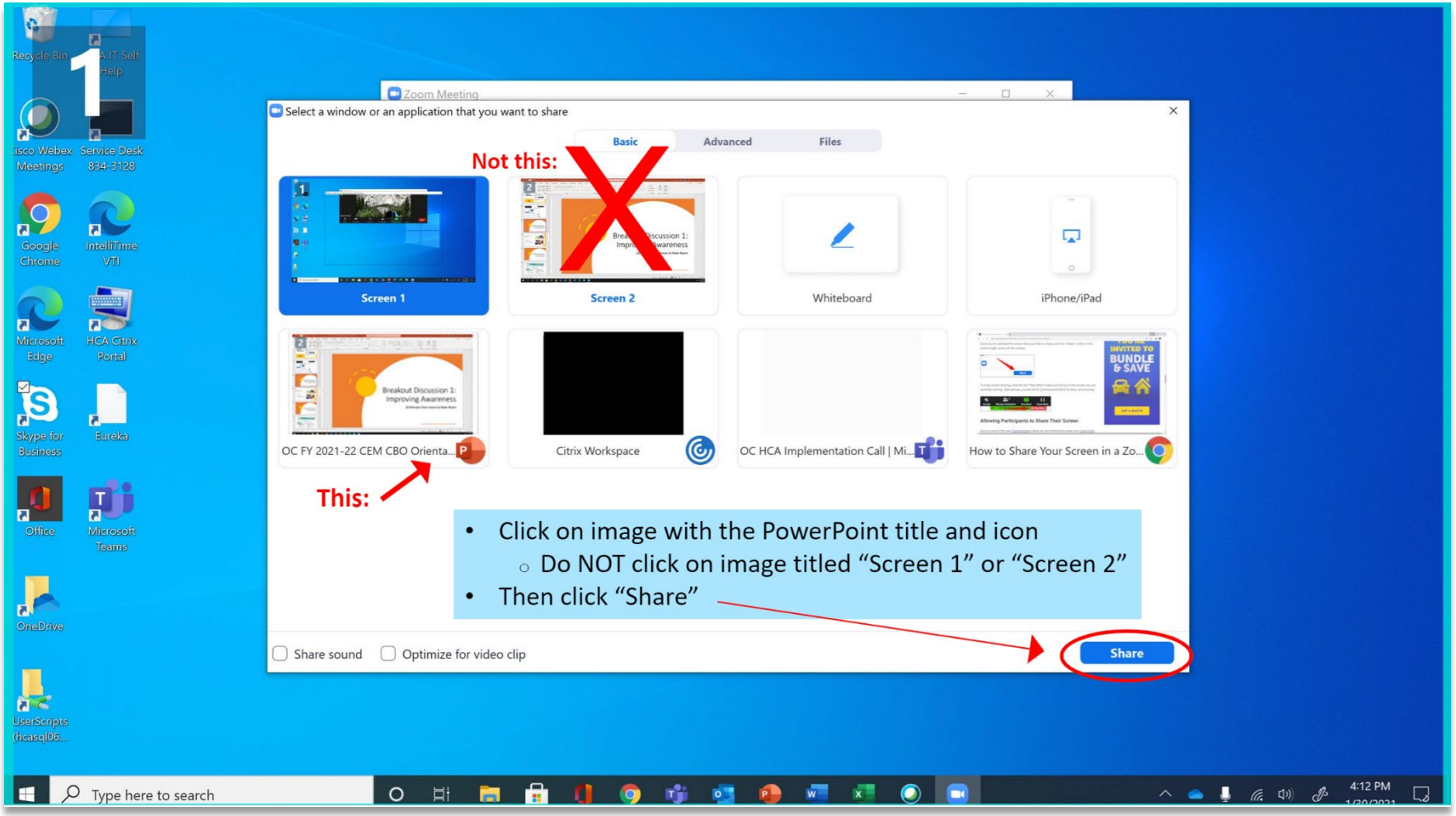
2



Select the image/title of the slidedeck and Click “Share”

3

When you’re done, click “Stop Share”


Zoom Meeting
Select a window or an application that you want to share
Basic
Advanced
Files
Not this:
Screen 1
Screen 2
Whiteboard
iPhone/iPad
OC FY 2021-22 CEM CBO Orienta...
Citrix Workspace
OC HCA Implementation Call | Mi...
How to Share Your Screen in a Zo...
This:
• Click on image with the PowerPoint title and icon
○ Do NOT click on image titled “Screen 1” or “Screen 2”
• Then click “Share”
Share sound
Optimize for video clip
Share
Recycle Bin
Cisco Webex Meetings
Service Desk 834-3128
Google Chrome
IntelliTime VTI
Microsoft Edge
HCA Citrix Portal
Skype for Business
Eureka
Office
Microsoft Teams
OneDrive
UserScripts (hcasql06...
Type here to search
4:12 PM

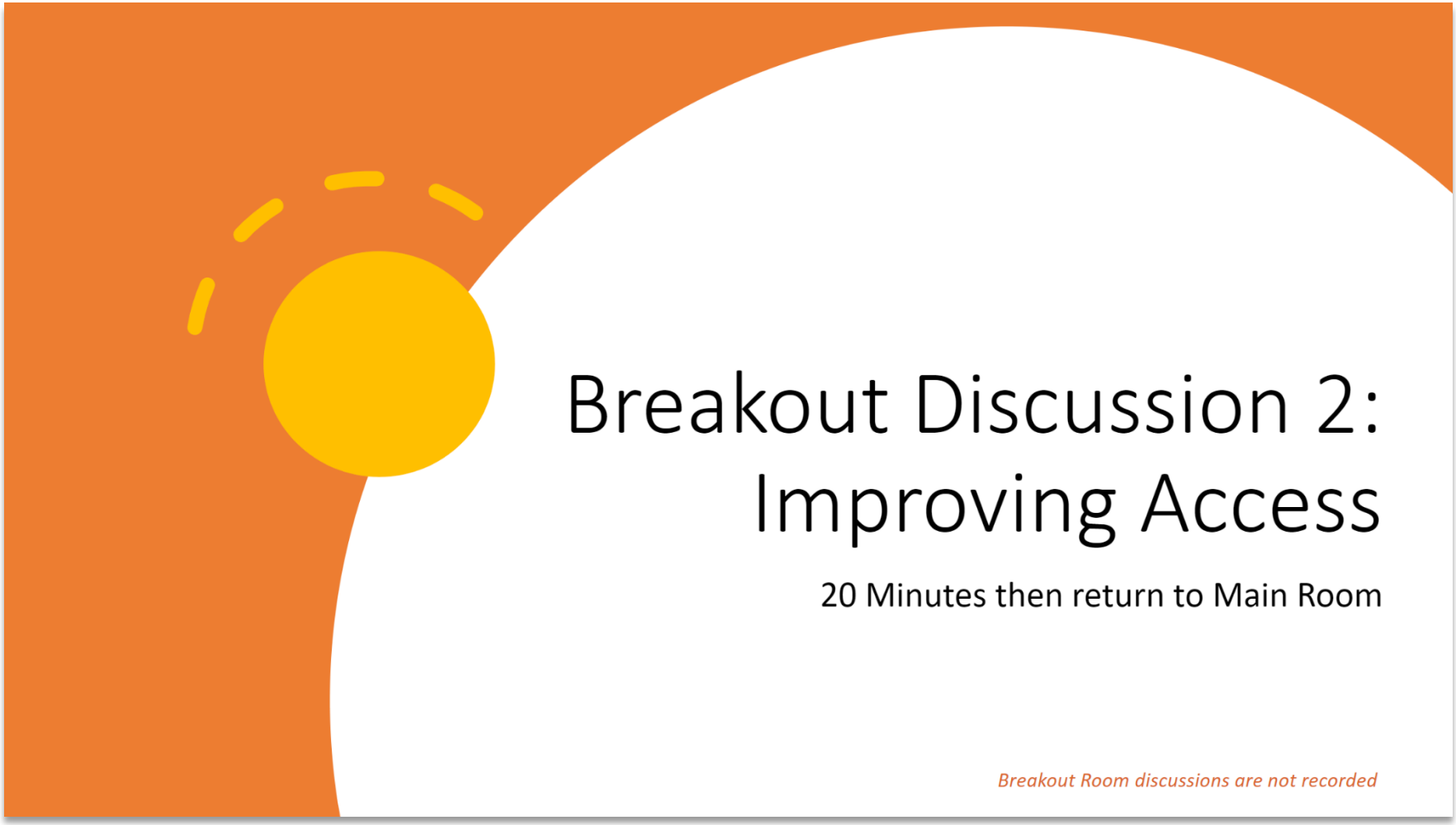

Breakout Discussion 1:
Improving Awareness
20 Minutes then return to Main Room
Breakout Room discussions are not recorded

Breakout Discussion 1: Report Out

Two minutes per group

Try not to repeat a point someone else has mentioned

so every group has a chance to report


Breakout Discussion 2:
Improving Access
20 Minutes then return to Main Room
Breakout Room discussions are not recorded

Breakout 2 – 20 minutes

IMPROVING ACCESS

MHSA Strategic Priorities: Improve access to behavioral health services, including suicide prevention supports

In recent surveys of Orange County residents (2020) and CalOptima members (2018), two common barriers to accessing mental health services included:

- **Stigma**
  - *"Don't want people to think something is wrong with me"*
  - *"Did not feel comfortable talking about personal problems"*
- **Preference for face-to-face services** *(compared to telehealth during COVID)*

MAIN QUESTION

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

PLEASE PROVIDE SPECIFIC EXAMPLES OF:

- Cultural practices
- Language: terms/phrasing to use? To avoid?
- Types of interventions that support well-being
- Finding a private space if you live with others to help make a telehealth session more comfortable

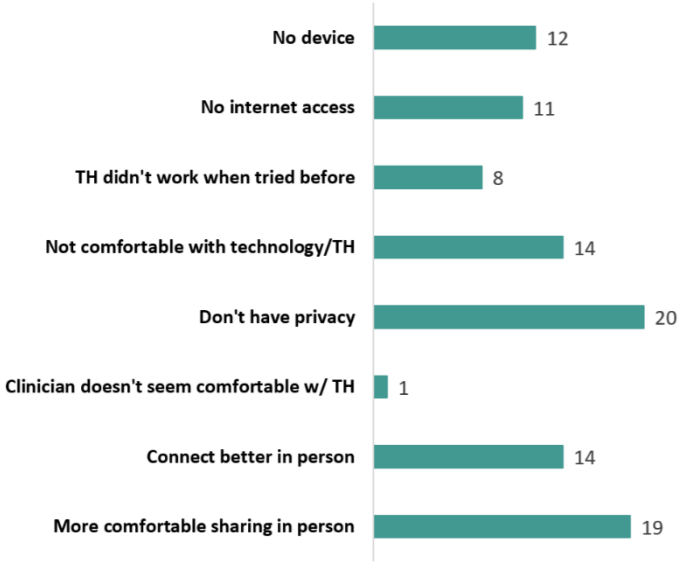
PROMPTS TO HELP US BETTER UNDERSTAND

- What types of changes or improvements would make services more welcoming for members of my community?
- What types of changes or improvements would make it easier for my community to connect with services, including telehealth?
- What are short-term strategies the OC Health Care Agency can use now to encourage people from diverse backgrounds (to apply) to work in the public mental health system?

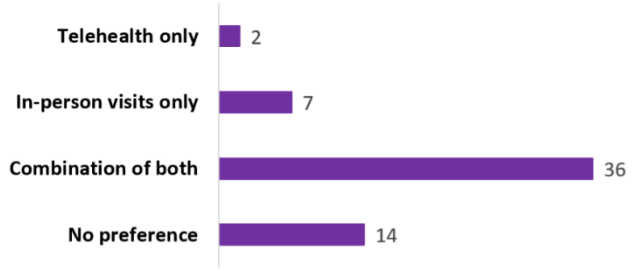
Participant Polling

Updated today!

Challenges to using telehealth (TH) for mental health or substance use services (select all that apply)



After social interactions and community gatherings are possible again, your preference for appointments is:



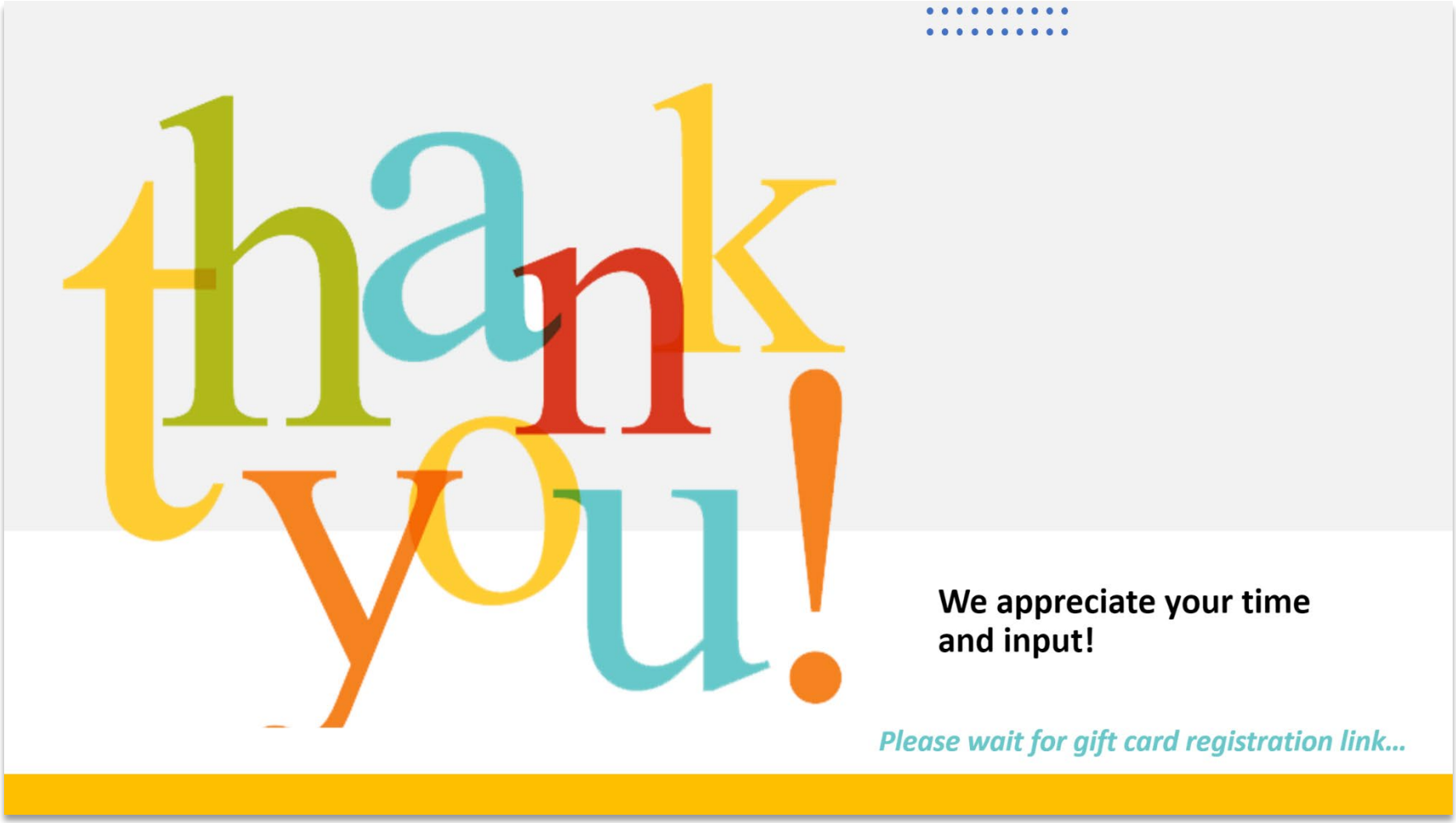
21

Breakout Discussion 2: Report Out

Two minutes per group

Try not to repeat a point someone else has mentioned

so every group has a chance to report


thank you!
We appreciate your time and input!
Please wait for gift card registration link...

How to Claim the Gift Card

Please be respectful of others when sharing your comments and opinions. Participants who use inappropriate or offensive language will be removed from the meeting and are no longer eligible for a gift card.

We appreciate your ideas and suggestions! Participants who attend the entire meeting are eligible for a $20 gift card to a grocery store.
All gift cards are physical gift cards and must be received in person.

TO RECEIVE YOUR GIFT CARD:

1. **Attend the entire meeting**
   a. *We will take attendance throughout the meeting so if you get disconnected we can readmit you to the meeting and you can still participate.*

2. **Decide how you would like to pick up the card:**
   a. Come to HCA in Santa Ana:
      - M - W - F between 8am-11am (except holidays)
      - T - Th between 2-5pm (except holidays)
      - *Please call before coming to confirm someone will be available to help you*

      OR

   b. Come to a community location:
      b. Dates, time and locations to be arranged
      c. *We will email/call when scheduled*

3. **Tell us what your preference for pick up is:**
   a. Before leaving the meeting:
      - Click on the URL link that will be sent through Zoom chat
      - Complete a brief, anonymous feedback survey
      - Click to go register in a separate gift card registration link

      OR

   b. After the meeting, contact us at:
      - mhsa@ochca.com or
      - 714-834-3104

Nuts & Bolts: After the CEM

- Notetakers and Facilitators will share notes to complete an online MHSA Post-CEM Summary survey **within three days** of the CEM
  - **One** online survey (notes) per Facilitator/Notetaker pair
  - Please complete survey in English ☺
    - *Link to be sent by HCA*

Nuts & Bolts

- **Confirmation of CBO staff names and Zoom names** (*Negar*)

- **Discuss gift card distribution plan** (*Negar*)

  Note: *All gift cards are physical gift cards. HCA must be present for signatures before the card can be given to the participant.*

  - Would participants be able to schedule a time to come to HCA to pick up?
    - M / W / F between 8am-11am (except holidays)
    - T / Th between 2-5pm (except holidays)
  - Is there another central location participants could go to pick up (that HCA could schedule designated pick up times)?
    - Dates/Times TBD
  - Gift card distribution must be scheduled within one month of the CEM

Nuts & Bolts

- **Optional:**
  - Troubleshoot ‘Share Screen’ issues in Breakout Room
  - Tutorial on Changing your Zoom login name (*Min*)
  - Update your Zoom software!

Questions

CEM CHECKLIST FOR FACILITATORS

BEFORE THE DAY OF THE CEM

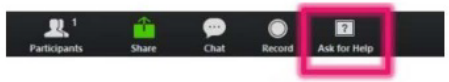
- ☐ Confirm the identified Notetaker is available to take notes during the breakout discussions
- ☐ Attend MHSA CEM Orientation
- ☐ Review CEM meeting materials:
  - MHSA Strategic Priorities from Three-Year Plan
  - 2021 Participant Breakout Room Questions
- ☐ Make sure you have a computer or laptop with a functioning microphone and webcam, and stable Wi-Fi/Internet connection
  - ***Do not*** use a tablet, iPad or smartphone
- ☐ Review Zoom facilitator tips on YouTube here

DAY OF THE CEM – BEFORE THE START OF THE MEETING

- ☐ Prepare yourself and your environment
  - Make sure you are in a quiet space with limited interruptions or distractions
  - Be aware of your background on camera
  - Have a bottled water on hand
- ☐ Have your CEM Facilitator Packet PDF easily accessible. The Packet includes:
  - MHSA Strategic Priorities from Three-Year Plan
  - 2021 Participant Breakout Room Questions
  - CEM Slide deck
  - Participating Effectively as a MHSA Stakeholder
- ☐ Make sure your computer is plugged in
- ☐ Have Breakout Session PowerPoint Slides open on your computer and ready to screenshare
- ☐ Close programs, emails, documents or any other materials that are not related to the CEM. Turn off all notifications.
- ☐ Go to your Outlook Calendar to access the Zoom link. Facilitators and Notetakers will **log in 15-minutes before** the start of the CEM to complete *all* the following
  - Make sure your name on Zoom matches the name provided to HCA prior to the CEM to be admitted from the wait-room
  - Be assigned as a Co-Host by HCA
  - Rename your Zoom name so it identifies your CBO after your name. Example: John Doe, OCHCA
  - Test microphone and speakers to make sure they are working properly

Created 1/21

☐ ***NOTE:*** The Notetaker can use the "Ask for Help" button for assistance from the HCA Staff



DURING THE BREAKOUT ROOM DISCUSSIONS

☐ To help create a comfortable and safe virtual environment, please review the following group agreement:

- Be respectful
- Take turns speaking
- Stay present and engaged
- Support each other, even when you disagree

Note: You have the ability to remove participants who use inappropriate or offensive language. Please notify the MHSA Host by direct message if a participant is removed from the meeting.

☐ Remind participants how to mute/unmute and raise/lower hand, especially if a participant joined by phone only (i.e., use ***9 to raise/lower hand** and ***6 to mute/unmute**)

☐ Identify a participant who will report out main discussion ideas to the larger group

☐ Share the Breakout Room Discussion purpose and goal

☐ Use the following facilitation Tips:

- Use questions and prompts provided by HCA
- Create a "parking lot" for ideas that are unrelated to questions/prompts
- Keep an eye on the time
- Encourage solution-focused discussions
- Balance participation so everyone has a chance to contribute
- Paraphrase comments to confirm they were captured accurately
- Draw upon your experience and use terms that connect with your community
- When the 120s countdown begins, transition to reviewing the main points the group participant will share in the Main Room

AFTER THE CEM

☐ Complete the MHSA Post-CEM Summary survey ***within 3 business days***

Mental Health Awareness & Stigma Reduction

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

Priority Populations	Strategies	Progress Update
• **LGBTIQ individuals** • **Boys ages 4-11** • **Transitional Age Youth (TAY) ages 18-25** • **Adults ages 25-34 and 45-54** • **Unemployed adults** • **Homeless individuals** • **Individuals living with co-occurring mental health and substance use conditions** • **Older Adults ages 60+**	★ **Continue partnering with local groups engaged with the priority populations** • Continue partnering with CalMHSA's Statewide Projects and other organizations • Partner with media/marketing organizations	★ **Establishing and/or strengthening outreach partnerships with trusted local organizations that serve priority populations** ✓ Offering range of mental health trainings for various community organizations ✓ Expanding reach of CalMHSA *Directing Change* project in OC schools ✓ Launched local digital stigma reduction and awareness campaigns *(click links to learn more)*: ○ Stigma Free OC Campaign ○ Stigma Free OC website ○ Connect OC Coalition website
	• Incorporate findings and recommendations from RAND reports on social marketing	⋯ Beginning to increase/expand use of social marketing to promote mental health-related messages

Note: Due to COVID-19, in-person outreach and events were postponed and, where possible, events and activities were transitioned into online and virtual formats.

How can I help? **At the Community Engagement Meeting (CEM), give examples of how mental health campaigns can be designed to more directly speak to me and my community.**

KEY: ★ Focus of CEM ✓ Completed & ongoing ⋯ In progress, some delays due to COVID ⏸ Paused due to COVID

Suicide Prevention

Expand support for suicide prevention efforts

★ Priority Populations	Strategies	Progress Update
• **People from all MHSA age groups** • **Homeless individuals** • **Individuals living with co-occurring mental health and substance use conditions** • **LGBTIQ individuals** • **Veterans**	• Increase capacity of Warmline and Suicide Prevention Services	✓ Warmline expanded to 24/7 ✓ Suicide Prevention Services increased staffing to manage rising call volume and community training requests o *While there has been some success outreaching to monolingual and limited English-speaking communities, cultural and generational barriers persist and callers continue to be predominantly English-speaking. A gradual shift in perceptions has been observed in younger generations, and there is also growing interest in suicide prevention in the Korean media*
	• Increase crisis services for youth under age 18 • Increase Crisis Residential Services for adults/older adults	✓ Crisis residential services expanded for adolescents and for adults/older adults
	• Continue partnering with OC Community Suicide Prevention Initiative	✓ Examples of resulting activities/campaigns *(also leverage CalMHSA's Know the Signs information; click links to view):* o Suicide Prevention Campaign for Adult/Older Adult Men o Adult "Help is Here" website o Youth "Be a Friend for Life" website
	• Use strategies from MHSOAC Striving for Zero report	⋯ HCA ramped up various suicide prevention and mental health resources in response to COVID pandemic (*click here for example*). These and other activities will be crosswalked to the MHSOAC strategies as time permits.

How can I help? **At the Community Engagement Meeting (CEM), give examples of how suicide prevention campaigns and messages can be designed to more directly speak to me and my community.**

KEY: ★ Focus of CEM ✓ Completed & ongoing ⋯ In progress, some delays due to COVID ⏸ Paused due to COVID

Access to Behavioral Health Services

Improve access to behavioral health services and address transportation challenges

Priority Populations	Strategies	Progress Update
• **Youth** • **Families with children living with a mental health condition** • **Asian/Pacific Islander** • **Latino/Hispanic** • **Black/African-American**	★ **Work with community to identify and integrate culturally and linguistically responsive strategies and approaches** • Offer telehealth/virtual behavioral health care options for people of all ages living w/ significant mental health conditions • Expand school-focused mental health services • Expand transportation services	★ **Establishing and/or strengthening partnerships with trusted local organizations that serve priority populations** ✓ Made rapid, systemwide transition to various virtual behavioral health services and supports in response to COVID-19 o *Continuing to work through challenges in accessing, transitioning to, and using technology by providers and/or clients* o *Expanded hours/availability of counseling services* ✓ Launched outreach, peer support, networking and resource activities for K-12 students, college students and TAY ✓ Along with OC Department of Education and OC School Districts, implementing a grant to coordinate referrals and linkages, and to train school staff on mental health topics ⏸ Waiting for State direction on new Medi-Cal program in schools ⏸ Transportation support remains available at reduced levels due to COVID-19; expansion on pause

How can I help? **At the Community Engagement Meeting (CEM), give examples of changes that would make services more welcoming and easier to connect with, particularly for unserved communities.**

KEY: ★ Focus of CEM ✓ Completed & ongoing … In progress, some delays due to COVID ⏸ Paused due to COVID

OC MHSA COMMUNITY ENGAGEMENT MEETING (CEM)
PARTICIPANT GUIDE

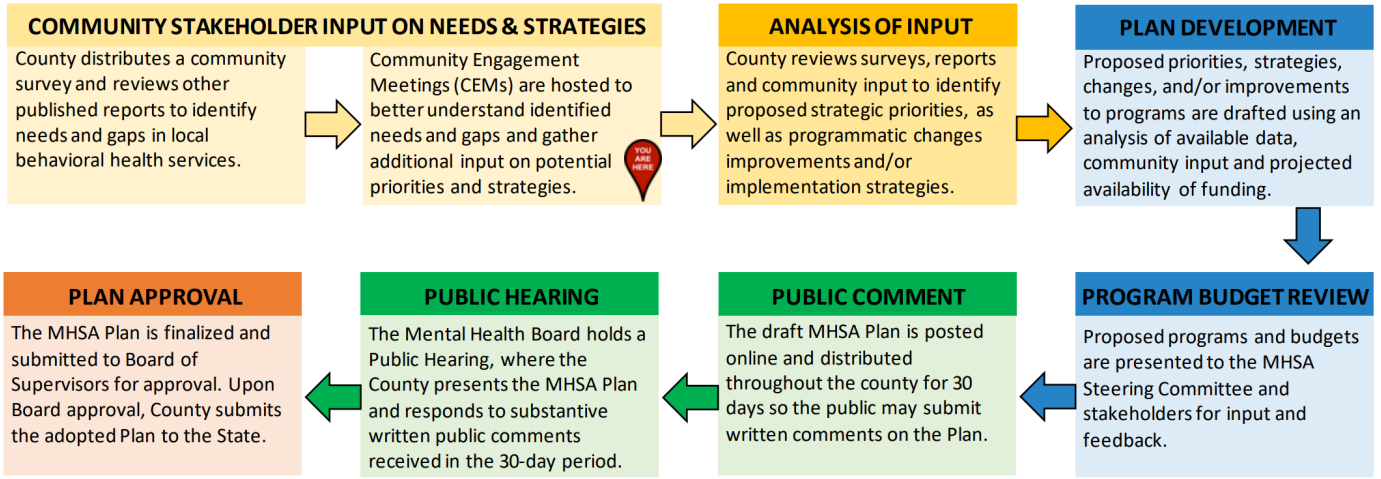
WHAT IS THE MENTAL HEALTH SERVICES ACT (MHSA)?

California voters passed the Mental Health Services Act (MHSA) – or Proposition 63 – in November 2004 to expand and improve public mental health services. The Act implemented a 1% state tax on income over $1 million to be used for services aimed at reducing the long-term impact on individuals and families resulting from untreated serious mental illness and serious emotional disturbance. Proposition 63 emphasizes transformation of the mental health system in order to improve the quality of life for Californians living with a mental health condition.

WHAT IS COMMUNITY PLANNING?

The MHSA was built upon the idea that each local community should take an active role in providing input on the county's mental health service needs and priorities, as well as the funding for those services. This community involvement, referred to as the Community Planning Process, is required by the Act and helps to ensure that county MHSA plans and updates are developed with local stakeholder input. It is an ongoing, inclusive process involving clients, families, caregivers and partner agencies to identify community issues related to mental illness resulting from gaps in community services and support, as well as stigma and discrimination. The Community Program Planning Process assesses the county's current capacity, defines the populations to be served, and determines the strategies for providing effective services. From this process, the MHSA Plan is developed and/or updated.

ORANGE COUNTY'S MHSA COMMUNITY PLANNING PROCESS:



ADAPTED FROM CAMHPRO

OC MHSA COMMUNITY ENGAGEMENT MEETING (CEM)
PARTICIPANT GUIDE

Ready...

HOW CAN I PREPARE?

Before the Meeting Day:

- ☐ Review materials sent out prior to the meeting
- ☐ Write down key points of your remarks
- ☐ Learn about Zoom and its functions
  - How to Join a Zoom Meeting
  - Zoom Controls for Participants

On the Meeting Day:

- ☐ Set up your environment
  - Find a quiet space
  - Be aware of your background on camera
  - Have a bottled water or snack on hand
  - Find your meeting materials
- ☐ Review the meeting objectives
- ☐ Have your Zoom meeting information ready

Set...

HOW SHOULD I PARTICIPATE?

Before you speak:

- ☐ Determine how much time you will have and plan to use it efficiently
- ☐ Respect any limitations on your speaking time in consideration of others who wish to speak

When you speak:

- ☐ Use everyday language that everyone can understand
- ☐ Use a conversational tone
- ☐ Tell your story in the first person, using "I" statements
  - Give examples, including your own experiences

During Discussion:

- ☐ Keep participating and listening for feedback

Engage!

WHAT HAPPENS IF WE DISAGREE?

Tips & Reminders:

- ☐ Do not just focus on the problems; remember to focus on the meeting goals
- ☐ Be prepared to suggest and support solutions!
- ☐ Be respectful, noting your points of agreement and disagreement without attacking anyone
- ☐ Put "principles over personalities"
- ☐ Find common ground and support each other
- ☐ Know how to occasionally "agree to disagree" and compromise
- ☐ Change takes time, be patient and think long-term: A partial success today gives you a foundation for future advocacy that may achieve your larger goals
- ☐ Listen to learn from others; look at it as a learning experience every time

We appreciate and value your time! To help create a comfortable and safe virtual environment, please be respectful of others when sharing your comments and opinions. Participants who use inappropriate or offensive language will be removed from the meeting and are no longer eligible for a gift card.

ADAPTED FROM CAMHPRO

Community Engagement Meeting

Co-HOSTS:

FY 2021-22 MHSA Annual Plan Update

1

Agenda

Welcome, Introductions	6:00
Overview of MHSA	6:10
Breakout Session 1: Improve Awareness Move to small groups	6:25
Report Out 1 Return to main room and present key discussion points from each group	6:45
Breakout Session 2: Improve Access Move to small groups	7:10
Report Out 2 Return to main room and present key discussion points from each group	7:30
Wrap Up *(includes link to register for gift card pick up)*	7:55

2

How to Zoom

The meeting in the Main Room is recorded.
Breakout Room discussions are not recorded.

In Zoom

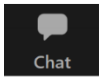
You can hear and see who is speaking

UNMUTED
Mic is **ON**

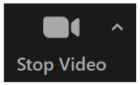
MUTED
Mic is **OFF**

find by your name

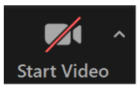
or tap MORE to find the hand



*with **EVERYONE** vs*
*Direct Message that is only seen by **Co-Host***



Video is **ON**



Video is **OFF**

If you are in a place with background noise, please keep your device/phone MUTED when you're not speaking *

To ask questions / make comments, use:

"RAISE HAND"

and the Co-Host will call on you when it's your turn to speak

or **CHAT**

Chat to EVERYONE is seen by everyone. Attendees can also direct message the OCHCA Co-Host, who will read your message anonymously

If the Zoom connection is breaking up, turning your video OFF may help

On Phone

You can only hear who is speaking

press *6
to **MUTE** and **UNMUTE**

press *9
to **RAISE HAND** and let the Co-Host know you would like to speak

** Participants who are On Zoom with a computer or tablet and calling in over a telephone may need to mute/unmute both, and watch out for feedback*

We appreciate and value your time! To help create a comfortable and safe virtual environment, please be respectful of others when sharing your comments and opinions.

3

How to Claim the Gift Card

Please be respectful of others when sharing your comments and opinions. Participants who use inappropriate or offensive language will be removed from the meeting and no longer eligible for a gift card.

We appreciate your ideas and suggestions! Participants who attend the entire meeting are eligible for a $20 gift card to a grocery store.
All gift cards are physical gift cards and must be received in person.

TO RECEIVE YOUR GIFT CARD:

1. **Attend the entire meeting**
   a. *We will take attendance throughout the meeting so if you get disconnected we can readmit you to the meeting and you can still participate*

2. **Decide how you would like to pick up the card:**
   a. Come to HCA in Santa Ana:
      - M - W - F between 8am-11am (except holidays)
      - T - Th between 2-5pm (except holidays)
      - *Please call before coming to confirm someone will be available to help you*

      OR

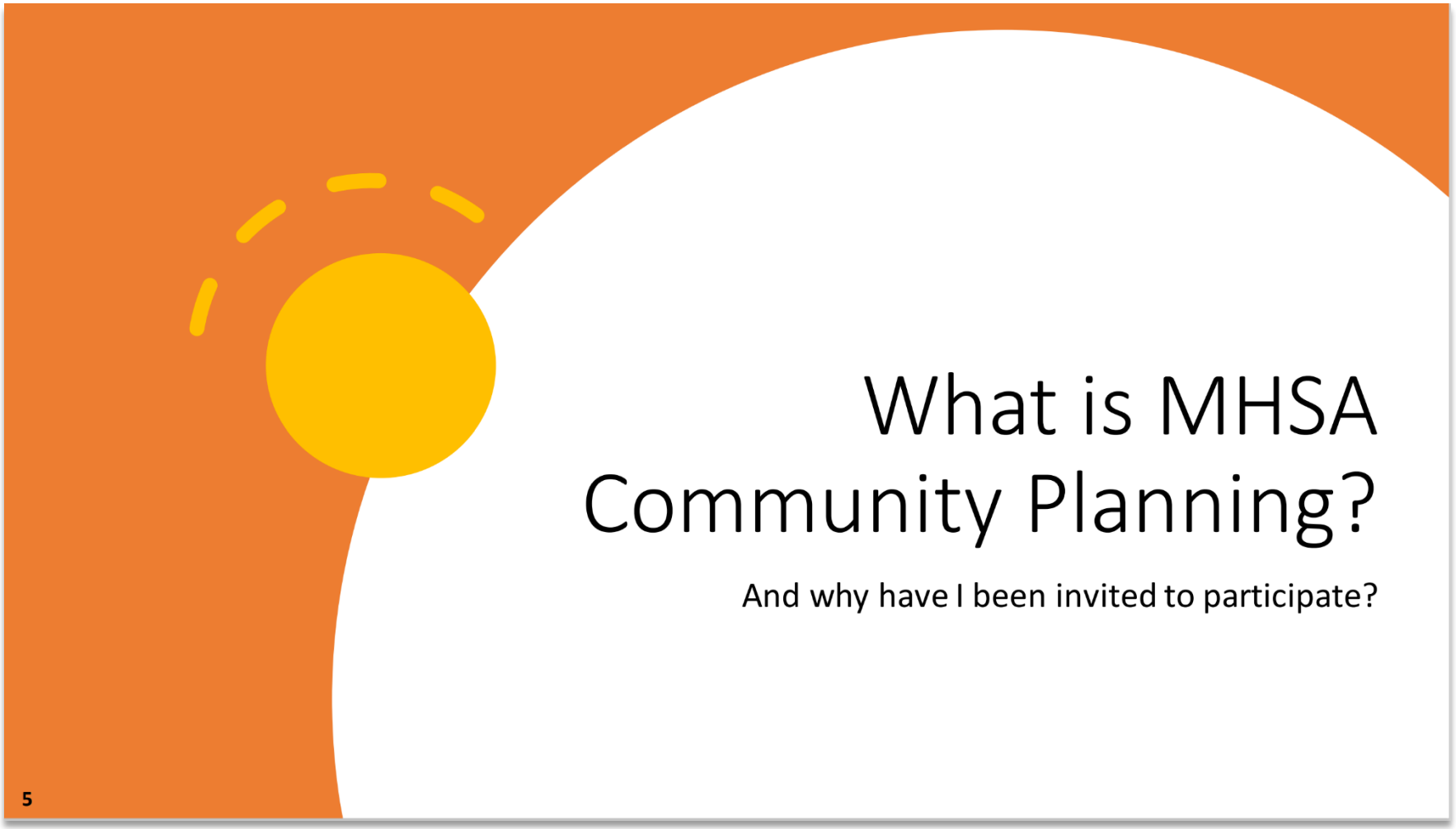
   b. Come to a community location:
      - Dates, time and locations to be arranged
      - *We will email/call when schedule*

3. **Tell us what your preference for pick up is:**
   a. At the end of today's meeting:
      - Click on the URL link that will be sent through Zoom chat
      - Complete a brief, anonymous feedback survey
      - Click to go register in a separate gift card registration link

      OR

   b. After today's meeting, contact us at:
      - mhsa@ochca.com or
      - 714-834-3104

4


What is MHSA Community Planning?
And why have I been invited to participate?
5

What is the **MHSA**?

Mental Health Services Act

- Passed by California voters in November 2004
- Implemented a 1% tax on income over $1 million
- Emphasizes transformation of the mental health system
- Strives to improve the quality of life for Californians living with a mental illness, particularly those living with serious mental illness (SMI) or serious emotional disturbance (SED), and their families

WELLNESS · RECOVERY · RESILIENCE

6

What are MHSA's **Core Values**?

- Community **Collaboration**
- **Cultural** Competence
- **Client** and **Family** Driven
- **Wellness**, **Recovery** and **Resilience** Focused
- **Integrated Services Experience** for Clients and their Families

- *Focus of the Feb-March 2021 CEMs*

CA Code of Regulations § 3320
CA Welfare & Institutions Code 5848

7

What is the **MHSA CPPP**?

Community Program Planning Process

- Refers to the **process used by the County** to **develop** the MHSA Three-Year Plan or Plan Updates, in partnership with stakeholders
- Involves clients with SED/SMI and their family members **in all aspects**
- Includes participation of **stakeholders**
- **Provides training**, as needed, to stakeholders, clients and family members participating in the CPPP

CA Code of Regulations 3200.070
CA Code of Regulations 3300

8

Who are **MHSA's** Stakeholders?

- **Adults and seniors living with severe mental illness**
- **Families of children, adults and seniors living with severe mental illness**
- Providers of services
- Law enforcement agencies
- Education
- Social services agencies
- Veterans, Representatives from Veterans organizations
- Providers of alcohol and drug services
- Health care organizations
- Other important interests

CA Welfare & Institutions Code 5848

- Stakeholders must include representatives of **un-/ under-served populations** & their **family** members
- Stakeholders should reflect the **diversity** of the county (i.e., geographic location, age, gender, race/ethnicity)

CA Code of Regulations 3300

- *Target audience for the Feb-March 2021 CEMs*

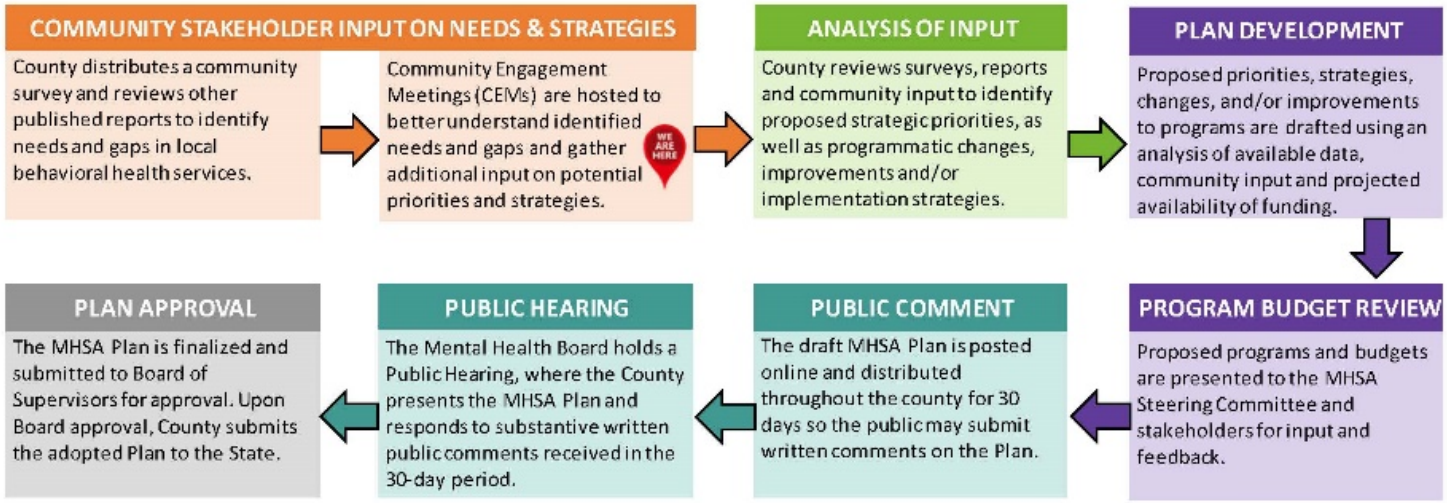
9

What is the **Goal** of the CPPP?

- Through the CPPP, local MHSA stakeholders help:
  - Identify **community issues** related to mental illness resulting from lack of community services and supports, including any issues identified during the implementation of the MHSA
  - Analyze the **mental health needs** in the community
  - Identify and re-evaluate **priorities** and **strategies** to meet those mental health needs

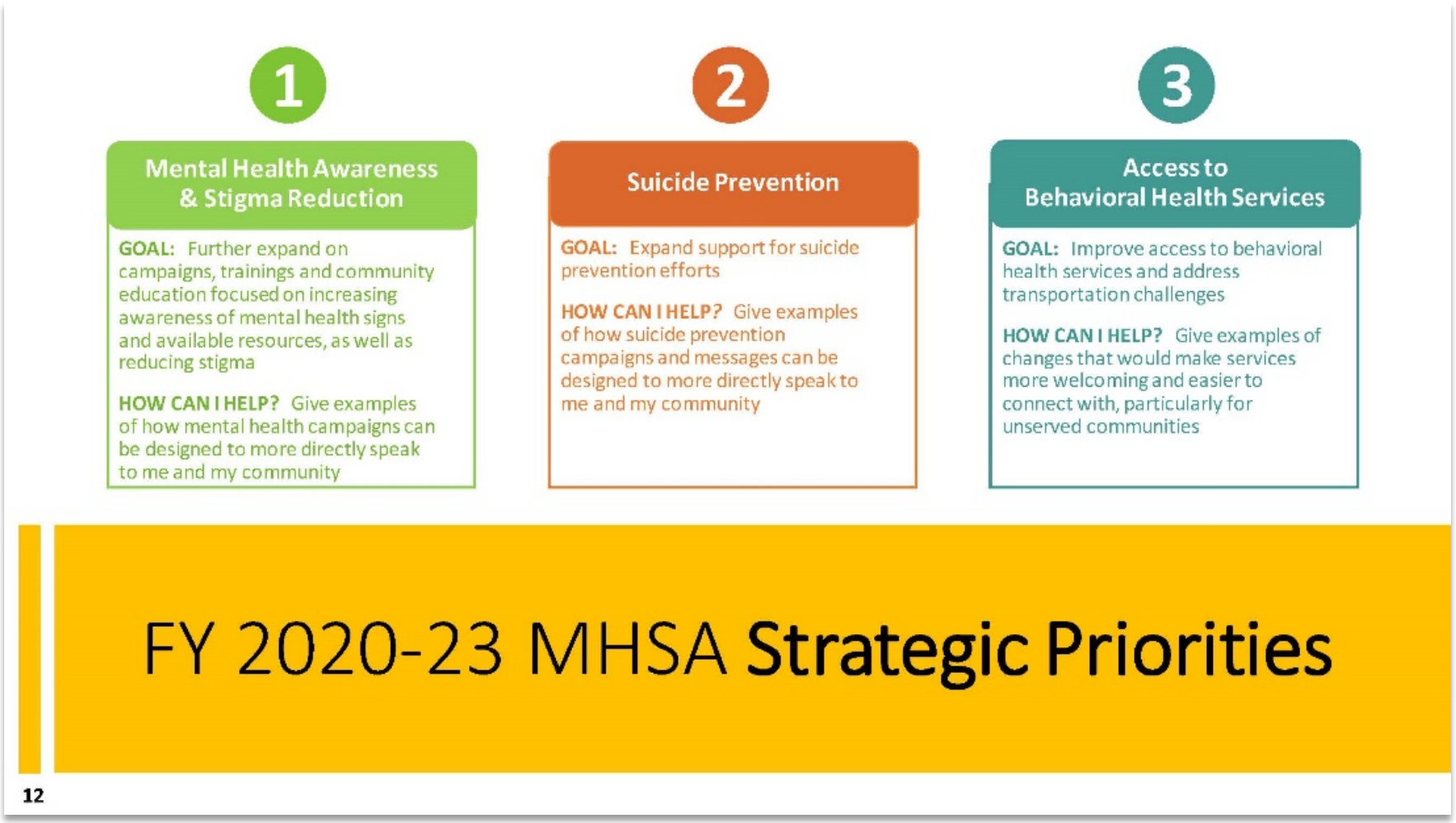
CA Code of Regulations 3200.070

10



What are the **Steps** in OC's CPPP?

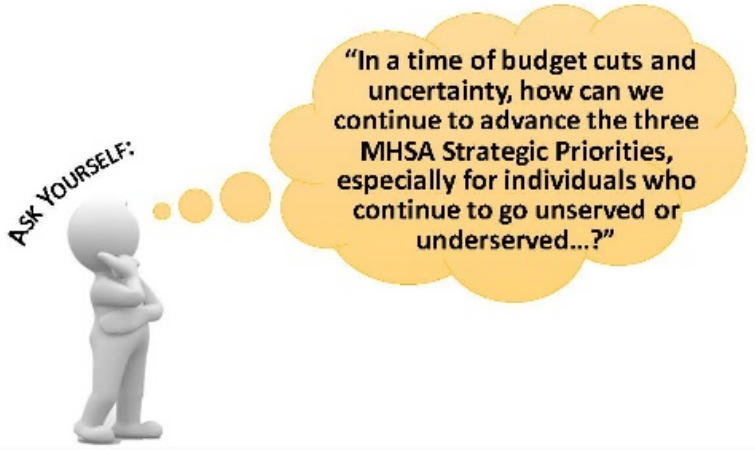
11


1
Mental Health Awareness & Stigma Reduction
GOAL: Further expand on campaigns, trainings and community education focused on increasing awareness of mental health signs and available resources, as well as reducing stigma
HOW CAN I HELP? Give examples of how mental health campaigns can be designed to more directly speak to me and my community
2
Suicide Prevention
GOAL: Expand support for suicide prevention efforts
HOW CAN I HELP? Give examples of how suicide prevention campaigns and messages can be designed to more directly speak to me and my community
3
Access to Behavioral Health Services
GOAL: Improve access to behavioral health services and address transportation challenges
HOW CAN I HELP? Give examples of changes that would make services more welcoming and easier to connect with, particularly for unserved communities
FY 2020-23 MHSA Strategic Priorities
12

What to **Consider** for the 2021 CEMs?

- Due to the fiscal impact of COVID-19, HCA had to evaluate its MHSA program budgets
- Initial budget reductions have been identified by HCA and reviewed with the MHSA Steering Committee
- Additional savings are currently being identified to help ensure continuity of services over the next several years

What does this mean for the 2021 CEMs?



13

Focus of the 2021 CEMs

Breakout sessions will gather input on two areas that cover all three MHSA Strategic Priorities:

1

BREAKOUT SESSION 1:
Strategies programs can use to improve outreach, advertising and messaging on mental health and suicide prevention in diverse communities

2

BREAKOUT SESSION 2:
Strategies programs can use to make mental health services more welcoming and easier to connect with, especially for individuals from unserved communities

14

Breakout Room discussions are not recorded


Breakout Discussion 1:
Improving Awareness
20 Minutes then return to Main Room
Breakout Room discussions are not recorded
15

IMPROVING AWARENESS

MHSA Strategic Priorities: Expand on campaigns and trainings focused on increasing awareness of mental health, suicide prevention and available resources, as well as reducing stigma

MAIN QUESTION

"What are the advertising and outreach strategies that would be most effective in getting mental health-related messages out to my community? The least effective?"

EXAMPLES OF ADVERTISING/OUTREACH METHODS:

- Billboards
- Bus Ads
- Bus Shelter Ads

Which locations?

- Television
- Radio
- Newspapers
- Internet
- Social Media

Names of most trusted or commonly used stations, papers, apps and/or websites?

- Emails
- Events/Fairs

Who should these come from/ be hosted by?

- Other

16

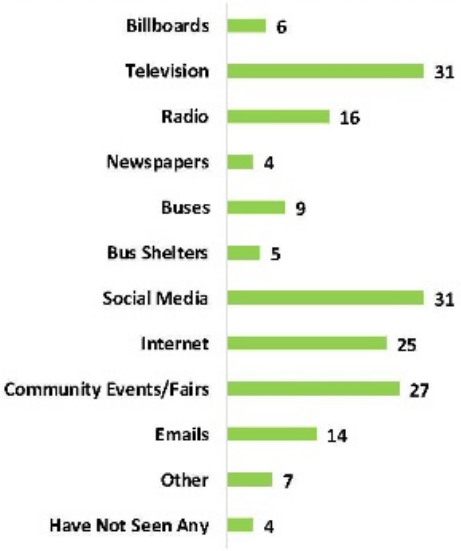
PROMPTS TO HELP US BETTER UNDERSTAND

- What would make an ad something you would remember or want to learn more about?
- Are some ways of advertising/promoting better suited for certain types of messages/information than others?
- Are certain ways of advertising/promoting better at reaching people of different ages, backgrounds, etc.?

Participant Polling

Updated today!

You Have Seen Mental Health-Related Ads On:



The Ads You Saw Were About:

The Ads Prompted You To:

All questions were"select all that apply"

17

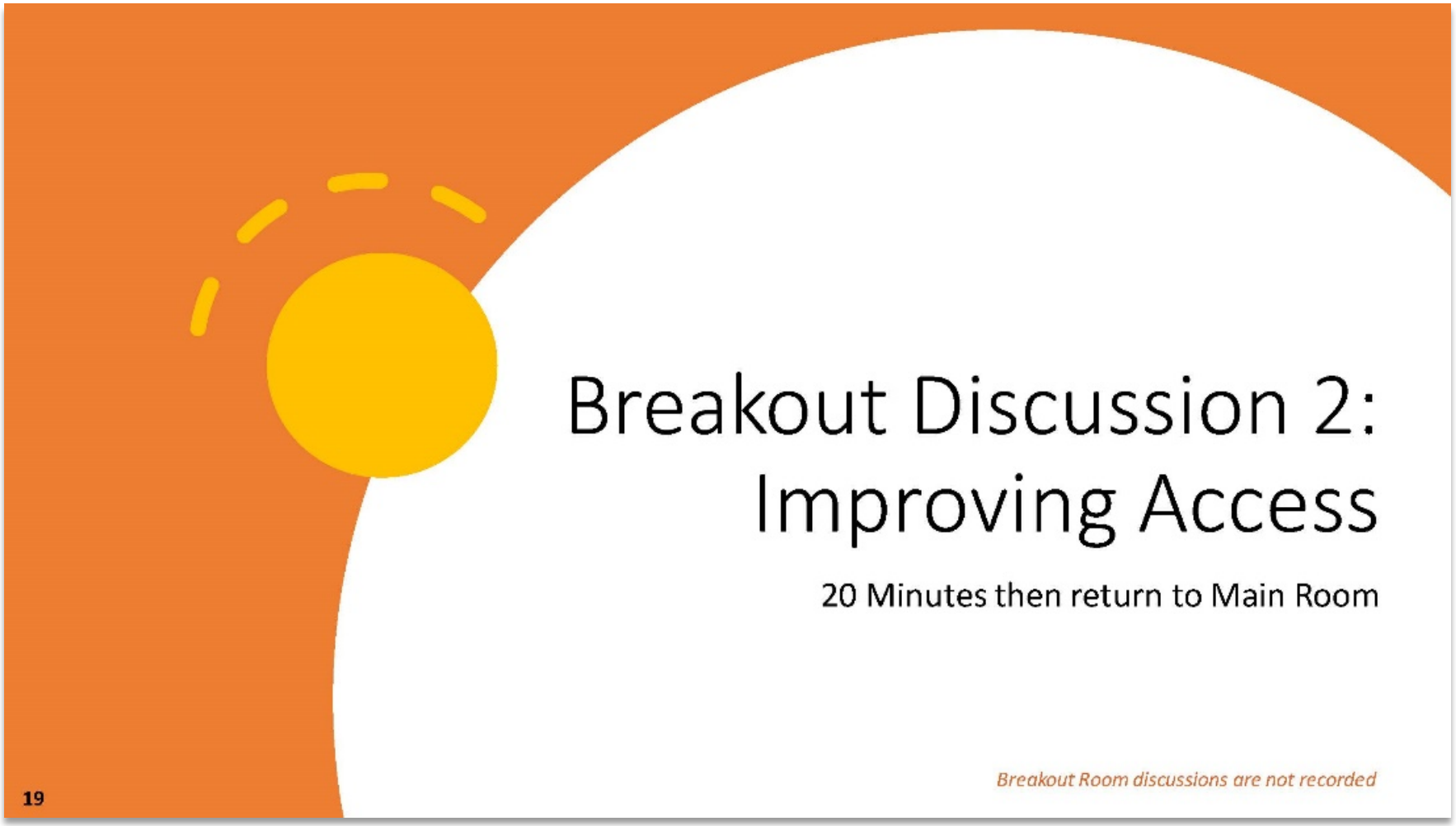
Breakout Discussion 1: Report Out

Two minutes per group

Try not to repeat a point someone else has mentioned

so every group has a chance to report

18


Breakout Discussion 2:
Improving Access
20 Minutes then return to Main Room
Breakout Room discussions are not recorded
19

IMPROVING ACCESS

MHSA Strategic Priorities: Improve access to behavioral health services, including suicide prevention supports

In recent surveys of Orange County residents (2020) and CalOptima members (2018), two common barriers to accessing mental health services included:

- **Stigma**
  "Don't want people to think something is wrong with me"
  "Did not feel comfortable talking about personal problems"
- **Preference for face-to-face services** *(compared to telehealth during COVID)*

MAIN QUESTION

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

PLEASE PROVIDE SPECIFIC EXAMPLES OF:

- Cultural practices
- Language: terms/phrasing to use? To avoid?
- Types of interventions that support well-being
- Finding a private space if you live with others to help make a telehealth session more comfortable

PROMPTS TO HELP US BETTER UNDERSTAND

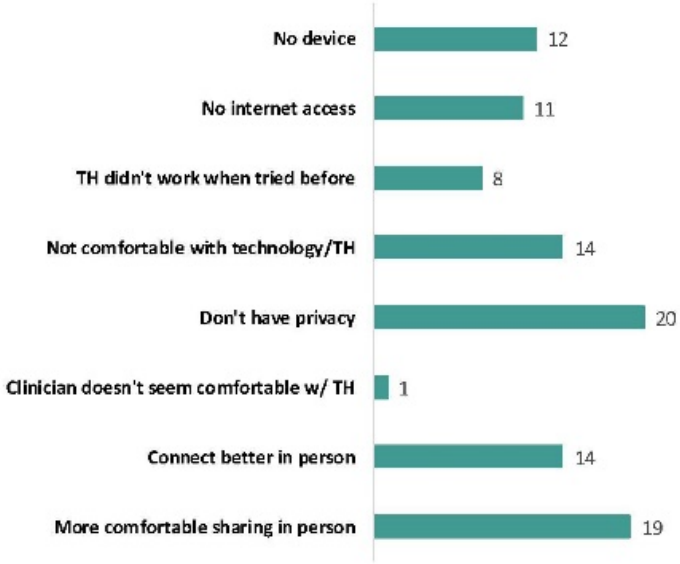
- What types of changes or improvements would make services more welcoming for members of my community?
- What types of changes or improvements would make it easier for my community to connect with services, including telehealth?
- What are short-term strategies the OC Health Care Agency can use now to encourage people from diverse backgrounds (to apply) to work in the public mental health system?

20

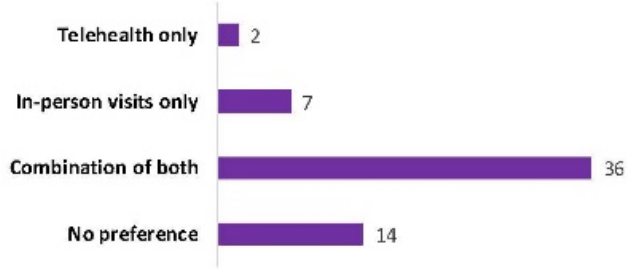
Participant Polling

Updated today!

Challenges to using telehealth (TH) for mental health or substance use services (select all that apply)



After social interactions and community gatherings are possible again, your preference for appointments is:



21

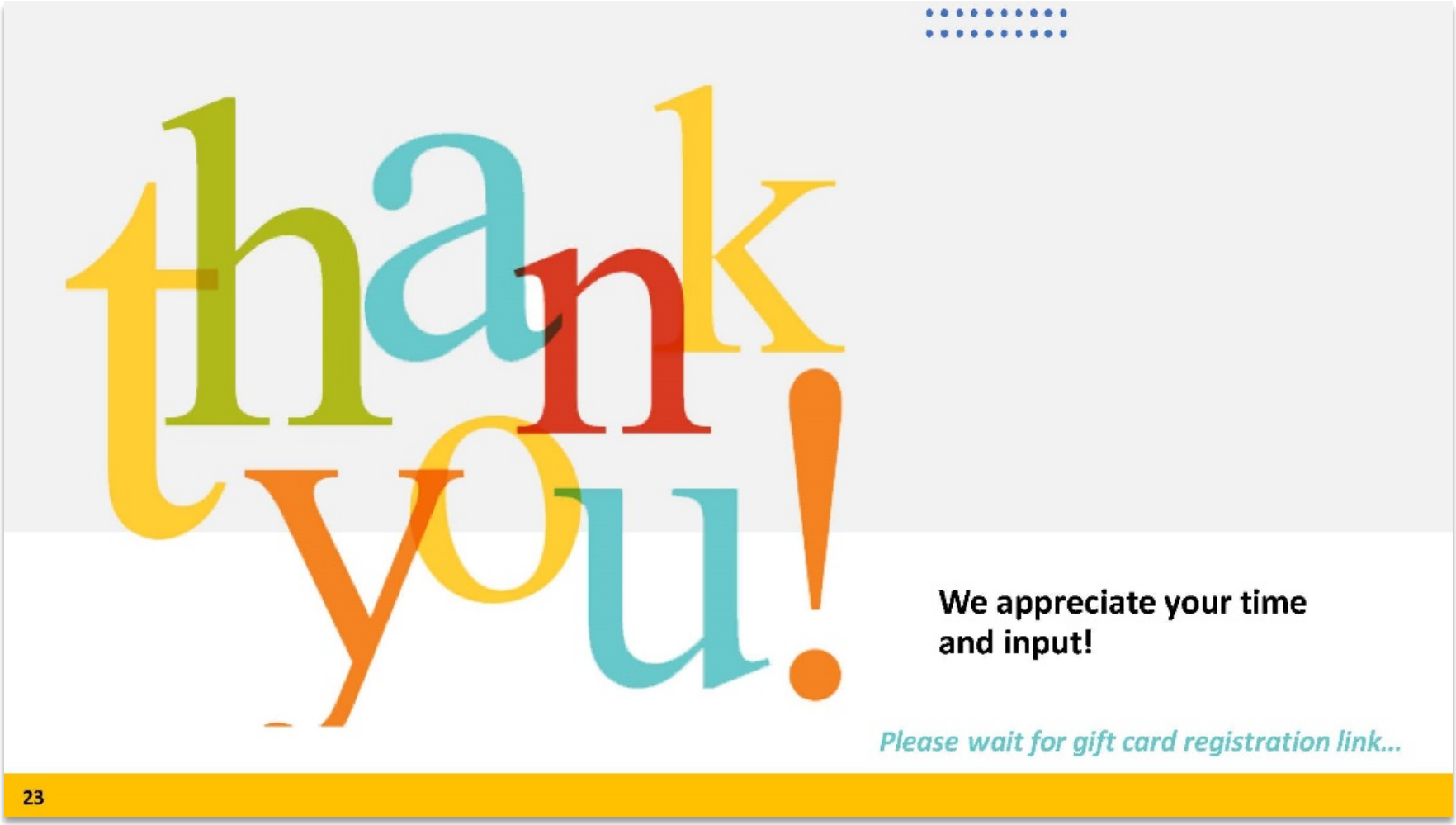
Breakout Discussion 2: Report Out

Two minutes per group

Try not to repeat a point someone else has mentioned

so every group has a chance to report

22


thank you!
We appreciate your time and input!
Please wait for gift card registration link...
23

How to Claim the Gift Card

Please be respectful of others when sharing your comments and opinions. Participants who use inappropriate or offensive language will be removed from the meeting and are no longer eligible for a gift card.

We appreciate your ideas and suggestions! Participants who attend the entire meeting are eligible for a $20 gift card to a grocery store.
All gift cards are physical gift cards and must be received in person.

TO RECEIVE YOUR GIFT CARD:

1. **Attend the entire meeting**
   a. *We will take attendance throughout the meeting so if you get disconnected we can readmit you to the meeting and you can still participate*
2. **Decide how you would like to pick up the card:**
   a. Come to HCA in Santa Ana:
      - M - W - F between 8am-11am (except holidays)
      - T - Th between 2-5pm (except holidays)
      - *Please call before coming to confirm someone will be available to help you*

      OR

   b. Come to a community location:
      - Dates, time and locations to be arranged
      - *We will email/call when scheduled*
3. **Tell us what your preference for pick up is:**
   a. Before leaving the meeting:
      - Click on the URL link that will be sent through Zoom chat
      - Complete a brief, anonymous feedback survey
      - Click to go register in a separate gift card registration link

      OR

   b. After the meeting, contact us at:
      - mhsa@ochca.com or
      - 714-834-3104

24

APPENDIX VII: Analytic Strategy for CEM Feedback

At the time of analysis, 61 feedback surveys were completed via Qualtrics Experience Management Software by representatives that attended each of the community engagement meetings as a facilitator (n = 12), notetaker (n = 37), or both (n = 12). Feedback from these surveys were analyzed using a mixed method approach, allowing for the combining of information from quantitative survey data and qualitative open-ended responses.

Analysis of Quantitative Survey Data

First, frequencies for all survey items, including demographics, were computed, and visualized using a combination of Qualtrics Software and Microsoft Excel for each of the survey polling responses (See Appendix, Sample Item: What are the advertising and outreach strategies that would be most effective in getting mental health-related messages out to my community?). This allowed participants to efficiently rank and select multiple choice responses which provided further nuanced detail into their answers. This process led to several key findings, including that even after the pandemic has subsided, participants still prefer a combination of in-person care and telehealth, and that television, social media, and events and fairs are among the most effective advertising and outreach strategies. Billboards, bus ads, and emails were stated as among the least effective.

Analysis of Qualitative Open-ended Responses

Next, qualitative responses were analyzed by the MHSA Office Research Staff using phenomenological thematic analysis (See example of coding process):

Roses are red, violets are blue → Flowers = 2, Color = 2

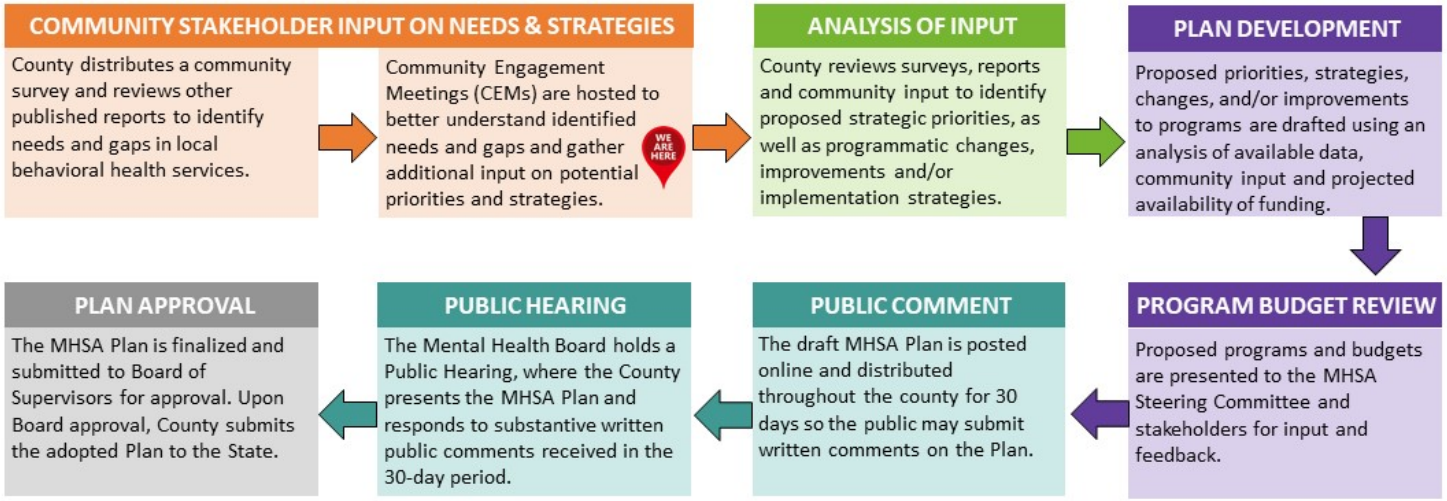
This iterative analytic approach contrasts thematic analysis that uses a pre-determined, or a priori established set of coding parameters, which does not allow for emergent themes to develop. This approach also provides an impartial framework to compile responses about individual experiences, feelings, and ideas. Analysis was conducted through multiple phases and loops of initial coding, and repeated focused coding. The pertinent, recurring categories and themes were analyzed from constant comparison and inferences gathered from each feedback survey. Themes were reviewed throughout this process first by RA IV (LC), then by the MHSA Coordinator (SI). This led to the development of higher-level categories and new themes to emerge. This procedure was repeated throughout the duration of the qualitative data analysis phase.

Resultingly, a count was tallied each time an emergent theme was mentioned. This led to an average of 3 - 4 themes per open-ended question (Sample Item: What would make an ad something you would remember or want to learn more about?), with an average tally of 15 - 30 per theme (See appendix). This process also led to several key findings, including the importance of representation and culturally appropriate messaging, positive messaging, good visuals and color, and simple wording and language accessibility as methods to make advertisements more engaging and memorable. Another key finding was that the modality of which advertisements were marketed using (i.e., Social media for youth, newspapers for seniors and older adults) varied more as a function of age, and less when considering gender or cultural background.

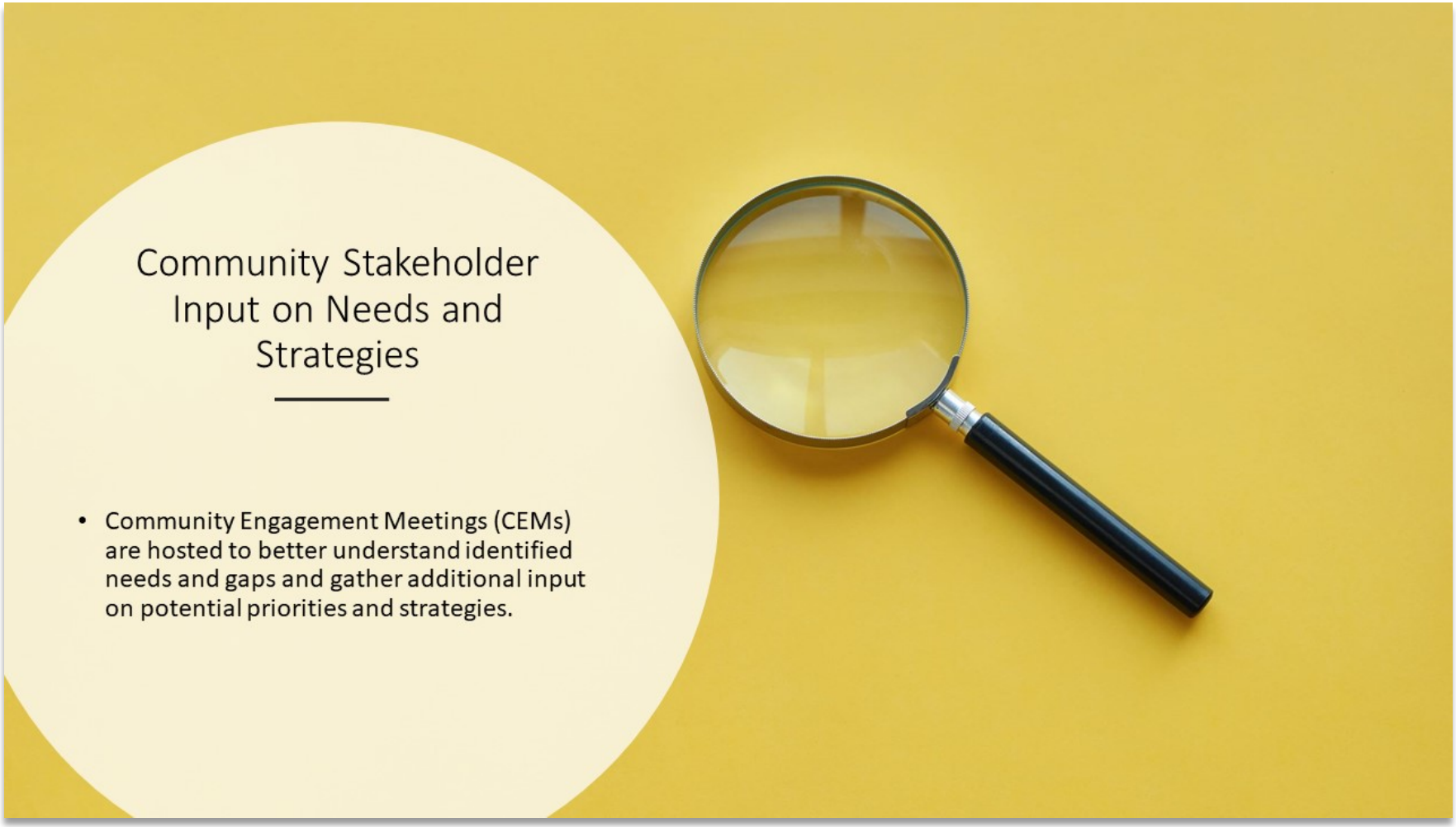
Ancillary Sentiment Analysis

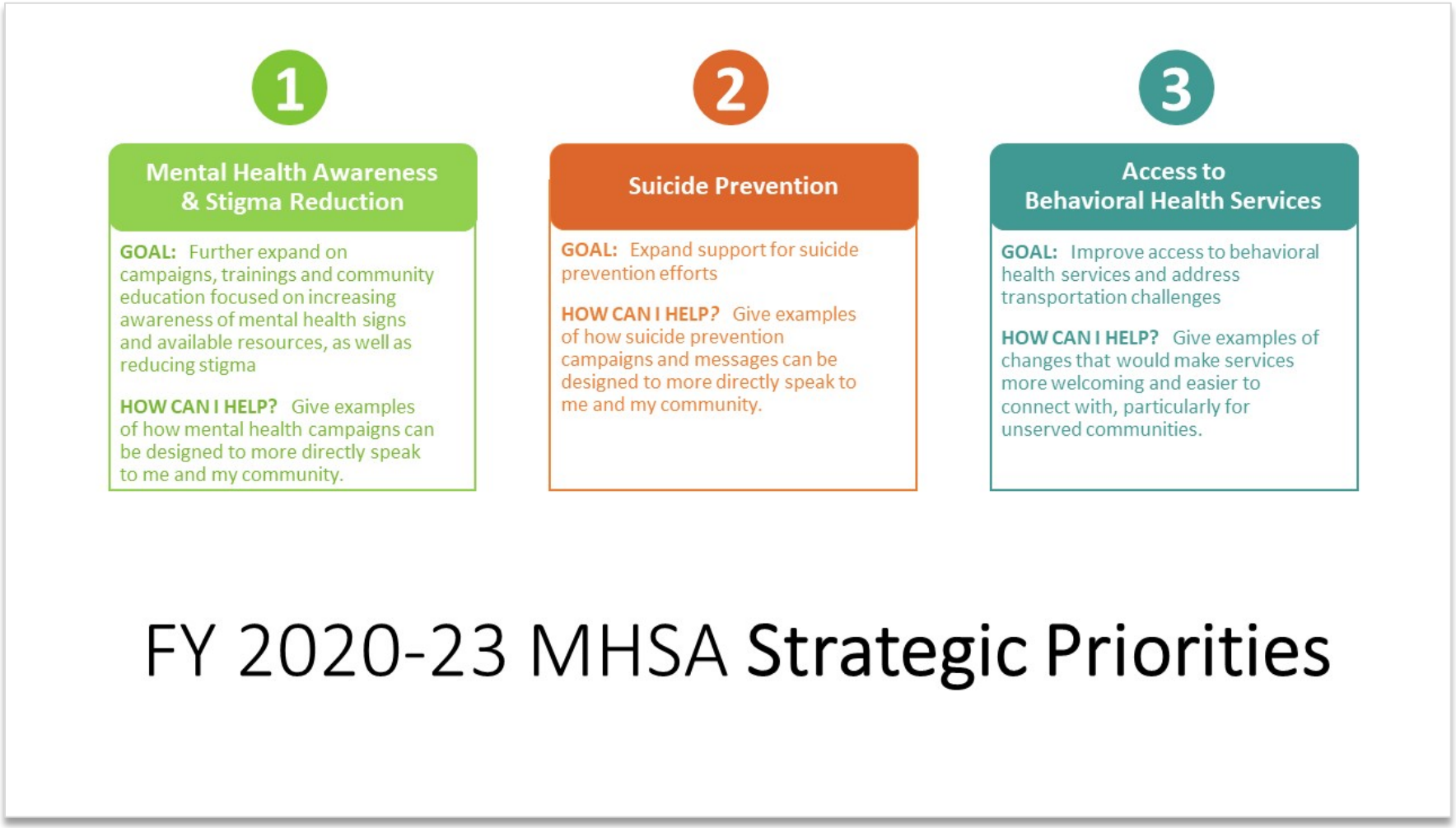
Using the same open-ended qualitative responses, sentiment was also analyzed using the Quantitative Discourse Analysis Package (also known as QDAP) in R Statistical Software using a general additive (GAM) smoothing model. The sentiment analysis chart illustrates that sentiment scores fell primarily between 0 to +1, indicating a high degree of positive sentiment across the results. Examples of positively valanced words, also known as sentiment, include words such as "joy", "pleasure", or "happiness". Examples of negatively valanced words include words such as "anger", "frustration", or "disgust". Overall, there was a positive response across the CEM surveys. This is important because monitoring community sentiment provides valuable insight for understanding stakeholder support and feedback, particularly over a longitudinal period of time.

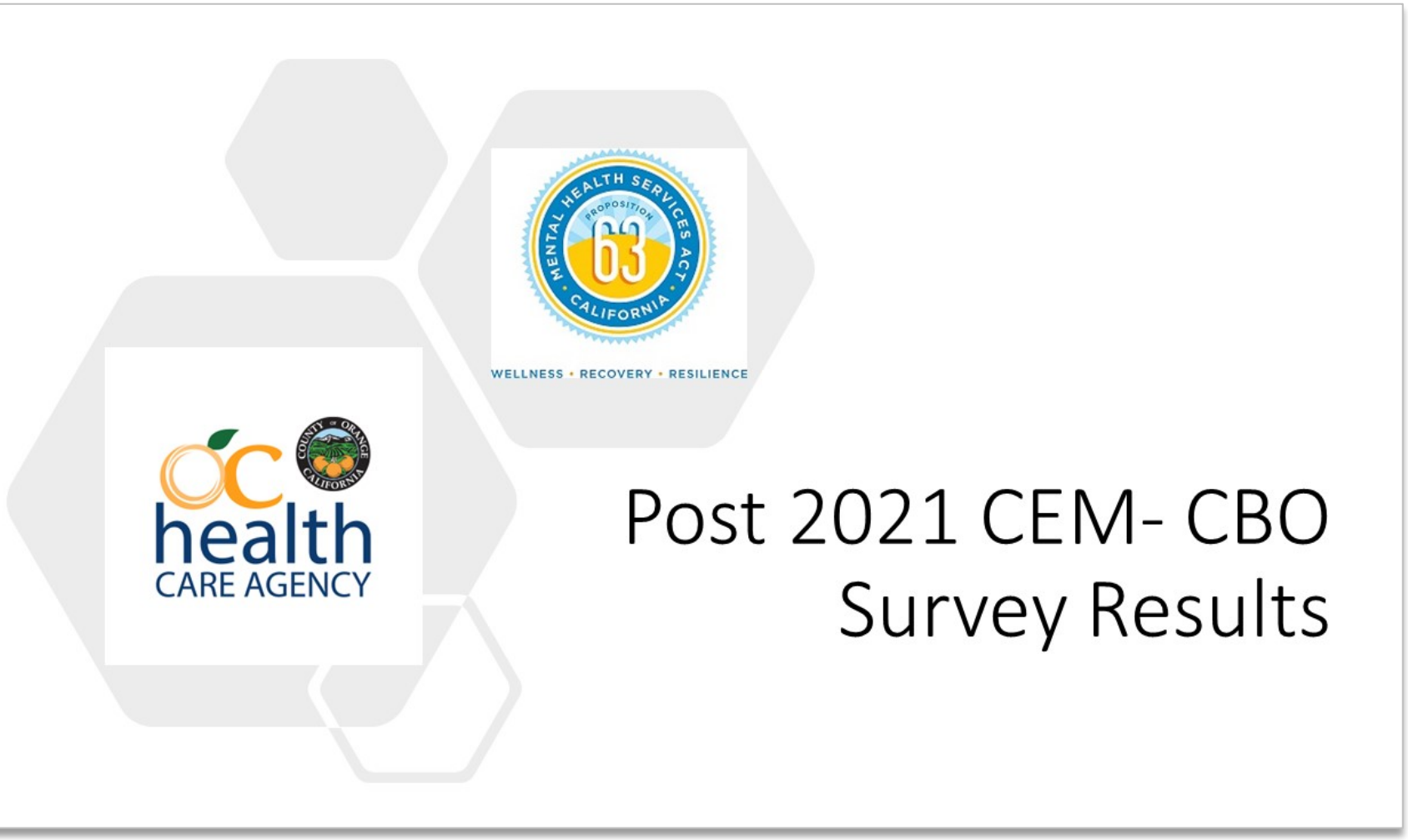
APPENDIX VIII: CEM Results March 2021



What are the **Steps** in OC's CPPP?

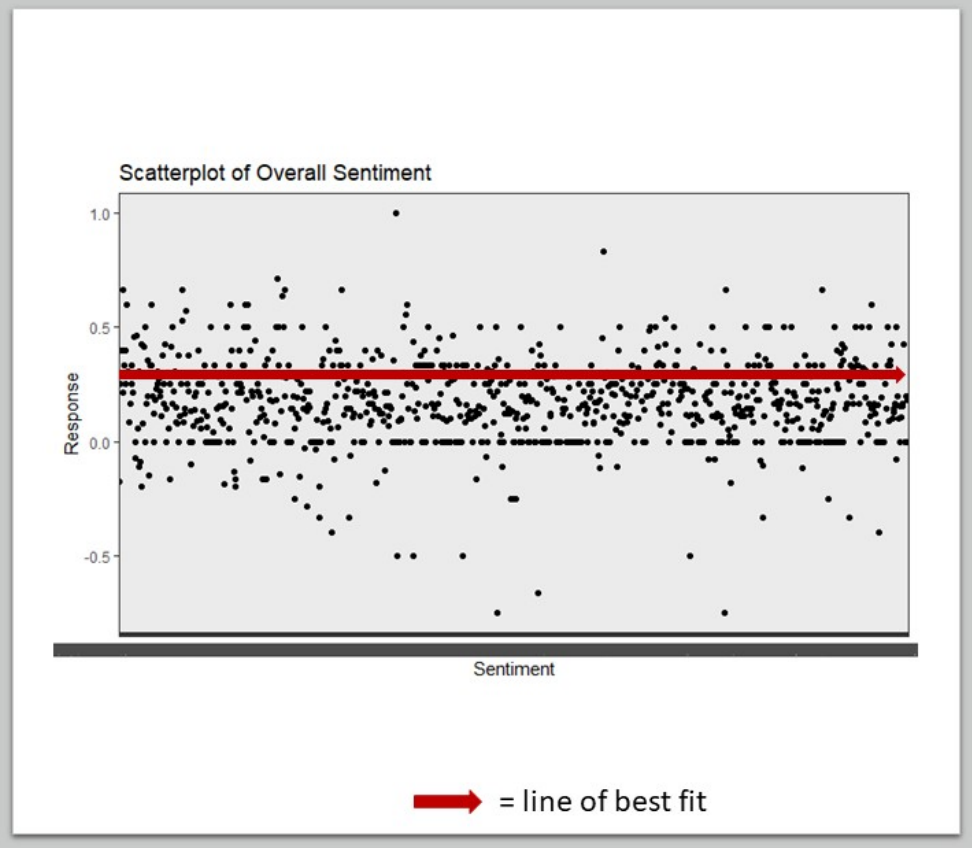

Community Stakeholder Input on Needs and Strategies
• Community Engagement Meetings (CEMs) are hosted to better understand identified needs and gaps and gather additional input on potential priorities and strategies.

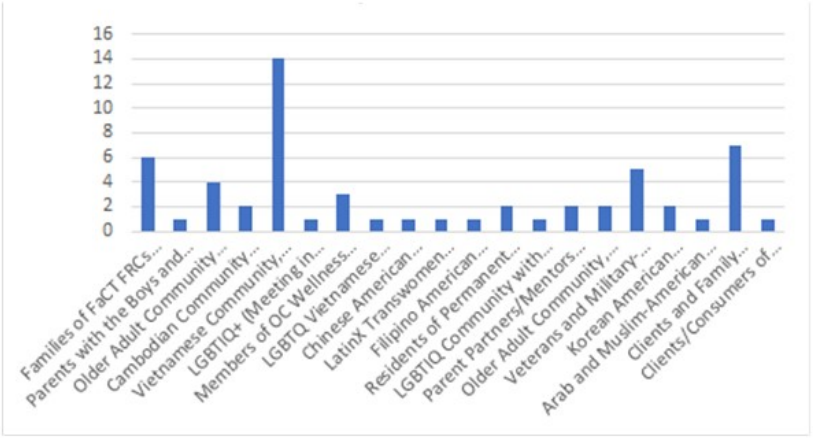

1
Mental Health Awareness & Stigma Reduction
GOAL: Further expand on campaigns, trainings and community education focused on increasing awareness of mental health signs and available resources, as well as reducing stigma
HOW CAN I HELP? Give examples of how mental health campaigns can be designed to more directly speak to me and my community.
2
Suicide Prevention
GOAL: Expand support for suicide prevention efforts
HOW CAN I HELP? Give examples of how suicide prevention campaigns and messages can be designed to more directly speak to me and my community.
3
Access to Behavioral Health Services
GOAL: Improve access to behavioral health services and address transportation challenges
HOW CAN I HELP? Give examples of changes that would make services more welcoming and easier to connect with, particularly for unserved communities.
FY 2020-23 MHSA Strategic Priorities


MENTAL HEALTH SERVICES ACT
PROPOSITION
63
CALIFORNIA
WELLNESS • RECOVERY • RESILIENCE
COUNTY OF ORANGE
CALIFORNIA
OC
health
CARE AGENCY
Post 2021 CEM- CBO
Survey Results

Overview

- Overall, participants were positively engaged in providing feedback across the CBO follow up survey results.
- Results using the Quantitative Discourse Analysis Package (also known as QDAP) in R Statistical Software using a general additive (GAM) smoothing model indicated that on average, responses were rated between 0 to +1.
- The sentiment analysis chart to the right illustrates that sentiment scores were mostly between 0 to +1, indicating a high degree of positive sentiment across the results.
- Examples of positively valanced words, also known as sentiment, include words such as “joy”, “pleasure”, or “happiness”. Examples of negatively valanced words include words such as “anger”, “frustration”, or “disgust”.
- This is important because monitoring community sentiment provides valuable insight for understanding stakeholder support and feedback.





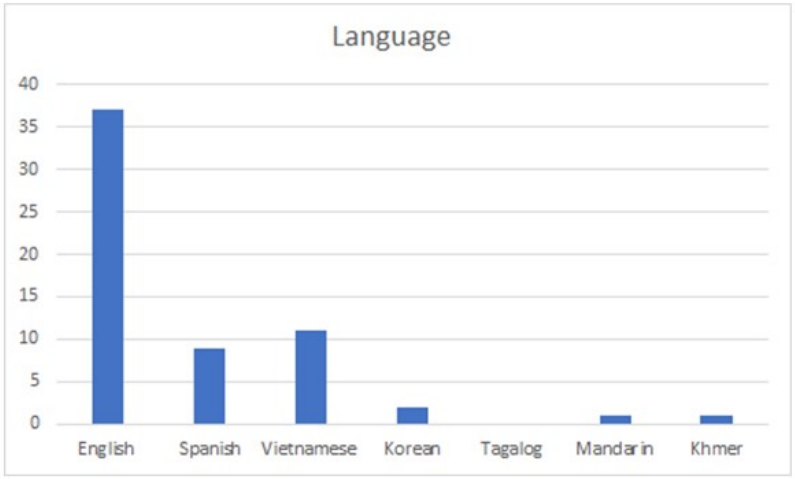
Group	N
Families of FaCT FRCs (Spanish) (2/3/21) - 4:00 pm	6
Parents with the Boys and Girls Club Garden Grove (Spanish), February 18, 2021, 4pm	1
Older Adult Community with CBOs, February 23, 2021, 10am	4
Cambodian Community with Cambodian Family Community Center, February 24, 2021, 7pm	2
Vietnamese Community, February 25, 2021, 6pm	14
LGBTIQ+ (Meeting in Spanish), February 25, 2021, 11am	1
Members of OC Wellness Centers, February 25, 2021, 1pm	3
LGBTQ Vietnamese Community, February 26, 2021, 4pm	1
Chinese American Community, March 2, 2021, 2pm	1
LatinX Transwomen Community, March 2, 2021, 6pm	1
Filipino American Community, March 3, 2021, 2pm	1
Residents of Permanent Supportive Housing (PSH), March 4, 2021, 1pm	2
LGBTIQ Community with Shanti OC and The Center OC, March 4, 2021, 6pm	1
Parent Partners/Mentors with FSN, March 9, 2021, 9am	2
Older Adult Community, March 9, 2pm	2
Veterans and Military-Connected Family Members, March 9, 6pm	5
Korean American Community, March 10, 2pm	2
Arab and Muslim-American Community, March 11, 2pm	1
Clients and Family Members of Substance Use Disorder (SUD) Services, March 11, 6pm	7
Clients/Consumers of Behavioral Health Services (BHS) Clinics, March 18, 5pm	3
Members of Peer Employee Advisory Committee (PEACe), March 25, 11:30am	1

Demographics – Group

- Sixty-one surveys were completed (N = 61)
- All groups had at least one engagement survey completed.

Demographics – Language

- Primary language of each breakout sessions conducted are reflected below.
- Nearly all languages were also represented, except for Tagalog with 0 members.



Language	N
English	37
Spanish	9
Vietnamese	11
Korean	2
Tagalog	0
Mandarin	1
Khmer	1

Breakout Session #1 Findings

- This session sought to obtain a better understanding of ways to promote awareness of mental health information, resources, stigma reduction, and suicide prevention.
- These include strategies programs can use to improve outreach, advertising, and messaging on mental health and suicide prevention in diverse communities.

Summary

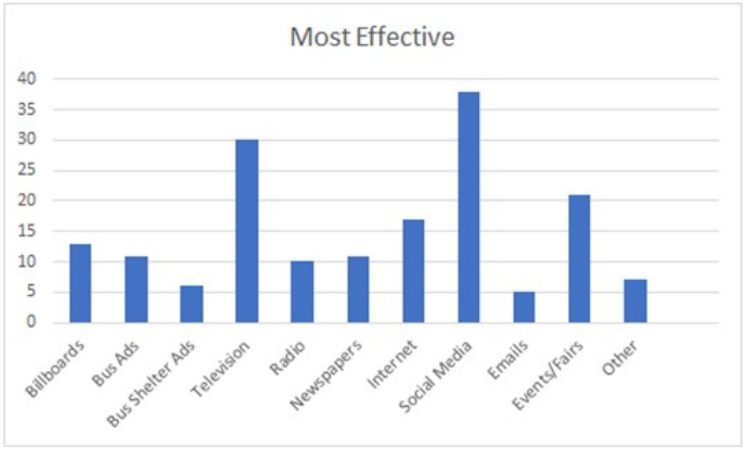
- Community Engagement Meetings (CEM) data indicated several effective strategies for engaging the community.
- To promote awareness of mental health information, resources, stigma reduction, and suicide prevention, several of the most effective advertising and outreach strategies include social media, television, and events and fairs.
- Other effective strategies include using colorful / artistic advertising and reaching consumers through socializing or word of mouth within respective communities.
- Among the least effective are emails, bus shelter ads, bus ads, and billboards. Other less effective strategies include billboards at a high eye level, and lengthy or spam emails.

Summary

To make an ad more memorable, or something a community member would want to learn more about, participants reported including representation and culturally appropriate messaging, positive messaging, simple wording and accessible language, with good visuals and color.

Participants shared that providing specific resources, using simple language from specific communities of interest, and short and precise content are some ways of advertising / promoting certain types of messages / information.

Using social media for younger adults, TV and radio for bilingual and older adults, and community centers for older adults are certain ways of advertising / promoting participants shared for reaching people of different ages and backgrounds.



Most Effective	N
Billboards	13
Bus Ads	12
Bus Shelter Ads	6
Television	32
Radio	10
Newspapers	11
Internet	18
Social Media	40
Emails	5
Events/Fairs	22
Other	7

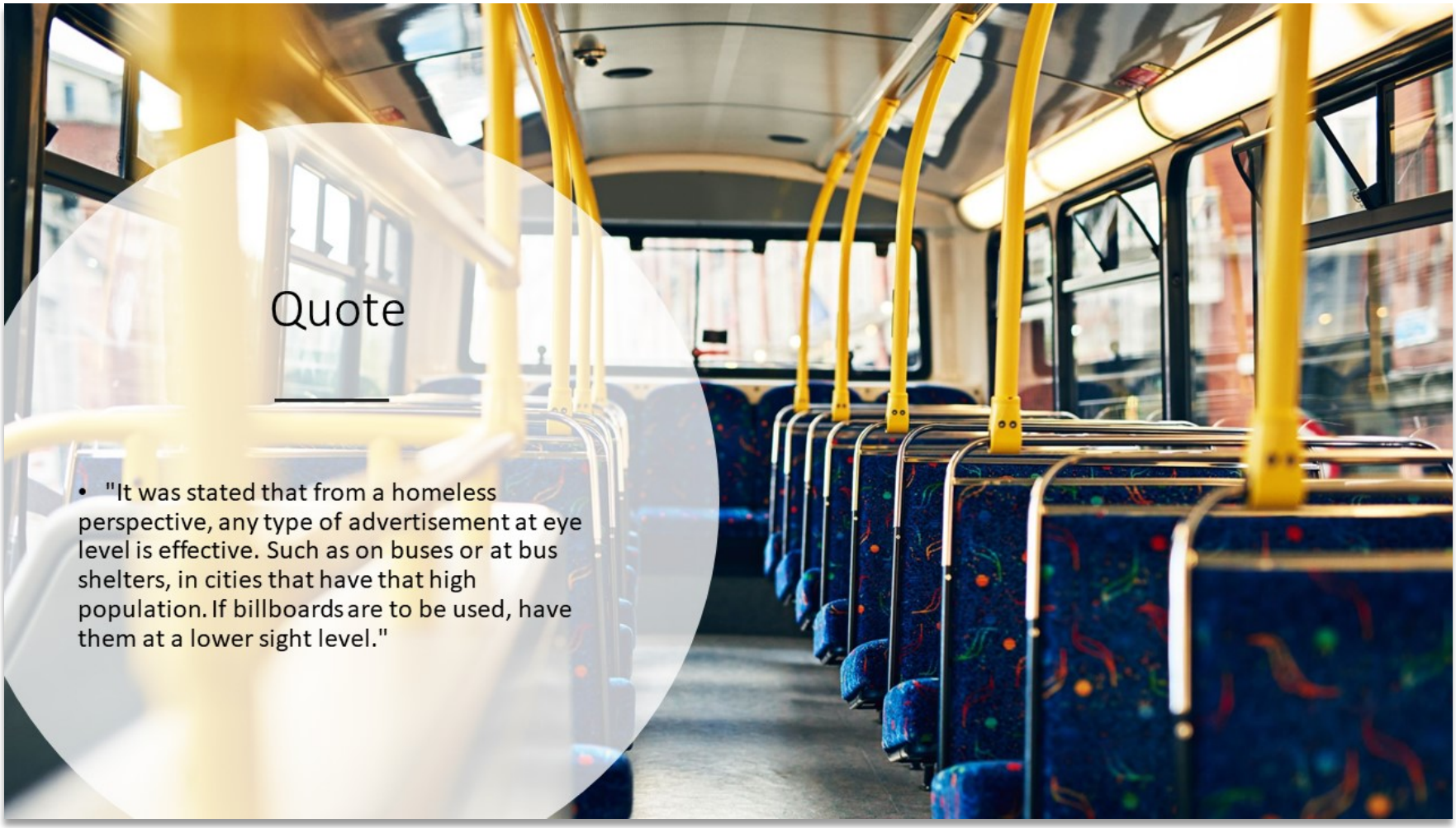
Most Effective Advertising and Outreach Strategies

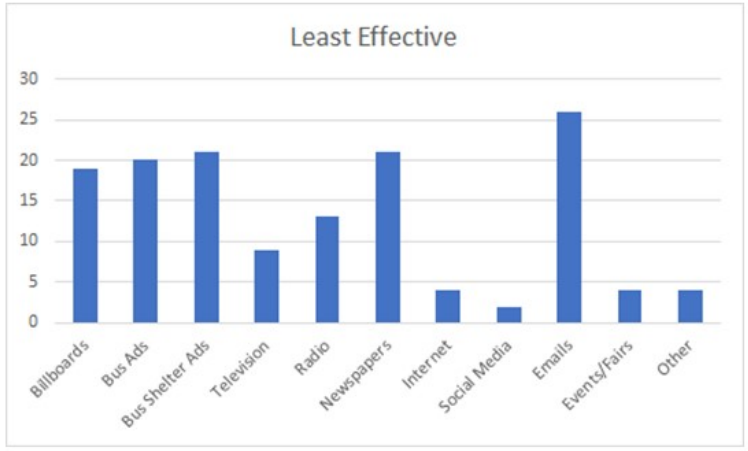
- Social Media, Television, and Events/Fairs were indicated as most effective advertising and outreach strategies.

Most Effective Advertising and Outreach Strategies – Qualitative Response

- Other effective advertising and outreach strategies included:

1. Using color/colorful or vibrant advertising (n = 7)
2. Word of mouth from others such as healthcare providers, family, and friends (n = 8)


Quote
• "It was stated that from a homeless perspective, any type of advertisement at eye level is effective. Such as on buses or at bus shelters, in cities that have that high population. If billboards are to be used, have them at a lower sight level."

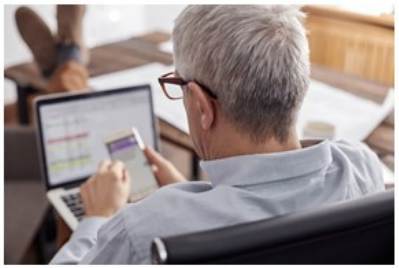


Least Effective	N
Billboards	22
Bus Ads	22
Bus Shelter Ads	23
Television	9
Radio	13
Newspapers	21
Internet	4
Social Media	2
Emails	26
Events/Fairs	4
Other	4

Least Effective Advertising and Outreach Strategies

- Emails, Bus shelter ads, Newspapers, and Billboards were indicated as among the least effective advertising and outreach strategies.

Least Effective Advertising and Outreach Strategies – Qualitative Response



- Other ineffective advertising and outreach strategies included:

1. Billboards, especially those at a high eye level (n = 9)
2. Lengthy emails, including spam (n = 14)

Quote

- "Billboards show images of a person crying or in desperate need of help. This, in turn, gives off a scary feeling to the viewer. It can turn the person away from admitting their strong feelings of sadness and despair."
- "It may lead a person to thinking they are vulnerable in the same way the person is depicted in the billboard. It may lead the person to believe that he/she should not talk about these internal struggles as there is a stigma attached and people may view him/her as "crazy, special, or different"."

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

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

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

Other comments regarding advertising/outreach strategies

Thematic Analysis

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

REPRESENTATION AND CULTURALLY APPROPRIATE MESSAGING (N = 19)

POSITIVE MESSAGING (N = 18)

SIMPLE WORDING AND LANGUAGE ACCESSIBILITY (N = 12)

GOOD VISUALS AND COLOR (N = 13)

Direct Quotes

- "Avoid scenes of anxiety or panic attacks, someone experiencing depression, etc. Participant said this may be triggering and promote negative stigma that will turn people away. Instead, show someone going through and getting help services / in recovery."
- "Persons talked about Ideas and phrases that help reduce stigma"

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

PROVIDE SPECIFIC RESOURCES (N = 13)

USE SIMPLE LANGUAGE FROM COMMUNITY OF INTEREST (N = 10)

SHORT AND PRECISE CONTENT (N = 7)

Direct Quotes

- "Understanding the culture of the population that is being attempted to reach."
- Encouraging phrases may be most effective when relaying a mental health related message. "It's never too late to reach out for help." "You've worked so hard until now." "Let's do this together." "Don't give up."

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

SOCIAL MEDIA (YOUNGER ADULTS)

(N = 25)

TV AND RADIO

(BILINGUAL AND OLDER ADULTS)

(N = 16)

COMMUNITY CENTERS

OLDER ADULTS

(N = 8)

Direct Quotes

- "Social media is a great way to reach the younger generation"
- "Promoting health services through community outread meetings with "mentoring" individuals – helping individuals to connect to services

Popular types of Social Media by Age Range (CEM Feedback)

Youth (0 – 16) / Young Adults (16 – 24)

- Instagram
- Tik-Tok
- Twitter
- YouTube
- Snapchat

Adults (24 – 65)

- Facebook
- Instagram
- Twitter
- YouTube
- WeChat

Older Adults (65+)

- Facebook

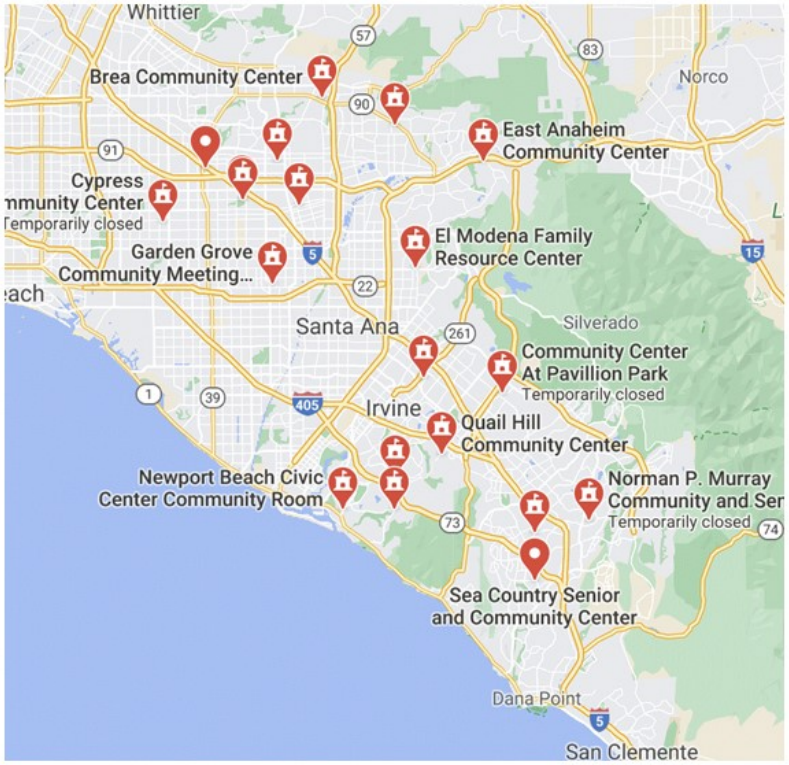
Data from the CEM Meeting Survey findings indicate social media is not *always* the most efficient way to reach older adults. Here are other strategies:

Older Adults Television Programming, Radio, Newspaper (Market Surveillance Scan)

Community Group	Television	Radio	Newspaper/Magazines
Arab and Muslim American	KSCI, MBC4, Al Jazeera, Al Arabiya	Yalla Mazzika	Al Akbhar, Al Arab, Al Enteshar
Cambodian	CTN, CBN, Khmer TV	World Khmer Radio	Khmer Times, Phnom Penh Post, The Cambodia Daily
Chinese	KSCI, Phoenix, ETTV, TVB	AM 1300, AM 1600, AM 1430	Sing Tao Daily, The China Press
Filipino	Myx TV, TFC		
LatinX	Univision, Telemundo	AM 900, AM 1580, AM 930, AM 830, AM 1020, AM 1330	Hoy, La Opinion,
Korean	KBS	AM 1650, AM 1230	Korean Times, Korean Daily
Vietnamese	SBTN	AM 1480	Nguoi Viet, Viet Bao Kinh Te

Community Center Resources

- Resources may provide interactive links / maps to community center resources
- Note, map is a placeholder
  - Update map based on population density of older adults with link to source data



Breakout Session #2 Findings

- This session sought to obtain a better understanding of ways to ***improve access*** to behavioral health services, including suicide prevention supports.
- These include strategies programs can use to make mental health services more welcoming and easier to connect with, especially for individuals from unserved communities.

Summary

- Community Engagement Meetings (CEM) data indicated ways to **improve access** to behavioral health services, including suicide prevention supports.
- Cultural representation in learning materials, using a simplified reading level, and providing digital health and literacy education are several helpful ways to overcome barriers to community access.
- Socializing content of services versus solely listing programs or services, using appropriate and representative language, and increasing collaboration or social activities are several changes or improvements that would make services more welcoming for community members.
- Having more services and outreach locations, including a blend of hybrid and in-person services are several changes or improvements that would make it easier for community members to connect with services, including telehealth.
- Providing internships, volunteer opportunities, and outreach in respective communities are several short-term strategies the OC Health Care Agency can use now to encourage people from diverse backgrounds (to apply) to work in the public mental health system.

Thematic Analysis

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

What types of changes or improvements would make services more welcoming for members of my community?

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

What are short-term strategies the OC Health Care Agency can use to encourage people from diverse backgrounds (to apply) to work in the public mental health system?

Other comments regarding improving access

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

1. Cultural representation (n = 40)
   - Visual
     - Ex. Culturally appropriate images
   - Verbal (Language)
     - Ex. Spanish, Vietnamese
   - Informal / Symbolic
     - Less stigmatization of wording
     - Ex. Military vs. civilian phrasing on marketing material

2. Simplified reading level (n = 15)
   - Reducing stigmatization of material
     - Ex. Grupos to terapia -> grupos de apoyo emocional
   - Use slogans / phrases

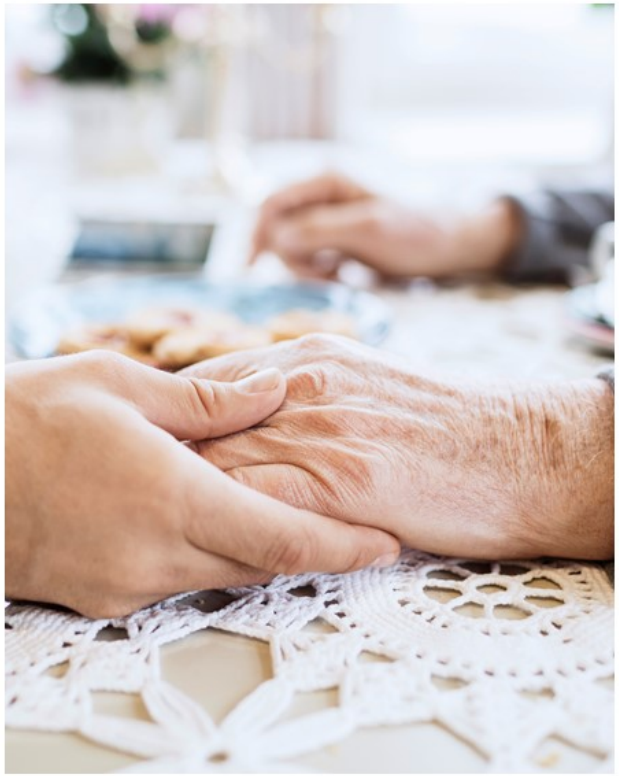
3. Technology upskilling (n = 27)
   - Learning and navigating tech
     - Enhancing digital literacy and digital health literacy
   - Access to computers and Wi-Fi

Quotes

- “Normalizing it from the top down. People in charge in the military need to speak up about mental health. Long wait for appointments gives veterans a sense of rejection, increases stigma, inconvenient and more likely to not engage.”
- "Meet people where they are. Make materials appropriate with correct language, images that are culturally appropriate. Colors that reflect a community."
- "Latinx is a term widely accepted and known by younger LGBTQ+ but not by older community members. Salud mental vs Salud emocional vs. salud comportamental most saw stigma attached to mental and comportamental."

What types of changes or improvements would make services more welcoming for members of my community?

1. Socializing content of services vs. listing title of services
   - Ex. Personable branding and marketing content of events, increase transparency of services provided (n = 24)
2. Use appropriate and representative language (n = 23)
3. Increase collaborative or group activities (n = 10)
   - Ex. Subgroup collaboration, community activities



Quotes

- "Meet the vet where they are at emotionally."
- "Avoid sterile, hospital-like relationships and counseling spaces that may be intimidating to disclose personal information. Create a more welcoming and home-like atmosphere."
- "Outreach: hitting the streets, visiting cultural centers, person-to-person, speaking common language"

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

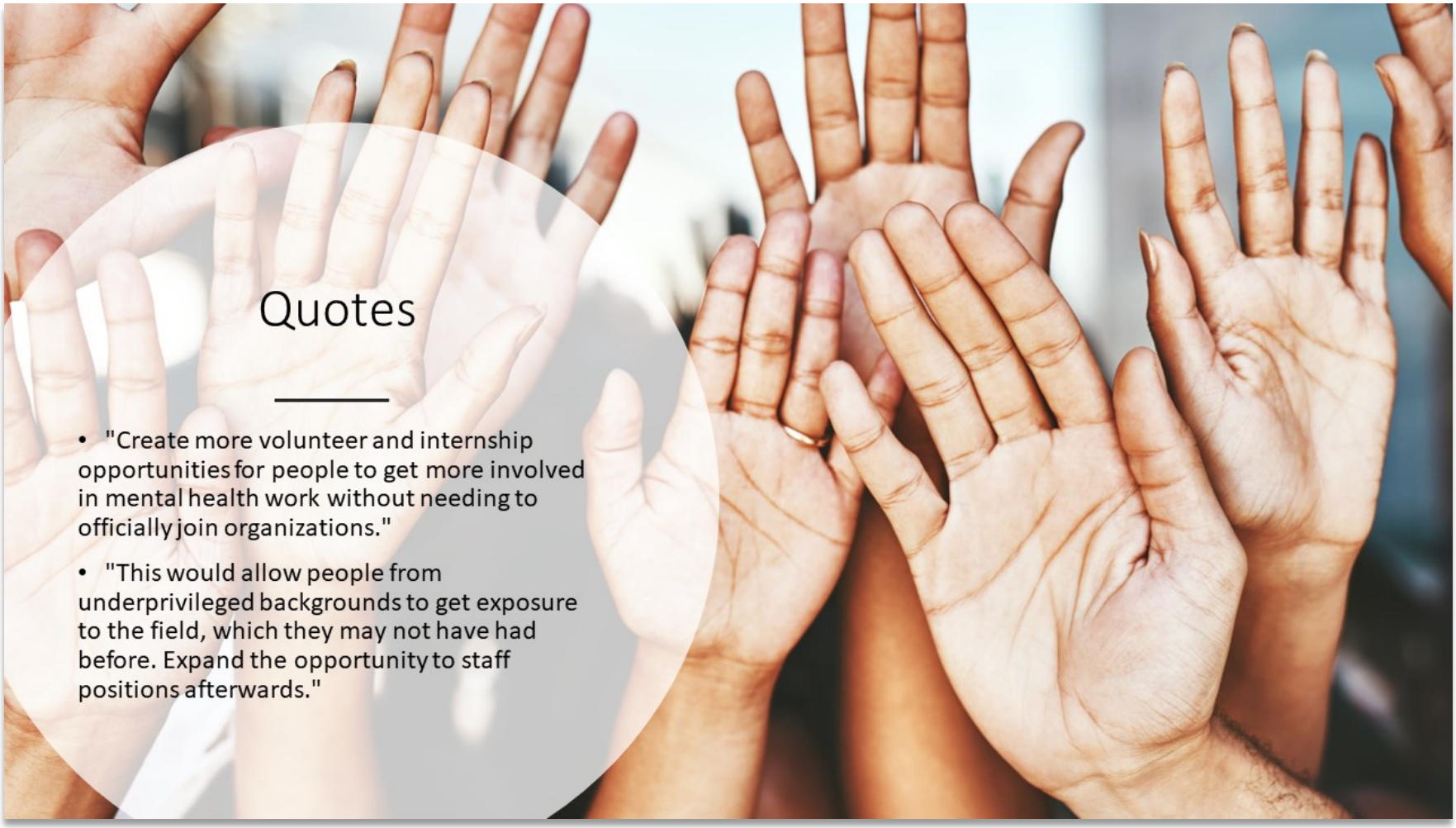
- Having more services and outreach locations (n = 10)
- Include a blended hybrid of remote (n = 49) and in-person (n = 8) services
- This includes reliable access to internet and mobile technology, tech support, and telehealth access at wellness centers.
    - Enhancing educational resources, including digital literacy and digital health.

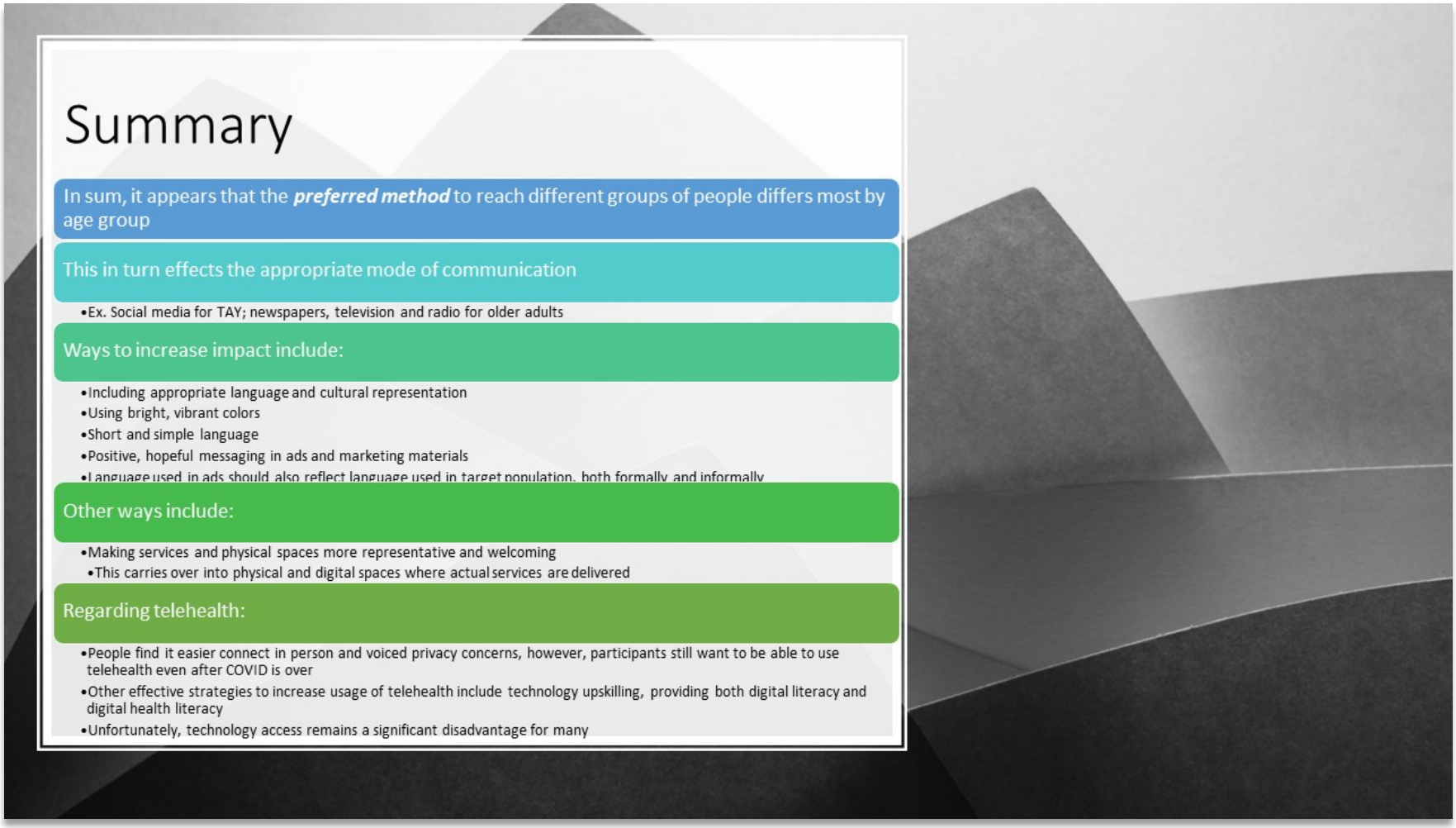
Quotes

- "Expand ability to search for in-language services. Participant shared that they do not know how to look for services / if there is a database that they have access to use to filter providers."

What are short-term strategies the OC Health Care Agency can use now to encourage people from diverse backgrounds (to apply) to work in the public mental health system?

- Providing internships (n = 4)
- Volunteer opportunities (n = 4)
- Outreach in respective communities (ex. colleges, tabling events across communities) (n = 7)


Quotes
• "Create more volunteer and internship opportunities for people to get more involved in mental health work without needing to officially join organizations."
• "This would allow people from underprivileged backgrounds to get exposure to the field, which they may not have had before. Expand the opportunity to staff positions afterwards."


Summary
In sum, it appears that the preferred method to reach different groups of people differs most by age group
This in turn effects the appropriate mode of communication
•Ex. Social media for TAY; newspapers, television and radio for older adults
Ways to increase impact include:
•Including appropriate language and cultural representation
•Using bright, vibrant colors
•Short and simple language
•Positive, hopeful messaging in ads and marketing materials
•Language used in ads should also reflect language used in target population, both formally and informally
Other ways include:
•Making services and physical spaces more representative and welcoming
•This carries over into physical and digital spaces where actual services are delivered
Regarding telehealth:
•People find it easier connect in person and voiced privacy concerns, however, participants still want to be able to use telehealth even after COVID is over
•Other effective strategies to increase usage of telehealth include technology upskilling, providing both digital literacy and digital health literacy
•Unfortunately, technology access remains a significant disadvantage for many

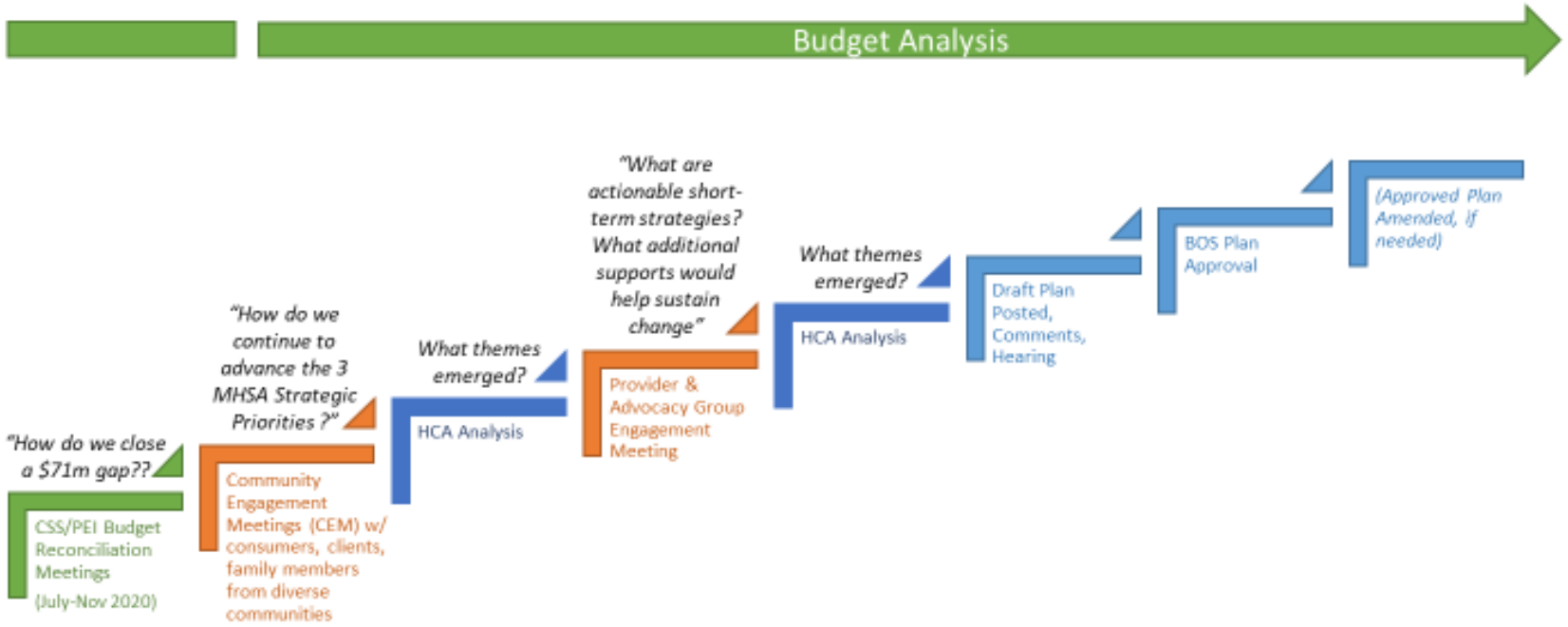
APPENDIX IX: Provider Engagement Meeting Findings

Agenda

- **Welcome, Introductions**
- **Synopsis of Community Engagement Meeting Results**
- **Discussion 1: Improve Technology Skills & Access**
  Move to small groups
- **Report Out 1**
  Return to main room and present key discussion points from each group
- **Discussion 2: Mental Health Terms & Language**
  Move to small groups
- **Report Out 2**
  Return to main room and present key discussion points from each group
- **Wrap Up**

2

2021 Community Planning Process



Synopsis of 2021 Community Engagement Meeting Results

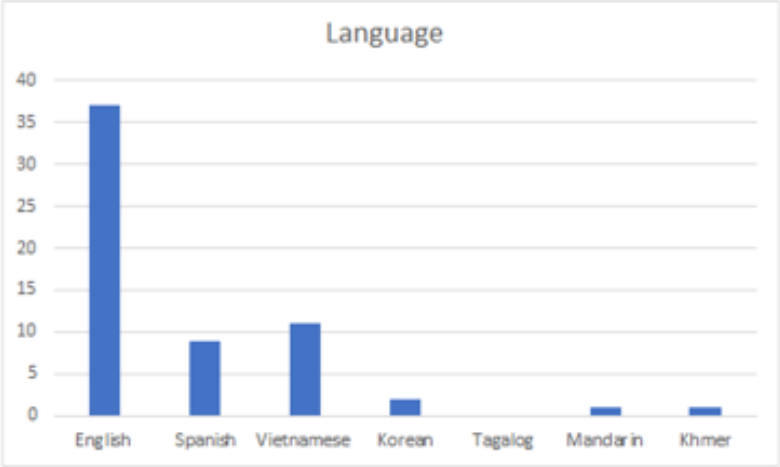
2021 CEM Outreach to Priority Populations

Community Engagement Meeting	Date	# Registered	Children	TAY	Adults	Older Adults	Additional Population Characteristics
Arabic/Muslim Community	3/11/2021	8			X	X	
Parents/Families (in Spanish)	2/18/2021	8	X	X			Latino/Hispanic
BHS Consumers	3/18/2021	31			X	X	In Recovery w/ SUD
HCA Peers	3/25/2021	12			X	X	
Cambodian Community	2/24/2021	16			X	X	Asian/Pacific Islander
Chinese Community	3/2/2021	6			X	X	Asian/Pacific Islander
Filipino Community	3/3/2021	5			X	X	Asian/Pacific Islander
Family Resource Centers of OC	2/3/2021	61	X	X			Latino/Hispanic
Korean Community	3/10/2021	8			X	X	Asian/Pacific Islander
LatinX Transwomen	3/2/2021	28					LGBTIQ, Latino/Hispanic
LGBTQ Community (in English)	¾/2021	6		X	X		LGBTIQ
LGBTQ Community (in Spanish)	2/26/2021	4		X	X		LGBTIQ, Latino/Hispanic
LGBTQ Community (in Vietnamese/ English)	2/26/2021	6		X	X		LGBTIQ, Asian/Pacific Islander
Older Adults (two meetings)	2/23 & 3/9/2021	26 / 31				X	
Parent Partners	3/9/2021	11	X	X			
Permanent Supportive Housing Residents	3/4/2021	9		X	X		Persons in Recovery, *(Homeless Individuals)*
Persons In Recovery	3/11/2021	41			X		Persons in Recovery w/ SUD
Veterans / Military-Connected Families	3/9/2021	30	X	X	X	X	Veterans
Vietnamese Community	2/25/2021	107		X	X	X	Asian/Pacific Islander
Wellness Center Members	2/26/2021	30			X		

Languages in which the CEMs were facilitated

- Meetings and/or breakout sessions were facilitated in seven languages *(see graph below)*
- Meetings facilitated in a language other than English were conducted entirely in the participants' preferred language
- Post-meeting summaries were all completed in English

- The meeting for Filipino Americans ended up being facilitated almost entirely in English, thus, Tagolog is listed as "0"
- Two meetings facilitated in English supported Farsi-speaking individuals through an interpreter
- One meeting facilitated in English supported Khmer-speaking individuals through an interpreter



Community Stakeholder Input on Needs and Strategies

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

MHSA STRATEGIC PRIORITIES

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

Input received in the 2021 CEMs

Breakout sessions gathered input on two areas that covered all three MHSA Strategic Priorities:

1

BREAKOUT SESSION 1:
Strategies programs can use to improve outreach, advertising and messaging on mental health and suicide prevention in diverse communities

2

BREAKOUT SESSION 2:
Strategies programs can use to make mental health services more welcoming and easier to connect with, especially for individuals from unserved communities

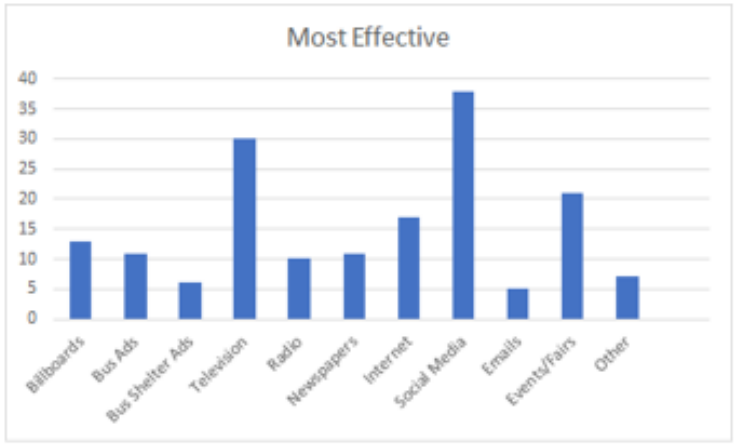
14

Collecting input

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

Analysis of 2021 Post-CEM CBO Summaries


What are the advertising and outreach strategies that would be most effective in getting mental health-related messages out to my community? The least effective?
What would make an ad something you would remember or want to learn more about?
Are some ways of advertising/promoting better suited for certain types of messages/ information than others?
Are certain ways of advertising/promoting better at reaching people of different ages, backgrounds, etc.?
Other comments regarding advertising/outreach strategies
Breakout Session 1 Responses

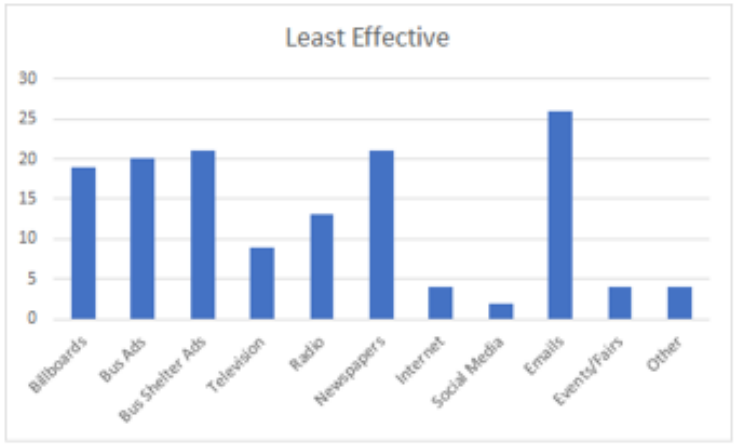


Most Effective Methods	N
Billboards	13
Bus Ads	12
Bus Shelter Ads	6
Television	**32**
Radio	10
Newspapers	11
Internet	18
Social Media	**40**
Emails	5
Events/Fairs	**22**
Other	7

Most Effective Advertising and Outreach Strategies:

DISCUSSION FREQUENCY

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



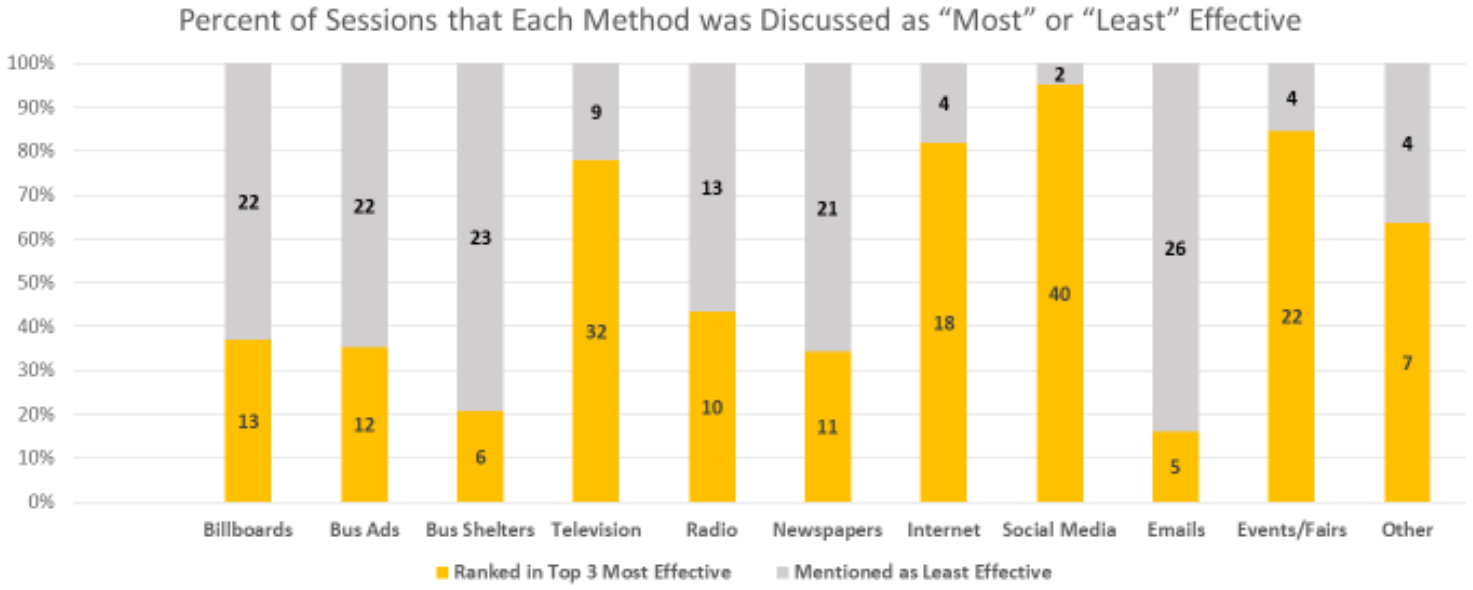
Least Effective Methods	N
Billboards	**22**
Bus Ads	**22**
Bus Shelter Ads	**23**
Television	9
Radio	13
Newspapers	**21**
Internet	4
Social Media	2
Emails	**26**
Events/Fairs	4
Other	4

Least Effective Advertising and Outreach Strategies:

DISCUSSION FREQUENCY

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

Perceived Effectiveness of Outreach Methods



How to read this chart: *The more a single color dominates the bar, the more that method was consistently discussed as either effective (yellow) or ineffective (gray) across the various meetings and breakout rooms. Thus, social media, internet and events/fairs were strongly viewed as effective and emails and bus shelter ads as ineffective. The perceived effectiveness of billboard and bus ads was more variable.*

Prompt 1: What would make an ad something you would remember or want to learn more about?*

REPRESENTATION AND CULTURALLY APPROPRIATE MESSAGING (N = 19)

POSITIVE MESSAGING (N = 18)

GOOD VISUALS AND COLOR

(N = 13 THEMATIC)

(N = 7 SESSIONS?)

SIMPLE WORDING AND LANGUAGE ACCESSIBILITY (N = 12)

APPROPRIATE AND REPRESENTATIVE LANGUAGE (N = 23 (SESSIONS?)

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

Representation and culturally appropriate messaging

"Understand the culture of the population that is being attempted to reach"

- Cultural representation (n = 40)
  - Visual, i.e., **culturally appropriate** images
  - Verbal
    - **Preferred language**, i.e., Spanish, Vietnamese, etc.
    - Wording that **lessens stigma**…
      - i.e., *Grupos to terapia -> Grupos de apoyo emocional*
    - … or accurately reflects culture
      - i.e., Military vs. civilian phrasing on marketing material

Positive Messaging: Images

- "Billboards show images of a **person crying** or in desperate need of help. This, in turn, gives off a **scary feeling** to the viewer. It can **turn the person away** from admitting their strong feelings of sadness and despair.
- It may lead a person to thinking they are **vulnerable** in the same way the person is depicted in the billboard. It may lead the person to believe that he/she **should not talk** about these internal struggles as there is a stigma attached and **people may view him/her as 'crazy, special, or different**'."
- "Avoid scenes of anxiety or panic attacks, someone experiencing depression, etc. [...This] may be **triggering** and **promote negative stigma** that will turn people away. Instead, show **someone going through and getting help services / in recovery**."

Prompt 2: Are some ways of advertising / promoting better suited for certain types of messages/information than others?

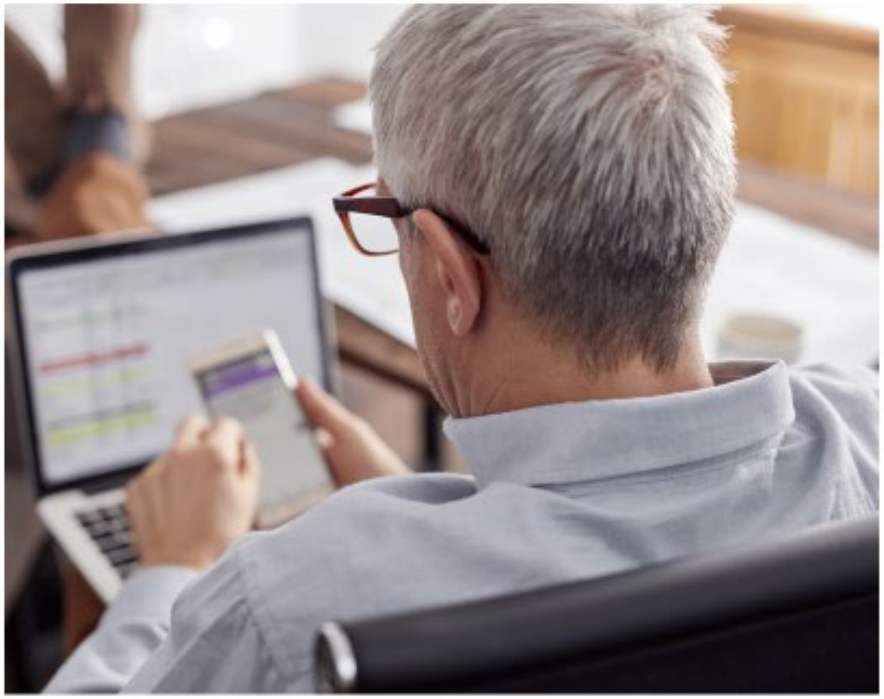
SHORT AND PRECISE CONTENT (N = 7)

USE SIMPLE LANGUAGE FROM COMMUNITY OF INTEREST (N = 10)

PROVIDE SPECIFIC RESOURCES (N = 13)

Language:
Positive, Simple, Clear

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



Lengthy emails, including spam, can be ignored or missed (n = 14)

When Providing Specific Resources…

- "Socialize" the content of services, don't just list the title of services
  - i.e., Make the branding **personable**, use clear marketing, provide **clear descriptions** of the events or services being promoted (n = 24)

- Other effective advertising and outreach strategies:
  - **Word of mouth** from **trusted sources**, such as healthcare providers, family, and friends (n = 8)

Prompt 3: Are certain ways of advertising/promoting better at reaching people of different ages, backgrounds, etc.?

SOCIAL MEDIA
(YOUNGER ADULTS)
(N = 25)

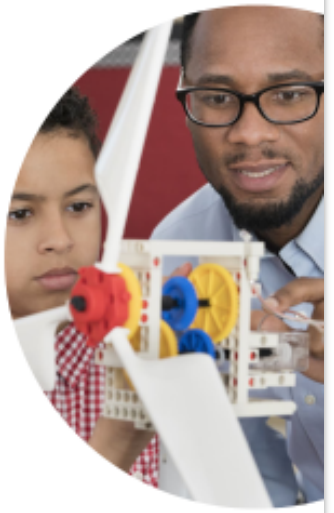
TV, RADIO & NEWSPAPERS
(BILINGUAL & OLDER ADULTS)
(N = 16)

COMMUNITY CENTERS
OLDER ADULTS
(N = 8)

Breakout Session 2 Responses

Prompt 1:

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



- Technology upskilling and access (n = 27):
  - **Learning** and navigating technology
  - Enhancing **digital literacy** and **digital health literacy**
  - Improving **access** to computers and Wi-Fi

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

Prompt 2:
What types of changes or improvements would make services more welcoming for members of my community?

- *As mentioned above when reviewing outreach/marketing:* Use appropriate and representative language (n = 23)
- Increase collaborative or group activities (n = 10)
  - i.e., Subgroup collaboration, community activities

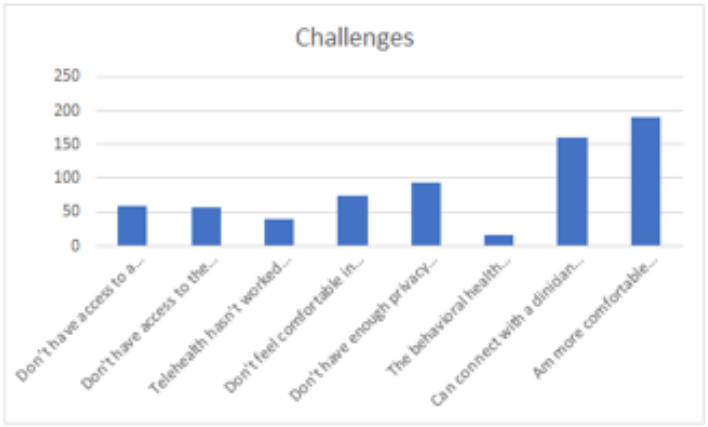
Prompt 3:
What types of changes or improvements would make it easier for my community to connect with services, including telehealth?

- Have **more services** and **outreach locations** (n = 10)
- Include a blended **hybrid** of remote (n = 49) and in-person (n = 8) services
- Provide:
  - Reliable **access** to internet and mobile technology, **tech support**
  - **Telehealth access** at Wellness Centers
  - Enhanced educational resources, including **digital literacy** and **digital health**

Continuing the Discussion…

Technology

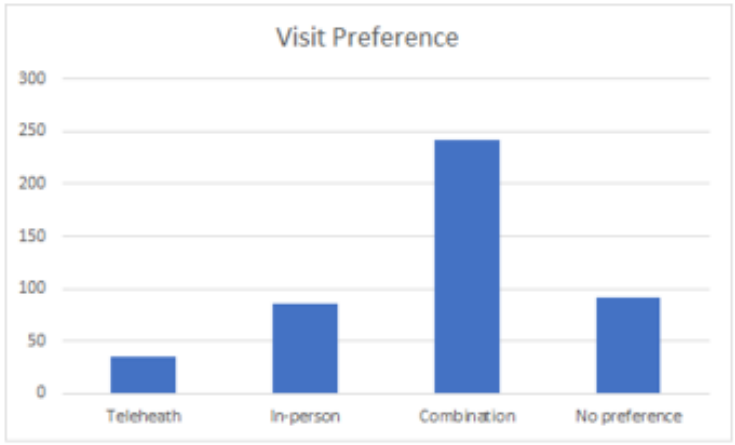
Mental health-related language



Challenges	N
Don't have access to a device (smartphone, tablet, desktop or laptop) to use telehealth	60
Don't have access to the internet to use telehealth	58
Telehealth hasn't worked when I tried it before (i.e., session kept dropping, could not connect)	39
Don't feel comfortable in ability to use telehealth/technology	74
Don't have enough privacy (i.e., other people are around, others might hear/see, etc.)	93
The behavioral health clinician doesn't seem to like or isn't comfortable with telehealth	16
Can connect with a clinician better in person	160
Am more comfortable sharing in person	191

CEM Polling Responses– What challenges do (or would) you, your family, friends or loved ones face if offered a telehealth appointment for mental health or substance use services?

Regarding telehealth, participants reported they are more comfortable sharing in person, can connect with a clinician better in person, and don't have enough privacy (I.e., other people are around, others might hear / see, etc.).



Visit Preference	N
Telehealth	35
In-person	86
Combination	241
No preference	92

CEM Polling Responses– Visit Preference

Participants were most likely to prefer a combination of telehealth and in-person visits.

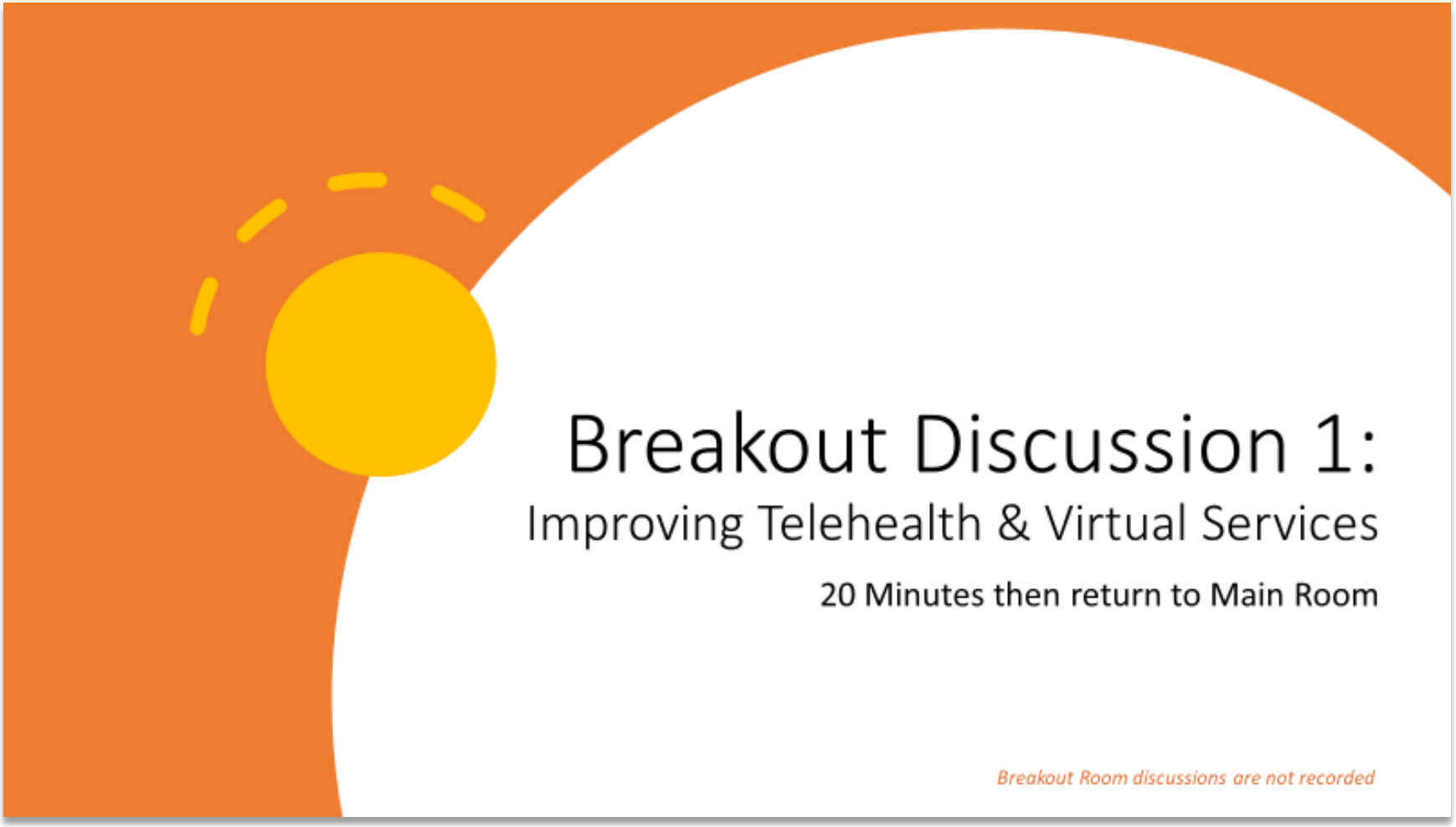
Telehealth Barriers

Telehealth Technology (check all that apply):	Count
Client cannot connect to telehealth session	8
Once connected, client does not turn on video	4
Connection keeps dropping during the session	4
Once connected, video isn't working properly (I.e., frozen image, spinning circle, etc.)	3
Once connected, audio isn't working properly (garbled sound, audio not synced with voice, etc.)	3
I cannot connect to telehealth session	1
Other (please specify)	2
Total	25

Experience w/ Telehealth (check all that apply):	Count
I don't feel technically proficient enough to use telehealth	4
I don't understand the documentation requirements for telehealth sessions	3
Total	7

Computer / Device Access (check all that apply):	Count
I don't have access to a webcam at my worksite	2
I telecommute and don't have an unlimited data plan or stable Wi-Fi at home	2
I telecommute and don't have access to a webcam at home	1
I don't have a stable connection at my worksite	1
Total	6

What else do you perceive to be barriers to providing telehealth for your clients? (Original text below)	Count
Technology (Wi-Fi: n=4)	8
Language	3
In-Person therapeutically better (Trust: n=1)	2
Privacy	1
Transportation	1
Work hours	1
Total	7


Breakout Discussion 1:
Improving Telehealth & Virtual Services
20 Minutes then return to Main Room
Breakout Room discussions are not recorded

Improving Technology Skills & Access

NEEDS IDENTIFIED IN COMMUNITY MEETINGS

Despite existing challenges, CEM participants overwhelmingly expressed a preference for a hybrid of in-person and remote/ virtual services even after COVID-19 restrictions are lifted. The challenges with telehealth or virtual services they reported include:

- Easier to share when face-to-face
- Lack of privacy during telehealth/virtual services
- Need for education and training on technology and devices, including digital literacy and digital health literacy
- Access to devices and Wi-Fi

QUESTIONS

- What strategies have you tried to address one or more of these challenges (i.e., improving skills/comfort/privacy during virtual services)? Which approaches worked? Didn't work?
- Of the strategies discussed and/or considered, what are you interested in trying?
- Are there barriers that you or your organization might face trying to implement these preferred strategies?

Breakout Discussion 1: Report Out

Two minutes per group

Please try not to repeat a point someone else has mentioned

so every group has a chance to report


Breakout Discussion 2:
Mental Health Terms & Language
20 Minutes then return to Main Room
Breakout Room discussions are not recorded

Mental Health Terms & Language

NEEDS IDENTIFIED IN COMMUNITY MEETINGS

Across the various meetings, participants continued to emphasize the role that words play in reducing stigma and making services feel more welcoming. They also stressed the importance of using culturally appropriate language.

QUESTIONS

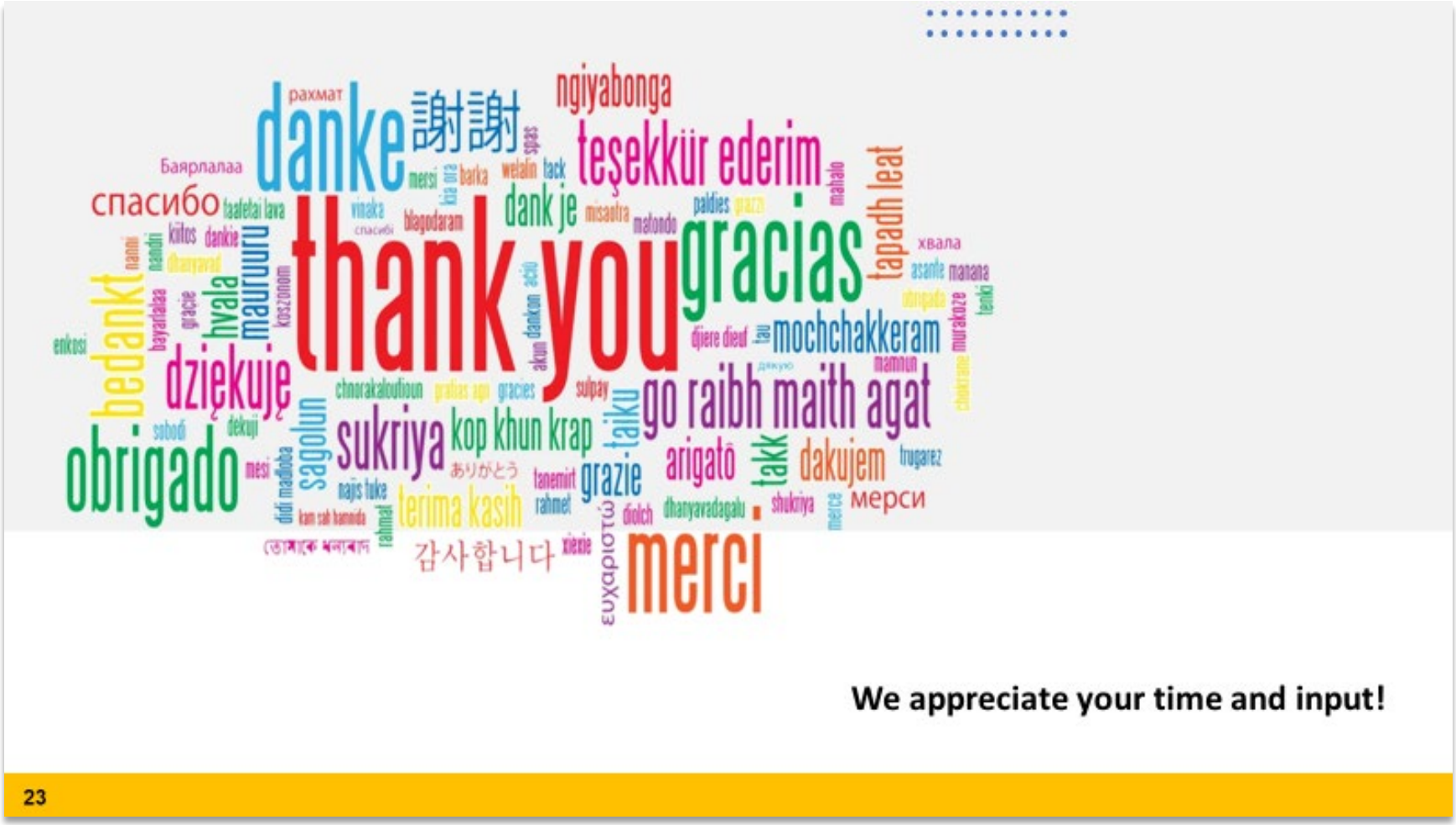
- When creating outreach and advertising materials, what terms have you (seen) used for the following constructs?
  - Mental illness, mental health disorder, behavioral health, etc.
  - Substance use disorder, substance use, drug use, addiction, etc.
  - Specific conditions, such as anxiety, depression, OCD/obsessive-compulsive disorder, etc.
  - Clients, consumers, etc.
- What impact have you noticed when different terms are used?
- Which words/phrases seem to be preferred? Should be avoided?

Breakout Discussion 2: Report Out

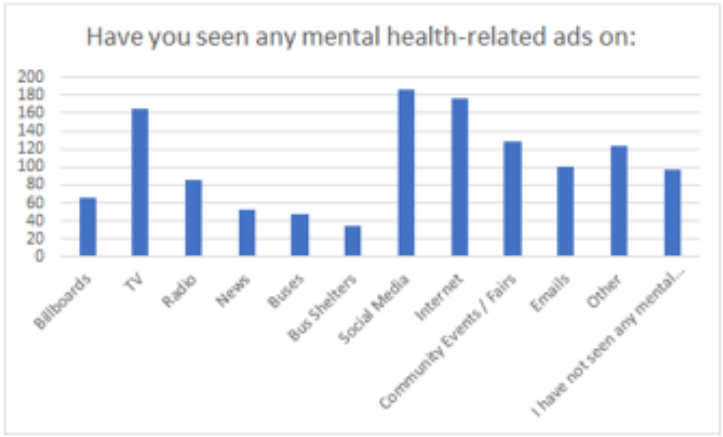
Two minutes per group

Please try not to repeat a point someone else has mentioned

so every group has a chance to report


thank you
danke
謝謝
ngiyabonga
teşekkür ederim
gracias
merci
go raibh maith agat
obrigado
dziękuję
bedankt
sukriya
kop khun krap
terima kasih
arigatō
dakujem
mochchakkeram
tapadh leat
спасибо
рахмат
Баярлалаа
dank je
hvala
mauruuru
grazie
takk
merci
We appreciate your time and input!

Appendix



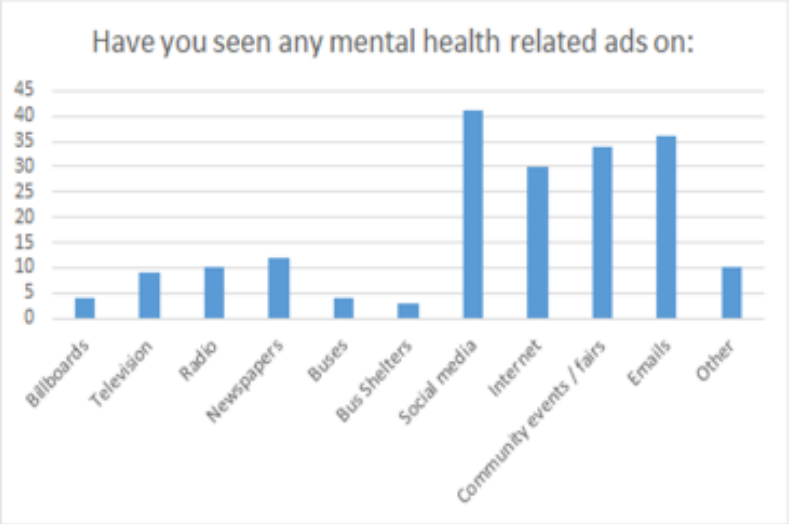
Type of Ad:	N
Billboards	48
TV	172
Radio	88
Newspaper	57
Buses	52
Bus Shelters	39
Social Media	196
Internet	184
Community Events / Fairs	135
Emails	107
Other	123
I have not seen any mental health-related ads	97

Pre-Meeting Registration Polling Responses (CEM):

"Have you seen any mental health ads on..."

Social Media, Internet, and Television were among the most popular places where CEM participants had reported seeing mental health-related ads.

Provider/Advocacy Group Polling Responses (PEM)

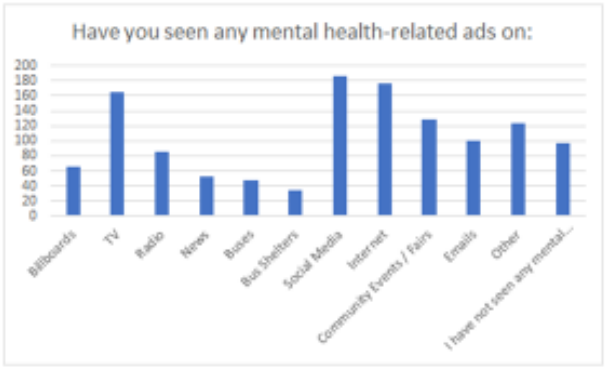


Provider/Advocacy Responses	Count
Billboards	4
Television	9
Radio	10
Newspapers	12
Buses	4
Bus Shelters	3
Social media	41
Internet	30
Community events / fairs	34
Emails	36
Other	10

Pre-Meeting Registration Polling Responses (CEM vs PEM):

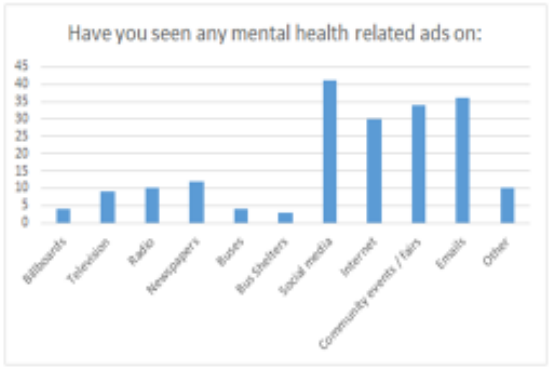
"Have you seen any mental health ads on…"

CEM

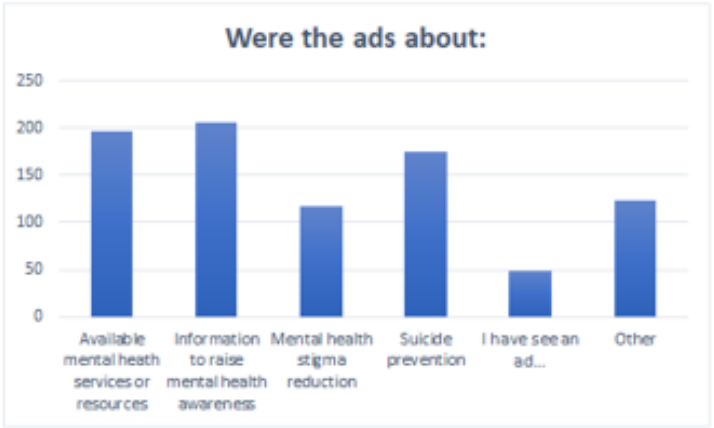


Type of Ad:	N
Billboards	48
TV	172
Radio	88
Newspaper	57
Buses	52
Bus Shelters	39
Social Media	196
Internet	184
Community Events / Fairs	135
Emails	107
Other	123
I have not seen any mental health-related ads	97

PEM



Type of Ad:	N
Billboards	4
TV	9
Radio	10
Newspaper	12
Buses	4
Bus Shelters	3
Social Media	41
Internet	30
Community Events / Fairs	34
Emails	38
Other	10



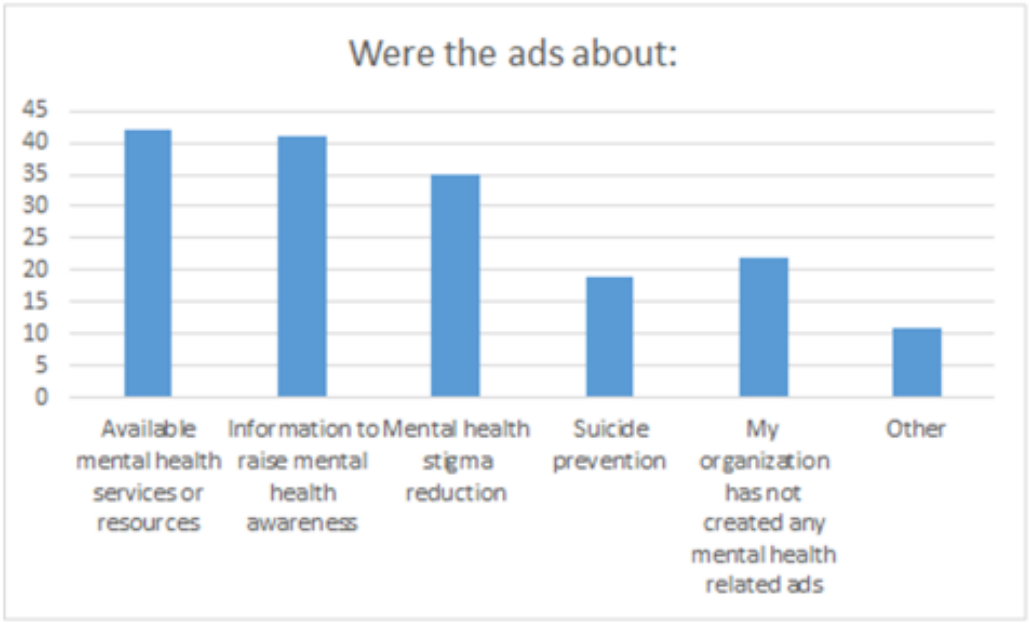
The Ads Were About	
Available mental health services or resources	205
Information to raise mental health awareness	214
Mental health stigma reduction	123
Suicide prevention	185
I have seen an ad but can't remember what it was about	49
Other	123

Pre-Meeting Registration Polling Responses:

"Were the ads about…"

Participants were most likely to see ads on available **mental health services or resources**, information to raise **mental health awareness**, and **suicide prevention**.

Provider/Advocacy Group Polling Responses

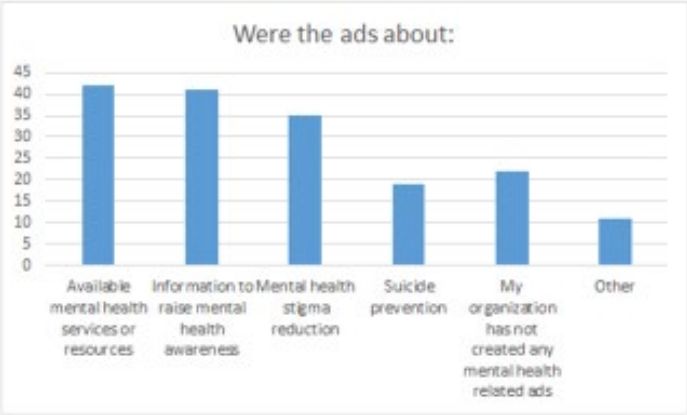


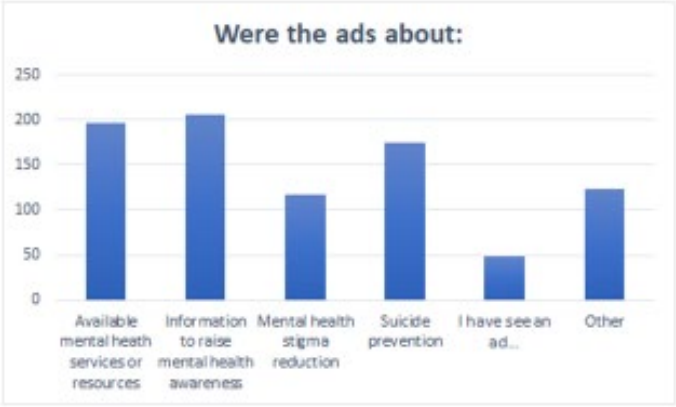
Provider/Advocacy Responses	Count
Available mental health services or resources	42
Information to raise mental health awareness	41
Mental health stigma reduction	35
Suicide prevention	19
My organization has not created any mental health related ads	22
Other	11

9

Pre-Meeting Registration Polling Responses (PEM vs CEM):

"Were the ads about..."



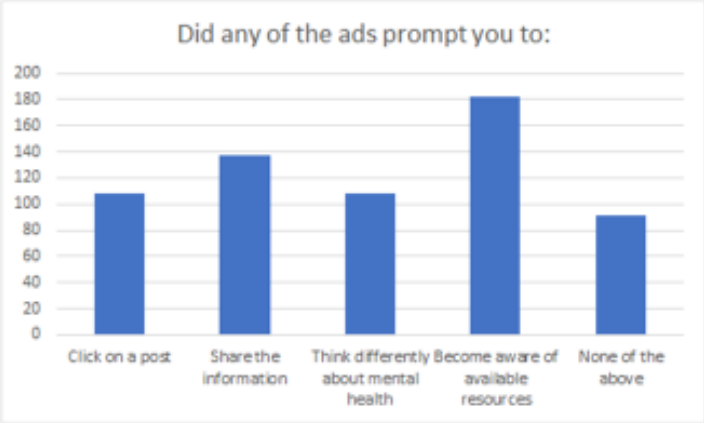


The Ads Were About (CEM)

Available mental health services or resources	205
Information to raise mental health awareness	214
Mental health stigma reduction	123
Suicide prevention	185
I have seen an ad but can't remember what it was about	49
Other	123

The Ads Were About (PEM)

Available mental health services or resources	42
Information to raise mental health awareness	41
Mental health stigma reduction	35
Suicide prevention	19
I have seen an ad but can't remember what it was about	22
Other	11



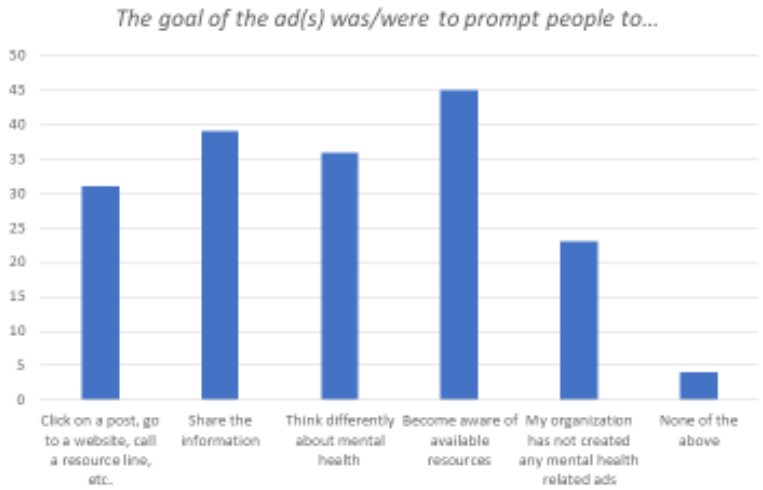
Resulting Action	N
Click on a post	114
Share the information	146
Think differently about mental health	112
Become aware of available resources	190
None of the above	91

Pre-Meeting Registration Polling Responses:

"Did any of the ads prompt you to..."

Once an ad was seen, participants were most likely prompted to **become aware** of available resources, **share** the information, and **click on a post**

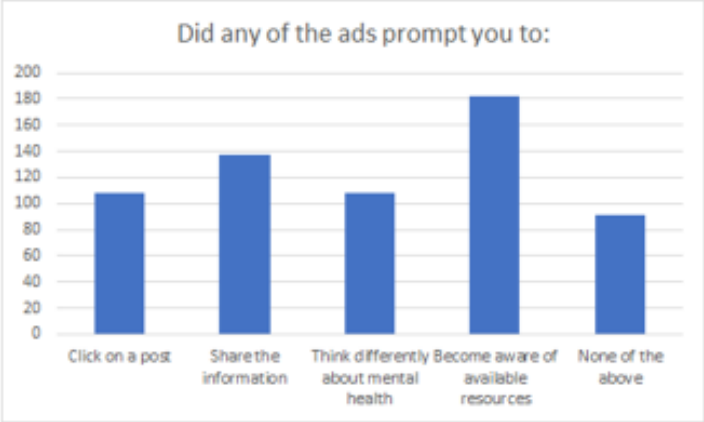
Provider/Advocacy Group Polling Responses



	Count
Click on a post, go to a website, call a resource line, etc.	31
Share the information	39
Think differently about mental health	36
Become aware of available resources	45
My organization has not created any mental health related ads	23
None of the above	4

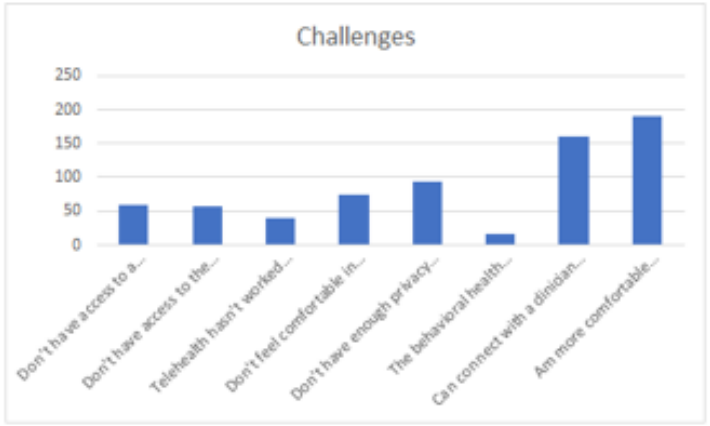
Pre-Meeting Registration Polling Responses (PEM vs CEM):

"Did any of the ads prompt you to..."
"The goal of the ad(s) was/were to prompt people to..."



Resulting Action (CEM)	N
Click on a post	114
Share the information	146
Think differently about mental health	112
Become aware of available resources	190
None of the above	91

Resulting Action (PEM)	N
Click on a post	31
Share the information	39
Think differently about mental health	36
Become aware of available resources	45
My organization has not created any mental health related ads	23
None of the above	4



Challenges	N
Don't have access to a device (smartphone, tablet, desktop or laptop) to use telehealth	60
Don't have access to the internet to use telehealth	58
Telehealth hasn't worked when I tried it before (i.e., session kept dropping, could not connect)	39
Don't feel comfortable in ability to use telehealth/technology	74
Don't have enough privacy (i.e., other people are around, others might hear/see, etc.)	93
The behavioral health clinician doesn't seem to like or isn't comfortable with telehealth	16
Can connect with a clinician better in person	160
Am more comfortable sharing in person	191

CEM Polling Responses– What challenges do (or would) you, your family, friends or loved ones face if offered a telehealth appointment for mental health or substance use services?

Regarding telehealth, participants reported they are more comfortable sharing in person, can connect with a clinician better in person, and don't have enough privacy (I.e., other people are around, others might hear / see, etc.).

9

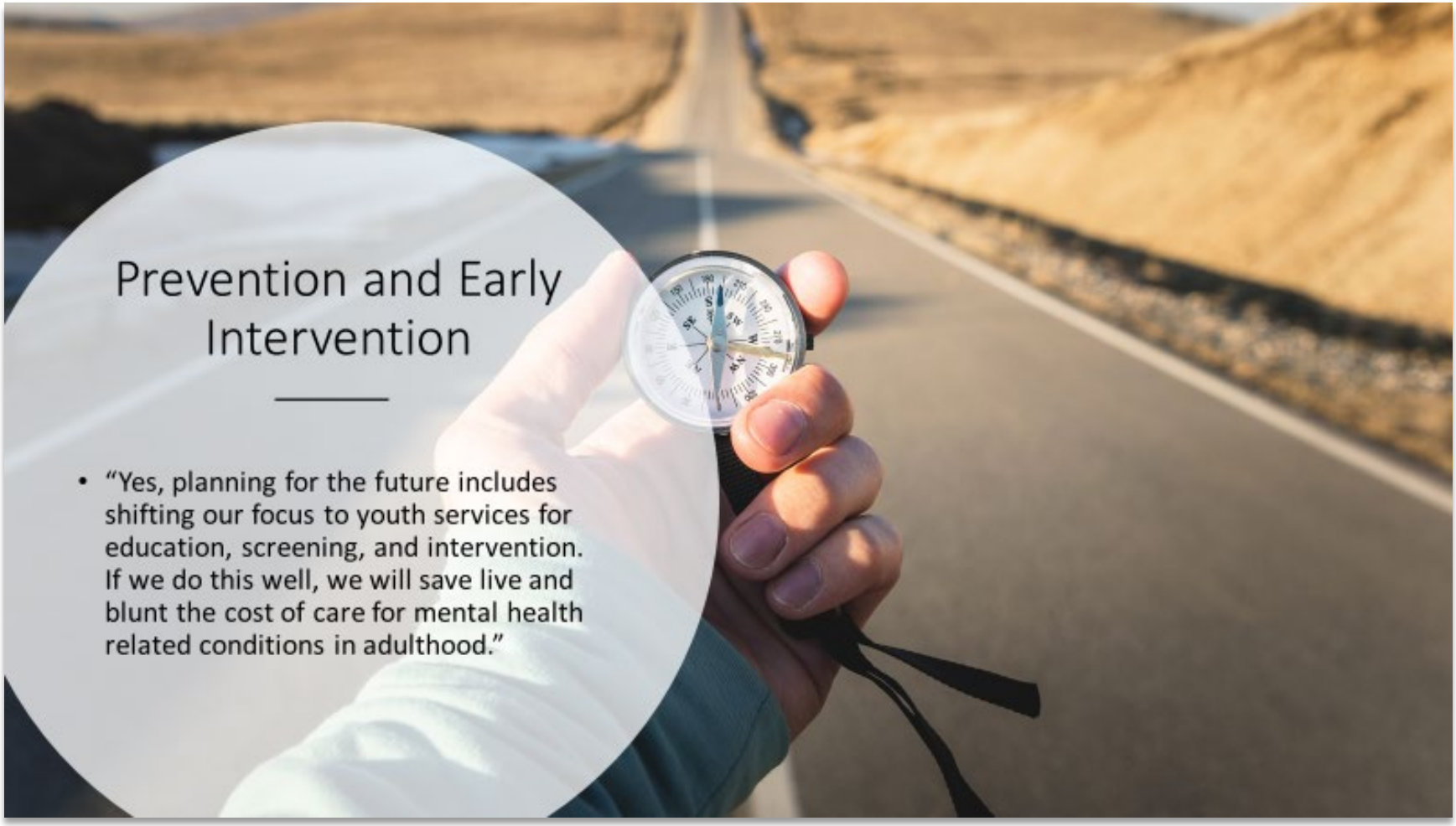
Provider / Advocacy Group Breakout Room #2

- (N = 56) Prompt #1 – When creating outreach and advertising materials, what terms have you (seen) used for the following constructs?
  - Mental illness, mental health disorder, behavioral health, etc.
  - Substance use disorder, substance use, drug use, addiction, etc.
  - Specific conditions, such as anxiety, depression, OCD/obsessive-compulsive disorder, etc.
  - Clients, consumers, etc.
- What impact have you noticed when different terms are used?
- Which words/phrases seem to be preferred? Should be avoided?

Person First Recovery Language
"A person with a mental illness" "Mental health condition"
"Person with an alcohol use disorder"
"User" "Person with a substance use disorder"
"Person living in recovery"
"Recurrence of use"

Direct Quotes

- "Talk about individuals and their issues and positive recovery outcomes, rather than general categories based on "diagnoses" that inevitably carry stigmatic connotations as well as dehumanizing and de-personalizing the entire therapeutic and recovery process"
- "Focus on humility and honor of the person, begin with "person", ask people what they prefer (e.g., client, consumer, person), promote language of suffering, language of positive state, resiliency, hope, what the service offers. Desire to do justice to the person"


Prevention and Early Intervention
• "Yes, planning for the future includes shifting our focus to youth services for education, screening, and intervention. If we do this well, we will save live and blunt the cost of care for mental health related conditions in adulthood."

APPENDIX X: Description of Assisted Outpatient Treatment (AOT) Screening Criteria and Procedures

AOT Purpose

Assisted Outpatient Treatment (AOT) is intended to interrupt the cycle of hospitalization, incarceration and homelessness for adults ages 18 and older who are living with serious mental illness and have been unable and/or unwilling to participate in mental health services on a voluntary basis.

AOT Criteria

In accordance with California Assembly Bill 1421 (AB 1421, also known as "Laura's Law"), the following criteria must be met for a person to qualify for AOT:

1. Adult is 18 years or older and suffering from a serious mental health illness;
2. A clinical determination is made that the person is unlikely to survive safely in the community without supervision;
3. A history of lack of compliance with treatment for mental illness, in that at least one of the following is true:
    a. The person must have two or more psychiatric hospitalizations in the past 36 months (or been placed on the acute mental health unit in jail); or
    b. The person has had one or more serious acts or threats of violence in the past 48 months;
4. The person has been offered an opportunity to participate in a treatment plan and continues to fail to engage in treatment;
5. The person's condition is substantially deteriorating;
6. It is likely the person will benefit from assisted outpatient treatment;
7. Assisted outpatient treatment is necessary to prevent relapse or deterioration that would be likely to result in grave disability or serious harm to self or others; and
8. Participation in the AOT program would be the least restrictive placement necessary to ensure the person's recovery and stability.

AOT Screening & Eligibility Determination

Per the legislation, the following individuals (also known as "qualified requestors") may refer a person for an AOT evaluation: (1) immediate family members such as a parent, sibling, spouse or adult children of the person; (2) adults residing with the person; (3) the director of any public or private agency, treatment facility, licensed residential care facility or hospital in which the person is a resident or patient; (4) a licensed mental health professional treating the individual; or (5) a peace officer, parole or probation officer supervising the individual. Orange County has established a toll free number (1 (855) 422-1421) for the general community to call for more information about the AOT program and for qualified requestors to make AOT referrals.

Due to the complexity of qualifying for AOT, Orange County has dedicated a trained, County-operated team to screen and assess all individuals referred for an AOT evaluation. The team determines whether referred individuals qualify for AOT, engages those who meet AOT criteria and attempts to link them directly to voluntary services prior to going through the court system as follows:

- Upon receiving a referral from a qualified requestor, the team connects with the requestor to gather additional information about the referral, including identifying information about the requestor and the referred individual; information about their circumstances; and the reason(s) for the AOT referral.
- When an AOT candidate appears to meet criteria for AOT but refuses voluntary services, a licensed clinical psychologist from the team meets with the candidate, reviews their records, and conducts a psychological assessment to determine if they meet AOT criteria.
- If the AOT candidate continues to meet criteria and refuses voluntary services, they may be ordered by the court to participate in the AOT FSP. Despite a court order to participate, however, the judge cannot impose involuntary treatment should a participant fail to comply because AOT in Orange County has been implemented with MHSA funds, which can only be used for voluntary services.

Strategies to Improve Timely Access to Services for Underserved Populations

There are many issues that may keep individuals from engaging in services including limited insight into the mental illness that results in non-compliance with treatment; homelessness or risk of homelessness; history of incarceration; difficulty finding permanent housing; lack of transportation; limited income and limited support. The team works to overcome these barriers by engaging in frequent contact with the participant through visits to their home, hospital, correctional facility or any place the participant is known to be. These contacts focus on building therapeutic relationships that facilitate trust, linkage to services and, ultimately, treatment adherence. Transportation support is also provided for participants as needed. In addition, the team has access to all languages through the use of a contracted interpreter service provider in order to minimize any potential language barriers.

Of those linked to services, an overwhelming majority continue to accept services voluntarily (76-81% over the past three years), thus demonstrating the team's success in working with this marginalized and unserved population.

AOT Assessment & Linkage Team Activity	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20
# Referrals	637	488	611	441
# Eligible for AOT	193	194	222	158
# Linked to Service	193	194	222	158
% Voluntarily Linked to Services	76% (n=147)	80% (n=156)	81% (n=179)	82% (n=130)

Community Impact

Through FY 2019-20, the AOT ALT has provided services to over 2,100 individuals since its inception in October 2014 and continues to receive a high volume of referrals through the toll-free number (approximately 20 to 25 each month). In addition to providing assessment and linkages services to eligible individuals, the

team also provides the community with information about AOT in Orange County. The program responded to 369 calls in FY 2019-20, 303 calls in FY 2018-19 and 582 informational calls in FY 2016-17.

APPENDIX XI: Glossary of Outcome Measures

Generalized Anxiety Disorder (GAD-7)

- ***Description:*** The GAD-7 is a widely used, 7-item measure of anxiety. It assesses the severity of symptoms related to social phobia, post-traumatic stress disorder and panic disorder. Scores can be classified according to their severity level (i.e., minimal, mild, moderate, severe, etc.).
- ***Rater:*** Clinician, staff, self-report; for individuals ages 18 and older

Grief Experiences Questionnaire (GEQ)

- ***Description:*** The GEQ is a 55-item measure of grief that captures the unique experience associated with losing someone to suicide. It assesses various components of grief and generates on overall score, as well as the following subscale scores:
  - Somatic Reactions
  - General Grief Reactions
  - Search for Explanation
  - Loss of Social Support
  - Stigmatization
  - Self-destructive Behavior or Orientation
  - Feelings of Guilt
  - Responsibility
  - Shame or Embarrassment
  - Abandonment or Rejection
  - Unique Reactions (i.e., reactions specific to this unique form of death).
- ***Rater:*** Self-report for adults ages 18 and older

North Carolina Family Assessment Scale (NCFAS)

- ***Description:*** The NCFAS is an assessment tool designed to examine family functioning at the individual and aggregate level. Family functioning is measured on five domains. It is used to inform the development of a service plan, as well as assess changes in family functioning between pre-and post-service delivery.
  The family functioning domains assessed include:

  - Environment (i.e., housing stability/habitability, neighborhood safety, etc.).
  - Parental Capabilities (i.e., supervision/ disciplinary practices, enrichment opportunities, etc.).
  - Family Interactions (i.e., emotional support, family bonding, etc.).
  - Family Safety (i.e., abuse and/or neglect of children).
  - Child Well-Being (i.e., mental health, behavior, school performance, etc.).

The NCFAS-General Services also assesses the following general functioning domains:

- Social/Community Life (i.e., social relationships, connection to neighborhood/cultural/ ethnic community, relationships with child care, schools, extracurricular services, etc.).
- Self-Sufficiency (i.e., stability of caregiver employment, family income).
- Family Health. (i.e., physical and mental health of the caregiver).

- ***Rater:*** Clinician, Staff

Outcome Questionnaire (OQ) 30 .2

- ***Description:*** The OQ measures the treatment progress for adults receiving any form of behavioral health treatment. This 30-item scale is sensitive to short-term change and assesses the frequency with which adults are experiencing general psychopathology symptoms and functioning related to intrapersonal distress, somatic concerns, interpersonal relations, social problems, behavioral dysfunction, and more. The measure contains a clinical cutoffs that identifies scores that fall in the clinical range of severity, as well as a reliable change index that quantifies whether the difference between baseline and follow-up scores is clinically meaningful rather than the result of random fluctuations.
- ***Rater:*** Self-Report for adults ages 18 and older

Parenting Children and Adolescents (PARCA-SE)

- ***Description:*** The PARCA-SE is a brief self-report measure designed to assess the frequency in which parents engaged in three important types of parenting behaviors. This measure consists of 19 questions that generate an Overall Score, as well as the following three subscale scores:
  - Supporting Positive Behavior (e.g., "Notice and praise your child's good behavior?").
  - Setting Limits (e.g., "Make sure your child followed the rules you set all or most of the time?")
  - Proactive Parenting (e.g., "Prepare your child for a challenging situation.").

  Each question rates how often they were able to engage in each parenting strategy on a scale from 1 (not at all) to 7 (most of the time) during the last month.

- ***Rater:*** Self-report for parents/caregivers

Patient Health Questionnaire (PHQ-9)

- ***Description:*** The PHQ-9 is a widely used, 9-item screening instrument for diagnosing, monitoring and measuring the severity of depression. Scores can be classified according to their severity level (i.e., minimal, mild, moderate, moderately severe, severe).
- ***Rater:*** Clinician, staff, self-report; for individuals ages 18 and older

Profile of Mood States (POMS)

- ***Description:*** The POMS is a scale that assesses the extent to which an individual is experiencing affective mood states: calm, agitated, annoyed, anxious, confused, depressed, helpless, overwhelmed, uncertain and worried.
- ***Rater:*** Self-rated (verbal rating) by individuals of any age calling the WarmLine

PROMIS Global Health

- ***Description:*** The PROMIS Global Health is a 10-item self-assessment of a participant's perceived overall health and functioning. This measure is from the National Institutes of Health (NIH) Patient Reported Outcome Measurement Information System (PROMIS) and includes subscales for Global Mental Health and Global Physical Health with a measure-defined cutoff score for each of the subscales.
- ***Rater*:** Self-report for adults ages 18 and older

PROMIS Pediatric Global Health

- ***Description:*** The PROMIS Pediatric and PROMIS Parent Proxy Global Health are 7-item measures that assess a child's overall evaluations of their physical, mental and social health. These scales are conceptually equivalent to its PROMIS adult counterpart, except these measures yield a single global health score that do not have a cutoff.
- ***Rater:*** Self-report for youth ages 8-17; parent-report for youth ages 5-17

Youth Outcome Questionnaire (YOQ)

- ***YOQ 30.2 Description:*** The YOQ is the youth analog of the OQ 30.2. It is sensitive to short-term change and assesses the frequency with which youth are experiencing general psychopathology symptoms and functioning related to intrapersonal distress, somatic concerns, interpersonal relations, social problems, behavioral dysfunction, and more. The measure contains a clinical cutoff that identifies scores that fall in the clinical range of severity, as well as a reliable change index that quantifies whether the difference between baseline and follow-up scores is clinically meaningful.
- ***YOQ 2.0 Description:*** The YOQ is the youth analog of the OQ 30.2. It is sensitive to short-term change and assesses the frequency with which youth are experiencing general psychopathology symptoms and functioning related to intrapersonal distress, somatic concerns, interpersonal relations, social problems, behavioral dysfunction, and more. The measure contains a clinical cutoff that identifies scores that fall in the clinical range of severity, as well as a reliable change index that quantifies whether the difference between baseline and follow-up scores is clinically meaningful.
- ***Rater (Both instruments)**:* Self-report for youth ages 12-18; parent-report for youth ages 4-17.

APPENDIX XII: Orange County MHSA Program Providers and Contracts by Service Area

Mental Health Awareness & Stigma Reduction Campaigns & Education	
PROGRAM: Outreach for Increasing Recognition of Early Signs of Mental Illness	
Portion of "Outreach for Increasing Recognition" budget operated by Behavioral Health Training Services (BHTS) Office through former Behavioral Health Community Training & Technical Assistance	**Provider:** County **Provider:** Western Youth Services **Contract Name:** Behavioral Health Training Services
Portion of "Outreach for Increasing Recognition" budget operated by PEI through former Early Childhood Mental Health Consultation Services	**Provider:** Charitable Ventures Orange County **Contract Name:** Early Childhood Mental Health Consultation Services
Portion of "Outreach for Increasing Recognition" budget operated by PEI through former K-12 School-Based Mental Health Services Expansion	**Provider:** Latino Center for Prevention and Action in Health & Welfare dba Latino Health Access **Contract Name:** K-12 School-Based Mental Health Training Services **Provider:** Orange County Department of Education for provision **Contract Name:** K-12 School-Based Mental Health Education Services **Provider:** Center for Applied Research Solutions **Contract Names:** K-12 School-Based Mental Health Resource Development Services, K-12 School-Based Mental Health Community Networking Services

Portion of "Outreach for Increasing Recognition" budget operated by PEI through former Services for TAY and Young Adults	**Provider:** Laguna Play House **Contract Name:** Transitional Age Youth and Young Adult Mental Health Outreach Services **Provider:** NAMI OC **Contract Name:** Transitional Age Youth and Young Adult Mental Health Educational Activities **Provider:** National Council on Alcoholism and Drug Dependency **Contract Names:** Transitional Age Youth and Young Adult Mental Health Community Networking Services
Portion of "Outreach for Increasing Recognition" budget Operated by PEI through former Outreach and Engagement Collaborative/Mental Health & Well-Being Promotion for Diverse Communities	**Provider:** County **Provider:** Other(s) TBD; solicitation to be released to add contracted provider(s) **Contract Name(s)**: TBD
Portion of "Outreach for Increasing Recognition" budget operated by PEI through former Statewide Projects (includes local mental health campaigns**)**	**Provider:** County **Contract Name:** Participation Agreement with CalMHSA **Contract Name:** Mental Health Awareness Campaign with Angels Baseball LP
Mental Health Community Education Events for Reducing Stigma and Discrimination	**Provider:** Council on Aging Southern California **Contract Name:** Mental Health Community Educational Event Services **Provider:** National Alliance on Mental Illness (NAMI) Orange County **Contract Name:** Mental Health Community Educational Event Services **Provider:** Gay and Lesbian Community Services Center of Orange County **Contract Name:** Mental Health Community Educational Event Services

	Provider: Access California Services **Contract Name:** Mental Health Community Educational Event Services **Provider:** Casa De La Familia **Contract Name:** Mental Health Community Educational Event Services **Provider:** Latino Center for Prevention and Action in Health and Welfare dba Latino Health Access and dba LACPRACH **Contract Name:** Mental Health Community Educational Event Services **Provider:** Multi-Ethnic Collaborative of Community Agencies (MECCA) **Contract Name:** Mental Health Community Educational Event Services **Provider:** Wellness and Prevention Foundation dba Wellness Prevention Center **Contract Name:** Mental Health Community Educational Event Services

Prevention Programs	
School Readiness	**Provider:** Orange County Child Abuse Prevention Center, Inc. dba Child Abuse Prevention Center **Contract Name:** School Readiness Services **Provider:** Children's Bureau of Southern California

	Contract Name: School Readiness Services
School-Based Behavioral Health Interventions and Support	**Provider:** Phoenix House Orange County, Inc. **Contract Name:** School Based Behavioral Health Intervention and Support Services **Provider:** Western Youth Services **Contract Name:** School Based Behavioral Health Intervention and Support Services
School-Based Stress Management	**Provider:** Orange County Superintendent of Schools dba Orange County Department of Education **Contract Name:** School Based Stress Management Education Services
Violence Prevention Education	**Provider:** Orange County Superintendent of Schools dba Orange County Department of Education **Contract Name:** School Based Violence Prevention Education Services
Gang Prevention Services	**Provider:** Waymakers **Contract Name:** School-Based Gang Prevention Services
Parent Education Services	**Provider:** Olive Crest **Contract Name:** Parent Education Services
Family Support Services	**Provider:** National Alliance on Mental Illness (NAMI) Orange County **Contract Name:** Family Support Services
Children's Support and Parenting	**Provider:** County

Access and Linkage to Treatment/Services	
OC Links (PEI)	**Provider:** County
BHS Outreach and Engagement (PEI)	**Provider:** County
Multi-Service Center for Homeless Mentally Ill Adults	**Provider:** Orange County Association for Mental Health dba Mental Health Association of Orange County **Contract Name:** Multi-Service Center Services for Homeless Mentally Ill Adults
Open Access	**Provider:** County
Correctional Health Services: Jail to Community Re-entry Program (JCRP)	**Provider:** County

Crisis Prevention and Support Services	
Warmline	**Provider:** National Alliance on Mental Illness (NAMI) Orange County **Contract Name:** Warmline Network Services
Suicide Prevention Services	**Provider:** Didi Hirsch Psychiatric Service dba Didi Hirsch Mental Health Services **Contract Name:** Suicide Prevention and Support Services
Mobile Crisis Assessment Team/PERT Portion of "Mobile Crisis Assessment" budget operated by CYBH for individuals ages 0-17 years Portion of "Mobile Crisis Assessment" budget operated by AOABH for individuals ages 18 and older	**Provider:** County
Crisis Stabilization Units	**Provider:** Exodus Recovery, Inc.

	Contract Name: Crisis Stabilization Services **Provider:** College Hospital Costa Mesa **Contract Name:** CSU, LLC, dba College Hospital Crisis Stabilization Unit
In Home Crisis Stabilization Portion of "In-Home Crisis Stabilization" budget operated by CYBH for individuals ages 0-17 years Portion of "In-Home Crisis Stabilization" budget operated by AOABH for individuals ages 18 and older	**Provider:** Orange County Child Abuse Prevention Center, INC. **Contract Name:** Children's In-Home Crisis Stabilization Services **Provider:** The Priority Center **Contract Name:** Adults In-Home Crisis Stabilization Services
Crisis Residential Services Portion of "Crisis Residential Services" budget operated by CYBH for individuals ages 0-17 years Portion of "Crisis Residential Services" budget operated by CYBH for individuals ages 18-25 years Portion of "Crisis Residential Services" budget operated by AOABH for individuals ages 18 and older	**Provider:** Waymakers (children) **Contract Name:** Children's Crisis Residential Services **Provider:** South Coast Children's Society (SCCS; TAY) **Contract Name:** Transitional Age Youth Crisis Residential Services **Provider:** Telecare Corporation (Adult/OA) **Contract Name:** Adult Crisis Residential Services North Region **Provider:** Telecare Corporation (Adult/OA) **Contract Name:** Adult Crisis Residential Services Central Region

	Provider: Telecare Corporation (Adult/OA) **Contract Name**: Adult Crisis Residential Services South Region **Provider:** Exodus Recovery, Inc. **Contract Name:** Adult Crisis Residential Services North Campus

Outpatient Treatment: Early Intervention Programs	
Community Counseling and Supportive Services CCSS	**Provider(s):** County
School-Based Mental Health Services	**Provider:** County
Early Intervention Services for Older Adults	**Provider:** Multi-Ethnic Collaborative of Community Agencies (MECCA) **Contract Name:** Early Intervention Services for Older Adults **Provider:** Council on Aging Southern California **Contract Name:** Early Intervention Services for Older Adults
OC Parent Wellness Program (Stress-Free Families, Connect the Tots)	**Provider:** County
First Onset of Psychiatric Illness (OC CREW)	**Provider:** County
Early Psychosis Learning Healthcare Network	**Administrative Oversight:** California Mental Health Services Authority (CalMHSA) **Participation Agreement Name:** Early Psychosis Learning Healthcare Network (EPLHCN)
OC4 Vets	**Provider:** County **Provider:** Working Wardrobes **Contract Name:** Veteran Peer Support Services **Provider:** United States Veterans Initiative

	Contract Name: Early Intervention Services for Veteran College Students **Provider:** Child Guidance Center, Inc. **Contract Name:** Behavioral Health Services for Military Families

Outpatient Treatment: Clinic Expansion Programs	
Child and Youth Clinic Expansion *(Formerly, in part, Youth Core Services)*	**Provider:** Western Youth Services **Contract Name:** Behavioral Health Services for Children and Youth
Services for the Short-Term Residential Therapeutic Program (STRTP)	**Provider:** New Alternatives, Inc. **Contract Name:** Short-Term Residential Therapeutic Programs **Provider:** Olive Crest **Contract Name:** Short-Term Residential Therapeutic Programs **Provider:** Rite of Passage Adolescent Treatment Centers and Schools, Inc. **Contract Name:** Short-Term Residential Therapeutic Programs **Provider:** Children's Hospital of Orange County (CHOC) **Contract Name:** Short-Term Residential Therapeutic Programs

Children and Youth with Co-Occurring Medical and Mental Health Disorders	**Provider:** Children's Hospital Orange County (CHOC) **Contract Name:** Behavioral Health Services for Children and Youth
Outpatient Recovery formerly Recovery Center/ Clinic	**Provider:** College Community Services **Contract Name:** Adult Behavioral Health Outpatient Recovery Center Service **Provider:** Orange County Association for Mental Health dba Mental Health Association of Orange County **Contract Name:** Adult Behavioral Health Outpatient Recovery Center Service **Provider:** County
Older Adult Services	**Provider:** County

Outpatient Treatment: Full Service Partnership Programs	
Children's/TAY FSPs	**Provider:** Pathways Community Services, LLC. **Contract Name:** Full Service Partnership/Wraparound Services **Provider:** Pathways Community Services, LLC. **Contract Name:** Children's Full Service Partnership/Wraparound Services **Provider:** Orange County Asian and Pacific Islander Community Alliance, Inc.

	Contract Name: Children and Transitional Age Youth Full Service Partnership/Wraparound Services **Provider:** Children's Hospital of Orange County, DBA CHOC Children's **Contract Name:** Children and Transitional Age youth Full Service Partnership/Wraparound Services for Co-Occurring Disorders **Provider:** Waymakers **Contract Name:** Collaborative Courts Full Service Partnership/Wraparound Services **Provider:** Orangewood Foundation **Contract Name:** Collaborative Courts Full Service Partnership/Wraparound Services **Provider:** Waymakers **Contract Name:** Full Service Partnership/Wraparound Services for Youthful Offenders
Adult FSPs Portion of "Adult FSP" budget operated by AOABH for individuals ages 18 and older being assessed for Assisted Outpatient Treatment FSP eligibility Portion of "Adult FSP" budget operated by AOABH for individuals ages 18 and older residing in Permanent Supportive Housing	**Provider:** College Community Services **Contract Name:** Older Adult Full Service Partnership Services **Provider:** Telecare Corporation **Contract Name:** General Population Region A Full Service Partnership Services **Provider:** Telecare Corporation **Contract Name:** General Population Region B Full Service Partnership Services

	Provider: Telecare Corporation **Contract Name:** Assisted Outpatient Treatment Full Service Partnership Services
Older Adult FSP	**Provider:** College Community Services **Contract:** Older Adult Full Service Partnership Services

Outpatient Treatment: Program for Assertive Community Treatment	
PACT Portion of "PACT" budget operated by CYBH for individuals ages 0-21 Portion of "PACT" budget operated by AOABH for individuals ages 18 and older	 **Provider:** County

Supportive Services	
Peer Mentor/Parent Partner Support	**Provider:** College Community Services **Contract Name:** Peer Mentoring Services for Adults and Older Adults
Wellness Centers	**Provider:** College Community Services **Contract Name:** Mental Health Peer Support and Wellness Center Services Central Region **Provider:** Orange County Association for Mental Health dba Mental Health Association of Orange County **Contract Name:** Mental Health Peer Support and Wellness Center Services South Region

	Provider: Orange County Association for Mental Health dba Mental Health Association of Orange County **Contract Name:** Mental Health Peer Support and Wellness Center Services West Region
Transportation	**Provider:** CABCO Yellow, Inc. dba California Yellow Cab **Contract Name:** Non-Emergency Transportation Services
Supported Employment	**Provider:** Goodwill Industries of Orange County **Contract Name:** Adult Supported Employment Services
Continuum of Care for Veterans and Military Families (INN)	**Provider:** Child Guidance Center **Contract Name:** Continuum of Care for Veterans and Military Families
Short-Term Housing Services formerly known as Year- Round Emergency Shelter	**Provider:** Grandma's House of Hope **Contract Name:** Short Term Housing Services **Provider:** Friendship Shelter **Contract Name:** Short Term Housing Services **Provider:** Colette's Children's Home **Contract Name:** Short Term Housing Services **Provider:** Mercy House **Contract Name:** Bridges at Kraemer Place **Provider:** PATH

	Contract Name: Yale Navigation Center
Bridge Housing for the Homeless	**Provider:** Grandma's House of Hope **Contract Name:** Homeless Bridge Housing Services **Provider:** Friendship Shelter **Contract Name:** Homeless Bridge Housing Services **Provider:** Colette's Children's Home **Contract Name:** Homeless Bridge Housing Services
MHSA/ CSS Housing Program	**Provider:** County

Special Projects	
Help@Hand (formerly Mental Health Technology Suite) (INN)	**Administrative Oversight:** California Mental Health Services Authority (CalMHSA) **Participation Agreement Name:** Mental Health Services Act Innovation Program
Behavioral Health System Transformation Innovation Project (INN)	**Provider:** Mind OC **Contract Name:** Behavioral Health System Transformation Innovation Project **Administrative Oversight:** CalMHSA

	Participation Agreement Name: Behavioral Health System Transformation Innovation Project Part II