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DRAFT

Orange County Mental Health Services Act

Three-Year Program and Expenditure Plan
Fiscal Years 2023-2024 through 2025-2026

Message from the Director

Thank you for your interest in Orange County, Mental Health and Recovery Services (MHRS) Mental Health Services Act (MHSA) Three-Year Plan for Fiscal Years 2023-24 through 2025-26 (Three-Year Plan). I would like to take this opportunity to thank the community for their collaboration as we continue to revamp the community planning process, embrace community input, and utilize MHSA funding as a key revenue source and vehicle to improve the public behavioral health safety net.

The vision of MHRS is to provide quality behavioral health services to our community. This MHSA Three-Year Plan embodies that vision and reflects an integrated pathway to quality behavioral health services. This plan will continue to fund existing programs, provide enhancements to the public behavioral health system that promote wellness, equity, recovery, and resilience, and expands efforts in response to community needs and statutory change.

The timing of this Three-Year Plan can only be described as pivotal. The public behavioral health system is experiencing significant changes in policy, as the state implements the California Advancing and Innovating Medi-Cal (CalAIM) program. CalAIM is an initiative to transform and strengthen Medi-Cal, offering a more equitable, coordinated, and person-centered approach to healthcare offered under the public safety net. At the same time, MHRS, along with the nation, is experiencing a behavioral health provider workforce shortage during a time of pandemic fueled growth in behavioral health needs and is required to implement new programs and mandates as a result of recently enacted laws. The Three- Year Plan reflects the support and pragmatic approach of MHRS during this time of significant transformation.

Highlights include a reorganization of the Three-Year Plan to align with statute and reflect each of the MHSA Components, the strategic expansion of Workforce Education and Training component initiatives to strengthen recruitment and retention efforts, the implementation of a new required Community Assistance, Recovery and Empowerment (CARE) collaborative court, expansion of children's, housing and crisis programming, and further development of the OC Navigator- a centralized access point and closed loop referral navigation tool.

Our progress to date would not have been possible without the support and guidance of community stakeholders and entities including the Orange County Board of Supervisors (Board), Behavioral Health Advisory Board (BHAB), representatives for unserved and underserved populations, members of our provider organizations, OC Health Care Agency (HCA) and County staff and, most importantly, the multitude of consumers and family members.

Thank you for taking the time to review and provide feedback on this plan. The Orange County Mental Health and Recovery Services Department looks forward to receiving your input at MHSA@ochca.com.

Sincerely,

Veronica Kelley, DSW, LCSW

Chief, Orange County Mental Health Recovery Services

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Executive Summary

MHSA BACKGROUND

In November 2004, California voters passed Proposition 63, also known as the Mental Health Services Act (MHSA). The Act implements a 1% state tax on personal income over $1 million and emphasizes transforming the mental health system to improve the quality of life for individuals living with a serious behavioral health condition and their families. With MHSA, Mental Health Plans ensure that key community stakeholders have the opportunity to provide input into program development, implementation, evaluation, finance and policy resulting in public behavioral health programs that have been tailored to meet the needs of diverse individuals, families, and communities across California. As a result, local communities and their residents are experiencing the benefits of expanded and improved mental health services.

Since the inception of MHSA, Orange County Health Care Agency, Mental Health and Recovery Services (MHRS) has used a comprehensive stakeholder engagement process to develop local MHSA programs that range from prevention and crisis services, through an expanded continuum of outpatient 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 the importance of mental 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 planned changes being proposed in Orange County's new MHSA Three-Year Program and Expenditure Plan for Fiscal Years 2023-24, 2024-25, and 2025-26. Included in this new MHSA Three-Year Plan, is a comprehensive overview of the Community Program Planning process (CPP), detailed program descriptions including target populations, budget projections, data, and supporting documentation in the Appendices.

Executive Summary

MHSA Components and Funding

To further define the use of this categorical funding, MHSA is broken down into six components, each identifying a targeted population and/or use. The PEI and CSS components provide direct services. The descriptions below also provide an estimate of the cumulative number of individuals to be served across the three-year timeframe of the plan:

- Prevention and Early Intervention (PEI): PEI is intended to provide supports or interventions as early as possible to prevent a mental health condition from becoming severe and disabling. The majority of PEI must be directed toward children and youth aged 25 and under and their families/caregivers. Approximately 230,000 individuals are expected participate in a PEI service over the three-year period. This number does not include the anticipated numbers of people that may contact the OC LINKS call center or be exposed to large scale campaigns.
- Community Services and Supports (CSS): This component provides programs and services geared toward individuals living with serious mental illness, including an allowance for MHSA Housing and a requirement that half of the funds be directed to support intensive outpatient wraparound services via Full Service Partnership programs. It is anticipated that over 94,000 individuals will benefit from a CSS program over the three year period of time.
- Innovation (INN): Innovation is intended to allow the testing and evaluation of new and/or changed practices or strategies in the field of mental health. This short term, learning focused projects, strive to improve an aspect of the public behavioral health system.
- Workforce Education and Training (WET): Qualified and competent staff are an essential ingredient to the success of MHSA. WET supports the recruitment, training, development, and retention of public behavioral health employees.
- Capital Facilities and Technological Needs (CFTN): CFTN further supports the infrastructure of the public behavioral health system through funding that helps modernize data and information systems and provide funds to build out space to provide MHSA mental health services.
- Community Program Planning (CPP): MHSA requires meaningful stakeholder engagement in the development, implementation, and analysis of MHSA programs. The stakeholder process establishes the path for continuous

communication between HCA and stakeholders to allow for real time adjustments and quality improvement. A complete overview of the CPP activities that occurred for the development of this plan can be reviewed in its entirety in the Community Program Planning Section.

Regulations provide large counties three years to spend their annual MHSA allocation. After the three-year period, funds revert to the state for redistribution. The values and available funding amounts proposed in the Three-Year Plan are determined through a budget "true up" process, which helps to identify available funds. The fiscal review includes a detailed process of aligning existing component program budgets more closely with actual program expenditures from the most recent fiscal years. The annual budget "true up" allows MHRS to identify cost savings for programs that could be utilized to cover costs of other programs within the same MHSA component. In addition, the MHSA Administrative team, MHRS Finance, and representation from the County CEO office, meet quarterly with a state Financial Consultant to closely monitor three years of MHSA projections, and explore additional state initiatives and legislation changes that could potentially impact MHSA funding. Each quarter, a summary of projections is presented at the OC Behavioral Health Advisory Board Community Meetings. Finally, MHRS managers, fiscal leadership, and the MHSA Administrative team met regularly during Fiscal Year 2022-23 to coordinate and evaluate program development progress, budgets, expenditures, and proposed plans. An overview of the proposed three-year funding level for each component is provided in the table below.

It is noted that these draft Component budgets and values are based on projections and not actual funds received. MHSA funds have historically been volatile and subject to change. Based on the information available at the time of this report, an overall increase in funding for the three-year plan timeframe is anticipated. Based on the projections, the plan reflects program expansions in five components.

Executive Summary

Overview of Proposed Funding to Serve Over 100,000 Individuals per Year

Component	FY 23-24	FY 24-25	FY 25-26	Total
Prevention & Early Intervention	$76,779,363	$82,273,482	$77,753,250	$236,806,095
Community Services & Supports	$228,994,278	$257,467,229	$259,181,497	$745,643,004
Innovation	$9,848,003	$7,323,668	$4,255,557	$21,427,228
WET	$7,504,623	$8,758,368	$8,787,501	$25,050,493
Capital Facilities	$20,901,030	$21,401,488	$23,091,028	$65,393,546
Total	**$344,027,297**	**$377,224,235**	**$373,068,833**	**$1,094,320,365**

MHSA Fiscal Year 2023-24, 2024—25, and 2025-26, Proposed Three-Year Program Plan and Expenditure Changes

The Three-Year Plan was developed based on stakeholder input received through the community program planning process, legislative changes, state policy updates, and with consideration of Orange Counties local initiatives.

Many programs contained within the draft Three Year Plan component are proposed for expansion to meet the needs of residents and to keep up with the increased costs of doing business.

Highlights of newly proposed programs or updates contained in the plan include:

Executive Summary

Community Services and Supports

- The development of a new Community Assistance, Recovery, and Empowerment (CARE) Full Service Partnership (FSP). Orange County is part of a first cohort required to implement the Community Assistance, Recovery, and Empowerment (CARE) Act under SB 1338. The CARE Act creates a pathway to deliver mental health and substance use disorder services to the most severely impaired Orange County residents who may be homeless/at-risk or frequently incarcerated due to their untreated behavioral health condition. The Full Service Partnership will work collaboratively with the Civic Court System to serve individuals deemed eligible, as they are at-risk of civic commitment/committed and are living with a qualifying diagnosis. The CARE FSP is not for everyone experiencing mental illness and focuses on individuals living with schizophrenia spectrum or other psychotic disorders who meet the specific criteria.
- Veteran's services were identified as a priority population that continues to be the subject of discussion in community planning meetings, including housing support. At this time, we continue to pursue establishing a Veterans FSP, creating support for Veterans through animal/pet care, and additional programming is proposed to expand services for Veterans.
- A significant expansion of Children's services is proposed for this three-year period. This includes expansion of Full Service Partnership to additional areas of the County and establishing a Family Full Service Partnership (FSP) in years two and three of the Plan. The Family FSP will provide services beyond the familial supports typically provided in a Children's FSP to be able to provide mental health services to other family members and not just the identified individual. In addition, outpatient Children and Youth Clinical Services will expand to include a strengthening of both contract and County clinical operations across the county.
- Housing and Homeless Services continues to be identified as a priority. HCA plans to invest additional MHSA funding to continue to support housing projects that are currently in process and to invest in the development of 100 more Permanent Supportive Housing units over years 2 and 3 of the Plan. This investment includes provisions for the establishment of Capitalized Operations Subsidy Reserves to cover potential or projected operating deficits over a defined period of time.

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Prevention and Early Intervention

- Several PEI component programs with similar scopes of work have been consolidated to form two “new” programs, the Prevention Services and Supports for Families and the Prevention Services and Supports for Youth programs.
- As California continues with the implementation of an updated and redesigned public healthcare service infrastructure, planning with system partners has become paramount to future success. With that, HCA, CalOptima, and Orange County Department of Education and a Superintendents Mental Health Workgroup are engaged in the collaborative work of designing a systems approach to increasing access to mental health services for children and youth. Updated regulations allow for schools to act as providers for CalOptima to be reimbursed for certain mental health services delivered by qualified school staff in school settings. This paradigm shift may allow for a shift in the MHSA investment. More information about this initiative can be reviewed in the Summary of Program Changes section of this Plan.
- Stakeholder feedback coupled with a review of utilization data resulted in the development of the new proposed Infant and Early Childhood Continuum of Care program. This new program will build on existing resources and establish a continuum of services for young children (aged 0-8) that includes a coordinated system to work across multiple agencies, partners, and communities to meet the needs of very young children and their families. System partners that serve this underserved age group are dedicated to working together to identify and fill gaps in infant and young child serving systems. Details of this new program will continue to be developed through this collaborative process and will be included in future updates.

Workforce Education and Training

- As California and the nation continue to experience a workforce shortage, the recruitment and retention of well trained and competent employees is critical. The plan proposes to expand the Internship Program and establish a new employee internship program. Providing internship opportunities is a proven way to increase the number of people working at MHRS and in contract agencies in the behavioral health professions. This action describes plans

to increase internships within MHRS as well as coordinate Intern Programs with contracted agencies and allow interns from those agencies to attend group supervision sessions conducted by MHRS.

- MHRS has identified a need to implement a leadership development program for staff and staff of contract agencies. Through this program, MHRS will develop leaders from existing staff, begin succession planning for future leadership of MHRS, begin to make leadership-based assignments, and build leadership into supervisory training.
- MHRS will establish a new Training and Technical Assistance program, Health and Wellness Coaches (HWCs). HWCs utilize integrative approaches with clients to support wellness and improve health and well-being and support clients to engage in behaviors that have been proven to improve health and prevent disease including fitness, nutrition, stress coping, sleep, mind-body wellness, and positive psychology interventions. MHRS proposes to train staff, contracted provider agency staff, and others that interact with behavioral health clients to become Health and Wellness Coaches. Health and Wellness Coaches are not required to have advanced degrees, thus, allowing staff to benefit from this quality training and supporting MHRS and providers the ability to up-train individuals already working in underserved settings.

Capital Facilities and Technological Needs

- MHRS continues to support the development of improved data systems, network infrastructure and supports through use of the CFTN funding transfer. In effort to keep up with demands and develop needed infrastructure, MHRS has actively pursued grant funding to expand clinical operations in underserved areas of the County. Some grants require a non-federal match and other awards may not cover full building costs. CFTN dollars may potentially be used to make projects whole. MHSA program services or administration is required to be provided in spaces where CFTN dollars have been utilized.

Community Program Planning

Introduction

The Mental Health Services Act (MHSA) has been integral in supporting the transformation of the public behavioral health system. Through the MHSA, County agencies ensure that key community stakeholders have the opportunity to provide input into program development, implementation, evaluation, and policy for MHSA funded programs. This approach assists County safety net organization in integrating the needs of diverse individuals, families, and communities in its programming. The Orange County Mental Health Services Act (MHSA) Three Year Program and expenditure Plan (Three Year Plan) for Fiscal Years (FY) 2023-24 through 2025-26 provides a comprehensive overview of the MHSA programs and services that contribute to sustaining the behavioral health and wellness of Orange County residents. It includes an overview of the ongoing stakeholder engaged community planning process conducted by MHRS, highlights MHSA programs, provides updates to established MHSA programs, and includes overviews of newly proposed programs. The programs contained in the Three Year Plan are designed to develop a continuum of services in which consumers, family members, providers, County agencies, faith-based and community-based organizations can work together to systematically improve the public behavioral health system.

The Three Year Plan is an example of MHRS's efforts to continue to integrate healthcare services across access points to create pathways that are easy to travel and in a way that allows individuals be able to navigate resources in the midst of significant changes to public policy that work to further transform behavioral healthcare in the public system. Program successes are described for each program and areas of opportunity are included, such as continued efforts to improve evaluation of programs across multiple domains, enhancing the use of technology in clinical care, efforts to recruit and retain qualified staff, and responding to policy changes.

The overall purpose of the MHSA Plan is to inform community stakeholders, leadership, and policy makers in the administration and management of public Behavioral Health Programs of changes in the provision of services, as well as meet the regulatory requirements of the MHSA.

Orange County at a Glance

Orange County is a region known for its mild climate, miles of beaches, acres of parks and forest land, a wide range of tourist attractions and world-class venues for cultural and performing arts events. Orange County is the third most populous county in California, the sixth most populous in the US, and more populous than 21 US states. There are 34 cities in the

Community Program Planning

County and multiple unincorporated or census designated places. The population of the county is estimated at over 3.2 million diverse residents as outlined below, including the demographics of those served in MHSA programs.

CA County Ranking

3rd
Most Populous

2nd
Most Densely Populated

OC Residents

About 3.2 million

- Veterans: 3.7%
- LGBTQ+ (18+): 5.3%
- Adults w/HS Diploma: 87.3%

OC Age Groups

21%
Under 18

16%
65 & Older

Language Spoken at Home (18+)

53%
English

24%
Spanish

16%
Asian / Pacific Islander

Highest Cost of Living

Compared to neighboring counties, driven by high housing costs

- Median household income: $100,559
- Median gross rent: $2,057
- Median house price: $832,300

Financial Insecurity

6% Residents unemployed

10% Living below poverty level

Community Program Planning

OC CENSUS

Orange County Residents by Demographic Characteristic

Age	2021 ACS
0-9 yrs	11%
10-19 yrs	13%
20-29 yrs	13%
30-39 yrs	14%
40-49 yrs	13%
50-59 yrs	14%
60+ yrs	22%

Gender	2021 ACS
Female	50%
Male	50%
Transgender	>1%
Genderqueer	>1%
Questioning/Unsure	>1%
Another	>1%

Race/Ethnicity	2021 ACS
African American/Black	2%
American Indian/Alaskan Native	>1%
Asian/Pacific Islander	22%
Caucasian/White	38%
Latino/Hispanic	34%
Middle Eastern/North African	NOT COLLECTED
Two or More Races	4%

2021 Population: 3,167,809

Source: American Community Survey (ACS) 2021

CSS/MHSA

Individuals Served in CSS Clinical Services by Demographic Characteristic

Age	Estimated
0-15 yrs	16%
16-25 yrs	24%
26-59 yrs	49%
60+ yrs	11%

Projected: 17,000

Gender Identity	Estimated
Female	48%
Male	51%
Transgender	1%
Genderqueer	>1%
Questioning/Unsure	>1%
Another	>1%

Race/Ethnicity	Estimated
African American/Black	6%
American Indian/Alaskan Native	1%
Asian/Pacific Islander	10%
Caucasian/White	35%
Latino/Hispanic	37%
Middle Eastern/North African	1%
Another	10%

Estimated demographic breakdown for the FY 2023-24 through FY 2025-26 Three-Year Plan based on individuals entered into Electronic Health Record in fiscal year 2021-2022. Those served only in Supportive Services not included.

PEI/MHSA

Individuals Served in PEI Programs by Demographic Characteristic

Age	Estimated
0-15 yrs	12%
16-25 yrs	8%
26-59 yrs	59%
60+ yrs	21%

Projected: 191,500

Gender Identity	Estimated
Female	51%
Male	43%
Transgender	1%
Genderqueer	0%
Questioning/Unsure	0%
Not Listed Above	0%
Decline to State	5%

Race/Ethnicity	Estimated
African American/Black	4%
American Indian/Alaskan Native	1%
Asian/Pacific Islander	19%
Caucasian/White	32%
Latino/Hispanic	29%
Middle Eastern/North African	>1%
Not Listed Above	14%

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.

Community Program Planning

WIC § 5848 states that counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on:

- *Mental health policy*
- *Program planning*
- *Implementation*
- *Monitoring*
- *Quality improvement*
- *Evaluation*
- *Budget allocations*

9 CCR § 3300(c) states that involvement of clients and their family members be in all aspects of the community planning process and that training shall be offered, as needed, to stakeholders, clients, and client's family who are participating in the process

The Orange County Health Care Agency, Mental Health and Recovery Services (MHRS) is dedicated to including diverse consumers, family members, stakeholders, and community members from throughout the county in the planning and implementation of Mental Health Services Act (MHSA) programs and services. MHRS's Community Program Planning (CPP) process is being updated. This enhancement encompasses a vision that encourages community participation with the goal of empowering the community for the purpose of generating ideas, providing input that contributes to decision making, and creating a county/community partnership dedicated to improving public behavioral health outcomes for Orange County residents. These efforts include engaging stakeholders in discussion topics related to public behavioral health policy, pending legislation, program planning, implementation, evaluation, and financial resources affiliated with public behavioral health programs, as well as obtaining feedback that is factored into decision-making.

MHRS is committed to continue to incorporate best practices in planning processes that allow our stakeholders to participate in meaningful discussion around critical behavioral health issues, topics, and populations. Under this updated

paradigm, MHRS considers community planning a continuous practice, resulting in a CPP component that has been enhanced to become a year-round practice, ensuring, at minimum, monthly engagement with stakeholders around MHSA topics. Under this framework, the CPP process will undergo review and analysis that allows us to systematically improve community program planning strategies.

This practice allows MHRS to:

- Be responsive to changes and concerns in the public behavioral health environment.
- Establish and maintain a two-way communication pathway for community identified areas of improvement, which are introduced into MHRS's larger process improvement efforts and report results back to the larger community.
- Educate consumers and stakeholders about the MHSA, behavioral health resources and topics, to include the entire public behavioral health system.

Meeting locations are coordinated in each region of Orange County and virtual meetings are hosted, at minimum monthly, to discuss prioritized programming and topics identified in previous CPP discussions. Meetings are advertised through established distribution lists, posted on social media, posted on the HCA website, and include the following meetings:

- Behavioral Health Advisory Board (BHAB) monthly meetings
- Monthly Community Engagement Meetings (CEM)
- Behavioral Health Equity Committee, along with 5 separate subcommittees.
  Subcommittees include:
  - Spirituality
  - Deaf and Hard of Hearing
  - Threshold Language Groups
  - Black/African-American
  - LGBTQ+
- MHRS Contract Provider monthly updates

Scheduled meetings may be cancelled or additional special meetings may be hosted.

Stakeholder attendance is recorded through meeting sign-in sheets or virtual attendance records and, for some meetings, stakeholder surveys. These optional surveys also document the attendance of underserved, unserved, and inappropriately served populations as outlined in Welfare and Institutions Code (WIC) 5848.

In addition to regularly scheduled meetings, MHRS participates as an active partner in several ad hoc planning committees and meetings with stakeholder partners to engage in focused conversation, system planning and improvement processes.

Culturally and Linguistically Congruent Approaches

MHRS has a commitment to cultural competency and ensuring that this value is incorporated into all aspects of MHRS policy, programming, and services, including planning, implementing, and evaluating programs and services. To ensure culturally sensitive approaches in each of these areas, MHRS is proposing a re-organization and will establish the Office of Equity (OE), which reports to the Chief of MHRS. The Office of Equity works with the Behavioral Health Equity Committee (BHEC), which currently consists of diverse, equitable representation from county and community and entails various population specific subcommittees. Currently, the subcommittees include Spirituality, Deaf and Hard of Hearing, Threshold Language Groups, Black/African-American Group, and LGBTQ+, with the intent of increasing and expanding these subcommittees to include Veterans, Homelessness, and additional populations over time. The Office of Equity is to be led by an Ethnic Services Manager (ESM), who reports directly to the Chief of MHRS. The ESM oversees the BHEC Steering Committee and works closely in conjunction with the MHSA program leads to ensure compliance with Culturally and Linguistically Appropriate Services (CLAS) standards to ensure that the services provided address cultural and linguistic needs. The ESM or OEI staff will regularly sit on boards or committees to provide input or effect change regarding program planning and implementation.

OE will also provide support by translating documents for the department, as well as coordinating interpretation services for stakeholder outreach, meetings, and training events. Language regarding cultural competence is included in all agency

contracts with community-based organizations and individual providers to ensure contract services are provided through a framework of cultural humility. Behavioral Health Trainings are also reviewed to ensure they address cultural congruence and responsiveness.

MHRS is highly committed to including consumers, family members, and other stakeholders within all levels of our organizational structure. It continues to be our mission to include consumers and family members into an active system of stakeholders. MHRS intends to establish the Office of Consumer and Family Affairs that reports to the ESM. Outreach to consumers and family members will performed through the Office of Consumer and Family Affairs, MHSA Program Support and Administration, Prevention and Intervention office, Innovations team, community partners and contracted provider agencies, to encourage regular participation in MHSA activities. Consumer engagement occurs through regularly scheduled Community Program Planning process meetings, community events, department activities, and committee meetings. Consumer input is always considered when making MHSA related system decisions in MHRS.

The MHSA Manager and Component Leads, in conjunction with the Office of Equity, and the HCA Communications Team, have shared responsibility for coordination and management of the Community Program Planning (CPP) process. This process is built upon existing stakeholder engagement practices and collaborative networks within the behavioral health system and continues to evolve through a quality improvement framework.

Community Planning Process Updates

In prior years, Orange County had utilized a 51-member Steering Committee as part of a formal group to support the community planning process. In June 2021, the Steering Committee was dissolved, and a new process was to be established. During this time of re-organization, the MHSA Program Planning and Administration office continued to engage with the community for the development of the last Annual Update through informational meetings to maintain communication and sharing information while the new structure was in development. The meetings focus on Mental Health and Recovery Services information, community Behavioral Health issues and needs, and presentations by MHSA funded programs.

Community Program Planning

During the 2022/23 fiscal year, an updated Community Program Planning (CPP) process began to emerge. MHRS continued to host monthly virtual Community Engagement Meetings (CEM) and began to build on this infrastructure through hosting population specific meetings, focus groups, and community meetings. As a kick-off to this reimagining, on November 10, 2022, MHRS hosted an MHSA Summit. Approximately 170 people attended this full day event which was held at the Behavioral Health Training Center in the City of Orange. The overarching goal of the Summit was to strategically advance MHSA communication and future planning with system partners, County residents, and key

Screenshots of MHSA Summit flyers in Spanish, Vietnamese, and English

stakeholders. Translation and transportation services were offered to support participation from diverse community stakeholders, consumers, and family members.

The day began with a land acknowledgment from the Native community and each transition incorporated a brief cultural activity or personal recovery testimony. Breakfast and lunch were provided to attendees and each participant received incentive items to thank them for their attendance. Consistent with CPP standards, self-identified consumer and family members were provided a gift card in appreciation for their participation.

The morning session of the Summit focused on providing an overview and educational session for stakeholder and staff attendees about Mental Health Services Act policies, requirements, finance, and opportunities for partnership. Following a break, attendees enjoyed a panel discussion comprised of both stakeholders and staff as they discussed and described the transformational power of MHSA programs and practices.

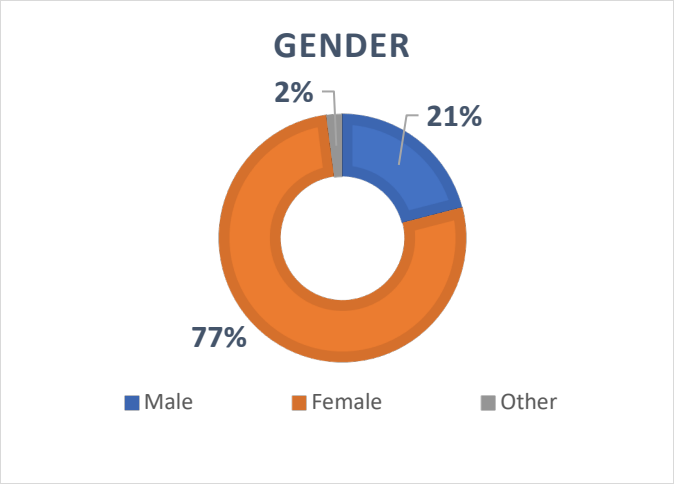
Panelist described first-hand accounts of how the system transformed to meet community needs, provided testimony of their journey into recovery via MHSA programs, and the ability to provide needed behavioral health supports and services beyond the standard insurance benefits allowable through Medi-Cal.

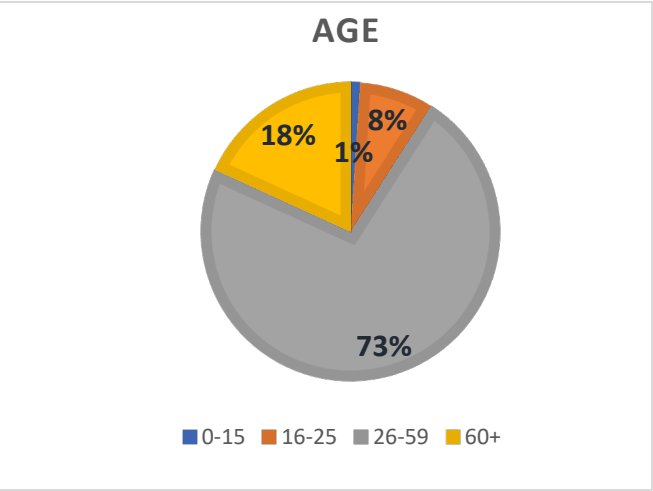
The afternoon session was a focused discussion and prioritization exercise for the development of proposed Innovation project concepts. Attendees participated in a World Café style planning session where four different Innovation Project Concepts were discussed.

Attendees broke out into four different groups, having the opportunity to listen to an overview of proposed concepts and weigh in with insights and recommendations. After participating in each group, attendees then prioritized which concepts should be considered for future development.

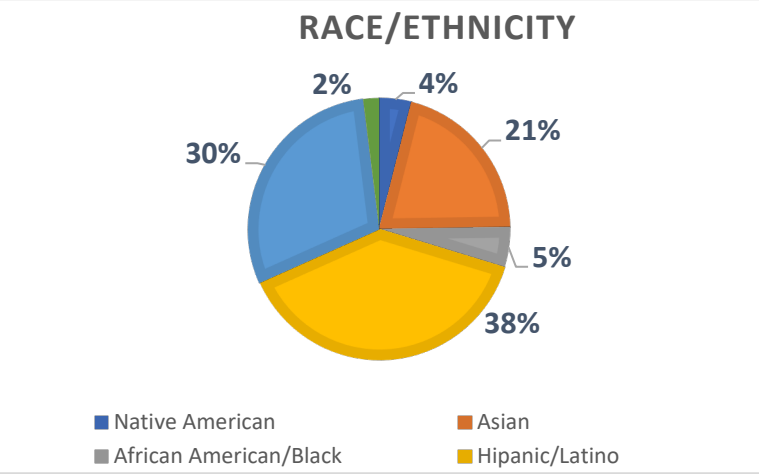
All attendees were encouraged to complete online stakeholder surveys. For individuals without internet access or electing not to use their electronic devices, iPads were provided by MHRS so they could access the survey. In addition, hard copies were made available upon request.

The demographic breakdown of participants who attended the Summit and completed a stakeholder survey is illustrated below. It is important to note that not every respondent answered every question. In addition, for the Groups Represented question, individuals could select more than one category. The majority of MHSA Summit attendees identified as adults between the ages of 26-59 and 77% of attendees identified as female.

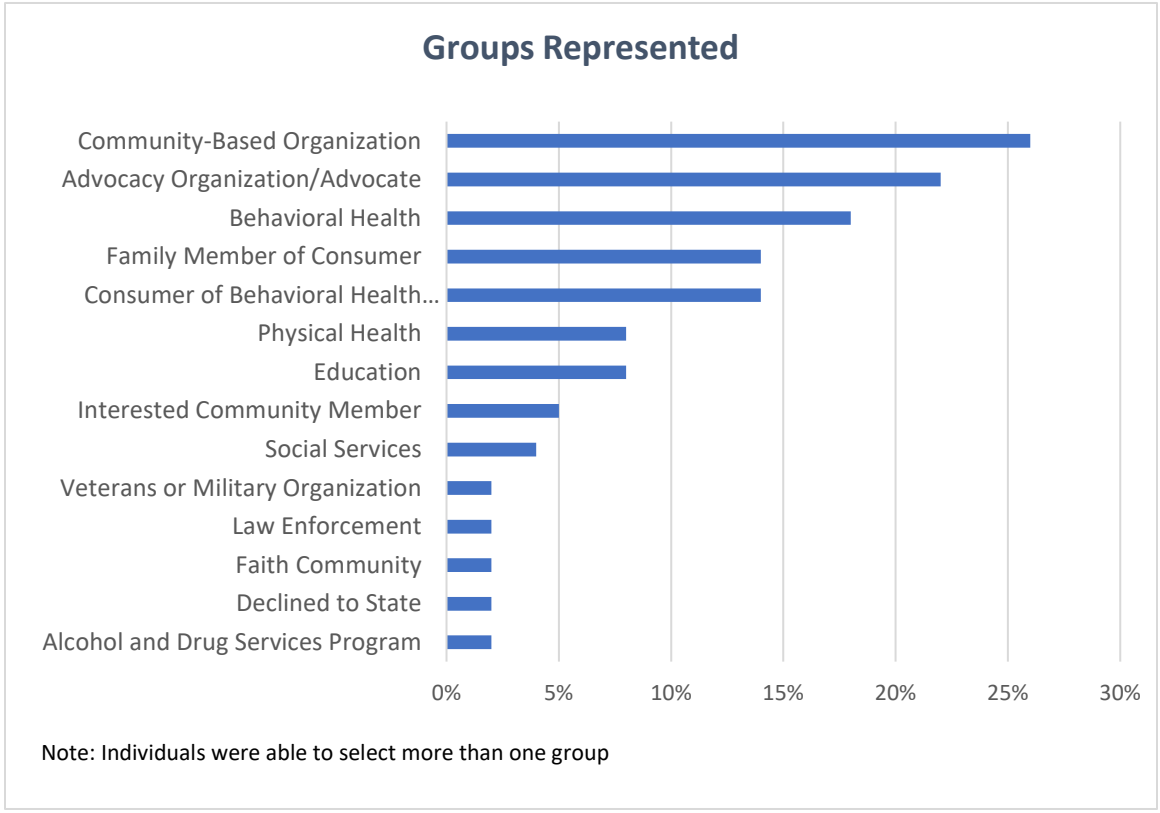




The majority of MHSA Summit attendees identified as Hispanic/Latino (38%) with the second largest group identifying as Caucasian/White (30%).



The graph below illustrates the survey respondent groups represented at the MHSA Summit.



After the MHSA Summit, in addition to the regularly scheduled Community Engagement Meetings, a series of ten (10) stakeholder focus groups were conducted with consumers of MHSA funded programs and services throughout December

and January. In addition, population specific planning meetings for older adults, veterans, very young children, and school-aged children and youth were hosted by system partners or hosted by MHRS for community input.

Sharing Information with Our Stakeholders

Materials and Reports

In effort to communicate information to our stakeholders, materials have been created to better disseminate the information that is being presented on or discussed. For example, in response to stakeholder feedback and to highlight the stakeholder comments MHRS receives during functions such as trainings and stakeholder meetings, simplified reports that summarize stakeholder feedback are created and shared at subsequent meetings. These snapshot reports can include stakeholder demographics, a summary of the feedback in the form of text, charts, and infographics that are incorporated into presentations to communicate this information. This process has been incorporated into monthly Community Engagement Meetings (CEMs). At the beginning of each meeting, an overview of the analysis from the previous meeting is presented that allows for additional conversation or feedback. This change has allowed MHRS to better communicate information and its services to the community and has allowed stakeholders to see how their involvement and suggestions shape and influence program planning and the services the agency provides.

In addition, MHRS has improved the collection and tracking of stakeholder demographics related to Community Program Planning. A set of questions has been developed and are requested of each participant at each stakeholder meeting. The demographics are collected via live polls launched during virtual meetings, a link to an online survey that can be accessed directly from the link or through a Quick Response (QR) code, and/or paper copies of the survey. All data is combined into a centralized data set. Monthly reports summarizing demographics related to stakeholder engagement are then provided to the OC Behavioral Health Advisory Board as part of their monthly report from the MHRS Chief.

Approaches to Extended Education and Information Sharing

To better advertise, communicate, and educate our diverse stakeholders and staff to the agencies' activities, events, goals, resources, and programs, the HCA incorporates multiple approaches to information sharing which will include, but

are not limited to, enhanced use of social media platforms, distribution of newsletters and information to the community and partners, and hosting information sessions.

The “Your Health Matters OC” livestreamed talk show on health hosted by HCA Director, Dr. Clayton Chau, and County Health Officer, Dr. Regina Chinsio-Kwong, is a prime example of these efforts. The live, bi-weekly talk show on YouTube and Facebook features healthcare professionals within the HCA and expert guests from within the OC community. Each Episode features a variety of relevant health topics that impact health and the Orange County community. Members of the public and media are encouraged to view the webcast live or at their convenience by clicking on the link https://youtu.be/_Jm9WW599D4.

Informational bulletins are distributed to staff and community partners as a way to provide agency updates. The “What’s Up” informational bulletin is distributed monthly to Health Care agency staff. The bulletin contains tributes to employees, tips for the workplace, program news, and other helpful directives and information. The bulletin is distributed through email and posted online at What’s Up Newsletter | Orange County California - Health Care Agency (ochealthinfo.com).

“The HUB” monthly newsletter is developed by the Community Networking Project team as part of MHRS’s collaboration with the education system. The HUB is specially designed to serve our community and connect to the rich array of K-12 school-based mental health events, activities, services, resources, webinars, trainings, policy, and funding opportunities, and more. This monthly newsletter provides information directly to education and community partners.

Three monthly meetings, the HCA Townhall, the MHRS Townhall, and the MHRS Contract Provide Monthly updates are part of an internal strategy that serves to inform HCA staff and stakeholders of changes, updates, and happenings across the agency, including MHSA processes.

- The HCA Townhall meetings provide an opportunity for the HCA Director to discuss agencywide happenings, communicate with and educate staff about changes, and acknowledge the achievements of staff and the agency.
- The MHRS Townhall provides focused updates specific to MHRS, addressing updates and changes happening within the agency, across the state and/or county, and with the broader behavioral health initiative context.

- The MHRS Contract Provider Monthly updates meeting provides the medium for regular information sharing, dialogue, and discussion of changes in policies, legislation, and procedures within and across the extended mental health plan.

In addition to community education, MHRS makes certain staff are aware of MHSA requirements and programming. As an example, at a Behavioral Health Operations Meeting, the MHSA Manager provided a comprehensive training concerning the Mental Health Services Act regulations and Community Program Planning requirements.

Community Program Planning Process for the MHSA Three Year Program and Expenditure Plan for FY's 2023-24 through 2025-26 (Three-Year Plan)

MHRS is fully committed to a year-round stakeholder engagement process. Preparation and development of this MHSA Three-Year Plan included meetings hosted in multiple venues in each region of the County, interactive countywide webinars, sessions hosted in collaboration with Wellness Centers, and a collaborative event hosted with *Community Voices*, a citizen group invested in supporting MHSA CPP activities. Scheduled meetings will be held throughout Orange County during the Three-Year Plan posting period. Different from previous years, MHRS posted the Three-Year Plan for 30 day public comment and posting while concurrently hosting the additional CPP meetings. This will allow stakeholders the opportunity to access the "live" Plan and comment forms in real time versus waiting until the meetings to review the plan had ended. *The information contained below, provides a detailed overview of the intended CPP process for the Three-Year Plan. This section will be updated and finalized as part of the final Plan.*

To meet the requirements of the MHSA, extensive outreach will be conducted to promote the MHSA Three Year Plan Community Program Planning (CPP) process. A variety of methods were used at multiple levels to give stakeholders, including consumers, family members, community members, and partner agencies the opportunity to have their feedback included and their voice heard. This included press releases to local media outlets, including culturally specific media and posting on the HCA website, distribution of emails and flyers to community partners, community and contracted organizations, other county agencies, cultural committees, and regularly scheduled stakeholder meetings, such as the Orange County Behavioral Health Advisory Board. These materials were distributed to representatives of our diverse

populations. Social media sites, such as Instagram, were also used to extend the reach of the agency in connecting interested community members with the stakeholder process. Finally, a zoom recording of the Three-Year Plan overview was posted for easy access for individuals who were unable to join a live session. You can access this recording at Orange County MHSA Three Year Program and Expenditure Plan Overview for FY 2023-24 through 2025-26. - YouTube.

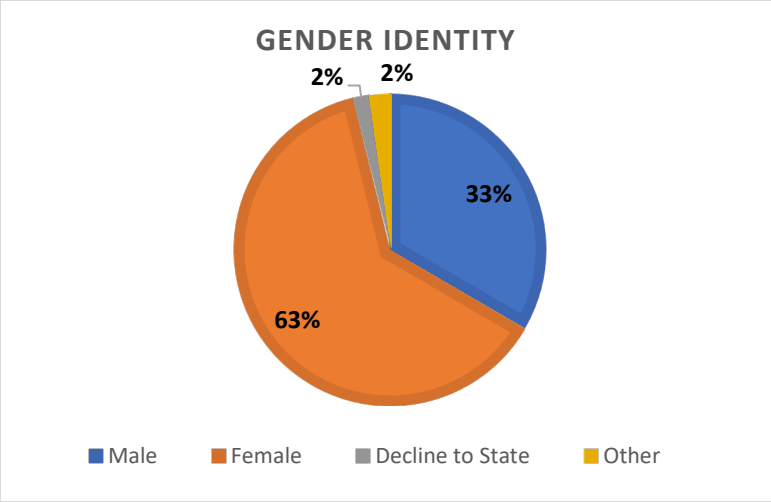
The MHSA Manager and Component Leads, in conjunction with the Office of Equity (OE), and HCA Communications have responsibility for coordination and management of the Community Program Planning (CPP) process. This process was built upon existing stakeholder engagement components, mechanisms, and collaborative networks within the behavioral health system. In many cases, meetings were held in the community at sites where consumers were already comfortable attending services, events, and meetings.

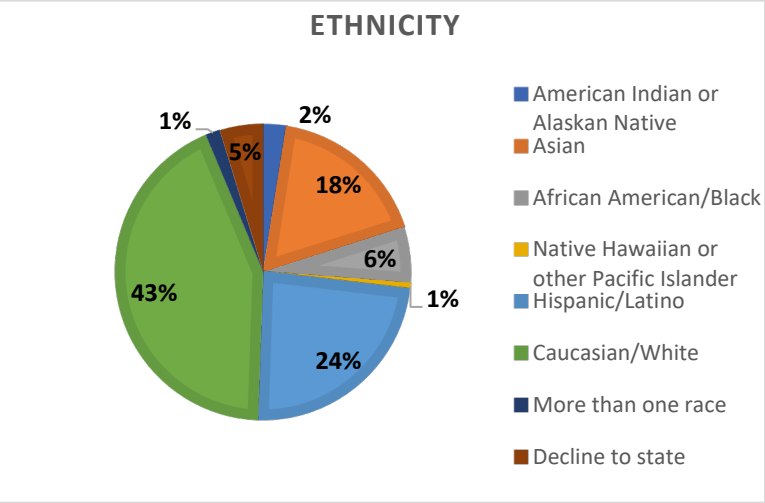
Congruent with WIC § 5848(a), participation by key groups of stakeholders included, but were not limited to:

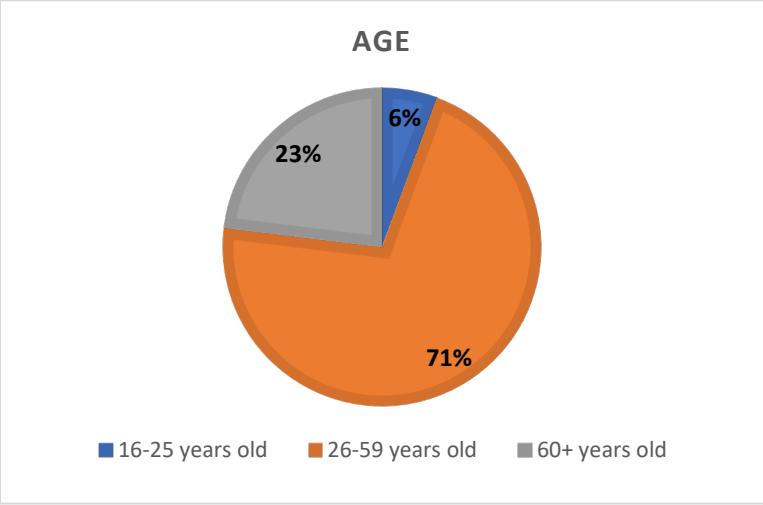
- Individuals with serious behavioral health illness and/or serious emotional disturbance and/or their families.
- Providers of behavioral health and/or related services such as physical health care and/or social services.
- Representatives from the education system.
- Representatives from local hospitals, hospital associations, and healthcare groups.
- Representatives of law enforcement and the justice system.
- Veteran/military population of services organizations.
- Other organizations that represent the interests of individuals with serious a behavioral health illness and/or serious emotional disturbance and/or their families.

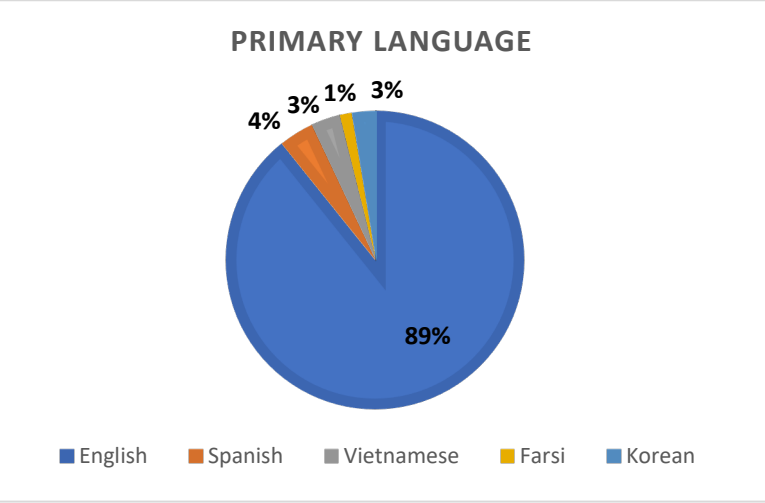
From October 2022 through January 2023, MHRS collected demographic information of CPP participants via in-person and online surveys and polls. The following is an overview of CPP participants who completed a survey during that timeframe. This demographic information will be updated to include data from the meetings during the 30 day public comment and posting period and will be included in the final version of the Three Year Plan.

CPP Demographics October 2022 through January 2023

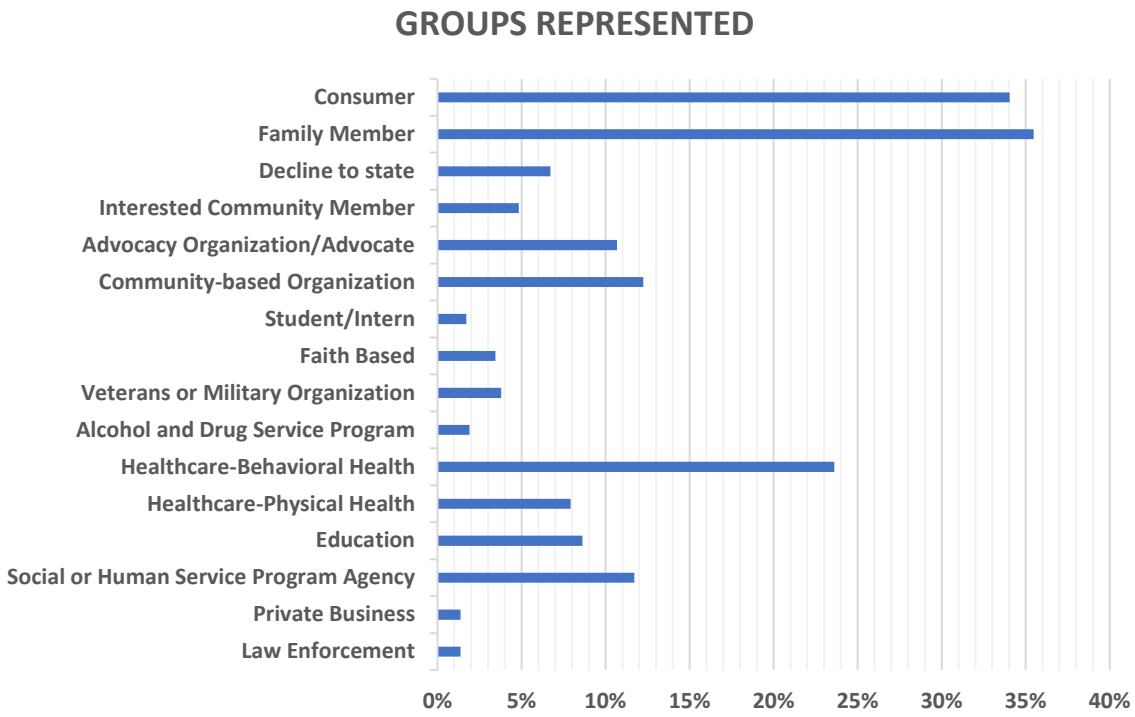


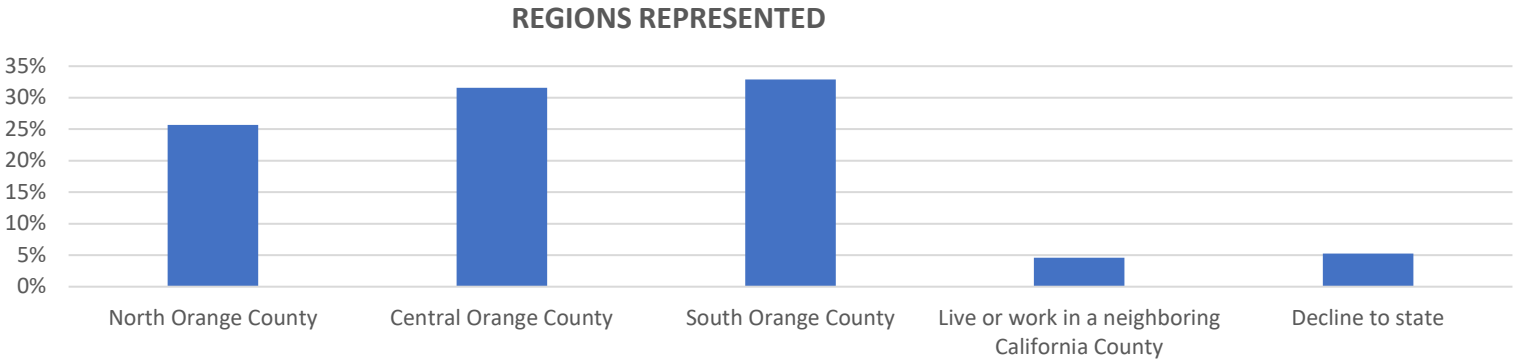






CPP Demographics (Continued)





Community Program Planning

As listed in the schedule included in this report, a CPP session was held by the OC Behavioral Health Advisory Board on March 8, 2023, additional meetings will be hosted to reach each geographic region of the county, and special sessions were offered to members of the Equity in OC committee on February 22, 2023.

To ensure participation of unserved, underserved, or inappropriately served cultural groups, the Office of Equity will offer stakeholder engagement meetings for the MHSA Three Year Plan for each of their BHEC subcommittees. To further include community involvement, sessions will be held in collaboration with Wellness Centers, Community Centers, and virtually across the County. MHRS staff will host a discussion with diverse attendees about the background and intent of the MHSA, the MHSA Three Year Plan, and proposed updates, as well as obtain feedback and recommendations for system improvement.

To ensure that stakeholders can fully benefit from the community meetings, MHRS staff arrange for Spanish, American Sign Language, and Vietnamese interpretation, and other languages, upon request, at each meeting. At the end of each presentation, the facilitator will open the presentation to encourage discussion, allow stakeholders to have questions answered, and provide input. Once the question and answer session concludes, participants will be advised about additional opportunities to provide feedback. The link to the survey is provided in the presentation and participants were also provided information for alternative methods to provide input and feedback including the email address, phone number for the MHSA Coordinator, and a link to the community surveys.

To further support this Community Planning Process (CPP) effort, a special session of the regular MHSA Community Engagement Meeting is scheduled to be hosted by MHSA Program Planning and Administration on March 20, 2023. The session will follow the format that had been established as a standard practice for all CEM meetings. Attendees participate in a group virtual session and will be moved into small break out groups, to allow for comfortable discussion opportunities. A special session of the Behavioral Health Equity Committee (BHEC) will be hosted by Ethnic Services Manager in collaboration with the MHSA Manager to ensure additional opportunities for stakeholders to interact with decision making staff. Attendees at all stakeholder engagement meetings will be afforded the opportunity to provide feedback and input into the MHSA Three Year Plan via verbal comment and discussion, live polls, and a post meeting

survey in which stakeholders may provide written comments. Surveys will be available in threshold languages, in hard copy, as well as provided a QR code or a link that directly connected to the electronic survey. Participants were also provided a handout that provided instruction for multiple ways to submit comments.

During the Community Program Planning (CPP) process meetings for the MHSA Three Year Plan, highlights included:

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Community Program Planning

The following pages provide the flyers distributed to the community to promote the MHSA Three Year Plan planning process:

OC health CARE AGENCY

Please join the Health Care Agency for a Mental Health Services Act (MHSA) Stakeholder Engagement opportunity!

Virtual Community Meetings

These stakeholder engagement meetings will provide an overview of the Mental Health Services Act (MHSA) Three Year Program and Expenditure Plan. Special focus will be placed on sharing how MHSA services are continuing to expand mental health safety net services, a discussion regarding future programs, and an opportunity to provide feedback to the MHSA Three Year Plan and future community program planning efforts.

MHSA Three Year Plan Overview and Stakeholder Feedback Session Monday March 13, 2023 / 3:30 pm – 5:00 pm Virtual Meeting https://us06web.zoom.us/j/89663315493 No Pass Code / Meeting ID: 896 6331 5493	**MHSA Three Year Plan Overview and Stakeholder Feedback Session** Wednesday March 15, 2023 / 9:00 am – 10:30 am Virtual Meeting https://us06web.zoom.us/j/85726697126 No Pass Code / Meeting ID: 857 2669 7126	**MHSA Three Year Plan Overview and Stakeholder Feedback Session** Monday March 20, 2023 / 8:30 am – 10:00 am Virtual Meeting https://us06web.zoom.us/j/87149791862 No Pass Code / Meeting ID: 871 4979 1862
MHSA Three Year Plan Overview and Stakeholder Feedback Session Thursday March 23, 2023 / 5:00 pm – 6:30 pm Virtual Meeting https://us06web.zoom.us/j/89448664383 No Pass Code / Meeting ID: 894 4866 4383	**MHSA Three Year Plan Overview and Stakeholder Feedback Session** Monday March 27, 2023 / 3:00 pm – 04:30 pm Virtual Meeting https://us06web.zoom.us/j/88065791852 No Pass Code / Meeting ID: 880 6579 1852	**MHSA Three Year Plan Overview and Stakeholder Feedback Session** Thursday March 30, 2023 / 9:00 am – 10:30 am Virtual Meeting https://us06web.zoom.us/j/85094302857 No Pass Code / Meeting ID: 850 9430 2857
MHSA Three Year Plan Overview and Stakeholder Feedback Session Monday April 3, 2023 / 2:30 pm – 4:00 pm Virtual Meeting https://us06web.zoom.us/j/85697461531 No Pass Code / Meeting ID: 856 9746 1531	**MHSA Three Year Plan Overview and Stakeholder Feedback Session** Thursday April 6, 2023 / 9:00 am – 10:30 am Virtual Meeting https://us06web.zoom.us/j/89965726342 No Pass Code / Meeting ID: 899 6572 6342	**MHSA Three Year Plan Overview and Stakeholder Feedback Session** Monday April 10, 2023 / 11:00 am – 12:30 pm Virtual Meeting https://us06web.zoom.us/j/82608119947 No Pass Code / Meeting ID: 826 0811 9947

For questions, concerns, interpretation services or requests for disability-related reasonable accommodations/alternative format, please contact BHTS@ochca.com. Please request accommodations at least 5 business days prior to the event. The Mental Health Services Act (MHSA, Prop 63) was passed by California voters in November 2004 to expand public mental health services for children and adults.

Community Program Planning

Please join the Health Care Agency for a Mental Health Services Act (MHSA) Stakeholder Engagement opportunity!

Community Meetings

These in-person community stakeholder engagement meetings will provide an overview of the Mental Health Services Act (MHSA) Three Year Program and Expenditure Plan. Special focus will be placed on sharing how MHSA services are continuing to expand mental health safety net services, a discussion regarding future programs, and an opportunity to provide feedback to the MHSA Plan and future community program planning efforts.

Behavioral Health Equity Committee **Spirituality Workgroup** Wednesday March 15, 2023 / 3:00 pm – 4:30 pm In-Person Meeting 750 The City Drive South, Suite 130 Orange, CA 92868	**MHSA Community Engagement Meeting** Monday March 20, 2023 / 1:00 pm – 3:00 pm Virtual Meeting https://zoom.us/j/95720185359 Meeting ID: 957 2018 5359 Passcode: 402453	**Behavioral Health Equity Committee** **Outreach to Black/African-American Community Workgroup** Tuesday March 21, 2023 / 2:00 pm – 3:00 pm Join Zoom Meeting Here
Behavioral Health Equity Committee **Deaf and Hard of Hearing Workgroup** Wednesday March 22, 2023 / 1:00 pm – 2:00 pm Join Zoom Meeting Here Meeting ID: 826 9009 2073 Passcode: 587860	**Behavioral Health Equity Committee** **LGBTQ+ Workgroup** Thursday March 23, 2023 / 11:00 am – 12:00 pm Join Teams Meeting Here	**Delhi Center** Wednesday March 29, 2023 / 3:00 pm – 5:00 pm In-Person Meeting 505 E. Central Ave. Santa Ana, CA 92707
Wellness Center West Tuesday April 4, 2023 / 10:00 am – 11:30 am In-Person Meeting 11277 Garden Grove Blvd. # 101A Garden Grove, CA 92843	**Wellness Center South** Wednesday April 5, 2023 / 10:30 am – 12:00 pm In-Person Meeting 23072 Lake Center Drive, # 115 Lake Forest, CA 92630	**Wellness Center Central** Wednesday April 5, 2023 / 11:00 am – 12:30 pm In-Person Meeting 401 South Tustin Street, Bldg. C Orange, CA 92866
Behavioral Health Equity Committee **Public Meeting** Thursday April 6, 2023 / 12:00 pm – 3:00 pm In-Person Meeting 750 The City Drive South, Suite 130 Orange, CA 92868	**Collaboration with Community Voices** Wednesday April 12, 2023 / 2:00 pm – 4:00 pm In-Person Meeting 601 North Ross Street, First Floor, Room 103 & 105 Santa Ana, California	**Behavioral Health Advisory Board Public Hearing** **Delhi Center** Wednesday April 26, 2023 / 10:00 am – 12:00pm In-Person Meeting 505 E. Central Ave. Santa Ana, CA 92707

Video Overview of MHSA Three Year Program and Expenditure Plan: https://www.youtube.com/watch?v=Km-HOVm8w-Y

For questions, concerns, interpretation services or requests for disability-related reasonable accommodations/alternative format, please contact BHTS@ochca.com. Please request accommodations at least 5 business days prior to the event. The Mental Health Services Act (MHSA, Prop 63) was passed by California voters in November 2004 to expand public mental health services for children and adults.

Community Program Planning

Below is the press release notifying the public of the Community Program Planning (CPP) process for the MHSA Three Year Integrated Plan for Fiscal Years 2020/21 through 2022/23:

COUNTY OF ORANGE – HEALTH CARE AGENCY

OC health CARE AGENCY

PRESS RELEASE

For Immediate Release: March 12, 2023

Contact: HCA Communications
HCAComm@ochca.com
(714) 834-2178

Mental Health Services Act Three-Year Plan
Available for Public Review

(Santa Ana, CA) – The OC Health Care Agency's (HCA) Mental Health and Recovery Services (MHRS) has released its Mental Health Services Act (MHSA) Three-Year Program and Expenditure plan. The plan is posted and ready for public review here www.ochealthinfo.com. It will remain posted for a 30-day review period beginning March 11 through April 14, 2023.

Orange County's MHSA Three-Year Plan for Fiscal Years 2023-24 through 2025-26 (Three-Year Plan) is a layout of current and future programs and funding allocation. Mental health programs provided under MHSA are consistent with local county-approved plans developed via broad-based community involvement, including input from both mental health service consumers and their family members.

Launched in 2004, with the passing of Proposition 63, the MHSA funding is provided by a 1% tax on personal income of more than $1 million. The MHSA creates an opportunity for the State of California to provide increased funding to support county mental health programs that specifically promote recovery, wellness, and resiliency for residents with serious mental health challenges and their families.

"The vision of MHRS is to provide quality behavioral health services to our community," said **Dr. Veronica Kelley**, Chief of MHRS. "This MHSA Three-Year Plan embodies that vision and reflects an integrated pathway to quality behavioral health services in Orange County."

HCA's Mental Health and Recovery Services team 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, and consumer- and family-driven services. Prioritization of serving the unserved and underserved is a focus, in addition to wellness, recovery, and resilience.

The 30-day review period will conclude with a Public Hearing scheduled for April 28, 2023. Specifics for this meeting can be found below.

To review the Draft MHSA Annual Update and Three-Year Expenditure Plan, please visit:
www.ochealthinfo.com

Public Review and Comment Period: March 11 – April 14, 2023

MHSA Annual Update Public Hearing: April 28, 2023: 1:00 PM – 3:00 PM at Delhi Center 505 E. Central Ave., Santa Ana, CA 92707.
Details to be posted here www.ochealthinfo.com.

Community Program Planning

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Summary of Program Changes

MHRS has made a practice of planning for growth in the development and implementation of MHSA and system of care services. This MHSA Three Year Plan reflects stakeholder informed changes, expansion of existing programs, and includes combined programs and new programs under the Prevention and Early Intervention, Community Services and Supports, and Workforce Education and Training components. Many stakeholder supported expansion efforts have occurred over the several last fiscal years. The program changes and updates proposed in the Three-Year Plan are outlined in the tables below. Full budget details can be found in the Fiscal section of this plan.

Prevention and Early Intervention		
Programs	**Program Changes, Updates, Proposed New Programs**	**Funding Changes**
Infant and Early Childhood Continuum of Care (NEW)	Proposing to establish a continuum of care for very young children (aged 0-8). Continuing coordinated planning with systems and community partners to identify needs, gaps, and opportunities to meet additional needs across early childhood serving systems. As this program is further developed, clear program goals, key outcomes, and service descriptions will be developed and included as an amendment to the Three-Year Plan or included in the Annual Update.	Placeholder: FY 23/24: $1,000,000 FY 24/25: $2,000,000 FY 24/25: $2,000,000
Prevention Services and Supports for Families	Consolidation and Name Change: Combined School Readiness Services, Parent Education Services, and Family Support Services in to one program.	Funding Increase
Prevention Services and Supports for Youth	Consolidation and Name Change: Combined School Based Behavioral Intervention and Supports, Gang and Violence Prevention Education in to one program. Includes expansion to sustain school-based services coordination once MHSSA grant end.	Funding Increase
Thrive Together	Clinical High-Risk program being transitioned from Innovation and sustained in PEI. Working with OC CREW, offers a continuum of specialized services for psychosis.	Transition from INN
OC4VETS	Transition of Military Families to program, while continuing to explore for possible enhancements for individuals in need of higher levels of care.	Funding Increase

Community Program Planning

Prevention and Early Intervention		
Programs	**Program Changes, Updates, Proposed New Programs**	**Funding Changes**
Outreach for Increasing Recognition of Mental Illness	Expansion of mental health outreach and education for: very young children and their families, diverse communities, TAY and young adults	Adjusted Funding over 3 Year Period
Mental Health Community Education for Reducing Stigma	Adjusting program with updated contracted provider	Reduced Funding
Statewide PEI Projects: Assignment to JPA	Reduced amount assigned to CalMHSA, a Joint Powers Authority working on behalf of County Mental Health Plans, based on current utilization	Reduced Assignment

Community Services and Supports: Full Service Partnerships		
Programs	**Program Changes, Updates, Proposed New Programs**	**Funding Changes**
Community Assistance, Recovery, and Empowerment (CARE) Court (New)	Orange County is part of first cohort required to implement the Community Assistance, Recovery, and Empowerment (CARE) act (SB1338). Establishing a Full Service Partnership for individuals deemed eligible (at-risk of civic commitment/committed and living with a qualifying diagnosis).	23/24: $2,000,000 24/25: $3,3500,000 25/26: $3,200,000
Children's Full Service Partnerships	Increase to keep up with service demand, expansion of teams to additional regions of County. Establish a Family Full Service Partnership, providing services beyond the familial supports typically provided in a Children's FSP.	Funding Increase
Adult Full Service Partnerships	Increase to keep up with business costs, establishment of Vietnamese, Spanish and Veterans serving FSPs, FSP supports for homelessness.	Funding Increase
Older Adult Full Service Partnerships	Increase to keep up with business costs, establishment of Vietnamese, Spanish and Veterans serving FSPs, FSP supports for homelessness.	Funding Increase

Community Program Planning

Community Services and Supports: Outreach & Engagement and General System Development		
Programs	**Program Changes, Updates, Proposed New Programs**	**Funding Changes**
Crisis Residential Treatment	Addition of Children and Youth Psychiatric Residential Treatment facility; contract increases for existing contracts to adjust for inflation	Funding Increase
Children and Youth Regional Outpatient	Expand program (County and Contracted) across the county to meet increase in demand	Funding Increase
Wellness Centers	Increase to support additional staffing and transportation	Funding Increase
Mobile Crisis Assessment Team (CAT)	Allows for establishment of satellite location, vehicle maintenance, and a community education campaign around mental health crisis services	Funding Increase
Crisis Stabilization Units	Increase in contracts to account for increased lengths of stay, increased costs related to salaries and inflation.	Funding Increase
CSS Supportive Housing	Expand program to build 100 additional units, including the Capitalized Operating Subsidy Reserve (COSR) for each unit and increased costs associated with bridge housing.	Funding Increase

Innovation		
Programs	**Program Changes, Updates, Proposed New Programs**	**Funding Changes**
Early Psychosis Learning Health Care Network	**Thrive Together OC Set Aside:** This portion of the project came to planned end and transitioned to PEI for sustainability. Works with OC CREW to enhance the continuum of specialized services for individuals at high clinical risk of or first experiencing psychosis.	Moved to PEI
Continuum of Care	Came to planned end.	Military Families moved to PEI

Workforce Education and Training		
Programs	**Program Changes, Updates, Proposed New Programs**	**Funding Changes**
***Mental Health Career Pathway*: Leadership Development Program (NEW)**	Develop and implement a Leadership Development Program for MHRS and contracted provider agency staff. MHRS will develop leaders from existing staff, begin succession planning, make leadership-based assignments, and build leadership into supervisory training.	Transfer Increase
***Training and Technical Assistance*: Professional and Paraprofessional Development (NEW)**	Expand Peer Specialist Training to ensure access for individuals interested in becoming a Peer Specialist. Train staff, contracted provider agency staff, and others that interact with behavioral health clients to become Behavioral Health and Wellness Coaches (HWC). HWCs are not required to have advanced degrees, allowing the ability to up-train individuals already working in underserved settings.	Transfer Increase
***Residencies and Internships*: Internship Expansion**	Increase internships within MHRS and with contract agencies, allowing interns from those agencies to attend group supervision. Provide additional clinical supervisors to the internship program to further the goals of enhanced supervisor competencies; supplement supervision of interns created by staff shortages; provide licensing preparation support to pre-licensed; and create an employee internship program.	Transfer Increase

Capital Facilities and Technological Needs		
Programs	**Program Changes, Updates, Proposed New Programs**	**Funding Changes**
Capital Facilities	Funding to offset costs associated with capital projects that will house MHSA services or administration, potentially including Be Well, CCE Preservation projects, and/or additional projects currently being pursued by MHRS to expand public behavioral health safety net services.	Transfer to CFTN
Technological Needs	Continue improvements and enhancements for data systems, electronic health records, network infrastructure, as well as data integration systems. Upgrades will allow compliance with CalAIM implementation.	Transfer to CFTN

Community Program Planning

WIC § 5848 states that an Annual Update shall be prepared and circulated for review and comment for at least 30 days to representative of stakeholder interests and any interested party who has requested a copy.

Additionally, the mental health board shall conduct a public hearing on the draft Three Year Plan or Annual Update at the close of the 30 day comment period

Public Review

30 Day Posting and Public Comment and Public Hearing

The MHSA Three Year Integrated Plan will be posted on the HCA website for stakeholder review and comment from March 16, 2023 through April 18, 2023 at OC Health Care Agency | Orange County California - Health Care Agency (ochealthinfo.com).

The Public Hearing hosted by the Behavioral Health Advisory Board to affirm the stakeholder process is scheduled to occur on April 26, 2023, from 10:00 a.m. to 12:00 p.m. at the Delhi Center located at 505 E. Central Ave., Santa Ana, CA 92707.

Substantive Comments/Recommendations

An analysis of substantive recommendations will be included in the Public Posting and Comment section of the final MHSA Three Year Plan. Comments/recommendations can be submitted via email to the MHRS MHSA email box at **MHSA@ochca.com** during the time the MHSA Three Year Plan draft is posted for public comment.

Stakeholders are informed that comments can be received anytime through the year, but will not be included in the final MHSA Three Year Plan unless provided during the 30-day comment period.

If you would like to provide comments/recommendations after the close of the 30-day posting period, you may request a comment form be sent to you by contacting MHRS at MHSA@ochca.com or calling 1-714-834-3104 for more information.

Overview of Public Posting and Comment Period

Mental Health and Recovery Services (MHRS) would like to thank those who are interested in the public review and comment portion of the stakeholder comment process. The MHSA Three Year Plan for Fiscal Years 2023-24 through 2025-26 will occur from March 16, 2023 through April 18, 2023. MHRS will continue to promote the 30- day posting and provide overviews and information related to the MHSA Three Year Plan.

THIS SECTION INTENTIONALLY BLANK AND WILL BE UPDATED UPON CONCLUSION OF THE POSTING PERIOD AND INCLUDED IN THE FINAL VERSION OF THE PLAN.

New Programs or Initiatives

Following are descriptions of new programs or initiatives planned to be introduced and implemented during this reporting period.

Prevention and Early Intervention

The School Aged Children and Youth Initiative provides both prevention and early intervention services focused on diverse K-12 students and their families and will be included in the **Prevention Services and Supports for Youth Programs**. The program provides access to both prevention education and supports and early intervention for substance abuse, mental health, emotional, and social issues. The program connects students and their families to a network of supports between schools, community-based organizations, and MHRS through an established framework of Multi-Tiered System Supports.

As a result of the pandemic, lawmakers and state officials have noted the increased need for timely access to all levels of behavioral health services for children and youth. To address the challenge, many state-driven initiatives to enhance access to school-based behavioral healthcare are underway.

Mental Health Student Services Act

The Mental Health Student Services Act (MHSSA) provides competitive state grants for partnerships between county behavioral health agencies and local education agencies to deliver school-based mental health services to children, youth and their families. These partnerships support outreach to identify early signs of unmet mental health needs, reduce stigma and discrimination, and prevent unmet mental health needs from becoming severe and disabling.

MHSSA programs provide support services that include, at a minimum, services provided on school campuses, suicide prevention, drop-out prevention related to unmet mental health concerns, placement assistance, continuum-of-care for students in need of ongoing services, and outreach to high-risk youth. High-risk youth include foster youth, youth who identify as LGBTQ+, and youth who have been expelled or suspended from school.

In 2020, MHRS and Orange County Office of Education (OCDE) were successfully awarded and established an MHSSA grant funded partnership intended to meet the grant identified goals to:

- Prevent mental health challenges from becoming severe and disabling
- Improve timely access to services for underserved populations
- Provide outreach to families, employers, primary health care providers, and others to promote recognition of early signs of potentially severe and disabling mental health challenges
- Reduce stigma associated with the diagnosis of a mental disorder or seeking mental health services
- Reduce discrimination against people with mental health needs

Through the MHSSA grant, a network of Regional Mental Health Coordinators are established across the County to support collaboration and facilitate partnerships among and between districts, contracted service providers, and the Health Care Agency; Support in the improvement of district infrastructure and capacity to provide mental health services; and Provide direct services such as care coordination, crisis response, and other small group services (as requested by districts) as well as various trainings on mental health topics for parents and students. The MHSSA partnership grant is funded through September 2024. For more information about MHSSA services, please refer to OCDE - Mental Health Student Services Act Grant page.

Student Behavioral Health Incentive Program (SBHIP)

Under Assembly Bill 133 (AB 133): Section 5961.3, the Student Behavioral Health Incentive Program (SBHIP) was established. The purpose of the initiative is to “transform the state’s behavioral health system into an innovative ecosystem in which all children and youth 25 years of age and younger, regardless of payer, are screened, supported, and served for emerging and existing behavioral health needs.” Under SBHIP, the local managed care plan, CalOptima, has partnered with local education area partners and HCA-MHRS to conduct needs assessments, prioritize goals and

objectives, and identify a plan for building the capacity of the system in preparation for implementing SBHIP, effective January 1, 2024.

For more information about AB 133, please see Assembly Bill 133: Section 5961.3

Establishing a New Paradigm

Currently, MHSA funded programs support school-aged children and youth through a comprehensive continuum of programs providing prevention, early intervention, outpatient and intensive services. Implementation of SBHIP shifts responsibility for many of the services and programs provided under the prevention and early intervention component to be managed by CalOptima. Higher levels of care continue to be managed by MHRS, but the shift in the law requires a change at the local level, as well.

To ensure that access to school-based services and supports continues, MHRS is committed to maintaining current level of services and programming while the system responds to these legislative changes and partners continue to build the capacity of both the school system and the managed care plan (CalOptima) to meet the January 2024 mandate. While SBHIP provides a payment mechanism for the provision of medically necessary school-based behavioral health services, there is not a mechanism for paying for coordination of behavioral health services at the systems level. Under the MHSSA, a network of regional coordinators has been successfully working to facilitate collaborative meetings between districts and community partners, host regional and countywide meetings between districts, MHRS and community providers, and coordinating services for school districts with other k-12 service providers and MHRS. The MHSSA funding that supports this coordination is set to end in 2024. MHRS intends to continue to fund the coordination of services and support the development of the capacity of the education system to work in partnership with both the Managed Care Plan (CalOptima) and the Mental Health Plan (MHRS) beginning in year two of the three year plan.

The collaborative planning for the shift will continue, with proposed MHSA changes being reflected in future MHSA Plans and Updates. As such, the current funding directed toward services for school-aged children and youth may be re-directed to support coordination and partnership, in lieu of direct services as the managed care plan, CalOptima establishes

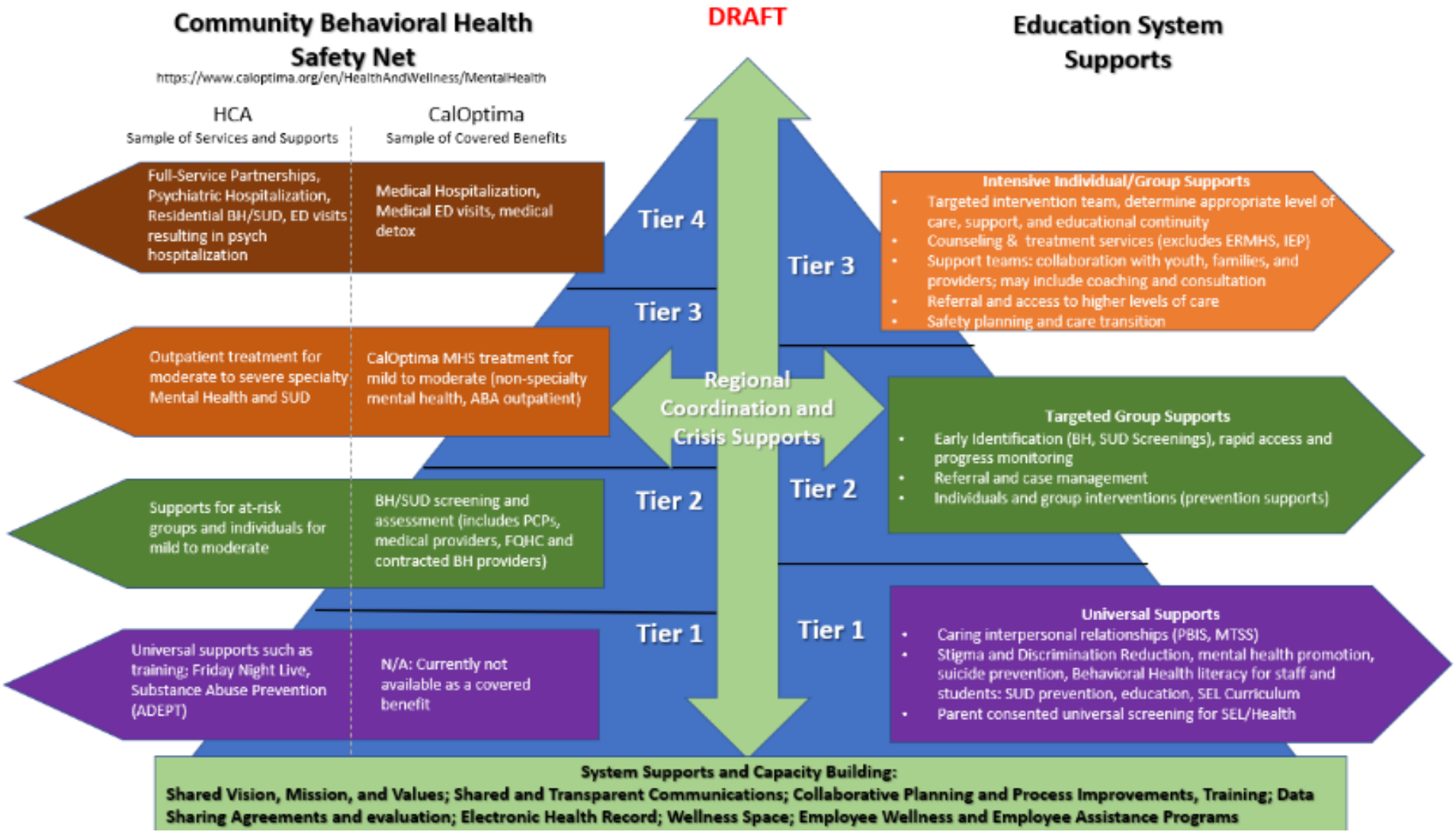
access to necessary services through their mandate. This change establishes an update to the multi-tiered system of supports framework that has been largely adopted across the state, revising it at the local level to reflect the addition of CalOptima as a systems partner, including an additional “tier” to clarify levels of care, supports, and allowing systems to better define and align roles and responsibilities.

The right-hand side of the infographic below outlines the current systems framework and how it aligns with PEI component programs. The left side of the graph illustrates the additional tier of service and includes the roles and responsibilities of each of the system partners.

The new draft paradigm:

- Demonstrates how we will back systems by supporting coordination at the universal level and via continuation of the MHSSA regional coordination approach and relevant behavioral health trainings.
- Includes information about coordination and access into and out of higher levels of acute care, including support for crisis services, etc.
- Demonstrates the new role the Managed Care Plan, CalOptima, will play in the new paradigm to support a newly defined tier II and/or tier III structure.
- Demonstrates educationally related mental health mandates and obligations within schools, along with suicide prevention plans, and other universal supports

Community Program Planning



Community Services and Supports

Community Assistance, Recovery, and Empowerment (CARE) Full Service Partnership

Orange County is part of first cohort required to implement the Community Assistance, Recovery, and Empowerment (CARE) Act under SB 1338. The CARE Act creates a pathway to deliver mental health and substance use disorder services to the most severely impaired Orange County residents who may be homeless/at-risk or frequently incarcerated due to their untreated mental health condition. The CARE Act moves care and support upstream, providing the most vulnerable residents with increased access to critical behavioral health services, housing and supports.

MHRS will establishing a Full Service Partnership that works collaboratively with the Civic Court System to serve an estimate 50 individuals deemed eligible, as they are at-risk of civic commitment/committed and are living with a qualifying diagnosis. The CARE FSP is not for everyone experiencing mental illness and focuses on individuals living with schizophrenia spectrum or other psychotic disorders who meet the specific criteria.

The full-service partnership framework is based on a “no fail” philosophy and does “whatever it takes” to meet the needs of consumers, and when appropriate their families, including supports, providing strong connections to community resources, and 24 hours per day, 7 days per week (24/7) field-based services. The primary goals of FSP programs are to improve quality of life by implementing practices which consistently promote good outcomes for the consumer. These outcomes include reducing the subjective suffering associated with mental illness, increasing safe and permanent housing, avoiding criminal justice involvement, and reducing high frequency use of psychiatric hospitalizations or emergency and crisis services. FSP programs strive to provide stabilizing services for the consumer at the lowest level of care, allowing for maximum flexibility to support wellness, resilience, and recovery.

CARE FSP will provide clinically and culturally appropriate community-based services and supports. Each CARE consumer will be partner with the FSP team and other members of the CARE team to develop an Individual Service Plan,

or CARE plan, to ensure a broad array of services and supports are provided. The range of services can include short-term stabilization medications, wellness and recovery supports, and connection to other social services, such as housing.

Overview of the Process

The California Health and Human Services has created an infographic to illustrate the Pathway through CARE (https://www.chhs.ca.gov/care-act/).

The Pathway demonstrates pathway from referral (from family members, behavioral health providers, first responders) through the process of evaluation (determining if the individual meets eligibility), the development of a CARE plan for individuals meeting criteria, implementation of necessary intervention and support, and concluding with successful recovery and transition to community. Access to voluntary mental health treatments and supports are offered throughout the process. Orange County intends to serve approximately 50 Full -Service Partners in the CARE FSP program.

Workforce Education and Training

Orange County Mental Health and Recovery Services Workforce Education and Training component of the Three-Year Program and Expenditure Plan continues to address the shortage of qualified individuals who provide services in Orange County's Public Behavioral Health System. This includes community-based organizations and individuals in solo or small group practices who provide publicly funded mental health services to the degree they comprise our county's Public Mental Health System workforce. The COVID-19 pandemic has exacerbated the shortage of qualified behavioral health workforce in Orange County (OC), across the state, and across the nation.

Review of the most recent OC workforce assessment, exit interview data, and anecdotal data from systems partners indicates that recruitment and retention challenges are resulting from:

- A lack of competitive salaries, including inadequate or more costly benefit packages in comparison to other local counties or private companies.
- Lengthy application and on-boarding processes.
- A lack of flexible schedules.
- Burnout.
- Competition for qualified staff with other systems.
- A breakdown in behavioral health pipelines and career pathways.

At the time of this draft report, MHRS is experiencing a 27% overall vacancy rate with mental health staff shortages in licensed therapists, psychiatrists, mental health specialists, and the absence of a stand-alone Certified Alcohol and Other Drug Counselor County position.

OC Workforce Education and Training unit works collaboratively with community partners, regional partners, and across the department to support the vision and mission of the WET component. Due to the current needs, the WET component will be expanded to include several new initiatives.

Training and Technical Assistance

Expansion of Peer Specialist Training

Peer Specialists are trained individuals with lived experience in mental health and/or their family members. Peer Specialists can provide Medi-Cal billable peer services across the continuum of care, including but not limited to, crisis response services, peer counseling, outreach and engagement, linkages to services and supports for consumers of MHRS services, and assist with the implementation, facilitation, and on-going coordination of activities of the MHSA plan. MHRS provides training for consumers and their family members as well as volunteers who want to become Peer Specialists. All Peer Specialist training provided is designed to promote the inclusion of mental health consumers and family members in the public mental health system. With recent legislative changes, MHRS will expand Peer Specialist Training to ensure access for individuals interested in becoming a Peer Specialist.

Health and Wellness Coaching

Health and Wellness Coaches (HWCs) utilize integrative approaches with clients to support wellness and improve health and well-being. HWCs support clients to engage in behaviors that have been proven to improve health and prevent disease including fitness, nutrition, stress coping, sleep, mind-body wellness and positive psychology interventions. MHRS proposes to train staff, contracted provider agency staff, and others that interact with behavioral health clients to become Health and Wellness Coaches. Health and Wellness Coaches are not required to have advanced degrees, thus, allowing staff to benefit from this quality training and supporting MHRS and providers the ability to up-train individuals already working in underserved settings.

A targeted 625 HWC employee students will receive training in how to work in both general medical and behavioral health team environments. Special focus will be placed on whole person care, prevention, and working with underserved

populations. Health equity, cultural humility, inclusion and health disparities training is including throughout the curriculum, as well as an adult and child /adolescent behavioral health and substance use disorders (BH-SUD) track.

Health and Wellness Coaching is a Nationally Board-Certified program. Graduates of the program are nationally board eligible through the American Board of Medical Specialists (ABMS) and includes career-long training upon graduation, at no additional cost.

All trainings include outcome measurements and reporting, to support continuous improvement and the ability to update curricula in response to the dynamic healthcare environment. The curricula are designed to progressively build knowledge and skill sets and includes 95 hours of coursework in Coaching Structure, Coaching Process, Health and Wellness, and Ethics and Legalities.

Mental Health Career Pathways

Leadership Development Program

Orange County MHRS has identified a need to implement a leadership development program for staff and staff of contract agencies. MHRS will contract with an organization specializing in designing curricula for leadership development, to plan for the leadership development program. Under this agreement, the contractor will work with MHRS to adapt the program to the needs of MHRS and to ensure that the specialized content (i.e., recovery orientation, cultural humility, and clinical and consumer service areas) is addressed. Through this program, MHRS will develop leaders from existing staff, begin succession planning for future leadership of MHRS, begin to make leadership-based assignments, and build leadership into supervisory training. Traditionally, clinicians have experienced difficulty in moving from direct service provision to supervision, administrative positions and management. Participation in the leadership program will give these employees the tools to be successful in future leadership opportunities.

Development of the Leadership Program will evolve through a five-step process:

1. Development of an MHRS Leadership Perspective/Vision which requires the involvement of key leaders within MHRS.
2. Identification of leadership needs through the development of data collection tools, implementation of data collection tools; and an analysis and report back to MHRS of the findings.
3. Engagement of key informants in the development of an organizational framework for the leadership competencies; presentation of a draft set of competencies; and review and revision of competencies, as needed.
4. Utilization of leadership competencies to identify curriculum needs; and
5. Development of an implementation plan.

The curriculum developer will engage county personnel, stakeholders, and community members to identify needs and propose leadership competencies. Through this process, proposed training components will be developed (including, but not limited to, competence-based curricula addressing the shared knowledge and behavioral requirements of all levels of leadership; specialized training addressing discipline specific roles and functions; and customized leadership assessment and coaching of identified personnel). Finally, the proposed training structure(s) will be developed (including, but not limited to: “Train the Trainers”, recommended training cycles; online courses; university-based didactic courses supporting to degree completion; and customized leadership assessment and coaching of identified personnel).

Residency, Internship Programs

Expand MHRS Internship Program

The county’s Workforce Needs Assessment clearly shows the need to identify ways of increasing the number of direct service staff members in Social Work; Marriage and Family Therapy; and Clinical Psychology. The county has experienced a loss of clinical positions to private industry, neighboring Counties, Mental Health pop-up businesses, the State and the hospital systems. These losses are attributed to higher salaries and increased benefits at the criminal

justice and state hospital systems. Providing internship opportunities is a way to increase the number of people working at MHRS and in contract agencies in the behavioral health professions.

This action describes plans to increase internships within MHRS as well as coordinate Intern Programs with contract agencies and allow interns from those agencies to attend group supervision sessions conducted by MHRS. In addition, this action will provide additional clinical supervisors to the internship program to further the goals of enhanced supervisor competencies; supplement supervision of interns created by staff shortages; provide licensing preparation support to pre-licensed clinicians; and create an employee internship program for current MHRS staff who have been accepted into a master's level program in a behavioral health related program. As shown in the capacity assessment, MHRS and partnering contract agencies need to improve services to underserved groups. Recruitment of potential employees from underrepresented populations to work in licensed direct service positions will strengthen the overall system. The Intern Supervisors will work with local universities to recruit interns from underrepresented populations.

The creation of an internship unit consisting of an Administrative Manager II and four (4) Service Chief II's to provide supervision for pre-licensed Clinical Therapists and interns will support this program. One FTE Staff Specialist will assist with coordination, placement, and administrative support. These positions mitigate the impact on current supervisors allowing for increased intern supervision. Clinical Supervisors hired for these positions must have training, be skilled in wellness and recovery and cultural competence, and utilize those skills in their supervision and training of interns and pre-licensed employees. Supporting the Intern Supervisors are MHRS clinical supervisors who provide the day-to-day supervision of interns. The new positions will spend a portion of their time in direct supervision of interns and pre-licensed Clinical Therapists in the clinics and a portion of their time working with pre-licensed MHRS employees training and preparing for licensing examinations.

Employee Internship Program

In addition, Orange County MHRS has identified a need to assist current County employees in completion of their educational goals. Implementation of the Employee Internship Program assists not only current employees but MHRS, as well. To be considered for the Employee Internship Program, employees must show proof of acceptance into a master's

level program. Employees in the program must agree to continue employment with MHRS as a condition of participation on a year-for-year basis. Those who receive educational assistance through the scholarship program for one academic year are required to continue to work for MHRS for one calendar year. This program benefits MHRS by providing programs with additional staff assistance and the ability to complete special projects; assisting clinical staff and other employees in meeting educational goals; increasing morale; improving retention of staff; enhancing the employees' current skills and competence; and increasing productivity and efficiency.

Prevention and Early Intervention (PEI)

Prevention and Early Intervention (PEI) program services are envisioned to develop and implement strategies that stop mental illness from becoming severe and disabling, giving emphasis to improvement in timely access to services for underserved populations. Strategies and activities are applied early on to avert the onset of mental health conditions or relapse among individuals. PEI programs serve all age ranges, however, 51% of services must target individuals aged 25 and under and their families. The component also seeks to change community conditions known to contribute to behavioral health concerns. PEI programs incorporate the values of cultural competence, consumer and community empowerment, collaboration, and inclusion in providing services that emphasize recovery, wellness, and resilience. PEI programs continue to strive to meet the needs identified by the California Mental Health Services Oversight and Accountability Committee (MHSOAC) and local diverse community stakeholders, meet the key community and priority population needs outlined in the Mental Health Services Act and transform the public mental health system.

MENTAL HEALTH SERVICES ACT · PROPOSITION 63 · CALIFORNIA

WELLNESS • RECOVERY • RESILIENCE

Prevention and Early Intervention (PEI)

The State defines six specific Prevention and Early Intervention Programs. Per statute, a program is defined as "a stand-alone organized and planned work, action, or approach that evidence indicates is likely to bring about positive mental health outcomes either for individuals and families with or at-risk of serious mental illness or for the mental health system (WIC §3701 (b))."

These State-Defined programs areas are:

Local PEI Construct

The Orange County PEI programs operate under the State-Defined Prevention and Early Intervention reporting construct as illustrated in the following tables:

Outreach for Increasing Recognition of Signs of Mental Illness
- Behavioral Health Training Collaborative
- Mental Health and Well Being Promotion for Diverse Communities
- Early Childhood Mental Health Providers Training
- K-12 School Based Mental Health Services
- Services for TAY and Young Adults

Stigma and Discrimination Reduction
- Mental Health Community Education Events for Reducing Stigma & Discrimination

Prevention Programs
- Prevention Services and Supports for Families
- Prevention Services and Supports for Youth
- Family Support Services

Suicide Prevention
- Community Suicide Prevention Initiative
- Crisis Prevention Line
- Survivor Support Program

Access and Linkage to Treatment
- OC Links
- OC Outreach and Engagement for Homeless
- Integrated Justice Involved Services

Early Intervention
- School Based Mental Health Services
- Thrive Together OC
- OC CREW
- OC Parent Wellness Program (OCPWP)
- Community Counseling and Supportive Services
- Early Intervention Services for Older Adults
- OC4VETS

SB 1004 PEI Program Priority Areas

All PEI programs are required to comply with WIC Section 5840.7 enacted by Senate Bill 1004 which necessitates counties to specify how they are incorporating the following six Mental Health Services Oversight and Accountability Commission (MHSOAC) identified priorities in the MHSA plan:

Per WIC section 5840.7/SB1004, counties are required to provide an estimate of the share of PEI funding allocated to each MHSOAC identified priority. The following provides these estimates for each fiscal year of Plan:		
SB 1004 Identified PEI Program Priority Categories:		**Percentage of Funding Allocated to Priority:**
1.	Childhood trauma prevention and early intervention to deal with early origins of mental health needs.	34%
2.	Early Psychosis and mood disorder detection and intervention; and mood disorder and suicide prevention programming that occurs across the lifespan.	21%
3.	Youth outreach and engagement strategies that target secondary school and transitional age youth, with priority on partnership with college and mental health programs.	15%
4.	Culturally competent and linguistically appropriate prevention and intervention.	15%
5.	Strategies targeting the mental health needs of older adults.	14%
6.	Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis.	1%

Each of these priorities outlined in WIC Section 5840.7/SB 1004 are integrated into the OC MHSA plan and aligned with our previously outlined programs and strategies.

Prevention and Early Intervention (PEI)

PEI State Program Category	Local Program	SB 1004 Identified Priority					
		Child Trauma	Early Psychosis/ Mood	Youth Outreach	Culture Comp	Older Adults	Early ID
Stigma and Discrimination Reduction	MH Community Education Events for Reducing Stigma & Discrimination	X		X	X	X	
Outreach for Increasing Recognition of Early Signs of Mental Illness	Behavioral Health Training Services	X			X	X	
	Early Childhood Mental Health Providers Training	X			X		
	MH & Well-Being Promotion for Diverse Communities			X	X	X	
	Services for TAY and Young Adults			X	X		
	K-12 School-Based MH Services			X	X		
	Statewide Projects			X	X		
Prevention	Prevention Services and Supports for Families	X			X		
	Prevention Services and Supports for Youth	X		X	X		X
Early Intervention	Community Counseling & Supportive Services	X	X		X	X	X
	School-Based Mental Health Services		X		X		X
	Early Intervention Services for Older Adults				X	X	X
	OC Parent Wellness Program	X	X		X		X
	Thrive Together OC		X		X		
	OC CREW		X		X		
	OC4Vets	X	X	X	X	X	X
Suicide Prevention	Suicide Prevention Services	X	X	X	X	X	X
Access and Linkage to Treatment	OC Links	X	X	X	X	X	X
	OC Outreach and Engagement for Homeless				X	X	X
	Integrated Justice Involved Services				X		

PEI Statewide Projects

Prevention and Early Intervention (PEI) Statewide Projects are intended to support PEI strategies and messaging across the state as well as locally via the California Mental Health Services Authority (CalMHSA), a joint powers authority (JPA), working on behalf of California Public Behavioral Health plans. The PEI Statewide effort was jointly initiated with other California counties for the purpose of making both a statewide and local impact. Orange County is a member of the JPA and a contributor to statewide PEI Projects. MHRS intends to assign $500,000/fiscal year of local PEI funding to the JPA the last two years of this plan.

The PEI Statewide Project is a collection of campaigns which seek to expand the awareness of mental health needs and supports, reduce stigma, prevent suicides, and teach individuals how to achieve mental wellness. All initiatives implemented under the Statewide PEI Project are collectively known as "Take Action for Mental Health/Toma Accion Para Las Salud." The initiative is marketed as the campaign for California's ongoing mental health movement. It builds upon established approaches and provides resources to support Californians' mental health needs.

Take Action for Mental Health is an evolution of the previous statewide initiative, the Each Mind Matters campaign. Over the last decade, Each Mind Matters has had a positive impact on reducing stigma of mental illness and increasing awareness of mental health needs and resources. Two hallmark projects from the Each Mind Matters campaign, Know the Signs, and Directing Change, continue under the Take Action for Mental Health initiative.

- Know the Signs/Reconozca Las Senales is California's suicide prevention campaign that encourages individuals to know the signs of suicide, find the words to ask a loved one if they are thinking about suicide, and reach out to local resources.
- The Directing Change Program and Film Contest engages students and young people throughout California to learn about the topics of suicide prevention and mental health through the medium of film.

Take Action for Mental Health builds on this progress and asks Californians to take action to support ourselves and the people we care about through a three-pronged approach: Check-in, Learn More, and Get Support.

Strategies administered by CalMHSA in support of the statewide efforts include:

- Distribution of campaign materials and messaging,
- Technical Assistance
- Suicide Prevention training
- Administration and engagement of youth and adult allies through the Directing Change program.

All program and statewide evaluations conducted by the RAND Corporation on behalf of CalMHSA can be found at: https://www.rand.org/health/projects/calmhsa/publications.html

Orange County Local Partnership and Impact

Statewide Projects serve the Orange County community at large through building on the state initiatives at the local level and through participation in CalMHSA-sponsored initiatives and technical assistance.

Suicide Prevention: These activities include social marketing and technical assistance designed to support helpers and gatekeepers appropriately identify and respond to suicide risk. This program also works with local suicide prevention partners to respond to individuals in crisis through hotlines.

In FY 2021-22, CalMHSA's PEI Program Contractor, Your Social Marketer (YSM), provided technical assistance to the OC HCA's Office of Suicide Prevention (OSP) and the Orange County Community Suicide Prevention Initiative (CSPI) leadership team with technical assistance related to advancing the goals of the Orange County's Community Suicide Prevention Initiative (CSPI) in the following areas:

Strategic Planning

- Short-term and long- term strategic planning including assisting the County with planning and writing the Suicide Prevention Strategic Plan for Orange County. Different strategic plan formats from other Counties were reviewed as examples and the best format for Orange County's updated strategic plan were discussed.

Organizational Structure of CSPI

- Fine tune the organizational structure of the CSPI including co-chair selection.
- Technical assistance was provided to the CSPI leadership on a variety of subjects, including strategies for workplace wellness and how to structure a first responder workgroup.

Firearm Safety Initiative

- Technical assistance to the Firearm Safety subcommittee of CSPI to develop a brochure on Firearm Safety, a first for the County.
- Subject Matter Expert presentations to Orange County law enforcement partners as a means of education, strengthening partnership and providing feedback for the development of safety briefings for the Orange County Board of Supervisors prepared by the Office of Suicide Prevention.
- Trained volunteers to conduct outreach and assisted the volunteers with outreach activities to twelve gun shops and ranges across Orange County.

Suicide Data Dashboard

- Input from subject matter experts for the OC HCA's newly launched suicide data dashboard. Support included assistance with preparing information and guidelines around using and sharing suicide data and the importance of offering context, applying safe messaging guidelines, and including a crisis resource.

Directing Change Program & Film Contest : The Directing Change Program and Film Contest engages students and young people throughout California to learn about the topics of suicide prevention and mental health through the medium of film.

- The Directing Change team provided subject matter expertise to school students and staff advisors in preparing 60 second videos on topics related to suicide prevention, stigma reduction and mental health awareness. Supports also included the award of mini grants for selected schools.
- The Directing Change team also submitted prompts and contest details to their monthly newsletter, the Hub, and participated in regular meetings to promote the program.
- The Directing Change Team assisted OC HCA and staff from one of its partners, the Los Angeles baseball team, to select and edit a 30 second film submission that was played at a home game and aired on the television.
- The winning film from Costa Mesa High School was aired at various games starting May 21st and broadcasted on television.

As a result of these efforts, 22 eligible Orange County schools submitted 150 entries to the Directing Change Program & Film Contest. For more information about Orange County Directing Change please visit DirectingChangeCA.org/OrangeCounty

Local Results	Numbers
Entries	150
Schools	22
Participants	350
Mini Grants	2
Total Estimated Reach	600

Stigma and Discrimination Reduction: These activities include implementation of best practices to develop policies, protocols and procedures that support help-seeking behavior and/ or build knowledge and change attitudes about mental illness. This initiative also provides informational and online resources, training and educational programs, and culturally responsive media and social marketing campaigns to engage and inform diverse communities about mental wellness.

The table below outlines the resources and materials distributed throughout the year in FY 2020-21:

Campaign Materials Distributed	**Quantity FY 2020-21**
Each Mind Matters (EMM) Green Ribbons	59,800
Sanamente Green Ribbons	3,000
EMM/Sanamente Wristbands	10,800
SWAG pens (English +Spanish)	1,500
Keychains	1,000
Stress balls	1,000
Metal Green Ribbon lapel pin	1,400
Car Magnet	1,000
EMM magnets	1,000
EMM/Sanamente Tee shirts	318
EMM/Sanamente Decals+ Tumbler cups+ sunglasses, +poly bags + base ball caps	2,632
Mental Health Support Guide Brochures English	1,100
Mental Health Support Guide Brochures Spanish	1,100
Fotonovela Educational materials	2,700
Know The Signs (KTS) Brochures and tent cards English	9,800
KTS Spanish	5,600
KTS brochure for parents	2,100
KTS Brochures Vietnamese	1,000
KTS Brochures Korean	500
KTS Brochures in Mandarin, Khmer, Hmong Tagalog combined	550
KTS pin Buttons	2,500
KTS Coasters	1,000
KTS Coffee Sleeves	1,000
LGBTQ+ Mental Health and Aging Support Guide	500
Be True and Be You - A Basic Guide for LGBTQ+ Youth Booklets	750
EMM Awareness LGBTQ+ cards	1,000

PEI: Outreach for Increased Recognition of Signs of Mental Illness

Program: Behavioral Health Training Collaborative

WIC § 3715 defines "Outreach" is a 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.

"Potential responders" include, but are not limited to, families, employers, primary health care providers, visiting nurses, school personnel, community service providers, peer providers, cultural brokers, law enforcement personnel, emergency medical service providers, people who provide services to individuals who are homeless, family law practitioners such as mediators, child protective services, leaders of faith-based organizations, and others in a position to identify early signs of potentially severe and disabling mental illness, provide support, and/or refer individuals who need treatment or other mental health services.

Overview of the Program:

The Behavioral Health Training Collaborative (BHTC) is a partnership between Mental Health and Recovery Services (MHRS) and Western Youth Services (WYS). This project collaborates with a network of community partners to provide trainings related to increasing awareness of signs and symptoms of mental health and/or substance use issues. To meet the needs of community, the program offers educational sessions and resources in both virtual and in-person, community-based settings.

Program goal(s) and intended outcome(s):

The goal of BHTC is to increase awareness and knowledge of signs and symptoms of mental health and/or substance use issues in the community. BHTC intends to provide a minimum of 548 trainings to 10,900 community members/attendees in FY 23/24 with minimum rating of 80% of service satisfaction from participants.

PEI: Outreach for Increased Recognition of Signs of Mental Illness

Description of Services:

BHTC utilizes curricula based in best practices or evidenced-based practices to engage the community, school personnel, students, youth, parents, and the general community to increase knowledge and understanding of the information being provided. Subject matter experts are utilized to train the community on behavioral health focused topics such as, but not limited to skills that improve mental health and support resilience in addressing future life challenges for both community members and providers.

Additionally, BHTC provides education focused on prevention and early intervention (PEI), wellness promotion, building resilient communities to support those with mental illness, and ameliorating associated challenges.

Target Population:

There are 3 primary populations targeted to support through this program: Community at large, non-clinical providers, and clinical providers.

- Community at large (Tier 1): General public such as parents, family members, community centers, etc.
- Non-clinical provider (Tier 2): A person who interacts with or provides services to those who may experience a behavioral health condition. Examples would be staff at public or private schools, childcare sites, colleges/universities, veteran service agencies; law enforcement, probation/parole, homeless or housing providers, religious leaders, faith-based centers, business owners, etc.
- Clinical providers (Tier 3): A direct service provider who provides services to a potential or current behavioral health client who wants more information on behavioral health topics, continuing education, or needs skills or techniques to assist the client or their family member.

PEI: Outreach for Increased Recognition of Signs of Mental Illness

Program Summary	
Program Serves	Children
	TAY (16-25)
	Adults (26-59)
	Older Adults
Location of Services	Virtual, Community-Based
Numbers of individuals to be Served	FY 2023-24: 10,900
	FY 2024-25: 10,900
	FY 2025-26: 10,900
Annual Budget	FY 2023-24: $1,547,086
	FY 2024-25: $1,547,086
	FY 2025-26: $1,547,086
Avg. Est. Cost per Person	$142
Services Offered	Community Engagement
	Training

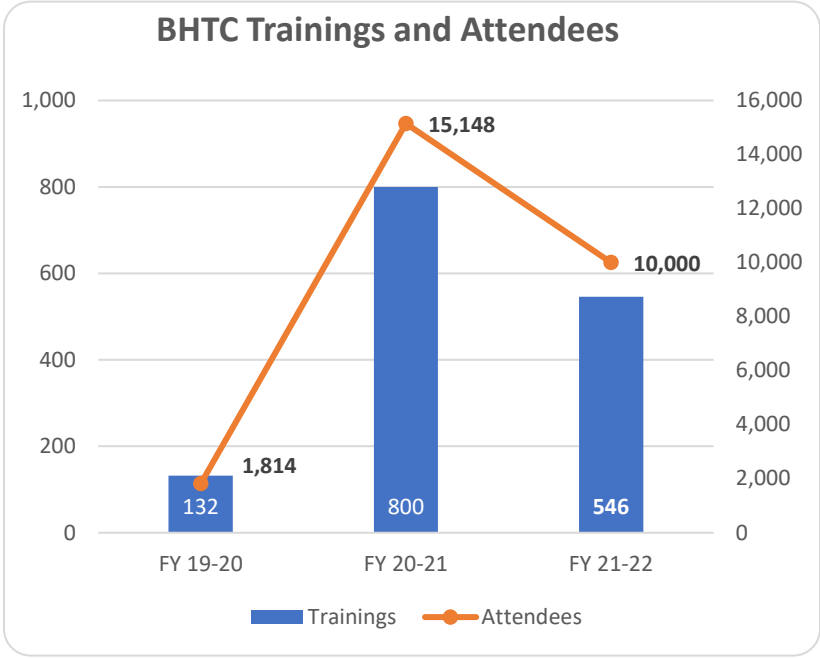
PEI: Outreach for Increased Recognition of Signs of Mental Illness

Results:

During FY 2021-22, 10,000 individuals participated in BHTC trainings including:

Potential Responders Type	
Behavioral Health Providers	Child Welfare
Medical Co-Morbidities Providers	Cultural and Ethnic Communities
Individuals Working with Substance Use	Homeless/At-Risk of Homelessness
Individuals Working with Criminal-Justice	Families
First Responders	LGBTQI+
Parents/Students/Schools	Trauma Exposed Individuals

There was a decrease in the number of facilitated trainings provided and attendees during FY 2021-22. This drop is largely due to the fact the provider launched the RESET Toolbox in FY 2020-21, which accounted for a significant increase in trainings provided to school communities and families and less training for other groups. The RESET Toolbox is an online "toolbox" of resources geared to buffer the effects of COVID-19, social isolation, Post-Traumatic Stress Disorder (PTSD), toxic stress, Adverse Childhood Experiences (ACEs) (including racism), to help participants build resilience and be emotionally equipped to succeed during and after COVID-19. While the RESET Toolbox is still available, utilization of this resource has declined as community transitions into post pandemic settings.



Satisfaction surveys were collected from participants on all trainings conducted, with a goal of maintaining an overall course satisfaction rate of 80%.

During FY 2021-2022, 99% of participants reported they were satisfied with these trainings.

PEI: Outreach for Increased Recognition of Signs of Mental Illness

Challenges/solutions:

Originally, the funding for this program was identified as time-limited for a three-year period. However, based on the demand and frequency of use by the community, this program will continue to be funded throughout this three year plan.

PEI: Outreach for Increasing Recognition of Early Signs of Mental Illness

Program: Mental Health and Well Being Promotion for Diverse Communities

Overview of the Program:

The Mental Health and Well Being Promotion for Diverse Communities program is a new program that utilizes a peer supported approach to promote mental health and wellness, reduce stigma, raise awareness regarding preventing behavioral health conditions (recognizing signs and symptoms), increase resilience and recovery by building on protective factors, address the risk factors and providing peer support. This is accomplished through outreach, information dissemination, community education and events, skill building, socialization group activities, and one-to-one to interactions and relationships with families and individuals representing diverse populations. Appropriate referrals and linkages to community resources and support are also provided, as needed.

Program goal(s) and intended outcome(s):

The goal of the Mental Health and Well Being Promotion for Diverse Communities program is to educate the community members regarding mental health, seek to improve mental health outcomes, increase help seeking behaviors and prevent the progression of untreated behavioral health conditions.

The following outcome measure goals are utilized to determine the effectiveness of the services provided:

- On average, participants will report an increased awareness of mental health needs pertaining to the target population.
- On average, participants will report an increase in knowledge of community mental health resources.
- On average, participants will report an increase in confidence to navigate the mental health system.
- On average, participants will report a decrease in stigma related to mental health conditions.
- On average, participants will report an increase in confidence to facilitate help seeking behaviors.

PEI: Outreach for Increasing Recognition of Early Signs of Mental Illness

Program Summary	
Program Serves: Diverse Cultural Communities	Children
	TAY (16-25)
	Adults (26-59)
	Older Adults
Location of Services	Virtual, Community-Based
Numbers of individuals to be Served	**FY 2023-24**: 4,417
	FY 2024-25: 8,734
	FY 2025-26: 8,734
Annual Budget	**FY 2023-24**: $3,454,674
	FY 2024-25: $6,226,752
	FY 2025-26: $6,226,752
Avg. Est. Cost per Person	$726.90
Services Offered	Community Outreach
	Educational Workshops
	Events, Development of Materials
	Peer Support

Description of Services:

Outreach

Community outreach is used to engage diverse communities to raise awareness, increase recognitions of early signs of mental illness and disseminate information regarding mental health and wellness. Community outreach also creates the opportunity to connect with individuals who may be experiencing or at an elevated risk of experiencing a mental health challenge. A combination of individualized and broad outreach strategies are utilized across traditional and non-traditional settings such as religious organizations, shelters, community gathering places, hospitals, health fairs, community centers, in homes, community businesses, or any other location from which mental health awareness may be promoted. Outreach is conducted by diverse peers who are trusted members of communities and are able to build rapport and trust within their communities.

Educational Workshops

Educational workshops are provided as part of these services. The workshops promote awareness of a wide variety of mental health topics, stigma reduction, suicide prevention, and help to increase help seeking behaviors. Workshops may include activities such as educational groups, socialization or skill building workshops which are

designed to raise awareness about behavioral health conditions and develop protective factors. The educational content of the workshops and groups address specific perceptions and beliefs about stigma, mental illness, substance use disorders, and barriers to help seeking. The workshops are also designed to be culturally relevant and appropriate to the audience.

Educational Material Development and Information Dissemination

Culturally responsive mental health related educational, informational, and/or resource materials are developed and made available in print via podcasts or online, as applicable, and appropriate for the target audience. These informational materials may include items such as brochures, pamphlets, posters, and other resource materials published via various online outlets such as email, websites and social media.

Events

Community events are organized, in partnership with collaborating community organizations, to engage diverse and vulnerable communities. These culturally informed events focus on reducing mental health stigma and raising awareness around a variety of health and wellness topics. The events may range from activities such as art exhibits, community performances, conferences highlighting mental health topics, or pop-up events and community forums. Services also incorporate social marketing and media campaigns via print, radio, television and social media platforms to raise awareness of mental health and wellness topics, suicide prevention and information about resources available to the community.

Peer Support

Services also incorporate peers with lived experience to support the events, workshops, and community events. The peers also engage vulnerable and at-risk community members on an individual basis to provide mentoring, support, education, advocacy, leadership, coaching, and referral and linkage assistance. Peers are recruited directly from the communities in which the services are provided and trained to engage their communities in support of enhancing stigma reduction, increasing mental health awareness, facilitating help seeking behaviors, and improving the overall health and wellness of their communities.

Target Population:

Mental Health and Well-Being Promotion for Diverse Communities support Orange County residents who are at risk of developing or who are exhibiting early signs of behavioral health conditions including mental illness and substance use disorders due to their risk factors or

environmental conditions. Services target individuals who are unserved, underserved especially individuals from racially and ethnically diverse communities including monolingual non-English speakers, recent immigrants and refugees in Orange County.

The target populations also include veterans, LGBTQI+ individuals who have typically been underserved and disproportionately impacted by risk factors for mental illness.

Outcomes and Results:

The program was implemented on January 1, 2023. Outcomes will be reported in future Plan Updates.

Challenges/solutions:

The program was implemented on January 1, 2023. Challenges/solutions will be reported in future Plan Updates.

Program: Early Childhood Mental Health Providers Training

Overview of the Program:

The Early Childhood Mental Health Providers Training is a prevention-based early childhood mental health consultation and training service with a goal to support the effective management of challenging behaviors in children up to 8 years of age and promote healthy social emotional development of young developing children in Early Childhood and Education (ECE) settings. This is accomplished by supporting and building the capacity of ECE providers, including site directors, owners and/or administrators and teachers, and the families they serve throughout Orange County through mental health consultation, education, coaching and support services utilizing evidence-based practices (EBP).

Program goal(s) and intended outcome(s):

- On average, ECE providers will demonstrate a significant skill increase in management of challenging behaviors in young children and importance of their social-emotional development.
- On average, ECE providers will report fewer children who engage in ongoing, persistent challenging behaviors.
- On average, Target children will demonstrate an increase in pro-social behaviors, a decrease in challenging behaviors, and greater engagement in tasks/activities.

Description of Services:

Consultation services educate and build capacity, increase knowledge and awareness of early childhood providers to provide appropriate behavior support for those children exhibiting ongoing challenging behaviors, and promote development of healthy identities in young children. Consultation services include consultation, practice-based coaching, direct observation and follow-up support.

Early Childhood Mental Health Consultation Services are provided to ECE providers in:

1) Areas of the county with the highest vulnerability in social and emotional development based on the Early Development Index (EDI),
2) ECE sites who have identified children with challenging behaviors and are at-risk of expulsions, and
3) ECE providers who may not have access to other state or federal funding.

PEI: Outreach for Increasing Recognition of Early Signs of Mental Illness

Program Summary	
Program Serves:	Children (0-8)
Location of Services	Virtual, ECE Settings, After School Programs, Schools
Numbers of individuals to be Served	**FY 2023-24**: 5,000
	FY 2024-25: 5,000
	FY 2025-26: 5,000
Annual Budget	**FY 2023-24**: $1,000,000
	FY 2024-25: $1,000,000
	FY 2025-26: $1,000,000
Avg. Est. Cost per Person	$200
Services Offered	Consultation
	Training
	Practice-Based Coaching

Target Population:

Children 0-8 years of age exhibiting challenging behaviors and at risk of developing a severe emotional disturbance in Early Childhood and Education settings throughout Orange County, transitional kindergarten programs through third grade, and before and after school programs.

Outcomes and Results:

Based on survey responses provided by ECE providers, the program met its goals and ECMHC services were successful at enhancing social and emotional development and/or the mental health and wellness of young children.

- 46% of ECE site directors, owners and administrators reported fewer children with persistent challenging behaviors.
- 73% of teachers demonstrated an increase in ability and knowledge to manage children's challenging behaviors effectively.
- 83% of children demonstrated an increase in pro-social behaviors.
- 100% of children maintained good engagement in classroom activities.

PEI: Outreach for Increasing Recognition of Early Signs of Mental Illness

The program provides referrals to parent participants for clinical services and parent education support.

ECMHC Referral & Linkage Rates			
	# Referrals	**# Linkages**	**% Linked**
FY 2019-20	1	1	100%
FY 2020-21	22	19	86%
FY 2021-22	21	13	62%

Challenges/solutions:

Throughout FYs 20-21 and 21-22 the program continued to experience limited accessibility to some ECE settings, as the effects of the COVID-19 pandemic continued.

As a solution, services were offered and provided virtually, as needed. As a result, the program was able to serve more staff members at the accessible sites and overachieved this output despite the barriers.

Program: Service for Transitional Age Youth (TAY) and Young Adults

Overview of the Program:

The Services for Transitional Age Youth and Young Adults program services are designed to support, engage and empower TAY and young adults between the ages 16-24 years who may be at risk of developing behavioral health conditions or experiencing an increase in severity of an existing condition. The services are provided through community building and networking activities, outreach, and raising knowledge and awareness on mental health education and available resources.

These services include three components:

1) TAY Mental Health Community Networking Services,
2) TAY Mental Health Outreach Services, and
3) TAY Mental Health Education Activities.

Program goal(s) and intended outcome(s):

A unifying goal of these three components is, through outreach to the TAY population, to raise awareness about mental health, increase youth connectedness, reduce behavioral health stigma, improve resource navigation, and increase access to behavioral health services and supports by increasing knowledge of available resources and improving help-seeking behaviors.

Description of Services:

TAY Mental Health Community Networking Services

The TAY Mental Health Community Networking Services support active collaborations with Orange County colleges, universities, trade schools and community-based organizations serving TAY and young adults to increase coalition building through Connect OC, a peer-based Countywide Coalition (Coalition) for TAY individuals. Connect OC is comprised of TAY from the community, peer youth leaders from the college and university campuses, faculty/staff, and representatives from various organizations serving TAY and young adults throughout Orange County. The Coalition provides a space for youth to connect, learn and share their experiences. Through coalition meetings and activities, community mental health educational forums, social media promotion and website resources, Connect OC enhances community collaborations across Orange County and expands behavioral health knowledge and awareness of community resources, specific to TAY and young adults.

Connect OC promotes mental health educational events throughout Orange County and educates the community

on a wide array of behavioral health topics impacting TAY and young adults including anxiety, depression, stress, trauma, suicide prevention, substance use prevention, signs and symptoms of mental illness, coping skills and community resources. Furthermore, Connect OC ensures community efforts towards raising mental health awareness are further aligned and strategize to implement the most effective ways of disseminating information to TAY and young adults, their friends and family members and individuals who serve these populations.

TAY Mental Health Outreach Services

The TAY Mental Health Outreach provides Outreach Services to community organizations and local colleges utilizing creative performance arts as a mechanism to reach TAY and young adults. Services include professional theater productions by youth under the guidance of professional artists and program staff, that highlight a variety of mental health topics focusing on TAY and young adults. The partnering community organizations and the youth they serve are invited to view these theatre performances, which are followed by panel discussions facilitated by mental health professionals and includes information on behavioral health resources. In addition, TAY have an opportunity to participate in a 10-12 week evidence-based program called "Life Stories" designed for creative self-expression through the formation of original dramatic works where participants use their own life experiences as inspiration to others. The Life Stories program is designed to connect with the hardest to reach TAY and young adults who may be experiencing challenging life events and engage them in creative self-expression.

TAY Mental Health Educational Activities

The TAY Mental Health Educational Activities provides a variety of educational activities to raise awareness and increase knowledge about mental health. Services seek to improve help-seeking behaviors among TAY and young adults and increase access to resources and services as

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARTERISTIC FOR FY 2023-24 through FY 2025-26

Age	%	Gender	%	Race/Ethnicity	%
0-15	16%	Female	63%	Latino/Hispanic	35%
16-25	34%	Male	36%	White	33%
26-59	39%	Other	1%	Asian/PI	26%
60+	11%			Black	5%
				Native American	0%
				Other	0%

PEI: Outreach for Increasing Recognition of Early Signs of Mental Illness

Program Summary	
Program Serves:	TAY (16-25)
Location of Services	School-Based, Online/Virtual Community-Based
Numbers of individuals to be Served	**FY 2023-24**: 6,975
	FY 2024-25: 6,975
	FY 2025-26: 6,975
Annual Budget	**FY 2023-24**: $700,871
	FY 2024-25: $700,871
	FY 2025-26: $700,871
Avg. Est. Cost per Person	$100.48
Services Offered	Community Networking
	Educational Outreach
	Education

well as improve linkage to on and off-campus community mental health services. This is accomplished by organizing student-led activities, engaging students to start on-campus clubs and host on-campus events, hosting educational presentations on campus and in the community, podcasts, and events.

Target Population:

TAY and young adults ages 16-25 years old including students in colleges and universities, and youth who are not enrolled in the educational institutions but may be at risk of behavioral health conditions developing or getting worse.

Services focus on youth who may be unserved and underserved including those who identify as lesbian, gay, bisexual, transgender, Intersex, Questioning (LGBTIQ), veterans, new immigrants, individuals from diverse ethnic communities and/or at-risk foster youth. Family and friends of these TAY and young adults and any individuals who support them are also included.

Outcomes and Results:

In line with this program's goals, those who provided feedback following an event hosted by various providers consistently supported positive statements about mental

PEI: Outreach for Increasing Recognition of Early Signs of Mental Illness

MENTAL HEALTH AWARENESS AND STIGMA REDUCTION SURVEY	n=1,015 participants n=97 surveys returned	n=4,094 participants n=776 surveys returned	n=10,393 participants n=608 surveys returned
	FY 19-20	**FY 20-21**	**FY21-22**
I would be willing to talk about mental health with people I meet.	86%	84%	86%
I learned how to treat people who are living with a mental illness.	75%	76%	75%
I would avoid people who are living with a mental illness.	7%	8%	8%
I learned how to find help for people living with a mental illness.	75%	76%	78%
I believe people living with a mental illness can have similar problems as I do.	96%	88%	90%
I believe anyone can have a mental illness at some point in their lives.	97%	91%	93%
I am willing to talk with someone about my mental health.	94%	83%	87%

health and people living with mental health conditions, and few agreed with a stigmatizing statement. Additionally, feedback from participants indicated that the events continue to increase a

willingness to reach out to others about their own mental health. Only about 6-19% of attendees completed a feedback survey, however, so it is unclear to what extent the events helped inform or shape the perspectives of the majority of attendees who did not share their feedback.

Challenges/solutions:

Engaging youth continues to be a challenge. Conflicting class schedules and stigma continue to be barriers in accessing different programing. To increase access and engagement, staff scheduled programs on a virtual platform but found that students were unresponsive due to "Zoom Fatigue". To overcome some of these challenges program staff is engaging youth mainly via social media

platforms frequented by the TAY demographic namely Instagram, Twitter, and YouTube.

Another strategy that has been successful has been to reach out to mental health TAY influencers on social media to spread awareness. These influencers are also creating more opportunities for direct collaboration with student clubs on local college and/or high school campuses.

The TAY collaborative partners are working on a new campaign for in which they will share community services through a campaign that encourages TAY to share resources with their peers, families, co-workers, and friends. This campaign will be implemented in a way that takes away the stigma of discussing and sharing mental health services and bridges the gap between making community services appealing and also reaching the people who need these services the most.

Another creative way to outreach to TAY students was through creative stickers with positive affirmations, program logos and a link to resources.

Staff also note difficulty in obtaining completed surveys after an event.

PEI: Outreach for Increasing Recognition of Early Signs of Mental Illness

Program: Mental Wellness Campaign

Overview of the Program:

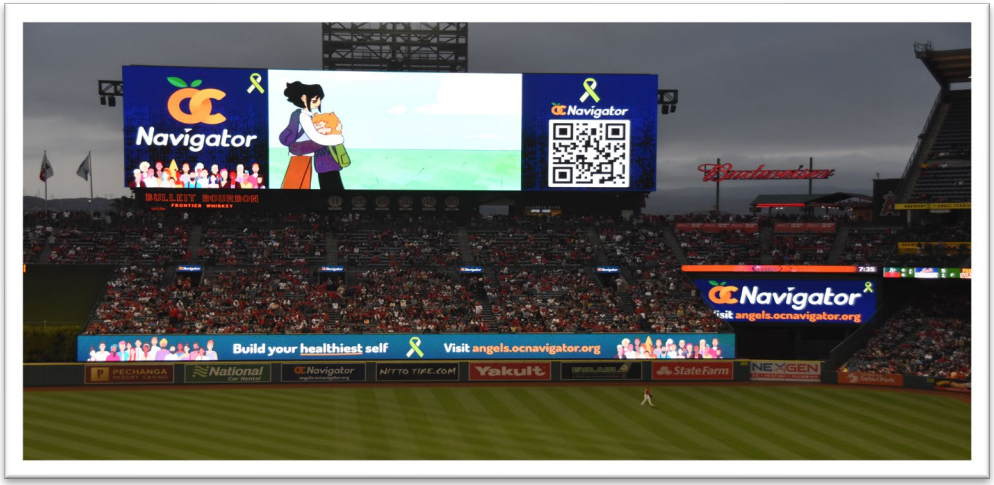
The Mental Wellness Campaign program was started as an extension of the PEI Statewide Projects Initiative. Orange County was able to leverage statewide efforts to maximize the local impact by implementing a targeted local campaign to start this program. This program covers large-scale, local mental health awareness campaigns and community educational activities. These efforts partner with and leverage the community reach and existing efforts of local professional sports teams (i.e., Angels Baseball, Anaheim Ducks hockey), County Agency partners, etc. Beginning in FY 2021-22, local campaigns focused on promotion of the OC Navigator, Orange County's self-guided, online resource navigation tool (see Behavioral Health System Transformation for more information on the OC Navigator).

Program goal(s) and intended outcome(s):

The services provided address the limitations of HCA's existing mental health and well-being outreach efforts by strategically placing its messaging in a professional sports venue attended by families and fans of all ages. These activities considerably increase the total number of people reached through HCA's mental health awareness campaigns and reach Orange County residents who might not otherwise be exposed to these messages and information. By continuing this large-scale outreach effort, HCA has the opportunity to connect with a diverse Orange County audience not normally reached in its usual mental health campaigns, which supports efforts to promote upstream wellness strategies, awareness of available mental health resources, and to reduce mental health-related stigma.

Description of Services:

- Mental health awareness branding and advertising for local fans attending an Angels Baseball or Anaheim Ducks hockey home game or hosted event



- In-person outreach events co-sponsored by the professional sports team
- Digital media support from the professional sports team
- Broadcast regional media support (sports league radio, Bally Sports West television)
- Wellness outreach incentives in partnership with the professional sports team

Target Population:

The target population includes all Orange County residents and individuals and families that may attend or watch professional sporting events.

Outcomes and Results:

Metrics for this program are currently only available for the local mental health awareness campaign and outreach efforts conducted in partnership with Angels Baseball. The partnership with Anaheim Ducks hockey began in Winter 2022 and will be reported in future Plan Updates.

Angels Baseball Campaign Asset	Season 2021	Season 2022
Mental Health Awareness (In-stadium, external signage)	443,455,612 impressions	• 800,746,645 impressions
Digital Media (Angels website, social media)	• 168 social posts resulting in 74.4 million impressions and 867k engagements; • 200k website pageviews	• 58 total social posts resulting in 20.7 million impressions and 282k engagements; • 1.5 million angels.com impressions, with 0.11% click-through rate; • 242.7 k impressions for three angels.com 24-hour home-page takeovers, with click-through rates ranging from 0.02 – 0.03%
Broadcast Regional Media (i.e., Bally Sports West television, Angels radio)	• 8,247,997 impressions (radio only)	98,900,000 impressions (radio, television)

PEI: Outreach for Increasing Recognition of Early Signs of Mental Illness

In FY 2021-22, the first season where baseball returned to regular play following the COVID pandemic, advertising assets resulted in nearly one billion impressions, reflecting the substantial reach of OC Navigator branding through the Angels Baseball campaign.

During the 2022 regular baseball season, which is the first season where branding was focused on a single resource (OC Navigator), 16.8 thousand new and returning users visited OCNavigator.org and viewed 365.5 thousand resource pages on the OC Navigator platform.

Nearly twice as many users visited the OC Navigator platform during Angels Baseball home games compared to away games and collectively viewed more than twice the number of pages. This demonstrates the added value of in-person outreach and in-stadium signage on boosting website visits compared to digital and broadcast regional media alone.

16.8 thousand

Total New & Returning Users Across the Season

365.5 thousand

Total Page Views

of self-guided wellness tips and tools, and local mental health and other resources

169

Home Games

86

Away Games

Average Daily Users

4,354

Home Games

1,836

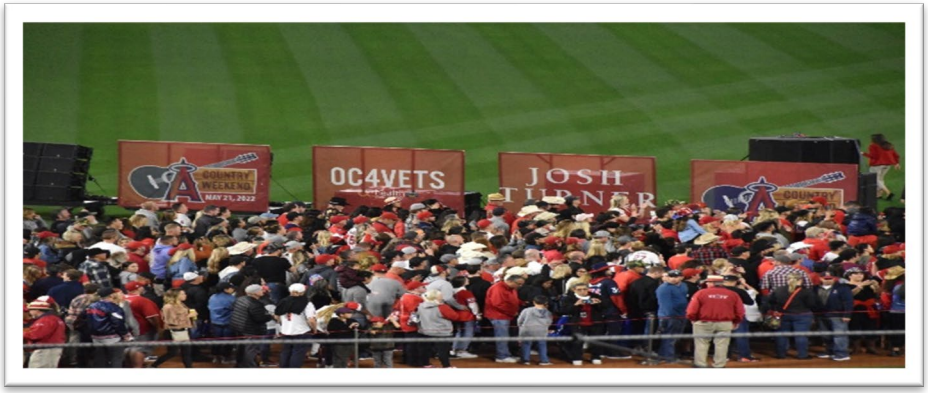
Away Games

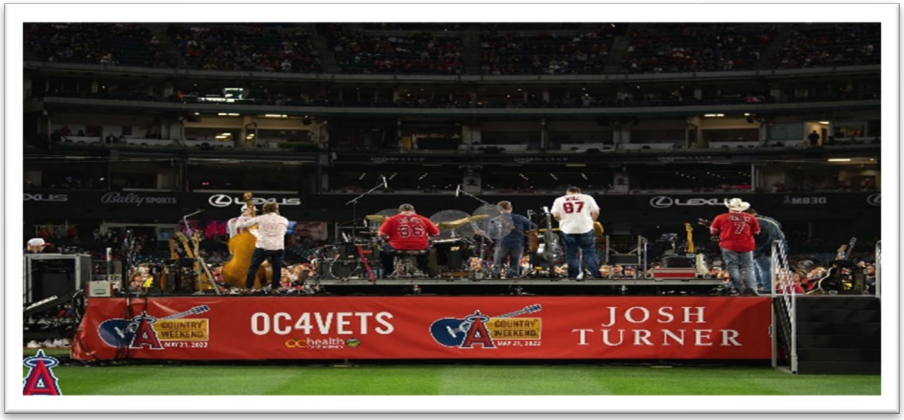
Average Daily Page Views

PEI: Outreach for Increasing Recognition of Early Signs of Mental Illness

Program Summary	
Program Serves:	All Ages
Location of Services	Community-Based; Online
Numbers of Impressions	**FY 2023-24**: 800,000,000
	FY 2024-25: 800,000,000
	FY 2025-26: 800,000,000
Annual Budget	**FY 2023-24**: $6,007,216
	FY 2024-25: $6,647,523
	FY 2025-26: $2,127,291
Services Offered	Awareness Building
	Educational Outreach
	Education

Finally, over 46,000 fans were reached during the 2021 season and nearly 300,000 fans during the 2022 season through various in-person outreach activities. This large jump between seasons is because the 2021 season was shortened and had reduced fan attendance and fewer in-person events compared to the 2022 season.





May 21st Josh Turner Post-Game Concert in support of Veteran Mental Health

PEI: Stigma and Discrimination Reduction

Program: Mental Health Community Education Events for Reducing Stigma and Discrimination

Overview of the Program:

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. Examples of events that have received funding include art workshops and exhibits, plays, conferences, multi-cultural musical and dance performances, and other related activities.

Program goal(s) and intended outcome(s):

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 participant's creative energy, encouraging their self-expression to reduce feelings of self-stigma, shame and/or isolation, and building connections with the larger community through interactive events open to all.

Description of Services:

The program hosts events that are open to all Orange County residents and are sensitive and responsive to participant's 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.

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.

PEI: Stigma and Discrimination Reduction

Program Summary	
Program Serves	Children
	TAY (16-25)
	Adults (26-59)
	Older Adults
Location of Services	Virtual, Community-Based
Numbers of individuals to be Served	**FY 2023-24**: N/A *Each year the number and type of events change
	FY 2024-25: N/A *Each year the number and type of events change
	FY 2025-26: N/A *Each year the number and type of events change
Annual Budget	**FY 2023-24**: $1,000,000
	FY 2024-25: $1,000,000
	FY 2025-26: $1,000,000
Avg. Est. Cost per Person	N/A
Services Offered	Community Outreach
	Educational Workshops
	Events, Development of Materials
	Peer Support

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.

Target Population:

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.

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARTERISTIC FOR FY 2023-24					
Age	%	Gender	%	Race/Ethnicity	%
0-15	8%	Female	76%	Latino/Hispanic	49%
16-25	20%	Male	23%	White	34%
26-59	67%	Other	1%	Asian/PI	10%
60+	5%			Black	4%
				Native American	1%
				Other	2%

PEI: Stigma and Discrimination Reduction

Outcomes and Results:

In line with this program's goals, most participants provided feedback following an event hosted by various providers and consistently supported positive statements about mental health and people living with mental health conditions. Few agreed with a stigmatizing statement.

Challenges/solutions:

The challenges encountered by the program in FY 2021-2022 were primarily related to staffing issues resulting from staff illness and attrition. In order to ensure that services were effectively provided, the programs experiencing these barriers were able to adjust the timelines for their educational events to allow the staff sufficient time to plan, coordinate and complete the events. An additional challenge faced by the programs was community member hesitance to attend in-person events. In order to ensure that the events were available to everyone, the programs provided a combination of virtual and in-person events and activities. The facilitation of mental health education events both virtually and in-person enhanced the reach of services and helped to ensure that the stigma reduction services were available to the community in a manner that felt safe and allowed for active engagement in activities.

Results			
Questions	FY19/20 Virtual & In-Person	FY20/21 Virtual	FY21/22 Virtual & In-Person
I would be willing to talk about mental health with people I meet.	91%	87%	81%
I learned how to treat people who are living with a mental illness.	92%	84%	79%
I would avoid people who are living with a mental illness.	23%	14%	27%
I learned how to find help for people living with a mental illness.	83%	84%	76%
I believe people living with a mental illness can have similar problems as I do.	84%	84%	80%
I believe anyone can have a mental illness at some point in their lives.	92%	90%	88%
I am willing to talk with someone about my mental health.	88%	87%	84%
	n= 2,488 n=1,643 surveys	n= 1,858 n=1,167 surveys	n= 1,055 n=753 surveys

PEI: Prevention

Program: Prevention Services and Support for Youth

Overview of the Program:

The Prevention Services and Supports for Youth program is the result of a consolidation of two previously approved Prevention Category programs: School-Based Behavioral Health Intervention and Support Services and School-Based Gang Prevention Services. These two prevention programs have been combined to streamline programming and service delivery. The Early Intervention portion of the School-Based Behavioral Health Intervention and Support program will continue to be reported under the Early Intervention Program Category.

The primary goal of these new services is to strengthen the coping skills, pro-social behaviors, personal empowerment, and resilience of youth to prevent and address distress and high-risk behaviors. This shall include specialized group education services to address a spectrum of risk factors that may impact youth, including stress, trauma, exposure to violence/bullying, and substance use and education and supports for strengthening family relationships, involving the youth, their caregivers and siblings of the youth as appropriate.

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC FOR FY 2023-24 THROUGH FY 2025-26					
Age	**%**	**Gender**	**%**	**Race/Ethnicity**	**%**
0-15	95	Female	55	African American/Black	2
16-25	5	Male	45	American Indian/Alaskan Native	4
26-59	0	Transgender	-	Asian/Pacific Islander	9
60+	0	Genderqueer	-	Caucasian/White	11
		Questioning or Unsure	-	Latino/Hispanic	74
		Another		Middle Easter/North African	-
				Another	-

PEI: Prevention

Program goal(s) and intended outcome(s):

The overall goals of the new Prevention Services and Support for Youth Program are:

- On average, program participants will show improvement in family functioning and well-being.
- On average, program participants will show increases in physical, mental and social health.
- On average, program participants will strengthen coping skills in themselves and their families.
- On average, program participants will show increases in self-concept, life skills and positive decision making.

Description of Services:

The program's design will utilize evidence-based, promising, and community defined practices as relevant to providing direct services to youth and families. The program model will provide services that will positively impact youth attitudes and behaviors and will ensure fidelity. Services may include but are not limited to: 1. Group educational services and activities for strengthening coping skills, pro-social behaviors, personal empowerment, and resiliency for vulnerable youth. 2. Family intervention(s) for vulnerable youth to reduce multiple risk factors such as those for alcohol and drug use, mental health, and maladaptive behaviors through parent and youth life skill building activities. 3. Assessment, case management, parent education, and referral(s) and linkages to community resources when appropriate. Outreach to the target population and promotion of these services are key to ensure services are provided throughout Orange County.

PEI: Prevention

Program Summary	
Program Serves:	Children (0-15)
	TAY (16-25)
Location of Services	Virtual, Community-Based
Numbers of individuals to be Served	**FY 2023-24**: 4,859
	FY 2024-25: 5,345
	FY 2025-26: 5,345
Annual Budget	**FY 2023-24**: $4,200,000
	FY 2024-25: $4,200,000
	FY 2025-26: $4,200,000
Avg. Est. Cost per Person	$810.34
Services Offered	Case Management
	Group Education
	Development of Materials
	Peer Support

Target Population:

Prevention Services and Supports for Youth shall be provided to youth ages 8-18 and their families in Orange County that are open to services with the highest need and risk factors as indicated by behavioral issues, substance use, challenging behaviors, or other signs of being at risk.

Outcomes and Results:

The program will be implemented on July 1, 2023. Outcomes will be reported in future Plan Updates.

Challenges/solutions:

The program will be implemented on July 1, 2023. Challenges/solutions will be reported in future Plan Updates.

PEI: Prevention

Program: Prevention Services and Support for Families

Overview of the Program:

The Prevention Services and Supports for Families is a comprehensive new programmatic approach that provides a milieu of prevention services designed to be delivered in a culturally and linguistically congruent manner to diverse county residents. This program includes the consolidation of three existing/approved programs from the previous plan, along with an expansion of services for identified additional priority populations. The three previous programs that were combined into one program include the School Readiness program, Parent Education Services, and Family Support Services.

Program goal(s) and intended outcome(s):

The primary goals of the program are to establish a unified family support system for families and caretakers of those who are challenged with behavioral health conditions and other stressful conditions putting the family at risk, to foster effective parenting skills and family communication; ensure healthy identities in children; child growth and social-emotional development; and self-esteem.

Description of Services:

Program services include advocacy and ongoing support to families by developing a network of contacts and mutual support including a broad range of personalized and peer to peer social development services. Families will be educated about behavior health and encouraged to improve parenting skills and familial communications to help prevent the development of behavioral health conditions. They will improve proactive parenting skills that enhance well-being in children, strengthen relationships with children, increase family cooperation, encourage healthy identities and further develop problem solving skills. Services include general screening and assessment for the early identification of emotional and behavioral conditions in young children birth to age 8. Services include case management and referral/linkages to other community services and supports.

All services utilize evidence-based practices or curricula and are provided in a culturally and linguistically appropriate manner for the targeted populations.

PEI: Prevention

Program Summary	
Program Serves:	Children
	TAY (16-25)
	Adults (26-59)
	Older Adults
Location of Services	Community Based, Field Based
Numbers of individuals to be Served	**FY 2023-24**: 3,737
	FY 2024-25: 3,924
	FY 2025-26: 3,924
Annual Budget	**FY 2023-24**: $3,900,000
	FY 2024-25: $3,900,000
	FY 2025-26: $3,900,000
Avg. Est. Cost per Person	$726.90
Services Offered	Prevention Education
	Case Management
	Referral and Linkage

Services are provided county wide and open to all residents with a focus on children and families who are underserved, isolated, difficult to engage, and at-greater risk, including but not limited to, parents of children with disabilities (cognitive, emotional, and/or physical), foster/adoptive parents, single parents, individuals with partners or a loved one with a history of substance use disorder or co-occurring disorders, families experiencing homelessness, incarceration (including parents who are themselves in Juvenile Hall or parents with children in Juvenile Hall), reunification, military families, LGBTQI families and families who are victims of domestic/school violence or other trauma, monolingual speaking communities, new immigrants, and refugees.

Target Population:

Orange County families and individuals in families challenged with behavioral health conditions or other stressful conditions placing the family at risk. Parents, grandparents, relatives, guardians or caregivers who have the responsibility for caring for children and youth birth to eighteen years of age, who are vulnerable to behavioral health problems. Families living with children birth to age 8 to identify children exhibiting challenging behaviors and early signs of emotional disturbance, putting them at increased risk of developing mental illness. Of special interest are those children and families that are underserved, isolated or difficult to engage due to cultural, linguistic, or other factors.

PEI: Prevention

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC FOR FY2023-24					
Age	**%**	**Gender**	**%**	**Race/Ethnicity**	**%**
0-15	13%	Female	66%	African American/Black	4%
16-25	8%	Male	34%	American Indian/Alaskan Native	3%
26-59	75%	Transgender	0%	Asian/PI	19%
60+	4%	Genderqueer	0%	Caucasian/White	24%
		Questioning or Unsure	0%	Latino/Hispanic	51%
		Another	0%	Middle Easter/North African	0%
				Another	0%

Outcomes and Results:

The program is new and will report outcomes in future Plan Updates.

Challenges/solutions:

The program is new and will report challenges and solutions in future Plan Updates.

PEI: Suicide Prevention

Program: Suicide Prevention Services

Overview of the Program:

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. This program is now supported by a new Office of Suicide Prevention, which was established in the HCA's Mental Health and Recovery Services area upon the direction of the Orange County Board of Supervisors in 2021.

Suicide Prevention and Support services comprise a critical system of support for individuals who are identified to be at their most vulnerable point.

Suicide Prevention and Support Services includes a continuum of services that includes a toll-free, confidential 24/7 suicide prevention Hotline Service which is also the 988 crisis lifeline, to any Orange County resident seeking crisis support for themselves or someone they know, supportive prevention, intervention and postvention services to survivors, a direct linkage of individuals, prior to being discharged from a healthcare setting to step-down prevention, therapeutic intervention, postvention services and post discharge two-month follow-up care by a therapist and up to 12 months of extended follow-up care. Finally, services also include community training and outreach. The program currently offers a range of training that uses 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 conducted in person. In lieu of ASSIST trainings, the provider offered virtual trainings for clinicians and the community at large. Additionally, the provider also offers a six-hour training with continuing education units (CEU's) on suicide assessment, prevention and intervention.

PEI: Suicide Prevention

Program Goal(s) and Intended Outcome(s):

The goal of the Suicide Prevention and Support services is to help assess the risk of and prevent crises; prevent and reduce suicidal behavior and its impact; provide bereavement services and support to the emotional needs of those who have their lives significantly affected by suicidal behavior; and provide a network of professional and peer support available round-the-clock for those at-risk of suicide.

Crisis Prevention Line (Hotline)

On average, callers rating themselves at high or imminent risk will show a decrease in their self-rated intent by the end of the call.

On average, callers rating themselves at medium risk will show a decrease in their self-rated intent by the end of the call.

Survivor Support Services

On average, Participants will increase their ability to manage grief based on the SSS survey

On average, Participants will show a reduction in depression based on the PHQ-9 scores.

On average, Participants will show a decrease in depression severity.

PEI: Suicide Prevention

Description of Services:

Crisis Hotline Telephone/Chat 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.

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.

PEI: Suicide Prevention

Crisis Prevention Line (Hotline) Services include immediate telephone support, referral and follow-up 24-hour telephone services are available in English and Spanish. Korean services are available eight hours per day during peak evening hours between 4:30 p.m. - 12:30 a.m. Other language coverage is available through volunteers or translation services via the Lifeline Language Line, which has the capacity to translate over 240 languages, including Vietnamese**.** The Survivor Support Services are intervention and postvention services including crisis assessment and support, individual and group therapy, emergency interventions and bereavement support to any Orange County resident who may have either experienced the loss of someone to suicide or may have attempted suicide. Survivors After Suicide - Support Groups for all eligible Participants affected by suicide.

After Participants finish the Support Groups, they can attend any of the monthly Drop-In Support Groups - designed to help individuals to continue the healing process in the months and years following their losses. Individual Counseling for Survivors after Suicide for individuals and a short-term counseling to a family who are coping with the loss of someone to suicide to improve their functioning. Survivors of Suicide Attempts (SOSA) Support Groups – designed to support the recovery for people who have survived a suicide attempt and provide them with skills for coping with deep hurt. Trainings in the community designed to address prevention for family members, clinicians, first responders, and medical providers. Various types of OUTREACH activities are conducted to educate the community about suicide; signs and symptoms and inform them about available resources. The suicide prevention step-down care services are designed for individuals who are discharged from higher level treatment settings including emergency departments, inpatient/outpatient programs, inpatient behavioral health units or other higher level of care services to case managers at Didi Hirsch's Survivor Support Services via a dedicated referral line. Individuals who are either assessed for suicidal ideation or at high risk for suicide, or who may have attempted a suicide are linked prior to being discharged, to Didi Hirsch's step-down therapeutic intervention, prevention and postvention services. Additionally, upon discharge from Didi Hirsch, two-month follow-up care by a therapist and up to 12 months of extended follow-up care is also available.

PEI: Suicide Prevention

Program Summary	
Program Targets	All age groups
Location of Services	In person Community locations Online
Numbers of Individuals to be Served	**FY 2023-24**: 35,500
	FY 2024-25: 35,500
	FY 2025-26: 35,500
Annual Budget	**FY 2023-24**: $4,700,000
	FY 2024-25: $4,700,000
	FY 2025-26: $4,700,000
Avg. Est. Cost per Person	$132 per call
Services Offered	Crisis Counseling

Target Population:

The services are available to all OC residents, regardless of their background, who are in crisis, experiencing suicidal thoughts or may have attempted suicide or who is concerned about a loved one who may have attempted suicide or lost a family member, friend, or loved one to suicide.

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARTERISTIC FOR FY 2023-24					
Age	**%**	**Gender**	**%**	**Race/Ethnicity**	**%**
0-15	9%	Female	47%	White	44%
16-25	38%	Male	49%	Hispanic/Latino	27%
26-59	47%	Other	3%	Asian	15%
60+	7%			Black	5%
				Native American	1%
				Native Hawaiian/PI	0%
				Other	8%

PEI: Suicide Prevention

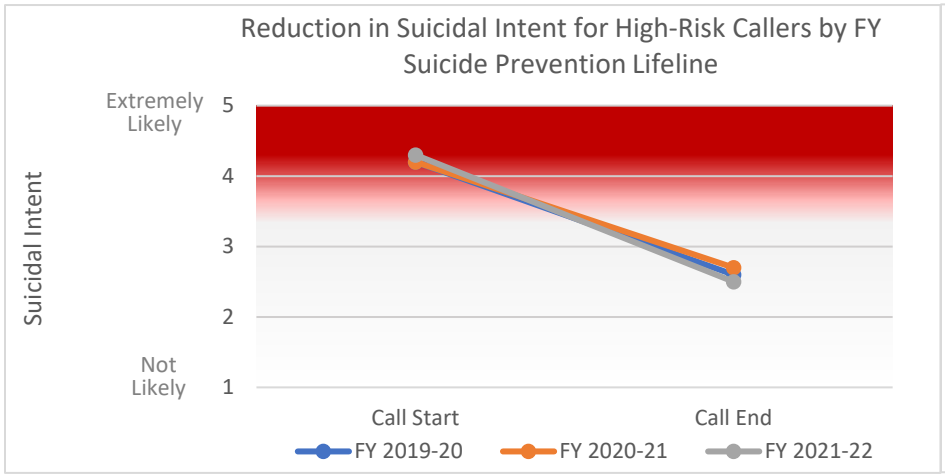
Outcomes and Results:

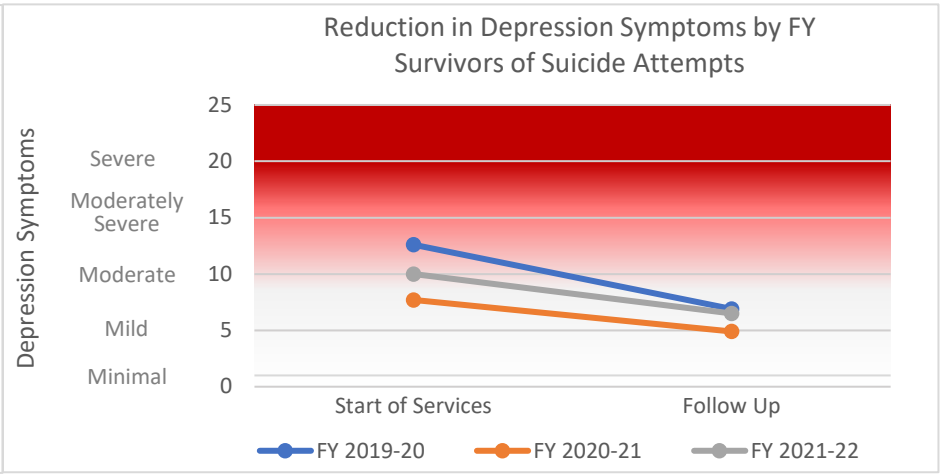
Crisis Prevention Line (Hotline)

The number of calls to the Hotline have steadily been trending up, reflecting the successful outreach efforts and awareness of the Hotline's services.

HOTLINE	FY 2019-20	FY 2020-21	FY 2021-22
Unique Callers	9,886	9,771	10,726
Total Calls	13,613	14,092	14,832

Crisis Prevention Line (Hotline) staff has been effective and consistent in de-escalating the likelihood of a caller acting upon their suicidal thoughts and feelings suicidal among those who begin the call with a medium-high to high level of intent.



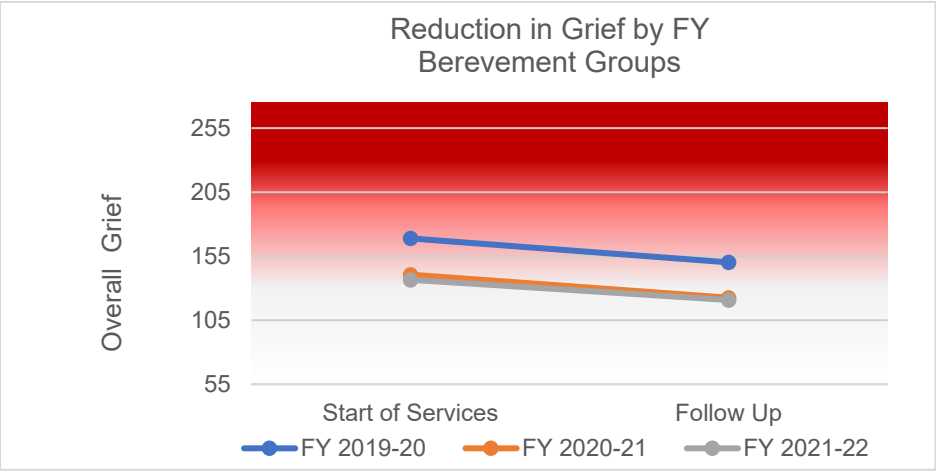


PEI: Suicide Prevention

Survivor Support Services

Survivors of suicide attempts continued to report reductions in the severity of their depression symptoms after enrolling in specialized services.

Individuals who experienced the loss of a loved one to suicide continued to report moderate decreases in their overall grief after attending specialized bereavement support groups.



The program provides referrals to individuals that need continuing services or higher level of care. Linkage rates fell in FY 2021-22.

Hotline Referral & Linkage Rates			
	# Referrals	# Linkages	% Linked
FY 2019-20	526	32	6%
FY 2020-21	488	35	7%
FY 2021-22	582	0	0%

PEI: Suicide Prevention

Challenges/Solutions:

The challenges are mostly associated with mental health stigma in the community, and especially in ethnic communities. Thus, there could be difficulties with obtaining referrals for suicide bereavement counseling and support groups due to the cultural barriers and stigma. Mental Health stigma, especially in ethnic communities, makes it difficult to heal. Another challenge is the ability of the program to hire qualified clinical staff.

Community Suicide Prevention Initiative (CSPI)

With upward trending rates of suicides in Orange County during 2016-18, HCA and various partners including OC hospitals, Saddle Back Church, and many community members came together to plan for a coordinated effort to address this issue. An initial community effort included individuals getting together informally at various community spaces such as sandwich and coffee shops throughout the county to discuss actionable ways to address suicides and extend support to loss survivors.

On March 12, 2019, the Orange County Board of Supervisors allocated $600,000 in funding to create a coordinated, countywide effort to build community awareness and drive system change to reverse this trend and reduce suicides in Orange County. In July 2019, the Community Suicide Prevention Initiative (CSPI) was formally established to achieve the following mission: "*The Orange County Community Suicide Prevention Initiative aims to prevent suicide by promoting hope and purposeful life in the community, especially among survivors, those at risk and their loved ones".*

A CSPI Leadership Group was established in May 2019 and is comprised of representatives from OCHCA, public and private organizations who are part of the Be Well movement as well as community stakeholders to provide strategic guidance to CSPI planning activities. In addition, there is a CSPI Community Forum that is comprised of a group of committed volunteers from the community who regularly convene to inform the efforts of CSPI, engage in awareness building, and serve as advisors to this community-driven initiative.

The CSPI has two elected co-chairs. The Leadership Group, with guidance from the CSPI Community members, established a project Charter to frame the need in Orange County and to gain consensus on the initiative's aim, goals and objectives as well as established a Framework for supporting community driven suicide prevention based on available suicide death data from Orange County.

PEI: Suicide Prevention

Program Goal(s) and Intended Outcome(s):

The goals of CSPI are to increase awareness about how to prevent suicide; increase connectedness between individuals, families, and communities; increase detection of individuals in need; increase access to mental health care and reduce access to lethal means.

Description of Services:

Organizational members have well developed efforts at their organizations related to the CSPI mission and are committed to a collaborative, coordinated approach to preventing suicides and suicide attempts. Members meet regularly to guide the development of a coordinated approach to address suicides in the target priority populations identified below. For example, all the prevention services related to the identified target populations outlined in this Plan were planned and implemented with intentionality and based on the input of the community members. Specifically see TAY Mental Health Services K-12 Mental Health services, Mental Health Promotion for Diverse Communities, and Early Intervention for Older Adults. These services include a variety of mental health promotion activities geared towards promoting mental health wellness and stigma reduction by raising awareness, providing education through outreach and interactive activities. The services focus on building emotional wellness and resilience and provide coping tools for addressing mental health concerns. They also encourage help seeking behaviors.

Target Population:

A Community-Driven Framework for suicide prevention efforts identified three priority populations in Orange County that are at risk of suicide and suicide attempts: youth and young adults, men in their middle years and older adults.

PEI: Suicide Prevention

Outcomes and Results:

Many different projects and activities were successfully organized in the community. See attached Calendar of events. A CSPI conference, titled “Be Well Together: Community Action for Suicide Prevention” the County’s first two-day conference focusing on suicide prevention, was held virtually in October 2021 as a collaborative effort. It featured keynote speakers on Day One and panel discussions on Day Two. The first Panel featured an engaging panel for youth, young adults, and those who support them. Panelists included youth with lived experience, LGBT+ youth, and suicide survivors. Discussions focused on how to change the narrative and stigma surrounding suicide prevention, how to assist peers and when to ask for help and strategies to creating future solutions for youth mental health and well- being. The second day highlighted the Older Adult and Caregiver population. Relevant statistics, prevention efforts, protective factors, and resources were shared.

A panelist discussion consisting of experts in the field including a gero-psychiatrist, a social worker from the Laguna Woods senior center and a professional from the Alzheimer’s association focused on promoting hope and providing new tools to enhance seniors’ quality of life.

A community “Out of the Darkness Orange County California Walk” was held at Saddleback Church and allowed community members to meet virtually or in their own neighborhoods. The theme of the walk was “A Time of Healing and Awareness”.

Challenges/solutions:

Hosting virtual sessions was an initial success as member participation at the CSPI and the Community Forum meetings saw a steady increase. However, “Zoom Fatigue” was identified as a challenge and participation in meetings fluctuated. One solution that is being considered is to host hybrid meetings with in-person and virtual meetings

PEI: Access & Linkage to Treatment

Program: OC LINKS

Overview of the Program:

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

Program goal(s) and intended outcome(s):

Serving as an entry point for the HCA MHRS System of Care, OC Links provides telephone and internet, chat-based support for any Orange County resident seeking HCA Behavioral Health services. OC Links operates 24 hours a day, 7 days a week, year-round. Callers receive assistance with navigating behavioral health 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 MHRS resources on the website at any time (OC Navigator).

Program Summary	
Program Serves:	Children
	TAY (16-25)
	Adults (26-59)
	Older Adults
Location of Services	Virtual, Telephone, Online (Chat)
Estimated Number of Calls	**FY 2023-24**: 50,000
	FY 2024-25: 50,000
	FY 2025-26: 50,000
Annual Budget	**FY 2023-24**: $5,380,000
	FY 2024-25: $5,380,000
	FY 2025-26: $5,380,000
Avg. Est. Cost per Person	$108 per call
Services Offered	Crisis Services
	Referral and Linkage

PEI: Access & Linkage to Treatment

Description of Services:

During a call or live chat, trained navigators provide screening, information, and referral and linkage directly to MHRS 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 linked to a service or offered resources, the navigator offers a follow-up call within the next 1-2 days to ensure a linkage has occurred. Beginning January 2021, when OC Links began operating 24/7, the staff also absorbed phone triage and dispatch duties for MHRS' mobile crisis assessment teams and OC Outreach and Engagement. FY 2021- 22 also represents a full year of OC Links services being provided 24/7, compared to the previous fiscal year.

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). Starting in FY 22-23, OC Links no longer facilitates outreach activities or events. This service transitioned to other programs.

Target Population:

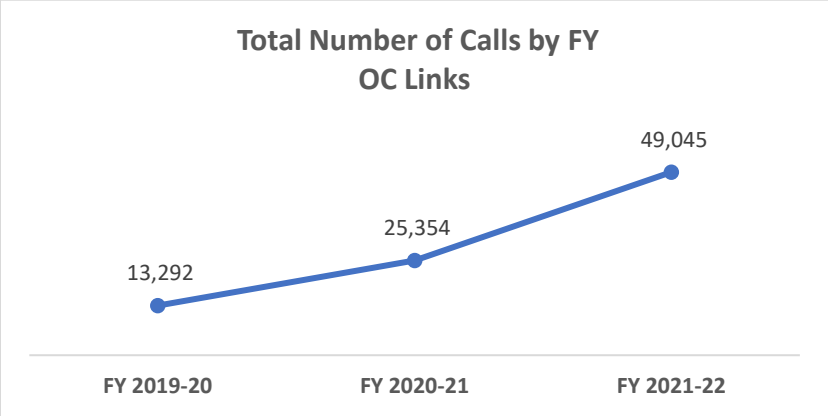
OC LINKS is available to all age groups and populations.

ESTIMATED PROPORTION OF CALLERS TO BE SERVED BY DEMOGRAPHIC CHARTERISTIC FOR FY 2023-24					
Age	%	Gender	%	Race/Ethnicity	%
0-15	3%	Female	65%	White	45%
16-25	12%	Male	35%	Hispanic/Latino	40%
26-59	67%	Other	< 1%	Asian	13%
60+	18%			Black	2%
				Native American	<1%
				Native Hawaiian/PI	<1%
				Other	<1%

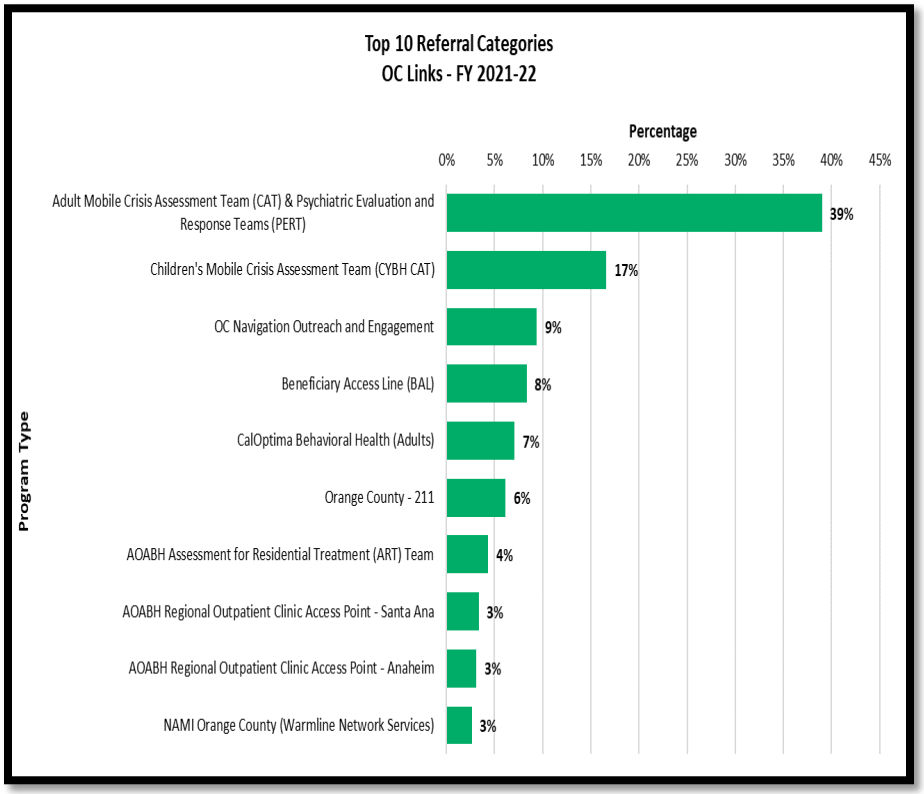
PEI: Access & Linkage to Treatment

Outcomes and Results:

Call Volume. As a result of the expanded hours and duties of the OC Links staff call volume has nearly doubled each of the past two years:



Referrals: Consistent with the expanded hours of operation, the total number of referrals made by OC Links in FY 2021-22 increased by 163% compared to FY 2020-21 (from 16,077 to 42,346), with the number of referrals averaging about 3,529 per month. The main programs to which OC Links referred callers was to the Orange County children's and adults' mobile crisis assessment teams (CAT) or Psychiatric Evaluation and Response Teams and OC Outreach and Engagement services, reflecting the fact that triage and dispatch duties for these programs had fully transitioned to OC Links in FY 2021-22. The percent of referrals that resulted in warm handoffs will be reported in future Plan updates.



PEI: Access & Linkage to Treatment

Of the 28,000 callers who agreed to rate their satisfaction with OC Links' staff and services, 99% agreed or strongly agreed that they received the help they needed, would use what they learned to access behavioral health resources available to them, and would recommend OC Links to others.

	Top Three Referral Categories by FY	# of Referrals
FY 19-20	Adult and Older Adult Behavioral Health Services (AOABH)	4,218
	Referrals Outside of HCA System	3,340
	Prevention & Early Intervention (P&I)	1,496
FY 20-21	Adult and Older Adult Behavioral Health Services (AOABH)	13,434
	Referrals Outside of HCA System	5,473
	Children & Youth Behavioral Health (CYBH)	3,274
FY 21-22	Adult Mobile Crisis Assessment Team (CAT) & Psychiatric Evaluation and Response Teams (PERT)	14,906
	Children's Mobile Crisis Assessment Team (CYBH CAT)	6,343
	OC Navigation Outreach and Engagement	3,578

Challenges/solutions:

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. HCA will be launching a new media campaign called "Where Wellness Begins," to get the word out there about what OC Links has to offer.

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 MHRS. 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 January 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 specific 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.

PEI: Access & Linkage to Treatment

Program: OC Outreach and Engagement (O&E) for Homeless

Overview of the Program:

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

Program goal(s) and intended outcome(s):

To promote awareness of, and increase referrals to its services, OC O&E for Homeless 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.).

Program Summary	
Program Serves:	Children
	TAY (16-25)
	Adults (26-59)
	Older Adults
Location of Services	Field; Community-Based
Numbers of Contacts	**FY 2023-24**: 30,000 contacts
	FY 2024-25: 30,000 contacts
	FY 2025-26: 30,000 contacts
Annual Budget	**FY 2023-24**: $8,500,000
	FY 2024-25: $8,500,000
	FY 2025-26: $8,500,000
Avg. Est. Cost per Contact	$ 283
Services Offered	Community Outreach & Engagement
	Psychoeducation
	Access and Linkage

PEI: Access & Linkage to Treatment

Description of Services:

When a person is referred to the program, staff screens each individual in the community or over the phone (via OC Links) 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).

Target Population:

Those who are homeless and who have had difficulty engaging in mental health, housing, and other supportive services on their own.

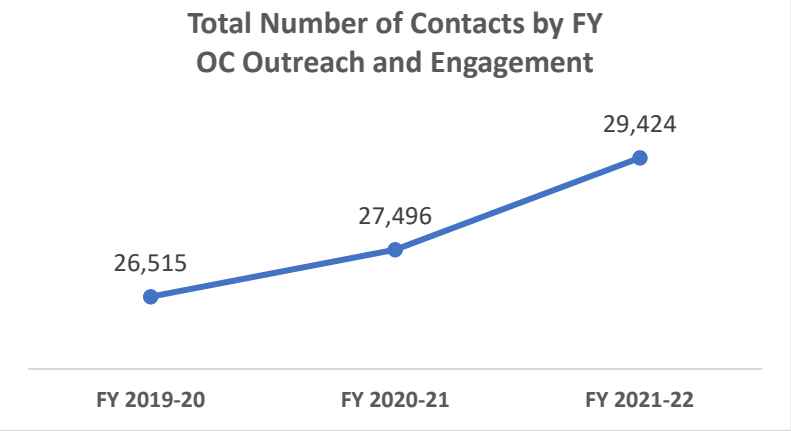
ESTIMATED PROPORTION OF CALLERS TO BE SERVED BY DEMOGRAPHIC CHARTERISTIC FOR FY 2023-24

Age	%	Gender	%	Race/Ethnicity	%
0-15	<1%	Female	31%	White	44$
16-25	2%	Male	69%	Hispanic/Latino	30%
26-59	73%	Other	<1%	Asian	19%
60+	25%			Black	<1%
				Native American	<1%
				Native Hawaiian/PI	0%
				Other	<1%

PEI: Access & Linkage to Treatment

Outcomes and Results:

Over the last three fiscal years, O&E staff increased the number of contacts with individuals experiencing unsheltered homelessness by 12.5%:



During FY 2021-22, OC O&E made 9,708 referrals to County or Contracted programs, with 2,366 individuals linking to 3,675 services (38% linkage rate). This linkage rate is an improvement from the 13% rate achieved in FY 2020-21, demonstrating the success of OC O&E's efforts in prioritizing following up with and supporting clients in connecting to services and confirming that clients successfully attended at least one appointment.

	Top Referral Categories	Number of Referrals	Percent Linked
FY 2019-20	Recovery Support	5,748	14%
	Housing Assistance	4,476	11%
	MHRS Outpatient Programs	1,696	23%
FY 2020-21	Recovery Support	7,624	9%
	Housing Assistance	4,767	14%
	MHRS Outpatient Programs	1,713	29%
FY 2021-22	Recovery Support	4,132	30%
	Housing Assistance	2,861	45%
	MHRS Outpatient Programs	2,285	46%

PEI: Access & Linkage to Treatment

Challenges/solutions:

Lack of affordable housing continues to be a barrier, especially for individuals who are homeless. The program continues to collaborate with agencies to improve access to affordable housing opportunities in addition to serving as a Coordinated Entry Access point to assist with matching individuals to housing opportunities. To address some participant's reluctance to provide personal information or enroll in engagement ser-vices, the programs have reached out to work with trusted community agencies/ organizations. Through these partnerships, OC O&E for Homeless staff have demonstrated the ability to follow through on commitments to address participant's needs and assist 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. OC O&E for Homeless 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 river- bed engagement four years ago, the community saw the impact of OC O&E for Homeless 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 OC O&E for Homeless support for both 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.

In July 2022, the program expanded by adding additional positions to increase outreach activities throughout the county and to create regional outreach teams. The program is also in the process of expanding operating hours from 7:00 AM to 7:00 PM Monday through Friday, and 8:00 AM to 5:30 PM on Saturdays and Sundays. This expansion has redefined the program's target population to be unsheltered homeless individuals with a more whole-person focus to ensure housing, physical health, and basic needs are addressed as these areas all impact behavioral health and serve as opportunities for participant trust and engagement. Referrals for an outreach response are made through the program's triage line at 800-364-2221, and is available 24/7 through the support of OC Links.

PEI: Access & Linkage to Treatment

Program: Integrated Justice Involved Services

Overview of the Program:

Integrated Justice Involved Services is a collaboration between Mental Health Recovery Services (MHRS) and Correctional Health Services (CHS) that serve adults ages 18 and older who are living with mental illness and detained in Orange County Jails. This program is a combination of two programs which include the Jail to Community Re-Entry Program (JCRP) and a new program, the Re-Entry Adult Success Center. The Community Support and Recovery Center (CSRC) program, which was previously funded under Proposition 47 grant, transitioned to the Re-Entry Adult Success Center (RSC)

The Re-Entry Success Center (RSC) is a contracted service that provides outreach to adults 18 and older, released from custody at the County's Main Jail or Theo Lacy that are experiencing mild to moderate mental health or substance use issues. Upon their release, they have access to needed resources such as clothing, access to a phone charging station, food, hygiene kits and to the RSC itself for resources, counseling services, transportation, and housing assistance.

Program goal(s) and intended outcome(s):

The Jail to Community Re-Entry Program (JCRP) 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.

- **Service Outcomes:** In 2022 over 3,600 discharge plans were created for patients released from Orange County Jails. Approximately 49% of the discharge plans included direct referrals to external programs and 10% further included scheduled appointments upon release. For 2023 JCRP seeks to increase the total number of direct referrals and scheduled appointments by 5%.
- **Staffing:** In 2022 JCRP experienced staffing challenges with hiring and retention. A total of 8 Behavioral Health Clinicians vacated the program and only one was hired within a two-year period. For 2023 JCRP seeks to hire 5 new staff to fill 10 vacant positions.
- **Collaboration:** In 2022 JCRP built relationships and collaborated with various external partners (i.e. MHRS, county contracted and collaborative partner agencies) for the purpose of working together to link

patients to treatment after their release. For 2023 JCRP plans on strengthening its partnership with the OC probation office by improving communication between agencies for the sole purpose of helping keep patients in treatment and reducing reincarceration. JCRP will also be increasing efforts and staffing allocated to the Multi-Disciplinary Team (MTD) Care Plus collaboration focusing on “high utilizers.”

The Re-Entry Success Center (RSC) program was developed to reduction incarceration and recidivism among adults experiencing mental health and/or substance use issues is achieved by providing immediate access to treatment and supportive services. Outreach contacts are provided to a minimum of 1,500 individuals per fiscal year. Of these outreach contacts, a goal of 250 individuals will be enrolled for case management services in addition to receiving recovery support, individual counseling, housing assistance, employment assistance and transportation assistance.

Other performance outcomes for this program include the following:

• 75% of clients who require a higher level of care receive a warm handoff to HCA Mental Health and Recovery Services

• 50% of clients who need housing receive housing assistance

• 30 % of client referrals will result in confirmed linkages

• 75% of clients receiving mental health counseling services will report improvement in well-being and quality of life as indicated by the Outcome Questionnaire (OQ)

• 80% of enrolled clients will report satisfaction with service

PEI: Access & Linkage to Treatment

Program Summary	
Program Serves:	Adults (18+)
Location of Services	Other (Jail)
Numbers of individuals to be Served	**FY 2023-24**: 8,750
	FY 2024-25: 8,750
	FY 2025-26: 8,750
Annual Budget	**FY 2023-24**: $7,307,402
	FY 2024-25: $7,007,402
	FY 2025-26: $7,007,402
Avg. Est. Cost per Person	$1,080
Services Offered	Assessment
	Case Management
	Individual and Group Therapy
	Peer Supports

Description of Services:

Jail to Community Re-Entry Program (JCRP) uses a comprehensive approach for discharge planning and re-entry linkage. Services are provided to inmates who experience mental illness and are housed in the Orange County jail facilities. Discharge planning is conducted while individuals remain in custody and involve a thorough risk assessment, comprehensive individualized case management and evidence-based re-entry groups including Moral Recognition Therapy (MRT) aimed at identifying possible barriers to successful re-entry and developing tailored discharge plans.

Case management and rehabilitative 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, 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

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 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 makes direct referrals to the HCA Residential Treatment programs and assist with facilitating transitions for clients requiring residential in-treatment services.

The Re-Entry Success Center (RSC) uses a comprehensive approach to conduct in-reach, outreach and services to individuals being released from the Orange County jails that are experiencing mild to moderate mental health and substance use issues. The program utilizes In-reach Peer Navigators who will work in close collaboration with System Navigators located in the Intake and Release Center (IRC), Theo Lacy, Correctional Mental Health, and County Sheriff's Department to coordinate linkage to immediate and ongoing behavioral health services upon release from custody. The contractor is also stationed outside of the Orange County Main Jail and facilitates linkage to a range of services upon release, such as Medi-Cal enrollment and essential needs such as clothing and transportation. Connections with family and support systems such as peer support mentors is also provided. RSC enrolled clients are linked to mental health counseling, substance use counseling by certified drug and alcohol counselors, Recovery Circles, transportation, vocational and educational counseling, and housing assistance.

Short-term mental health and Substance Use counseling is provided at the RSC. Those needing a higher level of care are linked to the County's Behavioral Health System of Care. Recovery Circle groups are open to enrolled and non-enrolled individuals. This intervention uses a modified 12-Step Model that incorporates Seeking Safety trauma-informed modules to promote problem-solving, recognition of triggers, and supports community building for the individual. Housing assistance is defined as sessions that prepare the individual for housing, get needed documents for housing, provide transitional housing, and serve as an access point for the Coordinated Entry System. The program employs evidence-based models in the delivery of services including, but not limited to, the Assertive Community Treatment model, which embraces a "whatever it takes" approach to remove barriers for individuals to access the support needed to fully integrate into the community. Additionally, the program utilizes the Sanctuary Model, which is a non-hierarchical, highly participatory, "trauma-informed and evidence-supported"

operating system for human services organizations, which assists them in functioning in a humane, democratic, and socially responsible manner, thereby providing effective treatment for clients in a clinical setting. All enrolled clients are assigned a Peer Navigator upon enrollment in the RSC, who actively participates with the clinical team to work with the client in achieving established goals and to support and mentor individuals through knowledge and skills gained from their lived experiences.

Target Population:

The target population served by Jail to Community Re-Entry Program (JCRP) includes individuals incarcerated in Orange County Jails, ages 18 and older who are experiencing severe or persistent mental illness. Services provided by JCRP are only provided while the patient remains incarcerated and cease once they are released. Referrals and Linkage coordination with external partners is a crucial component for the JCRP.

The target population for the Re-Entry Success Center (RSC) program is individuals in the criminal justice system, ages 18 and older who are experiencing mild to moderate mental health and/or substance use issues. It is important to note that services being provided outside of the Main Jail are available to anyone who needs them. Once it is identified that they meet criteria for the RSC, they can be transported to the RSC where the provision of more in-depth services will be provided.

Outcomes and Results:

Beginning January 2020, Jail to Community Re-Entry Program (JCRP) established a process for measuring referral and linkage outcomes. Due to staffing challenges and public health restrictions related to the pandemic, JCRP had to adjust how it handled referral and linkage services this year. Information on the number of individuals received discharge planning services while incarcerated in an Orange County jails and total number of community-based referrals provided by the JCRP team are reported below. Individuals who were not referred either declined discharge planning services or had a previously established transition arrangement.

	Individuals Receiving Discharge Planning Services	Number of Referrals Provided
FY 2019-20	Not Operational	
FY 2020-21 (Jan-June 2021 only)	1,106	968
FY 2021-22	3,567	1,416

Efforts are underway to streamline and improve the JCRP team's ability to track confirmed linkage to services. This information will be reported in future Plan Updates as it becomes available.

The Re-Entry Success Center (RSC) is a new contract for MHSA and outcomes will be reported in future MHSA plan updates.

Challenges/solutions:

Jail to Community Re-Entry Program (JCRP): 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.

PEI: Early Intervention

Program: School-Based Mental Health Services

Overview of the Program:

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 a PEI mental health specialist to determine early onset of a mental health condition and program eligibility.

Program goal(s) and intended outcome(s):

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.

Program Summary	
Program Serves:	Children Ages 11-15
Location of Services	Field; Clinic
Numbers of individuals to be Served	**FY 2023-24**: 750
	FY 2024-25: 750
	FY 2025-26: 750
Annual Budget	**FY 2023-24**: $2,272,712
	FY 2024-25: $2,272,712
	FY 2025-26: $2,272,712
Avg. Est. Cost per Person	$3,000
Services Offered	Screening and Assessment
	Counseling
	Group Intervention
	Case Management

PEI: Early Intervention

Description of Services:

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) and Coping Cat, as well as Eye Movement Desensitization and Reprocessing (EMDR) and Trauma Focused Cognitive Behavioral Therapy.

Target Population:

Services are provided to children and youth aged 11-15 years old who may have been exposed to trauma, or who may be experiencing first symptoms of behavioral health concerns.

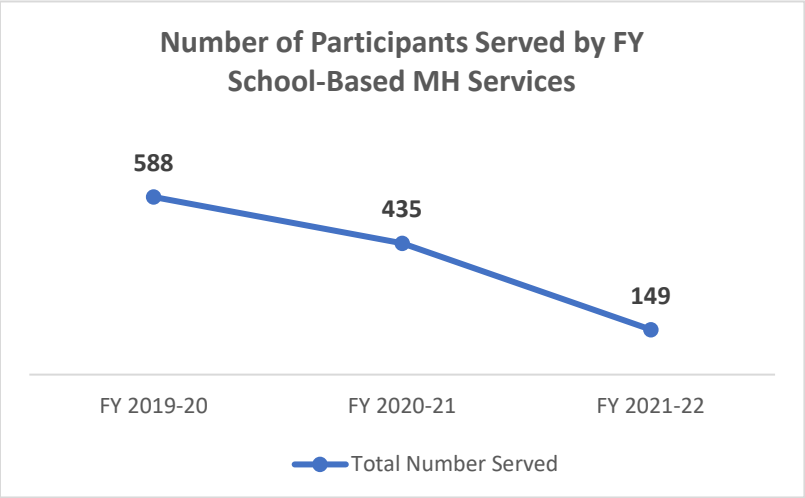
Proportion to be Served by Demographic Characteristics

Age Group	%	Gender	%	Race/Ethnicity	%
0-15	100	Female	71	African American/Black	1
16-25		Male	28	American Indian/Alaskan Native	0
26-59		Transgender	1	Asian/Pacific Islander	1
60+		Genderqueer		Caucasian/White	5
		Questioning/Unsure		Latino/Hispanic	90
		Other		Other	3

PEI: Early Intervention

Outcomes and Results:

Enrollment has been steadily dropping over the three years since the start of the COVID-19 pandemic. Funding had been given to School Districts (initially) to support with transitioning to a distance learning format, and presently the trend has been to coordinate with the Orange County Department of Education (OCDE) Regional Mental Health Coordination team to hire behavioral health providers directly. In addition, it has continued to be challenging to fill 14 vacancies. In FY 21-22, the program's capacity to provide services and supports on campus was limited to 3 School Districts (4 Middle School partners) with just 3 caseload-carrying clinicians.



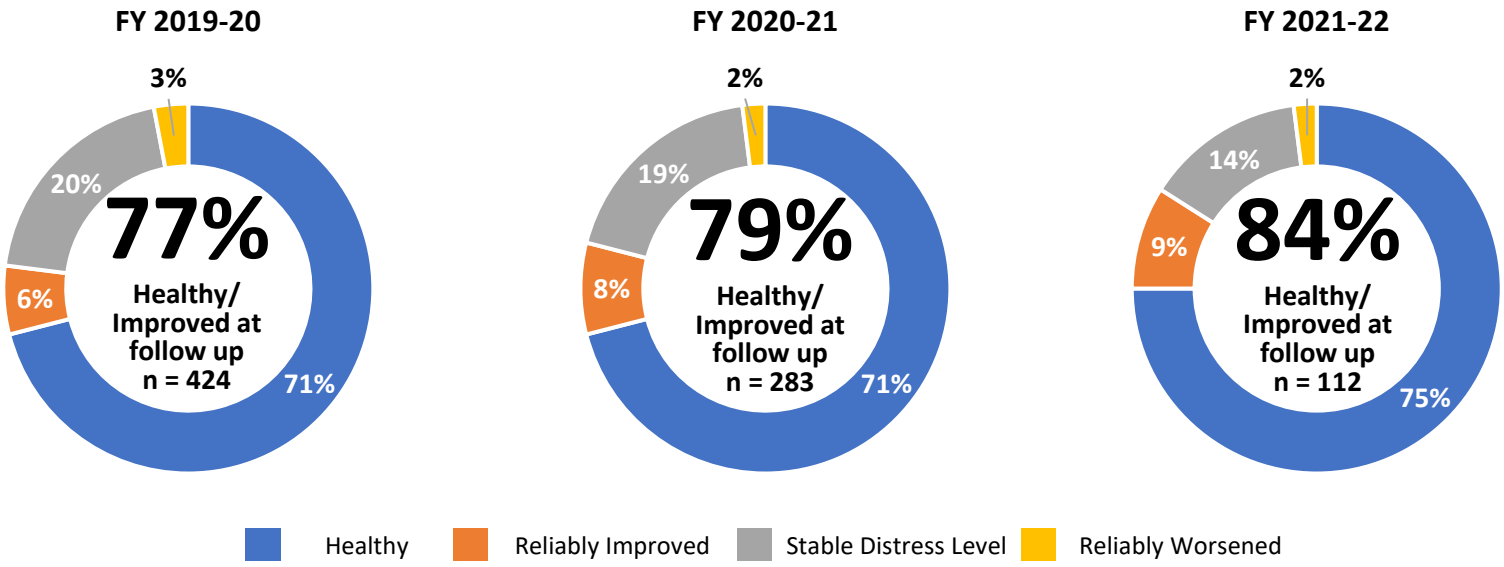
Linkage rates fell during FY 2020-21 due to service access issues related to the pandemic.

School-Based Mental Health Services Referral & Linkage Rates

	# Referrals	# Linkages	% Linked
FY 2019-20	455	110	24%
FY 2020-21	213	13	6%
FY 2021-22	108	23	21%

PEI: Early Intervention

Students receiving counseling services completed a measure of symptom distress (Outcome Questionnaire) while enrolled in services. During the past three fiscal years, the majority of students (77-84%) served reported healthy or reliably improved levels of distress after starting services. For the few who experienced worsening symptoms (2-3%), the program implemented procedures to identify those with greater needs and provided services and supports in order to access care. SBMHS provides referrals to students that need a higher level of care or have graduated to a lower level of service need.



Challenges/solutions:

In FY 2020-21, the program collaborated with the Orange County Department of Education (OCDE) Mental Health Student Services Act (MHSSA) Regional Mental Health Coordinators and participating school districts to discuss and identify service gaps of the students. As a result, the program received an increase in referrals for students from new school partners. During this period the program experienced a significant reduction in staffing due to clinical staff accepting school-based positions across Orange County school districts. To address the staffing issues recruitments efforts are actively in place to fill vacancies. Also, to meet the needs of enrolled students, the program shifted business hours allowing flexibility in serving students via a secure telehealth platform and during late afternoon hours increasing participation. As a Medi-Cal Certified program, SBMHS can look to expand staffing and increase their capacity to serve additional students as the need arises.

PEI: Early Intervention

Program: OC Center for Resiliency, Education, and Wellness (OC CREW)

Overview of the Program:

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.

Program goal(s) and intended outcome(s):

Clinicians seek to consistently observed modest reductions in the severity of participants' overall psychiatric symptoms while enrolled in services.

Program Summary	
Program Serves:	Children and TAY, Ages 12-25
Location of Services	Field; Clinic
Numbers of individuals to be Served	**FY 2023-24**: 100
	FY 2024-25: 100
	FY 2025-26: 100
Annual Budget	**FY 2023-24**: $3,738,072
	FY 2024-25: $3,738,072
	FY 2025-26: $3,738,072
Avg. Est. Cost per Person	$37,380.72
Services Offered	Screening and Assessment
	Therapy
	Case Management
	Medication Management
	Psychoeducation

PEI: Early Intervention

Description of 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 screening, assessment, individual therapy, case management, psychiatric care, psychoeducation, vocational and educational support, social wellness activities, substance use services, client and family consultation, 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.

Target Population:

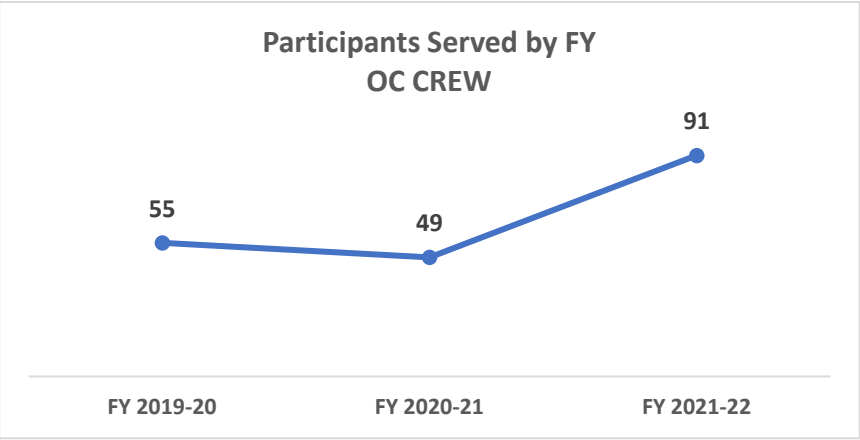
OC CREW provides services to youth ages 12 through 25 who are experiencing a first episode of psychotic illness with symptom onset within the past 24 months.

Proportion to be Served by Demographic Characteristics					
Age Group	**%**	**Gender**	**%**	**Race/Ethnicity**	**%**
0-15	30	Female	46	African American/Black	5
16-25	70	Male	52	American Indian/Alaskan Native	0
26-59		Transgender	1	Asian/Pacific Islander	21
60+		Genderqueer	1	Caucasian/White	9
		Questioning/Unsure		Latino/Hispanic	59
		Other	-	Other	5

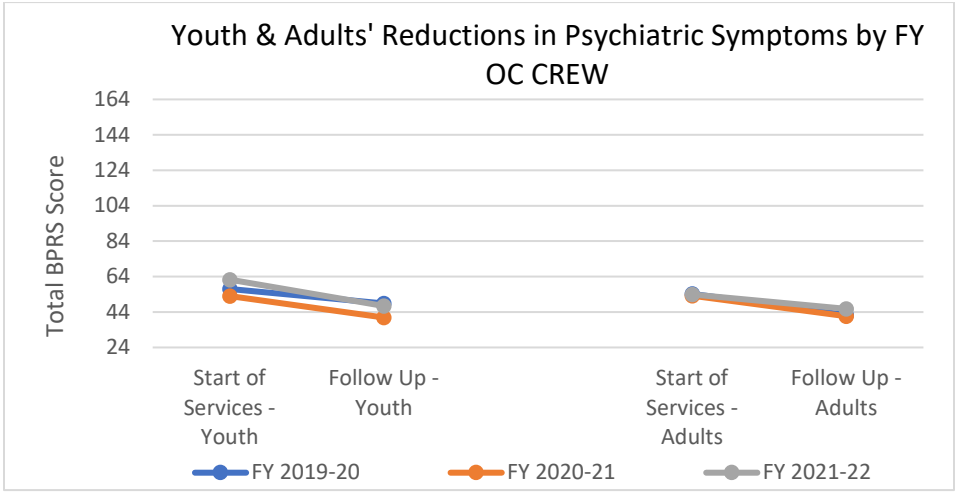
PEI: Early Intervention

Outcomes and Results:

In FY 2019-20 and FY 2020-21, OC CREW served fewer clients than usual due to challenges from the COVID-19 pandemic and multiple staffing vacancies. During this timeframe, the program also started the process of becoming a Medi-Cal Certified Site, which changed its procedures for admission. In FY 2021-22, OC CREW experienced significant growth in the number of participants served as it returned to more in-person services.



Clinicians consistently observed modest reductions in the severity of participants' overall psychiatric symptoms while enrolled in services. Across all years, average individual item scores on the Brief Psychiatric Rating Scale (BPRS) decreased from the "mild/moderate" range to the absent/minimal severity" range, suggesting that OC CREW was effective in helping to prevent first episode psychosis from becoming severe, persistent and disabling.



OC CREW provides referrals to participants that need continuing services or a higher level of care. Linkage rates remained consistent across the three years.

OC CREW Referral & Linkage Rates			
	# Referrals	**# Linkages**	**% Linked**
FY 2019-20	25	13	52%
FY 2020-21	21	14	67%
FY 2021-22	16	9	56%

Challenges/solutions:

In FY 2020-21, the program experienced additional vacant positions: Service Chief, two Behavioral Health Clinicians, and psychiatrist positions. The program is actively recruiting to fill all of these positions with some already filled. Meanwhile, clinicians in other P&I County Operated Programs with experience working with this population and currently underutilized as their programs were impacted by the COVID-19 pandemic, have been assigned to support OC CREW. At the start of the pandemic, the program transitioned from clinic- and field-based services to a largely telephone- and telehealth-based platform, with in-person appointments still available as clinically indicated. However, most enrolled youth and their family preferred in person services. Currently the team members provide mostly in-person services with telehealth an option for those individuals requesting it. OC CREW has resumed groups services, providing virtual socialization and MFG group services. The goal for the next FY is to resume community outreach to increase awareness of psychosis and the numbers of First Break of Psychosis presentations.

In FY 2019-20, the program began participating in the Early Psychosis Learning Health Care Network (EP LHCN) Innovation Project, a statewide effort to evaluate the impact of first onset psychosis programs throughout the state. With the implementation of this project, OC CREW program staff participated in discussions to identify appropriate screening and assessment tools for program participants and incorporated lessons learned from project evaluation activities to improve service delivery. In FY 2021-22, in addition to the program participating in the EPLHCN Statewide Collaboration, in partnership with University of California, Irvine, the program piloted early psychosis screening and assessment services. In FY 2022-23, these services will be expanded and integrated

into a larger effort to transform care for these youth and their families (see “Clinical High Risk for Psychosis Services: Improving Early Identification and Increasing Access to Care” under the MHSA Innovation component. Additionally, as Medi-Cal Certified program, OC CREW can look to expand staffing and increase their capacity to serve additional participants as the need arises.

Program: OC Parent Wellness Program

Overview of the Program:

The Orange County Parent Wellness Program (OCPW) offers a full spectrum of mental health services to at-risk and stressed families with children under 18 to provide specialized approaches for families with young children (aged 0-8) exhibiting concerning behaviors, families at-risk of child welfare involvement, and pregnant women and their partners affected by the pregnancy or birth of a child within the past 12 months. The program meets with families to assess needs to create individualized care plan intended to strengthen the familial unit.

Referrals sources include self-referral, hospitals, schools, behavioral health outpatient facilities, and Social Services Agency.

Program goal(s) and intended outcome(s):

The intended outcomes are to reduce the stress in families receiving services by providing early intervention services and support to address symptoms as well as strengthen the family unit.

Program Summary	
Program Serves:	All Ages
Location of Services	Field; Clinic
Numbers of individuals to be Served	**FY 2023-24**: 900
	FY 2024-25: 900
	FY 2025-26: 900
Annual Budget	**FY 2023-24**: $3,100,00
	FY 2024-25: $3,100,000
	FY 2025-26: $3,100,00
Avg. Est. Cost per Person	$3,444
Services Offered	Screening and Assessment
	Counseling
	Case Management
	Family Support

PEI: Early Intervention

Description of Services:

The 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 participating in a series of professional development and consultation groups to ensure they follow the fidelity of these models and remain current on best practices when working with trauma-exposed individuals.

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.

Target Population:

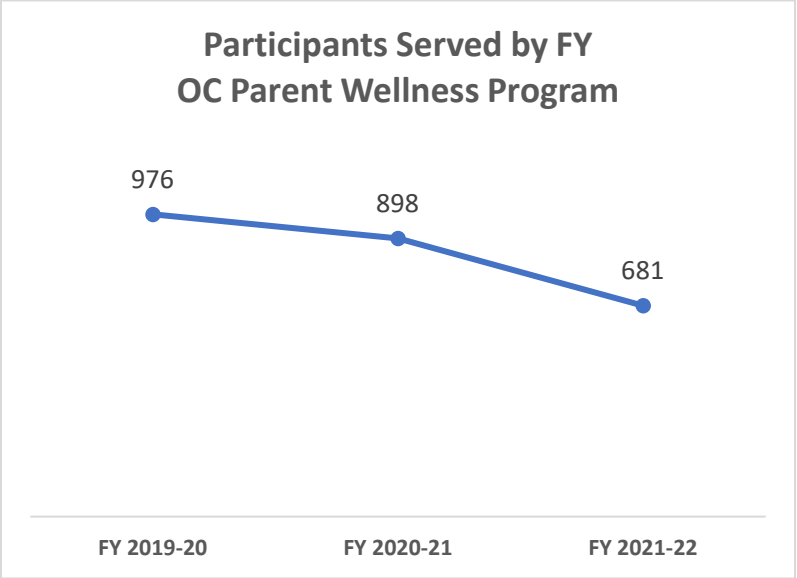
The Orange County Parent Wellness Program (OCPWP) provide services to at-risk and stressed families with children under age 18, including pregnant females and partners affected by the pregnancy or birth of a child within the past 12 months, families that have been reported to Child Protective Services (CPS) for allegations of child abuse or neglect, or families with a young child between

Proportion to be Served by Demographic Characteristics					
Age Group	**%**	**Gender**	**%**	**Race/Ethnicity**	**%**
0-15	2	Female	93	African American/Black	2
16-25	19	Male	7	American Indian/Alaskan Native	0
26-59	79	Transgender	< 1%	Asian/Pacific Islander	9
60+		Genderqueer	< 1%	Caucasian/White	15
		Questioning/Unsure		Latino/Hispanic	70
		Other		Other	4

the ages of 0 and 8 years who are exhibiting mild to moderate behavioral health symptoms that may negatively impact their readiness for school.

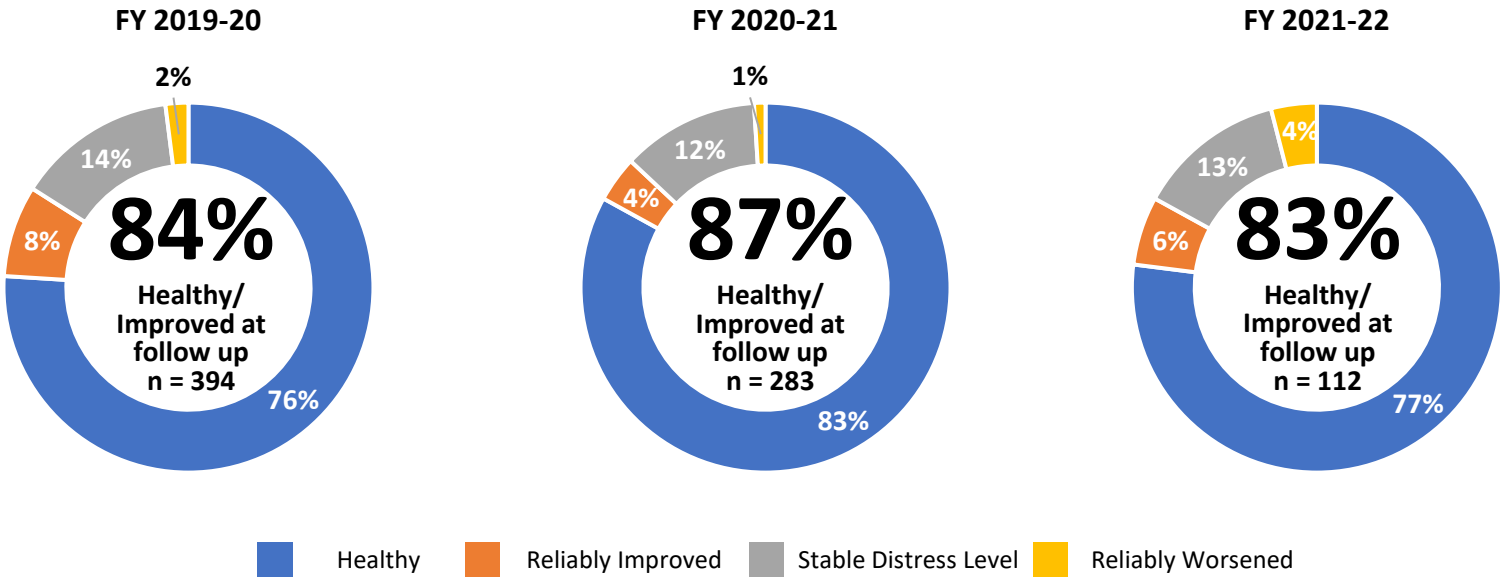
Outcomes and Results:

Over the past three fiscal years, the referral screening and scheduling of intake appointments for all early intervention programs was centralized with changes in the screening protocols. These new staff required on-going training and support to enhance their skill to engage participants for the various specialized program tracks, and the change to new system contributed to fewer enrollments during this period. Additionally, the CTT program shifted to enrolling the parent as the identified participant instead of enrolling the concerned child which led to some confusion with referring entities, and the shift to enrolling the parent as identified participant, caused some parents to decline services due to a reluctance to acknowledge they could benefit from additional support with addressing their child(ren)'s behaviors as the "focus" of treatment themselves. The COVID19 pandemic has disrupted or halted the community's likeliness to seek help. Staffing shortages resulted in temporary waiting lists and impacted the ability for program to consistently conduct outreach efforts. As a result of these evolutions, there was a noticeable decrease in referral and enrollment trend.



PEI: Early Intervention

Individual receiving counseling services completed a measure of symptom distress (Outcome Questionnaire) while enrolled in services. Across the past three fiscal years, the overwhelming majority of parents served (i.e., 83% to 87%) reported healthy or reliably improved levels of distress after starting services. For the few parents who reported a significant worsening of their distress (1% to 4%), program staff have streamlined procedures so that they may 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 with warm handoffs to a higher level of care provided by behavioral health outpatient providers or psychiatrists.



The Parent Wellness Program provides referrals to participants that need continuing services or a higher level of care. The linkage rates declined in FY 2020-21 and 2021-22 due to service closures related to the pandemic.

Parent Wellness Program Referral & Linkage Rates			
	# Referrals	**# Linkages**	**% Linked**
FY 2019-20	461	243	53%
FY 2020-21	373	94	25%
FY 2021-22	142	60	42%

Challenges/solutions:

In FY 2020-21, OC Parent Wellness Program received 1195 referrals and enrolled 909 participants into services. During this period the program experienced staffing vacancies due to the COVID-19 pandemic. As a result of the pandemic, in person services were transitioned to telehealth thus reducing travel time for staff. This allowed existing staff to increase their capacity to serve more participants and continue to meet the needs of the community during the pandemic. Additionally, staff participated in Mothers and Babies course, an evidence-based curriculum focused on both the prevention and treatment of major depression during the prenatal and postpartum periods, post training consultation groups and offered this intervention weekly. Offering the weekly group intervention provided additional support to participants in between individual sessions. The program continues to make strides toward becoming more father-inclusive by engaging expectant and new fathers.

OCPWP has continued to make adjustments in the intake counselor process and continued to provide training and support to counselors which has resulted in increased referrals and enrollments. Beyond this, OCPPW continues to maintain its strong collaborative relationships with community partners and with the increase in referrals, the program required three mental health specialists to screen program referrals for suitability. When appropriate, they immediately schedule an initial Intake session with a therapist to ensure timely access to care.

PEI: Early Intervention

Program: Community Counseling and Supportive Services (CCSS)

Overview of the Program:

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 have limited or no access to behavioral health services with face-to-face individual and collateral counseling, groups (i.e., psycho-educational, skill-building, insight oriented, etc.), clinical case management, and referral and linkage to community services.

Program goal(s) and intended outcome(s):

As an early intervention program, the intended goal of the program is to improve wellbeing, reduce symptoms of mental illness, and improve quality of life.

Program Summary	
Program Serves:	All Ages
Location of Services	Online; Clinic
Numbers of individuals to be Served	**FY 2023-24**: 700
	FY 2024-25: 700
	FY 2025-26: 700
Annual Budget	**FY 2023-24**: $2,536,136
	FY 2024-25: $2,536,136
	FY 2025-26: $2,536,136
Avg. Est. Cost per Person	$3,623
Services Offered	Counseling
	Case Management
	Referral and Linkage

PEI: Early Intervention

Description of Services:

Participants are referred to the CCSS program by family resource centers, medical offices, community-based organizations, County-operated and County-contracted programs and self-referral. CCSS provides face-to-face individual and collateral counseling, groups (i.e., psycho-educational, 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.

Target Population:

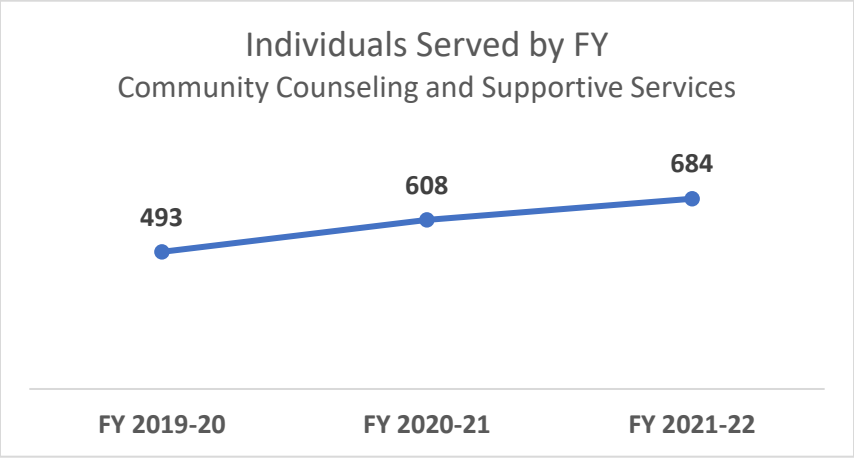
Community Counseling and Supportive Services (CCSS) serves residents of all ages who have, or are at risk of developing, a mild to moderate behavioral health condition and limited or no access to behavioral health services. The majority are uninsured or underinsured, speak a language other than English, and have a history of 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.

Proportion to be Served by Demographic Characteristics					
Age Group	**%**	**Gender**	**%**	**Race/Ethnicity**	**%**
0-15	19	Female	67	African American/Black	2
16-25	19	Male	29	American Indian/Alaskan Native	0
26-59	59	Transgender	2	Asian/Pacific Islander	7
60+	3	Genderqueer	1	Caucasian/White	13
		Questioning/Unsure		Latino/Hispanic	72
		Other	1	Other	6

PEI: Early Intervention

Outcomes and Results:

Following implementation of a new marketing and outreach strategy, CCSS has seen a steady increase in the number of clients served over the past three years, even during the COVID pandemic:

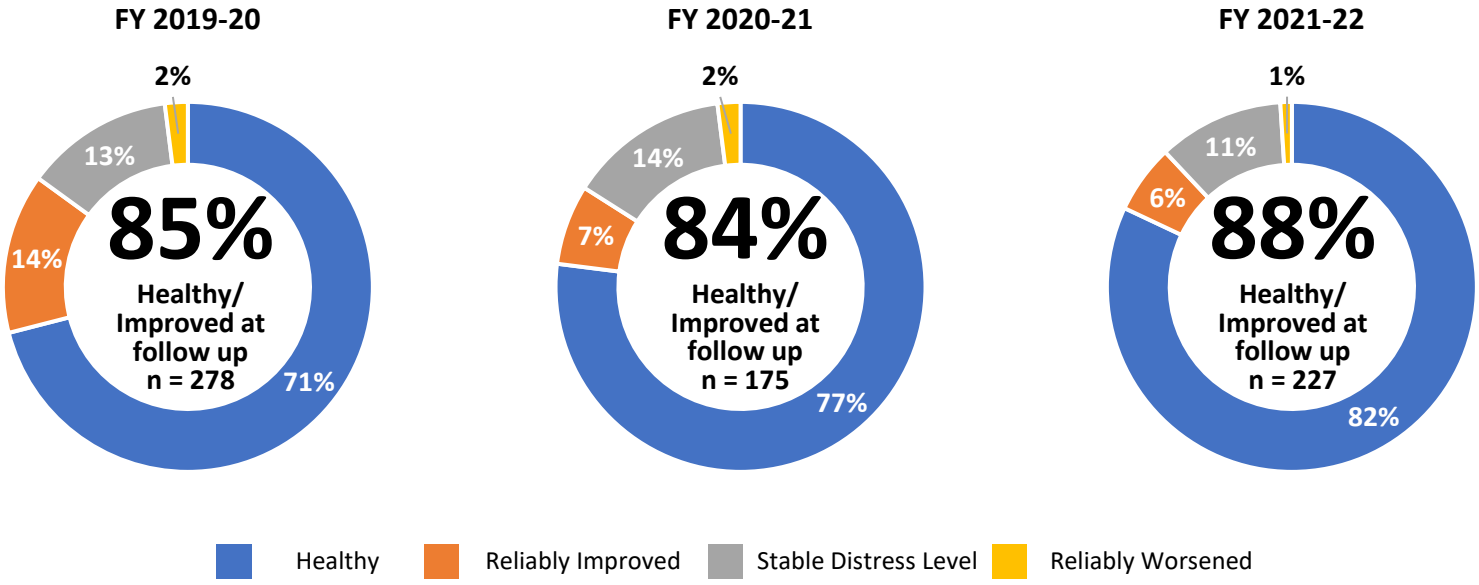


The program provides referrals to participants that need continuing services or a higher level of care. Linkage rates declined in FY 2020-21 and 2021-22 due to service closures related to the pandemic.

CCSS Referral & Linkage Rates			
	# Referrals	**# Linkages**	**% Linked**
FY 2019-20	197	131	66%
FY 2020-21	378	111	29%
FY 2021-22	238	59	25%

PEI: Early Intervention

Individuals receiving individual counseling completed an age-appropriate measure of symptom distress (Outcome Questionnaire, Youth Outcome Questionnaire) while enrolled in services. During the past three fiscal years, the majority of individuals served reported healthy or reliably improved levels of distress after starting services (84% to 88%). For the few who experienced worsening symptoms (1-2%), the program implemented procedures to identify those with greater needs and refer them to appropriate level of care.



Challenges/solutions:

In fiscal 2020-21, as a result of the COVID-19 pandemic, in person services transitioned to a virtual and telephonic platform. The pandemic initially impacted the number of referrals received. In response to program outreach efforts, referrals slowly increased and exceeded last fiscal year's numbers. To address timely screening of referrals made to the program, a universal Intake Coordinator (IC) system was piloted. The universal IC system involved cross training all P&I IC's to screen referrals made to any P&I program, regardless of their primary assignment. Previously, CCSS has two dedicated IC's and when they were unavailable to screen a new referral, other CCSS clinicians would help screen the callers. Now, if the dedicated CCSS IC's are unavailable, there are five additional IC's trained to screen new callers for services.

This allows clinician to focus on providing direct client care. The program continues to have over 90% of clinicians that are bilingual in two of the County's threshold languages thereby increasing the program's ability to serve monolingual communities. In this next fiscal year, the program plans on increasing outreach and resume trainings to collaborative partners and community members.

PEI: Early Intervention

Program: Early Intervention Services for Older Adults

Overview of the Program:

The Early Intervention Services for Older Adults (EISOA) program serves adults, 60 years of age and older, living in Orange County who are experiencing early onset of mental illness or those at risk of mental illness due to being isolated, homebound or unserved/underserved as a result of stigma related to behavioral health issues. These individuals become less physically active, isolated and often misuse or abuse prescription medications, drugs or alcohol, which increases their likelihood of developing behavioral health conditions. Designed to address these risk factors and build protective factors, services will include in-home assessment, an individualized service plan, case management, educational workshops and skills groups, peer mentor training, outreach, referral and linkage to support services, socialization activities in the community, transportation assistance and geropsychiatric services.

Program goal(s) and intended outcome(s):

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

Program Summary	
Program Serves:	Ages 60+
Location of Services	Field; Community
Numbers of individuals to be Served	**FY 2023-24**: 1,190
	FY 2024-25: 1,190
	FY 2025-26: 1,190
Annual Budget	**FY 2023-24**: $3,073,521
	FY 2024-25: $3,500,000
	FY 2025-26: $3,500,000
Avg. Est. Cost per Person	$2,873
Services Offered	Psychosocial Assessments
	Treatment Planning
	Support Groups
	Medication Supports

these results, staff then connects older adults to case managers who develop individualized care plans and facilitate participant's involvement in support groups, educational training, physical activity, workshops and other activities. A gero-psychiatrist 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.

Proportion to be Served by Demographic Characteristics for FY 2023-24

Age Group	%	Gender	%	Race/Ethnicity	%
0-15		Female	69	African American/Black	1
16-25		Male	31	American Indian/Alaskan Native	0
26-59		Transgender		Asian/Pacific Islander	38
60+	100	Genderqueer		Caucasian/White	36
		Questioning/ Unsure		Latino/Hispanic	23
		Other		Other	2

Description of Services:

EISOA utilizes the evidence-based practice Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors) which employs a observation, 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. 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.

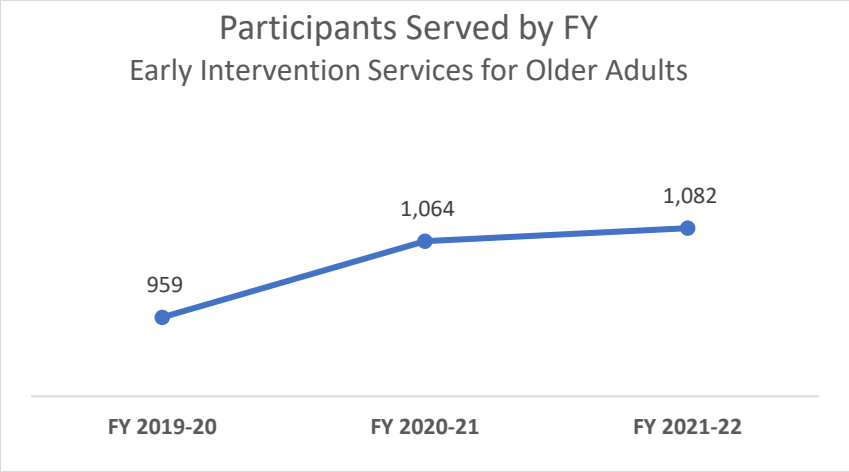
Target Population:

The target population is adults, 60 years of age and older, living in Orange County who are experiencing early onset of mental illness or those at risk of mental illness due to being isolated, homebound or unserved/ underserved as

a result of stigma related to behavioral health issues. Adults, aged 50 years can also be considered on an as needed basis.

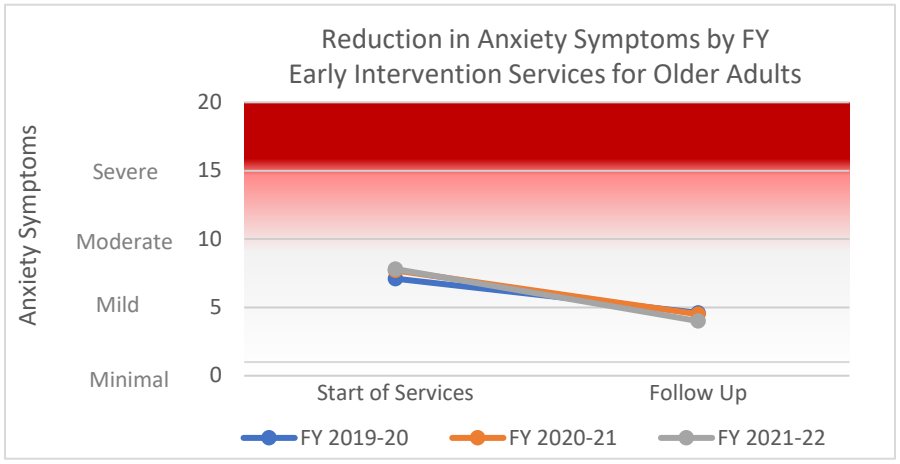
Outcomes and Results:

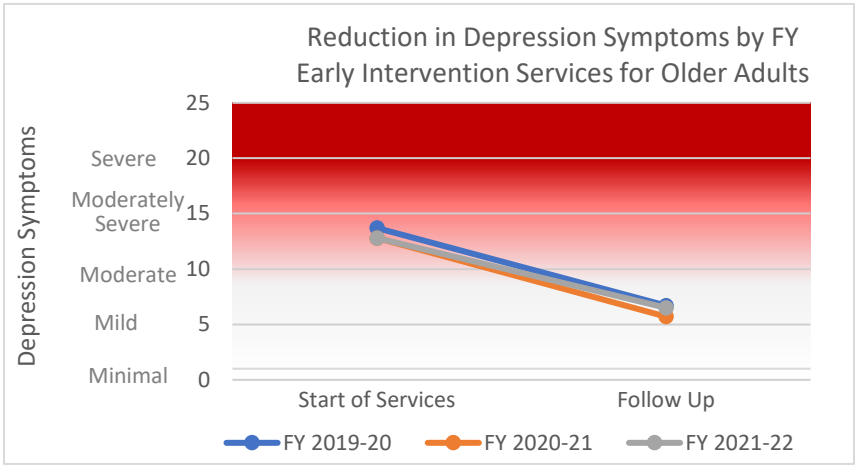
Over the past three fiscal years, EISOA saw an increase in the number of clients served during the COVID pandemic:



Over the past three fiscal years, participants who entered the program with clinically elevated depressive or anxiety symptoms consistently reported substantial declines in their symptoms while enrolled in services. In addition, participants reported moderate to large gains in their quality of life. These findings suggest that the program is effective at reducing prolonged suffering and/or preventing mental health symptoms and promoting quality of life

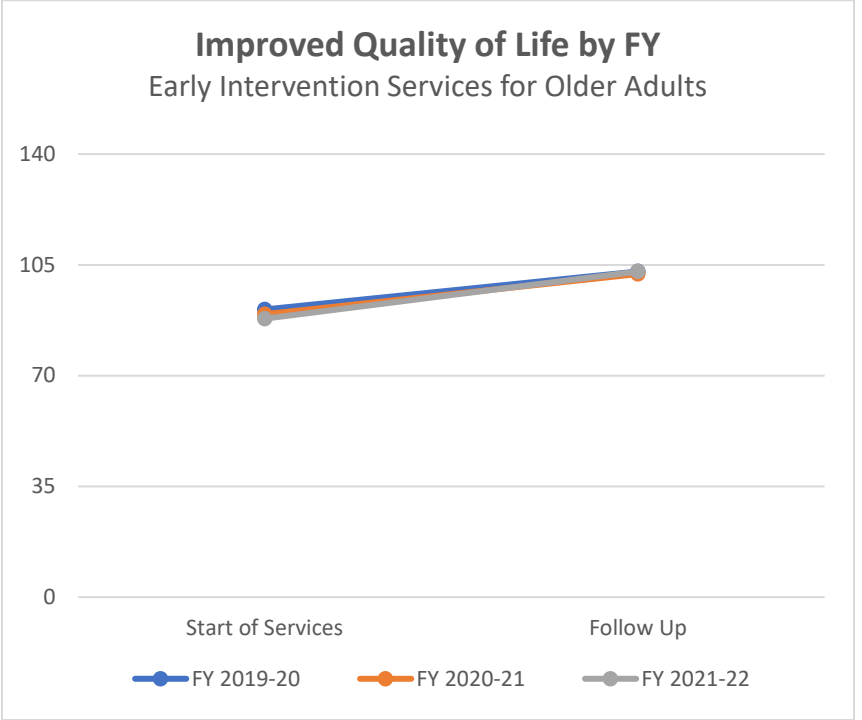
PEI: Early Intervention





In addition, participants reported markedly consistent moderate-to-large increases in their quality of life while receiving services.

The program provides referrals to participants for issues ranging from basic needs, medical services, housing, social support services, and higher-level mental health care. Linkage rates declined in FY 2020-21 due to service closures related to the pandemic.



PEI: Early Intervention

EISOA Referral & Linkage Rates			
	# Referrals	**# Linkages**	**% Linked**
FY 2019-20	9,779	5,567	57%
FY 2020-21	12,325	6,058	49%
FY 2021-22	8,872	5,287	60%

Challenges/solutions:

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.

PEI: Early Intervention

Program: OC4VETS

Overview of the Program:

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).

Program goal(s) and intended outcome(s):

The OC4Vets, County- and contract-operated providers 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.

Program Summary	
Program Serves:	All Ages
Location of Services	Field; Community
Numbers of individuals to be Served	**FY 2023-24**: 750
	FY 2024-25: 750
	FY 2025-26: 750
Annual Budget	**FY 2023-24**: $3,000,000
	FY 2024-25: $3,000,000
	FY 2025-26: $3,000,000
Avg. Est. Cost per Person	$4,000
Services Offered	Screening and Assessments
	Counseling
	Case Management
	Peer Supports

Description of 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 ongoing 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.

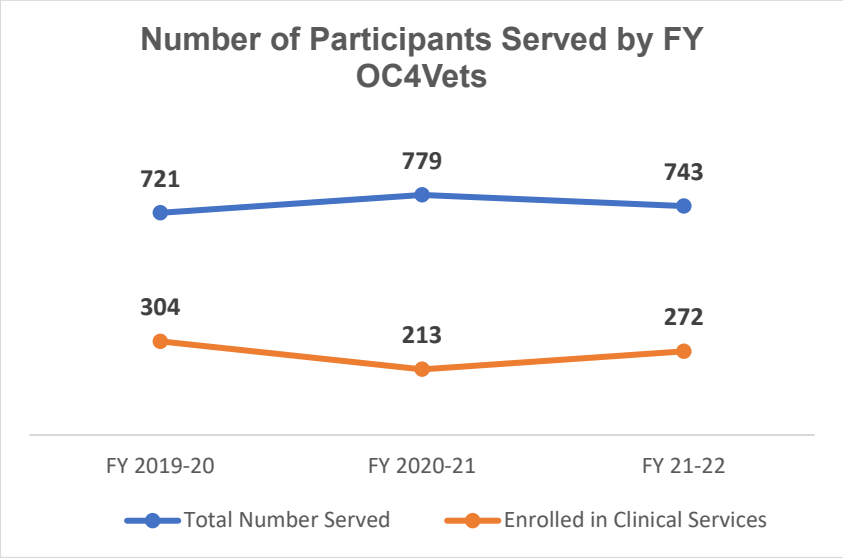
Target Population:

OC4VETS provides services to veterans and military connected veterans.

ESTIMATED PROPORTION OF CALLERS TO BE SERVED BY DEMOGRAPHIC CHARTERISTIC FOR FY 2023-24					
Age	%	Gender	%	Race/Ethnicity	%
0-15	25%	Female	40%	White	37%
16-25	13%	Male	60%	Hispanic/Latino	31%
26-59	54%	Other	<1%	Asian	10%
60+	8%			Black	6%
				Native American	<1%
				Native Hawaiian/PI	<1%
				Other	14%

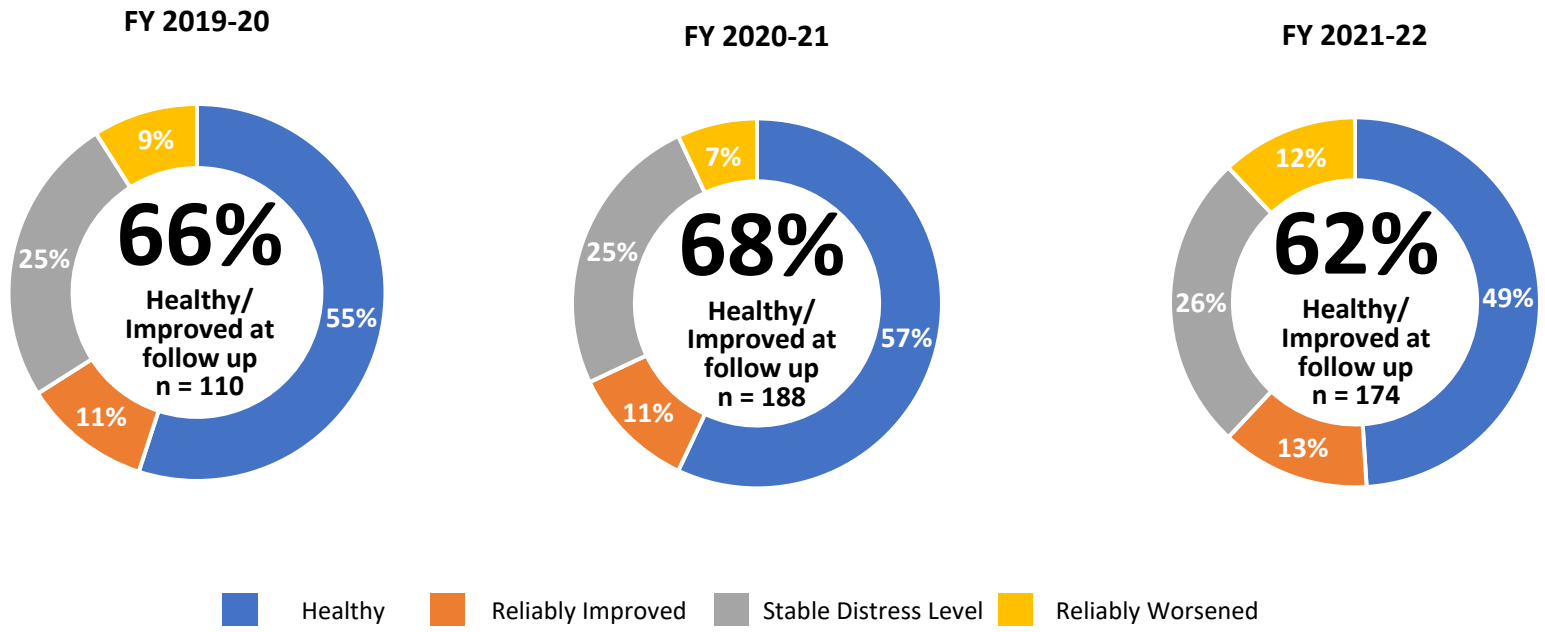
Outcomes and Results:

The number of individuals enrolled in OC4Vets and receiving clinical services has remained fairly consistent over the past three fiscal years. Not surprisingly, there was a small dip in individuals who received clinical services in FY 2020-21 (both in overall number and as a proportion of individuals served), likely reflecting the impact of COVID-19.



PEI: Early Intervention

Individuals receiving individual counseling completed an age-appropriate measure of symptom distress (Outcome Questionnaire, Youth Outcome Questionnaire) at different time points while enrolled in services. During the past three fiscal years, approximately two-thirds of OC4Vets participants reporting healthy or reliably improved levels of distress at follow up. FY 2021-22 results are largely accounted for by more veterans from Referral Paths 1 and 3 reporting healthy levels of distress at follow up.



Challenges/solutions:

The providers are working to improve their Outcome Questionnaire (OQ) administration procedures and use as a clinical tool. OC Health Care Agency (HCA) staff continue to provide 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.

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 fiscal year, 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 can enhance the stigma associated with seeking support and 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, Veteran Services Organizations, 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 fiscal year.

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.

Finally, the program has reported the need to extend treatment options for some individuals beyond the 18 month time frame that is allowable in Prevention and Early Intervention regulations. Program is currently partnering with MHSA Administration to engage in program planning discussions for meeting this need.

Community Services and Supports (CSS)

Under the Mental Health Services Act (MHSA), 76% of MHSA funding is directed toward the Community Services and Supports (CSS) component. The CSS component provides access to an expanded continuum of care for persons living with a serious mental illness (SMI) or serious emotional disturbance (SED). The goal of all CSS programs is providing the necessary services and supports that help consumers achieve mental health and wellness and recovery goals.

- The CSS section is organized according to programs that operate with similar service responsibilities but may serve different target populations.
- Programs intended to provide interventions or supports during a mental health crisis are described in the Crisis System of Care section.
- Programs designed to increase access into necessary care through a process of proactive engagement are aligned, along with Peer and Family Support programs which are consumer and family driven and feature a lived experience perspective.
- Clinical Outpatient programs support increased access to public safety net services across the County.
- Full Service Partnership (FSP) Programs for each MHSA identified age group are contained in the FSP section. FSP programs provide "whatever it takes" services.

WELLNESS • RECOVERY • RESILIENCE

CSS: Capacity Assessment

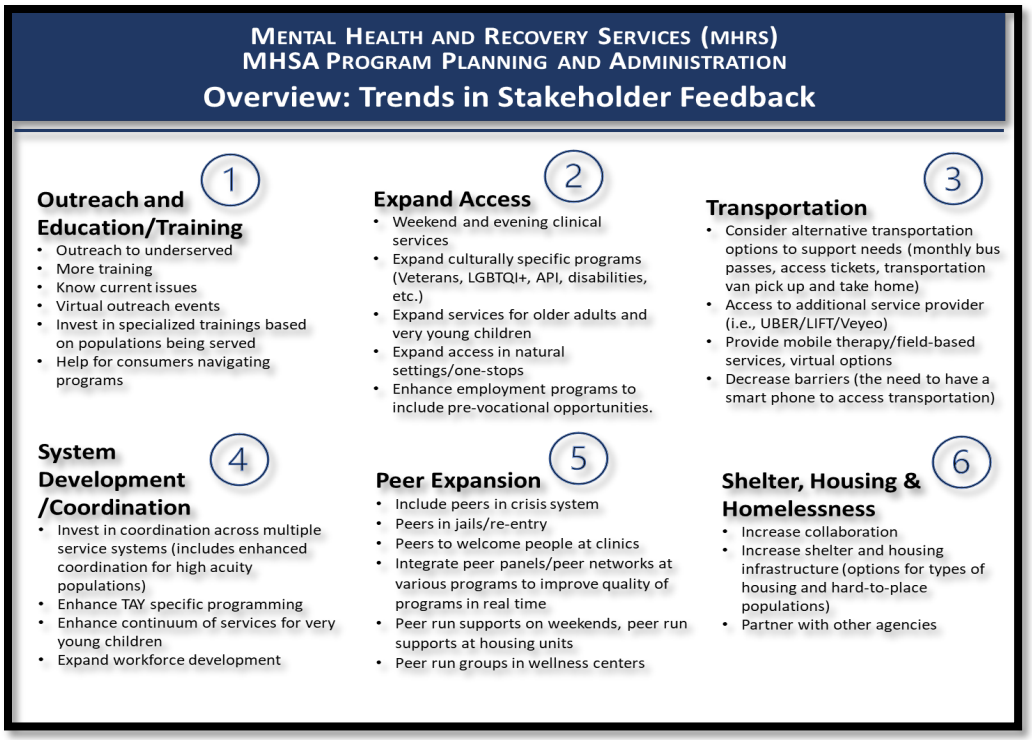
The Community Services and Supports component is comprised of twenty-two programs designed to support a continuum of services that support the mental health needs of diverse children, TAY, Adults, and Older Adults according to need. In accordance with 9 CCR § 3650, 9 CA ADC §3650, each program was developed through the Community Program Planning process and includes a description of services, goals of the program, the targeted number of people to be served by age group, demographics of consumers, program outcomes, and includes a summary of challenges and solutions related to program implementation.

MHSA statute requires an assessment for CSS programs.

As part of program implementation, MHRS is committed to ongoing review of community behavioral health needs, the capacity of staff and the public behavioral health system, and implementation of continuous improvement efforts based on qualitative and quantitative data and informatics. MHRS collects, prepares, and presents data and information with its stakeholders. Stakeholders review the information and provide feedback related to affirming existing programs, services, populations, and strategies, identifying additional populations, program improvement and design, priorities, as well as unmet need.

Trends in Stakeholder Feedback

The following trends have been identified from stakeholder feedback. Information is used in program development, expansion, evaluation and quality improvement efforts.



CSS: Capacity Assessment

Priority Issues by Age Group

Based on a recent analysis of stakeholder data from the past year, the following priorities have been identified by MHSA age group. The priorities were reviewed and affirmed at a Community Engagement Meeting held on 02/27/23.

Children/Youth	Transitional Aged Youth	Adults	Older Adults
Family and peer risks; at risk of out of home placement due to behavioral health condition	Homelessness	Homelessness	Homelessness
Build continuum of program/services for very young children (aged 0-8)	Enhance continuum of TAY specific programming	Access to Care: Transportation	Access and navigation of Care
Enhance school-based infrastructure	Employment issues; inability to work or gain meaningful experience	Employment issues; inability to work or gain meaningful experience	Lack of specialized services for individuals living with a serious mental illness and medical conditions.
Child Welfare/Juvenile justice involvement	Justice Involvement	Institutionalization and incarceration	Social isolation and need for peer support
Expanded access to services in natural settings (places where families comfortably go)	TAY specific outreach and engagement into services	Enhance culturally adaptive responses/approaches to work with different cultural populations	Cultural Sensitivity/Culturally specific programming
Expand services that build resiliency	Expand peer supports	Specialized services for Veterans	Specialized services for Veterans
Coordination of multiple service systems	Coordination of multiple service systems	Coordination of multiple service systems	Coordination of multiple service systems
Invest in specialized training for the early childhood system providers	Transition from child welfare or justice system	Frequent psychiatric hospitalizations	Older Adult specific outreach and engagement into treatment

CSS: Capacity Assessment

Demographic Overview

MHRS prepared an analysis of available Orange County data to understand the scope of mental health needs among the four age specific target populations. The data was reviewed and analyzed to determine estimates of the unserved, underserved, and inappropriately individuals in the county.

According to California Department of Finance estimates for 2021, Orange County has a total population of 3,209,272 with a projected growth of 28% between 2020 and 2045. The current breakdown of the population into gender, age, and racial and ethnic categories is indicated in the chart below.

2.1 Total Population of Orange County, California

	Population	*Percent of Total Population*
Gender		
Male	1,598,436	49.8%
Female	1,610,836	50.2%
Ethnicity		
White/Caucasian	1,328,850	41.4%
Hispanic/Latino	1,146,091	35.7%
Asian/Pacific Islander	592,162	18.5%
Black/African American	49,562	1.5%
Native American	6,907	0.2%
Multi Race/Other	85,700	2.7%
Age		
0-5 years	217,476	6.8%
6-17 years	485,132	15.2%
18-59 years	1,770,945	55.5%
60+ years	735,719	23.1%
Total Population	***3,209,272***	

Source: Department of Finance Population Statistics (2021)

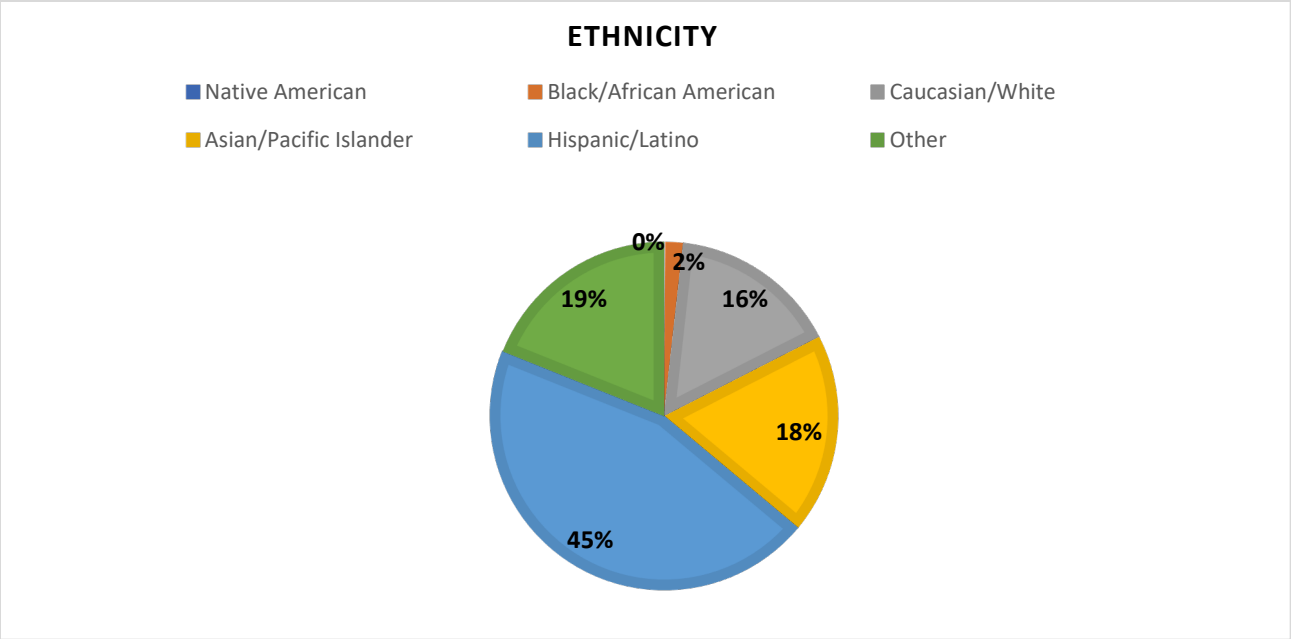
CSS: Capacity Assessment

Medi-Cal Beneficiaries

MHRS is the safety net provider for Medi-Cal beneficiaries that qualify for specialty mental health program services. Many CSS programs leverage Medi-Cal in the delivery of MHSA services. A review of Medi-Cal beneficiary demographics provides additional context for the target populations served through MHSA programs and assists in potentially identifying underserved, unserved, or inappropriately served populations. The number of Medi-Cal eligible beneficiaries is calculated each month by California Health and Human Services (CalHHS) and published online. The information below represents the Calendar Year 2021 average of Medi-Cal eligible beneficiaries. For CY 2021, an average of 954,394 Orange County residents were identified as Medi-Cal Eligible. The information below provides a snapshot of the demographics for Orange County Medi-Cal eligible beneficiaries during that time.

Ethnicity and Ancestry:

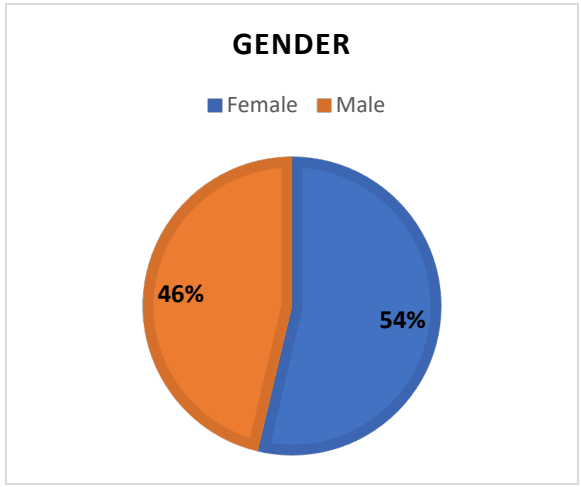
Medi-Cal eligible beneficiaries by Ethnicity and Ancestry was as follows: 2% were African American, 18% were Asian/Pacific Islander, 16% were Caucasian, 45% were Latino, .1% were Native American (illustrated as 0% in the graph), and 19% identified as not reported/other. N=954,394



CSS: Capacity Assessment

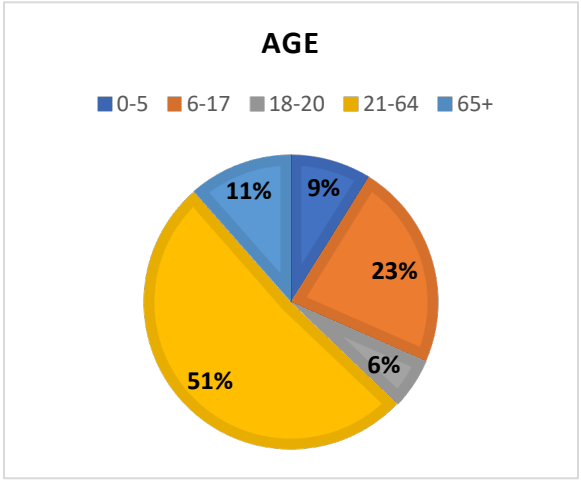
Gender:

Medi-Cal eligible beneficiaries by gender were as follows: 54% were female and 46% were male. N=954,394



Age:

Medi-Cal eligible beneficiaries by age groups were as follows: 9% were aged 0-5, 23% were aged 6-17, 6% were 18-20, 51% were aged 21-64, and 11% were over 65 years of age. N=954,394



CSS: Capacity Assessment

Estimation of Needs

Disparities can be identified by comparing the Medi-Cal eligible beneficiaries group to the Mental Health Medi-Cal consumers served in Calendar Year 2021. A recent review conducted by the CalEQRO for Calendar Year (CY) 2021 reviewed OC MHRS Medi-Cal claims as a method to analyze utilization and other variables. For CSS programs, Medi-Cal is frequently leveraged to expand services. One of the variables CalEQRO analyzes is penetration rate. The penetration rate is a measure of total beneficiaries served based upon the total Medi-Cal eligible. This measure can partially assist in identifying disparities. It is important to note that Medi-Cal utilization only represents a portion of MHSA services. *Individuals served through non-billable MHSA services are not included in this analysis*. The table below shows beneficiaries served by ethnicity in CY 2021.

The review of the CY 2021 claims indicated that the Asian Pacific Islander group had the lowest penetration rate of any group, whereas African-Americans had the highest penetration rates in comparison to County Medi-Cal beneficiary rates, while still being underserved in comparison to state rates.

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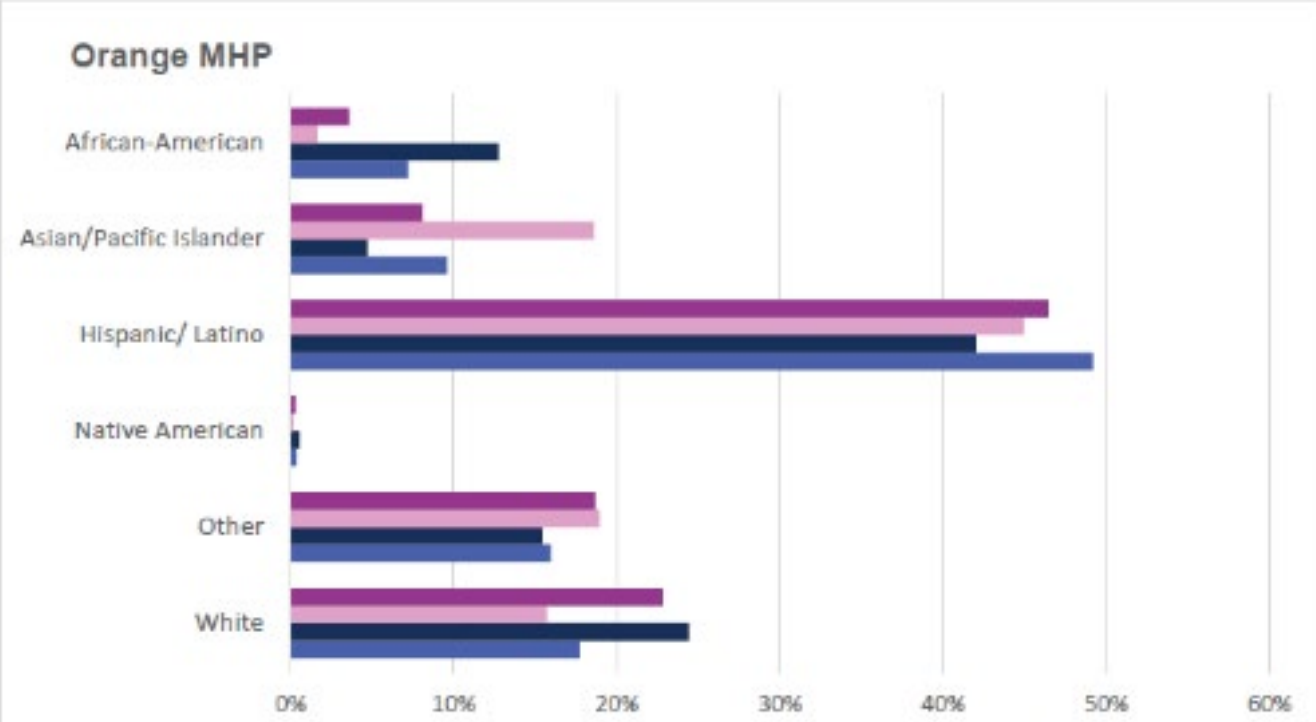
Race/Ethnicity	# MHP Served	CY 2021 # MHP Eligibles	MHP PR	Statewide PR
African-American	837	15,436	5.42%	6.83%
Asian/Pacific Islander	1,891	177,504	1.07%	1.90%
Hispanic/Latino	10,834	429,250	2.52%	3.29%
Native American	72	1,376	5.23%	5.58%
Other	4,363	180,793	2.41%	3.72%
White	5,313	150,035	3.54%	5.32%
Total	**23,310**	**954,394**	**2.44%**	**3.85%**

CSS: Capacity Assessment

White beneficiaries were the most disproportionately overrepresented racial/ethnic group served. Asian/Pacific Islander (API) beneficiaries were the most disproportionately underrepresented.



	White	Other	Native American	Hispanic/ Latino	Asian/Pacific Islander	African-American
MHP % Served	23%	19%	0%	46%	8%	4%
MHP % Eligibles	16%	19%	0%	45%	19%	2%
State % Served	24%	15%	1%	42%	5%	13%
State % Eligibles	18%	16%	0%	49%	10%	7%

CSS: Capacity Assessment

Penetration rates by age indicates penetration rates for all ages are lower than state averages, with very young children (0-5) and older adults indicating the largest differences.

Age Groups	Average # of Eligibles per Month	# Of Beneficiaries Served	Penetration Rate	Similar Size Counties Penetration Rate	Statewide Penetration Rate
Ages 0-5	84,542	543	0.64%	1.29%	1.59%
Ages 6-17	216,756	9,648	4.45%	4.65%	5.20%
Ages 18-20	52,823	1,698	3.21%	3.66%	4.02%
Ages 21-64	490,980	10,922	2.22%	3.73%	4.07%
Ages 65+	109,293	499	0.46%	1.52%	1.77%
TOTAL	**954,392**	**23,310**	**2.44%**	**3.47%**	**3.85%**

OC penetration rates were lower than those seen statewide across all racial/ethnic groups and all age groups. The lowest penetration rates were among adults over the age of 65 (0.46 percent), children from birth to five (0.64 percent), and API (1.07 percent).

On average, 19.3% of Asian or Pacific Islander residents were eligible for Medi-Cal services, yet only 8.0% received an approved service. Residents over 60 years of age comprised 16.4% of the Medi-Cal eligible population, yet only 6.1% had an approved service. There was also a noticeable difference for those who speak a language other than English at home. Spanish speakers comprised almost one-third of the Medi-Cal population (30.8%), but only 16.1% had an approved service. Similarly, those who spoke an Asian or Pacific Islander language made up 11.9% of the Medi-Cal population and only 3.0% had an approved service.

Based on the number of Medi-Cal eligible residents in CY 2021 and the number of beneficiaries with an approved service, the following groups were identified as underrepresented:

- Asian or Pacific Islanders
- Black or African Americans
- Youth 5 years of age and under
- Adults over the age of 60
- Native Americans
- Residents who spoke a language other than English

CSS: Capacity Assessment

Populations for Full Service Partnerships

The CSS section of this Three-Year Plan contains detailed overviews of all Full Service Partnership (FSP) programs, including demographics, numbers projected to be served, goals, and outcomes. Programs are designed to meet the needs of the specific populations. Below is a list of the prioritized populations to be served in FSP programs by MHSA age group.

Children and Youth
▪ Those children and youth identified as living with serious emotional disturbances ▪ Those children and youth having problems at school or at risk of dropping out due to emotional disturbance/mental illness ▪ Those children and youth at risk of, or are involved in the child welfare/justice system ▪ Those children and youth in need of crisis intervention and /or at serious risk of psychiatric hospitalization ▪ Those children and youth at risk of residential treatment or are stepping down from residential treatment ▪ Those children and youth who are homeless or at risk of homelessness ▪ Those children and youth who are high users of service, multiple hospitalizations or institutions ▪ Those children and youth who are at risk due to lack of services because of cultural, linguistic, or economic barriers ▪ Those children and youth at risk due to exposure to domestic violence, physical, emotional, verbal, sexual abuse. ▪ Those children and youth with co-occurring disorders ▪ Children and Youth at-risk of or experiencing sexual exploitation

CSS: Capacity Assessment

Transitional Aged Youth
▪ Those transitional age youth who live with serious mental illness or serious emotional disturbances ▪ Those transitional age youth who have repeated use of emergency mental health services ▪ Those transitional age youth who have co-occurring disorders ▪ Those transitional age youth who are homeless or at risk of homelessness ▪ Those transitional age youth who are at risk of involuntary hospitalization or institutionalization ▪ Those transitional age youth who are involved in the juvenile justice system ▪ Those transitional age youth who are in out-of-home placement ▪ Those transitional age youth aging out of or part of the child welfare system ▪ Those transitional age youth who are high utilizers of hospital services

Adults
▪ Those adults living with serious mental illness ▪ Those adults who are homeless or at risk of homelessness ▪ Those adults who have co-occurring substance use disorders ▪ Those adults who are involved in the criminal justice system or who are in transitioning/discharged from the criminal justice system ▪ Those adults who are recently discharged from psychiatric hospitals/higher levels of care ▪ Those adults who are frequently hospitalized or are frequent users of emergency room services for psychiatric problems ▪ Those adults who are at-risk of or who are civically committed or at risk of institutionalization

CSS: Capacity Assessment

Older Adults
▪ Those older adults who have serious mental illness ▪ Those older adults who are homeless or at risk of homelessness ▪ Those older adults who are frequent users of emergency room services for psychiatric problems or are frequently hospitalized ▪ Those older adults who have reduced personal and/or community functioning due to physical and/or health problems ▪ Those older adults who have co-occurring substance use disorder ▪ Those older adults who are isolated and at risk for suicide due to stigma surrounding their mental health concerns ▪ This older adults from underserved populations (Veterans, Vietnamese)

Program: Mobile Crisis Assessment Teams

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristic
All Ages	At-Risk Mild-Moderate Severe	Telephone Field-Based	BH Providers; 1st Responders; Students/Schools; Parents; Families; Medical Co-Morbidities; Criminal Justice Involved; Ethnic Communities; Homeless/At-Risk of; Recovery from SUD; LGBTIQ+; Trauma Exposed; Veterans/Miliary Connected

Overview of the Program:

The mobile **Crisis Assessment Team** (CAT) program serves individuals of all ages who are experiencing a mental 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 units 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 at police departments or ride along with assigned law enforcement officers to address mental health-related calls in their assigned cities or regionally.

Program goal(s) and intended outcome(s):

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.

In addition to dispatch-to-arrival times, the teams also evaluate the percentage of individuals who are placed on a psychiatric hold as a result of the risk assessment versus the percentage of individuals served who can be linked with safe alternatives to inpatient services in the community.

CSS: Crisis System of Care

Description of Services:

This multi-disciplinary program provides prompt response in the county when an individual is experiencing a mental 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 if applicable, emergency department staff and/or school personnel. CAT clinicians link individuals to an appropriate level of care to ensure safety, which may involve initiating hospitalization or linking to Crisis Residential or In Home Crisis Stabilization programs. CAT clinicians also conduct follow-up services with individuals and/or their parents/guardians to provide in- formation, referrals and linkage to ongoing mental health services that may help reduce the need for future crisis interventions and prevent recidivism.

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 mental health crisis event. PERT clinicians similarly educate police on mental health issues and provide officers with tools that allow them to assist individuals living with mental health issues more effectively.

There are currently 27 clinician positions on the children's crisis assessment team (CAT) serving youth under age 18, and 47 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.

CSS: Crisis System of Care

Target Population:

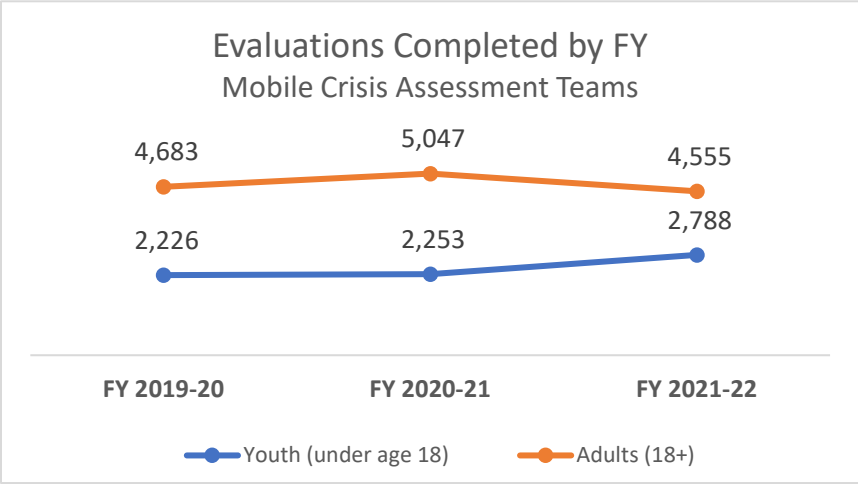
Proportion to be Served by Demographic Characteristic for FY 2023-24					
Age	%	Gender	%	Race/Ethnicity	%
0-15	22%	Female	51%	African American/Black	5%
16-25	24%	Male	48%	American Indian/Alaskan Native	0%
26-59	43%	Transgender	1%	Asian/Pacific Islander	9%
60+	11%	Genderqueer	0%	Caucasian/White	38%
		Questioning/Unsure	0%	Latino/Hispanic	30%
		Another	0%	Middle Eastern/North African	1%
				Another	16%

Fiscal Year	Budget	Number to be served	Cost Per Client
FY 2023-24	$11,600,000	7,000	$1,657
FY 2024-25	$11,650,000	7,000	$1,644
FY 2025-26	$11,400,000	7,000	$1,628

CSS: Crisis System of Care

Positive results/Outcomes:

Compared to early years, the Children's team experienced a slight increase and the adult team a slight decrease in the number of evaluations conducted in FY 2021-22:



In prior years, individuals were hospitalized less than half the time. Data for FY 2021-22 are still being processed and will be reported when available.

Hospitalization Rate					
FY 2019-20		FY2020-21		FY 2021-22	
Children	Adults	Children	Adults	Children	Adults
47%	46%	46%	46%	-	-

Dispatch to Arrival Rate 30 Minutes or Less (Target ≥ 70%)					
FY 2019-20		FY2020-21		FY 2021-22	
Children	Adults	Children	Adults	Children	Adults
51%	82%	45%	81%	48%	70%

Finally, the program evaluates its processes by monitoring the timeliness with which CAT is able to respond to calls, with the goal that the dispatch-to-arrival time is 30 minutes or less at least 70% of the time. Adult crisis response continues to meet the annual target. While Children's crisis response continues to struggle to meet the targeted time frame, historically the children's team responds to proportionately more calls in south county than does the adult team and their evaluations take more time due to requirements specific to WIC 5585, both of which can impact response time (i.e., distance traveled, staff available for dispatch).

CSS: Crisis System of Care

Success story:

Since their inception in January 2003, 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 or 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.

Challenges/solutions:

Over the last year, the HCA has engaged with collaborative partners including, OC Sheriff's Department and other police departments, first responders, EMS, Fire Departments, Family and Consumer Advocacy groups, local hospitals and treatment providers to start the development of a Regional Crisis Intervention Teams (CIT). The goals of a CIT are to improve the safety during law enforcement encounters with people experiencing a mental health crisis for everyone involved, to increase connections to effective and timely mental health services for people in mental health crisis, to use law enforcement strategically during crisis situations, such as when there is an imminent threat to safety or a criminal concern, increase the role mental health professionals, peer support specialists and other community supports and also to reduce the trauma that people experience during a mental health crisis and thus contribute to their long-term recovery. A CIT Steering Committee was created in April 2021, meets monthly and has worked to develop crisis intercept mapping to help individuals navigate through our mental health and criminal justice systems. It also provides a feedback loop and a place to provide feedback on best practices and identify gaps/needs. The CIT Steering Committee is currently working on certifying our CIT Regional Program. The HCA has also been exploring options that include the addition of CAT vehicles, a peer/clinician co-responder model, and only using law enforcement under special, clearly delineated circumstances. The HCA will continue to meet with stakeholders to increase and develop a collaborative model of crisis response.

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 premium pay and a 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, an initial response to the COVID-19 impact lead to changes in the dispatching process for clinicians, where they would be dispatched from home. Since March 2022, the children's team returned to dispatching from a centralized location in the city of Orange. HCA continues to explore options for alternative dispatch locations, including locations in south Orange County. Currently the demand for services, along with staffing challenges, clinicians are often traveling directly from one call to the next without returning to the office location. The HCA will continue to monitor and explore ways to decrease response times

Program: In-Home Crisis Stabilization

Program Serves	Symptom Severity	Location of Services	Typical Population Charateristic
All Ages	At-Risk Mild-Moderate Severe	Community Based Field Based	Students/Schools Parents Families Homeless/At-Risk of Trauma-Exposed

Overview of the Program:

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, case managers 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.

Program goal(s) and intended outcome(s):

The goal of IHCS is to help individuals manage their mental health crisis and make positive gains in recovery, to reduce unnecessary psychiatric hospitalizations which is quantified as achieving a psychiatric hospitalization rate of 25% or less in the 60 days after discharging from the program.

CSS: Crisis System of Care

Description of 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 and treatment 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 homeless- ness, and/or in any community setting that the individual or family feels comfortable. As an essential crisis service, the IHCS Teams continued to remain fully operational throughout the COVID-19 pandemic and were required to implement processes to keep both clients and clinicians safe, such as the temporary use of telehealth when appropriate and PPE.

CSS: Crisis System of Care

Target Population:

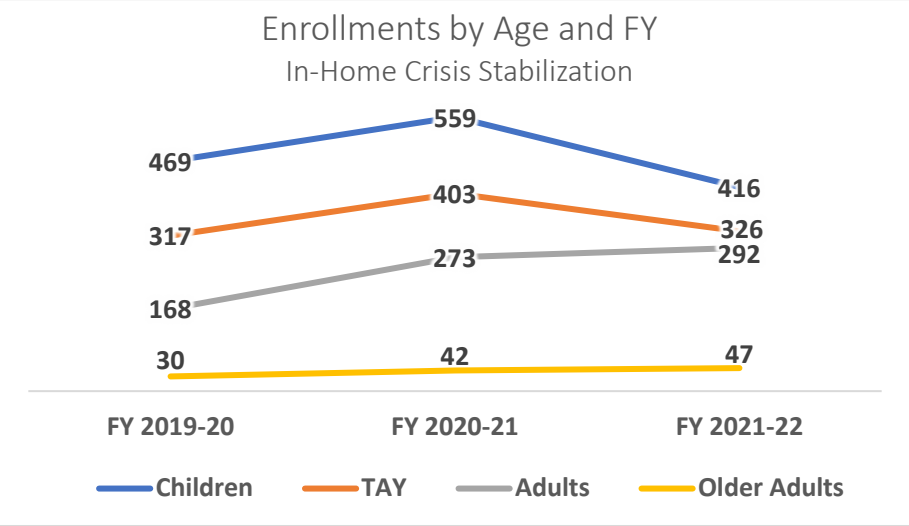
Proportion to be Served by Demographic Characteristic for FY 2023-24					
Age	%	Gender	%	Race/Ethnicity	%
0-15	25%	Female	59%	African American/Black	4%
16-25	34%	Male	41%	American Indian/Alaskan Native	0%
26-59	56%	Transgender	1%	Asian/Pacific Islander	11%
60+	10%	Genderqueer	0%	Caucasian/White	37%
		Questioning/Unsure	0%	Latino/Hispanic	39%
		Another	0%	Middle Eastern/North African	1%
				Another	7%

Fiscal Year	Budget	Number to be served	Cost Per Client
FY 2023-24	$3,786,900	1,468	$2,580
FY 2024-25	$3,786,900	1,468	$2,580
FY 2025-26	$3,786,900	1,468	$2,580

CSS: Crisis System of Care

Positive results/Outcomes:

Overall, the number of individuals who enrolled in services increased during COVID. In FY 2021-22, the number of children admitted to the program returned to pre-COVID levels, while the number of adults remained level.



The program met its goal of maintaining a hospitalization rate of 25% or less during the 60 days following discharge from services, with rates ranging from 4 – 9% across all fiscal years and age groups:

Hospitalization Rates* in the 60 Days Following Discharge

FY 2019-20				FY 2020-21				FY 2021-22			
Children	TAY	Adults	Older Adults	Children	TAY	Adults	Older Adults	Children	TAY	Adults	Older Adults
6%	6%	4%	6%	5%	5%	9%	5%	4%	5%	5%	0%

Green = Met target Red = Did not meet target

** Hospitalization data only available for Medi-Cal beneficiaries, which represented 100% of all enrollments.*

CSS: Crisis System of Care

Success story:

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.

Challenges/solutions:

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.

CSS: Crisis System of Care

Program: Crisis Stabilization Units

Program Serves	Symptom Severity	Location of Services	Typical Population Charateristic
Ages 13+	At-Risk Mild-Moderate Severe	Clinic Based	Parents Families Trauma-Exposed

Overview of the Program:

Crisis Stabilization Units (CSUs) provide the community with 24-hour, 7-day a week, year-round service for individuals who are experiencing a mental 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 mental 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 mental health need.

Program goal(s) and intended outcome(s):

The goals of CSU services are to provide timely and effective crisis intervention and stabilization for persons experiencing behavioral health emergencies that cannot wait for their regularly scheduled appointments. The goals also include: minimize distress for the client/family resulting from lengthy waits in emergency departments, reduce the wait time for law enforcement presenting clients for emergency behavioral health treatment; and treating the client in the least restrictive, most dignified setting as appropriate in lieu of inpatient settings, utilizing alternative, less restrictive treatment options whenever possible and appropriate to minimize the duration and extent of acute psychotic episodes to the benefit of the client and other clients in the communal milieu at the CSUs. Services shall be provided in compliance with Welfare & Institutions Code and consistent with all

patients' rights regulations, upholding the dignity and respect of all clients served. The services shall also be provided utilizing Trauma Informed and Recovery Model principles that are person-centered, strengths-based, individualized, focused on imparting hope and identifying strengths and resiliency in all persons served. Services shall be tailored to the unique strengths of each client and will use shared decision-making to encourage the client to manage their behavioral health treatment, set their own path toward recovery and fulfillment of their hopes and dreams. The performance outcome metrics and intended outcomes of CSU services are:

Provide timely evaluations as measured by completing ninety five percent (95%) of CSU admissions within one (1) hour of client's arrival on a monthly basis.

Provide the least restrictive alternatives and an effective medication approach that result in seclusion and restraint use of one point one percent (1.1%) or less of admissions per month.

Prevent unwarranted psychiatric hospitalizations by providing timely and appropriate evaluation and stabilization that result in discharging a minimum of fifty-five percent (70%) of admissions on a monthly basis.

Description of Services:

Crisis Stabilization Services, which are not to exceed 23 hours and 59 minutes, 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, 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.

CSS: Crisis System of Care

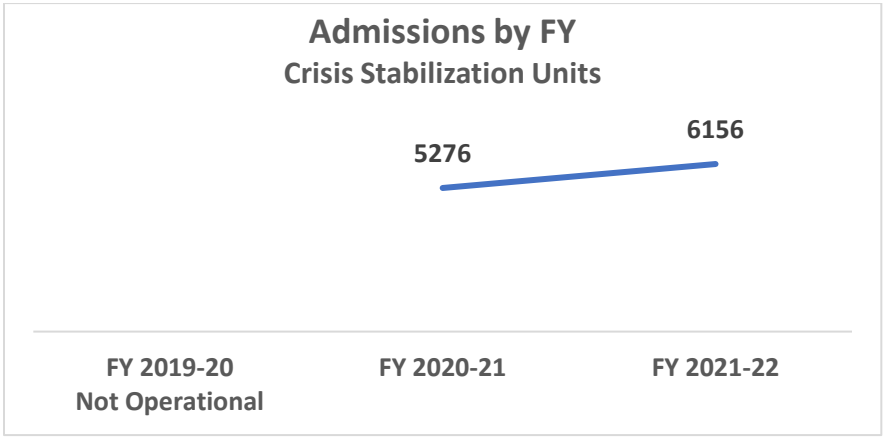
Target Population:

Proportion to be Served by Demographic Characteristic for FY 2023-24					
Age	%	Gender	%	Race/Ethnicity	%
0-15	7%	Female	43%	African American/Black	8%
16-25	27%	Male	56%	American Indian/Alaskan Native	0%
26-59	63%	Transgender	0%	Asian/Pacific Islander	9%
60+	4%	Genderqueer	0%	Caucasian/White	42%
		Questioning/Unsure	0%	Latino/Hispanic	33%
		Another	0%	Middle Eastern/North African	1%
				Another	6%

Fiscal Year	Budget	Number to be served	Cost Per Client
FY 2023-24	$16,000,000	10,000	$1,600
FY 2024-25	$16,000,000	10,000	$1,600
FY 2025-26	$16,000,000	10,000	$1,600

Positive results/Outcomes:

Admissions increased since the MHSA-funded CSUs first opened in FY 2020-21:



The CSUs strive to provide the least restrictive alternatives and an effective medication approach for individuals admitted to their program, with the goal of using seclusion and restraints in 1.6% or fewer admissions per month. This target was met both years that the MHSA-funded CSUs were operational:

Seclusion and Restraint Incidents	Target	FY20-21	FY21-22
Admissions - Children under age 18	≤ 1.6%	1% *Data did not include age*	1%
Admissions – Adults 18 and older	≤ 1.6%		1%

The CSUs also linked the majority of individuals they served to a less restrictive environment upon discharge:

Linkages to Lower Level of Care	FY20-21	FY21-22
Childrens CSU	68% *Data did not include age*	58%
Adult CSU		73%

CSS: Crisis System of Care

Success story:

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 order to hasten care for individuals experiencing a psychiatric crisis, CSUs recently implemented 'expedited admissions' pilot programs that allowed for partnerships with EDs to quickly refer individuals to CSUs for crisis stabilization while avoiding timely delays due to redundant or unnecessary lab orders. By doing so, individuals are able to quickly be connected to a treatment team focused on their immediate stabilization as well as long-term linkage to ongoing care.

CSUs have also implemented a public-facing BedBoard in efforts to improve bed visibility to Law Enforcement agencies. The BedBoard allows officers to quickly determine which CSU has a bed opening for an individual in crisis. Both the BedBoard and expedited admissions demonstrate continued efforts to increase access to needed services and a commitment to removing barriers.

Challenges/solutions:

Length of stay provided has been a challenge experienced within the CSU system in Orange County due to a limited availability of inpatient psychiatric beds. In FY 2021-22 new contracts were established increases the counties capacity of inpatient psychiatric services for those aged 12 and older.

Program: Crisis Residential Services

Program Serves	Symptom Severity	Location of Services	Typical Population Charateristic
Ages 12+	At-Risk Mild-Moderate Severe	Residential Based	Foster Youth Parents Families Criminal Justice Involved Homeless/At Risk of Recovery from SUD LGBTIQ+ Trauma-Exposed

Overview of the Program:

The Crisis Residential Services (CRS) program provides highly structured, voluntary services in a residential setting for individuals who are experiencing a mental 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 Adult and Older Adult 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 four sites operated by three contractors located throughout Orange County.

Program goal(s) and intended outcome(s):

The goal of the program is to help the person manage their mental health crisis and make positive gains in recovery, which is quantified as achieving a psychiatric hospitalization rate of 25% or less in the 60 days following discharge from the program.

CSS: Crisis System of Care

Description of Services:

Crisis Residential Services has several sites across the county tailored to meet the needs of different age groups:

- **Children** ages 12 to 17 receive services at three sites operated by Children Youth and Mental Health Recovery Services (CYMHRS; i.e., Laguna Beach, Huntington Beach, Tustin) with a total of 16 beds. Services generally last for three weeks, al- though children can remain in treatment for up to six weeks if needed.
- **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 Mental Health Recovery Services (AOAMHRS).
- **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 Ameri- cans with Disabilities Act (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-com- pliant). Stays last an average of 7 to 14 days. There are also four ADA beds at the Central CRP site that can accommodate clients meeting criteria for the program with this need.

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 ongoing mental 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 implement- ed 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. The planned budget increase for the Children's CRP for FY 2022-23, is to increase psychiatric services onsite at all three locations and increase support for system involved youth residing in Orange County.

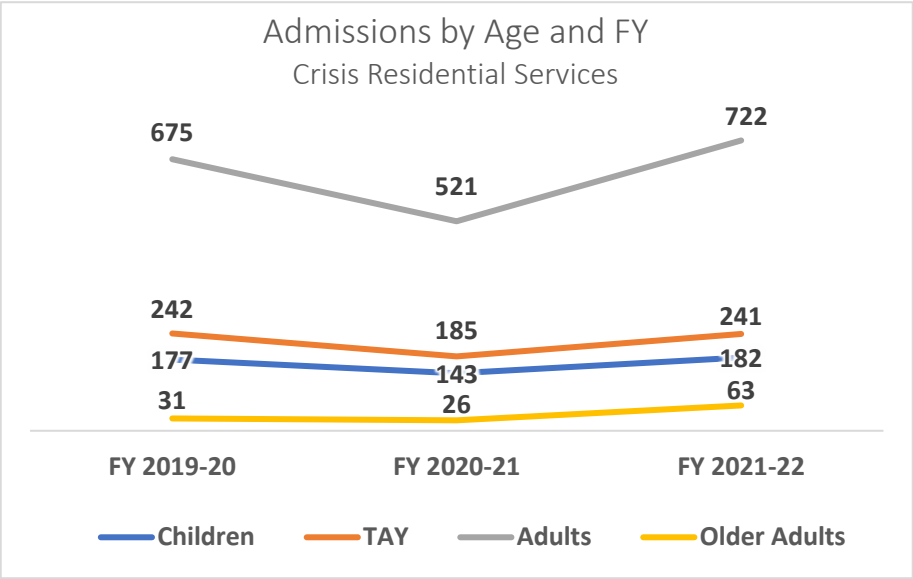
Target Population:

Proportion to be Served by Demographic Characteristic for FY 2023-24					
Age	%	Gender	%	Race/Ethnicity	%
0-15	5%	Female	43%	African American/Black	8%
16-25	19%	Male	57%	American Indian/Alaskan Native	1%
26-59	68%	Transgender	0%	Asian/Pacific Islander	5%
60+	7%	Genderqueer	0%	Caucasian/White	47%
		Questioning/Unsure	0%	Latino/Hispanic	32%
		Another	0%	Middle Eastern/North African	1%
				Another	6%

Fiscal Year	Budget	Number to be served	Cost Per Client
FY 2023-24	$13,179,616	1300	$10,138
FY 2024-25	$13,829,616	1500	$9,220
FY 2025-26	$13,829,616	1500	$9,220

Positive results/Outcomes:

Overall admissions to crisis residential services rebounded in FY 2021-22, following a dip in the previous year due to the impacts of COVID. Admissions, based on the individual's age at the time of admission, are shown in the following graph:



CSS: Crisis System of Care

The program met its goal of maintaining a hospitalization rate of 25% or less during the 60 days following discharge from services, with rates ranging from 8-25% across all fiscal years and age groups:

Hospitalization Rates* in the 60 Days Following Discharge											
FY 2019-20				FY 2020-21				FY 2021-22			
Children	TAY	Adults	Older Adults	Children	TAY	Adults	Older Adults	Children	TAY	Adults	Older Adults
12%	16%	19%	8%	14%	15%	18%	25%	18%	16%	15%	10%

Green = Met target Red = Did not meet target

** Hospitalization data only available for Medi-Cal beneficiaries, which represented approximately 98% of all enrollments.*

Success story:

Since inception, the program has assisted thousands of children, TAY, adults and older adults with intensive services provided in a therapeutic, home-like environment. The program reduces admissions to local emergency departments and provides a strength-based, recovery-oriented alternative to psychiatric hospitals for those experiencing a behavioral health crisis.

Challenges/solutions:

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, 2020, that exclusively addresses the needs of older adults in mental health crisis. This home has been at capacity and is well utilized by our community partners. TAY continue to face challenges with the lack of stable housing available when youth are ready for a lower level of care. The children Crisis Residential Program 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 program has adjusted the intake an treatment process to focus on 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 CCRP level of care fits into the continuum of crisis residential services for youth.

Program: Warmline

Program Serves	Symptom Severity	Location of Services	Typical Population Charateristic
All Ages	At Risk Mild-Moderate Severe	Telephone Based	BH Providers; 1st Responders; Students/Schools; Foster Youth; Parents; Families; Medical Co-Mobidities; Criminal Justice Invovled; Ethnic Communities; Homeless/At-Risk of; LGBTIQ+; Trauma Exposed; Veterans/Military Connected

Overview of the Program:

The **WarmLine** provides toll-free, non-emergency, non-crisis phone support, text and internet chat service available to any Orange County resident needing support for behavioral health issues for themselves or family members. The program also serves family members. Beginning July 2020, the WarmLine began providing services 24 hours a day, seven days a week, year-round. This program is supported by a new Office of Suicide Prevention, which was established in the HCA's Mental Health and Recovery Services area upon the direction of the Orange County Board of Supervisors in 2021.

Program goal(s) and intended outcome(s):

The goal of the Warmline is to track the number of callers as well as the improvement in mood of the caller by the end of the call session.

CSS: Crisis System of Care

Description of 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 mental crisis are immediately referred to the Crisis Prevention Hotline to another immediate service. Callers who do not indicate an imminent safety concern are provided emotional support and resources and referred to appropriate services as needed. Warmline staff work closely with the Hotline staff (see Crisis and Prevention Section) in providing a continuum of care.

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.

CSS: Crisis System of Care

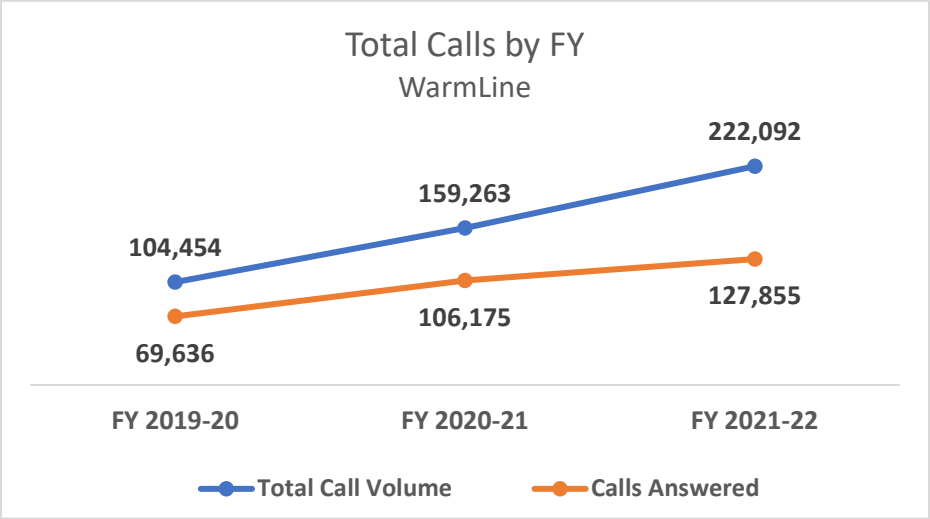
Target Population:

Proportion to be Served by Demographic Characteristic for FY 2023-24					
Age	%	Gender	%	Race/Ethnicity	%
0-15	0%	Female	54%	African American/Black	15%
16-25	5%	Male	46%	American Indian/Alaskan Native	0%
26-59	69%	Transgender	0%	Asian/Pacific Islander	15%
60+	26%	Genderqueer	0%	Caucasian/White	53%
		Questioning/Unsure	0%	Latino/Hispanic	13%
		Another	0%	Middle Eastern/North African	0%
				Another	4%

Fiscal Year	Budget	Call/Chat Volume	Cost Per Client
FY 2023-24	$12,000,000	226,000	$53
FY 2024-25	$12,000,000	226,000	$53
FY 2025-26	$12,000,000	226,000	$53

Positive results/Outcomes:

After hours of operation shifted to 24/7 in July 2020, calls coming in to the WarmLine dramatically increased. While staffing was modestly increased in FY 2021-21 to accommodate the increased hours of operation, staffing remained level in FY 2021-22 even though call volume continued to grow. Thus, the mentors' ability to answer calls fell from about 67% to 58%:



WarmLine Activity	FY 2019-20 Operated 18 hours/day	FY 2020-21 Operated 24/7	FY 2021-22 Operated 24/7
Total Unduplicated Callers	28,249	60,426	86,211
Total Calls to WarmLine	~104,454	~159,263	222,092
Total Calls Answered	69,636	106,175	127,855
Total Live Chats/Texts	1,475	3,510	3,857

Of the answered calls, WarmLine counselors and mentors continue to successfully reduce emotional distress of callers through the support and services they provide during the telephone contact. Over the past three years, the highest rates of improvement were observed for callers who said they felt, anxious, overwhelmed or depressed at the start of the call:

Negative Mood at Call Start	Callers Reporting Decreased Negative Mood at End of Call		
	FY 2019-20	FY 2020-21	FY 2021-22
Anxious	88%	91%	92%
Overwhelmed	89%	88%	90%
Depressed	60%	92%	86%
Worried	78%	85%	85%
Annoyed	82%	82%	83%
Uncertain	88%	81%	79%
Helpless	77%	79%	79%
Confused	75%	78%	78%
Agitated (manic)	64%	67%	64%

Success story:

The NAMI WarmLine launched in OC in October of 2010 and was developed from the NAMI-OC support line, which took an average of 140 calls per month from consumers and family members needing support, information and resources, regarding mental health issues. Since then, the volume of calls to the program continues to grow fast averaging approximately 11,000 calls a month, which indicates the level of need for services.

Challenges/solutions:

An ongoing challenge for the program has been the continuing increase in calls year after year.

At the beginning of the FY 20-21, the program expanded its hours of operation from 18 hours a day to a 24/7 service. The call volume increased from an average of 8,700 calls per month in FY 2019-20 to over 13,000 calls per month in FY 2020-21 and 18,500 calls per month in FY 2021-22. While program funding increased by 24% to cover this service expansion and the provider successfully recruited and filled all new positions within the first two months of the expansion, the anticipated funding and staffing needs were insufficient to meet this surge in demand (50% increase in call volume in FY 2020-21 and a 42% increase in FY 2021-22). The program is attempting to address these challenges by increasing funding that will allow, in part: hiring of additional mentors to staff the WarmLine with a focus on bilingual mentors, reducing reliance on volunteers who work limited and sporadic hours that do not always align with peak call hours, increasing pay to meet market rates in an attempt to reduce staff turnover, and modernizing the program's technical infrastructure so that it is better able to support the WarmLine's dramatically increased call volume.

While not being sufficiently funded to hire enough staff to cover the phoneline was a primary contributor to the escalation of missed calls, several additional factors contributed to this increase. The Warmline is designed to be an emotional support line for callers to reach out repeatedly, sometimes more than once per day, or as needed. A significant appeal of the Warmline is the ability of callers to reach out to the mentors/staff they formed trusting relationships with. If callers do not reach a particular mentor they prefer, they either drop the call/s or

leave a voicemail until they reach their preferred mentor. This led to an increased volume of calls being missed when hours of operation expanded. In addition, calls to the WarmLine are influenced by current events and other factors, including global and national events, which can bring up strong emotions in the callers. The first two years of the pandemic are illustrative of this phenomenon, as initially the predominant mood state of Uncertainty in year one gave way to Depression in year two coinciding with high mortality rates and a general shutdown of the economy. WarmLine staff reported that during the pandemic, Mentors spent more time with each caller; with average time spent with each caller increasing from 16 to 24 minutes. This resulted in creating longer wait times to return voicemails since staff were not always available to answer incoming calls immediately. Additionally, the volunteer pool became almost non-existent due to the pandemic; further straining the staffing coverage. The program has tried different strategies including cross training all WarmLine staff to answer the calls to try and close the gaps in call coverage, but ultimately the program needs to be able to scale up paid staffing positions at competitive market rates in order to sustain the service as a 24/7 program.

NAMI WarmLine program continues to be a crucial resource for the community in providing a 24/7, toll-free, non-crisis telephone support, text and internet chat service for anyone struggling with behavioral health issues. The program provides mental health supportive services, education and resources for Orange County families. The significant increase in the number of calls into the program indicates the wide utilization of these services by the community.

In FY 21-22, NAMI Warmline was able to overachieve most of its contracted goals with the exception of the outreach goal. COVID-19 continued impacting traditional outreach services in a way that is beyond the control of the Program, not allowing for any in-person events since the beginning of the pandemic. However, NAMI has been conducting other forms of outreach to the community including social marketing strategies such as use of social media, radio/TV advertisements and marketing through partner organizations. Additionally, the program its own Friends of the Warmline volunteer group, who held several informational sessions for the WL facilitated by Vietnamese-speaking Support Supervisor and a Peer Mentor.

CSS: Outreach, Engagement and Access to Treatment

Program: Multi-Service Center for Homeless Mentally Ill Adults

Program Serves	Symptom Severity	Location of Services	Typical Population Charateristic
Ages 18+	Severe	Community Based Field Based	Parents Families Medical Co-Morbidities Ethnic Communities Homeless/At-Risk of Recovery from SUD LGBTIQ+ Trauma-Exposed Veterans/Military Connected

Overview of the Program:

The Multi-Service Center for Homeless Mentally Ill Adults (MSC) program in Santa Ana is to offer a safe facility for adults 18 years of age and older with serious mental illness who may have a co-occurring substance use disorder and are experiencing homelessness. The program provides an array of services to meet the most basic and immediate needs of adults including, but not limited to access to showers and laundry facilities, the provision of a mailing address, clothing assistance and access to phones and internet to contact family or conduct a job search and nutritious snacks and beverages. Clients also receive appropriate screening, assessment and linkage to behavioral health treatment and emergency housing, assistance with access to medical services, benefits acquisition and additional food resources. Permanent housing placement assistance and access to pre-vocational services and employment opportunities are available. The program operates Monday through Friday, with the ability to serve 80 clients per day.

Program goal(s) and intended outcome(s):

The goal is to provide basic needs, education and referrals/linkages to resources in the community.

CSS: Outreach, Engagement and Access to Treatment

Description of Services:

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 to the right, 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.

Additional funding has been identified to site and open a second MHSA funded multi-service center to be located in North Orange County in FY 2022-23. Services at the new location will be similar to those at the existing central location. Outcomes for the new site will be available in the annual update to the MHSA 3-Year Plan FY 2023-24 to FY 2025-26.

CSS: Outreach, Engagement and Access to Treatment

Target Population:

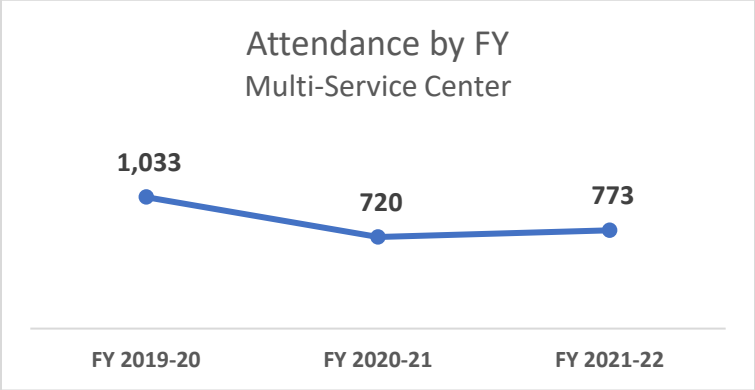
Proportion to be Served by Demographic Characteristic for FY 2023-24					
Age	%	Gender	%	Race/Ethnicity*	%
0-15	22%	Female	28%	African American/Black	14%
16-25	3%	Male	71%	American Indian/Alaskan Native	0%
26-59	80%	Transgender	<1%	Asian/Pacific Islander	5%
60+	17%	Genderqueer	0%	Caucasian/White	70%
		Questioning/Unsure	0%	Latino/Hispanic	33%
		Another	0%	Middle Eastern/North African	0%
				Another	10%

** The percentages do not total 100% due to how demographic data are collected in HMIS, with Caucasian/White including both Hispanic and Non-Hispanic white.*

Fiscal Year	Budget	Number to be served	Cost Per Client
FY 2023-24	$2,582,848	1,350	$1,913
FY 2024-25	$3,231,132	1,350	$2,393
FY 2025-26	$3,231,132	1,350	$2,393

Positive results/Outcomes:

Attendance at the MSC significantly dropped during COVID, and may have started showing signs of a rebound in FY 2021-22:



The overall number of referrals increased 41% from FY 2019-20 to FY 2020-21 and remained level in FY 2021-22. The linkage rate decreased during the pandemic and MSC staff has taken steps to increase successful linkage to services, particularly to MHRS programs.

Referrals to Mental Health and SUD Services		
Fiscal Year	**# Referrals**	**Linkage Rate**
FY 2019-20	**216**	**51.2%**
FY 2020-21	**305**	**31.5%**
FY 2021-22	**315**	**24.1%**

CSS: Outreach, Engagement and Access to Treatment

Success story:

The MSC team collaborates with a variety of human services and non- profit 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.

Challenges/solutions:

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.

CSS: Outreach, Engagement and Access to Treatment

Program: Open Access

Program Serves	Symptom Severity	Location of Services	Typical Population Charateristic
Ages 18+	Severe	Clinic Based	Criminal Justice Involved Recovery from SUD

Overview of the Program:

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 MHRS 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.

Program goal(s) and intended outcome(s):

1. Link adults discharged from the hospital for medication services within 3 business days
2. Link adults discharged from a jail for medication services within 3 business days
3. Link adults referred by open access to ongoing care within 30 days

CSS: Outreach, Engagement and Access to Treatment

Description of Services:

Recovery Open Access serves two key functions: (1) linking adults living 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.

Target Population:

Proportion to be Served by Demographic Characteristic for FY 2023-24					
Age	%	Gender	%	Race/Ethnicity	%
0-15	0%	Female	46%	African American/Black	6%
16-25	28%	Male	53%	American Indian/Alaskan Native	1%
26-59	71%	Transgender	1%	Asian/Pacific Islander	10%
60+	1%	Genderqueer	0%	Caucasian/White	33%
		Questioning/Unsure	0%	Latino/Hispanic	43%
		Another	1%	Middle Eastern/North African	2%
				Another	5%

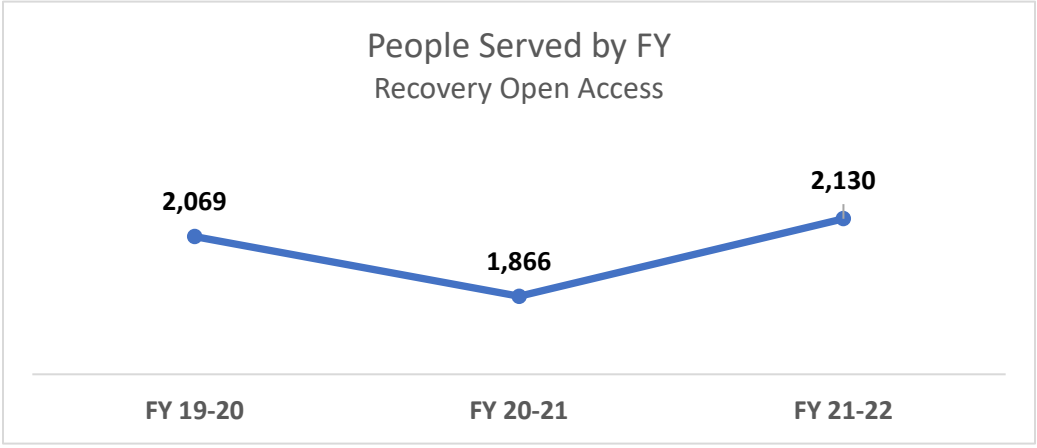
CSS: Outreach, Engagement and Access to Treatment

Projected portions to be served and associated demographics (can we include this as a chart):

Fiscal Year	Budget	Number to be served	Cost Per Client
FY 2023-24	$3,000,000	2,000	$1,500
FY 2024-25	$3,000,000	2,000	$1,500
FY 2025-26	$3,000,000	2,000	$1,500

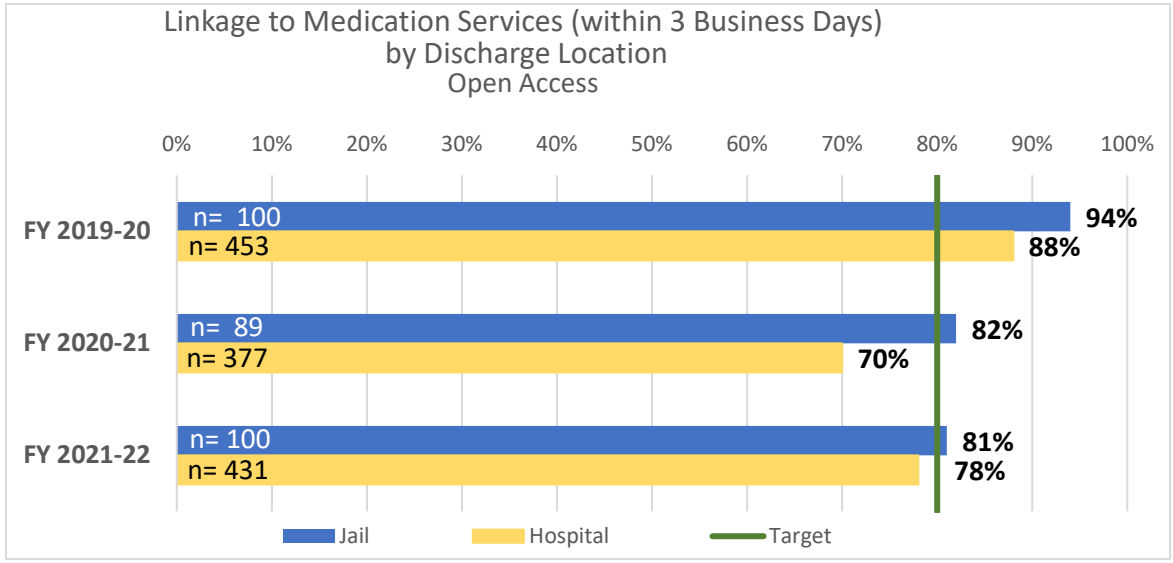
Positive results/Outcomes:

The number of people served has remained fairly consistent over the past three fiscal years, with a dip in FY 2020-21 due to the pandemic:



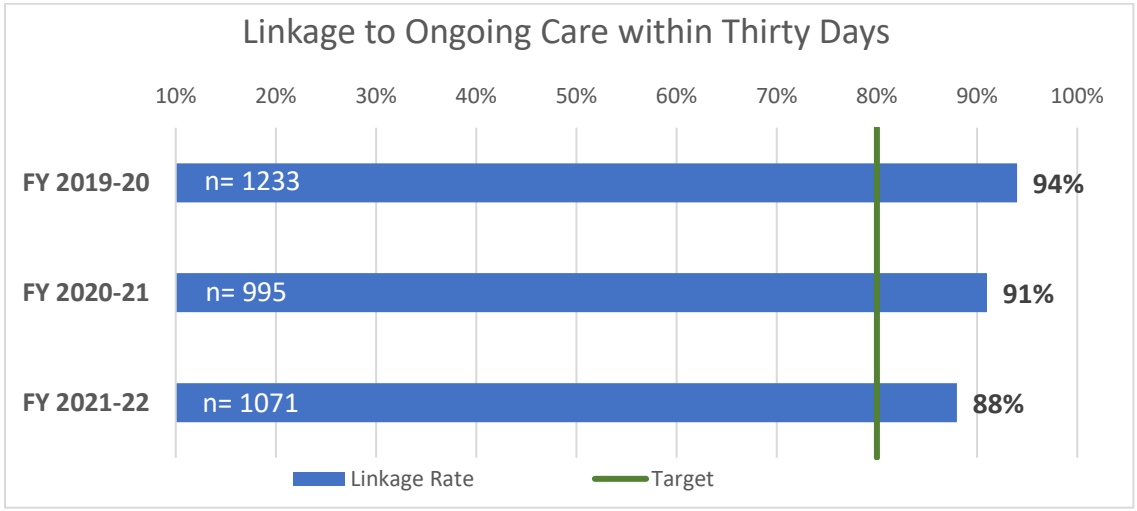
Open Access continued to meet or exceed most of its targets in the past three fiscal years. It missed its target of linking to medication services within 3 business days of discharging from the hospital over two years due to reduced medical staff in one region and limited availability of urgent appointments.

CSS: Outreach, Engagement and Access to Treatment



The program also exceeded its target linkage rate to on-going care across all three fiscal years:

CSS: Outreach, Engagement and Access to Treatment



Success story:

Recovery Open Access has provided services to more than 9,300 individuals since its inception through the end of FY 2021-22. 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.

Challenges/solutions:

Linkage to appointments after hospitalizations and incarcerations continue to be a challenge. The Open Access sites have continued to work on improving linkage to appointments. In addition to the peers located in the Open Access programs to assist with linkage to ongoing mental health services after their assessment at Open Access. Peer navigators have been assisting with linkages to appointments at Open Access from the jail. The Peer Navigator meets with the client prior to their release from jail to begin building rapport with the client. Then on day of release, the peer navigator picks the up and accompanies them to the Open Access appointment. The peer navigator has been instrumental in improving linkage of clients releasing from jail to Open Access.

CSS: Peer and Family Support

Program: Peer Mentor and Parent Partner Support

Program Serves	Symptom Severity	Location of Services	Typical Population Charateristic
All Ages	Mild-Moderate Severe	Clinic Based Field Based	Foster Youth; Parents; Families; Medical Co-Morbitities; Criminal Justice Involved; Ethnic Communities; Homeless/At-Risk of; Recovery from SUD; LGBTIQ+; Veterans/Miliatry Connected

Overview of the Program:

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 ser- vices of a Peer Specialist. Peer Specialists may include peer or youth mentors and/or parent partners who work with participant's 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.

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.

Program goal(s) and intended outcome(s):

The program goals are for adults/older adults engaged in outpatient care to successfully achieve skill-building goals with the support of their peer. Goals most often associated include navigating public transportation system, obtaining identification cards/drivers licenses, completing housing applications and increase socialization skills/activities.

CSS: Peer and Family Support

Description of 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 mental 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 mental 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

Referrals for support with linkage to services are provided by: 1) Therapists working with individuals who need additional support when transitioning between mental 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 reintegrate 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) MHRS therapists working with an individual, and perhaps

their families, on their treatment goals within an outpatient clinic and/or community setting; and/or 2) MHRS Outreach & Engagement (O&E) team and 3) Housing Navigators working with individuals in need of housing sustainability assistance after being placed as part of Orange County's Whole Person Care plan.

Target Population:

Proportion to be Served by Demographic Characteristic for FY 2023-24					
Age	%	Gender	%	Race/Ethnicity	%
0-15	0%	Female	51%	African American/Black	7%
16-25	17%	Male	46%	American Indian/Alaskan Native	2%
26-59	64%	Transgender	<1%	Asian/Pacific Islander	8%
60+	19%	Genderqueer	0%	Caucasian/White	35%
		Questioning/Unsure	1%	Latino/Hispanic	32%
		Another	<1%	Middle Eastern/North African	1%
				Another	16%

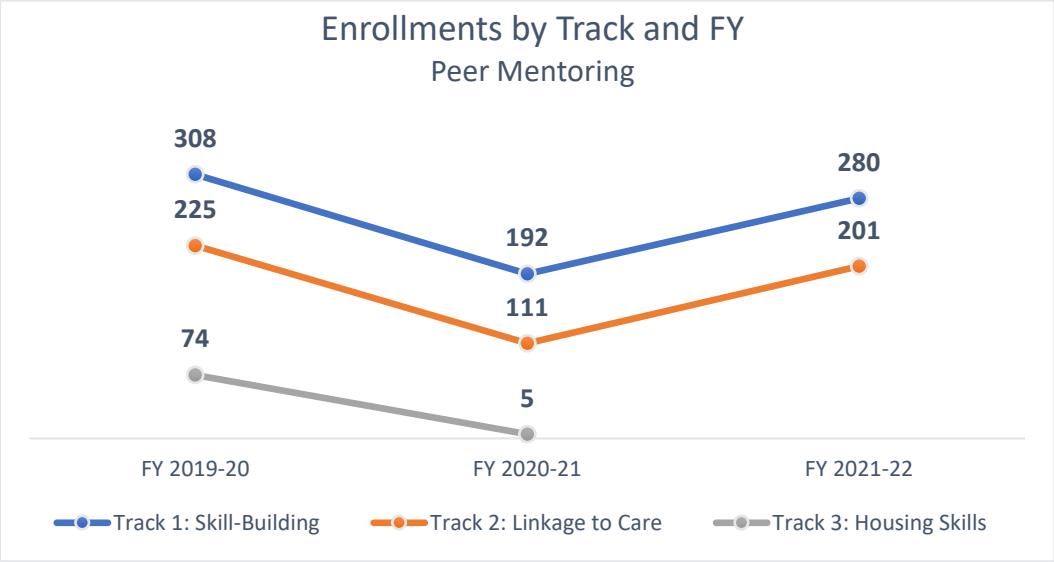
Projected portions to be served and associated demographics (can we include this as a chart):

Fiscal Year	Budget	Number to be served	Cost Per Client
FY 2023-24	$5,180,770	1,000	$5,181
FY 2024-25	$5,424,153	1,000	$5,424
FY 2025-26	$5,424,153	1,000	$5,424

CSS: Peer and Family Support

Positive results/Outcomes:

The number of people enrolled in peer services decreased in FY 2020-21 due to the pandemic, and showed signs of rebounding to pre-pandemic levels in FY 2021-2022, with the exception of Track 3 which was no longer funded by MHSA in FY 2021-22:



Peers consistently helped participants achieve their skill-building and housing goals. Lower rates were seen in helping participants link to care, due to pandemic-related impacts such as program closures, lack of access to technology, staffing shortages, and increased acuity of mental health symptoms.

Goal Achievement Rate	FY 2019-20	FY 2020-21	FY 2021-22
Track 1: Skill-Building	78%	84%	89%
Track 2: Linkage to Care	60%	48%	31%
Track 3: Housing Skills	92%	80%	N/A

Parent partner data for children and youth supported through this program are not currently available for analysis and will be reported in future MHSA Plans.

CSS: Peer and Family Support

Success story:

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 pro- gram also partners with the Wellness Centers, the Council on Aging, NAMI and housing agencies.

Challenges/solutions:

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.

CSS: Peer and Family Support

Program: Wellness Centers

Program Serves	Symptom Severity	Location of Services	Typical Population Charateristic
Ages 18+	At-Risk Mild-Moderate Severe	Community Based Field Based	Recovery from SUD LGBTIQ+ Tramua Exposed Veterans/Military Connected

Overview of the Program:

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.

Program goal(s) and intended outcome(s):

The Wellness Centers monitor their success in supporting recovery through two broad categories: social inclusion and self-reliance

CSS: Peer and Family Support

Description of 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.

CSS: Peer and Family Support

Target Population:

Proportion to be Served by Demographic Characteristic for FY 2023-24					
Age	%	Gender	%	Race/Ethnicity	%
0-15	0%	Female	46%	African American/Black	5%
16-25	10%	Male	52%	American Indian/Alaskan Native	1%
26-59	81%	Transgender	0%	Asian/Pacific Islander	14%
60+	9%	Genderqueer	0%	Caucasian/White	43%
		Questioning/Unsure	0%	Latino/Hispanic	22%
		Another	2%	Middle Eastern/North African	1%
				Another	14%

Projected portions to be served and associated demographics:

Fiscal Year	Budget	Number to be served	Cost Per Client
FY 2023-24	$4,590,244	1,453	$3,159
FY 2024-25	$4,775,513	1,500	$3,184
FY 2025-26	$4,775,513	1,500	$3,184

CSS: Peer and Family Support

Positive results/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 strive to encourage at least 30% of their total participants to engage in two or more groups or social activities each month (telegroups began to be offered in FY 2020-21 in response to COVID). The Centers have continued to meet this target each month for the past three fiscal years.

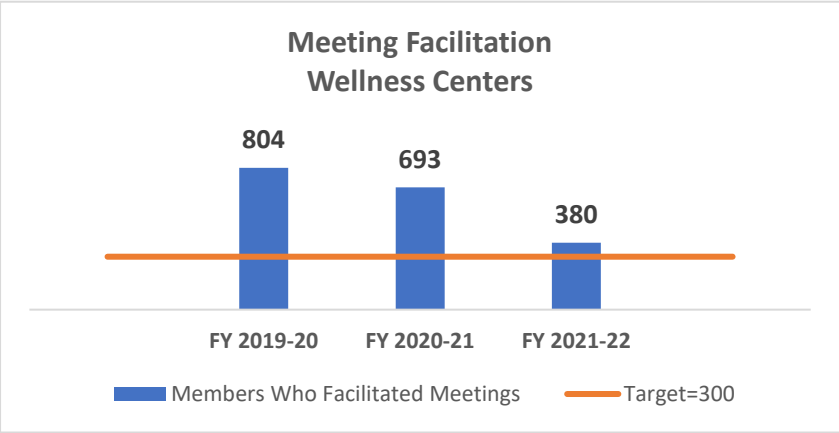
Second, the Centers encourage at least 90 members per month to engage in community integration activities as a key aspect of promoting their recovery. While members continued to participate in community integration activities over the past three years, this target was not met in FY 2020-21 due to limitations and concerns related to COVID. The Centers rebounded in FY 2021-22 to match pre-pandemic levels:

Social Inclusion Key Performance Indicators by FY			
	FY 2019-20	**FY 2020-21**	**FY 2021-22**
Participation in 2+ Groups			
Total Participants	5728	2056	4140
Months target met (>= 30% per month)	77%	59%	77%
Monthly Community Integration			
Total Participants (min / max monthly participants)	0 min / 597 max	1 min / 97 max	127 min / 333 max
Months target met (>= 90+ per month)	9	0	8

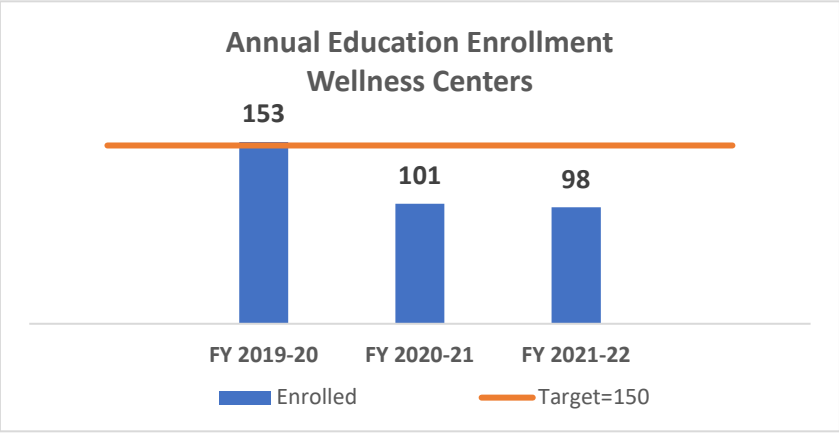
** Early in the pandemic, in-person groups were canceled until the Centers were able to offer telegroups, and in-person community integration activities had to be suspended.*

CSS: Peer and Family Support

The Centers also have a goal of having at least 300 members each year facilitating a meeting. This target was met all three fiscal years.

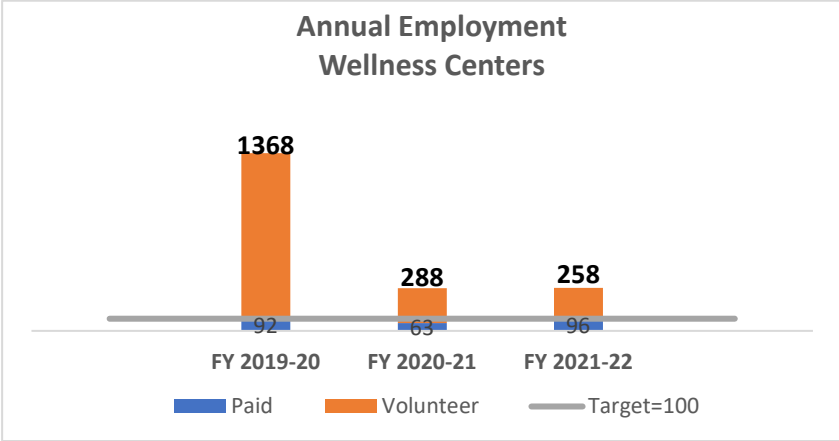


The Wellness Centers also strive to increase a member's self-reliance, as reflected by school enrollment and employment rates. A total of 153, 101, and 98 adults enrolled in education classes during FY 2019-20, FY 2020-21, and FY 2021-22, respectively. Thus, school enrollment remains a challenging area and HCA staff will continue to work with the providers to strategize new ways to increase interest and enrollment in classes.



CSS: Peer and Family Support

During the last three fiscal years, between 24% and 67% of members (24% in FY 2021-22, 31% in FY 2020-21, and 67% in FY 2019-20) were engaged in employment, largely due to participation 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.



Success story:

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.

Challenges/solutions:

Having sufficient healthcare access helps individuals proactively manage their mental health challenges, leading to positive long-term mental wellness outcomes. Members inability to travel to the center due to insufficient funds has been increasingly challenging. Many of our members lack the physical or financial means to afford transportation costs in order to access our services in-person. In addition, some of our members may not be able to afford of owning a computer/phone or lack the necessary knowledge of technologies in order to attend our on-line groups/activities. Mental healthcare is especially difficult due to lingering social stigmas including mental illness/ substance use and COVID-19 Pandemic.

Members may continue to feel unsafe or reluctant to return due to COVID-19 or other communicable diseases.

Although the negative impact of COVID-19 has lessened since the start of the pandemic, many of our members specially the older adults' still hesitant to participate in our in-person activities. To offset the lack of in-person participation we will continue to provide on-line groups to our members and plan additional program community outreach to increase members in-person participation, implementation of sharing resources, as well as promoting and introducing the Wellness Center program to the new potential members in Orange County community.

CSS: Peer and Family Support

Program: Supported Employment

Program Serves	Symptom Severity	Location of Services	Typical Population Charateristic
Ages 18+	Severe	Community Based Field Based	Homeless/At-Risk of Recovery from SUD LGBTIQ+ Trauma-Exposed Vetarns/Miliary Connected

Overview of the Program:

The Adult Supported Employment (ASE) program serves seriously and persistently mentally ill adults eighteen (18) years and older who are legally residing in Orange County and who require job assistance to obtain competitive or volunteer employment. Direct referrals shall be made to the Supported Employment Program from County and contracted Outpatient and Recovery programs, Full Service Partnerships, select Prevention and Intervention and Innovations programs and the Wellness Centers. Clients referred to and enrolled in the Supported Employment program must be engaged in mental health services during their entire enrollment in the program and must have an assigned Plan Coordinator or Personal Services Coordinator who will collaborate with the Supported Employment staff to assist with mental or treatment issues that may arise with their clients.

Program goal(s) and intended outcome(s):

The Supported Employment Program's goal include tracking of participants who graduate after achieving State of California job retention benchmark of 90 days in paid employment.

CSS: Peer and Family Support

Description of 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 mental health and substance use challenges, and who possess skills learned in formal training, and/or profession- al roles, to deliver services in a mental 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.

CSS: Peer and Family Support

Target Population:

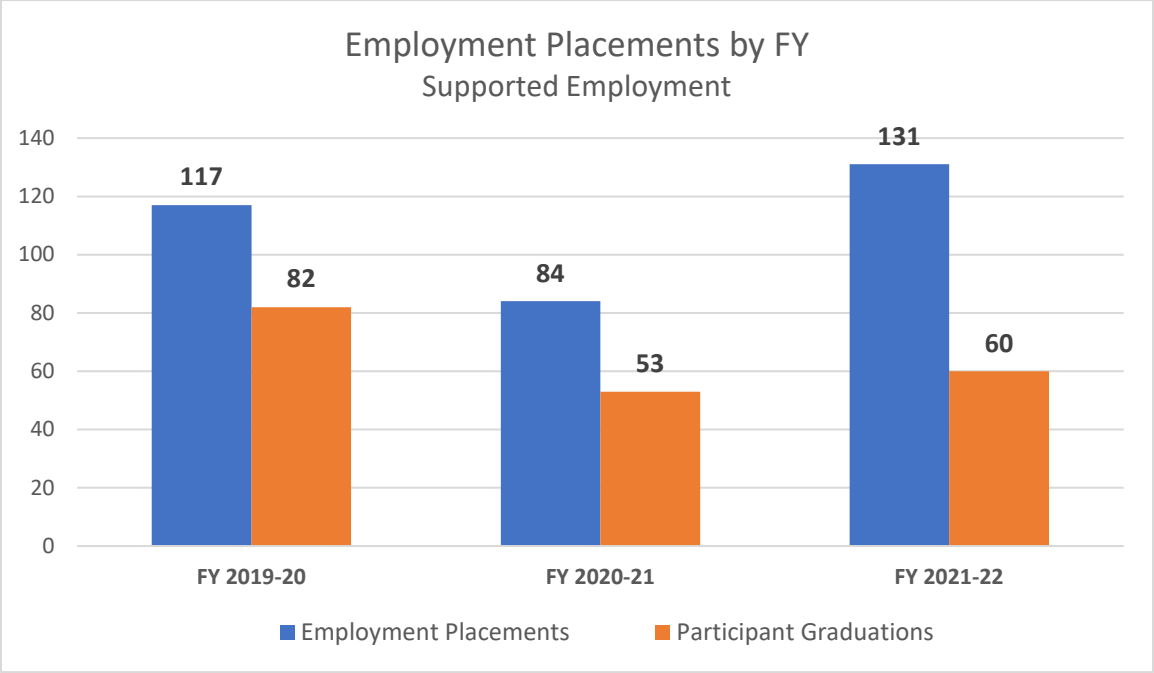
Proportion to be Served by Demographic Characteristic for FY 2023-24					
Age	%	Gender	%	Race/Ethnicity	%
0-15	0%	Female	40%	African American/Black	6%
16-25	20%	Male	60%	American Indian/Alaskan Native	1%
26-59	71%	Transgender	0%	Asian/Pacific Islander	10%
60+	9%	Genderqueer	0%	Caucasian/White	43%
		Questioning/Unsure	0%	Latino/Hispanic	35%
		Another	0%	Middle Eastern/North African	1%
				Another	4%

Projected portions to be served and associated demographics (can we include this as a chart):

Fiscal Year	Budget	Number to be served	Cost Per Client
FY 2023-24	$1,371,262	360	$3,809
FY 2024-25	$1,520,538	360	$4,224
FY 2025-26	$1,520,538	360	$4,224

CSS: Peer and Family Support

Positive results/Outcomes:



	FY 2019-20	FY 2020-21	FY 2021-22
Total Participants Served in FY:	359	286	245
Total Consumers enrolled in FY:	237	218	194
Employment Placements During FY:	117	84	131
Total Graduations FY:	82	53	60
% Employed who Graduated	70%	63%	46%

CSS: Peer and Family Support

Program performance is evaluated by the number of participants who graduate after achieving the State of California job retention benchmark of 90 days of paid employment. A total of 46% met this benchmark during FY 2021-22, continuing the trend of a decreasing graduation rate since FY 2019-20. This is a positive outcome because the COVID-19 pandemic continues to be challenging for many other programs in improving employment outcomes for adults in the MHRS system of care.

During FY 2021-22, Supported Employment experienced changes in staffing by hiring an additional program manager, allowing for improved oversight of the two regions the program serves. There was also high staff-turnover in both North and South regions. Additionally, referrals to the program in South County were lower than anticipated. The provider has increased outreach efforts to programs in that region to improve referrals

Success story:

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.

Challenges/solutions:

During FY 2021-22, referrals to both the north and south programs have been low due to the pandemic, and hesitancy for some participants to join the work- force until there is further decline in the number of covid cases is a primary reason even though there is ample opportunity for employment and an abundance of jobs available. As the pandemic begins to subside, it is anticipated referrals will again increase to expected levels.

CSS: Outpatient Clinic Expansion

Program: Children and Youth Expansion

Program Serves	Symptom Severity	Location of Services	Typical Population Charateristic
Ages 0-21	Mild-Moderate Severe	Clinic Based Community Based Field Based Home Based	Students/Schools Foster Youth Parents Families Ethnic Communities Trauma Exposed

Overview of the Program:

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 Early and Periodic Screening, Diagnosis, and Treatment as part of having full-scope Medi-Cal; b) has a condition placing the child/youth at high risk for a mental health disorder due to the experience of trauma evidenced by scoring in the high-risk range under a trauma screening tool, child welfare or juvenile justice system involvement, or experiencing homelessness; c) requires medically necessary treatment services to address the child's mental health condition.

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

Program goal(s) and intended outcome(s):

The program looks to reduce clinical symptoms and distress over time.

CSS: Outpatient Clinic Expansion

Description of 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 matched to the needs of the client and provided in a culturally competent manner in the clinic, in the community or at a school (with permission) depending on what the youth/family prefers or is clinically appropriate. For foster and probation youth who qualify 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.

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

Target Population:

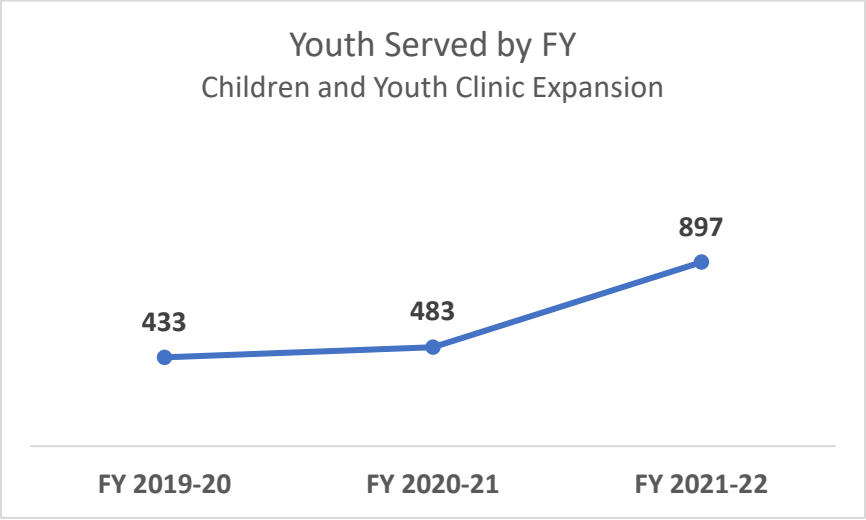
Proportion to be Served by Demographic Characteristic for FY 2023-24					
Age	%	Gender	%	Race/Ethnicity	%
0-15	79%	Female	57%	African American/Black	4%
16-25	21%	Male	43%	American Indian/Alaskan Native	1%
26-59	0%	Transgender	<1%	Asian/Pacific Islander	6%
60+	0%	Genderqueer	0%	Caucasian/White	12%
		Questioning/Unsure	0%	Latino/Hispanic	73%
		Another	<1%	Middle Eastern/North African	1%
				Another	3%

CSS: Outpatient Clinic Expansion

Fiscal Year	Budget	Number to be served	Cost Per Client
FY 2023-24	$21,500,000	2,250	$9,555
FY 2024-25	$23,000,000	2,400	$9,583
FY 2025-26	$23,000,000	2,400	$9,583

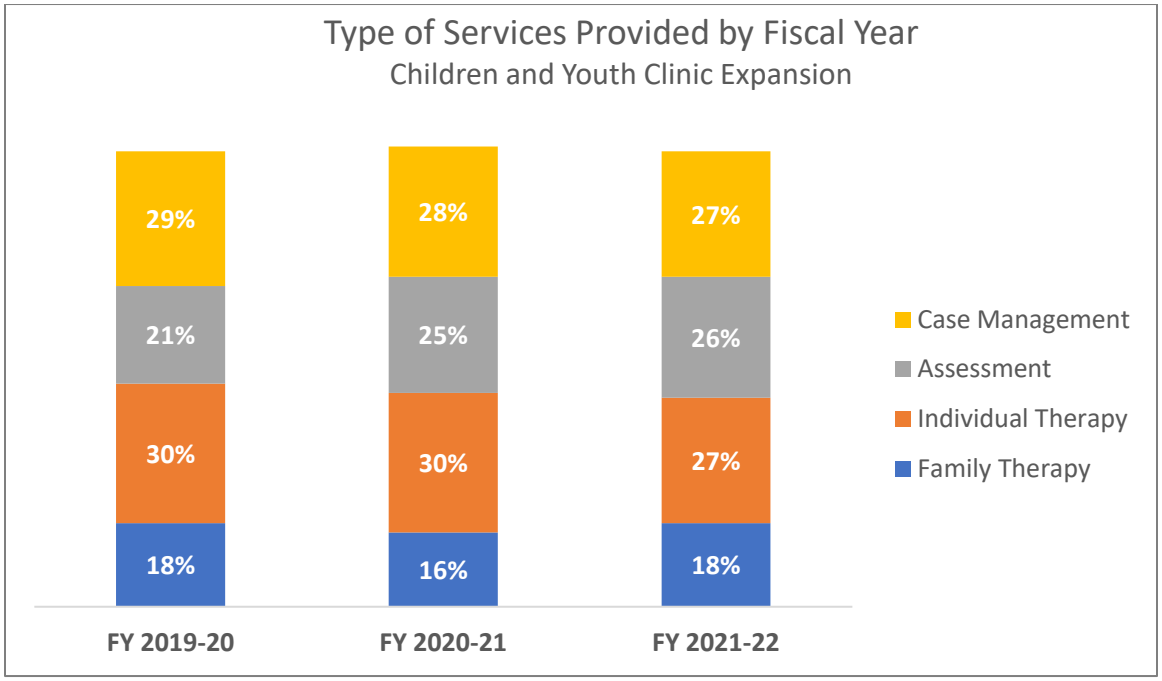
Positive results/Outcomes:

The number of youth served increased in FY 2021-22 as additional clinics received MHSA funding to provide services to children and youth living with serious mental health conditions:



The youth and their families received a variety of clinical services tailored to meet their needs:

CSS: Outpatient Clinic Expansion



NOTE: Group Therapy, Crisis Interventions, Prescriber/Medical Services, and Psych Therapy not shown as each account for 1% or less each FY.

Outcome measure reporting changed in FY 2021-22. Additional program outcomes using new measures will be reported in future Plan Updates.

CSS: Outpatient Clinic Expansion

Success story:

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, the HCA will work with the Orange County Superintendent of Schools (formerly Orange County Department of Education) 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. Be- cause 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.

Challenges/solutions:

The Children and Youth Expansion Services program faced a variety of challenges in FY 2021-22. 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 faced such as childcare, public transportation, unemployment, and hybrid school schedules were 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 can-not, 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. As COVID-19 restrictions begin to relax, an increasing number of children and youth have begun to

return to the clinics for in-person services. Outpatient clinic staff will continue to shift accordingly to meet this need.

CSS: Outpatient Clinic Expansion

Program: Services for Short Term Residential Therapeutic Programs

Program Serves	Symptom Severity	Location of Services	Typical Population Charateristic
Ages 6-20	Severe	Residential Based	Foster Youth Criminal Justice Involved Trauma Exposed

Overview of the Program:

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 up to 21 who need the highest level of mental health care in a trauma-informed residential setting. Residential costs are paid through the foster care system, and the HCA contracts with the S-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 the HCA. The HCA is contracted for 126 beds with seven STRTP providers who have 18 facilities across the county.

Program goal(s) and intended outcome(s):

The goal of STRTP program is to transition youth to lower levels of care at the time of their discharge.

CSS: Outpatient Clinic Expansion

Description of Services:

Per State legislation, youth who meet eligibility criteria may be placed in an S-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 S-STRTP will provide an integrated program of specialized and intensive mental 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, S-STRTP facilities are required to provide evidence-based practices (EBPs) that meet the needs of its targeted 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, 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

CSS: Outpatient Clinic Expansion

Target Population:

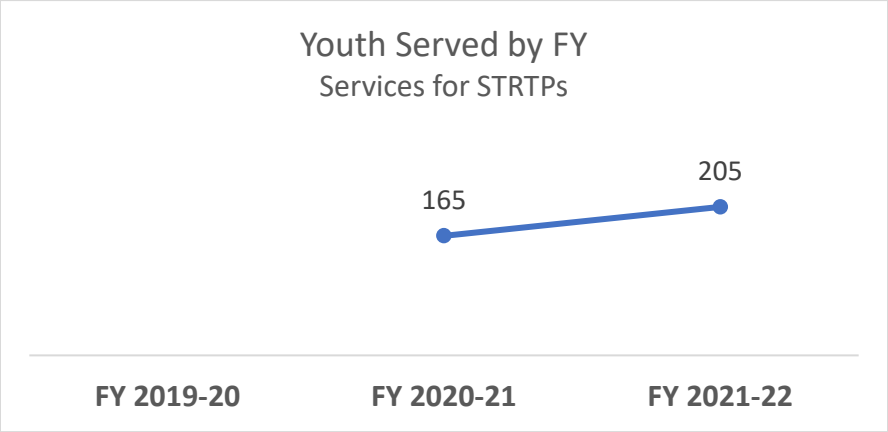
Proportion to be Served by Demographic Characteristic for FY 2023-24					
Age	%	Gender	%	Race/Ethnicity	%
0-15	48%	Female	53%	African American/Black	15%
16-25	52%	Male	45%	American Indian/Alaskan Native	1%
26-59	43%	Transgender	2%	Asian/Pacific Islander	4%
60+	11%	Genderqueer	0%	Caucasian/White	24%
		Questioning/Unsure	0%	Latino/Hispanic	43%
		Another	1%	Middle Eastern/North African	1%
				Another	14%

Fiscal Year	Budget	Number to be served	Cost Per Client
FY 2023-24	$7,000,000	200	$35,000
FY 2024-25	$7,000,000	200	$35,000
FY 2025-26	$7,000,000	200	$35,000

CSS: Outpatient Clinic Expansion

Positive results/Outcomes:

The number of youth served in the STRTPs increased by 24% over the past fiscal year:

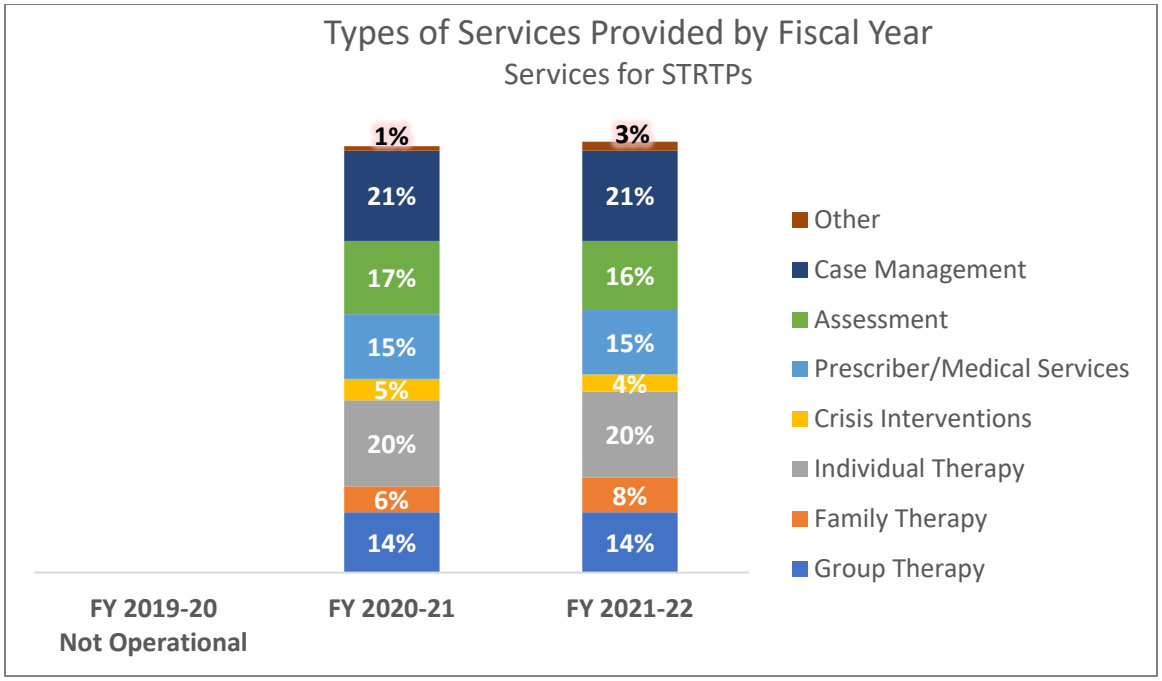


The average length of stay for youth served was longer than the target of six months, which reflects the intensive clinical needs of the youth served in the STRTPs:

	FY 2019-20	FY 2020-21	FY 2021-22
Average Length of Stay	Not operational	263 days (8.8 months)	371 days (12.2 months)

When enrolled in the STRTPs, youth received a variety of clinical services, including therapy, medication management and crisis intervention, that were tailored to meet their needs:

CSS: Outpatient Clinic Expansion



A little over half of the youth served transitioned to lower levels of care or longer-term, family-based placements. When clinically indicated, the programs connected youth to a higher level of care and, in other circumstances, referred youth to a different STRTP:

CSS: Outpatient Clinic Expansion

	FY 2019-20	FY 2020-21	FY 2021-22
Youth Discharged	Not operational	118	163
Transitioned to Lower Level of Care		29% (34)	34% (56)
Reunited with Family/Transitioned to Adulthood		23% (27)	19% (31)
Transferred to Another STRTP		16% (19)	18% (30)
Transferred to Higher Level of Care		15% (18)	14% (23)
No Discharge Destination due to Extended Absence		17% (20)	12% (20)
Unknown Destination		0%	2% (3)

Success story:

During the clients' tenure at the STRTP, the goal is to assimilate them into a supportive, loving, and structured environment that creates the foundation for healing and rebuilding their lives from trauma. A client who was admitted to an STRTP was initially displaying anger outbursts 1-2 times daily that would last an hour or longer, and involved physical and verbal aggression, attempts at running away, and massive emotional dysregulation. The client displayed difficulty in managing his impulsivity and aggressive behaviors in the community, at school, and at home. As a result of his behaviors, the client was removed from multiple placements before being placed at this STRTP. During his time at the STRTP, the clinical team provided individual therapy, group rehabilitation, intensive home based services, medication support services, and intensive care coordination to assist the youth in processing trauma and establishing coping skills to enhance self-regulation. The client began to open up to others gradually and use imaginative play to process his trauma. He developed safe and supportive connections with the residential and clinical team at the STRTP. The team watched the client blossom into a positive, affectionate, and playful youth. The client learned to use his words to express his feelings and to use coping skills to calm his dysregulation. He successfully transitioned to a foster home, and the STRTP clinical team continued to

provide aftercare to facilitate a smooth transition. The STRTP's intensive treatment interventions provided the opportunity for the client to break generational patterns of abuse and trauma, and helped rebuild the youth's life for long term success.

This is another story of persistence from both the client and the STRTP team. The client was placed in one of the STRTP homes in December 2020. Throughout his placement in the program, the client's transition plan was unclear. The client initially had visits with his mother with the potential of transitioning back to mother's care. However, the client and mother had a strained relationship, which the STRTP team helped to navigate. With the support of the clinical team, the client was able to advocate for himself and set healthy boundaries with his mother. Initially, the client engaged in substance use to cope with his trauma. As the client developed rapport with the program staff and worked on emotional regulation and implementing coping skills in his sessions with the clinical team, the client was able to decrease and eventually cease his use of substances. In the summer of 2022, the client took the initiative and got his first job. In the fall of that year, with the support of one of the mental health rehabilitation specialists, the client was linked to a counselor at a community college who helped him apply for college and scholarship programs. The client successfully graduated from high school early in December 2022. The STRTP team helped the client apply for Transitional Housing Programs (THP), and just over two years after being placed in the STRTP, on his 18th birthday, the client transitioned from the STRTP to a THP. The STRTP team planned a big celebration and helped the client move into his new home.

Challenges/solutions:

Due to the eligibility criteria for STRTP placements being quite stringent, the clients are placed at STRTPs only after they have disrupted from multiple previous placements, and are in need of high acuity of care. This means that the clients arrive with multiple traumas associated with abandonment, in addition to the reasons for initial removal from their families of origin, which creates additional barriers in establishing the trust needed for engagement and treatment. Additionally, the concentration of youth demonstrating in high risk behaviors and in need of intensive clinical interventions often leads to clients having negative influences on each other. If the STRTP placement requirements were stretched a bit to allow

clients to be placed at STRTPs earlier or to remain longer, not only would the STRTP team be able to strengthen the clinical gains for the clients, but also, the clients would have the opportunity for positive role modeling amongst their peers within the STRTPs. The STRTPs would be able to make a bigger impact in the clients' journey for healing and improve long term outcomes for the youth.

Another challenge encountered at the STRTPs is the difficulty in establishing viable and timely transition plans. A common occurrence is that the STRTP team is able to stabilize the clients, but with no concrete transition plans in place, the clients seem to lose hope and regress in their behaviors. The STRTP teams collaborate with the placing workers and discuss transition plans at the Child and Family Team (CFT) Meetings on an ongoing basis. The STRTP clinicians provide family therapy if there is a possibility of family reunification. In addition, some programs have a Parent Partner whose goal is to strengthen, and at times rebuild, connections with the caregivers, various family members, and other natural supports. The challenge often is in finding appropriate step down placements for the clients when they are ready for the transition from the STRTPs. One goal is for the STRTPs to facilitate pre-placement meetings with the placing workers to discuss the STRTP program expectations, the clients' clinical needs and treatment goals, and begin exploring transition plans early on so that the CFT members may consider all possible options together from the start of STRTP placement.

CSS: System Development: Outpatient Clinic Expansion

Program: Outpatient Recovery

Program Serves	Symptom Severity	Location of Services	Typical Population Charateristic
Ages 18+	Severe	Clinic Based Field Based	Ethnic Communities Recovery from SUD Trauma Exposed

Overview of the Program:

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 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

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 Mental Health Recovery Services(AOAMHRS) Outpatient Clinics after all emergent mental health issues have resolved. This typically occurs within the first 3 to 6 months

Program goal(s) and intended outcome(s):

There are two goals of the Outpatient Recovery program:

1. Have psychiatric hospitalization rate of less than 1% whole participants are enrolled
2. Discharging at least 60% of those with known discharge dispositions into a lower level of care.

CSS: System Development: Outpatient Clinic Expansion

Description of 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 pro- grams 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.

Target Population:

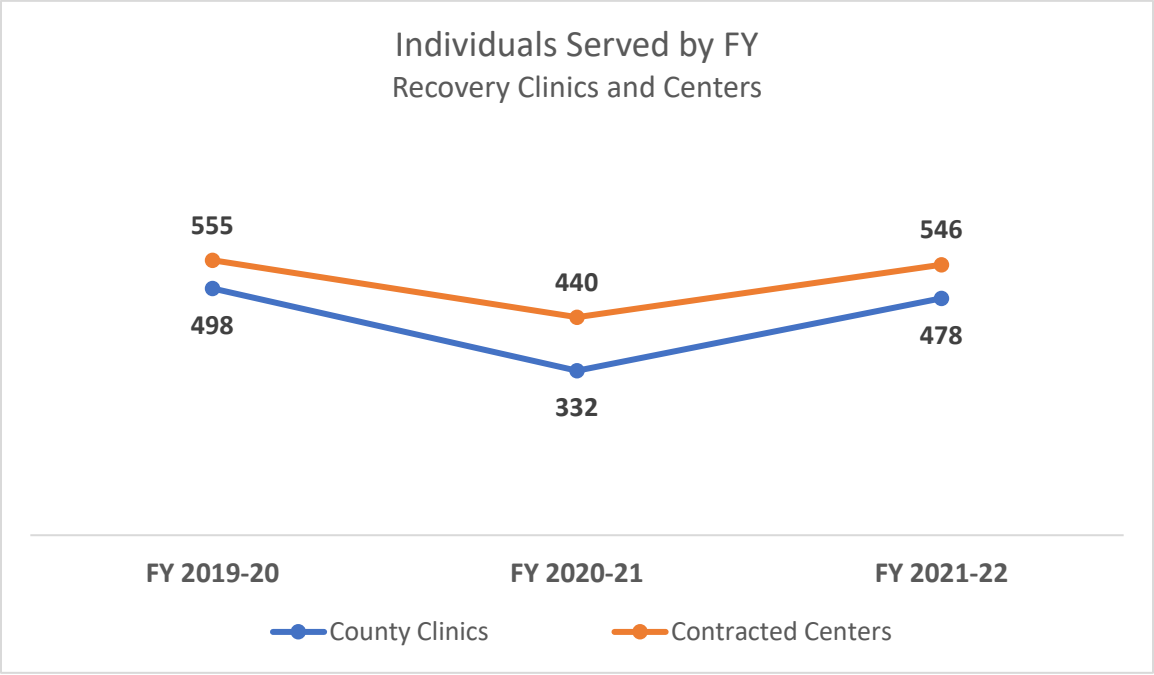
Proportion to be Served by Demographic Characteristic for FY 2023-24					
Age	%	Gender	%	Race/Ethnicity	%
0-15	0%	Female	53%	African American/Black	5%
16-25	8%	Male	46%	American Indian/Alaskan Native	0%
26-59	82%	Transgender	<1%	Asian/Pacific Islander	10%
60+	10%	Genderqueer	<1%	Caucasian/White	35%
		Questioning/Unsure	0%	Latino/Hispanic	41%
		Another	0%	Middle Eastern/North African	2%
				Another	6%

Fiscal Year	Budget	Number to be served	Cost Per Client
FY 2023-24	$7,400,000	1,050	$7,048
FY 2024-25	$7,400,000	1,050	$7,048
FY 2025-26	$7,400,000	1,050	$7,048

CSS: System Development: Outpatient Clinic Expansion

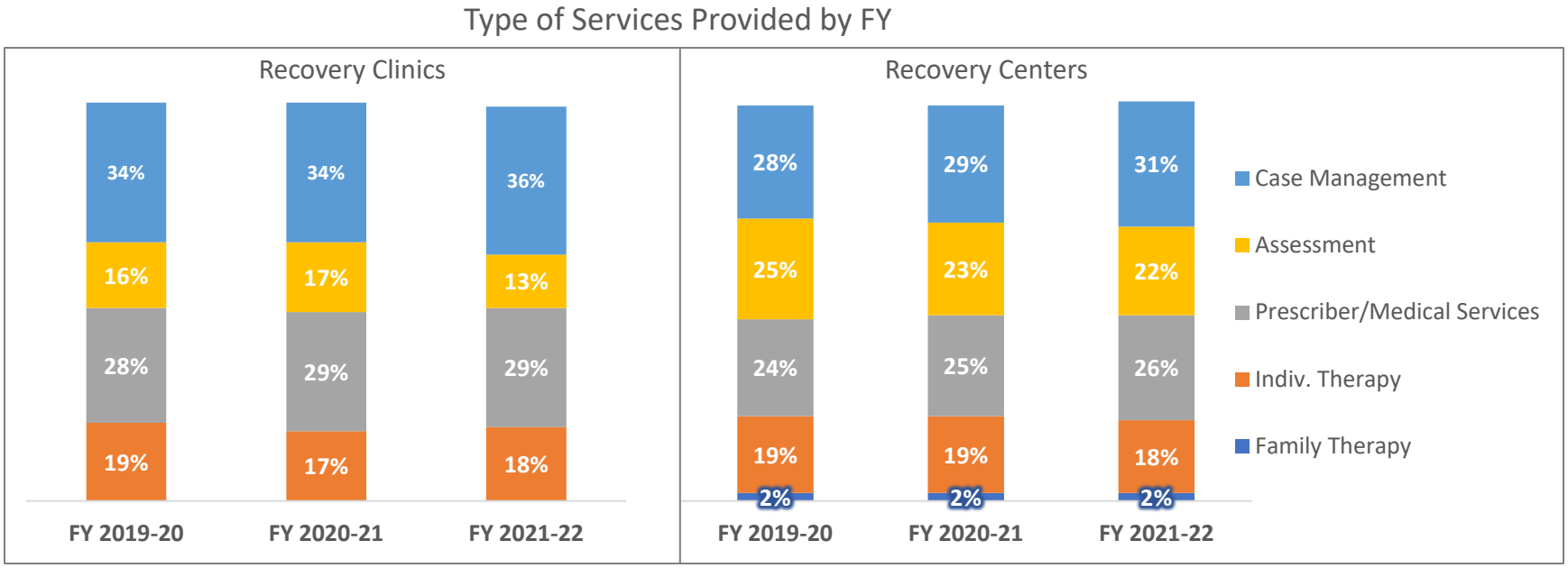
Positive results/Outcomes:

The number of people served in the Recovery Clinics and Centers rebounded in FY 2021-22 following a dip in enrollment during the pandemic:



CSS: System Development: Outpatient Clinic Expansion

The individuals served in the Recovery Clinics and Centers received a variety of clinical services tailored to meet their needs:



NOTE: Crisis Outpatient, Group Therapy, Family Therapy (Clinics only), Psych Testing, and Other each total < 1%.

Over the past three years, the Recovery Centers and Clinics were successful in meeting their target rate of hospitalization at less than 1% when discharging clients from the program, reflecting their success in helping individuals maintain recovery and remain within their communities.

The Recovery Clinics and Centers also continue to struggle with achieving their target rate of referring at least 60% of its participation to a lower level of care upon discharge. To address this area of on-going challenge, 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.

	Key Performance Indicators by FY					
	FY 2019-20		FY 2020-21		FY 2021-22	
	Hospitalization <1%	LLOC (Target 60%)	Hospitalization < 1%	LLOC (Target 60%)	Hospitalization < 1%	LLOC (Target 60%)
Contracted Centers	0.50%	53%	0.36%	47%	0.28%	41%
County Clinics	0.40%	53%	0.51%	62%	0.37%	28%

Green = Met target Red = Did not meet target

Success story:

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.

Challenges/solutions:

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.

CSS: System Development: Outpatient Clinic Expansion

Program: Older Adult Services

Program Serves	Symptom Severity	Location of Services	Typical Population Charateristic
Ages 60+	Severe	Community Based Field Based	Medical Co-Morbidities Criminal Justice Involved Homeless/At-Risk of Recovery from SUD Trauma Exposed

Overview of the Program:

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.

Program goal(s) and intended outcome(s):

There are two goals of the Outpatient Recovery program:

1. Have psychiatric hospitalization rate of less than 1% whole participants are enrolled
2. Discharging at least 60% of those with known discharge dispositions into a lower level of care.

CSS: System Development: Outpatient Clinic Expansion

Description of 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, pharmacist consultation, 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.

Target Population:

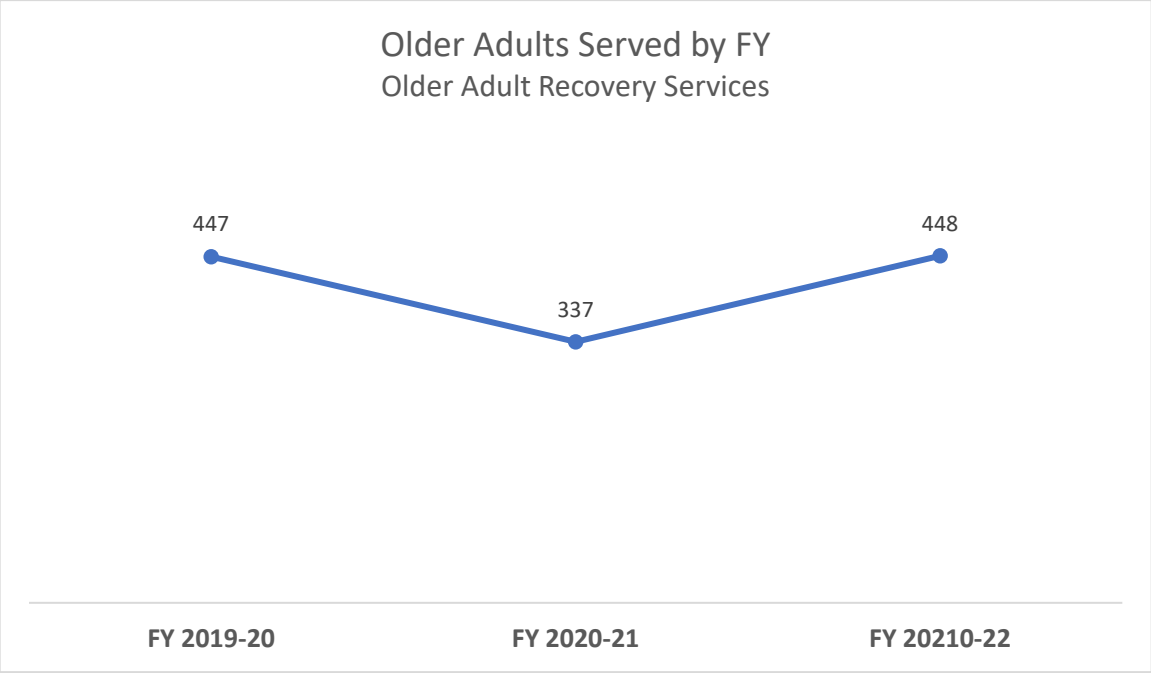
Proportion to be Served by Demographic Characteristic for FY 2023-24					
Age	%	Gender	%	Race/Ethnicity	%
0-15	0%	Female	57%	African American/Black	5%
16-25	0%	Male	43%	American Indian/Alaskan Native	0%
26-59	3%	Transgender	0%	Asian/Pacific Islander	12%
60+	97%	Genderqueer	0%	Caucasian/White	45%
		Questioning/Unsure	0%	Latino/Hispanic	16%
		Another	>1%	Middle Eastern/North African	2%
				Another	20%

Fiscal Year	Budget	Number to be served	Cost Per Client
FY 2023-24	$2,175,000	530	$4,104
FY 2024-25	$2,175,000	530	$4,104
FY 2025-26	$2,175,000	530	$4,104

CSS: System Development: Outpatient Clinic Expansion

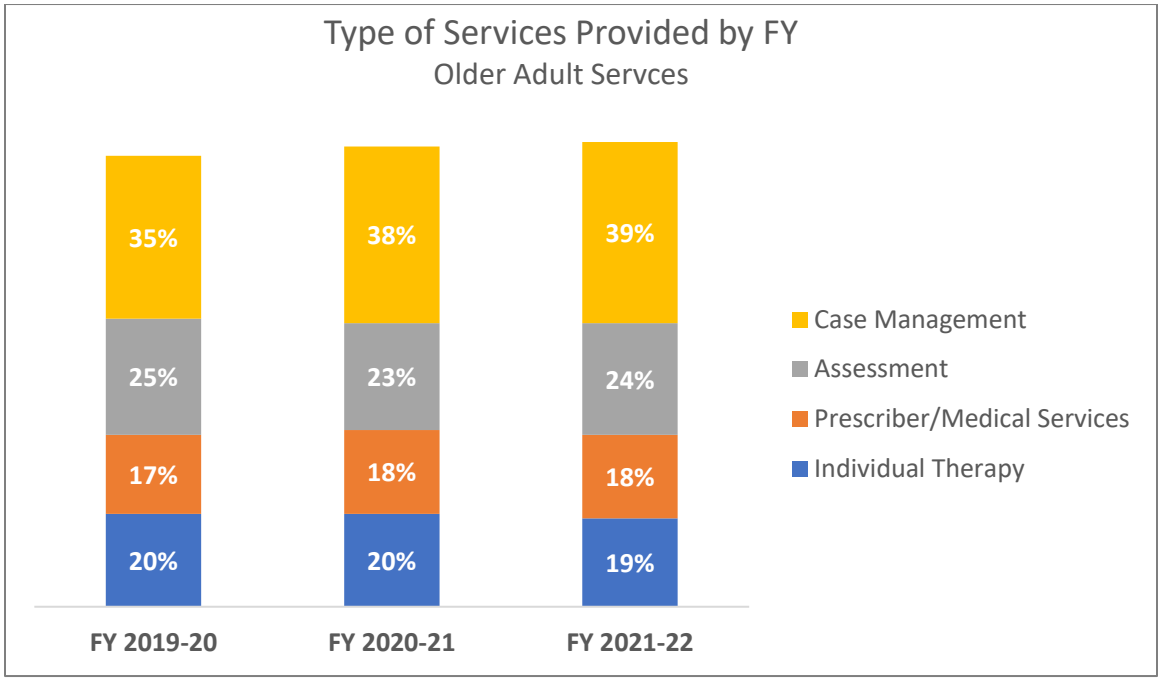
Positive results/Outcomes:

The number of older adults served appeared to rebound in FY 2021-22 after enrollment dipped during the pandemic:



The older adults served received a variety of clinical services tailored to meet their needs:

CSS: System Development: Outpatient Clinic Expansion



NOTE: Group Therapy, Crisis Outpatient, Psych Testing, and Other Services each total less than 1% for each FY and are not included in the above chart.

Older Adult Recovery Services was generally successful in meeting their target of discharging older adults to the hospital less than 1% of the time, reflecting their success in helping individuals maintain recovery and remain within their communities. More older adults were discharged to the hospital in FY 2020-21.

The program continued to struggle with achieving their target rate of referring at least 60% of older adults to a lower level of care upon discharge. The HCA is aware of the situation of addressing the ongoing needs of the older adults and at the same time refer to a lower level of care when it is appropriate and needed. Because older adults are more vulnerable, it sometimes takes more time to transition to a lower level of care to avoid re-referral and / or hospitalization.

CSS: System Development: Outpatient Clinic Expansion

FY 2019-20		FY 2020-21		FY 2021-2022	
Hospitalization <1%	LLOC (Target 60%)	Hospitalization < 1%	LLOC (Target 60%)	Hospitalization < 1%	LLOC (Target 60%)
0.00%	20.1%	1.36%	14.6%	0.60%	20.4%

Green = Met target Red = Did not meet target

Success story:

OAS collaborates with the Public Health Services Senior Health Out- reach 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, OC 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 participant's 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

Challenges/solutions:

OAS continues to encounter ongoing 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 such as implementing the PHQ-9 every six months. 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

CSS: Full Service Partnerships

Program: Children Full Service Partnership

Program Serves	Symptom Severity	Location of Services	Typical Population Charateristic
0-18	Severe	Community Based Field Based	Students/Schools; Parents; Families; Medical Co-Morbidities; Criminal Justice Involved; Ethnic Communities; Homeless/At-Risk-of; Recovery from SUD; Trauma Exposed

Overview of the Program:

The Children's Full Service Partnership/Wraparound programs provide intensive, community-based services to promote wellness and resilience in children living with serious emotional disturbance and their families. Services include case management; crisis intervention; education support; transportation; housing; and socialization and recreational activities. FSPs employ a "whatever it takes" team approach, are available 24/7, and provide flex funding. There are currently five distinct programs within the Children's Full Service Partnership (FSP)/Wraparound category, and each program focuses on a specific target population as described below.

- **Project Reaching Everyone Needing Effective Wrap (RENEW) FSP** provides services to children from birth to age 18 who are living with Serious Emotional Disturbance (SED). The program accepts referrals from the Outreach and Engagement teams, Crisis Assessment Team, general public, and County and contract clinics. Prominent among these referrals are children and youth who are homeless or at risk of homelessness. In addition to the treatment services provided to the children and youth, the parents frequently receive job assistance, especially when the needs of their child or youth with SED impact their ability to maintain employment.
- Project **For Our Children's Ultimate Success (FOCUS) FSP** specializes in serving culturally- and/or linguistically-isolated Asian-Pacific Islander youth living with SED or Serious Mental Illness (SMI), with a particular focus on the Korean and

Vietnamese communities in the County. The program serves children and youth ages 0-25 and their families.

- **Youthful Offender Wraparound (YOW) FSP** serves children and youth through age 25 who are experiencing SED/SMI and involved with the juvenile justice system. The program focuses on maintaining the gains the youth made while receiving services in custody and reintegrating the youth into the community. Learning how to obtain and maintain employment despite significant mental health issues is a particular focus of this FSP.
- **Collaborative Courts (Girls and Boys Courts) FSP** program primarily works with the Juvenile Court to support youth through age 25 with SED/SMI who are in the foster care system and have experienced multiple placement failures. These youth face a considerable number of problems and stressors and may require services well into early adulthood.
- **Collaborative Courts** (Juvenile Recovery [formerly Drug] and Truancy Courts) FSP works with Juvenile Recovery Court youth with SED/SMI both while within the Court's prevue and after graduation when they are no longer on Probation. The goal of the program is to assist the youth develop alternative coping skills, educational opportunities and job training. This FSP also supports the Juvenile Court's Truancy Response Program, providing services to youth with SED/SMI. Many of these youth face multiple problems and stressors. This is often the first time they have come to the attention of the "helping system." Both parts of this FSP program serve children and youth up through age 25.
- The Children and Youth Behavioral Health **Program of Assertive Community Treatment** (CYBH PACT) is an individualized treatment approach that offers intensive services in the community. The children and transitional age youth served in this program struggle with the onset of acute and chronic symptoms of mental illness and often present with co-occurring diagnoses and multiple functional impairments. This diverse population needs frequent and consistent contact to engage and remain in treatment, and typically requires intensive family involvement. The target population is children and youth ages 14-21 with Serious Emotional Disturbance (SED) or Serious

Mental Illness (SMI) who have had a previous hospitalization or incarceration or are in need of more intensive mental health services than those provided in a traditional outpatient program.

- **OC Children with Co-Occurring Mental Health and Physical Health FSP** serves children and youth with physical illness complicated by their mental health issues. These children's and youths' physical recovery is complicated by their mental health issues, and their reactions to physical health issues may exacerbate their mental health issues. Also included in this group are children and youth with severe eating disorders. The target population for this program is youth through age 18 who are being seen primarily by Oncology, Endocrinology and Neurology services at a local hospital. Parents and siblings are an integral part of the treatment process, given the disruption to the family structure when the survival of one family member becomes the family's main focus. Many of these children and youth are Medi-Cal beneficiaries and MHSA funds serve as a match to the drawdown of federal funds.

Program goal(s) and intended outcome(s):

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.

In addition to dispatch-to-arrival times, the teams also evaluate the percentage of individuals who are placed on a psychiatric hold as a result of the risk assessment versus the percentage of individuals served who can be linked with safe alternatives to inpatient services in the community.

CSS: Full Service Partnerships

Description of 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. FSP programs follow the Assertive Community Treatment (ACT) model of providing comprehensive, community-based interventions, linguistically and culturally congruent 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/caregiver 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 and entitlements, transportation resources, basic needs and other resources available in the community. PSCs and/or other FSP staff also help individuals develop skills to manage challenging symptoms, behaviors or impairments and work with significant others and caregivers, when

available, to support client learning and practicing new skills.

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 FSP programs approach to service and care planning. FSP programs offer family support groups, 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.

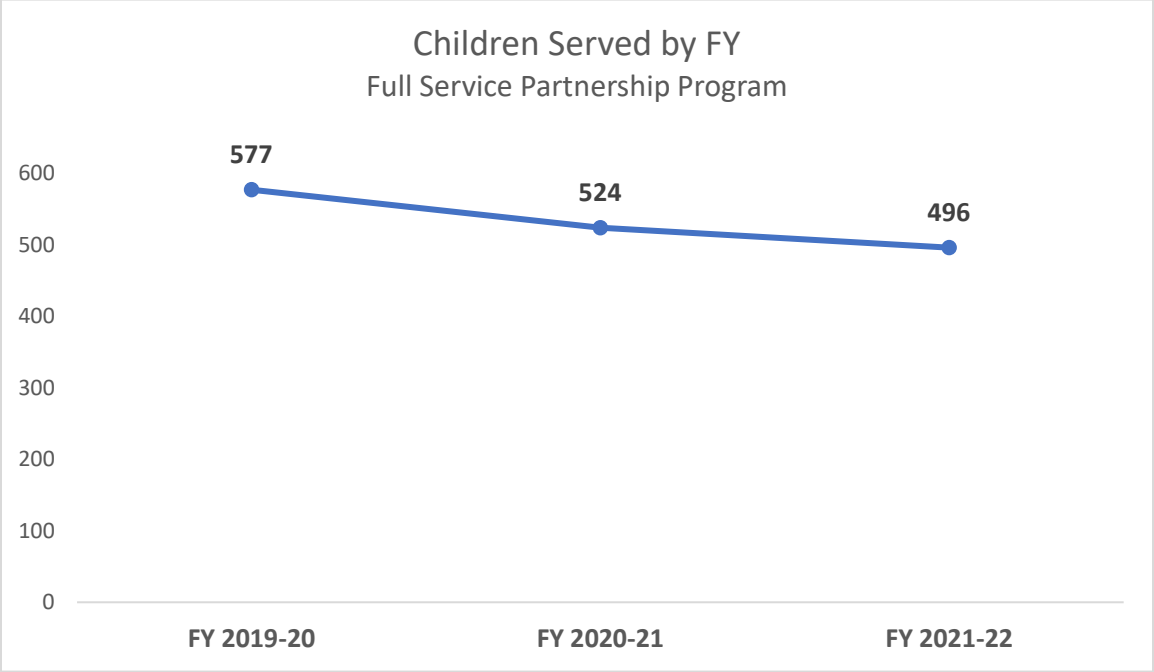
Target Population:

Proportion to be Served by Demographic Characteristic for FY 2023-24					
Age	%	Gender	%	Race/Ethnicity	%
0-15	100%	Female	50%	African American/Black	6%
16-25	0%	Male	50%	American Indian/Alaskan Native	1%
26-59	0%	Transgender	1%	Asian/Pacific Islander	20%
60+	0%	Genderqueer	>1%	Caucasian/White	19%
		Questioning/Unsure	0%	Latino/Hispanic	51%
		Another	>1%	Middle Eastern/North African	>1%
				Another	1%

CSS: Full Service Partnerships

Fiscal Year	Budget	Number to be served	Cost Per Client
FY 2023-24	$21,592,044	$21,592,044	1,000
FY 2024-25	$21,592,044	$22,592,044	1,000
FY 2025-26	$21,592,044	$22,592,044	1,000

Positive results/Outcomes:



CSS: Full Service Partnerships

FSP programs do “whatever it takes” to support the wellness, recovery and safety of its members, with the goal that at least 80% of members remain safely in the community and do not require psychiatric hospitalization or mental health-related emergency intervention, remain out of custody, avoid arrest and/or do not experience unsheltered homelessness or use of an emergency shelter.

Children (based on age at the start of the fiscal year being reported) met all targets during the past three years:

Key Performance Indicator	Children FSP Members			
	Target	FY 2019-2020	FY 2020-21	FY 2021-22
Mental Health Recovery				
No Days in Hospital	**≥80%**	**93.4%**	**93.3%**	**92.7%**
No Emergency Interventions	**≥80%**	**92.6%**	**93.7%**	**91.9%**
Justice Involvement				
No Days Incarcerated	**≥80%**	**95.4%**	**95.2%**	**95.8%**
No Arrests	**≥80%**	**97.2%**	**96.6%**	**96.6%**
Homelessness				
No Days Spent in Unsheltered Homelessness	**≥80%**	**99.5%**	**99.6%**	**100%**
No Days in Emergency Shelter	**≥80%**	**96.9%**	**100%**	**99.6%**

Green=Target met Red= Target not met

The 80% benchmarks, established in 2022, will be refined as additional years of data are analyzed, with particular attention paid to whether separate benchmarks should be established for programs that specialize in serving those who are justice-involved or experiencing unsheltered homelessness.

CSS: Full Service Partnerships

Success story:

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.

Challenges/solutions:

Finally, in FY 2020-21 the Children's Project RENEW program was expanded by 20 slots to serve children/youth in Intensive Services Foster Care (ISFC). While ISFC homes are not currently in place in Orange County, the program continues to provide FSP "whatever it takes" services to the foster youth (including those that would meet criteria for ISFC) of Orange County. With ISFC homes still pending in Orange County, Project RENEW has utilized the additional slots that were added in FY 2020-21 to support high need foster youth.

Employment has also continued to be an ongoing and significant challenge de- spite 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 in- crease 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.

CSS: Full Service Partnerships

Program: Transitional Aged Youth Full Service Partnership

Program Serves	Symptom Severity	Location of Services	Typical Population Charateristic
0-18	Severe	Community Based Field Based	Students/Schools; Parents; Families; Medical Co-Morbidities; Criminal Justice Involved; Ethnic Communities; Homeless/At-Risk-of; Recovery from SUD; Trauma Exposed

Overview of the Program:

The Transitional Aged Youth (TAY) Full Service Partnership (FSP) serves youth aged 16-25 through an array of who are homeless or at risk of homelessness, who are culturally or linguistically isolated, and/or who are at risk of incarceration or psychiatric hospitalization due to Serious Emotional Disturbance (SED) or Serious Mental Illness (SMI), frequently complicated by substance use. There are currently five programs within the Transitional Age Youth FSP category, which serve particular target populations.

- **Support Transitional Age Youth (STAY) Process FSP** serves TAY who are living with SED or Serious Mental Illness (SMI) that is frequently complicated by substance use, almost all of whom are at some risk of homelessness. TAY are provided support and guidance to help them increase their abilities and skills essential to being self-sufficient adults.
- **Project For Our Children's Ultimate Success (FOCUS) FSP** specializes in serving culturally and/or linguistically-isolated Asian-Pacific Islander youth living with SED or SMI), with a particular focus on the Korean and Vietnamese communities in the County. The program serves youth through age 25 and their families.
- **Youthful Offender Wraparound (YOW) FSP** serves youth through age 25 who are experiencing SED/SMI and involved with the juvenile justice system. The program focuses on maintaining the gains the youth made while receiving services in custody and reintegrating the youth into the community. Learning how to obtain and maintain

employment despite significant mental health issues is a particular focus of this FSP.

- **Collaborative Courts (Girls and Boys Courts) FSP** program primarily works with the Juvenile Court to support youth through age 25 with SED/SMI who are or were in the foster care system and have experienced multiple placement failures. These youth face a considerable number of problems and stressors and may require services well into early adulthood.
- **Collaborative Courts (Juvenile Recovery [formerly Drug] and Truancy) FSP** works with Juvenile Recovery Court youth with SED/SMI both while within the Court's prevue and after graduation when they are no longer on Probation. The goal of the program is to assist with alternative coping skills, educational opportunities and job training. This FSP also supports the Juvenile Court's Truancy Response Program, providing services to youth with SED/SMI. Many of these youth face multiple problems and stressors. This is often the first time they have come to the attention of the "helping system." Both parts of this FSP program serve children and youth up through age 25.
- The **Program of Assertive Community Treatment (PACT)** is the County-operated version of a Full Service Partnership program. PACT utilizes the evidence-based Assertive Community Treatment model to provide comprehensive, "whatever it takes," field-based outpatient services to persons ages 16-25 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.

Program Goal(s) and intended outcomes

The goal of the TAY FSP Program, as well as all FSP programs, are related to mental health recovery, living situation, legal involvement, employment and or school performance

CSS: Full Service Partnerships

Description of 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. FSP programs follow the Assertive Community Treatment (ACT) model of providing comprehensive, community-based interventions, linguistically and culturally congruent services, and around-the-clock crisis intervention and support by coordinated, multidisciplinary teams. The teams can include a combination of clinical and non-clinical staff, including peers, to support mental health, substance use, housing, case management, and employment needs of the consumer. All team members 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.

FSPs provides individual, family and group counseling and therapy to help individuals reduce and manage their symptoms, improve functional impairments and assist with family/caregiver dynamics. A wide array of evidence-based practices are available and, depending on the needs of the TAY, 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, Seeking Safety, Illness Management and Recovery, Moral Reconation Therapy (MRT), 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 and entitlements, transportation resources, basic needs and other resources available in the community. PSCs and/or other FSP staff also help individuals develop skills to manage challenging symptoms, behaviors or impairments and work with significant others and caregivers, when

available, to support client learning and practicing new skills.

Employment and/or housing support and coordination services are provided to assist and support participants in these essential elements of recovery. Numerous workshops and classes to teach and hone prevocational and vocational skills such as resume writing, interviewing skills, computer skills, etc. are offered. Housing coordination services are provided to 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 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.

Family involvement in treatment and services can be critical to supporting and maintaining an individual's recovery and has been central to the TAY FSP program providers' approach to service and care planning.

enable them to assist their family member's recovery.

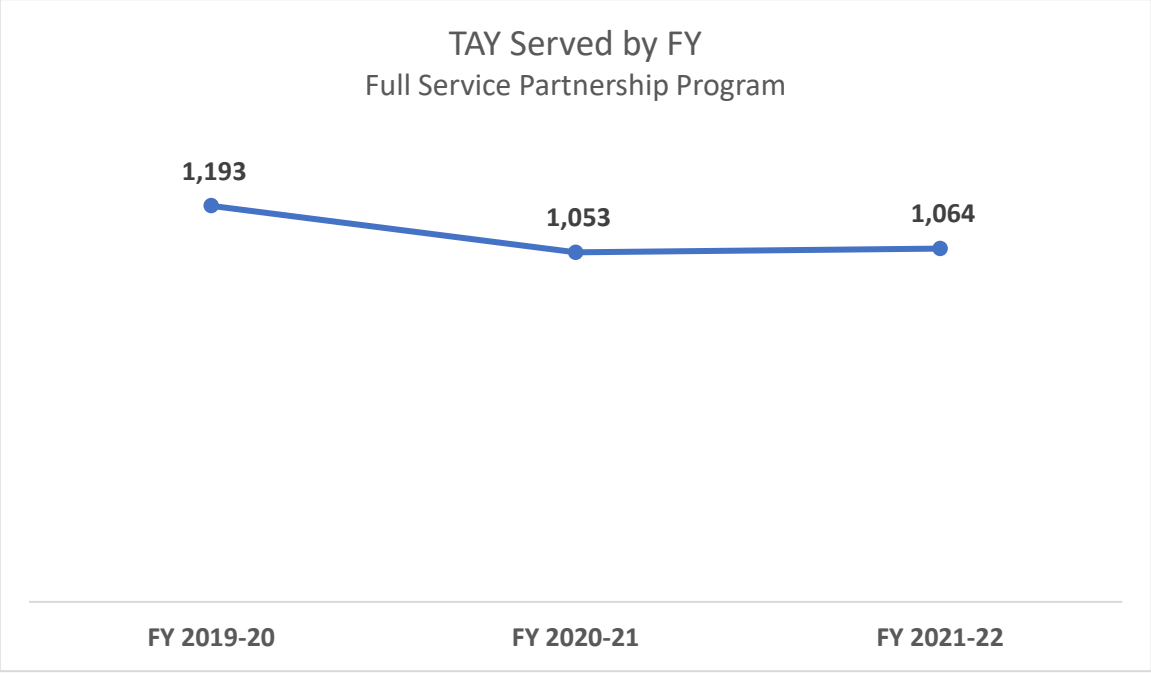
Target Population:

Proportion to be Served by Demographic Characteristic for FY 2023-24					
Age	%	Gender	%	Race/Ethnicity	%
0-15	0%	Female	46%	African American/Black	7%
16-25	100%	Male	54%	American Indian/Alaskan Native	>1%
26-59	0%	Transgender	>1%	Asian/Pacific Islander	11%
60+	0%	Genderqueer	0%	Caucasian/White	18%
		Questioning/Unsure	0%	Latino/Hispanic	61%
		Another	>1%	Middle Eastern/North African	1%
				Another	1%

CSS: Full Service Partnerships

Fiscal Year	Budget	Number to be served	Cost Per Client
FY 2023-24	$8,184,468	1,100	$7,440
FY 2024-25	$8,184,468	1,100	$7,440
FY 2025-26	$8,184,468	1,100	$7,440

The number of TAY served in the FSP program dipped slightly in FY 2020-21 during COVID and remained level through FY 2021-22:



CSS: Full Service Partnerships

FSP programs do "whatever it takes" to support the wellness, recovery and safety of its members, with the goal that at least 80% of members remain safely in the community and do not require psychiatric hospitalization or mental health-related emergency intervention, remain out of custody, avoid arrest and/or do not experience unsheltered homelessness or use of an emergency shelter.

TAY (based on age at the start of the fiscal year being reported) met all targets during the past three years, reflecting the FSP program's success in helping youth maintain their recovery and remain safely in their communities:

Key Performance Indicator	TAY FSP Members			
	Target	FY 2019-2020	FY 2020-21	FY 2021-22
Mental Health Recovery				
No Days in Hospital	**≥80%**	**88.4%**	**90.5%**	**92.1%**
No Emergency Interventions	**≥80%**	**90.7%**	**91.8%**	**94.6%**
Justice Involvement				
No Days Incarcerated	**≥80%**	**87.3%**	**87.7%**	**87.7%**
No Arrests	**≥80%**	**92.9%**	**92.0%**	**91.6%**
Homelessness				
No Days Spent in Unsheltered Homelessness	**≥80%**	**91.8%**	**95.0%**	**95.9%**
No Days in Emergency Shelter	**≥80%**	**93.0%**	**94.8%**	**94.4%**

Green=Target met Red= Target not met

The 80% benchmarks, established in 2022, will be refined as additional years of data are analyzed, with particular attention paid to whether separate benchmarks should be established for programs that specialize in serving those who are justice-involved or experiencing unsheltered homelessness.

CSS: Full Service Partnerships

Success Story:

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.

Challenges/solutions:

Finding safe, affordable and permanent housing in the neighborhoods in which the TAY have support networks 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 TAY becomes increasingly responsible for housing costs so that, when clinical goals are met, the individual is able to maintain housing independently. This strategy creates stability so that

clinical advances can be maintained upon discharge from the program.

Employment has also continued to be an ongoing and significant challenge despite the recovering job market. FSP programs can encounter difficulties identifying employers who are flexible enough to employ individuals who may need a flexible schedule, or time away form work to support their recovery. Yet employment serves as a critical component of recovery by helping increase people's connection with their community, providing a sense of purpose and increasing self-sufficiency. Drawing upon these principles, as well as an 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 vocation skills, gain experience, and increase their confidence in being able to succeed in the workforce.

Addressing co-occurring substance use issues among TAY participants continues to be a challenge. FSP programs continue to focus efforts supporting co-occurring treatment by offering 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 services gaps. FSP staff also work collaboratively with Housing and Supportive Services staff to help individuals with co-occurring issues maintain their housing.

CSS: Full Service Partnerships

Program: Adult Full Service Partnership

Program Serves	Symptom Severity	Location of Services	Typical Population Charateristic
18-59	Severe	Community Based Field Based	Students/Schools; Parents; Families; Medical Co-Morbidities; Criminal Justice Involved; Ethnic Communities; Homeless/At-Risk-of; Recovery from SUD; Trauma Exposed

Overview of the Program:

The Adult Full Service Partnership (FSP) programs provide intensive, community-based outpatient services which include peer support, supportive education/employment services, transportation services, housing, benefits acquisition, counseling and therapy, integration and linkage with primary care, intensive case management, 24/7 on-call response, crisis intervention and co-occurring disorder treatment. These programs strive to reduce barriers to accessing treatment by bringing treatment into the community. Adult FSP programs provide services in a linguistically and culturally competent manner to diverse, underserved populations in Orange County, which includes individuals who may have co-occurring substance use disorders. The target population for the Full Service Partnership (FSP) programs includes adults who have a mental illness and are unserved or underserved and who may be homeless or at risk of homelessness, involved in the criminal justice system, or are frequent users of inpatient psychiatric treatment.

The adult FSP programs operating in Orange County each target unique populations:

- **Criminal Justice FSP** program serves adults who have current legal issues or experience recidivism with the criminal justice system.
- **General Population FSP** serves adults who live with a serious mental illness and who are homeless or at risk of homelessness. These individuals typically have not been able to access or benefit from traditional models of treatment.
- **Enhanced Recovery FSP** is a program that targets adults who are on LPS conservatorship and

returning to the community from long-term care placements such as Institutions for Mental Disease (IMDs), and adults who have offenses and are referred by the Public Defender's Office to the Mental Health Court (Assisted Intervention Court).

- **Collaborative Court FSP** is a voluntary program for non-violent offenders who are referred through the Collaborative Court. The program works in collaboration with probation, the court team and judge, District Attorney's Office and the Public Defender's Office to provide treatment that re-integrates members into the community and reduces recidivism.
- **Assisted Outpatient Treatment FSP** serves adults who have been court-ordered to participate in assisted outpatient treatment and individuals who have voluntarily agreed to participate in treatment and are referred by the county Assisted Outpatient Treatment Assessment and Linkage Team.
- **Housing FSP** serves individuals who are living in permanent housing but struggling to maintain their housing and are at risk of becoming homeless.
- **FSP for Special Populations (new program)** is proposed as an expansion of the adult FSP program. The intention is to provide culturally congruent wraparound services for underserved populations, including but not limited to Veterans, Vietnamese, and Spanish speaking populations.
- The **Program of Assertive Community Treatment (PACT)** is the County-operated version of a Full Service Partnership program. PACT utilizes the evidence-based Assertive Community Treatment model to provide comprehensive, "whatever it takes," field-based outpatient services to persons ages 18-59 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.

Program Goal(s) and intended outcomes

The goal of the Adult FSP Program, as well as all FSP programs, are related to mental health recovery, living situation, justice involvement, and reduced symptoms.

CSS: Full Service Partnerships

Description of Services:

The FSP programs provide personalized services through a coordinated team approach that operates from a “no fail” and “whatever it takes” philosophy, to meet the needs of consumers. This approach included 24/7 access and crisis intervention, along with flexible funding to support individuals in meeting their recovery goals. FSP programs are grounded in the Assertive Community Treatment (ACT) model of providing comprehensive, community-based interventions, linguistically and culturally congruent services, and around-the-clock crisis intervention and support through a coordinated, multidisciplinary teams. The teams can include a combination of clinical and non-clinical staff, including peers, to support mental health, substance use disorder services, housing, case management, and employment needs of the consumer. All team members are committed to the recovery model and the success of their participants. Peer Recovery Specialists/Coaches 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.

Services include individual, family and group counseling and therapy to help individuals reduce and manage their behavioral health symptoms, improve daily functioning, and assist with self-defined family/caregiver dynamics. Consumers enrolled in an FSP programs also receive psychiatric care, medication management, psychoeducation, co-occurring substance use disorder services, mindfulness training, crisis intervention and/or 24/7 support as needed.

To maintain high quality delivery of services, FSP teams are trained in a wide array of evidence-based practices (EBPs) are available, based on individuals needs. EBPs 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, Seeking Safety, Illness Management and Recovery, Moral Reconation Therapy (MRT), behavioral modification and others.

Personal Services Coordinators (PSCs) provide intensive case management to help consumers access crucial medical care, educational support, social and recreational opportunities, mental health rehabilitation, benefits and entitlements, transportation resources, basic needs and other resources available in the community. PSCs and/or other FSP staff also help individuals develop skills to manage challenging symptoms, behaviors or impairments and work with significant others and caregivers, when available, to support client learning and practicing new skills.

Employment and/or housing support and coordination services are provided to assist and support consumers in these essential elements of recovery. Numerous workshops and classes to teach and hone prevocational and vocational skills such as resume writing, interviewing skills, computer skills, etc are offered. Housing coordination services are provided to assist individuals with finding and maintaining safe, suitable housing, as reducing homelessness is one of the target outcomes for the FSPs.

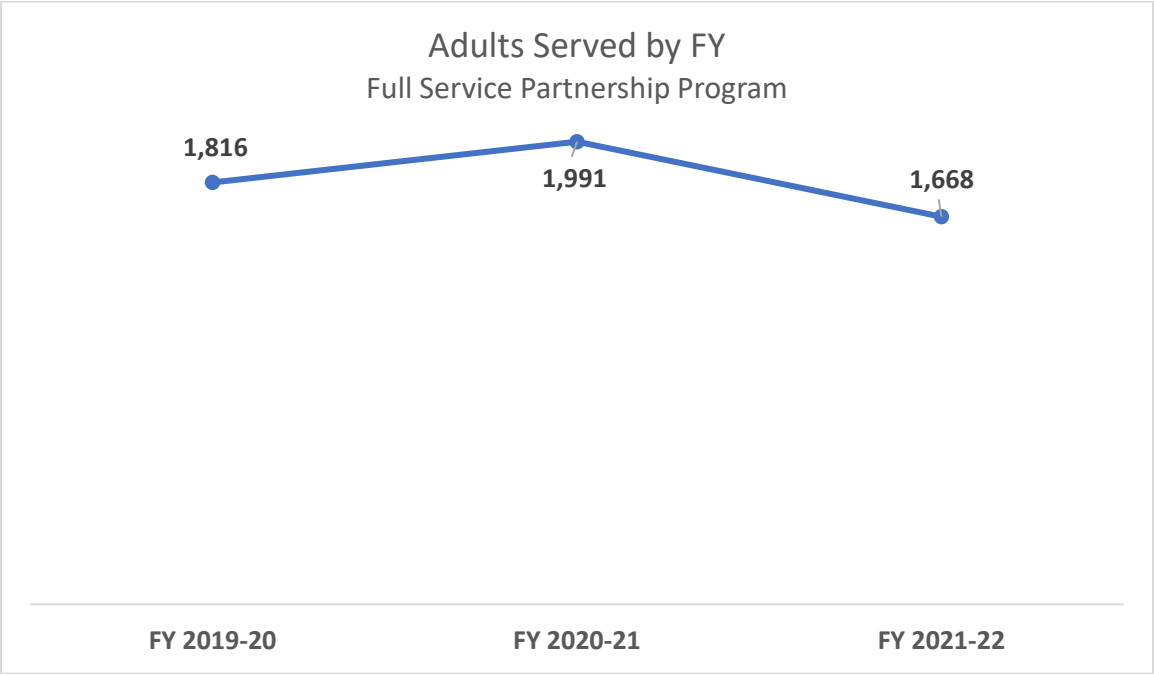
Target Population:

Proportion to be Served by Demographic Characteristic for FY 2023-24					
Age	%	Gender	%	Race/Ethnicity	%
0-15	0%	Female	37%	African American/Black	8%
16-25	0%	Male	63%	American Indian/Alaskan Native	2%
26-59	100%	Transgender	>1%	Asian/Pacific Islander	13%
60+	0%	Genderqueer	0%	Caucasian/White	42%
		Questioning/Unsure	0%	Latino/Hispanic	32%
		Another	>1%	Middle Eastern/North African	2%
				Another	2%

CSS: Full Service Partnerships

Fiscal Year	Budget	Number to be served	Cost Per Client
FY 2023-24	$46,821,467	2,573	$18,197
FY 2024-25	$50,203,733	2,758	$18,202
FY 2025-26	$52,090,590	2,862	$18,200

Positive results/Outcomes:



CSS: Full Service Partnerships

FSP programs do “whatever it takes” to support the wellness, recovery and safety of its members, with the goal that at least 80% of members remain safely in the community and do not require psychiatric hospitalization or mental health-related emergency intervention, remain out of custody, avoid arrest and/or do not experience unsheltered homelessness or use of an emergency shelter.

Adults (based on age at the start of the fiscal year being reported) met almost all targets during the past three years, narrowly missing the 80% benchmark in earlier years, reflecting the FSP program’s success in helping adults maintain their recovery and remain safely in their communities:

Key Performance Indicator	Adult FSP Members			
	Target	FY 2019-2020	FY 2020-21	FY 2021-22
Mental Health Recovery				
No Days in Hospital	≥80%	78.7%	80.4%	85.7%
No Emergency Interventions	≥80%	79.7%	81.7%	86.1%
Justice Involvement				
No Days Incarcerated	≥80%	82.7%	88.7%	86.3%
No Arrests	≥80%	90.7%	92.4%	95.6%
Homelessness				
No Days Spent in Unsheltered Homelessness	≥80%	80.7%	79.7%	80.3%
No Days in Emergency Shelter	≥80%	86.4%	84.4%	84.2%

Green=Target met Red= Target not met

The 80% benchmarks, established in 2022, will be refined as additional years of data are analyzed, with particular attention paid to whether separate benchmarks should be established for programs that specialize in serving those who are justice-involved or experiencing unsheltered homelessness.

CSS: Full Service Partnerships

Success story:

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. The FSP programs have been successful at working 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, Wellness Centers, NAMI, immigration services, faith-based organizations, other 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. In recent years, the FSP programs have also increased collaboration with other HCA departments such as Housing and Supportive Services, Correctional Health Services, and Outreach and Engagement to increase access and coordinate services for individuals who are homeless and/or involved with the justice system. Additionally, the FSP programs have increased collaboration with other agencies including the Orange County Superior Court, Probation Department, Public Defender's Office, and District Attorney's Office, expanded their capacity to serve the justice involved population and developed treatment strategies to support the collaboration and increase individuals chances of successful completion of court program.

Challenges/solutions:

Finding safe, affordable and permanent housing in the neighborhoods in which the individuals/families have support networks 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 for

housing 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. 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.

Addressing co-occurring substance use issues among adult participants continues to be a challenge. The FSP programs are offering more co-occurring groups, working to partner with community substance use treatment programs to expand resources, and developing co-occurring interventions and supports to fill identified service gaps. In addition, the FSP programs have hired more staff that are trained and capable of addressing co-occurring substance use issues, which has increased education and supports for individuals served.

CSS: Full Service Partnerships

Program: Older Adult Full Service Partnership

Program Serves	Symptom Severity	Location of Services	Typical Population Charateristic
60+	Severe	Community Based Field Based	Students/Schools; Parents; Families; Medical Co-Morbidities; Criminal Justice Involved; Ethnic Communities; Homeless/At-Risk-of; Recovery from SUD; Trauma Exposed

Overview of the Program:

The Older Adult Full Service Partnership (FSP) includes both County operated Program of Assertive Community Treatment (PACT) and contracted Older Adult FSP program services. The FSP program provides intensive, community-based outpatient mental health services. The program strives to reduce barriers to access by bringing treatment out into the community. The team provides many services in the field, seeing the individuals at home, in hospitals, or in jail in order to reduce barriers to access treatment. Services are provided in a linguistically and culturally congruent manner to the diverse, underserved older adult population in Orange County. FSP programs utilize multidisciplinary teams which include mental health specialists, clinical social workers, marriage family therapists, life coaches and psychiatrists.

The target population for the Older Adult FSP program is unserved adults ages 60 and older living with a mental illness and who may be homeless or at risk of homelessness, involved in the criminal justice system, frequent users of inpatient psychiatric treatment or emergency rooms, and/or experiencing a reduction in personal and/or community functioning. In addition, those who have repeated emergency room visits or excessive 911 calls due to behavioral health issues are also appropriate for PACT.

Program Goal(s) and intended outcomes

The program's overarching goals include engaging individuals into voluntary treatment and assisting them in reintegrating into the community through stable housing, education, employment, and linking to community based support.

CSS: Full Service Partnerships

Description of Services:

Older Adult FSP's provide intensive, community-based outpatient mental health services which include peer support, supportive education/employment services, transportation services, housing, benefits acquisition, linkage to community resources, counseling and therapy, medication management, integration and linkage with primary care, intensive case management, 24/7 on-call response, crisis intervention and co-occurring disorder treatment. The program strives to reduce barriers to access by bringing treatment out into the community.

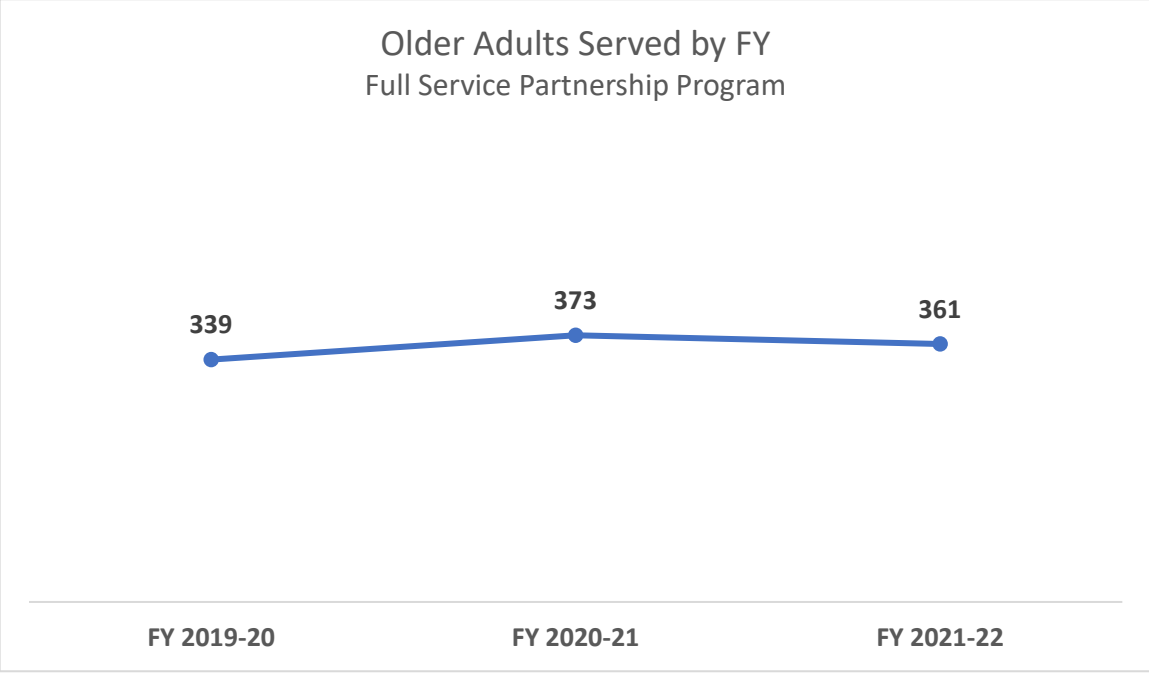
Target Population:

Proportion to be Served by Demographic Characteristic for FY 2023-24					
Age	%	Gender	%	Race/Ethnicity	%
0-15	0%	Female	48%	African American/Black	8%
16-25	0%	Male	52%	American Indian/Alaskan Native	1%
26-59	0%	Transgender	0%	Asian/Pacific Islander	9%
60+	100%	Genderqueer	0%	Caucasian/White	59%
		Questioning/Unsure	0%	Latino/Hispanic	16%
		Another	0%	Middle Eastern/North African	3%
				Another	3%

CSS: Full Service Partnerships

Fiscal Year	Budget	Number to be served	Cost Per Client
FY 2023-24	$4,432,466	350	$12,664
FY 2024-25	$4,432,466	350	$12,664
FY 2025-26	$4,432,466	350	$12,664

Positive results/Outcomes:



FSP programs do “whatever it takes” to support the wellness, recovery and safety of its members, with the goal that at least 80% of members remain safely in the community and do not require psychiatric hospitalization or mental health-related

emergency intervention, remain out of custody, avoid arrest and/or do not experience unsheltered homelessness or use of an emergency shelter.

Older adults (based on age at the start of the fiscal year being reported) met all targets during the past three years, reflecting the FSP program's success in helping older adults maintain their recovery and remain safely in their communities:

Key Performance Indicator	Older Adult FSP Members			
	Target	FY 2019-2020	FY 2020-21	FY 2021-22
Mental Health Recovery				
No Days in Hospital	**≥80%**	**90.9%**	**90.9%**	**92.0%**
No Emergency Interventions	**≥80%**	**95.9%**	**93.6%**	**94.5%**
Justice Involvement				
No Days Incarcerated	**≥80%**	**96.2%**	**96.8%**	**98.6%**
No Arrests	**≥80%**	**98.5%**	**98.7%**	**99.7%**
Homelessness				
No Days Spent in Unsheltered Homelessness	**≥80%**	**87.0%**	**86.9%**	**83.9%**
No Days in Emergency Shelter	**≥80%**	**82.3%**	**82.3%**	**89.5%**

Green=Target met Red= Target not met

The 80% benchmarks, established in 2022, will be refined as additional years of data are analyzed, with particular attention paid to whether separate benchmarks should be established for programs that specialize in serving those who are justice-involved or experiencing unsheltered homelessness.

Challenges/solutions:

Employment has also continued to be an ongoing and significant challenge de- spite 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 in- crease 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 years, the Adult FSP program has worked to secure additional community opportunities and created internal opportunities for volunteer work. Nevertheless, more than any other target out- come, programs continues to struggle with finding supports for individuals to sustain employment..

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 ongoing basis

CSS: Supportive Services – Housing Support

Program: Housing and Year Round Emergency Shelter

Program Serves	Symptom Severity	Location of Services	Typical Population Charateristic
Ages 18+	At-Risk Severe	Residential Based	Criminal Justice Involved Homeless/At-Risk of Trauma Exposed

Overview of the Program:

Year-Round Emergency Shelter (formerly called Short-Term Housing) serves adults with serious mental illness who may have a co-occurring substance use disorder, are experiencing homelessness and in need of immediate shelter. Individuals referred to the program are actively participating in services at Mental Health and Recovery Services Adult and Older Adult County clinics including PACT or County-contracted outpatient clinic.

Program goal(s) and intended outcome(s):

Providers are expected to have the following outcomes

- The average length of stay will be 180 days or less
- Twenty-five percent (25%) of the participants will find transitional or permanent housing within 180 days.

Description of Services:

This program has MHSA-dedicated beds within four existing shelters. In addition to daily shelter, the program provides basic needs items such as food, clothing and hygiene goods. The individuals are also receiving case management and linkage to services designed to assist them in their transition from shelter and into a permanent housing situation. The estimated length of stay for each episode of shelter housing is 180 days. Extensions are considered on a case-by-case basis.

CSS: Supportive Services – Housing Support

Target Population:

Residents eighteen years and older that are experiencing homelessness and need of immediate shelter that are living with a serious mental health illness and may have a co-occurring substance use disorder and are actively participating in Mental Health and Recovery Services Adult and Older Adult clinic services.

Fiscal Year	Budget	Number to be served	Cost Per Client
FY 2023-24	$1,250,000	90	$13,889
FY 2024-25	$1,250,000	90	$13,889
FY 2025-26	$1,250,000	90	$13,889

Positive results/Outcomes:

During Fiscal Year 2021-2022, a total of 68 clients were served by the Year-Round Emergency Shelter program. 49% of participants obtained transitional, or permanent housing within 180 days and the average length of stay was 68 days. As of February 2023, 66 individuals have been served and 43% of those who have exited the shelters have obtained transitional or permanent housing.

CSS: Supportive Services – Housing Support

Challenges/solutions:

Due to COVID-19, facilities experienced times when they were not accepting referrals due to covid positive cases. This limited the amount of available beds. During these incidents facilities followed Public Health Services guidelines in order to resume intakes as quickly as possible. The program continues providing the participants with in-person support and virtual activities to increase receptiveness to staying in the shelter. Programs 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 MHRS 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. Due to the post pandemic economic and housing market hardship, HCA increased the expected length of stay from 120 to 180 days.

CSS: Supportive Services – Housing Support

Program: Bridge Housing for Homeless

Program Serves	Symptom Severity	Location of Services	Typical Population Charateristic
Ages 18+	At-Risk Severe	Residential Based	Criminal Justice Involved Homeless/At-Risk of Trauma Exposed

Overview of the Program:

Homeless Bridge Housing offers interim housing for adults who have been matched to a permanent housing opportunity. The program also serves adults experiencing homelessness who are in the beginning stages of obtaining permanent housing. Adults (including women with children) 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 Mental Health and Recovery Services Adult and Older Adult Services Housing and Supportive Services. Participants can only be referred to the Homeless Bridge Housing Services if they are actively participating in treatment at an MHRS outpatient clinic or a County contracted Full Service Partnership (FSP). The Bridge Re-Entry program serves individuals exiting jail that are in need of shelter and permanent housing.

Program goal(s) and intended outcome(s):

- Minimum of 15 potential landlords contacted a month
- Minimum of 50% of clients with CoC certifications will move into permanent housing in one year
- Minimum of 50% of clients without CoC certificates will move into permanent housing in 18 months
- 50% of clients wills secure work or entitlements within six months of intake

CSS: Supportive Services – Housing Support

Description of Services:

The program provides interim shelter, along with 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 participant's transition to independent living. The provider assists participants in obtaining housing opportunities that include Continuum of Care 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.

Target Population:

Adults eighteen years or older that are experiencing homelessness in Orange County that are diagnosed with a serious mental illness and their income does not exceed 30% Area Median Income (typically around the SSI/SSDI rate or lower). Individuals also need to be actively participating in treatment at an MHRS outpatient clinic or a County contracted Full Service Partnership (FSP).

Fiscal Year	Budget	Number to be served	Cost Per Client
FY 2023-24	$2,400,000	80	$30,000
FY 2024-25	$2,400,000	80	$30,000
FY 2025-26	$2,400,000	80	$30,000

Positive results/Outcomes:

Homeless Bridge Housing tracks a number of measures to monitor its performance in supporting adults living with serious mental illness find permanent housing.

Bridge Housing for the Homeless				
	FY 2018-19	**FY 2019-20**	**FY 2020-21**	**FY 2021-22**
Average # of Potential Landlords contacted per month (Target >15)	27	39	16	16
% of participants with CoC certificates who moved into permanent housing within 1-year (Target >50%)	100%	74%	50%	76%
% of participants without CoC certificates who moved into permanent housing with 18 months (Target >50%)	In progress* (16% housed in 12 months)	41%	35%	35%
% of participants who secured work or entitlements within 6 months of intake (Target >50%)	60%	78%	18%	56%
Persons served by Bridge Housing	78	116	85	132

Challenges/solutions:

Due to COVID-19 facilities experienced times when they were not accepting referrals due to covid positive cases. This limited the number of available beds. During these incidents facilities followed Public Health Services guidelines in order to resume intakes as quickly as possible. The program continues providing the participants with in-person 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. Due to the post pandemic economic and housing market hardship, it has been challenging for the Bridge program to help individuals get matched to a voucher and secure permanent housing within one year of enrolling in the program. HCA has addressed these concerns by approving extensions for the individual to stay in the Bridge program.

CSS: Supportive Services – Housing Support

Program: CSS Housing

Program Serves	Symptom Severity	Location of Services	Typical Population Charateristic
Ages 18+	Severe	Residential Based	Criminal Justice Involved Homeless/At-Risk of Trauma Exposed

Overview of the Program:

In contrast to the programs described 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.

Program goal(s) and intended outcome(s):

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.

Description of Services:

When the MHSA Housing Program concluded in May 2016, the state created the Local Government Special Needs Housing Program (SNHP). Local stakeholders identified an ongoing 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 May 19, 2020, the Board approved allocating $15.5 million to the 2020 Supportive Housing Notice of Funding Availability (OCCR 2020 NOFA) and $20.5 million to the Orange County Housing Finance Trust (Trust).

Each MHSA funded housing development provides onsite support services to all residents. Services are focused on housing sustainability and helping residents meet life goals. Some examples of services include groups that focus on life skills and promote wellness, therapeutic interventions and assessments, linkage to treatment, monthly events calendars, advocacy and open office hours.

CSS: Supportive Services – Housing Support

Target Population:

Individuals living in Orange County with serious mental illness who may have a co-occurring substance use disorder and are experiencing homelessness.

Projected portions to be served and associated demographics (can we include this as a chart):

Fiscal Year	Budget
FY 2023-24	$808,267
FY 2024-25	$20,842,016
FY 2025-26	$20,919,427

CSS: Supportive Services – Housing Support

Positive results/Outcomes:

Completed MHSA Housing Projects				
Name	**City**	**Total MHSA Units**	**Total Units**	**Opened**
Diamond Apartments	Anaheim	24	25	2008
Doria I Apartment Homes	Irvine	10		Sep-11
Doria II Apartment Homes	Irvine	10	134	Dec-13
Avenida Villas	Anaheim	28	29	Mar-13
Cotton's Point	San Clemente	15	76	Nov-14
Capestone Family Apartments	Anaheim	19	60	Dec-14
Alegre	Irvine	11	104	Aug-15
Henderson House	San Clemente	14	14	Mar-16
Rockwood Apartments	Anaheim	15	70	Oct-16
Depot at Santiago	Santa Ana	10	70	Apr-18
Fullerton Heights	Fullerton	24	36	Aug-18
Oakcrest Heights	Yorba Linda	14	54	2018
Santa Ana Arts Collective	Santa Ana	15	58	Jul-20
Hero's Landing	Santa Ana	20	76	Jun-20
Casa Querencia	Santa Ana	28	57	Jan-21
Buena Esperanza	Anaheim	35	70	Jul-21
Westmnister Crossing	Westminster	20	65	Sep-21
Altrudy	Yorba Linda	10	48	Jul-22
The Grove	San Juan Capistrano	10	75	Oct-22
Total		332	1121	

CSS: Supportive Services – Housing Support

MHSA Housing Projects 2023-2025 Pipeline Projects*			
Project Name	**City**	**Estimated Completion**	**MHSA Units**
Casa Paloma	Midway City	2023	24 Units
Ascent	Buena Park	2023	28 Units
Legacy Square	Santa Ana	2023	16 Units
North Harbor Village	Santa Ana	2023	14 Units
Center of Hope	Anaheim	2023	34 Units
Mountain View	Lake Forest	2023	8 Units
Anaheim Midway	Anaheim	2024	8 Units
Motel 6 (Homekey)	Costa Mesa	2024	10 Units
Huntington Beach Senior	Huntington Beach	2024	21 Units
Francis Xavier	Santa Ana	2024	16 Units
Riviera (Homekey)	Stanton	2024	9 Units
Crossroad @Washinton	Santa Ana	2024	20 Units
Santa Angelina Senior	Placentia	2024	21 Units
Stanton Inn and Suite (Homekey)	Stanton	2024	10 Units
Villa St. Joseph	Orange	2024	18 Units
Westview House	Santa ana	2024	26 Units
Paseo Adelanto	San Juan Capistrano	2024	24 Units
Orchard View Gardens	Orange	2024	13 Units
The Meadows	Lake Forest	2025	7 Units
Cartwright	Irvine	2025	10 Units
Lincoln Ave. Apartment	Buena Park	**2025**	**13 Units**
Total Units			**350**

For a complete breakdown of Housing Projects funded by SNHP/NPLH/Trust/NOFA please see page 276 of the MHSA FY 2022-23 Plan Update

CSS: Supportive Services – Housing Support

Challenges/solutions:

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.

Innovation

The MHSA Innovation (INN) component is designed to evaluate the effectiveness of new and/or changed practices or strategies in the field of mental health, with a primary focus on learning and process change, rather than filling a program need or gap. As such, INN strives to change some aspect of the public behavioral health system that may include system or administrative modifications. According to the MHSA INN Project Regulations, each project must focus on mental health, identify an innovative element and clearly state the learning objectives.

An INN project is required to contribute to learning in one or more of the following ways:

- 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 different 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.

In addition, an INN project must serve one or more of the following purposes:

- Increase access to mental health services to underserved groups.
- Increase the quality of mental health services, including measurable outcomes.
- Promote interagency and community collaboration related to mental health services or supports or outcomes.
- Increase access to mental health services.

Each project must be approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC). Projects are time-limited to a maximum of five years, after which successful approaches, strategies or elements may be integrated into existing programs or continued through an alternative source of funding. INN funds are subject to reversion if not spent within three years of allocation or encumbered under an approved INN project.

WELLNESS • RECOVERY • RESILIENCE

Program: Help@Hand

Program Serves	Symptom Severity	Location of Services	Typical Population Charateristic
Adults 18+	Mild, Moderate, Severe	Telehealth	N/A

Overview of the Program:

Help@Hand (formerly Tech Suite) is a statewide project comprised of multiple counties that leverages interactive technology-based mental health solutions (i.e., internet-based and/or mobile applications) to improve access to behavioral health 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 and 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.

Program goal(s) and intended outcome(s):

The Help@Hand Project will examine the following learning objectives:

1. Detect and acknowledge mental health symptoms sooner.
2. Reduce stigma associated with mental illness by promoting wellness.
3. Increase access to the appropriate level of support and care.
4. Increase purpose, belonging and social connectedness of individuals served.
5. Analyze and collect data to improve mental health needs assessment and service deliver.

Description of Services:

Orange County was approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC) to join this statewide collaborative project on April 27, 2018, and immediately began project implementation planning. HCA originally joined as a four-year project, but requested and was 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 test an increase in 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 include:

- Technology Apps (3):
  - 24/7 Peer chat, offering around-the-clock, anonymous peer chat support to an individual.
  - Therapy Avatar, offering 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, utilizing 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/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.

In April 2020, Orange County launched Mindstrong, a technology app that fits within the Customized Wellness Coach component. Mindstrong is a digital mental health app through which licensed therapists, psychiatrists and/or care partners (i.e., Care Team) provide access to telehealth services via phone, or in-app texting, and virtual 24-hour crisis support. The secure smartphone app also uses innovative and proprietary algorithms to anticipate when a person may benefit from additional support, prompting someone from the Care Team to reach out proactively and provide additional, unscheduled support before the person experiences a mental health emergency. 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 Mindstrong app and services are only available to eligible participants within specific partnered programs within Orange County. Services include telehealth, such as therapy, psychiatry and medication management; access to virtual urgent/crisis support 24 hours a day, seven days a week; secure in-app text messaging for on-demand support; proactive clinician outreach; and access to psychoeducation materials, including a personalized in-app dashboard graphing the participant's Mindstrong algorithm results.

During FY 2021-22, Orange County continued its pilot of Mindstrong within a local outpatient psychiatry clinic and expanded to include Mindstrong as a resource on the Mental Health America (MHA) website. Project activities

focused on creating a digital referral and consent process, and refining project implementation to adjust the processes and requirements of multiple partners (i.e., HCA, Mindstrong, outpatient psychiatry clinic, MHA). Details about the Help@Hand Collaborative activities during FY 2021-2022 are available in the Help@Hand Statewide and Orange County Evaluation Reports.

Positive results/Outcomes:

Project learning objectives, along with outcomes from the Mindstrong pilot, will be provided in the Help@Hand Innovation Project Final Report. Outputs of the Mindstrong pilot implementation at the outpatient psychiatry clinic from July 1, 2021, through June 30, 2022, are listed in the table below:

REFERRALS AND ENGAGEMENT	OUTPUT
Total Referrals	294
Total Enrollments	158
Referral to Enrollment Conversion Rate	60%
Total Virtual Therapy Sessions	3,186
% who used virtual therapy sessions	78%
Total Virtual Urgent Sessions (i.e., crisis)	81
% after business hours and during weekends	35%
Average response time (in minutes) from request to connection	7 minutes
Number of unduplicated consumers who used urgent sessions	39
Number of urgent sessions resulting in a call to OC Crisis Assessment Team	0
Total In-App Text Messages (outside of scheduled sessions)	5,047
Average number of days/month consumers use the Mindstrong app	11 days/month
Proactive Clinician Outreach	~50 times/month

Challenges/solutions:

The 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 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.). All phases of the project (e.g., planning, implementation) should include ongoing strategies for effective communication and decision-making. For example, 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 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. Regarding 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. Additional lessons learned will be highlighted in the Help@Hand Project Final Report.

Program: Continuum of Care for Veterans and Military Families

Program Serves	Symptom Severity	Location of Services	Typical Population Charateristic
All Ages	At-Risk Mild-Moderate Severe	Clinic Based Field Based	Parents, Families, At-Risk of or Homeless, Veterans/Military-Connected

Overview of the Program:

Continuum of Care for Veterans and Military Families was implemented July 1, 2018 and ended services on June 30, 2022. Innovation funds for this project ended March 2023. The Continuum of Care for Veterans and Military Families Innovation project integrated military family culture and services into Families and Communities Together (FaCT) Family Resource Centers (FRCs) located throughout Orange County. It sought 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 included active service members, reservists, veterans (regardless of their discharge status) and their children, spouses, partners and loved ones.

Program goal(s) and intended outcome(s):

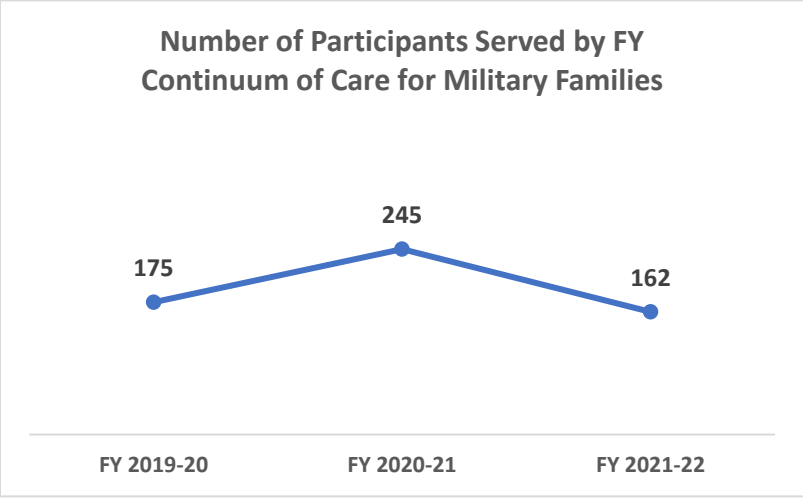
The primary purpose of this project was to increase access to mental health services, with a goal of making a change to an existing practice in the field of mental health, including but not limited to, application to a different population.

Description of Services:

Peer Navigators with lived military experience were 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 was also staffed with clinicians who, with the ongoing support of peer navigators, provide counseling and trauma-informed care utilizing evidence-based practices. Additional services included referral and linkage to County and community programs.

Positive results/Outcomes:

Project outcomes and lessons learned will be reported in the COC Innovation Project Final Report. Outputs of the project from the past three fiscal years are provided below:



The table below provides an overview of the numbers of referrals, the most frequent types of referrals and the percentage of successful linkages.

	Top Referral Categories	Number of Referrals	Percent of Referrals Linked
FY 2019-20	Homeless Services, Affordable Housing & Housing Advocacy	91	74%
	Clothing and other Donated Items	84	86%
	Mental Health & Substance Abuse Services	57	82%
FY 2020-21	Homeless Services, Affordable Housing & Housing Advocacy	106	85%
	Mental Health Services	101	69%
	Clothing and other Donated Items	54	91%
FY 2021-22	Homeless Services, Affordable Housing & Housing Advocacy	63	84%
	Clothing and other Donated Items	61	93%
	Mental Health & Substance Abuse Services	39	54%

Program: Statewide Early Psychosis Learning Health Care Collaborative Network

Overview of the Program:

The Early Psychosis Learning Health Care Network (EP LHCN) is a multicounty 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.

Orange County's participation was approved by the MHSOAC in 2018, and local project start up began in January 2020. Orange County is implementing this project in partnership 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. 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 project will not require that OC CREW change the clinical services that it provides.

To further support this INN project, Orange County also partnered with PEI to develop Thrive Together OC (TTOC) to provide screening, assessment, to youth up to 25 years and their families, who are at clinical high risk of experiencing an early psychosis spectrum condition. TTOC also provides consultation and training to County and community behavioral health providers seeking support in serving this target population. In FY 2021-22, TTOC activities focused on startup activities, including staff recruitment, training development, and assessment and consultation workflow. The TTOC program will transition to PEI to continue the screening, assessment, consultation and training services

Program goal(s) and intended outcome(s):

The EP LHCN INN project does not provide direct services. Details on project activities, lessons learned from implementation and evaluation activities within OC CREW and other first onset programs in participating counties can be found in FY 2021-22 EPLHCN MHSA INN Annual Report.

Program: Behavioral Health System Transformation

Program Serves	Symptom Severity	Location of Services	Typical Population Charateristic
Adults 18+	Mild, Moderate, Severe	Online	BH Providers; 1st Responders; Parents; Families; Medical Co-Mobidities; Criminal Justice Invovled; Ethnic Communities; Homeless/At-Risk of; LGBTIQ+; Trauma Exposed; Veterans/Military Connected

Overview of the Program:

The **Behavioral Health System Transformation** (BHST) project is a 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, 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.

Program goal(s) and intended outcome(s):

The BHST project's goal is to transform the behavioral health system of care by:

1. identifying strategies to braid public and private funding;
2. creating a value-based system;
3. improving navigation of and access to needed resources.

Description of Services:

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, involves the development of a digital navigation tool (i.e., OC Navigator) to guide individuals to resources that support their behavioral health and wellbeing. The development of the OC Navigator, such as features, functionality and resources to include, involves a participatory engagement process with consumers, family members and behavioral health providers throughout Orange County. Core features of the OC Navigator include an optional wellness check-in survey, curated list of resources across various categories of health and wellbeing, translation in the County's threshold languages and ability to update resource information in real-time. Key steps and activities include:

- Curating behavioral health and wellness resources
- Feature and functionality development and testing
- Continuous review and refinement

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 interagency 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.

Positive Results/Outcomes:

The BHST project does not provide direct services, as a result, there are no outcomes to report. However, during FY 2021-22, BHST Part 1 and Part 2 made significant progress in their respective key steps and activities. A full report of all project activities is described in the MHSA INN BHST Annual Project Report.

Program: 05 Psychiatric Advance Directives

Program Serves	Symptom Severity	Location of Services	Typical Population Charateristic
Adults 18+	Mild, Moderate, Severe	Online	Consumers of Behavioral Health, First Responders, Behavioral Health Providers, Parents/ Families of Consumers, Criminal Justice Involved

Overview of the Program:

The Psychiatric Advance Directives (PADs) project is a multicounty INN project designed to help counties improve a consumer's access to appropriate services and quality of care while preserving the individual's life goals and mental health preferences. On June 24, 2021, the MHSOAC approved Orange County, along with several other counties, to participate in this four-year statewide project.

Program goal(s) and intended outcome(s):

The PADs INN project seeks to implement the training and use of PADs across multiple counties, with the goal of developing a standardized PAD training, template and "tool kit" for all California counties.

Description of Services:

The project will engage the expertise of ethnically and culturally diverse communities, threshold populations, consumers, peers with lived experience, consumer and family advocacy groups, and disability rights groups. Participating counties will pilot PADs with adults (ages 18+). Each county has a specific population or program as its focus to identify learnings across diverse groups. Participating counties will be supported by subject matter experts with experience and knowledge in the development, implementation and evaluation of PADs.

Orange County has identified three HCA Programs to pilot the PADs project. These include: Adult Correctional Health Services, Adult Full Service Partnership (FSP) - Program for Assertive Community Treatment (PACT), and Crisis Stabilization Units (CSUs). Additional programs may be added in later phases of the project.

The PADs Innovation Project proposal provides additional details on project activities, which include but are not limited to the following:

- Provide standardized training to increase understanding of the existence and benefits of PADs by communities and stakeholders.
- Develop and implement a standardized PAD template, ensuring that individuals have autonomy and are the leading “voice” in their care, especially during a mental health crisis.
- Utilize peers to facilitate creation of PADs so that shared lived experience and understanding will lead to more open dialogue, trust, and improved outcomes.
- Develop and implement a standardized training "tool-kit" to enable PAD education, policy, and practice fidelity from county to county.
- Align mental health PADs with medical Advance Directives, with a focus on treating the “whole person” throughout the life course.
- Utilize a technology platform for easy access to training, materials, creation, storage, and review of PADs.
- Create a fully functioning cloud-based PADs Technology Platform, for ease of use by consumers, law enforcement, or hospitals for in-the-moment use.

- Use legislative and policy advocacy, with consumer voices in the lead, to create a legal structure to recognize and enforce PADs, so that consumer choice and self-determination are recognized and respected throughout California.
- Evaluate (a) the effectiveness of this project; (b) the ease of use and recognition of PADs; (c) the impact of PADs on the quality of mental health supports and services; and (d) most importantly, the impact of PADs on the quality of life of consumers.

Positive results/Outcomes:

The PADs INN project does not provide direct services, as a result, there are no participant outcomes to report. However, the project includes a formative evaluation to capture the process of developing and implementing PADs, as well as the PAD technology platform. In FY 2021-22, INN Project Staff engaged in ongoing meetings with participating counties to execute contracts with subject matter experts who will be supporting this project. Annual project and evaluation reports will be included in future MHSA Plan updates.

Program: Young Adult Court

Program Serves	Symptom Severity	Location of Services	Typical Population Charateristic
Tranistional Aged Youth (ages 18-25)	Mild, Moderate, Severe	Clinic and Field Based	Justice Involved

Overview of the Program:

The Young Adult Court (YAC) is a five-year INN Project that expands and extends an existing program within the Orange County pilot Young Adult Court developed and piloted by the University of California at Irvine (UCI). There are two primary purposes of the project; to increase access to mental health services to underserved groups and to promote interagency and community collaboration related to mental health service or supports or outcomes. Orange County's project proposal was approved by the MHSOAC in May 2022 and the project started utilizing Innovation funds in September 2022.

Program goal(s) and intended outcome(s):

The overall goal is to make a change to an existing practice in the field of mental health, including, but not limited to, application of a practice for a different population.

Description of Services:

This project uses a randomized controlled trial (RCT) research design to evaluate whether an inter-agency collaboration integrating early intervention services within the YAC effectively reduces recidivism and promotes positive life outcomes for eligible YAC young men ages 18-25. This collaboration includes the Superior Court, District Attorney's Office, Public Defender's Office, Orange County Health Care Agency, Probation Department, community service providers and UCI. This pilot court addresses the multiple needs of the court participants while holding them accountable in a developmentally appropriate way.

The program consists of two components. The first component integrates a broad range of resources and supports including employment, educational and behavioral health support, directly into the court to prevent the worsening of mental health and substance use conditions. The second component leverages the existing RCT design to evaluate those in the YAC compared to those youth participating in a traditional court.

Projected Target Population:

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC FOR FY 2023-24					
Age	**%**	**Gender**	**%**	**Race/Ethnicity**	**%**
0-15	0%	Female	0%	African American/Black	14.8%
16-25	0%	Male	100%	American Indian/Alaskan Native	8.5%
26-59	100%	Transgender	N/A	Asian/Pacific Islander	2.8%
60+	0%	Genderqueer	N/A	Caucasian/White	26.1%
		Questioning or Unsure	N/A	Latino/Hispanic	1.0%
		Another	N/A	Middle Easter/North African	34.8%
				Another	12.0%

Projected portions to be served and associated demographics:

Fiscal Year	Budget	Number to be served*	Cost Per Client
FY 2023-24	$2,121,716	300	$7,072
FY 2024-25	$2,517,225	300	$8,391
FY 2025-26	$2,584,720	300	$8,616

* The final numbers served are based on a variety of legal factors, such as the overall number of charges filed in OC and the number of referrals made to the Young Adult Court. These numbers are estimated based on anticipated caseloads through the courts and subject to change.

Positive results/Outcomes:

The program began under Innovation in September 2022, thus there is limited data available. To protect the rigor of the RCT design, outcomes centered on recidivism, justice involvement rates, survey scores, etc. will not be reported until after a large enough sample of data have been collected and/or the five-year project has been concluded. Output information such as numbers served, interviews conducted, therapy sessions completed, etc. will be tracked and reported annually and included in next year's MHSA Annual Update.

Program: Potential Innovation Projects

1. **INN Community Program Planning Proposal**

The MHSOAC approved the INN Community Program Planning proposal on May 25, 2022. This proposal will utilize INN funds toward community planning and related activities for new and/or ongoing INN Plans over five years. Activities will include, but not be limited to:

- INN Staff time, such as researching concepts, developing materials, coordinating and/or facilitating meetings, drafting proposals, etc.
- Translation and interpretation services to support Orange County's diverse community. Orange County's threshold languages currently include Arabic, Chinese, Farsi, Korean, Spanish, Vietnamese. Materials will also be translated in Khmer and Tagalog to support these sub-threshold communities that are highly active and engaged in community planning meetings.
- Consultants/Subject Matter Experts to support and/or facilitate meetings. These may include individuals with expertise in a specific field, consultants with lived experience (i.e., Peers, family members) or individuals from diverse groups (e.g., Veterans and/or military-connected families, LGBTQ, older adults, deaf and hard of hearing, young adults/transitional age youth, etc.). This effort will also support more culturally responsive INN projects by engaging Orange County's diverse communities and incorporating varying cultural views and perspectives into proposals.
- Marketing strategies and materials to reach the broader community (i.e., flyers/announcements, online surveys, etc.).
- Program supplies (i.e., Stipends for consumers and family members; transportation costs for consumers and family members to attend in-person meetings, as appropriate; presentation/discussion materials; printing costs, etc.).

Proposal activities are anticipated to begin in FY 2023-24.

2. **Community Training, Screening, Clinical Care and Consultation Services for Clinical High Risk for Psychosis**

HCA will implement a new integrated suite of programs and services built off Orange County's pending MHSA INN proposal, "Improving the Early Identification of Youth at Clinical High Risk for Psychosis and Increasing Access to Care." These services will be nested within an overall coordinated system of care designed for youth who are at clinical high risk for psychosis (CHR-P). Where relevant and applicable, services will incorporate and reflect the best practice strategies and learnings identified through the ongoing EP LHCN INN Project.

Online Screening and Engagement: This potential project is pending MHSOAC approval for the use of Innovation funding. The project proposes to engage with young people online, where many youth first go for information, and identify ways to increase the likelihood that those who screen as CHR-P move from the online space to seeking available mental health services. More specifically, Orange County will leverage the Mental Health America (MHA) National online screener to:

- Offer a direct link to CHR-P-specific support in Orange County
- Create enhanced, culturally responsive psychoeducational materials on psychosis and post them on the MHA's website
- Implement online Personalized Normative Feedback interventions

Orange County anticipates that this Innovation proposal will be brought before the MHSOAC Commission in FY 2023-24.

Outreach and Training: Funded through PEI, outreach and training will be offered to two broad categories of potential responder groups: the youth social network and the healthcare provider network. These services will also be offered to campus resource and law enforcement officers. Training will aim to improve the knowledge and skills of potential responders who are present within young people's naturally existing social networks or where they typically spend time (i.e., schools) so they feel:

- Better equipped with how to recognize a young person who may be experiencing symptoms of CHR for psychosis, and
- More comfortable with knowing when and how to refer youth for screening and/or treatment services.

To ensure cultural responsivity, outreach and training materials will be co-developed with peers, family members and community members and leaders from the various potential responder groups.

CHR-P Clinical Services: Funded through PEI, Orange County will establish a program specifically for youth between the approximate ages of 12 to 25 years and who are identified as clinical high risk for psychosis, and their families. Ser- vices will include screening, comprehensive psychosocial assessment, symptom monitoring, prescribing and medication monitoring, psychoeducation, peer sup- port, psychosocial rehabilitation, case management, referrals and linkages to community-based care, and consumer and family consultation. It will also offer a range of evidence-supported clinical interventions for youth at CHR-P such as cognitive behavioral therapy for psychosis and harm reduction. Services will be co-located with Orange County's first episode psychosis program, Orange County Center for Resiliency and Wellness (OC CREW), thus allowing for more supportive care transitions for youth who are identified as experiencing a first episode of psychosis during screening and assessment, or who transition from CHR-P to a first episode of psychosis.

Provider Training and Consultation: Funded through PEI, Orange County will greatly expand and enhance its consultation services for mental health care providers who may work with or encounter youth at risk of developing psycho- sis symptoms. Trainings will use a systematic, evidence-based and trauma-in- formed approach to building the existing

skills and expertise of the healthcare provider, which can include, but is not limited to, the Modular Approach to Care for Individuals at CHR (Thompson et al., 2015). Trainings will consist of didactic training, practice-based coaching, direct observation and follow-up support.

To support and sustain healthcare providers' on-going learning, this program will create a CHR-P Project ECHO "community of practice." This community of practice will be complemented with stepped consultation services:

- One-Time Consultations: Scheduled CHR-P case consultation for healthcare providers. Relevant clinical records are to be shared ahead of time with an authorization to disclose (ATD) completed by the youth and/or parent/guardian
- On-Going Team Consultations: Scheduled monthly case consultation with the youth, family and provider(s) with a completed ATD
- CHR-P Office Hours (anonymous): Casual, drop-in stye office hours for providers to attend as needed for support, questions, etc.
- CHR-P Post-Training Office Hours (anonymous): Casual, drop-in stye office hours for providers, family, support network, etc. following their participation in a training to reinforce learning and use of new skills.

During FY 2021-22 HCA continued to explore the ability to move forward with several potential INN project ideas submitted through the Innovation Idea Generation Website, as well as statewide project opportunities and a World Café event. After additional review of submissions and the MHSA Innovation Regulations and criteria, the potential ideas listed in the table below remain under consideration. 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.

Innovation

Potential INN Project Ideas, listed in alphabetical order:

POTENTIAL IDEA	BRIEF DESCRIPTION	STATUS
Deaf & Hard of Hearing Concept	Workforce development and behavioral health services for the Deaf and Hard of Hearing (DHH) community	Pending further development and review of INN requirements
Older Adult Concept	Develop a system of care for older adults living with both behavioral health and physical conditions who are homeless or at-risk of homelessness	Pending further development and review of INN requirements

Workforce Development and Training

California's public behavioral health system has experienced a shortage of behavioral health workers, changes in mental health occupational classifications, and underrepresentation of diversity of professionals with consumer and family member experience. To address challenges faced by the public behavioral health workforce, the MHSA included a component for Mental Health Workforce Education and Training (WET) programs. WET is a program that provides training opportunities to the MHRS' staff and contract agency staff, promotes the recruitment and hiring of a culturally diverse workforce, offers financial incentives, facilitates clinical intern programs, supports the inclusion and incorporation of consumers and their family members into the behavioral health workforce, and is committed to addressing the workforce shortage within Orange County through utilization of various strategies to recruit and retain qualified behavioral health employees. WET carries forth the vision of the MHSA to create a transformed, culturally-competent system that promotes wellness, recovery, and resilience across the lifespan of all age groups and all cultural backgrounds.

MENTAL HEALTH SERVICES ACT PROPOSITION 63 CALIFORNIA

WELLNESS • RECOVERY • RESILIENCE

Program: Workforce Staffing Support

Program Description

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 OC behavioral health workforce, consumers, family members and the wider OC community.

(1) 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.

(2) Consumer Employment Specialist Trainings and 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. 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.

(3) Liaison to the Regional Workforce Education and Training Partnership

The Liaison to the Regional Partnership represents OC by coordinating regional educational programs; disseminating information and strategies about consumer and family member employment throughout the region; and sharing strategies that increase diversity in the public mental health system workforce. They are also responsible for disseminating OC program information to other counties in the region; and coordinating regional actions that take place in OC such as Trauma-Informed trainings, cultural humility trainings, and support for building our Mental Health First Aid trainer capacity. Furthermore, through the SCRP, the Health Care Access and Information (HCAI) WET grant components will be implemented. The focus areas are Staff Retention,

Workforce Recruitment and Workforce Development/Pipeline programs.

Positive Results

In FY 21/22, WET offered 59 trainings to Staff and contract providers of Orange County either virtually or in-person.

The Consumer Employment Support Specialist has been able to offer trainings and consultations either virtually or in-person which has helped consumers and community providers receive valuable information on returning to work and their benefits. The CES provided 95 trainings and consultations in FY 21/22.

Through the SCRP funded loan repayment program to address staff retention, Orange County approved 61 MHRS staff or contract providers with the loan repayment award. Furthermore, Orange County also participated in the graduate student stipend program which provided a stipend to graduate student interns placed in an eligible public mental health setting for one academic year. 32 students received this award of $6,000.

Challenges and Solutions

Due to the pandemic, all trainings shifted to virtual platforms; however, there is a big push to return to in-person trainings which requires a shift in delivery of services and leveraging staffing resources. Behavioral Health Training Services (BHTS) staff oversee and manage the BH Training Center as well, which is in high demand due to the return of in-person meetings, trainings, and events. Ensuring that staff, equipment, and resources are ready to support the training center and training requests has been a focus of the BHTS team and MHRS leadership.

Fiscal Year	Budget
FY 2023-24	$700,000
FY 2024-25	$800,000
FY 2025-26	$800,000

Program: Training and Technical Assistance

Program Description

The Training and Technical Assistance (TTA) component of WET offers trainings on evidence-based practices, consumer and family member perspectives, and multicultural competency trainings and support for behavioral health providers. 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 (CE) units to MHRS staff and other departments in the HCA requesting trainings for their clinical or medical staff.

Positive Results

In FY 2021-2022, TTA provided a total of 63 trainings to 3,556 attendees. Of these, 57 trainings were focused on specific evidenced-based practices and 58 trainings were CE/CME trainings. Training topics included a Law and Ethics series that covered Legal and Ethical Considerations when Working with Multi-Client and Subpoenas, When Therapists and Client Values Conflict, and Legal and Ethical Issues in Times of COVID. Additional training topics included Cultivating Competency-Based Clinical Supervision, Making Recovery Practice Training Series; Meeting of the Minds Conference; Understanding and Responding to Childhood Trauma and ACEs; and Veterans Conference.

	Total Number of Trainings	Total Number of Attendees	CEs/CMEs Offered	Evidence-Based Practice Trainings
FY 2019-20	78	3,642	52	69
FY 2020-21	42	6,699	27	33
FY 2021-22	63	3,556	35	57

During FY 2021-22, there was a continued need for 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.

Program staff translated, reviewed and field-tested a total of 337 documents into the threshold languages of Spanish, Vietnamese, Farsi, Korean and Arabic in FY 2021-22, which was more than 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 2021-22, the Behavioral Health Equity Committee (BHEC) (formerly called the Cultural Competence Committee) continued to meet regularly via Zoom. The BHEC consists of multi-ethnic partners and multi-cultural experts in OC who meet to provide input on how to incorporate cultural sensitivity and awareness into the Mental Health and Recovery Services (MHRS) system of care and how to provide linguistically and culturally appropriate behavioral health information, resources and trainings to underserved consumers and family members.

The BHEC efforts are focused on the promotion of behavioral health equity for unserved and underserved racial and ethnic communities, as well as lesbian, gay, bisexual, transgender, questioning/queer and intersex (LGBTQI), Veterans, deaf and hard of hearing and other cultural groups.

The BHEC consists of the steering committee, along with members from six workgroups:

- Deaf and Hard of Hearing
- Threshold Languages
- Community Relations & Education
- Spirituality
- Outreach to the Black/African American Communities
- LGBTQ+

During FY 2021-22, BHEC held quarterly public meetings, bringing together steering committee members, workgroup members, and the public, and provided opportunities for direct feedback and input on how to operationalize the CLAS standards' implementation at program/clinic levels; continue to deepen relationships with the communities that we serve; continue to develop diversity, equity, and inclusion in the County's work; and continue to address racism as a public health crisis

Some of the accomplishments include:

- Increasing community participation,
- Providing a 6-hour CE/CME course in LGBTQ+ Affirmative and Informed Practices as a direct result of the collaboration within the LGBTQ+ workgroup,
- Sending out a mental health and substance use needs assessment for faith/spiritual communities,
- Conducting multiple presentations about resources available through HCA at community events to raise awareness and reduce stigma around mental health and recovery practices

Challenges and Solutions

N/A

Program Updates

The following are proposed expansions to this component:

Peer Support Specialist Trainings

Peer Support Specialists are trained individuals with lived experience in mental health and/or their family members. Peer Support Specialists can provide Medi-Cal billable peer services across the continuum of care, including but not limited to, crisis response services, peer counseling, outreach and engagement, linkages to services and supports for consumers of MHRS services, and assist with the implementation, facilitation, and on-going coordination of activities of the MHSA plan. MHRS provides training for consumers and their family members as well as volunteers who want to become Peer Specialists. All Peer Specialist training provided is designed to promote the inclusion of mental health consumers and family members in the public mental health system. With recent legislative changes, MHRS will expand Peer Specialist Training to ensure access for individuals interested in becoming a Peer Specialist.

Health and Wellness Coaching

Health and Wellness Coaches (HWCs) utilize integrative approaches with clients to support wellness and improve health and well-being. HWCs support clients to engage in behaviors that have been proven to improve health and prevent disease including fitness, nutrition, stress coping, sleep, mind-body wellness, and positive psychology interventions. MHRS proposes to train staff, contracted provider agency staff, and others that interact with behavioral health clients to become Health and Wellness Coaches. Health and Wellness Coaches are not required to have advanced degrees, thus, allowing staff to benefit from this quality training and supporting MHRS and providers the ability to up-train individuals already working in underserved settings.

A targeted 625 HWC students (MHRS or contract provider employees) will receive training in how to work in both general medical and behavioral health team environments. Special focus will be placed on whole person care, prevention, and working with underserved populations. Health equity, cultural humility, inclusion, and health disparities_training is including throughout the curriculum, as well as an adult and child /adolescent behavioral health and substance use disorders (BH-SUD) track.

Workforce Education and Training (WET)

Health and Wellness Coaching is a Nationally Board-Certified program. Graduates of the program are nationally board eligible through the American Board of Medical Specialists (ABMS) and includes career-long training upon graduation, at no additional cost. All trainings include outcome measurements and reporting, to support continuous improvement and the ability to update curricula in response to the dynamic healthcare environment. The curricula are designed to progressively build knowledge and skill sets and includes 95 hours of coursework in Coaching Structure, Coaching Process, Health and Wellness, and Ethics and Legalities.

Fiscal Year	Budget
FY 2023-24	$2,315794
FY 2024-25	$2,965,794
FY 2025-26	$3,315794

Program: Mental Health Career Pathways

Introduction

The Mental Health Career pathways component seeks to engage individuals in the community to enter the behavioral health field through a variety of pathways. One of the primary strategies has been to assist consumers and family members of consumers with higher education to seek gainful employment in the behavioral health field (or public mental health system).

Program Description

The Recovery Education Institute's (REI) primary goal is to provide mental health training services to behavioral health consumers and family members of consumers as they move into higher levels of recovery. The trainings include basic issues of life, career management skills, and other skills that are prerequisites for either working or preparing to work in behavioral health services. Classes offered will prepare students to enter either the consumer training program or a certification program by developing and solidifying the personal and academic skills necessary to continue with their education. Students enrolled in the program must be consumers or family members of consumers within the public behavioral health system of County of Orange.

Services provided at the Recovery Education Institute include four (4) basic components: Workshop Courses that include Peer Support Specialist (PSS) training; Pre-Vocational Courses; College Credit Courses; and Extended Education Courses. College credit courses are offered by regionally accredited post-secondary educational institutions, and all courses are culturally appropriate for the behavioral health population(s) served. The Peer Support Specialist training is eighty (80) hours cohort training which prepares students and current peers working in the behavioral health field for the PSS CalMHSA certification. Student advisement sessions support academic counseling, student code of conduct, a student grievance process and student disciplinary procedures, and success coaches provide students with additional academic support, such as tutoring sessions, career coaching, and much more.

Positive Results

Based on FY 2021-22 survey results completed by REI students, 97% of those surveyed strongly agreed or agreed that they can succeed academically, while 96% said they were comfortable applying the skills they learned. The majority also felt comfortable seeking out new job opportunities after engaging in these courses (88%). Also, participants were asked to rate their

satisfaction with REI's program, staff, and services using three Health Care Agency-wide questions. 97% of those surveyed were satisfied with the trainings, and the majority would recommend these trainings to others (97%). These trends are similar to what students reported during FY 2019-20 and FY 2020-21.

Challenges and Solutions

Recently approved by Cal MHSA, REI is the central hub of PSS training vendor and the institution assisting students and current peers to apply for PSS certification. Therefore, REI is experiencing an increased demand for assistance with supporting students and peers applying for the Medi-Cal PSS Certification, grandparenting process, and exam preparation. The process includes walking students through the application steps on CalMHSA's website, retrieving their GED or HS Diploma, assisting them with completing the application, registering for the exams as well as providing PSS training hours and preparing students for the exams. Due to high demand of REI's Employment Specialist and Peer Partner's availability for assisting PSS process, REI's Academic Advisors and Success Coaches are also supporting the PSS process at their best capacity.

Program Updates

After successfully launching the new Peer Support Specialist (PSS) training in Orange County, REI's PSS curriculum is now accredited by CalMHSA. REI assists students who are interested in the Peer Specialist role to meet the eligibility to apply for certification exam. Moreover, REI is the central hub of services providing grandparenting process to peers currently working in the behavioral health field. The PSS curriculum has been a great accomplishment, and as a part of the PSS program, REI provides Peer Partner support for students and has been receiving great feedback.

The following is a proposed expansion to this WET Component:

Orange County MHRS has identified a need to implement a leadership development program (LDP) for staff and staff of contract agencies. MHRS will contract with an organization specializing in designing curricula for leadership development, to plan for the leadership development program. Under this agreement, the contractor will work with MHRS to adapt the program to the needs of MHRS and to ensure that the specialized content (i.e., recovery orientation, cultural humility, and clinical and consumer service areas) is addressed.

Workforce Education and Training (WET)

Through this program, MHRS will develop leaders from existing staff, begin succession planning for future leadership of MHRS, begin to make leadership-based assignments, and build leadership into supervisory training. Traditionally, clinicians have experienced difficulty in moving from direct service provision to supervision, administrative positions and management. Participation in the leadership program will give these employees the tools to be successful in future leadership opportunities.

Fiscal Year	Budget	Number to be served	Cost Per Client
FY 2023-24	$946,384.00	500	$1,892.77
FY 2024-25	$1,246,384.00	500	$2492.77
FY 2025-26	$1,246,384.00	500	$2492.77

Program: Residencies and Internship Programs

Program Description

The Residencies and Internships program trains and supports individuals who aspire to work in the public mental health system.

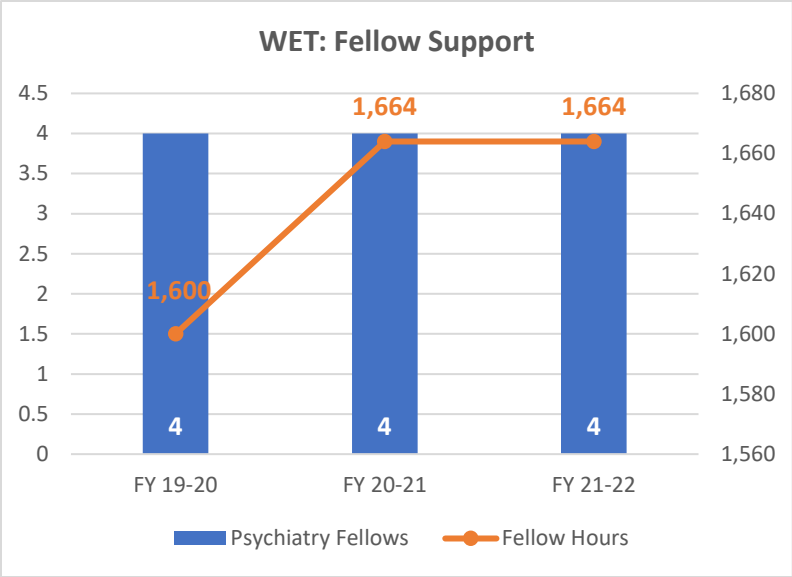
In collaboration with the Psychiatry Department at the University of California-Irvine (UCI) School of Medicine, supervised trainings were provided in the program to teach the recovery philosophy; enhance cultural humility and understanding from the consumer and family perspectives; and recruit talented 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.

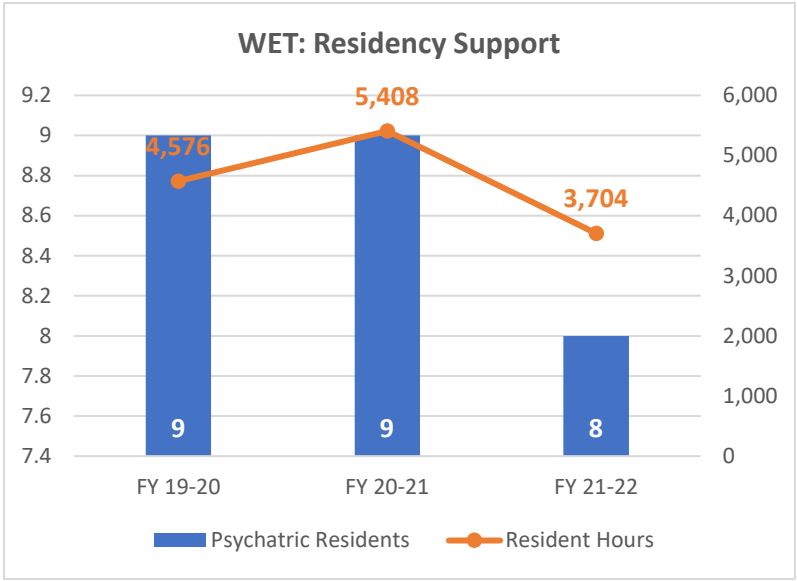
In FY 2021-22, the WET program developed a centralized clinical supervision and internship program, that is being implemented over four phases, to better support clinical supervisors, ensure compliance with state mandates, improve clinical training, and strengthen the formation of new clinicians.

Positive Results

Of the 15 clinical staff that participated in a yearlong intensive training sponsored and funded by the Southern California Regional Partnership of Training Organizations (SCRP), four staff from that group continued for a further six-months in a Train-the-Trainer framework designed to bring updated clinical supervision core principles and practices to the 10 Southern California counties who are part of SCRP. These four staff make up the Clinical Supervision Program Core Team. Since beginning implementation, the WET Program provided its own in-house clinical supervision training with the first new supervisors being trained and ready to practice by the end of August 2022. The Clinical Supervision program has created consultation groups for current supervisors to train them on current state mandates and to increase support for them in their new role. The Core Team created a training program for student interns from local universities who spend an internship year working for Health Care Agency. These started in Fall 2022 and there will be 10-12 monthly trainings that will expose the students to different divisions and programs within MHRS, provide an overview of different therapeutic modalities, discuss the road to clinical licensure, and other salient topics.

Workforce Education and Training (WET)





Challenges and Solutions

Because of the new requirements of California State Assembly Bill 93 which passed into law in 2019, Mental Health and Recovery Services (MHRS) now has greater responsibility to ensure high quality, legally and ethically defensible clinical supervision to its pre-licensed employees. However, there a shortage of interested and available clinical supervisors in MHRS. Due to a variety factors, including lack of differential pay or incentive, it is difficult to recruit highly qualified staff to take the added responsibility of clinical supervision to their already large workload.

Program Updates

The following are proposed expansion to this WET Component:

Expand MHRS Internship Program

The county's Workforce Needs Assessment clearly shows the need to identify ways of increasing the number of Behavioral Health Clinicians (pre-licensed and licensed) and Clinical Psychologists. The county has experienced a loss of clinical positions to private industry, neighboring

Counties, Mental Health pop-up businesses, the State and the hospital systems. These losses are attributed to higher salaries and increased benefits at the criminal justice and state hospital systems. Providing internship opportunities is a way to increase the number of people working at MHRS and in contract agencies in the behavioral health professions.

This action describes plans to increase internships within MHRS as well as coordinate Intern Programs with contract agencies and allow interns from those agencies to attend group supervision sessions conducted by MHRS. In addition, this action will provide additional clinical supervisors to the internship program to further the goals of enhanced supervisor competencies; supplement supervision of interns created by staff shortages; provide licensing preparation support to pre-licensed clinicians; and create an employee internship program for current MHRS staff who have been accepted into a master's level program in a behavioral health related program. As shown in the capacity assessment, MHRS and partnering contract agencies need to improve services to underserved groups. Recruitment of potential employees from underrepresented populations to work in licensed direct service positions will strengthen the overall system. The Intern Supervisors will work with local universities to recruit interns from underrepresented populations.

The creation of an internship unit consisting of an Administrative Manager II and four (4) Service Chief II's to provide supervision for pre-licensed Clinical Therapists and interns will support this program. One FTE Staff Specialist will assist with coordination, placement, and administrative support. These positions mitigate the impact on current supervisors allowing for increased intern supervision. Clinical Supervisors hired for these positions must have training, be skilled in wellness and recovery and cultural competence, and utilize those skills in their supervision and training of interns and pre-licensed employees. Supporting the Intern Supervisors are MHRS clinical supervisors who provide the day-to-day supervision of interns. The new positions will spend a portion of their time in direct supervision of interns and pre-licensed Clinical Therapists in the clinics and a portion of their time working with pre-licensed MHRS employees training and preparing for licensing examinations.

Employee Internship Program

In addition, Orange County MHRS has identified a need to assist current County employees in completion of their educational goals. Implementation of the Employee

Internship Program assists not only current employees but MHRS, as well. To be considered for the Employee Internship Program, employees must show proof of acceptance into a master's level program.

Employees in the program must agree to continue employment with MHRS as a condition of participation on a year-for-year basis. Those who receive educational assistance through the scholarship program for one academic year are required to continue to work for MHRS for one calendar year. This program benefits MHRS by providing programs with additional staff assistance and the ability to complete special projects; assisting clinical staff and other employees in meeting educational goals; increasing morale; improving retention of staff; enhancing the employees' current skills and competence; and increasing productivity and efficiency.

Fiscal Year	Budget
FY 2023-24	$700,000
FY 2024-25	$800,000
FY 2025-26	$800,000

Program: Financial Incentive Programs

Program Description

The Financial Incentive Program (FIP) is designed to assist with retention of existing MHRS staff. The original FIP was a program to expand a diverse bilingual and bicultural workforce by providing tuition coverage through a scholarship to existing MHRS 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 OC public mental health system. Recently, this program has expanded to include the Southern Counties Regional Partnership (SCRP) funded Loan Repayment program for existing MHRS and contract provider staff. This program is a loan forgiveness program to those that qualify and commit to serving the public mental health system (MHRS) for one year.

Positive Results

In FY 21/22, 61 MHRS staff or contract providers were awarded up to $10,000 towards their school loan with the commitment of working in MHRS (or one of its contracted programs) for an additional year. 6 psychiatrists utilized the loan forgiveness program for a total of $273,016 spent towards paying down their loans.

In FY 2021-22, three individuals were enrolled in the FIP, receiving a graduate-level stipend. All three students graduated with their master's degree in a mental health-related field. Over half self-identified as Mexican/Hispanic (66%), followed by Asian (33%) descent. The primary languages spoken were English (66%) and Spanish (33%). These trends are similar to what was reported in previous fiscal years.

Challenges and Solutions

Currently, there are several loan repayment and loan forgiveness programs available to public mental health employees through the Health Care Access and Information (HCAI) state website, which has created some confusion for applicants. Moreover, the original scholarship program discontinued due to lack of interest and lack of flexible intern placement in MHRS. This is currently being reviewed and more flexible terms are being discussed.

Fiscal Year	Budget	Number to be served	Cost Per Client
FY 2023-24	$718,468	71	$10,000
FY 2024-25	$718,468	71	$10,000
FY 2025-26	$718,468	71	$10,000

Capital Facilities and Technological Needs (CFTN)

The Capital Facilities and Technological Needs (CFTN) component must support the goals of the Mental Health Services Act (MHSA) and the provision of MHSA services. The planned use of CFTN funds produce long-term impacts with lasting benefits to include the development of a variety of technological advancements, strategies, and/or community-based facilities to house MHSA and public behavioral health services that support culturally and linguistically appropriate integrated service experiences. Funds may also be used to support an increase in:

- Peer-support and consumer-run facilities,
- Development of community-based, least restrictive settings that will reduce the need for incarceration or institutionalization, and
- The development of technological infrastructure for the public behavioral health system to facilitate high quality, cost-effective services and supports for consumers and their families

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Capital Facilities and Technological Needs (CFTN)

Program: 01 Capital Facilities and Technological Needs

Overview of the Program:

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 programs and 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.

Program Description:

Requirements for Capital Facilities 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).

Capital Facilities and Technological Needs (CFTN)

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.

Requirements for use of Technology Needs 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).

Capital Facilities and Technological Needs (CFTN)

Program Updates

In the MHSA FY 2022-23 Plan Update on Capital Facilities: "Proposed activities in FY22-23 to increase budget $6.3M to contract vendors to get systems in compliance with state regulations. Added $7M for Population Health, add $1.2M for Business Intelligence, $2M Cerner upgrade. Adding $20M for additional Wellness Campus to be built. Right size Behavioral Health Training Facility budget."

"HCA Electronic Health Record (EHR): The county Mental Health and Recovery Services (MHRS) continues to make progress on its planned trajectory of increased deployment and utilization of the Cerner based electronic health record system (EHR), and efforts at promoting increased adoption and effective use to allow better coordination of care with access to more comprehensive data, and realize improvements in outcomes and quality. The goals and objectives of this effort support the goals of "MHSA to promote well-being, recovery, and resilience. There is an ongoing effort to continue to expand to include all areas of MHRS, and to continue to implement additional functionality that supports operational efficiency, the planning and delivery of care, and to comply with all emerging laws and regulations and security and privacy guidelines. The scope of work includes a combination of software, technology infrastructure and services to develop and enhance the overall system. MHRS continues to plan and develop implementation strategies on supporting compliance with goals and objectives of current and emerging complex and large mandated state initiatives.

CURRENT TECHNOLOGY PROJECTS

1. Transition the on-premise model of the Cerner related technology infrastructure to a remote hosted cloud environment provided by Cerner. This will provide several advantages such as high availability and scalability of the system, allow access to the system from anywhere especially as we accommodate a hybrid telecommuting work schedule for staff, increased levels of security, improved monitoring processes, support for an easier path to interoperability and data integration and sharing with other partners in the community, and transference of certain risks to the vendor.

2. Build models for our contract providers to allow secure data interfaces to the Cerner EHR, and to participate, as appropriate, in consent-based Health Information Exchanges to allow data sharing as permitted under the appropriate laws and regulations This data exchange framework will also comply with the state's initiative on

enabling increased data sharing amongst the provider community through their California Data Exchange Framework program.

3. Develop and implement a technology infrastructure using a curated set of software applications that will allow for improved data collection, storage, access and use with the goal of improving client outcomes and enhance the client experience. These efforts will, in part, leverage machine learning data science principles, predictive modeling and artificial intelligence to support MHRS providers in making data-informed clinical decisions at the points-of-care through tools such as real time alerts and reminders. These efforts will also support quality and operational improvements through real-time data visualizations of historical data trends and patterns.

This will be a continuing journey with a focus on the use of data to help develop more effective strategic and tactical plans.

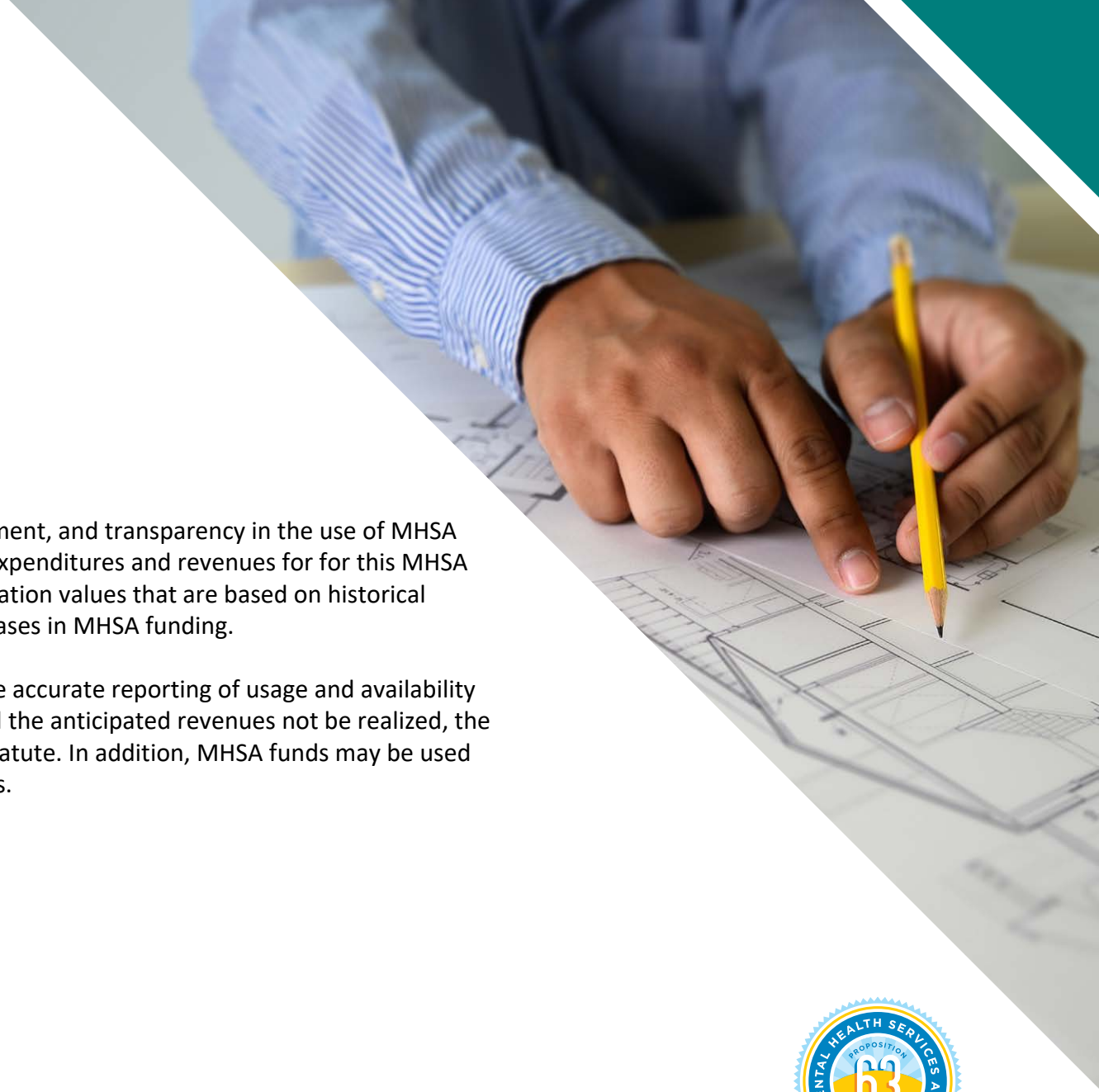
4. Develop and build capability to support the goals and objectives of the state CalAIM program and Payment Reform. These are very comprehensive and large initiatives that seek to transform the delivery system through value-based initiatives and modernization though components involving billing and claims submission, quality monitoring, improvement and reporting, and data-sharing.

5. Implement system upgrades to support the requirements of the CDC Prescription Drug Monitoring Program which includes the tracking of controlled substance prescriptions.

6. Enable increased data sharing internally across the agency to support broader use of available data with the goal of improving client health outcomes.

CFTN Projects	FY 2023-24	FY 2024-25	FY 2025-26
Wellness Campus	$0	$0	$0
BH Training Facility	$25,000	$25,000	$25,000
TN Projects	FY 2023-24	FY 2024-25	FY 2025-26
E.H.R.	$20,620,753	$21,108,448	$22,784,586

Fiscal



As part of continued fiscal accountability, management, and transparency in the use of MHSA funds, MHRS continues the reporting of program expenditures and revenues for for this MHSA Three-Year Plan to be in-line with anticipated utilization values that are based on historical trends, as well as anticipated growth and/or decreases in MHSA funding.

This method of tracking and planning support more accurate reporting of usage and availability of the MHSA funds received from the State. Should the anticipated revenues not be realized, the Plan will be adjusted, in accordance with related statute. In addition, MHSA funds may be used in support of CalAIM implementation requirements.

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FY 2023/24 - 25/26 Annual Update - Mental Health Services Act Expenditure Plan
Funding Summary

County: **Orange** Date: 3/13/2023

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2023-24 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	45,618,568	18,543,644	23,656,007	-	24,733,039	33,258,769
2. Estimated New FY 2023-24 Funding	235,669,335	59,424,500	15,427,500	-	-	
3. Transfer in FY 2023-24	(40,465,983)	-	-	7,504,623	32,961,360	-
4. Access Local Prudent Reserve in FY 2023-24	-	-				-
5. Estimated Available Funding for FY 2023-24	240,821,920	77,968,144	39,083,507	7,504,623	57,694,399	33,258,769
B. Estimated FY2023-24 Expenditures	(187,775,308)	(61,423,491)	(9,848,003)	(7,504,623)	(20,901,030)	
Estimated FY 2024-25 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	53,046,612	16,544,653	29,235,504	-	36,793,369	33,258,769
2. Estimated New FY 2024-25 Funding	235,046,135	59,268,700	15,386,500	-	-	-
3. Transfer in FY 2024-25	(30,159,856)	-		8,758,368	21,401,488	-
4. Access Local Prudent Reserve in FY 2024-25	-	-				-
5. Estimated Available Funding for FY 2024-25	257,932,891	75,813,353	44,622,004	8,758,368	58,194,857	33,258,769
Estimated FY 2025-26 Expenditures	(211,123,128)	(65,818,786)	(7,323,668)	(8,758,368)	(21,401,488)	
E. Estimated FY 2025-26 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	46,809,763	9,994,567	37,298,336	-	36,793,369	33,258,769
2. Estimated New FY 2025-26 Funding	235,046,135	59,268,700	15,386,500	-	-	
3. Transfer in FY2025-26	(31,878,529)	-	-	8,787,501	23,091,028	
4. Access Local Prudent Reserve in FY 2025-26	-	-				-
5. Estimated Available Funding for FY 2025-26	249,977,369	69,263,267	52,684,836	8,787,501	59,884,397	33,258,769
F. Estimated FY 2025-26 Expenditures	(212,528,828)	(62,202,600)	(4,255,557)	(8,787,501)	(23,091,028)	
Estimated FY 2025-26 Unspent Fund Balance	**$ 37,448,541**	**$ 7,060,667**	**$ 48,429,279**	**$ -**	**$ 36,793,369**	**$ 33,258,769**

Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2023	$ 33,258,769
2. Contributions to the Local Prudent Reserve in FY 2023-24	-
3. Distributions from the Local Prudent Reserve in FY 2023-24	-
4. Estimated Local Prudent Reserve Balance on June 30, 2024	$ 33,258,769
5. Contributions to the Local Prudent Reserve in FY 2024-25	-
6. Distributions from the Local Prudent Reserve in FY 2024-25	-
7. Estimated Local Prudent Reserve Balance on June 30, 2025	33,258,769
8. Contributions to the Local Prudent Reserve in FY 2025-26	-
9. Distributions from the Local Prudent Reserve in FY 2025-26	-
Estimated Local Prudent Reserve Balance on June 30, 2026	**$ 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/ 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 2023-24 through FY 2025-26. 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.

c/ Estimated Unspent Fund Balances in CSS and PEI are allocated to support the Strategic Priorities identified in the three-year plan.

FY 2022-23 Annual Update - Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: **Orange** Date: 3/13/2023

Program Description	Fiscal Year 2023/24					
	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. Prevention Services and Supports for Families	**4,400,000**	**4,400,000**				
2. Prevention Services and Support for Youth	**6,200,000**	**4,700,000**				1,500,000
3. Infant and Early Childhood Continuum	**1,000,000**	**1,000,000**				
MENTAL HEALTH AWARENESS & STIGMA REDUCTION CAMPAIGNS & EDUCATION						
4. Mental Health Community Educ. Events for Reducing Stigma & Discrimination	**1,000,000**	**1,000,000**				
5. Outreach for Increasing Recognition of Early Signs of Mental Illness	**13,260,102**	**13,254,592**	-	-	-	**5,510**
Behavioral Health Training Services	1,547,086	1,547,086				
Early Childhood Mental Health Providers Training	1,000,000	1,000,000				
Mental Health & Well-Being Promotion for Diverse Communities	3,457,298	3,454,674				2,624
K-12 School-Based Mental Health Services Expansion	547,631	544,745				2,886
Services for TAY and Young Adults	700,871	700,871				
Statewide Projects	6,007,216	6,007,216				
CRISIS PREVENTION & SUPPORT						
6. Suicide Prevention Services	**4,725,826**	**4,700,000**				**25,826**
SUPPORTIVE SERVICES						
7. Transportation Assistance	**5,000**	**5,000**				
ACCESS & LINKAGE TO TREATMENT (TX)						
8. OCLinks	**5,380,000**	**5,380,000**				
9. BHS Outreach & Engagement (O&E)	**8,689,673**	**8,500,000**				**189,673**
10. Integrated Justice Involved Services	**7,307,402**	**7,307,402**				
OUTPATIENT TREATMENT - Early Intervention						
11. School-Based Mental Health Services	**2,437,807**	**2,272,712**	**4,888**			**160,206**
12. Clinical High Risk for Psychosis	**1,300,000**	**1,300,000**				
13. 1st Onset of Psychiatric Illness	**1,511,932**	**1,250,000**	**191,218**			**70,714**
14. OC Parent Wellness Program	**3,100,000**	**3,100,000**				
15. Community Counseling & Supportive Services	**2,536,136**	**2,536,136**				
16. Early Intervention Services for Older Adults	**3,073,521**	**3,073,521**				
17. OC4VETS	**3,017,663**	**3,000,000**				**17,663**
PEI Administration	10,000,000	10,000,000				
Total PEI Program Estimated Expenditures	**$ 78,945,062**	**$ 76,779,363**	**$ 196,106**	**$ -**	**$ -**	**$ 1,969,593**

Program Description	Fiscal Year 2024/25					
	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. Prevention Services and Supports for Families	**4,400,000**	**4,400,000**				
2. Prevention Services and Support for Youth	**6,200,000**	**6,200,000**				
3. Infant and Early Childhood Continuum	**2,000,000**	**2,000,000**				
MENTAL HEALTH AWARENESS & STIGMA REDUCTION CAMPAIGNS & EDUCATION						
4. Mental Health Community Educ. Events for Reducing Stigma & Discrimination	**1,000,000**	**1,000,000**				
5. Outreach for Increasing Recognition of Early Signs of Mental Illness	**16,126,961**	**16,122,232**	**-**	**-**	**-**	**4,729**
Behavioral Health Training Services	1,547,086	1,547,086				
Early Childhood Mental Health Providers Training	1,000,000	1,000,000				
Mental Health & Well-Being Promotion for Diverse Communities	6,231,481	6,226,752				4,729
K-12 School-Based Mental Health Services Expansion	-	-				
Services for TAY and Young Adults	700,871	700,871				
Statewide Projects	6,647,523	6,647,523				
CRISIS PREVENTION & SUPPORT						
6. Suicide Prevention Services	**4,725,826**	**4,700,000**				**25,826**
SUPPORTIVE SERVICES						
7. Transportation Assistance	**5,000**	**5,000**				
ACCESS & LINKAGE TO TREATMENT (TX)						
8. OCLinks	**5,380,000**	**5,380,000**				
9. BHS Outreach & Engagement (O&E)	**8,689,673**	**8,500,000**				**189,673**
10. Integrated Justice Involved Services	**7,007,402**	**7,007,402**				
OUTPATIENT TREATMENT - Early Intervention						
11. School-Based Mental Health Services	**2,437,807**	**2,272,712**	**4,888**			**160,206**
12. Clinical High Risk for Psychosis	**1,300,000**	**1,300,000**				
13. 1st Onset of Psychiatric Illness	**1,511,932**	**1,250,000**	**191,218**			**70,714**
14. OC Parent Wellness Program	**3,100,000**	**3,100,000**				
15. Community Counseling & Supportive Services	**2,536,136**	**2,536,136**				
16. Early Intervention Services for Older Adults	**3,500,000**	**3,500,000**				
17. OC4VETS	**3,017,663**	**3,000,000**				**17,663**
PEI Administration	10,000,000	10,000,000				
Total PEI Program Estimated Expenditures	**$ 82,938,400**	**$ 82,273,482**	**$ 196,106**	**$ -**	**$ -**	**$ 468,812**

Program Description	Fiscal Year 2025/26					
	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. Prevention Services and Supports for Families	**4,400,000**	**4,400,000**				
2. Prevention Services and Support for Youth	**6,200,000**	**6,200,000**				
3. Infant and Early Childhood Continuum	**2,000,000**	**2,000,000**				
MENTAL HEALTH AWARENESS & STIGMA REDUCTION CAMPAIGNS & EDUCATION						
4. Mental Health Community Educ. Events for Reducing Stigma & Discrimination	**1,000,000**	**1,000,000**				
5. Outreach for Increasing Recognition of Early Signs of Mental Illness	**11,606,729**	**11,602,000**	**-**	**-**	**-**	**4,729**
Behavioral Health Training Services	1,547,086	1,547,086				
Early Childhood Mental Health Providers Training	1,000,000	1,000,000				
Mental Health & Well-Being Promotion for Diverse Communities	6,231,481	6,226,752				4,729
K-12 School-Based Mental Health Services Expansion	-	-				
Services for TAY and Young Adults	700,871	700,871				
Statewide Projects	2,127,291	2,127,291				
CRISIS PREVENTION & SUPPORT						
6. Suicide Prevention Services	**4,725,826**	**4,700,000**				**25,826**
SUPPORTIVE SERVICES						
7. Transportation Assistance	**5,000**	**5,000**				
ACCESS & LINKAGE TO TREATMENT (TX)						
8. OCLinks	**5,380,000**	**5,380,000**				
9. BHS Outreach & Engagement (O&E)	**8,689,673**	**8,500,000**				**189,673**
10. Integrated Justice Involved Services	**7,007,402**	**7,007,402**				
OUTPATIENT TREATMENT - Early Intervention						
11. School-Based Mental Health Services	**2,437,807**	**2,272,712**	**4,888**			**160,206**
12. Clinical High Risk for Psychosis	**1,300,000**	**1,300,000**				
13. 1st Onset of Psychiatric Illness	**1,511,932**	**1,250,000**	**191,218**			**70,714**
14. OC Parent Wellness Program	**3,100,000**	**3,100,000**				
15. Community Counseling & Supportive Services	**2,536,136**	**2,536,136**				
16. Early Intervention Services for Older Adults	**3,500,000**	**3,500,000**				
17. OC4VETS	**3,017,663**	**3,000,000**				**17,663**
PEI Administration	10,000,000	10,000,000				
Total PEI Program Estimated Expenditures	**$ 78,418,168**	**$ 77,753,250**	**$ 196,106**	**$ -**	**$ -**	**$ 468,812**

FY 2023-24 Annual Update - Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Orange Date: 3/13/2023

Program Description	Fiscal Year 2023-24					
	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	**27,174,772**	**21,592,044**	**5,398,011**	**-**	**-**	**184,717**
2. Transitional Age Youth (TAY) Full Service Partnership	**10,668,889**	**8,184,468**	**2,373,496**	**-**	**-**	**110,925**
3. Adult Full Service Partnership	**59,921,350**	**46,821,467**	**12,286,222**	**-**	**-**	**813,661**
Adults	42,333,490	32,105,626	9,631,688	-	-	596,176
Assisted Outpatient Treatment Assessment & Linkage	5,565,576	4,715,841	754,535	-	-	95,200
CARE Court	2,400,000	2,000,000	300,000	-	-	100,000
Supportive services for clients in permanent housing	9,622,285	8,000,000	1,600,000	-	-	22,285
4. Older Adult Full Service Partnership	**5,358,960**	**4,432,466**	**886,493**	**-**	**-**	**40,000**
5. Program for Assertive Community Treatment	**15,092,420**	**11,119,650**	**3,669,485**	**-**	**-**	**303,285**
Non-FSP Programs Partially Categorized as FSP:						
Access and Linkage to Treatment Section:						
1. Multi-Service Center for Homeless Mentally Illness Adults	**129,142**	**129,142**	**-**	**-**	**-**	**-**
2. Open Access	**1,941,102**	**1,500,000**	**420,000**	**-**	**-**	**21,102**
Crisis & Crisis Prevention Section:						
3. Mobile Crisis Assessment Team	**5,887,200**	**4,444,000**	**1,333,200**	**-**	**-**	**110,000**
4. Crisis Stabilization Units (CSUs)	**4,509,750**	**2,400,000**	**2,040,000**	**-**	**-**	**69,750**
5. In-Home Crisis Stabilization	**2,997,282**	**1,715,830**	**1,252,556**	**-**	**-**	**28,896**
6. Crisis Residential Services	**12,867,749**	**6,225,731**	**6,537,018**	**-**	**-**	**105,000**
OUTPATIENT TREATMENT: Clinic Expansion						
7. Outpatient Recovery	**227,000**	**148,000**	**74,000**	**-**	**-**	**5,000**
8. Older Adult Services	**184,314**	**130,500**	**52,200**	**-**	**-**	**1,614**
Supportive Services Section:						
9. Wellness Centers	**414,653**	**414,462**	**-**	**-**	**-**	**191**
10. Supported Employment	**507,389**	**504,927**	**-**	**-**	**-**	**2,462**
Supportive Housing/Homelessness Section:						
11. Housing & Year Round Emergency Shelter	**375,000**	**375,000**	**-**	**-**	**-**	**-**
12. Bridge Housing for the Homeless	**1,577,450**	**1,560,000**	**-**	**-**	**-**	**17,450**
13. CSS Housing	**606,200**	**606,200**	**-**	**-**	**-**	**-**
FSP Sub-Total	***$ 150,440,621***	***$ 112,303,888***	***$ 36,322,680***	***$ -***	***$ -***	***$ 1,814,053***
Non-FSP Programs Not Categorized as FSP:						
Access and Linkage to Treatment Section:						
1. Multi-Service Center for Homeless Mentally Illness Adults	**2,453,706**	**2,453,706**	**-**	**-**	**-**	**-**
2. Open Access	**1,941,102**	**1,500,000**	**420,000**	**-**	**-**	**21,102**
Crisis & Crisis Prevention Section:	-					
3. Warmline	**12,000,000**	**12,000,000**	**-**	**-**	**-**	**-**
4. Mobile Crisis Assessment Team	**9,412,800**	**7,156,000**	**2,146,800**	**-**	**-**	**110,000**
5. Crisis Stabilization Units (CSUs)	**25,555,250**	**13,600,000**	**11,560,000**	**-**	**-**	**395,250**
6. In-Home Crisis Stabilization	**3,631,085**	**2,071,070**	**1,511,881**	**-**	**-**	**48,134**
7. Crisis Residential Services	**14,685,464**	**6,953,885**	**7,301,579**	**-**	**-**	**430,000**
OUTPATIENT TREATMENT: Clinic Expansion	-					
8. Children & Youth Expansion	**27,984,314**	**21,500,000**	**6,450,000**	**-**	**-**	**34,314**
9. Outpatient Recovery	**11,115,973**	**7,252,000**	**3,626,000**	**-**	**-**	**237,973**
10. Older Adult Services	**2,887,587**	**2,044,500**	**817,800**	**-**	**-**	**25,287**
11. Services for the Short-Term Residential Therapeutic Program	**9,521,680**	**7,000,000**	**2,500,000**	**-**	**-**	**21,680**
Supportive Services Section:	-					
12. Peer Mentor and Parent Partner Support	**4,766,308**	**4,766,308**	**-**	**-**	**-**	**-**
13. Wellness Centers	**4,086,864**	**4,085,317**	**-**	**-**	**-**	**1,547**
14. Supported Employment	**1,530,389**	**1,520,538**	**-**	**-**	**-**	**9,851**
15. Transportation	**870,000**	**870,000**	**-**	**-**	**-**	**-**
Supportive Housing/Homelessness Section:	-					
16. Housing & Year Round Emergency Shelter	**875,000**	**875,000**	**-**	**-**	**-**	**-**
17. Bridge Housing for the Homeless	**849,396**	**840,000**	**-**	**-**	**-**	**9,396**
18. CSS Housing	**202,067**	**202,067**	**-**	**-**	**-**	**-**
Sub-Total	***$ 134,368,985***	***$ 96,690,391***	***$ 36,334,060***	***$ -***	***$ -***	***$ 1,344,534***
CSS Administration	20,000,000	20,000,000	-	-	-	
Total CSS Program Estimated Expenditures	**$ 304,809,606**	**$ 228,994,278**	**$ 72,656,741**	**$ -**	**$ -**	**$ 3,158,588**
FSP Programs as Percent of Total	**49%**					

FY 2024-25 Annual Update - Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Orange Date: 3/13/2023

Program Description	Fiscal Year 2024-25					
	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	**28,424,772**	**22,592,044**	**5,648,011**	**-**	**-**	**184,717**
2. Transitional Age Youth (TAY) Full Service Partnership	**10,996,267**	**8,184,468**	**2,700,874**	**-**	**-**	**110,925**
3. Adult Full Service Partnership	**64,275,796**	**50,203,733**	**13,258,402**	**-**	**-**	**813,661**
Adults	44,975,436	34,137,892	10,241,368	-	-	596,176
Assisted Outpatient Treatment Assessment & Linkage	5,565,576	4,715,841	754,535	-	-	95,200
CARE Court	3,952,500	3,350,000	502,500	-	-	100,000
Supportive services for clients in permanent housing	9,782,285	8,000,000	1,760,000	-	-	22,285
4. Older Adult Full Service Partnership	**5,358,960**	**4,432,466**	**886,493**	**-**	**-**	**40,000**
5. Program for Assertive Community Treatment	**16,129,820**	**11,899,650**	**3,926,885**	**-**	**-**	**303,285**
Non-FSP Programs Partially Categorized as FSP:						
Access and Linkage to Treatment Section:						
1. Multi-Service Center for Homeless Mentally Illness Adults	**161,557**	**161,557**	**-**	**-**	**-**	**-**
2. Open Access	**1,941,102**	**1,500,000**	**420,000**	**-**	**-**	**21,102**
Crisis & Crisis Prevention Section:						-
3. Mobile Crisis Assessment Team	**5,904,100**	**4,457,000**	**1,337,100**	**-**	**-**	**110,000**
4. Crisis Stabilization Units (CSUs)	**4,509,750**	**2,400,000**	**2,040,000**	**-**	**-**	**69,750**
5. In-Home Crisis Stabilization	**2,997,282**	**1,715,830**	**1,252,556**	**-**	**-**	**28,896**
6. Crisis Residential Services	**13,800,499**	**6,680,731**	**7,014,768**	**-**	**-**	**105,000**
OUTPATIENT TREATMENT: Clinic Expansion						
7. Outpatient Recovery	**227,000**	**148,000**	**74,000**	**-**	**-**	**5,000**
8. Older Adult Services	**184,314**	**130,500**	**52,200**	**-**	**-**	**1,614**
Supportive Services Section:						
9. Wellness Centers	**434,123**	**433,932**	**-**	**-**	**-**	**191**
10. Supported Employment	**527,768**	**525,306**	**-**	**-**	**-**	**2,462**
Supportive Housing/Homelessness Section:						
11. Housing & Year Round Emergency Shelter	**375,000**	**375,000**	**-**	**-**	**-**	**-**
12. Bridge Housing for the Homeless	**1,577,450**	**1,560,000**	**-**	**-**	**-**	**17,450**
13. CSS Housing	**15,631,512**	**15,631,512**	**-**	**-**	**-**	**-**
FSP Sub-Total	***$ 173,457,072***	***$ 133,031,730***	***$ 38,611,289***	***$ -***	***$ -***	***$ 1,814,053***
Non-FSP Programs Not Categorized as FSP:						
Access and Linkage to Treatment Section:						
1. Multi-Service Center for Homeless Mentally Illness Adults	**3,069,575**	**3,069,575**	**-**	**-**	**-**	**-**
2. Open Access	**1,941,102**	**1,500,000**	**420,000**	**-**	**-**	**21,102**
Crisis & Crisis Prevention Section:	-					
3. Warmline	**12,000,000**	**12,000,000**	**-**	**-**	**-**	**-**
4. Mobile Crisis Assessment Team	**9,460,900**	**7,193,000**	**2,157,900**	**-**	**-**	**110,000**
5. Crisis Stabilization Units (CSUs)	**25,555,250**	**13,600,000**	**11,560,000**	**-**	**-**	**395,250**
6. In-Home Crisis Stabilization	**3,631,085**	**2,071,070**	**1,511,881**	**-**	**-**	**48,134**
7. Crisis Residential Services	**15,085,214**	**7,148,885**	**7,506,329**	**-**	**-**	**430,000**
OUTPATIENT TREATMENT: Clinic Expansion	-					
8. Children & Youth Expansion	**29,934,314**	**23,000,000**	**6,900,000**	**-**	**-**	**34,314**
9. Outpatient Recovery	**11,115,973**	**7,252,000**	**3,626,000**	**-**	**-**	**237,973**
10. Older Adult Services	**2,887,587**	**2,044,500**	**817,800**	**-**	**-**	**25,287**
11. Services for the Short-Term Residential Therapeutic Program	**9,521,680**	**7,000,000**	**2,500,000**	**-**	**-**	**21,680**
Supportive Services Section:	-					-
12. Peer Mentor and Parent Partner Support	**4,990,221**	**4,990,221**	**-**	**-**	**-**	**-**
13. Wellness Centers	**4,251,754**	**4,250,207**	**-**	**-**	**-**	**1,547**
14. Supported Employment	**1,530,389**	**1,520,538**	**-**	**-**	**-**	**9,851**
15. Transportation	**870,000**	**870,000**	**-**	**-**	**-**	**-**
Supportive Housing/Homelessness Section:	-					-
16. Housing & Year Round Emergency Shelter	**875,000**	**875,000**	**-**	**-**	**-**	**-**
17. Bridge Housing for the Homeless	**849,396**	**840,000**	**-**	**-**	**-**	**9,396**
18. CSS Housing	**5,210,504**	**5,210,504**	**-**	**-**	**-**	**-**
Sub-Total	***$ 142,779,944***	***$ 104,435,500***	***$ 36,999,910***	***$ -***	***$ -***	***$ 1,344,534***
CSS Administration	20,000,000	20,000,000	-	-	-	
Total CSS Program Estimated Expenditures	**$ 336,237,016**	**$ 257,467,229**	**$ 75,611,199**	**$ -**	**$ -**	**$ 3,158,588**
FSP Programs as Percent of Total	**52%**					

FY 2025-26 Annual Update - Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Orange Date: 3/13/2023

Program Description	Fiscal Year 2025-26					
	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	**28,424,772**	**22,592,044**	**5,648,011**	**-**	**-**	**184,717**
2. Transitional Age Youth (TAY) Full Service Partnership	**11,159,957**	**8,184,468**	**2,864,564**	**-**	**-**	**110,925**
3. Adult Full Service Partnership	**66,991,210**	**52,090,590**	**14,086,959**	**-**	**-**	**813,661**
Adults	47,623,350	36,174,749	10,852,425	-	-	596,176
Assisted Outpatient Treatment Assessment & Linkage	5,565,576	4,715,841	754,535	-	-	95,200
CARE Court	3,780,000	3,200,000	480,000	-	-	100,000
Supportive services for clients in permanent housing	10,022,285	8,000,000	2,000,000	-	-	22,285
4. Older Adult Full Service Partnership	**5,358,960**	**4,432,466**	**886,493**	**-**	**-**	**40,000**
5. Program for Assertive Community Treatment	**16,129,820**	**11,899,650**	**3,926,885**	**-**	**-**	**303,285**
Non-FSP Programs Partially Categorized as FSP:						
Access and Linkage to Treatment Section:						
1. Multi-Service Center for Homeless Mentally Illness Adults	**161,557**	**161,557**	**-**	**-**	**-**	**-**
2. Open Access	**1,941,102**	**1,500,000**	**420,000**	**-**	**-**	**21,102**
Crisis & Crisis Prevention Section:						-
3. Mobile Crisis Assessment Team	**5,819,600**	**4,392,000**	**1,317,600**	**-**	**-**	**110,000**
4. Crisis Stabilization Units (CSUs)	**4,509,750**	**2,400,000**	**2,040,000**	**-**	**-**	**69,750**
5. In-Home Crisis Stabilization	**2,997,282**	**1,715,830**	**1,252,556**	**-**	**-**	**28,896**
6. Crisis Residential Services	**13,800,499**	**6,680,731**	**7,014,768**	**-**	**-**	**105,000**
OUTPATIENT TREATMENT: Clinic Expansion						
7. Outpatient Recovery	**227,000**	**148,000**	**74,000**	**-**	**-**	**5,000**
8. Older Adult Services	**184,314**	**130,500**	**52,200**	**-**	**-**	**1,614**
Supportive Services Section:						
9. Wellness Centers	**434,123**	**433,932**	**-**	**-**	**-**	**191**
10. Supported Employment	**527,768**	**525,306**	**-**	**-**	**-**	**2,462**
Supportive Housing/Homelessness Section:						
11. Housing & Year Round Emergency Shelter	**375,000**	**375,000**	**-**	**-**	**-**	**-**
12. Bridge Housing for the Homeless	**1,577,450**	**1,560,000**	**-**	**-**	**-**	**17,450**
13. CSS Housing	**15,689,570**	**15,689,570**	**-**	**-**	**-**	**-**
FSP Sub-Total	***$ 176,309,734***	***$ 134,911,645***	***$ 39,584,035***	***$ -***	***$ -***	***$ 1,814,053***
Non-FSP Programs Not Categorized as FSP:						
Access and Linkage to Treatment Section:						
1. Multi-Service Center for Homeless Mentally Illness Adults	**3,069,575**	**3,069,575**	**-**	**-**	**-**	**-**
2. Open Access	**1,941,102**	**1,500,000**	**420,000**	**-**	**-**	**21,102**
Crisis & Crisis Prevention Section:	-					
3. Warmline	**12,000,000**	**12,000,000**	**-**	**-**	**-**	**-**
4. Mobile Crisis Assessment Team	**9,220,400**	**7,008,000**	**2,102,400**	**-**	**-**	**110,000**
5. Crisis Stabilization Units (CSUs)	**25,555,250**	**13,600,000**	**11,560,000**	**-**	**-**	**395,250**
6. In-Home Crisis Stabilization	**3,631,085**	**2,071,070**	**1,511,881**	**-**	**-**	**48,134**
7. Crisis Residential Services	**15,085,214**	**7,148,885**	**7,506,329**	**-**	**-**	**430,000**
OUTPATIENT TREATMENT: Clinic Expansion	-					
8. Children & Youth Expansion	**29,934,314**	**23,000,000**	**6,900,000**	**-**	**-**	**34,314**
9. Outpatient Recovery	**11,115,973**	**7,252,000**	**3,626,000**	**-**	**-**	**237,973**
10. Older Adult Services	**2,887,587**	**2,044,500**	**817,800**	**-**	**-**	**25,287**
11. Services for the Short-Term Residential Therapeutic Program	**9,521,680**	**7,000,000**	**2,500,000**	**-**	**-**	**21,680**
Supportive Services Section:	-					-
12. Peer Mentor and Parent Partner Support	**4,990,221**	**4,990,221**	**-**	**-**	**-**	**-**
13. Wellness Centers	**4,251,754**	**4,250,207**	**-**	**-**	**-**	**1,547**
14. Supported Employment	**1,530,389**	**1,520,538**	**-**	**-**	**-**	**9,851**
15. Transportation	**870,000**	**870,000**	**-**	**-**	**-**	**-**
Supportive Housing/Homelessness Section:	-					-
16. Housing & Year Round Emergency Shelter	**875,000**	**875,000**	**-**	**-**	**-**	**-**
17. Bridge Housing for the Homeless	**849,396**	**840,000**	**-**	**-**	**-**	**9,396**
18. CSS Housing	**5,229,857**	**5,229,857**	**-**	**-**	**-**	**-**
Sub-Total	***$ 142,558,797***	***$ 104,269,852***	***$ 36,944,410***	***$ -***	***$ -***	***$ 1,344,534***
CSS Administration	20,000,000	20,000,000	-	-	-	
Total CSS Program Estimated Expenditures	**$ 338,868,530**	**$ 259,181,497**	**$ 76,528,446**	**$ -**	**$ -**	**$ 3,158,588**
FSP Programs as Percent of Total	**52%**					

FY 2023-24 - 2025-26 3 Yr Plan - Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: **Orange** Date: 3/13/2023

Program Description	Fiscal Year 2023/24					
	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
Statewide Early Psychosis Learning Health Care Collaborative Network	506,213	506,213	-	-	-	-
Behavioral Health System Transformation	2,399,624	2,399,624	-	-	-	-
Psychiatric Advance Directives (PADS)	3,149,613	3,149,613	-	-	-	-
Young Adult Court	2,121,716	2,121,716	-	-	-	-
Community Planning	190,000	190,000				
Subtotal Of All INN Programs	***8,367,166***	***8,367,166***	**-**	**-**	**-**	**-**
INN Administration	1,480,837	1,480,837	-	-	-	-
Total INN Program Estimated Expenditures	**$ 9,848,003**	**$ 9,848,003**	**$ -**	**$ -**	**$ -**	**$ -**

Program Description	Fiscal Year 2024/25					
	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
Psychiatric Advance Directives (PADS)	3,135,606	3,135,606	-	-	-	-
Young Adult Court	2,517,225	2,517,225	-	-	-	-
Community Planning	190,000	190,000	-	-	-	-
Subtotal Of All INN Programs	***5,842,831***	***5,842,831***	**-**	**-**	**-**	**-**
INN Administration	1,480,837	1,480,837	-	-	-	-
Total INN Program Estimated Expenditures	**$ 7,323,668**	**$ 7,323,668**	**$ -**	**$ -**	**$ -**	**$ -**

Program Description	Fiscal Year 2025/26					
	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
Young Adult Court	2,584,720	2,584,720	-	-	-	-
Community Planning	190,000	190,000	-	-	-	-
Subtotal Of All INN Programs	***2,774,720***	***2,774,720***	**-**	**-**	**-**	**-**
INN Administration	1,480,837	1,480,837	-	-	-	-
Total INN Program Estimated Expenditures	**$ 4,255,557**	**$ 4,255,557**	**$ -**	**$ -**	**$ -**	**$ -**

FY 2023-24 - 2025-26 3 Yr Plan - Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: **Orange** Date: 3/13/2023

Program Description	Fiscal Year 2023/24					
	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
Workforce Staffing Support	1,814,758	1,814,758	-	-	-	-
Training and Technical Assistance	2,273,329	2,273,329	-	-	-	-
Mental Health Career Pathways	1,440,663	1,440,663	-	-	-	-
Residencies and Internships	700,000	700,000	-	-	-	-
Financial Incentives Programs	718,468	718,468	-	-	-	-
Subtotal Of All WET Programs	***6,947,218***	***6,947,218***	**-**	**-**	**-**	**-**
WET Administration	557,605	557,605	-	-	-	-
Total WET Program Estimated Expenditures	**$ 7,504,823**	**$ 7,504,823**	**$ -**	**$ -**	**$ -**	**$ -**

Program Description	Fiscal Year 2024/25					
	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
Workforce Staffing Support	1,814,758	1,814,758	-	-	-	-
Training and Technical Assistance	2,973,329	2,973,329	-	-	-	-
Mental Health Career Pathways	1,666,663	1,666,663	-	-	-	-
Residencies and Internships	1,000,000	1,000,000	-	-	-	-
Financial Incentives Programs	718,468	718,468	-	-	-	-
Subtotal Of All WET Programs	***8,173,218***	***8,173,218***	**-**	**-**	**-**	**-**
WET Administration	585,150	585,150	-	-	-	-
Total WET Program Estimated Expenditures	**$ 8,758,368**	**$ 8,758,368**	**$ -**	**$ -**	**$ -**	**$ -**

Program Description	Fiscal Year 2025/26					
	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
Workforce Staffing Support	1,814,758	1,814,758	-	-	-	-
Training and Technical Assistance	2,973,329	2,973,329	-	-	-	-
Mental Health Career Pathways	1,666,663	1,666,663	-	-	-	-
Residencies and Internships	1,000,000	1,000,000	-	-	-	-
Financial Incentives Programs	718,468	718,468	-	-	-	-
Subtotal Of All WET Programs	***8,173,218***	***8,173,218***	**-**	**-**	**-**	**-**
WET Administration	614,283	614,283	-	-	-	-
Total WET Program Estimated Expenditures	**$ 8,787,501**	**$ 8,787,501**	**$ -**	**$ -**	**$ -**	**$ -**

FY 2023-24 - 2025-26 3 Yr Plan - Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: **Orange** Date: 3/13/2023

Program Description	Fiscal Year 2023/24					
	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						
Behavioral Health Training Facility	25,000	25,000	-	-	-	-
Technological Needs Projects						
Electronic Health Record (E.H.R)	20,620,753	20,620,753	-	-	-	-
CFTN Administration	255,276	255,276	-	-	-	-
Total CFTN Program Estimated Expenditures	**$ 20,901,029**	**$ 20,901,029**	**$ -**	**$ -**	**$ -**	**$ -**

Program Description	Fiscal Year 2024/25					
	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						
Behavioral Health Training Facility	25,000	25,000	-	-	-	-
Technological Needs Projects						
Electronic Health Record (E.H.R)	21,108,448	21,108,448	-	-	-	-
CFTN Administration	268,040	268,040	-	-	-	-
Total CFTN Program Estimated Expenditures	**$ 21,401,488**	**$ 21,401,488**	**$ -**	**$ -**	**$ -**	**$ -**

Program Description	Fiscal Year 2025/26					
	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	25,000	25,000	-	-	-	-
Technological Needs Projects						
2. Electronic Health Record (E.H.R)	22,784,586	22,784,586	-	-	-	-
CFTN Administration	281,442	281,442	-	-	-	-
Total CFTN Program Estimated Expenditures	**$ 23,091,028**	**$ 23,091,028**	**$ -**	**$ -**	**$ -**	**$ -**